Milwaukee BHD
Milwaukee County Behavioral Health Division

REQUEST FOR PROPOSALS

For Provider of Crisis (Emergency Department), Observation and Inpatient Care (Acute Adult and Child and Adolescent) Services for the Behavioral Health Division – Including High Acuity and Involuntary Detention Services

RFP # 2015-RFP-BHD-1000

RFP Issue Date: July 15, 2015

INFORMATION SUMMARY SHEET

RFP Issuing Office: Milwaukee BHD – Behavioral Health Division

RFP Issue Date: July 15, 2015

Deadline for Receipt of Mandatory Conference Questions: July 28, 2015 at 5:00PM

Date of Mandatory Pre-Proposal Conference: August 24, 2015 at 1:30pm

Mandatory Pre-Proposal Conference Location:

Milwaukee BHD Behavior Health Division
9455 Watertown Plank Road
Wauwatosa, WI 53226
Room 1045

Deadline for Receipt of Post-Proposal Conference Questions: August 10, 2015 at 5:00PM

Written Q & A Posted to Website: August 17, 2015

RFP Proposal Receipt Deadline: Noon, November 15, 2015

RFP Submission Location: County Clerk's Office
Room 105
901 North 9th Street
Milwaukee, WI 53233

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Proposal, Q&A and Addenda Posting Site: http://BHD.milwaukee.gov/Corrections22671.htm. It shall be the responsibility of each Provider, prior to submitting a proposal, to check the website for addenda and other postings related to this RFP.

MILESTONES

RFP Milestones	Proposed Completion Dates
RFP issue date	July 15, 2015
Questions to be addressed at Pre-proposal Conference due	July 28, 2015
Pre-proposal Conference	August 24, 2015
Post-proposal Questions Due	August 10, 2015
Written Q&A posted to website	August 17, 2015
Written Proposals due	November 15, 2015
Evaluation Period	November 30, 2015 Oral presentation to occur about the evaluation period (only done to select the finalist)
Notice of Intent to Award Contract	January
Presentation to Mental Health Board	April – June BHD Board meeting
Contract Start Date	TBD

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SECTION 1

PURPOSE, BACKGROUND AND MEASURES

1.1 PURPOSE AND OVERVIEW

The purpose of this Request For Proposals (RFP) is to obtain proposals from an independent contractor (Contracted Provider, Provider or Proposer) to provide and operate a physical facility to offer acute care behavioral health services to the community currently served by the Milwaukee County Behavioral Health Division (BHD). Specifically, the Contracted Provider will: (1) provide acute inpatient behavioral health services; (2) operate a 24-hour psychiatric emergency department that serves as the designated legal detention facility pursuant to Wis. Stat. s. 51.08; (3) provide observation services; and (4) provide all services specified below in Section 2.2 - Obligations (collectively, Contracted Services or Services). Contracted Services shall be provided to the members of the Milwaukee County community including adults, adolescents and children, with a focus on high acuity and involuntarily detained patients.

The BHD Strategic plan outlines the intent to provide all required services through highly qualified and effective contracted providers. This RFP for emergency and acute services sets the stage for BHD to operate as a purchaser of services with a goal of eventually operating as a managed care organization with a full continuum of behavioral health services. In the next two to five years, BHD will explore and evaluate the feasibility of developing an Accountable Care Organization (ACO) with behavioral health as the core service focus as well as primary care supports by developing other key community relationships. Some of the primary goals of the ACO will be to accomplish the following objectives, to the extent feasible and otherwise permitted under applicable state and federal law:

- Encourage shared accountability at the provider level for the cost and quality of mental and behavioral health care services.
- Create a clinically integrated delivery system that coordinates a wide array of outpatient and inpatient behavioral health services to improve the quality of care and curb costly hospitalization expenditures, particularly for those with chronic conditions.
- Leverage community and provider partnerships to promote integration/coordination between primary care and behavioral health services through enhanced payment models.
- Develop and implement innovative ways to tie payments to performance on select quality measures that reflect improved quality of care and improved outcomes.
- Eliminate or reduce electronic medical record interoperability challenges that serve as barriers to data exchange so that providers can have access to shared patient information including, without limitation:

patient diagnosis, appointment scheduling, care treatment plan, prescribed medications, and other clinical information.

BHD is also in the process of developing a comprehensive program to ensure all clients can easily navigate through the continuum of behavioral health services. As a patient centered, recovery focused organization, it is imperative BHD provide services which meet the unique needs of the individual as they travel through their personal recovery journey. The Contracted Provider is expected to embrace BHD's person centered, recovery oriented, trauma informed, culturally intelligent focused philosophy of care. (See Attachment A). Additionally, Contracted Provider is expected to demonstrate and commit to working with clients and ensure services are received in the least restrictive environment. Milwaukee County has long been the safety net for people with mental health needs, hence the Contracted Provider must embrace this responsibility.

BHD is statutorily required to provide certain behavioral health services pursuant to Chapter 51 of the Wisconsin Statutes (Required Services) which include, among others, the Contracted Services. BHD will continue to provide certain required contracted services including community based services (Community Services) intended to achieve the BHD's mandate to provide services in the least restrictive setting.
BHD currently provides these services in the Milwaukee County Behavioral Health Complex, located at 9455 Watertown Plank Road, Wauwatosa, Wisconsin (Complex). The Complex is physically deteriorating such that it is reaching the end of its useful life. The Contracted Provider will need to provide the physical facility for the Contracted Services. Therefore, the Contracted Provider shall submit a plan identifying the specifics of providing the Contracted Services. The plan shall specify the logistics of daily operation, ownership and maintenance of all assets and facilities. The plan should also identify industry standards, evidence-based best practices, and applicable Federal, State and local regulations and standards to ensure safe operations for employees, patients and the general public.

Additionally, Provider may consider entering into a transitional separate agreement to ensure and facilitate a seamless transition. The transitional agreement may include services provided by members of the current medical staff: psychiatrists, psychologists, general practitioners, allied health staff, and other critical staff as deemed by Provider. BHD would lease services of said staff at cost until such time as Provider is ready to start recruitment efforts.

The Contracted Provider will regularly report to BHD and the Board of Directors regarding quality, safety, clinical outcomes, utilization, financial, service, operational assessments of the system, or other parameters identified by BHD.

Ultimately, the goal for this project is for the Contracted Provider to work collaboratively with BHD to operate collectively to provide patient-centered, recovery-focused, trauma informed, and culturally intelligent, streamlined, efficient, and high quality behavioral health care.

1.2 BACKGROUND

Mission

BHD is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

Vision

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

Core Values:

- Patient centered care
- Best practice standards and outcomes
- Accountability at all levels
- Recovery support in the least restrictive environment
- Integrated service delivery

Philosophy of and Partnership in Care – BHD and Contracted Provider shall work together to ensure coordination and cooperation among all Providers to improve patient outcomes and increase the value of care by providing patient-centered, recovery-oriented, trauma informed, culturally intelligent, and cost-efficient care for individuals in the least restrictive environment, as well as improve population health outcomes. It is crucial to the BHD philosophy that the patients and their families participate as active members of the care team. Partners in this vision include other stakeholders within Milwaukee County, the greater Milwaukee and Wisconsin communities, and nationally.

Culture of Quality, Safety and Innovation – BHD and Contracted Provider will promote and maintain a culture of data-driven decision making and continuous improvement, focused on quality and safety, meeting and exceeding regulatory, accreditation, best practice standards and patient and family expectations. BHD and Contracted Provider will implement technology and other mechanisms to treat each individual patient in a coordinated way across care settings.

Healthy, Learning Environment – BHD and Contracted Provider will facilitate a positive learning environment and a culture grounded in respectful communication, collaboration, and healthy working relationships. BHD and Contracted Provider will be committed to the philosophy of appropriate clinical training to ensure well-informed patient care.

Financial Resources – BHD and Contracted Provider are committed to the principle of joint accountability for cost effective services and preservation of infrastructure. BHD and Contracted Provider shall work together to build and maintain sustainable resources to ensure continued availability of Contracted Services into the foreseeable future.

BHD provides intensive short term inpatient behavioral health care and treatment to adults, children and adolescents, including inpatient, adult observation and psychiatric emergency room. BHD specializes in managing patients with high acuity and those who are involuntarily detained (civil commitments). Services are currently provided in the Complex, which is an aging and too-large facility.

The 24-hour Psychiatric Emergency Department is currently operated with an adjunct Observation unit consisting of 18 beds. The Acute Inpatient Service is currently budgeted for 60 acute adult psychiatric beds and one child and adolescent unit (CAIS) budgeted for 12 beds (licensed capacity 18). In all, the acute service has 90 beds. BHD is licensed to operate 144 acute beds.

The adult units consists of a 24 bed Acute Treatment Unit (ATU), one 18 bed Women's Treatment Unit (WTU) and one 18 bed Intensive Treatment Unit (ITU). All units provide inpatient care to individuals who require safe, secure, short-term or occasionally extended hospitalization. A multi-disciplinary team approach of psychiatry, psychology, nursing, social service and rehabilitation therapy provide assessment and treatment

designed to stabilize an acute psychiatric need and assist the return of the patient to his or her own community. The WTU program provides specialized services for women recovering from complex and co-occurring severe mental health disorders. The ITU program provides a safe, supportive environment for those individuals with mental health conditions who are at high risk for aggressive behavior and in need for intensive behavioral and pharmacological interventions. The Child and Adolescent Inpatient Service (CAIS) unit provides inpatient care to individuals age 18 and under. The CAIS unit also provides emergency detention services for Milwaukee BHD as well as inpatient evaluations for Children's Court/Juvenile Detention.

Until recently BHD provided long-term rehabilitative care for residents with complex medical and behavioral needs provided through two Skilled Nursing Facility programs, Rehabilitation Central, an Institute of Mental Disease and Hilltop, an Institute for Developmentally Disabled. In December of 2014, Hilltop, the 72-bed Medicaid-certified unit for adults with developmental disabilities, closed.
"Rehab" Central, the 70-bed Medicaid certified unit, is expected to close during 2015. The current census is 20.

A recent analysis by the Milwaukee-based independent research organization, the Public Policy Forum (PPF) and their national partner Human Services Research Institute (HSRI), has identified that there remains a need for approximately 60 adult inpatient beds for patients with high acuity behavioral health problems, in addition to observation beds and inpatient services for children and adolescents. (See Attachment L)

Currently, services at BHD are provided by a combination of contracted services as well as employees of BHD.
Clinical contracted services include:

- Pharmacy
- Radiology
- Physical Therapy
- EKG
- Laboratory

Non – clinical contracted services include:

- Housekeeping
- Security
- Food Service

Services Rendered by BHD Employees include:

- Psychiatry
- Family Medicine Physicians and Advance Practice Nurses
- Psychologist
- Registered Nurses
- Certified Nursing Assistants
- Social Workers
- Occupational Therapy
- Music Therapy

Services Provided by BHD Administration include:

- Facility Executive Administration and Oversight
- Quality Improvement and Compliance
- Medical Records
- Billing and Fiscal
- Medical Staff Services

Services Provided by Milwaukee County Administration on a cross-charge basis include:

- Information Technology

- Human Resources
- Payroll
- Legal
- Risk Management

Since 2010 BHD experienced a 20% reduction in the utilization of the psychiatric emergency department, a 30%reduction in emergency detentions, and a 48% decrease in admissions to adult inpatient units. The decrease in utilization of services is related to the stated goal to reduce reliance on inpatient care and increase community-based services that was part of the Mental Health Redesign Initiative begun in 2010. This strategy reflects the national trend in strengthening community services, and supports the rights of individuals with mental disabilities to live in the community in the least restrictive setting. These positive trends are consistent with the directives of the Affordable Care Act. Further analysis of inpatient utilization patterns in Milwaukee County can be found in the report titled Analysis of Adult Bed Capacity for Milwaukee County Behavioral Health System, published by the Public Policy Forum September 2014. (See Attachment L.)

There are two additional reports which support this strategy. The Public Policy Forum also published A Fiscal Analysis of the Milwaukee County Behavioral Health Division Re-design, which analyzes expenses of BHD from 2010-2014 reflecting the impact of the initiative (see Attachment C), and The Department of Health Services published its Assessment of the Milwaukee County Behavioral Health System, November 14, 2014, which evaluates the effectiveness of the Mental Health System (see Attachment B).

1.3 SERVICE STATISTICS AND MARKET DATA INFORMATION

Service statistics – See Attachment D-J.

1.4 FACILITIES

A strategic facilities committee has been meeting since November of 2014 and has determined the current facility is no longer financially sustainable, therefore the current patient population served by BHD will need to be cared for in a different location.

- The Proposal shall identify and explain the process to create an acute facility
- Must reflect that the acute facility is of sufficient size and space for excellent care, reflecting the projected intended square footage and number of beds
- Must identify the intent to meet all federal, state, local and Joint Commission requirements for safe acute psychiatric space
- Describe the proposed plan for transitioning services, departments and patients to a different facility
- Must commit that the acute facility would be located in Milwaukee County, and on a bus line
- Must commit that the acute facility would be available for use/occupancy by the first quarter of 2018 or before
- In the event of a Provider default resulting in a termination of the contract, must include a right for BHD to lease the portion of the facility necessary to meet BHD's obligations
- Must include a right of first refusal for BHD to purchase the facility
- Must commit that the facility will be limited to use for providing only healthcare services

1.5 BEST PRACTICES

The Contracted Provider shall use the best available research to select evidence-based practices that have been shown to support the achievement of a positive patient experience that is also patient centered, trauma informed, culturally intelligent and recovery oriented approach to care. Additionally, workflows and policies should reflect the need to ensure clients and their supports participate in care planning focused on the least restrictive and safe environment. The Contracted Provider shall develop and propose performance measures to demonstrate the monitoring of, and ongoing improvement of, those measures in addition to the required performance measures in section 1.6.

1.6 PERFORMANCE MEASURES

BHD will provide oversight of Providers' performance through the ongoing review of performance measures. The Provider is required to obtain Joint Commission Accreditation as well as meet Centers for Medicare and Medicaid Services (CMS) conditions of participation within the first 18 months of operating a new entity. In addition to the accreditation requirement, the Provider is required to report on performance measures in four (4) quality domains listed below to ensure patients are receiving safe, quality services. The measures will be reviewed quarterly. The measures listed are nationally recognized measures.

These measures, targets, incentives and disincentive scores may change over time as national trends in improvement occur. Performance Measures, incentive scores and disincentive scores will be re-evaluated every two years and adjusted as needed by BHD. Specifically the addition of coordination of care, and physical health performance measures to be added after the first 18 months once CMS releases the final rules.

Domain	**Incentive Amount**	**Dis-incentive Amount**
Clinical Measures	.5%	.5%
Patient experience/Satisfaction	.5%	.5%
Safety of at risk patients	NA	NA
Meaningful use of the electronic health record	.5%	.5%
Total	1.5%	1.5%

See Section 3.14 for financial incentive and dis-incentive details.

The Provider is required to submit performance measure data on a quarterly basis. See chart below:

Review Time frame	Data Submission Date
January, February and March	May 1st
April, May and June	August 1st
July, August and September	November 1st

October, November and December	February 1st

Clinical Measures:

The following list of nationally reported clinical measures were chosen from the Hospital Based Inpatient Psychiatric Services (HBPS). These measures set by CMS provide benchmarking opportunities, and are clearly defined.

Measure	**National Average Score**	**Incentive score**	**Disincentive score**
Hours of physical restraint rate	.49	>0.5	<.49
Hours of locked seclusion rate	.32	>.33	<.32
Percent of patients discharged on multiple antipsychotic medications	10%	>11%	<10%
Percent of patients discharged on multiple antipsychotic medications with appropriate justification	54%	>55%	<54%
Percent of patients discharged with a continuing care plan	94%	>95%	<94%
Post discharged continuing care plan transmitted to next level of care Provider	88%	>89%	<88%
Readmission to the hospital within 30 days of discharge from same or other behavioral health hospital.	Adult 7%, Child/Ad. 11%	Adult 6% Child/Ad. 10%	Adult >7% Child/Ad. >10%

Patient Satisfaction Measures:

A patient satisfaction survey is one mechanism to efficiently compare key quantifiable aspects of performance. Therefore, the Provider is required to utilize one of the national validated patient satisfaction tools for psychiatric facilities such as the Mental Health Statistics Improvement Program (MHSIP) to measure patient satisfaction. Additionally, the Provider must obtain a 40% response rate to qualify for the financial incentive.

Measure	National Average Score	Incentive score	Disincentive score
Patient Satisfaction Aggregate score	70th percentile	>70th percentile	<70th percentile

Safety Measures/ At Risk Population:

The Joint Commission stresses the importance of identifying, monitoring and implementing process improvements to address patient safety. The safety measures, or sentinel events listed below are commonly reported and investigated events which lead to improved patient and staff safety. The Provider will be required to notify BHD within 24 hours of a Sentinel/Never Event and conduct a root cause analysis. Root cause analysis results, and improvement plan is to be submitted to BHD within 10 business days of the identification of a Sentinel/Never Event.

- Patient death or serious disability associated with patient elopement (disappearance)
- Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route or administration.)
- Patient suicide, attempted suicide, or self-harm resulting in serious disability, while being cared for in a health care facility
- Patient death or serious injury associated with a fall while being cared for in a health care setting
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- Patient death or serious injury associated with the use of restraints or bedrails while being cared for in a health care setting
- Sexual abuse/assault on a patient within or on the ground of a healthcare setting
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting

Electronic Health Record Meaningful Use Criteria

Provider will be required to meet Meaningful Use Criteria as established by CMS. Stage 2 criteria final rules published in 2012 are listed for reference.

- Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
- Generate and transmit permissible prescriptions electronically
- Use clinical decision support to improve performance on high-priority health conditions
- Provide patients the ability to view online, download and transmit their health information
- Incorporate clinical lab-test results into certified EHR technology
- Use secure electronic messaging to communicate with patients on relevant health information

The facility must be in compliance and remain in good standing with State and Federal Conditions of Participation and Joint Commission standards for psychiatric hospitals. Deficiencies identified by any governing or regulatory body must result in an acceptable plan of correction including completion of all elements within required time lines to remove all deficiencies. Failure to achieve full compliance will result in removal of eligibility to participate as a provider of services under state and federal law.

SECTION 2

SCOPE OF SERVICES

2.1 QUALIFICATIONS OF CONTRACTED PROVIDER

The organization/proposer submitting a solution must demonstrate a history of successful operations and provision of services to other healthcare facilities of this type with comparable size and market dynamics. Each response shall be of sufficient detail to substantiate a Proposer's ability to perform key aspects of managing a high quality behavioral health hospital with noted quality and performance measures. Proposers should have a track record of successful behavioral health operations and management experience. Proposers should demonstrate strong experience with a culturally diverse patient mix, and care of people with highly acute behavioral health conditions including potentially aggressive behaviors.

2.2 OBLIGATIONS OF CONTRACTED PROVIDER

1. Provide a facility for rendering the Contracted Services either through new construction or re-purposing of an existing building (New Facility).
2. Serve as the legal detention center contemplated in Wisconsin Statutes Chapter 51.
3. Provide the following services including but not limited to:

Clinical services:

- Behavioral health services
- Pharmacy
- Radiology
- Physical therapy
- EKG
- Laboratory
- Psychiatry
- Family Medicine Physicians and Advance Practice Nurses
- Psychologist
- Nursing Services
- Certified Nursing Assistants
- Social Work
- Occupational Therapy
- Music Therapy

Nonclinical services:

- Housekeeping
- Security
- Food Service
- Facility Executive Administration and Oversight
- Quality Improvement and Compliance
- Medical Records
- Billing and Fiscal
- Medical Staff Services

Administrative Services

- Information Technology
- Human Resources
- Payroll
- Legal
- Risk Management

4. Interview and consider hiring BHD management, professional, clinical and non-professional staff.

5. Provide and maintain an interoperable electronic health record that includes a bidirectional HL7 connectivity to the electronic health records used by Milwaukee County and its community services.

6. Electronic Health Record is to be accessible to the Court, Corporate Counsel, and Public Defender as required in 51.35.

7. Participate in, and be a member of any county, state, or regional health information exchange in place currently and in the future.

8. Obtain prior written Milwaukee County Behavioral Health Division approval for all subcontractors and/or associates to be used in performing its contractual obligations. The Provider will be responsible for contract performance when subcontractors are used.

9. Provide that any subcontracting by the Provider in performing the duties described under this contract shall subject the subcontractor and/or associates to the same contract terms and conditions as the Provider.

10. Establish and maintain contractual relationships with Medicaid, Medicare and other key payers, and ensure that all practitioners are appropriately credentialed with each payer as required.

11. Ensure that all providers are appropriately privileged and credentialed as members of the Contracted Provider's medical staff.

12. Provide acute behavioral health services to adults, adolescents, children regardless of payer source.

13. Provide behavioral health inpatient, observation and 24 hour emergency department services.

14. Provide Emergency Services including:
    - Voluntary Protective Placement (55.05)
    - Court-ordered protective placement / protective services (55.06)
    - Emergency Detention (51.15)
    - Voluntary presentment of intoxicated individual to an approved treatment facility (51.45(11)(a))
    - Involuntary presentment of an individual incapacitated by alcohol to an approved treatment facility (by law enforcement) (51.45(11)(b))
    - Emergency Commitment - i.e., the commitment of an intoxicated person who has threatened harm or a person who is otherwise incapacitated by alcohol. (51.45(12))
    - Emergency Protective Services for not more than 72 hours (55.13)
    - Emergency or Temporary Protective Placement (55.135)

15. Establish systems for maintaining the seamless transitions for patients and open collaborative relationships between acute behavioral health services and the community-based services provided by BHD and others.

16. Provide psychiatric assessment, evaluation, treatment, medication administration, symptom management, stabilization, and nursing care as specified in individual treatment plans and as required by applicable law or standards.

17. Work with county-funded service providers to facilitate coordinated and appropriate outpatient/community treatment and discharge planning for individuals.

18. Enter into an agreement with the Department of Health Services or Milwaukee County pursuant to Wis. Stat. s. 51.35 granting authority to transfer involuntary patients between treatment facilities or from treatment facilities into the community.

19. Affiliate with Medical College of Wisconsin to be a Medical Student teaching site, Affiliate with Medical College of Wisconsin Affiliated Hospitals as a residency and fellowship teaching site - including continuing current level of stipend support for residents and fellows, and coordinate with CMS for transfer of teaching facility status to be eligible for direct medical education (DME) and indirect medical education (IME) payments.

20. Facilitate MOUs or affiliations with schools of nursing, including undergraduate, graduate, and doctoral programs.

21. Participate in BHD efforts to improve systems for management and coordination related to behavioral health and clinical needs of consumers and other system-wide needs.

22. Provide an electronic prescribing protocol for patients that are consistent with HL7 standards.

23. Implement systematic parameters to ensure effective management of care provided directly to patients to meet all safety and quality requirements and standards.

24. Develop and implement methods to prevent hospital and emergency readmissions.

25. Develop strategies to maximize communication and coordination between providers to promote a seamless patient centered clinical treatment approach.

26. Provide services which lead to and enable patients to function effectively in less restrictive environments within the community.

27. Work with BHD and other providers to ensure smooth transitions back to the community.

28. Provide services which include but are not limited to assessment/diagnosis, care planning, monitoring and ongoing review; counseling/psychotherapy; physical health activities; education/training; personal care; supervision and therapy.

29. Protect the safety of all patients and staff.

30. Complete and obtain authorization of admission and additional in-patient days, specifying the number of days approved for funding. BHD will provide a comprehensive assessment to determine the appropriate initial length of stay and a continued hospitalization. The length of the hospital stay will also be compared with the average length of stay for similar diagnoses.

31. Facilitate with BHD to coordinate, communicate, and collaborate through community Case Management Services to achieve goals that promote high quality, cost-effective strategies, maximizing positive patient outcomes focusing on individual patient assessments.

32. Collaborate with BHD Utilization Management department by providing information necessary to enable BHD to monitor length of stay for each authorized admission.

33. Notify BHD promptly when a given patient requires inpatient care for a period of time in excess of the pre-authorized days, and provide sufficient information to allow BHD to determine whether an extension will be authorized. BHD will only pay for authorized inpatient days.

34. Dispense appropriate one (1) month supply of outpatient medications to low income and indigent patients without insurance.

35. Provider shall request approval/authorization from BHD for any specialized psychiatric and psychological evaluations before the services are delivered. The following services and/or professional services fees must be approved in advance (prior authorization) by MCBHD to be considered for reimbursement:
    - CNS Assessments/Tests 96101-96125
    - Crisis Psychotherapy 90839-90840
    - Psychoanalysis 90845
    - Narcosynthesis 90865
    - Therapeutic Repetitive Trans cranial Magnetic Stimulation (rTMS) 90867-90869
    - Electroconvulsive Therapy 90870
    - Biofeedback 90901-90911

    The following services and/or professional services fees will not be authorized

- Any service beyond the scope of care of the faculty or the credentialing of the providing licensed independent practitioner.
- Other Psychiatric Services or Procedures 90863-90899 - unless declaratively listed above
- Miscellaneous Services coded under CPT 99000-99091

36. Have available the necessary technology to perform video conferencing with the court for individuals in Emergency Detention.
37. Ensure quality of care and protect the civil and legal rights of patients.

36. BHD will petition the Milwaukee Healthcare Partnership and the Emergency Management System (EMS) to allow Service Provider to participate / membership.

2.3 FACILITY REQUIREMENTS

Contracted Provider shall ensure the New Facility meets all of the following requirements throughout the term of the agreement:

1. Possesses and maintains license throughout the term of the agreement for sufficient beds to accommodate involuntary and voluntary patients, and to ensure financial viability of the New Facility.
2. The New Facility is easily accessible by public transportation.
3. The New Facility shall comply with the applicable regulations summarized in Sections 2.6 and 2.7 below.
4. The New Facility shall be located in Milwaukee County, Wisconsin and provide services [24/7].
5. Inpatient acute adult, adolescence, pediatric, observation and crisis psychiatric emergency room services 24 hours a day 365 days a year in a location owned, or leased by the Provider.

6. Milwaukee County is required to establish and maintain a county mental health complex. The Contracted Provider shall ensure that the New Facility meets the parameters of Wis. Stat. s. 51.08:

Wis. Stat. s. 51.08: Any county having a population of 500,000 or more may, pursuant to s. 46.17, establish and maintain a county mental health complex. The county mental health complex shall be a hospital devoted to the detention and care of drug addicts, alcoholics, chronic patients and mentally ill persons whose mental illness is acute. Such hospital shall be governed pursuant to s. 46.21. Treatment of alcoholics at the county mental health complex is subject to approval by the department under s. 51.45(8). The county mental health complex established pursuant to this section is subject to rules promulgated by the department concerning hospital standards.
Additionally, the Provider may choose to consider the option of having a courtroom located at the facility to enhance the patient experience and enter discussions with Milwaukee County regarding a lease of the current land.

2.4 PERFORMANCE REVIEW

Contracted Provider will be subject to a periodic review of services. Review is based on the overall compliance to the contract and the Provider's adherence to the scope of work as outlined in the RFP, specifically Section 2.2

herein. Frequency of review will be determined in conjunction with the Provider's level of compliance with contractual agreement but not less than quarterly.

2.5 GOVERNANCE AND OVERSIGHT

The Milwaukee Mental Health Board is the governing body of the BHD. Contracted Provider will be accountable to the Milwaukee County Mental Health Board (Behavioral Health Board). The Mental Health Board delegates (to Milwaukee County Department of Health and Human Services and BHD Administration) the daily oversight of the safe and effective delivery of care, continuous improvement of quality, and contractual compliance.

Contracted Provider shall comply with all applicable laws, including, without limitation:

2.6 FEDERAL STATUTES AND REGULATIONS

1. 42 CFR § 411 Exclusions from Medicare and Limitations on Medicare Payment. Services for which neither the beneficiary nor any other person is legally obligated to pay

2. 42 CFR § 412 Prospective Payment Systems for Inpatient Hospital Services - Subpart B Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. 42 CFR § 435 Eligibility for Medical Assistance Programs in the States

4. 42 CFR § 440 Medical Assistance Programs, Services: General Provisions

5. 42 CFR §§ 482.1-482.23 & 482.25-482.57 Hospital Conditions of Participation (CoPs)

6. 42 CFR §§ 482.60-482.62 Special CoPs For Psychiatric Hospitals

7. 42 CFR § 489.13(c)(2) Effective Date. Newly applying accredited psychiatric hospital, effective date.

8. 42 U.S.C. § 290dd-2 & 290ee-3 and 42 CFR § 2 Confidentiality of Alcohol and Drug Abuse Patient Records

9. Social Security Act § 1861

10. The Joint Commission Comprehensive Accreditation Standards for Hospitals and for Inpatient Psychiatric Facilities.

11. CMS Life Safety Code

2.7 STATE STATUES AND REGULATIONS

1. Wis. Stat. § 49 Public Assistance and Children and Family Services
2. Wis. Stat. § 51 State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act
3. Wis. Stat. § 55 Protective Service System
4. DHS 34 Emergency Mental Health Service Programs
5. DHS 35 Outpatient Mental Health Clinics and Services
6. DHS 40 Mental Health Day Treatment Services for Children
7. DHS 61 Community Health and Developmental Disabilities
8. DHS 75 Community Substance Abuse Service Standards
9. DHS 92 Confidentiality of Treatment Records (Implements Wis. Stat. § 51.30)
10. DHS 94 Patient Rights and Resolution of Patient Grievances (Implements Wis. Stat. § 51.61)
11. DHS 105 Provider Certification (Medicaid)
12. DHS 107 Covered Services (Medicaid). DHS 107.13: Coverage of mental health services
13. DHS 124 Hospitals

2.8 CHAPTER 51 - CIVIL COMMITMENTS

- Provider understands that the system of care for its consumers may include court oversight. Provider is responsible for knowing which of its consumers are subjects of Wisconsin Statues Chapter 51, Commitments or Settlement Agreements, Chapter 5 Guardianship, Chapter 55 Protective Placement and /or Protective Services and any Probation and Parole orders/rules.
- Provider shall maintain the following information in the individual's chart as applicable:
    - The guardian's name, current address, phone number and email address.
    - A copy of the current Determination and Order for Protective Service/Protective Placement, or other specific court order or rules.
    - Provider shall confidentially maintain these documents. A copy of the Letter of Guardianship specifying the consumer's rights retained and the extent of the guardian's responsibility.
- Non-emergency transfer of protective placement: If Provider initiates a transfer of a person under a protective placement order, it shall provide notice of transfer to the Probate Office, the guardian(s), the case manager, Adult Protective services, and the consumer with 10 day prior written notice. Provider must obtain written consent of the guardian prior to transfer. Provider must have a safe discharge plan.
- Emergency transfer of protective placement: If Provider initiates an emergency transfer of a person under a protective placement order, it shall no later than 48 hours after the transfer provide notice of transfer to the Probate Office, the guardian(s), Adult Protective Services and the consumer. Provider must have a safe discharge plan.
- Provider shall prepare a report to the Court when ordered by the Court or requested by BHD.

- Unless instructed otherwise, the Provider shall transport and accompany its consumer to all Court Hearings or otherwise ensure the consumer's presence at the hearings
- When requested, Provider shall provide testimony in court hearing.
- To facilitate the acquisition of the medical reports required for Court Hearings, the Provider, when requested shall schedule an appointment with the appropriate physician or psychologist and shall take the consumer to the appointed or otherwise assure the consumer's presence at the appointment.

Section 3

FUNDING, BILLING, INCENTIVES, AUTHORIZATION AND CONTRACT DURATION

3.1 FUNDING

BHD services shall consist only of emergency room mental health services for clients who have been independently verified by BHD as having no payer source, and of psychiatric observation and psychiatric inpatient services authorized as medically necessary by BHD for clients who have been independently verified by BHD as having no payer source.

Pricing shall be all inclusive; including but not limited to all necessary planning and implementation activities prior to commencement of a contract, all salary, benefits and associated employment costs for executive management personnel, inclusive of all wages, benefits and associated employment costs for support functions, inclusive of administrative equipment, supplies and materials, services, travel, costs related to contracted services and all supervisory staff not included in the management expenses.

BHD will fund services utilizing established percentage of provider's Wisconsin Medicaid rates as determined through the annual cost reporting mechanism. Providers are to propose a rate estimate as outlined in Attachment N. For future years BHD will pay Provider's percentage of the Medicaid rate established through their annual cost report. BHD will pay for the following codes: 450, 760, 124, and 124+pro-fees (which includes professional services).

This payment methodology may be amended, as required by Wisconsin Medicaid regulatory changes.

3.2 FUNDING PROCEDURES

At time of registration for emergency room service, the Proposer will request verification of insurance from the client and will complete a Medicaid eligibility check on ForwardHealth (Wisconsin Medicaid Database) and a Medicare eligibility check on Ability (the CMS Medicare eligibility service). All clients with third party insurance coverage or found through eligibility checks on ForwardHealth and Ability to have Medicaid or Medicare coverage are the responsibility of the Proposer. The Proposer will assume all costs for these clients and will be responsible for all third party payer claiming. Third party payer revenue will be considered as payment in full, and the Proposer will not bill BHD for the cost of any service to these clients.

Clients who are found at a later date to have third party coverage for the dates of service in question and for whom third party claims can still be submitted will be the responsibility of the Proposer and the agency will refund any payments received from BHD for those services.

Charges for clients with no third party payer or for services that are the responsibility of BHD, but for which Medicaid and Medicare does not provide coverage (Institute for Mental Disease (IMD) Excluded and Exhausted Bed Day clients), shall be the responsibility of BHD.

3.3 EMERGENCY ROOM

Commercial Insurance Coverage/Medicaid/Medicare – Proposer bills Insurance for Facility Charge and Professional Fees (No BHD responsibility).

Self-Pay Clients – Proposer bills BHD bundled rate for Facility Charge and Professional Fees at established rate.

3.4 OBSERVATION

Commercial Insurance Coverage/Medicaid/Medicare – Proposer bills Insurance for Facility Charge and Professional Fees (No BHD responsibility).

Self-Pay Clients – Proposer bills BHD bundled rate for Facility Charge and Professional Fees for all authorized services at established rate.

3.5 INPATIENT

Children under the Age of 21

Children of all income levels are covered by Medicaid for inpatient psychiatric services on an episodic basis – Proposer bills commercial insurance or Medicaid for all per diem and professional fee charges (No BHD responsibility). Medicaid applications are the responsibility of the Proposer.

Commercial Insurance Coverage

Proposer bills the Insurance for all per diem and professional fee charges (No BHD responsibility).

Medicaid HMO

Proposer bills Medicaid HMO for all per diem and professional fee charges (No BHD responsibility).

Straight Medicaid

Adults aged 65 and over – Proposer bills Medicaid for all per diem and professional fee charges (No BHD responsibility).

Professional fees for Adults ages 22 to 64 – Proposer bills Medicaid (No BHD responsibility).

Per Diem Charges for Adults ages 22 to 64 (Psychiatric Inpatient Institute for Mental Disease Excluded Clients) – Proposer bills BHD for all authorized services at established rate.

Medicare Part B Coverage

Proposer bills Medicare for all professional fee charges (No BHD responsibility).

Medicare Part A Coverage

Proposer bills Medicare for clients with remaining inpatient psychiatric bed day coverage. Proposer bills BHD for all authorized per diem services at established rate for clients with exhausted bed day coverage.

Self-Pay Clients

Proposer bills BHD for all authorized professional fee and per diem charges at established rate.

3.6 OUT OF COUNTY CLIENTS

BHD will pay for services of Non-Milwaukee County residents brought to the Proposer under a Chapter 51 emergency detention for a period of up to 72 hours. During that time period it is the responsibility of the Proposer to arrange for the transfer of said client to their county of residence.

3.7 SUBMISSION AND PAYMENT OF CLAIMS

Proposer will submit claims to BHD on a Form CMS 1500 or UB-04, as appropriate. Claims will contain ICD-10 diagnostic codes associated with DSM-5 diagnostic criteria.

A completed Form CMS 1500 or UB-04 containing all information necessary for adjudication will constitute a clean claim and no more information shall be required before the claim is paid.

Proposer will submit to BHD, Proposer's claim for payment no later than 90 days from the last date Services were rendered during the patient encounter being billed. BHD shall pay Proposer for Services within 45 days of receipt of a clean claim or within such shorter time as may be required by federal or state law. If a claim is determined to be incomplete, BHD must notify the Proposer within 30 days of receipt of the claim, or the claim will be deemed complete.

Upon receipt of notice from BHD that a claim has been determined to be incomplete, Proposer shall have 60 days to resubmit the claim in order to make it complete.

Billing denials will only be made for lack of authorization or for timely filing. Appeals for billing denials must be submitted within 30 days of denial.

3.8 PATIENT BILLING

Proposer may bill and collect from a BHD client for whom the Proposer is submitting third party billing, co-payments, co-insurance and deductible amounts. Proposer may also bill and collect Proposer's usual and customary charges from a BHD client for any non-BHD covered services. Proposer may bill and collect for all co-payments, deductibles, non-covered services, or any other related charges not otherwise prohibited by law. Proposer will comply with the requirements under Wis. Stat. § 609.91, Wisconsin Medicaid Regulations and CMS Medicare Regulations and agrees not to opt-out of those requirements.

3.9 RECORDS

BHD shall pay to Proposer amounts for the copying of records requested by BHD according to the terms of the BHD invoice for such copies.

3.10 CLIENT CONSENT

It is the responsibility of the Proposer to obtain all consents required for billing third party insurance.

3.11 CREDENTIALING

BHD shall rely upon Proposer's certification attesting to the fact that Proposer's physicians have been properly credentialed in accordance with credentialing policies and procedures. Upon request, Proposer will provide BHD with a description of Proposer's credentialing process, policies and procedures. Proposer shall periodically update the names of all physicians who are credentialed and shall provide such updated list to BHD upon request.

3.12 ASSIGNMENT

Neither the Proposer nor BHD may assign its contractual responsibilities pursuant to this RFP or the Proposal without the prior written consent of the other party.

3.13 CONFIDENTIALITY

All information and material provided by either party to the other remains proprietary to the disclosing party. Such information and material includes, but is not limited to, contracts, including any agreement between the Proposer and BHD, reimbursement rates and methodologies, member lists, and any operations manuals. Neither the Proposer nor BHD shall disclose any of such information or material or use such information or material except under the following circumstances: (1) as may be required to perform obligations or exercise its rights hereunder; (2) as required to deliver Services; and/or (3) as required by law. Notwithstanding the foregoing, either party may disclose such proprietary information to its legal and financial advisors, to any auditor that executes a confidentiality agreement for the benefit of BHD and Proposer, and to affiliates under majority ownership or control by a common entity. All proposals and other information submitted pursuant to this RFP are subject to the Wisconsin Open Records Law, Wis. Stat. § 19.31 et seq. Proposals and other information cannot be kept confidential unless they are subject to an exception under the Open Records Law.

3.14 PERFORMANCE FINANCIAL INCENTIVES AND DIS-INCENTIVES

BHD will pay Provider a financial incentive of up to 1.5% of revenues paid for services rendered to patients defined in this RFP for exceeding performance measures as outlined in section 1.6. Conversely, BHD will withhold (dis-incentive) up to 1.5% of revenues if the performance measure drops below the stated benchmark. The appropriate financial incentive will be paid in full on the first business day of the second quarter of the following year. Conversely, the appropriate financial dis-incentive will be withheld in full on the first business day of the second quarter. The incentives/dis-incentive is calculated on the total amount of review the Provider received the previous year.

Performance measures available for incentive include:

1. Clinical Measures
2. Patient Experience/Satisfaction
3. Meaningful use of Electronic Health Record

3.15 AUTHORIZATION OF SERVICES

- BHD will not fund individuals covered by any other insurer. BHD is the payer of last resort.
- Provider shall contact BHD to request authorization for BHD funding for individuals who are not covered by another insurer prior to admission or within 24 hours of admission. If patient is admitted during the weekend hours notification must occur the following Monday. BHD will determine when funding will begin for all requests that occur after the individual has been admitted.
- If Provider learns that an individual's third party insurer does not cover the service, Provider shall request BHD funding within one (1) working day following admission.
- Provider shall notify BHD Chief Quality Officer or designee for UR oversight regarding disagreements over admission decisions and funding authorizations. BHD may conduct a formal appeal to review denials and notify all parties of its decision.
- If an individual from another county or state is admitted under an involuntary emergency detention BHD will be responsible for payment only for the first seventy-two (72) hours for uninsured individuals pending further funding authorization. Provider shall notify the County or State of origin as soon as possible and within seventy-two (72) hours following the involuntary admission to discuss treatment and funding options.
- Provider shall immediately notify BHD of any impending transfers to other inpatient settings so that a review for BHD funding may be made.
- Provider shall proceed as follows for all BHD funded admissions:
    - Provider shall determine the extent of the individual's ability to pay, including third party coverage.
    - Provider bears the same responsibility as BHD to ensure individuals served who are eligible for Medical Assistance (MA) or Presumptive Disability receive such funding.
    - Provider shall notify BHD of any Medical Assistance (MA) and/or Presumptive Disability Application that has been started but not completed prior to discharge so that responsibility can be fixed within the community treatment system ensuring that the application is completed.
- Provider shall inform all individuals receiving BHD authorized funding that they are statutorily liable to BHD for inpatient cost of care assumed by BHD, based on their future ability to pay for services provided.
- Provider shall submit invoices no later than 90 days from date of the provision of services. BHD will not issue and Provider waives payment for any late invoices.
- Provider shall accept BHD's payment as "payment in full" and will not bill patients for any balances due.
- BHD assumes responsibilities for identification of those services not reimbursable under this contract, and for notifying Provider of these determinations. In the event of any dispute it will be the obligation of Provider to justify the relationship between the specific treatment procedure under question and the mental health problem for which the individual is being treated.

3.16 CONTRACT DURATION

The period of performance contracted will be for a period of 20 years, or from _____ 2016 to _____ 2036. There will be an option for three five-year renewals upon the expiration of the initial 20 year term. Such renewals shall be made by a mutual agreement and be on the same terms and conditions as the initial contract.

Responses to this RFP shall be based upon a 20 year term. The contract will be subject to termination for convenience and for cause, as described below.

3.17 TYPE OF CONTRACT/PAYMENTS

Milwaukee County Behavioral Health Division contemplates award of a contract resulting from this RFP that reflects payment for services. Those services outlined in this RFP are for those services which Milwaukee County is required to provide and stipulated in Wisconsin's State Statute 51.15 which assigns to counties to mandate of providing for "the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug depended citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."
Any final contract structure resulting from this RFP will be subject to the negotiation and approval of Milwaukee BHD Mental Health Board.

3.18 MODIFICATION OF SCOPE OF SERVICES/LIMITATIONS

All proposers are notified that Milwaukee County Behavioral Health Division reserves the right to delete or modify any task from the Scope of Services at any time during the course of the RFP process or the contract period on notice to the Provider. All proposers are notified that contracts are contingent upon Federal, State, and local appropriations. The Behavioral Health Division has determined that it is best to define its own needs, desired operating objectives, and desired operating environment. The Behavioral Health Division will not tailor these needs to fit particular solutions suppliers may have available; rather, the suppliers shall propose to meet the Behavioral Health Division needs as defined in this RFP. All claims shall be subject to demonstration. Proposers are cautioned that conditional proposals restricting or placing requirements for proposal acceptance upon Behavioral Health Division or based upon assumptions may be deemed non-responsive.

SECTION 4

CONTENT OF PROPOSAL

4.1 PRE-PROPOSAL CONFERENCE

A mandatory pre-proposal conference will be held at the following date, time, and location as provided on the Information Summary Sheet. Failure to attend, be represented, or participate by phone at this pre-proposal meeting may automatically disqualify your proposal.

During the pre-proposal conference, attendees may:

Request clarification of any section of the RFP.

Ask any other relevant questions relating to the RFP.

Be provided an opportunity to take a group site visit of the operating facilities, as this will be the only opportunity for a site visit.

Milwaukee County Behavioral Health Division may provide oral responses to written questions received prior to the mandatory pre-proposal conference. Proposers are required to submit written questions via e-mail, for possible response at the pre-proposal conference to RFP Contact/Administrator (by date and time provided in the Information Summary Sheet) to enable Milwaukee County Behavioral Health Division to formulate its oral responses. No oral or written responses will be given prior to the pre-proposal conference. Questions submitted will not be carried over automatically as a "Proposal Question."

Any responses provided to questions during the pre-proposal conference will be considered drafts, and will be non-binding. Questions submitted for pre-proposal meeting and associated responses will not be carried over automatically as a "Proposal Question and Contact Restrictions" and the associated written responses.

Only the final answers to written questions submitted prior to the "Receipt of Questions" deadline (by date and time provided in the Information Summary Sheet) and posted on the website (web address provided on the Information Summary Sheet) will be considered official. Remarks and explanations at the conference shall not qualify the terms of the solicitation; and terms of the solicitation and specifications remain unchanged unless the solicitation is amended in writing.

4.2 PROPOSAL QUESTIONS AND CONTACT RESTRICTIONS

Proposers may submit questions and requests for clarification regarding this RFP. All questions regarding this RFP shall be made in writing, citing the RFP title, RFP number, page, section, and paragraph, and shall be submitted via e-mail to the RFP Contact/Administrator. Questions submitted for pre-proposal meeting and associated responses will not be carried over automatically as a "Proposal Question".

Questions sent to anyone other than the RFP Contact/Administrator will not be considered. The RFP Contact/Administrator is the sole point of contact during this process and no information provided by any other personnel will be considered binding.
All questions must be submitted by the specified deadline as identified on the Information Summary Sheet. Milwaukee County Behavioral Health Division will not respond to any questions received after this date and time. Responses to all questions and inquiries received by Milwaukee County Behavioral Health Division will be posted on Milwaukee BHD's website as identified in the Information Summary Sheet. Milwaukee County Behavioral Health Division reserves the right to answer or to not answer any question submitted at its sole discretion. It is the responsibility of Proposers to check this website for any and all information such as answers or addenda related to the RFP.

This RFP is issued by the Milwaukee County Behavioral Health Division. The RFP Contact/Administrator assigned to this RFP, along with contact information, is noted. The RFP Contact/Administrator is the sole point of contact during this process and no information provided by any other personnel will be considered binding.

Communication initiated by a proposer to any official, employee or representative evaluating or considering the proposals, prior to the time of any award is prohibited unless at the explicit direction of the RFP Contact/Administrator and any such unauthorized communication may constitute grounds for rejection or elimination of a proposal from further consideration, in the sole discretion of the BHD.

All respondents should use this written document, its attachments and any amendments as the sole basis for responding.

4.3 PROPOSER NOTIFICATION REQUIREMENT AND AMENDMENT AKNOWLEDGEMENT

Should proposer discover any significant ambiguity, error, omission or other deficiency in the RFP document, they must immediately notify the RFP Contact/Administrator in writing, via email, prior to the submission of a proposal. The failure of a proposer to notify the RFP Contact/Administrator of any such matter prior to submission of its proposal constitutes a waiver of appeal or administrative review rights based upon any such ambiguity, error, omission or other deficiency in the RFP document.

If it becomes necessary to clarify or revise any part of this RFP, amendments will be posted to the Milwaukee BHD website; it is the responsibility and obligation of prospective proposers and proposers to check the website for any amendments prior to the RFP submission date. If the Proposer fails to monitor the web site for any changes or modifications to the RFP, such failure will not relieve the Proposer of its obligation to fulfill the requirements as posted.

4.4 PROPOSAL SUBMISSION

All proposals shall consist of two (2) Volumes: a Technical Proposal (Volume I) and a Price Proposal (Volume II). Each Volume must be submitted in separate envelopes and marked as requested below. The signature of an official of the proposer authorized to bind the proposer shall be on each volume.

Proposals submitted in response to this RFP must be received no later than the deadline at the location identified in the Information Summary Sheet. Proposals received after the deadline or at a destination other than the

identified location will not be accepted nor will additional time be granted to any proposer. Proposers must submit one (1) original with signatures, and eight (8) copies, of the RFP response in sealed envelopes.

Each hard copy should be double-sided and bound, with the exception of the original, which should be double-sided but not bound. The copies should be bound by staple, binder clip or in a three-ring binder. Spiral, wire or comb bound copies are not acceptable. Each proposal should be prepared simply and economically, providing a straightforward, concise description of the proposer's ability to meet the requirements of the RFP. Fancy bindings, colored displays, promotional material, etc., will receive no evaluation credit. Emphasis should be on completeness and clarity of content in the format specified

Responses should be identified in the lower left corner as follows:

Technical Proposal (Volume I)
Response To: Inpatient Services for the Milwaukee County Behavioral Health Division
PROPOSAL RESPONSE, RFP #: 2015-RFP-BHD-1000
DEADLINE DATE: (Date as provided on the Information Summary Sheet)

and

Price Proposal (Volume II)
Response To: Inpatient Services for the Milwaukee County Behavioral Health Division
PROPOSAL RESPONSE, RFP #: 2015-RFP-BHD-1000
DEADLINE DATE: (Date as provided on the Information Summary Sheet)

Note that if hand delivering proposals, allow adequate time for travel, parking, and security screening. It is the sole responsibility and obligation of proposers to ensure submission of proposals prior to deadline.

4.5 CONTENT OF TECHNICAL PROPOSAL (VOLUME I)

Technical proposals shall contain three sections:

MANDATORY RESPONSES
GENERAL QUALIFICATIONS & EXPERIENCE
TECHNICAL QUALIFICATIONS, APPROACH & QUALITY

Technical proposals may not contain any reference to price

Through its proposal, the proposer offers a solution to the objectives, problem, or need specified in the RFP, and defines how it intends to meet or exceed the RFP requirements. Failure to respond completely may result in disqualification of the proposal.

Proposers are encouraged provide substantiation, information, metrics and any other documentation in all their responses to reflect their qualifications.

RFP submission must address, at a minimum, the requests enumerated below.

Please indicate for each response the number of the request that it addresses (e.g. Response to Request 1, Response to Request 2…) and present responses in order of requests below.

4.6 MANDATORY RESPONSE

This section outlines information and requests that are a matter of responsiveness to this RFP, where a response to each "Request" is required.

Request 01: Proposers shall provide a title page listing the RFP number and subject, name of the company and date.

Request 02: A signed letter of transmittal shall accompany the proposal that provides an understanding of the work to be performed, name, title and contact information for the individual(s) who are authorized to make representations and enter into any agreement on behalf of the proposer.

Request 03: Completed Attachment P – "Authorization for Reference Check"

Request 04a: Completed Attachment Q – "Conflict of Interest Stipulation"

Request 04b: Completed Attachment R – "Sworn Statement of Bidder"

Request 05: Completed Attachment S – "Cover Sheet for Main Proposal"

Request 06 Completed Attachment Y – For references, Milwaukee County Behavioral Health Division will be using Dun & Bradstreet's Past Performance Evaluation Report (PPE) and Supplier Qualifier Report (SQR) as part of the evaluation process for this RFP.

Request 07: Completed Attachment V – "Certification Regarding Debarment and Suspension"

Request 08: Completed Attachment W – "Additional Disclosures"

Request 9: Completed Attachment O – "Indemnity/Insurance Requirements Acknowledgement"

Request 10: Completed Attachment Z – "Designation of Confidential/Proprietary Information"

4.7 GENERAL QUALIFICATIONS & EXPERIENCE RESPONSE

All proposers must possess current substantial and demonstrable experience in the successful planning, budgeting, managing, directing, and operating of a psychiatric hospital similar to the size and scope of Milwaukee BHD's Behavioral Health Division system.

Administrative and Operations

Request 1: Describe your organization, for example, its size, scope and holdings.

Request 2: Provide a listing of hospitals the firm/company owns and /or operates.

Request 3: Describe the length of time your organization has been in business.

Request 4: Describe the experience and professional qualifications of key leadership staff.

Request 5: Provide examples of hospitals similar to BHD, with similar demographics, size, function, that the firm/company has direct experience operating or managing.

Request 6: Describe your experience in operations and management of behavioral healthcare facilities.

Request 7: Describe your experience in building hospitals or remodeling existing space.

Request 8: Describe the size of facility (sq. ft.) and number of beds you propose.

Request 9: Provide a detailed schedule that illustrates the various phases, mile stones and overall time period for the opening of a new hospital including building space, and operations, and a potential occupancy date.

Request 10: Demonstrate the firm's financial capabilities and resources to perform the services proposed.

Request 11: Provide an estimated expense budget required for implementation of the proposed solution with delineation between startup costs (i.e., working capital) and ongoing operational costs.

Request 12: Provide an independent rating from an agency of the organization's financial standing (e.g. Standard & Poor's, Moody's, or Fitch).

Request 13: The changes currently shaping the delivery of behavioral health services, either driven by federal governmental reform, through state legislation or demonstration projects, are affecting the manner in which insurers, hospitals, and physicians operate. Discuss how these changes will impact operation of the hospital. Describe how your organization is preparing for these changes and how your plans will specifically enable the hospital to successfully navigate in this new arena.

Request 14: Describe your hiring policies and how you expect to appropriately recruit, hire, retain and train new hospital staff. Please include an overview of your recruitment expertise, and consideration process of current BHD personnel.

Request 15: Describe your experience with implementing robust information systems.

Request 16: Describe your experience working with an electronic health records and implementation of meaningful use criteria.

Request 17: Describe your current information system platforms that are utilized by your hospital organization, and describe how these systems would be applied to this facility (remote, regional billing office etc.). Proposer submissions may be limited just to the implementation of data management and IT services.

Request 18: Describe which services you plan on providing and which services you plan on outsourcing.

Request 19: For those services outsourced, list the services and provide the name of the corporation responsible for providing those services.

Request 20: Describe which services will be provided by your "corporate" infrastructure.

Request 21: Will you be performing research in the facility, and if so please describe the intent of the research and the proposed structure for its oversight.

Request 22: Describe you experience with clinical professional teaching and medical residency programs, and /or any concerns you have regarding the operation of such programs.

Request 22a: Reference check /Reference Check results from Open Ratings.

Quality

Request 23: Provide a history of demonstrable experience of your ability to provide services that meet or exceed applicable accreditation and certification standards. These include, but are not limited to, the standards (or requirements) of the following organizations: Joint Commission on Accreditation of Healthcare Organizations; American Osteopathic Association; Health Care Financing Administration; National Committee for Quality Assurance.

Request 24: Provide documentation of the results of Joint Commission on Accreditation of Healthcare Organizations, Health Care Financing Administration, National Committee for Quality Assurance, state, or other accreditation or regulatory surveys conducted in the last 12 calendar months for 3 current sites.

Request 25: Submit any and all violations, citations, sanctions, settlements, fines, or other concerns raised by any local, state, or federal regulatory body or other oversight bodies such as JCAHO.

Request 26: Describe your process of handling patient grievances.

Request 27: Provide samples of quality and operational metrics currently used and data demonstrating results of the last 18-24 months.

Request 28: Describe your experience in developing quality and operational metrics.

Request 29: Describe your experience in developing and carrying out the action plans to address any operational or quality issues and tracking improvements.

Request 30: Describe which third party payers you are currently contracting with. In the last two years which of those payers have you received incentives from, and which of those payers have penalized you.

Clinical Services

Request 31: Provide a detailed proposal of the care delivery model that will address the behavioral healthcare needs of the persons served.

Request 32: Describe your experience working with highly acute behavioral health population who at times have aggressive behaviors.

Request 33: Describe your experience providing quality and culturally intelligent behavioral health care.

Request 34: Describe your experience integrating preventative / recovery oriented acute hospital services.

Request 35: Describe you experience in providing trauma informed care.

Request 36: Describe your experience in providing care in a least restrictive environment.

Request 37: Describe your experience working with involuntary acute adult patients.

Request 38: Describe your experience working with involuntary pediatric and adolescent patients.

Request 39: Describe your experience working with involuntary observation patients.

Request 40: Describe your experience working with involuntary patients in a psychiatric emergency room.

Request 41: Describe your experience with multidisciplinary care coordination planning conferences.

Request 42: Describe your model and experience transitioning patients into community services and facilities.

Request 43: Describe your experience, failures and success with preventing readmissions.

Request 44: Describe you experience in the provision of supplying discharge medications.

Request 45: Describe your experience working with a closed loop medication administration system.

Request 46: Describe your experience and treatment model regarding seclusion and restraint (physical and chemical).

4.8 APPROACH AND QUALITY RESPONSE

The section should provide an overview of the proposer's management philosophy. This section of the Technical Proposal should address the way in which the proposer will manage the hospital and emergency services operations and adhering to applicable standards. The section should provide an understanding of the Milwaukee County Behavioral Health Division request for services and how the provider will address the opportunities and challenges that currently exist within the system. This section of the Technical Proposal provides the proposer with the opportunity to present experience, ideas and initiatives to maintain or enhance service, increase efficiency and reduce costs for the Milwaukee County Behavioral Health Division.

Administrative and Operations

Request 1: Describe how you will form relationships and work with other healthcare systems in Milwaukee to care for those individuals experiencing a psychiatric crisis and in need of medical services

Request 2: Describe how you build a solid relationship with law enforcement to ensure patients receive care in the least restrictive environment.

Request 3: Describe how you would effectively collaborate between in-patient and community to achieve maximum benefits from hospitalization within a context of a long term community plan for each individual.

Request 4: Describe in detail how you will ensure the financial sustainability of the facility and program.

Request 5: Describe how you will ensure the ongoing sustainability of the facility in light of the ever changing regulatory environment.

Request 6: Describe how you will ensure appropriate staffing patterns with the current and future inevitable staffing challenges.

Request 7: Describe how you will ensure the organization's sustainability over the next 20 years.

Quality

Request 8: List and describe performance measures addressing person centered care/services and how you will ensure and monitor person centered care/services are provided.

Request 9: List and describe performance measures addressing trauma informed services and how you will ensure and monitor trauma informed care/services are provided.

Request 10: List and describe performance measures addressing culturally intelligent care/services and how you ensure and monitor culturally intelligent care/services are provided.

Request 11: List and describe the performance measures addressing recovery oriented care/services and how you will ensure and monitor recovery oriented care/services are provided.

Request 12: List and describe the performance measures addressing “least restrictive environment” and how you will ensure and monitor how “least restrictive environment” is utilized within the facility and in discharge planning.

Request 13: List and describe the performance measures you have developed and how you will monitor a positive client experience.

Request 14: Describe how you will support the ongoing quality improvement and sustainability of the performance measures.

Request 15: Describe how you will measure structure, process, outcomes, efficiency and effectiveness of clinical services.

Request 16: Describe how you will measure organization/facility/practice, individual healthcare professionals, multi-disciplinary teams, system coordination, and population health outcomes.

Request 17: Describe how you will measure effectiveness in care transitions along with developing strategies and processes to fill the gaps to ensure seamless patient care across the system.

Request 18: Describe how records will be maintained in a confidential manner in accordance with Wisconsin State Statutes 146.81 to 146.83 and any other applicable state or federal laws.

Clinical Care

Request 19: Describe how you will develop, or implement current care models for treating persons with co-occurring challenges.

Request 20: Describe how you will provide consultation on all aspects of the provision of acute inpatient services.

Request 21: Describe your experience with Peer Support Specialists and how you will integrate their role in acute the acute hospital setting.

Request 22: Describe how you will engage the patient, family members, or significant others in the care planning process.

Request 23: Describe how you will ensure the patients discharge plan includes elements to reduce recidivism.

Request 24: Describe how you will work with BHD Community Services to coordinate and facilitate a smooth and seamless discharge plan for the patients served.

Request 25: Describe how you will care for and provide for a safe environment in the emergency room for individuals with aggressive behaviors and those detained.

Request 26: Describe how you will have processes in place that allow for clients to refuse treatment to the extent permitted by laws and shall be informed of the consequences of the refusal.

Request 27: Describe how you will provide services that are co-occurring, trauma-informed, recovery oriented, and person centered.

Request 28: Describe how you will provide services that reflect patients are treated with consideration, respect and recognition of their individuality and personal needs, including the need for privacy in treatment.

Request 29: Describe how you will integrate into processes and policy the provision of person centered services.

Request 30: Describe how you will integrate into processes and policy the provision of trauma informed services.

Request 31: Describe how you will integrate into processes and policy the provision of culturally intelligent services.

Request 32: Describe how you will integrate processes and policy for recovery oriented services.

Request 33: Describe how you will ensure the patients discharge plan includes transitional elements to enhance the patient experience.

Request 34: Describe how you will maintain an effective, ongoing discharge planning program that is coordinated with community resources to facilitate the provision of follow-up care to discharged patients.

Request 35: Describe how you will ensure the hospital has current information on community resources available for continuing care of the clients post discharge.

4.9 CONTENT OF PRICE PROPOSAL (VOLUME II)

All price data and information must be provided in a separate sealed envelope marked Price Proposal (Volume II).

It is understood that funding is subject to appropriation and may change over the contact period. Milwaukee County Behavioral Health Division reserves the right to amend any resulting contract to reflect changes in funding on an annual basis

Request 36: Complete Attachment M – "Cover Sheet for Pricing Proposal"
Request 37: All proposers shall complete Attachment N – 'Cost Proposal' in the prescribed format, requested information and pricing structure. The Milwaukee County Behavioral Health Division will pay the Proposer for the cost of Milwaukee County resident clients with no known payer source. Payment will occur based upon authorized services for clients whose payment status has been independently verified by BHD.

SECTION 5

CRITERIA FOR RFP EVALUATION

5.1 RFP EVALUATION PROCESS

The evaluation process is designed to award the contract resulting from this RFP not necessarily to the Respondent offering the lowest cost, but rather to the Respondent deemed by the Milwaukee County Behavioral Health Division to be responsive and responsible who offers the best combination of attributes based upon the evaluation criteria. ("Responsive Respondent" is defined as a Respondent that has submitted a response that conforms in all material respects to the RFP. "Responsible Respondent" is defined as a Respondent that has the capacity in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.)

An administrative review, by RFP Administrator, of all proposals shall be performed. Proposals that do not comply with submittal instructions established in this document and/or that do not include the required or mandatory information may be rejected as insufficient or non-responsive. Milwaukee County Behavioral Health Division reserves the right to seek clarification or waive a requirement when it is in its best interests to do so. The Proposer assumes all responsibility for meeting all RFP requirements.

An Evaluation Committee will be established by Milwaukee County Behavioral Health Division, consisting of three or more individuals, to evaluate all responsive proposals and to make a recommendation to Chief Administrator. A proposer may not contact any member of an evaluation committee or any County or BHD official, employee or representative, prior to the time of any award except at the explicit direction of the RFP Contact/Administrator. Any such unauthorized communication may constitute grounds for rejection or elimination of a proposal from further consideration, in the sole discretion of BHD. Reference the "Questions" section for additional information.

Technical Proposal scoring: each member of the Evaluation Committee shall conduct an independent and individual evaluation of the technical merit of the all responsive proposals. The process involves applying the evaluation criteria and the associated weighting as outlined in the RFP to assess each provider's proposal. The criteria that will be used by the Evaluation Committee for the technical evaluation of this RFP are outlined below. Aggregate scoring will occur after individual and independent review by each evaluator. The evaluation panel will meet and an aggregate score will be established by the evaluation panel for each proposal, becoming the formal evaluation results and used for recommendation.

The BHD reserves the right, at its sole discretion, to request proposer clarification of a Technical Response or to conduct clarification discussions with any or all Respondents. All communications, clarifications, and negotiations shall be conducted in a manner that supports fairness in response improvement.

Before Cost Proposals are opened, the Proposal Evaluation Team will review the Technical Response Evaluation record and any other available information pertinent to whether or not each Respondent is responsive and responsible.

Cost Proposal scoring: cost is one of the evaluation categories listed below and will be a defined percentage of the total RFP evaluation. Calculation of points to be awarded to lowest and each subsequent proposal will use the lowest dollar proposed amount as a constant numerator and the dollar amount of the proposer being scored as the denominator. The result then is multiplied by the total number of points provided in the cost section of the RFP. Lowest cost proposal will receive the maximum number of points available for the cost category. Other cost proposals will receive prorated scores based on the proportion that the costs of the proposals vary from the lowest cost proposal. Cost proposals will be evaluated based on proposer's percentage of Medicaid Rate, and total cost for stated codes. See attachment N.

The evaluation committee's scoring will be tabulated and proposals ranked based on the total numerical scores, comprising the sum of both technical and cost scoring to determine the best value proposal.

Oral presentations will be requested by Milwaukee County Behavioral Health Division to one or more highest scoring respondents. Proposers will be notified of when the presentations are to take place and what information should be provided.

Milwaukee County Behavioral Health Division may enter into clarification and/or negotiations and request Best and Final Offer from any or all respondents. Best and Final Offers are a supplement to the original offer. Milwaukee County Behavioral Health Division reserves the right to make an offer based on the original submitted proposal. Proposers are cautioned to propose the best possible offer at the outset of the process, as there is no guarantee that any proposer will be allowed an opportunity to submit a Best and Final Offer. Milwaukee BHD Behavioral Health Division reserves the right to select a proposer for contract award based upon the proposer's Technical Proposal and Price Proposal without further discussion.

Clarifications: the BHD may identify areas of a response that may require further clarification or areas in which it is apparent that there may have been miscommunications or misunderstandings as to the BHD's specifications or requirements. The BHD may seek to clarify those issues identified during one or multiple clarification rounds. Each clarification sought by the BHD may be unique to an individual proposer, provided that the process is conducted in a manner that supports fairness in response improvement.

Negotiations: the BHD may elect to negotiate with one or more proposers by requesting revised responses, negotiating costs, or contract terms and conditions. The BHD reserves the right to conduct multiple negotiation rounds or no negotiations at all.

If the BHD determines that it is unable to successfully negotiate a contract with the apparent best evaluated proposer, the BHD reserves the right to bypass the apparent best evaluated proposer and enter into contract negotiations with the next apparent best evaluated proposer.

Following completed evaluation, the Committee will make a recommendation to Milwaukee BHD Behavioral Health Chief Administrator as to whose proposal is determined to provide the best value. The Behavioral Health Chief Administrator will be responsible for contract and execution. Award may be made to the proposal with a higher technical ranking even if its price proposal is not the lowest.

Milwaukee County Behavioral Health Division may undertake any due diligence relating to any topic including but not limited to Provider's demonstration of financial strength, which may include for example recent annual reports, income statements, balance statement, audited financials, tax returns, any independent business valuations or statements of net worth, demonstrations of financial solvency, or reference checks. Milwaukee County Behavioral Health Division may require any of this information at any time, whether prior to or subsequent to indicating intent to award the contract.

BHD reserves the right to make an offer regarding the award based on the original submitted proposal.

The award of the contract, if made, shall be to an organization whose proposal provides the best value to Milwaukee County Behavioral Health Division. Milwaukee County Behavioral Health Division reserves the right to reject any and all proposals received if it deems appropriate and may modify, cancel or republish the RFP at any time prior to a contract being awarded up to and through final action of the Milwaukee BHD Behavioral Health Board.

The BHD reserves the right to reject any and all proposals.

5.2 EVALUATION CRITERIA

The BHD will consider and apply weighting for categories detailed below to each proposal deemed to be responsive.

Mandatory Response	**Required**
General Qualifications & Experience	**25%**
Technical Qualifications, Approach and Quality	**45%**
Cost Proposal	**30%**

5.3 DETERMINATION

Following evaluation, the Committee will make a recommendation to the Administrator as to which proposal is determined to provide the best value to Milwaukee County Behavioral Health Division. Award may be made to the proposal with a higher technical ranking even if its price proposal is not the lowest.

5.4 SELECTION PROCESS

An Intent to Award will be issued and all proposers will be notified. Milwaukee BHD Behavioral Health Division reserves the right to negotiate with the selected proposer, at its option, regarding the terms of a contract and other issues to be incorporated into the contract.

In the event that a successful agreement cannot be executed, Milwaukee County Behavioral Health Division reserves the right to proceed with contract negotiations with the other responsive, qualified proposer to provide service.

Prior to contract, the Chief Administrator shall make a recommendation of award to the Mental Health Board as is subject to their approval. A contract will only be executed following final approval by the Mental Health Board.

SECTION 6 PROPOSAL TERMS AND CONDITIONS

6.1 FIRM COMMITMENT, AVAILABILITY, PROPOSAL VALIDITY

Proposers shall maintain their availability of service and proposed price as set forth in their proposals for an anticipated service starting date to be determined (TBD) as identified in the Information Summary Sheet. Proposers are expected to perform all necessary planning and implementation activities prior to commencement of a contract. Milwaukee County Behavioral Health Division will not reimburse for these costs.

6.2 NON-INTEREST OF BHD EMPLOYEES AND OFFICIALS

No BHD or Milwaukee County official, employee or representative on the evaluation committee shall have any financial interest, either direct or indirect, in the proposal or contract or shall exercise any undue influence in the awarding of the contract.

No Milwaukee County employee, officer or agent shall participate in the selection, award or administration of a contract if a conflict of interest, real or apparent, would be involved.

Milwaukee County Specific Requirements: No person(s) with a personal financial interest in the approval or denial of a contract or proposal being considered by a County department or with an agency funded and regulated by a County department, shall make a campaign contribution to any County elected official who has approval authority over that contract or proposal during its consideration. Contract or proposal consideration shall begin when a contract or proposal is submitted directly to a County department or to an agency funded or regulated by a County department until the contract or proposal has reached final disposition, including adoption, County executive action, proceedings on veto (if necessary) or departmental approval.

6.3 COMPLIANCE WITH LOCAL, STATE AND FEDERAL LAWS AND REGULATIONS

Successful proposers will be required to enter into an agreement with Milwaukee County Behavioral Health Division that complies with all Federal, State, and local laws, regulations, standards, including, but not limited to, such laws, regulations, and standards pertaining to health, accessibility, the environment and safety.

6.4 ERRORS, OMISSIONS, MINOR IRREGULARITIES AND RETAINED RIGHTS

All information in this RFP, including any addenda, has been developed from the best available sources; however, Milwaukee County Behavioral Health Division makes no representation, warranty or guarantee as to its accuracy.

Should proposer discover any significant ambiguity, error, omission or other deficiency in the RFP document, they must immediately notify the RFP Contact/Administrator in writing, via email, prior to the submission of the proposal. The failure of a proposer to notify the RFP Contact/Administrator of any such matter prior to submission of its proposal constitutes a waiver of appeal or administrative review rights based upon any such ambiguity, error, omission or other deficiency in the RFP document.

Milwaukee County Behavioral Health Division reserves the right to waive minor irregularities in proposals. Minor irregularities are defined as those that have no adverse effect on the outcome of the selection process by giving a Proposer an advantage or benefit not afforded by other Proposers. Milwaukee County Behavioral Health Division may waive any requirements that are not material.

Milwaukee County Behavioral Health Division may make an award under the RFP in whole or in part and change any scheduled dates.

Milwaukee County Behavioral Health Division reserves the right to use ideas presented in reply to this RFP notwithstanding selection or rejection of proposals.

Milwaukee County Behavioral Health Division reserves the right to make changes to and/or withdraw this RFP at any time.

6.5 DISCLOSURE OF RFP INFORMATION

All materials submitted become the property of Milwaukee County Behavioral Health Division.

Any restriction on the use of data contained within a request must be clearly stated in the proposal itself. Proprietary information submitted in response to a request will be handled in accordance with applicable BHD policies, State of Wisconsin procurement regulations, and the Wisconsin Public Records Law. Proprietary restrictions normally are not accepted. However, when accepted, it is the provider's responsibility to defend the determination in the event of an appeal or litigation.

Data contained in a Request for Proposal, all documentation provided therein, and innovations developed as a result of the contracted commodities or services cannot be copyrighted or patented. All data, documentation and innovations become the property of Milwaukee County Behavioral Health Division.

Milwaukee County Behavioral Health Division may, at any time during the procurement process, request and/or require additional disclosures, acknowledgments, and/or warranties, relating to, without limitation, confidentiality, EEOC compliance, collusion, disbarment, and/or conflict of interest.

Any materials submitted by the applicant in response to this Request for Proposal that the applicant considers confidential and proprietary information and which proposer believes qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats, or material which can be kept confidential under the Wisconsin public record law, must be identified on the Designation of Confidential and Proprietary Information Form (Attachment Z – Proprietary Information Disclosure). Confidential information must be labeled as such. Costs (pricing) always become public information and therefore cannot be kept confidential. Any other requests for confidentiality must be justified in writing on the form provided and included in the proposal and attached to Attachment Z – Proprietary Information Disclosure. Milwaukee County Behavioral Health Division has the sole right to determine whether designations made by a proposer qualify as trade secrets under the Wisconsin Public Records Law.

6.6 PROPOSAL ACCEPTANCE, REJECTION, CANCELLATION AND WITHDRAWAL

Each proposal is submitted with the understanding that it is subject to negotiation at the option of

Milwaukee Behavioral Health Division. However, Milwaukee County Behavioral Health Division reserves the right to make an award on the basis of the original proposal, without negotiation with any proposer.

Milwaukee Behavioral Health Division reserves the right to negotiate with the successful proposer within the scope of the RFP in the best interests of Milwaukee County Behavioral Health Division.

Milwaukee Behavioral Health Division may request and require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an officer's proposal and/or to determine an officer's compliance with the requirements of the solicitation.

Milwaukee County Behavioral Health Division may use information obtained through site visits, management interviews and the BHD's investigation of a bidder's qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the BHD's request for clarifying information in the course of evaluation and/or selection under the RFP.

Upon acceptance in writing by Milwaukee County Behavioral Health Division of the final offer to furnish any and all of the services described herein, and upon receipt of any required federal, state and local government approvals, the parties shall promptly execute the final contract documents. The written contract shall bind the proposer to furnish and deliver all services as specified herein in accordance with conditions of said accepted proposal and this RFP as negotiated. Milwaukee County Behavioral Health Division reserves the right to accept or reject any and all proposals submitted or cancel this RFP in whole or in part if such cancellation is in the best interest of Milwaukee County Behavioral Health Division.

Prior to the date and time set forth in the Proposal Receipt Deadline, proposals may be modified or withdrawn by the proposer's authorized representative via e-mail to the RFP Contact/Administrator. After the proposal deadline, proposals may not be modified or withdrawn without the consent of Milwaukee County Behavioral Health Division.

6.7 INCURRED EXPENSES

Milwaukee County Behavioral Health Division shall not be responsible for any cost or expense incurred by the proposers preparing and submitting a proposal or cost associated with meetings and evaluations of proposals prior to execution of an agreement. This includes any legal fees for work performed or representation by proposer's legal counsel during any and all phases of the RFP process, any appeal or administrative review process, and prior to BHD Board approval of a contract award.

6.8 MODIFICATION OF PROPOSAL

A Proposal is irrevocable until the Contract is awarded, unless the Proposal is withdrawn. Proposers may withdraw a Proposal in writing at any time up to the Proposal submission date and time.

To accomplish this, the written request must be signed by an authorized representative of the Proposer and submitted to the RFP Contact/Administrator. If a previously submitted Proposal is withdrawn before the Proposal due date and time, the Proposer may submit another at any time up to the closing date and time.

6.9 REASONABLE ACCOMMODATIONS

The BHD will provide reasonable accommodations, including the provision of informational material in alternative format, for qualified individuals with disabilities upon request. If the Proposer needs accommodations, please contact the RFP Contact/Administrator.

6.10 PROTEST AND APPEALS PROCEDURES

Protests and appeals related to this RFP are subject to the provisions of the Milwaukee County Behavioral Health Division Article 1- Legal and Contractual Remedies.

Any dispute arising from the contract must be resolved in the State of Wisconsin. With respect to any claim between the parties, Provider consents to venue in Milwaukee BHD, Wisconsin, and irrevocably waives any objections it may have to the jurisdiction on the grounds of lack of personal jurisdiction of the court or the laying of venue of the court or on the basis of forum non-convenience or otherwise.

6.11 AUDIT

Provider, its officers, directors, agents, partners, and employees shall allow the Milwaukee County Audit Services Division, BHD and department contract administrators (collectively, "Designated Personnel") and any other party the Designated Personnel may name, with or without notice, to audit, examine and make copies of any and all records of the Provider related to the performance of the Agreement for a period of up to five (5) years following the date of last payment. Any subcontractors or other parties performing work on this Agreement will be bound by the same terms and responsibilities as the Provider. All subcontracts or other agreements for work performed on this Agreement will include written notice that the subcontractors or other parties understand and will comply with the terms and responsibilities. The Provider agrees to prominently post in locations accessible to its employees County-provided bulletins concerning the County Fraud Hotline. Any subcontractors or other parties performing work on this Agreement will be bound by the same terms and responsibilities as the Provider. All subcontracts or other agreements for work performed on this Agreement will include written notice that the subcontractors or other parties understand and will comply with the terms and responsibilities.

6.12 CODE OF ETHICS

Proposers shall strictly adhere to Chapter 9 of the Milwaukee County Code of Ethics, with particular attention to Subsection 9.05(2) (k):

"No campaign contributions to Milwaukee County officials with approval authority: No person(s) with a personal financial interest in the approval or denial of a contract or proposal being considered by a Milwaukee County department or with an agency funded and regulated by a Milwaukee County department, shall make a campaign contribution to any Milwaukee County elected official who has approval authority over that contract or proposal during its consideration. Contract or proposal consideration shall begin when a contract or proposal is submitted directly to BHD or to an agency funded or regulated by a Milwaukee County department until the contract or proposal has reached final disposition, including adoption, BHD approval. This provision does not apply to those items covered by section 9.14 unless an acceptance by an elected official would conflict with this section. The language in subsection
9.05(2) (k) shall be included in all Requests for Proposals and bid documents."

6.13 DISADVANTAGED BUSINESS ENTERPRISE (DBE)

While this Procurement opportunity does not have a specific participation goal, all respondents to this solicitation are hereby directed to use active and aggressive efforts to assist BHD in participation of DBE firms on BHD procurements. The directory of certified firms, and further assistance with this initiative, can be obtained by contacting the Community Business Development Partners Department of Milwaukee County (CBDP) at (414) 278-4747, or mailto:cbdp@milwaukeeBHDwi.gov

The directory of DBE firms currently certified in the State of Wisconsin can be found at: https://app.mylcm.com/wisdot/Reports/WisDotUCPDirectory.aspx

6.14 DRAFT OF AGREEMENT

Milwaukee County Behavioral Health Division intends to incorporate the response to this RFP as an attachment to any resulting agreement.

6.15 TERMINATION FOR CAUSE (DISPUTE)

In the event that a dispute arises with respect to the manner in which Provider meets its obligations under the Agreement, the parties will negotiate in good faith to resolve such dispute. In the event that the parties are not able to resolve the dispute within sixty days, then BHD may terminate this Agreement on eighteen (18) months written notice to the Provider.

6.16 TERMINATION FOR CAUSE (GENERAL PROVISIONS)

The resulting services agreement will include provisions for termination of the agreement for cause, which shall include the following:

- Loss of qualification or certification as a provider of Medicare or Medicaid
- Loss of necessary licenses to provide the Services
- Bankruptcy, receivership or similar insolvency proceeding with respect to the Provider
- Consistent, persistent or repeated failure to meet necessary quality standards
- Where necessary to comply with law or changes in law.

6.17 NO CAUSE TERMINATION

Either party may terminate this Agreement without cause upon twenty-four (24) months prior written notice to the other party.

6.18 EFFECT OF TERMINATION

Upon any termination of the contract:

- The Provider shall cooperate in transitioning the Services to a successor provider.
- The BHD shall have the right to lease, pursuant to commercially reasonable terms, the premises or portion thereof of the Facility where the Services are provided, including the emergency department of the Facility.

- At the option of the BHD, the Provider must provide support services such as food service, laundry and other support services to the extent provided prior to termination to the successor provider at a price not to exceed cost plus five (5) percent.
- The BHD shall select any successor provider in its sole discretion.

6.19 PERFORMANCE BOND

In order to ensure that the Provider can meet its statutory obligations to provide the mental health services that the BHD is required to provide under Wisconsin law, the successful Provider will provide to the BHD a $2,000,000 Performance Bond with surety satisfactory to the BHD, within ten (10) working days after notice is received from the BHD that the contract has been awarded to the Provider. The cost of providing the bond shall be considered as included in the proposal price (but listed separately) and no additional compensation will be allowed therefore. All other specifications pertaining to insurance requirements e.g., Bond insurer underwriting agency, etc. (refer to Certification for Indemnity and Insurance, Attachment O) will pertain to this bond requirement. The BHD may, at its sole discretion, waive or reduce this requirement and corresponding price adjustment.

Note: Performance Bond is not required at the time of RFP submission. Only the successful Proposer will be required to submit the Performance Bond.

6.20 LEGAL DISCLAIMER

This RFP does not commit BHD to award a contract nor does it grant any rights of any kind to any proposer or respondent. This RFP and the process it describes are proprietary and for the sole and exclusive benefit of BHD. Any proposal including written or electronic documents and oral communication by any bidder shall become the property of BHD, and subject to disclosure only at BHD's discretion or as required by law.

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ATTACHMENT- A
Action Team: Person-Centered Care
Mental Health Redesign and Implementation Task Force

All people, programs, and systems providing and supporting mental health care in Milwaukee County should commit to multiple pathways to improve person-centered, welcoming, recovery-oriented, trauma-informed, and co-occurring-capable service. Community-based services and supports must be expanded to ensure that individuals experience recovery in the least restrictive setting. A culture of person-centered care strives to inspire the hopes of all individuals and families with complex needs and appreciates the value of life experiences and personal strengths that form the foundation of caring partnerships. The aim of person-centered care is to assist individuals and families in facing the challenges that arise from combinations of emotional and mental health conditions, substance use issues, cognitive and intellectual disabilities and brain injuries, trauma, physical health problems, and myriad social wellbeing concerns. By ensuring that all services are person-centered, the mental health system in Milwaukee County will empower all individuals and families to live their vision of happiness.

Individuals seeking mental health services in Milwaukee County will be welcomed as full collaborative partners whose values and informed choices guide the evolution of the mental health system and the ongoing provision of recovery-oriented, culturally competent services throughout the community, including expanded peer support and consumer-operated services to increase satisfaction, increase participation in services, and facilitate easier navigation between various access points and levels of care. Informed choice includes the maximization of options available to individuals and families enabling them to choose how, when, and where they can access services.

Public and private stakeholders will incorporate the principles of trauma-informed care and person-centered recovery into policies and procedures, hiring and training processes, and service delivery at all levels, and the application of the Comprehensive, Continuous, Integrated System of Care (Minkoff & Cline, 2004, 2005) will be expanded to create accessible and therapeutic environments for persons with mental health needs throughout the community.

In order to create educated and responsive communities, move beyond the medical model, and maximize the independence of consumers to experience recovery in least restrictive environments, information about prevention, early signs and symptoms, and the spectrum of available services will be freely and easily accessible in multiple media, written in understandable language, promoted by outreach efforts, and maintained for accuracy.

This team anticipates providing guidance for the implementation and monitoring of the recommendations it has endorsed. An entity such as this team – comprised of consumers, providers, and other mental health stakeholders – should periodically convene throughout the redesign and the coming transitions in the system to ensure ongoing adherence to the principles of person-centered care and recovery. Training will be necessary at all levels of service delivery to achieve the vision articulated here, and we are eager to work with an entity such as the Workforce Action Team to determine specific training needs and strategies for workforce development. Additionally, this team anticipates collaborating with the Quality Action Team (or a QA/QI Steering Committee, per that team's vision) to identify outcome measures and fidelity tools to achieve consistent, system-wide application of our envisioned principles.

The redesigned, recovery-oriented system will support person-centered and self-directed approaches to care that build upon the strengths of individuals, families, and communities to take responsibility for their sustained health, wellness, and recovery.

Glossary of terms

Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in determining an individual's mental wellness/illness and incorporating those variables into assessment and treatment. (*SAMHSA*)

Person-centered care is an ongoing, interactive process between consumers, caregivers, and others that honor an individual's dignity and choices in directing his or her daily life. This is accomplished through communication, education, and collaboration. (*Wisconsin Coalition for Person Directed Care*)

Person-centered planning . . . is widely respected as a best practice to design effective networks of services and supports that enable people to have a higher quality of life and to achieve full citizenship and integration into their communities. (*Yale Program for Recovery and Community Health* – http://www.yale.edu/PRCH/index.html)

Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential. Recovery:

- Is person-driven;
- Occurs via many pathways;
- Is holistic;
- Is supported by peers;
- Is supported through relationships;
- Is culturally-based and influenced;
- Is supported by addressing trauma;
- Involves individual, family, and community strengths and responsibility;
- Is based on respect; and
- Emerges from hope. (*SAMHSA*)

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. (*SAMHSA-NCTIC*)

ATTACHMENT P – AUTHORIZATION FOR REFERENCE CHECK

AUTHORIZATION FOR REFERENCE CHECK

The undersigned hereby authorizes the recipient of this authorization (or a copy thereof) to furnish to the Milwaukee County Behavioral Health Division any and all information that said recipient may have concerning the undersigned's contract performance history.

This information is to be furnished to the Milwaukee County Behavioral Health Division Office for the purposes of evaluating the ability of the undersigned to perform Crisis (Emergency Department), Observation and Inpatient Care (Acute Adult and Child and Adolescent) Services for the Behavioral Health Division – Including High Acuity and Involuntary Detention Services to the Milwaukee County Behavioral Health Division.

The undersigned further authorizes any person contacted to give the Milwaukee BHD Behavioral Health Division any and all information concerning the undersigned's (and the employees of the undersigned) education, work experience, and character which they may have, personal or otherwise, and releases all parties from all liability for any damage that may result from furnishing the same to the Milwaukee County Behavioral Health Division.

A photocopy of this authorization shall be deemed equivalent to the original.

Dated this _____ day of _____, 20____.

_____
Authorized Signature

_____
Title

_____
Name of Firm

Volume I)

ATTACHMENT Q – CONFLICT OF INTEREST STIPULATION

CONFLICT OF INTEREST STIPULATION (Sign and Submit with Technical Proposal –

Milwaukee County Behavioral Health Division REQUEST FOR PROPOSAL FOR Crisis (Emergency Department), Observation and Inpatient Care (Acute Adult and Child and Adolescent) Services for the Behavioral Health Division – Including High Acuity and Involuntary Detention Services

For purposes of determining any possible conflict of interest, all providers submitting a proposal in response to this RFP must disclose if any MC employee, agent or representative or an immediate family member is also an owner, corporate officer, employee, agent or representative of the business submitting the bid. This completed form must be submitted with the proposal. Furthermore, according to the Milwaukee County Code of Ethics, no person may offer to give to any County officer or employee or immediate family member, may solicit or receive anything of value pursuant to an understanding that such County representatives' vote, official actions or judgment would be influenced thereby.

Please answer below either YES or NO to the question of whether any MC employee, agent or representative or immediate family member is involved with your company in any way:

YES _____

NO _____

IF THE ANSWER TO THE QUESTION ABOVE IS YES, THEN IDENTIFY THE NAME OF THE INDIVIDUAL, THE POSITION WITH MC, AND THE RELATIONSHIP TO YOUR BUSINESS:

NAME _____

BHD POSITION _____

BUSINESS RELATIONSHIP _____

THE APPROPRIATE CORPORATE REPRESENTATIVE MUST SIGN AND DATE BELOW:

Volume I)

PRINTED NAME _____

AUTHORIZED SIGNATURE

_____

TITLE _____

DATE _____

Volume I)

ATTACHMENT R – SWORN STATEMENT OF BIDDER –

SWORN STATEMENT OF BIDDER (Sign and Submit with Technical Proposal –

MILWAUKEE BHD REQUEST FOR PROPOSAL For Crisis (Emergency Department), Observation and Inpatient Care (Acute Adult and Child and Adolescent) Services for the Behavioral Health Division – Including High Acuity and Involuntary Detention Services

I, being first duly sworn at _____,

City, State

On oath, depose and say I am the _____

Official Title

Of the Proposer, _____,

Name of Company

Do state the following: that I have fully and carefully examined the terms and conditions of this Request for Proposal, and prepared this submission directly and only from the RFP and including all accessory data. I attest to the facts that:

- I have reviewed the RFP, all related attachments, questions and answers, addenda, and information provided through MC, in detail before submitting this proposal.
- I have indicated review, understanding and acceptance of the RFP (or relevant service component being bid upon).
- I certify that all statements within this proposal are made on behalf of the Bidder identified above.
- I have full authority to make such statements and to submit this proposal as the duly recognized representative of the Bidder. I have reviewed our response to the bid/proposal specifications and certify that it is an accurate representation of our organization, capabilities, and proposed services, and is in agreement with the RFP requirements
- I further stipulate that the said statements contained within this proposal are true and correct and this sworn statement is hereby made a part of the foregoing RFP response.

Volume I)

Signature

Legal Address

Subscribed and sworn to before me

This _____ day of _____, _____

Notary Public, _____ BHD

State of _____ my commission expires _____.

Volume I)

ATTACHMENT S – COVER SHEET FOR MAIN PROPOSAL

COVER SHEET FOR MAIN PROPOSAL (Sign and Submit with Technical Proposal –

In submitting and signing this proposal, we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free trade or competition; that no attempt has been made to induce any other person or firm to submit or not to submit a proposal; that this proposal has been independently arrived at without collusion with any other provider, competitor, or potential competitor; that this proposal has not knowingly been disclosed prior to the opening of the proposals to any other provider or competitor; that the above statement is accurate under penalty of perjury.

In submitting and signing this proposal, we represent that we have thoroughly read and reviewed this Request for Proposal and are submitting this response in good faith. We understand the requirements of the program and have provided the required information listed within the Request for Proposal.

The undersigned certifies and represents that all data, pricing, representations, and other information of any sort or type, contained in this response, is true, complete, accurate, and correct. Further, the undersigned acknowledges that MC is, in part, relying on the information contained in this proposal in order to evaluate and compare the responses to the RFP for Crisis (Emergency Department), Observation and Inpatient Care (Acute Adult and Child and Adolescent) Services for the Behavioral Health Division – Including High Acuity and Involuntary Detention Services

_____

Provider's Name

_____

Title

_____

Signature

_____

Date

ATTACHMENT V – CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION (Sign and Submit with Technical Proposal – Volume I)

The applicant certifies to the best of its knowledge and belief, that its' principals, owners, officers, shareholders, key employees, directors and member partners: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and, (4) have not within a three-year period preceding this proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

Authorized Signature: _____ Date: _____

Printed Name: _____Title: _____

Company: _____

ADDITIONAL DISCLOSURES

1. Has your company or any representative, owner, partner or officer ever failed to perform work awarded or had a contract terminated for failure to perform or for providing unsatisfactory service?

☐ Yes ☐ No If yes, on a separate page please provide a detailed explanation.

2. Within the past five (5) years, has your organization or any representative, owner, partner or officer (collectively "your company) ever been a party to any court or administrative proceedings or disciplinary action, where the violation of any local, state or federal statute, ordinance, rules, regulation, or serious violation of company work rules by your Company was alleged?

☐ Yes ☐ No If yes, on a separate page, please provide a detailed explanation outlining the following:

- **Date of citation or violation**
- **Description of violation**
- **Parties involved**
- **Current status of citation**

3. Have you, any principals, owners, partners, shareholders, directors, members or officers of your business entity ever been convicted of, or pleaded guilty, or no contest to, a felony, serious or gross misdemeanor, or any crime or municipal violation, involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you or any of the above persons for any such crimes by information, indictment or otherwise?

☐ Yes ☐ No If yes, on a separate page, please provide a detailed explanation.

4. The Proposer certifies, and in the case of a joint Proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

The prices in this Proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder/Proposer or with any competitor;

Unless otherwise required by law, the prices which have been quoted in this Proposal have not been knowingly disclosed by the Proposer and will not knowingly be disclosed by the Proposer prior to opening in the case of an advertised procurement, or prior to award in the case of a negotiated procurement, directly or indirectly to any other Proposer or to any competitor; and

No attempt has been made or will be made by the Proposer to induce any other person or firm to submit or not to submit a Proposal for the purpose of restricting competition.

Authorized Signature: _____ Date: _____

Printed Name: _____Title: _____

Company: _____

ATTACHMENT O - INDEMNITY AND INSURANCE REQUIREMENTS ACKNOWLEDGEMENT

INDEMNITY

Contractor agrees, to the fullest extent permitted by law, to indemnify, defend and hold harmless, the County and its agents, officers and employees, from and against all loss or expenses including cost and attorney's fees by reason of liability for damages including suits at law or in equity, caused by any act or omission of Contactor, or its agents or guests, which may arise out of or are connected with the activities covered by the agreement.

INSURANCE

Provider agrees to evidence and maintain proof of financial responsibility to cover costs as may arise from claims of tort, malpractice, errors and omissions, statutes and benefits under Workers' Compensation laws and/or vicarious liability arising from employees or agents. Such evidence shall include insurance coverage for Worker's Compensation claims as required by the State of Wisconsin, Commercial General Liability and/or Business Owner's Liability, Automobile Liability (if the Agency owns or leases any vehicles) and Professional Liability (where applicable) in the minimum amounts listed below.

Automobile insurance that meets the Minimum Limits as described in the Contract is required for all agency vehicles (owned, non-owned, and/or hired).

Provider hereby certifies that Provider's Direct Service Providers who use personal vehicles for any purpose related to the provision of Covered Services have in effect insurance policies in companies licensed to do business in the State of Wisconsin providing protection against all liability, including public liability and property damage, arising out of the use of their automobiles during the course of their employment. Provider further certifies that said Direct Service Providers have a Driver's License valid in the state of Wisconsin.

If the services provided under the contract constitute professional services, Provider shall maintain Professional Liability coverage as listed below. Treatment providers (including psychiatrists, psychologists, social workers) who provide treatment off premises must obtain General Liability coverage (on premises liability and off-premise liability), to which Milwaukee BHD is added as an additional insured, unless not otherwise obtainable.

It being further understood that failure to comply with insurance requirements might result in suspension or termination of the Contract.

Type of Coverage & Requirements	**Minimum Limit**
Wisconsin Workers' Compensation Statutory or Proof of all States Coverage	
Employers' Liability	$100,000/$500,000/$100,000
Commercial General and/or Business Owner's Liability	
Bodily Injury & Property Damage (Incl. Personal Injury, Fire, Legal Contractual & Products/Completed Operations)	$1,000,000 - Per Occurrence $1,000,000 - General Aggregate
Automobile Liability	
Bodily Injury & Property Damage All Autos - Owned, Non-Owned and/or Hired	$1,000,000 per Accident
Uninsured Motorists	per Wisconsin Requirements
Professional Liability	
To include Certified/Licensed Mental Health and AODA Clinics and Providers $3,000,000 Annual Aggregate and	$1,000,000 Per Occurrence
Hospital, Licensed Physician or any other qualified healthcare provider under Sect 655 Wisconsin Patient Compensation Fund Statute	As required by State Statute
Any non-qualified Provider under Sec 655 Wisconsin Patient Compensation Fund Statute State of Wisconsin (indicate if Claims Made	$1,000,000 Per Occurrence/ Claim $3,000,000 Annual Aggregate or Occurrence)
Other Licensed Professionals	$1,000,000 Per Occurrence $1,000,000 Annual aggregate or Statutory limits whichever is higher

Should the statutory minimum limits change, it is agreed the minimum limits stated herein shall automatically change as well

Milwaukee BHD, as its interests may appear, shall be named as, and receive copies of, an "additional insured" endorsement, for general liability, automobile insurance, and umbrella/excess insurance. BHD must be afforded a thirty day (30) written notice of cancellation, or non-renewal. Disclosure must be made of any non-standard or restrictive additional insured endorsement, and any use of non-standard or restrictive additional insured endorsement will not be acceptable.

Exceptions of compliance with "additional insured" endorsement are:

1. Transport companies insured through the State "Assigned Risk Business" (ARB).

2. Professional Liability where additional insured is not allowed.

A Waiver of Subrogation for Workers' Compensation by endorsement in favor of Milwaukee BHD is also required. A copy of the endorsement shall be provided.

Provider shall furnish BHD annually on or before the date of renewal, evidence of a Certificate indicating the above coverages (with the Milwaukee Behavioral Health Division named as the "Certificate Holder," as noted below). The Certificate shall be submitted for review and approval by BHD throughout the duration of this Contract. If said Certificate of Insurance is issued by the insurance agent, it is Provider's responsibility to ensure that a copy is sent to the insurance company to ensure that the BHD is notified in the event of a lapse or cancellation of coverage.
Milwaukee BHD

Department of Administration
Attention: Risk Manager
901 North 9th Street Room 302
Milwaukee, WI 53233

Provider must at the time of the contract award provide to the BHD proof of all Liability clauses listed above.

Indicate an understanding of Milwaukee BHD requirements and willingness to comply:

Authorized Signature: _____ Date: _____

Printed Name: _____Title: _____

Company: _____

ATTACHMENT Z – DESIGNATION OF CONFIDENTIAL/PROPRIETARY INFORMATION

PROPRIETARY INFORMATION DISCLOSURE FORM (Sign and Submit with Technical Proposal – Volume I)

The attached material submitted in response to the Request for Proposal includes proprietary and confidential information, which qualifies as a trade secret, as provided in s. 19.36(5), Wis. Stats. or is otherwise material that can be kept confidential under the Wisconsin Open Records Law. As such, we ask that certain pages, as indicated below, of this proposal response be treated as confidential material and not be released without our written approval.

Prices always become public information and therefore cannot be kept confidential.

Other information cannot be kept confidential unless it is a trade secret. Trade secret is defined in s. 134.90(1) (c). Wis. Stats. As follows: "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

1. The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.
2. The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

We request that the following pages not be released:

Section Page # Topic

_____

_____

_____

IN THE EVENT THE DESIGNATION OF CONFIDENTIALITY OF THIS INFORMATION IS CHALLENGED, THE UNDERSIGNED HERBY AGREES TO PROVIDE LEGAL COULSEL OR OTHER NECESSARY ASSISTANCE TO DEFEND THE DESIGNATION OF CONFIDENTIALITY AND AGREES TO HOLD BHD HARMLESS FOR ANY COSTS OR DAMAGES ARISING OUT OF BHD's AGREEMENT TO WITHOLD THE MATERIALS.

Failure to include this form in the Request for Proposal may mean that all information provided as part of the proposal response will be open to examination and copying. BHD considers other markings of confidential in the proposal document to be insufficient. The undersigned agrees to hold BHD harmless for any damages arising out of the release of any materials unless they are specifically identified above.

Company Name _____

Authorized Representative _____
Signature

Authorized Representative _____
Type or Print

Date _____

COVER SHEET FOR RATE PROPOSAL (Sign and Submit with Price Proposal – Volume II)

In submitting and signing this proposal, we also certify that we have not, either directly or indirectly, entered into any agreement or participated in any collusion or otherwise taken any action in restraint of free trade or competition; that no attempt has been made to induce any other person or firm to submit or not to submit a proposal; that this proposal has been independently arrived at without collusion with any other provider, competitor, or potential competitor; that this proposal has not knowingly been disclosed prior to the opening of the proposals to any other provider or competitor; that the above statement is accurate under penalty of perjury.

In submitting and signing this proposal, we represent that we have thoroughly read and reviewed this Request for Proposal and are submitting this response in good faith. We understand the requirements of the program and have provided the required information listed within the Request for Proposal.

Unless otherwise required by law, the prices which have been quoted in this Proposal have not been knowingly disclosed by the Proposer and will not knowingly be disclosed by the Proposer prior to opening in the case of an advertised procurement, or prior to award in the case of a negotiated procurement, directly or indirectly to any other Proposer or to any competitor; and

No attempt has been made or will be made by the Proposer to induce any other person or firm to submit or not to submit a Proposal for the purpose of restricting competition.

The undersigned certifies and represents that all data, pricing, representations, and other information, of any sort or type, contained in this response, is true, complete, accurate, and correct. Further, the undersigned acknowledges that MC is, in part, relying on the information contained in this proposal in order to evaluate and compare the response to the RFP for Crisis (Emergency Department), Observation and Inpatient Care (Acute Adult and Child and Adolescent) Services for the Behavioral Health Division – Including High Acuity and Involuntary Detention Services.

_____

Provider's Name

_____

Title

_____

Signature/Date

ATTACHMENT N - COST PROPOSAL

RATE PROPOSAL

The Cost Proposal, detailed below, shall indicate the all-inclusive proposed price for providing goods or services as defined by this RFP.

This Cost Proposal must be signed, in the space below, by an individual empowered to bind the Respondent to the provisions of this RFP and any contract awarded pursuant to this RFP and any contracts awarded pursuant to this RFP.

This attachment must include submission of documents verifying Proposer's Medicaid Rate as determined by the state of Wisconsin.

Revenue Code	Service Description	2014 Volume (cost evaluation)	Proposer's Annual Percentage of Medicaid Modifier	Proposer's Annual Medicaid Modifier
450	Emergency Room Bundled Rate for Facility Fee and all Professional, Lab, Pharmacy and all other charges	1345	%	$
760	Observation Bundled Rate for Facility Per Diem and all Professional, Lab, Pharmacy and all other charges	170	%	$
124	Adult Psychiatric Inpatient Per Diem (IMD and Exhausted Bed Day Clients)	199 IMD 255 exhausted bed days	%	$
124-P	Adult Psychiatric Inpatient Per Diem Bundled With Pro Fees (Self Pay Clients)	129	%	$

2014 Volume (Cost Evaluation), will be used for total cost for RFP evaluation purposes.

Proposer's Percentage Modifier, a percentage when multiplied by the Proposer's Annual Medicaid Rate, as provided by the State of Wisconsin, will determine BHD's cost.

Proposer's Annual Medicaid Rate, rate available from and determined by the State of Wisconsin.

_____ _____ _____

Print Name Signature Date

Attachment B

Deloitte.

Wisconsin Department of Health Services

Assessment of the Milwaukee County Behavioral Health System

SUMMARY OF FINDINGS WORKING PAPER

November 25, 2014
Prepared by Deloitte Consulting

Executive Summary

Introduction

In 2013, the Wisconsin legislature passed Act 203 that requires the Wisconsin Department of Health Services (DHS) to conduct an operational and programmatic audit of the Milwaukee County Mental Health system. The objective of the audit is to evaluate the effectiveness of the Milwaukee County Mental Health system and make recommendations for transition of oversight and operations among the behavioral health division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and related community based behavioral health programs.

Ultimately, DHS is charged with determining if county-based resources and services can better meet the needs of mental health consumers in a cost-effective, quality manner.

The Act calls for DHS to complete the audit by December 1, 2014, and issue a report to the Department's Secretary that includes recommendations for the State to:

- Assume oversight for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex;
- Develop a plan to close the complex; and
- Develop a plan for state oversight of a regional facility for delivery of institutional, inpatient, crisis services, and behavioral health services using similar state-operated regional facilities as a model.

In August 2014, the Wisconsin Department of Health Services (DHS) engaged Deloitte Consulting as a contractor to help implement Act 203 by providing recommendations to the Governor and Legislature for improving the cost and quality of delivering publicly-funded behavioral health services in Milwaukee County.

The goal of Deloitte's assessment was to provide DHS with high-level insight and data so that it may develop policy recommendations for the continued care of Mental Health and Substance Abuse (MH/SA) consumers in Milwaukee County, including consumers using inpatient psychiatric and Emergency Detention services, consumers using crisis services, and consumers using community-based services. Between August and October 2014, Deloitte partnered with The Management Group (TMG) to assess several operational and programmatic aspects of the Milwaukee County behavioral health system. The assessment included findings from previously published reports on the system: the analysis of the adult mental health care delivery system completed by the Public Policy Forum and Human Services Research Institute (HSRI) in 2010; the Wisconsin public mental health and substance abuse infrastructure study completed by The Management Group (TMG) in 2009; and HSRI's report on the County's inpatient service capacity.

Introduction and Project Background

Study Purpose and Scope

In 2013, the Wisconsin Legislature passed Act 203 stipulating that the Wisconsin Department of Health Services (DHS) conduct an operational and programmatic assessment of the Milwaukee County Behavioral Health System. The objective of the assessment was to evaluate the effectiveness of the Milwaukee County Behavioral Health System and include recommendations for transition of oversight and operations of the Behavioral Health Division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and related community-based behavioral health programs.

The goal of this report is to provide Milwaukee County Behavioral Health System with recommendations for the following items:

1. The state assuming oversight responsibility for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex.
2. The development of a plan to close the complex.
3. The development of a plan for state oversight of a regional facility for delivery of institutional, inpatient, crisis services, and behavioral health services using similar state-operated regional facilities as a model.

Act 203 also requires the Milwaukee County Mental Health Board to arrange for a study to be conducted on alternate funding sources for mental health services and programs including fee-for-service models and managed care models that integrate mental health services by March 1, 2016. This activity is not included in the scope of this current project.

Study Approach and Methodology

The methodology includes three main steps:

1. **Gather data inputs:** Includes research questions based on Milwaukee County Behavioral Health System goals, major literature, relevant utilization and outcome reports, policies and interview results, to help understand patient needs, availability of services, processes, and associated health outcomes.
2. **Analyze current demand, supply, operations, best practices, policy implications and outcomes:** Answers research questions comparing the current state with proposed future transformational system goals using data that has been previously published and is readily available.

In addition to reviewing existing reports, members of the project team facilitated two stakeholder sessions for behavioral health consumers and advocates at two different Milwaukee locations on September 23, 2014 to gather critical information. The invitation for the stakeholder sessions was distributed by the project team a week prior to the scheduled sessions to:

1. Leadership from Milwaukee Mental Health Task Force
2. Leadership from the Comprehensive Community Services (CCS) Recovery Advisory Committee
3. Consumer representatives on the Mental Health Redesign and Implementation Task Force
4. Representatives of advocacy organizations, including Disability Rights Wisconsin (DRW), the National Alliance for the Mentally Ill (NAMI) Greater Milwaukee, Mental Health of America, and Community Advocates
5. Individuals of peer service organizations used by BHD consumers including Our Space, Grand Avenue Club, La Causa, and Horizon Healthcare – Office of Consumer Affairs

The project team would like to acknowledge the assistance provided by Barbara Beckert of DRW and Sue Gadacz of the Milwaukee County BHD, who provided insights on the distribution list for the focus group invitations and the location of the sessions, and forwarded the invitation broadly to their networks of consumers, peer specialists and/or advocacy representatives. Those receiving the email invitation where also asked to share it with other individuals with lived experience who might be interested in attending the sessions.

In addition, the invitation to the sessions provided contact information for individuals not able to attend but who wanted to provide input. The project team also offered the opportunity for individuals to provide feedback via email to the questions covered during the sessions.

The purpose of the feedback sessions was to hear from individuals—those with lived experience and individuals who advocate on their behalf regarding input on the strengths, progress, challenges, and gaps of the Milwaukee County behavioral health system—in order to gain insights on the broader redesign and system issues, including impact on areas such as access, quality, recovery and best practices.

It should be noted that various community stakeholders provided input to the 2010 study on the adult mental health system in Milwaukee County and the more recent inpatient capacity study this past April. In the stakeholder feedback for this assessment, the project team tried to build on the input from those previous studies to capture any new or updated information on the progress that has been made or issues that have emerged since then.

The project team held two sessions attended by 30 individuals and received input via phone from one individual. Participants at the sessions were told that comments made in the sessions would be shared in aggregate, without identifying the individual(s) making the comments. This

Research Questions

The research questions listed below are sample questions and are not an exhaustive list. The topics are specific to each domain and are aligned with the goals of the assessment.

Assessment Area	High Level Question
Inpatient	1. **Supply and Demand:** What IP services are presently provided? 2. **Operations and Outcomes:** How has utilization of beds trended relative to the quality of care? 3. **Operations and Outcomes:** Have staff and services provided adequate care and access? 4. **Best Practices:** Are there opportunities to increase efficiencies and effectiveness of admission, discharge/referral policies and procedures, in order to support principles of community-based recovery, and care in the least restrictive setting? 5. **Best Practices:** Are there evidenced models of care in other communities that can be leveraged? 6. **Policy:** What is the future need for IP services given the available payment constructs?
Crisis Services	1. **Supply and Demand:** What crisis services are presently provided? 2. **Operations and Outcomes:** Do the current crisis services offered meet the needs of Milwaukee County consumers in terms of access/capacity, quality and safety? 3. **Best Practices:** Are there opportunities to increase efficiencies and effectiveness of crisis services? 4. **Best Practices:** Are there evidenced models of care in other communities that can be leveraged? 5. **Policy:** What is the future need for crisis services given the available payment constructs? 6. **Policy:** Are there evidenced models of care in other communities that can be leveraged?

assumed that the health status of the population is constant; thus the improvement in admission in readmission rates cannot be correlated solely to improved care, community and crisis services, or processes at BHD.

5. The assessment process did not include a comparison of training and credentialing requirements of inpatient, crisis services and community services settings as this information, although it was requested, was not provided to Deloitte.
6. In order to respect individual privacy, the facilitators of the advocate/consumer sessions did not ask people to share what specific services their comments referred to unless they volunteered this information. It should be noted that not knowing what specific services individuals had experienced may be a limitation of the feedback received in the sessions.
7. Some advocates expressed concerns that certain groups of consumers (e.g., consumers with substance use issues and those with hearing impairments) were underrepresented in the focus group sessions due to issues with the location of the sessions or the lack of a session facilitated by an individual who was deaf. The project team provided the opportunity for individuals who expressed concerns and did not attend one of the scheduled sessions to provide written comments in response to the questions via email. In addition, given the limited timeframe and scope of this project, the project team was not able to engage in extensive outreach activities, schedule multi-day focus group sessions, or conduct broad surveys. It should be noted that past studies of the Milwaukee County behavioral health system more broadly solicited stakeholder feedback, with community stakeholder meetings held as recently as April 2014. The summary feedback from those studies was reviewed for consideration in the meta-analysis conducted for this assessment.
8. The assessment was not able to gain access to several Standard Operating Procedures for the Complex, staffing patterns at the Complex or around the system.

Even under these stressed circumstances, Milwaukee County continues to operate its own inpatient psychiatric units. The BHD operates four 24-bed units for short-term inpatient stabilization.[4] BHD's inpatient hospital is categorized as an Institution for Mental Disease (IMD) which, by federal mandate, means it is excluded from pursuing Medicaid reimbursement for care provided to adults, enrolled in Medicaid, that are older than 21 and younger than 65. This creates an additional hardship on an already financially stressed county system.

Demographics

With a population of 956,000 residents, Milwaukee County is the most populous in Wisconsin and accounts for approximately 17% of Wisconsin's population. In addition, the demographics of Milwaukee County are more diverse than the rest of Wisconsin as demonstrated by the table below.[5]

Table 1: Representation of Races in Milwaukee compared to the rest of Wisconsin

Race	Milwaukee County	Wisconsin
White, Non-Hispanic or Latino	53%	83%
Black or African American	27%	7%
Hispanic or Latino	14%	6%
Asian	4%	3%
Two or more races	3%	2%

Milwaukee County also has the largest city in Wisconsin, Milwaukee, and as a result its residents suffer from many of the issues associated with urban poverty[6]:

- 22% of residents live below 100% of FPL, compared to 12% of residents in Wisconsin
- The September 2014 unemployment rate in Milwaukee County is 6.3%, compared to a 4.7% average statewide[7]
- 19% of residents are on Medicaid in Milwaukee County, compared to 12% in Wisconsin
- 10% of Milwaukee County residents have been uninsured all of the past year, compared to 6% in Wisconsin

[4] Transforming the Adult Mental Health Care Delivery System in Milwaukee County.

[5] State & County Quick Facts. United States Census Bureau. http://quickfacts.census.gov/qfd/states/55/55079.html

[6] Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics, Health Analytics Section. Public Health Profiles,

[7] http://worknet.wisconsin.gov/worknet_info/maps/pdf/uRatesCo.pdf

The emergency detention procedure in Milwaukee County is different from that in other counties. Milwaukee County is the only county in which the treatment director (i.e., licensed BHD or contracted physician or psychologist with clinical responsibility for the provision of emergency service care) must make a detention decision within 24 hours of when the officer brought the person to the detention facility. The treatment director determines whether to release or detain the person for a period not to exceed 72 hours (excluding weekends and holidays) from the time the person was brought to the facility. Apparently, this different statutory procedure for Milwaukee was put in place in the late 1970s at the urging of law enforcement.

As a result of this statutory provision, the treatment director's determination, also known as a Treatment Director Supplement (TDS), is required before the emergency detention statement is filed with the court. The TDS must be done in the first 24 hours that the person has been brought to the facility.

- **Pros**: The requirement to do the TDS within 24 hours is important because the TDS serves to identify individuals who do not fit the emergency detention criteria and should not be detained. Advocates maintain that without the requirement of a TDS within 24 hours, a person could be detained for up to 72 hours or longer (if a weekend and/or holiday is involved) waiting for their probable cause hearing.

- **Cons**: Milwaukee County H&HS has urged elimination of the TDS requirement, and indicated in testimony to the Legislature in 2010 that "the primary concern with TDS is if a patient also requires medical clearance before entering BHD's PCS, the 24-hour TDS time period has likely expired ... due to either a pre-existing medical condition or as a result of physical harm they have done to themselves that led to the ED. This can result in some of the most serious cases being dismissed that otherwise would have been addressed."

Two pieces of legislation that went into effect this past spring impacted Milwaukee's emergency detention procedures. The first, 2013 Wisconsin Act 158, was supported by advocacy groups and Milwaukee County, and made several changes to the statutory provisions relating to emergency detention, including:

- Changed the emergency detention statute to make it clear that the purpose of emergency detention "is to provide, on an emergency basis, treatment by the least restrictive means appropriate to the individual's needs", to individuals who meet all the following criteria: (a) are mentally ill, drug dependent, or developmentally disabled; (b) evidence of the statutory standards of dangerousness; and (c) are reasonably believed to be unable or unwilling to cooperate with voluntary treatment.

Table 2: Comparison of Milwaukee County ED Practices to Other Wisconsin Counties

Milwaukee County	Other Wisconsin Counties
Law enforcement can determine who will be brought in on a potential emergency detention and is required by state law to sign a statement of emergency detention and deliver it to the detention facility with the individual (Wisconsin Stats. 51.15(4)(4)). **There is no similar approval by the county mental health authority required before a potential emergency detention is initiated and a person is delivered to the detention facility.**	Law enforcement needs approval from the county department of community programs (i.e., mental health authority) to initiate the emergency detention process and transport a person for detention (Wisconsin Stats. 51.15(2)(2)). In addition, the county may approve the detention only if the county reasonably believes the individual will not voluntarily consent to evaluation, diagnosis and treatment.
Doctors have 24 hours, not including delays due to medical clearance, from the time a person is brought to PCS at the Mental Health Complex to determine if an individual meets criteria for emergency detention and, if that determination is not made, the person is required to be released. This determination by the doctor at the detention facility is referred to as the Treatment Director Supplement (TDS). ***"Upon delivery of the individual, the treatment director of the facility, or his or her designee, shall determine within 24 hours, except as provided in par. (c), whether the individual shall be detained"***	*No 24 hour requirement and doctors in other counties are not required to complete a TDS.*

Structure, Roles and Responsibilities, Service Delivery Model

Budget and Payers

According to Wisconsin Act 203, the Milwaukee County Mental Health Board (MCMHB) is responsible for proposing an annual budget to the county executive. The proposal outlines how much of the budget will come from community aids funding, county tax level, patient revenue and other sources (including grants). The county tax levy must be between $53 million and $65 million; this amount can only be increased if additional mental health programs and services are transferred to MCMBH.

In 2015, approximately $183,500,000 was allocated to Milwaukee County's Behavioral Health Department; $67,400,000 from direct revenue, $54,000,000 from intergovernmental revenue and $62,000,000 from tax levy. The direct revenue includes an additional $500,000 in expected Medicaid reimbursement as a result of expanded access to BadgerCare Plus, Wisconsin's Medicaid program for low income families and people without dependent children.

The County recommended BHD budget is approximately 14% of the county's annual budget. This includes an increase in revenue expenditures of $3,699,353 to support the following:

- Increasing fringe benefit costs
- A strengthened inpatient staffing model to support the higher acuity patient load seen in the inpatient psych units over the past several years
- Expanding community-based crisis services focus on crisis services to divert patients from unnecessary hospitalization

Despite plans to close both long-term rehabilitation facilities by the end of 2015, Milwaukee County must continue to maintain the facilities in compliance with State and Federal regulations until the facilities are fully closed. Subsequently, even though several FTEs will be eliminated, there are still significant overhead costs associated with operating the facilities.

Wisconsin Behavioral Health Department Payer Profile

As in many places throughout the country, the Milwaukee County BHD takes on the role of "Safety Net" and treats many of the Medicaid and uninsured residents of Milwaukee County. In 2013, only 9% of admissions had private insurance. Medicaid was the most common payer, with 32% of admissions covered by Medicaid HMO and 22% of admissions covered by Medicaid

In addition to inpatient care, Milwaukee County provides community-based services directly and through contracts with community-based services. The services that are currently provided include:

- Community Support Program
- Targeted Case Management
- Community Residential
- Outpatient Treatment
- Day Treatment Partial Hospitalization Program

For those without direct access to community-based services, crisis services are a vital source of support. These services include[13]:

- Psychiatric Crisis Services
- Observation Unit
- Crisis Line
- Mobile Crisis Teams
- Geriatric Psychiatric Services
- Crisis Assessment Response Team
- Community Consultation Team
- Access Clinic
- Crisis Stabilization Houses
- Crisis Resource Centers
- Community Linkages and Stabilization Program

Coordination and Partnership with Private Systems

BHD is not the only provider of inpatient psychiatric services. In Milwaukee County, there are approximately 225 adult inpatient psychiatric beds projected to be available in 2015; 165 of those beds are at private hospitals.

[13] Transforming the Adult Mental Health Care Delivery System in Milwaukee County.

The MCMHB will be made of 11 active members and 2 representatives from academia serving in *ex-officio* positions. The proposed board composition is as follows:[16]

- Two psychiatrists or psychologists
- A representative of the community who is a consumer of mental health services
- A psychiatric mental health advanced practice nurse
- An individual specializing in finance and administration
- A health care provider with experience in the delivery of substance abuse services
- An individual with legal expertise
- A health care provider representing community–based mental health service providers
- An individual who is a consumer or family member representing community–based mental health service providers
- The chairperson of the county community programs board in Milwaukee County under s. 51.42 (4), or his or her designee who is not an elected official as community programs board in Milwaukee County is an elected official, the chairperson shall designate a member of the county community programs board who is not an elected official to be a member under this subdivision.
- The chairperson of the Milwaukee Mental Health Task Force, or his or her designee.
- A health care provider who is an employee of a higher education institution suggested by the Medical College of Wisconsin.
- A health care provider who is an employee of a higher education institution suggested by the University of Wisconsin—Madison.

The MCMHB has the following responsibilities:

- Oversee the provision of mental health services in Milwaukee County;
- Work with DHS to recommend and establish policies for inpatient mental health treatment facilities and related services in Milwaukee County;
- Allocate funds for mental health services, functions and programs in Milwaukee County
- Establish and adopt policies regarding mental health in Milwaukee County;
- Perform all mental health functions in Milwaukee County that were previously the responsibility of the county board of supervisors; and
- Attempt to achieve cost savings.

[16] http://docs.legis.wisconsin.gov/2013/related/acts/203

Summary of Findings

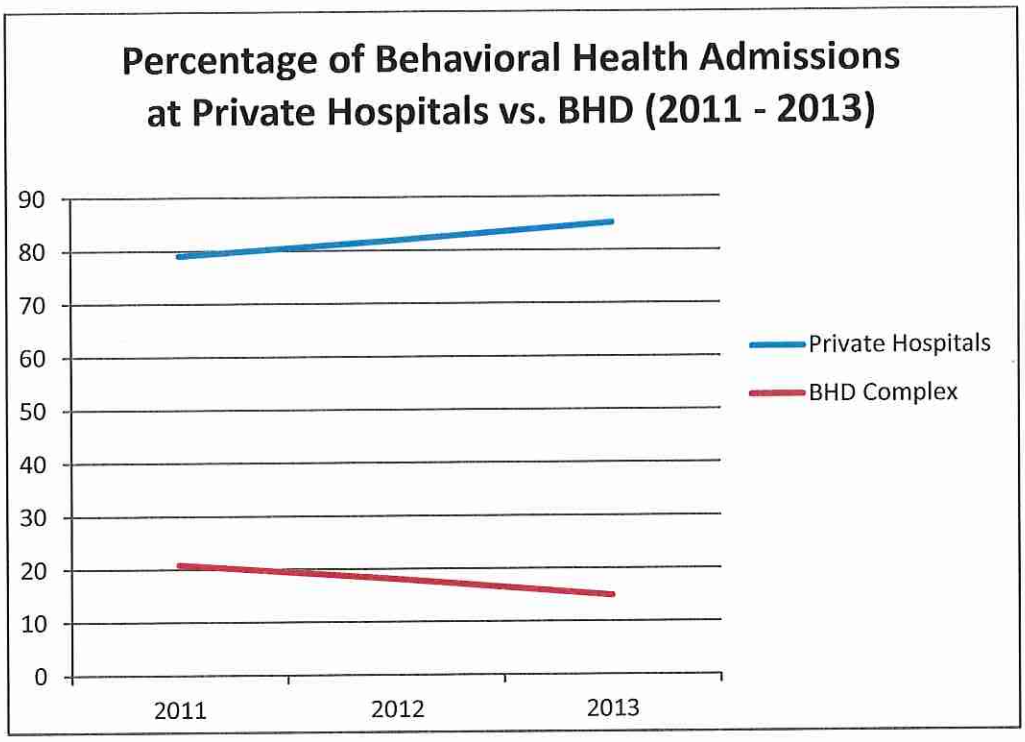
Inpatient Supply and Demand, Behavioral Health Division (BHD) Operations and Associated Outcomes

Background on the Reduction in Inpatient Beds

The Milwaukee County Behavioral Health Division (BHD) has pursued several initiatives to align with the recommendations posed in the 2010 study "Transforming the Adult Mental Health Care Delivery System in Milwaukee County." First and foremost, in an effort to rebalance the County's behavioral health system away from inpatient to community-based services, BHD has downsized inpatient bed capacity at the Milwaukee Mental Health Complex (the Complex) from nearly 100 beds in 2006 to 60 in 2013. This is a reduction of roughly 39%. [Source: 2014 Analysis of Adult Bed Capacity]. This is a reduction in *staffed* beds. BHD reported that its four adult inpatient units are licensed at 24 beds each and that one of those units is empty. BHD did not relinquish the license for that unit so as to remain flexible in the use of the space.

The reduction in beds is accompanied by decreasing utilization at the Complex. BHD has experienced dramatic decreases in inpatient admissions from 2010 to 2014: a 46% decrease in the average number of acute adult admissions per month and a 40% reduction in the average number of child and adolescent admissions per month. The table below demonstrates the trend over the last three years.

Graph 3: Percentage of Behavioral Health Admissions at Private Hospitals vs. BHD Complex



Note, the 2014 *Analysis of Adult Bed Capacity* reports 3,244 admissions to BHD in 2011 and 2,793 admissions in 2012. The date received from BHD for this study did not include 2011 data and 2,802 admissions in 2012, which is still roughly 18% of admissions. Both sources reported 2,285 admissions in 2013.

Census

BHD tracks licensed capacity, operating capacity and average daily census as the table below demonstrates.

Continued Downsizing

According to its Proposed 2015 Budget Narrative[19], BHD plans to retain 60 inpatient beds at the Complex, for acute inpatient needs, amid the 2014 closure of Hilltop and November 2015 closure of Rehab Central. BHD leadership shared that plans to downsize the Complex to one or two 16-bed units are under consideration as well.

A representative from the Mental Health Redesign Task Force cautioned against down-sizing the number of beds too quickly, as it could overwhelm the entire County behavioral health system. In addition, the perspective was shared that capacity is not a static number and that staffing and consumer acuity impacts capacity on a daily basis. Given these factors, strategies to reduce the volatility of the system, specifically related to behavioral health workforce stability, needs to be studied and planned before any additional inpatient reductions occur at the Complex. The pace of bed reduction must also align closely with ensuring adequate access to step-down and wraparound services in the community as well as the provision of high quality inpatient care.

Below are findings based on an assessment of inpatient rebalancing initiatives reflecting supply and demand, current and future operating paradigms and measured improvement in outcomes.

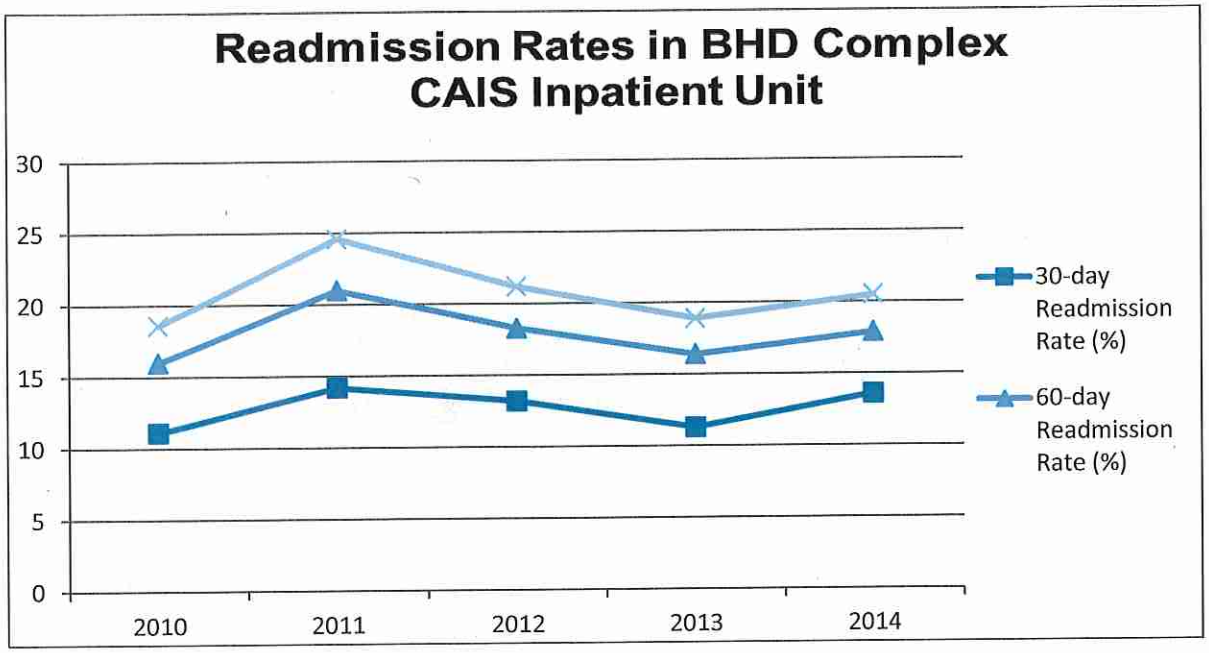
Finding 1: BHD has developed a standard data set to measure the quality of care of inpatient services delivered at the Complex. There is a significant opportunity to enhance the collection and reporting of quality and cost outcomes data that would allow BHD to measure itself against comparable facilities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

Impact on System and Quality of Care

One goal of this assessment is to understand the level of quality of care that is delivered at the Complex in the context of declining beds and inpatient admissions. BHD collects several outcome metrics that policy researchers commonly accept as measures of quality that was, in turn, relied upon to assess performance of the Complex. For example, outcome metrics, such as the rate of 30-, 60-, and 90-day readmissions correlate to a provider's ability to successfully discharge individuals from its facility into the community. In the case of a behavioral health

[19] http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/BHD/Mental-Health-Board/BudgetNarrative2015.pdf

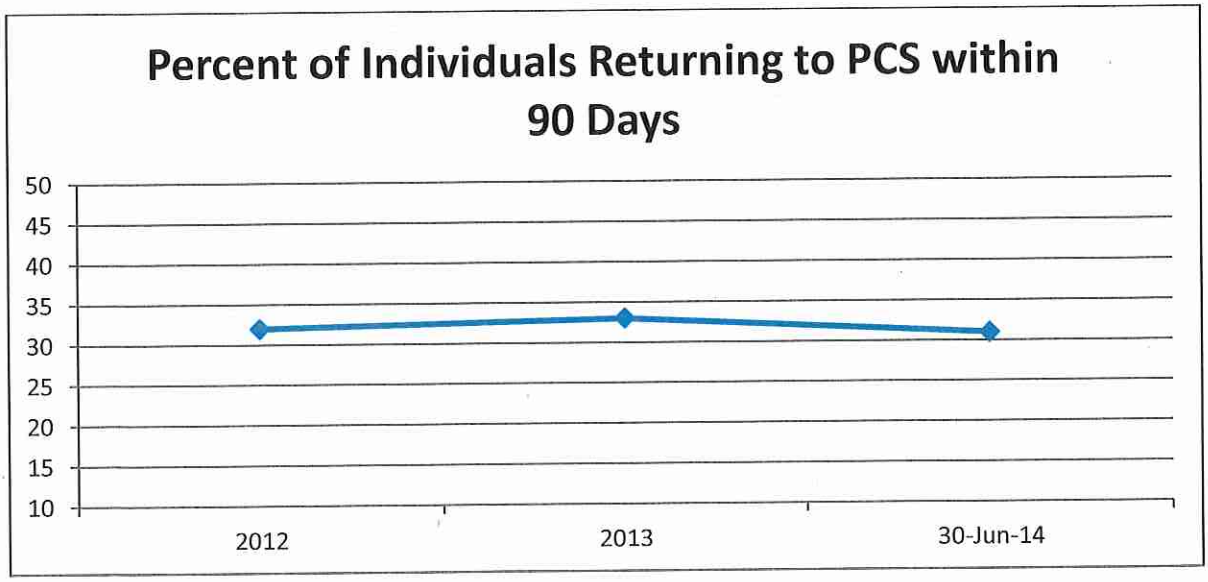
Graph 5: Readmission Rates in BHD Complex CAIS Inpatient Unit



NOTE: The rate of readmissions was calculated by BHD using a numerator defined as the count of consumers having less than, or equal to, 30 days between an Acute Adult admission and a past discharge from Acute Adult (within a specific time period); the denominator is the total Acute Adult Admissions (within a specific time period). The rate for 2014 reflects readmission rates from January 1, 2014 – September 28, 2014.

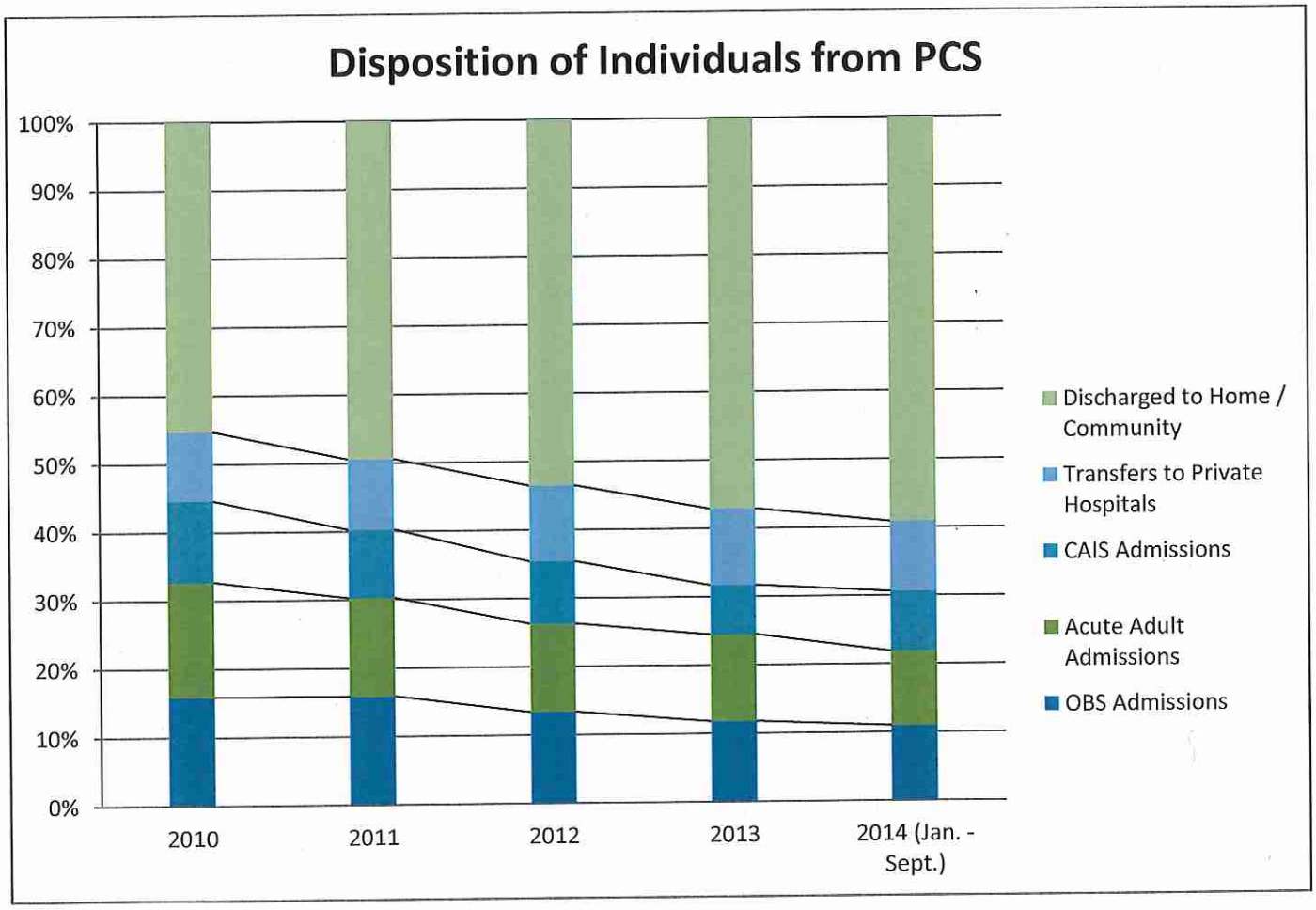
Additional outcomes reported by BHD as measures of inpatient treatment and discharge effectiveness include readmissions to Psychiatric Crisis Services. The graph below depicts a relatively steady trend over the past three years.

Graph 6: Percent of Individuals Returning to PCS within 90 Days



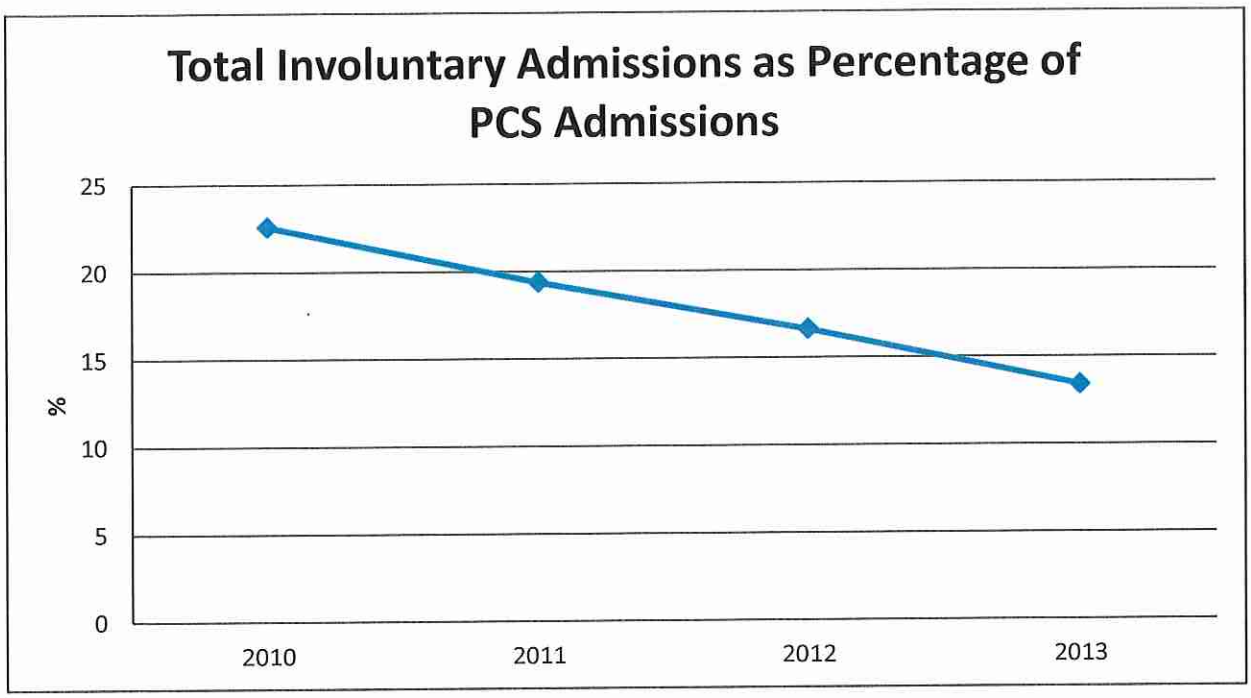
The success with which BHD has partnered with private systems to identify and transfer appropriate individuals is demonstrated in the metrics around the use of PCS, including the disposition of consumers to private hospitals. The percentage of involuntary admissions as a percentage of PCS admissions is depicted as well. The bullets below provide context to these outcome metrics reflected in the following graphs and table.

Graph 7: Percentage of PCS Admissions Transferred/Discharged to Inpatient Levels of Care and Community/Home

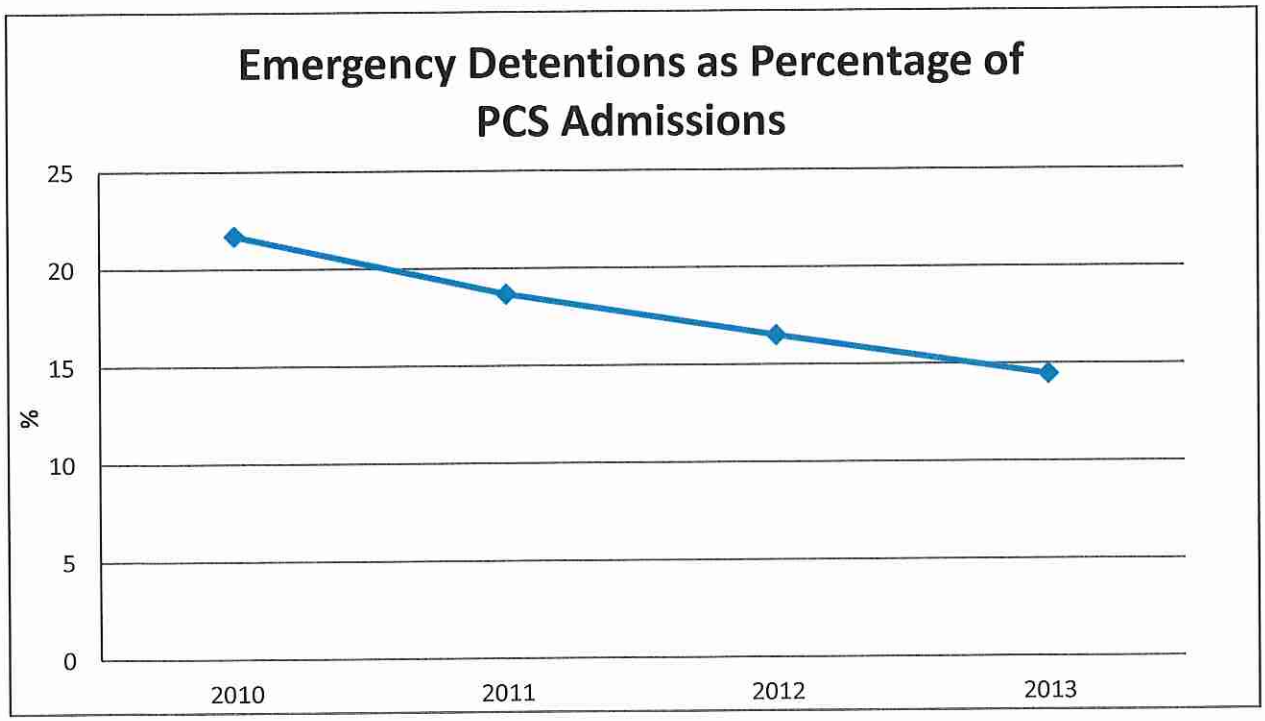


Year	Month	PCS Admissions	OBS Admissions		Acute Adult Admissions		CAIS Admissions		Transfers to Private Hospitals		Discharged to Home / Community		Total	
2012	Jan	1,130	166	14.7%	136.0	12.0%	112	9.9%	142	12.6%	574	50.8%	1,130	100%
	Feb	989	127	12.8%	127.0	12.8%	103	10.4%	128	12.9%	504	51.0%	989	100%
	Mar	1,115	140	12.6%	130.0	11.7%	131	11.7%	152	13.6%	562	50.4%	1,115	100%
	Apr	1,101	151	13.7%	152.0	13.8%	104	9.4%	155	14.1%	539	49.0%	1,101	100%
	May	1,150	152	13.2%	139.0	12.1%	129	11.2%	131	11.4%	599	52.1%	1,150	100%
	Jun	1,058	137	12.9%	142.0	13.4%	84	7.9%	109	10.3%	586	55.4%	1,058	100%
	Jul	1,085	152	14.0%	156.0	14.4%	70	6.5%	119	11.0%	588	54.2%	1,085	100%
	Aug	1,078	146	13.5%	142.0	13.2%	79	7.3%	104	9.6%	607	56.3%	1,078	100%
	Sep	1,014	131	12.9%	114.0	11.2%	87	8.6%	92	9.1%	590	58.2%	1,014	100%
	Oct	1,004	125	12.5%	152.0	15.1%	95	9.5%	104	10.4%	528	52.6%	1,004	100%
	Nov	943	123	13.0%	119.0	12.6%	72	7.6%	98	10.4%	531	56.3%	943	100%
	Dec	1,031	153	14.8%	131.0	12.7%	87	8.4%	78	7.6%	582	56.5%	1,031	100%
	Total	**12,698**	**1,703**	**13.4%**	**1,640**	**12.9%**	**1,153**	**9.1%**	**1,412**	**11.1%**	**6,790**	**53.5%**	**12,698**	100%
2013	Jan	975	148	15.2%	134.0	13.7%	97	9.9%	81	8.35	515	52.8%	975	100%
	Feb	923	125	13.5%	120.0	13.0%	42	4.6%	110	11.9%	526	57.0%	923	100%
	Mar	1,017	127	12.5%	122.0	12.0%	70	6.9%	123	12.1%	575	56.5%	1,017	100%
	Apr	986	97	9.8%	122.0	12.4%	79	8.0%	94	9.5%	594	60.2%	986	100%
	May	986	110	11.2%	122.0	12.4%	87	8.8%	106	10.8%	561	56.9%	986	100%
	Jun	937	126	13.4%	112.0	12.0%	52	5.5%	115	12.3%	532	56.8%	937	100%
	Jul	978	128	13.1%	149.0	15.2%	60	6.1%	103	10.5%	538	55.0%	978	100%
	Aug	956	117	12.2%	117.0	12.2%	63	6.6%	73	7.6%	586	61.3%	956	100%
	Sep	974	104	10.7%	119.0	12.2%	75	7.7%	94	9.7%	582	59.8%	974	100%
	Oct	1,017	97	9.5%	119.0	11.7%	66	6.5%	132	13.0%	603	59.3%	1,017	100%
	Nov	838	87	10.4%	105.0	12.5%	66	7.9%	125	14.9%	455	54.3%	838	100%
	Dec	877	86	9.8%	115.0	13.1%	72	8.2%	125	14.3%	479	54.6%	877	100%
	Total	**11,464**	**1,352**	**11.8%**	**1,456**	**12.7%**	**829**	**7.2%**	**1,281**	**11.2%**	**6,546**	**57.1%**	**11,464**	100%
2014	Jan	888	80	9.0%	110.0	12.4%	85	9.6%	111	12.5%	502	56.5%	888	100%
	Feb	835	89	10.7%	99.0	11.9%	80	9.6%	92	11.0%	475	56.9%	835	100%
	Mar	882	84	9.5%	95.0	10.8%	75	8.5%	83	9.4%	545	61.8%	882	100%
	Apr	914	91	10.0%	100.0	10.9%	88	9.6%	94	10.3%	541	59.2%	914	100%
	May	940	118	12.6%	75.0	8.0%	91	9.7%	91	9.7%	565	60.1%	940	100%
	Jun	916	114	12.4%	99.0	10.8%	70	7.6%	84	9.2%	549	59.9%	916	100%
	Jul	831	100	12.0%	94.0	11.3%	68	8.2%	74	8.9%	495	59.6%	831	100%
	Aug	935	120	12.8%	88.0	9.4%	74	7.9%	99	10.6%	554	59.3%	935	100%
	Sep	891	90	10.1%	112.0	12.6%	70	7.9%	98	11.0%	521	58.5%	891	100%

Graph 8: Total Involuntary Admissions as a Percentage of PCS Admissions



Graph 9: ED Admissions as a Percentage of PCS Admissions (Subset of Total Involuntary Admissions)



Note, BHD projects that the rate of PCS admissions resulting in EDs in 2014 to be 54%.

- **Declining rates of Psychiatric Crisis Service (PCS) admissions and emergency detentions**. According to the 2010-2014 Q1 Milwaukee County Behavioral Health Division Utilizations Trends report, the average number of PCS admissions per month has decreased 23% from 2010 to 2014. Similarly there has been seven-point decrease in the number of emergency detentions as a percentage of PCS admissions. BHD believes the reduction in emergency detentions are driving the reduction in PCS admissions overall. Finally, the percentage of PCS admissions transferred to community hospitals has increased slightly from 10.1% (in 2010) to 11.2% (2013).

- **Declining frequency with which the Complex invokes wait list and diversion status to community providers.** BHD reports that its partnership efforts have led to a significant reduction in Wait List Status. In 2007, BHD was on Wait List Status 48% of the time; in 2013 that number reduced to below 3%. Thus far in 2014, the numbers have increased to 6.7%.

  According to BHD, Observation beds are another absolutely essential element in minimizing the frequency and duration of Wait List events. The Complex enters Wait List Status when there are five beds or fewer in the BHD system, (Acute and Observation beds combined). Typically it is available Observation beds that allow BHD to avoid Wait List Status. The unit is staffed with a full clinical team, however it is seen as either a rapid stabilization unit or a unit that is used when more time is required for disposition decisions.

  When on Wait List Status any individual requiring transfer from a private hospital setting must wait to send the individual to BHD until beds open up. If Observation Beds, Inpatient Beds and PCS all are filled to capacity, then BHD moves to Full Diversion Status. When on full diversion, essentially PCS closes and individuals must be seen at a private hospital emergency. BHD reports that full diversion status is extremely rare, "[we] have not had to go on diversion in several years, but we have been close recently."

BHD tracks additional performance metrics that demonstrate mixed results. For example, the rate of incidents per patient days demonstrates a decreasing rate of elopements, patient falls (falls and falls with injury), adverse medication events causing harm and suicide attempts. The Complex has experienced an increasing rate of contraband, aggression (patient-to-patient and patient-to-employee), medical emergencies, self-inflicted injuries and sexual contact.
BHD also reports that average length of stay at the Complex is steadily increasing. The average length of stay within the acute adult units increased slightly from 2010-2014 from 14.8 days to 15 in the acute adult inpatient unit. The median increased from 7 to 9 days in that same time

BHD can integrate HBIPS measurement into its evolving Quality Management and Electronic Medical Record (EMR) roll-out plan for 2015. Since the core set is an industry-accepted measurement of quality, achievement rates can be shared transparently with community, state and federal stakeholders. It will also allow for the comparison of the Complex with other free-standing psychiatric hospitals in Wisconsin such as Aurora, Rogers and the state mental health facilities.

2) **Adjustment of utilization metrics by consumer population risk/acuity/health status.** There are challenges in attributing reductions in inpatient admissions, readmissions and EDs directly to improved access to care and quality services when the acuity/health status of the consumer population is not understood and tracked. Currently, the declining rate of admission and readmission suggests that consumer health status/acuity remains constant. Yet, BHD makes the assumption that its inpatient population is growing more complex, based on clinical experience on the increasing length of stay. Confounding this contradiction is the lack of a standardized method to determine health status in individuals with mental illness and substance use/abuse.

BHD, itself reports,

> At this time, there are no widely accepted, validated global measures of acuity in psychiatry. Conceptually, attributes of acuity are severity, intensity and the pairing of acuity measurements with another concept such as level or location or care provision, medical versus psychological co-morbidity, degree of engagement, severity of dangerous behaviors, etc. Thus far (BHD has] operationalized two measures or processes. [BHD uses] the Broset Violence Checklist (BVC), this is a validated, reliable, easily administered measure that is accurate in predicting likelihood of short-term violence and have paired this with a functional screen of risk factors including presence of complex, difficult-to-manage patient symptoms that the private hospital exclude such as pica or psychogenic polydypsia, complex risk/legal issues that private hospitals exclude such as recent arson, sexual offender status or criminal commitment conversion, recent aggressive or violent behavior, and history of documented repeated treatment failures at that facility.[21]

Nevertheless, it would benefit BHD to explore using surrogate measures of risk/acuity/health status such as comparisons between admission and discharge diagnosis or integrating a case mix algorithm (i.e. Johns Hopkins Adjusted Clinical Groupers or 3M's Clinical Risk Groupers) as it gains more functionality within the EMR system and potentially through its Joint Commission accreditation process. A further

[21] Follow-up Questions and Clarifications of Data Requests. BHD to Deloitte Team.

Role of Safety Net Provider

When applying the definition of safety net provider adopted by the Institute of Medicine23—meaning those providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable consumers—the Mental Health Complex meets that criteria more so than other private providers in the County. Supporting this notion is the broad consensus among Milwaukee County stakeholders that the Complex plays an important role as an inpatient provider for highly complex consumers who have diagnoses, histories, socioeconomic factors, care coordination needs and payment considerations that make treatment in a private hospital less conducive to their recovery. It was even noted by one stakeholder that treatment of a higher acuity population requires clinicians with a special type of expertise and passion, and that private providers may not meet physical or clinical capacity requirements to serve higher acuity individuals with complex social needs.

Inpatient Bed Capacity at the Complex

There is general agreement among stakeholders the methodology used in the inpatient study for determining appropriate inpatient capacity is strong. Findings from the 2014 *Analysis of Adult Bed Capacity* determined that a range of 54-60 beds is needed to serve the highest acuity individuals and that 128-134 beds provide adequate capacity to serve low to moderate acuity individuals. BHD leadership reported agreement with the range put forth by the *Analysis of Adult Bed Capacity* Report and noted that BHD would be operating at 54 beds if not for the loss of beds at Columbia/St. Mary's and Aurora.

Intake and Referral of Low-Moderate Acuity Consumers

BHD reports that over the past six to seven years, there has been a major focus to transfer as many individuals as possible into the private system. This allows BHD to manage census much more proactively and maintain its role of a high-acuity provider. According to BHD, it has established MOUs with Aurora Psychiatric Hospital, Aurora St Luke's Southshore, Rogers Memorial, and St. Francis to be detaining facilities (i.e. inpatient psychiatric facilities). According to the 2014 *Analysis of Adult Bed Capacity*, private hospital systems now operate 68% of the psychiatric beds and account for 85% of total psychiatric admissions.

BHD has developed a methodology to screen individuals for possible transfer to private hospitals, excluding any individual that exhibits complex, difficult to manage symptoms (i.e., pica or psychogenic polydipsia), complex risk/legal issues such as recent arson, or sex offender status. This intake and referral process demonstrated in Appendix 1 also has a dedicated transfer coordinator to procure beds at a partner MOU facility (individuals on emergency detention) or any in-network provider for individuals admitted on a voluntary basis. Despite this, Wisconsin State Statute 51.15(2) allows for private hospitals to refuse to detain the patient.

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[23] **AMERICA'S HEALTH CARE SAFETY NET INTACT BUT ENDANGERED. Institute of Medicine. 2000. Retrieved from:** http://iom.edu/~/media/Files/Report%20Files/2000/Americas-Health-Care-Safety-Net/Insurance%20Safety%20Net%202000%20%20report%20brief.pdf

Note that numbers listed above do not represent the entire universe of individuals referred to the private hospital system, they are a representative sample. This data is only tracked during hours when there are staff in the emergency room dedicated to transferring individuals. In addition, this assessment was not able to clarifying with BHD if private hospitals have different criteria for which they will accept transfers—noted by differing denominators for each hospital.

Of the 843 low-moderate risk/acuity individuals eligible for transfer to a private hospital from January – July 2014, only 42% were accepted by private hospitals.

Current referral patterns suggest that the private hospitals don't accept referrals of low-moderate acuity consumers (those that meet criteria) 100% of the time. So as a result, BHD uses beds for these lower risk consumers. Perhaps if there were financial incentives, standardized methods of gauging acuity across the system, etc. then the bed at the Complex would be available for the high-acuity individuals that are excluded from being referred elsewhere.

Additional Considerations of Finding #2:

1) **More rigorous processes and agreements with private system providers to assume responsibility for low-moderate acuity consumers.** BHD has an opportunity to engage members of the Mental Health Board to establish a system-wide transfer criterion to allow for objective, timely, seamless and person-centered transfer of individuals to private hospitals. The 2014 *Analysis of Adult Bed Capacity* report describes attributes a lack of clear guidelines around inpatient bed capacity and responsibility. "The lack of formal system criteria with regard to admissions is [also] problematic, as individual providers can establish their own criteria that are determined by variables such as patient acuity or payer factors. Payer factors may become an increasing concern as private hospitals engage in managed care and create accountable care networks that will drive bed capacity."

   Common, transparent view of consumers through a system-wide tool for consumer intake, referral and patient management across the system that eliminates subjectivity when determining eligibility and responsibility for transfer. There may be opportunities for DHS, BHD and private hospital partners to create a more transparent view into bed availability that would better inform referral processes and determine appropriate staff and overall system reconfiguration to support individual transitions to private hospitals in a sustainable manner.

2) **Explore incentives.** Multiple stakeholders noted that there are currently no financial incentives for private providers to accept a higher percentage of referrals/transfers. In fact, it was reported that the inadequacy of outpatient and housing resources creates disincentives for private providers to accept transfers as this may result in longer inpatient stays. There are opportunities to pursue strategies for more stringent

- Identification of specific areas for additional resources and investments to be made; process changes to further reduce inpatient use.

Please note that this assessment discovered numerous gaps in the information received from BHD specific to staffing patterns, detailed levels, training, etc. that limited the ability to evaluate the program.

Inpatient Diversion: Crisis and Community-Based Alternatives and Associated Outcomes

BHD is gradually decreasing the number of inpatient beds; it is seeking to increase access to crisis services and community-based services for those discharged from the hospital or requiring more intensive alternatives to inpatient care. *Transforming the Adult Mental Care Delivery System in Milwaukee County* report (2010) provided recommendations to develop peer-run crisis respites, educate law enforcement and consumers about the Crisis Resource Center and ensure funding for the retention of CRC. The study suggests that funding for crisis alternatives can be found in cost-savings associated with ED and crisis inpatient services and that county funding should be directed toward these resources.

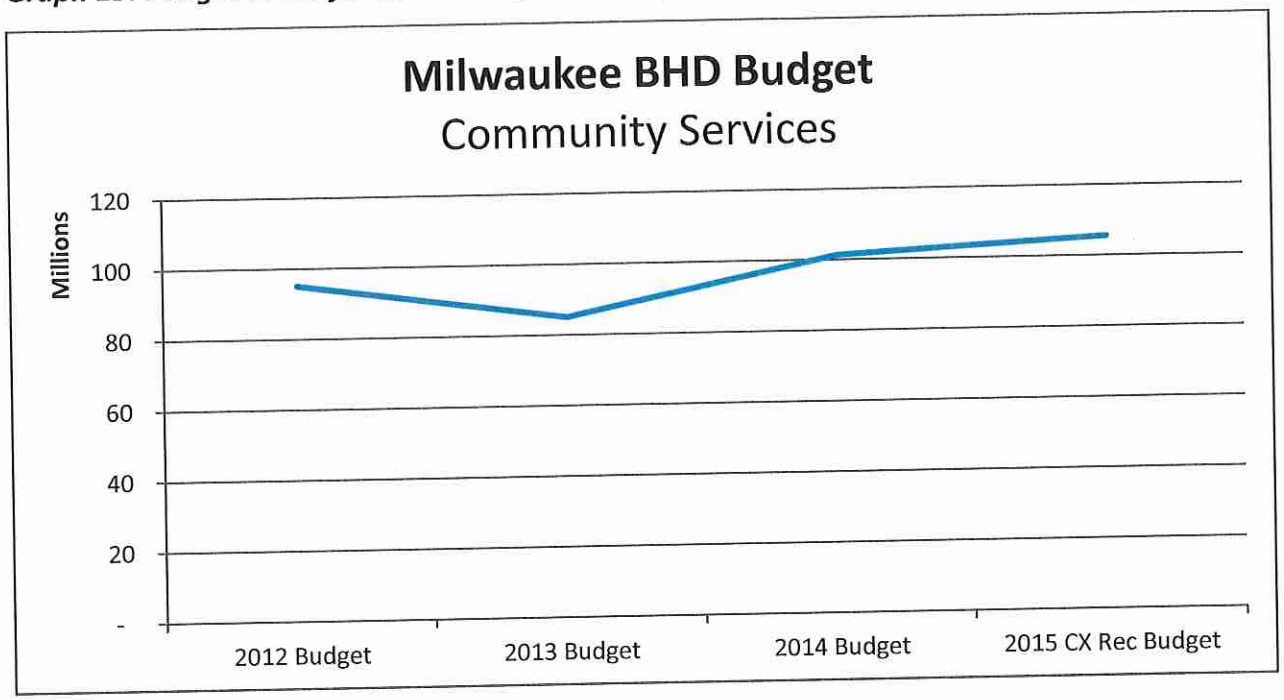
The narrative below provides detail around BHD's investment in crisis and community services.

Spending on inpatient services at the BHD Complex (excluding the Hilltop and Central facilities) remained flat from 2013 and 2014, but increased 8% from 2014 to 2015 by $2.7M. Prescription medication expenditures accounted for 24% ($633,998). Professional service contracts accounted for 33% of the increase due to contract and temporary staff at the Complex.

The 2014 BHD recommended budget narrative[24] reports that the savings from downsizing inpatient facilities will be reinvested into community services; however, there didn't appear to be an account of the costs to maintain legacy inpatient infrastructure. The 2014 and 2015 budgets do not specifically list or mention capital costs. It could be included in the $10.5 million budgeted to run Hilltop and Central in 2015, but there is not enough detail to evaluate.

[24] http://county.milwaukee.gov/ImageLibrary/User/bpariseau/2014-Budget-/2014FinalRevisedCEXOperating.pdf

Graph 15: Budget Trend for Community Services Spending (2012-2015)



The 2014 budget increase included plans to make investments in the following (not an exhaustive list):

- Expanding the Crisis Mobile Team.
- Starting a peer-run drop-in center.
- Continuing to implement the Community Recovery Services program.
- Adding ACT/IDDT models to the existing CSP programs.
- Opening a Southside Access Clinic.
- Creating 40 permanent supportive housing units to serve BHD consumers.
- Developing a Crisis Resource Center for individuals with intellectual/developmental disabilities and a co-occurring mental illness.

The 2015 Budget passed by Mental Health Board increase includes investment in the following (not an exhaustive list):

- Partial-year funding of community placements for Rehab Central clients.
- Contracting of two eight-bed CBRFs.
- Fully implementing the Comprehensive Community Services program.

Below is a table of the Crisis Diversion and Community Based Services for which BHD has made investments in development and growth.

Program	Start Date	Alignment with Transforming the Adult Mental Care Delivery System in Milwaukee County report (2010	Outcome Metrics Collected	Relevant Notes from BHD 2015 Budget
SAIL	Pre-2011		• Approved requests - new clients	
Wiser Choice	Pre-2011		• Consumer satisfaction • Abstinent alcohol 30 days • Abstinent drugs 30 days • Permanent housing • Employed, full or part time • Employed OR Enrolled in school/training • Arrested in past 30 days • Arrested in past 6 months • No supportive family, friend, or group	
Community Support Program	Pre-2011		• Consumer satisfaction • Percent in private residence or household • Percent homeless or in shelters • Percent with any kind of employment • Percent with competitive employment • Percent with no criminal involvement in last 6 months • Percent with arrest/incarceration in last 6 months • Percent kept medical care appointment or needed no care • Percent kept dental care appointment or needed no care • Percent kept vision care appointment or needed no care • Percent with activity or other respected status • Percent with no educ, social, or other activity • Percent with high potential for suicide • Percent with no risk factors for suicide • Average psychiatric bed days in past 6 months • Average number of PCS episodes in past 6 months	$4,418 average dollars expended per CSP slot. BHD will outsource the caseload currently covered by BHD's Community Support Program (CSP) – Downtown and Southside locations and have all 290 caseloads assumed by community providers through purchase of service contract.
Partial Hospital	Pre-2011			
CBRF	Pre-2011		Consumer satisfaction	
Outpatient	Pre-2011			

Perhaps the most valid measure of the expansion of access is presented through the number of new individuals served in the SAIL program—the central access point for Milwaukee County residents requiring long term community support such as case management, day treatment, group home placements, and outpatient services. Clients screened and placed through SAIL have increased steadily over the past several years.

Finally, the 2015 BHD budget narrative attributes the decreases in PCS admissions and EDs to increased use of community-based crisis services such as the Crisis Mobile Team and the Crisis Assessment Response Team. BHD reports the ED rate for consumers who receive crisis services at the time of the initial request has dropped from 57.2% in 2012 to 54.1% in 2014.

Additionally, the rate of emergency detention from January 1, 2013 – October 1, 2014 for individuals who are recipients of crisis services more than once in is only 3.7%. Baseline or historical trended data was not available for this assessment.

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

While BHD has made progress in developing programs and initiatives specified by the *Alignment with Transforming the Adult Mental Care Delivery System in Milwaukee County* report (2010), it appears that developing partnerships with Federally Qualified Health Centers (FQHCs) has not been fully explored. There are at least seven FQHCs serving Milwaukee and surrounding communities[25] that potentially have co-located behavioral health with physical health services. These providers who offer care coordination and disease management services, should be a close partner with BHD in inpatient discharge planning and with community services as a wraparound clinical service provider.

[25] https://www.dhs.wisconsin.gov/forwardhealth/pdf/fqhc.pdf

- Finally, consumer and advocate feedback reflected a lack of care coordination of services, especially for individuals with more complex needs such as those who have had involvement with the criminal justice system.

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

The rapid rate of deployment of new Evidence-Based Practices may create some change management challenges that BHD needs to anticipate and manage. Rapid change across the system without a clear strategic plan in place to anticipate and mitigate issues and risks as they arise may create a "reactive" model of management, rather than a "proactive" model. Additionally, as new skills, processes and policies are adopted, a period of learning and adjustment will occur. When many sectors of the system are undergoing this period at the same time a sense of instability may occur.

Additional Considerations of Finding #5

- Investment in community programs should be guided by the fidelity measures and specific outcomes for the types of services being provided. The System Evaluation Program at University of Maryland provides a framework for collaboration in developing and measuring robust statewide community programs.

- There appears to be only one source of crisis services for children and adolescents that also includes children and adolescents with intellectual and developmental disabilities. This gap may result in a higher rate of restraint use, commitments and use of the criminal justice system. The State of Oklahoma has developed a system of care in which children who are identified with more complex behavioral health concerns are monitored by a community board and managed by a case manager who works closely with the board, the family, the child and their service providers. Additionally, SAMSHA offers numerous evidence-based practices for treatment of children.

- Community involvement is currently being measured by a lack of negative events, compliance to treatment, housing and employment. Outcomes should instead reflect a shift to more strength-based engagement in the community such as clubs, sporting activities, community/religious-based memberships that reflect quality of life.

Scenario	Description	Considerations
BHD assumes oversight responsibility with regional operations	BHD operates a regionalized facility that serves Milwaukee County residents and residents from surrounding counties who would otherwise be referred to a state hospital	• Stakeholders shared that surrounding communities may not be amenable to partnership with Milwaukee County. • Requires structural change to current delivery of MH/SA services, including contracting with surrounding counties to become payers. • Payment agreements would need to be established with surrounding counties. • Implications of IMD status and managed care reimbursement would need to be studied. • Future of operating inpatient unit at large Complex building remains an issue, but if excess capacity (resulting from reduction in high-acuity beds once dedicated to Milwaukee County residents) were to be populated by consumers from around the region, an additional revenue stream would be gained. However, this only partially addresses the sustainability of the Complex. The capital cost per patient will actually grow as portion of total cost given the infrastructure aging. For this scenario to be viable, inpatient payment rates and consistent benefit coverage policies will need to be considered.
Public-private partnership for oversight, management of operations	BHD purchases high-acuity at private hospital or hospitals	• Leverages the large scale operations of a private system, including administrative functions such as accounting and staffing as well as quality management, IT and reporting. • Private hospitals not presently equipped to care for the highest acuity consumers with forensic histories or those who current meet exclusionary criteria. • Significant investments in infrastructure and staff would be required as would financial incentives on the part of the County, State and Federal government. • Possibility exists for BHD to transfer only the most complex (forensic history/involvement, extreme risk for violence) to state hospital setting. • Requires more robust negotiation and contracting, likely payment model would need to include financial incentives. • Cultural shift and training required for law enforcement in Milwaukee County to modify crisis and ED response. • Statute requiring a designated treatment director to examine individuals within 24 hours becomes significant issue when accounting for individuals at the five private hospitals that accept involuntary individuals.

- Data reflects residents of Milwaukee County who are enrolled in Wisconsin Medicaid full-benefit plans in years 2010-2013; the data does not include information on children enrolled in the Milwaukee Wraparound integrated mental health and substance abuse program for Severally Emotionally Disturbed (SED) youths.

- Both fee-for-service claims and managed care encounter claims are aggregated within the analysis. The significant time and resources required to analyze fee-for-service and managed care populations separately was not available given the Assessment project's timing and scope.

- Behavioral health (mental health and substance abuse) services used by Milwaukee County residents are reflected in several tables. The methodology in which claims/encounters are filed allows for a beneficiary to receive care in multiple places of service/settings during the same visit. For example, services billed during one visit could be reflected as an IMD claim/encounter and as an inpatient claim/encounter. An IMD claim/encounter could also reflect nursing facility services. Similarly, services billed under an outpatient clinic visit could also be billed as an outpatient hospital visit, depending on the services provided. Therefore, comparing the number of IMD services to inpatient hospital visits is not a valid exercise. Rather, analysis of the trend from 2010-2013 that demonstrates growth or decline in a particular setting can provide insight.

- Detailed analysis, such as a comparison of Emergency Department visits for Mental Health for Substance Abuse diagnoses at inpatient hospitals vs. IMDs, can be performed if additional time and resources need are dedicated to the project.

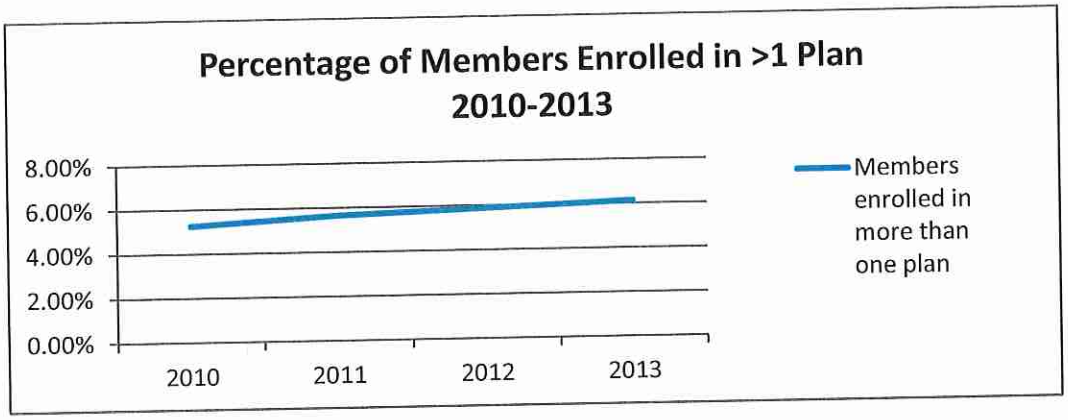
Table 9 continued

Plan	Description of Eligibles[1]	Major MH/SA Benefits	Avg. Age[2]	Average Months of Eligibility[2]
Medicaid for Foster Care	• All youths placed in Foster Care, subsidized guardianship, or court-ordered Kinship Care	• Full coverage (not including room and board). • $0.50 to $3 copayment per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. • Copayments are not required when services are provided in a hospital setting.	8.15	10.64
Medicaid for SSI	• People who are age 65 or over, disabled, or blind, who qualify for federal SSI payments	Full Benefit Medicaid Services	39.18	11.46
Medicaid Purchase Plan	• Disabled adults who are working or interested in working	Full Benefit Medicaid Services	54.88	10.39
Medicaid Purchase Plan Waiver	• Disabled adults who are working or interested in working	Full Benefit Medicaid Services	53.55	11.44
Medicaid Waiver	• People who are age 65 or over, disabled, or blind, with income at or below monthly limits	Full Benefit Medicaid Services	60.17	11.24
Wisconsin Well Woman Medicaid	• Women who have been diagnosed and are in need of treatment for breast or cervical cancer	Full Benefit Medicaid Services	49.58	9.57

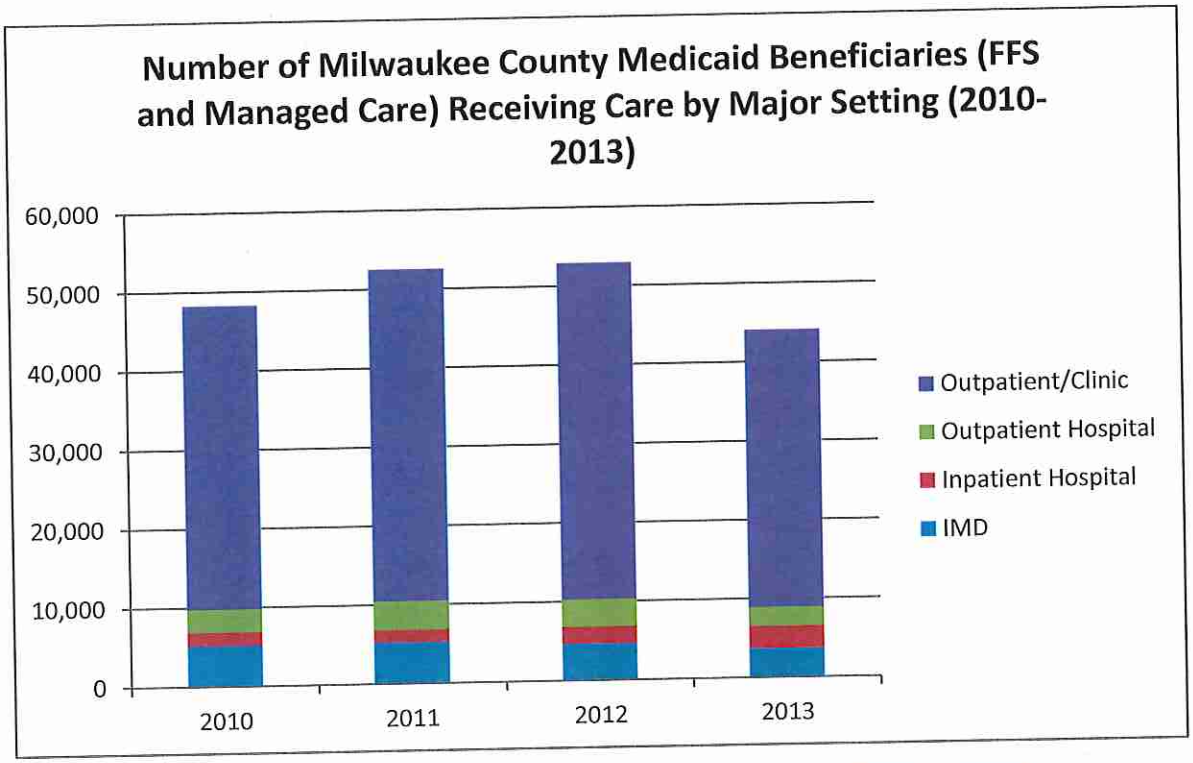
[1] Eligibility as of April 1, 2014

[2] Based on 2013 data, provided by Wisconsin DHS Division of Health Care Access and Affordability

Graph 18: Percentage of Milwaukee County Residents Enrolled in More than One Benefit Plan



Graph 19: Milwaukee County Medicaid Beneficiaries Receiving Care by Major Setting



Care Setting	2010	2011	2012	2013
IMD	5,212	5,269	4,708	3,731
Inpatient Hospital	1,668	1,563	2,105	2,774
Outpatient Hospital	2,930	3,675	3,495	2,418
Outpatient/Clinic	38,497	42,050	42,669	35,205

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

Exclusion for Institutes for Mental Disease (IMD)

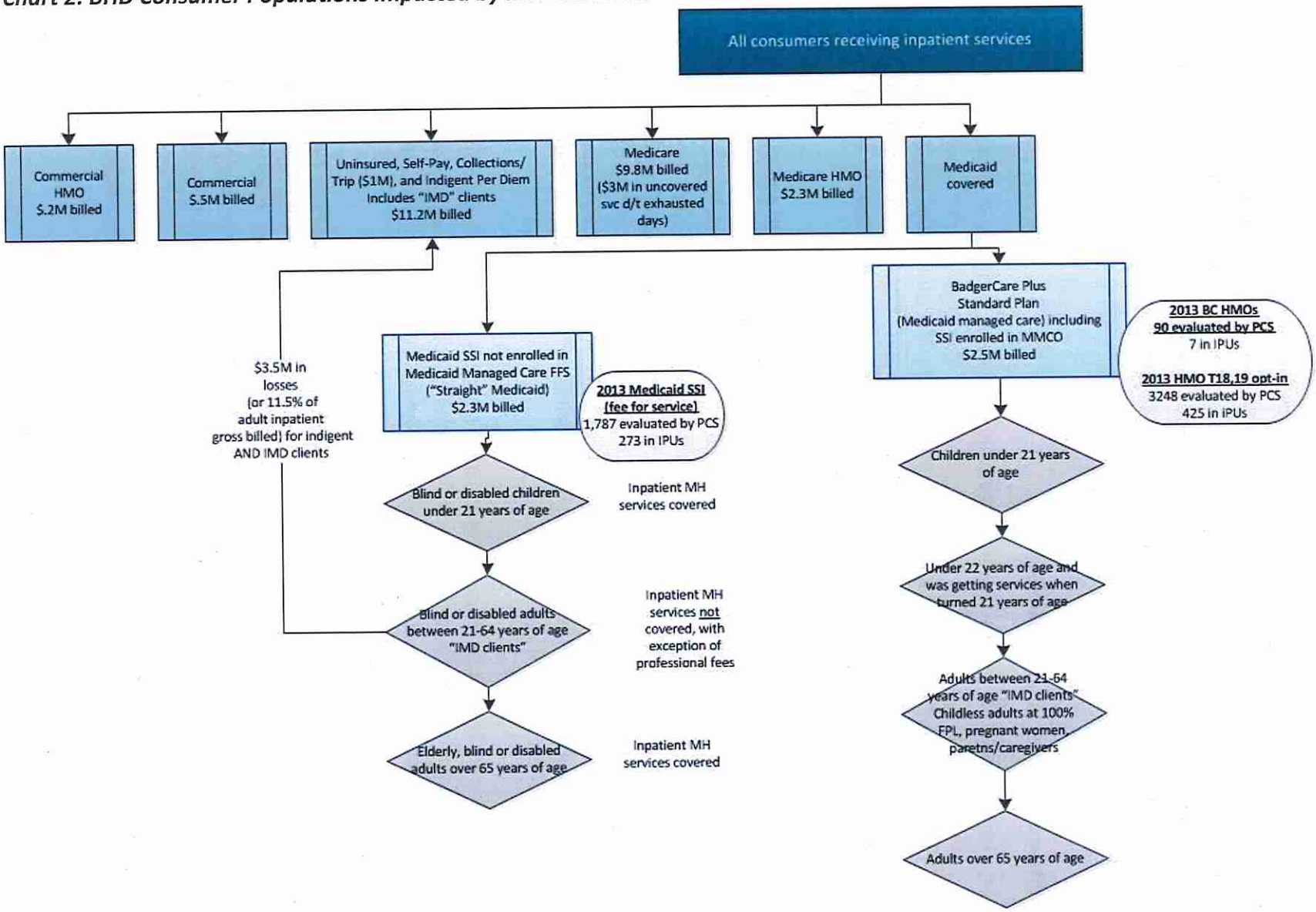
Section 1905(c) of the Social Security act prohibits Wisconsin Medicaid from paying for services provided to certain Medicaid beneficiaries while in a public mental health facility or private psychiatric inpatient treatment facility. BHD, Aurora Psychiatric and Rogers Memorial qualify as Institutes for Mental Disease (IMD) and are thereby impacted by this provision. There are certain populations of Medicaid beneficiaries who are exempt from the IMD exclusion—individuals 65 and older and those under age 21. In addition, it appears that in Wisconsin, IMD facilities can contract with the Medicaid HMOs for the payment of member hospitalizations that would have normally been uncompensated due to the IMD exclusion. This includes both BadgerCare (which now encompasses a richer behavioral health benefit for childless adults, parents and caretakers) and SSI plans that cover aged, blind, disabled individuals who elect to participate in an SSI HMO. BHD reports that it has contracts and/or agreements with many, if not all, of the HMO plans serving SSI beneficiaries.

Beneficiaries between the ages of 22-64 eligible for Medicaid due to age, blindness or a disability, whose benefits are reimbursed through fee-for-service payments, remain subject to the IMD exclusion; BHD refers to this population as T19/Straight Medicaid, also known as Medicaid fee for service (FFS). Moreover, BHD asserts that the complexity of this population (variable to non-compliance, high grade disease burden, and treatment refractory despite high service utilization) predicates them to emergency detention/involuntary holds that creates exclusionary criteria preventing transfer to private partners.

Thus, despite having a robust menu of Medicaid contracts and relationships in which BHD receives reimbursement, it reports serving a disproportionate share of Medicaid FFS beneficiaries.

Conversely, Disability Rights Wisconsin (DRW), in written comments in reaction to the 2014 *Analysis of Adult Bed Capacity* provided to the Mental Health Board on September 23, 2014, maintains that a minority of consumers hospitalized at IMD is in FFS Medicaid and are impacted by the IMD exclusion.

Chart 2: BHD Consumer Populations Impacted by IMD Exclusion



However, if selection of an HMO in Milwaukee County were required for individuals eligible for SSI benefits (an SSI HMO), this would improve the opportunity for payment of IMD services.

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

Growth in BadgerCare Childless Adult Population

Further analysis is needed to understand the impact of Medicaid expansion and coverage initiatives on payment, access and capacity. In addition to the growth of Medicaid managed care shifting the impact of IMD exclusion on BHD, it is not yet understood if the new Medicaid benefits and plans will result in significantly increased access, or provide merely a different funding stream for consumers in Milwaukee County already seeking behavioral health services, or a mixture of both.

Also not well understood is the risk/acuity of these newly covered individuals. BHD will need to develop a framework to scale up its programs, as well as contract with HMOs that are required to enroll the childless adults and serve additional consumers that could result from the expanded BadgerCare coverage. Specifically, consideration should be given to completing a needs analysis to determine which services may be required, which services are effective and the infrastructure needed to successfully increase and/or develop services to meet the identified needs.

- For the most part, Wisconsin Medicaid HMO contracts[27] require plans to perform traditional insurance administration functions; however, there are minimal requirements for care coordination and case management interventions. Requirements are limited to utilization management, coordination of benefits, education about benefits, and efforts to reduce missed appointment reduction, health education and disease prevention.
- Case management requirements exist for SSI HMOs; however, they are very broad and do not specifically require plans to identify and stratify members with co-occurring substance abuse or those with comorbid physical health conditions. Nor do they prescribe specific evidence based interventions, such as medication management.
- In addition, sanctions are imposed related to a plans' failure to provide medically necessary services, submitting data in required form/format, removal of erred encounter records without Department approval, and failure to perform administrative functions. However, there are no incentives/disincentives around performance/achievement of quality outcomes,

Additional Considerations of Finding #8

- **Accountability for outcomes assigned to community partners.** The system can be further strengthened by assigning accountability to community partners for improving outcomes and incentivizing achievement of outcomes. Naturally, this implies providers and Wisconsin HMOs, but also includes exploration of incentive-based performance with law enforcement in Milwaukee County, community mental health centers, etc.

- **Although it would be significant departure from the current operational and funding structure in Milwaukee County, DHS has the opportunity to establish new contracts and develop accountability mechanisms with Milwaukee County HMOs to provide integrated behavioral and physical health benefits to Medicaid beneficiaries.** Over half of all Medicaid beneficiaries with disabilities are diagnosed with a mental illness. For those with common chronic conditions, health care costs are as much as 75% higher for those with mental illness compared to those without a mental illness and the addition of a co-occurring substance use disorder results in two- to three-fold higher health care costs.[28] There exists opportunities within managed care delivery systems to

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[27] https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage

[28] http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/bh-briefing-document-1006.pdf

health practitioners can be included in the calculation of health centers' prospective rates.

- Health Home. Explore Integrated Care Medicaid "health home" option for mental health and substance abuse consumers through ACA Section 2703. Community mental health centers are one natural choice to be designated health home providers for Medicaid beneficiaries with serious mental illness.
- System-level integration. Explore system-level integration—one that that directly provides and is at financial risk for the entire complement of acute physical and behavioral health services covered by Medicaid.

- **Maximize Funding Sources.** BHD has an opportunity to maximize funding sources to support additional system investments and improvement. These strategies include a reinvestment of savings from reduction in inpatient beds. The County's [2014] budget for inpatient services decreased $10 million or 15% since 2012. [53] The County plans to close Hilltop facility by the end of 2014. According to BHD, the savings from the closure, calculated by BHD to be $758,863, will be invested in community services.[53] One premise of system redesign was that savings from both inpatient downsizing (see 2010 *Transforming the Adult Mental Health Care Delivery System in Milwaukee County* report recommendation 5.2 – "Shift resources from inpatient to community-based services") and transition to a community-based model of service delivery (see county resolution, RES 11-516 adopted by the Milwaukee County Board and signed by the County Executive in October 2011) would be reinvested to expand community-based services. Some of these savings would potentially result from, and include, the future use of Medicaid reimbursement for inpatient and/or community-based services.

  In addition, it appears that there is an opportunity to maximize the county property tax levy, if necessary. Wisconsin Act 203 authorizes the Milwaukee County Mental Health Board (MCMHB) to propose a budget to the County Executive that includes a county property tax levy amount of at least $53 million but not more than $65 million, unless a different amount is agreed to by the MCMHB, County Executive and County Board or additional programs and services are transferred to the oversight of the MCMHB. The mental health levy becomes part of Milwaukee County overall property tax levy that is subject to state imposed levy rate limits. The proposed mental health levy is approximately $62 million, leaving about $3 million available for mental health services and other county-funded services.

operate the inpatient psychiatric unit. One stakeholder suggested that a move to urban Milwaukee presents an opportunity to change the culture within the Complex but also create much-needed jobs in urban Milwaukee.

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

In Milwaukee County, law enforcement is required to bring all emergency detentions, except those requiring medical stabilization, to the 24 hour/7 day a week psychiatric emergency room located at the MH Complex, referred to as Psychiatric Crisis Services PCS. In situations requiring medical stabilization, an individual is first taken to a private hospital for medical care and once s/he receives medical clearance, is transported to PCS. In addition to all law enforcement emergency detentions, all inpatient admissions to BHD are referred to PCS for evaluation.

The emergency detention procedure in Milwaukee County is different from other counties in that the treatment director (i.e., licensed BHD or contracted physician or psychologist with clinical responsibility for the provision of emergency service care) must make a decision as to whether to detain an individual within 24 hours of when the officer arrives with the individual at the facility. The treatment director is required to complete a Treatment Director Supplement (TDS) within the first 24 hours that the person has been detained.

Advocates support the TDS requirement because they believe it serves to identify individuals who do not fit the emergency detention criteria and should be released. Advocates maintain that without the requirement of a TDS within 24 hours, a person could be detained for up to 72 hours or longer (if over a weekend and/or holiday) awaiting their probable cause hearing.

Conversely Milwaukee County DHS has urged elimination of the TDS requirement, and indicated in testimony to the Legislature in 2010 that "the primary concern with TDS is if a patient also requires medical clearance before entering BHD's PCS, the 24-hour TDS time period has likely expired ... due to either a pre-existing medical condition or as a result of physical harm they have done to themselves that led to the ED. This can result in some of the most serious cases being dismissed that otherwise would have been addressed."

In the spring of 2014, two pieces of legislation went into effect impacting Milwaukee County's ED procedures. The first, 2013 Wisconsin Act 158, was supported by advocacy groups and BHD,

- **Evaluation Procedures**. Best practice and the ED statute call for treatment, including emergency treatment, in the least restrictive environment. BHD has increased the use of crisis intervention to divert individuals from inpatient. The Crisis Mobile Team and CART assist law enforcement, provide evaluation services in the field and support use of voluntary treatment whenever possible. Incorporating these mobile approaches and moving away from the current model of bringing emergency detentions to the PCS at the MH Complex for evaluation will better align emergency detention procedures with best practice. Like Milwaukee County, communities that have adopted a more effective crisis response, have seen decreases in the number of ED and inpatient admissions. In addition, consideration can be given to other public behavioral health systems that have moved away from models to evaluate emergency detentions at sites that are co-located with inpatient facilities.

- **National ED Policy Trends.** According to a report on 2013 State legislative trends[32], themes and best practices in state mental health legislation, the National Alliance for Mental Health (NAM) reported that lawmaking on involuntary inpatient and outpatient commitment was common in 2013. A few examples included:
    - Iowa's SF 406 expanding the scope of providers qualified to authorize inpatient admission from examining physicians to physician assistants and psychiatric advanced registered nurse practitioners.
    - Washington's bills strengthening rights of people with mental illness during civil commitment and criminal incompetency procedures, requiring providers to consider history of symptoms or behavior when making a civil commitment decision, and improving planning and care coordination associated with discharge from inpatient civil commitment.
    - In Nevada, Hawaii and Virginia, outpatient treatment can be ordered for individuals not deemed dangerous to self or others.

[32] http://www.nami.org/Content/NavigationMenu/State_Advocacy/Tools_for_Leaders/2013StateLegislationReportFinal.pdf

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

The Division of Mental Health and Substance Abuse Services reports that according to a 2010 survey, 65.0% of consumers in Milwaukee County were overall satisfied with the services they received, compared to 76.4% consumer satisfaction statewide. In 2011, 63.4% of consumers in Milwaukee County were overall satisfied with the services they received, compared to 74.9% consumer satisfaction statewide. Consumers and advocates surveyed through this assessment process shared insight around different levels of satisfaction with the system as it currently exists. They provided a broad range of feedback on what is working well, progress that has been made, as well as issues and challenges that need to be addressed. These comments are summarized in the Summary of Feedback section. The questions that were used to guide the discussion at the focus group sessions can be found in the appendices.

Since this assessment was conducted as a meta-analysis, whenever applicable, the summary of feedback references similar stakeholder feedback included in the 2010 study, *Transforming the Adult Mental Health Care Delivery System in Milwaukee* County and the 2014 study, *Analysis of Adult Bed Capacity for the Milwaukee County Behavioral Health System*. Both of those studies were prepared by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC) and the Public Policy Forum (PPF), but will be referred to in the Summary of Feedback section as the 2010 or 2014 HSRI studies.

Progress and Improvements

- There was general recognition of the investments made by Milwaukee County in community-based services to rebalance the behavioral health system, as well as specific mention of services and initiatives that are viewed as particularly beneficial, such as peer-run services, increased access and crisis services, peer specialist services, and community intervention specialist services to connect people with housing and appropriate community resources. However, it was stated that the results from the recent initiatives are not yet known, and that it may be too early to see the impact of the investments on systems change.

- There was recognition of the collaborative approach of the Mental Health Task Force and the value of the Task Force to raise important issues. Efforts of the MC3, Milwaukee Co-Occurring Competency Cadre, were also lauded, as was the work of the Mental Health Redesign and Implementation Task Force on the SMART goals for the behavioral health system. Additionally, the effectiveness of the Milwaukee Wraparound approach

- Stakeholders identified areas for enhancing the recovery-orientation of the behavioral health system, and the improvements needed to achieve this. These areas include:
    - The development of a common understanding of what is meant by recovery-orientation to include all aspects important to a person's recovery, well beyond the treatment of their mental illness or addiction. *(Note: This was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*
    - The implementation of the philosophy and principles of recovery and a person-centered approach throughout the entire behavioral health system, including all County and provider agency personnel. *(Note: This was also an identified theme from the stakeholder interviews in the 2010 HSRI study. That study further noted the need for education about recovery to "both clarify the vision of the BHD leadership and elicit buy-in from all system stakeholders." In particular, the 2010 study noted the need for more recovery education of providers and case managers, in particular, and the use of peer specialists in providing education for consumers about available resources.)*
    - The provision of culturally competent services and more bilingual services. *(Note: This was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*
    - The development of a more comforting, person-centered front door access to inpatient and mobile crisis services. *(Note: An identified theme from the stakeholder interviews in the 2014 HSRI study was that "police intervention as a frontline for psychiatric crisis response is fundamentally flawed.")*
    - Greater and more meaningful involvement of consumers in the design of new initiatives before they are launched. *(Note: More active and influential consumer involvement was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*
- Many said further investments in the system are needed, but several stressed it is also important to target dollars to the best possible use and invest in what is working. Specific areas include:
    - Peer-run services (e.g., Grand Avenue Club, Our Space): Stakeholders stated that these services provide a sense of purpose and belonging within a community of people that understands consumers and cares. One individual shared that the biggest obstacle to their own wellness and recovery is feeling isolated and alone. *(Note: The importance of peer-run services was also an identified theme from the stakeholder interviews in the 2010 HSRI study.)*

- Integrated services: Stakeholders felt a system that provides better coordinated care in the community to address a person's physical and behavioral health needs would provide better quality care and reduce costs. *(Note: This was also an identified theme from the stakeholder interviews.)*

Report on
Mental Health Service Delivery in Milwaukee County
December 2014

Wisconsin
Department of Health Services

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December 2014

Ms. Kitty Rhoades, Secretary
Department of Health Services
1 W. Wilson St., Rm. 650
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Secretary Rhoades:

With this letter, I am transmitting to you the Department's recommendations for changes to the delivery of mental health services in Milwaukee County. The Department's recommendations are based on an assessment of the current mental health delivery system in Milwaukee County by Deloitte Consulting. Together, these documents satisfy the requirements of 2013 Wisconsin Act 203 Section 53 (4). The Division of Mental Health and Substance Abuse (DMHSAS) supports reforms to the current Milwaukee County mental health service delivery system that ensures individuals in Milwaukee County receive mental health services in the most appropriate and least restrictive settings.

DMHSAS looks forward to partnering with the Department, the Governor, the Legislature, Milwaukee County, advocates, as well as other stakeholders to develop and implement the reforms needed to transition mental health care in Milwaukee County from a heavy reliance on institutional services to more proactive community based programs designed to address crisis in the community and to reduce institutional and other inpatient care.

Thank you.

Sincerely,

Linda A. Harris

Linda A. Harris
Administrator

Mental Health Service Delivery

Recommended changes to mental health service delivery in Milwaukee County

Department of Health Services

December 8, 2014

Background

2013 Wisconsin Act 203 requires the Department (DHS) to arrange for an operational and programmatic audit of:

1. The behavioral health division (BHD) of the Milwaukee County department of health and human services;
2. The psychiatric hospital of the Milwaukee County mental health complex (MCMHC); and
3. Other related behavioral health programs.

The act further requires that the audit include recommendations for:

1. The state assuming oversight responsibility for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex; and
2. Development of a plan for closing the Milwaukee County Mental Health Complex, developing a plan for state oversight of a regional facility for the delivery of institutional, inpatient, crisis services, and behavioral health services using similar state-operated regional facilities as a model.

Finally, the act requires the audit to provide details and specifications on, after the transitioning of the county-run institutional model to a state-based regionalized model, how:

1. The state-based Milwaukee County Mental Health Board (MCMHB) will transition to a county-based board;
2. The positions on the MCMHB will transition to community-based focus;
3. The funding for inpatient services and community-based services will continue; and
4. Mental health services will be delivered in a manner that reflects the following principles:
    a. Community-based, person-centered, recovery-oriented mental health systems.
    b. Maximizing comprehensive community-based services.
    c. Prioritizing access to community-based services and reducing reliance on institutional and inpatient care.

d. Protecting the personal liberty of individuals experiencing mental illness so that they may be treated in the least restrictive environment to the greatest extent possible.
e. Providing early intervention to minimize the length and depth of psychotic and other mental health episodes.
f. Diverting people experiencing mental illness from the corrections system when appropriate.
g. Maximizing use of mobile crisis units and crisis intervention training.

The Department contracted with Deloitte Consulting to meet the requirements of 2013 Act 203. Deloitte provided an assessment and findings to DHS on November 26th, 2014. The act also requires DHS to submit the assessment and recommendations to MCMHB, the Milwaukee County board, the Milwaukee County executive, and the Legislature.

The Deloitte assessment includes twelve findings that summarize the current system of mental health service delivery in Milwaukee County. The assessment identifies several areas where differences in state law, the processes used in assessing individuals in need of mental health services, and the role of community programs create unique challenges for Milwaukee County in delivering mental health services. While the assessment identifies strengths in the current system, the Department believes the assessment also identifies areas for improvement.

Based on the Deloitte assessment, the Department offers four recommendations to improve the mental health service delivery system in Milwaukee County:

1. Consider statutory changes to align the emergency detention process in Milwaukee County with the process in other counties in the state.
2. Require community based crisis services prior to emergency detention.
3. Strengthen community based mental health services.
4. Implement reforms and policies that reduce inpatient utilization in Milwaukee County, and over time, transition the Milwaukee County inpatient treatment model to deliver services in the most efficient and cost effective setting.

Recommendations

Emergency Detention Statutes:

The Department recommends that the state consider changes to align the emergency detention process in Milwaukee County with other Wisconsin counties.

Wisconsin law provides for the emergency detention of individuals who present a risk of harm to themselves or others. Generally, law enforcement initiates emergency detentions. In counties except Milwaukee, law enforcement is required to receive approval from the county department of community programs prior to delivering an individual to an authorized detention facility. The county department is permitted to approve the detention only if it reasonably believes the individual will not voluntarily consent to evaluation, diagnosis, and treatment necessary to stabilize the individual. This provision provides the county human services programs the opportunity to address the individual's needs through community based services, which in the case of a potential emergency detention is most likely to be crisis services. Crisis services are effective in avoiding the need for an inpatient admission.

However, in Milwaukee County, the statutes direct that anyone being held because they pose a risk of harm to themselves or others be brought to a treatment facility for assessment for up to 24 hours to determine if an emergency detention is appropriate. In Milwaukee County, the MCMHC is the facility where these assessments are made. In addition to inpatient beds, MCMHC operates approximately 18 observation beds for, among other purposes, determining if someone should be admitted for inpatient services on an emergency detention. In addition, MCMHC also operates the Psychiatric Crisis Services (PCS), which is the psychiatric emergency room / admission point of the MCMHC.

Statutes for emergency detention in Milwaukee County further require that the treatment director of the facility determine within 24 hours of an individual being brought to the facility by law enforcement whether or not the individuals should be detained for up to a total of 72 hours under an emergency detention. If the treatment director determines the individual does not meet the criteria for detention, the individual is released and no detention order is filed with the court.

2013 Wisconsin Act 235 created a two-year emergency detention pilot program in Milwaukee County. This pilot expands the treatment director role in current statute to allow the treatment director or a licensed mental health professional designated by the treatment director to take a

person into custody for emergency detention if the person meets all of the criteria for detention.

This process differs significantly from other Wisconsin counties. The current statutes requiring individuals to be assessed at the MCMHC embeds the emergency detention assessment process into the inpatient admission process at MCMHC. The Deloitte assessment indicates that 85% of PCS admissions do not result in an emergency detention. Given that fact, it could be argued that many of these individuals could have been more appropriately served through community based programs, such as crisis intervention services. If the assessment of individuals in need of emergency mental health services occurs in the community, and the approval for emergency detention is granted first by the county department for community programs or a community based crisis services program, inpatient utilization is likely to be reduced.

The Department recommends that the state consider a statutory requirement that an assessment by a community based crisis program in Milwaukee be completed prior to a law enforcement officer taking an individual to the PCS at MCMHC.

In Milwaukee County, law enforcement determines when crisis intervention is initiated and this, in turn, has an impact on the setting in which individuals are initially triaged and screened. The Deloitte assessment indicates that studies on the Milwaukee system recommend training law enforcement on community based crisis programs to reduce incidence of emergency detentions. Advocates and treatment professionals indicate that the determination solely by law enforcement raises questions about unintentional bias and may impede creating a recovery-orientated, person-centered system of care.

The assessment indicates that there appears to be only one source of crisis services for children and adolescents that also includes children and adolescents with intellectual and developmental disabilities. The assessment suggests that this gap may result in a higher rate of restraint use, commitments and use of the criminal justice system.

It should be noted that funding pressures may also be contributing to the limited availability of crisis interventions and other community based mental health services. The report cites previous studies that have indicated a savings from a reduction in inpatient bed capacity and utilization that result from strengthening community based crisis programs would offset the cost of the investment in community programs. However, this may not consider the full legacy costs associated with maintaining a facility like MCMHC. For example, according to the report, the 2015 recommended BHD budget includes an increase of approximately $3.7 million, but roughly $2.7 million is needed to fund increased fringe benefit costs for MCMHC staff and other costs to continue inpatient operations. If BHD is to expand community services, additional

funds are likely needed to support community programs until savings can be generated through inpatient reductions, which may take several years to realize.

The Department will continue to support Milwaukee County in developing community programs by providing technical assistance and training to county staff. The Department will also continue to support policy changes that encourage further utilization of community based mental health services.

Strengthen Community Based Programs:

The Department recommends strengthening community programs through an increased focus on community crisis interventions and other crisis services, and continued expansion of other community based psychosocial services, including Comprehensive Community Services (CCS) and other Medicaid mental health programs available to counties.

The Deloitte assessment finds that Milwaukee County has initiated community based programs, but identifies many areas where these programs can be strengthened and expanded to serve individuals in the least restrictive setting and reduce inpatient utilization. For example, the report indicates that approximately 30% of individuals served through PCS return to PCS within 90 days, and at the same time over 50% of individuals served by PCS are returned to their home or the community rather than entering an inpatient facility. It could be argued that many individuals being served by PCS and returned to their home or the community without inpatient hospitalization could have been better served by more robust community based programs.

The Deloitte assessment also indicates that both emergency detentions and involuntary admissions as a percentage of all PCS admissions has declined for several years. This may also indicate that an increasing percentage of individuals entering the PCS do not need inpatient services and could be more appropriately served through less restrictive community based alternatives may be more appropriate.

In 2014, Milwaukee County implemented the Comprehensive Community Services (CCS) and Community Recovery Services (CRS) programs. These Medicaid programs provide counties reimbursement for community based psychosocial services provided at home or in the community.

The Governor and Legislature expanded CCS in the 2013-15 biennial budget, 2013 Wisconsin Act 20. The budget created an option for counties to receive full reimbursement for the costs of providing CCS if services are provided through a regional program approved by the Department. Previously, like CRS, counties were required to provide the non-federal share of CCS costs. Milwaukee formed a region consisting of Milwaukee County and was certified as a regional CCS provider in September of 2014. As of November 24, 2014, Milwaukee County had enrolled 41 individuals in the CCS program. The Department projects that 169 individuals will be enrolled in CCS in Milwaukee County by the end of SFY 15.

CRS provides psychosocial rehabilitation services, including peer supports, employment supports, and residential supports to aid individuals with activities of daily living.

Inpatient Services:

The Department recommends that the Governor and Legislature implement reforms and policies that reduce inpatient utilization in Milwaukee County, and over time, transition the Milwaukee County inpatient treatment model to deliver services in the most efficient and cost effective setting.

The current decentralized county-based mental health system in Wisconsin creates disparities in the services that are provided across the state and creates budgetary pressures for counties. Behavioral health services must compete for resources with other county priorities. Milwaukee County faces special budgetary pressures because of the fact that the MCMHC serves as the "safety net" treatment facility for individuals in need of emergency mental health services. In other counties, state run mental health institutes (MHI) serve as the "safety net" facilities. The report cites a 2010 Human Services Research Institute (HSRI) report that suggests Milwaukee County government lacks administrative flexibility and independence to effectively govern a behavioral health system that includes psychiatric inpatient units and an emergency department. The result in Milwaukee County is that community based mental health services not only compete with other county priorities for budget resources, but also compete with the cost to continue operations of an inpatient mental health facility.

The assessment discovered a number of gaps in the information available from BHD, creating challenges for the assessment to thoroughly evaluate the inpatient program on a number of key issues with the current inpatient facility and the existing administrative structure. However, there is a general consensus between BHD, state staff and advocates on the following issues:

1. MCMHC is an aging facility. The design and limitations of the facility infrastructure create additional workload for treatment staff.
2. Overhead costs of the aging facility are increasing over time. At the same time, inpatient capacity has decreased, resulting in higher per patient overhead costs to provide inpatient services.
3. Efficient operation of MCMHC as a "safety net" facility is complicated and compromised when the facility shifts to "waitlist" or "full-diversion" status.
4. The Institution for Mental Disease (IMD) status of MCMHC limits opportunities to maximize federal funding through Medicaid.

There is consensus that the MCMHC serves a unique role among inpatient mental health providers in Milwaukee County as the "safety net" facility, serving the most complex and

challenging consumers, and that ongoing inpatient capacity and services will be needed to serve this population in the future. The report indicates general agreement among stakeholders that 54-60 adult inpatient beds are needed to serve the highest acuity adults. However, it could be argued that fewer beds would be needed if a greater emphasis were placed on crisis services and other community based programs since the current facility has a staffed operating capacity of 60 adult beds and operates beyond the scope of a true "safety net" facility.

The assessment includes a range of options for the provision of inpatient services in Milwaukee County in the future (See finding #6 and the table following finding #6). However, the Department believes there are three important decision points to be considered in planning for future inpatient needs in Milwaukee County that will drive the inpatient service model:

1) **Administration** – Should future inpatient services continue to be administered by BHD or should the state operate one or more facilities to provide inpatient services?
2) **Service Area** – Should the inpatient services be provided exclusively for Milwaukee County residents or should the inpatient services be designed to serve individuals from a larger southeastern Wisconsin region who would otherwise be referred to a state Mental Health Institute (MHI) under current law?
3) **Facility type** – What type of facility should be used for inpatient mental health services?
    a. Existing MCMHC facility
    b. Contracted or leased private hospital beds
    c. 16 bed or smaller community hospitals
    d. New IMD inpatient facility

It should be noted that capital investments would be needed under any scenario that transitions inpatient care from the use of the current inpatient facility. It is likely that such a project would take at least 5 years before a new state facility could be constructed based on the timing of the state capital budget process. Further analysis would be necessary to determine what funding and actions would be needed to assist Milwaukee County in constructing a facility or purchasing inpatient beds from a private hospital.

It could be argued that the nature of a county operated facility like MCMHC creates a situation where the only means to address and reduce the utilization of inpatient services is a transfer of administration of the inpatient facility from the county to the state. Such a transfer would force a reprioritization by BHD to focus more exclusively on community-based solutions, even for more intensive services. However, there may also be opportunities to create financial incentives sufficient to modulate Milwaukee County policy to focus on reducing inpatient services by strengthening and expanding utilization of community based programs.

In conclusion, this report outlines recommendations that the Department has identified to provide policy makers opportunities to improve mental health service delivery in Milwaukee County. It is important to note that that this report only recommends a broad framework for changes that should be considered by state and local policymakers. A number of the recommendations in this report reflect major changes to the existing service delivery system. Careful planning and analysis by the state and the county will be required to implement any of the recommendations in this report. The Department is committed to improving the mental health delivery system in Milwaukee County by supporting reforms at the state and county level that ensure individuals in Milwaukee County receive appropriate services in the least restrictive settings.

Attachment C

Public Policy Forum

Impartial research. Informed debate.

Fiscal Analysis of Mental Health Redesign in Milwaukee County

About the Public Policy Forum

Milwaukee-based Public Policy Forum – which was established in 1913 as a local government watchdog – is a nonpartisan, nonprofit organization dedicated to enhancing the effectiveness of government and the development of southeastern Wisconsin through objective research of regional public policy issues.

Acknowledgements

We wish to thank the Milwaukee County Department of Health and Human Services and Milwaukee County Behavioral Health Division for commissioning and helping to fund this research. Report authors also would like to thank the leadership and staff of DHHS and BHD for their assistance in providing budget and programmatic information and patiently answering our questions. We especially appreciate the many hours of assistance provided by BHD fiscal and budget staff (most notably Randy Oleszak, Clare O'Brien and Chris Walker), as well as former BHD Interim Administrator Jim Kubicek and Adult Community Services Branch Associate Director Jennifer Wittwer.

Finally, we would like to thank the Forum's former Senior Fiscal Researcher, Vanessa Allen, for her work on this project. Vanessa left the Forum in July 2014 to pursue her MBA but was the primary researcher and analyst for the section on BHD's community-based services budget prior to her departure.

Fiscal Analysis of Mental Health Redesign in Milwaukee County

March 2015

Davida Amenta, Researcher
Rob Henken, President

Public Policy Forum
Impartial research. Informed debate.

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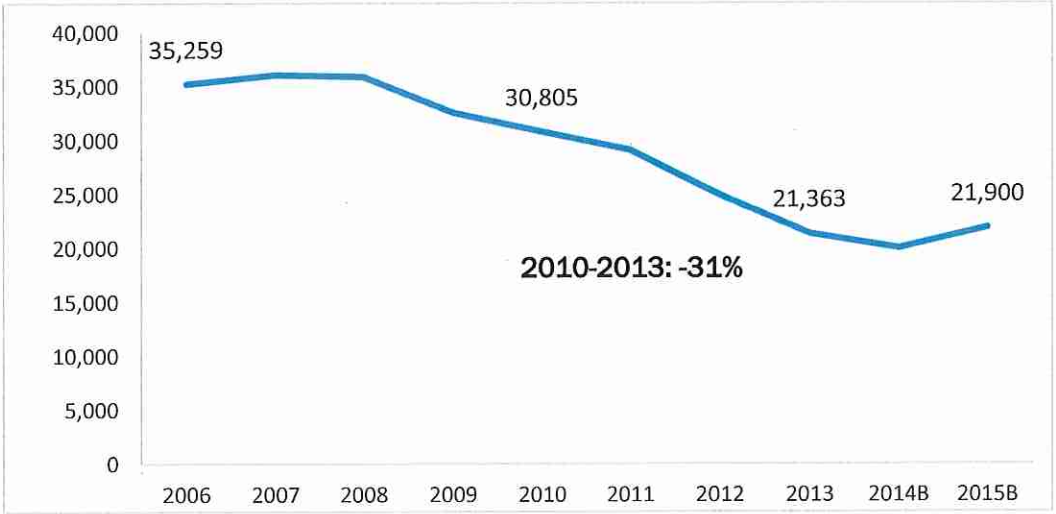
Executive Summary

The mental health care system in Milwaukee County has undergone dramatic change in recent years, as County and community leaders have sought to ease reliance on emergency and inpatient care while enhancing the range and scope of community-based mental health services. Between 2010 and 2013, adult inpatient capacity at the County's Mental Health Complex decreased by 31%, while admissions at its emergency room facility (referred to as the Psychiatric Crisis Service, or PCS) dropped by 15%. In addition, the County recently closed one of its 72-bed long-term care facilities and plans to complete the closure of its second facility by the end of 2015.

Adult inpatient capacity reduction (measured by patient bed days)



On the community side, an array of new treatment and recovery-oriented services has been added, including Comprehensive Community Services (CCS), a new Medicaid benefit that seeks to reduce inpatient admissions by strengthening early intervention and treatment programs; Community Recovery Services (CRS), which offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients; and a range of new community-based crisis services.

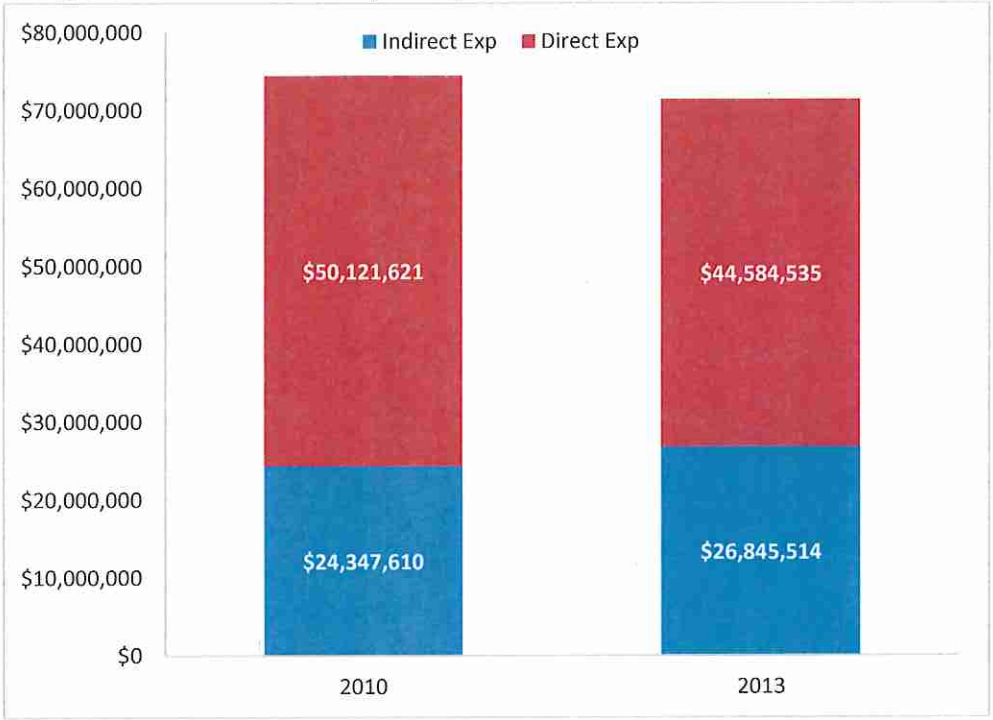
While it is relatively easy to describe these service changes, far less is known about the ***financial*** impacts of ongoing mental health redesign efforts. For example, how much is being saved on an annual basis from the vastly reduced inpatient/long-term care census? And, perhaps more important, can continued bed reductions at the Mental Health Complex generate the property tax levy savings that are likely to be required to achieve desired levels of community-based care?

In this report – commissioned by Milwaukee County and its Mental Health Redesign Task Force – the Public Policy Forum seeks to answer those questions. We do so first by assessing the fiscal impacts of the County's mental health redesign activities that have occurred to date, which we accomplish by "deconstructing" BHD's budget to isolate direct and indirect cost centers and appropriately distinguish between hospital and community-based expenditures. Then, we use that knowledge to consider how the implementation of a fully redesigned system of care will impact the Behavioral Health Division's (BHD) financial situation in the next two years.

The report begins by examining financial trends from the 2010-2013 timeframe, which was the period of time in which BHD initiated various mental health redesign strategies aimed at moving toward a community-based system of care. Our trend analysis revealed the following:

- While direct hospital-related expenditures at the Mental Health Complex decreased by $5.5 million (11%) – an amount that intuitively would appear to correlate with the decline in bed capacity – indirect costs unexpectedly increased by $2.5 million. To some degree, this was caused by factors beyond BHD's control, such as the central budget office's determination of BHD's legacy costs from retired employees, facility expenses, and charges from other departments.

Change in Mental Health Complex Expenditures, 2010-2013



- Overall staffing levels at the Mental Health Complex remained largely the same despite the reduced patient volume. We found this was largely attributed to increased staffing levels at PCS, which may have reflected a need to utilize clinical staff freed up from inpatient and long-term care downsizing to address previous understaffing at PCS.

- BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, but the reduced patient census produced an overall net loss of about $3 million in patient revenue. Because that loss largely offset expenditure reductions, the County was unable to reduce its allocation of property tax levy to Mental Health Complex services.[1]

[1] In this analysis, when we refer to property tax levy we also include the County's annual Base Community Aids (BCA) allocation from the State of Wisconsin. Property tax levy and BCA are used interchangeably by the County to fill the gap between the amount spent to provide mental health services and the revenue that is recovered from patients and other sources.

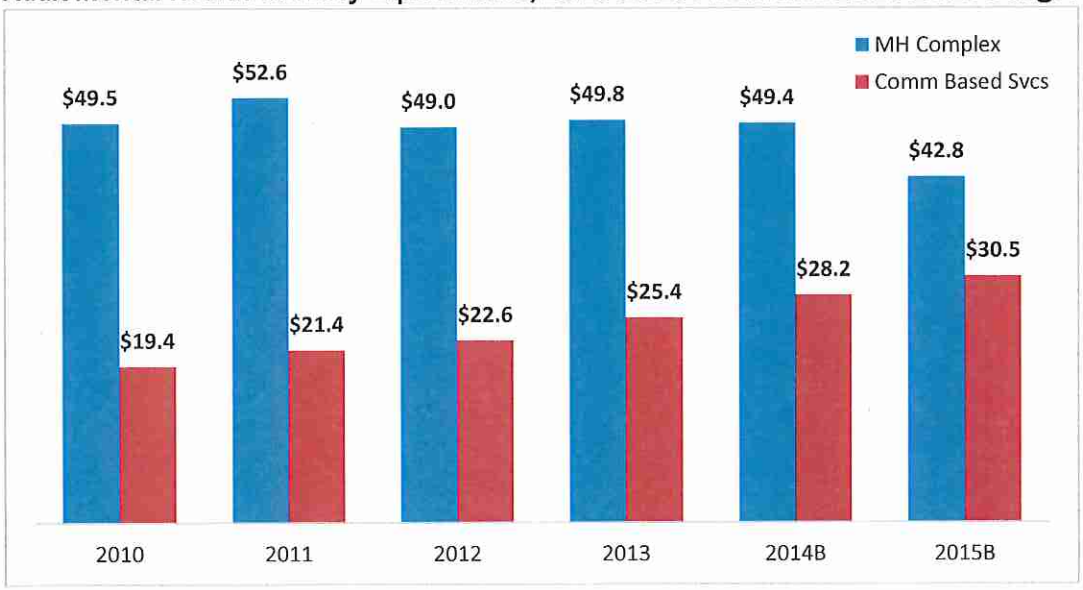
- BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million (12%). However, BHD's community services as a whole became more dependent on property tax resources, which increased by $6 million. Because levy savings did not materialize from Mental Health Complex downsizing, those additional resources came from other parts of County government and/or general increases in the tax levy.

Overall, our trend analysis found that a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up property tax resources to invest in community-based services – had not been achieved as of the end of 2013.

We then turned to the 2014 and 2015 budgets to determine whether any of the trends observed for the previous four years had reversed, and whether additional savings associated with continued Mental Health Complex downsizing in those years were being generated for reinvestment in community-based services. The 2014 and 2015 budgets were characterized by even greater downsizing than had occurred the previous four years, including the closure of both long-term care facilities by the end of 2015; and by increased investment in community-based services.

We found that the financial benefits associated with these sharper declines in patient census had indeed become more pronounced. For example, property tax levy expenditures for Mental Health Complex service areas were budgeted to fall by about $7 million (14%) in 2015 when compared with 2013 actual amounts. However, the potential for greater savings still was limited by BHD's inability to substantially reduce indirect costs, which were projected to decline by only 4%; and by substantial budgeted reductions in patient revenue in conjunction with the reduced census. We also observed that increased staffing and expenditure levels at PCS continued to partially offset inpatient and long-term care savings.

Adult Mental Health Tax Levy Expenditures, 2010-2013 Actual and 2014-2015 Budget (millions)

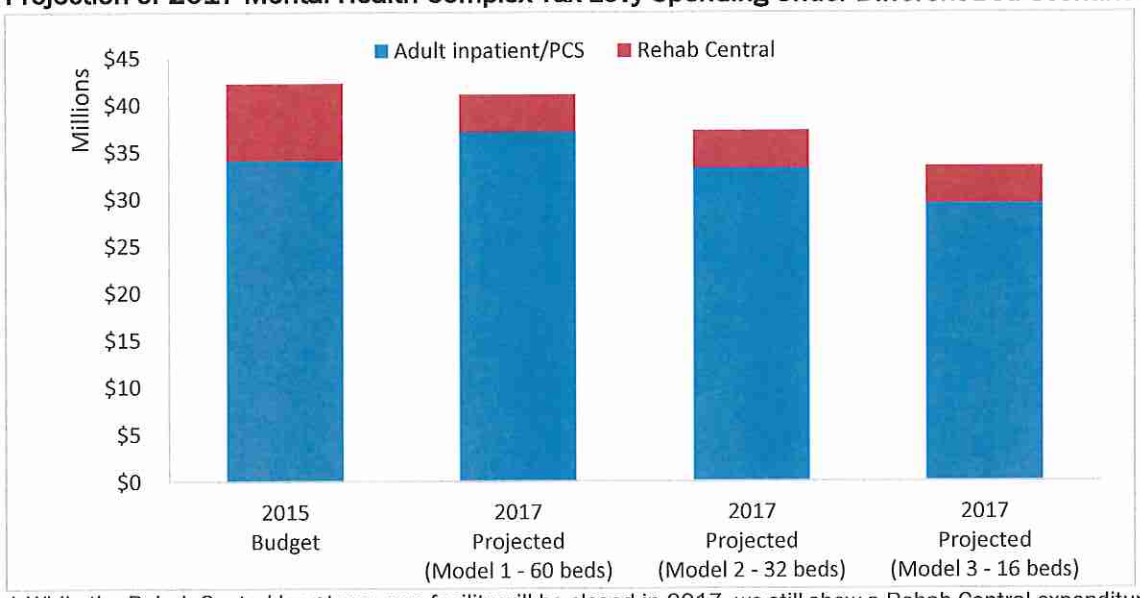


Finally, we used the information and insights gained from our trend analysis to conduct financial modeling that allowed us to estimate the financial impacts of 60-, 32-, and 16-bed adult inpatient scenarios. For each of our models, we took into account both the financial impacts associated with each bed capacity scenario, plus a calculation of the ongoing savings that would result from the closure of the Rehab Central long-term care facility in 2015.

Our modeling showed that BHD would need about $3 million of additional property tax levy in 2017 to support the two remaining Mental Health Complex functions (adult inpatient and PCS) than it budgeted for those functions in 2015. However, because $4.2 million in net savings would be derived from the closure of Rehab Central, there would be a total of about $1.2 million available for community reinvestment under that scenario in 2017. We also found that BHD could generate a $5 million property tax levy savings in 2017 (when compared to the 2015 budget) by downsizing from 60 to 32 adult inpatient beds, and an $8.8 million savings by downsizing to 16 adult inpatient beds. Again, both of those savings amounts include the positive fiscal impact associated with the closure of Rehab Central.

A key question is whether an investment of the projected savings from the 32- and 16-bed scenarios in community-based services would be sufficient to appropriately offset the increased need for such services in light of reduced inpatient bed capacity. We were unable to determine the answer to that question, but suggested that BHD should ascertain the types and scope of enhanced community-based services that might be implemented to make such a determination.

Projection of 2017 Mental Health Complex Tax Levy Spending Under Different Bed Scenarios



* While the Rehab Central long-term care facility will be closed in 2017, we still show a Rehab Central expenditure in 2017 in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Our modeling exercise not only revealed the amount of estimated savings that could be achieved through continued bed reductions, but also highlighted the fundamental constraints that will continue to impact BHD's financial future:

1. The Mental Health Complex's indirect costs are only loosely linked to its bed capacity, and this factor will continue to curtail overall savings that can be achieved with future downsizing initiatives.

2. Because key components of BHD's indirect cost structure are linked to its existing facility and its treatment as a regular department of Milwaukee County government, there is little it can do to reduce indirect costs without changes to those two circumstances.

3. While BHD can continue to generate sizable direct cost savings from additional reductions in adult inpatient bed capacity, the direct cost pressures associated with continued operation of PCS at its existing capacity will erode those savings and reduce the amounts available for community reinvestment.

The report concludes with five observations derived from our modeling and trend analysis:

- **Milwaukee County leaders should contemplate a new financial structure for the Mental Health Complex that sets it apart from the rest of Milwaukee County government.**

  As long as the Mental Health Complex continues to be subject to charges from other County departments and central service allocations from the central budget office, it is likely to receive only limited benefit from bed capacity and associated staffing reductions. An argument could be made – particularly in light of BHD's new governance structure that has it reporting to a new Mental Health Board – that the additional step of segregating BHD's finances from the rest of Milwaukee County government should occur, or that it should be placed under a separate mental health district or authority. Should this approach prove unworkable from an accounting, legal, or logistical perspective, then the County budget office and BHD at least should consider reforming internal budgeting and accounting practices to better isolate costs and revenues associated with BHD's various service areas.

- **Milwaukee County and State of Wisconsin leaders need to work jointly to address BHD's facility needs and questions.**

  Our analysis confirms what Milwaukee County leaders have known for quite some time: that facility costs at the existing facility are influenced most prominently not by the amount of square footage that BHD occupies for its hospital-related operations, but instead by its continued need to service and maintain the entire sprawling Mental Health Complex regardless of inpatient bed capacity, and by cost factors associated with its use of County facilities staff to do so. Furthermore, BHD officials have cited millions of dollars of needed repairs at the existing Complex, which have been deferred pending consideration of a possible new facility. It is unclear how those needs will be addressed given that recent state legislation places BHD operations spending under the purview of the Mental Health Board, but leaves capital and debt service costs under the purview of the County Board.

- **The future size, mission, and location of PCS will be central to any decision-making regarding adult inpatient bed capacity and a potential new facility.**

  An often overlooked issue in BHD's consideration of its optimal inpatient capacity and the possible construction of a new facility is the future size, scope, and operation of PCS. Our analysis shows that as long as PCS maintains its approximate current patient volume and staffing, then its costs are likely to continue to grow with inflation, thus partially offsetting any savings accrued from inpatient downsizing. In determining possible downsizing options and the size and location of a new facility, therefore, County and Mental Health Board leaders also should be considering how PCS will function in the future.

- **BHD should develop effective and transparent ways to measure the impacts of its community investments on inpatient and PCS demand and to track and project community-based service costs.**

  It will be tempting to view an opportunity to generate almost $9 million in annual savings from a 16-bed scenario as too promising to ignore, and to simply assume that by reinvesting those dollars in community-based services an appropriate balance of services can be created. We suggest, however, that the ability to safely downsize in such a substantial manner will be predicated on whether community-based investments truly decrease demand for inpatient care, and that a performance measurement system be developed to provide insight into that question before substantial additional downsizing occurs. Similarly, we recommend that BHD develop the financial data collection and reporting mechanisms that will be required to appropriately model future year community-based expenditures and revenues and guide decision-making on future investment options.

- **BHD needs more detailed analysis of its revenue structure and revenue opportunities to guide bed capacity decisions.**

  While BHD has made great progress in implementing a new electronic medical records system and improving its revenue collection practices, it would benefit from greater capacity to conduct sophisticated analysis of revenue trends and its patient mix. BHD also would benefit from additional expertise on Medicaid and Affordable Care Act issues and opportunities to help it appropriately gauge the impacts of major changes in its service design and delivery. Consequently, we suggest that BHD and the Mental Health Board consider options for developing the capacity to better monitor and analyze BHD's revenue performance, and to produce the types of revenue profiles and analyses that will be critical to determining the pros and cons of different bed capacity options.

INTRODUCTION

In October 2010, the Human Services Research Institute (HSRI) and Public Policy Forum published a report that detailed the need to redesign the adult mental health care delivery system in Milwaukee County. The report suggested a series of carefully-calibrated strategies to transition from a system that relied primarily on emergency and inpatient care to one that was predicated on services in community settings. The report stressed, however, that a safe and orderly reduction in bed capacity would require simultaneous investments in an appropriate and expanded mix of community-based services.

Since that time, Milwaukee County's Behavioral Health Division (BHD) has aggressively moved to implement several elements of the recommended redesigned system. Adult inpatient bed capacity has been substantially reduced; one of the County's two long-term care facilities has closed, with the second slated for closure by the end of 2015; and volume at the County's psychiatric emergency room has declined. At the same time, additional investments have been made to enhance community-based services.

The County's resolve to reduce its operations at the Mental Health Complex also created a need for detailed financial planning. Specifically, this initiative created an imperative for the County to accompany its downsizing initiatives with financial analysis that would reveal the budgetary impacts associated with a vastly reduced inpatient/long-term care census and the extent to which resulting savings could offset the cost of enhanced community-based alternatives.

A first step in this financial planning was taken in 2013, with the publication of a report by the Forum that assessed the fiscal challenges of Milwaukee County's Behavioral Health Division. The 2013 report sought to provide a baseline fiscal assessment that would be used to inform the mental health redesign process and ensure that programmatic recommendations were accompanied by a fundamental understanding of BHD's financial constraints.

In this report – commissioned again by Milwaukee County at the urging of leaders of its Mental Health Redesign Task Force – the Forum builds off its 2013 baseline analysis with a new and detailed fiscal examination. The primary purposes of this report are to 1) assess the fiscal impacts of the County's mental health redesign activities that have occurred to date; and 2) use that knowledge to consider how the full implementation of a redesigned system of care will impact BHD's financial situation and the finances of Milwaukee County as a whole.

An overriding research question at the root of this analysis is whether continued bed reductions at the Mental Health Complex will generate sufficient property tax levy savings to achieve desired spending levels on community-based services. To some extent, this is a "chicken and egg" problem. Enhanced community-based services are needed to reduce the Mental Health Complex census, but the savings derived from bed reductions are needed to provide additional community-based services.

Our starting point is an examination of actual BHD spending and revenue performance for the 2010-2013 timeframe in the areas of emergency, inpatient, long-term care, and community-based adult mental health services. We "de-construct" BHD's budget, peeling back multiple allocations of indirect costs to show the real impacts of the downsizing that occurred between 2010 and 2013. Both Mental Health Complex and community services budgets are reviewed from 2010 to 2013. After that task is accomplished, we present updated financial information from the 2014 budget and 2015 budgets. Finally, the analysis includes financial projections for 2017 under various adult

inpatient bed scenarios to estimate how much additional financial capacity actually would be derived from additional inpatient reductions to support enhanced investment in community-based services.

As we stated in the Introduction to our March 2013 report, the objective of our work is not to critique BHD's fiscal management, but instead to objectively analyze its financial challenges and opportunities. Our hope is to provide Milwaukee County budget officials and the new Milwaukee County Mental Health Board with an independent fiscal assessment and forecast with which to consider important programmatic changes moving forward.

BACKGROUND

BHD provides and/or administers a variety of inpatient, emergency, and community-based care and treatment to children and adults with mental health and substance abuse disorders. The County's responsibilities in this area are stipulated in Wisconsin's State statute 51.15, which assigns to counties the mandate of providing for "the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."

BHD is housed at the Milwaukee County Mental Health Complex on Watertown Plank Road in Wauwatosa. At the Complex, Milwaukee County owns and runs an inpatient hospital consisting of four licensed units (one of which is for children and adolescents); two long-term care facilities (one for individuals with complex needs who require long-term treatment and one for individuals diagnosed with both developmental disability and serious behavioral health needs);[2] and a Psychiatric Crisis Service (PCS) that serves persons in need of emergency mental health treatment, a majority of whom are brought in by law enforcement on an Emergency Detention. PCS also encompasses a mental health outpatient Access Clinic and a Mobile Treatment Team.

In addition to being a direct provider of mental health services at the Complex, BHD contracts for a wide variety of community-based services, including targeted case management (TCM), community support programs (CSP), community residential services, outpatient treatment, substance abuse treatment and recovery support, crisis respite, and specialized services for children and adolescents.

The governance, administration, and funding of Milwaukee County's behavioral health services changed dramatically in April 2014 with the adoption of Wisconsin Act 203 by the Wisconsin Legislature and governor. The Act removes jurisdiction of those services from the Milwaukee County Board of Supervisors and instead places them under the control of a newly created Mental Health Board (MHB) comprised of 11 individuals with expertise or experience in various facets of mental health services and administration. Members were appointed in June 2014 and the Board held its initial meeting in July.

In addition to "oversee(ing) the provision of mental health programs and services in Milwaukee County," the MHB has administrative control over BHD's budget and personnel. That includes both the programs and services provided by the division at the Mental Health Complex and the services administered by its community services branch. While the MHB has the power to approve BHD's annual budget, the legislation stipulates that the property tax levy contained in the budget must be between $53 million and $65 million, unless a higher or lower amount is agreed to by the MHB, county executive, and county board. BHD's 2015 expenditure budget is $179.6 million, including $59.1 million in property tax levy. The budget funds 585 full-time equivalent employees (FTEs).

The focus of this report is the set of BHD programs and services that have been the subject of mental health redesign activities. Specifically, those are programs and services that pertain to adult mental health. Major programs that are excluded from this analysis are BHD's Wraparound Milwaukee program, its Family Intervention Support Services, its range of AODA services, and its Children's and Adolescent Inpatient Services (CAIS). In addition, the County's Emergency Medical

[2] One of the long-term care facilities, Hilltop, closed in January 2015 but it was in operation during much of the period of this analysis.

Services program has been housed in the BHD budget in recent years but is excluded from this analysis.

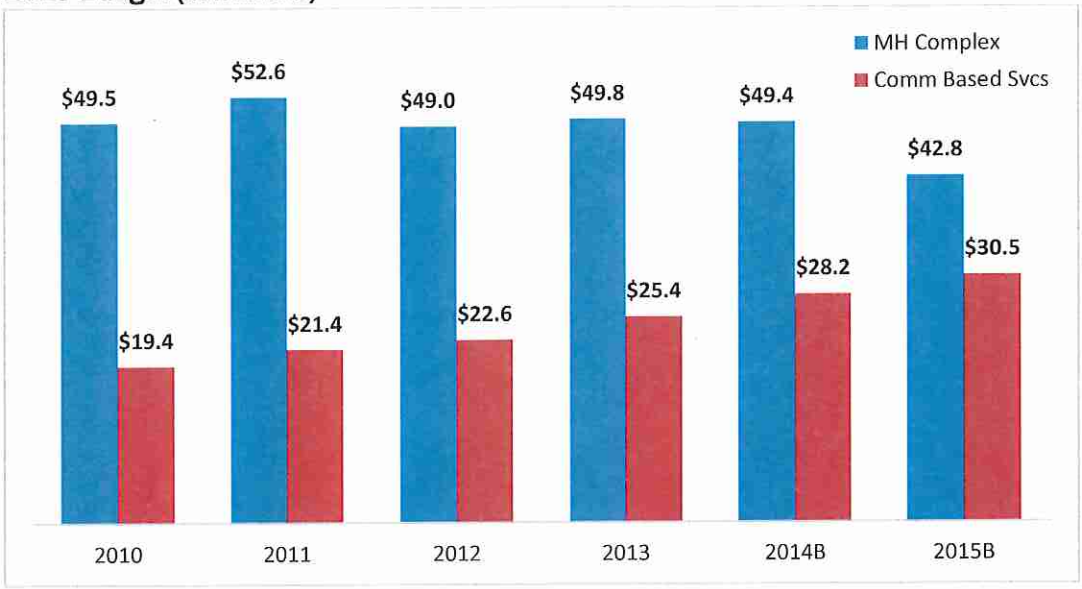
As the redesign process has progressed, BHD has been successful in reducing the patient census at the Mental Health Complex. **Figure 1,** which compares total expenditures for inpatient, crisis, and long-term care services provided at the Mental Health Complex with community-based services over the past six years, suggests that the redesign has had substantial fiscal effect, at least in recent budgets. Whereas in 2010, BHD's expenditures on community-based services were only 44% of its expenditures on Mental Health Complex services, that ratio rose to 52% in 2013. In the 2015 budget, with Hilltop closed and Rehab Central projected to close by year end, the ratio of community-based to Mental Health Complex expenditures rises to 73%.

Figure 1: Adult Mental Health Expenditures, 2010-2013 Actual and 2014 and 2015 Budget (in millions)

Source: Data for this and all following tables were provided by BHD.

When we consider the expenditure of discretionary County resources (i.e. property tax levy and Base Community Aids), as opposed to total expenditures, a different picture emerges. In **Figure 2**, we see that despite a decline in Mental Health Complex patient censuses since 2010, the amount of levy/BCA required to support Mental Health Complex services remained stubbornly close to $50 million until the 2015 budget.

Figure 2: Adult Mental Health Property Tax Levy/BCA Expenditures, 2010-2013 Actual and 2014-2015 Budget (in millions)



Figures 1 and **2** raise several questions, including:

- Why have total expenses for Mental Health Complex services not declined more given the closure of long-term care facilities and overall declines in patient census?
- Why has the property tax levy required to support Mental Health Complex services declined by only 15% even though the patient census has decreased by a much larger margin?
- Are there actions BHD can take in the future to realize greater savings from Mental Health Complex downsizing that can support increased investment in community-based services?

This analysis attempts to answer these questions and provide a better understanding of BHD finances as the redesign process continues.

Inpatient, Long-term Care, and Emergency Services – Fiscal Trends

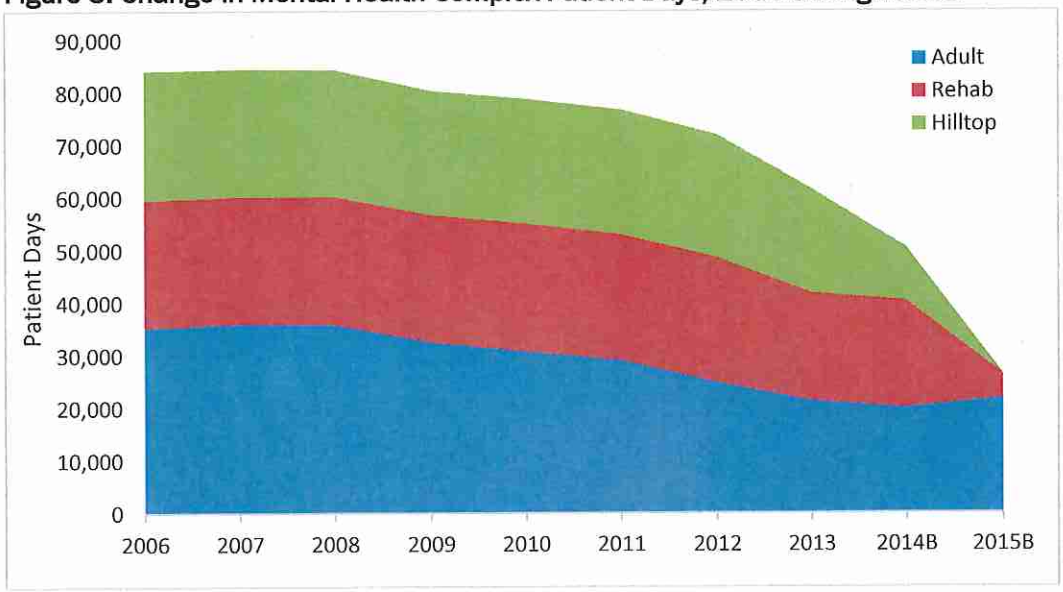
The starting point for our exploration of how downsizing has affected BHD's budget is an analysis of the budgetary changes between 2010 and 2013, the most recent year of actual budget data. (The 2014 and 2015 budgets are reviewed in a subsequent chapter and are incorporated into the projections of 2017 expenditure and levy.) Between 2010 and 2013, BHD substantially reduced its bed capacity at the Mental Health Complex. By teasing out the fiscal changes during that time period, we can begin to understand some of the dynamics of BHD's budget that may explain why greater savings have not been realized from those reductions.

Change in Mental Health Complex Patient Census by Service Area

Figure 3 illustrates how dramatically bed capacity at the Mental Health Complex has been transformed since 2006. With the projected closure of both Hilltop and Rehab Central by the end of 2015, the number of patient days – which is defined as the number of days a bed in any of the three inpatient areas is occupied – will have declined from more than 84,000 in 2006 to an estimated 26,413.

> BHD accomplished a substantial reduction in inpatient and long-term care bed capacity between 2010 and 2013 and plans to reduce Mental Health Complex bed capacity even more by the end of 2015, when both long-term care facilities are scheduled to be closed. At the same time, BHD has seen a decline in PCS admissions.

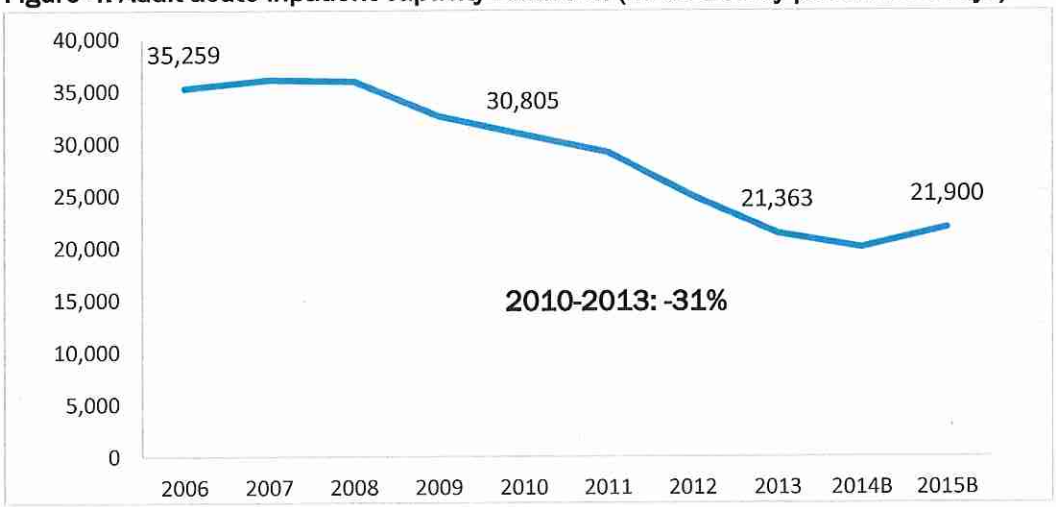
Figure 3: Change in Mental Health Complex Patient Days, 2006 through 2015



In **Figure 4**, we see that adult acute inpatient bed days declined by 31% from 2010 through 2013. This reflects a reduction in the number of licensed beds from 96 prior to 2010 (four 24-bed acute treatment units) to 66 in 2013 (one 24-bed women's treatment unit, one 18-bed intensive treatment unit, and one 24-bed acute treatment unit). The 2015 budget assumes a capacity of 60 inpatient beds.

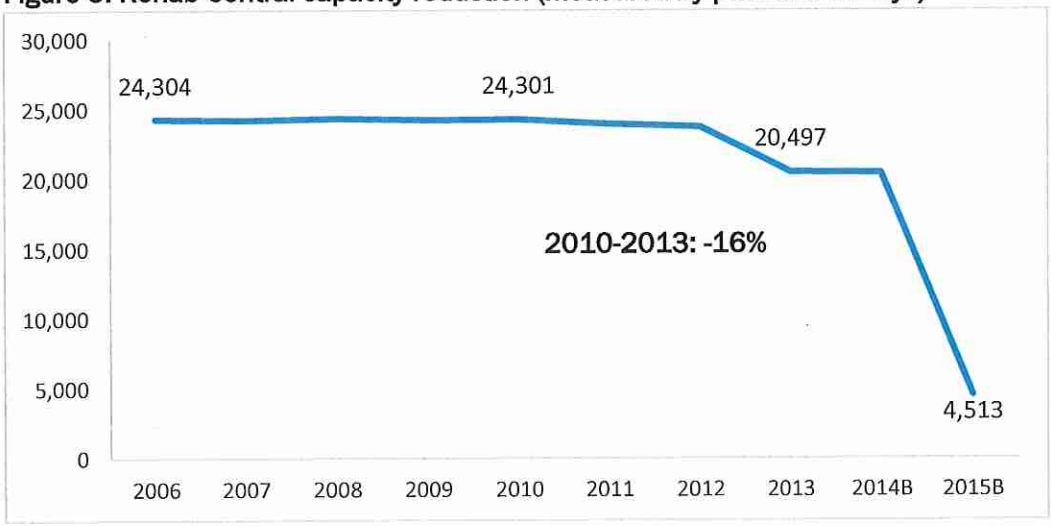
These inpatient bed reductions have been accomplished – in large measure – by a cooperative effort between BHD and private health systems to create agreements that stipulate conditions under which private hospitals with inpatient mental health capacity will accept transfers of patients from BHD. Those transfers generally have been limited to patients who have insurance coverage and who have relatively low levels of acuity. The confidence of private hospitals in being able to secure a safe and appropriate setting for a patient upon discharge from an inpatient unit also impacts their willingness to accept transfers from BHD.

Figure 4: Adult acute inpatient capacity reduction (measured by patient bed days)



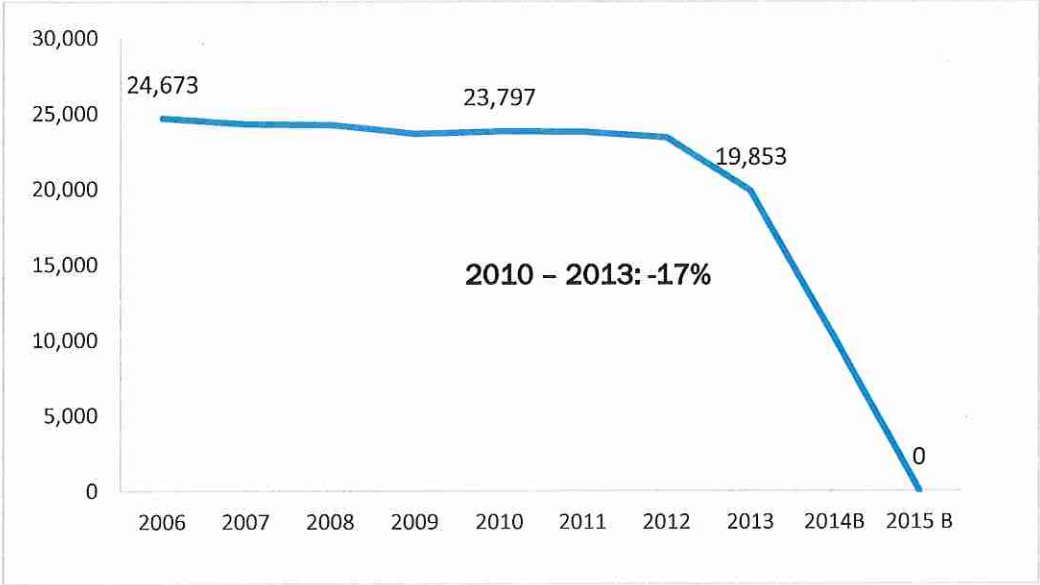
Rehabilitation Center–Central ("Rehab Central") is BHD's long-term care facility for individuals with complex physical, mental, and behavioral needs. Adjudicated patients, or patients referred by the court system due to criminal convictions, also are housed at Rehab Central. As shown in **Figure 5**, Rehab Central experienced a 16% reduction in patient days between 2010 and 2013, with most of that reduction occurring in 2013 as BHD moved several individuals into community placements in preparation for plans to close one of the facility's three 24-bed units by July 1, 2014 (an initiative that was successfully completed). BHD plans to continue the transfer of patients throughout 2015 with a goal of closing the facility completely by the end of the year.

Figure 5: Rehab Central capacity reduction (measured by patient bed days)



The Center for Independence and Development (also known as "Rehabilitation Center-Hilltop") provided a long-term care setting for individuals with co-occurring mental illness and intellectual disabilities. In April 2011, BHD notified the State of Wisconsin of its intention to begin a voluntary downsizing from 72 to 48 beds. That initiative is reflected in **Figure 6**, which shows a 17% reduction in patient bed days between 2010 and 2013. In February 2013, BHD announced plans to close the facility entirely, and that closure took place in January 2015.

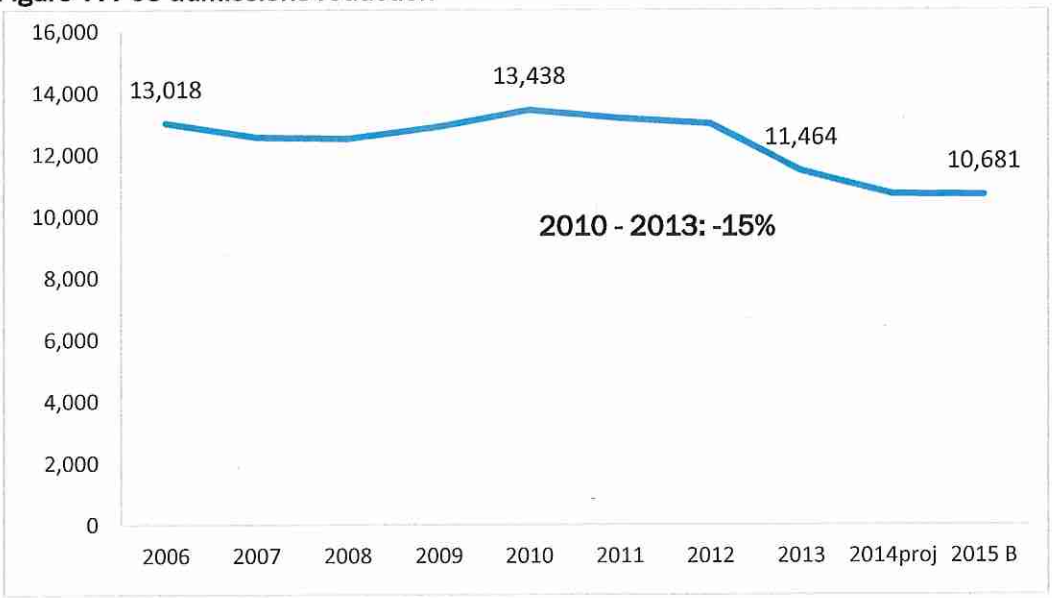
Figure 6: Hilltop capacity reduction (measured by patient bed days)



The other major hospital-related function performed by BHD at the Mental Health Complex is the operation of Milwaukee County's only psychiatric hospital emergency room, which serves both the general public and individuals brought in under "emergency detention (ED)" proceedings by law enforcement. Referred to as the Psychiatric Crisis Service (PCS), the emergency room operation provides 24/7 psychiatric emergency services including assessment, crisis intervention, and medications. PCS also maintains more than a dozen observation beds that are used for client observation for up to 48 hours as needed.

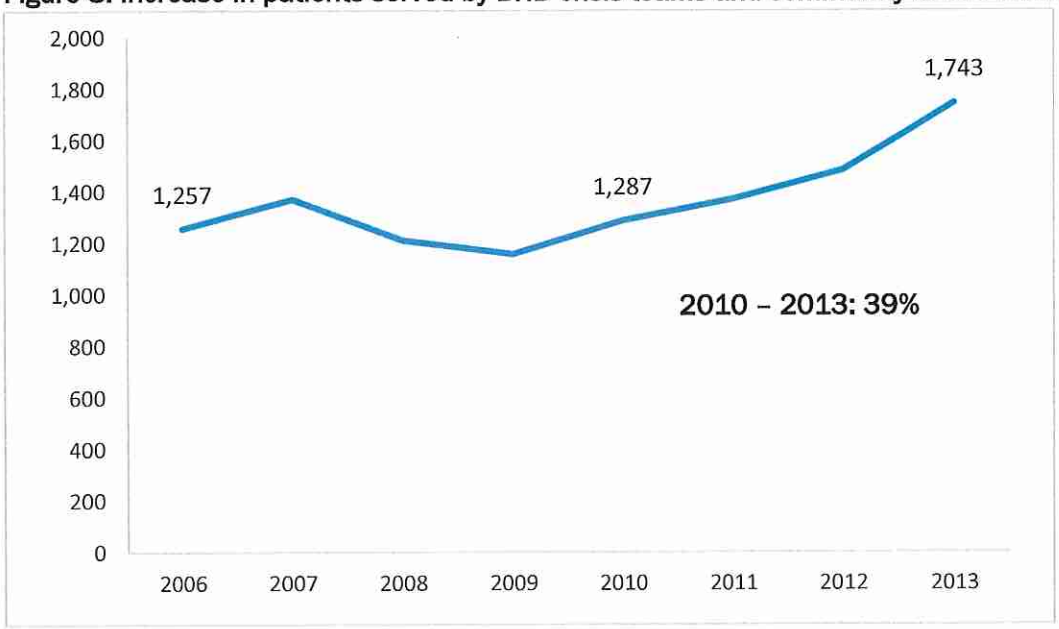
While PCS generally is not included in BHD's downsizing planning, BHD administrators have undertaken a number of initiatives in recent years to establish greater crisis capacity in the community and to diminish the use of PCS as the "front door" for the mental health system. As shown in **Figure 7**, PCS admissions declined by 15% from 2010 to 2013.

Figure 7: PCS admissions reduction



One of the central strategies used by BHD to reduce PCS admissions has been an expansion of its mobile treatment unit, which is designed to stabilize individuals experiencing mental health crisis in general hospital emergency rooms or other settings so as to potentially avoid a transfer or visit to PCS. In addition, BHD has made use of an increased number of crisis respite beds, which are beds purchased from community-based providers that similarly can be used to stabilize individuals and preclude a visit to PCS. **Figure 8** shows that nearly 1,800 patients were served by BHD crisis teams and crisis respite beds in 2013, an increase of 39% from 2010.

Figure 8: Increase in patients served by BHD crisis teams and community-based crisis respite beds



Expenditure Trends

Based on the decline in patient census in all four Mental Health Complex service areas from 2010 through 2013, we would expect to see sizable decreases in total BHD expenditures for those services. Somewhat surprisingly, as shown earlier in **Figure 1**, total expenditures in those service areas decreased by only 4%, from $74.5 million to $71.4 million.

> While direct expenditures at the Mental Health Complex decreased during the past four years as would have been expected given the decline in the patient census, indirect costs unexpectedly increased. To some degree, this is attributable to factors that are beyond BHD's control, such as the central budget office's determination of BHD's legacy costs, facility expenses, and charges from other departments. BHD did realize savings in direct costs, but those are largely attributable to reductions in active fringe benefit expenses, and not to reductions in overall staffing levels. BHD also experienced savings in hospital support and drug expenses that are linked to reduced patient volumes.

To understand why expenditure decreases did not mirror the decline in patient census, we realigned BHD's Mental Health Complex expenditures into "direct" and "indirect" expenditure categories. (See box for further explanation of direct and indirect expenditures). As shown in **Figure 9**, between 2010 and 2013, direct expenditures decreased by about $5.5 million, or 11.5%, presumably as a result of reduced patient census. Indirect expenses, on the other hand, increased by about $2.5 million, or 9.3%.

A Note on Budget Methodology

Our analysis separates costs into direct and indirect categories. Direct costs are those that would be expected to change with patient census. Broadly speaking, indirect costs are overhead expenses that might be less sensitive to changes in the number of patients seen at BHD.

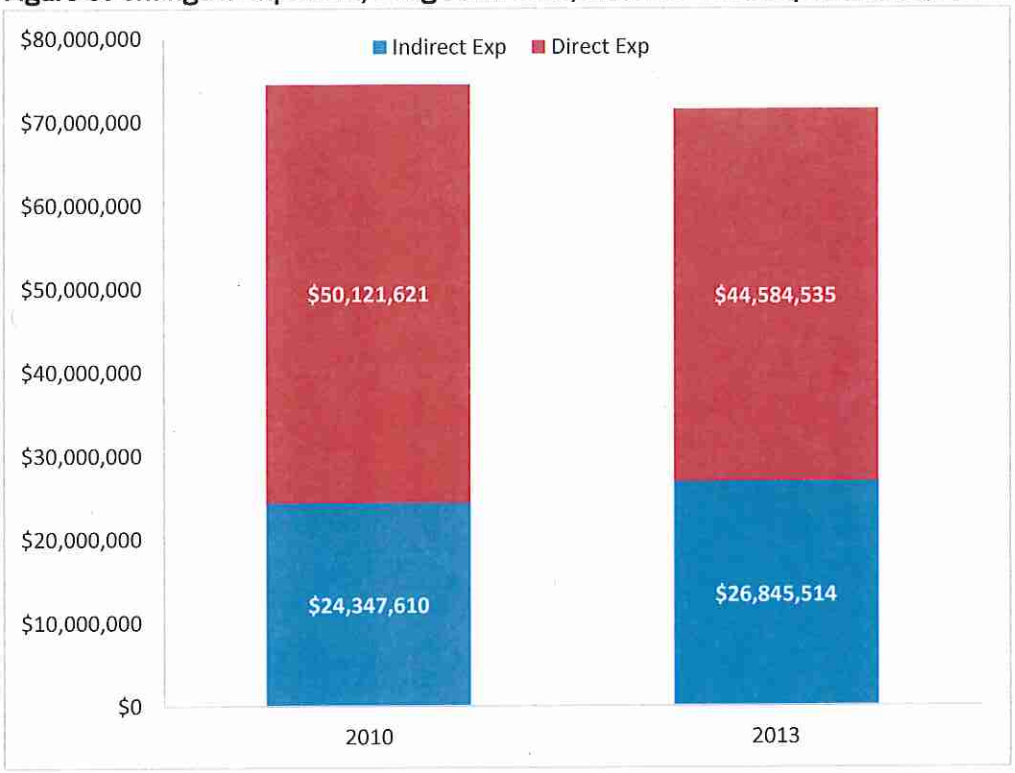
Direct expenses include the cost of doctors, nurses and other clinical personnel involved in direct patient care, as well as the cost of prescription drugs and other "commodities," and contractual services that directly support hospital operations. BHD organizes these costs into separate service areas for each facility: PCS, Adult Inpatient, Hilltop, and Rehab Central.

Our analysis makes a few adjustments to these direct budgets: 1) legacy expenses are removed and are instead considered as indirect costs; and 2) hospital support expenses (which BHD budgets within the indirect cost category of Operations), such as security, housekeeping, linen, dietary, storeroom, and support services administration, are added to direct costs. Additional adjustments are made to the PCS budget to remove expenditures related to the Access Clinic, Mobile Treatment Team, and community-based crisis service contracts and add those expenditures instead to the community-based services category. Observation beds in PCS are included in the analysis.

BHD budgets indirect costs in three basic services areas: Management, Operations, and Fiscal. These budget units include expenses relating to fiscal, human resources, information technology, facilities, and other overhead functions. They also include a variety of charges from other County departments (referred to as "crosscharges") that are applied to BHD's budget by the central budget office.

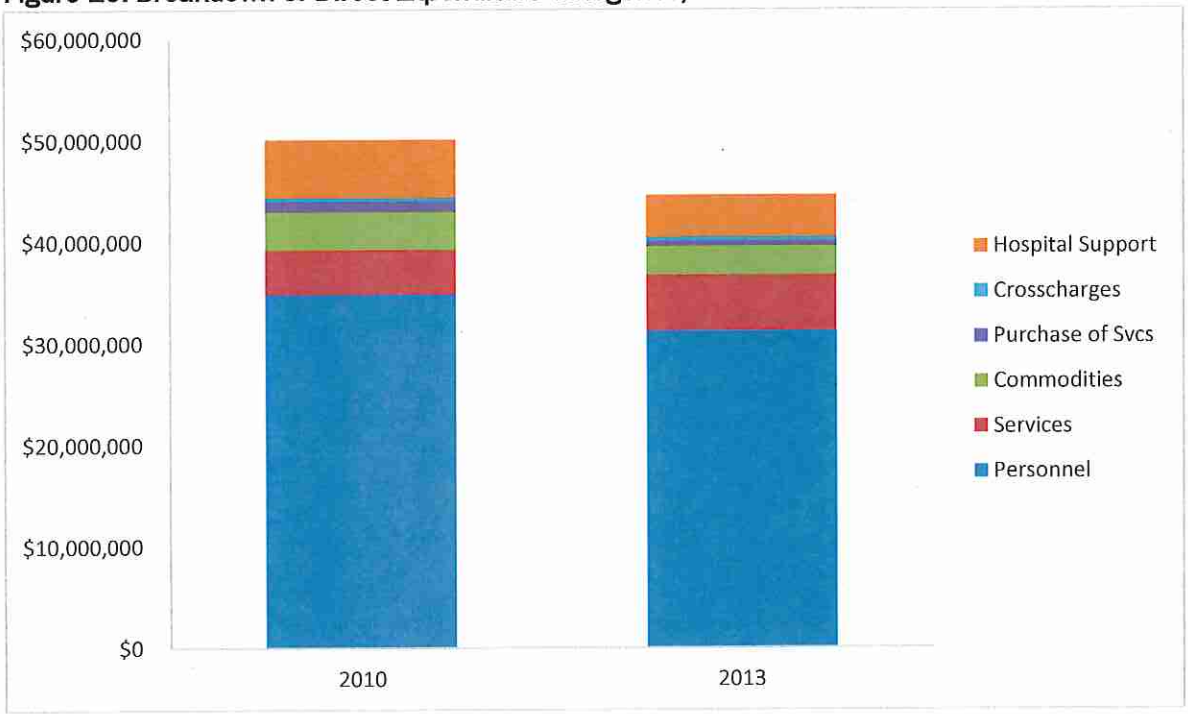
In addition to stripping out hospital support and adding it to the direct cost category, this analysis also reorganizes indirect costs into different categories that are more informative to the overall analysis: General Administration, Hospital Administration, and Facilities. **Appendix A** shows the "crosswalk" of budget units from the BHD budgeted area to the cost categories used throughout this analysis.

Figure 9: Change in Inpatient, Long-Term Care, and PCS Total Expenditures, 2010-2013



In **Figures 10** and **11**, we compare the different categories of direct and indirect expenditures for 2010 and 2013. This detailed breakdown provides additional insight into why the substantial reduction in patient capacity at BHD did not produce an even larger reduction in expenditures.

Figure 10: Breakdown of Direct Expenditure Categories, 2010 and 2013



With regard to direct expenditures, personnel costs – which are the largest category of direct expenditure – declined by about $3.6 million. Personnel costs include direct compensation such as salary, overtime, premium and other types of pay, as well as health care and pension expenses for active employees, social security, and assorted other benefits. Interestingly, as shown in **Table 1**, the expenditure decrease is not linked as much to a decline in the number of full-time equivalent employees (FTEs) – which decreased by about seven positions during the period – as to reductions in fringe benefit costs for active employees, which resulted from health care savings experienced countywide. Other direct expenditure categories that decreased included commodities (primarily drug costs) and hospital support services.

Table 1: Actual FTEs, 2010 and 2013[3]

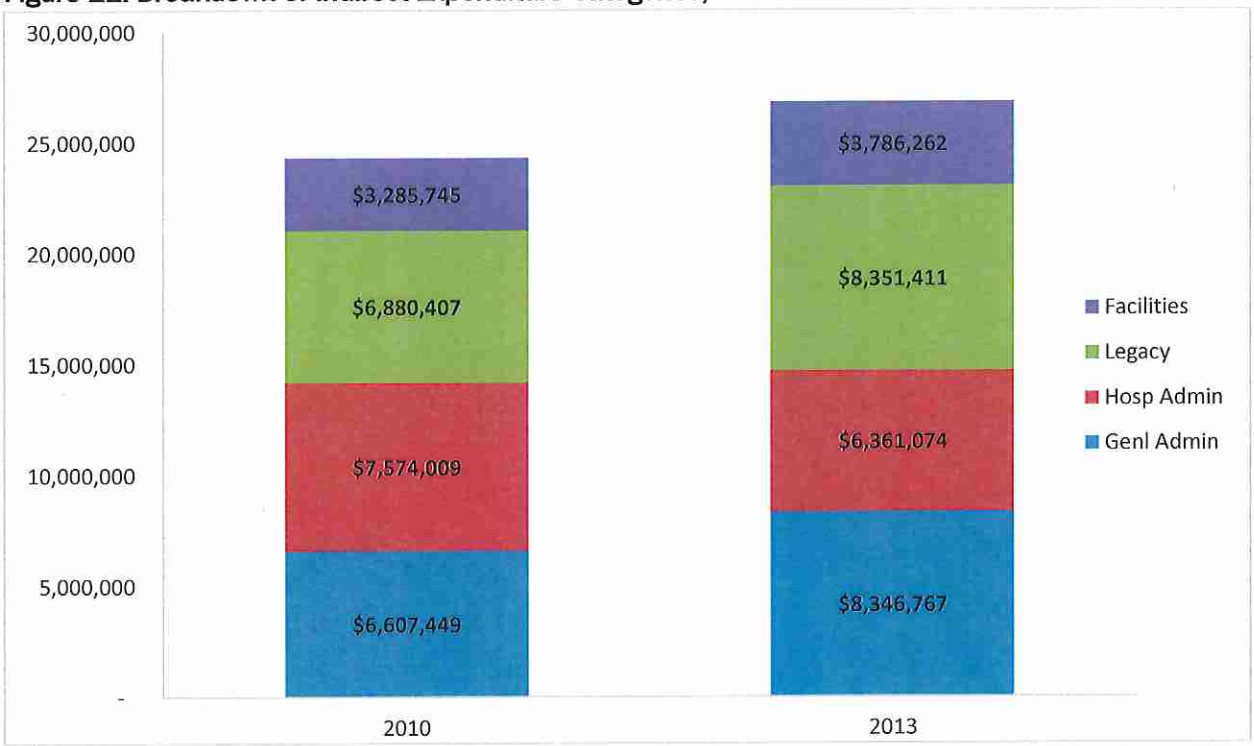
	2010	2013
Adult Inpatient	190.09	171.60
Rehab Central	82.32	89.84
Hilltop	97.60	86.96
PCS	58.87	73.65
Total	**428.88**	**422.05**

The savings in direct costs between 2010 and 2013 would have been considerably larger if not for an increase of about 15 FTEs in PCS over this period. It is unclear why PCS saw an increase in staffing during a period when admissions declined. One explanation may be linked to data limitations. BHD managers often shift personnel between service areas, and some psychologists and psychiatrists are shared between PCS and other Mental Health Complex services. This dynamic may not be accurately portrayed in BHD's assignment of personnel and costs for budgetary purposes, making it difficult to reliably compare FTEs between service areas. Another explanation may be that staffing levels in 2010 were deemed insufficient, and BHD used the opportunity of adult inpatient and long-term care downsizing to transfer staff from those areas to fill perceived gaps at PCS.

It is also important to note that BHD administrators report the number of patients who require "one-to-one" supervision has increased, limiting their ability to reduce staffing. The physical layout of inpatient wards also presents challenges to reducing staffing. With the reduction in census, more patients can be accommodated in single rooms, so staff is still required to supervise the same amount of space.

[3] Actual FTEs reflect actual expenditures for salaries and overtime (divided by 1.5) and do not necessarily correspond to budgeted FTE. Also, the FTEs for PCS in **Table 1** reflect only the ER and Observation unit.

Figure 11: Breakdown of Indirect Expenditure Categories, 2010 and 2013



With regard to indirect expenditures, we see that hospital administration costs declined while General Administration, Legacy, and Facilities experienced substantial cost increases. The following provides additional details on those three cost categories.

- **General administration** expenditures charged to Mental Health Complex areas increased by $1.7 million from 2010 to 2013. About two thirds of this cost category is related to BHD administrative staff such as managers, accountants, human resources personnel, and clerical personnel. That portion of general administration overhead actually declined by about $400,000 (1.6%). BHD' ability to reduce expenses in this area even further may have been limited given that the division's administrative needs do not necessarily decline at the same pace as its patient capacity (e.g. a budget still needs to be monitored and produced every year regardless of whether the patient census has declined). In addition, BHD faced substantial pressure during this period to undertake corrective actions and other responses to federal and state audits, which required it to develop new quality control and tracking measures.

  About 31% of the general administration category is comprised of County crosscharges, which reflect charges from other County departments over which BHD has little control, and which increased by about $2 million during the time period.[4] Those charges include direct charges from departments like the Corporation Counsel for representation of persons in commitment proceedings. The largest single crosscharge is for the Central Services Allocation ($1.3 million in

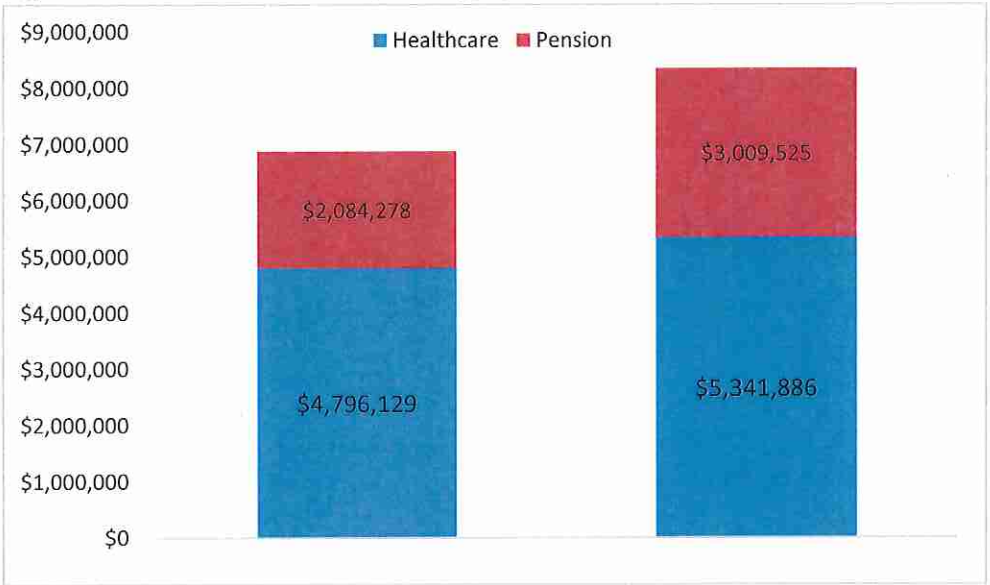
[4] As will be discussed later in this report, while crosscharge amounts are determined by the central budget office, BHD does have some control over how they affect the Mental Health Complex because it elects how to allocate such costs among each of its own service areas.

2013). This charge helps to ensure that users of centralized County services in areas like Audit, Central Accounting, Human Resources, and Payroll pay for the costs of those services.

- **Legacy costs** are one of the primary components of indirect costs. In 2013, they accounted for almost one third of indirect costs, and they increased by $1.5 million between 2010 and 2013. Legacy costs reflect BHD's share of overall County pension and retiree health care costs, which is determined by a formula developed by the central budget office that is largely based on the division's share of the County workforce. Legacy expenses are impacted by general health care inflation in southeast Wisconsin and the performance of the County's pension fund investments.

  It is also worth noting that most of BHD's legacy costs are allocated to the Mental Health Complex service areas, as those areas employ the greatest number of personnel in the division by a wide margin. **Figure 12** shows the change in legacy costs for the four Mental Health Complex service areas during the period.

Figure 12: Mental Health Complex Legacy Costs, 2010 and 2013[5]



- **Facilities** expenditures charged to Mental Health Complex areas increased by about $500,000 between 2010 and 2013. Because of the physical design of the Complex, reductions in bed capacity do not always translate into a reduced footprint of usable space. For example, rooms that were previously occupied by two patients are now generally used as single rooms. In some cases, units that are no longer in use for patient care have been repurposed as office or storage space. Another important factor in facilities expenses is that BHD was under a state-imposed statement of deficiency regarding its facilities and was required to make additional investment in a variety of facility improvements. About 20% of the division's facilities expenses are crosscharges from the Facilities Maintenance division and other County departments that pay for skilled trades labor.

[5] Legacy expenses shown in **Figure 11** reflect direct expenditure areas only. This figure does not include legacy expense tied to employees in indirect cost centers that are allocated to direct service areas (for example, legacy related to fiscal and general administrative staff) or legacy related to hospital support staff.

The sprawling nature of the Mental Health Complex over 25 acres of land and the aging condition of its basic infrastructure have been cited as fiscal and operational problems for years. As long as BHD programs are located at the Mental Heath Complex, costs associated with maintaining the Complex will represent a significant source of indirect spending that will be difficult to control or reduce in conjunction with service levels.

Revenue Trends

Our examination of Mental Health Complex expenditure levels during the 2010-2013 timeframe provides only partial information about the financial impacts of downsizing initiatives. Equally important is what happened on the revenue side of the ledger, given that a lower patient census would be expected to reduce the amount of reimbursement revenues collected by BHD.

> While BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, the reduced patient census at the Mental Health Complex produced an overall net loss of patient revenue of about $3 million. That loss – combined with a decrease of about $450,000 in other revenue – tracked closely to expenditure reductions. As a result, the County was unable to reduce its allocation of tax levy/BCA to Mental Health Complex services. Thus, a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up resources to invest in community-based services – had not been achieved as of the end of 2013.

Net Patient Revenue

The predominant type of revenue collected by BHD for its inpatient services is "Net Patient Revenue" (NPR). This revenue category consists of revenue collected from the federal Medicaid and Medicare programs, as well as private insurance reimbursement, reimbursement collected directly from patients, and other forms of third party reimbursement. As shown in **Table 2**, BHD collected $20.3 million in NPR in 2013, which was about $3 million (13%) less than it collected in 2010, when it was serving considerably more patients.[6] (A smaller revenue source – referred to as "Other Revenues" – consists primarily of grants. Because it only comprised 2% of total Mental Health Complex revenues of $71.4 million in 2013, that category is not considered in detail here.)

Table 2: Mental Health Complex Patient Revenue, 2010 and 2013

	2010	2013	% Change 2010-2013
Net Patient Revenue	$22,984,207	$20,030,204	-13%
Other Revenue	$2,003,971	$1,558,703	-22%

Figures 13 and **14** break down the different types of NPR in 2010 and 2013. The majority of BHD clients are enrolled in Medicaid (T-19), which generally covers low-income individuals with limited assets, or Medicare (T-18), which generally covers individuals age 65 and over.

BHD's revenue "pie" distinguishes between two types of Medicaid reimbursement: "Straight T-19" and "T-19 HMO." In Wisconsin, nearly two thirds of all Medicaid enrollees are enrolled in plans managed by Health Maintenance Organizations, or HMOs. "T-19 HMO" revenue is related to services

[6] This includes revenue from the Wisconsin Medicaid Cost Reporting (WIMCR) program, which provides reimbursement to counties for patient services that they are unable to claim from Medicaid themselves because of state Medicaid policies.

provided to those Medicaid managed care recipients. "Straight T-19" revenue is received directly from the state Medicaid program to reimburse BHD for care to those patients who are not enrolled in managed care.

Figure 13: Net Patient Revenue by Payer Source, 2010

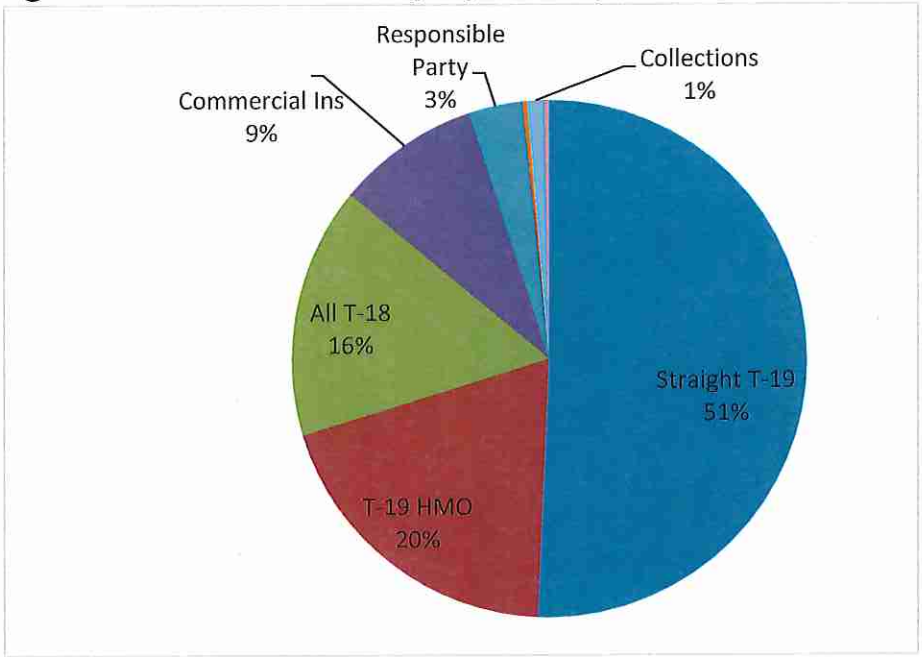
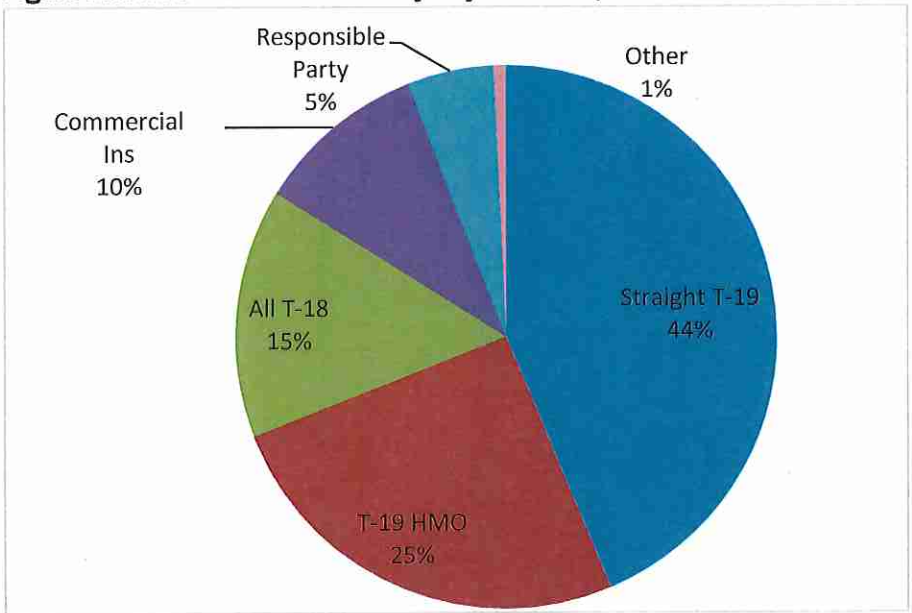


Figure 14: Net Patient Revenue by Payer Source, 2013[7]



[7] **Figures 13** and **14** depict cash receipts during each year, which may not correspond to dates of service. Also, while most of the revenues shown above are related to care provided at the Mental Health Complex, also included are smaller amounts related to outpatient, case management, and other community-based services. The data in **Figures 13** and **14** do not include WIMCR payments.

Most straight T-19 Medicaid reimbursement received for BHD inpatient services is based on a per diem rate that is negotiated with the state annually and that takes into account both direct and indirect expenses. The Medicaid per diem rate covers some, but not all, BHD costs. Medicaid also reimburses for professional services fees, which are fees charged for procedures or specific treatments.

Taken together, Medicaid and Medicare represent 85% of BHD patient revenue. Consequently, it is important to note some of the limitations associated with these revenue sources, such as:

- Reimbursement for professional services under straight T-19 is much lower than the per diem rate relative to costs covered.
- BHD does not receive a per diem reimbursement for inpatient services provided to individuals between the ages of 18 and 64 who are on straight T-19 because the Mental Health Complex is classified by the Federal government as an "Institute of Mental Disease" (IMD).[8] Federal law excludes IMDs from receiving reimbursement for those patients through straight T-19.
- Medicaid HMOs pay per diem rates for their clients between the ages of 18 and 64 who arrive at the Complex via an emergency detention. The HMOs will not reimburse BHD for care related to voluntary inpatient admissions for such clients.
- Medicare coverage has a lifetime limit on inpatient days which can limit reimbursement.
- BHD's management of issues such as eligibility determination, claiming, tracking, and collecting revenues can affect the amount of revenue that is collected.

It is also important to note that in 2013, 12.5% of patients in acute adult inpatient units had no insurance, and the entire cost of providing their care was assumed by BHD. Going forward, the percentage of uninsured patients – as well as the percentages of patients enrolled in Medicaid HMOs and straight T-19 – likely will change as a result of implementation of the Affordable Care Act.

Figures 13 and **14** show that there has been noticeable growth in BHD's T-19 HMO revenue, and a corresponding decline in revenue from patients with Straight T-19. As a percentage of NPR, T-19 HMO revenue has grown from 20% in 2010 to 25% in 2013. This shift is good news for BHD given the reimbursement limitations associated with straight T-19. The figures also indicate that the percentage of NPR collected from commercial insurance did not decline during the period (and actually increased slightly), which also is good news in light of concerns that the Complex's "payer mix" would be negatively impacted by its efforts to transfer more patients with commercial insurance to private hospitals for care.

Overall, while total NPR declined between 2010 and 2013 (due to the declining patient census), **Table 3** shows that on a per patient (or patient day) basis, reimbursement rates increased between 2010 and 2013 for most service areas.[9] BHD has made it a priority in recent years to maximize NPR, most notably through the implementation of electronic medical records and new claims processing procedures. In addition, BHD has emphasized enrolling as many uninsured patients as possible in Medicaid, and steering those patients to Medicaid managed care, which is not affected

[8]An IMD is any institution with more than 16 beds that is primarily engaged in mental health care.
[9] Net Patient Revenue/patient day is calculated by dividing total net patient revenue (including WIMCR) by patient days for Adult Inpatient, Rehab Central and Hilltop. The calculation for PCS divides Net Patient Revenue by ER admissions.

by the IMD exclusion. Rehab Central is the one area where revenues per patient day have declined. This is due to a reduction in Medicaid rates during this period.

Table 3: NPR per Patient Day in Four Mental Health Complex Service Areas

	2010	2013	% Change
Adult Inpatient	$319.02	$375.83	18%
PCS	$335.63	$374.79	12%
Central	$133.61	$122.35	-8%
Hilltop	$226.91	$261.77	15%

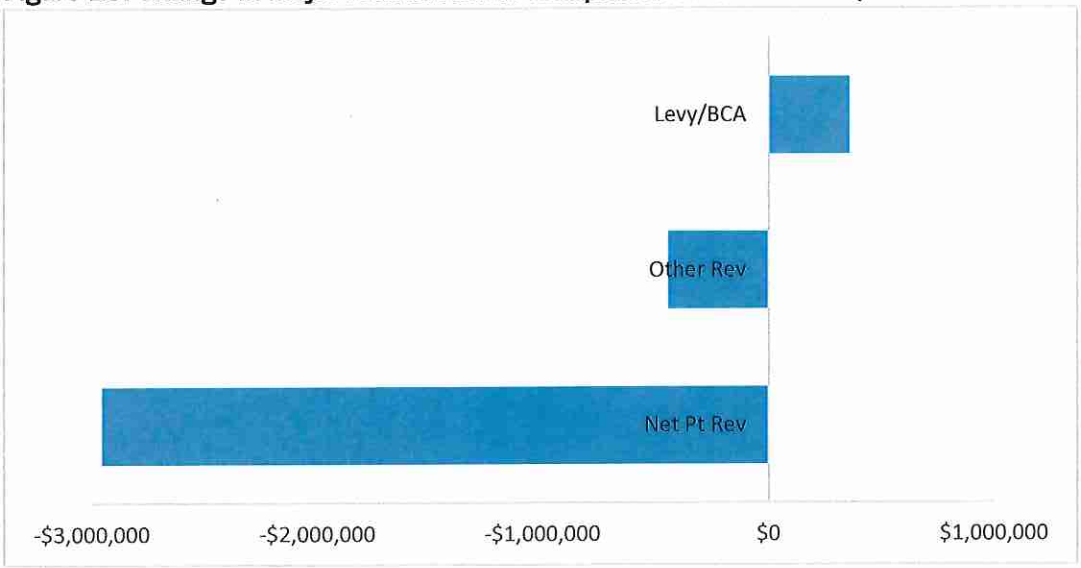
Levy/BCA

As discussed in the introduction to this report, evaluating the fiscal impacts of mental health redesign activities requires looking at both total expenses and local discretionary funds. In addition to property tax levy, in this analysis we include the County's annual Base Community Aids (BCA) allocation from the State of Wisconsin as a source of discretionary revenue. Property tax levy and BCA are used interchangeably by the County to fill the gap between the amount spent to provide mental health services and the revenue that is recovered from patients and other sources.

BCA is a source of general social services funding provided by the State of Wisconsin that can be used at the County's discretion to support a variety of social services, including mental health, substance abuse treatment, disabilities, and delinquency services. In 2015, the County projects that its state BCA allocation will be about $32 million; about $22 million of that amount will be earmarked to BHD, with the remainder allocated to the Department of Health and Human Services (DHHS).

The Forum's March 2013 report found that as BHD had begun to initiate downsizing activities, patient revenues were decreasing faster than expenses, requiring a larger subsidy of property tax levy and BCA. **Figure 15** incorporates actual revenue figures for 2013 and shows that situation has been alleviated somewhat but still remains true. Revenues still are decreasing in line with patient census, but the overall increases in BHD's reimbursement rates (as shown in **Table 3**) have helped limit revenue losses. In 2013, BHD dedicated slightly more levy/BCA (about $360,000) to Mental Health Complex services than it had in 2010.

Figure 15: Change in Major Mental Health Complex Revenue Sources, 2010-2013



Trend Analysis Conclusion

Our analysis of fiscal trends at the Mental Health Complex from 2010 through 2013 indicates that substantial reductions in the patient census in all four service areas yielded only a 5% reduction in overall expenditures and necessitated a slight *increase* in the amount of levy/BCA dedicated to Mental Health Complex activities. We cite several explanations for these findings.

One explanation is that total FTEs at the Mental Health Complex have stayed relatively constant. Expenditure savings in direct costs between 2010 and 2013 instead are attributable to fringe benefit reductions and savings in services and commodities. As noted above, there may be several causes for the relatively constant staffing levels at the Complex despite reduced patient volumes.

Trends in indirect costs also contribute to BHD's challenge in reducing overall expenditures. Many of the indirect charges included in BHD's budget – such as legacy costs and general County overhead – are beyond the control of BHD. It is important to note that from a countywide budgetary perspective, there is logic in the manner in which many of these charges are allocated to BHD. These costs make up part of BHD's Medicaid reimbursement rate and are added to other reimbursement claims to state and federal programs. By including a share of the County's overall overhead costs in BHD's claims to external payer sources, the County can legitimately boost reimbursement for BHD services.

Where logic may be lacking, however, is the expectation that as BHD downsizes it can also absorb a growing load of indirect costs. This analysis has shown that BHD has been able both to reduce direct expenditures (to some extent) and to increase revenues on a per patient basis. While both of those trends have generated levy savings, increases in indirect costs have eaten away at those savings. As a result, property tax levy was not freed up for reinvestment in community services, and the community-based investments that were made were derived from countywide sources.

We did a parallel analysis for each of the service areas individually, which found differing trends with regard to expenditures, revenues, and use of levy/BCA. Detailed descriptions of fiscal trends and

indicators by service area are contained in **Appendix B. Figure 16** summarizes the 2010-2013 changes in levy/BCA by service area.

Figure 16: Change in levy/BCA expenditures in Mental Health Complex service areas, 2010-2013

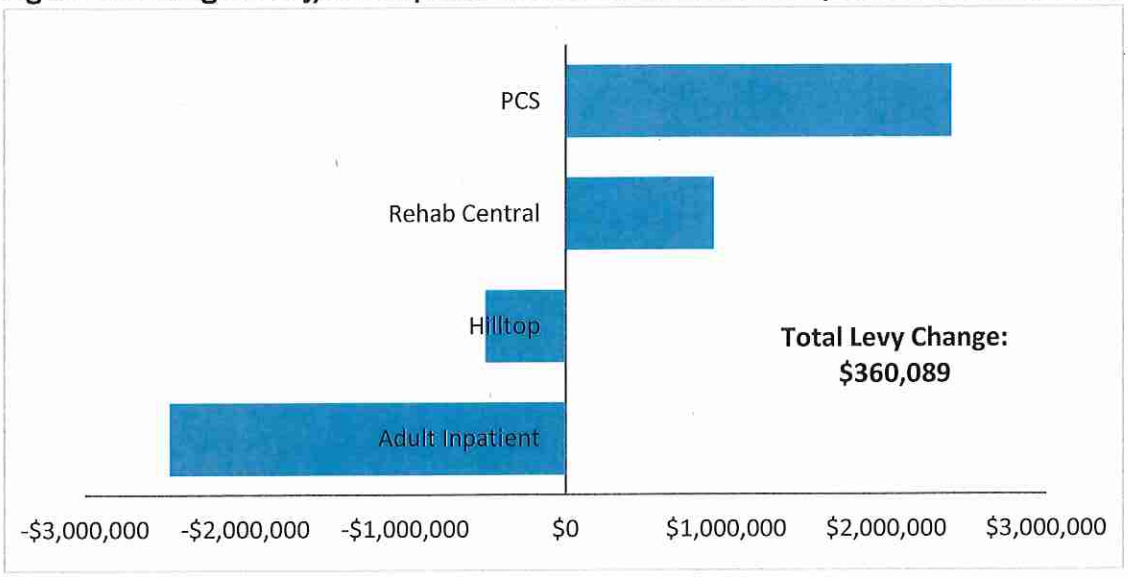


Figure 16 suggests that if costs had been maintained at PCS, or even increased at a rate which corresponded to revenues, overall levy savings at the Mental Health Complex would have been much greater. While there may be very good clinical reasons for increased expenditures at PCS, from a fiscal perspective it appears that some of the savings from downsizing are being redirected to PCS rather than to community-based services.

Community-Based Services – Fiscal Trends

A primary goal of the County's mental health redesign is to increase the availability of community-based services. This objective recognizes the advantages of community-based care from a clinical perspective, as well as the fact that any efforts to downsize hospital-related functions *must* be carefully calibrated with enhanced services in the community to allow for a safe and orderly reduction in bed capacity.

Examination of financial trend data indicates that BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million, or 12%. We also find that because many of the services on the community side are provided by outside vendors, indirect and overhead costs were not a significant factor in the growth in expenditures. Our analysis also shows that BHD's community services as a whole became more dependent on property tax levy/BCA during the period. The levy/BCA allocation increased in total by $6 million, with about $2 million of that amount needed to make up for losses in other types of revenue.

In this section, we examine expenditure and revenue trends for the wide array of County-funded community-based mental health services. For the purposes of this report, the term "community-based service" refers to any mental health program funded by the County other than emergency, inpatient, or long-term care provided at the County's Mental Health Complex. The County contracts for most community-based services with nonprofit social services agencies, but it does provide some types of those services itself.

This analysis, like the previous analysis of Mental Health Complex fiscal trends, focuses on actual expenditures and revenues for the 2010 to 2013 timeframe.

Description of Community-Based Programs

BHD funds a broad array of community-based services ranging from case management to outpatient psychiatric care to community-based crisis respite. The "front door" to many of the County's community mental health services is Service Access to Independent Living (SAIL), a County-funded and County-staffed unit that conducts needs assessments and refers clients to appropriate services.

The following provides a brief description of the major community-based mental health services that are funded and/or provided by BHD. In describing those services, we place them into four categories: treatment, recovery, crisis, and residential.

Treatment Services

- **Outpatient services** are clinic-based services, such as medication management and one-on-one or group therapy. The County contracts with two providers for outpatient services: the Medical College of Wisconsin and Outreach Community Health Centers. In addition, the County runs a drop-in Access Clinic at the Mental Health Complex that is staffed by County personnel. The County Access Clinic is not strictly comparable to the other two outpatient settings in that it provides assessment and referral services, in addition to outpatient treatment. The Access Clinic has been described as an Urgent Care setting for individuals with ongoing mental health

concerns. It serves uninsured indigent individuals, while clients with some form of insurance (including Medicaid) are referred to the contracted outpatient providers.

- **Day Treatment**, also known as partial hospitalization, provides clients a regular daily array of therapeutic services in both group and individual settings. Clients attend treatment for a minimum of five hours each day, over a term of weeks or months. Day Treatment is provided exclusively by County personnel at the Mental Health Complex. We classify it as a community-based service because it could be provided at other community locations and does not require support from a hospital or long-term care setting.

- **Targeted Case Management (TCM)** provides case management to individuals with severe and persistent mental illness. This form of case management does not directly involve licensed clinicians; instead, it offers support and monitoring, and it helps coordinate resources available in the community such as housing, medical, and social services. Medication management can be a major component of TCM as well. In 2010, the County operated its own TCM programming and also outsourced some TCM services to community agencies, but it began outsourcing all TCM services in 2013. Currently, the County uses nine TCM providers.

- **Community Support Program (CSP)** offers more comprehensive case management than TCM that also involves intense clinical treatment. The County staffed two CSPs in 2013 and contracted for additional CSP services with six community providers. The 2015 budget eliminates the remaining County CSPs and contracts for all CSP services.

Recovery Services

- **Community Recovery Services (CRS)** is a mental health benefit created in the 2009-11 state budget that offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients. CRS focuses on assessment, development of an individualized plan of care, and supporting the consumer in their plan of care. Individuals can participate in CRS and other programs such as CSP or TCM at the same time, maximizing their opportunity for recovery and independence. The program began at the start of 2014 with a capacity of 63 clients and was expected to grow to 140 by the end of the year.

- **Comprehensive Community Services (CCS)** is a new Medicaid benefit that, according to the State, seeks to reduce inpatient admissions by strengthening the array of county resources in early intervention and treatment. CCS also is viewed as a "step down" benefit for individuals with mental health needs who are transitioning away from a CSP but require more service intensity than outpatient care. BHD believes this program will address the wide "clinical gap" between CSP and TCM by offering clients access to a flexible array of individualized services that will help them meet their recovery potential. CCS funds a wide array of services, including medication management, psychotherapy, employment training, and life skills training. In its initial implementation, CCS expenses will be fully funded by the federal and state governments. BHD began its CCS program in August 2014, with an anticipated enrollment of 92 clients through December.

- **Community Linkages and Stabilization Program (CLASP)** supports recovery and independence through post-hospitalization extended support and treatment, making use of Certified Peer Specialists who are overseen by a clinical coordinator. In 2013, BHD served 248 individuals in CLASP.

Crisis Services

- **Crisis Resource Center (CRC)** is a 24-hour walk-in resource facility that offers short-term stabilization to people experiencing a psychiatric crisis. BHD contracts for the operation of two such centers in the community. The centers provide clients with a comprehensive crisis stabilization plan and links to community-based resources. They also provide a range of services themselves, including nursing, psychotherapy, group therapy, and peer support.

- The **Mobile Treatment Team (MTT)** responds to behavioral health crises in the community, with the goal of reducing PCS admissions, in particular those involving law enforcement. BHD's MTT is comprised of nurses, emergency service clinicians, and a psychologist, all of whom are County employees. In a review of 2011 data, BHD found that the MTT was able to significantly reduce the need for Emergency Detentions. For example, of 102 referrals from law enforcement, 88% of those EDs were dropped and clients were able to find a voluntary alternative to an ED.[10] According to BHD data, the MTT responded 1,413 times in 2013, an increase of 52% from 2010 levels.

- **Crisis stabilization homes (crisis respite beds**) are provided by contract agencies and serve adults who need additional stabilization following inpatient treatment or observation. Stabilization beds also are used to serve individuals awaiting a residential placement who could benefit from a short-term stay to provide structure and support before the intended placement. These beds also can be used to provide temporary support for individuals who are in crisis and who need respite from their present living environment.

Residential Services

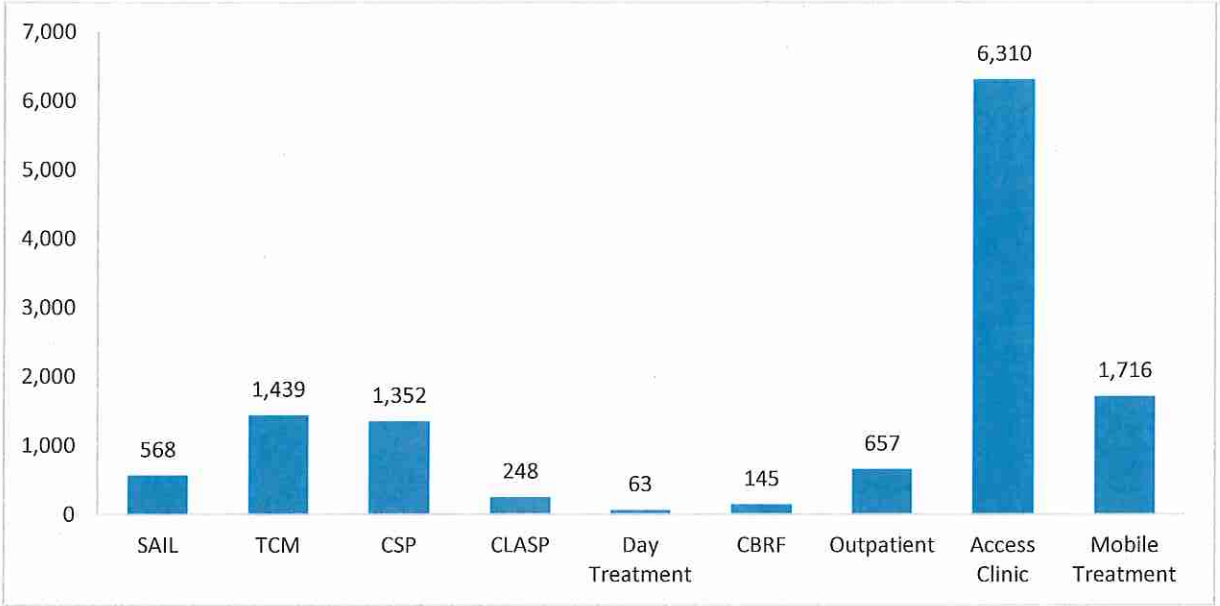
- **Community-Based Residential Facilities (CBRF)** are contracted residential units (typically eight beds) that provide a structured group residential setting for clients with substantial clinical needs. Clients are supervised 24 hours each day, with staff and other members of the client's support network helping in the transition to more independent living. Services include individual counseling, support groups, medication education and monitoring, financial management, and crisis prevention.

- **Adult Family Homes** are four- to six-bed residential units that offer less intensive supervision and support than CBRFs. They are often used by clients transitioning out of a long-term care setting. BHD does not contract for adult family home services, but instead refers clients to such homes from a State directory and reimburses the homes as utilized on a fee-for-service basis. Reimbursement does not involve levy/BCA or other revenue sources discussed in this report, but instead typically involves Community Options Program (COP) funding, which is a form of Medicaid funding available to elderly people and people with long-term disabilities. Because of the specialized use of these residential services, their unique funding arrangement, and BHD's limited and sporadic use of these homes, they are not part of the analysis in this section.

Figure 17 summarizes the number of clients served by BHD community-based treatment and recovery programs in 2013.

[10] Informational Report by DHHS Director Hector Colon dated October 10, 2013.

Figure 17: Number of clients served in major community-based programs, 2013



Note: These are not exclusive categories, in other words the same patient may have been served by two or more programs.

It is important to note that the County's Department of Health and Human Services has a Housing Division that works closely with BHD to provide various forms of housing to individuals who receive services from BHD or who have recently been discharged from the Mental Health Complex. Those include **Pathways to Permanent Housing**, a 27-bed transitional housing program serving individuals who require a lower level of residential care than that provided by a CBRF; **supported apartments** that transition clients to independent living; and various **supportive housing** units that provide independent living in conjunction with on-site case management and peer support.

Because these programs are not included in BHD's budget and are not under the purview of the Mental Health Board, we do not consider them in detail in this report. However, enhancing capacity in these housing programs likely will be critical to achieving broader redesign goals of downsizing inpatient and long-term care services.

Expenditure Trends

Table 4 breaks down the division's expenditures in 2013 by the major program components described above, and also distinguishes between expenditures on County-operated versus contracted community-based services. It should be noted that CRS and CCS are not included in this table, as both programs began enrolling clients in 2014.

Table 4: Community services expenditures, 2013

	Community Provider	County Programs	Total
TCM	$3,623,237	$169,571	$3,792,808
CSP	$3,737,749	$6,114,160	$9,851,909
CLASP	$404,714		$404,714
Outpatient	$2,829,423		$2,829,423
Crisis Services	$2,279,435		$2,279,435
Day Treatment	$0	$2,567,655	$2,567,655
Other	$576,945		$576,945
SAIL – Contracted Services	$1,442,219	$2,248,975	$3,691,194
PCS – Crisis Services, MTT, Access Clinic	$2,484,073	$3,783,978	$6,268,051
CBRF - Vendor Pymts	$4,647,385		$4,647,385
Total	**$22,025,179**	**$14,884,339**	**$36,909,518**

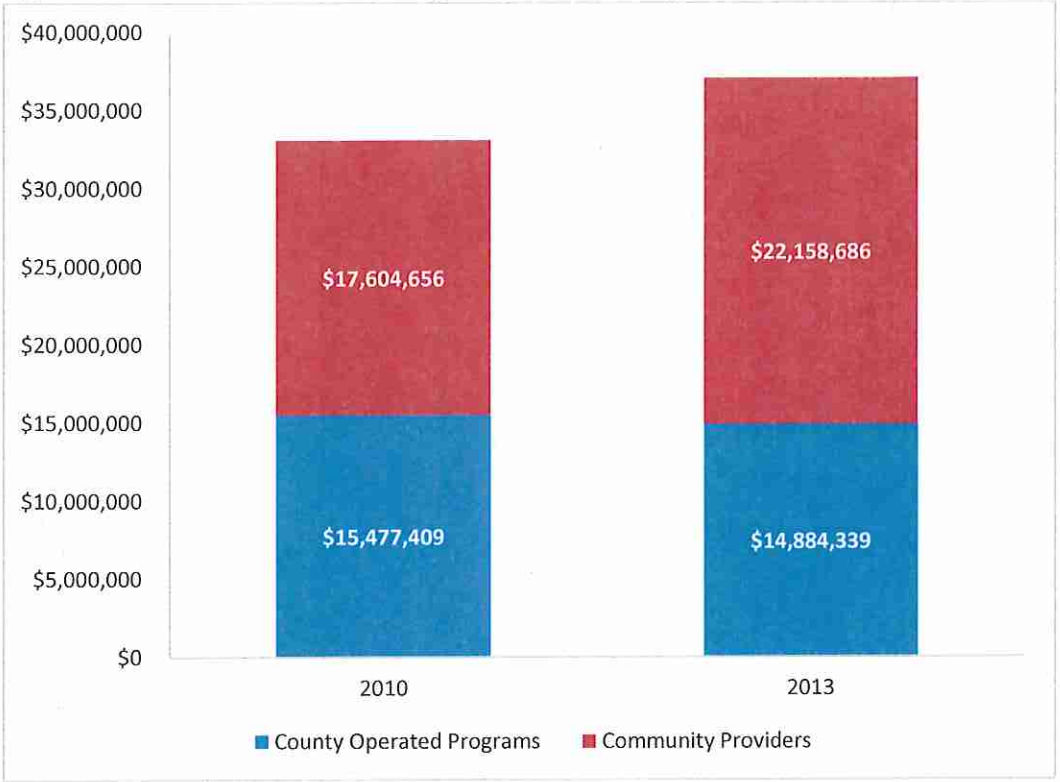
Source: Total purchase of service costs taken from data sent by BHD's budget staff; program costs provided by BHD's Community Services and Reinvestment Division. Due to differences in data sources, expenditures for community-provided services do not add up exactly to the total shown in ***Figure 20****.*

It is important to note that the costs reflected in BHD's budget for contracts with community providers are indicative only of the net expense to the provider. In other words, because the providers submit their own claims to Medicaid and other sources of insurance, BHD's contract cost does not reflect the full cost of services, but only the net cost (or levy/BCA contribution) after Medicaid and insurance reimbursement is taken into account. In addition, in some cases, providers serve more individuals than specified in their contract with the County, and those additional expenditures are not accounted for here.[11]

Notwithstanding that important caveat, **Figure 18** shows that from 2010 to 2013, BHD's budget for mental health community services increased by $3.9 million, with expenses totaling $37 million in 2013. **Figure 18** also shows that expenditures on programs administered by County staff declined during this period, which is largely attributed to the phasing out of County-provided TCM.

[11] Reimbursement for that care, however, is part of the WIMCR claim submitted by the County to Medicaid on an annual basis.

Figure 18: Mental health community-based services expenditures, 2010-2013[12]



Indirect costs, which proved to be a major factor in cost trends of inpatient service areas, are far less significant for community-based services. That is because those costs are applied only to County-operated programs, which made up only one third of total community-based services expenditures in 2013. As a result, indirect costs comprise only about 14% of BHD's community services budget.

Revenue Trends

While the primary source of revenue support for inpatient services is patient revenue, community-based services are financed through a wider variety of revenue sources. In fact, net patient revenue made up less than one tenth of BHD's total community-based services revenue in 2013 and was related solely to CSP and Day Treatment. It is important to recognize, however, that Medicaid and other insurance reimbursement for contracted services do play a larger role in financing community-based services than is reflected in BHD's budget; as discussed above, those forms of reimbursement typically are collected by the vendors and are not shown in BHD's budget.

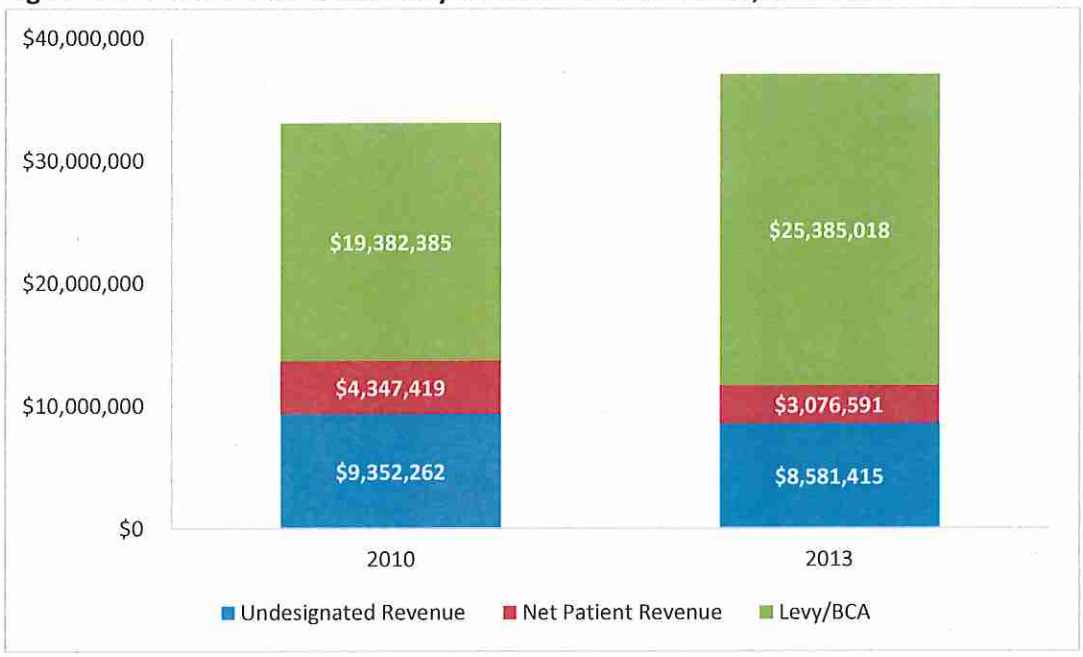
Significantly, undesignated revenues make up about one quarter of revenues in the community-based services budget. Those include State grants such as the Mental Health Block grant and IMD regular relocation revenue, both of which are general sources of State funding for mental health

[12] Expenditures for Community Providers includes all of CBS Administration (6402) and provider payments budgeted in SAIL and in the PCS Budget. County-Operated Programs include County-run CSP, TCM, SAIL, Day Treatment, and estimated expenditures in PCS for the Mobile Treatment Team and Access Clinic.

services that are not tied to specific services or clients. Because undesignated revenues are not connected to a specific expense, BHD has some discretion in how they are budgeted.

Between 2010 and 2013, the proportion of BCA/levy dedicated to community-based services increased, as shown in **Figure 19**. This was caused, in part, by the outsourcing of TCM, which reduced patient revenue. IMD relocation revenue also dropped by $622,000 between 2010 and 2013.

Figure 19: Mental health community-based services revenues, 2010-2013[13]



A key question that cannot be answered by fiscal analysis, but instead must involve evaluation of specific services and service populations, is how much of the increase in new levy/BCA investment funded additional capacity to serve people who had previously been unable to access care, as opposed to enhanced services for individuals already receiving support from BHD. That question is important because a redesigned system of care that relies less heavily on inpatient and emergency services should provide better access to community-based services for individuals who have not already become part of the BHD "system" through hospitalization.

[13] Community-based services total expenditures includes $3.7 million in 2010 and $3.8 million in 2013 related to MTT and Access Clinic. This analysis assumes that these expenditures are entirely funded with levy.

2014 AND 2015 BUDGETS

This section briefly reviews the 2014 and 2015 BHD budgets in the context of the trends described in the previous sections. Analysis of these budgets – which show continued progress in the redesign of the mental health system – also sets the stage for the financial modeling conducted in the next section of this report.

> In BHD's 2014 and 2015 budgets, we see more clearly the effect of recent sharp declines in patient census, as expenditures for Mental Health Complex service areas fall by about $13 million (18%) by 2015 when compared with 2013 actual amounts. We also see a $7 million (14%) decline in the amount of levy/BCA dedicated to the Mental Health Complex. However, reductions in levy/BCA expenditures at the Mental Health Complex still do not come close to the 75% reduction in bed capacity that has occurred since 2010. This demonstrates the financial challenges that policymakers will face in attempting to finance a fully redesigned system, assuming that BHD continues to be a provider of inpatient and emergency services.

It is important to note our analysis is somewhat limited in these sections because *budgeted* amounts can differ substantially from *actual* budgets, particularly with regard to patient expenditures and revenues. Budgeted amounts in those areas represent a "best guess" based on anticipated bed capacity and trends in revenue collections. The *actual* expenditures, posted after the year-end close, reflect changes in patient volume or payer mix, policy changes that are enacted during the budget year, and changes in Medicaid reimbursement that may not have been anticipated in the budget. In addition, certain indirect costs – including legacy – are not finalized until late in the budget year and can differ substantially from budgeted projections.

2014 BUDGET – OVERVIEW

BHD's 2014 budget significantly accelerated inpatient and long-term care downsizing initiatives while also piloting new community-based treatment models and introducing new recovery and rehabilitation benefit programs. The following is a summary of major new or expanded redesign initiatives contained in the 2014 budget:

- **Adult Hospital Programs**
  - Adult Acute Inpatient – A total of 57 acute adult inpatient beds were anticipated (one 21-bed women's treatment unit, one 15-bed intensive treatment unit, and one 21-bed acute treatment unit).[14]
  - Rehab Central – The number of licensed beds were reduced from 72 to 48 (and from three to two units) by July 1, 2014. To accommodate this reduction, $793,000 was invested in community-based services intended to directly serve those discharged from the facility, including 20 additional CSP slots and additional group home and adult family home beds.

[14] The County's 2014 adopted budget narrative describes the 57-bed alignment noted above, but the budget contained sufficient funding for BHD to accommodate 66 beds if deemed necessary.

- Hilltop – Full closure of Hilltop was projected to occur by November 1 and actually occurred early in 2015. Net savings of $759,000 were budgeted for the phased closure, with the full financial impact being recognized in 2015.

- PCS – No major changes.

- **Community-Based Services.** Overall, the 2014 budget cited $4.9 million in new and enhanced community investments, including:

  - An additional $417,000 for existing CSP programs to pilot Assertive Community Treatment (ACT) and Integrated Dual Disorder Treatment (IDDT) models.

  - Funding for a peer-run drop-in center evening and weekend operation.

  - $275,000 for CRS implementation.

  - In the PCS budget, $365,000 was added to increase Mobile Treatment Team staffing and to expand its capacity to 24 hours per day.

  - CCS was projected to begin enrolling participants in July. No County funding was allocated, as the State has agreed to reimburse the County for both the federal and non-federal shares of Medicaid-allowable costs.

While final 2014 fiscal results are not yet available, BHD's most recent projection is for a property tax levy surplus of $9.0 million for the year. Mental Health Complex services tracked closely to budgeted property tax levy amounts. On the community-based services side (which includes AODA and other service not considered in this analysis), expenses were substantially lower than budgeted at $94 million, compared with a budget of $102 million. Revenues also were lower, but to a much lesser extent, generating a levy savings of $4.9 million.

According to fiscal staff, some of the surplus is attributed to changes in billing practices. By bringing billing closer to dates of service, BHD was able to increase collections on a one-time basis for Wraparound and crisis services. BHD also has been able to increase rates of collection for adult inpatient services, which will have an ongoing positive effect.

An additional positive note is that BHD's new status under Wisconsin Act 203 allows it to retain any 2014 surplus in a reserve for use in future years. In prior years, this surplus would have gone to the County General Fund.

2015 Budget – Overview

BHD's 2015 requested budget was the first to be considered by the new Mental Health Board, and the first that was subject to Wisconsin statutory provisions capping the property tax levy amount at $65 million unless agreed to by the Mental Health Board, County Executive, and County Board. The following summarizes major redesign initiatives.

Mental Health Complex Programs

- Adult Acute Inpatient – The budget assumes a total of 60 adult inpatient beds. Higher acuity levels of patients at the Mental Health Complex necessitated an increase of 19 FTEs to implement a new nursing staffing model.

- Rehab Central – Two units at Rehab Central will close in 2015: one by July 1 and the second by November 1. An expenditure reduction of $1.5 million related to closure is offset by a loss of revenue of $1.7 million (the full impact of savings from the closure will be recognized in 2016). Also, to accommodate the closure, $2.3 million is invested in services needed to serve eight high-acuity Rehab Central clients in the community or at State institutions.

- Hilltop – With the closure of Hilltop in 2014, the 2015 budget includes only clean-up expenses and revenues.

- PCS – A new nursing model for PCS adds 11 FTEs (while also eliminating 4.7 FTEs of overtime).

- Overhead –More than 20 FTEs are abolished from indirect organizations during the course of the year. In addition, the budget reflects more than $1 million in savings from reduced dietary, security, housekeeping, maintenance, and utilities savings linked to downsizing.

- **Community-Based Services**

  - The two remaining County-provided CSPs are outsourced in the 2015 budget.

  - CRS is not expanded beyond the 140 participants anticipated in 2014. The service array is enhanced via the addition of two eight-bed CBRFs to house CRS participants. This produces an increased property tax levy cost of $315,000.

  - The 2015 budget reflects full implementation of CCS, serving 245 clients. The budget indicates that some TCM and CSP clients will be transferred to the CCS benefit if clinically appropriate. No additional tax levy is budgeted given the State's ongoing commitment to cover all Medicaid-reimbursable costs with federal and state revenues.

2014 and 2015 Budgets in Context of 2010-2013 Fiscal Trends

The 2014 and 2015 budgets both show accelerating progress toward the goal of redirecting resources from inpatient to community-based services. Indeed, as shown in **Figure 20**, expenditures on community-based services jump by almost $6 million (15%) between 2013 actual spending levels and 2015 budgeted amounts, while Mental Health Complex expenditures fall by nearly $13 million (18%). **Figure 21** focuses on levy/BCA and shows a similar pattern.

Figure 20: Total adult mental health expenditures, 2013 actual through 2015 budgeted (in millions)

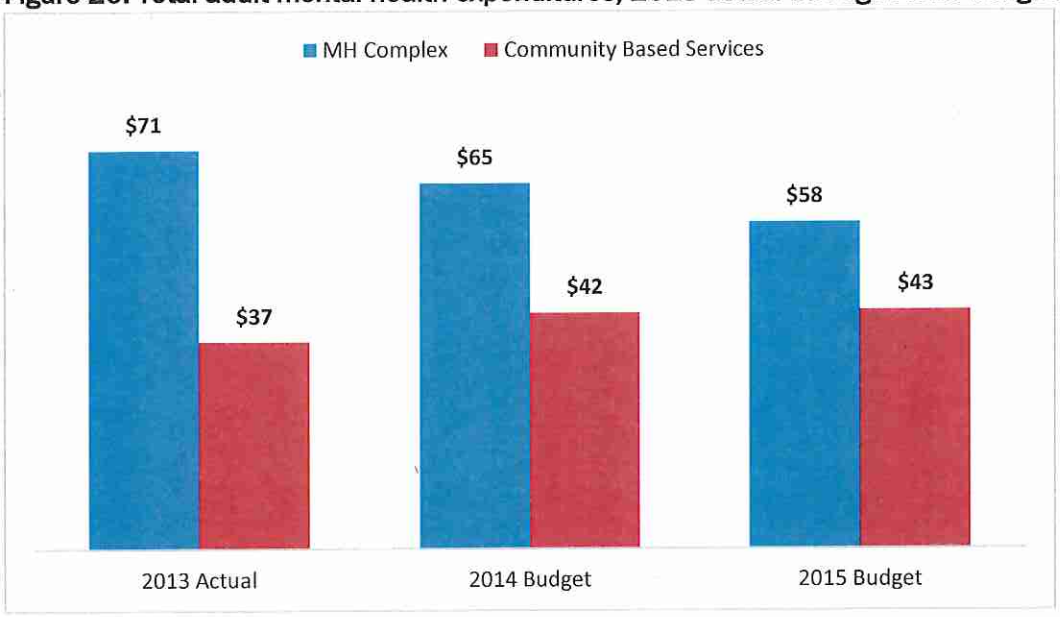
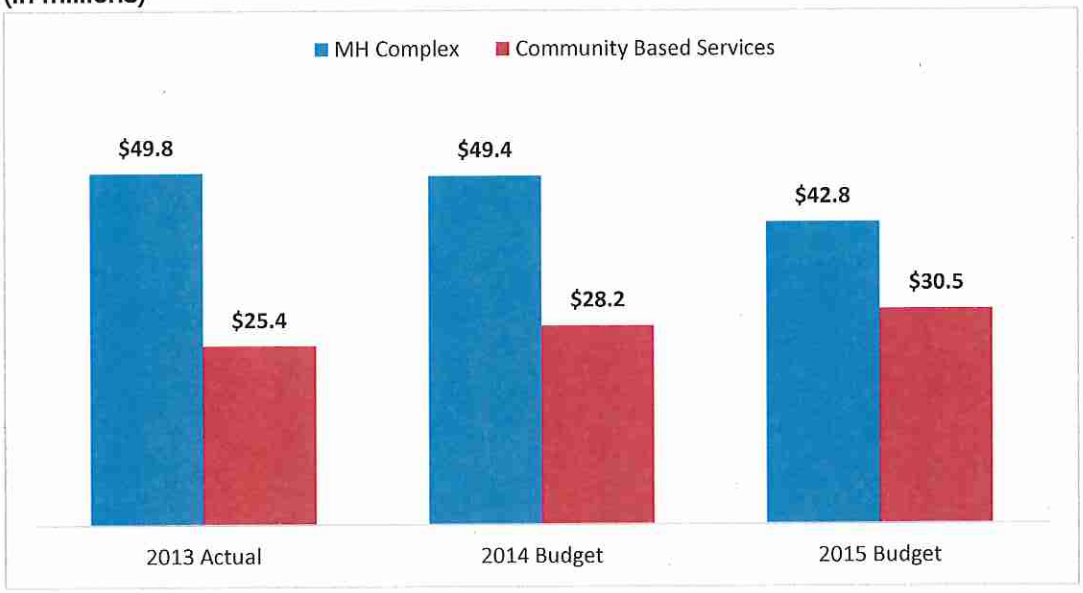


Figure 21: Mental health BCA/property tax levy expenditures, 2013 actual through 2015 budgeted (in millions)



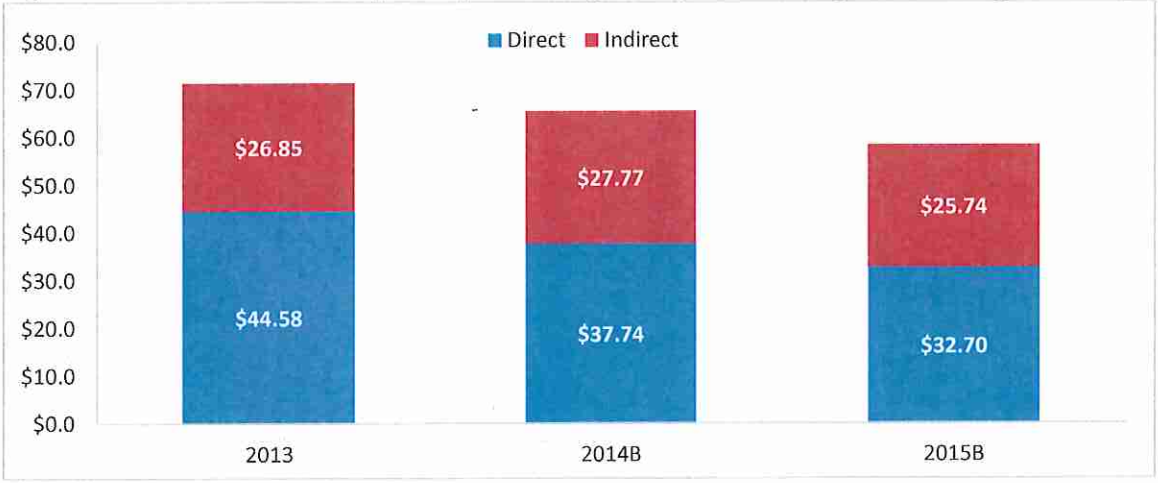
A couple of important caveats are in order regarding these findings, however. First, comparisons between prior year actual expenditure amounts and current or future year budgeted amounts are not always accurate given the volatility of BHD's budget, as noted at the beginning of this section.

In addition, increased expenditures on community-based services do not necessarily reflect an expansion of such services to serve new clients or to enhance the array of available services available to the broad spectrum of existing clients. Instead, those increases may reflect increases in the rates paid to contracted service providers, or the shift of dollars to serve specific individuals in the community who previously were housed at the Mental Health Complex. For example, as noted

above, BHD's 2015 budget contains an additional $2.3 million in community-based services specifically to serve eight former Rehab Central clients in the community. While accomplishing that goal for these eight individuals is consistent with the principles of redesign, the $2.3 million should not be viewed as an enhancement of general community-based mental health services.

With regard to Mental Health Complex expenditures, **Figure 22** shows that direct expenditures continue to fall substantially as Hilltop and Rehab Central are closed. Yet, remarkably, indirect expenditures decline by only 4% despite the vastly reduced census.

Figure 22: Mental Health Complex expenditures, 2013 actual through 2015 budgeted (in millions)



As explained earlier, a significant component of BHD's indirect costs is crosscharges from other County departments. It can be difficult to analyze annual fluctuations in County crosscharges because expenses can shift between cost categories. For example, in the 2015 budget, the Information Management Services Division transferred software contracts from BHD's budget (where they were shown as a direct cost) to its own budget, and then increased its crosscharge to BHD. If we deduct the $900,000 relating to software expenses from total County crosscharges, there is still an increase of about $450,000 in County crosscharges between 2013 and 2015. BHD's charges from Risk Management and the Cost Allocation Plan both increased substantially, although some other charges declined. The portion of indirect costs attributable to BHD's own overhead declined during this time period by a more substantial $2.5 million, or 10%.

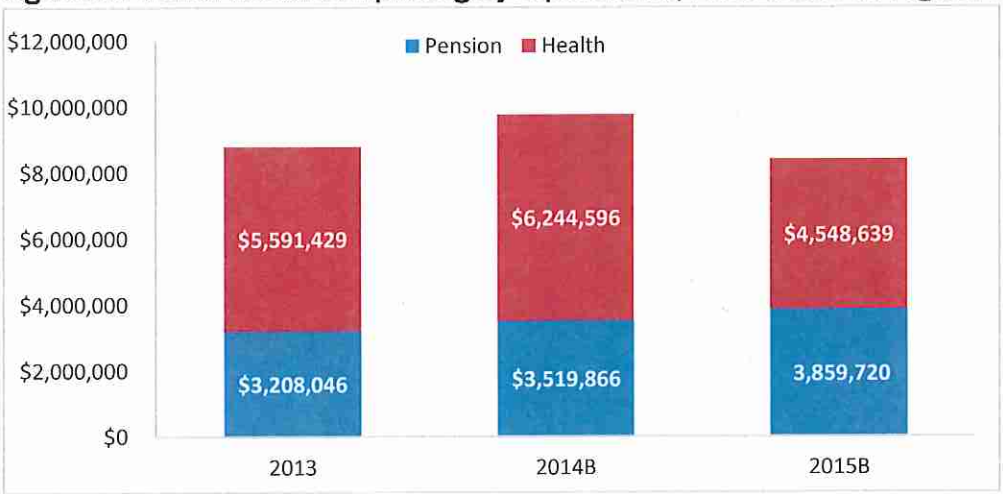
Drilling down further into direct costs, we see in **Table 5** that FTEs decreased by about 27% between 2013 and the 2015 budget. The bulk of those reductions are attributed to the downsizing and eventual closures of Hilltop and Rehab Central. Staffing of adult inpatient units and PCS has increased over the past two budgets.

Table 5: Mental Health Complex FTEs, 2013-2015

	2013 Actual	2014 B	2015 B
Adult Inpatient	171.60	168.64	175.18
Rehab Central	89.84	82.34	51.26
Hilltop	86.96	43.47	0.00
PCS	73.65	75.52	82.21
Total	**422.05**	**369.98**	**308.65**

Finally, with regard to the legacy component of indirect expenditures at the Mental Health Complex, **Figure 23** shows that those expenditures have declined only slightly since 2013, dropping by 4.5% despite the sharp reduction in FTEs. One reason for the consistency of legacy expenses is that the central budget office allocates legacy costs to departments based on a three-year average. Consequently, BHD's projected allocations in 2014 and 2015 lag the declines in FTEs.

Figure 23: Mental Health Complex legacy expenditures, 2013 actual through 2015 budgeted



Financial Modeling: Projection of BHD's 2017 Financial Status

In this section, we report on the results of a financial model that projects BHD's budgetary outlook in 2017 based on three different adult inpatient bed capacity scenarios. We selected 2017 – only two years from now – based on input from BHD officials, who see that as the year in which key community-based enhancements will have fully taken hold and in which BHD might be able to move to a different and potentially much smaller inpatient model.

Some of the variables in our 2017 funding model were relatively easy to determine, such as anticipated salary and fringe benefit increases, which are based on assumptions in the County's five-year projections for County government as a whole. Other variables are more subjective, such as staffing levels for various inpatient bed scenarios and allocation of indirect costs among service areas. For both of those variables, we relied on BHD fiscal and clinical staff to supply us with information to plug into our model. In fact, all major modeling assumptions – if not developed by BHD staff – at least were reviewed by BHD.

Overall, the projections in this section should be recognized as only a general indicator of change over the next two to three years. Its value is as a starting point for consideration of the fiscal impacts associated with different system redesign scenarios, and for deliberation over how fiscal impacts should influence eventual decision-making.

The primary objective of our modeling is first to determine how much local property tax levy may be needed in 2017 to support Mental Health Complex operations under different bed capacity scenarios, and then to compare that amount with 2015 budgeted levy/BCA to determine whether "savings" would be available for reinvestment in community-based services. These are critical questions given both the property tax limitations contained in Wisconsin Act 203, and the fact that additional property tax levy savings achieved through Mental Health Complex downsizing are likely to continue to be required to enhance investment in the community.

To calculate 2017 property tax levy/BCA amounts, we needed to project Mental Health Complex expenditures, and then "net out" projected revenue. Assumptions regarding inpatient staffing levels are a primary component of our expenditure projections. As noted above, because of our lack of clinical knowledge regarding the staffing required to maintain appropriate levels of patient care, we turned to BHD to supply those assumptions. Other important assumptions are that admissions and FTEs at PCS do not change regardless of inpatient bed capacity, and that BHD remains in its current facilities at the Mental Health Complex in Wauwatosa.

Upon determining the projected amounts of property tax levy/BCA required for each bed capacity scenario in 2017 for the two remaining Mental Health Complex service areas (adult inpatient and PCS), we then compare those amounts with 2015 budgeted levy/BCA allocations for the two service areas to come up with a net fiscal impact. However, to estimate the total amount of levy/BCA "savings" available for reinvestment, we also need to take into account the impacts associated with the closure of Rehab Central, which is scheduled to occur at the end of 2015.

BHD's 2015 budget includes $8.2 million of levy/BCA to support the operation of Rehab Central until it closes at year end. After the facility closes, some of that levy/BCA will be needed to directly support Rehab Central clients in community settings. While it is impossible to predict that cost, in consultation with BHD we roughly estimate it to be $3.6 million. When we combine that cost with $400,000 in legacy charges to Rehab Central that will not be fully phased out until 2018, we arrive

at a total estimated levy/BCA savings of $4.2 million in 2017. Consequently, $4.2 million of net Rehab Central "savings" are taken into account in each of our inpatient bed capacity models.

It is important to recognize that while our modeling shows that $4.2 million theoretically will be freed up in future budgets from the closure of Rehab Central, there are several other factors – including the need to reallocate certain Rehab Central costs to other areas of BHD's budget – that also must be taken into account by decision-makers when they determine the amount of resources available for community reinvestment in the 2016 budget.

The Three Models

The financial modeling exercise conducted in this section explores fiscal impacts associated with 60-, 32-, and 16-bed adult inpatient capacity scenarios in 2017. These three scenarios were selected after consultation with BHD officials.

For each of the scenarios, it is assumed that BHD operates the beds at the existing Mental Health Complex in Wauwatosa and that it does so alongside a Psychiatric Crisis Service (PCS) that continues to see the same volume of patients. Each of the scenarios also assumes the closure of the Rehab Central long-term care facility by the end of 2015 (as currently anticipated), leaving adult inpatient and PCS as the only two Mental Health Complex functions serving adults.

The 60-bed scenario represents the "status quo" and is seen as the maximum number of inpatient beds that BHD will continue to operate going forward. Conversely, the 16-bed scenario is seen as the minimum number of beds that BHD would operate without getting out of the inpatient business entirely. The 32-bed scenario is seen as a possible middle ground, though 40- and 48-bed scenarios also could have been explored for that purpose.

The following summarizes each model in terms of beds, FTE requirements, and levy/BCA savings (when compared to the 2015 budget).

Model 1	Model 2	Model 3
60 beds	32 beds	16 beds
385 FTEs	312 FTEs	249 FTEs
$1.2 million savings	$5.0 million savings	$8.8 million savings

Model #1: 60 Acute Adult Inpatient Beds

Model 1 assumes that BHD's adult inpatient bed capacity stays at its current capacity of 60 beds. This is essentially the "status quo" scenario.

Model 1 shows only $1.2 million in net savings for Mental Health Complex services in the 2017 budget, despite the full closure of Rehab Central. This reflects BHD's inability to substantially reduce facilities and internal overhead costs, and its need to accommodate inflationary increases in employee compensation, commodities, and other hospital-related costs. This model shows that if BHD's current bed capacity stays the same, annual cost increases associated with operating those beds and PCS will eliminate the net savings accrued from the closure of Rehab Central within a few years.

Staffing Projection

Direct FTEs, or workers directly involved in patient care in the four adult inpatient areas, have declined since 2010 largely because of reductions in the number of beds and patient days. **Table 6** shows the trend in direct FTEs among the four Mental Health Complex service areas and our projection of direct FTEs in 2017 under a 60-bed scenario. The 267 FTES is a reduction of about 53 positions, or 16%, from the 2015 budget. This reduction is almost entirely attributable to the anticipated closure of Rehab Central by the end of 2015, as well as a slight reduction in hospital support personnel.

Table 6: Model 1 Direct Staffing FTEs

	2010 Actual	2013 Actual	2015 Budget	2017 Projected
Adult Inpatient	190.09	171.60	175.18	175.18
Rehab Central	82.32	89.84	51.26	-
Hilltop	97.60	86.96	0.00	-
PCS	58.87	73.65	82.21	82.21
Hospital Support	19.22	17.37	11.12	9.80
Total Direct	**448.10**	**439.78**	**319.77**	**267.19**

As we have seen in our previous analysis, indirect staffing does not decline at the same rate as direct staffing. In **Table 7**, we show recent trends and a 2017 projection for staffing for indirect cost areas of the Mental Health Complex budget under the 60-bed scenario (e.g. administration, human resources). As with direct FTEs, this staffing projection also was provided directly by BHD. It should be noted that for this calculation, we first had to determine indirect staffing levels for all of BHD, and then project the allocation of indirect staff to the Mental Health Complex functions. Both totals are shown in the table.

Table 7: Model 1 Indirect Staffing FTEs

	2010 Actual	2013 Actual	2015 Budget	2017 Projected
General Admin	52.9	57.3	43.4	40.7
Hospital Admin	66.0	60.1	70.6	62.0
Facilities	19.4	18.1	16.0	14.9
Total	**138.2**	**135.5**	**129.9**	**117.6**
Total Allocated to MH Complex	**100.9**	**94.9**	**92.6**	**78.8**

Expenditure Projection

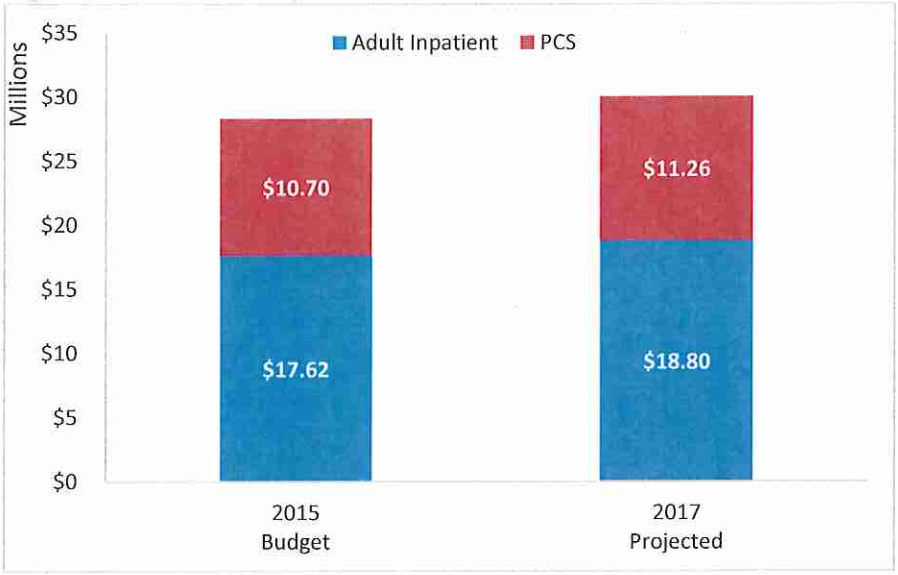
Using the staffing projections outlined above – as well as assumptions contained in the County's five-year modeling regarding countywide salary and fringe benefit cost increases over the next two years – we can estimate 2017 personnel-related expenditures. We also project expenditures for other parts of the Mental Health Complex budget, including contracted services, commodities (e.g. food and prescription drugs), and crosscharges from other County departments. In general, these budgetary accounts are assumed to increase 2.5% between 2015 and 2017.

These projections allow us to calculate an overall estimate of Mental Health Complex expenditures for 2017. As in our budget and trend analyses in previous sections, we break down our estimates by both direct and indirect costs, using the same allocation methodology we employed earlier.[15]

Figure 24 shows that direct expenditures to support the two remaining Mental Health Complex service areas (adult inpatient and PCS) would grow by about $1.7 million (6.1%), from $28.3 million in 2015 to $30.1 million. This increase relates primarily to rising salary and fringe benefit costs, as well as inflationary increases in services, commodities, crosscharges, etc. As noted above, staffing levels for these two service areas would remain largely the same.

[15] See page 13 for a description of our budget methodology. Essentially, this methodology is designed to appropriately segregate Mental Health Complex costs from community-based service costs and distinguish costs that are directly related to hospital-based services from other categories of overhead costs.

Figure 24: Model 1 Projection of Direct Expenditures[16]



In **Table 8**, we show our projection of total indirect expenditures for the Mental Health Complex, again broken down between adult inpatient and PCS. We also distinguish between traditional indirect costs – which include the Mental Health Complex's share of general BHD management and administration, general County overhead charges, hospital administration, and facilities – and legacy costs charged to the Mental Health Complex functions. Here, we see an increase of about $2.6 million, or 13.1%.

Table 8: Model 1 Projection of Indirect Expenditures

	2015 Budget	2017 Projected	Percent Change
Adult Inpatient			
Indirect Orgs	$9,634,061	$11,028,534	
Legacy	$3,372,550	$3,717,635	
Total Indirect	$13,006,611	$14,746,169	13.4%
PCS			
Indirect Orgs	$4,679,697	$5,332,534	
Legacy	$1,925,382	$2,110,876	
Total Indirect	$6,605,079	$7,443,410	12.7%
Total Mental Health Complex	**$19,611,690**	**$22,189,579**	**13.1%**

[16] 2015 direct expenditures in **Figure 24** are lower than the total amount shown in **Figure 22** in the previous section because they do not include 2015 expenditures for Rehab Central.

A few notes are in order regarding the development of these indirect cost projections:

- Facilities expenses increase (from $6.3 million in the 2015 budget to $6.5 million in our projection) even though the number of FTEs associated with facilities is projected to decline by one FTE. This is because salaries are a relatively small proportion of the total facility expense. Crosscharges for DAS – Facilities Maintenance are projected to increase by 2.5%, as are utilities and other building-related services. Essentially, the model suggests that as long as BHD remains in its current facility, this source of indirect cost will not change substantially.

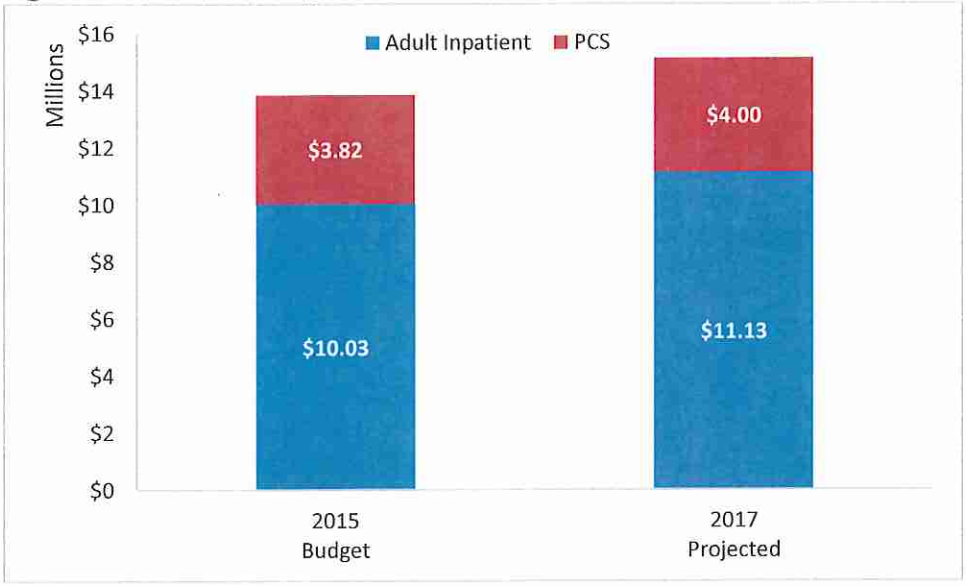
- In order to project indirect costs for adult inpatient and PCS in 2017, we estimated total costs for certain indirect cost categories within BHD's budget, and then made assumptions regarding how those costs would be allocated across all of BHD's direct service areas. Our methodology for doing so was reviewed by BHD fiscal staff. While total indirect costs for BHD are not projected to change significantly by 2017, our model assumes that the percentage allocated to adult inpatient and PCS each will increase (in part because the closure of Rehab Central and Hilltop leaves fewer service areas), resulting in an increase in indirect costs to both areas. It is important to recognize that these projections do rest on somewhat speculative assumptions. If actual indirect cost allocations differ substantially from our assumptions, then our overall fiscal projections would be materially impacted.

- Indirect costs include County crosscharges that are allocated to BHD by the County Comptroller's office and the Department of Administrative Services. These costs were described in detail in previous sections of this report. The model assumes that County crosscharges in their entirety will increase by 2.5%, but that because of decreasing FTEs at BHD, the overall allocation of County crosscharges to BHD will offset that increase.

Revenue Projection

In order to calculate the total property tax levy/BCA required to support Mental Health Complex operations in 2017, we also need to take into account the amount of revenue that will be generated from those operations. BHD provided revenue projections for adult inpatient for 2017, which take into account recent changes in Medicaid reimbursement rates and assumptions regarding patient acuity and insurance coverage. For PCS, we assume a revenue increase of 5%. As shown in **Figure 25**, total revenues for the two service areas are projected to increase by about $1.3 million, or 9.3%.

Figure 25 - Model 1 Projection of Mental Health Complex Revenues



Projection of 2017 Property Tax Levy/BCA and Savings Available for Reinvestment

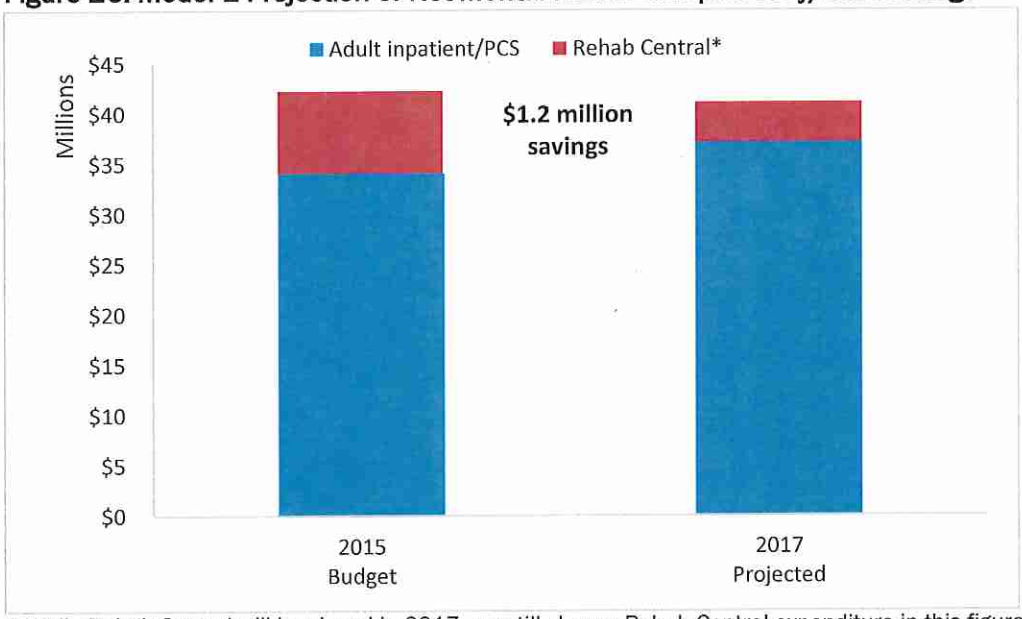
To determine levy/BCA impacts in the two Mental Health Complex service areas in 2017, we subtract projected revenues from projected expenses and compare those totals to 2015 budgeted amounts. **Table 9** shows that BHD would need about $3 million of additional tax levy/BCA in 2017 to support remaining Mental Health Complex operations, although staffing levels for those operations essentially are unchanged.

Table 9: Model 1 Projection of Mental Health Complex Levy/BCA

	2015 Budget	2017 Projected	Percent Change
Adult Inpatient			
Direct Expense	$17,621,326	$18,795,149	6.7%
Indirect Expense	$13,006,611	$14,746,169	13.4%
Total Expense	$30,627,937	$33,541,318	9.5%
Revenue	$10,029,584	$11,133,670	11.0%
Levy/BCA	$20,598,353	$22,407,648	8.8%
PCS			
Direct Expense	$10,704,871	$11,262,154	5.2%
Indirect Expense	$6,605,079	$7,443,410	12.7%
Total Expense	$17,309,950	$18,705,564	8.1%
Revenue	$3,822,627	$4,002,661	4.7%
Levy/BCA	$13,487,323	$14,702,903	9.0%
Total Mental Health Complex	**$34,085,676**	**$37,110,551**	**8.9%**

The projected $3 million increase in levy/BCA requirements for remaining Mental Health Complex operations does not take into account the $4.2 million in net levy/BCA savings related to the closure of Rehab Central. Consequently, as shown in **Figure 26**, when we factor in those savings, our modeling suggests ***that about $1.2 million in levy "savings" would be available to BHD in 2017 for reinvestment in community-based services*** under our Model 1 scenario of 60 adult inpatient beds.

Figure 26: Model 1 Projection of Net Mental Health Complex Levy/BCA Savings



* While Rehab Central will be closed in 2017, we still show a Rehab Central expenditure in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Summary of Model 1

Given the trends described earlier in this report, it is not surprising that Model 1 shows only $1.2 million in net savings for Mental Health Complex services in the 2017 budget, despite the full closure of Rehab Central. Model 1 maintains existing adult inpatient bed capacity and assumes that PCS activity and staffing remains the same, which requires a projected $3 million increase in the amount of BCA/levy required to operate the two service areas in 2017. This reflects the fiscal pressure exerted on BHD by its inability to substantially reduce facilities costs and other forms of internal indirect costs, and its need to accommodate assumed inflationary increases in employee compensation, commodities, etc. Hence, the $4.2 million in net savings associated with the final stage of the Rehab Central closure are largely offset n 2017 by the projected increased cost of maintaining the adult inpatient and PCS service areas at existing capacity.

Model #2 – 32 Acute Adult Inpatient Beds

Model 2 explores the fiscal impacts of a scenario in which BHD's acute adult inpatient beds are reduced from 60 to 32. As with Model 1, Model 2 assumes that PCS utilization and staffing remain at 2015 levels.

Staffing Projection

Tables 10 and **11** show FTE projections for direct and indirect cost areas. These projections were developed by BHD based on their estimate of staffing needs for a 32-bed facility. The number of beds declines by 47% as compared to Model 1, but BHD projects more modest decreases in direct and indirect staffing. We see a decrease of 57 FTEs (22%) in direct cost areas and a decrease of 14 FTEs (18%) in indirect cost areas.

Model 2 yields $5 million in net savings when the closure of Rehab Central is taken into account. A key consideration is whether the potential availability of $5 million to reinvest in community-based services would be sufficient to offset the impacts of a 28-bed reduction in the county's overall system of care.

Savings related to the reduction of 28 adult inpatient beds total only $1.6 million. The relatively insignificant nature of the inpatient savings stems from several factors, including BHD's assumption that hospital staffing only could be reduced by 21%, an inability to produce substantial savings in indirect cost areas, and a projected decline in annual patient revenues of more than $5 million.

Table 10: Model 2 Direct Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Adult Inpatient	175.20	175.20	119.10
Rehab Central	51.30	-	-
Hilltop	0.00	-	-
PCS	82.20	82.20	82.20
Hospital Support	11.10	9.80	8.50
Total Direct	**319.80**	**267.20**	**209.80**

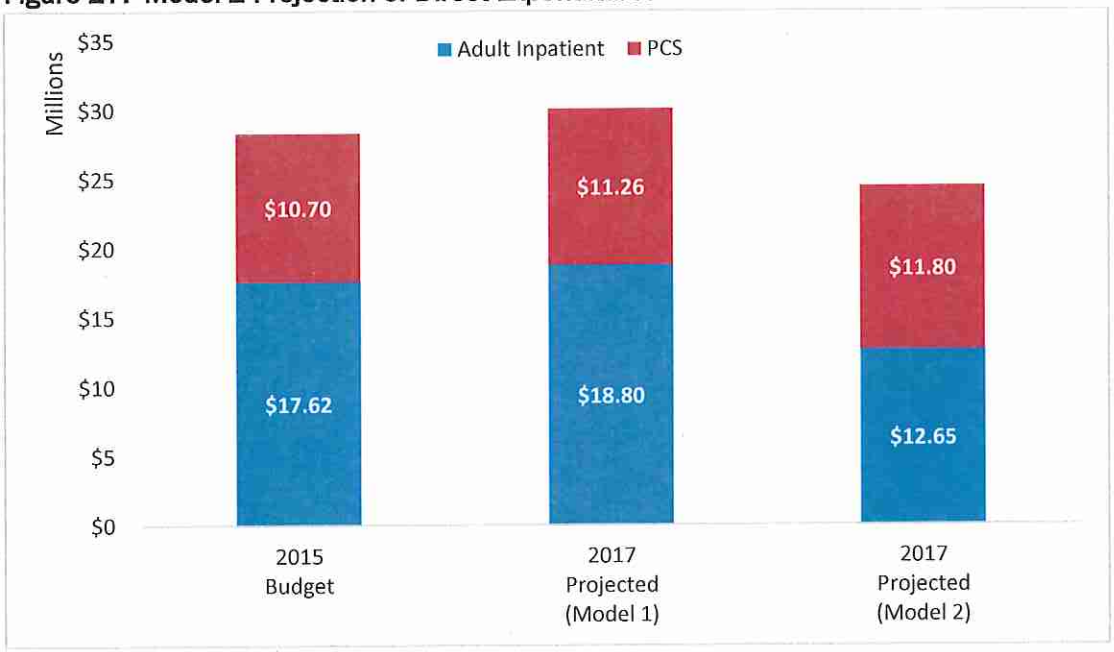
Table 11: Model 2 Indirect Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Facilities	16.0	14.9	13.4
Hosp Admin	70.6	62.0	50.6
Genl Admin	43.4	40.7	38.3
Total Indirect	**129.9**	**117.6**	**102.3**
Total Allocated to MH Complex	**92.6**	**78.8**	**64.4**

Expenditure Projection

Using these staffing projections and the assumptions described in Model 1 regarding salaries and benefits, contractual services, commodities, and other direct and indirect costs associated with Mental Health Complex operations, we can calculate projected direct and indirect expenditures under the 32-bed scenario. **Figure 27** shows that direct expenditures would be reduced by $3.9 million from 2015 expenditure levels.

Figure 27: Model 2 Projection of Direct Expenditures



Indirect expenses under this model decline by only $866,000 in comparison with 2015, as shown in **Table 12**. The fact that indirect expenditures decrease by such a small amount when compared to the 2015 budget – despite the reduction of 28 beds – again shows the difficulty BHD will face in achieving substantial savings from downsizing because of its inability to reduce indirect staffing and costs.

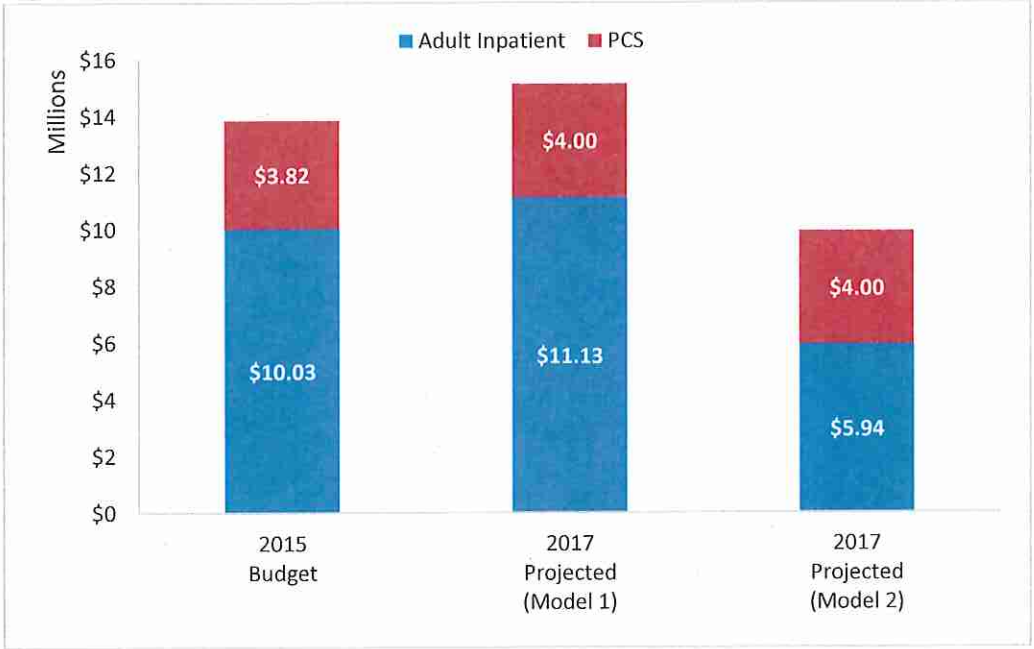
Table 12: Model 2 Projection of Indirect Expenditures

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Adult Inpatient			
Indirect Orgs	$9,634,061	$11,028,534	$9,181,110
Legacy	$3,372,550	$3,717,635	$3,122,890
Total Indirect	$13,006,611	$14,746,169	$12,304,000
PCS			
Indirect Orgs	$4,679,697	$5,332,534	$4,330,559
Legacy	$1,925,382	$2,110,876	$2,110,876
Total Indirect	$6,605,079	$7,443,410	$6,441,435
Total Mental Health Complex	**$19,611,690**	**$22,189,579**	**$18,745,435**

Revenue Projection

Our revenue projection for a 32-bed adult inpatient facility again was developed by BHD staff, taking into account projected Medicaid reimbursement rates and assumptions regarding patient acuity and insurance coverage. For PCS, we again assume a revenue increase of 5%. As shown in **Figure 28**, total revenues for the two service areas are projected to decrease by $3.9 million when compared to the 2015 budget and $5 million when compared to the 2017 60-bed scenario.

Figure 28: Model 2 Projection of Mental Health Complex Revenues



Projection of 2017 Property Tax Levy/BCA and Savings Available for Reinvestment

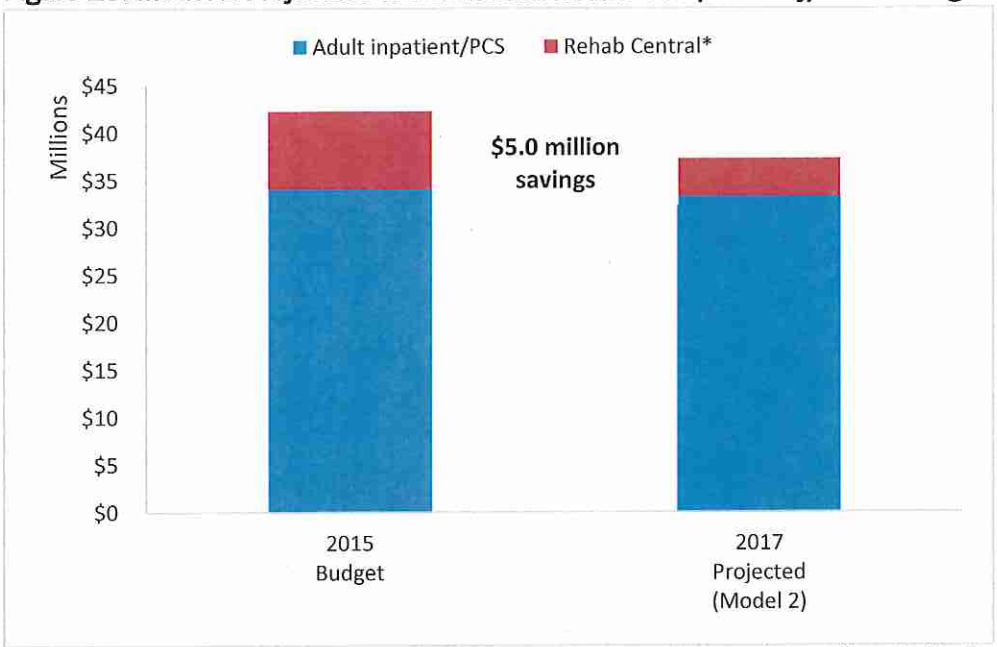
In **Table 13**, we combine our expenditure and revenue projections to develop an estimate of total property tax levy/BCA required to support the Mental Health Complex for the 32-bed adult inpatient scenario. We find that for the two remaining service areas combined, there is a $3.9 million levy/BCA savings when compared to Model 1, and an $828,000 levy/BCA savings when compared to the 2015 budget.

Table 13: Model 2 Projection of Mental Health Complex Levy/BCA

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Adult Inpatient			
Direct Expense	$17,621,326	$18,795,149	$12,653,047
Indirect Expense	$13,006,611	$14,746,169	$12,304,000
Total Expense	$30,627,937	$33,541,318	$24,957,048
Revenue	$10,029,584	$11,133,670	$5,937,957
Levy/BCA	$20,598,353	$22,407,648	$19,019,090
PCS			
Direct Expense	$10,704,871	$11,262,154	$11,800,047
Indirect Expense	$6,605,079	$7,443,410	$6,441,435
Total Expense	$17,309,950	$18,705,564	$18,241,482
Revenue	$3,822,627	$4,002,661	$4,002,661
Levy/BCA	$13,487,323	$14,702,903	$14,238,821
Total Mental Health Complex	**$34,085,676**	**$37,110,551**	**$33,257,911**

The projected $828,000 savings in levy/BCA requirements for remaining Mental Health Complex operations does not take into account the net estimated levy/BCA savings of $4.2 million in the 2017 budget from the closure of Rehab Central. As shown in **Figure 29**, when we factor in those savings, our modeling suggests ***that about $5 million in levy "savings" would be available to BHD in 2017 for reinvestment in community-based services*** under our Model 2 scenario of 32 adult inpatient beds.

Figure 29: Model 2 Projection of Net Mental Health Complex Levy/BCA Savings



* While Rehab Central will be closed in 2017, we still show a Rehab Central expenditure in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Summary of Model 2 Fiscal Impact

Looking only at the adult inpatient service area, our modeling indicates that a reduction of beds from 60 to 32 would produce a savings of only $1.6 million in levy/BCA expenditures when compared to budgeted expenditures in 2015. Given that PCS would require an additional expenditure of $750,000, this means that BHD would save less than $1 million in levy/BCA in 2017 from its combined operation of adult inpatient and PCS services if it were to reduce its capacity to 32 beds.

When we factor the closure of Rehab Central into our analysis, we arrive at an overall projection of $5 million in net savings. A key consideration for policymakers is whether the potential availability of $5 million to reinvest in community-based services is sufficient to offset the growth in community-based services that would be needed to accommodate the elimination of 28 inpatient beds in the county's overall system of care.

The relatively modest nature of the levy/BCA savings that would be generated from a 47% reduction adult inpatient bed capacity stems from several factors. First, a key component of our estimate is the direct and indirect staffing that would be required for a 32-bed facility, which according to BHD could be reduced substantially (by about 21% when compared to our Model 1 staffing estimate), but not by a percentage that is equivalent to the reduction in bed capacity. In addition, we see that important indirect cost areas would not see substantial reductions, and that annual patient revenues would decline substantially, reducing expenditure savings.

Model #3 – 16 Acute Adult Inpatient Beds

This scenario explores the fiscal impacts of a scenario in which BHD's acute adult inpatient beds are reduced from 60 to 16. Again, we assume that PCS remains at status quo (i.e. utilization and staffing at PCS remain at 2015 levels).

Staffing Projection

Tables 14 and **15** show FTE projections for direct and indirect cost areas under the 16-bed model. These projections again were developed by BHD based on their estimate of staffing needs for a 16-bed facility. Here, we see a decline of an additional 56.5 direct FTEs (27%) from Model 2, and a reduction of about seven indirect FTEs (7%). The relatively small reduction in indirect FTEs reflects the fact that a certain level of administrative staffing is required to support PCS operations irrespective of the Mental Health Complex's bed capacity.

Model 3 would produce a net savings of $8.8 million for community reinvestment when compared to the 2015 budget. Whether this amount is sufficient to offset the impacts of a 44-bed reduction in adult inpatient capacity would hinge on factors such as the willingness of private health systems to enhance their inpatient bed capacity and the effectiveness of community-based services in decreasing demand for inpatient care. Meanwhile, the cost per bed under this scenario is almost $1 million on an annual basis. Hence, if BHD wishes to pursue this alternative, then it would appear to make sense to explore whether there are other providers that could operate a 16-bed facility less expensively, or whether BHD could reduce its costs at a different location or under a different administrative structure.

Table 14: Model 3 Direct Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Adult Inpatient	175.20	175.20	119.10	63.90
Rehab Central	51.30	-	-	-
Hilltop	0.00	-	-	-
PCS	82.20	82.20	82.20	82.20
Hospital Support	11.10	9.80	8.50	7.20
Total Direct	**319.80**	**267.20**	**209.80**	**153.30**

Table 15: Model 3 Indirect Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Facilities	16.0	14.9	13.4	13.4
Hosp Admin	70.6	62.0	50.6	44.8
Genl Admin	43.4	40.7	38.3	37.4
Total Indirect	**129.9**	**117.6**	**102.3**	**95.5**
Total Allocated to MH Complex	**92.6**	**78.8**	**64.4**	**57.3**

Expenditure Projection

Using these staffing projections and the assumptions used in earlier models regarding salaries and benefits and other costs, we can calculate projected direct and indirect expenditures under the 16-bed scenario. **Figure 30** shows that direct expenditures would be reduced by $9.7 million, and **Table 16** shows that indirect expenses would decline by $3.1.million, when compared to 2015 budgeted amounts.

Figure 30: Model 3 Projection of Direct Expenditures

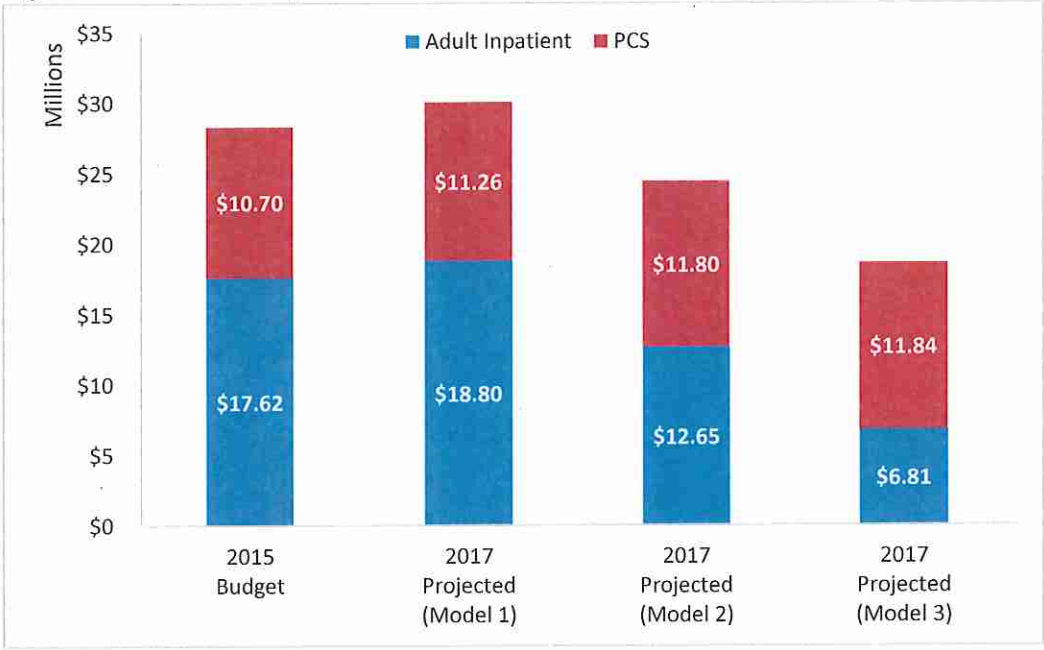


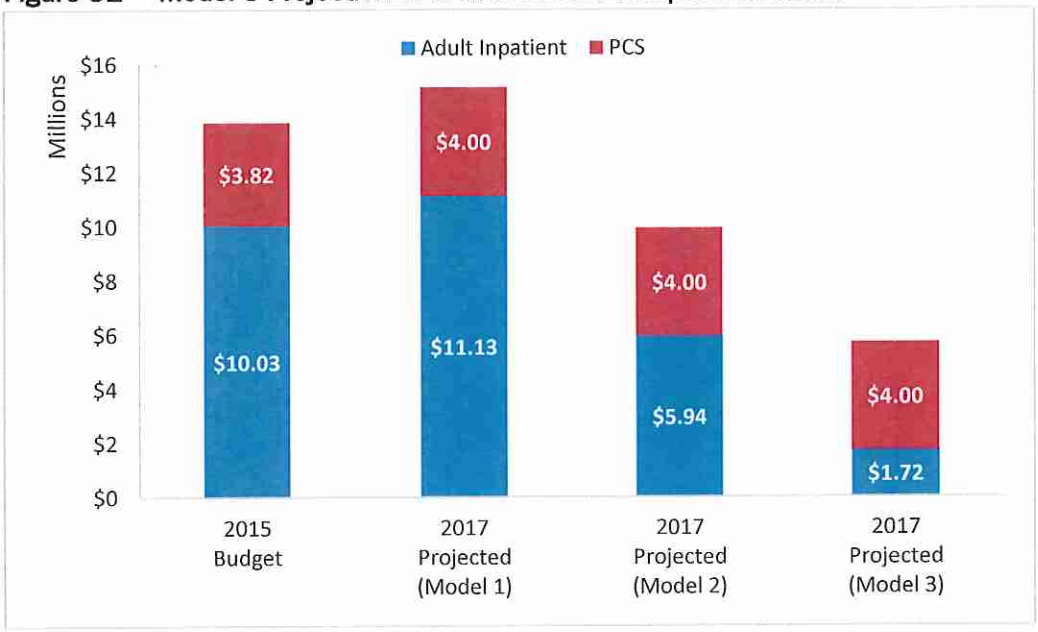
Table 16: Model 3 Projection of Indirect Expenditures

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Adult Inpatient				
Indirect Orgs	$9,634,061	$11,028,534	$9,181,110	$8,034,368
Legacy	$3,372,550	$3,717,635	$3,122,890	$2,563,788
Total Indirect	$13,006,611	$14,746,169	$12,304,000	$10,571,155
PCS				
Indirect Orgs	$4,679,697	$5,332,534	$4,330,559	$3,847,711
Legacy	$1,925,382	$2,110,876	$2,110,876	$2,110,876
Total Indirect	$6,605,079	$7,443,410	$6,441,435	$5,958,587
Total Mental Health Complex	**$19,611,690**	**$22,189,579**	**$18,745,435**	**$16,529,742**

Revenue Projection

Our revenue projection for a 16-bed adult inpatient facility again was developed by BHD staff, while we again assume a revenue increase of 5% for PCS. As shown in **Figure 31**, total revenues for the two service areas are projected to decrease by about $8.2 million in comparison with the 2015 budget. The substantial (82%) decrease in adult inpatient revenues – which are projected to total only $1.7 million in 2017 for a 16-bed facility – stems from BHD's analysis of its current patient mix and its assumption that a 16-bed publicly administered facility would need to be largely reserved for patients with no insurance coverage. This, of course, is an important assumption that will significantly impact decision-making on the viability of a 16-bed facility.[17]

Figure 31 - Model 3 Projection of Mental Health Complex Revenues



Projection of 2017 Property Tax Levy/BCA and Savings Available for Reinvestment

In **Table 17**, we combine our expenditure and revenue projections to develop an estimate of total property tax levy/BCA required to support the Mental Health Complex for the 16-bed adult inpatient scenario. We find that for the two remaining service areas combined, there is a $4.6 million savings when compared to the 2015 budget. This represents a savings of 13% from a 73% reduction in adult inpatient bed capacity.

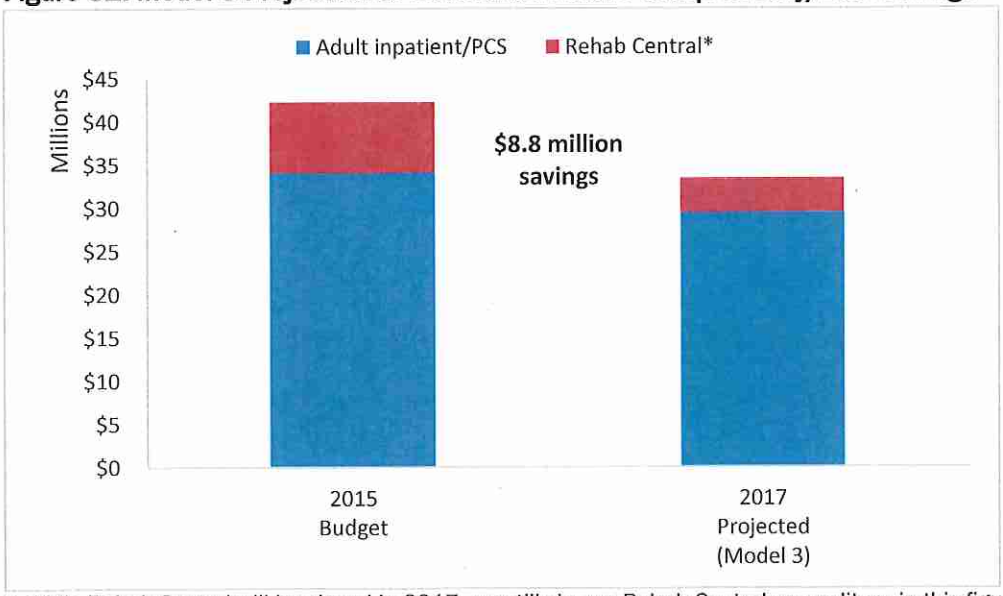
[17] The so-called "IMD exclusion" that prevents BHD from receiving Medicaid reimbursement for inpatient services provided to certain Medicaid-eligible individuals between the ages of 21 and 64 likely would be lifted under this model, as it only applies to facilities with more than 16 beds. However, because it is assumed that the facility largely would serve uninsured individuals, BHD would not benefit significantly from this circumstance.

Table 17: Model 3 Projection of Mental Health Complex Levy/BCA

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Adult Inpatient				
Direct Expense	$17,621,326	$18,795,149	$12,653,047	$6,809,298
Indirect Expense	$13,006,611	$14,746,169	$12,304,000	$10,571,155
Total Expense	$30,627,937	$33,541,318	$24,957,048	$17,380,453
Revenue	$10,029,584	$11,133,670	$5,937,957	$1,717,233
Levy	$20,598,353	$22,407,648	$19,019,090	$15,663,220
PCS				
Direct Expense	$10,704,871	$11,262,154	$11,800,047	$11,837,940
Indirect Expense	$6,605,079	$7,443,410	$6,441,435	$5,958,587
Total Expense	$17,309,950	$18,705,564	$18,241,482	$17,796,527
Revenue	$3,822,627	$4,002,661	$4,002,661	$4,002,661
Levy	$13,487,323	$14,702,903	$14,238,821	$13,793,866
Total Mental Health Complex	**$34,085,676**	**$37,110,551**	**$33,257,911**	**$29,457,086**

The projected $4.6 million savings in levy/BCA requirements for remaining Mental Health Complex operations does not take into account the net estimated levy/BCA savings of $4.2 million in the 2017 budget from the closure of Rehab Central. As shown in **Figure 32**, when we factor in that savings, our modeling suggests ***that about $8.8 million in levy "savings" would be available to BHD in 2017 for reinvestment in community-based services*** under our Model 3 scenario of 16 adult inpatient beds.

Figure 32: Model 3 Projection of Net Mental Health Complex Levy/BCA Savings



* While Rehab Central will be closed in 2017, we still show a Rehab Central expenditure in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Summary of Model 3 Fiscal Impact

Our modeling indicates that a reduction of adult inpatient beds from 60 to 16 – combined with the impacts of PCS' cost to continue existing levels of service and the closure of Rehab Central – would produce a net savings of $8.8 million for community reinvestment when compared to the 2015 budget. Whether this amount is sufficient to justify a bed reduction of that magnitude is difficult to determine.

We are not in a position to comment on the efficacy of such a scenario from the standpoint of countywide inpatient bed capacity, as that analysis would hinge on factors such as the willingness of private health systems to enhance their inpatient bed capacity and the effectiveness of community-based services in decreasing demand for inpatient care. Similarly, because we are unable to determine whether the County would be able to reinvest most or all of the $8.8 million in community-based mental health services (as opposed to using some of these savings for other countywide needs), and precisely how it would do so, we cannot speculate on the programmatic and clinical impacts that would be associated with such a decision.

From a financial standpoint, while Model 3 at first glance seems like an attractive option, it is important to recognize that the levy/BCA cost under this option is almost $1 million per bed on an annual basis, as shown in **Figure 33**.

Figure 33: Levy/BCA Cost per Adult Inpatient Bed Under Different Bed Capacity Scenarios

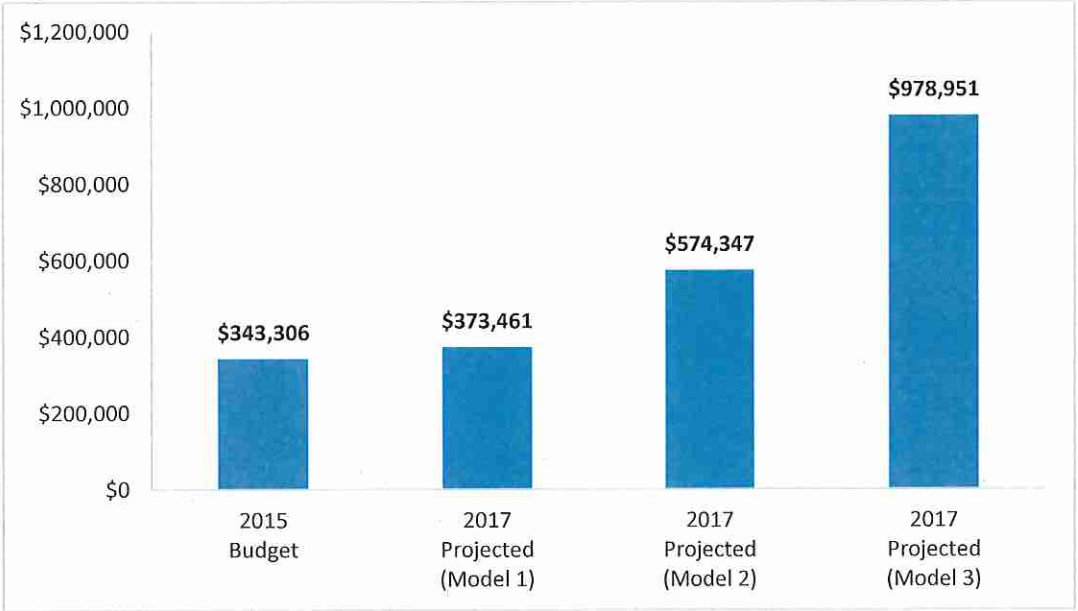


Figure 33 brings up an important set of questions for BHD, the Mental Health Board, and other providers of inpatient mental health services in Milwaukee County. For example, if there is a determination that BHD can and should reduce its inpatient bed capacity, then it would appear to make sense to explore whether there are other providers that could make available 32 beds at less than $575,000 per bed in local subsidy, or operate a 16-bed facility for less than $975,000 per

bed.[18] On the other hand, these numbers could lead some to argue that if BHD plans to retain an adult inpatient facility, then economies of scale might dictate that it pursue a larger facility that can spread indirect costs across a larger number of revenue-producing beds and hold down per-bed costs.

An additional set of questions revolves around the current Mental Health Complex facility, and whether the approximately $6.5 million in annual facility costs could be dramatically reduced at a different location. If that is the case, then the reduced bed capacity scenarios may produce greater financial benefits. It is also important to note, however, that capital expenditures have not been considered in our analysis, and that the fiscal impacts associated with building a new facility, demolishing the existing facility and selling the land on which it is located, and repairing and improving the existing facility if BHD should remain there would need to be thoroughly explored under any of our models.

Again, we cannot answer these questions. Our modeling suggests, however, that if the County is interested in exploring a scenario in which it operates only a small number of adult inpatient beds for highly acute and uninsured patients, then those beds may turn out to be very expensive to operate on a per-bed basis. Consequently, if that is the path it takes, then it may wish to consider a different governance and administrative structure for doing so.

[18] It should be noted that if BHD contracts with a private provider for inpatient services, then certain indirect costs (e.g. legacy costs and central service allotments) that are currently allocated to adult inpatient would be reallocated to PCS and other County departments, thus increasing expenditures in those areas.

CONCLUSION

This report was designed to provide Milwaukee County and its Mental Health Board with a detailed analysis of Mental Health Complex finances that would 1) shed light on the true fiscal impacts of recent and potential future bed reductions; and 2) provide insight into the resources that might be available as a result of such reductions for reinvestment in community-based services. Annual County budget documents have provided limited perspective on those questions by showing property tax levy trend information for the different BHD functional areas. Our analysis provides a far more complete and accurate picture by disaggregating direct and indirect cost centers and more accurately distinguishing between hospital-based elements of BHD's budget and those that are community-based.

We began by examining financial trends from the 2010-2013 timeframe, which was the period of time in which BHD initiated various mental health redesign strategies aimed at moving toward a community-based system of care. During this period, patient bed days at the Mental Health Complex declined from 79,000 in 2010 to 62,000 in 2013. Our trend analysis revealed the following:

- While direct hospital-related expenditures at the Mental Health Complex decreased by $5.5 million (11%) – an amount that intuitively would appear to correlate with the decline in bed capacity – indirect costs unexpectedly increased by $2.5 million. To some degree, the increase in indirect costs was attributable to factors beyond BHD's control, such as the central budget office's determination of BHD's legacy costs, facility expenses, and charges from other departments. With regard to direct expenditures, we found that the decrease was linked largely to reduced fringe benefit costs associated with countywide health care and pension savings. Overall staffing levels remained largely the same despite the reduced patient volume, in part because of increased staffing levels at PCS.

- BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, but the reduced patient census produced an overall net loss of about $3 million in patient revenue. Because that loss largely offset expenditure reductions, the County was unable to reduce its allocation of property tax levy/BCA to Mental Health Complex services.

- BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million (12%). However, our analysis also showed that BHD's community services as a whole became more dependent on property tax levy/BCA, which increased by $6 million. Because levy/BCA savings did not materialize from Mental Health Complex downsizing, those additional resources came from other parts of county government and/or general increases in the tax levy.

Overall, our trend analysis found that a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up property tax resources to invest in community-based services – had not been achieved as of the end of 2013.

We then turned to the 2014 and 2015 budgets to determine whether any of the trends observed for the previous four years had reversed, and whether additional savings associated with continued Mental Health Complex downsizing in those years were being generated for reinvestment in community-based services. The 2014 and 2015 budgets were characterized by even greater downsizing than had occurred the previous four years, as Hilltop was projected to close by the end of 2014 and Rehab Central by the end of 2015.

We found that the financial benefits associated with these sharper declines in patient census had indeed become more pronounced. For example, levy/BCA expenditures for Mental Health Complex service areas were budgeted to fall by about $7 million (14%) when compared with 2013 actual amounts. However, these levy savings still were restrained by BHD's inability to substantially reduce indirect costs, which were projected to decline by only 4%; and by substantial budgeted reductions in patient revenue in conjunction with the reduced census. We also observed that increased staffing and expenditure levels at PCS continued to partially offset inpatient and long-term care savings.

Finally, when we conducted financial modeling to estimate the financial impacts of three adult inpatient bed scenarios, we again observed the following dynamics first revealed by our trend analysis:

- The Mental Health Complex's indirect costs are only loosely linked to its bed capacity, and this factor will continue to curtail overall savings amounts that can be achieved with future downsizing initiatives.

- Because key components of BHD's indirect cost structure are linked to its existing facility and its treatment as a regular department of Milwaukee County government, there is little it can do to reduce indirect costs without changes to those two circumstances.

- While BHD can continue to generate sizable direct cost savings from additional reductions in adult inpatient bed capacity, the direct cost pressures associated with continued operation of PCS at its existing capacity will erode those savings and reduce the amounts available for community reinvestment.

Despite these obstacles, our modeling showed that BHD could generate a $5 million levy/BCA savings in 2017 (when compared to the 2015 budget) by downsizing to 32 adult inpatient beds, and an $8.8 million savings by downsizing to 16 adult inpatient beds, when cost savings from the closure of Rehab Central also are included. Should BHD and Mental Health Board leaders wish to pursue either of those alternatives, an important next step would be to determine the types and scope of enhanced community-based services that might be implemented with those savings amounts. Such an exercise would allow those with programmatic and clinical expertise to determine whether such enhancements would be sufficient to appropriately mitigate the impacts of reduced inpatient bed capacity, and to create the robust set of community-based services envisioned as part of the mental health redesign planning process.

From a narrower fiscal lens, the findings of our modeling and trend analysis lead us to the following concluding observations:

- **Milwaukee County leaders should contemplate a new financial structure for the Mental Health Complex that sets it apart from the rest of Milwaukee County government.**

  As long as the Mental Health Complex continues to be subject to crosscharges from other County departments and central service allocations and legacy charges from the central budget office, it is likely to receive only limited benefit from bed capacity and associated staffing reductions. This problem is partially attributed to the fact that these allocations and charges do not directly reflect the changes that are occurring at the Complex, though it also is attributed to the complicated manner in which BHD must allocate such centralized charges across its various functions.

An argument could be made that in light of BHD's new governance structure created by Wisconsin Act 203, additional steps should be taken to segregate its finances from the rest of Milwaukee County government, or to remove it entirely from the auspices of Milwaukee County and place it under a separate mental health district or authority. This approach could be pursued for all of BHD, or solely for the Mental Health Complex, with other functions remaining under the County's health and human services department.

Under such an approach, BHD could purchase administrative, legal, facilities, and other overhead services from the County or outside entities, and be billed for such services based on their actual cost. Similarly, legacy costs could be allocated based on actual BHD retirees, as opposed to a general allocation based on the size of its active workforce.

It is unclear whether these steps would produce savings for BHD or its Mental Health Complex functions, and it is likely that they would produce negative fiscal impacts for the rest of county government. However, forming a new financial structure for the Mental Health Complex that segregates its actual cost of doing business at least would ensure that decision-making regarding bed capacity is not skewed by an indirect cost structure that has limited linkage with actual activity.

Should this approach prove unworkable from an accounting, legal, or logistical perspective, then the Milwaukee County budget office and BHD at least should consider reforming internal budgeting and accounting practices to better isolate costs and revenues associated with BHD's various service areas. The new Mental Health Board needs accurate, service-level fiscal data to gauge bed capacity and community investment options going forward. Unfortunately, the current fiscal framework does not lend itself to that type of information gathering and sharing.

- **Milwaukee County and State of Wisconsin leaders need to work jointly to address BHD's facility needs and questions.**

Our analysis confirms what Milwaukee County leaders have known for quite some time: that facility costs at the existing facility are influenced most prominently not by the amount of square footage that BHD occupies for its hospital-related operations, but instead by the continued need to service and maintain the entire sprawling Mental Health Complex, and by cost factors associated with its use of County facilities staff to do so.

We are unable to determine whether the more than $6 million charged annually to the Mental Health Complex service areas for facilities costs is a reasonable amount and how that might compare to similar costs at a different facility. That question should be analyzed as part of the County's ongoing space planning activities and/or by BHD staff. What is crystal clear, however, is that the facilities savings that ostensibly should be available from a substantial reduction in bed capacity will not materialize at the existing Mental Health Complex location.

An equally important question emerges regarding the future capital needs of the Mental Health Complex and how those will be treated under the budget framework created by Wisconsin Act 203. BHD officials have cited millions of dollars of needed repairs at the existing Complex, which have been deferred pending consideration of a possible new facility. If BHD stays put, then those needs will need to be addressed, but it is unclear how that would occur.

Capital and debt service costs are not included in BHD's budget and are not subject to the fiscal parameters created by Wisconsin Act 203. Furthermore, the Mental Health Board does not have any direct bonding authority. Consequently, any major capital repairs or improvements at the Mental Health Complex that involve County bonding would need to be approved by the County Board, and would need to compete with other daunting capital needs faced by the County. The same holds true for any capital investment in a new facility that would involve County bonding.

This paradigm poses several questions, including the following:

- What if County Board leaders disagree with BHD or the Mental Health Board in terms of a facility plan, or if the County is otherwise unable or unwilling to dedicate bond proceeds for capital repairs or a new facility?

- Would BHD have the capacity to "cash finance" its capital needs, either through its regular operating budget or reserves, and how would that play into other budget considerations and the tax levy restrictions contained in Act 203?

- Would a facility lease be a better option than owning a building in light of these questions?

- Are there other ways to finance capital repairs or a new facility outside of the use of County borrowing (e.g. state or private sector financing that would be repaid by BHD as part of its operating budget)?

- Might the cost of constructing a new facility be accommodated in any financial arrangement involving the sale of the existing property?

Given that these questions are linked to state legislation as well as County concerns, it would be logical for policymakers from both governments to be engaged in identifying answers.

➢ **The future size, mission, and location of PCS will be central to any decision-making regarding adult inpatient bed capacity and a potential new facility.**

An often overlooked issue in BHD's consideration of its optimal inpatient capacity and the possible construction of a new facility is the future size, scope, and operation of PCS. Our analysis has shown that as long as PCS maintains its approximate current patient volume and staffing, then its costs are likely to continue to grow with inflation, thus partially offsetting any savings accrued from inpatient downsizing. In addition, it will continue to demand substantial physical space, administrative overhead, and other indirect components that comprise a significant portion of the Mental Health Complex's financial and physical structure.

In determining possible downsizing options and the size and location of a new facility, therefore, County and Mental Health Board leaders also should be considering how PCS will function in the future. While county government is statutorily mandated to ensure the provision of emergency mental health services in Milwaukee County, it is not required to provide those services itself, nor to provide them at one location or as part of a larger inpatient facility. It is possible, for example, that the County could consider the development of multiple smaller mental health emergency/crisis services within the community, or that it could contract with a private provider to provide those services at new or existing facilities. A consideration that would relate to either

of those options is whether 18 observation beds currently housed at PCS would need to be retained at the site of inpatient units.

Conversely, if a determination is made that the existing PCS service model should be continued, then that needs to be factored into the fiscal analysis of various inpatient bed capacity scenarios. It is possible, for example, that a decision to maintain PCS in its current form will steer policymakers toward consideration of a larger inpatient bed capacity scenario given that certain direct and indirect costs associated with additional beds could be shared and spread across a larger emergency room facility.

- **BHD should develop effective and transparent ways to measure the impacts of its community investments on inpatient and PCS demand and to track and project community-based service costs.**

In an analysis of mental health inpatient bed capacity released by the Forum and Human Services Research Institute in September 2014,[19] we recommended that BHD should "identify performance metrics to evaluate whether the (community-based) services that individuals are receiving are having a desired impact on hospitalizations and other recovery-oriented outcomes." We reiterate that recommendation here in light of the findings of our fiscal modeling.

It will be tempting, for example, to view an opportunity to generate almost $9 million in annual savings from a reduction to 16 beds as too promising to ignore, and to simply assume that by reinvesting those dollars in community-based services an appropriate balance of services can be created. We would caution, however, that the ability to safely downsize in such a substantial manner will be predicated on whether community-based investments truly decrease demand for inpatient care, and that a performance measurement system must be developed to provide insight into that question before such downsizing can occur.

We would make a similar point on the fiscal side of the community-based services equation. The expansion of CCS and CRS and the implementation of other community-based service enhancements still are in their early stages. Yet, BHD still does not possess (at least to our knowledge) the financial data collection and reporting mechanisms that will be needed to appropriately model future year community-based expenditures and revenues and guide decision-making on future investment options. Developing such mechanisms should be an immediate priority for BHD staff.

- **BHD needs more detailed analysis of its revenue structure and revenue opportunities to guide bed capacity decisions.**

While BHD has made great progress in implementing a new electronic medical records system and improving its revenue collection practices, we observe that it would benefit from greater capacity to analyze and respond to revenue trends on a timely basis, and to develop the type of sophisticated revenue profiles and projections that should be a central part of decision-making on bed capacity options. BHD also would benefit from additional expertise on Medicaid and

[19] This report can be accessed at http://publicpolicyforum.org/sites/default/files/MilwaukeeInpatientCapacity.pdf.

Affordable Care Act issues and opportunities to help it appropriately gauge the impacts of major changes in its service design and delivery.

As shown in our modeling, the mix of insured and uninsured patients under different bed capacity scenarios – as well as the types of insurance coverage these patients possess and anticipated reimbursement rates – will have a huge financial impact and must be carefully examined during upcoming discussions about the future size and location of the Mental Health Complex. While our modeling used recent revenue trends to broadly estimate projected revenues under the various scenarios, the fact that BHD only recently converted to an electronic medical records system precluded our ability to access the types of information that would have allowed for more sophisticated analysis. Furthermore, we were unable to ascertain where future opportunities might exist to grow revenue streams under different capacity scenarios.

Consequently, we would suggest that BHD and the Mental Health Board consider options for developing the capacity to better monitor and analyze BHD's revenue performance, and to produce the types of revenue profiles and analyses that will be critical to determining the pros and cons of different bed capacity options. While outside consulting expertise may be required for such a task, it is also possible that this type of expertise could be built within BHD, or that it exists within organizations affiliated with current Mental Health Board members and could be secured on an in-kind basis.

Appendix A – Crosswalk from BHD Indirect Areas to PPF Analysis Indirect Categories

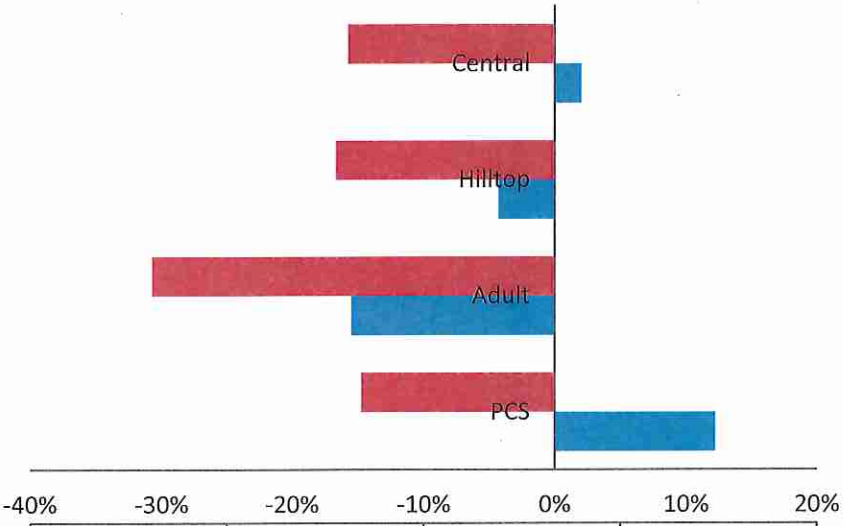
			Functional Indirect Cost Categories			
			General Admin	Hospital Admin	Hospital Support	Facilities
6312	CENTRAL ADMINISTRATION	MANAGEMENT	6312	0		
6313	CLINICAL COMPLIANCE	MANAGEMENT		6313		
6323	PSYCHIATRY ADMINISTRATION	MANAGEMENT		6323		
6324	PSYCHOLOGY ADMINISTRATION	MANAGEMENT		6324		
6325	NURSING ADMINISTRATION	MANAGEMENT		6325		
6326	SOCIAL SERVICES ADMINISTRATION	MANAGEMENT		6326		
6328	PROFESSIONAL EDUC-PSYCHCHIATRY	MANAGEMENT		6328		
6332	ORGANIZATIONAL DEV ADMIN	MANAGEMENT	6332			
6333	PERSONNAL AND PAYROLL	MANAGEMENT	6333			
6334	QUALITY MANAGEMENT	MANAGEMENT		6334		
6336	EDUCATION	MANAGEMENT		6336		
6503	SECURITY	OPERATIONS			6503	
6504	LEGAL SERVICES	OPERATIONS	6504			
6512	SUPPORT SERV ADMIN	OPERATIONS			6512	
6513	DIETARY	OPERATIONS			6513	
6514	STOREROOM	OPERATIONS			6514	
6515	PHARMACY	OPERATIONS			6515	
6516	CLERICAL POOL	OPERATIONS	6516			
6532	FACILITIES MAIN ADMIN	OPERATIONS				6532
6533	FACLT MAINT-MAIN BLD	OPERATIONS				6533
6535	HOUSEKEEPING	OPERATIONS			6535	
6536	LINEN	OPERATIONS			6536	
6537	FACILITY MAINT--DAY HOSP	OPERATIONS				6537
6552	FISCAL ADMIN	FISCAL	6552			
6553	FISCAL SERVICES	FISCAL	6553			
6554	ACCOUNTS RECEIVABLE	FISCAL	6554			
6555	ADMISSIONS	FISCAL		6555		
6556	MANAGEMENT INFORMATION	FISCAL	6556			
6557	MEDICAL RECORDS	FISCAL		6557		
6558	STAFFING OFFICE	FISCAL		6558		

Appendix B – Fiscal Trends by Service Area

To provide further insight into the fiscal performance of Milwaukee County's Mental Health Complex during the 2010-2013 timeframe, we examined the four service areas independently.

In the first set of figures below, we show percentage changes in total expenditures, direct expenditures, and indirect expenditures for each of the service areas, and also compare those to the percentage change in patient census. It is notable that while each of the service areas experienced a decline in patient activity, direct expenditures declined for only three of the four service areas; at PCS, they increased by 7%. It is also notable that indirect expenditures increased for each of the four service areas despite the decrease in patient census.

Figure B1: Percentage change in census and total expenditures for Mental Health Complex Service areas, 2010-2013



	PCS	Adult	Hilltop	Central
% Change Census	-15%	-31%	-17%	-16%
% Change Exp	12%	-15%	-4%	2%

Figure B2: Percentage change in census and direct expenditures for Mental Health Complex Service areas, 2010-2013

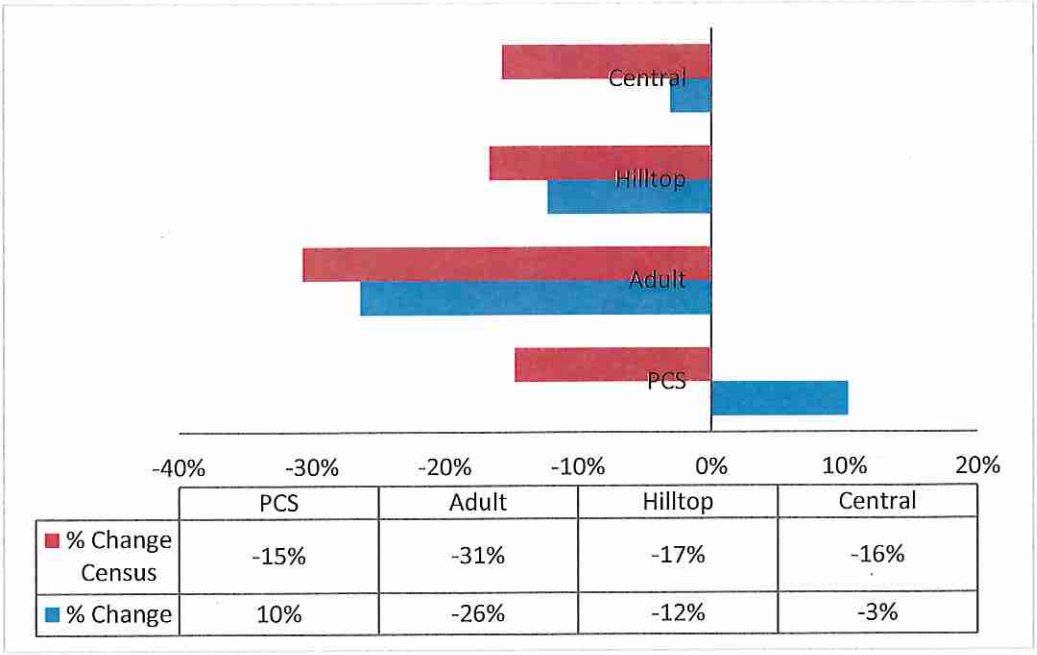
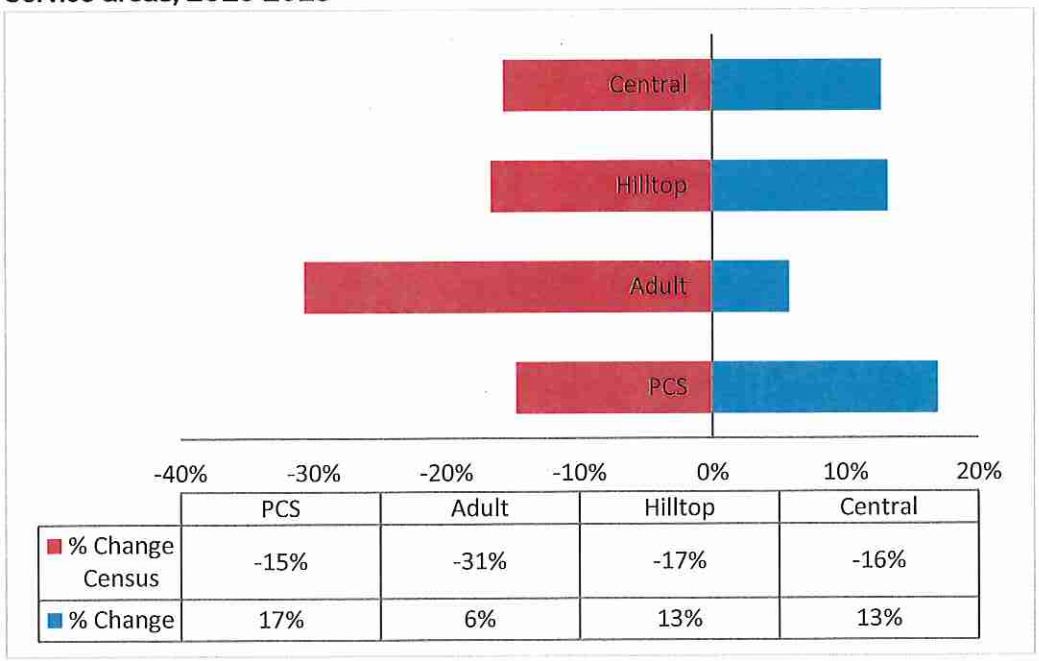


Figure B3: Percentage change in census and indirect expenditures for Mental Health Complex Service areas, 2010-2013



Adult Inpatient

Adult inpatient had the largest decline in patient census of the four areas. We see in **Table B1** that direct expenditures declined by 26%, which tracked pretty closely to the decline in patient census, although indirect expenditures grew by 6%. The number of FTEs[20] allocated to adult inpatient decreased by 18, from 190 to 172. Other areas of savings included commodities accounts (primarily drug expenses), which decreased by $1.3 million, and hospital support, which fell by almost $600,000.

Table B1: General Financial Data, Adult Inpatient

	2010	2013	% Change
Patient Days	30,805	21,363	-31%
Direct FTE	190	172	-10%
Total Expense	$32,549,926	$28,278,567	-15%
Direct Expense	$21,183,365	$16,251,914	-26%
Indirect Expense	$11,366,561	$12,026,653	6%
Net Pt Revenue	($9,827,383)	($8,028,890)	-18%
BCA/Levy	($22,721,695)	($20,249,677)	-14%

On the revenue side, as shown in **Table B2**, NPR per patient day increased from $319 to $376, thus softening the impact of the decline in patient census. In fact, shrinking costs exceeded the decline in net patient revenue, allowing for levy/BCA savings of $3.4 million in this service area.

Table B2: Financial Indicators, Adult Inpatient

	2010	2013
Expense/Patient Day	$1,056.64	$1,323.72
NPR/Patient Day	($319.02)	($375.83)
Recovery Rate	30%	28%

Rehab Central

Table B3 shows that although census declined at Rehab Central, total operating expenses increased slightly. This was caused, at least in part, by an increase in the number of FTEs during the study period from 82 to 90. Rehab Central did experience reduced costs for drugs and hospital support, but increasing indirect costs overrode those savings.

[20] FTEs were determined by dividing the average budgeted salary into actual salary and overtime expenses for the year. Actual expenses take into account labor transfers, vacancies and overtime and are a better indicator of labor costs than budgeted salary amounts.

Table B3: General Financial Data, Rehab Central

	2010	2013	% Change
Patient Days	24,301	20,497	-16%
Direct FTE	82	90	9%
Total Expense	$13,297,803	$13,570,590	2%
Direct Expense	$8,985,333	$8,709,330	-3%
Indirect Expense	$4,312,470	$4,861,260	13%
Net Pt Revenue	($3,246,863)	($2,507,776)	-23%
BCA/Levy	($9,399,738)	($10,321,873)	13%

On the revenue side, we see in **Table B3** and **Table B4** that total NPR declined by 23%, while on a per patient basis it also declined by 9%. As a result, levy/BCA increased by 13% to compensate for the slight increase in total expenses and a reduction in NPR. The reduction in revenue is also quite noticeable in terms of the recovery rate, or the percentage of expense offset by NPR. This declined from 24% to 18% between 2010 and 2013.

Table B4: Financial Indicators, Rehab Central

	2010	2013
Expense/Patient Day	$547.21	$662.08
NPR/Patient Day	($133.61)	($122.35)
Recovery Rate	24%	18%

Hilltop

While the patient census at Hilltop declined by roughly the same amount as that of Rehab Central during the 2010-2013 timeframe, BHD reduced actual FTEs at Hilltop, generating a decrease in direct expenditures, as shown in **Table B5**. Hospital support expenditures also decreased by almost $500,000. Even with an increase in indirect expenditures, total expenditures at Hilltop declined by 4%.

Table B5: General Financial Data, Hilltop

	2010	2013	% Change
Change in Census	23,797	19,853	-17%
Direct FTE	98	87	-11%
Total Expense	$15,414,912	$14,757,769	-4%
Direct Expense	$10,585,414	$9,289,878	-12%
Indirect Expense	$4,829,498	$5,467,891	13%
Net Pt Revenue	($5,399,802)	($5,196,950)	-4%
BCA/Levy	($9,469,790)	($8,972,607)	-5%

Net patient revenue on a per patient basis also increased by 15% at Hilltop, as shown in **Table B6**, from $227 in 2010 to $262 in 2013. The combination of a decrease in total expenditures and an increase in per capita revenues generated a 5% savings in levy/BCA.

Table B6: Financial Indicators, Hilltop

	2010	2013
Expense/Pt Day	$647.77	$743.35
NPR/Pt Day	($226.91)	($261.77)
Recovery Rate	35%	35%

PCS[21]

Although admissions dropped during the study period, FTEs at PCS increased by 15 positions, from 59 to 74. As shown in **Table B7**, this led to a 10% increase in direct expenditures, coupled with the overall increasing trend in indirect costs.

Table B7: General Financial Data, Crisis Services

	2010	2013	% Change
ER Admissions	13,438	11,464	-15%
ER/Obs only	59	74	31%
Total Expense	$13,206,590	$14,823,123	12%
Direct Expense	$9,367,509	$10,333,414	10%
Indirect Expense	$3,839,081	$4,489,709	17%
Net Pt Revenue	($4,510,159)	($4,296,588)	-5%
BCA/Levy	($7,885,963)	($10,270,986)	30%

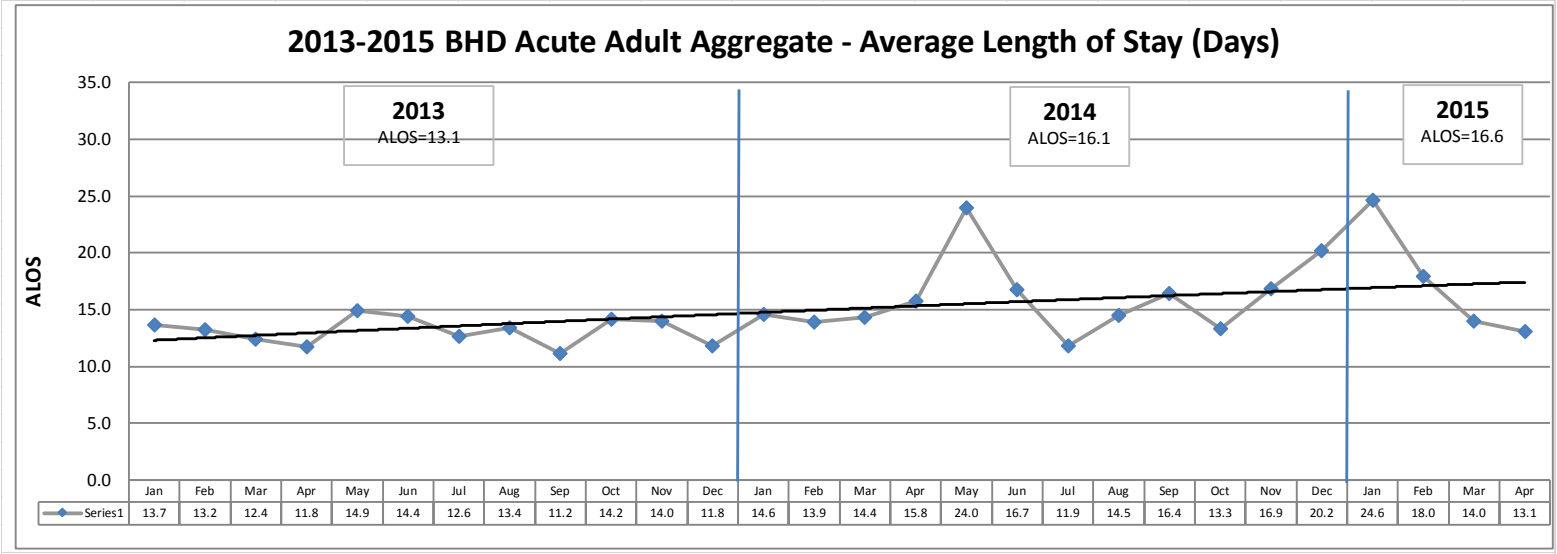
Net patient revenue also declined by 5% at, PCS during the period. Consequently, levy/BCA invested in PCS grew by 30%, offsetting the savings experienced in other areas.

Table B8: Financial Indicators, Crisis Services

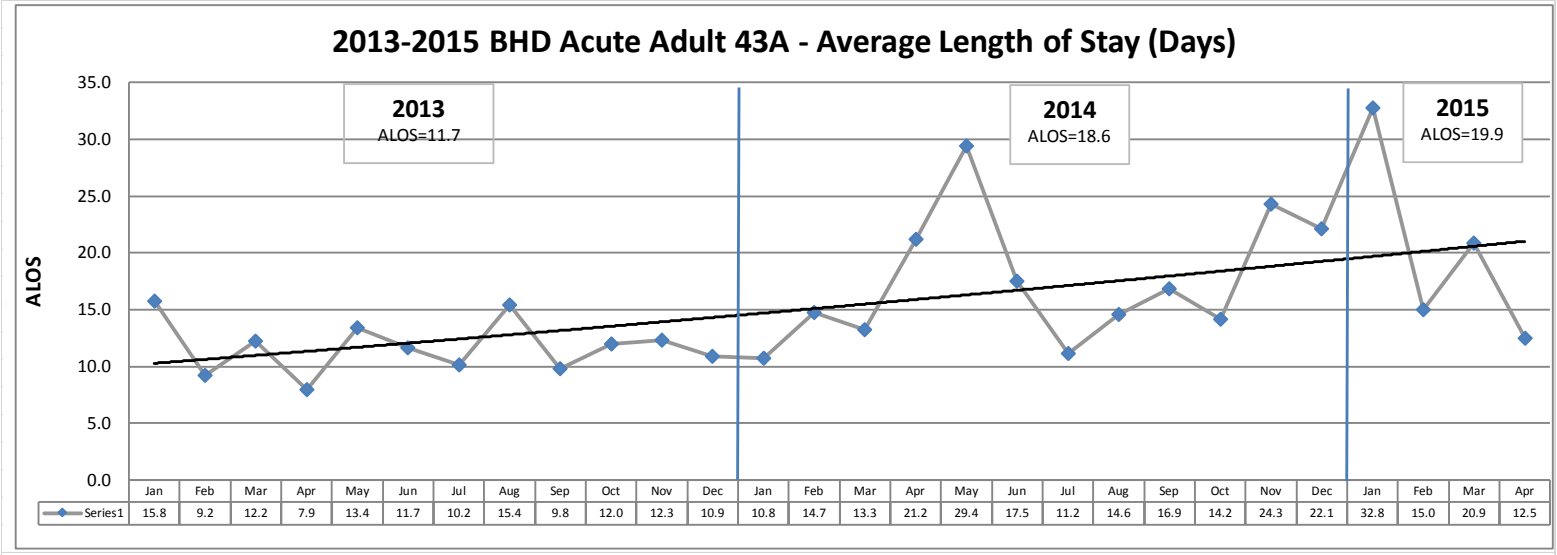
	2010	2013
Expense/Pt Day	982.78	1,293.01
NPR/Pt Day	($335.63)	($374.79)
Recovery Rate	34%	29%

[21] For purposes of this analysis, between 23% and 27% of total PCS expense was determined to be properly categorized as community-based services, rather than inpatient services. These include purchase of service contracts that are budgeted in PCS and expenses relating to the Mobile Treatment Team and Outpatient Clinic. BHD reported that these services are entirely funded with levy.

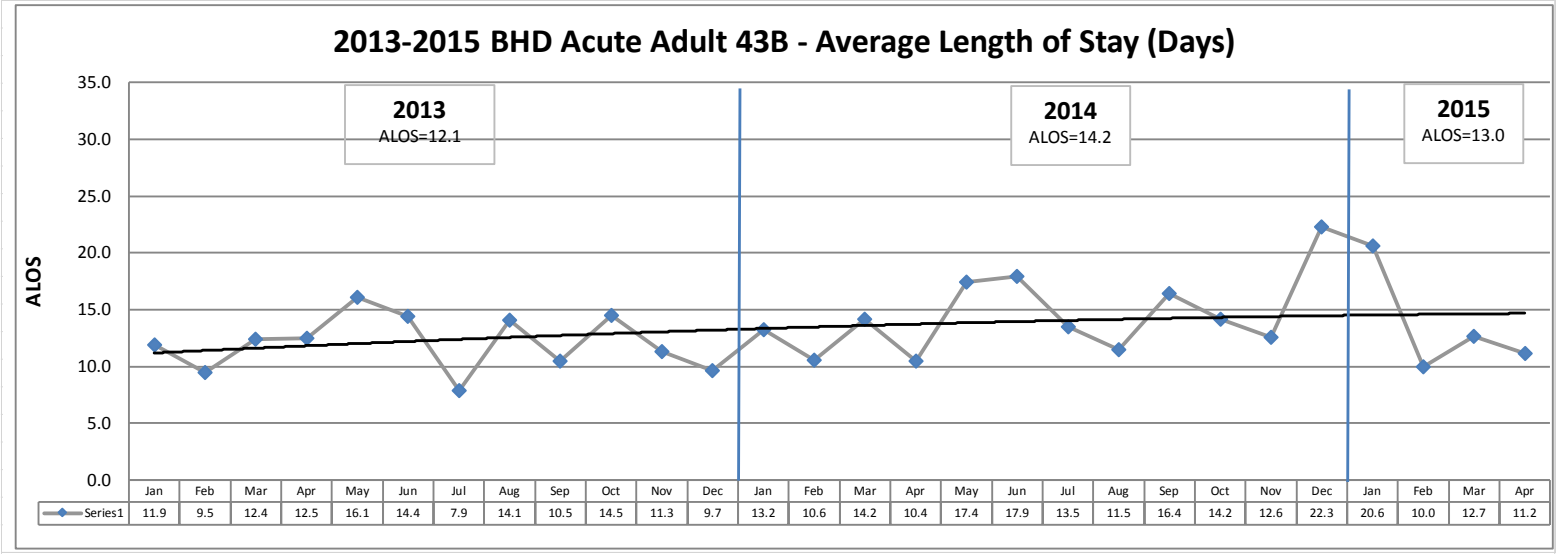
ATTACHMENT - D



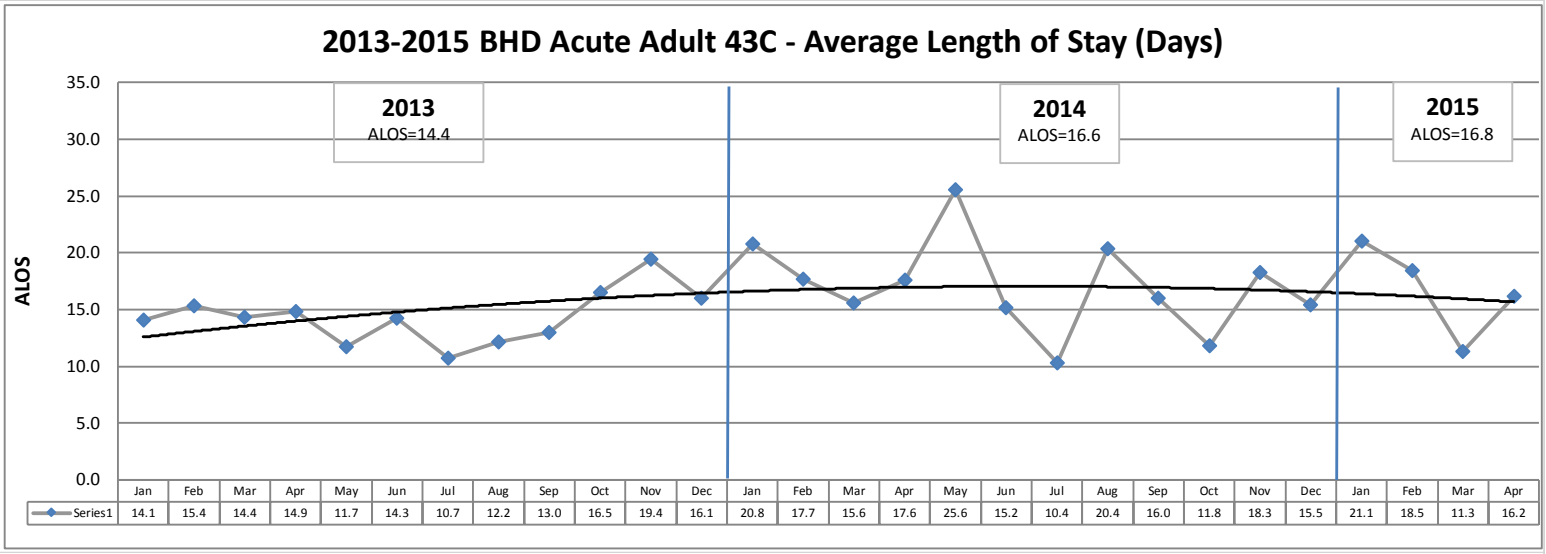
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Series1	13.7	13.2	12.4	11.8	14.9	14.4	12.6	13.4	11.2	14.2	14.0	11.8	14.6	13.9	14.4	15.8	24.0	16.7	11.9	14.5	16.4	13.3	16.9	20.2	24.6	18.0	14.0	13.1

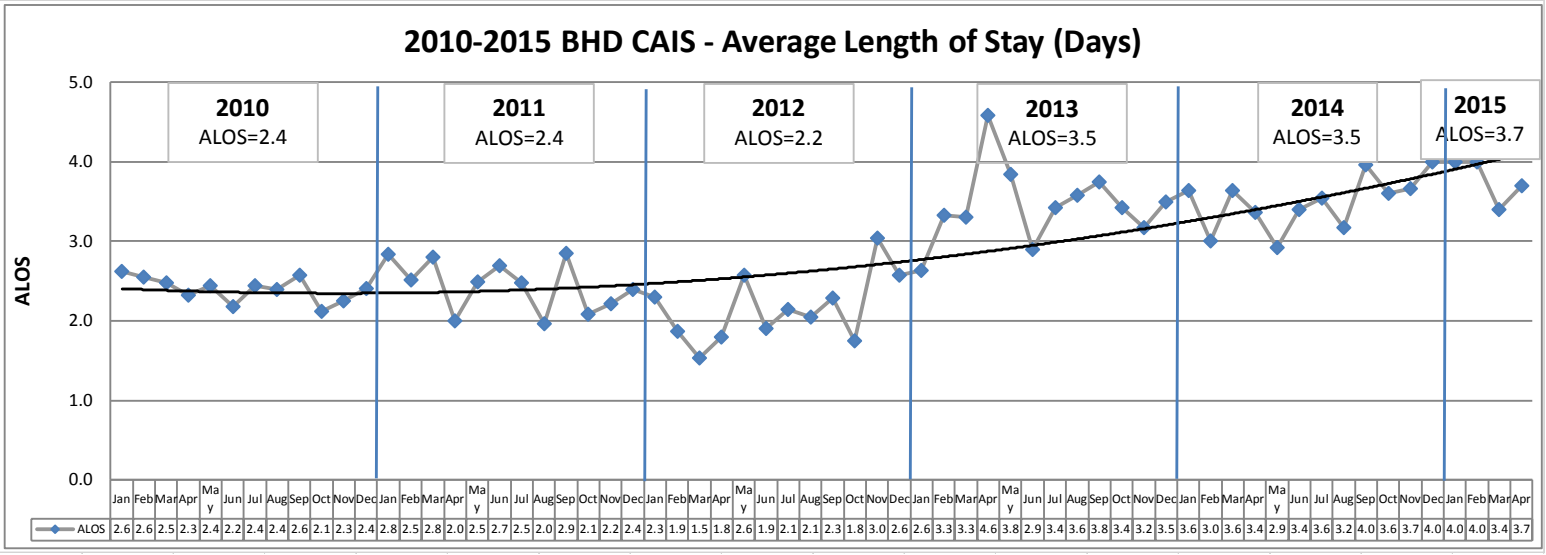


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Series1	15.8	9.2	12.2	7.9	13.4	11.7	10.2	15.4	9.8	12.0	12.3	10.9	10.8	14.7	13.3	21.2	29.4	17.5	11.2	14.6	16.9	14.2	24.3	22.1	32.8	15.0	20.9	12.5



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Series1	11.9	9.5	12.4	12.5	16.1	14.4	7.9	14.1	10.5	14.5	11.3	9.7	13.2	10.6	14.2	10.4	17.4	17.9	13.5	11.5	16.4	14.2	12.6	22.3	20.6	10.0	12.7	11.2


2013-2015 BHD Acute Adult 43C - Average Length of Stay (Days)
ALOS
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
2013
ALOS=14.4
2014
ALOS=16.6
2015
ALOS=16.8
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
Series1 14.1 15.4 14.4 14.9 11.7 14.3 10.7 12.2 13.0 16.5 19.4 16.1 20.8 17.7 15.6 17.6 25.6 15.2 10.4 20.4 16.0 11.8 18.3 15.5 21.1 18.5 11.3 16.2


2010-2015 BHD CAIS - Average Length of Stay (Days)
ALOS
5.0
4.0
3.0
2.0
1.0
0.0
2010
ALOS=2.4
2011
ALOS=2.4
2012
ALOS=2.2
2013
ALOS=3.5
2014
ALOS=3.5
2015
ALOS=3.7
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr
ALOS 2.6 2.6 2.5 2.3 2.4 2.2 2.4 2.4 2.6 2.1 2.3 2.4 2.8 2.5 2.8 2.0 2.5 2.7 2.5 2.0 2.9 2.1 2.2 2.4 2.3 1.9 1.5 1.8 2.6 1.9 2.1 2.1 2.3 1.8 3.0 2.6 2.6 3.3 3.3 4.6 3.8 2.9 3.4 3.6 3.8 3.4 3.2 3.5 3.6 3.0 3.6 3.4 2.9 3.4 3.6 3.2 4.0 3.6 3.7 4.0 4.0 4.0 3.4 3.7

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Attachment E

Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

Program	Diagnosis Description	Patient Gender		
		Female	Male	Total
43A Intensive Treatment Unit	ADJUST DIS EMOT/CONDUCT DISTUR	0	1	1
	ADJUSTMENT DISORDER ANXIETY	0	1	1
	ADJUSTMENT DISORDER DEPRESSED	0	1	1
	ADJUSTMENT DISORDER MIXED	1	1	2
	BIPOLAR DISORDER UNSPECIFIED	0	1	1
	BIPOLAR I DIS MANIC MILD	0	1	1
	BIPOLAR I DIS MANIC MODERATE	0	1	1
	BIPOLAR I DIS MANIC SEV NO PSYCH	2	5	7
	BIPOLAR I DIS MANIC SEV PSYCH	3	49	52
	BIPOLAR I DIS MANIC UNS	0	1	1
	BORDERLINE PERSONALITY DIS	1	0	1
	DELIRIUM IN OTHER CONDITIONS	0	1	1
	DEPRESSIVE DISORDER OTHER	0	4	4
	DRUG-INDUCED MOOD DISORDER	1	5	6
	MAJ DEPRESS DIS RECUR EPI SEV PSYCH	0	2	2
	SCHIZOAFFECTIVE DIS UNSPEC	10	105	115
	SCHIZOPHREN PARANOID CHRONIC	0	2	2
	SCHIZOPHREN PARANOID UNS	0	7	7
	UNS IMPULSE CONTROL DISORDER	0	2	2
	UNS SCHIZOPHRENIA	0	29	29
	UNSPEC EPISODIC MOOD DISORDER	1	14	15
	UNSPECIFIED PSYCHOSIS	1	21	22
	Total	20	254	274
43B Adult Acute Unit	ADJUST DIS EMOT/CONDUCT DISTUR	0	4	4
	ADJUSTMENT DISORDER ANXIETY	1	0	1
	ADJUSTMENT DISORDER DEPRESSED	0	2	2
	ADJUSTMENT DISORDER MIXED	0	2	2
	ALCOHOL ABUSE UNSPEC	0	1	1

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
43B Adult Acute Unit	ALCOHOL-INDUCED PERSIST DEMENTIA	0	1	1
	ANTISOCIAL PERSONALITY DISORDER	0	2	2
	BIPOLAR DISORDER UNSPECIFIED	4	10	14
	BIPOLAR I DIS DEPRESS SEV NO PSYCH	0	1	1
	BIPOLAR I DIS DEPRESSED MODERATE	0	1	1
	BIPOLAR I DIS DEPRESSED UNS	0	1	1
	BIPOLAR I DIS MANIC MILD	1	1	2
	BIPOLAR I DIS MANIC MODERATE	1	5	6
	BIPOLAR I DIS MANIC SEV NO PSYCH	0	3	3
	BIPOLAR I DIS MANIC SEV PSYCH	11	18	29
	BIPOLAR I DIS MANIC UNS	2	7	9
	BIPOLAR I DIS MIXED MODERATE	1	0	1
	BIPOLAR I DIS MIXED SEV NO PSYCH	0	1	1
	BIPOLAR I DIS MIXED SEV PSYCH	1	2	3
	BIPOLAR I DISORDER UNSPECIFIED	3	3	6
	BORDERLINE PERSONALITY DIS	1	3	4
	COCAINE ABUSE UNS	1	0	1
	COMBO DRUG DEPEND EX OPIOIDS UNS	0	1	1
	CONVERSION DISORDER	1	0	1
	DEFERRED	0	1	1
	DELUSIONAL DISORDER	1	0	1
	DEMENTIA DUE TO HEAD TRAUMA, OR HIV DISE	0	1	1
	DEPENDENT PERSONALITY DISORDER	0	1	1
	DEPRESSIVE DISORDER OTHER	1	3	4
	DEPRESSIVE TYPE PSYCHOSIS	0	1	1
	DRUG WITHDRAWAL	0	1	1
	DRUG-INDUCD DELIRIUM	0	1	1
	DRUG-INDUCED MOOD DISORDER	0	3	3
	DRUG-INDUCED PSYCHOT DELUSIONS	0	1	1

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Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
43B Adult Acute Unit	DYSTHYMIC DISORDER	0	1	1
	GENERALIZED ANXIETY DISORDER	0	1	1
	MAJ DEPRESS DIS RECUR EPI SEV	0	11	11
	MAJ DEPRESS DIS RECUR EPI SEV PSYCH	0	4	4
	MAJ DEPRESS DIS RECURR EPI MILD	0	1	1
	MAJ DEPRESS DIS RECURR EPI MOD	0	1	1
	MAJ DEPRESS DIS RECURR EPI UNS	0	1	1
	MAJ DEPRESS DIS SGL EPI MODERATE	0	1	1
	MAJ DEPRESS DIS SGL EPI SEV	1	0	1
	MAJ DEPRESS DIS SGL EPI SEV PSYCH	1	1	2
	OTH MENTAL PROBLEMS	0	2	2
	OTH/UNS ALCOHOL DEPENDENCE UNS	0	3	3
	OTH/UNS REACTIVE PSYCHOSIS	1	0	1
	OTH/UNSP BIPOLAR DISORDER OTHER	0	1	1
	POSTTRAUMATIC STRESS DISORDER	0	2	2
	SCHIZOAFFECTIVE DIS UNSPEC	24	98	122
	SCHIZOPHREN CATATONIC UNS	0	3	3
	SCHIZOPHREN DISORGANIZED CHRONIC	0	2	2
	SCHIZOPHREN DISORGANIZED UNS	0	2	2
	SCHIZOPHREN PARANOID CHRONIC	0	15	15
	SCHIZOPHREN PARANOID UNS	0	22	22
	UNS DRUG-INDUCD MENTAL DISORDER	0	1	1
	UNS IMPULSE CONTROL DISORDER	0	2	2
	UNS PERSONALITY DISORDER	0	5	5
	UNS SCHIZOPHRENIA	3	52	55
	UNSPEC EPISODIC MOOD DISORDER	2	13	15
	UNSPECIFIED PSYCHOSIS	10	45	55
	Total	72	372	444
43C Women's Treatment	ADJUST DIS EMOT/CONDUCT DISTUR	2	0	2

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
43C Women's Treatment Unit	ADJUSTMENT DISORDER DEPRESSED	3	0	3
	ADJUSTMENT DISORDER MIXED	1	0	1
	ANXIETY STATE UNSPECIFIED	2	0	2
	AUTISTIC DISORDER CURR/ACTIVE	1	0	1
	BIPOLAR DISORDER UNSPECIFIED	14	0	14
	BIPOLAR I DIS DEPRESS SEV NO PSYCH	2	0	2
	BIPOLAR I DIS DEPRESSED MODERATE	1	0	1
	BIPOLAR I DIS DEPRESSED SEV PSYCH	1	0	1
	BIPOLAR I DIS MANIC MILD	1	0	1
	BIPOLAR I DIS MANIC SEV NO PSYCH	6	0	6
	BIPOLAR I DIS MANIC SEV PSYCH	48	0	48
	BIPOLAR I DIS MANIC UNS	1	0	1
	BIPOLAR I DIS MIXED MODERATE	1	0	1
	BIPOLAR I DIS MIXED SEV NO PSYCH	1	0	1
	BIPOLAR I DIS MIXED SEV PSYCH	3	0	3
	BIPOLAR I DIS MIXED UNS	1	0	1
	BIPOLAR I DISORDER UNSPECIFIED	3	0	3
	BORDERLINE PERSONALITY DIS	3	0	3
	COMBO DRUG DEPEND EX OPIOIDS UNS	2	0	2
	DEFERRED	3	0	3
	DELIRIUM IN OTHER CONDITIONS	1	0	1
	DELUSIONAL DISORDER	1	0	1
	DEPRESSIVE DISORDER OTHER	8	0	8
	DRUG-INDUCD DELIRIUM	1	0	1
	DRUG-INDUCED MOOD DISORDER	2	0	2
	DRUG-INDUCED PSYCHOT DELUSIONS	1	0	1
	MAJ DEPRESS DIS RECUR EPI SEV	9	0	9
	MAJ DEPRESS DIS RECUR EPI SEV PSYCH	3	0	3
	MAJ DEPRESS DIS RECURR EPI MOD	4	0	4

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
43C Women's Treatment Unit	MAJ DEPRESS DIS SGL EPI MODERATE	2	0	2
	MAJ DEPRESS DIS SGL EPI SEV	1	0	1
	MAJ DEPRESS DIS SGL EPI SEV PSYCH	3	0	3
	MENTAL DISORDER ANTEPART	1	0	1
	OPIOID ABUSE UNS	1	0	1
	OTH MENTAL PROBLEMS	1	0	1
	OTH/UNS ALCOHOL DEPENDENCE UNS	1	0	1
	SCHIZOAFFECTIVE DIS UNSPEC	132	0	132
	SCHIZOPHREN DISORGANIZED UNS	1	0	1
	SCHIZOPHREN PARANOID CHRONIC	11	0	11
	SCHIZOPHREN PARANOID UNS	10	0	10
	SCHIZOPHRENIFORM DISORDER UNS	3	0	3
	SHARED PSYCHOTIC DISORDER	1	0	1
	UNS IMPULSE CONTROL DISORDER	1	0	1
	UNS PERSONALITY DISORDER	1	0	1
	UNS SCHIZOPHRENIA	16	0	16
	UNSPEC EPISODIC MOOD DISORDER	33	0	33
	UNSPECIFIED PSYCHOSIS	41	0	41
	VASCULAR DEMENTIA UNCOMPL	1	0	1
	Total	391	0	391
Total		483	626	1,109

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Attachment F

Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

Program	Diagnosis Description	Patient Gender		
		Female	Male	Total
53B Acute CAIS	AC STRESS REAC EMOTIONAL DISTURB	1	0	1
	ADJUST DIS CONDUCT DISTURB	2	0	2
	ADJUST DIS EMOT/CONDUCT DISTUR	42	37	79
	ADJUSTMENT DISORDER ANXIETY	1	1	2
	ADJUSTMENT DISORDER DEPRESSED	17	10	27
	ADJUSTMENT DISORDER MIXED	14	13	27
	AMPHETAMINE/RELATED DRUG ABUSE UNS	1	0	1
	ANXIETY STATE UNSPECIFIED	3	3	6
	ATTENTION DEFICIT DIS W HYPERACT	5	7	12
	AUTISTIC DISORDER CURR/ACTIVE	1	1	2
	BIPOLAR DISORDER UNSPECIFIED	3	5	8
	BIPOLAR I DIS DEPRESS SEV NO PSYCH	2	1	3
	BIPOLAR I DIS DEPRESSED MODERATE	2	1	3
	BIPOLAR I DIS DEPRESSED SEV PSYCH	0	1	1
	BIPOLAR I DIS MANIC MODERATE	1	1	2
	BIPOLAR I DIS MANIC SEV NO PSYCH	4	0	4
	BIPOLAR I DIS MANIC SEV PSYCH	2	2	4
	BIPOLAR I DIS MANIC UNS	1	0	1
	BIPOLAR I DIS MIXED MODERATE	3	2	5
	BIPOLAR I DIS MIXED SEV NO PSYCH	6	1	7
	BIPOLAR I DIS MIXED UNS	1	1	2
	BIPOLAR I DISORDER UNSPECIFIED	6	1	7
	BORDERLINE PERSONALITY DIS	5	0	5
	CANNABIS ABUSE UNS	0	2	2
	CONDUCT DISORDER ADOLESCENT ONSET	3	4	7
	CONDUCT DISORDER CHILDHOOD ONSET	1	11	12
	CONVERSION DISORDER	0	1	1
	DEFERRED	1	0	1

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
53B Acute CAIS	DEPRESSIVE DISORDER OTHER	61	32	93
	DEPRESSIVE TYPE PSYCHOSIS	2	3	5
	DRUG-INDUCED MOOD DISORDER	0	1	1
	GENERALIZED ANXIETY DISORDER	3	2	5
	INTERMITTENT EXPLOSIVE DISORDER	0	1	1
	MAJ DEPRESS DIS RECUR EPI SEV	12	9	21
	MAJ DEPRESS DIS RECUR EPI SEV PSYCH	1	1	2
	MAJ DEPRESS DIS RECURR EPI MILD	0	1	1
	MAJ DEPRESS DIS RECURR EPI MOD	13	4	17
	MAJ DEPRESS DIS RECURR EPI UNS	4	1	5
	MAJ DEPRESS DIS SGL EPI MODERATE	6	1	7
	MAJ DEPRESS DIS SGL EPI SEV	32	9	41
	MAJ DEPRESS DIS SGL EPI SEV PSYCH	6	2	8
	MAJ DEPRESS DIS SINGLE EPI MILD	1	0	1
	OPPOSITIONAL DEFIANT DISORDER	11	9	20
	OTH EMOTIONAL DISTURBANCE CHILDHOOD	0	2	2
	OTH MIXED/UNS DRUG ABUSE UNS	0	1	1
	POSTTRAUMATIC STRESS DISORDER	12	12	24
	SCHIZOAFFECTIVE DIS UNSPEC	1	4	5
	SCHIZOPHREN DISORGANIZED CHRONIC	0	1	1
	SCHIZOPHREN PARANOID CHRONIC	1	0	1
	SCHIZOPHREN PARANOID UNS	0	1	1
	SCHIZOPHRENIFORM DISORDER UNS	1	2	3
	UNS ADJUST REAC	3	1	4
	UNS DISTURBANCE CONDUCT	3	12	15
	UNS IMPULSE CONTROL DISORDER	4	2	6
	UNS SCHIZOPHRENIA	1	0	1
	UNSP NONPSYCHOTIC MENTAL DIS	0	1	1
	UNSP PERVASIVE DEVELOP DIS ACTIVE	0	2	2

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
53B Acute CAIS	UNSPEC EPISODIC MOOD DISORDER	223	171	394
	UNSPECIFIED PSYCHOSIS	5	23	28
	Total	534	417	951
Total		534	417	951

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Attachment G

Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

Program	Diagnosis Description	Patient Gender		
		Female	Male	Total
Observation	AC STRESS REAC EMOTIONAL DISTURB	1	0	1
	ACUTE ALCOHOLIC INTOXI UNS	2	5	7
	ADJUST DIS CONDUCT DISTURB	3	1	4
	ADJUST DIS EMOT/CONDUCT DISTUR	2	4	6
	ADJUSTMENT DISORDER ANXIETY	0	1	1
	ADJUSTMENT DISORDER DEPRESSED	11	18	29
	ADJUSTMENT DISORDER MIXED	13	13	26
	ALCOHOL ABUSE UNSPEC	1	2	3
	AMPHETAMINE/RELATED DRUG ABUSE UNS	0	1	1
	ANTISOCIAL PERSONALITY DISORDER	0	8	8
	ANXIETY STATE UNSPECIFIED	2	4	6
	ATTENTION DEFICIT DIS WO HYPERACTV	0	1	1
	AUTISTIC DISORDER CURR/ACTIVE	2	5	7
	BIPOLAR DISORDER UNSPECIFIED	8	12	20
	BIPOLAR I DIS DEPRESS SEV NO PSYCH	2	1	3
	BIPOLAR I DIS DEPRESSED MODERATE	4	4	8
	BIPOLAR I DIS DEPRESSED SEV PSYCH	1	0	1
	BIPOLAR I DIS DEPRESSED UNS	1	1	2
	BIPOLAR I DIS MANIC MILD	4	1	5
	BIPOLAR I DIS MANIC MODERATE	5	4	9
	BIPOLAR I DIS MANIC SEV NO PSYCH	9	7	16
	BIPOLAR I DIS MANIC SEV PSYCH	15	16	31
	BIPOLAR I DIS MANIC UNS	4	5	9
	BIPOLAR I DIS MIXED MODERATE	1	0	1
	BIPOLAR I DIS MIXED SEV NO PSYCH	0	2	2
	BIPOLAR I DIS MIXED SEV PSYCH	0	2	2
	BIPOLAR I DIS MIXED UNS	4	5	9
	BIPOLAR I DIS SINGLE EPI UNS	0	1	1

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Observation	BIPOLAR I DISORDER UNSPECIFIED	2	3	5
	BORDERLINE PERSONALITY DIS	19	3	22
	CANNABIS ABUSE UNS	0	1	1
	COCAINE ABUSE UNS	0	2	2
	COCAINE DEPENDENCE UNS	2	5	7
	COMBO DRUG DEPEND EX OPIOIDS REMISS	0	1	1
	COMBO DRUG DEPEND EX OPIOIDS UNS	1	4	5
	CONVERSION DISORDER	1	0	1
	DEFERRED	1	0	1
	DELIRIUM IN OTHER CONDITIONS	0	1	1
	DELUSIONAL DISORDER	2	2	4
	DEMENTIA UNSPEC W BEHAV DISTURBANCE	0	1	1
	DEMENTIA W BEHAVIORAL DISTURBANCE	0	1	1
	DEPRESSIVE DISORDER OTHER	46	55	101
	DEPRESSIVE TYPE PSYCHOSIS	0	3	3
	DRUG-INDUCED MOOD DISORDER	4	8	12
	DRUG-INDUCED PSYCHOT HALLUCINATN	2	1	3
	DYSTHYMIC DISORDER	1	1	2
	HISTORY SCHIZOPHRENIA	0	1	1
	IDIOSYNCRATIC ALCOHOL INTOXICATION	1	2	3
	INTERMITTENT EXPLOSIVE DISORDER	0	2	2
	MAJ DEPRESS DIS RECUR EPI SEV	9	7	16
	MAJ DEPRESS DIS RECUR EPI SEV PSYCH	3	1	4
	MAJ DEPRESS DIS RECURR EPI MILD	4	4	8
	MAJ DEPRESS DIS RECURR EPI MOD	19	5	24
	MAJ DEPRESS DIS RECURR EPI UNS	1	2	3
	MAJ DEPRESS DIS SGL EPI MODERATE	2	4	6
	MAJ DEPRESS DIS SGL EPI SEV	2	3	5
	MAJ DEPRESS DIS SGL EPI SEV PSYCH	1	2	3

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Observation	MODERATE INTELLECTUAL DISABILITIES	3	3	6
	No Entry	0	1	1
	OBSESSIVE COMPULSIVE DISORDERS	1	1	2
	OPIOID ABUSE UNS	0	1	1
	OPIOID TYPE DEPENDENCE UNS	2	1	3
	OPPOSITIONAL DEFIANT DISORDER	0	1	1
	OTH DISORDERS IMPULSE CONTROL	0	1	1
	OTH MENTAL PROBLEMS	3	2	5
	OTH/UNS ALCOHOL DEPENDENCE UNS	1	5	6
	OTH/UNS REACTIVE PSYCHOSIS	3	2	5
	OTH/UNSP BIPOLAR DISORDER OTHER	1	1	2
	POSTTRAUMATIC STRESS DISORDER	9	6	15
	SCHIZOAFFECTIVE DIS UNSPEC	43	73	116
	SCHIZOPHREN DISORGANIZED CHRONIC	0	2	2
	SCHIZOPHREN DISORGANIZED UNS	1	4	5
	SCHIZOPHREN PARANOID CHRONIC	4	2	6
	SCHIZOPHREN PARANOID UNS	10	22	32
	SCHIZOPHRENIFORM DISORDER UNS	1	0	1
	SED/HYP/ANX DEPEND UNS	0	1	1
	SENILE DEMENTIA UNCOMPLICATED	0	1	1
	SOMATIZATION DISORDER	1	0	1
	UNS ADJUST REAC	3	4	7
	UNS DISTURBANCE CONDUCT	0	2	2
	UNS DRUG-INDUCD MENTAL DISORDER	0	3	3
	UNS IMPULSE CONTROL DISORDER	8	19	27
	UNS INTELLECTUAL DISABILITIES	2	1	3
	UNS MENTAL/BEHAVIORAL PROBLEM	3	1	4
	UNS PERSONALITY DISORDER	11	11	22
	UNS SCHIZOPHRENIA	24	67	91

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Observation	UNS SCHIZOPHRENIA CHRONIC	0	2	2
	UNSP PERVASIVE DEVELOP DIS ACTIVE	2	2	4
	UNSPEC EPISODIC MOOD DISORDER	73	98	171
	UNSPECIFIED PSYCHOSIS	53	123	176
	Total	480	712	1,192
Total		480	712	1,192

Attachment H

2014 BHD Psychiatric Crisis Service Admissions by Zip Code

Rank	Zip	City	Admissions		
			N	%	Percentile %
1	53206	Milwaukee	815	7.6	
2	53218	Milwaukee	746	7.0	
3	53205	Milwaukee	739	6.9	
4	53209	Milwaukee	727	6.8	
5	53208	Milwaukee	671	6.3	
6	53216	Milwaukee	542	5.1	
7	53204	Milwaukee	536	5.0	
8	53210	Milwaukee	535	5.0	
9	53215	Milwaukee	482	4.5	
10	53212	Milwaukee	479	4.5	58.6
11	53214	Milwaukee	362	3.4	
12	53225	Milwaukee	298	2.8	
13	53222	Milwaukee	286	2.7	
14	53219	Milwaukee	278	2.6	
15	53221	Milwaukee	239	2.2	
16	53223	Milwaukee	236	2.2	
17	53207	Milwaukee	230	2.2	
18	53224	Milwaukee	198	1.9	
19	53233	Milwaukee	186	1.7	
20	53227	Milwaukee	178	1.7	81.9
21	53220	Milwaukee	174	1.6	
22	53202	Milwaukee	159	1.5	
23	53172	South Milwaukee	154	1.4	
24	53154	Oak Creek	140	1.3	
25	53226	Milwaukee	120	1.1	
26	53110	Cudahy	111	1.0	
27	53213	Milwaukee	93	0.9	
28	53132	Franklin	79	0.7	
29	53129	Greendale	73	0.7	
30	53211	Milwaukee	67	0.6	92.9
31	53228	Milwaukee	61	0.6	
32	53235	Milwaukee	60	0.6	
33	53217	Milwaukee	57	0.5	
34	53130	Hales Corners	36	0.3	
35	53186	Waukesha	31	0.3	
36	53072	Pewaukee	20	0.2	
37	53092	Theinsville	17	0.2	
38	53151	New Berlin	15	0.1	
39	53140	Kenosha	14	0.1	
40	53188	Waukesha	14	0.1	95.9
41	53203	Milwaukee	13	0.1	
42	60609	Chicago	13	0.1	
43	53029	Hartland	10	0.1	
44	53051	Menomonee Falls	10	0.1	
45	53066	Oconomowoc	10	0.1	
46	53406	Racine	10	0.1	
47	53005	Brookfield	9	0.1	
48	53189	Waukesha	8	0.1	
49	53403	Racine	8	0.1	
50	53149	Mukwonago	7	0.1	96.8
51 - 209	Other Zip Codes		340	3.2	
Total			10696	100.0	

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Attachment I

Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

Program	Diagnosis Description	Patient Gender		
		Female	Male	Total
Psychiatric Crisis Services	AC STRESS REAC EMOTIONAL DISTURB	9	2	11
	ACUTE ALCOHOLIC INTOXI EPISODIC	0	1	1
	ACUTE ALCOHOLIC INTOXI UNS	88	259	347
	ADJUST DIS CONDUCT DISTURB	36	73	109
	ADJUST DIS EMOT/CONDUCT DISTUR	68	79	147
	ADJUSTMENT DISORDER ANXIETY	23	35	58
	ADJUSTMENT DISORDER DEPRESSED	149	171	320
	ADJUSTMENT DISORDER MIXED	209	232	441
	ALCOHOL ABUSE UNSPEC	66	148	214
	ALCOHOL PERSIST AMNESTIC DISORDER	0	1	1
	ALCOHOL WDRAWAL DELIRIUM	0	1	1
	ALCOHOL WITHDRAWAL	6	8	14
	ALCOHOL-INDUCED DELUSIONS	1	0	1
	ALCOHOL-INDUCED HALLUCINATIONS	0	2	2
	ALCOHOL-INDUCED PERSIST DEMENTIA	0	1	1
	AMPHETAMINE/RELATED DRUG ABUSE UNS	1	1	2
	ANTISOCIAL PERSONALITY DISORDER	8	136	144
	ANXIETY STATE UNSPECIFIED	45	33	78
	ATTENTION DEFICIT DIS W HYPERACT	8	47	55
	ATTENTION DEFICIT DIS WO HYPERACTV	4	9	13
	AUTISTIC DISORDER CURR/ACTIVE	7	17	24
	BEREAVEMENT UNCOMPLICATED	6	3	9
	BIPOLAR DISORDER UNSPECIFIED	77	73	150
	BIPOLAR I DIS DEPRESS SEV NO PSYCH	4	4	8
	BIPOLAR I DIS DEPRESSED MILD	4	0	4
	BIPOLAR I DIS DEPRESSED MODERATE	11	6	17
	BIPOLAR I DIS DEPRESSED SEV PSYCH	4	2	6
	BIPOLAR I DIS DEPRESSED UNS	5	5	10

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Psychiatric Crisis Services	BIPOLAR I DIS MANIC MILD	11	7	18
	BIPOLAR I DIS MANIC MODERATE	9	9	18
	BIPOLAR I DIS MANIC SEV NO PSYCH	12	6	18
	BIPOLAR I DIS MANIC SEV PSYCH	44	45	89
	BIPOLAR I DIS MANIC UNS	32	25	57
	BIPOLAR I DIS MIXED MODERATE	3	0	3
	BIPOLAR I DIS MIXED SEV NO PSYCH	4	3	7
	BIPOLAR I DIS MIXED SEV PSYCH	2	5	7
	BIPOLAR I DIS MIXED UNS	20	13	33
	BIPOLAR I DIS SINGLE EPI UNS	0	1	1
	BIPOLAR I DISORDER UNSPECIFIED	19	21	40
	BORDERLINE PERSONALITY DIS	123	15	138
	CANNABIS ABUSE UNS	4	25	29
	CANNABIS DEPENDENCE UNS	3	14	17
	COCAINE ABUSE UNS	26	75	101
	COCAINE DEPENDENCE UNS	63	78	141
	COMBO DRUG DEPEND EX OPIOIDS REMISS	0	1	1
	COMBO DRUG DEPEND EX OPIOIDS UNS	65	211	276
	CONDUCT DISORDER ADOLESCENT ONSET	9	23	32
	CONDUCT DISORDER CHILDHOOD ONSET	5	35	40
	CONVERSION DISORDER	2	0	2
	DEFERRED	19	40	59
	DELIRIUM IN OTHER CONDITIONS	10	4	14
	DELUSIONAL DISORDER	10	3	13
	DEMENTIA UNSPEC W BEHAV DISTURBANCE	2	6	8
	DEMENTIA W BEHAVIORAL DISTURBANCE	4	5	9
	DEPENDENT PERSONALITY DISORDER	2	0	2
	DEPRESSIVE DISORDER OTHER	505	370	875
	DEPRESSIVE TYPE PSYCHOSIS	6	4	10

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Psychiatric Crisis Services	DRUG WITHDRAWAL	3	2	5
	DRUG-INDUCD DELIRIUM	0	2	2
	DRUG-INDUCED MOOD DISORDER	56	114	170
	DRUG-INDUCED PSYCHOT DELUSIONS	0	3	3
	DRUG-INDUCED PSYCHOT HALLUCINATN	8	10	18
	DYSTHYMIC DISORDER	2	1	3
	EATING DISORDER UNSPECIFIED	2	0	2
	FACTITIOUS DISORDER W PSYCH SYMPTOM	0	1	1
	FETISHISM	0	2	2
	GENERALIZED ANXIETY DISORDER	8	7	15
	HISTORY SCHIZOPHRENIA	0	3	3
	IDIOSYNCRATIC ALCOHOL INTOXICATION	51	181	232
	INTERMITTENT EXPLOSIVE DISORDER	3	21	24
	LATENT SCHIZOPHRENIA CHRONIC	0	1	1
	LATENT SCHIZOPHRENIA UNS	0	2	2
	MAJ DEPRESS DIS RECUR EPI SEV	48	23	71
	MAJ DEPRESS DIS RECUR EPI SEV PSYCH	15	13	28
	MAJ DEPRESS DIS RECURR EPI MILD	9	10	19
	MAJ DEPRESS DIS RECURR EPI MOD	54	20	74
	MAJ DEPRESS DIS RECURR EPI UNS	22	9	31
	MAJ DEPRESS DIS SGL EPI MODERATE	18	18	36
	MAJ DEPRESS DIS SGL EPI SEV	38	22	60
	MAJ DEPRESS DIS SGL EPI SEV PSYCH	8	6	14
	MAJ DEPRESS DIS SINGLE EPI MILD	2	6	8
	MILD INTELLECTUAL DISABILITIES	4	4	8
	MODERATE INTELLECTUAL DISABILITIES	3	2	5
	MOOD DISORDER IN OTHER CONDITIONS	0	1	1
	NO DIAGNOSIS	93	172	265
	No Entry	4	12	16

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Psychiatric Crisis Services	OBSESSIVE COMPULSIVE DISORDERS	0	8	8
	OPIOID ABUSE UNS	5	12	17
	OPIOID TYPE DEPENDENCE CONTINUOUS	0	2	2
	OPIOID TYPE DEPENDENCE UNS	26	71	97
	OPPOSITIONAL DEFIANT DISORDER	69	51	120
	OTH ALTERATION CONSCIOUSNESS	1	2	3
	OTH DISORDERS IMPULSE CONTROL	0	6	6
	OTH EMOTIONAL DISTURBANCE CHILDHOOD	0	2	2
	OTH MENTAL PROBLEMS	23	27	50
	OTH MIXED/UNS DRUG ABUSE UNS	1	4	5
	OTH PSYCHOLOGICAL/PHYSICAL STRESS	3	4	7
	OTH/UNS ALCOHOL DEPENDENCE UNS	82	265	347
	OTH/UNS REACTIVE PSYCHOSIS	5	15	20
	OTH/UNSP BIPOLAR DISORDER OTHER	7	1	8
	OTHER ALCOHOL-INDUCED MENTAL DIS	4	20	24
	OTHER DRUG DEPENDENCE UNS	2	5	7
	OTHER PERVASIVE DEVELOP DIS ACTIVE	2	4	6
	PANIC DISORDER WO AGORAPHOBIA	0	2	2
	PATHOLOGICAL DRUG INTOXICATION	1	4	5
	PATHOLOGICAL GAMBLING	0	1	1
	PERSON FEIGNING ILLNESS	0	15	15
	POSTTRAUMATIC STRESS DISORDER	48	47	95
	SCHIZOAFFECTIVE DIS CHRONIC	2	1	3
	SCHIZOAFFECTIVE DIS UNSPEC	305	394	699
	SCHIZOPHREN CATATONIC UNS	1	1	2
	SCHIZOPHREN DISORGANIZED CHRONIC	1	11	12
	SCHIZOPHREN DISORGANIZED UNS	11	13	24
	SCHIZOPHREN PARANOID CHRONIC	22	23	45
	SCHIZOPHREN PARANOID UNS	48	88	136

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Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Psychiatric Crisis Services	SCHIZOPHREN SIMPLE UNS	0	3	3
	SCHIZOPHRENIC DIS RESIDUAL UNS	0	4	4
	SCHIZOPHRENIFORM DISORDER UNS	1	4	5
	SED/HYP/ANX ABUSE UNS	1	1	2
	SED/HYP/ANX DEPEND UNS	0	2	2
	SENILE DEMENTIA UNCOMPLICATED	2	1	3
	SEVERE INTELLECTUAL DISABILITIES	1	2	3
	SOCIALIZED CONDUCT DISORDER SEVERE	0	1	1
	UNS ADJUST REAC	53	79	132
	UNS DELAY IN DEVELOPMENT	2	2	4
	UNS DISSOCIATIVE DISORDER/REACTION	0	1	1
	UNS DISTURBANCE CONDUCT	19	58	77
	UNS DRUG-INDUCD MENTAL DISORDER	1	8	9
	UNS IMPULSE CONTROL DISORDER	58	110	168
	UNS INTELLECTUAL DISABILITIES	6	5	11
	UNS MENTAL/BEHAVIORAL PROBLEM	21	39	60
	UNS NONORGANIC SLEEP DISORDER	2	1	3
	UNS PERSIST MENT DIS IN OT COND	1	1	2
	UNS PERSONALITY DISORDER	26	40	66
	UNS SCHIZOPHRENIA	127	254	381
	UNS SCHIZOPHRENIA CHRONIC	0	5	5
	UNS TRANSIENT MENT DIS IN OT COND	0	1	1
	UNSP NONPSYCHOTIC MENTAL DIS	1	2	3
	UNSP PERVASIVE DEVELOP DIS ACTIVE	6	10	16
	UNSPEC EPISODIC MOOD DISORDER	825	855	1,680
	UNSPEC PARANOID STATE	1	0	1
	UNSPECIFIED PSYCHOSIS	317	599	916
	VASC DEMENTIA W DEPRESS MOOD	0	1	1
	VASCULAR DEMENTIA UNCOMPL	4	0	4

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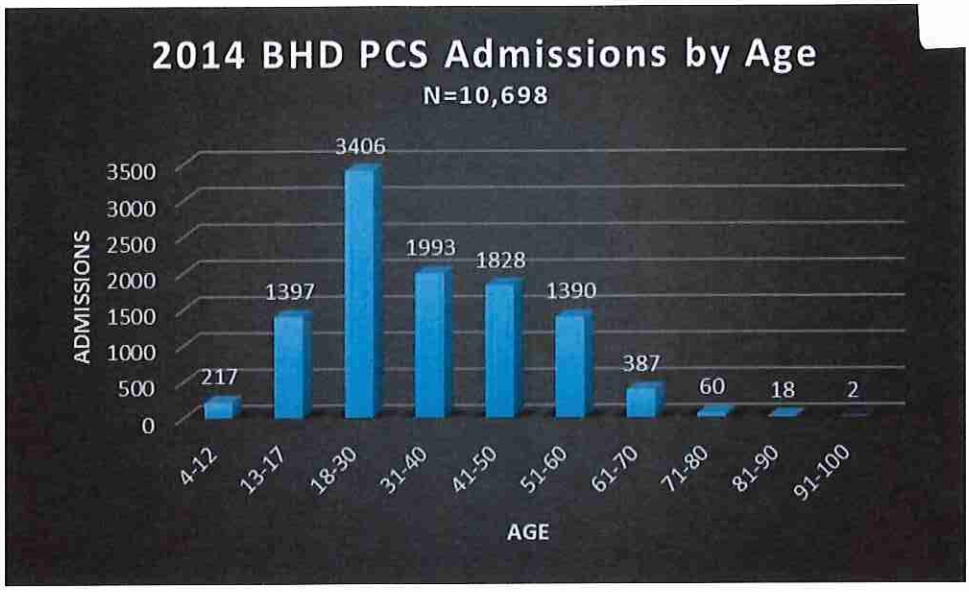
Discharges By Program Diagnosis and Gender

Discharges From: 1/1/2014 Through : 12/31/2014

		Female	Male	Total
Psychiatric Crisis	Total	**4,448**	**6,249**	**10,697**
Total		**4,448**	**6,249**	**10,697**

Attachment J



2014 BHD PCS Admissions by Ethnicity		
Ethnicity	N	%
Black/African-American	5,925	55.4
White/Caucasian	3,393	31.7
Other	1,058	9.9
No Entry	133	1.2
Alaskan Native/American Indian	96	0.9
Asian	80	0.7
Native Hawaiian/Pacific Islander	13	0.1
Total PCS Admissions	**10,698**	**100.0**

2014 BHD PCS Admissions by Payor		
Payor	N	%
Medicaid (Title 19) HMO	3,910	36.5
Medicaid (Title 19)	1,918	17.9
Medicare (Title 18)	1,412	13.2
Self Pay (no insurance)	1,379	12.9
Commercial Insurance	1,028	9.6
T18 HMO	677	6.3
Family Care HMO	227	2.1
Commercial HMO	50	0.5
Other	97	0.9
Total	10,698	100.0

2012-2014 BHD Crisis Service & Acute Inpatient - Admissions & Patient Days							
Year	Admissions				Patient Days		
	PCS	Observation	Acute Adult	CAIS	Observation	Acute Adult	CAIS
2012	12,698	1,703	1,640	1,152	-	24,586	2,311
2013	11,464	1,352	1,456	829	2,258	21,363	2,930
2014	10,698	1,192	1,093	953	2,660	19,913	3,250

Attachment L

ANALYSIS OF ADULT BED CAPACITY

For Milwaukee County Behavioral Health System

Prepared by:

Human Services Research Institute
Technical Assistance Collaborative
Public Policy Forum

September 2014

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Section 1
Introduction

The Milwaukee County mental health system has seen several changes over the past few years. A number of stakeholders have recommended a move to a more recovery-oriented and community-focused system of care, one that is more consistent with SAMHSA's vision of "A Good and Modern Addictions and Mental Health System"[1]; this was also the recommendation of a 2010 report produced by the Human Services Research Institute, Technical Assistance Collaborative and the Public Policy Forum (HSRI/TAC/PPF). A decreased reliance on crisis response and inpatient care is another important goal of such a reform.

Between 2011 and 2013, the Milwaukee County Behavioral Health Division (BHD) experienced a 14% reduction in the utilization of Psychiatric Crisis Services (PCS) and a 30% decrease in admissions to its adult inpatient units at the Mental Health Complex. As a result, BHD has begun downsizing its bed capacity with the stated intent of increasing its community-based services. While there is general support for reducing the county's reliance on a hospital-based system, particularly among service recipients themselves, total inpatient admissions across Milwaukee County hospitals remain consistent and questions have arisen about the adult psychiatric inpatient capacity in the county.

This report provides an analysis of adult psychiatric inpatient bed capacity in Milwaukee County. It looks at aspects of the behavioral health system based on available data (inpatient, outpatient, crisis services, case management, evidence-based practices, etc.), recommends adult psychiatric inpatient bed capacity for Milwaukee County based on current utilization, and suggests considerations for determining future inpatient bed need.

These recommendations should be considered in the context of two key points pertaining to mental health system reconfiguration:

- The diverse array of service providers in a given area complicates efforts to view the mental health care delivery network as a "system." In most areas, including Milwaukee, provider organizations represent a variety of organizational and ownership types with differing incentives, constraints, and approaches to strategic planning.
- There is no standard, universally applicable formula for "right-sizing" the components of a behavioral health system. Because of the variability and complexity of the organizational characteristics across mental health systems and the nature of the relationships among their constituent parts, the appropriate allocation of resources differs from one system to another. This is particularly true with respect to the

[1] SAMHSA. (2011). Description of a Good and Modern Addictions and Mental Health Service System. Rockville, MD: Substance Abuse and Mental Health Services Administration.

relationship between inpatient and community-based services, where it is generally assumed that the latter may be substituted for the former to some degree at equal or better quality and cost. Precisely how this balance is to be achieved is difficult to determine, primarily due to the variability in the types, capacity, and effectiveness of available outpatient services. Additionally, population characteristics (including the prevalence of mental disorders, availability or lack of social supports, and barriers of race and poverty, among others) vary by locale.

Given all these variables, comparative data from other systems have limited utility and must be carefully weighed when applied to any particular case, such as that of Milwaukee County. National trends in the supply and utilization of inpatient services and the factors that influence them, as discussed below, may provide a general gauge, but these must be considered in the context of Milwaukee County's particular circumstances. A recent report by the National Association of State Mental Health Program Directors indicated that there is no standard formula to apply when seeking to project or estimate the number of inpatient beds that should exist in a system, and that the unique circumstances within the system should be taken into account when determining what the capacity should be.[2]

Assuming continued progress in the shift to a more community-based system of care, we anticipate that demand for adult beds could further decrease over time. In the final section of this report, we present four configuration scenarios for the County to consider as the system evolves over the next several years to meet the inpatient needs of county residents in the most cost-efficient manner.

[2] National Association of State Mental Health Program Directors Medical Directors Council. *The Vital Role of State Psychiatric Hospitals*. July 2014. http://www.nasmhpd.org/Publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

Section 2
National Context

Public behavioral health systems play a vital role in ensuring access to a continuum of treatment and services designed to meet a range of needs. Safety net services, such as psychiatric inpatient treatment and crisis intervention, are at one end of this continuum. Inpatient bed need and utilization, as well as interaction with other systems such as criminal justice and homeless service systems, are often contingent on the availability of quality community-based services, including an organized psychiatric crisis response and diversion system. Generally, stronger and more accessible community-based services and a well developed psychiatric emergency response system will result in decreased reliance on costly inpatient care and overutilization of police intervention.[3]

Changes to Milwaukee's behavioral health system can be viewed in the context of what is occurring nationally and in other Wisconsin counties. Understanding Milwaukee County inpatient and systemic issues through the national lens helps to provide context for the current and future planning of inpatient capacity within the county. While there is no valid or reliable standard formula to determine the number of beds needed in a particular system, national context provides a general gauge. National trends in inpatient utilization and capacity have been driven by a variety of issues, including the strength of community services infrastructure, the U.S. Supreme Court's 1999 *Olmstead* decision, reimbursement and payer issues, and the Affordable Care Act (ACA).

Systems across the country are generally evolving in the context of three national trends: 1) decreases in overall psychiatric inpatient capacity; 2) a shift in the provision of inpatient treatment from public hospitals to general acute care hospitals; and 3) growth of community-based alternatives.

2.1 Decreasing Psychiatric Inpatient Capacity and the Provision of Psychiatric Inpatient Treatment

From a high point in the 1950s, the number of psychiatric beds in the United States has declined steadily over the years. Notably, the number of non-psychiatric, acute care beds has also dropped. In 1999, the nationwide average for hospital beds (all types) was 3.0 beds per 1,000 people; in 2009, the average was 2.6 per 1,000—a 13.3% drop. Additionally, lengths of stay are dropping as well.[4]

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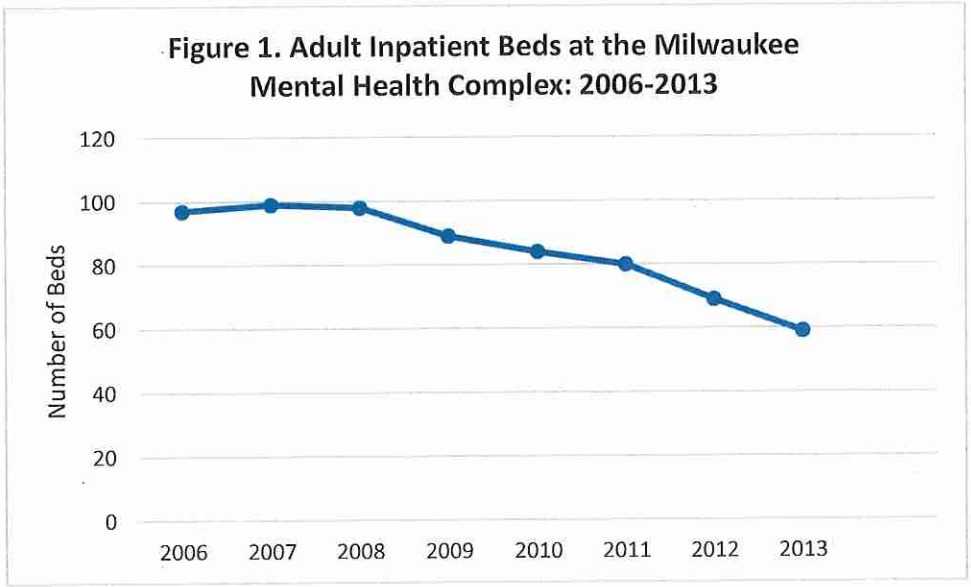
[3] President's New Freedom Commission on Mental Health (2003) Achieving the promise: Transforming mental health care in America. Rockville, MD.

[4] National Center for Health Statistics (2011). Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD.

In 1950, there were more than 500,000 state/county public psychiatric hospital beds in the United States. As of 2010, there were fewer than 44,000.[5] In 1955, there were 340 public psychiatric beds per 100,000 people; by 2005, this figure was down to 17 beds per 100,000, a 95% reduction.[6] At the same time, the number of psychiatric beds in general hospitals increased from virtually none in the late 1940s to more than 54,000 by 1998 (note: this number has been reduced to about 40,000 today). In the late 1940s, over 94% of psychiatric inpatient care was provided in public mental health facilities; by 1998, almost 50% of such care was provided in general hospital psychiatric units. In addition, the number of private psychiatric facility beds increased from fewer than 15,000 in 1970 to almost 45,000 in 1990,[7] but dropped to 28,000 in 2004.[8]

For the most part, BHD's experience has mirrored these national trends. In 2013, BHD had an average daily census of 59 individuals in its adult inpatient units at the Mental Health Complex,[9] a decline of roughly 39% since 2006, as shown in Figure 1, below.[10] However, among the counties with a county-operated psychiatric hospital, Milwaukee County is the only county in Wisconsin to have experienced an increase in private inpatient beds between 2010 and 2013.[11]



[5] Treatment Advocacy Center (2012). *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals 2005 – 2010*. July 2012.

[6] Treatment Advocacy Center (Unpublished). *The Shortage of Public Hospital Beds for Mentally Ill Persons*.

[7] Liptzin, B., Gottlieb, G., & Summergrad, P. (2007). The future of psychiatric services in general hospitals. *American Journal of Psychiatry, 164*(10), 1468-1472.

[8] National Center for Health Statistics (2011). Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.

[9] Source: BHD

[10] BHD is operating approximately 60 beds as of this report.

[11] Source: Wisconsin Hospital Association

2.2 Reasons for Decreasing Capacity

Nationally, several factors are driving the reductions in psychiatric beds. These include advances in care and treatment, policy direction, budget constraints, and decreasing utilization. Much of the shift was driven by humane and clinical concerns surrounding quality of care and the negative effects of long-term institutionalization on people with mental illness.[12] The Community Mental Health Centers Act of 1963 was expected to be a remedy for long-term institutionalization. The Act was amended over the years to add essential services needed to supplant the multiple functions of institutional care. The introduction of psychotropic medications also allowed many previously hospitalized individuals to function effectively in the community.

In addition, the enactment in 1980 of the Civil Rights of Institutionalized Persons Act (CRIPA) enabled legal challenges to involuntary long-term institutionalization and to inadequate care in large public facilities. CRIPA predated the Americans with Disabilities Act (see below), and resulted in the closure or downsizing of many state hospitals. Finally, the enactment of Medicaid in 1965, with its parallel allowance for inpatient psychiatric care in general hospitals and prohibition of reimbursement for institutions for Mental Disease (IMDs – see below), fostered the development of general hospital alternatives to state-operated inpatient care. The end result of all these complementary forces was to significantly reduce the need and demand for publicly operated inpatient psychiatric care.

2.3 Influence of Olmstead

The 1999 U.S. Supreme Court decision in ***Olmstead v. L.C***. affirmed the right of people with disabilities under Title II of the Americans with Disabilities Act (ADA) to live in the least restrictive setting appropriate to their abilities. Through proactive Olmstead planning, litigation, and/or settlement agreements, states have identified large numbers of individuals who no longer require inpatient or institutional care and are strengthening community capacity to serve people in more integrated settings. A recent federal Department of Justice policy brief lays out the characteristics of such settings:

> Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies, and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not

[12] Abt Associates and Technical Assistance Collaborative. Massachusetts General Court Mental Health Advisory Committee Report Phase I and Phase II. June 2014

> limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities.[13]

Under *Olmstead*, states have an affirmative obligation to assure that people with disabilities who choose to live in integrated community settings have maximum opportunities to do so consistent with the resources available to the state. The fact that a given state might have resources committed to institutional settings and thereby claim to have insufficient resources to provide community alternatives has been found in many courts to be no defense.

There are 12 states with active *Olmstead*-related mental health settlement agreements or investigations: Arizona, Connecticut, Delaware, Georgia, Illinois, Kentucky, Mississippi, New Hampshire, New Jersey, New York, North Carolina, and Oregon. However, it is important to note that just because a state does not have active Olmstead litigation does not mean that the state is compliant with *Olmstead* and Title II of the ADA.

2.4 Institutions for Mental Disease (IMD) Exclusion and Other Reimbursement Issues

2.4.1 IMD Exclusion

Section 1905(a) of the Social Security Act "prohibits the federal government from reimbursing states under the Medicaid program for services rendered to a Medicaid beneficiary who is a patient in an institution for mental disease (IMD)."[14] In accordance with this statutory prohibition, CMS has defined an IMD as: "a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care for people with mental disease."[15]

The IMD exclusion does not apply to people 65 and older or to individuals under age 21. Nor does it apply to facilities with 16 or fewer beds. Typically, the IMD exclusion applies to public mental health inpatient facilities, such as Milwaukee County's Mental Health Complex, and to private inpatient psychiatric treatment facilities, such as Rogers Memorial Hospital and Aurora Psychiatric Hospital.

The underlying motivation of the federal government for the development of the IMD rule was to dissuade states from relying on institutions as the primary care settings. The premise was that state and county governments would not unnecessarily utilize institutional settings that

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[13] U.S. Department of Justice Civil Rights Division (2011). *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* Washington, DC: U.S. Department of Justice, June 22, 2011.

[14] *Social Security Act §1905*, 42 U.S.C. §1396(d). See also 42 *CFR* §435.1010.

[15] SAMHSA (2013). *Medicaid Handbook: Interface with Behavioral Health Services*, HHS Publication No. SMA-13-4773. Rockville, MD: Substance Abuse and Mental Health Services Administration, August 2013.

are costly and segregated if they were responsible for total costs. Despite the IMD rule, many IMDs still exist today, but, as stated earlier, the trend is to serve individuals in more integrated settings that are also able share costs through federal government programs like Medicaid.

All states in the United States, including Wisconsin, have made serious efforts to shift the cost of mental health services away from state (and county) general fund appropriations and toward Medicaid services that receive at least 50% federal reimbursement. In parallel with quality of care and clinical effectiveness motivations, the IMD exclusion serves as one of the primary reasons for states to shift care away from large publicly operated inpatient facilities. As a practical matter, a decision to operate facility-based care and treatment in an IMD, or a facility that is likely to be treated as an IMD by CMS, is a decision to forego federal reimbursements for services provided to Medicaid-eligible individuals.

2.4.2 Other Reimbursement Issues

In public psychiatric hospitals, underutilization is often cited as a reason for budget reductions and decreases in bed capacity. In fact, during the most recent recession between 2009 and 2012, at least 3,222 state psychiatric hospital beds across the country were eliminated.[16] In light of decreasing utilization, public funders are more likely to reduce underutilized beds than to reduce community-based alternatives such as outpatient treatment, residential programs, and crisis response services.

The availability of reimbursement from Medicaid, Medicaid managed care, and commercial insurance also places a strain on the ability and willingness of private or general acute care hospitals to operate psychiatric inpatient beds. Within states there is a constant tension to reduce the number of publicly operated beds in favor of beds operated by local acute care hospitals and diversion to community-based services, but payer issues for non-public beds often create an unstable bed environment. Sometimes the issue may not be the bed capacity of a certain system but rather who is admitted. With fiscal pressure to keep beds full in private or general acute care hospitals, beds are sometimes occupied by individuals with good payer sources (e.g., private insurance) rather than those who may be a greater priority from a system need perspective.

Consequently, building some flexibility or fluidity into systems to ensure that hospitals are being adequately reimbursed may be a necessity to ensure sufficient psychiatric inpatient capacity at private or general acute care hospitals. This is particularly the case if there is an expectation that more complex patients previously treated in the public hospitals will be pushed to the local acute care system for treatment, possibly longer stays, and discharge to community-based services.

[16] NASMHPD Research Institute. The Impact of the State Fiscal Crisis on State Mental Health Systems: Winter 2011-2012. http://media.wix.com/ugd/186708_c2fd199b2a9f4d04818b889b93c3a884.pdf

2.5 The Affordable Care Act

The 2010 enactment of the Affordable Care Act (ACA) signaled significant changes in health care delivery and financing throughout the United States. Nationally, the ACA has the potential to extend coverage to many of the 47 million nonelderly uninsured people nationwide.

Approximately 566,000 uninsured Wisconsinites could benefit from the insurance mandate and the BadgerCare Reform waiver.[17] In Wisconsin, 70% of uninsured nonelderly people are eligible for financial assistance to gain coverage through either Medicaid or the Marketplaces established by the federal government. Roughly 36% of these individuals are eligible for Medicaid or CHIP (i.e., "Children's Medicaid") as of 2014. An additional third (34%) of those currently uninsured in the state are eligible for premium tax credits to help them purchase coverage in the Marketplace. The remaining 30% of uninsured individuals either have incomes that are too high for subsidized insurance or are ineligible due to their undocumented status.

Wisconsin's BadgerCare Program extends benefits for single adults at 100% of the Federal Poverty Level (FPL).[18] The result is expanded coverage for approximately 99,000 childless adults who are expected to enroll in 2014 with another 5,000 going to the federally subsidized Marketplace. The BadgerCare Reform waiver also expands benefits through the BadgerCare Plus Standard Plan, which is more comprehensive than the previous BadgerCare Plus Core Plan.

It is anticipated that this coverage expansion, stronger mental health parity provisions, standards for Essential Health Benefits and benefit plan changes, and new program features such as the revised 1915(i) Home and Community-Based Services state plan option will provide greater opportunities for individuals to receive behavioral health services. The result of these changes is likely additional individuals seeking treatment and services within the system. However, it is unclear if the level of reimbursement and availability of qualified professionals will be sufficient to meet the potential increase in demand.

2.6 Shift in Provision of Inpatient Treatment

Today, in most states, acute psychiatric inpatient care is provided in general hospitals or private hospitals rather than publicly operated beds, though this does vary by state. The remaining public beds, provided in state or county hospitals and with some variation among states, generally provide forensic services (evaluation, restoration to competency, and long-term commitment for people found not guilty by reason of insanity) and longer term treatment for people not ready for discharge to the community after a short-term acute hospitalization.

There are few remaining county-operated psychiatric hospitals in the country, largely due to trends toward serving individuals in more cost effective, integrated settings. The county-operated psychiatric hospitals that remain are likely to be classified as IMDs and therefore

[17] Kaiser Family Foundation. *Wisconsin's BadgerCare Program and the ACA*. February 2014.
[18] Ibid

ineligible for Medicaid reimbursement, resulting in an increased financial burden on state or county general funds. In states where county hospitals do exist, they have helped fill the need for intermediate-length stays and short-term acute care stays for individuals with more complex needs or who are indigent. For example, other counties in Wisconsin (e.g., Brown County) and in other states (e.g., San Diego) operate county facilities that serve an acute care function with typically short stays. Brown County also performs a regional function and contracts with other counties to meet acute care needs. In other states, like New Jersey, county hospitals have more of an intermediate level of care role; responsibility for shorter lengths of stay is delegated to acute care hospitals and longer lengths of stay to the state hospitals.

2.7 Growth of Community-Based Alternatives

Many public behavioral health systems across the country have successfully shifted emphasis toward community-based services. With advances in psychiatry and the development of evidence-based practices—including Assertive Community Treatment (ACT), Permanent Supportive Housing (PSH), and peer-delivered supports—community-based services are producing positive outcomes, reducing the need for inpatient care, and reducing costs. These services are known to be effective with individuals with a broad range of needs; ACT, in particular, is known to be successful with individuals who are the hardest to serve and keep out of the hospital. While inpatient care in an IMD could cost over $300,000 per year, evidence-based alternatives like ACT and PSH cost less than $20,000 per year and can be offset by federal financial participation through Medicaid.[19,20]

However, critics in many communities argue that community-based services have not been made sufficiently available or accessible to those who could benefit from them. Reasons for this include limited funding for community services in general as compared with inpatient funding, and eligibility criteria that do not target those with the most complex conditions who are most likely to be hospitalized. The challenge in developing a "good and modern" behavioral health system is achieving the proper balance of a strong, accessible, quality community-based system capable of meeting the diverse needs of individuals and an adequate number of inpatient beds and crisis intervention capacity to ensure a sufficient safety net. Until the science and technology of treating mental illness advances further, some individuals will require an inpatient level of care; however, a strong, accessible community-based system can reduce the frequency and duration of inpatient stays.

Interestingly, some studies have shown that decreases in publicly funded/operated acute and long-term inpatient beds have not resulted in increased negative outcomes such as suicide,

[19] The FY2012 daily rate for Adult Treatment Services in Oregon State Hospital is $945/day, or $345,000/year. http://www.oregon.gov/oha/amh/osh/Pages/cost-of-care.aspx

[20] FY2013 New York State Budget for ACT. https://www.omh.ny.gov/omhweb/spguidelines/case_mngmt_models/2013_Upstate_Downstate_Models.pdf

incarceration, police interactions, decreased level of functioning, or homelessness.[21]
In addition, demand for acute inpatient care appears to be "elastic,"[22] in that capacity was fully used when it was available, but other options were found to meet patients' basic needs when it was no longer available. This suggests that when a person no longer meets inpatient criteria, system partners can maximize the availability of community resources to meet the individual's needs. The ability of community-based providers to piecemeal a package of services together does not justify underfunding the availability of programs known to produce positive outcomes. Rather, it does suggest that the combination of community provider expertise and resource availability can create alternatives to the need for inpatient care for many individuals.

[21] Shumway, Martha, et al. *Impact of Capacity Reductions in Acute Public-Sector Inpatient Psychiatric Services*. Psychiatric Services. February 2012 Vol. 63 No. 2
[22] Ibid

Section 3
Methodology

3.1. Data Sources

Data for this report were obtained by request from the Milwaukee County Behavioral Health Division (BHD) and private hospitals and health systems within the county. Monthly inpatient admissions data were requested from 2011 through the first quarter of 2014, by age and payer source, as well as average length of stay. Annual summaries from 2011-2013 were requested for average 30-day readmission rates, number of admissions by discharge setting, and the percentage of annual admissions with co-occurring medical problems, substance abuse, mental illness and intellectual disability/developmental disability, and legal involvement.

Crisis Services data requested from BHD included: monthly Psychiatric Crisis Services (PCS) admissions by acuity level; number of admissions resulting in admit to BHD and local inpatient facilities; number of discharges to detox and law enforcement; and number of admissions returned/referred back to the community. Monthly admissions to BHD's Access Clinic and Crisis Stabilization services were also requested.

In-person and telephone interviews were conducted with key stakeholders, including senior staff from BHD, the project advisory committee (consisting of officials from BHD and private health systems), and representatives from private hospitals to further understand factors influencing inpatient capacity and bed need in Milwaukee County.

The Wisconsin Hospital Association (WHA) supplied prevalence data and bed numbers across counties, and these were used to compare Milwaukee County to other Wisconsin counties.

3.2. Bed Utilization and Projections

A utilization-based formula was used to determine the estimated number of beds needed in the system now, based on how the system is currently functioning. This approach relies more on the actual experience within the system, and inherently captures factors like prevalence of mental illness in the county. Bed utilization for 2013 was estimated from inpatient admissions and median length of stay, using the following formula:

[Adult admissions * Median Length of stay]/365 = Number of beds utilized

This formula allowed us to translate the number of bed days consumed in the psychiatric inpatient units in the system into an approximate number of beds utilized in the system on an average day. Adult admissions was defined as age 18+. The number of beds utilized was calculated first by hospital then summed across hospitals to estimate the total bed utilization in Milwaukee County.

The total bed utilization across psychiatric inpatient units was considered the base utilization of beds in the county. However, the hospitals made the case that a unit often intentionally operates under capacity to accommodate unique circumstances—patient acuity, gender issues or medical co-morbidity for example—that affect unit milieu. Essentially, the hospitals balance unit census to ensure safety and therapeutic milieu. Based on feedback from the hospitals, we applied an occupancy rate range of 80% to 90% on units to project the maximum bed capacity needed to accommodate utilization and unit environmental circumstances.[23]

Because there are many variables that will influence future bed need, several of which are not quantifiable at this time, we applied a similar utilization-based approach based on admission trends to determine how many beds could be decreased over time in the County, with an underlying assumption that more accessible community-based services will decrease admissions and lengths of stay.

We used the following formula to determine future bed need:

[# of Decreased Adult Admissions * Median Length of Stay]/365 = Number of fewer beds utilized

While this methodology provides data-driven guidance for future decisions on psychiatric bed capacity, we recommend that a trend analysis should occur for any decrease in admissions and that it is sustained for a period of at least six months before any decreases in bed capacity occur across the county.

[23] Based on the American Hospital Association annual survey data, the bed occupancy rate across all hospitals in the U.S. in 2009 was 67.8%. However, hospital officials in Milwaukee County indicated that the 80% to 90% occupancy range was more consistent with where they are operating, and necessary to ensure financial viability.

Section 4
Stakeholder Perspectives

In addition to the meetings with BHD and the project advisory committee, HSRI/TAC/PPF spoke with several stakeholders to inform our understanding of issues that affect the level of need for inpatient beds in Milwaukee County. Stakeholder interviews, particularly with service recipients, help provide additional context that data does not always capture. The following are some of the meetings and telephone interviews conducted for this purpose:

- Mental Health Task Force members; February 11, 2014
- Milwaukee Health Care Partnership Behavioral Health Provider workgroup; April 16, 2014
- A diverse group of stakeholders, including consumers, family members, providers, the public defender's office, and Disability Rights Wisconsin; April 17, 2014
- Area hospital systems; various dates
- Wisconsin Hospital Association

The facilitated discussions covered a range of system topics, including but not limited to:

- Access to inpatient beds and bed capacity
- Access to community services and community services capacity
- The interrelation between community services, crisis systems, and inpatient utilization
- Psychiatric emergency response services, policy involvement and emergency detentions
- Funding issues and priorities
- Consumer/patient needs (housing, co-occurring disorders treatment, medical care, etc.)

All stakeholders brought unique perspectives to the table, and all were genuinely concerned that the "system" should serve people with the right services, in the right place, at the right time. Stakeholders expressed the following sentiments about bed capacity in general in Milwaukee County; no single perspective dominated.

- Some said inpatient bed capacity should continue to decrease.
- Some were indifferent about bed capacity but clearly identified additional community-based services as an area of need.
- Some expressed concern that BHD was downsizing too quickly.
- Some said additional beds are needed (without regard to who operates them).

Many issues about the behavioral health system were voiced during these discussions. Some were anecdotal and hard to substantiate, but several emerged as consistent and overlapping themes. The various themes that stakeholders identified as system issues that may affect bed need were:

- Insufficient community-based capacity

- Lack of accountability to ensure system-wide inpatient capacity
- Consumers with specialized or complex needs
- Role of Milwaukee County in providing inpatient services

A more detailed summary of stakeholder discussions can be found in Appendix B.

Section 5
Findings & Discussion

5.1 Current Inpatient Bed Capacity & Concerns

Based on information provided by BHD and the private hospitals, there are approximately 201 adult inpatient psychiatric beds in Milwaukee County at present, as shown in Table 1. This figure does not include beds at the State hospitals occupied by Milwaukee County residents or at Columbia St. Mary's Ozaukee campus outside the county; however, the Columbia-Ozaukee hospital is able to take voluntary Milwaukee County residents and, according to hospital officials, about one third of its psychiatric admissions do come from Milwaukee County. Of the 201 beds, 135 (67%), are operated by the private hospitals. While there are more beds that are licensed, this capacity considers the beds that are staffed, budgeted, and able to accommodate patients.[24]

Table 1. Psychiatric Inpatient Bed Capacity in Milwaukee County

Hospital	Adult Beds Budgeted 2014	Projected Adult Beds FY2015
BHD	66	60
Private Psychiatric Hospitals		
Rogers Memorial	50	76
Aurora Psychiatric Hospital	40	40
Aurora St. Luke's South Shore (SLSS)	23	23
Wheaton-St. Francis	22	25
Columbia St. Mary's	0	0
TOTAL	**201**	**224**

Note: Rogers Memorial Hospital plans to open 56 additional beds (28 adult beds and 28 child/adolescent beds).

As shown in Table 2, while the median length of stay at BHD is approximately eight days, BHD's current inpatient census includes a group of individuals with very long lengths of stay because a) they continue to meet commitment criteria; or b) they no longer meet commitment criteria but intensive community services appropriate for their needs have not been developed yet. As a result, there is no admissions flow or turnover in these beds. To the extent that intensive

[24] Froedtert Hospital is not included in this table because it does not currently operate inpatient psychiatric beds. Froedtert does provide medical assistance to BHD, however, and does typically serve a number of patients with behavioral health diagnoses on its medical units.

community services can be developed to meet their needs, these beds could otherwise be used to address admission pressures in the system or closed.

Table 2. Patients with Extended Lengths of Stay at BHD

Length of Stay	Number of Patients
30 – 59 days	6
60 – 99 days	7
100 – 199 days	5
200 – 499 days	3
TOTAL	**21**

According to WHA's analysis of inpatient capacity among Wisconsin counties with a county-operated hospital, Milwaukee County was the only county to see an increase in the number of private psychiatric hospital beds between 2010 and 2013.

The steady decline in beds at BHD in recent years—combined with BHD having to activate its "waitlist" policy and divert admissions at various times this year (as shown in Table 3)—has caused concern that the system is at a tipping point for bed capacity.

Table 3. BHD PCS Waitlist Status, Jan-July 2014

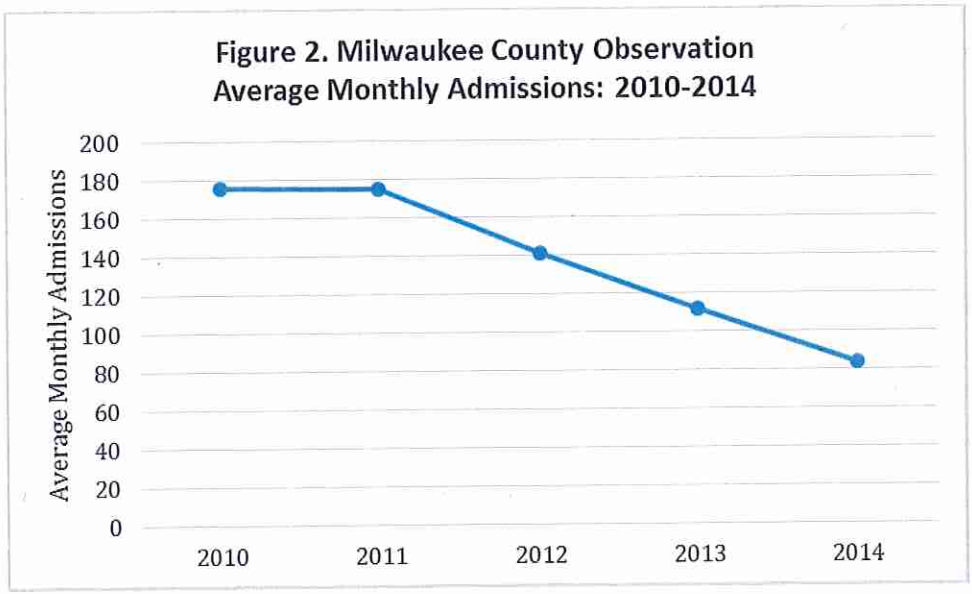
Month	Number of Days on Waitlist	BHD Actual Operating Capacity
January	0	66
February	1	66
March	0	60
April	6	60*
May	14	54
June	4	54**
July	4	66

*Census capacity was 63 for the last two days of April for which there was a waitlist.

** Census capacity for the first nine days of June was 54 beds, and between 60-66 beds for the remainder of the month.

The timing of the BHD bed reductions at the Mental Health Complex and the closure of the 18-bed unit at Columbia St. Mary's at the beginning of 2014 appear to be the primary drivers for the recent strain on the inpatient system. Aurora Psychiatric Hospital also had a temporary reduction of 5 beds in early 2014 due to staffing challenges. BHD saw a roughly 30% decrease in admissions between 2011 and 2013, and it decreased its number of beds as a result. (Factors that have impacted decreased admissions to BHD, such as a decrease in emergency detentions, increased psychiatric mobile response capacity, and some community-based services expansion, are discussed later.) However, as shown in Section 5.2, overall inpatient bed admissions in Milwaukee County remain relatively steady. In other words, the balance of system-wide admissions has shifted, and other hospitals—particularly Aurora Psychiatric Hospital and Rogers—have seen an increase in admissions while BHD's admissions have declined.

Observation beds at BHD (there are currently 18) have been used as an effective diversion to inpatient admission. In fact, data show that nearly 80% of admissions to observation beds result in diversion from inpatient units. However, Figure 2 shows that utilization of observation beds has decreased by approximately 45% between 2010 and 2014. From one perspective, decreased reliance on any type of hospital bed use may be perceived as positive. Despite the fact that there has been decreased pressure in PCS, a significant number of individuals are still admitted to inpatient beds throughout the system. Continued utilization of observation beds could further reduce pressure on inpatient admissions, and BHD should examine the role that observation beds should have in future system-wide inpatient bed capacity decisions.



5.2 Behavioral Health Admissions in Milwaukee County

Total admissions to psychiatric inpatient units (adult and child/adolescent) in Milwaukee County from 2011 through 2013[25] are shown in Table 4, by hospital. Private hospitals accounted for 79% of total admissions in 2011, increasing to 85% in 2013. Accordingly, BHD accounted for a small percentage of admissions from 2011 to 2013, dropping from 21% to 15%. Rogers Memorial had the greatest number of inpatient admissions, representing 35% of total admissions in 2013. This data does not include primary psychiatric admissions to general medical/surgical beds (i.e. not in a designated psychiatric unit) operated by the private hospitals.[26]

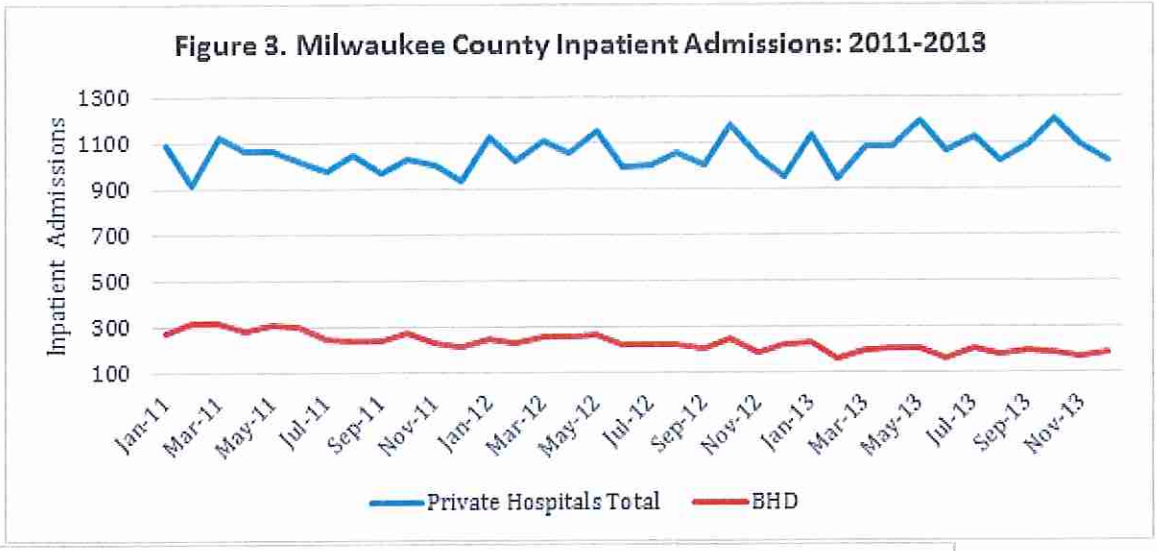
Table 4. Milwaukee County Behavioral Health Inpatient Admissions, N (%)

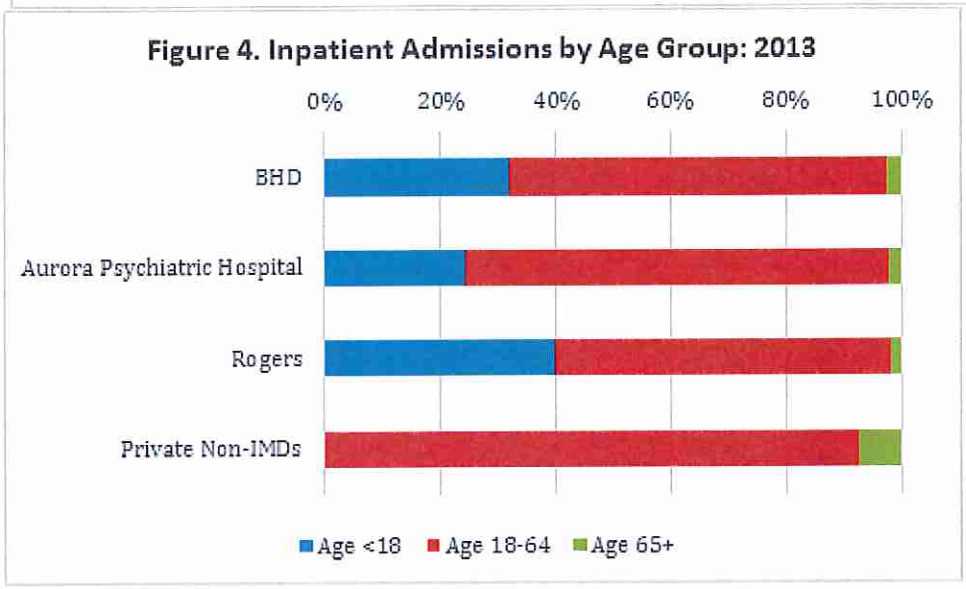
	2011	2012	2013
BHD	3,244 (20.9%)	2,793 (18.1%)	2,285 (14.9%)
Aurora Psychiatric Hospital	3,186 (20.6%)	3,205 (20.7%)	3,470 (22.6%)
Aurora SLSS	1,110 (7.2%)	1,167 (7.5%)	1,255 (8.2%)
Columbia St. Mary's	1,789 (11.6%)	1,975 (12.8%)	1,894 (12.4%)
Rogers Memorial	5,197 (33.6%)	5,341 (34.6%)	5,406 (35.2%)
Wheaton-St. Francis	959 (6.1%)	977 (6.3%)	1,029 (6.7%)
Private Hospitals Total	12,241 (79.1%)	12,665 (81.9%)	13,054 (85.1%)
TOTAL	**15,485**	**15,458**	**15,339**

Sources: BHD Dashboard (includes Adult Acute and CAIS), and data provided by private hospitals.
Note: The percentages above are out of the total admissions for each year, shown in the bottom row. The percentages add to 100% within a given year, not including the Private Hospital Total, which is the sum of all private hospitals not including BHD.

Admissions by facility and age are presented in Figures 3 and 4. In 2013, youth (younger than age 18) accounted for 40% of admissions to Rogers, 32% of admissions to BHD, and 24% of admissions to Aurora Psychiatric Hospital. Adults aged 18 to 64 accounted for 93% of admissions to the non-IMD private hospitals, and for 65%, 74%, and 58% of admissions at BHD, Aurora Psychiatric Hospital, and Rogers, respectively.

[25] We only included data in the table for years we had complete data.
[26] It was reported that the hospitals may admit patients with a primary psychiatric diagnosis to medical/surgical beds at times due to various circumstances. While these admissions add to the total bed days utilized in the system, they do not appear to be as a result of problems accessing designated psychiatric inpatient beds.





5.3 Additional Factors That Influence Psychiatric Inpatient Admissions & Demand in Milwaukee County

There are many variables that impact the capacity, availability, demand for, and utilization of psychiatric inpatient services in behavioral health systems—even beyond the national trends discussed in Section 2. Because of this variability, there is no single, reliable formula that can be applied across systems to determine the number of psychiatric beds needed. An often-cited report suggests 50 beds per 100,000 individuals;[27] however, this figure oversimplifies the variables in each unique system and may reflect a period of time when there was more reliance on treatment in inpatient settings rather than in the community. While there may be

[27] Treatment Advocacy Center. The Shortage of Public Hospital Beds for Mentally Ill Persons. http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf

innumerable variables that influence bed capacity and demand in Milwaukee County, several with particular relevance are discussed below.

5.3.1 Patient Characteristics

People with mental illness often have other diagnoses or complicating issues that affect the type of treatment, support, and supervision needed within inpatient settings. In fact, this is more likely the case than not. The most commonly associated factors include individuals with:

- Medical diagnoses that need attention, ranging from less serious issues to significant issues that require intensive medical oversight
- Forensic involvement due to criminal behavior as a result of mental illness
- Behavior management issues, including individuals who are assaultive or have disruptive behaviors
- A co-existing intellectual or development disability, or a substance use disorder

Because the hospitals do not currently collect the types of information needed to produce system-level data on patient characteristics and acuity, our ability to analyze patient characteristics and acuity specifically in Milwaukee County was limited.[28] Functionally, the hospitals appear to address these characteristics by categorizing beds as low/moderate or high acuity. There does not seem to be an operational definition for each of these categories, but we have interpreted these for purposes of this report.

Generally, the inpatient system of care in Milwaukee County has relied on BHD for inpatient treatment for individuals with more symptomatology and complexity—such as individuals who are highly treatment-resistant or are exhibiting assaultive and aggressive behavior—and those who are more likely to have a longer length of stay. Aurora Psychiatric Hospital did open a higher acuity unit in 2013, but continues to refer the highest acuity patients to BHD. Those with low/moderate acuity—individuals who are more likely to benefit from shorter inpatient length of stay and tend to present with fewer risks—tend to be admitted to private hospitals. Absent an organized approach to the county's inpatient system of care, this issue places pressure on BHD's bed capacity and utilization.

It is unrealistic to think that there can be dedicated beds designed to meet the needs of all possible patient diagnoses or characteristics. Rather, individual hospitals (including state, county, private, and general acute) each should maintain or contract for clinical capacity to meet the unique, diverse needs of individuals who require access to different types of specialty care on units (for example, general medical practitioners, addiction specialists, and behaviorists). For private hospitals to work with more complex patients, they will likely need to

[28] It is recommended that a standardized assessment of level of functioning and treatment needs that impact bed placement (e.g., medical needs, criminal justice status, behavioral-related issues) be jointly adopted by BHD and the private hospitals to provide an improved data source for future bed need planning.

increase professional and para-professional expertise and coverage to ensure safe, therapeutic environments.

Based on the current functional configuration of beds in the system, Tables 5 and 6 show the average open beds by acuity between January and October 2013. While the 2013 data in both tables appear to show open capacity that can accommodate admissions pressures, patient acuity or other related factors can affect the unit milieu, impacting a hospital's ability to fully utilize beds. At times, hospitals make decisions to keep bed occupancy lower to ensure a safer, more therapeutic environment; thus, vacant beds do not necessarily mean there is additional or underutilized capacity. In addition, the loss of capacity through closure of the Columbia St. Mary's unit in January 2014 has increased bed utilization in the other hospitals.

Table 5. Average Open Low– to Moderate-Acuity Beds by Hospital, Jan-Oct 2013

Month	Rogers	Aurora Psychiatric Hospital	Columbia St. Mary's	Wheaton-St. Francis	Aurora SLSS	TOTAL
Jan	6	6	2	2	--	**16**
Feb	5	6	3	2	--	**16**
Mar	3	6	1	2	4	**16**
Apr	3	4	1	1	2	**11**
May	4	5	4	1	4	**18**
Jun	3	6	2	2	4	**16**
Jul	2	3	2	0	3	**10**
Aug	2	4	1	1	1	**9**
Sep	5	5	1	1	1	**13**
Oct	6	5	3	3	3	**20**

Source: BHD dashboard

Table 6. Average Open High-Acuity Beds, Jan-Oct 2013

Month	Aurora Psychiatric Hospital-Adult Unit 4	43A Intensive Treatment Unit	43B Acute Treatment Unit	43C Women's Treatment Unit	TOTAL
Jan	4	1	1	1	**7**
Feb	5	1	1	2	**9**
Mar	4	5	3	2	**14**
Apr	3	2	4	3	**12**
May	4	1	2	8	**15**
Jun	4	2	1	2	**9**
Jul	4	2	3	8	**17**
Aug	3	2	2	4	**11**
Sep	3	2	2	2	**9**
Oct	4	2	2	2	**10**

Source: BHD dashboard

5.3.2 Medicaid and Other Payer Issues

As discussed in the National Context section, reimbursement issues affect system-wide bed capacity. While patient characteristics and acuity are a primary factor in the ability and willingness of private hospitals to admit patients, hospitals are also challenged to ensure that reimbursement meets budget expectations. Most individuals who are admitted to hospitals have some type of insurance. Hospitals and managed care companies enter into contracts to ensure some access to beds for members at negotiated rates. This results in a complicated balancing act for hospitals as they work across contracts to ensure maximum occupancy.

Because they are classified as IMDs, however, BHD, Aurora Psychiatric Hospital, and Rogers Memorial do not receive Medicaid fee-for-service reimbursement for individuals between the ages of 22 and 64. Consequently, these individuals, as well as those without insurance, are usually referred to BHD, which has traditionally assumed the role of "public safety net" for the Medicaid fee-for-service and indigent populations despite the fact that it holds the same IMD classification as the other two hospitals.

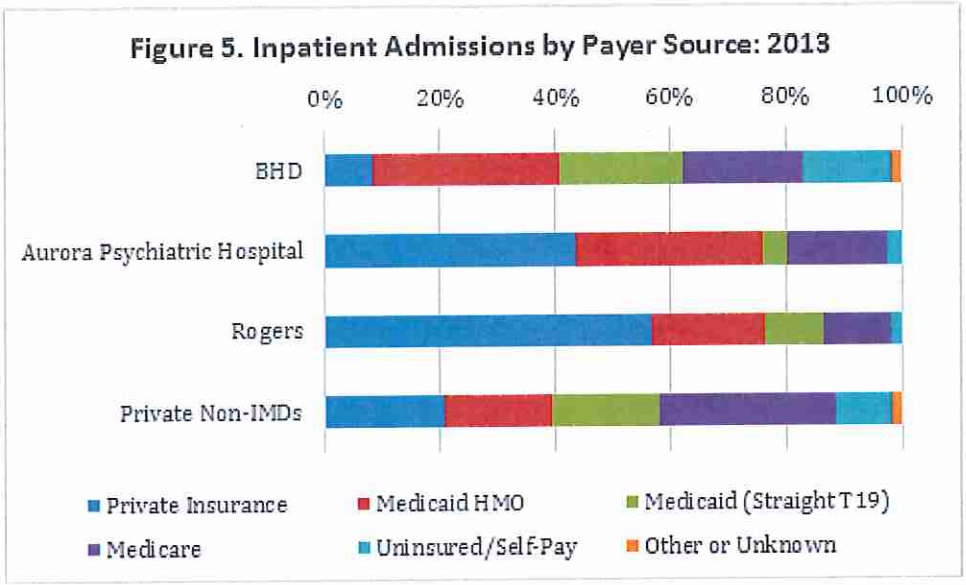
Milwaukee County is not unique in assuming this safety net role. Indeed, the public system in other states also often assumes the financial burden and admits indigent individuals in the 22- to 64-year-old age group to public hospitals. It is important to recognize, however, that if additional psychiatric units within private hospitals that are not classified as IMDs existed in the county, like the existing psychiatric units at Aurora SLSS and Wheaton-St. Francis, individuals with less complex conditions could be successfully treated there at a lower cost because Medicaid reimbursement would be possible.

While non-IMD private hospitals can accept individuals with traditional Medicaid and receive reimbursement on a fee-for-service basis, they face other reimbursement challenges. Reimbursement is based on a Diagnosis-Related Group (DRG) system that basically pays a predetermined, set rate based on the patient's diagnosis. The shorter the stay, the greater the financial incentive; the hospital could lose money if the stay is too long. Individuals who are likely to have longer lengths of stay are often referred to BHD due to the financial impact to the hospital. To the extent that the private, non-IMD hospitals are able to serve individuals with Medicaid or other insurance, however, the lower the burden on public, non-Medicaid matched funds.

A sizable subset of the population that is enrolled in Medicaid in Wisconsin receives services under a managed care approach from "Medicaid HMOs." For those individuals, reimbursement for hospital care is provided directly from the health maintenance organization (HMO). Since Medicaid funding cannot be used to pay for services in an IMD, the IMD services covered by HMOs are substitutes for covered acute inpatient days. This does not represent the use of Medicaid funds for long-term IMD services and enables the Medicaid HMOs to pay for care in the IMDs. However, individuals with longer stays are often converted to non-Medicaid HMO status, and the cost of care in the IMD becomes the responsibility of public funds.

Figure 5 illustrates the greater reliance of the private hospitals on managed care (including Medicaid HMO); in contrast, BHD bears a greater responsibility for individuals who are without insurance or eligible payer sources. Notably, 57% of admissions to Rogers had private insurance compared to 9% at BHD. Medicaid was the most common payer source of BHD patients: 32% had Medicaid HMO and 22% Medicaid fee for service (T19).[29]

[29] It is important to note that because of data limitations, Figure 5 reflects inpatient admissions for all age groups, and not just adults. The inclusion of children and adolescents may paint a slightly different picture than would be the case if only adults were considered. For example, the figure shows a higher percentage of Straight T19 admissions at BHD than exists only for the adult population.



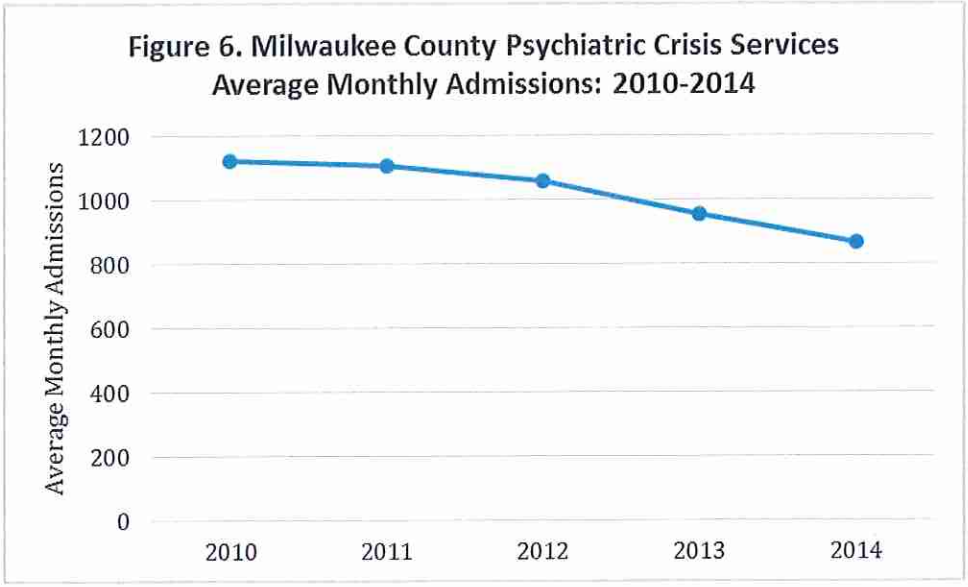
One issue to consider is the potential financial impact to private hospitals if they take on higher-acuity patients. Patients with serious mental illness are potentially more likely to be readmitted than individuals with lower acuity. Managed care organizations may structure rates based on performance measures such as readmission rates. As hospitals negotiate rates with managed care organizations, hospitals could be faced with lower reimbursement as a result of higher readmission rates if working with higher-acuity patients. While readmission rates are an indicator of the quality of discharge planning by the hospital, much of this is contingent on the ability of the community services system to meet consumer needs.

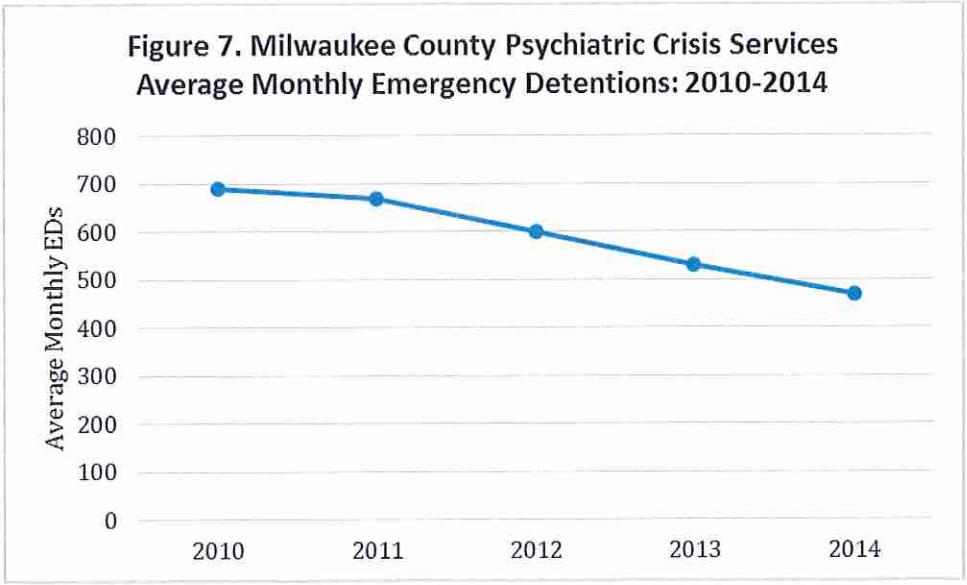
The Public Policy Forum is conducting a separate review of the expenses and revenues of operating the BHD Mental Health Complex and community-based services; this review—available later this year—should further inform inpatient capacity planning.

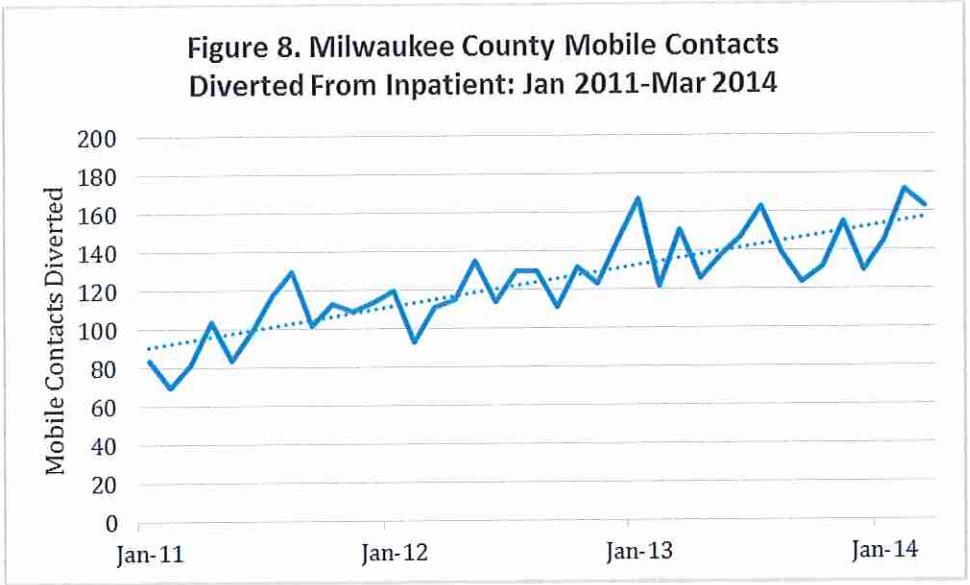
5.3.3 Increased Crisis Diversionary Activity

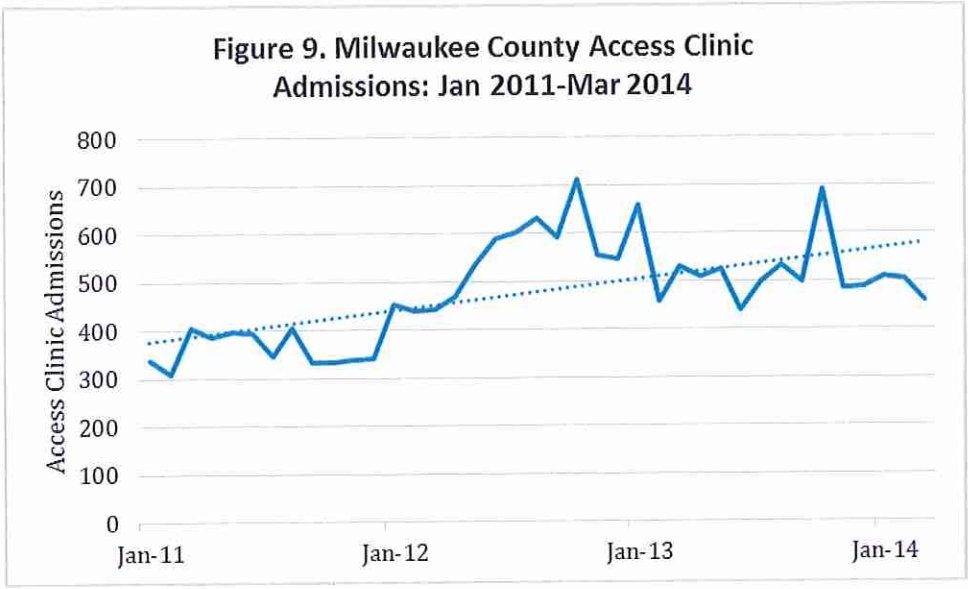
By focusing attention on the front door of the inpatient system, BHD appears to have decreased the need for hospitalization for those likely to need high acuity inpatient care. This is evidenced by the shift in admissions to private hospitals and reduced utilization of crisis services, including a decrease in PCS admissions (Figure 6) and emergency detentions (Figure 7), and increased use of mobile response. Most notably, it appears that expansion of mobile crisis response capacity has increased the number of individuals diverted from inpatient (Figure 8) and is related to decreased utilization of police intervention, emergency room visits, and admissions to BHD. Between 2011 and 2013, BHD data show the number of emergency detentions and crisis admissions in Milwaukee decreased by 21% and 14%, respectively. Increased use of the Access Clinic (which provides a variety of outpatient clinical services) by those who are indigent may have also contributed to decreased utilization of emergency detentions and BHD admissions

(Figure 9). Note: An additional Access Clinic site is now being added which should increase the number served.









Despite the real progress discussed above, there is evidence to suggest that Milwaukee County's behavioral health system still relies too heavily on crisis services in emergency rooms or crisis clinics. Data prepared by the Wisconsin Hospital Association (WHA) for this report show that when adjusting for poverty, an estimated 36% of individuals with serious mental illness in Milwaukee County had an emergency room visit in 2013, compared with a state average of approximately 20%. Additionally, the use of police interventions and emergency detentions remains high. For comparison, Houston's population of 2.1 million is more than

twice that of Milwaukee County, yet in 2011 Houston had 2,259 emergency detentions,[30] or about 28% of the number of emergency detentions in Milwaukee County (8,109).[31]

WHA data also suggest that when comparing the inpatient penetration of individuals with serious mental illness (SMI) who are in poverty, an estimated 17% of individuals with SMI in Milwaukee County had an inpatient discharge for mental illness in 2013, ranking it 11th out of 20 counties it compared data with.[32] While emergency detentions remain problematic, this data suggests that Milwaukee County residents with SMI who are in poverty are less likely to be admitted as compared with other counties.

5.3.4 Access to and Availability of Community-based Services

While use of crisis diversion services such as mobile response and the Access Clinic are important, the strength, quality and accessibility of non-crisis oriented, community-based services is equally or perhaps even more critical. The 2010 HSRI/TAC/PPF report highlighted the voice of stakeholders in the system calling for a more recovery-oriented, higher quality, accessible community-based system that is less reliant on crisis-oriented, emergency, and inpatient treatment service. One of the challenges to this inpatient bed need analysis was to understand the extent to which the increase in community-based services that has occurred since that time has lessened demand for inpatient services and the use of emergency detentions.

Since the release of the HSRI/TAC/PPF report on Milwaukee's mental health system, the county has allocated additional resources to community-based services and made progress in several areas. Budgeted initiatives since 2011 have included expansion of crisis residential beds, peer support services, supported housing assistance, and mobile crisis response services. As shown in Appendix C, the current 2014 budget allocates a significant investment of approximately $4.8 million to expand a range of community services. It is important to note that BHD has begun piloting more intensive community-based supports that resemble Assertive Community Treatment (ACT). The implementation and projected expansion of Community Recovery Services (CRS) 1915(i) Medicaid state plan services will provide a good platform to meet the needs of individuals, but these will take time to phase in and achieve positive outcomes. CRS is initially being used to transition people from community-based residential facilities (CBRFs) to lower levels of care, making room for those who need more intensive support. Meanwhile, the phase-in of Comprehensive Community Services (CCS) during the remainder of 2014 and projected growth in 2015 will provide an opportunity for more persons who are receiving case

[30] Houston Police Department, Mental Health Unit. 2011 Annual Report: Success through collaboration. 2011. http://www.houstontx.gov/police/department_reports/MHU_2011_Annual_Report.pdf

[31] The process for counting the number of Emergency Detentions (ED's) for Milwaukee and Houston is comparable. After recognizing problems with the number of ED's, the Houston Police Department and the Mental Health Mental Retardation Authority of Harris County implemented a series of reforms to reduce the use of ED's and improve access to care. http://www.houstoncit.org/history/

[32] Wisconsin Hospital Association. Data analysis provided July 9, 2014.

management services to receive a more comprehensive array of support. The use of CCS can be intensive, and BHD is seeking to develop ACT-like[33] services through this mechanism.

However, many of these newer services are budgeted for implementation during 2014 and expansion in 2015, and have yet to be sufficiently established to the point where they lessen existing demand for inpatient capacity across the system. While BHD's bed utilization is down, the overall admissions throughout the county have generally remained consistent for the past three years, and the reliance on police as the frontline for psychiatric emergency services in Milwaukee County, evidenced by the persistently high number of emergency detentions, remains problematic.

In addition, while most individuals in inpatient care have lengths of stay of roughly one week, there is a group of individuals at BHD with very long lengths of stay that occupy beds. These individuals have complex situations such that they: a) continue to meet commitment criteria; or b) they no longer meet commitment criteria but intensive community services appropriate for their needs have not been developed yet. An argument can be made that if appropriate services could be developed in the community for these individuals, then the beds that they currently occupy would not be needed. One explanation for the system's admissions and discharge challenges may be the system's historic reliance on less-intensive services with limited access, such as Targeted Case Management, compared to other better-performing jurisdictions that utilize services like ACT, intensive case management, and peer-delivered supports.

Table 7 shows the various types of community-based services offered by the County prior to this year (when CRS and CCS were added and an ACT pilot was initiated) and changes in the number of individuals served since 2011. Projected increases by BHD in the number of individuals that could be served between 2015 and 2017 with continued growth of community-based services could reduce inpatient demand further. Appendix A has a more detailed description of each service.

[33] Assertive Community Treatment is an evidence-based practice with established fidelity standards. ACT should not be confused with services that are intensive but do not adhere to fidelity standards.

Table 7. Milwaukee County Behavioral Health System Services: 2011-2014

	2011	2012	2013	2014 YTD*	2014 Projected
Targeted Case Management					
Capacity	1234	1234	1252	1292	1292
# served	1314	1378	1439	1370	1505
Length of stay (Years)	3.6	5.6	3.5		
# with PCS encounter	362	399	356		
# with inpatient stay (BHD)	101	144	149		
# with inpatient stay (Self-reported)	331	351	329		
Community Support Program					
Capacity	1315	1310	1340	1340	1340
# served	1408	1384	1352	1337	1392
Length of stay (Years)	10.0	7.7	9.7		
# with PCS encounter	396	360	363		
# with inpatient stay (BHD)	121	133	125		
# with inpatient stay (Self-reported)	334	319	255		
SAIL[34]					
New Clients Requesting Services	432	470	568	199	600
Total Approved Requests	1348	1297	1619		
Denied Requests	427	499	649		
CLASP					
Capacity	n/a	75	150	150	150
# served	n/a	59	248	158	243
Length of stay (Months)	n/a	2.0	3.2		
# with PCS encounter	n/a	52	182		
# with inpatient stay (BHD)	n/a	36	120		
Recidivism rate	n/a	8.5%	8.3%		
Partial Hospital					
Capacity	24	24	24		
# served	65	63	63	38	54
# with PCS encounter	39	30	26		
# with inpatient stay (BHD)	14	14	14		
# with inpatient stay (Self-reported)	33	30	31		
Community-Based Residential Facility (CBRF)					
# of beds	136	136	136		
# with PCS encounter	42	52	51		
# with inpatient stay (BHD)	31	24	20		
# with inpatient stay (Self-reported)	17	29	30		
Outpatient					
# served	998	978	657	464	988
# with PCS encounter	459	440	141		
# with inpatient stay (BHD)	134	109	93		

Source: BHD

*2014 YTD is 01/01/2014 – 04/30/2014

[34] The Service Access to Independent Living (SAIL) program makes assessments and referrals to programs and is not a direct service program. It is shown here to reflect increased demand for services.

5.3.5 System-wide Inpatient Bed Planning and Management

Because Milwaukee County operates its own inpatient and long-term care facilities, it rarely sends consumers to the state hospitals. In most states, as well as in those Wisconsin counties without a county hospital, consumers who require longer lengths of stay tend to be admitted to state facilities either after a short-term admission at a local hospital or directly if no beds are available locally.[35] State psychiatric hospitals admit individuals with the most complex conditions only after they have been served in a local, private hospital unit.[36,37]

The balance of inpatient care is managed by private hospitals at the local acute care level. In 26 states,[38] the availability of psychiatric beds is regulated through a Certificate of Need process to ensure bed availability and that clear requirements exist for things like admissions and discharge criteria, minimum staffing and clinical expertise, and the types of services that should be provided. Absent a Certificate of Need process for psychiatric inpatient services (or a similar oversight, regulatory or coordination process), challenges could emerge with regard to access to care, system coordination, and fragmentation.

In Milwaukee County, the lack of such clear guidelines to govern psychiatric inpatient bed capacity and responsibility is problematic. For example, the ability of individual providers to open and close beds unilaterally and on short notice—and sometimes solely in response to psychiatrist vacations or absences—can negatively impact overall system capacity in ways that cannot be anticipated and effectively addressed by other providers. The lack of formal system criteria with regard to admissions is also problematic, as individual providers can establish their own criteria that are determined by variables such as patient acuity or payer factors. Payer factors may become an increasing concern as private hospitals engage in managed care and create accountable care networks that will drive bed capacity.

Overall, the lack of system-wide coordinated planning between BHD and its partners (e.g., private hospitals, providers, and stakeholders) and resulting uncertainty regarding bed capacity, availability, and access remains a significant system issue, despite the real progress that has been made in recent years to implement a public-private provider working group and to establish contractual relationships between BHD and certain providers. A high-level review of data shows a slight decrease in admissions to inpatient settings overall. However, bed planning

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[35] National Association of State Mental Health Program Directors Medical Directors Council. *The Vital Role of State Psychiatric Hospitals*. July 2014.

[36] Despite this, state hospitals are typically not equipped to treat individuals with serious medical conditions and individuals are often treated in private, acute care hospitals with mental health staff providing supervision in the medical setting.

[37] There are some situations where patient acuity of circumstances are so complex that private hospitals are precluded from serving individuals. Examples include court-ordered or otherwise forensic situations, or severe risk of dangerousness.

[38] According to the National Conference of State Legislatures, 26 states, excluding Wisconsin, have a Certificate of Need process for psychiatric inpatient bed capacity. http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Regulated

should not occur in a vacuum. The admission trends suggest that beds could be reduced at BHD, but several factors should be considered, including the future plans of individual hospitals and the impact of community services expansion.

The role of the State of Wisconsin also must be clarified. For example, like the County, the State is also considering strategies to reduce census in its facilities at Mendota and Winnebago. While such action is consistent with national efforts from economic and community integration perspectives, it could be detrimental to BHD's downsizing efforts; an inability to send additional consumers to state hospitals could preclude an important option for certain patients served by Milwaukee County.

5.3.6 Closure of Rehab Hilltop and Rehab Central

In February 2013, the Milwaukee County Executive announced the County's intent to close the long-term care rehabilitation units at the Mental Health Complex. The stated intent was to provide residents living at Rehab Hilltop and Rehab Central the opportunity to live in the least restrictive environments and more integrated settings consistent with *Olmstead*. Rehab Hilltop has operated as a 72-bed intermediate-care facility for individuals with intellectual and developmental disabilities and co-occurring mental illness, and it is scheduled for closure at the end of 2014. Rehab Central has operated as a 70-bed skilled nursing facility/home for individuals with complex physical, mental and behavioral needs, and its closure is slated for December 2015.

As of August 2014, there were 38 individuals in Hilltop and fewer than 35 in Rehab Central. Both facilities have 24-hour supervision and are highly structured environments with comprehensive treatment and supports. As a result, it is reported by BHD that there has been low utilization of psychiatric inpatient beds by the Hilltop and Rehab Central residents. As residents are moved into community-based settings, however, there is some possibility that there will be an increase in psychiatric inpatient utilization if services do not meet individuals' needs, creating a new pressure point. In addition, individuals who otherwise would have been admitted to either of these facilities could also remain on BHD inpatient units for a longer period of time if sufficient community-based options do not exist.

According to BHD, two former residents were admitted to BHD once, and another individual was admitted twice, since downsizing of the two facilities began. While there have been few admissions to BHD of former residents of Rehab Central and Hilltop since downsizing began, the number of inpatient bed days consumed is long, with one presently exceeding 425 days. Over time, it is likely that some of these individuals, and individuals with similar needs, will need inpatient treatment, and BHD should track this issue to understand the impact to bed demand and the need to deliver more enhanced services to those individuals in community settings.

5.3.7 Workforce

Consistent with workforce challenges experienced nationally, Milwaukee is experiencing a shortage of behavioral health professionals and paraprofessionals. Most directly, this impacts inpatient bed capacity at BHD and the other hospitals. Hospitals struggle to recruit and retain qualified staff, and these difficulties are compounded by the typical staffing challenges associated with vacations and sick leave. When hospitals are at the staffing margin, any staff vacancies directly reduce bed capacity.

Area hospitals have made limited use of nurse practitioners for prescribing. Nurse practitioners have been used successfully in some states, not as a replacement for psychiatrists but as a complement to the milieu. While there is little research on differences in quality of care, nurse practitioners are able to prescribe in Wisconsin and could—at minimum—play a role in helping to ensure that existing bed capacity is staffed and can be fully utilized. A key issue in Wisconsin is a decided lack of certified psychiatric mental health nurse practitioners.

It appears common in Milwaukee County for bed capacity to fluctuate depending on staffing. While the availability of workforce is a documented issue in Milwaukee and other parts of the country, it was surprising to hear about the frequency of fluctuations in bed capacity caused by temporary staff vacancies. While clinical care and safety must not be compromised by high caseloads, there could be greater efforts to ensure consistent staffing to ensure consistent bed capacity (for example, shared professionals, use of APNs, and locum tenens).

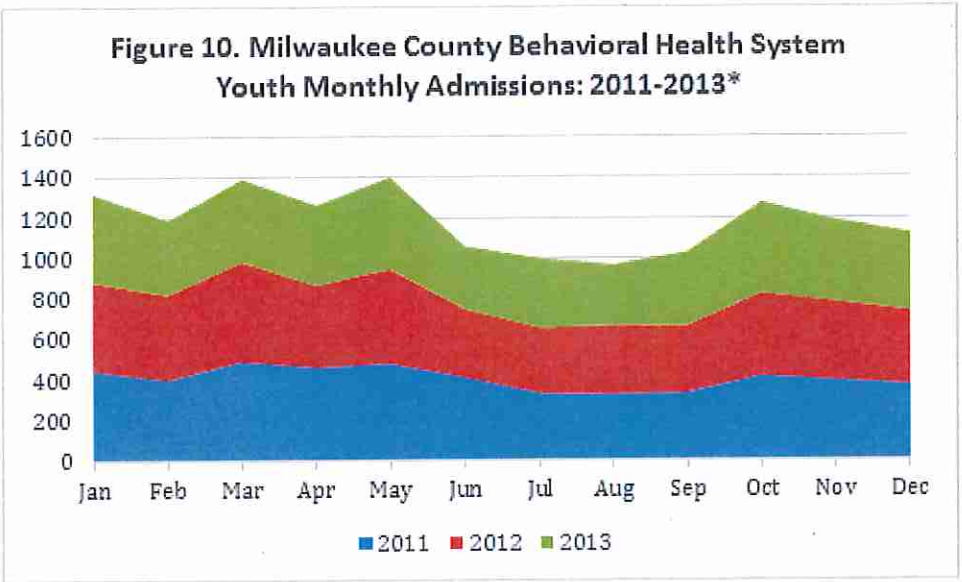
Key informants also expressed concern about the lack of available and skilled community-based workforce to meet demand, including staff for program services such as Assertive Community Treatment and licensed clinical professionals like psychiatrists and therapists to meet clinical outpatient demand. That issue also could impact inpatient bed capacity but it is beyond the scope of this report to quantify it; the issue will be addressed, however, by an outpatient capacity analysis that will be initiated shortly after the release of this report.

It was suggested by some providers that the hospitals should consider a joint approach to meeting the skilled workforce needs across the inpatient system. This model would include sharing treatment professionals such as psychiatrists or other licensed professionals with expertise in various areas to meet the needs of individuals with complex conditions. This could enhance the ability and willingness of the private hospitals to admit some patients who might otherwise be admitted to a more restrictive setting at BHD. This idea merits discussion among the hospitals, including BHD.

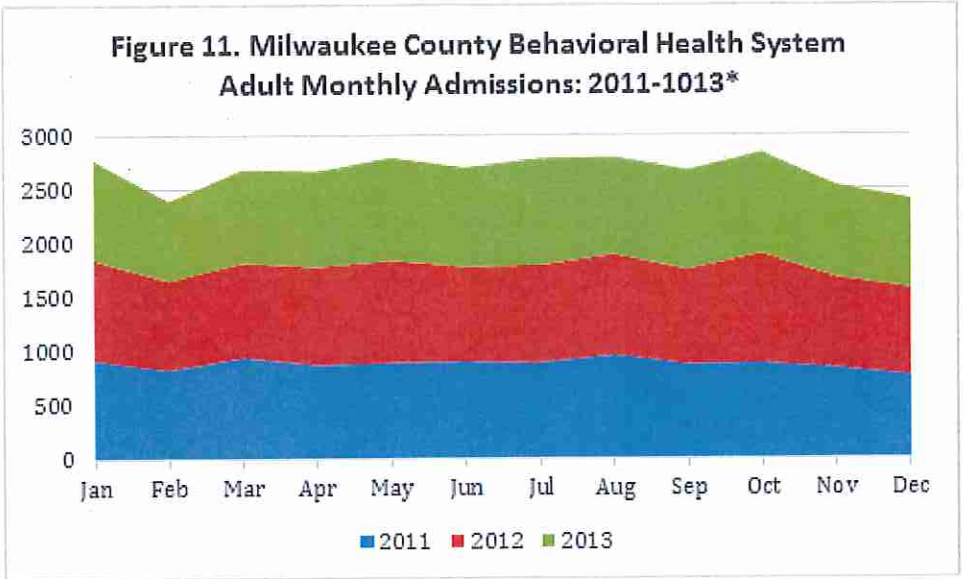
5.3.8 Seasonality

During this project, the notion of seasonal effect on admissions was raised by various stakeholders. A review of the data for the past three years shows significant fluctuations in total admissions (i.e., adult and child/adolescent) on a monthly basis each year. A closer look at the data—as displayed in Figures 10 and 11—indicates that for children and adolescents

(younger than age 20), there seems to be a decrease in admissions during the summer months. For adults over 20, however, there seems to be general consistency of admissions throughout the year.



*Includes private hospital admissions for persons age <21, and CAIS admissions to BHD.



*Includes private hospital admissions for persons age ≥21, and Adult Acute admissions to BHD.

For adults, it appears that any strain on inpatient capacity is unrelated to seasonality. However, given the current number of adult beds in the county, it appears that there is enough capacity to accommodate any minor, temporary fluctuations that arise due to seasonality or other

issues, and hospital systems should be prepared to staff up accordingly. It is cost prohibitive to maintain additional staffed bed capacity for short-term spikes in demand.

While it does not appear that seasonality is a major issue for adult inpatient demand, it is important to point out that admissions that may be related to seasonality are not necessarily indicative of a greater clinical need during these months. Many experts in the County agree that seasonal variations could be partly weather-related; for example, people who are homeless are more likely to be admitted for sheltering reasons due to extreme cold despite the fact that this is not consistent with commitment criteria. However, our data do not show an increase in adult admissions in the winter months. If such a situation should occur, greater attention to community service needs would be more appropriate than utilizing costly inpatient beds as shelter.

5.3.9 Transfer of Authority

Recently passed state legislation that provides for a different means of oversight of Milwaukee County's behavioral health system will affect how psychiatric inpatient care is approached and managed in the county. Until recently, per the Wisconsin state statutes, the county board of supervisors in all counties had "the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcohol and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."

However, this authority in Milwaukee County was recently changed by state lawmakers and assigned to a new Mental Health Board (MHB). Effective July 1, 2014, the new Mental Health Board assumed responsibility for the oversight and direction of Milwaukee's behavioral health system. Details of this role can be found in Chapter 51 (i.e., 51.41) of the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act. While the Mental Health Board is just beginning its work, it will have a direct role in how the system evolves, including BHD's role in inpatient care, system-wide bed capacity, and the capacity and quality of community-based services.

Section 6
Recommendations

The purpose of this analysis is to understand the demand for adult psychiatric inpatient beds and the capacity that should exist in Milwaukee County. As stated earlier in the report, much of the demand and capacity for inpatient beds depends on multiple variables, including the overall community-based services infrastructure. We reviewed several of these variables in making our recommendations. It is important to point out, however, that a detailed assessment of outpatient capacity (e.g., community-based programs and licensed treatment professionals)—which will be a key determinant of the inpatient capacity needed in Milwaukee County—is beyond the scope of this project. An analysis of outpatient treatment capacity is planned as a second phase that will begin after the completion of this report.

6.1 Short-Term Demand and Need for Adult Psychiatric Beds

Recommendation: Based on the current capacity and composition of the overall adult mental health system in Milwaukee, adult inpatient bed capacity should be in the range of 167 to 188 beds.

Currently, among both public and private hospitals, we calculate that there are approximately 201 adult psychiatric beds in the system; of these, roughly 150 beds are utilized. These utilization figures are based on 2013 admissions trends and lengths of stay, and they capture seasonality and other factors. As discussed in the Methodology section, however, hospital psychiatric units often intentionally operate under capacity to accommodate unique circumstances—patient acuity, gender issues or medical co-morbidity for example—that affect unit milieu. Essentially, the hospitals balance unit census to ensure safety and a therapeutic environment. As a result, the system needs more beds than are utilized to account for these variables.

Based on feedback from the hospitals, we applied a lower and upper occupancy rate and calculated the range of beds that should exist in the current system to accommodate actual utilization. This means that the psychiatric units will generally operate at 80% to 90%[39] of capacity to meet inpatient demand. In Milwaukee County, there should be approximately 167 to 188 beds to meet the current utilization rate of 150 beds. Given that there are 201 beds budgeted among all of the hospitals in the County (with 23 more planned for 2015), we believe there is enough total capacity to meet current demand.

While we find the current county-wide budgeted bed capacity sufficient and that demand for inpatient beds appears to be lessening throughout the county, recent data shows a "tipping

[39] Based on the American Hospital Association annual survey data, the bed occupancy rate across all hospitals in the U.S. in 2009 was 67.8%.

point" where the system appeared to have sufficient bed capacity but then suffered a strain when that capacity was diminished earlier this year. In 2013, there were approximately 223 beds operating (66 at BHD and 157 among the private hospitals) compared to 201 in 2014. With admissions in the county remaining relatively stable, the strain on capacity appears to stem largely from the reductions in beds at both Columbia St. Mary's and at BHD. It is important to keep in mind that fluctuations in staffed bed capacity at BHD and the private hospitals due to vacations and other leave time add to this strain.

This data also does not include admissions to medical/surgical beds operated by the private hospitals. It was reported that the hospitals may admit patients with a primary psychiatric diagnosis to medical/surgical beds at times due to various circumstances. While these admissions add to the total bed days utilized in the system, they do not appear to be as a result of problems accessing designated psychiatric inpatient beds. BHD should monitor the extent of such admissions to ensure that it does not underestimate psychiatric inpatient bed need.

Several private hospitals have increased their admissions in the past three years, particularly Aurora Psychiatric Hospital and Rogers. However, the closure of Columbia St. Mary's 18-bed unit in Milwaukee seems to have added pressure on bed capacity throughout the county.[40] In 2013, Columbia St. Mary's admitted 1,892 adults and had an average daily census of approximately 12 individuals who were there involuntarily or voluntarily. That loss of capacity--combined with a reduction in beds operated by BHD from 66 to 54 earlier this year—placed added pressure on the system. Consequently, it is reasonable to suggest that for short-term planning, the number of beds needed now in Milwaukee County should be based on recent experience and utilization, which suggests the range of 167 to 188 beds.

This does not suggest that the 167 to 188 bed range needed now is ideal for the longer term. Instead, it reflects the need based on the current capability and capacity of Milwaukee County's overall behavioral health system. We found that new investments made in mobile response, for example, have helped lessen the pressure on PCS and inpatient demand at BHD; however, these investments have not significantly improved access to community-based services. Ideally, Milwaukee County and the new Mental Health Board should emphasize the development of the types of accessible, community-based services that could reduce the demand for inpatient beds.

[40] It is important to note that several other health systems in Milwaukee also have closed psychiatric inpatient beds during the past several years. Our discussion of this closure is not meant to single out the Columbia-St. Mary's system, but simply reflects the timing of this specific reduction in beds and its relevance to the consideration of near-term inpatient capacity.

6.2 Type and Configuration of Beds

Recommendation: Using the upper range of beds needed in the system to meet demand (188 beds), 54 to 60 adult inpatient beds should be maintained to serve high-acuity and/or indigent patients and roughly 128 to 134 beds should be maintained to serve low– to moderate-acuity patients.

Current data shows that most admissions can be accommodated by the private hospitals and tend to be low to moderate in acuity. As discussed earlier, functionally, the county appears to categorize beds as low/moderate or high acuity. Generally, individuals with low to moderate acuity tend to be admitted to the private hospitals. These individuals are more likely to benefit from shorter inpatient lengths of stay and tend to present with fewer risks, such as assaultive behavior. As the inpatient system is currently configured, those with more complex presentations—such as individuals with dual diagnosis, co-occurring disorders, and assaultive behaviors—and those who are more likely to have a longer length of stay tend to be referred to BHD for inpatient treatment. In addition, BHD is more likely to serve those enrolled in Medicaid fee-for-service and the indigent population as uncompensated care.

As discussed earlier, private hospitals handled 79% of the behavioral health admissions in the county in 2011; this percentage increased to 85% in 2013. Accordingly, we can broadly assume that in 2013, roughly 85% of admissions were for patients with low to moderate needs, and 15% were to BHD for higher acuity (though we acknowledge that payer source also impacts BHD admissions). Because BHD admits higher-acuity patients and has longer lengths of stay, however, it is clear that based on the current demand/capacity approach, BHD should operate far more than 15% of the total beds. The data suggest that 54 to 60 beds is the needed capacity for high-acuity and/or indigent patients who historically have been served by BHD, and that roughly 128 to 134 adult beds should be available for patients with low/moderate acuity who historically have been served in the private hospitals.[41] However, as discussed above, the ability of BHD and the hospitals to cooperatively gauge and plan needed bed capacity on an ongoing basis will be important to maximize beds and ensure a seamless system.[42]

In the near future, it is likely that BHD's inpatient beds will continue to serve patients with higher acuity and/or those who are indigent unless agreements are worked out with private hospitals to admit higher-acuity patients and use public funds to reimburse those hospitals for uncompensated care. Based on beds in operation at the beginning of 2014, bed capacity at the private hospitals appears mostly stable, aside from the closure of beds at Columbia St. Mary's Milwaukee. In fact, Rogers Memorial is adding 56 new beds, which will result in an additional

[41] BHD is budgeting for 60 adult beds for CY2015.

[42] The private hospitals have no legal obligation to provide beds to meet recommended county-wide need. Therefore, we do not feel it is appropriate to recommend a per hospital allocation of beds. However, we feel it is in the hospitals' and county's interest to coordinate how best to meet the system's bed need.

28 beds for adults and 28 beds for children and adolescents. Rogers also anticipates adding additional intensive outpatient and partial hospital capacity.

As discussed earlier in the report, there is some risk of relying on the private hospitals to maintain capacity, and the county and private hospitals should engage in regular joint planning to meet the inpatient needs of county residents. Prior to 2009, there was very little interaction among the hospitals and BHD. However, over the past few years there have been efforts to improve coordination. The newly constituted Mental Health Board should consider how best to ensure active coordination and planning among BHD and the hospital providers.

6.3 Planning for Future Bed Capacity

Recommendation: BHD should expand community-based services that have been shown to promote recovery and decrease the need for hospitalization. Future decreases in bed capacity should be based on inpatient and community-based services metrics that demonstrate a sustainable decrease in demand for inpatient beds.

Strategies to decrease admissions to the private hospitals and BHD will be essential to enabling further decreases in bed capacity. If the goal of Milwaukee County/MHB is to decrease reliance on inpatient bed utilization, then the enhancement of the community-based system must take place. As previously mentioned, inpatient bed demand is contingent on the foundation of the community-based system of care. BHD should enhance its efforts to expand the availability of community-based services that have been shown to decrease inpatient admissions.

While we found that the County has expanded some community-based services, and that this expansion has reduced activity at PCS and helped to successfully accommodate the reductions in bed capacity that have occurred to date, the increase has not been sufficient to further decrease bed capacity at this time. To some degree, the overall coordination and organization of the system, including the need to establish a culture built on community support and diversion (as compared to a "get sick first" system), is as important as simply expanding services.

There is solid evidence to suggest that more available and accessible community-based services can decrease the demand for inpatient care. For Milwaukee County, this would require further investment (new or reallocated resources) to improve access to community-based services targeted to those most likely to utilize crisis and inpatient services. Among these are efforts to increase mobile response activity or other interventions aimed to divert and reduce police interventions and emergency detentions; intensive and flexible services such as Assertive Community Treatment and supportive housing strategies; increased access to peer-delivered supports; and increased access to prescribers.

BHD should utilize SAMHSA's *Description of a Good and Modern Addictions and Mental Health Service System* as a reference for the continuum of services that should be available to

Milwaukee County residents. BHD should also refer to emerging best practices on the integration of behavioral health and primary healthcare. Critical to the outcomes, BHD should evaluate how individuals are assessed and matched to services. Individuals with the highest needs and who are most at risk for hospitalization should have access to the most intensive community-based services; those who are further along in recovery and present with lower risk should have access to less intensive but flexible supports. As part of this process, BHD should identify performance metrics to evaluate whether the services that individuals are receiving are having a desired impact on hospitalizations and other recovery-oriented outcomes (e.g., employment, quality of life).

Similarly, system-wide and hospital-specific metrics should be utilized when changing inpatient bed capacity and considered in the context of the community-based performance indicators. Community-based performance indicators that demonstrate an expansion of services that demonstrate desired outcomes such as fewer crisis episodes, stable housing, and engagement in meaningful activities (employment and positive social relationships, among others) will likely result in fewer hospital admissions. The ability of the system to correlate these metrics will provide a data-driven justification for additional decreases to inpatient bed capacity.

Hospital admissions data is another source of information that could be carefully tracked and used to determine how many beds could be decreased in the system. We applied a utilization-based approach based on admission trends to estimate the number of beds that could be decreased over time in the county, with an underlying assumption that more accessible community-based services metrics will support decreasing admissions and lengths of stay.

Based on current lengths of stay, we estimate, based on our bed calculation methodology, that for every 225 BHD admissions (median length of stay of 8 days) that the system can divert and sustain, roughly five fewer high-acuity beds are needed in the system. For every 450 admissions to the private hospitals (median length of stay of 4 days) the system can divert, roughly five fewer low/moderate acuity beds are needed in the system. However, before these estimates are actually used to decrease bed capacity across the county, we recommend that a trend analysis occur for community metrics described above and any decrease in admissions, and that the decrease is sustained for a period of at least six months before any bed capacity is reduced. This is important since there are many variables that will affect future bed need, several of which are not quantifiable at this time.

These estimates depend on several factors, and the numbers above should be used as a guide. Some beds have patients with very long lengths of stay, essentially resulting in limited utilization of those beds. Consequently, the less efficient the hospitals and system are at managing lengths of stay, the greater the likelihood that bed capacity will need to remain higher.

Recommendation: The private hospitals should continue to increase their role in meeting the psychiatric inpatient needs of Milwaukee County residents. BHD should collaborate with and assist the private hospitals to successfully treat individuals with complex situations and seamlessly facilitate their discharge back into the community.

We also think that much of the inpatient care provided at BHD can be provided by the private hospitals, especially if the community-based services are increased and providers are equipped to work with consumers who have more challenging behaviors. It is likely there will still be a need for beds to serve a higher level of acuity, but BHD does not necessarily have to be the entity to operate those beds. This decision ideally should be determined by which party can provide those beds in the most cost-effective and clinically proficient manner.

The private hospitals have expressed concerns about their ability and willingness to assume this responsibility, including finding appropriate community settings to which patients can be discharged and additional financial risks they would incur for delayed discharges if community resources are unavailable or nonexistent. The County, and possibly the State, will need to consider the roles that they might play in appropriately addressing those and related concerns. Another alternative would be for the State to assume the responsibility for those limited instances when higher-acuity beds for the most complex patients are needed.

Much of the bed capacity in Milwaukee County is driven by the private hospitals and market factors, such as demand and payer sources, and is beyond the control of the County. Similar to third party insurance payers, the County/MHB should determine what inpatient bed capacity is needed in Milwaukee County, especially with regard to beds capable of serving patients with high acuity, and devise strategies to ensure that capacity exists. While providing appropriate high-acuity capacity itself is one option for the County, procuring it through private hospitals is another.

It was difficult for us to determine the private hospitals' precise future plans for inpatient bed capacity, and the feedback we did receive from hospital officials about future bed capacity can only be considered speculative. However, Rogers Memorial's expansion to a second site will result in roughly 28 additional adult beds in the county, and BHD should be engaging Rogers Memorial for bed planning purposes.

It also is difficult to predict the impact that the BadgerCare expansion will have on inpatient need, and this data should be regularly reviewed. We expect it is more likely that this will result in increased pressure on outpatient services as people will be more likely to seek services. Since inpatient care is emergency-based, we believe this population already accessed inpatient treatment when brought in through emergency detentions or other means.

It is possible, however, that greater access to community services will positively impact the system in that some people who were previously uninsured and admitted to inpatient treatment will instead access outpatient services and be less likely to be admitted in crisis. The

impact to inpatient and outpatient services through this newly insured group should be tracked. Increased insurance coverage could be a factor in increased emergency department pressure, as some other states have experienced.[43] However, this does not necessarily mean that this pressure should result in increased admissions to psychiatric inpatient units, and there should be some leveling off as newly insured individuals engage in and learn to navigate outpatient services.

[43] Taubman, Sarah, L., et al. Medicaid Increase Emergency Department Use. Evidence from Oregon's health insurance experiment. Science Express. January 2, 2014; Page 1 / 10.1126/science.1246183

Section 7
Concluding Thoughts

Our analysis has found that based on the current adult mental health system in Milwaukee County, there will be a continued need for inpatient beds for consumers with higher acuity and lack of insurance to pay for care. It is reasonable that demand for these beds could further decrease if certain types of community-based services are increased. In the near term, however, individuals with higher acuity and Medicaid fee-for-service or no insurance will likely continue to be admitted to BHD rather than to Aurora Psychiatric Hospital or Rogers Memorial due to lack of reimbursement and other factors discussed throughout this analysis.

Given that the private hospitals currently handle approximately 85% of all admissions to inpatient care, however, a major consideration for the longer term is at what point it becomes economically inefficient for the County to continue to provide care at the Mental Health Complex. BHD could negotiate a rate to pay for Medicaid-eligible or uninsured individuals at the private hospitals, or work with non-IMD private hospitals to admit more individuals with Medicaid to reduce the burden on public funds.

To accommodate a reduced but continued need for high-acuity beds and the reimbursement issues discussed throughout this report, we suggest that four scenarios exist:

- BHD continues to operate a smaller number of high-acuity beds at the Mental Health Complex or in a smaller facility.
- BHD purchases high-acuity capacity at a private hospital or hospitals.
- Milwaukee County residents with high-acuity, longer term needs are referred to a State-operated hospital.
- BHD or the State operates a regionalized facility that serves Milwaukee County residents and residents from surrounding counties who otherwise would have been referred to a State hospital for longer term care.

Each scenario is discussed briefly below and will require additional examination as the Mental Health Board considers the future role of the Mental Health Complex.

Scenario I: BHD continues to operate a smaller number of high-acuity beds at the Mental Health Complex or in a smaller facility.

Over time, the number of consumers admitted to the Mental Health Complex has decreased as community capacity increased and psychopharmacological treatments became more effective. Despite this progress, there will still be a need for some longer term, high-acuity beds to serve Milwaukee County residents. We believe, however, that if there is willingness to devote sufficient resources to the types of community-based services described in the previous

section, then the number of such beds can be reduced substantially below the 54 to 60 that currently are required.

In many states, the public authority (mostly at the state level) charged with this responsibility continues to provide this service. For Milwaukee County, the efficiency of operating this service at the current Mental Health Complex or providing the service in a more cost-efficient setting is at issue.

At some point the cost to provide services to relatively few individuals in a larger facility becomes inefficient, particularly when that facility is classified as an IMD and when it exists as part of a county government structure that allocates centralized costs to the Mental Health Complex as if it is a regular county department (as opposed to a health care facility). If the MHB determines that the County should continue providing inpatient services, then it should consider the point at which it provides the service in a smaller setting at a different location. One consideration could be to secure space to provide one or more 16-bed units, which might not be considered IMDs and would therefore be eligible to receive Medicaid reimbursement. Discussions would need to occur with the state Medicaid office, however, to determine whether the site or sites would be IMDs. Notwithstanding the IMD consideration, there may be other cost savings that could be realized if the county operated its inpatient beds at a different location in a smaller facility.

Scenario II: BHD purchases high-acuity capacity at a private hospital.

BHD could get out of the business altogether and purchase capacity from private hospitals or other private behavioral health providers. Historically, BHD has taken responsibility for providing inpatient and emergency care of indigent individuals with mental health and substance abuse disorders. However, there are examples across the country where the public system purchases that capacity from private hospitals. It is likely there will still be instances when a patient's situation is so complex (for example, forensic involvement, extreme risk for violence, history of sexual offense) that the public system will need to play a role. In this scenario, in those limited instances, the state hospital system typically provides treatment. Despite the fact that BHD currently transfers very few county residents to the state hospitals, the State hypothetically could be asked to play a greater role in accepting such patients, though state officials obviously would have to be open to that idea and heavily involved in this planning process.

Scenario III: Milwaukee County residents with high-acuity, longer term needs are referred to a state-operated hospital.

Unlike the previous scenario, in which the state hospitals would play a greater role solely with regard to the most complex patients, in this scenario they would be expected to serve all Milwaukee County residents with high-acuity and longer term needs. This scenario assumes an increased ability of the private hospitals to serve more individuals, thereby resulting in a lower

number of individuals who would be referred to the state hospitals. Most systems across the nation, including other counties in Wisconsin, do not have county-operated hospitals. In these systems, patients who cannot be served well in local acute care hospitals are served in the state hospitals. While state systems are working to reduce their census, they continue to play a role in serving individuals with the most complicated situations. As in Scenario II, the state may reject any additional pressure on its state hospital beds, and this scenario would need to be discussed and negotiated with state officials. A separate fiscal analysis by the Public Policy Forum will be released later this year, and this analysis will be helpful in comparing the actual costs of operating beds at the Mental Health Complex against potential charges for state hospital beds.

Scenario IV: BHD or the State operates a regionalized facility.

Instead of seeking to move to a smaller facility, BHD could use the excess capacity at the Mental Health Complex that has been (and will continue to be) created from decreasing utilization of high-acuity beds to provide beds to adjacent counties. As the State seeks to decrease its census in the state hospitals, it could utilize the Mental Health Complex, or a facility in an alternate location, in a regional capacity to serve out-of-county residents who need higher-acuity beds, rather than referring them to the state hospitals. Reimbursement arrangements with sending counties would need to be made. While it would be logical for the County to run such a regionalized facility, its operation also potentially could be turned over to the State. Either way, the facility would continue to be an IMD, and other cost factors, such as capital costs for the aging complex, remain an issue.

Appendix A: Description of Community-Based Services

SAIL: Within the BHD, the Service Access to Independent Living (SAIL) unit within the Community Services Branch centrally manages access to long-term community-based services. Eligibility for long-term community-based services, initiated through the SAIL program, is restricted to persons who are most in need of services and who have not been adequately served through traditional outpatient services. Behavioral and medical providers must initiate a referral to SAIL. Referrals involve a psychiatric evaluation, two psychiatric hospital discharge summaries, and a SAIL assessment. The purpose of this lengthy assessment process is to determine that community services are being delivered to those most in need.

CARS: Community Access to Recovery Services (CARS) is a BHD program that provides recovery-oriented services to people with severe and persistent mental illness and/or issues with substance use disorder.

Community Support Program: The CSP is based on the Assertive Community Treatment (ACT) model of case management, although it is not a true ACT program. It is the most intensive case management service available in Milwaukee County.

Targeted Case Management: TCM is a less intensive case management program designed to involve fewer contacts with clients and a focus on ongoing monitoring and service coordination.

CLASP: Community Linkages and Stabilization Program (CLASP) provides post-hospitalization extended support and treatment designed to support an individual's recovery, increase ability to function independently in the community, and reduce incidents of emergency room contacts and re-hospitalizations through individual support from Certified Peer Specialists under the supervision of a clinical coordinator.

Day Treatment Partial Hospitalization Program: A structured non-residential treatment service consisting of regularly scheduled sessions of various modalities such as counseling, case management, group or individual therapy, medical services and mental health and substance abuse services, as indicated, by interdisciplinary providers for a scheduled number of sessions per day and week.

Community-Based Residential Facility (CBRF): Residential treatment is available in varying intensities in community-based residential facilities and transitional housing programs.

Outpatient: Services available through outpatient treatment include medication management and individual and group psychotherapy.

Comprehensive Community Services (CCS): CCS programs provide psychosocial rehabilitation services to consumers who have needs for ongoing, high or low-intensity services resulting from mental health or substance use disorders but who are not in need of Community Support Program (CSP) services. Psychosocial rehabilitation includes medical and remedial services and

supportive activities provided to or arranged for a individual by a comprehensive community services program authorized by a mental health professional to assist individuals with mental disorders and/or substance use disorders to achieve the individual's highest possible level of independent functioning, stability and independence and to facilitate recovery. CCS programs use a wraparound model that is flexible, consumer directed, recovery oriented, as well as strength and outcome based.

Community Recovery Services (CRS): CRS provides three (3) specific services: Community Living Supportive Services, Supported Employment, and Peer Supports, under the umbrella of psychosocial rehabilitation. The goal of CRS is to enable people with mental illness to live with maximum independence within the community, while at the same time offering these members more control over designing the services they receive.

Appendix B: Stakeholder Perspectives

Capacity

By far, the concern expressed most was that the system does not have sufficient community-based capacity or psychiatric emergency response services to divert people from inpatient settings. There was some acknowledgement of new funding (for example, CLASP, mobile response), but the concern was raised that it is insufficient and has not been implemented in advance of inpatient downsizing.

Several people commented that access to psychiatrists is limited, that long waitlists jeopardize stability, services are not intensive enough or aligned with the types that are needed (for example, ACT, PSH), that too many individuals are discharged to homeless settings, shelters or other substandard housing, and that there are not enough treatment options for substance abuse or co-occurring disorders. Several felt that because of BHD funding, it is easier to get access if a person is indigent and without insurance than it is for a person with Medicaid coverage due to rate reimbursement issues and a shortage of providers that accept Medicaid. Several noted that the inclusion of Recovery Case Management was good, but that new case management capacity was not actually added to the system. Concerns about waitlists for case management were expressed.

Regarding crisis services, participants acknowledged the decrease in emergency detentions, but they were critical that police intervention as a frontline to psychiatric crisis response services is fundamentally flawed. The increase in mobile response capacity has been seen as beneficial, but there was criticism that the response time is inadequate.

Stakeholders liked the concept of Comprehensive Community Services (CCS) and Community Recovery Services (CRS), but expressed some skepticism that the services would be implemented in a manner that will meet the needs of consumers. The lack of affordable, supportive housing was also identified as a significant gap.

Regarding inpatient capacity, several felt that resources would be better spent on strengthening the community system of care. However, others felt that there must be bed capacity to serve as the safety net when needed.

Stakeholders felt strongly that any funding saved from BHD downsizing should be reallocated to community services.

Accountability

Several stakeholders expressed concern with a lack of accountability over psychiatric inpatient capacity in the system. While BHD has a mandate to address the acute care needs of Milwaukee residents, stakeholders felt that some of these issues were beyond the control or

authority of BHD. Even if there was a formula to determine the optimal number of beds for the county, there is no incentive or leverage to ensure that capacity is developed or maintained.

There is a perception that the local hospitals are not doing all they can to meet the behavioral health needs of Milwaukee County, and that they should step up. There is a perception that there is no real admission/exclusionary criteria, that hospitals refuse admissions indiscriminately, and that situations default to BHD. Absent any authority, contractual or regulatory, it is difficult for BHD to have a planned inpatient system.

Specialized/Complex Needs

Concerns were expressed that hospital and community-based providers do not do a good job working with consumers with complex needs, and that this results in consumers being unnecessarily pushed into deeper levels of care. Some qualified this, stating that the intent is good on the part of providers, but that providers' workforce shortages and lack of training are the issue. Stakeholders identified co-existing medical conditions, co-occurring mental illness and substance use disorders, and severe symptomatology and behaviors as needing more specialized expertise in inpatient and outpatient settings. In inpatient settings, stakeholders expressed that hospitals should be able to work with patients with more complex conditions. In community-based settings, some stakeholders expressed that community providers could work with more challenging individuals, but need adequate levels of reimbursement to provide more services such as Assertive Community Treatment, supportive housing, and peer supports.

Stakeholders also expressed concern about the closure of the Hilltop and Rehab Central facilities. There was general support for the closures themselves; however, there was concern that the level of community supports being made available to individuals being discharged may be inadequate to meet their needs. There were also concerns that these individuals may place additional pressure on inpatient bed capacity.

Also, some individuals commented that some patients at BHD need a longer length of stay prior to being ready for discharge back to a community setting. However, there was recognition that this would result in some congestion in bed capacity and flow.

Roles

Roles came up in several discussions with stakeholders. Several comments were made regarding whether BHD should be in the business of providing and operating inpatient and crisis services or whether those functions should be delegated through contracts. Participants also expressed that there should be increased clarity on the role of the hospital systems in meeting the psychiatric inpatient needs of county residents. This further called into question the role of the State in providing inpatient care to those with the most complex needs.

Other questions involved the role of the new Mental Health Board going forward

Appendix C: Community Investments

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General - 0077

Appendix Table

2014 Budget - Community Investments (DHHS and BHD)

January 1, 2014

Expand BHD's partnership with the Milwaukee Police Department for the **Crisis Mobile Team**, by adding one clinician to work directly with law enforcement in serving as first responders to ED calls with the goal of reducing involuntary Emergency Detentions.	$	115,327
Start a **Peer Run Drop in Center** that will operate on evenings and weekends to increase the existing peer services contracts.	$	278,000
Add **quality assurance staff** - which includes one position dedicated to Crisis Services in January.	$	81,214
Continue implementing the **Community Recovery Services (CRS)** program, which is a co-participation benefit for individuals with a severe and persistent mental illness that connects clients to necessary recovery services, such as supported employment and housing, to promote independence. This includes the creation of three positions.	$	275,000
Continue the **expanded case management**, including additional TCM slots.	$	125,000
Maintain funding for **Families Moving Forward**, focusing on the African American community.	$	150,000
Invest in a new partnership with the **UCC/16th street clinic** to focus on the Latino community.	$	45,000
Add resources specifically for clients moving out of **Rehab-Centers Central**, including 20 additional CSP slots, more group home beds and other additional supports such as adult family homes and other needed services.	$	793,174
Add **ACT/Integrated Dual Disorder Treatment (IDDT)** models, which are evidence based, to the existing CSP programs to improve and expand services for clients enrolled in that program.	$	416,800
Include a **cost of living adjustment** for all CSP providers that have been level funded since 2000. BHD will continue to review and consider COLA increases for other service areas in future years.	$	738,731

July 1, 2014

Open a **Southside Access Clinic** in July 2014 to help meet increased demand and also to address community needs by having a second location for services that individuals can more easily access.	$	250,000
Apply for funds to implement **Comprehensive Community Services (CCS),** which is a Medicaid psychosocial rehabilitation benefit.	$	-

BEHAVIORAL HEALTH DIVISION (6300) BUDGET

DEPT: Behavioral Health Division

UNIT NO. 6300
FUND: General – 0077

Phased in over 2014

In partnership with the Division of Housing, BHD plans to offer a new **housing pilot program** specifically aimed at AODA clients, to provide a safe living environment coupled with Targeted Case Management (TCM) services for individuals who are in the early stages of recovery from a substance use disorder.	$	100,000
Expand the capacity to **provide mobile assessments to individuals in the community to 24 hour coverage**. If any call was deemed to be emergent, requiring immediate assessment, the BHD staff would then dispatch two on-call clinicians. This on call service would be provided by a contracted vendor. The vendors' Clinical staff would receive the full BHD Clinician training. Each member of the Mobile Crisis Team will receive additional training in related to address the behavioral health, medical and cognitive needs of elderly individuals in Milwaukee County.	$	200,000
The Housing Division's **Pathways To Permanent Housing** program is funded on an annual basis and provides transitional housing including intensive care management and the presence of a robust level of peer specialist resources and expertise in 2014. $276,250 is transferred from BHD to Housing and an additional $70,000 in increased tax levy is invested.	$	70,000
The Housing Division plans to implement a new initiative to create **40 permanent supportive housing scattered site units** to serve BHD consumers. The Housing Division will work with existing landlords to secure these units and the service model will include peer specialists to supplement the work of case managers.	$	400,000
Establish a **Community Consultation Team** specifically for individuals dually diagnosed with both a developmental disability and mental health issue. This includes the creation/transfer of 5 positions throughout 2014.	$	247,452
BHD and DSD will develop a **Crisis Resource Center** that will be available to individuals with Intellectual/Developmental Disabilities and a co-occurring mental illness. The primary goal of this program is to provide intensive support to assist an individual in acquiring the necessary skills to maintain or return to community living following behavioral or symptoms changes leading to crisis destabilization.	$	250,000
To assist BHD clients moving into the community, BHD will provide **prescriber availability** as a part of the Day Treatment program. This service will help provide continuity and outpatient services for individuals who are relocated from Hilltop and Rehab Central in order to avoid more intensive services. This will be a short-term initiative to help clients move to the community and allow time for a prescriber base to be developed.	$	65,578
An evening and weekend on-call **Crisis Response Team (CRT)** for individuals with ID/DD and MH clients is created through a partnership with the agency selected to run the DSD CRC. The main responsibilities of the on-call workers will be to answer crisis calls, provide support and guidance, and on-site assessment and intervention if needed.	$	154,544
The Housing Division will also fund **two case managers** to provide services to approximately 50 veterans who are disabled and homeless.	$	100,000
TOTAL INVESTMENT IN 2014	**$**	**4,855,820**

Appendix D: Data Tables

Table D1. Aurora Psychiatric Hospital Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual Medicaid/Medicare	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	284	23	50	14	194	3	139	85	12	33	7	8	0	4.8	4	4
Feb-11	249	20	54	15	155	5	125	74	11	33	1	5	0	5.2	4	3
Mar-11	311	29	64	23	191	4	144	107	10	38	8	4	0	4.5	4	3
Apr-11	294	23	52	27	187	5	163	74	9	39	5	4	0	4.7	4	3
May-11	268	23	50	14	178	3	142	81	10	28	2	5	0	4.7	4	3
Jun-11	232	11	33	20	163	5	121	72	4	26	5	4	0	4.9	4	3
Jul-11	247	6	28	16	193	4	122	75	4	35	6	5	0	4.5	4	3
Aug-11	249	8	23	17	191	10	120	77	4	36	4	8	0	4.5	4	3
Sep-11	255	15	40	20	176	4	118	92	2	31	8	4	0	4.4	4	3
Oct-11	275	18	46	16	191	4	132	96	14	25	5	3	0	5.0	4	3
Nov-11	280	16	60	15	186	3	149	81	12	30	5	3	0	4.6	4	2
Dec-11	242	10	49	18	161	4	116	69	12	34	4	7	0	5.0	4	3
Jan-12	293	19	46	16	207	5	144	100	10	31	6	2	0	5.1	4	4
Feb-12	267	23	51	16	174	3	120	91	14	32	5	5	0	4.7	4	3
Mar-12	309	36	59	28	181	5	149	98	19	26	13	4	0	5.4	4	4
Apr-12	299	19	48	25	203	4	154	91	9	32	8	5	0	5.0	4	4
May-12	308	28	54	19	200	7	138	95	20	38	11	6	0	4.8	4	3
Jun-12	232	13	38	15	164	2	112	71	10	24	5	10	0	4.7	4	3
Jul-12	254	8	36	17	190	3	108	93	5	32	8	8	0	5.3	4	4
Aug-12	261	17	40	10	193	1	134	71	18	26	10	2	0	5.0	4	4
Sep-12	237	23	36	10	161	7	104	78	12	32	8	3	0	4.8	4	3
Oct-12	282	15	42	24	194	7	134	76	11	46	8	7	0	5.3	4	3
Nov-12	253	12	48	12	175	6	136	63	11	31	7	5	0	5.2	4	3
Dec-12	210	11	44	17	134	4	104	51	17	27	5	6	0	5.0	4	4
Jan-13	296	13	48	14	214	7	146	66	20	41	14	9	0	5.4	4	3
Feb-13	236	13	52	19	148	4	115	67	19	28	4	3	0	5.3	4	3
Mar-13	300	19	56	24	197	4	152	94	12	31	11	0	0	4.9	4	4
Apr-13	255	10	55	16	169	5	103	89	8	37	8	10	0	5.1	4	3
May-13	308	18	52	24	212	2	141	106	3	41	9	8	0	5.0	4	4
Jun-13	274	13	40	8	207	6	103	100	8	48	5	10	0	4.3	4	3
Jul-13	246	12	38	12	178	6	101	78	10	51	1	5	0	5.2	4	4
Aug-13	249	15	30	15	183	6	94	88	4	47	5	11	0	4.5	4	3
Sep-13	289	11	53	19	200	6	129	81	11	53	5	10	0	5.1	4	4
Oct-13	355	20	88	20	223	4	151	120	18	49	7	10	0	4.8	4	4
Nov-13	344	21	82	26	205	10	149	126	16	39	8	6	0	5.1	4	3
Dec-13	318	23	59	22	204	10	132	111	12	51	8	4	0	5.5	4	4
Jan-14	335	13	75	25	219	3	146	121	15	35	6	12	0	5.3	5	4
Feb-14	351	22	95	23	202	9	158	114	20	47	4	8	0	5.1	5	5
Mar-14	349	29	79	35	197	9	152	111	19	57	3	7	0	5.3	5	3
2011 Total	**3186**	**202**	**549**	**215**	**2166**	**54**	**1591**	**983**	**104**	**388**	**60**	**60**	**0**	**4.7**	--	--
2012 Total	**3205**	**224**	**542**	**209**	**2176**	**54**	**1537**	**978**	**156**	**377**	**94**	**63**	**0**	**5.0**	--	--
2013 Total	**3470**	**188**	**653**	**219**	**2340**	**70**	**1516**	**1126**	**141**	**516**	**85**	**86**	**0**	**5.0**	--	--

Table D2. Aurora St. Luke's South Shore Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual Medicaid/Medicare	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	90	0	0	8	74	8	17	23	14	29	4	3	0	5.0	5	3
Feb-11	75	0	0	1	64	10	19	12	9	25	7	3	0	5.4	4	3
Mar-11	100	0	0	2	91	7	13	24	20	29	8	6	0	4.9	4.5	4
Apr-11	97	0	0	1	88	8	21	31	14	20	10	1	0	4.8	4	3
May-11	111	0	0	4	101	6	24	21	19	38	7	2	0	4.4	4	3
Jun-11	96	0	0	1	90	5	19	25	12	27	10	3	0	4.7	4	2
Jul-11	88	0	0	1	83	4	16	20	15	23	11	3	0	4.7	4	3
Aug-11	113	0	0	2	104	7	21	37	13	29	9	4	0	4.2	4	3
Sep-11	93	0	0	4	83	6	14	26	18	27	7	1	0	4.7	5	5
Oct-11	85	0	0	2	77	6	20	10	18	27	6	4	0	4.4	4	3
Nov-11	75	0	0	2	72	1	10	26	16	19	3	1	0	5.1	5	4
Dec-11	87	0	0	1	74	12	9	23	18	29	5	3	0	5.0	5	4
Jan-12	89	0	0	2	78	9	12	20	17	30	6	4	0	5.0	4	3
Feb-12	86	0	0	4	79	3	19	16	20	21	8	2	0	5.2	5	5
Mar-12	106	0	0	1	97	8	24	21	19	36	5	1	0	4.9	4	3
Apr-12	100	0	0	2	89	9	29	19	22	16	12	2	0	4.6	4	4
May-12	107	0	0	5	97	5	26	22	18	20	19	2	0	4.3	4	3
Jun-12	86	0	0	4	74	8	16	15	24	15	14	2	0	4.9	4	4
Jul-12	90	0	0	7	81	2	23	14	14	25	12	2	0	5.0	5	4
Aug-12	102	0	0	2	98	2	14	19	27	19	16	7	0	4.4	4	4
Sep-12	100	0	0	0	93	7	25	25	14	21	15	0	0	4.3	4	3
Oct-12	105	0	0	6	93	6	26	19	15	20	19	6	0	4.6	5	5
Nov-12	105	0	0	3	100	2	16	14	37	17	14	7	0	4.9	4	4
Dec-12	91	0	0	2	86	3	13	13	31	15	14	5	0	4.8	4	4
Jan-13	104	0	0	5	94	5	21	16	25	16	18	8	0	4.8	5	5
Feb-13	75	0	0	4	68	3	9	19	25	12	7	3	0	4.4	4	5
Mar-13	101	0	0	5	90	6	11	25	20	20	20	5	0	4.9	4	4
Apr-13	100	0	0	2	94	4	28	20	16	19	14	3	0	4.4	4	3
May-13	113	0	0	3	107	3	21	24	27	18	20	3	0	4.1	4	4
Jun-13	119	0	0	2	112	5	22	30	24	17	21	5	0	4.1	3	3
Jul-13	135	0	0	4	128	3	29	43	25	15	15	8	0	4.1	4	4
Aug-13	96	0	0	3	90	3	24	17	20	20	13	2	0	4.7	4	3
Sep-13	101	0	0	1	95	5	19	21	28	15	13	5	0	4.8	5	6
Oct-13	120	0	0	3	111	6	17	26	24	19	27	7	0	4.5	4	4
Nov-13	95	0	0	4	84	7	17	19	20	22	11	6	0	4.6	4	3
Dec-13	96	0	0	8	82	6	24	23	12	17	11	9	0	4.1	4	3
Jan-14	100	0	0	4	93	3	19	17	28	18	16	2	0	4.9	4	6
Feb-14	80	0	0	1	73	6	12	22	11	21	9	5	0	4.5	4	4
Mar-14	96	0	0	6	87	3	22	16	21	18	14	5	0	4.7	4	4
2011 Total	**1110**	**0**	**0**	**29**	**1001**	**80**	**203**	**278**	**186**	**322**	**87**	**34**	**0**	**4.7**	--	--
2012 Total	**1167**	**0**	**0**	**38**	**1065**	**64**	**243**	**217**	**258**	**255**	**154**	**40**	**0**	**4.7**	--	--
2013 Total	**1255**	**0**	**0**	**44**	**1155**	**56**	**242**	**283**	**266**	**210**	**190**	**64**	**0**	**4.4**	--	--

Table D3. Columbia-St. Mary's Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source*							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other/Unknown	Mean	Median	Mode
Jan-11	144	0	0	15	114	15	33	27	25	38	n/a	13	8	3.9	3	1
Feb-11	133	0	0	7	105	21	44	28	7	39	n/a	8	7	5.6	4	3
Mar-11	153	0	0	3	137	13	59	21	16	41	n/a	10	6	4.7	3	2
Apr-11	158	0	1	5	138	14	36	32	19	50	n/a	14	7	4.3	4	1
May-11	146	0	0	18	116	12	44	32	15	41	n/a	10	4	4.3	3	2
Jun-11	151	0	0	8	123	20	37	34	12	44	n/a	8	16	5.2	4	2
Jul-11	151	0	0	11	129	11	44	33	11	42	n/a	12	9	4.5	3	1
Aug-11	147	0	0	7	126	14	38	27	13	48	n/a	14	7	4.2	4	1
Sep-11	143	0	0	8	119	16	41	27	8	42	n/a	13	12	4.5	4	2
Oct-11	156	0	0	12	135	9	47	28	21	38	n/a	10	12	3.9	3	2
Nov-11	156	0	0	7	133	16	40	30	13	54	n/a	12	7	4.5	4	2
Dec-11	151	0	0	10	118	23	41	32	15	46	n/a	12	5	4.3	3	1
Jan-12	167	0	0	4	149	14	42	31	19	53	n/a	15	7	3.9	3	3
Feb-12	148	0	0	9	124	15	42	30	25	33	n/a	12	6	4.7	4	2
Mar-12	161	0	0	8	143	10	43	28	24	45	n/a	15	6	4.8	3	2
Apr-12	147	0	0	9	125	13	32	36	19	42	n/a	11	7	5.2	4	2
May-12	200	0	0	9	174	17	46	43	30	55	n/a	18	8	4.4	4	2
Jun-12	162	0	0	2	146	14	41	28	17	55	n/a	11	10	4.1	3	2
Jul-12	161	0	1	7	142	11	33	33	24	40	n/a	25	6	4.2	3	3
Aug-12	163	0	1	1	147	14	44	29	16	48	n/a	18	8	4.4	3	3
Sep-12	162	0	0	4	137	21	28	20	19	57	n/a	23	15	4.0	3	3
Oct-12	183	0	0	7	169	7	54	29	22	40	n/a	27	11	4.0	3	2
Nov-12	157	0	0	7	136	14	46	20	22	44	n/a	17	8	3.7	3	2
Dec-12	164	0	0	9	136	19	49	14	30	44	n/a	18	9	4.6	3	2
Jan-13	151	0	0	7	119	25	43	19	19	42	n/a	25	3	5.0	4	2
Feb-13	143	0	0	7	125	11	43	17	19	39	n/a	20	5	5.4	3	3
Mar-13	156	0	0	5	139	12	38	25	22	43	n/a	21	7	4.8	4	2
Apr-13	175	0	0	9	154	12	41	32	31	44	n/a	17	10	4.1	3	2
May-13	175	0	1	10	149	15	40	20	31	54	n/a	28	2	4.2	3	1
Jun-13	163	0	0	8	139	16	48	20	28	32	n/a	26	9	4.1	3	3
Jul-13	185	0	1	6	165	13	58	24	22	50	n/a	25	6	5.0	3	2
Aug-13	170	0	0	3	152	15	47	24	19	51	n/a	23	6	4.6	4	1
Sep-13	160	0	0	10	131	19	38	21	17	51	n/a	23	10	4.8	3	3
Oct-13	144	0	0	7	121	16	39	26	19	37	n/a	19	4	4.2	3	2
Nov-13	142	0	0	11	120	11	38	18	23	33	n/a	23	7	4.2	3	2
Dec-13	130	0	0	3	114	13	26	13	19	41	n/a	24	7	4.5	3	2
Jan-14	116	0	0	7	97	12	33	14	14	33	n/a	18	4	5.4	4	2
Feb-14	107	0	0	5	92	10	32	17	11	24	n/a	22	1	4.8	4	4
Mar-14	109	0	0	13	84	12	39	17	8	20	n/a	17	8	3.7	3	2
2011 Total	**1789**	**0**	**1**	**111**	**1493**	**184**	**504**	**351**	**175**	**523**	--	**136**	**100**	**4.5**	--	--
2012 Total	**1975**	**0**	**2**	**76**	**1728**	**169**	**500**	**341**	**267**	**556**	--	**210**	**101**	**4.3**	--	--
2013 Total	**1894**	**0**	**2**	**86**	**1628**	**178**	**499**	**259**	**269**	**517**	--	**274**	**76**	**4.5**	--	--

*Private insurance includes Commercial/Indemnity and Managed Care/NON-CAP; Medicaid HMO includes Medicaid MGD CARE CAP and Medicaid MGD CARE NON-CAP; Medicare includes Medicare Traditional, Medicare MGD CARE CAP, and Medicare MGD CARE NON-CAP; Other or Unknown includes Other Government, Workers Comp, and Unknown.

Table D4. Froedtert Hospital Inpatient Admissions 2011-Q1 2014

Month-Year	Total	By Age					By Payer Source							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other or Unknown*	Mean	Median	Mode
Jan-11	11	0	0	0	8	3	1	5	1	4	n/a	0	0	5.7	n/a	n/a
Feb-11	15	0	0	1	9	5	2	2	2	7	n/a	2	0	4.3	n/a	n/a
Mar-11	11	0	0	2	8	1	0	3	4	1	n/a	3	0	3.1	n/a	n/a
Apr-11	12	0	0	0	9	3	1	4	1	4	n/a	1	1	3.5	n/a	n/a
May-11	14	0	0	0	12	2	1	3	3	4	n/a	3	0	4.0	n/a	n/a
Jun-11	17	0	0	0	16	1	3	4	2	3	n/a	4	1	5.7	n/a	n/a
Jul-11	16	0	0	0	11	5	1	4	2	7	n/a	2	0	2.5	n/a	n/a
Aug-11	17	0	0	1	11	5	2	3	3	6	n/a	2	1	4.1	n/a	n/a
Sep-11	15	0	0	0	13	2	0	4	1	5	n/a	5	0	4.3	n/a	n/a
Oct-11	11	0	0	0	11	0	4	2	0	0	n/a	2	3	3.0	n/a	n/a
Nov-11	5	0	0	0	5	0	1	0	1	1	n/a	1	1	3.0	n/a	n/a
Dec-11	6	0	0	0	6	0	0	0	2	0	n/a	4	0	1.8	n/a	n/a
Jan-12	14	0	0	0	13	1	1	1	5	4	n/a	3	0	4.8	n/a	n/a
Feb-12	11	0	0	0	9	2	2	1	2	3	n/a	1	2	3.3	n/a	n/a
Mar-12	10	0	1	0	7	2	1	4	1	3	n/a	1	0	1.8	n/a	n/a
Apr-12	10	0	0	1	7	2	0	1	2	2	n/a	4	1	5.0	n/a	n/a
May-12	10	0	0	0	9	1	1	2	2	2	n/a	3	0	3.1	n/a	n/a
Jun-12	14	0	0	0	13	1	4	1	3	2	n/a	4	0	4.1	n/a	n/a
Jul-12	12	0	0	0	12	0	0	1	4	1	n/a	6	0	5.6	n/a	n/a
Aug-12	10	0	0	0	9	1	2	2	1	2	n/a	3	0	6.4	n/a	n/a
Sep-12	8	0	0	0	6	2	1	0	2	3	n/a	2	0	6.4	n/a	n/a
Oct-12	12	0	0	0	9	3	1	1	1	4	n/a	4	1	5.4	n/a	n/a
Nov-12	9	0	0	0	8	1	4	0	0	3	n/a	2	0	3.7	n/a	n/a
Dec-12	7	0	0	0	5	2	2	0	2	3	n/a	0	0	3.3	n/a	n/a
Jan-13	12	0	0	0	9	3	4	0	0	5	n/a	3	0	4.0	n/a	n/a
Feb-13	10	0	0	0	10	0	2	3	1	1	n/a	3	0	5.4	n/a	n/a
Mar-13	7	0	0	0	5	2	0	0	1	2	n/a	3	1	2.6	n/a	n/a
Apr-13	15	0	0	0	13	2	0	2	3	2	n/a	7	1	3.5	n/a	n/a
May-13	17	0	0	1	12	4	3	0	2	7	n/a	5	0	4.1	n/a	n/a
Jun-13	6	0	0	0	4	2	3	0	1	2	n/a	0	0	4.8	n/a	n/a
Jul-13	9	0	0	0	6	3	0	1	2	4	n/a	1	1	6.3	n/a	n/a
Aug-13	20	0	0	0	14	6	5	0	1	8	n/a	5	1	5.4	n/a	n/a
Sep-13	11	0	0	0	11	0	1	2	3	2	n/a	2	1	10.6	n/a	n/a
Oct-13	16	0	0	0	13	3	2	1	2	6	n/a	4	1	5.1	n/a	n/a
Nov-13	7	0	0	0	7	0	1	1	2	2	n/a	1	0	4.3	n/a	n/a
Dec-13	19	0	0	0	19	0	2	3	0	4	n/a	9	1	3.1	n/a	n/a
Jan-14	17	0	0	2	11	4	4	1	1	4	n/a	7	0	3.3	n/a	n/a
Feb-14	14	0	0	0	12	2	2	1	0	5	n/a	6	0	2.9	n/a	n/a
Mar-14	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
2011 Total	**150**	**0**	**0**	**4**	**119**	**27**	**16**	**34**	**22**	**42**	--	**29**	**7**	**3.9**	--	--
2012 Total	**127**	**0**	**1**	**1**	**107**	**18**	**19**	**14**	**25**	**32**	--	**33**	**4**	**4.4**	--	--
2013 Total	**149**	**0**	**0**	**1**	**123**	**25**	**23**	**13**	**18**	**45**	--	**43**	**7**	**4.9**	--	--

*The Other or Unknown category is other government insurance.

Table D5. Rogers Memorial Inpatient Admissions 2011-May 2014†

		By Age					By Payer Source*							Length of Stay (Days)		
Month- Year	Total	≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	504	62	111	41	276	14	253	116	49	73	n/a	13	0	6.7	5	4
Feb-11	395	48	104	35	192	16	213	83	30	60	n/a	9	0	6.3	5	3
Mar-11	456	66	123	39	221	7	238	114	38	56	n/a	10	0	6.1	5	3
Apr-11	423	62	115	39	199	8	228	106	39	44	n/a	6	0	6.2	6	3
May-11	461	74	122	38	214	13	234	120	40	55	n/a	12	0	5.9	5	6
Jun-11	447	66	112	37	223	9	232	104	37	61	n/a	13	0	6.0	5	5
Jul-11	411	60	79	31	224	17	215	90	35	64	n/a	7	0	6.0	5	3
Aug-11	441	65	83	38	244	11	207	111	51	63	n/a	9	0	5.8	5	3
Sep-11	395	49	75	28	233	10	202	96	34	54	n/a	9	0	5.9	5	3
Oct-11	432	71	95	32	224	10	240	93	36	55	n/a	8	0	6.3	5	3
Nov-11	432	65	107	29	223	8	238	112	36	39	n/a	7	0	6.4	6	4
Dec-11	400	66	110	36	180	8	209	119	31	37	n/a	4	0	5.7	5	3
Jan-12	498	72	120	43	258	5	274	108	53	54	n/a	9	0	6.6	5	3
Feb-12	434	70	102	38	218	6	245	88	39	57	n/a	5	0	6.8	6	7
Mar-12	460	70	113	46	221	10	248	107	41	57	n/a	7	0	6.0	5	3
Apr-12	431	63	105	31	227	5	213	108	45	59	n/a	6	0	6.1	5	4
May-12	435	74	107	41	208	5	220	124	38	47	n/a	6	0	6.4	6	6
Jun-12	435	71	81	26	250	7	222	114	41	49	n/a	9	0	6.3	5	3
Jul-12	425	68	75	34	244	4	199	119	33	62	n/a	12	0	6.8	6	4
Aug-12	442	67	74	48	241	12	230	108	37	63	n/a	4	0	6.2	5	3
Sep-12	421	61	79	28	246	7	227	110	29	43	n/a	12	0	6.2	6	7
Oct-12	511	62	125	31	284	9	289	112	43	58	n/a	9	0	6.5	6	3
Nov-12	440	66	124	44	200	6	232	87	67	44	n/a	10	0	6.8	6	4
Dec-12	409	45	116	28	213	7	234	50	56	59	n/a	10	0	6.1	5	5
Jan-13	504	77	135	38	243	11	306	68	60	58	n/a	12	0	7.0	6	7
Feb-13	426	78	124	28	189	7	248	62	61	45	n/a	10	0	6.6	6	7
Mar-13	445	70	123	33	204	15	235	79	58	63	n/a	10	0	7.6	6	7
Apr-13	470	54	128	39	245	4	290	79	39	50	n/a	12	0	7.0	6	3
May-13	517	74	145	38	246	14	320	92	45	55	n/a	5	0	6.9	6	5
Jun-13	413	62	95	26	224	6	224	94	44	46	n/a	5	0	8.0	6	7
Jul-13	469	65	105	38	252	9	256	98	53	49	n/a	13	0	6.6	6	7
Aug-13	436	60	83	26	256	11	236	86	44	58	n/a	12	0	7.1	5	3
Sep-13	441	39	121	34	243	4	238	102	30	57	n/a	14	0	6.4	5	4
Oct-13	478	65	138	41	233	1	258	116	46	54	n/a	4	0	7.0	6	3
Nov-13	413	48	109	32	219	5	242	89	38	42	n/a	2	0	7.1	6	3
Dec-13	394	46	117	30	191	10	217	103	30	40	n/a	4	0	6.5	6	3
Jan-14	481	41	159	37	236	8	277	103	30	62	n/a	9	0	8.2	6	4
Feb-14	430	47	128	25	226	4	254	100	30	42	n/a	4	0	7.1	6	7
Mar-14	419	38	120	37	219	5	227	111	29	47	n/a	5	0	6.4	5	3
Apr-14	462	72	126	35	218	11	242	124	41	50	n/a	5	0	7.4	6	4
May-14	463	56	145	43	210	9	228	113	58	53	n/a	11	0	7.6	6	4
2011 Total	**5197**	**754**	**1236**	**423**	**2653**	**131**	**2709**	**1264**	**456**	**661**	--	**107**	**0**	**6.1**	--	--
2012 Total	**5341**	**789**	**1221**	**438**	**2810**	**83**	**2833**	**1235**	**522**	**652**	--	**99**	**0**	**6.4**	--	--
2013 Total	**5406**	**738**	**1423**	**403**	**2745**	**97**	**3070**	**1068**	**548**	**617**	--	**103**	**0**	**7.0**	--	--

†Includes Oconomowoc and Milwaukee sites; *Private Insurance category includes HMP/PPO, UBH, Value Options, Anthem BCBS, Commercial Misc. and Health EOS; Medicare category includes Medicare HMO and Medicare

Table D6. Wheaton Hospital Inpatient Admissions 2011-Q1 2014

Month- Year	Total	By Age					By Payer Source*							Length of Stay (Days)		
		≤12	13-17	18-20	21-64	≥65	Private Insurance	Medicaid HMO	Medicaid (T19)	Medicare	Dual	Self -Pay	Other or Unknown	Mean	Median	Mode
Jan-11	70	0	0	1	63	6	9	27	11	18	0	4	1	6	4	2
Feb-11	63	0	0	1	59	3	8	17	13	23	0	2	0	6	5	3
Mar-11	105	0	0	3	97	5	13	28	18	40	0	6	0	5	4	4
Apr-11	87	0	1	6	77	3	12	29	10	31	0	5	0	5	3	3
May-11	81	0	0	2	71	8	10	25	18	25	0	3	0	6	5	2
Jun-11	95	0	0	3	89	3	17	29	12	33	0	4	0	6	4	4
Jul-11	82	0	0	3	74	5	7	25	16	27	0	7	0	4	3	3
Aug-11	98	0	0	1	82	15	8	25	17	39	0	9	0	6	5	3
Sep-11	85	0	0	2	72	11	12	19	11	34	0	9	0	5	4	2
Oct-11	79	0	0	5	64	10	13	17	15	31	0	3	0	6	5	4
Nov-11	59	0	0	4	51	4	9	21	8	17	0	4	0	5	4	4
Dec-11	55	0	0	0	48	7	10	13	9	22	0	1	0	7	4	2
Jan-12	73	0	0	3	62	8	9	17	16	25	0	6	0	5	4	2
Feb-12	82	0	0	5	72	5	15	26	14	20	0	6	1	5	4	2
Mar-12	72	0	0	0	65	7	5	21	14	25	0	7	0	6	4	3
Apr-12	81	0	0	1	73	7	10	23	10	30	0	8	0	6	5	3
May-12	98	0	0	1	85	12	12	21	9	46	0	10	0	6	4	4
Jun-12	77	0	0	4	66	7	11	18	15	25	0	8	0	5	4	2
Jul-12	74	0	0	2	64	8	11	17	14	25	0	7	0	5	4	3
Aug-12	85	0	0	1	74	10	17	16	15	30	0	7	0	4	4	3
Sep-12	86	0	0	3	78	5	14	21	20	24	0	7	0	4	4	4
Oct-12	91	0	0	1	86	4	7	12	27	41	0	4	0	5	4	4
Nov-12	79	0	0	0	68	11	10	13	18	29	0	9	0	5	4	5
Dec-12	79	0	0	4	70	5	7	16	23	27	0	6	0	7	4	4
Jan-13	74	0	0	3	65	6	15	20	14	22	0	3	0	5	4	3
Feb-13	65	0	0	1	60	4	8	12	17	24	0	4	0	6	4	3
Mar-13	80	0	0	3	71	6	15	17	18	26	0	4	0	5	4	1
Apr-13	84	0	0	3	76	5	7	18	25	29	0	5	0	5	4	2
May-13	84	0	0	2	79	3	9	23	21	24	0	7	0	5	4	3
Jun-13	95	0	0	3	81	11	12	25	19	36	0	3	0	5	4	2
Jul-13	87	0	0	0	81	6	4	25	18	32	0	8	0	5	4	2
Aug-13	73	0	0	1	66	6	10	18	16	24	0	5	0	5	5	5
Sep-13	101	0	0	1	89	11	14	26	24	31	0	6	0	5	4	2
Oct-13	109	0	0	1	103	5	15	27	27	33	0	6	1	5	4	2
Nov-13	92	0	0	3	85	4	7	19	27	31	0	8	0	5	4	3
Dec-13	85	0	0	4	74	7	10	17	15	34	0	9	0	5	4	3
Jan-14	87	0	0	0	82	5	9	16	19	31	0	11	1	6	5	5
Feb-14	77	0	0	2	73	2	5	23	19	26	0	4	0	7	5	2
Mar-14	98	0	0	5	83	10	14	19	24	30	0	11	0	6	5	3
2011 Total	**959**	**0**	**1**	**31**	**847**	**80**	**128**	**275**	**158**	**340**	**0**	**57**	**1**	**5.7**	--	--
2012 Total	**977**	**0**	**0**	**25**	**863**	**89**	**128**	**221**	**195**	**347**	**0**	**85**	**1**	**5.2**	--	--
2013 Total	**1029**	**0**	**0**	**25**	**930**	**74**	**126**	**247**	**241**	**346**	**0**	**68**	**1**	**5.1**	--	--

Table D7. BHD Inpatient Admissions 2011-2013

Month-Year	Adult Acute	CAIS	TOTAL
Jan-11	153	122	275
Feb-11	203	117	320
Mar-11	174	142	316
Apr-11	149	131	280
May-11	172	136	308
Jun-11	174	122	296
Jul-11	147	97	244
Aug-11	157	84	241
Sep-11	149	93	242
Oct-11	157	120	277
Nov-11	144	91	235
Dec-11	135	75	210
Jan-12	136	112	248
Feb-12	127	103	230
Mar-12	130	131	261
Apr-12	152	104	256
May-12	139	129	268
Jun-12	142	84	226
Jul-12	156	70	226
Aug-12	142	79	221
Sep-12	114	87	201
Oct-12	152	95	247
Nov-12	119	72	191
Dec-12	131	87	218
Jan-13	134	97	231
Feb-13	120	42	162
Mar-13	122	70	192
Apr-13	122	79	201
May-13	122	87	209
Jun-13	112	52	164
Jul-13	149	60	209
Aug-13	117	63	180
Sep-13	119	75	194
Oct-13	119	66	185
Nov-13	105	66	171
Dec-13	115	72	187
2011 Total	1914	1330	3244
2012 Total	1640	1153	2793
2013 Total	1456	829	2285

Source: BHD Dashboard

Table D8. BHD Inpatient Admissions by Characteristic Dec 2012-Mar 2014

Month- Year	Total	By Age						By Payer Source						Length of Stay (Days)		
		<18	18-25	26-39	40-54	55-64	≥65	Private	Medicaid HMO	Medicaid (T19)	Medicare	Self -Pay	Other*	Mean	Median	Mode
Dec-12	217	55	66	39	41	12	4	29	58	56	37	30	7	9.8	4	2
Jan-13	213	68	44	36	42	19	4	13	76	46	42	31	5	8.5	5	1
Feb-13	165	29	35	35	44	19	3	10	53	34	38	26	4	9.6	6	6
Mar-13	187	59	39	38	28	19	4	26	58	36	29	29	9	8.2	5	3
Apr-13	205	70	22	41	37	24	11	20	56	51	47	28	3	9.8	5	3
May-13	209	79	32	39	35	22	2	18	77	45	38	28	3	9.7	6	2
Jun-13	162	46	20	45	38	9	4	9	54	35	33	29	2	9.6	5	2
Jul-13	210	57	35	57	40	18	3	14	68	49	40	36	3	8.7	5	2
Aug-13	180	60	32	33	33	18	4	12	51	49	34	31	3	10.7	5.5	5
Sep-13	196	68	26	33	37	24	8	23	61	37	50	21	4	10.0	5	3
Oct-13	183	60	34	27	39	16	7	15	58	40	42	26	2	10.2	5	4
Nov-13	172	62	19	50	22	16	3	13	55	38	36	28	2	9.7	5	4
Dec-13	187	67	31	36	34	13	6	21	64	31	39	30	2	9.3	5	3
Jan-14	195	84	24	44	27	13	3	19	69	43	25	38	1	9.6	5	3
Feb-14	179	79	26	30	28	11	5	21	55	44	23	34	2	8.2	5	2
Mar-14	170	74	27	30	21	16	2	19	62	29	26	31	3	8.2	5	4
2013 Total	2269	725	369	470	429	217	59	194	731	491	468	343	42	**9.5**	--	--

*Other Includes Military and Family Care

Source: BHD by request

Table D9. BHD Psychiatric Crisis Services (PCS) Admissions 2011-Q1 2014

Month-Year	Total PCS Admits	Number Resulting in Admit to Acute Adult	Number Resulting in Admit to CAIS	Number Resulting in Admit to Local In-patient	Discharge to Detox/ Genesis	Discharge to Law Enforcement	Discharge to Obs. Unit	Number Returned/ Referred Back to Community	Number Mobile Contacts Returned/ Referred Back to Community
Jan-11	1075	153	122	123	132	21	183	341	84
Feb-11	1093	136	131	102	119	27	175	403	70
Mar-11	1179	173	142	143	139	40	207	335	82
Apr-11	1107	149	131	135	131	16	181	364	104
May-11	1187	172	136	129	135	25	181	409	84
Jun-11	1108	174	121	117	117	20	184	375	99
Jul-11	1103	147	97	118	165	3	180	393	118
Aug-11	1155	157	84	115	156	13	175	455	130
Sep-11	1069	149	93	112	164	7	156	388	102
Oct-11	1127	157	120	99	161	6	177	407	113
Nov-11	1035	144	91	86	136	6	153	419	109
Dec-11	1051	135	75	91	148	3	159	440	114
Jan-12	1130	136	112	142	168	34	166	372	120
Feb-12	989	127	103	128	145	33	127	326	93
Mar-12	1115	130	131	152	155	21	140	386	111
Apr-12	1101	153	104	155	147	35	151	356	115
May-12	1150	139	129	131	135	34	152	430	135
Jun-12	1058	142	84	109	126	34	137	426	114
Jul-12	1085	156	70	119	121	34	152	433	130
Aug-12	1078	142	79	104	150	41	146	416	130
Sep-12	1014	114	87	92	135	28	131	427	111
Oct-12	1004	152	95	104	139	27	125	362	132
Nov-12	943	119	72	98	125	34	123	372	123
Dec-12	1031	102	79	244	111	31	145	574	146
Jan-13	975	87	81	241	103	38	142	527	167
Feb-13	923	99	39	248	115	44	127	492	122
Mar-13	1017	103	68	255	134	51	124	540	151
Apr-13	986	102	78	206	126	37	96	563	126
May-13	986	103	83	230	129	36	111	533	138
Jun-13	937	100	47	238	109	46	115	506	147
Jul-13	978	126	58	238	117	38	124	518	163
Aug-12	956	97	60	206	121	41	120	553	139
Sep-13	974	102	73	203	122	35	99	562	124
Oct-13	1017	102	66	246	113	28	95	574	132
Nov-13	838	90	63	220	87	28	86	437	155
Dec-13	877	96	70	222	117	19	88	465	130
Jan-14	888	107	85	206	105	25	81	465	145
Feb-14	835	86	78	193	105	17	87	462	172
Mar-14	882	81	77	190	110	22	84	513	163
2011	**13,289**	**1,846**	**1,343**	**1,370**	**1,703**	**187**	**2,111**	**4,729**	**1,209**
2012	**12,698**	**1,612**	**1,145**	**1,578**	**1,657**	**386**	**1,695**	**4,880**	**1,460**
2013	**11,464**	**1,207**	**786**	**2,753**	**1,393**	**441**	**1,327**	**6,270**	**1,694**

Source: BHD by request

Table D10. BHD Admissions to Access Clinic or Crisis Resource Center 2011-Q1 2014

Month-Year	Total Access Clinic Admissions	Number Sent to PCS	Number Sent to Community Provider
Jan-11	339	4	339
Feb-11	309	1	309
Mar-11	404	3	404
Apr-11	385	5	385
May-11	397	1	397
Jun-11	395	4	395
Jul-11	345	1	345
Aug-11	404	1	404
Sep-11	332	2	332
Oct-11	333	1	333
Nov-11	337	1	337
Dec-11	340	0	340
Jan-12	452	7	452
Feb-12	439	11	439
Mar-12	442	7	442
Apr-12	468	4	468
May-12	535	7	535
Jun-12	588	4	588
Jul-12	601	4	601
Aug-12	632	6	632
Sep-12	592	3	592
Oct-12	711	8	711
Nov-12	555	7	555
Dec-12	545	6	545
Jan-13	659	9	659
Feb-13	457	3	457
Mar-13	530	1	530
Apr-13	508	7	508
May-13	524	2	524
Jun-13	440	2	440
Jul-13	498	2	498
Aug-12	532	4	532
Sep-13	499	6	499
Oct-13	690	3	690
Nov-13	485	3	485
Dec-13	488	2	488
Jan-14	508	2	339
Feb-14	504	3	309
Mar-14	459	2	404
2011	**4,320**	**24**	**4,320**
2012	**6,560**	**74**	**6,560**
2013	**6,310**	**44**	**6,310**

Source: BHD by request

Table D11. BHD Admissions to Crisis Stabilization 2011-Q1 2014

Month-Year	Number Admitted by Community as Diversions	Number Admitted by BHD or Local Inpatient as Step-downs	Number Discharged to Community Provider
Jan-11	2	21	5
Feb-11	5	16	6
Mar-11	8	23	5
Apr-11	4	17	9
May-11	5	23	5
Jun-11	12	26	1
Jul-11	3	27	5
Aug-11	5	30	4
Sep-11	3	30	9
Oct-11	4	29	6
Nov-11	5	18	5
Dec-11	10	10	10
Jan-12	5	25	3
Feb-12	1	21	4
Mar-12	5	17	9
Apr-12	4	26	3
May-12	7	22	6
Jun-12	3	14	6
Jul-12	5	22	5
Aug-12	3	19	6
Sep-12	4	20	6
Oct-12	4	24	1
Nov-12	5	15	2
Dec-12	2	18	3
Jan-13	7	29	1
Feb-13	4	21	4
Mar-13	1	22	5
Apr-13	4	18	6
May-13	2	14	6
Jun-13	7	20	3
Jul-13	10	16	7
Aug-12	7	29	5
Sep-13	6	19	4
Oct-13	3	24	6
Nov-13	5	12	4
Dec-13	2	16	5
Jan-14	4	26	5
Feb-14	3	16	9
Mar-14	4	14	2
2011 Total	**66**	**270**	**70**
2012 Total	**48**	**243**	**54**
2013 Total	**58**	**240**	**56**

Source: BHD by request

Table D12. BHD Admissions to Observation Dec 2012-Q1 2014

Month-Year	Total OBS Admissions	Number Resulting in Admit to Local Inpatient	Number Discharge to Detox/ Genesis	Number Discharge to Acute or CAIS	Number Returned/Referred Back to Community
Dec-12	153	15	2	22	115
Jan-13	148	14	4	21	106
Feb-13	125	9	4	20	94
Mar-13	127	10	4	10	103
Apr-13	97	5	4	17	73
May-13	110	7	3	16	85
Jun-13	126	7	1	16	102
Jul-13	128	8	2	17	102
Aug-13	117	9	2	14	93
Sep-13	104	10	5	11	81
Oct-13	96	8	5	15	72
Nov-13	86	8	0	11	64
Dec-13	85	6	1	18	60
Jan-14	80	9	2	6	64
Feb-14	89	9	3	12	68
Mar-14	84	10	1	13	60

Source: BHD by request

Table D13. Private Hospitals' Average 30-Day Readmission Rates for Behavioral Health Admissions

	2011	2012	2013
Aurora	9.7%	11.0%	12.1%
Aurora SLSS	6.4%	10.0%	9.4%
Columbia St. Mary's	3.2%	3.0%	3.7%
Rogers*	10.0%	7.0%	8.0%
Wheaton	8.5%	8.9%	9.2%

*Transfers back to inpatient from RMH programs not included

Table D14. BHD Average 30-, 60-, and 90-Day Readmission Rates

	2011	2012	2013
Average 30-day readmission rate			
PCS	21.3%	22.5%	22.7%
Acute Adult	14.9%	15.9%	16.6%
CAIS	14.2%	13.2%	11.3%
Average 60-day readmission rate			
PCS	28.1%	28.7%	29.0%
Acute Adult	20.0%	20.7%	21.1%
CAIS	21.0%	18.3%	16.4%
Average 90-day readmission rate			
PCS	31.4%	32.2%	32.5%
Acute Adult	22.6%	24.1%	24.4%
CAIS	24.6%	21.2%	18.9%

Source: BHD by request

Multi-County Comparative Data from the Wisconsin Hospital Association[1.]

Table D15. Estimates of Prevalence of Mental Illness Adjusted for Poverty Levels

County[2]	Total population (2013)	Total population under 200% FPL[3]	% of population under 200% FPL	How much higher is MKE[4] County's rate of poverty (200% FPL)?	Projected number under 200% FPL with serious psych. distress based on CDC data*	Estimated % of population with serious psych. distress based on CDC data*, adjusted for poverty	How much higher is MKE County's estimated % of population with serious psych. distress based on CDC data*, adjusted for poverty?
Milwaukee County	**822,532**	**358,195**	**43.5%**	**0.0%**	**47,282**	**8.1%**	**0.00%**
Dane County	435,998	117,318	26.9%	61.8%	15,486	6.5%	23.12%
Waukesha County	326,877	45,727	14.0%	211.3%	6,036	5.4%	50.06%
Brown County	216,374	63,055	29.1%	49.4%	8,323	6.8%	19.42%
Racine County	163,400	50,252	30.8%	41.6%	6,633	6.9%	16.88%
Outagamie County	154,159	37,795	24.5%	77.6%	4,989	6.3%	27.35%
Lincoln, Langlade, Marathon 51.42 Board	151,552	44,688	29.5%	47.7%	5,899	6.8%	18.86%
Kenosha County	143,945	44,089	30.6%	42.2%	5,820	6.9%	17.07%
Winnebago County	138,018	39,400	28.5%	52.5%	5,201	6.7%	20.38%
Rock County	134,950	45,759	33.9%	28.4%	6,040	7.2%	12.21%
Washington County	112,361	20,071	17.9%	143.8%	2,649	5.7%	40.82%
La Crosse County	95,984	30,736	32.0%	36.0%	4,057	7.0%	14.95%
St. Croix County	94,750	26,384	27.8%	56.4%	3,483	6.6%	21.54%
Walworth County	85,759	26,939	31.4%	38.6%	3,556	7.0%	15.87%
Fond du Lac County	83,039	22,668	27.3%	59.5%	2,992	6.6%	22.46%
Eau Claire County	82,937	28,787	34.7%	25.5%	3,800	7.3%	11.08%
Sheboygan County	75,008	14,442	19.3%	126.2%	1,906	5.9%	37.78%
Ozaukee County	70,812	9,684	13.7%	218.4%	1,278	5.3%	50.86%
Jefferson County	69,726	18,962	27.2%	60.1%	2,503	6.6%	22.63%
Dodge County	69,196	18,593	26.9%	62.1%	2,454	6.5%	23.19%
Wisconsin	4,777,110	1,471,755	30.8%	41.4%	194,272	6.9%	16.79%

Notes:

1. Source: Wisconsin Hospital Association and WHA Information Center

*http://www.cdc.gov/nchs/data/hus/hus11.pdf See Table 59. CDC estimates that 13.2% of individuals below 200% FPL and 4.1% of individuals above 200% FPL had serious psychological distress in 2010-2011

2. The counties compared in this table are the Top 20 highest populated counties in Wisconsin.

3. FPL stands for Federal Poverty Level.

4. MKE stands for Milwaukee.

Table D16. Comparison of Emergency Department Visits with Mental Health Diagnosis in 2013[1]

County	Total ER visits (all dx)[2]	ER visits with primary MH dx	% of ER visits with primary MH dx	ER visits with primary MH dx per capita	How much higher is MKE County's ER visits per capita?	ER visits with primary MH dx per projected number with serious psych. distress based on CDC data*, adjusted for poverty	How much higher is MKE County's MH ER visits per projected number with serious psych. distress based on CDC data*, adjusted for poverty
Milwaukee County	**431,269**	**23,794**	**5.52%**	**2.89%**	**0.0%**	**35.9%**	**0.0%**
Dane County	125,180	6,416	5.13%	1.47%	96.6%	22.5%	59.7%
Waukesha County	91,029	3,345	3.67%	1.02%	182.7%	19.0%	88.4%
Brown County	99,345	2,393	2.41%	1.11%	161.6%	16.4%	119.0%
Racine County	79,170	3,400	4.29%	2.08%	39.0%	30.2%	18.9%
Outagamie County	54,310	2,673	4.92%	1.73%	66.8%	27.4%	31.0%
Lincoln, Langlade, Marathon 51.42 Board	57,818	1,512	2.62%	1.00%	190.0%	14.7%	143.9%
Kenosha County	74,600	2,801	3.75%	1.95%	48.7%	28.3%	27.0%
Winnebago County	52,731	2,707	5.13%	1.96%	47.5%	29.3%	22.5%
Rock County	69,396	2,530	3.65%	1.87%	54.3%	26.1%	37.5%
Washington County	29,587	1,292	4.37%	1.15%	151.6%	20.1%	78.6%
La Crosse County	27,227	2,478	9.10%	2.58%	12.1%	36.8%	-2.5%
St. Croix County	17,509	697	3.98%	0.74%	293.2%	11.1%	223.6%
Walworth County	33,556	1,144	3.41%	1.33%	116.9%	19.2%	87.2%
Fond du Lac County	29,276	1,226	4.19%	1.48%	95.9%	22.4%	60.0%
Eau Claire County	29,821	1,942	6.51%	2.34%	23.5%	32.3%	11.2%
Sheboygan County	32,084	1,979	6.17%	2.64%	9.6%	45.1%	-20.4%
Ozaukee County	19,624	858	4.37%	1.21%	138.7%	22.7%	58.3%
Jefferson County	25,950	774	2.98%	1.11%	160.6%	16.9%	112.5%
Dodge County	31,538	1,036	3.28%	1.50%	93.2%	22.9%	56.8%
Wisconsin	1,978,954	66,573	3.36%	1.39%	34.5%	20.2%	77.7%

Notes:

1. Source: Wisconsin Hospital Association and WHA Information Center

*http://www.cdc.gov/nchs/data/hus/hus11.pdf See Table 59. CDC estimates that 13.2% of individuals below 200% FPL and 4.1% of individuals above 200% FPL had serious psychological distress in 2010-2011

2. dx stands for diagnosis.

Table D17. Comparison of Inpatient Discharges with Mental Health Diagnosis in 2013

County	Total inpatient discharges (all dx)	Inpatient discharges with primary MH dx	% of inpatient discharges with primary MH dx	Inpatient discharges with primary MH dx per capita	How much higher is MKE County's MH inpatient discharges per capita?	Inpatient discharges with primary MH dx per projected number with serious psych. distress based on CDC data*, adjusted for poverty	How much higher is MKE County's MH inpatient discharges per projected number with serious psych. distress based on CDC data*, adjusted for poverty
Milwaukee County	**127,186**	**11,517**	**9.1%**	**1.40%**	**0.0%**	**17.4%**	**0.0%**
Dane County	45,138	3,412	7.6%	0.78%	78.9%	12.0%	45.3%
Waukesha County	40,192	3,069	7.6%	0.94%	49.1%	17.5%	-0.6%
Brown County	24,868	1,869	7.5%	0.86%	62.1%	12.8%	35.7%
Racine County	25,141	2,045	8.1%	1.25%	11.9%	18.1%	-4.3%
Outagamie County	16,127	1,829	11.3%	1.19%	18.0%	18.7%	-7.3%
Lincoln, Langlade, Marathon 51.42 Board	19,523	1,368	7.0%	0.90%	55.1%	13.3%	30.5%
Kenosha County	17,990	1,647	9.2%	1.14%	22.4%	16.6%	4.5%
Winnebago County	15,193	1,632	10.7%	1.18%	18.4%	17.7%	-1.6%
Rock County	17,506	1,481	8.5%	1.10%	27.6%	15.3%	13.7%
Washington County	12,862	955	7.4%	0.85%	64.7%	14.8%	17.0%
La Crosse County	10,359	1,287	12.4%	1.34%	4.4%	19.1%	-9.2%
St. Croix County	11,058	1,231	11.1%	1.30%	7.8%	19.6%	-11.3%
Walworth County	9,881	650	6.6%	0.76%	84.7%	10.9%	59.4%
Fond du Lac County	9,754	999	10.2%	1.20%	16.4%	18.3%	-5.0%
Eau Claire County	10,043	1,086	10.8%	1.31%	6.9%	18.0%	-3.7%
Sheboygan County	3,486	340	9.8%	0.45%	208.9%	7.7%	124.2%
Ozaukee County	8,488	667	7.9%	0.94%	48.7%	17.6%	-1.5%
Jefferson County	7,181	563	7.8%	0.81%	73.4%	12.3%	41.4%
Dodge County	9,142	627	6.9%	0.91%	54.5%	13.8%	25.4%
Wisconsin	451,447	39,140	8.7%	0.82%	70.9%	11.9%	46.3%

Source: Wisconsin Hospital Association and WHA Information Center

*http://www.cdc.gov/nchs/data/hus/hus11.pdf. See Table 59. CDC estimates that 13.2% of individuals below 200% FPL and 4.1% of individuals above 200% FPL had serious psychological distress in 2010-2011

Table D18. Percent of the County's Inpatient Mental Health Discharges Made from Private Hospitals

County	2010	2011	2012	2013
Brown	50.0%	51.1%	59.7%	64.9%
Dane	91.6%	91.8%	91.4%	90.6%
Fond du Lac	52.9%	47.9%	50.2%	49.3%
Lincoln, Langlade, Marathon Combined 51.42 Board	45.7%	37.1%	34.0%	30.0%
Milwaukee	70.6%	74.7%	78.1%	80.4%
Waukesha	67.7%	70.2%	72.9%	72.3%
Wood	55.0%	44.3%	47.3%	39.6%

Notes:

1. Source: Wisconsin Hospital Association and WHA Information Center
2. This table includes all of the counties that have a county-owned psychiatric hospital (like Milwaukee).
3. Dane County is included because it is the most similar to Milwaukee County in terms of population.