

Chairperson: Thomas Lutzow
Vice-Chairperson: Maria Perez
Secretary: Michael Davis
Senior Executive Assistant: Jodi Mapp, 257-5202

2

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, October 25, 2018 - 8:00 A.M.
Zoofari Conference Center
9715 West Bluemound Road

MINUTES

PRESENT: Michael Davis, Kathie Eilers, Rachel Forman, *Walter Lanier, Jon Lehrmann, Thomas Lutzow, Mary Neubauer, Maria Perez, Duncan Shrout, and Brenda Wesley

EXCUSED: Robert Curry and Sheri Johnson

*Board Member Walter Lanier was not present at the time the roll was called but joined the meeting shortly thereafter.

SCHEDULED ITEMS:

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

1. **Welcome.**

Chairman Lutzow greeted Board Members and welcomed everyone to the October 25, 2018, Mental Health Board meeting. Audience members were asked to introduce themselves.

2. **Approval of the Minutes from the Milwaukee County Mental Health Board August 23, 2018, Regular Meeting, the September 26, 2018, Special Meeting, and the September 27, 2018, Public Hearing.**

MOTION BY: (Eilers) *Approve the Minutes from the August 23, 2018, Regular Meeting, the September 26, 2018, Special Meeting, and the September 27, 2018, Public Hearing. 8-0*

MOTION 2ND BY: (Perez)

AYES: Davis, Eilers, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8

NOES: 0

EXCUSED: Lanier – 1

SCHEDULED ITEMS (CONTINUED):

3.	<p>Behavioral Health Division Abatement and 2019 Recommended Budget.</p> <p>Teig Whaley-Smith, Director, Department of Administrative Services</p> <p>Mr. Whaley-Smith provided background information on Milwaukee County’s overall 2019 Budget and the \$17.5 million operating budget gap the County is facing. The Behavioral Health Division (BHD) is the largest singular department of the County Budget. BHD makes up 19% of total Milwaukee County expenditures and 29% of total Milwaukee County operating tax levy.</p> <p>BHD’s reserves (Operational, Capital, and Wraparound) were discussed in detail, including future commitments and projected use of these funds. Mr. Whaley-Smith stated due to high reserve levels and recent surplus activity, the Milwaukee County 2019 Recommended Budget will include a \$2 million abatement from BHD’s operational reserve. The abatement will not impact expenditure authority pertaining to the budget recommended by the Mental Health Board. If the abatement causes BHD to deficit, BHD will need to draw from reserves to cover the deficit. Abatement and use of reserves will continue in future years until the BHD operational reserve is reduced to \$10 million.</p> <p>Questions and comments ensued at length.</p> <p>Mr. Whaley-Smith agreed to appear before the Mental Health Board quarterly to keep Board Members abreast of overall County matters that affect BHD.</p>
4.	<p>Administrative Update.</p> <p>Michael Lappen, Administrator, Behavioral Health Division</p> <p>Mr. Lappen highlighted key activities and issues related to BHD operations. He provided an update on the Universal Health Services Contract for inpatient psychiatric services by addressing questions posed by the Nurse’s Union. The goal is to turn the commonly asked questions into a Frequently Asked Questions (FAQ) sheet.</p> <p>Board Member Neubauer indicated she recently met with the Nurses Union in an attempt to address their concerns.</p> <p>Questions and comments ensued.</p>
5.	<p>Reserve Fund Policy.</p> <p>Jeanne Dorff, Fiscal Administrator, Department of Health and Human Services</p> <p>Ms. Dorff explained a provision of Act 203 requires at year end, any unexpended or unencumbered mental health budget funds be held by the Milwaukee County Treasurer in a mental health reserve fund. Once the fund reaches a \$10 million balance, any surplus amounts may be used for “any mental health function, program, or service in Milwaukee</p>

SCHEDULED ITEMS (CONTINUED):

	<p>County.” It also shifted authority for the building reserve fund to the Mental Health Board (MHB).</p> <p>The policy outlines the procedure for accessing the funds. The Behavioral Health Division (BHD) Administrator will submit a memorandum to the MHB’s Finance Committee requesting the release of funds. In the memo, BHD will outline the project(s) being funded, the amount being requested, justification as to why the project(s) are appropriate for reserve funds, and the anticipated impact on reserve funds.</p> <p>The Finance Committee will review the request and make a recommendation to the Board. If approved by the Board, BHD will submit a fund transfer to the Department of Administrative Services requesting an amendment to the current year budget.</p> <p>Questions and comments ensued.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the Reserve Fund Policy to the Board.</p> <p>MOTION BY: (Perez) Approve the Reserve Fund Policy. 9-0 MOTION 2ND BY: (Shrout) AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 9 NOES: 0</p>
6.	<p>Mental Health Board Finance Committee Professional Services Contracts Recommendations.</p> <p>Jennifer Bergersen, Chief Operations Officer, Behavioral Health Division</p> <ul style="list-style-type: none">• 2018 Contract Amendments<ul style="list-style-type: none">➤ AMN Healthcare, Inc. (dba Merritt Hawkins)➤ Aramark➤ Evaluation Research Services➤ Locum Tenens.com, LLC➤ Netsmart Technologies➤ New Resources Consulting (dba Clinical Path Consulting, LLC)➤ Robert Half International (dba Robert HalfTechnology)➤ U.S. Securities/Allied Universal <p>Professional Services Contracts focus on facility-based programming, supports functions that are critical to patient care, and are necessary to maintain hospital and crisis services licensure. A detailed description was provided on all services the contracted agencies provide. A recommendation to approve would be for 2018 Contract Amendments.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2018 Professional Services Contract Amendments to the Board.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: <i>(Perez) Approve the 2018 Professional Services Contract Amendments Delineated in the Corresponding Report. 9-0</i></p> <p>MOTION 2ND BY: <i>(Shrout)</i></p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 9</p> <p>NOES: 0</p>
7.	<p>Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.</p> <p>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services, Behavioral Health Division (BHD) Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</p> <ul style="list-style-type: none"> • 2019 Contracts <p>Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the various program contracts. A recommendation to approve would be for 2019 Contracts.</p> <p>The Board was informed the Finance Committee, at their meeting on September 13, 2018, recommended approval of the 2019 Contracts delineated in the corresponding report.</p> <p>Questions and comments ensued.</p> <p>Board Member Forman requested separate action be taken related to the Grand Avenue Club contract.</p> <p>Board Member Neubauer requested separate action be taken to consider the two Mental Health America WI contracts together.</p> <p>Vice-Chairwoman Perez requested separate action be taken on the United Community Center contract.</p> <p>MOTION BY: <i>(Perez) Approve the Grand Avenue Club, Inc., Contract Delineated the Corresponding Report Dated September 13, 2018. 6-0-3</i></p> <p>MOTION 2ND BY: <i>(Lanier)</i></p> <p>AYES: Davis, Lanier, Lutzow, Perez, Shrout, and Wesley - 6</p> <p>NOES: 0</p> <p>ABSTENTIONS: Eilers, Forman, and Neubauer – 3</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: <i>(Eilers) Approve Both Mental Health America of WI, Inc., Contracts Delineated the Corresponding Report Dated September 13, 2018. 8-0-1</i></p> <p>MOTION 2ND BY: <i>(Shrout)</i></p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Perez, Shrout, and Wesley - 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: Neubauer – 1</p> <p>MOTION BY: <i>(Neubauer) Approve the United Community Center Contract Delineated the Corresponding Report Dated September 13, 2018. 8-0-1</i></p> <p>MOTION 2ND BY: <i>(Wesley)</i></p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Shrout and Wesley - 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: Perez - 1</p> <p>MOTION BY: <i>(Eilers) Approve the Balance of Purchase-of-Service Contracts Delineated in the Corresponding Report Dated September 13, 2018. 9-0</i></p> <p>MOTION 2ND BY: <i>(Forman)</i></p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout and Wesley - 9</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p>
8.	<p>Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.</p> <ul style="list-style-type: none"> • 2018 Contract Amendment • 2019 Contracts <p>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services, Behavioral Health Division (BHD)</p> <p>Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</p> <p>A recommendation to approve would be for a 2018 Contract Amendment and 2019 Contracts.</p> <p>An update was provided on Community Medical Services and progress with ongoing efforts related to converting the contract from Purchase-of-Service to Fee-for-Service.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the Purchase-of-Service Contract Amendment and 2019 Contracts delineated in the corresponding report to the Board.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Perez) Approve the Purchase-of-Service Contracts Delineated in the Corresponding Report Dated October 16, 2018. 9-0</p> <p>MOTION 2ND BY: (Shrout)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout and Wesley - 9</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p>
9.	<p>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</p> <p>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services, BHD Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</p> <p>Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the various program agreements, which provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of Amendments to the 2018 Fee-for-Service Agreements delineated in the corresponding report to the Board.</p> <p>MOTION BY: (Davis) Approve the Fee-for-Service Agreements Delineated in the Corresponding Report Dated September 13, 2018. 9-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout and Wesley - 9</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p>
10.	<p>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</p> <p>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services, BHD Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of Amendments to the 2018 Fee-for-Service Agreements as well as 2019 Fee-for-Service Agreements delineated in the corresponding report to the Board.</p> <p>Board Member Eilers requested separate action be taken related to the MCFI dba Whole Health Medical contract.</p>

SCHEDULED ITEMS (CONTINUED):

	Board Member Neubauer requested separate action be taken related to the Mental Health America WI contract.
	Board Member Wesley requested separate action be taken on the Bracy Psychological Services and Stress Management contract.
MOTION BY:	<i>(Forman) Approve the MCFI dba Whole Health Medical Agreement Delineated the Corresponding Report Dated October 17, 2018. 8-0-1</i>
MOTION 2ND BY:	<i>(Neubauer)</i>
AYES:	Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley - 8
NOES:	0
ABSTENTIONS:	Eilers – 1
MOTION BY:	<i>(Davis) Approve the Mental Health America of WI, Inc., Agreement Delineated the Corresponding Report Dated October 17, 2018. 8-0-1</i>
MOTION 2ND BY:	<i>(Shrout)</i>
AYES:	Davis, Eilers, Forman, Lanier, Lutzow, Perez, Shrout, and Wesley - 8
NOES:	0
ABSTENTIONS:	Neubauer – 1
MOTION BY:	<i>(Davis) Approve the Bracy Psychological Services and Stress Management Agreement Delineated the Corresponding Report Dated September 13, 2018. 8-0-1</i>
MOTION 2ND BY:	<i>(Eilers)</i>
AYES:	Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Shrout - 8
NOES:	0
ABSTENTIONS:	Wesley - 1
MOTION BY:	<i>(Shrout) Approve the Balance of Fee-for-Service Agreements Delineated in the Corresponding Report Dated October 17, 2018. 9-0</i>
MOTION 2ND BY:	<i>(Forman)</i>
AYES:	Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout and Wesley - 9
NOES:	0
ABSTENTIONS:	0

SCHEDULED ITEMS (CONTINUED):

11.	<p>Mental Health Board Finance Committee Quarterly Update.</p> <p>Jeanne Dorff, Fiscal Administrator, Department of Health and Human Services</p> <p>Vice-Chairwoman Perez, Chairwoman of the Finance Committee, reviewed topics addressed at the Finance Committee’s quarterly meeting. She discussed the analysis of BHD’s reserve funds and policy, which was presented earlier in this meeting, the 2018 financial reporting package, and the Veteran Health Support Program, which was derived from an amendment submitted during the budget process.</p>
12.	<p>Mental Health Board Quality Committee Quarterly Update.</p> <p>Jennifer Bergersen, Chief of Operations, Behavioral Health Division</p> <p>Board Member Neubauer, Chairwoman of the Quality Committee, reviewed topics addressed at the Quality Committee’s quarterly meeting. She discussed the analysis of the key performance indicator dashboard, the Community Access to Recovery Services customer satisfaction survey, the seclusion and restraint third quarter report, Temporary Assistance for Needy Families (TANF) Alcohol and Other Drug Abuse (AODA) Grant activities, the Centers for Medicare and Medicaid Services (CMS) survey, the hospital transfer waitlist, and the status of updated policies and procedures.</p> <p>Questions and comments ensued.</p>
13.	<p>Medical Executive Report and Credentialing and Privileging Recommendations.</p> <p>Dr. Shane Moisio, Medical Director, Behavioral Health Division</p> <p>MOTION BY: <i>(Perez) Adjourn into Closed Session under the provisions of Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item 13. At the conclusion of the Closed Session, the Board may reconvene in Open Session to take whatever action(s) it may deem necessary on the aforesaid item. 9-0</i></p> <p>MOTION 2ND BY: <i>(Shrout)</i></p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 9</p> <p>NOES: 0</p> <p>The Board convened into Closed Session at 9:48 a.m. to discuss Item 13 and reconvened back into Open Session at approximately 9:55 a.m. The roll was taken, and all Board</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Members were present except for Board Member Shrout, who joined the meeting shortly thereafter.</p> <p>MOTION BY: (Eilers) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 8-1</p> <p>MOTION 2ND BY: (Neubauer)</p> <p>AYES: Davis, Eilers, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8</p> <p>NOES: Forman - 1</p>
14.	<p>Mental Health Board and Committee 2019 Tentative Meeting Schedule.</p> <p>A draft 2019 Mental Health Board (MHB) and Committee meeting schedule was provided to Board Members. Board Members suggested a rotation process related to locations used for Public Hearings. Board Members also recommended BHD work closely with Kane Communications to explore additional options for notifying the community of MHB Public Hearings.</p> <p>A final draft of the 2019 meeting schedule will be included in the December Board materials. Calendar invitations are forthcoming.</p>
15.	<p>Adjournment.</p> <p>MOTION BY: (Shrout) Adjourn. 9-0</p> <p>MOTION 2ND BY: (Forman)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 9</p> <p>NOES: 0</p>
	<p>This meeting was recorded. The aforementioned agenda items were not necessarily considered in agenda order. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.</p> <p>Length of meeting: 8:08 a.m. to 11:02 a.m.</p> <p>Adjourned,</p> <p>Jodi Mapp Senior Executive Assistant Milwaukee County Mental Health Board</p>

SCHEDULED ITEMS (CONTINUED):

**The next meeting for the Milwaukee County Mental Health Board will be on
Thursday, December 13, 2018, @ 8:00 a.m. at the
Zoofari Conference Center
9715 West Bluemound Road**

Visit the Milwaukee County Mental Health Board Web Page at:

<https://county.milwaukee.gov/EN/DHHS/About/Governance#MCMHBrecords>

The October 25, 2018, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.



Michael Davis, Secretary
Milwaukee County Mental Health Board

Milwaukee Psychiatric Crisis Service
Redesign

Phase 1 Adult Services Planning Summary

December 2018



Contents

- 1. Introduction 1
- 2. Overview of the Current BHD Psychiatric Crisis Service System: Components and Utilization 2
 - Psychiatric Crisis Services - Admission Center (PCS/Observation Unit)..... 2
 - Crisis Line..... 2
 - Crisis Mobile Team 3
 - Geriatric Crisis Services 3
 - Crisis Assessment Response Team (CART) 3
 - Community Consultation Team (CCT) 3
 - The Access Clinic..... 3
 - Crisis Stabilization Houses 4
 - Crisis Resource Centers..... 4
 - Community Linkage and Stabilization Program (CLASP)..... 4
 - Team Connect: Short-Term Follow-Up 4
 - Implications of BHD Psychiatric Crisis Service Utilization for System Redesign 5
 - Private Health Systems Emergency Utilization 6
- 3. Redesign Plan: Assumptions 7
 - Legal and Regulatory Assumptions 7
 - Law Enforcement Assumptions 8
 - DHHS/BHD Operating Assumptions 8
 - Private Provider Operating Assumptions 9
 - Medicaid Managed Care Assumptions..... 9
 - Integrated (Public/Private) Delivery System Assumptions..... 10
 - Consumer and Advocate Input 10
- 4. Redesign Plan: Recommendations..... 10
- 5. The Redesign Model 12
 - Proposed New Services 16
- 6. Utilization Changes in the Redesigned Model 18
- 7. Next Steps 21

1. Introduction

For the past decade, the Milwaukee County Behavioral Health Division (BHD) has been engaged in a long-term transition to a more community-based continuum of care for residents needing mental health and substance use treatment and services. As the latest phase of this process, the County has made a decision to close the Milwaukee County Mental Health Complex (MHC) inpatient units and contract with a private provider for inpatient behavioral health services.

The MHC is also the site of the BHD-operated psychiatric emergency department and observation unit (known as PCS). With the shift to contracted inpatient units, it no longer makes programmatic or financial sense for BHD to operate a freestanding PCS at this site. BHD also sees this pending change as an opportunity to redesign the entire psychiatric crisis service system consistent with its continued goal of transitioning to a more community-based system of care. To fully consider an array of models for both psychiatric emergency department and community-based services, BHD has collaborated with the Milwaukee Health Care Partnership to commission an analysis aimed at redesigning the county's full psychiatric crisis service system.

While the timing is not yet certain, it is assumed the redesigned system is to be implemented in full in 2021. A number of preliminary steps need to be taken, including some that are already underway, to build up to the final system.

The redesign project was guided by a team consisting of the Wisconsin Policy Forum (WPF), the Human Services Research Institute (HSRI), and the Technical Assistance Collaborative (TAC). The planning and implementation process consisted of:

- 1) Convening a public-private Advisory Committee to participate in all aspects of the planning, decision-making, and implementation.
- 2) Developing a set of basic assumptions to guide the planning process.
- 3) Conducting an environmental scan, including interviews and focus groups with stakeholders, review of the current system services including functions and utilization rates, and review of national models and best practices.
- 4) Reporting the results of the environmental scan to the Advisory Committee and presenting decision points, options, and recommendations (reviewed in several meetings during the course of development).
- 5) Convening an all-day planning meeting with the Advisory Committee to formulate the model for the redesigned system as it pertains to adults. (Held July 16, 2018.)
- 6) Convening a separate planning meeting to consider the redesigned system for children/adolescents, with a report to be issued separately. (Held September 18, 2018.)

This report summarizes the conceptual redesign plan for the adult psychiatric crisis system developed by the Advisory Committee with the assistance of the project team. A lengthier environmental scan document—containing data findings, results of key informant interviews,

descriptions of national models and best practices, and additional information used by the Committee to help develop and guide the plan—has been published as a separate document accompanying this summary. In addition, a summary of progress to date on the separate planning process for the child and adolescent psychiatric crisis system has been provided to the Advisory Committee by the project team.

The overall approach to the redesign process has been to frame it as an opportunity to design a system from the ground up, and to consider perceived shortcomings as opportunities for improvement. While incorporating lessons learned from past experience and seeking to retain the features of the previous system that were most effective, the goal of the redesign is to address gaps and limitations of that system and introduce forward-thinking innovations that will best serve the residents of Milwaukee County.

The Milwaukee Psychiatric Crisis Service Redesign has occurred as a matter of necessity, compelled by the closure of Milwaukee County’s Mental Health Complex. It is occurring at an opportune time, however, as there has recently been a nationwide surge of interest, innovation, learning, and improvement in how psychiatric crisis services are organized and delivered.

2. Overview of the Current BHD Psychiatric Crisis Service System: Components and Utilization

BHD’s current psychiatric crisis system for adults consists of the following components, briefly described below. A lengthier description is contained in our accompanying environmental scan document.

Psychiatric Crisis Services - Admission Center (PCS/Observation Unit)

Psychiatric Crisis Services (PCS) is a 24-hour a day, seven days a week psychiatric emergency room. This essential component of BHD’s current system provides crisis intervention and face-to-face medical/psychiatric assessment for individuals who are, or who believe themselves to be, in psychiatric emergency and in need of psychiatric assessment, treatment, and/or referral. PCS physicians also provide medical oversight and consultation for all Crisis Mobile Team, Crisis Assessment Response Team (CART), Community Consultation Team (CCT), and Geriatric Crisis Services. All individuals admitted to BHD’s inpatient units are evaluated first in PCS, as are individuals brought in on Emergency Detention, under Chapter 51 of the Wisconsin Statutes, by law enforcement.

Crisis Line

The Crisis Line is the community access line for adult crisis services in Milwaukee County. In 2017, IMPACT 2-1-2, a community agency, began answering the first line of calls on the Crisis

Line. IMPACT 2-1-2 handles all calls for resources and triages crisis calls to a clinician on the Crisis Mobile Team for immediate response.

Crisis Mobile Team

The Crisis Mobile Team (CMT) consists of master's level clinicians and nurses who provide community-based crisis services to individuals ages 18 and older. CMT provides crisis response, assessment, linkage to services, and follow-up support to people throughout Milwaukee County 24 hours a day, 365 days a year. Coverage is provided first and second shift by Milwaukee County staff; the third shift is covered by a contracted provider. For the first shift there are two or three teams, and for the second shift and weekends there are one or two teams. BHD is working to increase proactive follow-up to ensure people's needs are being met post crisis. BHD projects that there will be 3,200 CMT contacts in 2018.

Geriatric Crisis Services

Dedicated geriatric psychiatric crisis intervention and stabilization services are available on a mobile outreach basis for individuals age 60+. A designated geriatric psychiatric nurse specialist is also available to connect with people in need.

Crisis Assessment Response Team (CART)

CART is a co-responder program that pairs master's level clinicians with law enforcement officers who have received crisis intervention training (CIT). CART responds to mental health calls that are dispatched through law enforcement or the Crisis Mobile Team, or by proactive response by the officer. Currently, there are five teams, with three teams serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County. A sixth team is currently in the process of being developed in collaboration with the Milwaukee County Sheriff's Department. Unlike CMTs, CART services are not available around the clock. The City of Milwaukee teams are available 11am-10pm M-F and 11am-7pm on weekends; the West Allis team is available M-F from 11am-7pm; and the county-wide team is available M-F 9am-5pm.

Community Consultation Team (CCT)

Specializing in helping individuals with co-occurring intellectual/developmental and mental health needs, the team goes into the community to provide crisis response. CCT also offers ongoing education and consultative services for providers and offers support to family members.

The Access Clinic

The Access Clinic is a short-term stabilization clinic that provides comprehensive assessment, brief term recovery planning, care coordination, peer services, psychotherapy, prescriber services, assertive outreach and follow-up, and referral and linkage to needed services. The Access Clinic primarily serves individuals with no insurance.

Crisis Stabilization Houses

Crisis Stabilization Houses are two licensed Community Based Residential Facilities with 16 beds each serving people with significant mental health needs for up to six months (there are short-term beds with stays of around 14 days and long-term beds with stays up to 6 months). CSH is operated by a community-based partner in collaboration with the Crisis Mobile Team. CSH provides a caring, supportive, and therapeutic environment to assist people to stabilize and to meet their individualized needs. Clinicians and nurses from the Crisis Mobile Team have daily strengths-based interactions with each person to ensure their mental health and physical needs are being met in a strengths-based, trauma-informed, and person-centered manner. Clinicians and nurses coordinate each individual's care, provide short-term crisis therapy (motivational interviewing), facilitate team meetings with the person's care team (comprised of both formal and informal supports), and collaborate with house staff.

Crisis Resource Centers

Crisis Resource Centers (CRCs) provide people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. CRC services are funded by BHD and provided by a contracted community partner. There are two CRCs – one in the northern part of the city of Milwaukee and one on the south side – with a total of 27 beds, including 8 beds that were converted from CSH to CRC beds in 2017 to better meet community needs. Services are wrapped around the individual's full array of needs to support stabilization in a community setting. Onsite supportive services include peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, and linkage to ongoing support and services. CRCs provide extensive stabilization services to prevent emergency room visits or hospitalization. The average length of stay is 5-7 days. People are directly referred to CRCs through BHD Crisis Services and community agencies; others are self-referrals, either via phone or walk-in.

Community Linkage and Stabilization Program (CLASP)

CLASP is a community-based peer specialist program. People are voluntarily referred to the program through one of the Crisis Services programs (CRC, Crisis Mobile Team, CART, Team Connect, Observation Unit, Inpatient Units, Access Clinic).

Team Connect: Short-Term Follow-Up

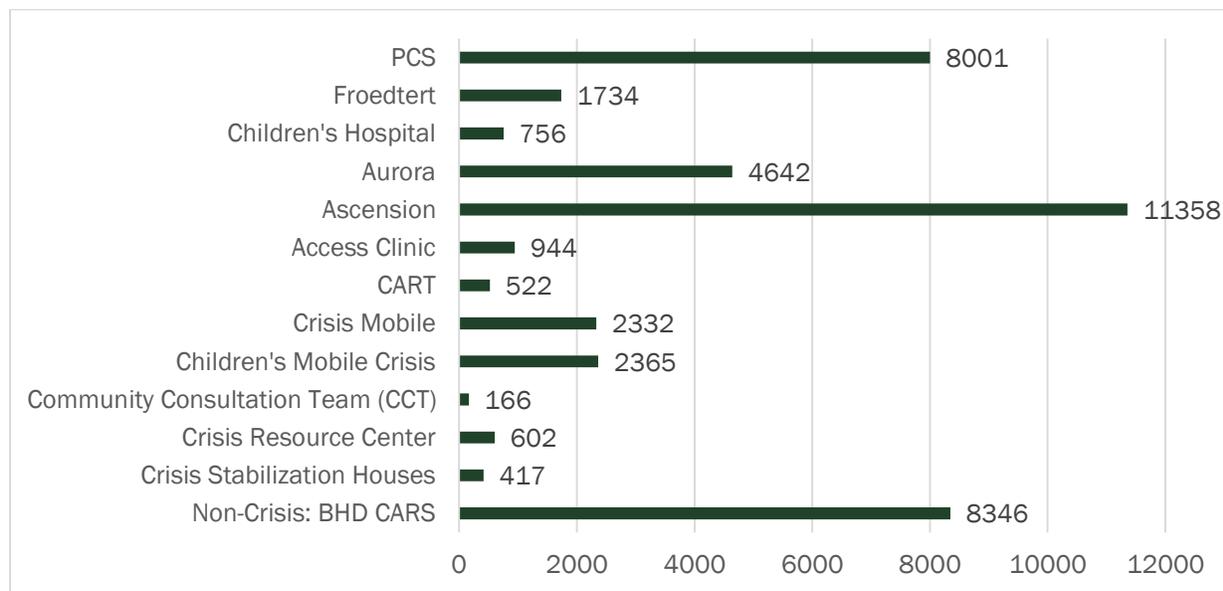
Team Connect consists of master's level clinicians and peer specialists who provide services to individuals who are discharged from PCS, the Observation Unit, or the BHD inpatient units. Team Connect provides additional support via telephone and in person to people as they return to the community to reduce the risk of harm.

Figure 1 shows the number of individuals assessed or served in 2017 in Milwaukee County by the crisis programs directly run or contracted for by BHD and those served by the private health

system emergency departments. To provide a sense of post-crisis capacity, utilization of BHD’s Community Access to Recovery Services (CARS) non-crisis services is also shown. The distribution of utilization across both BHD services and private systems demonstrates the importance of joint planning and participation by both public and private stakeholders in a redesigned psychiatric crisis system.

Figure 1

Numbers assessed or served by crisis programs in 2017



Note: The data represent admissions to ERs and BHD programs for persons with a primary behavioral health diagnosis. Legal disposition is not consistently collected in ERs and these data reflect the combined numbers of voluntary and involuntary admissions.

Implications of BHD Psychiatric Crisis Service Utilization for System Redesign

The environmental scan portion of the project involved collection and analysis of utilization data from BHD and private health systems. Detailed consideration of those data is contained in the environmental scan document that accompanies this report.

The data available on the flow of individuals through the system and characteristics of those being served reveal some key considerations for future crisis service design in Milwaukee County. Certain zip codes (e.g., 53215, 53204, 53218, 53209) have a higher concentration of individuals served by some crisis services, suggesting that these areas should be considered as possible priorities for siting of any new crisis (especially diversion) programs.

The data also show that nearly a third of PCS admissions are walk-ins, possibly indicating a lack of other crisis alternatives available for those individuals.

These data also suggest that for many BHD crisis programs, the predominant way of accessing the service is by way of law enforcement involvement—a potentially traumatizing experience. It

would be useful to know what proportion of emergency detentions were “lifted”, which would indicate potential diversions; however, this information is not collected systematically.

Age ranges are similar for all services, with the exception of PCS, which serves more youth (under 18) and transition age youth (between the ages of 18-25) than others, but fewer individuals age 40 and above. CART also serves a relatively high percentage of transition age youth. These data suggest that crisis models considered should take into account the needs of youth, as more than 1 in 5 individuals currently receiving crisis services through PCS are under 18.

The proportion of African Americans served in the systems is notable, especially in PCS (nearly 60%), as census figures indicate that African Americans comprise 27% of the population in Milwaukee County. These data indicate that cultural competency should be a key consideration in the selection of crisis service options.

Private Health Systems Emergency Utilization

For future crisis service planning purposes, it is also important to understand who is being served by private health systems and how these individuals flow through those systems. Availability of specific data elements varied among facilities reporting. The following is a summary of relevant data highlights based on information provided.

- Ascension: Of the 11,358 individuals assessed for behavioral health issues, about half were male and about half were non-white. More than half were diagnosed with a substance use disorder, and disposition for about 80% was return to home, with fewer than 2% admitted to a private behavioral health inpatient facility.
- Aurora: Of the 4,642 individuals assessed, only 2% were under involuntary status, with three-quarters admitted as walk-ins and the same number given a mental health diagnosis. Approximately 40% were discharged to home and about the same proportion were admitted to a private inpatient psychiatric facility.
- Children’s: Fewer than 2% of the 756 admissions were assessed under involuntary status, about three quarters were walk-ins, and a quarter arrived by ambulance. About half were non-white, and nearly all were under the age of 18, with about a third in the 14-17 age range. About 9% were admitted to private psychiatric inpatient facilities.
- Froedtert: Only about 6% of the 1,734 admissions were under involuntary status and about three quarters were given a mental health diagnosis. About half were male, White and African American individuals were seen in about equal numbers, 16% were admitted to inpatient medical care, and 10% were admitted to private behavioral health inpatient.

These statistics demonstrate that the psychiatric crisis system in Milwaukee County is not limited to BHD services, but also includes extensive use of services provided by private health systems. Consideration of how to improve and enhance the relationship and partnership between BHD and private health systems throughout the psychiatric crisis service continuum was deemed to be a key element of redesign planning.

3. Redesign Plan: Assumptions

Following the completion of the environmental scan and review of the report by the Advisory Committee, the committee engaged in planning to formulate a conceptual approach for the redesigned crisis service system. Planning was guided by the following assumptions developed by the Advisory Committee.

Legal and Regulatory Assumptions

- Under WI statute, Milwaukee County BHD serves as the “Treatment Director” and has the authority to detain individuals who meet certain criteria, including being a risk to themselves or others, under emergency detention. The Treatment Director role is assigned to the BHD Chief Medical Officer or their designee(s).
- Under statute, law enforcement has the responsibility to place individuals they believe meet criteria under emergency detention in the field, and to convey these individuals to the County’s designated treatment facility.
- Under statute (Chapter 51), the “Treatment Director must assess and authenticate the legal disposition of individuals placed under emergency detention by law enforcement. In Milwaukee that determination must be made within 24 hours of an emergency detention order.”
- In addition to assessing and authenticating the legal status of individuals, the Treatment Director function must ensure for the stabilization, immediate treatment, and safe discharge disposition for individuals placed under detention and connect individuals to the next appropriate level of care.
- Milwaukee County could identify additional “designees” to perform the Treatment Director duties, but there are legal, fiscal, and clinical practice philosophy reasons for the County to maintain exclusive operational responsibility for those duties.
- Under statute, Milwaukee County must provide a place (either itself or via contract with an outside entity) where persons taken into custody by law enforcement officers under Wis. Stat. § 51.15 (“Emergency detention”) can be detained, evaluated, diagnosed, and treated.
- Under § 51.15(2), a law enforcement officer who takes a person into custody is required to transport that person to one of the following facilities: “Detention may only be in a treatment facility approved by [Wisconsin DHS] or the county department, if the facility agrees to detain the individual, or a state treatment facility.”
- It is unlikely that Chapter 51/emergency detention rules and regulations will change within the next 3 to 5 years.
- Milwaukee County DHHS/BHD can influence law enforcement and court policies and practices, but it will take time and resources to transform the practice philosophy and behaviors of the judiciary and the 20+ municipal law enforcement agencies in Milwaukee County. There is an opportunity to engage law enforcement, particularly if redesign strategies can be shown to reduce time spent by law enforcement addressing individuals in crisis.

Law Enforcement Assumptions

- Law enforcement personnel issue emergency detentions as a mechanism to address complex clinical and behavioral incidents and to efficiently discharge their responsibility for the safety and protection of citizens.
- There will continue to be variation in law enforcement emergency detention practices across the 20+ municipal law enforcement agencies in Milwaukee County, given the sheer number of agencies and personnel as well as the socio-economic diversity of the populations they serve.
- Law enforcement personnel value clear policies and destination protocols for transporting and transferring patients and will continue to want to discharge their legal custody and documentation responsibilities in a timely and efficient manner so they can return to community policing.

DHHS/BHD Operating Assumptions

- Milwaukee County DHHS/BHD will outsource inpatient care for county residents under emergency detention to Universal Health Systems and will not continue to operate a psychiatric emergency department at the Milwaukee County Mental Health Complex. (Estimated closure date: 2021).
- As the outsource inpatient provider, Universal will assume responsibility for being the primary receiving facility for inpatient care for all County residents placed under emergency detention; either directly or under transfer agreements with private behavioral health inpatient providers.
- Under the DHHS/BHD contract, Universal will ensure timely inpatient access for all county residents under emergency detention who require hospitalization or BHD will need to arrange for stabilization or inpatient care at private health systems or State institutions. BHD will be responsible for ensuring the safety and clinically appropriate care for patients waiting for inpatient admission, should an inpatient bed not be readily available.
- Universal will have responsibility for transition care planning for inpatients prior to discharge, though it is in BHD's best interest to ensure that such planning be effective. BHD will likely assist in such planning to prevent emergency crisis or inpatient readmissions.
- Universal has indicated that it will not operate a psychiatric emergency department, though it may be willing to operate an admission/intake center. BHD will retain the duties of the "Treatment Director" function including responsibility for the stabilization, clinical and behavioral assessment, immediate crisis treatment, discharge disposition determination, and transition care management (navigation and linkage) for patients under emergency detention; serving as the "gatekeeper" to ascertain involuntary status, inpatient admissions, and/or community-based service and care management connections.
- Milwaukee County will not invest additional property tax levy, above the amount currently expended, on the psychiatric crisis continuum of services, and BHD would like to reduce its total expense for its psychiatric crisis services operations.

- The current BHD psychiatric crisis system experiences some cost efficiencies associated with the cross coverage of psychiatrists and behavioral health professional and support staff across the current continuum of psychiatric crisis services (PCS, Observation Beds, Access Clinic, and Mobile Crisis and Team Connect transition care management). The redesigned system will retain this characteristic.
- But BHD also currently experiences higher operating expense and revenue shortfalls due to County overhead and legacy expenses, the cost of ancillary and support services, current facility design and maintenance expenses, HIT limitations, and billing inefficiencies. These will change under the new model, with the potential for additional gains in efficiency.

Private Provider Operating Assumptions

- Private health care providers have responsibility for the assessment, stabilization, treatment, and transition care management for individuals with mental health and substance use disorders who are NOT placed under emergency detention; be that in emergency department, inpatient, or outpatient settings.
- Under EMTALA, private health system providers are also responsible for providing medical services and medical clearance for patients under emergency detention who are in their emergency departments.
- There is variation in the clinical capabilities among private health systems to effectively care for patients with mental health and substance use disorders in ER, outpatient, and inpatient settings. These variable capabilities are exacerbated by behavioral health provider workforce turnover and shortages.
- The health systems recognize the need to enhance their capabilities, and some are already actively working to address this.
- Private health systems benefit from having a dedicated psychiatric emergency department which has the clinical expertise, physical environment/milieu, legal acumen and personnel, and efficient Treatment Director stabilization, assessment, disposition, and transition care management functions. Private hospitals and Milwaukee County DHHS/BHD would not be able to replicate these services in multiple ER settings cost-effectively, given the unique expertise and treatment setting required; this is compounded by significant behavioral health professional workforce shortages.

Medicaid Managed Care Assumptions

- The majority of individuals in a psychiatric crisis who are placed under emergency detention are covered by Medicaid and are enrolled in a BadgerCare, SSI, or Family Care Medicaid managed care organization (MCO), given the State's expanded Medicaid managed care system.
- The 10 Medicaid MCOs serving Medicaid beneficiaries in Milwaukee County are accountable for ensuring positive health outcomes, per contract and pay-for-performance incentives, and for ongoing member care management. They are also financially incentivized to reduce avoidable health care utilization and associated cost. DHS is also creating new contractual

requirements and incentives for MCOs to enter into Alternative Payment Models (APMs) with providers to improve outcomes and member satisfaction and lower costs.

Integrated (Public/Private) Delivery System Assumptions

- There are gaps in behavioral health prevention, early intervention, outpatient, and non-emergency crisis resources for individuals with mental health and substance use disorders. These gaps in access are particularly acute for uninsured, underinsured, and Medicaid beneficiaries and influence the rates of emergency incidents and detention placements.
- Treatment gaps may be linked, in part, to the fact that individuals are not always aware of and do not seek care in non-emergency settings.
- Low Medicaid reimbursement rates contribute significantly to gaps in provider participation and access to outpatient or alternative and non-emergency crisis services.
- Behavioral health provider workforce shortages further exacerbate gaps in access and result in delays in treatment and increased crisis incidents.
- Increasingly, telemedicine and teleconsultation services are being implemented to address workforce shortages and ensure timely, clinically appropriate, and more cost-effective care.
- There are significant gaps in the exchange of demographic, health care, and care plan information within and across providers and care management organizations, including managed care organizations/issuers. WISHIN is evolving as a multisector tool for clinical and care plan information exchange.

Consumer and Advocate Input

In addition to the above assumptions reflecting various perspectives on the redesign, input provided by consumers and advocates in focus groups held by the project team was used to inform redesign planning. A detailed description of consumer and advocate input is included in the environmental scan report.

4. Redesign Plan: Recommendations

After developing these overriding assumptions, the Advisory Committee turned to three models suggested by the project planning team as part of the environmental scan process to guide its decision-making process (a full description of those models, including pros and cons of each, is contained in the environmental scan document):

1. A centralized system organized around a single large psychiatric emergency facility, having arrangements with hospital emergency departments to receive individuals who have been medically stabilized. It may or may not be hospital-adjacent and may or may not be hospital-operated/staffed.
2. A decentralized system, with multiple sites providing a diverse array of crisis services including some capacity for receiving individuals on petitions. This array of smaller sites could be adjacent to or affiliated with other types of facilities such as shelters or FQHCs and

would be strategically located in the community to provide accessible crisis walk-in services. Sites could be a mix with some providing voluntary services only and others accepting involuntary admissions.

3. A dispersed system with county investments largely in non-emergency department settings, with an intention of shifting the bulk of crisis episodes out of the ED. In this model, private health system emergency departments would focus their attention on a smaller group of individuals with more complex healthcare needs who essentially need to be served at this level of care.

The Advisory Committee recommends a system that generally adheres to Model 3, with the proviso that the system include some form of dedicated psychiatric ED. That facility is envisioned, however, to serve a much smaller number of persons than the current PCS and a narrower population largely limited to individuals on petitions and those who require highly specialized, intensive care for their complex needs. This conceptual approach was selected with the understanding that the precise structure of the system would depend on a variety of contingencies and questions of feasibility, some of which have been addressed in initial planning and others of which will require further consideration.

In this model, BHD would function as Treatment Director and would oversee and coordinate a continuum of crisis services, delivered primarily through contracted providers. It is likely that implementation would take place over a multi-year period with gradual scaling up of some services and possibly some pilot projects to assess effectiveness and costs.

Implementation of the redesign would proceed on two levels: a program planning level and an organizational philosophy level. Programmatically, the redesign emphasizes a broadly collaborative community-based approach described in more detail below. Philosophically, there is a commitment to continue shifting toward a person-centered approach that emphasizes resolution of crises and rapid stabilization instead of disposition decision-making and overreliance on involuntary holds.

Additionally, there is consensus that to the maximum extent possible, crisis resolution should occur “upstream”—that is, the system should emphasize and invest in crisis prevention and resolution at earlier stages of a crisis, before more intensive, costly, and potentially restrictive interventions are required. There was agreement that this philosophical commitment needs to extend beyond direct behavioral health care stakeholders and that considerable effort must be undertaken to also extend it to law enforcement, justice system leaders, and the broader community.

As widely reported by stakeholders, BHD has made great strides in transforming its approach to crisis interventions in recent years. It was emphasized in the planning process that these efforts should continue and even be accelerated in the redesign. Central to BHD’s role in the redesigned system is oversight and support to ensure ongoing commitment to the principles cited above—prevention, crisis resolution rather than disposition, person-centered and trauma-informed care, coordination and collaboration throughout the system. Some possible activities for BHD in this area are to facilitate collaboration protocols and MOUs among service providers,

hold regular service system meetings to review problems and formulate solutions, and provide trainings to promote the use of person-centered care in crisis services.

5. The Redesign Model

The programmatic model recommended by the Advisory Committee emphasizes upstream prevention and early intervention, increased crisis competency, expanded and enhanced access to community-based crisis services (such as crisis mobile teams and telepsychiatry), and improved post-crisis recovery/reintegration services.

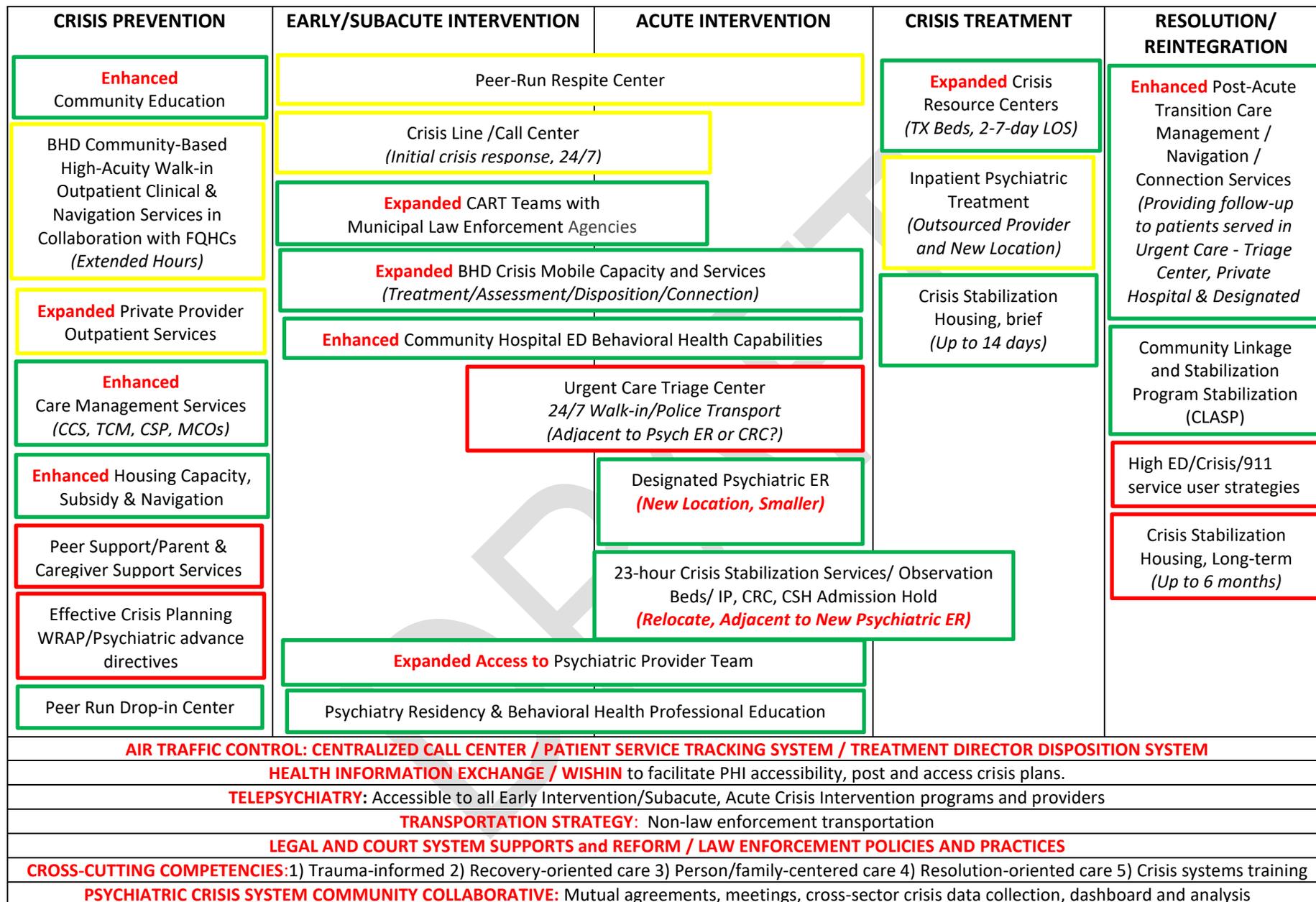
With the closure of PCS, some shift in service episodes to private hospital emergency departments is likely and some expanded behavioral health crisis expertise and capacity in those departments is anticipated; however, better front-door triaging and back-door coordination should reduce overall volume and lengths of stay in the emergency department and improve care continuity. In addition, transporting individuals from the emergency department to a separate facility for evaluation will be avoided by successfully resolving more crises in the ED.

Finally, the model recognizes that while some form of dedicated psychiatric emergency facility is still required, that facility should operate on a much smaller scale than the existing PCS and its usage should be limited to those individuals with the most highly complex needs.

Figure 2, on the following page, shows a diagram of the redesigned adult crisis system, as envisioned by the Advisory Committee. The system components have been color-coded based on their status within the current system at this point in time and represent the continuum from prevention to reintegration. Elements that support a continuum of care model are listed at the bottom of the diagram. Below, we summarize how current services and programs would be impacted by the redesign model:

Crisis Resource Centers: BHD funds two CRCs. These Centers serve as a key component for early intervention and diversion from EDs and inpatient treatment and are a step-down from these more intensive services. The redesign plan envisions a significant expansion of capacity and functionality for the CRCs. Expanded capacity would include greater allocation of beds for BHD consumers and increased functions would include providing for direct admissions from Crisis Mobile Team, CART, and Team Connect, as well as control of discharges.

Figure 2- Milwaukee County Psychiatric Crisis Redesign Adult Care Delivery Model



KEY: **Current Service** **Under Development** **Enhancement or New Service**

Federally Qualified Health Centers (FQHCs):

BHD is in the process of establishing a care delivery partnership with two Federally Qualified Health Centers (FQHCs) to expand community-based access to mental health and substance use disorder treatment services. By capitalizing on the current array of FQHC services and their favorable reimbursement structure, BHD will provide upstream prevention and early crisis intervention services to historically underserved communities that have generated significant psychiatric emergency department admissions both at PCS and private EDs. The initial phase of the project would expand immediate capabilities at the FQHCs by embedding BHD resources at two FQHC sites on the North and South sides. These services would provide short-term high intensity behavioral health services, same-day walk-in urgent care, and navigation services to the full continuum of BHD and community mental health and substance use services.

The current Access Clinic outpatient resources combined with other existing community-based services – including Crisis Case Management, Comprehensive Community Services (CCS), CLASP, Team Connect, Certified Peer Specialists, and other BHD care coordination programs – will support BHD’s and the FQHCs’ shared goal of delivering fully integrated medical/behavioral health services to Milwaukee County residents in locations that are more proximate to their home. Additionally, the expanded outpatient and navigation services co-located at FQHCs should reduce avoidable and costly emergency detentions, ER visits, and inpatient admissions. The co-located service also will provide access for behavioral health patients to the broader array of primary care, dental, and social support services offered by FQHCs. If successful, partnerships with other Milwaukee FQHCs could also be considered in the future.

Urgent Care/Triage Clinic: This would be a new component of the system, distinct from outpatient clinics, that could be located either adjacent to a CRC or the dedicated Psychiatric ED. It would operate 24/7 for walk-in and police drop-off with the primary function of diversion from EDs, inpatient admissions, out-of-home placement, and police custody. The service would assist with the de-escalation of a person’s clinical behavioral health crisis by providing 24/7 access to a safe environment with assessment, diagnosis, and treatment capability (including medication), delivered in a timely manner and leading to stabilization. The clinic would serve in coordination with outpatient services if currently being received, or if not, as an entry point to long-term, ongoing service delivery and care. Anyone experiencing a mental health and/or substance-related crisis would be eligible for acceptance.

Crisis Mobile Teams (CMTs): Expansion of the CMTs and some redefinition of their functions are also important considerations in the redesign. Recent improvements in productivity and efficiency have already resulted in increased capacity, and BHD believes there are opportunities for additional improvements. A key issue for CMTs in the redesign is to redefine their function, from primarily assessing for involuntary holds in hospital EDs to crisis resolution in the community and follow-up to ensure stabilization. Addition of more peer specialists to CMTs would also be an important goal in the redesign.

Crisis Assessment Response Team (CART): CART is a co-responder program that pairs master’s level clinicians with law enforcement officers. Currently, CART serves 10% of crisis volume and could expand its function to include transporting people to community caregivers. The redesign will continue to focus on increasing utilization of CART, through consultation with law enforcement and increasing awareness of this service in the community. The goal is to ensure that CART clinicians play a greater role in providing a “warm hand-off” to a care coordinator to develop a crisis plan and plan of care, and to coordinate services for the individual.

Peer-Run Respite: Milwaukee County’s first Peer Run Respite is set to open in 2019. The Peer Run Respite is a short-term respite that consists of 4-5 beds. It provides individuals with mental health needs with additional support in a safe and accepting environment. BHD will continue partnering with the contracted agency, Our Space, to successfully implement services. Assuming sufficient demand and positive outcomes associated with this initial service, the redesign will include expanded or additional Peer Run Respite facilities.

Crisis Stabilization Houses: The redesign envisions either expanded CSH capacity or addition of a new component in the crisis system that would be similar to the Hennepin County (MN) model. This is a residential step-down program for individuals with complex needs who would benefit from longer-term (30-day) transitional support. This non-hospital based intermediate rehabilitation level of care provides specialized support for individuals who are experiencing a mental health crisis; it could also be utilized for individuals on an involuntary commitment and who require a medically managed care plan. This model is a treatment alternative for individuals who require a medically managed service.

Community Linkages and Stabilization Program (CLASP): CLASP is a community-based peer specialist program to which people are voluntarily referred through one of the Crisis Services programs. In the redesigned system, CLASP could be part of the team serving individuals through a Care Coordination model. This is a model developed for the treatment of chronic conditions that provides a framework for communication and shared goals among multiple providers and the patient. Adding referral streams to CLASP through additional funding provided through HMOs and health systems would provide the opportunity to serve more people. This peer service provides a particularly important function of navigation, which could be expanded in the redesign.

Crisis Line: Through the Crisis Line, individuals and family members who are experiencing a mental health crisis or co-occurring crisis can speak with someone directly to provide crisis response and resources. The redesign model envisions continued operation of the crisis line through a partnership with IMPACT 2-1-1. This arrangement has freed up Crisis Mobile Team clinicians to respond to more calls in the community, consistent with the goal of the redesign.

Team Connect: Team Connect consists of master’s level clinicians and peer specialists who provide services to individuals who are discharged from PCS, the Observation Unit, or the BHD inpatient units. The team provides linkage to services in the community and supports engagement in post-discharge care. In the redesigned system, Team Connect may be

transitioned to a Care Coordination model. This model might also entail embedding social workers or crisis staff in area emergency rooms for additional coordination of services, improved discharge planning, and quicker Emergency Detention reviews and assessments.

Dedicated Psychiatric Emergency Department: The redesigned system will continue to feature a dedicated psychiatric ED that will replace the current PCS, but in a modified form. It is envisioned that financial responsibility for the new ED will be shared between the County and the private health systems, with possible joint governance. The facility would serve a smaller volume than the current PCS—as shown in Table 2 on page 18, estimated to be approximately 3,200 admissions, down from the current volume of about 8,000.

It was determined that at least in the short to medium term, developing enough crisis alternatives to divert *all* of the current volume of PCS episodes was not feasible for a variety of reasons. Those include the length of time that would be required to implement many new or expanded services, which will be complicated by workforce challenges and the need to determine contractual and financial frameworks.

Nevertheless, we do believe that a significant reduction of PCS volume within the next three to five years is achievable. Much of this reduction will be accomplished by redirecting many of the approximately one-third of current admissions that are voluntary walk-ins to other services, including private hospital EDs. These less-challenging cases will be diverted through the emphasis of the redesign on increased use of less intensive “upstream” services and the expanded capacity of private hospital EDs. The new facility will serve a narrower population, which is envisioned by the Advisory Committee and other stakeholders to consist exclusively of those individuals currently served by PCS who need more specialized psychiatric crisis treatment services than private hospital EDs will be equipped to provide.

At the same time, it is envisioned that the new facility will maximize measures to support a therapeutic environment such as availability of peer specialists and avoidance of restraints. The facility will also provide more behavioral health and social services directly (rather than by referral) and provide medical oversight of mobile services. It will continue to be a collaborative partner with law enforcement, EMS, and private health care systems. Issues that need to be determined include the location of the facility, whether it will be administered and staffed by BHD or a private entity or entities, and details of how it will intersect with the 120-bed inpatient facility to be operated by BHD’s new contracted inpatient service provider (Universal).

Proposed New Services

In addition to the enhanced and modified services described above, the Advisory Committee agreed that several new enhancements to the redesigned system should be explored. As with the dedicated psychiatric ED and the expanded services delineated above, questions regarding the mix of potential public and private resources to support these new services – as well as service delivery, administration, and governance – will need to be determined in the next phase of planning.

“Air Traffic Control”: Implementation of an electronic surveillance and scheduling solution would allow crisis staff, contracted providers, and others to know and utilize real-time surveillance and access to crisis resources. Crisis staff, future care managers, partners, and providers would be able to see available resources needed by clients in crisis. Resources would include: hospital and diversion beds, care management intake slots, psychotherapy and prescriber appointments, peer services appointments, and other ancillary services. Such a system would support real-time, same-day access to care and help ensure full utilization of available resources.

Crisis Services Care Coordination (CSCC): CSCC would provide for short-term (up to 6 months) Care Management for clients with recent psychiatric emergencies, including those who have had contacts with Crisis Mobile, ER, or walk-in clinic. The program would utilize crisis assessment and development of a plan of care with consumers, and would authorize peer services, prescriber services, psychotherapy, and other services. The model would entail close supervision of staff, management and oversight of ancillary providers, and electronic system change to allow proper data collection and management (e.g., development of dashboards, improved communication across providers, consumer use of record/portal).

Long-term Crisis Stabilization Housing: This proposed addition to the continuum of crisis services would serve those who need more intensive and extended step-down support, such as those with complex medical co-morbidities.

High Crisis Service User Strategies: This would be a data-driven process of identifying individuals who are frequent users of crisis services, conducting outreach and further assessment to identify unmet needs, and developing treatment plans that would provide alternatives to use of crisis services.

Telepsychiatry: Increased provision of telepsychiatry by BHD is considered to be an important aspect in the redesign, particularly to support the expanded role of hospital EDs. Telepsychiatry consultation can provide specialized support and expand the range of services available within hospital EDs.

WISHIN: The Advisory Committee considered this shared data system as a potential resource for managing the crisis system. One limitation is that it has an opt-out option, which may reduce representativeness, though the opt-out rate is currently only 2%.

Transportation: Developing a system or modes of transportation apart from law enforcement would be a cross-cutting feature of the redesign.

Support and reform of legal, court and law enforcement policies and practices: Though not a service per se, a comprehensive review of the role of the courts and law enforcement in the psychiatric crisis system would advance the goals of the redesign.

6. Utilization Changes in the Redesigned Model

As preparation for the implementation phase of the redesigned crisis system, the project team developed illustrative modeling to show how the distribution of services across the system ideally would be changed. In developing estimates for the numbers to be served by each of these components, three considerations are important.

First, it should be emphasized that it would not be appropriate to simply transfer capacity from one component to its equivalent replacement in the redesign (e.g., the individuals currently served by PCS to private hospital emergency departments). Instead, estimates should take into consideration the greater emphasis on “upstream” intervention, such that some transfers will occur to components higher “up” in the system—i.e., diversion and resolution services—as well as laterally.

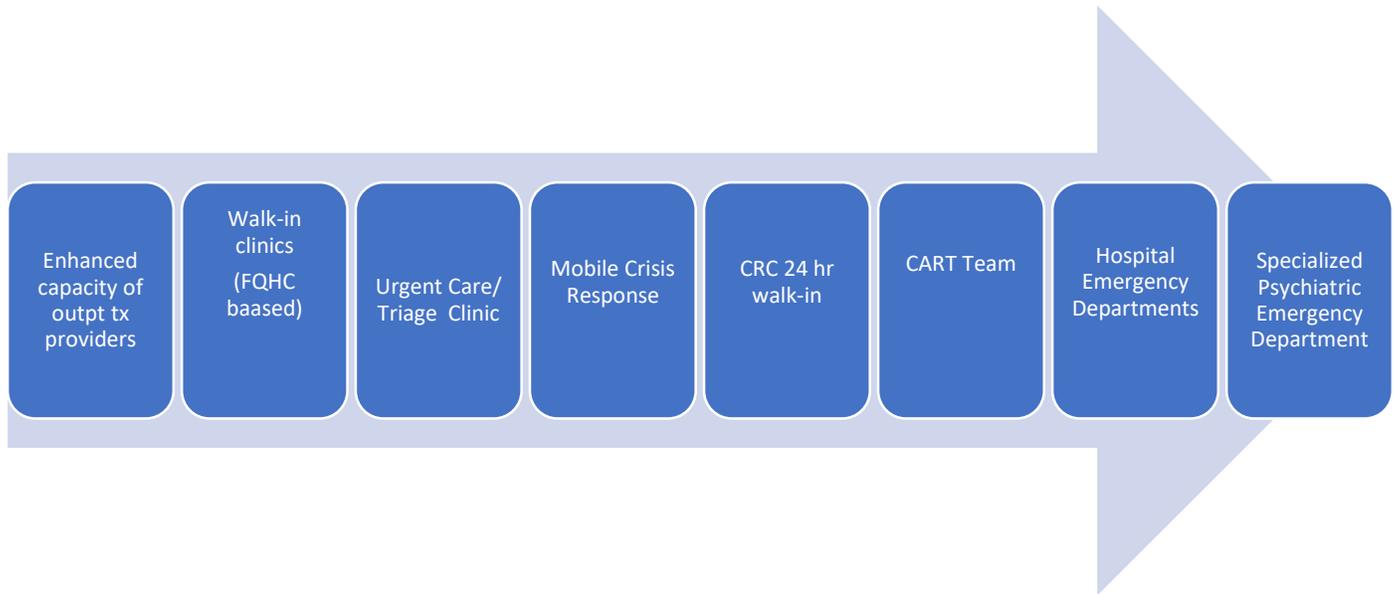
Second, historically there has been a fair amount of duplication among at least three key crisis system components (private hospital EDs, PCS, and Crisis Mobile), meaning in the course of a single crisis episode an individual might be served by two or even all three of the services. Because of the emphasis on treatment and resolution in the redesign, some reduction in movement between system parts is anticipated. Indeed, reduction in movement is a key quality indicator to monitor.

A third consideration is that this redistribution will not occur immediately, as it will depend on changes in practice patterns, community awareness, and the aforementioned continuing evolution of organizational philosophy. BHD has indicated the likely need for piloting and staging some services, which will allow refinement and readjustment of these numbers. Accordingly, estimates of capacity should reflect this staged implementation process, showing changes in the distribution over periods of time.

Figure 3 represents the direction for changes in utilization patterns of the redesigned systems. The arrow represents the range of crisis services proceeding from least restrictive and intensive on the left to most restrictive and intensive on the right. The expectation is that the changes would involve reductions in the services on the right and increases in ones on the left. However, reductions on the right would be greater than increases on the left, because the expectation is that the overall number of persons entering the crisis system would be reduced (by more effective outpatient intervention, etc.). Also, transfers from one service to another are expected to be reduced, which will influence percentages in each service.

Figure 3

Direction of Changes in Utilization Patterns



While it is not possible to project with certainty how utilization patterns would change under the redesigned system, Tables 1 and 2 offer a model of how utilization could shift across the spectrum of psychiatric crisis services as implementation of the redesign proceeds, leading up to 2021. We emphasize that these shifts should not be considered as “hard” targets against which success should be measured, but rather as cautiously optimistic projections based on our knowledge about the population currently receiving services and the anticipated impacts of system improvements. For example, we know that a substantial proportion of current PCS admissions are walk-ins; in our tables, this group is represented as shifting to less intensive services in accordance with assumptions of the redesign plan.

Overall, these projections are intended to illustrate how the redesign plan is intended to change utilization through investment in non-ED prevention services and “upstream” crisis resolution services—first, by diverting some number of persons from the crisis system entirely through prevention, and then by shifting numbers from more intensive, facility-based services to less-intensive, community-based services.

Somewhat arbitrarily, we specify these time periods as years, although it may turn out that the shifts may be achieved more rapidly or more slowly, in which case the distribution presented here will need to be adjusted. For example, the planned expansion of some diversion services may require more time than is currently anticipated, or the programs’ ability to absorb the increased caseload may take longer. Alternatively, these processes may occur more rapidly than expected.

Reflecting the fact that initiatives are already underway to modify these utilization patterns (with expanded service capacity, efficiencies, etc.), the shifts represented in the tables reflect changes beginning with the present as baseline and leading up to full implementation in 2021.

BHD has indicated that some piloting and staging of implementation may be desirable, in which case the trends leading up to implementation may be expected to continue beyond 2021.

Table 1 shows annual potential diversions from the crisis system from 2019-2021, while Table 2 shows potential changes in utilization for specific crisis system components for the same period. These projections are presented to illustrate how investment in “upstream” and non-ED crisis services may positively impact the entire continuum based on three considerations:

- First, we drew upon information obtained in the environmental scan and input from the Advisory Committee on recent trends and expectations for the redesigned system (e.g., recent improvements in the efficiency of mobile crisis teams, and plans for expanded services by FQHCs).
- Second, we based expectations for diversion and substitution (for example, expanded clinics substituting for ED visits) on the experience of the project team with similar crisis system redesign initiatives.
- Third, we conducted a brief survey of research on crisis respite centers, peer support programs, mobile crisis teams and CART-like co-responder teams focusing on their impact on the overall service system, such as reducing ED and inpatient utilization.

Table 1

Estimates of potential diversion from the continuum of psychiatric crisis care by year

Year	N	%
2019	750	2
2020	2,250	7
2021	3,350	10

Table 2

Estimated potential changes in volume in the continuum of psychiatric crisis care by year

Year	ACCESS		CMT		CSH		CRC		CART Mobile		Hospital EDs		Psych ED		Total Minus Diversion	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Current	940	3	2310	7	400	1	1270	4	1230	4	18000	56	8100	25	32250	100
2019	1000	3	2400	8	600	2	1800	6	1600	5	17000	54	7100	22	31500	100
2020	1100	4	2700	9	800	3	2400	8	2000	7	16000	53	5000	16	30000	100
2021	1600	6	3000	10	1000	3	3000	10	2300	8	14000	48	4000	15	28900	100

7. Next Steps

The information presented in this summary represents the findings of the adult crisis redesign planning group, or “Phase 1” of the proposed redesign. “Phase 2” would consist of assembling a public/private work team and multiple subgroups that will focus on the development of financial, operational, and structural details for each component and the delivery system, as well as a detailed, phased implementation plan



Environmental Scan

Milwaukee Psychiatric Crisis Service Redesign
December 2018



Table of Contents

01

Introduction and Background

Approach
Background

07

Components of Psychiatric Service Systems Nationally

Modern Crisis Service Systems
Traditional Crisis System Parts

15

Current Crisis Services, Utilization, and Stakeholder Feedback

Summary of Current System
Clients Served & Key Data Takeaways
Stakeholder Feedback

32

National Models for Consideration

Best Practice: System Components

38

Next Steps for Milwaukee County

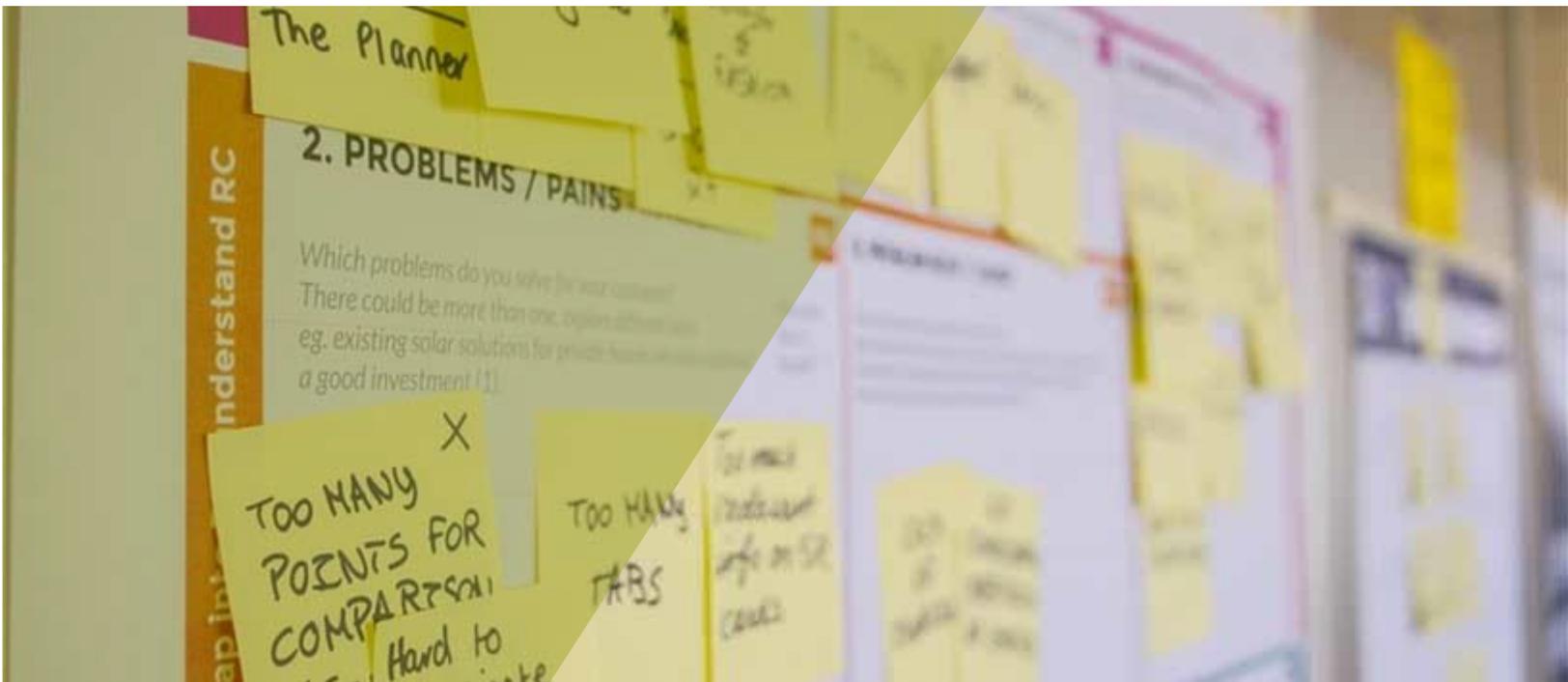
Best Practice Strategies to Be Considered
A Path Forward

44

Appendices

Appendix A: Environmental Scan Methodology & Informant List
Appendix B: Crisis Service Information Sheets
Appendix C: GIS Maps of Home Zip Codes of Those Served
Appendix D: Data Displays for Key Variables by Program/System
Appendix E: References

Introduction & Background



Introduction

For the past decade, the Milwaukee County Behavioral Health Division (BHD) has been engaged in a long-term transition to a more community-based continuum of care for residents needing mental health and substance use treatment and services. As the latest phase of this process, the County has made a decision to close the Milwaukee County Mental Health Complex (MHC) inpatient units and contract with a private provider for inpatient behavioral health services.

The MHC is also the site of the BHD-operated psychiatric emergency department and observation unit (known as PCS). With the shift to contracted inpatient units, it no longer makes programmatic or financial sense for BHD to operate a freestanding PCS at this site. BHD also sees this pending change as an opportunity to redesign the entire psychiatric crisis service system consistent with its continued goal of transitioning to a more community-based system of care. To fully consider an array of models for both psychiatric emergency department and community-based services, BHD has collaborated with the Milwaukee Health Care Partnership to commission an analysis aimed at redesigning the county's full psychiatric crisis service system.

While the timing is not yet certain, it is assumed the redesigned system is to be implemented in full in 2021. A number of preliminary steps need to be taken, including some that are already underway, to build up to the final system.

The redesign project was guided by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC), and the Wisconsin Policy Forum (WPF) under the direction of a five-person project Advisory Team. That team consisted of the BHD administrator, the Milwaukee Health Care Partnership director, the Milwaukee Department of Health and Human Services director, the president of Aurora Behavioral Health Services, and the chair of the Medical College of Wisconsin's Department of Psychiatry and Behavioral Medicine.

The project sponsors established the following conditions at the start of the project:

- The design will consider the current and future continuum of BHD psychiatric crisis services.
- The design will address the current and future role of both public (county and state) and private providers.
- The design will consider the County's legal and regulatory responsibilities.
- If a psychiatric emergency department is among the recommendations for the new system, it would not be operated by BHD or located in the current BHD facility.
- The new design will consider the County's current property tax levy expenditures on psychiatric emergency services and seek to reduce the amount of those annual expenditures.
- The redesigned system must be implemented on or before the date of outsourcing and relocation of BHD inpatient services, which is slated for late 2020 or early 2021.

Approach

The project team views the redesign process as an opportunity to design a system from the ground up. While incorporating lessons learned from past experience and seeking to retain the features of the previous system that were most effective, the goal is to address gaps and limitations of that system and introduce forward-thinking innovations that will best serve the residents of Milwaukee County.

To gain as much information as possible about the size and characteristics of the population that is currently served by the crisis service system, we collected and analyzed data on crisis service utilization provided by BHD, private health systems, and the Wisconsin Hospital Association. The resulting information is presented in the section titled "Utilization of Current Crisis Services."

Interviews and focus groups with a wide range of stakeholders were the primary source of information for identifying current system strengths and opportunities for improvement. The key themes that emerged are presented in a subsequent section, under the heading "What We Heard from Milwaukee County Stakeholders."

As a third source of information to inform the redesign decision-making process, we drew from published literature and sought input from experts to identify varieties of

models and practices around the country, with a focus on innovative and exemplary practices that might feasibly be applied to Milwaukee County. These are presented in the section titled “National Models for Consideration.”

Background

The Milwaukee Crisis Service Redesign has occurred as a matter of necessity, compelled by the closure of Milwaukee County’s Mental Health Complex; however, it is occurring at an opportune time, as there has recently been a nationwide surge of interest, innovation, learning, and improvement in how psychiatric crisis services are organized and delivered. This intensified attention is the result of a combination of factors, including:

- In general, a widespread recognition of the need to transform psychiatric crises services to being less restrictive and more therapeutic.
- The need to plan for and comply with the Americans with Disabilities Act (ADA) Integration Mandate following the *Olmstead* ruling; cities, counties, and states are building community-based crisis systems of care to prevent avoidable institutionalization.
- The critical need to address factors that contribute to reduce “boarding” of individuals with behavioral health crises in emergency departments.
- The need to reduce the practice of using 911 as a way to initiate crisis care and to avoid using law enforcement officers in any aspect of behavioral health crisis delivery (including compelling treatment, initiating involuntary evaluation orders, carrying out court orders for evaluation, transportation, supervision/guarding in emergency departments).
- The need to view effective psychiatric crisis services as an essential aspect of state or local initiatives to reduce community violence.
- A desire to apply evidence-based practices that are trauma-informed, person/family-centered, and recovery-oriented in the delivery of crisis services.
- A rise of peer-inclusive interdisciplinary treatment teams and peer-operated crisis service models that have challenged conventional thinking of what helps in a crisis.
- An overarching desire by many healthcare thought leaders to change the care experience of individuals with behavioral health conditions and their families—as has been done in other medical disciplines.
- The desire to deliver services that are empowering and promote whole-health activation.

Overcrowding of hospital emergency rooms with those needing psychiatric care, increasing numbers of psychiatric ER visits, and boarding of ER patients with psychiatric disorders are widespread national problems caused by a relatively

common set of circumstances. These circumstances should be considered in any crisis service planning process and include:

- **Lack of less-restrictive, walk-in, or rapid mobile response resources.** This gap means that, in a crisis, ERs are used as a first choice rather than a last resort. These avoidable visits contribute to overcrowding. Often this also signals a need to enhance the crisis competencies of outpatient treatment providers in crisis prevention and early intervention response and to increase the competency of professionals in other systems that have frequent or even daily interaction with individuals who have mental health conditions (i.e., schools, criminal/juvenile justice systems, social services providers, homelessness/housing services) to reduce stigma, increase knowledge, and build effective, trauma-informed engagement skills.
- **Lack of service specialization.** Emergency department teams often lack sufficient specialized knowledge of how to treat individuals experiencing behavioral health crises, starting with how to empathically engage and offer calming and soothing support. The absence of these skills can create a care experience in which a person feels marginalized and stigmatized.
- **Lack of treatment initiation.** Without the introduction of relieving treatment, symptoms generally persist or worsen. Whether by default (and related to a lack of service specialization) or design (for example, purposefully limiting the role of the ER team to assessment and referral), a lack of treatment initiation can increase the length of stay and delay symptom relief.
- **Under-defined roles.** Whereas emergency departments often have clear protocols for other health care conditions, their protocols for behavioral health conditions may be less defined, leaving team members unclear about whether, when, and how to proceed in a meaningful way. There are multiple, competing priorities in an emergency department, and in the absence of clearly defined roles, team members may gravitate to the work that is most clear and familiar; in this way, care of the individual in crisis may be placed on the back burner or passed along to the next shift.
- **Early use and overuse of involuntary treatment.** An emergency department physician can be reticent to release an involuntary hold even if a patient has improved—particularly if this is outside the physician’s area of specialty. Sometimes the decision to initiate a hold occurs prior to transport to an ER, and sometimes a hold is initiated in an emergency department. These practices are worthy of close scrutiny with an eye toward pushing the decision downstream, focusing on early, voluntary, and person-centered engagement and shared decision-making, and eliminating the use of holds when they are avoidable (for example, when the hold is being used more for the benefit of the system than the needs of the person).
- **Lack of a trauma-informed environment.** Emergency departments are challenged every day to assure the safety of patients and staff. The approaches they use to ensure safety can create settings that are experienced as

traumatizing for individuals with behavioral health conditions. For example, these environments may include staff who are not welcoming; barren rooms; a locked treatment area; the presence of police

Emergency room experiences can be undermining and countertherapeutic for people experiencing behavioral health crises.

Environments that offer comfort, control, agency, connection, and understanding can help prevent trauma and preserve dignity.

officers, guards or sitters; restrictions on clothing and personal belongings; and the threat of restraints. These approaches are often iatrogenic in the sense that they can serve to escalate rather than calm, shame rather than instill feelings of acceptance and hope, inhibit rather than promote active participation and candor, and reduce rather than increase treatment adherence/follow-up. In a crisis, individuals often are experiencing an absence of safety, comfort, control, agency, choice, connection, and understanding; providing an environment that offers these experiences can deescalate a crisis and help preserve dignity.

- **Inadequate supply (or access to supply) of outpatient treatment resources.** It is very common to find a significant disconnect between private hospital emergency departments and community behavioral health systems. Emergency department teams may believe the community lacks outpatient resources to assure adequate treatment; because of this, they may assume the safest course of action is to admit a person to an inpatient treatment unit where the sense of the available service is better known. Community mental health systems that are not well connected to emergency departments often lack the supply of urgent slots necessary for timely follow-up with post-ER discharges—even for their current clients. Emergency departments operate 24/7/365, and the most efficient systems figure out mechanisms to offer firm appointments at the time of discharge rather than simply offering a list of agencies and phone numbers for the patient to call.
- **Lack of systemic strategies for individuals with specialized needs.** Strategies for individuals with specialized needs have to be built one by one, in partnership with subject matter experts and stakeholders. Such individuals include those who:
 - Are experiencing homelessness
 - Are uninsured
 - Have criminal justice involvement
 - Have a comorbid medical or substance use issues
 - Have an intellectual or developmental disability
 - Display/have a history of extreme aggression
 - Are child protective services involved

For developing strategies for special needs individuals, the use of data and a shared commitment for a good outcome go a long way when developing memorandums of understanding, service pathways, 24/7/365 telephonic consultation models, etc. Without well-developed person-centered strategies for these individuals, episodes of psychiatric crisis episodes are more frequent and more drawn out, which is overwhelming for patients, family members, and treatment teams, and exposes all parties to avoidable risk.

Components of Psychiatric Crisis Service Systems Nationally



Modern Crisis Service Systems

Modern crisis systems have evolved well beyond a collection of programmatic parts into systems that are highly planned, dynamic, and driven by real-time data. The best functioning systems are decidedly cross-sector in nature with macro-level oversight, data analytics, and systems improvement capability.

The Crisis System Community Coordination and Collaboration Continuum describes five levels of maturation (see Figure 1 on the following page). Each subsequent level represents a greater advancement of a crisis system's functionality. For a crisis service system to provide Level 5 integrated care, "it must implement an integrated suite of software applications that employ online, real-time, and 24/7 ability to communicate about, update, and monitor available resources in a network of provider agencies" (National Action Alliance for Suicide Prevention: Crisis Services Task Force, 2016).

Figure 1
Levels of Coordination and Collaboration



Crisis System of Care Framework

Individuals in crisis often “touch” multiple systems (schools, social services, criminal justice, primary care, etc.). For example, in the course of just one crisis episode, a person may move through or touch law enforcement, an emergency department, a mobile crisis team, and an inpatient treatment team. Moreover, crises impact individuals across the socioeconomic spectrum, the age spectrum, and of all races and cultures; and only a portion of individuals in crisis are known to community mental health providers prior to the crisis. To meet the health and safety needs of a diverse community—and to impact both those who seek traditional treatment and those who do not—a public health lens is essential.

Unless purposefully developed, general hospital emergency departments (and inpatient psychiatric treatment units) tend to function in isolation from community outpatient treatment systems. Individuals presenting with psychiatric crises are assessed, medically cleared, and either admitted for inpatient treatment or discharged back to the community. In the absence of dependable plans for treatment continuity and assuring community safety, this often leads to “erring on the side of safety” and hospitalizing an individual; in many instances, such hospitalization is involuntary.

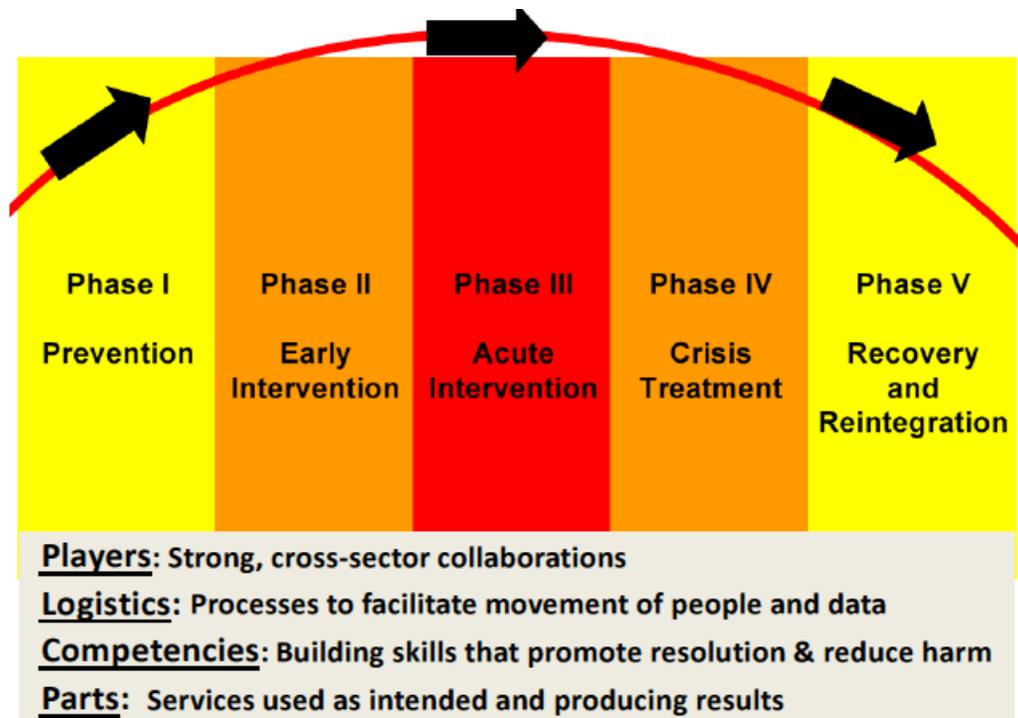
The relationship between the crisis system and the larger service system may be well-planned and well-built, in which case the result will be care that is coordinated, integrated, and efficient; or the relationship may be unplanned, underdeveloped, and/or ad hoc, in which case there will likely be default reliance on 911, law enforcement, and emergency departments, as well as frequent disruptions and inefficiencies in care.

In Milwaukee County, we find considerable efforts at building a crisis system of care, significant system investment in new models and services, and considerable opportunity to do more and do it better—a perception widely supported by the informants we interviewed. As many of those informants emphasized, the most important consideration for the redesign is that it presents an opportunity for careful planning for coordination and integration with the broader behavioral health system and cross-sector stakeholders.

The Crisis System of Care framework (Figure 2) offers a way to conceptualize the whole of the organized crisis system for a particular community and to determine opportunities to invest across five “phases of crises”: prevention, early intervention, acute intervention, crisis treatment, and recovery/reintegration. Often, attention and

money are focused narrowly on the “acute intervention” without attending to upstream/downstream opportunities.

Figure 2
Crisis System of Care Framework



Source: Madenwald & Day, Technical Assistance Collaborative

In addition, effective crisis systems attend to four key crisis system components: Players, Logistics, Competencies, and Parts. Often, communities focus solely on adding more “parts” and bemoan that there aren’t resources to pay for the parts, when in fact it is development of the players, logistics, and competencies (often low-cost investments) that promotes return on investment, improved care experience, and system efficiency.

We recommend that Milwaukee County and its stakeholders consider investment opportunities in each of the elements of the Crisis System of Care framework. Upstream, this can include increasing the competency of treatment providers to support individuals in crisis planning and the capacity to provide same-day appointments for clients in crisis. Downstream, this can include improving “back door” movement out of emergency departments, crisis beds, and inpatient units by enhancing service coordination, increasing the supply of urgent appointments, and increasing collaboration with managed care companies and key partners (for example, in homelessness/housing services, schools, and child protective services).

Regardless of the specific service array, Milwaukee County can consider a cross-cutting philosophy of care and a set of core competencies so that as individuals progress through a crisis episode, there is a commonality of approach to care—preferably one that is trauma-informed, strengths-based, person-centered, and resolution-focused.

There is significant opportunity to improve system logistics, including how people, resources, and data move through the system and across entities in ways that are HIPAA-compliant but also service user–friendly.

Traditional Psychiatric Crisis System Parts

Crisis service systems across the country vary in their management, organizational structure, relative allocation of resources to different types of services, and prevailing culture; however, most (at least in urban settings like Milwaukee County) provide a fairly standard array of service parts, briefly described as follows:

Regional or Statewide Crisis Call Centers

Crisis call centers are often well positioned to serve as the intelligence hub for a community’s crisis system, providing telephonic support, authorizing and/or dispatching services, coordinating care (including transportation), performing bed searches or insurance preauthorization, facilitating transfer of records, and capturing real-time data.

The premier model for a crisis call center operates an “air traffic control” level of connectivity. An example of this approach is the Georgia Crisis & Access Line, which employs state-of-the-art technology, including an integrated software infrastructure capable of tracking individuals at a statewide level, providing built-in insurance of consistent triage, level of care protocols, and warm hand-offs to the appropriate crisis service teams across the state (Covington 2016).

These are programs that adhere to National Suicide Prevention Lifeline (NSPL) standards, provide support to individuals and families in crisis using technology for real-time coordination across a system of care, and leverage data for performance improvement and accountability.

BHD currently maintains a crisis line and recently expanded its functionality through a partnership with IMPACT/211.

Walk-In Crisis Centers

Walk-in crisis centers vary greatly in terms of staffing models, hours of operation, and capacity. Many are freestanding (Massachusetts has 21 freestanding, regional walk-in crisis centers) while others are hospital-adjacent (in Philadelphia, for example). Some communities co-locate 23-hour observation and/or crisis stabilization beds with walk-in crisis centers (Columbus, Ohio).

For Milwaukee County, 24/7/365 accessibility is essential. Currently, PCS serves as the County's primary walk-in crisis center, but it is questionable whether a similar center would be the optimal approach in the redesign. An alternative would be establishment of one or more comfortable, walk-in treatment settings that are less restrictive than an emergency department but that maintain some capability to screen for and manage some medical needs, as well as the ability to accept individuals on involuntary holds. Expansion of walk-in crisis centers is currently being planned by BHD.

Free of some of the regulations that govern emergency departments, walk-in crisis centers can be designed to provide a flexible and person-specific service based on expressed needs and preferences. Walk-in crisis centers often are a great resource for crisis intervention teams who seek to connect individuals with a crisis treatment program.

Mobile Crisis Teams

Since the 1970s, community-based mobile crisis services have been a core component of crisis care systems. Many communities have specialized mobile teams for specific populations such as older adults, children, or individuals with intellectual or developmental disabilities. Some mobile crisis teams offer one-time interventions; other teams offer follow-up crisis support services over the course of several days or even weeks.

A brief period of follow-up crisis support in certain circumstances can be quite effective in diverting people from higher levels of care, assuring care continuity, or for sufficiently resolving a crisis such that no further treatment is needed.

Mobile crisis teams are increasingly pairing clinicians (generally master's prepared, but this differs by the licensure/service requirements in each state) with adult peer specialists (examples include Southern AZ, Southwest WA) or parent peer support specialists on children's teams (examples include Massachusetts, Philadelphia).

Another variation of the mobile crisis team model is creation of co-responder teams composed of a master's level clinician and a law enforcement officer, the latter of whom typically has received Crisis Intervention Training (CIT). Milwaukee's model of that approach consists of five Crisis Assessment and Response Teams (CART), with three teams dedicated serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County.

The function of mobile crisis teams must be carefully considered to prevent them from becoming narrow in scope. Optimally, the goal of a mobile crisis team is to deliver resolution-oriented crisis intervention and support designed to ameliorate the crisis and promote community tenure.

Since the mid-2000s, many metropolitan area mobile crisis programs have used GPS programming to identify the location of teams by GPS signal and determine which team can arrive the soonest at the site of a person in crisis.

BHD currently has a crisis mobile team that provides 24-hour, 365-day service.

Peer-Delivered Services

According to SAMHSA (2009), mental health crisis services:

. . . should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. This can include but is not limited to staff members that serve as peer specialists. Recruiting individuals with personal experience is key to shifting culture in organizations that have been operating in a traditional provider-driven care model.

There are examples of peer specialists working in virtually every behavioral health crisis setting—including but not limited to hospital emergency departments, inpatient psychiatric units, crisis stabilization units, mobile crisis teams, and crisis call centers. In addition, there are an increasing number of peer-operated crisis programs, including Living Room model programs described in more detail later in this report.

BHD staff describe a significant commitment to peer involvement and the division is planning considerable expansion, which is described in detail in the following section.

Crisis Stabilization Facilities

Crisis stabilization facilities vary in title, licensure, intensity, staffing model, and locale. Generally, however, they are described as bed-based services that are less-restrictive than, and serve as a diversionary alternative to, inpatient treatment units. In a review of nationwide crisis services, SAMHSA (2014) defined crisis stabilization as:

A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.

In general, evidence reviewed by SAMHSA suggests a high proportion of people in crisis who are evaluated for hospitalization can safely be cared for in a crisis facility. The same evidence suggests the outcomes for these individuals are at least as good as hospital care, and the cost of crisis care is substantially less than the cost of inpatient care. (SAMHSA, 2014.)

Crisis stabilization beds are effective only in so far as they are available at the time of the crisis. We have seen far too many examples of laborious admission processes, long lists of admission “exceptions,” beds used for shelter/housing, beds being used for hospital stepdown rather than diversion, and poorly managed discharge practices leading to extended lengths of stay. In some communities, the front door and even the back door of crisis stabilization units is largely managed by crisis teams.

Milwaukee County’s psychiatric crisis system currently includes two crisis resource centers and two crisis stabilization houses operated by contracted providers. While generally receiving praise from key informants for the role they serve in offering an alternative to PCS, private hospital emergency rooms, and inpatient units, areas for improvement also were identified.

Extended observation or 23-hour beds

Extended observation units (EOUs) and 23-hour beds are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than a hospital and when it is expected that the acute crisis can be resolved in less than 24 hours. Services include medication, meeting with extended family or significant others, and referral to more appropriate services (Technical Assistance Collaborative, 2005). Additionally, these facilities may be suitable for patients in substance-induced states, while they return to sobriety.

Milwaukee County currently has 18 observation beds housed at PCS. This resource is used when it is likely that a period of brief stabilization or treatment initiation can sufficiently resolve the crisis.

Transportation

Transportation resources are essential for well-functioning crisis systems, but issues with transportation are not necessarily easy to solve. Engaging law enforcement officers for the purpose of transportation should be minimized. Some communities use peer specialists, ambulettes, taxi cabs, family members, and/or mobile teams for transportation. Minimizing the need to transport is useful as well. Providing services in the community where an individual lives will reduce transportation needs.

According to 2017 data, two thirds of the admissions to Milwaukee County’s PCS were by police transport. BHD’s Team Connect and Care Coordination Teams also transport individuals and, additionally, BHD has a contract with a transportation company to provide transports.

It should be noted, however, that the crisis system in Wisconsin is law enforcement-based by statute, and barring a significant change in the law (which most observers consider unlikely at least in the short term), law enforcement will continue to have a

significant role in transport. A key emphasis in the redesign planning, therefore, is a less direct approach to reducing the role of law enforcement—by enhancing capacity for prevention and diversion as alternatives to psychiatric ED admission. That said, law enforcement will continue to be the principal means of transport to a dedicated psychiatric ED, as that is determined by the Chapter 51 process.

Current Milwaukee County Psychiatric Crisis Services, Utilization, and Stakeholder Feedback



Summary of Current Milwaukee County Psychiatric Crisis System Services

In this section, we provide an overview of the components that comprise the current Milwaukee County psychiatric crisis service system. Please refer to Appendix B for additional information on the current crisis system services.

Crisis Line

The Crisis Line (257-7222) is the community access line for adult crisis services in Milwaukee County. Individuals and family members who are experiencing a psychiatric crisis can speak with someone directly to obtain crisis response and resources. In May 2017, IMPACT/211, a community agency, began answering the first line of calls on the Crisis Line. IMPACT/211 is a call center that specializes in taking crisis, shelter, resources, and general information calls. IMPACT/211 handles all calls for resources and triages crisis calls to a clinician on the Crisis Mobile Team for

immediate response. The partnership with IMPACT/211 has increased the ability of the Crisis Mobile Team clinicians to respond to calls in the community by reducing time spent staffing the Crisis Line. In 2017, the Crisis Line consistently received over 3,000 calls a month.

BHD is a call center for the National Suicide Prevention Lifeline.

Crisis Mobile Team

The Crisis Mobile Team (CMT) is composed of master's level clinicians and nurses who provide community-based crisis services to individuals 18 years and older. CMT provides crisis response, assessment, linkage to services, and follow-up support to people throughout Milwaukee County 24 hours a day, 365 days a year. Responses are individualized to meet the person's unique needs and in the setting most convenient to the individual (home, work, school, etc.). Milwaukee County employees cover the first and second shifts of the day; a contracted partner, La Causa, covers the third shift. BHD is currently working to increase proactive follow-up to ensure people's needs are being met post crisis. BHD projects that there will be 3,200 CMT contacts in 2018.

Children's Mobile Crisis Team

The Children's Mobile Crisis team is similar in structure to the CMT but focused on off-site assessment for children and adolescents (under 18 years of age).

Community Consultation Team

Specializing in helping individuals with co-occurring intellectual/developmental and mental health needs, the Community Consultation Team (CCT) goes into the community to provide crisis response. CCT also offers ongoing education and consultative services for providers and offers support to family members.

Crisis Assessment Response Team

The Crisis Assessment Response Team (CART) is a co-responder program that consists of paired teams of master's level clinicians and law enforcement officers. Participating officers go through Crisis Intervention Training (CIT) and additional extensive training with Milwaukee County Crisis Services, and the teams respond to calls for service for individuals with significant mental health or co-occurring needs that require a mental health and law enforcement response.

CART responds to mental health calls that are dispatched through law enforcement, the Crisis Mobile Team, or proactive response by the officer. CART clinicians provide the immediate stabilization, linkage to services, and follow up with the people served.

Currently, there are five teams, with three teams serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County. A sixth team is currently in the process of being developed in collaboration with the Milwaukee County Sheriff's Department. Unlike CMTs, CART services are not available around the clock. The City of Milwaukee teams are available 11am-10pm M-F and 11am-7pm

on weekends; the West Allis team is available M-F from 11am-7pm; and the county-wide team is available M-F 9am-5pm.

Access Clinic

The Access Clinic is a short-term stabilization clinic located at the Mental Health Complex that provides comprehensive assessment, brief-term recovery planning, care coordination, peer services, psychotherapy, prescriber services, assertive outreach and follow up, and referral and linkage to needed services. The primary population served is individuals with no insurance, and the clinic functions as a walk-in alternative to the PCS. Once the Complex closes, BHD plans to partner with two Federally Qualified Health Centers to provide walk-in clinic options.

Crisis Stabilization Houses

Crisis Stabilization Houses are two licensed Community Based Residential Facilities comprised of 16 beds each serving people with significant mental health needs for up to six months (there are short-term beds with stays of around 14 days and long-term beds with stays up to 6 months). CSH is operated by a community-based partner in collaboration with the Crisis Mobile Team. CSH provides a caring, supportive, and therapeutic environment to assist people to stabilize and to meet their individualized needs. Clinicians and nurses from the Crisis Mobile Team have daily strengths-based interactions with each person to ensure their mental health and physical needs are being met in a strengths-based, trauma-informed, and person-centered manner. Clinicians and nurses coordinate each individual's care, provide short-term crisis therapy (motivational interviewing), facilitate team meetings with the person's care team (comprised of both formal and informal supports), and collaborate with house staff.

Peer-Run Respite (Planned)

Milwaukee County's first peer-run respite is set to open in 2019. The Peer Run Respite is a short-term respite consisting of 4-5 beds for individuals with mental health needs and in need of additional support in a safe and accepting environment. People coming to the Peer Run Respite are looking to strengthen their recovery and proactively address any need they may be experiencing. Programming will be self-directed and will use a strengths-based holistic approach. People will be offered wellness opportunities through one-on-one or group peer support. A stay at the Peer Run Respite will begin with a potential guest speaking directly with staff about what they are experiencing, their hopes and needs, and how a temporary stay would be beneficial to their recovery. Peer Run Respite programming is person-centered and recovery-focused, and activities are strictly voluntary.

Crisis Resource Centers

Crisis Resource Centers (CRCs) provide people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. Crisis Resource Center (CRC) services are funded by BHD and delivered by a contracted community-based provider. The two CRCs, located in the northern part of the city of

Milwaukee and on its south side, provide people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. There are currently 27 beds, including 8 beds that were converted from CSH to CRC beds in 2017 to better meet community needs. Services are wrapped around the individual to support stabilization in a community setting through the CRC's array of onsite supportive services, including peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, and linkage to ongoing support and services. CRCs provide extensive stabilization services to prevent emergency room visits or hospitalization. The average length of stay at the CRCs is 5-7 days. People are directly referred to CRCs through BHD Crisis Services, hospital EDs, and community agencies; others are self-referrals, either via phone or walk-in. In the redesign, as discussed in the Planning Summary, the emphasis of CRC admissions will shift from ED step-down to ED diversion.

Community Linkage and Stabilization Program

The Community Linkage and Stabilization Program (CLASP) is a community-based peer specialist program. Individuals are voluntarily referred to the program through one of the Crisis Services programs (CRC, Crisis Mobile Team, CART, Team Connect, Observation Unit, Inpatient Units, Access Clinic). The peer specialists utilize their own unique recovery experiences to engage people who are beginning their recovery. The CLASP team provides individualized care and planning in the community at the location that best serves the person's needs. CLASP has been able to successfully engage people who have traditionally not engaged in services. CLASP focuses on stabilizing the crisis, partnering with the person to meet their needs, and developing strong support systems to prevent crisis. Duration of service is generally 6 months but is based on the individual's needs. Services are provided under contract by La Causa, Inc. There is currently capacity for a caseload of 80 people program-wide. It is hoped that expanding funding sources through HMOs and other revenue streams will increase capacity and the ability to serve more people.

Psychiatric Crisis Services - Admission Center (PCS/Observation Unit)

Psychiatric Crisis Services (PCS) is a 24-hour, seven days per week psychiatric emergency room. This essential component of the County's current system of crisis services provides crisis intervention and face-to-face medical/psychiatric assessment for individuals who are, or who believe themselves to be, in psychiatric emergency and in need of psychiatric assessment, treatment, and/or referral. PCS physicians also provide medical oversight and consultation for all Crisis Mobile Team, CART, Community Consultation Team, and Geriatric Crisis services. Individuals who come in either voluntarily or involuntarily can be seen immediately. All inpatient admissions to the Behavioral Health Division are evaluated first in the Psychiatric Crisis Services, as are individuals brought in on Emergency Detention, under Chapter 51 of the Wisconsin Statutes, by law enforcement. There were 8,001 individuals seen in PCS in 2017 (7,194 for whom legal status is known and demographic information is available, and about one quarter of whom were children).

Geriatric Crisis Services

Dedicated geriatric psychiatric crisis intervention and stabilization services are available on a mobile, outreach basis for individuals age 60+. A designated geriatric psychiatric nurse specialist is also available to connect with people in need.

Team Connect: Short-Term Follow Up

Team connect is comprised of master's level clinicians and peer specialists who provide services to individuals who are discharged from PCS, the Observation Unit, or the BHD Inpatient Units. Team Connect provides additional support via telephone and in person to people as they return to the community to reduce the risk of harm. Contact is made or attempted with the person within 24 hours or the next business day of discharge. The team provides linkage to services in the community, supports engagement in post discharge care, and community-based crisis response. Team Connect was implemented in 2017 and continues to evolve. The team will continue focusing on engaging people post discharge from BHD Mobile Crisis, private EDs, and inpatient to ensure their needs are being met and to reduce PCS visits, BHD readmissions, and overall crisis episodes. Going forward, additional emphasis will be placed on Care Coordination. Expanding services to HMOs for people being discharged from private hospitals is also being considered.

Utilization of Current Psychiatric Crisis Services

The preceding section provides context on the basic characteristics of the psychiatric crisis service system in Milwaukee County. In this section, we provide more granular context by summarizing utilization data and information provided by BHD, private health systems, and the Wisconsin Hospital Association (WHA).

BHD provided summary information on the number and characteristics of people receiving crisis services and assessments through PCS, Crisis Mobile, and CART teams in 2017 (the most recent full year for which data were available), as well as numbers served for the Access Clinic, Crisis Stabilization Houses, Crisis Resource Centers, Community Consultation Team, and Children's Crisis Mobile (formerly known as MUTT). Ascension, Aurora, Froedtert, and Children's health systems provided numbers and characteristics of individuals presenting in their EDs for behavioral health problems.

The data requested focused on the flow of individuals through the system, such as how they accessed crisis or ED services and where they live; the individuals who are being served according to various demographic characteristics; and information on their disposition (where they went after assessment).

The aggregate data received from BHD and the private health systems are summarized below. Data provided by WHA and analyzed separately is presented in Appendix D. It is important to note that there were some inconsistencies in data collection and reporting among the different systems that result in some imprecision and gaps. For example, BHD (PCS, Crisis Mobile, CART) and Froedtert were able to distinguish legal status within their records, and BHD provided data for those with a known legal status. Aurora and Children's assumed anyone arriving via law enforcement was involuntary, and Ascension was unable to distinguish legal status.

It also should be noted that the purpose of this summary is not to compare different systems, but rather to provide a picture of the overall population of persons receiving crisis services as they are distributed across various facilities in Milwaukee County and the volume of services provided. These organizations differ in structure, populations served, and functions within the overall Milwaukee County health care system, and it should not be expected that they would be comparable with respect to crisis services and patients.

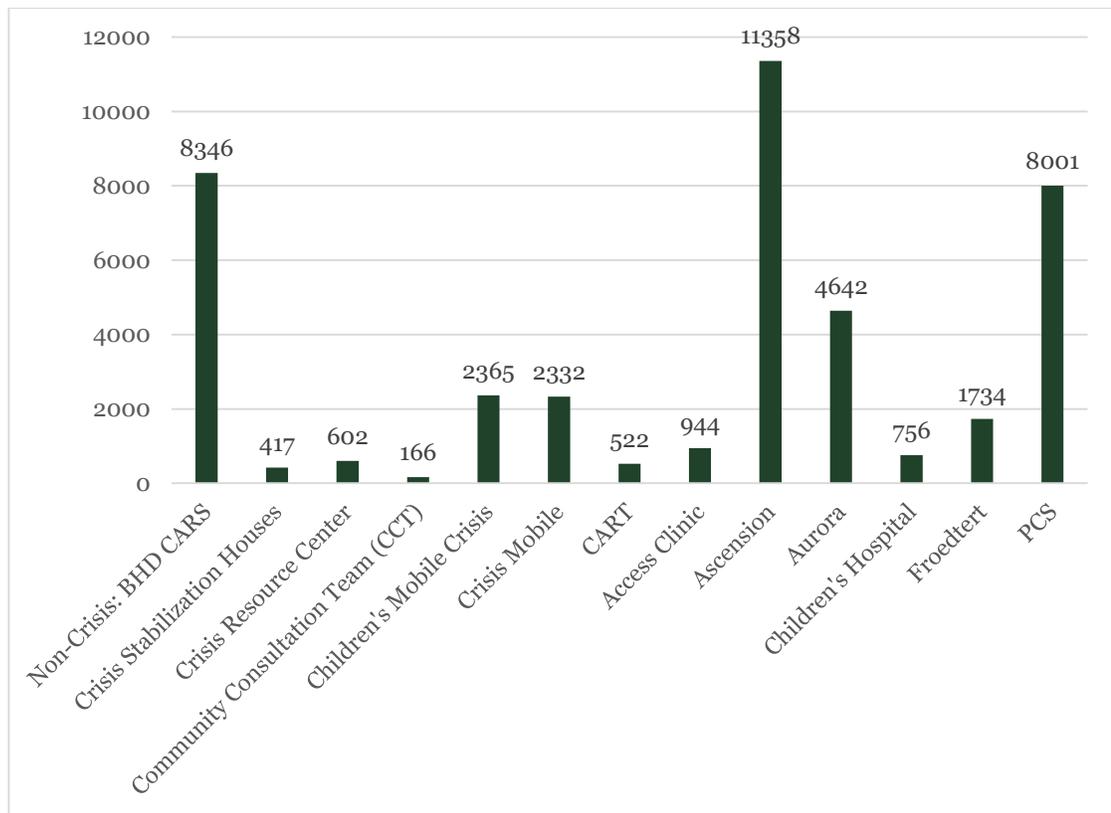
Finally, while each program or system provided unduplicated counts of individuals served, it is possible that some individuals were counted under multiple programs or systems if they received services from multiple programs or systems in 2017. As such, it is important to realize that the data presented represent the best estimates available for our purposes, but there is likely to be more error than with alternate approaches that can be employed when individual-level data are available.

Psychiatric Crisis Service Clients Served

To understand the need for potential changes or expansion to various components of the current psychiatric crisis service system, it is important to understand the utilization of existing crisis programs. Figure 3 shows an overall view of the number of individuals assessed or served in 2017 by the various crisis programs directly run or contracted for by BHD as well as by BHD's Community Access to Recovery Services (CARS) non-crisis services (to give a sense of post-crisis capacity). We also show the collective number of individuals assessed for behavioral health reasons at the emergency departments of hospitals in the Ascension, Aurora, Froedtert, and Children's Hospital health systems in Milwaukee County.

Figure 3

Number of Individuals Assessed or Served by Program/System, 2017



Note: The data represent admissions to ERs and BHD programs for persons with a primary behavioral health diagnosis. Legal disposition is not consistently collected in ERs and these data reflect the combined numbers of voluntary and involuntary admissions.

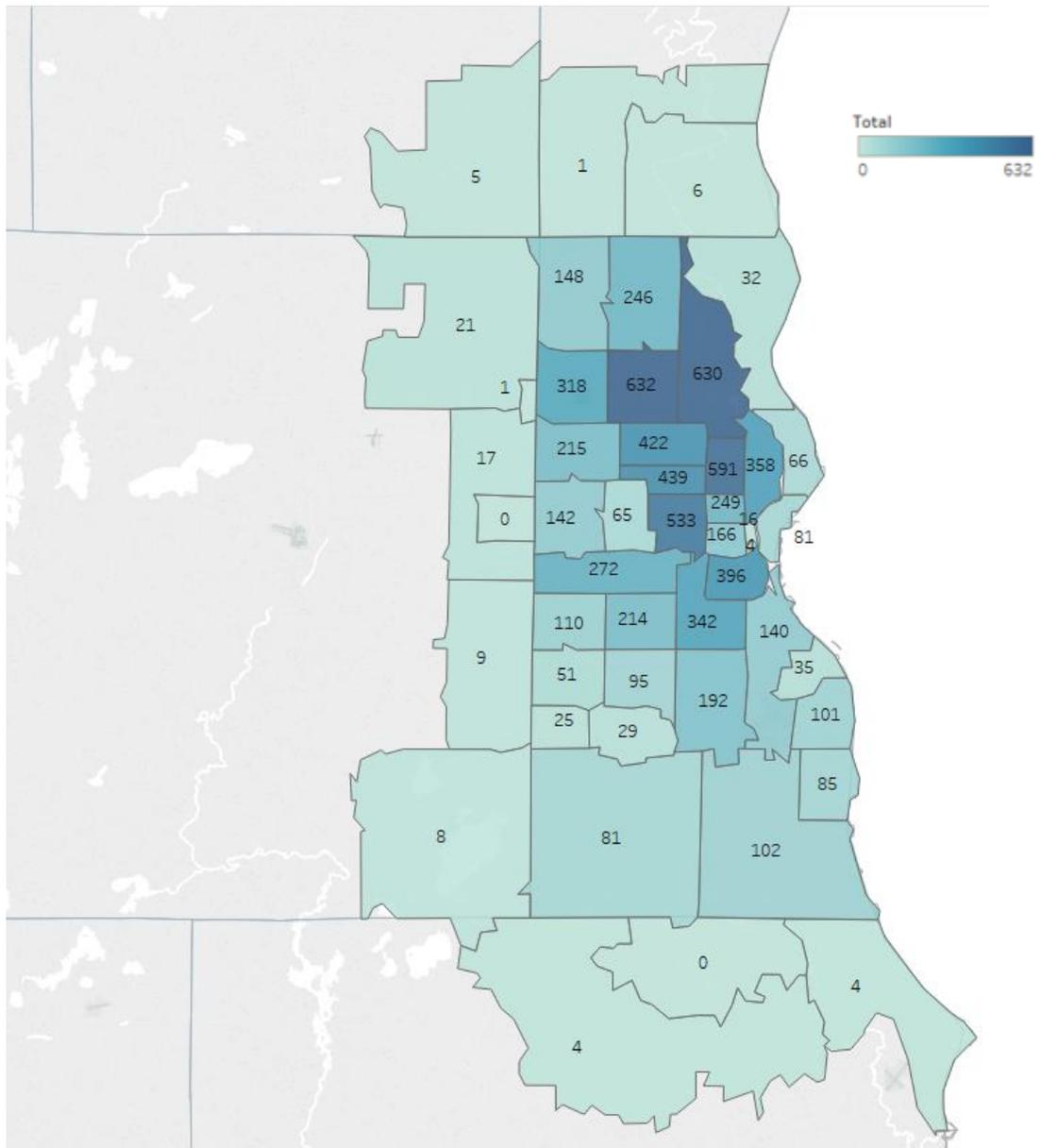
For future crisis service planning purposes, it is also important to understand who is being served by each of the crisis programs and their flow through those programs. For example, where do they come from, who are they, and where do they go after they are assessed or have received services?

We were not able to obtain data summarizing user characteristics for all programs; consequently, characteristics of those served are only summarized for those programs for which data were available. Characteristics summarized include admission status (voluntary or involuntary when available), geographical distribution, mode of access, demographic information (age, gender, race, and ethnicity), diagnosis, payment source, and disposition once the psychiatric assessment or crisis service was provided.

PSYCHIATRIC CRISIS SERVICES

The 53218, 53209, 53206, and 53208 zip codes had the highest numbers of individuals served, with these four zip codes alone accounting for 33% of PCS users in 2017. Figure 4 shows the number served for each zip code in Milwaukee County and abutting zip code boundaries, with darker shades indicating a higher number of individuals served. Similar maps for other BHD services and for private health systems are included in Appendix C.

Figure 4
 GIS map of home zip codes of individuals using Psychiatric Crisis Services



Other notable characteristics of those served by PCS:

- Of the 7,194 individuals with known legal status assessed in 2017, 59% were at PCS under involuntary status.
- 69% of individuals served were under the age of 40, including 23% under age 18.
- Those served were most likely to be male (58%) and African American (59%).
- 72% of those served had a mental health (as opposed to a substance use) diagnosis.

- The majority of individuals served were covered by Medicaid (59%) or Medicare (21%).
- The most common disposition after assessment was a return home with community services (58%), though 16% experienced a BHD inpatient stay and 8% experienced an inpatient stay at a private hospital.

CRISIS MOBILE

- Of the 2,332 individuals assessed by Crisis Mobile in 2017, 60% were assessed under involuntary status.
- The 53218, 53209, 53204, and 53215 zip codes accounted for 31% of individuals served (see Appendix C for map).
- About a third (33%) of those served were in the 26-39 age range, with the 18-25 range the next highest at 19%.
- Individuals served were split evenly between males and females.
- Of those served by Crisis Mobile, 51% were white and 43% were African American.
- Most of those served were covered by Medicaid (49%) or Medicare (27%). About 12% had no insurance source.
- After being assessed by Crisis Mobile, the most likely disposition was return home with community services (59%), with 10% experiencing an inpatient stay in a private behavioral health facility. Fewer than 1% experienced an inpatient stay at the BHD complex.

CART

- Of the 522 individuals assessed by CART in 2017, 22% were assessed under involuntary status.
- The 53218, 53209, and 53208 zip codes accounted for 26% of individuals served, with another 22% residing in the 53204, 53206, and 53216 zip codes (see Appendix C for map).
- 32.8% of those served were in the 26-39 age range and 23% in the 18-25 age range.
- 58% were male and 53% were Black/African American.
- The majority were covered by Medicaid (49%) or Medicare (30%); 12% were classified as having no insurance or were self-pay.
- The most frequent disposition was return to home with community services (57%), while 15% were admitted to a private behavioral health facility. Fewer than 1% were admitted to a BHD inpatient bed.

ASCENSION

- Of the 11,358 individuals assessed for behavioral health issues in Ascension emergency rooms, the most frequently reported home zip codes were 53215, 53204, and 53210, accounting for 24% of individuals served (see Appendix C for map).
- 25% of those served were in the 26-39 age range, and 22% were in the 50-59 age range.
- 55% were male, and of the one third for whom data on ethnicity was reported, 52% were White.
- 59% were given a substance use diagnosis.
- The majority were covered by Medicaid (53%) or Medicare (24%).
- The most frequent disposition was return to home with community services (81%); fewer than 2% were admitted to a private behavioral health inpatient facility.

AURORA

- Of the 4,642 individuals assessed in Aurora emergency departments, 2% were under involuntary status.
- 31% lived within the 53215, 53204, 53208, 53214, and 53219 zip codes (see Appendix C for map).
- The majority (74%) accessed Aurora EDs as walk-ins; 24% arrived by way of ambulance; and 2% arrived by way of law enforcement.
- Most were in the 26-39 age range (32%) or the 40-49 age range (22%).
- 55% were male and 65% were White.
- 76% were given a mental health diagnosis.
- The majority were covered by Medicaid (55%) or were dual eligible for Medicaid and Medicare (19%).
- The most frequent disposition was return to home with community services (44%), though a nearly identical proportion (43%) were admitted to a private behavioral health inpatient facility.

CHILDREN'S

- Fewer than 2% of the 756 individuals assessed in Children's ED in 2017 were assessed under involuntary status.
- Most individuals served by Children's lived within the 53209, 53218, 53216, 53215, and 53206 zip codes, accounting for 27% of the total individuals served (see Appendix C for map).

- The majority (71%) accessed Children’s ED as walk-ins; 26% arrived by ambulance; and fewer than 2% arrived by way of law enforcement.
- Most of those served were in the 14-17 age range (36%), with all but a few under the age of 18.
- 57% were male, 46% were White and 42% were African American.
- The majority were covered by Medicaid (66%) or private insurance (31%).
- 9% were admitted to a private behavioral health inpatient stay.

FROEDTERT

- Fewer than 6% of the 1,734 individuals assessed in Froedtert’s ED in 2017 were under involuntary status.
- Most of those served by Froedtert lived within the 53218, 53226, 53208, 53209, and 53225 zip codes, accounting for 33% of individuals served (see Appendix C for map).
- Most of those served were in the 26-39 age range (34%) or the 40-49 age range (20%).
- 56% were male, 48% were White, and 42% were African American.
- Most had a mental health diagnosis (72%).
- The majority were covered by Medicaid (31%) or Medicare (26%).
- The most frequent disposition (65%) was discharge to something other than BHD inpatient: private behavioral health inpatient, medical inpatient, home with community services, or unknown. 16.5% were admitted to inpatient medical care, and 10% were admitted to private behavioral health inpatient care.

Other data

The data summarized above were collected from programs and systems using a template that made use of common variables and response categories, focused only on the most recent full calendar year, so that information was available for the same time period in a comparable way across programs. Appendix C provides additional data displays for the information summarized above, showing the information for all response categories across all programs and health systems for which the data were available.

Key Data Takeaways

These data points demonstrate that the psychiatric crisis system in Milwaukee County is not limited to BHD services, but also includes extensive use of services provided by private health systems. Consideration of how to improve and enhance the relationship and partnership between BHD and private health systems throughout the psychiatric crisis continuum was deemed to be a key element of redesign planning.

Overall, the data available on the flow and characteristics of those being served impart some key considerations for future crisis service design in Milwaukee County.

Service Areas: Figure 4 and Appendix C indicate there are certain zip codes (e.g., 53215, 53204, 53218, 53209) with higher numbers of individuals served by some crisis services, suggesting that these areas be considered as possible priorities for siting of any new crisis programs.

Access method: The data also show that nearly a third of PCS admissions are walk-ins, possibly indicating a lack of other crisis alternatives available for those individuals. These data also suggest that for many BHD crisis programs, the predominant way of accessing the service is by way of law enforcement involvement—a potentially traumatizing experience.

Age groups: Age ranges are similar for all services, with the exception of PCS, which serves more under 18 and 18-25 than others, but fewer age 40 and above. CART also served a relatively high percentage of transition-aged youth. It is unclear if these programs have targeted such youth in some way, or if this may be an artifact of the fact that PCS and CART had the largest proportion of individuals accessing the services via law enforcement, and individuals in these age ranges are the most likely to have some sort of police contact (Eith & Durose, 2011). These data suggest that crisis models considered should take into account the needs of youth, as more than 1 in 5 individuals currently receiving crisis services through PCS are under 18.

Race: The proportion of African Americans served in the systems is notable, especially in PCS (nearly 60%), as census figures indicate that African Americans comprise 27% of the population in Milwaukee County. These data indicate that cultural competency should be a key consideration in the choosing of crisis service options.

Substance use disorders: Ascension appeared to be serving more individuals with some sort of substance use disorder, with nearly 60% of individuals having this type of diagnosis, roughly 2-3 times the amount seen in the other programs and health systems. It is not clear if this is related to the characteristics of the Ascension system or possibly to the way in which the data were collected and drawn from data systems. If not a data-related anomaly, this might suggest Ascension as a natural fit for any crisis service models more attuned to co-occurring or substance use disorders.

Disposition: Finally, and perhaps most notably, a very large proportion of emergency service admissions, and even those at PCS, do not result in an admission

to inpatient behavioral health services. While desirable with respect to avoiding unnecessary hospitalization, this also suggests there is potential to divert greater numbers of individuals from emergency departments via more extensive use of “front end” crisis stabilization services such as walk-in crisis centers and respite programs. These functions will be addressed in the next phase of the redesign planning process.

What We Heard from Milwaukee County Stakeholders

Milwaukee County and its taxpayers have made significant investment in the delivery of psychiatric crisis services, inpatient psychiatric hospital treatment, law enforcement crisis intervention training, and a number of other service components described throughout this report. BHD staff described a number of these improvements, especially in the last year and a half, and particularly with regard to providing greater care through mobile teams in the community and less in hospitals.

The number of community mobile teams has increased, and there has been increased focus on follow-up contacts and connecting people to community-based services. Some other areas of recent enhancement include the previously noted partnership with IMPACT 2-1-1, which is now answering the crisis line. Also, changes have been made to make it easier to refer to Crisis Stabilization Houses, and direct admissions to Crisis Resource Centers have been added.

However, a common and recurring theme voiced by the wide range of stakeholders we interviewed is that elements of the crisis system have functioned in discordant fashion rather than as part of a coordinated whole. This lessens the return on the County’s investment and produces avoidable costs for other providers and those in crisis.

We also heard that for many, “crisis services” connotes “involuntary treatment.” Too many crisis experiences involve law enforcement, and that has an impact on how individuals with mental health conditions view themselves, how they think others view them, and how they view the mental health system and the treatment they receive (particularly if it is compelled). Too few crisis care experiences include meaningful peer support and service delivery models and care informed by those who live with mental illness. And too much crisis work is occurring in bubbles across the community—with daily missed opportunities for communication, care continuity, and collaboration.

We conducted semi-structured interviews and focus groups to gain insight into what features of the current system are most effective and should be retained and what is lacking or less effective that might be improved. Additional key themes that emerged are summarized below.

It should be noted that this section represents the perceptions of a diverse group of stakeholders who vary in their experience and familiarity with all aspects of the crisis service system in Milwaukee County. BHD staff have offered corrections or clarifications about some statements of fact related to features of the crisis systems, which are noted in the relevant passages. The original stakeholder comments have

been retained, however, as it will be important for the redesign communication strategy to address these apparent misperceptions on the part of some members of the community. As noted in the comments from BHD staff below, many improvements have occurred only in the past year and half, and it may be that some of these improvements have yet to be recognized or experienced by some community members.

Quality of Services. Although informants cite significant shortcomings and limitations in the current system that they hope will be addressed in the redesign, they also cite great improvement in the crisis service system in recent years, which they generally attribute to positive leadership.

- **Mobile Crisis Service:** The mobile crisis teams were frequently discussed in connection with the quality of the current system. They are highly valued, but limited capacity is described as a problem that results in long wait times and poor communication. Also, there is a desire to expand the functions of mobile crisis teams. There is a perception, indicated by consumers, family members and other stakeholders, that Chapter 51 assessments are the primary activity of these teams, more so than providing treatment and crisis resolution. Some informants from the private hospitals stated that the teams come into the hospital EDs to evaluate but do not coordinate treatment or communicate with staff, which most informants attribute to lack of capacity. It is clear that the mobile crisis service should be an important focus of the redesign planning.
- PCS is generally regarded as having improved significantly in recent years, and representatives of private health systems noted the value as a training site. Some suggested there is still room for improvement, however, particularly in regard to treating patients with dignity and focusing more on crisis resolution in addition to assessing for commitment. Some felt there has been excessive concern about safety and liability, at the expense of regard for the well-being of patients. While it is not entirely clear whether these views reflect current practices or past experience, these issues of philosophy and culture are certainly important for consideration in planning the redesign.
- Crisis resource centers are also valued, including by managed care organizations (MCOs). Some identified limitations such as requirements for stable housing and health insurance to be eligible for the service. Some consumers noted that the CRCs tend to have an overly directive/bordering on coercive, provider-driven orientation (e.g., requiring medications be taken) that can be at odds with community programs' approach of person-centered care. In response, however, BHD states that there is no insurance requirement for eligibility nor is there a requirement for medications. Some consumers also expressed the view that CRCs are located in "unsafe" sections of town.
- The Access Clinic is valued and there is hope that it can at least be preserved if not expanded. Consumers and other stakeholders identified a need for walk-in

crisis services as a means of diversion, and the Access Clinic provides rapid, voluntary services in a minimally restrictive setting.

Preferred models. Informants, including consumers, widely endorsed a community-based system with a continuity of services of multiple levels of intensity, beginning with prevention and continuing through early crisis resolution; the use of respite and crisis resource centers for diversion from the ED; and, when an ED visit becomes necessary, a smooth transition afterward that includes step-down services and coordination with outpatient care. Some suggested there needs to be a redefinition of what constitutes “crisis”; too often, individuals are only viewed as being in crisis when it gets to a point that involuntary commitment is an option being considered. Not all crises involve lethality risk or psychosis; narrowing access to crisis services in this manner leaves out too many individuals who are suffering. In addition, if crisis services are delivered earlier (before symptoms are most acute), there is more flexibility in service delivery and post-crisis services and safety planning.

The wider use of crisis respite, crisis resource centers, and peer supports are seen as necessary for a system supporting this broader view. The call for increased flexibility and availability of the mobile crisis service was also identified with this orientation, as was increased accessibility by location of crisis prevention services where people live. BHD and FQHCs have been actively planning a partnership that is expected to be in place within the next six months. The partnership will be beneficial in multiple ways: FQHCs are community-based, offer better reimbursement, and are already integrated with health care. Shelters also are an important point for heading off crises and increased co-location of services and collaboration would be beneficial.

At the same time, some emphasized the complexity of needs for individuals experiencing crises, including medical comorbidity, substance use disorders, homelessness, and developmental disability, with the recommendation that this not be underestimated in the redesign. We believe, based on knowledge of model systems, that these two considerations—preventing or resolving crises early and attending to individuals in crisis with complex needs—are not incompatible, and we recommend that the planning process take into account both scenarios.

Communication and coordination. Lack of communication among health systems, crisis services, community outpatient treatment providers, and MCOs was widely cited as a longstanding and seemingly intractable problem. Representatives of MCOs identified a challenge in communicating with BHD staff mid- and post-crisis. Although this situation has improved, the MCOs feel they have a lot to offer in stabilizing an individual in crisis, but often they don’t even know when one of their members is in the ER or is receiving post-discharge case management. BHD has responded by acknowledging this shortcoming in the current system and the importance of addressing it in the redesign, noting that coordination and communication are two-way processes, and it will be important for both parties to engage in making improvements in this area.

The fragmentation of services throughout BHD and in the community was emphasized. The system was said to be an overwhelming maze to navigate even for professionals embedded within it; consumers and advocates noted that it is even more challenging for individuals and families. When asked why this situation had persisted, stakeholders had no definitive explanations; however, one stakeholder mentioned that competition among agencies for clients and funding contributes to a lack of willingness to collaborate. It is also possible, based on our observations, that the individual components of the system are so strained that there is little capacity to reach out and build relationships.

Long waiting periods in hospital emergency rooms were identified as a common quality of care issue. These waits may be due to a variety of factors, such as finding an open bed, organizing community social services when that is the need rather than hospitalization, varying emergency room expertise/specialized staffing models, and delays in response by mobile crisis teams who may be occupied with other cases. Hospital EDs have limited staffing to attend to patients while awaiting disposition. This is a common national problem, as noted in our preceding discussion of ED boarding; however, hospitals around the country have developed practices for reducing the frequency and duration. One means of improving both communication and efficiency, mentioned by a number of informants, is the increased use of telepsychiatry—for example, to provide consultation to hospital EDs.

We strongly recommend that the planning process address not only the various services that make up the system but also the mechanisms for ensuring that these services are interconnected and coordinated with other providers and community services.

Law enforcement. There was a widespread view, especially among consumers and advocates, that the functions of law enforcement, though an essential and valued adjunct to crisis services, ought to be limited to those functions that cannot be performed safely in any other way. Representative of this issue is the current legislation authorizing only law enforcement, and not hospital doctors, to determine Chapter 51 status; one informant described this practice as “archaic, iatrogenic and inefficient.” The stigmatizing nature of having law enforcement respond for psychiatric crisis was emphasized by many. Prior traumatic experiences with law enforcement can lead people to avoid reaching out to crisis services when in need—particularly when law enforcement is intertwined with crisis response. BHD staff note that making major changes in the role of law enforcement will be a large-scale, complex, and long-term policy issue. Yet they also report that much progress has been made in cooperation with law enforcement agencies, affecting how crises are addressed and relations with crisis service providers, as evidenced by the expansion of CART and CIT.

There is a view that while the understanding of mental health issues and crises have improved in recent years, there is still room for progress. For example, consumer focus group members reported that the default response to veterans experiencing crisis is often to dispatch a SWAT team because of concerns of the possible threat an individual may pose to police because of his or her military training. Informants

suggested there is a need for more de-escalation training, and one informant indicated that the way CIT training is provided lacks fidelity to the evidence-based model.

National Models for Consideration



With a basic understanding of the characteristics of those accessing psychiatric crisis services in Milwaukee County and where they are accessing those services—as well as a basic grasp of the various services offered in the county and how those compare to national norms—we now turn to consideration of system enhancements and improvements. In this section, we offer examples of national best practices in the different psychiatric crisis service areas.

Examples of Best Practice: System Components

The following are descriptions of best practices for some services to be combined in a seamless continuum of psychiatric crisis care.

emPATH

Dr. Scott Zeller, whom we interviewed for this project, has designed a model for psychiatric crisis facilities known as emPATH (emergency Psychiatric Assessment, Treatment & Healing). While still connected to or in proximity of hospital emergency departments, the most recent replications of this model are smaller and less restrictive; they provide an open, comfortable, shared treatment space; help-yourself access to food and beverages; and blankets and restful spaces. They use intuitive care models—with staff following the patient’s lead in terms of what the patient needs throughout their stay—that are focused on engagement and delivery of crisis

treatment. Peer specialists are embedded in the program and deliver supportive interventions.

Dr. Zeller describes programs that have virtually eliminated the use of restraints and greatly reduced the need for inpatient hospitalization—particularly on an involuntary basis. He cautions that the programs must have minimal “exceptions” with regard to whom they will treat (have high tolerance for some medical symptomatology, individuals brought by police, individuals on involuntary holds) while providing care that is trauma-informed and person-centered.

The following is a description of a new emPATH program that opened in April 2018 in Billings, Montana:

Using the Alameda Model, also referred to as an emPATH (emergency Psychiatric Assessment, Treatment & Healing) Unit, psychiatric patients once medically cleared are directed to a dedicated space with specially trained providers, away from the noise, hectic activity, flashing lights, and other norms of a traditional emergency care setting. Like many other medical emergencies, psychiatric emergencies can often be resolved in less than 24 hours when prompt, skilled care is available. Compared to emergency departments, the emPATH setting is calmer, more home-like, and offers a supportive environment for patients in psychiatric crisis. This setting decreases patient agitation and reduces the need for coercive measures (like restraints). In the large, comfortable central room are recliners and stations where patients can access snacks and beverages. There are opportunities to read, watch TV, play board games, or visit privately with a therapist or counselor. The design is safer for patients and more cost effective than building a separate emergency room. (Helmsley Charitable Trust)

The emPATH model involves a general shift in organizational and system culture, a redefinition that the primary intent of each and every crisis service—from the first call to the crisis line to a course of inpatient treatment—is resolution rather than problem identification and referral. As opposed to completing screening tools or a series of assessments, the focus instead is on the delivery of relieving interventions (not limited to medication) that reduce or ease the sense of crisis and the discomforting symptoms; reduce actual risks of harm; are change-promoting; activate coping skills and problem solving; offer support and information to caregivers; and lead to collaborative development of person-specific care strategies.

The “Living Room” Model

The Living Room model was first developed by Recovery Innovations (now Recovery International). The organization has now established 10 Living Room programs in five states and has influenced the practice of many other programs that have sent teams to train at Recovery International’s Arizona headquarters. Living Room programs use a recovery model to support stabilization and return to active participation in the community. Individuals in crisis are admitted as “guests” into a pleasant, home-like environment designed to promote a sense of safety and privacy.

The programs employ teams consisting of doctors, nursing staff, and peers with lived experience to engage with the guest. Risk assessment and management, treatment planning, and discharge goals are set, and a peer counselor is assigned to the guest to discuss crisis and coping skills that can be used to reduce distress and empower the individual. In some communities, “living rooms”/crisis respite facilities are available for direct drop-off by trained law enforcement teams. The programs make every effort to eliminate seclusion and restraint and to serve all people regardless of level of acuity without resorting to physical interventions.

Walk-In Centers: Colorado

Six previously established mental health care organizations operate a network of seven walk-in centers in Colorado. Anyone can be treated at the walk-in clinics, which are open around the clock. Many of those using the service are directed to them by crisis hotline operators or a mobile crisis team. The center’s professional staff work with patients to determine a personalized treatment plan and connect them with outpatient services. Patients may remain in the center for up to 24 hours.

Community Crisis Response Teams: Netcare (Columbus, Ohio)

Netcare’s Community Crisis Response provides immediate, on-the-scene response to traumatic events. These teams work with the Red Cross, police, and fire departments to assist citizens in the community who are impacted by traumatic events such as homicides, suicides, unexpected deaths, motor vehicle accidents, fires, and other events where significant physical trauma or death is involved.

Community Mental Health Clinic Outreach Team

Boudreaux, Crapanzano et al. (2016) describe a component of a service system that combines a Mental Health Emergency Room Extension (MHERE) with a community mental health outreach team. The MHERE is a psychiatric observation unit and annex of the ED, located in a building adjacent to the ED that holds patients who were having a psychiatric emergency after they receive medical clearance and triage services. The community mental health clinic provides an outreach team that comes to the ED, Monday through Friday, to meet with patients who are being referred to their agency for follow up to discuss their needs and to educate them about the available services at the outpatient clinic. The team also obtains contact information and assists with obtaining transportation to the clinic. After discharge, team members make phone contact to remind the client of the appointment.

Transportation

The Carolinas HealthCare System, one of the largest freestanding psychiatric emergency departments in the country, was prompted to explore transportation options other than law enforcement because of the increasing number of patients presenting in crisis and the desire to decrease the number who are involuntarily committed. They contracted with a company that uses unmarked vehicles with drivers wearing non-police-type uniforms. They allow the patient to choose the music that is

played in the vehicle, and they do not use any type of restraints (Rachal, Sparks et al., 2017).

Southern Arizona uses non-ambulance transportation services often staffed by peer specialists who are dispatched by a centralized crisis line (also responsible for dispatching mobile crisis teams).

Minnesota has developed various alternatives to police and ambulance transportation. Allina Health, which owns Abbott Northwestern and 11 other hospitals statewide, keeps an unmarked Ford Escape among its fleet of ambulances at its emergency medical base, which community paramedics use for visiting recently discharged patients or transporting them to outpatient follow-up appointments. Yellow Medicine County Sheriff's Department in southwest Minnesota uses an unmarked Chevrolet Malibu to transport psychiatric patients from the hospital emergency room to mental-health facilities across the region.

The main obstacle to alternative forms of transportation is that insurance companies and government-funded programs such as Medicaid reimburse people for ambulance trips but not for private security guard transports. As of 2014, the Minnesota Legislature had taken steps to address the problem by creating a special class of nonemergency transports under state law, and advocacy groups were asking the legislature to include nonemergency transport as a reimbursable expense under Medicaid (Serres, 2014).

Telepsychiatry

Technological solutions to improve the efficiency and quality of care are receiving increasing emphasis. The American Psychiatric Association has recently published a book on the subject. The book is a comprehensive guide for psychiatrists, psychologists, and other mental health clinicians to use for care delivered in whole or in part by technological devices and applications (Yellowlees & Shore, 2018).

The Carolinas HealthCare System, mentioned above, sees around 1,000 patients per month across 21 EDs; it has made telepsychiatry a central element in its operations (Rachal, Sparks et al., 2017). The process for telepsychiatry begins with an initial interview by licensed clinical staff (licensed professional counselor, licensed clinical social worker, or a registered nurse [RN]), similar to the initial evaluation completed by RNs in the psychiatric emergency service. The psychiatrist then reviews this information and contacts the medical ED to set up the virtual evaluation, where the patient is interviewed over secure, HIPAA-compliant video and audio lines. The assessment is documented, and recommendations for further treatment are provided to the medical ED physician. An automatic alert notifies the medical ED when the consultation is complete and the assessment and recommendations are in the chart for their review.

If a patient requires inpatient treatment but cannot immediately be admitted—an unfortunate but common occurrence—the patient is boarded until a psychiatric bed becomes available. While held in the ED, patients are started on medications right away for their psychiatric treatment. The consulting psychiatrist places these

medication orders after evaluating the patient. Patients are visited by a member of the licensed clinical team daily, and the psychiatrist or psychiatric nurse practitioner rounds on patients at least every 48 hours. Whereas nearly every patient was admitted prior to implementation of this system, now 35% to 40% are discharged.

Respite Care: Colorado

Colorado's system has extensive capacity for respite care. The walk-in centers and Crisis Stabilization Units have the option of referring clients to respite care services, which provide therapy management, medication management, and inpatient mental health treatment for up to 14 days. Separate respite services exist for adults and children/adolescents. Adult respite services connect patients to designated beds in the community, where they can remain for up to 14 days. Respite care locations offer counseling and medication management as well as support for families and caregivers. Children can stay in respite care for two consecutive nights on the weekend, and for several additional hours during the week. Child-specific respite services specialize in supporting the family in its efforts to care for the child and in developing a multi-generational, in-home treatment plan.

Volunteers are recruited and trained by Colorado Crisis Services to provide respite care. Respite vouchers provide funds for respite care to family caregivers across the state of Colorado, serving all ages and special health care needs. This program offers a resource for unserved and underserved family caregivers who have limited access to respite care and/or other supports through current systems. The program is intended to act as a payer of last resort. Vouchers are for services by approved providers, and families may receive up to \$2,000 a year. The system is supported by a coalition of numerous provider organizations and advocacy groups.

Virtual Care Coordination

The Carolinas HealthCare System has implemented a “virtual care coordination model” that uses audio-video technology to provide remote assistance to patients in medical EDs over a large geographic area in order to get appropriate outpatient care. The virtual care coordinators perform the same functions as an on-site coordinator, such as setting up follow-up appointments and ensuring they are able to get medications to last until the next appointment to prevent another emergent visit just for refills. They also are able to assist with issues related to social determinants that pose barriers to the patient staying well (Rachal, Sparks et al., 2017).

Resource Directories: Colorado

Rocky Mountain Crisis Partners in Colorado maintains an online resource directory that includes over 5,000 different providers, assistance programs, and support resources throughout the community. The platform uses Google translation capabilities for non-English speaking users, allows for search by provider, type of problem or illness and location, and utilizes an automatic update system to ensure the correct contact information.

Enhancement of Psychiatric Crisis Treatment in Medical EDs

As an alternative to transferring persons in psychiatric crisis to a specialty service, medical EDs may increase capacity to treat some subset on site (Zun, 2016). This requires enhancing the competency of medical ED staff to assess, manage, and treat patients presenting with psychiatric symptoms, such as agitation. To promote this enhancement of medical EDs, the American Society of Emergency Physicians has developed a consensus statement on the management of agitation that includes recommendations for the use of various mechanisms for enhancing capacity for EDs, including the use of psychiatric triage scales, a psychiatric medical clearance checklist, suicide and homicide risk assessment, and protocols for psychopharmacological treatment (Wilson, Currier et al., 2012).

Next Steps for Milwaukee County



In this section, we identify best practice strategies that stakeholders in Milwaukee County should consider. We also outline a decision framework highlighted by three potential models. These concluding observations are based on feedback from key informants, our analysis of utilization data, and our review of national models and exemplary practices.

What “best practice” strategies do we lack that we should consider?

Milwaukee County has a reasonable number of crisis system parts—and this will continue to be the case once key decisions are made about repurposing existing resources in a redesigned system. However, the county system is missing sufficient structures to tie all of the core crisis parts together into a functional whole. In addition, there is significant opportunity to assess and strengthen services that address other phases of the crisis continuum. Strategies to consider:

- Develop an overarching structure for managing the crisis system of care that is either managed by the county or procured. A centralized call system can be a key part, but additional elements are required to maintain appropriate oversight of a crisis system; assure daily function; assure service continuity for each person in crisis; formalize partnerships, processes, and collaborations; perform cross-sector outcomes evaluation; and promote continuous

improvement. The development of a crisis system of care is never complete; it requires continual attention, evaluation, refinement, and advancement.

- Develop a crisis system of care plan that addresses the mental health and related public safety needs of the whole community. Addressing the regulatory responsibilities of BHD and the service components that are funded by BHD are a key part but should not constitute all of the plan.
- Seek a high level of transparency across the crisis system of care. Real-time data is the most important data for a crisis system. With high-quality data, all players' decisions are better informed, performance is better honed, and interpretation of outcomes is more accurate throughout the entire system of care.
- Involve individuals with lived experience (including parents of children who have used crisis services) as consultants in the crisis system redesign. This would build on the involvement of peers in the BHD Crisis Executive Team and redesign planning over the past 11 years.
- Invest in peer-delivered services and peer-infused treatment teams.
- Proceed with implementation of the Zero Suicide model, which is currently in process. Zero Suicide is an approach developed by the National Action Alliance to Prevent Suicide that embeds suicide prevention into the standard practices and culture of behavioral health systems.
- Implement the No Force First model, which consists of a set of practice and cultural changes, in this case aiming to reduce the use of coercive measures.
- Develop a working consensus document that explains the crisis system, its philosophy, and its operations. This document becomes a transparent go-to resource for all sectors. This should be a focus of the next phase of the redesign planning process.

A Path Forward

Based on our understanding of Milwaukee County's health and behavioral health needs and assets, the utilization patterns of the current psychiatric crisis service system, the characteristics of the community, and consideration of modern principles and national best practice models, we have identified three general adult crisis system models for Milwaukee County to consider. It is important to note that we have not yet addressed issues of cost and have not completed a fiscal analysis of the three models.

We suggest that this consideration be made with the following questions in mind:

- What is the intended purpose of the future crisis system of care?
- How could the system, as a whole, best be organized?
- What are its core programmatic components?

- What is it expected to deliver?
- What are the principles by which it will operate?
- What cross-cutting core competencies are necessary to achieve delivery objectives?
- And, critically, how should the system be experienced by the adults, children and their families who use it?

The three models are as follows:

1. A centralized system organized around a single large psychiatric emergency services program.
2. A decentralized system, with multiple sites providing a diverse array of crisis services, including some capacity for receiving individuals on petitions.
3. A dispersed system with county investments largely in non-emergency department settings with an intention of shifting the bulk of crisis episodes out of the ED. In this model, private health system emergency departments would focus their attention on a smaller group of individuals with more complex healthcare needs who essentially need to be served at this level of care.

These three models are described in Figure 5, with a starter set of pros and cons to consider for each model.

It should be noted that this typology actually represents a continuum with some flexibility in the boundaries of each. That is, depending on the relative allocations to different components of the system and the ways in which these components are coordinated, elements of two or all three models could be incorporated in a final redesign strategy.

That said, we recommend moving as far toward a decentralized and multi-faceted crisis system of care model as is reasonably feasible and sustainable. This kind of model would necessarily alter the utilization patterns that characterize the current system. While that would be disruptive, it is also most likely to improve patients' experience of care.

Figure 5

Potential Adult Psychiatric Crisis Models for Consideration by Milwaukee County

<p>Model 1 Single centralized magnet psychiatric emergency department</p>	<p>Model 2 Decentralized crisis walk-in/drop-off system (multiple sites around the county)</p>	<p>Model 3 Enhance competency/capacity of existing emergency departments combined with an expansion of early intervention and post-crisis recovery/reintegration services</p>
<p>Select a single large site that serves as a psychiatric ER for the county and has arrangements with hospital emergency departments to receive individuals who have been medically stabilized. The psychiatric ER may or may not be hospital-adjacent and may either be operated/staffed by a private health system or by BHD.</p> <p>Provides:</p> <ul style="list-style-type: none"> • Large receiving facility for individuals on petitions • Voluntary crisis treatment services • Crisis treatment services (not limited to assessment) • Peer support services • Treatment and support services linkage 	<p>Establish an array of smaller sites strategically located in the community offering crisis walk-in services. This could be accomplished by repurposing some or all of the existing crisis system components.</p> <p>Could be a mix of distributed sites, some providing voluntary services only, others accepting involuntary admissions.</p> <p>Sites could be adjacent to or affiliated with other types of facilities such as shelters or FQHCs.</p>	<p>Enhance competency/capacity of existing private hospital emergency departments to better serve individuals in crisis. The number of such individuals would shrink via investment in:</p> <ul style="list-style-type: none"> • Expanded crisis prevention and early intervention capacity (urgent cares, open access treatment sites, effective crisis planning, harm reduction models); • Less restrictive acute crisis intervention and treatment services (mobile crisis, brief crisis stabilization/detox beds); • Post-crisis capacity (e.g., back door coordination of services from EDs, inpatient units, crisis beds, bridge services, peer support and engagement, brief intensive 30-60 day service programs to divert from high-intensity services).
<p>PROs:</p> <p>Single centralized site</p> <ul style="list-style-type: none"> • Simple decision making for system, law enforcement, hospitals • Some logistic simplicity—smaller number of sites to coordinate/manage • There may be a financial advantage if adjacent to a general hospital emergency department • Close proximity to a general hospital emergency room may permit inclusion of individuals with more complex health needs 	<p>PROs:</p> <ul style="list-style-type: none"> • A balanced system that provides some of the benefits of each of the two alternative models with an array of sites offering various levels of service intensity • Individual sites embedded in the community, attuned to neighborhood needs and characteristics, more culturally competent • Flexible—allowing for adjustment to meet changing or unanticipated needs by changing mission or expanding/shrinking components • Brings more treatment providers and system stakeholders under the crisis continuum umbrella—opportunity to have more competent providers 	<p>PROs:</p> <ul style="list-style-type: none"> • Broadest approach—investing in all phases of the crisis system of care framework rather than primarily focused on acute crisis response • Less restrictive: Primarily focused on engagement in voluntary services • Improved broad, systemic competency in crisis prevention and early intervention—reducing need for acute intervention, hospitalization, petition initiation • Improved broad, systemic competency in post-crisis support, reintegration • Brings broad group of treatment providers and system stakeholders under the crisis continuum umbrella—opportunity to have many more competent providers

Model 1 Single centralized magnet psychiatric emergency department	Model 2 Decentralized crisis walk-in/drop-off system (multiple sites around the county)	Model 3 Enhance competency/capacity of existing emergency departments combined with an expansion of early intervention and post-crisis recovery/reintegration services
<p>CONS:</p> <p>Single centralized site</p> <ul style="list-style-type: none"> • Limits choice for individuals • Location may be a deterrent or barrier to service and family participation • If ED-adjacent, may reduce flexibility in service model • Longer transport from EDs, longer transport for MPD coming from all parts of the city • Have to work hard to minimize use of coercion (petitions, restraints, restrictions, security...) • May be viewed as panacea, limiting efforts to implement more challenging system culture changes • Over time may become overused and a place where people get stuck • More difficult to provide culturally informed and linguistically competent care for diverse community • Preserves an approach where there is a small pool of providers/clinicians with crisis expertise • Might require substantial capital investment in a new site if not contained within an existing facility 	<p>CONS:</p> <ul style="list-style-type: none"> • More complex to implement and manage • Requires greater system logistics • Not ED-adjacent so there may be more limits as to who can be seen in these sites due to co-occurring medical conditions • Might entail siting challenges and/or greater capital investment in multiple sites 	<p>CONS:</p> <ul style="list-style-type: none"> • It is the most complex to implement and manage • Requires well developed logistical processes • Requires greater transparency across the system • Requires maximum buy-in by diverse and cross-sector set of systems/organizations
<p>Comparison to this model: Unity Center in Portland, OR Unity Center in Portland is an example of an emPATH program (described previously) that provides a hospital ER-adjacent centralized psychiatric receiving facility for the city. It is a collaboration between four health care systems. Other hospitals can medically clear individuals and transport to Unity Center for comprehensive assessment and treatment. In addition, Unity</p>	<p>Comparison to this model: Massachusetts example Massachusetts has developed a state-wide system of 17 emergency services programs (ESPs), each of which has a walk-in crisis site along with crisis line services, mobile crisis teams for children and adults, and co-located crisis stabilization beds. The vast majority of ESP sites are not emergency department-adjacent. All private nonprofit service providers. Crisis system procurement/oversight by an MCO</p>	<p>Comparison to this model: Southern Arizona example Southern Arizona has very low use of emergency departments and inpatient psychiatric treatment. The region has made very high investments in smaller, primarily voluntary, community-based walk-in sites, some of which provide detox services. There is a high expectation for peer embedded models. The system is tied together by a sophisticated regional call and dispatch center that is affiliated and works closely</p>

Model 1 Single centralized magnet psychiatric emergency department	Model 2 Decentralized crisis walk-in/drop-off system (multiple sites around the county)	Model 3 Enhance competency/capacity of existing emergency departments combined with an expansion of early intervention and post-crisis recovery/reintegration services
Center is a police drop-off site for individuals on petitions.	that coordinates with the other MCOs on provision of crisis services. ESP teams employ adult peer and parent peer support specialists.	with the regional behavioral health authority (RHBA). The call center dispatches crisis teams and transportation resources, authorizes and activates follow-up services, reconnects with service users to assure continuity, uses real-time dashboards and GPS tracking systems for mobile teams, and uses advanced data analytics. Arizona has achieved high participation in county-specific crisis system of care collaboratives and developed mutual care protocols.
	<p>Franklin County, Ohio example (Columbus and vicinity). Franklin County operates a county-level crisis system (Netcare) consisting of two community-based walk-in crisis agencies, each with 23-hr observation beds. The walk-in sites are receiving facilities for individuals on petition; they coordinate admission to state hospital beds when unavoidable. In addition, crisis stabilization unit is adjacent to one of the walk-in sites and there is a freestanding sub-acute, brief crisis respite program. The County recently added a brief bed-based program as a pathway to permanent supported housing. Netcare also provides a mobile petition pre-screening service. There is high coordination transparency across the network of private hospital emergency department and inpatient units, Netcare, the county, and the state hospital to maximize the flow of individuals throughout an episode of care; and a well-evolved collaboration with criminal justice/law enforcement.</p>	

Appendix A: Key Informant Interview Guide

1. What is your role/relation to the crisis services?
2. How are people currently accessing crisis services and where are they located? How often is law enforcement involved?
3. What are the characteristics of individuals who may need psychiatric inpatient care?
4. Why are people presenting for crisis services? What happens during crisis services?
5. How are people experiencing crisis services? How about family members?
6. What role do peers have in the crisis response system now? What role do you think peers should have in the crisis response system?
7. What have been the major strengths of the existing crisis service system? Major limitations?
8. What features of the existing crisis service system do you think are important to retain?
9. What features could or should be dispensed with?
10. What opportunities do you see for the redesign to improve the crisis services?
11. Do you know of models in other communities that you think would work well in Milwaukee County?
12. What services are most important to help avoid the need for crisis services? What is the provider capacity to address emerging crisis issues? What is the capacity after hours or on weekends?
13. What services are available post crisis now? What are most important to have available?
14. Which of the following crisis-related services do you think are most important?
 - Psychiatric ER Services
 - 24-Hour Crisis Telephone Lines (including Warm Lines)
 - Walk-In Crisis Services
 - Mobile Crisis Services
 - Respite programs
 - Individual crisis services
 - Crisis Stabilization Units
15. What will be the major challenges in the design?
16. Are there other issues that are important to consider in the redesign that we did not touch on today that you think are important related to redesigned crisis services?

Appendix B: Crisis Service Information Sheets

Crisis System Element: Crisis Line

If section is N/A for this element, leave blank

Service Description: The Crisis Line (257-7222) is the community access line for adult crisis services in Milwaukee County. Individuals and family members who are experiencing a mental health or co-occurring crisis can speak with someone directly to obtain crisis response and resources. In May 2017, Impact/211, a community agency, began answering the first line of calls on the Crisis Line. Impact/211 is a call center that specializes in taking crisis, shelter, resources, and general information calls. Impact/211 handles all calls for resources and triages crisis calls to a clinician on the Crisis Mobile Team for immediate response.

FUTURE VISION: The partnership with Impact/211 will allow the Crisis Mobile Team clinicians to respond to calls in the community and reduce staffing on the Crisis Line. The partnership will lead to all calls being answered, additional community contacts, and allow clinicians to be in the community doing clinical work.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
Operator of Service and Service location(s)	Impact/211	
Hours of Operation	24 hours per day and 365 days per year	
Current Service Volume	All calls on the Crisis Line	Added efficiencies to allow additional face-to-face contacts in the community
Current Service FTEs	Contracted Agency Staff	
Target Population	Adults and caregivers/loved ones of people experiencing a mental health crisis	
Referral Source	Self-referral	
Expected Future Volume		
Funding Source(s)	County Tax Levy	
Funding model (FFS, Block, Case rate, etc)	County Tax Levy-Purchase of Service Contract	
Peer Involvement	No peers currently	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> physical plant modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required programmatic modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required Competencies 		
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES

• NIMBY issues?		
• Acceptance of Emergency Petitions?		
• Exceptions to services at this level of care		
• Consider co-location of mobile crisis teams to these sites		

Crisis System Element: Crisis Mobile Team

If section is N/A for this element, leave blank

Service Description: The Crisis Mobile Team (CMT) master’s level clinicians and nurses who provide community-based crisis services to individuals 18 years of age and older. CMT provides crisis response, assessment, linkage to services, and follow-up support to people throughout Milwaukee County. Responses are individualized to meet the person’s unique needs and in the setting most convenient to the individual (home, work, school, etc.) Coverage is provided first and second shift by Milwaukee County employees; third shift is covered by a contracted partner, La Causa, Inc.

FUTURE VISION: Focus on increasing community-based contacts to stabilize people in the community and reduce emergency detentions. Increase proactive follow-up to ensure people’s needs are being met post crisis.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
Operator of Service and Service location(s)	Milwaukee County BHD	
Hours of Operation	24 hours per day, 365 days per year	
Current Service Volume and number of teams (if applicable)	2,332 (2017) First shift=2-3 teams 2 nd shift and weekends=1-2 teams 3 rd shift=1 team	
Current Service FTEs	20	6 Nurses, 12 Clinicians, and 2 Psychologists
Target Population	Adults with mental health and co-occurring needs	
Referral Source	Community	Anyone needing crisis mental health services
Expected Future Volume	3,200 in 2018	Over 1,500 contacts through June 2018 and projecting 3,500 contacts in 2019
Funding Source(s)	Medicaid and County Tax Levy	
Funding model (FFS, Block, Case rate, etc)	Medicaid FFS and County Tax Levy	Working toward developing insurance contracts with HMOs
Peer Involvement	No peer specialists currently	In the planning process of adding peer specialists in 2019 to CMT like other areas of Crisis Services. CMT connects people to peer specialist programs including CLASP.
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		

CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> NIMBY issues? 		
<ul style="list-style-type: none"> Acceptance of Emergency Petitions? 		
<ul style="list-style-type: none"> Exceptions to services at this level of care 		
<ul style="list-style-type: none"> Consider co-location of mobile crisis teams to these sites 		

Crisis System Element: Crisis Assessment and Response Team

If section is N/A for this element, leave blank

Service Description: CART is a co-responder program of teams composed of a master’s level clinician and a law enforcement officer. The law enforcement officer is CIT trained and goes through extensive training with Milwaukee County Crisis Services. CART responds to mental health calls that are dispatched through the law enforcement agency, the Crisis Mobile Team, or proactive response by the officer through law enforcement’s CAD system. Calls for service are for individuals with significant mental health or co-occurring needs that require a mental health and law enforcement response. CART clinicians provide the immediate stabilization, linkage to services, and follow up with the people served. Currently, there are five teams with three teams dedicated serving the City of Milwaukee, one team serving West Allis, and one team serving all of Milwaukee County.

FUTURE VISION: Continued focus on increasing utilization, increasing awareness and consultation with law enforcement officers, and further expanding on the success of the program. Data has shown that a CART response results in people being stabilized in the community and connecting with VOLUNTARY treatment options. A sixth team is currently in the process of being developed in collaboration with the Milwaukee County Sheriff’s Department.

Future state would have CART in the community responding to as many calls for service as possible to prevent emergency detention. The CART Clinician would provide a warm hand off to a Care Coordinator to develop a crisis plan, plan of care, and coordinate services for the individual. In addition, future state would have law enforcement dispatch contact CART or the Crisis Mobile Team for mental health calls.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
Operator of Service and Service location(s)	Milwaukee County BHD and Law Enforcement Agencies (Milwaukee Police Department, West Allis Police Department, and District Attorney Investigator’s office)	
Hours of Operation	MPD: 7 days per week 11-7, 1-9, or 2-10 (weekend coverage 11-7) West Allis: Monday-Friday 11-7 County Wide CART: Monday-Friday 9-5	
Current Service Volume and number of teams (if applicable)	502 (2017)	
Current Service FTEs	5 Clinicians 5 Law Enforcement Officers	
Target Population	Adults in mental health crisis requiring law enforcement intervention	
Referral Source	Crisis Mobile Team and Law Enforcement Dispatch	

Expected Future Volume	1,200 in 2018	590 people served through June 2018 (more people were served in 6 months of 2018 compared to all of 2017). Projecting over 1,500 face-to-face contacts in 2019.
Funding Source(s)	Medicaid, Grant Funding, County Tax Levy	
Funding model (FFS, Block, Case rate, etc)	Medicaid Fee for Service, Grant Funding, County Tax Levy	
Peer Involvement	No peer specialists Currently	CART Clinicians connect people to peer specialist programs including CLASP
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> physical plant modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required programmatic modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required Competencies 		

Crisis System Element: The Access Clinics

If section is N/A for this element, leave blank

FUTURE VISION: *A Short-Term Stabilization Clinic that provides comp. assessment, brief term recovery planning, care coordination, peer services, psychotherapy, prescriber services, assertive outreach and follow up, and referral and linkage to needed services. The Access Clinics (2) will be located at a North and South location, will be integrated with two partner Federally Qualified Health Centers, and will focus on service to individuals who have had recent psychiatric emergencies (PCS/Obs admission, Crisis Mobile contacts, IP Hospitalization). The expectation will be that clients will be served for a short term, approximately 2-6 months of time. Service intensity would vary based on client need, but clients open to care would be seen at least weekly by LCSW/LPC, care coordinators and peers (all three staff weekly); in addition, clients will see prescribers bi-weekly for the first month or two, then as needed.*

The Program will have the ability to divert willing clients from higher levels of care; however, the exact impact is difficult to determine.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
<ul style="list-style-type: none"> Operator of Service and Service location(s) 	BHD; current plans call for one clinic on the North Side of Milwaukee and one on the South Side; both clinics are planned to be collocated (then integrated with two Federally Qualified Health Centers)	
<ul style="list-style-type: none"> Hours of Operation 	Hours will be consistent with the current FQHC clinic hours.	
<ul style="list-style-type: none"> Current Service Volume 	YTD 2018 is showing: 50 walk-ins per month (visits with BHESC) 126 prescriber sessions per month (initial and med check) Access staff provide approximately 30 "outreach phone calls" per week "Teams" is not an appropriate term per current clinic design. See staffing below.	
<ul style="list-style-type: none"> Current Service FTEs 	1.0 Director 2.0 FTE BHESC 1.0 RN 1.56 FTE Prescriber (1.0 APNP; .56 MD) 1.0 Receptionist	

• Target Population	Adults, 18+. Clients will be assessed and then referred to the right service per need and desire.	
• Referral Source	Walk-ins, Crisis Mobile Team, PCS/OBS, Crisis Case Management (Care Coordination Team), CARS Intake Team	
• Expected Future Volume	The Access Clinics are planned to include 1.0 Director 5.0 FTE BHESC 2.0 MD/APNP 2.0 peers 2.0 BA Level Care Coordinator The two clinics should be able to serve approximately 3,000 clients per year	
• Funding Source(s)	Medicaid, Medicare, Private Insurance, County Levy; working to partner with FQHC and get PPS rate for clients with Medicaid	
• Funding model (FFS, Block, Case rate, etc)	Fee for Service	
• Peer Involvement	No peers currently; future plan calls for use of peers to complete Health Navigation, Outreach, and Care Coordination	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
• NIMBY issues?		

<ul style="list-style-type: none"> • Acceptance of Emergency Petitions? 		<p>BHD Team and FQHC partners discussed that at this time they would not be including voluntary clients who would be dropped off by law enforcement.</p>
<ul style="list-style-type: none"> • Exceptions to services at this level of care 		
<ul style="list-style-type: none"> • Consider co-location of mobile crisis teams to these sites 		<p>Crisis Mobile, Crisis Stabilization Clinic (Access) and FQHC services will be co-located.</p>

Crisis System Element: Crisis Stabilization Houses (CSH)

If section is N/A for this element, leave blank

Service Description: Crisis Stabilization Houses are two licensed Community Based Residential Facilities comprised of 16 beds serving people with significant mental health needs for up to six months (there are short-term beds with stays of around 14 days and long-term beds with stays up to 6 months). CSH is operated by a community-based partner in collaboration with the Crisis Mobile Team. CSH provides a caring, supportive, and therapeutic environment to assist people to stabilize and meet their individualized needs. Clinicians and nurses from the Crisis Mobile Team have daily strengths-based interactions with each person to ensure their mental health and physical needs are being met in a strengths-based, trauma-informed, and person-centered manner. Clinicians and nurses coordinate each individual’s care, provide short-term crisis therapy (motivational interviewing), facilitate team meetings with the persons care team (both formal and informal supports), and collaborate with house staff.

FUTURE VISION: Continued focus on ensuring beds are being utilized and people’s needs are being met prior to discharge.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
<ul style="list-style-type: none"> Operator of Service and Service location(s) 	Bell Therapy (CBRF) Crisis Mobile Team (clinical and nursing services)	
<ul style="list-style-type: none"> Hours of Operation 		
<ul style="list-style-type: none"> Current Service Volume and number of teams (if applicable) 	16 beds	In 2017, 8 CSH beds were converted to Crisis Resource Center (CRC) beds to meet the needs of the community.
<ul style="list-style-type: none"> Current Service FTEs 	2 locations <ul style="list-style-type: none"> Contracted Vendor Operates CSH and provides house staff Milwaukee County provides clinicians and nurses from the Crisis Mobile Team 	
<ul style="list-style-type: none"> Occupancy Rate 	16	
<ul style="list-style-type: none"> Target Population 	Adults with mental health and co-occurring needs. Either hospital step down or crisis placements	
<ul style="list-style-type: none"> Referral Source 	Hospitals, crisis teams, community partners (case management agencies).	
<ul style="list-style-type: none"> Expected Future Volume 	16 beds	
<ul style="list-style-type: none"> Funding Source(s) 	Medicaid and County Tax Levy	
<ul style="list-style-type: none"> Funding model (FFS, Block, Case rate, etc.) 	Medicaid Fee for Service, Medicaid Daily Per Diem, and County Tax Levy	
<ul style="list-style-type: none"> Peer Involvement 	Peer specialists provide daily services to the individuals residing	In 2018, the use of peer specialists was expanded within CSH. Peer specialists are at the houses daily.

	in CSH. This includes individual and group peer support.	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> physical plant modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required programmatic modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required Competencies 		

Crisis System Element: The Parachute House (Peer Run Respite)

If section is N/A for this element, leave blank

Service Description: The Peer Run Respite, scheduled to open in 2019, will be a short-term respite consisting of 4-5 beds for individuals with mental health needs and in the need of additional support in a safe and accepting environment. People coming to Peer Run Respite are looking to strengthen their recovery and proactively address any need they may be experiencing. Programming is self-directed and uses a strengths-based holistic approach. People are offered wellness opportunities through one-on-one or group peer support. A stay at the Peer Run Respite begins with a potential guest speaking directly with staff about what they are experiencing, their hopes and needs, and how a temporary stay would be beneficial to their recovery. Peer Run Respite programming is person-centered and recovery-focused, and activities are strictly voluntary.

FUTURE VISION: Milwaukee County’s first Peer Run Respite is set to open in 2019. BHD Crisis Services will continue partnering with the contracted agency, Our Space, to successfully implement services.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	Our Space	Location to be determined, but in the City of Milwaukee
• Hours of Operation	24 hours per day, 365 days per year	
• Current Service Volume	4-5 beds scheduled to open in 2019	Our Space was awarded the Peer Run Respite contract in 2018 through a competitive RFP process. BHD Crisis Services is working closely with Our Space to implement services in 2019.
• Current Service FTEs		
• Occupancy Rate	4-5 adults	
• Target Population	Adults with mental health and co-occurring needs	
• Referral Source	Self-Referral	
• Expected Future Volume	4-5 person capacity per day	
• Funding Source(s)	County Tax Levy	
• Funding model (FFS, Block, Case rate, etc)	County Tax Levy-Purchase of Services Contract	
• Peer Involvement	Program is completely peer run	Crisis Services has also coordinated peer specialist training, funded by BHD, to expand the number of peer specialists in Milwaukee County
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		
• Required Competencies		
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
• NIMBY issues?	Potential issues related to zoning	

• Acceptance of Emergency Petitions?	No	
• Exceptions to services at this level of care		
• Consider co-location of mobile crisis teams to these sites	No	

Crisis System Element: Crisis Resource Center (CRC)

If section is N/A for this element, leave blank

Service Description: CRC services are funded by BHD and provided by a contracted community partner: the Whole Health Clinical Group at the Milwaukee Center for Independence. CRC provides people who are experiencing a mental health crisis a safe and supportive environment to meet their individualized needs. Services are wrapped around the individual to support stabilization in a community setting through the CRC’s array of onsite supportive services including: peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, and linkage to ongoing support and services. CRC provides extensive stabilization services to prevent emergency room visits or hospitalization. The average length of stay at the CRC is 5-7 days. People are directly referred to CRC through BHD Crisis Services or community agencies, or they are self-referrals via phone or walk-in.

FUTURE VISION: Continued planning and focus on direct admissions from BHD Crisis Services including PCS, Crisis Mobile Team, CART, and Team Connect.

Future state, CRC would directly admit individuals being served through crisis services to divert people from ERs and hospitals. Utilizing CRC as a step down from hospitalization is reducing the capacity for crisis admissions (pre ER and hospital). Prioritizing CRC beds for Crisis Services, reducing barriers to direct admissions, and CMT controlling CRC admissions and discharges is essential to Crisis Redesign efforts. HMOs currently have contracts with CRC which is reducing crisis services capacity. CRCs in future state could act as service hubs where people can walk in for services. ****Getting to a system where the Crisis Mobile Team/Crisis Services controls admissions and discharges is an essential part of redesign efforts.****

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	Whole Health Clinical Group at the Milwaukee Center for Independence	
• Hours of Operation	24 hours per day and 365 days per year	
• Current Service Volume and number of teams (if applicable)	27 beds	Expanded to 27 beds in 2017 with 8 Crisis Stabilization House beds being converted to CRC beds to meet needs of the community.
• Current Service FTEs	Contracted Service	
• Target Population	Adults experiencing a mental health and co-occurring crisis	
• Referral Source	BHD crisis services, self-referral, HMO	
• Expected Future Volume	27 beds	
• Funding Source(s)	Medicaid, HMO Contracting, County Tax Levy	Provider Agency has contracts with various HMOs. Any future expansion would be through insurance contracts/revenue. HMO utilization is taking away from crisis services direct admission opportunities.
• Funding model (FFS, Block, Case rate, etc)	Medicaid Fee for Service, Medicaid Daily Per Diem, and Tax Levy	Future state needs to advocate for increase in Medicaid rates (rates need to be comparable to HMO rates) to increase capacity. BHD looking at fee for service agreement for the future.

		2018-increased revenue due to Medicaid professional service billing
<ul style="list-style-type: none"> Peer Involvement 	peer specialists are a key component of the treatment team	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> physical plant modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required programmatic modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required Competencies 		
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> NIMBY issues? 		
<ul style="list-style-type: none"> Acceptance of Emergency Petitions? 		
<ul style="list-style-type: none"> Exceptions to services at this level of care 	Hospital step downs in future state	CRC needs to be used for crisis services direct admission and diversion from hospitals and ERs when appropriate
<ul style="list-style-type: none"> Consider co-location of mobile crisis teams to these sites 		There's potential for including additional crisis services at CRC to create additional walk-in crisis clinics and services.

Crisis System Element: Community Linkages and Stabilization (CLASP)

If section is N/A for this element, leave blank

Service Description: CLASP is a community-based peer specialist program where people are voluntarily referred to the program through one of the Crisis Services programs (CRC, Crisis Mobile Team, CART, Team Connect, Observation Unit, Inpatient Units, Access Clinic). The peer specialists utilize their own unique recovery experiences to engage people who are beginning their recovery. The CLASP team of peer specialists provides individualized care and planning to provide the strength and hope that recovery is possible. CLASP provides peer support in the community at the location that best serves the person’s needs. CLASP has been able to successfully engage people who have traditionally not engaged in services. CLASP focuses on stabilizing the crisis, partnering with the person to meet their needs, and developing strong support systems to prevent crisis. Duration of service is generally 6 months but is based on the individual’s needs. Services are provided by BHD contracted partner La Causa, Inc.

FUTURE VISION: Continue to increase the utilization of CLASP by making appropriate referrals to the program. Expanding funding sources through HMOs and other revenue streams will add to increased capacity and the ability to serve more people. Future state, CLASP could be part of the team serving the individual through a Care Coordination model. Continued and increased access to CLASP for individuals who struggle to engage in traditional services (TCM, CSP, etc.) is essential. Adding other referral streams through additional funding provided through HMOs and health systems would provide the opportunity to serve more people.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	La Causa, Inc. 804 W. Greenfield Ave. Milwaukee WI 53204	CLASP office is on the South Side of Milwaukee but the peer specialists provide services in the community at locations convenient to the person being served by the program (home, etc.).
• Hours of Operation	Monday-Friday 830 AM-5PM	
• Current Service Volume and number of teams (if applicable)	CLASP has the capacity to serve a caseload of 80 people	
• Current Service FTEs	1.0 Supervisor 1 Clinician 7 peer specialists	
• Target Population	Adults with mental health and co-occurring needs	
• Referral Source	Crisis Services Programs (CRC, Crisis Mobile Team, CART, Team Connect, Observation Unit, Inpatient Units, Access Clinic)	
• Expected Future Volume	80 people when fully staffed	
• Funding Source(s)	Medicaid and County Tax Levy	
• Funding model (FFS, Block, Case rate, etc)	Medicaid FFS and Tax Levy	Increased funding through HMOs and/or health systems would support expansion of the service.

<ul style="list-style-type: none"> Peer Involvement 	CLASP is a community-based peer specialist program composed of the equivalent of 7 full-time peer specialists	Crisis Services has also coordinated peer specialist training funded by BHD to expand the number of peer specialists in Milwaukee County
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> physical plant modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required programmatic modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required Competencies 		
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> NIMBY issues? 		
<ul style="list-style-type: none"> Acceptance of Emergency Petitions? 		
<ul style="list-style-type: none"> Exceptions to services at this level of care 	People who are on commitments	
<ul style="list-style-type: none"> Consider co-location of mobile crisis teams to these sites 	Possibly relocating CLASP to walk-in clinic sites with Care Coordinators	

Crisis System Element: Psychiatric Crisis Services (PCS)

If section is N/A for this element, leave blank

Service Description: *Psychiatric Crisis Services (PCS) is a 24-hour a day, seven days a week psychiatric emergency room. This essential component of BHD’s current system of crisis services provides crisis intervention and face-to-face medical/psychiatric assessment for individuals who are, or who believe themselves to be, in psychiatric emergency and in need of psychiatric assessment, treatment and/or referral. Individuals who come in either voluntarily or involuntarily can be seen immediately. All inpatient admissions to the Behavioral Health Division are evaluated first in the Psychiatric Crisis Service, as are individuals brought in on Emergency Detention, under Ch. 51 of the Wisconsin Statutes, by law enforcement.*

FUTURE VISION: *Continue to be recognized as a national best practice standard model that other communities are currently replicating while expanding behavioral health/social services directly from the ER to include expansion of mobile capability and medical oversight of mobile services. Continue to be a collaborative partner with law enforcement, emergency medical services (EMS), and private healthcare systems in Milwaukee County to coordinate care and services for individuals receiving voluntary or involuntary psychiatric care.*

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
<ul style="list-style-type: none"> Operator of Service and Service location(s) 	BHD; 9455 Watertown Plank Road	
<ul style="list-style-type: none"> Hours of Operation 	24/7 365 days/year	
<ul style="list-style-type: none"> Current Service Volume and number of teams (if applicable) 	8,001 individuals seen in PCS in 2017 1,428 individuals managed as part of waitlist protocols	PCS physicians also provide medical oversight and consultation for all Crisis Mobile Team, CART, CCT and Gero RN mobile teams
<ul style="list-style-type: none"> Current Service FTEs 	<ul style="list-style-type: none"> 1.0 FTE Medical Director 8.25 FTE physicians Hourly physician coverage for remaining shifts 25.0 FTE RNs 4.0 Pool RNs 3.5 RN II UR Transfer Coordinators 5.0 Psych Techs 15.0 FTE CNAs 8 Pool CNAs 3.5 Unit Clerks Contracted 24/7 security/public safety presence in PCS -- stationed at the intake bay 	<ul style="list-style-type: none"> Physician staffing provides services/coverage to PCS, OBS, Access Clinic, and medical oversight for CMT, CART, CCT, and Crisis Stabilization Houses. RN, Psych Tech, and CNA staff provide services/coverage for PCS and OBS.

• Target Population	All individuals (adult and children) experiencing a psychiatric crisis and/or in need of behavioral health services	PCS must assess, treat, and stabilize any individual presenting for services to PCS regardless of place of residence and/or ability to pay as per emergency department standards
• Referral Source	Any source	
• Expected Future Volume	2018 Projection=7,431 individuals seen in PCS 2018 Projection=929 individuals managed as part of waitlist protocols	
• Funding Source(s)	Medicaid/Medicare; all insurances billed for services; tax levy	
• Funding model (FFS, Block, Case rate, etc)	Insurance billing and tax levy	
• Peer Involvement	None at this time	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
• physical plant modifications (None, Minor, Moderate, Major)	Major: Similar-sized emergency department in a freestanding location on the north side of Milwaukee; or co-location with physical care ED on the north side of Milwaukee; smaller size Observation Unit	
• Required programmatic modifications (None, Minor, Moderate, Major)	Moderate: Need a social service/service navigator presence in PCS along with connection to peer services; decreased RN/CNA presence due to decreased Observation status	
• Required Competencies	Competencies as per board certifications, state licensure, and credentialing/privileging in addition to DHS 34 Emergency Mental Health Services	
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
• NIMBY issues?	No	Healthcare/ED partners supportive of services.
• Acceptance of Emergency Petitions?	Yes	

<ul style="list-style-type: none">• Exceptions to services at this level of care	Individuals experiencing medical emergencies need to have medical conditions stabilized at a medical ED	
<ul style="list-style-type: none">• Consider co-location of mobile crisis teams to these sites	Yes	

Crisis System Element: Team Connect

If section is N/A for this element, leave blank

Service Description: Team Connect is composed of master’s level clinicians and peer specialists who provide services to individuals who are discharged from PCS, the Observation Unit, or the BHD Inpatient Units. Team Connect provides additional support via telephone and in person to people as they return to the community to reduce the risk of harm. Contact is made or attempted with the person within 24 hours or the next business day of discharge. The team provides linkage to services in the community, supports engagement in post discharge care, and provides community-based crisis response.

FUTURE VISION: Team Connect was implemented in 2017 and continues to evolve as a program. The team will continue focusing on engaging people post discharge to ensure their needs are being met and reduce PCS visits. Additional emphasis will be placed on Care Coordination. Expand services to HMOs for people being discharged from private hospitals.

Future state, will look comprehensively at the continued impact of Team Connect services and transitioning Team Connect resources to a Care Coordination model. Team Connect follow-up has been successful at engaging people being discharged from inpatient units. Expanding services to individuals discharged from inpatient care throughout the system with HMO and other revenue streams could further support the redesign efforts. Embedding social workers or crisis staff in area emergency rooms would lead to additional coordination of services, increase discharge planning, quicker Emergency Detention reviews and assessments (dropping EDs, safety planning, connection to resource) and support crisis redesign efforts.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	Milwaukee County BHD	
• Hours of Operation	Sunday-Friday 8 AM – 7 PM	
• Current Service Volume and number of teams (if applicable)	All people being discharged from PCS, BHD Inpatient, and Observation Unit Currently 5 teams (shared peer specialist resources)	Additional peer specialist time would be beneficial to further engage people. Service could be provided with expanded use of peer support and reduction in the number of clinicians.
• Current Service FTEs	5 Clinicians 2 peer specialists	
• Target Population	Adults with mental health and co-occurring needs being discharged from BHD inpatient, observation unit, or PCS	
• Referral Source	BHD inpatient, observation unit, and PCS	
• Expected Future Volume		
• Funding Source(s)	Medicaid and Grant Funding	Grant Funding through STR

<ul style="list-style-type: none"> Funding model (FFS, Block, Case rate, etc) 	Medicaid FFS, Grant Funding, County Tax Levy	HMO contracting to provide additional services to people being discharged from private hospitals would further support redesign efforts
<ul style="list-style-type: none"> Peer Involvement 	peer specialists are part of the team	Crisis Services has also coordinated peer specialist training funded by BHD to expand the number of peer specialists in Milwaukee County
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
<ul style="list-style-type: none"> physical plant modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required programmatic modifications (None, Minor, Moderate, Major) 		
<ul style="list-style-type: none"> Required Competencies 		

Crisis System Element: “Air Traffic Control” Crisis Resources (P

If section is N/A for this element, leave blank

Strategy

FUTURE VISION: Adopt an electronic surveillance and scheduling solution that will allow Crisis Staff, contracted providers, and others with need to know to utilize real time surveillance and access to crisis resources. Crisis staff, future care managers, partners and providers will be able to see available resources needed by clients in crisis. Resources will include: hospital and diversion beds, care management intake slots, psychotherapy and prescriber appointments, Peer services appointments, and other ancillary services. Will support real-time, same-day access to care and will fully utilize available resources.

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
• Operator of Service and Service location(s)	BHD Managed/TBD	
• Hours of Operation	24/7	
• Current Service Volume		See estimates provided for Crisis Services.
• Target Population		Individuals who are experiencing a psych crisis; resources may also support individuals with lack of access to services to help them avoid a psychiatric crisis.
• Referral Source		Services that are connected to the Milwaukee County BHD Crisis Service would utilize this model.
• Current Service FTEs		
• Expected Future Volume		
• Funding Source(s)		
• Funding model (FFS, Block, Case rate, etc)		
• Peer Involvement	N/A	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
• physical plant modifications (None, Minor, Moderate, Major)		
• Required programmatic modifications (None, Minor, Moderate, Major)		Will lead to great improvement in teamwork and will spur major system change.
• Required Competencies		Will require all providers to join and allow admission based on set criteria. Considerable training needed re: admission criteria and least restrictive use of resources.
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
• NIMBY issues?		Not expected to be a problem
• Acceptance of Emergency Petitions?		Yes.
• Exceptions to services at this level of care	Acute medical emergency	

- Consider co-location of mobile crisis teams to these sites

Crisis System Element: Crisis Services Care Coordination (Plan)

If section is N/A for this element, leave blank

FUTURE VISION: Provide a short-term (up to 6 months) Care Management model for clients with recent psych emergencies, contacts with Crisis Mobile, ER or walk-in clinic. The Program utilizes crisis assessment, develops a Plan of Care with the consumer, and authorizes peer services, prescriber services, psychotherapy, and other services per client need and agreement. Plan is comprised of SMART output and outcome-focused goals designed to improve client safety, health, wellness, improve symptoms. The model will require close supervision of staff, management and oversight of ancillary providers, and electronic system change to allow proper data collection and management (development of dashboards, improved communication across providers, consumer use of record/portal).

CURRENT INFORMATION	ACTUAL or ESTIMATE	QUESTIONS/NOTES
<ul style="list-style-type: none"> Operator of Service and Service location(s) 	BHD has Crisis Case Management Team in place; discussions have identified this team be built into Care Coordination Team	
<ul style="list-style-type: none"> Hours of Operation 	Will use the Access Clinic Hours, consistent with FQHC Partners; will consider a few weekdays per week with later evening options.	
<ul style="list-style-type: none"> Current Service Volume and number of teams (if applicable) 	1.0 FTE Crisis Coordinator (Team Leader); 7.0 FTE Care Coordinators; 2.0 FTE Peers will also provide service in this model; if each Care Coordinator can serve 15 clients, then 105 clients will be served concurrently within this program	
<ul style="list-style-type: none"> Current Service FTEs 	1.0 FTE Crisis Coordinator (Team Leader); 7.0 FTE Care	

	Coordinators; 2.0 FTE peers will also provide service in this model	
• Target Population	Adults 18+ who have had recent psych crisis contacts and are determined to be higher risk (multiple ER/IP admissions, failure at Outpatient Level of care, recent suicidal planning, behavior, difficulties adhering to recommended treatment	
• Referral Source	Crisis Mobile, CART, PCS/ER, IP, Walk in, FQHC	
• Expected Future Volume	105 clients served concurrently	
• Funding Source(s)		
• Funding model (FFS, Block, Case rate, etc)		
• Peer Involvement	N/A	
MODIFICATIONS REQUIRED?	DESIRED RESULT	QUESTIONS/NOTES
• physical plant modifications (None, Minor, Moderate, Major)		Space required for Care Management staff in phase one; could be contracted to high-performing agency.
• Required programmatic modifications (None, Minor, Moderate, Major)		Major system change. Will need to build a new team and thoroughly train staff. Current staffing, credentials of staff, and training plan may not serve new model.
• Required Competencies		
CONSIDERATIONS	DESIRED RESULT	QUESTIONS/NOTES
• NIMBY issues?		Not expected to be a problem
• Acceptance of Emergency Petitions?		Yes.
• Exceptions to services at this level of care	Acute medical emergency	

- Consider co-location of mobile crisis teams to these sites

Appendix C: GIS Maps of Home Zip Codes of Those Receiving Crisis Services by BHD Program or Health System ED

Data for these maps were provided by the services

Figure A1: Total Assessed/Served Across Programs & Private Health Systems

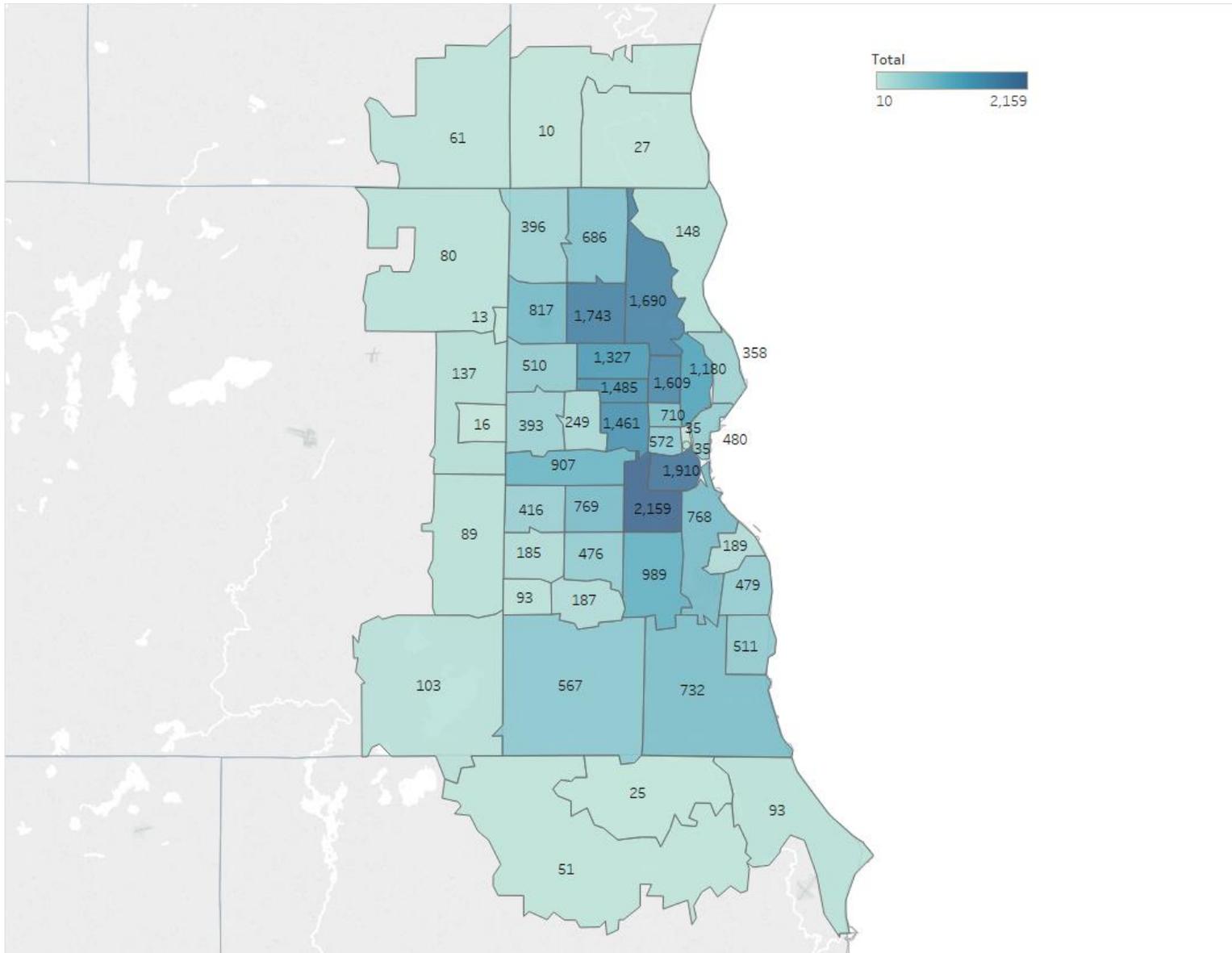


Figure A2: Crisis Mobile Service

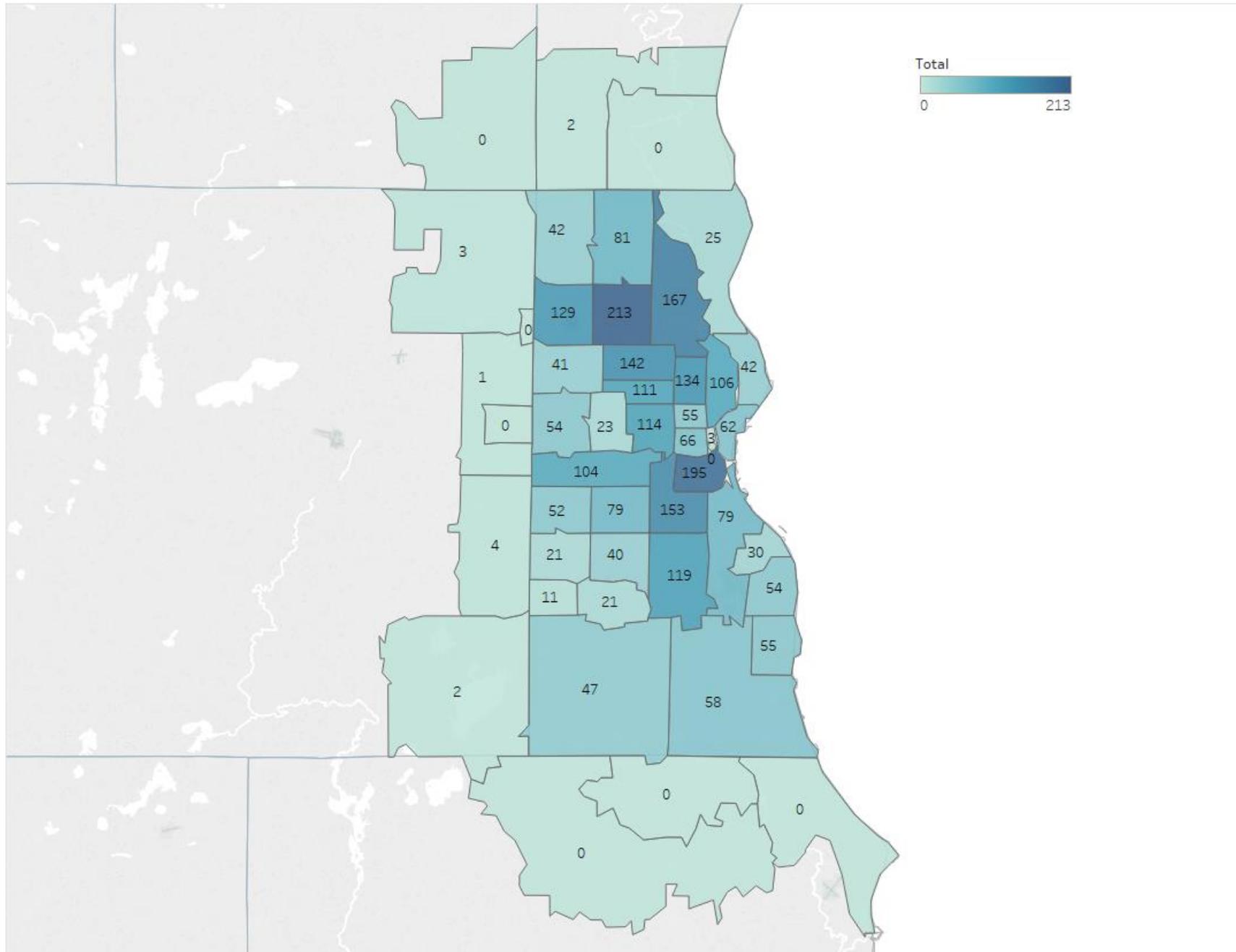


Figure A3: CART

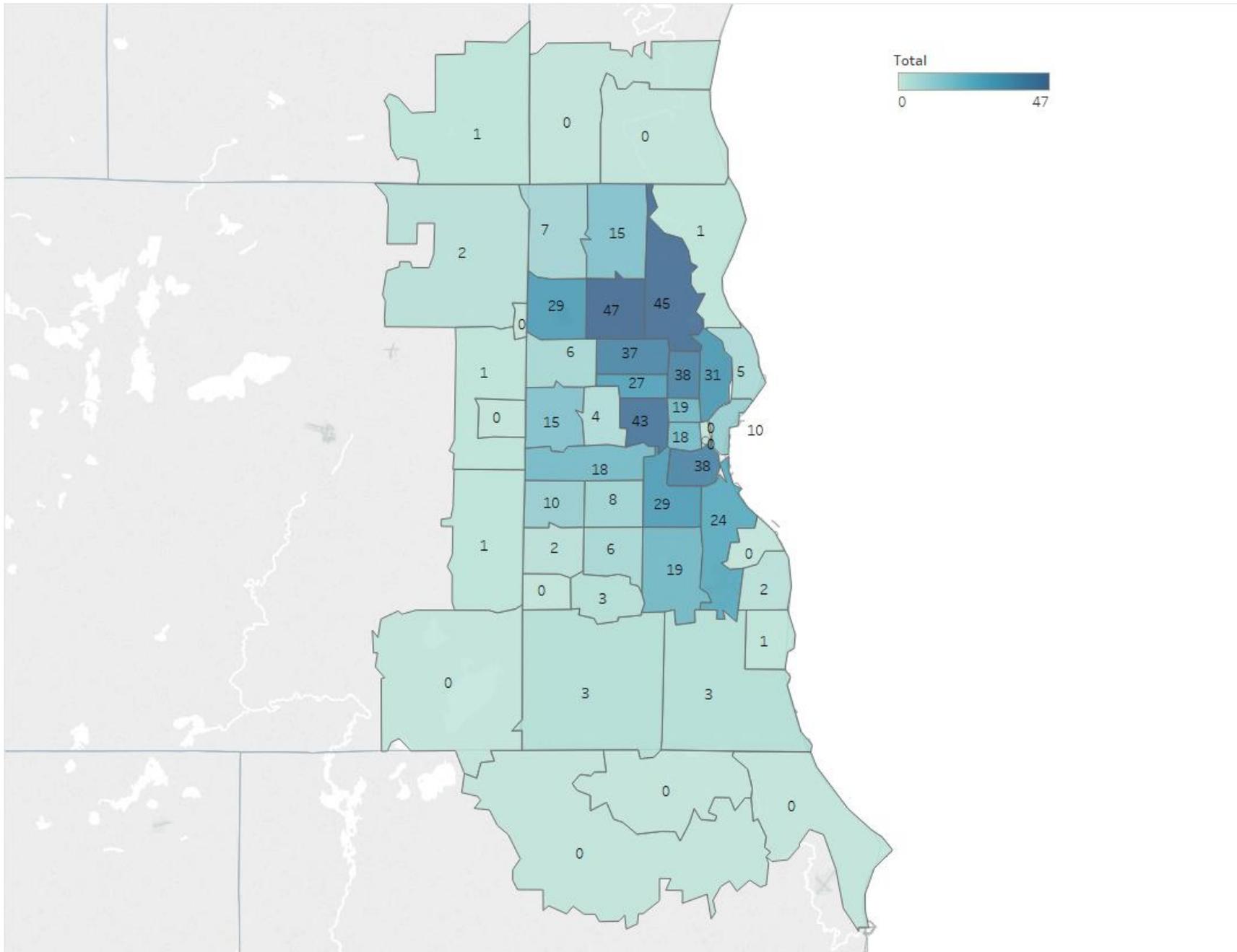


Figure A4: Ascension

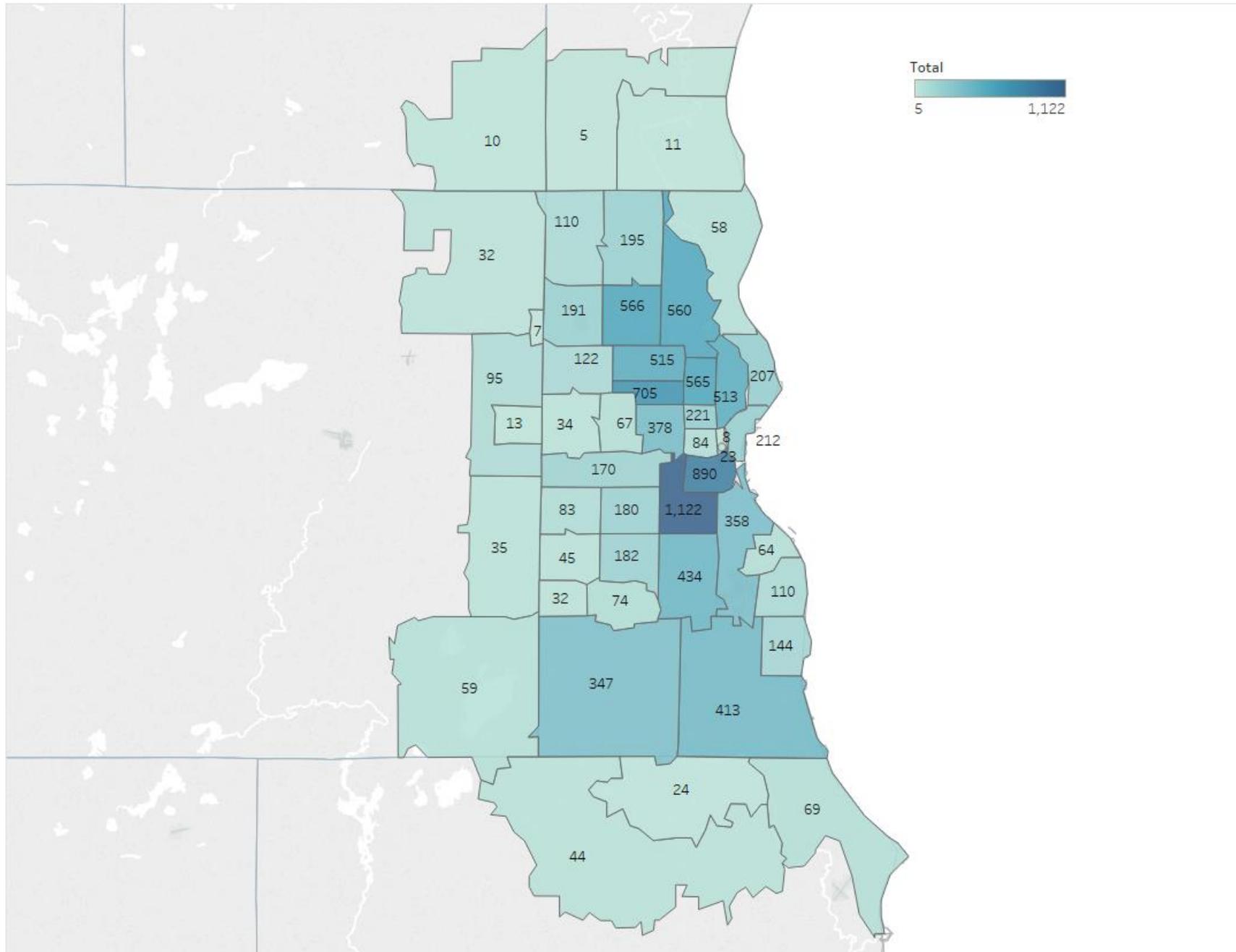


Figure A5: Aurora

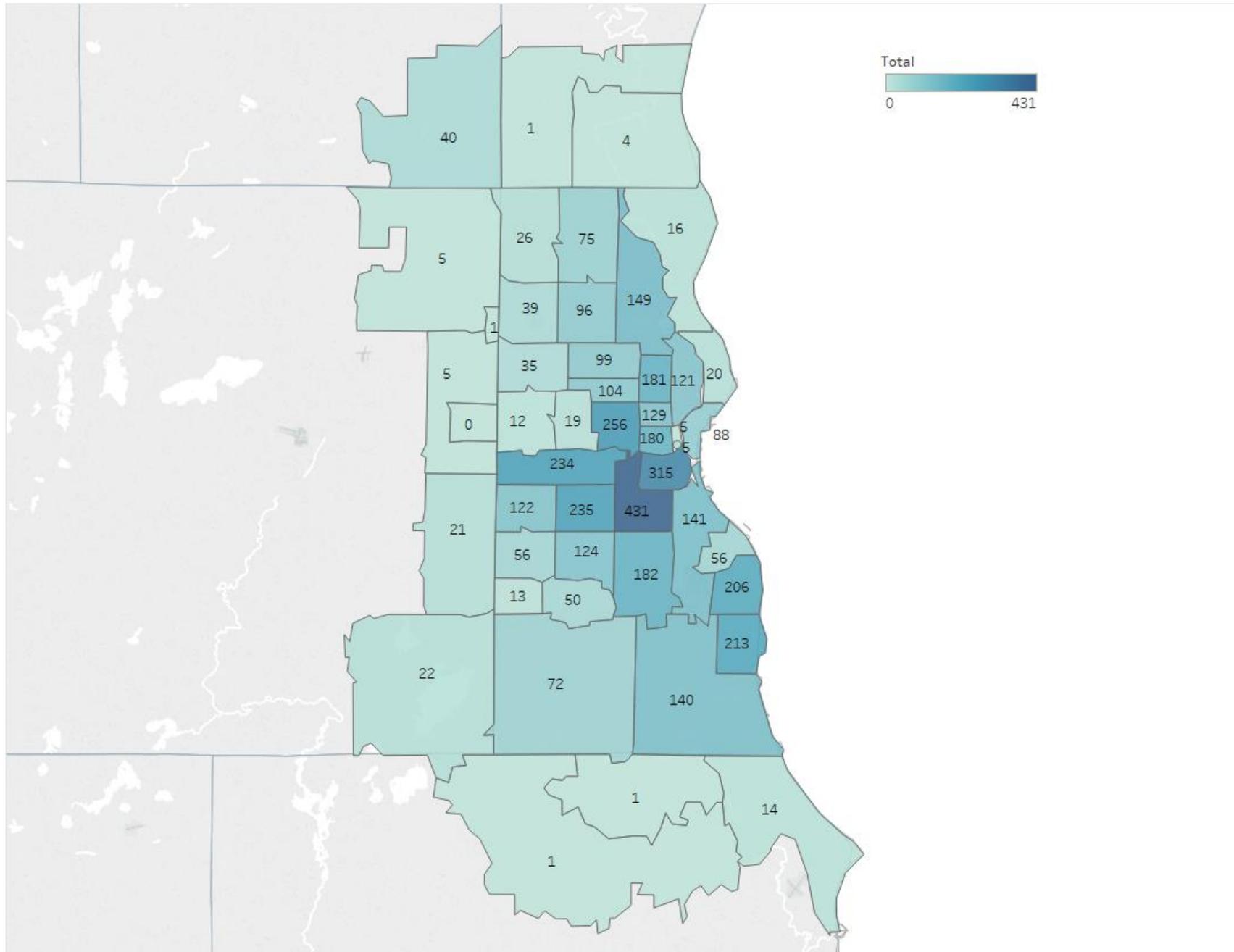


Figure A6: Children's

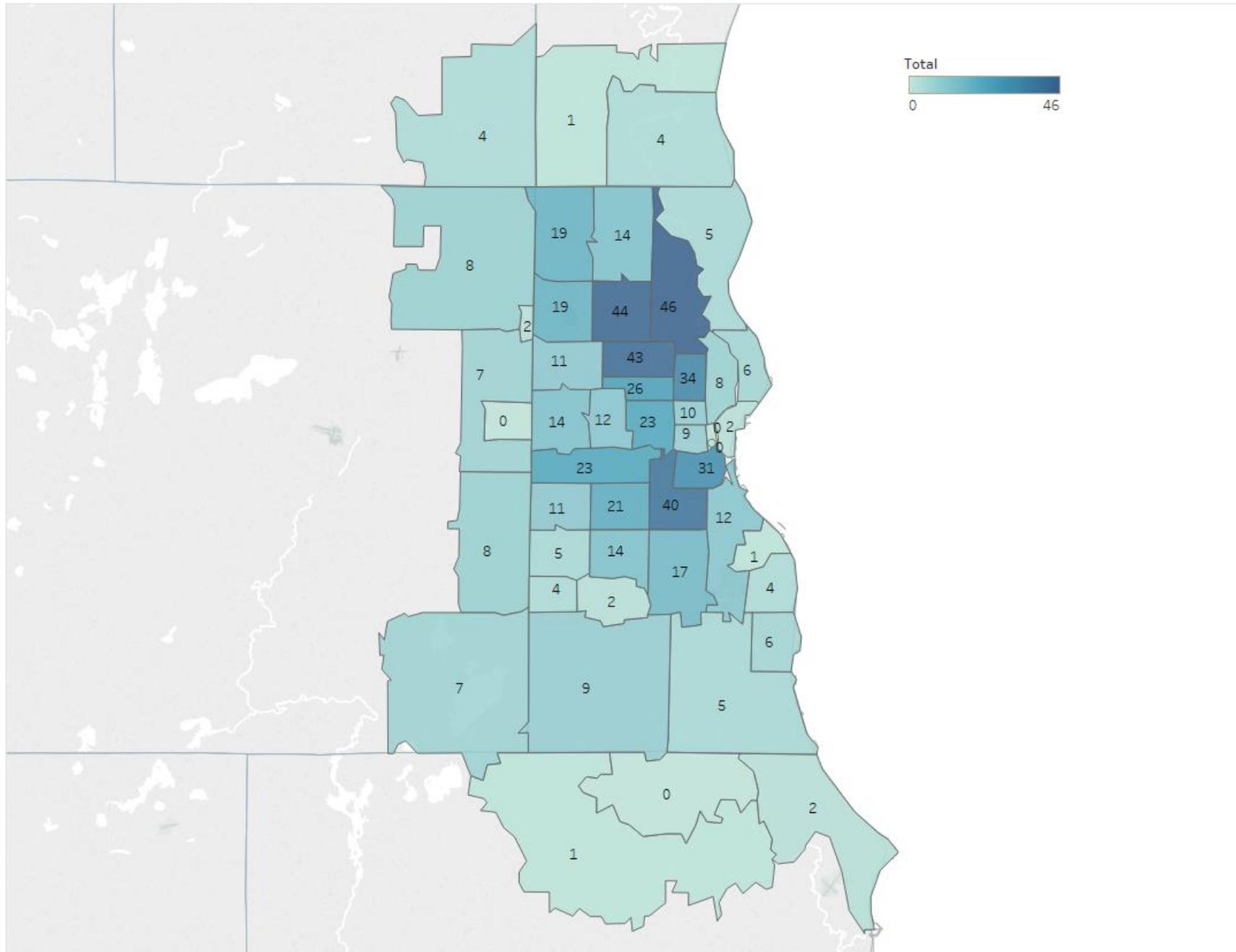
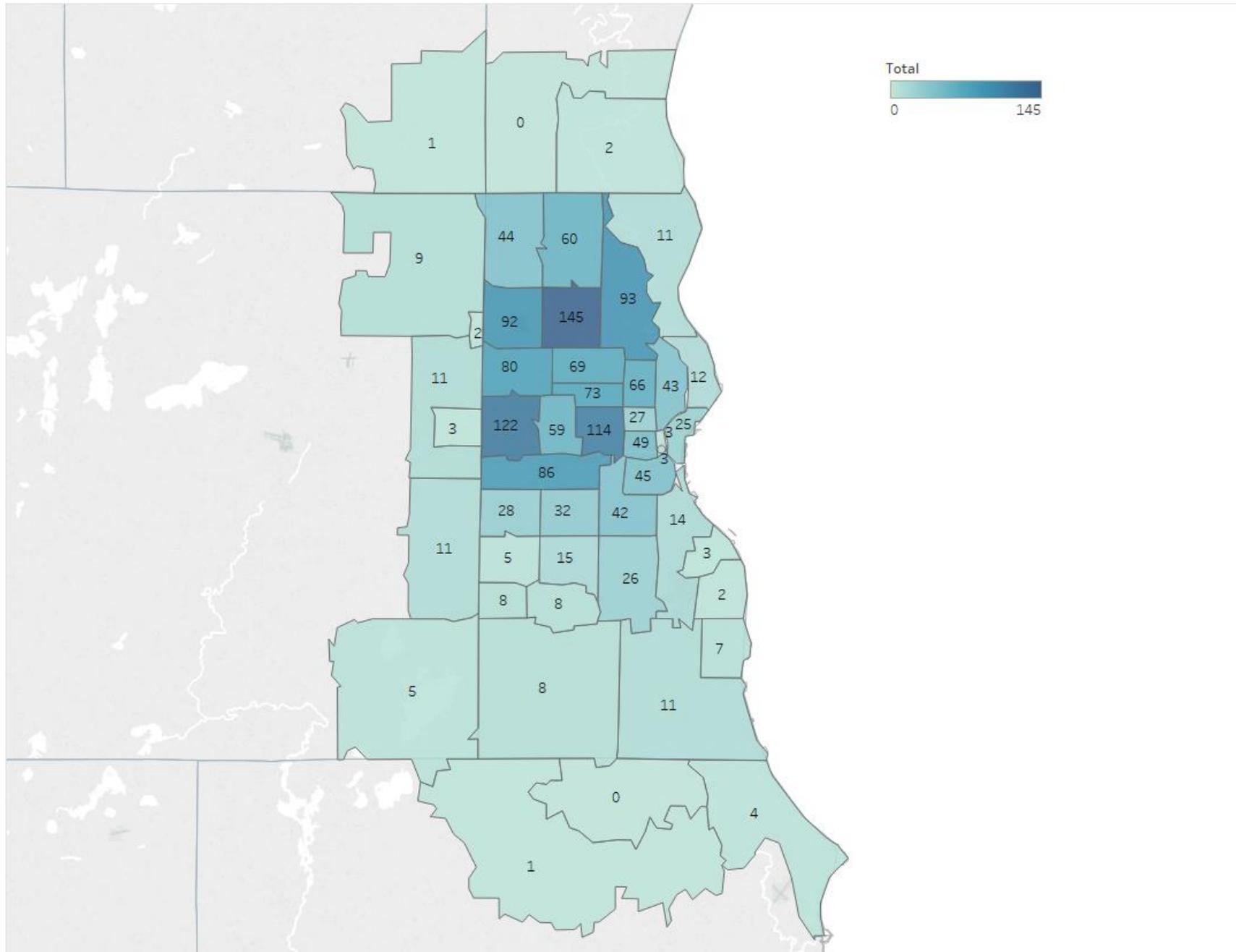


Figure A7: Froedtert



Appendix D: Data Displays for Key Variables by Program/Health System

To assess the implications of the redesign for the overall health care system, we analyzed trends in utilization using data provided by the Wisconsin Hospital Association (WHA). These data involve various aspects of ED and inpatient utilization by Milwaukee County hospitals, including the PCS and BHD inpatient units. (NOTE: Totals from WHA in these tables differ to some extent from those cited elsewhere in the report, which were obtained from the health systems and BHD. This occurs frequently with data drawn from different information systems and may be due to a variety of factors, including differences in coding, variation in consistency of data entry, and data extraction criteria. In this case, the most likely explanation is that the data reported by WHA include a primary mental health diagnosis in the extraction criteria, resulting in a more restricted population. Consequently, each total should be considered only in the context in which it is presented rather than applying across contexts; in these tables, for example, the questions of interest are 1) the changes in the volume of visits over the 5-year period; and 2) changes in the relative proportion of the volume served by PCS and the total crisis system including private health system EDs.

Table A1 presents trends for the past five years in the number of ED visits with a primary mental health diagnosis (PMHD) for all Milwaukee County EDs, including PCS. The portion of total visits represented by those with a primary mental health diagnosis is relatively small and has declined over the past five years to less than 5% in 2017. PCS's portion of total PMHD visits—which represents the number that will be redistributed in the redesigned system once PCS closes—has also declined, even more rapidly, to slightly over one quarter of the total PMHD admissions.

Table A1: PMHD visits, crisis system total including hospitals and PCS portion, 2013-2017

	2013	2014	2015	2016	2017
Total system PMHD ED visits	23,023	24,316	32,216	25,178	24,565
PMHD as % of total ED visits	5.6	5.2	5.4	5.0	4.8
PCS PMHD visits	9,614	9,053	11,027	7,400	6,795
PCS % of total PMHD visits	41.8	37.2	34.2	29.4	27.7

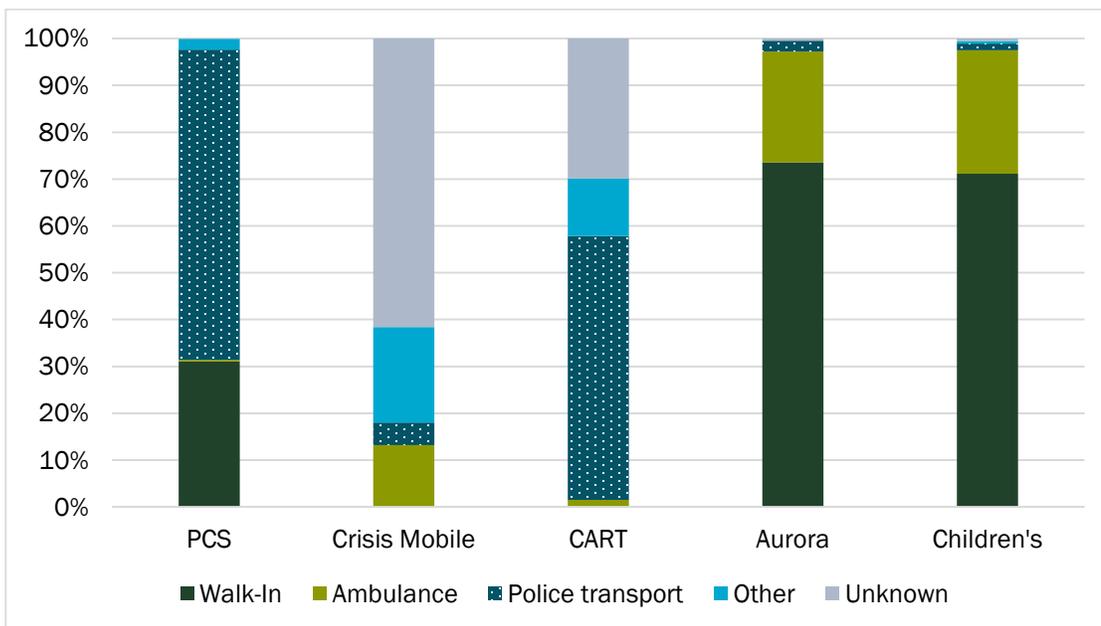
Individuals discharged with a PMHD from inpatient units represent a population at risk of crisis and readmission, thereby requiring step-down and transitional support services. Table A2 presents total PMHD discharges from Milwaukee County inpatient units including the Mental Health Complex (MHC) and the portion of the total represented by MHC. The pattern is again one of decline by nearly half, consistent with the downsizing of the facility over the five-year period.

Table A2: System including hospitals total PMHD discharges and Mental Health Complex (MHC) portion of PMHD discharges, 2013-2017

	2013	2014	2015	2016	2017
Total PMHD inpatient discharges	10,803	10,548	11,157	12,301	13,326
Total MHC PMHD discharges	2,060	1,942	1,790	1,227	1,267
MHC % of total PMH discharges	19.1	18.4	16.0	10.0	9.5

The figures on the following pages of this appendix show detailed breakdowns by health system for a variety of characteristics. These displays are based on the self-report data from BHD and the private health systems.

Figure A8: Mode of Access to Crisis Services



Note: Data unavailable from Ascension; data for Crisis Mobile and CART are incomplete and an error in Froedtert data was discovered in the analysis.

Figure A9: Age Distribution: BHD Crisis Services and Health System EDs

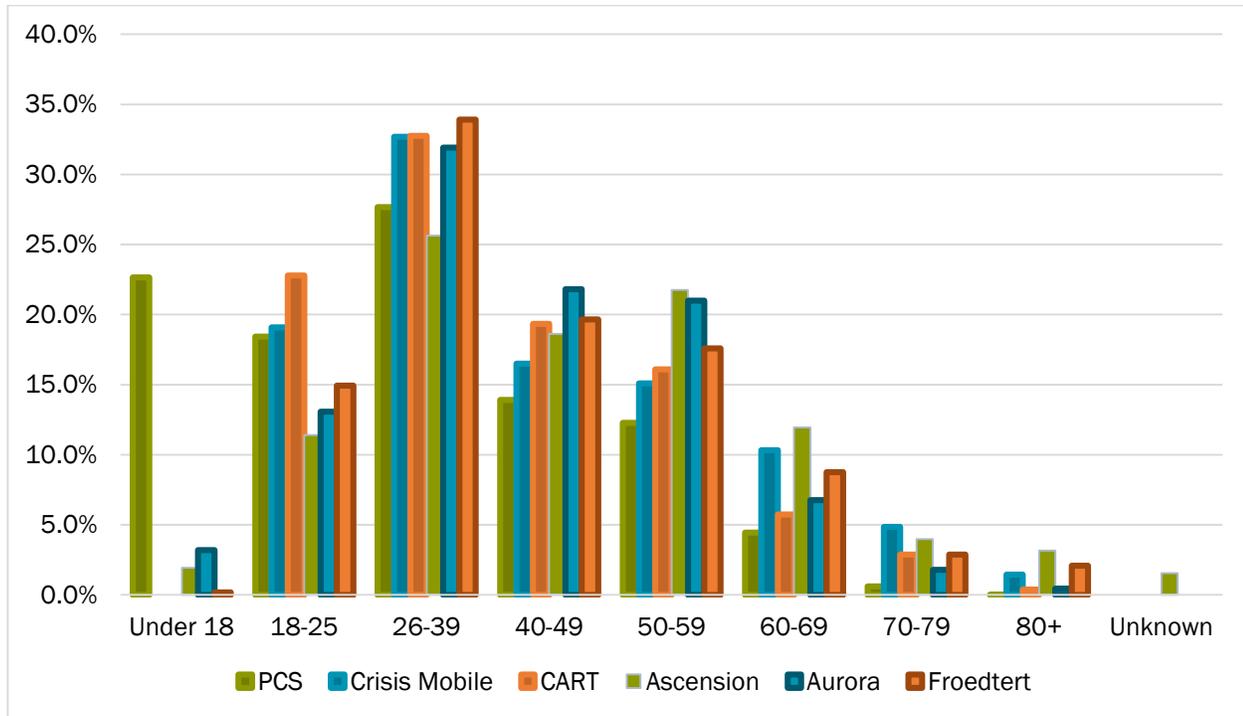


Figure A10: Age Distribution: Children’s Hospital ED

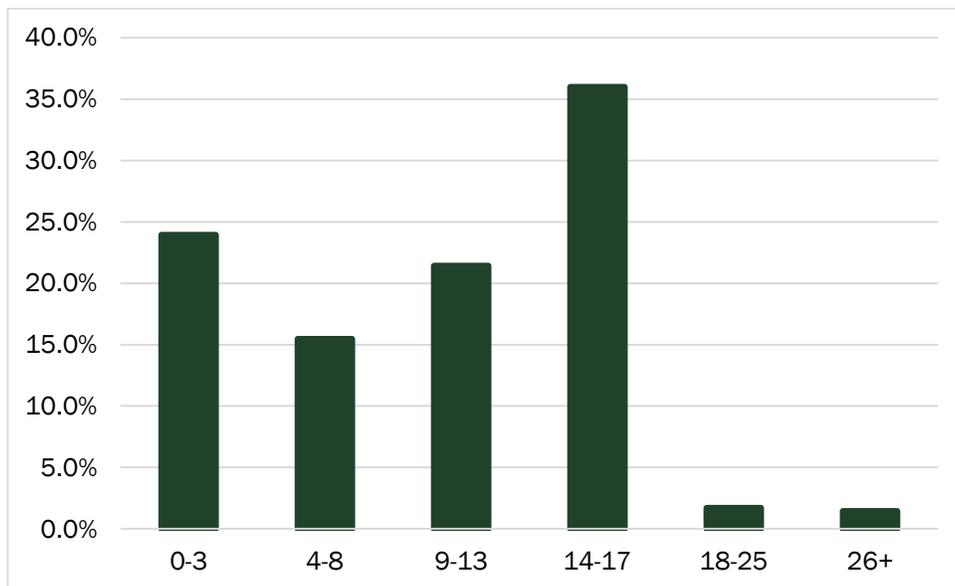


Figure A11: Gender: BHD Crisis Services and Health System EDs

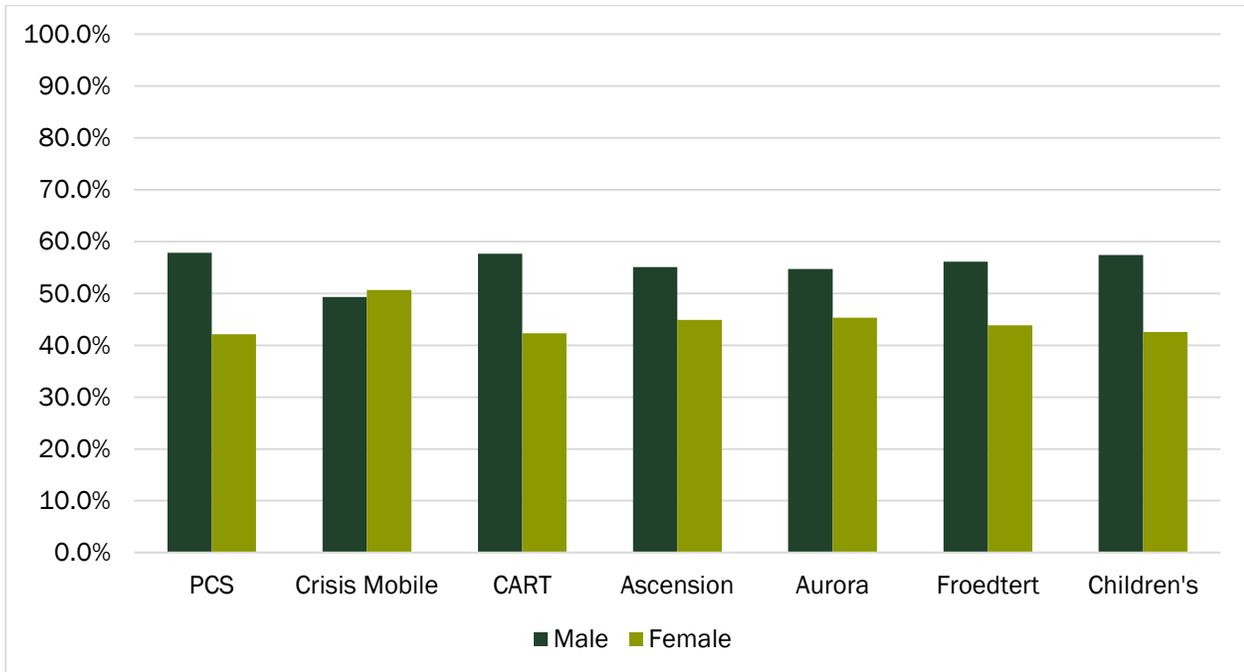


Figure A12: Race and Ethnicity: BHD Crisis Services and Health System EDs

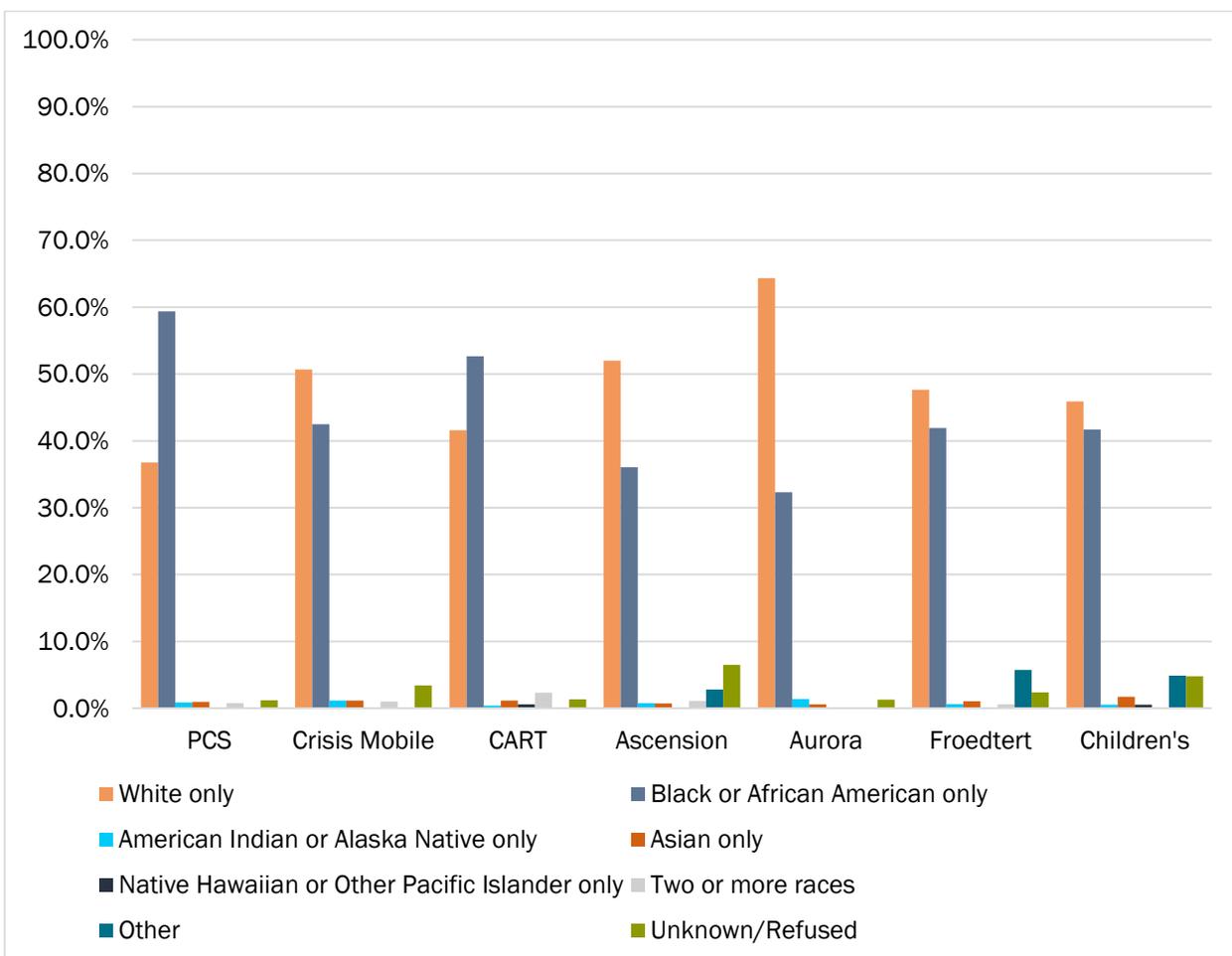
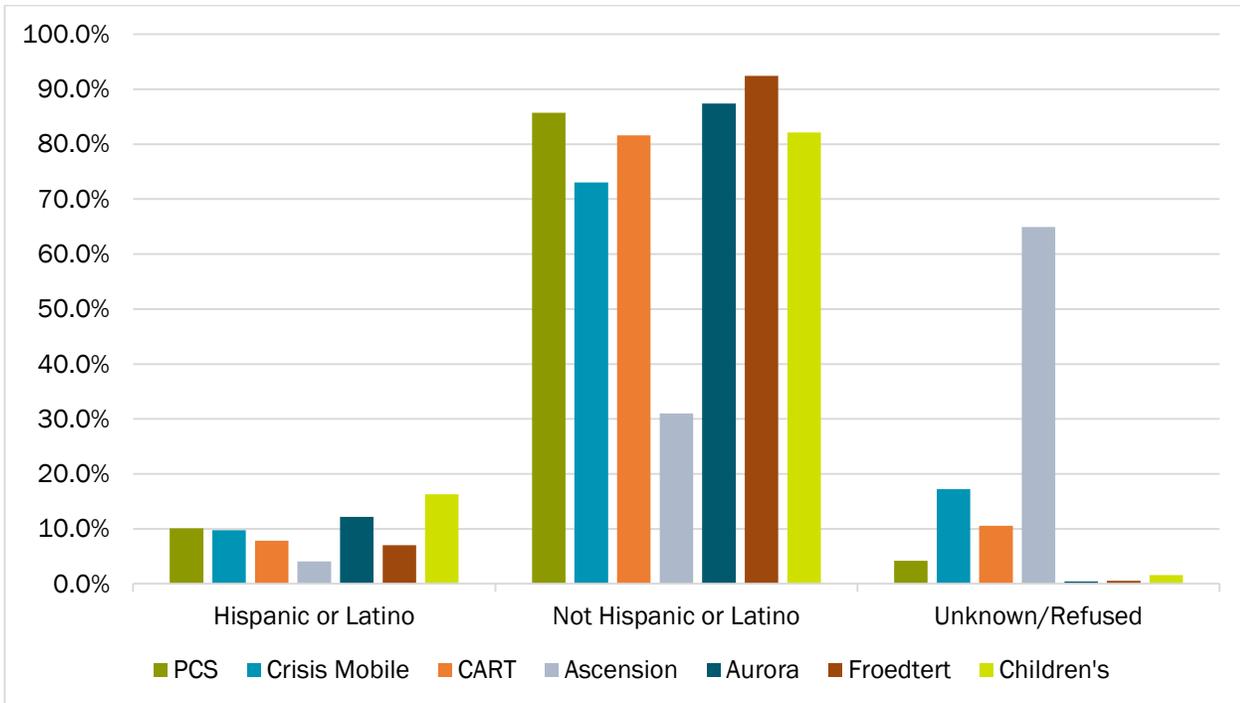


Figure A13: Mental health (MH) and substance use disorder (SUD) diagnosis BHD Crisis Services and Health System EDs

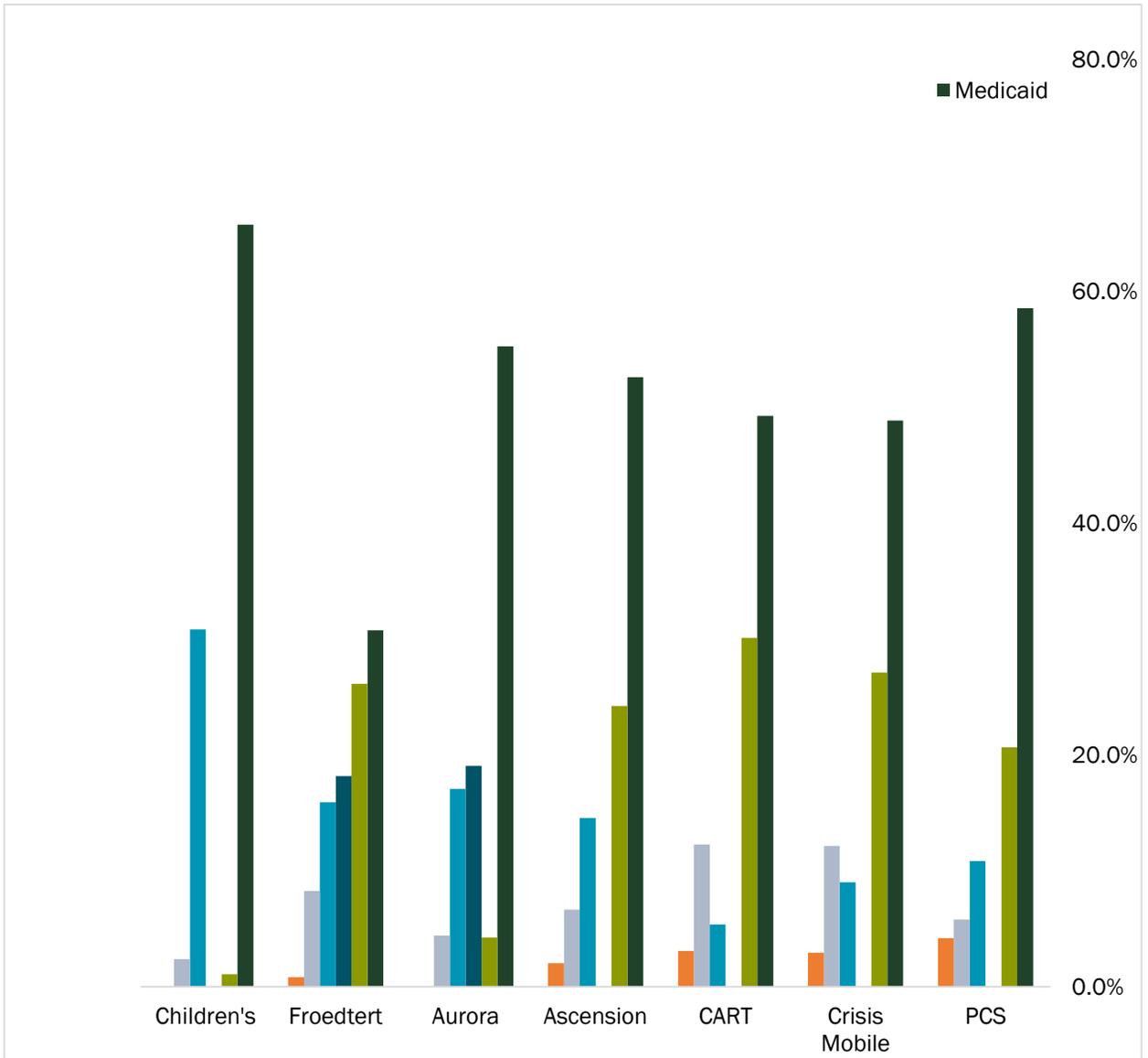
Type of diagnosis	PCS	Crisis Mobile ¹	CART ¹	Ascension	Aurora	Froedtert	Children's ²
<i>MH only</i>	72.4%	1.4%	3.8%	39.5%	76.3% ³	71.8%	-
<i>MH only but SMI/SPMI</i>	52.9%	1.3%	3.8%	39.5%	-	13.9%	-
<i>AODA/SUD only</i>	17.6%	0.3%	0.2%	59.1%	18.3%	28.2%	-
<i>Unknown</i>	10.0%	98.3%	96.0%	1.5%	5.4%	0.0%	-
Total N	7,194	2,332	522	11,358	4,642	1,753	-

¹ Extensive missing data

² Data on diagnosis unavailable

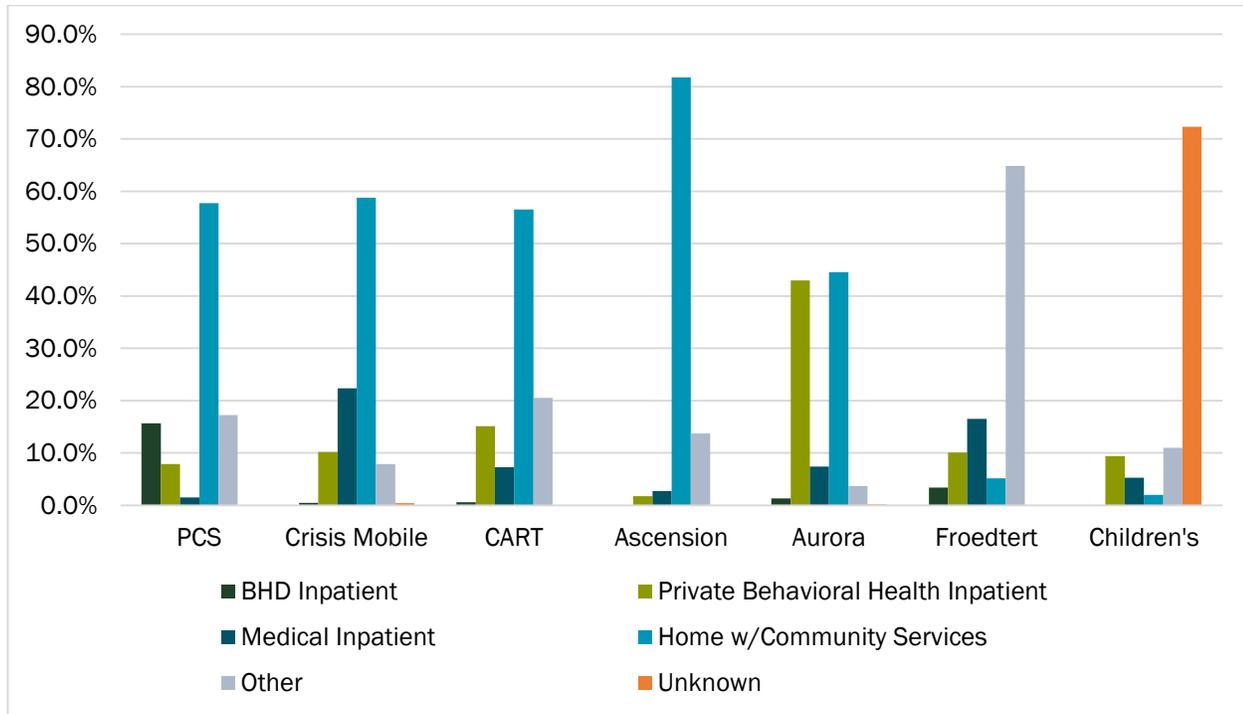
³ Includes 758 individuals with a dual diagnosis of MH and SUD; SMI/SPMI count unavailable

Figure A14: Payment Source



Note: PCS, Crisis Mobile, CART, Ascension, Children's were unable to distinguish if someone had both Medicaid and Medicare.

Figure A15: Disposition After Assessment

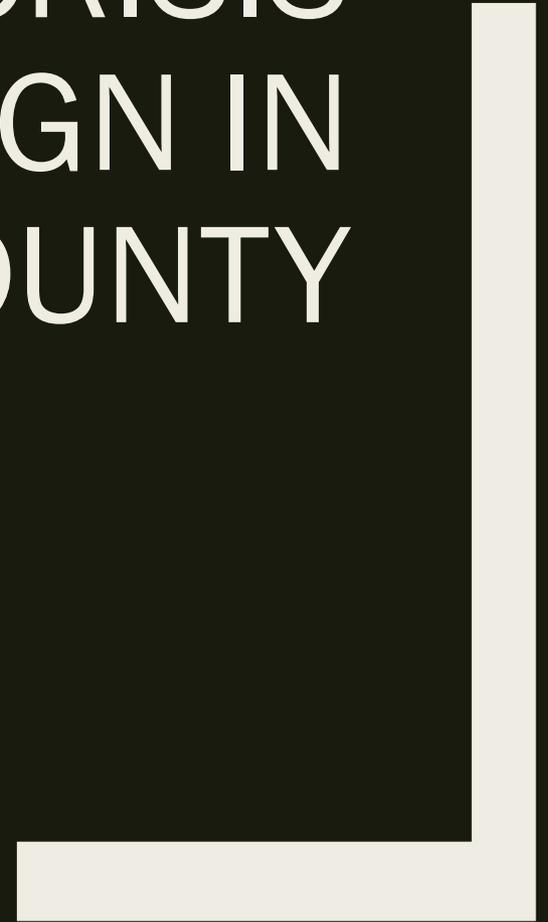


Appendix E: References

- Abid Z, M. A., Lazar D, (2014). "Psychiatric boarding in U.S. EDs: A multifactorial problem that requires multidisciplinary solutions. ." Policy Brief **1**(2).
- Allen MH, Forster P, et al. (2002). Report and recommendations regarding psychiatric emergency and crisis services: a review and model program descriptions. Arlington (VA):, American Psychiatric Association.
- Balfour M, and Santopietro J. 2018. "Addressing Emergency Department Boarding." SAMHSA Webinar,
<https://surveygizmolibrary.s3.amazonaws.com/library/133093/AddressingEmergencyDepartmentPsychiatricBoardingAContinuumofSolutions.pdf>.
- Boudreaux, J., K. Crapanzano, et al. (2016). "Using Mental Health Outreach Teams in the Emergency Department to Improve Engagement in Treatment." Community Ment Health J **52**(8): 1009-1014.
- Chun, T. H. (2014). "Medical Clearance: Time for This Dinosaur to Go Extinct." Annals of Emergency Medicine **63**(6): 676-677.
- Covington, D. (June 30 2016). "Georgia Crisis Line 10 Years Later."
<https://davidwcovington.com>
- Daryl, K. K. and H. H. Garland (2012). "Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup." Western Journal of Emergency Medicine **13**(1): 35-40.
- Discovery Work Group (2017). Discovery Work Group Findings and Considerations: Draft Executive Summary.
- Helmsley Charitable Trust. New Helmsley Psychiatric Stabilization Unit at Billings Clinic Will Improve Care and Reduce Expenses.
(<https://helmsleytrust.org/case-studies/new-helmsley-psychiatric-stabilization-unit-billings-clinic-will-improve-care-and>)
- Eith, C. & Durose, M. R. (2011). Contacts between police and the public, 2008. Washington, D.C.: US DOJ, Bureau of Justice Statistics.
- Institute of Medicine (IOM) (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C, National Academy Press.
- Joint Commission (2015). "Alleviating ED boarding of psychiatric patients " Quick Safety(19): 1-3.
- Lofchy, J., P. Boyles, et al. (2015). "Emergency Psychiatry: Clinical and Training Approaches." Canadian journal of psychiatry. Revue canadienne de psychiatrie **60**(6): 1.

- National Action Alliance for Suicide Prevention: Clinical Care and Intervention Task Force (2011). Suicide care in systems framework. Washington, DC, Education Development Center, Inc.
- National Action Alliance for Suicide Prevention: Crisis Services Task Force (2016). Crisis now: Transforming services is within our reach. Washington, DC, Education Development Center, Inc.
- Nordstrom K, Z. L., Wilson MP (2012). "Medical evaluation and triage of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup." West J Emerg Med **13**(1): 3-10.
- Rachal, J., W. Sparks, et al. (2017). "Highlight in Telepsychiatry and Behavioral Health Emergencies." Psychiatric Clinics of North America **40**(3): 585-596.
- Serres C (2014). For mental health patients, an unmarked ride to psychiatric care. Star-Tribune.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). Practice Guidelines: Core Elements for Responding to Mental Health Crises. Rockville, MD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies. Rockville, MD, Substance Abuse and Mental Health Services Administration.
- Technical Assistance Collaborative (TAC) (2005). A Community-Based Comprehensive Psychiatric Crisis Response Service.
- Wilson MP, P. D., Currier GW, et al (2012). "The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup." West J Emerg Med **13**(1): 26-34.
- Woo, B. K. P., V. T. Chan, et al. (2007). "Comparison of two models for delivery of services in psychiatric emergencies." General Hospital Psychiatry **29**(6): 489-491.
- Yellowlees P and Shore JH, Eds. (2018). Telepsychiatry and Health Technologies A Guide for Mental Health Professionals. Arlington, VA, American Psychiatric Association.
- Medicine **17**(2): 173-176.
- Zun L (2016). "Care of Psychiatric Patients: The Challenge to Emergency Physicians." Western Journal of Emergency

PSYCHIATRIC CRISIS
REDESIGN IN
MILWAUKEE COUNTY



Redesign Planning Team

- Wisconsin Policy Forum
- Human Services Research Institute
- Technical Assistance Collaborative
- Public-Private Advisory Committee

Phase 1: Planning to Date

- Convene a Public-Private Advisory Committee
- Develop basic redesign assumptions
- Conduct environmental scan (review current system, collect & analyze BHD & health system data, stakeholder interviews/focus groups, review national models/best practices)
- Develop environmental scan report
- Develop conceptual models for adults and children; develop adult planning summary report and children's planning internal summary

Phase 2: Continued Planning & Implementation

- Assemble public/private work team and multiple subgroups
- Focus on the development of:
 - *Financial, operational and structural details for each component and the delivery system*
 - *A phased implementation plan*

Key Planning Assumptions

- By statute, Milwaukee County BHD serves as Treatment Director and there are legal, fiscal, & clinical reasons for BHD to maintain exclusive operational responsibility for those duties.
- BHD can influence law enforcement and court policies and practices, but it will take time and resources to transform the practice philosophy and behaviors of the judiciary and the 20+ municipal law enforcement agencies in Milwaukee County.
- Milwaukee County will not invest additional property tax levy, above the amount currently expended, on the psychiatric crisis continuum of services.
- There is variation in the private health systems' clinical capabilities to effectively care for patients with behavioral health disorders in ER, outpatient, and inpatient settings; the health systems recognize the need to enhance their capabilities, and some are already actively working to address this.
- Private health systems benefit from having a dedicated psychiatric ED and would not be able to replicate these services in multiple ER settings cost-effectively, given the unique expertise and treatment setting required and significant workforce shortages.
- The county's 10 Medicaid MCOs are accountable for ensuring positive health outcomes and financially incentivized to reduce avoidable health care utilizations and costs.

Three Models

- 1) A centralized system organized around a single large psychiatric emergency facility.
- 2) A decentralized system, with multiple sites providing a diverse array of crisis services (including some capacity for receiving individuals under emergency detention).
- 3) A dispersed system with vastly enhanced county investment to shift most crisis episodes out of ED into less intensive support services; private health system EDs care for individuals with more complex needs.

Milwaukee County Psychiatric Crisis System Redesign: Modified Model 3

CRISIS PREVENTION	EARLY/SUBACUTE INTERVENTION	ACUTE INTERVENTION	CRISIS TREATMENT	RESOLUTION/ REINTEGRATION
<p>Enhanced Community Education</p>	<p>Peer-Run Respite Center</p>		<p>Expanded Crisis Resource Centers (TX Beds, 2-7-day LOS)</p>	<p>Enhanced Post-Acute Transition Care Management / Navigation / Connection Services (Providing follow-up to patients served in Urgent Care - Triage Center, Private Hospital & Designated)</p>
<p>BHD Community – Based High Acuity Walk-in Outpatient Clinical & Navigation Services in Collaboration with FQHCs (Extended Hours)</p>	<p>Crisis Line /Call Center (Initial crisis response, 24/7)</p>	<p>Expanded CART Teams with Municipal Law Enforcement Agencies</p>	<p>Inpatient Psychiatric Treatment (Outsourced Provider and New Location)</p>	
<p>Expanded Private Provider Outpatient Services</p>	<p>Expanded BHD Crisis Mobile Capacity and Services (Treatment/Assessment/Disposition/Connection)</p>		<p>Crisis Stabilization Housing, brief (Up to 14 days)</p>	<p>Community Linkage and Stabilization Program Stabilization (CLASP)</p>
<p>Enhanced Care Management Services (CCS, TCM, CSP, MCOs)</p>	<p>Enhanced Community Hospital ED Behavioral Health Capabilities</p>			
<p>Enhanced Housing Capacity, Subsidy & Navigation</p>	<p>Urgent Care Triage Center 24/7 Walk-in/Police Transport (Adjacent to Psych ER or CRC?)</p>		<p>High ED/Crisis/911 service user strategies</p>	<p>Crisis Stabilization Housing, Long-term (Up to 6 months)</p>
<p>Peer Support/Parent & Caregiver Support Services</p>	<p>Designated Psychiatric ER (New Location, Smaller)</p>			
<p>Effective Crisis Planning WRAP/Psychiatric advance directives</p>	<p>23-hour Crisis Stabilization Services/ Observation Beds/ IP, CRC, CSH Admission Hold (Relocate, Adjacent to New Psychiatric ER)</p>			
<p>Peer Run Drop-in Center</p>	<p>Expanded Access to Psychiatric Provider Team</p>			
	<p>Psychiatry Residency & Behavioral Health Professional Education</p>			

KEY: Current Service Under Development Enhancement or New Service

Care Delivery Philosophy

- Continue transition from a system focused on emergency detentions and disposition decisions...To one informed by principles of prevention, diversion, person-centered care, dignity, recovery, and crisis resolution.
- This philosophy must be embraced by all private providers involved in the continuum, as well as justice system and community stakeholders.

Cross-Cutting Functions

- **Air traffic control:** a centralized call center, patient service tracking system, and treatment director disposition system
- **Health information exchange/WISHIN:** to facilitate personal health information accessibility and access to crisis plans
- **Telepsychiatry:** Accessible to all early intervention/subacute, acute crisis intervention programs and providers
- **Transportation strategy:** enhanced, coordinated non-law enforcement transportation
- **Justice system/law enforcement:** buy-in for new overriding philosophy, reformed policies and practices

Dedicated Psychiatric ED

- Despite increased investment in all other continuum components, *a dedicated psychiatric emergency department will be needed*
- Dedicated psychiatric ED must include appropriate clinical expertise, physical environment/milieu, and legal acumen
- Much smaller population with narrower focus - mainly individuals under emergency detentions and those with highly complex needs
- BHD retains Treatment Direction function

Dedicated Psychiatric ED

- Details still need to be determined:
 - *Exact mix of joint public-private financial support (for both ED and entire continuum)*
 - *Location*
 - *Capacity*
 - *Governance*
 - *Operations*

Other Key Components

Partnerships with FQHCs

- Early crisis intervention services delivered by embedding BHD resources at two FQHC locations on North and South sides.
- Will include short-term high intensity services, same day walk-in urgent care, navigation services.
- Will deliver fully integrated medical/behavioral health services to county residents at locations closer to their homes.
- Partnerships could be expanded to additional FQHCs in the future.

Other Key Components

Crisis Resource Centers

- Key for early intervention and diversion from EDs and inpatient treatment; step down from these more intensive services
- Currently funded by BHD, provided by contracted community partner
- CRCs provide an array of onsite supportive services including:
 - *Peer support, clinical assessment, access to medication, short-term therapy, nursing, supportive services, recovery services, linkage to ongoing support and services.*
- Planning for expanded capacity and functionality for the CRCs:
 - *Direct admissions from Crisis Mobile Team, CART, and Team Connect*
 - *Control of discharges*
 - *Potential development of additional centers*

Other Key Components

Enhanced Private Hospital ER Behavioral Health Capabilities

- Behavioral health provider education
- Telepsychiatry
 - *Provided by BHD clinicians*
- Psychiatric provider team
 - *Improve capacity to serve voluntary and involuntary clients*
 - *Provide consults, telepsychiatry to help triage and find right disposition*

Other Key Components

Crisis Stabilization Houses

- Licensed Community Based Residential Facilities
- Currently two CSHs operated by a community-based partner in collaboration with the Crisis Mobile Team
 - *16 beds serving people with significant mental health needs; short-term beds with stays of around 14 days and long-term beds with stays up to 6 months*
- CSHs provide a caring, supportive, therapeutic environment to assist people stabilize and meet their individualized needs
- There is a current capacity shortage; could add to existing types of CSH beds or potentially pursue adding new types of “step-down” beds modeled after Hennepin County

Other Key Components

Urgent Care/Triage Clinic

- New 24/7 clinic distinct from outpatient clinics and potentially located adjacent to a CRC or dedicated psychiatric ED; could also be folded into another component of the continuum of crisis services.
- Would serve as an alternative police drop-off site and also could accommodate walk-ins with the primary function of diversion from EDs, inpatient admissions, out-of-home placement, and police custody.
- Would include assessment, diagnosis, and treatment capability (including medication), delivered in a timely manner and leading to stabilization.

Other Key Components

Crisis Mobile Teams & Crisis Assessment Response Teams

- Expand CMTs and redefine functions from primarily assessing for involuntary holds to crisis resolution in the community and follow-up to ensure stabilization
 - *Addition of more peer specialists to CMTs also an important goal*
- Expand functionality of CARTs to ensure CART clinicians play a greater role in providing “warm hand-off” to care coordinators

Changing Utilization

- Utilization will be changed in two ways:
 - *Shifting from intensive, restrictive, and facility-based services to those that are more person-centered, supportive, and community-based.*
 - *Reduce volume overall*
- Reduction in volume occurs at three levels:
 - *Individuals (# individuals entering crisis service system)*
 - *Episodes (# crisis episodes per individual)*
 - *Admissions (# admissions to different crisis services per episode)*

Strategies for Reducing Volume

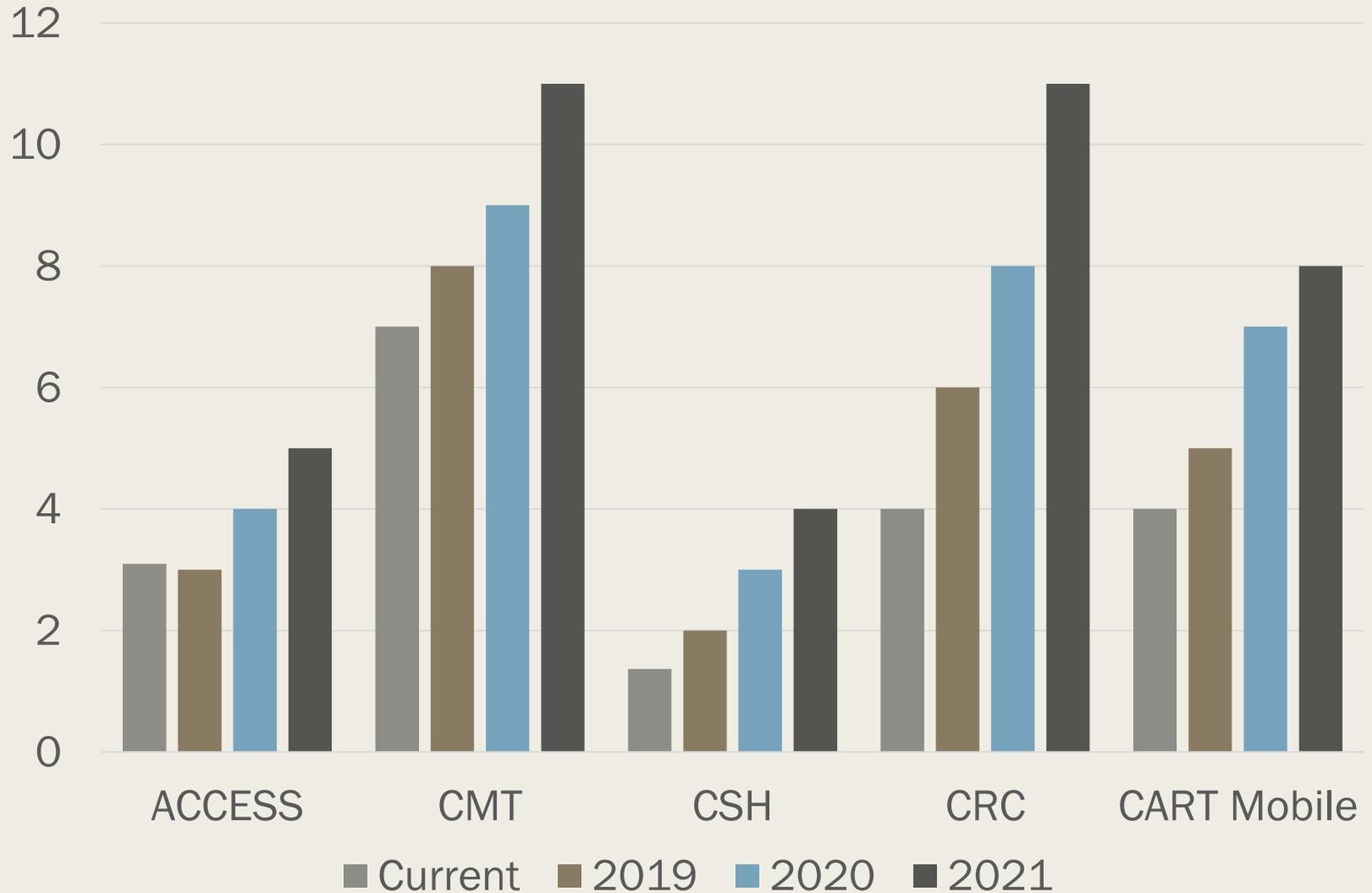
- Individual level: Prevention (enhanced competencies of community providers at advanced planning, anticipating crisis, preemptive intervention and support)
- Episode level: Diversion (identification and care planning for high utilizers)
- Admissions: Early resolution in less intensive crisis services, increased coordination and communication (among crisis services and between crisis services and community providers, including HMOs)

Potential admissions diverted from the crisis system & EDs

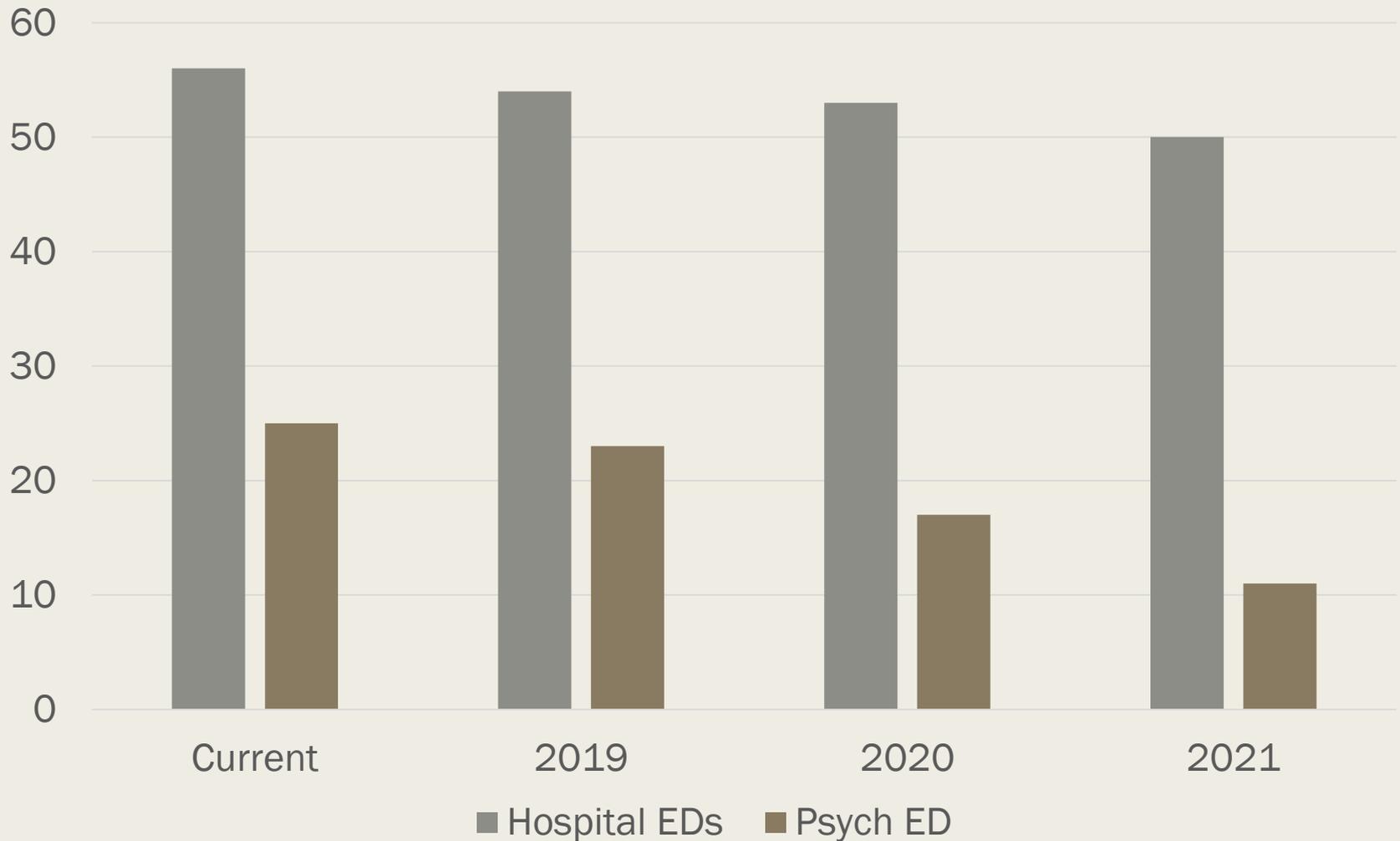
Year	N	%
2019	750	2
2020	2,250	7
2021	3,350	10

Year	ACCESS		CMT		CSH		CRC		CART Mobile		Hospital EDs		Psych ED		Total Minus Diversion	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Current	940	3	2310	7	400	1	1270	4	1230	4	18000	56	8100	25	32250	100
2019	1000	3	2400	8	600	2	1800	6	1600	5	17000	54	7100	22	31500	100
2020	1100	4	2700	9	800	3	2400	8	2000	7	16000	53	5000	16	30000	100
2021	1600	6	3000	10	1000	3	3000	10	2300	8	14000	48	4000	15	28900	100

Change in Community-Based Crisis Service - % of Admissions



Change in Facility-Based Crisis Services - % of Total Admission



Next Steps

- Review Phase 1 Adult Conceptual Model with Key Stakeholders
 - Mental Health Board
 - Health System ER and Behavioral Health Leaders
 - Community Justice Council
 - Mental Health Task Force
 - State DHS
 - BHD Leaders
- Integrate Feedback and Finalize Phase 2 Planning Process
- Concurrently Implement Enhancements to Existing Psychiatric Crisis Continuum, such as:
 - Service Enhancements (Mobile Crisis, CART, Team Connect...)
 - BHD/FQHC Community Access Centers
 - CRC Expansion

Next Steps

- Support Ongoing Communication/Redesign Process Tracking
 - Phase 1 Communication Themes (being developed by Kane)
 - Oversight Structure to be developed

- Begin Phase 2
 - Develop and Test Alternative Psychiatric ER Business Models
 - Conduct Fiscal, Operating and Implementation Analysis of All Other Components of the Adult Continuum
 - Complete Phase 1 Model for Child and Adolescent Psychiatric Crisis Services

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

DATE: November 28, 2018

TO: Thomas Lutzow, Chairperson – Milwaukee County Mental Health Board

FROM: Michael Lappen, Administrator, Behavioral Health Division

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

Background

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

Discussion

High Quality and Accountable Service Delivery

- **Grant Awards**

The Behavioral Health Division (BHD) received a grant for primary prevention for minority youth for \$50,000.00. We also received the \$1,000,000 award discussed at the October meeting to expand Medication Assisted Treatment (MAT). The funds will enable Community Medical Services to provide MAT services 24/7 and provide immediate assistance to individuals seeking to stop using opioids. The program anticipates beginning operations Feb 1, 2019.

Workforce Investment, Development, and Engagement

- **Merit Increases**

BHD was able to give about 17% of employees a merit increase in 2018 utilizing a limited pool of funds designated for merit. The increases ranged from 2% to 5%, and were based on criteria including performance evaluation scores, no recent discipline, non-probationary, and equity between similar positions. Exclusions included individuals at the top of their range, individuals who had been recently promoted, and staff who

recently received raises or a position reclassification. Between 2017 and 2018, BHD has given a merit increase to about 24% of employees above the Cost of Living Adjustment (COLA).

- **MC3 Collaboration**

BHD is taking part in a workforce development effort in collaboration with MC3 and our provider network. The idea is to develop new internship opportunities with a focus on MC3 and BHD values and targeting a more diverse workforce. The initial universities interested are the University of Wisconsin Milwaukee (UWM) School of Social Welfare, Concordia University, and Mount Mary.

Other Topics of Interest

- **Journal Sentinel Letter to the Editor**

After the reforms began (at BHD), a reader sent this note:

I had to get in touch with you regarding my sister's recent visit at the Milwaukee County Mental Health Complex. She's been chronically mentally ill for decades now, and has been to County more than two dozen times; police holds, etc. On our last visit there, at my insistence, I was met with a stern "No! I'm not going there. They are awful" from my sister. But she eventually agreed. I was stunned frankly; she stabilized after agreeing to take her meds ... the staff was very responsive to her and our family. But what was most stunning was the aftercare ... They fixed her up in an assisted living situation; called us on nights and weekends during her initial stay at County; and have followed her several weeks now post hospitalization. It's just incredible! My sister is responding to this treatment. ... Frankly our family owes this to you and the Journal. Things seem to have genuinely changed.

<https://www.jsonline.com/story/news/columnists/george-stanley/2018/11/09/journal-sentinel-what-matters-most-local-reporting-helps-find-better-ways/1947566002/>

Respectfully Submitted,



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

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: November 19, 2018

TO: Thomas Lutzow, Chairperson – Milwaukee County Mental Health Board

FROM: Mary Jo Meyers, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute a 2018 Professional Services Contract Amendment for Legal Services**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least \$100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018.

Background

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

Professional Services Contracts

Reinhart, Boerner Van Deuren, S.C. - \$25,000

The Behavioral Health Division (BHD) is seeking an amendment to the current agreement with Reinhart, Boerner Van Deuren, S.C., contractor was retained in February 2016 to provide Legal Counsel for the acute services restructuring. BHD is seeking to amend the existing agreement by \$25,000 for 2018. The new contract total will be \$374,000.

Fiscal Summary

The amount of spending requested in this report is summarized below.

Vendor Name	New/Amendment	2018 Increase Amount	Total Contract Amount
Reinhart, Boerner Van Deuren, S.C.	Amendment	\$25,000	\$374,000
Total		\$25,000	\$374,000

*Denotes a Vendor whose funding is supported by a grant.



Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: November 19, 2018

TO: Thomas Lutzow, Chairperson – Milwaukee County Mental Health Board

FROM: Mary Jo Meyers, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Division

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute a 2018 Purchase-of-Service Contract Amendment with a Value in Excess of \$100,000 for the Behavioral Health Division for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least \$100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018 and 2019.

Background

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

Purchase-of-Service Contracts

SEA Group - \$340,000

The Vendor provides Educational Advocacy services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$115,000 for 2018 making the total 2018 contract amount \$415,000. BHD previously requested \$300,000 on October 25, 2018 for the 2019 contract and is now requesting an additional \$225,000 making the total contract amount for 2019, \$525,000.

Fiscal Summary

The amount of spending requested in this report is summarized below.

Vendor Name	New/Amendment	2018 Amount	2019 Amount	Total Contract Amount
SEA Group	Amendment	\$115,000	\$225,000	\$940,000
Total		\$115,000	\$225,000	\$940,000

*Denotes a Vendor whose funding is supported by a grant.

Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

Date: November 20, 2018
To: Milwaukee County Mental Health Board
From: Margo Franklin, Director of Employee Relations, Department of Human Resources.
RE: Ratification of the 2018 Memorandum of Agreement between Milwaukee County and the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO

Milwaukee County has reached an understanding with the bargaining team for the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO that establishes a Memorandum of Agreement (MOA) for 2018.

I am requesting that this item be placed on the next agenda for the meeting of the Milwaukee County Mental Health Board.

The following documents will be provided to the Committee for their review:

- 1) The MOA between the County and the Union;
- 2) A Union notification that the MOA was ratified by the membership;
- 3) A fiscal note that has been prepared by the Office of the Comptroller.

If you have any questions, please call me at 278-4852.

**2018
AGREEMENT
BETWEEN THE
COUNTY OF MILWAUKEE
AND THE
WISCONSIN FEDERATION OF NURSES AND HEALTH PROFESSIONALS,
LOCAL 5000, AFT, AFL-CIO**

**MILWAUKEE COUNTY
DEPARTMENT OF HUMAN RESOURCES
EMPLOYEE RELATIONS
COURTHOUSE, ROOM 210
901 NORTH. 9TH STREET
MILWAUKEE, WI 53233
414-278-4852**

This Page Intentionally Left Blank

TABLE OF CONTENTS

<u>SECTION</u>	<u>PAGE</u>
 PART 1	
1.01	Recognition..... 1
1.02	Employee Defined.....2
1.03	Duration of Agreement.....2
 PART 2	
2.01	Wages.....2

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

2018
AGREEMENT
between the
COUNTY OF MILWAUKEE
and the
WISCONSIN FEDERATION OF NURSES & HEALTH PROFESSIONALS,
LOCAL 5000, AFT, AFL-CIO

This Agreement, made and entered into by and between the County of Milwaukee, a municipal body corporate, as municipal employer, hereinafter referred to as “County”, and the Wisconsin Federation of Nurses & Health Professionals, Local 5000, AFT, AFL-CIO, as representatives of employees who are employed by the County of Milwaukee, hereinafter referred to as “Association”. The County is a party to this agreement by virtue of the power granted to the Milwaukee County Mental Health Board under Wis. Stat. 51.41(10).

W I T N E S S E T H

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

PART 1

1.01 RECOGNITION

The County of Milwaukee agrees to recognize, and herewith does recognize, the Wisconsin Federation of Nurses & Health Professionals, Local 5000, AFT, AFL-CIO as the exclusive collective Bargaining agent of behalf of the employees of Milwaukee County in accordance with the certification of the Wisconsin Employment Relations Commission, as amended, in respect to wages, pursuant to Subchapter IV, Chapter 111.70, Wisconsin Statutes.

1 1.02 EMPLOYEE DEFINED

2 Wherever the term “employee” is used in this Agreement, it shall mean and include only those
3 employees of Milwaukee County within the certified bargaining unit represented by the
4 Association as seen in Appendix 1.

5

6 1.03 DURATION OF AGREEMENT

7 This Agreement is to take effect on January 1, 2018. Unless otherwise modified or extended by
8 mutual agreement of the parties, this Agreement shall expire on December 31, 2018.

9

10

PART 2

11

12 2.01 WAGES

13 Effective Pay Period 14, 2018 (June 17, 2018) the wages of bargaining unit employees shall be
14 increased by one percent (1.0%).

Appendix 1

WFNHP ORG List

Union Code	High Org	Low Org	Job Code Description
NS	4800	4842	EMS Instructor Hrly
NS	4800	4842	Instructor EMS
NS	4900	4900	Forensic Chemist
NS	6300	6313	RN Utilization Review
NS	6300	6316	RN Educator
NS	6300	6325	RN Infection Control
NS	6300	6373	Advanced Nurse Prescriber
NS	6300	6373	Advanced Nurse Prescriber Pool
NS	6300	6373	RN
NS	6300	6373	RN Pool
NS	6300	6373	Therapist Music
NS	6300	6373	Therapist Occupational
NS	6300	6373	Therapist Occupational Pool
NS	6300	6375	RN
NS	6300	6375	RN Pool
NS	6300	6376	RN
NS	6300	6376	RN Educator
NS	6300	6376	RN Pool
NS	6300	6377	RN
NS	6300	6383	Advanced Nurse Prescriber
NS	6300	6383	RN
NS	6300	6383	Therapist Occupational
NS	6300	6443	Advanced Nurse Prescriber
NS	6300	6443	RN
NS	6300	6443	RN Pool
NS	6300	6443	RN Utilization Review
NS	6300	6443	Therapist Occupational
NS	6300	6445	RN
NS	6300	6446	RN
NS	6300	6448	Therapist Music
NS	6300	6474	RN
NS	7900	7973	RN 2 - Dept on Aging
NS	8000	8921	RN 1
NS	8000	8921	RN 2

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the parties hereto have executed this Contract on the day, month and year first above written.

Wisconsin Federation of Nurses & Health
Professionals, Local 5000, AFT, AFL-CIO

By: _____ Date: _____

Department of Human Resources

By: _____ Date: _____

Director of Employee Relations

Approved for execution:

By: _____ Date: _____

Corporation Counsel

*Approved as to funds available per
Wisconsin Statutes Section 59.255(2)(e):*

By: _____ Date: _____

Comptroller

Approved:

By: _____ Date: _____

County Executive

Approved as compliant under sec. 59.42(2)(b)5, Stats.:

By: _____ Date: _____

Corporation Counsel



9620 West Greenfield Ave.
Milwaukee, WI 53214-2645
T: 414/475-6065
800/828-2256
F: 414/475-5722
www.wfnhp.org

Sent via email

October 31, 2018

Ms. Margo Franklin
Director of Employee Relations
Milwaukee County Dept of Human Resources
901 N 9th Street, Suite 210
Milwaukee, WI 53233

RE: 2018 Contract Ratification

Dear Ms. Franklin,

This letter is inform you that on October 30, 2018, the members of the Milwaukee County Chapter of Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO, voted to ratify both the 2018 BHD and non-BHD tentative agreements between the County and the Union.

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

Sincerely,

Jamie Lucas
Executive Director

Candice Owley, RN
WFNHP President

CC: Anna Maring, Chapter President

JL:CO/ak opeiu9aficio

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: November 14, 2018

TO: Tom Lutzow, Chairman, Milwaukee County Mental Health Board

FROM: Scott B. Manske, Comptroller
Cynthia (CJ) Pahl, Financial Services Manager, Office of the Comptroller

SUBJECT: Fiscal Impact – 2018 Collective Bargaining Agreement with the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO

Under Wisconsin Employment Relations Commission (WERC) rules and Statute Statute, non-public safety bargaining units are only allowed to negotiate for base wage increases on an annual basis. The start of the bargaining year for the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO (FNHP) was January 1, 2018. The last day of their previously negotiated contract was December 31, 2017. The bargaining unit was recertified in 2018.

2017 Base Wage Limit

Using rules provided by WERC, a calculation was made to provide the maximum base wage increase allowable for 2018 for this bargaining unit. The calculation was based on the members of the bargaining unit in the pay period that was 180 days prior to the expiration date of the most recent collective bargaining agreement. The pay period used was Pay Period 14 2017 (ending July 1, 2017). At that time, the bargaining unit had 123 members who were actively employed¹. The annual wages of the members were calculated based upon their existing wage rates and were then multiplied by the CPI applicable to bargaining years beginning on January 1, 2018, or 1.84 percent. This became the maximum base wage increase allowable for purposes of bargaining or \$102,106²; this is the maximum amount that can be paid in additional base wages in 2018 and can be paid out however agreed upon by the union and the County.

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

² The FNHP bargaining unit had 123 total authorized positions as of July 1, 2017 (authorized positions having the definition provided by WERC “...those positions in the bargaining unit that are filled”). However, 23 of these employees were pool or hourly positions. These employees have been excluded for purposes of calculating the maximum base wage increase and total salary lift due to language within the WERC rule ERC 90.03(3) which states to multiply the hourly base wage rate by the annual number of regularly scheduled hours for each authorized position when determining maximum base wage increases. Since these positions do not have regularly scheduled hours, they have been excluded.

2018 Wage Increase and Base Wage Compliance

Based upon the proposed agreement with the bargaining unit, the base wage rates will increase by 1.0 percent effective with Pay Period 14 (beginning June 17, 2018) for all members. The base wage increase results in a total salary lift for 2018 of \$30,467 for the bargaining unit, which is \$71,639 below the maximum base wage increase allowable. Calculation of the maximum base wage increase for the bargaining unit was made in accordance with the WERC rules. The Office of the Comptroller and outside legal counsel have discussed and have agreed to the definition, application and calculation of base wages.

Impact of 2018 Wage Increase on 2018 Budget and 2019 Budget

Based upon the proposed agreement with the bargaining unit, the base wage rates will increase by 1.0 percent effective with Pay Period 14 (beginning June 17, 2018). The cost of the wage increase for 2018, using the contract effective date, would be as follows:

2018 Salary Increase	30,467
FICA	2,331
Net cost	32,798

The 2018 Adopted Budget included an appropriation for a 1.0 percent wage increase for all employees, effective Pay Period 14 (beginning June 17, 2018), or approximately \$34,595 in additional salary dollars. Therefore, there is a \$4,444 savings based on the proposed agreement for the current year.

2018 Budgeted Salary Increase	\$ 34,595
FICA	\$ 2,647
Net Budgeted Amount	\$ 37,242
Net Actual Cost	\$ 32,798
Savings / (Cost)	\$ 4,444

Since this wage increase inflates the base wage of these employees it would therefore impact each subsequent year budget. The budget impact on 2019, assuming the same pension percentages, would be as follows:

2019 Salary Increase	56,582
FICA	4,328
Net cost	60,910



Scott B. Manske
Comptroller



Cynthia (CJ) Pahl
Financial Services Manager

OFFICE OF CORPORATION COUNSEL



Client-Driven. Community-Focused.

PAUL D. KUGLITSCH
ANNE B. KEARNEY
Deputy Corporation Counsel

TIMOTHY R. KARASKIEWICZ
MOLLY J. ZILLIG
ALAN M. POLAN
JAMES M. CARROLL
KATHRYN M. WEST
DALE R. NIKOLAY
SCOTT F. BROWN
TEDIA K. GAMIÑO
MARYNELL REGAN
DAVID N. FARWELL
Assistant Corporation Counsel

TO: Milwaukee County Mental Health Board Members

FROM: Margaret C. Daun, Corporation Counsel
Anne Berleman Kearney, Deputy Corporation Counsel *AKK*

DATE: December 3, 2018

RE: Advisory Opinion on the Milwaukee County Executive's Authority over the Behavioral Health Division Budget

The Milwaukee County Mental Health Board ("MHB") recently asked the Office of the Corporation Counsel the following question: Does the Milwaukee County Executive ("County Executive") have the authority to place an abatement (decrease) in the Behavioral Health Division ("BHD") budget and, if so, what limits are imposed on that authority?

Short Answer

The County Executive does have the authority to change the BHD budget, including an abatement and reserve drawn down like those contemplated in the 2019 budget, so long as, discussed below, (1) any changes be considered by the Executive "desirable or proper"; (2) the tax levy for BHD is not less than \$53 million or more than \$65 million, (3) a \$10 million reserve is maintained and (4) any money drawn from the BHD reserve be used for a "mental health function, program, or service."

Analysis

County Executive's Authority

To begin, the budget that MHB compiles and submits for BHD is a budget *recommendation* to the County Executive. Specifically, under Wis. Stat. §51.41(4)(b)(1), the "Milwaukee County mental health board shall *propose* to the Milwaukee County executive the total amount of the mental health budget." (emphasis added).

Following the MHB's submission of a proposed BHD budget, as is the case for budget submissions of other boards, agencies or departments, the Department of Administration compiles and submits these budget requests to the County Executive, as stated in Wis. Stat. §59.60(6). *See also* Milwaukee County General Ordinances ("MCGO") §32.81. Consistent with this same

CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATION

Milwaukee County Mental Health Board Members

December 3, 2018

Page 2 of 3

statutory provision, the County Executive reviews the budget requests and gathers additional information through public hearings. Wis. Stat. §59.60(6); MCGO §1.24.

As part of the County budget process, the state statute contemplates that the County Executive will make changes to the proposed budget. Wis. Stat. §59.60(6)(a) states as follows: “The county executive or county administrator *shall make changes in the proposed budget that in the executive’s or administrator’s discretion are considered desirable or proper.*” (emphasis added).

Expressly stated under this provision, then, the County Executive has the authority to make changes in the “proposed budget,” which changes are “in the executive’s . . . discretion,” as long as the changes are by the County Executive “considered desirable or proper.” *Id.*

The provisions of Wis. Stat. §51.41, which govern the MHB, do not call for any different process in the County Executive’s consideration of the BHD budget and the corresponding tax levy. Wis. Stat. §51.41(4)(b)(2), which specifically deals with the BHD budget, accounts for the fact that the County Executive may make changes in the proposed budget of the BHD and the tax levy. Specifically, Wis. Stat. §51.41(4)(b)(2) provides that the “county executive, in his or her proposed budget for Milwaukee County for a fiscal year, may include *a tax levy amount that is different than the tax levy amount proposed*” by the MHB for BHD. (emphasis added). Wis. Stat. §51.41(4)(b)(4),(5), then provides that the Milwaukee County Board “shall incorporate into the budget for Milwaukee County” the “tax levy amount as proposed by the county executive.”

Were there to be any resulting shortfall in the BHD budget, there is provision made under Wis. Stat. § 51.41, to cover a shortfall. Wis. Stat. §51.41(4)(d) provides that, if certain requirements are met, as outlined below, “[m]oneys in the reserve fund may be used at any time to cover deficits in the Milwaukee County mental health budget.”

Limitations

Understanding that the County Executive can make changes in the BHD budget, there are certain limitations:

- (1) ***“Desirable or proper” change.*** The first limitation, as stated above in Wis. Stat. §59.60(6)(a), provides that changes in the proposed BHD budget be “in the executive’s or administrator’s discretion . . . *considered desirable or proper.*” (emphasis added). There is nothing in the statute or in Wisconsin case law that defines “desirable or proper.”
- (2) ***Tax levy within a statutorily-set range.*** The second limitation arises from Wis. Stat. §51.41(4)(b)(2): the “county executive, in his or her proposed budget for Milwaukee County for a fiscal year, may include a tax levy amount that is different than the tax levy amount proposed” by the MHB for the BHD so long as the tax levy is *not “less than \$53,000,000 or*

CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATION

Milwaukee County Mental Health Board Members

December 3, 2018

Page 3 of 3

more than \$65,000,000,” with certain exceptions not relevant in this situation (emphasis added).

The BHD-relevant statutory requirements are satisfied by the 2019 budget and the County Executive acted within his authority. As stated in the County’s 2019 budget, the tax levy for BHD complies with this statutory requirement; it is set at \$57.13 million, which is above the \$53 million floor.

(3) and (4) *Minimum reserve level and use of reserve.* The third and fourth limitations are contained in Wis. Stat. §51.41(4)(d), which permits “[m]oneys in the reserve fund [to] be used at any time to cover deficits in the Milwaukee County mental health budget.” However, that use of reserves has statutory conditions: “If the amount in the reserve fund exceeds \$10,000,000, the amount exceeding \$10,000,000 may be used at any time for any mental health function, program, or service in Milwaukee County.”

Here again, the statutory requirements are met. BHD has a current operational reserve amount that exceeds \$10 million and any reserve amount needed to cover a gap in its budget would be used to provide a “mental health function, program, or service.”

The abatement of the BHD budget is within the authority of the County Executive and the statutory requirements for the current abatement are met.

###

Chairperson: Maria Perez
Senior Executive Assistant: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD FINANCE COMMITTEE

Thursday, December 6, 2018 - 1:30 P.M.
 Milwaukee County Mental Health Complex
 9455 West Watertown Plank Road
 Conference Room 1045

A G E N D A

SCHEDULED ITEMS:

1.	Welcome. (Chairwoman Perez)
2.	Mental Health Board Finance Committee Professional Services Contracts Recommendation. (Jennifer Bergersen, Behavioral Health Division/Recommendation Item) <ul style="list-style-type: none"> • 2018 Contract Amendment <ul style="list-style-type: none"> ➤ Reinhart, Boerner Van Duran, S.C.
3.	Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation. (Brian McBride, Behavioral Health Division/Recommendation Item) <ul style="list-style-type: none"> • 2018 Contract Amendment
4.	2018 Collective Bargaining Agreement with the Federation of Nurses and Health Professionals. (Lisa Ruiz, Department of Health and Human Services/Recommendation Item)
5.	September 2018 Financial Reporting Package. (Jeanne Dorff, Department of Health and Human Services/Informational)
6.	Crisis Services Financial Snapshot. (Jeanne Dorff, Department of Health and Human Services/Informational)
7.	Behavioral Health Division 2018 Third Quarter Dashboard. (Jeanne Dorff, Department of Health and Human Services/Informational)

SCHEDULED ITEMS (CONTINUED):

8.	Quarterly Fund Transfers. (Jeanne Dorff, Department of Health and Human Services/Informational)
9.	Adjournment.
<p style="text-align: center;">The next meeting of the Milwaukee County Mental Health Board Finance Committee is Thursday, February 28, 2019, at 7:00 a.m. at a location To Be Determined</p> <p style="text-align: center;">Visit the Milwaukee County Mental Health Board Web Page at:</p> <p style="text-align: center;">https://county.milwaukee.gov/EN/DHHS/About/Governance#MCMHBrecords</p>	
<p style="text-align: center;"><i>ADA accommodation requests should be filed with the Milwaukee County Office for Persons with Disabilities, 278-3932 (voice) or 711 (TRS), upon receipt of this notice.</i></p>	

Finance Committee Item 2

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

DATE: November 19, 2018

TO: Thomas Lutzow, Chairperson – Milwaukee County Mental Health Board

FROM: Mary Jo Meyers, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Division

**SUBJECT: Report from the Director, Department of Health and Human Services,
Requesting Authorization to Execute a 2018 Professional Services Contract
Amendment for Legal Services**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least \$100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018.

Background

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

Professional Services Contracts

Reinhart, Boerner Van Deuren, S.C. - \$25,000

The Behavioral Health Division (BHD) is seeking an amendment to the current agreement with Reinhart, Boerner Van Deuren, S.C., contractor was retained in February 2016 to provide Legal Counsel for the acute services restructuring. BHD is seeking to amend the existing agreement by \$25,000 for 2018. The new contract total will be \$374,000.

Fiscal Summary

The amount of spending requested in this report is summarized below.

Vendor Name	New/Amendment	2018 Increase Amount	Total Contract Amount
Reinhart, Boerner Van Deuren, S.C.	Amendment	\$25,000	\$374,000
Total		\$25,000	\$374,000

*Denotes a Vendor whose funding is supported by a grant.



Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

Finance Committee Item 3

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: November 19, 2018

TO: Thomas Lutzow, Chairperson – Milwaukee County Mental Health Board

FROM: Mary Jo Meyers, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute a 2018 Purchase-of-Service Contract Amendment with a Value in Excess of \$100,000 for the Behavioral Health Division for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least \$100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018 and 2019.

Background

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

Purchase-of-Service Contracts

SEA Group - \$340,000

The Vendor provides Educational Advocacy services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$115,000 for 2018 making the total 2018 contract amount \$415,000. BHD previously requested \$300,000 on October 25, 2018 for the 2019 contract and is now requesting an additional \$225,000 making the total contract amount for 2019, \$525,000.

Fiscal Summary

The amount of spending requested in this report is summarized below.

Vendor Name	New/Amendment	2018 Amount	2019 Amount	Total Contract Amount
SEA Group	Amendment	\$115,000	\$225,000	\$940,000
Total		\$115,000	\$225,000	\$940,000

*Denotes a Vendor whose funding is supported by a grant.

Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

Finance Committee Item 4

COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

Date: November 20, 2018
To: Milwaukee County Mental Health Board
From: Margo Franklin, Director of Employee Relations, Department of Human Resources.
RE: Ratification of the 2018 Memorandum of Agreement between Milwaukee County and the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO

Milwaukee County has reached an understanding with the bargaining team for the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO that establishes a Memorandum of Agreement (MOA) for 2018.

I am requesting that this item be placed on the next agenda for the meeting of the Milwaukee County Mental Health Board.

The following documents will be provided to the Committee for their review:

- 1) The MOA between the County and the Union;
- 2) A Union notification that the MOA was ratified by the membership;
- 3) A fiscal note that has been prepared by the Office of the Comptroller.

If you have any questions, please call me at 278-4852.

**2018
AGREEMENT
BETWEEN THE
COUNTY OF MILWAUKEE
AND THE
WISCONSIN FEDERATION OF NURSES AND HEALTH PROFESSIONALS,
LOCAL 5000, AFT, AFL-CIO**

**MILWAUKEE COUNTY
DEPARTMENT OF HUMAN RESOURCES
EMPLOYEE RELATIONS
COURTHOUSE, ROOM 210
901 NORTH. 9TH STREET
MILWAUKEE, WI 53233
414-278-4852**

This Page Intentionally Left Blank

TABLE OF CONTENTS

<u>SECTION</u>	<u>PAGE</u>
 PART 1	
1.01	Recognition..... 1
1.02	Employee Defined.....2
1.03	Duration of Agreement.....2
 PART 2	
2.01	Wages.....2

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

2018
AGREEMENT
between the
COUNTY OF MILWAUKEE
and the
WISCONSIN FEDERATION OF NURSES & HEALTH PROFESSIONALS,
LOCAL 5000, AFT, AFL-CIO

This Agreement, made and entered into by and between the County of Milwaukee, a municipal body corporate, as municipal employer, hereinafter referred to as “County”, and the Wisconsin Federation of Nurses & Health Professionals, Local 5000, AFT, AFL-CIO, as representatives of employees who are employed by the County of Milwaukee, hereinafter referred to as “Association”. The County is a party to this agreement by virtue of the power granted to the Milwaukee County Mental Health Board under Wis. Stat. 51.41(10).

WITNESSETH

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

PART 1

1.01 RECOGNITION

The County of Milwaukee agrees to recognize, and herewith does recognize, the Wisconsin Federation of Nurses & Health Professionals, Local 5000, AFT, AFL-CIO as the exclusive collective Bargaining agent of behalf of the employees of Milwaukee County in accordance with the certification of the Wisconsin Employment Relations Commission, as amended, in respect to wages, pursuant to Subchapter IV, Chapter 111.70, Wisconsin Statutes.

1 1.02 EMPLOYEE DEFINED

2 Wherever the term “employee” is used in this Agreement, it shall mean and include only those
3 employees of Milwaukee County within the certified bargaining unit represented by the
4 Association as seen in Appendix 1.

5
6 1.03 DURATION OF AGREEMENT

7 This Agreement is to take effect on January 1, 2018. Unless otherwise modified or extended by
8 mutual agreement of the parties, this Agreement shall expire on December 31, 2018.

9

10 **PART 2**

11

12 2.01 WAGES

13 Effective Pay Period 14, 2018 (June 17, 2018) the wages of bargaining unit employees shall be
14 increased by one percent (1.0%).

Appendix 1

WFNHP ORG List

Union Code	High Org	Low Org	Job Code Description
NS	4800	4842	EMS Instructor Hrly
NS	4800	4842	Instructor EMS
NS	4900	4900	Forensic Chemist
NS	6300	6313	RN Utilization Review
NS	6300	6316	RN Educator
NS	6300	6325	RN Infection Control
NS	6300	6373	Advanced Nurse Prescriber
NS	6300	6373	Advanced Nurse Prescriber Pool
NS	6300	6373	RN
NS	6300	6373	RN Pool
NS	6300	6373	Therapist Music
NS	6300	6373	Therapist Occupational
NS	6300	6373	Therapist Occupational Pool
NS	6300	6375	RN
NS	6300	6375	RN Pool
NS	6300	6376	RN
NS	6300	6376	RN Educator
NS	6300	6376	RN Pool
NS	6300	6377	RN
NS	6300	6383	Advanced Nurse Prescriber
NS	6300	6383	RN
NS	6300	6383	Therapist Occupational
NS	6300	6443	Advanced Nurse Prescriber
NS	6300	6443	RN
NS	6300	6443	RN Pool
NS	6300	6443	RN Utilization Review
NS	6300	6443	Therapist Occupational
NS	6300	6445	RN
NS	6300	6446	RN
NS	6300	6448	Therapist Music
NS	6300	6474	RN
NS	7900	7973	RN 2 - Dept on Aging
NS	8000	8921	RN 1
NS	8000	8921	RN 2

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the parties hereto have executed this Contract on the day, month and year first above written.

Wisconsin Federation of Nurses & Health
Professionals, Local 5000, AFT, AFL-CIO

By: _____ Date: _____

Department of Human Resources

By: _____ Date: _____

Director of Employee Relations

Approved for execution:

By: _____ Date: _____

Corporation Counsel

*Approved as to funds available per
Wisconsin Statutes Section 59.255(2)(e):*

By: _____ Date: _____

Comptroller

Approved:

By: _____ Date: _____

County Executive

Approved as compliant under sec. 59.42(2)(b)5, Stats.:

By: _____ Date: _____

Corporation Counsel



9620 West Greenfield Ave.
Milwaukee, WI 53214-2645
T: 414/475-6065
800/828-2256
F: 414/475-5722
www.wfnhp.org

Sent via email

October 31, 2018

Ms. Margo Franklin
Director of Employee Relations
Milwaukee County Dept of Human Resources
901 N 9th Street, Suite 210
Milwaukee, WI 53233

RE: 2018 Contract Ratification

Dear Ms. Franklin,

This letter is inform you that on October 30, 2018, the members of the Milwaukee County Chapter of Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO, voted to ratify both the 2018 BHD and non-BHD tentative agreements between the County and the Union.

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

Sincerely,

Jamie Lucas
Executive Director

Candice Owley, RN
WFNHP President

CC: Anna Maring, Chapter President

JL:CO/ak opeiu9aficio

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: November 14, 2018

TO: Tom Lutzow, Chairman, Milwaukee County Mental Health Board

FROM: Scott B. Manske, Comptroller
Cynthia (CJ) Pahl, Financial Services Manager, Office of the Comptroller

SUBJECT: Fiscal Impact – 2018 Collective Bargaining Agreement with the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO

Under Wisconsin Employment Relations Commission (WERC) rules and Statute Statute, non-public safety bargaining units are only allowed to negotiate for base wage increases on an annual basis. The start of the bargaining year for the Wisconsin Federation of Nurses and Health Professionals, Local 5000, AFT, AFL-CIO (FNHP) was January 1, 2018. The last day of their previously negotiated contract was December 31, 2017. The bargaining unit was recertified in 2018.

2017 Base Wage Limit

Using rules provided by WERC, a calculation was made to provide the maximum base wage increase allowable for 2018 for this bargaining unit. The calculation was based on the members of the bargaining unit in the pay period that was 180 days prior to the expiration date of the most recent collective bargaining agreement. The pay period used was Pay Period 14 2017 (ending July 1, 2017). At that time, the bargaining unit had 123 members who were actively employed¹. The annual wages of the members were calculated based upon their existing wage rates and were then multiplied by the CPI applicable to bargaining years beginning on January 1, 2018, or 1.84 percent. This became the maximum base wage increase allowable for purposes of bargaining or \$102,106²; this is the maximum amount that can be paid in additional base wages in 2018 and can be paid out however agreed upon by the union and the County.

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

² The FNHP bargaining unit had 123 total authorized positions as of July 1, 2017 (authorized positions having the definition provided by WERC “...those positions in the bargaining unit that are filled”). However, 23 of these employees were pool or hourly positions. These employees have been excluded for purposes of calculating the maximum base wage increase and total salary lift due to language within the WERC rule ERC 90.03(3) which states to multiply the hourly base wage rate by the annual number of regularly scheduled hours for each authorized position when determining maximum base wage increases. Since these positions do not have regularly scheduled hours, they have been excluded.

2018 Wage Increase and Base Wage Compliance

Based upon the proposed agreement with the bargaining unit, the base wage rates will increase by 1.0 percent effective with Pay Period 14 (beginning June 17, 2018) for all members. The base wage increase results in a total salary lift for 2018 of \$30,467 for the bargaining unit, which is \$71,639 below the maximum base wage increase allowable. Calculation of the maximum base wage increase for the bargaining unit was made in accordance with the WERC rules. The Office of the Comptroller and outside legal counsel have discussed and have agreed to the definition, application and calculation of base wages.

Impact of 2018 Wage Increase on 2018 Budget and 2019 Budget

Based upon the proposed agreement with the bargaining unit, the base wage rates will increase by 1.0 percent effective with Pay Period 14 (beginning June 17, 2018). The cost of the wage increase for 2018, using the contract effective date, would be as follows:

2018 Salary Increase	30,467
FICA	2,331
Net cost	32,798

The 2018 Adopted Budget included an appropriation for a 1.0 percent wage increase for all employees, effective Pay Period 14 (beginning June 17, 2018), or approximately \$34,595 in additional salary dollars. Therefore, there is a \$4,444 savings based on the proposed agreement for the current year.

2018 Budgeted Salary Increase	\$ 34,595
FICA	\$ 2,647
Net Budgeted Amount	\$ 37,242
Net Actual Cost	\$ 32,798
Savings / (Cost)	\$ 4,444

Since this wage increase inflates the base wage of these employees it would therefore impact each subsequent year budget. The budget impact on 2019, assuming the same pension percentages, would be as follows:

2019 Salary Increase	56,582
FICA	4,328
Net cost	60,910



Scott B. Manske
Comptroller



Cynthia (CJ) Pahl
Financial Services Manager

Finance Committee Item 5

Milwaukee County Behavioral Health Division 2018 September Year to Date Projection - Major Variances (\$ millions)

Total BHD Projected Surplus/(Deficit)		\$ 2.7
Hospital (Adult Inpatient, CAIS, ER/Obs)		(\$1.9)
REVENUE:		
<i>Patient Revenue - CAIS (\$1.5), PCS-ER/Obs (\$1.7), Adult (\$1)</i>	\$ (3.3)	
EXPENSES:		
<i>Personnel Expenses (Overtime over Budget)</i>	\$ (0.5)	
<i>Miscellaneous Patient Expenses</i>	\$ 1.7	
<i>State Institutes</i>	\$ (0.8)	
<i>Internal Allocation revised, favorable to Inpatient</i>	\$ 1.0	
<i>Sub-Total Hospital Expenses</i>	<u>\$ 1.4</u>	
Management/Operations/Fiscal		\$0.5
<i>Personnel Expenses - Salary surplus from vacant positions</i>		
Community Services		\$4.1
REVENUE:		
<i>CCS WIMCR</i>	\$ 1.8	
<i>Wraparound (enrollment, anticipated rate decrease)</i>	\$ (4.3)	
EXPENSES:		
<i>Wraparound (enrollment, lower residential utilization)</i>	\$ 7.1	
<i>CRS/IOP/Day Tx Underspend</i>	\$ 1.5	
<i>Residential - CBRF</i>	\$ (1.7)	
<i>Salary Underspend</i>	\$ 1.4	
<i>RSC/Outpatient Overspend</i>	\$ (1.6)	
<i>Sub-Total Community Expenses</i>	<u>\$ 6.7</u>	

Behavioral Health Division

Combined Reporting

Q3 2018 - 2018 September YTD Projection

	2018 Budget				2018 September YTD Projection				2018 Surplus/(Deficit)			
	Hospital	Community Services	Mgmt/Ops/Fiscal	Total BHD	Hospital	Community Services	Mgmt/Ops/Fiscal	Total BHD	Hospital	Community Services	Mgmt/Ops/Fiscal	Total BHD
Revenue												
BCA	7,700,026	14,636,560	-	22,336,586	7,700,026	14,636,560	-	22,336,586	-	-	-	-
State & Federal	-	19,202,016	-	19,202,016	159,040	18,436,120	-	18,595,160	159,040	(765,896)	-	(606,856)
Patient Revenue	20,796,123	89,970,204	333,247	111,099,574	17,295,000	84,500,783	47,129	101,842,912	(3,501,123)	(5,469,421)	(286,118)	(9,256,662)
Other	-	1,691,351	573,997	2,265,348	21,158	1,885,272	278,446	2,184,876	21,158	193,921	(295,551)	(80,472)
Sub-Total Revenue	28,496,149	125,500,131	907,244	154,903,524	25,175,224	119,458,734	325,575	144,959,533	(3,320,925)	(6,041,397)	(581,669)	(9,943,991)
Expense												
Salary	15,632,324	9,115,938	8,199,146	32,947,408	15,066,009	7,643,191	6,567,243	29,276,443	566,315	1,472,747	1,631,903	3,670,965
Overtime	1,085,928	3,060	137,496	1,226,484	2,025,734	154,732	202,765	2,383,231	(939,806)	(151,672)	(65,269)	(1,156,747)
Fringe	16,751,777	8,944,329	9,492,181	35,188,287	16,834,346	8,868,420	9,315,826	35,018,592	(82,569)	75,909	176,355	169,695
Services/Commodities	5,533,271	806,595	9,570,257	15,910,123	3,822,564	1,182,919	9,968,710	14,974,193	1,710,707	(376,324)	(398,453)	935,930
Other Charges/Vendor	2,500,000	125,758,133	-	128,258,133	3,311,778	112,564,517	0	115,876,295	(811,778)	13,193,616	(0)	12,381,838
Capital	8,508	-	502,500	511,008	6,693	2,371	505,256	514,321	1,815	(2,371)	(2,756)	(3,313)
Cross Charges	16,302,089	38,108,286	6,818,211	61,228,586	15,312,671	19,721,209	6,550,270	41,584,151	989,418	18,387,077	267,941	19,644,435
Abatements	-	(27,513,557)	(33,297,997)	(60,811,554)	-	(5,044,187)	(32,784,495)	(37,828,682)	-	(22,469,370)	(513,502)	(22,982,872)
Total Expense	57,813,897	155,222,784	1,421,794	214,458,475	56,379,795	145,093,174	325,575	201,798,545	1,434,102	10,129,610	1,096,219	12,659,930
Tax Levy	29,317,748	29,722,653	514,550	59,554,951	31,204,571	25,634,440	0	56,839,011	(1,886,823)	4,088,213	514,550	2,715,940

Hospital includes Adult Inpatient, Child and Adolescent Inpatient and Crisis ER/Observation.

Mgmt/Ops/Fiscal includes administrative functions includes all support functions such as: management, quality, contracts, legal, dietary, fiscal, admissions, medical records and facilities.

The projected cost of these functions which is allocated out to the BHD programs is: \$32,784,495

Community includes Wraparound, AODA and Community Mental Health.

Community Mental Health includes major programs: TCM, CCS, CSP and CRS in addition to CBRF, CCC, IOP, Day Treatment, Community Administrative functions and Community Crisis programs including Mobile Teams, Access Clinic and contracted crisis services.

Behavioral Health Division

CARSD

Q3 2018 - 2018 September YTD Projection

	2018 Budget				2018 September YTD Projection				2018 Surplus/Deficit			
	AODA	Mental Health	WRAP	Total CARSD	AODA	Mental Health	WRAP	Total CARSD	AODA	Mental Health	WRAP	Total CARSD
Revenue												
BCA	2,333,731	12,302,829	-	14,636,560	2,333,731	12,302,829	-	14,636,560	-	-	-	-
State & Federal	8,711,615	9,118,337	1,372,064	19,202,016	8,472,269	8,492,433	1,471,418	18,436,120	(239,346)	(625,904)	99,354	(765,896)
Patient Revenue	-	30,931,786	59,038,418	89,970,204	0	29,967,762	54,533,021	84,500,783	-	(964,024)	(4,505,397)	(5,469,421)
Other	665,246	846,105	180,000	1,691,351	560,885	1,118,937	205,450	1,885,272	(104,361)	272,832	25,450	193,921
Sub-Total Revenue	11,710,592	53,199,057	60,590,482	125,500,131	11,366,885	51,881,961	56,209,888	119,458,734	(343,707)	(1,317,096)	(4,380,594)	(6,041,397)
Expense												
Salary	62,028	6,299,936	2,753,974	9,115,938	68,019	5,379,598	2,195,574	7,643,191	(5,991)	920,338	558,400	1,472,747
Overtime	-	-	3,060	3,060	0	141,965	12,767	154,732	-	(141,965)	(9,707)	(151,672)
Fringe	64,185	6,425,968	2,454,176	8,944,329	64,634	6,377,606	2,426,180	8,868,420	(449)	48,362	27,996	75,909
Services/Commodities	115,000	470,386	221,209	806,595	142,286	584,691	455,943	1,182,919	(27,286)	(114,305)	(234,734)	(376,324)
Other Charges/Vendor	12,228,695	55,868,210	57,661,228	125,758,133	14,187,407	51,850,864	46,526,246	112,564,517	(1,958,712)	4,017,346	11,134,982	13,193,616
Capital	-	-	-	-	0	-	2,371	2,371	-	-	(2,371)	(2,371)
Cross Charges	1,526,457	20,414,101	16,167,728	38,108,286	1,209,696	11,632,451	6,879,062	19,721,209	316,761	8,781,650	9,288,666	18,387,077
Abatements	-	(8,834,695)	(18,678,862)	(27,513,557)	-	-	(5,044,187)	(5,044,187)	-	(8,834,695)	(13,634,675)	(22,469,370)
Total Expense	13,996,365	80,643,906	60,582,513	155,222,784	15,672,043	75,967,175	53,453,957	145,093,174	(1,675,678)	4,676,731	7,128,556	10,129,610
Tax Levy	2,285,773	27,444,849	(7,969)	29,722,653	4,305,158	24,085,213	(2,755,932)	25,634,440	(2,019,385)	3,359,636	2,747,963	4,088,213

Community Mental Health includes the following major programs: TCM, CCS, CSP and CRS in addition to CBRF, CCC, IOP, Day Treatment, Community Administrative functions, and Community Crisis programs including Mobile Teams, Access Clinic and contracted crisis services.

Community Mental Health - Major Variances:

CCS WIMCR	\$	1.8
CARS CARE Coord billing	\$	0.2
CRS Underspend	\$	0.2
Salary underspend	\$	0.9
PoS Underspend	\$	1.1
Residential	\$	(0.8)
	\$	3.4

AODA Variances

Grant underspend	\$	(0.5)
RSC/Outpatient Overspend	\$	(1.5)

Wrap Variance

Salary underspend	\$	0.5
-------------------	----	-----

Underspend due to enrollr	\$	2.1
Grant Revenue	\$	0.1

Behavioral Health Division

Inpatient - Hospital

Q3 2018 - 2018 September YTD Projection

	2018 Budget				2018 September YTD Projection				2018 Surplus/(Deficit)			
	Adult	CAIS	Crisis ER/Obs	Total Inpatient	Adult	CAIS	Crisis ER/Obs	Total Inpatient	Adult	CAIS	Crisis ER/Obs	Total Inpatient
Revenue												
BCA	-	-	7,700,026	7,700,026	-	-	7,700,026	7,700,026	-	-	-	-
State & Federal	-	-	-	-	159,040	-	-	159,040	159,040	-	-	159,040
Patient Revenue	12,977,749	4,629,746	3,188,628	20,796,123	12,725,104	3,106,995	1,462,901	17,295,000	(252,645)	(1,522,751)	(1,725,727)	(3,501,123)
Other	-	-	-	-	-	21,158	-	21,158	-	21,158	-	21,158
Sub-Total Revenue	12,977,749	4,629,746	10,888,654	28,496,149	12,884,144	3,128,153	9,162,927	25,175,224	(93,605)	(1,501,593)	(1,725,727)	(3,320,925)
Expense												
Salary	7,945,372	1,989,396	5,697,556	15,632,324	7,385,369	1,832,358	5,848,282	15,066,009	560,003	157,038	(150,726)	566,315
Overtime	757,152	41,556	287,220	1,085,928	1,122,256	83,414	820,064	2,025,734	(365,104)	(41,858)	(532,844)	(939,806)
Fringe	9,734,660	2,081,971	4,935,146	16,751,777	9,753,029	2,051,290	5,030,028	16,834,346	(18,369)	30,681	(94,882)	(82,569)
Services/Commodities	3,633,673	480,969	1,418,629	5,533,271	3,176,138	241,118	405,308	3,822,564	457,535	239,851	1,013,321	1,710,707
Other Charges/Vendor	2,500,000	-	-	2,500,000	3,311,778	-	-	3,311,778	(811,778)	-	-	(811,778)
Capital	3,000	-	5,508	8,508	-	-	6,693	6,693	3,000	-	(1,185)	1,815
Cross Charges	8,556,278	2,523,861	5,221,950	16,302,089	8,006,652	2,620,398	4,685,621	15,312,671	549,626	(96,537)	536,329	989,418
Abatements	-	-	-	-	-	-	-	-	-	-	-	-
Total Expense	33,130,135	7,117,753	17,566,009	57,813,897	32,755,221	6,828,578	16,795,997	56,379,795	374,914	289,175	770,012	1,434,102
Tax Levy	20,152,386	2,488,007	6,677,355	29,317,748	19,871,077	3,700,425	7,633,069	31,204,571	281,309	(1,212,418)	(955,714)	(1,886,823)

(218,656) Total Personnel Variance incl Locum's Temp Psychiatrists (\$395,187)

Inpatient Programs - Major Variances:

Adult - Patient Revenue (\$1.6m) offset by DSH + State Plan \$1.3m	\$	(0.3)
Adult - Revenue from State for rebalancing initiative	\$	0.1
Adult - Savings in patient related expenses - food, transp, drugs etc \$.8m offset by Temp Doctors (\$.4m)	\$	0.4
Adult/CAIS - State Institutes	\$	(0.8)
CAIS - Patient Revenue due to low census and not billing when CON needed	\$	(1.5)
CAIS - Patient related expenses - food and drugs	\$	0.2
PCS - Patient Revenue - admissions down 6% (\$.9), and WIMCR moved to community (\$.8)	\$	(1.7)
PCS - Personnel expenses (\$.8m), services - Security \$.8m moved to cross charge, other expenses lower	\$	0.2
Inpatient Hospital Operations - Internal Allocation revised versus budget - more \$ to community	\$	1.0

Behavioral Health Division
Management/Operations/Fiscal
Q3 2018 - 2018 September YTD Projection

	2018 Budget	2018 September YTD Projection	2018 Surplus/(Deficit)
Revenue			
BCA	-	-	-
State & Federal	-	-	-
Patient Revenue	333,247	47,129	(286,118)
Other	573,997	278,446	(295,551)
Sub-Total Revenue	907,244	325,575	(581,669)
Expense			
Salary	8,199,146	6,567,243	1,631,903
Overtime	137,496	202,765	(65,269)
Fringe	9,492,181	9,315,826	176,355
Services/Commodities	9,570,257	9,968,710	(398,453)
Other Charges/Vendor	-	0	(0)
Capital	502,500	505,256	(2,756)
Cross Charges	6,818,211	6,550,270	267,941
Abatements	(33,297,997)	(32,784,495)	(513,502)
Total Expense	1,421,794	325,575	1,096,219
Tax Levy	514,550	0	514,550

Surplus/(Deficit) before allocating out: 1,028,052

Major Variances:

- Salaries - Of the \$1.6m in surplus, \$1.0m represents positions that are currently vacant and will not be filled.
- Services/Commodities - security paid here but budgeted in programs
- Revenue - State Plan Amendment budgeted in Fiscal, recorded in Adult Inpatient

Finance Committee Item 6

Milwaukee County Behavioral Health Division Crisis Services - Hospital and Community Based Services Overview

2018 Projection (\$ in Millions)

Statistics (projected 2018):

Admissions/Clients Served

²Emergency Detentions

PCS Disposition of Admits:

Observation

Adult Inpatient

Child Inpatient

Transfers to hospitals

Other Disposition

BHD Employees Utilized:

Current # of employees (incl Hrly)

Expenses:

Personnel³

Other Expenses

Internal Overhead Allocated

Total Expenses

Funding Sources:

Patient Revenue

WIMCR (Medicaid Cost Rpt)

County Tax Levy

BCA (State Tax \$)

Sub-Total Govt Funds

Total Funding

	PCS ER/Obs	Mobile Teams Incl CART	Team Connect	Contracted Services ¹	Current ⁴ Access Clinic	TOTAL
Admissions/Clients Served	7,375	6,301	No Measures	CRC 1,138	2,482	
² Emergency Detentions	3,077	84	available at this time, but positive feedback.	Capacity: CRC - 27 beds Stabilization Houses - 16 beds		
Observation	365	CART-2,816				
Adult Inpatient	756	contacts and				
Child Inpatient	623	Mobile-3,485				
Transfers to hospitals	589					
Other Disposition	5,042					
	7,375					
Current # of employees (incl Hrly)	93.0	33.0	5.0	-	7.0	138.0
Personnel ³	\$ 11.7	\$ 4.3	\$ 0.3	\$ -	\$ 1.5	\$ 17.8
Other Expenses	\$ 0.6	\$ 0.4	\$ -	\$ 3.0	\$ 0.2	\$ 4.2
Internal Overhead Allocated	\$ 4.5	\$ 0.8	\$ -	\$ 0.3	\$ 0.4	\$ 6.0
Total Expenses	\$ 16.8	\$ 5.5	\$ 0.3	\$ 3.3	\$ 2.1	\$ 28.0
Patient Revenue	\$ 1.5	\$ 0.8	\$ 0.2	\$ 1.7	\$ 0.1	\$ 4.3
WIMCR (Medicaid Cost Rpt)	\$ -	\$ -	\$ -	\$ 0.8	\$ -	\$ 0.8
County Tax Levy	\$ 7.6	\$ 4.7	\$ 0.1	\$ 0.8	\$ 0.7	\$ 13.9
BCA (State Tax \$)	\$ 7.7	\$ -	\$ -	\$ -	\$ 1.3	\$ 9.0
Sub-Total Govt Funds	\$ 15.3	\$ 4.7	\$ 0.1	\$ 0.8	\$ 2.0	\$ 22.9
Total Funding	\$ 16.8	\$ 5.5	\$ 0.3	\$ 3.3	\$ 2.1	\$ 28.0

Expenses funded by Patient Revenue 9% 15% 67% 76% 5% 18%
Avg Expense per client (initial) \$ 2,278 \$ 873 \$ 846

¹Contracted Services include CLASP, Stabilization Houses, Crisis Resource Centers etc.

²In 2017 there were 1,466 Adult and 670 Juvenile CH51 cases taken to court for a total of 2,136.

³There is some sharing of personnel that is not reflected in costs - Consultation for mobiles, orders for Stabilization House admits, and (.30 FTE) of Prescriber time from ER utilized in Access Clinic. The FQHC's, however, are budgeting for their own prescribers.

⁴Tentative FQHC plans include using this tax levy plus additional tax levy and FTE's from BHD Community Services.

Personnel (Active)	\$ 8.9	\$ 2.9	\$ 0.3	\$ -	\$ 0.9	\$ 13.0
Legacy Benefits	\$ 2.8	\$ 1.4	\$ -	\$ -	\$ 0.6	\$ 4.8
	\$ 11.70	\$ 4.30	\$ 0.30	\$ -	\$ 1.50	\$ 17.80

Finance Committee Item 7

BEHAVIORAL HEALTH DIVISION

DASHBOARD REPORT

3rd Quarter 2018

Table of Contents

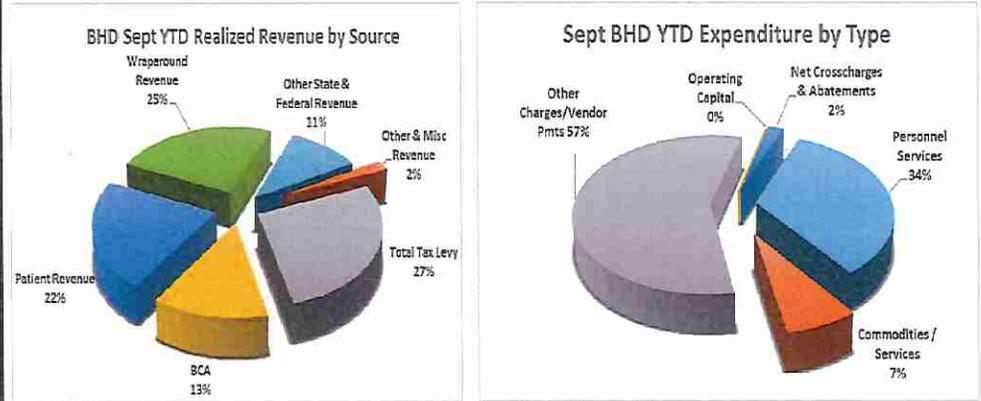
PAGE 2	Table of Contents
PAGE 3	BHD Combined
PAGE 4	Acute Adult Inpatient
PAGE 5	Child and Adolescent Inpatient (CAIS)
PAGE 6	Psychiatric Crisis Services
PAGE 7	AODA
PAGE 8	Wraparound
PAGE 9	TCM (Targeted Case Management)
PAGE 10	CCS (Comprehensive Community Services)
PAGE 11	CSP (Community Support Program)

BHD COMBINED DASHBOARD

3rd Quarter 2018

	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	99,107,706	144,959,533	154,903,524	(9,943,991)
Expense				
Personnel	46,116,682	66,678,267	69,362,179	2,683,912
Svcs/Commodities	10,002,136	14,974,193	15,910,123	935,930
Other Chgs/Vendor	77,339,790	115,876,295	128,258,133	12,381,838
Capital	12,118	514,321	511,008	(3,313)
Cross Charges	27,761,159	41,584,151	61,228,586	19,644,435
Abatements	(24,817,699)	(37,828,682)	(60,811,554)	(22,982,872)
Total Expense	136,414,186	201,798,545	214,458,475	12,659,930
Tax Levy	37,306,480	56,839,012	59,554,951	2,715,939
Wraparound		(2,755,931)	(7,969)	2,747,962
BHD Excluding Wraparound		59,594,943	59,562,920	(32,023)
Percentage Spent	64%			
Percentage Yr Elapsed	75%			

2018 SEPTEMBER YTD Revenues & Expenses by Percentage



Note: "Other Charges" in Expenditures include all Provider Payments - Fee For Service, Purchase of Service and other contracted services.

3rd Quarter Financial Highlights

- Inpatient Census below budget YTD
- Adult Inpatient Payer Mix favorable
- State Institutions \$900,000 deficit
- Staffing turnover creating salary surplus
- Slower CCS growth
- Lower Wraparound enrollment
- Lower Wraparound residential utilization

2018 Budget Initiatives

Initiative	Status
Northside Hub	➡ On hold
CCS Expansion	➡ Continued growth
Crisis Mobile Productivity	⬆️ \$0.5m revenue increase
Add West Allis CART team	⬆️

Complete ⬆️
Not Done ⬆️
Progressing ➡

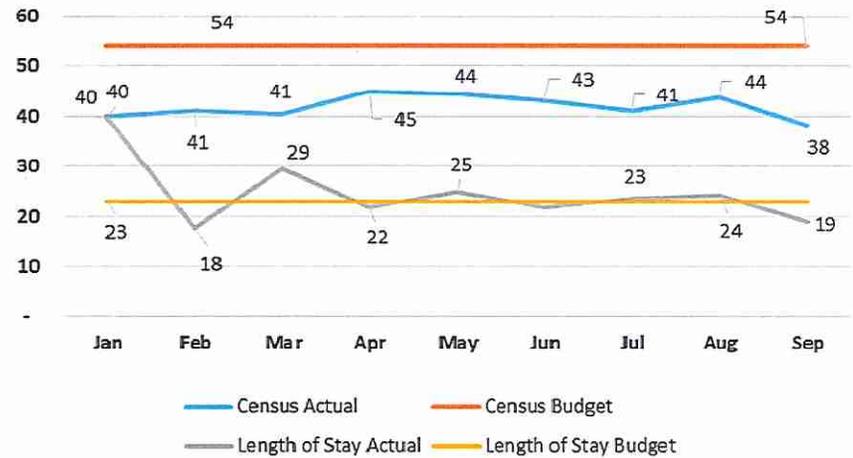
ACUTE ADULT INPATIENT DASHBOARD

3rd Quarter 2018

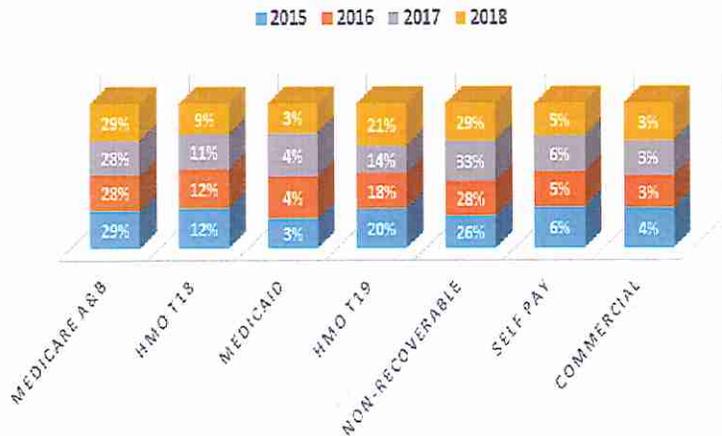
	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	9,652,494	12,884,144	12,977,749	(93,605)
Expense				
Personnel	12,319,979	18,260,653	18,437,184	176,531
Svcs/Commodities	2,161,621	3,176,138	3,633,673	457,535
Other Chgs/Vendor	2,240,559	3,311,778	2,500,000	(811,778)
Capital	-	-	3,000	3,000
Cross Charges	5,247,383	8,006,652	8,556,278	549,626
Abatements	-	-	-	-
Total Expense	21,969,542	32,755,221	33,130,135	374,914
Tax Levy	12,317,048	19,871,077	20,152,386	281,309

Percentage Spent 66%
 Percentage Yr Elapsed 75%

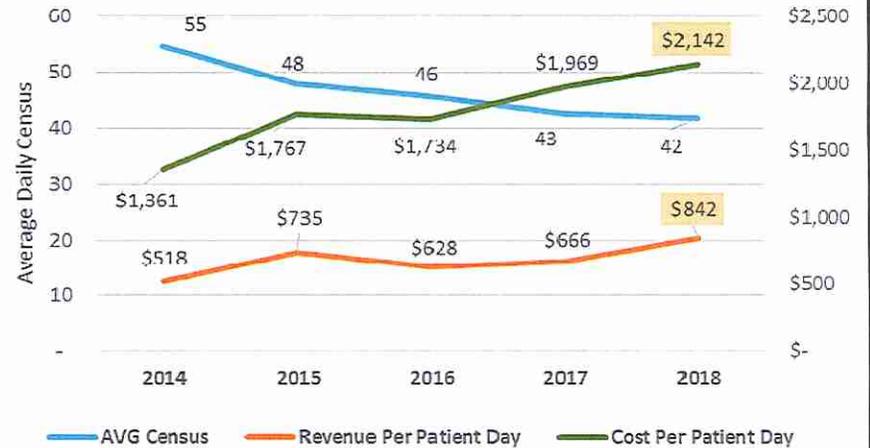
Adult Census and Length of Stay



ADULT INPATIENT PAYER SOURCES



Avg Census, Cost & Net Revenue per Patient Day



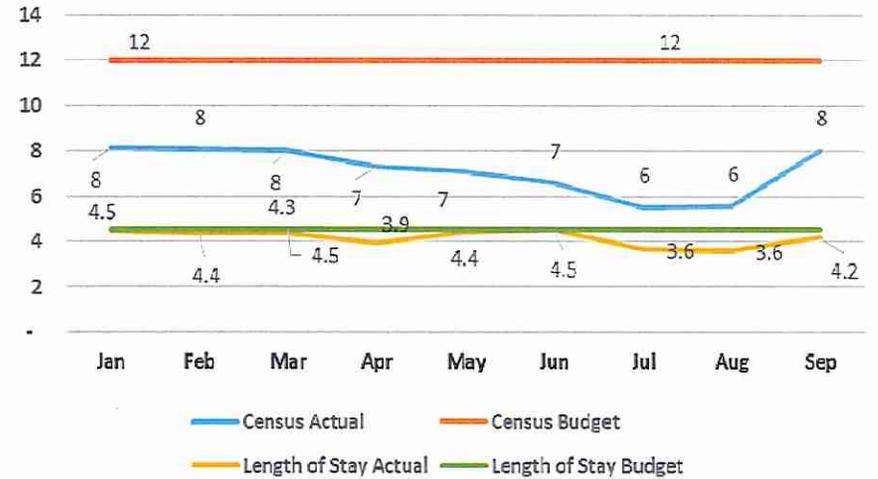
CAIS (Child & Adolescent Inpatient) DASHBOARD

3rd Quarter 2018

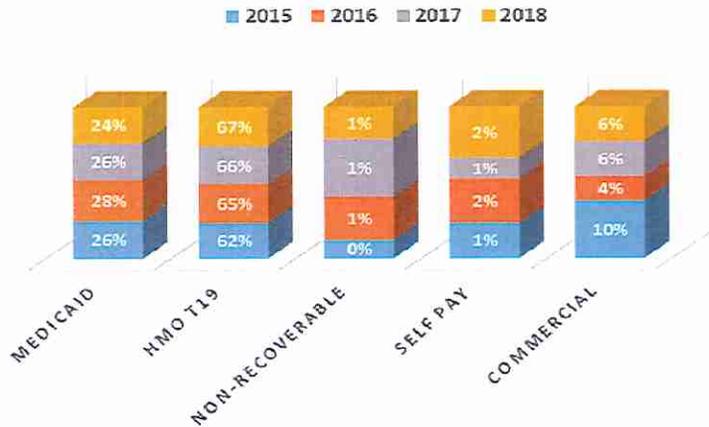
	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	2,351,404	3,128,153	4,629,746	(1,501,593)
Expense				
Personnel	2,912,833	3,967,062	4,112,923	145,861
Svcs/Commodities	173,305	241,118	480,969	239,851
Other Chgs/Vendor	-	-	-	-
Capital	-	-	-	-
Cross Charges	1,717,286	2,620,398	2,523,861	(96,537)
Abatements	-	-	-	-
Total Expense	4,803,424	6,828,578	7,117,753	289,175
Tax Levy	2,452,020	3,700,425	2,488,007	(1,212,418)

Percentage Spent 67%
 Percentage Yr Elapsed 75%

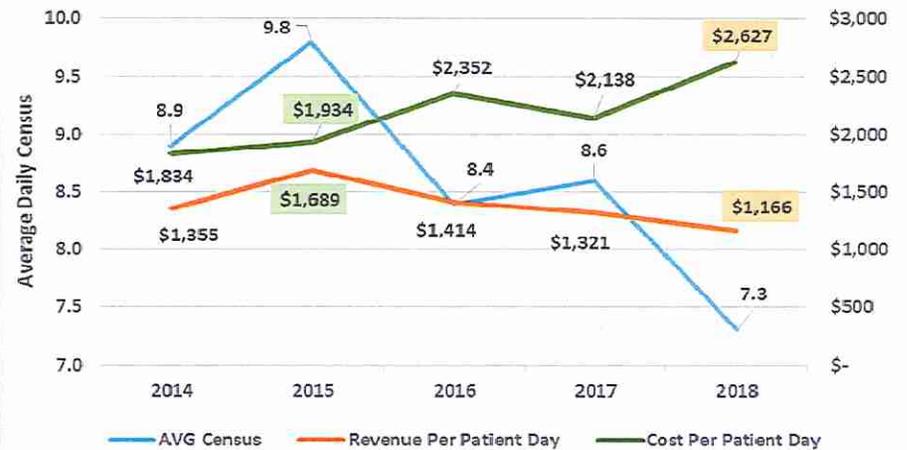
CAIS Census and Length of Stay



CAIS REVENUE - PAYER SOURCES



CAIS-Avg Census, Cost & Net Revenue per Patient Day



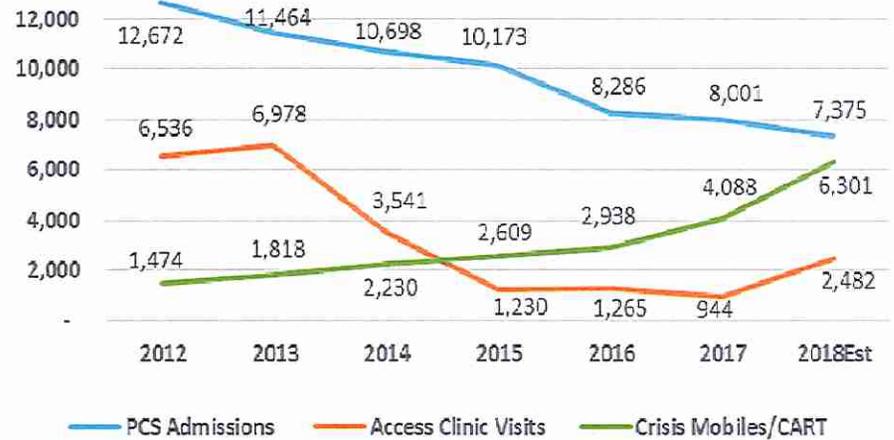
PCS - ER and Observation DASHBOARD

3rd Quarter 2018

	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	7,257,198	9,162,927	10,888,654	(1,725,727)
Expense				
Personnel	8,733,228	11,698,374	10,919,922	(778,452)
Svcs/Commodities	279,810	405,308	1,418,629	1,013,321
Other Chgs/Vendor	-	-	-	-
Capital	6,397	6,693	5,508	(1,185)
Cross Charges	3,073,443	4,685,621	5,221,950	536,329
Abatements	-	-	-	-
Total Expense	12,092,878	16,795,996	17,566,009	770,013
Tax Levy	4,835,680	7,633,069	6,677,355	(955,714)

Percentage Spent 69%
 Percentage Yr Elapsed 75%

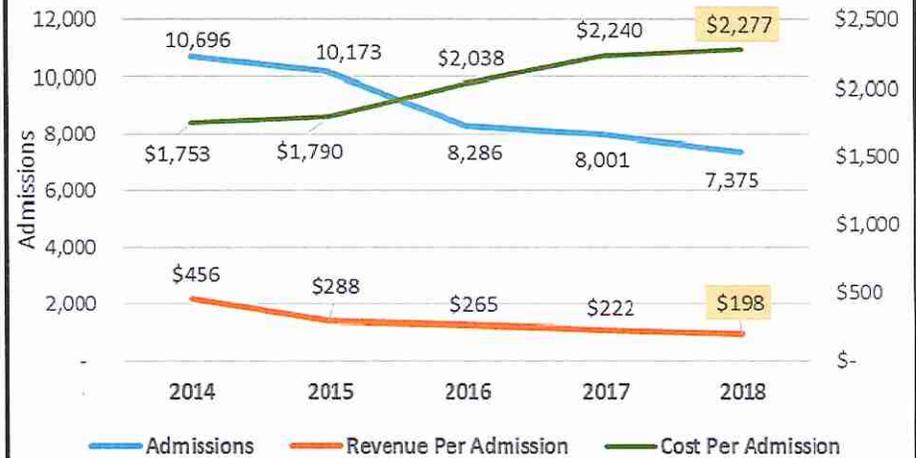
PCS Trends 2012-2018



PCS/OBS Salary Trends and Admissions



Admissions, Cost and Revenue Per Admission

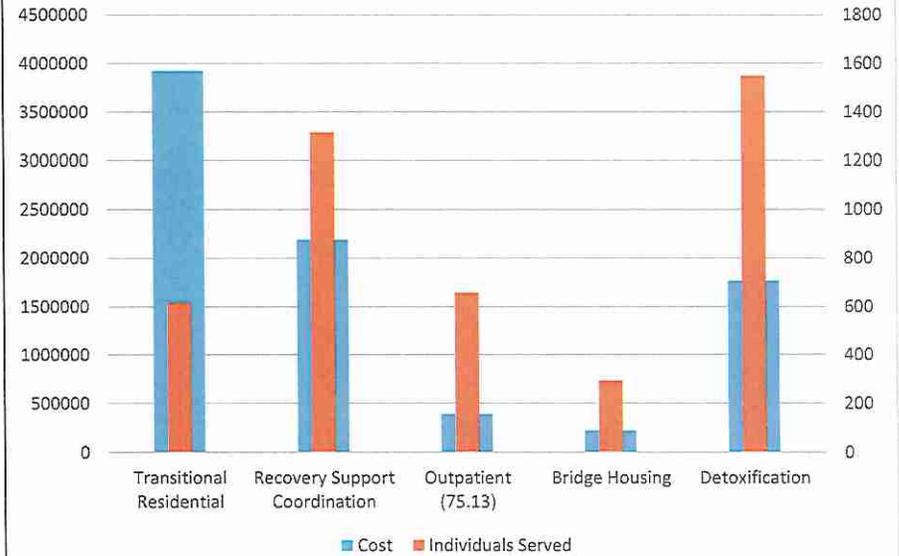


AODA DASHBOARD 3rd Quarter 2018

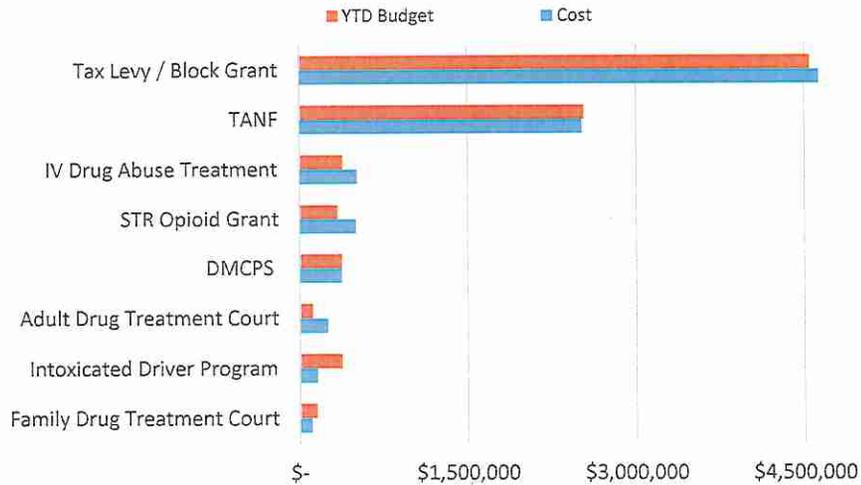
	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	8,543,108	11,366,885	11,710,592	(343,707)
Expense				
Personnel	105,013	132,653	126,213	(6,440)
Svcs/Commodities	106,715	142,286	115,000	(27,286)
Other Chgs/Vendor	9,934,964	14,187,407	12,228,695	(1,958,712)
Capital	-	-	-	-
Cross Charges	795,225	1,209,696	1,526,457	316,761
Abatements	-	-	-	-
Total Expense	10,941,917	15,672,042	13,996,365	(1,675,677)
Tax Levy	2,398,809	4,305,157	2,285,773	(2,019,384)

Percentage Spent 78%
 Percentage Yr Elapsed 75%

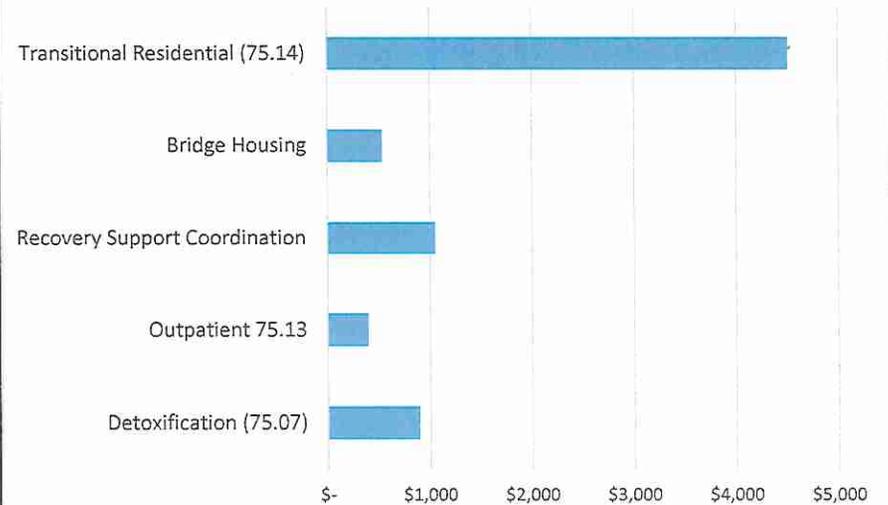
Spending & Clients Served by Program



AODA Revenue vs. Budget Q3 2018



Spend Per Client

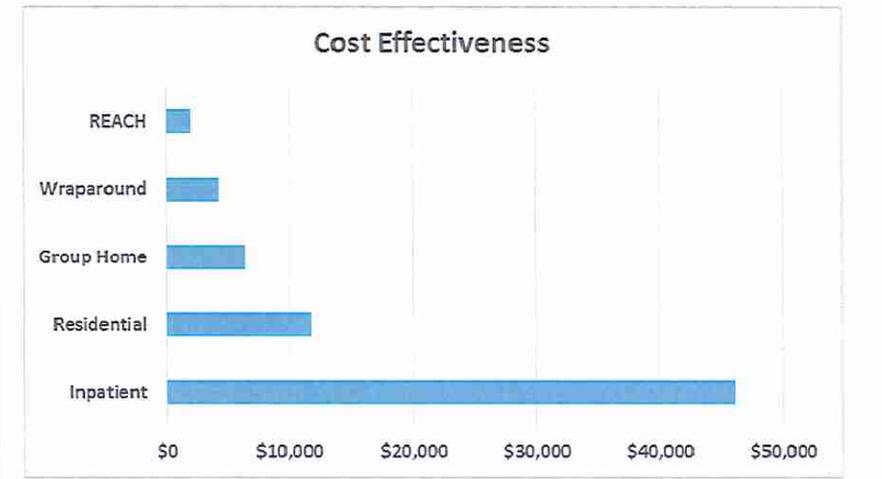
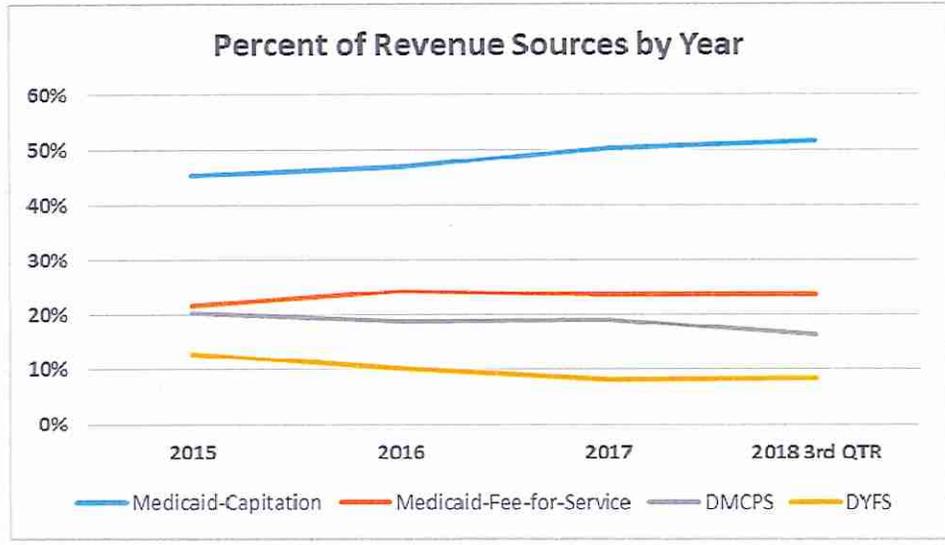
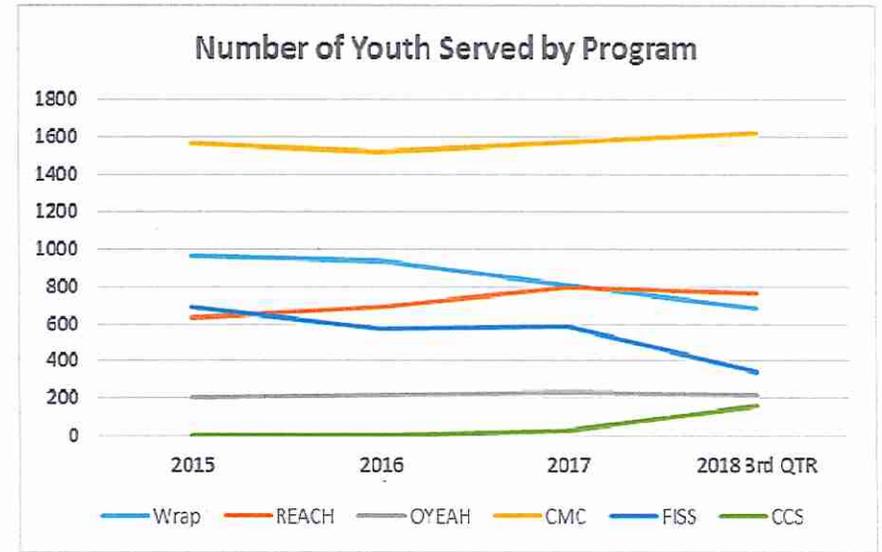


WRAPAROUND DASHBOARD

3rd Quarter 2018

	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	34,538,961	56,209,888	60,590,482	(4,380,594)
Expense				
Personnel	3,290,187	4,634,522	5,211,210	576,688
Svcs/Commodities	341,957	455,943	221,209	(234,734)
Other Chgs/Vendor	31,603,817	46,526,246	57,661,228	11,134,982
Capital	1,779	2,371		(2,371)
Cross Charges	4,524,982	6,879,062	16,167,728	9,288,666
Abatements	(3,334,949)	(5,044,187)	(18,678,862)	(13,634,675)
Total Expense	36,427,773	53,453,957	60,582,513	7,128,556
Tax Levy	1,888,812	(2,755,931)	(7,969)	2,747,962

Percentage Spent 60%
 Percentage Yr Elapsed 75%

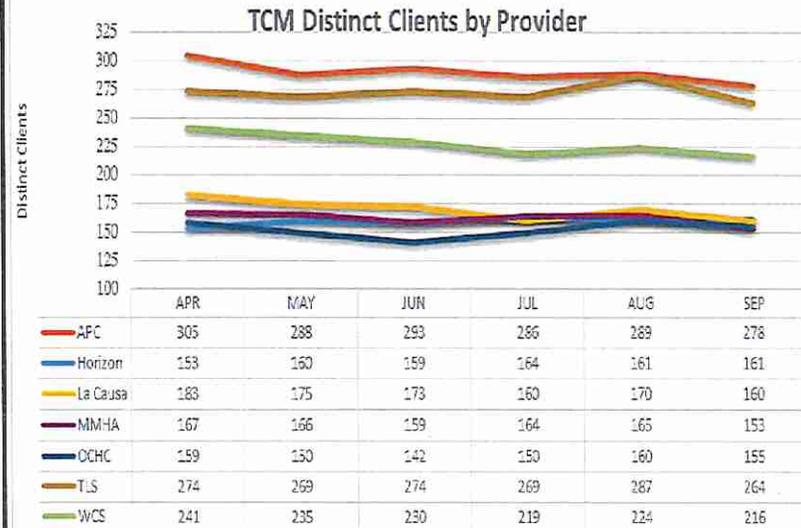


*** Inpatient services are clients in CAIS
 *** Wraparound and REACH services are outpatient services

TCM (Targeted Case Management) DASHBOARD
3rd Quarter 2018

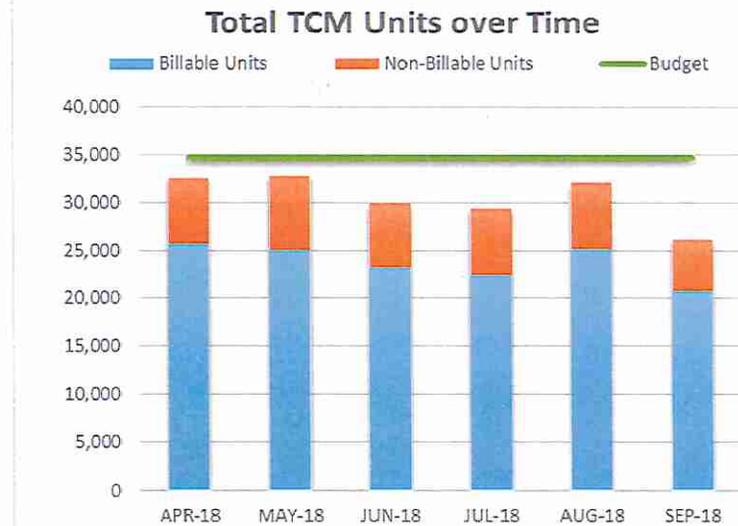
	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	1,689,282	2,690,695	2,416,464	274,231
Expense				
Personnel	187,713	304,738	352,810	48,072
Svcs/Commodities	10,380	13,839	1,559	(12,280)
Other Chgs/Vendor	4,144,442	5,943,936	5,541,284	(402,652)
Capital	-	-	-	-
Cross Charges	340,657	519,283	771,866	252,583
Abatements	-	-	-	-
Total Expense	4,683,192	6,781,796	6,667,519	(114,277)
Tax Levy	2,993,910	4,091,101	4,251,055	159,954

Average Enrollment 1,471 1,471 1,610



	2018 Q3			2018 YTD		
	Billable	Non-billable	% Non-billable	Billable	Non-billable	% Non-billable
APC	15,574	4,583	23%	52,079	14,233	21%
Horizon	6,490	3,086	32%	20,006	8,391	30%
La Causa	7,745	1,302	14%	25,292	4,858	16%
MMHA	8,099	2,624	24%	21,733	8,708	26%
OCHC	6,298	752	11%	19,037	3,409	15%
Whole Health	13,249	2,800	17%	44,102	9,646	18%
WCS	10,961	4,120	27%	36,044	13,855	28%
Total	68,416	19,267	22%	221,293	63,100	22%

*** Non-billable is paid to Provider, but not billable to Medicaid



CCS (Comprehensive Community Services) DASHBOARD

3rd Quarter 2018

	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	9,146,182	14,805,681	16,513,433	(1,707,752)
Expense				
Personnel	481,174	632,174	610,892	(21,282)
Svcs/Commodities	516	688	-	(688)
Other Chgs/Vendor	8,728,066	13,623,065	16,930,000	3,306,935
Capital	-	-	-	-
Cross Charges	1,101,050	1,680,296	2,270,720	590,424
Abatements	-	-	-	-
Total Expense	10,310,806	15,936,223	19,811,612	3,875,389
Tax Levy	1,164,624	1,130,542	3,298,179	2,167,637

Average Enrollment	763	791	1,100
--------------------	-----	-----	-------

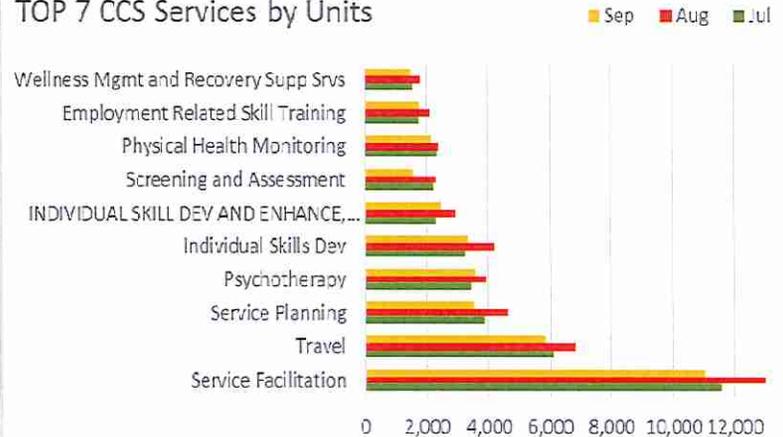
Distinct Clients Served 2018



Number of Billable to Nonbillable Units - Top 10 Providers

	2018 Q3 Totals			2018 YTD TOTALS		
	Billable	Non-Billable	% Non-Billable	Billable	Non-Billable	% Non-Billable
Whole Health	21,450	211	1.0%	64,196	520	0.8%
APC	16,863	404	2.4%	47,919	826	1.7%
Guest	16,780	112	0.7%	46,318	387	0.8%
Bell	12,180	229	1.9%	36,539	596	1.6%
Justice	9,387	382	4.1%	21,634	790	3.7%
La Causa	4,082	7	0.2%	20,116	154	0.8%
WCS	7,224	160	2.2%	18,620	395	2.1%
Summit	10,684	-	0.0%	16,071	-	0.0%
OCHC	3,451	21	0.6%	13,418	262	2.0%
Project	3,604	178	4.9%	10,969	565	5.2%

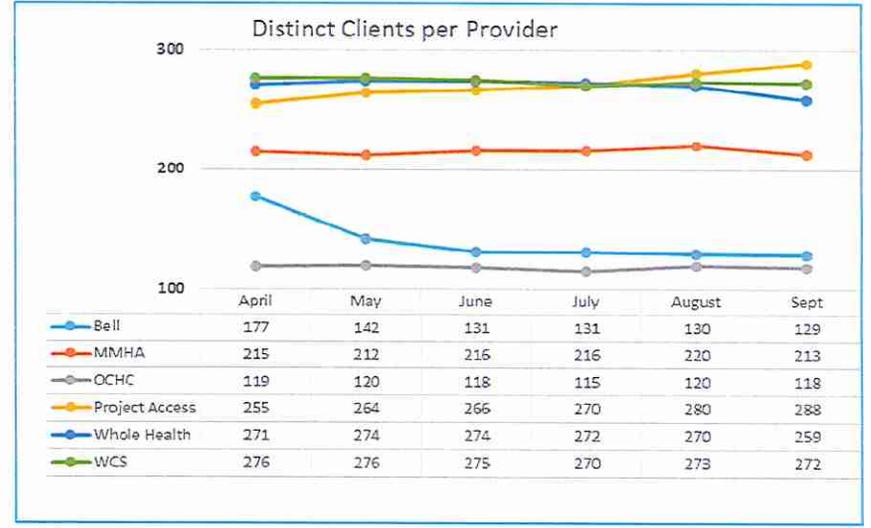
TOP 7 CCS Services by Units



CSP (Community Support Program) DASHBOARD 3rd Quarter 2018

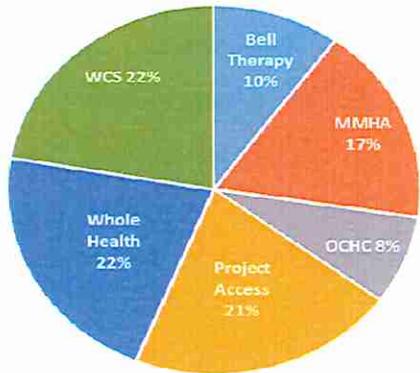
	2018 September YTD			
	Sept YTD	Projection	Budget	Variance
Revenue	6,469,920	9,326,560	9,880,388	(553,828)
Expense				
Personnel	216,063	268,983	261,192	(7,791)
Svcs/Commodities	19	26	-	(26)
Other Chgs/Vendor	8,745,108	13,856,603	14,560,708	704,105
Capital	-	-	-	-
Cross Charges	878,140	1,340,116	1,973,189	633,073
Abatements	-	-	-	-
Total Expense	9,839,330	15,465,728	16,795,089	1,329,361
Tax Levy	3,369,410	6,139,168	6,914,701	775,533

	2018	2017	2016
Average Enrollment	1,291	1,288	1,267



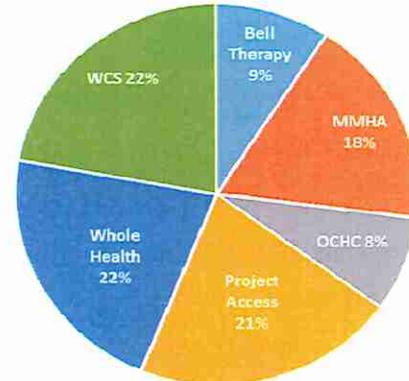
	2016	2017	2018
* Ave Capacity	1,245	1,234	1,291

Units of Service per Provider - September 2018



Agency	September	YTD Total
Bell Therapy	6,597	73,303
MMHA	11,413	135,136
OCHC	5,072	52,503
Project Access	13,833	119,136
Whole Health	14,132	152,495
WCS	14,653	143,291
Grand Total	65,700	675,864

Cost of Service per Provider - September 2018



Agency	September	YTD Total
Bell Therapy	188,405	2,222,978
MMHA	364,963	4,407,005
OCHC	165,948	1,706,150
Project Access	433,870	3,748,215
Whole Health	442,763	4,747,453
WCS	456,573	4,485,400
Grand Total	2,052,520	21,317,200

Finance Committee Item 8

COUNTY OF MILWAUKEE

Behavioral Health Division Administration

Inter-Office Communication

DATE: November 20, 2018

TO: Thomas Lutzow, Chairperson – Milwaukee County Mental Health Board

FROM: Mary Jo Meyers, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Division

SUBJECT: Report from the Director, Department of Health and Human Services, Notifying the Milwaukee County Mental Health Board of Fund Transfers Processed in the Previous Quarter

Issue

Per the “BHD Fund Transfer Policy” adopted by the Mental Health Board, the BHD Fiscal Administrator will provide a quarterly informational report notifying the MHB as to any administrative fund transfers that have occurred during the previous quarter.

Background

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

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

Q2 2018 Fund Transfers

Title	Description	Total Funds Transferred
Misc. Account Corrections	This transfer realigns budgeted revenues and expenses with actuals for the following areas for the following categories: Wisconsin Medicaid Cost Report (WIMCR) revenue related to community crisis services, Disproportionate Hospital Share (DSH) revenue related to inpatient services, and CRS revenue.	\$1,740,343

Title	Description	Total Funds Transferred
Wrap Expense Transfer	This transfer updates the 2018 budgeted org structure to match the org structure actually in use. This will result in better tracking and reporting for each program while maintaining the ability to report grant spending.	\$37,552,687
Wrap Revenue Transfer	This transfer updates the 2018 budgeted org structure to match the org structure actually in use. This will result in better tracking and reporting for each program while maintaining the ability to report grant spending.	\$39,293,030

Respectfully Submitted,



Mary Jo Meyers, Director
 Department of Health and Human Services

APPROPRIATION TRANSFER REQUEST

1699 R4E

MILWAUKEE COUNTY

FISCAL YEAR
2018

DEPT. NO.
6300

INSTRUCTIONS: REFER TO MILW. COUNTY ADMINISTRATIVE MANUAL SECTION 4.05 FOR INSTRUCTIONS ON PREPARING THIS FORM.

DEPARTMENT NAME

Behavioral Health Division

Were Appropriations Requested Below Denied For The Current Budget?

No

No

Line No.	ACCOUNT DISTRIBUTION						OBJECT CODE DESCRIPTION	Transfer Request	DAS Account Modification
	Fund	Agency	Org. Unit	Revenue/Objct	Activity	Project			
TO (Credit)	77	630	6472	2254			PROVIDED SERVICES-ADMIN	85,000.00	
	77	630	6472	4999			OTHER MISC REVENUE	150,000.00	
	77	630	6473	3710			REVENUE FR PATIENT SRV	11,672,430.00	
	77	630	6473	3720			T19 REVENUE	7,986,000.00	
	77	630	6473	3722			TITLE XIX REVENUES-CAPITATION	13,249,295.00	
	77	630	6475	3720			T19 REVENUE	798,600.00	
	77	630	6475	3722			TITLE XIX REVENUES-CAPITATION	2,656,051.00	
	77	630	6476	2270			MUTT FOSTER FAMILY	692,064.00	
	77	630	6476	3720			T19 REVENUE	798,600.00	

S (Credit) \$ 38,088,040.00 \$ -

FROM	77	630	6474	2254			PROVIDED SERVICES-ADMIN	85,000.00	
	77	630	6474	2270			MUTT FOSTER FAMILY	692,064.00	
	77	630	6474	3710			REVENUE FR PATIENT SRV	11,672,430.00	
	77	630	6474	3720			T19 REVENUE	9,583,200.00	
	77	630	6474	3722			TITLE XIX REVENUES-CAPITATION	15,905,346.00	
	77	630	6474	4999			OTHER MISC REVENUE	150,000.00	

-S (Debit) \$ 38,088,040.00 \$ -

A N A

BHD (agency 630) is requesting an appropriation fund transfer in the amount of \$38,088,040. This transfer updates the 2018 budgeted org structure to match the org structure actually in use. This will result in better tracking and reporting for each program while maintaining the ability to report grant spending.

TYPE OF TRANSFER							TRANSFER NO.
	AP		EB			RB	

REQUIRED, PLEASE ATTACH ADDITIONAL PAGES.

DATE OF REQUEST	SIGNATURE OF DEPARTMENT HEAD	TITLE

A c t i o n		Dept. of Administration	County Executive	Finance Committee	County Board
	DATE				
	APPROVE				
	DISAPPROVE				
	MODIFY				

DEPARTMENT NAME Behavioral Health Division

Were Appropriations Requested Below Denied For The Current Budget?		No	No					
Line No.	ACCOUNT DISTRIBUTION				OBJECT CODE DESCRIPTION	Transfer Request	DAS Account Modification	
	Fund	Agency	Org. Unit	Revenue/Objct				
TO (Credit)	77	630	6474	5190		DIRECT LABOR TRANSFER IN	\$ 204,062.00	
	77	630	6474	5199		SALARIES-WAGES BUDGET	\$ 1,859,114.00	
	77	630	6474	5201		OVERTIME	\$ 3,060.00	
	77	630	6474	5312		SOCIAL SECURITY TAXES	\$ 134,830.00	
	77	630	6474	5420		EMPLOYEE HEALTH CARE	\$ 392,537.00	
	77	630	6474	5421		EMPLOYEE PENSION	\$ 267,998.00	
	77	630	6474	5422		LEGACY HEALTHCARE	\$ 449,425.00	
	77	630	6474	5423		LEGACY PENSION	\$ 564,238.00	
	77	630	6474	5490		Fringe Benefit Trf-IND IN	\$ 38,707.00	
	77	630	6474	6050		CONTRACT PERS SERV-SHORT	\$ 18,000.00	
	77	630	6474	6080		POSTAGE	\$ 2,000.00	
	77	630	6474	6127		TRNSCRPT FEES OUTSIDE SRV	\$ 10,000.00	
	77	630	6474	6148		PROF. SERV-RECURRING OPER	\$ 13,355.00	
	77	630	6474	6329		TEL AND TEL OUTSIDE VEN	\$ 9,000.00	
	77	630	6474	6339		RECORDS CENTER CHARGES	\$ 3,500.00	
	77	630	6474	6409		PRINTING AND STATIONERY	\$ 4,000.00	
	77	630	6474	6610		R/M-BLDG AND STRUCTURES	\$ 55,000.00	
	77	630	6474	6803		AUTO ALLOWANCE	\$ 3,000.00	
	77	630	6474	6805		EDUCATION/SEMINAR PAYM'TS	\$ 2,000.00	
	77	630	6474	6809		CONFERENCE EXPENSES	\$ 4,000.00	
	77	630	6474	6812		MEETINGS OTHER AUTH TRAVL	\$ 4,000.00	
	77	630	6474	6999		SUNDRY SERVICES	\$ 2,000.00	
	77	630	6474	7301		MEALS	\$ 14,000.00	
	77	630	6474	7729		OTHER GENL MED SURG SUPL	\$ 3,000.00	
	77	630	6474	7840		REPAIR PARTS	\$ 2,000.00	
	77	630	6474	7900		MISC COMMODITIES-BUDGET	\$ 5,000.00	
	77	630	6474	7910		OFFICE SUPPLIES	\$ 30,500.00	
	77	630	6474	7973		MINOR OFFICE EQUIPMENT	\$ 33,250.00	
	77	630	6474	7999		SUNDRY MATERIALS & SUPPL	\$ 2,000.00	
	77	630	6474	5199		SALARIES-WAGES BUDGET	\$ 574,026.00	
	77	630	6474	5312		SOCIAL SECURITY TAXES	\$ 43,928.00	
	77	630	6474	5420		EMPLOYEE HEALTH CARE	\$ 104,799.00	
	77	630	6474	5421		EMPLOYEE PENSION	\$ 82,679.00	
	77	630	6474	5422		LEGACY HEALTHCARE	\$ 112,356.00	
	77	630	6474	5423		LEGACY PENSION	\$ 141,060.00	
	77	630	6474	6040		MEMBERSHIP DUES	\$ 1,350.00	
	77	630	6474	8123		PURCHASE OF SERVICE	\$ 791,544.00	
	77	630	6474	8139		WRAPAROUND CLIENT SERVICES	\$ 36,468,939.00	
	77	630	6474	9750		ADMINISTRATIVE SERVICES A	\$ 11,332,882.00	
	77	630	6474	9755		ADMINISTRATIVE SERVICES-5	\$ 1,588,860.00	
77	630	6474	9850		ABATE-ADMIN SERVICES A	\$ (10,056,006.00)		
77	630	6474	9851		Abatement-Administrative Srv-1	\$ (1,402,711.00)		
77	630	6474	9855		Abatement-Administrative Srv-5	\$ (6,364,605.00)		
TO TOTALS (Credit)						\$ 37,552,687.00	\$ -	

Line No.	ACCOUNT DISTRIBUTION				OBJECT CODE DESCRIPTION	Transfer Request	DAS Account Modification	
	Fund	Agency	Org. Unit	Revenue/Objct				
FROM (Debit)	77	630	6472	5190		DIRECT LABOR TRANSFER IN	\$ 204,062.00	
	77	630	6472	5199		SALARIES-WAGES BUDGET	\$ 1,859,114.00	
	77	630	6472	5201		OVERTIME	\$ 3,060.00	
	77	630	6472	5312		SOCIAL SECURITY TAXES	\$ 134,830.00	
	77	630	6472	5420		EMPLOYEE HEALTH CARE	\$ 392,537.00	
	77	630	6472	5421		EMPLOYEE PENSION	\$ 267,998.00	
	77	630	6472	5422		LEGACY HEALTHCARE	\$ 449,425.00	
	77	630	6472	5423		LEGACY PENSION	\$ 564,238.00	
	77	630	6472	5490		Fringe Benefit Trf-IND IN	\$ 38,707.00	
	77	630	6472	6040		MEMBERSHIP DUES	\$ 1,350.00	
	77	630	6472	6050		CONTRACT PERS SERV-SHORT	\$ 18,000.00	
	77	630	6472	6080		POSTAGE	\$ 2,000.00	
	77	630	6472	6127		TRNSCRPT FEES OUTSIDE SRV	\$ 10,000.00	
	77	630	6472	6148		PROF. SERV-RECURRING OPER	\$ 13,355.00	
	77	630	6472	6329		TEL AND TEL OUTSIDE VEN	\$ 9,000.00	
	77	630	6472	6339		RECORDS CENTER CHARGES	\$ 3,500.00	
	77	630	6472	6409		PRINTING AND STATIONERY	\$ 4,000.00	
	77	630	6472	6610		R/M-BLDG AND STRUCTURES	\$ 55,000.00	
	77	630	6472	6803		AUTO ALLOWANCE	\$ 3,000.00	
	77	630	6472	6805		EDUCATION/SEMINAR PAYM'TS	\$ 2,000.00	
	77	630	6472	6809		CONFERENCE EXPENSES	\$ 4,000.00	
	77	630	6472	6812		MEETINGS OTHER AUTH TRAVL	\$ 4,000.00	
	77	630	6472	6999		SUNDRY SERVICES	\$ 2,000.00	
	77	630	6472	7301		MEALS	\$ 14,000.00	
	77	630	6472	7729		OTHER GENL MED SURG SUPL	\$ 3,000.00	
	77	630	6472	7840		REPAIR PARTS	\$ 2,000.00	
	77	630	6472	7900		MISC COMMODITIES-BUDGET	\$ 5,000.00	
	77	630	6472	7910		OFFICE SUPPLIES	\$ 30,500.00	
	77	630	6472	7973		MINOR OFFICE EQUIPMENT	\$ 33,250.00	
	77	630	6472	7999		SUNDRY MATERIALS & SUPPL	\$ 2,000.00	
	77	630	6472	8123		PURCHASE OF SERVICE	\$ 504,044.00	
	77	630	6472	9750		ADMINISTRATIVE SERVICES A	\$ 5,852,036.00	
	77	630	6472	9850		ABATE-ADMIN SERVICES A	\$ (10,056,006.00)	
	77	630	6473	8123		PURCHASE OF SERVICE	\$ 287,500.00	
	77	630	6473	8139		WRAPAROUND CLIENT SERVICES	\$ 33,087,056.00	
	77	630	6473	9750		ADMINISTRATIVE SERVICES A	\$ 5,094,739.00	
	77	630	6473	9755		ADMINISTRATIVE SERVICES-5	\$ 1,588,860.00	
	77	630	6473	9851		Abatement-Administrative Srv-1	\$ (1,402,711.00)	
	77	630	6473	9855		Abatement-Administrative Srv-5	\$ (6,364,605.00)	
	77	630	6475	8139		WRAPAROUND CLIENT SERVICES	\$ 3,101,911.00	
77	630	6475	9750		ADMINISTRATIVE SERVICES A	\$ 586,117.00		
77	630	6476	5199		SALARIES-WAGES BUDGET	\$ 574,026.00		
77	630	6476	5312		SOCIAL SECURITY TAXES	\$ 43,928.00		
77	630	6476	5420		EMPLOYEE HEALTH CARE	\$ 104,799.00		
77	630	6476	5421		EMPLOYEE PENSION	\$ 82,679.00		
77	630	6476	5422		LEGACY HEALTHCARE	\$ 112,356.00		
77	630	6476	5423		LEGACY PENSION	\$ 141,060.00		
77	630	6476	8139		WRAPAROUND CLIENT SERVICES	\$ 279,972.00		
FROM TOTALS (Debit)						\$ 37,552,687.00	\$ -	

EXPLANATION

BHD (agency 630) is requesting an appropriation fund transfer in the amount of \$37,552,687. This transfer updates the 2018 budgeted org structure to match the org structure actually in use. This will result in better tracking and reporting for each program while maintaining the ability to report grant spending.

TYPE OF TRANSFER		TRANSFER NO.	
AP	EB	RB	
IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH ADDITIONAL PAGES.			
DATE OF REQUEST	SIGNATURE OF DEPARTMENT HEAD		TITLE
A c t i o n	Dept. of Administration	County Executive	Finance Committee
	DATE		
	APPROVE		
	DISAPPROVE		
	County Board		
	MODIFY		

APPROPRIATION TRANSFER REQUEST

1699 R4E

MILWAUKEE COUNTY

FISCAL YEAR
2018

DEPT. NO.
6300

INSTRUCTIONS: REFER TO MILW. COUNTY ADMINISTRATIVE MANUAL SECTION 4.05 FOR INSTRUCTIONS ON PREPARING THIS FORM.

DEPARTMENT NAME

Behavioral Health Division

Were Appropriations Requested Below Denied For The Current Budget?

No

No

Line No.	ACCOUNT DISTRIBUTION						OBJECT CODE DESCRIPTION	Transfer Request	DAS Account Modification
	Fund	Agency	Org. Unit	Revenue/Objct	Activity	Project			
TO (Credit)	77	630	6443	3790			Other Health Revenues	\$ 813,294.00	
	77	630	6552	3790			Other Health Revenues	\$ 278,000.00	
	77	630	6410	8131			Vendor Payments #1	\$ 649,049.00	

TO TOTALS (Credit) \$ 1,740,343.00 \$ -

FROM (Debit)	77	630	6444	3790			Other Health Revenues	\$ 813,294.00	
	77	630	6373	3790			Other Health Revenues	\$ 278,000.00	
	77	630	6410	8135			MDCDCPS	\$ 649,049.00	

FROM TOTALS (Debit) \$ 1,740,343.00 \$ -

E X P L A N A T I O N

BHD (agency 630) is requesting an appropriation fund transfer in the amount of \$1,740,343. This transfer realigns budgeted revenues and expenses with actuals for the following areas for the following categories: Wisconsin Medicaid Cost Report (WIMCR) revenue related to community crisis services, Disproportionate Hospital Share (DSH) revenue related to inpatient services, and CRS revenue.

TYPE OF TRANSFER							TRANSFER NO.
	AP		EB			RB	

IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH ADDITIONAL PAGES.

DATE OF REQUEST	SIGNATURE OF DEPARTMENT HEAD	TITLE

A c t i o n		Dept. of Administration	County Executive	Finance Committee	County Board
	DATE				
	APPROVE				
	DISAPPROVE				
	MODIFY				

Chairperson: Mary Neubauer
Executive Assistant: Kiara Abram, 257-7212
BHD Staff: Jennifer Bergersen

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
QUALITY COMMITTEE**

December 3, 2018 - 10:00 A.M.

**Milwaukee County Mental Health Complex
Conference Room 1045**

A G E N D A

SCHEDULED ITEMS:

1.	Welcome. (Chairwoman Neubauer)
2.	Organizational Accountability: Developing Core Domains to Realize the Quadruple Aim. (Dr. Matt Drymalski, Clinical Program Director) (Action Item)
3.	Community Based Key Performance Indicators (KPI) Dashboard, Third Quarter Summaries and CARS Quality Dashboard. (Jennifer Bergersen, Chief Operations Officer; Pam Erdman, Quality Assurance Director; Justin Heller, Integrated Services Manager; and Dr. Matt Drymalski, Clinical Program Director)
4.	BHD Zero Suicide Overview & the Access Clinic Pilot. (Eric Diamond, Director of Outpatient Programs)
5.	Institutional Review Board Report. (Dr. Justin Kuehl, Chief Psychologist)
6.	Psychiatric Hospital Reports: Inpatient KPI Metrics, Seclusion & Restraint Summary & Survey Update (Dr. John Schneider, Chief Medical Officer; Linda Oczus, Chief Nursing Officer; Edward Warzonek, Quality Assurance Coordinator)
7.	Quality & Safety: MRMC Emergency Operations Plan Exercise & BHD Policy & Procedure Status Report (Lynn Gram)
8.	Next Scheduled Meeting Date. <ul style="list-style-type: none"> • March 4, 2019 at 10:00 a.m.
9.	Adjournment.

The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is Monday, March 4, 2019 at 10:00 a.m.

Visit the Milwaukee County Mental Health Board Web Page at:
<https://county.milwaukee.gov/EN/DHHS/About/Governance#MCMHBrecords>

ADA accommodation requests should be filed with the Milwaukee County Office for Persons with Disabilities, 278-3932 (voice) or 711 (TRS), upon receipt of this notice.

Quality Committee Item 2

Total Organizational Accountability

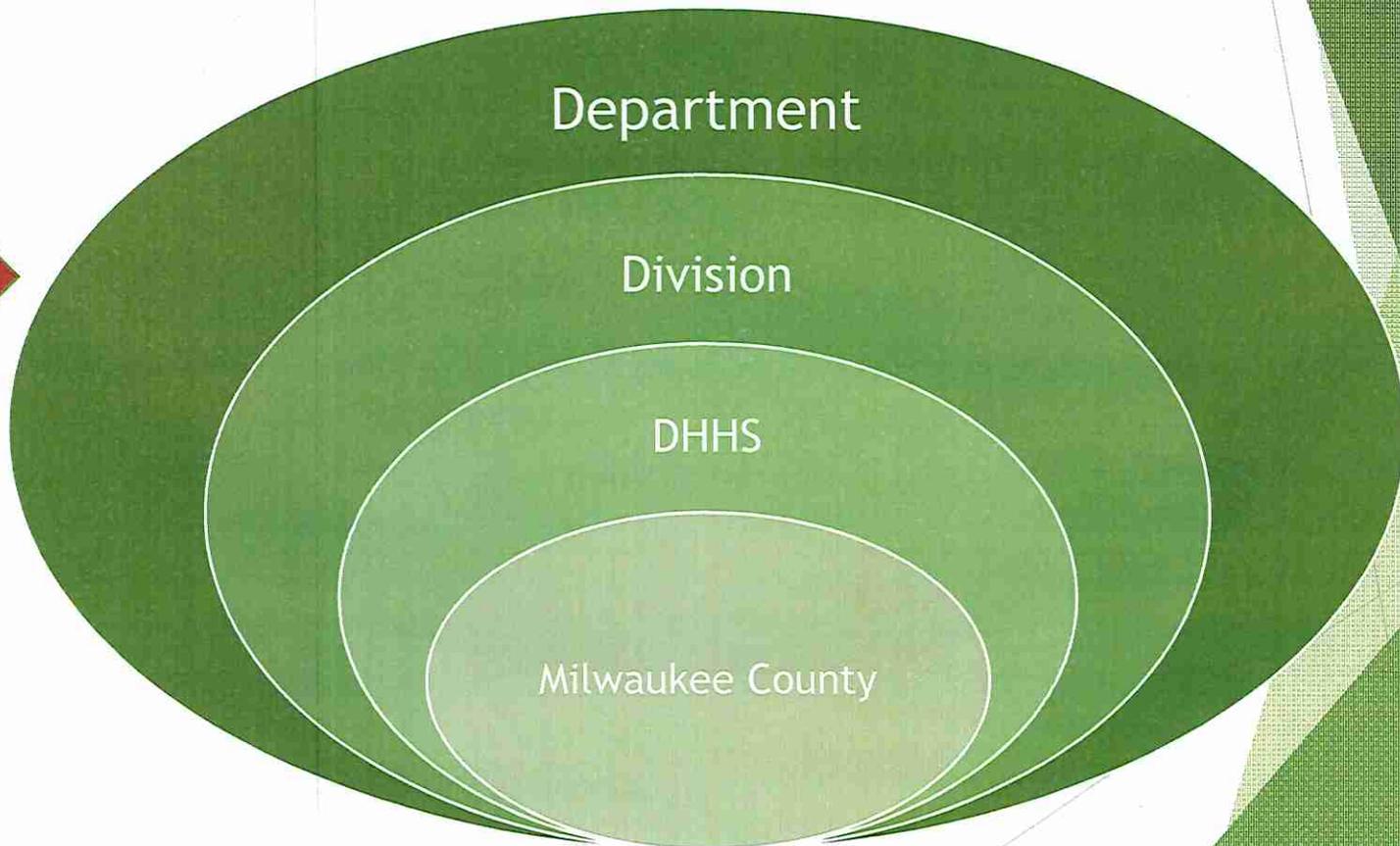
*Developing Core Domains to
Realize the Quadruple Aim*

The Current BHD KPIs

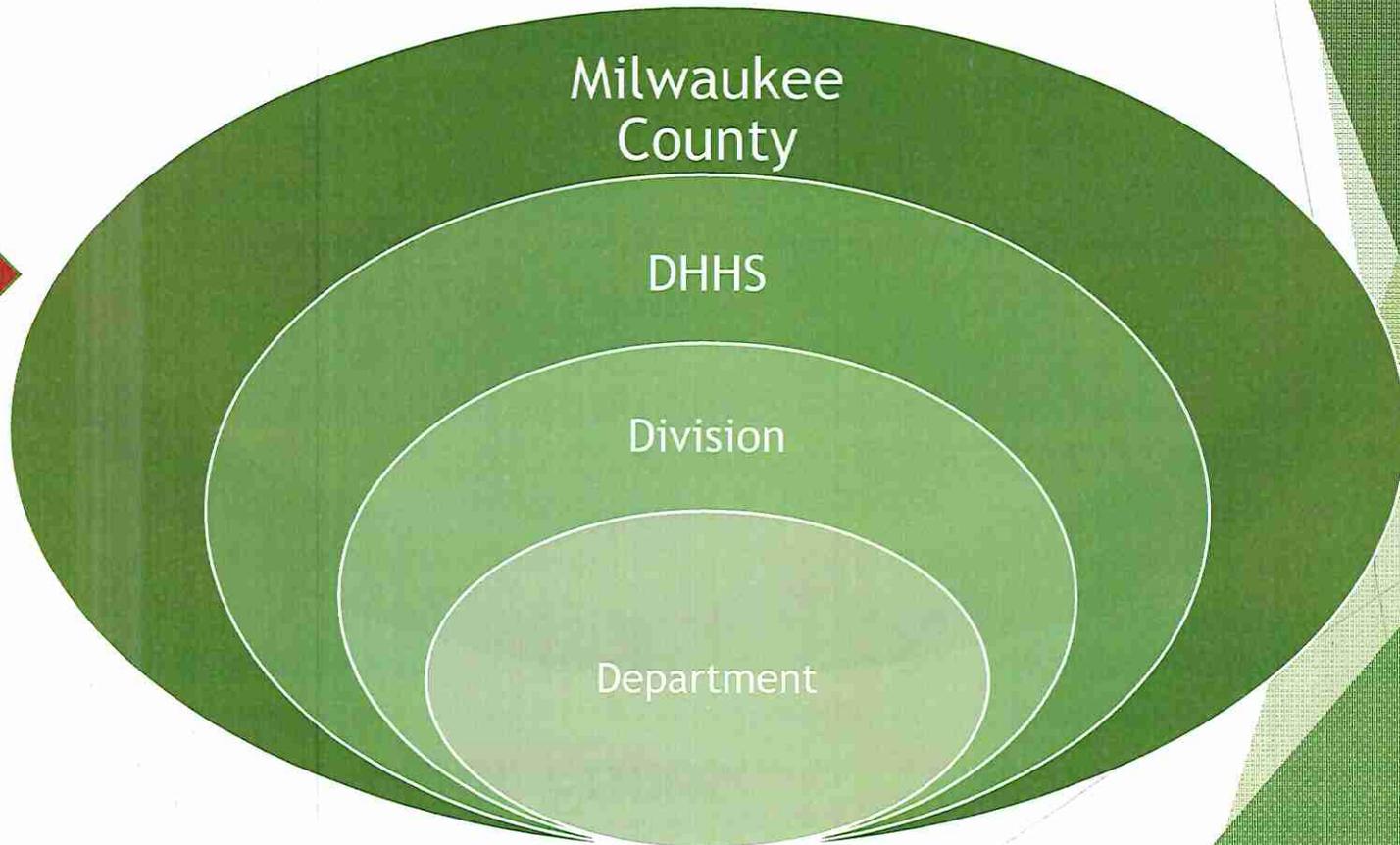
- ▶ We currently have **40** Key Performance Indicators that we report to the MHB
- ▶ Too many to be interpretable or actionable
- ▶ Not necessarily focused on the long-term, strategic objectives of BHD or DHHS



We Need to Shift Our Focus...



...as an Embedded System!!!



Moving to a Population Health Focus

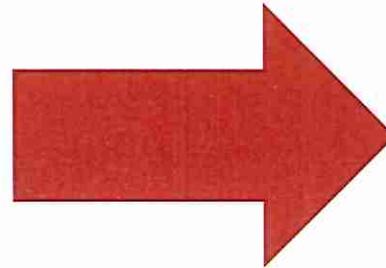
From This:

**Outcomes by
Program**



To This:

**Outcomes by
Client**



But, how do we get there?

(without doing this)



What Informs Our Core Data Domains???





Milwaukee County Department of Health and Human Services

Mission: Empowering safe, healthy, and meaningful lives. **Vision:** Together, creating healthy communities.

Values

- PARTNERSHIP – We work collaboratively, fostering trusting relationships with others
- RESPECT – We value the dignity and worth of each individual
- INTEGRITY – We adhere to the highest standards of moral and ethical principles
- DIVERSITY – We view differences of all people, values, and ideas as strengths
- EXCELLENCE – We challenge ourselves and others to innovate and achieve exceptional outcomes

Core Competencies

- DHHS is a values driven culture with societal responsibility as a motivation to Do the Right Thing
- Our workforce is dedicated to serving the most vulnerable in the community where others may not be willing or able to serve
- DHHS influences community health and well-being by leveraging partnerships to provide a broad array of critical human services through one accountable department

Department Strategies

Workforce Investment and Engagement		Community and Partner Engagement		Financial Health and Sustainability		High Quality and Accountable Service Delivery	
Make DHHS an employer of choice for employees to work, grow, and lead meaningful change		Foster trusting relationships with stakeholders to build capacity and broader solutions		Build long-term fiscal viability through maximizing revenue and improving cost efficiencies.		Cultivate a culture of continuous improvement	
Advance person-centered, preventative, and integrative health and human services strategies at the individual, family and community levels							
Employee Engagement Score	Target: TBD • Q3: 46.8% • Q4:	% Trust Score on Survey	Target: TBD • Q3: • Q4	Ratio of change of revenue to change in expense	Target: Positive ratio • Q3: • Q4:	HSVC Assessment	Target: 2.5 • Q3 & Q4: 2.3
Turnover as a % of Total Workforce	Target: TBD • Q3: • Q4:	# of Listening sessions	Target: TBD • Q3: • Q4:			Customer Satisfaction Score	Target: TBD • Q3: • Q4:

Focus areas for Divisional action plans to support the Department's Strategies:

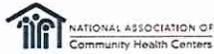
- Increase the physical, virtual and economic aspects of customer access
- Increase inter-departmental collaboration through integrated service delivery to achieve a consistent customer experience
- Pursue and lead innovative solutions that advance the Department's progress up the Human Services Value Curve
- Demonstrate greater efficiency and utilization of human and financial capital

10 year lifespan

5-10 years

3-5 year intended lifespan

Other Sources



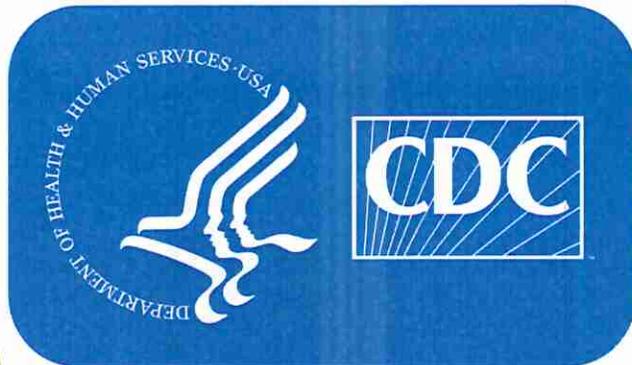
NATIONAL ASSOCIATION OF
Community Health Centers

QM

The Quality Management Plan
A Practical, Patient-Centered Template

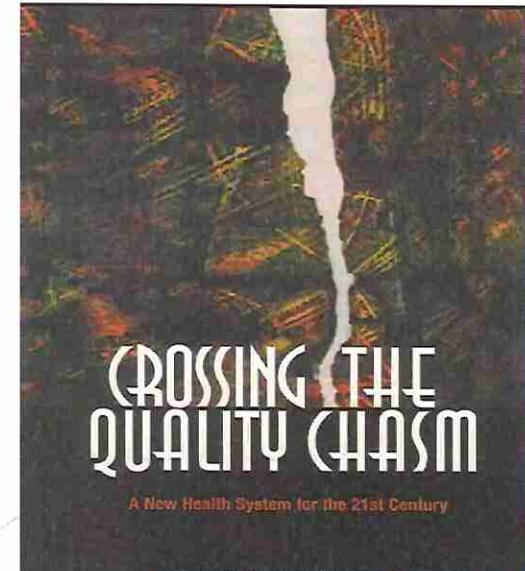
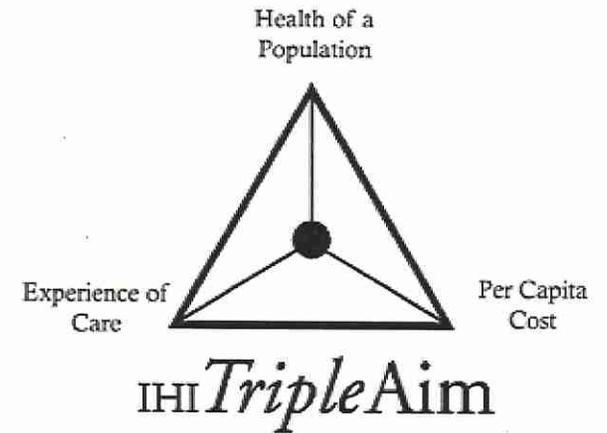
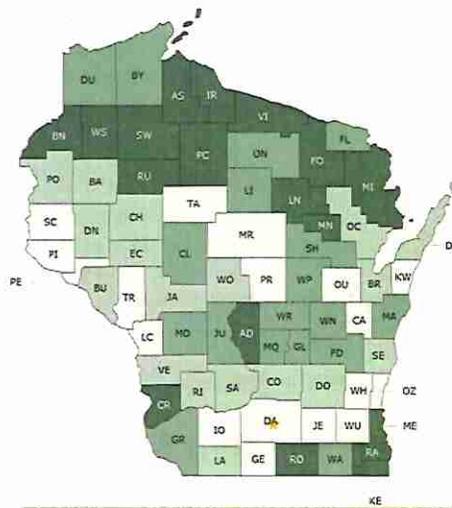
June 2011

Primary Authors
Tara S. Brennan, MD, MCHC
Harold S. Benjamin, MD, MPA
Special Contributor
Doreen O'Brien

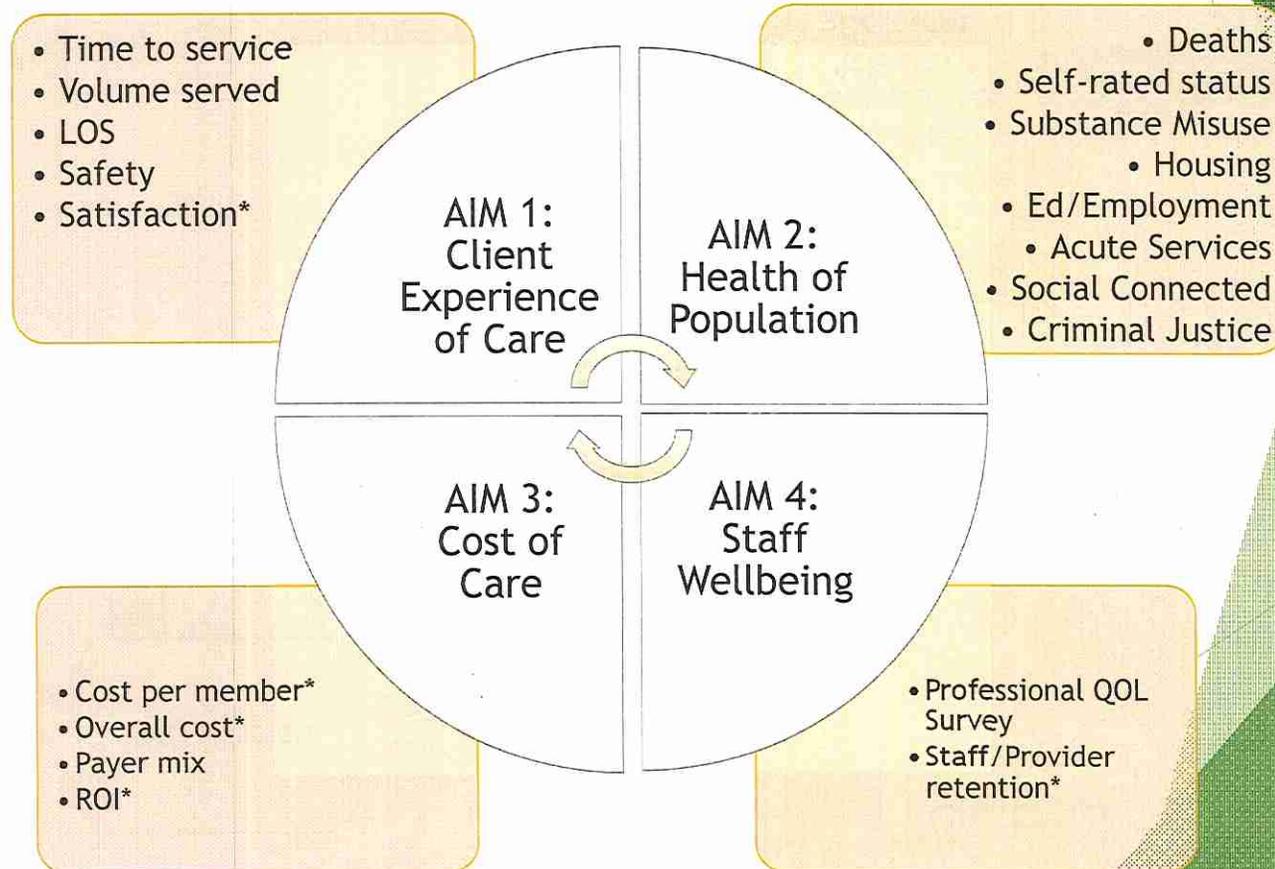


2017 Health Outcomes - Wisconsin

INSTITUTE OF
MEDICINE

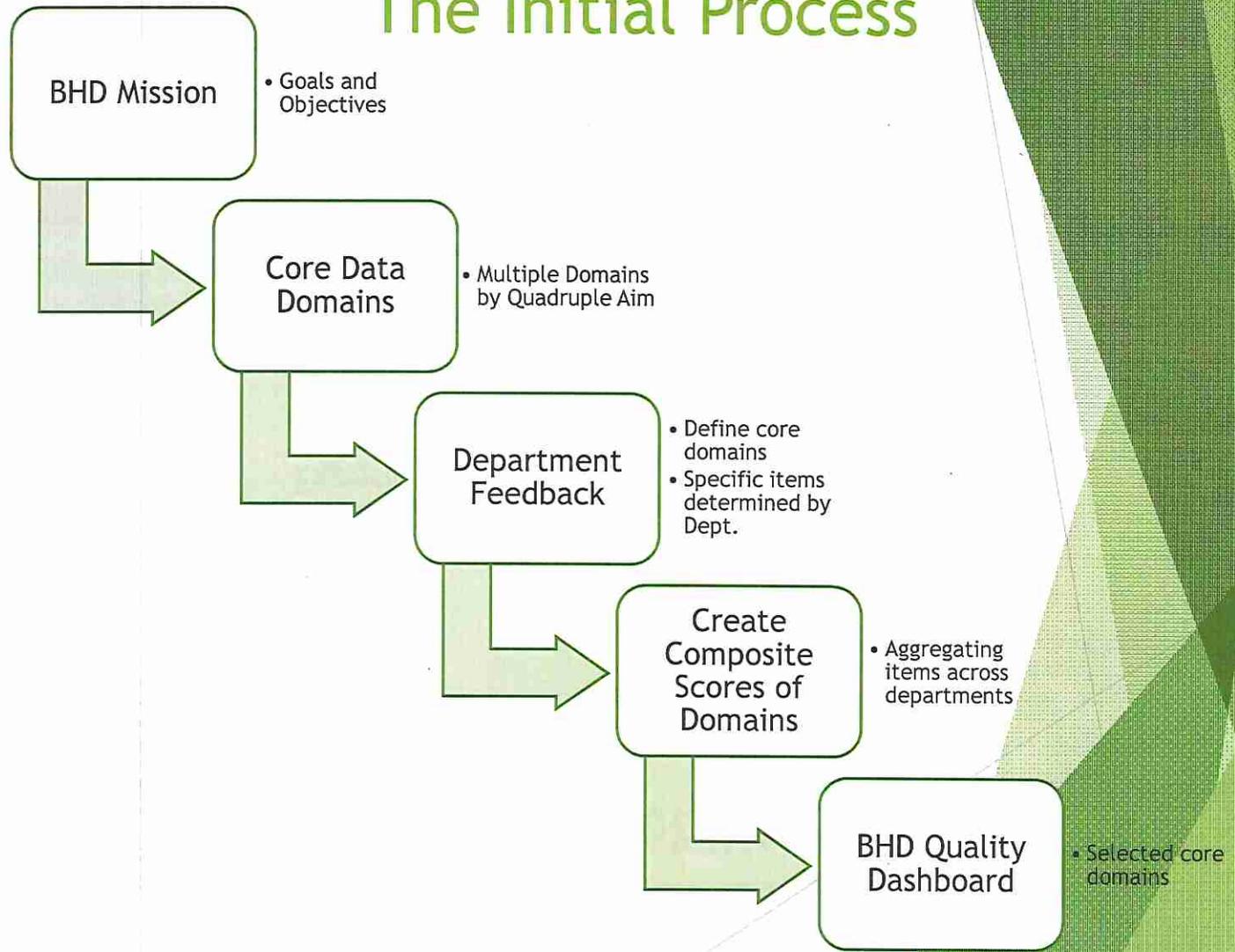


The Quadruple Aim and the Core Domains: A Framework for Quality and Accountability

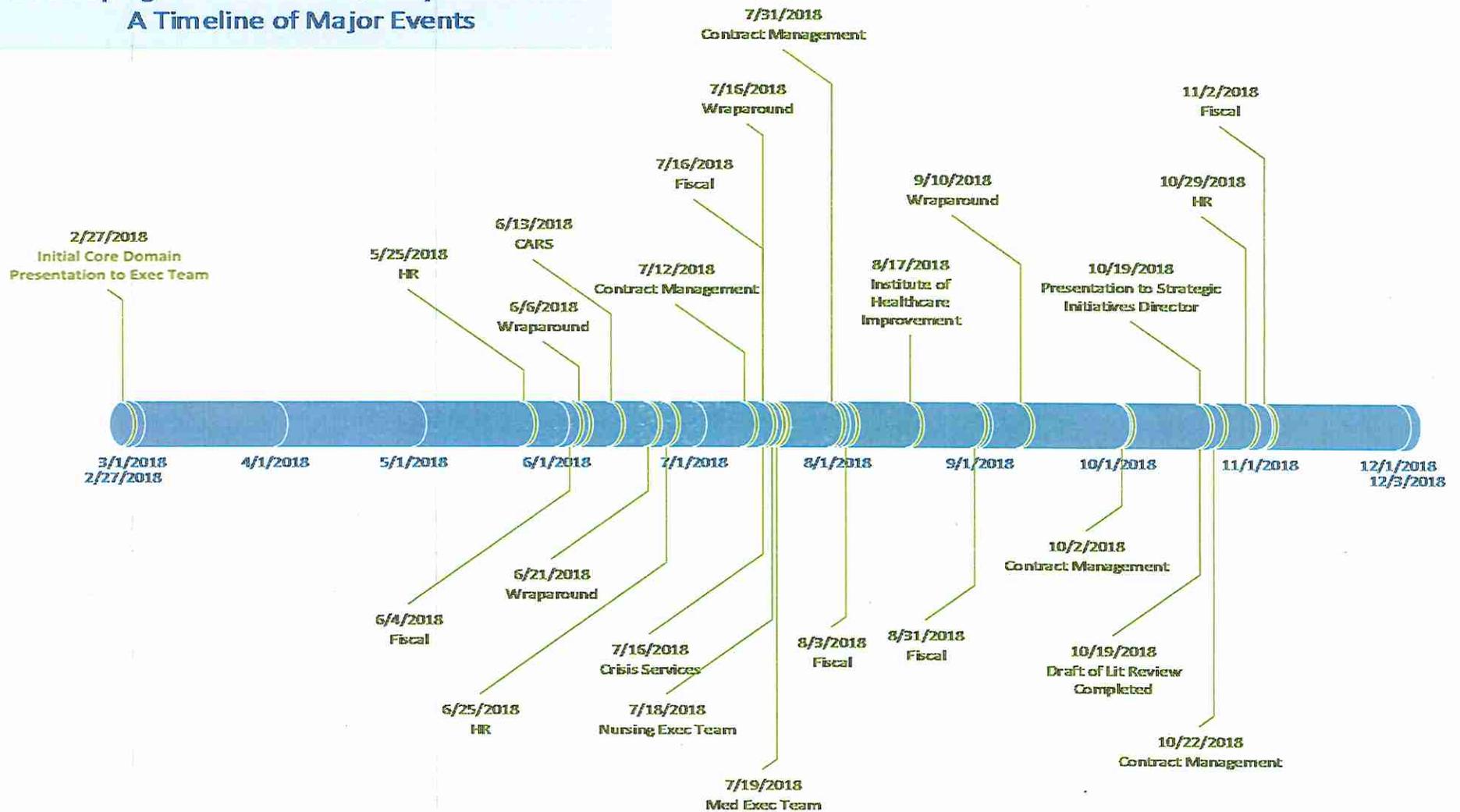


* Consistent with DHHS Strategic Pillars

The Initial Process



Developing the New BHD Quality Dashboard: A Timeline of Major Events



To Start:

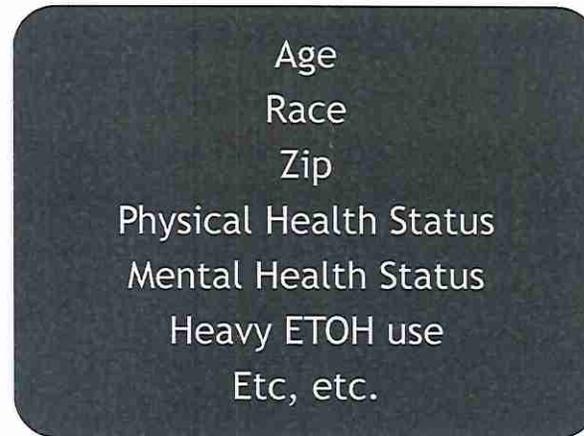
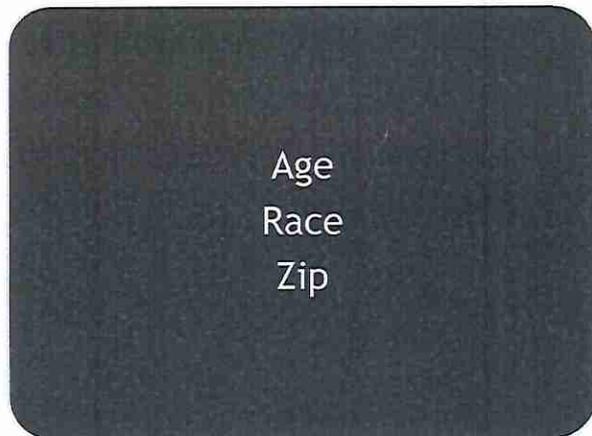
- ▶ The Domains are universal, the items by department are idiosyncratic

Domain	Focus	Shared Definition	Items by Department			
			CARS	Crisis	Wraparound	
					Wrap Dept 1	Wrap Dept 2
Employment/ Education	Employment/ Education	“Defined as...”	Unique Item 1	Unique Item 1	Unique Item 1	Unique Item 1
Housing	Homelessness		So on and so forth			
Social Support	Social Connectedness					

The Future?

Core Domains (Data) as Demographics

- ▶ Can we treat the data used to capture the Core Domains as we would our demographics data?



Quality Committee Item 3

Milwaukee County Behavioral Health Division 2018 Key Performance Indicators (KPI) Dashboard											
Program	Item	Measure	2017 Actual	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	2018 Actual	2018 Target	2018 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵	8,346	5,771	5,861	5,995		8,323	8,555		
		Sample Size for Rows 2-6 (Unique Clients)		3,546	3,371	3,477					
	2	Percent with any acute service utilization ⁶	17.40%	15.78%	15.91%	18.19%			16.52%		
	3	Percent with any emergency room utilization ⁷	13.87%	12.26%	13.82%	16.25%			13.04%		
	4	Percent abstinence from drug and alcohol use	63.65%	65.22%	62.91%	63.14%			64.54%		
	5	Percent homeless	7.61%	8.17%	9.67%	9.39%			7.24%		
	6	Percent employed	18.09%	20.04%	20.32%	19.49%			18.58%		
		Sample Size for Row 7 (Admissions)		1,622	1,673	1,743					
	7	Percent of all admissions that are 30 day readmissions	59.55%	60.05%	62.22%	57.54%			58.47%		
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,404	1,749	2,185	2,506			3,670		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.5	4.5	4.6			>= 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	64.5%	63.6%	65.6%			>= 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.25	2.68	2.35			>= 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	57.8%	43.1%	53.0%	60.6%			>= 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	44.1%	40.8%	39.4%	38.3%			>= 50%		BHD (2)
Crisis Service	14	PCS Visits	8,001	1,866	1,844	1,821			8,000		BHD (2)
	15	Emergency Detentions in PCS	3,979	756	799	753			4,000		BHD (2)
	16	Percent of patients returning to PCS within 3 days	7.3%	6.2%	8.0%	7.6%			8%		BHD (2)
	17	Percent of patients returning to PCS within 30 days	23.1%	20.0%	26.3%	25.1%			24%		BHD (2)
	18	Percent of time on waitlist status	75.0%	54.3%	100.0%	100.0%			25%		BHD (2)
Acute Adult Inpatient Service	19	Admissions	656	189	183	195			800		BHD (2)
	20	Average Daily Census	42.9	40.6	44.1	41.1			54		BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	1.4%	0.5%	3.4%	0.5%			3%		BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	7.7%	5.2%	9.0%	4.9%			10%		NRI (3)
	23	Percent of patients responding positively to satisfaction survey	74.0%	74.5%	72.9%	80.0%			75%		NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	68.8%	62.1%	71.2%			65%		BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.26	0.94	0.38			0.44		CMS (4)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.36	0.38	0.13			0.29		CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	13.5%	21.5%	22.4%			9.5%		CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	92.3%	94.7%	100.0%			90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	709	164	152	151			800		BHD (2)
	30	Average Daily Census	8.6	8.1	7.0	6.4			12.0		BHD (2)
	31	Percent of patients returning to CAIS within 7 days	5.2%	2.4%	5.3%	4.7%			5%		BHD (2)
	32	Percent of patients returning to CAIS within 30 days	12.3%	10.0%	15.2%	14.0%			12%		BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71.3%	76.4%	67.9%	72.9%			75%		BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	75.0%	86.4%	65.4%			75%		BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.38	1.78	0.54			0.44		CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.93	0.49	0.20			0.29		CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.2%	0.7%	2.0%			3.0%		CMS (4)
	38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	100.0%	0.0%	100.0%			90.0%		BHD (2)
Financial	39	Total BHD Revenue (millions)	\$149.9	\$154.9	\$154.9	\$154.9					
	40	Total BHD Expenditure (millions)	\$207.3	\$213.5	\$213.5	\$213.5					

Notes:

- (1) 2018 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
- (2) Performance measure target was set using historical BHD trends
- (3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages
- (4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages
- (5) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.
- (6) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days
- (7) Includes any medical or psychiatric ER utilization in last 30 days

CARS QUALITY DASHBOARD SUMMARY Q3 2018

CHANGES

Further Development of the Quadruple Aim

The CARS Quality Dashboard has continued to undergo further development/refinement of the data elements organized by the Quadruple Aim.

Population Health

1. This and future iterations of the Dashboard will now include Milwaukee County demographic data as a point of comparison for the population served by CARS.
2. CARS will consider the adoption of other population health benchmarks from Milwaukee County for other data elements in the Dashboard (e.g., homelessness status, average age of death, etc.).

Patient Experience of Care

Future versions of the dashboard will include more information about patient satisfaction with care (date TBD in 2019). This will coincide with our Press Ganey satisfaction survey rollout in 2019.

Staff Wellbeing

CARS is working with BHD's Human Resources Department to obtain data on CARS staff turnover. We anticipate that this data will be available in the first quarter of 2019. CARS will also be working with Human Resources to establish appropriate turnover rate targets by department and/or staff classification that are indicative of healthy and high functioning social service organizations.

Cost of Care

The CARS Quality Dashboard has been expanded to now include an approximate cost of care metric based on a per person, per month calculation for all expenditures in CARS programs. This metric, because it is restricted to CARS programs, does not include expenditures for Inpatient or Crisis programs. These will be included in a future iteration of the BHD Quality Dashboard and will include all BHD services a patient receives, irrespective of program.

RESULTS

CARS clients generally experienced an increase in emergency department and inpatient acute service utilization in the third quarter of 2018. These rates will continue to be monitored. Other metrics, however, either remained relatively stable, such as rates of homelessness and employment, whereas others improved, such as 30 day readmission rates for detoxification services.

NEXT STEPS

One of the major initiatives in CARS currently is the development of contract performance measures (CPMs) for all CARS programs. The development of these CPMs has also provided the impetus for the creation of individual programmatic dashboards, which include both the CPMs and other operational and quality metrics of value to program management and oversight. There are now dashboards which have either been created or are in development for several of our CARS programs, with more to come. These initiatives have made data more available to our internal staff and our providers, but even more importantly, they symbolize a paradigm shift within CARS (and BHD more generally) to become a more transparent, data-driven culture. At every level within CARS, staff are utilizing data to make day-to-day decisions, to improve operations, and enhance quality of care.

2018 Wraparound Milwaukee KPI Dashboard Summary – 3rd Quarter

		2017 Actual	1 st Q	2 nd Q	3 rd Q	4 th Q	2018 Target	Status	
Wraparound	8 Families served in Wraparound HMO (unduplicated count)	3,404	1,749	2,185	2,506		3,670		BHD (2)
	9 Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.5	4.5	4.6		>= 4.0		BHD (2)
	10 Percentage of enrollee days in a home type setting (enrolled through Juvenile J)	65.7%	64.5%	63.6%	65.6%		>= 75%		BHD (2)
	11 Average level of "Needs Met" at disenrollement (Rating scale of 1-5)	2.59	2.25	2.68	2.35		>= 3.0		BHD (2)
	12 Percentage of youth who have achieved permanency at disenrollment	57.8%	43.1%	53.0%	60.6%		>= 70%		BHD (2)
	13 Percentage of Informal Supports on a Child and Family Team	44.1%	40.8%	39.4%	38.3%		>= 50%		BHD (2)

8 – There was approx. a 13% increase in families served (unduplicated count) from the 2nd quarter to the 3rd quarter.

9 – On target. No comments.

10 - Achieved 87.4% of the target of "75% or greater". Improved 2% overall from 63.6% to 65.6%. Within 20% range of the benchmark. Continued efforts to have youth reside in the least restrictive setting possible.

11 – Overall decrease of .33 from the 2nd quarter. Currently at 2.35 on a scale of 5.0. Below the 20% benchmark (2.4) and below the set standard of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. Those in Wraparound court ordered programs who are disenrolled to a home type setting have a higher "Need Met" score (2.75) than those disenrolled on runaway status or to corrections (2.03). Discharge placement appears correlated with Needs Met. Those in the REACH program average a disenrollment Needs Score of 2.23.

#12 –There was a 7.6% increase in the percentage of youth achieving permanency at disenrollment compared to the 2nd quarter. This is 4.6% above the "within 20% of the benchmark" status (which would be 56%). The increase is notable. The majority were discharged from the program with an end code of "Program Completed" or "Services No Longer Desired" (34 out of 66 or 52%).

"Permanency" is defined as:

- 1.) Youth who returned home with their parent(s)
- 2.) Youth who were adopted
- 3.) Youth who were placed with a relative/family friend
- 4.) Youth placed in subsidized guardianship
- 5.) Youth placed in sustaining care
- 6.) Youth in independent living

#13 – This item is monitored within the context of the Care Coordination Agency Performance Report (APR) that is distributed semi-annually. The data is available at all times to all Care Coordination agencies for self-monitoring. The current percentage of compliance (38.3%) just falls short of the "within the 20% of the benchmark" score which is 40%. There is a 1.1% decrease from the 2nd quarter.



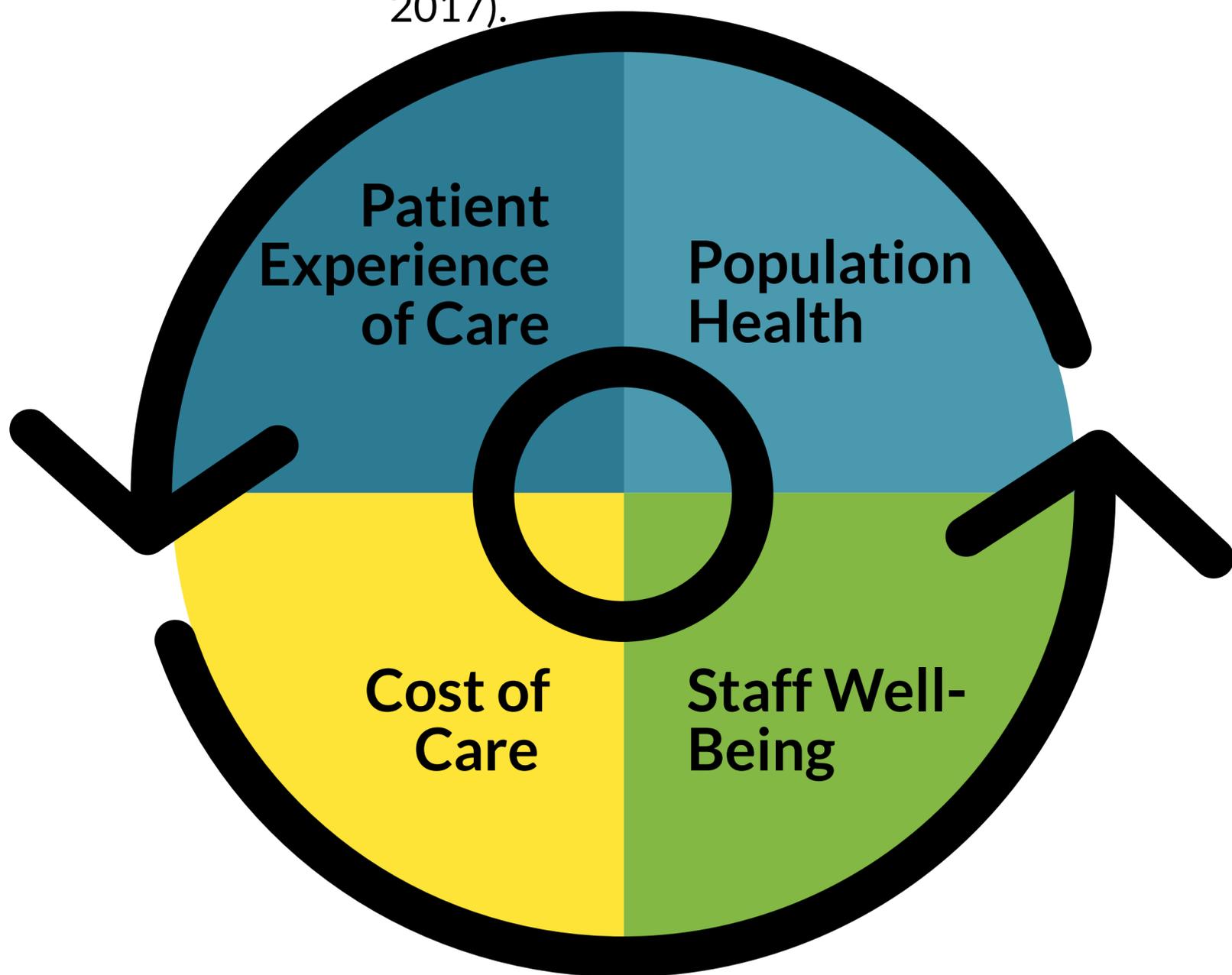
CARS Quality Dashboard

CARS Research + Evaluation Team

The Framework: The Quadruple Aim

The patient experience of care encompasses the range of interactions that patients have with the healthcare system and includes several aspects of healthcare delivery, including satisfaction, timely appointments, and easy access to information, among others (AHRQ, 2017).

"Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group." (Kindig and Stoddart, 2003).



The total cost of care a patient receives across all settings and services, often presented as cost per member of the population per month. (Stiefel & Nolan, 2012)

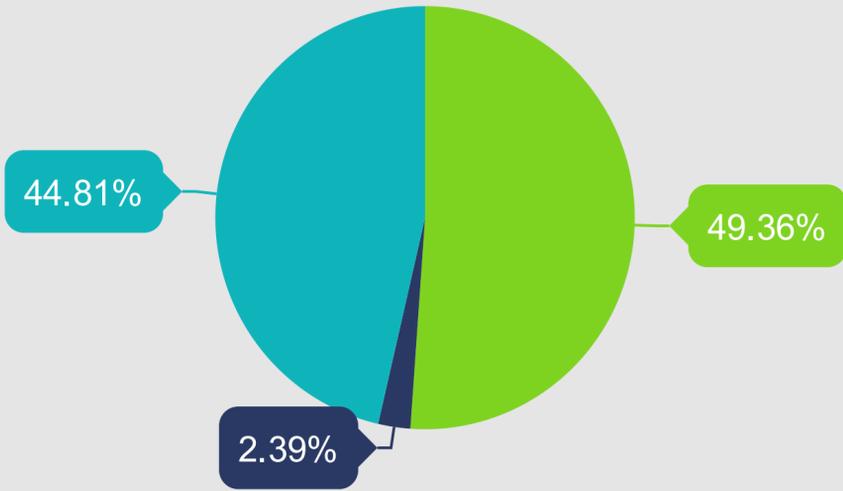
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

Demographic Information of the Population We Serve

This section outlines the demographics of the consumers CARS served or continues to serve in the past quarter.

Race (CARS)

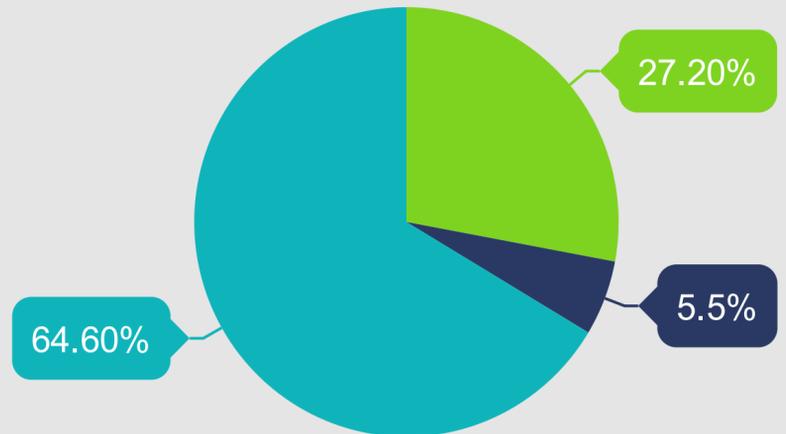
■ Black/African-American
■ White/Caucasian ■ Other



"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

Race (Milwaukee County)*

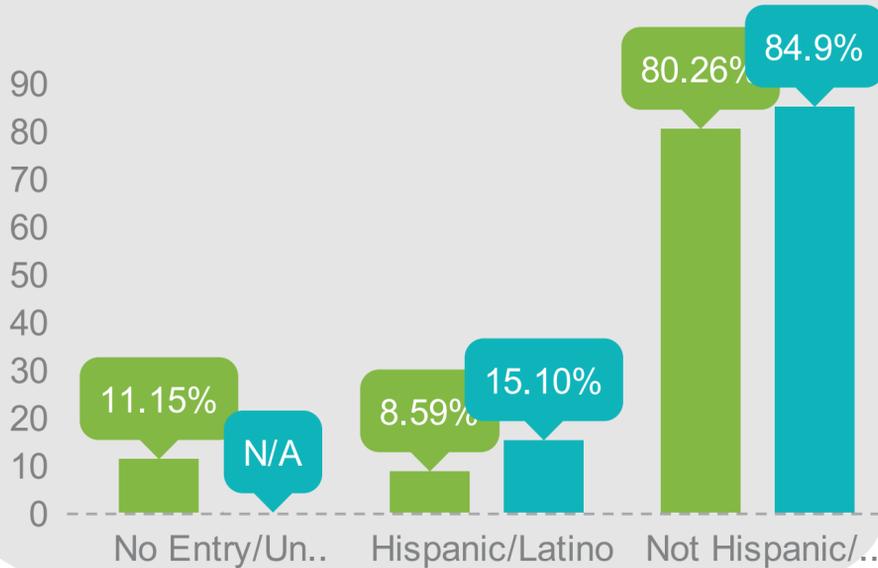
■ Black/African-American
■ White/Caucasian ■ Other



"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

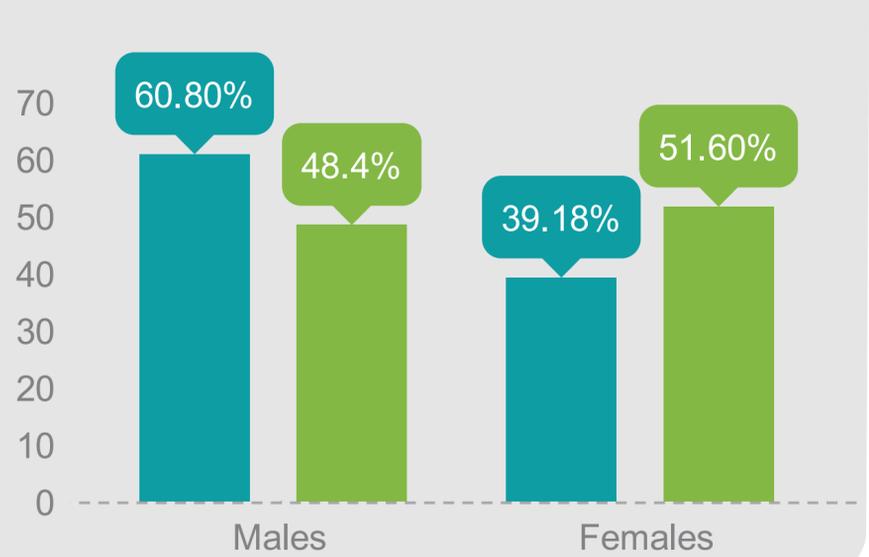
Ethnicity*

■ CARS ■ Milwaukee County

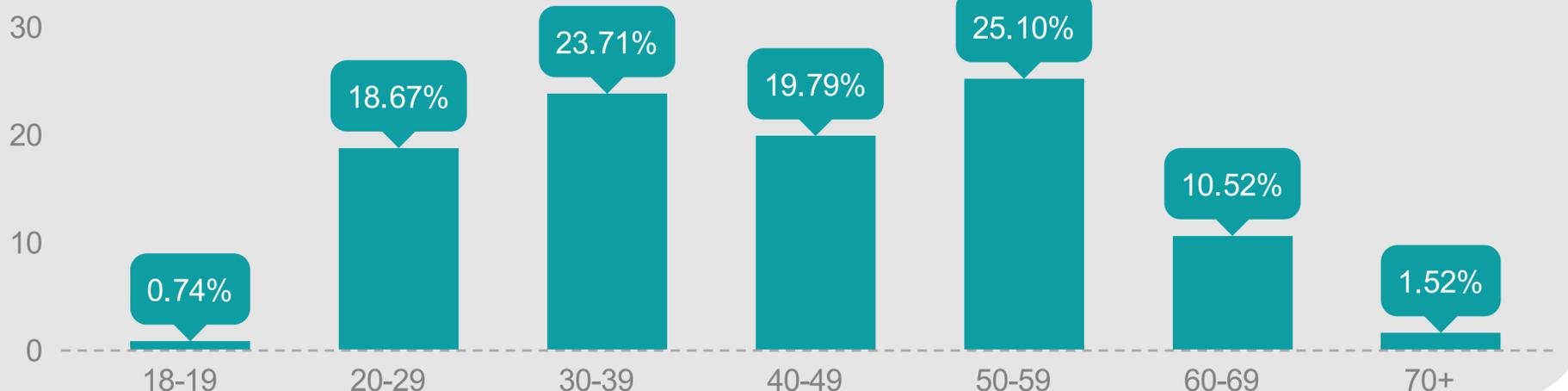


Gender*

■ CARS ■ Milwaukee County



Age



*Comparable data has been pulled from the United States Census Bureau, which can be found at: <https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/PST045217#qf-flag-Z>



Domain: Patient Experience of Care

Items within this domain encompass volume, averages, and percentages. These data points compare the past four quarters in order to indicate change over time.



Referrals

Total number of referrals at community-based and internal Access Points per quarter.



Time to Service

Average number of days between the time of referral to the first service date.



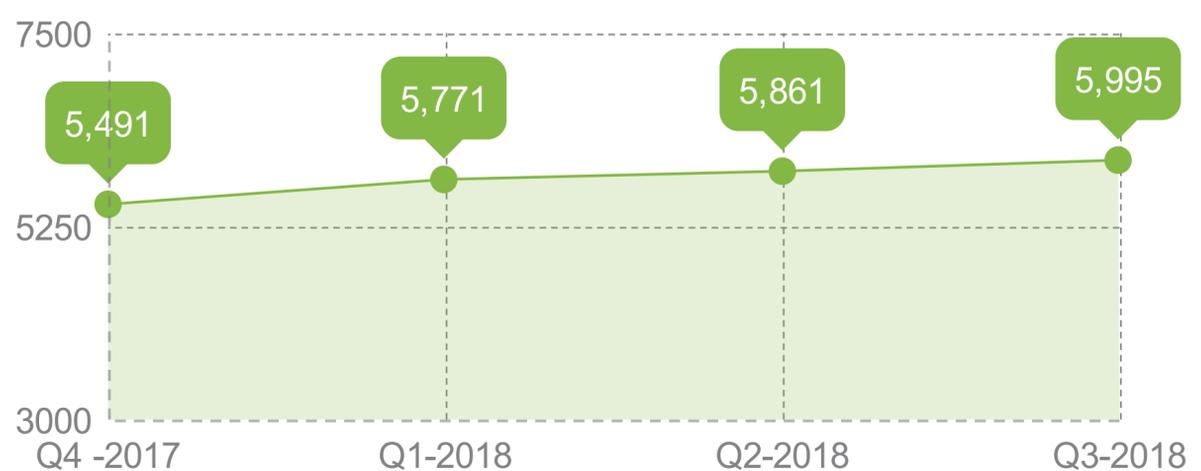
Admissions

All admissions for the past four quarters (not unique clients as some clients had multiple admissions during the quarter). This includes detoxification admissions.



Volume Served

Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.





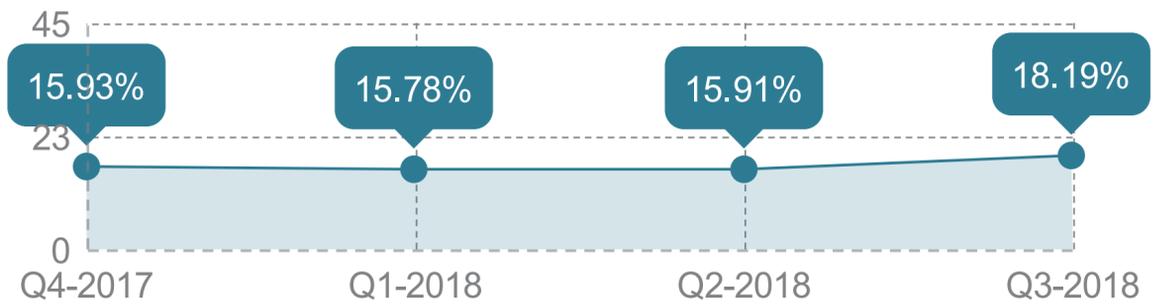
Domain: Population Health

Data informing each item is formatted as percentages based on the description. Most of the data points compare the past four quarters in order to indicate change over time.



Acute Services

Percent of all unique clients who reported that they had received a psychiatric hospitalization, medical hospitalization, or detoxification service in the last 30 days.



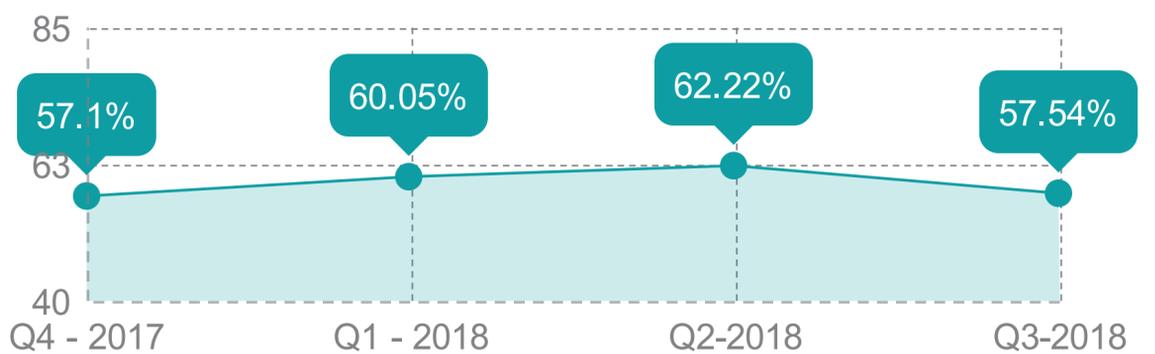
ER Utilization

Percent with any emergency room utilization. Includes any medical or psychiatric ER utilization in last 30 days.



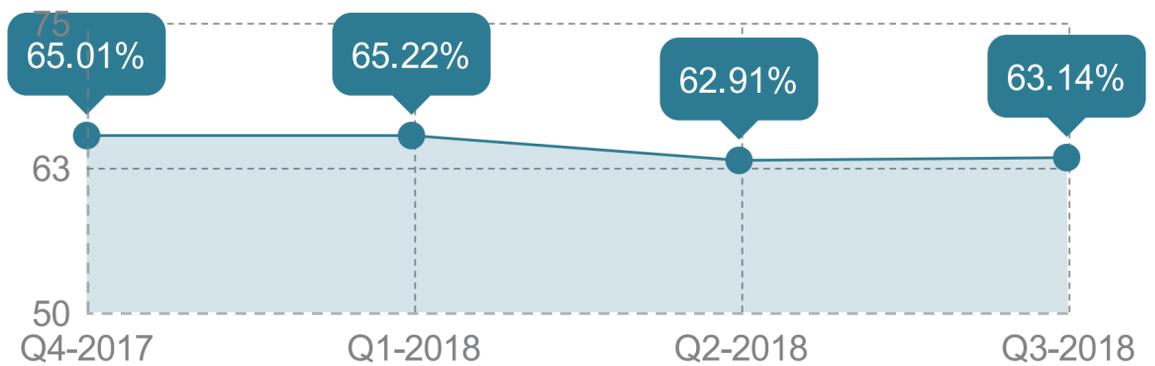
Detoxification 30 Day Readmissions

Percent of consumers returning to detoxification within 30 days.



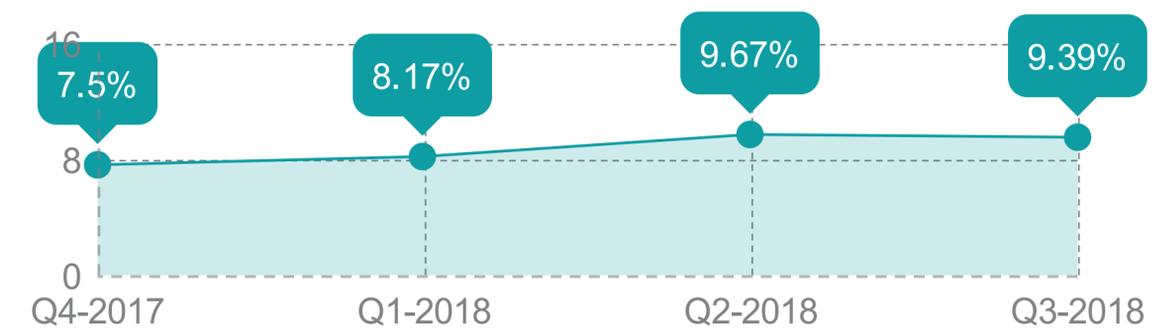
Abstinence

Percent of consumers abstinent from drug and alcohol use.



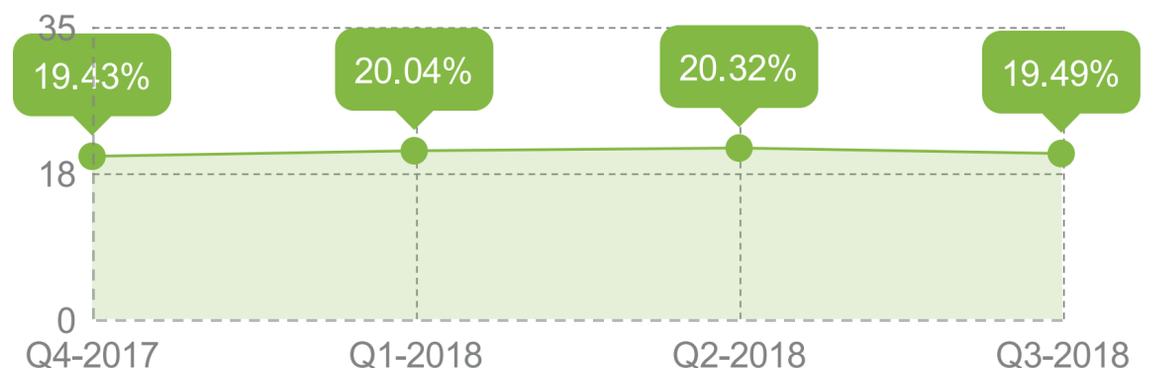
Homelessness

Percent of all unique clients who reported their current living situation was "street, shelter, no fixed address, homeless".



Employment

Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".





Domain: Population Health (Continued)

Items within this domain encompass volume, averages, and percentages. Most of the data points compare the past four quarters in order to indicate change over time.

Mortality Over Time

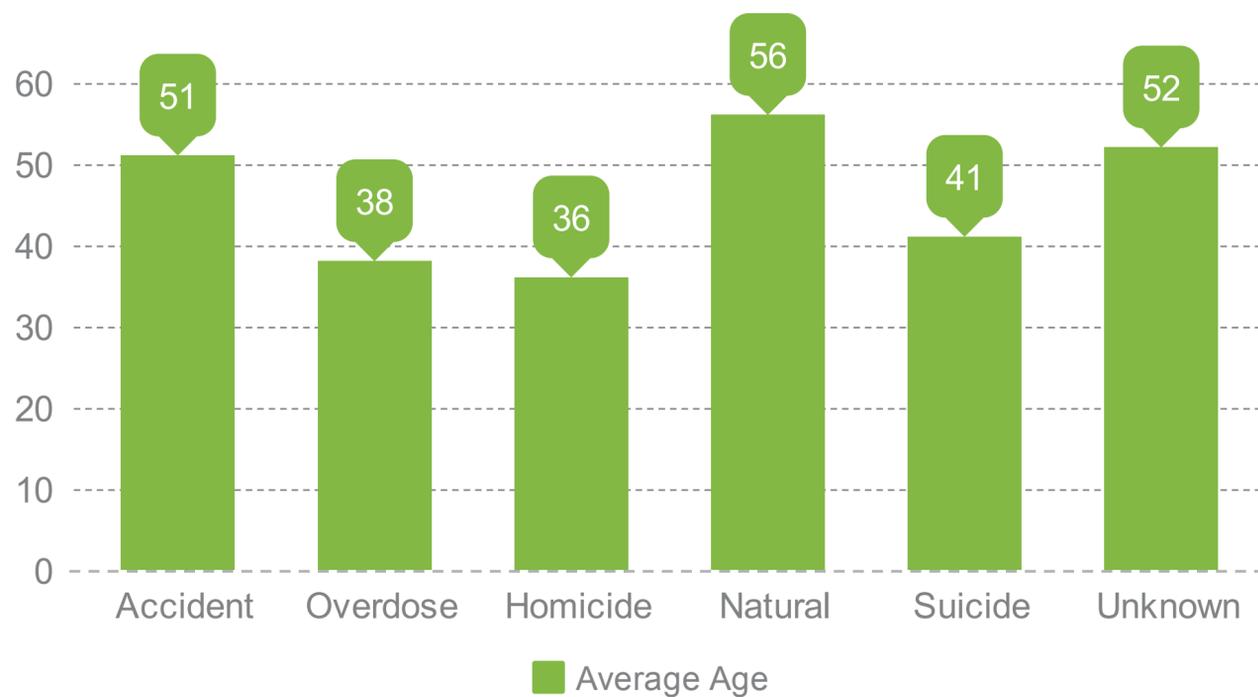
Mortality is a population health metric used by other institutions such as the Center for Disease Control, U.S. Department of Health and Human Services, the World Health Organization and more. The graph represents the total number of deaths in the past four quarters by the cause of death. The total count over time is below:

Q4 - 2017 N = 17	Q1 - 2018 N = 23
Q2 - 2018 N = 11	Q3 - 2018 N = 25



Average Age by Cause of Death

This is the reported average age at time of death by cause of death in the past four quarters.

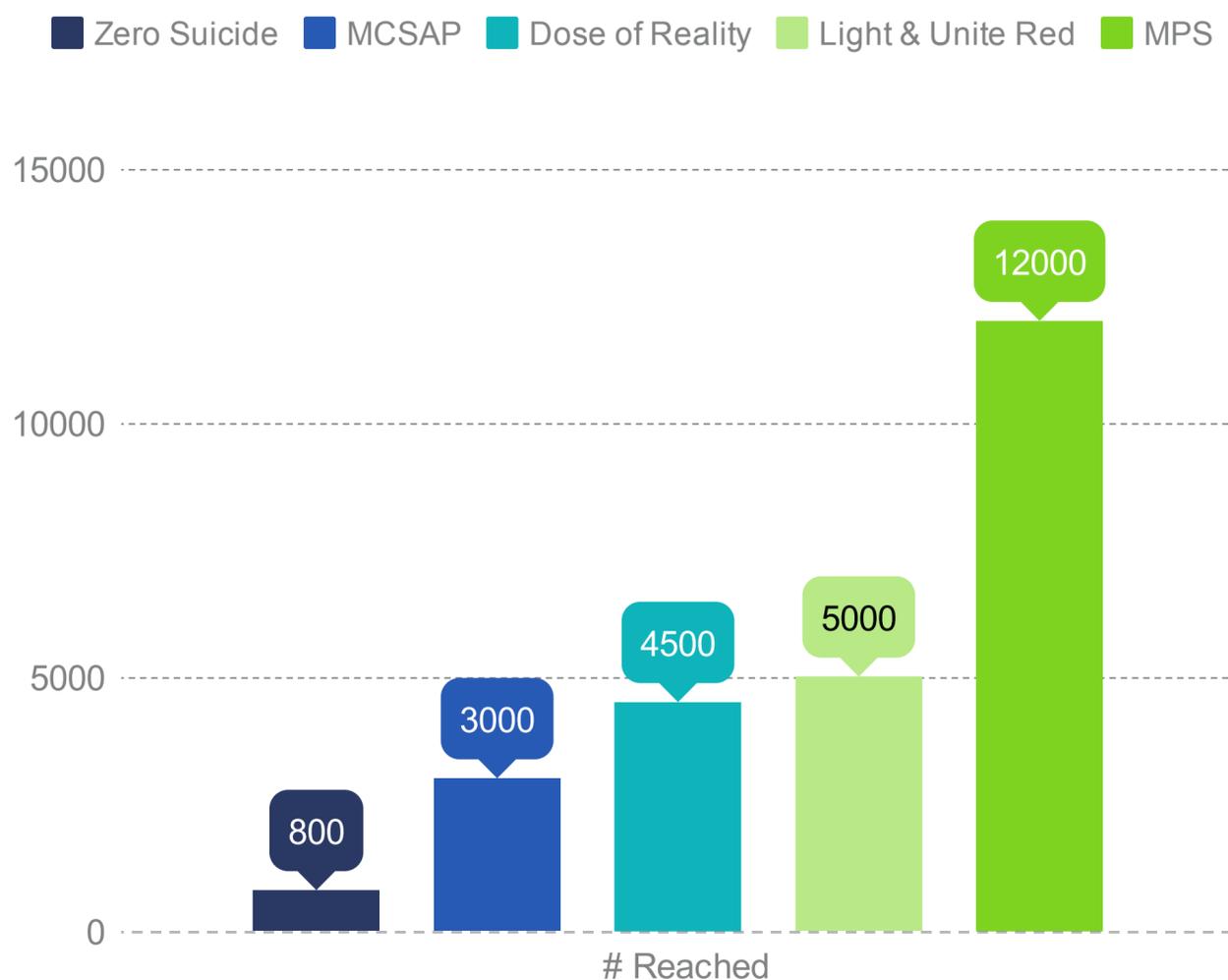


Top Prevention Activities/Initiatives

Prevention is also an important population health factor. Many prevention activities include evidence based practices, presentations, and more. The top five prevention activities are listed in the graphic. Each number is associated with the number of families reached through that initiative in 2017.



The CARS Research and Evaluation team plans to describe forms of primary, secondary, and tertiary prevention activities for topics like substance abuse prevention and suicide prevention.





Domain: Cost of Care

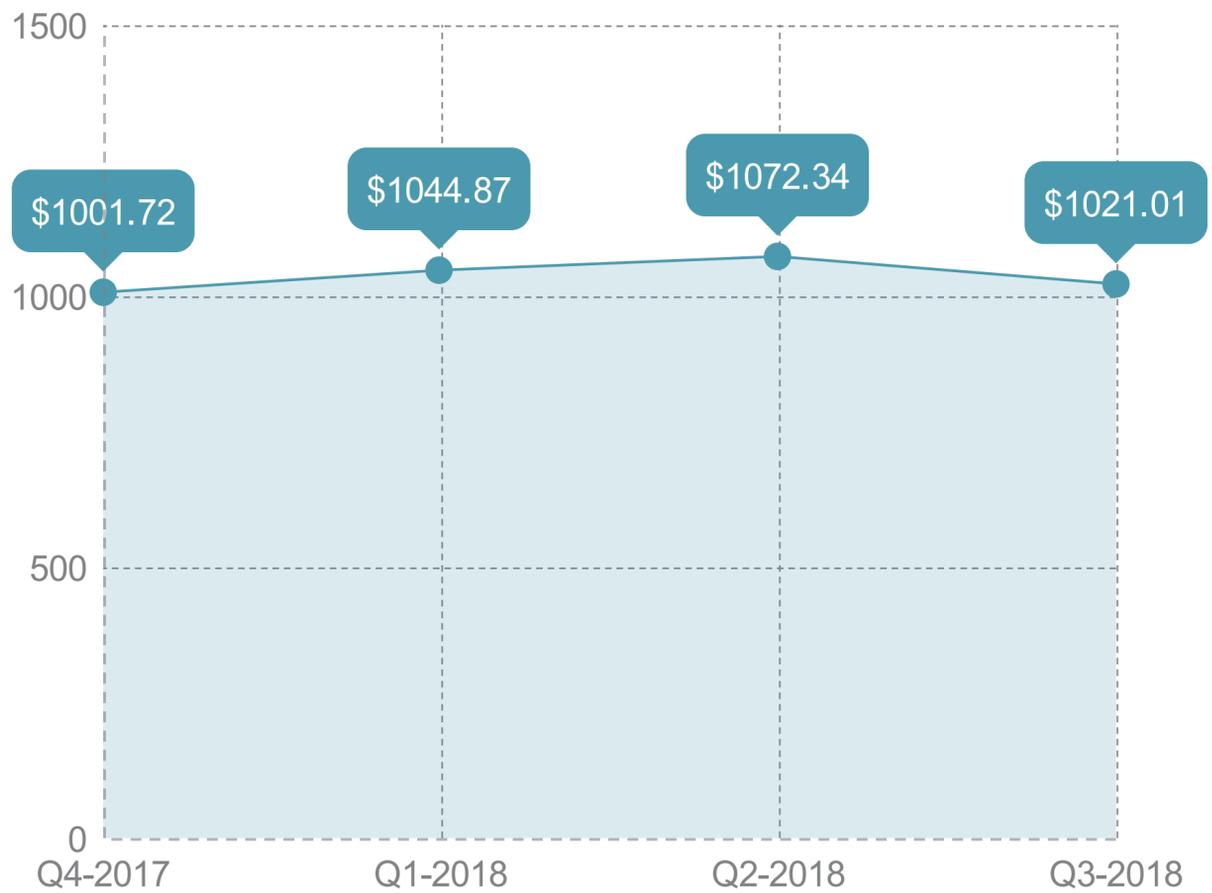
Cost of care compares average cost per month over the past four quarters in order to indicate change over time.

Average Cost Per Consumer Per Month

The average cost per consumer per month within each quarter for CARS services received by CARS consumers (not including inpatient and crisis). This is not separated out by funding stream or limited to those dollars spent by Milwaukee County on these services. The average number of consumers per month within each quarter is below:



Q4 - 2017 N = 4631	Q1 - 2018 N = 4844
Q2 - 2018 N = 4865	Q3 - 2018 N = 5031



Under Development

These are data points the CARS Research and Evaluation team plans to implement in future iterations of the Quarterly Dashboard. Each will contribute to a more comprehensive picture of each domain within The Quadruple Aim.



Staff Well-Being Domain: Staff Turnover

Future dashboards will report on the degree of turnover among CARS staff initially. Future iterations will include staff within the CARS provider network.



All Domains: Case Study

The CARS Research and Evaluation team will capture case study interviews twice a year from consumers, community providers, and other stakeholders as it relates to one of the four domains within The Quadruple Aim.



Patient Experience of Care Domain: Consumer Satisfaction

Press Ganey consumer satisfaction surveys are being adopted in many BHD departments including CARS. Future versions of this report will include overall mean scores of numerous CARS programs.



**BHD Zero Suicide Overview and the Access Clinic Pilot
Quality Management Services Committee, December 3, 2018**

Introduction:

BHD has a Zero Suicide Team. Its members are staff from CARS and Crisis Services, as well as three community members. Our Team seeks to implement evidence based practices across BHD and the provider network to improve client safety and health. Our Team finalized its most recent plan in May 2018 after a year of development. The plan implemented a package of Evidence Based Practices and Tools into the Access Clinic, a short term, walk in and crisis stabilization clinic. After six months of practice and review, there are a number of successes to celebrate, as well as improvements and next steps to pursue.

Our Plan, Our Goals:

Plan Item/ZS Intervention	Related Goal
1. Suicide Screening & Assessment using Evidence Based Tools	1. 100% of clients will be screened for suicide risk. 2. 100% of clients who respond "yes" to SI/SB Questions will receive the full SAFE-T.
2. Safety Planning and Lethal Means Restriction with clients assessed to be at Moderate or High risk	3. 100% of clients who are assessed as Moderate or High Risk for suicide will complete a Safety Plan (which includes Lethal Means Restriction).
3. Post-Visit "Caring" Outreach and Follow up for clients assessed to be at Moderate or High risk	4. 100% of clients who are assessed to be Moderate or High risk for suicide will receive a follow up call.
4. Data Collection, Team Review and Continuous Process Improvement	5. The Access Clinic Team will complete weekly reviews of plan elements. 6. The Zero Suicide Team will complete bi-monthly reviews of plan elements.



Our Outcomes:

What we planned	What we did	What we learned
1. 100% of clients will be screened for suicide risk.	Goal Met. 100% (970) clients between May-Sept. 2018 have received screens in the clinic.	Discussed using the full C-SSRS and embedding in Avatar.
2. 100% of clients who respond "yes" to SI/SB Questions will receive the full SAFE-T.	Goal Met for new clients. 194 new clients (walk ins) between May-Sept. 2018 received SAFE-Ts Goal Not met for returning clients	Clinician time not always available for follow up with returning clients due to walk in clinic needs; team to consider using client alerts in system to follow up when missed.
3. 100% of clients who are assessed as Moderate or High Risk for suicide will complete a Safety Plan (which includes Lethal Means Restriction).	Goal Not Met: 97% (90) of Total Walk ins (93) who were assessed at Moderate/High between May-Sept. 2018 received a Safety Plan with Lethal Means Restriction. Goal not met for returning clients.	Format/Agenda of session appreciated by most; paper Safety Plan not ideal for all; team will look into mobile application and provide choice; not all clients want to stay and complete Safety Plan.
4. 100% of clients who are assessed to be Moderate or High risk for suicide will receive a follow up call.	Goal Not Met: For May-Sept. 2018, 655 clients required follow up calls. Attempts (2 calls made and documented): 89% (583 clients) Completes (phone contact with client): 64% (419 clients)	Staff and clients enjoy the extra contacts; at the same time many don't interact with us by phone (would they by text?). More success with this process for new and returning clients. Large number of follow ups includes multiple, successive contacts.
5. The Access Clinic Team will complete weekly reviews 6. The Zero Suicide Team will complete bi-monthly reviews of plan elements.	Goal Not Met	Clinician card has led to a number of improvements in clinician production, awareness of expectations ZS Team met and reviewed program 1x only to date.



Our Next Steps:

1. Invest (more talent, more time) in the Zero Suicide Team and develop a Phase II:
 - a. Reboot the Zero Suicide Charter
 - b. Have ZS Team include a “working group” and an “advisory group”; have the former meet frequently and build a Phase II plan for ZS expansion across BHD
 - c. Invite members from across DHHS, MPS, VA, Our Partner FQHCs, BHD Provider Network, and more
 - d. Include suicide attempt survivors (family, friends, clients) and Certified Peer Specialists on the Team
 - e. Better connect effort to Exec Team, its high priority projects, goals, its Quality Improvement work
2. Build a better data collection and review system; develop schedule to review, plan, improve with both ZS Team and direct practice clinicians
3. Consider embedding the Zero Suicide tools fully into Avatar (as a part of Phase II)
4. Consider spreading Access Clinic interventions across BHD Crisis Services (Team Connect, Crisis Case Management, Crisis Mobile) as a key part of our Phase II
5. Consider improvements to Screening Tool, use of Safety Planning Mobile Application, Caring Follow ups by text, and use of Certified Peers to provide a portion of the Screening check ins (for returning clients) and Caring Follow ups
6. Pursue Mental Health America Grant to train BHD/Contracted Provider staff in additional Evidence Based ZS Practices

Quality Committee Item 5

Quality Management Committee Institutional Review Board (IRB) Report December 3, 2018

The Institutional Review Board (IRB) is a committee designed to assure that the rights and welfare of individuals are protected. Its purpose is to review, approve, and monitor any research involving individuals served or employed by the Milwaukee County Behavioral Health Division (BHD). The review and approval process must occur prior to initiation of any research activities. The IRB also conducts periodic monitoring of approved research.

IRB Membership Update

- Current membership of the IRB includes: Dr. Justin Kuehl (Chair), Dr. Denis Birgenheir, Ms. Mary Casey, Ms. Shirley Drake, Dr. Matt Drymalski, Dr. Shane Moisis, Ms. Linda Oczus, and Dr. Jaquaye Russell.
- In recent months, the committee extended invitations to two new members. Ms. Shirley Drake is the Supervisor of the BHD's Office of Consumer Affairs. Ms. Mary Casey is a community representative with no direct affiliation to the BHD, but she brings a wealth of knowledge based on her work and volunteer experiences.
- With the addition of these new members, the IRB meets the membership criteria that aligns with best practice and regulatory guidelines.

Recently Completed Research

- Ms. Leah Donovan completed her research titled, "Providing Comprehensive Contraception Counseling for Women Living with a Mental Illness: An Evidence Based Practice Project."

Existing Research

- On May 24, 2017, the IRB approved a proposal submitted by Dr. Tina Freiburger titled, "An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division." The research is ongoing and the IRB continues to receive routine semi-annual updates.

Research Proposals

- In the past six months, the IRB addressed preliminary inquiries regarding two new research proposals. The committee awaits final proposals for review.

Monthly IRB Chairs Meeting

- The Medical College of Wisconsin (MCW) hosts a monthly meeting of local IRB Chairs. The purpose of the meeting is to share information and discuss pertinent issues, which promotes best practices amongst the various IRBs. Dr. Kuehl received an invitation to participate in these meetings and he attended for the first time on 10/18/18.

IRB Training

- There is an online training curriculum offered by the Collaborative Institutional Training Initiative, which is commonly referred to as the CITI Program. It is a common for IRB members to complete this type of formal training to establish competence to serve on the committee.
- The BHD purchased an institutional membership for CITI Program and IRB members have started to access this essential training.
- With an institutional membership, other BHD employees can benefit from these training courses. Interested employees may contact Dr. Kuehl for additional information.

Frieda Brunn Mental Health Research Foundation

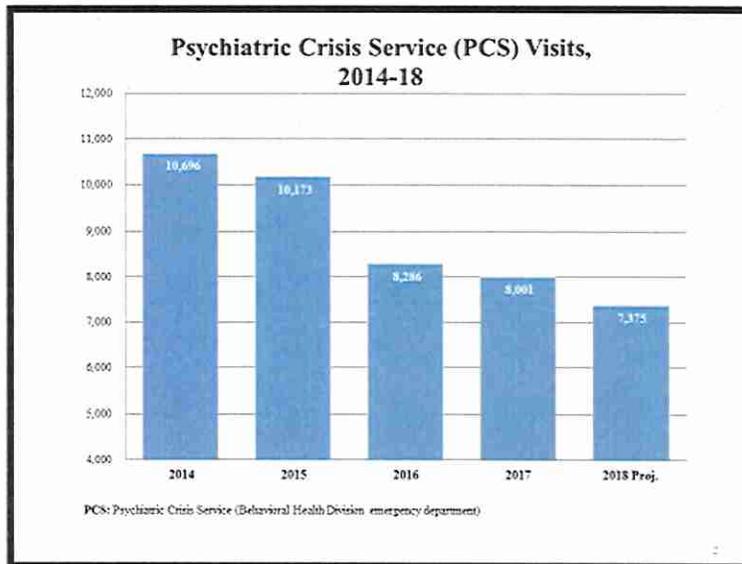
- In 1970, the Frieda Brunn Mental Health Research Foundation created a trust fund with the intent to financially support mental health research.
- As of May 2018, there was a balance of \$216,704.
- The IRB has continued to work on the development of guidelines regarding eligibility and use of the funds.

Respectfully submitted,

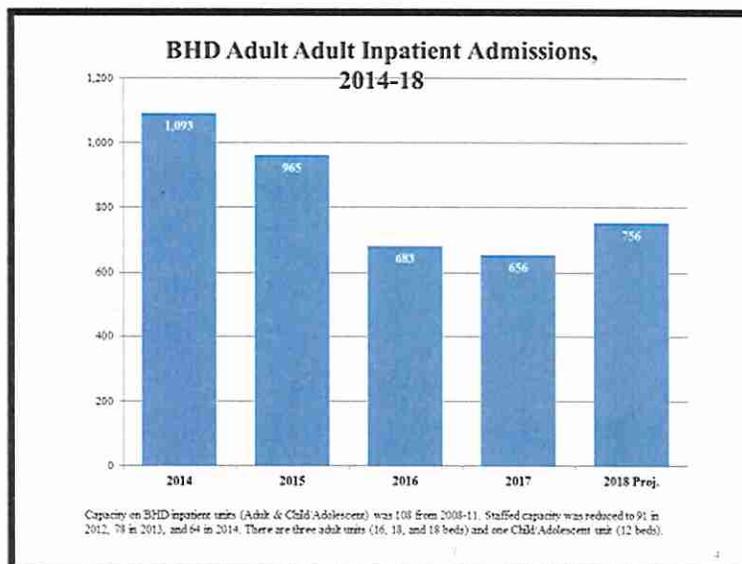
Justin Kuehl, PsyD
Chief Psychologist
IRB Chair

Quality Committee Item 6
2018 Quarter 3 (Q3) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

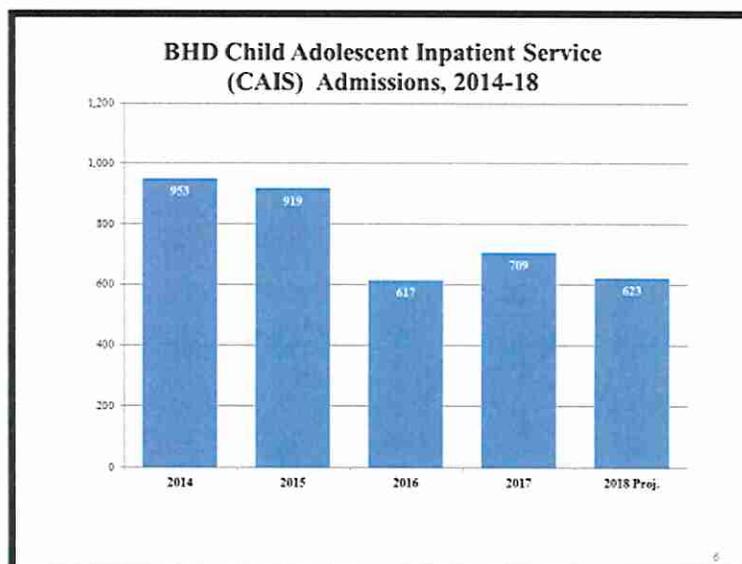
Psychiatric Crisis Service annual patient visits continue to decline from 10,696 in 2014 to 7,375 projected annual visits in 2018 (31% decline from 2014 to 2018). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (54% in 2018 Q1, 100% in Q2 & Q3).



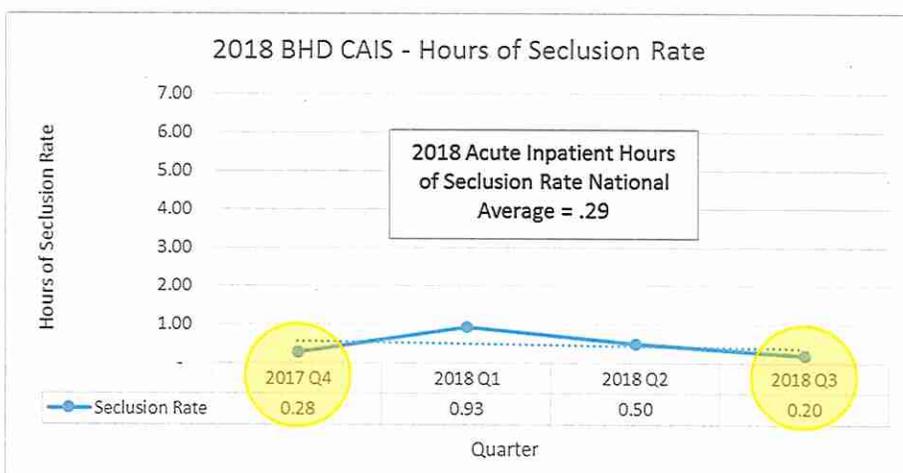
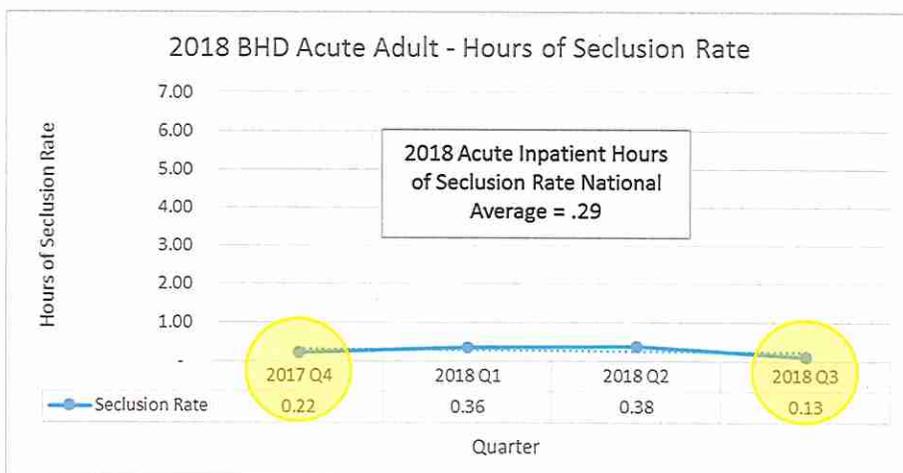
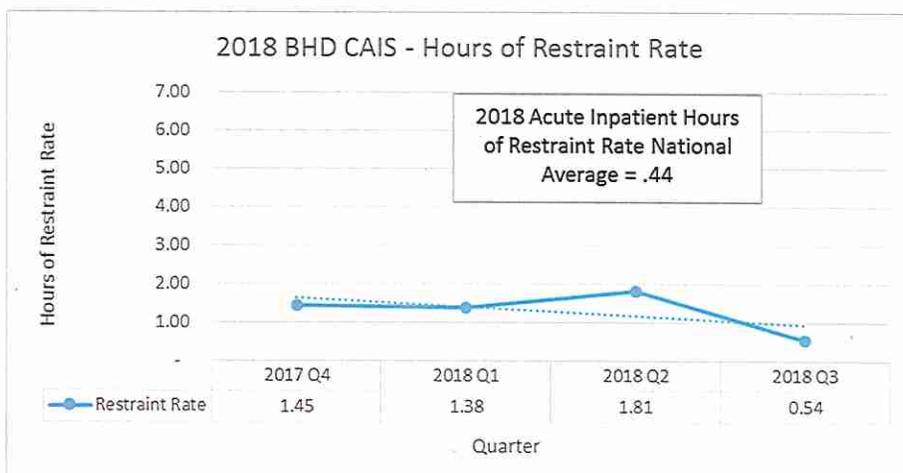
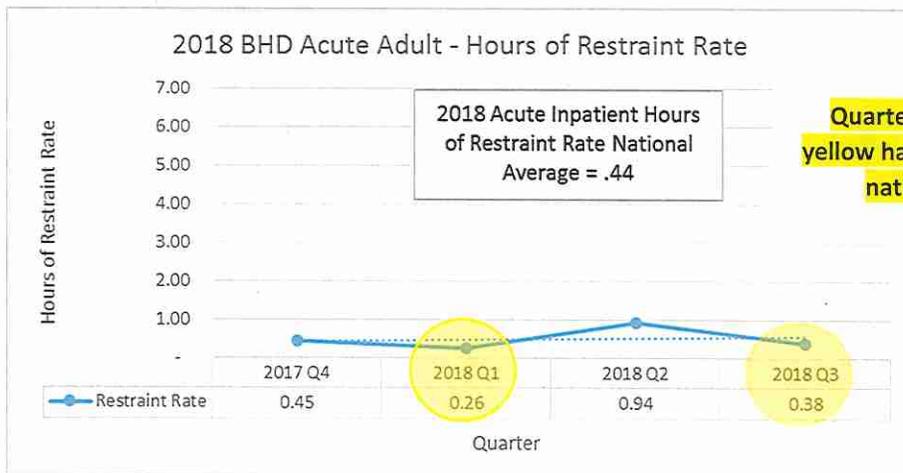
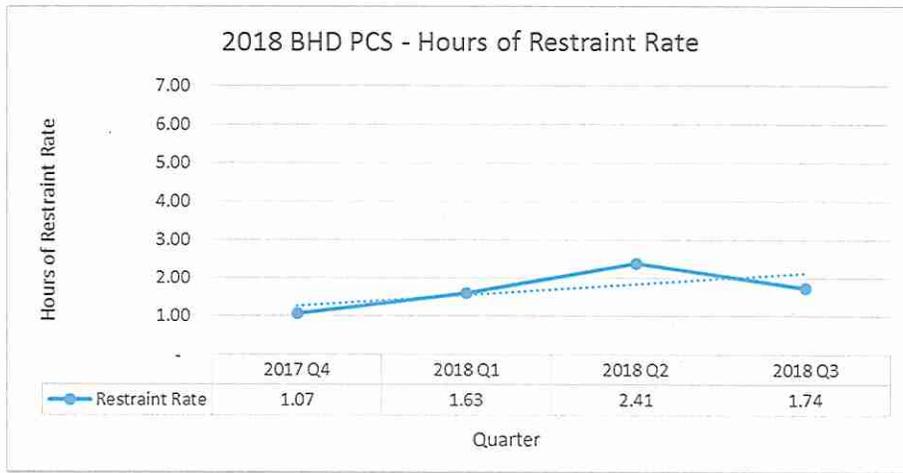
Acute Adult Inpatient Service’s annual patient admissions are projected to increase to 756, the first increase since the Redesign Task Force was established in 2010. While Acute Adult admissions are projected to rise, readmission rates have continued to decline over the past four years (30-day readmission rate: 11% in 2015, 5% in 2018 Q3). In the third quarter of 2018, Acute Adult’s hours of physical restraint rate was below CMS’ inpatient psychiatric facility national average by 14%. Acute Adult’s 2018 Q3 MHSIP overall patient satisfaction survey scores exceeded the national average by 5 percentage points (2018 Q3 BHD Acute Adult overall score 80%, NRI national average 75%)



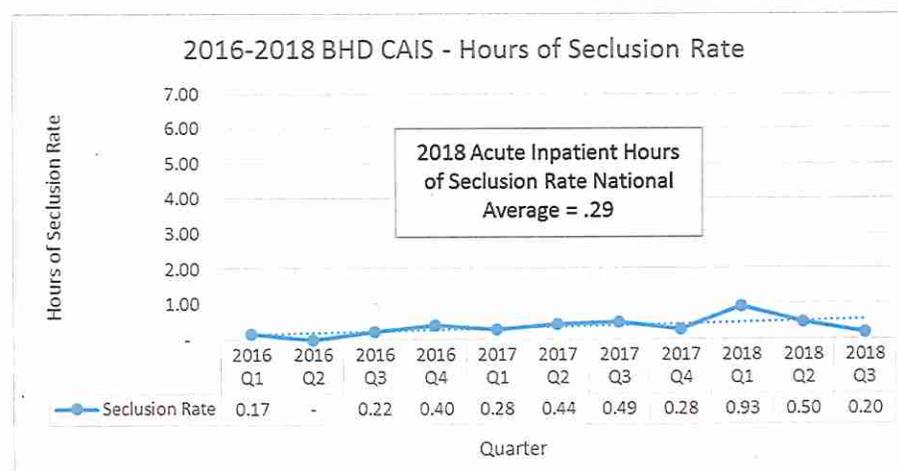
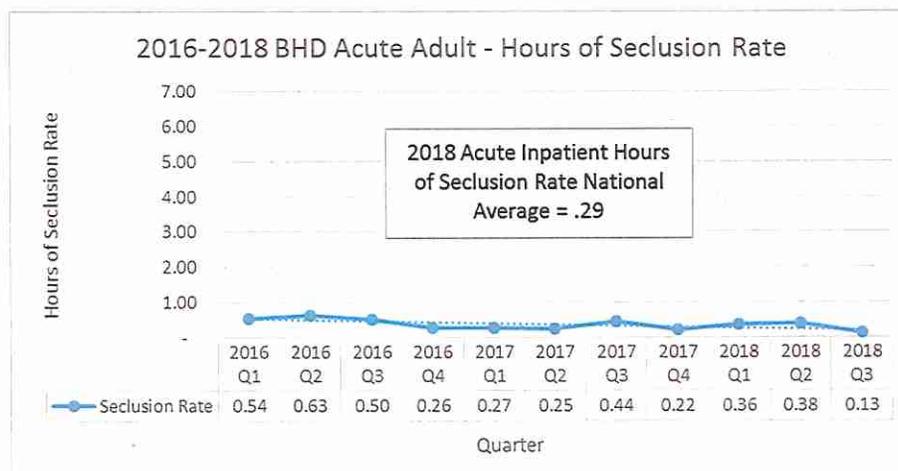
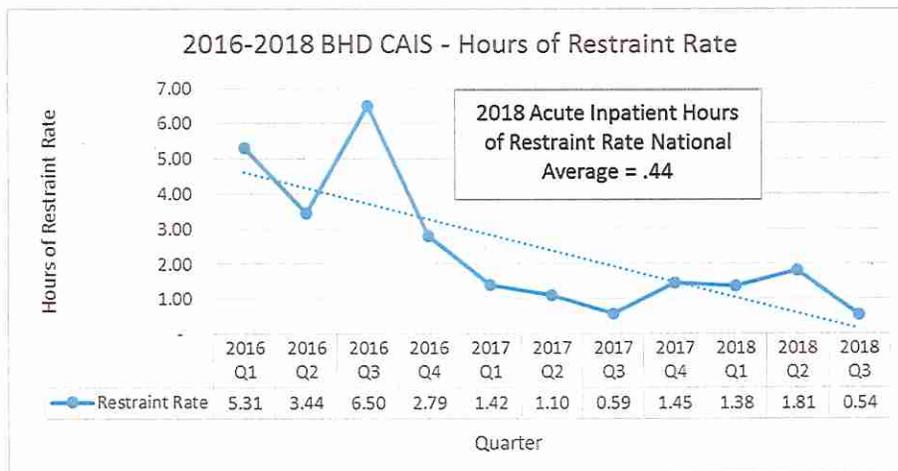
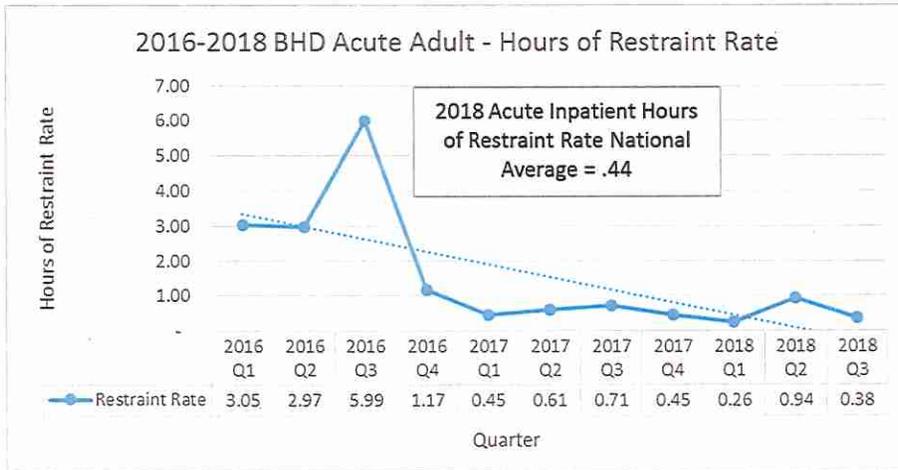
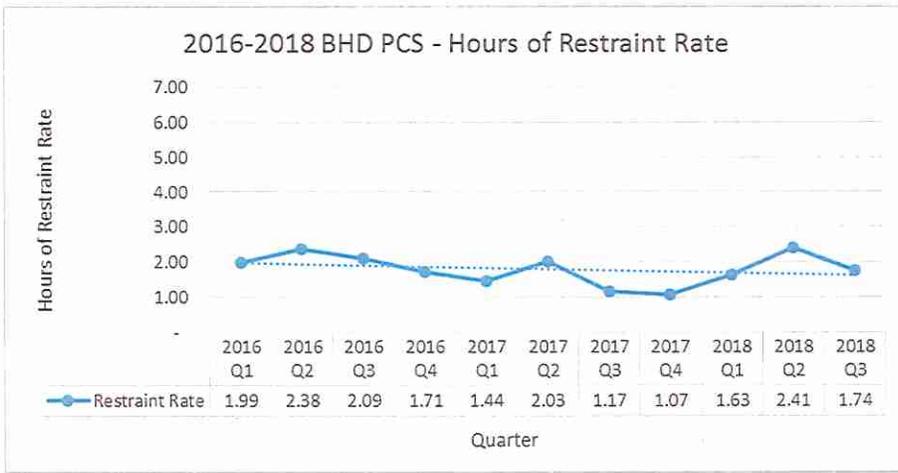
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past few years and are projected at 623 for annual 2018. Over the past four years, CAIS’ 30-day readmission rates have declined from 16% in 2015 to 14% in 2018 Q3. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to .54 in 2018 Q3, and is now only 23% higher than the national average. CAIS’ Youth Satisfaction Survey overall scores increased in 2018 Q3 and are now above BHD’s historical average.



2018 Quarter 3 (Q3) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



2016-2018 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary



Hours of Restraint Rate Formula: $\text{Restraint Hours} / (\text{Inpatient Hours} / 1,000)$

Quality Committee Item 7

EXECUTIVE SUMMARY

MRMC VIOLENT EVENT FULL SCALE EXERCISE

THURSDAY OCTOBER 11, 2018

Hospitals are required to conduct exercises to assess the Emergency Operations Plan's appropriateness; adequacy; and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the plan to support assessment of the organization's preparedness and performance. The design of the exercise should reflect likely disasters but should test the organization's ability to respond to the effects of emergencies on its capabilities to provide care, treatment, and services. At least one event per year should involve others in the community and one should be an escalating event.

Over the past year the Milwaukee Regional Medical Center (MRMC) members planned a full scale emergency exercise activity. This year's event was held on Thursday October 11th and simulated an active shooter event that notionally started at State Fair Park and progressed to the MRMC Campus. The scenario included over twenty simulated casualties delivered to each hospital emergency department with varying injuries. The shooter traveled through the campus area, starting at Wisconsin Lutheran College and ending at the vacant Child and Adolescent Treatment Center (CATC) building just west of (BHD). For the purposes of the exercise the vacant building was to be presumed to be a BHD operating location and was used for Police and Fire Recue Task Force and Evacuation Task Force operations.

Multiple organizations were involved in the planning and implementation of the drill as listed on page 2 of this document.

The exercise focused on the following Core Capabilities:

- Operational Coordination
- Operational Communication
- On Scene Security, Protection and Law Enforcement
- Public Information and Warning Public Health, Healthcare and EMS

BHD is part of the Milwaukee Regional Medical Center's Emergency Coordination Plan (ECP), implemented in late 2017, which focuses on coordinating efforts and resources of the 6 partner organizations. BHD provides coverage for one of two Emergency Command Positions (Duty Officer or Liaison Officer) 12 weeks per year.

BHD was responsible for the Duty Officer role on the day of the exercise. This further tested our internal incident command processes.

The event lasted about 3 hours. BHD received emergency notification from MRMC and sent internal emergency communication messages to all BHD employees through the Milwaukee County Emergency Alert system, Everbridge; Locked down the facility; and utilized the camera system to attempt to track the suspect's movements.

The BHD specific objectives included:

Mission Area: Protection

Operational coordination:

Physical Protective Measures

Objective: BHD Security and Maintenance Staff lockdown the facility within 5 minutes of being given direction to do so.

Mission Area: Mitigation

Objective: Situational assessment

1. BHD Security Dispatch staff monitoring camera system accurately assist with tracking the alleged shooter on BHD property and provide an accurate description of movements and location to law enforcement and BHD administration.

Mission Area: Response

Objective -Operational Communications

1. BHD staff assigned, calls into the Conference line for the event briefings within 5 minutes of receipt of notification.
2. BHD command staff open the Emergency Operations Center (EOC) and staff the center with key positions
3. BHD command staff assume control of internal incident command from initial reporting personnel (Security).
4. BHD command staff create an Incident Action Plan for the first operational period.

Objective: Situational assessment

1. Based on briefing information, BHD Leadership staff communicate with Security, Operations and General staff as appropriate.
2. BHD Command staff effectively communicate key information to Wauwatosa Incident Command

Mission Area: Recovery

Objective – Operational Communications

1. Communicate all clear to Security, Operations and General staff.
2. Deactivate the Emergency Operations Center and return to normal operations.

Strengths:

- Standard Operating Procedures (SOP) are in place regarding internal and external coordination.
- Internal communication went well, and necessary announcements and requests were conducted.
- BHD staff offered psychological first aid resources to other members.
- The tabletop exercise identified the need to have a group text to notify EOC personnel. This was attempted and functioned as designed.
- BHD leadership received the MRMC alert directly and opened Incident Command directly vs transferring command from security team.
- Physical lockdown occurred within target times.
- The MRMC Emergency Coordination Plan (ECP) has been fully implemented and is understood by all members and partners.
- MRMCs reoccurring Training and Exercise program continues to improve performance.
- BHD opened the Emergency Operations Center and implemented the emergency procedures in an effective and timely manner.
- The Staff responded properly to the lockdown directive until the all clear.
- Internal mass communication system test was successful at communicating the chain of events.
- BHD Public Information Officer (PIO) responded to Joint Information Center (JIC) activation and uploaded emergency alert to BHD's internal message boards.

Areas for Improvement/Analysis: The following areas require improvement to achieve full capability level:

- Review SOPs and consider clarifying roles and responsibilities and create/fine tune checklists.
- Consider additional tools/methods to track incident related actions and information.
- The Public Address notification was not audible in some locations. Consider a review of PA system coverage.
- The group text system will need to be further tested in a no-notice scenario and during off-duty hours to ensure it works under those conditions.
- Everbridge Internal Alert message call log showed multiple hang-ups and contact numbers that were out of service. Continuous updating of call list is required, and staff should add alert message sender phone number to contacts list. Coordinate with Office of Emergency Management to update lists.
- Continue to improve on communications between key parties during the incident.

Participating Organizations

- Blood Center of Wisconsin
- Children's Hospital of Wisconsin
- Curative Care Network
- Froedtert Hospital
- Medical College of Wisconsin
- Milwaukee County Behavioral

- Health Division
- 911 Communications Division
 - Milwaukee County Office of Emergency Management
 - Milwaukee Police Department

- Milwaukee Regional Medical Center
- Wauwatosa Fire Department
- Wauwatosa Police Department
- Wisconsin Lutheran College

Conclusion

The overall execution of the MRMC Emergency Coordination Plan and existing violent event protocols and lock down processes went well. Additional increased familiarity and practice will improve the efficiencies of completion of the various tasks required. The progress of the improvement actions will be reviewed in the Environment of Care Committee meetings.

POLICY & PROCEDURE STATUS REPORT -GOAL=96%

Baseline 71.5% as of August 2016 LAB report

Review period	Number of Policies	Percentage of total
Reviewed within Scheduled Period	361	71.5%
Up to 1 year Overdue	32	6.3%
More than 1 year and up to 3 years overdue	20	4.0%
More than 3 years and up to 5 years overdue	31	6.1%
More than 5 years and up to 10 years overdue	18	3.6%
More than 10 years overdue	43	8.5%
Total	505	100.0%

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
June	2	7	3
July	4	18	0
August	1	21	0
September	5	10	1
October	4	14	1

Overall Progress 96.2% as of Nov. 1, 2018

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	500	505	95.8%	96.2%
Up to 1 year Overdue	17	15	3.3%	2.9%
More than 1 year and up to 3 years overdue	2	2	0.4%	0.4%
More than 3 years and up to 5 years overdue	0	0	0.0%	0.0%
More than 5 years and up to 10 years overdue	1	1	0.2%	0.2%
More than 10 years overdue	2	2	0.4%	0.4%
Total	522	525	100%	100%

Forecast Due for Review

Past Due Policies - 25

Coming Due Policies

November - 3
 December - 24
 January - 4
 February - 3
 March - 5

April - 2
 May - 4
 June - 11
 July - 8
 August - 46
 September - 1
 October - 20

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

DATE: November 14, 2018

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

FROM: Clarence P. Chou, MD, President of the Medical Staff Organization
Prepared by Lora Dooley, Director of Medical Staff Services

SUBJECT: A Report from the President of the Medical Staff Organization Requesting Approval of Appointment and Privilege Recommendations Made by the Medical Staff Executive Committee

Background

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

Discussion

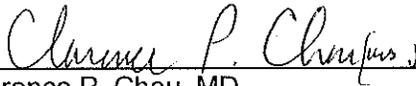
From the President of the Medical Staff Organization and Chair of the Medical Executive Committee presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C¹:

- A. New Appointments
- B. Reappointments
- C. Provisional Period Reviews, Amendments &/or Status Changes
- D. Notations Reporting (to be presented in **CLOSED SESSION** in accordance with protections afforded under Wisconsin Statute 146.38)

Recommendation

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

Respectfully Submitted,



Clarence P. Chou, MD
President, BHD Medical Staff Organization

cc Michael Lappen, BHD Administrator
John Schneider, BHD Chief Medical Officer
Shane Moasio, MD, Vice-President of the Medical Staff Organization
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

Attachments

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
NOVEMBER-DECEMBER 2018**

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

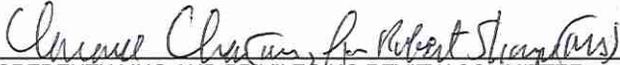
INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE OCTOBER 31, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 14, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Sabeen Haque, MD	General Psychiatry	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested.	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
Hillary Wynn, MD	General Psychiatry; Child Psychiatry	Active/ Provisional		Dr. Moiso recommends appointment & privileges, as requested.	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD							

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE OCTOBER 31, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 14, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Tanya Heinrich, MD	General Psychiatry	Active / Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Cynthia Love, MD	General Psychiatry	Active / Full	HS	Dr. Schneider recommends reappointment & privileges, as requested	Contingent upon timely return from leave of absence prior to expiration of current appointment period, the Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Abby Noack Haggas, PsyD	General Adult Psychology; Child Psychology	Associate / Full		Drs. Kuehl & Moiso recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Dawn Puls, MD	General Practice	Active / Full	M#	Dr. Schneider recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Rebecca Radue, MD	General Psychiatry	Affiliate / Provisional *		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. <i>* Privileges were amended and newly granted in this category effective 9/1/18 and remain subject to a minimum provisional period of 6 months</i>	Recommends reappointment and privileging as per C&PR Committee.	

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE OCTOBER 31, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 14, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Robert Ruskiewicz, MD	General Psychiatry	Affiliate / Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Diana Verde, MD	General Psychiatry	Affiliate / Full		Dr. Zincke recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Elliott Wagner, MD	Diagnostic Radiology-X-Ray & Ultrasound Interpretation	Consulting Telemedicine / Full	M#	Dr. Puls recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 1 year. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Pamela Wolfe, MD	General Psychiatry	Affiliate / Full	M#	Dr. Zincke recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
Kanisha Hayden, MSN	Advanced Practice Nursing-Family Practice	Allied Health / Full	CB	Dr. Puls recommends privileges, as requested	Committee recommends privileges, as requested, for 2 years. No changes.	Recommends privileging as per C&PR Committee.	
Josie Veal, MSN	Advanced Practice Nursing-Family Practice	Allied Health / Full		Dr. Puls recommends privileges, as requested	Committee recommends privileges, as requested, for 2 years. No changes.	Recommends privileging as per C&PR Committee.	

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE OCTOBER 31, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 14, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<i>The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.</i>							
MEDICAL STAFF							
Diana Verde, MD	General Psychiatry	Affiliate/ Provisional	Affiliate / Full	Dr. Zincke recommends full privileges	Committee recommends change in privilege status from provisional to full in conjunction with reappointment recommendation.	Recommends privileging status change, as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD							

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	RECOMMENDED CHANGE	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE OCTOBER 31, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE NOVEMBER 14, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NONE THIS PERIOD						


 CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
 (OR PHYSICIAN COMMITTEE MEMBER/DESIGNEE)

11/15/18
 DATE


 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

11/15/18
 DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS: _____

RECOMMENDATIONS OF THE MCBHD MEDICAL STAFF CREDENTIALING & PRIVILEGING REVIEW AND MEDICAL STAFF EXECUTIVE COMMITTEES WERE REVIEWED. ALL PRIVILEGE AND APPOINTMENTS ARE HEREBY GRANTED AND APPROVED, AS RECOMMENDED BY THE MEC, UNLESS OTHERWISE INDICATED ABOVE.

 GOVERNING BOARD CHAIRPERSON
 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
 MEDICAL STAFF CREDENTIALS & EXECUTIVE COMMITTEE REPORT TO GOVERNING BODY – NOVEMBER-DECEMBER 2018
 PAGE 2 of 2

 DATE

BOARD ACTION DATE: DECEMBER 13, 2018

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
2019 COMMITTEE/BOARD SCHEDULE**

13

DATE

COMMITTEE/BOARD

January 24, 2019, at 4:30 p.m.	Mental Health Board (<i>Public Comment/General</i>) - Washington Park Senior Center
February 28, 2019, at 7:00 a.m.	Finance Committee (<i>Contracts Approval</i>) - Location TBD
February 28, 2019, at 8:00 a.m.	Mental Health Board - Location TBD
March 4, 2019, at 10:00 a.m.	Quality Committee - Mental Health Complex
March 21, 2019, at 4:30 p.m.	Mental Health Board (<i>Public Comment/Budget</i>) - Location TBD
March 28, 2019, at 1:30 p.m.	Finance Committee (<i>Contracts Approval/Quarterly Meeting</i>) - Mental Health Complex
April 25, 2019, at 8:00 a.m.	Mental Health Board - Zoofari Conference Center
June 3, 2019, at 10:00 a.m.	Quality Committee - Mental Health Complex
June 6, 2019, at 4:30 p.m.	Finance Committee (<i>Public Comment/Budget</i>) - Location TBD
June 20, 2019, at 7:00 a.m.	Finance Committee (<i>Contracts Approval</i>) - Zoofari Conference Center
June 20, 2019, at 8:00 a.m.	Mental Health Board - Zoofari Conference Center
June 27, 2019, at 1:30 p.m.	Finance Committee (<i>Budget Presentation/Public Comment/Budget Approval</i>) - Mental Health Complex
July 11, 2019, at 8:00 a.m.	Mental Health Board (<i>Budget Presentation/Approval</i>) - Zoofari Conference Center
August 22, 2019, at 7:00 a.m.	Finance Committee (<i>Contracts Approval</i>) - Location TBD
August 22, 2019, at 8:00 a.m.	Mental Health Board - Location TBD
September 9, 2019, at 10:00 a.m.	Quality Committee - Mental Health Complex
September 12, 2019, at 1:30 p.m.	Finance Committee - (<i>Quarterly Meeting</i>) Mental Health Complex
September 26, 2019, at 4:30 p.m.	Mental Health Board (<i>Public Comment/General</i>) - Location TBD
October 24, 2019, at 7:00 a.m.	Finance Committee (<i>Contracts Approval</i>) - Zoofari Conference Center
October 24, 2019, at 8:00 a.m.	Mental Health Board - Zoofari Conference Center
December 2, 2019, at 10:00 a.m.	Quality Committee - Mental Health Complex
December 5, 2019, at 1:30 p.m.	Finance Committee (<i>Contracts Approval/Quarterly Meeting</i>) - Mental Health Complex

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
2019 COMMITTEE/BOARD SCHEDULE**

DATE

COMMITTEE/BOARD

December 12, 2019, at 8:00 a.m.	Mental Health Board - Zoofari Conference Center
---------------------------------	---