

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

2

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, April 25, 2019 - 8:00 A.M.
Zoofari Conference Center
9715 West Bluemound Road

MINUTES

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

*Board Members Walter Lanier and Mary Neubauer were 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. | <p>Welcome.</p> <p>Chairman Lutzow greeted Board Members and welcomed everyone to the April 25, 2019, Mental Health Board meeting.</p> |
| 2. | <p>Approval of the Minutes from the February 28, 2019, and March 21, 2019, Milwaukee County Mental Health Board Meeting and Public Hearing.</p> <p>Board Member Neubauer requested separate action be taken on the Board Meeting and Public Hearing minutes.</p> <p>Board Member Forman requested the February 28, 2019, meeting minutes wording on the first line in the first paragraph on Page 1, Item 2, be corrected to reflect the word “clarity” as opposed to “transparency.”</p> <p>MOTION BY: (Eilers) Approve the Minutes AS CORRECTED from the February 28, 2019, Milwaukee County Mental Health Board Meeting. 8-0</p> <p>MOTION 2ND BY: (Lanier)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> |

SCHEDULED ITEMS (CONTINUED):

| | |
|----|--|
| | <p>MOTION BY: (Perez) Approve the Minutes from the March 21, 2019, Milwaukee County Mental Health Board Public Hearing. 6-0-2</p> <p>MOTION 2ND BY: (Eilers)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, and Perez – 6</p> <p>NOES: 0</p> <p>ABSTENTIONS: Neubauer and Wesley - 2</p> |
| 3. | <p>Administrative Update.</p> <p>Michael Lappen, Administrator, Behavioral Health Division (BHD)</p> <p>Mr. Lappen highlighted key activities and issues related to BHD operations. He provided updates on Psychiatric Crisis Redesign efforts, reimbursement rates for mental health and Alcohol and Other Drug Abuse (AODA) services, interest earned on reserve fund accounts, the Universal Health Services contract and the acute hospital transition, and BHD’s undertaking of major projects in an attempt to organize and effectively allocate available resources to the transition. He also discussed the Journal Sentinel article on Crisis Resource Centers (CRCs) and referenced the Kane Communications Update, which is attached to the report.</p> <p>Questions and comments ensued.</p> <p>Chairman Lutzow stated the Board would be willing to submit a recommendation letter of support for Medicaid expansion.</p> <p>Board Member Lehrmann recommended either adding to or submitting a separate recommendation letter from the Board addressing shared revenue related to mental health services.</p> <p>When crafting the recommendation letters, Chairman Lutzow emphasized the importance of staying within the scope of specifically addressing how both Medicaid expansion and shared revenue affect the provision of mental health services. The Board directed Mr. Lappen to draft said letter(s) for review by the Board.</p> <p>The Board had a robust discussion surrounding interest earned on BHD’s reserve accounts and came to a consensus that it is, at the very least, their fiduciary duty to examine further the pros and cons of pursuing the request of a separate account for reserve funds through the County Board of Supervisors, including getting the County Executive’s position on the issue.</p> <p>Mr. Lappen was directed to look into the matter and report back to the Board at the June meeting.</p> |

SCHEDULED ITEMS (CONTINUED):

| | |
|---|--|
| 4. | <p>Mental Health Board Executive Committee Update.</p> <p>Chairman Lutzow stated the intent of the report was to provide the Board with content related to future issues requiring Board consideration and to basically serve as a roadmap of the general direction the Board needs to go collectively. Top priorities include the Universal Health Services (UHS) contract, facility relocation, and crisis redesign.</p> <p>Mr. Lappen was directed by the Executive Committee to report on the above referenced topics and the State's reimbursement rate for mental health services. A meeting with Representative Sanfelippo to discuss issues faced by the Behavioral Health Division was also recommended.</p> <p>Mr. Lappen addressed the Executive Committee's recommendations during the presentation of the Administrative Report (Item 3).</p> |
| <p>Item #s 5, 6, and 7 were considered together.</p> | |
| 5. | <p>Mental Health Board Finance Committee Professional Services Contracts Recommendations.</p> <ul style="list-style-type: none">• 2018 Contract Amendment<ul style="list-style-type: none">➤ U.S. Security Associates/Allied Universal• 2019 Contracts<ul style="list-style-type: none">➤ Medical College of Wisconsin Affiliated Hospitals, Inc.➤ The Medical College of Wisconsin, Inc. <p>Jennifer Bergersen, Chief Operating Officer, Behavioral Health Division</p> <p>Professional Services Contracts focus on facility-based programming, supports functions that are critical to patient care, and are necessary to maintain hospital and crisis services licensure.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2018 Professional Services Contract Amendment and 2019 Contracts, with the exception of Board Member Lehrmann who abstained from Medical College of Wisconsin and its Affiliated Hospitals' contracts.</p> <p style="text-align: center;">SEE ITEM 7 FOR BOARD ACTION</p> |
| 6. | <p>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</p> <p>Brian McBride, Director, Children's Community Services and Wraparound Milwaukee, Behavioral Health Division</p> |

SCHEDULED ITEMS (CONTINUED):

| | |
|----|---|
| | <p>Fee-for-Service Agreements are for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services. This program agreement provides a broad range of rehabilitation and support services for pregnant teens and girls with children.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of 2018 Agreement Amendment as delineated in the corresponding report.</p> <p style="text-align: center;">SEE ITEM 7 FOR BOARD ACTION</p> |
| 7. | <p>Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.</p> <p>Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, Behavioral Health Division</p> <ul style="list-style-type: none">• 2019 Contract Amendments <p>Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed.</p> <p>Questions were posed related to the program contracts and their respective services.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2019 Contract Amendments delineated in the corresponding report.</p> <p>MOTION BY: (Eilers) Approve All Contracts Delineated in the Corresponding Reports for Item #s 5, 6, and 7. 8-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> |
| 8. | <p>Mental Health Board Finance Committee Update.</p> <p>Jeanne Dorff, Fiscal Administrator, Behavioral Health Division</p> <p>Vice-Chairwoman Perez, Chairwoman of the Finance Committee, stated the Finance Committee was provided with helpful information related to the 2020 Budget and timeline, facility relocation, and County-wide cross charges.</p> <p>She pointed out it was decided public input would be more informed if the public had a budget document to react to. In review of the 2020 Budget timeline for Finance Committee dates and deliverables, the Public Hearing, originally scheduled for Thursday, June 6, 2019, is being rescheduled to Tuesday, June 18, 2019. BHD’s Fiscal</p> |

SCHEDULED ITEMS (CONTINUED):

| | |
|-----|---|
| | <p>Administrator will still present BHD's Preliminary 2020 Budget on June 6, 2019, with a time and location to be determined. The Budget narrative will be posted as planned on Friday, June 14, 2019. This change will allow the public time to review the Budget narrative and prepare prior to recommendations being submitted by Mental Health Board Members to the Finance Chair.</p> <p>Ms. Dorff explained there will be another abatement to BHD's 2020 Budget similar to what was done for 2019. The County plans to reduce the tax levy, which applies to all County departments, in addition to having to find money to fill the Budget gap.</p> |
| 9. | <p>2018 Annual Environment of Care Program Report and 2019 Environment of Care Management Plans.</p> <p>Dr. John Schneider, Chief Medical Officer, Behavioral Health Division</p> <p>Dr. Schneider explained how both documents are regulatory and federally required annually to manage environmental risk.</p> <p>The Board was informed the Quality Committee, at their meeting on March 4, 2019, unanimously recommended approval of this Item.</p> <p>MOTION BY: (Neubauer) Approve the Environment of Care 2018 Annual Report and 2019 Goals and Plans Recommendation. 8-0</p> <p>MOTION 2ND BY: (Forman)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8</p> <p>NOES: 0</p> |
| 10. | <p>Mental Health Board Quality Committee Update.</p> <p>Board Member Neubauer, Chairwoman of the Quality Committee, reviewed topics addressed at the Quality Committee's quarterly meeting. She discussed the key performance indicator (KPI) Fourth Quarter dashboard; the supported employment/education services and individual placement and support (IPS) model; Fourth Quarter KPI inpatient metrics; the seclusion and restraint summary; the Access Clinic pilot; the report from the Institutional Review Board; the Centers for Medicare and Medicaid Services (CMS) analysis of readmission rates and survey update; 2018 Mental Health Statistics Improvement Program (MHSIP) survey results; compliments, complaints, and grievances executive summary; and the status of updated policies and procedures.</p> <p>Questions and comments ensued.</p> <p>Board Member Forman requested a meeting between the group running the IPS model and the Grand Avenue Club to explore the possibility of sharing the Grand Avenue Club's resources with private sector employers. This would be in the best interest of individuals who experience mental illness who could be stimulated by seeking out integrated paid</p> |

SCHEDULED ITEMS (CONTINUED):

| | |
|-----------------------------|--|
| | <p>employment and opportunities to access secondary education. Board Member Forman believes this to be the logical and best approach.</p> <p style="text-align: center;">The Board did not go into Closed Session for Item 11</p> |
| 11. | <p>Medical Executive Report and Credentialing and Privileging Recommendations.</p> <p>Dr. M. Zincke, Medical Staff Vice-President, Behavioral Health Division (BHD) Dr. John Schneider, Chief Medical Officer, BHD</p> <p>Dr. Zincke provided a summary of the Medical Executive Committee recommendations related to medical staff credentialing and privileging.</p> <p>Dr. Schneider explained the factors that determine whether or not the Board needs to go into closed session for this standing item.</p> <p>MOTION BY: (Davis) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 8-0</p> <p>MOTION 2ND BY: (Eilers)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> |
| 12. | <p>Adjournment.</p> <p>MOTION BY: (Neubauer) Adjourn. 8-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> |
| ADDENDUM NO. 1 ITEMS | |
| 13. | <p>Fair Deal with the State of Wisconsin on Shared Revenue.</p> <p>County Executive Chris Abele</p> <p>The County Executive stated the County Board, led by Chairman Lipscomb, created the Fair Deal Workgroup. Mental Health Board (MHB) Member Pastor Lanier is part of this Workgroup, which includes representatives from all of Milwaukee County’s local municipalities. The Workgroup recognizes the State Department of Revenue’s data reflecting Milwaukee County sends the State revenue, which has grown significantly over the past ten years, and is a huge subsidy for the State. The revenue the State returns back to Milwaukee County has not grown at nearly the pace, and some funding sources</p> |

SCHEDULED ITEMS (CONTINUED):

| | |
|--|---|
| | <p>have not grown at all. The County has steadily had to find ways to make cuts in the budget year after year without cutting services and taking into account Milwaukee County's limited flexibility locally to generate revenue.</p> <p>The Intergovernmental Cooperation Council (ICC) unanimously supported the Fair Deal, and the Greater Milwaukee Committee and the Metropolitan Milwaukee Association of Commerce (MMAC) both agreed to make this issue their highest legislative priority. The current Governor also acknowledges the issue and agrees discussions are needed.</p> <p>Next steps include a submission to the legislature during the first legislative cycle after the State Budget is complete. This option would most likely require a referendum added to the November ballot. The County Executive explained how the support of the MHB would be extremely helpful, in addition to the Board's assistance with garnering collaborative letters of support from advocate groups. He is also requesting departments detail the impact of constant cuts on programs and show the impact of what could be done with more.</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: 8:06 a.m. to 10:27 a.m.</p> <p>Adjourned,</p> <p><i>Jodi Mapp</i> Senior Executive Assistant Milwaukee County Mental Health Board</p> | |
| <p>The next meeting for the Milwaukee County Mental Health Board will be on Thursday, June 20, 2019, @ 9:00 a.m. at the Zoofari Conference Center 9715 West Bluemound Road</p> <p>Visit the Milwaukee County Mental Health Board Web Page at:</p> <p>https://county.milwaukee.gov/EN/DHHS/About/Governance</p> | |

SCHEDULED ITEMS (CONTINUED):

The April 25, 2019, 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.

A handwritten signature in black ink that reads "Michael G. Davis". The signature is written in a cursive style with a large, stylized "G" and "D".

Michael Davis, Secretary
Milwaukee County Mental Health Board

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE : 5/28/19
TO : Thomas Lutzow, Chairman, Milwaukee County Mental Health Board
FROM : Joe Lamers, Director, DAS Office of Performance, Strategy, and Budget
SUBJECT : Update on 2020 Operating Budget Gap and Process

OVERVIEW

As part of the 2020 budget process, the Office of Performance, Strategy, and Budget has provided monthly budget updates to the County Board's Finance and Audit Committee. The Budget Director also updated the Mental Health Board at its February meeting and will provide further information at the meeting scheduled in June.

Attached to this document is Report File 19-26, which was presented to the Finance and Audit Committee on April 18, 2019. This information in this report will be shared with the Mental Health Board at its meeting on June 20, 2019.

In summary, the attached report provides an updated operating budget gap estimate of \$28.0 million for 2020. The report summarizes options which are being considered to close the budget gap. Details are included in the attachment.

RECOMMENDATION

This report is for informational purposes only.



Joseph Lamers, Director
Office of Performance, Strategy and Budget
Department of Administrative Services

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE : 3/22/2019

TO : Supervisor Theodore Lipscomb Sr., Chair, County Board of Supervisors

FROM : Joe Lamers, Director, Office of Performance, Strategy, and Budget (PSB)

SUBJECT : 2020 Operating Budget Planning Updates

Background/Discussion

In the January and March cycle, PSB provided the County Board a report (File 19-26) on the estimated 2020 Operating budget gap of approximately \$26.5 million and draft options to help close the gap. This report provides an update on the 2020 Operating Budget Gap and provides an opportunity for further discussion on 2020 departmental levy targets, revenues, and other gap closing strategies.

The below chart shows that the projected 2020 Operating Budget Gap is \$28.0 million, up from the \$26.5 million projection in January. Projection changes are described below.

| Estimated 2020 Operating Budget Gap | | |
|--|------------------------------------|-------------------------------------|
| Description | Initial Draft (Jan) | Update Draft (April) |
| Compensation Increase | \$ 5.7 | \$ 5.7 |
| Health Care | \$ 2.8 | \$ 5.5 |
| Pension | \$ 6.6 | \$ 6.6 |
| Debt Service P&I | \$ 1.0 | \$ 1.0 |
| Other Operating Cost to Continue | \$ 10.7 | \$ 10.7 |
| Inmate Medical Cost Increase | \$ 5.0 | \$ 4.5 |
| Court Appointed Attorney Fees | \$ 1.5 | \$ 1.5 |
| Total Expense Change | \$ 33.3 | \$ 35.5 |
| Revenue Change - Lost Revenues | | |
| Debt Service Reserve | \$ 3.3 | \$ 3.3 |
| Unclaimed Revenue | \$ 1.3 | \$ 1.3 |
| Revenue Change - Increased Revenue | | |
| Property Tax | \$ (3.9) | \$ (3.9) |
| Sales Tax | \$ (2.6) | \$ (3.6) |
| GTA | \$ (0.5) | \$ (0.5) |
| VRF | \$ (0.4) | \$ - |
| Other/Reimbursement Revenue | \$ (4.1) | \$ (4.1) |
| Total Revenue Change | \$ (6.8) | \$ (7.5) |
| Gap Total | \$ 26.5 | \$ 28.0 |

Changes for April:

- Based on updated information including a review with the Office of the Comptroller, the increase in health care is now projected at \$5.5 million.
- Inmate Medical costs are now projected to increase by \$4.5 million, based on the value of executed contracts.
- Sales tax revenue is now projected to grow by \$3.6 million. This is based on updated actuals from 2018 and projected growth of 2% per year going forward.
- Vehicle Registration Fee revenue is now projected to be flat. Although recent revenue receipts have trended above budget, the State has published updated registration data for calendar year 2018 which indicates Milwaukee County vehicle registrations are in line with the current budget.

Other Updates:

- The Wisconsin Supreme Court ruled against Milwaukee County in the case *Milwaukee District Council 48 v. Milwaukee County* on March 19, 2019. The ruling will likely increase the County's unfunded pension liability, the County's annual contribution, and the general employee contribution rate. Retirement Plan Services is working with the pension actuary to develop an up-to-date actuarial analysis of the ruling. That information will be shared with the County Board and the public when available.
- As indicated in prior month reports, the cost of court appointed attorney fees are projected to increase by \$1.5 million, based on a Wisconsin Supreme Court ruling which increases the attorney fee rate from \$70 to \$100 in 2020. While the current financial impact estimate is not changed, PSB is working with the courts to refine this estimate during the 2020 budget process. An updated analysis of fees specifically impacted by the court ruling is being prepared. This update will be shared during the 2020 budget process.

Gap Closing Options

Three broad options for closing the budget gap were also presented in previous reports in the manner shown below. The below chart includes one assumption change since the March report. Due to the \$1.5 million increase in the gap projection, the "Cash Capital or Other Reduction" assumption is increased from \$2.5 million to \$4.0 million.

| 2020 Gap Closing Options | Divest | Temp Fix | Temp Fix |
|---|----------------|-----------------|-----------------|
| Dept's Self Fund Operating Cost-to-Continue | \$ 10.7 | \$ 10.7 | \$ - |
| Debt Service Withdrawl Equal to 2019 | \$ 3.3 | \$ 3.3 | \$ - |
| Cash Capital or Other Reduction | \$ 4.0 | \$ 4.0 | \$ - |
| Departmental Levy Targets | \$ 10.0 | \$ - | \$ - |
| New Revenues | \$ - | \$ 10.0 | \$ 28.0 |
| Total | \$ 28.0 | \$ 28.0 | \$ 28.0 |

The following information is similar to what was presented in the March cycle and is repeated in this report to continue the conversation on 2020 gap closing strategies.

Divest Option / Levy Targets

If the Divest strategy is followed for the 2020 budget process, levy reduction targets totaling \$10 million will be distributed to departments. The amount is subject to change based on updates to the budget gap analysis, decisions around capital funding, the use of debt service reserves and other factors. A \$10 million reduction in levy targets would amount to an approximately 1.6% reduction to the total budget for departments.

The below chart provides preliminary draft tax levy targets by department, which add up to \$10.0 million. A similar methodology that was applied to 2019 levy targets was used. This methodology included across-the-board percentage reductions to most departments, although some revenue generating and high-risk departments are exempted (as detailed in the chart). These are not final levy targets, but are representative of reductions which will be needed if new revenues are not available.

For the 2020 draft levy targets, two changes are included from methodology that was used in 2019. The cost of providing inmate medical services is excluded from the House of Correction levy reduction calculation, and the Emergency Medical Service function in the Office of Emergency Management is also removed since any levy savings in that area would be offset by a reduction in the levy limit per state statute.

All departments will be expected to follow the levy target instructions in the requested budget process. If departments do not meet their levy target within their request, the County Executive's recommended budget will make adjustments accordingly to ensure that all departments participate in efforts to achieve a balanced budget.

| 2020 BUDGET PRELIMINARY DRAFT TAX LEVY REDUCTION TARGETS: 1.6% TOTAL BUDGET | | | | | |
|---|-----------------------|----------------------------|-----------------------|--|------------------------|
| County Executive Cabinet Departments | | Elected Departments | | Excluded Departments | |
| Agency | Reduction | Agency | Reduction | Agency | Reduction |
| 102 CEX - Vets | \$ (3,245) | 200 Courts | \$ (434,977) | <i>Revenue Departments:</i> | |
| 103 CEX - Gov Affairs | \$ (3,719) | 290 Courts Pre-Trial | \$ (83,520) | 504 DOT-Airport | \$ - |
| 109 OAAA | \$ (12,142) | 340 ROD | \$ (23,803) | 580 DOT-Directors | \$ - |
| 112 PRB | \$ (4,449) | 370 Comptroller | \$ (71,274) | 530 DOT-Fleet | \$ - |
| 113 Corp Counsel | \$ (18,165) | 450 DA | \$ (186,287) | 510 DOT-Highway | \$ - |
| 114 Human Resources | \$ (85,272) | 400 Sheriff | \$ (675,152) | 507 DOT-Tran Svcs | \$ - |
| 115 DAS | \$ (600,065) | | | 550 DAS-Utility | \$ - |
| 430 HOC | \$ (486,531) | | | 243 Child Support | \$ - |
| 480 OEM | \$ (71,137) | | | <i>Elected Offices with Limited Staff:</i> | |
| 490 Medical Examiner | \$ (68,928) | | | 110 CEX - General | \$ - |
| 560 DOT-Transit | \$ (1,660,235) | | | 100 County Board | \$ - |
| 630 DHHS-BHD | \$ (2,772,814) | | | 309 Treasurer | \$ - |
| 800 DHHS | \$ (1,510,104) | | | 327 Clerk | \$ - |
| 790 Aging | \$ (248,038) | | | <i>High Risk Areas:</i> | |
| 900 Parks | \$ (597,265) | | | 116 DAS-IMSD | \$ - |
| 950 Zoo | \$ (268,593) | | | 117 DAS-Risk | \$ - |
| 990 UW-Ext | \$ (7,440) | | | 301 Election Commission | \$ - |
| Culturals | \$ (106,846) | | | | |
| Total Cabinet Depts | \$ (8,524,987) | Total Elected Depts | \$ (1,475,013) | Excluded Depts | \$ - |
| GRAND TOTAL | | | | | \$ (10,000,000) |

Temporary Fix Option

Under the temporary fix option, \$10 million of new revenues and or non/departamental cost savings need to be identified, in order to avoid further departamental budget reductions.

County taxing authority is granted by State Statute, and the County has limited options for generating new revenues. Property tax for operating purposes is limited to the percentage of growth in net new construction; this growth rate is already factored into the budget gap analysis. The County share of sales tax receipts is limited to 0.5%; growth in sales tax is also factored into the above budget gap analysis.

The County does have an option to increase the Vehicle Registration Fee (VRF) from the current rate of \$30 up to approximately \$60 to replace tax levy for all transportation services. The below table shows the additional amount of VRF that could be generated with fee increases ranging from \$5 to \$30. A fee increase of approximately \$20 would be needed in order to generate \$10 million.

| VRF Increase Scenarios | | |
|------------------------|---------------------|-----------------------|
| Increase Amount | Annualized Increase | 2020 Budget Estimate* |
| \$ 5 | \$ 2,843,444.73 | \$ 2,606,491 |
| \$ 10 | \$ 5,679,808.36 | \$ 5,206,491 |
| \$ 15 | \$ 8,516,172.00 | \$ 7,806,491 |
| \$ 20 | \$ 11,352,535.64 | \$ 10,406,491 |
| \$ 25 | \$ 14,079,808.36 | \$ 12,906,491 |
| \$ 30 | \$ 16,916,172.00 | \$ 15,506,491 |

**VRF increases become effective three months after an ordinance change. If a VRF change were to be included in the budget that is adopted in November, it would not be collected for the full fiscal year in 2020. In order to be effective for the full year, the ordinance would need to be changed in September.*

VRF & Transit Budget Detail

It is important to note that VRF revenue can only be used for Transit and Transportation related expenses, including operating and capital costs. The Transit department in particular is a significant tax levy cost center. Transit’s 2019 operating budget includes \$9.4 million in tax levy funding. Transit’s estimated cost-to-continue is \$3.2 million for 2020, representing approximately 2% growth in operating costs. In addition, Transit’s 2019 operating budget included \$1.6 million of one-time revenues which are not expected to be available in 2020. Also, the preliminary tax levy reduction target chart shown above indicates that Transit may be faced with a \$1.6 million reduction target for 2020. When combining the cost-to-continue, one-time revenues, and a potential levy reduction target, the Transit operating budget is estimated to have a potential shortfall of \$6.4 million in 2020. This amount has the potential of being further increased by the ATU contract which has not been negotiated.

If a VRF increase were to be pursued, decisions would need to be made regarding how the funds are allocated, including whether the fee increase would support the Transit budget and/or other areas of operations, as well as the capital budget.

Sustainability Option

The sustainability option would require \$26.5 million or more in additional revenues. Current State Statutes largely prevent the County from raising revenues of this magnitude.

The “Fair Deal for Milwaukee County Workgroup” was created to identify and propose options for enhancing the long-term fiscal stability of Milwaukee County, and to increase State funding of mandated services. This Workgroup has held meetings and recommended a platform for lobbying activity and legislative change. Changes at the State level will be needed to meet a sustainable budget.

The Governor has proposed a State budget that would provide additional support to all local governments, including Milwaukee County. It is uncertain if the proposed budget will be adopted in time for the County’s 2020 budget preparations. It is also unknown if items impacting County will be included in the adopted State budget. For the 2020 budget process,

DAS-PSB will operate under a status quo set of revenue assumptions unless new information is made available. This means that most State revenues are currently projected to remain flat in 2020.

Proposed State Budget Detail

During the March Finance & Audit Committee meeting there was discussion surrounding the Governor’s Proposed Budget and PSB indicated that additional information would be shared in April. Below is a summary of some of the high level potential impacts on the County’s budget. The Governor’s budget includes a number of proposals which would improve the County’s revenue forecast. These proposals are not included in current revenue estimates described above, given that the State budget has not been approved.

Below is a summary of items in the Governor’s proposed budget for which an estimated Milwaukee County impact can be quantified.

- **Shared Revenue** is proposed to be increased by 2% in 2021. This would represent the first increase in shared revenue in over a decade. The estimated Milwaukee County impact is approximately \$620,000.
- **Levy Limit Revision:** The Governor’s budget allows counties to increase their property tax levies by the greater of the percentage change in equalized value due to net new construction or 2 percent, with the 2 percent clause being a new proposal. Allowing for 2% growth would provide an option to increase the County levy by an additional \$1.0 million to \$1.5 million, compared to net new construction increases in recent years.
- **Local Transit Aids** are proposed to be increased by 10% by 2021, phased over two years. MCDOT estimates that this would lead to a \$5.5 million increase for MCTS.
- **General Transportation Aids** are also proposed to be increased by 10%. MCDOT estimates a potential increase of \$271,000 for DOT-highways.

| Summary of State Budget Impacts | SFY 2020 | SFY 2021 |
|---|------------------|------------------|
| Levy Limit Floor (2% or net net new construction) | 1,250,000 | 1,250,000 |
| Shared Revenue 2% Increase 2021 | - | 620,000 |
| Local Transit Aids 10% Increase in 2021 | 1,300,000 | 5,536,000 |
| General Transportation Aids | 271,000 | 271,000 |
| Total Estimate | 2,821,000 | 7,677,000 |

The following proposals would also have an impact on the County. The financial impact of these items has not been fully quantified.

- **Child Support:**

- The Governor's budget proposes to increase Child Support General Purpose Revenue statewide by \$750,000 in 2020 and \$1.5 million in 2021.
 - The Governor's budget also recommends ending Birth Cost Recovery (BCR), which includes a recovery of Medicaid funded birth expenses from non-custodial fathers. This is estimated to result in a loss of \$2.6 million statewide for child support agencies, beginning in 2020.
 - It is expected that these two budget proposals would have a combined negative impact on child support revenues, particularly in year one of the proposed State budget when the GPR revenue increase is at the lower value. While the above numbers above reflect statewide impact, the County impact estimate is under review and updates will be provided.
- **Medicaid Expansion:** The Governor's budget proposes an expansion of Medicaid eligibility under the Affordable Care Act by covering all Wisconsin residents who earn incomes up to 138 percent of the federal poverty level. This is expected to improve reimbursement levels for services provided by DHHS and BHD.
 - **Medicaid Community Health Benefit:** The Governor's budget creates a Medicaid community health benefit that invests \$45 million for nonmedical services to reduce and prevent health disparities that result from economic and social determinants of health. Major services included in the Community Health Benefit are housing referral services, stress management, and nutritional counseling.
 - **Homeless Prevention:** The Governor recommends increasing funding for homeless prevention programs by \$3.4 million Statewide in 2020 and 2021.
 - **Crisis Intervention Services:** The Governor's budget recommends the state pay for a portion of the nonfederal share of Medicaid Crisis Intervention services currently funded by counties in Wisconsin. Under the proposal, counties will provide a 75% maintenance of effort payment based on CY17 expenditures. This is expected to free up over \$0.6 million in local funding in the short term and could result in over \$1.0 million savings in local funds as Milwaukee County redesigns and expand crisis services.
 - **Cross Municipal Transit Routes:** The proposed budget includes language for creating an exclusion to county and municipal levy limits for cross-municipality transit routes where the counties and municipalities meet several criteria and that each participating county or municipality must pass a referendum approving the agreement. The exclusion shall be limited to operating and capital costs directly associated with the transit route or routes crossing municipal or county boundaries and cannot be claimed for any amounts currently levied by counties and municipalities for existing cross-boundary routes or for any other route.
 - **VW Settlement Funds:** The Governor's budget allocates 60% of the remaining \$25 million in Volkswagen emissions settlement funds dedicated to the replacement of public

transit vehicles and 40% towards electric vehicle charging stations. In addition, the current law would be modified by reducing the percentage of the of the total grant award returned to the state through shared revenue reduction by Milwaukee County's transit system from 75-20 percent. There may not be many MCTS buses that will qualify for the program due to not meeting the age (depreciation) requirements.

- **Internet Sales Tax:** The Governor's budget includes language explicitly requiring internet marketplace providers to collect and remit sales and use tax. While internet sales taxes are already being collected as of 2018, this provision would likely increase enforcement and collection of the tax.

The Wisconsin Counties Association has prepared a comprehensive review of the Governor's proposed budget which is available online at:
https://www.wicounties.org/uploads/budget_documents/final-budget-summary-march-8.pdf.

RECOMMENDATION

This report is for informational purposes only. No action is needed. However, as part of the budget process, feedback from the Finance and Audit Committee and the County Board will be taken into consideration in regards to budget planning items such as levy targets and new revenues. The administration looks forward to continuing work with the Board to develop a long term fiscal sustainability plan for the County.



Joseph Lamers, Director
Office of Performance, Strategy and Budget
Department of Administrative Services

Cc: Chris Abele, Milwaukee County Executive
James "Luigi" Schmitt, Chair, Finance and Audit Committee
Willie Johnson Jr., Co-chair, Finance and Audit Committee
Sheldon Wasserman, Finance Committee
Supreme Moore Omokunde, County Supervisor
Jason Haas, County Supervisor
Sequanna Taylor, County Supervisor
Eddie Cullen, County Supervisor
Scott Manske, County Comptroller
Steven Cady, Research and Policy Director, Office of the Comptroller
Teig Whaley-Smith, DAS Director

Raisa Koltun, Chief of Staff, Office of the County Executive
Kelly Bablitch, Chief of Staff, County Board
Dan Laurila, DAS-PSB Operating Budget Manager



22 EAST MIFFLIN STREET, SUITE 900
 MADISON, WI 53703
 TOLL FREE: 1.866.404.2700
 PHONE: 608.663.7188
 FAX: 608.663.7189
www.wicounties.org

2019-21 STATE BIENNIAL BUDGET SUMMARY

Governor Tony Evers introduced the 2019-21 State Biennial Budget on February 28, 2019.

County-related highlights of the Governor's proposed two-year spending plan include:

- **Child Welfare:** The Governor's budget allocates an additional \$15 million annually in the Children and Families Aids allocation beginning in CY20.
- **Juvenile Corrections:** The Governor's budget provides additional funding for SRCCCYs and returns 17-year-olds to the juvenile justice system. The budget creates a sum sufficient appropriation to reimburse counties for costs associated with this policy change.
- **County Transportation:** The Governor's budget increases county general transportation aids and general transit aids by 10 percent. The budget also increases funding for the local road improvement program by 4 percent and allocates an additional \$3 million annually for the seniors and individuals with disabilities specialized transportation aids program.
- **Shared Revenue:** The Governor's budget increases county shared revenue by 2 percent beginning in 2020. This is the first proposed increase in over a decade.
- **Property Taxes:** The Governor's budget allows counties to increase their property tax levies by the greater of the percentage change in equalized value due to net new construction or 2 percent. The budget also amends assessment practices by incorporating language from last session's dark store and *Walgreens v. City of Madison* reversal legislation.
- **County Conservation:** The Governor's budget allocates \$10.4 million annually for county land conservation staffing and cost-sharing grants, the highest funding amount in over a decade.
- **Broadband Expansion:** The Governor's budget increases the broadband expansion grant program to \$39.3 million in each year of the upcoming biennium. This is an increase of nearly five-fold over current funding levels.

The WCA Government Affairs staff has prepared the following summary of county-related provisions in the Governor's budget. Please contact the WCA Government Affairs team with

any questions and please visit the WCA website at www.wicounties.org as the summary will be updated as additional information is obtained.

AGRICULTURE, ENVIRONMENT AND LAND USE

Stewardship Reauthorization: The Governor's budget extends the Warren Knowles-Gaylord Nelson Stewardship 2000 program until fiscal year 2021-22 at current funding levels using authorized unobligated bonding authority. The extension of the program will allow the department and stakeholders to identify future options for the program.

Water Quality and Environmental Protection: The Governor's budget recommends increasing position authority to provide 4.0 FTE project positions to facilitate implementation of water quality restoration and improvement plans. The Governor's budget also recommends providing additional conservation fund-supported general obligation bonding authority of \$4 million to provide grants that facilitate implementation of water quality restoration and improvement plans. The Governor's budget further recommends increasing expenditure authority by \$76,600 SEG and position authority by 1.0 FTE SEG position in each fiscal year to implement the water quality grant program. Finally, the Governor recommends increasing expenditure authority by \$1,457,900 SEG in each year of the biennium to fund river and lake protection grants.

Grants for Local Organizations that Coordinate Grazing: The Governor's budget proposal requires the Department of Trade Agriculture and Consumer Protection (DATCP) to promote the dairy industry by providing grants to local organizations that coordinate grazing.

Local Pollution Control Grants (TMDL Watersheds): The Governor's budget proposal requires the Department of Natural Resources (DNR) to award grants to both municipalities and counties for infrastructure projects related to pollution control that have a Total Maximum Daily Load (TMDL). A TMDL is the maximum amount of pollution allowed while still meeting water quality standards. The Governor's budget provides \$4,000,000 in general obligation bonding for this purpose.

State Park Funding: The Governor's budget recommends increasing funding to the state park system to reflect the greater costs associated with increased park system attendance. The total funding increase is approximately \$2.8 million in the biennium.

Wisconsin Forestry Practices Study: The Governor's budget provides \$450,000 in funding for the implementation of the recommendations made in the Wisconsin Forestry Practices Study.

Forest Fire Protection Grants: The Governor's budget increases funding for the Forest Fire Protection Grant Program to enable the department to provide more grants to local fire departments.

Targeted Runoff Conservation Activities: The Governor's budget provides \$6.5 million in environmental fund-supported general obligation bonding authority for nonpoint source pollution abatement-targeted runoff management infrastructure projects. The Governor also recommends providing \$400,000 SEG in each year for nonpoint source pollution abatement -targeted runoff management grants.

Soil and Water Resource Management Bond Authority and Cost Share Grants: The Governor's budget provides \$10 million in SEG-supported general obligation bonds for grants to counties for implementation of land and water resource management plans, including cost-share grants to landowners. This funding level is an increase of \$3 million from the previous biennium.

Urban Nonpoint Storm Water Control: The Governor's budget provides \$4 million in environmental fund-supported general obligation bonding authority for urban nonpoint source cost-sharing. This is an increase from \$53,600,000 to \$57,600,000 in the biennium. The goal of this program is to provide financial assistance for projects that manage urban storm water and runoff.

Contaminated Sediment Bonding: The Governor's budget provides \$25 million in environmental fund-supported general obligation bonding authority for contaminated sediment removal for sites in the Great Lakes or its tributaries that are on Wisconsin's impaired waters list.

Dam Repair and Removal: The Governor's budget provides \$4 million in GPR-supported general obligation bonds for grants to be used for dam repair, reconstruction and removal projects.

Nonpoint Source Pollution Funding Adjustments: The Governor's budget increases expenditure authority by \$1,500,000 SEG in each year for nutrient management cost-sharing. The Governor also recommends increasing the amount the department may allocate for producer-led watershed grants to \$750,000 in each year.

Permitting of Concentrated Animal Feeding Operations (CAFO): The Governor's budget provides expenditure and position authority in the amount of \$425,000 in each year of the biennium to oversee the permitting, inspection and enforcement of concentrated animal feeding operations (CAFO) in Wisconsin. The Governor's budget also recommends increasing the annual fee assessed to operators of CAFOs and establishing an application and renewal fee for the operation of a CAFO.

Bonding for Nonpoint Water Pollution Abatement: The Governor's budget increases by \$6,500,000, general obligation bonding authority for financial assistance for projects that manage urban storm-water runoff. The total bonding authority is increased from \$44,050,000 to \$50,550,000 in the biennium. The financial assistance will enhance water pollution abatement

projects and assist concentrated animal feeding operations in implementing best management practices.

County Conservation Staffing and Cost Sharing Grants: The Governor's budget provides a \$1.4 million annual increase in grant funding to counties for county conservation staff to support land and water conservation activities. The annual base funding allocation for the program will increase from \$8.96 million annually in the 2017-19 biennium to \$10.396 million annually in both years of the 2019-21 biennium.

Industrial Hemp Program: The Governor's budget provides expenditure and project position authority to assist in the licensing, registration and testing of industrial hemp.

Replacement of Lead Service Lines: The Governor's budget authorizes \$40 million in GPR-supported bonding for the replacement of up to 50 percent of the cost to replace lead service lines through the Safe Drinking Water Loan Program. It is estimated that there are 170,000 lead service lines in Wisconsin. The lead service line program would be structured as a forgivable loan.

Changes to the Well Compensation Program: The Governor's budget proposal increases the eligibility income threshold for a family or individual well owner from \$65,000 to \$100,000 annually. In addition, a well owner or renter whose family income is below the state's median income may receive a grant of up to 100 percent of a project's eligible costs, not to exceed \$16,000.

Private On-site Wastewater Treatment System Replacement or Rehabilitation Program (Wisconsin Fund): The Governor's budget proposal eliminates the sunset date (June 30, 2021) for the Private On-Site Wastewater Treatment System Replacement or Rehabilitation Program. The program will continue to assist home owners and small commercial establishments meeting certain income and eligibility criteria to repair or replace eligible failing private on-site wastewater treatment systems.

Bonding Authority for the Clean Water Fund Program: The Governor's budget proposal increases the general obligation bonding authority for the Clean Water Fund Program from \$646,283,200 to \$659,783,200 or by \$13,500,000. This program provides financial assistance to local governmental units for projects to control water pollution such as sewage treatment plants.

COUNTY ORGANIZATION AND PERSONNEL

Broadband Expansion: The Governor's budget includes several initiatives to aid in the expansion of broadband across Wisconsin. First, the Governor's budget recommends an increase in expenditure authority for the Public Service Commission (PSC) broadband expansion grant

program to \$39.3 million in each year of the biennium. This allocation includes a minimum of \$2 million annually from the universal service fund, a transfer of \$6.9 million in FY20 and \$17.3 million in FY21 from the Department of Administration e-rate funds, and an allocation of \$30.4 million in GPR in the first year of the biennium and \$20 million in the second year.

The Governor's budget also recommends the modification of current law to provide a goal for the state to provide all homes and businesses within the state access to high-speed broadband with a minimum download speed of at least 25 megabits per second and a minimum upload speed of at least 3 megabits per second by the year 2025.

The Governor's budget also includes a modification to current law to adjust the definition of broadband "underserved" as an area that lacks access to service of download speeds of at least 25 megabits per second and upload speeds of at least 3 megabits per second and "unserved" as an area that lacks access to service of download speeds of at least 10 megabits per second and upload speeds of at least 1 megabit per second. Finally, the Governor's budget would modify state statutes that in any way discourages municipalities from providing broadband service to residents in broadband "unserved" and "underserved" areas.

Elections: The Governor's budget modifies current law regarding voting requirements that were included in 2017 Wisconsin Act 369. Modifications include elimination of the proof of enrollment for a student ID card and allows the use of a card that expires no later than five years after the issuance date. The Governor's budget would also eliminate the requirement that the card have the student's signature. The Governor's budget also extends the expiration date of a receipt from the DOT as a temporary identification card to 180 days.

The Governor's budget requires the Elections Commission to facilitate the registration of all eligible electors of the state and maintain the registration of all eligible electors for as long as they are eligible. The Governor's budget directs the Commission and Department of Transportation (DOT) to work together so that the DOT may transfer information in their records to the commission. Individuals will have the opportunity to "opt out" of the DOT transfer of information when applying for a driver's license or state ID.

The Governor's budget would eliminate the restriction on how soon a person may complete an absentee ballot in person and would further provide that a person must complete such a ballot no later than Friday preceding the election.

Redistricting: The Governor's budget directs the Legislative Reference Bureau (LRB) to redraw legislative and congressional redistricting maps and appropriate \$10,000 biennially for that purpose. The Governor's budget also establishes a five-member Redistricting Advisory Commission to oversee the work of the LRB. The members will consist of the speaker and

minority leader of the Assembly, the majority and minority leader of the Senate, and the fifth member will be selected by the four legislative members.

UW-Extension: The Governor's budget provides funding of \$1.5 million in each year of the biennium and 20 new county-based UW-Extension agricultural positions.

Veterans: The Governor's budget recommends that County Veterans Service Officer Grants appropriations be consolidated into a single appropriation. No additional funds were included in the Governor's budget for this grant program.

Minimum Wage: The Governor's budget includes an increase in the state's minimum wage. Minimum wage would be increased by \$1 on January 1, 2020 and by \$0.75 in each year beginning January 1, 2021 for three years. Thereafter, the minimum wage would increase based on the consumer price index yearly.

Prevailing Wage: The Governor's budget reinstates Wisconsin's prevailing wage law.

Project Labor Agreements: The Governor's budget also repeals 2017 Wisconsin Act 3 which prohibited agreements (collective bargaining, project labor agreements or community workforce agreements) between governments and labor organizations on public works projects.

Right-to-Work: The Governor's budget eliminates the state's right-to-work law. Currently, the right-to-work law prohibits a person from requiring, as a condition of obtaining or continuing employment, and individual to refrain or resign from membership in a labor organization, to become or remain a member of a labor organization, to pay dues or other charges to a labor organization, or to pay any other person an amount that is in place of dues or charges required of members of a labor organization.

State and Local Employment Regulations: The Governor's budget would repeal the preemption of local governments from enacting or enforcing ordinances related to various employment matters. Currently, local governments may not enact an ordinance regulating wages, overtime pay, employee hours, and benefits (2017 Wisconsin Act 327).

HEALTH AND HUMAN SERVICES

Department of Health Services (DHS)

Medicaid Expansion: The Governor's budget changes the family income eligibility level to up to 133 percent of the federal poverty level for parents and caretaker relatives under BadgerCare Plus and for childless adults currently covered under BadgerCare Plus Core, who are incorporated into BadgerCare Plus in the budget. An additional 82,000 Wisconsinites will

receive healthcare coverage through Medicaid. The Governor's budget anticipates \$320 million in GPR savings through this initiative.

Childless Adult Demonstration Project: The Governor's budget eliminates the statutory implementation requirement for the BadgerCare Reform waiver, including the deadline and penalties, eliminates the statutory requirement for DHS to seek the waiver, and allows DHS to modify or withdraw the waiver. The waiver called for imposing premiums on, requiring a health risk assessment of, and time-limiting eligibility for recipients of BadgerCare Plus under the childless adult demonstration project waiver.

Drug Screening and Testing Requirements: The Governor's budget eliminates provisions under current law that, with certain exceptions, require controlled substance abuse screening and, in some cases, testing and treatment of all of the following: (a) individuals who apply to participate in certain work experience programs administered by DCF and DWD; (b) noncustodial parents who apply for W-2; (c) every adult member of an individual's W-2 group whose income or assets are included in determining the individual's eligibility for a W-2 program.

Eliminating Child Support Compliance Requirement: Current law prohibits certain able-bodied adults and able-bodied parents who refuse to cooperate in determining the paternity of a child, establishing or enforcing any support order, or obtaining any other payments or property to which the adult or child has rights, and certain parents who are delinquent in child support payments from being eligible for the MA program. The Governor's budget eliminates these prohibitions and reinstates the requirement that a person seeking MA benefits must cooperate, in accordance with federal law, in good faith with efforts directed at establishing paternity of a nonmarital child and obtaining support payments or any other payments or property to which the person and the dependent child or children may have rights.

FoodShare Work Requirements: The Governor's budget repeals the drug screening and testing requirements for able-bodied adults seeking to participate in the FoodShare employment and training program. The Governor's budget eliminates the requirement to implement a drug screening, testing, and treatment policy.

FSET Requirement: 2017 Wisconsin Act 264 requires DHS, beginning on October 1, 2019, to require all able-bodied adults, with some limited exceptions, who seek benefits from the FoodShare program to participate in FSET unless they are already employed. The Governor's budget eliminates that requirement for able-bodied adults with dependents but retains the requirement for able-bodied adults without dependents.

FSET Pay-for-Performance: 2017 Wisconsin Act 266 requires DHS to create and implement a payment system based on performance for entities that perform administrative functions for the

FoodShare employment and training program. Act 266 specified performance outcomes on which the pay-for-performance system must be based. The Governor's budget eliminates the requirement for DHS to create a pay-for-performance system for FSET vendors.

FoodShare Paternity and Child Support Compliance: The Governor's budget eliminates all of the ineligibility provisions in FoodShare for failing to comply with paternity and child support requirements in 2017 Wisconsin Act 59.

Medicaid Waivers: The Governor's budget repeals the portion of 2017 Wisconsin Act 370 that requires legislation be enacted in order for DHS to submit a request for a waiver or renewal, modification, withdrawal, suspension, or termination of a waiver of federal law or rules or for authorization to implement a pilot program or demonstration project. The Governor's budget also eliminates the legislative review procedure for requests for waivers, pilot programs, or demonstration projects required by Act 370.

Medicaid Community Health Benefit: The Governor's budget creates a Medicaid community health benefit that invests \$45 million for non-medical services to reduce and prevent health disparities that result from economic and social determinants of health. Services include but are not limited to housing referral services, stress management, and nutritional counseling. DHS is required to seek any necessary state plan amendment or request any waiver of federal Medicaid law to provide the benefit but is not required to provide the services as a Medical Assistance benefit if the federal Department of Health and Human Services does not provide federal financial participation for the services.

Income Maintenance Administration Allocation: The Governor's budget provides no increase in the income maintenance administration allocation.

FoodShare Employment and Training: The Governor's budget reduces funding for the FoodShare Employment and Training program to reflect changes in work requirements.

Medicaid Dental Access: The Governor's budget:

- Increases Medicaid reimbursement rates for dental providers who provide services to Medicaid and BadgerCare Plus patients to increase access to dental services under the Medical Assistance program.
- Ends the dental reimbursement pilot project.
- Creates a dental therapist training program.
- Increases the maximum award under the rural provider loan payment program.
- Increases expenditure authority for the Seal-A-Smile program.
- Increases funding for low-income dental clinics to expand services and deliver better access.

- Increases payments to dental providers that serve Medicaid recipients with physical and intellectual disabilities (\$2,000,000 AF in FY20 and \$3,000,000 AF in FY21).

Childhood Lead Poisoning: The Governor's budget:

- Increases blood lead testing.
- Creates a health service initiative to provide funding to abate lead hazards in homes where Children's Health Insurance Program (CHIP) participants reside (this initiative will receive federal funds at the enhanced FMAP rate).
- Provides a grant for lead abatement in non-CHIP eligible homes (\$1 million GPR).
- Provides 1.14 FTE positions to administer the health service initiative.
- Expands Birth to 3 services to children that are lead poisoned. Eligibility criteria will be lowered from a blood lead level of 10 mcg/dL to 5 mcg/dL to allow more children to receive services. The Governor also recommends utilizing surplus Community Options Program high-cost funds to provide a funding increase to the Birth-to-3 program (\$1.55 million in FY20 and \$7,600,000 in FY21).

These initiatives are funded with \$24,996,000 in FY20 and \$27,158,700 in FY21.

Children's Long-Term Care: The Governor's budget provides additional funding to eliminate the waiting list for the Children's Long-Term Support program. Base funding for the program was \$81.4 million in FY19. The budget increases that amount to \$117.3 million in FY20 and \$119.9 million in FY21. As of July 2018, there were 2,054 children on a waiting list for services. The Governor's budget requires DHS to ensure that any eligible child who applies for the disabled children's long-term support waiver program receives services under that program.

The Governor's budget recommends streamlining the intake, application, and screening functions for children's long-term care programs by implementing a statewide contract to administer all Katie Beckett Medicaid screens and all initial screens for the CLTS program and the Children's Community Options Program.

As part of a statewide contract, the governor recommends providing for children's services navigators (five) and children's disability resource specialists (two) to help direct families towards available community resources, programs, and services. The Governor also recommends providing for children's disability ombudsmen (two) to provide advocacy services for children with long-term support needs (\$2.1 million in FY20 and \$2.4 million in FY21).

Mental Health Services:

Crisis Intervention Services: Currently, mental health crisis intervention services are a benefit provided by the Medical Assistance program. Current law specifies that for a county that becomes certified as a Medical Assistance provider, the county pays the nonfederal share of the

Medical Assistance reimbursement and DHS reimburses the county for the federal share of the Medical Assistance reimbursement.

The Governor's budget changes the name of the services to "crisis intervention services" and specifies that those services are for the treatment of mental illness, intellectual disability, substance abuse, and dementia. The budget also specifies that for a county that elects to deliver crisis intervention services under MA on a regional basis, DHS reimburses the service provider both the federal and nonfederal share of the allowable charges for the amount that exceeds a required annual county contribution. After January 1, 2020, the required annual county contribution is equal to 75 percent of the county's expenditures for crisis intervention services in CY17, as determined by DHS.

Crisis Stabilization Facilities: The Governor's budget creates a new grant program to establish five regional crisis stabilization facilities. These facilities are designed to help individuals in crisis and reduce involuntary commitments at state-run institutions. DHS will establish the grant criteria.

Definition of Crisis: The Governor's budget expands the definition of crisis to include substance abuse and dementia-related crises.

Crisis Program Enhancement Grant: The Governor's budget requires DHS to award grants each fiscal biennium to counties or regions comprising multiple counties to establish or *enhance* crisis programs to serve individuals having crises in rural areas. The budget changes the terminology of "mobile crisis teams" to "crisis program enhancement." The total amount of grants awarded remains at \$250,000 in each fiscal biennium.

The Governor's budget funds these mental health initiatives with \$9,210,100 in FY20 and \$30,547,900 in FY21.

Mental Health Consultation Program: The Governor's budget requires DHS to convene a statewide group of interested persons, in partnership with the Medical College of Wisconsin, to develop a concept paper, business plan, and standards for a comprehensive mental health consultation program that incorporates general, geriatric, and addiction psychiatry, a perinatal psychiatry consultation program, and the child psychiatry consultation program, which operates under current law (\$66,700 GPR in FY20).

Definition of Telehealth: The Governor's budget expands the definition of "telehealth" for the purposes of reimbursement of mental health services provided through telehealth under the Medical Assistance program. Currently, the definition of "telehealth" includes only real-time communications between individuals and health care providers. The Governor's budget includes in the definition real-time communications between providers and, in circumstances determined

by DHS, asynchronous transmissions of digital images or data between providers, known as store-and-forward technology.

Mental Health Services Under BadgerCare Plus: The Governor's budget recommends increasing noninstitutional rates for physicians and medical clinics that provide mental health, behavioral health, and psychiatric services. The \$69 million investment will provide more services for Medicaid recipients who seek mental health and behavioral health care.

Peer Run Respite Centers for Veterans: The Governor's budget fully funds the peer run respite center for veterans. The facility will provide peer support services and hospital diversion services at no cost to veterans struggling with a mental health or substance abuse disorder.

Youth Crisis Stabilization Facility: The Governor's budget fully funds a youth crisis stabilization facility. The facility will provide residential mental health services to children whose needs are greater than what is available in their community but not severe enough to warrant commitment to an institution.

Substance Use Disorder: The Governor's budget provides \$898,800 in FY21 to develop a Hub-and-Spoke treatment model utilizing the Medicaid Home Health Benefit to provide care coordination for individuals at three opioid treatment centers across the state. The Governor's budget allows methadone as an appropriate treatment at these clinics. The Hub-and-Spoke model relies on regional hubs to support an individual's initial treatment and spokes to provide maintenance treatment in local communities. DHS plans to pilot the model in two urban communities and one rural community.

Healthy Women, Healthy Babies Initiative: The Governor's budget:

- Increases funding for the Women's Health Block Grant by \$193,600 GPR.
- Eliminates the current law requirement that DHS apply for federal Title X grant funds and to distribute any funds to public entities for family planning and related preventive health services.
- Retains the authorization for public entities that receive funding under Title V from DHS to provide some or all of the funding to other public or private entities, but eliminates the restriction (entities cannot provide abortion services, make referrals for abortion services, or have an affiliate that provides abortion services or makes referrals for abortion services) on which public or private entities may receive those funds.
- Allocates 5.0 FTE positions to create an Infant Mortality Prevention Program to address disparities in birth outcomes in our state.
- Expands postpartum eligibility for women in the Medicaid program up to 300 percent of the FPL from 60 days to 12 months by providing \$22,988,000 in FY21 (requires a Medicaid waiver).

- Provides an additional \$1,012,500 TANF in FY20 and \$2,175,000 TANF in FY21 to expand home visiting to support expecting mothers and mothers with infants and small children.
- Requires DHS to request any necessary federal approval to allow MA reimbursement for doula services.
- Requires DHS to award in FY20 grants totaling \$192,000 to public or private entities, American Indian tribes or tribal organizations, or community-based organizations for community-based doulas. The recipients must use the grants to identify and train local community workers to mentor pregnant women.

WIC: The Governor's budget makes several changes to the Supplemental Nutrition Program for Women, Infants, and Children:

- Allows DHS to identify an alternate participant, who is someone authorized by a WIC program participant to request benefits and otherwise participate in the WIC program, as the WIC program cardholder for purposes of electronic administration.
- Adds to the criteria to be an authorized vendor or authorized distribution center that the vendor or distribution center has an electronic benefit transfer-capable cash register system or payment device that meets the criteria specified in the budget.
- Specifies that, except for certain mobile stores specially authorized in accordance with federal law, each store is a separate vendor, must have a single, fixed location, and must be separately authorized under the WIC program.
- Adds to the activities prohibited under the WIC program related to trafficking.
- Incorporates infant formula suppliers into the types of entities for which DHS must promulgate rules regarding standards for authorization.
- Adds civil monetary penalty, warning letter, and implementation of a corrective action plan to the list of consequences for violating a rule promulgated by DHS relating to the WIC program.
- Specifies that information about an applicant for, participant in, or vendor in the WIC program is confidential and then specifies who may access that confidential information and for what purpose.
- Makes some additional changes to the language of the WIC program statutes.

Tobacco Cessation: The Governor's budget provides an additional \$3.3 million GPR annually for tobacco cessation activities:

- \$2,300,000 for the Wisconsin Tobacco Quit Line
- \$500,000 in the Wisconsin Nicotine Integration Project
- \$500,000 to improve outreach and cessation resources for individuals with adverse childhood experiences

Healthy Aging Programs: The Governor's budget requires DHS to award in each fiscal year a \$250,000 GPR grant to an entity that conducts healthy aging programs (falls prevention and chronic disease management).

Dementia Care Specialists: The Governor's budget provides \$2.8 million annually to expand the dementia care specialists program to all aging and disability resource centers in the state. That equates to 27 positions for non-tribal ADRCs and 3 tribal positions.

Nursing Home Rate Increases: The Governor's budget provides \$8.7 million in FY20 and \$17.8 million in FY21 for a 2.5 percent general rate increase for nursing homes with a 1.5 percent increase targeted to direct care workforce and 1.0 percent for acuity.

Workforce Shortages: The Governor's budget:

- Provides \$14.8 million in each year to increase the direct care and services portion of the capitation rates DHS provides to long-term care managed care organizations in recognition of the direct caregiver workforce challenges facing the state.
- Provides \$3.3 million in FY20 and \$13.4 million in FY21 to fund rate increases for personal care direct care services (1.5 percent increase year over year).

Assisted Living Reporting and Fees: The Governor's budget requires certain assisted living facilities, specifically adult day centers, community-based residential facilities, and residential care apartment complexes, to submit biennial reports to DHS through an online system prescribed by DHS.

Department of Children and Families (DCF)

Children and Family Aids: The Governor's budget increases funding for Children and Family Aids by \$15 million GPR beginning in CY20, as well as funding the costs related to the 2.5 percent foster care rate increase included in the 2017-19 biennial budget. The budget increases the maximum amount DCF must distribute to counties for these services to \$78,708,100 in FY20 and \$90,478,400 in FY21.

Child Support: The Governor's budget increases funding for county child support agencies by \$750,000 GPR in FY20 and \$1,500,000 in FY21.

Birth Cost Recovery: The Governor's budget eliminates the requirement that a court include in a judgment or order relating to paternity an order for a father to pay for a portion of pregnancy and birth expenses. The budget also eliminates orders relating to pregnancy and birth expenses, and expressly prohibits the state from seeking recovery of birth expenses.

Child Support Custodial Parent Fee: The Governor's budget changes the annual fee collected from every individual receiving child support or family support payments from \$25 to \$35 in order to conform to applicable federal law.

Children First: The Governor's budget provides \$1,140,000 TANF in each fiscal year to increase the capitated payment from \$400 to \$800 in the Children First program to ensure noncustodial parents who are in arrears in meeting their child support are receiving adequate services to help them meet their child support obligations.

Foster Care Rate Increase: The Governor's budget provides \$258,300 GPR/FED in FY20 and \$777,900 GPR/FED in FY21 for a 2 percent increase in foster care rates in each calendar year (2% increase in CY20 and an additional 2% in CY21).

Kinship Care Rate Increase: The Governor's budget provides \$247,200 TANF in FY20 and \$770,500 TANF in FY21 for a 2 percent increase in kinship care rates.

Driver's Licenses for Foster Care Youth: The Governor's budget requires DCF to establish or contract for a driver education program for individuals who are 15 years of age or older and in out-of-home care. The budget requires the program to provide assistance with identifying and enrolling in an appropriate driver education course, obtaining an operator's license, and obtaining motor vehicle liability insurance. The budget authorizes DCF to pay, for any individual in the program, any fees required to enroll in a driver education course or to obtain an operator's license and the cost of motor vehicle liability insurance on the vehicle owned or used by the individual during the program and after the individual obtains an operator's license. The program is allocated \$89,700 GPR in FY20 and \$289,200 GPR in FY21.

Runaway and Homeless Youth Shelters: The Governor's budget increases funding for runaway and homeless youth shelters by \$250,000 GPR in each fiscal year to expand services in rural areas.

Family First Prevention Services: The Governor's budget makes changes to child welfare laws to allow foster care payments to be made on behalf of a child who is placed with his or her parent in a licensed family-based residential alcohol or drug abuse treatment facility under a voluntary agreement or under an order of the court assigned to exercise jurisdiction under the Children's Code in order to claim federal funding under Title IV-E of the federal Social Security Act. The Governor's budget requires DCF to prepare a permanency plan for such a child, and allows DCF to place the child with the parent at the treatment program under a voluntary agreement or by an order of the juvenile court if the parent consents and if such a placement is recommended by the permanency plan. If the child is placed with his or her parent under such a voluntary agreement or an order of the juvenile court, the budget authorizes DCF to provide foster care funding for the placement.

Background Checks for Congregate Care Workers: The Governor's budget requires a licensing entity to perform a fingerprint-based background check for all workers at a congregate care facility, as required under federal law. The budget defines a congregate care facility to be a group home, shelter care facility, or residential care center for children and youth.

Juvenile Justice

17-Year-Olds: The Governor's budget reverts jurisdiction of 17-year-old offenders from adult court to juvenile court for acts committed on or after January 1, 2021 and provides sum sufficient funding to Wisconsin counties to cover eligible costs associated with returning these youth to the juvenile justice system. The sum-sufficient appropriation will start with a base of \$5 million GPR in FY21 and will be used to reimburse counties for the increased costs associated with raising the age. Expenses eligible for reimbursement will be determined by the Department of Children and Families in consultation with representatives of the counties. The change applies to violations under the criminal code, as well as violations of civil law or municipal ordinances.

Lincoln Hills/Copper Lake: The Governor's budget removes the January 1, 2021 closure date for Lincoln Hills/Copper Lake and commits to transferring youth out of the facilities as soon as a Type 1 or SRCCCY facility that meets the needs of the youth is available. The intention is to close Lincoln Hills as soon as it is possible to ensure a safe and appropriate placement for all youth. The date change also applies to the construction of SRCCCYs.

The Governor's budget includes funding for building up to three new Type 1 facilities at a total cost of \$115 million.

SRCCCYs: The Governor's budget provides \$100 million for SRCCCY grants to counties and allows counties to apply for Youth Aids for start-up costs.

The Governor's budget changes the deadline for counties to submit SRCCCY grants from March 31, 2019 to July 1, 2019 and changes the date that the Juvenile Corrections Grant Committee must submit SRCCCY recommendations to JCF from July 1, 2019 to October 1, 2019. The budget also allows counties to submit grants prior to the deadline and allows the committee to forward early applicants to the JCF prior to the deadline under 14-day passive review to ensure that counties that are ready to move forward are able to do so without delay.

The budget also requires legislative minority representation on the Juvenile Corrections Grant Committee – one member appointed from each house of the legislature. Appointments from each house by the majority party drops from three members under current law to two members.

The Governor's budget provides \$3.5 million GPR in FY21 to reimburse one-time start-up costs for counties that create SRCCCYs. Expenses eligible for reimbursement will be determined by the Department of Children and Families in consultation with representatives of the counties.

MJTC: The Governor's budget increases treatment capacity and improves mental health treatment services to juveniles who need services by providing 50.5 FTE positions and \$3.1 million in FY21 for a 14-bed expansion at the Mendota Juvenile Treatment Center.

Under the Governor's budget a court may place a juvenile under the supervision of a county at MJTC only if DHS approves. In addition, only the Mendota Mental Health Institute director or his or her designee may make decisions regarding the admission of juveniles to and the treatment of juveniles at MJTC and the release and return of juveniles to the appropriate state or county facility. Juveniles placed in MJTC remain under the supervision of the county, and DHS may directly charge the county a rate that DHS sets for care provided to juveniles at MJTC.

The Governor's budget eliminates JCF approval of the MJTC expansion included in 2017 Wisconsin Act 185. Under Act 185, DHS is required to construct an expansion of MJTC to accommodate no fewer than 29 additional juveniles, subject to the approval of the JCF.

Youth Aids: The Governor's budget proposes nonstatutory language directing the Department of Children and Families and counties to examine potential modifications to the overall youth aids formula.

The Governor's budget appropriates to DCF a sum sufficient for youth-aids related purposes but only to reimburse counties, beginning on January 1, 2021, for costs associated with juveniles who were alleged to have violated a state or federal criminal law or any civil law or municipal ordinance at age 17. The Governor's budget also provides funding and requires DCF to reimburse counties for one-time start-up costs incurred for youth aids-related purposes in establishing, alone or jointly with one or more counties, a secured residential care center for children and youth. The Governor's budget requires DCF to consult with county representatives to determine those expenses that are eligible for reimbursement.

Youth aids funding amounts under the budget are \$45,572,100 for the last six months of 2019; \$91,150,200 for 2020; and \$45,578,100 for the first six months of 2021.

Youth Justice System: The Governor's budget recommends adding an additional position and increasing expenditure authority to provide training, performance monitoring, data collection and analysis to set standards of practice for the youth justice system.

JCI Rates: The Governor's budget increases the daily rates for placements at Lincoln

Hills/Copper Lake: \$501 FY20

\$513 July 1, 2020 to December 2020

\$588 January 1, 2021 – June 30, 2021

Other

Homelessness: The Governor's budget increases funding for the following homeless prevention programs:

- \$500,000 GPR in each year for the Homelessness Prevention Program and \$300,000 GPR in each year for the creation of a new diversion program.
- \$500,000 GPR in each year for the State Shelter Subsidy Grant.
- \$900,000 GPR in each year for the Housing Assistance Program.
- \$500,000 TANF in each year for the Homeless Case Management Services Grant.
- \$250,000 GPR in each year for the Skills Enhancement Grant at DCF.
- \$500,000 GPR in each year to create a new Housing Quality Standards grant.
- \$300,000 GPR in each year to create a grant for housing navigation.

The Governor's budget repurposes funding from the Employment Services Grant program to support 1.0 FTE position within DOA's Division of Energy, Housing and Community Resources to support the expanded programs and convert 1.0 federal FTE position to program revenue service funded with TANF.

Elderly and Disabled Transportation Aids: The Governor's budget increases elderly and disabled transportation aids by \$6 million over the biennium (\$3 million in each year of the budget).

Special Education Funding: The Governor's budget increases the amount DPI pays to school boards, cooperative educational services agencies, county children with disabilities education boards, and operators of independent charter schools for costs incurred to provide special education and related services to a child with a disability that exceeds \$30,000 in one school year from 90 percent of the costs that exceed \$30,000 to 100 percent of the costs that exceed \$30,000 (additional special education aid). Under current law, if the amount appropriated for additional special education aid is insufficient to pay the full amount to the eligible entities, DPI must prorate payments among all eligible entities. The Governor's budget converts the appropriation for the aid to a sum sufficient, eliminating the need to prorate aid due to an insufficient appropriation.

JUDICIAL AND PUBLIC SAFETY

Decriminalization of Marijuana: The Governor's budget recommends the decriminalization of marijuana in amounts of 25 grams or fewer. Further, the Governor recommends creating an

expungement process for those convicted of possessing, manufacturing, or distributing less than 25 grams of marijuana and have completed their sentence or probation. Finally, the Governor is recommending a process be established for individuals to petition for the dismissal of their conviction for small amounts of marijuana.

The Governor's budget retains current law for distributing or delivering any amount of marijuana to a minor who is no more than 17 years old by a person who is at least three years older than the minor. The Governor's budget would also limit local governments ability to enact ordinances prohibiting only the possession of more than 25 grams of marijuana.

State Public Defender: The Governor's budget recommends that the private bar rate be increased to \$70 per hour (currently rate is set statutorily at \$40 per hour) by January 1, 2020 by providing \$8.6 million in FY20 and \$16.6 million in FY21. The Governor's budget does not provide any additional funds to counties to offset the Supreme Court Rule to increase the county court appointed attorney rate from \$70 per hour to \$100 per hour starting January 1, 2020.

Treatment Alternatives and Diversion (TAD) Program Expansion: The Governor's budget provides \$1 million in both years of the biennium as a one-time increase for TAD. Of the \$1 million, \$500,000 would be used for expansion of existing programs and the other \$500,000 for new programs.

Opening Avenues to Reentry Success (OARS): The Governor's budget provides one position and expenditure authority for the expansion of the OARS program. OARS is currently available in 44 counties and supports the prison to community transition of inmates living with a serious and persistent mental illness who are medium-to-high-risk of reoffending.

Dispatcher Assisted Cardiopulmonary Resuscitation (CPR): The Governor's budget provides additional monies to support the ongoing cost of the Dispatcher Assisted CPR program established in 2017 Wisconsin Act 296.

Office of Emergency Communications: The Governor's budget recommends transferring the Interoperability Council, the Wisconsin Interoperable System for Communications program, the 9-1-1 Subcommittee, the Next Generation 9-1-1 program, the public safety broadband program and the land mobile radio program to the Department of Transportation from the Department of Military Affairs. The 2017-19 state budget moved the aforementioned programs from multiple state departments to be housed under one department, the Department of Military Affairs within the Office of Emergency Communications.

District Attorneys: The Governor's budget recommends 19.6 new assistant district attorney positions, as well as funding and position authority to increase part-time assistant district attorney positions to full-time (6.90 positions). The Governor's budget also recommends one-

time funding (\$307,300 in FY20 and \$918,000 in FY21) for pay progression for assistant district attorneys and deputy district attorneys.

TAXATION AND FINANCE

Shared Revenue: The Governor's budget increases funding for the County and Municipal Aid Program (shared revenue) by 2 percent starting in 2020.

Levy Limits: The Governor's budget modifies the current levy limit program by allowing county property tax levies to increase by the greater of the percentage change in equalized value due to net new constructions or 2 percent beginning with levies set in 2019.

Levy Limits – Covered Services: The Governor's budget eliminates the requirement that local governments make a negative levy adjustment based on fees generated from certain municipal services.

Levy Limits – Transit Services: The Governor's budget creates a levy limit exemption for cross-municipality transit routes where the counties and municipalities meet a number of criteria. The criteria includes that the counties and municipalities claiming the exclusion must be adjacent, must have entered an intergovernmental cooperation agreement to provide new or enhanced transit services across county boundaries, and that each participating county or municipality must pass a referendum approving the agreement.

Dark Stores / Property Assessments: The Governor's budget amends assessment practices by incorporating the statutory language from last legislative session's dark store and *Walgreens v. City of Madison* reversal legislation (2017 Assembly Bills 386 and 387).

Property Tax Transparency: The Governor's budget requires local property tax bills to include information containing the gross reduction in state aid as a result of private school choice programs.

Property Tax Credits: The Governor's budget repeals the school levy tax credit and the first dollar credit. The Governor's budget converts the school levy and first dollar credits into general equalization aids to schools beginning in fiscal year 2021.

General Fund Transfer: The Governor's budget repeals the 0.25 percent general fund tax transfer to the transportation fund.

Homestead Tax Credit: The Governor's budget restores indexing for the Homestead Credit beginning in tax year 2020.

Tax Incremental Financing (TIF): The Governor's budget limits the percentage of a TIF district's project costs that can go toward cash grants for developers to 20 percent. The Governor's budget also requires TIF project plans to contain "stress tests" in their financial projections so that local governments better understand the risks of TIF utilization.

Sales and Use Tax: The Governor's budget includes language explicitly requiring internet marketplace providers to collect and remit sales and use tax on taxable sales that they facilitate on their websites on behalf of third parties.

Sales Tax Exemptions: The Governor's budget eliminates the sales tax exemptions for the sale of live game birds and clay pigeons and eliminates the sales tax exemption for the sale of farm-raised deer.

Real Estate Transfer Fee Exemption: The Governor's budget modifies two current law exemptions to the real estate transfer fee. The first change clarifies that the exemption for transfers from a subsidiary corporation to its parent corporation does not apply in cases where a noncorporate entity owns a majority of shares in the corporation. The second change would modify the exemption to transfers for the purposes of providing security for debt or other obligations to specify that the exemption does not apply to conveyances between different owners.

TRANSPORTATION AND PUBLIC WORKS

Segregated Transportation Fund: The Governor's budget funds the state's infrastructure with approximately \$6.6 billion, up from \$6.1 billion in the current biennium. New transportation revenues are generated by an eight-cent increase in the gas tax (\$485 million), elimination of the minimum markup on motor fuel, an increase in the heavy vehicle registration fee (\$36 million), an increase in the title fee (\$36 million) and by a proposed activation of the hybrid vehicle surcharge fee (\$9.7 million). In total, the increase in revenue for the Segregated Transportation Fund is approximately \$566 million in the biennium. The budget also reinstates indexing of the gas tax rate to the consumer price index.

Transportation Project Requirements: The Governor's budget repeals requirements passed in the 2018 Extraordinary Session requiring that any project with federal dollars in the Majors, Southeast Mega and Highway Rehabilitation Programs to be composed at least 70 percent federal dollars. The Governor's budget proposal also repeals language passed in the 2018 Extraordinary Session requiring the Wisconsin Department of Transportation (WisDOT) to notify a political subdivision receiving aid for local project whether the aid includes federal monies and how that money must be spent. Finally, the Governor's budget repeals 2018 Extraordinary Session language stating that WisDOT may not require political subdivisions to

comply with any portion of the agency's Facility Development Manual, other than requirements related to design standards.

General Transportation Aids: The Governor's budget increases county general transportation aids (GTA) from \$111,093,800 in the 2017-19 budget cycle to \$122,203,200 by calendar year 2020.

Routine Maintenance Agreements: The Governor's budget maintains funding and preserves recent increases for Routine Maintenance of the State Trunk Highway System (STH) performed by counties.

General Transit Aids: The Governor's budget increases annual funding for General Transit Aids by 10 percent or \$11,073,800 by the second year of the biennium: Mass Transit Systems with operating expenses of:

- Greater than \$80,000,000: Funding is increased in the second year of the biennium from \$64,193,900 to \$70,613,300
- Between \$20,000,000 and \$80,000,000: Funding is increased from \$16,868,000 to \$18,554,800
- Less than \$20,000,000 and a serving population of at least 50,000: Funding is increased from \$24,486,700 to \$26,935,400.
- Mass Transit Systems serving an area with a population of less than 50,000: Funding is increased from \$5,188,900 to \$5,707,800.

Transit Capital Assistance: The Governor's budget establishes a Transit Capital Assistance Program to aid in the replacement of buses for eligible applicants. A total of \$10 million is allocated in the second year of the biennium to establish the program.

Paratransit Aids: The Governor's budget increases funding for Paratransit Aids by 10 percent or by \$275,000 in FY 2020 and again in FY 2021. This is a total funding increase of \$550,000 over the biennium.

Local Bridge Improvement Assistance: The Governor's budget maintains level funding for the Local Bridge Improvement Program, resulting in \$22.9 million in both years of the biennium.

Local Road Improvement Program (LRIP): The Governor's budget increases the funding for the Local Road Improvement Program (LRIP) by 4 percent in the 2019-21 biennium. A total of \$1,288,000 will be added to the overall program. Funding for the county component of LRIP, the

County Highway Improvement Program (CHIP), (Discretionary Program funding) will be \$5,569,400 in FY 2020 and \$5,688,400 in FY 2021.

Majors Projects: The Governor's budget provides \$558 million in total funding for the Major Highway Development Program in the 2019-21 biennium. The total funding level for the program was \$669 million in the 2017-19 biennium. This is a funding decrease for the program of approximately \$111 million.

Southeast Mega Projects Program: The Governor's budget increases funding for the Southeast Mega Projects Program from \$122 million in the 2017-19 biennium to \$332 million in the program. This is a proposed funding increase of approximately \$210 million for the upcoming budget cycle.

State Highway Rehabilitation Funding: The Governor's budget provides an increase in the program from approximately \$1.7 billion in 2017-19 to \$1.9 billion. This is a funding increase of approximately \$176 million over the previous budget cycle.

Seniors and Individuals with Disabilities Specialized Transportation Aids: The Governor's budget increases funding for the program by \$3 million in each year of the biennium. This amounts to a \$6 million, or approximately 24% increase, in funding in the 2019-21 biennium.

Passenger Rail Bonding: The Governor's budget provides \$45,000,000 in general fund supported general obligation bonding for passenger rail improvements for travel between Milwaukee and Chicago. The Governor's budget also earmarks track or rail passenger station improvements related to an Amtrak service extension route, or the establishment of commuter rail service, between the City of Milwaukee and Waukesha County.

Harbor Assistance Program: The Governor's budget increases funding for the Harbor Assistance Program by \$13,200,000 in FY20. In addition, the Governor's budget recommends giving priority to municipalities in which a shipbuilder in the state is conducting operations. Finally, the Governor's budget recommends providing \$39,000,000 in transportation fund-supported general obligation bonding for the program.

Freight Rail Preservation Program: The Governor's budget provides \$30,000,000 in transportation fund supported general obligation bonding for the freight rail preservation program.

Volkswagen Settlement: The Governor's budget allocates 60 percent of the remaining \$25 million in Volkswagen emissions settlement funds to be dedicated to the replacement of public transit vehicles and 40 percent towards electric vehicle charging stations. Additionally, the budget modifies current law by reducing the percentage of the total grant award returned to the

state through a shared revenue reduction by the Milwaukee County and city of Madison public transit systems from 75 to 20 percent.

Railroad Crossing and Repair: The Governor's budget increases funding for railroad crossing and repair by \$465,000 in each year of the biennium to address a backlog of projects. The total funding increase for the program in the 2019-21 biennium is \$930,000.

Next Generation Air Traffic Control Systems: The Governor's budget increases state funding by \$1 million in each year of the biennium to aid local airports in the conversion to Next Generation Air Traffic Control System.

Project Labor Agreements (PLA): The Governor's budget restores a local unit of government's ability to require that a bidder enter into a Project Labor Agreement (PLA).

State Prevailing Wage Requirements: The Governor's budget restores Prevailing Wage requirements for projects using state dollars.

Local Government Use of Eminent Domain Authority for Bicycle and Pedestrian Facilities: The Governor's budget restores the ability of local governments to use eminent domain authority for the installation of bike and pedestrian paths.

MILWAUKEE COUNTY
Inter-Office Communication

DATE: June 20, 2019

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

FROM: Paul Schwegel, Loss Control Manager, Risk Management

SUBJECT: Five Year Analysis of the Behavioral Health Division's Workers' Compensation Claims (INFORMATIONAL ONLY)

INTRODUCTION

The basic principles of risk management consist of identifying organizational exposures, analyzing these risks, controlling liabilities through a risk mitigation plan, and continually monitoring the plan for effectiveness. This report and the associated presentation are a high-level review of the past five years of the Behavioral Health Division's (BHD) workers' compensation claims. Several frequency and severity measures are displayed to demonstrate the financial impact of these claims, along with the corresponding liability reduction and employee safety plans.

WORKERS' COMPENSATION

Workers' compensation claims are statutory wage and medical benefits for employees to compensate for injuries that occur in the course and scope of their employment. Historically high claim averages in Milwaukee County presented an opportunity for improvement in both frequency and severity measures and resulted in a new workers' compensation program implementation by Risk Management in 2014. Transitioning the model of claims handling from self-administration to a third-party administrator in November of 2014 resulted in the introduction of new resources for County employees such as the Milwaukee County Care Line, a twenty-four-hour dedicated triage nurse to assist employees in their recovery, and transitional work options to encourage employee engagement post injury. This new program transition also resulted in industry appropriate claim tracking methods which reduced the prior data classification anomalies. Risk Management's other major focus during this time was to increase the safety of employees by rolling out extensive updated safety policies, expanding OSHA training, and rejuvenating the Milwaukee County Safety and Health Committee, the combined impact of which has greatly improved frequency and severity measures for workers' compensation claims from 2015 through the present.

BHD also helped reduce division specific losses by implementing new programs including authoring a new employee handbook in 2015, which clearly defined workplace expectations and policies, and investing significantly in leadership development. New service models, such as the assignment of acute staff to a dedicated unit, has increased employee accountability and closer manager oversight. In addition, BHD Leadership has established goals dedicated to decreasing seclusion and restraint rates. The concentrated effort utilizes conflict management training that is reoccurring and practical with a focus on triggers and mitigation strategies. These initiatives continue to shift the culture of injury management from reactive to proactive, ensuring our employees are working safely. Also, likely contributing to the decreasing claim trend has been a reduction in staffing services offered, such as the closing of Rehabilitation Hilltop and Central.

BHD averaged 67 claims with a total incurred cost of \$811,262 annually between 2014 – 2015. Most notable is the drastic decrease in frequency and severity measures in 2015, wherein BHD recorded only 40 claims with a total incurred cost of \$536,364. This represents a 40% decrease in frequency measures and a 34% decrease in severity when compared to the 2014 and 2015 averages. BHD has been able to sustain this reduction through 2018. On average, the department has recorded 29 claims with a total incurred cost of \$337,950 between 2017-2018. These two years are still developing and could fluctuate as the data continues to mature, but include reserve estimates to bring the claims to full conclusion. The most common claim causes represented between the years 2014 - 2018 is “struck by” and “altercation”, codes that typically denote an injury resulting from an encounter with a patient. These two claim cause categories accounted for 50% of all workers’ compensation claims filed at BHD, and 63% of the total incurred.

WORKERS’ COMPENSATION RECOMMENDATIONS

Risk Management has drilled down on specific exposure data for workers’ compensation claims at the departmental level and authored individualized loss reduction plans based on the departments’ claims history and operations. These plans contain performance measures and risk management goals along with tailored training to be followed up by claims meetings between the department and Risk Management. A focus on strategic partnerships and accountability through incentives, resource allocation, and training will continue to decrease liabilities and improve positive organizational behaviors to ensure the safety of our workforce and the success of effective long-term risk management for Milwaukee County.

Paul Schwegel

Paul Schwegel, Loss Control Manager, Risk Management

CC: Chris Abele, County Executive
Raisa Koltun, Chief of Staff, County Executive's Office
Teig Whaley-Smith, Director of Administrative Services
Mary Jo Meyers, Director of Health and Human Services
Mike Lappen, Director of Behavioral Health Division



BHD 2019 Risk Review



Principles of Risk Management

1. Identify exposures
2. Analyze losses
3. Develop plan to minimize
4. Monitor and adjust plan
 - Performance Measures:
 - A. Frequency of claims (#)
 - B. Severity of claims (\$)
 - C. OSHA Compliance





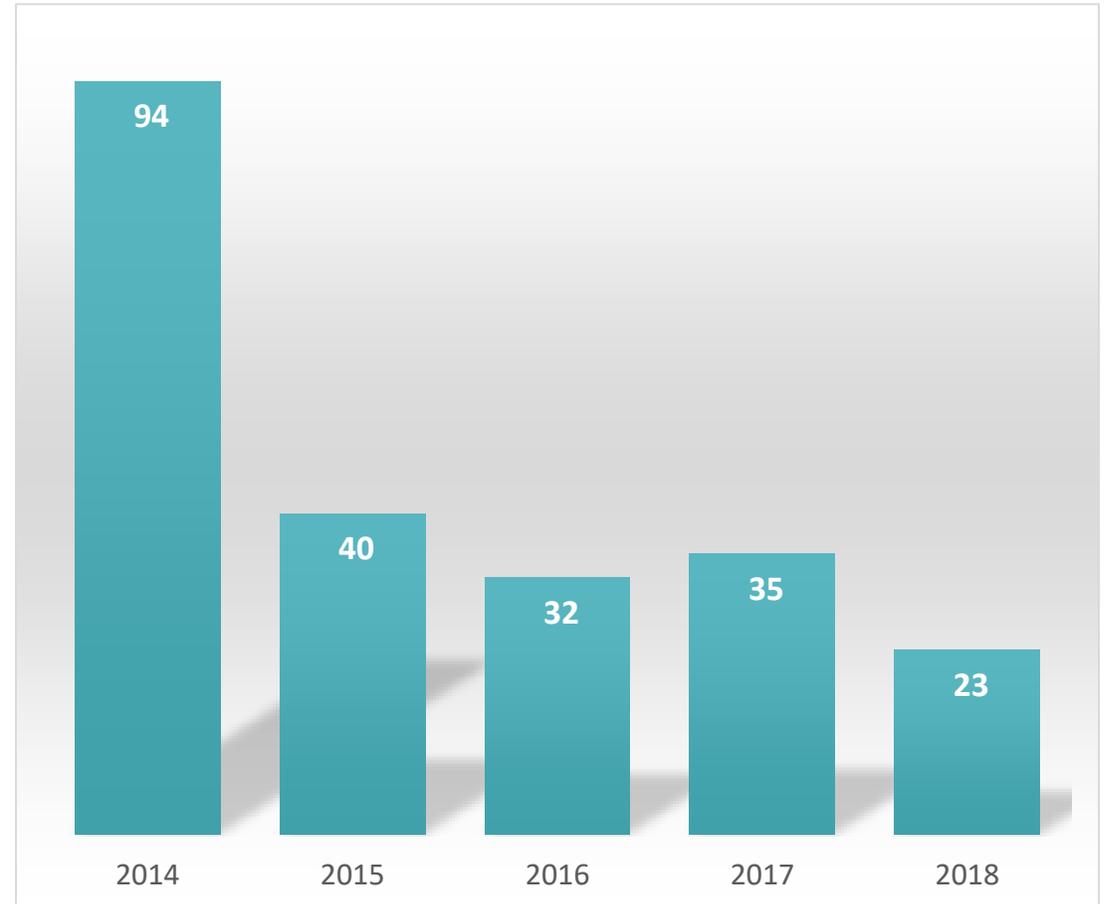
Workers' Compensation

- Statutory wage and medical benefit for individuals injured in the course and scope of their employment
- Milwaukee County has approximately 5,000 employees in the Workers' Compensation program
- Historically highest claim exposure impacting the county



Workers' Compensation Claim Frequency

| Year | # of Claims |
|--------------|-------------|
| 2014 | 94 |
| 2015 | 40 |
| 2016 | 32 |
| 2017 | 35 |
| 2018 | 23 |
| Total | 224 |





Workers' Compensation Injury Rate Per Employee

| Year | Injury Rate/Employee |
|------|----------------------|
| 2014 | 21% (1 out of 5) |
| 2015 | 8% (1 out of 12) |
| 2016 | 8% (1 out of 12) |
| 2017 | 8% (1 out of 12) |
| 2018 | 5% (1 out of 20) |

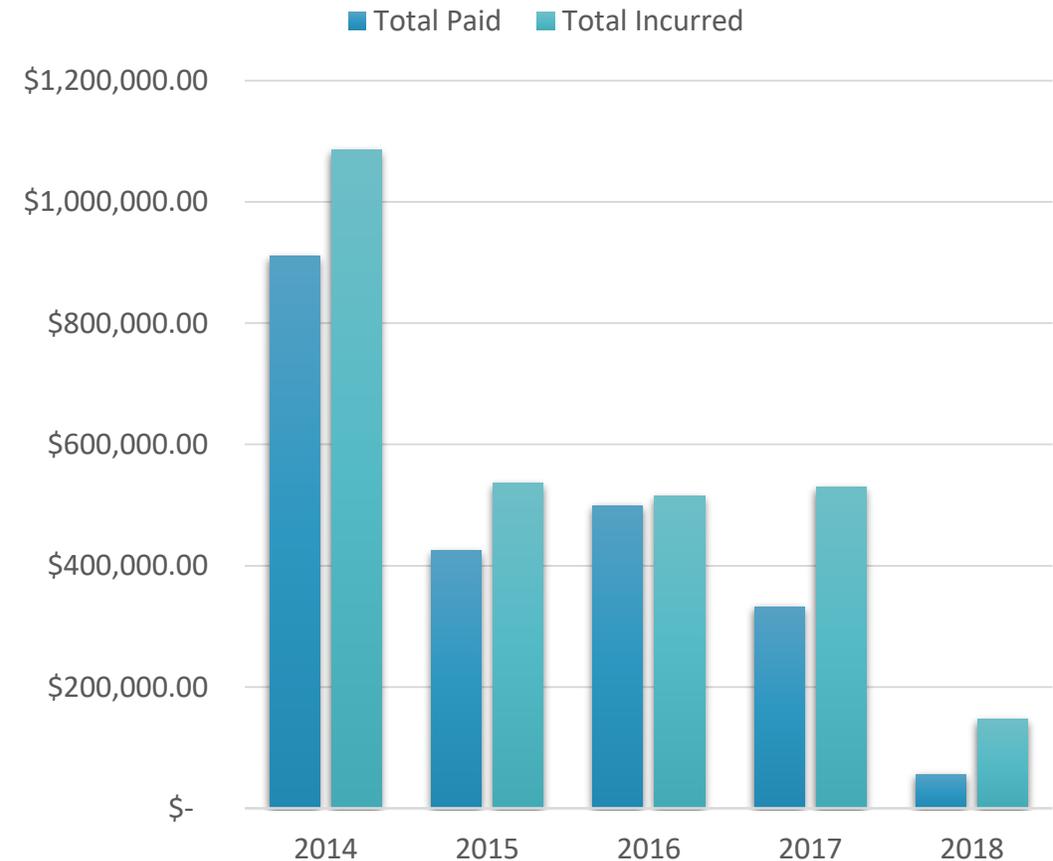
All employees making over \$30,000/year are included in this display.





Workers' Compensation Claim Financial Summary

| Year | Total Paid | Total Incurred |
|--------------|-----------------------|-----------------------|
| 2014 | \$910,919.43 | \$1,086,159.74 |
| 2015 | \$424,317.55 | \$536,364.40 |
| 2016 | \$499,486.97 | \$515,094.99 |
| 2017 | \$332,188.12 | \$529,232.56 |
| 2018 | \$55,714.93 | \$146,667.15 |
| Total | \$2,222,627.00 | \$2,813,518.84 |

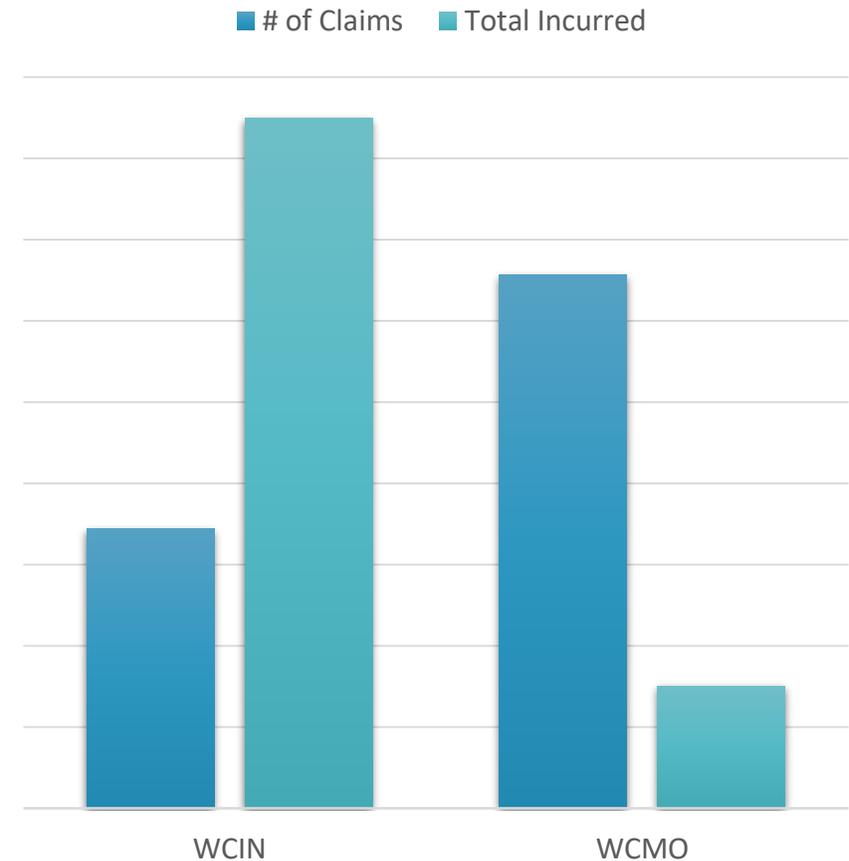




Workers' Compensation

Claim Frequency & Severity by Claim Type

| | # of Claims | Total Incurred | Average Incurred |
|--------------|-------------|-----------------------|--------------------|
| WCIN | 77 | \$2,390,349.46 | \$31,043.50 |
| WCMO | 147 | \$423,169.38 | \$2,878.70 |
| Total | 224 | \$2,813,518.84 | \$12,878.70 |

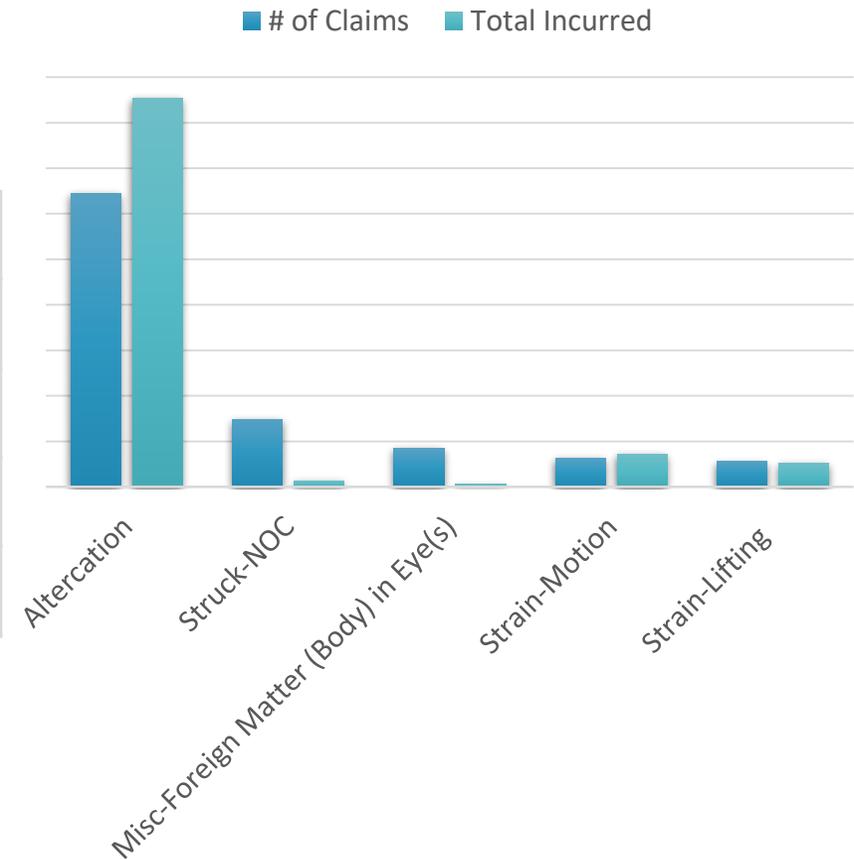




Workers' Compensation

Top 5 Most Frequent Accident Types

| | Claim Count | Total Incurred | Average Incurred |
|------------------|-------------|----------------|------------------|
| Altercation | 91 | \$1,745,163.15 | \$19,177.62 |
| Struck – NOC | 21 | \$27,929.16 | \$1,329.96 |
| Exposure | 12 | \$12,878.28 | \$1,073.19 |
| Strain – Motion | 9 | \$147,539.08 | \$16,393.23 |
| Strain – Lifting | 8 | \$108,036.26 | \$13,504.53 |

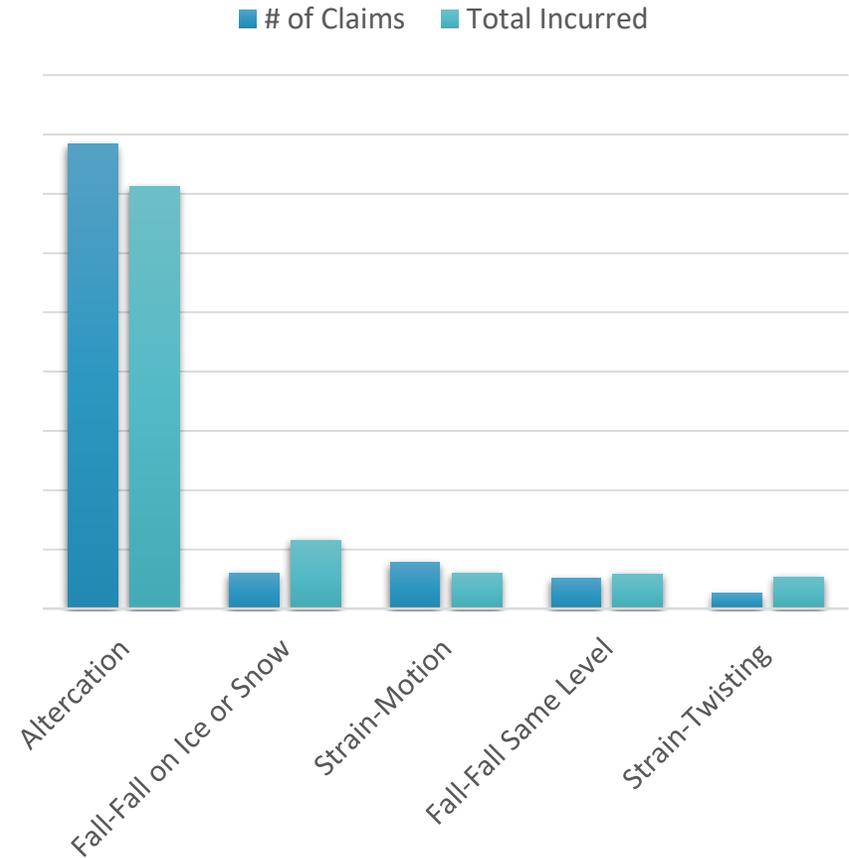




Workers' Compensation

Top 5 Most Severe Accident Types

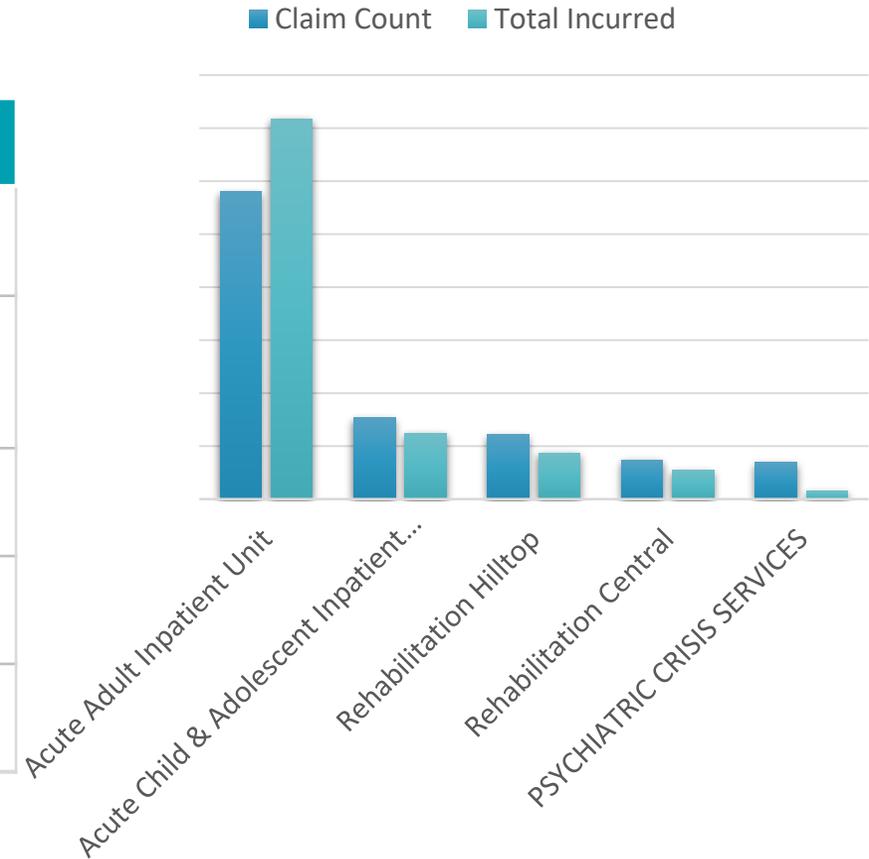
| | Claim Count | Total Incurred | Average Incurred |
|----------------------------|-------------|----------------|------------------|
| Altercation | 91 | \$1,745,163.15 | \$19,177.62 |
| Fall – Fall in Ice or Snow | 7 | \$284,505.46 | \$40,643.64 |
| Strain – Motion | 9 | \$147,539.08 | \$16,393.23 |
| Fall – Same Level | 6 | \$143,645.21 | \$23,940.87 |
| Strain - Twisting | 3 | \$132,347.76 | \$44,115.92 |





Workers' Compensation Frequency: Top 5 Divisions

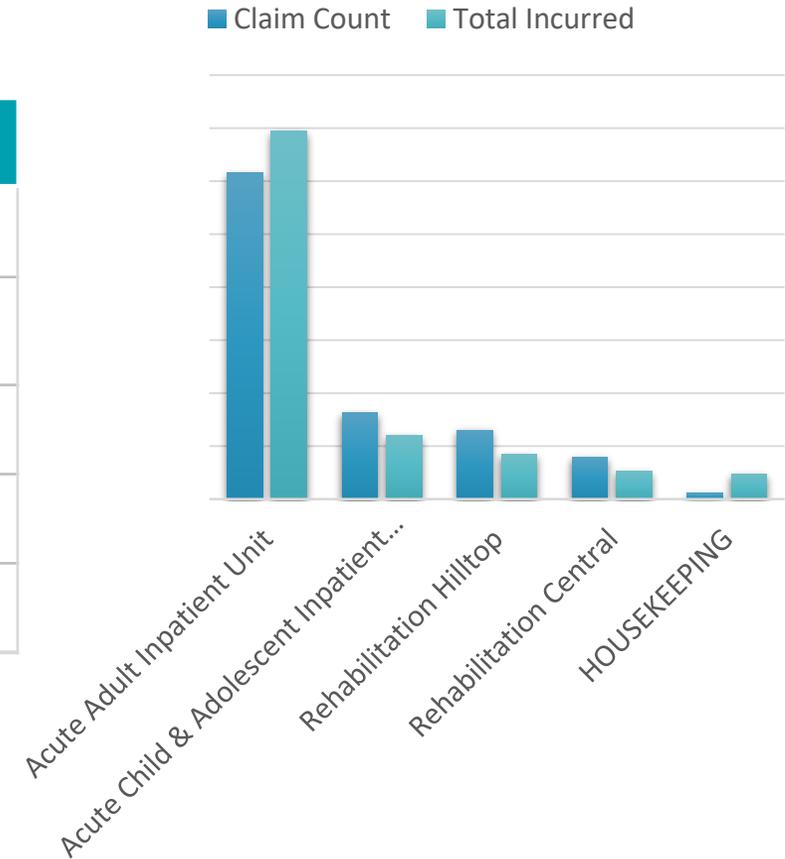
| | Claim Count | Total Incurred | Average Incurred |
|--|-------------|----------------|------------------|
| Acute Adult Inpatient Unit | 109 | \$1,856,971.62 | \$17,036.44 |
| Acute Child & Adolescent Inpatient Service | 29 | \$322,345.00 | \$11,115.34 |
| Rehabilitation Hilltop | 23 | \$225,790.30 | \$9,816.97 |
| Rehabilitation Central | 14 | \$141,107.25 | \$10,079.08 |
| Psychiatric Crisis Services | 13 | \$39,461.06 | \$3,035.46 |





Workers' Compensation Severity: Top 5 Divisions

| | Claim Count | Total Incurred | Average Incurred |
|--|-------------|----------------|------------------|
| Acute Adult Inpatient Unit | 109 | \$1,856,971.62 | \$17,036.44 |
| Acute Child & Adolescent Inpatient Service | 29 | \$322,345.00 | \$11,115.34 |
| Rehabilitation Hilltop | 23 | \$225,790.30 | \$9,816.97 |
| Rehabilitation Central | 14 | \$141,107.25 | \$10,079.08 |
| Housekeeping | 2 | \$126,991.96 | \$63,495.98 |





Workers' Compensation Experience Modification Factor

Experience Modification Factor: .93

Minimum Mod: .41

Controllable Mod: .52

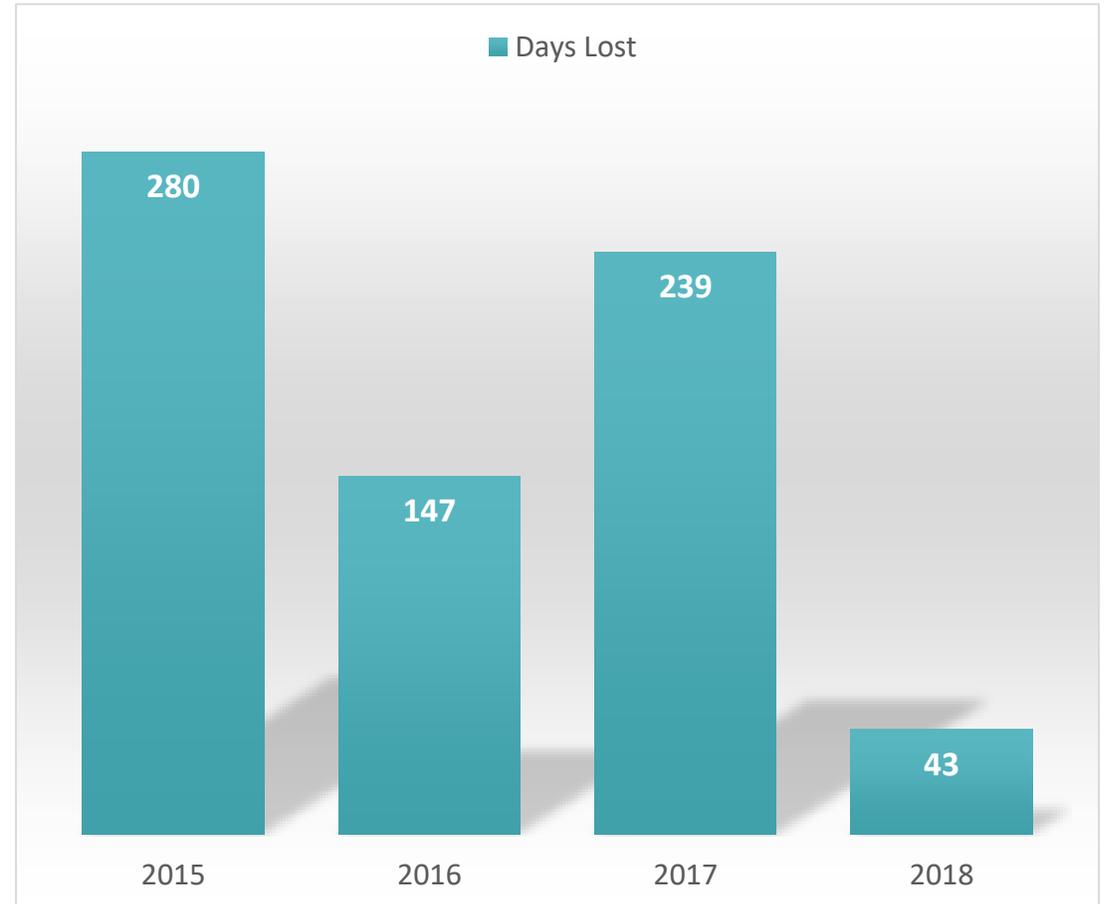
The **Minimum Mod** is payroll information multiplied against job classification rates, or loss experience rates. It is the mod without any losses.

The **Controllable Mod**, or the portion of the mod that you affect with losses, is determined by your specific loss history and different weighting of small and large claims, and claims involving lost time or medicals only.



Workers' Compensation Days Lost – 1/1 thru 12/31

| | DAFW |
|------|------|
| 2015 | 280 |
| 2016 | 147 |
| 2017 | 239 |
| 2018 | 43 |





Workers' Compensation Loss Control Initiatives

- **Milwaukee County Programs & Policies**
 - Utilize Milwaukee County Transitional Duty Program (AMOP 5.05)
 - Utilize Milwaukee County Safety & Health Program (AMOP 5.03)
 - *Development of County Safety Manual*
 - Development of Milwaukee County Occupational Health Programs (Respiratory, Hearing Protection & Bloodborne Pathogens)
- **Milwaukee County Employee Engagement Initiatives**
 - Promotion of Find It Fix It Program – Safety and Property Issues
 - Participation in Joint Safety Committee / VARC
 - Total Health Newsletter
 - 4 Field Safety Staff at Highway/Fleet, Airport, Parks and Zoo.
- **Employee Training**
 - Established OSHA Compliance Training Curriculum for all County employees
 - *Curriculums built in LMS (Learning Management System)*
 - Established County OSHA Compliance Training Database
 - *In-person classes / webinar / hand-outs*
 - Focus on Safe Lifting/Back Injury Prevention
 - Job Safety Analysis (JSA) implementation
 - Focus on Ergonomics for office and field staff
 - Vistelar Conflict Management Training

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

DATE: June 6, 2019

TO: Thomas Lutzow, Chairman – 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

Optimal Operations and Administrative Efficiencies

- **Psychiatric Crisis Redesign**

Corporation Counsel, at the direction of the Mental Health Board Chairman, was asked to provide a legal opinion on Milwaukee County Behavioral Health Division (BHD) crisis responsibilities. Nelson Phillips, Assistant Corporation Counsel, has begun the investigation into this legal question and has had several one-on-one interviews with individuals involved in the day-to-day local crisis legal system. He met with the BHD Administrator on May 31, 2019, when he indicated he planned to collect historical opinions and to also reach out to several regional Counties to compare other interpretations of State law regarding county responsibility related to mental health crisis services. His thorough analysis will require additional time but will likely be ready for the August meeting.

- **Interest Earned on the Behavioral Health Division's Reserve Fund Accounts**

As directed, the BHD Administrator reviewed the issue of interest with the County Executive. The County Executive had no issue with the Mental Health Board seeking County Board approval for the establishment of a trust account to maintain the interest

Optimal Operations and Administrative Efficiencies (Continued)

within BHD. It is my opinion, however, that this would have little benefit to the BHD bottom line as any interest generated into the account would create a deficit elsewhere in the greater County Budget that would likely be filled with a reduction in the BHD tax levy allocation to BHD, given that BHD is currently allocated more than the minimum required under State Statutes. It is also my opinion that bringing this issue to the County Board is very unlikely to end in approval.

- **State Budget/Reimbursement Rates for Mental Health/Alcohol and Other Drug Abuse (AODA) Services**

As directed by Chairman Lutzow, the BHD Administrator was scheduled to meet with Representative Sanfelippo on May 31, 2019, to discuss reimbursement rates and a series of potential revenue enhancements that could positively impact BHD, provide an update on the Mental Health Board's progress, and to solicit his feedback. A last minute conflict emerged, and the meeting was cancelled with the promise of being rescheduled in the future (but at the time of submission of this report, there was no firm date).

As suggested at the previous meeting, the BHD Administrator provided some bullet points to Chairman Lutzow regarding the potential impact of the Governor's Budget, Medicaid Expansion, and the County Executive and County Board's "Fair Deal for Milwaukee" initiative on BHD. A draft for the Board's review is attached (**Attachment A**).

High Quality and Accountable Service Delivery

- **Universal Health Services (UHS)**

On Friday, May 31, 2019, UHS submitted their application to purchase a city-owned parcel in the City of West Allis to build their new 120 bed psychiatric hospital. This location was included in UHS' proposal to the Milwaukee County Mental Health Board but had remained confidential until the submission of the application. The links below connect to news/media articles recently published on the announcement.

[Universal Health Services plan \\$33 million hospital in West Allis](#)

Biz Times

June 3, 2019

[Universal Health Services plans \\$33 million mental health hospital in West Allis](#)

Milwaukee Business Journal

June 3, 2019

Administrative Update

06/06/2019

Page 3

High Quality and Accountable Service Delivery (Continued)

[Proposal submitted for new West Allis Behavioral Health Hospital](#)

CBS 58 News

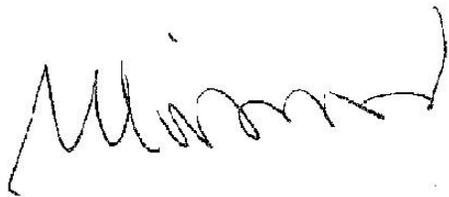
June 3, 2019

[New Behavioral Health Hospital Planned for West Allis](#)

Wisconsin Health News

June 3, 2019

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Mike Lappen". The signature is written in a cursive, flowing style.

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

Attachment A

To: XXXXX XXXXX

From: Milwaukee County Mental Health Board

Date: June, 2019

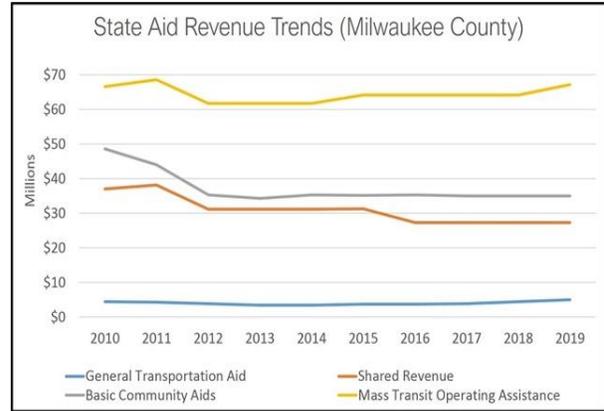
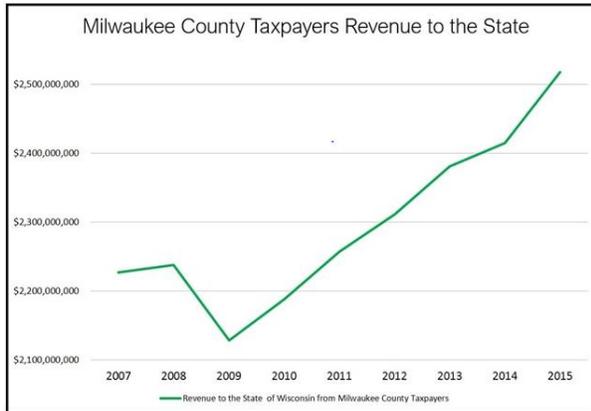
The Milwaukee County Mental Health Board of Directors would like to recognize the effort by so many to restructure the manner in which mental health and behavioral health services are delivered to Milwaukee County residents. This work began more than a decade ago. So many of the dedicated originators of this reform are no longer active; their names are remembered by some, but not all.

The Milwaukee County 51.41 Mental Health Board is attempting to honor and fulfil the promise these reformers made to the community, including for special recognition the Milwaukee County Executive, the Milwaukee County Board of Supervisors, the State of Wisconsin Joint Finance Committee, the State of Wisconsin Committee on Health, and the Governor's office, along with many community groups that include the Mental Health Task Force, the Milwaukee Healthcare Partnership, Disability Rights of Wisconsin, and many others. This planning was bipartisan throughout and has produced outcomes that were only imagined in the beginning.

In its aim to continue fulfilling the promise of this redesign, the Milwaukee County Mental Health Board has recently approved a contract with Universal Health Services to build a new mental health hospital in Milwaukee County. This hospital will be a 120 facility that will serve all southeastern Wisconsin counties and perhaps other counties.

Once this hospital is opened in 2021, BHD inpatient facilities will close and the County's inpatient mental health services will be fully privatized with considerable savings to Milwaukee County tax payers. Along with this opening, the Mental Health Board will need develop a new emergency psychiatric crisis center, additional step-down short-term residential treatments centers, expand community services for delivery of care in least restrictive settings, attract additional caregivers who are appropriately qualified in these disciplines, and strengthen our support of first-responder capabilities at incident locations. The application of the redesign principles includes a combination of reduced expenditures and reallocation resources for improved effectiveness. The Milwaukee County Mental Health Board, however, is projecting a steady decrease over the next five years on local funding to allow this reform to continue:

Given this grave concern, the Milwaukee County Mental Health Board would like to encourage consideration of the observations offered by the Fair Deal for Milwaukee County Committee.



Certainly, the State Legislature and Administration have been thoughtful in making IRIS, Family Care and Family Care Partnership services available to Milwaukee County residential patients with mental health and/or behavioral health conditions. This availability has enabled the partial elimination of BHD facility beds and bed days. Further developments in Medicaid coverage would provide additional means to correct the increasing imbalance in the outflow of resources from Milwaukee County, reducing our ability to cover mental health and behavioral health services within Milwaukee County. The decision to not expand Medicaid has increased dependencies on local subsidies and eliminated coverages that would have improved the imbalance in support:

Missed Opportunity to Strengthen Milwaukee County MI/BH/AODA Services

- \$12.3 million in expanded crisis intervention and telehealth services
- \$14.3 million in prevention of childhood lead poisoning
- \$13 million in expanded access to dental care
- \$219.8 million in the elimination of uninsured Milwaukee County individuals

These and other areas of opportunity address concerns that have come up over the past few years local by stakeholders and advocates. These increases would have gone a long way to protect the reform initiative and community services from future cuts. If not through Medicaid expansion (in one form or another), the Milwaukee County Mental Health Board would like to partner with local and State leadership in finding a way to get closer to the goal of the Fair Deal Committee to reduce the threat to future mental health services in Milwaukee County. For long-term viability of mental health, behavioral health, and AODA programs in Milwaukee County, two things to happen: better and broader reimbursement from the State of Wisconsin Medicaid program and increased shared revenue County wide. The Milwaukee County Mental Health Board of Directors, each appointed by the previous Governor of the State of Wisconsin and then reconfirmed by the current Milwaukee County Executive, ask that you share our concern about the gap in resources for Milwaukee County’s patients with mental health and/or behavioral health conditions.

Milwaukee County Mental Health Board of Directors:

| | |
|---|---|
| Signature: _____ Name: Robert Curry | Signature: _____ Name: Jon Lehrmann |
| Signature: _____ Name: Michael Davis | Signature: _____ Name: Thomas Lutzow |
| Signature: _____ Name: Kathie Eilers | Signature: _____ Name: Mary Neubauer |
| Signature: _____ Name: Rachel Forman | Signature: _____ Name: Maria Perez |
| Signature: _____ Name: Sheri Johnson | Signature: _____ Name: Duncan Shrout |
| Signature: _____ Name: Walter Lanier | Signature: _____ Name: Brenda Wesley |

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: June 5, 2019

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 2019 Purchase-of-Service Contract Amendments 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 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

IMPACT Alcohol & Other Drug Abuse Services, Inc. - \$254,706

The Vendor provides Access Point Services. The Access Point (AP) program is designed to provide individuals and families a welcoming and comprehensive approach to the universal screening and assessment of needs and aligning those needs with the available services throughout Milwaukee County. BHD is requesting an additional \$254,706 for 2019. The total contract amount will be \$509,412 for 2019.

M&S Clinical Services, Inc. - \$274,150

The Vendor provides Access Point Services. The Access Point (AP) program is designed to provide individuals and families a welcoming and comprehensive approach to the universal screening and assessment of needs and aligning those needs with the available services throughout Milwaukee County. BHD is requesting an additional \$274,150 for 2019. The total contract amount will be \$548,000 for 2019.

Our Space, Inc. - \$15,000

The Vendor provides Peer Run Respite (PRR) Services for CARS. Peer Run Respite (PRR) is intended to serve as a short-term, respite resource for individuals who are experiencing an increase in symptoms, or life needs, and who are in need of support and services to aid in their recovery and thereby avert crises and prevent hospitalization. BHD is asking for an additional \$15,000 for 2019 to cover start-up costs for the program that were not utilized in 2018. The total contract amount will be \$415,000.

Wisconsin Community Services - \$157,756

The Vendor provides Access Point Services. The Access Point (AP) program is designed to provide individuals and families a welcoming and comprehensive approach to the universal screening and assessment of needs and aligning those needs with the available services throughout Milwaukee County. BHD is requesting an additional \$157,756 for 2019. The total contract amount will be \$315,512 for 2019.

Fiscal Summary

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

| Vendor Name | New/Amendment | 2019 Increase Amount | Total Contract Amount |
|--|----------------------|-----------------------------|------------------------------|
| IMPACT Alcohol & Other Drug Abuse Services, Inc. | Amendment | \$254,706 | \$509,412 |
| M&S Clinical Services, Inc. | Amendment | \$274,150 | \$548,000 |
| Our Space, Inc. | Amendment | \$15,000 | \$415,000 |
| Wisconsin Community Services, Inc. | Amendment | \$157,756 | \$315,512 |
| Total | | \$701,612 | \$1,787,924 |

*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: June 5, 2019

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 2019 Fee-for-Service Agreements 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 2019.

Background

Approval of the recommended contract allocation **projections** 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.

Fee-for-Service Agreements

Genesis Behavioral Services, Inc. – 141,000

The Vendor plans to provide the Targeted Case Management (TCM) services that are currently provided by Horizon Healthcare, Inc. (Horizon) effective October 1, 2019 when the current Horizon agreement for TCM ends on 9/30/2019. TCM is a community-based service for those with severe and persistent mentally illness in the CARS network. These case management services are designed to allow individuals to maintain as much independence in the community as possible by providing assistance with psychiatric services, medical appointments, housing, family and social issues. BHD is requesting an additional \$141,000 for 2019. The total contract amount will be \$2,613,944 for 2019.

Mindstar Counseling, LLC - \$40,000

The Vendor provides Individual/Family Therapy, Individual/Family AODA counseling, Psychological Evaluation Services and Group counseling & Therapy for the Wraparound Milwaukee Program. BHD is requesting an additional \$40,000 for 2019 to add youth Comprehensive Community Services. The total contract amount will be \$330,035.00 for 2019.

Wisconsin Community Services - \$996,000

The Vendor provides Individual/Family Psychoeducation, Substance Abuse Treatment, In-Home AODA/Substance Abuse Counseling, and Psychoeducational Support Group-ART for the Wraparound Milwaukee Program. BHD is requesting an additional \$996,000 for 2019 to add Type II, State Licensed Residential Services and Multisystemic Therapy through Bakari House. Wraparound Milwaukee will pay the daily rate that is set by the State of Wisconsin for the Residential Services. The total contract amount will be \$1,224,000 for 2019.

The following Fee for Service Agreements are for Comprehensive Community Services (CCS) Medicaid increases**Access Recovery Mental Health Services – \$180,000**

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$180,000 for 2019. The total contract amount will be \$694,000 for 2019.

Alternatives Family Services, LLC - \$4,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$4,000 for 2019. The total contract amount will be \$159,000 for 2019.

Alternatives in Psychological Consultation, S.C. – \$327,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$327,000 for 2019. The total contract amount will be \$4,768,512.67 for 2019.

Bell Therapy, Inc. (Phoenix Care Systems, Inc.) – \$940,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$940,000 for 2019. The total contract amount will be \$13,944,725 for 2019.

Benedict Center, Inc. – \$36,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$36,000 for 2019. The total contract amount will be \$124,000 for 2019.

Column Rehab Services, Inc. – \$30,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$30,000 for 2019. The total contract amount will be \$110,000 for 2019.

Creative Counseling of Milwaukee, LLC – \$270,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$270,000 for 2019. The total contract amount will be \$368,000 for 2019.

Great Lakes Dryhootch, Inc. – \$280,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$280,000 for 2019. The total contract amount will be \$330,000 for 2019.

Easter Seals Southeast WI, Inc. – \$52,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$52,000 for 2019. The total contract amount will be \$708,000 for 2019.

Goodwill Industries of Southeastern Wisconsin – \$49,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$49,000 for 2019. The total contract amount will be \$686,236 for 2019.

Guest House of Milwaukee – \$510,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$510,000 for 2019. The total contract amount will be \$3,030,000 for 2019.

Jewish Family Services, Inc. – \$110,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$110,000 for 2019. The total contract amount will be \$370,000 for 2019.

Justice Point, Inc. – \$29,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$29,000 for 2019. The total contract amount will be \$4,837,551 for 2019.

Kajsiab Senior Center, Inc. – \$60,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$60,000 for 2019. The total contract amount will be \$170,000 for 2019.

Mental Health America of Wisconsin, Inc. – \$10,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$10,000 for 2019. The total contract amount will be \$160,000 for 2019.

Milwaukee Mental Health Associates, Inc. – \$488,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$488,000 for 2019. The total contract amount will be \$932,000 for 2019.

Our Space, Inc. – \$10,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$10,000 for 2019. The total contract amount will be \$195,393.90 for 2019.

Outreach Community Health Centers, Inc. – \$110,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$110,000 for 2019. The total contract amount will be \$1,145,619.93 for 2019.

Professional Services Group, Inc. – 440,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$440,000 for 2019. The total contract amount will be \$763,000 for 2019.

Project Access, Inc. – \$340,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$340,000 for 2019. The total contract amount will be \$1,212,000 for 2019.

Sebastian Family Psychology Practice, LLC – \$50,000

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$50,000 for 2019. The total contract amount will be \$725,000 for 2019.

Summit Wellness, Inc. – \$857,748

The Vendor provides Comprehensive Community Services (CCS), a voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and requests. BHD is requesting an additional \$857,748 for 2019. The total contract amount will be \$2,022,000 for 2019.

The following Fee for Service Agreements are for Recovery Support Coordination (RSC). On March 1, 2019, Community Access to Recovery Services (CARS) released a Request for Proposal (RFP) to solicit Community interest in doing the RSC program for the CARS network. Based on the results of the RFP, CARS would like to award the following Vendors a contract

Justice Point, Inc. - \$920,000

The Vendor will provide Recovery Support Coordination (RSC) services, which are designed to provide individuals with substance use disorders and their families support in their recovery and help them live fulfilling lives in the community. The program can achieve this by helping to facilitate treatment, outreach, intervention, multi-system collaboration, and recovery support services that are gender and culturally responsive. RSCs offer services to various target populations including, but not limited to: pregnant women coping with a substance use disorder, families with minor children, IV drug users, and individuals receiving Medicated-Assisted Treatment (MAT). BHD is requesting an additional \$920,000 for 2019. The total contract amount will be \$5,728,551 for 2019.

La Causa, Inc. - \$540,000

The Vendor will provide Recovery Support Coordination (RSC) services, which are designed to provide individuals with substance use disorders and their families support in their recovery and help them live fulfilling lives in the community. The program can achieve this by helping to

facilitate treatment, outreach, intervention, multi-system collaboration, and recovery support services that are gender and culturally responsive. RSCs offer services to various target populations including, but not limited to: pregnant women coping with a substance use disorder, families with minor children, IV drug users, and individuals receiving Medicated-Assisted Treatment (MAT). BHD is requesting an additional \$540,000 for 2019. The total contract amount will be \$4,849,895 for 2019.

St. Charles Youth and Family Services, Inc. - \$440,000

The Vendor will provide Recovery Support Coordination (RSC) services, which are designed to provide individuals with substance use disorders and their families support in their recovery and help them live fulfilling lives in the community. The program can achieve this by helping to facilitate treatment, outreach, intervention, multi-system collaboration, and recovery support services that are gender and culturally responsive. RSCs offer services to various target populations including, but not limited to: pregnant women coping with a substance use disorder, families with minor children, IV drug users, and individuals receiving Medicated-Assisted Treatment (MAT). BHD is requesting an additional \$440,000 for 2019. The total contract amount will be \$600,000 for 2019.

United Community Center - \$490,000

The Vendor will provide Recovery Support Coordination (RSC) services, which are designed to provide individuals with substance use disorders and their families support in their recovery and help them live fulfilling lives in the community. The program can achieve this by helping to facilitate treatment, outreach, intervention, multi-system collaboration, and recovery support services that are gender and culturally responsive. RSCs offer services to various target populations including, but not limited to: pregnant women coping with a substance use disorder, families with minor children, IV drug users, and individuals receiving Medicated-Assisted Treatment (MAT). BHD is requesting an additional \$490,000 for 2019. The total contract amount will be \$2,332,446 for 2019.

Wisconsin Community Services, Inc. - \$460,000

The Vendor will provide Recovery Support Coordination (RSC) services, which are designed to provide individuals with substance use disorders and their families support in their recovery and help them live fulfilling lives in the community. The program can achieve this by helping to facilitate treatment, outreach, intervention, multi-system collaboration, and recovery support services that are gender and culturally responsive. RSCs offer services to various target populations including, but not limited to: pregnant women coping with a substance use disorder, families with minor children, IV drug users, and individuals receiving Medicated-Assisted Treatment (MAT). BHD is requesting an additional \$460,000 for 2019. The total contract amount will be \$3,195,848 for 2019.

Fiscal Summary

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

| Vendor Name | New/Amendment | 2018 Contract Amount | 2019 Contract Amount | 2019 Request for Increase Amount | Total Contract Amount |
|---|---------------|----------------------|----------------------|----------------------------------|-----------------------|
| Genesis Behavioral Services, Inc. | Amendment | \$851,472 | \$770,000 | \$141,000 | \$3,465,416 |
| Mindstar Counseling, LLC | Amendment | \$170,035.00 | \$120,000 | \$40,000 | \$330,035.00 |
| Wisconsin Community Services, Inc. | Amendment | \$152,000 | \$76,000 | \$996,000 | \$1,224,000 |
| Alternative Family Services, LLLC | Amendment | \$99,000 | \$56,000 | \$4,000 | \$159,000 |
| Alternatives in Psychological Consultation, SC | Amendment | \$2,228,512.67 | \$2,213,000 | \$327,000 | \$4,468,512.67 |
| Bell Therapy, Inc. (Phoenix Care Systems, Inc.) | Amendment | 6,289,724.17 | 6,715,000 | \$940,000 | \$13,944,725 |
| Benedict Center, Inc. | Amendment | \$44,000 | \$44,000 | \$36,000 | \$124,000 |
| Column Rehab Services, Inc. | Amendment | \$40,000 | \$40,000 | \$30,000 | \$110,000 |
| Great Lakes Dryhooch, Inc. | Amendment | \$20,000 | \$30,000 | \$280,000 | \$330,000 |
| Easter Seals Southeast WI, Inc. | Amendment | \$328,000 | \$328,000 | \$52,000 | \$708,000 |
| Goodwill Industries of Southeastern Wisconsin | Amendment | \$336,236 | \$301,000 | \$49,000 | \$686,236 |
| Guest House of Milwaukee | Amendment | \$1,260,000 | \$1,260,000 | \$510,000 | \$3,030,000 |
| Jewish Family Services, Inc. | Amendment | \$130,000 | \$130,000 | \$110,000 | \$370,000 |
| Justice Point, Inc. | Amendment | \$2,747,551 | \$2,061,000 | \$29,000 | \$4,837,551 |
| Kajsiab Senior Center, Inc. | Amendment | \$55,000 | \$55,000 | \$60,000 | \$170,000 |

| Vendor Name | New/Amendment | 2018 Contract Amount | 2019 Contract Amount | 2019 Request for Increase Amount | Total Contract Amount |
|--|---------------|----------------------|----------------------|----------------------------------|-----------------------|
| Mental Health America of Wisconsin, Inc. | Amendment | \$20,000 | \$130,000 | \$10,000 | \$160,000 |
| Milwaukee Mental Health Associates, Inc. | Amendment | \$222,000 | \$222,000 | \$488,000 | \$932,000 |
| Our Space, Inc. | Amendment | \$170,000 | \$15,393.90 | \$10,000 | \$195,393.90 |
| Outreach Community Health Centers, Inc. | Amendment | \$535,619.93 | \$500,000 | \$110,000 | \$1,145,619.93 |
| Professional Services Group, Inc. | Amendment | \$170,000 | \$153,000 | \$440,000 | \$763,000 |
| Project Access, Inc. | Amendment | \$440,000 | \$432,000 | \$340,000 | \$1,212,000 |
| Sebastian Family Psychology Practice, LLC | Amendment | \$350,000 | \$325,000 | \$50,000 | \$725,000 |
| Summit Wellness, Inc. | Amendment | \$402,252 | \$762,000 | \$857,748 | \$2,022,000 |
| Access Recovery Mental Health Services | Amendment | \$257,000 | \$180,000 | \$180,000 | \$694,000 |
| Creative Counseling of Milwaukee, LLC | Amendment | N/A | \$98,000 | \$270,000 | \$368,000 |
| Justice Point, Inc.* | Amendment | \$2,747,551 | \$2,061,000 | \$920,000 | \$5,728,551 |
| La Causa, Inc.* | Amendment | \$2,521,895 | \$1,788,000 | \$540,000 | \$4,849,895 |
| St. Charles Youth and Family Services, Inc.* | Amendment | \$80,000 | \$80,000 | \$440,000 | \$600,000 |
| United Community Center* | Amendment | \$1,709,446 | \$133,000 | \$490,000 | \$2,332,446 |
| Wisconsin Community Services, Inc.* | Amendment | \$1,367,924 | \$1,367,924 | \$460,000 | \$3,195,848 |

| Vendor Name | New/Amendment | 2018 Contract Amount | 2019 Contract Amount | 2019 Request for Increase Amount | Total Contract Amount |
|-------------|---------------|----------------------|----------------------|----------------------------------|-----------------------|
| | | \$25,725,219 | \$21,078,394 | \$9,209,748 | \$58,881,230 |

*Denotes a Vendors whose funding is supported by a grant

Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

**Milwaukee County BHD
Preliminary 2020 Budget Presentation
June 6th, 2019**

**2020 BHD Budget
(\$millions)**

Initial Budget Gap

| | |
|-------------------------|--------------|
| Reduction Target | (2.8) |
| CtC Salaries | (0.4) |
| Cost to Continue | (3.2) |

Major Revenue Variances

| | |
|-----------------|-----|
| Patient Revenue | 3.0 |
| WIMCR | 1.3 |
| Grant Increases | 2.4 |

Major Expense Variances

| | |
|--------------------------------------|-------|
| CRC3 and CRC Savings | (0.5) |
| Access Point RFP | (0.5) |
| Recovery Support Coordination RFP | (0.2) |
| Oxford House | 0.2 |
| FQHC Partnerships | 0.3 |
| Inpatient Staffing | 0.5 |
| Security Increase | 0.6 |
| CSP Adjustment | 0.7 |
| State Institutes | 1.2 |
| Community-Based Residential Increase | 1.2 |

Revenue Subtotal **6.7**

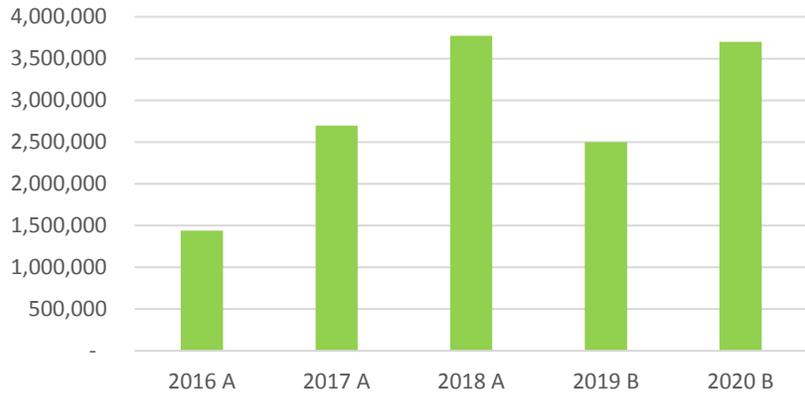
Expense Subtotal **3.5**

Current Budget Gap **(0)**

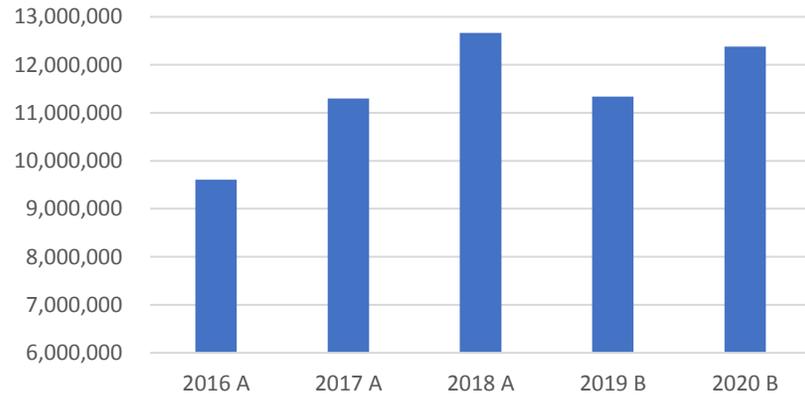
Milwaukee County WIMCR Payments

| | <i>Budget (Receipt) Year</i> | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 B | 2020 B |
|---|------------------------------|------------------|------------------|------------------|------------------|------------------|--------------------|--------------------|
| | <i>Settlement Year</i> | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
| Program Name | WIMCR Payment | WIMCR Payment | WIMCR Payment | WIMCR Payment | WIMCR Payment | WIMCR Payment | 2019 Budget | 2020 Budget |
| Crisis Stabilization Services | 1,985,601 | 1,055,935 | 763,838 | 1,565,191 | 3,430,761 | 2,100,000 | 2,142,000 | |
| Day Treatment | 149,305 | 237,923 | 71,110 | 121,413 | 117,809 | | | |
| TCM- Targeted Case Management | 488,676 | 76,852 | | 574,940 | 1,048,603 | 400,000 | 1,000,000 | |
| CSP - Community Support Program | 2,102,755 | | 777,419 | 0 | (988,048) | 630,000 | 777,418 | |
| CRS - Community Recovery Services | | | | | 263,345 | | | |
| CCS - Comprehensive Community Services | | | 129,933 | 2,206,204 | 2,430,890 | 2,000,000 | 2,500,000 | |
| | 4,726,338 | 1,370,710 | 1,742,300 | 4,467,748 | 6,303,360 | 5,130,000 | 6,419,418 | |

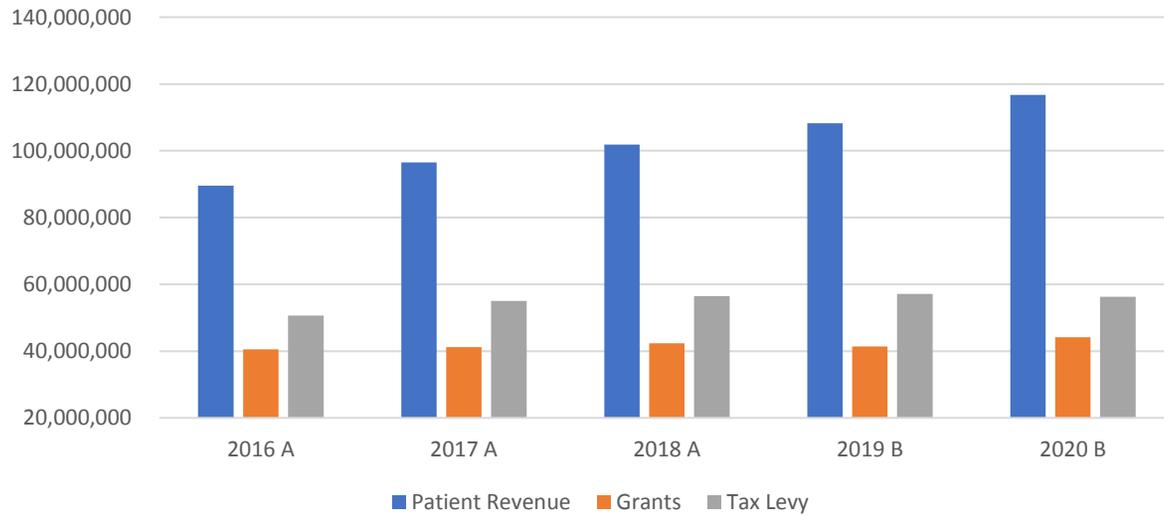
Milwaukee County BHD
State Institute Spending History



Milwaukee County BHD
Residential Facility Spending History



Milwaukee County BHD
Revenue History



Attachment A

**BUDGET RECOMMENDATION FORM
2020 REQUESTED BUDGET
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION**



Please send completed recommendation forms to:
Maria Perez, PhD (Maria.Perez@milwaukeecountywi.gov) &
Matt Fortman (Matthew.Fortman@milwaukeecountywi.gov)

Title:

MCMHB Sponsor:

Narrative Description:

Anticipated Financial Impact of Recommendation:

| Description | Revenue | Expense | Tax Levy |
|--------------|---------|---------|----------|
| | - | - | - |
| | - | - | - |
| | - | - | - |
| | - | - | - |
| | - | - | - |
| | - | - | - |
| | - | - | - |
| | - | - | - |
| Total | - | - | - |

B U D G E T S U M M A R Y

| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance** |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|
| Expenditures | | | | | |
| Personnel Costs | \$60,127,406 | \$64,418,840 | \$69,594,171 | \$70,112,735 | \$518,564 |
| Operations Costs | \$127,344,973 | \$133,196,938 | \$134,113,489 | \$143,718,079 | \$9,604,590 |
| Debt & Depreciation | \$0 | \$0 | \$0 | \$0 | \$0 |
| Capital Outlay | \$95,869 | \$110,056 | \$200,000 | \$100,000 | (\$100,000) |
| Interdept Charges | \$5,194,962 | \$2,915,144 | \$2,888,459 | \$2,627,823 | (\$260,636) |
| Total Expenditures | \$192,763,210 | \$200,640,978 | \$206,796,118 | \$216,558,637 | \$9,762,519 |
| Revenues | | | | | |
| Direct Revenue | \$96,489,177 | \$101,822,123 | \$108,264,629 | \$118,532,240 | \$10,267,611 |
| Intergov Revenue | \$41,228,830 | \$42,348,233 | \$41,400,097 | \$44,143,221 | \$2,743,124 |
| Total Revenues | \$137,718,007 | \$144,170,356 | \$149,664,726 | \$162,675,461 | \$13,010,735 |
| Tax Levy | | | | | |
| Tax Levy | \$55,045,203 | \$56,470,622 | \$57,131,392 | \$53,843,176 | (\$3,288,216) |
| Effective Tax Levy* | \$23,011,845 | \$23,283,433 | \$18,630,502 | \$15,823,374 | (\$2,807,128) |
| Impact on Reserves Increase/(Decrease) | \$2,340,507 | \$0 | (\$351,697) | (\$151,697) | \$200,000 |
| Personnel | | | | | |
| Full-Time Pos.(FTE) | 539.0 | 505.15 | 486.3 | 477.3 | (9.0) |
| Seas/Hourly/Pool Pos. | 14.6 | 24.3 | 20.0 | 23.6 | 3.6 |
| Overtime\$ | \$2,359,378 | \$2,433,039 | \$618,000 | \$767,028 | \$149,028 |

* Effective Tax Levy excludes interdepartmental charges and fringe benefit costs.

** Rounding differences exist in variance numbers.

Department Vision: Together, creating healthy communities

Department Mission: Empowering safe, healthy and meaningful lives

Department Description: The Behavioral Health Division (BHD) consists of Management and Support Services, Psychiatric Crisis ER/Observation, Adult and Child Acute Inpatient Services, Community Services Branch & Wraparound Milwaukee.

Executive Summary: For Milwaukee County, the 2020 budget cycle continues to face the realities of costs growing faster than revenues. To assist in bridging the budget gap, all departments were given a targeted reduction of their operating expenditures from the 2019 Adopted Budget. For the Behavioral Health Division, that reduction is \$2.7m. This reduction to the budget is accomplished through numerous adjustments to revenue and expenses across the department.

2020 funding for behavioral health services are enhanced and expanded in the following areas:

- \$6.0m increased spending in the Comprehensive Community Service (CCS) Adult and Children's program with a projected enrollment of 1,780 by the end of 2020.
- \$1.0m to fund ongoing community placements in residential settings for adult consumers with complex needs.
- \$1.2m to fund ongoing placements at Mendota and Winnebago Mental Health Institutes.
- A third Crisis Resource Center (CRC) location.
- \$0.2m to fund Oxford House, a safe, sober home environment for individuals in recovery from alcohol and other substances.
- Additional funding for mental health services in collaboration with area Federally Qualified Health Centers.
- Increased budget for inpatient and psychiatric emergency room staffing of \$0.6m
- Enhanced security at the Mental Health Complex at a cost of \$0.6m

Strategic Program Area 1: Management & Support Services

Service Provision: **Administrative**

Strategic Outcome: **High Quality, Responsive Services**

| What We Do: Activity Data | | | | |
|--|-------------|-------------|-------------|-------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target |
| This program area does not have activity data. | | | | |

| How We Do It: Program Budget Summary | | | | | |
|--------------------------------------|-------------|-------------|---------------|---------------|--------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$309,246 | (\$148,586) | (\$1,697,002) | (\$1,697,003) | (\$1) |
| Revenues | \$316,340 | \$279,039 | \$302,997 | \$302,997 | \$0 |
| Tax Levy | (\$7,094) | (\$427,625) | (\$1,999,999) | (\$2,000,000) | (\$1) |
| FTE Positions | 138.6 | 143.3 | 126.0 | 124.0 | (2.0) |

| How Well We Do It: Performance Measures | | | | |
|--|-------------|-------------|-------------|-------------|
| Performance Measure | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target |
| Revenue dollars/fiscal staff | \$5,553,145 | \$6,931,267 | \$6,288,434 | \$7,113,311 |
| Patient revenue collected/Billed revenue | 36.6% | 41.7% | 45.1% | 54.3% |

Strategic Overview: Management and Support Services provides fiscal management, compliance, and administration.

Strategic Implementation: The actual expenditures budgeted in this area are \$30.9m, which is allocated out to the direct service areas. There is a net reduction of 2.0 FTEs in Management and Support Services, with some positions added and some vacant positions abolished. There is a reduction of \$1.0m in overall personnel costs due to a shift in legacy fringe allocation between departments (\$.7m) and a decrease in employee merit increase funds (\$.3m). A \$2.0m general expenditure reduction is added to this strategic area to budget cost savings or potential reserve contributions, which may be actualized by the Department in 2020.

Expenditures for security increased \$.6m over 2019 Budget in order to continue contracting for security services. Utility cost increases of \$0.2m are partially offset by (\$.1m) reduction in capital expenditures for building maintenance expenses.

A Focus on Quality:

The Behavioral Health Division (BHD) will strategically foster partnerships and participate in an enhanced and integrated community-based behavioral health system of care in 2020. Our vision will include the promotion of early crisis intervention and prevention, as to enhance individuals' access to care, while providing crisis options and community-based locations with warmer front doors. Our system of care will support strength-based interventions, will be needs driven while ensuring linkages and coordination of a Quality, and a value-based network of provider services. Ultimately, more individuals with behavioral health needs throughout Milwaukee County will be served through financially sustainable models of care in support of the **"Right Care, Right Place, Right Time."**

BHD will continue to transform into a community system of care in 2020 with an emphasis on:

- Racial equity.
- Quality and safety.
- Client experience of care.
- Streamlined access to help.
- Workforce development and training.
- Building trusting relationships with stakeholders.
- Building network service capacity, identifying racial equity gaps, and broader community-based solutions.
- Long-term fiscal sustainability and cost efficiencies.

Behavioral Health Division (BHD) Quality Management Services will continue to be strengthened in 2020 to assure ongoing excellence in the quality and safety of care as to meet clients' needs. We will define quality as a collective measure of excellence in BHDs (and our network) systems, processes, staff and provider performance, decisions, and human interactions. The overarching organizational aim we are undertaking in this and the next quality plan biennium is to align our Quality Program Structure, Management, and Knowledge Base to a customer-driven, performance based, innovation rewarding, and self-learning paradigm. BHD, our staff, partners, and the Milwaukee County Mental Health Board (MCMHB) will continue to demonstrate a commitment to improving the health of clients and ultimately the health of our community.

To truly transform into a healthcare system of high reliability, excellent client experience, and quality and safety, the Behavioral Health Division (BHD) will engage in purposeful activities in support of a quality journey. Mental Health Board governance and BHD Leadership will remain committed to quality care and services, including increased efforts to delineate contract performance expectations and increased monitoring, fostering a culture of safety, and supporting a continuous learning environment with an on-going emphasis on performance improvement. Efforts to centralize BHD quality-related functions with an emphasis on an enhanced community-based system of care and client outcomes, incorporating measurement targets, data, technology and benchmarks are the hallmarks of these continued efforts. Plans to eliminate barriers and individual program and department silos in favor of an integrated system of care and coordinated quality activities are currently underway. The goals will include strengthening the quality approach to increase operational efficiency, support an environment of safety, reduce cost, and create a community-based healthcare system.

Strategic Program Area 2: Psychiatric Crisis ER/Observation

Service Provision: Mandated

Strategic Outcome: High Quality, Responsive Services

| What We Do: Activity Data | | | | |
|---|-------------|-------------|-------------|-------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target |
| <i>Psychiatric Emergency Department</i> | | | | |
| Admissions | 8,001 | 7,375 | 8,000 | 8,250 |

| How We Do It: Program Budget Summary | | | | | |
|--------------------------------------|--------------|--------------|--------------|--------------|--------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$17,925,676 | \$16,963,438 | \$17,328,003 | \$18,335,060 | \$1,007,057 |
| Revenues | \$9,478,667 | \$8,921,538 | \$9,235,541 | \$8,959,547 | (\$275,994) |
| Tax Levy | \$8,447,009 | \$8,041,900 | \$8,092,462 | \$9,375,513 | \$1,283,051 |
| FTE Positions | 75.3 | 60.3 | 59.0 | 60.0 | 1.0 |

| How Well We Do It: Performance Measures | | | | |
|--|-------------|-------------|-------------|-------------|
| Performance Measure | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target |
| Percent of clients returning to PCS within 30 days | 23.1% | 24.0% | 24.0% | 24.0% |
| Percent of Time on Waitlist Status | 75% | 83.2% | 60.0% | 80.0% |

Strategic Overview: Psychiatric Crisis ER/Observation includes:

- Psychiatric Crisis Service (PCS) Emergency Room: PCS is a 24-hour a day, seven days a week psychiatric emergency room. This component of BHD’s 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.
- Observation Unit: Consumers may be placed on Observation Status as an alternative to inpatient hospitalization when they are experiencing a mental health crisis and need brief intensive assessment and treatment. The Observation Unit is designed to provide crisis intervention and stabilization services that are less than 48 hours in duration.

Strategic Implementation: Budgeted Patient Revenue for the Emergency Room and Observation Unit decreases \$0.3m in 2020 to reflect current experience.

Personnel expenses increase by \$1.0m due to the increased cost of Psychiatrists of \$0.4m and legacy pension and health care costs of \$0.6m. There is a net increase of 1.0 FTE due to the reallocation of Psych Tech and Certified Nursing Assistant positions across the hospital.

Strategic Program Area 3: Inpatient Services (Adult and Children)

Service Provision: Mandated

Strategic Outcome: Self-sufficiency

| What We Do: Activity Data | | | | | |
|---|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| <i>Acute Adult Inpatient</i> | | | | | |
| Average Daily Census | 42.8 | 41.8 | 44 | 44 | 0 |
| Number of Admissions | 656 | 770 | 700 | 700 | 0 |
| Number of Patient Days | 15,648 | 15,272 | 16,100 | 16,100 | 0 |
| Average Length of Stay (Days) | 24 | 23 | 23 | 23 | 0 |
| <i>Child and Adolescent Inpatient Services</i> | | | | | |
| Average Daily Census | 8.6 | 7.5 | 8 | 8 | 0 |
| Number of Admissions | 709 | 644 | 650 | 650 | 0 |
| Number of Patient Days | 3,146 | 2,734 | 3,000 | 3,000 | 0 |
| Average Length of Stay (Days) | 4.4 | 4.2 | 4.5 | 4.5 | 0 |

| How We Do It: Program Budget Summary | | | | | |
|---|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$37,481,336 | \$37,903,846 | \$37,523,610 | \$39,048,294 | \$1,524,684 |
| Revenues | \$14,626,499 | \$15,547,280 | \$16,488,612 | \$20,408,055 | \$3,919,443 |
| Tax Levy | \$22,854,837 | \$22,356,566 | \$21,034,998 | \$18,640,239 | (\$2,394,759) |
| FTE Positions | 185.0 | 159.75 | 153.5 | 143.0 | (10.50) |

| How Well We Do It: Performance Measures | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Performance Measure | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| Acute Adult Inpatient | | | | | |
| Percent of clients returning to Acute Adult within 30 days | 7.7% | 6.6% | 10% | 10% | 0% |
| Patients Responding Positively to Satisfaction Survey | 73.8% | 74.8% | 75% | 75% | 0% |
| Child and Adolescent Inpatient Services | | | | | |
| Percent of children who return to CAIS within 30 days | 12.3% | 12.4% | 12% | 12% | 0% |
| Patients Responding Positively to Satisfaction Survey | 71.3% | 71.1% | 75% | 75% | 0% |

Strategic Overview: BHD's inpatient services are provided in four licensed psychiatric hospital units with three specialized programs for adults and one specialized unit for children and adolescents. Adult units include one 16 bed adult unit called the Acute Treatment Unit (ATU), one 16 bed Women's Treatment Unit (WTU), and one 16 bed Intensive Treatment Unit (ITU). A total of 48 adult beds will be available in 2020 with a projected 90% occupancy rate. All units provide inpatient care to individuals who require safe, secure, short-term, or occasionally extended psychiatric hospitalization. A multi-disciplinary team approach of psychiatry, psychology, nursing, social service, and rehabilitation therapy provides assessment and treatment. This approach is designed to stabilize any patient with acute psychiatric needs and assist the return of the patient to their own community. The ATU program is the primary area for a variety of students including psychiatric residents, medical students, and nursing students to gain experience in the care of individuals who require inpatient care. The WTU program provides specialized services for women recovering from complex and co-occurring severe mental health disorders. The ITU program provides a safe, supportive environment for those individuals with mental health conditions who are at high risk for aggressive behavior and in need of intensive behavioral and pharmacological interventions. The Child and Adolescent (CAIS) unit provides inpatient care to individuals age 18 and under. The CAIS unit also provides emergency detention services for Milwaukee County, as well as inpatient screening for Children's Court.

Strategic Implementation: Inpatient expenditures increase \$1.5m in the 2020 Budget. The budget for State Institutes increases by \$1.2m to reflect current trends in spending. Personnel cost increases include an increase of \$0.1m for overtime and an increase of \$0.2m for temporary physician services to provide additional coverage on the inpatient units. The budget for Certified Nursing Assistants (CNA) and Psych Techs is adjusted for 2020 to reflect the continued usage of CNAs on the Inpatient Units. The 10.50 reduction of FTEs is the result of moving staff within departments and abolishing vacant positions.

In 2020, patient revenue increases by \$3.4m primarily related to the increase in Medicaid HMO clients. Disproportionate Share Hospital (DSH) revenue is increases by \$0.5m for a total revenue increase of \$3.9m.

Strategic Program Area 4: Community Access to Recovery Services Division (CARSD)

Service Provision: Mandated

Strategic Outcome: Self-Sufficiency/Quality of Life

| How We Do It: Program Budget Summary | | | | | |
|---|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$82,707,109 | \$89,914,819 | \$98,366,305 | \$102,950,860 | \$4,584,555 |
| Revenues | \$58,433,197 | \$64,089,966 | \$68,235,948 | \$75,336,738 | \$7,100,790 |
| Tax Levy | \$24,273,912 | \$25,824,853 | \$30,130,357 | \$27,614,122 | (\$2,516,235) |
| FTE Positions | 102.1 | 99.80 | 102.3 | 105.8 | 3.5 |

| How Well We Do It: Performance Measures | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Performance Measure | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| Average Satisfaction Survey Score | 78.9% | 77.4% | 78% | 78% | 0% |
| Percent with any emergency room utilization | 14.5% | 14.6% | 10% | 10% | 0% |
| Percent Homeless | 7.4% | 9.18% | 6.8% | 6.8% | 0% |
| Percent Employed | 16.35% | 20.06% | 18.25% | 18.25% | 0% |

Strategic Overview:

CARSD consists of two program areas:

1. Community Mental Health and Community Crisis Services
2. Community AODA Services

Strategic Implementation: Community Access to Recovery Services (CARS) is the community-based mental health and substance abuse system for adults in Milwaukee County. CARS provides a variety of services to help adults with mental illness achieve the greatest possible independence and quality of life by assessing individual needs and facilitating access to appropriate community services and supports. CARS is committed to fostering independence, choice, and hope for individuals by creating an array of services that are person-centered, recovery oriented, trauma informed, and culturally intelligent. The 2020 Budget sustains investment in community-based mental health care with an emphasis on recovery.

CARS: Community Mental Health and Community Crisis Services

| What We Do: Activity Data | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|-----------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | Variance |
| <i>Crisis Mobile Team</i> | | | | | |
| Mobiles Completed | 2,898 | 3,337 | 3,504 | 3,600 | 96 |
| <i>Targeted Case Management</i> | | | | | |
| Average Enrollment | 1,715 | 1,566 | 1,602 | 1,602 | 0 |
| <i>Community Support Program</i> | | | | | |
| Average Enrollment | 1,359 | 1,320 | 1,300 | 1,300 | 0 |
| <i>Comprehensive Community Services</i> | | | | | |
| Year-End Enrollment | 745 | 922 | 1,200 | 1,430 | 230 |

| How We Do It: Program Budget Summary | | | | | |
|---|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$66,879,552 | \$73,672,957 | \$82,748,105 | \$87,702,871 | \$4,954,766 |
| Revenues | \$46,514,742 | \$51,484,921 | \$56,686,212 | \$61,777,043 | \$5,090,831 |
| Tax Levy | \$20,364,810 | \$22,188,036 | \$26,061,893 | \$25,925,828 | (\$136,065) |

| How Well We Do It: Performance Measures | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Performance Measure | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| CCS: Tax levy per capacity | \$617 | \$123 | \$1,646 | \$1,167 | (\$479) |
| CSP: Tax levy per capacity | \$5,553 | \$5,912 | \$5,036 | \$5,376 | \$340 |
| TCM: Tax levy per capacity | \$2,827 | \$2,228 | \$2,330 | \$2,204 | (\$126) |

Strategic Overview:

Community Mental Health and Crisis Services includes the following service options: Comprehensive Community Services (CCS), Targeted Case Management (TCM), Community Support Program (CSP), Community-Based Residential Facilities (CBRF), Access Clinic, Crisis Mobile Team (CMT), Community Assessment Response Team (CART), Community Consultation Team (CCT), Team Connect, Crisis Resource Centers (CRC), Crisis Stabilization Houses (CSH), and Community Linkage and Stabilization Program (CLASP).

Strategic Implementation: The 2020 Budget includes \$0.7m in increased Mental Health Block Grant funding to support ongoing behavioral health services in Milwaukee County. This funding will be used to support Parachute House (peer run respite) and ongoing behavioral health therapy services through the Mental Health Outpatient Program (MHOP). Parachute was formerly funded through reserve funds.

CARS continues to increase enrollments into Comprehensive Community Services (CCS), which is a Medicaid entitlement that provides a coordinated and comprehensive array of recovery, treatment, and psychosocial rehabilitation services. As a part of this continued expansion, CARS staff are working to enroll individuals into CCS services that are designed to enhance their community-based residential facility (CBRF) placement. Adult CCS enrollment is expected to increase to 1,430 by the end of 2020.

Targeted Case Management (TCM) expenses are decreased by \$0.3m due to ongoing utilization trends. Community Support Program (CSP) revenue is decreased by a net of \$0.3m primarily to account for an increased number of clients in the program without active Medicaid enrollment.

CARS serves individuals in need of community residential settings, such as Adult Family Homes and CBRFs. These placements are often individualized to meet the person's clinical and residential needs in the community. These individualized plans support people with complex needs with various supportive services with varying costs. To continue to support these placements and service plans, an additional \$1.0m is dedicated to fund ongoing community placements for individuals with complex needs.

The Crisis Resource Center (CRC) offers a safe, recovery-oriented environment that provides short-term crisis intervention to individuals. They provide a multitude of services, which includes crisis stabilization, peer support, and linkage to ongoing support and services. There is one CRC located on the Southside of Milwaukee and one on the Northside that provides walk-in crisis services along with short-term stabilization services. Plans are currently underway to have a third CRC location in Milwaukee, which will be supported partly through BHD funding. The third Crisis Resource Center is funded at a cost of \$0.7m. The budget also assumes \$1.2m savings for all Crisis Resource Center locations related to a proposed amendment to the contract between Medicaid HMOs and the Wisconsin Department of Health Services that would provide coverage for all HMO enrollees to receive services at CRC locations.

The development of the Northside and Southside Clinics has been a priority redesign and improvement project for BHD, our partners, stakeholders, and the community for the last two years. The 2020 Budget plans for the integration of BHD staff into three Federally Qualified Health Centers (FQHC) in Milwaukee. This project will implement and sustain an array of operational and clinical evidence-based practices, which more closely integrate BHD services with existing FQHC services and resources. Successful implementation will lead to more same day services for residents, improved safety for clients and families, a more efficient service delivery system, and increased billable revenues for crisis and outpatient services. These investments are possible through reallocation of the current Access Clinic and Adult Day Treatment Resources, as well as the addition of 3.0 FTEs. Funds are also provided to include Peer Specialists in the centers.

Wisconsin Medicaid Cost Report (WIMCR) and CCS cost report revenue is increased by \$1.4m. This impacts the following areas: crisis services, TCM, CSP, and CCS. Funding in 2020 will be based on the FY 2019 cost report.

| Community Mental Health Financials by Major Program Area | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| <i>Crisis Mobile Team & CART</i> | | | | | |
| Expense | \$3,977,776 | \$4,443,833 | \$4,942,861 | \$4,857,089 | (\$85,772) |
| Revenue | \$447,064 | \$1,449,635 | \$885,019 | \$1,298,160 | \$413,141 |
| Tax Levy | \$3,530,712 | \$2,994,198 | \$4,057,842 | \$3,558,929 | (\$498,913) |
| <i>CARS Care Coordination</i> | | | | | |
| Expense | \$894,732 | \$884,136 | \$1,015,031 | \$1,039,892 | \$24,861 |
| Revenue | \$4,696 | \$168,098 | \$112,320 | \$86,351 | (\$25,969) |
| Tax Levy | \$890,036 | \$716,038 | \$902,711 | \$953,541 | \$50,830 |
| <i>Targeted Case Management</i> | | | | | |
| Expense | \$7,330,411 | \$6,505,212 | \$7,325,902 | \$6,983,018 | (342,884) |
| Revenue | \$2,481,341 | \$3,015,369 | \$3,553,778 | \$3,452,193 | (\$101,585) |
| Tax Levy | \$4,849,070 | \$3,489,842 | \$3,772,124 | \$3,530,825 | (\$241,299) |
| <i>Community Support Program</i> | | | | | |
| Expense | \$14,559,321 | \$15,164,903 | \$15,725,083 | \$15,718,253 | (\$6,830) |
| Revenue | \$7,039,205 | \$7,360,606 | \$9,095,234 | \$8,729,866 | (\$365,368) |
| Tax Levy | \$7,520,116 | \$7,804,297 | \$6,629,849 | \$6,988,387 | \$358,538 |
| <i>Comprehensive Community Services</i> | | | | | |
| Expense | \$11,895,126 | \$15,492,052 | \$19,236,838 | \$24,121,386 | \$4,884,548 |
| Revenue | \$11,434,999 | \$15,378,461 | \$17,160,888 | \$22,452,495 | \$5,291,607 |
| Tax Levy | \$460,127 | \$113,591 | \$2,075,950 | \$1,668,891 | (\$407,059) |
| <i>Community Recovery Services</i> | | | | | |
| Expense | \$1,136,526 | \$230,836 | \$110,452 | \$0 | (\$110,452) |
| Revenue | \$508,463 | \$348,543 | \$50,000 | \$0 | (\$50,000) |
| Tax Levy | \$628,063 | (\$117,707) | \$60,452 | \$0 | (\$60,452) |
| <i>Community-Based Residential</i> | | | | | |
| Expense | \$12,681,192 | \$13,551,949 | \$12,412,211 | \$13,458,465 | \$1,046,254 |
| Revenue | \$9,780,317 | \$9,780,317 | \$9,780,317 | \$10,572,898 | \$792,581 |
| Tax Levy | \$2,900,875 | \$3,771,632 | \$2,631,894 | \$2,885,567 | \$253,673 |
| <i>Access Clinic and FQHC Partnerships (2017/2018 included Day Treatment)</i> | | | | | |
| Expense | \$1,810,953 | \$1,700,952 | \$3,528,182 | \$4,467,975 | \$939,793 |
| Revenue | \$1,566,363 | \$1,500,780 | \$2,051,815 | \$2,045,686 | (\$6,129) |
| Tax Levy | \$244,590 | \$250,171 | \$1,476,367 | \$2,422,289 | \$945,922 |

CARS: Community AODA Services

| What We Do: Activity Data | | | | | |
|--------------------------------------|-------------|-------------|-------------|-------------|--------------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| <i>Detoxification</i> | | | | | |
| Admissions | 6,483 | 6,698 | 6,000 | 6,000 | 0 |
| <i>AODA Residential</i> | | | | | |
| Capacity | 99 | 112 | 112 | 112 | 0 |
| <i>Recovery Support Coordination</i> | | | | | |
| Average Enrollment | 397 | 386 | 400 | 400 | 0 |
| <i>Recovery Support Services</i> | | | | | |
| Average Enrollment | 187 | 188 | 240 | 240 | 0 |

| How We Do It: Program Budget Summary | | | | | |
|--------------------------------------|--------------|--------------|--------------|--------------|--------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$15,827,557 | \$16,241,982 | \$15,618,200 | \$15,247,989 | (\$370,211) |
| Revenues | \$11,918,455 | \$12,605,045 | \$11,549,736 | \$13,559,695 | \$2,009,959 |
| Tax Levy | \$3,909,101 | \$3,636,938 | \$4,068,464 | \$1,688,294 | (\$2,380,170) |

Strategic Overview: Milwaukee County’s community AODA service program is an alcohol, drug treatment, and recovery service system. These services are open to Milwaukee County residents ages 18-59 with a history of alcohol or drug use. Priority is given to families with children and pregnant women (regardless of age). Milwaukee County BHD has a provider network for AODA residential services that provides a continuum of services, which include traditional residential, medically monitored residential and co-occurring bio-medically monitored residential, day treatment, recovery support coordination, outpatient services, and numerous recovery support services.

Strategic Implementation: The 2020 Budget includes \$2.0m in increased grant funding to support ongoing AODA needs in Milwaukee County. This includes \$1.1m in AODA Block Grant funding and \$0.9m in Opioid Crisis State Targeted Response (STR) funding. These additional funds will be used to support the sober housing continuum needed to support individuals in recovery to include, but not limited to, bridge housing, Oxford Houses, residential treatment, a new option for Medication Assisted Treatment (MAT) services, and prevention efforts.

\$0.2m is provided to fund a start-up for Oxford House, a democratically run, self-supporting drug free housing recovery model. Oxford Houses are rented family houses where groups of recovering individuals rent to live together in an environment supportive of recovery from addiction.

\$0.2m in savings is anticipated in Recovery Support Coordination by changing the payment method for this service delivery from per-diem reimbursement to unit-based reimbursement.

\$0.5m in savings is anticipated related to changing the payment method for community Access Point providers from purchase-of-service to fee-for-service.

Other adjustments are made based on anticipated demand.

| AODA Financials by Major Program Area¹ | | | | | |
|---|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| <i>Detoxification</i> | | | | | |
| Expense | - | \$2,661,453 | \$2,926,081 | \$2,905,596 | (\$20,485) |
| Revenue | - | \$2,333,731 | \$2,333,731 | \$2,333,731 | \$0 |
| Tax Levy | - | \$327,722 | \$592,350 | \$571,865 | (\$20,485) |
| <i>AODA Residential</i> | | | | | |
| Expense | - | \$5,607,958 | \$5,939,414 | 5,538,758 | (400,656) |
| Revenue | - | \$5,351,007 | \$4,455,371 | 5,430,371 | \$975,000 |
| Tax Levy | - | \$256,951 | \$1,484,043 | 108,387 | (1,375,656) |
| <i>Day Treatment & Outpatient - AODA²</i> | | | | | |
| Expense | - | \$631,923 | \$1,195,818 | \$636,471 | (\$559,347) ² |
| Revenue | - | \$619,489 | \$480,000 | \$532,000 | \$52,000 |
| Tax Levy | - | \$12,434 | \$715,818 | \$104,471 | (\$611,347) |
| <i>Recovery House</i> | | | | | |
| Expense | - | \$71,640 | \$45,326 | \$49,328 | \$4,002 |
| Revenue | - | \$0 | \$0 | \$0 | \$0 |
| Tax Levy | - | \$71,640 | \$45,326 | \$49,328 | \$4,002 |
| <i>Recovery Support Coordination</i> | | | | | |
| Expense | - | \$3,296,405 | \$3,094,512 | \$2,909,341 | (\$185,171) |
| Revenue | - | \$3,470,248 | \$2,610,011 | \$2,810,011 | \$200,000 |
| Tax Levy | - | (\$173,843) | \$484,501 | \$99,330 | (\$385,171) |
| <i>Recovery Support Services²</i> | | | | | |
| Expense | - | \$729,921 | \$1,001,357 | \$1,577,505 | \$576,148 |
| Revenue | - | \$542,839 | \$610,429 | \$1,127,388 | \$516,959 |
| Tax Levy | - | \$186,990 | \$390,928 | \$450,117 | \$59,189 |
| <i>Medication Assisted Treatment</i> | | | | | |
| Expense | - | \$79,777 | \$153,392 | \$376,843 | \$223,451 |
| Revenue | - | \$0 | \$0 | \$100,000 | \$100,000 |
| Tax Levy | - | \$79,777 | \$153,392 | \$276,843 | \$123,451 |
| <i>Prevention</i> | | | | | |
| Expense | - | \$3,138,513 | \$1,220,831 | \$1,214,445 | (\$6,386) |
| Revenue | - | \$287,639 | \$1,025,194 | \$1,191,194 | \$166,000 |
| Tax Levy | - | \$2,850,874 | \$195,637 | \$23,251 | (\$172,386) |

1 2017 financials are not available because these programs were not budgeted at this level of detail prior to 2017.

2 Outpatient Plus program is now budgeted in the Recovery Support Services cost center.

Strategic Program Area 5: Wraparound Services

Service Provision: Mandated

Strategic Outcome: Self-Sufficiency/Quality of Life

| What We Do: Activity Data | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Activity | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| <i>Wraparound</i> | | | | | |
| Average Total Enrollment | 1,201 | 1,139 | 1,198 | 1,246 | 48 |
| Average Daily Number of REACH enrollees | 521 | 540 | 550 | 600 | 50 |
| <i>Children's Mobile Crisis Team</i> | | | | | |
| Number of Clients Seen (face-to-face) | 1,507 | 1,235 | 1,750 | 1,650 | (100) |
| <i>Children's Comprehensive Community Services</i> | | | | | |
| Average Total Census | 33 | 79 | 280 | 350 | 70 |

| How We Do It: Program Budget Summary | | | | | |
|---|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Category | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| Expenditures | \$54,339,842 | \$56,007,462 | \$55,275,202 | \$57,921,426 | \$2,646,224 |
| Revenues | \$54,863,303 | \$55,332,534 | \$55,401,628 | \$57,668,124 | \$2,266,496 |
| Tax Levy | (\$523,461) | \$674,929 | (\$126,426) | \$253,302 | \$379,728 |
| FTE Positions | 38.0 | 42.0 | 45.5 | 44.5 | (1.0) |

| How Well We Do It: Performance Measures | | | | | |
|---|-------------|-------------|-------------|-------------|--------------------|
| Performance Measures | 2017 Actual | 2018 Actual | 2019 Target | 2020 Target | 2020/2019 Variance |
| Family Satisfaction with Care Coordination (5.0 Scale) | 4.7 | 4.68 | >= 4.0 | 4.0 | 0 |
| Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system) | 65.8% | 65.3% | >= 75% | 75% | 0 |
| Percentage of youth who achieved permanency at disenrollment | 55.1% | 53.9% | >= 70% | 70% | 0 |
| Average level of "Needs Met" at disenrollment (Scale of 1-5) | 2.6 | 2.4 | >= 3.0 | 3.0 | 0 |

Strategic Overview: BHD'S Children's Community Services and Wraparound Milwaukee system of care serves youth and young adults (aged 5-23) along with their families. Through this system of care, eligible youth and young adults in Milwaukee County receive coordinated, community-based mental health services and connections to community resources. All programs emphasize a strength-based care coordination model rooted in underlying need that offers a range of services and supportive options to youth and their families. These community-based services are designed to be individualized to meet the needs of each family. To fulfill eligibility requirements for all programs, children or young adults must meet Serious Emotional Disturbance (SED) criteria. For the first three options listed below, those programs in which enrollment includes participation in the specialized Managed Care carve out Wraparound Milwaukee, other eligibility criteria consist of risk level for out of home care, including hospitalization, and involvement in two or more systems (Child Welfare, Juvenile Justice, Mental Health Social Services, and Education). For enrollment in Comprehensive Community Services (CCS), individuals must be founded functionally eligible per the state assessment, in addition to having a SED diagnosis. Due to our historical ability to manage resources well and form valuable partnerships, the remaining options were able to be developed and sustained to offer Milwaukee County families increased access and choice. Once a determination of eligibility and need is made in partnership with the youth and their family, the following options are available under the Wraparound umbrella:

- **Wraparound:** Referrals are received from the Division of Youth and Family Services (DYFS) and the Division of Milwaukee Child Protective Services (DMCPS) for youth either placed out of home and outside of their community or are at risk of being placed. It provides cost-effective, community-based alternatives to residential treatment placements, juvenile correctional placements, and psychiatric hospitalization.
- **REACH (Reaching, Engaging, and Assisting Children):** Referrals come directly from families, schools, service providers, and the Children's Mobile Crisis (CMC) Team. Youth generally are not involved with DYFS or DMCPS. Under the same practice model, youth and families receive the same type of supports and services as those in the Wraparound program with the exception of placement services.
- **OYEAH (Older Youth and Emerging Adult Heroes):** Supports older youth and young adults (age 16-23) who are experiencing emotional and behavioral challenges to successfully transition to adulthood. In addition to mental health services, there is a focus on life skills, housing, and employment/training.
- **CCS (Comprehensive Community Services for Children):** An option for families, which provides support and services to youth and young adults who may be experiencing mental health or substance abuse diagnoses. As a voluntary community-based program, CCS addresses needs throughout a person's lifespan, with a coordinated and comprehensive array of recovery, treatment, and psychosocial rehabilitation services.

- FISS (Family Intervention and Support Services): A contract from DMCPs in partnership with St. Charles, which utilizes a shorter-term care coordination model aimed at stabilization and prevention. It is designed to assist families in meeting their needs while preventing court and system involvement. Children who are enrolled have identified behavioral issues, but diagnostic information is not required.
- Children’s Mobile Crisis Team (CMC): Provides 24/7 crisis intervention services to any family in Milwaukee County with a child who is experiencing a mental health emergency in which the behavior of the child threatens his/or her removal from home, a community placement, and/or school placement. The team can also provide short-term case management and can link the child and family to crisis stabilization and community resources.

Strategic Implementation: BHD’S Children’s Community Services and Wraparound Milwaukee system of care contains a diverse number of programs, services, and supports available to Milwaukee County families and young adults and all aimed at providing comprehensive, individualized, and cost-effective care to children with complex mental health and emotional needs. The 2020 expectation for Wraparound Milwaukee is a daily enrollment of 1,246 children, young adults, and their families. Enrollment numbers in Wraparound are expected to remain consistent or slightly increase due to a planned integration of screening and assessment between DYFS and Wraparound Milwaukee. The expectation is to continue to see an increase in enrollments for both REACH and CCS, as new potential referral sources are identified and an integration with the Disability Services Division – Children’s area continues. Additionally, enrollment into CORE (Coordinated Opportunities for Recovery and Empowerment), a specialized program within CCS, continues to see a steady enrollment of youth and young adults who are clinically at high risk for psychosis or who have already experienced their first episode of psychosis. The number of youth and young adults seen by Children’s Mobile Crisis may exceed projections, however numbers reflect current staffing. With the implementation of Crisis Redesign, there is an expectation the continuum of care within crisis response will increase in both capacity and breadth. Wraparound will continue to depend on the use of Crisis Stabilization services as a component of this expansion.

Expenses increase by \$2.6m and revenues increase by \$2.3m based on projected enrollment increases for both Wraparound and Youth CCS.

| Wraparound Services by Program Area | | | | | |
|--|--------------------|--------------------|--------------------|--------------------|---------------------------|
| Program | 2017 Actual | 2018 Actual | 2019 Budget | 2020 Budget | 2020/2019 Variance |
| <i>Wraparound Services (Reach, O-Yeah, CMC)</i> | | | | | |
| Expense | \$53,362,606 | \$52,995,112 | \$52,526,815 | \$54,130,551 | \$1,603,737 |
| Revenue | \$54,210,150 | \$53,849,963 | \$53,027,000 | \$54,357,800 | \$1,330,800 |
| Tax Levy | (\$847,744) | (\$854,851) | (\$500,186) | (\$227,249) | \$272,937 |
| <i>Youth CCS</i> | | | | | |
| Expense | \$146,922 | \$2,387,473 | \$1,986,762 | \$3,064,594 | \$1,077,832 |
| Revenue | \$133,853 | \$1,051,291 | \$1,834,628 | \$2,879,044 | \$1,044,416 |
| Tax Levy | \$13,069 | \$1,336,182 | \$152,134 | \$185,550 | \$33,416 |
| <i>Family Intervention and Support Services</i> | | | | | |
| Expense | \$830,314 | \$624,877 | \$761,626 | \$726,281 | (\$35,345) |
| Revenue | \$519,300 | \$431,280 | \$540,000 | \$431,280 | (\$108,720) |
| Tax Levy | \$311,214 | \$193,597 | \$221,626 | \$295,001 | \$73,375 |

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

10

DATE: May 23, 2019

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

FROM: Michael Lappen, BHD Administrator
Submitted by John Schneider, MD, FAPA, BHD Chief Medical Officer

SUBJECT: **Report from the Behavioral Health Division Administrator, Requesting Approval to Implement an “Employment Agreement Amendment” As Established Under BHD Personnel Policy for Specific Classified, Unclassified and Exempt Physician County Employees**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health with a value of at least \$100,000. The contract shall take effect only if the Milwaukee County Mental Health Board votes to approve, or does not vote to reject, the contract within 28 days after the contract is signed or countersigned by the County Executive.

Per the above Statute, the BHD Administrator is requesting authorization to amend one (1) “Employment Agreement” with a current employee who has achieved BHD’s threshold for advancement from Junior Attending to Senior Attending status, based on post-residency experience. The salary specified within the agreement exceeds \$100,000 annually.

As it has been determined that “Employment Agreements” fall under BOTH personnel policy AND contract requirements, Board approval is being sought to advance this psychiatrist’s salary, in accordance with the October 2017 personnel action authorization that was approved by the DHHS Director and County Executive allowing for the following:

- Advancement of Psychiatrist Staff and Psychiatrist Staff-hourly from junior pay status to senior pay status upon achieving 10 years post-residency status and supervisor recommendation. Changes shall be implemented with written notification and request to DHR by the BHD Chief Medical Officer/designee.

Discussion

We submit the table below, which lists the one (1) personnel transaction that BHD will be requesting the Milwaukee County Chief Human Resources Officer to implement, in connection with an Employment Agreement amendment.

| ITEM ID | HIGH/LOW ORG | CURRENT | NO. POSITIONS | CURRENT | | RECOMMENDED | | INFORMATIONAL: Market equitable alignment based on overall job duties/ responsibilities, industry competition, competencies and education/experience requirements. | EFFECTIVE DATE | | | |
|---|--------------|-----------------------|---------------|-----------|-----------------|-------------|-----------------|---|----------------|---|------------|---|
| | | JOB CODE / POSITION # | | PAY RANGE | ANNUAL PAY RATE | PAY RANGE | ANNUAL PAY RATE | | | | | |
| EA2019-6A | 6300/6443 | 21025000000011 | 1 | P026 | Min | 163,059 | P026 | Min | 163,059 | | 06/30/2019 | |
| | | | | | Mid | 199,747 | | Mid | 199,747 | X | | Retention |
| | | | | | Max | 236,435 | | Max | 236,435 | X | | Industry shortage / high competition for profession |
| | | | | | \$207,050 | | | \$220,000 | | X | | Other: Equity adjustment upon achieving Senior attending status |
| <p>The individual under this agreement amendment shall maintain current status as a benefit-eligible COUNTY EMPLOYEE, including ERS enrollment, and subject to all applicable County and BHD personnel policies and Civil Service rules, where applicable.</p> <p style="text-align: center;">All other terms of current Employment Agreement remain unchanged.</p> | | | | | | | | | | | | |

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve amending the "Employment Agreement" (contract) with the incumbent of the above position for the equity increase recommended.

References

Wis. Stats. [46.19\(4\)](#): the salaries of any superintendent of a mental health institution and the salaries of any visiting physician and necessary additional officers and employees whose duties are related to mental health shall be fixed by the county executive.

Wis. Stats. [51.41\(10\)](#): MENTAL HEALTH CONTRACTS. Any contract related to mental health with a value of at least \$100,000, to which Milwaukee County is a party may take effect only if the Milwaukee County mental health board votes to approve, or does not vote to reject, the contract within 28 days after the contract is signed or countersigned by the county executive.

Wis. Stats. [51.42\(6m\)\(i\)](#): Establish salaries and personnel policies of the programs of the county department of community programs subject to approval of the county executive or county administrator and county board of supervisors, except in Milwaukee County, or the Milwaukee County mental health board in Milwaukee County unless the county board of supervisors or the Milwaukee County mental health board elects not to review the salaries and personnel policies.

Fiscal Effect

The recommended compensation contained in this report is supported by currently funded and authorized positions within the Behavioral Health Division's 2019 operating budget. There is no tax levy associated with this request.

Respectfully Submitted,



Michael Lappen, Administrator
Behavioral Health Division

cc Maria Perez, PhD, LCSW, Chairperson, Milwaukee County Mental Health Board Finance Committee
Mary Jo Meyers, Director, Department of Health and Human Services
John Schneider, MD, BHD Chief Medical Officer
Matt Fortman, Acting DHHS/BHD Chief Financial Officer
Dean Legler, Milwaukee County Director of Total Rewards
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

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

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
 QUALITY COMMITTEE
June 03, 2019 - 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. | First Quarter - BHD Community Key Performance Indicator (KPI) Dashboard, CARS Quarterly Narrative Summary and Population Health Metrics for CARS clients (Dana James, Quality Assurance Coordinator; Justin Heller, Integrated Services Manager; Dr. Matt Drymalski, Clinical Program Director) |
| 3. | Core Data Development – Phases 1& 2 (Dr. Matt Drymalski, Clinical Program Director) |
| 4. | Comprehensive Community Services (CCS) – QAPI (Quality Assurance Performance Improvement Plan) (Jennifer Bergersen, Chief Operations Officer; CCS QAPI Team) |
| 5. | 2018 Sentinel Event Committee Quality Summary (Dr. Sara Coleman, SEC Chair; Jennifer Bergersen, COO) |
| 6. | Psychiatric Hospital Reports: First Quarter Inpatient KPI Metrics, Seclusion & Restraint Summary (Dr. John Schneider, Chief Medical Officer; Linda Oczus, Chief Nursing Officer; Edward Warzonek, Quality Assurance Coordinator) |
| 7. | CMS – Acute Hospital Survey Verbal Update (Dr. John Schneider, Chief Medical Officer; Linda Oczus, Chief Nursing Officer) |
| 8. | Contract Quality Monitoring Reports – First Quarter (Jennifer Bergersen, COO; Dennis Buesing, Contract Administrator) |
| 9. | Institutional Review Board (IRB) Report (Dr. Justin Kuehl, Chief Psychologist) |
| 10. | BHD Policy & Procedure Status Report (Lynn Gram, Safety Officer) |
| 11. | Adjournment. (Chairwoman Neubauer) |

The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is September 09, 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.



Milwaukee County Behavioral Health Division
2019 Key Performance Indicators (KPI) Dashboard

Quality Committee Item 2

| Program | Item | Measure | 2017 Actual | 2018 Actual | 2019 Quarter 1 | 2019 Quarter 2 | 2019 Quarter 3 | 2019 Quarter 4 | 2019 Actual | 2019 Target | 2019 Status (1) | Benchmark Source |
|---|------------------------------------|--|-------------|-------------|----------------|----------------|----------------|----------------|-------------|-------------|-----------------|------------------|
| Community Access To Recovery Services | 1 | Service Volume - All CARS Programs ⁵ | 8,346 | 9,393 | 6,032 | | | | 6,032 | 9,500 | Green | |
| | | Sample Size for Rows 2-6 (Unique Clients) | | | 3,531 | | | | 3,531 | | | |
| | 2 | Percent with any acute service utilization ⁶ | 17.40% | 17.05% | 19.55% | | | | 19.55% | 16.35% | Yellow | |
| | 3 | Percent with any emergency room utilization ⁷ | 13.87% | 14.60% | 15.33% | | | | 15.33% | 13.64% | Yellow | |
| | 4 | Percent abstinence from drug and alcohol use | 63.65% | 63.65% | 64.67% | | | | 64.67% | 64.18% | Green | |
| | 5 | Percent homeless | 7.61% | 9.18% | 8.46% | | | | 8.46% | 8.84% | Green | |
| | 6 | Percent employed | 18.09% | 20.06% | 19.51% | | | | 19.51% | 20.27% | Yellow | |
| | Sample Size for Row 7 (Admissions) | | | | | | | | | | | |
| | 7 | Percent of all admissions that are 7 day readmissions | 59.55% | 60.12% | 49.11% | | | | 49.11% | 49.00% | Yellow | |
| Wraparound | 8 | Families served in Wraparound HMO (unduplicated count) | 3,404 | 2,955 | 1,697 | | | | 1,697 | 3,450 | Green | BHD (2) |
| | 9 | Annual Family Satisfaction Average Score (Rating scale of 1-5) | 4.8 | 4.60 | 4.5 | | | | 4.5 | > = 4.0 | Green | BHD (2) |
| | 10 | Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system) | 65.7% | 65.3% | 66.2% | | | | 66.2% | > = 75% | Yellow | BHD (2) |
| | 11 | Average level of "Needs Met" at disenrollment (Rating scale of 1-5) | 2.59 | 2.38 | 2.35 | | | | 2.35 | > = 3.0 | Red | BHD (2) |
| | 12 | Percentage of youth who have achieved permanency at disenrollment | 57.8% | 58.0% | 69.1% | | | | 69.1% | > = 70% | Yellow | BHD (2) |
| | 13 | Percentage of Informal Supports on a Child and Family Team | 44.1% | 38.4% | 34.3% | | | | 34.3% | > = 50% | Red | BHD (2) |
| Crisis Service | 14 | PCS Visits | 8,001 | 7,375 | 1,905 | | | | 7,620 | 8,000 | Green | BHD (2) |
| | 15 | Emergency Detentions in PCS | 3,979 | 3,023 | 795 | | | | 3,180 | 4,000 | Green | BHD (2) |
| | 16 | Percent of patients returning to PCS within 3 days | 7.3% | 7.5% | 11.0% | | | | 11.0% | 8% | Red | BHD (2) |
| | 17 | Percent of patients returning to PCS within 30 days | 23.1% | 24.0% | 25.8% | | | | 25.8% | 24% | Yellow | BHD (2) |
| | 18 | Percent of time on waitlist status | 75.2% | 83.2% | 100.0% | | | | 100.0% | 50% | Red | BHD (2) |
| Acute Adult Inpatient Service | 19 | Admissions | 656 | 770 | 162 | | | | 648 | 800 | Green | BHD (2) |
| | 20 | Average Daily Census | 42.9 | 41.8 | 43.8 | | | | 43.8 | 54 | Green | BHD (2) |
| | 21 | Percent of patients returning to Acute Adult within 7 days | 1.4% | 1.6% | 1.8% | | | | 1.8% | 3% | Green | BHD (2) |
| | 22 | Percent of patients returning to Acute Adult within 30 days | 7.7% | 6.6% | 4.1% | | | | 4.1% | 10% | Green | NRI (3) |
| | 23 | Percent of patients responding positively to satisfaction survey | 74.0% | 74.8% | 79.6% | | | | 79.6% | 75.0% | Green | NRI (3) |
| | 24 | If I had a choice of hospitals, I would still choose this one. (MHSIP Survey) | 65.4% | 65.2% | 70.6% | | | | 70.6% | 65% | Green | BHD (2) |
| | 25 | HBIPS 2 - Hours of Physical Restraint Rate | 0.56 | 0.51 | 0.24 | | | | 0.24 | 0.36 | Green | CMS (4) |
| | 26 | HBIPS 3 - Hours of Locked Seclusion Rate | 0.30 | 0.28 | 0.15 | | | | 0.15 | 0.23 | Green | CMS (4) |
| | 27 | HBIPS 4 - Patients discharged on multiple antipsychotic medications | 17.5% | 21.5% | 25.3% | | | | 25.3% | 9.5% | Green | CMS (4) |
| | 28 | HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification | 89.6% | 95.8% | 92.5% | | | | 92.5% | 90.0% | Green | BHD (2) |
| Child / Adolescent Inpatient Service (CAIS) | 29 | Admissions | 709 | 644 | 168 | | | | 672 | 800 | Green | BHD (2) |
| | 30 | Average Daily Census | 8.6 | 7.5 | 8.2 | | | | 8.2 | 12.0 | Green | BHD (2) |
| | 31 | Percent of patients returning to CAIS within 7 days | 5.2% | 3.4% | 7.2% | | | | 7.2% | 5% | Red | BHD (2) |
| | 32 | Percent of patients returning to CAIS within 30 days | 12.3% | 12.4% | 16.6% | | | | 16.6% | 12% | Green | BHD (2) |
| | 33 | Percent of patients responding positively to satisfaction survey | 71.3% | 71.1% | 80.1% | | | | 80.1% | 75% | Green | BHD (2) |
| | 34 | Overall, I am satisfied with the services I received. (CAIS Youth Survey) | 76.8% | 74.2% | 87.9% | | | | 87.9% | 75% | Green | BHD (2) |
| | 35 | HBIPS 2 - Hours of Physical Restraint Rate | 1.17 | 1.18 | 1.96 | | | | 1.96 | 0.36 | Red | CMS (4) |
| | 36 | HBIPS 3 - Hours of Locked Seclusion Rate | 0.37 | 0.47 | 0.39 | | | | 0.39 | 0.23 | Red | CMS (4) |
| | 37 | HBIPS 4 - Patients discharged on multiple antipsychotic medications | 5.0% | 1.1% | 0.0% | | | | 0.0% | 3.0% | Green | CMS (4) |
| | 38 | HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification | 97.1% | 85.7% | - | | | | - | 90.0% | Green | BHD (2) |
| Financial | 39 | Total BHD Revenue (millions) | \$149.9 | \$154.9 | \$149.7 | | | | | \$149.7 | Yellow | |
| | 40 | Total BHD Expenditure (millions) | \$207.3 | \$213.5 | \$208.2 | | | | | \$208.2 | Yellow | |

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



Milwaukee County Behavioral Health Division 2019 Key Performance Indicators (KPI) Dashboard

| Program | Item | Measure | 2017 Actual | 2018 Actual | 2019 Quarter 1 | 2019 Quarter 2 | 2019 Quarter 3 | 2019 Quarter 4 | 2019 Actual | 2019 Target | 2019 Status (1) | Benchmark Source |
|------------|------|---|-------------|-------------|----------------|----------------|----------------|----------------|-------------|-------------|-----------------|------------------|
| Wraparound | 8 | Families served in Wraparound HMO (unduplicated count) | 3,404 | 2,955 | 1,697 | | | | | 3,450 | | BHD (2) |
| | 9 | Annual Family Satisfaction Average Score (Rating scale of 1-5) | 4.8 | 4.60 | 4.5 | | | | | > = 4.0 | | BHD (2) |
| | 10 | Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system) | 65.7% | 65.3% | 66.2% | | | | | > = 75% | | BHD (2) |
| | 11 | Average level of "Needs Met" at disenrollment (Rating scale of 1-5) | 2.59 | 2.38 | 2.35 | | | | | > = 3.0 | | BHD (2) |
| | 12 | Percentage of youth who have achieved permanency at disenrollment | 57.8% | 58.0% | 69.1% | | | | | > = 70% | | BHD (2) |
| | 13 | Percentage of Informal Supports on a Child and Family Team | 44.1% | 38.4% | 34.3% | | | | | > = 50% | | BHD (2) |

Notes:

(1) 2019 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

SUMMARY - 1st QUARTER/CY 2019

8 - No additional comments at this time.

9 – On target for the 1st quarter of 2019. Exceeding the threshold of 4.0.

10 - Improved .9% in the 1st quarter of 2019 as compared to the 2018 CY average of 65.3%. Within the 20% benchmark range. Efforts are ongoing to have youth reside in the least restrictive setting possible.

11 – Decrease of .03 in the 1st quarter of 2019 (2.35) compared to the 2018 CY average of 2.38. This is outside the 20% benchmark (2.4) by .05% and .65 below the target score of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. NOTE: Those in Wraparound court ordered programs who are disenrolled to a home type setting in the 1st quarter of 2019 have a higher "Needs Met" score (3.34) than those disenrolled on runaway status or to corrections (1.47).

#12 – In the 1st quarter, there was an 11.1% increase (69.1%) in the percentage of youth achieving permanency at disenrollment compared to the 2018 CY average of 58%. This is within the 20% benchmark and .9% below the 70% standard.

"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 1st quarter compliance (34.3%) is 4.1% lower than the 2018 CY average of 38.4% This falls outside 20% benchmark of 40%, and the established target score of 50%.

CARS QUALITY DASHBOARD SUMMARY Q1 2019

CHANGES AND UPDATES

Further Development of the Quadruple Aim

The CARS Quality Dashboard continues to undergo further development/refinement of the data elements organized by the Quadruple Aim. CARS has also finished a draft of the CARS Quality Plan, which is also aligned with the Quadruple Aim. This Plan will likely be released at a future MHB Quality Committee meeting, once it has undergone an appropriate internal review. Progress towards each goal in the Plan will be reviewed by the CARS Leadership Team on a quarterly basis.

Population Health

CARS is piloting a “change over time” set of population health metrics during the first quarter of 2019 (please see attached handout). These metrics represent our initial attempt to answer the question, “Are we helping our clients in their recovery journey?” As we revise and refine metrics, they will be added to or may even supplant the metrics in our current quality dashboard. Please note that the detox readmission metric and target has been updated to reflect 7-day readmission rates.

Patient Experience of Care

The Press Ganey survey has been distributed to most CARS programs. Training in Motivational Interviewing (MI) amongst key CARS and network staff is ongoing, as is the development of an MI fidelity review process, including an assessment of the client experience and an accompanying manual.

Staff Wellbeing

CARS continues to work with BHD’s Human Resources Department to obtain data on CARS staff turnover and to establish appropriate turnover rate targets by department and/or staff classification that are indicative of healthy and high functioning social service organizations. There is also a continuing effort to develop reports on provider turnover in the CARS contracted network.

Cost of Care

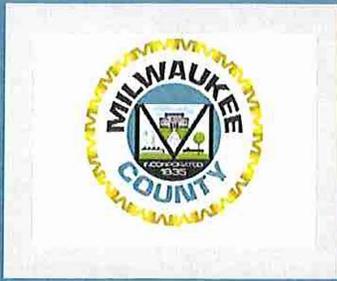
The cost per member per month metric on the CARS Quality Dashboard continues to evolve, with new quarterly figures based on revised purchase of service contracts and the transition of existing purchase of service contracts to a fee for service model.

RESULTS

Most population health metrics for CARS clients remained stable in the first quarter of 2019 relative to the last quarter of 2018. There was a slight increase in the number of clients reporting an inpatient visit in the previous 30 days, as well as a decrease in the proportion of clients reporting their housing status as “homeless”. CARS has also adjusted our performance targets for 2019, based on our 2018 performance. A description of this methodology is available upon request.

NEXT STEPS

The CARS Quality Dashboard will undergo further revisions and refinements as CARS pursues the goals of the Quality Plan and continues to create more robust mechanisms to track improvements in the experience of care and general health of the population we serve. We will also continue to link the cost of the care we deliver to the outcomes of the clients we serve, which will enable us to better determine the value of the care we are purchasing. It is important to note that there are many ongoing CARS initiatives that are focused on increasing the quality of the care our clients receive or improving their quality of life. These initiatives are too numerous to mention here, but it is only through the important work of the CARS team that any improvement noted above is and will be realized.



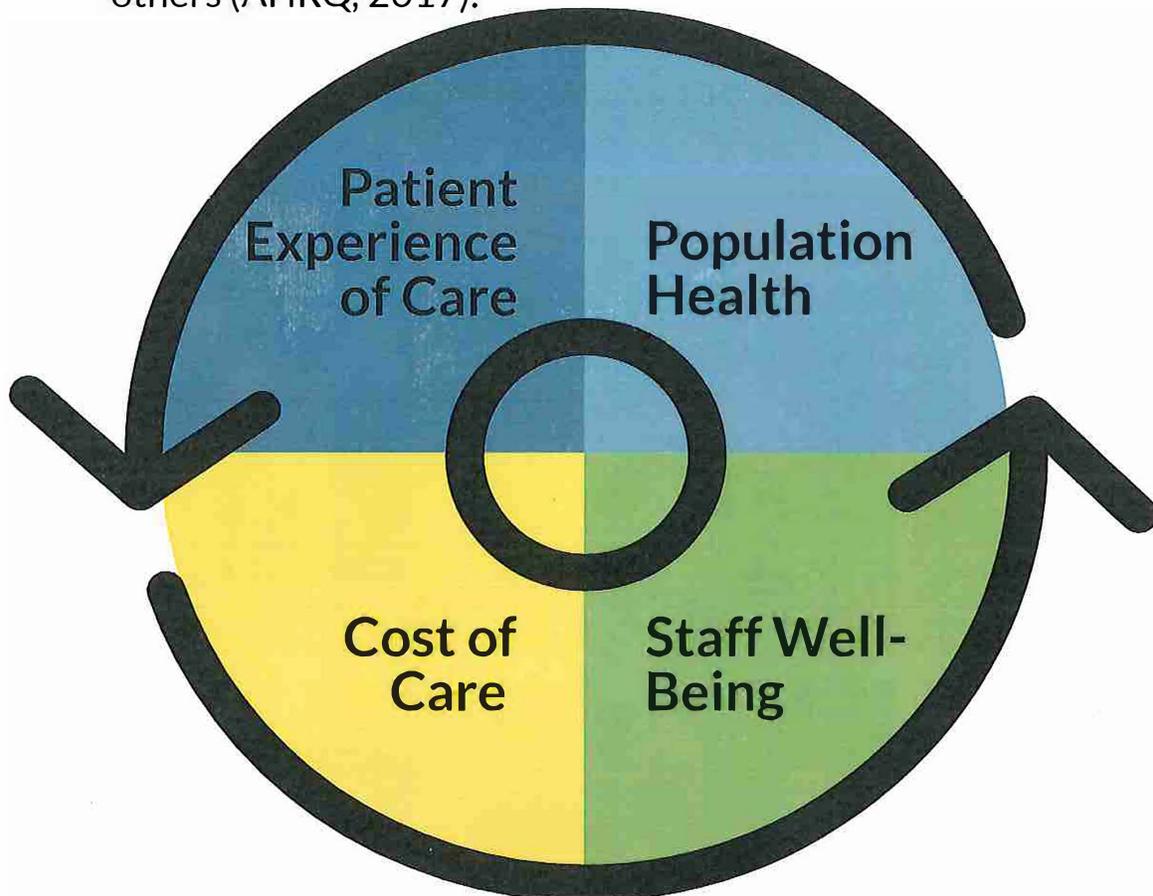
CARS Quality Dashboard

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).

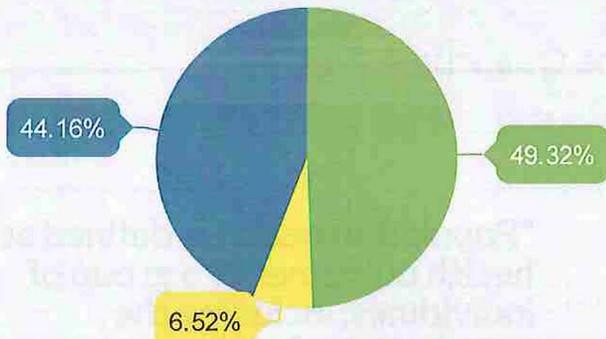
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

Demographic Information of the Population We Serve

This section outlines demographics of the consumers CARS served last quarter.

Race (CARS)

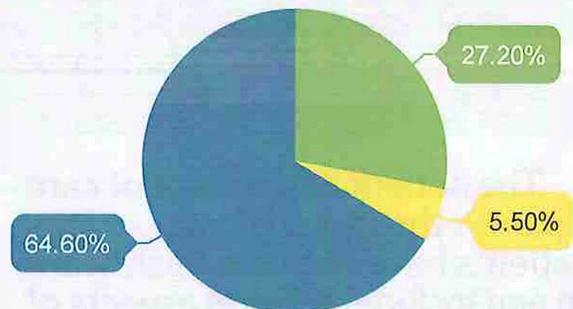
- Black/African-American
- White/Caucasian
- Other



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

Race (Milwaukee County)*

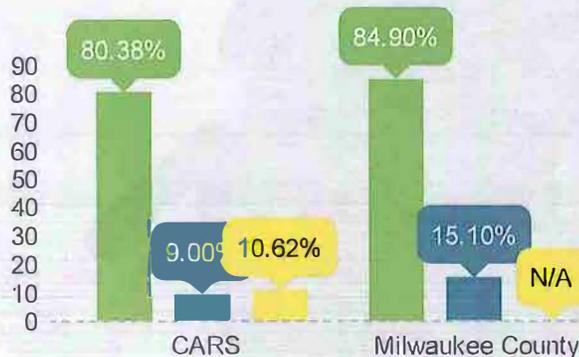
- Black/African-American
- White/Caucasian
- Other



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

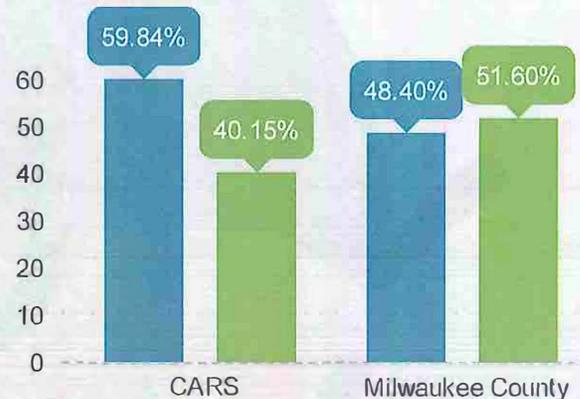
Ethnicity*

- Not Hispanic/Latino
- Hispanic/Latino
- No Entry/Unknown

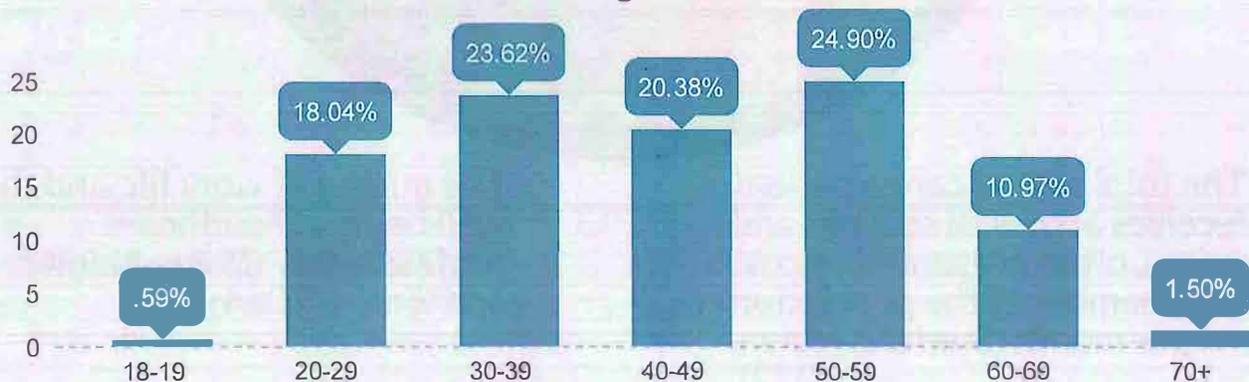


Gender*

- Males
- Females



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>



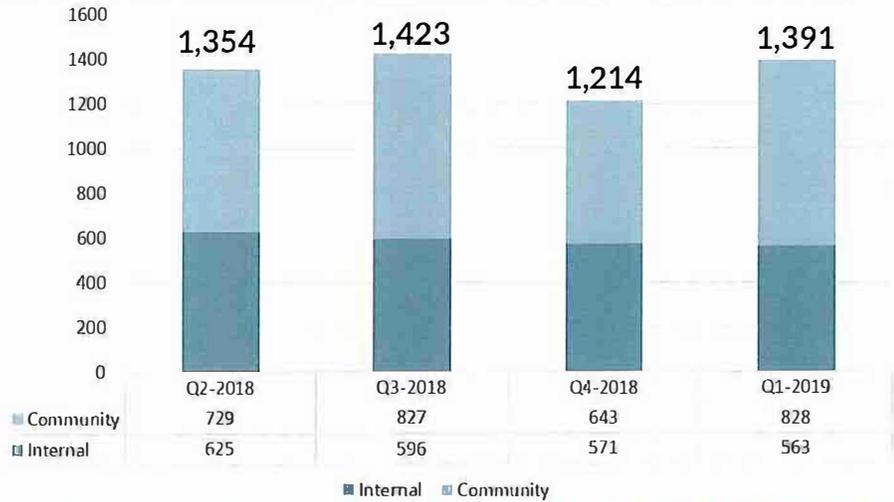
Domain: Patient Experience of Care

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



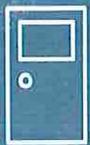
Referrals

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



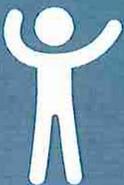
Time to Service

Average number of days between the time of the CARS Comprehensive Assessment to the first service date.



Admissions

All admissions during 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.



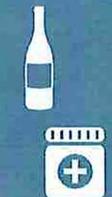
ER Utilization

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



Detoxification 7-Day Readmissions

Percent of consumers returning to detoxification within 7 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".





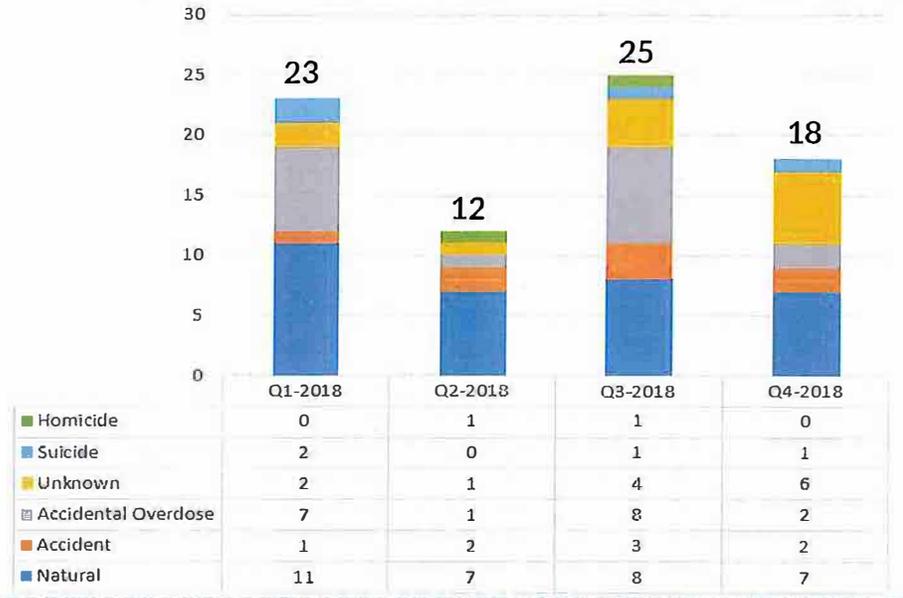
Domain: Population Health (Continued)

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, the U.S. Department of Health and Human Services, and the World Health Organization. This graph represents the total number of deaths by cause of death from Q1-2018 to Q4-2018.

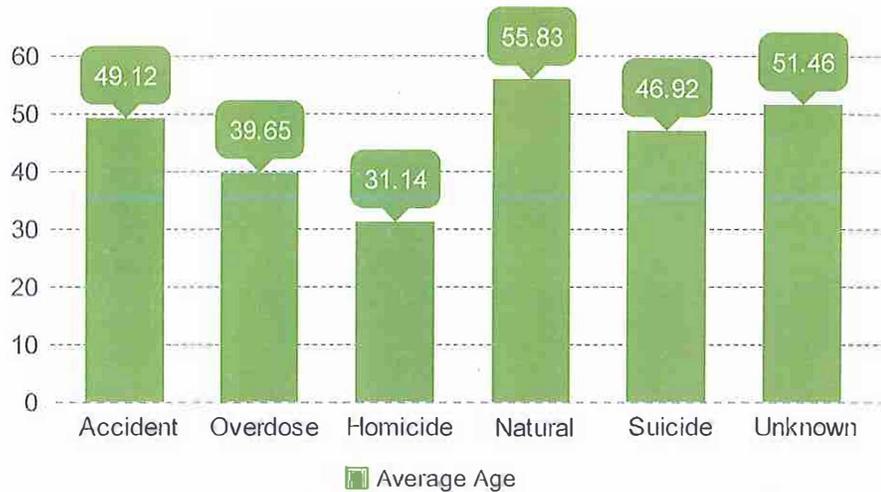
Note: There is a lag in death reporting. See note in the next item.



Average Age by Cause of Death

This is the reported average age at time of death by cause of death from Q1-2018 to Q4-2018.

Please note that there is a one quarter lag of the mortality data on the CARS Quarterly Dashboard. This decision was made to ensure that CARS has accurate cause of death data from the Milwaukee County Medical Examiner's office, a determination which can sometimes take several months for the Medical Examiner's office to render.



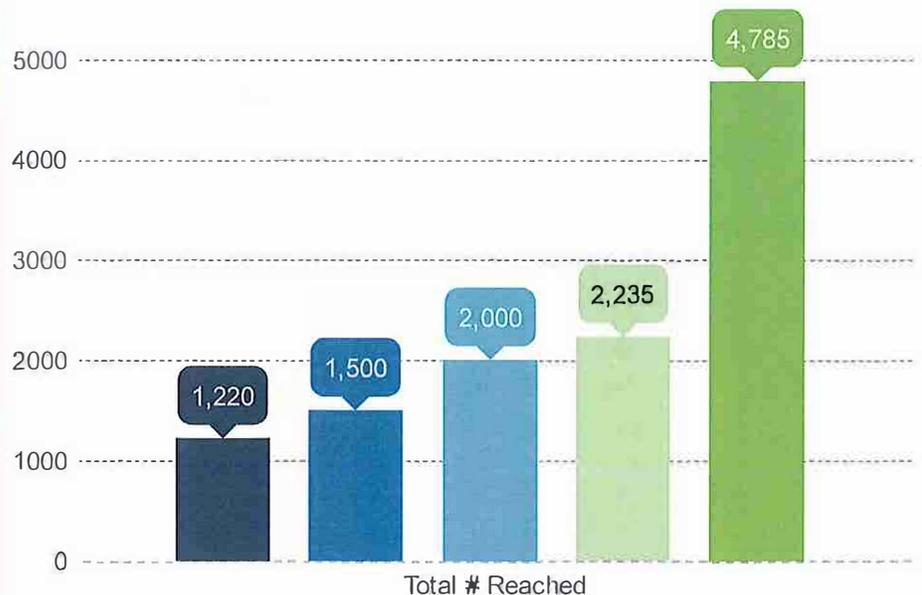
Top Prevention Activities/Initiatives

Prevention is also an important population health factor. Many prevention activities include evidence based practices, and presentations. The top five prevention activities for Q1 are listed in the graphic.



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.

■ Families Moving Forward
 ■ MPL
 ■ MPS
 ■ Dose of Reality
 ■ Light Unite Red





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:

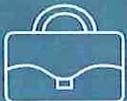


| | |
|------------------------|------------------------|
| Q2 - 2018 N = 4,865 | Q3 - 2018 N = 5,042 |
| Q4 - 2018 N = 5,056 | Q1 - 2019 N = 5,096 |



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, starting in 2019. Subsequent iterations of the dashboard will also include staff turnover 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

The Press Ganey Consumer Satisfaction Survey is currently being distributed to all CARS providers. Results will be reported in the coming months.

[DRAFT]

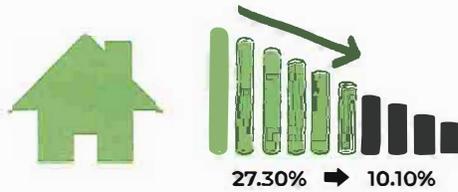
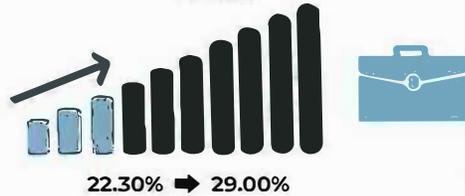
Population Health Metrics - Change Over Time

This dashboard contains preliminary measures of 6-month population health outcome data (intake to follow-up) for our consumers

Q1 2019

30.04% increase in
Employment*

n=355

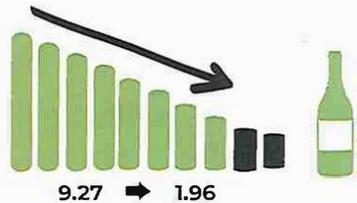
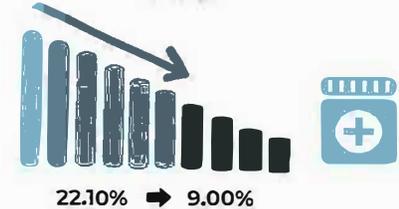


63.00% decrease in
Homelessness***

n=366

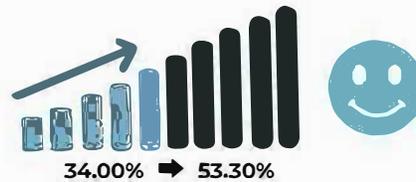
59.28% decrease in Past
30 days Detox Use***

n=367



78.86% decrease in Days
of Heavy ETOH Use in
Past 30 days***

n=137



56.76% increase in Good or
Very Good Quality of Life***

n=212

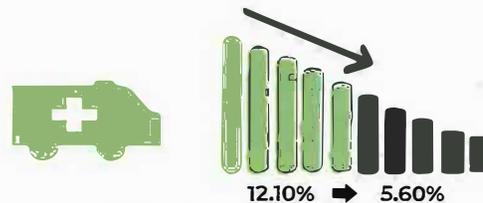
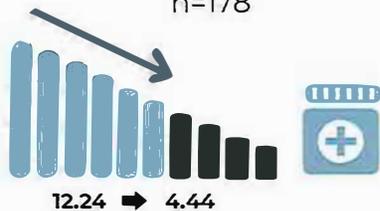


77.68% decrease in Past 30
days Psych Inpatient Use***

n=325

63.73% decrease in Past 30
days Days of Drug Use***

n=178



53.72% decrease in Past 30
days Psych ER Use**

n=354

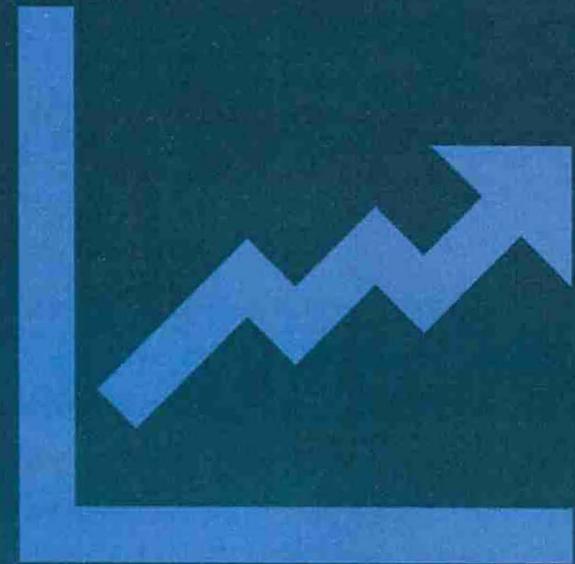
Note: Only consumers with a Comprehensive Assessment and subsequent PPS completed within 4-7 months are included in these measures.

*p<.05 **p<.01 ***p<.001

Quality Committee Item 3

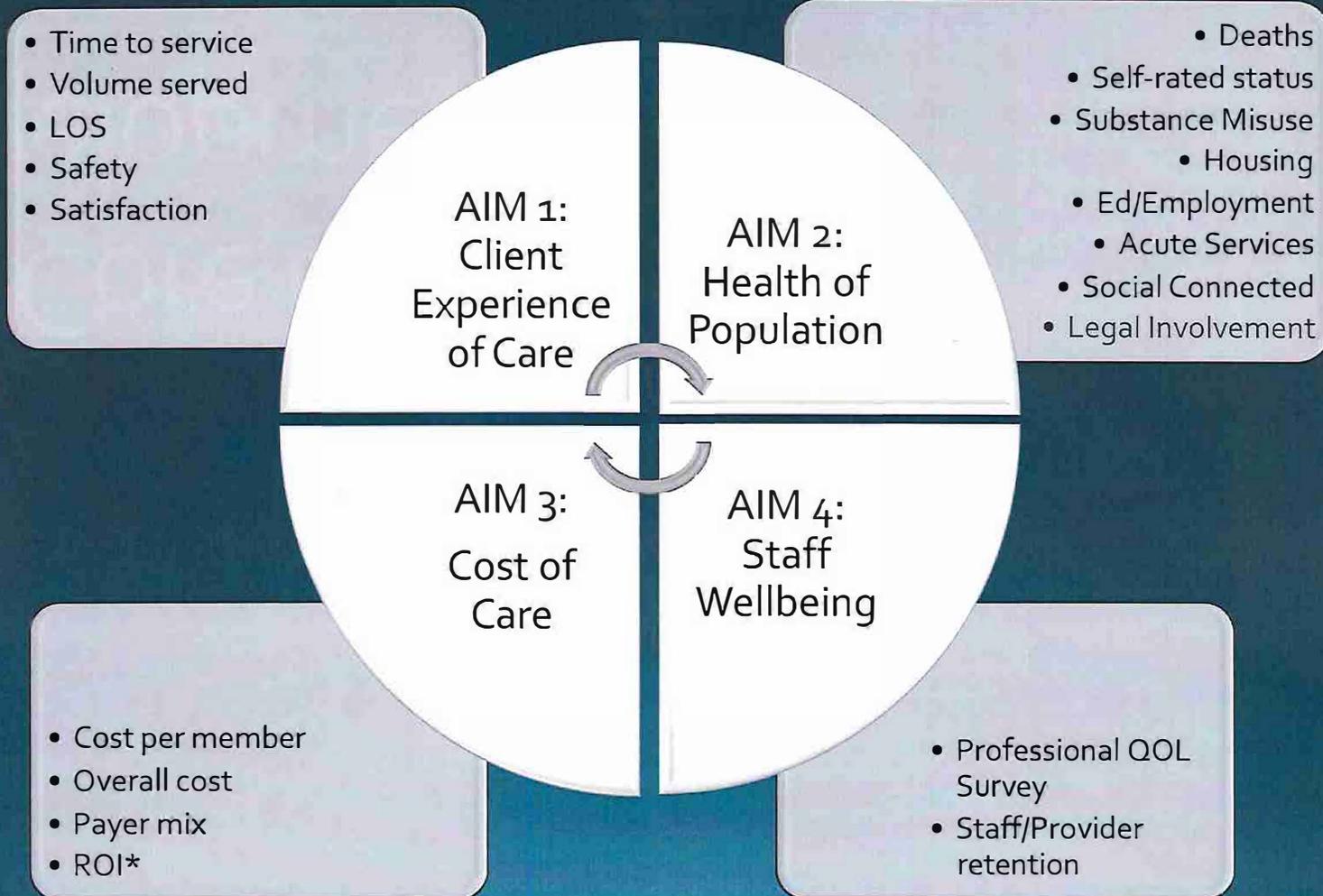
Phases I (and II)

Core Data Development

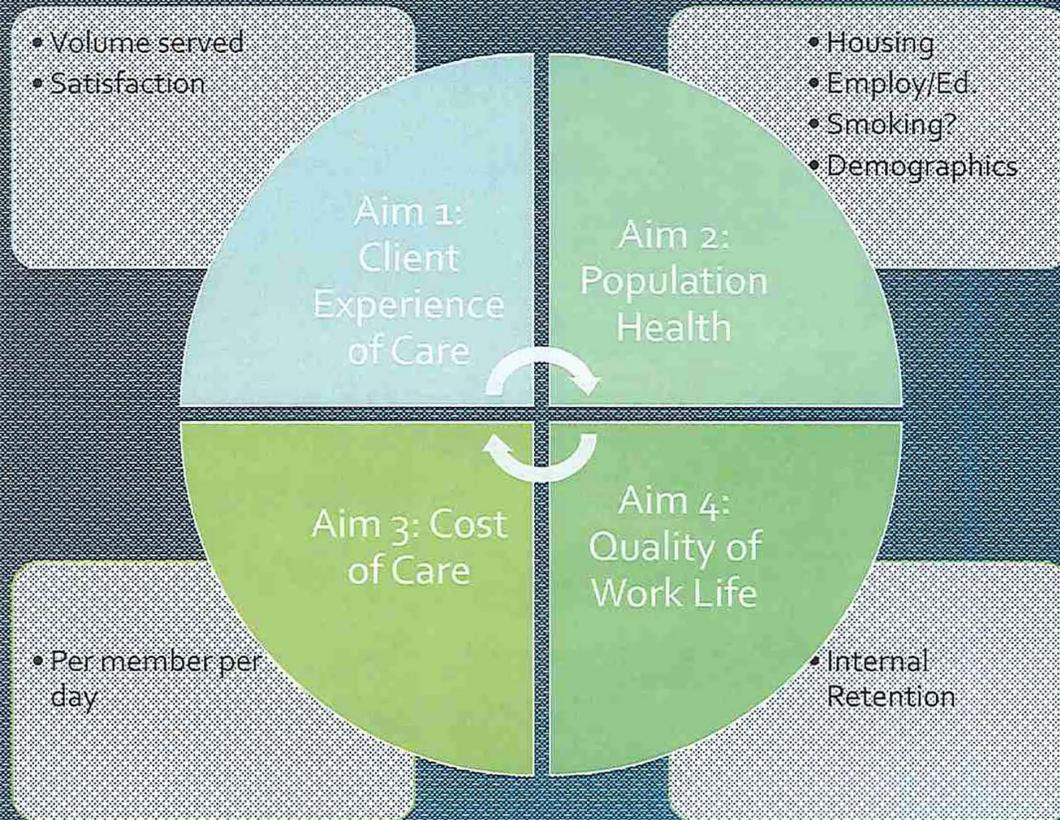


Recap of Core Domains

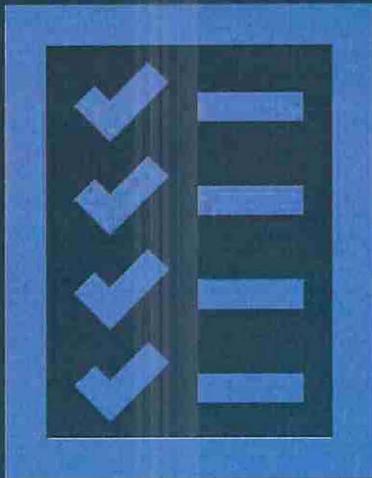
The Quadruple Aim



Phase 1: Quadruple Aim Data Elements

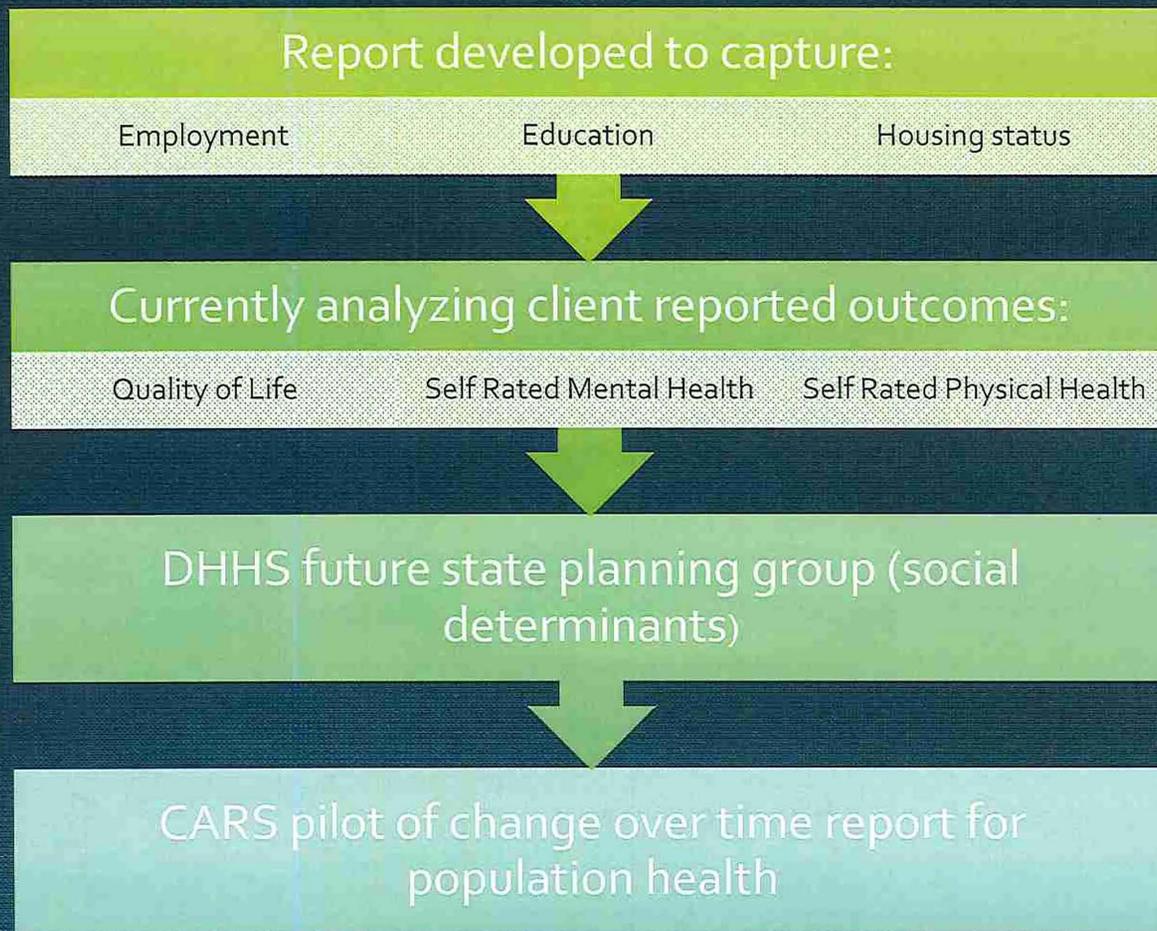


Aim 1: Client Experience of Care



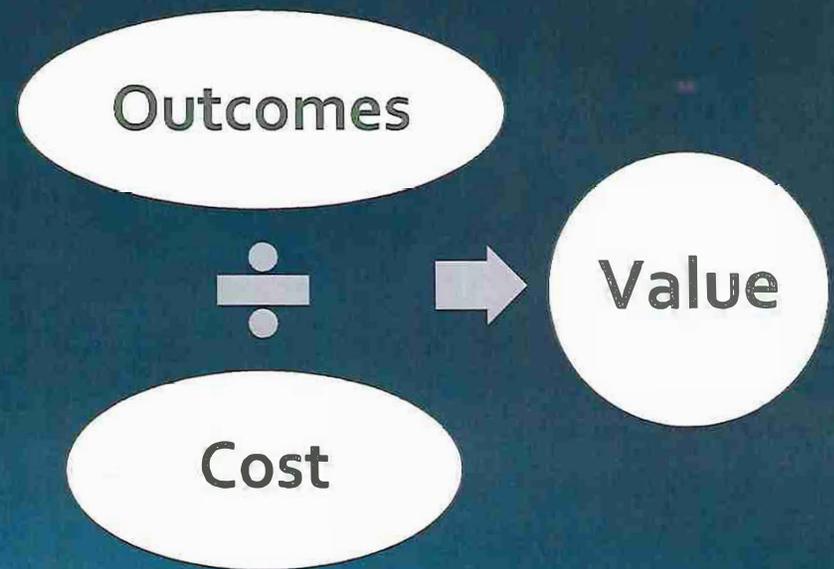
1. Client experience is focal point of BHD Quality Plan
2. Assessment of client experience near completion
 1. Will be piloted in CARS later this year or early next year
3. Press Ganey survey
4. Report developed for total volume served

Aim 2: Population Health



Aim 3: Cost of Care

- Report on cost of care on a per member per month basis exists in CARS
- Report in development of cost on a per member per day cost for all BHD clients
 - This report will be crucial for:
 - Future value-based purchasing
 - Risk adjustment
 - Identifying high risk individuals



Aim 4: Staff Quality of Work Life

Downtown HR to produce staff turnover rates for all of BHD quarterly

Turnover benchmarks under development for our employees, based on position/role, locality, etc. (thanks Peter and Lisa!)

Contract Management working to collect more complete data on turnover within the contracted network (thanks Brenda!)

Preliminary report targeted
Fall of 2019

Continued statistical analysis
of key metrics

Master Data Management
and Analytics project

DHHS future planning project
work

Next Steps

Quality Committee Item 4

2019

Comprehensive Community Services Quality Plan CCS QAPI Subcommittee

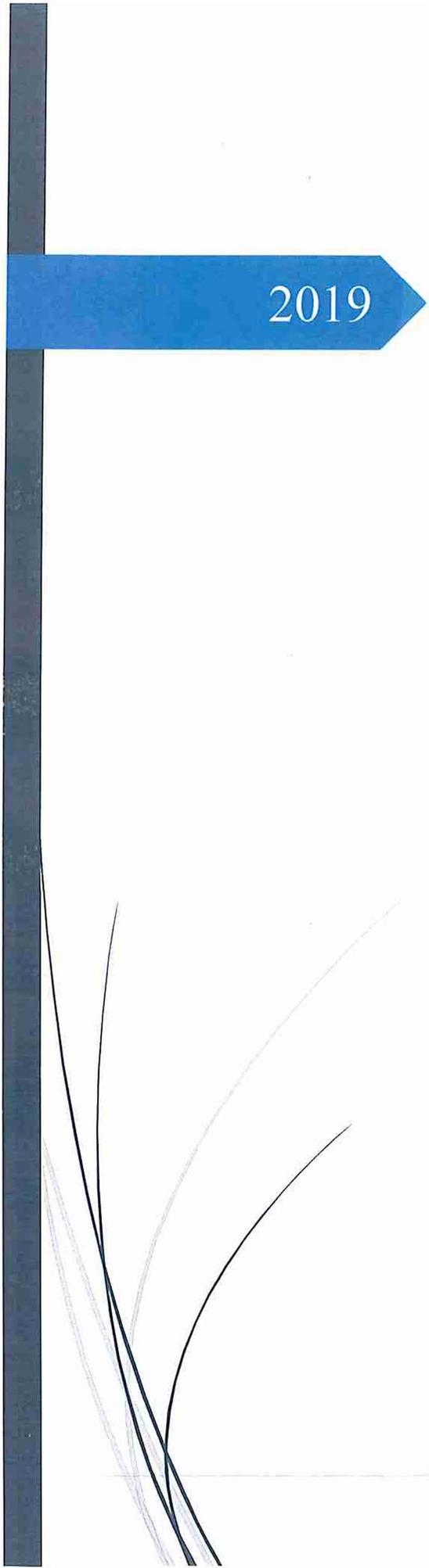


TABLE OF CONTENTS

| | |
|--|----|
| 1. PURPOSE OF THE QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI) PLAN | 1 |
| 2. CCS SCOPE OF WORK | 1 |
| 3. ADDRESSING KEY QAPI ISSUES | 8 |
| 4. CURRENT & PAST QUALITY ASSURANCE ACTIVITIES | 8 |
| 5. USE OF BEST AVAILABLE EVIDENCE | 9 |
| 6. RESPONSIBILITY AND ACCOUNTABILITY: QAPI ACTIVITIES & THE GOVERNING BODY | 10 |
| 7. SOURCING OF THE QAPI PLAN | 11 |
| 8. STAFF TRAINING & ORIENTATION | 11 |
| 9. QAPI FRAMEWORK | 11 |
| 10. IMPLEMENTATION OF NON-PUNITIVE STAFF CULTURE | 12 |
| 11. DATA SOURCES UTILIZED TO ANALYZE PERFORMANCE | 12 |
| 12. DATA SOURCES TO IDENTIFY RISK. | 13 |
| 13. DATA SOURCES TO COLLECT FEEDBACK/INPUT | 13 |
| 14. CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS (PIP'S) | 14 |
| 15. IDENTIFICATION OF PIP TOPICS | 14 |
| 16. PRIORITIZING & SELECTING PIP'S | 14 |
| 17. PIP CHARTER DEVELOPMENT | 14 |
| 18. THE DESIGNATION OF PIP TEAMS | 15 |
| 19. CONDUCTING THE PIP | 15 |
| 20. DOCUMENTATION OF THE PIP | 15 |
| 21. PIP APPROACH & TOOLS | 16 |
| 22. PREVENTING NEGATIVE EVENTS & PROMOTING SUSTAINED IMPROVEMENT | 16 |
| 23. ENSURING PLANNED CHANGES/INTERVENTIONS ARE IMPLEMENTED & EFFECTIVE | 16 |

1. PURPOSE OF THE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) PLAN

This quality improvement plan has been developed to assess Comprehensive Community Services (CCS) consumer satisfaction, progress toward desired outcomes and program adherence to the rules and regulations outlined by DHS 36. The plan includes a description of the methods for measuring participant opinion related to the services offered by CCS, assessment, service planning, service delivery and service facilitation activities. The quality improvement plan includes a description of the methods that CCS will use to evaluate the effectiveness of changes in the program based on the results of the consumer satisfaction survey and other measurements, recommendations for program improvement by the Milwaukee County CCS Recovery Advisory Committee (CCS Coordination Committee), and other relevant information (DHS 36.08).

2. CCS SCOPE OF WORK

Comprehensive Community Services (CCS) is a program that offers a wide range of psychosocial rehabilitative services and supportive activities that assist consumers with mental health and/or substance abuse conditions achieve their highest possible level of independent functioning, stability, and independence to promote long-term recovery. Services are both designed and offered to support consumers across the lifespan (minors, adults and elders). CCS is a community-based program, meaning the majority of services are provided to consumers in their homes and communities. The program is person-centered and utilizes consumer-directed service plans to outline individualized strengths, goals and desired service interventions. CCS services are provided by a wide range of professionals, paraprofessionals and natural and informal supports selected by the consumer to support them in obtaining their goals and improving their overall quality of life.

The CCS program employs the use of a care coordination model, meaning that a care coordinator is designated to provide service linkage and oversight, crisis prevention, and ongoing review of the consumer's needs. The care coordinator and consumer meet at a frequency that is jointly agreed upon by both the care coordinator and the consumer but no less than directed by DHS 36, to support the recovery planning process and assess the consumer's level of satisfaction with their services, as well as their progress toward their identified goals.

Comprehensive Community Services places primary emphasis on the therapeutic relationship and collaborative partnership between the identified care coordinator, the consumer, and their recovery team. The recovery team is defined as being the group of individuals who are identified to participate in an assessment of the needs of the consumer, service planning and delivery, and evaluation of desired outcomes.

Another important component of the CCS program is the development and inclusion of natural supports in the recovery planning and supportive process. A natural support is defined as a friend, or other person available in the community (outside of professional supports) who may assist consumers seeking stability and independence. The CCS care coordinator works directly with the

consumer to regularly explore, identify and promote the development, and inclusion, of natural supports in the recovery planning process.

A. CCS CORE VALUES

- 1) ***Family-Centered:*** A family-centered approach means that families are a family of choice defined by the consumers themselves. Families are responsible for their children and are respected and listened to as we support them in meeting their needs, reducing system barriers, and promoting changes that can be sustained overtime. The goal of a family-centered team and system is to move away from the focus of a single consumer represented in systems, to a focus on the functioning, safety, and well-being of the family as a whole.
- 2) ***Consumer Involvement:*** The consumer and their family's involvement in the recovery planning process is empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives including decisions made about their service plans.
- 3) ***Builds on Natural and Community Supports:*** Recognizes and utilizes all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include an individual and/or families' relative, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately individuals and families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- 4) ***Strength-Based:*** Strength-based planning builds on the individual and/or family's unique qualities and identified strengths that can then be used to support strategies to meet their needs. Strengths should also be found in the individual and/or family's environment through their informal support networks as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the individual and/or family's initial needs are met and new needs emerge with strategies discussed and implemented.
- 5) ***Unconditional Care:*** Means that we care for the individual or family, not that we care "if." It means that it is the responsibility of the service team to adapt to the needs of the individual and/or family, not the individual and/or family to adapt to the needs of a program. We will coordinate services and supports for the individual and/or family that we would hope are done for us. If difficulties arise, the individualized services and supports change to meet the individual and/or family's needs.
- 6) ***Collaboration Across Systems:*** An interactive process in which people with diverse expertise, along with individuals and/or their families, generate solutions

to mutually defined needs and goals building on identified strengths. All systems working with the individual and/or family have an understanding of the role each program serves in the individual and/or family's life and a commitment and willingness to work together to assist them in achieving their goals. The substance abuse, mental health, child welfare, and other identified systems collaborate and coordinate a single system of care for individuals and families involved within their services.

- 7) ***Team Approach Across Agencies:*** Planning, decision-making, and strategies rely on the strengths, skills, mutual respect, creative, and flexible resources of a diversified, committed team. Team member strengths, skills, experience, and resources are utilized to select strategies that will support the individual and/or family in meeting their needs. Individuals, their families, formal, and informal team members share responsibility, accountability, authority, and understand and respect each other's strengths, roles, and limitations.
- 8) ***Ensuring Safety:*** When child protective services are involved, the team will maintain a focus on child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible, and whether the safety services in place are effectively controlling those threats. When safety concerns are present, a primary goal of the family team is to ensure that supervision be appropriately provided to participants to address any safety concerns.
- 9) ***Gender/Age/Culturally Responsive Treatment:*** Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity, religion and sexual orientation, and reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- 10) ***Self-sufficiency:*** Individuals and/or families will be supported, resources shared, and team members held responsible in achieving self-sufficiency in essential life domains. (Domains include but are not limited to safety, housing, employment, financial, educational, psychological, emotional, and spiritual.)
- 11) ***Education and Work Focus:*** Dedication to positive, immediate, and consistent education, employment, and/or employment-related activities which results in resiliency and self-sufficiency, improved quality of life for self, family, and the community.
- 12) ***Belief in Growth, Learning and Recovery:*** Individual and/or family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals and families with compassion, dignity, and respect. Team members operate from a belief that every individual and/or family desire change and can take steps toward attaining a productive and self-sufficient life.

- 13) **Outcome-oriented:** From the onset of recovery team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports are discussed, agreed-upon, and maintained. Identified desirable outcomes are understood and shared by all team members. Legal, education, employment, safety, and other applicable mandates are considered in developing strategies, progress is monitored, and each team member participates in defining success. To achieve outcomes, desired outcomes are standardized, measurable, based on the life of the individual and/or family and its individual members.

B. TARGET POPULATION

Everyone who is interested in CCS has the opportunity to participate in a screening process that will determine whether they are eligible for CCS. There are a few criteria individuals **NEED** to meet/have in order to participate:

- 1) Milwaukee County residency
- 2) Medicaid (T-19, Forward Health) Eligible
- 3) A mental health and/or substance use disorder
- 4) Functional eligibility- determined by the State of Wisconsin Mental Health/AODA Functional Screen (for adults) or the Children's Long-Term Services (CLTS) screen (for children)
- 5) Clinical appropriateness for the program, as determined by the Mental Health Professional and documented on a Determination of Need form

C. CCS SERVICE DESCRIPTIONS

- 1) **Screening and Assessment:** Screening and assessment services include: Completion of initial and annual Functional Screens and completion of the initial comprehensive assessment and ongoing assessments as needed. The assessment must cover all the domains, including substance use, which may include using the Uniform Placement Criteria or the American Society of Addiction Medicine Criteria. The assessment must address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyles of the member and identify how to evaluate progress toward the member's desired outcomes. Assessments for minors must address the minor's and family's strengths, needs, recovery and/or resilience goals, priorities, preferences, values, and lifestyle of the member including an assessment of the relationships between the minor and his or her family. Assessments for minors should be age (developmentally) appropriate.
- 2) **Service Planning:** Service planning includes the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member. All services must be authorized by a Mental Health Professional and a Substance Abuse Professional if substance abuse services will be provided. The service plan is based on the assessed needs of the member. It must include measurable goals and the type and frequency of data that will be used to measure progress toward the desired outcomes.
- 3) **Service Facilitation:** Service Facilitation includes activities that ensure the member receives: assessment services, service planning, service delivery and

supportive activities in an appropriate and timely manner. It also includes ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning. Service facilitation includes assisting the member in self-advocacy and helping the member obtain other necessary services such as: medical, dental, legal, financial and housing services. Service facilitation for minors includes advocating and assisting the member's family in advocating for the minor to obtain necessary services. When working with the minor, service facilitation that is designated to support the family must be directly related to the assessed needs of the minor. Service facilitation includes coordinating a person's crisis services, but not actually providing crisis services.

- 4) **Diagnostic Evaluation:** Diagnostic evaluations include specialized evaluations needed by the consumer including but not limited to neuropsychological, geropsychiatric, specialized trauma, and eating disorder evaluations. For minors, diagnostic evaluations can also include functional behavioral evaluations and adolescent alcohol/drug assessments. The CCS program does not cover evaluations for autism and developmental disabilities or learning disabilities.
- 5) **Medication Management:** Medication management services administered by prescribers include: diagnosing and specifying target symptoms; prescribing medication to alleviate the identified symptoms; monitoring changes in the member's symptoms and tolerability of side effects; and reviewing data including other medications used to make medication decisions. Prescribers may also provide all services that non-prescribers can provide as noted below.

Medication management for non-prescribers include: supporting the member in taking his or her medications; increasing the consumer's understanding of the benefits of medication and the symptoms it is treating, and monitoring changes in the consumer's symptoms and tolerability of side effects.

- 6) **Physical Health Monitoring:** Physical health monitoring services focus on how the consumer's mental health and/or substance abuse issues impact his or her ability to monitor and manage physical health and health risks. Physical health monitoring services include activities related to the monitoring and management of a consumer's physical health. Services may include assisting and training the consumer and the consumer's family to: identify symptoms of physical health conditions, monitor physical health medications and treatments, and develop health monitoring and management skills. Service can be provided in both individual and group settings.
- 7) **Peer Support:** Peer Support services include a wide range of supports to assist the consumer and the consumer's family with mental health and/or substance abuse issues in the recovery process. These services promote wellness, self-direction, and recovery by enhancing the skills and abilities of members to meet their chosen goals. The services also help consumers negotiate the mental health

and/or substance use disorder systems with dignity and without trauma. Through a mutually empowering relationship, Certified Peer Specialists and consumers work as equals toward living in recovery.

- 8) ***Individual Skill Development Enhancement:*** Individual skill development and enhancement services include training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the member's service plan. Services also include training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services (including health care services), and other specific daily living needs identified in the consumer's service plan.

Services provided to minors should also focus on improving integration into and interaction with the minor's family, school, community, and other social networks. Services include assisting the minor's family in gaining skills to assist the minor with individual skill development and enhancement. Services that are designed to support the family must be directly related to the assessed needs of the minor. Skills training may be provided by various methods; including but not limited to modeling, monitoring, mentoring, supervision, assistance, and cuing. Service can be provided individually or in a group setting.

- 9) ***Employment – Related Skill Training:*** Employment-related skill training services address the consumer's illness or symptom-related issues in finding, securing, and keeping a job. Services may include but are not limited to: employment and education assessments; assistance in accessing or participating in educational and employment related services; education about appropriate job-related behaviors; assistance with job preparation activities such as personal hygiene, clothing, and transportation; onsite employment evaluation and feedback sessions to identify and manage work-related symptoms; assistance with work-related crises; and individual therapeutic support. The CCS program does not cover time spent by the consumer working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the service array, for the member if those services are identified in the consumer's service plan. Service can be provided individually or in a group setting.

- 10) ***Individual and/or Family Psychoeducation:*** Psychoeducation services include: providing education and information resources about the consumer's mental health and/or substance abuse issues; skills training, problem solving, and ongoing guidance about managing and coping with mental health and/or substance abuse issues; and social and emotional support for dealing with mental health and/or substance abuse issues. Psychoeducation may be provided individually or in a group setting to the member or the member's family and natural supports (i.e. anyone the member identifies as being supportive in his or her recovery and/or resilience process). Psychoeducation is not psychotherapy. Family psychoeducation must be provided for the direct benefit of the member.

Consultation to family members for treatment of their issues not related to the consumer is not included as part of family psychoeducation. Family psychoeducation may include anticipatory guidance when the member is a minor. If psychoeducation is provided without the other components of the wellness management and recovery service array category (#11), it should be billed under this service category. Service can be provided individually or in a group setting.

11) *Wellness Management/Recovery Supportive Services:* Wellness management and recovery services, which are generally provided as mental health services, include empowering consumers to manage their mental health and/or substance abuse issues, helping them develop their own goals, and teaching them the knowledge and skills necessary to help them make informed treatment decisions. These services include: psychoeducation; behavioral tailoring; relapse prevention; development of a recovery action plan; recovery and/or resilience training; treatment strategies; social support building; and coping skills. Services can be taught using motivational, educational, and cognitive-behavioral strategies. If psychoeducation is provided without the other components of wellness management and recovery, it should be billed under the individual and/or family psychoeducation service array under category (#10). Recovery support services, which are generally provided as substance abuse services, include emotional, informational, instrumental, and affiliated support. Services include assisting the member in increasing engagement in treatment, developing appropriate coping strategies, and providing aftercare and assertive continuing care. Continuing care includes relapse prevention support and periodic follow-ups and is designated to provide fewer intensive services as the member progresses in recovery. Service can be provided individually or in a group setting.

12) *Psychotherapy:* Psychotherapy includes the diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, or addictions through the application of methods derived from established psychological or systemic principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics, which may include the purpose of understanding unconscious processes or intrapersonal, interpersonal, or psychosocial dynamics. Service can be provided individually or in a group setting.

13) *Substance Abuse Treatment:* Substance abuse treatment services include day treatment (Wisconsin Administrative Code DHS 75.12) and outpatient substance abuse counseling (DHS 75.13). Substance abuse treatment services can be in an individual or group setting. The other categories in the services array also include psychosocial rehabilitation substance abuse services that support consumers in their recovery. Service can be provided individually or in a group setting. The CCS program does not cover Operating While Intoxicated assessments, urinalysis and drug screening, detoxification services, medically managed inpatient treatment services, or narcotic treatment services (opioid treatment

programs). Some of these services may be covered under Medicaid outside of the CCS program.

3. ADDRESSING KEY QAPI ISSUES

The outlined quality assessment and performance improvement plan will address key issues including:

- CCS consumer satisfaction
- CCS service accessibility
- Integration of adult and youth CCS services
- Development and inclusion of natural supports in the recovery planning process

4. CURRENT AND PAST QUALITY ASSURANCE ACTIVITIES

A. CCS Evaluation Dimension 1: Monitoring and Summative Evaluation for Policy-Related Compliance

Policy and state mandated compliance data for CCS are monitored through Avatar, Synthesis, and Provider Connect. These programs hold information such as medical records and other personal health information. These data sources satisfy program monitoring and compliance needs for state and policy requirements. Oftentimes, the data collected through the Electronic Health Record (HER) are analyzed to drive various performance improvement projects (PIP) (e.g. NIATx change projects, PDSA cycles, etc.) in order to enhance the quality of the CCS program.

B. BHD – CCS Evaluation Dimension 2: Monitoring and Summative Evaluation for Consumer Outcomes

The Program Participation System (PPS) form bundle is not only utilized to meet State reporting requirements, but also to support CCS monitoring of consumer-based outcomes and programmatic success. This information is used internally to identify service gaps, process change needs, program evaluation, and consumer level outcomes. In addition, the information received, may be shared externally with contracted providers or BHD stakeholders (Milwaukee County Mental Health Board) to help drive performance improvement. This is an area in which the CCS program will utilize outcome reports (i.e. dashboards, Agency Performance Reports (APR), etc.) for managers to keep track of factors like monitoring State compliance requirements, aggregate health outcomes, and contract performance measures (CPMs).

C. BHD – CCS Evaluation Dimension 3: Formative Evaluation for Processes

CCS service providers may identify “change projects” within their own agencies to improve process or attain desired programmatic outcomes. NIATx models are utilized for this purpose. The NIATx model encourages providers to identify a quality assurance change project within the agency. This is an opportunity for providers to identify an issue, plan how to fix it, use the democratically-decided change projects, study results, and act upon it in the interest of improving process, outcomes, and quality care. CCS service providers are encouraged to present their internal change projects once a year at BHD, but it is not required. CCS, as a program also engages in an annual internal PIP

projects to enhance the quality of the program. Examples of past PIP projects include: increased involvement of natural supports (family, friends, and other supports outside of traditional providers) in the recovery planning process; decreasing the length of time it takes to get into CCS services and decreasing the time it takes to refer consumers to CCS ancillary providers. Change teams are welcome to collect their own data, or request information that is provided by CCS. This mechanism may bring systemic change to processes, but it is generally on a smaller, agency level. Link to more information about the NIATx model: <https://niatx.net/Content/ContentPage.aspx?PNID=1&NID=8>.

D. Monitoring and Outcomes Evaluation for State of CCS Meetings

“State of CCS” meetings are held once a year. The following items are reviewed at the meeting in the form of a data summary:

- 1) Census by Age Over Time
- 2) CCS Census by Gender
- 3) Annual CCS Census
- 4) Cumulative Admissions and Discharges for CCS Adult and Youth Consumers
- 5) Average Duration from Inquiry to Admission for Adult Consumers
- 6) Average Duration from Admission to Prescription Attainment for Adult Consumers
- 7) Average Duration from Admission to Deemed Eligibility for Adult Consumers
- 8) Average Duration from Admission to Service Plan Entry
- 9) Average Ancillary Providers Usage in the Past Quarter
- 10) Average Number of Ancillary Services Per Consumer External to Care Coordination Providers
- 11) Count of CCS Consumers Employed at Admission and Six-Month Follow-Up
- 12) Count of CCS Consumers Attending School/Higher Education
- 13) Count of Living Situation Type for CCS Consumers at Admission and at Six-Month Follow-Up
- 14) Satisfaction Survey Results

5. USE OF BEST AVAILABLE EVIDENCE

A. Program Participation System (PPS)

The PPS form bundle is a required State reporting tool that all State/County funded programs need to complete. The PPS “bundle” (forms with a wide range of questions intended to monitor client progress and program efficacy, including the PPS/NOMS Supplemental Form for adults) are required to be completed at intake, every six months a consumer is in a particular service, and at discharge. The bundles are completed by the individual’s Care Coordinator for CCS.

B. Recovery Oriented Systems Indicators (ROSI) Survey

This is a State required (by DHS 36) evaluation tool. The ROSI survey is administered on an annual basis by Vital Voices, a local organization contracted with Milwaukee County Behavioral Health Division. Eligible consumers must have received service in the CCS

program for at least six months, and/or discharged no more than three months ago from the State of the sampling period. This survey is voluntary, but the CCS team works diligently with contracted CCS care coordination agencies to promote higher rates of consumer participation. The survey is done in person, but if the consumer cannot be reached face-to-face, then a phone interview commences. Once the ROSI is completed, service managers, administrative coordinators, the Recovery Advisory Committee, and supervisors from CCS agencies are given data summaries that cover strengths and areas in need of improvement based on consumer responses.

C. Family & Youth Mental Health Statistics Improvement (MHSIP) Surveys

The annual Family MHSIP survey gauges parent/caregiver's perceptions of the CCS services their child/children received in the past six-months, and/or discharged no more than three months from the start of the sampling period. The survey is voluntary and confidential. This is filled out by the family caregiver of children who are not able to complete the MHSIP Youth survey.

The annual Youth MHSIP survey gauges opinions of adolescents in CCS services (aged 13 – 17 years) who have been in services for six months or longer, and/or discharged no more than three months from the start of the sampling period this survey follows similar protocol to the Family MHSIP survey.

6. RESPONSIBILITY AND ACCOUNTABILITY: QAPI ACTIVITIES AND THE GOVERNING BOARD

The CCS Program Administrator or designee will perform all functions as required by statute. These responsibilities shall include overall responsibility for the CCS program, including compliance with DHS Chapter 36 and other applicable state and federal regulations to include developing policies and procedures.

BHD quality personnel, CCS program leadership and the CCS provider network team(s) will have the responsibility for championing all aspects of quality, to include the promotion of a culture of continuous improvement.

The Milwaukee County CCS Recovery Advisory Committee (CCS Coordinating Committee) is a group of individuals (service providers, mental health and substance abuse advocates, consumers, family members & interested citizens) who meet every other month to review and make recommendations and address quality issues. The CCS Recovery Advisory Committee (RAC) will ensure committee participation reflects 1/3 consumer participation and will be responsible for the oversight of planning, designing, implementing, and selection of quality improvement activities to best meet the needs of the consumers the CCS program serves. Written minutes and a membership list are maintained. Results of consumer satisfaction surveys, relevant policy and procedural changes, changes to the Quality Plan and other recommendations pertaining to programmatic improvement are reviewed, approved and often directed by the Recovery Advisory Committee.

The CCS Operations Committee will be responsible to review CCS quality improvement activities including recommendations of the RAC and performance toward established programmatic outcomes. Ultimately, the CCS Quality Plan and continuous improvement updates will be submitted annually to the Quality Committee of the Mental Health Board (and subsequently the Governing Board) for review, input and approval.

7. SOURCING OF THE QAPI PLAN

The CCS Operations Committee and Program Leadership will assess needs and request financial resources to ensure quality improvement activities are properly planned and budgeted on an annual basis. BHD Executive Personnel will ensure to establish the appropriate budget to support continuous improvement activities across the organization. These expenses may include, but not limited to; financial support for projects, resources, and training. The budget will be reviewed annually by the CCS Operations Committee, reviewed with the Chief Financial Officer, and revised as needed. Refer to the positions identified below that list the staffing that support the continuous improvement activities. Staffing and needs will be assessed and identified to support the expansion and function of future needs and adjusted accordingly. The positions involved in the CCS Program and supporting the CCS QAPI Plan for Children's Community Mental Health Services are the Director, Associate Director, CCS Program Manager, Quality Assurance Director, Quality Assurance Coordinator, and Quality Assurance Specialist. Additional positions involved in the support of the CCS Program for adults include; Associate Director, Integrated Service Coordinators, Administrative Coordinators, Program Evaluator, Chief Operations Officer, Manager of Quality Improvement, Quality Improvement Coordinators, Quality Assurance Coordinator, and Client Rights Specialist.

8. STAFF TRAINING AND ORIENTATION

Per 36.07 (5) (i) all Comprehensive Community Services (CCS) staff shall be provided with orientation and training that meets the requirements outlined under DHS 36.12. The orientation and training program will be provided, but not limited to, CCS staff, providers, peer specialists, volunteers and consumers. All CCS staff are required to review the "CCS Orientation & Training" policy found in PolicyStat and on the BHD Provider Webpage, which outlines initial and ongoing training requirements.

Additionally, staff are required to review the "CCS Quality Improvement", "CCS Revising Plan", "CCS Monitoring and Compliance" policies, and all other policies associated with the CCS program.

9. QAPI FRAMEWORK

The CCS Recovery Advisory Committee (RAC) and the BHD CCS Operations Committee are the two committees that have responsibility for the oversight of planning, designing and selection of quality improvement activities to best meet the needs of the CCS consumers. Individuals from

the organization will be selected to conduct performance improvement projects to include monitoring progress, providing input and ensuring individuals involved in projects have technical assistance and guidance.

10. IMPLEMENTATION OF A NON-PUNITIVE STAFF CULTURE

Executive Leadership and the CCS Operations Committee of the Behavioral Health Division will provide an environment that supports individual expression about the CCS Program, any quality concerns, or suggestions for areas of improvement. BHD will support practices and principles of a learning environment and a non-punitive or Just Culture. At all levels of the organization, individuals will be encouraged to bring forth opportunities to improve CCS quality without fear of retaliation. Performance improvement will be encouraged with the deliberate attention to on-going quality with input from those served.

11. DATA SOURCES UTILIZED TO ANALYZE PERFORMANCE

Below are data source for performance options that may be utilized:

| Data Source | Data Collection | Benchmarks Used | Who will analyze the data | Data Analysis Frequency | Data will be communicated with | Communicate data analysis via | Frequency of communication |
|--|-----------------|-------------------------------------|--|-------------------------|---|--|----------------------------|
| PPS Form Bundle | Weekly | Organizational and State Data | CARS and Wraparound Evaluator/Analyst | Monthly | Service Managers, agency supervisors | Dashboard, staff meetings, QAPI Meeting | Monthly |
| RPOC/Domain Based Plan of Care | Weekly | Organizational Data; Best Practices | Care Coordinators, Contract Management | Quarterly | Care coordinators, agency supervisors, service managers | Audit, staff meetings | Quarterly |
| ROSI | Annually | State Data | CARS Program Evaluator/Analyst | Annually | QAPI committee, RAC committee, CCS Staff | Data summary, QAPI Meeting, RAC Meeting, operations Meeting | Annually |
| Billing - Ancillary Services | Daily | Organizational Data | CARS and Wraparound Evaluator/Analyst | Monthly | Service Managers, agency supervisors | State of CCS Staff Meeting (Annual), operations meeting, Dashboard | Monthly |
| Census | Annually | Organizational Data | CARS and Wraparound Evaluator/Analyst | Annually | Service Managers, agency supervisors | Dashboard, staff meetings, QAPI Meeting | Annually |
| MHSIP Family Survey (Ages 12 years or younger) | Annually | State | Wraparound Analyst | Annually | Care coordinators, agency supervisors, service managers | Data summary, QAPI Meeting, RAC Meeting, operations meeting | Annually |
| MHSIP Youth Survey (Ages 13 - 17) | Annually | State | Wraparound Analyst | Annually | Care coordinators, agency supervisors, service managers | Data summary, QAPI Meeting, RAC Meeting, operations meeting | Annually |

12. DATA SOURCES TO IDENTIFY RISK

Below are risk measurement options that may be utilized:

| Data Sources | Data Collection | | Who will analyze the data? | Data Analysis | | Data will be communicated with | Communicate data analysis via | Frequency of communication |
|--------------------------------------|-----------------|-------------------------------------|---|---------------|--|---|---|----------------------------|
| | Frequency | Benchmarks Used | | Frequency | | | | |
| Complaints/Grievances | As Identified | Organizational Data | Client Rights Specialist/Evaluator | As Needed | | Service Managers, agency supervisors, QAPI Committee, and RAC | Reports, QAPI and RAC Meetings | As Needed |
| ROSI | Annually | State Data | BHD Evaluator, Care Coordinators, Contract Management | Annually | | Care coordinators, agency supervisors, service managers | Data summary, QAPI Meeting, RAC Meeting, operations Meeting | Annually |
| Abuse, Neglect, Maltreatment reports | As Identified | Best Practices; Organizational Data | TBD | As Needed | | QAPI committee, RAC, CCS Staff | Data summary, QAPI Meeting, RAC Meeting, operations Meeting | As Needed |
| PPS/NOMs | Ongoing | Organizational Data | Evaluator/Analyst | Monthly | | Service Managers | Operations Meeting, Dashboard | Monthly |
| MHSIP Family Survey | Annually | State Data | Wraparound Analyst | Annually | | Care coordinators, agency supervisors, service managers | Data summary, QAPI Meeting, RAC Meeting, operations Meeting | Annually |
| MHSIP Youth Survey | Annually | State Data | Wraparound Analyst | Annually | | Care coordinators, agency supervisors, service managers | Data summary, QAPI Meeting, RAC Meeting, operations Meeting | Annually |
| Critical/Sentinel Events | As Identified | Case by case | SCC Committee | As Needed | | Programs as indicated, MHB, and MHB quality committee | Data summary | Annually |

13. DATA SOURCES TO COLLECT FEEDBACK/INPUT

Below are options that may be utilized for feedback/input from consumers and providers:

| Data Sources | Data Collection | | Who will analyze the data? | Data Analysis | | Data will be communicated with | Communicate data analysis via | Frequency of communication |
|---|-----------------|---------------------|---|---------------|--|---|---|----------------------------|
| | Frequency | Benchmarks Used | | Frequency | | | | |
| ROSI | Annually | State Data | Care Coordinators, Contract Management | Annually | | Care coordinators, agency supervisors at the care coordination agency, service managers | QAPI, RAC, and Operations Meetings, data summary and presentation | Annually |
| ROSI - CORE | Annually | State Data | Wraparound Evaluator/Analyst | Annually | | TBD | TBD | TBD |
| Recovery Team Meeting (RPOC)/Plan of Care Meeting | Monthly | Organizational Data | CARS CCS Staff, Contract Management | Quarterly | | CCS Staff, QAPI Committee | Brief Report/Scorecard, recovery team meetings and QAPI meeting | Quarterly |
| Focus Groups (For Contract Performance Measures (CPMs)) | As Needed | Organizational Data | CARS and Wraparound Evaluator/Analyst, CPM Workgroup | As Needed | | Service Managers, Executive Leaders, CCS Staff | Data summary, QAPI Meeting, CPM Workgroup Meeting | As Needed |
| MHSIP Family Survey | Annually | State | Wraparound Analyst | Annually | | Care coordinators, agency supervisors, service managers | TBD | Annually |
| MHSIP Youth Survey | Annually | State | Wraparound Analyst | Annually | | Care coordinators, agency supervisors, service managers | TBD | Annually |
| Family Provider Surveys | Quarterly | Organizational Data | Wraparound Quality Assurance Department and Evaluator | Annually | | Provider agencies, internal administrative staff, identified BHD and community partners, and State partners | Data summary and reports, QAPI meeting, RAC meeting | Annually |

14. CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS (PIP's)

The Comprehensive Community Services (CCS) program/Behavioral Health Division will conduct PIP's in identified areas, in an effort to improve direct client care, services, or practices that may affect client care. PIP's will be conducted that address areas of concern/need/risk that may cross both adult and children's services. PIP's may address client/staff quality of life and/or quality of care issues, service delivery, efficiencies issues, desired outcomes and satisfaction levels for the populations served.

15. IDENTIFICATION OF PIP TOPICS

PIP's will be chosen using a systematic approach that considers a topic important to the population served or service staff, one that effects a significant portion of the staff or the population served, and one that reflects a high-volume or high-risk condition of the population served. Input from clients, families, staff, stakeholders, service providers, etc., will be sought. Data and any outcome information will be analyzed to support needed improvements/topic areas. In addition, consideration will be given to the following:

- Existing standards or guidelines available to provide direction for the PIP
- Measures that can be used to monitor progress
- The ability to benchmark against community, state and national outcomes

16. PRIORITIZING AND SELECTING PIP's

Potential areas for improvement are based on the needs of the population served and the program/organization. How relevant (high-risk, high prevalence, high volume) and important is the PIP to those served? How does it relate to the health, functional status and quality of life of the population? How many will be impacted by the hopeful improvement? Does the organization have all the resources (staff, money, supplies, technology, training capacity) to implement all the identified strategies? Will the change affect the efficiencies of the organization/staff? Does the PIP support the organizations goals and strategic plan? Will any change be able to be sustained? Are there identified "champions" to lead the PIP?

All of the above will be discussed and considered in an effort to prioritize all the ideas on the table. The top identified 2-3 items will be further discussed and a team decision will be made as to the selected topic. If the Team cannot arrive at a decision, then a voting process may be implemented, and /or the ideas may need to go to an identified committee for final determination.

17. PIP CHARTER DEVELOPEMENT

PIP Charters may need to be developed if it is determined that it would be helpful to have a group/committee of individuals direct the project. A Charter can establish the goals, scope, timing, milestones, team roles and responsibilities for the PIP. The Charter will help the team/workgroup stay focused by reminding them of the hopeful outcomes and the goals to be accomplished.

18. THE DESIGNATION OF PIP TEAMS

When establishing the PIP work team, the following will be considered:

- Is the individual in a position to explore the issue, i.e. – staff/families/stakeholders/community partners closest to the problem?
- Does the individual know how to and have the authority to acquire the necessary “tools” to implement and make decisions about the project?
- Is each job role that is affected represented?
- What are the needed “characteristics” of the team, i.e. – historical knowledge, interdisciplinary membership including families and clients, level of experience/qualifications – i.e. - leader/organizer/coordinator/analyst/author, etc.

19. CONDUCTING THE PIP

If the PIP must be conducted in a designated contractually-driven fashion, then that project guideline will be followed. If the team identifies another framework to utilize, i.e. – NIATx. Model, PDSA Cycles, then that will provide guidance to the project. Some overarching guidelines to follow are:

- Select a study topic
- What information/supplies are needed?
- Define a study question
- Select study indicators
- Define a study population/sample size
- Define a timeline/action plan
- Create/locate data collection/measurement tools
- Implement improvement strategies/interventions
- Collect/analyze data
- Prepare and present results

20. DOCUMENTATION OF THE PIP

If the PIP must be documented in a designated contractually-driven fashion, then that template will be followed. If not, a template will be determined that will best highlight the project. Formats that will be considered will present the data in a structured, chronologically mindful, clear and sequential manner. The use of charts, graphs, tables, dashboards, posters, etc. will be considered.

Results of the PIP will be communicated to identified individuals/groups, i.e. – families, clients, staff, board members, stakeholders, community partners, the State, etc.

Mechanisms for communication of the project results may take the form of dashboards, posters, Power Point presentations, newsletters, board meetings, QA/QI meetings, staff meetings, community forums, etc.

21. PIP APPROACH AND TOOLS

The CCS QAPI Plan is under the larger BHD Quality Plan, which includes the usage of data informed practices, statistical tools, and continuous improvement. The NIATx protocol provides useful tool for the CCS QAPI committee and its constituents such as flowcharts, fishbone diagrams, Plan-Do-Study-Act (PDSA) cycles, swim-lane diagrams, inter-relationship digraphs, i2 charts, and more. These tools help the QAPI Committee identify and assess gaps, root causes, and other items.

22. PREVENTING NEGATIVE EVENTS AND PROMOTING SUSTAINED IMPROVEMENT

In alignment to the BHD Quality Plan, the CCS QAPI Committee instills this tenant: prevention over correction. Planning will be proactive rather than reactive. This will be done through the following mechanisms:

- A. The RAC will request updates to policies and procedures reflective of change and when necessary.
- B. Contract Performance Measures (CPMs) and other data points will be monitored as needed in the form of audits, data dashboards, and/or scorecards. CCS managers at the County level will review and share information with CCS community provider supervisors at operations meetings.
- C. The QAPI committee will help identify if a gap or problem exists through gap analysis, fishbone diagrams, flowcharts, or other quality improvement mechanisms.

23. ENSURING PLANNED CHANGES/INTERVENTIONS ARE IMPLEMENTED AND EFFECTIVE

Establish SMART Goals. SMART stands for:

- Specific
- Measurable
- Achievable
- Relevant
- Time-Bound

At least one goal should have a form of alignment to the BHD Quality Plan. This may be in alignment to the mission, vision, core values, guiding elements, service quality tenants, quality improvement principles, or continuous quality improvement activities. The QAPI Committee exists under the umbrella of the BHD Quality Plan, and thus should enact Continuous Quality Improvement (CQI) Projects, PIPS, or PDSA cycles relevant to the larger plan.

Contract Performance Measures (CPMs) will also be developed to ensure the CCS program is delivering quality, consumer focused care. The creation and implementation of CPMs is a BHD wide effort to identify quality performance indicators, monitors the achievement of indicators,

and assesses effectiveness. CPMs are supported through literature reviews and focus groups with staff and consumers, reviewed and approved by subject-matter experts, and are continuously revisited by the end of the contract period.

Quality Committee Item 5

Mental Health Board
Quality Subcommittee Meeting
June 3, 2019

Sentinel Event Committee
Quality Summary

The Behavioral Health Division reviewed 13 total events in 2018. These included 6 Sentinel Events and 7 Other Events. In 2017 ten events were reviewed. In prior years the number of total events reviewed has been as high as 39 in 2012 and as low as 5 in 2016.

(Note: Over the years, who is being reviewed under the Sentinel Event procedure has changed. Examples include expanding the reviews to include CARS agencies in July, 2015, the closing of Acute unit 43D in December, 2012 and the closing of the Rehab Center units in December, 2015.)

This year, 46% of reviewed events were deaths by suicide. For comparison:

| | |
|--------------|-------------|
| 50% in 2017 | 18% in 2014 |
| 40% in 2016 | 0% in 2013 |
| 67% in 2015* | 0% in 2012 |

2018 Root Cause Analysis Findings Themes and Findings of Significance

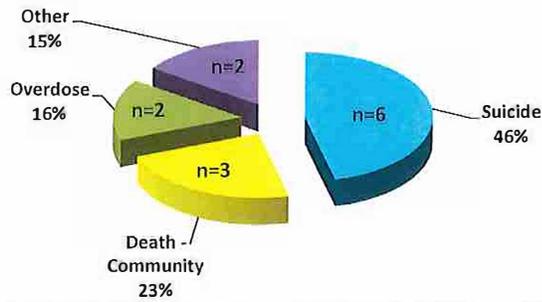
- The vast majority (92%) of events for 2018 occurred in the community. One case occurred within BHD.
- Themes found from reviewed community events include:
 - Lack of sufficient risk assessment. This includes not altering a treatment plan after identified increased risk to self.
 - Patients were not assessed for nor placed in Crisis Case Management when they met the criteria.
 - Frequency of patient contact was consistently less than recommended level.
 - Clinical documentation was too often not thorough or up-to-date.
 - TCM agencies were not consistently in compliance with the BHD Inpatient/Outpatient Collaboration Policy.
- Other themes include:
 - Not all medical record information is available to those in need of the information due to not having access to the utilized EHR.
 - The current service offerings in Milwaukee do not offer an option for true dual-diagnosis treatment. Also lacking is a means by which to offer involuntary AODA treatment.

2018 BHD Sentinel Events

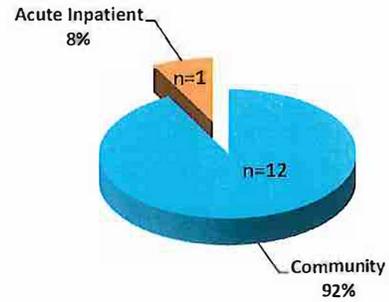
CONFIDENTIAL Peer Review Information

13 incidents reviewed

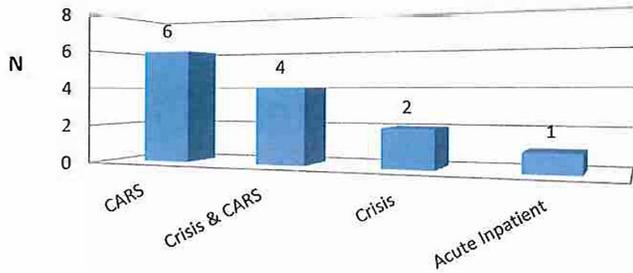
Type of Event



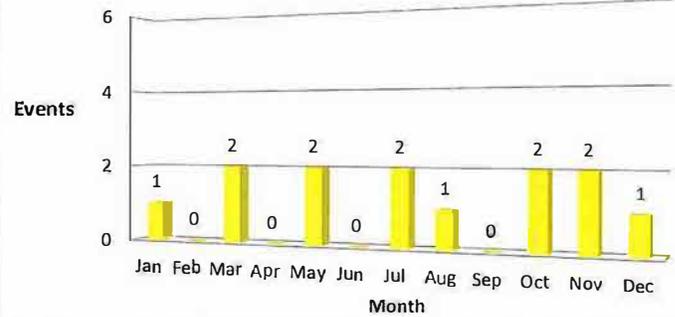
Location of Event



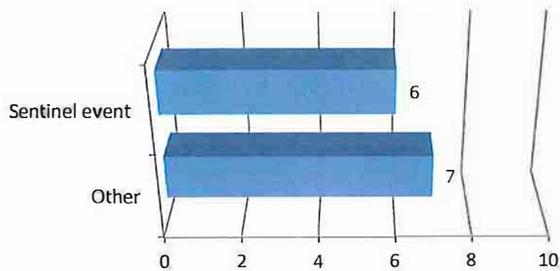
Program (Open with/last contact)



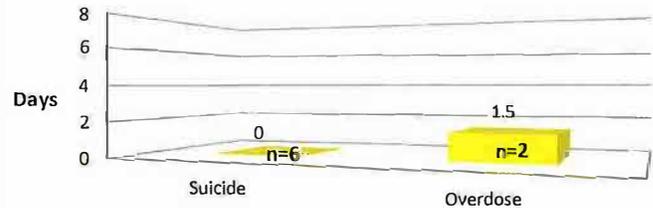
Month of Event



Level of Review

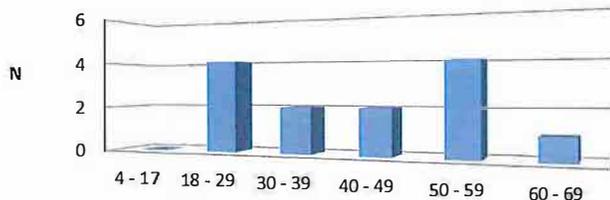


Average Days After Last BHD Contact



Patient Age

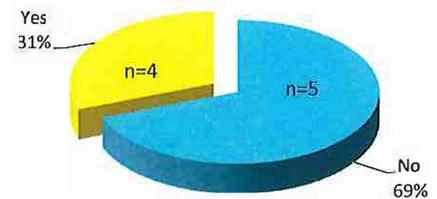
Average Age: 39 yrs male, 47 yrs female; Gender: 77% male, 23% female



| N | 4 - 17 | 18 - 29 | 30 - 39 | 40 - 49 | 50 - 59 | 60 - 69 |
|---|--------|---------|---------|---------|---------|---------|
| N | 0 | 4 | 2 | 2 | 4 | 1 |

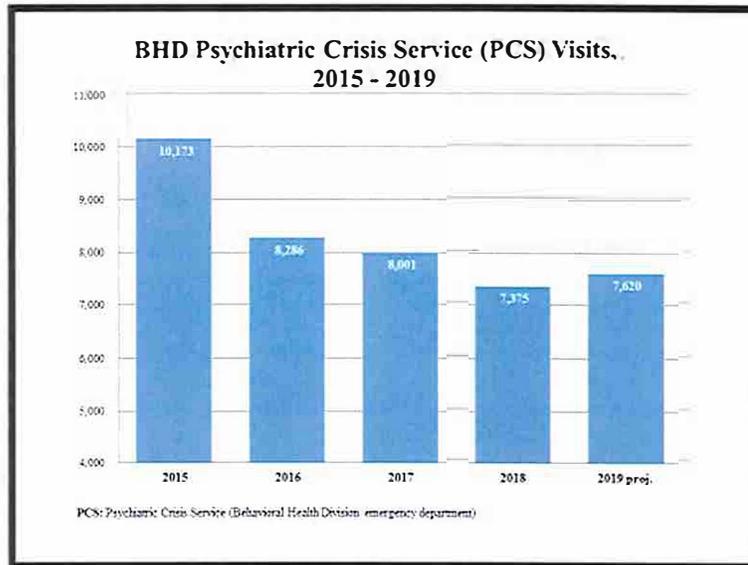
Significant AODA Component to Event

30% (n=4) of events reviewed had a significant AODA component

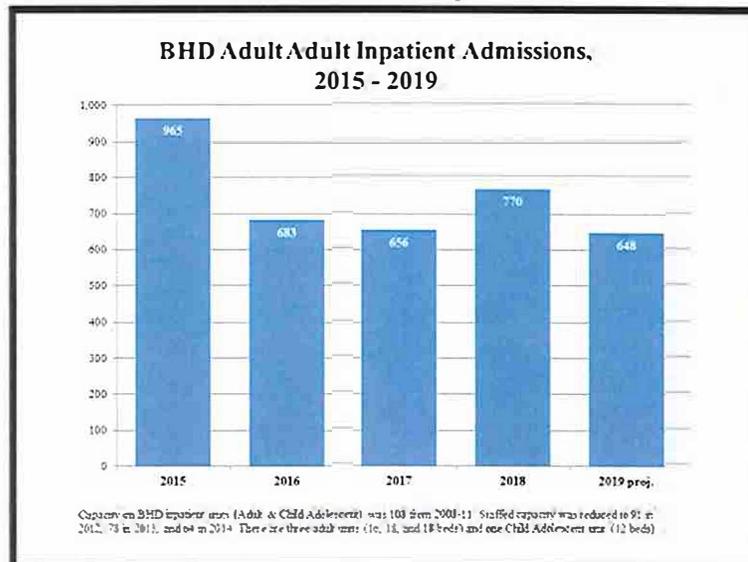


2019 Q1 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary **Quality Committee Item 6**

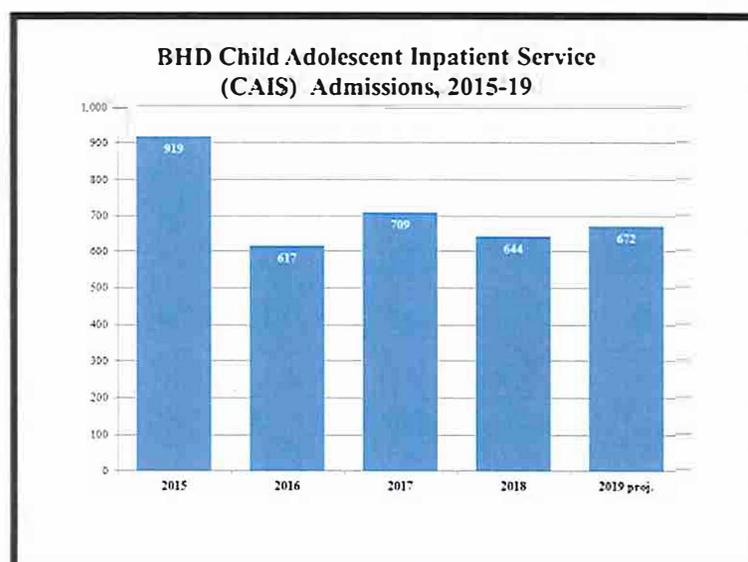
Psychiatric Crisis Service annual patient visits continue to decline from 10,173 in 2014 to 7,620 projected annual visits in 2019 (25% decline from 2015 to 2019). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (9% in 2014, 100% in 2019).



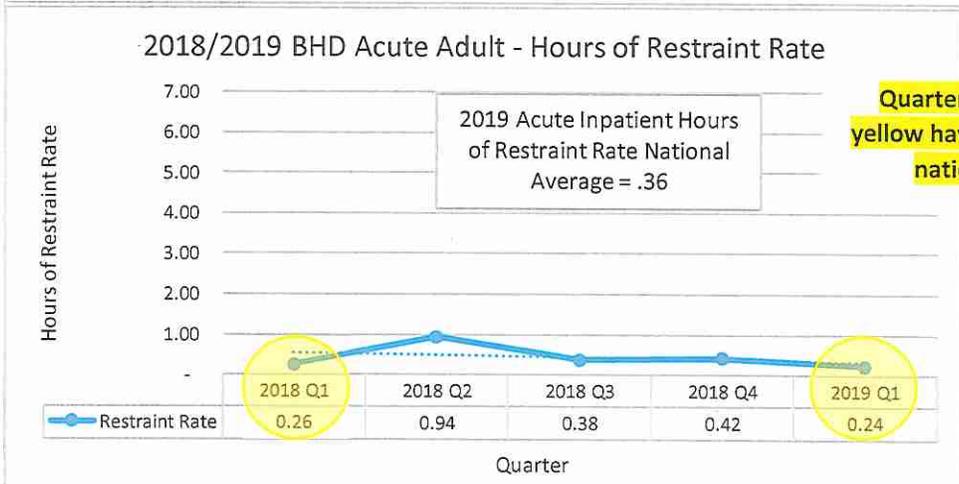
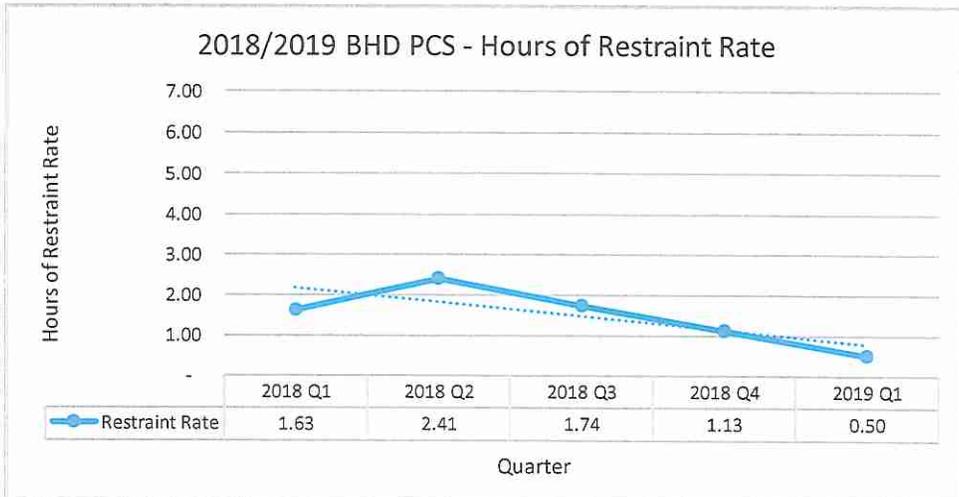
Acute Adult Inpatient Service’s annual patient admissions are projected at 649 in 2019. While Acute Adult admissions have plateaued over the past 4 years, readmission rates have continued to decline (30-day readmission rate: 11% in 2015, 4% in 2019). Acute Adult’s hours of physical restraint rate in 2019 was .24, well below CMS’ inpatient psychiatric facility national average of .36, and below Wisconsin’s average rate of .73. Acute Adult’s 2019 MHSIP overall patient satisfaction survey score of 79.6% was significantly better than NRI’s reported national average of 75%.



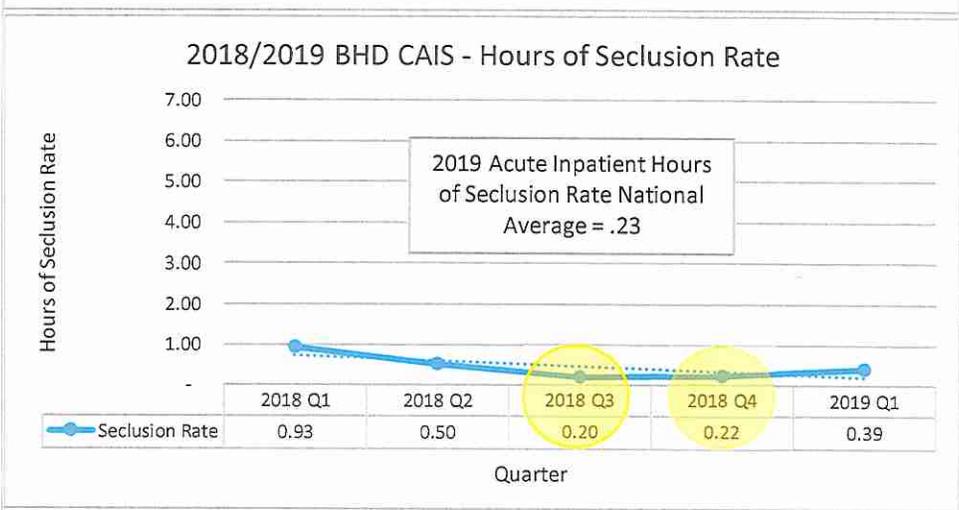
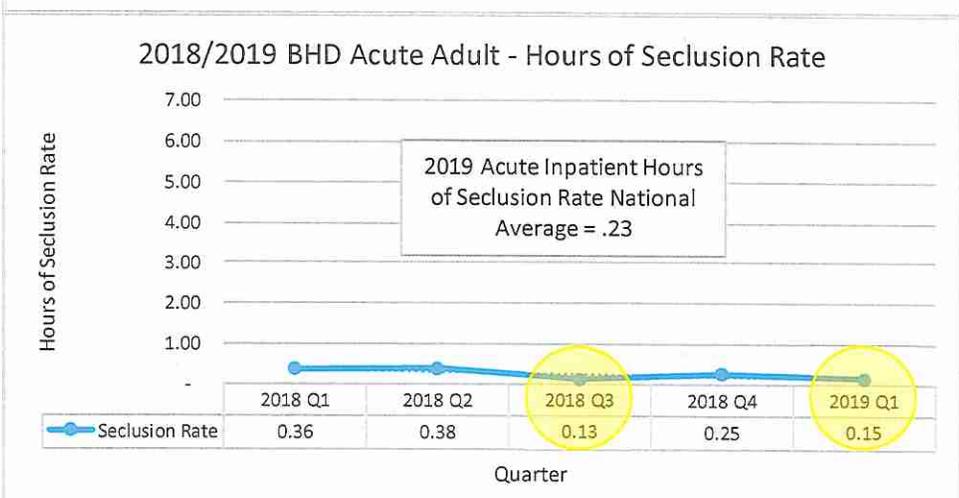
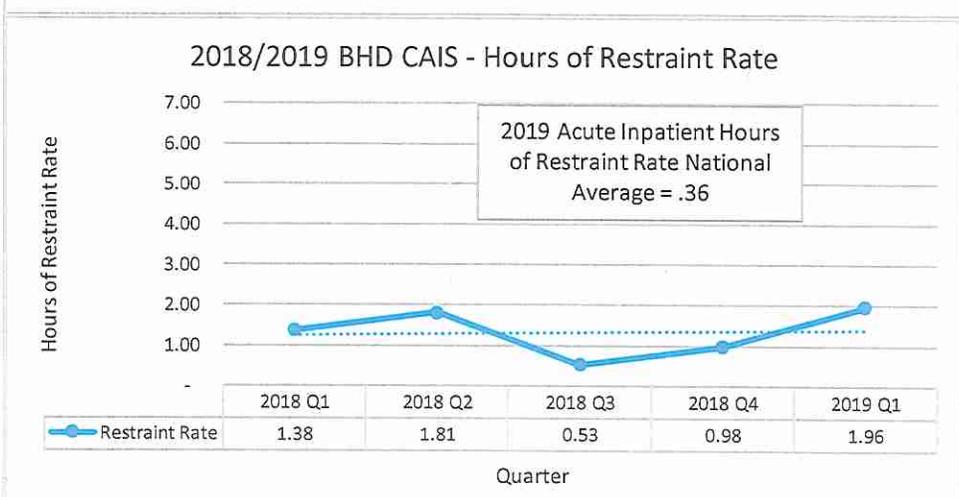
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past 4 years and are projected at 672 for annual 2019. Over the past few years, CAIS’ 30-day readmission rates have remained at 16%. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.9 in 2019, but remains above CMS’ reported average of .36. CAIS’ Youth Satisfaction Survey overall score of 80% positive rating is 5 percentage points higher than BHD’s historical average.



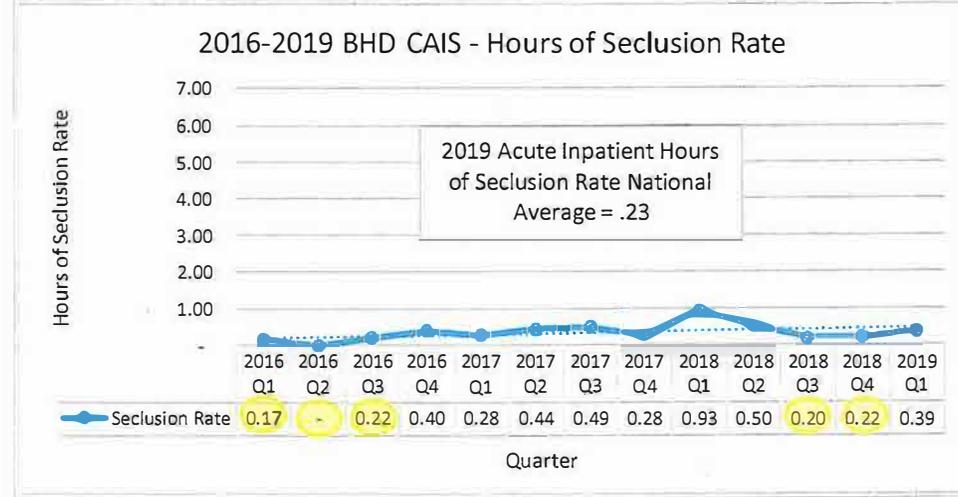
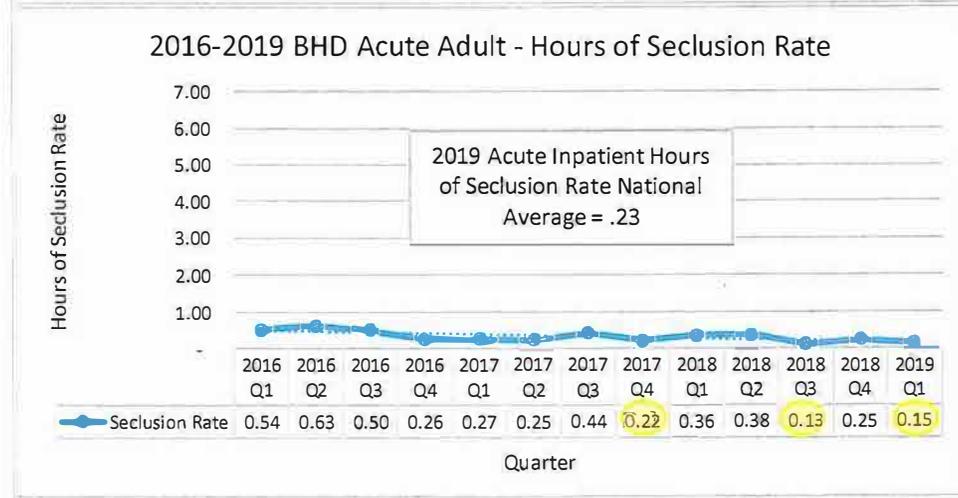
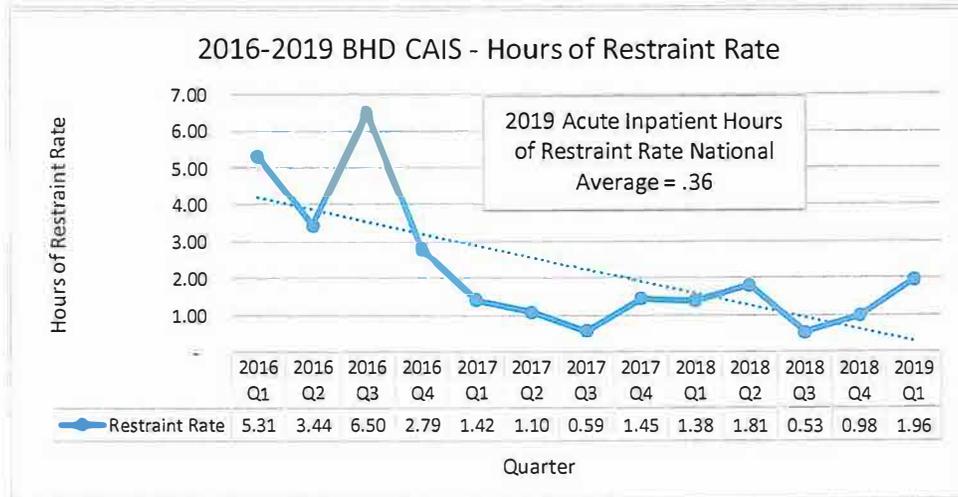
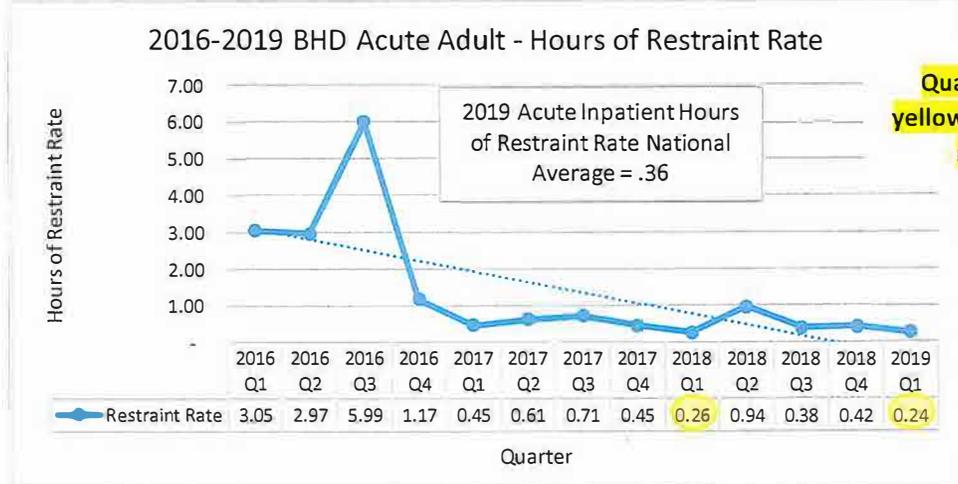
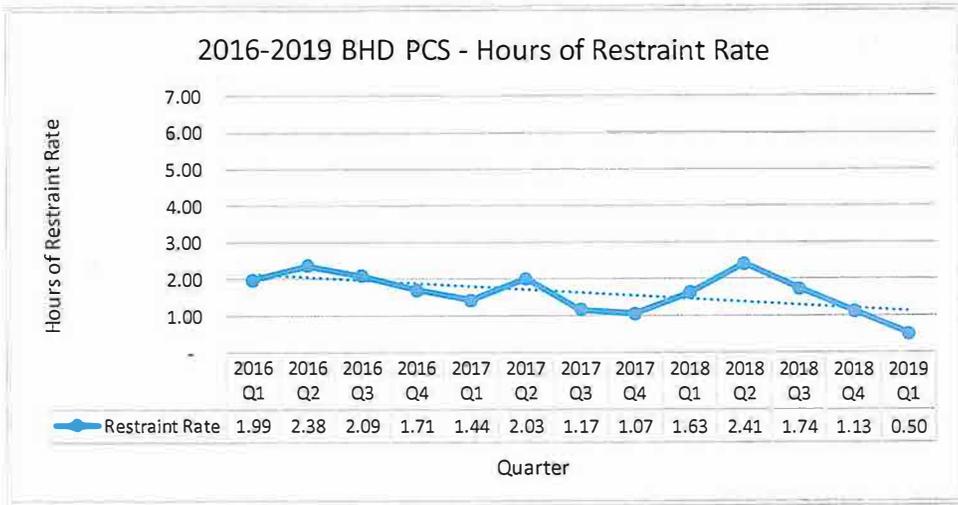
2019 Quarter 1 (Q1) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



Quarters highlighted in yellow have rates below the national average



2016-2019 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary



Hours of Restraint Rate Formula: Restraint Hours / (Inpatient Hours/1,000)



MARY JO MEYERS, MS • Director
MICHEAL LAPPEN MS, LPC • Division Administrator

April 23, 2019

John Chianelli
Executive Director
Whole Health Clinical Group
932 S. 60th St.
West Allis, WI 53214

Re: Notice regarding Whole Health Clinical Group (WHCG) Community Support Program (CSP)

Dear Mr. Chianelli,

Milwaukee County Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) is submitting this communication as notice that all referrals to the Whole Health Clinical Group Community Support Program (CSP) are being suspended as of this date until further notice. Milwaukee County BHD has previously had to stop referrals to WHCG CSP on February 28, 2017, and June 20, 2018, due to quality concerns.

This action is being taken due to concerns regarding deficiencies in standards of care, quality and timeliness of documentation, and billing practices. Some examples of these concerns, listed below, come from a record review, completed on documentation from October 1, 2018 to December 31, 2018:

- Only 5 of the 29 client files reviewed in this audit (17%) have evident that clients are being seen and receiving services at the frequency identified in their Recovery Plan of Care (RPOC)
- 114 of 288 clients (40%) had 2 hours/week or less of services
51 of 288 clients (18%) had 1 hour/week or less of services
28 of 288 clients (10%) had 30 minutes/week or less of services
- 48 of 142 authorizations (34%) were submitted late
- Duplicate and triplicate notes submitted that led to double and triple billing (recoupment in process)

Attached is the full agency review report from an audit that was completed in March 2019. This report includes all findings from the audit to include positive trends, qualitative findings, and quantitative findings. CARS leadership is requesting to meet with your CSP leadership team to discuss the audit findings on Monday, April 29, 2019, at 3:30pm in CARS unit 44A conference



BHD

MILWAUKEE COUNTY
Behavioral
Health
Division

room 13. If your team is unable to meet at that time, please let me know, and we will find a date and time that is more accommodating.

Please be aware that as a contracted provider of services with Milwaukee County BHD, the findings, corrections, and/or outcomes of quality and compliance audits will be reported to the Quality Committee of the Milwaukee County Mental Health Board and other applicable entities as required.

Sincerely,

A handwritten signature in black ink that reads "Amy Lorenz".

Amy Lorenz, MSSW, LCSW
Deputy Administrator
Community Access to Recovery Services
Milwaukee County Behavioral Health Division

Quality Committee Item 9

Quality Management Committee Institutional Review Board (IRB) Report June 3, 2019

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 Moisio, Ms. Linda Oczus, and Dr. Jaquaye Russell.

Recently Completed Research

- Ms. Jessica Saldivar completed a quality improvement project titled: “Perceptions of Compassion Fatigue in Psychiatric Nurses” (2/19/19).

Existing Research

- The IRB has approved and continues to routinely monitor the following proposals:
 - i) Dr. Tina Freiburger: “An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division” (5/24/17).
 - ii) Dr. Gary Stark: “Survey of Suicidal Behavior Among Individuals with a Developmental Disability” (2/7/19).
 - iii) Dr. Pnina Goldfarb: “Building a Collaborative Care Model: An Approach for Effective Early Identification and Treatment of High School Students at Risk for Developing Psychosis” (2/18/19).
 - iv) Dr. John Schneider: “A Comparison of Adult Patient Experiences of Voluntary and Involuntary Commitment at Milwaukee’s Behavioral Health Department” (3/25/19).

Research Proposals

- The IRB recently received a proposal submitted by Ms. Chioma Anyanwu titled: “Improving the Quality of Nursing Assessment and Documentation of Patients with Suicide Risk” (4/29/19).

Monthly IRB Chairs Meeting

- The Medical College of Wisconsin (MCW) hosts a monthly meeting of IRB Chairs. The purpose of the meeting is to share information and discuss pertinent issues, which promotes best practices among the various IRBs. Dr. Kuehl continues to routinely attend these meetings.
- At a recent meeting, the MCW leadership offered to provide additional training to support the BHD IRB. The training is scheduled occur in August 2019.

Crisis Services Grand Rounds: November 4, 2019

- The IRB believes there is an opportunity to offer additional training for BHD staff. The training would discuss the basic definition of research while promoting the existence and utilization of the IRB. With these goals in mind, there will be an upcoming Crisis Services Grand Rounds presentation titled, “Research in Mental Health: An IRB Update.”

Respectfully submitted,

Justin Kuehl, PsyD
Chief Psychologist
IRB Chair

Quality Committee Item 10

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 |
|----------------------------|--------------|----------------------------|------------------|
| December | 10 | 9 | 1 |
| January | 5 | 12 | 0 |
| February | 1 | 15 | 1 |
| March | 3 | 16 | 0 |
| April | 2 | 9 | 0 |

Overall Progress 96.2% as of May 1, 2019

| Current | | | | |
|--|--------------------|------------|---------------------|-------------|
| Review period | Number of Policies | | Percentage of total | |
| | Last Month | This Month | Last Month | This Month |
| Within Scheduled Period | 530 | 534 | 95.8% | 96.2% |
| Up to 1 year Overdue | 18 | 15 | 3.3% | 2.7% |
| More than 1 year and up to 3 years overdue | 2 | 3 | 0.4% | 0.5% |
| More than 3 years and up to 5 years overdue | 1 | 1 | 0.2% | 0.2% |
| More than 5 years and up to 10 years overdue | 1 | 1 | 0.2% | 0.2% |
| More than 10 years overdue | 1 | 1 | 0.2% | 0.2% |
| Total | 553 | 555 | 100% | 100% |

Forecast Due for Review

Past Due Policies - 21

Coming Due Policies

May - 2

June - 4

July - 8

August - 44

September - 1

October - 19

November - 10

December - 18

January 2020 - 9

February 2020 - 12

March 2020 - 12

April 2020 - 4

COMMUNICATIONS UPDATE

Mental Health Board Report / June 2019

EMPLOYEE ENGAGEMENT

- The Q1/Spring Newsletter was distributed in April and featured a recap of the success of Light & Unite Red, an Employee Spotlight article about Lauren Hubbard, the Director of Community Crisis Services and a Program Spotlight article on Peer Run Respite. New sections of the newsletter are a Calendar of Events and a poll question to assess employee perception of the content of the newsletter. Q1/Spring Newsletter analytics follow:
 - Distribution - 567; Successful Deliveries - 479
 - Open Rate - 60% or 288
 - Poll Question (Did this newsletter provide useful information?) - 84% of respondents said yes to indicate they feel the newsletter provided useful information.
- The Q2/Summer Newsletter will be sent out at the end of June to BHD staff, Mental Health Board members and providers.
- Town Hall Meetings
 - April
 - The agenda for the April Town Hall Meetings included updates on the Universal Health Services hospital, crisis services redesign, retention agreements and security and answers to the questions employees submitted using the BHD question boxes.
 - Round-Up analytics
 - Distribution - 534; Successful Deliveries - 453
 - Open Rate - 54% or 245
 - May - the May Town Hall Meetings will take place on Thursday, May 16.

MENTAL HEALTH BOARD ENGAGEMENT

Board Member Biography Project - Kane developed a new biography template and drafted updated biographies for review and approval by Mental Health Board members. The new biographies will be used on the BHD website and placed in board member binders.

COMMUNITY RELATIONS

- Innovation Day event coordination and communications support. BHD is a partner in the 3rd Annual Innovation Day hosted by UnitedHealthcare Community Plan and Miracle. The event, *Think Differently & Innovate Uniquely* will be on June 6, 2019 at 11 a.m. at the Zoofari Conference Center. Innovation Day highlights include:
 - Lunch and networking
 - Opening remarks by Lieutenant Governor Mandela Barnes



- Special presentation of *Pieces in My Own Voice*, an evidence-based play written by Brenda Wesley, Milwaukee County Mental Health Board Member and Director of Programming, Miracle
- Conversations with leading mental and behavioral health experts about how they “Think Differently & Innovate Uniquely” (TED talk style)
- An update from Michael Lappen, the Administrator of Milwaukee County Behavioral Health Division on the Milwaukee County mental health system redesign and an opportunity to meet the Milwaukee County Mental Health Board Members

Please register at <https://innovationday2019.app.rsvpify.com/> no later than May 30, 2019. Reach out to Theresa Hunter, UnitedHealthcare Community Plan Marketing Communications Manager, at theresa_a_hunter@uhc.com with any questions.

- Mental Health Month / Nurses Week
 - Distributed 5 e-blasts to Mental Health Board members, staff and providers.
 - Mental Health Month, Mike Lappen
 - A message introducing Mental Health Month and the community events planned for the month.
 - Happy Nurses Week, Linda Oczus
 - A message thanking nurses for their service, a history of Nurses Week and a video of BHD nurses talking about their careers.
 - Happy Nurses Week, Mental Health Board
 - A message thanking BHD staff for their commitment and service, along with a video of Mental Health Board member Kathleen Eilers discussing her career as a nurse.
 - Mental Health Month, Mike Lappen
 - A follow-up message about Mental Health Month, the community events that are remaining in the month and a video of Mental Health Board chair Tom Lutzow discussing the progress in the industry.
 - Mental Health Month, Mike Lappen
 - A final message thanking BHD staff or their participation in Mental Health Month and their commitment to the community and a video of Mental Health Board Member Pastor Lanier encouraging community members that there are mental health resources and supports available if needed.
 - Created 3 videos
 - 1 for Nurses Week featuring Kathleen Eilers. The video can be repurposed for nurse recruitment.
 - 2 for Mental Health Month, featuring Tom Lutzow and Pastor Lanier. Both videos can be repurposed for future use.
 - Wrote a press release on behalf of the County Executive and BHD explaining the importance of Nurses Week and the free community events taking place.
 - Recorded employee testimonials for nurse recruitment Facebook page
 - Media Pitching
 - Secured various placements for both Mental Health Month and Nurses Week including:
 - Lauren Hubbard, interview with *Milwaukee Courier*



- Mike Lappen and Lauren Hubbard, live interview on WNOV radio
- Jeff Munz, live interview on WISN12
- Mike Lappen, interview with *Milwaukee Courier*
- Jessica Saldivar, interview with Telemundo Television
- Vie Lucas, interview with TMJ4

TRANSITION COMMUNICATIONS

An analysis of the BHD website was completed in March and recommendations were presented to BHD leadership in April. The recommendations are in the process of being implemented and include tactics for enhancing the content, measuring the effectiveness of the content and increasing the intuitiveness and overall usefulness of the website.

NURSE RECRUITMENT CAMPAIGN

- Connected BHD and downtown HR for the purposes of sharing nurse recruitment campaign plans, coordinating the promotion of the campaign and clearly defining the roles of Kane, BHD HR and downtown HR.
- Reached out to 19 local universities for opportunities to promote the Nurse Recruitment Fairs. Nine colleges responded with interest. The Kane team provided a summary sheet to Jeff Munz with action items from those colleges.
 - Kane sent the nurse recruitment job fair flyer to those nine colleges.
 - Kane suggested putting together a Handshake account for the county, which is a career network for college students and recent grads - where BHD can target graduating nursing seniors.
- Developed a nurse recruitment brochure for ambassadors to take one piece of collateral with them.
- The next Nurse Recruitment Job Fair is May 20th from 1 - 4 p.m. at the Behavioral Health Division.

MEDIA COVERAGE

| | | | |
|--------------------------|--|--|--------------|
| <i>Milwaukee Courier</i> | Community partners across the county will host free events throughout the month of May | Mental Health Awareness Month | May 3, 2019 |
| WNOV | WNOV Community Voice Segment | Mental Health Awareness Month / Nurse Appreciation | May 6, 2019 |
| WISN12 | Jeff Live Shot | Nurse Appreciation / Nurse Recruitment | May 6, 2019 |
| TMJ4 | Talking About Trauma With Your Children | Childhood Trauma | May 10, 2019 |
| <i>Milwaukee Courier</i> | Anyone Can be Affected by Mental Health | Nurse Appreciation | May 10, 2019 |
| <i>Milwaukee Courier</i> | Interview with Mike Lappen and Dr. Dykstra | Mental Health Awareness Month | May 21, 2019 |



| | | | |
|-----------|---|---|--------------|
| Telemundo | Interview with Jessica Saldivar | Mental Health Month | May 21, 2019 |
| TMJ4 | Vie Live Shot | Mental Health Month / Nurse Appreciation | May 23, 2019 |



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

DATE: May 22, 2019

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

FROM: Shane V. Moiso, 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

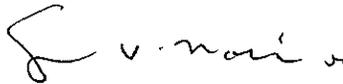
From the President of the Medical Staff Organization and Chair of the Medical Executive Committee presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C¹ :

- 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,



05/22/19

Shane V. Moasio, MD
President, BHD Medical Staff Organization

cc Michael Lappen, BHD Administrator
John Schneider, BHD Chief Medical Officer
M. Tanja Zincke, MD, BHD 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
MAY-JUNE 2019**

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 MAY 8, 2019 | MEDICAL STAFF EXECUTIVE COMMITTEE MAY 15, 2019 | GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY) |
|----------------------|--------------------|--------------------------|-----------|------------------------------------|--|--|--|
| MEDICAL STAFF | | | | | | | |
| NONE THIS PERIOD | | | | | | | |
| ALLIED HEALTH | | | | | | | |
| NONE THIS PERIOD | | | | | | | |

| REAPPOINTMENT / REPRIVILEGING | PRIVILEGE GROUP(S) | APPT CAT/ PRIV STATUS | NOTATIONS | SERVICE CHIEF(S) RECOMMENDATION | CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 8, 2019 | MEDICAL STAFF EXECUTIVE COMMITTEE MAY 15, 2019 | GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY) |
|----------------------------------|---|--------------------------------------|-----------|--|--|--|--|
| MEDICAL STAFF | | | | | | | |
| Reono Bertagnolli, MD | Diagnostic Radiology – X-Ray Interpretation and Ultrasound Interpretation | Consulting Telemedicine / Full | | Dr. Schneider on behalf of Dr. Puls recommends reappointment & privileges, as requested | Committee recommends reappointment and privileges, as requested, for 2 years. No changes. | Recommends reappointment and privileging as per C&PR Committee. | |
| Steven Dykstra, PhD | General Psychology- Adult, Child and Adolescent | Associate / Full | | Drs. Kuehl & Moiso recommend reappointment & privileges, as requested | Committee recommends reappointment and privileges, as requested, for 2 years. No changes, contingent on receipt of outstanding dues payment by 12:30P 5/15/19. <i>Dues payment received before close of business on 05/08/19.</i> | Recommends reappointment and privileging as per C&PR Committee. | |
| Michael Hinz, MD | Diagnostic Radiology – X-Ray Interpretation and Ultrasound Interpretation | Consulting Telemedicine / Full | | Dr. Schneider on behalf of Dr. Puls recommends reappointment & privileges, as requested | Committee recommends reappointment and privileges, as requested, for 2 years. No changes. | Recommends reappointment and privileging as per C&PR Committee. | |
| Noah Jeannette, DO | General Psychiatry | Active / 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. | |
| Gregory Jurenc, PhD | Privileges Not Requested / Psychology Dept. | Consulting / Appointment Only | | Drs. Kuehl & Schneider recommend reappointment, as requested | Committee recommends reappointment, as requested, for 2 years. | Recommends reappointment and privileging as per C&PR Committee. | |
| Annaliese Koller Shumate, DO | General Psychiatry | Active / Full | B | 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. | |
| David Macherey, PsyD | General Psychology- Adult; Extended Psychology-Acute Adult Inpatient | Associate / Full | M# | Drs. Kuehl & Zincke 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. | |
| Kevin Murtaugh, MD | General Psychiatry | Affiliate / Full | B | 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. | |

| REAPPOINTMENT / REPRIVILEGING | PRIVILEGE GROUP(S) | APPT CAT/ PRIV STATUS | NOTATIONS | SERVICE CHIEF(S) RECOMMENDATION | CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 8, 2019 | MEDICAL STAFF EXECUTIVE COMMITTEE MAY 15, 2019 | GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY) |
|-------------------------------|---|--------------------------------|-----------|---|---|---|---|
| Maitrayee Vadali, MD | Internal Medicine/Cardiovascular Disease – EKG Interpretation | Consulting Telemedicine / Full | M# | Dr. Schneider on behalf of Dr. Puls recommends reappointment & privileges, as requested | Committee recommends reappointment and privileges, as requested, for 2 years. No changes. | Recommends reappointment and privileging as per C&PR Committee. | |
| ALLIED HEALTH | | | | | | | |
| Jenta Alexander, MSN | Advanced Practice Nursing-Family Practice | Allied Health / Full | B | Dr. Schneider on behalf of Dr. Puls recommends privileges, as requested | Committee recommends privileges, as requested, for 6 months. 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 MAY 8, 2019 | MEDICAL STAFF EXECUTIVE COMMITTEE MAY 15, 2019 | 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 | | | | | | | |
| Denis Birgenheir, PhD | General Psychology | Associate / Provisional | Associate / Full | Dr. Thrasher 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. | |
| Sabeen Haque, MD | General Psychiatry | Affiliate/ Provisional | Affiliate / Full | Dr. Thrasher 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. | |
| Hillary Wynn, MD | General Psychiatry; Child Psychiatry | Active/ Provisional | Active / Full | Dr. Moio 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 MAY 8, 2019 | MEDICAL STAFF EXECUTIVE COMMITTEE MAY 15, 2019 | GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY) |
|-------------------------------|--|-----------------------------------|---|--|--|---|
| Olga Hadden, MD | Affiliate Staff | Active Staff | Dr. Schneider recommends amending appointment, as requested | Committee recommends change in appointment from Affiliate to Active Staff for remainder of current appointment biennium. | Recommends appointment change, as per C&PR Committee. | |
| Samantha Lavarda, PsyD | General Psychology | Amend to include Child Psychology | Drs. Kuehl & Moio recommend amending privileges, as requested | Committee recommends amending current privileges to include Child Psychology, subject to a minimum provisional period of 6 months. | Recommends amending privileges, as per C&PR Committee. | |

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

5/17/19

DATE

 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

05/22/19

DATE

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

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

 GOVERNING BOARD CHAIRPERSON

 DATE

BOARD ACTION DATE: JUNE 20, 2019

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

DATE: May 22, 2019
TO: Thomas Lutzow, Chairperson, Milwaukee County Mental Health Board
FROM: Shane V. Moisio, 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 Changes to the Behavioral Health Division Medical Staff Organization Rules and Regulations

Background

Under Wisconsin and Federal regulatory requirements, the Medical Staff Organization must develop and adopt Bylaws, Rules and Regulations. After adoption or amendment by the Medical Staff Organization, it is also required that these governing documents, and any changes thereto, be presented to the Governing Authority for action. All Bylaws and Rules and Regulations amendments become effective only upon Governing Authority approval. In accordance with Joint Commission standard MS.01.01.03 and CMS CoP §482.12(a)(4), neither the organized medical staff or the governing body may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. As is permitted, the Bylaws grant authority to the Medical Staff Executive Committee (MEC) to adopt rules and regulations on behalf of the Medical Staff Organization, with appropriate advance notification to medical staff members. The required advance notification regarding the amendment contained herein was provided on May 3, 2019 prior to approval action by the MEC on May 15, 2019.

Discussion

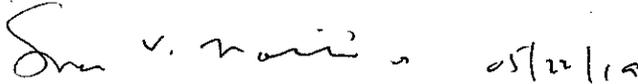
The following Rules and Regulation change was recommended and approved by the Medical Executive Committee:

| SCOPE & REASON FOR CHANGE | |
|--|---|
| This change is being made to conform with current CMS regulation [§ CFR(s):482.61(b)]: | |
| 2.5.4 | Inpatient Programs - The patient's record shall contain: <ul style="list-style-type: none"> 2.5.4.1 a psychiatric evaluation including an initial plan of treatment, mental status examination, <u>an inventory of the patient's assets in descriptive, non-interpretive fashion</u>, diagnosis, and estimated length of stay, shall be completed and documented within <u>24-60</u> hours after admission of the patient; |

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve the Rules and Regulations, as amended and adopted by the Medical Staff Executive Committee, on behalf of the Medical Staff Organization on May 15, 2019.

Respectfully Submitted,



Shane V. Moisis, MD
President, BHD Medical Staff Organization

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

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

DATE: May 22, 2019

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 Approval of the Newly Developed Provider Network Credentialing Program for Community Access to Recovery Services and Wraparound Milwaukee

Background

Wraparound Milwaukee has had a formal practitioner credentialing process in place for many years, but similar credentialing processes have not been fully applied or required, to date, for the Community Access to Recovery Services (CARS) providers.

To better serve the interests of Milwaukee County's citizens and provider network members and service recipients of all ages, it is the duty and responsibility of the Behavioral Health Division to require every licensed independent practitioner to undergo a comprehensive credentialing review, when seeking to participate in the network.

Discussion

The purpose of the BHD Provider Network Credentialing Program is to ensure that its physician, advanced practice nurse and licensed clinical and counseling psychologist practitioners participating, or those seeking to participate, in the network meet the established minimum thresholds for participation, which include, but are not limited to, the standards of professional licensure, training and certification.

The BHD Provider Network Credentialing Program was developed based upon Centers for Medicare/Medicaid, Wisconsin Department of Health Services, and National Committee for Quality Assurance standards and guidelines as well as nationally recognized managed care credentialing best practices. The scope of the BHD Provider Network Credentialing Program includes credentialing of all practitioners seeking initial approval as well as requisite periodic recredentialing and ongoing monitoring of all practitioners once approved as network participants.

With adoption of this new Provider Network Credentialing Program, standardized credentialing processes will be performed on licensed independent practitioners who are

- (a) beginning a relationship with the BHD Provider Network; or
- (b) have an existing relationship at the time that this plan is adopted but have not previously been required to complete the credentialing process; and
- (c) are practitioners who meet the established minimum requirements to apply for participation with the BHD Provider Network

If approved by the Mental Health Board, the Behavioral Health Division Community Access to Recovery Services and Wraparound Milwaukee Provider Networks, with oversight and administration by the Medical Directors and a single Provider Network Credentialing Committee, are prepared to consistently, uniformly and fairly carryout the processes detailed within the BHD Provider Network Credentialing Program.

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve the BHD Provider Network Credentialing Program, as presented and approved by the BHD Provider Network Credentialing Committee on May 22, 2019, for implementation beginning July 1, 2019.

Respectfully Submitted,



Mary Jo Meyers, Director
Department of Health and Human Services

- cc John Schneider, MD, Chief Medical Officer and PN-Credentialing Committee Chair
Amy Lorenz, Deputy Administrator, CARS
Brian McBride, Director, Wraparound Milwaukee
Shane Moasio, MD, Medical Director-Child and Adolescent Services
Dennis Buesing, DHHS Contract Administrator
Auriel Ackerman, Manager of Contract Compliance-Contract Management
Heidi Ciske-Schmidt, Integrated Services Manager of Operations, Wraparound Milwaukee
Brenda Smith-Jenkins, BHD Manager of Contracts & Network Services
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

Attachment

- 1 BHD Provider Network Credentialing Program - CARS & Wraparound Milwaukee



BHD

MILWAUKEE COUNTY
Behavioral
Health
Division

Provider Network Credentialing Program

**Community Access to Recovery Services
(CARS)**

and

Wraparound Milwaukee

July 2019

Executive Summary: Credentialing Program Description

Effective: July 2019

Purpose:

The BHD Provider Network Credentialing Program is comprehensive and ensures that its practitioners meet the standards of professional licensure, training and certification. The process enables BHD to recruit and retain a quality network of practitioners to serve its members and ensure ongoing access to care.

Scope:

The scope of the Credentialing Program is comprehensive and includes credentialing, recredentialing and ongoing monitoring of all BHD Provider Network physicians, licensed clinical and counseling psychologists and advanced practice nurses. All such physicians and licensed independent practitioners with an unrestricted, current and valid Wisconsin professional license are eligible to participate.

The BHD Provider Network Credentialing Program is reviewed and updated, at least biennially, by the Credentialing Committee based upon CMS, Wisconsin DHS, NCQA requirements and recognized managed care credentialing best practices. The Credentialing Program shall be approved by the BHD Provider Network Credentialing Committee, the Wraparound and Community Access to Recovery Services Administrators, the BHD Chief Medical Officer, the BHD Administrator and the Mental Health Board.

TABLE OF CONTENTS

| | |
|--|----|
| I. Definitions | 1 |
| II. Introduction | 5 |
| III. Authority and Responsibility for Credentialing | 5 |
| IV. Purpose | 6 |
| V. Credentialing Committee Structure and Activities | 6 |
| A. Committee Composition | |
| B. Committee Responsibilities/Duties | |
| C. Committee Chair Responsibilities/Duties | |
| D. Quality Manager(s) and Credentialing Manager(s) Responsibilities/Duties | |
| E. Quorum | |
| F. Agenda, Minutes and Reports | |
| G. Confidentiality | |
| H. Conflict of Interest | |
| VI. The Credentialing Program – Practitioners | 10 |
| A. Practitioners who will be credentialed | |
| B. Practitioners who do not need to be credentialed | |
| VII. Standards of Participation – Practitioners | 11 |
| A. Minimum Professional Criteria for Acceptance | |
| B. Minimum Standards for Participation | |
| C. Clean Application Criteria | |
| D. Automatic Exclusion Criteria | |
| E. Quality of Practice Criteria | |
| F. Business Administrative Criteria | |
| VIII. Initial Credentialing – Practitioners | 14 |
| A. Process and Requirements | |
| B. Primary Source Verification | |
| C. Practitioner Office Site Quality | |
| IX. Recredentialing – Practitioners | 21 |
| A. Process and Requirements | |
| B. Performance Monitoring Information | |
| C. Re/Credentialing Decision | |

| | |
|--|-----------|
| X. Termination, Restriction or Suspension..... | 22 |
| A. Termination by Credentialing Committee | |
| B. Termination by BHD Provider Network Credentialing Staff | |
| C. Immediate Restriction, Suspension or Termination by Chief Medical Officer | |
| XI. Practitioner Rights and Responsibilities..... | 23 |
| A. To Correct Erroneous Information | |
| B. To Review Information | |
| C. To Be Informed of Application Status | |
| D. To Be Notified of His/Her Rights | |
| E. To Be Responsible For Reporting Status Changes to the Credentialing Committee | |
| XII. Credentialing File Confidentiality and Retention..... | 25 |
| XIII. Reinstatement | 26 |
| XIV. Ongoing Monitoring | 26 |
| XV. Nondiscriminatory Practices | 27 |
| XVI. Credentialing Appeal Review Process..... | 27 |
| XVII. Delegated Credentialing | 28 |
| A. BHD Provider Network Delegated Agreements | |
| B. Protected Health Information (PHI) | |
| XVIII. Dual Credentialing and Contracting | 29 |
| A. Dually Credentialed | |
| B. Dually Contracted | |
| XIX. Credentialing Program Description Signature Page | 30 |
| | |
| Addendum A | A-1 – A-4 |
| A. BHD Provider Network – Appeal Process | |
| A. Overview | |
| B. Receipt of Appeal | |
| C. Appeal Levels | |
| D. Exclusions | |
| E. Appeal Request Form | |
| | |
| Addendum B | B-1 |
| A. Credentialing Structure and Governance | |

I. DEFINITIONS

The acronyms, phrases, words and terms used in this document shall have the following meanings unless the context specifically states otherwise:

1. **Administrator:**

BHD Administrator: The individual appointed to oversee overall operations of the Behavioral Health Division programs and services. Accountable to the Director of Health and Human Services and the Mental Health Board.

Community Access to Recovery Services (CARS) Administrator: The individual appointed to oversee operations for Behavioral Health Division non-inpatient programs and services and community-based programs and services for adults.

Wraparound Program Administrator: The individual appointed to oversee operations for Behavioral Health Division non-inpatient programs and services and community-based programs and services for children and adolescents.

2. **Board:** The Milwaukee County Mental Health Board (MHB) created by 2013 Wisconsin Act 203 and charged with jurisdiction over all inpatient and community-based mental health functions, programs, and services in Milwaukee County, including those relating to alcohol and other drug abuse.
3. **BHD:** The Milwaukee County Behavioral Health Division.
4. **CARS:** The Community Access to Recovery Services adult outpatient services and programs of the Behavioral Health Division and Provider Network.
5. **Clean Application:** A practitioner's application submission that meets the standards, guidelines, and established minimum professional threshold criteria for network participation.
6. **CMS:** Centers for Medicare and Medicaid Services.
7. **Credentialing Committee (Committee):** A peer review body chaired by a Medical Director (or equally qualified physician designee) to make recommendations to approve, deny, suspend, or terminate a practitioner's participation in the Network based on the established criteria.
8. **Credentialing Process:** Includes both the credentialing and recredentialing of licensed practitioners that may independently bill for their services.
9. **DEA:** The Drug Enforcement Administration is a United States federal law enforcement agency, under the United States Department of Justice, tasked with combating drug smuggling and distribution within the United States; and has a system in place which authorizes eligible individuals and entities to register in order to manufacture, import, export, distribute, research, prescribe, have access to and/or dispense scheduled drugs.

10. **DHS-Wisconsin:** The Wisconsin Department of Health Services oversees Medicaid and other health social service programs to ensure that the care provided to Wisconsin residents is high quality and provided in accordance with state and federal law; ensures that Wisconsin taxpayer dollars are being used effectively and efficiently by preventing and detecting waste, fraud, and abuse.
11. **Delegated Credentialing:** Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.
12. **Dual Credentialing:** A practitioner who is educated and trained to provide care in two (or more) specialties.
13. **Dual Contracting:** A practitioner that is contracted directly with the BHD Provider Network and also with an agency that contracts with the BHD Provider Network or works with two or more agencies that contract with the BHD Provider Network.
14. **Impaneling:** The determination of eligibility for individuals applying to become a part of the MCBHD Provider Network(s). Impaneling consists of a review of required documentation set forth by county, state and/or federal licensing and regulatory agencies, but does not encompass full credentialing, as outlined in this Program.
15. **Licensed independent practitioner (LIP):** A practitioner who does not work under the auspices or authority of another practitioner.
16. **Locum Tenens:** A Latin phrase that means "to hold the place of, to substitute for." In layman's terms, it means a temporary and/or covering practitioner.
17. **Medical Directors:** The Behavioral Health Division's staff of employed Medical Director(s).

Chief Medical Officer (CMO): The CMO is responsible for providing direction for the development and implementation of the Credentialing Program.

Service Medical Director(s): The Service Medical Director(s) is responsible for peer review activities and for collaboration with the Chief Medical Officer, Credentialing and Quality Management Staff on the development and implementation of the Credentialing Program. One Service Medical Director shall be selected to serve as Chairman of the BHD Provider Network Credentialing Committee.

Administrative Medical Director – BHD Service Medical Director(s) are not required to be credentialed by the BHD Provider Network when s/he is not contracted to provide direct care to BHD Provider Network members. The Medical Director(s)' license shall be verified to ensure it is unrestricted, current and/or valid, and shall be included in the Human Resources File. In the event the Medical Director provides hospital and/or clinic services under the Behavioral Health Division's operational licenses and authority, the BHD Medical Staff Organization will assume any further credentialing requirements.

Non-Administrative Medical Director – BHD Service Medical Director(s) who are required to be credentialed by the BHD Provider Network because s/he is contracted individually or as part of a group/agency to perform direct care to BHD Provider Network members. Care

provided falls outside of BHD licensed settings and the scope of the Medical Director(s)' BHD employment duties and schedule.

18. **Member:** An individual residing in Milwaukee County and eligible for BHD Provider Network services.
19. **Nationally Recognized Accrediting Entity/Body:** An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, as well as other areas covered in this document and provides accreditation to hospitals, managed care organizations and managed care health insurance plans pursuant to national standards. The following entities are examples of nationally recognized accrediting entities/bodies:
 - **TJC:** The Joint Commission
 - **NCQA:** National Committee for Quality Assurance
 - **HFAP:** Healthcare Facilities Accreditation Program
 - **URAC:** Utilization Review Accreditation Commission
 - **DNV:** Det Norske Veritas Healthcare, Inc.
20. **Network:** Refers to the BHD Provider Network
21. **Network Practitioner:** A verified person who has been credentialed by the BHD Provider Network to provide healthcare services to its members and follow all established network policies and procedures.
22. **Network Provider:** An individual or agency that holds a contractual agreement with the BHD Provider Network to provide healthcare services to its members and follow all established network policies and procedures.
23. **Office of the Inspector General (OIG):** The Health and Human Services Office of Inspector General responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to, fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

If identified billing practices are suspected to be potentially fraudulent or abusive, the **OIG's National Hotline** should be contacted at **1-800-HHS-TIPS (1-800-447-8477)** to report the activity.

Contacting the HHS OIG Hotline:

By Phone: 1-800-HHS-TIPS (1-800-447-8477) By Fax: 1-800-223-8164

By E-Mail: HHSTips@oig.hhs.gov By TTY: 1-800-377-4950

By Mail:

Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Centers for Medicare & Medicaid Services (CMS): Suspicions of fraud or abuse may also be reported to Medicare’s Customer Service Center at **1-800-MEDICARE (1-800-633-4227)**.

24. **Primary Source Verification (PSV):** The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner. Primary source examples include medical school, graduate medical education programs, and state medical/professional licensing boards.

25. **Recognized Equivalent to Primary Source (TJC) or Approved Sources (NCQA):** Consistent with The Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS) and the National Center for Quality Assurance (NCQA) standards, the following are considered to be an equivalent and/or an approved source for primary source verification of education and for ongoing monitoring of certain credentials and sanctions/exclusion monitoring:

1. The American Medical Association (AMA) Physician Masterfile
2. The American Osteopathic Association (AOA) Physician Database
3. The Education Commission for Foreign Medical Graduates (ECFMG)
4. American Board of Medical Specialties (ABMS) through the on-line data base (CertiFACTS)
5. Federation of State Medical Boards (FSMB)
6. National Student Clearinghouse

26. **Wraparound Milwaukee:** The child and adolescent outpatient services and programs of the Behavioral Health Division and Provider Network.

II. INTRODUCTION

The BHD Provider Network is committed to providing its members with high quality health care. This commitment is achieved, in part, by establishing and maintaining a credentialing system to assure the selection and maintenance of a network of highly qualified and competent professionals. Such a system includes developing specific, objective criteria intended to reflect professional competency and character and ascertaining whether or not individual health care professionals meet the criteria.

Credentials, as referred to in this document, are records of an individual's education, training, certifications, licensures, experience, character and other professional qualifications. Credentialing is defined as the administrative processes that support the collection, verification, review and evaluation of an individual's credentials.

The credentialing program incorporates the following three functions:

- (1) Initial credentialing: involves the evaluation of an individual's application for participation as a BHD Provider Network practitioner.
- (2) Recredentialing: assesses practitioners' qualifications for continued participation with the BHD Provider Network.
- (3) On-going monitoring: includes the continuous monitoring of license actions, Medicare/Medicaid and other state or local exclusions, sanctions and member complaint information.

III. AUTHORITY AND RESPONSIBILITY FOR CREDENTIALING

The Milwaukee County Mental Health Board ("Board") has ultimate authority, accountability and responsibility for the Provider Network Credentialing evaluation process ("Credentialing Program") and delegates the full oversight and administration of the Credentialing Program to the BHD Provider Network Medical Director(s) and the Credentialing Committee ("Committee"). The BHD Provider Network Medical Director(s) and Credentialing Committee accept the responsibility of administering the Credentialing Program and for the oversight of operational activities, which include making the final decision, (i.e., approve, table, or deny) for all physicians, advanced practice nurses, doctoral level licensed psychologists and any other licensed independent practitioners or allied health professionals that it deems credentialing shall be necessary for network participation.

The Credentialing Program Description shall be reviewed and amended, as necessary, but shall be reapproved at least every two years by the Credentialing Committee, Administration and the Board. Such reviews shall be documented in the minutes of the Credentialing Committee and Mental Health Board. On recommendation of the Credentialing Committee, the Credentialing Program shall be approved by the BHD Provider Network Credentialing Committee, the Wraparound and Community Access to Recovery Services Administrators, the BHD Chief Medical Officer, the BHD Administrator and the Mental Health Board.

In addition to the Credentialing Program, the Provider Network has in place written policies and procedures that support implementation of the Credentialing Program. Such policies and procedures including any modifications thereto shall first be reviewed and recommended for approval by the BHD

Provider Network Credentialing Committee and approved by the Wraparound and Community Access to Recovery Services Administrators, the BHD Chief Medical Officer and the BHD Administrator.

IV. PURPOSE

The purpose of the Credentialing Program is to support a systematic approach to credentialing within the BHD Provider Network. A Credentialing Program includes having in place a written Credentialing plan, documenting compliance with the plan, assigning specific credentialing responsibilities to administrative and professional staff, and establishing a mechanism for the periodic review and revision of the plan. The purpose of the Credentialing Program is to provide general guidance for the decision-making surrounding acceptance or continued participation of professional staff (practitioners) who are initially seeking association with the BHD Provider Network, practitioners who are seeking approval of on-going association, or practitioners for whom there is reason to conduct a special review.

The process enables the BHD Provider Network to recruit and retain a broad range of quality network practitioners to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's ability to deliver quality care between credentialing and recredentialing cycles, and it emphasizes and supports a practitioner's ability to successfully manage the health care of network members in a cost-effective manner.

Specific objectives of the Credentialing Program include:

- Setting forth the criteria to be used in assessing the qualifications of applicants seeking initial or on-going association with the BHD Provider Network;
- Establishing the processes for verification and evaluation of a practitioner's credentials;
- Establishing the processes for action, if a practitioner's credentials do not meet the established minimum criteria.

Unless there are clear and convincing reasons to depart from these guidelines, the BHD Provider Network's Credentialing Committee, Quality Management Staff and Credentialing Staff are expected to adhere to these guidelines.

Nothing contained in the Credentialing Program shall limit the BHD Provider Network's discretion in accepting, restricting, disciplining, or terminating a practitioner's association with the BHD Provider Network. The Credentialing Program may be changed at any time. Such changes shall be effective on the date of approval of the change for new applicants and existing practitioners.

V. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Committee Composition:

The BHD Provider Network Credentialing Committee is a peer-review body comprised of not less than four (4) voting physician members including the Chief Medical Officer and the Service Medical Director(s). One Service Medical Director (CARS or Wraparound) shall be selected to serve as chair of the Committee at the first meeting of each year by volunteering and/or by appointment of the Chief

Medical Officer, in the absence of a volunteer. The Chair, in consultation with the Chief Medical Officer and Service Medical Director(s) shall select the additional physician member(s). Alternate physician committee members may be utilized when a voting committee member is unable to attend a committee meeting. Alternates are identified and appointed by one of the BHD Provider Network Medical Directors. The Chair shall select one doctoral level licensed psychologist to serve as a non-voting member. Allied health representatives shall be selected and appointed by the Chair to serve as non-voting members, on an ad-hoc basis, when applications are being considered by the Committee and the practitioner specialty is not represented. All members are asked to make a one year commitment to the Committee. Members shall be reaffirmed at the first meeting of each year with new members appointed, when needed. Members may be removed from the Committee on recommendation of two voting members of the Committee.

Additional non-voting membership may include the CARS and Wraparound Quality Director(s) and Credentialing Manager(s).

B. Committee Responsibilities/Duties:

The Credentialing Committee shall be responsible for assuring that each practitioner granted participation in the BHD Provider Network possesses the qualifications necessary to deliver quality care to members. The Credentialing Committee shall be responsible for recommendations and decisions for approval, denial, termination, or restriction of a practitioner's participation in the BHD Provider Network.

The Credentialing Committee shall be responsible for the credentialing and recredentialing of all physicians, advanced practice nurses, and doctoral level licensed psychologists.

Other behavioral health professionals and other allied health practitioners that provide an independent billable level of care shall be subject to the impaneling process, at this time. However, these practitioners may also become subject to the full credentialing process, if so determined by the BHD Provider Network at a later time.

- Allied health practitioners are defined as nurse midwives, traditional midwives, nurse practitioners, chiropractors, optometrists, physician assistants, psychologists, licensed marriage and family therapists, alcohol and chemical dependency counselors, licensed independent clinical social workers, licensed professional counselors, board certified behavioral analysts, and clinical nurse specialists.
- All other individuals applying to participate in the BHD Provider Network(s) shall be subject to the impaneling process.

The Credentialing Committee is responsible for the review and evaluation of the credentials of individuals (*physicians, advanced practice nurses and doctoral level licensed psychologists*) applying for new or on-going participation as BHD Provider Network practitioners and at any time that concerns arise regarding an individual practitioner's credentials and/or practice. The Committee shall monitor all credentialing activities and delegated credentialing arrangements, which includes but is not limited to responsibility to:

- Receive, review and evaluate the credentials of all physician, advanced practice nurse and psychologist practitioners applying for new or on-going participation as BHD Provider Network

practitioners and at any time that concerns arise regarding an individual practitioner's credentials and/or practice.

- Receive, review and evaluate the credentials of practitioners who do not meet the organization's established clean application criteria (e.g. malpractice cases, licensure issues, sanctions, quality concerns, missing documentation, etc.)
- Review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care
- Establish, implement, monitor, and revise policies and procedures for BHD Provider Network credentialing and recredentialing
- Report to BHD Administration, the Board and other appropriate authorities, as required
- Review and approve Committee minutes
- Review the Credentialing Program Description at least every two years
- Other related responsibilities

C. Committee Chair Responsibilities/Duties:

The Credentialing Committee Chair (a Medical Director or his/her physician designee) may approve a practitioner independent of the Credentialing Committee who fully meets the established criteria before, between, and after each Committee meeting. At the next scheduled Committee meeting, a list of all such approved practitioners and dates of approval shall be presented to ensure network participation decisions are recorded in the meeting minutes.

The Credentialing Committee or Chair may accept the applications of practitioners who meet all established criteria as defined in Section VII. Credentialing Committee review and discussion is required for any practitioners who have an identified variance from the minimum standards for participation criteria.

In addition, files requiring special review due to recent license or other disciplinary actions, member complaints or Medicare/Medicaid sanctions, must be reviewed by the Credentialing Committee. A special review is defined as review of a practitioner's credentials outside the initial credentialing or recredentialing cycle. Recommendations by the Credentialing Committee to deny or restrict participation are communicated, in writing, to the practitioner within 30 days of the decision.

D. Quality Manager(s) and Credentialing Manager(s) Responsibilities/Duties:

The Quality Manager(s) and Credentialing Manager(s) shall report to the Credentialing Committee. The Quality Manager(s) and Credentialing Manager(s) are responsible for ensuring network practitioners and providers are providing high quality care to network members, for ensuring the quality improvement programs comply with accreditation and state and federal regulatory requirements, and for the ongoing monitoring activities. The Quality/Credentialing Manager(s) shall report all physician, advanced practice nurse and psychologist practitioner specific quality concerns to the Credentialing Committee. The Quality/Credentialing Manager(s) may delegate continuous monitoring of license actions, Medicare/Medicaid exclusions and other state or local exclusions to credentialing staff.

E. Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid transaction of business by the Committee, which shall meet monthly and/or as deemed necessary by the Chairperson. The Committee action may be implemented in the absence of a face-to-face or other type meeting if consent in writing, setting forth the action, is obtained, i.e., telephone conference, skype meeting. A meeting may not be conducted only through e-mail. Voting members include only the Committee Physicians. Non-voting members include one psychologist member, the Quality and Credentialing Manager(s) and ad hoc allied health practitioners when asked to participate. Non-voting members are not considered part of the quorum.

F. Agenda, Minutes and Reports:

The credentialing staff shall prepare each meeting agenda and shall be responsible for the preparation and maintenance of complete and accurate minutes for each meeting and for bringing all credentialing files associated with practitioners requiring Committee review to the meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect meaningful discussion, decisions and recommendations regarding practitioner files presented, the status of activities in progress, reports of practitioner approvals that occurred outside of the Committee, the implementation status of recommendations/planned actions, when appropriate, including responsible person and follow-up. Applicable reports and substantiating data will be appended for reporting purposes.

The Committee will be responsible for reviewing minutes for accuracy. Minutes shall be securely retained electronically and/or manually by credentialing staff. Copies shall not be distributed but shall be made available at each meeting and then collected at the conclusion of the meeting. Committee members not able to attend a meeting(s) may review the minutes in the credentialing staff office but shall not receive printed or electronic copies.

G. Confidentiality:

It is the policy and procedure of the BHD Provider Network to consider and treat all credentialing documents received from the practitioner and from verification sources for the purposes of credentialing, and subsequently retained as a result of the credentialing process, as confidential. The mechanisms, in effect, to ensure the confidentiality of information collected in this process are as follows:

- Access to such documents shall be restricted to:
 - (1) The practitioner being credentialed, pursuant to the requirements outlined in Section XI. A – Practitioner Right To Correct Erroneous Information,”
 - (2) BHD Provider Network Credentialing and Quality Staff,
 - (3) Credentialing Committee Members (voting and non-voting),
 - (4) the CARS Administrator, the Wraparound Administrator, the BHD Chief Medical Officer and/or the BHD Administrator, when a legitimate purpose is identified,
 - (5) Board Members, when a legitimate purpose is identified,
 - (6) Other specific individuals as designated by the BHD Credentialing Committee, when a legitimate purpose is identified.

- Limiting the number of staff with access to the credentialing files and/or credentialing databases is required to ensure that confidentiality and federal and state statutory peer review protections are met.
- Credentialing files and materials shall be secured via a passcode protected database, a shared database with access limited to only authorized credentialing staff and/or files secured within a double locked environment, i.e., in locked file cabinets within a locked room, whenever unattended.

All staff that have access to credentialing files and materials shall be required to sign confidentiality and non-disclosure statements expressly agreeing not to share information obtained or learned and to follow the established credentialing information security procedures.

H. Conflict of Interest:

In situations where a conflict of interest may exist, the Chairperson of the Credentialing Committee shall have the authority to excuse a voting member from the credentialing decision.

VI. THE CREDENTIALING PROGRAM: PRACTITIONERS

A. Practitioners Who Will Be Credentialed and Reviewed On An Ongoing Monitoring Basis Include:

The Credentialing Program applies to all individuals who are applying for initial or on-going participation as BHD Provider Network practitioners. This includes practitioners who either are parties to a BHD Provider Network contract or are employed by an organization or entity with whom the BHD Provider Network has a contract. BHD Provider Network practitioners are considered to have an independent relationship and are located in an outpatient setting. An independent relationship exists when BHD Provider Network selects and directs its members to see a specific practitioner or group of practitioners.

Practitioners that are subject to credentialing requirements are defined as licensed individuals who are legally authorized to provide independent care and treatment to patients. The practitioner types included in this definition include: physicians, doctoral level psychologists and advanced practice nurses (clinical nurse specialists, certified nurse midwives, certified nurse practitioners).

B. Practitioners Defined Above Who Do Not Need To Be Credentialed:

- Practitioners who practice exclusively within an inpatient setting and provide care or treatment to BHD Provider Network members only because members are directed to the hospital, or other inpatient setting.
- Practitioners who are not participants in the BHD Provider Network to whom limited or specialty referrals may be made on a case-by-case basis by participating practitioners or the BHD Provider Network. Such referrals are considered to be out-of-network.
- Locum Tenens practitioners, i.e., practitioners who are filling in temporarily. This exception applies only to locum tenens practitioners who are covering on a short-term basis in an urgent situation (e.g. covering for a practitioner who has an unexpected family or medical leave). Locum tenens status is limited to a cumulative lifetime total of three months work anywhere in

the BHD Provider Network. Practitioners who have exhausted their locum tenens eligibility by working more than three months may not practice in any capacity in the BHD Provider Network without first being credentialed. Verification of a valid Wisconsin professional license, a check for exclusions from state and federal programs and Wisconsin Caregiver background check must be completed prior to the practitioner seeing BHD Provider Network members regardless of service length.

Practitioners identified in any of the above categories are beyond the scope of the BHD Provider Network Credentialing Program.

VII. STANDARDS OF PARTICIPATION: PRACTITIONERS

A. Minimum Professional Criteria for Acceptance

The BHD Provider Network accepts professional practitioners into its network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

Each network practitioner must meet the minimum standards for participation or continued participation in the BHD Provider Network. These guidelines are intended to comply with BHD Provider Network policy, NCQA, state, federal and other applicable regulatory and/or accreditation entities where applicable.

B. Minimum Standards for Participation Include:

- Unrestricted (no limitations), current and valid professional licensure to practice in Wisconsin.
- Current and valid Federal DEA Registration for practitioners with the authority to write prescriptions, as applicable, for practice.
- Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have completed relevant pre- or post-graduate education (residency, fellowship, practicum, preceptorship, etc.) in his/her practicing specialty.
- Documentation of a collaboration arrangement for certified nurse practitioners, clinical nurse specialists, mid-wives and physician assistants with a participating physician credentialed by the BHD Provider Network
- Acceptable, current and valid malpractice insurance in the amount \$1 Million per incident and \$3 Million per aggregate per year or as otherwise required by State Statute and/or Milwaukee County Risk Management.
- Absence of a history of denial or cancellation of professional liability insurance and has had no or minimal involvement in malpractice suits, arbitration or settlements and evidence shows that the history does not suggest any ongoing substandard professional competence or conduct.
- Absence of active disabling health problems including, but not limited to substance use disorders, which might adversely affect judgment or competence, so as to substantially impede the

professional practitioner's ability to perform the essential functions of his/her practice/profession with reasonable skill and safety.

- Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, hospital, health care organization, managed care organization, governmental health care program; or evidence that this history does not suggest any ongoing substandard professional competence or conduct.
- Absence of a history of criminal/felony convictions or indictments or evidence that this history does not suggest an effect on current professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.

The Credentialing Committee may accept non-compliance with one or more of the participation criteria if the Committee determines that the non-compliance does not indicate a potential or existing administrative or performance issue.

If a participating practitioner becomes non-compliant with one or more of the participation criteria after initial credentialing or recredentialing, the practitioner's credentials shall be brought to the Credentials Committee for further review.

C. Clean Application Criteria

Applicants who meet all of the criteria for participation listed below may be approved for participation by the Credentialing Committee Chair (or his/her physician designee), without review by the Credentialing Committee.

Initial Credentialing:

- No history of corrective action (hospital/licensing board)
- Criminal Background Check reveals no felony convictions or criminal charges pending; and/or if history of non-felony conviction(s), matter is > than 7 years ago AND unrelated to Caregiver Law Offences AND judged by the Credentialing Committee Chair (or Medical Director designee) to have no bearing on current professional abilities or responsibilities
- No history of Operating While Intoxicated/Driving Under the Influence (OWI/DUI--alcohol or drug) offenses
- No malpractice history or minimal involvement, which is defined as not more than two (2) claim dismissals and/or not more than two (2) settlements/payments of \$30,000 or less and/or no more than one (1) open claim pending and/or matter(s) is older than 20 years
- All services practitioner is requesting to provide to members are appropriate to his/her specialty training

Recredentialing:

- If prior history of corrective action (hospital/licensing board), matter was > 7 years ago

- Criminal Background Check reveals no new non-Caregiver or other criminal (felony or misdemeanor) law offenses since last credentialed;
- First and only OWI/DUI > 7 years ago and no current cause for concern is shown following assessment of current statement by applicant and the specific event circumstances, as judged by Committee Chair (or Medical Director designee)
- Minimal or no malpractice claims history changes since last credentialed (no new claims and/or prior history of no more than 2 settlements/payments and/or no more than one open claim and/or matters are older than 20 years)
- All services practitioner is requesting to provide to members are appropriate to his/her specialty training
- No patterns or trends of member complaints/grievances or practice concerns

D. Automatic Exclusion Criteria:

The BHD Provider Network shall, upon obtaining information or receiving information from a verifiable and reliable source, exclude from participation any practitioner that may fall into one or more of the following categories (references to the Act in this section refer to the Social Security Act):

- Individuals or entities, which could be excluded under [§ 1128\(b\)\(8\)](#), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has been convicted of any of the following crimes:
 1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in [§ 1128\(a\)\(1\)](#) of the Act, as amended);
 2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in [§ 1128\(a\)\(2\)](#) of the Act, as amended);
 3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary duty;
- Practitioners who appear on the Office of Inspector General list of excluded individuals and entities report ([OIG-LEIE](#))
- Practitioners who appear on any ~~County~~ or State exclusions list
- Practitioners who have a suspended, revoked or terminated license to practice
- Practitioners who have a suspended, revoked or terminated drug enforcement administration registration
- Wisconsin Caregiver Law required exclusions

- Any other automatic exclusion required by law or regulation

If an automatic exclusion is discovered during the credentialing process, application processing shall immediately be halted. Furthermore, an approved practitioner shall have his or her participation terminated upon obtaining information or receiving information from a verifiable and reliable source of any of the aforementioned. The practitioner has no right to appeal under such circumstances.

E. Quality of Practice Criteria:

- Professional practitioner(s) must demonstrate acceptable office site survey and medical record keeping practices, which meet CMS, DHS, NCQA, BHD Provider Network, or any other standards adopted by the BHD Provider Network.
- Professional practitioner(s) practice patterns must reflect a general adherence to established practice standards and protocols as adopted by the BHD Provider Network.
- Professional practitioner(s) must maintain satisfactory performance in the area of practice quality indicators (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.) established by the BHD Provider Network.
- The BHD Provider Network retains the right to approve/deny new practitioners based on quality issues, and to terminate individual practitioners for same. Termination of individual practitioners for quality of care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for practitioners. The BHD Provider Network has a prescribed system of appeals available, which shall be followed.

F. Business Administrative Criteria:

The decision to contract with an individual practitioner or group practice/agency is made by the BHD Provider Network's Administrators. Considerations for making such a decision include:

- the geographic distribution of specialty care practitioners,
- the need for additional or specific specialty care practitioners based on membership numbers and demographics,
- willingness of the provider and/or individual to abide by the BHD Provider Network policies and procedures and willingness of the individual or provider group to execute a provider contract and abide by the terms of such contract,
- willingness of the individual or provider group to comply with all credentialing requirements and/or
- statutory, regulatory or related changes or requirements.

VIII. INITIAL CREDENTIALING: PRACTITIONERS

A. Process and Requirements:

Initial credentialing is performed on all practitioners (*except those specifically excluded under Section VI.B*) who are (a) beginning a relationship with the BHD Provider Network or (b) have an existing

relationship at the time that this plan is adopted but have not previously been required to complete the credentialing process; and (c) are practitioners who meet the minimum requirements to apply for participation with the BHD Provider Network, as outlined in Section VII.

The BHD Provider Network credentials all physician, advanced practice nurses and licensed psychologist practitioners prior to being admitted into the BHD Provider Network. The intent of the process is to validate and/or confirm credentials related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 calendar days of the Committee Decision or in the matter of applications deemed as clean, the decision of the Medical Director when Committee review is not required.

Each practitioner must submit a legible and complete application, signed and dated consent and release of information form, and all other required documentation as specified by the BHD Provider Network. The following information is obtained and verified according to NCQA standards as described herein and utilizes sources listed under Initial Credentialing:

- Completed BHD Provider Network application (Universal Application or equivalent), which includes a current signed and dated release of information, attestation, and disclosure statement.

Each practitioner applying for participation shall attest to the following:

1. Reasons for inability to perform the essential functions of the position, with or without accommodation
 2. Lack of present illegal drug use
 3. History of restriction or loss of license
 4. History of criminal conviction(s)
 5. History of loss or limitation of privileges or disciplinary actions
 6. Current malpractice insurance coverage
 7. The correctness and completeness of the application
- Copy of the unrestricted (no limitations), current and valid Wisconsin license for the participating practitioner
 - Copy of the current and valid DEA Registration, if applicable
 - Copy of the medical malpractice policy face sheet, or completed liability information section on the application inclusive of policy number, effective dates of coverage, and coverage amounts.
 - Copy of the Board certificate or highest level of education in specialty for which practitioner is seeking participation status in the BHD Provider Network.
 - Copy of the current Curriculum Vitae (CV) or detailed work history which must include month/year. All gaps or interruptions in work history of greater than 30 days must be explained. CV or work history must cover not less than the previous five years.
 - Completed Wisconsin Caregiver Background Information Disclosure (BID) form

- Name and contact information for at least two (2) professional peers (reference) with whom practitioner has worked within the last 24 months
- Practitioner written explanation to any “yes” response to disclosure questions that reveal an adverse action or require special consideration including, but not limited to:
 - 1) Any limitation in ability to perform the functions of the position, with or without accommodation;
 - 2) History of restriction or loss of license;
 - 3) History of any misdemeanor and/or felony convictions;
 - 4) History of any abuse of controlled substances or alcohol, including non-criminal first offense OWI/DUI;
 - 5) History of loss or limitation of privileges, memberships or disciplinary activity;
 - 6) Any malpractice history, either reported or non-reported to the NPDB or other regulatory bodies.

Applications deemed as incomplete cannot be considered. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for network participation and for resolving any doubts about such qualifications to the satisfaction of the Chair. Applications are not considered complete until so deemed by the Credentialing Committee and/or Chair. The credentialing staff, on behalf of the Committee, shall notify the practitioner of any areas of incompleteness, question, discrepancy and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant’s obligation to correct, explain or obtain all required information within the next thirty (30) days. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or resolve doubts about qualifications, current abilities or credentials within thirty (30) days, when additional information is requested, may, in the sole discretion of the credentialing staff, be deemed a voluntary withdrawal of the application due to incompleteness. Practitioners shall have no appeal rights for failing to complete application requirements.

B. Primary Source Verification:

The BHD Provider Network credentialing staff shall conduct primary source verification (PSV) as required by the most current and applicable CMS, NCQA, and any other BHD Provider Network adopted guidelines. The BHD Provider Network accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification, with appropriate reference documentation (i.e., the name of the person who provided the verification, the date of the call and the verification source). The credentialing staff shall authenticate all required PSVs by signature/initials and date. The information must be accurate and current.

Verbal verifications documented in credentialing files are dated and signed by the credentialing staff member who receives the information, noting source and date. Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DHS, NCQA, and/or BHD Provider Network-approved web-site source, as applicable, and signed/initialed and dated by the verifier.

To meet verification standards, all credentials must be valid at the time of the Credentialing Committee's decision, and PSVs must be within the specific time limits as set forth by CMS, DHS, NCQA, BHD Provider Network and any other applicable regulatory and/or accreditation entities:

Table VIII-B:

| Primary Source Information: | Acceptable Verification Sources: |
|---|---|
| <p>Credential: License</p> <ul style="list-style-type: none"> ○ Verification Time Limit: 180 calendar days* <p>Must confirm that practitioner holds a valid, current Wisconsin license or certification, which must be in effect at the time of the Committee's decision; verification must come directly from the state licensing or certification agency.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p> | <ul style="list-style-type: none"> ○ Wisconsin Department of Safety and Professional Services [State Licensing Board(s)] |
| <p>Credential: DEA Certificate</p> <ul style="list-style-type: none"> ○ Verification Time Limit: 180 calendar days * <p>Must be effective at the time of the credentialing decision; registration must display a Wisconsin address.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p> | <ul style="list-style-type: none"> ○ A copy of the DEA certificate ○ Documented visual inspection of the original certificate ○ Confirmation with the DEA Agency <p>Approved Equivalent to Primary Source</p> <ul style="list-style-type: none"> ○ Entry in the National Technical Information Service (NTIS) database https://www.ntis.gov/ ○ Entry in the American Medical Association (AMA) Physician Master File |
| <p>Credential: Education and Training</p> <ul style="list-style-type: none"> ○ Verification Time Limit: None for graduation from medical or professional school and/or completion of residency <p>The organization must verify the highest of the three levels of education and training completed by the practitioner.</p> <ol style="list-style-type: none"> 1. Graduation from medical or professional School 2. Residency program completion, if appropriate 3. Board certification, if appropriate <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p> <p>Note: If a practitioner's education has not changed during the recredentialing cycle, the previous education verification will stand and need not be re-verified.</p> | <p>Graduation from medical school (MD, DO):</p> <ul style="list-style-type: none"> ○ Medical School ○ Residency Completion ○ Residency Training Program <p>Approved Equivalent to Primary Source</p> <ul style="list-style-type: none"> ○ AMA Physician Master File ○ American Osteopathic Association (AOA) (Official Osteopathic Physician Profile Report or AOA) ○ Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986 ○ Association of schools of the health professional, if the association performs primary source verification. At least annually, the organization must obtain written confirmation from the association that it performs primary source verification. ○ Sealed transcripts: Received directly from the school or, if a practitioner submits transcripts to the organization that are in the institution's sealed envelope with an unbroken institution seal, NCQA accepts this as primary source verification if the organization provides evidence that it inspected the contents of the envelope and confirmed that transcript shows that the practitioner completed (graduated from) the appropriate training program. <p>Note: If the practitioner states that education and training were completed through the AMA's Fifth Pathway program, the organization must confirm it through primary-source verification from the AMA.</p> |

| | |
|---|--|
| | <p>For non-doctors of medicine and osteopathy.</p> <ul style="list-style-type: none"> • The state licensing agency may be used, if it performs primary source verification. <ul style="list-style-type: none"> – The organization must: <ul style="list-style-type: none"> ▪ Obtain and maintain on file a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of education and training information for the specific practitioner type, or ▪ Obtain and maintain evidence of the applicable state statute for the practitioner type requiring the licensing agency, to obtain verification of education and training directly from the learning institution. <p>Psychologists - graduation from professional school (PhD, PsyD, EdD)</p> <ul style="list-style-type: none"> ○ Professional School <p>Post-doctoral Fellowship</p> <ul style="list-style-type: none"> ○ Professional Training Institution <p>Advanced Practice Nurses</p> <ul style="list-style-type: none"> ○ Professional School (Masters Program) <p>Approved Equivalent to Primary Source</p> <ul style="list-style-type: none"> ○ National Register of Health Service Psychologists ○ State Licensing agency, if above conditions are met |
| <p>Credential: Board Certification</p> <ul style="list-style-type: none"> ○ Verification Time Limit: 180 calendar days* <p><u>Physicians (MD/DO)</u>: not required but must be verified if practitioner lists it on the application. If practitioner is board certified, verifying board certification fully meets standards for education and training.</p> <p><u>Advanced Practice Nurses</u>: required and must be verified.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p> | <p>Physician (MD, DO) board certification:</p> <ul style="list-style-type: none"> ○ American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. <p>Advanced Practice Nurse board certification</p> <ul style="list-style-type: none"> ○ American Nurses Credentialing Center (ANCC) ○ American Academy of Nurse Practitioners (AANP) <p>Psychologists (PhD, PsyD, EdD):</p> <ul style="list-style-type: none"> ○ Association of State and Provincial Psychology Boards (ASPPB) <p>Approved Equivalent to Primary Source</p> <ul style="list-style-type: none"> ○ AMA Physician Master File. ○ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ○ National Register of Health Service Psychologists ○ For Psychologists and Advanced Practice Nurses, the state licensing agency may be used, if it performs primary source verification. The organization must: <ul style="list-style-type: none"> ○ Obtain and maintain on file a printed, dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of education and training information for the specific practitioner type, or |

| | |
|---|--|
| | <ul style="list-style-type: none"> ○ Obtain and maintain evidence of the applicable state statute for the practitioner type requiring the licensing agency, to obtain verification of education and training directly from the learning institution. <p>Please refer to the applicable CMS, DHS, &/or NCQA standards required for other practitioner types.</p> |
| <p>Credential: State and Federal Sanctions and Exclusions</p> <p>Medicaid and Medicare Sanctions Restrictions on Licensure Limitations on scope of practice Exclusions and limitations related to fraud and abuse and Opt In/Opt Out status</p> <ul style="list-style-type: none"> ○ Verification Time Limits: 180 calendar days* <p>The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations prior to presenting a practitioner to the Committee for review.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable).</p> | <p>Sources for Licensure Sanctions:</p> <p>Physicians:</p> <ul style="list-style-type: none"> ○ Appropriate state agencies ○ Federation of State Medical Boards (FSMB) ○ National Practitioner Databank (NPDB) <p>Non-physician behavioral healthcare professionals:</p> <ul style="list-style-type: none"> ○ Appropriate state agency ○ NPDB ○ State licensure or certification board <p>Sources for Medicare/Medicaid Sanctions</p> <ul style="list-style-type: none"> ○ AMA Physician Master File entry ○ FSMB ○ List of Excluded Individuals and Entities (maintained by OIG; OIG-LEIE), available over the Internet ○ Government Services Administration/System for Award Management (GSA/SAM) ○ Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracting organizations ○ NPDB ○ State Medicaid agency or intermediary and the Medicare intermediary ○ Trailblazers.com – Opt In/Opt Out Website <p>Please refer to the applicable CMS, DHS, NCQA, standards required for non-doctors of medicine and osteopathy.</p> |
| <p>Credential: Malpractice Insurance</p> <ul style="list-style-type: none"> ○ Verification Time Limit: 180 calendar days* <p>The Provider Network must obtain confirmation of the past five year history of malpractice settlements; the five-year period may include residency or fellowship years; however, confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship does not need to be obtained.</p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p> | <ul style="list-style-type: none"> ○ National Practitioner Data Bank ○ Malpractice Carrier |
| <p>Credential: Work History</p> <ul style="list-style-type: none"> ○ Verification Time Limit: 180 calendar days* <p>NCQA does not require primary-source verification of work history; the organization must obtain a minimum of five years of relevant work history through the practitioner's application or CV; relevant experience includes work as a healthcare professional; if the practitioner has practiced fewer than five years from the date of</p> | <ul style="list-style-type: none"> ○ CV and/or Completed Work History section on application ○ Documented visual verification of above for gap analysis |

| | |
|---|--|
| <p>verification of work history, it starts at the time of initial licensure; experience practicing as a non-physician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included.</p> <p>A gap exceeding 30 days must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner’s employment experience; verbal communication must be appropriately documented in the credentialing file; <u>a gap in work history that exceeds 30 days must be explained in writing.</u></p> <p>Copy of verification must be signed and dated by verifier (electronic signature/date is acceptable)</p> | |
| <p>Credential: Professional Peer Reference</p> <ul style="list-style-type: none"> ○ Verification Time Limit: 180 calendar days* | <ul style="list-style-type: none"> ○ Written documentation obtained directly from peer(s) (mail, email, phone, fax receipt) |

* The 180 days begins calculating on the date of the practitioner’s attestation, or the first signed PSV, whichever is first. The end of the calculation period is the date of the BHD Provider Network Credentialing Committee decision or Medical Director action on Committee’s behalf, when permissible.

A checklist may be utilized by the verifier in lieu of authenticating each individual verification obtained. The checklist must include a listing for each item verified, the date each item was verified and the name of the source that was utilized for each verification.

The Credentialing Committee shall make an approval decision on an application within 30 days of completion. The practitioner shall be notified in writing within 60 calendar days of the Committee’s or Medical Director’s decision. The credentialing staff shall be responsible for preparing such communications, on behalf of the Credentialing Committee Chair. The notification shall include the specific decision and the date of the decision. Types of decisions are described in section IX.C. If the decision is not to approve or the approval includes limitations or restrictions to participation, the notification shall include instructions, in writing, on how to appeal a denied, limited or restricted request for credentialing.

C. Practitioner Office Site Quality:

The initial credentialing process includes an on-site office evaluation and medical record review for all new agencies that apply to provide service for Provider Network members. As part of the site review for mental health and AODA practitioners, standards for access to services, including emergency coverage and appointment availability are reviewed in order to assure reasonable access to services for provider network members/service recipients. Medical groups and group practices do not need a separate site visit for each practitioner.

The site evaluation includes but is not limited to:

- Practitioner information (i.e. licenses/certifications, background checks, etc.)
- Office policies/general information
- Physical plant/physical accessibility
- Scheduling/appointments availability
- Availability of emergency equipment (as applicable)

- Medication storage policies and procedures
- Medical record keeping format including forms, practices and procedures
- Access/on-call coverage policies and procedures

The results of the office site evaluation and medical record keeping review are considered in the initial credentialing decision-making process. Practitioners with evaluation scores that fall below the threshold of 80% or that lack essential elements are subject to corrective action and re-review to monitor compliance as a requirement for enrollment in the BHD Provider Network.

Agencies/practitioners whose site evaluation reveals substandard scores will be monitored by the BHD Provider Network Coordinator for corrective action. Agencies/practitioners will be required to submit evidence of correction in non-compliant areas within a prescribed time frame not to exceed three (3) months for existing Network agencies/providers and prior to enrollment in the Network for new agencies/providers.

IX. RECREREDENTIALING: PRACTITIONERS

A. Process and Requirements:

Recredentialing of practitioners is completed at least every thirty-six (36) months. Recredentialing may occur more often if the Credentialing Committee determines that more frequent recredentialing is appropriate.

The BHD Provider Network recredentials all practitioners within 36 months of their last credentialing or recredentialing date (or before end of credentialing approval period if approved for a lesser period of time). Recredentialing must be completed by the last day of the same month in which the previous credentialing approval occurred (i.e., if approval took place on March 12, reapproval must take place not later than March 31). The intent of the recredentialing process is to identify any changes that may affect a practitioner's ability to perform the services that s/he is under contract to provide.

All application requirements detailed in Section: VIII-A are applicable to the recredentialing process. All verification time frames detailed in Table: VIII-B are applicable to the recredentialing process.

Each practitioner must complete and sign the BHD Provider Network Recredentialing Application that includes the professional disclosure questions and attestation that the information given is correct and gives the BHD Provider Network the right to verify the information. The following information is obtained and verified according to the standards and utilizes the sources listed under Initial Credentialing:

- State licenses (unrestricted, current and valid)
- DEA registration (if applicable; current and valid)
- Additional Education, if applicable
- Board certification
- Malpractice coverage
- Malpractice claims
- Sanction information

B. The Recredentialing Process Shall Include Performance-Monitoring Information:

Sources of such performance-monitoring information may include one or more of the following:

- Member grievances/complaints
- Member and Practitioner/Provider satisfaction surveys
- Utilization Management
- Risk Management
- Quality improvement activities, performance quality measures, quality deficiencies, and/or trending patterns
- Site Assessment
- Medical Record Keeping Practices/Treatment Assessments

C. Re/Credentialing Decision:

Each practitioner will receive one of the following designations from the Committee or Medical Director Chair acting on behalf of the Committee:

1. Approved without reservation
2. Approved with reservation (credentialing approval may be less than three years)
3. Not approved due to competency or professional behavior concerns (final decision)

The BHD Provider Network has the right to make the final determination about which practitioners may participate within its network. If the BHD Provider Network documents unfavorable information (e.g., excessive malpractice claims, deficient site visits and sanctions) about a specific practitioner during the credentialing or recredentialing process, it may choose to approve, deny, restrict, or not credential or recredential the practitioner.

The approval decision shall be determined by majority vote. The Chair has the prerogative to abstain, vote on all matters, or vote only in the event of need to break a tie. An abstention is not a vote, and is not counted. In the event of a tie, the motion is lost.

X. TERMINATION, RESTRICTION OR SUSPENSION

A. Termination by Credentialing Committee

The BHD Provider Network Credentialing Committee may decide to deny or terminate the participation status of any practitioner. The Committee may rely upon any of the following as a basis for denial or termination.

1. A determination, based upon failure to meet one or more of the BHD Provider Network Professional Criteria for Acceptance or any other information available to the Credentialing Committee, that the practitioner has not adequately demonstrated that he or she would provide safe, high-quality care to all BHD Provider Network members.
2. The practitioner has engaged in uncooperative, unprofessional, or abusive behavior towards one or more BHD Provider Network members, BHD Provider Network employees, or members of the Credentials Committee or Mental Health Board.

B. Termination by BHD Provider Network Credentialing Staff

Notwithstanding any provision in this Credentialing Program, the BHD Provider Network Credentialing Staff may terminate the participation status of any practitioner, in accordance with terms of the BHD Provider Network contract. The BHD Provider Network Credentialing staff may terminate the credentialing process for a practitioner who has not returned required credentialing information that is necessary to process their application for participation. Credentialing staff may administratively terminate a practitioner who has not returned required recredentialing information that is necessary to process their application for continued participation.

Credentialing staff shall immediately terminate a practitioner upon notice that the practitioner's license has been revoked or suspended, that the practitioner has been excluded from federal, state or local government programs, or that the practitioner otherwise fails to meet the minimum requirements of the BHD Provider Network's Professional Criteria for Acceptance.

Applications from practitioners seeking to participate with the BHD Provider Network will not be processed if the practitioner is currently excluded from federal, state, or local government programs, or if the practitioner must otherwise automatically be excluded from participation.

C. Immediate Restriction, Suspension or Termination

The BHD Chief Medical Officer or his/her physician designee has the authority to immediately restrict, suspend or terminate the participation status of a practitioner to prevent the threat of imminent danger to the health of any individual. Such immediate restriction, suspension or termination shall not initially exceed fourteen days pending the outcome of an investigation to determine the need for a professional review action. The BHD Chief Medical Officer shall make a good faith effort to consult with the Credentialing Committee Chair and/or BHD Provider Network Administrators and Quality Review Directors prior to taking such action. Any immediate restriction, suspension, or termination exceeding fourteen days requires notice to the affected practitioner of the appeals process and right to a hearing.

XI. PRACTITIONER RIGHTS AND RESPONSIBILITIES

A. To Correct Erroneous Information

The BHD Provider Network's policies do not preclude practitioners' rights to review and correct erroneous information obtained and used to evaluate their credentialing application from outside primary sources. Such information could include, but is not limited to malpractice insurance carriers, state licensing boards, the OIG-LEIE, GSA/SAM, etc.

Upon notification of discrepancy, the applicant shall have 30 days to correct erroneous information submitted by other parties and/or to correct his/her own information or the processing of his/her application shall be terminated.

The practitioner shall not be permitted to review or otherwise have access to peer review protected information, such as peer references and recommendations, when applicable. The BHD Provider Network is not required to reveal the source of information, if the information was not obtained to meet credentialing verification requirements or if the law prohibits disclosure.

Notifications to practitioner to correct erroneous information submitted by a source shall clearly state:

- The time frame for reply

- The format for submitting corrections/changes
- The person to whom corrections/changes must be submitted

B. To Review Information

The BHD Provider Network ensures that practitioners can access their own information obtained by the BHD Provider Network during the credentialing process and used to support their credentialing application, with limitations.

C. To Be Informed Of Application Status

The BHD Provider Network’s policy is to notify a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If the credentialing staff receives a request it shall be responded to within five (5) business days of receipt

The Credentialing Department staff can advise the practitioner, once key information is verified, of the following information via phone or in writing, if requested by the practitioner:

- The date the application was received
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee/Chair
- Answer any questions the practitioner may ask
- Prior to disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner:
 - Practitioner’s full name
 - Practitioner’s primary office location
 - Practitioner date of birth or last 4 digits of social security number (SSN)

D. To Be Notified Of His/Her Rights

Each prospective and existing practitioner has the right to be notified of the aforementioned rights and will be notified via one or more of the following methods:

- Applications
- Contracts
- Policies
- Mail
- Email
- Fax
- Website
- Other Suitable Method

E. To Be Responsible For Reporting Status Changes to the Credentialing Committee

Each prospective and existing practitioner shall report promptly (within two business days) to the Credentialing Committee any of the following:

- Any and all notices of investigation or challenge to any licensure or registration, any discipline or voluntary or involuntary limitation or relinquishment of such licensure or registration.

- Any and all voluntary or involuntary terminations of Medical Staff/professional membership or voluntary or involuntary limitations, reductions, or losses of clinical privileges at any facility.
- The circumstances surrounding any and all involvements in professional liability actions, including notice of injury, claim or intent to file and all final judgments, settlements, or dismissals, even if not resulting in monetary damages.
- Any arrest, indictment, pending charges or conviction to a felony, a serious or gross misdemeanor, any crime or municipal violation involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol.
- Any and all notices of reprimand, censure, exclusion, sanction, suspension, or disqualification by Medicare, Medicaid, CLIA or other health care program or any notice of investigation that could lead to such an action.
- Any other change in status of information maintained in the credentials file, including but not limited to, change in name, practice address, contact information, Board certification attainment or lapse, provider enrollment certification, etc.

XII. CREDENTIALING FILE CONFIDENTIALITY AND RETENTION

Credentialing files shall be retained for not less than seven (7) years from date of practitioner separation from the BHD Provider Network.

Credentialing files are considered protected and confidential. Electronic files shall be password protected or otherwise restricted to allow access by only staff directly involved in BHD Provider Network credentialing processes and decisions. File cabinets containing practitioner files shall be locked and/or secured after normal business hours within a locked room. Offices containing practitioner credentialing files shall be secured, as practical or business appropriate, after normal business hours. If files are archived and shipped to an offsite secure file retention company, there shall be a file destruction date set to seven (7) years post-separation from the Provider Network. A list of these files shall be maintained for reference and secured by employee password. Electronic files shall be backed up regularly.

All non-public information collected during the credentialing process is considered confidential. Access to credentialing information is limited to authorized individuals and is accessible to the applicant except for the information protected under [Wisconsin Stat. §§ 146.37, 146.38](#) and [Title IV-Health Care Quality Improvement Act SEC 411 \[42 U.S.C. sec 11111 et seq\] Professional Review](#).

XIII. REINSTATEMENT

If a practitioner is credentialed and leaves the network voluntarily or in such a way that the BHD Provider Network has not terminated the practitioner for quality issues or any other adverse or egregious event, she/he may re-enter the network within thirty (30) calendar days. S/he must submit a written explanation to include activities during the absence, and complete a recredentialing application.

The practitioner will not have to go through the primary source verification process if all documents remained unrestricted, current and valid during the absence period. The Committee Chairperson and/or the Committee retain the authority to approve or disapprove absences, on a case-by-case basis, regardless of the time frame absent from the network.

XIV. ONGOING MONITORING

The BHD Provider Network monitors practitioner sanctions, grievances/complaints and quality issues between credentialing cycles and takes appropriate action(s) to improve practitioner performance when it identifies occurrences of poor quality. The BHD Provider Network acts on important quality and safety issues in a timely manner by reporting such occurrences at monthly credentialing meetings. If an occurrence requires urgent attention, the Chief Medical Officer or designee will address it immediately; engage the Committee if necessary, and appropriate action(s) will be taken to ensure quality. On an ongoing monitoring basis, the BHD Provider Network collects and takes appropriate intervention and/or action by:

A. Collecting and Reviewing Medicare and Medicaid Sanctions

The BHD Provider Network will review sanction information within 30 calendar days of being posted on the [OIG Report Website](#).

B. Collecting and Reviewing Sanctions or Limitations on Licensure:

The BHD Provider Network Quality or Credentialing Staff will review sanction information within 30 calendar days of release. In areas where reporting entities do not publish sanction information on a set schedule, the BHD Provider Network Quality or Credentialing Staff will query for this information at least every six months. The Wisconsin DSPS publishes discipline information on a quarterly basis, but Board updates are available on the [WDSPS](#) website on a regular basis and may be queried for new actions, at any time.

C. Collecting and Reviewing Grievances/Complaints:

The BHD Provider Network may evaluate both the specific grievance/complaint and the practitioner's history of issues. Evaluation of the practitioner's history of grievances/complaints will occur at least every six months; if a practitioner has had two complaints within a six month period or any other pattern or trend is identified, or if a practitioner has a combination thereof, the information will be presented at the next Credentialing Committee Meeting for discussion.

D. Collecting and Reviewing Information from Identified Adverse Events:

The BHD Provider Network monitors for adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the nature of the adverse event, the BHD Provider Network will implement actions and/or interventions based on its policies and procedures when instances of poor quality is identified. When practitioner specific matters are identified, those matters shall be referred to the Credentialing Committee for review.

XV. NONDISCRIMINATORY PRACTICES

The BHD Provider Network conducts each Committee meeting in a nondiscriminatory manner. All credentialing decisions will be based on the BHD Provider Network professional criteria for acceptance. The BHD Provider Network does not make credentialing decisions based on an applicant's race, gender, age, disability, creed, color, sexual orientation, marital status, military service membership, arrest/conviction *record (unless offense is substantially related to professional services and/or licensed activity)*, national origin, any physical or mental impairment that after any legally-required reasonable accommodation does not preclude abilities to perform services, client population served or any other basis prohibited by law.

All committee members responsible for credentialing decisions sign a statement affirming nondiscrimination for credentialing decisions. Periodic audits of practitioner grievances/complaints will also be conducted to determine if there are grievances/complaints alleging discrimination.

In credentialing practitioners, the BHD Provider Network shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner, prospective or existing, who is acting within the scope of his or her license or certification under state law solely on the basis of the license or certification.

If a practitioner or group of practitioners is declined network participation, the reason for denial by the Committee shall be communicated, in writing, within 60 calendar days of the Committee's final decision.

This prohibition does not preclude the BHD Provider Network from refusing to grant participation to a practitioner if there is no network need.

XVI. CREDENTIALING APPEAL REVIEW PROCESS

The Committee shall implement a mechanism to resolve disputes with participating practitioners regarding actions by the Provider Network that relate to either:

- (1) a participating practitioner's status within the network or
- (2) any action by the Provider Network related to a practitioner's professional competency or conduct.

In the case of a practitioner where the Committee makes an adverse determination and rejects the application, the Committee shall specify one of the two following reasons for the adverse determination:

A. Business or Administrative

- Not related to the practitioner's competence or professional conduct

B. Competence and/or Professional Conduct – Quality Related

- As it affects or may affect the health and welfare of a member
- Occurrences of this type, for physicians and non-physicians, may be reported to the National Practitioner Data Bank, the Department of Safety and Professional Services, American

Medical Association, Office of Inspector General and/or Department of Health and Human Services.

The Committee shall review all available information and notify each practitioner via certified mail of the decision to decline, suspend, reduce or terminate network participation. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., restrict a practitioner to perform specific duties, require oversight by another participating practitioner, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing.

XVII. DELEGATED CREDENTIALING

The BHD Provider Network may opt to delegate credentialing responsibility and authority for designated group practices or entities where the following conditions are met:

- The group practice or entity agrees to provide to the BHD Provider Network a copy of its Credentialing Program, including documentation of the professional criteria to be evaluated in the credentialing processes and mechanisms for their verification and review. The criteria and processes must be deemed equivalent to those established by the BHD Provider Network.
- There is a written agreement that states the scope of delegated activities and delegate's accountabilities to the BHD Provider Network.
- The group practice or entity agrees to provide the BHD Provider Network with any modifications to its Credentialing Program.
- The group practice or entity agrees to cooperate with the BHD Provider Network's requests to audit the Group's credentialing and/or recredentialing processes at least annually.
- The group practice or entity agrees to provide the BHD Provider Network with timely updates concerning additions and terminations of its practitioners.

A list of group practices and other organizations or entities to which credentialing responsibility and authority have been delegated is maintained by the BHD Provider Network's credentialing and quality staff.

XVIII. DUAL CREDENTIALING AND CONTRACTING

A. Dually Credentialed:

The BHD Provider Network grants dual credentialing to participating practitioners who can satisfactorily demonstrate the appropriate level of education and training in the specialties s/he wishes to practice. Appropriate education and training must be provided to the BHD Provider Network, and if not, there must be satisfactory evidence, as determined by the BHD Provider Network, of experience and hours of practice in the desired specialties. These types of practitioners are considered "dually credentialed"

practitioners. For example: A psychiatrist who has completed a fellowship can act as a sub-specialist within that area, i.e., child psychiatry, geriatric psychiatry, forensic psychiatry.

B. Dually Contracted:

The BHD Provider Network considers those practitioners contracted directly with the BHD Provider Network as a licensed independent practitioner and with a provider organization or with more than one provider organization as “dually contracted” practitioners. Dually contracted practitioners shall not be required to complete separate credentialing applications for each provider/agency but must be authorized as a credentialed practitioner to provide services with each contracted provider/agency with which she or he is affiliated.

XIX. CREDENTIALING PROGRAM DESCRIPTION SIGNATURE PAGE

Effective Date: July 1, 2019

**RECOMMENDED FOR APPROVAL BY THE PROVIDER NETWORK CREDENTIALING COMMITTEE ON
MAY 22, 2019:**

BHD Provider Network Credentialing Committee (Chair)

Date

APPROVED BY:

Community Access to Recovery Services Administrator

Date

Wraparound Milwaukee Administrator

Date

BHD Chief Medical Officer

Date

BHD Administrator

Date

Milwaukee County Mental Health Board (Chairman)

Date

Original Effective Date: July 1, 2019

Reviewed Date(s):

Revised Date(s):

ADDENDA

ADDENDUM A: BHD Provider Network Practitioner Credentialing/Recredentialing Appeals Process

ADDENDUM B: BHD Provider Network Credentialing Structure and Governance

ADDENDUM A

BHD PROVIDER NETWORK PRACTITIONER CREDENTIALING/RE-CREDENTIALING APPEALS PROCESS

RIGHT TO APPEAL

If a determination is made by the BHD Provider Network Credentialing Committee to deny or restrict a practitioner's participation request; or to suspend, restrict or revoke a participating practitioner's status, the practitioner is provided with a written explanation of the rationale for the Committee's decision and a description of the appeal rights available to him/her. The practitioner is afforded the opportunity to review the information submitted in support of their application except for any information that is protected by state peer review or other law.

During the time an individual's appeal for initial participation is being considered she/he may not provide care or treatment to BHD Provider Network members. During the time an individual's appeal for continued participation is being considered she/he may provide care or treatment to BHD Provider Network members, if there is reasonable belief that there is no significant potential for patient harm and his/her current credentialing approval period has not expired.

In addition to restrictive actions or denials imposed by the Credentialing Committee, any immediate restriction, suspension or termination of a practitioner's participating status by the BHD Chief Medical Officer, Medical Director or his/her physician designee which exceeds fourteen days shall include notification to the practitioner of his/her right to an appeal. A practitioner may not appeal such a decision if the restriction, suspension, or termination does not exceed fourteen days during which time an investigation is being conducted to determine the need for further action.

RECONSIDERATION PROCESS – FIRST LEVEL

If a practitioner's participation request has been denied or restricted or a participating practitioner's participation status has been restricted, suspended, revoked, or denied, the practitioner may request reconsideration of the determination to the **BHD Provider Network Credentialing Committee**. A request for reconsideration must be submitted in writing within 30 days of the date of the notice of the challenged action. A request shall be considered submitted upon mailing (postmark, email, facsimile or by hand delivery with date/time of receipt noted). Failure to submit a written request for reconsideration within this 30-day period will be deemed a waiver of the practitioner's right to appeal. Such request for reconsideration must address the issues identified by the Credentialing Committee through the provision of additional information and copies of appropriate supporting documentation.

Upon receipt of a request for reconsideration, the Credentialing Committee shall review all new information, including the supporting documentation submitted by the practitioner, and then votes to overturn or uphold the original determination. The decision of the Credentialing Committee is communicated in writing to the practitioner within 14 days of the decision.

If the Credentialing Committee upholds its original decision, the practitioner must be given information concerning his/her right to a hearing and a summary of the rights in the hearing. This process is described below.

HEARING PROCESS – SECOND LEVEL APPEAL

Within 30 days of receipt of notification of the Credentialing Committee decision to uphold a practitioner's restriction, suspension, revocation, or termination, the practitioner has the right to request a hearing before an Appeals Committee. A request shall be considered submitted upon mailing (postmark, email, facsimile or by hand delivery with date/time of receipt noted). If a hearing is requested within the 30 days, the applicant must be given written notice setting forth the following:

1. Date, time and place of the hearing. The hearing date will not be less than thirty (30) days from the date the practitioner receives the hearing notice, unless a shorter period is mutually agreed to by the parties.
2. A list of witnesses (if any) expected to testify at the hearing on behalf of BHD Provider Network.
3. The practitioner's right to representation by an attorney or other person of the applicant's choice.
4. The practitioner's right to have a record made of the proceedings.
5. The practitioner's right to call, examine, and cross-examine witnesses.
6. The practitioner's right to present evidence determined to be relevant by the hearing committee, regardless of its admissibility in a court of law.
7. The practitioner's right to submit a written statement at the close of the hearing.
8. That the practitioner's right to the hearing may be forfeited if the applicant fails, without good cause, to appear.

APPEALS COMMITTEE – SECOND LEVEL

An Appeals Committee shall be an ad hoc committee composed of not less than five (5) individuals jointly selected by the Chief Medical Officer, the Credentialing Committee Chair and the CARS or Wraparound Administrator, as applicable. One (1) member shall be a member of the BHD Executive Team and one member shall be a BHD Provider Network Medical Director. Other Appeals Committee members shall be professional peers of the affected practitioner. Members of the Appeals Committee, other than the required Executive Team member, may be network practitioners, BHD Wraparound or Cars Staff, BHD hospital medical staff or allied health professional staff or may be out of network practitioners recommended by the Chief Medical Officer or a Provider Network Medical Director.

After listening to and reviewing all evidence, the Appeals Committee shall meet and privately discuss the evidence presented for the purpose of making a final determination. The Appeals Committee may vote to uphold, reject, or modify the decision of the Credentialing Committee.

Decisions will be communicated, in writing, to the practitioner within 30 days of the decision. Such decisions are final.

In accordance with requirements under the HCQIA, the majority of the voting members on the appeals committee shall be professional peers of the affected practitioner.

EXCLUSIONS FROM APPEAL

Practitioners who meet the criteria below are not eligible for the credentialing appeals process:

- 1) A breach or termination in the practitioner's contract with the BHD Provider Network
- 2) A suspended, revoked or terminated professional license
- 3) A suspended, revoked or terminated Drug Enforcement Administration registration
- 4) Listed on the OIG Exclusions List
- 5) Listed on any ~~County~~ or State Exclusions List
- 6) Wisconsin Caregiver Law required exclusions
- 7) Any other automatic exclusion required by law or regulation
- 8) Failure to submit a complete and accurate credentialing or recredentialing application

PLEASE NOTE

- At all levels, the practitioner has the burden of establishing that s/he meets BHD Provider Network's standards for participation.
- At all levels, the practitioner may submit additional written evidence to correct the record of erroneous information within thirty (30) calendar days of his or her intention to appeal.
- At the BHD Provider Network's discretion, all appeals filed after the 30-calendar day timeframe are at risk for not being accepted. Appeals received outside of the 30 calendar day timeframe for filing shall be reviewed on a case-by-case basis.
- The practitioner will have exhausted all appeal rights at the conclusion of the 2nd Level Appeal Hearing process.
- The recommendation of the Credentialing Committee Appeal's Panel shall be final.
- The BHD Provider Network's Appeal process is modeled after the requirements in the Health Care Quality Improvement Committee Act of 1986. The practitioner has no procedural rights, other than those set forth herein or required by law.
- The BHD Provider Network reserves the right to make the "final" decision (i.e., uphold or overturn) at all appeal, panel and/or hearing levels (i.e., 1st or 2nd), and no further appeal rights shall apply.

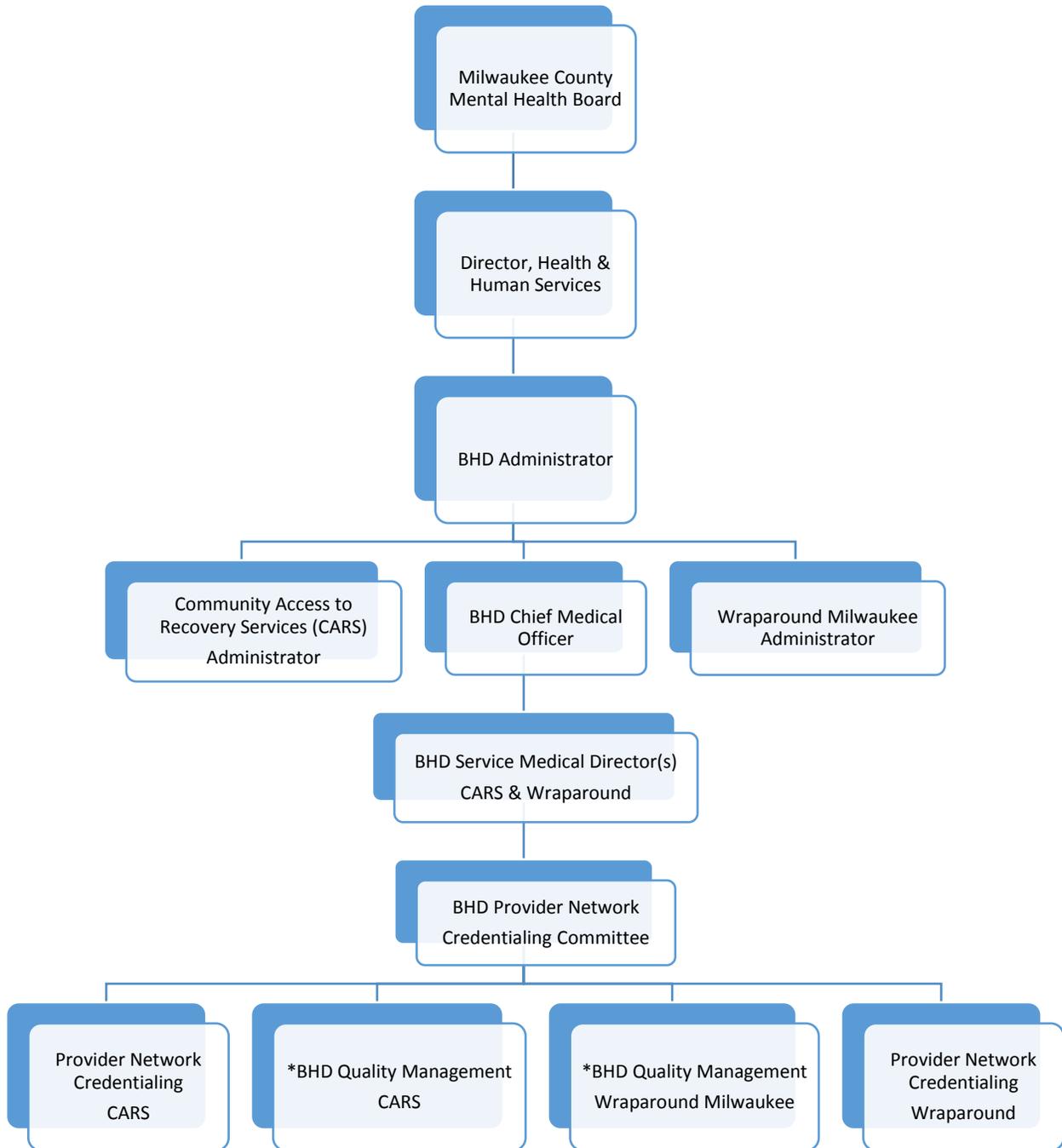
BHD PROVIDER NETWORK – PRACTITIONER CREDENTIALING/RE-CREDENTIALING

| CREDENTIALING DENIAL, RESTRICTION OR LIMITATION DECISION - APPEAL REQUEST FORM | |
|--|---|
| Practitioner's Name | |
| Practitioner's Specialty | |
| Practitioner's Address | |
| Practitioner's Phone # | Fax #: |
| Practitioner's E-Mail | |
| Credentialing Denial Reason | |
| Practitioner's Rebuttal / Comments | |
| <i>If additional space is required, please attach using a separate sheet.</i> | |
| I am requesting the type of appeal checked below. I understand that I am not required to attend document only investigations. | |
| Select 1 Option only <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 | <ul style="list-style-type: none"> • Committee Review and Appeal – Document Review/Investigation only • Expanded Review – Meet with Committee and Appeal Document Review/Investigation • Appeal Committee/Hearing (only applicable following Level 1 appeal and Committee restriction or denial decision was upheld) <p><small>*Applicants are allowed one appeal under Level 1 and Level 2 subject to timely request and conditions specified within the Appeals Process.</small></p> |
| Practitioner's Signature: | Date: |
| PLEASE NOTE: The Appeal Request Form must be completed, signed and dated <u>by the practitioner</u> who is filing the appeal in order to be considered valid. If there is supporting documentation, attach it to the Appeal Request Form. | |

RETURN TO: BHD Provider Network Credentialing Committee
 Attn: John H. Schneider, MD, FAPA, Chairperson
 9455 W. Watertown Plank Road
 Milwaukee, WI 53226

ADDENDUM B

BHD PROVIDER NETWORK CREDENTIALING PROGRAM ORGANIZATIONAL STRUCTURE AND GOVERNANCE



*Quality Management functions, as they pertain to Provider Network practitioner matters