

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

3

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, February 22, 2018 - 8:00 A.M.

Zoofari Conference Center
9715 West Bluemound Road

MINUTES

PRESENT: Robert Chayer, *Robert Curry, Michael Davis, Ronald Diamond, Rachel Forman, *Walter Lanier, Thomas Lutzow, Mary Neubauer, Maria Perez, Duncan ShROUT, and Brenda Wesley

EXCUSED: Jon Lehrmann

*Board Members Robert Curry and Walter Lanier 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. **Welcome.**

Chairman ShROUT welcomed Board Members and the audience to the meeting. Board Member Chayer was recognized for his long-term service and commitment to the Board as Board Secretary since its inception, and it was announced this would be Board Member Diamond's last Board meeting. Board Member Diamond provided brief comments. He was thanked for his service.

2. **Election of Board Officers – Chair, Vice-Chair, and Secretary.**

Chairman ShROUT outlined the election process.

Chairman ShROUT nominated Board Member Thomas Lutzow for Chairman of the Milwaukee County Mental Health Board.

Board Member Lutzow accepted the nomination. No other nominations for Chairman were made.

SCHEDULED ITEMS (CONTINUED):

MOTION BY: *(Perez) Vote Thomas Lutzow Chairman of the Milwaukee County Mental Health Board. 8-0-2*
MOTION 2ND BY: *(Wesley)*
AYES: Chayer, Davis, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley - 8
NOES: 0
ABSTENTIONS: 0
EXCUSED: Curry and Lanier - 2

Immediately following the election of the Chairman, Board Member Lutzow assumed his role as Chairman and facilitated the balance of the meeting.

Board Member Shrout nominated Board Member Maria Perez for Vice-Chair of the Milwaukee County Mental Health Board.

Board Member Perez accepted the nomination. No other nominations for Vice-Chair were made.

MOTION BY: *(Neubauer) Vote Maria Perez Vice-Chair of the Milwaukee County Mental Health Board. 8-0-2*
MOTION 2ND BY: *(Forman)*
AYES: Chayer, Davis, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley - 8
NOES: 0
ABSTENTIONS: 0
EXCUSED: Curry and Lanier - 2

Board Member Shrout nominated Board Member Michael Davis for Secretary of the Milwaukee County Mental Health Board.

Board Member Davis accepted the nomination. No other nominations for Secretary were made.

MOTION BY: *(Shrout) Vote Michael Davis Secretary of the Milwaukee County Mental Health Board. 8-0-2*
MOTION 2ND BY: *(Wesley)*
AYES: Chayer, Davis, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley - 8
NOES: 0
ABSTENTIONS: 0
EXCUSED: Curry and Lanier - 2

Chairman Lutzow greeted Board Members and the audience as the newly elected Chairman of the Board. Following the past practice of the Board's previous Chairman, Chairman Lutzow asked audience members to introduce themselves.

SCHEDULED ITEMS (CONTINUED):

3.	<p>Legacy Costs and Their Impact on the Mental Health Board's Statutory Obligation to Fund Institutional and Community Mental Health Services.</p> <p>Teig Whaley-Smith, Director, Department of Administrative Services</p> <p>Mr. Whaley-Smith explained in 2000, our pension contribution as a County was approximately \$800,000. As of 2018, that number has risen to \$72 million, with a projection of \$100 million if circumstances remain status quo. Different mechanisms have been deployed to help with the enormous liability. This impacts departments county-wide. It also has an impact on tax levy resources available to the Mental Health Board in fulfilling its statutory duties. There are things done through the County's overall budget to mitigate the effects, which Mr. Whaley-Smith described in detail.</p> <p>Additional resources will be needed to address the problem. From approximately 2008 through 2015, the State has received \$400,000 million per year while the County has received \$100,000 million less per year. A shift is needed in order for Milwaukee County to be able to continue to provide statutory services. Without additional revenue to offset costs, every single department's allocated property tax levy will decline every year going forward.</p> <p>Mr. Whaley-Smith described next steps as drafting long-term projections and creating a plan to stabilize services throughout Milwaukee County.</p> <p>Questions and comments ensued.</p>
4.	<p>Approval of the Minutes from the December 14, 2017, and January 25, 2018, Milwaukee County Mental Health Board Meetings.</p> <p>Board Member Neubauer requested the December 4, 2017, meeting minutes' typographical error in the first paragraph on Page 3, Item 6, be corrected to reflect the word "negotiation" as opposed to "negation."</p> <p>MOTION BY: (Shrout) Approve the Minutes AS CORRECTED from the December 14, 2017, Milwaukee County Mental Health Board Meeting. 10-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Shrout) Approve the Minutes from the January 25, 2018, Milwaukee County Mental Health Board Meeting. 10-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>
5.	<p>Board Positions Update.</p> <p>Evans Gant, Director of Community Relations, County Executive’s Office</p> <p>Mr. Gant stated he recently received Board Member recommendations from the County Board Chairman related to the University of Wisconsin-Madison representative seat, soon to be vacated by Board Member Diamond, and the Mental Health Nurse representative seat vacated by Dr. Jeffrey Miller.</p> <p>Onboarding of new Board Members was discussed.</p>
6.	<p>Local Public/Private Partnership and National Entity Partnership Joint Task Force Request for Authorization to Begin Negotiations with Universal Health Services.</p> <p>Board Member Shrout explained at the January 4, 2018, meeting of the Joint Task Force, a motion was unanimously approved to move negotiations forward with Universal Health Services to provide acute inpatient care.</p> <p>Mr. Lappen referenced an excerpt from a plan/study titled “A New Management System for Mental Health Services in Milwaukee County” dated 1973 where a taskforce was chartered with the same charge of the Mental Health Board’s Joint Task Force.</p> <p>MOTION BY: (Neubauer) Approve the Local Public/Private Partnership and National Entity Partnership Joint Task Force’s Recommendation that the Behavioral Health Division Proceed with Negotiations with Universal Health Services (UHS) and Provide UHS with a Letter of Exclusivity Regarding Said Negotiations. 10-0</p> <p>MOTION 2ND BY: (Shrout)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Board Member Neubauer stated the Local Public/Private Partnership and National Entity Partnership Joint Task Force, convened originally on November 30, 2015, has now completed their directive to conduct a due diligence review and identify a vendor for the outsourcing of Acute Psychiatric Services.</p> <p>MOTION BY: (Neubauer) <i>Sunset the Local Public/Private Partnership and National Entity Partnership Joint Task Force as of February 22, 2018, Originally Convened on November 30, 2015, Based on Completion of Duties and Fulfilling their Charge. 10-0</i></p> <p>MOTION 2ND BY: (Shrout)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>
7.	<p>Proposed Employee Severance and Retention Packages.</p> <p>Michael Lappen, Administrator, Behavioral Health Division</p> <p>This item was initially intended to be an action item requesting reserve funds be used for employee severance and retention packages in anticipation of moving forward with the outsource of in-patient hospital services. The packages, once implemented, will help assure staff incentives are in place to encourage employees to stay. The plans for the packages are currently being drafted but await a confirmed timeline. A detailed plan will be presented at an upcoming Board meeting. The packages will be for specific staff impacted by the outsource. This includes individuals whose jobs would be eliminated due to the contract with an acute provider. The plan proposes a minimum and a maximum number weeks.</p> <p>Severance has been targeted at a minimum of four weeks and a maximum of eight weeks with staff basically earning a week of severance per year of service up to eight weeks. Severance would be higher for leadership positions, knowing some of those positions will be more challenging for individuals to find equivalent employment. In those particular cases, the plan would be based on a week of severance per year of service with a minimum of eight weeks and a maximum of sixteen weeks. There is still a lot of work to do to identify who will be impacted. Staff impacted will get severance to aid in the transition as they look for new jobs.</p> <p>The retention piece is proving to be more challenging for Human Resources (HR). In order to most easily account for a retention package for staff, it needs to be implemented in the form of a bonus over a fixed period. Federal Legal Standard Act (FLSA) rules, which apply, are very particular as to how the package must be calculated. The calculation of that incentive period begins once the plan is finalized and presented.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>The retention package, depending on the timeline, would be two bonus payments payable in approximately 2020 and 2021. The bonus would be approximately twenty percent based on the gross salary of employees affected split over two payments. There is still a lot of work to do to identify who will be eligible. The purpose of retention is to keep key clinical staff employed until the Behavioral Health Division (BHD) is no longer running a hospital.</p> <p>Another key factor depends on negotiations with Universal Health Services (UHS) and their willingness to partner with BHD and its employees in that UHS may hire BHD employees before their work at the Mental Health Complex ends. Some individuals may not be interested in the County's retention and severance packages because an incentive more beneficial may be offered by UHS.</p> <p>A workgroup was formed, met regularly, and created two near-final drafts of both the severance agreement and the retention agreement. Once negotiations are further along, the packages can be implemented.</p> <p>Once a plan is in place and the agreements are submitted as final, the Administrator will do a Town Hall Meetings tour of the inpatient units to talk directly to the individuals who will be impacted by severance and retention ensuring employees' questions are answered. The Chief Nursing Officer and an HR representative will participate. Most inpatient staff have a hard time attending regular Town Hall Meetings due to their shifts. The goal is to make employees feel confident that there will be a benefit to staying with BHD.</p>
8.	<p>Administrative Update.</p> <p>Michael Lappen, Administrator, Behavioral Health Division</p> <p>Mr. Lappen highlighted key activities and issues related to BHD operations. He provided updates on BHD's collaborations with the Milwaukee Health Care Partnership for Crisis Services Redesign and the MacArthur Foundation's Safety and Justice Challenge for the Criminal Justice Post Booking Stabilization Program. Mr. Lappen referenced the Kane Communications Update attached to the corresponding report.</p> <p>Questions and comments ensued.</p>
9.	<p>The Behavioral Health Division's Funding Allocations and Program Efficiencies Report for Mental Health Programs in Compliance with Chapter 51 of Wisconsin Statutes.</p> <p>Michael Lappen, Administrator, Behavioral Health Division</p> <p>Mr. Lappen explained the Funding Allocations and Program Efficiencies for Mental Health Programs report, in compliance with Chapter 51 of Wisconsin Statutes, is a statutory obligation and required on an annual basis. It includes a description of the funding</p>

SCHEDULED ITEMS (CONTINUED):

	<p>allocations for mental health functions; services; and programs; as well as describes improvements and efficiencies in these areas, and is an overall summary of 2017 activities.</p> <p>The report will be forwarded to the County Board, the County Executive, and the State Department of Health and Human Services.</p> <p>Questions and comments ensued.</p>
10.	<p>Mental Health Board Finance Committee Professional Services Contracts Recommendations.</p> <p>Dennis Buesing, Contract Administrator, Department of Health and Human Services</p> <ul style="list-style-type: none">• 2017 Contract Amendments<ul style="list-style-type: none">➢ University of Wisconsin – Milwaukee➢ Netsmart• 2018 Contract<ul style="list-style-type: none">➢ West Allis Crisis Assessment Response Team <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. Mr. Buesing provided background information on services the contracted agencies provide, which include program evaluation, information technology, and crisis services. Approvals are for a 2018 Contract and Amendments to 2017 Contracts.</p> <p>An update was provided on Netsmart’s contract and progress with ongoing efforts related to Electronic Medical Record Optimization.</p> <p>The Finance Committee unanimously agreed to recommend approval of the 2018 Professional Services Contract and 2017 Contract Amendments to the full Board.</p> <p>MOTION BY: (Perez) Approve the 2018 Professional Services Contract and 2017 Contract Amendments as Delineated in the Corresponding Report. 10-0</p> <p>MOTION 2ND BY: (Neubauer)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>

SCHEDULED ITEMS (CONTINUED):

11.	<p>Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.</p> <p>Dennis Buesing, Contract Administrator, Department of Health and Human Services</p> <ul style="list-style-type: none">• 2017 Contract Amendments• 2018 Contracts <p>Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. Mr. Buesing provided an overview detailing the various program contracts. Approvals are for 2018 Contracts and Amendments to 2017 Contracts.</p> <p>The Request for Proposals process for Family Engagement and Advocacy Services and the appeal filed as a result were explained.</p> <p>Questions and comments ensued.</p> <p>The Finance Committee unanimously agreed to recommend approval of the 2018 Purchase-of-Service Contracts and 2017 Contract Amendments to the full Board.</p> <p>MOTION BY: (Perez) <i>Approve the 2018 Purchase-of-Service Contracts and 2017 Contract Amendments as Delineated in the Corresponding Report. 10-0</i></p> <p>MOTION 2ND BY: (Davis)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shroul, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>
12.	<p>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</p> <p>Dennis Buesing, Contract Administrator, Department of Health and Human Services</p> <p>Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. Mr. Buesing provided an overview detailing the various program agreements, which provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.</p> <p>The Finance Committee unanimously agreed to recommend approval of the Fee-for-Service Agreements to the full Board.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Davis) Approve the Fee-for-Service Agreements as Delineated in the Corresponding Report. 10-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>
13.	<p>State of Wisconsin Contracts for Social Services and Community Programs Recommendation.</p> <p>Dennis Buesing, Contract Administrator, Department of Health and Human Services</p> <ul style="list-style-type: none"> • 2017 Contract Amendments • 2018 Contracts <p>State Contracts for Social Services and Community Programs, also referred to as Community Aids, provide State and Federal funding for County services to persons with mental illness, disabilities, and substance abuse problems and to juvenile delinquents and their families as mandated by State and/or Federal law. Approvals are for 2018 Contracts and Amendments to 2017 Contracts.</p> <p>The Finance Committee unanimously recommended approval of 2018 Social Services and Community Programs Contracts and 2017 Contract Amendments to the full Board.</p> <p>MOTION BY: (Perez) Approve the 2018 State Contracts for Social Services and Community Programs 2017 Contract Amendments as Delineated in the Corresponding Report. 9-0-1</p> <p>MOTION 2ND BY: (Davis)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley – 9</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: Lanier - 1</p>
14.	<p>Medical Staff Organization Governing Body’s Proposed Changes to its Rules and Regulations.</p> <p>Dr. Clarence Chou, President, Medical Staff Organization, Behavioral Health Division</p> <p>Dr. Chou provided a summary of notable changes proposed to the Medical Staff Organization Rules and Regulations.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Shrout) Approve the Behavioral Health Division Medical Staff Organization Rules and Regulations as Amended. 10-0</p> <p>MOTION 2ND BY: (Forman)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>
15.	<p>Medical Executive Report and Credentialing and Privileging Recommendations.</p> <p>Dr. Clarence Chou, President, Medical Staff Organization, Behavioral Health Division</p> <p>Dr. Chou provided a summary of the Medical Executive Committee recommendations related to medical staff credentialing.</p> <p>MOTION BY: (Shrout) Adjourn into Closed Session under the provisions of Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item 15. At the conclusion of the Closed Session, the Board may reconvene in Open Session to take whatever action(s) it may deem necessary on the aforesaid item. 10-0</p> <p>MOTION 2ND BY: (Davis)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p> <p>The Board convened into Closed Session at 9:45 a.m. to discuss Item 15 and reconvened back into Open Session at approximately 10:05 a.m. The roll was taken, and all Board Members were present.</p> <p>MOTION BY: (Perez) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 10-0</p> <p>MOTION 2ND BY: (Neubauer)</p> <p>AYES: Chayer, Curry, Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 10</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>

SCHEDULED ITEMS (CONTINUED):

16. **Adjournment.**

Chairman Lutzow announced Board Members will be receiving assignments to repopulate Committees where vacancies exist.

MOTION BY: (Shrout) Adjourn. 9-0-1
MOTION 2ND BY: (Chayer)
AYES: Chayer, Curry, Davis, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley - 9
NOES: 0
EXCUSED: Lanier - 1

ADDENDUM ITEM

17. **Assembly Bill 939 Provisions.**

Board Member Shrout addressed changes in the Bill that directly affect the Board, including the elimination of the Board of Trustees requirement, protocol for filling vacant Board seats, and protocol for removal of the Behavioral Health Division Administrator from Office. Board Member Shrout and Chairman Lutzow expressed concern related to the latter of the three and indicated it will require some discussion with the Acting Director of the Department of Health and Human Services and the County Executive.

Questions and comments ensued.

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.

Length of meeting: 8:04 a.m. to 10:33 a.m.

Adjourned,

Jodi Mapp

Senior Executive Assistant
Milwaukee County Mental Health Board

**The next meeting for the Milwaukee County Mental Health Board will be on
Thursday, March 22, 2018, @ 4:30 p.m. at the
Washington Park Senior Center
4420 West Vliet Street**

SCHEDULED ITEMS (CONTINUED):

**PUBLIC COMMENT WILL BE HEARD ON
THE 2019 BUDGET**

Visit the Milwaukee County Mental Health Board Web Page at:

<http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board.htm>

The February 22, 2018, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.



Michael Davis, Secretary
Milwaukee County Mental Health Board

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

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, March 22, 2018 - 4:30 P.M.
Washington Park Senior Center
4420 West Vliet Street

MINUTES

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

*Board Member Sheri Pattillo Johnson was not present at the time the roll was called but joined the meeting shortly thereafter.

SCHEDULED ITEMS:

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

1. **Welcome.**

Chairman Lutzow welcomed everyone to the Budget Public Comment Hearing.

2. **Explanation of the Budget Public Comment Process.**

Michael Lappen, Administrator, Behavioral Health Division

Mr. Lappen stated this is the first 2019 Budget specific Public Comment Hearing of the year. It is an opportunity for the public to provide input prior to moving forward with the process. Tax levy targets have yet to be put in place. However, it is very important to hear the public's concerns and ideas related to the 2019 Budget. Comments will be limited to three minutes. There is also unlimited access to provide written budget related comments on the Mental Health Board web page.

3. **Milwaukee County Behavioral Health Division 2019 Budget Discussion.**

The meeting opened for public comment on the Milwaukee County Behavioral Health Division 2019 Budget. The following individuals appeared and provided comments:

SCHEDULED ITEMS (CONTINUED):

	Cindy Krahenbuhl, Guest House of Milwaukee Jane Johnston Maureen Conrad Maria I. Nogueron, Mental Health Task Force Paul Neymeyer Pat Spoerl Barbara Beckert, Disability Rights Wisconsin Valerie Vidal, Meta House, Inc. Donna Kay
4.	Adjournment. MOTION BY: (Neubauer) <i>Adjourn. 7-0</i> MOTION 2ND BY: (Perez) AYES: Chayer, Davis, Forman, Lutzow, Neubauer, Perez, and Wesley - 7 NOES: 0
<p>This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.</p> <p>Length of meeting: 4:35 p.m. to 5:17 p.m.</p> <p>Adjourned,</p> <p><i>Jodi Mapp</i> Senior Executive Assistant Milwaukee County Mental Health Board</p>	
<p>The next regular meeting for the Milwaukee County Mental Health Board is Thursday, April 26, 2018, @ 8:00 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>http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board.htm</p>	

SCHEDULED ITEMS (CONTINUED):

The March 22, 2018, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.

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

Michael Davis, Secretary
Milwaukee County Mental Health Board

MILWAUKEE COUNTY
Inter-Office Communication

DATE: April 26, 2018

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

FROM: Amy Pechacek, Director, 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 all 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 is 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 Joint Safety 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, a focus on training to safety policies and procedures and the revitalization of internal BHD incident analysis over the past several years has shifted the culture of injury management from reactive to proactive, and renewed BHD's commitment to ensuring our employees are working safely. Also likely contributing to the decreasing claim trend has been a reduction in staffing and services offered, such as the closing of the Hilltop Unit.

The loss leader departments in workers' compensation claims County-wide are as expected given the nature of departmental functions, with Behavioral Health leading in the total number of claims filed between 2013 – 2017 and the Sheriff's Department leading in the highest expenses associated with their injury claims from this same time period. The Parks, House of Correction, Airport, and Highway also make the list of departments with higher claim volume and expense. The top claim driver throughout the County is the insurance industry code designation of "muscle strains" which represent 24% of all claim types filed and roughly 38% of the total expenses incurred.

As a division, BHD averaged 202 claims with a total incurred cost of \$890,167 annually between 2013 – 2014. Most notable is the drastic decrease in frequency and severity measures in 2015, wherein BHD recorded only 39 claims with a total incurred cost of \$329,033. This represents an 81% decrease in frequency measures and a 63% decrease in severity when compared to the immediately preceding two years. BHD has been able to sustain this reduction through 2017. On average, the department has recorded 32 claims with a total incurred cost of \$409,142 between 2016-2017. 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 2013 - 2017 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 47% of all workers' compensation claims filed at BHD, and 45% 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. It is recommended that an annual presentation on the County's claims and liabilities be presented to the County Executive, the Judiciary, Safety, and General Services Committee, and the Milwaukee County Mental Health Board to monitor progress and positive gains.

A handwritten signature in black ink, appearing to read "Amy Pechacek". The signature is fluid and cursive, with the first name "Amy" written in a larger, more prominent script than the last name "Pechacek".

Amy Pechacek, Director, 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



Risk Management

Milwaukee County BHD WC Review

Amy C. Pechacek - Director, Risk Management



Risk Management

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



Risk Management

- Statutory wage and medical benefit for individuals injured in the course and scope of their employment
- Milwaukee County has approx. 5,000 employees in WC program
- Historically the highest claim exposure impacting the County

Workers' Compensation - Countywide Claim Frequency

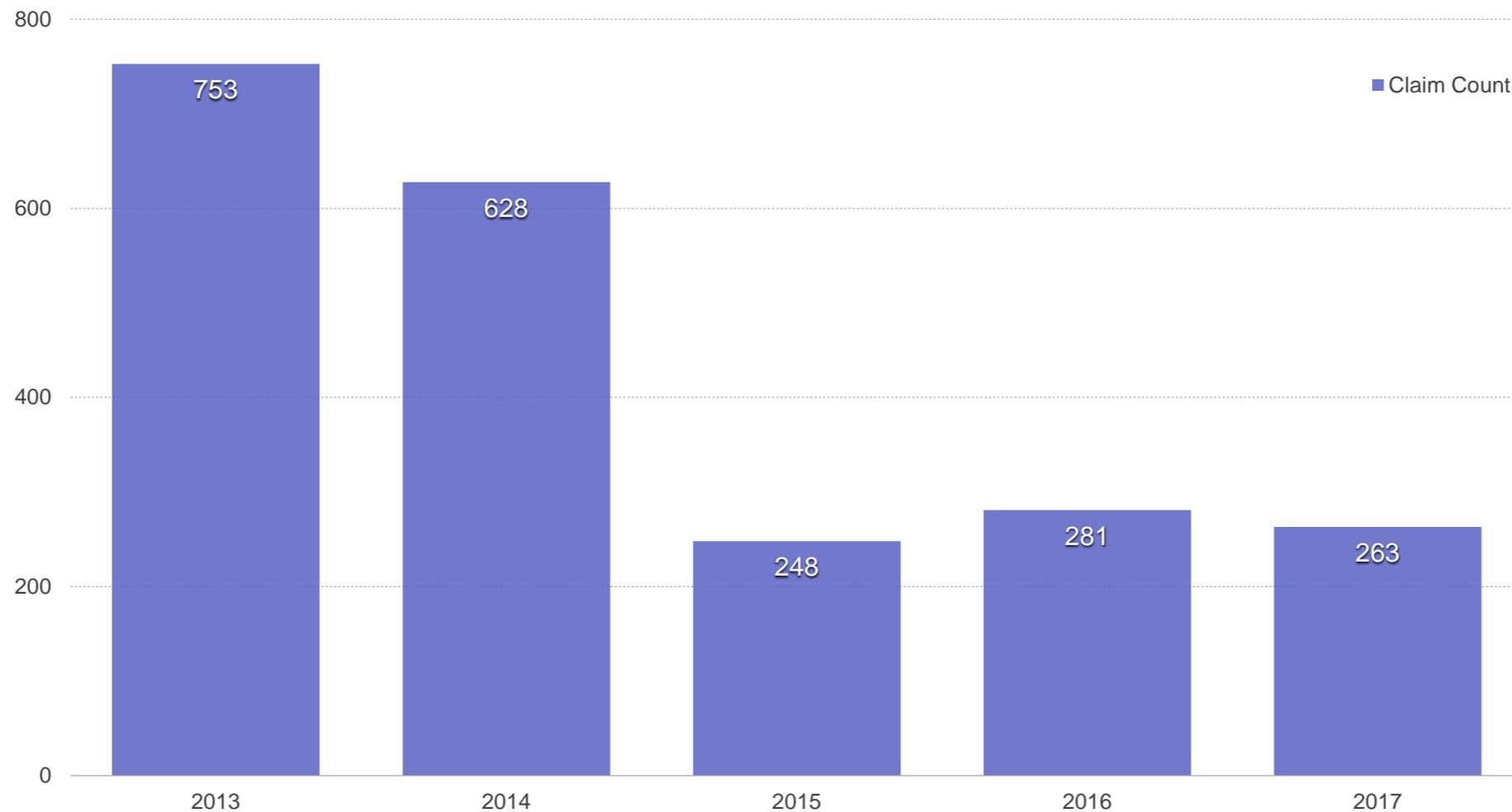


Risk Management

Claim Frequency | 2013 - 2017

	Claim Count
2013	753
2014	628
2015	248
2016	281
2017	263
TOTAL	2173

Claim Frequency | 2013 - 2017



Workers' Compensation - Countywide Claim Financial Summary

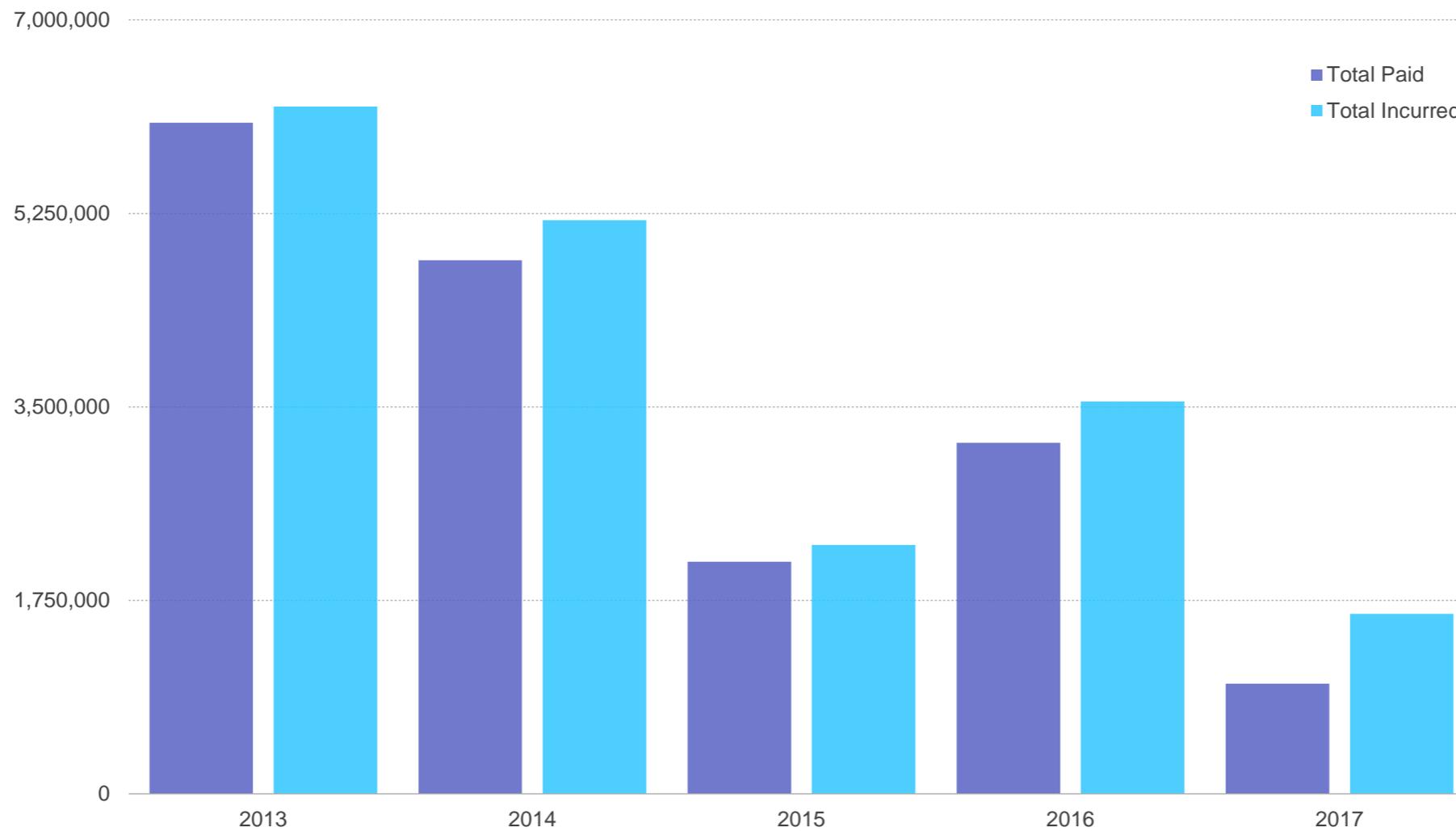


Risk Management

Claim Financial Summary | 2013 - 2017

	Total Paid	Total Incurred
2013	\$6,069,132	\$6,217,877
2014	\$4,826,195	\$5,187,923
2015	\$2,101,090	\$2,250,976
2016	\$3,174,440	\$3,548,485
2017	\$996,515	\$1,628,222
TOTAL	\$17,167,372	\$18,833,483

Claim Financial Summary | 2013 - 2017



Workers' Compensation - Countywide

Claim Frequency & Severity by Department



Risk Management

Claim Frequency & Severity by Department | 2013 - 2017

	Claim Count	Total Incurred
BHD	505	\$2,927,652
Sheriff	472	\$5,974,715
Parks	291	\$2,052,170
House of Corrections	178	\$1,714,107
DOT - Airport	147	\$1,756,431
DOT - Highway Maintenance	133	\$1,027,481
DHHS	107	\$1,464,676
Zoo	93	\$353,660
DOT - Fleet Management	40	\$232,421
District Attorney	35	\$197,229
Facilities	31	\$200,646
All Others (26)	141	\$932,295
TOTAL	2173	\$18,833,483

Workers' Compensation - Countywide

Top Claim Frequency & Severity Accident Types



Risk Management

Top 5 Most Frequent Accident Types | 2013 - 2017

	Total Incurred	Total Incurred
Strain	531	\$7,186,986
Struck By	292	\$1,119,790
Slip, Trip or Fall	182	\$2,136,768
Altercation	170	\$2,013,575
Laceration	107	\$276,609

Top 5 Most Severe Accident Types | 2013 - 2017

	Total Incurred	Claim Count
Strain	\$7,186,986	531
Slip, Trip or Fall	\$2,136,768	182
Altercation	\$2,013,575	170
Motor Vehicle Accident	\$1,916,107	75
Struck By	\$1,119,790	85

Workers' Compensation - BHD

Claim Frequency

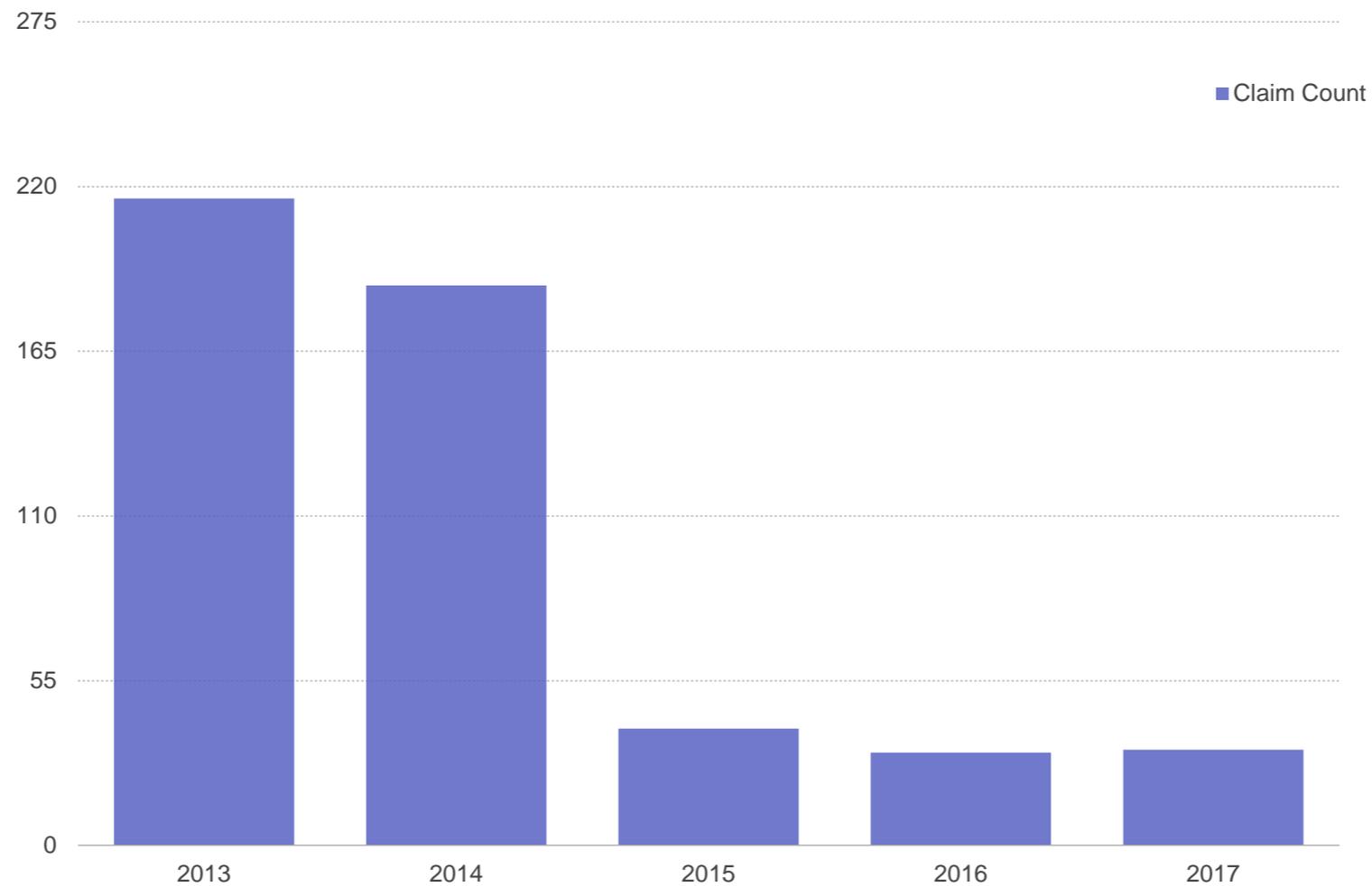


Risk Management

Claim Frequency | 2013 - 2017

	Claim Count
2013	216
2014	187
2015	39
2016	31
2017	32
TOTAL	505

Claim Frequency | 2013 - 2017



Workers' Compensation - BHD

Claim Financial Summary

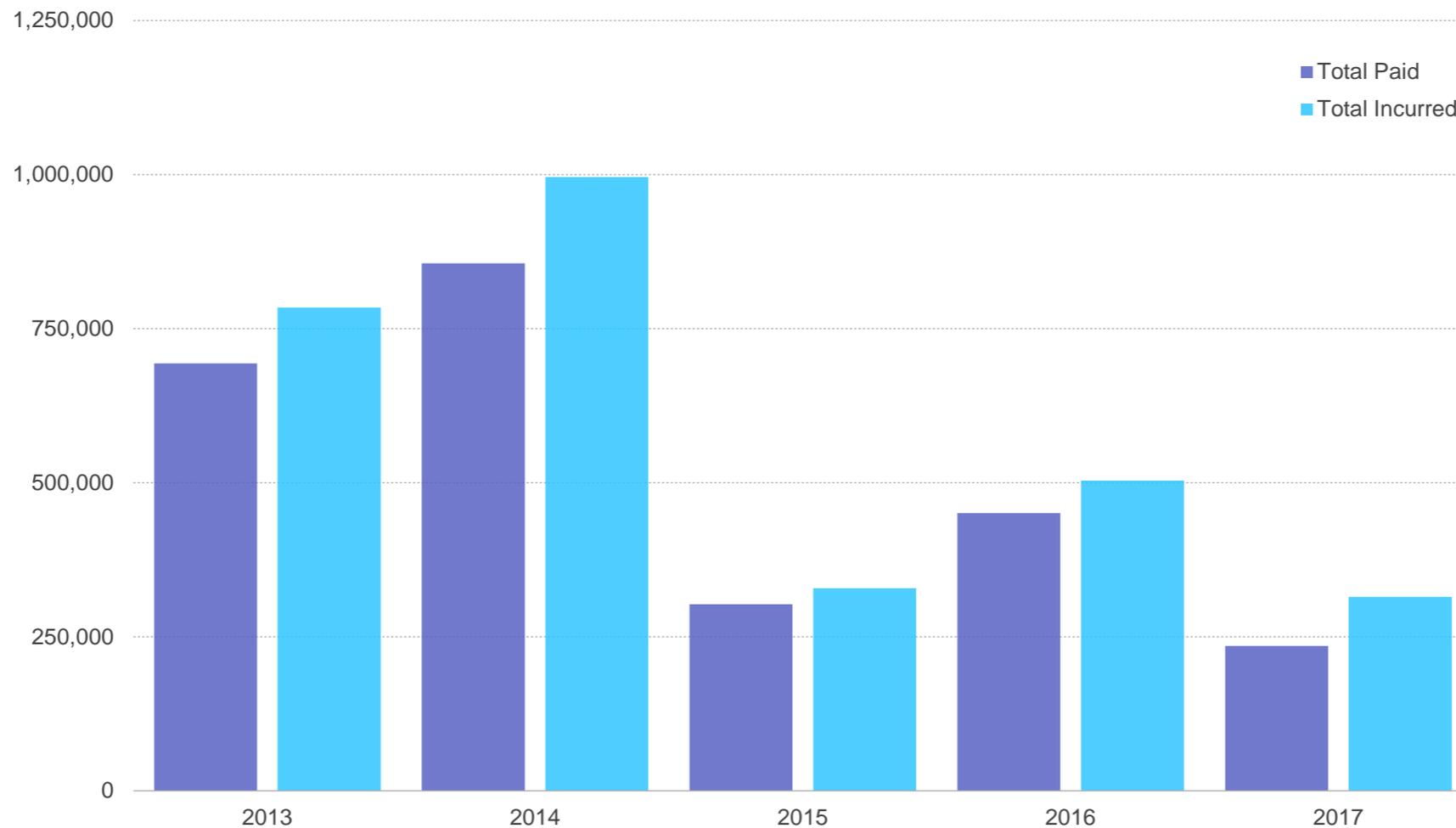


Risk Management

Claim Financial Summary | 2013 - 2017

	Total Paid	Total Incurred
2013	\$693,784	\$784,213
2014	\$856,295	\$996,121
2015	\$303,040	\$329,033
2016	\$451,011	\$503,540
2017	\$235,231	\$314,744
TOTAL	\$2,539,361	\$2,927,652

Claim Financial Summary | 2013 - 2017



Workers' Compensation - BHD

Claim Frequency & Severity by Claim Type

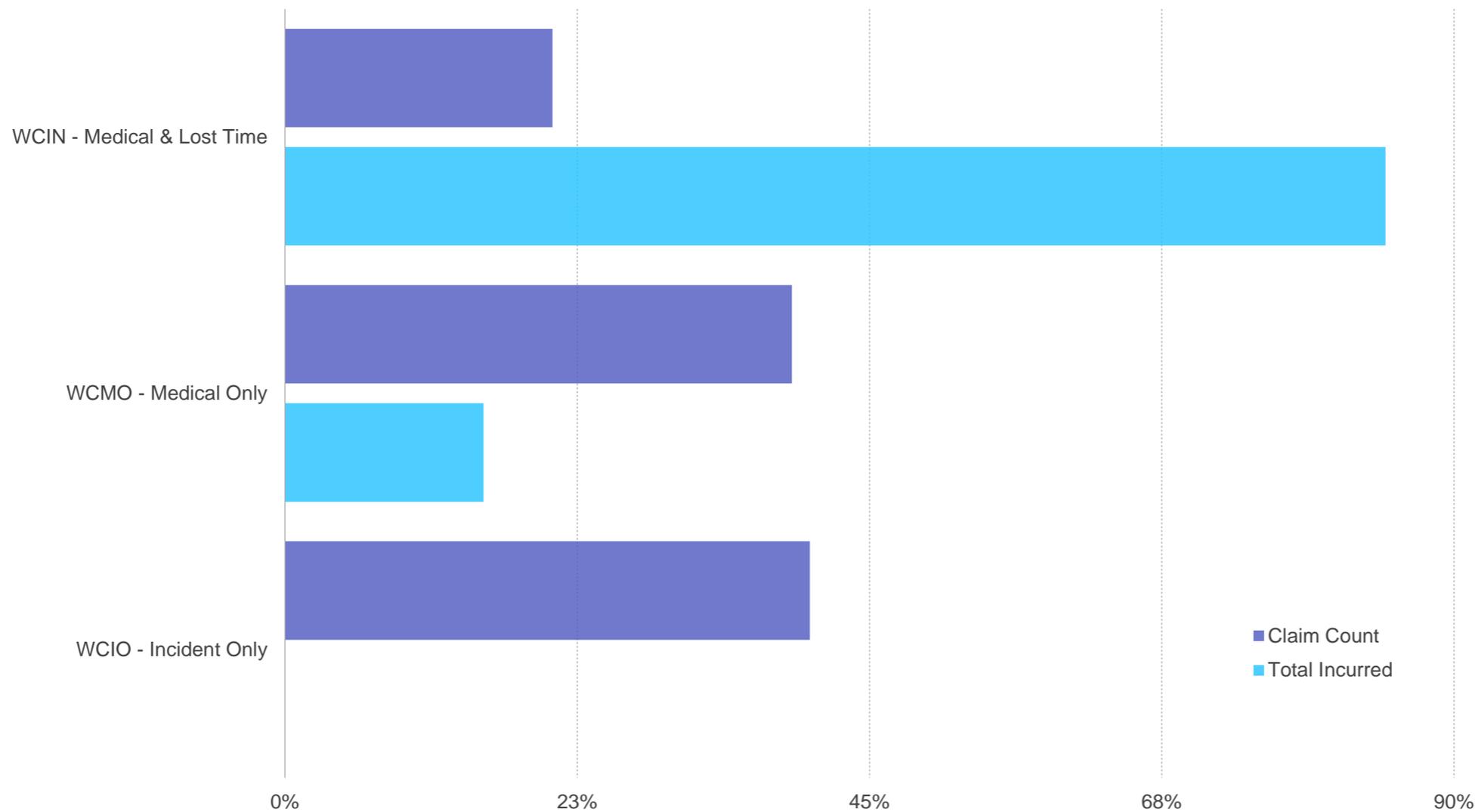


Risk Management

Claim Frequency & Severity by Claim Type | 2013 - 2017

	Claim Count	Total Incurred
WCIN - Medical & Lost Time	104	\$2,480,299
WCMO - Medical Only	197	\$447,353
WCIO	204	\$0
TOTAL	505	\$2,927,652

Claim Frequency & Severity by Claim Identifiers | 2013 - 2017



Workers' Compensation - BHD

Frequency: Top 5 Divisions

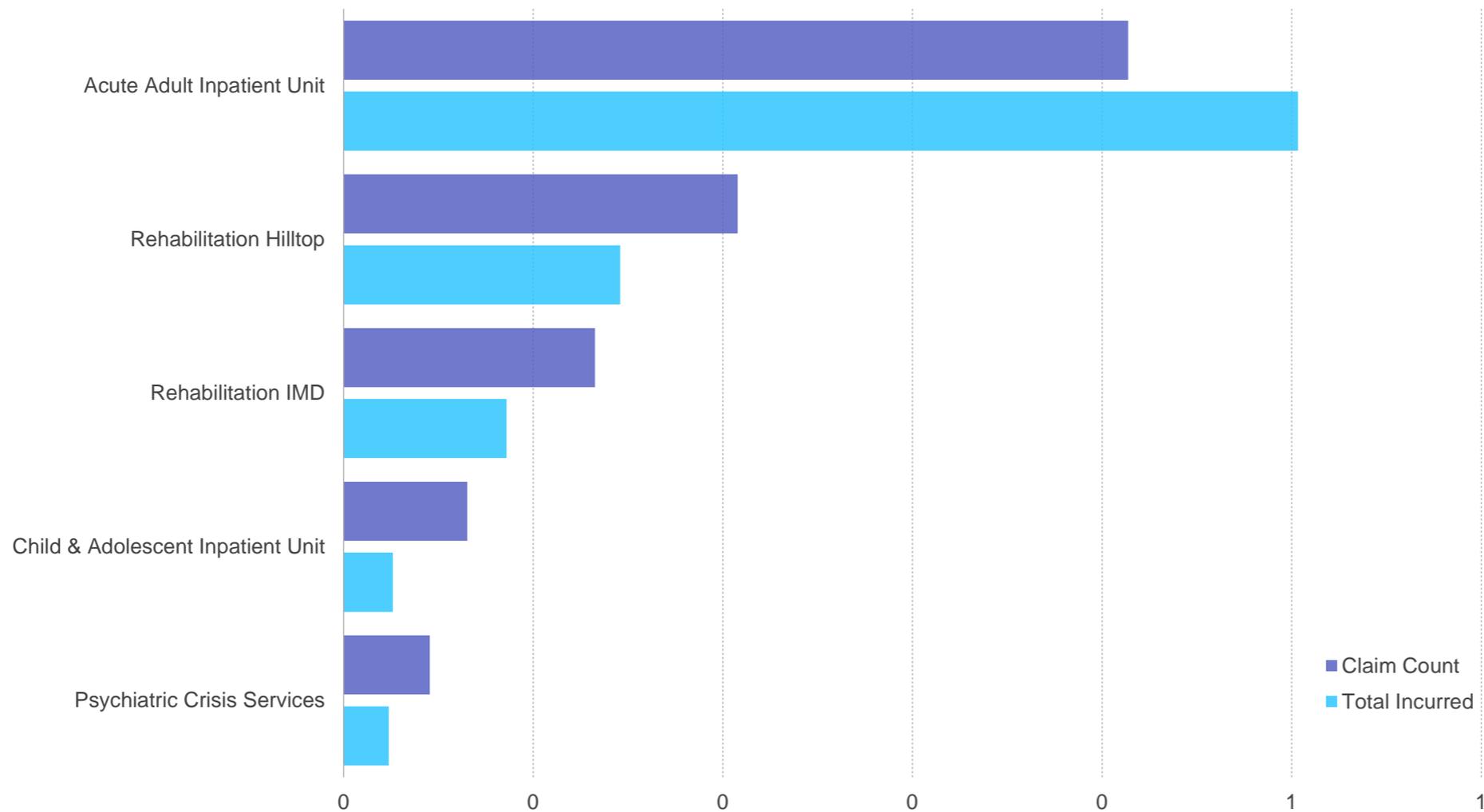


Risk Management

Frequency: Top 5 Divisions | 2013 - 2017

	Claim Count	Total Incurred
Acute Adult Inpatient Unit	209	\$1,474,034
Rehabilitation Hilltop	105	\$427,068
Rehabilitation IMD	67	\$251,811
Child & Adolescent Inpatient Unit	33	\$76,017
Psychiatric Crisis Services	23	\$69,612

Frequency: Top 5 Divisions | 2013 - 2017



Workers' Compensation - BHD

Severity: Top 5 Divisions

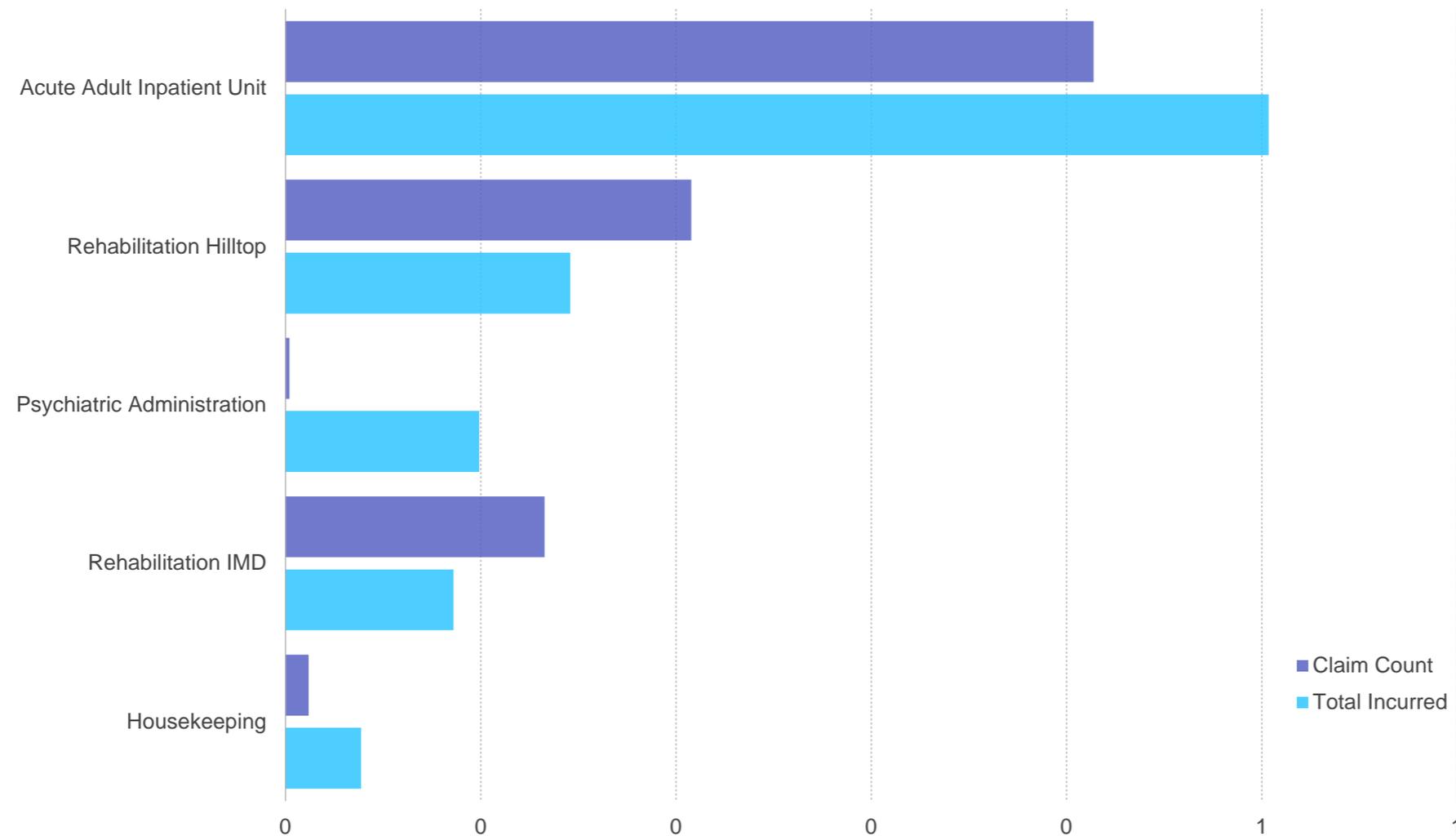


Risk Management

Severity: Top 5 Divisions | 2013 - 2017

	Claim Count	Total Incurred
Acute Adult Inpatient Unit	209	\$1,474,034
Rehabilitation Hilltop	105	\$427,068
Psychiatric Administration	1	\$290,565
Rehabilitation IMD	67	\$251,811
Housekeeping	6	\$113,313

Severity: Top 5 Divisions | 2013 - 2017



Workers' Compensation - BHD

Top 5 Most Severe Accidents Types

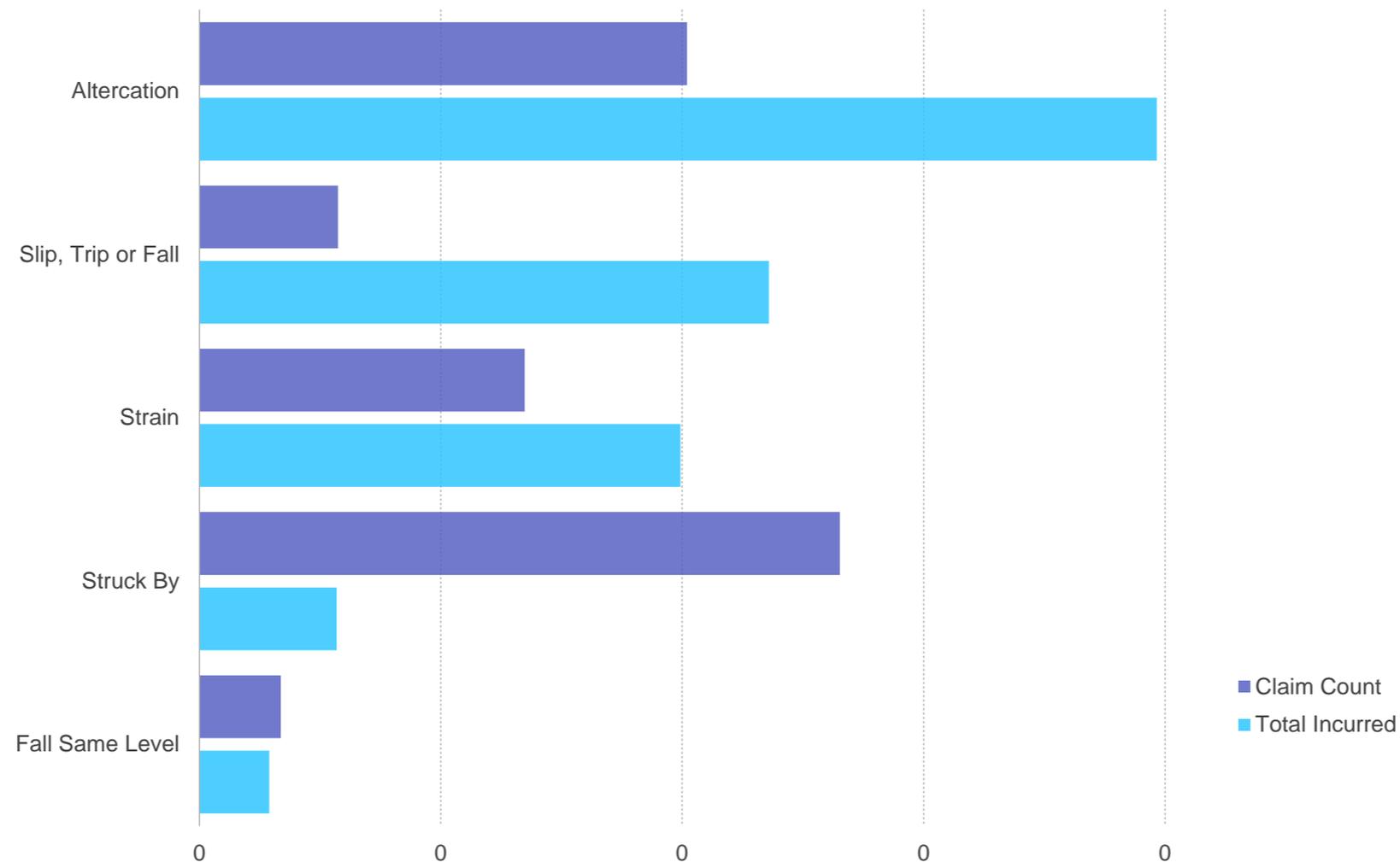


Risk Management

Top 5 Most Severe Accident Types | 2013 - 2017

	Claim Count	Total Incurred
Altercation	102	\$1,161,015
Slip, Trip or Fall	29	\$690,595
Strain	68	\$583,427
Struck By	134	\$166,272
Fall Same Level	17	\$84,965

Top 5 Most Severe Accident types | 2013 - 2017



Workers' Compensation - BHD

Experience Modification Factor



Risk Management

BHD Experience Modification Factor: .96

Minimum Mod: .38

Controllable Mod: .58

The **Minimum Mod** is your payroll information multiplied by your employee's job classification rates, or loss experience rates. It is your mod without any losses.

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



Risk Management

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 Milwaukee County Occupational Health Programs (Respiratory, Hearing Protection & Bloodborne Pathogens)
- Formalized Accident Investigation Procedures

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

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*
- Partnership City of Milwaukee FUSION Center to deliver personal safety in the field and community.
- Focus on Safe Lifting/Back Injury Prevention
- Focus on De-Escalation & Defense Training
- Focus on Slip, Trips and Falls Injury Prevention



Social**Solutions** presents...

5

THE

AN INTRODUCTION TO

CULTURAL INTELLIGENCE (CQ)

TRAINING FOR THE HUMAN SERVICES PROFESSION

CQ EXPERIENCE

Milwaukee County Behavioral Health Division (MCBHD)

Cultural Intelligence Training

Volume 18-1



The CQ Experience TRAINING WORKBOOK

Milwaukee County Behavioral Health Division (MCBHD)
Cultural Intelligence Training
Volume 18-1

Shawn Green-Smith
Social Solutions - President
414-429-0864
shawn.green@thesocial.solutions

Derek Kenner, Ph.D.
Social Solutions - CLO
414-699-5303
derekkenner@yahoo.com



TABLE *of* CONTENTS

S O C I A L S O L U T I O N S , I N C - C Q T R A I N I N G

What is RECOVERY?

- 01** What is CQ and Why Does It Matter?
- 02** Competence vs EQ vs Diversity vs CQ
- 03** Implicit Bias?
- 04** A Look Inside a CQ Score
- 05** What Does Your CQ Score Say About You?
- 06** The Impact of Your CQ Score on You
- 07** Capabilities & Sub-Dimensions
- 08** How is CQ best applied?
- 09** Questions - Dismissal

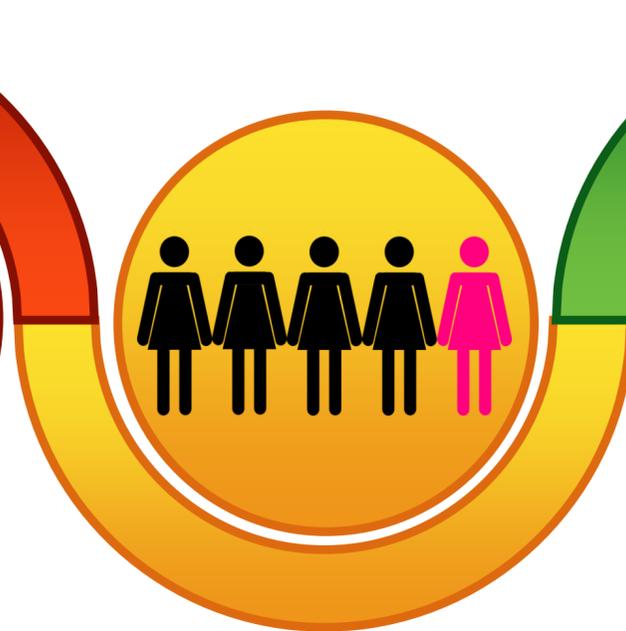
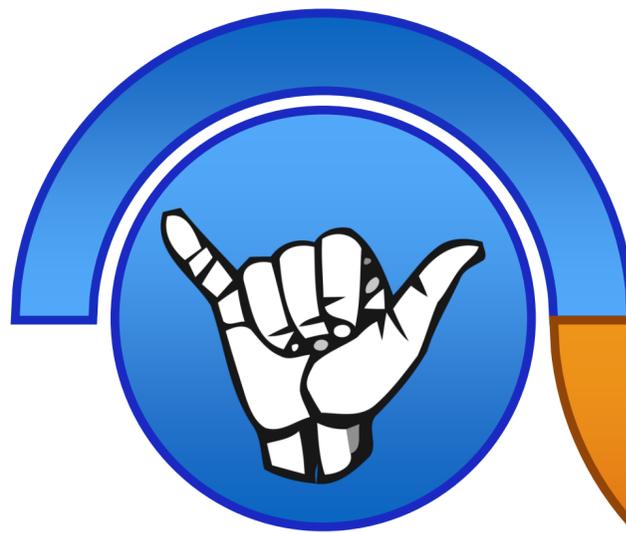
What is Culture?

Culture is the characteristics and knowledge of a particular group of people, defined by everything from:

Religion

Social Habits

Arts

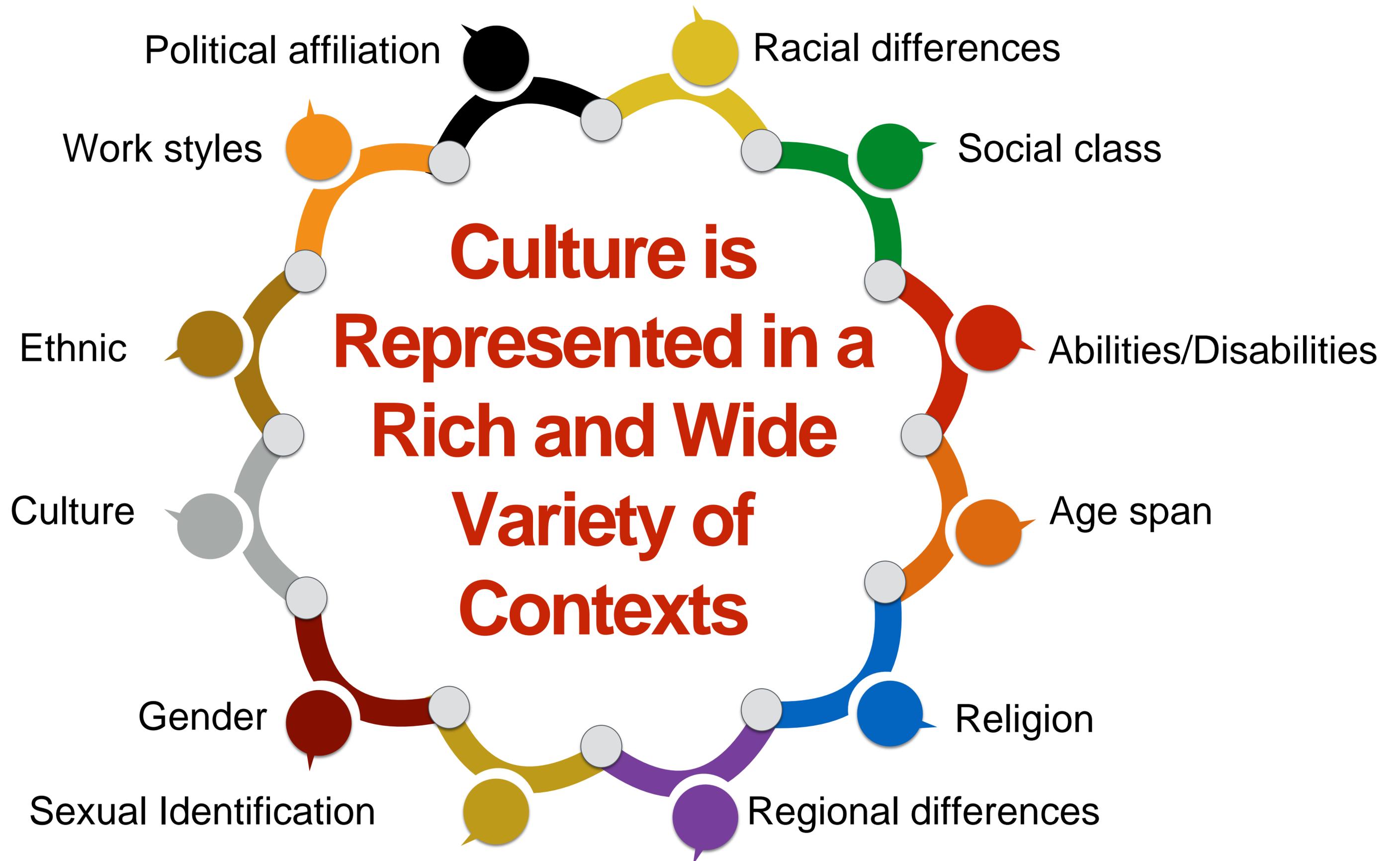


Language

Cuisine

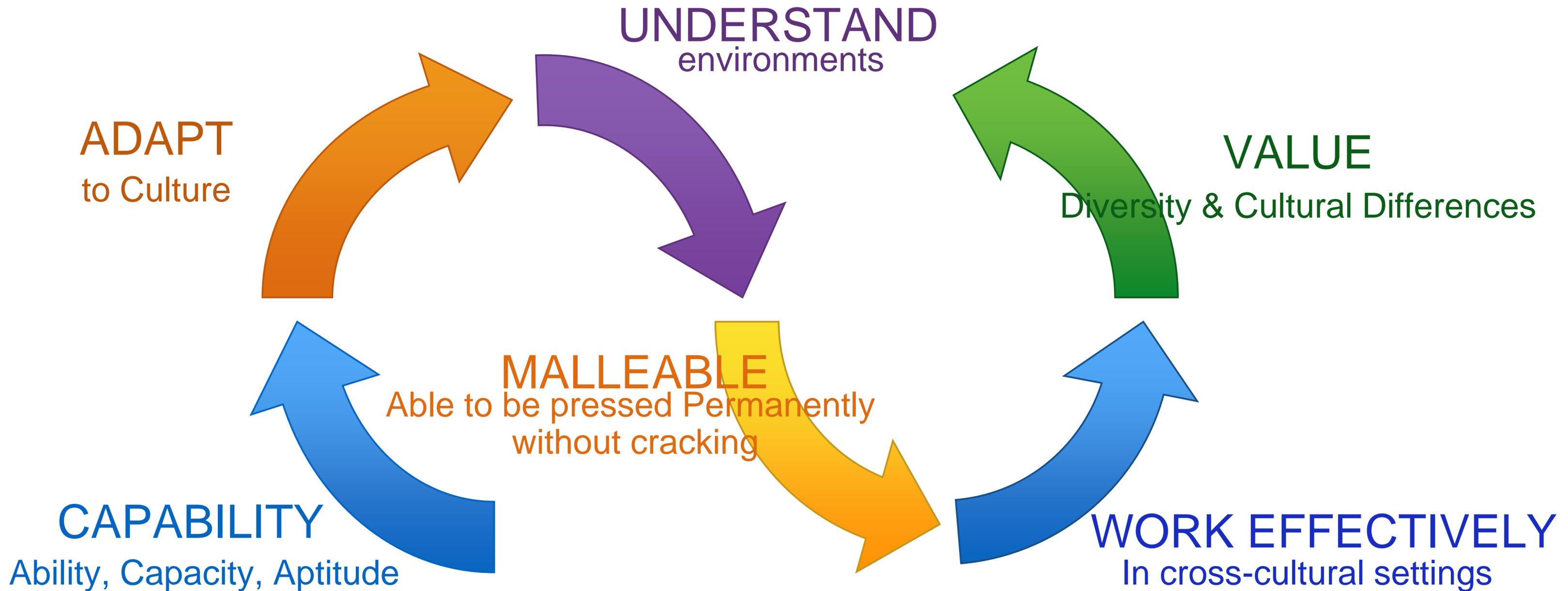
Music

Shared patterns of doing, thinking, understanding and interacting, learned through socialization



What is Cultural Intelligence?

Fundamentally, CQ is a Strategy!

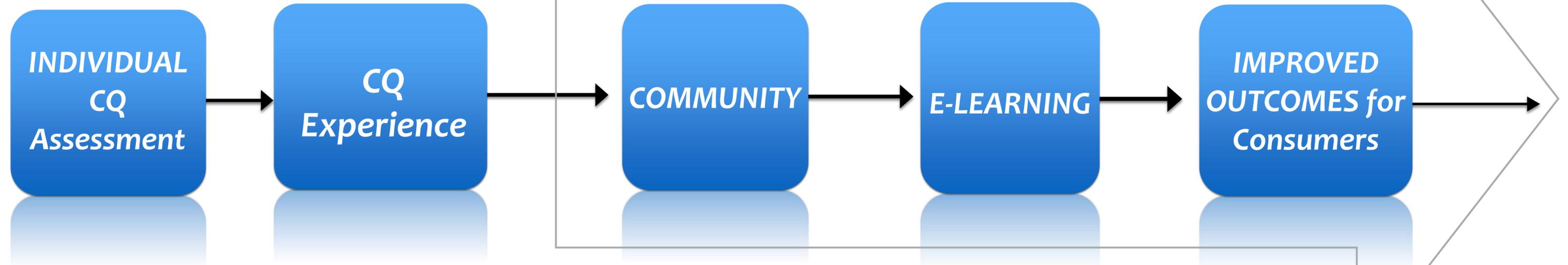


CQ's Role

Individual Pathway To Cultural Fluency

Cultural Intelligence develops over an Individual's Pathway to Cultural Fluency

Pathway to Cultural Fluency





1 BIG GOAL

Assist and Empower
People to Live More
Meaningful Lives

What is Your CQ Score?



Goals for feedback session:

Personal Development

Opportunity to Change Behavior

It's important to **make sense of their CQ feedback**

Your **answers** to the survey
represent a snapshot in time and the frame of mind they had while
completing the assessment

This assessment has been
tested and validated with more than 58,000 people across numerous
contexts, life stages, and cultures

Worldwide Norms

Scores in this range are in the **bottom 25%** of worldwide norms

Scores in this range are in the **middle 50%** of worldwide norms

Scores in this range are in the **top 25%** of the worldwide norms

LOW

MODERATE

HIGH

React to external Stimuli

Recognize cultural norms and begin to accommodate for them

Adapt and adjust thinking and behavior as needed

CQ Drive

CQ Drive is the extent to which you are energized and persistent in your approach to multicultural situations. It includes your self-confidence in your abilities as well as your sense of the benefits you will gain from intercultural interactions.

CQ DRIVE SUB-DIMENSIONS

Intrinsic Interest: Deriving enjoyment from culturally diverse experiences.

Extrinsic Interest: Gaining benefits from culturally diverse experiences.

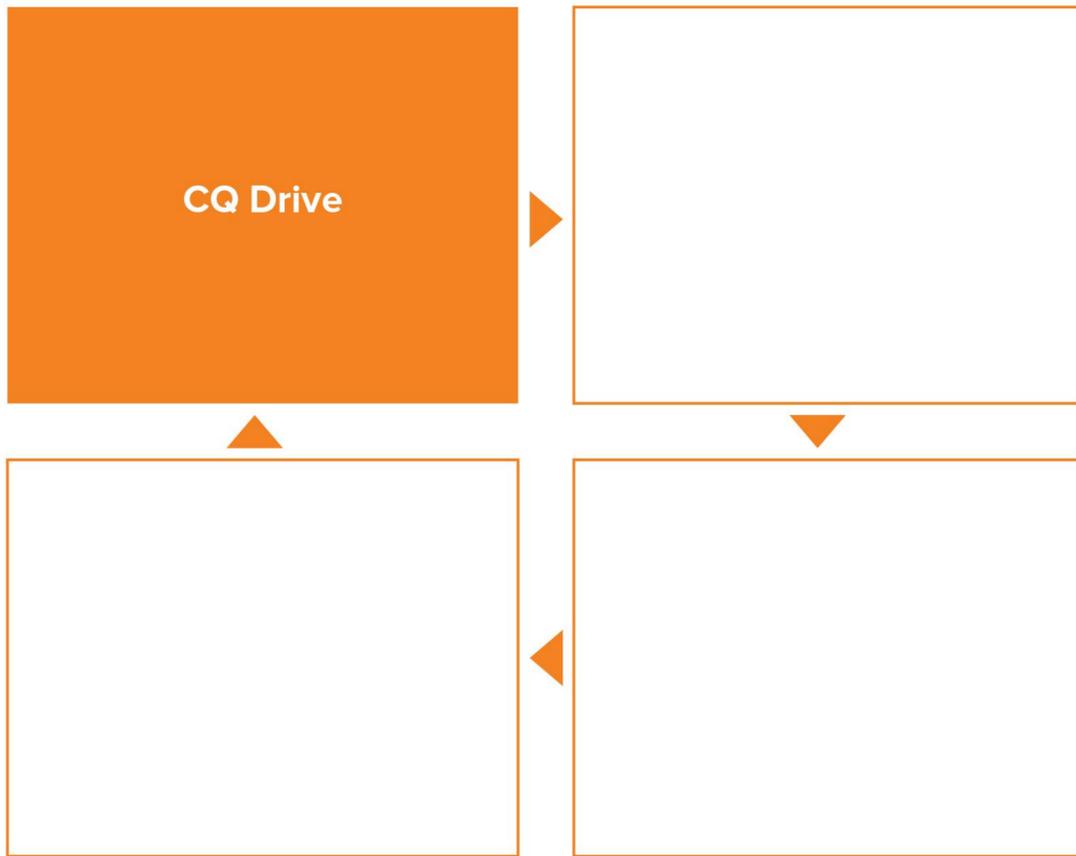
Self-Efficacy: Having the confidence to be effective in culturally diverse situations.

WHAT DOES HIGH CQ DRIVE LOOK LIKE?

Individuals with high CQ Drive are motivated to learn and adapt to new and diverse cultural settings. Their confidence in their adaptive abilities influences the way they perform in intercultural situations.



Self-Rating



CQ Drive is your level of interest, drive, and motivation to adapt interculturally.

Individuals with high CQ Drive are motivated to learn and adapt to new and diverse cultural settings.

CQ Drive:

- **Reveals what you feel about an intercultural encounter**
- **Predicts your capability to persevere** when stress and disorientation occur in an intercultural situation

CQ Knowledge

CQ Knowledge is the degree to which you understand how culture influences how people think and behave and your level of familiarity with how cultures are similar and different.



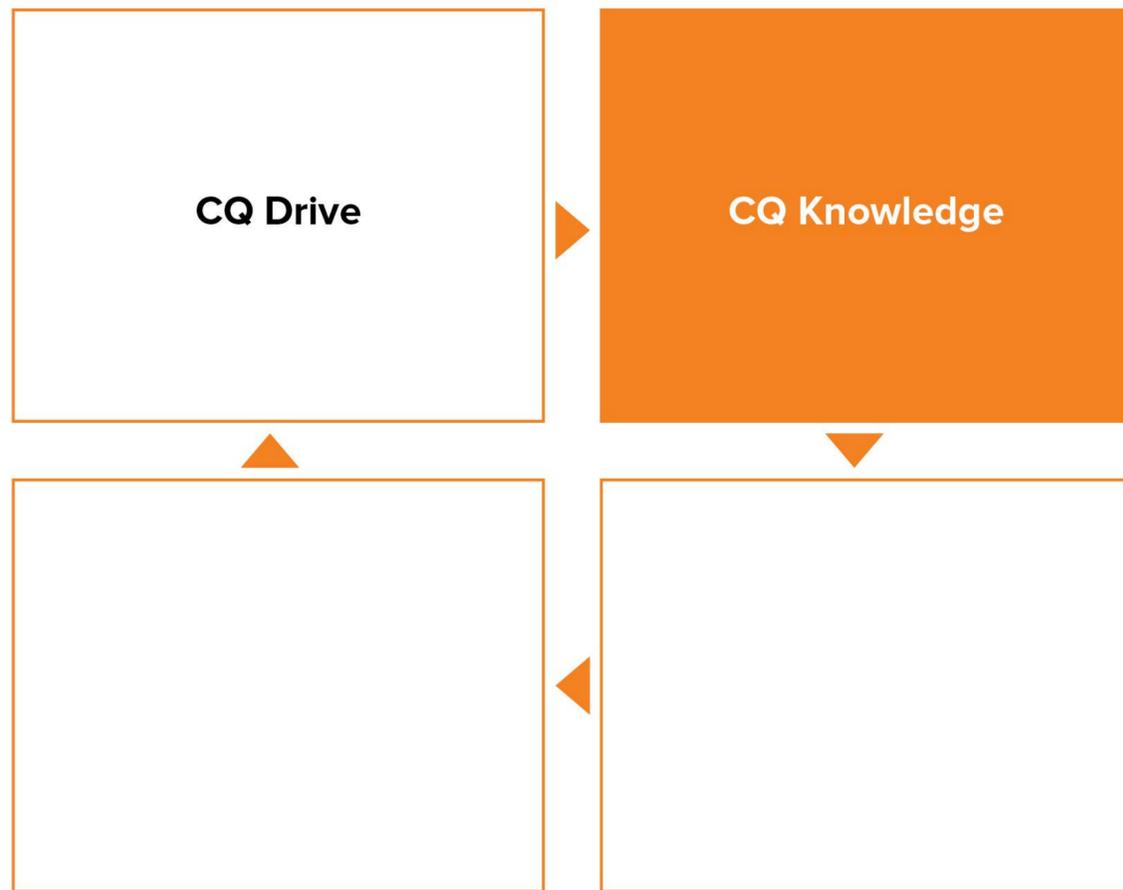
Self-Rating

CQ KNOWLEDGE SUB-DIMENSIONS

- Business:** Knowledge about economic and legal systems.
- Values & Norms:** Knowledge about values, social interaction norms and religious beliefs.
- Socio-Linguistic:** Knowledge about rules of languages and rules for expressing non-verbal behaviors.
- Leadership:** Knowledge about managing people and relationships across cultures.
(Context Specific)

WHAT DOES HIGH CQ KNOWLEDGE LOOK LIKE?

Individuals with high CQ Knowledge have a rich, well-organized understanding of culture and how it affects the way people think and behave. They possess a repertoire of knowledge of how cultures are similar and how they are different. They understand how culture shapes behavior.



CQ Knowledge is your level of understanding about how cultures are similar and different.

Individuals with high CQ Knowledge have a rich, well-organized understanding of culture and how it affects the way people think and behave.

CQ Knowledge:

- **Reveals your understanding of cultural differences**
- **Predicts your cultural knowledge and self-directed learning** in the midst of an intercultural engagement

CQ Strategy

CQ Strategy is the extent to which you are aware of what's going on in a multicultural situation and are able to check and plan accordingly.

CQ STRATEGY SUB-DIMENSIONS

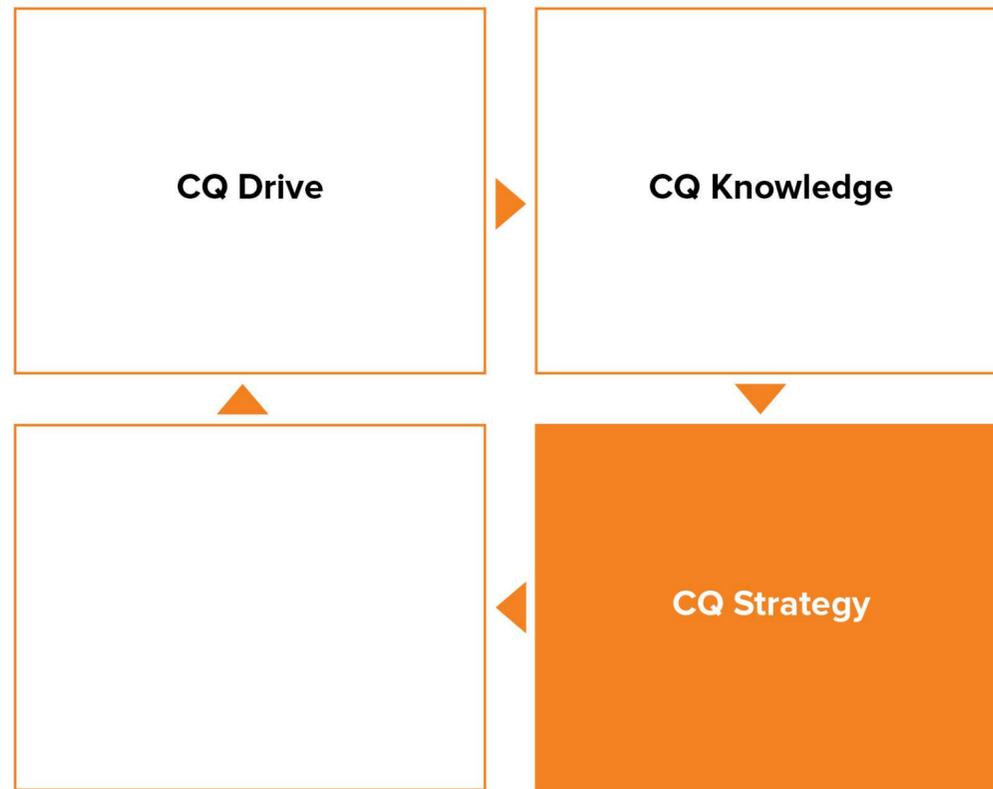
- Planning:** Strategizing before a culturally diverse encounter.
- Awareness:** Sensing the perspectives of self and others.
- Checking:** Checking assumptions and adjusting mental maps when experiences differ from expectations.

WHAT DOES HIGH CQ STRATEGY LOOK LIKE?

Individuals with high CQ Strategy think about intercultural interactions before and after they occur. They plan ahead, check their assumptions and expectations during interactions, and reflect on experiences later. This refines their mental maps and enhances strategies for effective interactions.



Self-Rating



CQ Strategy is the degree to which you are mindful, aware, and able to plan for multicultural interactions

Individuals with high CQ Strategy **use cultural understanding to develop plans for new intercultural situations.** They monitor, analyze, and adjust their behaviors to different cultural settings

CQ Strategy:

- How you **plan for and interpret** an intercultural encounter
- Scores predict the degree to which you accurately anticipate and make sense of what's going on

CQ Action

CQ Action is the extent to which you can act appropriately in multicultural situations. It includes your flexibility in verbal and non-verbal behaviors and your ability to adapt to different cultural norms.



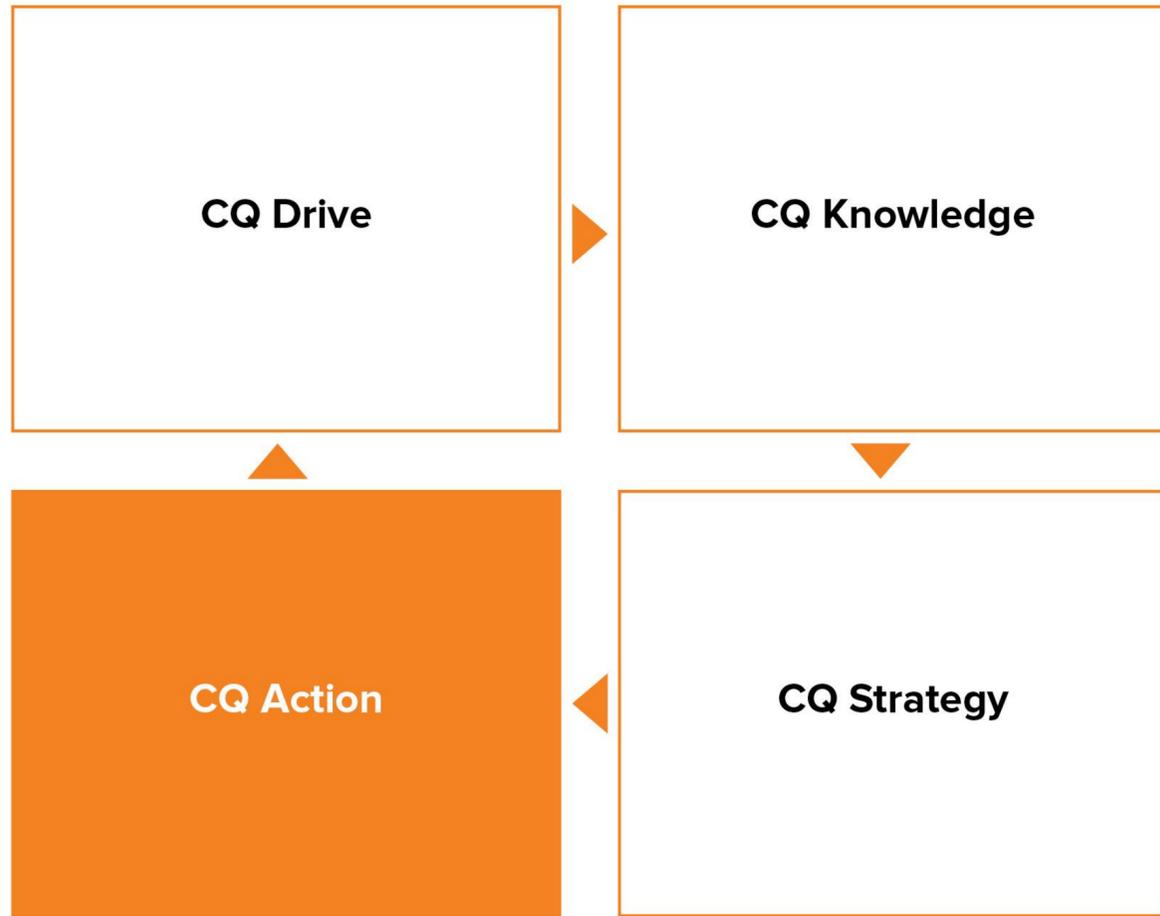
Self-Rating

CQ ACTION SUB-DIMENSIONS

- Speech Acts:** Modifying the manner and content of communications (e.g., direct, indirect).
- Verbal:** Modifying verbal behaviors (e.g., accent, tone).
- Non-Verbal:** Modifying non-verbal behaviors (e.g., gestures, facial expressions).

WHAT DOES HIGH CQ ACTION LOOK LIKE?

Individuals with high CQ Action translate their CQ Drive, CQ Knowledge, and CQ Strategy capabilities into action. They possess a broad repertoire of verbal behaviors, nonverbal behaviors, and speech acts which they can apply to fit a specific context. They know when to adapt and when not to adapt.



CQ Action is the degree to which *you can appropriately change your verbal and nonverbal actions as well as your speech acts* by drawing upon a broad repertoire of behaviors and skills

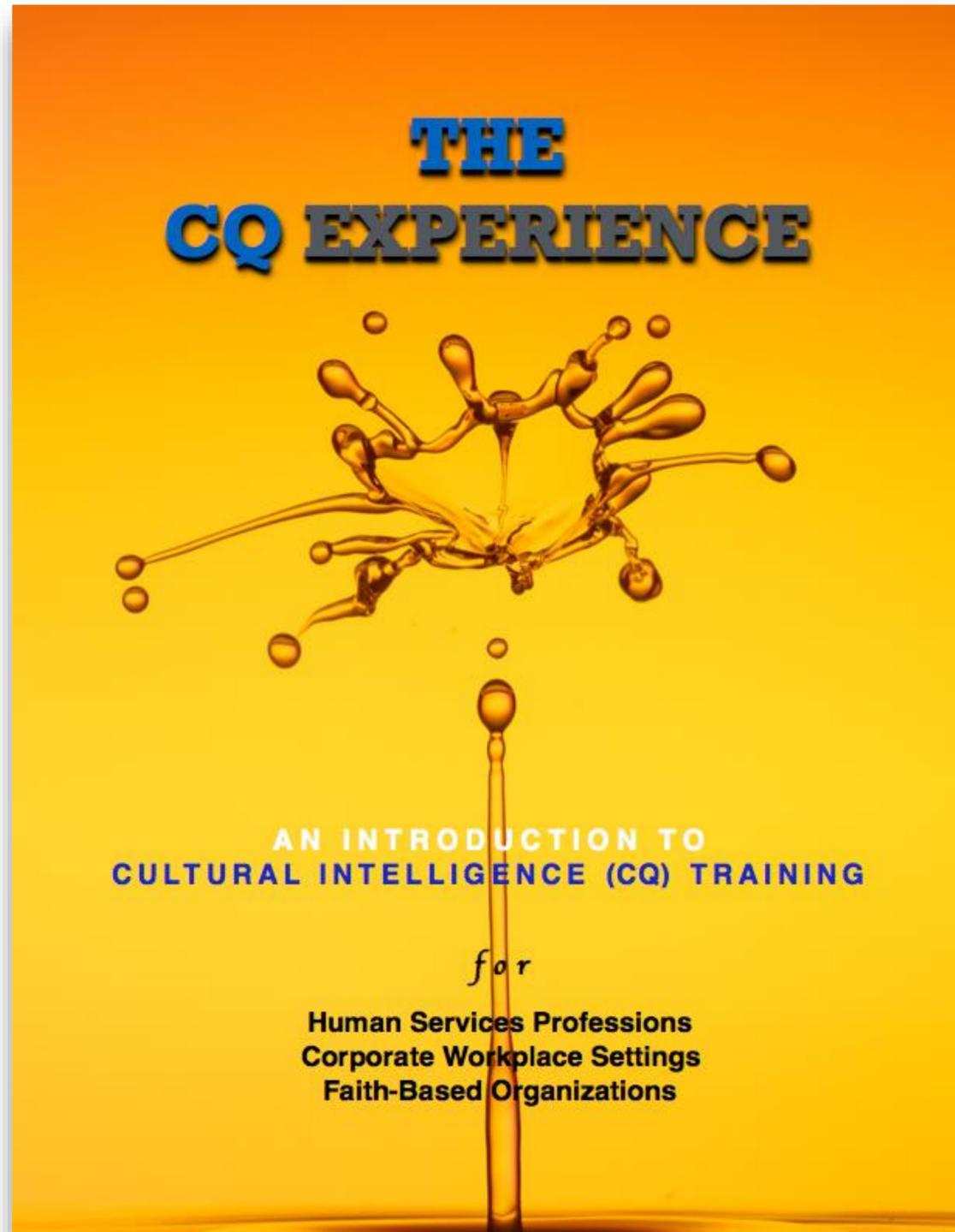
Individuals with **high CQ Action** draw upon the other **three CQ capabilities** to translate their motivation, understanding, and strategic thinking into action

CQ Action:

- **How you actually behave** when you're in an intercultural situation
- **Predicts the degree to which you appropriately adapt** while not over-adapting or compromising yourself or the organization you represent

What's Next?

How do we move from Education... to Application?



Cultural Intelligence Training	2017 -2018 Training		Students Trained
	<i>2/23/2017</i>	<i>2/8/2018</i>	370

CQ Smart Experience - BHD Cultural Intelligence Training Class Schedule:
Feb-Dec 2018

Class Days, Dates and Start Time		Maximum Class Size
February 6	7	
February 8	10	
March 6	25	
March 8	7	
April 10	15	
April 12	12	
May 8		
May 10		
June 12		
June 14		
July 10		
July 12		
August 7		
August 9		
September 11		
September 13		
October 16		
October 18		
November 6		
November 8		
December 4		
December 6		

QUESTIONS?



How can CQ services be integrated among BHD staff and consumers?

How would you like to see CQ applied to services BHD provides?

How does BHD apply CQ skill sets in its global and culture specific programming?

What CQ tools and resources are needed for the

Population that BHD serves?

Where are the CQ priority areas that staff and management believe should be applied and within what timeframe?



THE BIG ISSUES

Application

How do we master the application of CQ within BHD?

Accountability

How is management accountable for the application of CQ within BHD?

Scope

How broad within BHD will CQ skillsets be expected to be applied?

Sustainability

How do we assure long-term sustainable application & growth of CQ within BHD?

A Pathway to the Next Step

The most comprehensive answers to many of the issues and questions above lie within the experiences and knowledge of the professionals within BHD

Survey participants who have taken CQ Experience to determine what they might suggest as viable applications of CQ within BHD

Prepare report and submit findings to BHD Executive and Management teams

Explore new directions using information gleaned from survey results as foundation for new ideas as BHD moves into the new system of care



THE BIG PICTURE: A Competent Cultural Intelligent System

1

CONSUMER 1st

Needs of the Consumer are Identified & Come First

2

Leadership Commitment

Secure Long-Term Commitment from Top Leadership & Resources

3

Strategic Plan

Develop & Adhere to a Strategic Plan with Meaningful Involvement of Key Diverse Persons



4

Mission Statement

Create & Manage Mission Statements, Definitions, Policies & Procedures Reflecting the Values & Principles

5

Data Collection

Conduct Ongoing Needs Assessment/Data Collection

6

Diverse Staff

Recruit & Retain Diverse Staff, Including Training & Skill Development

QUESTIONS ?



COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: April 6, 2018

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

FROM: Michael Lappen, Administrator, Behavioral Health Division

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

Background

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

Discussion

Legislative Audit Bureau (LAB) Recommendations Update

- **Board of Trustees**

Per the LAB Audit Report published in 2017, the BHD and the Mental Health Board were out of compliance with a requirement that had previously been ignored by the Milwaukee County Board for a “Board of Trustees” to be appointed to govern the Milwaukee County Mental Health Complex. A legislative solution was sought and was realized with the passage of SB680, which allows for the Milwaukee County Mental Health Board to satisfy the Board of Trustees requirement in Milwaukee County.

High Quality and Accountable Service Delivery

- **Criminal Justice Collaborative**

BHD staff were invited, along with Chief Judge Maxine White, to present at the SAMHSA Best Practice Academy on Trauma Informed initiatives related to the McArthur Safety and Justice Challenge. Local efforts like CART, Trauma Response Team, Team Connect, Crisis Resource Centers, Housing First, Post Booking Stabilization, etc. have been recognized as leading the way for national reform in preventing individuals experiencing mental health or substance use challenges ending up in the criminal justice system.

- **Transportation Subsidy Pilot Program**

There have been few applications for the transit assistance funding made available by the Mental Health Board in late 2017 for individuals for whom transportation was the limiting factor in being able to achieve the goals of their Individual Recovery Plans and who had exhausted all other transportation options. CARS has regularly circulated the information to provider agencies, including a presentation at a recent CARS "All Provider" meeting. BHD will continue to monitor utilization and encourage utilization of the program where appropriate. At this point, we are projecting that the budgeted funds will be adequate to support the program through 2018.

Optimal Operations and Administrative Efficiencies

- **Milwaukee Health Care Partnership Letter**

Attached (**Attachment A**) is a letter from the Milwaukee Health Partnership regarding the contract negotiations with Universal Health Services.

Other Topics of Interest

- **NAMI Greater Milwaukee Financial Distress**

In March, BHD was made aware that NAMI Greater Milwaukee was in significant financial distress. Their CEO had resigned and a Transition Director had been hired. Soon after, it was reported the rest of the NAMI staff had been laid off. I spoke with several Board Members and eventually spoke with the Transitional Director, Shawn Perrin. Shawn shared the deliverables of her contract, the current NAMI financials, what services had to be suspended, and how other services would be sustained during this challenging transitional period for NAMI. Program priorities during the three-month transition includes:

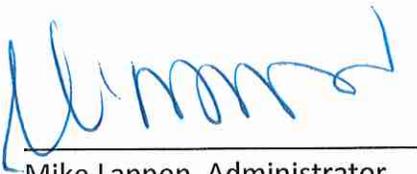
- **Direct Services to People Living with Mental Illness and Their Families/Loved Ones**
 - Connection: Peer Support group for those living with a mental illness
 - Wrap: Recovery planning class for those living with a mental illness
 - Family to Family: Education for family/loved ones
 - Family to Family Support groups
 - Peer to Peer: Ongoing classes and support groups for those living with a mental illness
 - Telephone/email triage/navigation: 90% is calls from families during a mental health crisis; 10% is people living with mental illness looking for support

- **Direct Services to Those Who May Serve Our Primary Constituents**
 - CIT/CIP Trainings

- **Community Awareness to Reduce Stigma**
 - In Our Own Voice – Not scheduling new engagements during the transition
 - Pieces – Not scheduling new performance engagements during the transition

I was assured that the advocacy and peer support services that are deliverables of the \$30,000 contract with BHD will continue to be provided during the transition, and the staff who had been coordinating those programs as paid employee have agreed to continue in their roles as unpaid volunteers.

Respectfully Submitted,



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

Attachment A



Date: March 16, 2018

To: Mike Lappen, BHD Administrator, Mary Jo Meyer, DHHS Director, and Tom Lutzow, Chair, Milwaukee County Mental Health Board

From: Joy Tapper

Tom, Mary Jo and Mike,

The health system members of the Milwaukee Health Care Partnership (MHCP), and the other behavioral health providers participating in the MHCP Behavioral Health Steering Committee, appreciate the efforts of the Behavioral Health Division (BHD) and the Mental Health Board (MHB) to outsource inpatient behavioral health services for Milwaukee County residents who suffer with severe and persistent mental illness and are legally detained under Chapter 51. We understand that BHD and the MHB have completed their due diligence process and that Milwaukee County, under the leadership of Teig Whaley-Smith and with support from a contract advisory team, is now beginning contract negotiations with Universal Health Services as the future inpatient provider.

*As fellow providers involved in the current and future provision of medical, emergency and behavioral health care to children and adults who are placed under emergency detention, the health systems are very interested in ensuring that the BHD contract supports a **coordinated delivery system** for this patient population, focused on quality, cost-effective and patient-centered care. The health systems, along with BHD and the MHB, also have a shared interest in ensuring that Universal provides adequate and timely access to inpatient services and efficient care transitions to prevent treatment delays, avoidable admissions, and poor outcomes, as well as clinical or legal risks for any organization.*

As such, the Milwaukee health systems and MHCP staff are interested in providing input to outsourcing contract provisions that impact access and care coordination. Additionally, as leaders of accredited hospitals, health system behavioral health leaders are open to lending their expertise as to how BHD and the MHB can make certain that Universal maintains the highest standards of patient care and meets all regulatory requirements.

We would appreciate if you would identify the best avenue for providing such input so that together we can ensure the design and implementation of a cost-efficient and coordinated system of care for this high acuity patient population. Thank you in advance for your feedback.

CC:

Cathy Buck, Dr. Chris Decker, Dr. Jon Lehrmann and Dr. Tom Heinrich, Froedtert/MCW

Dennis Potts and Pete Carlson, Aurora

Travis Andersen and Tim Waldoch, Ascension

Bob Duncan, Amy Herbst, and Tracy Oreter, Children's

Attachment B



Greater Milwaukee

3200 S. Street
Milwaukee, WI 53207
414.344.0447; (Fax) 414.344.0450
www.namigrm.org
help@namigrm.org

April 24, 2018

Mr. Michael Lappen
Behavioral Health Division Administrator
Milwaukee County Behavioral Health Division

Re: NAMI Greater Milwaukee Update for Mental Health Board

Dear Mr. Lappen,

As the Chair of the Board of Directors of NAMI Greater Milwaukee, I write to update you, our valued partner in fulfilling our mission of support, education and advocacy for those affected by a mental illness.

To prepare for hiring our next Executive Director, we implemented a 3-month transition period to assess what would be needed from the new leader to further our organization's development. Early in this transition, the board discovered that financial challenges would have greater impact than we had previously anticipated. The Board has taken full responsibility to preserve core services as we work to course correct. These course corrections have required difficult decisions in the short-term, as we restructure for a strong, sustainable NAMI Greater Milwaukee for the long-term.

Despite significant challenge, I'm pleased to update you on the following:

- Dedicated staff continue to coordinate core programs and services. Classes and support groups that serve those living with a mental illness as well their loved ones continue uninterrupted.
- Telephone support and referral continues through an organized group of staff, and volunteers with lived experience.
- In Our Own Voice presentations continue to be given as community education to end stigma.
- Planning and preparation for our annual fundraising Walk is well underway. Community support has never been more generous.

With deep gratitude, we recognize our dedicated team of staff and volunteers, Walk captains, and community supporters. We are also grateful for our valued community partners in sectors of government, nonprofit, local business, and faith communities. They have joined us in this long view with a shared belief that the NAMI mission is too important to those we serve, and it must go on to grow.

As an affiliate of the largest grassroots organization on mental illness, we are working closely with NAMI Wisconsin to deliver NAMI National and State signature programs that we can sustain year after year. We are fortunate to have the support of the NAMI organization at both the national and state level. Together, they support our unique mission of self-help, connection, education, support and advocacy for those living with a mental illness, as well as for those who love and care for them.

Together, we are committed to provide more peer connection, support, learning and recovery. Ending the effects of stigma begins in the hearts and minds of those affected and expands to educate all communities of the challenges and bravery of recovery.

We encourage you to call us with your questions and ideas so we may fully address your questions or concerns. Please do join us May 19th at 11 AM at Veterans Park at the NAMI-Greater Milwaukee Annual Walk. Register today at: <https://www.namigrm.org/nami-walks>.

Very truly yours,

Patrice A. Baker, Board President

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

DATE: March 8, 2018

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

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

SUBJECT: **Report from the Acting Director, Department of Health and Human Services, Requesting Authorization to Execute 2018 Professional Services Contract Amendments for Pharmacy and Information Technology Services**

Issue

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

Background

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

Professional Services Contracts

Pharmacy Systems, Inc.	\$1,339,804
Pharmacy Systems, Inc., provides pharmaceutical services to BHD.	

New Resources Consulting; d.b.a. Clinical Path Consulting, LLC

New Resources Consulting	\$24,000
New Resources Consulting is a professional services agreement to provide BHD with a position critical to the success of the EMR Optimization project providing oversight of the BHD clinical application tools. This is an amendment to the agreement to extend the end date to 3/30/2018	

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: March 8, 2018

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

FROM: Mary Jo Meyer, Acting Director, Department of Health and Human Services
Approved by Mike Lappen, Administrator, Behavioral Health Division

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

Issue

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

Background

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

Purchase-of-Service Contracts

Wisconsin Community Services, Inc. - \$223,524

A request for proposal was issued for the Office of Consumer Affairs – Peer Specialist Program and through the selection process Wisconsin Community Services, Inc. is being recommended for approval of the funds for this program. The funds are being requested for 2018.

Our Space, Inc. - \$200,000

A request for proposal was issued for the Peer Run Respite Center and through the selection process Our Space, Inc. is being recommended for approval of the funds for this program. The funds are being requested for 2018.

Fiscal Summary

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

Vendor Name	New/Amendment	2018 Amount
Wisconsin Community Services, Inc.	New	\$223,524
Our Space, Inc.	New	\$200,000
Total		\$423,524



Mary Jo Meyers, Acting Director
Department of Health and Human Services

to account for the completed transition of the Clinical Informaticist from contract to BHD employee.

New Resources Consulting			
Date	New/Amendment	2017 Amount	2018 Amount
2017	Original Contract	91,200	
(1/1/2018 – 2/21/2018)	Amendment		33,600
(2/22/2018- 3/30/2018)	Amendment		24,000
Total		91,200	57,600

Fiscal Summary

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

Vendor Name	New/Amendment	2018 Amount	2019 Amount
Pharmacy Systems, Inc.	Amendment	\$394,060	\$945,744
New Resources Consulting	Amendment	\$57,600	-
Total		\$451,660	\$945,744



Mary Jo Meyers, Acting Director
Department of Health and Human Services

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: March 1, 2018

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

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

SUBJECT: **Report from the Acting Director, Department of Health and Human Services, Requesting Authorization to Execute 2018 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 2018.

Background

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

Fee-for-Service Agreements

Grateful Girls - \$100,000

This agency provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. These funds are being requested for 2018.

MD Therapy - \$110,000

This agency provides youth CCS, Therapy and other services for Wraparound Milwaukee Program serving children/youth and their families. The total contract amount will be \$338,698. These funds are being requested for 2018.

Fiscal Summary

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

Vendor Name	New/Amendment/ Renewal	2018 Amount
Grateful Girls	Renewal	\$100,000
MD Therapy	Amendment	\$110,000
Total		\$210,000



Mary Jo Meyers, Acting Director
Department of Health and Human Services

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
FINANCE COMMITTEE**

Thursday, March 29, 2018 - 1:30 P.M.
Mental Health Complex
9455 West Watertown Plank Road
Conference Room 1045

MINUTES

PRESENT: Maria Perez and Michael Davis

EXCUSED: Jon Lehrmann, Walter Lanier, and Robert Curry

SCHEDULED ITEMS:

- | | |
|----|--|
| 1. | <p>Welcome.</p> <p>Chairwoman Perez welcomed everyone to the March 29, 2018, Mental Health Board Finance Committee meeting and her first meeting as the Chairperson.</p> |
| 2. | <p>2019 Preliminary Behavioral Health Division Budget Assumptions.</p> <p>The Behavioral Health Division (BHD) continues to be in the early stages of the budget process. Two public listening sessions have been completed, in addition to offering unlimited access to submit written budget related comments on the Mental Health Board web page. The majority of comments received recognize the successes of previous initiatives with encouragement to maintain and expand efforts proven to be successful. Examples include Crisis Assessment Response Teams (CART), Housing First, Crisis Resource Centers (CRC), Team Connect, etc.</p> <p>There have also been concerns raised surrounding negotiations with Universal Health Services (UHS), all of which BHD has addressed through the UHS proposal. It is anticipated the proposal will guide the final contractual negotiations and language of the agreement.</p> <p>Issues surrounding all monies realized as a result of the closure of Acute Inpatient Services being invested back into the community were addressed. There may be tax levy savings achieved that could assist in maintaining and possibly expanding the strong continuum of community programming. However, BHD will still be responsible for funding inpatient care for a significant population of individuals who need it and for whom Milwaukee County is statutorily responsible. There is also a financial reality that must be faced regarding pension and legacy costs, as well as significant uncertainty in long-term Medicaid and Affordable Care Act funding.</p> |

SCHEDULED ITEMS (CONTINUED):

	<p>While tax levy targets have yet to be received, 2019 Preliminary Budget Assumptions were detailed.</p> <p>Questions and comments ensued.</p>
3.	<p>2017 Financial Results.</p> <p>2017 financial results have been finalized and the Behavioral Health Division realized a surplus of \$3.9 million. Obligations include \$1.2 million for the Capital Reserve, \$1.1 million for the Wrap Reserve, and \$1.6 million for the General Reserve. Inpatient Services suffered an \$8 million deficit, which was made up in Community Services. Inpatient numbers are due to revenue, a low census, and the current payor mix. Community Services' numbers are generally due to low enrollment in some areas and initiatives that have yet to be implemented.</p> <p>Questions and comments ensued.</p> <p>For information purposes, the Committee was briefed on statutory language related to reserve accounts that states, "Monies in the reserve fund may be used at any time to cover deficits in the Milwaukee County Mental Health Budget. If the amount in the reserve fund exceeds \$10 million, the amount exceeding \$10 million may be used at any time for any mental health function, program, or service in Milwaukee County. Monies in the reserve fund may be used only for the purposes described in the paragraph."</p>
4.	<p>Office of Consumer Affairs and Peer Run Respite 2018 Purchase of Service Contract Update.</p> <p style="text-align: center;">SEE ITEM 6 FOR COMMITTEE RECOMMENDATION AND/OR DISCUSSION</p>
5.	<p>Mental Health Board Finance Committee 2018 Professional Services Contracts Recommendation.</p> <ul style="list-style-type: none">• Pharmacy Systems, Inc.• New Resources Consulting d.b.a. Clinical Path Consulting, LLC <p>Professional Services Contracts focus on facility-based programming, supports functions that are critical to patient care, and are necessary to maintain hospital and crisis services licensure. Background information was provided on services the contracted agencies provide, which include pharmacy and information technology services. Approvals are for a 2018 Contract Amendments.</p> <p>The Finance Committee unanimously agreed to recommend approval of the 2018 Professional Services Contract Amendments delineated in the corresponding report to the full Board.</p>

SCHEDULED ITEMS (CONTINUED):

6.	<p>Mental Health Board Finance Committee 2018 Purchase-of-Service Contracts Recommendation.</p> <p>Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the various program contracts. Approvals are for 2018 Contracts.</p> <p>The contracts are cost-reimbursed contracts and are the result of the Request for Proposals (RFP) process completed last Fall. The RFPs were for the Office of Consumer Affairs' Peer Specialist Program and the Peer Run Respite Center. Both were competitively bid and scored. Wisconsin Community Services, Inc., was awarded a one-year contract for the Peer Specialist Program, and Our Space, Inc., was awarded a three-year contract for the Peer Run Respite Center.</p> <p>The Finance Committee unanimously agreed to recommend approval of the 2018 Purchase-of-Service Contracts delineated in the corresponding report to the full Board.</p>
7.	<p>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</p> <p>Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the various program agreements, which provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.</p> <p>The Finance Committee unanimously agreed to recommend approval of the Fee-for-Service Agreements delineated in the corresponding report to the full Board.</p>
8.	<p>Adjournment.</p> <p>Chairwoman Perez ordered the meeting adjourned.</p>
<p>This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.</p> <p>Length of meeting: 1:35 p.m. to 2:10 p.m.</p> <p>Adjourned,</p> <p>Jodi Mapp Senior Executive Assistant Milwaukee County Mental Health Board</p>	

SCHEDULED ITEMS (CONTINUED):

**The next meeting of the Milwaukee County Mental Health Board
Finance Committee is Thursday, June 7, 2018, at 4:30 p.m.**

**PUBLIC COMMENT WILL BE HEARD ON
THE 2019 BUDGET**

Visit the Milwaukee County Mental Health Board Web Page at:

<http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board.htm>

Finance Committee Item 2

Milwaukee County Mental Health Board Finance Committee March 29, 2018

BHD and the Milwaukee County Mental Health Board have held two public listening sessions for input into the 2019 Budget and received budget feedback from the public through the web link below:

<http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board/2018-Mental-Health-Board-Budget.htm>

Additionally, written testimony has been submitted from the Milwaukee County Mental Health Task Force and Disability Rights Wisconsin. Recognizing some of the successes of previous initiatives, the testimony encourages BHD to maintain and expand efforts that have been successful like CART, Housing First, Crisis Resource Centers (CRC), Team Connect, etc. A significant list of concerns have been raised by the Milwaukee Mental Health Task Force regarding the contract negotiations with Universal Health Services (UHS), all of which we believe have been addressed in the UHS proposal, which is anticipated to guide the final contractual agreement.

DRW specifically mentions that BHD should: **“Honor the commitment that every dollar previously used to support long-term care or inpatient services will be invested in the community.”** BHD did make such a promise regarding the closure of long-term care and Hilltop. The closures, completed in 2015, achieved about \$6.9 million in tax levy savings from 2014 to 2016. It is very difficult to accurately track the tax levy associated with individuals who have moved on to other treatment providers, but we can say with certainty that a small number of individuals with very significant needs represent about \$2 million in annual spending. The allocation of tax levy in the BHD budget was increased to community services from \$6.0 million in 2014 to \$18.0 million in 2016 - an increase of nearly twice what had been saved from the closures over three years. We are proud of this achievement. This was not only a promise kept, but an area where we significantly exceeded expectations.

It will not be possible to achieve a “dollar for dollar investment into the community” as a result of the closure of Acute Inpatient Services and a contract with UHS. While we do hope that there are tax levy savings achieved in the future as a result of the closure and that those savings will assist BHD to maintain and even expand a strong continuum of community programming, BHD will still be responsible for funding inpatient care for a significant population of individuals who need it and for whom Milwaukee County is statutorily responsible. We believe UHS will have a much more favorable payer mix in their proposed 120 bed facility, which will significantly reduce the cost per patient day for BHD funded clients. Additionally, BHD is making every effort to expand and improve preventative interventions and to focus on a collaborative and person centered continuum of care that will reduce the need for involuntary inpatient care over time. There is a financial reality that must be faced regarding pension and legacy costs, as well as significant uncertainty in Medicaid and Affordable Care Act funding long-term. The closure of the current aging BHD facility is part of the attempt to address those fiscal challenges without impacting community services.

While BHD has not yet received our Tax Levy targets for 2019, we have made some preliminary assumptions as we begin to craft the 2019 Budget. Given the major initiatives underway with the acute outsource, the crisis redesign, the development of the community facilities, and the eventual

relocation of BHD operations, the overriding assumption for 2019 and 2020 must be that significant resources will be directed to a historic transition away from an institutionally based model of care and into the community. BHD will not likely have the luxury to add new initiatives as we have in recent years. Our focus will be on maintaining high quality services through a complicated transition, maximizing efficiencies, and effectiveness. Our preliminary 2019 assumptions:

- A projected Adult Inpatient capacity of 48 with an average census of 43 or 90% capacity
- A Child and Adolescent Inpatient Service (CAIS) capacity of 10 with an average census of 8 (80% capacity)
- CBRF - Maintain current capacity and continue to develop and explore person-centered options that meet individual needs
- CCS - Continue to expand capacity
- AODA - Continue to expand services and prevention efforts with grants and other creative funding in collaboration with community partners and seeking numerous grant funded opportunities to expand treatment and prevention
- CSP - Maintain current capacity, RFP for new providers, move into fee-for-service
- TCM - Maintain current capacity
- Northside - Finalize partnerships with FQHCs on Northside and Southside. Repurpose existing tax levy positions from Day Treatment in the 2018 Budget
- Peer Run Respite - RFP winner established, start-up funds mobilized in 2018. \$400,000.00 already committed to 2019 Budget
- West Allis CART - Up and running April 23, 2018. \$100,000.00 committed to 2019 Budget

Finance Committee Item 3

BHD 2017 Year End Results (\$ millions)

Total BHD Surplus

\$ 3.9

Hospital (Adult Inpatient, CAIS, ER/Obs)

(8.0)

Revenue - All programs census & payer mix \$ (8.4)

Miscellaneous Patient Expenses \$ 0.4

Community Services

\$11.9

Wraparound - fewer clients & services from Lincoln Hills \$ 2.3

WIMCR- State settlement greater than budget \$ 2.5

Northside Hub Rent, IOP and Day Treatment changes \$ 1.7

Community Crisis- Mobile Team, Access Clinic & Contracts \$ 1.9

Community Recovery Services - Lower enrollment \$ 0.5

Various contract underspend \$ 0.6

Position vacancies \$ 0.8

Behavioral Health Division
 Combined Reporting
 Q4 2017 - 2017 Full Year Results

	2017 Budget			2017 Year End Results			2017 Surplus/(Deficit)		
	Hospital	Community Services	Total BHD	Hospital	Community Services	Total BHD	Hospital	Community Services	Total BHD
Revenue									
BCA	7,700,026	14,636,560	22,336,586	7,700,026	14,636,560	22,336,586	-	-	-
State & Federal	-	18,704,262	18,704,262	60,984	18,831,260	18,892,244	60,984	126,998	187,982
Patient Revenue	24,772,962	82,448,593	107,221,555	16,344,651	79,454,280	95,798,931	(8,428,311)	(2,994,313)	(11,422,624)
Other	306,200	1,872,449	2,178,649	315,845	1,802,394	2,118,239	9,645	(70,055)	(60,410)
Sub-Total Revenue	32,779,188	117,661,864	150,441,052	24,421,506	114,724,494	139,146,000	(8,357,682)	(2,937,370)	(11,295,052)
Expense									
Salary	25,060,386	8,984,227	34,044,613	21,590,427	7,126,668	28,717,095	3,469,959	1,857,559	5,327,518
Overtime	1,027,944	2,964	1,030,908	2,204,325	155,053	2,359,378	(1,176,381)	(152,089)	(1,328,470)
Fringe	22,799,388	7,390,045	30,189,433	21,780,303	7,249,200	29,029,503	1,019,085	140,845	1,159,930
Services/Commodities	16,430,262	1,714,245	18,144,507	15,364,548	647,185	16,011,733	1,065,714	1,067,060	2,132,774
Other Charges/Vendor	1,505,000	122,241,913	123,746,913	2,697,313	109,548,973	112,246,286	(1,192,313)	12,692,940	11,500,628
Capital	236,456	45,000	281,456	95,865	890	96,755	140,591	44,110	184,701
Cross Charges	27,460,033	21,065,854	48,525,887	24,999,110	25,066,795	50,065,905	2,460,923	(4,000,941)	(1,540,018)
Abatements	(37,581,262)	(9,518,824)	(47,100,086)	(32,134,097)	(12,739,326)	(44,873,423)	(5,447,165)	3,220,502	(2,226,663)
Total Expense	56,938,207	151,925,424	208,863,631	56,597,794	137,055,438	193,653,232	340,413	14,869,986	15,210,399
Tax Levy	24,159,019	34,263,560	58,422,579	32,176,288	22,330,944	54,507,232	(8,017,269)	11,932,616	3,915,347

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

Community includes Wraparound, AODA and Community Mental Health.

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

Behavioral Health Division
 Inpatient - Hospital
 Q4 2017 - 2017 Full Year Results

	2017 Budget					2017 Year End Results					2017 Surplus/(Deficit)				
	Adult	CAIS	Crisis ER/Obs	Mgmt/ Ops/Fiscal	Total Inpatient	Adult	CAIS	Crisis ER/Obs	Mgmt/ Ops/Fiscal	Total Inpatient	Adult	CAIS	Crisis ER/Obs	Mgmt/ Ops/Fiscal	Total Inpatient
Revenue															
BCA	-	-	7,700,026	-	7,700,026	-	-	7,700,026	-	7,700,026	-	-	-	-	-
State & Federal	-	-	-	-	-	60,984	-	-	-	60,984	60,984	-	-	-	60,984
Patient Revenue	14,587,005	5,869,200	3,768,757	548,000	24,772,962	10,348,836	4,145,768	1,778,641	71,406	16,344,651	(4,238,169)	(1,723,432)	(1,990,116)	(476,594)	(8,428,311)
Other	-	-	-	306,200	306,200	-	70,911	-	244,934	315,845	-	70,911	-	(61,266)	9,645
Sub-Total Revenue	14,587,005	5,869,200	11,468,783	854,200	32,779,188	10,409,820	4,216,679	9,478,667	316,340	24,421,506	(4,177,185)	(1,652,521)	(1,990,116)	(537,860)	(8,357,682)
Expense															
Salary	8,386,497	2,174,556	6,536,338	7,962,995	25,060,386	7,406,254	1,928,471	5,772,068	6,483,634	21,590,427	980,243	246,085	764,270	1,479,361	3,469,959
Overtime	757,152	41,568	87,288	141,936	1,027,944	1,006,767	119,455	774,856	303,247	2,204,325	(249,615)	(77,887)	(687,568)	(161,311)	(1,176,381)
Fringe	7,785,485	1,955,699	5,111,116	7,947,088	22,799,388	7,757,887	1,911,800	5,128,205	6,982,411	21,780,303	27,598	43,899	(17,089)	964,677	1,019,085
Services/Commodities	2,395,674	291,914	1,447,424	12,295,250	16,430,262	3,560,685	243,187	660,320	10,900,356	15,364,548	(1,165,011)	48,727	787,104	1,394,894	1,065,714
Other Charges/Vendor	1,500,000	-	-	5,000	1,505,000	2,697,313	-	-	-	2,697,313	(1,197,313)	-	-	5,000	(1,192,313)
Capital	17,500	-	2,000	216,956	236,456	-	-	5,508	90,357	95,865	17,500	-	(3,508)	126,599	140,591
Cross Charges	9,556,659	2,655,558	5,448,553	9,799,263	27,460,033	8,504,585	2,525,142	5,627,188	8,342,195	24,999,110	1,052,074	130,416	(178,635)	1,457,068	2,460,923
Abatements	-	-	-	(37,581,262)	(37,581,262)	-	-	-	(32,134,097)	(32,134,097)	-	-	-	(5,447,165)	(5,447,165)
Total Expense	30,398,967	7,119,295	18,632,719	787,226	56,938,207	30,933,491	6,728,055	17,968,145	968,103	56,597,794	(534,524)	391,240	664,574	(180,877)	340,413
Tax Levy	15,811,962	1,250,095	7,163,936	(66,974)	24,159,019	20,523,671	2,511,376	8,489,478	651,763	32,176,288	(4,711,709)	(1,261,281)	(1,325,542)	(718,737)	(8,017,269)

Behavioral Health Division

CARSD

Q4 2017 - 2017 Full Year Results

	2017 Budget				2017 Year End Results				2017 Surplus/Deficit			
	AODA	Mental Health	WRAP	Total CARSD	AODA	Mental Health	WRAP	Total CARSD	AODA	Mental Health	WRAP	Total CARSD
Revenue												
BCA	2,333,731	12,302,829	-	14,636,560	2,333,731	12,302,829	-	14,636,560	-	-	-	-
State & Federal	8,647,255	8,684,943	1,372,064	18,704,262	9,040,437	8,444,525	1,346,298	18,831,260	393,182	(240,418)	(25,766)	126,998
Patient Revenue	-	26,766,625	55,681,968	82,448,593	0	24,928,685	54,525,595	79,454,280	-	(1,837,940)	(1,156,373)	(2,994,313)
Other	765,246	837,203	270,000	1,872,449	544,287	838,703	419,403	1,802,394	(220,959)	1,500	149,403	(70,055)
Sub-Total Revenue	11,746,232	48,591,600	57,324,032	117,661,864	11,918,455	46,514,742	56,291,296	114,724,494	172,223	(2,076,858)	(1,032,736)	(2,937,370)
Expense												
Salary	411,494	6,127,189	2,445,544	8,984,227	60,834	5,191,137	1,874,697	7,126,668	350,660	936,052	570,847	1,857,559
Overtime	-	-	2,964	2,964	0	143,402	11,652	155,053	-	(143,402)	(8,688)	(152,089)
Fringe	92,038	5,232,361	2,065,646	7,390,045	69,704	5,150,442	2,029,054	7,249,200	22,334	81,919	36,592	140,845
Services/Commodities	297,857	1,197,412	218,976	1,714,245	106,943	441,592	98,650	647,185	190,914	755,820	120,326	1,067,060
Other Charges/Vendor	12,790,842	53,096,545	56,354,526	122,241,913	13,852,631	46,713,744	48,982,597	109,548,973	(1,061,789)	6,382,801	7,371,929	12,692,940
Capital	-	45,000	-	45,000	0	890	-	890	-	44,110	-	44,110
Cross Charges	1,675,485	13,266,355	6,124,014	21,065,854	1,735,694	16,496,357	6,834,744	25,066,795	(60,209)	(3,230,002)	(710,730)	(4,000,941)
Abatements	-	-	(9,518,824)	(9,518,824)	-	(7,254,287)	(5,485,039)	(12,739,326)	-	7,254,287	(4,033,785)	3,220,502
Total Expense	15,267,716	78,964,862	57,692,846	151,925,424	15,825,807	66,883,276	54,346,355	137,055,438	(558,091)	12,081,586	3,346,491	14,869,986
Tax Levy	3,521,484	30,373,262	368,814	34,263,560	3,907,351	20,368,534	(1,944,942)	22,330,944	(385,867)	10,004,728	2,313,756	11,932,616

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

Chairperson: Mary Neubauer
Executive Assistant: Kiara Abram, 257-7212

MILWAUKEE COUNTY MENTAL HEALTH BOARD QUALITY COMMITTEE

March 5, 2018 - 10:00 A.M.
 Milwaukee County Mental Health Complex
 Conference Room 1045

Present: Mary Neubauer, Robert Chayer, Rachel Forman, Brenda Wesley, Ron Diamond (by telephone).

MINUTES

SCHEDULED ITEMS:

- | | |
|----|---|
| 1. | <p>Welcome. (Chairwoman Neubauer)</p> <p>Chairwoman Neubauer encouraged board members to introduce themselves and welcomed everyone to the March 5, 2018 meeting.</p> <p>Dr. Diamond announced this will be his last Quality Committee Meeting.</p> |
| 2. | <p>2017 Key Performance Indicator Dashboard & Community Access to Recovery Services Quarterly Report. (Pam Erdman, Quality Manager; Justin Heller, Program Evaluator; Edward Warzonek, Quality Assurance Coordinator; Jim Feagles, Integrated Services Coordinator; and Dr. Matt Drymalski, Clinical Program Director)</p> <p>KPI Dashboard measures and status updates were reviewed with progress noted. A discussion ensued regarding how to continually evolve and report organizational data in a more meaningful way. A request for a brief executive summary of the data was suggested. Program services and waitlist times were discussed. A plan to revise the quarterly report format is underway.</p> |
| 3. | <p>BHD Compliments, Complaints, and Grievances Update. (Heidi Ciske-Schmidt, Integrated Services Coordinator; Sherrie Bailey-Holland, Client Rights Specialist)</p> <p>BHD process for obtaining and addressing client concerns was reviewed. General data trends and types discussed, including rounding interventions to address immediate concerns. A suggestion to incorporate client/patient and/or family focus groups to participate in improvement selection was suggested.</p> |
| 4. | <p>Improving Youth Medication Adherence; Wraparound Milwaukee (Pamela Erdman, Quality Manager)</p> |

	Performance improvement project targeting medication adherence for youth that receive medication through the Wraparound Milwaukee Wellness Clinic was discussed. Rationale, procedure and research design reviewed.
5.	<p>PCS Hospital Transfer Waitlist Report; End of Year 2017 (Richard Wright, Program Analyst; Dr. Schneider, Chief Medical Officer)</p> <p>The average waitlist period per patient has remained consistently under eight hours (7.6), with a median wait time for individuals delayed at 4.6 hours. Further monitoring of individual dispositions continues; refer to Figure 14. 2017.</p>
6.	<p>Seclusion and Restraint Reports; End of Year 2017 (Linda Oczus, Chief Nursing Officer)</p> <p>Acute adult restraint hourly rate has decreased by 81.8 % from 2016 through end of year 2017 and below the national average. CAIS restraint hourly rate decreased by 72.7% from 2016 through end of year 2017, yet still above national average. Additional staff education has had a positive impact. Continued emphasis on prevention and other intervention alternatives are prioritized.</p>
7.	<p>Customer Satisfaction/Client Experience 2017 Year-End Data. (Edward Warzonek, Quality Assurance Coordinator)</p> <p>Survey response rates from the acute hospital were at 33%, significantly above national average. Domain rankings and opportunities for improvement were shared as well as customer comments. A 31% survey response rate for CAIS was shared as well as domain category comparisons, trends and customer comments.</p>
8.	<p>Policy & Procedure Update. (Lynn Gram, Safety Officer)</p> <p>The completion goal of 90 percent for outstanding policies has been exceeded. An updated March report was distributed.</p>
9.	<p>Next Scheduled Meeting Date.</p> <ul style="list-style-type: none"> • June 4, 2018 at 10:00 a.m.
10.	<p>Adjournment.</p> <p>Chairwoman Neubauer ordered the meeting adjourned.</p>

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.

Length of meeting: 10:00 a.m. to 12:13 p.m.

- **The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is Monday, June 4, 2018 at 10:00 a.m.**

Visit the Milwaukee County Mental Health Board Web Page at:

<http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board.htm>



Milwaukee County Behavioral Health Division
2017 Key Performance Indicators (KPI) Dashboard

Quality Committee Item 2

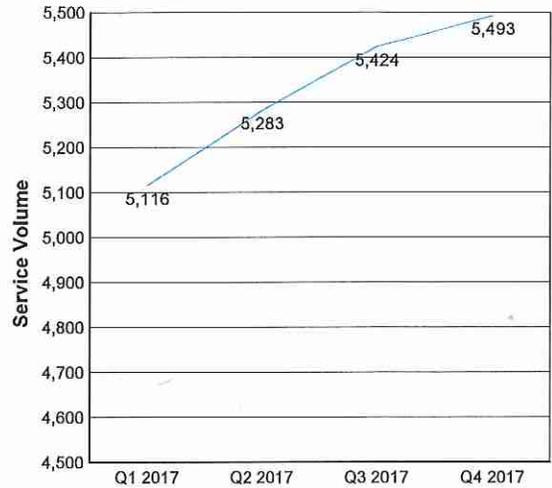
Program	Item	Measure	2015 Actual	2016 Actual	2017 Quarter 1	2017 Quarter 2	2017 Quarter 3	2017 Quarter 4	2017 Actual	2017 Target	2017 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵ Sample Size (Unique Clients)	9,624	7,971	5,105	5,276	5,410	5,493	8,346	8,370	Green	BHD (2)
	2	Percent with any acute service utilization ⁶	-		2,414	2,519	2,529	2,993		-	Green	BHD (2)
	3	Percent with any emergency room utilization ⁷	-	13.09%	16.94%	19.02%	19.89%	16.87%	18.18%	12.05%	Red	BHD (2)
	4	Percent abstinence from drug and alcohol use	-	12.44%	12.80%	16.08%	15.78%	13.46%	14.53%	11.20%	Red	BHD (2)
	5	Percent homeless	-	66.71%	63.34%	60.82%	61.8%	63.3%	62.30%	73.81%	Yellow	BHD (2)
	6	Percent employed	-	4.74%	6.71%	7.26%	8.42%	7.35%	7.44%	4.00%	Red	BHD (2)
	7	Sample Size (Admissions)	-	15.80%	15.29%	16.83%	16.57%	16.71%	16.35%	17.38%	Yellow	BHD (2)
		Percent of clients returning to Detox within 30 days	19.6%	6,315	1,688	1,642	1,708	1,451		-	Yellow	BHD (2)
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,329	3,500	1,949	2,532	2,950	3,404	3,404	3,670	Yellow	BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.6	4.6	4.8	4.8	4.6	4.8	4.75	> = 4.0	Green	BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	62%	60.2	63.9%	65.6%	66.9%	66.5%	65.7%	> = 75%	Yellow	BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.2	2.86	2.68	2.76	2.68	2.34	2.59	> = 3.0	Yellow	BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	58%	53.6%	55.6%	55.1%	64.1%	56.4%	57.8%	> = 70%	Yellow	BHD (2)
		Percentage of Informal Supports on a Child and Family Team	42%	43.6%	45.1%	44.3%	45.1%	42.2%	> = 50%	Yellow	BHD (2)	
Crisis Service	14	PCS Visits	10,173	8,286	1,896	2,046	2,081	1,978	8,001	9,000	Green	BHD (2)
	15	Emergency Detentions in PCS	5,334	4,059	893	1,017	979	1,090	3,979	4,000	Green	BHD (2)
	16	Percent of patients returning to PCS within 3 days	8%	7.9%	7.8%	7.5%	7.3%	7.3%	7.3%	8%	Green	BHD (2)
	17	Percent of patients returning to PCS within 30 days	25%	24.8%	23.8%	23.0%	22.8%	23.1%	23.1%	24%	Green	BHD (2)
		Percent of time on waitlist status	16%	80.1%	75.6%	91.7%	70.4%	62.3%	75.0%	25%	Red	BHD (2)
Acute Adult Inpatient Service	19	Admissions	965	683	169	155	175	157	656	900	Green	BHD (2)
	20	Average Daily Census	47.2	45.8	42.7	43.9	42.7	42.1	42.9	54	Green	BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	3%	3.6%	2.4%	2.2%	2.0%	1.4%	1.4%	3%	Green	BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	11%	10.8%	9.6%	9.0%	8.3%	7.7%	7.7%	10%	Green	BHD (2)
	23	Percent of patients responding positively to satisfaction survey	73%	70.6%	69.5%	78.7%	71.4%	76.7%	74.0%	74%	Green	NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	63%	57.1%	64.1%	67.2%	65.1%	65.1%	65.4%	65%	Green	NRI (3)
	25	HBIPS 2 - Hours of Physical Restraint Rate	7.2	3.32	0.45	0.61	0.71	0.45	0.56	0.66	Green	BHD (2)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.47	0.48	0.27	0.25	0.21	0.22	0.30	0.14	Green	CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	18%	18.5%	17.9%	21.5%	16.9%	13.6%	17.5%	9.5%	Red	CMS (4)
		HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	98%	95.0%	90.3%	94.1%	78.6%	95.5%	89.6%	90.0%	Yellow	CMS (4)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	919	617	184	167	167	191	709	930	Green	BHD (2)
	30	Average Daily Census	9.8	8.4	10.2	8.9	7.2	8.2	8.6	12.0	Green	BHD (2)
	31	Percent of patients returning to CAIS within 7 days	6%	5.2%	4.4%	5.0%	4.7%	5.2%	5.2%	5%	Yellow	BHD (2)
	32	Percent of patients returning to CAIS within 30 days	16%	11.8%	11.6%	12.5%	11.0%	12.3%	12.3%	11%	Yellow	BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71%	78.1%	77.7%	72.1%	68.1%	65.0%	71.3%	74%	Yellow	BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	74%	82.1%	84.7%	81.8%	71.4%	68.9%	76.8%	80%	Yellow	BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	5.2	4.51	1.42	1.10	0.59	1.45	1.17	0.22	Red	BHD (2)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.42	0.20	0.28	0.44	0.49	0.28	0.37	0.34	Yellow	CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2%	1.6%	1.7%	7.5%	7.5%	3.7%	5.0%	3.0%	Red	CMS (4)
			HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100%	88.9%	100.0%	100.0%	100.0%	85.7%	97.1%	90.0%	Red
Financial	39	Total BHD Revenue (millions)	\$120.2	\$129.4	\$149.9	\$149.9	\$149.9	\$149.9	\$149.9	\$149.9	Green	BHD (2)
	40	Total BHD Expenditure (millions)	\$173.5	\$188.2	\$207.3	\$207.3	\$207.3	\$207.3	\$207.3	\$207.3	Yellow	BHD (2)

- Notes:
- (1) 2017 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
 - (2) Performance measure target was set using historical BHD trends
 - (3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages
 - (4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages
 - (5) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.
 - (6) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days
 - (7) Includes any medical or psychiatric ER utilization in last 30 days

CARS Quarterly Report

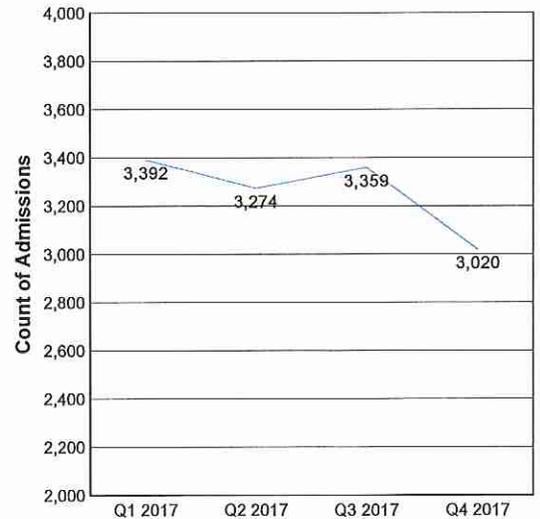
Number of Clients Receiving Service, By Program

	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adult Family Home	18	19	19	23
Case Mgmt & After Care Support	81	77	60	50
CBRF	134	128	135	144
CCS	622	665	704	745
CLASP	66	65	63	76
Community Support Program	1,276	1,284	1,329	1,359
Crisis	0	0	80	131
Crisis Case Management	219	222	185	130
CRS	28	25	24	23
Day Treatment (75.12)	18	27	18	18
Detoxification (75.07)	642	667	690	632
Med. Monitor Residentl (75.11)	3	0	0	0
Medication Assisted Treatment	4	7	15	16
MH Day Treatment	16	17	10	0
Outpatient 75.13	283	321	323	313
Outpatient-MH	60	53	49	68
Recovery House Plus OP/DT	33	24	23	19
Recovery Support Coordination	552	601	605	609
RSS-Employment	101	82	66	46
RSS-Housing	125	132	145	145
RSS-Psych. Self Mgmt	53	43	51	62
RSS-School and Training	75	61	55	37
Targeted Case Management	1,542	1,640	1,700	1,715
Transitional Residential (75.14)	299	292	296	297
Youth CCS	0	0	8	20
Total	5,116	5,283	5,424	5,493

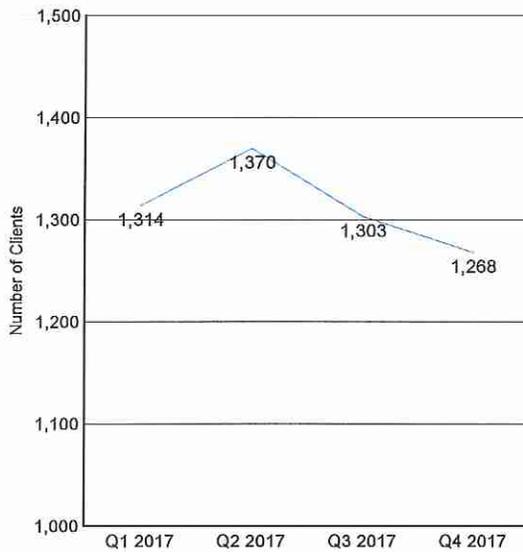


Admissions By Program

	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Adult Family Home	3	0	2	4
Case Mgmt & After Care Support	28	32	17	21
CBRF	17	12	12	13
CCS	100	104	109	99
CLASP	13	20	24	36
Community Support Program	62	75	89	70
Crisis Case Management	112	78	87	61
CRS	0	1	0	0
Day Treatment (75.12)	17	30	37	39
Detoxification	1,683	1,641	1,708	1,451
MH Day Treatment	5	14	8	7
Outpatient (75.13)	173	198	179	207
Outpatient-MH	115	62	76	65
Recovery House Plus OP/DT	26	23	26	9
Recovery Support Coordination	359	329	325	328
RSS-Employment	85	72	57	42
RSS-Family	0	1	0	0
RSS-Housing	88	85	100	88
RSS-Psych Self Mgmt	21	18	27	27
RSS-School and Training	71	59	54	36
Targeted Case Management	185	211	203	184
Transitional Residential	229	209	219	233
Total	3,392	3,274	3,359	3,020



Referrals/Intakes By Access Point



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Total
Access Clinic at BHD	116	98	140	129	476
CARS	407	465	482	502	1,761
IMPACT	310	340	269	288	1,168
JusticePoint	36	38	40	61	165
M & S	250	224	194	173	817
UCC	61	67	69	18	213
WCS	160	164	145	123	576
Total	1,314	1,370	1,303	1,268	4,854

Time to Treatment

Average Number of Days from Intake to Admission					
Program	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Trend
CBRF	55	94	-	161	
CSP	86	73	22	33	
TCM	22	17	15	18	
CCS	1.2	0.5	0.8	2	
AODA Transitional Residential	16	22	24	28	
AODA Day Treatment	8	7	9	15	
AODA Outpatient	13	10	9	11	
Recovery Support Services	11	7	9	7	

Quality Committee Item 3

Quality Management Services Update Compliments, Complaints & Grievance Team Charter Executive Summary

Milwaukee County Mental Health Board – Quality Committee Meeting
March 5, 2018

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

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

Progress:

- March 2017: Go-live with the electronic system, referred to as Verge
- Compliments, complaints & grievances tracked in the system are related to in-house services
 - Psychiatric Crisis Services, Observation and Inpatient Units
 - Access Clinic
 - Community Consultation Team
 - Day Treatment
 - Wraparound Wellness Clinic
 - Fiscal Management Department (billing)
 - Children’s Mobile Crisis Team (formerly known as the Mobile Urgent Treatment Team)
 - Crisis Mobile Team (adult services)
- Comprehensive review and revisions of all related Policies related to the process and system
- Revision of the “Compliment, Complaint, Grievance Form #4397-1”
 - More user friendly
 - Included “compliments” on the form

Quality Management Services Update
Compliments, Complaints & Grievance Team Charter
Executive Summary

2017 Data & Trends (01/01/2017-12/31/2017)

Case Type:

Compliant: 54% (28)

Grievance: 42% (22)

Compliment: 2% (1)

Top 4 Locations with Concern:

Psychiatric Crisis Services

43A-ITU

43B-ATU

43C-WTU

Top 4 Areas of Concern:

1. Staff Behavior: Intervention/PDSA

- a. Customer service strategies
- b. Cell phone usage

2. Discharge Process

- a. Discharge Delay
- b. Loss/damaged belongings
- c. Not ready for discharge

3. Billing (Work with a collection specialist to offer the following options)

- a. Itemized billing and summary
- b. Payment plan
- c. Deferment
- d. Settlement

4. Treatment

- a. Change in medication
- b. Release date and time
- c. Treatment team review

Quality Committee Item 4

QA Mental Health Board Meeting

3/5/18

ITEM #1

Announcement

Interim Director and Associate Director of Wraparound Milwaukee

1/30/18 - From the desk of Mary Jo Meyers – DHHS Director:

It is my pleasure to announce that effective today, Brian McBride will be Interim Director of Wraparound Milwaukee and Jenna Kreuzer (Reetz) will be Interim Associate Director of Wraparound Milwaukee during the recruitment process. Both positions will be posted within the next two weeks. I am confident Brian and Jenna will step into these roles and continue our established vision of helping build healthy and strong communities by enhancing children and families' ability to meet life's challenges and to foster resiliency and hope for a better future. They both possess a wealth of knowledge and experience working with children and families and I believe they will provide stability during this transition.

ITEM#2

2018 Wraparound Milwaukee Performance Improvement Project

The administrative & clinical staff of Wraparound were brought together to discuss areas of potential improvement in the Wraparound program. The topic that emerged as highly relevant and of critical importance is medication compliance for youth that receive medication through the Wraparound Milwaukee Wellness Clinic.

Medication compliance/adherence has been a topic of clinical concern since the 1970's (Jing J. et.al. 2008). Hundreds of research articles have been published on non-adherence, and dozens of devices and programs have been developed to assess and resolve adherence-related problems. Yet, despite the tremendous efforts of health care providers, medication non-adherence remains a major public health problem. (Nichols-English G. & Poirier S. 2000). Low adherence increases morbidity and medical complications, contributes to poorer quality of life and an overuse of the health care system.

According to a meta-analysis that focused on non-psychiatrist physician prescriptions, the average study-defined adherence was highest in HIV disease (88.3%) followed by arthritis (81.2%), gastrointestinal disorders (80.4%), and cancer (79.1%). The average adherence in other physical diseases ranged between 74% and 77%. The concern becomes direr as the research delves into individuals with mental health concerns. Most studies on psychotic patients reported high frequencies of non/poor adherence, ranging from 24% to 40%. (Kane J. et.al. 2013). The studies of non-adherence in childhood/adolescent and adult ADHD reveals a prevalence of medication discontinuation or non-adherence ranges of 13.2% to 64 %.(Adler L. & Nierenberg A. 2015)

Furthermore, the high prevalence of low adherence to medication treatment during adolescence varies widely from 10% to 89%. This variability seems to be related to the range of specific chronic related illnesses, the perceived stigma related to the illness (Sirey J. et. al. 2001) and how adherence is measured (full or partial compliance). Compounding this problem in adolescents is the very nature of adolescence, which includes cognitive maturation, self-identity challenges and the powerful desire to function autonomously (Taddeo D. et. al. 2007).

Rationale for Study

Through the Wraparound Milwaukee Wellness Clinic, children and youth are seen for medication management related to their diagnosed mental health concerns. The population that is served in the clinic, as indicated in the literature, exhibits great challenges with medication compliance. First, their average age is 14.2; well within the most difficult age range (adolescents) for managing medication. In addition to their mental health challenges, nearly 70% live below the 50% of poverty rate (Goldfarb, P. 2015) and display familial issues including mental illness, incarceration, drugs and significant family losses (Wraparound Milwaukee Quality Assurance/Quality Improvement Annual Report 2016). The literature findings are supported by Wellness Clinic medical personnel who have expressed strong concern about medication compliance.

Study Population

The targeted population will be all youth who are enrolled in Wraparound Milwaukee who are coming to the Wellness Clinic for their Intake Appointments from December 11, 2017 through the week of February 5, 2018.

Procedure & Research Design

1. A Simple Random Sampling Technique will be applied at the beginning of the study to all Intake appointment slots, 77 in total. Beginning with youth who have Intake appointments the first week of the study, December 11, 2017 through the eighth week of Intake appointments, February 5, 2018; youth will be divided into 2 groups, a Control and an Experimental Group.
2. Both groups will receive the same orientation to the medications as follows:
 - a. Explain the risks and benefits of medication, include side effects and potential medical risks
 - b. Help youth & family articulate their concerns about medication and goals for medication use
 - c. Articulate medication adherence practices
 - d. Provide educational materials about the medication to youth and family
3. Except for the orientation as described above, no additional support will be provided for the Control group
4. The Experimental Group will be provided with the Medication Planning Tool to further support medication adherence practice.
 - a. The tool will be introduced and individualized for each youth in discussion with the youth, nurse/doctor, the parent/guardian and the Care Coordinator
 - b. The family will take home the completed tool which reflects the plan for daily medication(s) administration
 - c. The Medication Planning Tool will be uploaded to the File Store of the youth's medical record in Synthesis (Wraparound Milwaukee's electronic medical record) so that it can be referred to in subsequent Follow-up Medication appointments
5. At return visits of both groups (every 10-12 weeks), the physician will review medication, asking about adherence, how it is helping and any side effects and/or concerns.
6. Physician will rate the level of compliance on the Clinician Rating Scale (CRS) (See below) after every return visit

7. After two med review appointments (approximate total time 20-24 weeks), the Experimental Group will be divided into two groups using a simple randomization process; Experimental Group #1 & Experimental Group #2.
8. Experimental Group #1 will continue using the Medication Planning Tool for two additional medication review appointments (another 20-24 weeks).
9. Experimental Group #2 will continue using the Medication Planning Tool for two additional medication review appointments as well. Additionally, there will be the introduction of a phone call from the nurse one week after each appointment to again encourage medication compliance by reminding the youth and family about their personalized plan laid out on the Medication Planning Tool and to answer any questions or concerns.

Conclusion

The purpose of this Performance Improvement Project is to improve the medication compliance/adherence of youth in Wraparound Milwaukee. Following through with their individualized medication plan will have direct short term and long term positive impact on the quality of life for these youth. It has potential for moderating psychological and emotional symptomology, increase success in school and work, and reduce any reactive, impulsive behaviors that may result in challenges in the home and/or community.

TO BE COMPLETED BY PSYCHIATRIST

Clinician Rating Scale; CRS
(Kemp et al. 1990 *Sanz, M. 1998*)

The CRS uses an ordinal scale of 1-7 to quantify the clinician's assessment of the level of adherence shown by the patient.
Higher numbers represent greater adherence.

Circle the type of appointment and the rating that seems to fit the youth's behavior best

Client ID # _____ Intake Appointment _____ Date _____
 Follow-up #1 _____
 Follow-up #2 _____
 Follow-up #3 _____
 Follow-up #4 _____

Level of Adherence	Rating
Complete refusal	1
Partial refusal or only accepts minimum dose	2
Accepts only because compulsory, or very reluctant / requires persuasion, or questions the need for medication often (e.g. every 2 days)	3
Occasional reluctance (e.g. questions the need for medication once a week)	4
Passive acceptance	5
Moderate participation, some knowledge and interest in medication and no prompting required	6
Active participation, readily accepts, and shows some responsibility for regimen	7

 | MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
WRAPAROUND MILWAUKEE WELLNESS CLINIC

Youth's Name: _____ Today's Date: _____

Medication Name:	Medication Planning					
	School day	No school day	School day	No school day	School day	No school day
6:00 AM						
7:00 AM						
8:00 AM						
9:00 AM						
10:00 AM						
11:00 AM						
12:00 PM						
1:00 PM						
2:00 PM						
3:00 PM						
4:00 PM						
5:00 PM						
6:00 PM						
7:00 PM						
8:00 PM						
9:00 PM						
10:00 PM						

My helpful notes: _____

My next appointment is _____.

If I have any questions, I can call the Wellness Clinic at 414-257-7610.

PHONE: (414) 257-7610 9455 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226 FAX: (414) 257-7575

Quality Committee Item 5

Draft

PCS Hospital Transfer Waitlist Report

End Of Year Report Update

2017

This report contains information describing 2017 are summarized as follows:

- 5 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 75.2%
- The 1528 individuals delayed comprised 19.1% of the total PCS admissions (8,001)
- The median wait time for all individuals delayed was 4.6 hours
- The average length of waitlist per patient is 7.6 hours

Prepared by:
Quality Improvement Department

Date: January 25, 2018

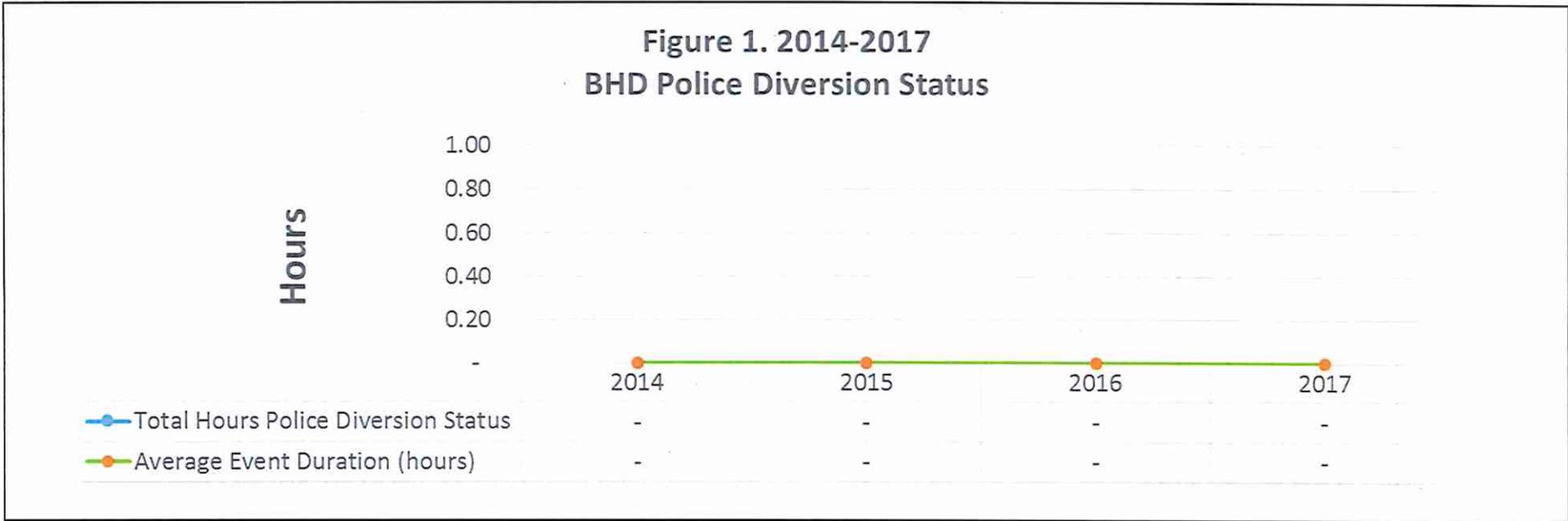
Definitions:

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

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

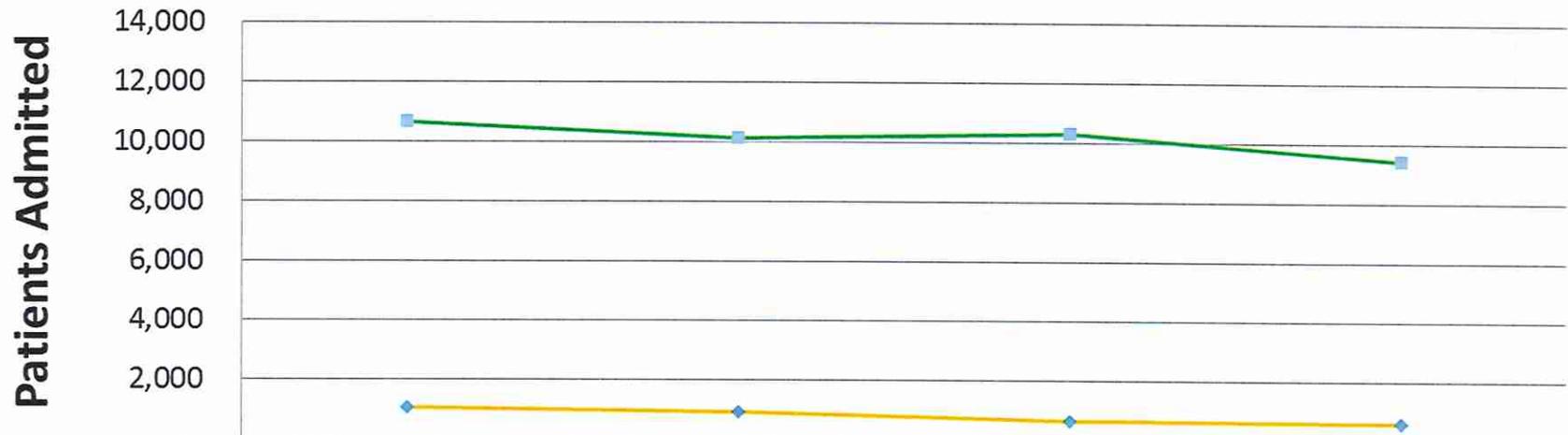
Reporting Time Period: The data in this report reflects three (3) years or the last twelve (12) quarters, unless specified otherwise.

Figure 1. 2014-2017
BHD Police Diversion Status



*There have been no police diversion in the last 8 year, last police diversion was in 2008

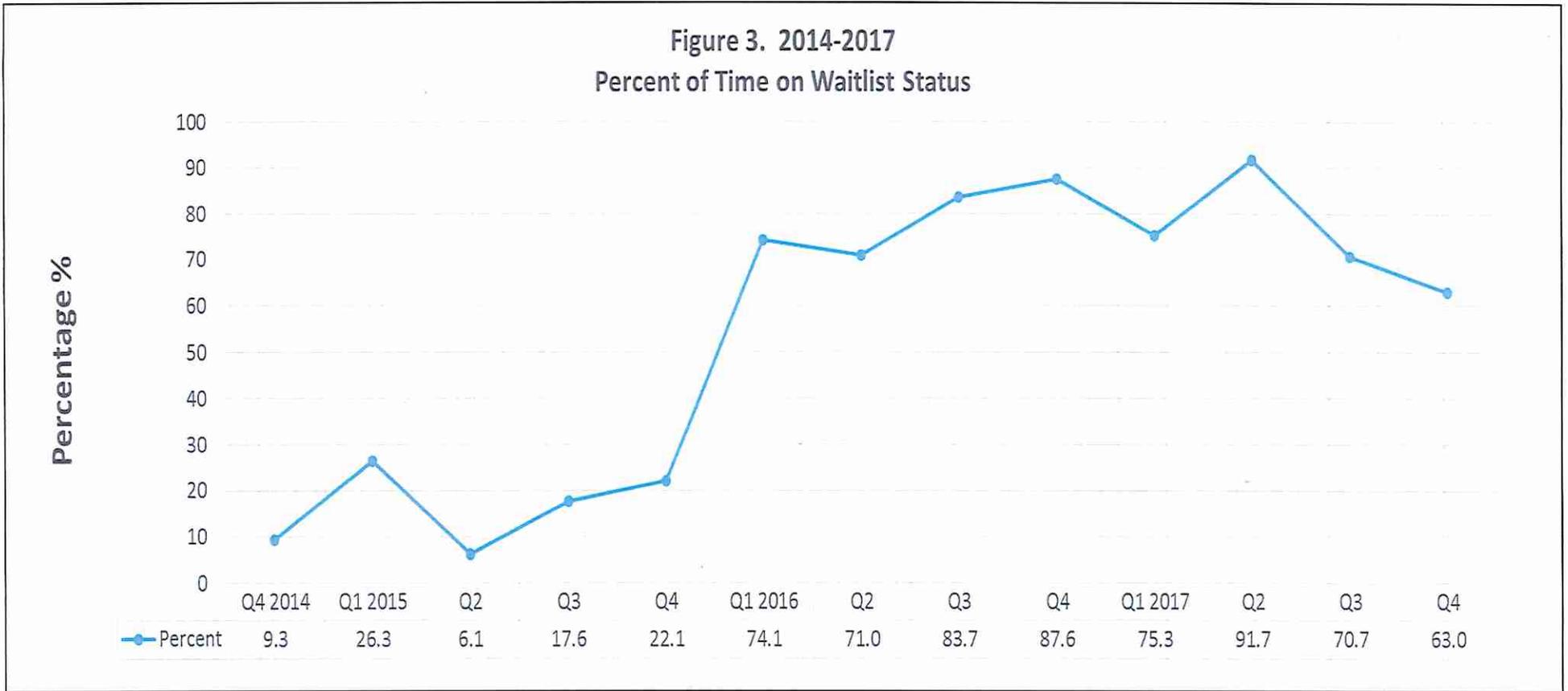
**Figure 2. 2014-2017
PCS and Acute Adult Admissions**



	2014	2015	2016	2017
Acute Adult Admissions	1,093	965	683	656
PCS Admissions	10,698	10,173	10,334	9,429

*PCS Admissions = Waitlist Clients + PCS Clients

Figure 3. 2014-2017
Percent of Time on Waitlist Status



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

Figure 4. 2014-2017
Patients on Hospital Transfer Waitlist



Figure 5. Waitlist Events
2014-2017



Figure 6. 2014-2017
Average Duration of Event
(Hours)



Figure 7. 2014 - 2017
Median Wait Time For Individuals Delayed
(Hours)



Figure 8. 2014-2017
Average Length of Waitlist For Individuals Delayed
(Hours)

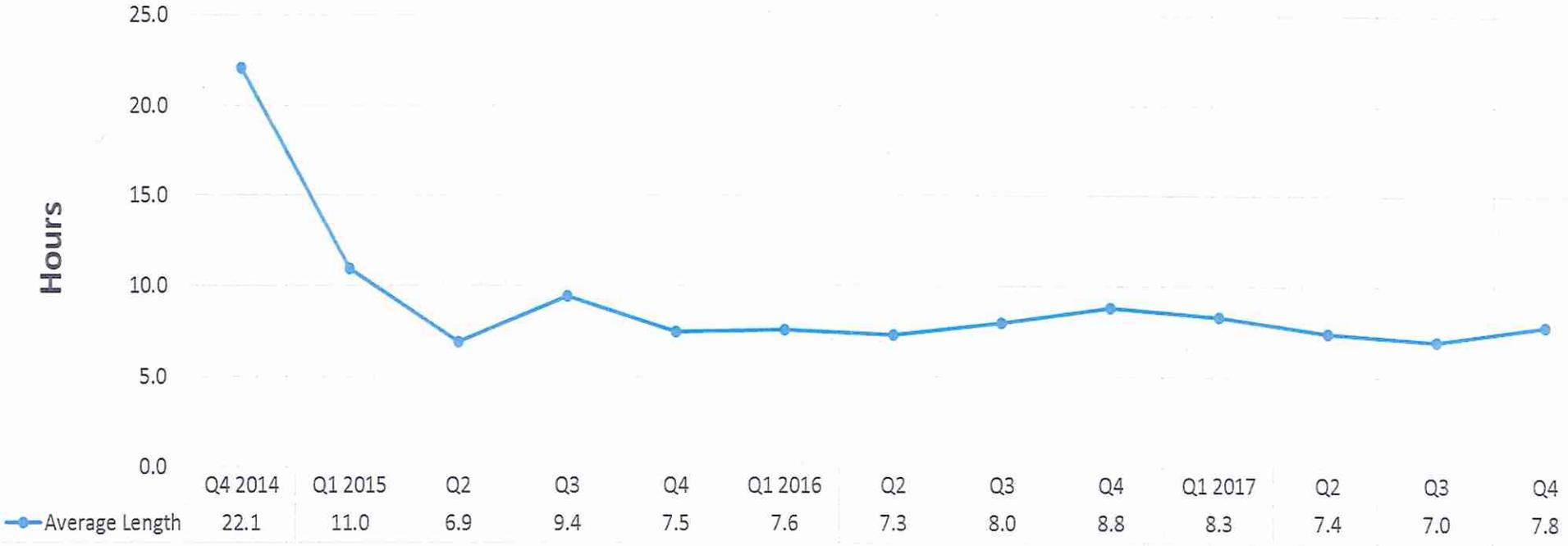
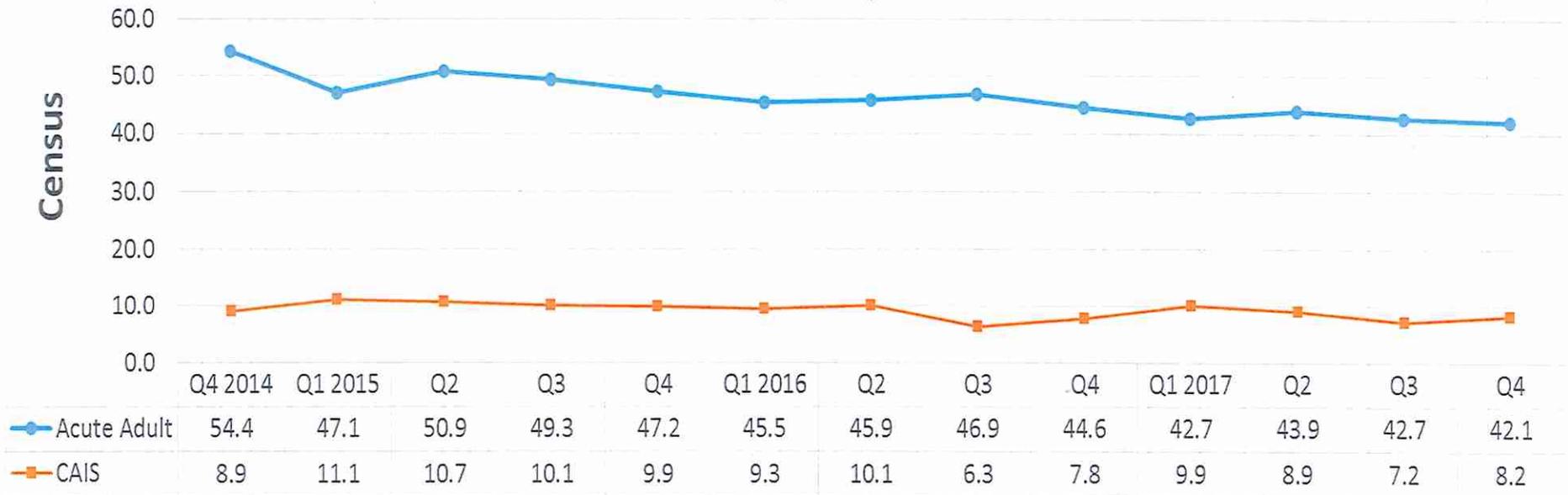
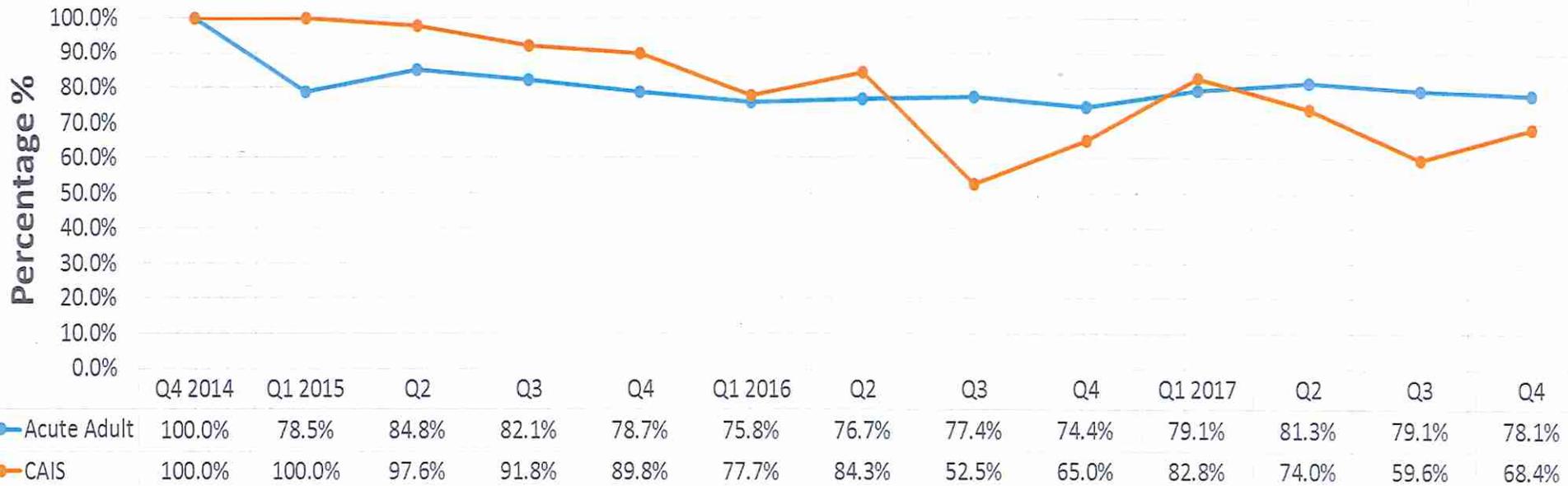


Figure 9. 2014-2017
Acute Adult/CAIS
Average Daily Census



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

Figure 10. 2014-2017
Acute Adult/CAIS
Budgeted Occupancy Rate



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

*Reduced staffing impacted operation bed count

Figure 11. 2014-2017
Number of patients on waitlist for 24 hours or greater

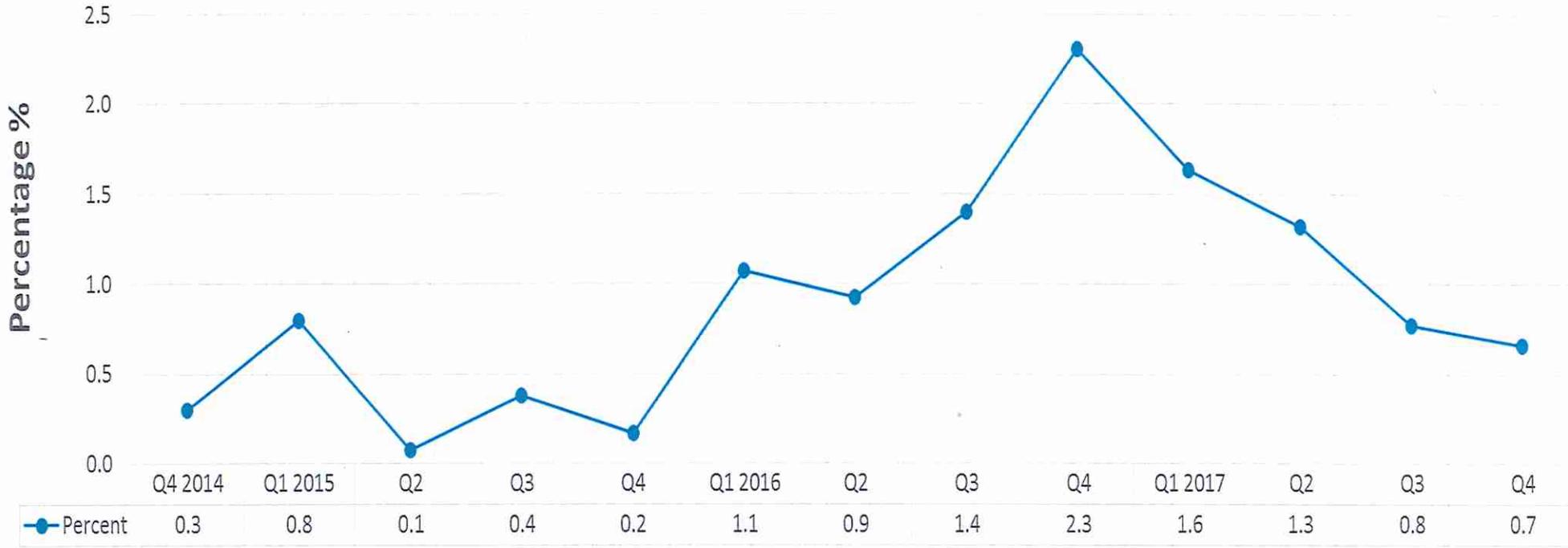


Figure 12. 2014-2017
Patients on waitlist for 24 hours or greater as a percentage of number of clients waitlisted



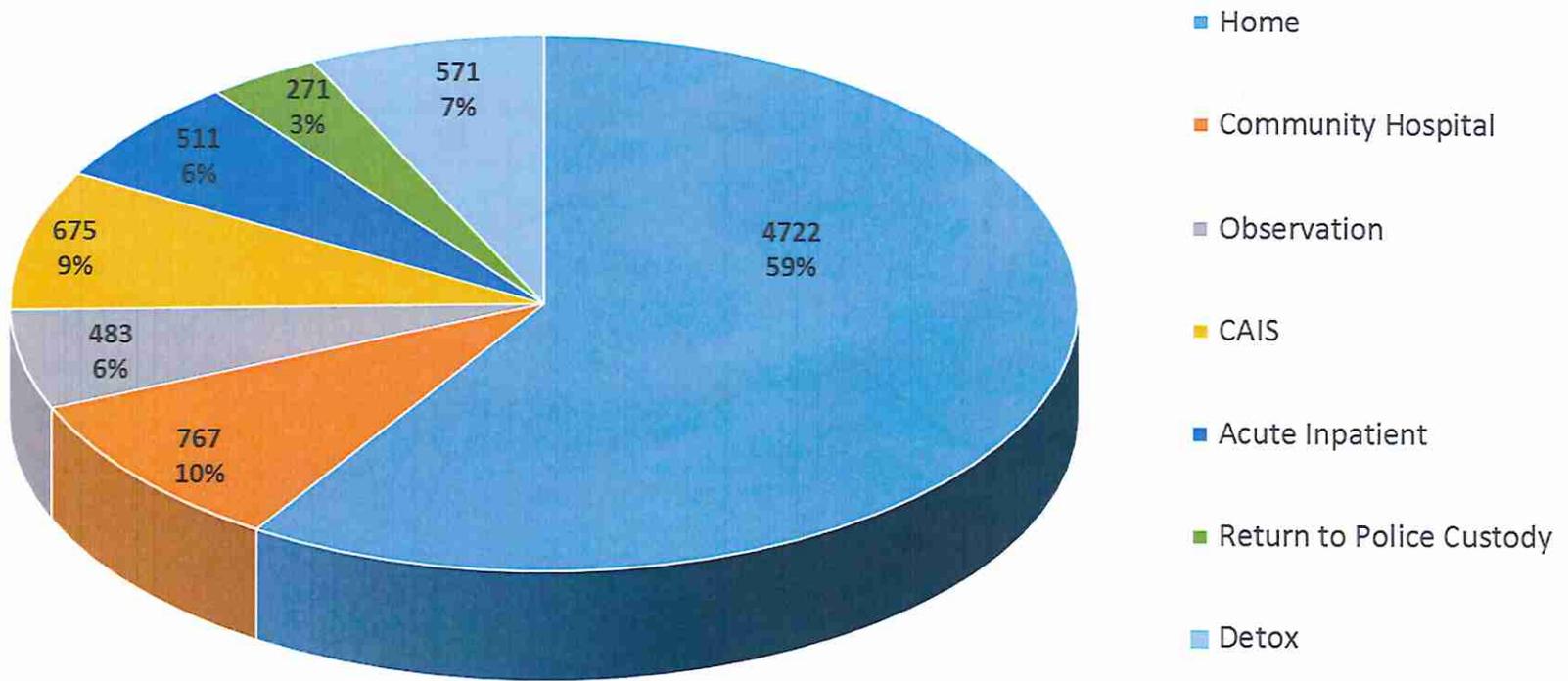
*Percent = Number of Patients on waitlist for 24 hours or greater/Number of Clients Waitlisted

Figure 13. 2014-2017
Patients on waitlist for 24 hours or greater as a percentage of PCS Admission



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

**Figure 14. 2017
Disposition of all PCS admission**



Quality Committee Item 6

Acute Inpatient Seclusion and Restraint

End of Year Update

2017

This report contains information describing 2017 as summarized:

- Acute Adult: Restraint hourly rate decreased by 81.8% from 2016 through end of year 2017 while restraint incident rate decreased by 59.0% during the same time period. Seclusion incident rate decreased by 17.0% from 2016 through end of year 2017 while Seclusion hourly rate decreased by 40.0% during the same time period.
- CAIS: Restraint hourly rate decreased by 72.7% from 2016 through end of year 2017.

Prepared by: Quality
Improvement
Department

Date: January 24, 2018

Summary

43A

- 43A rate of restraint hours decreased by 86.4% from 2016 through end of year 2017.
- 43A had 109.38 reported restraint hours, 45.3 reported restraint hours were for 5 individuals (41% of all hours)
- 43A restraint incident rate decreased by 63.5% from 2016 through end of year 2017.
- 43A had 93 reported restraint incidents, 37 reported restraint incidents were for 5 individuals (40% of all incidents)
- 43A seclusion hour's rate decreased by 55.6% from 2016 through end of year 2017, while the seclusion incident rate decreased by 47.2%.

43B

- 43B rate of restraint hours decreased by 78.6% from 2016 through end of year 2017.
- 43B had 72.4 reported restraint hours, 38.6 reported restraint hours were for 5 individuals (53% of all hours)
- 43B restraint incident rate decreased by 65.3% from 2016 through end of year 2017.
- 43B seclusion hour's rate remained the same from 2016 through end of year 2017, while the seclusion incident rate increased by 6.1%.

43C

- 43C rate of restraint hours decreased by 60.0% from 2016 through end of year 2017.
- 43C had 28.4 reported restraint hours, 14.6 reported restraint hours were for 3 individuals (51% of all hours)
- 43C restraint incident rate decreased by 21.6% from 2016 through end of year 2017.
- 43C seclusion hour's rate decreased by 25.0% from 2016 through end of year 2017, while the seclusion incident rate increased by 50.5%.

CAIS

- CAIS rate of restraint hours decreased by 72.7% from 2016 through end of year 2017.
- Five (5) individuals had 36 reported restraint hours, 41% of all restraints
- CAIS restraint incident rate decreased by 67.2% from 2016 through the third quarter of 2017.

Acute Adult

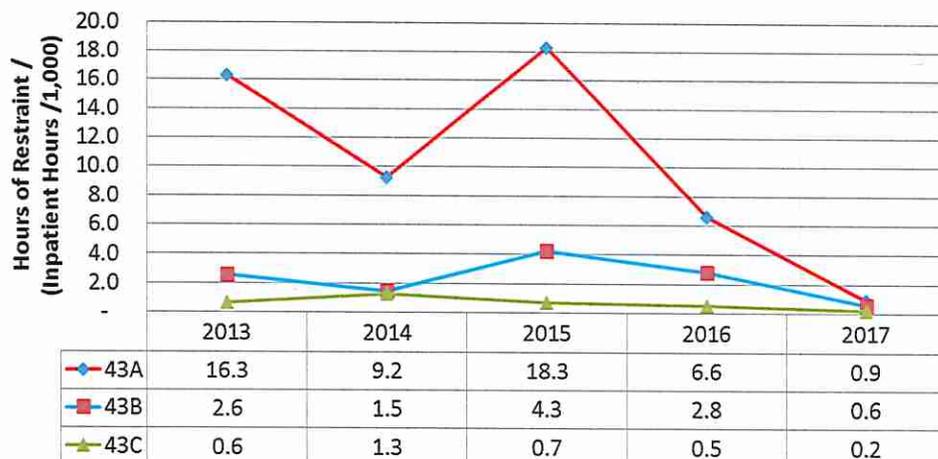
Acute Adult

2013-2017 Hours of Restraint (Aggregate)



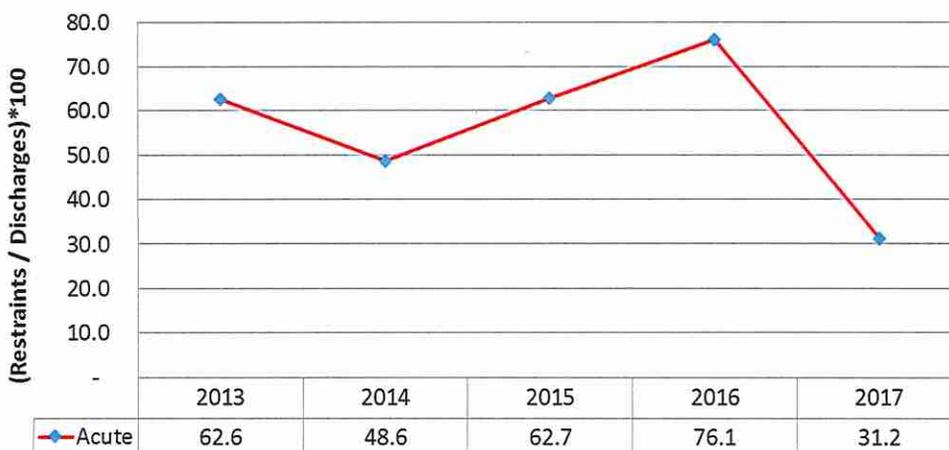
Acute Adult

2013-2017 BHD - Hours of Restraint by Unit



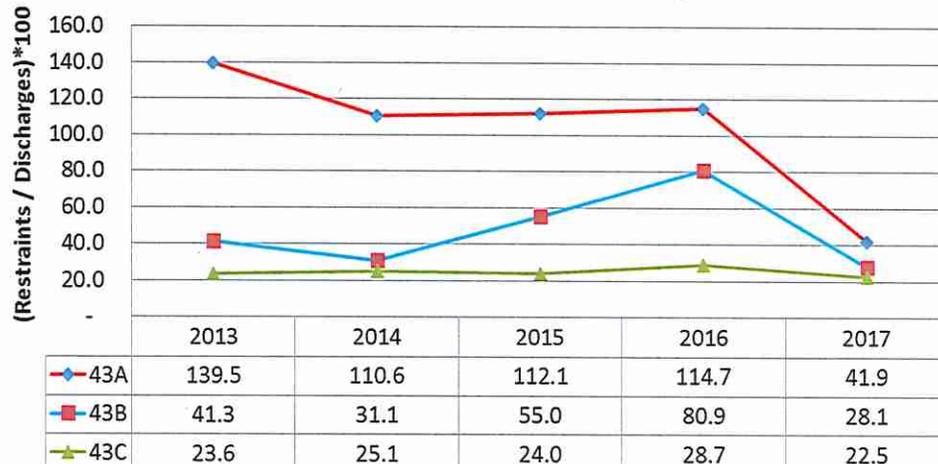
Acute Adult

2013-2017 Restraint Incident % (Aggregate)



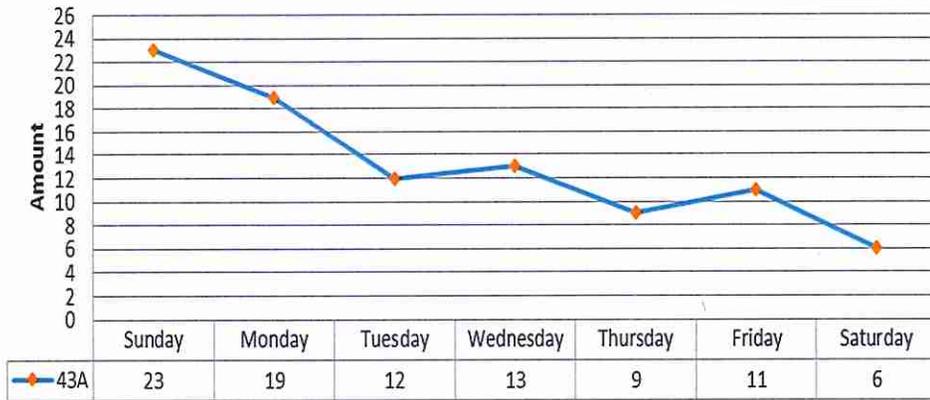
Acute Adult

2013-2017 BHD - Restraint Incident % by Unit

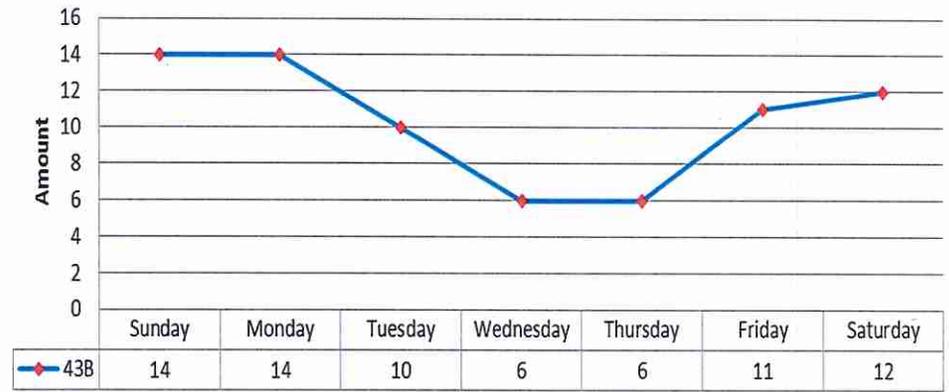


Acute Adult

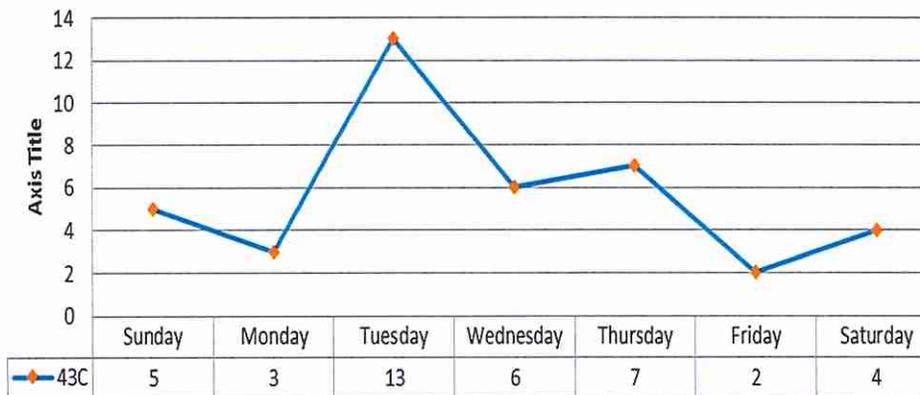
43A Restraints by Day of Week
N = 93



43B Restraints by Day of Week
N = 73

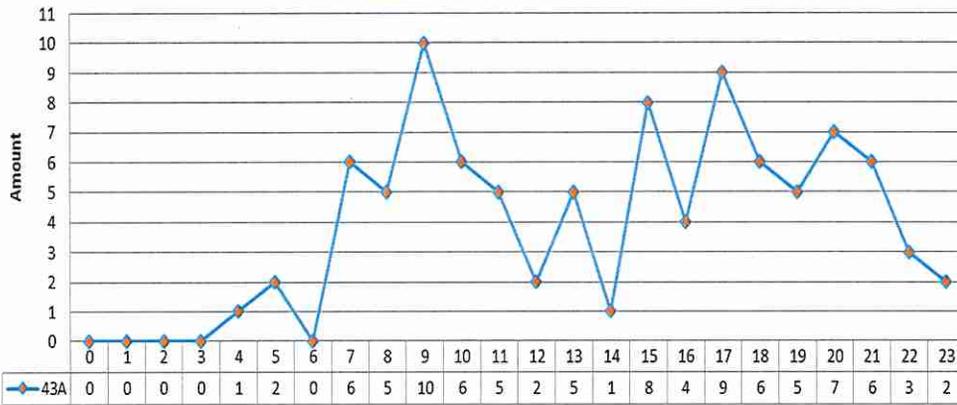


43C Restraints by Day of Week
N = 40

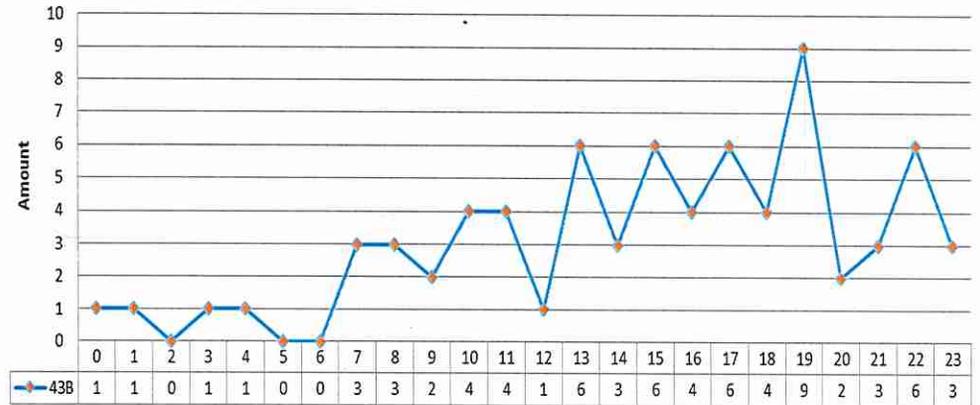


Acute Adult

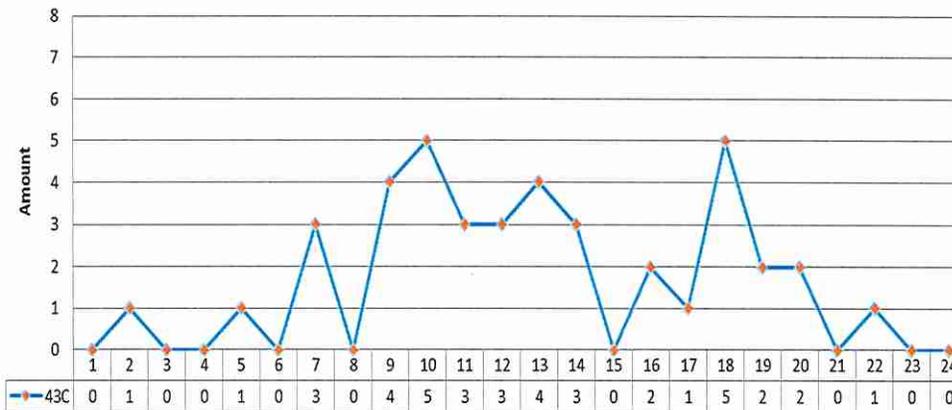
43A Restraints by Time of Day
N = 93



43B Restraints by Time of Day
N = 73



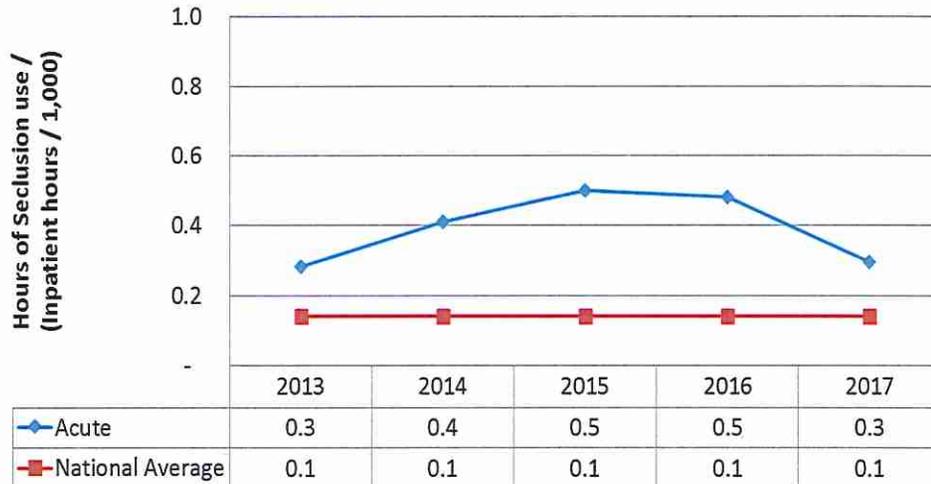
43C Restraints by Time of Day
N = 40



Acute Adult

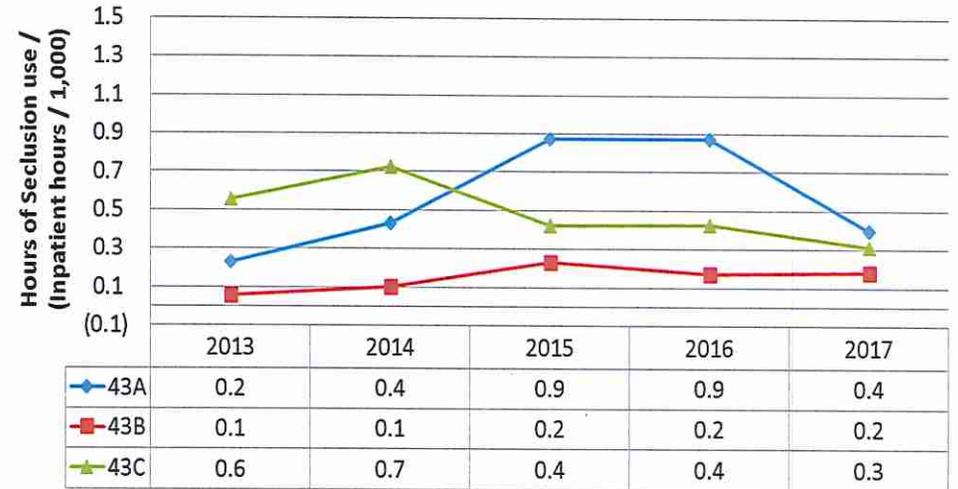
Acute Adult

2013-2017 Hours of Seclusion Rate (Aggregate)



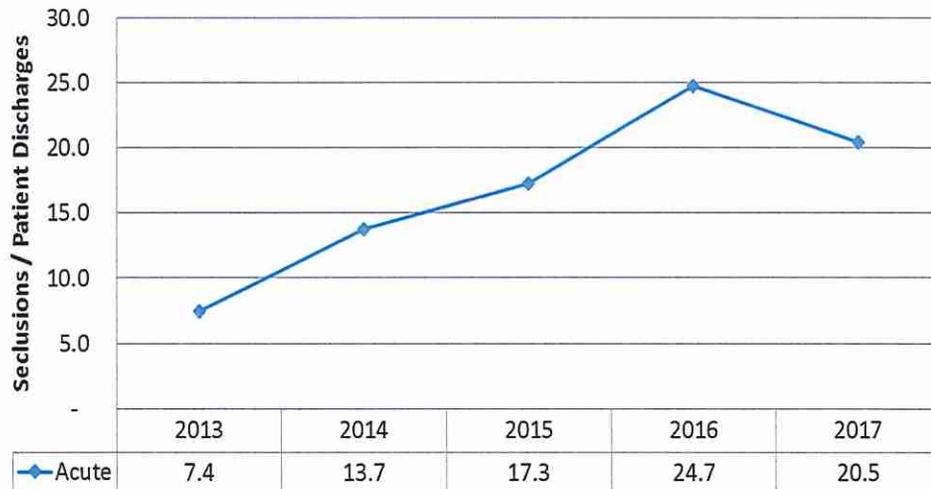
Acute Adult

2013-2017 Hours of Seclusion Rate by Unit



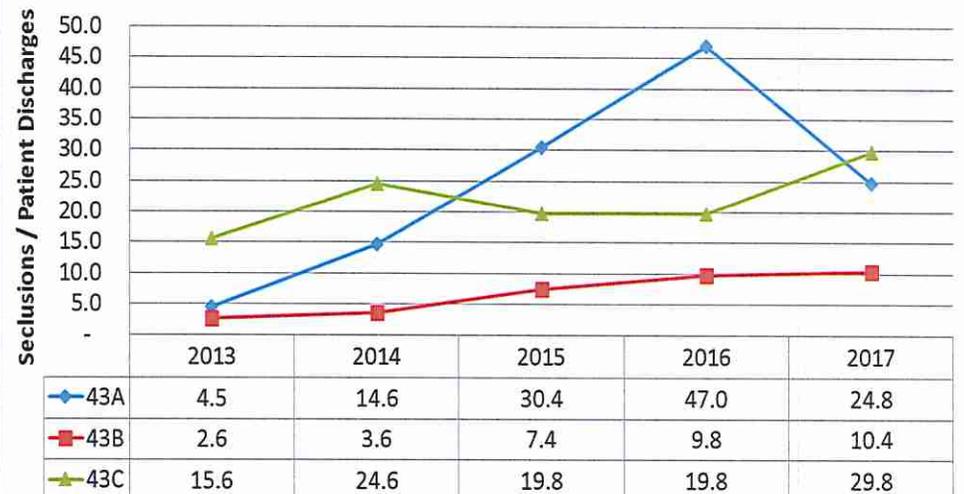
Acute Adult

2013-2017 Seclusion Incident % (Aggregate)

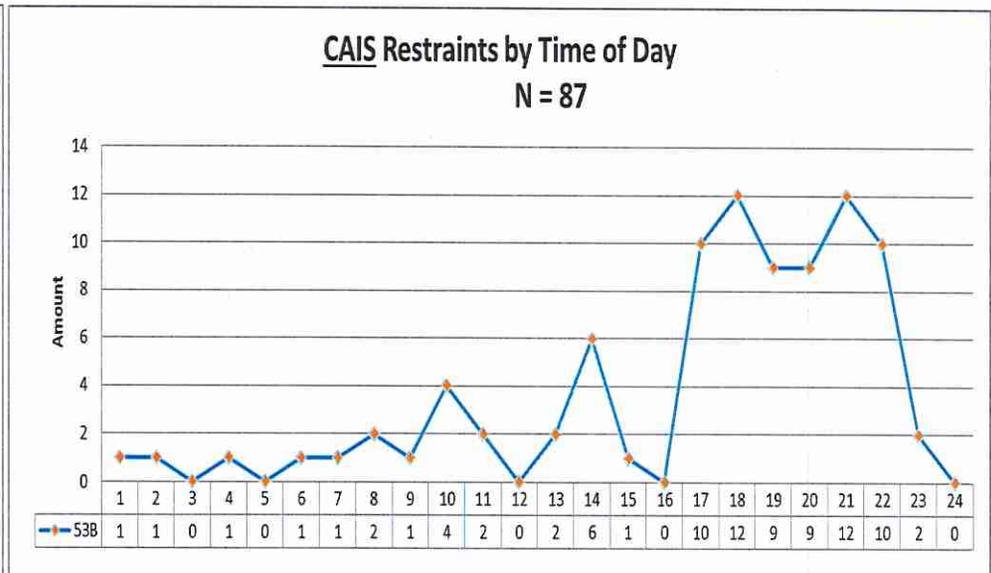
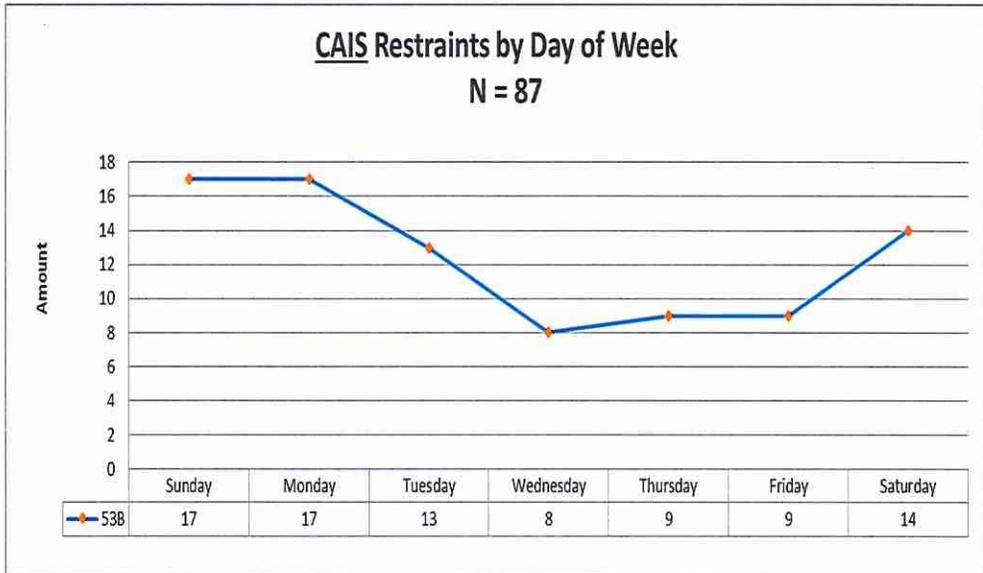
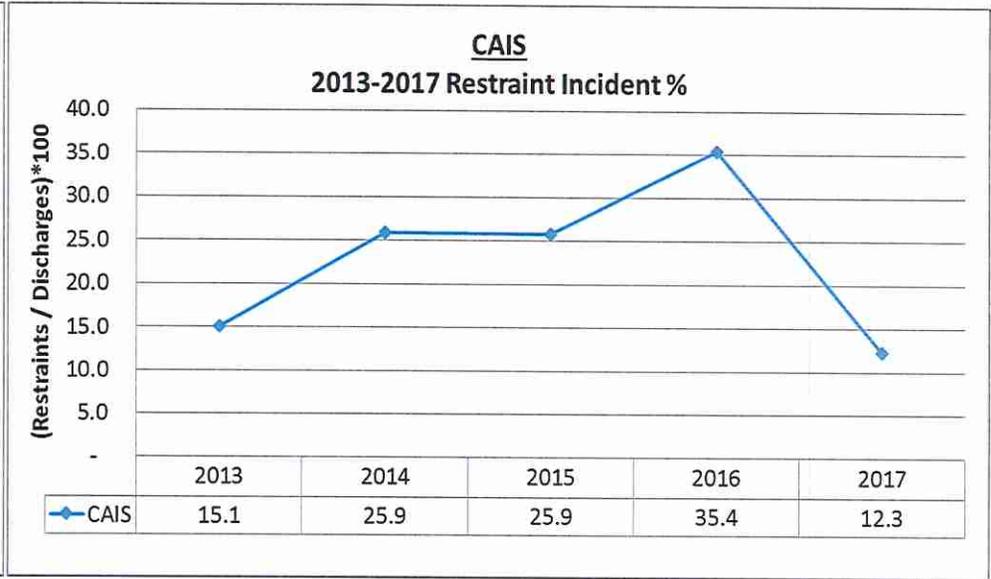
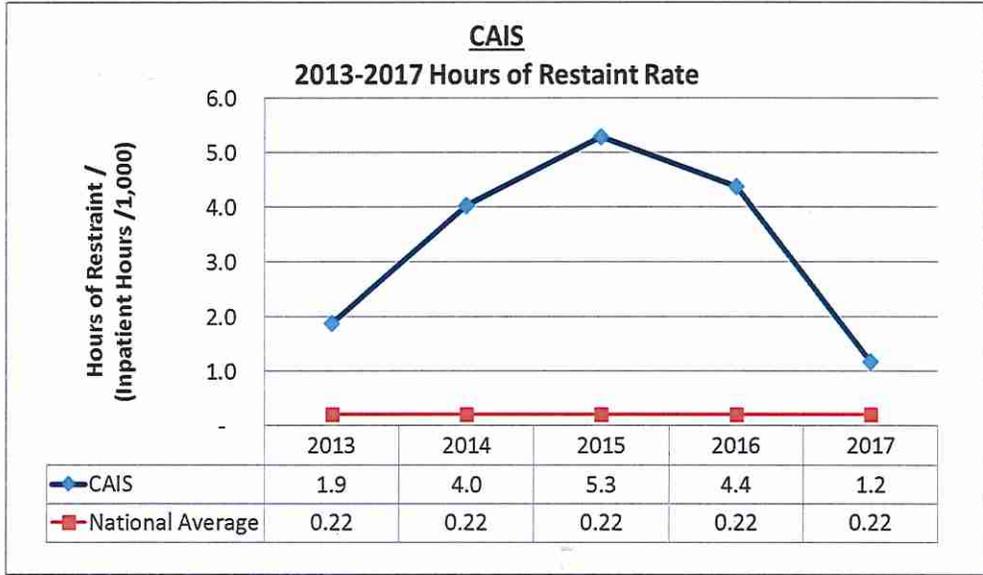


Acute Adult

2013-2017 Seclusion Incident % by Unit



CAIS



Facility Data

Program		Restraint Incidents							Restraint Hours						
		2011	2012	2013	2014	2015	2016	2017	2011	2012	2013	2014	2015	2016	2017
Acute	43A	282	367	558	303	306	249	93	1,704	1,473	2,321	1,293	2,402	864	109
	43B	78	124	236	138	237	207	73	89	139	492	259	600	399	72
	43C	173	88	112	98	63	58	40	1,602	78	113	205	104	67	28
	Total	966	775	906	539	606	514	206	4,579	2,268	2,926	1,757	3,106	1,330	210
CAIS	CAIS	173	84	124	246	238	218	87	476	98	133	314	458	323	88
Crisis	PCS	638	537	445	405	417	373	275	651	514	509	413	445	408	269
	OBS	122	76	106	146	83	74	63	190	100	179	207	117	98	46

Program/Unit		Seclusion Incidents							Seclusion Hours						
		2011	2012	2013	2014	2015	2016	2017	2011	2012	2013	2014	2015	2016	2017
Acute	43A	47	22	18	40	83	102	55	87	17	33	61	115	115	49
	43B	4	12	15	16	32	25	27	4	8	11	18	32	24	23
	43C	58	15	74	96	52	40	53	73	10	100	118	60	54	40
	Total	154	62	107	152	167	167	135	218	48	144	196	207	193	111
CAIS	CAIS	27	6	5	32	44	17	45	32	4	3	21	35	13	28

Quality Committee Item 7

MHSIP
Consumer
Satisfaction
Survey

Annual

2017

Prepared By:
Quality
Improvement
Department

Created 1/23/17

Overview

- In 2017, 218 of the 656 consumers discharged from Acute Adult Inpatient Service completed the MHSIP survey. Acute Adult Inpatient Service's 2017 MHSIP survey response rate of 33% is significantly above the 27% national average response rate for inpatient behavioral health patient satisfaction surveys.
- Acute Adult Inpatient Service's survey item domain scores are within 3 percentage points of the published national averages.
- The survey results for 2017 revealed an **increase** in positive rating for all six survey item domain categories in comparison to 2016's scores. In 2017, the Dignity and Environment domains received the highest positive rating in the 15 year history of administering this survey.
- The following are *general guidelines* for interpreting the inpatient consumer survey results based on thirteen years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
 - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
 - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
 - Percentages in the 80 - 89% range can be considered 'high'
 - Percentages 90% and above can be considered 'exceptional'
- The results revealed a "High" response score for the Dignity domain (81%), "Good" response scores for 4 of the 6 survey item domains: 77% for Outcome, 75% for Participation, 75% for Empowerment, and 74% for Environment. Relatively low response scores were obtained for the patient Rights domain 65%.
- Survey items with the highest positive response scores were:
 - I was encouraged to use self-help/support groups (84%)
 - Staff here believe that I could grow, change and recover (81%)
 - My contact with nurses and therapists was helpful (81%)
 - I felt comfortable asking questions about my treatment and medications (81%)
 - The hospital environment was clean and comfortable (81%)
 - I participated in planning my discharge (79%)
 - I was treated with dignity and respect (78%)
 - I do better in social situations (78%)
 - My symptoms are not bothering me as much (77%)

Introduction

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

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

Method

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

Instrument

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

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

NRI/MHSIP Inpatient Consumer Survey (2001)

Outcome Domain:

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

Dignity Domain:

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

Rights Domain:

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

Participation Domain:

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

Environment Domain:

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

Empowerment Domain:

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

Other survey items:

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

Results

The following presents the results of the Inpatient MHSIP Consumer survey completed by consumers of the Acute Adult Inpatient Service in 2017. Data from 2013 – 2016 administrations of the survey are also presented in select tables of this report to allow for comparisons.

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

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

Response Rate

Completed surveys were obtained at discharge from 33% of the 656 consumers discharged from the Acute Adult Inpatient service in 2017. Acute Adult Inpatient Service's 2017 MHSIP survey response rate of 33% is significantly above the 27% national average response rate for inpatient behavioral health patient satisfaction surveys.

Table 1 presents data on response rates by unit and the total BHD Acute Adult Inpatient Service for 2014 – 2017.

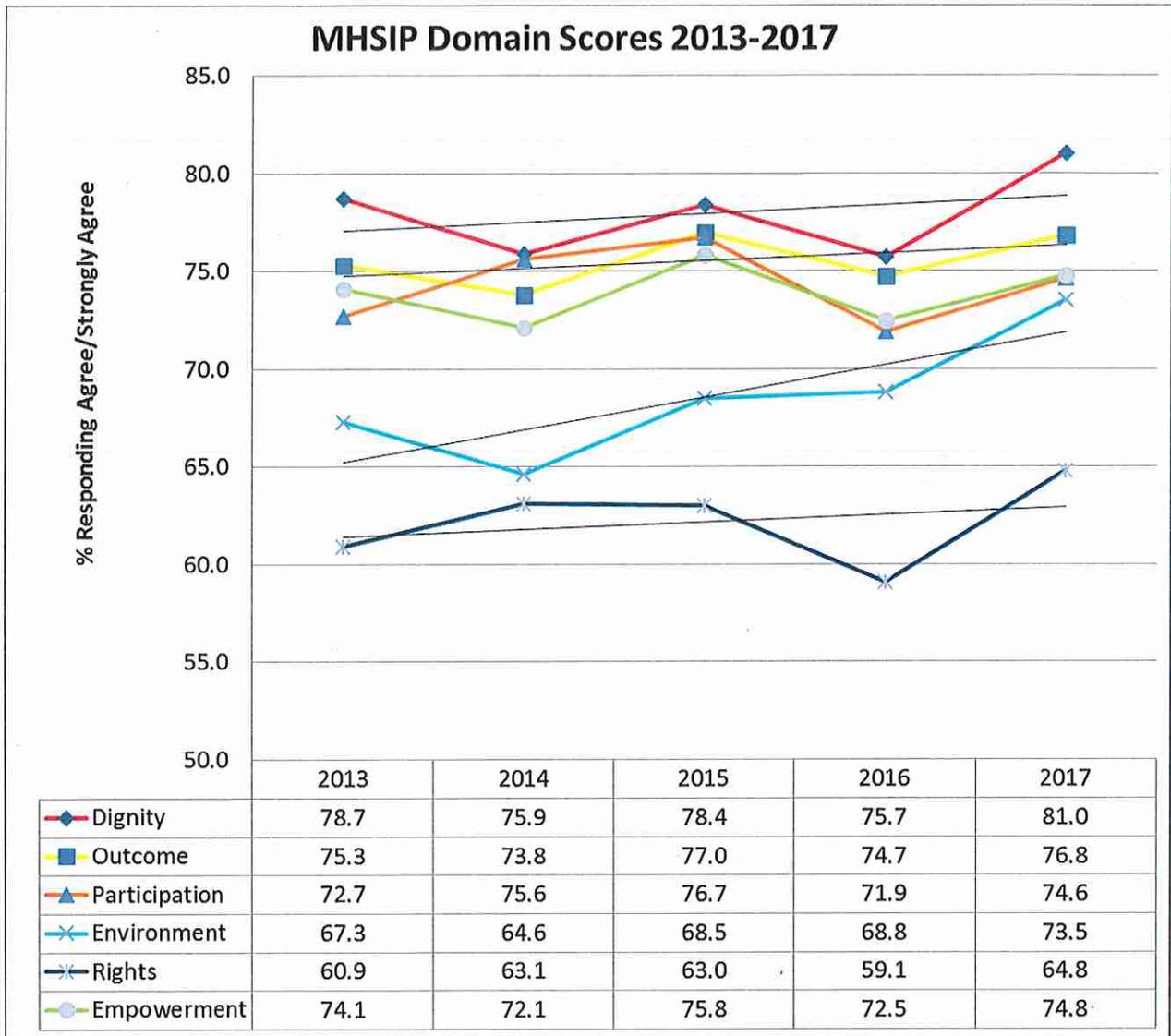
Table 1. Inpatient MHSIP Consumer Survey - Response Rate by Unit								
Unit	2014		2015		2016		2017	
	Completed Surveys	Response Rate						
43A - ITU	48	19.6%	76	27.8%	70	30.2%	48	21.6%
43B - ATU	143	29.7%	334	77.5%	171	66.5%	154	59.5%
43C - WTU	94	25.7%	92	35.1%	39	20.1%	16	9.0%
Total	285	26.1%	502	52.0%	280	41.0%	218	33.1%

Acute Adult Inpatient Service

Table 2 presents Acute Adult Inpatient Service’s consumer positive (agree/strongly agree) responses for 2013 – 2017. In 2017, the results revealed a “High” response score for the Dignity domain (81%), “Good” response scores for 4 of the 6 survey item domains: 77% for Outcome, 75% for Participation, 75% for Empowerment, and 74% for Environment. Relatively low response scores were obtained for the patient Rights domain 65%.

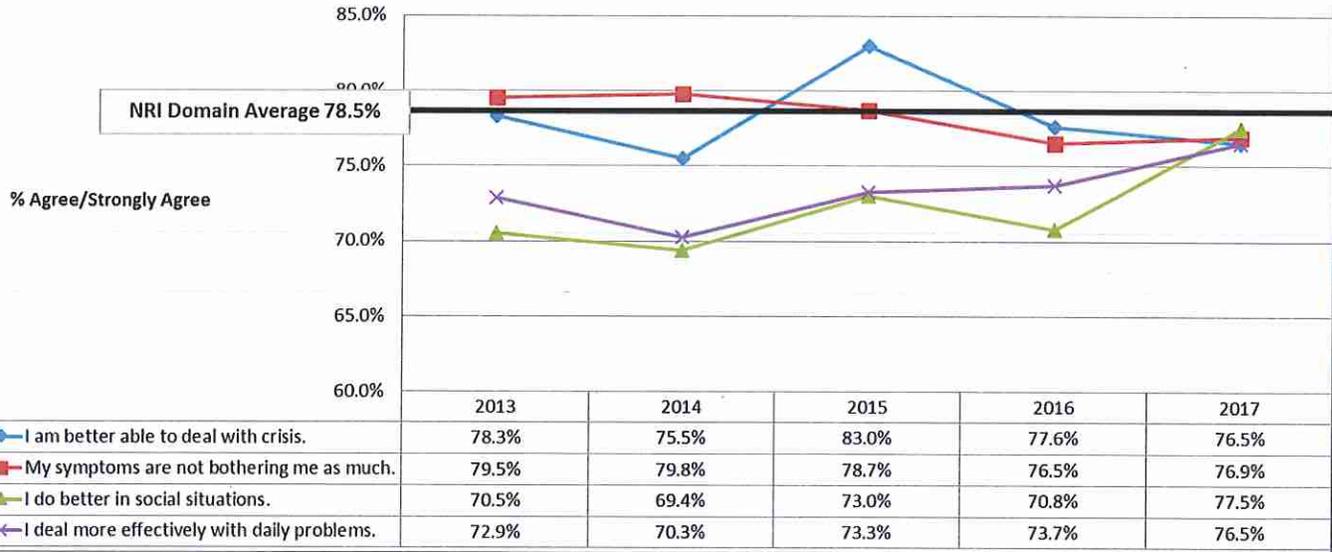
Table 2. Inpatient MHSIP Consumer Survey - All Units					
Domains	Agree/Strongly Agree Response %				
	2013	2014	2015	2016	2017
Dignity	78.7%	75.9%	78.4%	75.7%	81.0%
Outcome	75.3%	73.8%	77.0%	74.7%	76.8%
Participation	72.7%	75.6%	76.7%	71.9%	74.6%
Environment	67.3%	64.6%	68.5%	68.8%	73.5%
Rights	60.9%	63.1%	63.0%	59.1%	64.8%
Empowerment	74.1%	72.1%	75.8%	72.5%	74.8%
Additional Questions					
My family and/or friends were able to visit me.	79.0%	78.8%	78.6%	77.9%	81.8%
The Medications I am taking help me control my symptoms that used to bother me.	73.2%	74.8%	77.0%	74.3%	76.9%
My other medical conditions were treated.	72.4%	66.3%	68.1%	67.7%	72.5%
Staff were sensitive to my cultural background.	61.9%	63.8%	67.4%	64.7%	71.3%
I felt this hospital stay was necessary.	66.0%	68.4%	65.8%	62.5%	66.0%
I was given information about how to manage my medication side effects.	64.7%	63.3%	72.1%	66.1%	69.2%
If I had a choice of hospitals, I would still choose this one.	60.3%	55.3%	63.2%	56.0%	65.4%
Surveys Completed	487	285	502	280	218

The following graph presents Acute Adult Inpatient Service's 2013-2017 positive (agree/strongly agree) Domain scores.

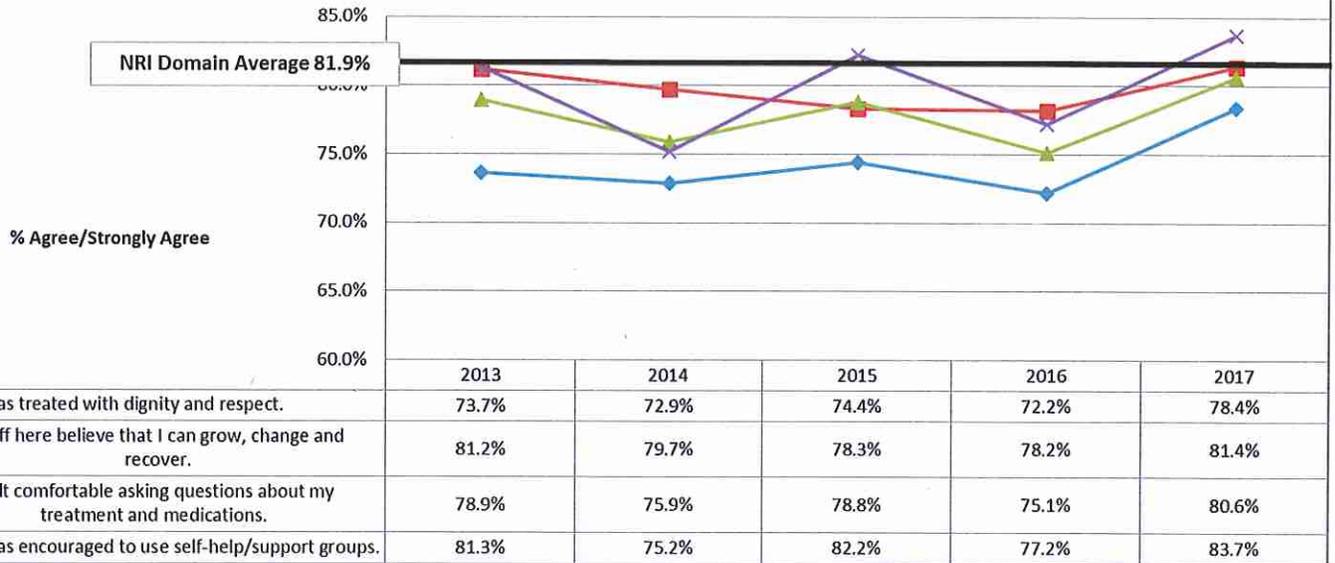


The following graphs present Acute Adult Inpatient Service's 2013-2017 positive (agree/strongly agree) survey item scores and NRI's domain average.

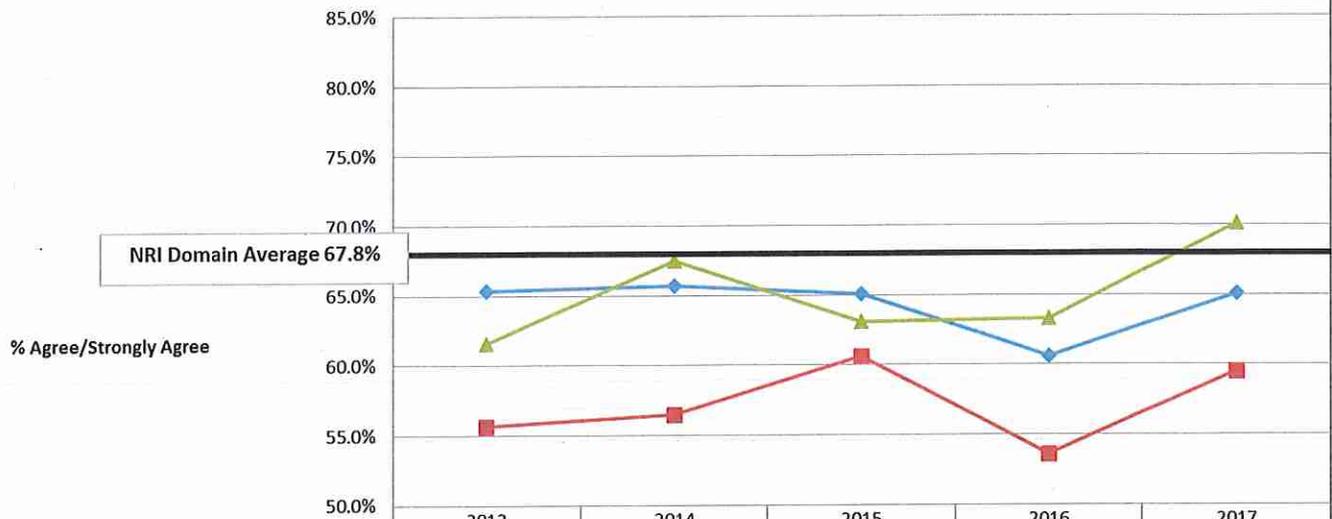
2013 - 2017 MHSIP Survey - Outcomes Domain



2013 - 2017 MHSIP Survey - Dignity Domain

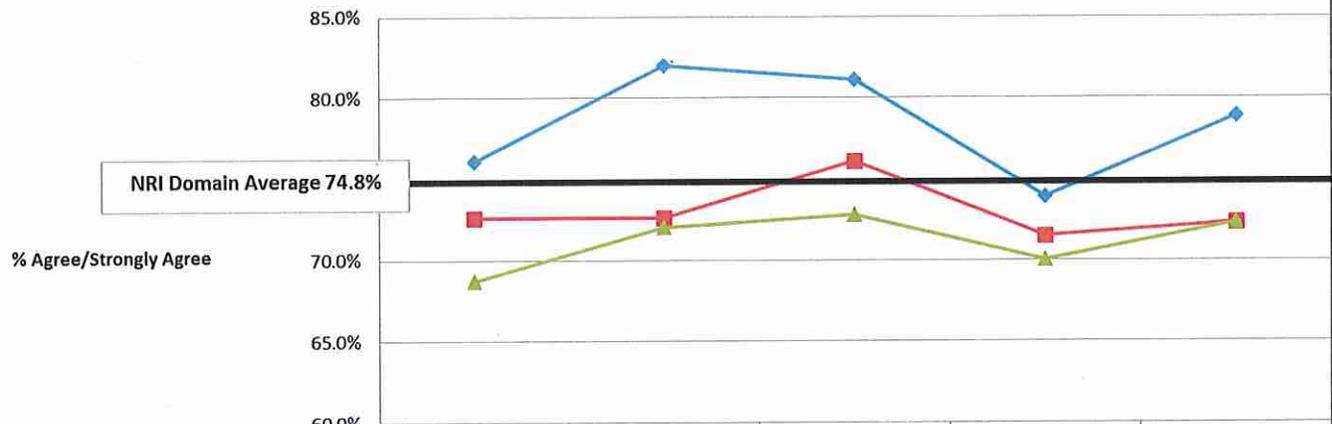


2013 - 2017 MHSIP Survey - Rights Domain



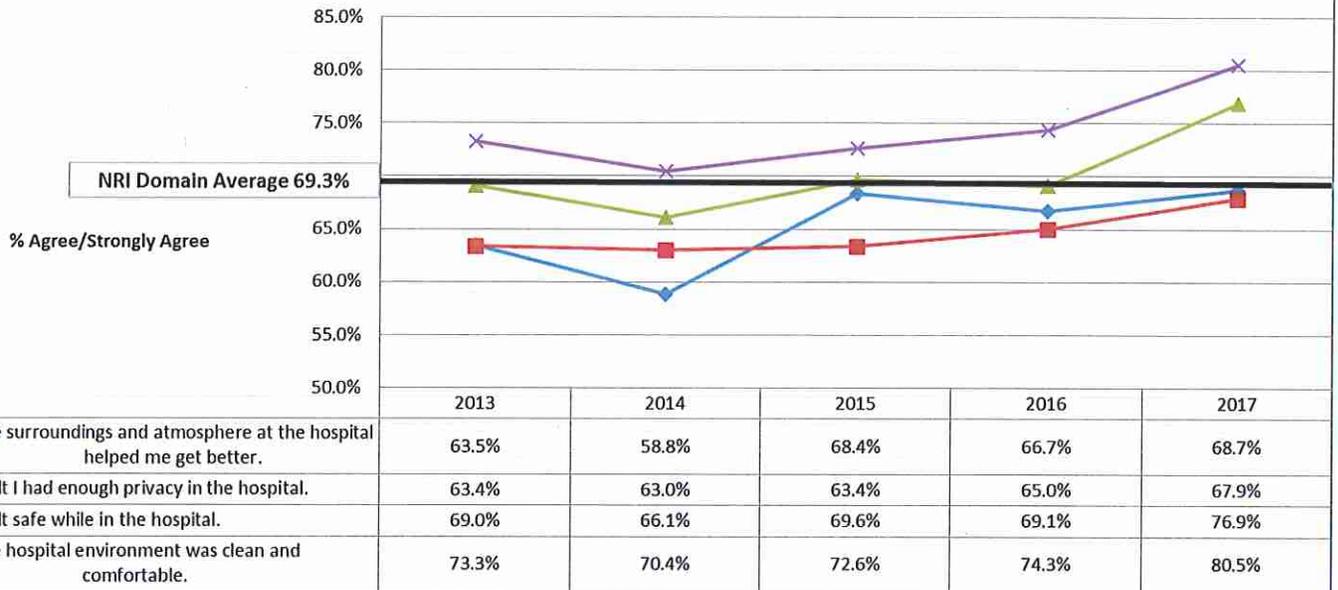
	2013	2014	2015	2016	2017
I felt free to complain without fear of retaliation.	65.4%	65.7%	65.1%	60.6%	65.1%
I felt safe to refuse medication or treatment during my hospital stay.	55.7%	56.5%	60.6%	53.6%	59.5%
My complaints and grievances were addressed.	61.6%	67.5%	63.1%	63.3%	70.1%

2013 - 2017 MHSIP Survey - Participation Domain

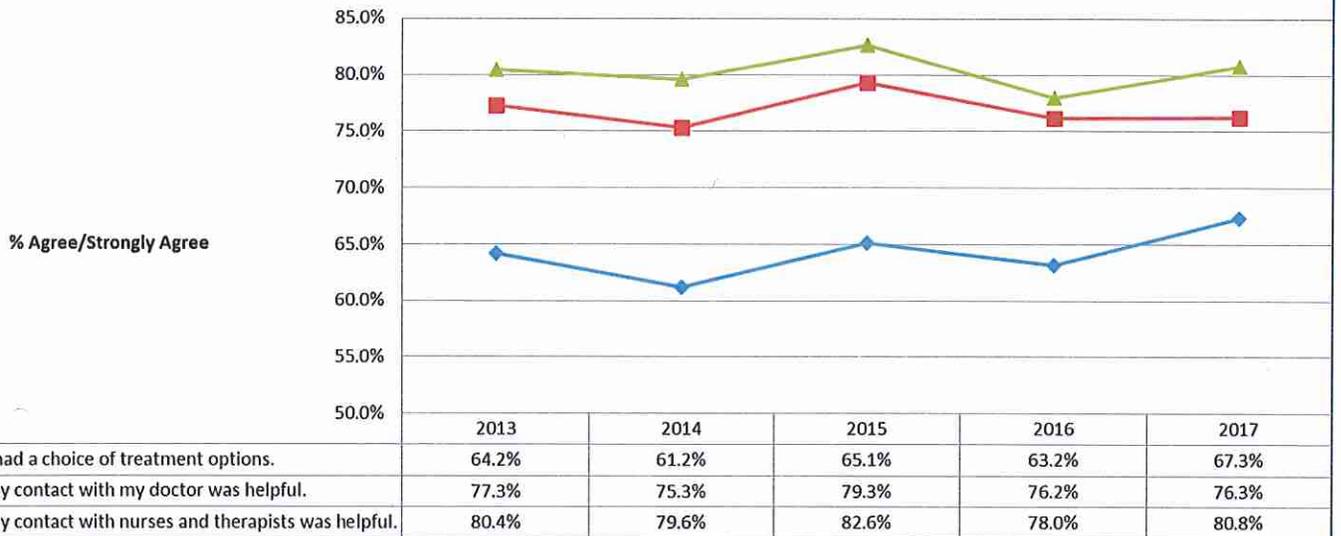


	2013	2014	2015	2016	2017
I participated in planning my discharge.	76.1%	82.0%	81.1%	73.9%	78.9%
Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	72.6%	72.6%	76.1%	71.5%	72.3%
I had the opportunity to talk with my doctor or therapist from the community prior to discharge.	68.7%	72.0%	72.8%	70.0%	72.3%

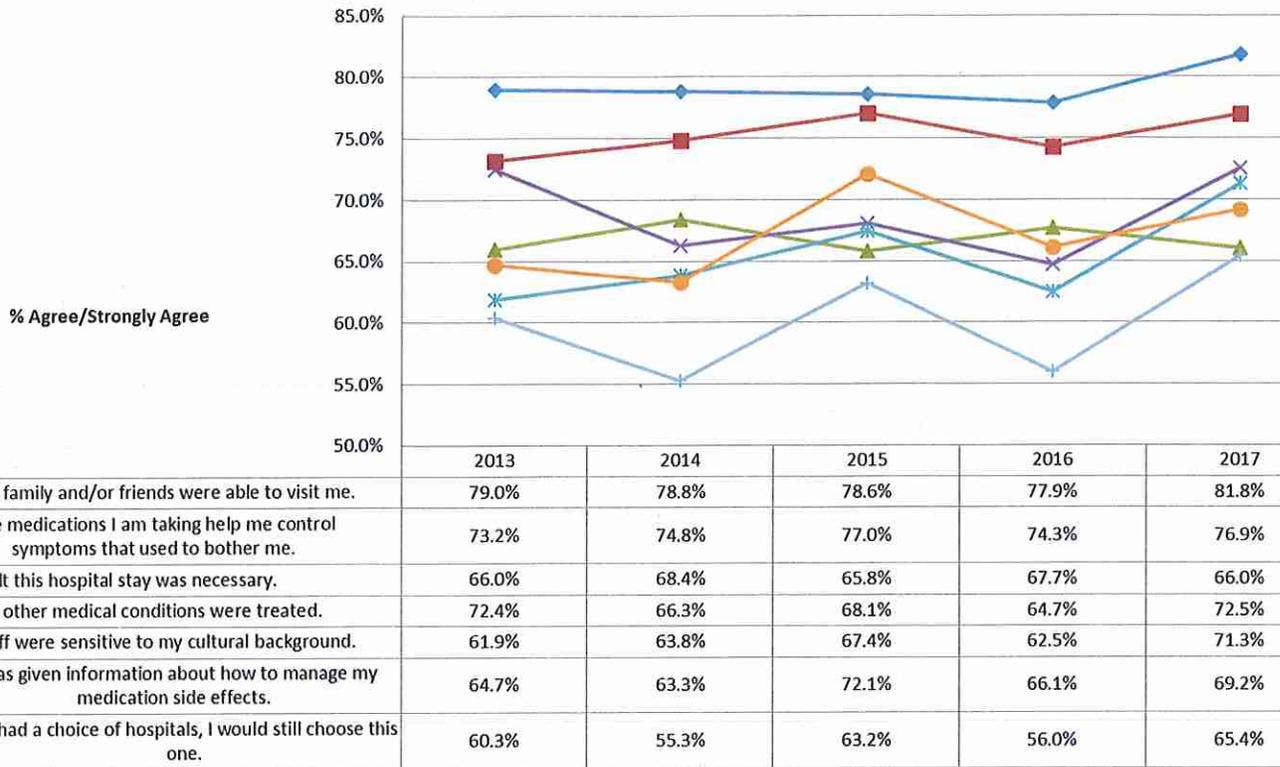
2013 - 2017 MHSIP Survey - Environment Domain



2013 - 2017 MHSIP Survey - Empowerment Domain



2013 - 2017 MHSIP Survey - Other Items



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

Table 3. BHD Inpatient MHSIP Agree/Strongly Agree Domain Response Scores Comparison to NRI National Average			
Domains	National Average	2017 BHD	BHD/National Avg Variance
Dignity	81.9%	81.0%	-0.9%
Outcome	78.5%	76.8%	-1.7%
Participation	74.8%	74.6%	-0.2%
Environment	69.3%	73.5%	4.2%
Rights	67.8%	64.8%	-3.0%
Empowerment	Not Reported	74.8%	-

Table 4 presents 2017 survey results for domain and additional items by each Acute Adult Inpatient Unit. The following summarizes these comparisons and should be interpreted as a *general* measure of a unit's performance based on consumers' perceptions of their inpatient stay:

Table 4. 2017 Inpatient MHSIP Consumer Survey - By Unit			
Domains	Agree/Strongly Agree Response		
	43A	43B	43C
Dignity	81.0%	81.4%	77.8%
Outcome	74.7%	76.3%	88.7%
Participation	77.6%	73.0%	81.0%
Environment	66.0%	74.5%	85.9%
Rights	65.9%	63.5%	73.9%
Empowerment	73.4%	74.0%	87.0%
Additional Questions			
My family and/or friends were able to visit me.	82.9%	80.8%	87.5%
The Medications I am taking help me control my symptoms that used to bother me.	71.7%	78.8%	75.0%
My other medical conditions were treated.	82.9%	67.6%	87.5%
Staff were sensitive to my cultural background	68.9%	70.4%	86.7%
I felt this hospital stay was necessary	57.8%	66.4%	86.7%
I was given information about how to manage my medication side effects	73.9%	68.0%	66.7%
If I had a choice of hospitals, I would still choose this one.	59.1%	65.5%	81.3%
Surveys Completed	48	154	16

Appendix

The comments below were written on surveys administered in 2017.

43A - Positive Comments

1. I enjoyed staff of doctors and some staffers.
2. Maurice, Doreen, Todd, Ms. Ophelia, Ms. Courtney, Mr. Percy, Ms. Laurie, Doctor Clark, I am more than grateful for the help provided and exceptional treatment and care.
3. Staff was understanding.
4. Thank you for your support.
5. Thank you to all levels of staff and your help, lessons and practices are that much more appreciated.
6. This hospital is very helpful and targeted at meeting my needs.
7. Todd was helpful to me.
8. The staff were excellent and helpful.

43A - Negative Comments

1. The food is subpar (needs improvement)

43B - Positive Comments

1. Social worker and nursing/ancillary staff were great.
2. Thanks for everything you and staff have done for me, very helpful to me and my needs, greatly appreciated. Thanks a lot.
3. My stay here was the best treatment in over 25 stay across the U.S.A.
4. Thank you for all the help.
5. Very well informed about my treatment and discharge planning.

43B - Negative Comments

1. Cheryl the C.N.A. is not nice and have a bad attitude! Bring negative energy.
2. I prefer not to come back.
3. I would fire everyone, make necessary changes, then have open hiring.
4. Too much noise and lack of privacy, lengthy stay.

CAIS Youth Survey

Annual Report

2017

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

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

Prepared By:
Quality
Improvement
Department

Created 1/29/18

Overview

- In 2017, 182 of the 572 youth (aged 13 years or older) discharged from CAIS completed the CAIS Youth Survey, **yielding a 31.8% response rate.**
- The survey results for 2017 revealed a **decrease** in all five domain categories in comparison to 2016. Over the past five years (please see graph on page 5), the trend lines for Appropriateness of Treatment, Participation of Treatment, and Cultural Sensitivity/Respectful Treatment domains are horizontal (stable) in the range of 77%-80% positive satisfaction. The Access to Services and Patient Outcomes domains have declining trend lines over the past 5 years and have an average range of 66%-68% positive satisfaction.
- Currently, no national averages/benchmarks are publicly available for this survey. The following are *general guidelines* for interpreting the inpatient consumer survey results based on nine years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
 - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
 - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
 - Percentages in the 80 - 89% range can be considered 'high'
 - Percentages 90% and above can be considered 'exceptional'
- The results revealed "Good" positive response scores for 3 of the 5 domains: Cultural Sensitivity/Respectful Treatment (78%), and Appropriateness of Treatment (77%), and Participation in Treatment (76%). Relatively low positive response scores were obtained for the Access to Services (63%) and Patient Outcomes (61%) domains.
- Survey items with the highest positive response scores were:
 - Staff spoke with me in a way that I understood (84%)
 - I participated in my own treatment (84%)
 - I felt I had someone to talk to when I was troubled (82%)
 - Staff respected my family's religious/spiritual beliefs (81%)
 - The people helping me stuck with me no matter what (79%)
 - Staff treated me with respect (79%)
 - I helped to choose my treatment goals (77%)
 - Overall, I am satisfied with the services I received (77%)
- The open ended survey item "Most helpful things you received during your stay" resulted in patients writing comments regarding: caring, respectful staff (24%), staff listening to patient (20%), anger management techniques (13%), treatment received (13%), safe environment (10%), groups (8%), medication received (8%), and coping skills taught (4%).
- The open ended survey item "What would improve the program here" resulted in patients writing comments regarding: better food (47%), more groups and activities (18%), no improvements needed (15%), respectful staff (9%), better communication between staff and patients (5%), and better treatment (5%).

Method

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

Results

The following presents the results of the CAIS Youth Survey completed by consumers of the Child/Adolescent Inpatient Service in 2017. Data from 2013 – 2016 administrations of the survey are also presented in select tables of this report to allow for comparisons.

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

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

In 2017, 182 of the 572 youth (13 years or older) discharged from CAIS completed the CAIS Youth Survey, **yielding a 31.8% response rate.**

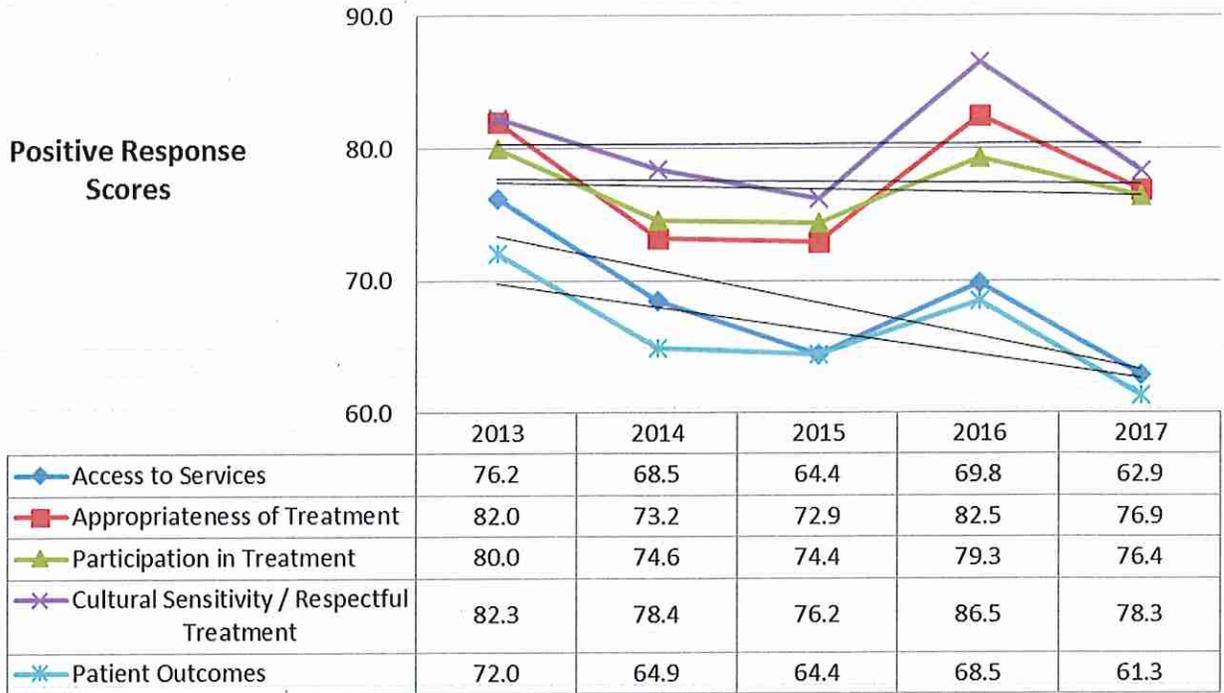
Table 1 presents Child/Adolescent Inpatient Service's consumer positive (agree/strongly agree) responses for 2013 – 2017. In 2017, the results revealed "Good" positive response scores for 3 of the 5 domains: Cultural Sensitivity/Respectful Treatment (78%), and Appropriateness of Treatment (77%), and Participation in Treatment (76%). Relatively low positive response scores were obtained for the Access to Services (63%) and Patient Outcomes (61%) domains.

- The survey results for 2017 revealed a **decrease** in all five domain categories in comparison to 2016. Over the past five years (please see graph on page 5), the trend lines for Appropriateness of Treatment, Participation of Treatment, and Cultural Sensitivity/Respectful Treatment domains are horizontal (stable) in the range of 77%-80% positive satisfaction. The Access to Services and Patient Outcomes domains have declining trend lines over the past 5 years and have an average range of 66%-68% positive satisfaction.

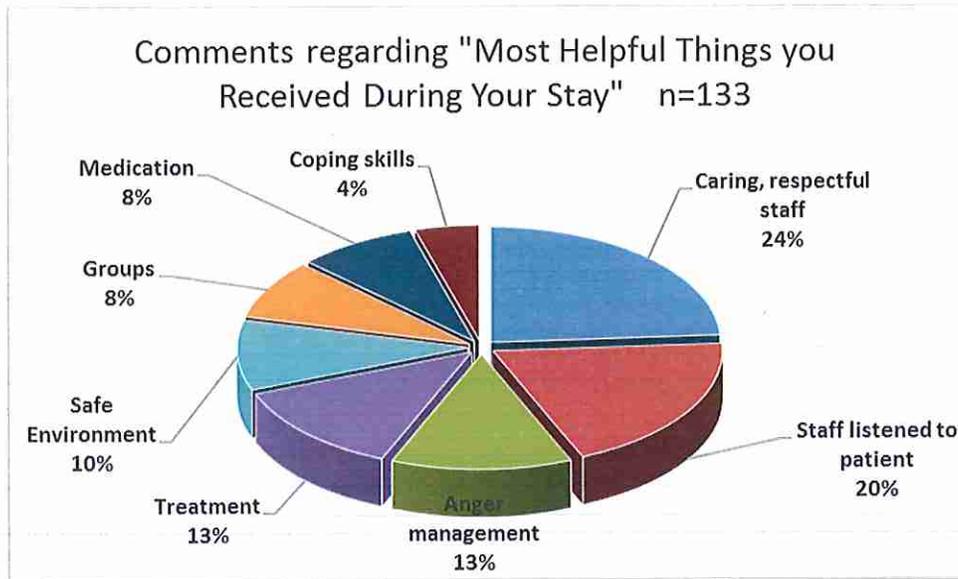
Table 1. 2013-2017 CAIS Youth Survey - Positive Response Rate Summary

Survey Item	Year					2016/2017 Variance
	2013 N = 112	2014 N = 327	2015 N = 618	2016 N = 106	2017 N = 182	
The location of services was convenient	73.4	62.0	61.6	58.7	54.0	-4.7
Services were available at times that were convenient for me	78.9	75.0	67.2	80.8	71.8	-9.0
Total Access to Services	76.2	68.5	64.4	69.8	62.9	-6.9
Overall, I am satisfied with the services I received	80.4	72.8	74.0	82.1	76.8	-5.3
The people helping me stuck with me no matter what	84.8	75.5	71.6	82.1	79.0	-3.1
I felt I had someone to talk to when I was troubled	80.4	74.9	72.6	81.0	81.9	0.9
I received the services that were right for me	83.8	72.6	74.0	84.6	76.4	-8.2
I got the help I wanted	82.9	71.0	72.0	84.0	72.4	-11.6
I got as much help as I needed	79.8	72.6	73.1	81.0	75.1	-5.9
Total Appropriateness of Treatment	82.0	73.2	72.9	82.5	76.9	-5.5
I helped to choose my services	70.3	64.6	65.5	66.7	68.0	1.3
I helped to choose my treatment goals	87.5	79.8	76.6	85.6	77.2	-8.4
I participated in my own treatment	82.1	79.4	81.2	85.6	84.0	-1.6
Total Participation in Treatment	80.0	74.6	74.4	79.3	76.4	-2.9
Staff treated me with respect	85.7	73.6	72.2	81.0	78.9	-2.1
Staff respected my family's religious/spiritual beliefs	75.9	78.5	78.6	88.1	80.9	-7.2
Staff spoke with me in a way that I understood	85.6	84.4	82.2	91.4	84.1	-7.3
Staff were sensitive to my cultural/ethnic background	82.0	77.0	71.9	85.6	69.3	-16.3
Total Cultural Sensitivity / Respectful Treatment	82.3	78.4	76.2	86.5	78.3	-8.2
As a result of the services I received:						
I am better at handling daily life	78.4	69.6	70.9	68.9	70.4	1.5
I get along better with family members	69.4	57.1	60.2	64.2	53.9	-10.3
I get along better with friends and other people	78.0	75.7	70.5	74.3	65.7	-8.6
I am doing better in school and/or work	62.7	59.4	58.8	62.5	53.4	-9.1
I am better able to cope when things go wrong	74.5	69.1	65.1	74.0	65.0	-9.0
I am satisfied with my family life right now	69.1	58.6	60.9	66.7	59.4	-7.3
Total Outcomes	72.0	64.9	64.4	68.4	61.3	-7.1

2013-2017 CAIS Youth Survey Results



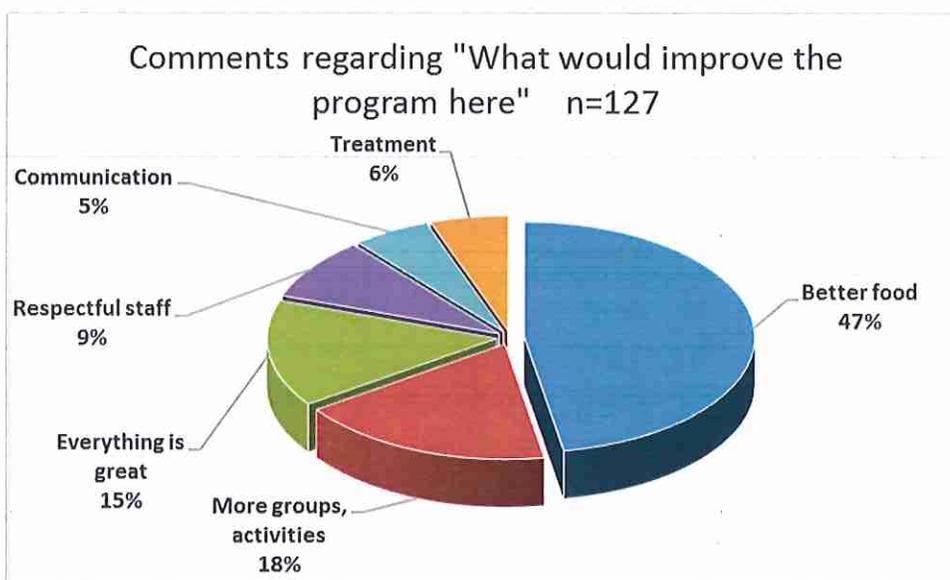
The comments below were written on surveys administered in 2017.



Category	Comments "Most Helpful Things You Received During Your Stay"
<p style="text-align: center;">Anger management</p>	<p>A book on how to manage my anger, and also a stress ball. Advice and ways to deal with my anger. Helped me with my anger. I had people to calm me down when I was angry. The people are nice to talk to. I learned how to control my anger, it helped me a lot cause I used to get angry fast. I learned how to handle my situations better than I did before. I learned when I get irritated just to my room or find someone to talk to. I think it was helpful a lot, they helped me with my anger and they told me that I have a good life ahead of me I shouldn't want to die. Stress ball, books. Food. Stress Ball. Stress ball. A notebook to write in when I'm mad. Take deep breaths. Teaching me to cope with my anger. That they remove me when I get angry. The things that were helpful was calming me down and understand that life is important To learn to stay calm. When I was angry Lisa and James helped me calm down.</p>
<p style="text-align: center;">Caring, Respectful Staff</p>	<p>Gabe and Matt are awesome at their jobs. Help from the nurses. I kind of liked it here. I was sick the first week but now I know that they were really trying to help me. I think that the most helpful things were knowing that people are there for me and care. Also having all these people help me. I would like to thank all those people that had my back and had the help. You've made me a better stronger person. Just the women in green were helpful and were people you could joke with and talk with. Love the staff. Nurse Chrissy and Ashlee helped me the most by helping me stay happy and positive while I stayed. People were nice and understanding. Shout out when you need help, don't just think there is no one. Staff asked me if I was okay! Staff being nice and having friends to talk to. Staff was great to me. Support when feeling unsafe. Support. Thank you a lot. Great experience won't be back! Thank you for your help. Thank you. The most that helped me was the staff because when I was sad they were working with me. The nurses cared and funny and mindful. The staff are very helpful they do their best to help you with your problems so you can get out of here as fast as you can. The staff talking to me and helping me out. The staff treating me/talking to me like I know and understand things. The staff, especially Ms. Freda when I was feeling down she helped me out and assured me everything was going to be ok. There is really nice staff on the unit. What help me most is talking with staff. When certain people talked to me to get the help I need. When I got to talk to the staff. When I was upset some of the staff lifted me up. When Ms. Pat and Jennifer the C.N.A. talked to us about valuing life more. When the staff helped me when I was crying and saying that this was my fault but they said it wasn't. When the staff was telling things about my depression and anger they helped me understand.</p>
<p style="text-align: center;">Coping skills</p>	<p>I learned to handle my situations I'm in and a better way. I learned how to communicate better with people if I'm having problems. Achieving the goals I needed to work on and using coping skills. Coping mechanisms. Coping skills. I learned more coping skills and how to work things out with my problems. I learned some coping skills.</p>

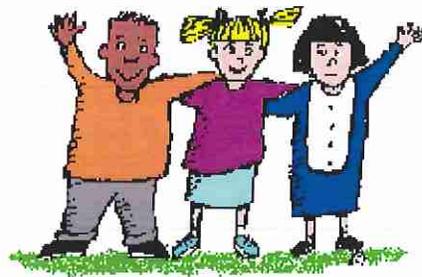
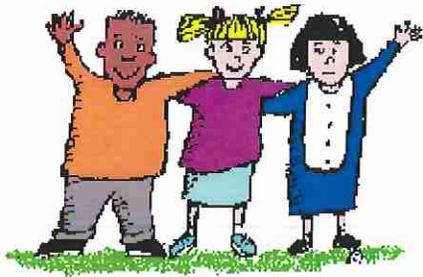
Category	Comments "Most Helpful Things You Received During Your Stay"
Groups	Fight toys, art work. Groups. I participated in groups. Group therapy. Music therapy. O.T. and music groups. OT groups. School at everyone's level, like diverse. School. It was a distraction and kept my mind busy. Schooling, arts and crafts therapy, music therapy, and the just dance game made me smile and happy. The most helpful thing was OT.
Medication	Meds. Meds. I'm sleeping and eating better. Medication. Medicine and nurses. Getting my meds. My meds. Prescription. Taking my meds. The medicine helps a lot. The medication and always having people around. The medication that the doctor prescribed.
Safe environment	Being able to mingle. Being able to talk to someone. Being away for awhile. Being with other kids. I got lots of sleep and read books. I got to get my mind off the bad things. I got to meet people with the same problems. Option to stay in room as much as I wanted and items provided with shower. Overall the program could be peaceful and relaxing Space when I needed it the most. Talking to other children that I didn't know before and knowing that I wasn't judged for anything. The most helpful things were cards which gave me something to do and allowed me to interact. Time to think.
Staff listened to patient	Being able to talk to the nurse (Gabe) He's awesome. Coloring, talking to someone. Communicate working together. Communication and understanding my medical needs. Getting a one on one talk and getting drawings and quotes. Having someone to talk with, positive vibes, respect. How to open up to people. I was able to speak with workers about my problems. I was able to talk to someone when I needed help. Lots of water, people that listen, amazing 1:1's. People talking to me helping me calm down and people respecting me and caring about me. People to talk to and release my emotions. Someone to talk to when I felt down. Someone to talk to, groups, and other kids to talk to. Staff talking to me. Talking about my problems. Talking to people I trust. Talking to staff and workers. Talking to staff when needed. Using my coping skills. Talking to staff. That I was able to talk to someone when I was troubled and able to tell someone that's a professional and understands what I'm going thru. That people took time to talk to me when I'm sad. The fact that I had people to talk to help me with my problems. The talks to help with my disorder. There was always someone to talk to. When people started listening.

Category	Comments "Most Helpful Things You Received During Your Stay"
Treatment	I felt like I needed this so I can learn from my mistakes.
	I think the medicine although I can't detect a change in my actions, I feel happier.
	I think the medicine help a big part of my recovery.
	I'm very glad I experienced this because I feel like a new person.
	It's a good place for kids who tries to kill themselves.
	My problems were respected and approached carefully, nothing was forced upon me, allowing willful treatment.
	That everyday staff/psychiatrists would check in to make sure I was okay/feeling better.
	The conversations with doctors and therapy groups.
	The most helpful things I received is what I suppose to do and not to do.
	The most helpful things in this program was the therapists talking to me helping me open up a little more.
	The right kind of treatment I needed along with help I need.
	Therapy.
	They give me helpful advice and was there when I felt down.
	They helped me with what I needed help with.
They talk to me about my problems and they really understood me and if I needed help with anything I got it.	
Things they taught me.	
Told me stay focused on the positive so I can get out the hospital	



Category	Comments "What would improve the program here"
Better food	Better food and help more with coping skills instead of school.
	Better food and like more time talking to the people about problems we are having and to also have groups where we talk about things to make us better.
	Better food. (x44)
	Better food. Didn't get vegetarian food until my 3rd day.
	Better food. More groups and freedom, etc.
	Better food. More things to do on the weekend. (x4)
	Food, and letting us wear our own clothes we are comfortable with.
	I think that the food needs lots of improvement and we all should stay in one class and the staff that isn't in a bad mood.
	I think the food can improve the program but other than that this place is in a good position.
	If they had better food and if it was so cold.
	The food and staff behavior towards patients. (x3)
	They just need better food more school time here.

Category	Comments "What would improve the program here"
Communication	<p>Communicating. Improve the way your staff communications. OT and groups should allow optioned activities for all to participate and strengthen People listen more. Prep talks. The hallways being quieter at night. We should be able to talk to the therapist more.</p>
Everything is great	<p>Everything was ok. I don't think there's anything to improve. I enjoyed my time here. Thank you. No improvements, great patient service. Nothing but stay positive and be happy. Nothing everything was good. Nothing I think the program is great, especially Mrs. Ayanna and Mr. Terry. Nothing it is perfect. Nothing keep it the way it is. Nothing, It was really good here. Nothing, very good service. Nothing. I think its fine the way it is. Nothing. (x8)</p>
More groups, activities	<p>A gymnasium. (x2) Allow more programs. For me I would have liked to be outside more. Groups that helped patients needs. Gym to run around. Having a gym so we can play basketball and other fun things. Letting us bring crayons in our room and color because it is more safer. People should have sound machines at night when they here voices and one scared and feel alone. More activities. (x4) More fun things , more positive and things. Better movies. More groups, to talk and get minds off of things. More groups. (x4) More hand on hand or more helping or coloring. More outside time and the food here. More outside time. The program needs more active things to do here. Writing groups and food getting better.</p>
Respectful staff	<p>Better people. Better staff. Help staff enjoy working here. I guess fire Linda! Her job is to be a nurse not my mom. My mother calls herself our old lady and when I mentioned "my old lady" she started yelling saying you wonder why your mom doesn't like you; even after I explained my mom calls herself that. What Linda said hurt my feelings. Making people feel more comfortable. New Staff (CNA's) Nurses are rude disrespectful Patience with the patient in class and better respect toward patients. Some of the staff be too focused on other stuff things personal. Staff that know what they're doing. They should know the schedule and rules. The staff needs to be more respectful and they violated rights. Try to understand what the patient is going through.</p>
Treatment	<p>Getting people out on weekends. Have a more personalized treatment plan for everyone because everyone is different. More 1 - 1. More one on one therapy. More therapy during regular hours and less school. More things geared toward helping us emotionally. More watch over kids to help them.</p>



CAIS YOUTH SURVEY

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

Today's Date: ____ / ____ / ____

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

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

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

23. What would improve the program here? _____

24. Other comments: _____

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

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

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

Age: _____ years old

Gender (mark with X): Male Female



Quality Committee Item 8

POLICY & PROCEDURE STATUS REPORT -GOAL=90%

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
September	1	6	3
October	1	11	9
November	3	20	0
December	10	46	7
January	3	42	5

Overall Progress 93.7% as of February 1, 2018

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	429	460	87.0%	93.7%
Up to 1 year Overdue	39	19	7.9%	3.9%
More than 1 year and up to 3 years overdue	5	4	1.0%	0.8%
More than 3 years and up to 5 years overdue	2	2	0.4%	0.4%
More than 5 years and up to 10 years overdue	6	0	1.2%	0%
More than 10 years overdue	12	6	2.4%	1.2%
Total	492	491	100%	100%

Forcast Due for Review	
Past Due Policies - 31	June - 0
Coming Due Policies	July - 5
February - 1	August - 3
March - 2	September - 1
April - 1	October - 1
May - 14	November - 5
	December - 7

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

DATE: March 21, 2018

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

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

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

Background

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

Discussion

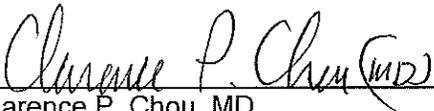
From the President of the Medical Staff Organization and Chair of the Medical Executive Committee presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C¹:

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

Recommendation

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

Respectfully Submitted,



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

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

Attachments

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
MARCH / APRIL 2018**

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

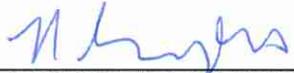
INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 14, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 21, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Betsy Bittman, MD	General Psychiatry	Affiliate/ Provisional		Dr. Zincke recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
Amanda Delaney, MD	Psychiatric Officer and Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
Amanda Liewen, MD	Psychiatric Officer and Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
Vuong Vu, MD	Psychiatric Officer and Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD							

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 14, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 21, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NONE THIS PERIOD							

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 14, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 21, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<i>The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.</i>							
MEDICAL STAFF							
Jeremy Chapman, MD	Psychiatric Officer and Medical Officer of the Day	Affiliate/ Provisional	Affiliate / Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Claire Drom, MD	Psychiatric Officer and Medical Officer of the Day	Affiliate/ Provisional	Affiliate / Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Noah Jeannette, DO	General Psychiatry	Active/ Provisional	Active / Full	Dr. Zincke recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 14, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 21, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<i>The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.</i>							
Sarah Slocum, MD	Psychiatric Officer and Medical Officer of the Day	Affiliate/ Provisional	Affiliate / Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
James Stevens, MD	General Psychiatry	Affiliate/ Provisional	Affiliate / Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Miriam Tanja Zincke, MD	General Psychiatry	Active/ Provisional	Active / Full	Dr. Schneider recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
ALLIED HEALTH							
Jenta Alexander, MSN	Advanced Practice Nursing-Family Practice	Allied Health/ Provisional	Allied Health / Full	Dr. Puls recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	SERVICE CHIEF* RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 14, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 21, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NONE THIS PERIOD							


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

3/21/2018
 DATE


 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

3/21/18
 DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

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

 GOVERNING BOARD CHAIRPERSON

 DATE

BOARD ACTION DATE: APRIL 26, 2018