

Chairperson: Kimberly Walker
Vice-Chairman: Peter Carlson
Secretary: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, August 27, 2015 - 8:00 A.M.
Milwaukee County Mental Health Complex Auditorium

MINUTES

PRESENT: Peter Carlson, Robert Chayer, Ronald Diamond, Rochelle Landingham, Jon Lehrmann, Thomas, Lutzow, Lyn Malofsky, Jeffrey Miller, Mary Neubauer, Maria Perez, Duncan Shrout, Kimberly Walker, and Brenda Wesley

SCHEDULED ITEMS:

- | | |
|----|--|
| 1. | <p>Welcome.</p> <p>Madame Chair opened the meeting by greeting the Board and the audience.</p> <p><i>The Board took no action regarding this item.</i></p> |
| 2. | <p>Appearance from the County Executive.</p> <p>APPEARANCE:
 County Executive Abele, Milwaukee County Executive's Office</p> <p>County Executive Able provided remarks expressing his gratitude and thanked the Board for their willingness to serve in such an important capacity, which is to improve the lives of citizens with mental illness that the Milwaukee County Behavioral Health Division serves. He clarified what the charge and focus of the Board should be and spoke to his overall County Budget.</p> <p><i>The Board took no action regarding this informational item.</i></p> |
| 3. | <p>Approval of the Minutes from the July 9, 2015, Milwaukee County Mental Health Board Meeting.</p> <p>The minutes from the July 9, 2015, meeting were reviewed.</p> <p>MOTION BY: (Malofsky) <i>Approve the Minutes from the April 23, 2015, Milwaukee County Mental Health Board Meeting. 10-0-1</i></p> <p>MOTION 2ND BY: (Carlson)</p> <p>AYES: Carlson, Chayer, Landingham, Lutzow, Malofsky, Miller, Neubauer, Perez, Walker, and Wesley - 10</p> |

SCHEDULED ITEMS (CONTINUED):

	<p>NOES: 0 ABSTENTIONS: Shrout - 1</p> <p style="text-align: center;">A voice vote was taken on this item.</p>
4.	<p>Annual Review and Presentation of the Role of a Governing Board.</p> <p>APPEARANCE: Katie Pritchard, PhD, IMPACT Planning Council</p> <p>Ms. Pritchard provided a PowerPoint presentation to the Board titled “A Closer Look at Effective Boards.” She discussed the standards for board operation; the rules of order; provided tips on how to address confusion, tension, and difference of opinions; and reviewed the characteristics and skill sets of an effective board.</p> <p><i>The Board took no action regarding this informational item.</i></p>
5.	<p>New Behavioral Health Division Facility Committee and Consultants Update.</p> <p>APPEARANCES: Patricia Schroeder, Administrator, Behavioral Health Division, Department of Health and Human Services Teig Whaley-Smith, Director, Department of Administrative Services Frank Pitts, Architects Plus</p> <p>Ms. Schroeder indicated August’s report represents a full year’s work and analysis. She provided an overview of the Facility Committee’s overall work and plan for a new space.</p> <p>Mr. Whaley-Smith explained a mid-stream change in the implementation model, which now includes Acute Services and the North and South Side Hubs. He indicated work continues on the space program and discussed program statements.</p> <p>Mr. Pitts provided information on the study done by Architects Plus stating it was focused on what the County’s needs would be if it were to replace the existing hospital’s inpatient facilities on the basis of current and future bed utilization patterns. He discussed overall program spacing providing different bed count scenarios broken down by area.</p> <p>Questions and comments ensued.</p> <p><i>The Board took no action regarding this informational item.</i></p>
6.	<p>Update, Support, and Optimization of Electronic Medical Records.</p> <p>APPEARANCES: Laurie Panella, Chief Information Officer, Information Management Services Division (IMSD), Department of Administrative Services</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Patricia Schroeder, Administrator, Behavioral Health Division, Department of Health and Human Services</p> <p>Ms. Panella stated it is anticipated that the last phase of the Electronic Medical Records (EMR) system will be implemented by September 1, 2015. Support services, as well as optimization, will be ongoing. The contract amendment addresses the implementation and ongoing support services needed.</p> <p>Ms. Schroeder provided a brief history on Avatar, and explained the Administration, clinical teams, IMSD, and NetSmart have been working closely together on this project. She stated the community component to the system has been initiated. The work is challenging but important.</p> <p>Questions and comments ensued.</p> <p>Board Member Perez requested the Board be provided with screenshots of Avatar.</p> <p>Board Member Neubauer requested the Board be provided with a report that reflects where the amendment money, if approved, is being spent, as well as accomplishments achieved as a result.</p> <p>MOTION BY: (Miller) <i>Approve the Professional Services Contract Amendment with the Joxel Group, LLC, for Implementation and Support Services for the Electronic Medical Records System. 11-0</i></p> <p>MOTION 2ND BY: (Shrout)</p> <p>AYES: Carlson, Chayer, Landingham, Lutzow, Malofsky, Miller, Neubauer, Perez, Shrout, Walker, and Wesley - 11</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p style="text-align: center;">A voice vote was taken on this item.</p>
7.	<p>Reconsideration of Salary and Personnel Policies Decision Making.</p> <p>APPEARANCE: Colleen Foley, Deputy, Corporation Counsel</p> <p>Chairwoman Walker stated Board members requested this item be brought back before the Board for reconsideration. She reviewed the previous actions taken by the Board pertaining to this item and referred to the letter written by State Representative Joe Sanfelippo that clearly states what his intent was when drafting Act 203.</p> <p>Discussion ensued.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Shrout) <i>The Mental Health Board Elects Not to Review the Salary and Personnel Policies of the County Department of Community Programs. 7-4</i></p> <p>MOTION 2ND BY: (Miller)</p> <p>AYES: Carlson, Chayer, Lutzow, Miller, Perez, Shrout, and Walker - 7</p> <p>NOES: Landingham, Malofsky, Neubauer, and Wesley - 4</p> <p>ABSTENTIONS: 0</p> <p style="text-align: center;">A voice vote was taken on this item.</p> <p style="text-align: center;">The Board took a break after Item 7 at 10:15 a.m. and reconvened at approximately 10:30 a.m. The roll was taken and all Board Members were present.</p>
8.	<p>Administrative Update.</p> <p>APPEARANCES: Patricia Schroeder, Administrator, Behavioral Health Division, Department of Health and Human Services Colleen Foley, Deputy, Corporation Counsel</p> <p>Ms. Schroeder began her report by showing the employee video “Making a Difference at the Milwaukee County Behavioral Health Division (BHD).” Highlights were provided of key activities and issues related to BHD operations, which include the release of the Request for Proposals (RFP) for the delivery of Acute Services, North Side community location update, and closure of the 9201 building.</p> <p>Ms. Schroeder stated the Audit Division will be conducting an audit of BHD. She stated in March 2015, the Milwaukee County Board of Supervisors Committee on Health and Human Needs passed a resolution directing the Audit Division of the Comptroller’s Office to conduct a follow-up five-year audit to the BHD audit conducted in 2010.</p> <p>Ms. Foley explained the statute and the statutory authority that applies to the Comptroller’s Office ability to conduct audits County-wide, inclusive of BHD.</p> <p>Mr. Lutzow requested the Board be provided with a report that addresses the concerns raised in the Deloitte report. Ms. Schroeder indicated that an analysis will be brought before the Committee for the October Board meeting.</p> <p>Chairwoman Walker raised the possibility of a Special Board meeting in November related to the Acute Services RFP process.</p> <p>Board Member Neubauer requested that the Audit Division be invited to a Board meeting to present the results once the BHD audit is completed.</p> <p><i>The Board took no action regarding this informational item.</i></p>

SCHEDULED ITEMS (CONTINUED):

9.	<p>2016 Mental Health Board Meeting Dates and Recommendation for 2016 Board Meetings Location.</p> <p>APPEARANCE: Patricia Schroeder, Administrator, Behavioral Health Division, Department of Health and Human Services</p> <p>Ms. Schroeder stated locations for 2016 Board meetings are still being vetted. A tour was taken of the Hubbard Park Pavilion, which would provide the needed capacity; however, the facility does not have audio/visual capabilities. It still may be an option. Tours are being scheduled of other Parks facilities. Ms. Schroeder indicated she would keep the Board informed.</p> <p>Discussion was held amongst Board Members regarding the proposed 2016 meeting schedule. The consensus was to add two additional meetings to the year's schedule. The additional meetings will be held on March 24, 2016, and September 16, 2016.</p> <p>MOTION BY: <i>(Neubauer) Approve the 2016 Mental Health Board and Committee Meeting Schedule as Revised. 11-0</i></p> <p>MOTION 2ND BY: <i>(Shrout)</i></p> <p>AYES: Carlson, Chayer, Landingham, Lutzow, Malofsky, Miller, Neubauer, Perez, Shrout, Walker, and Wesley - 11</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p style="text-align: center;">A voice vote was taken on this item.</p>
10.	<p>Comprehensive Community Services Update.</p> <p>APPEARANCE: Amy Lorenz, Director, Community Access to Recovery Services (CARS), Behavioral Health Division, Department of Health and Human Services</p> <p>Ms. Lorenz discussed enrollment progress, new Care Coordination Agencies and how the Branch Offices are diligently trying to hire and increase their workforce, the Ancillary Service Provider Network, and CARS' collaboration with Wraparound Milwaukee and the Disability Services Division to enroll children and adolescents into the Comprehensive Community Services (CCS) benefit. Ms. Lorenz also touched upon the restructuring of CARS and the need for more resources. She stated an Administrative Coordinator position was added and is solely dedicated to CCS.</p> <p>Board Member Lehrman requested the Outpatient Capacity Analysis, once complete, be brought forth to the Board for discussion.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Madame Chair requested Rob Henken of the Public Policy Forum be invited to a Board meeting to present their report on Community Resources Available for the Uninsured/Underinsured.</p> <p>Questions and comments ensued.</p> <p><i>The Board took no action regarding this informational item.</i></p>
11.	<p>Milwaukee Co-Occurring Competency Cadre (MC3) Update and Presentation.</p> <p>APPEARANCES: Sue Clark, Vital Voices John Hyatt, IMPACT</p> <p>Ms. Clark provided an MC3 presentation on who and what MC3 is; their challenge, mission, and goals; change agents, where MC3 is headed, and their results.</p> <p>Mr. Hyatt explained MC3's core values.</p> <p>Questions and comments ensued.</p> <p><i>The Board took no action regarding this informational item.</i></p>
12.	<p>Distribution of Medications Under the New Pharmaceutical Contract.</p> <p>APPEARANCE: Dr. John Schneider, Chief Medical Officer, Behavioral Health Division (BHD), Department of Health and Human Services</p> <p>Dr. Schneider provided the Board with the history behind BHD's pharmacy. He explained today, discounts are given to health systems to get medications cheaper, which allows money to be spent more wisely. There are, however, limitations. BHD does not give medications to patients at the point of discharge unless they are indigent. If they have insurance, they will go to their local pharmacy.</p> <p>Questions and comments ensued.</p> <p><i>The Board took no action regarding this informational item.</i></p>

SCHEDULED ITEMS (CONTINUED):

Pursuant to Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as they relate to the following matter(s):

13. Medical Executive Report and Credentialing and Privileging Recommendations.

APPEARANCE:

Dr. Clarence Chou, President, Medical Staff Organization, Behavioral Health Division (BHD), Department of Health and Human Services (DHHS)

MOTION BY: *(Carlson) Adjourn into closed session under the provisions of Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item #13. At the conclusion of the Closed Session, the Board may reconvene in open session to take whatever action(s) it may deem necessary on the aforesaid item. 10-0*

MOTION 2ND BY: *(Chayer)*

AYES: Carlson, Chayer, Landingham, Malofsky, Miller, Neubauer, Perez, Shrout, Walker, and Wesley - 10

NOES: 0

ABSTENTIONS: 0

EXCUSED: Lutzow - 1

A voice vote was taken on this item.

The Committee convened into Closed Session at 12:17 p.m. and reconvened back into open session at approximately 12:35 p.m. The roll was taken, and all Board Members were present except for Board Member Lutzow, who was excused.

MOTION BY: *(Neubauer) Approve the Medical Staff Credentialing Report and Executive Committee Recommendations. 10-0*

MOTION 2ND BY: *(Miller)*

AYES: Carlson, Chayer, Landingham, Malofsky, Miller, Neubauer, Perez, Shrout, Walker, and Wesley - 10

NOES: 0

ABSTENTIONS: 0

EXCUSED: Lutzow - 1

A voice vote was taken on this item.

SCHEDULED ITEMS (CONTINUED):

14.	<p>Adjournment.</p> <p>MOTION BY: (Neubauer) Adjourn. 10-0 MOTION 2ND BY: (Chayer) AYES: Carlson, Chayer, Landingham, Malofsky, Miller, Neubauer, Perez, Shrou, Walker, and Wesley - 10 NOES: 0 ABSTENTIONS: 0 EXCUSED: Lutzow - 1</p> <p style="text-align: center;">A voice vote was taken on this item.</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: 8:05 a.m. to 12:42 p.m.</p> <p>Adjourned,</p> <p><i>Jodi Mapp</i> Senior Executive Assistant Milwaukee County Mental Health Board</p>	
<p>The next meeting for the Milwaukee County Mental Health Board will be on Thursday, October 22, 2015, @ 8:00 a.m.</p>	

The August 27, 2015, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.

Dr. Robert Chayer, Secretary
Milwaukee County Mental Health Board

Mental Health Board
RFP Status Change Announcement

Dear Mental Health Board Members

I am reaching out today with news about our Acute Care Services RFP. With backing from the Director of the Department of Health and Human Services, the County Executive, and the distinguished panel of experts convened for the RFP process, BHD's leadership team has decided to suspend the RFP.

The process established a high bar from the start. Our patients deserve no less. We committed to selecting an acute care provider with a proven track record of experience delivering the model of care our patients need. This included a person-centered, trauma-informed, recovery-oriented approach that closely engaged community-based programs in very high quality care to help patients heal. These are key qualifications that we knew from the start must be met.

Each provider who demonstrated interest in submitting a proposal had a very strong track record and solid reputation. However, the depth of their experience delivering care with the recovery-oriented philosophies our mental health redesign envisions was limited. We knew this was a possibility. Our leadership made the decision to suspend the RFP only after lengthy discussions and a comprehensive review by our distinguished panel of experts. We weighed the option of letting the process continue, but based on the facts and the time involved, this did not make sense. The panel of experts unanimously approved our recommendation.

As a county, as a community of caregivers, we are deeply committed to transforming our mental healthcare system and providing the high quality, compassionate care we know patients need to heal. It has taken Milwaukee County decades to get to this point, so we have to get it right. The RFP process was important to go through, it enabled us to invite organizations across the nation to the table. Now, we must work together to identify the ideal next step. I am confident we can do this.

I want to personally thank you for your continued commitment to the Milwaukee County Mental Health board and this transformative process. We will discuss next steps at the October 22, 2015 meeting of the full board. Please reach out to me with any questions. We will be sharing this news with our employees today.

Thank you,



Patricia Schroeder, RN, MSN, MBA, FAAN
Administrator
Behavioral Health Division

Options for Future Acute Services and Facility for Milwaukee County Behavioral Health Division

Option A:

Open a Request for Proposals (RFP) for operating acute services to include psychiatric emergency department, observation beds, acute inpatient for adults and for children and adolescents. Must include the development/ownership of an acute care facility.

This option was completed and did not produce results that met with expectations.

Options B,C,D and more

Work with regional private health care systems in the ownership and operations of all (and potentially parts, with different models for each) of the following:

Psychiatric Emergency Department with Observation Beds

Acute inpatient services for adults

Acute inpatient services for children and adolescents

Provision of acute care facility(ies)

There is community need for a Chapter 55 unit, as well as consideration of a Medical-psychiatric intensive care unit, beyond the current delivery systems.

There is community need for additional community based services, and support for a continuum of care from all providers.

These options require a timeline that fits with pressing operational and facility considerations.

Option E

Identify a national entity willing and capable of owning and operating acute services as described above along with the development/ownership of an acute care facility. Negotiate a "sole source" contract. This option requires a timeline that fits with pressing operational and facility considerations.

COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

Date: October 5, 2015

To: Kimberly Walker, Chairperson - Mental Health Board

From: Hector Colon, Director, Department of Health and Human Services
Patricia Schroeder, Administrator, Behavioral Health Division
Laurie Panella, CIO, Information Management Services Division
Prepared by Matt Krueger, IMSD Project Manager

Subject: **Informational Report – Avatar Electronic Medical Record System Implementation**

Issue

This informational report is a high-level summary of Exhibit A, (EMR Timeline & Milestones) that displays timeline, milestones, challenges and costs associated with the Milwaukee County Behavioral Health Department's (BHD) installation of the Electronic Medical Record (EMR), Avatar (and associated modules).

Exhibit A Overview

Exhibit A: initiates in 2010. In August 2010, the discovery process for an electronic medical record was launched by documenting process flows and technical requirements...

In 2011, efforts focused on understanding BHD's needs, soliciting proposals and engaging in the vetting process. Out of thirteen vendors who responded to the County's Request for Proposals (RFP) for an Electronic Medical Record (EMR) system, the top three were vendors were selected for an interview. After presentations and further evaluation, Netsmart's Avatar EMR was selected by the cross-functional committee.

In 2012, Avatar went live in the Psychiatric Crisis Services (PCS), the Observation Unit (OBS) and Access Clinic. The project entailed documentation of clinical and administrative processes including "converting" patient and financial records from CMHC the previous system to Avatar. Various other capabilities were added throughout the year to enable additional functionality. Unfortunately, at this time BHD lacked sufficient technical and clinical resources to fully and properly redesign work flows which *is a key element of successful EMR implementations*. Additionally, certain aspects of Avatar were deemed not to meet BHD's requirements and were therefore not implemented (1). As a result, EMR functionality is sub-optimal affecting a number of clinical operating units, (requiring paper forms as supplementation to the electronic record in many key areas).

In 2013 Acute, Crisis Stabilization and Crisis Mobile were implemented in Avatar again without work flow redesign. In August, Computer Physician Order Entry (CPOE) and Electronic Medication Administration Record (eMAR) were implemented for PCS, OBS and Access Clinic. Acute and Crisis Stabilization would go live with CPOE/eMar in October. eMAR lacked "best practice" process flows (until recently when the closed-loop medication administration system was implemented- see below).

In 2014, Avatar contained a full year of data thus, fiscal and management reporting was consolidated in Avatar in the first quarter. The work to plan the Community Services Branch consisting of 20 levels of care, 65 agencies and over 200 locations/sites was initiated. Documentation of all clinical and administrative process flows was undertaken. The initial documentation process followed previous patterns.

Late in 2014 through the first quarter of 2015 BHD placed greater scrutiny and began to critically assess the clinical processes in Acute, PCS and OBS. A number of interviews were conducted with clinical and administrative staff which lead to Netsmart (1) producing a Health Check Document, including a list of areas to focus resources and workflow redesign. The list was prioritized to include the following:

Early this year a direct network link was established to Netsmart's server improving network connectivity and stability in Avatar and grew the "size of the pipe" information could flow through.

Complete workflow re-design for the community go live (phase III) was in full swing by mid-June. Additionally, the International Classification of Diseases, Tenth Edition (ICD-10) was implemented. A new pharmacy vendor was identified and pharmacy systems implemented to include the management of pharmacy inventory, adding RxConnect (an Avatar module) and upgrading and expanding the number of Pyxis (medication dispensing) machine, scanning protocols, resulting in the deployment of a closed-loop medication management system. The scanning protocol that matches patient ID to medication greatly improved patient safety.

In late July PCS was upgraded to allow multiple episodes to be open simultaneously, improving the patient experience and streamlining process including major changes to the patient/client registration process which was centralized to standardize data capture and minimize duplicative medical records.

Live training for community providers was initiated in late July and continued into September. Data conversion from CMHC to Avatar was successfully completed in late September. Avatar/Provider Connect went live on October 1, 2015 without incident. In addition, the central registration model was deployed on October 1 for all community providers in order to improve the patient experience and streamlining processes.

At this juncture, phases 1-3 of EMR implementation can be considered completed. The remainder of 2015 and into the first quarter of 2016, the focus will be on maintenance and optimization of the new workflows as well as addressing the remaining areas requiring re-design. As requirements and processes evolve, there is an on-going need to re-test hypotheses, adopt new modules (providing greater capabilities), continually stress test the system, and evolve it. BHD will also prioritize the implementation of other needed Avatar modules and continue to enhance current systems.

Exhibit B Overview

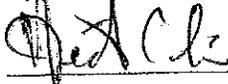
Per the Board's request, Exhibit B is a series of screen shots taken from Avatar. Avatar supports a number of critical processes. One of these involves medication ordering and the process through administration. Exhibit B shows screen shots associated with the various steps in the medication process from ordering to administration.

- (1) Examples are Treatment Plan and Medicine Reconciliation.
- (2) Netsmart's "Health Check" is a formal review of Avatar system set up and conformance to best practices.

Recommendation

The Director of the Department of Health and Human Services, the Administrator of the Behavioral Health Division and the Chief Information Officer of the Information Management Services Division, respectfully request this report be placed on file.

Approved By:



Hector Colon, Director
Department of Health and
Human Services

Approved By:



Patricia Schroeder, Administrator
Behavioral Health Division

Approved By:

Laurie Panella, CIO
IMSD

cc: Chris Abele, County Executive
Raisa Koltun, Chief of Staff, County Executive's Office
Teig Whaley-Smith, Director, Department of Administrative Services
Jeanne Dorff, Deputy Director, Department of Health and Human Services
Randy Oleszak, Fiscal Administrator, DHHS/BHD
Alicia Modjeska, Chief Administrative Officer - BHD
Jodi Mapp, Senior Executive Administrative Assistant - BHD
Clare O'Brien, Fiscal and Budget Manager, DAS Central Business Office

Medication Process (From ordering through administration)

The screenshot shows a web-based medical application interface. At the top, there is a navigation bar with 'Home', a user profile for 'Brookfield W', and utility links like 'Preferences', 'Lock', 'Sign Out', 'Switch', 'Help', and 'IPPSYCHI'. Below this, a header section displays the patient's name 'BROOKFIELD WISCONSIN (008149377)', gender 'F', and age '40, 03/02/1975'. A 'Client Profile / Physicians Orders' tab is active, and a sidebar on the left contains a menu with 'Client Profile', 'Create Order' (highlighted with a red box), 'Renew/DC/Val.', 'View/Change', 'Order Notes', and 'Hold/Resume'. The main content area is titled 'Client Profile / Physicians Orders' and contains several sections: 'Order Entry Source' (set to 'Computer Entry'), 'Delayed Entry' (checkbox), 'New Order Will Be For Episode' (set to 'Episode # 3'), and 'Order Category' (radio buttons for 'History-Only Order', 'Leave Order', 'Discharge Order', and 'Other Order'). A 'Clear New Order Information' button is also present. Below these, a note states 'For direct entry of individual orders, go to Page 2.' There are two main options: 'Create New Order From Order Group' and 'Create New Order From Existing Order (Copy)'. The 'Create New Order From Existing Order (Copy)' section includes a 'Display Order List / Select Order(s) to Copy' button and a note: 'Note: The subset of orders displayed in the Order List is determined by the filtering criteria specified on the Client Profile tab.' At the bottom, there is a 'Latest Diagnosis Information' section with a scrollable text area and a checkbox for 'Check here if entering a banner or titration series of orders'.

Physician creates order from the CPOE screen.

Rx Summary Patient Profile Favorites Reports/Labels Order Tracking Drug Master Configuration Enterprise Help Logout

Rx Summary Hospital MilwaukeeTEST User YancySuber Access Pharmacist1 Rep Book Expired 1248 alerts, 233 pending, 0 DC MSG COM BLG WS

Pending Unvalidated Soft Stop Hard Stop Low Inventory Alerts Unit Dose NCPDP Responses Refresh

Summary
Stat: 20, ASAP: 0, Routine: 213, Discharge: 0, Leave: 0

Status	Priority	Type	Patient Name	Start	DC	Description	Quantity	Max Quantity	Route ID	Route Text	Frequency	Times
Locked	R	N	WISCONSIN, MILWAUKEE	2015/08/27 12:19		AMITRIPTYLINE HYDR	1 tablet	--	PO	ORAL	Q2HR	
	R	N	WISCONSIN, BROOKFIELD	2015/09/29 17:14		CITALOPRAM HYDROBF	20 MG	--	PO	ORAL	ACD	1800
	R	N	TWO, PATIENT	2015/08/03 13:26		AGGRENOX (ASPIRIN-E	25 mg	--	PO	ORAL	Once	2000
	S	N	TWILIGHTIII, BELLA	2015/06/10 11:06		VALIUM (DIAZEPAM) (	10 mg	--	PO	ORAL	STAT	
	R	N	TWILIGHTIII, BELLA	2015/06/04 11:31		AMBIEN (ZOLPIDEM T	10 MG	--	PO	ORAL	QHSPRN	
	R	N	TWILIGHTIII, BELLA	2015/06/04 11:32		REMERON (MIRTAZAP	15 MG	--	PO	ORAL	QHSPRN	
	R	N	TWILIGHTIII, BELLA	2015/06/04 11:52		CATAPRES (CLONIDINE	0.1 mg	--	PO	ORAL	Q8H	0500,1300
	R	N	TWILIGHTIII, BELLA	2015/06/04 13:47		HALOPERIDOL (5 MG)	5 MG	--	PO	ORAL	Q1HPRN	
	R	N	TWILIGHTIII, BELLA	2015/06/06 11:55		ASPIRIN (325 MG)	325 mg	--	PO	ORAL	Daily	0800
	R	N	TWILIGHTIII, BELLA	2015/06/08 11:45		CIPRO (CIPROFLOXACI	250 mg	--	PO	ORAL	BID	0800,2000
	R	N	TWILIGHTIII, BELLA	2015/06/08 12:40		ZEBETA (BISOPROLOL	10 mg	--	PO	ORAL	Daily	0800
	R	N	TWILIGHTIII, BELLA	2015/06/08 13:03		BISOPROLOL FUMARAT	10 mg	--	PO	ORAL	Daily	0800
	R	N	TWILIGHTIII, BELLA	2015/06/08 14:29		AMITIZA (LUBIPROST	24 mcg	--	PO	ORAL	Q2HPRN	
	R	N	TWILIGHTIII, BELLA	2015/06/08 14:30		CLARITHROMYCIN (500	500 mg	--	PO	ORAL	Q2HPRN	
	R	N	TWILIGHTIII, BELLA	2015/06/08 14:31		CEFUROXIME AXETIL (	500 mg	--	PO	ORAL	Q2HPRN	
	R	N	TWILIGHTIII, BELLA	2015/06/11 10:51		HUMALOG MIX 75/25 (I	1 ml	--	SC	SUBCUTANE	3XW	
	R	N	TWILIGHTIII, BELLA	2015/06/11 10:52		VALIUM (DIAZEPAM) (	10 mg	--	PO	ORAL	3XW	
	R	N	TWILIGHTIII, BELLA	2015/06/11 10:58		RISPERDAL (RISPERID	1 mg	--	PO	ORAL	3XW	
	R	N	TWILIGHTIII, BELLA	2015/06/17 13:33		VALIUM (DIAZEPAM) (	10 mg	--	PO	ORAL	Daily	0800
	S	N	TWILIGHTII, BELLA	2015/06/09 14:11	Y	DEPAKOTE (DIVALPRO	500 mg	--	PO	ORAL	Once	
	R	N	TWILIGHTII, BELLA	2015/06/17 13:28		VALIUM (DIAZEPAM) (	10 mg	--	PO	ORAL	Daily	0800
Locked	R	N	TWILIGHT, BELLA	2015/05/15 13:15	Y	VALIUM (DIAZEPAM) (	10	--	PO	ORAL	Q3H	0000,0300
	R	N	TWILIGHT, BELLA	2015/06/23 19:17		VALIUM (DIAZEPAM) (	10 mg	--	PO	ORAL	Daily	0800
	R	N	TRITON, ARIEL	2015/07/09 13:20		RISPERDAL (RISPERID	1 tablet	--	PO	ORAL	Q4HPRN	

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Physician's order shows in RXConnect for pharmacy staff review and validation.

Avatar eMAR

Avatar eMAR

My Nursing Caseload Only Unit (000003) 43... Administration Date 09/29/2015 Time Through

Order Type

- Pharmacy
- Lab
- Food Service
- Nursing/Clinical
- Diagnostics

Group Orders By Order Type Show Hidden Orders
 Disable Flyovers Medications/Treatments **Show All**
 Enable multiple administration selection Display Only Items I can Administer

All Orders Missed Administrations Administrations Due Now

Client WISCONSIN, BROOKFIELD (8149... Episode Episode# 3 Admit 09/29/... Med ID Loc 000003 Room

Administer

Online Documentation

Latest Client Information and Allergies

Facility Chart#: N/A

Gender: Female DOB: 03/02/1975

Att. Practitioner: NOT ASSIGNED, PCS (999999) (Ep. 3 - 1)

Ht: N/A Wt: N/A

All Orders Routine Orders PRN Orders Other / STAT Orders Notes

Order Description	Fri 09/25	Sat 09/26	Sun 09/27	Mon 09/28	Tue 09/29
Acknowledgement Required CITALOPRAM HBR 20 MG et CeleXA 20 MG Oral Tablet Give: 20 mg = 1 Tablet Before dinner Start: 09/29/2015 05:14PM Stop: 10/13/2015 05:13PM <u>Client education NOT performed</u> Order# 217797 Ordering Practitioner: THRASHER, TOHY W (005615)					06:00 PM

AVPH (UAT) 09/29/2015 05:39 PM

The nurse sees patient's orders on the EMAR form.

Avatar eMAR Administration Record - Order Acknowledgement

Client: WISCONSIN,BROOKFIELD ID: 8149377 Chart# Loc: 000003 Room 31 A

CITALOPRAM HBR 20 MG et CeleXA 20 MG Oral Tablet
Administration Time(s)===> 06:00 PM
Give: 20 mg = 1 Tablet Before dinner
Start Date: 09/29/2015 05:14PM Stop Date: 10/13/2015 05:13PM
Order# 217797
Ordering Practitioner: THRASHER, TONY W (005615)

WISCONSIN,BROOKFIELD has not been educated about this order.

Acknowledged by: TEST, NURSING
Acknowledged Date/Time: 09/29/2015 05:43 PM

Entered By: TEST, NURSING
Entered On: 09/29/2015 05:43 PM

Ok Cancel

AVPH (UAT) 09/29/2015 05:42 PM

Avatar eMAR My Nursing Caseload Only Unit: 0000
Order Type: Pharmacy Lab Food Service Nursing/Clinical Discharge
Client: WISCONSIN,BROOKFIELD (8149...)
Administer Latest Client Information and Allergies
Online Documentation Facility Chart#: N/A
Gender: Female DOB: 03/02/197
Att. Practitioner: NOT ASSIGNED
Ht: N/A Wt: N/A
All Orders Routine Orders PRN On
Acknowledgement Required
CITALOPRAM HBR 20 MG et CeleX
Give: 20 mg = 1 Tablet Before dinner
Start: 09/29/2015 05:14PM Stop:
Client education NOT performed
Order# 217797
Ordering Practitioner: THRASHER, TON

09/27 Mon 09/28 Tue 09/29
06:00 PM

Nurse acknowledges new order.

Avatar 2015

Administration Record - Administration Event

Client: WISCONSIN, BROOKFIELD ID: 8149377 Chart# Loc: 000003 Room 31 A

CITALOPRAM HBR 20 MG et CeleXA 20 MG Oral Tablet

Administration Time(s)====> 06:00 PM
 Give: 20 mg = 1 Tablet Before dinner
 Start Date: 09/29/2015 05:14PM Stop Date: 10/13/2015 05:13PM
 Order# 217797
 Ordering Practitioner: THRASHER, TONY W (005615)

WISCONSIN, BROOKFIELD has not been educated about this order.

Administration Event Details

Default Administration Event: []

Order	Scheduled Date	Scheduled Time	First Dose	Med ID	Qty	Unit	SSI	Administration Event	Comment	Route	Site	Warning
CITALOPRAM HBR 20 MG et Cele...	09/29/2015	06:00 PM	<input type="checkbox"/>		20	mg	011		View	ORAL		View

Administration Date/Time: 09/29/2015 05:55 PM

Administered By: TEST, NURSING

Witnessed By: []

Entered By: TEST, NURSING Entered On: 09/29/2015 05:55 PM

Accept administration information entered OK Cancel

Nurse provides education to patient on the medication and nurse administers medication when dose is scheduled for administration.



Server

Milwaukee myAvatar UAT

System Code

UAT

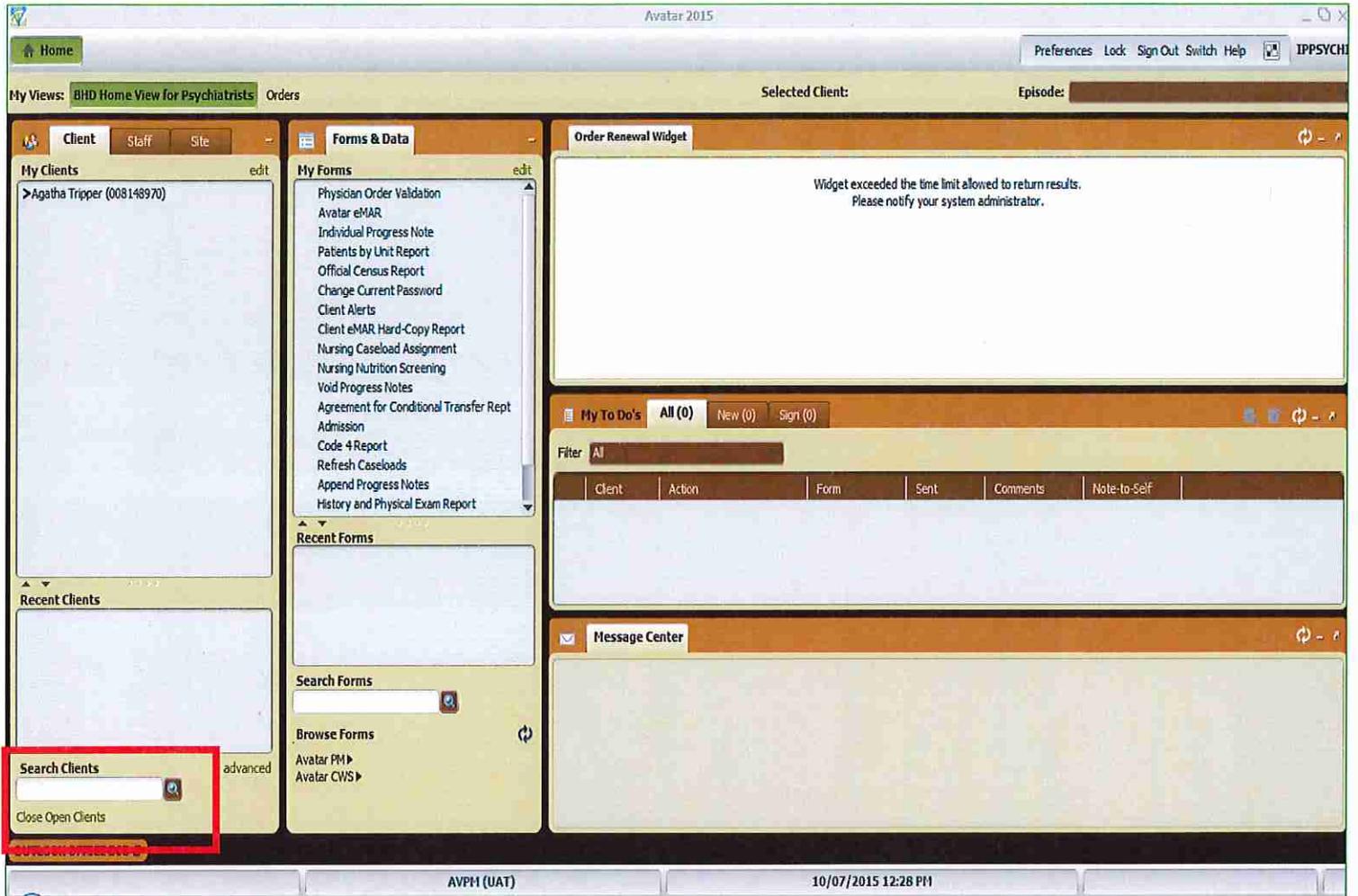
Username

Password

Sign In

Exit

Provider logs in to the Avatar application.



After logging in, the provider is at the Avatar Home Screen. This is where they will search for their client.

Home **Brookfield W** Preferences Lock Sign Out Switch Help **IPPSYCHI**

BROOKFIELD WISCONSIN (008149377) Allergies (0)
F, 40, 03/02/1975

Chart Overview

IP Standard Workflow

- IP Psychiatric/Psychological Assess
- IP Psychiatric/APNP Assessment
- Mental Status Examination (MSE)
- (SAFE T) Suicide Assessment and i
- Trauma and Abuse Evaluation
- Risk Assessment
- Nutrition Assessment
- Allergies and Hypersensitivities
- Informed Consent to Receive Psyc
- Client Profile / Physicians Orders
- IP Attending Discharge Summary/I
- Append Progress Notes
- IP Discharge Narrative

Other IP/PCS/OBS Forms

- Client Contact Information
- Clinical Institute Withdrawal Asses
- Abnormal Involuntary Movement S
- Brosset Violence Checklist (BVC)
- Morse Fall Risk Assessment
- I'm Safe (Pediatric Fall Assessment)
- Substance Abuse
- Vitals Entry
- Minor Voluntary Application And Tr
- Voluntary Application And Treatme
- Risk Assessment
- Lab Tests
- IP Nursing Discharge Summary/Ins
- IP Social Work Discharge Summary
- General Comments/Note
- Crisis Mobile Physical Assessment
- Crisis Mobile Disposition
- Crisis Plan

Client Episodes

Episode Number	Program	Admit Practitioner	Attending Practitioner	Admit Date	Discharge Date	Primary Diagnosis
3	43A Intensive Treatment Unit	NOT ASSIGNED,PCS	NOT ASSIGNED,PCS	09/29/2015	Open Episode	Missing Diagnosis
2	CARS	No Entry		09/24/2015	Open Episode	Missing Diagnosis
1	43B Adult Acute Unit	NOT ASSIGNED,PCS	NOT ASSIGNED,PCS	08/27/2015	09/24/2015	Encntr for f/u exam aft trmt for cond oth than malig neopl

Vital Signs

Vital Type	Most Recent	Previous
Heart Rate	-	-
Blood Pressure	-	-
Temp (F)	-	-
Respiration	-	-
O2 Saturation	-	-
Height (ft in)	-	-
Weight (lbs)	-	-

Progress Notes

Previous 30 days

Selection: All Notes

No information found.

Current Medications & Lab Results & My To Do's &

AVPH (UAT) 10/07/2015 12:32 PM

After searching for and then selecting their client, the provider will then see the Client's Avatar Chart View

Exhibit A

EMR Timeline & Milestones

Note: **Bolded text** below conotes specific milestones being achieved.

Year	Accomplishments	Source	Direct Costs
2010	- Discovery process initiated August, 2010. - Process flows for administrative, clinical, and fiscal areas for BHD - Technical requirements were documented based on the IMSD standards requirement (Note: Mapping of process flows for the Sheriff's Department was in-scope at the time and was completed as a part of this phase of work.	Joxel	\$ 185,630
2011	- RFP generated in January 2011 - Cross-functional team established to score responses - Responses received and evaluated, three of thirteen were selected as finalists - Finalist demonstrations were conducted - Contract was signed with Netsmart, October 2011 - Includes software subscription costs, implementation and support	Joxel Netsmart	\$ 169,400 \$ 1,419,225
2012	- Avatar implementation initiated for PCS, OBS and Access Clinic, February 2012, capabilities included: - Billing for all BHD-operated programs (except LTC) - Electronic Whiteboard established for documenting of patient status - Scanning enabled to supplement patient record - Data conversion of active patient history populated in Avatar - Integration of ADT information to Pyxis completed for medication dispensing - Includes software subscription costs, implementation and support	Joxel Netsmart	\$ 613,625 (1) \$ 113,112
2013	- Avatar implementation initiated for Acute (IP), Crisis Stabilization and Crisis Mobile, February 2013 - CPOE/eMAR implemented for PCS, OBS and Access Clinic, August 2013 - CPOE/eMAR implemented for Acute and Crisis Stabilization, October 2013 - Includes software subscription costs, implementation and support	Joxel Netsmart	\$ 758,305 (1) \$ 1,401,413
2014	- Implementation of fiscal and management reporting into Avatar (following completion of first full year) - Initiation of Community programs discovery process, Q1 2014 - Process flows mapped for clinical, administrative and fiscal functions, Q1 2014 (2) - Implemented new scanning solution to enable multi-page indexing and retrieval - Includes software subscription costs, implementation and support	Joxel Netsmart	\$ 968,145 (1) \$ 836,931
2015 (YTD)	- Netsmart's Health Check completed, February 2015 - MPLS implemented providing a more stable and capable internet environment for Avatar, March 2015 - Avatar moved to the cloud, May 2015 - ICD-10 implemented, June 2015 (3) - RxConnect implemented, June 2015 (4) - Pyxis upgraded, June 2015 (4) - PCS upgraded to allow multiple open episodes, August 2015 - Live training of Community providers/development of on-line training videos and materials, July-August 2015 - Final data conversion from CMHC to Avatar: 81,000 records, September 2015 - Phase III, Community go-live, October 2015 - Includes software subscription costs, implementation and support	Joxel Netsmart	\$ 648,560 (1) \$ 955,165
Total			\$ 8,069,511 (5)(6)

Joxel \$ 3,343,665
Netsmart \$ 4,725,846

Footnotes:

- (1) Includes 24/7/365 functional and technical support for PCS, OBS and Access Clinic (+ Inpatient beginning in 2013)
- (2) Includes 20 levels of care provided by 65 community agencies at over 200 locations
- (3) ICD-10 mandatory use October 1, 2015
- (4) In conjunction with BHD taking over inventory control, installing a new pharmacy team. This work enabled BHD to have a closed-loop medication management system.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: October 5, 2015

TO: Kimberly Walker, Chairperson – Milwaukee County Mental Health Board

FROM: Patricia Schroeder, Administrator, Behavioral Health Division

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

Background

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

Discussion

1. Temporary Inpatient Bed Hold Related to Psychiatry Staffing

Health care, and specifically behavioral health care, environments across the country continue to meet the needs of more clients in light of growing workforce challenges. One increasingly recognized resource in short supply is psychiatrists. The Milwaukee County Behavioral Health Division (BHD) has been working with recruiters for several years to expand psychiatry staffing. We have several physician recruiting organizations contracted to source both temporary and permanent psychiatry staff. Despite these efforts, we have been challenged to replace several psychiatrists who have left for other positions or for health or retirement reasons.

On September 24, 2015, leaders at BHD notified the community that we will be on a temporary inpatient bed hold for adults, taking our already restricted beds from 53 adults to 50 adults. Child and adolescent beds were not changed, nor was Psychiatry Crisis Services (PCS) access and observation beds. This is an important decision to support quality and safety in our care environment.

We are hopeful that our recruitment practices will be successful in identifying additional psychiatrists to support our clinical services.

Previous bed holds at BHD in the past year were related to nurse staffing. At this time, staffing in the nursing department has stabilized. Our goal to eliminate mandatory overtime has been achieved, decreasing dramatically since the beginning of the year, and with the last day of mandatory overtime occurring on May 26th. Linda Oczus, Director of Nursing, has provided leadership to recruitment including nurse manager recruitment, realignment of staffing needs with changes in census, as well as overtime monitoring and reduction.

It is challenging to identify a reliable metric and measure of vacancy given current technology, but we believe the Registered Nurse (RN) vacancy rate is about 22.8%, down from August which we believe was 30.8%. Turnover remains high, given the perception of transitions for the acute care facility and the easy access to jobs in other settings. The Certified Nursing Assistant (CNA) vacancy rate is less volatile, at 12.7%, down from 13.3%, given the movement of staff from long-term care.

We continue to address retention and development of staff, including a retention workgroup with managers and staff, a teamwork initiative, and enhancement of staffing and scheduling guidelines and practices.

2. Communications

Kimberly Kane, and the Kane Communications Team, has been contracted at BHD to provide support and strategy for internal and external communications. We are grateful for the support and expertise. One of the elements of the contract will be the redesign of webpages, including those for the Department of Health and Human Services (DHHS) as well as BHD.

The Mental Health Web page has been redesigned as part of this process. Changes include the photos and bios of Mental Health Board members, notices of meetings, and a web address for people to contact the Board. The address of the site is:

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

3. Organizational Chart

The decision was reached to eliminate the Chief Quality Officer role with BHD. A revised Organizational Chart (Attachment A) of BHD leadership is included.

4. Safety Audit by Milwaukee County Department of Audit

The audit being conducted by Milwaukee County on patient and staff safety has begun. This audit was requested by the Milwaukee County Board of Supervisors in March 2015,

repeating a review completed in 2010. The timeline for completion is not yet known. A report will be brought to the Mental Health Board when completed.

5. Public Policy Forum Report on Outpatient Behavioral Health Capacity

The Public Policy Forum's report on Outpatient Behavioral Health Capacity Assessment is being finalized and will be brought to the December Board meeting.

6. Comprehensive Community Services (CCS) State Survey – Amy Lorenz

On August 25, 2015, an on-site recertification survey was completed for the Milwaukee County Comprehensive Community Services (CCS) Program. On September 1, 2015, Milwaukee County received notification that a one-year provisional certification was granted as a result of the survey. Additionally, three areas were identified for improvement:

- a. The Recovery Advisory Committee needs to be one-third consumer membership. The Committee does meet this requirement, but this was not being identified on the attendance sheets and has since been rectified.
- b. Each consumer record needs to be organized in the same manner and all the same forms used regardless of contracted agency. A workgroup has been formed and has created the structure and forms for the consumer records.
- c. The enrollment process is to begin with the completion of the CCS application. We are working with the Division of Mental Health and Substance Abuse Services (DMHSAS) and having technical assistance meetings every other week to create and implement this change.

All areas of improvement will be completed and/or clearly identified in the plan of correction to be submitted to the Division of Quality Assurance (DQA) on October 2, 2015.

7. Community Recovery Services (CRS) State Survey – Amy Lorenz

From September 22 – September 24, 2015, an on-site survey was completed regarding the provision of Community Recovery Services (CRS) in Milwaukee County. On September 27, 2015, we received notification from the State of Wisconsin Bureau of Prevention Treatment and Recovery CRS Coordinator that there was marked improvement in progress notes from the last review and that the prepared Individual Recovery Plans continue to be exceptionally well done. In the survey exit interview, the State acknowledged Milwaukee County's increased quality

assurance efforts regarding this service and were impressed with the resulting improvements.

8. Planning for North Side Community Based "Place"

Planning has been fully underway in developing the community based "place" on the north side to serve as the front door to behavioral health services. We want to assure that this community based place is not built on simply taking services that exist on the BHD campus and moving them into a new building, but rather re-visioning the client experience and creating a place that supports, assesses, and provides warm handoffs to other needed services.

The planning has had participation and insights of many groups internal to BHD, including clinical and operational staff, medical staff, and patients/families. It has also benefitted from a robust process of seeking input from stakeholders including provider organizations, other health care system representatives, law enforcement, and the community itself. Through the support of a community partner, Shawn Green of Faith Based Partnership, multiple community groups were invited to "listening sessions" to share their perspectives and experiences on important aspects for the new place to support those with behavioral health needs and prevent them from needing an emergency department. Groups were asked, "How should this place look and feel?", "What services should be offered?", and "What should it be called?" The groups numbered about 25-55 people and were energized and insightful in their recommendations. Very important insights were shared. A commitment was made to share the plan that will move forward once it is created. We are working to define space needs to be able to move forward in securing a location and site. Planning around the client experience and the model will of course continue even after the space is identified.

9. Request for Resources to Provide Food for Staff

Research on employee engagement and creating a positive work environment often cite the impact of food or an occasional treat in supporting staff members. That experience is no different at BHD with about 600 staff members, medical staff and other partner groups. While we have tried to modestly support groups with things such as an occasional pizza for a group, for example the medical staff meeting through lunch, those expenses are being paid out of pocket by leaders. Food expenses for staff are not being reimbursed given BHD is a public entity. Some food expenses are supported, if being used for those external to the organization. Cakes to celebrate retirements or employee events are paid for by employees themselves. Recognition of such events as nurses week or health systems week often come with staff members chipping in for popcorn or a cake.

Recruitment of new staff, including medical residents, might be facilitated with the ability to buy a dinner for them. Such experiences now are paid out of pocket by leaders. We would like to initiate a monthly "birthday" event with staff interacting informally with the executive team, and a monthly cake could help that experience. We lose ground when we expect leaders or staff to pay for these simple gestures. These are days when support of employee engagement is critical in retaining staff and medical staff.

I am requesting that the Mental Health Board support the spending of approximately \$5000 annually to support food for employees and medical staff members. These expenses might include:

Cakes for retirement or significant staff event	6 X \$50	\$300
Monthly cake for "birthday" discussion meetings	12 X \$50	600
Occasional supports for medical staff meetings over lunch		1000
Recruitment dinners for med staff or key others		1000
Organization wide celebrations for staff members		1000
Strategic meetings, lunch		1000

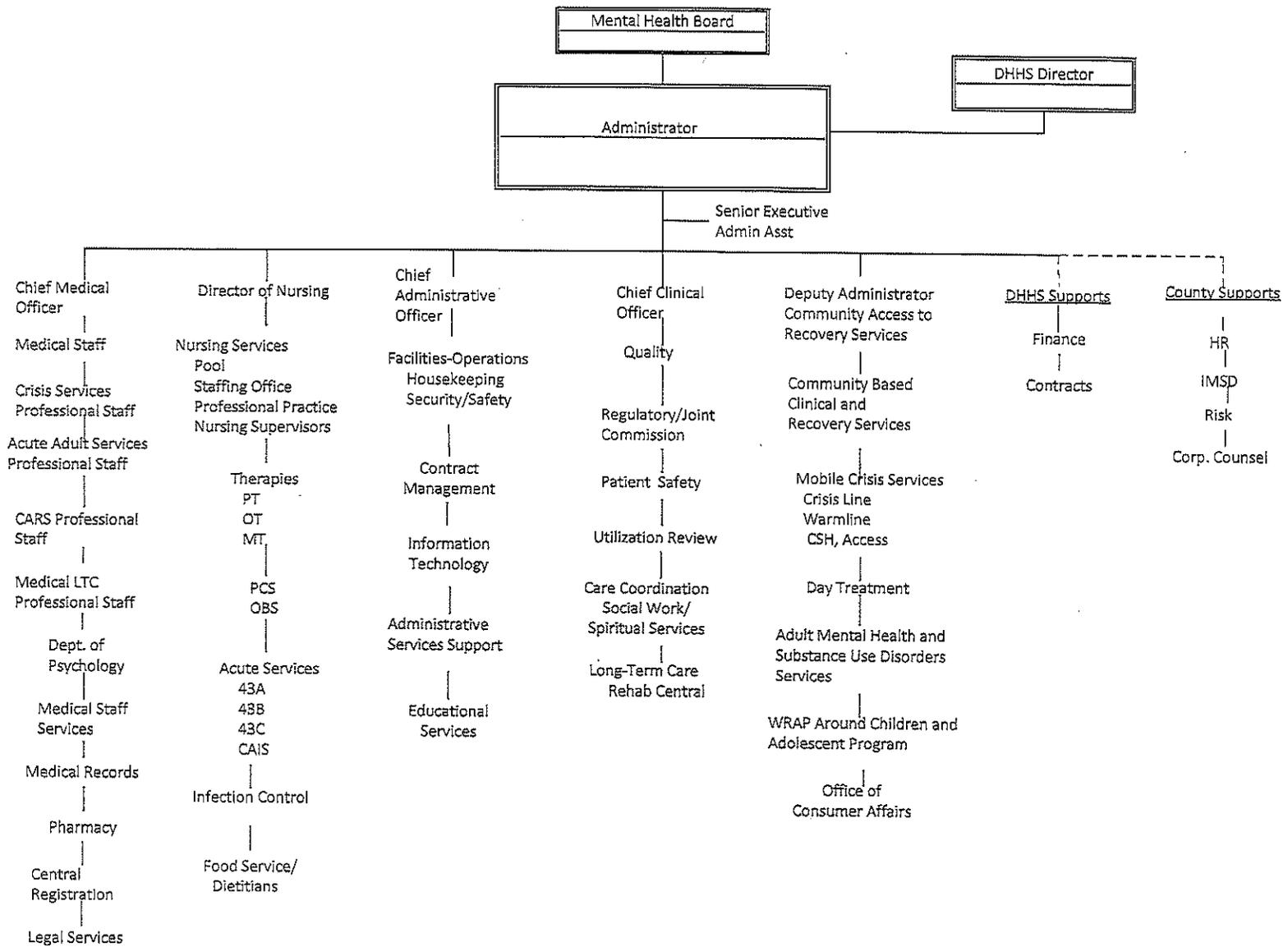
These are examples of costs, which would be closely overseen. Thank you for this consideration.

Respectfully Submitted,



Patricia Schroeder, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services

ATTACHMENT A



Chairperson: Peter Carlson
Senior Executive Assistant: Jodi Mapp, 257-5202

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
 FINANCE COMMITTEE**

Thursday, September 24, 2015 - 1:30 P.M.
Milwaukee Mental Health Complex
9201 Building, Conference Room 413 (Near Auditorium)

MINUTES

SCHEDULED ITEMS:

- | | |
|----|--|
| 1. | <p>2015 Financial Results.</p> <p>An overview was provided of the Second Quarter June 2015 Fiscal Report detailing 2015 risks and opportunities in the areas of inpatient and Community Access to Recovery Services along with annual 2015 projections. Items highlighted for 2015 that have the most financial importance include Rehab Central closure, adult inpatient bed reduction, State plan amendment revenue, fringe surplus, community based residential facility completion, community billing implementation, Alcohol and Other Drug Abuse (AODA) surplus, Comprehensive Community Services expansion, value-based contracting, Family Care expansion, and WIMCR.</p> |
| 2. | <p>State Budget Update.</p> <p>Initiatives in the 2015-2017 State Budget that may or may not have an impact on the Behavioral Health Division (BHD) were identified as future changes related to emergency detentions, changes to Badger Care for childless adults, disproportionate share hospital, State mental health allocation, and residential substance abuse services. This initial assessment of potential changes is based on staff interpretation, so additional information is needed in order to ascertain the full impact on BHD.</p> |
| 3. | <p>Behavioral Health Division (BHD) Trust Fund.</p> <p>BHD has two trust funds. They are the Patient Activity Fund and the Research Trust Fund. The Patient Activity Fund was established in 1957, and it stipulates that money should be used for "providing entertainment to clients in this asylum that is not customarily included in the budget." In the past, it has been used for things like field trips for clients in the long-term care unit. With the closure of long-term care, discussions are being had as to what the best utilization of this trust fund would be.</p> <p>The Research Trust Fund was established in 1970 for the purpose of supporting mental health research in Milwaukee County. A research project possibly on the horizon is to access the demand capacity for community services within Milwaukee County.</p> |

SCHEDULED ITEMS (CONTINUED):

	<p>Recommendations from the Committee for the use of both funds is welcomed. The Committee suggested that a report be provided to the Board as to how the funds' money will be utilized.</p>
4.	<p>ACT 203 Reporting Requirements.</p> <p>A requirement within Act 203 states a study is to be conducted on alternate funding sources and programs and other funding models with a report of the results of the study due to the Milwaukee County Board of Supervisors and the County Executive on that March 1, 2016, date. Discussions were held with Deloitte to complete the study. Because of Deloitte's experience, it is being proposed that the Behavioral Health Division enters into a single source agreement to complete the research study and report. The agreement will be before the Board at its October 22, 2015, meeting.</p>
5.	<p>2016 Budget Status Update.</p> <p>A timeline was provided on the sequence of events that are going to occur now that the Behavioral Health Division's (BHD) Budget has been forwarded to the County Executive for his review. At the October 22, 2015, Board meeting, information will be presented on the differences between BHD's Budget requests and what was included in the County Executive's Requested Budget.</p>
<p style="text-align: center;">The next meeting of the Milwaukee County Mental Health Board Finance Committee is Thursday, December 3, 2015, at 1:30 p.m.</p>	

BEHAVIORAL HEALTH DIVISION

**2nd QUARTER JUNE 2015
FISCAL REPORT**

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2015 Risks and Opportunities

Behavioral Health Division – Inpatient

Central Closure

Adult Inpatient Bed Reduction

State Plan Amendment Revenue

Fringe Surplus

CARSD – Community Access to Recovery Services Division

CBRF Completion

Community Billing Implementation

AODA Surplus

Comprehensive Community Services (CCS) Expansion

Value Based Contracting

Family Care Expansion

WIMCR

Behavioral Health Division
Combined Reporting
Q2 2015 - Annual 2015 Projection

	2015 Budget			2015 Projection			Budget Variance		
	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	996,442	30,322,518	31,318,960	309,700	29,386,214	29,695,914	(686,742)	(936,304)	(1,623,046)
Patient Revenue	20,158,873	44,181,464	64,340,337	21,211,090	36,625,618	57,836,708	1,052,217	(7,555,846)	(6,503,629)
Other	758,137	1,742,219	2,500,356	757,732	1,886,724	2,644,456	(405)	144,505	144,100
Sub-Total Revenue	29,613,478	90,882,761	120,496,239	29,978,548	82,535,116	112,513,664	365,070	(8,347,645)	(7,982,575)
Tax Levy	48,455,690	13,484,476	61,940,166	46,546,408	12,141,676	58,688,084	(1,909,282)	(1,342,800)	(3,252,082)
Total Revenue	78,069,168	104,367,237	182,436,405	76,524,956	94,676,792	171,201,748	(1,544,212)	(9,690,445)	(11,234,657)
Expense									
Salary	26,328,129	6,281,219	32,609,348	26,445,529	6,374,711	32,820,240	(117,400)	(93,492)	(210,892)
Overtime	1,178,988	9,516	1,188,504	2,333,794	28,242	2,362,036	(1,154,806)	(18,726)	(1,173,532)
Fringe	23,701,383	5,671,683	29,373,066	23,076,340	5,702,612	28,778,952	625,043	(30,929)	594,114
Services/Commodities	18,265,895	1,762,046	20,027,941	15,670,117	1,017,338	16,687,455	2,595,778	744,708	3,340,486
Other Charges/Vendor	4,401,872	94,397,621	98,799,493	4,194,006	85,248,400	89,442,405	207,866	9,149,221	9,357,088
Capital	672,285	55,000	727,285	1,022,735	-	1,022,735	(350,450)	55,000	(295,450)
Cross Charges	32,585,189	6,060,742	38,645,931	32,151,310	6,060,742	38,212,052	433,879	-	433,879
Abatements	(29,064,573)	(9,870,590)	(38,935,163)	(28,368,873)	(9,755,253)	(38,124,126)	(695,700)	(115,337)	(811,037)
Total Expense	78,069,168	104,367,237	182,436,405	76,524,956	94,676,792	171,201,748	1,544,212	9,690,445	11,234,657

Behavioral Health Division

Inpatient - Hospital

Q2 2015 - Annual 2015 Projection

	2015 Budget					2015 Projection					2015 Projected Surplus/Deficit				
	Adult	CAIS	Central	Crisis Services	Total Inpatient	Adult	CAIS	Central	Crisis Services	Total Inpatient	Adult	CAIS	Central	Crisis Services	Total Inpatient
Revenue															
BCA	-	-	-	7,700,026	7,700,026	-	-	-	7,700,026	7,700,026	-	-	-	-	-
State & Federal	-	-	765,500	221,942	987,442	-	-	309,700	-	309,700	-	-	(455,800)	(221,942)	(677,742)
Patient Revenue	10,029,584	4,561,426	1,053,178	3,600,685	19,244,873	9,752,522	5,785,816	1,114,470	3,763,440	20,416,248	(277,062)	1,224,390	61,292	162,755	1,171,375
Other	-	15,000	-	-	15,000	-	37,130	399	(91,948)	(54,419)	-	22,130	399	(91,948)	(69,419)
Sub-Total Revenue	10,029,584	4,576,426	1,818,678	11,522,653	27,947,341	9,752,522	5,822,945	1,424,569	11,371,519	28,371,555	(277,062)	1,246,519	(394,109)	(151,134)	424,214
Tax Levy	20,969,825	1,173,803	8,790,103	13,430,930	44,364,661	20,539,266	(428,573)	9,567,694	12,848,848	42,527,235	(430,559)	(1,602,376)	777,591	(582,082)	(1,837,426)
Total Revenue	30,999,409	5,750,229	10,608,781	24,953,583	72,312,002	30,291,788	5,394,373	10,992,262	24,220,367	70,898,790	(707,621)	(355,856)	383,481	(733,216)	(1,413,212)
Expense															
Salary	7,697,080	1,735,350	2,029,194	7,420,524	18,882,148	7,987,863	1,610,881	2,383,339	7,041,092	19,023,175	(290,783)	124,469	(354,145)	379,432	(141,027)
Overtime	753,852	35,736	131,844	87,144	1,008,576	972,980	231,549	182,170	715,699	2,102,398	(219,128)	(195,813)	(50,326)	(628,555)	(1,093,822)
Fringe	6,681,043	1,362,252	3,409,093	5,295,932	16,748,320	6,390,353	1,244,252	3,603,101	5,305,569	16,543,275	290,690	118,000	(194,008)	(9,637)	205,045
Services/Commodities	3,830,803	491,608	807,451	2,621,066	7,750,928	2,611,754	282,022	599,676	1,627,768	5,121,220	1,219,049	209,586	207,775	993,298	2,629,708
Other Charges/Vendor	890,378	100,000	-	3,011,494	4,001,872	1,182,506	-	5	3,011,494	4,194,006	(292,128)	100,000	(5)	-	(192,134)
Capital	26,940	-	-	4,750	31,690	26,940	-	-	5,500	32,440	-	-	-	(750)	(750)
Cross Charges	11,119,313	2,025,283	4,231,199	6,512,673	23,888,468	11,119,392	2,025,669	4,223,972	6,513,244	23,882,276	(79)	(386)	7,227	(571)	6,192
Abatements	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Expense	30,999,409	5,750,229	10,608,781	24,953,583	72,312,002	30,291,788	5,394,373	10,992,262	24,220,367	70,898,790	707,621	355,856	(383,481)	733,216	1,413,212

This schedule presents the financial projections for the Inpatient Hospital areas including allocations of overhead departments. The difference between the Inpatient Total above and the Total Hospital projection is the sum of various overhead departments - Operations, Management, Fiscal which are currently projected to surplus also.

Behavioral Health Division
Inpatient Adult
Q2 2015 - Year to Date June

Revenue

Gross Revenue by Payor :	2014 Actual Full Year	% of Total	2015 Budget June YTD	2015 Actual June YTD ¹	% of Total	Surplus/Deficit	
Medicare A&B	7,984,436	27.6%		3,792,092	27.6%		
HMO T18 (Medicare)	2,635,386	9.1%		1,634,724	11.9%		Medicare = 39.5%
Medicaid	939,488	3.2%		384,967	2.8%		64.9%
HMO T19 (Medicaid)	3,892,855	13.5%		3,120,748	22.7%		Medicaid = 25.5%
Self Pay/Non Recov/Collections	12,384,404	42.8%		4,107,682	29.9%		
Commercial/HMO	947,115	3.3%		541,589	3.9%		
Military	100,209	0.3%		66,772	0.5%		
Family Care	42,665	0.1%		107,658	0.8%		
Total Gross Revenue	28,926,558		15,433,660	13,756,231	100%	(1,677,429)	
Less: Write Offs	(20,036,130) -69%		(10,956,368) -71%	(9,148,579) -67%		1,807,789	Net Revenue is above budget in spite of the lower census due to bed restrictions. Write off is 67% versus budget of 71%.
Net Revenue	8,890,428		4,477,292	4,607,652		130,360	
Other Patient Revenue	1,169,655		387,500	197,862		(189,638)	DSH Payments
	215,997		150,000	86,081		(63,919)	T18 Settlements
Total Revenue	10,276,080		5,014,792	4,891,595		(123,197)	
Rate per Day	\$ 1,364		\$ 1,364	\$ 1,537			

FTE's Nursing Staff :

	Budget	Actual
RN's	46.5	47.7
CNA's	61.9	75.0

Average Daily Census
 Admissions (1/2 year)
 Patient Days (1/2 year)
 Average Length of Stay

60	48.7
571	499
10,950	8,810
16	16.2

1st Qtr = 47.1, 2nd Qtr=50.2
 1st Qtr = 224, 2nd Qtr=275
 1st Qtr = 4,241, 2nd Qtr=4,569
 1st Qtr = 18.9, 2nd Qtr=13.5

¹ Year to Date Actual Revenue equals 5 months actual and one month projected.

Behavioral Health Division

CAIS - Child and Adolescent Inpatient Services

Q2 2015 - Year to Date June

Revenue

Gross Revenue by Payor :	2014 Actual		2015 Budget	2015 Actual ¹	% of Total	Surplus/Deficit
	Full Year	% of Total				
Medicare A&B	326	0.0%		-	0.0%	
HMO T18 (Medicare)	177	0.0%		-	0.0%	
Medicaid	2,425,437	33.9%		1,494,019	28.9%	
HMO T19 (Medicaid)	3,835,822	53.7%		3,196,558	61.8%	
Self Pay/Non Recov/Collections	276,217	3.9%		80,503	1.6%	
Commercial/HMO	590,927	8.3%		402,913	7.8%	
Military	16,698	0.2%		-	0.0%	
Family Care	-	0.0%		-	0.0%	
Total Gross Revenue	7,145,604		3,575,175	5,173,993	100%	1,598,818
Less: Write Offs	(2,744,490)		(1,294,462)	(1,965,290)		(670,828)
	-38%		-36%	-38%		
Net Revenue	4,401,114		2,280,713	3,208,703		927,990
Other Patient Revenue			-	-		-
	25,214		-	-		-
Total Revenue	4,426,328		2,280,713	3,208,703		927,990

Medicaid = 90.7%

Rates increased

Write off is 38% versus budget of 36%.

Rate per Day \$ 1,959 \$ 2,672

FTE's Nursing Staff :

	Budget	Actual
RN's	13.0	13.4
CNA's	10.7	9.7

Average Daily Census
Admissions (1/2 year)
Patient Days (1/2 year)
Average Length of Stay

11	10.75
503	527
2,190	1,943
3	3.75

1st Qtr = 11.1, 2nd Qtr=10.4

1st Qtr = 270, 2nd Qtr=257

1st Qtr = 997, 2nd Qtr=946

1st Qtr = 3.8, 2nd Qtr=3.7

¹ Year to Date Actual Revenue equals 5 months actual and one month projected.

Behavioral Health Division
Central Rehab Nursing Facility
 Q2 2015 - Year to Date June

Revenue

Gross Revenue by Payor :

Medicare A&B
 HMO T18 (Medicare)
 Medicaid
 HMO T19 (Medicaid)
 Self Pay/Non Recov/Collections
 Commercial/HMO
 Military
 Family Care

2015 Budget	2015 Actual ¹	Surplus/Deficit
	- 0.0%	
	13,726 0.6%	
	1,459,783 63.0%	
	716,111 30.9%	
	128,671 5.6%	
	- 0.0%	
	- 0.0%	
	- 0.0%	
2,072,864	2,318,291 100%	245,427
(1,571,194) -76%	(1,700,518) -73%	(129,324)
501,670	617,773	116,103
42,000	79,765	37,765
7,840	-	(7,840)
551,510	697,538	146,028

Medicaid = 93.9%

Total Gross Revenue

Less: Write Offs

Net Revenue

Other Patient Revenue

Total Revenue

Active Treatment Supplement

Rate per Day

\$ 518 \$ 679

FTE's Nursing Staff :

	Budget 3/1	Current
RN's	5.0	3.6
CNA's	28.0	21.1
LPN's	6.6	3.9

Budget 9/1
5.0
14.8
3.3

Census

Budget 1/1	8/4/2015
28	18

Census is budgeted to be 14 clients in one unit by Sept 1st

¹ Year to Date Actual Revenue equals 5 months actual and one month projected.

Revenue

	2014 Actual Full Year	% of Total	2015 Budget	2015 Actual ¹	% of Total	Surplus/Deficit	
Gross Revenue by Payor :							
Medicare A&B	1,631,675	10.6%		799,374	11.6%		
HMO T18 (Medicare)	664,203	4.3%		313,798	4.6%		Medicare = 16.2%
Medicaid	6,489,846	42.2%		2,526,257	36.7%		
HMO T19 (Medicaid)	2,567,693	16.7%		1,903,753	27.7%		Medicaid = 64.4%
Self Pay/Non Recov/Collections	3,334,502	21.7%		890,036	12.9%		
Commercial/HMO	608,092	4.0%		417,874	6.1%		Total Medicaid and Medicare = 80.6%
Military	60,851	0.4%		20,138	0.3%		
Family Care	20,922	0.1%		3,842	0.1%		
Total Gross Revenue	15,377,784		5,815,255	6,875,073	100%	1,059,818	
Less: Write Offs	(12,154,059)	-79%	(4,483,562)	(5,505,844)	-80%	(1,022,282)	Write off is 80% versus budget of 77%.
Net Revenue	3,223,725		1,331,693	1,369,229		37,536	Patient Revenue is at Budget.
Other Patient Revenue	1,985,601		468,649	4,013		(464,636)	WIMCR will be received at year end
Total Revenue	5,209,326		1,800,342	1,373,242		(427,100)	

Revenue by Program:

PCS
OBS
Access Clinic
Mobile Team
Respite
CLASP

Gross	Writeoff	%	Net Revenue	Major Payer Sources
3,460,955	(2,657,851)	-77%	803,104	63% Medicaid, 17% Medicare, 12% Non-Recov/Self-Pay, 6% Commercial
1,789,385	(1,522,705)	-85%	266,680	53% Medicaid, 26% Medicare, 12% Non-Recov/Self-Pay, 6% Commercial
37,770	(30,811)	-82%	6,959	70% Self-Pay/Non-Recov
180,995	(112,707)	-62%	68,288	63% Medicaid, 26% Non-Recov/Self-Pay, 10% Commercial
843,329	(728,745)	-86%	114,584	Respite is 82% Medicaid
562,637	(453,024)	-81%	109,613	CLASP is 100% Medicaid

FTE's Nursing Staff :

	Budget
RN's	28.0
CNA's	27.2

	Actual
	27.1
	22.1

Nursing Staff has been at or below budget

Budgeted too many CNA's in PCS, changed staffing model for 2016

¹ Year to Date Actual Revenue equals 5 months actual and one month projected.

Behavioral Health Division
 CARSD
 Q2 2015 - Annual 2015 Projection

	2015 Budget			
	AODA	Mental Health	WRAP	Total CARSD
Revenue				
BCA	2,333,731	12,302,829	-	14,636,560
State & Federal	8,242,135	8,122,047	13,958,336	30,322,518
Patient Revenue	250,000	12,544,622	31,386,842	44,181,464
Other	1,265,246	337,203	139,770	1,742,219
Sub-Total Revenue	12,091,112	33,306,701	45,484,948	90,882,761
Tax Levy	2,893,824	11,315,783	(725,131)	13,484,476
Total Revenue	14,984,936	44,622,484	44,759,817	104,367,237
Expense				
Salary	622,743	3,291,888	2,366,588	6,281,219
Overtime	-	6,720	2,796	9,516
Fringe	478,909	3,291,316	1,901,458	5,671,683
Services/Commodities	151,155	1,450,980	159,911	1,762,046
Other Charges/Vendor	13,222,880	33,411,570	47,763,171	94,397,621
Capital	-	55,000	-	55,000
Cross Charges	579,249	3,115,010	2,366,483	6,060,742
Abatements	(70,000)	-	(9,800,590)	(9,870,590)
Total Expense	14,984,936	44,622,484	44,759,817	104,367,237

	2015 Projection			
	AODA	Mental Health	WRAP	Total CARSD
	2,333,730	12,302,830	-	14,636,560
	8,319,040	8,302,459	12,764,715	29,386,214
	0	2,730,434	33,895,184	36,625,618
	1,215,494	338,130	333,101	1,886,724
	11,868,264	23,673,853	46,993,000	82,535,116
	2,048,244	10,602,545	(509,113)	12,141,676
	13,916,507	34,276,398	46,483,887	94,676,792
	566,312	3,659,703	2,902,415	7,128,430
	3,428	7,164	17,650	28,242
	402,763	2,966,033	1,580,097	4,948,894
	55,018	879,730	82,591	1,017,338
	12,379,737	23,648,758	49,219,904	85,248,400
	0	-	-	-
	579,249	3,115,010	2,366,483	6,060,742
	(70,000)	-	(9,685,253)	(9,755,253)
	13,916,507	34,276,398	46,483,887	94,676,792

	2015 Projected Surplus/Deficit			
	AODA	Mental Health	WRAP	Total CARSD
	(1)	1	-	-
	76,905	180,412	(1,193,621)	(936,304)
	(250,000)	(9,814,188)	2,508,342	(7,555,846)
	(49,752)	927	193,331	144,505
	(222,848)	(9,632,848)	1,508,052	(8,347,645)
	(845,580)	(713,238)	216,018	(1,342,800)
	(1,068,429)	(10,346,086)	1,724,070	(9,690,445)
	56,431	(367,815)	(535,827)	(847,211)
	(3,428)	(444)	(14,854)	(18,726)
	76,146	325,283	321,361	722,789
	96,137	571,250	77,320	744,708
	843,143	9,762,812	(1,456,733)	9,149,221
	-	55,000	-	55,000
	-	-	-	-
	-	-	(115,337)	(115,337)
	1,068,429	10,346,086	(1,724,070)	9,690,445

2,048,244 10,602,545 (509,113) 12,141,676

CARSD Mental Health

Major Programs

		2014 Actual	2015 Budget	Projected	Surplus/(Deficit)
TCM	Rev	\$ -	\$ 1,464,515	\$ -	\$ (1,464,515)
	Exp	\$ 3,546,930	\$ 5,392,670	\$ 3,928,155	\$ (1,464,515)
	Tax Levy	\$ (3,546,930)	\$ (3,928,155)	\$ (3,928,155)	\$ -
	Capacity	1,292	-	1,292	1,292
	Individuals Served	1,505	-	1,578	1,578
CSP	Rev	\$ 985,525	\$ 7,572,295	\$ 168,320	\$ (7,403,975)
	Exp	\$ 10,979,378	\$ 16,343,953	\$ 8,689,742	\$ (7,654,211)
	Tax Levy	\$ 9,993,854	\$ 8,771,658	\$ 8,521,422	\$ (250,236)
	Capacity	1,340	-	1,340	1,340
	Individuals Served	1,392	-	1,419	1,419
CRS	Rev	* \$ 1,980,287	\$ 1,980,287	\$ 1,133,325	\$ (846,962)
	Exp	* \$ 2,072,032	\$ 2,072,032	\$ 2,060,590	\$ (11,442)
	Tax Levy	* \$ 91,745	\$ 91,745	\$ 927,265	\$ 835,520
	Individuals Served	140	140	61	(79)
CCS	Rev	\$ -	\$ 500,000	\$ 1,293,341	\$ 793,341
	Exp	\$ 48,540	\$ -	\$ 1,521,578	\$ 1,521,578
	Tax Levy	\$ 48,540	\$ (500,000)	\$ 228,237	\$ 728,237
	Individuals Served	23	314	236	(78)
Day Treatment	Rev	\$ 1,717,820	\$ 1,894,673	\$ 1,600,130	\$ (294,543)
	Exp	\$ 2,367,114	\$ 2,683,963	\$ 2,415,359	\$ (268,604)
	Tax Levy	\$ 649,294	\$ 789,290	\$ 815,229	\$ 25,939
	Individuals Served	54	54	55	1

*2014 Financials not available for CRS

CARSD AODA

Major Programs

		2014 Actual	2015 Budget	Projected	Surplus/(Deficit)
AODA Detox	Rev				\$ -
	Exp	\$ 2,572,145	\$ 2,572,145	\$ 2,572,145	\$ -
	Tax Levy	\$ 2,572,145	\$ 2,572,145	\$ 2,572,145	\$ -
	Individuals Served	1,896	-	1,858	
AODA Clinical	Rev	\$ 15,016,374	\$ 10,804,908	\$ 10,601,897	\$ (203,011)
	Exp	\$ 11,857,639	\$ 11,421,442	\$ 10,390,629	\$ (1,030,813)
	Tax Levy	\$ (3,158,735)	\$ 616,534	\$ (211,268)	\$ (827,802)
	Individuals Served	5,474	-	5,583	-
AODA Prevention	Rev	\$ 773,047	\$ 1,286,204	\$ 1,264,282	\$ (21,922)
	Exp	\$ 948,945	\$ 991,349	\$ 991,349	\$ -
	Tax Levy	\$ 175,898	\$ (294,855)	\$ (272,933)	\$ 21,922
	Individuals Served	4,914	-	*	

*2015 Projected individuals served for AODA prevention forthcoming

WRAPAROUND MILWAUKEE

Wraparound Spending by Service Group

Percent of Total Spending

	2014 Actual	2015 Projection	Variance	2014	2015
Residential Treatment	\$ 12,363,947	\$ 10,746,300	\$ (1,617,647)	28%	25%
Discretion/Flex Fund	\$ 248,467	\$ 159,142	\$ (89,325)	1%	0%
Med. Mgmt/Nursing	\$ 99,270	\$ 62,592	\$ (36,678)	0%	0%
Outpatient	\$ 803,066	\$ 776,064	\$ (27,002)	2%	2%
AODA Svcs	\$ 96,909	\$ 79,231	\$ (17,678)	0%	0%
Youth Support Svcs	\$ 237,903	\$ 226,634	\$ (11,269)	1%	1%
Child Care/Recreation	\$ 19,883	\$ 11,467	\$ (8,416)	0%	0%
Respite	\$ 74,908	\$ 79,860	\$ 4,952	0%	0%
Transportation	\$ 290,167	\$ 295,685	\$ 5,518	1%	1%
Psychological Assmts	\$ 155,820	\$ 163,224	\$ 7,404	0%	0%
Independent Living	\$ 266,613	\$ 275,580	\$ 8,967	1%	1%
Foster Care	\$ 3,183,117	\$ 3,194,945	\$ 11,828	7%	7%
Occupational Therapy (new)	\$ 25,520	\$ 37,536	\$ 12,016	0%	0%
Life Skills	\$ 339,818	\$ 370,661	\$ 30,843	1%	1%
Day Treatment	\$ 52,976	\$ 100,800	\$ 47,824	0%	0%
Crisis	\$ 6,224,246	\$ 6,294,106	\$ 69,860	14%	14%
Group Home	\$ 5,164,228	\$ 5,251,027	\$ 86,799	12%	12%
Fam/Parent Support Svcs	\$ 386,022	\$ 503,527	\$ 117,505	1%	1%
Inpatient	\$ 904,430	\$ 1,070,695	\$ 166,265	2%	2%
In-Home	\$ 2,489,559	\$ 2,801,710	\$ 312,151	6%	6%
Care Coordination	\$ 10,612,978	\$ 11,141,366	\$ 528,388	24%	26%
				100%	100%

	2014 Actual	2015 Projection	Variance
Member Months	13,114	14,023	909

Finance Committee Item #2

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: August 31, 2015
TO: Kimberly Walker, Chairperson, Milwaukee County Mental Health Board
FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Randy Oleszak, Deputy Administrator, Community Access to Recovery Services
SUBJECT: Report from the Director, Department Health and Human Services, detailing potential 2015-2017 State Budget impacts on the Behavioral Health Division

Issue

On July 12th, 2015 Gov. Walker signed the 2015-2017 State Budget into law. Fiscal and program staff for the Behavioral Health Division have reviewed the budget and identified potential risks and initiatives that could conceivably impact programs and services.

At this time, this initial assessment is based on staff interpretation of WI Act 55. For many of these initiatives, additional information is needed in order to ascertain the full impact to the Behavioral Health Division.

Discussion

The following are initiatives identified as potential impact and/or risk items for BHD:

Emergency Detentions:

Provide \$1,500,000 in one-time funding in 2015-16 for DHS to distribute as grants to counties for mental health crisis services. Funding for these grants would be budgeted in a program revenue appropriation that supports the Department's institutional operations. This appropriation is one of the principal funding sources for the state's mental health institutes, and reflects the receipt of various revenue sources, including county payments and Medical Assistance program reimbursement for services provided by those facilities. In addition, make the following statutory changes:

Modify provisions related to the emergency detention of persons for reasons of mental illness, drug dependency, or developmental disability to specify that a county human services department may not approve the detention of a person unless a physician who has completed a residency in psychiatry, a licensed psychologist, or a mental health professional "as determined by the Department" has performed a crisis assessment on the individual and agrees for the need for detention.

Crisis assessments may be done in person, by telephone, or by telemedicine or video conferencing technology. BHD originally estimated the added cost of these assessments to be between \$2 and \$2.5

million. With the added provision allowing telephone assessments, this cost will be much lower. It is not clear if Milwaukee County's share for the \$1.5 million will be enough to cover the increased costs.

The Governor's provision that would eliminate the alternative ED procedures for Milwaukee County have been deleted. The Milwaukee County ED pilot program allowing treatment director of a facility to take a person into custody for the purposes of emergency detention is not eliminated; the sunset date for the pilot program is extended from May 1, 2016 to July 1, 2017.

Changes to Badger Care for Childless Adults

Based on statewide enrollment projections, Badger Care for Childless Adults is expected to increase to 159,800 by 2016-2017 compared to a starting point of 21,000 in 2011-2012. It also contributes to over half of the department's cost to continue for general purpose revenue funding, or \$362 million.

In order to contain costs, the budget lays out a number of eligibility changes. The budget indicates that DHS will seek a waiver to alter coverage for childless adults by requesting the following changes: 1) monthly premiums will be imposed 2) higher premiums for those engaging in risky behaviors 3) requirement for a health risk assessment 4) eligibility limit of four years and 5) mandatory drug testing.

The eligibility changes contained in the 2015-2017 State Budget could potentially reverse the positive effects BHD has experienced with the elimination of the childless adult waitlist and expansion of Badger Care to this population. Since Medicaid expansion took effect, BHD has experienced a significant decline in those visiting the Access Clinic. As a result, the Access Clinic, which provides mental health services for uninsured Milwaukee County residents, experienced a 44 percent decrease in the number of individuals seeking care and services in 2014 compared to 2013.

The eligibility changes to the Badger Care program for this population may impact both BHD's success in implementing the plan submitted to the State for the Comprehensive Community Services (CCS) program and extending Targeted Case Management (TCM) to the AODA population. Individuals enrolled in CCS who lose their Badger Care eligibility will subsequently lose eligibility for CCS and other Medicaid programs. These changes will also have an impact on the ability of clients to obtain and/or maintain housing benefits that require ongoing case management services.

Disproportionate Share Hospital (DSH)

These payments are provided to hospitals, including BHD, which care for indigent patients. The total payments budgeted statewide is \$35.9 million in SFY2016 and go down slightly to \$35.8 million in SFY2017. The State budgeted \$36.7 million statewide in SFY2015 so the allocation for SFY2016 reflects a reduction of \$800,000. BHD received a total of nearly \$1.2 million in DSH revenue in 2014. Based on the statewide cut, BHD may realize a reduction in DSH revenue for 2015.

State Mental Health Allocation

Effective January 1, 2016, the budget consolidates mental health funding of \$24.3 million for distribution statewide to counties. This provision expands the statutory purpose of community aids funding to

include mental health funding which would reflect Mental Health Treatment Services, Community Support Programs/Psychosocial Services and the Community Options Program. The intent is to create efficiencies in the "distribution of funding to counties." The LFB summary indicates that the change would still provide for the same allocation to individual counties. More information is needed as to how this change will be implemented.

Funding Transfers for the Creation of Community Mental Health Services Grants		
Appropriation	2015-16	2016-17
Mental Health Treatment Services	-\$4,006,800	-\$8,013,700
Community Support Programs and Psychosocial Services	-\$1,878,800	-\$3,757,500
Community Options Program (Mental Health/Substance Abuse)	-\$6,288,800	-\$12,577,500
Community Aids -- Community Mental Health Services	\$12,174,400	\$24,348,700

Residential Substance Abuse Services

This provision provides an additional \$5.4 million of funding over the biennium for residential-based substance abuse treatment services. Currently, Medical Assistance revenue is only available for hospital inpatient and outpatient services but not for services provided in a residential setting. This is one area that could provide an opportunity for additional revenue to BHD CARS.

Respectfully submitted,



Héctor Colón, Director
Department of Health and Human Services

Finance Committee Item #3

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: August 31, 2015
TO: Kimberly Walker, Chairperson, Milwaukee County Mental Health Board
FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Randy Oleszak, Deputy Administrator, Community Access to Recovery Services
SUBJECT: Report from the Director, Department Health and Human Services, detailing BHD Expendable Trust Funds.

Issue

BHD has two expendable trust funds: the Patient Activity Fund and the Research Trust Fund. These funds were originally established, and are sustained through, donations to BHD from outside individuals or entities.

Discussion

The Patient Activity Fund was originally established with a donation from Mabel Yahr in 1957. It is now comprised of various trusts which stipulate the expenditures should be made to provide for patient activities and special events. The fund currently has a balance of \$85,840.15.

The Research Trust fund was initially established in 1970 with a donation from Frieda Brunn. This fund was created in 1970 for the purpose of supporting mental health research in Milwaukee County. Expenditure recommendations from this fund are made by the Research Committee at BHD. The fund currently has a balance of \$216,704.83

Activity in these funds has no tax levy impact on BHD.

Respectfully submitted,



Héctor Colón, Director
Department of Health and Human Services

Finance Committee Item #4

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: August 31, 2015
TO: Kimberly Walker, Chairperson, Milwaukee County Mental Health Board
FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Randy Oleszak, Deputy Administrator, Community Access to Recovery Services
SUBJECT: Report from the Director, Department Health and Human Services, detailing 2013 Wisconsin Act 203 requirement for alternate fund source study.

Background

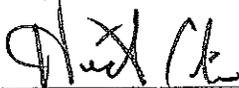
2013 Wisconsin Act 203 requires the Milwaukee County Mental Health Board to arrange for a study to be conducted regarding possible alternate fund sources for mental health services at the Behavioral Health Division.

Discussion

The following language is included in 2013 Wisconsin Act 203:

"The Milwaukee County mental health board shall arrange for a study to be conducted on alternate funding sources for mental health services and programs including fee-for-service models, managed care models that integrate mental health services into the contracts with an increased offset through basic county allocation reduction, and other funding models. By March 1, 2016, the Milwaukee County mental health board shall submit to the Milwaukee County board of supervisors, the Milwaukee County executive, and the department a report of the results of the study."

Respectfully submitted,



Héctor Colón, Director
Department of Health and Human Services

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

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
QUALITY COMMITTEE**

September 28 2015 - 10:00 A.M.
Milwaukee County Mental Health Complex
9201 Building, Conference Room 413 (Near Auditorium)

MINUTES

SCHEDULED ITEMS:

1. Welcome.

Chairman Chayer welcomed everyone to the September 28, 2015, Mental Health Board Quality Committee meeting.

It was announced that the person who was in the Chief Quality Officer role left the organization. A decision was made to not fill the position. Going forward, Jennifer Bergersen has graciously agreed to absorb the duties.

2. Behavioral Health Division 2015 – 2016 Quality Plan Goals and Objectives.

A look was taken at the quality plan presented to the Board at the beginning of the year. The report related to this item reflects the progress in meeting those goals and objectives. The objectives for 2015 include some items and initiatives that were already underway, including simplifying the Behavioral Health Division's front door access and the ability to navigate the healthcare options offered by Milwaukee County.

Simplifying front door accessibility includes the creation of Northside and Southside sites. With input from the community, the needs will be determined in order to create a model. To help with this process, internal teams and the community have been engaged, as well as patients, their families, and external stakeholders.

Other objectives highlighted were the establishment of the Family Advisory Council, education and training, and the Quality Improvement Key Performance Measure Dashboard.

3. Quality Dashboard and Improvement Plan.

The appropriate comparison and benchmarks have been incorporated into the Dashboard. It continues to be refined to identify what needs to be measured. The Dashboard was reviewed in detail with explanations provided related to yellow and red status items. It is important to make sure to capture the appropriate data to make it meaningful and to better target the changes. National standards will be included in future reports. This Dashboard contains key points and does not include all data being collected, analyzed, and improved.

SCHEDULED ITEMS (CONTINUED):

	<p>Information was also provided regarding contract redesign.</p>
4.	<p>Joint Commission Mock Survey Update.</p> <p>Findings of the latest visit by the external consultant, Critical Management Solutions, were explained. Improvements from the August 2014 site visit included a shift in workplace environment to being more proactive and stable as opposed to reactive and crisis oriented, qualified and competent staff and delivery of care, and medication management. Improvements still needed included environment of care aspects throughout the facility, maintaining and creating life safety measures, contract management processes, human resources processes, quality controls in use of point-of-care testing, and infection control plans.</p> <p>It was recommended that the Board do a self-evaluation, complete conflict of interest declarations, and create policy on conflict management and resolutions.</p> <p>The Behavioral Health Division's plan entails improving and sustaining performance with all Joint Commission standards, applying for Joint Commission accreditation in December of 2015, and an initial survey to be carried out, unannounced, in the twelve months following.</p>
5.	<p>Transition to Closed Loop Medication System Quality Update.</p> <p>This system was implemented on June 17, 2005. The process involves computer physician order entry; the pharmacy verifies the order; the confirmed order information is electronically sent from the interface to the automated dispensing cabinet; the nurse scans the bar-code of medication with the patient wrist band to ensure right dose, right time, and right patient; and electronic confirmation of patient identity before administration. A process evaluation has been conducted to see if there are additional safeguards that can be put in place to prevent errors.</p> <p>Additional services provided by the pharmacy include forty-two clinical pharmacist interventions to improve patient safety, weekly clinical pharmacist attendance on patient care rounds, and a passed State of Wisconsin inspection with no variances. This significant transition was guided by data tracking, education, and continuous improvement.</p>
6.	<p>Rehab Central/Long-Term Care Resident Transitions - Monitoring Outcomes.</p> <p>There are thirteen individuals that remain in Rehab Center Central (RCC), and everything is on target for relocation of those individuals to the community by December 2015. The two remaining resident care Units 44A and 44B will soon be consolidated as the census reduces. RCC is targeted for closure at the end of the year. Readmission rates were discussed and 2013 – 2015 Behavioral Health Division Crisis Service and Acute Adult Admissions from Discharged Rehab Center Residents were reviewed.</p>

SCHEDULED ITEMS (CONTINUED):

7.	<p>Zero Suicide Initiative.</p> <p>In April of 2015, seven staff members attended the State of Wisconsin Zero Suicide academy. The overall purpose of the initiative is to, of course, reduce the number of suicides occurring and to evaluate internal practices and policies. It is recognized that this is not just a Behavioral Health Division (BHD) issue but an issue that needs to be addressed throughout the County. BHD is taking an internal approach to this problem. The work that needs to be done was broken down into the following five stages: organization structure and assessment, build support and planning, communication and training, implementation, and evaluation and on-going improvement practices.</p>
8.	<p>Active Shooter/Environmental Safety Review.</p> <p>Details were provided regarding an incident where the Behavioral Health Division (BHD) received two threatening telephone calls on August 20, 2015. A decision was made through leadership to declare an essential movement only condition, which is a modified form of a lockdown. Unfortunately, a BHD staff member notified a family member of the situation, who in turn, notified the police. Overall, the event response was successful. Strengths and improvement opportunities were reviewed.</p>
9.	<p>Next Scheduled Meeting and 2016 Meeting Dates:</p> <ul style="list-style-type: none">• November 2, 2015, 10:00a.m. <p>The next meeting date was announced as November 2, 2015, at 10:00 a.m. The location is to be determined.</p>
<p>The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is Monday, November 2, 2015, @ 10:00 a.m.</p>	

Quality Committee Item #2

BHD Quality Plan Goals and Objectives 2015-2016

The BHD Quality, Compliance and patient Safety Council will identify and define goals and specific objectives to be accomplished each year. Goals and objectives will be embedded in all aspects of operational and clinical planning in all parts of BHD. Alignment of Goals and Objectives will cascade down into each leadership committee and every staff annual performance review. Progress in meeting these goals and objectives will be periodically reviewed, reported and progress adjusted as needed.

Quality Plan Goals for 2015-2016

1. Ensuring all services enable people's ability to have maximum quality of life and health while living in the community.
2. Improving the patient experience in all services.
3. Evolving state of the art quality structures, processes and a culture of safety in all we do.

Quality Plan Objectives for 2015

1. Simplify the "Front Door" access and ability to navigate health care options in Milwaukee County.
 - North side strategy
2. Focus all services on engaging patients around their self-selection of health outcomes
 -
3. Develop programming and coordination for in creating family/support system involvement and engagement in all services.
 - Family Advisory Council
4. Increase staff competency around human interactions.
 - Educational sessions offered
5. Train all staff on basic quality improvement principles
 - Progress toward quality staff working together across the continuum of BHD
6. Implement Key Performance Indicators for all programs and leadership committees.
 - Data reports structured for PCS, Acute, CARS, Wrap

Quality Improvement Initiatives for 2015

1. Develop a Community Key Performance Indicator Dashboard of meaningful patient outcome measures
 - KPIs for community added to the overall performance dashboard. Continuing to refine

2. Develop a best practice update of our Suicide Assessment and Prevention Interventions in support of the Zero Suicide in Health and Behavioral Health Care goal of the National Action Alliance.
 - Progress to be discussed in Quality Committee meeting.
3. Develop and implement integration of pharmacy, electronic health record and staff practice for an updated state of the art medication management policy and procedure.
 - Implementation of closed loop med system, along with advanced in EHR for med management
 - Impressive implementation approaches and outcomes

Quality Committee Item #3



Milwaukee County Behavioral Health Division 2015 Key Performance Measure (KPM) Dashboard

Program	Measure	2015 (1)	2015 Status (2)	2015 Target (3)
Community Access To Recovery Services	Number Served - AODA	6,080	Green	5,529 *
	Number Served - Mental Health	5,097	Green	4,663*
	Comprehensive Community Service (CCS) Enrollees	236	Green	236 *
	Reduction in past 6 months psychiatric bed days, admission to six months after admission	52%	Red	64% *
	Reduction in past 30 days alcohol or drug use, admission to six months after admission	85%	Green	79% *
	Reduction in homeless or in shelters, admission to six months after admission	79%	Yellow	82% *
	Increase in employment (full or part time-competitive), admission to six months after admission	41%	Red	54% *
	Percent of clients returning to Detox within 30 days	24%	Red	18% *
Wraparound	Families served in Wraparound HMO (unduplicated count)	2,648	Green	2,650 *
	Average level of Family Satisfaction (Rating scale of 1-5)	4.7	Green	> = 4.0 *
	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	68%	Green	> = 75% *
	Average level of "Needs Met" at disenrollement (Rating scale of 1-5)	3.3	Green	> = 3.0 *
	Percentage of youth who have achieved permanency at disenrollment	72%	Green	> = 70% *
	Percentage of Informal Supports on a Child and Family Team	43%	Green	> = 50% *
Crisis Service	Admissions	10,562	Green	10,500 *
	Emergency Detentions	5,558	Green	5,400 *
	Percent of patients returning to PCS within 3 days	8%	Green	8%
	Percent of patients returning to PCS within 30 days	25%	Yellow	20%
	Percent of time on waitlist status	20%	Red	10% *
Acute Adult Inpatient Service	Admissions	1,002	Green	1,125 *
	Mean Daily Census	48.7	Green	52.0 *
	Percent of patients returning to Acute Adult within 30 days	12%	Yellow	7%
	Percent of patients responding positively to satisfaction survey	72%	Yellow	74%
	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	55%	Red	65% *
	HBIPS 1 - Admission screen for violence risk, substance abuse, trauma history, & patient strengths	95%	Green	95% *
	HBIPS 2 - Hours of Physical Restraint Rate	9.0	Red	0.72
	HBIPS 3 - Hours of Locked Seclusion Rate	0.41	Yellow	0.31
	HBIPS 4 - Patients discharged on multiple antipsychotic medications	16%	Yellow	10%
	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96%	Green	30%
	HBIPS 6 - Patients discharged with a continuing care plan	10%	Red	75%
HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	10%	Red	68%	
Child / Adolescent Inpatient Service (CAIS)	Admissions	1,066	Green	1,100 *
	Mean Daily Census	10.8	Green	11.0 *
	Percent of patients returning to CAIS within 30 days	16%	Red	11%
	Percent of patients responding positively to satisfaction survey	69%	Yellow	74% *
	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	73%	Yellow	80% *
	HBIPS 1 - Admission screen for violence risk, substance abuse, trauma history, & patient strengths	95%	Green	95% *
	HBIPS 2 - Hours of Physical Restraint Rate	5.6	Red	0.23
	HBIPS 3 - Hours of Locked Seclusion Rate	0.80	Red	0.30
	HBIPS 4 - Patients discharged on multiple antipsychotic medications	3%	Green	3%
	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96%	Green	36%
	HBIPS 6 - Patients discharged with a continuing care plan	10%	Red	88%
HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	10%	Red	81%	
Financial	Total BHD Revenue (millions)	\$120.5	Yellow	120.5 *
	Total BHD Expenditure (millions)	\$179.6	Yellow	179.6 *

Notes:

(1) 2015 estimates are based on annualized 2015 mid-year data

(2) 2015 Status color definitions: Red (below 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)

(3) * notes that performance measure target was set using historical BHD trends

Quality Committee Item #4

Joint Commission on Accreditation of Hospitals—Behavioral Health

Background:

Milwaukee County Behavioral Health Division maintained accreditation of acute services by the Joint Commission until about 2000. Over the past several years, there has been engagement to pursue Joint Commission standards and actually seek accreditation. An external consultant, Critical Management Solutions, was contracted to do periodic site visits to educate, counsel and assess. Their latest visits were in August, 2014, and now August 18-20, 2015.

Summary of Findings:

Two of the three surveyors onsite were present in 2014 as well as now. They identified

Significant improvements over the past year related to:

- General workplace environment has successfully shifted to being more proactive and stable, rather than reactive and crisis oriented.
- Improvement in qualified and competent staff and their engagement in improving care delivery.
- Significant improvements in aspects of medication management including the closed loop medication system
- Multiple other processes were improved based on previous review.

And beyond.

Additional improvements are needed in:

- Environment of care aspects throughout the facility
- Maintaining and in creating life safety measures
- Contract management processes to include expansion of performance measures and assurance that vendor staff are qualified, oriented and competent
- Improved HR processes and completeness of employee records
- enhanced processes and quality controls in use of point-of-care testing
- Improved infection control plans

And beyond.

Related to Joint Commission standards for the governing board, there is a need for:

- Annual Board self evaluation
- Annual completion of conflict of interest declarations by all board members
- Board policy on conflict management and resolution

Multiple steps and improvements have already been taken since the time of the survey and the feedback report.

Recommendations

- Improve and sustain performance with all Joint Commission standards
- Apply for Joint Commission accreditation in December 2015
- Initial survey to be carried out, unannounced, in the following 12 months
- Anticipated cost of this survey is about \$48,000

Quality Committee Item #5

Transition to Closed Loop Medication System Quality Update

9/15/2015

The BHD Pharmacy department strives to deliver clinical expertise related to pharmaceutical distribution, storage, dispensing, and administration for the hospital to meet the needs of the patients served. The process should be completed efficiently and cost effectively while maintaining optimal patient outcomes. To meet this goal a Closed Loop Medication System, was put into action on June 17th, 2015. Automated Dispensing Cabinets by Pyxis were installed throughout the facility in June 2015 to enhance the Closed Loop Medication System.

The Closed Loop Medication System process at BHD:

1. Computer Physician Order Entry by which physicians enter orders electronically.
2. Pharmacy verifies the Physician Electric Order with an electronic interface.
3. Confirmed order information is electronically sent from the interface to Automated Dispensing Cabinet for nurse medication accessibility.
4. Nurse accesses medication from the Automated Dispensing Cabinet electronically.
5. Nurse scans bar-code of medication with wrist band of patient to confirm right medication, right dose, right time, and right patient.
6. Confirmation of patient identity before administration,
7. Nurse confirms administration electronically.

Since start-up BHD Pharmacy department, with appropriate BHD services, began to evaluate the Closed Loop Medication System as it related to patient outcomes.

The bar code-scanning system and Closed Loop Medication System is a safeguard that helps prevent medication errors from the time a prescription is ordered through each time a drug is given.

Three months of Micromedex and software (Medication database) updates were installed in the BHD electronic medication systems. This combined effort improved nurse scanning of doses at time of medication administration from an estimated 60- 65% at startup to over 90%. Current industry standards indicate scanning of medications to ensure right medication, right dose, and right patient is about 95% Prior to startup no medication doses were scanned.

The Closed Loop Medication System has proven to be beneficial to physicians, nursing, the clinical staff, and patient safety in providing timely administration of medications and improving patient outcomes.

Overall, the Closed Loop Medication System implementation has been successful in reducing medication variances and has promoted a more efficient pharmaceutical process with positive patient outcomes.

Variations

Since start up there has been a reduction in medication variations from 1st quarter 2015 of 33 to 4. (Since startup June 17th, 2015).

This is a reduction of medication variations by 90% in units currently served.

All variations rated as Category A or B (Lowest severity rankings)

Additional Services by BHD Pharmacy

Forty-Two Clinical Pharmacist interventions to improve patient safety

Weekly Clinical Pharmacist attendance on patient care rounds.

BHD Pharmacy passed State of Wisconsin inspection with no variations

Conclusion

Automated Dispensing Cabinets have proven to be beneficial to nursing, the clinical staff, and patient safety in providing timely administration of medications and improving patient outcomes. Overall, the Closed Loop Medication System implementation has been successful in reducing medication variations and has promoted a more efficient pharmaceutical process with positive patient outcomes as the primary goal.

The number of variations has been significantly reduced.

Over 90% of doses dispensed are confirmed through the Closed Loop Medication System process.

Quality Committee Item #6

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: September 16, 2015

TO: Dr. Robert Chayer, Chairperson, Quality Sub-Committee,
Mental Health Board

FROM: Patricia Schroeder, Administrator, Behavioral Health Division (BHD)
Prepared by Jennifer Bergersen, MSW, Chief Clinical Officer, (BHD)

SUBJECT: Informational Report: Update Rehabilitation Centers – Hilltop and Central

In April 2012, the Milwaukee County Department of Health and Human Services notified the State Division of Long Term Care the intention to begin closure of the Rehabilitation Center Hilltop facility. Hilltop and approximately sixty-five residents that had resided at the BHD were relocated to community settings and the program closed end of year 2014.

In August 2013, the BHD also filed intent to close the skilled nursing facility, Rehabilitation Center Central (RCC). As of September 10, 2015, fourteen residents remain from the total of approximately sixty-five at the BHD Rehabilitation Center Central with several more community transitions of individuals targeted within the next several weeks. Twenty-Eight residents had been residing at RCC at the start of year 2015. Rehab Center Central is targeted for closure end of year 2015. The two remaining RCC resident care units 44A and 44B will soon be consolidated as census reduces.

The Behavioral Health Division (BHD) continues to be actively engaged in comprehensive resident community relocation activities. This includes the bi-weekly oversight from participants of the Rehab Center Central Relocation Team in the review of all discharge planning elements including attention to individual resident strengths and planning for potential obstacles, while engaging each resident and their support system, facility team and providers to secure an appropriate community home setting. Careful attention to resident rights, health, safety and welfare are considered by all in the development and implementation of these plans.

Plans are in place to transition the remaining residents upon the conclusion of new site construction, community provider readiness, and participation by residents and/or guardians in the final selection of services, locations and funding agreements. The BHD facility staff continue to participate with the planning, preparation and transition of each resident as to ensure a successful and safe move. Special attention to resident reaction and preparation for relocation

is a priority as to best address the emotional, physical and behavioral health needs of each resident, many who have resided in this facility for some many years.

There continues to be incident and stories of successful initial community transitions. Staff from BHD have also assisted in ensuring residents have participated in the transition activities including engaging with community providers and case managers, facilitating home tours and overnight passes for residents and families, visiting after discharge, and ensuring residents have special items to ensure a warm and welcoming move while under the continued oversight of the clinical treatment team. As a measure of further quality, the BHD is eagerly anticipating the results of the quality reviews of these community placements conducted by advocacy agency (DRW) in conjunction of a grant to review resident progress both at thirty days and six months post-discharge. Further measures of quality are being determined.

The BHD continues to monitor these individuals who have utilized Crisis and Inpatient Services as well, also understanding that use and access to these services may not in itself be identified as an indicator of a treatment failure rather a potential opportunity for improvement or a necessary step in some residents recovery paths. The graph below is a general overview to monitor the frequency individuals from Hilltop and Central accessed Crisis Mobile Services Psychiatric Crisis Services (PCS), Observation and admission to an Acute Inpatient unit respectively. An individual may have accessed several levels of service within a particular time frame. Readmission rates have been calculated and included. Further detail by individual resident is available for additional analysis and quality review.

2013 - 2015 BHD Crisis Service & Acute Adult Admissions from Discharged Rehab Center Residents (Discharged after 4/1/13) – Update 9/3/15

Program	Year	Resident Discharges	Admissions From Discharged Rehab Center Residents						Inpatient Readmission Rate
			Crisis Service			Acute Adult			
			Crisis Mobile	PCS	Observation	43A	43B	43C	
Central	2013	19	1	3	1	0	1	0	5.3%
	2014	23	5	12	3	1	4	0	14.3%
	2015	13	5	23	9	2	3	1	10.9%
	Total	55	11	38	13	3	8	1	10.2%
Hilltop	2013	8	0	0	0	0	0	0	0.0%
	2014	45	6	9	4	1	0	0	2.2%
	2015	1	7	18	7	0	0	0	0.0%
	Total	54	13	27	11	1	0	0	0.7%

Informational item only.



WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

» LEAD

» TRAIN

» IDENTIFY

» ENGAGE

» TREAT

» TRANSITION

» IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

- 1 LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
- 2 TRAIN** » Develop a competent, confident, and caring workforce.
- 3 IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
- 4 ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
- 5 TREAT** » Use effective, evidence-based treatments that directly target suicidality.
- 6 TRANSITION** » Provide continuous contact and support, especially after acute care.
- 7 IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

"It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It's about purposefully aiming for a higher level of performance."

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com.



FOR MORE INFORMATION, PLEASE CONTACT:

Julie Goldstein Grumet, PhD

Director of Prevention and Practice
Suicide Prevention Resource Center

Education Development Center, Inc.

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Washington, DC 20007

Phone: 202.572.3721

Email: jgoldstein@edc.org

Phase 1: Organization structure and assessment (April – December 2015)

Strategy	Action Steps	Staff Responsible	Due Date	Updates
1) Organization of Zero Suicide Task Force (ZSTF)	<ol style="list-style-type: none"> 1) Identify team to attend ZS Academy 2) Review ZS Self Assessment. 3) Review ZS Workplan. 4) Develop BHD workplan. 5) Set target goals and evaluation plan to determine growth and success. 	<p>Amy ZSTF ZSTF ZSTF ZSTF</p>	<p>April 2015 June 2015 July 2015 August 2015 September 2015</p>	<p>Have gone through Self-Assessment and Workplan. Need to review workplan and establish goals and evaluation plan.</p>
2) Build capacity of ZSTF	<ol style="list-style-type: none"> 1) Consider internal groups to partner with. 2) Engage external partner groups i.e. PSGM 3) Identify attempt survivors and family members who lost someone to suicide 	<p>Amy Annie Heather, Darrell</p>	<p>September 2015 October 2015 October 2015</p>	<p>Amy will determine groups that oversee policies that can help with policy assessment see if we can sit in on that group. Started outreach to external organizations for partnership. Will present at Oct. PSGM Quarterly Meeting.</p>
3) Assess organization's current policies for suicide management	<ol style="list-style-type: none"> 1) Ensure policies and procedures assess and screen individuals at risk for suicide on a suicide care management plan and develop clear protocols around documentation of patient status and when patient is no longer considered suicidal. 2) Policies and procedures should include support for staff who have experience the suicide death of a patient. 4) Determine a valid and reliable screening measure is used by appropriate staff. 5) Staff are routinely documenting suicide risk screenings. 6) Outline frequency of screening and assessment. 7) Establish workflows on screening and identification process. 8) Ensure facility has a written policy and procedure stating suicide risk assessment is completed during the same visit whenever a patient screens positive for suicide risk. 9) Ensure facility has a written policy and procedure stating patients are provided timely 	<p>Matt, Andre, Sylvia, Brian (Consider Ad-hoc group to include Lynn Gramm, Mel or that we sit in on groups)</p>	<p>October 2015</p>	<p>Need to review all policies and then determine 3-5 we want to address with the understanding it may take awhile to address all and implement. Also need to think about anything we want as qualifiable data as reviewing policies so we will know how to measure. Amy will determine groups that ZS committee members could be a part of as policies are being reviewed.</p>

	access to clinically trained staff after screening positive for suicide risk. 10) Establish a template for lethal means and safety planning.			
4) Assess workforce for skills and confidence in providing suicide care.	1) Create survey (or does ZS have one) 2) Utilize healthstream to survey internal staff 3) Utilize MC3 to survey contracted providers and include question about policy around suicide care (screening/assessment) 4) Utilize United Way/PSGM to survey community orgs. 5) VA/healthcare partnership and medical society	Annie, Andre, Amy M.	December 2015	Check to see if ZS has a workforce survey.

Phase 2: Build Support and Planning (January – June 2016)

5) Review and develop plan	1) Review results from the assessment of policies and staff confidence	ZSTF	February 2016	
	2) Develop a plan for policy changes, training, and implementation	ZSTF	February 2016	
	3) Start to identify better practices for warm hand-offs between organizations	ZSTF	April 2016	
6) Board and management support	1) Present assessment findings 2) Present plan for implementation 3) Determine others who may need to be on ZSTF	Amy	March 2016	
7) Partner with Discharge team for best practices and assessment of services	1) Establish a discharge team.	Amy	April 2016	
	2) Establish protocols for discharge team.	Sylvia, Matt	April 2016	
	3) Establish an engagement plan for patients who are hard to reach.	Discharge/Care Coordination	April 2016	
	4) Discharge team to help determine which tools are best for document linking, bridging strategies and follow-up.		July 2016	
8) Design an evaluation plan to assess impact	1) Create evaluation plan to track progress of policy implementation and trainings. 2) Establish a review team of internal/external data to report on-going progress and success.	Matt, Andre	February 2016	

Phase 3: Communication and Training

Phase 4: Implementation

Phase 5: Evaluation and On-going improvement practices

Quality Committee Item #8

UPDATE ON ENVIRONMENTAL SAFETY

EXECUTIVE SUMMARY

THREAT EVENT: AUGUST 2015

The Milwaukee County Behavioral Health Division (BHD) received two threatening telephone calls between 1430 and 1530 on August 20, 2015. The Milwaukee County Sheriff's Office (MCSO) was notified, and responded to the unit to conduct the investigation. The nurse managers reported the incident to leadership who, in the interest of safety, declared an "essential movement only condition", which is a modified form of a lockdown. The announcement for "essential movement only condition" was communicated via overhead page and the Emergency Operations Center was established.

Within the first 25 minutes of the lockdown a BHD staff texted a message to a family member informing them of the lockdown and communicated a farewell message in case the situation became grave. The family member proceeded to call the Milwaukee Police Department (MPD) to report his daughters' message, that there was an active shooter in the building, and an unknown number of shots had already been fired. MPD relayed that shots had been fired to MCSO. As a result additional law enforcement responded including the Wauwatosa Police Department and SWAT team who responded based on the information of an "active shooter" present in the building. Responders entered and proceeded to conduct a partial sweep of the building until 1715 at which time it was determined there was not an active shooter. After further discussion with the MCSO, BHD provided an all clear announcement via overhead page. BHD security completed the sweep of the inside and exterior of the building. Visiting hours were cancelled for the remainder of the evening. MCSO was able to obtain the caller's identity who made the threats through a telephone trace and arrested the individual at his home later that night.

Overall the event response was successful. Individuals displayed good teamwork in accomplishing the necessary tasks in a timely fashion. Future exercise involving similar situations should test the initiation of the Emergency Operations Center, Command team response, and communication within the organization.

Strengths

- ✓ BHD staff implemented the emergency procedures in an effective and timely manner to ensure everyone's safety.
- ✓ The Emergency Operations Center was successfully opened and utilized to centralize and coordinate activities.
- ✓ The majority of the staff responded to the essential movement only directive until the all clear.
- ✓ Security Officers responded by checking and ensuring all exterior doors were locked.
- ✓ The Emergency Operations Center had all the necessary equipment available to monitor radio communications between the Sheriff's department and Wauwatosa Police department.
- ✓ Leadership staff utilized cell phones and text messaging as necessary.

Improvement Opportunities

Quality Committee Item #9

Milwaukee County Mental Health Board Quality Committee

2016 Meeting Schedule

November 2, 2015

March 7, 2016

June 6, 2016

*September 6, 2016

December 5, 2016

All dates fall on the first Monday of the month.

Meeting time is 10:00 a.m. – 12:00 noon.

****Note: The first Monday of the month in September is a holiday, therefore, the meeting date falls on that following Tuesday.***

BEHAVIORAL HEALTH DIVISION

October 2015
FISCAL REPORT

2015 FISCAL SUMMARY

Behavioral Health Division – Inpatient

- Central Closure
- Patient Census/Bed Reduction
- Fringe Surplus

CARSD – Community Access to Recovery Services Division

- WIMCR
- Community EMR Implementation
- AODA Surplus
- Comprehensive Community Services
- Value Based Contracting

**BHD - Combined Reporting
2015 Fiscal Results
P & L Summary**

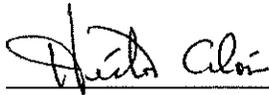
		2015 Budget	2015 Projection	Surplus/ (Deficit)
BHD Combined	Revenue	120,496,239	112,513,664	(7,982,575)
	Expense	182,436,405	171,201,748	11,234,657
	Tax Levy	61,940,166	58,688,084	3,252,082
BHD Inpatient	Revenue	29,613,478	29,978,548	365,070
	Expense	78,069,168	76,524,956	1,544,212
	Tax Levy	48,455,690	46,546,408	1,909,282
CARSD	Revenue	90,882,761	82,535,116	(8,347,645)
	Expense	104,367,237	94,676,792	9,690,445
	Tax Levy	13,484,476	12,141,676	1,342,800

Budget Timeline

The remainder of the County's budget calendar is detailed below. The County Board cannot set policy for BHD and will not alter the tax levy set by the County Executive of \$58,812,971.

No later than October 1st	County Executive presents to the County Board the Executive budget for the subsequent year. This is then referred to the Board's Finance, Personnel & Audit Committee for review and recommendation.
October 1 – to 1st Week in November	Finance, Personnel & Audit Committee reviews the County Executive budget.
November – Not later than the 1st Monday in the Month	County Board public hearing on Budget, inviting member of the general public to comment on the Executive budget and Finance, Personnel & Audit Committee changes to date.
Monday after 1st Thursday in November	County Board annual meeting and the adoption of the Budget and tax levies. During this meeting, the County Board votes on the amendments and recommendations submitted by the Finance, Personnel & Audit Committee relative to the County Executive budget as well as the amendments submitted by individual County Board members.
Mid-November	After being presented with the budget, the County Executive has one week to return the budget with vetoes
Mid-November	If necessary, County Board votes on vetoes. Vetoes can be overridden with a two-thirds majority vote.
Mid/Late-November	County budget is final.
January 1st of the Following Year	Budget is enacted.

Respectfully submitted,



Héctor Colón, Director

Department of Health and Human Services

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: September 30, 2015

TO: Kimberly Walker, Chairperson, Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division
Prepared by Randy Oleszak, Deputy Administrator, Community Access to Recovery Services

SUBJECT: Report from the Director, Department Health and Human Services, requesting to enter into a contract with Deloitte in order to conduct a study of alternate fund sources required in 2013 Wisconsin Act 203.

Issue

Wisconsin Statutes 51.41(10) requires Milwaukee County Mental Health Board approval for contracts with a value of \$100,000 or greater. Per the statute, the Director, Department of Health and Human Services (DHHS), is requesting authorization for BHD to enter into a professional services contract with Deloitte not to exceed \$500,000.

Background

2013 Wisconsin Act 203 added language to WI 51.41 requiring the Milwaukee County Mental Health Board to arrange for a study regarding possible alternate fund sources for mental health services at the Behavioral Health Division:

“The Milwaukee County mental health board shall arrange for a study to be conducted on alternate funding sources for mental health services and programs including fee-for-service models, managed care models that integrate mental health services into the contracts with an increased offset through basic county allocation reduction, and other funding models. By March 1, 2016, the Milwaukee County mental health board shall submit to the Milwaukee County board of supervisors, the Milwaukee County executive, and the department a report of the results of the study.”

Recommendation

The Department recommends Deloitte be selected to conduct this study. Deloitte completed the Milwaukee County Mental Health State Audit in December 2014, was a participant in the drafting of ACT 203, is experienced with State hospital rate setting and State Medicaid managed care policy. It is recommended that Deloitte be awarded a no-bid contract to conduct this study by March 1, 2016.

Fiscal Note

The estimated cost of the study is \$500,000. This expenditure was not included in the Behavioral Health Division's 2015 Budget. The Department will fund this study through projected 2015 surplus.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Héctor Colón", written over a horizontal line.

Héctor Colón, Director
Department of Health and Human Services

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

DATE: September 23, 2015

TO: Kimberly R. Walker, JD, Chairperson, Milwaukee County Mental Health Board

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

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

Background

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

Discussion

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

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

As of the date of this report, there are no notations to report.

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 Patricia Schroeder, BHD Administrator
John Schneider, BHD Chief Medical Officer
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

Attachment

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
SEPTEMBER / OCTOBER 2015**

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

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 2, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 17, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Gregory Burek, MD	Psychiatric Officer of the Day; 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.	
Stanley Lyndon, MD	Psychiatric Officer of the Day; 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							
Karl Kaeser, RN	51.15 Treatment Director Designee	Allied Health/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends appointment and privileges through 6/30/17*, subject to a minimum provisional period of 6 months contingent on successful completion of 51.15 Treatment Director Designee training on 9/10/15. (Verification of completion and passing score received 9/14/15)	Recommends appointment and privileging as per C&PR Committee.	
Sean Ryan, MS	51.15 Treatment Director Designee	Allied Health/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends appointment and privileges through 6/30/17*, subject to a minimum provisional period of 6 months contingent on successful completion of 51.15 Treatment Director Designee training on 9/10/15. (Verification of completion and passing score received 9/14/15)	Recommends appointment and privileging as per C&PR Committee.	
John Runnoe, RN	51.15 Treatment Director Designee	Allied Health/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends appointment and privileges through 6/30/17*, subject to a minimum provisional period of 6 months contingent on successful completion of 51.15 Treatment Director Designee training on 9/10/15. (Verification of completion and passing score received 9/14/15)	Recommends appointment and privileging as per C&PR Committee.	
Brian Wimmer, MSW	51.15 Treatment Director Designee	Allied Health/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends appointment and privileges through 6/30/17*, subject to a minimum provisional period of 6 months contingent on successful completion of 51.15 Treatment Director Designee training on 9/10/15. (Verification of completion and passing score received 9/14/15)	Recommends appointment and privileging as per C&PR Committee.	

*Appointment period recommended is less than two-years to correlate with 51.15 Treatment Director Designee pilot period, which was extended through 6/30/2017, in the Governor's 2015-2017 Budget

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 2, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 17, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NO REAPPOINTMENTS DUE THIS PERIOD							

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 2, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 17, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NO PROVISIONAL PERIOD ASSESSMENT REVIEWS DUE THIS PERIOD.							

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE SEPTEMBER 2, 2015	MEDICAL STAFF EXECUTIVE COMMITTEE SEPTEMBER 17, 2015	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Jason Burns, MD	Psychiatric Officer of the Day; Medical Officer of the Day / Affiliate	General Psychiatry; General Medical Practice / Affiliate		Dr. Thrasher recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium.	Recommends amending privileging as per C&PR Committee.	
Annaliese Koller Shumate, DO	Psychiatric Officer of the Day; Medical Officer of the Day / Affiliate	General Psychiatry; General Medical Practice / Affiliate		Dr. Thrasher recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for remainder of current biennium.	Recommends amending privileging as per C&PR Committee.	

MEDICAL STAFF ORGANIZATION GOVERNING DOCUMENTS AND POLICY/PROCEDURE UPDATES	MEDICAL STAFF ACTION	GOVERNING BODY ACTION
NONE THIS PERIOD.		

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

9/18/2015
 DATE

Cherine Choum
 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

9/17/15
 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 APPROVED BY BOARD