Report 16-14
December 2016

Milwaukee County Mental Health Board

State of Wisconsin



Legislative Audit Bureau

Report 16-14
December 2016

Milwaukee County Mental Health Board

Joint Legislative Audit Committee Members

Senate Members:

Robert Cowles, Co-chairperson
Mary Lazich
Alberta Darling
Kathleen Vinehout
Janet Bewley

Assembly Members:

Samantha Kerkman, Co-chairperson
John Macco
John Nygren
Melissa Sargent
Terese Berceau

Report 16-14
December 2016

LEGISLATIVE AUDIT BUREAU

State Auditor
Joe Chrisman

Special Assistant to the State Auditor
Anne Sappenfield

Deputy State Auditor for Performance Evaluation
Paul Stuiber

Team Leader
Dan Kleinmaier

Evaluators
Laura Brauer
Ken Karnovsky
Nick Lardinois
Maria Toniolo

Publications and Design Coordinator
Susan Skowronski

The Bureau is a nonpartisan legislative service agency responsible for conducting financial audits and performance evaluations of state agencies. The Bureau's purpose is to provide assurance to the Legislature that financial transactions and management decisions are made effectively, efficiently, and in compliance with state law and that state agencies carry out the policies of the Legislature and the Governor. Audit Bureau reports typically contain reviews of financial transactions, analyses of agency performance or public policy issues, conclusions regarding the causes of problems found, and recommendations for improvement.

Reports are submitted to the Joint Legislative Audit Committee and made available to other committees of the Legislature and to the public. The Audit Committee may arrange public hearings on the issues identified in a report and may introduce legislation in response to the audit recommendations. However, the findings, conclusions, and recommendations in the report are those of the Legislative Audit Bureau.

The Bureau accepts confidential tips about fraud, waste, and mismanagement in any Wisconsin state agency or program through its hotline at 1-877-FRAUD-17.

For more information, visit *www.legis.wisconsin.gov/lab.*

Contact the Bureau at 22 East Mifflin Street, Suite 500, Madison, Wisconsin 53703; *AskLAB@legis.wisconsin.gov;* or (608) 266-2818.

CONTENTS

STATE OF WISCONSIN
Legislative Audit Bureau

Celebrating 50 Years of Service 1966-2016

22 East Mifflin Street, Suite 500 ▪ Madison, WI 53703 ▪ (608) 266-2818 ▪ Hotline: 1-877-FRAUD-17 ▪ www.legis.wisconsin.gov/lab

Joe Chrisman
State Auditor

December 20, 2016

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

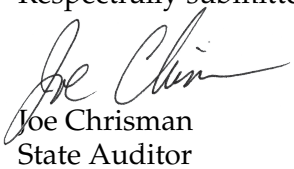
As required by s. 13.94 (1) (mg), Wis. Stats., we have completed our first biennial audit of the Milwaukee County Mental Health Board. The Board was created to assume responsibility for overseeing all mental health functions, programs, and services that had previously been the responsibility of the Milwaukee County Board of Supervisors and to establish policies and develop budgets for such functions, programs, and services.

Since July 2014, the Board has overseen the Behavioral Health Division (BHD) of the Milwaukee County Department of Health and Human Services, which is responsible for ensuring the provision of mental health services to county residents. From 2014 to 2015, BHD's expenditures increased from $171.4 million to $173.5 million (1.3 percent), while the number of authorized full-time equivalent (FTE) positions decreased from 669.0 FTE positions to 585.3 FTE positions. This decrease was in part the result of efforts to reduce the provision of care in institutional-based settings and increase the provision of care in less restrictive, community-based settings.
In 2015, BHD provided mental health services through 26 programs. It provided institutional-based services directly, such as psychiatric emergency room services and hospital services, and it entered into agreements with hundreds of vendors to provide most community-based services, such as treatment and residential services.

Our analysis was limited by several factors. For example, BHD has not consistently budgeted or maintained expenditure information on a program-level basis, has not consistently included in its contracts the specific policies with which vendors are expected to comply or the standards that it will use to measure their performance, and has not developed overall performance indicators for each of the community-based programs it administers. We make a series of recommendations to address these issues, and we also recommend the Board comply with statutes by appointing a Board of Trustees for BHD's psychiatric hospital.

We appreciate the courtesy and cooperation extended to us by Board members, BHD, and community stakeholders. A response from BHD follows the appendices.

Respectfully submitted,



Joe Chrisman
State Auditor

JC/PS/ss

Report Highlights ■

BHD has not consistently or clearly delineated the specific programs and services it administers.

BHD's expenditures increased from $171.4 million in 2014 to $173.5 million in 2015, or by 1.3 percent.

BHD plans to close the Mental Health Complex and discontinue its direct provision of institutional-based care in 2018 or later.

BHD has not developed specific performance indicators for each of its community-based programs.

The Milwaukee County Mental Health Board was created by 2013 Wisconsin Act 203 to assume responsibility for overseeing mental health functions, programs, and services that had previously been the responsibility of the Milwaukee County Board of Supervisors and to establish policies and develop budgets regarding them. Since July 2014, the Board has overseen the Behavioral Health Division (BHD) of the Milwaukee County Department of Health and Human Services, which is responsible for ensuring the provision of mental health services to county residents.

Under s. 13.94 (1) (mg), Wis. Stats., the Legislative Audit Bureau is required to conduct a biennial financial and performance evaluation audit of the Board and of the mental health functions, programs, and services it oversees. Therefore, we analyzed:

- the policies adopted by the Board;
- the mental health programs and services overseen by the Board;
- expenditures for mental health functions, programs, and services; and
- available data on the outcomes of mental health programs and services in the period after formation of the Board.

Our analysis of the mental health functions, programs, and services overseen by the Board was limited by several factors. For example, BHD has not:

- consistently or clearly delineated the specific programs it administers or the services it provides;
- consistently budgeted on a program-level basis or maintained expenditure information in sufficient detail to allow for an accurate estimation of program-level expenditures for most of its 26 programs;
- consistently included in its contracts the specific policies with which vendors are expected to comply or the standards that BHD will use to measure performance; and
- developed overall performance indicators for each of its community-based programs.

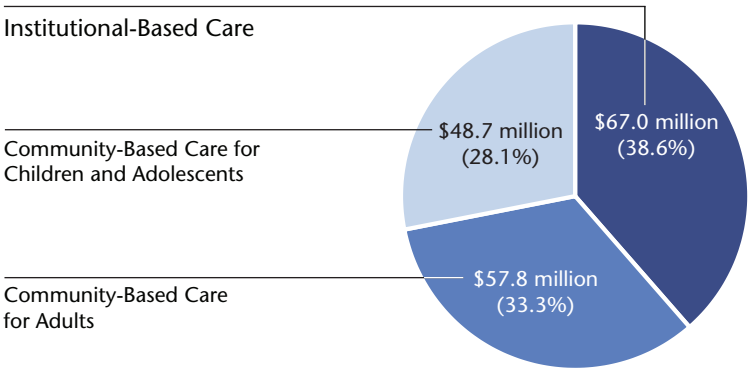
Therefore, we focused our analyses on strategies to improve the ability of BHD and the Board to administer and oversee mental health functions, programs, and services in Milwaukee County.

Expenditures

BHD's expenditures increased from $171.4 million in 2014 to $173.5 million in 2015, or by 1.3 percent. Medical Assistance was the largest funding source in both years. Because most program-level expenditures could not be accurately estimated, we instead grouped expenditures into three broad categories: institutional-based care, community-based care for adults, and community-based care for children and adolescents, which are shown in Figure 1.

Figure 1

BHD Expenditures by Program Category
2015



Institutional-Based Care

In 2015, BHD provided institutional-based care through three programs: a psychiatric emergency room, a 72-bed psychiatric hospital, and two long-term care facilities. In 2015, there were 10,173 admissions of 5,987 recipients to the psychiatric emergency room.

BHD plans to close the Mental Health Complex and discontinue its direct provision of institutional-based care in 2018 or later. As of November 2016, BHD and the Board were pursuing options to enter into a multi-year contract with a private vendor. In addition, BHD closed both long-term care facilities, one in January 2015 and the other in January 2016. Of the 133 recipients who had resided in these facilities before their closure, 100 (75.2 percent) were determined to be eligible for the State's Family Care program.

In 2015, BHD used 27 performance indicators to help measure its performance in providing mental health services through its psychiatric emergency room and hospital. We found that it met 9 (33.3 percent) of the 27 goals it established for these indicators.

Community-Based Care for Adults

In 2015, BHD provided mental health services to adult recipients through 19 community-based programs. We found that BHD has not clearly or consistently defined the programs and services it

provides. In addition, BHD does not maintain or make available consistent descriptions of its programs that identify who may be served and what services are available under each program, nor does it electronically maintain information documenting what services have been provided to which recipients in a readily accessible format.

We found that BHD had not developed performance indicators for each of its 19 programs for adults and instead relied on eight performance indicators to help assess the overall operation and effectiveness of these programs. In 2015, it met its goals for three (37.5 percent) of the eight performance indicators for adults.

Community-Based Care for Children and Adolescents

In 2015, BHD provided mental health services to children and adolescents through four community-based programs. Services provided include on-site assessment and crisis stabilization of those with urgent mental health needs, counseling, medication, and support services.

We found that BHD had not developed performance indicators for each of its four programs for children and adolescents. Instead it relied on six performance indicators to help assess the overall operation and effectiveness of these programs, but only two were directly associated with a specific program. In 2015, BHD met its goals for three (50.0 percent) of its six performance indicators for children and adolescents.

Oversight

We reviewed the oversight provided by BHD and the Board. We found that BHD's contracts for community-based mental health services do not generally contain provisions for assessing vendor performance, describing what constitutes acceptable performance, or delineating what actions BHD may take in instances of inadequate performance. This may limit BHD's ability to address instances of inadequate performance.

We also found that as of August 2016, BHD had not reviewed 144 of its 505 policies (28.5 percent) in a timely manner, including 43 that were overdue for review by over 10 years. Timely review is important to ensuring that policies reflect current legal requirements and Board priorities, as well as adequately meet the needs of recipients.

Through September 2016, the Board had adopted 27 policies. However, BHD has not centrally compiled these policies or made them readily available to Board members or the public. We identified two instances in which the Board was not following its own bylaws. After we raised these issues during the course of our audit, the Board took action in August 2016 to amend its bylaws.

Recommendations

We include recommendations for BHD to:

- ☑ budget for mental health expenditures on a program-level basis, maintain detailed expenditure information, and regularly provide the Board with status reports *(p. 19)*;
- ☑ submit to the Board for its review and approval all fee-for-service contracts that are likely to total or exceed $100,000 *(p. 20)*;
- ☑ maintain and analyze electronic data on the specific community-based services provided to all recipients who are discharged home from its psychiatric emergency room *(p. 26)*;
- ☑ develop and submit to the Board for its approval adequate performance indicators for each of its programs, modify the calculation of certain performance indicators to ensure they are accurate, maintain information on the procedures it used, and annually report performance results to the Board *(pp. 34, 52, and 61)*;
- ☑ modify its contracts for mental health services to include provisions establishing performance-based standards, annually assess vendor performance, and annually report to the Board on these assessments *(p. 64)*; and
- ☑ centrally maintain all policies adopted by the Board and make them accessible to Board members and the public *(p. 67)*.

We include recommendations for BHD to report to the Joint Legislative Audit Committee and the Board by June 1, 2017 on:

- ☑ developing a strategy to address staffing issues at its hospital *(p. 39);*
- ☑ developing performance indicators for individuals placed on a waiting list for institutional-based care *(p. 39);*
- ☑ clearly delineating the community-based programs for adults that it administers and the services provided by each *(p. 48);*
- ☑ electronically maintaining records of services provided to recipients *(p. 48);*
- ☑ identifying the policies that apply to each of its programs and the policies with which vendors are expected to comply *(p. 48);* and
- ☑ reviewing 144 policies that are overdue for review *(p. 65).*

We also recommend the Board comply with statutes by appointing a Board of Trustees for BHD's psychiatric hospital, as specified in s. 46.18 (1), Wis. Stats. *(p. 70).*

■ ■ ■ ■

Introduction ■

The Board's 13 members include mental health care professionals, consumers, and advocates.

Since July 2014, the Milwaukee County Mental Health Board has overseen the mental health functions, programs, and services administered by the Behavioral Health Division of the Milwaukee County Department of Health and Human Services (DHHS). The Board consists of 13 members who include mental health care professionals, consumers, and advocates. At its inception, 11 members were to be nominated by the Governor and approved by the Senate for staggered four-year terms, including:

- 5 from lists of potential members suggested by the Milwaukee County Board of Supervisors;
- 4 from lists of potential members suggested by the Milwaukee County Executive; and
- 2 non-voting members, one each from lists provided by the Medical College of Wisconsin and the University of Wisconsin-Madison.

An additional two ex officio members are represented on the Board based on their respective positions as chairpersons, or the designees of the chairpersons, of the Milwaukee County Combined Community Services Board and the Milwaukee Mental Health Task Force. No board member may be an employee of Milwaukee County or a lobbyist or hold an elected office.

For administrative purposes, statutes initially established the Board as a state entity attached to the State's Department of Health Services

(DHS). Beginning on January 1, 2015, the Board was reconstituted as a county entity, with the county executive, rather than the Governor, assuming responsibility for appointing Board members. Appendix 1 lists the members as of October 2016.

Board Responsibilities

The Board develops policies and budgets, and it oversees the provision of mental health programs and services in Milwaukee County.

2013 Wisconsin Act 203 provides the Board with primary responsibility for the well-being, treatment, and care of mentally ill and drug-dependent citizens residing in Milwaukee County. The most common mental illnesses for which individuals receive treatment and care include depressive and bipolar disorders, substance-related disorders, and schizophrenia. The Act gives the Board broad responsibility for developing mental health policies and budgets and for overseeing the provision of mental health programs and services in Milwaukee County. It also removes jurisdiction for mental health from the Milwaukee County Board of Supervisors and prevents it from establishing mental health policies.

Examples of specific responsibilities of the Milwaukee County Mental Health Board under Act 203, include:

- allocating budgeted funds for mental health functions, programs, and services;
- maximizing the provision of comprehensive community-based services;
- focusing on treating individuals with mental illness in the least-restrictive environment possible;
- diverting individuals with mental illness from the corrections system when appropriate;
- maximizing the use of mobile-crisis units and crisis-intervention training; and
- attempting to achieve costs savings in the provision of mental health programs and services.

The mental health functions, programs, and services the Board is responsible for overseeing are administered by BHD, which provides mental health services, including services related to alcohol and other drug abuse (AODA), directly through its psychiatric emergency room and hospital, which are located at the Milwaukee County Mental Health Complex, and throughout the community under agreements with numerous vendors. The types of services

provided include emergency mental health care, psychiatric hospital care, residential care, outpatient treatment programs, and counseling.

Mental Health Programs Overseen by the Board

BHD has not consistently or clearly delineated the specific programs and services it administers.

In reviewing the mental health services overseen by the Board, we found that BHD has not consistently or clearly delineated the specific programs and services it administers. Consequently, neither documents produced by BHD nor by consultants hired to review its operations have consistently reported on the number of programs or on the categories of programs and the services they provide.

In conducting our evaluation, we reviewed available information produced by BHD on its programs and services, including budget and expenditure information, and we discussed with BHD managers their views of how best to group services into distinct and meaningful programs. Based on these discussions, BHD grouped the services it provided into 26 programs. For the purposes of our evaluation, a program is defined as a collection of services, provided either directly by BHD or through vendors, which are delivered to a specific group of recipients in order to help prevent or ameliorate mental illnesses, including substance abuse.

BHD administered 26 programs in 2015.

Table 1 shows the 26 programs that BHD administered in 2015. We grouped these programs into three broad categories: institutional-based care, community-based care for adults, and community-based care for children and adolescents. Appendix 2 identifies the services provided by each of these programs. In addition, program descriptions, information on the number and type of recipients served, and information on program performance are presented in Appendix 3 for institutional-based programs, Appendix 4 for community-based programs for adults, and Appendix 5 for community-based programs for children and adolescents.

Table 1

Programs Overseen by the Milwaukee County Mental Health Board[1]
2015

Institutional-Based Care
Inpatient Services Program
Long-Term Care Program[2]
Psychiatric Emergency Medical Services Program
Community-Based Care for Adults
Acute Crisis Programs
Crisis Line Program
Mobile Treatment Teams Program
Outpatient Access Clinics Program
Recovery Programs
Community Linkages and Stabilization Program
Community Options Program
Community Recovery Services Program
Comprehensive Community Services Program
Recovery Support Coordination Program
Recovery Support Services Program
Residential Programs
Community-Based Alcohol and Other Drug Abuse Residential Program
Community-Based Detoxification Residential Program
Community-Based Mental Health Residential Program
Crisis Resource Centers Program
Crisis Stabilization Homes Program
Treatment Programs
Care Coordination Unit Program
Community Support Program
Day Treatment Program
Outpatient Treatment Clinics Program
Targeted Case Management Program
Community-Based Care for Children and Adolescents
Court-Ordered Wraparound Program
Mobile Urgent Treatment Team Program
Project Older Youth and Emerging Adult Heroes Program
Reaching, Engaging and Assisting Children and Families Program

[1] As indicated by BHD.

[2] This program was discontinued in January 2016.

In conducting our audit we spoke with 10 current and former Board members; staff of BHD, DHS, and the Wisconsin Public Defender's Office; other county legal, financial, and law enforcement personnel; and representatives of nonprofit organizations with an interest in mental health issues.

■ ■ ■ ■

Expenditures and Staffing ■

The Board has responsibility for overseeing the process for developing the annual mental health budget, approving the budget, and monitoring BHD's expenditures. We used the available information to estimate and analyze mental health expenditures, assess the Board's statutory compliance with contract approval requirements, and review staffing levels. We found that BHD's expenditures increased by 1.3 percent from 2014 through 2015, and approximately 60 percent of its expenditures were funded with Medical Assistance and county tax levy funds. We also found that BHD does not maintain adequate information to accurately estimate expenditures for each of its 26 programs. We make recommendations to improve expenditure tracking and reporting as well as the contract approval process.

Budgeting for Mental Health Services

Since 2014, Milwaukee County's annual mental health budget has been prepared by BHD at the direction of the Board.

Since 2014, Milwaukee County's annual mental health budget for the upcoming year has been prepared by BHD at the direction of the Board. BHD staff begin budget planning as early as January and are required by s. 59.60 (4), Wis. Stats., to submit a Board-approved budget request for the upcoming year by July 15. For 2015, the Board did not approve BHD's budget request until August 2014, primarily because the Board met for the first time after its creation on July 17, 2014, and was not prepared to both receive and approve BHD's budget request at its initial meeting.

The county executive has the authority to modify the portion of the mental health budget funded by county tax levy before forwarding it as part of the overall county budget to the Milwaukee County Board of Supervisors for approval. Section 51.41 (4) (b), Wis. Stats., provides that the County's annual tax levy amount for mental health services cannot be less than $53.0 million nor more than $65.0 million. The amount of tax levy budgeted was $59.1 million in 2015 and $58.8 million in 2016.

Section 59.60 (6) (b), Wis. Stats., requires the county executive to present the executive budget to the County Board by October 1 of each year. The County's budget is generally finalized in late November, after the county executive has had the opportunity to veto amendments approved by the County Board, which has authority to override any vetoes.

Since the Milwaukee County Mental Health Board began operations in July 2014, Board members indicated that the first two budget cycles served as an adjustment period as it worked to develop a suitable budget timeline and process. After the first Board meeting in July 2014, Board members had 42 days to approve the 2015 budget. However, additional time has been provided in subsequent years. From the time preliminary budget information was presented to the Board's finance committee, the Board had 49 days to act on the 2016 budget and 84 days to act on the 2017 budget.

Expenditures for Mental Health Services

BHD's estimated expenditures increased from $171.4 million in 2014 to $173.5 million in 2015, or by 1.3 percent.

BHD does not maintain detailed expenditure information by funding source. Therefore, expenditures had to be estimated based on the best available information. As shown in Table 2, estimated BHD expenditures by funding source increased from $171.4 million in 2014 to $173.5 million in 2015, or by 1.3 percent. Medical Assistance was the largest funding source in both years, followed closely by county tax levy. When combined these two funding sources accounted for approximately 60 percent of BHD's expenditures. The Basic County Allocation, a combination of general purpose revenue (GPR) and federal revenue, which DHS distributes to all counties to support social services programs, funded 13.6 percent of BHD's expenditures in 2015.

Table 2

Estimated BHD Expenditures, by Funding Source[1]

Funding Source	2014	2015	Percentage Change
Medical Assistance	$ 52,985,700	$ 54,014,700	1.9%
County Tax Levy	47,440,000	53,299,000	12.4
Other Federal and State Revenue[2]	36,775,000	30,653,800	(16.6)
Basic County Allocation[3]	22,016,600	23,550,900	7.0
Medicare	6,194,300	7,403,600	19.5
Miscellaneous Revenue	3,493,600	2,028,700	(41.9)
Commercial Insurance	2,463,700	2,594,500	5.3
Total	**$171,368,900**	**$173,545,200**	1.3

[1] BHD does not maintain detailed expenditure information by funding source. Therefore, expenditures had to be estimated based on the best available information.

[2] Includes federal funds, such as Mental Health Block Grant funds, Substance Abuse Treatment Block Grant funds, and Title IV-E funds to support child welfare services, as well as some state funds, such as additional GPR funding not allocated through the Basic County Allocation.

[3] Includes GPR, federal Social Services Block Grant funds, and federal Temporary Assistance for Needy Families (TANF) funds.

Prior to the creation of the Board, BHD's budgeted tax levy amount equaled the difference between its budgeted expenditures and the total of all other budgeted revenues. When actual BHD revenues and budgeted tax levy were insufficient to cover annual expenditures, Milwaukee County assumed the cost of any shortfall. When actual revenues exceeded budgeted revenues, excess tax levy was returned to the County's general fund, as required by statutes.

Statutes require the establishment of a reserve fund to help support mental health services in the event of budget shortfalls.

Section 51.41 (4) (d), Wis. Stats., requires the Milwaukee County Treasurer to transfer any amount that has not been expended or encumbered from the amount budgeted for mental health functions, programs, and services into a reserve fund to help support mental health services in the event of a budget shortfall. It also provides that reserve amounts in excess of $10.0 million may be used at any time for mental health functions, programs, and services. Through 2015, a total of $13.2 million has been transferred to the mental health reserve fund, including $6.9 million in 2014 and $6.3 million in 2015.

Expenditures for BHD salaries and fringe benefits decreased from $68.8 million in 2014 to $62.0 million in 2015 (10.0 percent).

As shown in Table 3, expenditures for BHD salaries and fringe benefits decreased from $68.8 million in 2014 to $62.0 million in 2015 (10.0 percent), in part due to the closing of one long-term care facility in January 2015 and the downsizing and subsequent closure of a second long-term care facility in January 2016. Expenditures for contracted services increased by $11.1 million (13.8 percent) over this period.

Table 3

BHD Expenditures, by Type

Expenditure Type	2014	2015	Percentage Change
Personnel Expenditures			
Salaries	$ 41,835,000	$ 34,887,200	(16.6)%
Fringe Benefits	27,011,300	27,101,900	0.3
Subtotal	68,846,300	61,989,100	(10.0)
Other Expenditures			
Contracted Services	80,392,500	91,521,400	13.8
Administrative and Professional Services[1]	11,936,300	9,226,600	(22.7)
Facilities-Related Expenditures[2]	6,653,400	6,033,800	(9.3)
Equipment, Supplies, and Miscellaneous Services	3,324,000	4,638,100	39.5
Travel and Training	216,400	136,200	(37.1)
Subtotal	102,522,600	111,556,100	8.8
Total	**$171,368,900**	**$173,545,200**	1.3

[1] Includes salaries and benefits for staff of other Milwaukee County departments providing services to BHD, such as financial services by the Milwaukee County Comptroller's office and legal services by the Milwaukee Office of Corporation Counsel, as well as professional services provided by contractors, such as interpreters, psychiatrists, and food service vendors.

[2] Includes expenditures for costs such as electricity, fire protection, and plumbing materials.

BHD does not consistently budget or maintain expenditure information on a program-level basis.

BHD does not consistently budget on a program-level basis or maintain expenditure information in sufficient detail to allow for an accurate estimation of program-level expenditures for most of its 26 programs. Complete and accurate program-level budget and expenditure information is important to ensuring effective administration of any program, and it would also be useful to Board members in exercising their oversight responsibilities.

Because program-level expenditures could not be accurately estimated for most programs, we instead grouped expenditures into three broad categories for which expenditures could be accurately estimated: institutional-based care, community-based care for adults, and community-based care for children and adolescents. As shown in Table 4, expenditures for institutional-based care decreased from $76.3 million in 2014 to $67.0 million in 2015, or by 12.2 percent. This is, in part, due to the downsizing and closure of BHD's long-term care facilities. In contrast, expenditures for all community-based care increased by $11.5 million (12.1 percent).

Table 4

BHD Expenditures, by Program Area

Program Area	2014	2015	Percentage Change
Institutional-Based Care	$ 76,265,100	$ 66,965,800	(12.2)%
Community-Based Care for Adults	50,568,600	57,838,300	14.4
Community-Based Care for Children and Adolescents	44,535,200	48,741,100	9.4
Total	**$171,368,900**	**$173,545,200**	1.3

☑ Recommendation

We recommend the Behavioral Health Division:

- *budget for mental health expenditures on a program-level basis for all of its programs;*
- *maintain expenditure information in sufficient detail to accurately estimate program-level expenditures for all of its programs; and*
- *regularly provide the Milwaukee County Mental Health Board with status reports that include a comparison of budgeted to an estimate of actual expenditures for each program.*

Contracting for Services

BHD contracts for a variety of different services, including mental health services, legal services, food services, and janitorial services. Section 51.41 (10), Wis. Stats., requires that all mental health contracts with a value of $100,000 or more be presented to the Board for its approval. To date, BHD has submitted to the Board all purchase of service contracts with a value of $100,000 or more. Purchase of service contracts have a known predetermined value when they are executed.

BHD has not typically submitted fee-for-service contracts to the Board for its approval, even when incurred costs have totaled $100,000 or more.

In contrast, BHD has not typically submitted fee-for-service contracts to the Board for its approval, even when incurred costs have totaled $100,000 or more. Fee-for-service contracts do not have a predetermined value at the time they are executed and instead specify a per-unit cost associated with the purchase of a specific service. BHD makes extensive use of fee-for service contracts, which accounted for 918 (85.8 percent) of the 1,070 contracts it entered into from 2014 through 2016. For example, BHD reported spending $100,000 or more for at least 79 fee-for-service contracts during 2015. The average expenditure for these contracts was $695,000.

Although BHD may not have been able to predict all instances in which fee-for-service contracts would have totaled at least $100,000, BHD should have been able to anticipate that some fee-for-service contracts would total or exceed $100,000 based on the nature of the services provided or on the amount incurred under similar contracts. After we raised these issues with BHD during the course of our audit, it began submitting fee-for-service contracts to the Board beginning in August 2016.

☑ Recommendation

We recommend the Behavioral Health Division submit to the Milwaukee County Mental Health Board for its review and approval all fee-for-service contracts that are likely to total or exceed a value of $100,000.

Staffing

From December 2014 to December 2015, BHD experienced a net reduction of 83.7 authorized FTE positions.

As BHD expanded community-based care for adults, the Board approved the elimination of some positions and the reallocation of other positions to various program areas. For example, as one long-term care facility downsized and ultimately closed in January 2015, BHD's 2014 budget included provisions to eliminate 53.5 full-time equivalent (FTE) positions and transfer 3.0 FTE positions to the Community Consultation Team, which helps support long-term care

recipients in their community placements. From December 2014 to December 2015, BHD experienced a net reduction of 83.7 authorized FTE positions, with the largest decrease occurring in institutional-based care, as shown in Table 5. BHD attributes a 78.6 percent net reduction of 65.8 authorized FTE positions to the downsizing and closure of its long-term care facilities.

Table 5

Authorized FTE Positions
(as of December 31)

	2014	2015	Difference
Program Area			
Institutional-Based Care	387.1	314.3	(72.8)
Community-Based Care for Adults	100.9	98.5	(2.4)
Community-Based Care for Children and Adolescents	32.0	34.0	2.0
Subtotal	520.0	446.8	(73.2)
BHD Administration	149.0	138.5	(10.5)
Total	**669.0**	**585.3**	(83.7)

As of March 2016, 86.0 vacant FTE positions (65.0 percent) were related to the provision of institutional-based care.

Because some positions were intentionally left vacant in 2014 and 2015 as a result of the downsizing and closure of its long-term care facilities, we analyzed more recent information on BHD's staffing levels. As shown in Table 6, almost one-fourth of BHD's 544.0 authorized FTE positions were vacant as of March 2016. Of the 132.3 FTE positions that were vacant, 86.0 FTE positions (65.0 percent) were related to the provision of institutional-based care. To address this, BHD indicated that it budgeted $1.3 million in 2016 to fund approximately 100 temporary employees to help maintain sufficient staffing levels. In addition, BHD indicated that it makes adjustments to the number of beds available to provide inpatient care in accordance with daily staffing levels.

Table 6

Vacant FTE Positions
(as of March 2016)

	Authorized FTE Positions	Vacant FTE Positions	Percentage Vacant
Program Area			
Institutional-Based Care	278.6	86.0	30.9%
Community-Based Care for Adults	94.6	23.0	24.3
Community-Based Care for Children and Adolescents	39.0	5.0	12.8
Subtotal	412.2	114.0	27.7
BHD Administration	131.8	18.3	13.9
Total	**544.0**	**132.3**	24.3

BHD has expressed concern over its ability to recruit and retain staff and indicated that it is planning aggressive recruitment and retention efforts, including developing a marketing campaign, providing hiring bonuses to those accepting job offers, and instituting referral bonuses for current employees who assist in recruiting new employees.

The most common positions that BHD has difficulty filling are those related to the direct provision of care.

The most common positions that BHD has difficulty filling are those related to the direct provision of care, including physicians, psychiatrists, registered nurses, certified nursing assistants, and emergency clinicians. This may be in part a result of concerns about the permanence of these positions given plans to contract for all institutional-based services in the future. The Board and BHD intend to continue reducing the direct provision of institutional-based care, which will lead to a further reduction in the number of FTE positions and an increase in contract expenditures.

■ ■ ■ ■

Institutional-Based Care ■

Recipients who receive services directly from BHD are generally treated at the Milwaukee County Mental Health Complex. In 2014 and 2015, these services were provided through three programs: the Psychiatric Emergency Medical Services program, the Inpatient Services program, and the Long-Term Care program. We found that BHD met 9 of its 27 performance indicators for institutional-based care in 2015. In January 2016, BHD discontinued its provision of long-term care services, and the Board plans to contract with a private vendor to provide both psychiatric emergency medical services and inpatient services beginning in 2018 or later. We make recommendations for BHD to improve program administration, including to enhance the usefulness and accuracy of its performance indicators and to address staffing issues that have limited bed capacity at its psychiatric hospital.

Psychiatric Emergency Medical Services Program

The Psychiatric Emergency Medical Services program consists of a psychiatric emergency room and a psychiatric observation unit.

The Psychiatric Emergency Medical Services program serves individuals seeking emergency psychiatric care regardless of their age, income, or insurance coverage. Located at the Milwaukee County Mental Health Complex in Wauwatosa, it consists of a psychiatric emergency room and a psychiatric observation unit that are operated 24 hours per day and seven days per week. In 2015, the program was authorized 78.5 FTE employees, including psychiatrists, psychologists, registered nurses, behavioral health

emergency service clinicians, and certified nursing assistants. The program serves individuals who may be experiencing mental health crises, which include:

- intense feelings of emotional distress, such as anxiety, depression, anger, panic, or hopelessness;
- obvious changes in functioning, such as neglect of personal hygiene or exhibiting unusual behavior; and
- catastrophic life events, such as the loss of a family member or divorce.

Admission to the psychiatric emergency room may be voluntary or involuntary.

Admission to the psychiatric emergency room may be voluntary, which indicates the recipient is willingly seeking care, or involuntary, which indicates the recipient appears to be in need of emergency psychiatric attention but is believed to be unable or unwilling to cooperate with voluntary treatment. Almost all involuntary admissions are done through a process of emergency detention, which generally involves recipients being escorted to the psychiatric emergency room by law enforcement personnel. Recipients in emergency detention are believed to be likely to cause physical harm to themselves or others, and are thought to be in need of immediate mental health services, but are not willing to seek them. Other examples of involuntary admissions include recipients who are committed under court order.

When recipients arrive at the psychiatric emergency room they have their mental and physical health assessed, are provided with stabilization treatment including any necessary medication, and receive a disposition regarding their next level of care, if any is to be provided. For example, recipients may be discharged home, admitted to a hospital for psychiatric care, or returned to police custody.

If only brief treatment is necessary, or additional monitoring is required to determine the appropriate next level of care, BHD policies allow recipients to be placed in the 18-bed psychiatric observation unit. BHD policies state that treatment in the observation unit is intended to last less than 48 hours, but BHD staff indicated that recipients will occasionally remain in the observation unit longer than 48 hours while they wait for a bed in BHD's psychiatric hospital to become available or when staff believe recipients need additional care that does not require hospital admission.

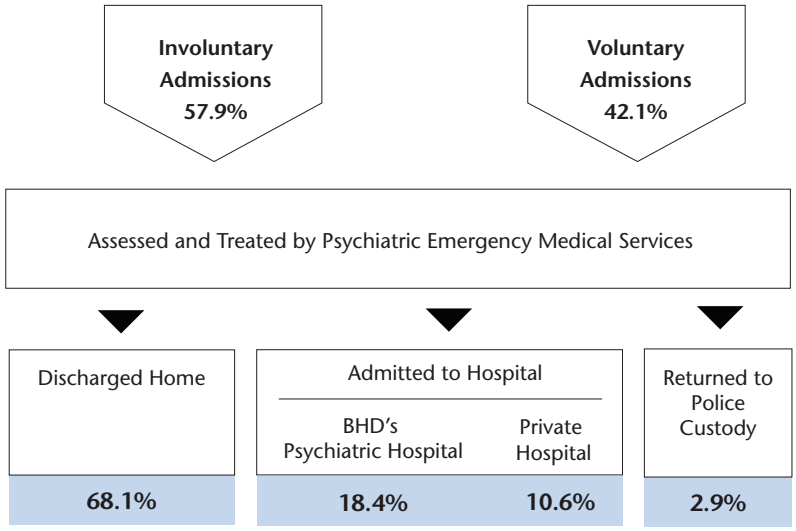
There were 10,173 admissions to the psychiatric emergency room in 2015. In 1,047 (10.3 percent) instances, recipients were placed in the observation unit. The average time spent in the observation unit was 39.6 hours, but there were 253 (24.2 percent) instances in which recipients remained in the observation unit for longer than 48 hours, including one recipient who spent 7.6 days in the observation unit before being transferred to BHD's psychiatric hospital.

In 2015, 26.3 percent of the 5,987 recipients were admitted to the psychiatric emergency room more than once.

Figure 2 summarizes the admission and disposition process for the Psychiatric Emergency Medical Services program in 2015. In 2015, there were 10,173 admissions of 5,987 recipients to the psychiatric emergency room, because 1,572 recipients (26.3 percent) were admitted more than once.

Figure 2

Admission and Disposition for Psychiatric Emergency Medical Services Program
2015



We attempted to determine the extent to which recipients who were discharged home received supplemental community-based services. However, the only reliable data maintained by BHD on these services were contained in individual recipient files. Having reliable electronic information on these services would be useful to BHD in assessing the extent to which the recipients they serve in the psychiatric emergency room are receiving the continuity of services needed to address their mental health needs and to help reduce the need for emergency mental health services in the future.

☑ Recommendation

We recommend the Behavioral Health Division maintain reliable electronic data on the specific community-based services provided to all recipients who are discharged home from the psychiatric emergency room and that it regularly analyze this information to ensure recipients are receiving needed mental health services after discharge.

The most common diagnoses of recipients admitted to the psychiatric emergency room in 2015 involved depressive and bipolar disorders.

Of the 5,987 recipients who were served by BHD's psychiatric emergency room, 4,700 were adults and 1,287 were children and adolescents. As shown in Table 7, 32.7 percent of recipients admitted to the psychiatric emergency room had primary diagnoses involving depressive and bipolar disorders.

Table 7

Primary Diagnoses for Recipients Admitted to the Psychiatric Emergency Room[1]
2015

Diagnosis Category	Number of Recipients	Percentage of Recipients
Depressive and Bipolar Disorders	1,955	32.7%
Substance-Related Disorders	1,078	18.0
Schizophrenia and Other Psychotic Disorders	965	16.1
Trauma-Related Disorders[2]	917	15.3
Impulse-Control and Conduct Disorders[3]	175	2.9
Neurodevelopmental Disorders[4]	131	2.2
Personality Disorders	121	2.0
Anxiety Disorders[5]	76	1.3
Other[6]	202	3.4
Unknown	367	6.1
Total	**5,987**	**100.0%**

[1] Represents recipients' most recent diagnosis if they were admitted more than once in 2015 with different diagnoses.

[2] Includes disorders such as post-traumatic stress disorder and disorders involving problems adjusting to or coping with stressful life events.

[3] Includes disorders involving difficulty in controlling one's emotions and behaviors.

[4] Includes disorders that produce impairments of personal, social, academic, or occupational functioning, such as autism and attention deficit disorder.

[5] Includes disorders such as generalized anxiety disorder and phobias.

[6] Primarily includes unspecified mental health disorders.

In 2015, 72 recipients (1.3 percent) were each admitted to the psychiatric emergency room 10 or more times.

Of the 1,572 recipients who were admitted to BHD's psychiatric emergency room more than once in 2015, 72 recipients were each admitted 10 or more times, including one adult recipient who was admitted 47 times. Information on actual costs per recipient was not available. Therefore, we used the amount billed by BHD as a proxy for cost. Information on the amount billed was available for 5,705 of the 5,987 recipients admitted to the psychiatric emergency room in 2015, including those recipients who were admitted 10 or more times. In 2015, the 72 recipients (1.3 percent) accounted for 1,219 of the total admissions (12.0 percent) and $731,140 of the total amount billed (10.7 percent) to public and private sources. The total amount billed for the 72 recipients who were admitted 10 or more times averaged $10,150 per recipient compared to $1,190 for all recipients. We also found that the 72 recipients were:

- more likely to be voluntarily admitted (76.2 percent compared to 42.1 percent for all recipients served in the psychiatric emergency room);
- more likely to have a substance-related disorder as a primary diagnosis (27.8 percent compared to 18.0 percent for all recipients served in the psychiatric emergency room);
- more likely to have schizophrenia and other psychotic disorders as a primary diagnosis (30.6 percent compared to 16.1 percent for all recipients served in the psychiatric emergency room);
- less likely to have depressive and bipolar disorders as a primary diagnosis (13.9 percent compared to 32.7 percent for all recipients served in the psychiatric emergency room); and
- more likely to be discharged home rather than being admitted to a hospital (91.4 percent compared to 67.9 percent for all recipients served in the psychiatric emergency room).

Appendix 3 provides additional information on the number and type of recipients served and on program performance for BHD's Psychiatric Emergency Medical Services program.

Inpatient Services Program

The Inpatient Services program provides services to recipients with mental health needs requiring a hospital stay, regardless of their age, income, or insurance coverage. Services are provided at BHD's

psychiatric hospital, which is co-located with its psychiatric emergency room at the Milwaukee County Mental Health Complex, where all recipients are initially assessed before they are admitted to the hospital. Recipients receive care from psychiatrists, psychologists, nurses, and other health care professionals who provide mental health assessments, social services, and rehabilitation therapy. Children and adolescents also receive educational services.

In 2015, the psychiatric hospital had 185.6 FTE employees and 72 beds, 60 of which were for adults and 12 for children and adolescents. As noted, BHD has restricted its adult bed capacity at times due to staffing constraints. As a result of staffing constraints, BHD maintained a reported average of 63.2 inpatient beds in 2015, including 51.2 beds for adults and 12.0 beds for children and adolescents.

In 2015, the psychiatric hospital served 1,330 recipients, with 329 of these recipients (24.7 percent) being admitted more than once.

In 2015, the psychiatric hospital had 1,884 admissions of 1,330 recipients, because 329 recipients (24.7 percent) were admitted more than once. Of these 1,330 recipients, 702 were adults and 628 were children and adolescents. In 2015, the average length of stay in the psychiatric hospital was 16.2 days for adults and 4.1 days for children and adolescents.

Recipients who were admitted to the psychiatric hospital in 2015 tended to have different diagnoses than those who were assessed in BHD's psychiatric emergency room but not admitted to the hospital. For example, those admitted to the psychiatric hospital tended to be:

- more likely to have depressive and bipolar disorders as a primary diagnosis (44.9 percent compared to 32.7 percent for all those served in the psychiatric emergency room);

- more likely to have schizophrenia and other psychotic disorders as a primary diagnosis (32.8 percent compared to 16.1 percent for all those served in the psychiatric emergency room); and

- less likely to have a substance-related disorder as a primary diagnosis (2.0 percent compared to 18.0 percent for all those served in the psychiatric emergency room).

We analyzed the amount billed for the 1,330 recipients admitted to BHD's psychiatric hospital in 2015. We found that 155 recipients (11.7 percent) spent at least 30 days in the psychiatric hospital, including 141 adults and 14 children and adolescents. The average amount billed for the 141 adult recipients was $101,500, compared to

an average of $35,700 for all adult recipients in 2015. The average amount billed for the 14 child and adolescent recipients was $117,700, compared to an average of $15,700 for all child and adolescent recipients in 2015.

We also found that the 155 recipients who spent at least 30 days in the psychiatric hospital were:

- more likely to have schizophrenia and other psychotic disorders as a primary diagnosis (72.9 percent compared to 32.8 percent for all recipients served in the psychiatric hospital);

- less likely to have depressive and bipolar disorders as a primary diagnosis (22.6 percent compared to 44.9 percent for all recipients served in the psychiatric hospital); and

- less likely to have trauma-related disorders as a primary diagnosis (1.3 percent compared to 10.0 percent for all recipients served in the psychiatric hospital).

Appendix 3 provides additional information on the number and type of recipients served and on program performance for BHD's Inpatient Services program.

Changes to Inpatient Services

The amount of services provided through BHD's psychiatric hospital has been affected by a shift in policy over the past five years. This follows a national trend that resulted in the deinstitutionalization of many mental health care services in the late 1990s and early 2000s in which inpatient care provided by psychiatric hospitals and long-term care facilities was replaced, when possible, with the provision of less restrictive community-based services.

In April 2011, the Milwaukee County Board of Supervisors passed a resolution that created the Mental Health Redesign and Implementation Task Force, which was comprised of BHD staff; state, county, and city staff; and representatives of health care and advocacy organizations. The role of the Task Force was to develop new initiatives for the provision of mental health services in Milwaukee County based on input from both public and private entities. The efforts of the Task Force resulted in several recommendations, including working to provide a more integrated approach to the provision of mental health services, reducing the number of inpatient beds provided by BHD, and expanding the provision of services in community-based settings.

BHD plans to close the Mental Health Complex and discontinue its direct provision of institutional-based care in 2018 or later.

As part of the redesign initiative, the future operations of BHD's psychiatric emergency room and hospital were considered. Due to the facility's age and resulting high maintenance costs, as well as the directive to provide care in the least-restrictive setting available, BHD plans to close the Mental Health Complex and discontinue its direct provision of institutional-based care in 2018 or later. As of November 2016, BHD and the Board were pursuing options to enter into a multi-year contract with a private vendor to provide these services.

Long-Term Care Program

Through January 2016, BHD administered the Long-Term Care program, which provided rehabilitative care to recipients with complex medical, mental health, and behavioral needs. BHD operated the program through two facilities, each of which had approximately 70 beds and was co-located at the Mental Health Complex:

- Rehab Hilltop served recipients with developmental disabilities and discontinued operations in January 2015; and

- Rehab Central provided 24-hour skilled nursing care and discontinued operations in January 2016.

BHD indicated that it closed its long-term care facilities in response to a 1999 Supreme Court ruling.

BHD indicated that it closed its long-term care facilities in response to a 1999 ruling by the Supreme Court of the United States in which the court ruled that, under the Americans with Disabilities Act, individuals with mental disabilities must generally be placed in the community rather than in institutions when community placement is determined to be the most appropriate placement. The reason for the 16-year period between the Supreme Court's ruling and closure of the first facility was not explained by BHD.

The services provided by BHD's long-term care facilities included those associated with helping recipients to improve and maintain their social and living skills. DHS staff indicated that while neither facility required recipients to have a mental health diagnosis, residents of these facilities had higher rates of mental illness than is typical for those in other skilled nursing facilities or other facilities for the developmentally disabled. From 2014 through 2015, the Long-Term Care program served a total of 54 recipients, including 32 at Rehab Hilltop and 22 at Rehab Central. Appendix 3 provides additional information on the number and type of recipients served and on program performance for BHD's Long-Term Care program.

Disability Rights Wisconsin, a private, nonprofit organization that is part of a national system of federally mandated independent disability advocacy agencies, was involved in assessing the closure of BHD's two long-term care facilities, including conducting a follow-up review on the placement of the recipients. Although its report had not been published at the time of our fieldwork, Disability Rights Wisconsin indicated to us that the placement process was successful.

A total of 100 of the 133 recipients to whom BHD provided long-term care services were eligible for the State's Family Care program.

When the relocation process began in April 2013, BHD was providing direct services to 133 recipients in its two long-term care facilities. Of the 133 recipients, 100 (75.2 percent) were determined to be eligible for the State's Family Care program, which is a Medical Assistance-funded program intended to provide care to individuals in their homes and other community settings in order to prevent the need for institutional care. However, BHD could have reduced its costs and assisted some of its long-term care recipients' transition into a home or community-based setting as early as November 2009, when Milwaukee County residents between 18 to 59 years of age first became eligible for the Family Care program. As shown in Table 8, 79 (59.4 percent) of the 133 recipients were discharged from BHD's long-term facilities into adult family homes.

Table 8

Immediate Care Arrangements for Recipients Discharged from BHD's Long-Term Care Facilities

Care Arrangement	Number of Recipients	Percentage of Recipients
Adult Family Home	79	59.4%
Community-Based Residential Facility	29	21.8
Supported Apartment[1]	10	7.5
Hospital	5	3.8
Private Nursing Home	4	3.0
Family Member's Home	4	3.0
Crisis Stabilization Home[2]	1	0.8
Hospice Care	1	0.8
Total	**133**	**100.0%**

[1] Supported apartments are apartments in which residents live independently but receive frequent visits from care providers to assist with daily-living activities and mental health needs.

[2] Crisis stabilization homes provide services to recipients who are experiencing immediate threats to their mental health.

Expenditures for BHD's long-term care facilities decreased from $24.3 million in 2014 to $10.6 million in 2015. Although BHD is no longer responsible for the 100 recipients whose care is currently funded by the State's Family Care program, it continues to incur costs associated with some of the individuals placed in community-based settings that it serves through contracts with private vendors. For example, BHD contracted with one vendor to provide residential and therapy services for up to 10 relocated recipients at an annual cost of $2.2 million, which includes providing assistance with activities of daily living, psychiatric assessment and monitoring, and transportation to medical appointments. In addition, BHD incurs ongoing direct costs associated with monitoring the progress of relocated residents in their community-based settings.

BHD Policy Additions and Modifications

Since the creation of the Board in July 2014, BHD has adopted and modified policies related to the provision of mental health care. These additions and modifications are intended to clarify procedures and policy goals, as well as to enhance the provision of services to recipients. From July 2014 through December 2015, BHD established one new policy related to institutional-based care that addresses required competency testing for certified nursing assistants assigned to the psychiatric emergency room. In addition, BHD made substantive modifications to another policy in order to clarify several issues, such as the purpose and role of the psychiatric observation unit.

Program Performance

BHD established 27 performance indicators to help assess the operation and effectiveness of its institutional-based care programs.

BHD established 27 performance indicators to help assess the operation and effectiveness of the Psychiatric Emergency Medical Services program and the Inpatient Services program. BHD establishes its performance indicators based on prior performance and national averages. These performance indicators are presented to the Board's Quality Committee, which is a five-member committee of the Board. We conducted an independent analysis of these performance indicators in order to assess the accuracy of the results BHD reported. We found that although BHD had generally calculated its performance accurately with respect to the indicators it established, BHD miscategorized the results of three performance indicators in its March 2016 report. BHD reported that it was within 20 percent of meeting three goals, when it was actually more than 20 percent from meeting these goals, including measures of:

- the extent to which recipients return to the psychiatric emergency room within 30 days of their last discharge;

- the extent to which adult recipients returned to the psychiatric hospital within 30 days of their last discharge; and

- the amount of time adult recipients were in locked seclusion in the psychiatric hospital.

We identified flaws in the methodology BHD used to measure its performance.

We also identified flaws in the methodology BHD used to measure its performance related to two other indicators. For example, BHD established a performance indicator that involves calculating the number of recipients admitted to its psychiatric emergency room through emergency detentions rather than through voluntary admissions. However, BHD's electronic data system does not automatically include individuals whose detentions were extended beyond 24 hours when calculating this performance indicator. Therefore, in assessing its 2015 performance, BHD excluded 204 recipients whose emergency detentions were extended beyond 24 hours based on their psychiatric treatment needs. When these recipients are included in the number of emergency detentions, BHD's performance changes from meeting its goal for the number of emergency detentions to failing to meet its goal by less than 20 percent.

In addition, BHD established a goal of having a daily average of 52 or fewer adult recipients in its psychiatric hospital. Due to staff turnover, BHD often had to restrict its 2015 bed capacity below the 60 beds it had budgeted in order to ensure it could adequately serve those who were already admitted to its psychiatric hospital. This staffing reduction had the effect of limiting capacity to a maximum of 51.2 average daily beds available for use, based on data reported by BHD. Consequently, the goal was made irrelevant due to changes BHD made in response to staffing levels.

In 2015, BHD met 9 of its 27 performance indicator goals associated with institutional-based care.

Table 9 summarizes the 2015 results for BHD's 27 performance indicators associated with institutional-based care. It includes a correction to accurately reflect all recipients who were admitted through emergency detentions, including those whose detentions were extended beyond 24 hours. With this correction, BHD met its goals for 9 of the 27 performance indicators associated with institutional-based care; was within 20 percent of its goal for 5 performance indicators; and was more than 20 percent from achieving its goal for 13 performance indicators. Appendix 6 shows a complete list of BHD's 2015 performance indicators and results.

Table 9

Summary of Performance Indicator Results for Institutional-Based Care Programs
2015

Program	Goals Met	Goals Not Met	
		Performance Was Within 20 Percent of Goal	Performance Was More than 20 Percent from Goal
Psychiatric Emergency Medical Services Program	2	1[1]	2
Inpatient Services Program (Adult Care)	3[2]	2	6
Inpatient Services Program (Child and Adolescent Care)	4	2	5
Total	**9**	**5**	**13**

[1] Includes a correction to one performance indicator that BHD incorrectly measured so that the number accurately reflects all recipients who were admitted through emergency detentions.

[2] Includes one performance indicator that BHD established related to the number of daily adult recipients it served that was automatically met regardless of its performance.

☑ Recommendation

We recommend the Behavioral Health Division:

- *ensure that all recipients who are admitted through emergency detentions are included when calculating its performance indicator, regardless of whether the detentions were extended beyond 24 hours; and*

- *modify its goal related to the average daily number of adult recipients in its psychiatric hospital to take into account the average daily number of hospital beds that are actually available.*

Performance and Compliance Reviews

In addition to the performance indicators BHD has adopted, DHS conducts reviews of BHD's institutional-based care programs to determine compliance with state standards, as well as compliance with federal standards on behalf of the federal Department of Health and Human Services.

From July 2014 through August 2016, DHS issued BHD a total of 42 citations for violating hospital standards.

DHS conducts reviews of BHD's institutional-based care programs either when a complaint is received or during the recertification process, which occurs at least once every five years. Previously, there were separate standards for state and federal regulations, but as of July 2016 DHS adopted the more stringent federal standards as a minimum requirement. From July 2014 through August 2016, DHS conducted five reviews and issued a total of 42 citations for violations of state and federal hospital standards. In some instances the same violation can result in the issuance of two citations, one for a violation of state standards and one for a violation of federal standards.

In 2015, BHD reported using physical restraints on children and adolescent recipients 19.3 times more often than the national average.

As part of its June 2016 review, DHS issued 34 citations to BHD for violating hospital standards, including building safety standards. None of the 34 citations were classified as "immediate jeopardy" citations, which are the most serious and require immediate corrective action because they have caused, or are likely to cause, serious harm to recipients' safety or rights. During its August 2016 review, DHS issued eight citations to BHD, including one immediate jeopardy citation concerning its use of physical restraints. In 2015, BHD reported using physical restraints on children and adolescent recipients 19.3 times more often than the national average and on adult recipients 6.0 times more often than the national average. While DHS reviewers were on-site in August 2016, BHD submitted an abatement plan that established a goal for reducing the frequency with which recipients are placed in physical restraints that included revising its policies and procedures, enhancing staff training, and conducting more stringent reviews of recipients' records to monitor the use of restraints. The 42 citations are summarized in Table 10.

Table 10

Citations Issued by DHS of BHD's Psychiatric Hospital[1]

Category	Number of Citations
Failure to Maintain a Safe Building[2]	16
Failure to Develop or Ensure Individualized Treatment Plans for Recipients	7
Failure to Maintain Sanitary Conditions	5
Failure to Adequately Document Recipients' Files	4
Failure to Protect Recipients' Rights[3]	3
Failure to Follow Adequate Infection Control Procedures	3
Failure to Ensure a Safe Physical Setting for Those at Risk of Suicide	2
Failure to Follow Safe Techniques in Storing Medication	1
Failure to Monitor Contract Agreements	1
Total	**42**

[1] Based on issues identified in June 2016 and August 2016 reviews by DHS.

[2] Includes citations related to inadequate fire and smoke barriers and alarm systems; electrical, sprinkler, and ventilation systems; and emergency exit preparedness.

[3] Includes one citation that was classified as an "immediate jeopardy" citation.

Since the creation of the Board in July 2014 and through 2015, DHS reviewed Rehab Central twice, once in January 2015, which did not result in the issuance of any citations, and another time in May 2015, which resulted in the issuance of nine citations. None of the citations were classified as the most serious category of immediate jeopardy citations. During this period, DHS also twice reviewed Rehab Hilltop, BHD's other long-term care facility. A July 2014 review resulted in one citation for failing to provide nursing services in accordance with the needs of two recipients, which was not an immediate jeopardy citation. The other review in November 2014 resulted in no citations being issued.

Waiting List for Institutional-Based Services

BHD may place on a waiting list those individuals who are awaiting transfer from other hospitals.

BHD staff indicated that recipients who either present themselves or are escorted by law enforcement personnel directly to BHD's psychiatric emergency room are never placed on a waiting list. However, when BHD's psychiatric hospital is nearing its maximum service capacity, BHD may delay accepting recipients from other local hospitals who are seeking to transfer patients based on factors such as their acuity and insurance coverage. In these instances, recipients who are experiencing an immediate threat to their mental

health and are seeking psychiatric emergency room assessments are placed on a waiting list until there is sufficient capacity to serve them.

A total of 801 recipients were placed on the waiting list during the first six months of 2016, which is more than in all of 2014 and 2015 combined.

We analyzed data compiled by BHD and found that 291 recipients in 2014 and 385 recipients in 2015 were placed on the waiting list. Some recipients may have been placed on the waiting list more than once as a result of separate hospital stays, but the data BHD provided did not allow us to determine whether this was the case. The average monthly number of recipients on the waiting list increased from 24.3 recipients in 2014 to 32.1 recipients in 2015. In addition, based on data reported by BHD, 801 recipients were placed on the waiting list during the first six months of 2016, which is more than the total number placed on the waiting list during 2014 and 2015 combined.

BHD's goal is to limit the amount of time recipients spend on the waiting list to a maximum of 24 hours.

BHD's goal is to limit the amount of time recipients spend on the waiting list to a maximum of 24 hours. Sufficient data were available to allow us to analyze the duration of the wait for 621 of the 676 recipients that were placed on the waiting list from 2014 through 2015. As shown in Table 11, 37 recipients were on the waiting list for more than 24 hours, including 7 recipients who were on the waiting list for more than 48 hours. This includes one recipient who was on the waiting list for 99.7 hours in November 2015. This occurred at a time when BHD's psychiatric hospital was operating with an estimated 50 adult beds, despite being budgeted for 60.

Table 11

Waiting Time for Psychiatric Emergency Room[1]
2014 through 2015

Time Spent on the Waiting List	Number of Recipients Placed on the Waiting List	Percentage of Recipients Placed on the Waiting List
3 hours or less	161	25.9%
More than 3 hours up to 6 hours	161	25.9
More than 6 hours up to 12 hours	162	26.1
More than 12 hours up to 24 hours	100	16.1
More than 24 hours up to 48 hours	30	4.8
More than 48 hours	7[2]	1.1
Total	**621**	**100.0%**

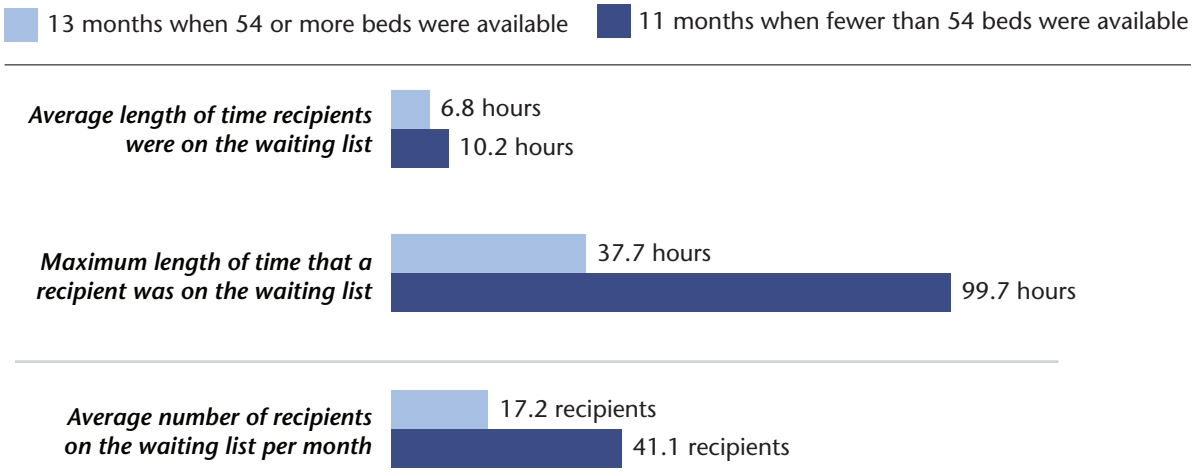
[1] Excludes 55 recipients whose waiting times were not electronically recorded.

[2] All but one of the 7 instances occurred in 2015.

A 2014 study by the Public Policy Forum, a private, nonprofit research organization, recommended that BHD's psychiatric hospital provide between 54 and 60 beds for adults so that the hospital can generally operate at between 80 and 90 percent of its capacity. The study asserted that having a capacity in this range would provide a buffer of available beds during situations in which an unusually large number of recipients require inpatient care. Although BHD was budgeted for 66 adult beds in 2014 and 60 adult beds in 2015, the number of beds actually available may fluctuate each day based on staffing resources. Based on monthly estimates reported by BHD, the number of available beds in its psychiatric hospital fell below the number BHD budgeted during 17 of the 24 months from 2014 through 2015, including during all of 2015. Additionally, the number of beds was below the Public Policy Forum's recommended minimum number of 54 beds for 11 months during this period. As shown in Figure 3, we found that as the number of available beds decreased, both the average length of time and the maximum length of time recipients spent on the waiting list increased, as did the average number of recipients on the waiting list.

Figure 3

Psychiatric Emergency Room Waiting List Comparisons
Based on Number of Available Beds
2014 through 2015



Although BHD has provided the Board with updates regarding the waiting list and noted a relationship between the waiting list and bed capacity, it has not provided the Board with data showing the

extent to which the length of the waiting list is affected by bed capacity. Currently, BHD reports as a performance indicator only the percentage of time that at least one person is on the waiting list. Although this is a meaningful measure, we believe that additional measures would provide more useful information, such as the number of individuals who are placed on the waiting list and the average amount of time they are on the waiting list before being served.

☑ Recommendation

We recommend the Behavioral Health Division:

- *develop a strategy to address staffing issues at its psychiatric hospital that will allow it to consistently provide the number of beds it has budgeted to provide;*

- *develop performance indicators of the number of individuals placed on the Psychiatric Emergency Medical Services program waiting list and the amount of time they spend on the waiting list before they are served; and*

- *report to the Joint Legislative Audit Committee and the Milwaukee County Mental Health Board on the status of its efforts by June 1, 2017.*

■ ■ ■ ■

Community-Based Care for Adults ■

Community-based care for adults is provided through programs offering a variety of acute crisis, recovery, residential, and treatment services. These services are provided primarily through contracts with private vendors operating throughout Milwaukee County. We found that BHD has not clearly or consistently defined the programs and services it provides. We also found that BHD has not developed specific performance indicators for each of its community-based programs for adults, or sufficiently documented the methodology used to calculate some performance indicators. We make recommendations for BHD to improve program administration, including to consistently define and record information on its community-based programs and services for adults and to expand and improve its performance indicators.

Range of Programs and Services

BHD administers 19 community-based programs to provide services to adult recipients in the least-restrictive setting.

BHD provides mental health and AODA services to adult recipients through 19 community-based programs. As shown in Figure 4, BHD grouped these programs into four categories—acute crisis, recovery, residential, and treatment—based on the primary types of services provided. These programs primarily serve recipients who do not require institutional-based care or who require additional care after discharge from an institutional-based program. They are intended to provide recipient care in the least-restrictive setting.

Figure 4

Community-Based Care Programs for Adults
2015

Acute Crisis Programs	Recovery Programs	Residential Programs	Treatment Programs
Crisis Line Program	Community Linkages and Stabilization Program	Community-Based Alcohol and Other Drug Abuse Residential Program	Care Coordination Unit Program
Mobile Treatment Teams Program	Community Options Program	Community-Based Detoxification Residential Program	Community Support Program
Outpatient Access Clinics Program	Community Recovery Services Program	Community-Based Mental Health Residential Program	Day Treatment Program
	Comprehensive Community Services Program	Crisis Resource Centers Program	Outpatient Treatment Clinics Program
	Recovery Support Coordination Program	Crisis Stabilization Homes Program	Targeted Case Management Program
	Recovery Support Services Program		

Adult recipients gain access to community-based services in several ways. Referrals for care are typically made by external health care professionals, the judicial system, or BHD staff. Adults referred to community-based care are generally assessed by BHD clinical staff to determine which program is most appropriate to meet their needs. However, those programs providing crisis services, such as the Outpatient Access Clinics program and the Crisis Resources Centers program, do not require an assessment before services are provided and instead allow recipients to walk into the facilities or make telephone requests to receive services as needed.

As shown in Table 12, 3,057 (29.0 percent) of the adult recipients who received community-based mental health services in 2015 had a primary diagnosis involving a substance-related disorder. However, it should be noted that 3,104 recipients (29.5 percent) had either unspecified mental disorders or had suicidal thoughts but were not given a diagnosis.

Table 12

Primary Diagnoses of Recipients Served by Community-Based Programs for Adults[1]
2015

Diagnosis Category	Number of Recipients	Percentage of Recipients
Substance-Related Disorders	3,057	29.0%
Schizophrenia and Other Psychotic Disorders	1,305	12.4
Personality Disorders	1,110	10.5
Depressive and Bipolar Disorders	648	6.2
Trauma-Related Disorders[2]	72	0.7
Anxiety Disorders[3]	39	0.4
Other[4]	3,104	29.5
Unknown	1,189	11.3
Total	**10,524**	**100.0%**

[1] Represents recipients' most recent diagnosis if they were admitted more than once in 2015 with different diagnoses.

[2] Includes disorders such as post-traumatic stress disorder and disorders involving problems adjusting to or coping with stressful life events.

[3] Includes disorders such as generalized anxiety disorder and phobias.

[4] Primarily includes unspecified mental health disorders and having suicidal thoughts but no diagnosis.

Acute Crisis Programs

Acute crisis programs provide services to adult recipients in need of immediate care.

Acute crisis programs for adults provide crisis assessment and stabilization services to recipients in need of immediate care. These programs are often the first point of contact for a recipient because they provide services immediately upon request to those who may not yet be receiving services through other BHD programs. Crisis assessment and stabilization services are provided over the phone, in the community by mobile treatment teams, and in person through outpatient access clinics. Crisis assessment and stabilization services involve the identification of behaviors exhibited by recipients that may result in harm to themselves or others, an assessment of the level of risk to themselves and others, an intervention designed to deescalate crises, and a determination of the most appropriate response. After recipients have been assessed and stabilized, they are generally referred to other appropriate services based on their individual needs, including institutional-based services or other community-based services.

BHD provides acute crisis services to individuals in need of immediate care through three programs:

- the Crisis Line program is a 24-hour telephone service that provides to all individuals access to basic mental health screenings and assessments, counseling, crisis intervention services, and referrals to other community-based or institutional-based services by receiving and responding to telephone calls;

- the Mobile Treatment Teams program makes available to all individuals on-site support services, such as mental health assessments and crisis intervention services, in order to determine whether to refer individuals to other BHD services or begin emergency detention proceedings; and

- the Outpatient Access Clinics program provides uninsured recipients with mental health issues access to services such as mental health assessments, counseling, medication, and referrals to other community-based services.

Appendix 4 provides additional information on the number and type of recipients served and on program performance for BHD's community-based acute crisis programs.

Recovery Programs

Six recovery programs provide an array of clinical and non-clinical support services to adult recipients.

Recovery programs provide recipients with an array of services that provide both clinical services, such as counseling and medication, and non-clinical support services, such as assistance in finding employment and obtaining housing. BHD provides recovery services through six programs:

- the Community Linkages and Stabilization Program provides non-clinical supportive services needed to allow recipients to live independently in the community with the goal of reducing their future need for emergency care;

- the Community Options Program is a state-established, county-operated program for recipients with disabilities, regardless of their income, that is intended to divert recipients from nursing homes and other institutional settings by funding long-term support services not covered

by other programs, such as home modification and housekeeping;

- the Community Recovery Services program provides support services, including care planning, care coordination, and assistance in obtaining employment, to recipients with severe and persistent mental health issues who are living in community-based residential facilities and who are at or below 150 percent of the federal poverty level;

- the Comprehensive Community Services program provides services to those recipients with severe mental illnesses and AODA issues who are in need of a wide array of services;

- the Recovery Support Coordination program provides care planning and care coordination services to recipients with the greatest AODA issues in order to assist them in accessing other needed medical, social, and employment services; and

- the Recovery Support Services program consists of a network of vendors who help to address the non-clinical needs of recipients with AODA issues by assisting them with needs such as finding employment and obtaining housing.

Appendix 4 provides additional information on the number and type of recipients served and on program performance for BHD's community-based recovery programs.

Residential Programs

Five residential programs provide adult recipients with residential care and other services through a variety of privately operated facilities.

Residential programs provide recipients with residential care and other services through a variety of licensed and certified community-based residential and detoxification facilities. These facilities are all privately operated. BHD provides residential services through five programs:

- the Community-Based Alcohol and Other Drug Abuse Residential Program funds certified and licensed residential facilities to provide services, such as 24-hour supervision, counseling, and treatment, to recipients with diagnosed AODA issues;

- the Community-Based Detoxification Residential Program funds a licensed detoxification facility that manages AODA intoxication and withdrawal symptoms in order to minimize the harm to recipients;

- the Community-Based Mental Health Residential Program funds certified and licensed residential facilities to provide services, such as 24-hour supervision, care planning, case management, and assistance in obtaining housing, to recipients with mental health issues;

- the Crisis Resource Centers program provides, as an alternative to psychiatric inpatient hospitalization, walk-in intervention and short-term stabilization services typically lasting no more than seven days to recipients experiencing psychological crises; and

- the Crisis Stabilization Homes program provides longer-term stabilization services, which average 23 days, to recipients who are experiencing psychological crises.

Appendix 4 provides additional information on the number and type of recipients served and on program performance for BHD's community-based residential programs.

Treatment Programs

Five treatment programs provide structured, clinical services to adult recipients with substantial needs.

Treatment programs provide structured, clinical services to recipients with greater mental health and AODA needs than can be addressed solely through community-based recovery programs. BHD provides treatment services through five programs:

- the Care Coordination Unit program began in spring 2015 and provides interim crisis case management services, such as care planning, care coordination, and assistance in obtaining housing to recipients who are enrolled in the Community Options Program or who are awaiting enrollment in other BHD programs, such as the Community Support Program or the Targeted Case Management program;

- the Community Support Program provides clinical and non-clinical services, largely in a non-clinical setting, to recipients with the most severe and persistent mental health issues and functional limitations;

- the Day Treatment program provides intensive clinical services to recipients with complex mental health and AODA issues;

- the Outpatient Treatment Clinics program provides outpatient services, such as care planning, counseling, and medication, to indigent and uninsured recipients with mental health and AODA issues; and

- the Targeted Case Management program provides care coordination, including care planning and assistance in gaining employment and in obtaining housing, to recipients with serious and persistent mental health and AODA issues that indicate a high risk for re-hospitalization but do not rise to the level of need required for enrollment in the Community Support Program.

Appendix 4 provides additional information on the number and type of recipients served and on program performance for BHD's community-based treatment programs.

Clarity and Consistency of Policies and Programmatic Information

BHD has not clearly or consistently defined the programs and services it provides.

In analyzing the community-based care programs for adults, we found that BHD has not clearly or consistently defined the programs and services it provides. For example, BHD staff had differing views of the number and type of programs BHD actually administers, and the terms "program" and "services" were often used interchangeably. This can lead to confusion on the part of Board members, service providers, and BHD staff and may make it difficult for prospective recipients and their family members to identify, understand, and access the assistance recipients need to address their mental health and AODA needs.

In addition, we found that BHD does not maintain or make available consistent descriptions of its programs that identify who may be served and what services are available under each program, nor does its electronically maintain information documenting what

services have been provided to which recipients in a readily accessible format. This may limit the ability of prospective recipients and their family members to identify needed programs and services and limit the ability of BHD to effectively manage its community-based programs for adults, including by ensuring that proper and adequate services are being provided and identifying and preventing potential duplication of services.

The contracts BHD enters into with vendors do not generally identify which BHD policies the vendors are required to follow.

We also found that BHD's electronic policy management system and its written policies do not consistently identify which policies apply to which of its programs, and the contracts BHD enters into with vendors do not generally identify which of BHD's policies the vendors are required to follow in providing services.

☑ Recommendation

We recommend the Behavioral Health Division:

- *clearly delineate the community-based programs for adults that it administers and the services provided by each, and provide this information to Milwaukee County Mental Health Board members, service providers, and prospective recipients and their family members;*

- *electronically maintain records identifying the specific services provided to recipients and the specific program that provided each service;*

- *identify in all of its program-related policies the specific programs to which the policies apply;*

- *include in its contracts, including fee-for-service agreements, the specific policies with which vendors will be expected to comply; and*

- *report its progress in addressing these issues to the Joint Legislative Audit Committee and the Milwaukee County Mental Health Board by June 1, 2017.*

BHD Policy Additions and Modifications

Since the creation of the Board in July 2014 and through December 2015, BHD adopted and modified several policies related to the provision of community-based care for adults. These additions and

modifications are intended to clarify procedures and policy goals, as well as enhance the provision of services to adult recipients.

BHD established seven new policies related to community-based care for adults, including:

- three policies associated with modifying outpatient pharmacy procedures corresponding with the implementation of a more automated pharmacy management system;
- two policies associated with clarifying how the Community Options Program is to provide services to recipients;
- one policy associated with establishing procedures for handling recipient death reports; and
- one policy associated with documenting that certain vendors have received, read, and understand applicable policies.

In addition, BHD amended 40 existing policies related to community-based programs for adults. Of these, two included material changes, both associated with identifying how the Recovery Support Coordination program is to provide care coordination to recipients.

Program Performance

BHD has not developed specific performance indicators for each of its 19 community-based programs for adults.

We found that BHD has not developed specific performance indicators for each of its 19 community-based programs for adults. In 2015, it relied on eight performance indicators to help assess the overall operation and effectiveness of these programs. As shown in Table 13, BHD reported meeting its goals for three (37.5 percent) of its eight performance indicators.

Table 13

BHD Performance Indicators for Community-Based Care for Adults
2015

Performance Indicator	Goal	Outcome
Number of AODA Recipients Served	At Least 5,529	6,254
Number of Mental Health Recipients Served	At Least 4,663	5,010
Number of Enrollees in the Comprehensive Community Services Program	At Least 236	233
Reduction in Psychiatric Bed Days in the Past Six Months	At Least 64.0%	60.3%
Reduction in Alcohol or Other Drug Use in the Past 30 Days	At Least 79.0%	82.5%
Reduction in Homelessness or Shelter Use Six Months after Admission	At Least 82.0%	77.3%
Increase in Recipient Employment Six Months after Admission	At Least 54.0%	33.9%
Percentage of Clients Returning to the Community-Based Detoxification Residential Program within 30 Days of Discharge	No More Than 18.0%	19.6%

Shaded areas indicate goals that BHD did not meet.

Using the available data, we attempted to independently verify the accuracy of the information BHD reported. However, the documentation BHD provided on its results and procedures was inadequate to allow us to verify the accuracy of seven of the eight indicators. The only indicator verified was the percentage of clients returning to detoxification facilities within 30 days of discharge. BHD did not provide sufficient data to allow us to verify the number of AODA and mental health recipients served or the number of enrollees in the Comprehensive Community Services program. In addition, BHD staff indicated that four other performance indicators were calculated by a former employee who did not sufficiently document the work performed.

The amount of time adult recipients in five programs spent on waiting lists before being served has increased.

In addition to these performance indicators, BHD has, since October 2015, consistently measured the amount of time recipients in five programs—the Community-Based Alcohol and Other Drug Abuse Residential Program, the Community-Based Mental Health Residential Program, the Community Support Program, the Day Treatment program, and the Targeted Case Management program—spent on waiting lists prior to receiving services. As shown in Table 14, the average number of days recipients spent on waiting lists increased for each of the programs from the fourth quarter of 2015 to the second quarter of 2016.

Table 14

Average Number of Days Adult Recipients Spent on Waiting Lists Prior to Receiving Services

Program	October through December 2015	January through March 2016	April through June 2016
Community-Based Alcohol and Other Drug Abuse Residential Program	14	23	22
Community-Based Mental Health Residential Program	0	96	138
Community Support Program	22	63	89
Day Treatment Program	82	56	95
Targeted Case Management Program	33	35	67

The modifications BHD made to its performance indicators in 2016 do not address many of their limitations.

For 2016, BHD made minor modifications to its performance indicators for community-based adult care. However, these modifications do not address many of the indicators' limitations. For example, it is still unclear to which programs some of the indicators apply, and because most of the indicators are not program specific, they cannot be used to help assess the performance of individual programs. In addition, some indicators are output measures, such as the number of recipients served, rather than measures of actual outcomes that would better help BHD and the Board assess program performance.

To provide additional performance information, BHD contracts with a vendor to annually survey adult recipients of some of its community-based programs. One survey of recipients in the Community-Based Alcohol and Other Drug Abuse Residential Program, the Community-Based Mental Health Residential Program, the Community Support Program, the Targeted Case Management program, and the Day Treatment program was designed to assess recipient satisfaction. In 2015, 488 individuals responded to the survey with 87.5 percent indicating that they were satisfied with the services they received and 83.6 percent indicating that, given other options, they would still select the agency from which they received services. Another survey of recipients in the Comprehensive Community Services program was designed to assess results for adults with serious and prolonged psychiatric disorders. In 2015, 54 individuals responded to the survey with 77.8 percent indicating that they have the support needed to function in the community and 79.6 percent indicating that the services they received help them to develop needed skills.

☑ Recommendation

We recommend the Behavioral Health Division:

- *develop performance indicators specific to each of its 19 community-based programs for adults;*
- *submit the proposed performance indicators for community-based programs for adults to the Milwaukee County Mental Health Board for its review and approval;*
- *annually report to the Milwaukee County Mental Health Board on the results of its performance indicators for community-based programs for adults; and*
- *adequately document and maintain information on its procedures and the data used to support its measurements for at least five years from the time the performance results are reported to the Milwaukee County Mental Health Board.*

■■■■

Community-Based Care for Children and Adolescents ■

Community-based services for children and adolescents are provided through programs offering a variety of crisis, recovery, residential, and treatment services. These services are provided through contracts with private vendors operating throughout Milwaukee County. We found that BHD has not developed specific performance indicators for each of its community-based programs for children and adolescents, but BHD reported data that indicates that recipients were generally satisfied with the services they received. We make recommendations for BHD to improve program administration, including developing program-specific performance indicators and improving its methodology for determining program performance.

Range of Programs and Services

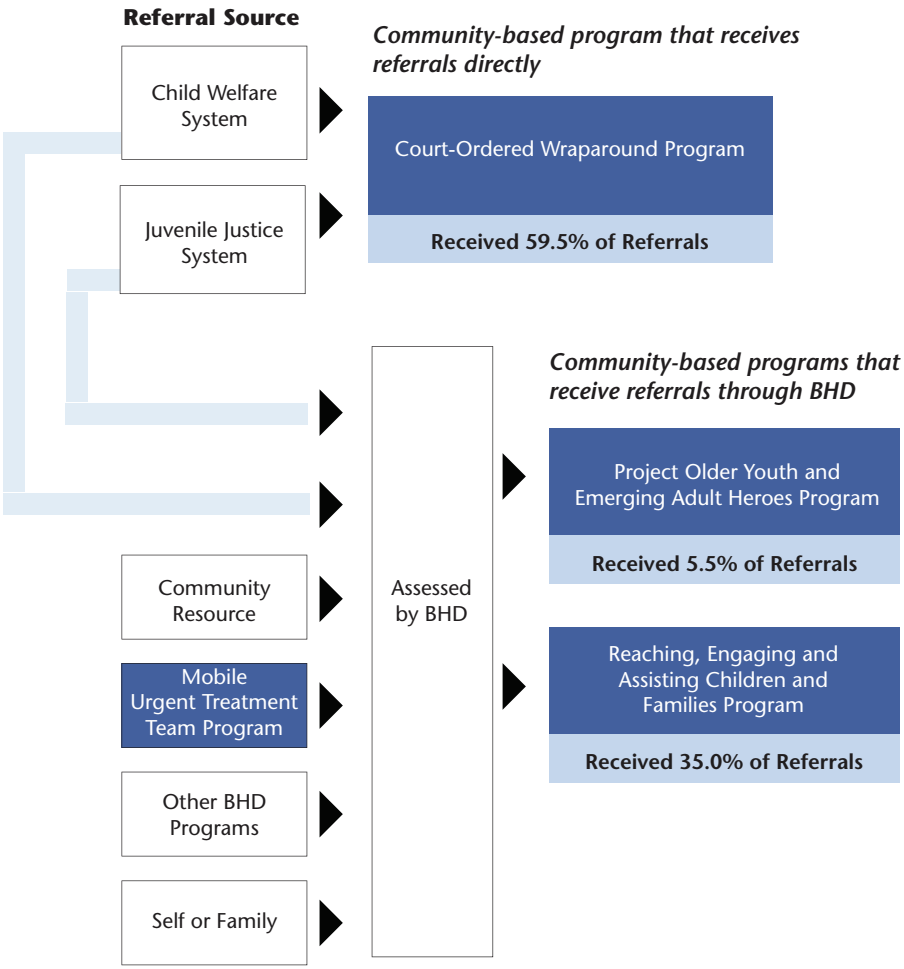
BHD administers four community-based programs to provide services to children and adolescents.

Child and adolescent recipients requiring mental health or AODA care receive services through four community-based programs administered by BHD, including the Court-Ordered Wraparound program; the Mobile Urgent Treatment Team program; the Project Older Youth and Emerging Adult Heroes program; and the Reaching, Engaging and Assisting Children and Families program. Figure 5 shows the referral process to the three main community-based programs. Children and adolescents in need of immediate mental health services gain access to these three programs through the Mobile Urgent Treatment Team program, while others gain access through the juvenile justice system, the child welfare system,

community resources, family members, self-referrals, and other BHD programs. BHD clinical staff assess the recipients to determine which of the programs is most appropriate to meet their needs.

Figure 5

Referral Process to Community-Based Programs for Children and Adolescents
2015



As shown in Table 15, the most common primary diagnoses for children and adolescents served in community-based programs in 2015 were depressive and bipolar disorders.

Table 15

Primary Diagnoses of Recipients Served by Community-Based Programs for Children and Adolescents[1]
2015

Diagnosis Category	Number of Recipients	Percentage of Recipients
Depressive and Bipolar Disorders	654	25.3%
Neurodevelopmental Disorders[2]	495	19.1
Impulse-Control and Conduct Disorders[3]	466	18.0
Trauma-Related Disorders[4]	273	10.6
Substance-Related Disorders	146	5.6
Anxiety Disorders[5]	118	4.6
Schizophrenia and Other Psychotic Disorders	53	2.0
Other[6]	184	7.1
Unknown[7]	197	7.6
Total	2,586	100.0%

[1] Represents recipients' most recent diagnosis if they were admitted more than once in 2015 with different diagnoses.

[2] Includes disorders that produce impairments of personal, social, academic, or occupational functioning, such as autism and attention deficit disorder.

[3] Includes disorders involving difficulty in controlling one's emotions and behaviors.

[4] Includes disorders such as post-traumatic stress disorder and disorders involving problems adjusting to or coping with stressful life events.

[5] Includes disorders such as generalized anxiety disorder and phobias.

[6] Primarily includes recipients with unspecified mental health disorders or who have issues in their home lives.

[7] Includes 177 individuals served by the Mobile Urgent Treatment Team program for whom diagnosis information is not collected.

The Court-Ordered Wraparound program provides services to children and adolescents who are at risk of being removed from their homes.

The Court-Ordered Wraparound program provides services to children and adolescents who are at risk of being removed from their homes and placed in foster care, psychiatric hospitals, detention facilities, or other residential facilities, based largely on the severity of their mental health or AODA issues. Common services provided include crisis stabilization, counseling, psychological assessments, and transportation.

The Mobile Urgent Treatment Team program provides on-site services throughout the community to assess and stabilize recipients who have immediate mental health needs and are either under the age of 18, if not enrolled in other BHD community-based programs, or up to the age of 23, if enrolled in other BHD community-based programs. Recipients may be transferred to BHD's psychiatric hospital or a private hospital if the Mobile Urgent Treatment Team program determines that such care is needed.

The Project Older Youth and Emerging Adult Heroes program provides care coordination and treatment services to recipients who are 16 to 23 years old. The services provided emphasize life skills, such as assistance in gaining employment and accessing financial aid in order to obtain housing.

The Reaching, Engaging and Assisting Children and Families program provides the same services as the Court-Ordered Wraparound program, such as crisis stabilization and counseling, but it typically serves those recipients who are neither involved with the juvenile justice system nor the child welfare system. In addition, rather than being court-ordered, services are provided at the request of the recipient or the recipient's parent or guardian.

Appendix 5 provides additional information on the number and type of recipients served and on program performance for each of the four community-based programs for children and adolescents.

BHD Policy Additions and Modifications

Since the creation of the Board in July 2014 and through December 2015, BHD adopted and modified several policies related to the provision of community-based care for children and adolescents. These additions and modifications are intended to clarify procedures and policy goals, as well as to enhance the provision of services to recipients. During this time, BHD adopted three new policies related to community-based care for children and adolescents, including:

- requiring vendors to have a written emergency management plan for any natural or man-made disasters or any other internal or external hazards;

- providing interpretation or translation services at no cost to recipients and legal guardians who are non-English speakers or have hearing impairments; and

- requiring vendors to adopt and implement a whistleblower policy to protect their employees.

In addition, BHD modified 38 existing policies related to its community-based programs for children and adolescents during the same time frame. Of these modifications, seven included material changes, including:

- establishing requirements for maintaining comprehensive recipient records and for proper disposal of these records;
- requiring vendors to report critical incidents to BHD staff within 24 hours of becoming aware of an incident;
- specifying requirements for in-home therapy related to credentialing, documentation, and billing by vendors;
- establishing requirements for developing and updating recipient care plans;
- establishing procedures for screening vendors' employees and obtaining approval from BHD before they are allowed to provide services through BHD's programs;
- establishing requirements for initial and ongoing caregiver background checks; and
- establishing specific requirements for vendors related to issues such as documenting and billing for services and responding to complaints.

Program Performance

BHD has not developed specific performance indicators for each of its four community-based programs for children and adolescents.

In 2015, BHD relied on six performance indicators to help assess the operation and effectiveness of its four community-based programs for children and adolescents, but only two of these indicators are directly associated with a specific program, which is the Court-Ordered Wraparound program. As shown in Table 16, BHD reported meeting its goals for three of its six performance indicators.

Table 16

BHD Performance Indicators for Community-Based Care for Children and Adolescents
2015

Performance Indicator	Goal	Outcome
Number of Families Served	At least 2,650	3,047
Average Level of Family Satisfaction (on a Scale of 1 to 5)	At least 4.0	4.6
Percentage of Time Recipients Were Placed in a Home-Type Setting for Those Who Were Enrolled through the Juvenile Justice System[1]	At least 75.0%	62.0%
Average Level of Needs Met at Disenrollment (on a Scale of 1 to 5)	At least 3.0	3.2
Percentage of Recipients Who Achieved Permanency at Disenrollment[1, 2]	At least 70.0%	58.0%
Percentage of a Recipients' Support Team Members Who Provide Informal Support[3]	At least 50.0%	42.0%

[1] Applies exclusively to the Court-Ordered Wraparound program.

[2] Permanency refers to a recipient's living situation and includes situations such as a return to living with biological parents, placement with relatives, adoption, and independent living.

[3] Support teams include service providers, family members, friends, advocates, volunteers, and other community members.

Shaded areas indicate goals that BHD did not meet.

Using the available data, we attempted to independently verify the accuracy of the information BHD reported. We were able to verify the information reported for five of the six performance indicators, but the number of families served could not be verified based on the data maintained by BHD. After we brought this to the attention of BHD during the course of our review, it indicated it modified its methodology to ensure that its future counts of the number of families served do not include duplicates.

BHD has established some additional performance measures but they are not comprehensive.

In addition to these six performance indicators, BHD also compiles and reports information on a variety of additional measures that can be used to help assess performance, such as the level of recipients' school attendance and the number and content of complaints and grievances filed. However, not all of these performance measures are collected and reported for each of its four programs. In addition, because data for individual programs are sometimes grouped together, it is not always possible to assess the performance of individual programs using these reports. We focused our review on four of these performance measures, including progress made toward meeting recipients' needs, changes in recipients' level of functioning, school attendance, and satisfaction with services provided.

First, BHD records the progress made toward meeting the needs of recipients that are identified in the care plans of those served by the Court-Ordered Wraparound program; the Project Older Youth and Emerging Adult Heroes program; and the Reaching, Engaging and Assisting Children and Families program. Recipients' progress is scored on a scale of 0 to 5. A score of "0" indicates either that progress toward meeting a particular need is not able to be assessed or that progress was not recorded. If progress was assessed, it was scored from 1 to 5, with "1" indicating minimum progress was made toward meeting a particular need and "5" indicating that a need was entirely met. We believe BHD's inclusion of "0s" in its calculation of average scores is not methodologically sound, because under BHD's methodology "0" reflects a lack of information rather than an assessment of recipient progress. As shown in Table 17, over 60.0 percent of the 560 recipients who were discharged from the program in 2015 had average scores of 3.0 or higher.

Table 17

Average Progress Made by Recipients Discharged from Community-Based Programs for Children and Adolescents[1]
2015

Average Score[2]	Number of Recipients	Percentage of Total
0 to 0.9	26	4.6%
1.0 to 1.9	66	11.8
2.0 to 2.9	118	21.1
3.0 to 3.9	136	24.3
4.0 to 4.9	150	26.8
5.0	64	11.4
Total	**560**	**100.0%**

[1] Includes information for recipients discharged from the Court-Ordered Wraparound program; the Project Older Youth and Emerging Adult Heroes program; and the Reaching, Engaging and Assisting Children and Families program.

[2] Represents progress on a scale of 0 to 5. A score of "0" indicates that progress toward meeting a particular need is either not able to be assessed or was not recorded. If progress was assessed, it was scored from 1 to 5, with "1" indicating minimum progress was made toward meeting a particular need and "5" indicating that a need was entirely met.

BHD reported that the average level of functioning improved for those discharged in 2015 from two of its programs for children and adolescents.

Second, BHD records recipients' level of behavioral functioning, which is a measure of how well they cope with common demands in life and how independent they are compared to others of a similar age and background. The functioning of recipients is assessed at enrollment, after the first six months, annually, and at disenrollment for those served by the Court-Ordered Wraparound program and the Reaching, Engaging and Assisting Children and Families program. Recipients' level of functioning is calculated using a checklist of behaviors that is completed by their parents or guardians. For 2015, BHD reported that the level of functioning improved, on average, for those discharged from each of the two programs for which it assessed recipient progress.

Third, BHD records the school attendance of recipients in the Court-Ordered Wraparound program and the Reaching, Engaging and Assisting Children and Families program. BHD has set a goal for attendance of 85 percent for recipients in each program. For 2015, BHD reported that recipients in the Court-Ordered Wraparound program had a school attendance rate of approximately 86 percent while recipients in the Reaching, Engaging and Assisting Children and Families program had a school attendance rate of approximately 91 percent.

Fourth, BHD conducts two types of satisfaction surveys related to the Court-Ordered Wraparound program and the Reaching, Engaging and Assisting Children and Families program. Surveys of recipients and their families regarding care coordination services are conducted one month and six months after enrollment, as well as at annual intervals. Surveys regarding all other services provided by these programs, such as counseling and mentoring, are conducted four months and nine months after enrollment. Respondents are asked to rate their level of satisfaction on a scale of 1 to 5, with "1" representing the greatest level of dissatisfaction and "5" representing the greatest level of satisfaction. BHD reported that the overall satisfaction level of respondents based on surveys conducted in 2015 averaged 4.23 for care coordination services and 4.42 for all other services. Because the survey results for the two programs were combined, it prevented a separate assessment of each program's performance related to satisfaction.

Finally, unlike some community-based programs for adults, BHD does not report on waiting times for recipients receiving services through community-based programs for children and adolescents. BHD staff indicated that services are provided when needed without placing children and adolescents on waiting lists.

☑ Recommendation

We recommend the Behavioral Health Division:

- *develop performance indicators specific to each of its four community-based programs for children and adolescents;*

- *submit the proposed performance indicators for community-based programs for children and adolescents to the Milwaukee County Mental Health Board for its review and approval;*

- *exclude scores of zero in calculating the average progress made by recipients who are served by community-based programs for children and adolescents;*

- *annually report to the Milwaukee County Mental Health Board on the results of its performance indicators for community-based programs for children and adolescents; and*

- *adequately document and maintain information on its procedures and the data used to support its measurements for at least five years from the time the performance results are reported to the Milwaukee County Mental Health Board.*

■ ■ ■ ■

Oversight ■

We reviewed the adequacy of BHD's oversight of its contracts with vendors and the timeliness with which it reviews and updates its internal policies. We make recommendations for BHD to include contract provisions that help it to measure vendor performance and to conduct reviews of its policies that are overdue for review. 2013 Wisconsin Act 203 outlined the purpose and composition of the Milwaukee County Mental Health Board, and the Act instructed the Board to oversee the provision of mental health services in Milwaukee County. We analyzed the policies established by the Board and found they had not been centrally compiled or disseminated to all Board members, and we identified issues with the Board's compliance with some statutory requirements and its adherence to its bylaws. We make recommendations for improvement in each of these areas.

Oversight of Vendors

BHD oversees its vendors using several different strategies. For example, before BHD enters into a contract with a vendor, it:

- verifies that the prospective vendor and its staff have the appropriate licenses, education requirements, and certifications;
- determines whether the prospective vendor has any Medical Assistance sanctions or malpractice claims; and
- conducts an on-site evaluation and a review of medical records to help ensure the adequacy of the prospective vendor's services.

Once a vendor is approved to deliver services, BHD staff indicated that they regularly review any complaints or grievances made by recipients and annually verify that the vendor is maintaining applicable certifications and licenses.

BHD's contracts generally do not establish standards for acceptable vendor performance or how performance will be measured.

However, we found that most of BHD's contracts for mental health services for adults and for children and adolescents do not generally contain requirements associated with the adequacy of the services provided. Contract requirements are generally limited to broad statements related to complying with legal requirements, informing BHD of administrative changes, ensuring that vendor staff have adequate training, reporting certain incidents involving recipients, and maintaining adequate documentation. Although the contracts require vendors to submit annual independent financial audits, most contain few provisions establishing standards BHD can apply in assessing vendor performance, describing what constitutes acceptable performance, or delineating what actions BHD may take in instances of inadequate performance.

Not addressing performance expectations more broadly in contracts may limit BHD's ability to address inadequate performance in instances in which inadequate performance does not include violation of specific legal requirements or BHD policies. For example, from January 2014 through December 2015, BHD had contracts with more than 300 vendors of mental health services but was only able to identify one instance in which it took corrective action against a vendor based on inadequate performance. During this period, BHD also took corrective action against two other vendors based on financial-related contract violations rather than inadequate performance in serving recipients. BHD indicated that it is in the process of modifying its vendor contracts to require vendors to collect and report specific information to BHD that can be used in assessing their performance.

☑ Recommendation

We recommend the Behavioral Health Division:

- *modify its contracts for mental health services to include provisions establishing performance-based standards and use these standards to measure vendor performance;*

- *assess the performance of each of its vendors on an annual basis; and*

- *submit to the Milwaukee County Mental Health Board an annual report summarizing the results of its vendor performance assessments, including any significant performance concerns it may identify.*

Review of BHD Policies

As of August 2016, BHD had not reviewed 144 of its 505 policies (28.5 percent) in a timely manner.

As of August 2016, BHD had established a total of 505 policies related to its day-to-day operations. Once a policy is established, it is BHD's practice to schedule a review of the policy at regular intervals, which is typically every three years. As shown in Table 18, we found that 144 of 505 policies (28.5 percent) had not been reviewed in a timely manner. This includes 43 policies (8.5 percent) that were overdue for review by more than 10 years. Examples of topics included in these 43 policies include requirements for the type of information to be provided to recipients, the scope of services rendered, and recipient rights.

Table 18

Timeliness of Review of BHD Policies
(as of August 2016)

	Number	Percentage of Total
Reviewed Within Scheduled Period	361	71.5%
Up to 1 Year Overdue	32	6.3
More Than 1 Year and Up to 3 Years Overdue	20	4.0
More Than 3 Years and Up to 5 Years Overdue	31	6.1
More Than 5 Years and Up to 10 Years Overdue	18	3.6
More Than 10 Years Overdue	43	8.5
Total	**505**	**100.0%**

Reviewing policies in a timely manner is important to ensuring that they reflect current legal requirements and Board priorities, and meet recipients' needs.

Reviewing policies in a timely manner is important to ensuring that they reflect current legal requirements and Board priorities, as well as adequately meet the needs of recipients. It also provides BHD with an opportunity to modify policies in order to address any areas of concern that may have been identified in the years since they were established and to identify potential training issues for BHD and its vendors.

☑ Recommendation

We recommend the Behavioral Health Division conduct a review of the 144 policies that are overdue for review, update them as necessary, and report to the Joint Legislative Audit Committee and Milwaukee County Mental Health Board on its progress by June 1, 2017.

Establishing Mental Health Policies

Under the direction of the Board, BHD has begun to expand the provision of community-based mental health services.

One of the Board's most significant responsibilities under Act 203 is to "make the final determination on mental health policy in Milwaukee County." As noted, one major policy initiative was initiated in 2011 before the Board's creation when the Milwaukee County Board of Supervisors established the Mental Health Redesign and Implementation Task Force to develop new initiatives for the provision of mental health services in Milwaukee County. Based in part on the recommendations of the task force and under the direction of the Board, BHD has begun changing the manner in which it provides care to reduce the amount of mental health services being provided in institutional-based settings, such as its psychiatric hospital and long-term care facilities. In addition, BHD began working to expand the provision of mental health services in the least restrictive environment possible by contracting with vendors to provide most community-based services.

The Board has played a significant role in selecting a future vendor of institutional-based mental health services.

This broad policy shift is consistent with Act 203, which requires the Board to make a commitment to "prioritizing access to community-based services and reducing reliance on institutional and inpatient care," and this policy change would have been within the purview of the Board had the Board been created prior to the policy's adoption in 2011. Although the ten current and former Board members with whom we spoke indicated that they agree with the current focus of providing care in the least-restrictive community-based setting, some indicated that this substantial policy change made in 2011 has limited the need for the Board to adopt broad policies directly related to the provision of mental health services. One policy area in which the Board has had significant involvement is in selecting a future vendor of institutional-based mental health services. All Board members with whom we spoke indicated that the Board has been significantly involved in this decision-making process.

Overall, Board members expressed mixed opinions regarding whether the Board was fulfilling its responsibility to set mental health policy for Milwaukee County. Some believe the Board is allowing BHD to have too great a role in setting mental health policy. Others view the arrangement as an appropriate partnership between the Board and BHD, with BHD largely initiating proposals for mental health policies and services and the Board responding to and acting on them.

BHD has not centrally compiled Board policies or made them readily available to Board members or the public.

Board members with whom we spoke appeared to have limited knowledge of the policies that have been adopted by the Board. This lack of awareness is, in part, because not all of these individuals were members of the Board at the time the policies were adopted. In addition, BHD has not centrally compiled the policies or made them readily available to Board members or the public. In response to our request for information on policies adopted by the Board since its inception, the Milwaukee County Office of the Corporation Counsel

identified 27 policies adopted through September 2016. These are separate from operational policies established by BHD. The 27 policies adopted by the Board include:

- 10 related to the expenditure of funds, such as approval to increase expenditures for recipient services;
- 8 related to personnel issues, such as approval of organizational rules and regulations for BHD medical staff;
- 4 related to the Board, such as approval of its bylaws and member expectations;
- 3 related to the provision of services, such as approval of a request to proceed with a request for proposals for the outsourcing of institutional-based care; and
- 2 related to other issues, such as approving BHD's 2015-2016 Quality Plan.

A list of all 27 policies adopted by the Board through September 2016 is shown in Appendix 7.

Easy access to all of the policies adopted by the Board would be helpful to its members in fulfilling their statutory responsibilities in overseeing mental health policy for Milwaukee County. Making the policies readily available to recipients, caregivers, service providers, and other interested parties would also increase transparency and may facilitate improved provision of mental health services.

☑ Recommendation

We recommend the Behavioral Health Division:

- *maintain in a central location all of the policies adopted by the Milwaukee County Mental Health Board;*
- *ensure all Milwaukee County Mental Health Board members are provided with current copies of these policies, including information on the dates they were adopted and the dates they were revised, if applicable; and*
- *make these policies accessible to the public by posting them on the Milwaukee County Mental Health Board's website.*

Board Operations

Act 203 established requirements for general Board operations and the Board has adopted bylaws to help govern its day-to-day operations. We reviewed the Board's operations, including the minutes and audio recordings of its meetings, compliance with state statutes and its own bylaws, and certain issues that have been raised by Board members and stakeholder groups, such as the potential need for dedicated staff support for Board members and the manner in which the Board has conducted its meetings.

Section 51.41 (3), Wis. Stats., requires the Board to meet at least six times each year. We reviewed records of Board meetings and found that it met this requirement. The Board met:

- six times in 2014;
- seven times in 2015; and
- eight times in 2016.

The Board has generally operated through a consensus of its voting members.

We reviewed the minutes of the Board's meetings and found that it has generally operated through a consensus of its voting members. For example, from its inception through September 2016, we found that the motions on which the Board voted were usually approved unanimously. During this time the Board voted on a total of 164 motions, and in only seven instances did the number of voters in the minority total three or more.

Some have raised concerns about the manner in which DHHS officials participate in Board meetings.

In addition to generally operating by consensus, the Board has allowed DHHS staff to participate in an informal manner at Board meetings. Several Board members and stakeholder groups with whom we spoke raised a common concern about the perceived lack of distinction between the Board members and DHHS officials participating in Board meetings.

Some believe that this type of informal interaction during Board meetings may obscure the distinct and separate roles of Board members and DHHS officials, allow officials to exert undue influence in the establishment of mental health policy, and encourage Board members to inappropriately defer to these officials in carrying out their responsibilities. Others believe that the informal approach to Board meetings fosters communication, cooperation, and collegiality between the Board and DHHS officials.

Some Board members have also raised concerns regarding the responsiveness of BHD to their information requests, and discussion has occurred about hiring a dedicated staff member for the Board. Section 51.41 (7) (b), Wis. Stats., requires DHHS to respond to any

information requests of the Board. However, some Board members indicated that BHD, a division of DHHS, has not always been timely in responding to members' information requests. In June 2016, BHD agreed to allocate a portion of the time of one if its staff analysts to address information requests from Board members. This change may improve the responsiveness of BHD to Board member requests.

Adherence to Bylaws and Other Requirements

The Board has established bylaws to govern its operations. For example, its bylaws note that Board members are required to submit a statement of economic interests and disclose any conflicts of interest. This is important because many Board members are mental health practitioners who may have professional relationships with vendors that contract with BHD for the provision of mental health services. Board members are required to abstain from voting on the approval of any contract that would be considered a conflict of interest based on their relationship with a proposed vendor. We reviewed the minutes and audio recordings of meetings since the Board's inception through September 2016 and found that Board members appear to be following these provisions. When voting to approve contracts, we identified 18 motions on which Board members abstained from voting.

We identified two instances in which the Board has not adhered to its bylaws.

We also identified two instances in which the Board has not adhered to its bylaws. First, at the time of our fieldwork the Board's bylaws specified that the Board and its committees are to follow Robert's Rules of Order in conducting their meetings. However, we found that the Board's committees conducted their meetings in a less formal manner that did not follow these rules. For example, when actions were considered by the committees, motions were not made and votes were not tallied, as is specified in Robert's Rules of Order. In August 2016, in response to our inquiry about these committee practices, the Board revised its bylaws to allow committee meetings to operate in a less formal manner than is required by Robert's Rules of Order.

Second, we found that the operations of the Board's finance committee did not adhere to the policies it adopted in October 2014, which specified that the finance committee is to have five members with "expertise in the areas of budgets and finance." However, the language actually incorporated into the Board's bylaws was silent with respect to both the number of finance committee members and their required expertise. Based on meeting minutes, attendance documentation, and interviews with Board members, we found that the finance committee never included more than four members through July 2016 and not all of the finance committee members had expertise in budgets or finance. After we raised these issues with staff during the course of our audit, the Board took action in August 2016 to amend its bylaws to specify that the finance

committee will consist of five members "who have exposure to the areas of budgets and finance."

We also reviewed compliance of the Board with statutory requirements and found that it has not established a Board of Trustees for its psychiatric hospital, as required by s. 46.18 (1), Wis. Stats. We note that the statutory requirement to establish a Board of Trustees for county hospitals and institutions predates the creation of the Milwaukee County Mental Health Board, and BHD staff indicate that a Board of Trustees for the hospital has never been established. Some believe there would be few benefits associated with creating a Board of Trustees given the current oversight role played by the Milwaukee County Mental Health Board and its current plans to contract with a vendor for all institutional-based care beginning in 2018 or later. If the Board agrees, it could seek a statutory change in order to become exempt from this requirement.

☑ Recommendation

We recommend the Milwaukee County Mental Health Board comply with statutes by appointing a Board of Trustees for the psychiatric hospital as specified in s. 46.18 (1), Wis. Stats.

Results of External Surveys

The Milwaukee Mental Health Task Force conducted surveys on access to mental health services in Milwaukee County.

The Milwaukee Mental Health Task Force conducted surveys that may offer additional insight into BHD's performance. The results raise concern about mental health care accessibility because over seventy percent of respondents indicated that access to inpatient mental health services, community-based mental health services, and crisis mental health services in Milwaukee County had stayed the same or decreased.

In spring 2015, the Milwaukee Mental Health Task Force conducted a survey of recipients, service providers, advocacy organizations, law enforcement representatives, and family members of recipients. A total of 76 individuals responded and indicated that "over the past year or two":

- access to inpatient mental health services in Milwaukee County had improved (6 percent), decreased (54 percent), or stayed the same (40 percent);

- access to community mental health services in Milwaukee County had improved (21 percent), decreased (40 percent), or stayed the same (39 percent); and

- access to mental health crisis services in Milwaukee County had improved (17 percent), decreased (30 percent), or stayed the same (52 percent).

In February 2016, the Milwaukee Mental Health Task Force conducted another survey that asked respondents to indicate how the provision of services by BHD had changed from 2014 to 2015. The 88 respondents, including recipients, service providers, advocacy organizations, and other stakeholders, indicated that from 2014 to 2015:

- access to inpatient mental health services in Milwaukee County had increased (5 percent), decreased (44 percent), or stayed the same (41 percent);

- access to community mental health services in Milwaukee County had increased (15 percent), decreased (10 percent), or stayed the same (70 percent); and

- access to mental health crisis services in Milwaukee County had increased (20 percent), decreased (20 percent), or stayed the same (52 percent).

The February 2016 Milwaukee Mental Health Task Force survey also asked respondents to rank service priorities for BHD's 2017 budget, as well as the major barriers to receiving services. In considering priorities for the 2017 budget, over 70 percent of respondents listed as a high priority access to psychiatrists, housing, comprehensive community services, crisis services, and mental health prevention and intervention services for youth. In addition, over 70 percent of respondents indicated that it was "very important" to address a lack of support services after hospital discharge, a lack of service capacity, and a lack of places in the community to receive assistance.

These surveys may provide insight into the extent to which BHD and the Board are accomplishing their goals in the short term. However, because the surveys included a relatively small number of respondents, the extent to which they represent an accurate reflection of the general opinions of recipients and others involved in the provision and receipt of mental health services in Milwaukee County is unknown.

■ ■ ■ ■

Appendices ■

Appendix 1

Milwaukee County Mental Health Board

October 2016

Voting Members

Board Chairperson
Duncan Shrout, MSW
Statutory role: Designee of the Chairperson of the Milwaukee County Combined Community Services Board
Term expires: Does not expire

Board Vice-Chairperson
Thomas Lutzow, PhD, MBA
Statutory role: Finance and Administration Specialist
Term expires: June 10, 2020

Board Secretary
Robert Chayer, MD
Statutory role: Psychologist/Psychiatrist Specializing in Children
Term expires: May 1, 2018

Michael Davis
Statutory role: Substance Abuse Healthcare Provider
Term expires: May 2, 2020

Rachel Forman, PhD
Statutory role: Community-Based Mental Health Provider
Term expires: May 1, 2018

Walter Lanier, JD, MDiv
Statutory role: Individual with Legal Expertise
Term expires: May 1, 2017

Jeffrey Miller, DNP, APNP, ACRN
Statutory role: Psychiatric Mental Health Nurse
Term expires: May 1, 2017

Mary Neubauer, MSW, CPS
Statutory role: Chairperson of the Mental Health Task Force
Term expires: Does not expire

Maria Perez, PhD, LCSW
Statutory role: Psychologist/Psychiatrist Specializing in Adults
Term expired: May 1, 2016

(Note: Staff of the Milwaukee County Executive's Office indicated that the Milwaukee County Board of Supervisors has not yet responded to a June 2016 correspondence asking whether it would like to suggest reappointment or solicit suggestions for a new member.)

Brenda Wesley
Statutory role: Consumer/Family Member Representing Community-Based Mental Health Service Providers
Term expires: May 1, 2018

Michael Thorson, MBA
Statutory role: Mental Health Service Consumer
Term expires: May 1, 2017

Non-voting Members

Ronald Diamond, MD
Statutory role: University of Wisconsin-Madison Representative
Term expires: May 1, 2017

Jon Lehrmann, MD
Statutory role: Medical College of Wisconsin Representative
Term expires: May 1, 2017

Former Members

Peter Carlson, MBA, MEd
Statutory role: Community-Based Mental Health Provider

Rochelle Landingham, MBA
Statutory role: Substance Abuse Healthcare Provider

Lyn Malofsky
Statutory role: Mental Health Service Consumer

Kimberly Walker, JD
Statutory role: Individual with Legal Expertise

Nathan Zeiger, MSW, APSW
Statutory role: Substance Abuse Healthcare Provider

Appendix 2

Services Provided by Programs Administered by the Behavioral Health Division

Program	Services Provided											
	Eligibility Assessment	Service Assessment	Care Plan Development	Discharge Planning	Case Management[1]	Care Coordination[2]	Residential Care	Prescription Medication	Counseling	Employment-Related Assistance	Assistance in Obtaining Housing	Peer Support[3]
Institutional-Based Care												
Inpatient Services Program	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓
Long-Term Care Program	✓	✓	✓	✓	✓		✓	✓	✓		✓	
Psychiatric Emergency Medical Services Program	✓	✓	✓	✓	✓		✓	✓	✓			
Community-Based Care for Adults Acute Crisis Programs												
Crisis Line Program									✓			
Mobile Treatment Teams Program	✓	✓							✓			
Outpatient Access Clinics Program	✓	✓						✓	✓			
Community-Based Care for Adults Recovery Programs												
Community Linkages and Stabilization Program		✓	✓	✓								✓
Community Options Program		✓	✓	✓	✓		✓				✓	
Community Recovery Services Program		✓	✓	✓		✓				✓		
Comprehensive Community Services Program	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
Recovery Support Coordination Program		✓	✓	✓		✓					✓	
Recovery Support Services Program		✓	✓			✓				✓	✓	✓
Community-Based Care for Adults Residential Programs												
Community-Based Alcohol and Other Drug Abuse Residential Program		✓	✓	✓	✓		✓	✓	✓		✓	✓

Program	Services Provided											
	Eligibility Assessment	Service Assessment	Care Plan Development	Discharge Planning	Case Management[1]	Care Coordination[2]	Residential Care	Prescription Medication	Counseling	Employment-Related Assistance	Assistance in Obtaining Housing	Peer Support[3]
Community-Based Care for Adults Residential Programs (continued)												
Community-Based Detoxification Residential Program	✓	✓	✓	✓			✓	✓	✓			✓
Community-Based Mental Health Residential Program		✓	✓	✓	✓		✓				✓	
Crisis Resource Centers Program		✓	✓	✓			✓		✓		✓	✓
Crisis Stabilization Homes Program		✓	✓	✓		✓	✓		✓		✓	✓
Community-Based Care for Adults Treatment Programs												
Care Coordination Unit Program	✓	✓	✓	✓		✓					✓	
Community Support Program		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Day Treatment Program		✓	✓	✓		✓		✓	✓			
Outpatient Treatment Clinics Program		✓	✓	✓		✓		✓	✓			
Targeted Case Management Program		✓	✓	✓		✓				✓	✓	✓
Community-Based Care for Children and Adolescents												
Court-Ordered Wraparound Program	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mobile Urgent Treatment Team Program	✓	✓			✓		✓		✓			
Project Older Youth and Emerging Adult Heroes Program	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Reaching, Engaging and Assisting Children and Families Program	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓

[1] Involves the coordination and oversight of services provided to recipients to facilitate positive outcomes.

[2] Involves assistance in identifying and enrolling in other needed services provided through BHD.

[3] Involves the provision of informal counseling to recipients by certified peer specialists, who are not licensed counselors.

Appendix 3

Summary of Institutional-Based Programs

Inpatient Services Program

Provider: Behavioral Health Division

Target Population: Individuals who require intensive psychiatric care beyond that provided by the Psychiatric Emergency Medical Services program and BHD's community-based programs.

2015 Recipients

	Adults	Children and Adolescents	Total
Number of Recipients	702	628	1,330
Average Length of Treatment	16.2 days	4.1 days	10.3 days

	Recipients	Percentage
Gender		
Female	627	47.1%
Male	687	51.7
Unknown	16	1.2
Age		
Under 18	626	47.1
18 to 25	173	13.0
26 to 44	300	22.6
45 to 65	207	15.6
Over 65	23	1.7
Unknown	1	<0.1
Ethnicity		
African-American	766	57.6
Caucasian	393	29.5
Other	137	10.3
Unknown	34	2.6

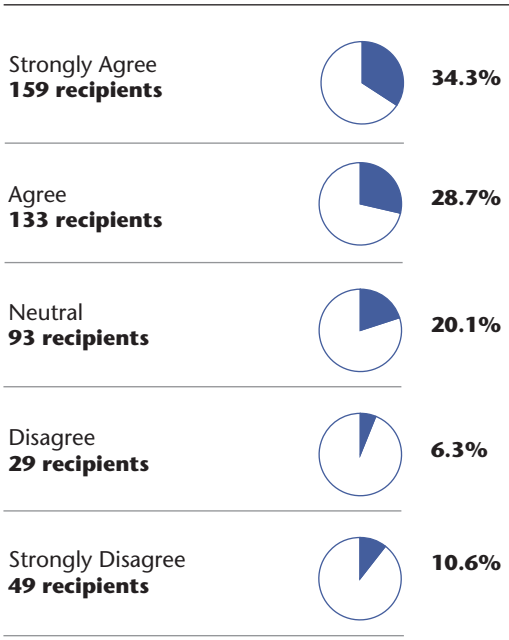
Program Description: The Inpatient Services program is administered through BHD's psychiatric hospital, which is located at the Milwaukee County Mental Health Complex in Wauwatosa. It serves adults, children, and adolescents. Recipients receive care from psychiatrists, psychologists, nurses, and other health care professionals who provide mental health assessments, social services, and rehabilitation therapy. Children and adolescents also receive educational services.

Selected Program Outcomes: The amount of time that elapsed between when a recipient was discharged and readmitted, for those who were admitted more than once in 2015, was as follows:

- fewer than 7 days for 15.8 percent of readmitted recipients;
- 7 to 29 days for 31.0 percent of readmitted recipients;
- 30 to 89 days for 33.9 percent of readmitted recipients; and
- 90 or more days for 19.4 percent of readmitted recipients.

BHD administers surveys to all recipients who receive services in its psychiatric hospital. The following figures show the responses to the two survey questions that BHD identified as most important.

Responses to Survey Question Posed to Adult Recipients (2015)
"If I had a choice of hospitals, I would still choose this one."



Responses to Survey Question Posed to Children and Adolescent Recipients (2015)
"Overall, I am satisfied with the services I received."

Strongly Agree **151 recipients**		**24.5%**
Agree **305 recipients**		**49.5%**
Neutral **90 recipients**		**14.6%**
Disagree **31 recipients**		**5.0%**
Strongly Disagree **39 recipients**		**6.3%**

Long-Term Care Program

Provider: Behavioral Health Division

Target Population: Individuals with complex medical, mental health, and behavioral needs requiring long-term rehabilitation services.

Recipients Served in 2014 and 2015

	Rehab Central	Rehab Hilltop	Total
Number of Recipients	22	32	54
Average Length of Treatment	11.3 years	13.7 years	12.7 years

	Recipients	Percentage
Gender		
Female	15	27.8%
Male	39	72.2
Age		
18 to 25	16	29.6
26 to 44	21	38.9
45 to 65	17	31.5
Over 65	0	0.0
Ethnicity		
African-American	21	38.9
Caucasian	31	57.4
Other	2	3.7

Program Description: The Long-Term Care program provided services at two facilities—Rehab Hilltop and Rehab Central—both located at the Milwaukee County Mental Health Complex in Wauwatosa. Rehab Hilltop was a long-term rehabilitation facility that provided care to recipients with developmental disabilities. It closed in January 2015. Rehab Central was a skilled nursing facility that provided care to recipients requiring 24-hour nursing services. It closed in January 2016. Recipients living at both facilities received services intended to improve and maintain their social and living skills. Neither facility required recipients to have a mental health diagnosis to be a resident, although recipients at each facility reportedly had higher rates of mental illness than recipients at other similar facilities.

Selected Program Outcomes: Since the creation of the Board in July 2014 and through 2015, DHS reviewed Rehab Central twice for regulatory compliance. Its review in January 2015 did not result in the issuance of any citations. Its review in May 2015 resulted in the issuance of nine

citations. None of the citations were classified as "immediate jeopardy" citations. Immediate jeopardy is the most serious category of citation and requires immediate corrective action be taken to address the concerns identified. During this period, DHS also reviewed Rehab Hilltop twice. Its July 2014 review resulted in one citation for failing to provide nursing services in accordance with the needs of two recipients, which was not an immediate jeopardy citation. The other review in November 2014 did not result in the issuance of any citations.

Psychiatric Emergency Medical Services Program

Provider: Behavioral Health Division

Target Population: Individuals who may be experiencing a mental health crisis and are in need of stabilization, brief treatment, and evaluation.

2015 Recipients

	Psychiatric Emergency Room	Observation Unit[1]
Number of Recipients	5,987	907
Average Length of Treatment	5.1 hours	39.6 hours

[1] All recipients admitted to the observation unit were first served in the psychiatric emergency room.

	Recipients	Percentage
Gender		
Female	2,590	43.3%
Male	3,120	52.1
Unknown	277	4.6
Age		
Under 18	1,286	21.5
18 to 25	1,215	20.3
26 to 44	2,025	33.8
45 to 65	1,351	22.6
Over 65	110	1.8
Ethnicity		
African-American	2,882	48.1
Caucasian	2,121	35.4
Other	594	9.9
Unknown	390	6.5

Program Description: The Psychiatric Emergency Medical Services program provides services through the Milwaukee County Mental Health Complex located in Wauwatosa. Any individual, regardless of age, income, or insurance coverage, who may be experiencing a mental health crisis can be admitted to the psychiatric emergency room, which is open 24 hours each day and seven days per week. Admissions can be either voluntary or involuntary. Recipients receive services to stabilize their condition and psychiatric assessments to determine their next level of care. If only brief treatment is necessary, or additional monitoring is required to determine the

appropriate next level of care, the individual can be admitted to the observation unit. This 18-bed unit is designed to provide additional psychiatric assessment or brief treatment lasting less than 48 hours. After an evaluation is completed, recipients are either discharged home, referred to community-based services, admitted to BHD's psychiatric hospital, transferred to a private hospital, or returned to police custody.

Selected Program Outcomes: The amount of time that elapsed between when a recipient was discharged and readmitted, for those who were readmitted more than once in 2015, was as follows.

- fewer than 7 days for 31.1 percent of readmitted recipients;
- 7 to 29 days for 29.7 percent of readmitted recipients;
- 30 to 89 days for 23.7 percent of readmitted recipients; and
- 90 or more days for 15.6 percent of readmitted recipients.

In 2015, the psychiatric emergency room placed 385 recipients on a waiting list and had at least one person on a waiting list 16.0 percent of the time. The average amount of time recipients spent on the waiting list was 10.2 hours. The longest time any recipient was on the waiting list was 99.7 hours. BHD established a goal of having no one on the waiting list for more than 24 hours. In 2015, 10.0 percent of those placed on the waiting list were on it for more than 24 hours, including 3.1 percent that waited for more than 48 hours.

Appendix 4

Summary of Community-Based Programs for Adults

Care Coordination Unit Program

Provider: Behavioral Health Division

Target Population: Adults who require mental health or AODA monitoring services to prevent utilization of emergency services while enrolled in the Community Options Program or while awaiting enrollment in other BHD programs.

2015 Recipients

BHD was unable to provide information on the recipients to whom services were provided because this information was not collected in 2015. BHD indicated that it began collecting this information in 2016.

Program Description: The Care Coordination Unit program began in spring 2015 to provide interim crisis case management services, such as care planning, care coordination, and assistance in obtaining housing. Services are provided to recipients with mental health or AODA issues who are enrolled in the Community Options Program or who are awaiting enrollment in other BHD programs, such as the Community Support Program or the Targeted Case Management program.

Selected Program Outcomes: In 2015, BHD did not collect information on outcomes for the Care Coordination Unit program.

Community-Based Alcohol and Other Drug Abuse Residential Program

Providers: Genesis Behavioral Services, Inc.; Matt Talbot Recovery Services, Inc.; Meta House, Inc.; and United Community Center, Inc.

Target Population: Adults who have severe AODA issues that require supervision and care in a residential setting.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	–	624	624
Average Length of Treatment	–	43 days	43 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	–	–	277	44.4%
Male	–	–	347	55.6
Age				
18 to 25	–	–	73	11.7
26 to 44	–	–	320	51.3
45 to 65	–	–	227	36.4
Over 65	–	–	4	0.6
Ethnicity				
African-American	–	–	254	40.7
Caucasian	–	–	290	46.5
Other	–	–	23	3.7
Unknown	–	–	57	9.1

Program Description: The Community-Based Alcohol and Other Drug Abuse Residential Program funds certified and licensed residential facilities to provide services, such as 24-hour supervision, counseling, and treatment, to recipients with diagnosed AODA issues.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Community-Based Alcohol and Other Drug Abuse Residential Program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **18 recipients**		**2.9%**
Moderate Improvement **65 recipients**		**10.4%**
Unchanged or Worsened **7 recipients**		**1.1%**
Left Program before Treatment Was Completed **199 recipients**		**31.9%**
Transferred to Another Program **140 recipients**		**22.4%**
Continued Treatment in Program **187 recipients**		**30.0%**
Unknown **8 recipients**		**1.3%**

Community-Based Detoxification Residential Program

Providers: Genesis Behavioral Services, Inc. (through March 15, 2015) and Matt Talbot Recovery Services, Inc. (beginning March 15, 2015)

Target Population: Adults who are experiencing alcohol or other drug intoxication issues that require immediate care.

2015 Recipients[1]

	Mental Health	AODA	Total
Number of Recipients	–	1,987	1,987

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	–	–	545	27.4%
Male	–	–	1,442	72.6
Age				
18 to 25	–	–	184	9.3
26 to 44	–	–	905	45.5
45 to 65	–	–	867	43.6
Over 65	–	–	31	1.6
Ethnicity				
African-American	–	–	968	48.7
Caucasian	–	–	742	37.3
Other	–	–	77	3.9
Unknown	–	–	200	10.1

[1] Data did not allow for an accurate calculation of the average length of treatment.

Program Description: The Community-Based Detoxification Residential Program funds a licensed detoxification facility that manages AODA intoxication and withdrawal symptoms in order to minimize the harm to recipients.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Community-Based Detoxification Residential Program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **0 recipients**		**0%**
Moderate Improvement **3 recipients**		**0.2%**
Unchanged or Worsened **89 recipients**		**4.5%**
Left Program before Treatment Was Completed **390 recipients**		**19.6%**
Transferred to Another Program **43 recipients**		**2.2%**
Continued Treatment in Program **49 recipients**		**2.5%**
Unknown **1,413 recipients**		**71.1%**

Community-Based Mental Health Residential Program

Providers: Bell Therapy, Inc.; Homes for Independent Living of Wisconsin, LLC; and Whole Health Clinical Group, Inc.

Target Population: Adults who have severe mental health issues that require supervision and care in a residential setting.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	180	–	180
Average Length of Treatment	5.7 years	–	5.7 years

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	66	36.7 %	–	–
Male	114	63.3	–	–
Age				
18 to 25	6	3.3	–	–
26 to 44	56	31.1	–	–
45 to 65	112	62.2	–	–
Over 65	6	3.3	–	–
Ethnicity				
African-American	56	31.1	–	–
Caucasian	115	63.9	–	–
Other	9	5.0	–	–

Program Description: The Community-Based Mental Health Residential Program funds certified and licensed residential facilities to provide services, such as 24-hour supervision and assistance in obtaining housing, to recipients with mental health issues.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Community-Based Mental Health Residential Program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **0 recipients**		**0%**
Moderate Improvement **0 recipients**		**0%**
Unchanged or Worsened **0 recipients**		**0%**
Left Program before Treatment Was Completed **3 recipients**		**1.7%**
Transferred to Another Program **1 recipient**		**0.6%**
Continued Treatment in Program **149 recipients**		**82.8%**
Unknown **27 recipients**		**15.0%**

Community Linkages and Stabilization Program

Provider: La Causa, Inc.

Target Population: Adults who require non-clinical mental health services to prevent utilization of emergency services.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	134	–	134
Average Length of Treatment	198 days	–	198 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	74	55.2%	–	–
Male	60	44.8	–	–
Age				
18 to 25	26	19.4	–	–
26 to 44	52	38.8	–	–
45 to 65	52	38.8	–	–
Over 65	4	3.0	–	–
Ethnicity				
African-American	59	44.0	–	–
Caucasian	59	44.0	–	–
Other	7	5.2	–	–
Unknown	9	6.7	–	–

Program Description: The Community Linkages and Stabilization Program provides non-clinical, supportive services needed to allow recipients to live independently in the community with the goal of reducing their future need for emergency care.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Community Linkages and Stabilization Program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **32 recipients**		**23.9%**
Moderate Improvement **1 recipient**		**0.7%**
Unchanged or Worsened **0 recipients**		**0%**
Left Program before Treatment Was Completed **42 recipients**		**31.3%**
Transferred to Another Program **3 recipients**		**2.2%**
Continued Treatment in Program **53 recipients**		**39.6%**
Unknown **3 recipients**		**2.2%**

Community Options Program

Providers: 13 providers

Target Population: Adults who are enrolled in the Community-Based Mental Health Residential program.

2015 Fourth Quarter Recipients[1]

	Mental Health	AODA	Total
Number of Recipients	43	–	43
Average Length of Treatment	4.0 years	–	4.0 years

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	20	46.5%	–	–
Male	23	53.5	–	–
Age				
18 to 25	1	2.3	–	–
26 to 44	9	20.9	–	–
45 to 65	30	69.8	–	–
Over 65	3	7.0	–	–
Ethnicity				
African-American	15	34.9	–	–
Caucasian	22	51.2	–	–
Other	4	9.3	–	–
Unknown	2	4.7	–	–

[1] BHD only began collecting recipient information in the fourth quarter of 2015.

Program Description: The Community Options Program is a state-established, county-operated program for recipients with disabilities regardless of their income that is intended to divert recipients from nursing homes and other institutional settings by funding long-term support services not covered by other programs, such as home modification and housekeeping.

Selected Program Outcomes: BHD did not collect outcome data for recipients enrolled in the Community Options Program.

Community Recovery Services Program

Providers: Bell Therapy, Inc.; La Causa, Inc.; St. Charles Youth & Family Services, Inc.; and Whole Health Clinical Group, Inc.

Target Population: Adults with severe and persistent depression, psychotic disorders, or bipolar disorders who are enrolled in the Community-Based Mental Health Residential program and are at or below 150 percent of the federal poverty level.

2015 Fourth Quarter Recipients[1]

	Mental Health	AODA	Total
Number of Recipients	44	–	44
Average Length of Treatment	4.2 years	–	4.2 years

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	13	29.5%	–	–
Male	31	70.5	–	–
Age				
18 to 25	1	2.3	–	–
26 to 44	10	22.7	–	–
45 to 65	32	72.7	–	-
Over 65	1	2.3	–	–
Ethnicity				
African-American	12	27.3	–	–
Caucasian	30	68.2	–	–
Other	2	4.5	–	–

[1] BHD only began collecting recipient information in the fourth quarter of 2015.

Program Description: The Community Recovery Services program provides support services, such as care coordination, and assistance in obtaining employment. Services are provided to recipients with severe and persistent mental health issues who are living in community-based residential facilities and who are at or below 150 percent of the federal poverty level.

Selected Program Outcomes: In 2015, program outcome information was reported for only one recipient who did not complete the program.

Community Support Program

Providers: Bell Therapy, Inc.; Milwaukee Mental Health Associates, Inc.; Outreach Community Health Centers, Inc.; Project Access, Inc.; Whole Health Clinical Group, Inc.; and Wisconsin Community Services, Inc.

Target Population: Adults with the most severe and persistent mental health issues and functional limitations who require high engagement with mental health services to prevent utilization of emergency care.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	1,425	–	1,425
Average Length of Treatment	6.5 years	–	6.5 years

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	536	37.6%	–	–
Male	889	62.4	–	–
Age				
18 to 25	280	19.6	–	–
26 to 44	742	52.1	–	–
45 to 65	382	26.8	–	–
Over 65	21	1.5	–	–
Ethnicity				
African-American	763	53.5	–	–
Caucasian	567	39.8	–	–
Other	77	5.4	–	–
Unknown	18	1.3	–	–

Program Description: The Community Support Program provides clinical and non-clinical services, largely in a non-clinical setting, to recipients with the most severe and persistent mental health issues and functional limitations.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Community Support Program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **3 recipients**		**0.2%**
Moderate Improvement **7 recipients**		**0.5%**
Unchanged or Worsened **1 recipient**		**0.1%**
Left Program before Treatment Was Completed **50 recipients**		**3.5%**
Transferred to Another Program **76 recipients**		**5.3%**
Continued Treatment in Program **1,207 recipients**		**84.7%**
Unknown **81 recipients**		**5.7%**

Comprehensive Community Services Program

Providers: 19 vendors

Target Population: Adults with severe mental health or AODA issues who require assistance with accessing and coordinating services to prevent utilization of emergency services.

2015 Recipients[1]

Total Number of Recipients	401
Average Length of Treatment	98 days

	Recipients	Percentage
Gender		
Female	213	53.1%
Male	188	46.9
Age		
18 to 25	37	9.2
26 to 44	155	38.7
45 to 65	205	51.1
Over 65	4	1.0
Ethnicity		
African-American	180	44.9
Caucasian	178	44.4
Other	10	2.5
Unknown	33	8.2

[1] Data did not allow for distinction between mental health and AODA recipients. BHD indicated that the majority of recipients received mental health services.

Program Description: The Comprehensive Community Services program provides services to those recipients with severe mental illnesses or AODA issues who are in need of a wide array of services.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Comprehensive Community Services program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **0 recipients**		**0%**
Moderate Improvement **1 recipient**		**0.2%**
Unchanged or Worsened **3 recipients**		**0.7%**
Left Program before Treatment Was Completed **51 recipients**		**12.7%**
Transferred to Another Program **14 recipients**		**3.5%**
Continued Treatment in Program **327 recipients**		**81.5%**
Unknown **5 recipients**		**1.2%**

Crisis Line Program

Provider: Behavioral Health Division

Target Population: Adults who are experiencing crises related to mental health or AODA issues.

2015 Recipients

Although BHD indicated it tracks basic recipient information, it did not provide this information to us.

Program Description: The Crisis Line program is a 24-hour telephone service that provides adult recipients who are experiencing crises related to mental health or AODA issues with screenings, assessments, counseling, crisis intervention, emergency service coordination, information, and referrals to other community-based or institutional-based services. The goals of the Crisis Line include reducing the risk of crisis escalation, protecting individuals by arranging for an emergency on-site response when necessary, and providing information and referrals to callers.

Selected Program Outcomes: In 2015, BHD did not collect information on outcomes for the Crisis Line program.

Crisis Resource Centers Program

Provider: Whole Health Clinical Group, Inc.

Target Population: Adults who are experiencing mental health crises that require short-term treatment and care, including in a residential setting.

2015 Recipients

BHD indicated that its service provider tracks basic recipient information, but it does not collect this information from the provider.

Program Description: The Crisis Resource Centers program provides, as an alternative to psychiatric inpatient hospitalization, walk-in intervention and short-term stabilization services typically lasting no more than seven days to recipients experiencing psychological crises.

Selected Program Outcomes: In 2015, BHD did not collect information on outcomes for the Crisis Resource Centers program.

Crisis Stabilization Homes Program

Providers: Bell Therapy, Inc. and Whole Health Clinical Group, Inc.

Target Population: Adults who are experiencing mental health crises that require treatment and care in a residential setting.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	280	–	280
Average Length of Treatment	23 days	–	23 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	113	40.4%	–	–
Male	167	59.6	–	–
Age				
18 to 25	51	18.2	–	–
26 to 44	117	41.8	–	–
45 to 65	101	36.1	–	–
Over 65	3	1.1	–	–
Unknown	8	2.9	–	–
Ethnicity				
African-American	140	50.0	–	–
Caucasian	105	37.5	–	–
Other	12	4.3	–	–
Unknown	23	8.2	–	–

Program Description: The Crisis Stabilization Homes program provides longer-term stabilization services, which averaged 23 days, to recipients who are experiencing psychological crises.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Crisis Stabilization Homes program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **3 recipients**		**1.1%**
Moderate Improvement **5 recipients**		**1.8%**
Unchanged or Worsened **5 recipients**		**1.8%**
Left Program before Treatment Was Completed **9 recipients**		**3.2%**
Transferred to Another Program **180 recipients**		**64.3%**
Continued Treatment in Program **42 recipients**		**15.0%**
Unknown **36 recipients**		**12.9%**

Day Treatment Program

Providers: AIDS Resource Center of Wisconsin, Inc.; Behavioral Health Division; GRO Family Services, LLC; Guest House of Milwaukee, Inc.; Meta House, Inc.; Ravenswood Clinic, Inc.; and United Community Center, Inc.

Target Population: Adults who require high engagement with mental health or AODA services but do not require care provided by the Inpatient Services program.

2015 Recipients[1]

	Mental Health	AODA	Total
Number of Recipients	61	90	151
Average Length of Treatment	193 days	59 days	121 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	49	80.3%	25	27.8%
Male	12	19.7	65	72.2
Age				
18 to 25	13	21.3	19	21.1
26 to 44	34	55.7	44	48.9
45 to 65	14	23.0	27	30.0
Over 65	0	0.0	0	0.0
Ethnicity				
African-American	17	27.9	25	27.8
Caucasian	37	60.7	52	57.8
Other	4	6.6	3	3.3
Unknown	3	4.9	10	11.1

[1] Data did not allow for identification of some recipients who likely received services through the program.

Program Description: The Day Treatment program provides intensive clinical services to recipients with complex mental health or AODA issues.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Day Treatment Program are shown below.

Mental Health Recipient Treatment Outcomes (2015)

Major Improvement **6 recipients**		**9.8%**
Moderate Improvement **14 recipients**		**23.0%**
Unchanged or Worsened **1 recipient**		**1.6%**
Left Program before Treatment Was Completed **7 recipients**		**11.5%**
Transferred to Another Program **4 recipients**		**6.6%**
Continued Treatment in Program **21 recipients**		**34.4%**
Unknown **8 recipients**		**13.1%**

AODA Recipient Treatment Outcomes (2015)

Major Improvement **5 recipients**		**5.6%**
Moderate Improvement **5 recipients**		**5.6%**
Unchanged or Worsened **3 recipients**		**3.3%**
Left Program before Treatment Was Completed **22 recipients**		**24.4%**
Transferred to Another Program **9 recipients**		**10.0%**
Continued Treatment in Program **46 recipients**		**51.1%**

Mobile Treatment Teams Program

Providers: Behavioral Health Division; Dungarvin, Inc.; La Causa, Inc.; and the Milwaukee Police Department

Target Population: Adults who are experiencing crises related to mental health or AODA issues.

2015 Recipients[1]

Number of Recipients	1,780

	Recipients	Percentage
Gender		
Female	887	49.8%
Male	892	50.1
Unknown	1	0.1
Age		
18 to 25	396	22.2
26 to 44	721	40.5
45 to 65	504	28.3
Over 65	123	6.9
Unknown	36	2.0
Ethnicity		
African-American	738	41.5
Caucasian	717	40.3
Other	157	8.8
Unknown	168	9.4

[1] Data did not allow for distinction between mental health and AODA recipients. Data also did not allow for accurate calculation of average length of treatment.

Program Description: The Mobile Treatment Teams program makes available to all individuals on-site support services, such as mental health assessments and crisis intervention services, in order to determine whether to refer individuals to other BHD services or begin emergency detention proceedings.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Mobile Treatment Teams program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement **2 recipients**		**0.1%**
Moderate Improvement **17 recipients**		**1.0%**
Unchanged or Worsened **8 recipients**		**0.4%**
Left Program before Treatment Was Completed **16 recipients**		**0.9%**
Transferred to Another Program **1,360 recipients**		**76.4%**
Continued Treatment in Program **13 recipients**		**0.7%**
Unknown **364 recipients**		**20.4%**

Outpatient Access Clinics Program

Providers: Behavioral Health Division and La Causa, Inc.

Target Population: Adult indigent and uninsured recipients requiring mental health services.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	576	–	576
Average Length of Treatment	122 days	–	122 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	227	39.4%	–	–
Male	349	60.6	–	–
Age				
18 to 25	76	13.2	–	–
26 to 44	213	37.0	–	–
45 to 65	113	19.6	–	–
Over 65	1	0.2	–	–
Unknown	173	30.0	–	–
Ethnicity				
African-American	164	28.5	–	–
Caucasian	179	31.1	–	–
Other	28	4.9	–	–
Unknown	205	35.6	–	–

Program Description: The Outpatient Access Clinics program provides to uninsured recipients with mental health issues services such as mental health assessments, counseling, medication management, and referrals to other community-based services.

Selected Program Outcomes: Providers are required to collect and report information on recipient treatment outcomes. However, treatment outcomes were only reported for 43 recipients in 2015.

Outpatient Treatment Clinics Program

Providers: 21 vendors

Target Population: Adults who require limited mental health or AODA services in order to prevent utilization of emergency care.

2015 Recipients[1]

	Mental Health	AODA	Total
Number of Recipients	582	1,465	2,014[2]
Average Length of Treatment	4.3 years	137 days	1.8 years

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	255	43.8%	237	16.2%
Male	327	56.2	1,228	83.8
Age				
18 to 25	94	16.2	314	21.4
26 to 44	276	47.4	867	59.2
45 to 65	206	35.4	278	19.0
Over 65	5	0.9	2	0.1
Unknown	1	0.2	4	0.3
Ethnicity				
African-American	131	22.5	595	40.6
Caucasian	366	62.9	538	36.7
Other	68	11.7	93	6.3
Unknown	17	2.9	239	16.3

[1] Data did not allow for identification of some recipients who likely received services through the program.

[2] Thirty-three recipients received both mental health and AODA services.

Program Description: The Outpatient Treatment Clinics program provides outpatient services, such as care planning, counseling, and medication, to indigent and uninsured recipients with mental health and AODA issues.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Outpatient Treatment Clinics program are shown below.

Mental Health Recipient Treatment Outcomes (2015)

Major Improvement **2 recipients**		**0.3%**
Moderate Improvement **0 recipients**		**0%**
Unchanged or Worsened **0 recipients**		**0%**
Left Program before Treatment Was Completed **100 recipients**		**17.2%**
Transferred to Another Program **34 recipients**		**5.8%**
Continued Treatment in Program **202 recipients**		**34.7%**
Unknown **244 recipients**		**41.9%**

AODA Recipient Treatment Outcomes (2015)

Major Improvement **119 recipients**		**8.1%**
Moderate Improvement **157 recipients**		**10.7%**
Unchanged or Worsened **8 recipients**		**0.5%**
Left Program before Treatment Was Completed **306 recipients**		**20.9%**
Transferred to Another Program **54 recipients**		**3.7%**
Continued Treatment in Program **814 recipients**		**55.6%**
Unknown **7 recipients**		**0.5%**

Recovery Support Coordination Program

Providers: JusticePoint, Inc.; La Causa, Inc.; My Home, Your Home, Inc.; St. Charles Youth & Family Services, Inc.; and Wisconsin Community Services, Inc.

Target Population: Adults who require extensive AODA services in order to prevent utilization of emergency care.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	–	1,217	1,217
Average Length of Treatment	–	118 days	118 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	–	–	576	47.3%
Male	–	–	641	52.7
Age				
18 to 25	–	–	201	16.5
26 to 44	–	–	816	67.1
45 to 65	–	–	194	15.9
Over 65	–	–	6	0.5
Ethnicity				
African-American	–	–	498	40.9
Caucasian	–	–	536	44.0
Other	–	–	56	4.6
Unknown	–	–	127	10.4

Program Description: The Recovery Support Coordination program provides care planning and care coordination services to recipients with the greatest AODA issues in order to assist them in accessing other needed medical, social, and employment services.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Recovery Support Coordination program are shown below.

Recipient Treatment Outcomes (2015)

Major Improvement
106 recipients
8.7%

Moderate Improvement
73 recipients
6.0%

Unchanged or Worsened
14 recipients
1.2%

Left Program before Treatment Was Completed
622 recipients
51.1%

Transferred to Another Program
48 recipients
3.9%

Continued Treatment in Program
342 recipients
28.1%

Unknown
12 recipients
1.0%

Recovery Support Services Program

Providers: 33 vendors

Target Population: Adults who require non-clinical AODA services in order to prevent utilization of emergency care.

2015 Recipients

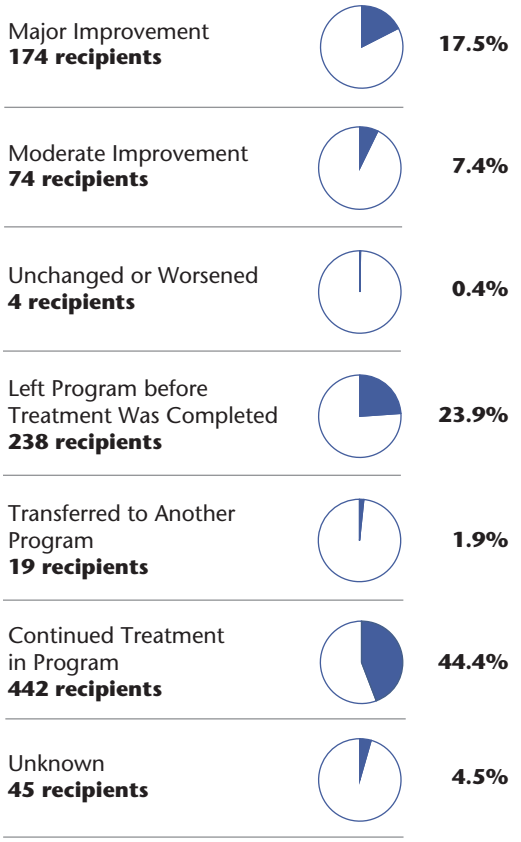
	Mental Health	AODA	Total
Number of Recipients	–	*996*	*996*
Average Length of Treatment	–	88 days	88 days

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	–	–	357	35.8%
Male	–	–	639	64.2
Age				
18 to 25	–	–	169	17.0
26 to 44	–	–	581	58.3
45 to 65	–	–	244	24.5
Over 65	–	–	2	0.2
Ethnicity				
African-American	–	–	628	63.1
Caucasian	–	–	271	27.2
Other	–	–	36	3.6
Unknown	–	–	61	6.1

Program Description: The Recovery Support Services program consists of a network of vendors who help to address the non-clinical needs of recipients with AODA issues by assisting them with needs such as finding employment and obtaining housing.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Recovery Support Services program are shown below.

Recipient Treatment Outcomes (2015)



Targeted Case Management Program

Providers: Alternatives in Psychological Consultation, S.C.; Bell Therapy, Inc.; Horizon Healthcare, Inc.; La Causa, Inc.; Milwaukee Mental Health Associates, Inc.; Outreach Community Health Center, Inc.; and Wisconsin Community Services, Inc.

Target Population: Adults with severe and persistent mental health or AODA issues who require extensive services in order to prevent utilization of emergency care.

2015 Recipients

	Mental Health	AODA	Total
Number of Recipients	1,665	43	1,704[1]
Average Length of Treatment	2.9 years	288 days	2.8 years

	Mental Health		AODA	
	Recipients	Percentage	Recipients	Percentage
Gender				
Female	693	41.6%	20	46.5%
Male	972	58.4	23	53.5
Age				
18 to 25	311	18.7	5	11.6
26 to 44	731	43.9	17	39.5
45 to 65	592	35.6	21	48.8
Over 65	28	1.7	0	0.0
Unknown	3	0.2	0	0.0
Ethnicity				
African-American	880	52.9	15	34.9
Caucasian	652	39.2	25	58.1
Other	91	5.5	2	4.7
Unknown	42	2.5	1	2.3

[1] Four recipients received both mental health and AODA services.

Program Description: The Targeted Case Management program provides care coordination services, such as care planning and assistance in gaining employment and in obtaining housing, to recipients with serious and persistent mental health or AODA issues that indicate a high risk for re-hospitalization but do not rise to the level of need required for enrollment in the Community Support Program.

Selected Program Outcomes: Providers collect and report information on recipient treatment outcomes. Treatment outcomes for recipients in the Targeted Case Management program are shown below.

Mental Health Recipient Treatment Outcomes (2015)

Major Improvement **32 recipients**		**1.9%**
Moderate Improvement **23 recipients**		**1.4%**
Unchanged or Worsened **12 recipients**		**0.7%**
Left Program before Treatment Was Completed **121 recipients**		**7.3%**
Transferred to Another Program **87 recipients**		**5.2%**
Continued Treatment in Program **1,333 recipients**		**80.1%**
Unknown **57 recipients**		**3.4%**

AODA Recipient Treatment Outcomes (2015)

Major Improvement **4 recipients**		**9.3%**
Moderate Improvement **2 recipients**		**4.7%**
Unchanged or Worsened **0 recipients**		**0%**
Left Program before Treatment Was Completed **9 recipients**		**20.9%**
Transferred to Another Program **3 recipients**		**7.0%**
Continued Treatment in Program **19 recipients**		**44.2%**
Unknown **6 recipients**		**14.0%**

Appendix 5

Summary of Community-Based Programs for Children and Adolescents

Court-Ordered Wraparound Program

Providers: Six care coordination vendors—AJA Enterprise, LLC; Alternatives in Psychological Consultation, S.C.; La Causa, Inc.; SaintA, Inc.; St. Charles Youth & Family Services, Inc.; and Willowglen Academy-Wisconsin, Inc.—and over 100 vendors of other types of services

Target Population: Children and adolescents through age 23 with mental health or AODA issues.

2015 Recipients

Total Number of Recipients	992
Average Length of Treatment	1.5 years

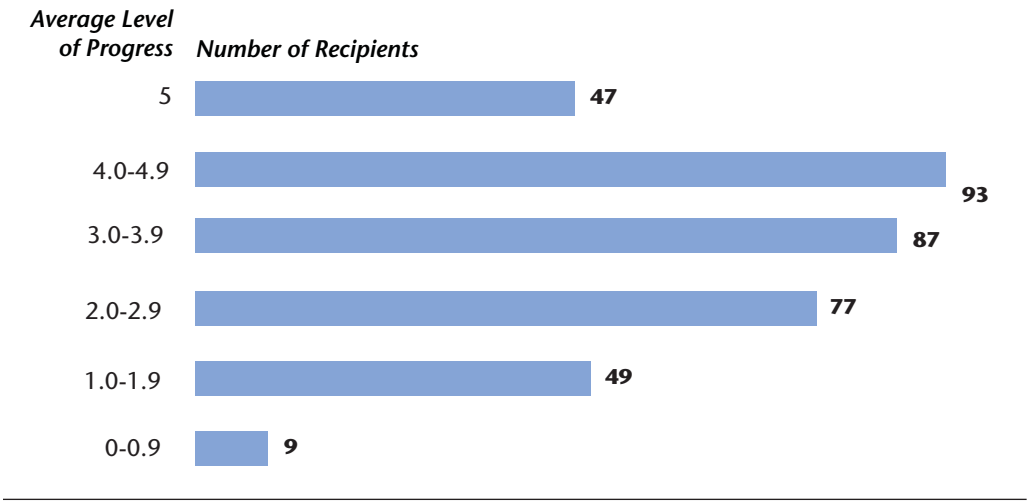
	Recipients	Percentage
Gender		
Female	303	30.5%
Male	689	69.5
Age		
Under 4	0	0
4 to 12	201	20.3
13 to 17	791	79.7
Over 17	0	0.0
Ethnicity		
African-American	753	75.9
Caucasian	106	10.7
Other	109	11.0
Unknown	24	2.4

Program Description: The Court-Ordered Wraparound program provides services to children and adolescents who are at risk of being removed from their homes and placed in foster care, psychiatric hospitals, detention facilities, or other residential facilities, based largely on the severity of their mental health or AODA issues. Common services provided include crisis stabilization, counseling, psychological assessments, and transportation.

Selected Program Outcomes: BHD tracks the level of progress recipients make toward addressing the needs identified in their care plans. At disenrollment, progress is ranked on a scale of 1 to 5, with 1 meaning minimal progress was made and 5 meaning the need was successfully met. A score of 0 indicates either that the need was not able to be assessed or that progress was not recorded. In 2015, the most common average progress score was between 4.0 and 4.9 for youth discharged from the Court-Ordered Wraparound program.

The figure shows the average level of progress made by recipients discharged from the Court-Ordered Wraparound program in 2015.

Average Level of Progress Made by Recipients Discharged (2015)
(5 = Needs Met, 1 = Minimal Progress, 0 = Needs Unable to Be Assessed or Were Not Recorded)



Mobile Urgent Treatment Team Program

Provider: Behavioral Health Division

Target Population: Children and adolescents who are experiencing a mental health crisis or have other immediate needs.

2015 Recipients[1]

Total Number of Recipients	787

	Recipients	Percentage
Gender		
Female	382	48.5%
Male	405	51.5
Age		
Under 4	7	0.9
4 to 12	374	47.5
13 to 17	403	51.2
Over 17	3	0.4
Ethnicity		
African-American	426	54.1
Caucasian	124	15.8
Other	119	15.1
Unknown	118	15.0

[1] Data did not allow for accurate calculation of average length of treatment.

Program Description: The Mobile Urgent Treatment Team program provides on-site services throughout the community to assess and stabilize recipients who are in crisis or who have immediate mental health needs and are either under the age of 18 if not enrolled in other BHD community-based programs, or up to the age of 23 if they are enrolled in other BHD community-based programs. Recipients may be transferred to BHD's psychiatric hospital or a private hospital, or referred to other BHD services, if the Mobile Urgent Treatment Team program determines that such care is needed.

Selected Program Outcomes: BHD does not collect information on program outcomes for the Mobile Urgent Treatment Team program.

Project Older Youth and Emerging Adult Heroes Program

Providers: Four care coordination providers—La Causa, Inc.; Lad Lake, Inc.; St. Charles Youth & Family Services, Inc.; and Pathfinders Milwaukee, Inc.—and over 100 providers of other types of services

Target Population: Adolescents ages 16 through 23 with mental health or AODA issues.

2015 Recipients

Total Number of Recipients	202
Average Length of Treatment	312 days

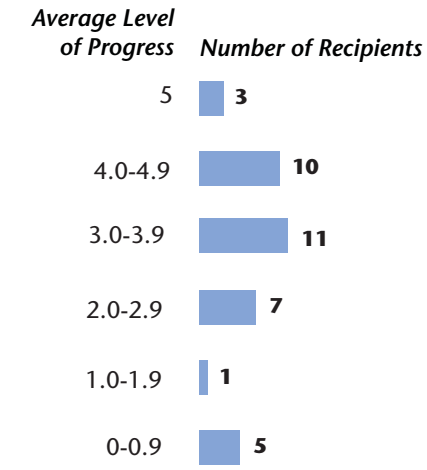
	Recipients	Percentage
Gender		
Female	81	40.1%
Male	120	59.4
Transgender	1	0.5
Age		
13 to 17	54	26.7
Over 17	148	73.3
Ethnicity		
African-American	150	74.3
Caucasian	26	12.9
Other	18	8.9
Unknown	8	4.0

Program Description: The Project Older Youth and Emerging Adult Heroes program provides care coordination and treatment services to recipients who are 16 to 23 years old. The services provided emphasize life skills, such as assistance in gaining employment and accessing financial aid in order to obtain housing.

Selected Program Outcomes: BHD tracks the level of progress recipients make toward addressing the needs identified in their care plans. At disenrollment, progress is ranked on a scale of 1 to 5, with 1 meaning minimal progress was made and 5 meaning the need was successfully met. A score of 0 indicates either that the need was not able to be assessed or that progress was not recorded. In 2015, the most common average progress score was between 3.0 and 3.9 for youth discharged from the Project Older Youth and Emerging Adult Heroes program.

The figure shows the average level of progress made by recipients discharged from the Project Older Youth and Emerging Adult Heroes program in 2015.

Average Level of Progress Made by Recipients Discharged (2015)
(5 = Needs Met, 1 = Minimal Progress, 0 = Needs Unable to Be Assessed or Were Not Recorded)



Reaching, Engaging and Assisting Children and Families Program

Providers: Four care coordination providers—AJA Enterprise, LLC; Alternatives in Psychological Consultation, S.C.; La Causa, Inc.; and SaintA, Inc.—and over 100 providers of other types of service

Target Population: Children and adolescents through age 23 with mental health or AODA issues.

2015 Recipients

Total Number of Recipients	636
Average Length of Treatment	1.4 years

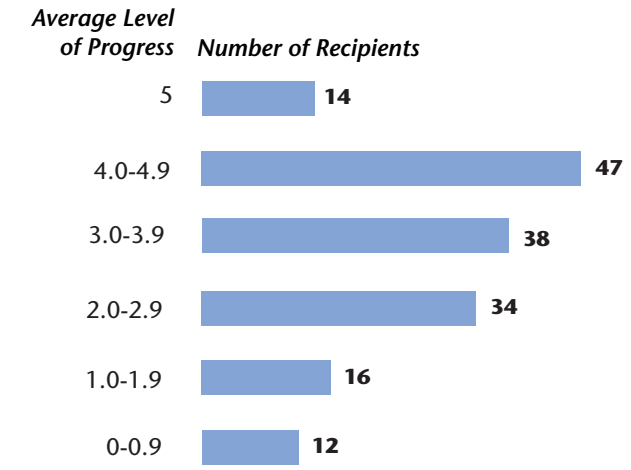
	Recipients	Percentage
Gender		
Female	209	32.9%
Male	427	67.1
Age		
Under 4	0	0
4 to 12	364	57.2
13 to 17	260	40.9
Over 17	12	1.9
Ethnicity		
African-American	278	43.7
Caucasian	104	16.4
Other	116	18.2
Unknown	138	21.7

Program Description: The Reaching, Engaging and Assisting Children and Families program provides the same services as the Court-Ordered Wraparound program, such as crisis stabilization and counseling, but it typically serves those children and adolescents who are neither involved with the juvenile justice system nor the child welfare system. In addition, rather than being court-ordered, services are provided at the request of the recipient or the recipient's parent or guardian.

Selected Program Outcomes: BHD tracks the level of progress recipients make toward addressing the needs identified in their care plans. At disenrollment, progress is ranked on a scale of 1 to 5, with 1 meaning minimal progress was made and 5 meaning the need was successfully met. A score of 0 indicates either that the need was not able to be assessed or that progress was not recorded. In 2015, the most common average progress score was between 4.0 and 4.9 for youth discharged from the Reaching, Engaging and Assisting Children and Families program.

The figure shows the average level of progress made by recipients discharged from the Reaching, Engaging and Assisting Children and Families program in 2015.

Average Level of Progress Made by Recipients Discharged (2015)
(5 = Needs Met, 1 = Minimal Progress, 0 = Needs Unable to Be Assessed or Were Not Recorded)



Appendix 6

Performance Indicators Reported by the Behavioral Health Division

2015

Shaded areas indicate goals that BHD did not meet.

		2015 Goal	2015 Actual Performance
Psychiatric Emergency Medical Services	Number of Admissions	No more than 10,500	10,173
	Number of Emergency Detentions[1]	No more than 5,400	5,538
	Percentage of Recipients Returning to Psychiatric Emergency Medical Services within Three Days	No more than 8%	8%
	Percentage of Recipients Returning to Psychiatric Emergency Medical Services within 30 Days	No more than 20%	25%
	Percentage of Time that Psychiatric Emergency Medical Services Did Not Accept Individuals from Private Hospitals Because of Limited Capacity	No More than 10%	16%
Inpatient Services Program (Adult Care)	Number of Admissions	No more than 1,125	965
	Average Number of Adult Recipients per Day	No more than 52.0	47.2
	Percentage of Adults Returning to the Psychiatric Hospital within 30 days	No More than 7%	11%
	Percentage of Recipients Responding Positively to the Satisfaction Survey	At least 74%	73%
	Percentage of Recipients Stating in Survey "If I had a choice of hospitals, I would still choose this one."	At least 65%	63%
	Number of Hours that Recipients Are in Physical Restraint per Every 1,000 Recipient Hours	No more than 1.21	7.2
	Number of Hours that Recipients Are Locked in Seclusion per Every 1,000 Recipient Hours	No more than 0.34	0.47
	Percentage of Recipients Discharged on Multiple Antipsychotic Medications	No more than 10%	18%
	Percentage of Recipients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	At least 26%	98%
	Percentage of Recipients Discharged with a Continuing Care Plan	At least 74%	15%
	Percentage of Recipients Discharged with a Continuing Care Plan That Was Transmitted to the Next Care Provider	At least 67%	15%

Shaded areas indicate goals that BHD did not meet.

		2015 Goal	2015 Actual Performance
Inpatient Services Program (Child and Adolescent Care)	Number of Admissions	No more than 1,100	919
	Average Number of Children and Adolescent Recipients per Day	No more than 11.0	9.8
	Percentage of Children and Adolescents Returning to the Psychiatric Hospital within 30 Days	No more than 11%	16%
	Percentage of Recipients Responding Positively to the Satisfaction Survey	At least 74%	71%
	Percentage of Recipients Stating in the Survey "Overall, I am satisfied with the services I received."	At least 80%	74%
	Number of Hours that Recipients Are in Physical Restraint per Every 1,000 Recipient Hours	No more than 0.27	5.2
	Number of Hours that Recipients Are Locked in Seclusion per Every 1,000 Recipient Hours	No more than 0.30	0.42
	Percentage of Recipients Discharged on Multiple Antipsychotic Medications	No more than 3%	2%
	Percentage of Recipients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	At least 41%	100%
	Percentage of Recipients Discharged with a Continuing Care Plan	At least 88%	4%
	Percentage of Recipients Discharged with a Continuing Care Plan That Was Transmitted to the Next Care Provider	At least 81%	4%
Community-Based Care for Adults	Number of AODA Recipients Served	At least 5,529	6,254
	Number of Mental Health Recipients Served	At least 4,663	5,010
	Number of Enrollees in the Comprehensive Community Services Program	At least 236	233
	Reduction in Psychiatric Bed Days in the Past Six Months	At least 64.0%	60.3%
	Reduction in Alcohol or Drug Use in the Past 30 Days	At least 79.0%	82.5%
	Reduction in Homelessness or Shelter Use Six Months after Admission	At least 82.0%	77.3%
	Increase in Recipient Employment Six Months after Enrollment	At least 54.0%	33.9%
	Percentage of Clients Returning to the Community-Based Detoxification Residential Program within 30 Days of Discharge	No more than 18.0%	19.6%

Shaded areas indicate goals that BHD did not meet.

		2015 Goal	2015 Actual Performance
Community-Based Care for Children and Adolescents	Number of Families Served	At least 2,650	3,047
	Average Level of Family Satisfaction (on a Scale of 1 to 5)	At least 4.0	4.6
	Percentage of Time Recipients Were Placed in a Home-Type Setting for Those Who Were Enrolled through the Juvenile Justice System[2]	At least 75%	62%
	Average Level of Needs Met at Disenrollment (on a Scale of 1 to 5)	At least 3.0	3.2
	Percentage of Recipients Who Achieved Permanency at Disenrollment[2, 3]	At least 70%	58%
	Percentage of a Recipients' Support Team Members Who Provide Informal Support[4]	At least 50%	42%

[1] BHD erroneously reported that this goal had been met. It reported serving a total of 5,334 recipients because it mistakenly excluded 204 recipients.

[2] Applies exclusively to the Court-Ordered Wraparound program.

[3] Permanency refers to a recipient's living situation and includes situations such as a return to living with biological parents, placement with relatives, adoption, and independent living.

[4] Support teams include service providers, family members, friends, advocates, volunteers, and other community members.

Appendix 7

Policies Adopted by the Milwaukee County Mental Health Board

July 2014 through September 2016

Policy Adopted	Date Adopted
Policies Related to the Expenditure of Funds	
Approved an administrative fund transfer policy that allows the Director of Milwaukee County Department of Health and Human Services to adjust BHD's budget if the adjustment has no tax levy impact.	October 23, 2014
Approved the transfer of funds to the County's Housing Division to support the County's plan to eliminate chronic homelessness.	April 23, 2015
Approved BHD's request to increase expenditures for vendors providing services under the Targeted Case Management program and the Community Support Program to account for a new Medical Assistance billing methodology.	June 25, 2015
Approved BHD's request to enter into a master lease agreement to support housing options for recipients aging out of the foster care system that have emotional and mental health needs.	June 25, 2015
Approved equity adjustments for BHD employees that factor employee experience or time with BHD into pay adjustments to improve retention.	June 25, 2015
Approved the 2016 BHD budget and related amendments.	July 9, 2015
Approved an annual stipend of $5,000 to support employee recruitment and retention.	October 22, 2015
Approved the use of 2015 Informational Management Services Division funds to institute an on-site help desk for the electronic medical records system.	December 17, 2015
Approved the use of funds to pay vendor costs.	February 25, 2016
Approved the use of funds for food and restaurant events related to physician recruitment.	August 25, 2016

Policy Adopted	Date Adopted
Policies Related to Personnel Issues	
Approved BHD medical staff's organizational bylaws.	December 18, 2014
Approved amendments to BHD medical staff's organizational rules and regulations.	April 23, 2015
Approved the decision not to review the salary and personnel policies of the Milwaukee County Department of Community Programs.	August 27, 2015
Approved the use of county email addresses for Board members.	December 17, 2015
Approved the fiscal impact of the 2015 collective bargaining agreement with the Wisconsin Federation of Nurses & Health Professionals.	February 25, 2016
Approved amendments to the medical staff's organizational bylaws.	February 25, 2016
Approved amendments to the medical staff's organizational rules and regulations.	February 25, 2016
Approved amendments to the medical staff's organizational bylaws.	August 25, 2016
Policies Related to the Milwaukee County Mental Health Board	
Approved the Board's bylaws.	July 17, 2014
Approved expectations for Board members.	August 28, 2014
Approved amendments to the Board's bylaws.	October 23, 2014
Approved amendments to the Board's bylaws.	August 25, 2016
Policies Related to the Provision of Services	
Approved BHD's request to proceed with a request for proposals for a new facility to provide institutional-based services.	April 23, 2015
Approved BHD's continued exploration of outsourcing options for institutional-based services.	June 25, 2015
Approved the creation of task forces to explore vendors interested in and capable of providing institutional-based services.	October 22, 2015
Policies Related to Other Issues	
Approved BHD's 2015-2016 Quality Plan that addressed leadership, safety, and quality processes.	December 18, 2014
Approved policies required to achieve accreditation from the Joint Commission.	December 17, 2015

Response ■

DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

December 13, 2016

Mr. Joe Chrisman, State Auditor
Wisconsin Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703

Dear Mr. Chrisman,

The Milwaukee County Behavioral Health Division (BHD) has reviewed the Legislative Audit Bureau (LAB) Report on the Milwaukee County Mental Health Board and of the functions, programs, and services it oversees.

The administrative team at BHD appreciates the opportunity to provide a response to the report, and would like to acknowledge the LAB for their professionalism and diligence over the past year in completing the first biennial audit required under Act 203. LAB auditors reviewed data from 2015 for the purpose of the audit and recommendations. Our response is intended to highlight key areas of learning through the report findings, areas where BHD has already made significant progress and areas that require more detailed responses from BHD and the Milwaukee County Mental Health Board.

There are many observations and recommendations in the report, including many which question how the BHD budget process accounts for programs and services, areas where BHD should improve consumer level data reporting and suggestions regarding how key performance indicators are established, collected, interpreted and reported.

The majority of the recommendations suggest that BHD needs to improve the data it provides to the Board, so that the Board is able to make informed policy decisions, and is certain that the services BHD provides and contracts for demonstrate a high level of quality, efficiency, and effectiveness. BHD agrees that implementing these reporting changes will improve transparency and accountability to the Board and the community we serve. A number of these LAB recommendations were implemented or at least partially implemented in 2016. Other recommendations will inform improvements for 2017 and beyond that will allow BHD to more clearly and accurately demonstrate our successes, challenges, and opportunities.

There are a number of complex issues highlighted in the report that require a more detailed and thoughtful response than the time constraints for our initial review have allowed. BHD will prepare a detailed response to each recommendation, and will present a formal response to the

entire LAB report to the Milwaukee County Mental Health Board after the audit report has been made available to Board members and the public. We are eager to demonstrate where we have already fully addressed concerns, where we have made significant progress toward the LAB recommendations in 2016, and to incorporate Board feedback into our response to a number of issues and recommendations.

BHD will look to the Milwaukee Mental Health Board to guide our response to the challenge presented in the LAB recommendations that appear to direct BHD to create more program "silos" for consumers and their families. As part of our initiative to become a national best practice leader in behavioral health, we have been moving to a more integrated, person centered, co-occurring and flexible continuum of care, where consumer choice and need drives treatment versus arbitrary program and eligibility requirements. This appears to conflict with LAB suggestions to establish strict program boundaries. Additionally, there are a number of recommendations that represent major policy decisions that must include Board input and direction before changes can be made.

The audit process has been very valuable in assessing where BHD stands in its effort to re-design the mental health and substance use disorder treatment system in Milwaukee County. It has provided BHD and the Milwaukee County Mental Health Board detailed guidance for further improvements. We value the recommendations, and welcome the opportunity to improve accountability and transparency as we strive to reduce barriers to the quality services our community expects and deserves.

Sincerely,

Michael A. Lappen, MS, LPC
Behavioral Health Division Administrator