Chairperson: Dr. Maria Perez
Vice-Chairperson: Mary Neubauer
Secretary: Kathie Eilers
Research Analyst: Kate Flynn Post, (414) 257-7473
Board Liaison: Jodi Mapp, (414) 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, June 16, 2022 - 9:00 A.M.
Microsoft Teams Meeting

MINUTES

PRESENT: Shirley Drake, Kathie Eilers, *Ken Ginlack, Sheri Johnson, Dennise Lavrenz, Jon Lehrmann, Thomas Lutzow, Mary Neubauer, Maria Perez, and James Stevens
EXCUSED: Rachel Forman and Walter Lanier

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

SCHEDULED ITEMS:

1. **Welcome**

   Chairwoman Perez welcomed everyone to the Milwaukee County Mental Health Board's June 16, 2022, remote/virtual meeting.

2. **Approval of the Minutes from the April 28, 2022, Milwaukee County Mental Health Board Meeting.**

   MOTION BY: ***(Eilers) Approve the April 28, 2022, Minutes. 7-0***
   MOTION 2ND BY: ***(Lavrenz)***
   AYES: Drake, Eilers, Lavrenz, Lutzow, Neubauer, Perez, and Stevens - 7
   NOES: 0
   ABSTENTIONS: 0
   EXCUSED: Ginlack - 1

3. **Finance Committee Professional Services Contracts Recommendation**

   - Contract Amendment(s)
     - Clean Power, LLC
     - Column Rehab Services, Inc.
     - Comprehensive Pharmacy System, LLC
     - Locum-Tenens.com, LLC
     - MobileX USA
     - University of Wisconsin Milwaukee
     - Medical College of Wisconsin, Inc.
     - Wisconsin Diagnostic Laboratories, LLC

SCHEDULED ITEMS (CONTINUED):

Michael Lappen, Administrator, Behavioral Health Services

Professional Services Contracts focus on facility-based programming, supports functions critical to patient care, and are necessary to maintain hospital and crisis services licensure. An overview was presented of all hospital/operations services provided.

The Board was informed the Finance Committee unanimously recommended approval of the Professional Services Contracts as delineated in the corresponding report, except for Board Member Lehrmann who abstained from recommending approval of the Medical College of Wisconsin, Inc., contract.

Board Member Stevens requested separate action be taken on the Medical College of Wisconsin, Inc., contract.

Vice-Chairwoman Neubauer requested separate action be taken on the Column Rehab Services, Inc., contract.

MOTION BY:	***(Lutzow) Approve the Medical College of Wisconsin, Inc., Contract Delineated in the Corresponding Report. 6-0-1***
MOTION 2ND BY:	***(Eilers)***
AYES:	Drake, Eilers, Lavrenz, Lutzow, Neubauer, and Perez – 6
NOES:	0
ABSTENTIONS:	Stevens - 1
EXCUSED:	Ginlack - 1

MOTION BY:	***(Lutzow) Approve the Column Rehab Services, Inc., Contract Delineated in the Corresponding Report. 6-0-1***
MOTION 2ND BY:	***(Eilers)***
AYES:	Drake, Eilers, Lavrenz, Lutzow, Perez, and Stevens – 6
NOES:	0
ABSTENTIONS:	Neubauer - 1
EXCUSED:	Ginlack - 1

MOTION BY:	***(Lutzow) Approve the Balance of Professional Services Contracts Delineated in the Corresponding Report. 7-0***
MOTION 2ND BY:	***(Eilers)***
AYES:	Drake, Eilers, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 7
NOES:	0
ABSTENTIONS:	0
EXCUSED:	Ginlack - 1

SCHEDULED ITEMS (CONTINUED):

4.	**Finance Committee Purchase-of-Service Agreements Recommendation. (Amy Lorenz, Behavioral Health Services/Action Item)** • Agreement Amendment(s) • 2022 Agreement(s) Purchase-of-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the adult services agreements. The Board was informed the Finance Committee unanimously recommended approval of the Purchase-of-Service Agreements as delineated in the corresponding report. ***MOTION BY:*** ***(Lutzow) Approve the Purchase-of-Service Agreements Delineated in the Corresponding Report. 7-0*** ***MOTION 2ND BY:*** ***(Eilers)*** ***AYES:*** Drake, Eilers, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 7 ***NOES:*** 0 ***ABSTENTIONS:*** 0 ***EXCUSED:*** Ginlack - 1
5.	**2022 Wraparound Prepaid Inpatient Health Plan (PIHP) Revenue Recommendation.** Matt Fortman, Fiscal Administrator, Department of Health and Human Services This is an amendment to an agreement between the State of Wisconsin and Milwaukee County. It provides a 5% rate increase for a subset of service categories within the Wraparound Milwaukee program the State is rolling out utilizing American Rescue Plan Act (ARPA) funds. The Board was informed Finance Committee unanimously agreed to recommend approval of 2022 Wraparound PIHP Revenue as delineated in the corresponding report. ***MOTION BY:*** ***(Lutzow) Approve the 2022 Wraparound Prepaid Inpatient Health Plan (PIHP) Revenue as Delineated in the Corresponding Report. 6-0-1*** ***MOTION 2ND BY:*** ***(Lavrenz)*** ***AYES:*** Drake, Eilers, Lavrenz, Lutzow, Neubauer, and Perez – 6 ***NOES:*** 0 ***ABSTENTIONS:*** Stevens - 1 ***EXCUSED:*** Ginlack - 1

SCHEDULED ITEMS (CONTINUED):

6.	**Finance Committee Employment Agreement Recommendation.** The Board was informed the Finance Committee unanimously agreed to recommend approval of the Employment Agreement delineated in the corresponding report. ***MOTION BY:*** ***(Lutzow) Approve the Employment Agreement as Delineated in the Corresponding Report. 7-0*** ***MOTION 2ND BY:*** ***(Eilers)*** ***AYES:*** Drake, Eilers, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 7 ***NOES:*** 0 ***ABSTENTIONS:*** 0 ***EXCUSED:*** Ginlack – 1
7.	**Medical Executive Credentialing and Privileging Recommendations Report.** Dr. John Schneider, Chief Medical Officer, Behavioral Health Services Dr. Schneider stated there are three initial appointments and two reappointments. Closed session is not needed in this instance because there are no annotations. ***MOTION BY:*** ***(Eilers) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 7-0*** ***MOTION 2ND BY:*** ***(Drake)*** ***AYES:*** Drake, Eilers, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 7 ***NOES:*** 0 ***ABSTENTIONS:*** 0 ***EXCUSED:*** Ginlack – 1
8.	**Hospital Infection Prevention and Control Program Annual Plan.** Linda Oczus, Chief Nursing Officer, Behavioral Health Services (BHS) Ms. Oczus stated the infection control plan for this year is basically an extension of last year's plan due to the hospital's impending closure. With that being said, it was felt there was no need to look into any new items for the plan. In addition, it was changed because the plan should be hospital based. The previous plan was much more comprehensive; however, it didn't apply to most areas in BHS. This plan, which has been submitted to the Quality Committee, was much shorter, but is essentially the same plan from last year. ***MOTION BY:*** ***(Drake) Approve the Hospital Infection Prevention and Control Program Annual Plan. 7-0*** ***MOTION 2ND BY:*** ***(Neubauer)*** ***AYES:*** Drake, Eilers, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 7 ***NOES:*** 0 ***ABSTENTIONS:*** 0 ***EXCUSED:*** Ginlack – 1

SCHEDULED ITEMS (CONTINUED):

9.	**Office of Strategy, Budget, and Performance Quarterly Update on the State of Milwaukee County's Interests and Matters Related to Behavioral Health Services and Follow Up on the Cost-of-Living Adjustments (COLA) for Behavioral Health Division Employees.** Joseph Lamers, Director, Office of Strategy, Budget, and Performance Mr. Lamers indicated the County is currently seeing several items impacting finances. There is an anticipated budget gap of approximately $12 million. Although it is a challenge, it is much lower than what has been seen in previous years. Keep in mind, the projections are always subject to changes. Some of the changes seen since the last report given before this Body are trending in an unfavorable way as it relates to the County's budget outlook. One major factor is the high inflation rates happening right now impacting utility, energy, and health care costs. This factor, along with others, will make balancing the 2023 Budget a bit more challenging than originally expected. Mr. Lamers stated there is no further information or updates other than what was presented at the last meeting regarding the COLA. Questions and comments ensued. This Item was informational.
10.	**Supplemental Information Related to the Cost of Living and Pay Range Adjustments for Behavioral Health Services Employees.** Board Member Lutzow stated he and Vice-Chairwoman Neubauer appeared at the County Board's Personnel Committee in place of Chairwoman Perez, who had a conflicting engagement. The item before the Committee was presented as an informational item, so no action was taken. The Committee did acknowledge the situation as embarrassing and expects this not to happen again going forward. It was noted this occurred under the previous administration's watch. Board Member Lutzow stated the correction made is appreciated by all. The current Administration has vowed to make good going forward on an ongoing basis, which is also appreciated. Vice-Chairwoman Neubauer confirmed and supported statements made by Board Member Lutzow. This Item was informational.

SCHEDULED ITEMS (CONTINUED):

11.	**Department of Human Resources Report on Efforts Made to Assist the Transition of Impacted and Displaced Employees Due to the Hospital Closure.** Lisa Ruiz Garcia, Manager, Human Resources (HR) Ms. Ruiz Garcia stated Granite Hills continues to recruit registered nurses (RNs) and psych techs. Opportunities are posted for activity therapist, inpatient clinical therapist, nurse manager, housekeepers, and dietary aides, just to highlight some of the openings available. Since the April report, Advocate Aurora has hired an additional RN bringing the total of Behavioral Health Services (BHS) employees hired to approximately eight RNs and four psych techs. Four additional open houses have been scheduled at the Mental Health Emergency Center (MHEC). The two dates remaining are June 23rd and July 21st. Ms. Ruiz Garcia has begun to meet with Advocate Aurora's HR manager for the MHEC on a weekly basis to ensure they are connecting and communicating information related to openings available, as well as providing any information they may need. The first meeting was held last week. Both the MHEC and Granite Hills attended the Milwaukee County job fair held on May 23, 2022, at the Mitchell Park Domes. County leaders were available at the job fair to answer questions with some conducting interviews for specific positions onsite. Ms. Ruiz Garcia wants the Board to know HR is committed and will continue its efforts to keep staff informed of employment opportunities, retirement updates, and any other areas of concern. This Item was informational.
12.	**Update from the County Executive's Office and Report on Board Seat Vacancies, Current and Future.** It was announced the County Executive's Office had a conflicting engagement, and the Office's representative would not be available to appear. Chairwoman Perez requested a motion be made to lay this Item over to the August meeting. ***MOTION BY:*** ***(Neubauer) Lay Over Item 12 to the August 2022 Meeting. 8-0*** ***MOTION 2ND BY:*** ***(Lutzow)*** ***AYES:*** Drake, Eilers, Ginlack, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 8 ***NOES:*** 0 ***ABSTENTIONS:*** 0 ***EXCUSED:*** 0
13.	**The Department of Health and Human Services Strategic Plan Presentation.** Steve Gorodetskiy, Director of Strategic Initiatives, Department of Health and Human Services Mr. Gorodetskiy stated the strategic plan starts with the mission and vision. Population health outcomes cannot be achieved without working together with system partners. The County's overall vision has also been incorporated. In recent years, there has been a great deal of focus

SCHEDULED ITEMS (CONTINUED):

	on achieving racial equity, with the County declaring racism as a public health crisis. He discussed Milwaukee's overall county health ranking compared to other Wisconsin counties, the work done with leaders and staff, gathering of data, and the development of ideas for the future. A detailed explanation was provided related to the data collected, including root causes and social determinants. Research done led to themes, like "No Wrong Door." This, in turn, led to strategies and ways to be a leader in effecting major system change by developing and applying resources. Through the work, two strategies were developed, "No Wrong Door/Integrated Services & Care and Population Health & System Change. Questions and comments ensued. This Item was informational.
14.	**Administrative Update.** Michael Lappen, Administrator, Behavioral Health Services (BHS) Mr. Lappen provided the standard update on Granite Hills and the Mental Health Emergency Center (MHEC). Granite Hills is expected to expand capacity with a target of two 24-bed adult units and a 10-bed youth unit to be operational by September 1, 2022. The MHEC is scheduled to open September 6, 2022. There is a substantial communication plan in place. Conversations with law enforcement will begin leading up to September 9, 2022. This is the date when all patients and emergency detentions in law enforcement custody will no longer be brought to Psychiatric Crisis Services (PCS) and will start going to the MHEC. It is imperative to make sure everybody is clear and knows the PCS facility will be closed. Signs will go up July 1, 2022, at all entrances and PCS informing folks of the impending change. As BHS moves toward closure, there are a large number of historical artifacts, documents, and records, which will need to be addressed. In accordance with the County's Administrative Manual of Operating Procedures (AMOP) guidelines, Mr. Lappen is working with the Historical Society, who is eager to create a collection, to transfer the items to them for preservation of the rich history. The transfer of items will begin immediately. Some artifacts will be retained with the intent of creating a celebratory display at BHS' new location. Some of the items will be featured in social media posts along with videos over the next few weeks. Questions and comments ensued. This Item was informational.
15.	**Achieving Racial and Health Equity: Strengthening Milwaukee County's Public Health Infrastructure Mobilizing Action Toward Community Health Report by the University of Wisconsin Population Health Institute School of Medicine and Public Health.** Dr. Jonathan Heller, University of Wisconsin Population Health Institute, School of Medicine and Public Health

SCHEDULED ITEMS (CONTINUED):

	Board Member Johnson stated this report is a companion report to a study conducted by the Wisconsin Public Policy Forum. Both reports were presented to the County in early Spring. Health is understood as and determined by multiple factors. In addition to access to quality healthcare, social, economic, and environmental factors are largely responsible for driving how long and how well folks live at the community level. Various forms of racism, such as individual, interpersonal, community level, and structural, are discriminatory and impact health. Among other social factors, these all contribute both directly and indirectly to health outcomes. She explained these elements in detail. Dr. Heller shared findings derived through research done in terms of the way these historical practices and manifestations of structural racism impact the way public health is currently organized and what it means to do things differently in the future. He discussed redlining, hyper-segregation, health outcomes, and opportunities emerged during the research process. Questions and comments ensued. This Item was informational.
16.	**Mental Health Board Finance Committee Update.** Matt Fortman, Fiscal Administrator, Department of Health and Human Services Mr. Fortman stated the last two Finance meetings have been budget focused. The first meeting scheduled at the beginning of June was held to provide Board Members and the public with as much information as early possible in the process to allow time for reactions to the budget Behavioral Health Services (BHS) intends to put forth. This year's budget contains a level tax levy target. Key initiatives moving forward include rate increases for specific provider categories and continuing to increase Comprehensive Community Services enrollment. The 2023 Budget is the first year BHS will not be operating a psychiatric hospital or emergency room. There is no reliance on reserve funds in this budget. This puts BHS on a financially sustainable path while continuing to support and expand community services. This Item was informational.
17.	**Overview of the 2020 Client Assistance for Re-Employment and Economic Support System (CARES) Allocations for Community Resilience and Mental Health.** Matt Fortman, Fiscal Administrator, Department of Health and Human Services This report was originally submitted to the County Board of Supervisors in February 2021. Vice-Chairwoman Neubauer requested the report be presented to this Board. It details the CARES funding spent on community resiliency efforts focused on more informal non-traditional community mental health and wellbeing supports often unavailable to traditional County fund sources. A similar approach is being considered with America Rescue Plan Act (ARPA) funding and other new fund sources on the horizon to continue to pursue these community resiliency efforts and

SCHEDULED ITEMS (CONTINUED):

	engage with the smaller providers who might have difficulty accessing the network through traditional means. Vice Chairwoman Neubauer requested more detailed information related to who the smaller agencies are and the amount of funding received. Mr. Fortman indicated information reflecting the exact amounts awarded to each of the agencies would be provided to the Board in a separate spreadsheet as a follow-up item. This Item was informational.
18.	**Mental Health Board Quality Committee Update.** Vice-Chair Neubauer, Chairwoman of the Quality Committee, provided the update while acknowledging she was not present for the meeting. The meeting was Chaired by Board Member Drake. Vice-Chair Neubauer's report to the Board highlighted several items. As it relates to the community contract vendor quality section of the Quality packet, which includes sanctions, holds, and/or service suspensions imposed, new information was shared regarding Whole Health Clinic Group (WHCG). The notice of referral suspension for WHCG's Comprehensive Community Services program was first reported to the Committee in September 2021. Referral services resumed as of March 24, 2022. Since suspending referrals, there have been several meetings with WHGG's leadership team, and a quality improvement response plan was created. Audits showed the continuous improvement and sustainability. She also referenced the Community Access to Recovery Services authorization team. These are individuals cross-trained to provide coverage for all levels of care, which is a much more efficient use of time and resources and ensures people don't wait to get services initiated. Lastly, she discussed the Department of Health and Human Services' quality management update and how it ties into monitoring and evaluation, which is a priority quality function. Board Member Drake commented on how the Community Crisis Services dashboard is impressive. A lot of work is being done to try to make the system more responsive to what needs to be reported. This Item was informational.
19.	**Mental Health Board Community Engagement Committee Update.** Vice-Chair Neubauer, Interim Chairwoman of the Community Engagement Committee, provided a comprehensive update on the Stakeholder Advisory Council, which is being Chaired by Brenda Wesley. The first official meeting for this Council was held on May 23, 2022, and is scheduled to meet again on June 27, 2022. She also discussed the Committee's finalization of their mission and vision statement and provided a marketing update.

SCHEDULED ITEMS (CONTINUED):

	Board Member Eilers requested information on the Advisory Council's membership be forwarded to the Board. Questions and comments ensued. This Item was informational.
20.	**Adjournment.** Chairwoman Perez ordered the meeting adjourned.

This meeting was recorded. The aforementioned agenda items were not necessarily considered in agenda order. The official copy of these minutes and subject reports, along with the audio recording of this meeting, are available on Milwaukee County's Legislative Information Center website, which can be accessed by clicking the link below.

Length of meeting: 9:03 a.m. to 11:27 a.m.

Adjourned,

Jodi Mapp

Jodi Mapp
Board Liaison
Milwaukee County Mental Health Board

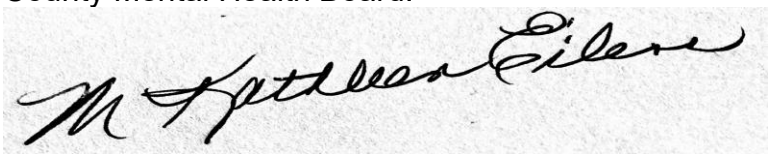
The next meeting for the Milwaukee County Mental Health Board will be on Thursday, July 7, 2022, @ 8:00 a.m.

To View All Associated Meeting Materials,
Visit the Milwaukee County Legislative Information Center at:
Milwaukee County - Calendar (legistar.com)

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

SCHEDULED ITEMS (CONTINUED):

The June 16, 2022, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.



Kathie Eilers, Secretary
Milwaukee County Mental Health Board

Chairperson: Dr. Maria Perez
Vice-Chairperson: Mary Neubauer
Secretary: Kathie Eilers
Research Analyst: Kate Flynn Post, (414) 257-7473
Board Liaison: Jodi Mapp, (414) 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD
BUDGET MEETING

Thursday, July 7, 2022 - 8:00 A.M.
Microsoft Teams Meeting

MINUTES

PRESENT: Shirley Drake, Kathie Eilers, Ken Ginlack, Dennise Lavrenz, Thomas Lutzow, Mary Neubauer, Maria Perez, and James Stevens
EXCUSED: Rachel Forman, Sheri Johnson, Walter Lanier, and Jon Lehrmann

SCHEDULED ITEMS:

1.	**Welcome.** Chairwoman Perez welcomed everyone to the Milwaukee County Mental Health Board's July 8, 2021, remote/virtual Budget meeting. She acknowledged this would be Board Member Stevens last meeting by honoring the good work he's done during his service on the Board. A letter of commendation was read aloud.
2.	**Milwaukee County Behavioral Health Services 2023 Recommended Budget Narrative Presentation.** Matt Fortman, Fiscal Administrator, Department of Health and Human Services Mr. Fortman stated the 2023 Budget is fully balanced and includes a tax levy of $53 million, which was reached by shifting funds. In previous years, there was a $2 million salary abatement with the intention of drawing down Behavioral Health Services reserve funds to support annual operating costs. The abatement is not included in the 2023 Budget. This budget anticipates the closure of the mental health psychiatric hospital and emergency services on Watertown Plank Road. The funding will be shifted to support the Granite Hills Hospital and the Mental Health Emergency Center. No services were cut to balance this budget. In fact, it reflects an expansion of services in the form of rate increases for Community Support Program providers to continue to combat ongoing labor shortages, Community-Based Residential Facilities, substance use disorder residential facilities, bridge housing facilities, and peer specialists. This Item was informational.

SCHEDULED ITEMS (CONTINUED):

3.	**Milwaukee County Behavioral Health Services 2023 Recommended Budget Consideration, Inclusive of the 2023 Budget Supplemental Requests.** Matt Fortman, Fiscal Administrator, Department of Health and Human Services Mr. Fortman provided an explanation of the new request process put in place for the 2023 Budget. It allows departments to request funding for initiatives outside of their tax levy target. Behavioral Health Services (BHS) will be submitting three items. The first item being requested is additional funding for internal staff increases. BHS, in addition to provider agencies, continue to struggle with vacancy and turnover in key positions. This was indicated as one of several top priority items on the internal staff survey for budget priorities conducted in May. The second item is a request for marketing and outreach. In addition to the internal survey, this item is a priority echoed by Board Members and the community as expressed at Mental Health Board public comment meetings. It addresses the need to provide a better understanding of service availability and how to access those services. The last item to be included in the supplemental requests to the County Executive is continued funding for the assistant district attorney position, which supports the jail diversion program. This item was initially forwarded as a budget amendment to be funded through BHS reserve funds. Because this new opportunity to request funding outside of the budget process exists, the Finance Committee opted not to commit BHS reserve funds. Instead, the initiative should be part of the County Executive request process to be included in the District Attorney's Office budget. More information will come on the status of the requests sometime in September or October. At that point, Mr. Fortman will come back to the Board with information as to whether the requests were approved or denied, and an update will be provided on next steps. ***MOTION BY:*** ***(Lutzow) Approve the 2023 Budget Supplemental Requests Submission to the County Executive's Office. 8-0*** ***MOTION 2ND BY:*** ***(Eilers)*** ***AYES:*** Drake, Eilers, Ginlack, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 8 ***NOES:*** 0 ***MOTION BY:*** ***(Lutzow) Approve the Behavioral Health Division's 2023 Recommended Budget. 8-0*** ***MOTION 2ND BY:*** ***(Eilers)*** ***AYES:*** Drake, Eilers, Ginlack, Lavrenz, Lutzow, Neubauer, Perez, and Stevens – 8 ***NOES:*** 0

SCHEDULED ITEMS (CONTINUED):

4.	**Adjournment.** Chairwoman Perez ordered the meeting adjourned.

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

Length of meeting: 8:09 a.m. to 8:22 a.m.

Adjourned,

Jodi Mapp

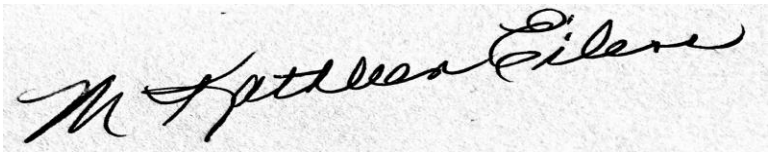
Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

The next regular meeting for the Milwaukee County Mental Health Board is Thursday, August 25, 2022, @ 9:00 a.m.

To View All Associated Meeting Materials,
Visit the Milwaukee County Legislative Information Center at:
Milwaukee County - Calendar (legistar.com)

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

The July 7, 2022, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.



Kathie Eilers, Secretary
Milwaukee County Mental Health Board

COUNTY OF MILWAUKEE
Behavioral Health Services Administration
Inter-Office Communication

DATE: **August 4, 2022**

TO: Maria Perez, Chairperson – Milwaukee County Mental Health Board

FROM: Shakita LaGrant-McClain, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Services

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to enter into 2022 Professional Services Contracts**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least $100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for the Behavioral Health Services (BHS) to enter into new agreements and amend existing professional services agreements.

Background

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

Professional Services Contracts

Kane Communication Group, LLC - $306,000
Kane Communications Group, LLC is developing a marketing campaign designed to express the importance of early identification of Severe Mental Illness (SMI) and to increase awareness of Children's Community Mental Health Services and Wraparound Milwaukee (WM), service options, especially for parents, teachers, social worker and caretakers of children and young adults with a mental illness. BHS is requesting an additional $7,000 for Kane Communications Group for a new contract total of $306,000.

United Tax Services, LLC – $169,500
United Tax Services, LLC provides Fiscal Agent Services and perform financial payments on behalf of BHS to process and administer invoices for services provided. This vendor primarily oversees payments to compensate external Request For Proposal (RFP) panelists for time spent reviewing RFP materials. This helps maintain racially and culturally diverse review panels. BHS is requesting an additional $70,000 for this vendor for a new total contract amount of $169,500.

Fiscal Summary

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

Vendor Name	Existing Amount	2022 Amount Requested	Total Contract Amount
Kane Communications Group, LLC	$299,000	$7,000	$306,000
United Tax Services, LLC	$99,500	$70,000	$169,500
Total	$398,500	$77,000	$475,500

*Represents an agreement with at least partial grant funding

Shakita LaGrant-McClain

Shakita LaGrant-McClain, Director
Department of Health and Human Services

cc: Thomas Lutzow, Finance Chairperson

COUNTY OF MILWAUKEE
Behavioral Health Services Administration
Inter-Office Communication

DATE: **August 4, 2022**

TO: Maria Perez, Chairperson – Milwaukee County Mental Health Board

FROM: Shakita LaGrant-McClain, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Services

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute a 2022 Purchase-of-Service Agreement**

Issue

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

Background

Approval of the recommended contract allocation will allow BHS to provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.

Purchase of Service Contract

2022 Contract for Adult Services

Oxford House, Inc. - $45,100
Oxford House, Inc. is a network of democratically, peer-run homes that are free of alcohol and substance use, designed for individuals with a shared goal of sobriety. The individuals who live in the house share the household expenses, all that is required to maintain the home, and are responsible for the mutual encouragement of one another to remain on a path of recovery. The Milwaukee County Behavioral Health Services contract supports Oxford House, Inc. Outreach Workers, who work locally to develop new homes and provide outreach to individuals who may be interested in moving into one of the local Oxford Houses. This request is being put in place to also add a local Resource Worker, who will work to build relationships with local support agencies for the benefit of Oxford House residents and their families. This individual will function as a liaison for those living in Oxford Houses to ensure that they are connected to all supports they require for treatment, services and resources that support a path of recovery. This position will be supported 100% by TANF grant funds.

Premier Care of WI dba Community Medical Services (CMS) - $159,462
Community Access to Recovery Services (CARS) was awarded a Bureau of Justice Assistance (BJA) grant from the federal government. This grant requires the provision of Medication Assisted Treatment to incarcerated individuals living with an opiate addiction at the House of Correction and Milwaukee County Jail prior to their release to the community. The program aids in the reduction of overdose risk and enhances engagement with community-based treatment options upon re-entry to the community. CMS provides a behavioral health clinician, nurse, and peer specialist services for this project, and we are requesting an additional $100,000 for this initiative to serve more individuals. The funds for this service will be entirely covered by the BJA grant until September 30, 2022, and by dollars from the opioid settlement after the grant ends. BHS is requesting an additional $65,000 for this vendor for a new total contract amount of $159,462.

2022 Contract for Youth Services

Wisconsin Community Services, Inc. - $281,420
Wisconsin Community Services, Inc. will provide specialized Mental Health Services for youth/young adults experiencing their first episode psychosis for the Wraparound Milwaukee Program serving children/youth and their families. This contract will be funded by the Community Mental Health Block Grant.

Fiscal Summary

The amount of spending requested in this report is summarized in the table below:

Vendor Name	Existing Amount	2022 Amount Requested	Total Contract Amount
*Oxford House, Inc.	$462,092	$45,100	$507,192
*Premier care of WI dba Community Medical Services	$94,462	$65,000	$159,462
*Wisconsin Community Services, Inc.	N/A	$281,420	$281,420
Total	**$556,554**	**$391,520**	**$948,074**

*Represents an agreement with at least partial grant funding

Shakita LaGrant-McClain

Shakita LaGrant-McClain, Director
Department of Health and Human Services

cc: Thomas Lutzow, Finance Chairperson

COUNTY OF MILWAUKEE
Behavioral Health Services Administration
Inter-Office Communication

DATE: **August 4, 2022**

TO: Maria Perez, Chairperson – Milwaukee County Mental Health Board

FROM: Shakita LaGrant-McClain, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Services

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute an Amendment of the 2022 Fee-for-Service Agreements**

Issue

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

Background

Approval of the recommended contract allocation ***projections*** will allow BHD CARS to provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders with serious emotional disturbances. CARS is a branch of BHD that offers a central access point for Milwaukee County adult residents seeking mental health and/or substance use disorder services through a network of community providers.

The following major services are reimbursed on a fee-for-service basis:

CCS – Comprehensive Community Services: A voluntary, consumer driven, Medicaid benefit that offers a wide variety of supports based on a consumer's needs and desires. CCS services are traditionally less intensive than a CSP but more intensive than an outpatient level of care. To be eligible for CCS, a consumer needs to be diagnosed with a mental health condition, substance use disorder, or both. Services are rehabilitative in nature and can include: peer support, service coordination and linkage to community resources, managing physical health, independent living skill development, psychotherapy, employment and education related skills training, medication management, substance abuse treatment, wellness management and recovery support, and individual and family psychoeducation. Other covered services include personal training, art therapy, yoga, etc.

CSP – Community Support Program: CSP is for adults living with a serious and persistent mental illness (SPMI). CSPs provide coordinated professional care and treatment in the community that includes a broad range of services to meet an individual's unique personal needs, reduce symptoms, and promote recovery. CSPs are designed to provide services that can be tailored to the individual's needs at any given time, ranging from minimal to intensive, or a level that might otherwise require care in a hospital setting. In Milwaukee County, all CSPs utilize ACT-IDDT (Assertive Community Treatment and Integrated Dual Disorder Treatment) which are evidenced-based practices.

CM – Case Management: Targeted Case Management (TCM) is a low intensity, co-occurring case management model. TCM includes a primary case manager model with peer specialist services. Crisis Care Management (CCM) is an intensive case management model. CCM utilizes a team approach to stabilize the crisis occurring in the individual's life. The team may consist of a supervisor, clinician, case manager, peer specialist, and crisis stabilizer.

Co-occurring Biomedically Enhanced or AODA Medically Monitored Residential Treatment Service: This type of treatment encompasses a 24-hour, community-based service that provides observation, monitoring and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient. Providers of this service must maintain clinic certification from the State of Wisconsin Department of Health Services, which is 'active' throughout the entire duration of the agreement with DHHS.

AODA Transitional Residential Treatment: A clinically supervised, peer supported, therapeutic environment with clinical involvement. This service offers three to 12 hours of substance abuse treatment in the form of counseling per consumer per week. Immediate access to peer support and intensive case management is available. Additional services may include education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping, and financial planning.

AODA CM – Alcohol and Other Drug Abuse Case Management: For individuals who are in the early stages of recovery and primarily struggling with a substance use disorder, CARS offers a specialized level of CM that meets consumers where they are at and works in a partnership to connect them to resources and services that will assist them in moving further along the recovery process.

AODA Day Treatment: Day Treatment is a medically monitored and non-residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities such as individual and group counseling as well as case management. Services are provided in a scheduled number of sessions with each patient receiving a minimum of 12 hours of counseling per week under the supervision of a physician.

CARS Fee-for-Service Agreements - Fiscal Summary

BHS is requesting an increase to the following 2022 contract amounts for the following vendors as outlined below. The amounts listed below are fee-for-service agreements and represent anticipated not-to-exceed payments to providers for the remainder of 2022. Fee-for-service agreements are not guaranteed payment amounts and are based on the number of units of authorized services provided by the vendor.

Vendor Name	Current Contract	Total 2022 Requested Amount	Total 2021 Adjusted Contract Amount
Adkins Counseling Services, LLC	$564,000	$310,000	$874,000
Broadstep-Wisconsin, Inc.	$9,054,000	$314,000	$9,368,000
Column Rehab Services, Inc.	$343,000	$464,000	$807,000
Community Advocates, Inc.	$44,321	$156,321	$156,321
Creative Counseling of Milwaukee, LLC	$957,000	$351,000	$1,308,000
D Taylor Properties	$54,000	$117,000	$171,000
Dominion Behavioral Health Services, LLC	$149,000	$35,000	$184,000
Great Lakes Dryhootch, Inc.	$282,000	$90,000	$372,000
Integration Healing Alivio Integral, LLC	$90,000	$189,000	$189,000
Jewish Family Services, Inc.	$743,000	$22,000	$765,000
Mindstar Counseling, LLC	$352,000	$617,000	$969,000
Mindy Myers dba Miracle Home Health of Wisconsin	$50,000	$726,000	$726,000
Navarro Professional Counseling Services, LLC	$356,000	$95,000	$451,000
Our safe Place, Inc,	$174,000	$32,000	$206,000
Our Space, Inc.	$321,000	$31,000	$352,000
Outreach Community Health Centers, Inc.	$2,675,000	$131,000	$2,806,000
Positive Outlook Clinical Services, LLC	$158,000	$49,000	$207,000
Premier Care of Wisconsin dba Community Medical Services	$207,000	$24,000	$231,000
Professional Services Group, Inc.	$1,093,000	$646,000	$1,739,000
Project Access, Inc.	$6,889,000	$2,594,000	$9,483,000
Sebastian Family Psychology Practice, LLC	$951,000	$56,000	$1,007,000
Sirona Recovery, Inc.	$3,009,000	$224,600	$3,233,600
Sixteenth Street Community Health Centers, Inc.	$263,000	$595,000	$858,000
Summit Wellness, Inc.	$1,708,000	$225,000	$1,933,000
United Community Center	$1,272,000	$136,000	$1,408,000

COUNTY OF MILWAUKEE
Behavioral Health Services Administration
Inter-Office Communication

DATE: August 10, 2022

TO: Maria Perez, Chairperson – Milwaukee County Mental Health Board

FROM: Shakita LaGrant-McClain, Director, Department of Health and Human Services
Approved by Michael Lappen, Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Approval of the Amended Severance Plan**

Issue

Severance package for Behavioral Health Services (BHS) staff impacted by the closure of the Acute Hospital and Psychiatric Crisis Services who are not able to secure comparable employment.

Background

On February 28, 2019, the Mental Health Board approved funding for severance and retention agreements for impacted BHS staff. At that time, the expected closure date was anticipated to be well before December 31, 2021, so the severance agreement associated with the approval expired on that date. Adequate funding for the anticipated severance payments and retention efforts remains consistent with the previously approved action.

Recommendation

The Administration seeks approval for the amended severance plan, which reflects the current employment market and has a new end date consistent with the closure date of September 30, 2022.

Fiscal Summary

Zero additional fiscal impact.

Shakita LaGrant-McClain

Shakita LaGrant-McClain, Director
Department of Health and Human Services

cc: Thomas Lutzow, Chairperson
Mental Health Board Finance Committee

Vendor Name	Current Contract	Total 2022 Requested Amount	Total 2021 Adjusted Contract Amount
Westcare Wisconsin	$310,000	$70,000	$380,000
Willow Creek Ranch, Inc.	$90,000	$118,000	$118,000
Wisconsin Community Services, Inc.	$8,555,000	$1,385,000	$9,940,000
Total	**$40,713,321**	**$9,802,921**	**$50,241,921**

*Represents an agreement with at least partial grant funding

Shakita LaGrant-McClain

Shakita LaGrant-McClain, Director
Department of Health and Human Services

cc: Thomas Lutzow, Finance Chairperson

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

DATE: July 18, 2022

TO: Maria Perez, PhD, LCSW; Chairperson, Milwaukee County Mental Health Board

FROM: Shane V. Moisio, MD, President of the Medical Staff Organization
Prepared by Lora Dooley, Director of Medical Staff Services

SUBJECT: **A Report from the President of the Medical Staff Organization Requesting Approval of Adopted Changes to Behavioral Health Services Medical Staff Organization Bylaws**

Background

Under Wisconsin and Federal regulatory requirements, the Medical Staff Organization must develop and adopt Bylaws. After adoption or any amendment by the Medical Staff Organization, it is required that the proposed Bylaws be presented to the Governing Authority for action. Bylaws and amendments thereto become effective only upon Governing Authority approval. In accordance with Joint Commission standard MS.01.01.03 and CMS CoP §482.12(a)(4), neither the organized medical staff or the governing body may unilaterally amend the Medical Staff Bylaws.

Discussion

Proposed changes to the Behavioral Health Services Medical Staff Organization Bylaws were presented to and adopted by the voting members in July 2022. The following is a summary of the major changes:

SCOPE & REASON FOR CHANGE
DEFINITIONS / TERMS USED All references to Behavioral Health Division were updated to Behavioral Health Services, in connection with DHHS rebranding initiatives. The "Chief Quality Officer" is not referenced within the current Bylaws, so the definition is deleted.
5.0 OFFICERS AND MEDICAL ADMINISTRATION 5.1 Officers and Members-At-Large - Exceptions to term limits have been added, in conjunction with hospital closure preparations.

5.0 OFFICERS AND MEDICAL ADMINISTRATION
5.3.2 Credentialing and Privileging Review Committee – language added specific to professional behavior review matters.
11.0 DUES
11.4 Disposal of Fund Balance - Language added specific to disposal of fund balance upon dissolution of the Medical Staff Organization.
12.0 DISSOLUTION OF THE MEDICAL STAFF ORGANIZATION UPON HOSPITAL CLOSURE
12.1 Dissolution Process and 12.2 Authority - New sections added to address dissolution adoption and authority and measures to be taken pertaining to the storage and/or disposal of Medical Staff Organization governing documents, minutes and records, and the medical staff and and allied health professional credentialing records.

Recommendation

A full copy of the amended Bylaws are enclosed. It is recommended that the Milwaukee County Mental Health Board approve the Behavioral Health Services Medical Staff Organization Bylaws, as amended and adopted on July 13, 2022 by the Medical Staff Organization.

Respectfully Submitted,

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

Enclosure

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

MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES~~DIVISION~~
MEDICAL STAFF ORGANIZATION

BYLAWS

PREAMBLE

Whereas, ~~the~~ Milwaukee County Behavioral Health Services~~Division~~ is organized under the laws of the County of Milwaukee and the State of Wisconsin and functions within the organizational framework established by the duly constituted authorities of the County of Milwaukee; and

Whereas, its purpose is to provide patient care, treatment, services, education, and research; and

Whereas, it is recognized that the Medical Staff Organization is self-governing in its responsibilities for overseeing quality medical and behavioral health care, treatment, and services provided by practitioners with privileges as well as for those providing education and research within the Milwaukee County Behavioral Health ~~Division~~Services facility and within community sites; and

Whereas, the Medical Staff shall accept and discharge this responsibility subject to the Governing Authority of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services; and

Whereas, ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services serves as a teaching resource for physicians and behavioral health professionals; and

Whereas, the cooperative efforts of the Medical Staff, the Administrative Staff and the Governing Authority are necessary to fulfill the obligations of ~~the~~ Behavioral Health ~~Division~~Services to its patients and to the community;

Therefore, the Medical Staff of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services hereby organize themselves in conformity with these Bylaws.

DEFINITIONS:

1. The term "Medical Staff" shall be interpreted to include licensed physicians (medical and osteopathic), and licensed psychologists. All "Medical Staff" shall have delineated clinical privileges and shall be eligible for membership in the Medical Staff Organization.

2. The term "Licensed Independent Practitioner (LIP)" shall be interpreted to be an individual permitted by law and by the organization to provide care, treatment and services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges.

3. The term "Allied Health Professional" shall be interpreted to include licensed health care providers other than physicians and psychologists who are permitted by scope of license, state law AND by the Hospital to provide patient care services within approved Hospital programs/services. Allied Health Professional Staff shall be categorized as independent or dependent and shall be permitted to practice with or without direction or supervision, based on the scope of his/her license, certification and/or registration and in conjunction with required approvals, including delineated clinical privileges. "Allied Health Professional" Staff shall not be eligible for membership in the Medical Staff Organization.

   A. Independent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, without the supervision or direction of a physician but in collaboration with a physician who is privileged and working with the same or very similar patient population and who is assigned to the same service or program. In accordance with these Bylaws and State and Federal standards, independent Allied Health Professional staff shall have delineated clinical privileges. Advanced Practice Nurses shall maintain a current collaboration agreement with a member of the Active or Affiliate staff.

   B. Dependent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, under the supervision or direction of a physician. It shall be determined by the Chief Medical Officer or designee whether supervision shall be direct or indirect based on ~~BHD~~BHS scope of practice. In accordance with these Bylaws and State and Federal standards, dependent Allied Health Professional staff shall have delineated clinical privileges whenever such services and supplies are furnished as an incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

4. The term "Governing Authority" shall be interpreted to refer to the Milwaukee County Mental Health Board as created under Wisconsin Statute ~~15.195(9)~~51.41.

5. The term "Executive Committee" shall be interpreted to refer to the Executive Committee of the Medical Staff of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services.

6. The term "Allied Staff" shall be interpreted to refer to clinical professional staff who provide service to patients under the direction of a member of the Medical Staff and do not have delineated clinical privileges. This group shall include but not be limited to registered nurses, social workers, occupational and music therapists, clinical dietitians and non-licensed psychologists.

7. The term "Chief Medical Officer" shall be interpreted to refer to the Executive Medical Director appointee of the Administrator of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services who shall serve as Chief Medical Officer and have authority and responsibility for the overall medical and clinical management of ~~the~~ MC~~BHD~~BHS.

8. The term "Administrator" shall be interpreted to refer to the Administrator of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services appointed by the Director of Health and Human Services and confirmed by the Governing Authority and is equivalent to that of the position of Chief Executive Officer.

9. The term "Chief of Staff" shall be interpreted to refer to the President of the Medical Staff Organization.

10. ~~The term "Chief Quality Officer" shall be interpreted to refer to the Deputy Administrator(s) of the Milwaukee County Behavioral Health Division charged with overseeing quality and clinical compliance.~~

1.0 ARTICLE I - NAME

The name of the organization shall be the "Medical Staff Organization of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services (MC~~BHD~~BHS)."

2.0 ARTICLE II - PURPOSE

The purpose of this organization shall be:

2.1 to ensure that all patients admitted to all programs of ~~the~~ MC~~BHD~~BHS receive a uniform standard of quality patient care, treatment and services through participation in the following:

2.1.1 direction, review and evaluation of the quality of patient care through continuous hospital-wide and Medical Staff quality improvement monitoring activities;

2.1.2 ongoing monitoring of patient care practices;

2.1.3 delineation of clinical privileges for Medical Staff and Allied Health Professional Staff commensurate with individual credentials and demonstrated ability and judgment;

2.1.4 provision of continuing medical and professional education based on needs identified through monitoring and review, evaluation, and planning mechanisms; and

2.1.5 review of utilization of ~~the~~ MC~~BHD~~BHS's resources to provide for the appropriate allocation to meet patient care needs;

2.2 to initiate and maintain Bylaws, Rules and Regulations and policies and procedures for self-governance of the Medical Staff, with at least biennial review of the Bylaws and Rules and Regulations. These reviews shall be more frequent, when necessary, to reflect the hospital's current practice and/or to comply with changes in law or regulation;

2.3 to provide a means whereby issues may be discussed by the Medical Staff with the Chief Medical Officer of MC~~BHD~~BHS and the Governing Authority;

2.4 to promote educational programs and activities for staff and trainees; and

2.5 to promote programs in research, in order to advance knowledge and skills in the behavioral health sciences.

3.0 ARTICLE III - APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

All new applicants seeking clinical privileges or current Medical Staff Members and Allied Health Professionals seeking amended clinical privileges shall be subject to the credentialing and privileging requirements in place, for privileges sought, at the time the initial privilege request or the privilege amendment is approved. Therefore, new applicants, current Medical Staff Members and Allied Health Professionals shall be held subject to any and all changes in credentialing and privileging requirements, for new privileges being sought, that are enacted during the period that the initial privilege request or privilege amendment is pending approval.

All credentialing and privileging requirements shall be as defined by these Bylaws. Methods for carrying out requirements shall be in accordance with Medical Staff policy and procedure.

3.1 Physician Qualifications. The applicant shall be a graduate of a recognized medical or osteopathic school and licensed to practice as a physician (medical or osteopathic) in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All physicians practicing within the hospital or its clinics shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. Applicants seeking tele-medicine privileges shall be licensed in the state of Wisconsin AND in the state from which the tele-service is provided, shall be privileged by the Medical Staff but shall not be eligible for Active staff membership. All applicants must demonstrate recent (within the last two-years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested. All physicians requesting and granted specialty privileges shall obtain board certification in his/her primary specialty and any subspecialty as recognized by the American Board of Medical Specialties or American Osteopathic Association within the time requirements and as recognized by the applicable ABMS or AOA specialty after the completion of his/her training. Practitioner shall remain board certified in his/her principal areas of practice at all times after the date he/she obtains or is required to obtain such board certification. Exceptions to the board certification requirements may be waived on recommendation of the Chief Medical Officer for applicants that have appropriate experience and urgent clinical need exists.

3.2 Psychologist Qualifications. The applicant shall be a graduate of a recognized doctoral program in clinical or counseling psychology, licensed to practice psychology in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All psychologists who meet these qualifications shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two-years) practice experience, which may include formal pre- or post-doctoral internship or fellowship training, commensurate to the privileges being requested.

3.3 Allied Health Professional Qualifications. The applicant shall be a graduate of a recognized master's degree program in their professional specialty and licensed, certified and/or registered to practice independently or dependently, in accordance with what scope of practice in the State of Wisconsin allows, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All independent allied health professionals shall be privileged by the Medical Staff but shall not be eligible for membership in the Medical Staff Organization. Dependent allied health professionals shall be privileged when recommended by the Medical Staff and authorized by the Hospital. Allied health professional staff may include, but shall not be limited to, Advanced Practice Nurses (including Nurse Practitioners, Clinical Nurse

Specialists and Nurse Midwives), Physician's Assistants, licensed Social Workers and Marriage and Family Therapists if permitted by the hospital to practice independently. All applicants must demonstrate recent (within the last two-years) practice experience or specialty training, commensurate to the privileges being requested.

3.4 Procedure for Appointment and/or Privileging.

3.4.1 Applicants for membership and/or privileges must meet the qualifications as specified above.

3.4.2 An applicant shall not be denied consideration for an appointment to the Medical Staff or for clinical privileges based on race, sex, age, disability, creed, color, sexual orientation, marital status, military service membership, arrest/conviction record (unless offense is substantially related to circumstances of position and/or licensed activity) or national origin or any other basis prohibited by law or any physical or mental impairment that, after any legally-required reasonable accommodation, does not preclude professional ability and compliance with the Medical Staff Bylaws or Hospital policies.

3.4.2.1 Criminal Activities.

An applicant may have his or her application for membership and/or clinical privileges denied, modified or restricted and a member may have his or her Medical Staff membership or clinical privileges modified, restricted or revoked, when the individual has a conviction of, or a plea of guilty or no contest to any felony, or to any misdemeanor involving controlled substances; illegal drugs; Medicare, Medicaid, or insurance or health care fraud or abuse; violence against another; sexual misconduct; or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a healthcare program) operated or financed in whole or in part by any Federal, State or local government agency, even if not yet excluded, debarred, or otherwise declared ineligible.
(Reference Social Security Act Sec. 1128)

3.4.2.2 Administrative Denial.

The Medical Staff Office may, with the approval of the Chief Medical Officer or Credentialing and Privileging Review Chairperson, deny any application for appointment or reappointment to the Medical Staff or Allied Health Professional Staff and/or application for clinical privileges, without further review, if it is determined that the applicant does not hold a valid Wisconsin medical/ professional license and/or other registrations or certifications applicable to his/her practice and no application is pending; does not have adequate professional liability insurance, if required; is not eligible to receive payment from the Medicare or Medicaid programs or is currently excluded from any health care program funded in whole or in part by the federal government or by a state or local government; or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. Reference Wisconsin DHS 12: Caregiver Background Checks)

3.4.3 Applications for initial Medical Staff membership and/or clinical privileges shall be in writing, and the form shall include evidence of current licensure (including, registrations and/or certifications, as required), relevant training and experience (including all

medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), current competence (including but not limited to names of peer references, one of which shall be directed, a chronological list of all past and present hospital appointments and practice affiliations, military history, faculty or clinical teaching appointments, recent continuing education activities), and ~~reasonable~~ evidence of current ability to perform privileges requested with reasonable skill and safety (health status). The application form shall request information relating to involvement in any professional liability action, previously successful or currently pending challenges to or any voluntary or involuntary limitation or relinquishment of any licensure or registration, any limitation, reduction, or loss of medical or professional staff membership or clinical privileges at another hospital, whether voluntary or involuntary, whether ever reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan, whether they have any present or pending guilty or no contest pleas or convictions involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol. The application form shall request names of at least two (2) peers who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding applicant's current clinical ability, ethical character, and ability to work with others. Allied Health professional references may be provided by a physician when recent work activities do not include a direct contact/observation of performance by a peer. At least one peer reference must be from the same professional discipline as the applicant. These peer recommendations and all other documentation obtained in connection with the application shall become a part of the applicant's permanent record and shall be maintained by Medical Staff Services on behalf of the Credentialing and Privileging Review Committee and Medical Staff Organization. Applicants must consent to the inspection of records and documents related to the application. Applications shall include a request for specific clinical privileges. Advanced Practice Nurse application requirements shall further include an approved written collaboration agreement(s), which shall include practice guidelines defining independent and/or dependent functions for which clinical privileges are being requested, when the hospital so requires. Each applicant for Medical Staff membership and/or privileges or Allied Health Professional privileges shall be provided with a copy of and be oriented to the Bylaws, Rules and Regulations, and major policies of the Medical Staff, and shall agree in writing to abide by them.

3.4.4 Application for membership and/or privileges by physicians, psychologists, and allied health professionals shall be submitted to the Chief Medical Officer or designee. The Chief Medical Officer or designee shall be responsible for processing the application and obtaining all required and any additional supporting documentation. Application processing shall include the collection of at least two peer references and for verifying from the primary source or an approved equivalent to primary source (i.e., AMA, AOA, ECFMG, ABMS, and/or FSMB) all required professional training (medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), required current professional licensure from the appropriate State Medical Board(s), DEA registration, and for querying the National Practitioner Data Bank (NPDB) and the Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE). Additional supporting documentation, including other hospital appointment and practice affiliation verifications, malpractice claims history verifications and recent continuing education may also be collected and used in the initial evaluation process. Before assigning initial clinical responsibilities, applicant identity is verified, criminal background check is completed and all applicable health screening requirements must be satisfied. Upon completion of the

credentialing verification processes, the Chief Medical Officer or designee shall transmit the application and all required and any supporting documentation to the Chief Psychologist (if applicable) and to the Service Medical Director. The Chief Psychologist's recommendation, when applicable, shall be forwarded to the Service Medical Director by Medical Staff Services. The Service Medical Director's recommendation shall be forwarded to the Medical Staff Credentialing and Privileging Review Committee. Temporary privileges, for a period of not more than 120 days, may be granted to an applicant pending appointment and/or privileging approval after receiving a recommendation by the Credentialing and Privileging Review Committee or by the Chair acting on behalf of the Committee, provided the application is complete and meets all Category 1 application criteria. A Category 1 application means that all required verifications as established by the Medical Staff Credentialing and Privileging Review Committee are in place, applicant has no history of corrective action (hospital/licensing board), has a clean/satisfactory criminal background check (no felony convictions or charges pending and no non-felony matters substantially related to ability to professionally practice), minimal or no malpractice history, privilege requests are appropriate to training, and all references are good. No Medical Staff member shall be permitted to recommend approval of his/her own privileges or appointment.

3.4.5 The Credentialing and Privileging Review Committee shall review the application and supporting documentation, review and confirm the validity of the applicant's credentials and may conduct an interview with the applicant. Applicants shall be acted upon by this committee within 90 days upon application completion and verification of meeting all credentialing requirements, or reasonable attempts thereto, for all privileges requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application for appointment and/or request for clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The Chief Medical Officer or Medical Staff Services, when designated shall notify the applicant of any areas of incompletion, question and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information within the next thirty (30) days. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or resolve doubts about qualifications, current abilities or credentials within thirty (30) days, when additional information is requested by the Chief Medical Officer or Medical Staff Services may, in the sole discretion of the Chief Medical Officer, be deemed a voluntary withdrawal of the application due to incompleteness and shall not be subject to hearing rights under these Bylaws. If temporary privileges were granted pending completion of the application approval process, they will be deemed expired at this time.

3.4.6 The Executive Committee shall recommend to the Governing Authority that the application be accepted or rejected; and if accepted, provisional or full clinical privileges shall be granted. The Executive Committee, as represented by the President of the Medical Staff Organization and/or by the Chairperson of the Credentialing and Privileging

Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff appointment and/or clinical privileging.

3.4.7 Temporary Privileges.

The Administrator, or designee, acting on behalf of the Governing Authority and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Governing Authority. Temporary privileges shall be granted by the Administrator or by one of the following authorized designees: the Chief Medical Officer or the Chairperson of the Medical Staff Credentialing and Privileging Review Committee. No Medical Staff member shall be permitted to approve his/her own privileges.

3.4.7.1 Important Patient Care, Treatment or Service Need.

Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges, the organized Medical Staff verifies current licensure and current competence.

3.4.7.2 Clean Application Awaiting Approval (Category 1).

Temporary privileges may be granted for up to 120 calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the Medical Staff Executive Committee and approval by the Governing Authority. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the hospital: current licensure; education, training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required (when applicable); malpractice history; ~~one~~ two positive reference~~s~~ specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; a query to the OIG-LEIE, and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1 privileging consideration, as described in section ~~3.6.4~~3.4.4 of these Bylaws.

3.4.7.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

3.4.7.4 Termination of temporary privileges: The Administrator, acting on behalf of the Governing Authority and after consultation with the President of the Medical

Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Chief Medical Officer acting as the Administrator's designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

3.4.7.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II or Appendix III of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

3.4.8 Disaster privileges – Medical Staff Leadership, in collaboration with Hospital Leadership and the Governing Authority, has determined that disaster privileging shall not be utilized at ~~the~~ Behavioral Health ~~Division~~Services (as a hospital specializing in psychiatric and behavioral care, instances would be too few where such volunteers would be required to come forward or would volunteer to come forward, to assist).

3.4.9 Telemedicine privileges - Licensed independent practitioners who are responsible for the care, treatment and/or services of an MC~~BHD~~BHS patient via telemedicine link, including interpretive services, are subject to credentialing and privileging requirements and will be processed through one of the following mechanisms:

3.4.9.1 MC~~BHD~~BHS shall fully privilege and credential the practitioner according to the processes described in sections ~~3.6.1 – 3.6.7~~3.4.1 – 3.4.7 of these Bylaws; or

3.4.9.2 MC~~BHD~~BHS may privilege practitioners using credentialing information from the distant site, if the distant site is a Joint Commission-accredited organization that follows hospital credentialing standards.

3.4.9.3 MC~~BHD~~BHS may use the credentialing and privileging decision from the distant site if all of the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization and has a direct contract/agreement with MC~~BHD~~BHS to provide services;
2. The practitioner is privileged at the distant site for those services to be provided at MC~~BHD~~BHS; and
3. MC~~BHD~~BHS has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant

site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

3.4.10 An expedited Governing Authority approval process shall not be used.

3.5 Appointment and/or Privileging. Medical Staff and Allied Health Professional appointment and/or clinical privileging shall be approved by the Governing Authority based on Medical Staff recommendations. Prior to a written decision of rejection, the Governing Authority shall meet with the President of the Medical Staff and the Chairperson of the Credentialing and Privileging Review Committee to review the recommendations and the concerns regarding the appointee's professional qualifications. The Credentialing and Privileging Review Committee Chairperson shall transmit the decision to the applicant. In cases of rejection, the applicant shall be informed and advised of his/her right to appeal in accordance with the provisions of Appendix II or Appendix III of these Bylaws. Medical Staff and Allied Health Professional appointment and/or privileging shall be for a period of no more than two (2) years. All initial appointments and privileges shall be subject to a provisional period of at least six (6) months and shall require a focused audit of practitioner performance based on an adequate volume of patient encounters prior to completion of the provisional privilege period. The decision to grant, limit or deny an initially requested privilege or existing privilege for renewal is communicated to the practitioner within 30 days of approval.

3.6 Reappointment and/or Reprivileging. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for continued membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The applicant's failure to sustain this burden shall constitute cause for recommendation that the application for reappointment and/or privileges be denied. Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging shall be approved by the Governing Authority based on Medical Staff recommendations. Any significant misstatements in, falsifications in, or omissions from the reprivileging application requirements, which shall include being current on annual dues assessments, if applicable, shall constitute cause for the application to be deemed incomplete. The Chief Medical Officer or Medical Staff Services shall notify the applicant of any areas of incompletion and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information prior to the Credentialing and Privileging Review Committee meeting at which the application is scheduled for review. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or doubts about qualifications, current abilities or credentials, or resolve dues delinquencies when requested, shall result in application being deemed incomplete and no further action shall be required. The Executive Committee, as represented by the President of the Medical Staff Organization and/or the Chairperson of the Credentialing and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging. The recommendations of the Executive Committee shall be derived, in part, from the recommendations of the Credentialing and Privileging Review Committee, who will review and reappraise the individual based on information collected. Information collection shall include the required two-year NPDB query, re-verification of current professional licensure from the appropriate State Medical Board(s), query of the OIG-LEIE and adherence to these Bylaws, the Rules and Regulations and Medical Staff Organization policies. Additional information collection shall include statements regarding the applicant's current ability to perform privileges with reasonable skill and safety

(health status), training and experience (continuing education specifically related to privileges being requested), and current competence (professional performance, judgment and clinical/technical skills as assessed by his/her supervisor and as indicated by the results of ongoing professional practice evaluations and other Medical Staff monitors and peer review activities). A Medical Staff peer reference shall also be required, when the Service Medical Director or other supervisor is not a clinical peer. In the case of Allied Health Professionals, the physician collaborator shall also provide a reference or assessment of professional performance, judgment and clinical/technical skills, if s/he is not the supervisor. Applications for reappointment and/or reprivileging shall be acted upon prior to expiration of current appointment and/or privileges. Medical Staff and Allied Health Professional reappointment and/or reprivileging shall be for a period of no more than two (2) years.

All applicants seeking reappointment and/or reprivileging within the Active, Associate or Affiliate Medical Staff Category or Allied Health Professional Staff Category must have exercised all privileges held at least once every three months from date of last appointment (excepting applicants formally granted medical, family or other leave of absence or applicants who are assigned by the Chief Medical Officer or his/her designee to provide vacation coverage on an as needed or seasonal basis) or s/he shall not be considered eligible for reappointment and/or reprivileging within those privilege areas that have not been utilized with sufficient frequency to allow for the required performance and current competency assessments. Applicants who do not utilize privileges held at least once every three months shall remain in good standing, as appropriate, upon expiration of such privileges. S/he shall remain eligible to reapply for appointment and/or such privileges should s/he so desire, and it is evident that s/he will be able to exercise such privileges with the required minimum frequency, and a current need and position vacancy in his/her specialty exists.

Failure without good cause to timely submit a completed application for reappointment shall result in automatic termination of the Medical Staff or Allied Health Professional member's membership and privileges upon expiration of the current appointment period.

3.7 Clinical Privileges. All individuals permitted by law and by ~~the~~ MC~~BHD~~BHS (as specified under sections 3.1 through 3.3 of these Bylaws) to provide patient care services independently, or dependently under the direction of a Medical Staff Member when privileging is recommended, shall have hospital specific delineated clinical privileges, whether or not they are members of the Medical Staff of ~~the~~ MC~~BHD~~BHS. Physicians, Psychologists and Allied Health Professionals who are not staff members but who meet the above independent practice definition, may request privileges through the Medical Staff by submitting a written request to the Chief Medical Officer or designee, who will review credentials and transmit the application to the appropriate Service Medical Director and to the Chief Psychologist, when applicable, and to the Credentialing and Privileging Review Committee.

3.7.1 The delineation of an individual's clinical privileges includes the limitations, if any, on the individual's privileges to treat patients or direct the course of treatment for the conditions for which the patient was admitted. Each patient cared for shall have a physical examination and/or medical history documented by a physician or authorized designee, such as an advanced practice nurse, privileged to perform such.

The physical examination shall include a thorough medical history and physical examination with all indicated laboratory examinations required to discover all structural, functional, systemic and metabolic disorders, and performance of a screening neurological exam. History shall include patient's past physical disorders, head trauma, accidents,

substance dependence/abuse, exposure to toxic agents, tumors, infections, seizure or temporary loss of consciousness or headaches, and past surgeries. Screenings shall include a complete neurological exam, when indicated (i.e., system review indicates positive neurologic symptomatology); a record of mental status; the onset of illness and circumstances leading to admission; attitudes and behavior; an estimate of intellectual functioning, memory functioning and orientation; and an inventory of the patient's assets in a descriptive fashion. More than one practitioner may participate in the performance, documenting and authentication of a history and physical for a single patient. The authenticating practitioner(s) shall be responsible for its content. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

If a physical examination was completed within 30 days of the patient's admission (or readmission), an update examination to document any changes in patient's condition is required within 24 hours after admission or re-admission. If the examining practitioner finds no change in the patient's condition since the history and physical was completed, s/he shall indicate in the patient's record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. However, any noted changes in the patient's condition must be documented in an update note and placed in the patient's record within 24 hours after admission [per TJC MS.03.01.01 EP 6~~DHS 124.14(3)(c)(2)~~ and CMS 482.22(c)(5)(ii)].

3.7.2 Clinical privileges to allied health professionals must be specifically defined and shall be limited to activities within the individual's assigned service/program or to service provisions defined within a provider's service contract. Independent Allied Health Professional practice is permitted only in Hospital approved programs and services and must be in collaboration with the service(s)/program(s) Medical Director and/or attending physician(s). Certified advanced practice nurses and physician's assistants may perform patient histories and physical examinations.

3.7.3 In an emergency, any Medical Staff member or Allied Health Professional who has clinical privileges is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff status or clinical privileges, provided that the care provided is within the scope of the individual's license.

3.8 Revised Clinical Privileges. The Credentialing and Privileging Review Committee shall review all applications and supporting documentation to revise or amend current privileges. Applicants are required to submit documentation as to licensure (including certifications, registrations, as applicable), training and experience, current competence and ability to perform privileges requested. All requests to revise privileges shall require primary source (or approved equivalent to primary source) verification of required training, primary source re-verification of required license(s), registrations and/or certifications, a new NPDB query and OIG-LEIE query. Requests shall be acted upon by this committee within 90 days upon completion of the verification of the applicant's credentials and current ability to perform the privilege requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application and request for revised clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. All clinical privilege revisions shall be subject to a provisional period of at least six (6) months and shall require a focused audit demonstrating satisfactory practitioner performance based on an adequate volume of patient encounters prior to advancing from provisional to full privilege status.

3.9 Reapplication After Adverse Action.

3.9.1 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who did not exercise any of the hearing rights provided in Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were subject of the adverse action for a period of one (1) year from the date of the final adverse action.

3.9.2 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who exercised some or all of the hearing rights provided under Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.

3.10 Leave of Absence and Reappointment.

3.10.1 Any member of the Active or Associate Medical Staff or Allied Health Professional who will be absent for a period of time exceeding twelve (12) weeks must provide written notification to the President of the Medical Staff and Chief Medical Officer which may be done through Medical Staff Services as designee for both. Such notification shall state the start and, if known, anticipated end date of the leave and the reasons for the leave (e.g., military duty, additional training, family matters, or personal health). The Medical Staff Member or Allied Health Professional shall be responsible for arranging for coverage with his or her Service Medical Director during the leave. If the practitioner fails to return following the last day of the approved leave (including any extension granted up to the end of the current term of appointment), and does not reapply as described below, the practitioner shall be considered to have resigned his or her membership and/or clinical privileges and shall not be entitled to any hearing or appellate review. A request for appointment to the Medical Staff or Allied Health Professional Staff and clinical privileges subsequently received from a practitioner so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointment.

3.10.2 Upon timely return from leave of absence prior to expiration of the practitioner's then current appointment period, the practitioner shall be required to submit a written request for reinstatement to the Credentialing and Privileging Review Committee. The practitioner may be required to submit such additional information as may be relevant to his/her request for reinstatement, including interval status information. Reinstatement of membership and privileges following a leave of absence may be granted subject to monitoring and/or a provisional period, when determined to be appropriate and recommended. The Credentialing and Privileging Review Committee will review the request and submit their recommendations to the Medical Staff Executive Committee. Thereafter, the process described for reappointment shall be followed.

3.10.3 A leave of absence may not extend beyond the term of the Medical Staff Member's or Allied Health Professional's current term of appointment. If the practitioner is not able to return from leave before his/her current appointment period and/or clinical privileges are set to expire but has submitted an application for reappointment and/or renewal of clinical privileges, action on the application will be deferred for up to two (2) years until the practitioner identifies, with reasonable certainty, the date of anticipated return from leave. Deferring the application due to continued leave of absence shall not give

practitioners any rights to hearing or appeal. The practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The practitioner's membership and/or clinical privileges shall be considered expired between the time of expiration of the term in which the leave began and the date of reappointment.

3.11 Impaired Practitioners.

3.11.1 Because it is inevitable that from time to time, some Medical Staff Members and Allied Health Professionals will develop physical or mental conditions that may limit their ability to safely exercise the clinical privileges they have been granted, it shall be the responsibility of all Medical Staff and Allied Health Professionals to bring to the attention of the Chief Medical Officer or his/her designee or the President of the Medical Staff, such conditions. Refer to Medical Staff Organization Policy on Health and Welfare.

3.11.2 If, as a result of a practitioner's self-reporting of a condition, the Medical Staff Executive Committee recommends modification of status or privileges, the affected practitioner shall be notified, in writing, of the recommendation. The recommendation shall not be considered a professional review action, if the practitioner voluntarily accepts the recommendation. If the Medical Staff Executive Committee recommends modifications of appointment status or privileges due to the practitioner's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights under Appendix II or Appendix III.

3.12 Ethics and Ethical Relationships.

3.12.1 The Code of Ethics as adopted by the professional organizations of each member profession shall govern the professional conduct of the membership of the Medical Staff and all individuals privileged by the Medical Staff.

3.12.2 Medical Staff and Allied Health Professionals shall sign a statement prior to appointment and/or privileging indicating an understanding of the requirement to observe the ethical principles of their profession as well as those of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services.

3.12.3 ~~The~~ Behavioral Health ~~Division~~Services and the Governing Authority shall take steps to protect and ensure the integrity of clinical decision making of all members of the Medical Staff and privileged Allied Health Professional Staff. Medical Staff and independent Allied Health Professional clinical decisions shall be autonomous and based solely on identified needs of the patient, regardless of their ability to pay. Dependent Allied Health Professionals shall consult with and defer to their supervising physician or the unit/program/service attending physician regarding clinical decisions, as appropriate. Medical Staff and Allied Health Professional clinical decisions shall be protected from financial issues or influences such as compensation, incentives or financial risk. Ethical conflicts related to patient care decisions may be referred to the Ethics Committee.

4.0 ARTICLE IV – APPOINTMENT CATEGORIES

4.1 Active Medical Staff.

The Active Medical Staff shall consist of fully licensed physicians who are full or part-time employees of, or on contract with ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services who function as the primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team, including, where appropriate, emergency service care, consultation assignments, and supervisory assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office, to hold member-at-large positions and to serve on all Medical Staff committees. Those physicians who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active staff for a period recommended by the Credentialing and Privileging Review Committee.

4.2 Associate Medical Staff.

The Associate Medical Staff shall consist of fully licensed psychologists who are full or part-time employees of, or on contract with ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services that have clinical responsibility as part of the primary treatment team, including, where appropriate, inpatient service care, emergency service care, ambulatory service care, consultation assignments, and supervisory assignments. Members of the associate Medical Staff shall be eligible to vote, to hold member-at-large positions, and to serve on Medical Staff committees. Those psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate staff for a period recommended by the Credentialing and Privileging Review Committee.

4.3 Affiliate Medical Staff.

The Affiliate Medical Staff shall consist of fully licensed physicians and psychologists who do not function as a primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team or are temporary staff (i.e., locum tenens). They shall be retained in a manner consistent with their professional preparation and qualifications within the overall plan of ~~the~~ Behavioral Health ~~Division~~Services and be subject to the Bylaws and Rules and Regulations of the Medical Staff that are applicable to their profession. Members of the Affiliate Medical Staff shall not be eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff, without vote. Those physicians or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

4.4 Consulting Medical Staff.

The Consulting Medical Staff shall consist of fully licensed physicians and psychologists who may treat patients ofat the Behavioral Health DivisionServices, or who are only engaged in consultation with members of the Medical Staff such as for special cases or procedures, or to conduct research or for teaching and/or lecturing to medical students, psychiatric residents and fellows and/or psychology interns and fellows. The consulting Medical Staff will include those physicians or psychologists who do not wish to accept a regular Active or Associate appointment. Members of the consulting Medical Staff are not eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff, without vote. Appointment to the consulting Medical Staff may be with or without privileges.

4.5 Telemedicine Consulting Medical Staff.

The Telemedicine Consulting Medical Staff shall consist of fully licensed physicians who may treat patients ofat the Behavioral Health DivisionServices via an electronic link, but who are mainly engaged in consultation with members of the Medical Staff by providing radiological or cardiology interpretive services. Members of the Telemedicine Consulting Medical Staff shall be eligible for Medical Staff membership but do not have the rights and privileges of a member of the Medical Staff to vote or to hold office or serve on committees.

4.6 Community Affiliate Medical Staff.

The Community Affiliate Medical Staff shall consist of fully licensed physicians and psychologists who are engaged in community practice in conjunction with an MCBHDBHS Community Access to Recovery Services and/or Children's Community Health Services and Wraparound Milwaukee contracted service provider. Community Affiliate Medical Staff are involved in the care and treatment of behavioral health clients and have need to engage in consultation with members of the MCBHDBHS Active, Associate or Affiliate Medical Staff. The Community Affiliate Medical Staff will include those physicians and psychologists who do not meet criteria for Active, Associate or Affiliate Staff appointment. Members of the Community Affiliate Medical Staff are not eligible to vote, hold office, or serve on Medical Staff committees. Appointment to the Community Affiliate Medical Staff may be with or without privileges.

4.7 Allied Health Professional Staff.

The Allied Health Professional Staff shall consist of fully licensed and certified Advanced Practice Nurses, Physician's Assistants, or other licensed independent practitioners other than physicians or psychologists who are allied with the Medical Staff and who are permitted by law and by the hospital to practice independently or dependently. Allied health professional staff may be full or part-time employees, or employed by a Medical Staff Member on contract or independent contractors or employed by a Medical Service Contractor whose services have been authorized by Milwaukee County for the Milwaukee County Behavioral Health DivisionServices. Members of the allied health professional staff shall not be eligible for Medical Staff membership and do not have the rights and privileges of a member of the Medical Staff to vote or to hold office. Those allied health professionals who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Affiliate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

Summary of Eligibilities by Appointment Category								
Appointment Category	May Hold Officer Positions	May Hold Member-at-Large Positions	May Vote for Officers	May Vote for Members-At-Large	May Vote on MSO Business Items	May Serve on Med Exec Cmt	May Serve on Other Med Staff Committees	May Be Required to Pay Dues
Active	YES*	YES*	YES	YES*	YES	YES	YES	YES
Associate	NO	YES*	YES	YES*	YES	YES	YES	YES
Affiliate	NO	NO	NO	NO	NO	YES	NO	NO
Consulting	NO	NO	NO	NO	NO	YES	NO	NO
Telemedicine-Consulting	NO	NO	NO	NO	NO	NO	NO	NO
Community Affiliate	NO	NO	NO	NO	NO	NO	NO	NO
Allied Health Professional	NO	NO	NO	NO	NO	NO	NO	NO
*Subject to eligibilities as described under Section 5.0 Article V – Officers and Medical Administration								

4.8 Appointment Amendment.

A Medical Staff Member may, at any time, request modification of his/her staff category by submitting a written request. All Medical Staff appointments are subject to the eligibility criteria, as described in sections 4.1 through 4.6.

5.0 ARTICLE V - OFFICERS AND MEDICAL ADMINISTRATION

5.1 Officers and Members-At-Large

The officers of the Medical Staff shall be the President of the Medical Staff Organization and the Vice-President of the Medical Staff Organization. The officers and members-at-large shall be elected biennially at a pre-determined meeting of the Medical Staff Organization or through a time-limited electronic ballot process, when more feasible, and shall hold office for the designated term or until a successor is elected. Each officer must be a member of the Active Medical Staff in good standing and shall have satisfactorily completed the requisite initial provisional appointment and privilege period. For the positions of President and Vice-President of the Medical Staff Organization, the candidate must be a physician. The Chief Medical Officer shall not be eligible to hold office.

There shall also be four (4) Members-At-Large positions. The qualifications for these positions are that each Member-At-Large must be a Member of the Active or Associate Medical Staff in good standing and shall have satisfactorily completed the requisite initial provisional appointment and privilege period.

5.1.1 The President shall be elected for a two-year term. S/he shall preside at meetings of the Medical Staff Organization and be Chairperson of the Executive Committee of the Medical Staff. S/he may delegate specific duties to the Vice-President of the Medical Staff Organization. The President may be re-elected to that office to succeed himself/herself for one additional term but for the exception described under Article XII.

5.1.2 The Vice-president of the Medical Staff Organization shall be elected for a two-year term. S/he shall act in the event of any absence of the President, and when acting in this

capacity, s/he shall assume all the duties, responsibilities, and authority of the President. S/he shall be responsible for keeping complete minutes of all general Medical Staff Organization meetings, Executive Committee meetings and meetings on order of the President. S/he shall make recommendations to the Executive Committee concerning dues assessments, as necessary, and shall be accountable for all funds of the Medical Staff, and s/he shall report on receipts and disbursements of such funds. The Vice-President of the Medical Staff Organization may be re-elected to that office to succeed himself/herself for one additional term but for the exception described under Article XII. In the event that the office of the President becomes permanently vacant, the Vice-President of the Medical Staff Organization shall succeed to the Presidency for the remainder of the term and a new Vice-President of the Medical Staff Organization shall be elected. In the event that a Vice-President of the Medical Staff Organization is unable to carry out his/her duties, a special election shall be held to fill his/her office.

5.1.3 The President upon taking office has the option to serve as the Member At-Large Quality Advisor or to appoint a member of the Active or Associate Staff to this position. The Quality Advisor shall be responsible for oversight of quality processes throughout MC~~BHD~~BHS and shall work closely with the Chief Medical Officer and Quality Management Services on projects that improve quality and support the reduction of medical/healthcare errors and other factors that could contribute to unintended adverse patient outcomes. S/he shall serve on hospital administrative quality committees and make recommendations to the Executive Committee and MHB Quality Committee~~Council~~ on such matters. The Member-At-Large Quality Advisor may be re-appointed to succeed himself/herself. There shall be no restriction on the number of terms that s/he may serve.

5.1.4 The Member-At-Large physician position is to represent the physician community at the Medical Staff Executive Committee. There shall be one physician Member-At-Large. She/he shall serve for a two-year term but for the exception described under Article XII. There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be held to fill his/her seat on the Medical Staff Executive Committee.

5.1.5 The Members-At-Large psychologist positions are to represent the psychology community at the Medical Staff Executive Committee. There shall be two psychologist Members-At-Large. Each Member-At-Large shall serve for a two-year term but for the exception described under Article XII. One election shall take place each year, with commencement of one position beginning on January 1 (even years) and the second on January 1 (odd years). There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be held to fill his/her seat on the Medical Staff Executive Committee.

5.2 Election and Removal of Officers and Members-At-Large.

5.2.1 Election of the President and the Vice-President of the Medical Staff Organization shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of the offices (even years). Office terms shall be for two-years beginning January 1 (odd years). Election of the Officers shall be by the Active and Associate Medical Staff.

Election of the Member-At-Large Quality Advisor shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of office (odd years). The office term shall be for two-years beginning January 1 (even years). Election of the Member-At-Large Quality Advisor shall be by the Active and Associate Medical Staff.

Election of the Member-At-Large physician shall take place at the November meeting that directly precedes the expiration of the term of office (even years). The office term shall be for two-years beginning January 1 (odd years). Election of the Member-At-Large physician shall be by the Active Medical Staff.

There shall be one Member-At-Large psychologist election held each year at the November meeting of the Medical Staff Organization and each Member-At-Large term shall be for two-years. Election of the Members-At-Large shall be by the psychology members of the Associate Medical Staff.

Special elections shall be held within sixty days for elected positions vacant due to disability, ineligibility, or unavailability. Elections shall be by simple majority vote, including absentee ballots. Elections may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff.

When only one nomination is put forth for a Member-At-Large position, the President of the Medical Staff may appoint that nominee to the vacant Member-At-Large position and shall communicate such appointment to the Medical Staff Organization.

5.2.2 In the event that an officer is unable to carry out his/her duties and following a review by the Peer Review Committee or Credentialing and Privileging Review Committee, as appropriate, an officer may be removed from office by two-thirds majority vote of the Active and Associate Medical Staff. The removal of an officer may be initiated by the Chief Medical Officer or designee or on written request of 25% or more of the voting members of the Medical Staff.

In the event that a Member-At-Large is unable to carry out his/her duties, the procedure for removal of Executive Committee members in section 5.3.1 of these Bylaws shall be followed.

5.3 Committees of the Medical Staff.

The committees of the Medical Staff shall be the Executive, Credentialing and Privileging Review, Medical Staff Peer Review and Utilization Review. The President of the Medical Staff shall have the right upon taking office to appoint Chairpersons in collaboration with the Chief Medical Officer and/or Chief Psychologist, as appropriate, and members unless specified otherwise in committee descriptions. The President of the Medical Staff and the Chief Medical Officer shall be Ex-Officio members of all Medical Staff committees, as well as any special ad hoc committees, if not appointed as regular members. For purposes of conducting business, a membership quorum with a physician majority must be present for all committees, unless quorum is otherwise defined for the committee. If a quorum is not present, the chairperson may entertain a motion to recess, to fix the time to which to adjourn to allow selection of a new date and time, or to adjourn the meeting.

5.3.1 Medical Staff Executive Committee.

The Medical Staff Executive Committee shall consist of the two elected officers of the Medical Staff, ~~four~~ the Members-At-Large, the Chairperson of the Credentialing and Privileging Review Committee, the Chairperson of the Medical Staff Peer Review Committee, the Chief Medical Officer, the Service Medical Directors, and the Chief Psychologist. A majority of voting Medical Staff Executive Committee members shall be fully licensed physicians within the Active Staff. Selection and appointment of Medical Staff members, in addition to the aforementioned automatic appointments, may be made upon the joint recommendation by the Chief Medical Officer and Medical Staff President, subject to maintaining majority composition requirements, and shall be approved by the Committee. All members of the Medical Staff shall be eligible for membership on the Executive Committee. The Administrator, the Chief Nursing Officer and the Director of Medical Staff Services shall attend each meeting on an ex-officio basis. The President of the Medical Staff shall chair the Medical Staff Executive Committee. The Medical Staff Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the Medical Staff process. Functions of the Medical Staff Executive Committee shall be as follows:

1. it shall be empowered to act for and represent the Medical Staff in the intervals between the general Medical Staff Organization Meetings. Such authority shall include the review, and recommendations for amendment of Medical Staff Bylaws and Rules and Regulations, the assessment of dues, and development, review, amendment and adoption of Medical Staff policies and procedures that form the system of rights, responsibilities, and accountabilities between the organized Medical Staff and the Governing Authority and between the organized Medical Staff and its members;

2. it shall review and make Medical Staff committee appointments and Medical Staff committee chairperson appointments at the first meeting of each year, and at any other time it is deemed necessary;

3. it shall receive quarterly reports from the hospital-wide Quality Improvement Program and shall concern itself with programmatic, departmental and support service quality improvement activities as well as the results and corrective actions taken from such activities;

4. it shall concern itself with all matters affecting the delivery and quality of professional services and medical services in the hospital, the organization of the Medical Staff, and with reports and recommendations from the Credentialing and Privileging Review Committee, the Medical Staff Peer Review Committee, and any hospital committees or services that recommend actions that impact individuals with privileges;

5. it shall ensure Medical Staff representation and participation in any hospital deliberation affecting the discharge of Medical Staff responsibilities;

6. it shall ensure Medical Staff representation for the opportunity to participate and provide advice in any hospital leadership deliberation concerning the selection of

medical services to be provided through a contractual arrangement (e.g., laboratory, radiological, pharmacy, rehabilitative, etc.) and in the selection of any medical or clinical staffing contractual arrangements [e.g., for primary or specialty care physicians, psychiatrists, psychologists, advanced practice nurses or any other licensed independent practitioners (LIPs) or non-LIPs if privileges are required];

7. it shall provide liaison between the Medical Staff, the Chief Medical Officer, and the Administrator of MC~~BHD~~BHS as well as the Governing Authority;

8. it shall ensure that the Medical Staff is kept abreast of the accreditation/regulatory compliance program and informed of the accreditation status of the hospital, and it shall direct the Medical Staff concerning its responsibilities in this area;

9. it shall coordinate the activities and policies governing the Medical Staff;

10. it shall communicate with the Allied Staff (defined in the Preamble of these Bylaws) through acceptable mechanisms as determined by their respective Clinical Discipline Heads and through mechanisms as determined by the appropriate Service Administrator for those Allied Staff who are not members of discipline departments;

11. it shall make recommendations directly to the Governing Authority for its approval, on matters relating to the following and other matters, as relevant:

    a. the structure of the Medical Staff;

    b. the participation of the Medical Staff in organization performance-improvement activities;

    c. the mechanisms used for evaluating individual professional practice;

    d. the mechanism used to review credentials and to delineate individual clinical privileges;

    e. recommendations of individuals for Medical Staff membership;

    f. recommendations for delineated clinical privileges for each eligible individual;

    g. the mechanism by which membership on the Medical Staff may be terminated;

    h. the mechanism by which clinical privileges may be terminated;

    i. the mechanism for fair hearing procedures; and

    j. other medical-administrative matters including sentinel events;

12. it shall take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff Members and Allied Health Professional Staff and shall request evaluation, by an appropriate body, in instances where there is doubt about an applicant's ability to perform privileges requested or privileges currently granted;

13. it shall review the Medical Staff Bylaws and Rules and Regulations at least every two-years and make recommendations for revisions, as necessary, and shall review Medical Staff policies and procedures at least every three years and make revisions, as necessary, and shall review the Utilization Review Plan at least annually and make revisions, as necessary;

    a. if the voting members of the Medical Staff Organization propose to adopt a rule, regulation or policy or an amendment thereto, they first communicate the proposal to the Medical Staff Executive Committee;

    b. if the Medical Staff Executive Committee proposes to adopt a rule, regulation or an amendment thereto, they first communicate the proposal to the Medical Staff;

    c. when the Medical Staff Executive Committee adopts a policy or an amendment thereto, they shall communicate this to the Medical Staff Organization and to the Governing Authority, as informational only, unless otherwise directed;

    d. in cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Staff Executive Committee may provisionally adopt and the Governing Authority may provisionally approve an urgent amendment without prior notification of the Medical Staff. The Medical Staff shall be notified and have opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Staff Organization and the Medical Staff Executive Committee, the provisional amendment shall stand.

    e. There shall be a defined process to manage and resolve conflicts between the Medical Staff and the Medical Staff Executive Committee regarding proposals to adopt Rules, Regulations, policies, or procedures of the Medical Staff Organization. Such conflicts may be identified by a petition signed by at least 25% of the members of the Active and Associate Medical Staff. When such conflicts are identified, the President of the Medical Staff must call a special meeting of the Medical Staff Organization, as provided in section 6.2 of these Bylaws. The sole issue for any such special meeting will be discussion of the issue in conflict, which shall be resolved as provided in Section 6.2 of these Bylaws. The MC~~BHD~~BHS Conflict Management policy and procedure shall be utilized for conflict between the Governing Authority and the Medical Staff and for all other issues of significant importance to the Medical Staff. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Authority on a rule, regulation, or policy adopted by the Medical Staff Organization or the Medical Staff Executive Committee. The Governing Authority shall determine the method of communication. No conflict management or dispute resolution process can amend the Medical Staff Bylaws, Rules and Regulations, or policies of the Medical Staff Organization. Bylaws, rules, regulations and policy amendments proposed as a result of a dispute management process must be acted upon by the Medical Staff and Governing Authority, in accordance with the requirements of these Bylaws.

f. The process for managing and resolving disputes or conflict between the Medical Staff Executive Committee and the Governing Authority shall be in accordance with the Governing Authority Conflict Management policy and procedure.

14. it shall receive and act on reports and recommendations from Medical Staff committees, hospital committees, clinical services, and assigned activity groups and make recommendations directly to the Governing Authority;

15. the Administrator or designee shall attend each Executive Committee Meeting on an ex-officio basis and may vote if s/he is a member of the Medical Staff;

16. it shall assure the provision of a single level of care to all patients, irrespective of the staff providing the care, by means of institution-wide and program specific standards of care, policies and procedures, monitors and corrective actions.

The Executive Committee shall meet as often as needed, but at least ten times per year, to represent the Medical Staff in the intervals between the general Medical Staff Organization meetings. All meetings shall be documented and made available to the Medical Staff as a whole. Regular attendance by all Committee members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by two-thirds majority vote of the Executive Committee. The removal of a member shall be initiated, with cause cited, by the joint recommendation of any two members of the Executive Committee.

5.3.2 Credentialing and Privileging Review Committee.

The Credentialing and Privileging Review Committee shall consist of at least six members of the Active and Associate Medical Staff to be comprised of a physician majority and not more than two psychologists. The Chairperson shall be a physician. The members and Chairperson shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer and Chief Psychologist. The Director of Medical Staff Services shall attend each meeting on an ex-officio basis. This committee shall be responsible for establishing credentialing and privileging requirements for each profession, in conjunction with recommendations from the Service Medical Directors and the Chief Psychologist, when applicable, subject to Medical Staff Executive Committee and Governing Authority approval, and for evaluating and recommending all applicants for Medical Staff appointment, privileging, reappointment, reprivileging and privilege revisions to the Medical Staff Executive Committee and for conveying all recommendations of the Medical Staff Executive Committee to the Governing Authority for approval. It shall further be responsible for the delineation of privileges, recommending promotions to Active Staff and other changes in appointment or privileges and for making recommendations thereon to the Executive Committee of the Medical Staff. It shall review credentials, reports and references, as well as reports and records from Peer Review, Medical Records, Quality Management, and other Medical Staff committees, when appropriate, in order to formulate its decisions and recommendations.

It shall act as the review body for all matters involving medical staff professional behavior including, but not limited, to professional and personal conduct, professional ethics, professional judgement, ability to perform privileges held, when concerns regarding the provision of safe, high quality patient care are identified through focused or ongoing professional practice evaluation or are triggered by single incident, compliance with

established Medical Staff and hospital rules, regulations and policies that relate to professional conduct or ability, and initiation of corrective action, when indicated. Recommendations may be that no action is warranted, a self-acknowledged action plan, education, or an informal or formal time-limited improvement plan. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff.

This committee shall meet as often as needed, but at least quarterly, and shall present written reports of all appointment and privileging recommendations, in summary fashion, to the Medical Staff Executive Committee, with notations reporting presented verbally and in closed session only. All meetings shall be documented. Records of reviews and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by request of the Chairperson to the Medical Staff President and Chief Medical Officer and to the Chief Psychologist, as applicable.

5.3.3 Medical Staff Peer Review Committee.

There shall be a Medical Staff Peer Review Committee. A physician and a psychologist shall be selected to serve as Co-Chairpersons and shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer and Chief Psychologist, as appropriate. The Chairpersons shall select three additional physicians and two additional psychologists from the Active and Associate Medical Staff to serve as members. This committee shall be responsible for carrying out quality improvement activities including, but not limited to, the review of clinical performance of members of their discipline to assess compliance with discipline established standards of practice, the review of Medical Staff monitors, compliance with established Medical Staff rules, regulations and policies that pertain to clinical performance, and initiation of corrective action, when indicated. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff. This committee may conduct a professional practice evaluation when questions arise through focused or ongoing professional practice evaluation activities, or through other mechanisms, regarding a practitioner's quality of care, treatment and service, professional competence, clinical judgment, ~~ability to perform privileges held,~~ or when concerns regarding the provision of safe, high quality patient care are identified through clinical practice trends evidenced during the course of focused or ongoing professional practice evaluation or are triggered by single incident. In these instances, the committee shall assign one or more of its members to serve as peer investigator(s) for the specific practice concern. The Committee may consult with or seek assistance from other members of the Medical Staff or from an external source, in some circumstances, such as need for specialty review, when there are a limited number or no Medical Staff members within the required specialty or with the appropriate technical expertise on the Medical Staff or when the Medical Staff Peer Review Committee and/or Credentialing and Privileging Review Committee is/are unable to make a determination and requests an external opinion. Upon completion and committee discussion of the investigator(s) findings, the committee shall make a recommendation as to whether or not any action is required. Recommendations may be that no action is warranted, a self-acknowledged action plan, education, an informal or formal time-limited improvement plan or referral to the Credentialing and Privileging Review Committee. Whenever corrective action could

result in consideration for reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee.

Ongoing professional review and required focused professional review activities associated with initial and provisional privileging may be delegated to members of the Medical Staff who are not members of this committee. All practitioners upon initial privilege approval or upon revised privilege approval shall be subject to a period of focused professional practice evaluation by his/her immediate supervisor or designee. Focused professional practice evaluation guidelines and evaluation monitors, for this purpose, shall be program or service specific and approved by the Medical Staff Peer Review Committee.

(Note: Per Wisconsin Stat. 146.37-Healthcare Services Review; civil immunity and 146.38-Healthcare Services Review; confidentiality of information and Title IV-Health Care Quality Improvement Act SEC 411 [42 U.S.C. sec 11111 et seq] Professional Review.

The Peer Review Committee shall meet as often as needed, but at least semi-annually, and shall report in statistical or summary fashion only to the Medical Staff Executive Committee. All meetings of the Peer Review Committee shall be documented. Records of reviews, inquiries, proceedings and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee at the discretion of the Co-chairpersons.

5.3.4 Utilization Review Committee.

The Utilization Review Committee shall consist of the Chief Medical Officer, the Service Medical Directors of Acute Adult Inpatient, Child and Adolescent Inpatient and Crisis Services. The Chairperson shall be a physician. The Chairperson and one additional physician selected from the Active Medical Staff shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer. Additional members who shall be non-voting shall include the Directors/Managers (or his/her designee) of Utilization Review, Quality and Fiscal. The Directors/Managers (or his/her designee) of Nursing, Social Services and Community Access to Recovery Services (CARS) shall serve as ad hoc members providing support, reports and feedback, as needed.

This committee shall oversee the utilization review activities of ~~the~~ Behavioral Health ~~Division~~Services through the implementation of a written Utilization Review Plan that describes and delineates the responsibilities and authority of those involved in various utilization review functions within MC~~BHD~~BHS. The committee will focus on the efficiency and cost effectiveness of patient care through the appropriate use of behavioral health services and the appropriate allocation of resources within MC~~BHD~~BHS.

The committee shall delegate the ongoing utilization review functions and activities to program and service teams. Program/Service Utilization Review teams shall consist of at least one physician reviewer (Chief Medical Officer or Service Medical Director), the Director/Manager of Utilization Review (or his/her designee), the unit/program staff UR-Nurse, the unit/program Nurse Manager, the Director of CARS or his/her designee, and

the attending physician for the patient whose care is to be reviewed. All utilization review teams shall conduct rounds generally on a weekly basis but not less than once monthly.

The committee shall meet as often as needed, but at least quarterly, and shall report to the Medical Staff Executive Committee. Regular attendance by all members is expected. All meetings shall be documented. Records of reviews, reports and other pertinent information shall be maintained by the Utilization Review Director/Manager and made available to the Chief Medical Officer, Service Medical Directors, Quality Director/ Manager and President of the Medical Staff, as needed.

5.4 Committees (Other).

5.4.1 Joint Conference Committee.

The Joint Conference Committee shall consist of not less than two members of the Governing Authority, the Administrator or his/her designee, the Chief Medical Officer and the President of the Medical Staff (or the Vice-President as his/her designee). Additional participants shall be invited, as deemed appropriate.

The purpose of this committee shall be for periodic consultation and discussion of matters related to the quality of medical care provided to patients of the hospital.

This committee shall meet at least semi-annually but may convene more frequently, at the request of the Governing Authority or President of the Medical Staff, when issues of patient safety or quality of care are identified through quality assessment and performance improvement activities, as needing the attention of the Governing Authority in consultation with the Medical Staff. All meetings shall be documented including a list of attendees. [Note: Required per CMS 482.12(a)(10)]

5.4.2 Nominating Committee.

The Nominating Committee shall consist of two physician members of the Active Medical Staff and one psychologist member of the Associate Medical Staff, selected by the Medical Staff at large at the May meeting of the Medical Staff Organization in the year when the biennial election of the President is scheduled (even years). The Nominating Committee shall serve as an ad hoc committee for a period of two-years and shall reconvene, as necessary during the two-year period for all other regularly scheduled elections or if should there be a need for a special election. Should there be a need to replace a member of the nominating committee, a new physician or psychologist, as appropriate, shall be selected by the Medical Staff at large at the next regular meeting of the Medical Staff Organization.

The Nominating Committee shall have the duty of preparing and presenting to the Medical Staff membership a slate of recommended candidates for the office(s) of the Medical Staff and the candidates for Member-At-Large positions at each meeting when an election is scheduled to take place or for any special election held. The Officers and Members-At-Large shall be nominated by any member of the Active or Associate Medical Staff.

5.4.3 Ad Hoc Committees.

Ad Hoc Committees, as recommended by the Medical Staff Executive Committee, shall be formed through appointment by the President of the Medical Staff to address Medical Staff issues not within the responsibilities of the Medical Staff committees.

5.5 Medical Administrative Organization.

The Medical Administrative Organization shall include the positions of Chief Medical Officer, the Service Medical Directors (Adult Inpatient, Child and Adolescent, Crisis, Community and Physical Care Services) and the Chief Psychologist.

All Medical Directors shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process. The Chief Psychologist shall be certified by an appropriate psychology board or affirmatively establish comparable competence through the credentialing process. All Medical Directors and the Chief Psychologist, as applicable to psychological services, shall be responsible or collaboratively responsible with Service Administrator(s) for the following, as appropriate to position and function within his/her MC~~BHD~~BHS service:

1. all clinical related activities of his/her department;

2. administratively related activities of the department;

3. continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

4. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

5. recommending clinical privileges for each member of the department;

6. assessing and recommending to the Administrator and/or Governing Authority off-site sources for needed patient care, treatment and services not provided by the department or MC~~BHD~~BHS;

7. integration of the department into the primary functions of the organization;

8. the coordination and integration of inter-departmental and intra-departmental services;

9. the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

10. recommending sufficient numbers of qualified and competent persons to provide care, treatment or service;

11. determining qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

12. the continuous assessment and improvement of the quality of care, treatment and services provided;

13. the maintenance of quality control programs, as appropriate;

14. the orientation and continuing education of all persons in the department; and

15. recommendations for space and other resources needed by the department.

5.5.1 Additional authority and responsibilities to the Medical Staff Organization shall be as follows:

1. serve as a voting member of the Medical Staff Executive Committee;

2. chair and/or serve on other Medical Staff committees, as appointed

3. be responsible for the Medical Staff Organization's adherence to State and Federal regulations as well as the monitoring and evaluation of required standards and shall work in conjunction with the Medical Staff Organization and MC~~BHD~~BHS to facilitate compliance;

4. formulate recommendations for rules, policies and responsibilities reasonably necessary for proper discharge of Medical Staff and service responsibilities, subject to the approval of the Medical Staff Executive Committee and Governing Authority, when appropriate; and

5. request, through the President, that special meetings of the Medical Staff Organization be called, when deemed necessary for the proper clinical functioning of ~~the~~ MC~~BHD~~BHS.

6.0 ARTICLE VI – MEETINGS

6.1 Regular Meetings and Agenda.

There shall be general meetings of the full Medical Staff Organization held at least quarterly. The agenda at each of these meetings shall be:

1. call to order;

2. reading of the minutes of the last regular meeting and of any special meetings held during the quarter and approval of said minutes;

3. unfinished business;

4. report from the Medical Staff Executive Committee regarding activities and actions including the results of Medical Staff and hospital quality management monitors and follow-up;

5. reports from chairpersons of other Medical Staff committees;

6. reports from hospital committee chairpersons and by representatives from the various programs and services;

7. reports from the Vice President and Quality Advisor;

8. reports from the Administrator and Chief Medical Officer;

9. new business; and

10. adjournment.

11. The last meeting of each calendar year shall be designated as the meeting at which election of officers and Members-At-Large shall occur in accordance with the office terms

defined in section 5.1 of these Bylaws. Newly elected officers and Members-At-Large shall take office as of the first of the New Year after the election. This item will be added to the agenda, as appropriate.

6.2 Special Meetings and Agenda.

Special meetings of the Medical Staff Organization may be called at any time by the President, at the request of the Medical Staff Executive Committee, at the request of the Chief Medical Officer, at the request of the Governing Authority Chair and/or Administrator of MC~~BHD~~BHS, or on written request of 25% or more of the voting members of the Medical Staff. Notification of a special meeting shall be published to the entire Medical Staff five days prior to the date set for the meeting.

The agenda at special meetings shall be limited to the reading of the notice calling the meeting, the transaction of only that business for which the meeting was called, and adjournment.

6.3 Attendance at Meetings.

Active Medical Staff - All Active Medical Staff are encouraged to attend all regularly scheduled quarterly meetings during each calendar year.

Associate Medical Staff - All Associate Medical Staff are encouraged to attend all regularly scheduled quarterly meetings during each calendar year.

Affiliate Medical Staff - may, but are not required to, attend meetings.

Consulting Medical Staff - may, but are not required to, attend meetings.

Telemedicine Consulting Medical Staff – may, but are not required to, attend meetings

Community Affiliate Medical Staff – may, but are not required to, attend meetings

Allied Health Professional Staff - may, but are not required to, attend meetings.

The Administrator, Chief Nursing Officer and Director of Medical Staff Services shall attend each meeting on an ex-officio basis.

Members of the Medical Staff, Allied Health Professional Staff and ex-officio attendees shall receive minutes from all regular and special meetings held. All Active Medical Staff and Associate Medical Staff shall be required to submit acknowledgement of receipt and review of information within the timeline designated.

6.4 Conduct of Meeting.

All meetings of the Medical Staff Organization and its Medical Staff committees shall be conducted according to the rules contained in "Robert's Rules of Order, Newly Revised" when they are appropriate and consistent with the Bylaws and Rules and Regulations of the Medical Staff.

7.0 ARTICLE VII - CORRECTIVE ACTION AND RIGHT OF APPEAL

7.1 Whenever the professional conduct or other activities of a Medical Staff Member are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Medical Staff appointment and/or privileges are detailed in Appendix I and Appendix II of these Bylaws.

7.2 Whenever the professional conduct or other activities of an Allied Health Professional are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Allied Health Professional appointment and/or privileges are detailed in Appendix I and Appendix III of these Bylaws.

8.0 ARTICLE VIII - HEARING AND APPELLATE REVIEW

8.1 Right to Hearing and to Appellate Review.

Whenever a Medical Staff Member or prospective Medical Staff Member is notified by the Credentialing and Privileging Review Committee of a recommendation that may adversely affect his/her Medical Staff appointment and/or clinical privileges, s/he shall be entitled to a hearing and appellate review, as outlined in Appendix II of these Bylaws.

Allied Health Professionals shall have a right to fair hearing but have no right to formal appellate review.

9.0 ARTICLE IX - RULES AND REGULATIONS, POLICIES AND PROCEDURES

9.1 The Medical Staff Executive Committee shall adopt by a simple majority of quorum vote subject to physician majority of all voting members such Rules and Regulations as may be necessary for the proper conduct of its work. Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. Amendments shall be communicated, considered and acted upon in accordance with Section 5.3.1, subsection 13 of these Bylaws. Amendments so made shall become effective when approved by the Governing Authority.

9.2 The Governing Authority delegates policy and procedure matters to the Executive Committee. The Executive Committee shall adopt by a simple majority of quorum vote subject to physician majority of voting members present such policies and procedures, as may be necessary. Policies that are adopted or amendments thereto shall be communicated to the Medical Staff and to the Governing Authority in accordance with Section 5.3.1, subsection 13 of these Bylaws.

10.0 ARTICLE X - BYLAWS

10.1 Amendments.

All voting members of the Medical Staff Organization shall be given written notice of any proposed amendment to these Bylaws at least ten days prior to the meeting at which a vote is scheduled to take place. The affirmative vote of two-thirds of the voting membership subject to physician majority shall be required for adoption of the proposed amendment(s). Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. An amendment vote may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff. Amendments so made shall become effective when approved by the Governing Authority.

Proposed amendments to these Bylaws may be originated by the Medical Staff Executive Committee or by a petition signed by 25% or more members of the Active and Associate Medical Staff.

10.2 Adoption.

These Bylaws, together with the appended Rules and Regulations, shall replace any previous Bylaws and Rules and Regulations. They shall, when adopted and approved, be equally binding on the Governing Authority, Medical Staff and privileged Allied Health Professional Staff.

11.0 ARTICLE XI - DUES

11.1 Authority.

Dues, as determined by the Executive Committee of the Medical Staff, may be assessed to voting members of the Medical Staff.

11.2 Assessment.

All members of the Medical Staff Organization holding appointment within the Active or Associate Staff Category (voting members) shall be required to pay dues within 45 days of receiving an assessment.

1. All new applicants who apply for and are formally appointed to the Active Staff or Associate Staff on or before July 1 shall be required to pay dues during his/her initial appointment year, unless no dues are assessed for that year.

2. All new applicants who apply for and are formally appointed to the Active Staff or Associate Staff after July 1 shall not be subject to a dues assessment until the following calendar year.

3. If a Medical Staff member is delinquent, payment of any outstanding dues assessment(s) must be made at time of application for reappointment or application shall be deemed incomplete.

11.3 Reporting.

In accordance with 5.0 Article V, Section 5.1.2, the Vice-president of the Medical Staff Organization shall be accountable for all funds of the Medical Staff. S/he shall report on receipts and disbursements of such funds to the Medical Staff Organization, at least annually. Dues accumulated within the treasury fund may be used for, but not limited to, the following purposes:

1. Bereavements
2. Birth/adoption of child by Medical Staff Member
3. Awards/Recognitions/Appreciations – Individual or Group
4. Scholarships/Education
5. Medical Staff Organization gatherings/functions
6. Other events/circumstances deemed to be appropriate

11.4 Disposal of Fund Balance.

Prior to formal dissolution of the BHS Medical Staff Organization and after making payment or making provision for payment of all of the liabilities of the Organization, the Medical Staff Executive Committee shall make recommendation as to the manner in which to dispose of any remaining funds whether by charitable donation, reimbursement, gifting or other means.

12.0 ARTICLE XII – DISSOLUTION OF THE MEDICAL STAFF ORGANIZATION UPON HOSPITAL CLOSURE

12.1 Dissolution Adoption.

Whereas, the cooperative efforts of the Medical Staff, the Administration and the Governing Authority are necessary to fulfill the obligations of BHS to its patients and to the community, accordingly any action initiated by the Governing Authority resulting in the hospital (inpatient and psychiatric emergency service) to permanently close and cease such operations and services shall be deemed as acceptance by the members of this Medical Staff Organization to automatically effectuate dissolution of the Medical Staff Organization that exists under these Bylaws. Dissolution processes shall commence upon making formal notification to the Centers for Medicare and Medicaid Services (CMS) that the hospital shall be closing in September 2022.

12.1.1 Officers – Exception to Term Limits Upon Notice of Hospital Closure Planning.

As a means of ensuring an efficient and organized transition and closure of hospital operations, the Medical Staff Organization agrees that the current Medical Staff Members holding the office of President and Vice-President shall retain these offices until the hospital closure and Medical Staff Organization dissolution processes are complete unless the Officer(s) give notice that he or she is unable to continue serving.

12.1.2 Physician and Psychologist Members-At-Large – Expiration of Terms

All At-Large positions shall be considered expired after 8-31-2022.

12.1.3 By adopting these amended Bylaws, the Medical Staff Organization accepts and agrees to dissolve upon hospital closure and authorizes the Medical Staff Executive Committee to work in collaboration with Administration and the Governing Authority to carry out any and all matters necessary to accomplish the hospital closure and Medical Staff Organization dissolution processes.

12.2 Authority.

12.2.1 The Governing Authority shall be responsible for making arrangements to dispose of the Medical Staff Organization governing documents, committee minutes and records, and the medical staff and allied health professional credentialing records and may delegate such responsibility to BHS Administration and/or Medical Staff Leadership.

12.2.2 Transferring to New or Succeeding Custodian: Arrangements shall be made to transfer current and historical governing documents, committee minutes and records and credentialing records to BHS Administration and/or Medical Staff Leadership for proper maintenance and storage until such time that records may be destroyed. The new or succeeding custodian shall treat these records as confidential.

12.2.3 Documenting Medical Staff and Allied Health Professional Credentials: The Governing Authority shall require BHS Administration and/or Medical Staff Leadership to make appropriate arrangements so that medical staff and allied health professional staff may make timely requests to obtain verification copies of their appointments and privileges and/or shall ensure there continues to be a process for responding to external verification queries.

12.2.4 Maintaining and Retaining Records: Medical Staff and Allied Health Professional credentialing information transferred to BHS Administration and/or Medical Staff Leadership or to a commercial storage firm shall be maintained and destroyed in a manner that conforms with the federal Privacy Act for ensuring confidentiality of personal information and with state and federal laws that govern and protect peer reviewed information.

APPENDIX I

CORRECTIVE ACTION:

Section 1.0 General Procedures:

1.1 Initiation of Corrective Action.

Whenever the activities or professional conduct of a Medical Staff Member or Allied Health Professional deviates from the standards, are inconsistent with the aims of the Medical Staff or are disruptive to the operations of the hospital, corrective action against such Medical Staff Member or Allied Health Professional may be requested by an officer of the Medical Staff, the Chief Medical Officer, a Service Medical Director or the Chief Psychologist, when applicable, or by the Administrator of MC~~BHD~~BHS or Governing Authority Chair. Applicants have the burden of producing adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. If an application is found to contain significant misstatements or omissions following appointment and/or privileging, this shall constitute cause for automatic relinquishment of membership and/or privileges with no right to hearing or appeal. All requests for corrective action shall be in writing, shall be made to the Peer Review Committee or Credentialing and Privileging Review Committee, as appropriate to the matter, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. Appropriate Civil Service procedures shall be followed, when indicated.

1.2 Reduction or Suspension of Clinical Privileges.

Professional Competence. The Peer Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee. The Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

Professional Conduct. The Credentialing and Privileging Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges or appointment, the Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

1.3 Credentialing and Privileging Review Committee Interview:

Within ten (10) days after the Credentialing and Privileging Review Committee's receipt of Peer Review Committee findings or by its own findings, the committee shall present a report to the Medical Staff Executive Committee. Prior to the presentation of such report, the Medical Staff Member or Allied Health Professional against whom corrective action has been requested shall have an opportunity for an interview with the Credentialing and Privileging Review Committee. At such interview, s/he shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing and shall be preliminary in nature. A record of such interview shall be made by the Credentialing and Privileging Review Committee and included with its report to the Executive Committee.

1.4 Withdrawal of Initial Application for Medical Staff Appointment or Clinical Privileges:

A Medical Staff Member or Allied Health Professional may voluntarily withdraw his/her initial application for Medical Staff appointment or clinical privileges prior to a final action. Right to hearing and appellate review shall be forfeited at that time. Such withdrawals are generally not reportable to the National Practitioner Data Bank.

1.5 Withdrawal of Application for Renewal of Medical Staff Appointment or Clinical Privileges While Under Investigation:

A Medical Staff Member or Allied Health Professional who applies for renewal of Medical Staff appointment or clinical privileges and voluntarily withdraws that application while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, must be reported to the National Practitioner Data Bank.

1.6 Resignation While Under or to Avoid Investigation:

A physician Medical Staff Member who resigns his/her Medical Staff appointment and/or clinical privileges while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action, must be reported to the National Practitioner Data Bank regardless of whether the physician was aware that they were under investigation. Non-physician Medical Staff Members and Allied Health Professionals may be reported to the National Practitioner Data Bank under these same circumstances, but it is not required.

1.7 A Medical Staff Member or Allied Health Professional that is reported to the National Practitioner Data Bank under the circumstances described under the aforementioned sections 1.5 or 1.6 has no right to hearing and appellate review procedures, as no professional review action was recommended or taken.

Section 2.0 Medical Staff Executive Committee Authority:

2.1 The action of the Medical Staff Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend: a.) reduction, b.) suspension or c.) revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that a Medical Staff Member's membership be suspended or revoked. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Appendix II (Hearing and Appellate Procedure: Medical Staff). Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion shall entitle the affected Allied Health Professional to the procedural rights provided in Appendix III (Fair Hearing and Appeal Procedure: Allied Health Professionals).

2.2 Responsibilities.

The President of the Medical Staff shall promptly notify the Administrator of MC~~BHD~~BHS, in writing, of all requests for corrective action received by the Medical Staff Executive Committee and shall continue to keep the Administrator of MC~~BHD~~BHS fully informed of all action taken. After the Medical Staff Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Appendix II or Appendix III of these Bylaws.

Section 3.0 Suspensions:

3.1 Summary.

Any one of the following--the President of the Medical Staff, the Chief Medical Officer, the Chief Psychologist (limited to psychologists), the Administrator, the chairperson of the Credentialing and Privileging Review Committee, or the Governing Authority Chair--shall each have the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition and amendment.

Circumstances which would lead to immediate summary suspensions would include any form of impairment while on duty, sexual misconduct with patients or other caregiver misconduct, conviction of a felony involving violence to others, or any other intentional act performed that endangers patient safety or is considered to be in clear violation of professional ethics.

3.2 Temporary.

A Medical Staff Member whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request that the Credentialing and Privileging Review Committee of the Medical Staff hold a hearing on the matter. The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within 30 days shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter under Appendix II of these Bylaws. The Credentialing and Privileging Review Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Credentialing and Privileging Review Committee does not recommend immediate termination of the summary suspension, the affected Medical Staff member shall be entitled to request an appellate review by the Governing Authority. The summary suspension, as sustained or as modified by the Credentialing and Privileging Review Committee, shall remain in effect pending a final decision by the Governing Authority.

An Allied Health Professional whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request a meeting on the matter before two physicians and one peer, appointed by the President. The failure of an Allied Health Professional to request a meeting from the President to which s/he is entitled by these Bylaws, within (30) days shall be deemed a waiver of his/her right to such a fair hearing and to any appeal to which s/he might otherwise have been entitled on the matter in under Appendix III of these Bylaws.

3.3 Automatic.

A temporary suspension in the form of a withdrawal of a Medical Staff Member's or Allied Health Professional's clinical privileges, effective until medical records are

completed, shall be imposed automatically seventy-two (72) hours after final warning of delinquency for failure to complete medical records within the time allotted by the hospital. Notification of such suspension to the Medical Staff Member or Allied Health Professional and appropriate hospital authorities shall be made by the Chief Medical Officer or designee.

Action by the State Board of Examiners revoking or suspending a Medical Staff Member's or Allied Health Professional's license, or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain current professional licensure shall automatically suspend all of his/her hospital privileges.

Action by the federal Drug Enforcement Administration revoking or suspending a Medical Staff Member's or Allied Health Professional's registration or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain registration, when required, shall automatically suspend his/her prescriptive authority. Automatic suspension of all hospital privileges shall be considered whenever circumstances warrant.

Action by Medicare/Medicaid resulting in exclusion or suspension from participating in these programs or becoming subject to conviction or offense under DHS 12 Wisconsin Caregiver Laws shall automatically suspend all of his/her hospital privileges.

It shall be the duty of the President of the Medical Staff to cooperate with the Administrator of MC~~BHD~~BHS in enforcing all automatic suspensions.

APPENDIX II

HEARING AND APPELLATE REVIEW: PROCEDURE (MEDICAL STAFF)

Section 1.0 Right to Hearing and to Appellate Review:

1.1 Whenever a Medical Staff Member or Medical Staff privilege applicant receives a notice of a recommendation by the Credentialing and Privileging Review Committee which, if approved by decisions of the Medical Staff Executive Committee and the Governing Authority, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges or is summarily suspended for a period of more than 14 days, s/he shall be entitled to a hearing before the Medical Staff Executive Committee. If the recommendation of the Medical Staff Executive Committee following such hearing is still adverse to the affected practitioner, s/he shall then be entitled to an appellate review by the Governing Authority before s/he makes a final decision on the matter.

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II of these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

1.2 When any Medical Staff Member receives notice of a decision by the Governing Authority that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges and such decision is not based on a prior adverse recommendation by the Credentialing and Privileging Review Committee of the Medical Staff, s/he shall be entitled to a hearing. Such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Active or Associate Medical Staff who are discipline peers appointed by the Chair of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee. If such a hearing does not result in a favorable recommendation, s/he shall be entitled to an appellate review by the Governing Authority before a final decision on the matter is made.

1.3 All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Appendix II to assure that the affected practitioner is accorded all rights to which s/he is entitled.

The notice of hearing shall state in concise language the acts or omissions with which the Medical Staff Member is charged, a list of specific or representative medical records being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 2.0 Request for Hearing:

2.1 The President of the Medical Staff or his/her designee shall be responsible for giving prompt written notice, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, of an adverse recommendation or decision to any affected Medical Staff Member who is entitled to a hearing or to an appellate review.

2.2 The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within thirty (30) days of receipt of the written notice by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter.

2.3 When the waiver of hearing or appellate review relates to an adverse recommendation of the Credentialing and Privileging Review Committee of the Medical Staff or of a hearing committee appointed by the Medical Staff Executive Committee, the same shall thereupon become and remain effective against the staff member pending decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Authority, the same shall thereupon become and remain effective against the Medical Staff Member in the same manner as a final decision of the Governing Authority, provided for in Section 7.0 of this Appendix II. The President of the Medical Staff shall promptly notify the affected Medical Staff Member of this status by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery.

Section 3.0 Notice of Hearing:

3.1 Within ten (10) days after receipt of a request for hearing from a Medical Staff Member, the Medical Staff Executive Committee or the Credentialing and Privileging Review Committee, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the Medical Staff Member of the time, place and date so scheduled, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery. The hearing date shall not be less than fifteen (15) days, nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Medical Staff Member who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than fifteen (15) days from the date of receipt of such staff member's request for hearing.

3.2 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the Administrator, in conjunction with the President of the Medical Staff, shall schedule the hearing and shall give written notice to the practitioner who requested the hearing. The notice shall include:

a) The time, place and date of the hearing;

b) A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the Medical Staff Executive Committee, (or Governing Authority), at the hearing;

c) The names of the hearing panel members and presiding officer or hearing officer, if known; and

d) A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to, in writing, by both parties.

Section 4.0 Composition of Hearing Committee:

4.1 When a hearing relates to an adverse recommendation of the Credentialing and Privileging Review Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Active or Associate Medical Staff who are discipline peers appointed by the Chairperson of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.

4.2 When a hearing relates to an adverse decision of the Medical Staff Executive Committee that is contrary to the recommendation of the Credentialing and Privileging Review Committee, the Medical Staff President shall appoint a hearing committee of not less than three (3) individuals to conduct such hearing and shall designate one of the members of said committee as Chairperson. At least one representative from the Medical Staff shall be included on this committee.

Section 5.0 Conduct of Hearing:

5.1 There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

5.2 An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of minutes.

5.3 The presence of the Medical Staff Member for whom the hearing has been scheduled shall be required. A Medical Staff Member who fails without good cause to appear at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2.0 of this Appendix II and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2.0 of this Appendix II.

5.4 Postponement of hearing beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponement shall only be for cause shown and at the sole discretion of the hearing committee.

5.5 The affected Medical Staff Member shall be entitled to be accompanied by and/or represented at the hearing by an attorney, a member of the Medical Staff in good standing or by a member of his/her local professional association.

5.6 The Chairperson of the hearing committee or his/her designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.

5.7 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

5.8 The Credentialing and Privileging Review Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff Member to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses. The Medical Staff Executive Committee, when its action has prompted the hearing, shall appoint one of its members to represent the committee at the hearing, to present the facts in support of the adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected Medical Staff Member shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved a lack of any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

5.9 The affected Medical Staff Member shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the Medical Staff Member does not testify in his/her own behalf, s/he may be called and examined as if under cross-examination.

5.10 The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, both sides shall be entitled to be represented by counsel of their choosing, in connection with preparation for the hearing or for a possible appeal.

5.11 The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon conduct its deliberations outside the presence of the staff member for whom the hearing was convened.

5.12 Within five (5) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Credentialing and Privileging Review Committee or to the Medical Staff Executive Committee, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Credentialing and Privileging Review Committee or decision of the Medical Staff Executive Committee.

Section 6.0 Appeal to the Governing Authority:

6.1 Within seven (7) days after receipt of a notice by an affected Medical Staff Member of an adverse recommendation or decision made or adhered to after a hearing as above provided, s/he may, by

a. written notice to the Governing Authority Chair, then

b. delivered through the President of the Medical Staff by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery

c. request an appellate review by the Governing Authority.

Such written notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Medical Staff Member's written statement provided for below or may also request that oral argument be permitted as part of the appellate review.

6.2 If such appellate review is not requested within seven (7) days, the affected Medical Staff Member shall be deemed to have waived his/her right to the same and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 7.2 of this Appendix II.

6.3 Within ten (10) days after receipt of such notice of request for appellate review, the Governing Authority Chair (or his/her designee) shall schedule a date for such review, including a time and place for oral argument if such has been requested and shall, through the President of the Medical Staff by written notice sent by certified mail

(return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, notify the affected Medical Staff Member of the same. The date of the appellate review shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request for appellate review, except that when the Medical Staff Member requesting the review is under a suspension which is currently in effect, such review shall be scheduled as soon as the arrangements can reasonably be made but not more than ten (10) days from the date of receipt of such notice.

6.4 The appellate review shall be conducted by the Governing Authority or by a duly appointed appellate review committee appointed by the Governing Authority Chair of not less than three (3) members with one designated as Chairperson.

6.5 The affected Medical Staff Member shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. S/he shall have seven (7) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which s/he disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Authority Chair through the President of the Medical Staff by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, at least five (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Credentialing and Privileging Review Committee of the Medical Staff. The President of the Medical Staff shall provide a copy thereof to the Medical Staff Member at least five (5) days prior to the date of such appellate review by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery.

6.6 The Governing Authority or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subparagraph 6.5 of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Medical Staff Member was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Medical Staff Member shall be present at such appellate review, s/he shall be permitted to speak against the adverse recommendation or decision and shall answer questions put to him/her by any member of the appellate review body. The Credentialing and Privileging Review Committee or the Medical Staff Executive Committee, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

6.7 New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, may be introduced at the appellate review under unusual circumstances, and the Governing Authority or the

committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

6.8 If the appellate review is conducted by the Governing Authority, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Credentialing and Privileging Review Committee of the Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

6.9 If the appellate review is conducted by a committee appointed by the Governing Authority Chair, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Authority affirm, modify or reverse its prior decision or refer the matter back to the Credentialing and Privileging Review Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Authority as above provided.

6.10 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6.0 have been completed or waived.

Section 7.0 Final Decision by the Governing Authority:

7.1 Within ten (10) days after the conclusion of the appellate review, the Governing Authority shall make their final decision in the matter and shall send notice thereof to the Credentialing and Privileging Review Committee and, through the President of the Medical Staff, to the affected Medical Staff Member, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery. This decision shall be immediately effective and final and shall not be subject to further hearing or appellate review. All final decision adverse actions shall be reported to the National Practitioner Data Bank.

7.2 Notwithstanding any other provision of these Bylaws, no Medical Staff Member shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MC~~BHD~~BHS, or by a duly authorized committee appointed by the Governing Authority Chair.

APPENDIX III

FAIR HEARING AND APPEAL: PROCEDURE (ALLIED HEALTH PROFESSIONALS)

Section 1.0 Right to Fair Hearing:

1.1 Allied Health Professional Staff are not entitled to the hearing and appeals procedures set forth in Appendix II of these Bylaws. In the event an Allied Health Professional receives notice of a recommendation by the Medical Staff Executive Committee that will adversely affect his/her exercise of clinical privileges, the Allied Health Professional and his/her supervising physician shall have the right to meet personally with two physicians and one peer assigned by the President of the Medical Staff to discuss the recommendation.

1.2 The Allied Health Professional and the supervising physician must request such a meeting, in writing, to the Administrator within ten (10) business days from the date of receipt of such notice. At the meeting, the Allied Health Professional and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing as specified for Medical Staff members and none of the procedural rules set forth in Appendix II of these Bylaws with respect to such hearings shall apply. The meeting shall take place as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the request for meeting unless an earlier date has been specifically agreed to, in writing, by both parties

1.3 Within five (5) days after the fair hearing meeting, findings from this review body will be forwarded to the affected Allied Health Professional, the Medical Staff Executive Committee and the Governing Authority.

Section 2.0 Right to Appeal:

2.1 The Allied Health Professional and the supervising physician may request an appeal, in writing, to the Administrator within ten (10) calendar days of receipt of the findings of the review body. The Administrator shall so notify the Governing Authority Chair of the request.

2.2 Within ten (10) calendar days after receipt of such notice of request for appeal, the Governing Authority shall schedule a date for such review, including a time and place through the Administrator, who shall by written notice sent by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery notify the affected Allied Health Professional and supervising physician of the same. The date of the appeal shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request.

2.3 Two members of the Governing Authority assigned by the Governing Authority Chair shall hear the appeal from the Allied Health Professional and the supervising physician. A representative from the Medical Staff leadership (President, Vice-President Chief

Medical Officer or Service Medical Director) may be present. The decision of the appeal body will be forwarded to the Governing Authority for final decision within five (5) days of hearing the appeal.

Section 3.0 Final Decision:

3.1 The Allied Health Professional and the supervising physician will be notified within ten (10) calendar days of the final decision of the Governing Authority.

3.2 Notwithstanding any other provision of these Bylaws, no Allied Health Professional shall be entitled as a right to more than one hearing and one appeal on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MC~~BHD~~BHS, or by a duly authorized committee appointed by the Governing Authority Chair.

BYLAWS
OF THE
MEDICAL STAFF ORGANIZATION
OF THE
MILWAUKEE COUNTY BEHAVIORAL HEALTH ~~DIVISION~~SERVICES

Approved and Adopted by the Medical Staff Organization
of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services
in accordance with existing Bylaws
~~August 5, 2020~~July 13, 2022

Date

Shane V. Moisio, MD, President of the Medical Staff
Milwaukee County Behavioral Health ~~Division~~Services

And

Approved and Adopted by the Milwaukee County Mental Health Board as Governing Authority
of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services
in accordance with existing Bylaws
August 2~~7~~5, 2022~~0~~

Date

Maria Perez, PhD, LCSW~~Thomas Lutzow~~, Chairperson
Milwaukee County Mental Health Board

Reviewed and Supported by Hospital Administration

Date

John H. Schneider, MD, FAPA, Chief Medical Officer
Milwaukee County Behavioral Health ~~Division~~Services

Date

Michael Lappen, MS, LPC, Administrator
Milwaukee County Behavioral Health ~~Division~~Services

References: (REGULATORY PUBLICATION DATES BELOW TO BE UPDATED)

- Joint Commission CAMH, Refreshed Core
- CMS Conditions of Participation, State Operations Manual - Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals *(Rev. 200, 02-21-20)*
- CMS Subpart E—Requirements for Specialty Hospitals, Sec 482.60 – 482.62
- Wisconsin State Statutes: 15.195(9); 50.36; 146.37, 146.38
- Title IV-Health Care Quality Improvement Act SEC 411 [42 U.S.C.sec 11111 et seq] Professional Review
- National Practitioner Data Bank Guidebook (rev. 2018)
- "Robert's Rules of Order"
- Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment Medicaid Integrity Group
- Social Security Act, Sec 1128
- Wisconsin Administrative Code, DHS 12 (Caregiver Background Checks) and DHS 124 (Hospitals)
- National Association of Medical Staff Services – Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals, February 2014
- National Association of Medical Staff Services – 2020 Hospital Closure Toolkit

DATES REVISED:
(Previous revision dates not kept)

June, 1986
December,1989; Addenda July, 1990 and March, 1991
December 1991; Addenda April, 1992 and June, 1993
April 1994
July 1994
September 1994
November 1996
August 1997
November 1998
November 2000
January 2002
September 2002
September 2004
March 2008
October 2010
December 2011
May 2012
February 2013
November 2014
February 2016
August 2016
August 2018
August 2020
August 2022

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

DATE: July 18, 2022

TO: Maria Perez, PhD, LCSW; Chairperson, Milwaukee County Mental Health Board

FROM: John Schneider, MD, FAPA, Chief Medical Officer
Prepared by Lora Dooley, Director of Medical Staff Services

SUBJECT: **A Report from the Medical Executive Committee (Future State) Requesting Approval of the Amended BHS Medical Staff and Provider Network Credentialing Program and Governing Document**

Background

The Behavioral Health Services and Mental Health Board adopted a formal Credentialing Program for the Provider Network that began in July 2019. Under this program, the Credentialing Committee ensures that all physician, advanced practice nurse and licensed clinical and counseling psychologist practitioners participating, or those seeking to participate, in the network meet established minimum thresholds for participation, which include, but are not limited to, the standards of professional licensure, training and certification.

At this time, as Behavioral Health Services prepares to close the inpatient hospital and psychiatric crisis service, the current BHS Medical Staff Organization shall dissolve. To ensure continued and uninterrupted Medical Staff services within BHS' community services and programs and the necessary oversight of the care provided, a future-state Medical Executive Committee has been formed, which includes establishing new Governing Documents and adopting the existing Credentialing Program for the BHS Medical Staff that is currently used for network practitioners.

Discussion

The purpose of the newly formed Medical Executive Committee (MEC) shall be to represent the Medical Staff by implementing, maintaining and enforcing the documents that govern Medical Staff activities by establishing rules, regulations, policies and procedures for self-governance. These documents shall ensure that all patients and clients served receive a uniform standard of quality care, treatment and service and that Medical Staff conduct themselves in an ethical and professional manner. This shall be achieved through BHS-wide and Medical Staff continuous quality improvement activities; ongoing evaluation of professional practice to improve patient care; and through the establishment of practitioner credentialing and peer review processes.

In addition, the new Medical Staff and MEC will provide a means to delegate Treatment Director Designee status to physicians at the Mental Health Emergency Center and their quality oversight, review and evaluation. The MEC shall further provide guidance and oversight to the

Credentialing Committee on all BHS Medical Staff applicant matters and when needed, shall offer guidance and recommendations concerning network practitioner matters.

The scope of the new Medical Executive Committee shall include governance over the medical/ clinical professional practice by BHS employed or contracted physicians, psychologists, and advanced practice nurses. Such authority may be extended to other BHS employed/contracted advanced practice professionals/licensed independent practitioners, when billing independently for their services.

With adoption of the amended credentialing program and newly formed governing document, standardized credentialing processes will pertain to both the BHS Medical Staff and Network participants.

If approved by the Mental Health Board, the Behavioral Health Services' newly formed Medical Executive Committee and the Credentialing Committee are prepared to consistently, uniformly and fairly carryout the processes detailed within this Governing Document.

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve the *BHS Medical Staff and Provider Network Credentialing Program and Governing Document,* as amended and adopted on July 15, 2022 by the future-state BHS Medical Executive Committee.

Respectfully Submitted,

John Schneider, MD, FAPA, Chief Medical Officer
Chair, Medical Executive Committee

cc Michael Lappen, Administrator
Amy Lorenz, Deputy Administrator, CARS
Brian McBride, Director, Wraparound Milwaukee
Shane Moisio, MD, Medical Director-Child and Adolescent Services
Dennis Buesing, DHHS Contract Administrator
Brenda Smith-Jenkins, BHS Manager of Contracts & Network Services
Lora Dooley, BHS Director of Medical Staff Services
Jodi Mapp, BHS Senior Executive Assistant

Attachment
1 BHS Medical Staff and Provider Network Credentialing Program & Governing Document

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

BHS Medical Staff and Provider Network

Credentialing Program and Governing Document

~~Community Access to Recovery Services (CARS) and Children's Community Mental Health Services & Wraparound Milwaukee~~

August 2022~~1~~

Executive Summary: Medical Executive Committee and Credentialing Program Description
Effective: August 2021~~1~~2

Purpose:

The Medical Executive Committee (MEC) shall serve to represent the Medical Staff by implementing, maintaining and enforcing the governing documents that establish the rules, regulations, policies and procedures for self-governance of the BHS Medical Staff, which shall ensure that all patients and clients served receive a uniform standard of quality care, treatment and service. This shall be achieved through direction, review and evaluation of the quality of patient care through continuous BHS-wide and Medical Staff quality improvement activities; ongoing evaluation of professional practice to improve patient care; and through the establishment of practitioner credentialing and peer review processes that confirm competence, experience and ability.

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

Scope:

The scope of the Medical Executive Committee is comprehensive and includes governance over the medical/clinical professional practice by BHS employed or contracted physicians, psychologists, and advanced practice nurses, which shall be known as the Medical Staff. Such authority may extend to other BHS employed/contracted advanced practice professionals/licensed independent practitioners, when billing independently for their services.

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

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

TABLE OF CONTENTS

I. DEFINITIONS

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

1. **Administrator:**

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

   Children's Community Mental Health Services & Wraparound Milwaukee Administrator: The individual appointed to oversee operations for Behavioral Health ~~Division~~Services' non-inpatient programs and services and community-based programs and services for children and adolescents.

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

2. **Board**: The Milwaukee County Mental Health Board (MHB) created by 2013 Wisconsin Act 203 and charged with management, operation, maintenance, improvement and jurisdiction over mental health policy,~~over all inpatient and community-based mental health~~ functions, programs, and services for ~~in~~ Milwaukee County, including those relating to alcohol and other drug abuse.

3. ~~**BHD**~~**BHS**: ~~The~~ Milwaukee County Behavioral Health ~~Division~~Services under the Department of Health and Human Services.

4. **CARS**: The Community Access to Recovery Services adult outpatient services and programs of ~~the~~Milwaukee County Behavioral Health ~~Division~~Services and Provider Network.

5. **Clean Application:** A practitioner's application submission that meets the standards, guidelines, and established minimum professional threshold criteria for medical staff and/or network participation.

6. **Client:** An individual residing in Milwaukee County that is receiving patient care services from one or more of the BHS operated clinics, programs or services.

~~6.~~7. **CMS:** Centers for Medicare and Medicaid Services.

~~7.~~8. **Credentialing Committee (Committee):** A peer review body chaired by a Medical Director (or equally qualified physician designee) to make recommendations to approve, deny, suspend, or terminate a practitioner's participation on the Medical Staff or in the Network based on the established criteria.

~~8.~~9. **Credentialing Process**: Includes both the credentialing and recredentialing of licensed practitioners that may independently bill for their services.

~~9.~~10. **DEA**: The Drug Enforcement Administration is a United States federal law enforcement agency, under the United States Department of Justice, tasked with combating drug smuggling and distribution within the United States; and has a system in place which authorizes eligible individuals and entities to register in order to manufacture, import, export, distribute, research, prescribe, have access to and/or dispense scheduled drugs.

~~10.~~11. **DHS-Wisconsin**: The Wisconsin Department of Health Services oversees Medicaid and other health social service programs to ensure that the care provided to Wisconsin residents is high quality and provided in accordance with state and federal law; ensures that Wisconsin taxpayer dollars are being used effectively and efficiently by preventing and detecting waste, fraud, and abuse.

~~11.~~12. **Delegated Credentialing**: Occurs when the credentialing functions of a managed care organization or other organization have been outsourced or contracted out to be performed by another capable organization.

~~12.~~13. **Dual Credentialing:** A practitioner who is educated and trained to provide care in two (or more) specialties.

~~13.~~14. **Dual Contracting**: A practitioner that is contracted directly/independently with the ~~BHD~~BHS Provider Network and also with an agency that contracts with the ~~BHD~~BHS Provider Network or works with two or more agencies that contract with the ~~BHD~~BHS Provider Network.

~~14.~~15. **Impaneling**: The determination of eligibility for individuals applying to become a part of the ~~MCBHD~~BHS Provider Network(s). Impaneling consists of a review of required documentation set forth by county, state and/or federal licensing and regulatory agencies, but does not encompass full credentialing, as outlined in this Program.

~~15.~~16. **Licensed independent practitioner** (LIP): A practitioner who does not work under the auspices or authority of another practitioner.

17. **Locum Tenens:** A Latin phrase that means "to hold the place of, to substitute for." In layman's terms, it means a temporary and/or covering practitioner.

~~16.~~

~~17.~~18. **Medical Directors:** ~~The~~ Milwaukee County Behavioral Health ~~Division~~Services'~~s~~ staff of employed Medical Director(s).

Chief Medical Officer (CMO): The CMO is responsible for providing direction for the development and implementation of the Credentialing Program, serves as Chair of the Medical Executive Committee, and have authority and responsibility for the overall medical and clinical management of Behavioral Health Services.

Service Medical Director(s): The Service Medical Director(s) is responsible for clinical related activities of his/her service or program, continuing surveillance of the professional performance of medical staff in his/her service or program, peer review activities and for collaboration with the Chief Medical Officer, Credentialing and Quality Management Staff on the development and implementation of the Credentialing Program. One Service

Medical Director shall be selected to serve as Chair~~man~~ of the ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee.

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

Non-Administrative Medical Director – ~~BHD~~BHS Service Medical Director(s) who are required to be credentialed within~~by~~ the ~~BHD~~BHS Provider Network because s/he is contracted individually or as part of a group/agency to perform direct care to ~~BHD~~BHS Provider Network members. Care provided falls outside of ~~BHD~~BHS licensed and/or operated settings and the scope of the Medical Director(s)' ~~BHD~~BHS employment duties and schedule.

19. **Medical Staff:** When used within this document, the term Medical Staff shall be interpreted to include the following categories of professional staff.

BHS Medical Staff – Physicians that are employed by or under a professional service agreement to provide medical/clinical care to clients served within one or more of the BHS operated programs and services and follow all established medical staff, BHS/DHHS policies and procedures.

Non-BHS Medical Staff – Physicians employed, contracted or under a locum tenens arrangement with the Mental Health Emergency Center who have received the necessary training and been granted Treatment Director designee status by BHS/Milwaukee County.

BHS Allied Health Practitioners – Licensed clinical and counseling psychologists, advanced practice nurses and other advanced practice/licensed independent practitioners that are employed by or under a professional service agreement to provide clinical care to clients served within one or more of the BHS operated programs and services, independently bill and follow all established medical staff, BHS/DHHS policies and procedures.

20. **Medical Executive Committee (MEC)** makes recommendations on matters that affect quality of care within BHS services and programs and ensures the ethical conduct and competent performance on the part of all Medical Staff practitioners.

~~18.~~21. **Member:** An individual residing in Milwaukee County and eligible for ~~BHD~~BHS Provider Network services.

~~19.~~22. **Nationally Recognized Accrediting Entity/Body**: An organization that sets national standards specifically governing healthcare quality assurance processes, utilization review, practitioner credentialing, as well as other areas covered in this document and provides accreditation to hospitals, managed care organizations and managed care health insurance plans pursuant to

national standards. The following entities are examples of nationally recognized accrediting entities/bodies:

- **TJC**: The Joint Commission
- **NCQA**: National Committee for Quality Assurance
- **HFAP**: Healthcare Facilities Accreditation Program
- **URAC**: Utilization Review Accreditation Commission
- **DNV**: Det Norske Veritas Healthcare, Inc.

~~20.~~23. **Network**: Refers to the ~~BHD~~BHS Provider Network

~~21.~~24. **Network Practitioner**: A verified person who has been credentialed by the ~~BHD~~BHS Provider Network to provide healthcare services to its members and follow all established network policies and procedures.

~~22.~~25. **Network Provider**: An individual or agency that holds a purchase-of-service or fee-for-service contractual agreement with the ~~BHD~~BHS Provider Network to provide community-based healthcare services to its members and follow all established network policies and procedures.

~~23.~~26. **Office of the Inspector General (OIG):** The Health and Human Services Office of Inspector General responsible for excluding individuals and maintaining a sanctions list that identifies those practitioners and providers who have participated or engaged in certain impermissible, inappropriate, or illegal conduct to include, but not limited to, fraudulent billing and misrepresentation of credentials. The OIG's List of Excluded Individuals and Entities (LEIE) provides information on all individuals and entities currently excluded from participation in the Medicare, Medicaid, and all other Federal health care programs.

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

Contacting the HHS OIG Hotline:

By Phone: 1-800-HHS-TIPS (1-800-447-8477)
By E-Mail: HHSTips@oig.hhs.gov
By Fax: 1-800-223-8164
By TTY: 1-800-377-4950

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

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

~~24.~~27. **Primary Source Verification (PSV)**: The original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner. Primary source examples include medical school, graduate medical education programs, and state medical/professional licensing boards.

~~25.~~28. **Recognized Equivalent to Primary Source (TJC) or Approved Sources (NCQA)**: Consistent with The Joint Commission (TJC), the Centers for Medicare and Medicaid Services (CMS) and the National Center for Quality Assurance (NCQA) standards, the following are considered to be an equivalent and/or an approved source for primary source verification of education and for ongoing monitoring of certain credentials and sanctions/exclusion monitoring:

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

29. **Treatment Director Designee:** A fully licensed physician that is NOT a BHS employee or is a fully licensed BHS credentialed psychologist who has been authorized to act on Milwaukee County's behalf to write and file a Treatment Director's Supplement to an Emergency Detention filed by law enforcement justifying the standard for commitment of a person, in accordance with the criteria established under the Wisconsin Mental Health Act.

~~26.~~30. **Wraparound Milwaukee**: The Children's Community Mental Health Services and Wraparound Milwaukee child and adolescent outpatient services and programs of ~~the~~ Milwaukee County Behavioral Health ~~Division~~Services and Provider Network.

II. INTRODUCTION

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

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

The credentialing program incorporates the following three functions:

(1) Initial credentialing: involves the evaluation of an individual's application for participation on the BHS Medical Staff and/or as a ~~BHD~~BHS Provider Network practitioner.

(2) Recredentialing: assesses practitioners' qualifications for continued participation on the BHS Medical Staff or with the ~~BHD~~BHS Provider Network.

(3) On-going monitoring: includes the continuous monitoring of license actions, Medicare/Medicaid and other state or local exclusions, sanctions and client/member complaint information.

III. AUTHORITY AND RESPONSIBILITY ~~FOR CREDENTIALING~~

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

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

In addition to the Credentialing Program, the BHS Medical Staff and Provider Network haves in place written policies and procedures that support implementation of the Credentialing Program. Such policies and procedures including any modifications thereto shall first be reviewed and recommended for approval by the ~~BHD~~BHS Provider Network Credentialing Committee and approved by the Children's Community Mental Health Services & Wraparound Milwaukee and Community Access to Recovery Services Administrators, the ~~BHD Chief Medical Officer~~Medical Executive Committee and the ~~BHD~~BHS Administrator.

IV. PURPOSE

The Medical Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by Medical Staff.

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

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

Specific objectives of the Credentialing Program include:

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

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

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

MEDICAL EXECUTIVE COMMITTEE STRUCTURE & ACTIVITIES

A. Committee Composition:

The BHS Medical Executive Committee (MEC) is comprised of physicians including the Chief Medical Officer and the Service Medical Directors who shall be voting members. The Chief Medical Officer shall serve as Chair. The BHS Administrator, the Chief Quality Officer, the Director of Outpatient Treatment Programs and the Director of Medical Staff Services shall attend each meeting on an ex-officio basis. The MEC shall have the primary authority for activities related to self-governance of the BHS Medical Staff and for the performance improvement of the professional services provided by these staff.

B. Committee Responsibilities/Duties

The Medical Executive Committee (MEC) shall have the authority for review and recommendations for amendments to the BHS Medical Staff and Provider Network Credentialing Program (Governing Document), the assessment of dues, and development, review, amendment and adoption of Medical Staff rules, regulations, policies and procedures.

The MEC shall receive quarterly reports from the BHS Quality Improvement Program and shall concern itself with Medical Staff programmatic and departmental quality improvement monitors and activities as well as the results and corrective actions taken from such activities.

The MEC shall concern itself with all matters affecting the delivery and quality of BHS medical and professional services and with reports and recommendations from the Credentialing Committee and any BHS committees or services that recommend actions that impact BHS Medical Staff activities.

The MEC shall ensure Medical Staff representation and participation in any BHS deliberation affecting the discharge of Medical Staff responsibilities.

The MEC shall provide liaison between the Medical Staff, the Chief Medical Officer, and the BHS Administrator as well as the Board.

The MEC shall ensure that the Medical Staff is kept abreast of the accreditation/regulatory compliance program and informed of the accreditation status of BHS programs and services, and it shall direct the Medical Staff concerning its responsibilities in this area.

The MEC shall coordinate the activities and policies governing BHS Medical Staff.

The MEC shall make recommendations directly to the Board for its approval, on matters relating to the following and other matters, as relevant:

- the structure and categories of the Medical Staff;
- the participation of the Medical Staff in organization performance-improvement activities;
- the mechanisms used for evaluating individual professional practice;
- the mechanism used to review credentials;

- the criteria for which BHS Medical Staff and Provider Network participation may be denied, restricted or terminated;

- the mechanism for an appeal process; and

- other medical-administrative matters including sentinel events;

The MEC shall receive and act on reports and recommendations from Medical Staff committees, BHS Committees, medical and clinical services, and assigned activity groups and make recommendations directly to the Board.

The MEC shall assure the provision of a single level of care to all patients, irrespective of the staff providing the care, by means of BHS-wide and program specific standards of care, policies and procedures, monitors and corrective actions.

The MEC shall review and adopt the Governing Document(s) at least every two-years and make recommendations for revisions, as necessary, and shall review Medical Staff policies and procedures at least every three years and make revisions, as necessary.

C. Quorum:

A quorum (majority of voting members present) shall be satisfactory for the valid transaction of business by the Committee. The Medical Executive Committee shall meet as often as needed, but at least quarterly. Regular attendance by all Committee members is expected. The Committee action may be implemented in the absence of a face-to-face or other type meeting if consent in writing, setting forth the action, is obtained, i.e., telephone conference, skype meeting. A meeting may not be conducted only through e-mail.

D. Professional Practice Evaluation and Peer Review Activities

The MEC shall take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff and may request evaluation, by an appropriate body, in instances where there is doubt about an applicant's or current practitioner's ability to practice with reasonable skill and safety.

The physician members of the MEC shall serve as the BHS Medical Staff Peer Review Committee, with additional discipline representation appointed on an ad hoc basis, as needed. One physician shall be selected to serve as chair at the first meeting of each year by volunteering and/or by Committee vote, in the absence of or more than one volunteer. The peer review committee shall conduct a professional practice evaluation when questions arise through focused or ongoing professional practice evaluation activities, or through other mechanisms, regarding a practitioner's quality of care, treatment and service, professional competence, clinical judgment or ability, or when concerns regarding the provision of safe, high quality patient care are identified through clinical practice trends evidenced during the course of focused or ongoing professional practice evaluation or are triggered by single incident. It shall further act as the peer review body for all matters involving Medical Staff professional behavior including, but not limited to, professional and personal conduct, professional ethics, compliance with established Medical Staff and hospital rules, regulations and policies that relate to professional conduct, and for initiation of corrective action, when indicated.

E. Conflict Resolution

There shall be a defined process to manage and resolve conflicts between the Medical Staff and the Medical Executive Committee regarding proposals to adopt rules, regulations, policies, or procedures. Such conflicts may be identified by a petition signed by at least three (3) BHS Medical Staff. When such conflicts are identified, the Chief Medical Officer must call a special meeting of the MEC. The sole issue for any such special meeting will be discussion of the issue in conflict, which shall be resolved as provided below. The BHS Conflict Management policy and procedure shall be utilized for conflict between the Board and the BHS Medical Staff and for all other issues of significant importance to the Medical Staff. Nothing in the foregoing is intended to prevent BHS Medical Staff from communicating with the Board on a rule, regulation, or policy adopted by the Medical Executive Committee. The Board shall determine the method of communication. No conflict management or dispute resolution process can amend the Governing Document(s) or policies of the Medical Staff. Governing Documents, rules, regulations and policy amendments proposed as a result of a dispute management process must be acted upon by the Medical Executive Committee and Board, in accordance with the requirements of this Governing Document.

- Special Meetings and Agenda: Special meetings of the MEC may be called at any time at the request of the Chief Medical Officer, at the request of the Board Chair and/or BHS Administrator or on written request of three (3) or more BHS Medical Staff. Notification of a special meeting shall be published to the entire Medical Staff five days prior to the date set for the meeting. The agenda at special meetings shall be limited to the reading of the notice calling the meeting, the transaction of only that business for which the meeting was called, and adjournment.

- The process for managing and resolving disputes or conflict between the Medical Executive Committee and the Board shall be in accordance with the Board Conflict Management policy and procedure.

F. Agenda, Minutes and Reports:

Medical Staff Services shall prepare each meeting agenda and shall be responsible for the preparation and maintenance of complete and accurate minutes and for preparing and distributing meeting materials. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect items discussed, decisions, recommendations and actions.

The Committee will be responsible for reviewing minutes for accuracy. Minutes and meeting materials shall be retained electronically and/or manually by Medical Staff Services.

V. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Committee Composition:

The ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee is a peer-review body comprised of not less than four (4) voting physician members including the Chief Medical Officer and the Service Medical Director(s). One Service Medical Director (CARS or Wraparound Milwaukee) shall be selected to serve as chair of the Committee at the first meeting of each year by volunteering and/or by appointment of the Chief Medical Officer, in the absence of a volunteer. The Chair, in consultation with the Chief Medical Officer and Service Medical Director(s) shall select the additional physician member(s). Alternate physician committee members may be utilized when a voting committee member

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

Additional non-voting membership may include the CARS and Wraparound Milwaukee Quality Director(s), the Director of Medical Staff Services and Credentialing Manager(s).

B. Committee Responsibilities/Duties:

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

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

Other behavioral health professionals and other allied health practitioners that provide an independent billable level of care shall be subject to the impaneling process (network) or Human Resources process (employees), at this time. However, these practitioners may also become subject to the full credentialing process, if so determined by the ~~BHD~~BHS Medical Staff and/or Provider Network at a later time.

- Allied health practitioners are defined as nurse midwives, traditional midwives, nurse practitioners, chiropractors, optometrists, physician assistants, psychologists, licensed marriage and family therapists, alcohol and chemical dependency counselors, licensed independent clinical social workers, licensed professional counselors, board certified behavioral analysts, and clinical nurse specialists.

- All other individuals applying to participate in the ~~BHD~~BHS Provider Network(s) shall be subject to the impaneling process.

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

- Receive, review and evaluate the credentials of all physician, advanced practice nurse, physician assistant and psychologist practitioners applying for new or on-going participation on the BHS Medical Staff and/or as ~~BHD~~BHS Provider Network practitioners and at any time that concerns arise regarding an individual practitioner's credentials and/or practice.

- Receive, review and evaluate the credentials of practitioners who do not meet the organization's established clean application criteria (~~e.g.~~e.g., malpractice cases, licensure issues, sanctions, quality concerns, missing documentation, etc.)

- Review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care

- Establish, implement, monitor, and revise policies and procedures for BHS Medical Staff and ~~BHD~~BHS Provider Network credentialing and recredentialing

- Report to the Medical Executive Committee, ~~BHD~~BHS Administration, the Board and other appropriate authorities, as required

- Review and approve Committee minutes

- Review the Credentialing Program Description at least every two years

- Other related responsibilities

C. Committee Chair Responsibilities/Duties:

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

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

In addition, files requiring special review due to ongoing monitoring findings, recent license or other disciplinary actions, client or member complaints or Medicare/Medicaid sanctions, shall first promptly be brought to the Chair's attention for review and must be reviewed by the Credentialing Committee. A special review is defined as review of a practitioner's credentials or performance outside the initial credentialing or recredentialing cycle.

Recommendations by the Credentialing Committee to deny or restrict participation are communicated, in writing, to the practitioner within 30 days of the decision.

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

The Quality Manager(s) and Credentialing Manager(s) shall report to the Credentialing Committee. The Quality Manager(s) and Credentialing Manager(s) are responsible for ensuring network practitioners and providers are providing high quality care to network members, for ensuring the quality improvement programs comply with accreditation and state and federal regulatory requirements, and for the ongoing monitoring activities. The Quality/Credentialing Manager(s) shall report all network physician, advanced practice nurse, physician assistant and psychologist practitioner specific quality concerns to the Credentialing Committee. All BHS Medical Staff practitioner specific quality concerns shall be referred to

the BHS Medical Staff Peer Review Committee. The Quality/Credentialing Manager(s) may delegate continuous monitoring of license actions, Medicare/Medicaid exclusions and other state or local exclusions to credentialing staff.

E. Quorum:

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

F. Agenda, Minutes and Reports:

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

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

G. Confidentiality:

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

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

- Limiting the number of staff with access to the credentialing files and/or credentialing databases is required to ensure ~~that~~ confidentiality in compliance with the federal Privacy Act and that federal and state statutory peer review protections are met.

- Credentialing files and materials shall be secured via a passcode protected database, a shared database with access limited to only authorized credentialing staff and/or files secured within a double locked environment, i.e., in locked file cabinets within a locked room, whenever unattended.

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

H. Conflict of Interest:

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

VI. THE CREDENTIALING PROGRAM: PRACTITIONERS

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

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

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

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

- Practitioners who practice exclusively within an inpatient setting and provide care or treatment to ~~BHD~~BHS clients and/or Provider Network members only because clients/members are directed to the hospital, or other inpatient setting.

- Practitioners who are not participants in the ~~BHD~~BHS Provider Network to whom limited or specialty referrals may be made on a case-by-case basis by participating practitioners or the ~~BHD~~BHS Provider Network. Such referrals are considered to be out-of-network.

- Locum Tenens practitioners in the provider network , i.e., practitioners who are filling in temporarily. This exception applies only to locum tenens practitioners who are covering on a short-term basis in an urgent situation (~~e.g.~~e.g., covering for a practitioner who has an unexpected family or medical leave). Locum tenens status is limited to a cumulative lifetime total of three ~~months~~months' work anywhere in the ~~BHD~~BHS Provider Network. Practitioners who have exhausted their locum tenens eligibility by working more than three months may not practice in any capacity in the ~~BHD~~BHS Provider Network without first being credentialed. Verification of a valid Wisconsin professional license, a check for exclusions from state and federal programs and Wisconsin Caregiver background check must be completed prior to the practitioner seeing ~~BHD~~BHS Provider Network members regardless of service length.

- Physicians working at the Mental Health Emergency Center (MHEC) but they shall be required to complete a training module in order to receive BHS authorization to act on Milwaukee County's behalf as a Treatment Director designee. All BHS Crisis Service physicians transitioning to the MHEC shall be exempt from the training requirement.

Practitioners identified in any of the above categories are beyond the scope of the ~~BHD~~BHS Medical Staff and Provider Network Credentialing Program.

VII. STANDARDS OF PARTICIPATION: PRACTITIONERS

A. Minimum Professional Criteria for Acceptance

The ~~BHD~~BHS Medical Staff and Provider Network accept~~s~~ professional practitioners into its employ and/or network at its sole discretion based on the need for professional practitioners in certain specialties, geographic areas, or similar considerations.

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

B. Minimum Standards for Participation Include:

- Unrestricted (no limitations), current and valid professional licensure to practice in Wisconsin.

- Current and valid Federal DEA Registration for practitioners with the authority to write prescriptions, as applicable, for practice.

- Board certification in a recognized practice specialty. In lieu of Board Certification, the practitioner must have completed relevant pre- or post-graduate education (residency, fellowship, practicum, preceptorship, etc.) in his/her practicing specialty.

- Documentation of a collaboration or ~~supervision~~ physician direction and practice management arrangement, as applicable, for certified nurse practitioners, clinical nurse specialists, mid-wives and physician assistants with a participating physician credentialed through the BHS Medical Staff and Provider Network Credentialing Program ~~by the BHD Provider Network~~

- Acceptable, current and valid malpractice insurance in the amount $1 Million per incident and $3 Million per aggregate per year or as otherwise required by State Statute and/or Milwaukee County Risk Management and/or be an employee of BHS/Milwaukee County and covered for malpractice under Milwaukee County's self-insurance program.

- Absence of a history of denial or cancellation of professional liability insurance and has had no or minimal involvement in malpractice suits, arbitration or settlements and evidence shows that the history does not suggest any ongoing substandard professional competence or conduct.

- Absence of active disabling health problems including, but not limited to substance use disorders, which might adversely affect judgment or competence, so as to substantially impede the professional practitioner's ability to perform the essential functions of his/her practice/profession with reasonable skill and safety.

- Absence of a history of disciplinary action resulting in suspension, repeal, or limitation by a licensing board, professional society, hospital, health care organization, managed care organization, governmental health care program; or evidence that this history does not suggest any ongoing substandard professional competence or conduct.

- Absence of a history of criminal/felony convictions or indictments or evidence that this history does not suggest an effect on current professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.

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

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

C. Clean Application Criteria

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

Initial Credentialing:

- No history of corrective action (hospital/licensing board)

- Criminal Background Check reveals no felony convictions or criminal charges pending; and/or if history of non-felony conviction(s), matter is > than 7 years ago AND unrelated to Caregiver Law Offences AND judged by the Credentialing Committee Chair (or Medical Director designee) to have no bearing on current professional abilities or responsibilities

- No history of Operating While Intoxicated/Driving Under the Influence (OWI/DUI--alcohol or drug) offenses

- No malpractice history or minimal involvement, which is defined as not more than two (2) claim dismissals and/or not more than two (2) settlements/payments of $30,000 or less and/or no more than one (1) open claim pending and/or matter(s) is older than 20 years

- All services practitioner is requesting to provide to members are ~~appropriate~~ within scope ofto his/her specialty training

Recredentialing:

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

- Criminal Background Check reveals no new non-Caregiver or other criminal (felony or misdemeanor) law offenses since last credentialed;

- First and only OWI/DUI > 7 years ago and no current cause for concern is shown following assessment of current statement by applicant and the specific event circumstances, as judged by Committee Chair (or Medical Director designee)

- Minimal or no malpractice claims history changes since last credentialed (no new claims and/or prior history of no more than 2 settlements/payments and/or no more than one open claim and/or matters are older than 20 years

- All services practitioner is requesting to provide to members are ~~appropriate~~ within scope ofto his/her specialty training

- No patterns or trends of member complaints/grievances or practice concerns

D. Automatic Exclusion Criteria:

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

- Individuals or entities, which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has been convicted of any of the following crimes:

    1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);

    2. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);

    3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary duty;

- Practitioners who appear on the Office of Inspector General list of excluded individuals and entities report (OIG-LEIE)
- Practitioners who appear on any State exclusions list
- Practitioners who have a suspended, revoked or terminated license to practice
- Practitioners who have a suspended, revoked or terminated drug enforcement administration registration
- Wisconsin Caregiver Law required exclusions
- Any other automatic exclusion required by law or regulation

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

E. Quality of Practice Criteria:

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

F. Business Administrative Criteria:

The decision to employ a Medical Staff physician or allied health practitioner is made by BHS Medical Staff Leadership, in consultation with Service and Program Administrators. Considerations for making such a decision include:

- the need for additional or specific specialty care practitioners,

- willingness of the practitioner to abide by BHS and BHS Medical Staff policies and procedures and willingness to execute an Employment Agreement and abide by the terms of such agreement,
- willingness to comply with all credentialing requirements and/or
- statutory, regulatory or related changes or requirements

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

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

VIII. INITIAL CREDENTIALING: PRACTITIONERS

A. Process and Requirements:

Initial credentialing is performed on all practitioners *(except those specifically excluded under Section VII.B)* who are (a) beginning an employment or contract relationship with BHS as Medical Staff or beginning a relationship with the ~~BHD~~BHS Provider Network or (b) have an existing relationship at the time that this plan is adopted but have not previously been required to complete the credentialing process; and (c) are practitioners who meet the minimum requirements to apply for BHS Medical Staff participation or participation with the ~~BHD~~BHS Provider Network, as outlined in Section VIII.

Medical Staff that have an existing appointment on the BHS Medical Staff Organization at the time of the September 30, 2022 hospital closure that have a continuing employment or contractual arrangement with BHS, after that date, shall have their Medical Staff Organization credentialing approval transferred to the BHS Medical Staff and Provider Network Credentialing Program and shall not be required to complete credentialing under this program until their current recredentialing date comes due.

The ~~BHD~~BHS Medical Staff and Provider Network credentials all physician, advanced practice nurses, physician assistants and licensed psychologist practitioners prior to being admitted to the Medical Staff and/or into the ~~BHD~~BHS Provider Network. The intent of the process is to validate and/or confirm credentials related to a prospective employee or participating practitioner by contacting the primary source of the issuing credential directly. All attestations and verification time limits, applicable in this Credentialing Program and referenced in this document, shall not exceed 180 or 365 calendar days, as applicable, of the Committee Decision or in the matter of applications deemed as clean, the decision of the Medical Director when Committee review is not required. If the signature attestation exceeds 365 days at the time of ~~limit before~~ the credentialing decision, the practitioner must attest that the information on the application remains correct and complete but is not required to complete another application.

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

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

  Each practitioner applying for participation shall attest to the following:

  1. Reasons for inability to perform the essential functions of the position, with or without accommodation
  2. Lack of present illegal drug use
  3. History of restriction or loss of license
  4. History of criminal conviction(s)
  5. History of loss or limitation of privileges or disciplinary actions
  6. Current malpractice insurance coverage
  7. The correctness and completeness of the application

- Copy of the unrestricted (no limitations), current and valid Wisconsin license for the participating practitioner

- Copy of the current and valid DEA Registration, if applicable

- Copy of the medical malpractice policy face sheet~~,~~ and ~~or~~ completed liability information section on the application inclusive of policy number, effective dates of coverage, and coverage amounts *(provision of policy facesheet not applicable for BHS Medical Staff employee applicants that will be covered under Milwaukee County's self-insurance program)*

- Copy of the Board certificate or highest level of education in specialty for which practitioner is seeking participation status on the BHS Medical Staff and/or in the ~~BHD~~BHS Provider Network

- Copy of the current Curriculum Vitae (CV) or detailed work history which must include month/year. All gaps or interruptions in work history of greater than 30 days must be explained. CV or work history must cover not less than the previous five years.

- Completed Wisconsin Caregiver Background Information Disclosure (BID) form

- Name and contact information for at least two (2) professional references with whom practitioner has worked within the last 24 months and have knowledge of applicant's current medical/clinical abilities, one (1) of whom must be a professional peer

- Practitioner written explanation to any "yes" response to disclosure questions that reveal an adverse action or require special consideration including, but not limited to:

  1) Any limitation in ability to perform the functions of the position, with or without accommodation;

  2) History of restriction or loss of license;

3) History of any misdemeanor and/or felony convictions;

4) History of any abuse of controlled substances or alcohol, including non-criminal first offense OWI/DUI;

5) History of loss or limitation of privileges, memberships or disciplinary activity;

6) Any malpractice history, either reported or non-reported to the NPDB or other regulatory bodies.

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

B. Primary Source Verification:

The ~~BHD~~BHS ~~Provider Network~~ credentialing staff shall conduct primary source verification (PSV) as required by the most current and applicable CMS, NCQA, and any other ~~BHD~~BHS Medical Staff and/or Provider Network adopted guidelines. The ~~BHD~~BHS Credentialing Program ~~Provider Network~~ accepts letters, telephone calls, faxes, computer printouts, and/or online viewing of information as acceptable sources of verification, with appropriate reference documentation (i.e., the name of the person who provided the verification, the date of the call and the verification source). The credentialing staff shall authenticate all required PSVs by signature/initials and date. The information must be accurate and current. If the verification is from a report, the date generated by the source when the information is retrieved shall be used but the individual who verifies the credential must also sign or initial the verification. Typed initials are acceptable when there is a unique electronic identifier on the checklist.

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

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

Table IX~~VIII~~-B:

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

	For non-doctors of medicine and osteopathy. • The state licensing agency may be ~~used, if~~used if it performs primary source verification. – The organization must: ▪ Obtain and maintain on file a letter or printed and~~,~~ dated screenshot of the state licensing agency website displaying the statement that it performs primary source verification of education and training information for the specific practitioner type (must be obtained annually), ***or*** ▪ Obtain and maintain evidence of the applicable state statute for the practitioner type requiring the licensing agency, to obtain verification of education and training directly from the learning institution. Psychologists - graduation from professional school (PhD, PsyD, EdD) ○ Professional School Post-doctoral Fellowship ○ Professional Training Institution Advanced Practice Nurses ○ Professional School (~~Masters~~Master's Program) Physician Assistants ○ Professional School **Approved Equivalent to Primary Source** ○ National Register of Health Service Psychologists ○ AMA Profile Master File (Physician Assistants) ○ State Licensing agency, if above conditions are met ○ National Student Clearinghouse
Credential: Board Certification ○ **Verification Time Limit: 180 calendar days*** Physicians (MD/DO): not required but must be verified if practitioner lists it on the application. If practitioner is board certified, verifying board certification fully meets standards for education and training. Advanced Practice Nurses: required and must be verified to confirm specialty. Psychologists: not required Physician Assistants: not required but should be verified if practitioner lists it on the application. Document expiration date, lifetime certification or remains current contingent on maintenance of certification (MOC) and is current at time of verification. Copy of verification must be signed/initialed and dated by verifier (electronic signature/date is acceptable provided authentication contains a unique identifier/validation mechanism)	Physician (MD, DO) board certification: ○ American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided. ○ American Board of Osteopathic Medicine Profiles Advanced Practice Nurse board certification ○ American Nurses Credentialing Center (ANCC) ○ American Academy of Nurse Practitioners (AANP) Psychologists (PhD, PsyD, EdD): ○ American Board of Professional Psychology (ABPP) Physician Assistants ○ The National Commission on Certification of Physician Assistants (NCCPA) **Approved Equivalent to Primary Source** ○ AMA Physician Master File. ○ AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. ○ National Register of Health Service Psychologists Please refer to the applicable CMS, DHS, &/or NCQA standards required for other practitioner types.

Credential: State and Federal Sanctions and Exclusions **Medicaid and Medicare Sanctions** **Restrictions on Licensure** **Limitations on scope of practice** **Exclusions and limitations related to fraud and abuse and Opt In/Opt Out status** ○ **Verification Time Limits: 180 calendar days*** The OIG and the Opt In/Opt Out listing must be queried for sanctions and limitations prior to presenting a practitioner to the Committee for review. Copy of verification must be signed/initialed and dated by verifier (electronic signature/date is acceptable provided authentication contains a unique identifier/validation mechanism).	**Sources for Licensure Sanctions:** Physicians: ○ Appropriate state agencies ○ Federation of State Medical Boards (FSMB) ○ National Practitioner Databank (NPDB) Non-physician behavioral healthcare professionals: ○ Appropriate state agency ○ NPDB ○ State licensure or certification board **Sources for Medicare/Medicaid Sanctions** ○ AMA Physician Master File entry ○ FSMB ○ List of Excluded Individuals and Entities (maintained by OIG; OIG-LEIE), available over the Internet – *must be queried for all practitioners regardless of other sources that may additionally be used* ○ Government Services Administration/System for Award Management (GSA/SAM) ○ Medicare and Medicaid Sanctions and Reinstatement Report, distributed to federally contracting organizations ○ NPDB ○ State Medicaid agency or intermediary and the Medicare intermediary ○ Trailblazers.com – Opt In/Opt Out Website Please refer to the applicable CMS, DHS, NCQA, standards required for non-doctors of medicine and osteopathy.
Credential: Malpractice Insurance ○ **Verification Time Limit: 180 calendar days*** The Provider Network must obtain confirmation of the past five year history of malpractice settlements; the five-year period may include residency or fellowship years; however, confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship does not need to be obtained. Copy of verification must be signed/initialed and dated by verifier (electronic signature/date is acceptable provided authentication contains a unique identifier/validation mechanism)	○ National Practitioner Data Bank ○ Malpractice Carrier
Credential: Work History ○ **Verification Time Limit: ~~180~~365 calendar days*** NCQA does not require primary-source verification of work history; the organization must obtain a minimum of five years of relevant work history through the practitioner's application or CV; relevant experience includes work as a healthcare professional; if the practitioner has practiced fewer than five years from the date of verification of work history, it starts at the time of initial licensure; experience practicing as a non-physician health professional (e.g., registered nurse, nurse practitioner, clinical social worker) within the five years should be included. A gap exceeding 30 days must be reviewed and clarified either verbally or in writing; a CV or application must include the beginning and ending month and year for each position in the practitioner's employment experience; verbal communication must be appropriately documented in	○ CV and/or Completed Work History section on application ○ Documented visual verification of above for gap analysis

the credentialing file; a gap in work history that exceeds 30 days must be explained in writing. Copy of verification must be signed/initialed and dated by verifier (electronic signature/date is acceptable provided authentication contains a unique identifier/validation mechanism)	
Credential: Professional Peer Reference ○ **Verification Time Limit: 180 calendar days***	○ Written documentation obtained directly from peer(s) (mail, email, phone, fax receipt). References must have worked with applicant within the last 24 months and be able to attest that they have directly observed or have other current knowledge of applicant's medical/ clinical abilities.

* The 180 day or 365 days ~~begins calculating on the date of the practitioner's attestation, or the first signed PSV, whichever is first. The end of the~~ calculation periods ~~is~~are based on the date of the ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee decision or Medical Director Chair action on Committee's behalf, when permissible.

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

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

C. Provider Network Practitioner Office Site Quality:

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

The site evaluation includes but is not limited to:

- Practitioner information (~~i.e.~~i.e., licenses/certifications, background checks, etc.)
- Office policies/general information
- Physical plant/physical accessibility
- Scheduling/appointments availability
- Availability of emergency equipment (as applicable)
- Medication storage policies and procedures
- Medical record keeping format including forms, practices and procedures

- Access/on-call coverage policies and procedures

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

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

~~I~~X. RECREDENTIALING: PRACTITIONERS

A. Process and Requirements:

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

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

The recredentialing cycle time frame may be extended beyond 36 months, if the practitioner is:

- On active military assignment
- On medical leave (e.g., maternity leave)
- On sabbatical

The specific circumstance for extending beyond 36 months (or lesser period, when applicable) shall be documented in the credentialing file, and the practitioner shall then be recredentialed within 60 calendar days of the practitioner's return to practice.

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

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

- State licenses (unrestricted, current and valid)

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

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

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

- Member grievances/complaints
- Member and Practitioner/Provider satisfaction surveys
- Utilization Management
- Risk Management
- Focused and/or ongoing professional practice evaluation activities
- Quality improvement activities, performance quality measures, quality deficiencies, and/or trending patterns
- Site Assessment (network participants)
- Medical Record Keeping Practices/Treatment Assessments

C. Re/Credentialing Decision:

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

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

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

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

XI. TERMINATION, RESTRICTION OR SUSPENSION

A. Termination by Credentialing Committee

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

1. A determination, based upon failure to meet and/or maintain one or more of the ~~BHD~~BHS Medical Staff and Provider Network Professional Criteria for Acceptance or any other information available to the Credentialing Committee, that the practitioner has not adequately demonstrated that he or she would provide safe, high-quality care to all ~~BHD~~BHS clients and/or Provider Network members.

2. The practitioner has engaged in uncooperative, unprofessional, or abusive behavior towards one or more ~~BHD~~BHS Medical Staff, Credentialing Staff, Provider Network/Contract Management Staff~~members~~, ~~BHD~~other BHS employees, Provider Network employees, BHS clients or network members, or members of the Credentials Committee, Medical Executive Committee or Mental Health Board.

B. Termination by ~~BHD~~BHS Medical Staff and Provider Network Credentialing Staff

Notwithstanding any provision in this Credentialing Program, BHS leadership and the ~~BHD~~BHS Provider Network Management~~Credentialing Staff~~ may terminate the participation status of any practitioner, in accordance with terms of an Employment Agreement, Civil Service Rule violations, professional service agreement and/or the ~~BHD~~BHS Provider Network contract. The ~~BHD~~BHS Medical Staff and Provider Network Credentialing staff may terminate the credentialing process for a practitioner who has not returned required credentialing information that is necessary to process their application for participation. Credentialing staff may administratively terminate a practitioner who has not returned required recredentialing information that is necessary to process their application for continued participation.

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

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

C. Immediate Restriction, Suspension or Termination

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

XII. PRACTITIONER RIGHTS AND RESPONSIBILITIES

A. To Correct Erroneous Information

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

Upon notification of discrepancy, the applicant shall have 30 calendar days for an initial credentialing application and ten (10) business days for a recredentialing application to correct erroneous information submitted by other parties and/or to correct his/her own information or the processing of his/her application ~~shall~~ may be terminated.

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

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

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

B. To Review Information

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

C. To Be Informed Of Application Status

The ~~BHD~~BHS Medical Staff and Provider Network's policy is to notify a practitioner of his/her application status upon request. The process allows for phone calls, emails, letters, or faxes from practitioners. If the credentialing staff receives a ~~request~~request, it shall be responded to within ~~five (5)~~ seven (7) business days of receipt.

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

- The date the application was received
- The status of the application – pending for additional information, etc.
- The date the application is tentatively scheduled to be presented to the Committee/Chair
- Answer any questions the practitioner may ask
- Prior to disclosing any confidential practitioner information via phone, the following must be verified by the Credentialing staff and confirmed by the practitioner:
    - Practitioner's full name

- Practitioner's primary office location
- Practitioner date of birth or last 4 digits of social security number (SSN)

D. To Be Notified Of His/Her Rights

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

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

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

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

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

- Any and all voluntary or involuntary terminations of Medical Staff/professional membership or employment or voluntary or involuntary limitations, reductions, or losses of clinical privileges at any facility.

- The circumstances surrounding any and all involvements in professional liability actions, including notice of injury, claim or intent to file and all final judgments, settlements, or dismissals, even if not resulting in monetary damages.

- Any arrest, indictment, pending charges or conviction to a felony, a serious or gross misdemeanor, any crime or municipal violation involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol.

- Any and all notices of reprimand, censure, exclusion, sanction, suspension, or disqualification by Medicare, Medicaid, CLIA or other health care program or any notice of investigation that could lead to such an action.

- Any other change in status of information maintained in the credentials file, including, but not limited to, change in name, practice address, contact information, Board certification attainment or lapse, provider enrollment certification, etc.

XIII. CREDENTIALING FILE CONFIDENTIALITY AND RETENTION

Medical Staff credentialing files shall be retained for not less than ten (10) years from date of separation from BHS. Credentialing files shall be retained for not less than seven (7) years from date of practitioner separation from the ~~BHD~~BHS Provider Network.

Credentialing files are considered protected and confidential. Electronic files shall be password protected or otherwise restricted to allow access by only staff directly involved in ~~BHD~~BHS Medical Staff/Provider Network credentialing processes and decisions. File cabinets containing practitioner files shall be locked and/or secured after normal business hours within a locked room. Offices containing practitioner credentialing files shall be secured, as practical or business appropriate, after normal business hours. If files are archived and shipped to an offsite secure file retention company, there shall be a file destruction date set to ten (10) years post-Separation from BHS or seven (7) years post-separation from the Provider Network. A list of these files shall be maintained for reference and secured by employee password. Electronic files shall be backed up regularly.

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

XIIIV. REINSTATEMENT

If a practitioner is credentialed and leaves the BHS Medical Staff and/or network voluntarily or in such a way that the ~~BHD~~BHS Medical Staff/Provider Network has not terminated the practitioner for quality issues or any other adverse or egregious event, she/he may return to BHS employ and/or re-enter the network within thirty (30) calendar days. S/he must submit a written explanation to include activities during the ~~absence, and~~absence and complete a recredentialing application. The practitioner will not have to go through the primary source verification process if all documents remained unrestricted, current and valid during the absence period. The Committee Chairperson and/or the Credentialing Committee retain the authority to approve or disapprove absences, on a case-by-case basis, regardless of the time frame absent from BHS and/or the network.

XIV. ONGOING MONITORING

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

A. Collecting and Reviewing Medicare and Medicaid Sanctions

The ~~BHD~~BHS Medical Staff and Provider Network Credentialing Staff will review sanction information within 30 calendar days of being posted on the OIG Report Website.

B. Collecting and Reviewing Sanctions or Limitations on Licensure:

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

C. Collecting and Reviewing Grievances/Complaints:

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

D. Collecting and Reviewing Information from Identified Adverse Events:

The BHS Sentinel Event Committee reviews all reported adverse events. Matters involving Medical Staff shall be referred for peer review and corrective actions and/or interventions shall be implemented based on its policies and procedures when instance(s) of poor quality is identified. Peer Review shall make referral to the Credentialing Committee, when recommendation is made to restrict, suspend or terminate Medical Staff participation.

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

XVI. NONDISCRIMINATORY PRACTICES

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

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

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

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

This prohibition does not preclude the ~~BHD~~BHS Medical Staff and/or Provider Network from refusing to grant participation to a practitioner if there is no Medical Staff or network need.

XVII. CREDENTIALING APPEAL REVIEW PROCESS

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

(1) a participating practitioner's status with BHS and/or within the network or
(2) any action by the Medical Staff and/or Provider Network related to a practitioner's professional competency or conduct.

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

A. Business or Administrative

- Not related to the practitioner's competence or professional conduct

B. Competence and/or Professional Conduct – Quality Related

- As it affects or may affect the health and welfare of a client or member
- Occurrences of this type, for physicians and non-physicians, may be reported to the National Practitioner Data Bank, the Department of Safety and Professional Services, American Medical Association, American Osteopathic Association, Office of Inspector General, ~~and/or~~ Department of Health and Human Services, and/or other Professional Associations and Organizations.

The Committee shall review all available information and notify each practitioner via certified mail of the decision to decline, suspend, reduce or terminate Medical Staff and/or network participation. In the event of an adverse event and prior to termination, a range of actions to improve performance may be provided to the practitioner (i.e., restrict a practitioner to perform specific duties, require oversight by

another participating practitioner, implement a focused performance improvement plan, periodic reviews of medical records, require continuing medical education course(s), require attendance at in-service(s), etc.). All practitioners adversely impacted shall receive instructions, in writing, on how to appeal a denied request for credentialing.

XVIII. DELEGATED CREDENTIALING

The ~~BHD~~BHS Medical Staff and Provider Network may opt to delegate credentialing responsibility and authority for designated group practices or entities where the following conditions are met:

- The group practice or entity agrees to provide to the ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee a copy of its Credentialing Program, including documentation of the professional criteria to be evaluated in the credentialing processes and mechanisms for their verification and review. The criteria and processes must be deemed equivalent to or exceed those established by the ~~BHD~~BHS Medical Staff and Provider Network.

- There is a written agreement that states the scope of delegated activities and delegate's accountabilities to the ~~BHD~~BHS Medical Staff and Provider Network.

- The group practice or entity agrees to provide the ~~BHD~~BHS Medical Staff and Provider Network with any modifications to its Credentialing Program.

- The group practice or entity agrees to cooperate with the ~~BHD~~BHS Medical Staff and Provider Network's requests to audit the Group's credentialing and/or recredentialing processes at least annually.

- The group practice or entity agrees to provide the ~~BHD~~BHS Medical Staff and Provider Network with timely updates concerning additions and terminations of its practitioners.

A list of group practices and other organizations or entities to which credentialing responsibility and authority have been delegated is maintained by the ~~BHD~~BHS Medical Staff and Provider Network's credentialing and quality staff.

X~~VIII~~X. DUAL CREDENTIALING AND CONTRACTING

A. Dually Credentialed:

The ~~BHD~~BHS Medical Staff and Provider Network grants dual credentialing to participating practitioners who can satisfactorily demonstrate the appropriate level of education and training in the specialties s/he wishes to practice. Appropriate education and training must be provided to the ~~BHD~~BHS Medical Staff/Provider Network, and if not, there must be satisfactory evidence, as determined by the ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee or Chair, of experience and hours of practice in the desired specialties. These types of practitioners are considered "dually credentialed" practitioners. For example: A psychiatrist who has completed a fellowship can act as a sub-specialist within that area, i.e., child psychiatry, geriatric psychiatry, forensic psychiatry.

B. Dually Contracted:

The ~~BHD~~BHS Medical Staff and Provider Network considers those practitioners contracted directly with BHS and/or the ~~BHD~~BHS Provider Network as a licensed independent practitioner and who simultaneously contracts with a provider organization or with more than one provider organization as "dually contracted" practitioners. Dually contracted practitioners shall not be required to complete separate credentialing applications for BHS and/or each provider/agency but must be authorized as a credentialed practitioner to provide services with BHS and/or each contracted provider/agency with which she or he is affiliated.

XIX. CREDENTIALING PROGRAM DESCRIPTION SIGNATURE PAGE

Effective Date: **August 2022~~1~~**

RECOMMENDED FOR APPROVAL BY THE PROVIDER NETWORK CREDENTIALING COMMITTEE ON ~~MAY~~ JULY 15~~20~~, 2022~~1~~

~~BHD~~BHS Provider Network Credentialing Committee (Chair) Date

APPROVED BY ~~BHD~~BHS MEDICAL STAFF LEADERSHIP ON JULY 15, 2022~~ADMINISTRATION~~

BHS Medical Executive Committee (Chair) Date

APPROVED BY BHS ADMINISTRATION

Community Access to Recovery Services Administrator Date

Children's Community Mental Health Services & Wraparound Milwaukee Administrator Date

~~BHD Chief Medical Officer~~ ~~Date~~

~~BHD~~BHS Administrator Date

APPROVED BY THE MENTAL HEALTH BOARD ON AUGUST 2~~6~~, 2022~~1~~

Milwaukee County Mental Health Board (Chair~~man~~) Date

Original Effective Date: **July 1, 2019**
Reviewed Date(s):
Revised Date(s): **May 20, 2021; July 15, 2022**

ADDENDA

ADDENDUM A: ~~BHD~~BHS Medical Staff and Provider Network Practitioner Credentialing/Recredentialing Appeals Process

ADDENDUM B: ~~BHD~~BHS Medical Staff and Provider Network Credentialing Structure and Governance

ADDENDUM C: BHS Medical Staff and Provider Network Credentialing Program High Level Credentialing Workflow

ADDENDUM A

~~BHD~~BHS MEDICAL STAFF AND PROVIDER NETWORK
PRACTITIONER CREDENTIALING/RECREDENTIALING APPEALS PROCESS

RIGHT TO APPEAL

If a determination is made by the ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee to deny or restrict a practitioner's participation request; or to suspend, restrict or revoke a participating practitioner's status, the practitioner is provided with a written explanation of the rationale for the Committee's decision and a description of the appeal rights available to him/her. The practitioner is afforded the opportunity to review the information submitted in support of their application except for any information that is protected by state peer review or other law.

During the time an individual's appeal for initial participation is being considered she/he may not provide care or treatment to ~~BHD~~BHS clients and/or Provider Network members. During the time an individual's appeal for continued participation is being considered she/he may provide care or treatment to ~~BHD~~BHS clients and/or Provider Network members, if there is reasonable belief that there is no significant potential for patient harm and his/her current credentialing approval period has not expired.

In addition to restrictive actions or denials imposed by the Credentialing Committee, any immediate restriction, suspension or termination of a practitioner's participating status by the ~~BHD~~BHS Chief Medical Officer, Medical Director or his/her physician designee which exceeds fourteen days shall include notification to the practitioner of his/her right to an appeal. A practitioner may not appeal such a decision if the restriction, suspension, or termination does not exceed fourteen days during which time an investigation is being conducted to determine the need for further action.

RECONSIDERATION PROCESS – FIRST LEVEL

If a practitioner's participation request has been denied or restricted or a participating practitioner's participation status has been restricted, suspended, revoked, or denied, the practitioner may request reconsideration of the determination to the **~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee**. A request for reconsideration must be submitted in writing within 30 days of the date of the notice of the challenged action. A request shall be considered submitted upon mailing (postmark, email, facsimile or by hand delivery with date/time of receipt noted). Failure to submit a written request for reconsideration within this 30-day period will be deemed a waiver of the practitioner's right to appeal. Such request for reconsideration must address the issues identified by the Credentialing Committee through the provision of additional information and copies of appropriate supporting documentation.

Upon receipt of a request for reconsideration, the Credentialing Committee shall review all new information, including the supporting documentation submitted by the practitioner, and then votes to overturn or uphold the original determination. The decision of the Credentialing Committee is communicated in writing to the practitioner within 14 days of the decision.

If the Credentialing Committee upholds its original decision, the practitioner must be given information concerning his/her right to a hearing and a summary of the rights in the hearing. This process is described below.

HEARING PROCESS – SECOND LEVEL APPEAL

Within 30 days of receipt of notification of the Credentialing Committee decision to uphold a practitioner's restriction, suspension, revocation, or termination, the practitioner has the right to request a hearing before an Appeals Committee. A request shall be considered submitted upon mailing (postmark, email, facsimile or by hand delivery with date/time of receipt noted). If a hearing is requested within the 30 days, the applicant must be given written notice setting forth the following:

1. Date, time and place of the hearing. The hearing date will not be less than thirty (30) days from the date the practitioner receives the hearing ~~notice, unless~~notice unless a shorter period is mutually agreed to by the parties.

2. A list of witnesses (if any) expected to testify at the hearing on behalf of the ~~BHD~~BHS Medical Staff and/or Provider Network.

3. The practitioner's right to representation by an attorney or other person of the applicant's choice.

4. The practitioner's right to have a record made of the proceedings.

5. The practitioner's right to call, examine, and cross-examine witnesses.

6. The practitioner's right to present evidence determined to be relevant by the hearing committee, regardless of its admissibility in a court of law.

7. The practitioner's right to submit a written statement at the close of the hearing.

8. That the practitioner's right to the hearing may be forfeited if the applicant fails, without good cause, to appear.

APPEALS COMMITTEE – SECOND LEVEL

An Appeals Committee shall be an ad hoc committee composed of not less than five (5) individuals jointly selected by the Chief Medical Officer or his/her Service or Program Medical Director designee, the Credentialing Committee Chair and the CARS or Wraparound Milwaukee Administrator, as applicable. One (1) member shall be a member of the ~~BHD~~BHS Executive Team and one member shall be a ~~BHD~~BHS Service, Program or Provider Network Medical Director. Other Appeals Committee members shall be professional peers of the affected practitioner. Members of the Appeals Committee, other than the required Executive Team member, may be network practitioners, ~~BHD~~BHS Wraparound Milwaukee or CARS Staff, ~~BHD~~BHS M~~hospital m~~edical S~~s~~taff or allied health practitioner~~professional~~ staff or may be out of network practitioners recommended by the Chief Medical Officer or a BHS Service, Program or Provider Network Medical Director.

After listening to and reviewing all evidence, the Appeals Committee shall meet and privately discuss the evidence presented for the purpose of making a final determination. The Appeals Committee may vote to uphold, reject, or modify the decision of the Credentialing Committee.

Decisions will be communicated to the Credentialing Committee who shall communicate, in writing, to the practitioner within 30 days of the decision. Such decisions are final.

In accordance with requirements under the HCQIA, the majority of the voting members on the appeals committee shall be professional peers of the affected practitioner.

EXCLUSIONS FROM APPEAL

Practitioners who meet the criteria below are not eligible for the credentialing appeals process:

1) A breach in the practitioner's Employment Agreement
2) A termination of employment or professional services agreement by Milwaukee County/BHS
~~1)~~3) A breach or termination in the practitioner's contract with the ~~BHD~~BHS Provider Network
~~2)~~4) A suspended, revoked or terminated professional license
~~3)~~5) A suspended, revoked or terminated Drug Enforcement Administration registration
~~4)~~6) Listed on the OIG Exclusions List
~~5)~~7) Listed on any State Exclusions List
~~6)~~8) Wisconsin Caregiver Law required exclusions
~~7)~~9) Any other automatic exclusion required by law or regulation
~~8)~~10) Failure to submit a complete and accurate credentialing or recredentialing application

PLEASE NOTE

- At all levels, the practitioner has the burden of establishing that s/he meets ~~BHD~~BHS Medical Staff and/or Provider Network's standards for participation.
- At all levels, the practitioner may submit additional written evidence to correct the record of erroneous information within thirty (30) calendar days of his or her intention to appeal.
- At the ~~BHD~~BHS Medical Staff's and/or Provider Network's discretion, all appeals filed after the 30-calendar day timeframe are at risk for not being accepted. Appeals received outside of the 30 calendar day timeframe for filing shall be reviewed on a case-by-case basis.
- The practitioner will have exhausted all appeal rights at the conclusion of the 2nd Level Appeal Hearing process.
- The recommendation of the Credentialing Committee Appeal's Panel shall be final.
- The ~~BHD~~BHS Medical Staff and Provider Network's Appeal process is modeled after the requirements in the Health Care Quality Improvement Committee Act of 1986. The practitioner has no procedural rights, other than those set forth herein or required by law.
- The ~~BHD~~BHS Medical Staff and Provider Network reserves the right to make the "final" decision (i.e., uphold or overturn) at all appeal, panel and/or hearing levels (i.e., 1st or 2nd), and no further appeal rights shall apply.

~~BHD~~BHS MEDICAL STAFF AND PROVIDER NETWORK – PRACTITIONER CREDENTIALING/RECREDENTIALING

CREDENTIALING DENIAL, RESTRICTION OR LIMITATION DECISION - APPEAL REQUEST FORM		
Practitioner's Name		
Practitioner's Specialty		
Practitioner's Address		
Practitioner's Phone #		Fax #:
Practitioner's E-Mail		
Credentialing Denial Reason		
Practitioner's Rebuttal / Comments	*If additional space is required, please attach using a separate sheet.*	

I am requesting the type of appeal checked below. I understand that I am not required to attend document only investigations.

Select 1 Option only	
❒ Level 1	• Committee Review and Appeal – Document Review/Investigation only
❒ Level 1	• Expanded Review – Meet with Committee and Appeal Document Review/Investigation
❒ Level 2	• Appeal Committee/Hearing (only applicable following Level 1 appeal and Committee restriction or denial decision was upheld)
	*Applicants are allowed one appeal under Level 1 and one appeal under Level 2 subject to timely request and conditions specified within the Appeals Process.

Practitioner's Signature:	**Date:**

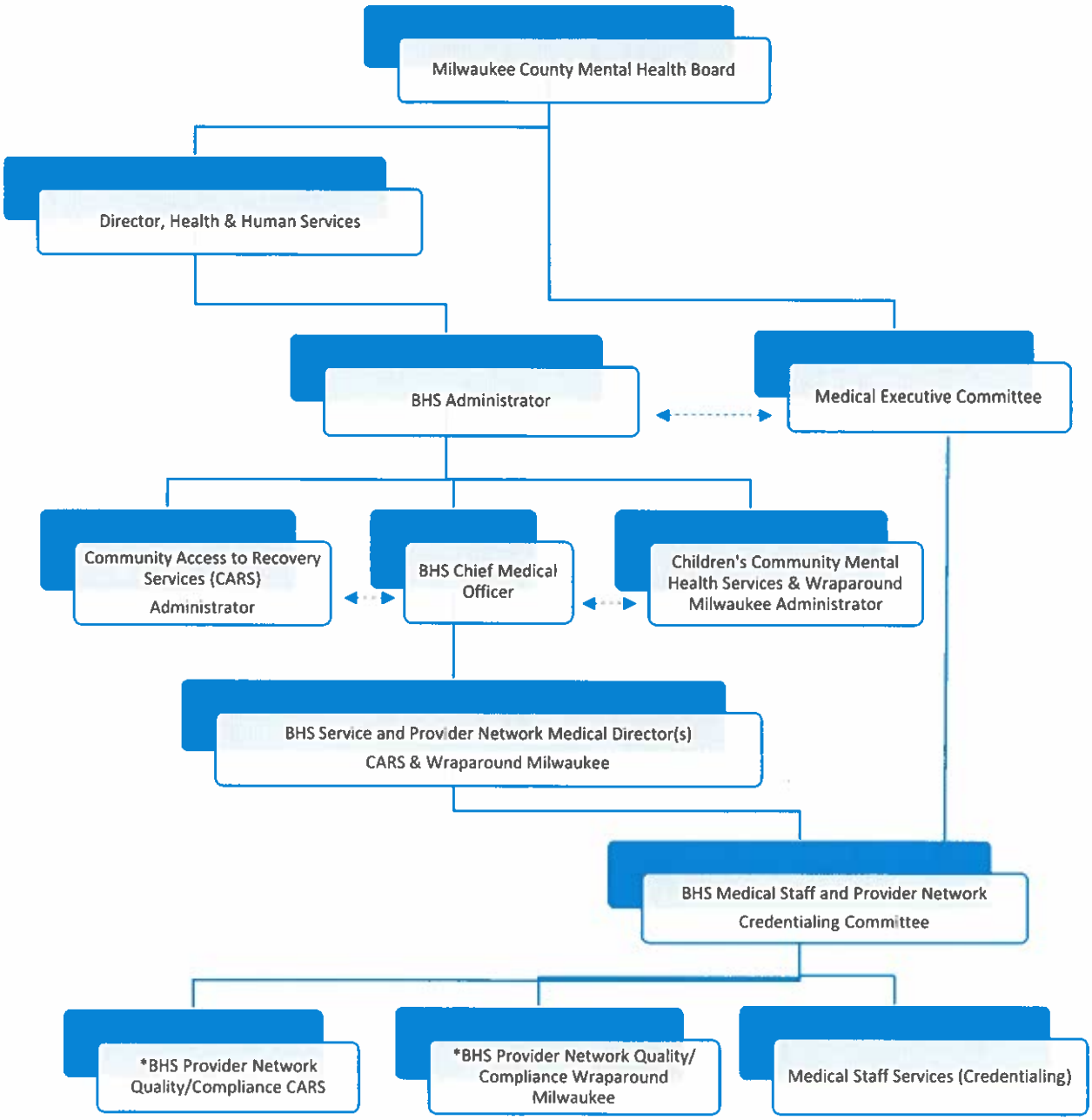
PLEAE NOTE: The Appeal Request Form must be completed, signed and dated by the practitioner who is filing the appeal in order to be considered valid. If there is supporting documentation, attach it to the Appeal Request Form.

RETURN TO: ~~BHD~~BHS Medical Staff and Provider Network Credentialing Committee
Attn: John H. Schneider, MD, FAPA, Chairperson
9455 W. Watertown Plank Road
Milwaukee, WI 53226

Or E-mail to: John.Schneider@milwaukeecountywi.gov

ADDENDUM B

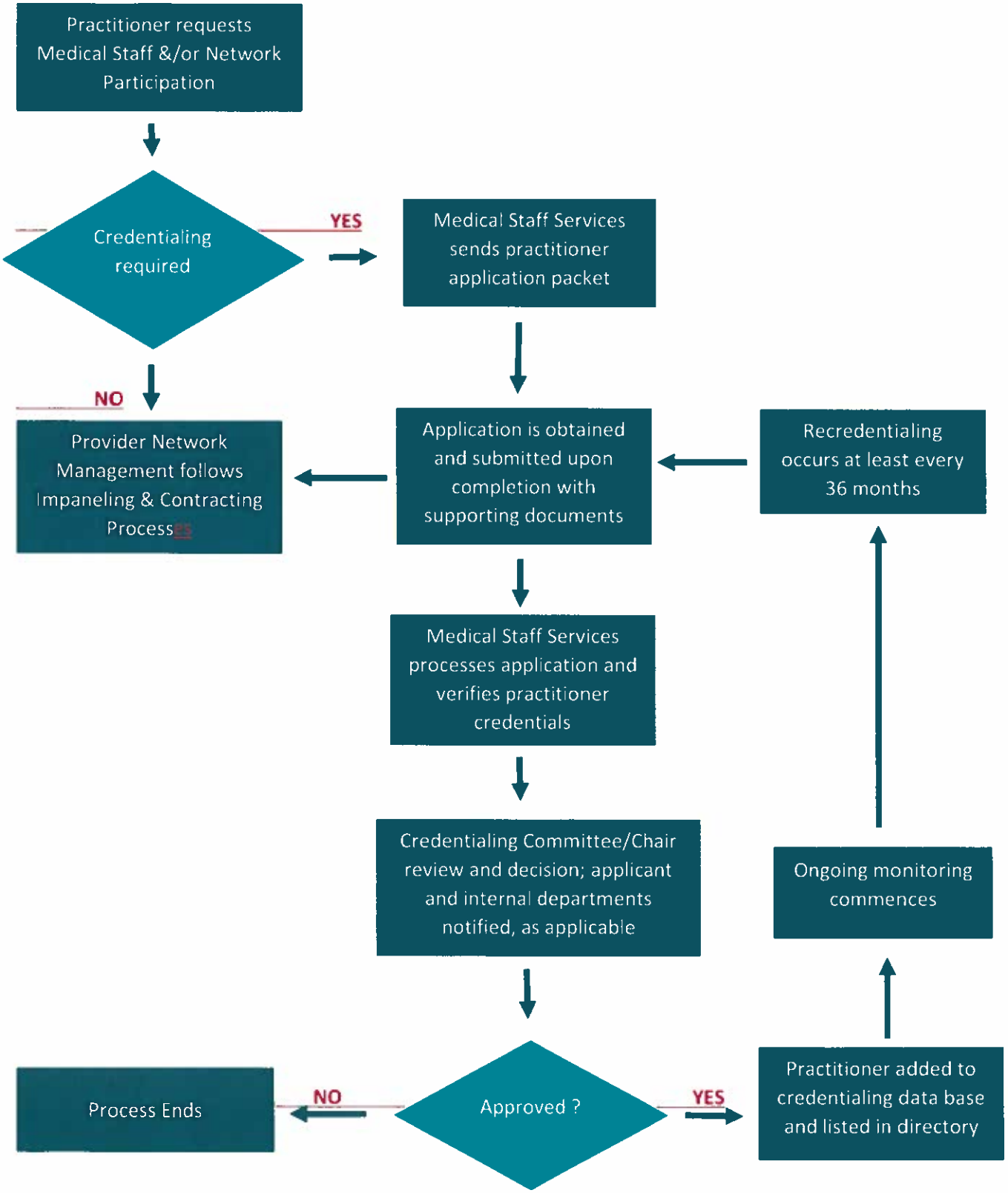
~~BHD~~BHS MEDICAL STAFF AND PROVIDER NETWORK CREDENTIALING PROGRAM ORGANIZATIONAL STRUCTURE AND GOVERNANCE



*This structure is specific to the credentialing approval and monitoring workflow only and is not intendend to depict the overall BHS organizational structure. ~~Quality Management functions, as they pertain to Provider Network practitioner matters~~

ADDENDUM C

BHS MEDICAL STAFF & PROVIDER NETWORK CREDENTIALING PROGRAM
HIGH LEVEL CREDENTIALING WORKFLOW



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

DATE: July 18, 2022

TO: Maria Perez, PhD, LCSW; Chairperson, Milwaukee County Mental Health Board

FROM: Shane V. Moisio, MD, President of the Medical Staff Organization
Prepared by Lora Dooley, Director of Medical Staff Services

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

Background

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

Discussion

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

A. New Appointments

B. Reappointments

C. Provisional Period Reviews, Amendments &/or Status Changes

D. Notations Reporting (to be presented in **CLOSED SESSION** in accordance with protections afforded under Wisconsin Statute 146.38)

Recommendation

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

Respectfully Submitted,

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

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

Attachment(s)
1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
JULY-AUGUST 2022

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

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 13, 2022	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 13, 2022	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Katie Cannon, MD *	General Psychiatry	Affiliate / Provisional		Dr. Zincke recommends appointment & privileges, as requested	Committee recommends 4-month appointment and privileges, as requested, subject to provisional period requirements.	Recommends appointment and privileging as per C&PR Committee.	
Paige Chardavoyne, MD *	Psychiatric Officer & Medical Officer	Affiliate / Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 4-month appointment and privileges, as requested, subject to provisional period requirements. *(activation of privileges subject to issuance on pending Wisconsin medical licensure application)*	Recommends appointment and privileging as per C&PR Committee. ***License issued on 7-14-22; verified on 7-15-22 / lmd***	
Dustin Hejdak, MD *	Psychiatric Officer & Medical Officer	Affiliate / Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 4-month appointment and privileges, as requested, subject to provisional period requirements.	Recommends appointment and privileging as per C&PR Committee.	
James Stevens, MD	General Psychiatry; Child Psychiatry	Active / Provisional		Dr. Moisio recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, as requested, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD.							

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 13, 2022	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 13, 2022	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Clarence Chou, MD *	General Psychiatry; Child Psychiatry	Active / Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 4 months.	Recommends reappointment and privileging as per C&PR Committee.	
Sara Coleman, PsyD	General Psychology	Associate / Full		Drs. Kuehl & Thrasher recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years.	Recommends reappointment and privileging as per C&PR Committee.	
Gunjan Khandpur, MD	General Psychiatry; Child Psychiatry	Active / Full		Dr. Moisio recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years.	Recommends reappointment and privileging as per C&PR Committee.	
Ahmed Numaan, MD *	General Psychiatry	Active / Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 4 months.	Recommends reappointment and privileging as per C&PR Committee.	
Elaine Sorem, MD *	General Psychiatry	Active / Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 4 months.	Recommends reappointment and privileging as per C&PR Committee.	

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 13, 2022	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 13, 2022	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Larry Sprung, MD *	General Psychiatry	Active / Full	M#	Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 4 months.	Recommends reappointment and privileging as per C&PR Committee.	
Tony Thrasher, DO	General Psychiatry	Active / Full		Dr. Schneider recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years.	Recommends reappointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
Yorbalica Martin-Thomas, MSN *	Advanced Practice Nurse-Family Practice	Allied Health Professional / Full		Dr. Puls recommends privileges, as requested	Committee recommends privileges, as requested, for 4 months.	Recommends privileging as per C&PR Committee.	
Maryan Torres, MSN	Advanced Practice Nurse-Psychiatric and Mental Health	Allied Health Professional / Full	CB	Dr. Moisio recommends privileges, as requested	Committee recommends privileges, as requested, for 6 months.	Recommends privileging as per C&PR Committee.	

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 13, 2022	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 13, 2022	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
The following applicants are completing the required six-month minimum provisional period, as required for all initial appointments and/or new privileges.							
MEDICAL STAFF							
NONE THIS PERIOD							
ALLIED HEALTH							
NONE THIS PERIOD.							

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	RECOMMENDED CHANGE	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 13, 2022	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 13, 2022	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Makenzie Hatfield-Kresch, MD *	Psychiatric Officer; Medical Officer / Affiliate	General Psychiatry / Affiliate	Dr. Thrasher recommends amending privileges, as requested	Committee recommends amending privileges, as requested, for the remainder of the current 2-year biennium subject to the required minimum provisional period.	Recommends amending privileging as per C&PR Committee.	

*The following medical staff are affected by the inpatient and crisis service closures and subject to lay-off by the end of 2022

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

7/13/2022
DATE

PRESIDENT, MEDICAL STAFF ORGANIZATION
CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

7/15/22
DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

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

GOVERNING BOARD CHAIRPERSON

DATE

BOARD ACTION DATE: AUGUST 25, 2022

Chairwoman: Dr. Maria Perez
Vice-Chairperson: Mary Neubauer
Secretary: Kathie Eilers
Research Analyst: Kate Flynn Post, (414) 257-7473
Board Liaison: Jodi Mapp, (414) 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD
EXECUTIVE COMMITTEE

Thursday, August 11, 2022 - 1:30 P.M.
Microsoft Teams Meeting

A G E N D A

SCHEDULED ITEMS:

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

1.	Welcome. **(Chairwoman Perez)**
2.	Discussion on the Functionality and Roles of the Executive and Governance Committees. **(Chairwoman Perez - Verbal Report/Recommendation Item)**
3.	Mental Health Board Member Selection Process. **(Vice-Chairwoman Neubauer/Informational)**
4.	Adjournment.

To Access the Meeting, Use the Link Below:

Click here to join the meeting

or call

(414) 436-3530

Phone Conference ID: 792 173 191#

The next meeting for the
Milwaukee County Mental Health Board Executive Committee
Will be Held at the Call of the Chair

To View All Associated Meeting Materials,
Visit the Milwaukee County Legislative Information Center at:
Milwaukee County - Calendar (legistar.com)

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

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

Executive Committee Item 3

Subject: Mr. LaNelle D. Ramey

From: Neubauer, Mary <Mary.Neubauer@milwaukeecountywi.gov>
Sent: Wednesday, August 3, 2022 4:01 PM
To: Meyers, Mary Jo <MaryJo.Meyers@milwaukeecountywi.gov>; Crowley, David <David.Crowley@milwaukeecountywi.gov>
Subject: Mr. LaNelle D. Ramey

Hello Mary Jo,

Myself as Co-chair/Vice-Chairwoman, and members of Milwaukee Mental Health Task Force Steering Committe took the opportunity to review Mr. Ramey's resume online during our mothly meeting yesterday. As a group we were first surprised and then extremely concerned that there is no mention of consumer/family experience with Mental Illness or Substance Use or representing community mental health service providers.

These are requirements stated in ACT 203 for the individual filling this position on the Milwaukee County Mental Health Board. In addition the process was not followed by the County Exectuive in filling the position.

I realize there have been many inconsistencies as to filling vacated positions on the Milwaukee County Mental Health Board over the past seven years. I would like understand the qualifications of Mr. Ramey.

In addition I would like to work with the County Exectuive and his staff to get all MCMHB positions in alignment with Act 203. A consistent and equitable process contributes to a quality product which are the best selection of community members to serve on the MCMHB.

In service,

Mary Neubauer, MSW,CPS
Vice-Chairwoman

9. An individual who is a consumer or family member representing community-based mental health service providers and who is suggested by the Milwaukee County executive. The Milwaukee County executive shall solicit suggestions from organizations including the Milwaukee Health Care Partnership, the Milwaukee Mental Health Task Force, and the Milwaukee Co-occurring Competency Cadre for consumers and family members representing community-based mental health service providers.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 10, 2022

TO: Maria Perez, Chairwoman – Milwaukee County Mental Health Board

FROM: Michael Lappen, Administrator, Behavioral Health Services

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

Background

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

Discussion

Workforce Investment, Development, and Engagement

- **BHS Staff Promotions and Opportunities**

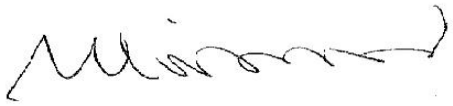
  There have been a large number of promotions and opportunities at BHS over the past few months. They include Matt Drymalski, Director Clinical Programs Quality Assurance; Beth Lohmann, Comprehensive Community Services (CCS) Administrator; Carla Kimber, Network Development Manager; and Jennifer Alfredson, Grants Manager.

  Future opportunities, either already posted or about to post, include Utilization Review/Utilization Management Manager, Safety/Risk/Infectious Control Registered Nurse, Integrated Services Coordinator (CCS), Integrated Services Coordinator (Individual Placement and Support), Integrated Services Manager (Alcohol and Other Drug Abuse), Integrated Services Manager - Opioid Program Leader, Opioid Project Manager, Monitoring and Evaluation (various positions), and the Senior Accountant Opioid Project.

Community and Partner Engagement

- **Kane Communications Update**

  See **Attachment A.**



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

Milwaukee County Behavioral Health Services

Communications Update

Mental Health Board Report / August 2022

Employee Engagement

BHS Newsletter

- The Q2/Summer Newsletter was distributed in June and featured a letter from Mike Lappen on information about the closure of PCS and upcoming job opportunities, an employee appreciation section sharing kudos of several BHS employees' hard work and successes, a program spotlight about the Youth Crisis Stabilization Facility and BHS' recent media coverage. The Q2 Newsletter analytics follow:
    - Distribution - 822
    - Open Rate - 8.6 %
    - Click Rate - 3.3 %
- BHS launched a new section in their quarterly Newsletter called "Employee Appreciation," in which they will highlight the fantastic work of their team. This section will be a standing part of the newsletter moving forward because it's so important to recognize the excellent work BHS employees do.
- It appears the emails sent from Constant Contact are going to BHS staff's spam folder. Kane has been working with IMSD to transition the distribution of the quarterly Newsletters to SendGrid so the emails will be sent from a county email account. IMSD also updated the list of all current BHS employees. The Q3/Fall Newsletter will be distributed at the end of September.

Town Hall Meetings

- April
    - Information was shared regarding updates from the Quality Department, COVID-19, the hospital closure and transition, Granite Hills Hospital, and the Mental Health Emergency Center.
- May
    - Information was shared regarding updates about COVID-19, Granite Hills Hospital, the Mental Health Emergency Center, the Milwaukee County Mental Health Clinic, the hospital closure and transition and current job openings.
- June
    - Information was shared regarding updates about the hospital closure and transition, BHS budget, COVID-19 and current job openings.
- July
    - Information was shared regarding employee kudos and appreciation, updates on the Opioid Settlement funding, the hospital closure and transition, COVID-19 and current job openings.

- August
    - The August Town Hall Meeting will be held on Thursday, August 18. Mike Lappen will share a PowerPoint presentation about the hospital closure, the Mental Health Redesign and next steps for employees.

PR / Community Relations

Social Media

- Kane drafted monthly suggested BHS social media posts for DHHS' Facebook and Twitter.

Alderman Stamper's Community Town Hall - May 19, 2022

- Kane coordinated and managed Ald. Stamper Community Town Hall event for the Milwaukee County Mental Health Clinic, including:
    - Communications and follow-ups with BHS and Ald. Stamper's teams
    - Drafted run of show, talking points, media alert and suggested social media posts, including developing an event flyer
    - Facilitated Zoom event
    - Recorded meeting and shared suggested social content following event

Wisconsin Health News Panel

- Kane coordinated panel discussion with Mike Lappen and Wisconsin Health News on what's next for mental health and examining the impact of COVID-19.

Opioid Settlement Fund

- Kane drafted talking points on the county's opioid settlement fund and how they plan to utilize the funds

Recruitment Efforts

- Kane drafted and is finalizing a press release and media pitch for BHS' recruitment efforts, highlighting the sign-on bonus, approved shift differentials, five percent pay increase and internship/fellowship program.
    - Kane is waiting on updates regarding final bonus amount
- Kane drafted a script and secured a radio spot with WUWM/NPR for recruitment ads highlighting the behavioral health emergency service clinicians positions.
    - Recruitment ads ran on May 25 and May 16
- Kane secured an interview with Mike Lappen and Lake Effect to discuss the available mental health resources and community-based services in our area and the opportunities individuals have by choosing a career with BHS.
    - Kane developed key messages and prepped Mike for Lake Effect interview
    - Mike's segment can be found here

Community Health & Healing Event

- Kane coordinated communications, location details, media alerts, social media posts, updates and next steps for the County Executive's Community Health & Healing event on May 3 at Reagan High School.

- Kane served as liaison between BHS and Reagan High School

Media Relations

- Kane coordinated interview opportunity with Mike Lappen and Eric Collins-Dyke for the Housing First Milwaukee Journal Sentinel story.
- Ongoing issues management support.
- Earned Media Coverage:

Wisconsin Public Radio	New Milwaukee County facility to provide emergency mental health care	April 1, 2022
Milwaukee Journal Sentinel	'Catalyst for change': Sen. Baldwin, County Exec Crowley sees promise in new Milwaukee County Mental Health Emergency Center	April 1, 2022
CBS 58 News	Sen. Baldwin tours new mental health facility in Milwaukee	April 1, 2022
Milwaukee BizTimes	Leaders tour new Mental Health Emergency Center in Milwaukee	April 1, 2022
Milwaukee Neighborhood News Service	Staffing search delays opening of Mental Health Emergency Center to September	April 4, 2022
Milwaukee Neighborhood News Service	Where to find substance abuse resources in Milwaukee	April 21, 2022
Spectrum News 1	A cheap piece of paper that can save a life is now legal in Wisconsin	April 28, 2022
Milwaukee Independent	Memorial bench unveiled at Red Arrow Park to honor Dontre Hamilton and support mental health	May 2, 2022
TMJ4	Candid conversations with those on the frontline to disrupt the cycle of gun violence	May 19, 2022

WISN	Department of Justice investigates Instagram's impact on young adults	May 30, 2022
Milwaukee Journal Sentinel	Milwaukee County is seeing a rise in its youth detention population. Will $7 million in pandemic funds reverse that trend?	June 10, 2022
Urban Milwaukee	Coggs Building Could Be Razed	June 14, 2022
Milwaukee Journal Sentinel	An anchor of the community, Milwaukee's Marcia P. Coggs Human Services Center could be demolished for a complete rebuild	June 17, 2022
Urban Milwaukee	Cost of Youth Offenders Keeps Rising	June 21, 2022
Milwaukee Journal Sentinel	988 will soon be the new number for the National Suicide Prevention Lifeline. Here's how the change helps Wisconsin.	June 27, 2022
WUWM 89.7 FM	Milwaukee County Behavioral Health Division makes mental health care accessible to all	August 3, 2022
Milwaukee Journal Sentinel	'A historic shift': Mental Health Emergency Center opening ushers in closure of the long-troubled Mental Health Complex	August 15, 2022
Fox6	Milwaukee County Mental Health Complex to close, transition services	August 15, 2022
BizTimes	Milwaukee County Mental Health Complex to shut down	August 15, 2022
CBS 58 News	Milwaukee County Mental Health Complex to close permanently Sept. 9	August 15, 2022

Mental Health Board Support

- Kane attended Mental Health Board and Community Engagement Committee meetings.
- Kane drafted a press release, website content and one page informational sheet for the Community Engagement Committee Stakeholder Advisory Council
    - Press release can be found here

BHS Redesign and Transition

- Kane drafted a comprehensive redesign communications plan and timeline and facilitated weekly touch base meetings with Mike Lappen and Jill Lintonen to review, update and approve content and deliverables.
- Kane drafted content including:
    - Key messages and talking points for managers about available job opportunities at BHS, Granite Hills and MHEC
    - Content for the new Mental Health Redesign and Past Present Future landing pages on the BHS website
    - Emails about the Mental Health Complex closure distributed to the following groups:
        - BHS employees
        - BHS providers
        - Mental health advocates/nonprofits/religious leaders
        - Law enforcement
        - Mental Health Board
        - County Courts
        - Health System Leaders
        - County Board
        - County employees
    - Key messages and talking points
    - Mental Health Redesign press release
    - Copy and design for Mental Health Redesign flyer
        - English, Spanish and Hmong
    - Copy for Mental Health Redesign fact sheet
        - English, Spanish and Hmong
    - Script for video
    - Timeline for BHS over the past 100 years
    - Additional emails on next steps for employees
    - Questions for spokespeople
    - Social media calendar and content
    - Interviewed FQHC leaders for social media videos (ongoing)
- Kane developed media contacts lists and pitched media about the Mental Health Redesign and next steps
    - These story pitches are ongoing through August and September and include local, community-based, and national media
- Community awareness advertising campaign about the closure of the Mental Health Complex behavioral health services available in the community to begin in late August

Mental Health Emergency Center
External Communications / Public Relations Efforts

- Senator Baldwin Tours MHEC - 4/1
    - Coordinated event with Sen. Baldwin's team, MHEC communications team and government relations leaders
    - Drafted and distributed media alert
        - Coordinated media attendance at event
    - Drafted and sent suggested social media content post event
    - Attended on-site event and coordinated media interviews
    - Reviewed, documented and shared media coverage with MHEC communications team
- Kane created collateral pieces for three audience groups
    - Law Enforcement
    - Providers
    - Consumer/Families
- Kane oversaw all aspects of open house events - August 16 and 17
    - Developed graphic both events (Special Invitation event/Community event)
    - Sent invitations for both events and managing RSVPs
    - Ordered all materials for day of including
        - Tent
        - Tables
        - Signage
        - Water/Face Makes
    - Developed talking points for tour guides
    - Developed media talking points
    - Distributed and followed up on media advisory
    - Developed run of show
- Law Enforcement training video
    - Developed script for event
    - Oversaw day of video production
    - Hired talent for video production/editing/voice over
    - Oversaw approval of draft
    - Provided final version for county law enforcement to use in roll call and training
- MHEC's part in the bigger BHS Redesign
    - Developed media advisory in conjunction with the grand opening of the facility in September

Internal Communications

- Kane developed necessary internal signage
    - Mask guidelines
    - Isolation precaution documents
    - Reviewed and updated privacy documents to match MHEC branding
        - Balance billing sheet

- EMTALA
- Right to an interpreter
- Notice of privacy policies

Website Updates/Management

- Kane updated website copy to reflect the "now open" status of the MHEC
- Kane updated website to adhere to ADA and Civil Rights Compliance expectations
- Kane oversaw migration of hosting responsibilities to Kane Communications Group

Milwaukee County

Department of Human Resources

INTER-OFFICE COMMUNICATION

Date: July 21, 2022

To: Maria Perez, Chairwoman, Milwaukee County Mental Health Board

From: Lisa Ruiz-Garcia, HR Manager, Department of Human Resources

Subject: Informational Report on Staff Impact of Hospital Transition to Granite Hills

Request

This informational report is being submitted in response to the Mental Health Board request for staff transition plans related to the closure of the Behavioral Health Hospital, impacting Milwaukee County inpatient mental health and emergency services.

Background

In 2022, the Behavioral Health Services (BHS) inpatient mental health services will transition to Granite Hills and the emergency services to the Joint Venture Mental Health Emergency Center (JVMHEC), which will impact BHS employees in these service areas.

Employees impacted by the transition of the BHS inpatient mental health services to Granite Hills and emergency services to the Joint Venture Mental Health Emergency Center have employment opportunities.

Internal Opportunities and Resources for Displaced BHS Hospital Employees

The Department of Human Resources (DHR) is committed to supporting BHS displaced employees. The BHS HR team continues to be available to assist BHS impacted employees on a one-on-one basis via phone, Teams and scheduling onsite meetings as requested, to answer employee questions and direct them to other necessary departments for assistance (Retirement Plan Services, Benefits, etc.). We have connected BHS leaders with other Milwaukee County department leaders to discuss employment opportunities and coordinate transfer dates to support employees and ensure incentives are not impacted.

The DHR hosted a Job and Resource Fair on July 19, 2022, from 1:00-4:00pm at BHS. Employees impacted by the hospital closure were invited to attend. Granite Hills and Advocate Aurora attended to discuss job opportunities and share the benefits and incentives offered at these facilities. Staff from Milwaukee County Retirement Plan Services, Benefits and Talent Acquisition/Recruitment were also in attendance to answer employee questions about the impact of the closure to their benefits. The event was well attended with over 30 employees, receiving positive feedback from employees, Granite Hills, Advocate Aurora and the DHR divisions present.

Milwaukee County

Department of Human Resources

INTER-OFFICE COMMUNICATION

In □une 2022, □□S □R □anager and t□e □R □anager of t□e □ □EC began meeting wee□ly to streamline t□e transition of □□S employees to □ □EC□ □R continues to s□are t□e contact information of t□e representatives at □ □EC and □ranite □ills to in□uire about career opportunities, benefits, and incentives□

□R also participates in t□e wee□ly □ospital closure meeting wit□ ot□er □□S leaders to ensure employees and leaders □ave a successful transition to ot□er employment, and closure of □□S □ospital□

□R assisted in implementing a second retention bonus to facilities staff given t□e critical nature of t□eir position to ensuring a successful closure of t□e □□S building□

□R coordinated efforts to review and revise t□e draft of t□e □□S Severance Agreement t□at is being considered to offer to eligible employees□

□R in partners□ip wit□ ot□er □ilwau□ee County department leaders, will wor□ to ensure transfers coincide wit□ closures to cause minimal disruption to □□S operations w□ile considering the needs of the employee's new department□

Granite Hills

□ranite □ills □as actively wor□ed to recruit □□S employees and attended t□e □ilwau□ee County □□S □ob and Resource □air on □uly 19, 2022, at □□S for impacted employees□

□ranite □ills □as reported □iring approximately eig□t □8□ to ten □10□□□S employees□ □□ey did not s□are t□e specific positions employees filled□ It is anticipated t□at as Granite Hills' census grows, the number of position vacancies will increase□

Advocate Aurora

Since last report, Advocate Aurora □ad two RN offers of employment rescinded□ □□erefore, t□e total number of □□S employees □ired to date are four □4□□e□avioral □ealt□ □ec□s and six □□□Registered Nurses□ Advocate Aurora continues to be committed to wor□ing closely wit□ □□S leaders□ip to ensure t□e stability of PCS staffing during t□e transition from PCS to t□e □ □EC, partnering on anticipated release dates in consideration of signed employee Retention □onus Agreements□

If you □ave any □uestions, please call Lisa Rui□ □arcia at 414□2□7□7489□

Milwaukee County

Department of Human Resources

INTER-OFFICE COMMUNICATION

SUMMARY

□ilwau□ee County is committed to providing support, guidance, and resources to impacted employees as t□ey loo□for new roles wit□in □ilwau□ee County as well as wit□ □ranite □ills and Advocate Aurora□□R will continue its efforts to ensure staff are informed of employment opportunities□

RECOMMENDATION

No recommendation, report for informational purposes only□

COUNTY OF MILWAUKEE
Behavioral Health Services Administration
Inter-Office Communication

Date: August 1, 2022

TO: Maria Perez, PhD, LCSW, Chairperson – Milwaukee County Mental Health Board
Mary Neubauer, Vice Chairperson – Milwaukee County Mental Health Board

FROM: Shakita LaGrant, Director, Department of Health and Human Services
Prepared by Dennis Buesing, Contracts Administrator, Management Services, Department of Health and Human Services

SUBJECT: **An Informational Report from Director, Depart of Health and Human Services, providing an update on achieving Racial Equity in contracting processes and related Race and Ethnicity surveys of BHS provider agencies by DHHS Contract Administration**

Issue

Many smaller BHS provider agencies face challenges participating in County contracting processes with access to capital, administrative capacity, and staff training. This can result in inadequate resources and knowledge gaps to complete administrative requirements in the BHS contracting process. These providers often encounter differences in the Request for Proposals (RFP) process or network application process moving from one provider network to other networks, or to other service areas with the Department.

Background

Whereas, as a governmental body, Milwaukee County recognizes its power to make change at a systemic level, on April 17, 2019, the Milwaukee County Board of Supervisors adopted File No. 20-173 which created Chapter 108, “Achieving Racial Equity and Health,” of the Milwaukee County Code of General Ordinances. BHS is in alignment with this ordinance as BHS leadership continues to focus on social determinants of health as well as racial and health equity through the work it does internally with its operations and externally, with its participants, contracted provider organizations, system, and community partners.

Discussion

Milwaukee County is ranked 70 of 72 in a composite of health indicators among Wisconsin counties. Milwaukee County has higher than the State average rates of infant mortality, sexually transmitted infections, cancer (breast, cervical, lung and prostate), violence, teen pregnancy, childhood lead poisoning, and mortality due to unintentional injuries.

Through DHHS research, stakeholders identified racism and a variety of disparities, including housing, employment, transportation, and healthcare, among others, as major barriers to health in Milwaukee County.

Racial Equity and contracting is one area identified by BHS leadership in which there is an opportunity to address structural barriers and advance equitable policies and practices. One of the major themes in the Department's strategic plan focuses on ensuring that our staff, contracted providers and agencies reflect the diversity of DHHS program participants, and that the ecosystem of nonprofit providers DHHS contracts with are supported in a manner in which they can prosper, be financially healthy, and deliver quality services. The availability of capacity-building services and assistance to local agencies, ensuring they have the knowledge and capabilities that reflect Milwaukee County values is a top priority in the DHHS *Strategic Plan*.

The primary goal of this report is to assess BHS's and DHHS's contract procurement strategy and develop additional tactics to address structural barriers to expand the BHS provider networks and ensure that its diversity is representative of those served by BHS. In response, DHHS/BHS established a collaborative Racial Equity in Contracting Workgroup to assess its institutional practices through a racial equity lens. Its goal is to develop BHS's and DHHS's capacity to improve its work with providers and institutional partners to ensure a consistent process that addresses their needs.

Part of this effort involved engaging a consultant, Kairo Communications, in an analysis off DHHS contracting and procurement policies and procedures which examined institutional practices that impact barriers to Racial and Health Equity in the contracting process. This work subsequently resulted in a related report from Kairo that identified specific recommendations and tactics to achieve greater racial equity in the department's contracting process. To that end, DHHS Contract Administration has increased outreach efforts and continues to streamline processes, reduce red tape and increase ease and efficiency for prospective applicants and proposers. It has reduced required RFP submission items by approximately 50% and continues to look for additional ways to reduce red tape and complexity. It has increased its outreach efforts to community providers and more than doubled the number of public informational sessions and media outlets in which it advertises.

In the fall of 2020, BHS and DHHS Contract Administration undertook a Request for Information (RFI) effort to establish base-line data on Racial and Ethnic provider participation in order to assess the current provider state with the goal of ensuring that contracted provider diversity is representative of those served by BHS. As a continuation of this effort, Contract Administration issued a similar survey in the fall of 2021. The results of the Request for Information (RFI) process are summarized in the tables below.

2021 BHS Agency Ownership Race/Ethnicity Data

2021 Payments to Minority Agencies

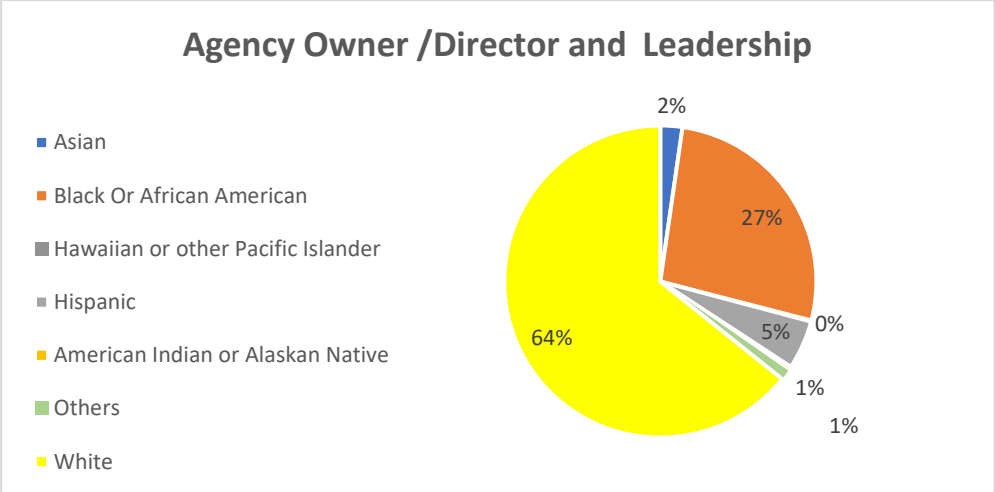
The first table below shows the amount and percentage of BHS contract payments that went to minority owned or led agencies. Of $142,189,945 in contract payments, $47,635,584, or 33.50%, went to minority led organizations.

BHS PAYMENTS		
Total payment	**Minority**	**Minority %**
$142,189,945	**$47,635,584**	**33.50%**

This second table, **Board of Directors/Agency Owners/Stockholders and Administrative Leadership** is broken out by Race, Ethnicity, Gender Identification and Disability. It shows that there are 877 leaders out of 2,454 that are of minority populations, which is roughly 36% of all leaders within organizations having BHS contracts. The pie chart further breaks out racial/ethnicity data indicating that African American leadership represents about 27% of all leaders, Hispanic leadership represents about 5%, and Asian represents about 2% of all leaders. All other minority races or ethnic groups comprise approximately 2%.

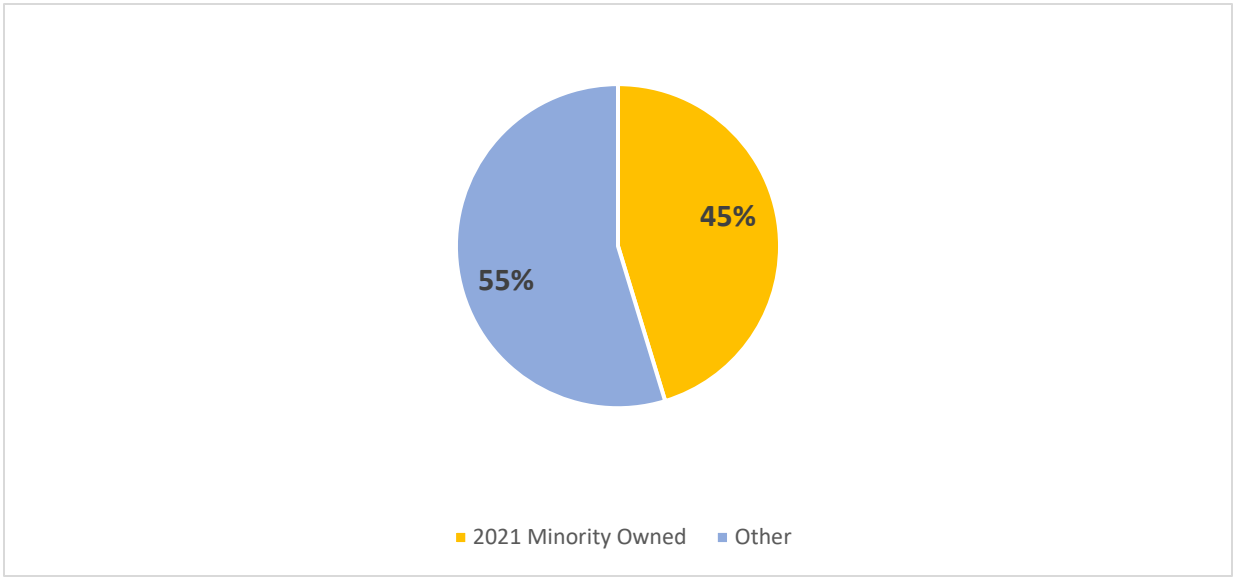
BOARD OF DIRECTORS/AGENCY OWNERS/STOCKHOLDERS AND ADMINISTRATIVE LEADERSHIP - DIRECTORS/ADMINISTRATORS DEMOGRAPHICS

Race/Ethnicity	Female	Male	Non-Binary	Disabled	Total
Asian	31	25	-	-	56
Black Or African American	414	242		6	656
Hawaiian or other Pacific Islander	3				3
Hispanic	78	47		-	125
American Indian or Alaskan Native	7	4		-	11
Others	17	8	1	2	26
White	1,064	506	7	8	1,577
Grand Total	**1,614**	**832**	**8**	**16**	**2,454**

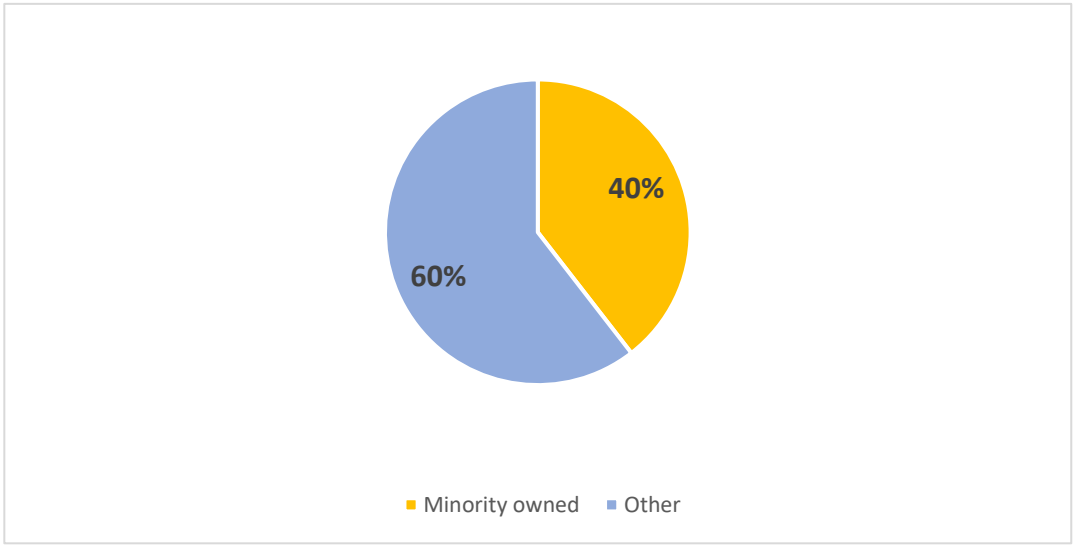


The below table, **2021 Data, # of Agencies**, shows that 170 agencies responded to the Request for Information. Of those 170 agencies, 77 are either minority owned, or minority led, which represents about 45% of BHS contracted agencies, which is represented as orange in the blue and orange pie chart (2021 Minority Owned) below the table. By contrast, 40% of contracted agencies were minority owned or led in 2020, i.e., a 5% increase in minority owned or led provider agencies.

2021 Data	# of Agencies
Minority Owned or Led	**77**
Other	**93**
Total	**170**



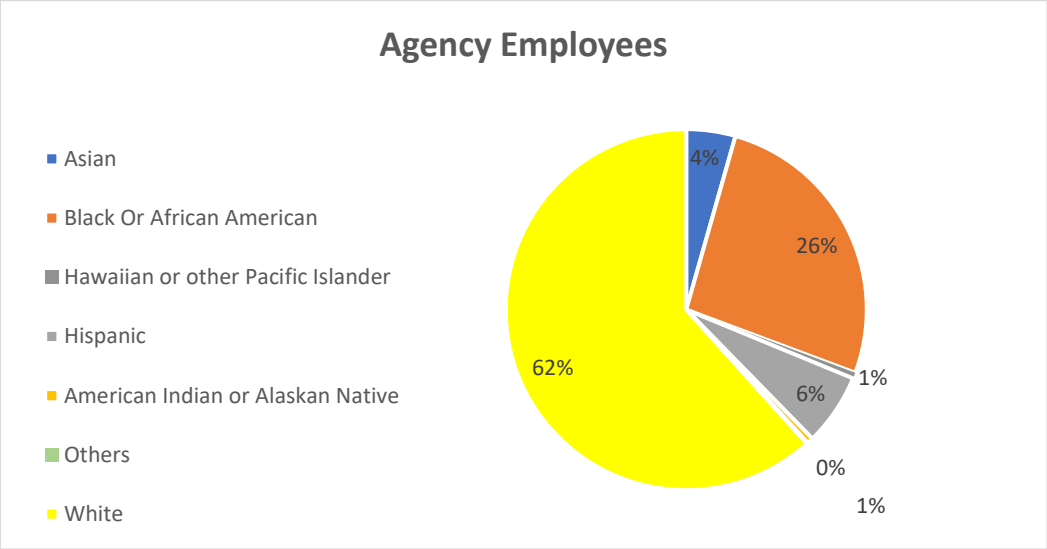
2020 Data	# of Agencies
Minority Owned or Led	64
Other	98
Total	162



The next table, **2021 AGENCY-WIDE EMPLOYEE DEMOGRAPHICS SUMMARY**, represents data on all employees at contracted agencies that responded to the Request for Information (RFI). This table shows that there are 7,294 provider employees that are of minority populations out of a total of 19,020 employees, which is roughly 38% of all agency staff. The pie chart further breaks out racial/ethnic data indicating that African American employees represent about 26% of all employees; Hispanic staff represents about 6%, and Asian represents about 4% of all agency employees. All other minority races or ethnic groups comprise approximately 2%.

2021 AGENCY-WIDE EMPLOYEE DEMOGRAPHICS SUMMARY

Race/Ethnicity	Female	Male	Non-Binary	Disabled	Total
Asian	573	263	1	9	837
Black Or African American	3,750	1,244	6	128	5,000
Hawaiian or other Pacific Islander	81	21		6	102
Hispanic	948	280		33	1,228
American Indian or Alaskan Native	76	29	-	5	105
Others	15	5	2	-	22
White	9,285	2,431	10	284	11,726
Grand Total	**14,728**	**4,273**	**19**	**465**	**19,020**



Limitations, Challenges and Opportunities

The above data is for BHS as a whole and does not break data out by Fee-for-Service Network or Purchase of Service Program. The data is at a point in time (fall of 2021). The data categories are the categories used by the Wis. Dept. of Health Services (DHS).

Many smaller agencies face challenges with administrative capacity and staff training. These providers often encounter differences in the Request for Proposals (RFP) process moving from one provider network to another provider network, or to other service areas (divisions). Additionally, there are key indicators that help providers successfully compete in the RFP process. Specifically, capacity building efforts, technical assistance and workshops can improve and ensure a more equitable contracting

process for BHS. In an effort to enhance some of these indicators, DHHS has both doubled the number of public information and technical assistance sessions held for prospective applicants and the period of time for which RFP solicitations remain open.

The minimum number of required review panel members scoring proposals has increased from three (3) to five (5), and reviewers are now reimbursed with a fee for each proposal they review. In May of this year, DHHS released a solicitation for Request for Reviewers (RFR) for a permanent standing pool of community members of review panel members to draw upon. The RFR has increased the fee per proposal reviewed to $150 and removed the cap on maximum reimbursement available per reviewer.

While it may be more organizationally efficient to work with large providers with stronger administrative capacity, this does not guarantee better health outcomes for impacted populations. BHS benefits from partnerships with providers that specialize in serving specific populations. Often, institutional, and implicit biases can lead to negative evaluations of organizations servicing specific populations and may work against smaller providers. The practice of looking at the contracting process through a racial equity lens has identified measures to help expand the BHS provider networks and encourage non-profit diversity, which positively impacts the talent pool that is available to Milwaukee County. One of the recommendations coming out of the DHHS Racial Equity in Contracting initiative and related consultant's report from Kairo Communications was to place greater importance on diversity, equity and inclusion through the contracting and RFP process. DHHS has implemented this recommendation by encouraging and rewarding diversity and cultural intelligence through the RFP evaluation process. The implementation of other recommendations coming out of this initiative have led to other efforts in the process that have advanced racial and health equity through the contracting processes and have helped address social determinants of health and the disparities in health outcomes among marginalized populations.

Summary

Milwaukee County DHHS and BHS are committed to providing person-centered, high-quality services through practices and policies that enhance and advance racial and health equity to the clients and communities that it serves.

Recommendation

This report is for informational purposes only, and no action is required.

Respectfully Submitted,

Shakita LaGrant-McClain

_____

Shakita LaGrant, Director, Department of Health and Human Services
cc: Thomas Lutzow, Chairman Finance Committee
Shirley Drake, Acting Quality Committee Chairperson

2021 BHS Agency Ownership Race/Ethnicity Data

BOARD OF DIRECTORS/AGENCY OWNERS/STOCKHOLDERS AND ADMINISTRATIVE LEADERSHIP - DIRECTORS/ADMINISTRATORS DEMOGRAPHICS

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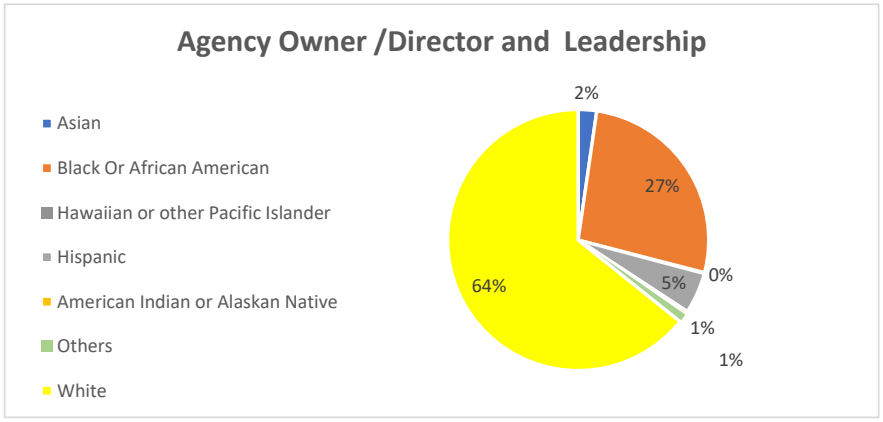
-
-
-
-
877 Minority Leaders
877
-



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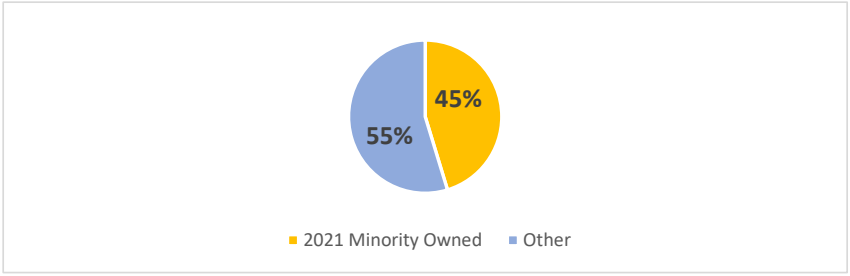
Other	**93**
Total	**170**



Chairperson: Mary Neubauer
Research Analyst: Kate Flynn Post, (414) 257- 7473
Committee Coordinator: Dairionne Washington, (414) 257-7606

MILWAUKEE COUNTY MENTAL HEALTH BOARD
QUALITY COMMITTEE

Monday, July 11, 2022 - 10:00 A.M.
Microsoft Teams Meeting

MINUTES

PRESENT: Mary Neubauer, Shirley Drake, Rachel Forman, and Dennise Lavrenz

SCHEDULED ITEMS:

1. **Welcome.**

   Chairwoman Neubauer welcomed everyone to the Milwaukee County Mental Health Board Quality Committee's July 11, 2022, remote/virtual meeting.

COMMUNITY SERVICES

2. **Combined Q1 2022 Community Report and Dashboards: Community Access to Recovery Services (CARS) and Children's Community Mental Health Services and Wraparound Milwaukee.**

   a) CARS Quarterly Report

   Community Access to Recovery Services (CARS) has been working to narrow the intervention and prevention efforts in higher need zip codes. Analyses have been done to identify those areas, and seven zip codes were identified. The intervention process in those areas are going to be multi-level. Some of it may be trying to increase the presence, whereas some may be looking to see if there are pre-existing services that could be invested in depending on what the needs of those zip codes are. Identifying those high need areas is the first step in the effort to target and concentrate community outreach and investment initiatives. Updates will continue to be provided as this development continues.

   b) BHS Community Population Dashboard Proposal

   Community Access to Recovery and Services (CARS) and Community Crisis Services are working together to create an integrated Behavioral Health Services (BHS) community population dashboard. With the closure of Psychiatric Crisis Service (PCS), it's important to

	highlight and recognize the continuum of care for both CARS and Crisis Services as one. The dashboard includes several data points representing the shift in paradigm. Data shows over 50% of enrollments start in Mobile Crisis or a CARS Access Point (AP). This also allows great opportunity for increased collaboration across the different departments having a focus effort on ensuring the continuum of care and services provided are being designed around the client. Clients who begin their enrollment in a Mobile Crisis or PCS service and then receive a service from AP within the first 90 days reduce their 30 days in Mobile Crisis or PCS utilization dramatically. This dashboard will promote the Department of Health and Human Services' (DHHS) vision of No Wrong Door because clients will have seamless access to the full array of BHS services regardless of their entry point. In addition, it will create greater satisfaction for clients and advance the Quadruple Aim throughout BHS, particularly its focus on the health of shared population of clients. The goal is to release this dashboard by the end of 2022. **c) BHD KPI Report - Children's Community Mental Health Services and Wraparound Milwaukee** There were over twenty-three hundred unique families served for Quarter 1, 2022. The average cost per family has been consistent throughout the past several quarters. All outcome goals have been met except for the percent of natural support. This continues to be a focus area for improvement. There was a total of twenty-two clients who moved from an out of home to an in-home type of setting. Permanency after discharge averaged 79% for the quarter. The youth and caregiver perception averages approximately a 4.2 out of 5, which surpasses the set goal and is an increase from previous quarters. Questions and comments ensued. This item was informational.
3.	**Community Contract Vendor Quality Updates: Sanctions, Holds, and Service Suspensions**. **a) Genesee Community Services – Corrective Action Plan from Desk Review Findings** As of June 30, 2022, a corrective action plan was accepted by Genesee Community Services due to findings from the desk review held in January 2022. After findings were identified, meetings were held to assist on how to implement changes to the issues outlined within the corrective action plan. As mentioned during the previous committee meeting, key findings included billing inaccuracies, incomplete case notes, and overlapping sessions. Immediately after being notified, billing inaccuracies were corrected. The agency has developed a case note template to ensure all required information is included moving forward. A service coordinator is now monitoring all case notes and entries to ensure all services billed are verified prior to the billing process occurring. To avoid overlapping sessions, the agency's information technology (IT) system has been updated to deny any sessions for the same date and time period for a provider. This will all be reviewed during an upcoming audit scheduled.

	Questions and comments ensued. This item was informational.
4.	**Community Crisis Services Dashboard Updates.** The Community Crisis Services dashboard currently does not display any hospital-based services, anonymous crisis line callers, or services by Impact Inc. on the crisis line data. These are all data points still in development. The current dashboard represents individuals who have received at least one community crisis service by zip code, ethnicity, race, and gender, as well as the averages of client experience scores. Overtime, there will be continuous efforts to build, produce, and display programmatic community services dashboards. One of the first programs to be displayed is going to be Crisis Line Services. The dashboard will reflect service level information through both the internal crisis line and the external services provided by Impact Inc. Questions and comments ensued. This item was informational.
5.	**Department of Health and Human Services (DHHS) Quality Management Updates.** Quality Management (QM) strategy roll-out, QM technical team engagement, the alignment of the QM framework to operations, and securing evaluation resources were recognized as four major activity updates. Good quality management aims to unite an organization's stakeholders in a common goal, improving processes, products, and services to achieve consistent success. A QM technical team meeting was held in May 2022. The objectives were to orient staff to the DHHS QM framework, establish shared-language amongst technical terms, build comradery amongst staff driving aligned efforts, and to identify department-wide opportunities to advance QM. The meeting also allowed an opportunity for staff to view what monitoring and evaluation looks like as a function and how each activity aligns with one another. One of the objectives of establishing shared language was to help staff build their understanding of terms to explore the intricacies and implications of different definitions for key concepts and terms. The other two were for them to become more comfortable discussing matters related to quality management and to create a shared understanding that will allow everyone to operate from the same foundation. Another update provided pertained to the roles and responsibilities in quality management. The purpose was to discuss how the day-to-day tasks of a specific role advances quality management based on the framework. The next steps are to secure resources to drive operationalized monitoring and evaluation, continue to digest and discuss the quality management framework with teams, cultivate professional development opportunities through ad-hoc projects, and more.

	Questions and comments ensued. This item was informational.
	HOSPITAL SERVICES
6.	**2022 Q1 Inpatient Dashboard/Q1 Behavioral Health Division Crisis Services and Acute Inpatient Reports.** A seclusion and restraint summary of Quarter 1 2022 was presented. There was a total of 1,475 patients seen in Psychiatric Crisis Service (PCS) for the quarter, which on average is at least sixteen patients per day. The Acute Adult restraint rate has been consistent over the last few quarters. There was a total of 18.3 restraint hours for the Acute Adult units and 7.8 for the Child Adolescent Inpatient Service (CAIS). There were only two patient elopements reported. Medication incidents reporting has increased over the last two quarters mainly due to the new nursing staff audits implemented. The aggression trends remain consistent on the units. The rate of patients returning to Psychiatric Crisis Service (PCS) within thirty days was at 24.3%, with a total of two aggression incidents reported. There was a 10.4% rate of patients returning to Acute Adult Inpatient Services within thirty days. Lastly, the Child Adolescent Inpatient Service (CAIS) rate of patients returning within thirty days was at 6.2% with four patient to staff aggression incidents reported. The Acute Inpatient Performance Measures Reported to Centers for Medicare and Medicaid Services (CMS) reports measures for Acute Adult and CAIS combined. The only area below national average is the restraint rate. All other areas either exceeds or meets the threshold. Questions and comments ensued. This item was informational.
7.	**Quality Assurance Performance Improvement (QAPI)/Patient Safety Updates**. During the most recent Quality Assurance Performance Improvement meeting, the Sentinel Event committee gave a presentation on some of the cases they have open. Hospital contracts were reviewed, and updates were provided on the inpatient provider monitoring tool. The monitoring tool goes through three specific items which include, hospital contracts, contract performance measures, and concerns brought forth by hospital physicians. Questions and comments ensued. This item was informational.

8.	**Contract Management Updates.** There are a few contracts up for review, however, due to attendance issues, updates were postponed for the next meeting.
9.	**Policy and Procedure Quarterly Report.** The overall progress as of June 1, 2022, was at 96.8%. Six-hundred and fifty-eight policies were reviewed. Of those, twenty-two were past due. The number of past due policies continue to decrease. In May 2022, fourteen policies were revised. None were new nor retired. Questions and comments ensued. This item was informational.
10.	**Adjournment.** Chairwoman Neubauer ordered the meeting adjourned.

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Legislative Information Center web page.

Length of meeting: 10:07 a.m. – 11:56 a.m.

Adjourned,

Dairionne Washington

Committee Coordinator
Milwaukee County Mental Health Board

The next meeting for the Milwaukee County Mental Health Board Quality Committee is scheduled for September 19, 2022

To View All Associated Meeting Materials, Visit the Milwaukee County Legislative Information Center at:
Milwaukee County - Calendar (legistar.com)

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

Quality Committee Item 2

Quarter 1 - 2022

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES

BEHAVIORAL
HEALTH SERVICES

CARS Quarterly Report

CARS Quality Report Summary – Q1 2022

POPULATION HEALTH

Among the key findings, our quality of life (QOL) data suggested that although our Black clients entered services with lower QOL relative to white clients (27.91% vs. 33.63%, respectively), their greater rate of improvement (93.23%) relative to white clients (60.18%) resulted in a greater proportion of Black clients experiencing “Good” or “Very Good” quality of life as of their last assessment.

We are currently focusing our efforts on analyzing the criteria and provisions of our various grants and other funding sources to explore how we can strategically invest these dollars upstream to address the social determinants of health and maximize the services we are able to provide to the community. We are also partnering with the Community Crisis Department on a System-Wide CQI Project to address racial disparities. Our recently selected project aim will focus on improving the health of the community through community outreach and engagement.

Finally, we would like to highlight the graphic focused on high need zip codes on page 3 of the Report. This graphic takes the place of our previous chart on penetration rates. We believe this graphic better represents the geographic focus of the population health improvement efforts in CARS and acknowledges the fact that the degree of socioeconomic need is not equally distributed by geography across Milwaukee County.

CLIENT EXPERIENCE

Historically we have been able to show positive outcomes regarding client experience with our quantitative data. We would like to supplement these findings through the expanded use of qualitative data through focus group studies. We are currently organizing a focus group to meet with the staff and clients from some of our contracted CBRFs. We are looking forward to hearing first hand what the participants are finding helpful within our CBRFs, along with identifying areas we can work on to improve their overall experiences.

Among our other results, last quarter we noted a rise in referrals to the CARS Access Points, largely due to an increase in Black clients seeking services. This appears to be leveling off this quarter, with just 1.7% increase in over all referrals. Notably, we have seen 14.71% increase in our Access to Service metric (28.69% to 32.91%).

COST OF CARE

We note a small increase (.061%) in the cost per client per month from the prior quarter. We also plan to release RFPs for our 75.07 and 75.09 withdrawal management services this summer. We believe this will further help us refine our cost of care estimates as this RFP includes a market rate analysis that is the first step in our transition from a purchase of service to a fee for service payment methodology for these services.

STAFF QUALITY OF LIFE

We did have 3 team members leave CARS this quarter, causing our turnover rate to nearly double from the prior quarter. Our turnover rate is still below the national average, however, and we are looking forward to adding new talent to our team in the coming months.

In the last few weeks, all CARs staff completed a DiSC assessment. We will be having a training session to learn about our results and are looking forward to the insights we will gain on how we can continue to work with each other in a constructive and collaborative manner.

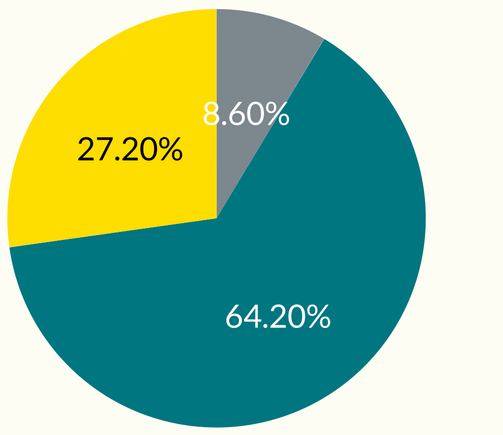
NEXT STEPS

Future iterations of this Quarterly Report will include several changes, the first of which will be a transition to a new data visualization and analysis platform that will allow for more efficient generation and manipulation of this report. We will also be exploring the addition of longitudinal outcome data that we believe will better depict the trajectory of change for our clients. Please look for these updates at the fall and winter MHB Quality Committee meetings.

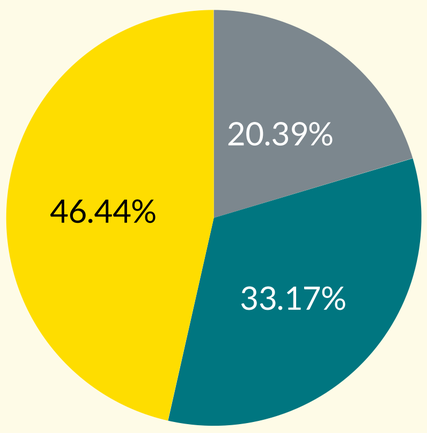
Demographic Information of the Population We Serve

This section outlines demographics of the consumers CARS served last quarter compared to the County population.

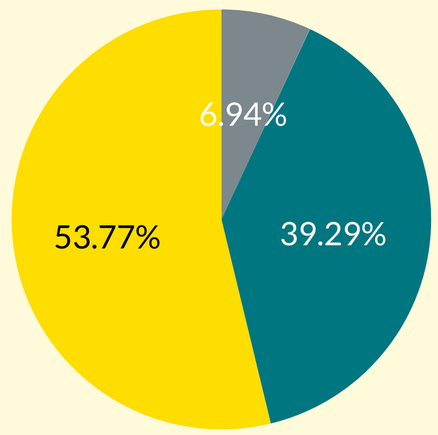
Race (Milwaukee County)*



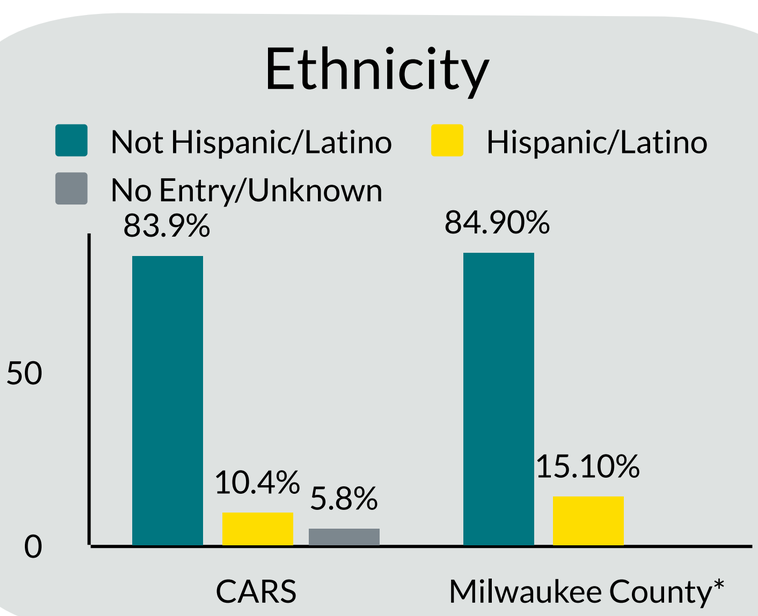
Race of MKE County at or Below 100% Poverty Level



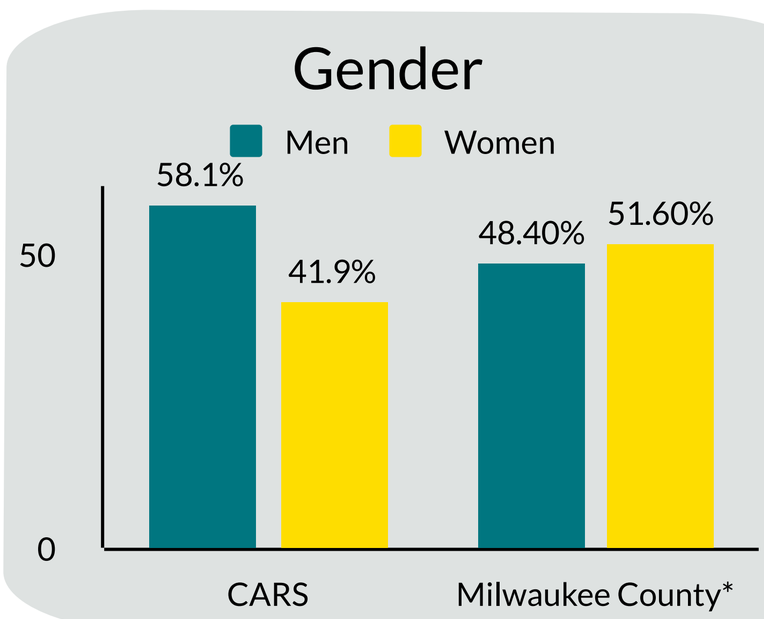
Race (CARS)



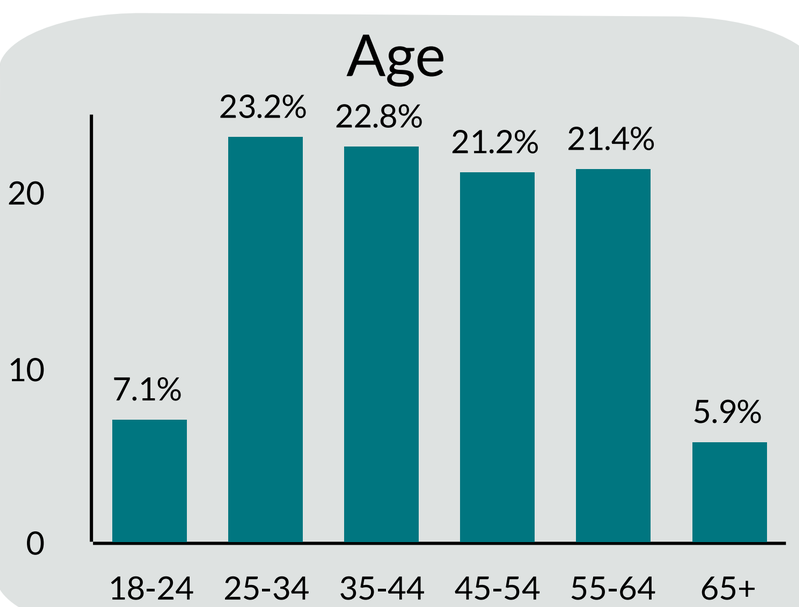
Ethnicity



Gender

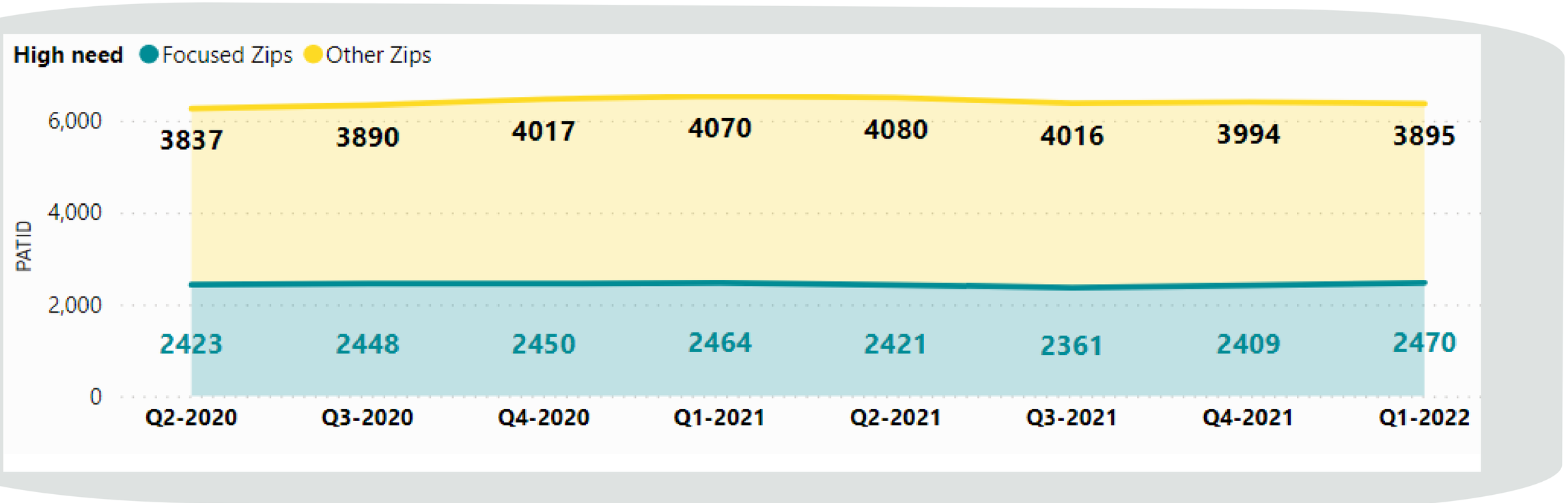


Age



CARS Focus on High Need Zip Codes

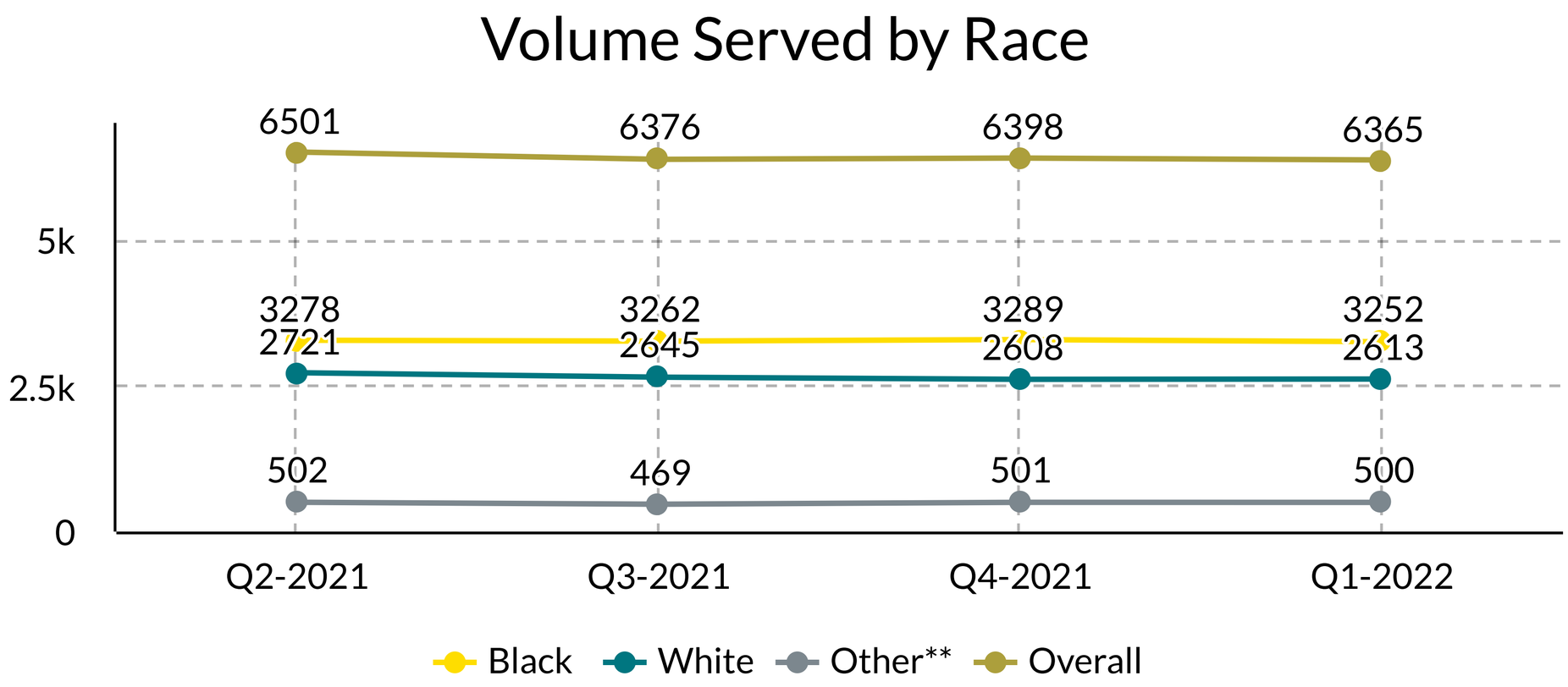
The Focused Zip Codes include 53215, 53205, 53206, 53204, 53233, 53209 and 53218. These zip codes were selected by CARS because of their significant social and economic needs, and because they have a significant portion of their population in the category of less than 200% of the poverty level. Identifying these high need areas is the first step in our efforts to target and concentrate our community outreach and investment initiatives.



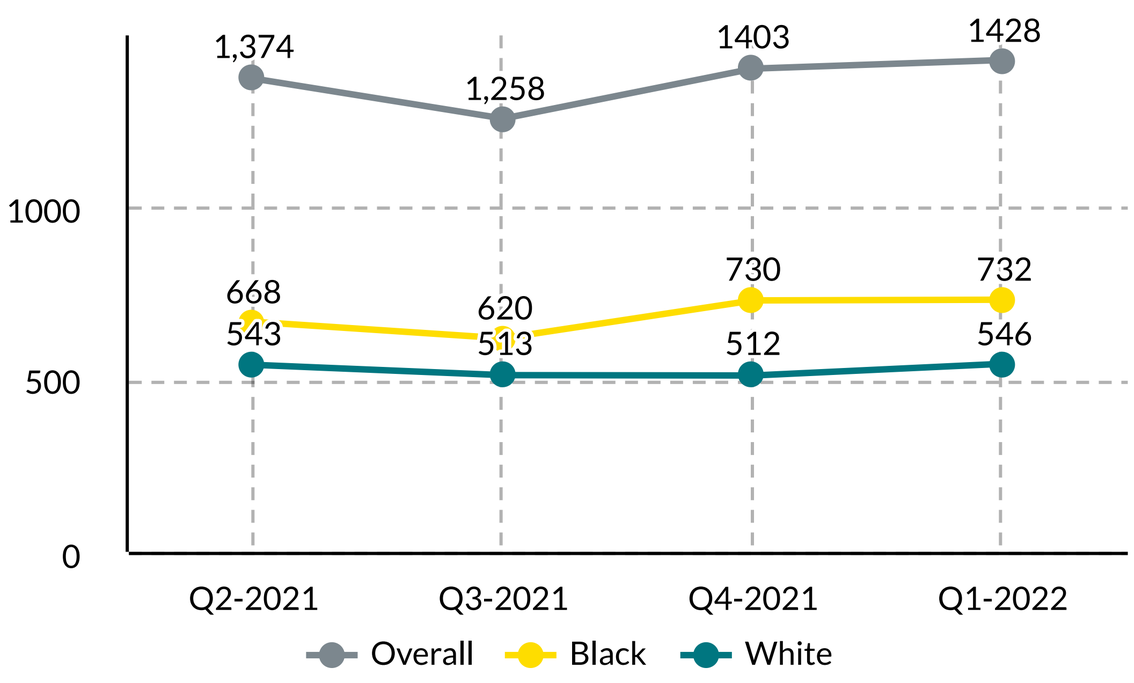
*Comparable data from United States Census Bureau, which can be found at: https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/PST045217#qf-flag-Z

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

Volume Served



Referrals



Time to First Service

Access to Service

32.91%

14.71%

Increase from previous quarter

Percentage* of clients who began their enrollment at a CARS Access Point who received a CARS community service within the first 30 days (231/702)

* Please note that not all clients who are assessed need or are eligible to receive CARS community services, therefore the expectation is not 100%. CARS R&E Team is working to develop access targets for future reports.

Average Consumer Satisfaction Score (Range from 1-5)

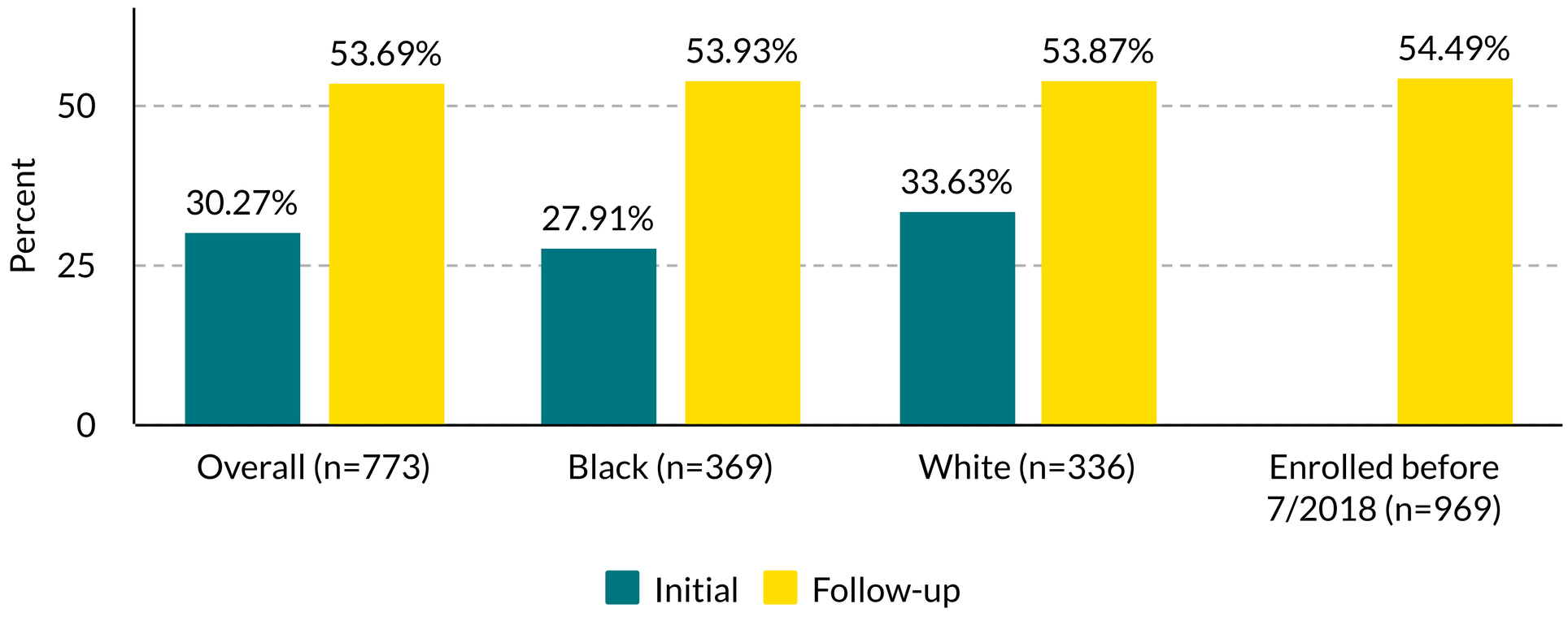
4.42	4.44	4.41	4.40
average for all consumers (n=846)	average for Black consumers (n=445)	average for White consumers (n=283)	average for "other" consumers (n=118)

Population Health

Change Over Time - Client Enrollment

Percent of clients selecting "Good" or "Very Good" Quality of Life Overall and by Race

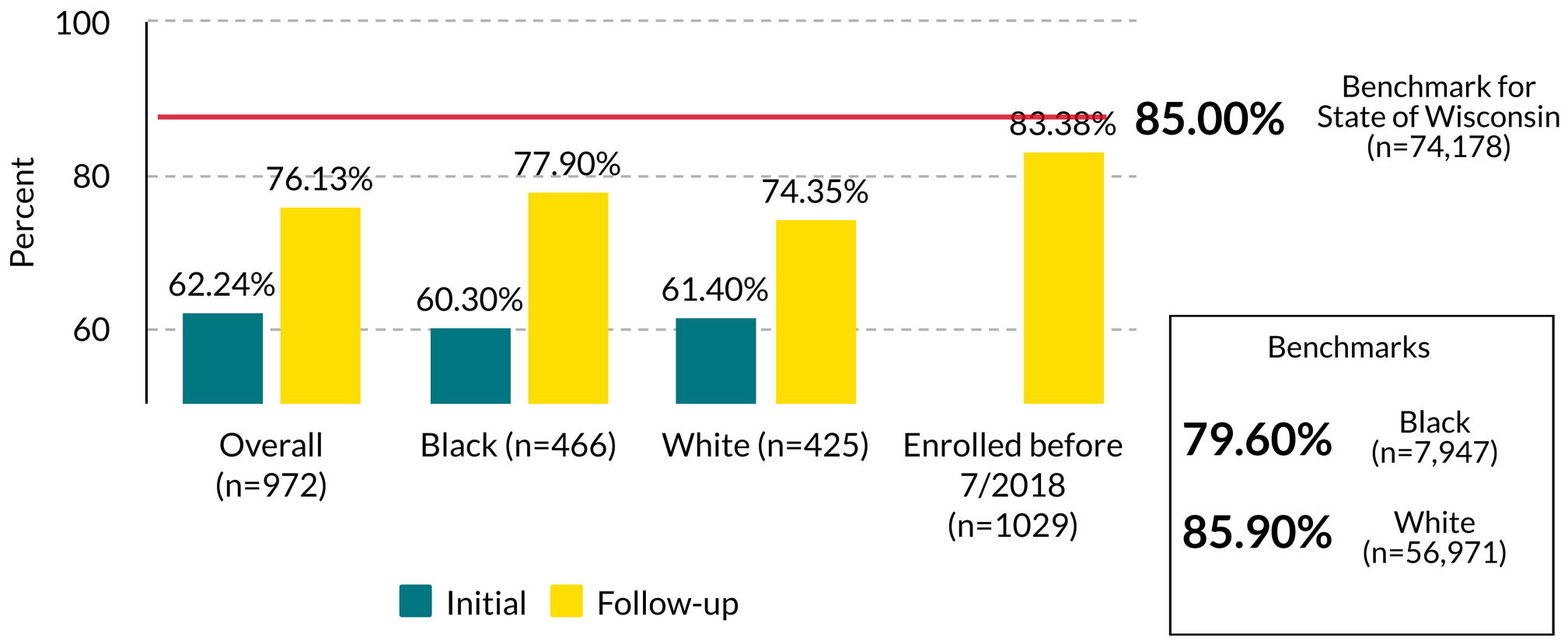
Average duration of enrollment: 512.75 days



Domain: Population Health (cont.)

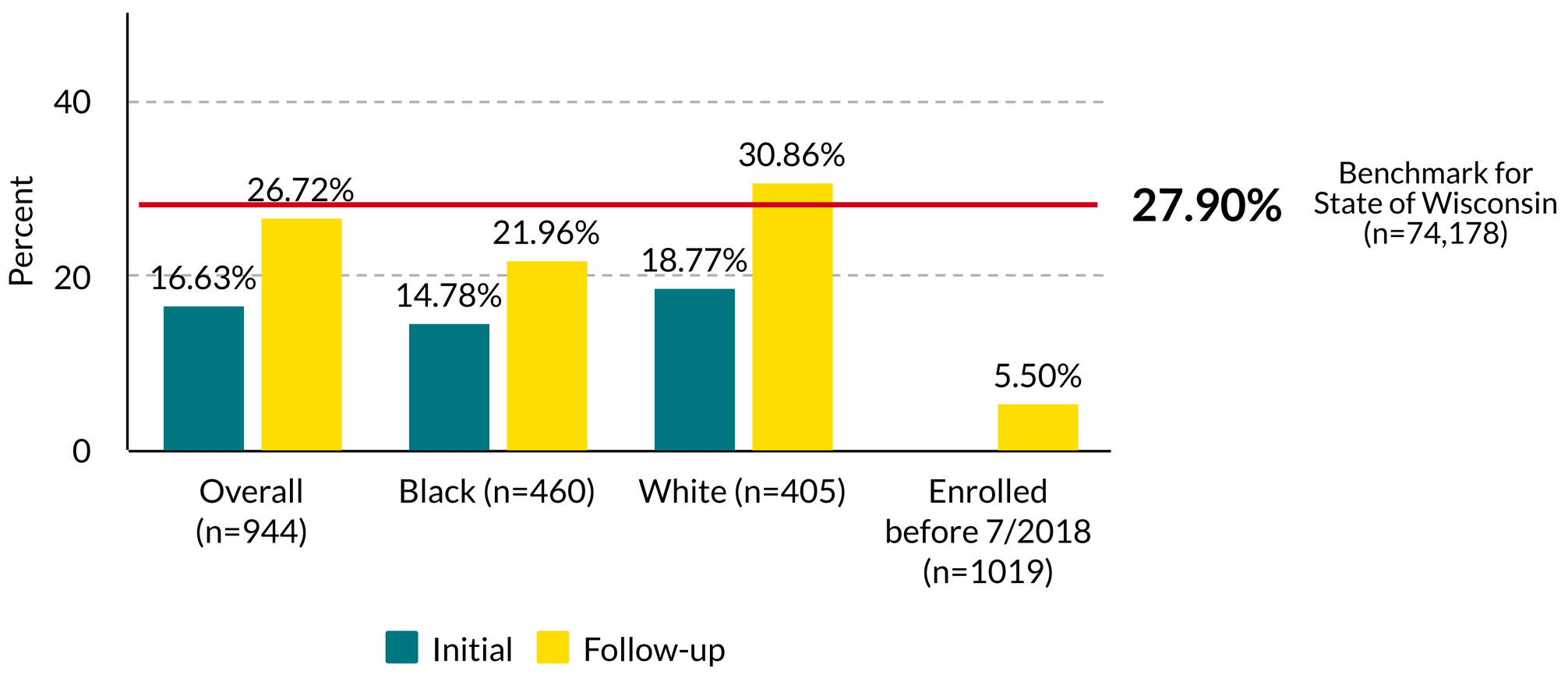
Percent with a Private Residence Overall and by Race

Average duration of enrollment: 494.20 days



Percent Employed Overall and by Race

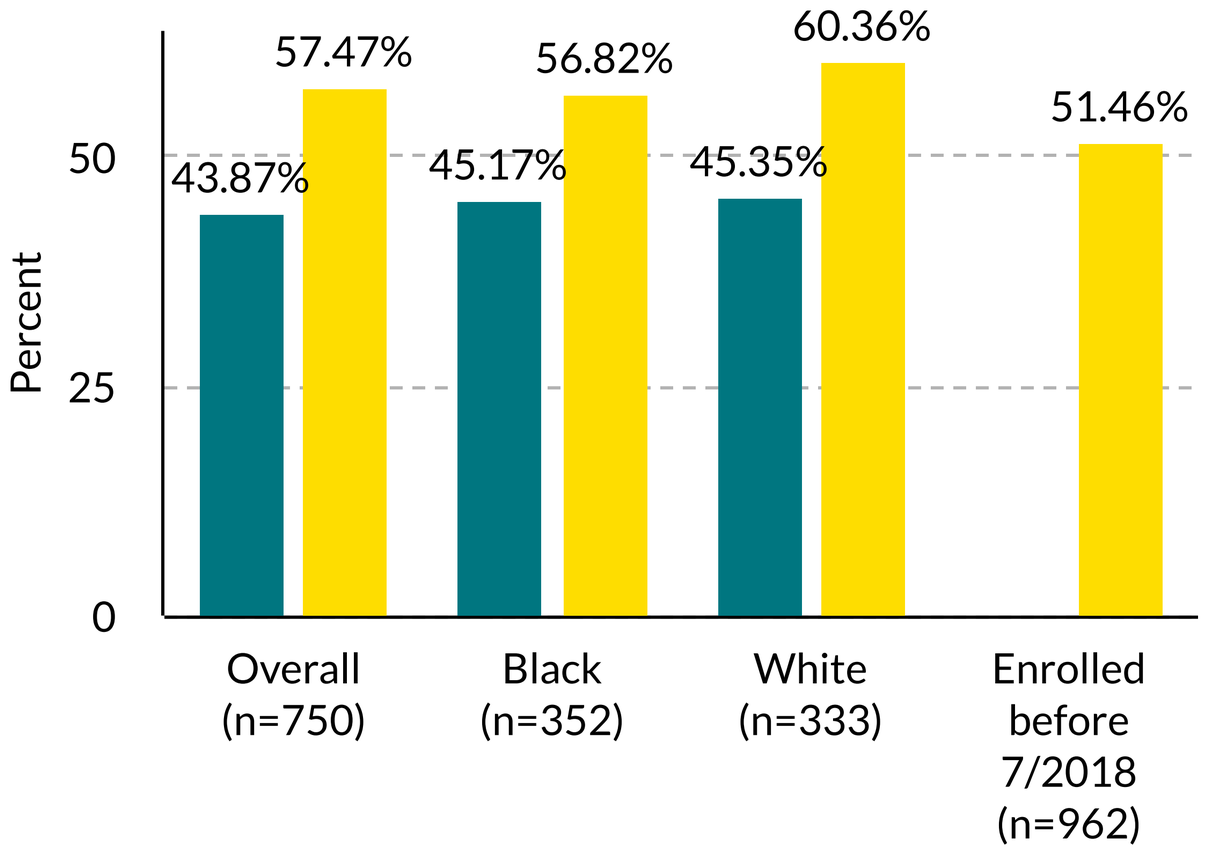
Average duration of enrollment: 488.60 days

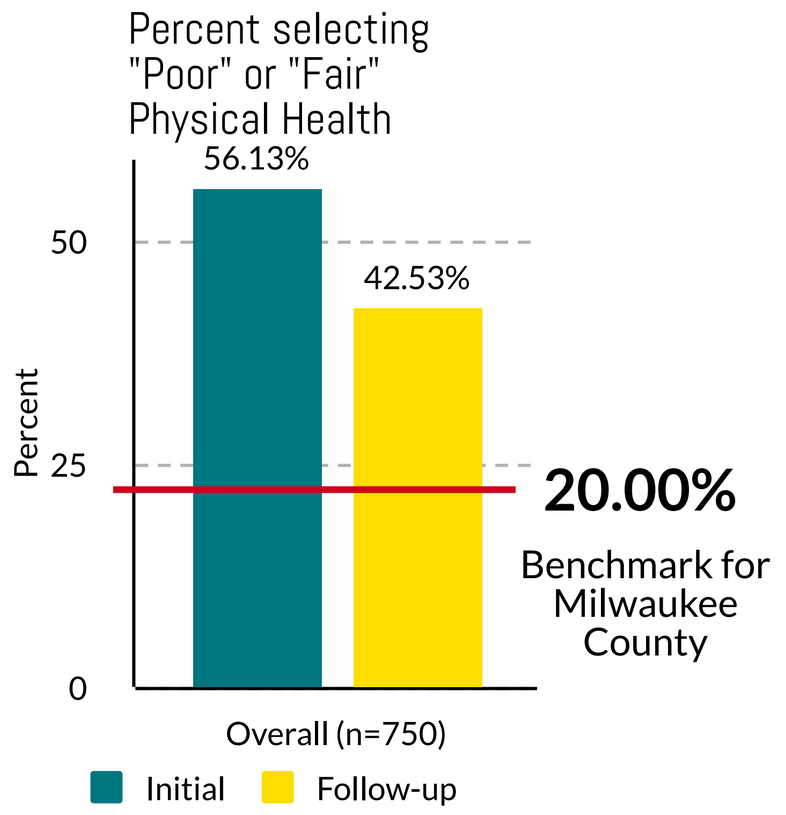


Percent selecting "Good", "Very Good" or "Excellent" Physical Health Overall and by Race

Average duration of enrollment: 502.61 days

Percent selecting "Poor" or "Fair" Physical Health

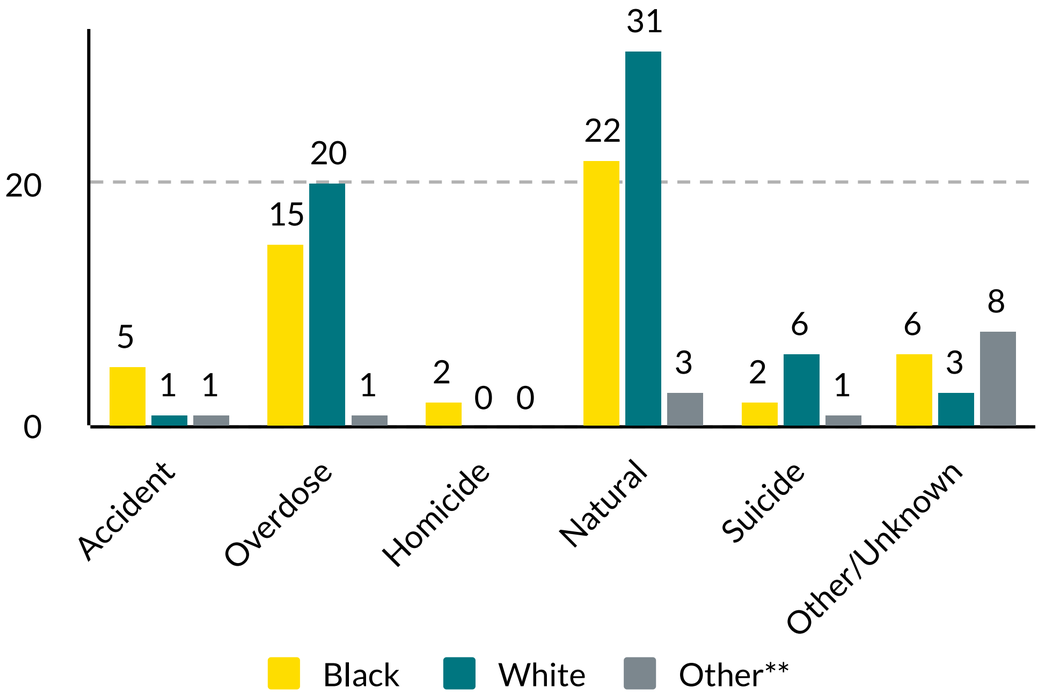




Domain: Population Health (cont.)

Cause of Death by Race

One quarter lag in reporting. For deaths between Q1-2021 and Q4-2021



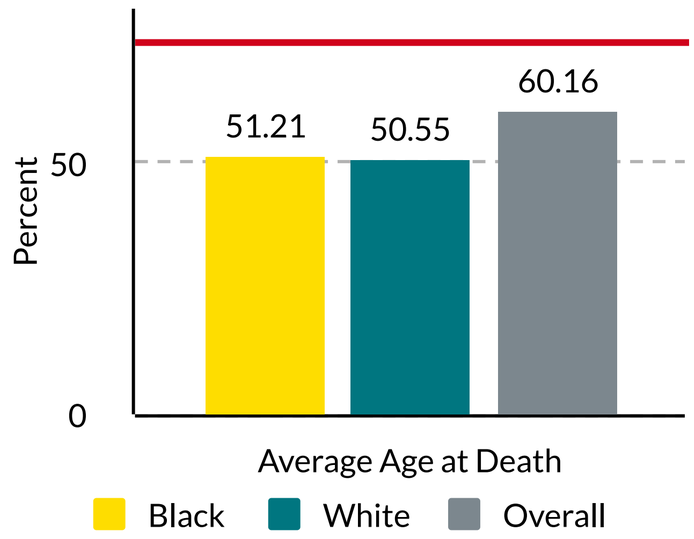
Average Age at Death

Benchmarks

White: 74.90

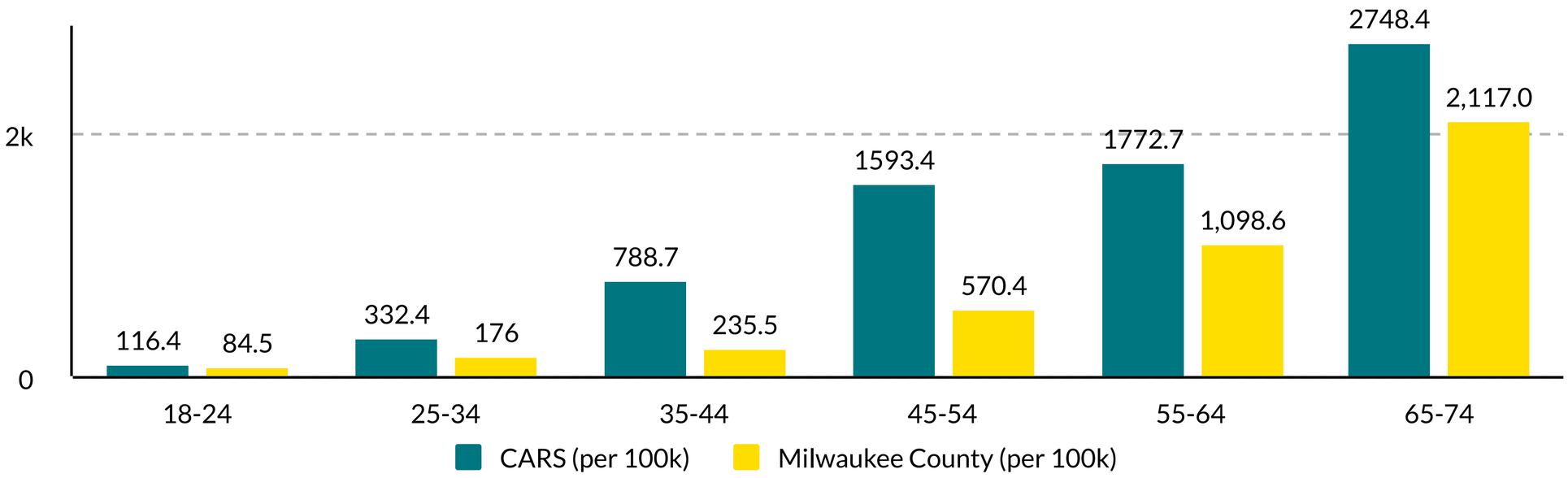
Overall: 71.50

Black: 62.40



Death Rate (per 100,000) by Age Range

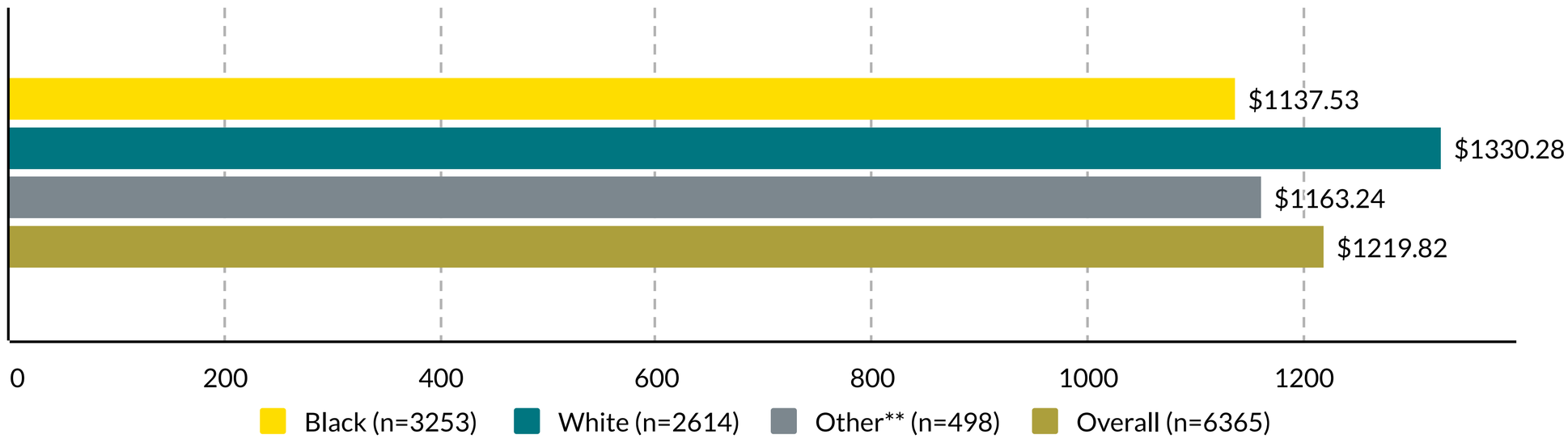
CARS number adjusted for comparison against Milwaukee County^



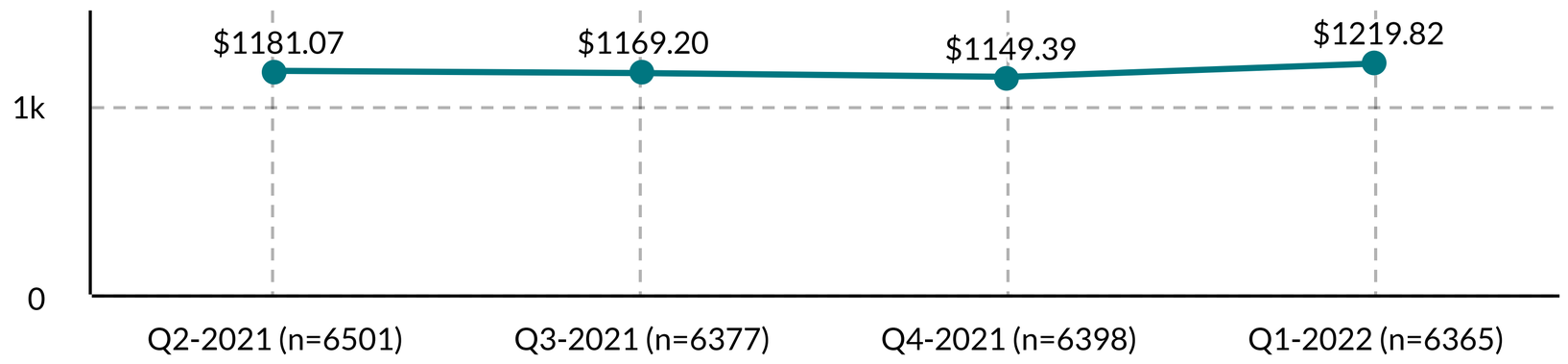
Domain: Cost of Care

Average Cost per Consumer per Month for Q1 by Race

"n" refers to an average of the number of unique consumers served per month for the quarter



Average Cost per Consumer per Month by Quarter



Domain: Staff Well-Being

Turnover

15.19%

CARS turnover rate

Staff Quality of Life

20.00%

Turnover rate for government employees (per year)^^

The Staff Quality of Life committee in CARS recently held a second World Café in early February of 2022, in which they solicited staff feedback on how to improve the quality of the work experience for CARS staff. The data gathered at the most recent World Café will be summarized and presented to CARS Leadership to inform and drive innovative initiatives and policies to ensure that CARS can continue to engage and retain its current skilled workforce, as well as attract new talent in the future.

Metric Definitions

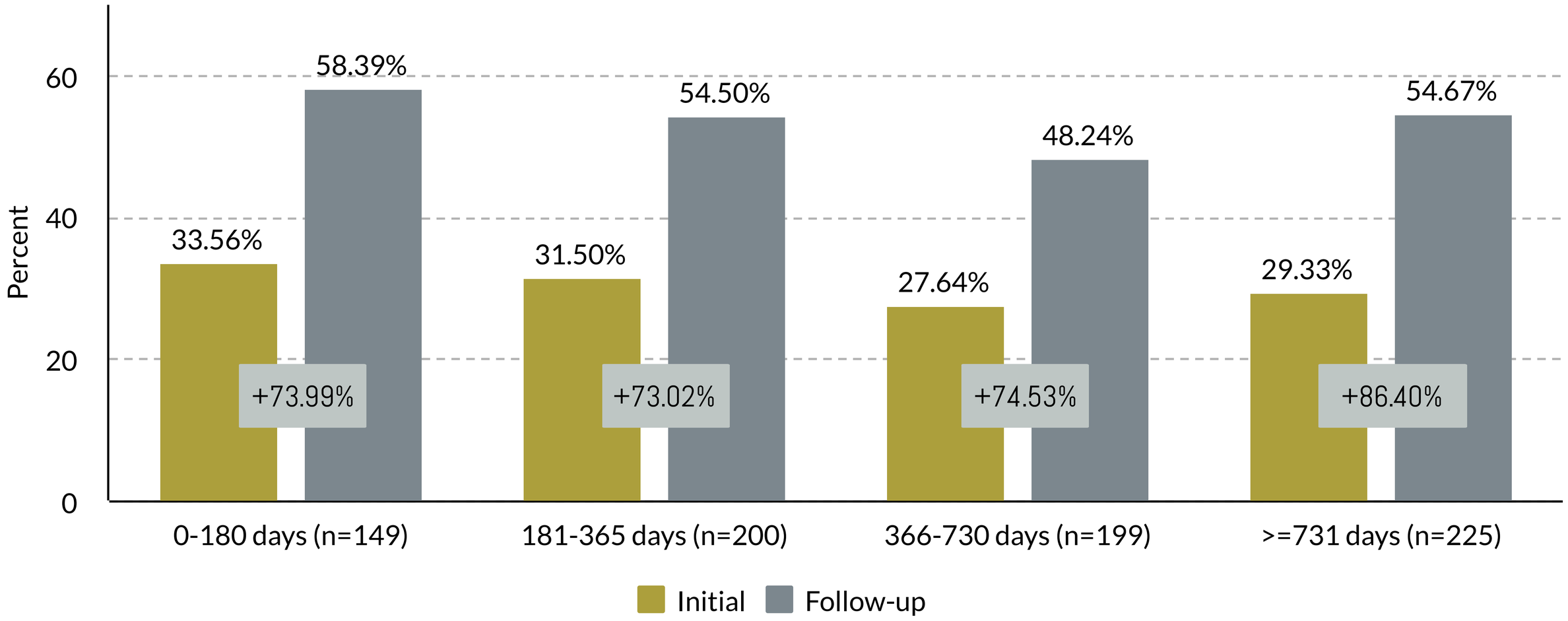
Access to Services	This measure examines the number of clients who received their first service at a CARS Access Point and then received a CARS community service within 30 days, divided by the total clients who received their first service at a CARS Access Point.
Average Age at Death	Death data is reported as an aggregate of the past four quarters, with a one-quarter lag. Average age at death for all causes of death. Benchmarks from 2019 Milwaukee County Mortality Data - Wisconsin Interactive Statistics on Health (WISH)
Cause of Death	Death data is reported as an aggregate of the past four quarters, with a one-quarter lag. Causes reported by the Milwaukee County Examiner when available. For those without an examiner report, cause of death reported by CARS is used.
Change Over Time	Change over time, through client enrollment, looks at clients who had their initial PPS within 60 days of enrollment and their follow-up PPS during the observation quarter. Some metrics are broken down by cohorts, which are determined by length of enrollment between their initial PPS and their latest PPS during the observation quarter.
Client Experience	Implementation of the new, more succinct Client Experience has begun. The survey ranges from 4-10 questions, depending on the program, and all questions range from 1="strongly disagree" to 5="strongly agree". The survey is currently being utilized in all CARS programs with the exception of CCS, CBRF, Adult Family Home, and Medication Assisted Treatment (MAT).
Cost of Care	The average cost per consumer per month within each quarter for CARS services received by CARS consumers (not including inpatient and crisis). This is not separated out by funding stream or limited to those dollars spent by Milwaukee County on these services. The "n" is an average of the unique number of consumers served per month for the 3 months in the observation quarter.
Death Rate	The CARS death rate has been adjusted to a rate per 100,000 to compare with Milwaukee County death data. ^^Comparison death data from Wisconsin Interactive Statistics on Health (WISH) data query system, 2019 mortality data
Employment	Percent of current employment status of unique clients reported as "full or part time employment" or "supported competitive employment" ^^Benchmark data from the SAMHSA Uniform Reporting System - Mental Health Community Services Block Grant 2020 State Summary Report
Private Residence	Percent of clients who reported their current living situation as a private residence. ^^Benchmark data from the SAMHSA Uniform Reporting System - Mental Health Community Services Block Grant 2020 State Summary Report
Quality of Life	This is a self-reported measure based on the question on the Comprehensive Assessment. Graphs shows the percentage of people that stated that their quality of life was "good" or "very good".
Referrals	Total number of referrals at community-based and internal Access Points per quarter.
Self-Rated Health	This is a self-reported measure based on the question on the Comprehensive Assessment. The graph shows the percentage of people that said that their physical health was "good", "very good" or "excellent". Benchmark from County Health Rankings
Turnover	Turnover is calculated by looking at the total number of staff who have left over the previous four quarters, divided by the average number of employees per month, for the previous four quarters ^^Source: Bureau of Labor Statistics (https://www.bls.gov/news.release/jolts.t16.htm)
Volume Served	Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.

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

Supplementary Analyses

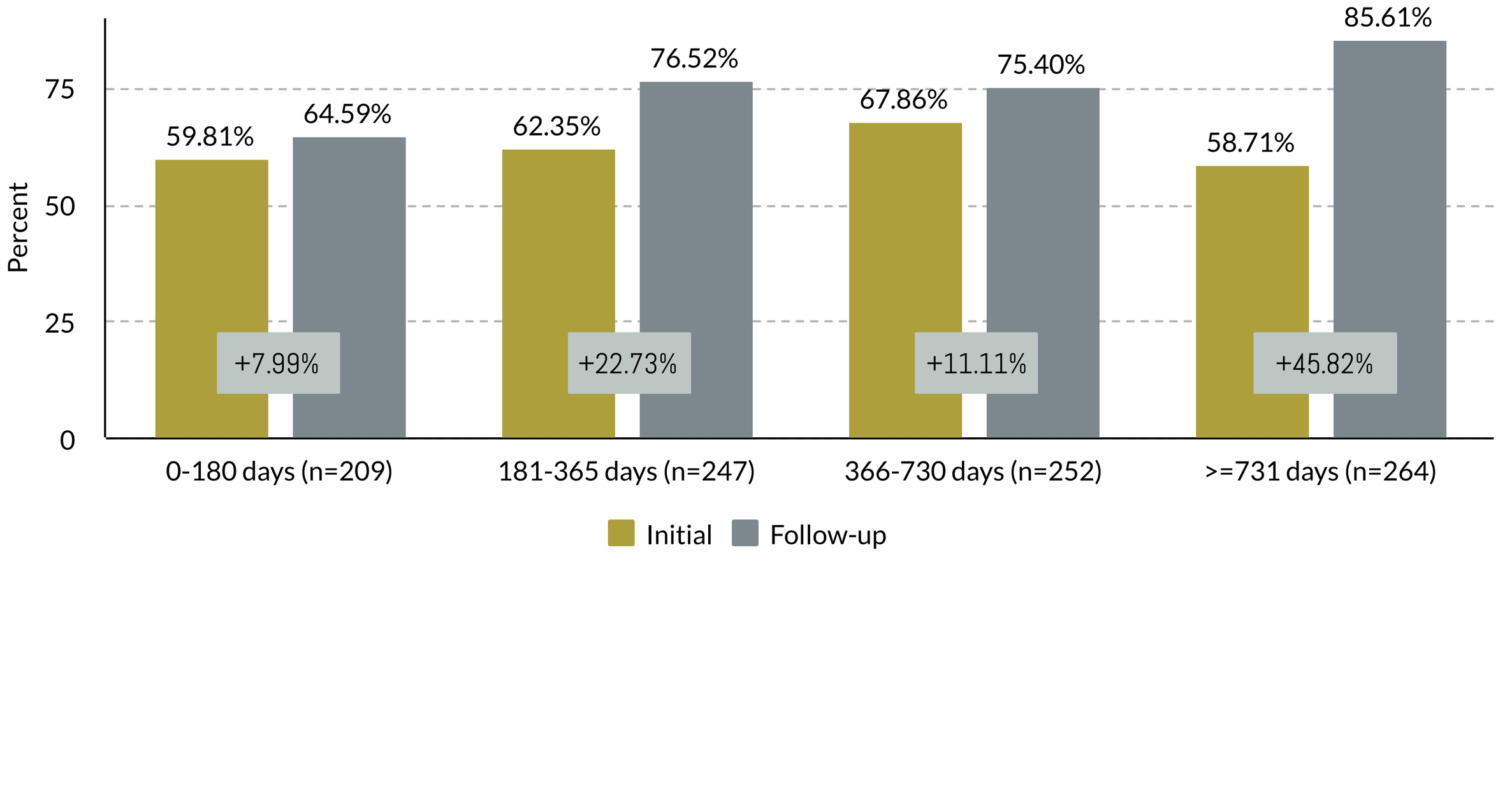
Percent of Clients selecting "Good" or "Very Good" Quality of Life by Length of Enrollment

The rates of improvement are relatively similar across the various cohorts with the exception of the longest term cohort experiencing the greatest levels of improvement.



Percent of Clients with a Private Residence

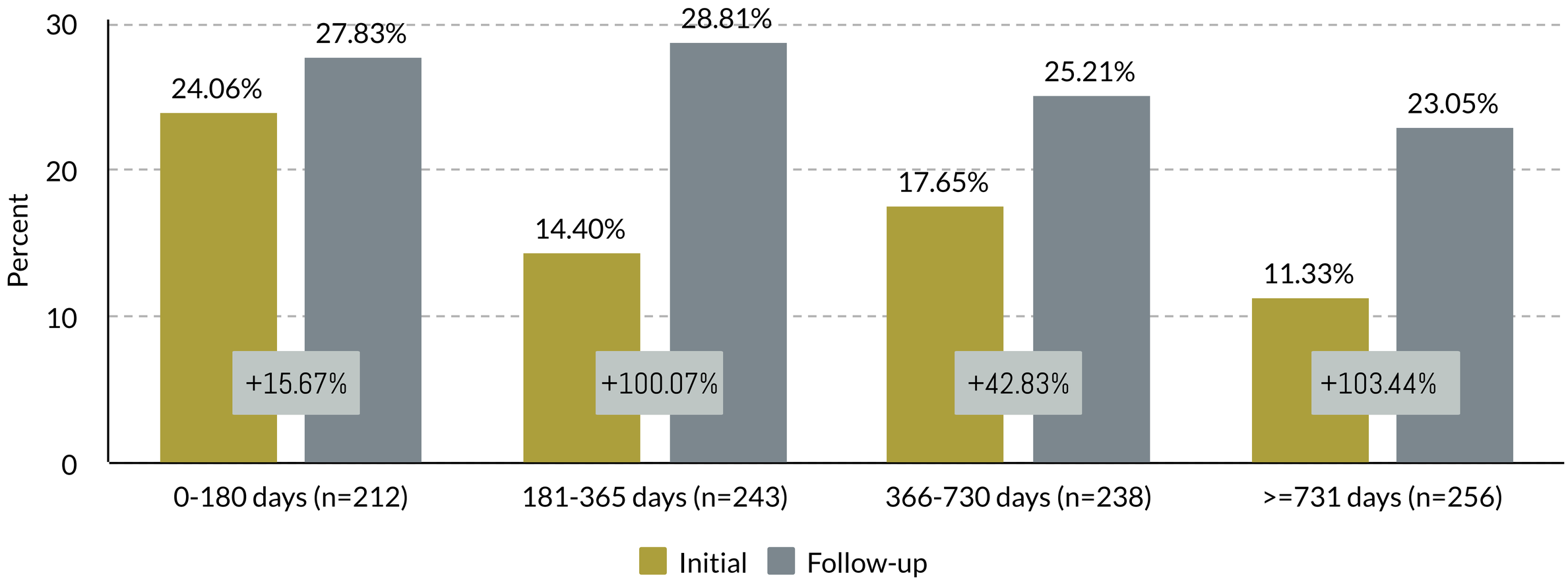
Consistent with previous reports, clients enrolled longer appear to have higher rates of private residence than clients enrolled for shorter lengths of time.



Supplementary Analyses (cont.)

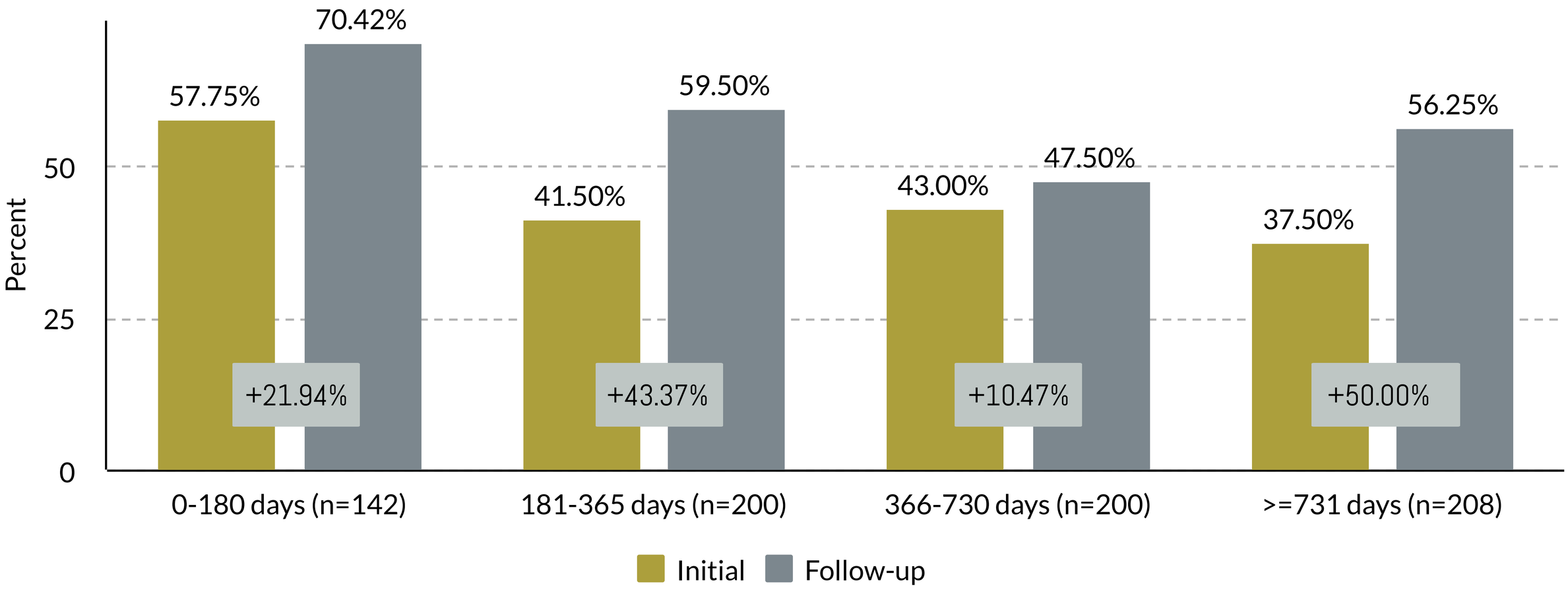
Percent of Clients Employed

Although the rates of change are higher in longer lengths of enrollment, this is likely due to a larger proportion of individuals in longer enrollment cohorts beginning their enrollments with lower rates of employment.



Percent of Clients selecting "Good", "Very Good" or "Excellent" Physical Health

This graph shows no clear trend in terms of rate of change between cohorts. Cohorts with longer enrollments did start with lower ratings of physical health, likely influencing their higher rates of change.



Creating a BHS Community Population Dashboard

MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

Changing Paradigms Through Collaboration

CARS and Community Crisis Integration

Many Points of Entry

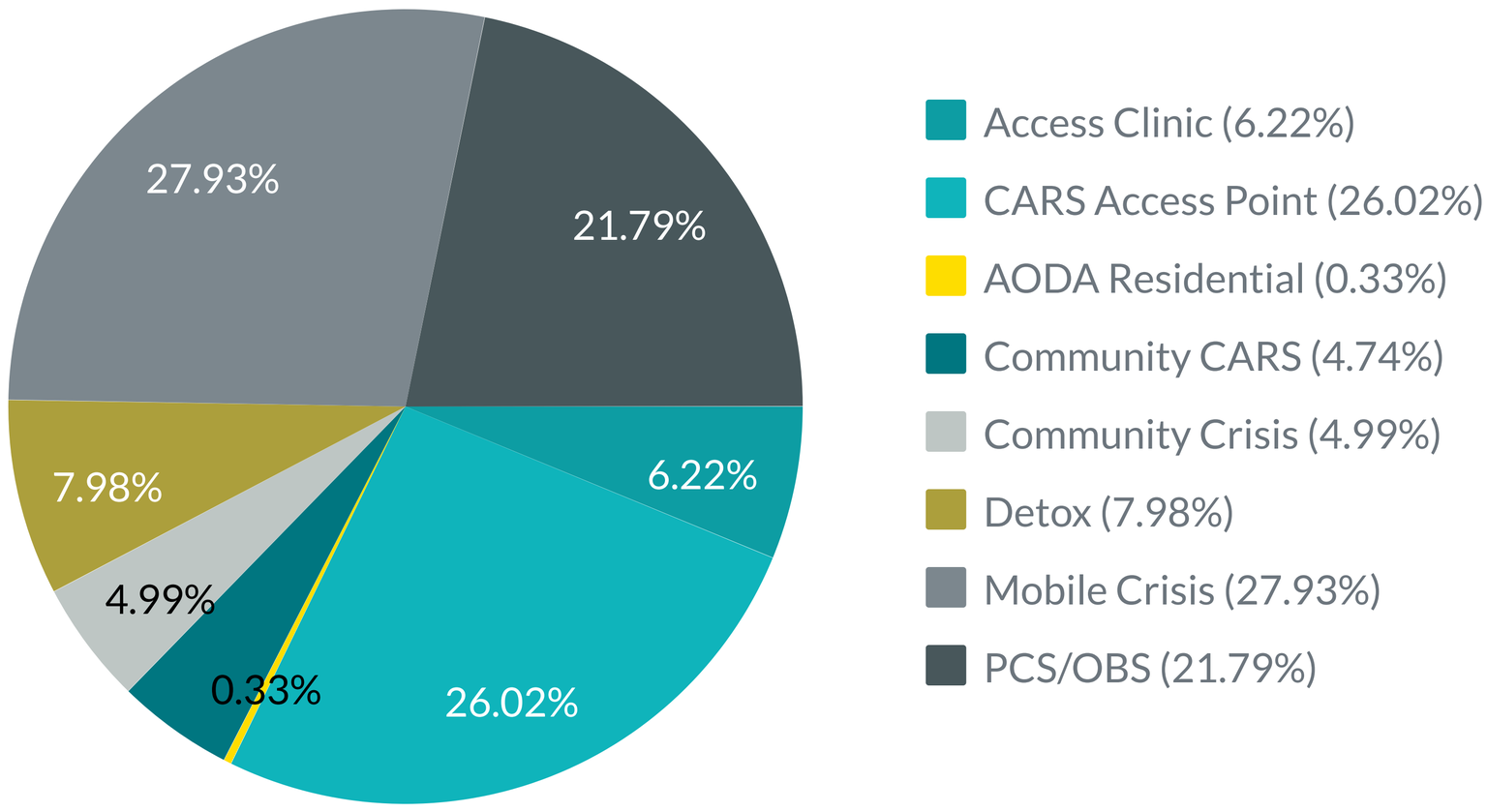
Milwaukee County Behavioral Health Services (BHS) does not have a single front door. This increases the need for strong collaboration between CARS and Community Crisis (Crisis) to ensure clients can access the services they need within the fully array of BHS's continuum of care.

53.95%

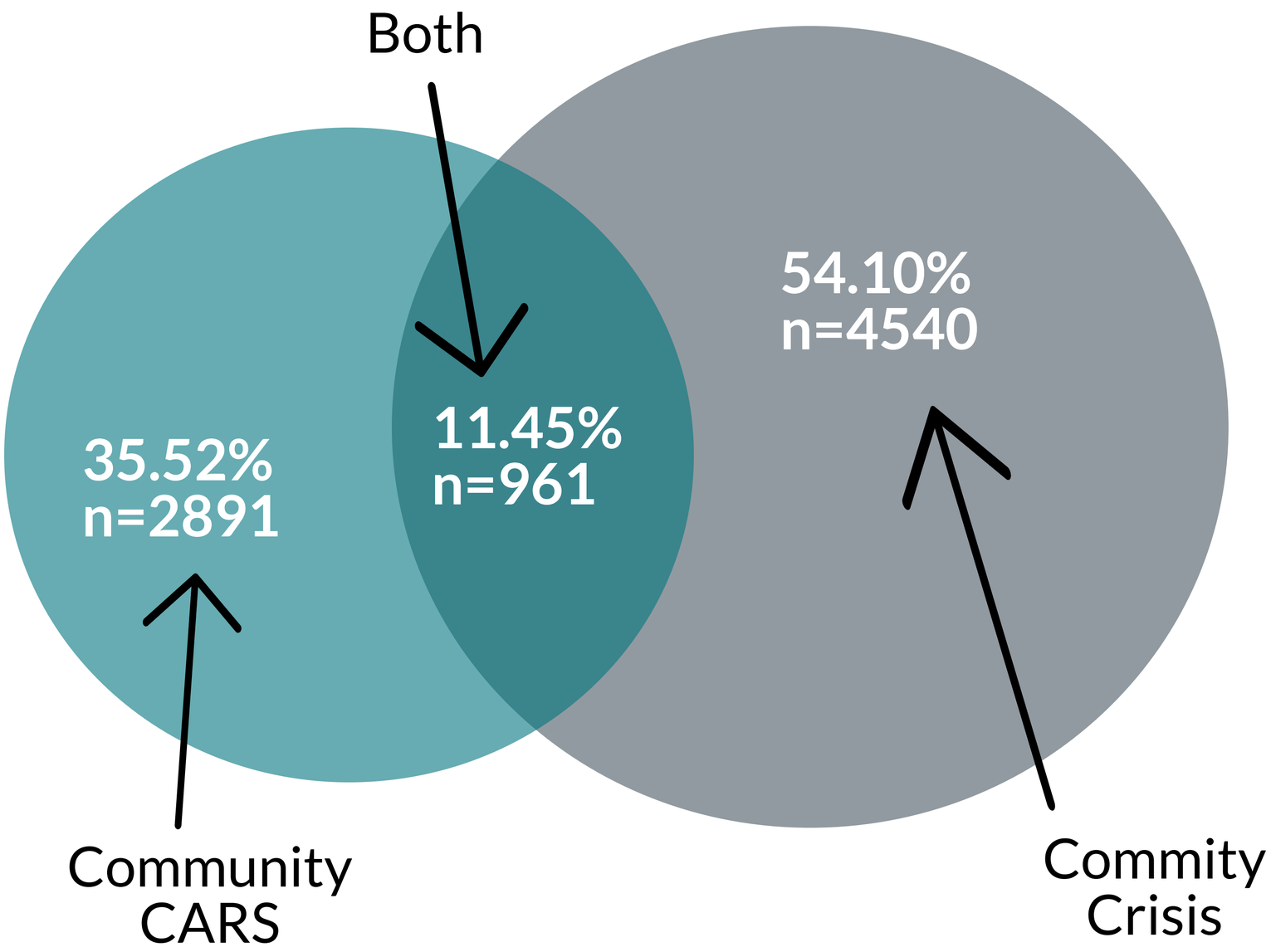
Percent of enrollments start in Mobile Crisis or a CARS Access Point

Where Do Clients First Present at BHS?

9214 New Enrollments 10/1/2020 to 9/30/2021



Proportion of Unique and Shared Clients Community CARS and Crisis: N=8392



An Opportunity to Integrate

Crisis and CARS share a substantial proportion of clients they serve.

Of the 8392 individuals who received services from either Crisis, CARS, or both, nearly 11.45% (961) received services from both within the first 90 days of enrollment.

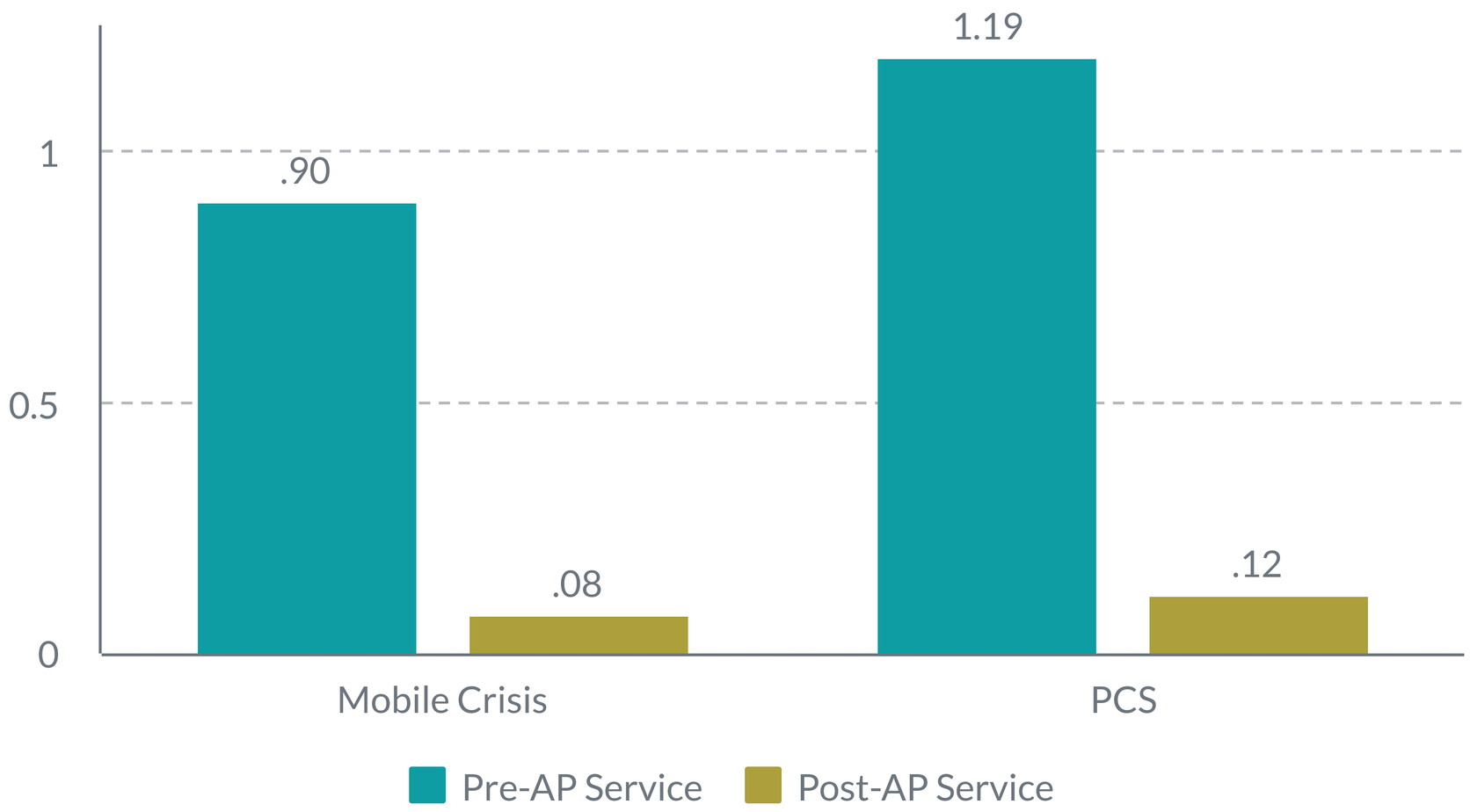
This represents 24.95% (961 of 3852) of clients receiving CARS services, and 17.47% (961 of 5501) of clients in Crisis Services.

Collaboration Works!

Seamless integration is a crucial component of an effective care continuum, as well as a vital element of a population-based approach to care.

Clients who begin their enrollment their enrollment in a Mobile Crisis or PCS service and then receive a service from a CARS Access Point (AP) within the first 90 days reduce their 30 day mean Mobile Crisis or PCS utilization dramatically.

Reduction in Mobile Crisis and PCS Visits Pre- and Post CARS AP Service (n=486)



=8.28%

Percent of Mobile Crisis or PCS clients with >= 3 acute service visits in first 90 days without a CARS service

Room to Grow

There remain opportunities for enhanced collaboration. There is a subset clients who started their enrollment in PCS or Mobile Crisis who have multiple acute service visits in the first 90 days of their enrollment who do not receive CARS services within that timeframe. These clients represent an important taget group.

Summary and Next Steps

Greater collaboration will:

- **Promote DHHS's vision of "No Wrong Door" because clients will have seamless access to the full array of BHS services, regardless of their entry point.**
- **Create greater satisfaction for our clients if they experience BHS as in integrated system of care.**
- **Advance the Quadruple Aim throughout BHS, particularly its focus on the health of our shared population of clients.**

By the end of 2022, the Crisis and CARS departments will jointly release a "Community Dashboard" that will focus on all the clients served with the community services at BHS,. These proposed metrics are in the graphic to the right.

Proposed Metrics for Community Population Dashboard

1 **Volume and Demographics**

Volume and demographics of clients served and shared in CARS and Crisis services at BHS

2 **Racial Equity**

Key metrics related to the BHS System-Wide CQI project focused on racial equity

3 **Integration Metrics**

Metrics related to care collaboration and integration between CARS and Crisis

Jennifer Wittwer, Director
Community Access to Recovery Services
Milwaukee County Behavioral Health Services

Lauren Hubbard, Director
Community Crisis Services
Milwaukee County Behavioral Health Services

BHD KPI Report Q1 2022

Children's Community Mental Health Services and Wraparound Milwaukee

Children's Community Mental Health Services and Wraparound Milwaukee BHD KPI Report

Report Overview

Unique Youth Served

2,371

Q1 2022

Children's Community Mental Health Services and Wraparound Milwaukee is a unique system of care for children with serious emotional, behavioral, and mental health needs and their families.

This report seeks to present information about quality care, costs, and outcomes framed by Wraparound values and DHHS values.

Average Cost of Care - average cost of care per family per month by program in the past quarter

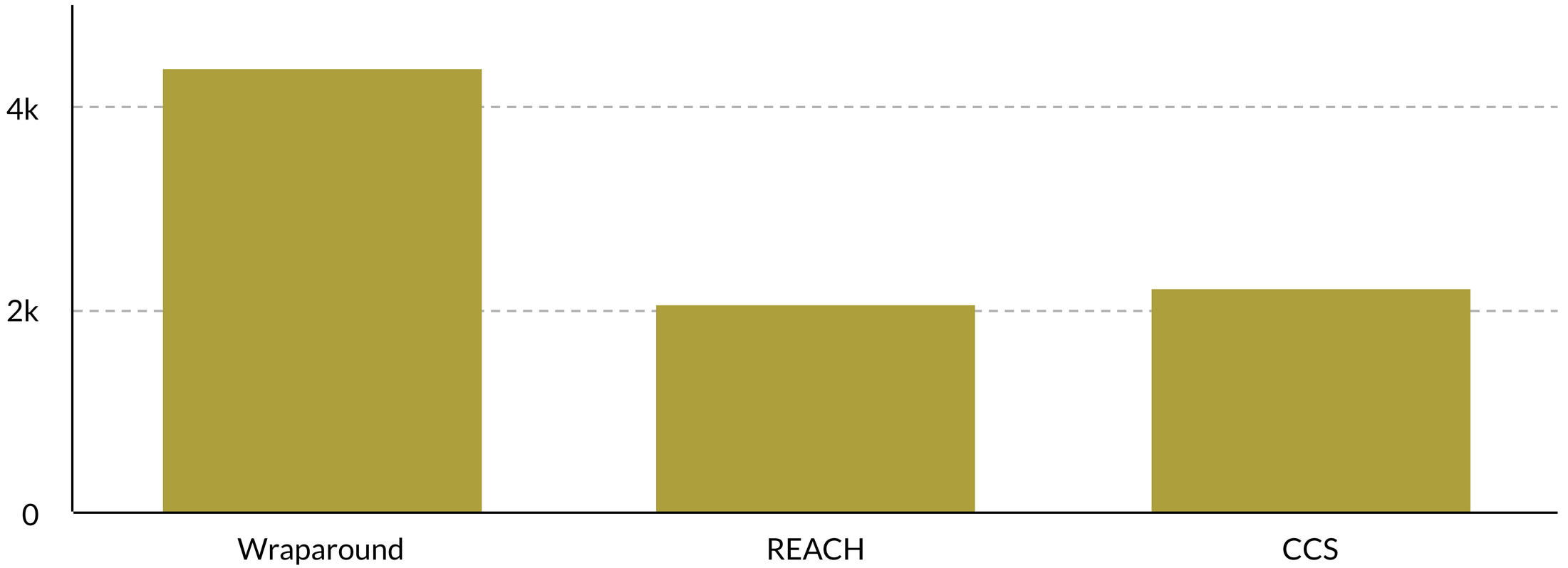
Population Health Metrics - social support and out-of-home recidivism

Outcomes - overall satisfaction, permanency at discharge, natural supports, and how well youth/caregiver is doing at discharge, discharge dispositions

Children's Community Mental Health Services
and Wraparound Milwaukee BHD KPI Report

Q1 2022

Average Cost Per Family



Wraparound
4,387

REACH
2,064

CCS
2,208

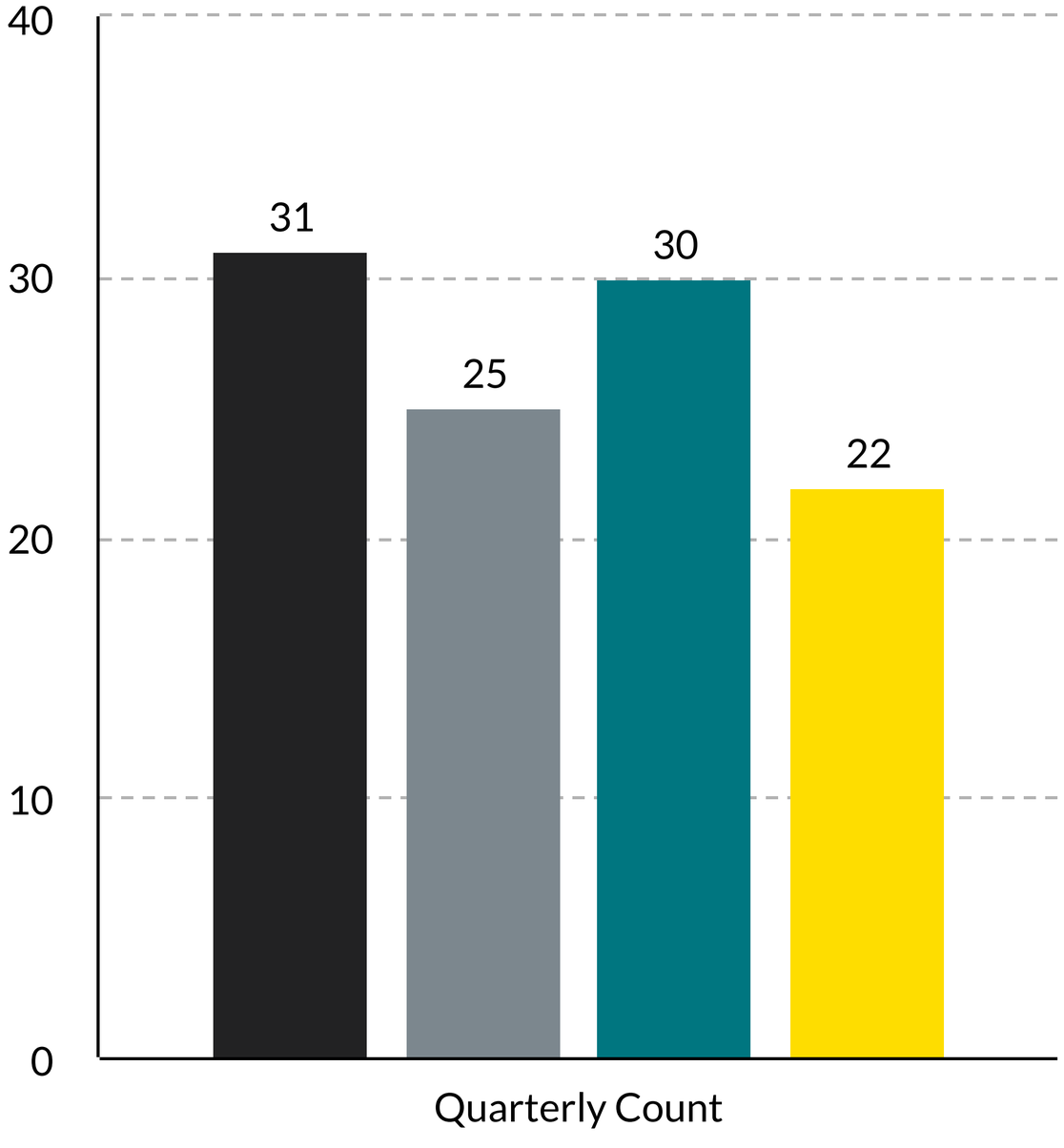
Average costs are based on the services utilized per family per month in the past quarter in Wraparound, REACH, and CCS.

Children's Community Mental Health Services
and Wraparound Milwaukee BHD KPI Report

Q1 2022

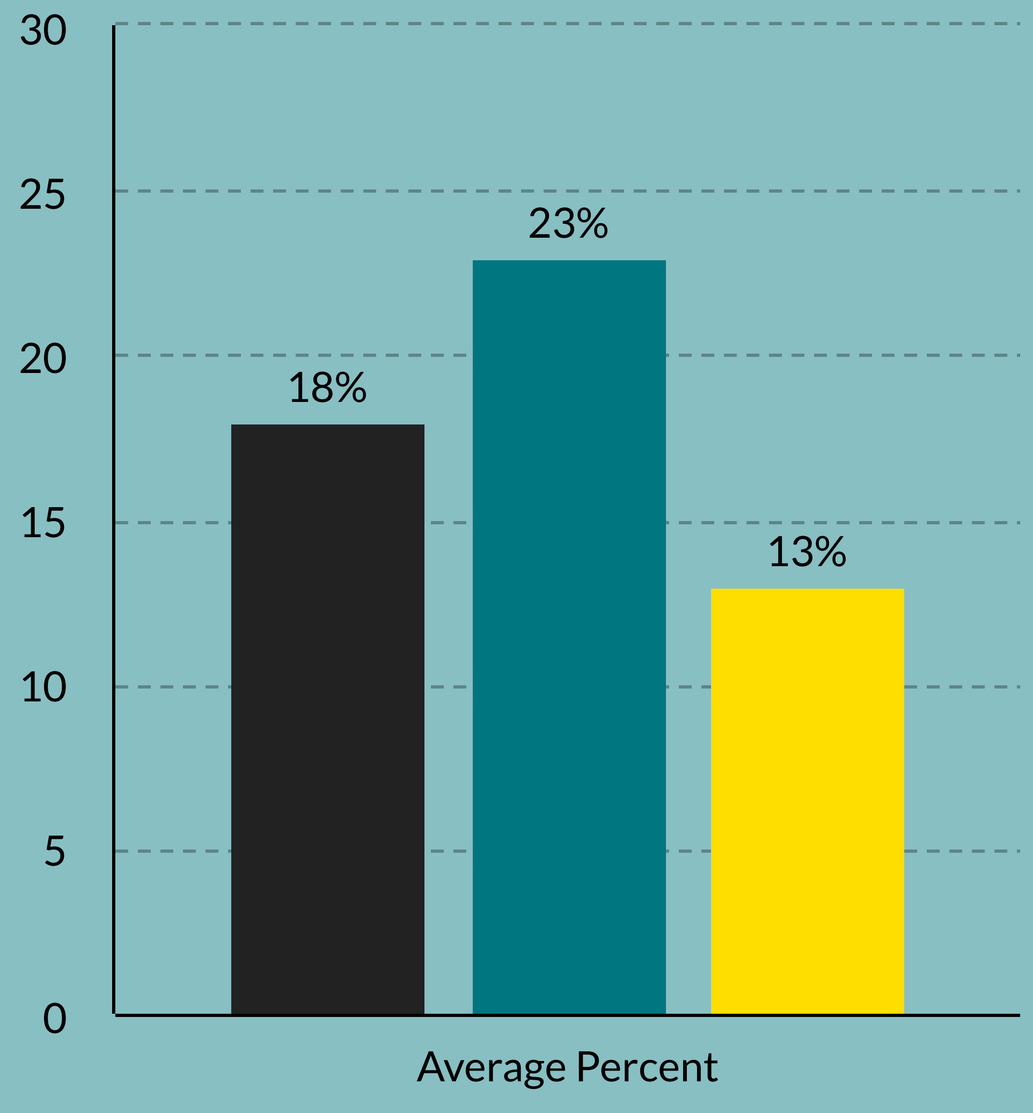
Population Health

Out of Home Recidivism Rate



Number of youth in Wraparound and REACH who moved from a home-type setting to an out of home type setting within each quarter displayed.

Percent of Natural Supports



Average percent of natural supports on teams in the past quarter.

Children's Community Mental Health Services and Wraparound Milwaukee BHD KPI Report

Outcomes

Q1 2022

Permanency at Discharge

79.3%

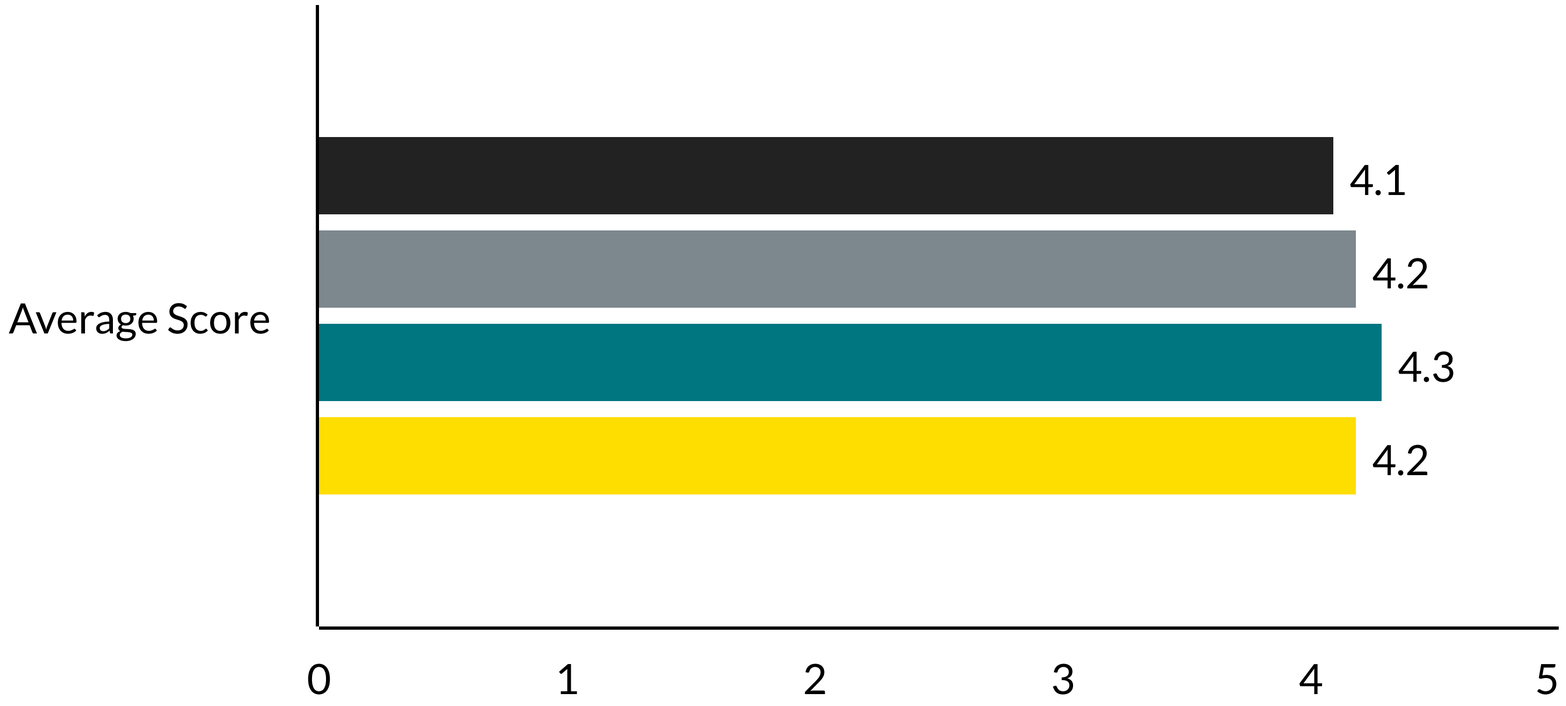
Percent of discharged youth placed in a home-type setting. Includes Wraparound, REACH, and CCS in the past quarter.

Family Satisfaction Overall Average Score

4.7

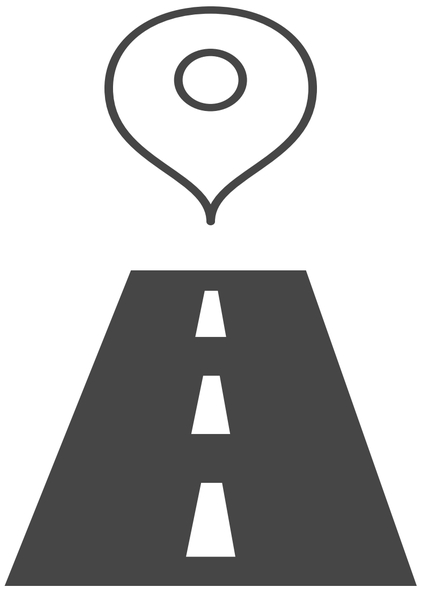
For Wraparound and REACH families in the past quarter

Youth and Caregiver Perceptions

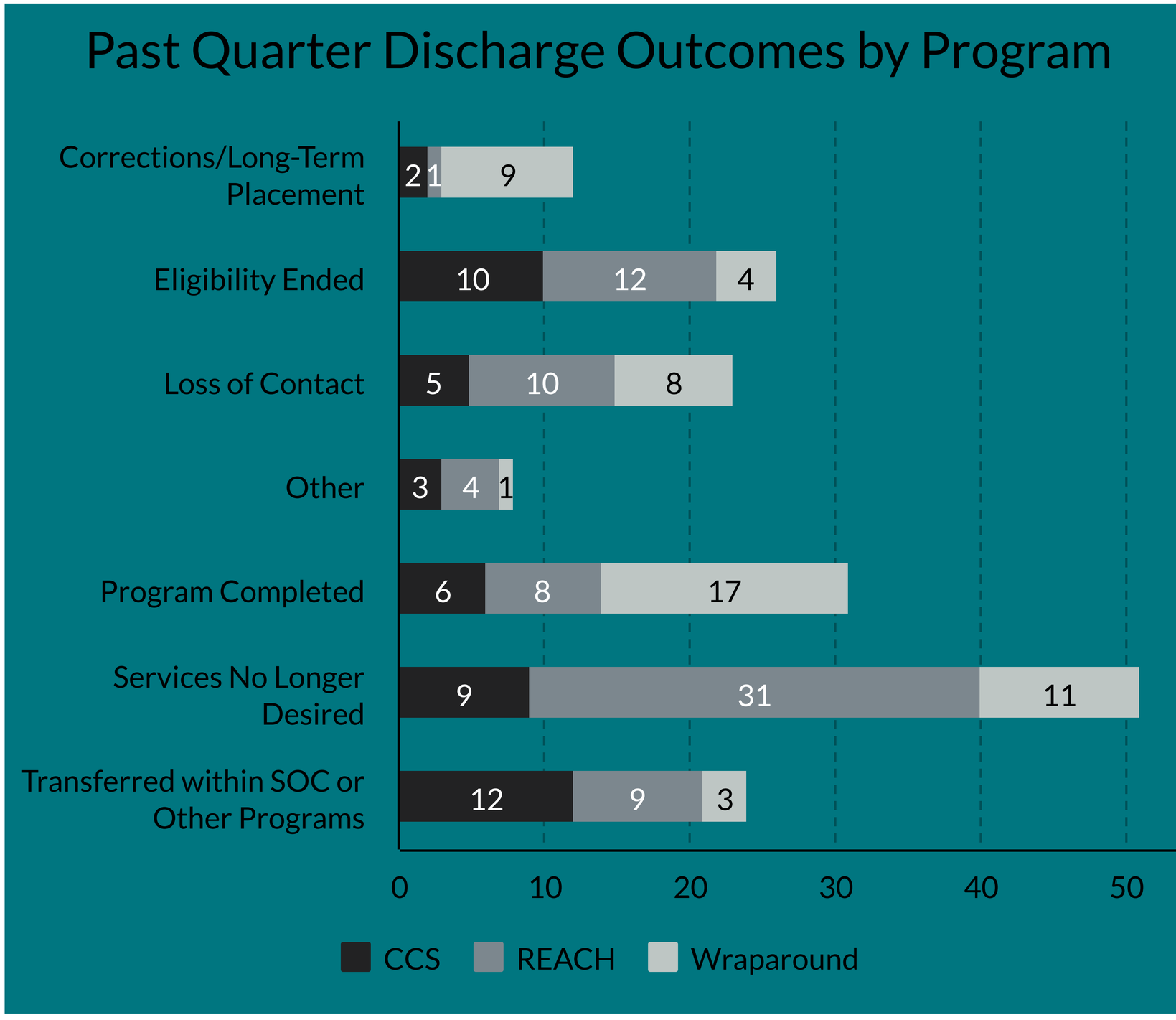


*Scores are from voluntary dis-enrollment surveys given to caregivers and youth in Wraparound and REACH programs in the past quarter.

Discharge Outcomes



Program	Discharges
Wraparound	53
REACH	75
CCS	47



Quality Committee Item 4

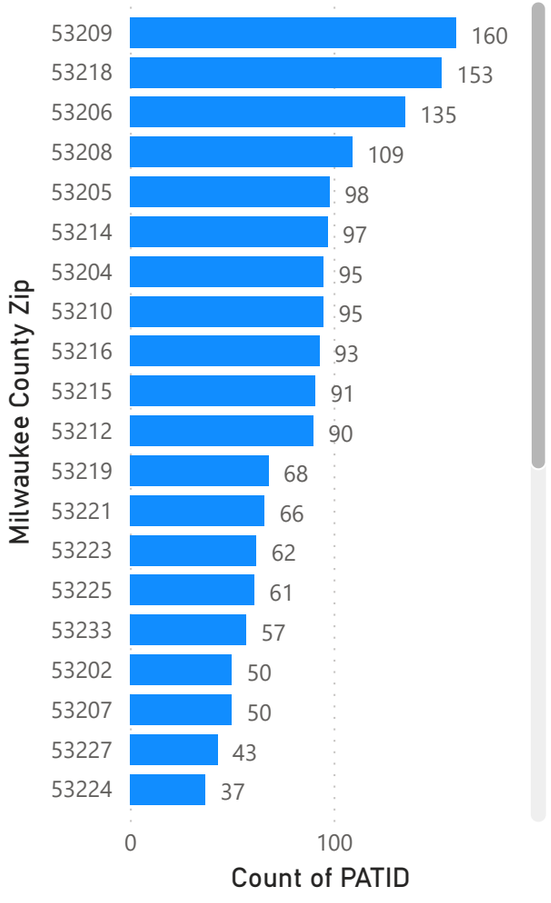
MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

Community Crisis Dashboard Q1 2022

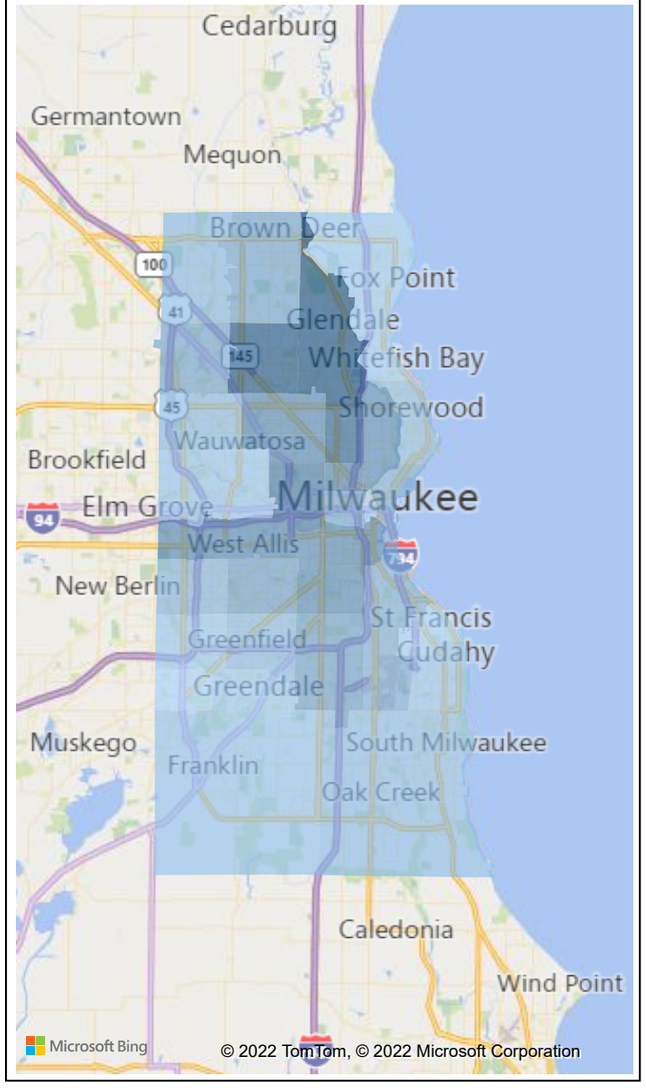
Clients with at Least One Crisis Service

2120

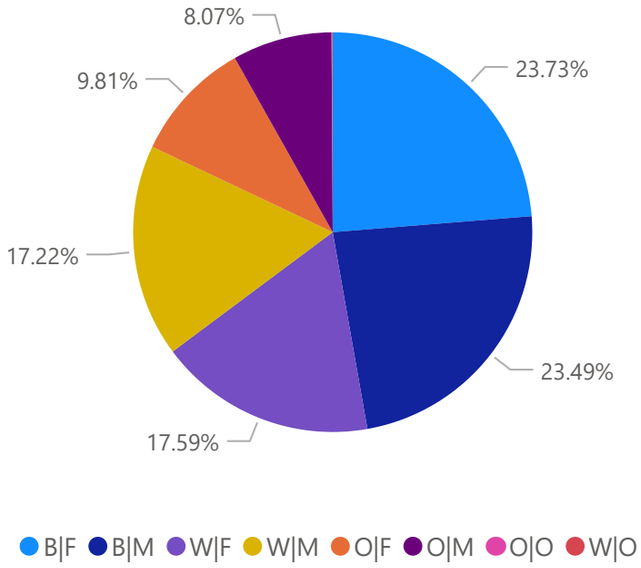
Unique Clients Served by Zip Code



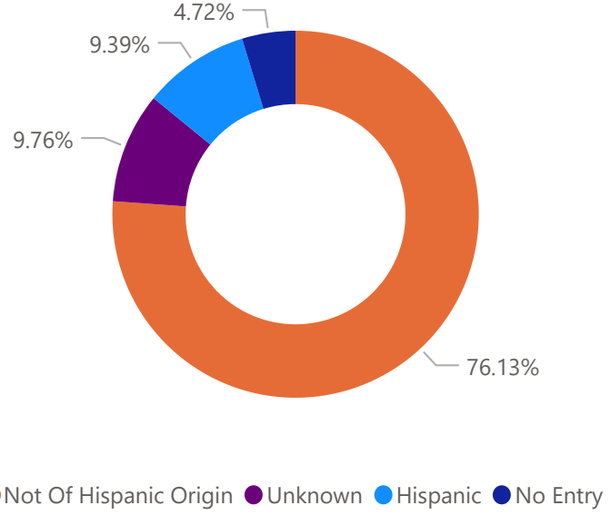
Unique Clients Served by Zip Code



Unique Clients by Race and Gender



Unique Clients by Ethnicity



Summary

The Community Crisis Dashboard currently displays the volume of unique clients who received a community crisis service by zip code, race, gender, and ethnicity, along with average client experience scores (OCA, CLASP, CMT). The department dashboard will expand over time to include additional metrics. This iteration of the Community Crisis Dashboard does not include hospital-based services (PCS/Observation), anonymous crisis line callers, or services provided by Impact Inc. on the Crisis Line.

Program dashboards are in development that will reflect service level information, including external crisis line services as provided by Impact Inc.

Client Experience Scores

Total (N=49): **4.61**

Black (n=28): **4.61**

White (n=13): **4.68**

Other (n=8): **4.48**

Quality Committee Item 5

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH & HUMAN SERVICES

Quality Management Update

To: Milwaukee County Mental Health Board Quality Committee

July 2022

Major Activity Updates

- Quality Management (QM) Strategy Roll-out
- QM Technical Team Engagement
- Alignment the QM Framework to operations
- Securing Evaluation Resources

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DHHS
Quality Management Strategy
Roll-Out

MILWAUKEE COUNTY

“Good quality management aims to unite an organization’s stakeholders in a common goal, improving processes, products, and services to achieve consistent success.”

QM Technical Team Engagement

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QM Technical Team Engagement

Objectives

- Orient staff to the DHHS Quality Management framework
- Establish shared-language amongst technical terms
- Build commodore amongst staff driving aligned efforts
- Identify department-wide opportunities to advance Quality Management

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QM Technical Team Engagement

Targeted Staff

Provide technical assistance to direct service teams and providers to ensure residents receive quality services. Staff with direct responsibilities that drive key organizational capabilities including:

- Workforce Development
- Network Management/Development
- Communications
- Technology
- Monitoring & Evaluation

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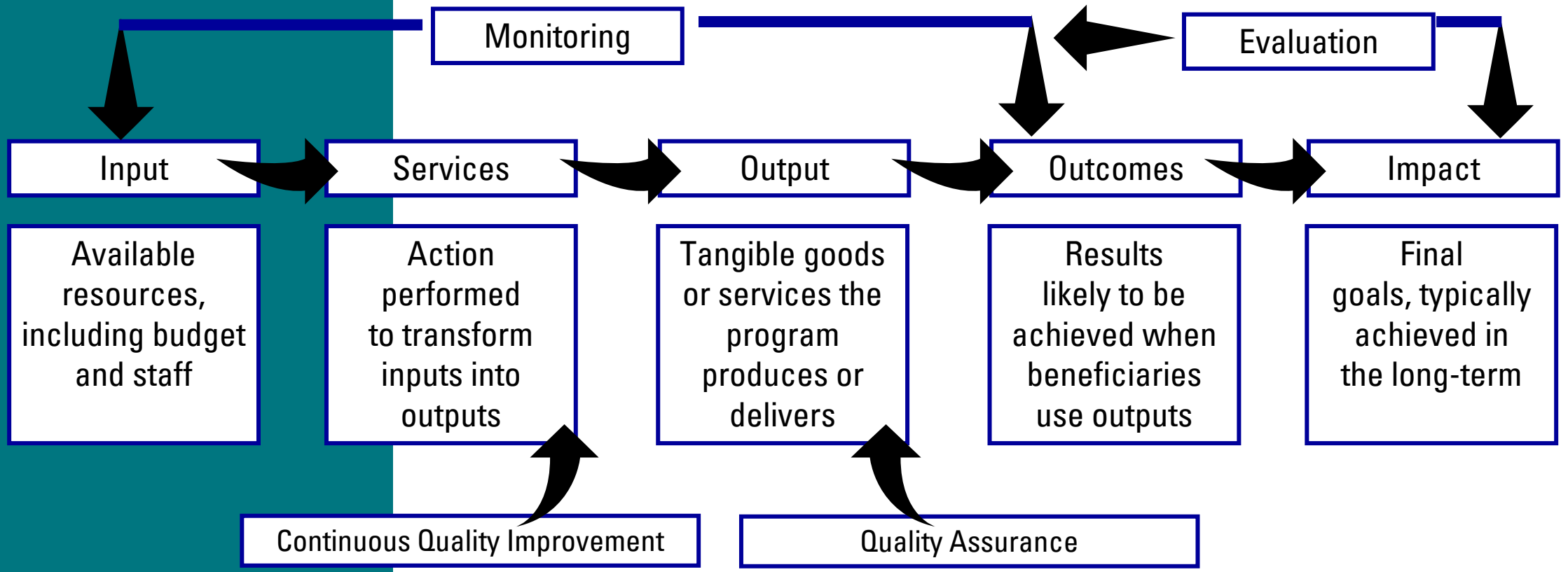
“

Successful quality management was never intended to be only one individual’s responsibility.

”

Monitoring & Evaluation Function



Quality is not a function nor activity but it's the degree something meets an established standards

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Shared-Language: Objectives

Objectives

- To help staff build their understanding terms, to explore the intricacies and implications of different definitions for key concepts and terms
- To become more comfortable discussing matters related to quality management.
- To create shared understanding for these terms and ensure everyone on the team is operating from the same foundational understanding.

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Shared Language in Quality Management

- Strategies
- Key Performance Indicators
- Goals
- Outcomes
- Indicators
- Metric
- Measure(s)
- Program Evaluation
- Assurance
- Continuous Improvement
- Compliance
- Audit

1. **Discuss terms and develop group definitions**
2. **Prepare to reflect and share on your discussion**
3. **Review and reflect DHHS other definitions**

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Having common language lays the groundwork for productive conversations and effective collaboration

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Roles + Responsibilities: Objectives

Objectives

- To learn and share how staff are currently supporting quality management.
- Identify similarities, difference and interest in QM-related work across teams.

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Roles in Quality Management

1. Discuss how your role and day-to-day work advances quality management based on the framework.
2. Capture key insights from discussion to share out

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Quality Management involves various functions beyond those that are data-related

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QUALITY MANAGEMENT

Priority

Technical Assistance
Policy Guidance
Strategy

Operational-Capabilities

Workforce Development
Staff Training
Employee Engagement
Performance Improvement
Capacity Building

Network Development
Community Engagement
Partnership Coordination
Policy Planning
Risk Management

Communication
Report Writing
Policy Development
Information Management
Change Management

Technology
Application Development

Monitoring x Evaluation
Research x Analytics
Program Planning
Data Management
Compliance/Audits
Continuous Improvement
Assurance

Change Management-Standardization

Information Reporting
Policy Guidance
Implementation

Service-Program Activities

Strategies
Key Performance Indicators
Goals
Outcomes
Indicators
Metrics
Measures

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Understanding each other's roles in quality management drive effectiveness and efficiency

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Call to Action

- Use the QM framework to clearly define functions and activities
- Be intentional about language when describing your work
- Share your ideas for scaling your work to department level or to enhancing it
- Identify needs you, your team or service areas have to support Monitoring & Evaluation
- Reach out directly with ongoing feedback

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Quality Management Alignment

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	Coordination and unity across teams	Stakeholder Engagement to contribute to results	Standardized data collection and reporting	Department-wide policies and procedures	Capacity building	Resource allocation for activities
What are you working on? (Service Area or Team)			-		-	
What should we be working? (Collectively or Department)						-

CYFS ADS BHS HOU MSDO

DHHS Project Priorities

DHHS QM Project Priorities (padlet.com)

QUALITY MANAGEMENT

Priority

Technical Assistance
Policy Guidance
Strategy

Operational-Capabilities

Workforce Development
Staff Training
Employee Engagement
Performance Improvement
Capacity Building

Network Development
Community Engagement
Partnership Coordination
Policy Planning
Risk Management

Communication
Report Writing
Policy Development
Information Management
Change Management

Technology
Application Development

Monitoring x Evaluation
Research x Analytics
Program Planning
Data Management
Compliance/Audits
Continuous Improvement
Assurance

Change Management-Standardization

Information Reporting
Policy Guidance
Implementation

Service-Program Activities

Strategies
Key Performance Indicators
Goals
Outcomes
Indicators
Metrics
Measures

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Monitoring & Evaluation Resources

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Next Steps

- Secure resources to drive operationalized Monitoring and Evaluation
- Continue to digest and discuss the quality management framework with teams
- Generate synergy by using the quality management framework to guide priorities and decisions
- Identify, align, and support projects to address department's Monitoring & Evaluation needs
- Cultivate professional development opportunities through ad-hoc projects

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Quality Committee Item 6

2022 Q1 MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES INPATIENT DASHBOARD

Psychiatric Crisis Service (PCS)

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: Rate=8.5% Q2: Q3: Q4:	Rate=8.5%	Percent of patients returning to PCS within 3 days	Rate X < 7.8% X = 7.8% X > 7.8%	Rate=Count of client visits within 3 days of prior visit/Total client visits Q1: 125 readmissions within 3 days by 86 unique individuals Q2: Q3: Q4:
Q1: Rate=24.3% Q2: Q3: Q4:	Rate=24.3%	Percent of patients returning to PCS within 30 days	Rate X < 24% X = 24% X > 24%	Rate=Count of client visits within 30 days of prior visit/Total client visits Q1: 358 readmissions within 30 days by 197 unique individuals Q2: Q3: Q4:
Q1: Rate=1.4 (n=2) Q2: Q3: Q4:	Rate=1.4 (n=2)	Behavioral Codes (Code 1)	Rate X < 2.3 X = 2.3 X > 2.3	Rate=Behavioral codes per 1,000 PCS visits The objective of this metric is to not only to monitor the quantity/rate of codes called resulting in further treatment (Restraint and Seclusion).
Q1: Rate=0.68 (n=1) Q2: Q3: Q4:	Rate=0.68 (n=1)	Physical Aggression - Patient/Patient	Incidents Zero 2 or Less > 2	Rate=Pt/Pt physical aggression incidents per 1,000 PCS visits.
Q1: Rate=0.68 (n=1) Q2: Q3: Q4:	Rate=0.68 (n=1)	Physical Aggression - Patient/Staff	Incidents Zero 2 or Less > 2	Rate=Pt/Staff physical aggression incidents per 1,000 PCS visits.
Q1: Rate=0.0 (n=0) Q2: Q3: Q4:	Rate=0.0 (n=0)	Patient Elopement	Incidents Zero 2 or Less > 2	Rate = Patient elopements per 1,000 PCS visits BHD's current Elopement definition: Patient eloped from locked unit and returned within the building or patient eloped from locked unit and exited the building. Joint Commission's elopement definition = unauthorized departure, of a patient from an around-the-clock care setting.

Q1: Rate=0.68 (n=1) Q2: Q3: Q4:	Rate=0.68 (n=1)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient Self Injurious Behavior Incidents per 1,000 PCS visits
Q1: Rate=27.2 (n=3) Q2: Q3: Q4:	Rate=27.2 (n=3)	Medication Errors	Rate X = 0 X < 1.1 X > 1.1	Rate=Medication Errors per 10,000 Doses Dispensed In 2022, PCS had (2) omitted doses, and (1) Incorrect administration protocol.

2022 Q1 MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES INPATIENT DASHBOARD

Acute Adult Inpatient Service

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: Rate=3.0% (n=4) Q2: Q3: Q4:	3.0% (n=4)	Percent of patients returning to Acute Adult within 7 days	Rate X < 3% X = 3% X > 3%	Rate=Percent of patient admissions occurring within 7 days of patient's prior discharge from the program
Q1: Rate=10.4% (n=14) Q2: Q3: Q4:	10.4% (n=14)	Percent of patients returning to Acute Adult within 30 days	Rate X < 9.6% X = 9.6% X > 9.6%	Rate=Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
Q1: 63.0% positive Q2: Q3: Q4:	63.0%	Percent of patients responding positively to MHSIP satisfaction survey	Rate X > 75% X = 75% X < 75%	Rate=Percent of patients selecting "Agree" or "Strongly Agree" to all survey items Q1: 41 completed surveys (30% response rate) Q2: Q3: Q4:
Q1: 44.7% positive Q2: Q3: Q4:	44.7%	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	Rate X > 65% X = 65% X < 65%	Rate=Percent of patients selecting "Agree" or "Strongly Agree" to survey item Q1: 41 completed surveys (30% response rate) Q2: Q3: Q4:
Q1: Rate=5.4 (n=10) Q2: Q3: Q4:	Rate=5.4 (n=10)	Behavioral Codes	Rate X < 9.2 X = 9.2 X > 9.2	Rate=Behavioral codes per 1,000 patient days The objective of this metric is to not only to monitor the quantity/rate of codes called resulting in further treatment (Restraint and Seclusion). 43A Incidents - Q1: 0 43B Incidents - Q1: 0 43C Incidents - Q1: 3 43D Incidents - Q1: 7
Q1: Rate=5.4 (n=10) Q2: Q3: Q4:	Rate=5.4 (n=10)	Physical Aggression - Patient/Patient	Rate X < 2.9 X = 2.9 X > 2.9	Rate=Pt/Pt physical aggression incidents per 1,000 patient days 43A Incidents - Q1: 0 43B Incidents - Q1: 0 43C Incidents - Q1: 0 43D Incidents - Q1: 10 (1 patient accounted for 4 of the total events on 43D)
Q1: Rate=6.5 (n=12) Q2: Q3: Q4:	Rate=6.5 (n=12)	Physical Aggression - Patient/Staff	Rate X < 2.9 X = 2.9 X > 2.9	Rate=Pt/Staff physical aggression incidents per 1,000 patient days 43A Incidents - Q1: 0 43B Incidents - Q1: 0 43C Incidents - Q1: 7

				43D Incidents - Q1: 5 (1 patient accounted for 3 of the total events on 43D)
Q1: Rate=1.1 (n=2) Q2: Q3: Q4:	Rate=1.1 (n=2)	Patient Elopement	Incidents Zero 1 > 2	Rate=Patient elopements per 1,000 patient days 43A Incidents - Q1: 0 43B Incidents - Q1: 0 43C Incidents - Q1: (1) patient eloped after staff entered through unit door, brought back safely by staff. 43D Incidents - Q1: (1) patient broke dining room door, eloped from building, found by nearby police and brought back safely.
Q1: Rate=0.0 (n=0) Q2: Q3: Q4:	Rate=0.0 (n=0)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient Self Injurious Behavior Incidents per 1,000 patient days 43A Incidents - Q1: 0 43B Incidents - Q1: 0 43C Incidents - Q1: 0 43D Incidents - Q1: 0
Q1: Rate=17.6 (n=26) Q2: Q3: Q4:	Rate=17.6 (n=26)	Medication Errors	Rate X < 1.1 X = 1.1 X > 1.1	Rate=Medication errors per 10,000 administered doses 43A Incidents - Q1: 0 43B Incidents - Q1: 0 43C Incidents - Q1: 11 43D Incidents - Q1: 15 In 2022, Acute Adult's medication errors were: Omitted dose (22), Incorrect dose (3), Incorrect patient (1).
Q1: Rate=.41 (18.3 hrs) Q2: Q3: Q4:	.41 (18.3 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate X < .26 X = .26 X > .26	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care 43A - Q1: 0.0 hrs 43B - Q1: 0.0 hrs 43C - Q1: 7.1 hrs 43D - Q1: 11.2 hrs
Q1: Rate=.20 (8.8 hrs) Q2: Q3: Q4:	.20 (8.8 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate X < .25 X = .25 X > .25	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care 43A - Q1: 0.0 hrs 43B - Q1: 0.0 hrs 43C - Q1: 4.4 hrs 43D - Q1: 4.3 hrs
Q1: Rate=16% (n=22) Q2: Q3: Q4:	16% (n=22)	HBIPS 4 - Patients discharged on multiple antipsychotic medications	Rate X < 9.5% X = 9.5% X > 9.5%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications
Q1: Rate=95% (n=21) Q2: Q3: Q4:	95% (n=21)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate X > 65% X = 65% X < 65%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification

2022 Q1 MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES INPATIENT DASHBOARD

Child Adolescent Inpatient Service (CAIS)

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: 3.7% (n=3) Q2: Q3: Q4:	Rate=3.7% (n=3)	Percent of patients returning to CAIS within 7 days	Rate X < 5.0% X = 5.0% X > 5.0%	Rate=Percent of patient admissions occurring within 7 days of patient's prior discharge from the program
Q1: 6.2% (n=5) Q2: Q3: Q4:	Rate=6.2% (n=5)	Percent of patients returning to CAIS within 30 days	Rate X < 9.6% X = 9.6% X > 9.6%	Rate=Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
Q1: 72.0% positive Q2: Q3: Q4:	72.0%	Percent of patients responding positively to satisfaction survey	Rate X > 75% X = 75% X < 75%	Rate=Percent of patients selecting "Agree" and "Strongly Agree" to all survey items Q1: 17 completed surveys (28% response rate) Q2: Q3: Q4:
Q1: 70.6% positive Q2: Q3: Q4:	70.6%	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	Rate X > 75% X = 75% X < 75%	Rate=Percent of patients selecting "Agree" and "Strongly Agree" to survey item Q1: 17 completed surveys (28% response rate) Q2: Q3: Q4:
Q1: Rate=4.8 (n=2) Q2: Q3: Q4:	Rate=4.8 (n=2)	Behavioral Codes (Code 1)	Rate X < 8.0 X = 8.0 X > 8.0	The objective of this metric is to not only to monitor the quantity of codes but of the codes called and how many of them resulted in further treatment with restraint and/or seclusion.
Q1: Rate=2.4 (n=1) Q2: Q3: Q4:	Rate=2.4 (n=1)	Physical Aggression - Patient/Patient	Incidents Zero 2 or Less > 2	Rate=Pt/Pt physical aggression incidents per 1,000 patient days
Q1: Rate=9.6 (n=4) Q2: Q3: Q4:	Rate=9.6 (n=4)	Physical Aggression - Patient/Staff	Incidents Zero 2 or Less > 2	Rate=Pt/Staff physical aggression incidents per 1,000 patient days

Q1: Rate=0.0 (n=0) Q2: Q3: Q4:	Rate=0.0 (n=0)	Patient Elopement	Incidents Zero 1 > 2	Rate=Patient elopements per 1,000 patient days
Q1: Rate=4.8 (n=2) Q2: Q3: Q4:	Rate=4.8 (n=2)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient self-injurious behavior Incidents per 1,000 patient days
Q1: Rate=5.0 (n=1) Q2: Q3: Q4:	Rate=5.0 (n=1)	Medication Errors	Rate X < 1.1 X = 1.1 X > 1.1	Rate=Medication errors per 10,000 doses administered In 2022, CAIS had (1) Omitted dose.
Q1: Rate=.78 (7.8 hrs) Q2: Q3: Q4:	.78 (7.8 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate X < .26 X = .26 X > .26	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care
Q1: Rate=.07 (0.8 hrs) Q2: Q3: Q4:	.07 (0.8 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate X < .25 X = .25 X > .25	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care
Q1: Rate=0.0% (n=0) Q2: Q3: Q4:	0.0% (n=0)	HBIPS 4 - Patients discharged on multiple antipsychotic medications	Rate X < 3% X = 3% X > 3%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications
Q1: -- Q2: Q3: Q4:	-- (n=0)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate X > 65% X = 65% X < 65%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification

2022 Q1 MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES INPATIENT DASHBOARD

Acute Inpatient Performance Measures Reported to CMS

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: Rate=.48 (26.1 hrs) Q2: Q3: Q4:	.48 (26.1 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate X < .26 X = .26 X > .26	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care
Q1: Rate=.17 (9.5 hrs) Q2: Q3: Q4:	.17 (9.5 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate X < .25 X = .25 X > .25	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care
Q1: 95% (n=21) Q2: Q3: Q4:	95% (n=21)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate X > 65% X = 65% X < 65%	Rate=Patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification
Q1: 87% (n=157) Q2: Q3: Q4:	87% (n=157)	Screening for metabolic disorders	Rate X > 78% X = 78% X < 78%	Rate=Patients discharged on antipsychotic medications who had a body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year
Q1: 51% (n=110) Q2: Q3: Q4:	51% (n=110)	Patient influenza immunization	Rate X > 79% X = 79% X < 79%	Rate=Patients assessed and given influenza vaccination (flu season time period 10/1 – 3/31)
Q1: 100% (n=29) Q2: Q3: Q4:	100% (n=29)	SUB 2 - Alcohol use brief intervention provided or offered	Rate X > 79% X = 79% X < 79%	Rate=Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay.
Q1: 83% (n=24) Q2: Q3: Q4:	83% (n=24)	SUB 2a - Alcohol use brief intervention provided	Rate X > 72% X = 72% X < 72%	Rate=Patients with alcohol abuse who received a brief intervention during their inpatient stay.

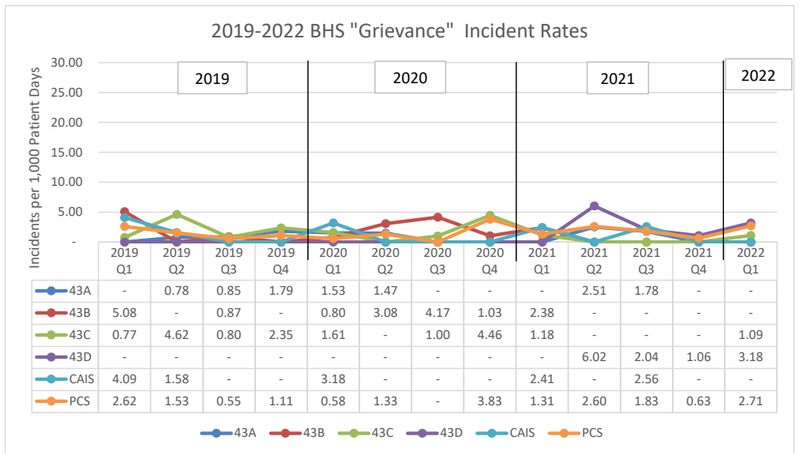
Q1: 100% (n=84) Q2: Q3: Q4:	100% (n=84)	SUB 3 - Alcohol and other drug use disorder treatment provided or offered at discharge	Rate X > 75% X = 75% X < 75%	Rate=Patients who screened positive for an alcohol or substance abuse disorder during their inpatient stay who, at discharge, either; received or refused a prescription for medications to treat their alcohol or drug use disorder, or received or refused a referral for addiction treatment
Q1: 39% (n=33) Q2: Q3: Q4:	39% (n=33)	SUB 3a - Alcohol and other drug use disorder treatment at discharge	Rate X > 63% X = 63% X < 63%	Rate=Patients who screened positive for an alcohol or substance abuse disorder during their inpatient stay who, at discharge, either; received a prescription for medications to treat their alcohol or drug use disorder, or received a referral for addiction treatment
Q1: 97% (n=63) Q2: Q3: Q4:	97% (n=63)	TOB 2 - Tobacco use treatment provided or offered	Rate X > 81% X = 81% X < 81%	Rate=Patients who use tobacco and who received or refused counseling to quit and received or refused medications to help them quit tobacco during their hospital stay
Q1: 83% (n=54) Q2: Q3: Q4:	83% (n=54)	TOB 2a - Tobacco use treatment (during the hospital stay)	Rate X > 45% X = 45% X < 45%	Rate=Patients who use tobacco and who received counseling to quit and received medications to help them quit tobacco during their hospital stay
Q1: 15% (n=10) Q2: Q3: Q4:	15% (n=10)	TOB 3 - Tobacco use treatment provided or offered at discharge	Rate X > 61% X = 61% X < 61%	Rate=Patients who use tobacco and at discharge received or refused a referral for outpatient counseling AND received or refused a prescription for medications to help them quit.
Q1: 3% (n=2) Q2: Q3: Q4:	3% (n=2)	TOB 3a - Tobacco use treatment provided at discharge	Rate X > 22% X = 22% X < 22%	Rate=Patients who use tobacco and at discharge received a referral for outpatient counseling AND received a prescription for medications to help them quit
2018: 29.4% 2019: 27.9% 2020: 27.3%		FUH 30 - Follow-up after hospitalization for mental illness	Rate X > 49.5% X = 49.5% X < 49.5%	Rate=Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 30 days of discharge. CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.
2018: 5.9% 2019: 8.1% 2020: 6.1%		FUH 7 - Follow-up after hospitalization for mental illness	Rate X > 27.9% X = 27.9% X < 27.9%	Rate=Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge. CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.

 2018: 19.4% 2019: 18.6% 2020: 17.5% CMS reports BHD is “no different than the national rate”		READMN 30 IPF - 30 day all cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	Rate  X < 20.2%  X = 20.2%  X > 20.2%	Rate=Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility CMS calculates this measure based on Medicare claims data and reports BHD’s performance on the https://data.medicare.gov/data/hospital-compare website annually.

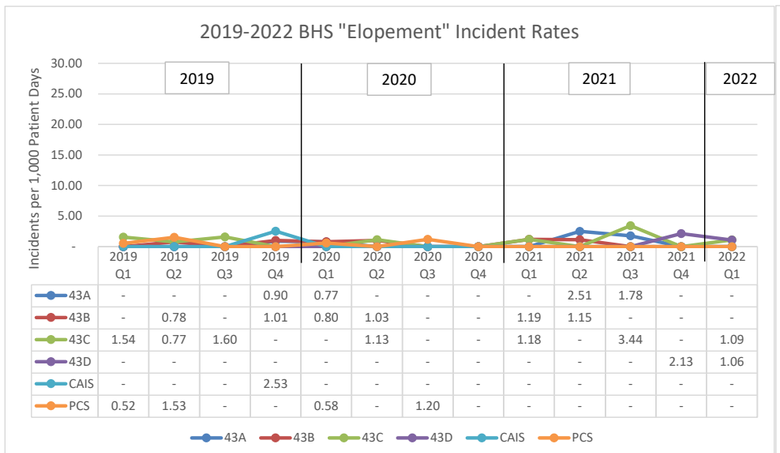
2022 BHS Reported Incidents

Time Period: 1/1/22-3/31/22

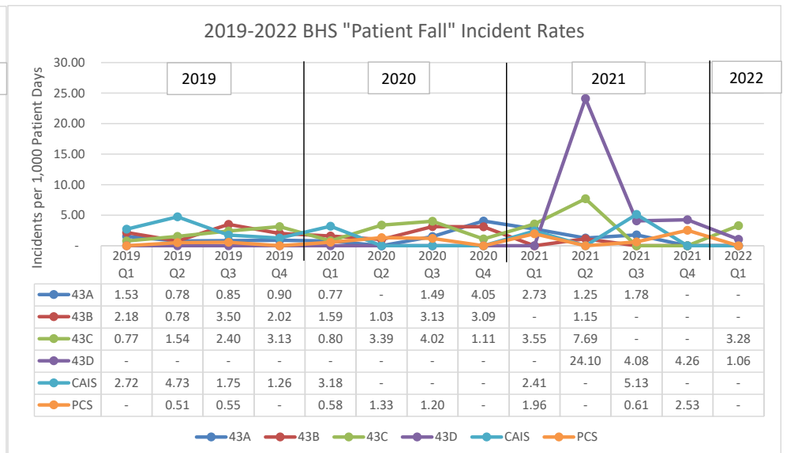
Incident Category	Unit																																		Total					
	43A						43B						43C						43D						CAIS						PCS						Other Areas											
	Q1	Q2	Q3	Q4	Total	%	Q1	Q2	Q3	Q4	Total	%	Q1	Q2	Q3	Q4	Total	%	Q1	Q2	Q3	Q4	Total	%	Q1	Q2	Q3	Q4	Total	%	Q1	Q2	Q3	Q4	Total	%	Q1	Q2	Q3	Q4	Total	%
Behavior	-				-	0.0%	-				-	0.0%	2				2	5.6%	1				1	1.6%	-				-	0.0%	2				2	8.0%	1				1	5.3%	6	-	-	-	6	3.4%
Device, Equipment or Supply	-				-	0.0%	-				-	0.0%	7				7	19.4%	13				13	20.6%	7				7	22.6%	3				3	12.0%	-				-	0.0%	30	-	-	-	30	17.1%
Diagnostic tests (labs/radiology/EKG)	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-	-	-	-	-	0.0%
Elopement	-				-	0.0%	-				-	0.0%	1				1	2.8%	1				1	1.6%	-				-	0.0%	-				-	0.0%	5				5	26.3%	7	-	-	-	7	4.0%
Falls	-				-	0.0%	-				-	0.0%	3				3	8.3%	1				1	1.6%	-				-	0.0%	-				-	0.0%	-				-	0.0%	4	-	-	-	4	2.3%
Fire	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-	-	-	-	-	0.0%
Grievances	1				1	100.0%	-				-	0.0%	1				1	2.8%	3				3	4.8%	-				-	0.0%	4				4	16.0%	3				3	15.8%	12	-	-	-	12	6.9%
Medical Emergency	-				-	0.0%	-				-	0.0%	-				-	0.0%	1				1	1.6%	-				-	0.0%	1				1	4.0%	-				-	0.0%	2	-	-	-	2	1.1%
Medication	-				-	0.0%	-				-	0.0%	11				11	30.6%	15				15	23.8%	1				1	3.2%	3				3	12.0%	2				2	10.5%	32	-	-	-	32	18.3%
Other	-				-	0.0%	-				-	0.0%	2				2	5.6%	5				5	7.9%	3				3	9.7%	2				2	8.0%	8				8	42.1%	20	-	-	-	20	11.4%
Physical Aggression - Patient/Employee	-				-	0.0%	-				-	0.0%	7				7	19.4%	5				5	7.9%	4				4	12.9%	1				1	4.0%	-				-	0.0%	17	-	-	-	17	9.7%
Physical Aggression - Patient/Patient	-				-	0.0%	-				-	0.0%	-				-	0.0%	10				10	15.9%	1				1	3.2%	1				1	4.0%	-				-	0.0%	12	-	-	-	12	6.9%
Property Damage	-				-	0.0%	-				-	0.0%	2				2	5.6%	5				5	7.9%	6				6	19.4%	3				3	12.0%	-				-	0.0%	16	-	-	-	16	9.1%
Search and seizure	-				-	0.0%	-				-	0.0%	-				-	0.0%	2				2	3.2%	3				3	9.7%	2				2	8.0%	-				-	0.0%	7	-	-	-	7	4.0%
Security/Property	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	4				4	12.9%	-				-	0.0%	-				-	0.0%	4	-	-	-	4	2.3%
Self Injurious Behavior	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	2				2	6.5%	1				1	4.0%	-				-	0.0%	3	-	-	-	3	1.7%
Sexual Contact	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-	-	-	-	-	0.0%
Sexually Inappropriate Behavior	-				-	0.0%	-				-	0.0%	-				-	0.0%	1				1	1.6%	-				-	0.0%	1				1	4.0%	-				-	0.0%	2	-	-	-	2	1.1%
Suicide Attempt	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	-				-	0.0%	1				1	4.0%	-				-	0.0%	1	-	-	-	1	0.6%
Total	1	-	-	-	1	100.0%	-	-	-	-	-	0.0%	36	-	-	-	36	100.0%	63	-	-	-	63	100.0%	31	-	-	-	31	100.0%	25	-	-	-	25	100.0%	19	-	-	-	19	100.0%	175	-	-	-	175	100.0%



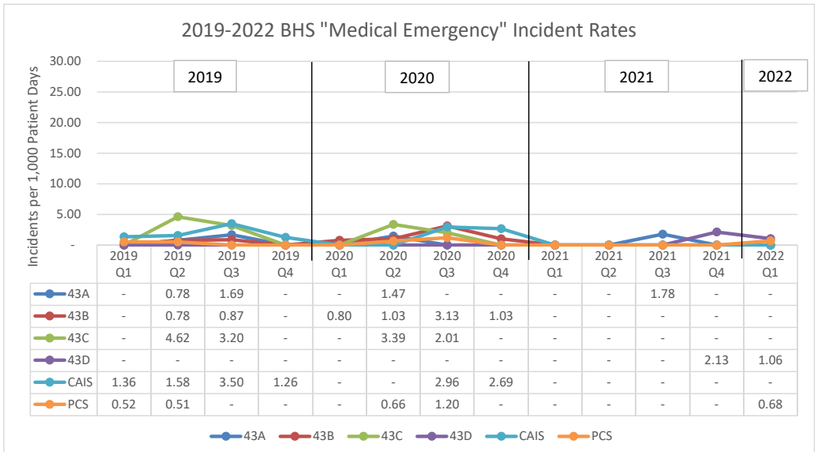
	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1
43A	-	0.78	0.85	1.79	1.53	1.47	-	-	-	2.51	1.78	-	-
43B	5.08	-	0.87	-	0.80	3.08	4.17	1.03	2.38	-	-	-	-
43C	0.77	4.62	0.80	2.35	1.61	-	1.00	4.46	1.18	-	-	-	1.09
43D	-	-	-	-	-	-	-	-	-	6.02	2.04	1.06	3.18
CAIS	4.09	1.58	-	-	3.18	-	-	-	2.41	-	2.56	-	-
PCS	2.62	1.53	0.55	1.11	0.58	1.33	-	3.83	1.31	2.60	1.83	0.63	2.71



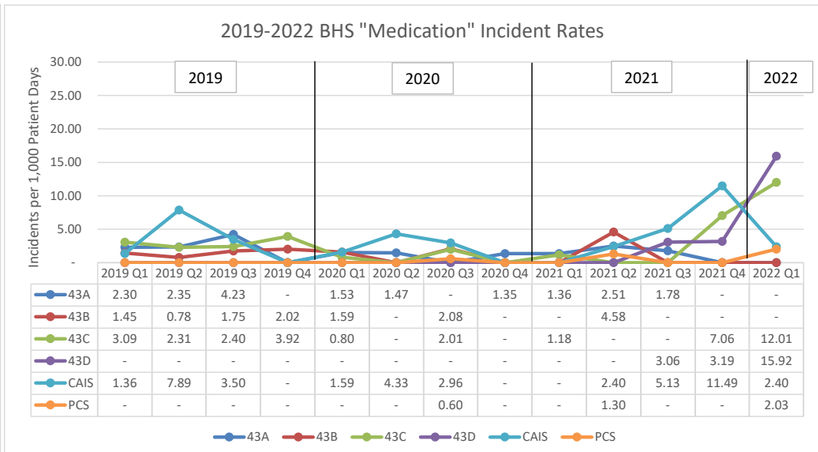
	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1
43A	-	-	-	0.90	0.77	-	-	-	-	2.51	1.78	-	-
43B	-	0.78	-	1.01	0.80	1.03	-	-	1.19	1.15	-	-	-
43C	1.54	0.77	1.60	-	-	1.13	-	-	1.18	-	3.44	-	1.09
43D	-	-	-	-	-	-	-	-	-	-	-	2.13	1.06
CAIS	-	-	-	2.53	-	-	-	-	-	-	-	-	-
PCS	0.52	1.53	-	-	0.58	-	1.20	-	-	-	-	-	-



	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1
43A	1.53	0.78	0.85	0.90	0.77	-	1.49	4.05	2.73	1.25	1.78	-	-
43B	2.18	0.78	3.50	2.02	1.59	1.03	3.13	3.09	-	1.15	-	-	-
43C	0.77	1.54	2.40	3.13	0.80	3.39	4.02	1.11	3.55	7.69	-	-	3.28
43D	-	-	-	-	-	-	-	-	-	24.10	4.08	4.26	1.06
CAIS	2.72	4.73	1.75	1.26	3.18	-	-	-	2.41	-	5.13	-	-
PCS	-	0.51	0.55	-	0.58	1.33	1.20	-	1.96	-	0.61	2.53	-



	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1
43A	-	0.78	1.69	-	-	1.47	-	-	-	-	1.78	-	-
43B	-	0.78	0.87	-	0.80	1.03	3.13	1.03	-	-	-	-	-
43C	-	4.62	3.20	-	-	3.39	2.01	-	-	-	-	-	-
43D	-	-	-	-	-	-	-	-	-	-	-	2.13	1.06
CAIS	1.36	1.58	3.50	1.26	-	-	2.96	2.69	-	-	-	-	-
PCS	0.52	0.51	-	-	-	0.66	1.20	-	-	-	-	-	0.68

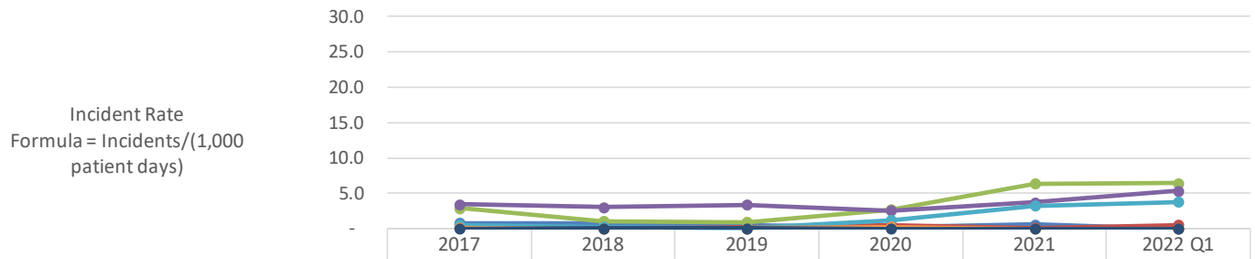


	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1
43A	2.30	2.35	4.23	-	1.53	1.47	-	1.35	1.36	2.51	1.78	-	-
43B	1.45	0.78	1.75	2.02	1.59	-	2.08	-	-	4.58	-	-	-
43C	3.09	2.31	2.40	3.92	0.80	-	2.01	-	1.18	-	-	7.06	12.01
43D	-	-	-	-	-	-	-	-	-	-	-	3.06	3.19	15.92
CAIS	1.36	7.89	3.50	-	1.59	4.33	2.96	-	-	2.40	5.13	11.49	2.40
PCS	-	-	-	-	-	-	0.60	-	-	1.30	-	-	2.03

2017-2022 BHS Crisis Service & Acute Inpatient Reported “Aggression” Incidents

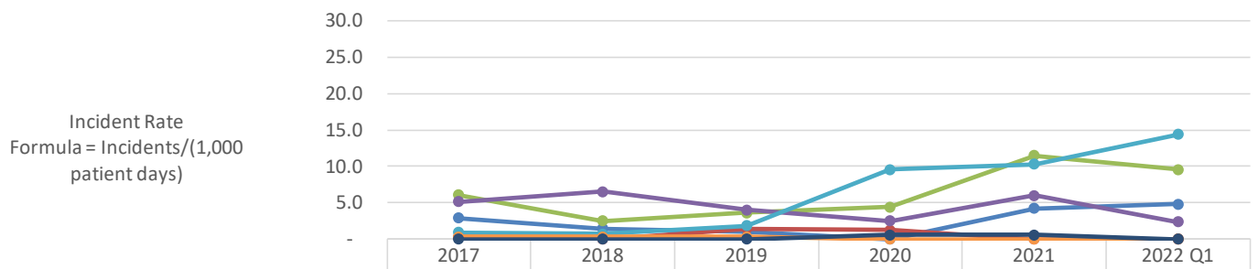
Created 4/13/22

2017-2022 BHS Acute Adult Inpatient Service Reported Patient "Aggression" Incident Trends



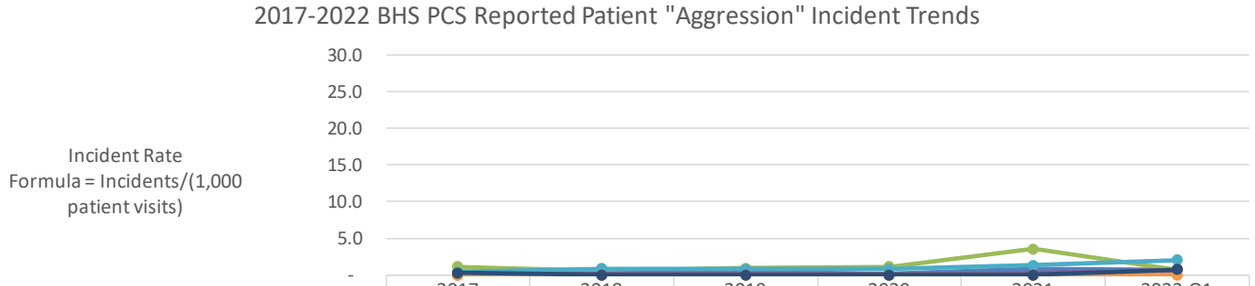
	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	0.8	0.7	0.5	0.3	0.6	-
Sexually Inappropriate Behavior	0.2	0.1	0.3	0.5	0.1	0.5
Physical Aggression - Patient/Employee	2.9	1.0	0.9	2.7	6.4	6.5
Physical Aggression - Patient/Patient	3.5	3.1	3.4	2.6	3.7	5.4
Property Damage	0.5	0.3	0.1	1.2	3.2	3.8
Sexual Contact	0.1	-	0.1	0.3	-	-
Suicide Attempt	-	0.1	0.1	-	-	-

2017-2022 BHS CAIS Inpatient Service Reported Patient "Aggression" Incident Trends



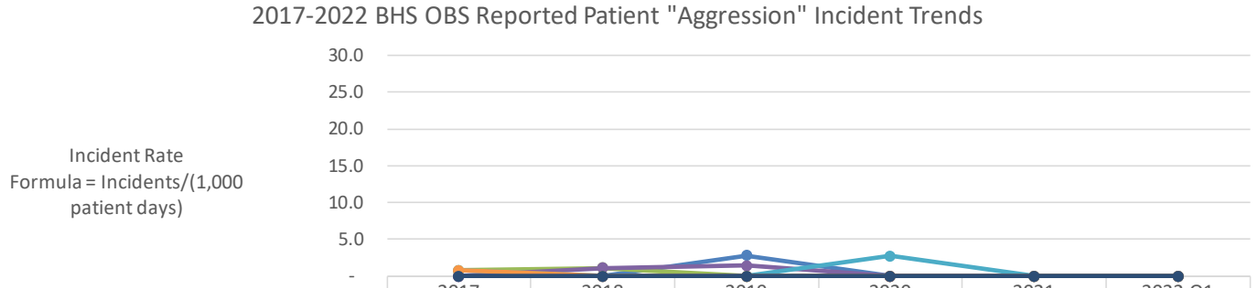
	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	2.9	1.5	1.1	-	4.2	4.8
Sexually Inappropriate Behavior	0.3	-	1.5	1.3	-	-
Physical Aggression - Patient/Employee	6.1	2.6	3.7	4.5	11.5	9.6
Physical Aggression - Patient/Patient	5.1	6.6	4.0	2.5	6.0	2.4
Property Damage	1.0	0.7	1.8	9.6	10.3	14.4
Sexual Contact	0.3	0.4	0.4	-	-	-
Suicide Attempt	-	-	-	0.6	0.6	-

2017-2022 BHS PCS Reported Patient "Aggression" Incident Trends



	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	0.4	0.1	0.3	0.2	0.8	0.7
Sexually Inappropriate Behavior	-	-	0.1	-	-	0.7
Physical Aggression - Patient/Employee	1.1	0.5	0.9	1.1	3.5	0.7
Physical Aggression - Patient/Patient	0.1	0.1	0.5	-	0.3	0.7
Property Damage	0.4	0.8	0.8	0.8	1.3	2.0
Sexual Contact	-	-	-	-	-	-
Suicide Attempt	0.2	-	-	-	-	0.7

2017-2022 BHS OBS Reported Patient "Aggression" Incident Trends



	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	-	-	2.8	-	-	-
Sexually Inappropriate Behavior	-	-	-	-	-	-
Physical Aggression - Patient/Employee	0.8	1.1	-	-	-	-
Physical Aggression - Patient/Patient	-	1.1	1.4	-	-	-
Property Damage	0.8	-	-	2.7	-	-
Sexual Contact	0.8	-	-	-	-	-
Suicide Attempt	-	-	-	-	-	-

Acute Adult - Incidents

Incident Category	Year								
	2014	2015	2016	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	43	19	8	13	11	8	3	5	0
Sexually Inappropriate Behavior	14	6	2	3	1	4	6	1	1
Physical Aggression - Patient/Employee	74	42	45	46	16	14	31	51	12
Physical Aggression - Patient/Patient	112	48	36	54	47	50	30	30	10
Property Damage	23	3	7	8	4	1	14	26	7
Sexual Contact	6	1	2	2	0	1	3	0	0
Suicide Attempt	2	2	3	0	1	1	-	0	0

CAIS - Incidents

Incident Category	Year								
	2014	2015	2016	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	5	8	11	9	4	3	-	7	2
Sexually Inappropriate Behavior	2	1	2	1	0	4	2	0	0
Physical Aggression - Patient/Employee	18	18	22	19	7	10	7	19	4
Physical Aggression - Patient/Patient	12	23	9	16	18	11	4	10	1
Property Damage	4	6	5	3	2	5	15	17	6
Sexual Contact	0	0	0	1	1	1	-	0	0
Suicide Attempt	1	0	2	0	0	0	1	1	0

PCS - Incidents

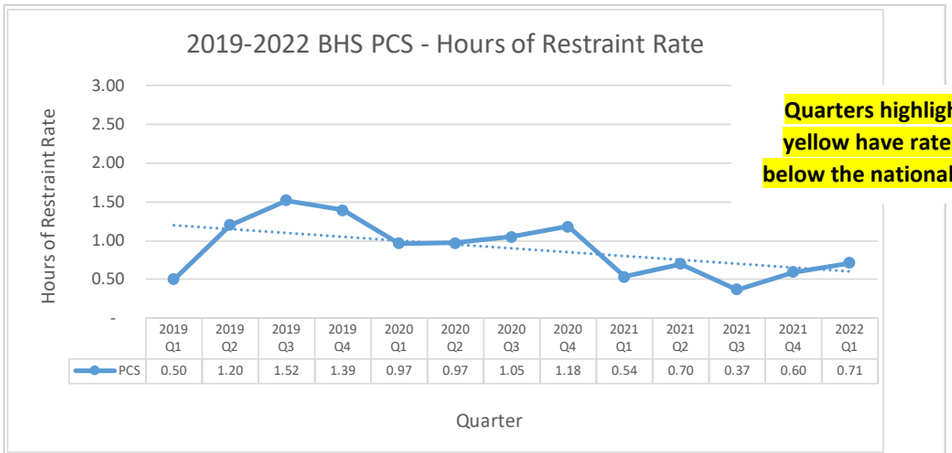
Incident Category	Year								
	2014	2015	2016	2017	2018	2019	2020	2021	2022 Q1
Self Injurious Behavior	2	2	7	3	1	2	1	5	1
Sexually Inappropriate Behavior	2	0	1	0	0	1	-	0	1
Physical Aggression - Patient/Employee	10	12	21	9	4	7	7	22	1
Physical Aggression - Patient/Patient	4	4	5	1	1	4	-	2	1
Property Damage	3	2	8	3	6	6	5	8	3
Sexual Contact	0	0	0	0	0	0	-	0	0
Suicide Attempt	0	0	2	2	0	0	-	0	1

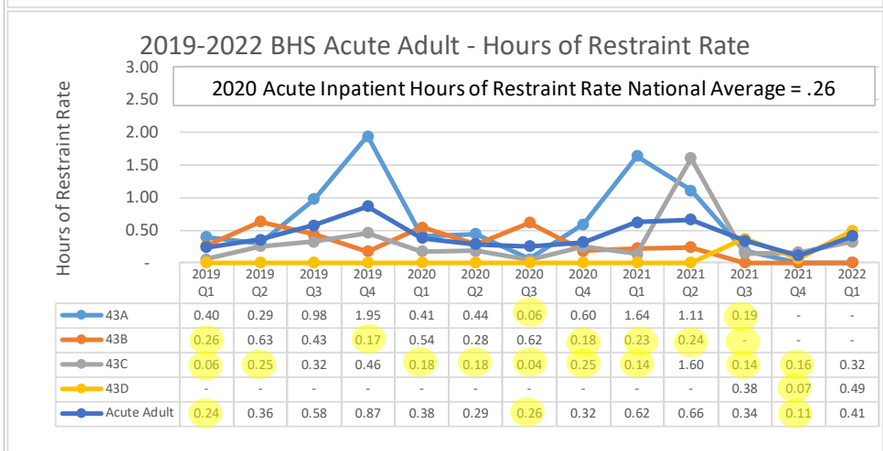
OBS - Incidents

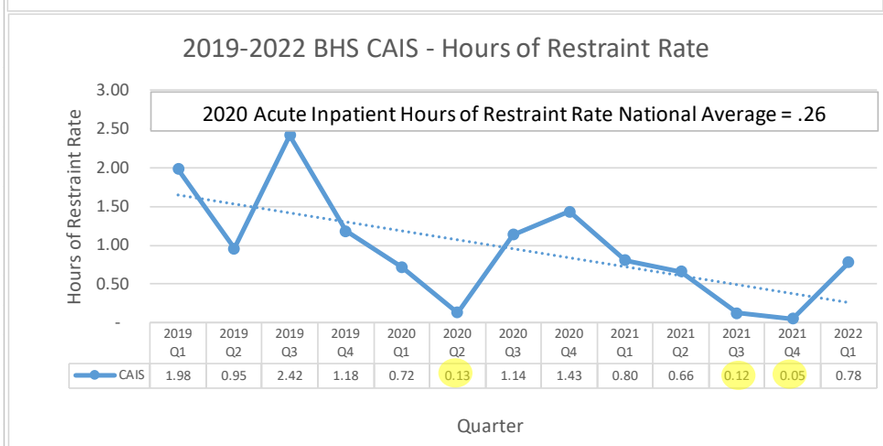
Incident Category	Year								
	2014	2015	2016	2017	2018	2019	2020	2021	2022 Q1
Self-Inflicted Injury	5	2	2	0	0	2	0	0	0
Sexually Inappropriate Behavior	2	1	0	0	0	0	0	0	0
Physical Aggression - Patient/Employee	11	9	5	1	1	0	0	0	0
Physical Aggression - Patient/Patient	15	1	3	0	1	1	0	0	0
Property Damage	1	4	1	1	0	0	1	0	0
Sexual Contact	0	1	0	1	0	0	0	0	0
Suicide Attempt	0	0	0	0	0	0	0	0	0

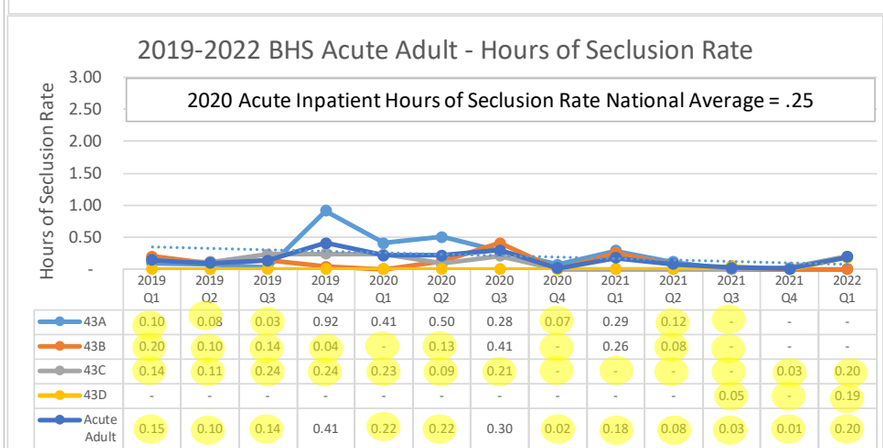
Program	Patient Days								
	2014	2015	2016	2017	2018	2019	2020	2021	2022 Q1
Acute Adult	19,696	17,205	16,713	15,641	15,272	14,793	11,582	8,007	1,858
CAIS	3,333	3,605	2,996	3,119	2,744	2,731	1,569	1,656	417
PCS	10,696	10,173	8,286	8,001	7,375	7,492	6,471	6,289	1,475
OBS	2,660	2,170	2,132	1,274	906	708	368	37	9

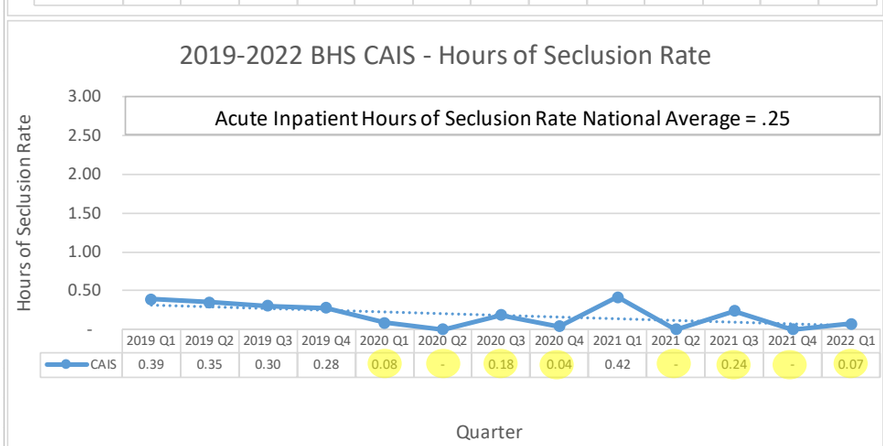
2022 Q1 Milwaukee County Behavioral Health Services (BHS) Crisis Service and Acute Inpatient Seclusion and Restraint Summary











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

Year / Quarter	Restraint Hours		Seclusion Hours	
	Acute Adult	CAIS	Acute Adult	CAIS
2019 Q1	23.0	35.0	14.3	6.9
2019 Q2	36.4	14.5	9.1	5.3
2019 Q3	49.4	33.2	11.7	4.2
2019 Q4	71.0	22.4	33.2	5.2
2020 Q1	34.7	10.8	19.8	1.3
2020 Q2	17.7	0.7	13.2	0.0
2020 Q3	16.2	9.2	19.1	1.5
2020 Q4	20.1	12.8	1.3	0.3
2021 Q1	36.1	8.0	10.4	4.2
2021 Q2	31.3	6.6	3.9	0.0
2021 Q3	14.9	1.2	1.2	2.3
2021 Q4	4.8	0.5	0.6	0.0
2022 Q1	18.3	7.8	8.8	0.8
2022 Q2				
2022 Q3				
2022 Q4				

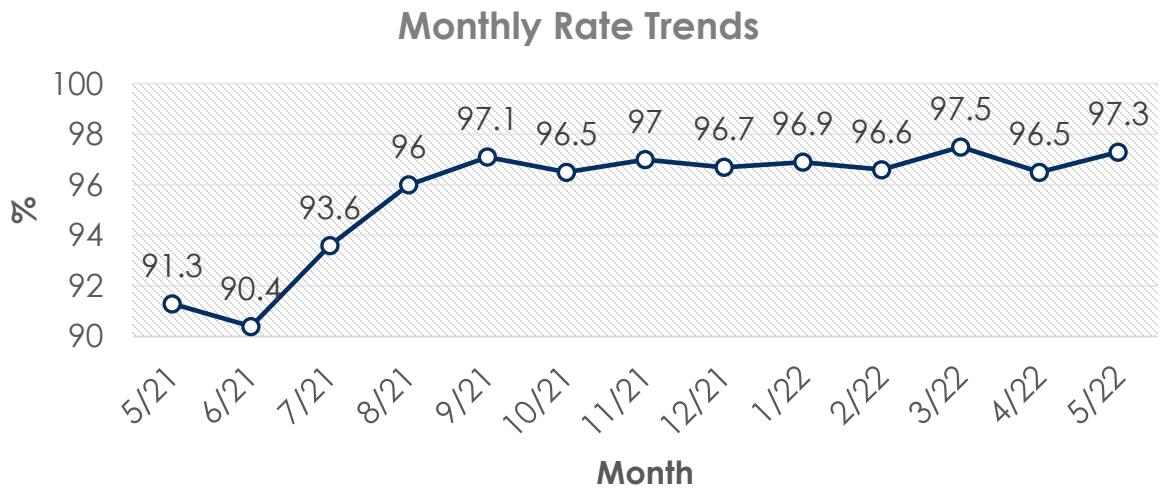
Quality Committee Item 9

Overall Progress 97.3% as of May 1, 2022

Baseline 71.5% as of August 2016 LAB report

Current Goal = 96%

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	655	661	96.5%	97.3%
Up to 1-year Overdue	20	14	2.9%	2.1%
More than 1 yr & up to 3 yrs overdue	1	1	0.1%	0.1%
More than 3 yrs & up to 5 yrs overdue	3	3	0.4%	0.4%
More than 5 yrs & up to 10 yrs overdue	0	0	0.0%	0.0%
Total	679	679	100%	100%



Past Due by Policy Area	Past Due
Contract Administration	1
Infection Prevention	6
Medical Staff Organization	1
Mental Health Board	3
Pharmacy	2
Provider Network-Credentialing and Impaneling	1
Public Health Emergency	1
Quality Management	1
Wraparound (Wrap, REACH, youth CCS)-Vendor	2
Total Past Due	18

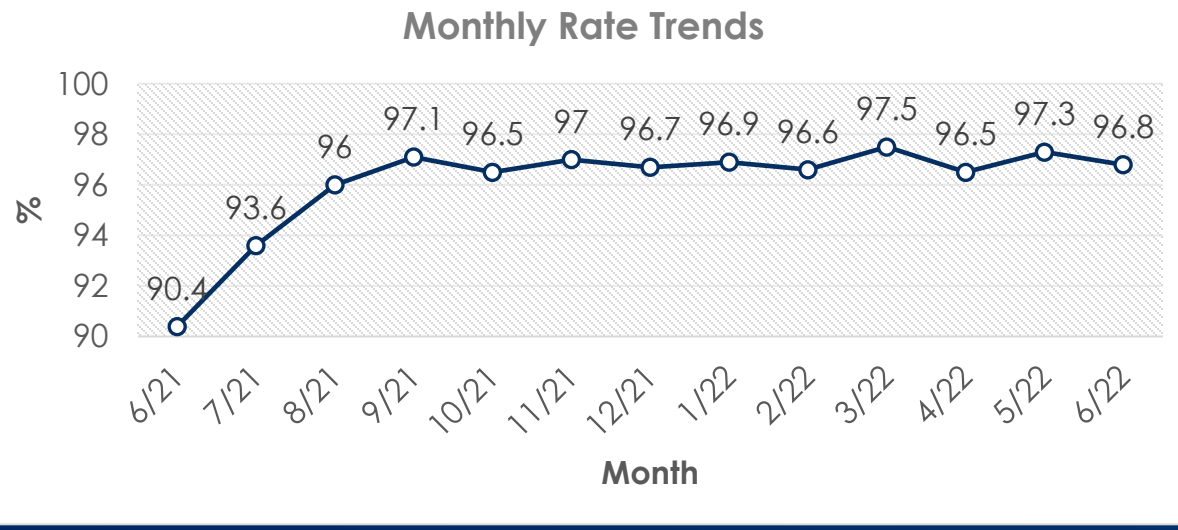
12 Month Forecast Due for Review	
Month/Year	# Due
May 2022	14
June 2022	28
July 2022	19
August 2022	18
September 2022	17
October 2022	20
November 2022	14
December 2022	19
January 2023	10
February 2023	9
March 2023	18
April 2023	21
May 2023	12

April Activity	
New Policies	0
Reviewed/Revised	12
Retired	0

Overall Progress 96.8% as of June 1, 2022

Current Goal = 96%

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	661	658	97.3%	96.8%
Up to 1-year Overdue	14	18	2.1%	2.6%
More than 1 yr & up to 3 yrs overdue	1	1	0.1%	0.1%
More than 3 yrs & up to 5 yrs overdue	3	3	0.4%	0.4%
More than 5 yrs & up to 10 yrs overdue	0	0	0.0%	0.0%
Total	679	680	100%	100%



Baseline 71.5% as of August 2016 LAB report

Past Due by Policy Area	Past Due
Contract Administration	1
Division Administration	2
Emergency Management	1
Engineering & Environmental Services-Operations	2
Human Resources	1
Mental Health Board	2
Pharmacy	6
Provider Network-Credentialing and Impaneling	1
Psychiatric Crisis Services - Mobile Team	3
Quality Management	1
Wraparound (Wrap, REACH, youth CCS)-Vendor	2
Total Past Due	**22**

12 Month Forecast Due for Review	
Month/Year	# Due
June 2022	27
July 2022	19
August 2022	18
September 2022	17
October 2022	20
November 2022	15
December 2022	19
January 2023	10
February 2023	9
March 2023	17
April 2023	21
May 2023	19
June 2023	43

May Activity

New Policies	0
Reviewed/Revised	14
Retired	0

Interim Chairperson: Mary Neubauer
Research Analyst: Kate Flynn Post, (414) 257-7475
Committee Coordinator: Dairionne Washington, (414) 257-7606

MILWAUKEE COUNTY MENTAL HEALTH BOARD
COMMUNITY ENGAGEMENT AD HOC COMMITTEE

Monday, July 18, 2022 – 10:00AM
Microsoft Teams Meeting

MINUTES

PRESENT: Shirley Drake, Walter Lanier, Dennise Lavrenz, and Mary Neubauer
EXCUSED: Kenneth Ginlack

SCHEDULED ITEMS:

1.	**Welcome.** Interim Chairwoman Neubauer welcomed everyone to the July 18, 2022, Mental Health Board Community Engagement Ad Hoc Committee's remote/virtual meeting.
2.	**Mental Health Community Stakeholder Advisory Council Updates.** Updates from the first two Council meetings were provided. It was stated during the first Council meeting member introductions were made and the charter was reviewed. The second meeting consisted of Board education, acknowledgements of Board accomplishments, and onboarding. Also, all Council members recently received a formal welcome letter for the Board's Chairwoman. The Council will soon have a tour of both the Mental Health Emergency Center and the Granite Hills Hospital. Questions and comments ensued. This item was informational.
3.	**Marketing and Communication Resource Memo Update** Kane Communications has recently sent out a press release for the Mental Health Board Community Stakeholder Advisory Council. Updates on the other projects in progress were shared. In review of the one-pager, some of the language used raised a small concern. It was suggested to create two separate info-sheets. One would be utilized for the County webpage which would be more formal, and the other would be used as a resource for the community. Questions and comments ensued. This item was informational.

4.	**Non-Contracted Vendor Presentations.** During a previous Committee meeting, there was a discussion pertaining to non-contracted vendors presenting to the Board or its Committees. Ethically, the Board is not the correct venue for this opportunity. When originally discussed, there was no type of forum designed to allow this opportunity. After creation of the Community Stakeholder Advisory Council, and further review and discussion, it was decided the Council would be the appropriate venue. Questions and comments ensued. This item was informational.
5.	**Adjournment.** Interim Chairwoman Neubauer ordered the meeting adjourned.

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Legislative Information Center.

Length of meeting: 10:05 a.m to 10:40 a.m.

Adjourned,

Dairionne Washington

Committee Coordinator
Milwaukee County Mental Health Board

The next meeting of the Milwaukee County Mental Health Board Community Engagement Committee is

September 19, 2022, at 10:00AM

To View All Associated Meeting Materials,
Visit the Milwaukee County Legislative Information Center at:
Milwaukee County - Calendar (legistar.com)

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

Milwaukee County Behavioral Health Services

Advisory Council Info Sheet

One-Pager / July 1, 2022

Milwaukee County Mental Health Board Community Stakeholder Advisory Council (Advisory Council)

Overview

The Milwaukee County Mental Health Board Community Stakeholder Advisory Council (Advisory Council) strategically engages consumers, families and the community-at-large as primary partners in the BHS system planning and delivery, to support Milwaukee County's vision of achieving racial and health equity. The advisory Council seeks to:

- Strengthen the county's overall strategy for addressing behavioral health within the community
- Provide ongoing communication about the services offered through the BHS provider network
- Gather information regarding the quality of the experience mental health care consumers, families and advocates receive when utilizing BHS supported services, including Granite Hills Hospital and the Mental Health Emergency Center (MHEC)
- Help support the BHS redesigned community-based mental health care model, ushered in with the opening of Granite Hills Hospital and the Mental Health Emergency Center (MHEC).

Advisory Council Membership

The Advisory Council is comprised of 11 to 15 individuals from a variety of community constituencies.

Current members include:

- Brenda Wesley (Chairperson)
- Mary Neubauer (Peer Advocate)
- Sandra Pasch (Peer Advocate and Family Member)
- Desilyn Smith (Peer Advocate and Family Member)
- Jona Morales (Peer Advocate)
- William Muhammad (Family Member)
- Darnelle Bowles (Faith Community)
- Lutrena Johnson (Family Member)
- Troney Small (Peer Advocate and Family Member)
- Claire Keys (Peer Advocate)
- John Griffith (Aging and LGBT

To learn more about the Advisory Council, visit https://county.milwaukee.gov/EN/DHHS/About/Governance, or use the QR code **[to be added]**.

Milwaukee County Behavioral Health Services

Advisory Council Website Content

Content for DHHS Governance Page / May 31, 2022

Location: https://county.milwaukee.gov/EN/DHHS/About/Governance
Under "Milwaukee County Mental Health Board" section
Add "Governance" page to BHS drop-down menu on DHHS website

HEADING: Milwaukee County Mental Health Board Community Stakeholder Advisory Council (Advisory Council)

Overview

The Milwaukee County Mental Health Board Community Stakeholder Advisory Council (Advisory Council) seeks to strengthen the county's overall strategy for addressing behavioral health within the community by providing ongoing communication about the services offered by the BHS provider network. It also serves as a resource to the Mental Health Board by gathering information regarding the quality of the experience mental health care consumers, families and advocates receive when utilizing BHS supported services, including Granite Hills Hospital and the Mental Health Emergency Center (MHEC). To learn more about the Advisory Council, please read our Charter.
[Link to PDF of Charter Document]

[Committee Member Grid; headshots to be added once available]

Current Advisory Council Members	Status
Brenda Wesley	Chairperson
Mary Neubauer	Peer Advocate
Sandra Pasch	Peer Advocate and Family Member
Desilyn Smith	Peer Advocate and Family Member
Jona Morales	Peer Advocate
William Muhammad	Family Member
Darnelle Bowles	Faith Community
Lutrena Johnson	Family Member

Troney Small	Peer Advocate and Family Member
Claire Keys	Peer Advocate
John Griffith	Aging and LGBTQ

2022 Advisory Board Meeting Schedule

Advisory Board meetings are open to the public and take place at 6 p.m. on the fourth Monday of each month throughl October 2022. Meetings after October 2022 will occur on a bi-monthly basis.

[Meeting Schedule Grid]

Date	Time	Location (Microsoft Teams or in person)
5/23/22	6 p.m.	
6/27/22	6 p.m.	
7/25/22	6 p.m.	
8/22/22	6 p.m.	
9/26/22	6 p.m.	
10/23/22	6 p.m.	

For more information about the Milwaukee County Mental Health Board Community Stakeholder Advisory Council, please click here, **[Link "here" to downloadable one-page info sheet PDF]** or visit our Facebook page. **[Link to Facebook page when developed]**

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

FOR IMMEDIATE RELEASE
Month XX, 2022

CONTACT:
Shelly Schumacher
(262)305-1713
shelly@kanecommgroup.com

Milwaukee County Mental Health Board Community Engagement Committee Establishes Stakeholder Advisory Council

Advisory Council will focus on consumer experiences with Milwaukee County Behavioral Health Services

MILWAUKEE (Month XX, 2022) - The Milwaukee County Mental Health Board, which governs Milwaukee County Behavioral Health Services (BHS), has established the **Milwaukee County Mental Health Board Community Stakeholder Advisory Council** (Advisory Council). The Advisory Council strategically engages consumers, families and the community-at-large as primary stakeholders in the BHS system planning and delivery, to support Milwaukee County's vision of achieving racial and health equity.

The Advisory Council seeks to strengthen the county's overall strategy for addressing behavioral health within the community by providing ongoing communication about the services offered by the BHS provider network. It also serves as a resource to the Mental Health Board by gathering information regarding the quality of the experience mental health care consumers, families and advocates receive.

The input of the advisory committee is particularly important in supporting the BHS redesigned community-based mental health care model, ushered in with the opening of Granite Hills Hospital this past winter and the Mental Health Emergency Center (MHEC), which is slated to open this fall.

Advisory Council members include individuals from a variety of community constituencies, including consumers of mental health services, family members, advocates, caregivers, faith communities and individuals from the criminal justice system. There are currently 11 Advisory Council members, including:

- Brenda Wesley (Chairperson)
- Mary Neubauer (Peer Advocate)
- Sandra Pasch (Peer Advocate and Family Member)
- Desilyn Smith (Peer Advocate and Family Member)
- Jona Morales (Peer Advocate)
- William Muhammad (Family Member)
- Darnelle Bowles (Faith Community)
- Lutrena Johnson (Family Member)

- Troney Small (Peer Advocate and Family Member)
- Claire Keys (Peer Advocate)
- John Griffith (Aging and LGBTQ)

The Advisory Council currently meets on the fourth Monday of each month. After October 2022, the meeting cadence will shift to a bi-monthly schedule. Meetings are open to the public.

For more information about the Milwaukee County Mental Health Board and Community Stakeholder Advisory Council, please visit https://county.milwaukee.gov/EN/DHHS/About/Governance.

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About Milwaukee County Behavioral Health Services
Behavioral Health Services provides care and treatment to adults, children, and adolescents with mental illness, substance use disorders, and intellectual disabilities through both County-operated programs and contracts with community agencies. Services include intensive short-term treatment through crisis services and inpatient services, and a full array of supportive community services for persons with serious mental illness and substance use disorders.

About the Milwaukee County Department of Health and Human Services
The mission of the Milwaukee County Department of Health & Human Services (DHHS) is to improve the quality of life for individuals who need support living healthy, independent, and safe lives within the Milwaukee County community. DHHS' vision is together, creating healthy communities to be recognized as the public model of excellence, leadership, and partnership in human services driving superior outcomes for our community.

Chairperson: Kathie Eilers
Research Analyst: Kate Flynn Post, (414) 257-7475
Board Liaison: Jodi Mapp, (414) 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD
GOVERNANCE AD HOC COMMITTEE

Wednesday, July 20, 2022 – 1:30 P.M.
Microsoft Teams Meeting

MINUTES

PRESENT: Kathie Eilers, Thomas Lutzow, Mary Neubauer, Maria Perez, and Ken Ginlack
EXCUSED: Walter Lanier

SCHEDULED ITEMS:

1. **Welcome.**

   Chairwoman Eilers welcomed everyone to the July 20, 2022, Mental Health Board Governance Committee's remote/virtual meeting.

2. **Code of Conduct Policy.**

   This Item was laid over from the April meeting for additional edits and revisions. Initially, rebranding Behavioral Health Division to Behavioral Health Services (BHS) accounted for most of the corrections made. Examples from various resources were reviewed and utilized to assist with developing the updated policy. All references to the employee concept were removed. The policy should be used as a tool to guide Board Members on how to conduct themselves both professionally and personally. Additions incorporated include the expectation for committee service and the nominating authority monitor related to the removal of a Board Member.

   Milwaukee County's County-wide Code of Ethics, contained in Chapter 9 of the Milwaukee County Code of General Ordinances, also applies to the Mental Health Board. Because it will take several documents/policies to address topics such as ethics, code of conduct, member expectations, etc., developing a cheat sheet reflecting the most fundamental operating principles was recommended. Documents created must work together. A best practice would be to have the Board as a whole review policies annually for discussion and agreement along with identifying communications procedures. These types of documents will help the Board function from a governance perspective.

   Discussion ensued at length.

   With no objections made, this Item was referred back to staff to draft an overarching policy of ethics with subsections to include code of conduct, conflict of interest, and member expectations.

SCHEDULED ITEMS (CONTINUED):

3.	**Delegation of Decision-Making Policy.** This is a past due policy assigned to the Behavioral Health Services (BHS) Administrator but belongs to the Board. Decisions are needed related to what, if anything, the Board would like to delegate. The policy isn't clear. Personnel and salary policies are broad issues. The Statutes, in Corporation Counsel's opinion, expressly includes salary as one of the categories this Board may direct, in agreeance with the County Executive. There is salary policy making in which this Board can engage. Discussion ensued related to the need for the policy. Corporation Counsel indicated if disparities are observed, the Board, in conjunction with the BHS Administrator, can exercise their oversight and policy directive authority, which clearly resides with the Mental Health Board, by having the Administration report back and explain compensation issues as a general directive moving forward. The subsection on personnel conceives and explicitly notes the Board may completely or on a policy-by-policy basis effectively cede and delegate the decision and policy making authority to the Administration relating to all personnel policy matters with this Body requiring direct reporting. Requests for information, reporting inclusive of a certain level of details related to topics of concern, and explanations from the Administration on any personnel matter related to BHS can be made. Preferences can also be designated to have the Administration come and share large personnel compensation decisions with the Board prior to implementation or as soon as practicable after a decision has been made. The policy could be scrapped, and the Board would need to decide how active it wants to be when supporting the Administration's issues surrounding positions and salaries. Again, it is within the Board's purview to be more active by having someone from Human Resources (HR) report to the Board. The authority is there. It just needs to be exercised more liberally. Clarity was requested related to the validity of the policy. The County Board is the Body which approves positions, salaries, and compensation County-wide. The authority does not lie entirely with the Compensation Division of HR. In the case of BHS, it does. BHS simply wants to be considered the same as and equal to every other departmental division in Milwaukee County. An unenforceable nebulous policy is not helpful. Inequity deserves an explanation. Where there is perceived unfairness on a broad scale, the Board certainly needs to ask questions. However, it is not the Board's role to get involved with individual employee details. Questions and comments ensued. The Committee agreed to retire this policy and have the Board direct the Administration to report issues requiring their involvement at a higher level, when necessary, to be helpful. Issues can be brought to the Board's attention via the Administrator's report. The Board will engage in oversight at a high level when disparities are observed and will include a reporting component. The Board will also expect to be informed of personnel compensation planning HR recommends for BHS

SCHEDULED ITEMS (CONTINUED):

	prior to implementation for the sake of transparency and allow for reporting expectations and cooperative discussions between HR and the Board. A new policy clearly articulating the Board's expectations from the Administration related to personnel policies and compensation decisions should be enacted to replace this 2015 policy. The Governance Committee unanimously recommended to retire this policy supplanting it with a policy regarding the Board's expectations regarding personnel matters. The Delegation of Decision-Making policy, PolicyStat Identification Number 11009247, will be retired with no further enforceability or validity. It will be reviewed and replaced. The Committee's consensus was this Item should not be taken to the Board for action without a replacement document. The BHS Administrator will assist in drafting the new policy.
4.	**Mental Health Board Relationship with the County Board. (Chairwoman Eilers/Verbal Report - Informational)** Chairwoman Eilers directed this Item be laid over to the next scheduled Governance Committee meeting due to time constraints.
5.	**Medical Staff Organization Structure – Future State**. Due to the absence of the presenter on this Item, it was laid over to the next scheduled Governance Committee meeting.
6.	**Ethics Committee and Institutional Review Board - Future State.** Due to the absence of the presenter on this Item, it was laid over to the next scheduled Governance Committee meeting.
7.	**Adjournment.** Chairwoman Eilers ordered the meeting adjourned.

SCHEDULED ITEMS (CONTINUED):

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Legislative Information Center.

Length of meeting: 1:33 p.m. to 3:18 p.m.

Adjourned,

Jodi Mapp

Jodi Mapp
Board Liaison
Milwaukee County Mental Health Board

To View All Associated Meeting Materials,
Visit the Milwaukee County Legislative Information Center at:
Milwaukee County - Calendar (legistar.com)

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

Mental Health Board Code of Conduct

Purpose:

To establish a set of guidelines for the Milwaukee County (MC) Mental Health Board (MHB) to set parameters and provide guidance regarding board conduct. The Code of Conduct shall be utilized in conjunction with the MHB Code of Ethics which outlines the Board's principles and expectations pertaining to ethics.

Scope:

All members of the Mental Health Board and related committees.

Policy:

Members of the MHB are committed to observing and promoting the highest standards of ethical conduct in the performance of their responsibilities on behalf of the citizens of Milwaukee County. Board members pledge to accept this code as minimum guidelines for conduct.

It is the intent of BHS to strive for the highest ethical conduct from all board members and staff.

In an effort to achieve the highest standards of conduct each board member is requested to acknowledge (by signing) the following adopted Code of Conduct.

Definitions:

N/A

Procedure:

All Members of the BHS Mental Health Board are required and expected to exercise the highest ethical standards of conduct and practice fundamental honesty at all times.

Each board member is expected to exercise the duties and responsibilities of their positions with integrity, collegiality, and care. This includes:

- Making attendance at all meetings of the board a high priority. Additionally, board members are expected to volunteer to serve on one or more committees to support the decision-making of the full board.
- Being prepared to discuss the issues and business on the agenda, having read all background material relevant to the topics at hand.
- Cooperating with and respecting the opinions of fellow board members, and leaving personal prejudices out of all board discussions, as well as supporting the actions of the board even when the board member holds a differing viewpoint.
- Putting the interests of BHS and the MHB above personal interests.
- Representing BHS and the MHB in a positive and supportive manner at all times and in all places.
- Showing respect and courteous conduct in all board and committee meetings.

- Refraining from intruding on administrative issues that are the responsibility of management, except to monitor the results and ensure that procedures are consistent with board policy.
- Observing established lines of communication and directing requests for information or assistance to the Board Chairperson.

In support of BHS standards of high ethical conduct, each board member WILL NOT

- Deceive, defraud, or mislead BHS/MHB consumers, members, officers, staff members, managers, supervisors, or other associates, or those with whom BHS has business or other relationships.
- Misrepresent BHS /MHB in any negotiations, dealings, contracts, or agreements.
- Divulge or release any information of a confidential or proprietary nature relating to BHS consumers, organizational plans or operations without appropriate approval.
- Obtain a personal advantage or benefit due to relationships established by any board member by use of the organization's name.
- Accept individual gifts of any kind in connection with the board member relationship with BHS.
- Withhold their best efforts to perform their duties in support of the public trust.
- Engage in unethical business practices of any type.
- Use BHS property, financial resources, or services of BHS personnel for personal benefit.
- Violate any applicable laws or ordinances.
- Retaliate against any board member, employee, or director of BHS for any reason.

Infractions of this Code of Conduct are to be reported directly to a member of the Governance committee who shall, in their determination, bring the infraction to the full Executive Committee.

- The Governance Committee shall review and investigate any allegations of infractions to the Code of Conduct, Code of Ethics, or Conflict of Interest policies and determine appropriate action to be taken.
- The Governance Committee may form and delegate authority to subcommittees when appropriate.
- Board Nominating Authorities (County Executive or County Board) may be notified.

References:

Milwaukee County Code of Ethics - Code of Ordinances Chapter 9

National Council of Nonprofits

Wisconsin State Statutes Chapter 51.41

Monitors:

Infractions and resulting actions taken may be reported to the full Mental Health Board and Nominating Authority.

Board members may be removed by Nominating Authority as described in WI Stats 51.41(1d)(i)1.

Governance Committee Item 3

Status **Pending** PolicyStat ID **11009247**

Date Issued	11/20/2018
Last Approved Date	N/A
Effective	Upon Approval
Last Revised Date	1/11/2022
Next Review	3 years after approval
Owner	Lynn Gram
Policy Area	Mental Health Board

MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

Delegation of Decision Making

Approved by the Mental Health Board on 08/27/15

Purpose:

To provide clarification of leadership decision making by identifying planning, management, and operational activities that are the responsibility of the leadership within the Behavioral Health Services (BHS).

To clarify the leadership structure the Mental Health Board and BHS.

Scope:

Mental Health Board and BHS Executive Team staff members.

Policy:

The Mental Health Board identifies those responsible for the planning, management, and operational activities of the Behavioral Health Services LD 01.01.01 EP 2

MHB provides for organization management and planning. LD 01.03.01 EP 2

The Governing Body MHB has the overall responsibility for the safety and quality of care, treatment, and services provided by the BHS

The governing body may delegate decision making to certain leadership groups LD 01.01.01 EP 2

Depending on the topic individuals from different leadership groups may participate in decision making LD 01.01.01 EP 2

Definitions:

Leadership groups: include governing body, senior managers, organized medical staff.

Procedure:

A. MHB will decide what areas/topics to delegate decision making authority to BHS leadership.
B. This delegation can be an ongoing delegation for an area or it may be by single topic or agenda item.
C. Delegation is done through the normal business process at any meeting of the Mental Health Board.
D. To date: The Mental Health Board delegated the review of the following areas to BHS senior management.
    1. Personnel Policies
    2. Salary Policies
E. Delegation can be revoked through the normal business process at any meeting of the Mental Health Board.

References:

The Joint Commission-

MHB Minutes 8/27/15

Monitors:

N/A

Approval Signatures

Step Description	Approver	Date
Mental Health Board	Michael Lappen: BHD Administrator	Pending
	Michael Lappen: BHD Administrator	1/12/2022
	Lynn Gram: Exdir2-Assthospadm2-Mhc	1/11/2022