

Chairperson: Duncan Shrout
Vice-Chairman: Thomas Lutzow
Secretary: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, April 27, 2017 - 8:00 A.M.

**Zoofari Conference Center
 9715 West Bluemound Road**

MINUTES

PRESENT: Robert Chayer, Michael Davis, Rachel Forman, *Walter Lanier, Jon Lehrmann,
 *Mary Neubauer, Maria Perez, Duncan Shrout, and Brenda Wesley

EXCUSED: Ronald Diamond, Thomas Lutzow, and Jeffrey Miller

*Board Members Walter Lanier and Mary Neubauer were not present at the time the roll was called but joined the meeting shortly thereafter.

SCHEDULED ITEMS:

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

1. Welcome.

Chairman Shrout opened the meeting by greeting Board Members and the audience.

2. Approval of the Minutes from the March 23, 2017, Milwaukee County Mental Health Board Meeting.

MOTION BY: (Davis) Approve the Minutes from the March 23, 2017, Milwaukee County Mental Health Board Meeting. 6-0

MOTION 2ND BY: (Perez)

AYES: Chayer, Davis, Forman, Perez, Shrout, and Wesley - 6

NOES: 0

ABSTENTIONS: 0

EXCUSED: Lanier and Neubauer - 2

3. Administrative Update.

Michael Lappen, Administrator, Behavioral Health Division (BHD)

Mr. Lappen highlighted key activities and issues related to BHD operations. He provided updates on the May 4, 2017, community conversation hosted by the Zeidler Center; State

SCHEDULED ITEMS (CONTINUED):

	<p>Legislative Audit Bureau recommendations; BHD's collaborations on the MacArthur Safety and Justice Challenge Pilot project and the Housing First Initiative; the Northside Facility's timeline and project transition from Patina Solutions to BHD staff; and Cambio Solution's Professional Services Contract and scope of work.</p> <p>Questions and comments ensued.</p>
4.	<p>2017 Behavioral Health Division Business Plan.</p> <p>Michael Lappen, Administrator, Behavioral Health Division (BHD)</p> <p>Mr. Lappen explained BHD's Business Plan is part of the Department of Health and Human Services' department-wide strategic plan. Initiatives and related goals to be achieved in 2017 include establishing an integrated community facility, outsourcing of acute services, workforce development and diversity expansion, crisis case management billing re-structure, Comprehensive Community Services expansion, completion of the Legislative Audit Bureau recommendations, implementation of performance-based contracting, and sustaining the reduction of seclusion and restraint usage.</p> <p>Questions and comments ensued.</p> <p>Board Members discussed the prospect of implementing a strategic plan for the Board.</p>
5.	<p>Funding the Go Pass.</p> <p>Board Member Neubauer discussed the challenges individuals face due to the elimination of funding for the Go Pass as of May 1, 2017. The populations effected by this change were identified. This item has been flagged for consideration in the 2018 Budget. Until then, there will be a gap in the service the Go Pass provides, which is non-emergency transportation. Board Member Neubauer proposed funds be extracted from the 2017 Operating Budget to cover the costs from May 1, 2017, through December 31, 2017.</p> <p>Chairman ShROUT directed Mr. Lappen to look into this matter and report back to the Board during the June meeting cycle.</p>
6.	<p>Mental Health Board Research Analyst for 2017.</p> <p>Board Member Neubauer conveyed the need for a full-time staff person to provide support to Board Members for research and a variety of other duties. The position is included in the 2018 Budget, however, Board Member Neubauer explained the immediate need for this position. Proposed responsibilities were reviewed, and Board Member Neubauer indicated the authority to hire and terminate this individual would be vested solely with the Board.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>Chairman ShROUT stated that he would be willing to work with Board Members Neubauer and Lanier to prepare this as an action item to be placed on the agenda for the June meeting cycle.</p>
7.	<p>Community Access to Recovery Services (CARS) Prevention and Access Presentation.</p> <p>Jennifer Wittwer, Operations Coordinator, CARS, Behavioral Health Division (BHD) Nzinga Khalid, Prevention Coordinator, CARS, BHD Justin Heller, Program Evaluator, CARS, BHD James Feagles, Integrated Services Coordinator, CARS, BHD</p> <p>Ms. Wittwer explained CARS is the BHD entity that manages the public-sector, community-based mental health and substance abuse system for adults in Milwaukee County and has four focus areas, including prevention, access to services, treatment and rehabilitation, and recovery. Due to time constraints, prevention and access to services will be presented, and treatment and rehabilitation and recovery will be presented at the June meeting.</p> <p>Ms. Khalid reviewed the yearly amount spent on prevention activities, number of providers that make up the prevention network, number of individuals served, and described the various programs involved.</p> <p>Mr. Heller continued the presentation with access to services detailing who receives them, who provides them, a list of services, and the cost of these services.</p> <p>Mr. Feagles provided an overview of community relationships.</p>
8.	<p>Netsmart Avatar Electronic Health Records (EHR) Update Presentation.</p> <p>Laurie Panella, Chief Information Officer, Information Management Services Division, Department of Administrative Services Cathleen Panowicz, Netsmart</p> <p>Ms. Panella provided background information surrounding the implementation of the EHR system. In the very beginning stages of implementation, it was discovered that many of the Avatar tools included were not being utilized leading to missed efficiencies. In addition, the lack of clinical input led to poor usability.</p> <p>After performing market research, Avatar was identified as the best option in the mental health electronic record market.</p> <p>Ms. Panella reviewed the next steps in this process and stated overall completion of the project is targeted for mid to late 2018.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>The Board took a break after Item 8 at 10:07 a.m. and reconvened at approximately 10:20 a.m. The roll was taken, and all Board Members were present, except for Board Member Lanier, who joined the meeting shortly thereafter.</p>
9.	<p>Mental Health Board Finance Committee Update and Contract Approval Recommendations.</p> <p>Randy Oleszak, Chief Financial Officer, Behavioral Health Division</p> <ul style="list-style-type: none">• Professional Services Contracts<ul style="list-style-type: none">➢ 2016 Professional Services Contract Amendment➢ 2017 Professional Services Contracts• 2017 Purchase-of-Service Contracts• 2017 Fee-for-Service Agreements <p>Professional Services Contracts focus on facility-based programming, supports functions that are critical to patient care and are necessary to maintain hospital and crisis services licensure. Background information was provided on services the contracted agencies provide, which include consultation, residency and fellowship stipends, and Information Technology (IT).</p> <p>Purchase-of-Service Contracts and Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were also reviewed. An overview was provided detailing the various program contracts and agreements.</p> <p>At the March 31, 2017, Finance Committee meeting, Committee Member Lehrmann abstained from recommending Medical College of Wisconsin contracts for approval.</p> <p>Remaining Committee Members agreed to recommend approval of Medical College of Wisconsin contracts to the full Board.</p> <p>The Finance Committee, as a whole, unanimously agreed to recommend approval of the balance of contracts contained in this Item to the full Board.</p> <p>MOTION BY: (Lanier) Approve the Medical College of Wisconsin – Affiliated Hospitals’ 2017 Professional Services Contract. 7-0-1</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Davis, Forman, Lanier, Neubauer, Perez, Shrout, and Wesley - 7</p> <p>NOES: 0</p> <p>ABSTENTIONS: Chayer – 1</p> <p>EXCUSED: 0</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Lanier) Approve the Balance of Professional Services and Purchase-of-Service Contracts and Fee-for-Service Agreements as Delineated in the Corresponding Report. 8-0</p> <p>MOTION 2ND BY: (Perez)</p> <p>AYES: Chayer, Davis, Forman, Lanier, Neubauer, Perez, Shrout, and Wesley - 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p>
10.	<p>Procurement Methodology and Spending Approvals Policy. (02/23/17: Laid over pending recommended revisions to the policy.)</p> <p>Randy Oleszak, Chief Financial Officer, Behavioral Health Division</p> <p>Mr. Oleszak explained the delay in bringing this item back before the Board. He stated a workgroup has been formed in conjunction with the Comptroller's Office, who is a very significant stakeholder in this process as it relates to contracts. Through this collaboration, a more robust policy will be developed.</p> <p>MOTION BY: (Davis) Lay this Item Over to the Call of the Chair. 7-0</p> <p>MOTION 2ND BY: (Forman)</p> <p>AYES: Chayer, Davis, Forman, Lanier, Neubauer, Shrout, and Wesley - 7</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: Perez - 1</p>
11.	<p>Mental Health Board Quality Committee Update and Environment of Care 2016 Annual Report and 2017 Goals Recommendation.</p> <p>Lynn Gram, Safety Officer, Behavioral Health Division</p> <p>Board Member Neubauer, Chairwoman of the Quality Committee, reviewed topics addressed at the Quality Committee's quarterly meeting. She discussed the analysis of the key performance indicators, system of care enrollment, contract performance measures, Community Access to Recovery Services' (CARS) quarterly report, the client experience workgroup, the compliments, complaints, and grievances process, seclusion and restraint progress, Wraparound performance-based measures, and the hospital transfer waitlist.</p> <p>Ms. Gram explained plans for managing environmental risk, which include safety, security, clinical and non-clinical equipment, handling of hazardous materials, fire prevention, and utility systems, which all together, make up the Behavioral Health Division Environment of Care Program.</p>

SCHEDULED ITEMS (CONTINUED):

	<p>MOTION BY: (Neubauer) Approve the Environment of Care 2016 Annual Report and 2017 Goals and Plans Recommendation. 7-0</p> <p>MOTION 2ND BY: (Lanier)</p> <p>AYES: Chayer, Davis, Forman, Lanier, Neubauer, Shrout, and Wesley - 7</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: Perez – 1</p>
<p><i>Pursuant to Wisconsin Statutes Section 19.85(1)(e), the Board may adjourn into Closed Session for the purpose of deliberating or negotiating the purchasing of public properties, the investing of public funds, or conducting other specified public business, whenever competitive or bargaining reasons require a closed session as it relates to the following matter(s):</i></p>	
<p>12.</p>	<p>Local Public/Private Partnership and National Entity Partnership Joint Task Force Update.</p> <p>MOTION BY: (Chayer) Adjourn into Closed Session under the provisions of Wisconsin Statutes Section 19.85(1)(e) for the purpose of deliberating or negotiating the purchasing of public properties, the investing of public funds, or conducting other specified public business, whenever competitive bargaining reasons require a closed session as it relates to Item 12. At the conclusion of the Closed Session, the Board may reconvene in open session to take whatever action(s) it may deem necessary on the aforesaid item. 8-0</p> <p>MOTION 2ND BY: (Neubauer)</p> <p>AYES: Chayer, Davis, Forman, Lanier, Neubauer, Perez, Shrout, and Wesley - 8</p> <p>NOES: 0</p> <p>ABSTENTIONS: 0</p> <p>EXCUSED: 0</p> <p>The Board convened into Closed Session at 11:09 a.m. to discuss Item 12 and reconvened back into Open Session at approximately 11:45 a.m. The roll was taken, and all Board Members, except for Lehrmann and Perez, were present.</p>

SCHEDULED ITEMS (CONTINUED):

13. Medical Executive Report and Credentialing and Privileging Recommendations.

Dr. Clarence Chou, President, Medical Staff Organization, Behavioral Health Division

MOTION BY: *(Chayer) Adjourn into Closed Session under the provisions of Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item #13. At the conclusion of the Closed Session, the Board may reconvene in Open Session to take whatever action(s) it may deem necessary on the aforesaid item. 8-0*

MOTION 2ND BY: *(Neubauer)*

AYES: Chayer, Davis, Forman, Lanier, Neubauer, Perez, Shrout, and Wesley - 8

NOES: 0

ABSTENTIONS: 0

EXCUSED: 0

The Board convened into Closed Session at 11:09 a.m. and reconvened back into Open Session at approximately 11:45 a.m. The roll was taken, and all Board Members, except for Lehrmann and Perez, were present.

MOTION BY: *(Forman) Approve Robert Perzacki's Medical Executive Committee Credentialing and Privileging Appointment Recommendation. 6-0-1*

MOTION 2ND BY: *(Lanier)*

AYES: Davis, Forman, Lanier, Neubauer Shrout, and Wesley - 6

NOES: 0

ABSTENTIONS: Chayer - 1

EXCUSED: Perez - 1

MOTION BY: *(Chayer) Approve the Balance of the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 7-0*

MOTION 2ND BY: *(Neubauer)*

AYES: Chayer, Davis, Forman, Lanier, Neubauer, Shrout, and Wesley - 7

NOES: 0

ABSTENTIONS: 0

EXCUSED: Perez - 1

SCHEDULED ITEMS (CONTINUED):

14. **Employee Agreement.**

Dr. John Schneider, Chief Medical Officer, Behavioral Health Division

The corresponding employment agreement is for medical staff stipulating total compensation.

MOTION BY: (Neubauer) Approve the Employment Agreement as Delineated in the Corresponding Report. 7-0

MOTION 2ND BY: (Davis)

AYES: Chayer, Davis, Forman, Lanier, Neubauer, Shrout, and Wesley - 7

NOES: 0

ABSTENTIONS: 0

EXCUSED: Perez – 1

ADDENDUM ITEMS

15. **Jefferson Crest, LLC, Fee-for-Service Agreement for Residential Services.**

Randy Oleszak, Chief Financial Officer, Behavioral Health Division (BHD)
Michael Lappen, Administrator, BHD

Mr. Oleszak informed the Board the Jefferson Crest Fee-for-Service Agreement was not presented at the Finance Committee meeting in March. It has been brought directly to the Board due to timing. This is an existing provider whose contract, with this approval, will exceed the reporting threshold. The process has just been completed to move a client from the adult unit into a community setting, which is why this approval could not wait for the next Finance/Board meeting cycle.

Mr. Lappen explained the challenges faced when a circumstance such as this arises between meeting cycles.

MOTION BY: (Forman) Approve the Jefferson Crest, LLC, Fee-for-Service Agreement. 7-0

MOTION 2ND BY: (Wesley)

AYES: Chayer, Davis, Forman, Lanier, Neubauer, Shrout, and Wesley - 7

NOES: 0

ABSTENTIONS: 0

EXCUSED: Perez - 1

SCHEDULED ITEMS (CONTINUED):

16.	Development of Integrated System and Practice Model. Hector Colon, Director, Department of Health and Human Services Mr. Colon stated the Department has a vision to develop an integrated system and practice model. Leaders from all across the Department have been involved with creating and moving this vision forward. Individuals entering the system generally have multiple needs that span multiple divisions within the Department. This model will help to identify, access, and enroll participants and their families in all programs and services available in a coordinated manner.
17.	Adjournment. Chairman Shrout ordered the meeting adjourned.
<p>This meeting was recorded. The aforementioned agenda items were not necessarily considered in agenda order. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.</p> <p>Length of meeting: 8:05 a.m. to 12:13 p.m.</p> <p>Adjourned,</p> <p>Jodi Mapp Senior Executive Assistant Milwaukee County Mental Health Board</p>	
<p style="text-align: center;">The next meeting for the Milwaukee County Mental Health Board will be on Thursday, June 22, 2017, @ 8:00 a.m. at the Zoofari Conference Center 9715 West Bluemound Road</p>	

The April 27, 2017, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.

Dr. Robert Chayer, Secretary
Milwaukee County Mental Health Board

Milwaukee County Mental Health Board
April 27, 2017

MILWAUKEE COUNTY
Inter-Office Communication

DATE: May 30, 2017

TO: Duncan Shrout, Chairman, Milwaukee County Mental Health Board

FROM: Amy Pechacek, Director, Risk Management

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

INTRODUCTION

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

WORKERS' COMPENSATION

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

BHD also helped reduce division specific losses by implementing new programs including authoring a new employee handbook in 2015, which clearly defined workplace expectations and policies, and investing significantly in leadership development and involvement in the day to day operations. New service models, such as the assignment of acute staff to a dedicated unit, has increased employee accountability and closer manager oversight. In addition, a focus on training to safety policies and procedures and the revitalization of internal BHD incident analysis over the past several years has shifted the culture of injury management from reactive to proactive, and renewed BHD's commitment to ensuring our employees are working safely. Also likely contributing to the decreasing claim trend has been a reduction in staffing and services offered, such as the closing of the Hilltop Unit.

The loss leader departments in workers' compensation claims County-wide are as expected given the nature of departmental functions, with Behavioral Health leading in the total number of claims filed between 2012 – 2016 and the Sheriff's Department leading in the highest expenses associated with their injury claims from this same time period. The Parks, Airport, Department of Transportation, and House of Correction also make the list of departments with higher claim volume and expense. The top claim driver throughout the County is the insurance industry code designation of "muscle strains" which represent 43% of all claim types filed and roughly 61% of the total expenses incurred.

As a division, BHD averaged 177 claims annually between 2012- 2014, with an uptick in claims in the year 2013, a trend consistent with other County departments. Most notable is the drastic decrease in frequency measures in 2015 – 2016, wherein BHS averaged only 37 claims annually. This represents a 79% decrease in frequency measures compared to the immediately preceding three years. The most common claim causes represented between the years 2012 - 2016 is "struck by" and "altercation", codes that typically denote an injury resulting from an encounter with a patient. These two claim cause categories accounted for 68% of all workers' compensation claims filed at BHD, and 53% of the total incurred. Again, there is a significant decrease in severity measures in 2015 and 2016 compared to the three prior years. BHD has a 75% decrease from \$1,237,446 annually in claim costs between 2012 - 2014 to annual average of claim costs of \$312,938 in the years 2015 – 2016. These two years are still developing and could fluctuate as the data continues to mature, but include reserve estimates to bring the claims to full conclusion.

WORKERS' COMPENSATION RECOMMENDATIONS

Risk Management has drilled down on specific exposure data for workers' compensation claims at the departmental level and authored individualized loss reduction plans based on the departments' claims history and operations. These plans contain performance measures and risk management goals along with tailored training

to be followed up by claims meetings between the department and Risk Management. A focus on strategic partnerships and accountability through incentives, resource allocation, and training will continue to decrease liabilities and improve positive organizational behaviors to ensure the safety of our workforce and the success of effective long-term risk management for Milwaukee County. It is recommended that an annual presentation on the County's claims and liabilities be presented to the County Executive, the Judiciary, Safety, and General Services Committee, and the Milwaukee County Mental Health Board to monitor progress and positive gains.



Amy Pechacek, Director, Risk Management

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



Milwaukee County BHD WC Review

Amy C. Pechacek - Director, Risk Management





Principles of Risk Management

1. Identify exposures
2. Analyze losses
3. Develop plan to minimize
4. Monitor and adjust plan
 - Performance measures:
 - a. Frequency of claims (#)
 - b. Severity of claims (cost)
 - c. OSHA compliance





Workers' Compensation

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



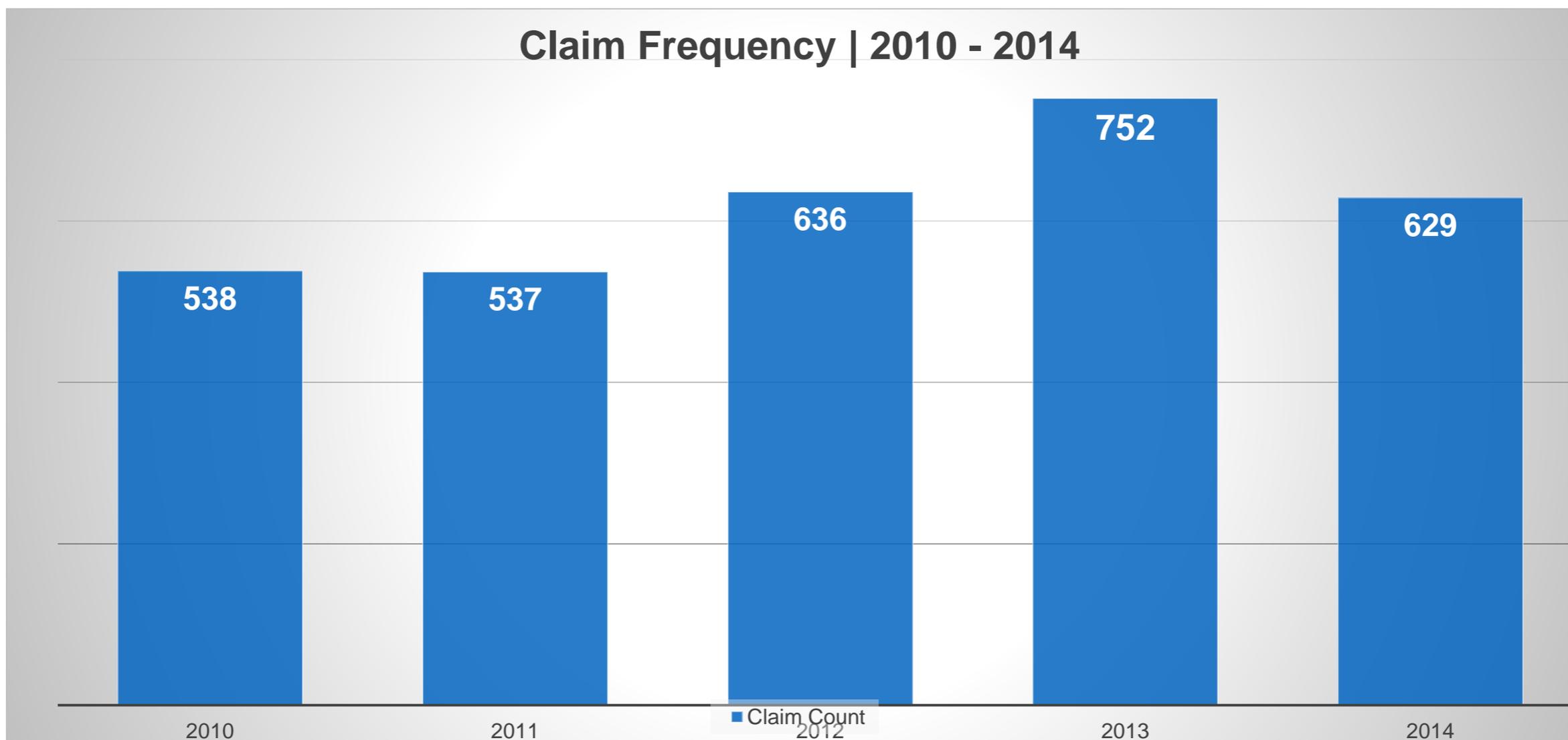
Workers' Compensation - Countywide

Claim Frequency

Claim Frequency | 2010 - 2014

	Claim Count
2010	538
2011	537
2012	636
2013	752
2014	629
TOTAL	3061

Claim Frequency | 2010 - 2014

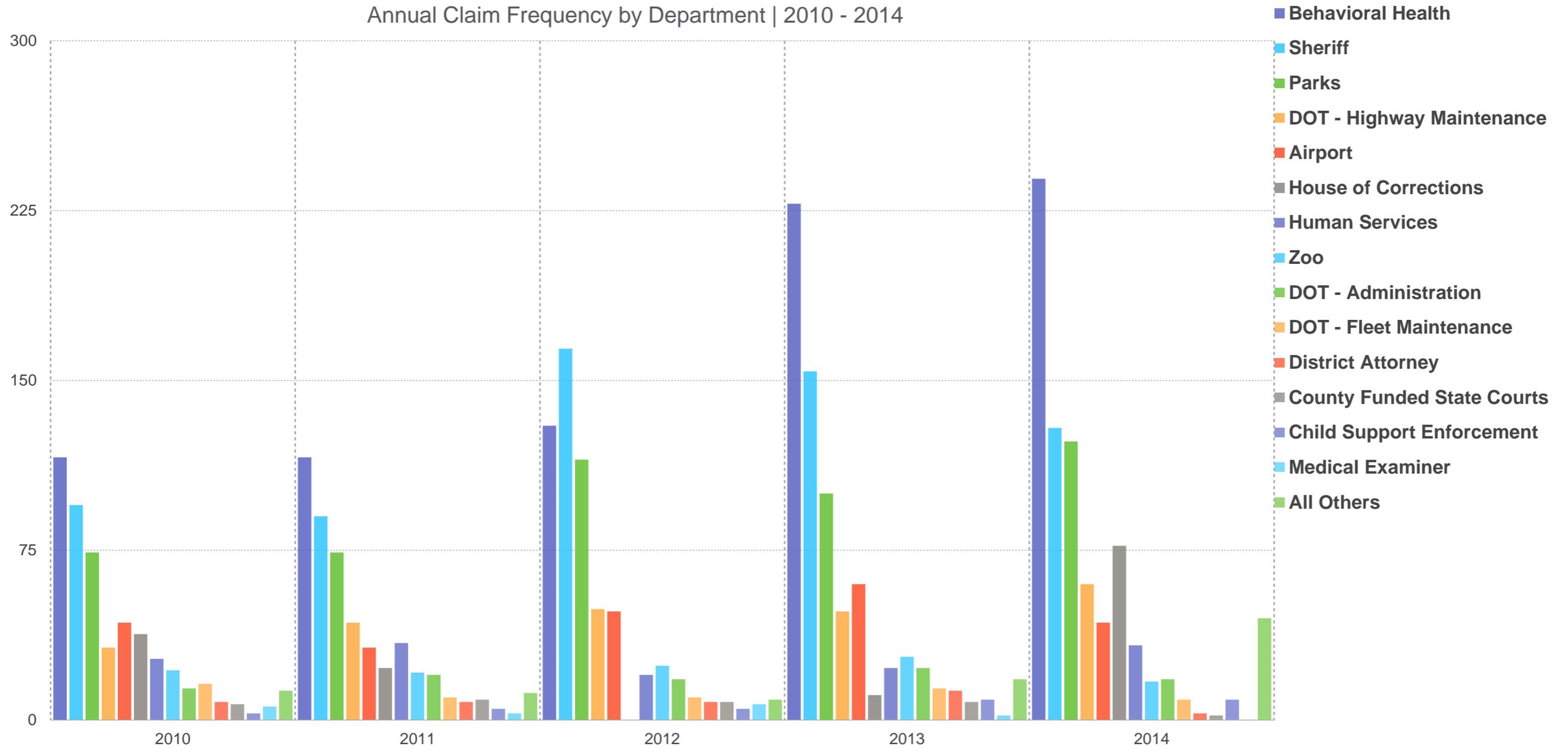




Workers' Compensation - Countywide

Annual Claim Frequency by Department

Annual Claim Frequency by Department | 2010 - 2014





Workers' Compensation

Claim Financial Summary

	Total Paid	Total Incurred
2012	\$5,132,303	\$5,542,399
2013	\$5,856,550	\$6,281,449
2014	\$4,610,052	\$5,312,459

*Total Incurred includes reserve amounts which are subject to future development.
Numbers reflect claims data as of January 2017



Contributing Factors

- Internal claim administration
- No medical management
- No return to work program
- Lack of safety culture



WC Administration:

Major Initiatives

- Third Party Administrator (TPA)
- Milwaukee County Care Line- medical triage
- Work restrictions from qualified professional / MD
- Transitional duty / return to work programs
- OSHA Compliance



Workers' Compensation Claim Frequency

Claim Frequency | 2012 - 2016

	Claim Count
2012	636
2013	753
2014	629
2015	247
2016	291
TOTAL	2556



2015 Goal: Reduce number of claims **15%** compared to 5 year historical average pre-2015 of **612 claims** per year



2015 Result: **60%** reduction **247 claims** in 2015

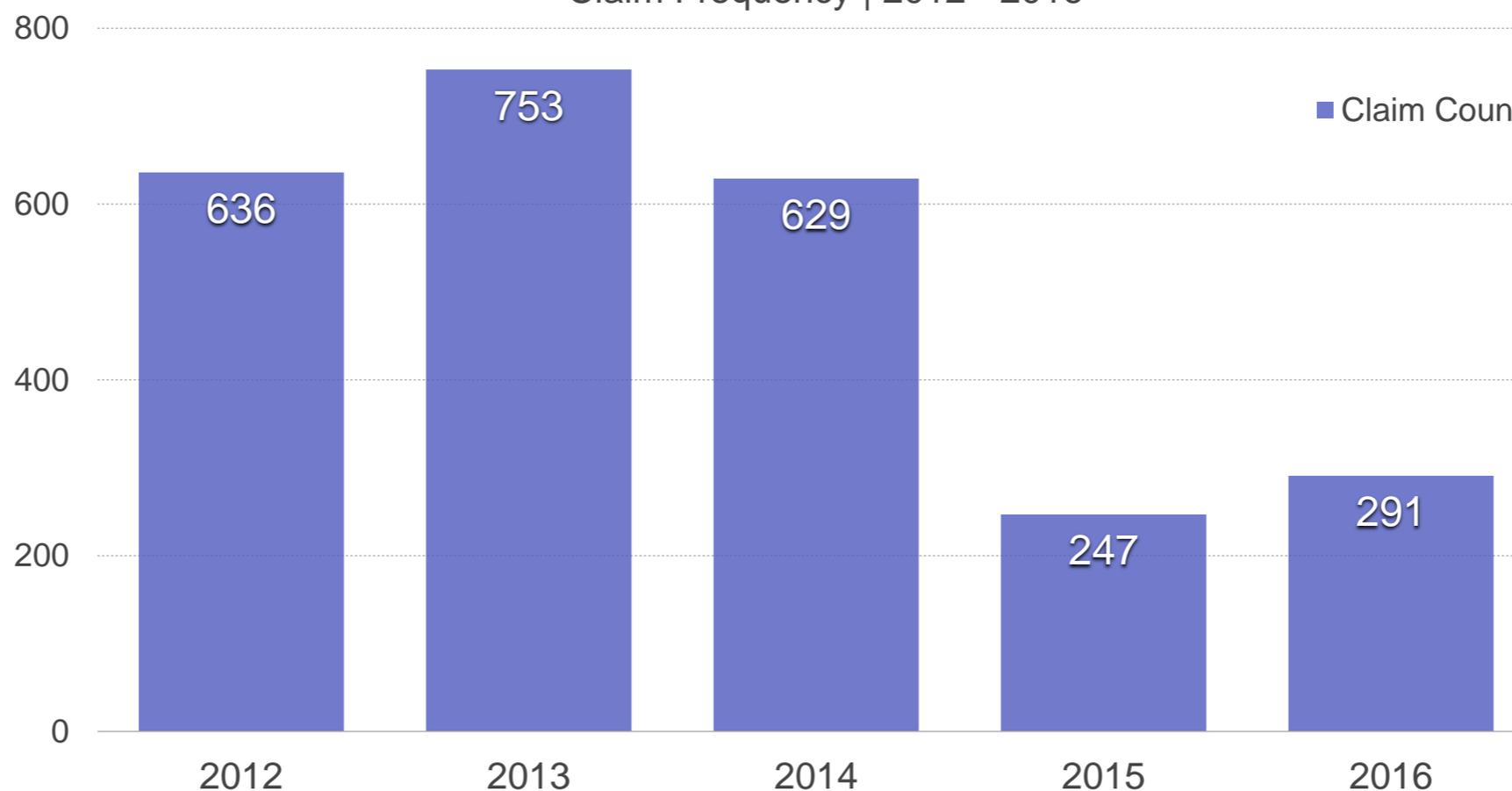


2016 Result: **53%** reduction **291 claims** in 2016



2 year sustained reduction of 56%

Claim Frequency | 2012 - 2016



Workers' Compensation Claim Financial Summary



Claim Financial Summary | 2012 - 2016

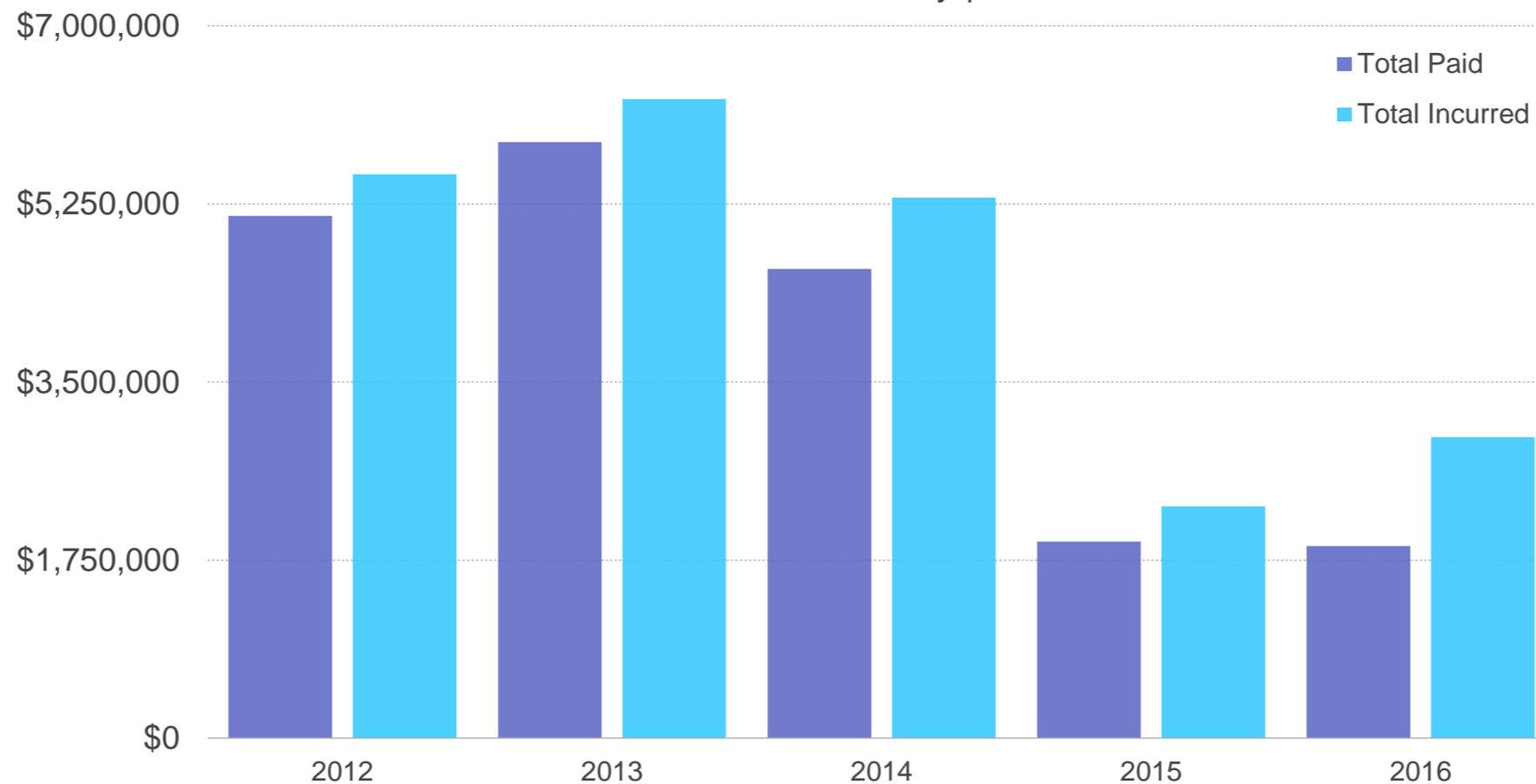
	Total Paid	Total Incurred
2012	\$5,132,303	\$5,542,399
2013	\$5,856,550	\$6,281,449
2014	\$4,610,052	\$5,312,459
2015	\$1,933,307	\$2,279,093
2016	\$1,888,321	\$2,957,762
TOTAL	\$19,420,533	\$22,373,164

 **Goal:** Reduce cost severity (total incurred) of new claims **15%** compared to 3 year historical average of **\$5,712,101** per year*

 **Result:** Total incurred for 2015 = **60%** reduction at **\$2,279,093***

 **Result:** Total incurred for 2016 = **48%** reduction at **\$2,957,762***

Claim Financial Summary | 2012 - 2016



Total Incurred includes reserves which are subject to future development

Workers' Compensation - Countywide

Top Claim Frequency & Severity Accident Types



Top 5 Most Frequent Accident Types | 2012 - 2016

	Total Incurred	Total Incurred
Strain	603	\$8,439,894
Struck By	360	\$1,214,992
Altercation	177	\$2,638,578
Slip or Trip	158	\$1,374,844
Laceration	122	\$277,538

Top 5 Most Severe Accident Types | 2012 - 2016

	Total Incurred	Claim Count
Strain	\$8,439,894	603
Altercation	\$2,638,578	177
Motor Vehicle Accident	\$2,560,316	77
Slip or Trip	\$1,374,844	158
Struck By	\$1,214,992	360

Workers' Compensation Claim Frequency & Severity by Department



Claim Frequency & Severity by Department | 2012 - 2016

	Claim Count	Total Incurred
BHD	606	\$4,340,964
Sheriff	551	\$6,639,003
Parks	359	\$2,207,755
House of Corrections	206	\$1,981,300
DOT - Airport	175	\$2,446,532
DOT - Highway Maintenance	175	\$1,166,801
Zoo	100	\$373,011
DHHS	97	\$1,122,008
Facilities Maintenance	83	\$733,918
DOT - Fleet Management	43	\$628,733
District Attorney	36	\$151,561
Child Support Enforcement	21	\$182,455
County Funded State Courts	19	\$78,201
Medical Examiner	12	\$61,467
All Others	73	\$259,456
TOTAL	2556	\$22,373,164



2017 OSHA Training Sessions

Under the Occupational Safety and Health Act of 1970, employers are responsible for providing a safe and healthy workplace. No employee should ever have to suffer illness, injury or death for a paycheck.

Many OSHA standards, which have prevented countless workplace tragedies, include explicit safety and health training requirements to ensure workers have the required skills and knowledge to work safely. These requirements reflect OSHA's belief that training is an essential part of every employer's safety and health program for protecting workers from injuries and illnesses.

To help facilitate and conduct these training requirements, Risk Management, along with the help of numerous other departments, has coordinated a series of training opportunities for employees throughout Milwaukee County. These classes are instructor led and in some cases provide a hands-on learning opportunity. Registration should be completed through the Milwaukee County Employee Development Center (EDC) formerly known as the Learning

January & February

January 17 • February 14

Fall Protection – 9 to 11:30 a.m.

Hoists & Slings – 12 noon to 3 p.m.

Class Capacity: 30 each session

Location: General Mitchell Airport, South
Maintenance Shop (Lunchroom)

Instructor: Nick Dillion (Aegis Corporation)

Location Contact: Tim Brown

January 18 • February 15

Global Harmonized System (Haz Com) –

9 to 9:45 a.m.

Bloodborne Pathogens – 9:45 to 10:30 a.m.

Lock Out Tag Out – 10:30 a.m. to 11:15 p.m.

Hearing Conservation – 11:15 a.m. to 12 noon

Respirator Protection – 12:30 to 1:15 p.m.

PPE – 1:15 to 2 p.m.

Safe Lifting – 2 to 3 p.m.

Class Capacity: 109 each session

Location: CATC Building, Large Auditorium

Instructor: Vance Forrest (Aegis Corporation)

Location Contact: Jason McCarthy

January 23 • February 23

Global Harmonized System (Haz Com) –

9 to 9:45 a.m.

Bloodborne Pathogens – 9:45 to 10:30 a.m.

Lock Out Tag Out – 10:30 a.m. to 11:15 p.m.

Hearing Conservation – 11:15 a.m. to 12 noon

Respirator Protection – 12:30 to 1:15 p.m.

PPE – 1:15 to 2 p.m.

Safe Lifting – 2 to 3 p.m.

Class Capacity: 100 each session

January 25

Fork Truck – 8 to 11:30 a.m.

Class Capacity: 20 each session

Confined Space – 12 noon to 3 p.m.

Class Capacity: 25 each session

Location: Lapham Building

Instructor: Vance Forrest (Aegis Corporation)

Location Contact: Lynelle Westrich

Certification is for a three-year period when training is required again.

February 7

First Aid, CPR, AED – 8:30 a.m. to 12:30 p.m.

Class Capacity: 20 each session

Location: CATC Building, Room 111

Instructor: Milwaukee County EMS

Location Contact: Ken Sternig

Certification is for a two-year period when training is required again. Cost: There is a \$30 cost per person for this class as it requires the purchase of textbooks, PPE and certification fee with the American Heart Association. Departments will be responsible for covering the cost of each individual who participates. The Office of Emergency Management will send a JV debit for all class participants.

February 8

Fall Protection – 9 to 11:30 a.m.

Hoists & Slings – 12 noon to 3 p.m.

Class Capacity: 30 each session

Location: Fleet Management Building

Instructor: Vance Forrest (Aegis Corporation)

Location Contact: John Blonien



Workers' Compensation - BHD

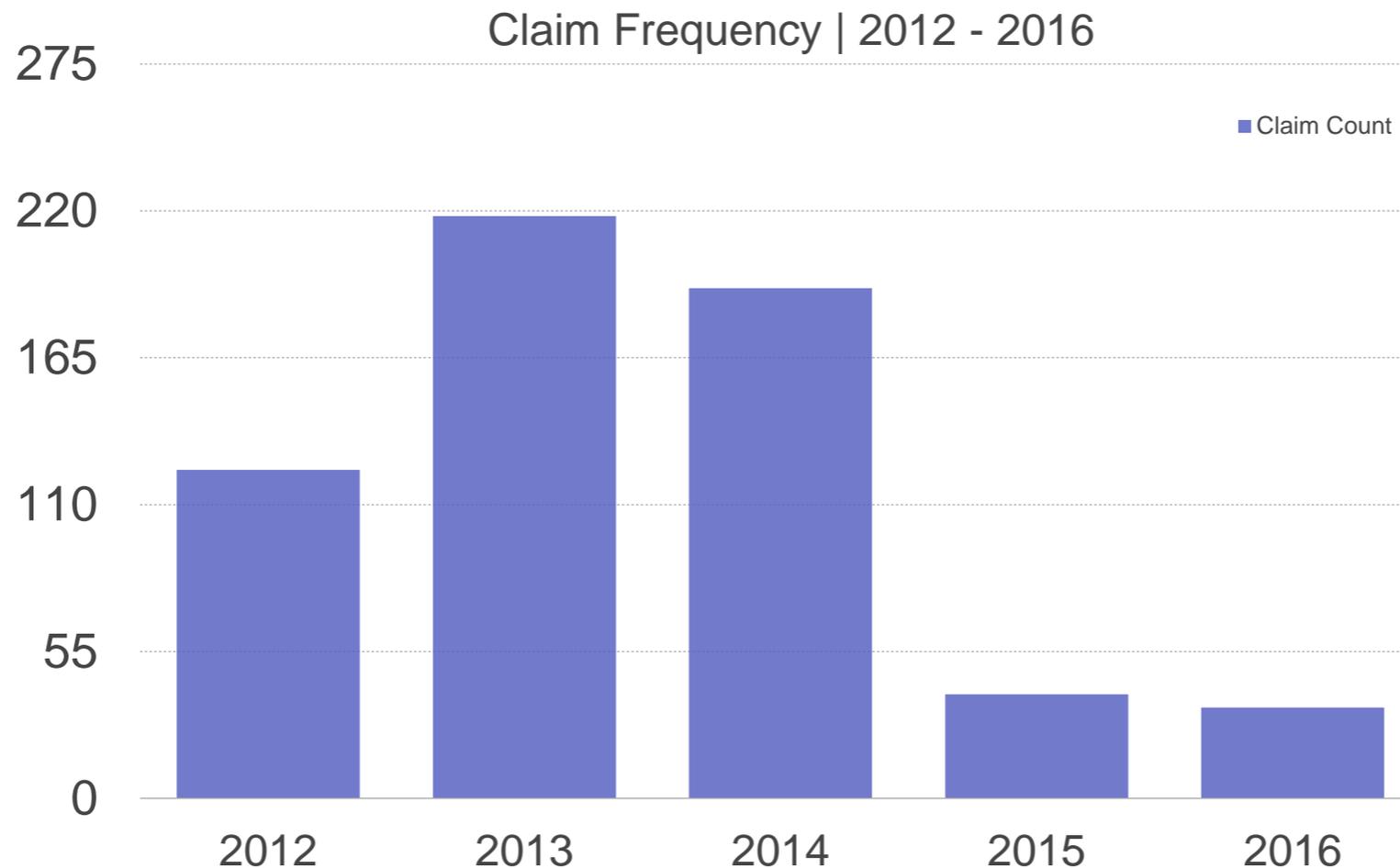
Claim Frequency

Claim Frequency | 2012 - 2016

	Claim Count
2012	123
2013	218
2014	191
2015	39
2016	34
TOTAL	605



79% decrease in frequency measures in 2015 – 2016 compared to averages in 2012 - 2014



Workers' Compensation - BHD

Claim Financial Summary

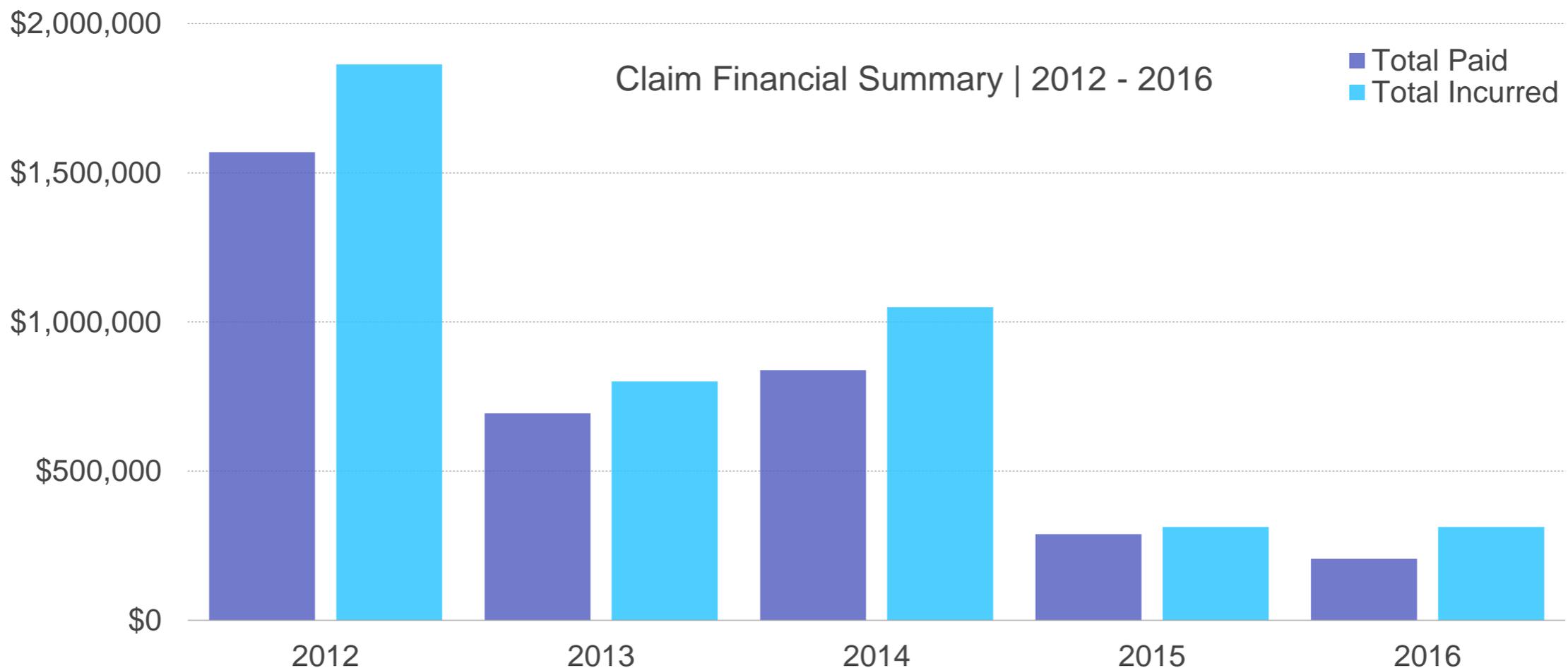


Claim Financial Summary | 2012 - 2016

	Total Paid	Total Incurred*
2012	\$1,569,192	\$1,862,954
2013	\$693,784	\$800,185
2014	\$838,380	\$1,049,199
2015	\$288,629	\$312,774
2016	\$206,248	\$313,101
TOTAL	\$3,596,234	\$4,338,214



75% decrease in severity measures in 2015 – 2016 compared to averages in 2012 - 2014



Total Incurred includes reserves which are subject to future development



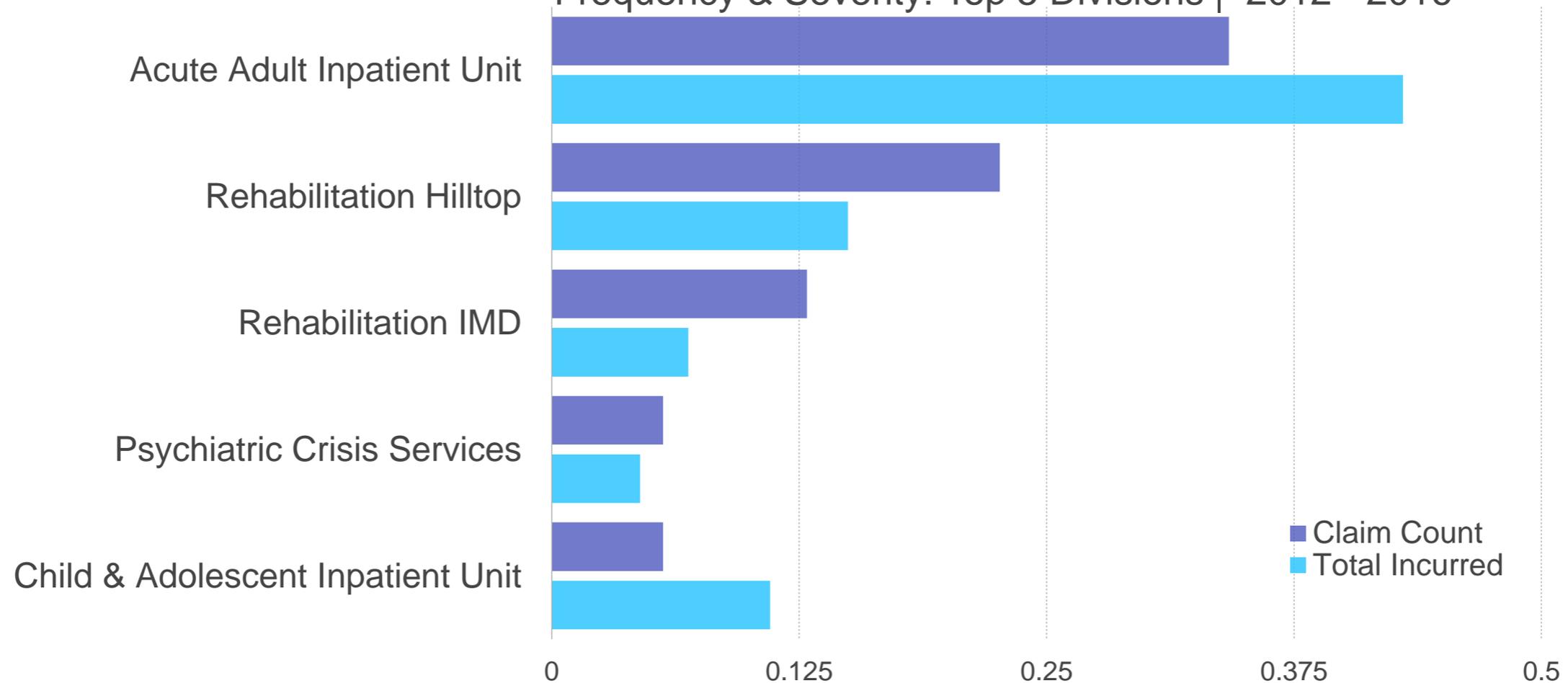
Workers' Compensation - BHD

Frequency & Severity: Top 5 Divisions

Frequency: Top 5 Divisions | 2012 - 2016

	Claim Count	Total Incurred
Acute Adult Inpatient Unit	207	\$1,865,668
Rehabilitation Hilltop	137	\$649,507
Rehabilitation IMD	78	\$299,235
Psychiatric Crisis Services	34	\$194,127
Child & Adolescent Inpatient Unit	34	\$478,533

Frequency & Severity: Top 5 Divisions | 2012 - 2016



Workers' Compensation - BHD

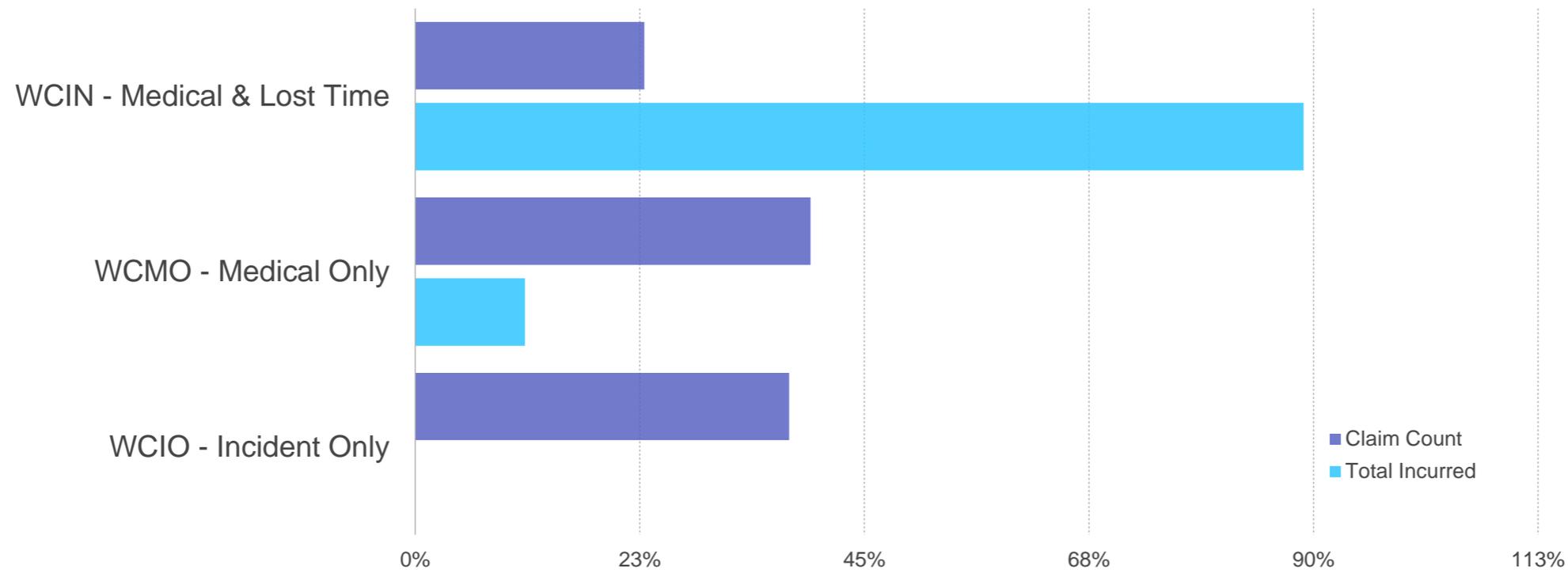
Claim Frequency & Severity by Claim Type



Claim Frequency & Severity by Claim Type | 2012 - 2016

	Claim Count	Total Incurred
WCIN - Medical & Lost Time	139	\$3,863,933
WCMO - Medical Only	239	\$474,281
WCIO	227	\$0
TOTAL	605	\$4,338,214

Claim Frequency & Severity by Claim Identifiers | 2012 - 2016





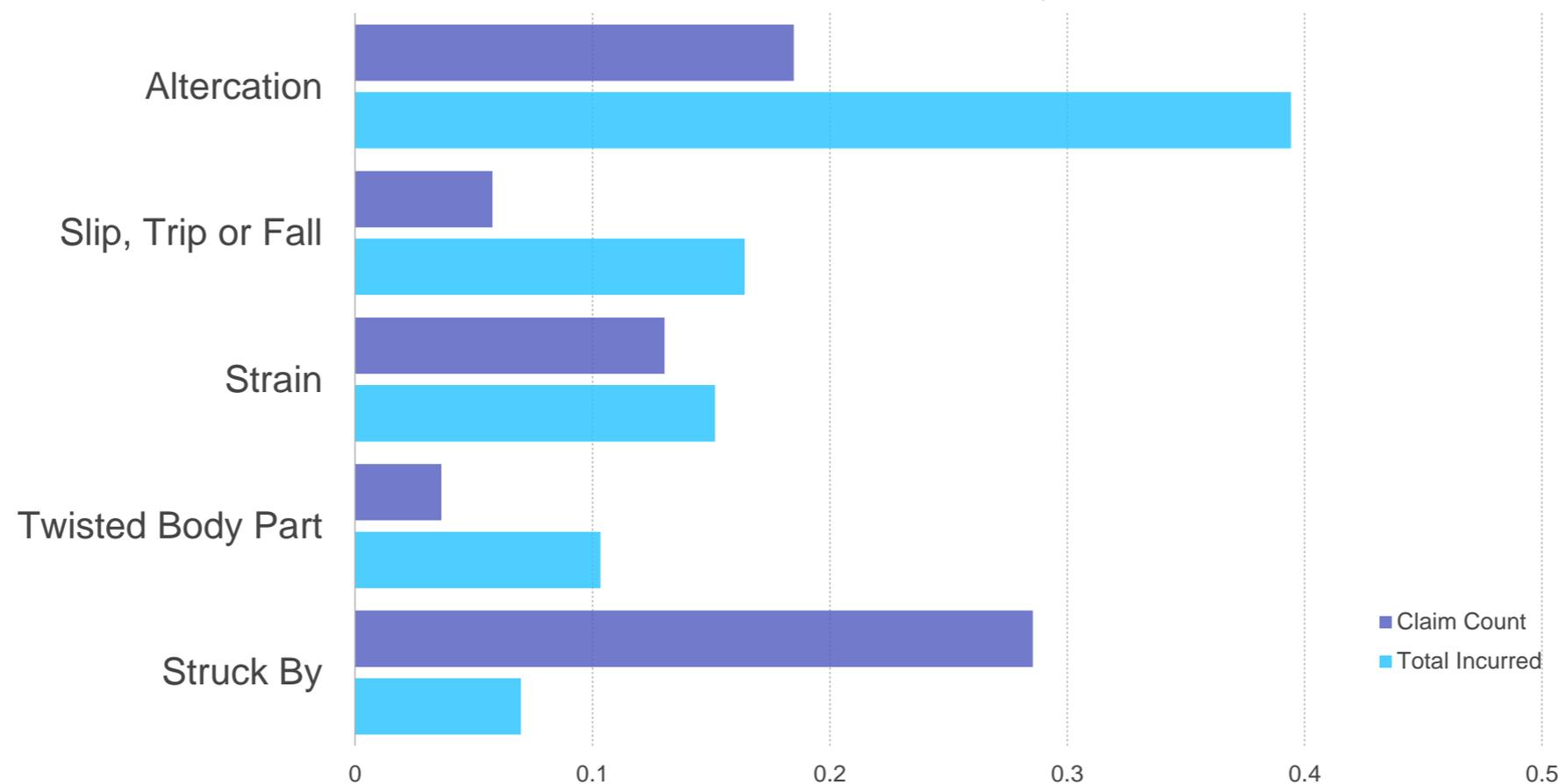
Workers' Compensation - BHD

Top 5 Most Severe Accidents Types

Top 5 Most Severe Accident Types | 2012 - 2016

	Claim Count	Total Incurred
Altercation	111	\$1,708,977
Slip, Trip or Fall	35	\$712,094
Strain	79	\$658,658
Twisted Body Part	22	\$448,800
Struck By	173	\$302,939

Top 5 Most Severe Accident types | 2012 - 2016



Workers' Compensation - BHD

Experience Modification Factor



BHD Experience Modification Factor: 1.04

Minimum Mod: .37

Controllable Mod: .67

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

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



Workers' Compensation Employee Safety & Loss Control Initiatives

Milwaukee County Programs & Policies

- Established Milwaukee County Transitional Duty Program (AMOP 5.05)
- Established Milwaukee County Safety & Health Program (AMOP 5.03)
- CityWorks – Incident Reporting Process
- Implemented OSHA Compliance Written Programs

Milwaukee County Employee Engagement Initiatives

- Promotion of Find It Fix It Program – Safety and Property Issues
- Participation in Joint Safety Committee / VARC
- Total Health Newsletter

Employee Training

- Established OSHA Compliance Training Curriculum for all County employees
 - *Curriculums built in LMS (Learning Management System)*
- Established County OSHA Compliance Training Database
 - *In-person classes / webinar / hand-outs*
- Focus on Safe Lifting/Back Injury Prevention
- Focus on De-Escalation Training

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

DATE: June 8, 2017

TO: Duncan Shrout, Chairperson – Milwaukee County Mental Health Board

FROM: Michael Lappen, Administrator, Behavioral Health Division

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

Background

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

Discussion

Legislative Audit Bureau (LAB) Recommendations: BHD's Progress Report Submitted June 1, 2017

- **Recommendation Response Letter and Summary**

The attached letter and summary (**Attachment A**) demonstrates a detailed update on progress made related to the LAB's recommendations.

High Quality and Accountable Service Delivery

- **BHD Initiative Related to Community Concerns Regarding Transportation**

Chairman Shrout directed the BHD Administrator to create a proposal to address concerns raised by several Board members regarding the impact of changes to the Go Pass system on individuals served by BHD programs and services, especially those who were homeless, involved in Housing First, and/or were waiting for a disability determination in order to receive benefits--a process could take a year or more. The changes in the Go Pass Program include transitioning oversight to the Department of Health and Human Services Disability Services Division (DSD) on June 26, 2017.

The Go Pass will have an initial \$5 fee, with a \$1 per day fee for unlimited rides. It works like a debit or "swipe" card. Users will be able to load money onto their cards at about 80 locations in the community. For individuals under 60 years of age, eligibility is based on being on SSD, SSI, Medicaid, or Foodshare. Individuals without a disability determination are eligible for half-fare with a doctor's excuse documenting their illness/disability that justifies the reduced fare. Also, those who are in the process of applying for benefits with the assistance of a Disability Benefits Specialist are eligible for half fare as well.

BHD will establish a pilot program in 2017 to assess need and to make sure our solution is fiscally responsible, sustainable, and effective. We have budgeted \$100,000 for transportation in the 2018 Budget. Our proposed program would require a basic application for up to 90 days of transportation assistance. The application would require individuals to demonstrate they are not eligible for other transportation assistance and have exhausted other options. DSD has agreed to assist BHD in confirming eligibility as needed and with providing benefits counseling and assistance for BHD consumers. If an individual can demonstrate a financial need, the application will require a person-centered transportation assistance request supported by that individual's treatment needs. If someone is eligible for the Go Pass but needs treatment related assistance for the daily fees because they are unable to pay, BHD could load the appropriate dollar amount as directed by that person-centered need onto their transit card. DSD has agreed to assist with this, and if the pilot identifies a need and is a sustainable program, DSD would assist BHD to acquire the technology to add funds to Go Passes/transit cards going forward.

For individuals who are not eligible for the Go Pass who have treatment related needs, BHD would provide limited-term funding for half-fare bus access based on those needs and that individual's person-centered treatment plan. This group would include those with little or no income and those who have applied for benefits but are waiting for a disability determination. DSD has agreed to a partnership with BHD to make sure that our clients get assistance with benefits and that transportation alone does not become a barrier to accessing mental health and substance use disorder treatment.

The initial pilot will identify challenges in such a program and will help establish the actual community need. Our goal is to avoid duplicative programs that waste valuable resources (for example, Housing First participants have access to bus tickets as part of that program) and to create a transportation solution that assists our clients to achieve their individual treatment goals with a strong focus on temporary or transitional assistance as much as possible.

Other Topics of Interest

- **RN Recruitment Campaign and Efforts**

As reported as part of the LAB required update, BHD has made numerous efforts to retain and attract nurses over the past eight months. BHD was experiencing little to no activity from nurses applying for posted positions through most of 2016. A major factor in this was the public perception that BHD had closed or was imminently closing its Acute Psychiatric Facility. In response to this recruitment challenge and a large number of nursing vacancies at BHD, a nurse recruitment campaign was developed by Kane Communications and implemented during the months of March-May of this year, in conjunction with a change in nurse recruiters earlier in 2017.

While we will provide a detailed report on the "Need Not Apply" campaign at a later date, we can report that the efforts so far have been a success. At the beginning of the campaign, BHD had significant openings on second and third shifts. We currently have no open third shift positions and have decreased our open second shift positions by more than 50%. We were able to link at least twenty-six viable candidates directly to the Kane campaign. Fifteen of these were offered positions, with fourteen actually hired (one rescinded after receiving a counter-offer from her employer).

All the candidates who responded to the campaign were contacted. Of those that were not hired, five declined offers and six were not offered positions, typically for lack of follow through on pre-employment requirements. Further supporting the effectiveness of the campaign, we have seen a significant decline in applicants since the media campaign ended. We are currently discussing ways to extend the campaign and continue to recruit in the most cost-effective and efficient manner. Our most challenging shift remains the evening or PM shift, and it is clear BHD must continue the effective campaign in a focused attempt to fill the remaining vacancies which stand at about 16 as of June 1.

A final point is that staffing turnover in nursing has been significantly reduced, suggesting that retention efforts have achieved the desired effect. The combination of effective recruiting and meaningful retention has us well on our way to resolving a very daunting workforce challenge.

- **BHD Physicians Elected to Leadership Roles**

Three BHD physicians have been elected to leadership roles (2017-2018) on the Executive Council of the Wisconsin Psychiatric Association (WPA): Dr. Chou - APA Assembly Representative, Dr. Thrasher - Milwaukee Chapter President, Dr. Schneider - WPA President - Elect.

Administrative Update

06/08/2017

Page 4

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Mike Lappen". The signature is fluid and cursive, with a horizontal line drawn underneath the name.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION

Milwaukee County

HÉCTOR COLÓN • Director
MICHAEL LAPPEN • Administrator

June 1, 2017

Senator Robert Cowles
Co-Chair, Joint Legislative Audit Committee
State Capitol
Room 118 South
Madison, WI 53703

Representative Samantha Kerkman
Co-Chair, Joint Legislative Audit Committee
State Capitol
P.O. Box 8952
Madison, WI 53708

RE: Update on Recommendations from the December 2016 Legislative Audit Bureau Report on the Milwaukee County Mental Health Board and the Functions, Programs, and Services it Oversees

Dear Senator Cowles and Representative Kerkman:

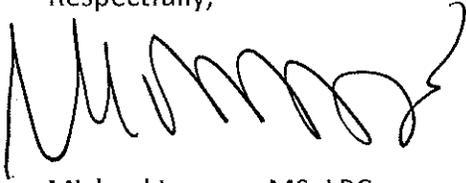
On behalf of the Milwaukee County Behavioral Health Division (BHD), and the Milwaukee County Mental Health Board (MCMHB), I would like to thank you for the opportunity to provide the Joint Legislative Audit Committee a progress report on our efforts to implement the recommendations contained in the Legislative Audit Bureau (LAB) Report on the Milwaukee County Mental Health Board from December 2016. As I noted in my letter to State Auditor Joe Chrisman dated December 13, 2016, the Administrative Team at BHD appreciated the professionalism and collaborative approach taken during the audit process.

BHD and our governing Board have taken the recommendations very seriously, and I am happy to report that we have made great progress in acting on many of them. In some cases, the recommendations have been fully implemented. Other recommendations were longer-term objectives, but BHD's Administrative Team has established timelines to fully implement them and in each case, has made significant progress over the past six months. I have reported on BHD's progress in implementing all of the LAB recommendations at each MCMHB meeting since the report was published last December. These reports are publically available, including audio on the MCMHB web page. BHD was instructed to report our progress to the Joint Legislative Audit Committee on a number of specific recommendations by June 1, 2017. Please find attached a detailed update on our progress on those recommendations for your review.

State Legislative Audit Bureau Recommendations
June 1, 2017

If there are any questions or concerns regarding BHD or our progress on the LAB recommendations, please do not hesitate to contact me. I am at your service.

Respectfully,

A handwritten signature in black ink, appearing to read "Michael Lappen", with a stylized flourish at the end.

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

cc: Joe Chrisman, State Auditor, Legislative Audit Bureau
Paul Stuiber, Deputy State Auditor, Legislative Audit Bureau
Duncan Shrout, Chairman, Milwaukee County Mental Health Board

Legislative Audit Bureau (LAB) Recommendations Requiring a Report to the Legislative Audit Committee from the Milwaukee County Behavioral Health Division (BHD) and the Milwaukee County Mental Health Board (MCMHB) by June 1, 2017

The LAB report from December 2016 recommended that BHD should:

Develop a strategy to address staffing issues at its hospital (p. 39). The recommendation is later rephrased that BHD should develop a strategy to address staffing issues at its psychiatric hospital that will allow it to consistently provide the number of beds it has budgeted to provide.

A comprehensive recruitment and retention plan was developed and implemented in late 2016 to address psychiatrist, registered nurse, and crisis clinician recruitment. Pay ranges for psychiatrists were modified, a new recruitment agency was hired, a temporary agency was retained for nurses, and the MCMHB Finance Committee approved \$2,000,000 at the December 2016 meeting to secure temporary nursing to maintain adequate staffing for BHD's Acute Hospital. Shift differentials were improved, sign-on bonuses were established, a referral bonus program was developed and implemented, an attendance incentive was implemented, and a school loan payback program was developed.

A marketing plan and public awareness campaign was developed by Kane Communications to make the public aware that BHD continues to operate an acute psychiatric hospital (since so many in the community believed we were closed or imminently closing), that BHD is a thought leader in Behavioral Health with the most experienced and capable staff serving the most challenging clients, and identifying BHD as the top local learning opportunity for recent nursing graduates interested in a career in mental health. The campaign featured several current employee ambassadors representing a number of potential target groups—new graduates, those exploring a second career in nursing, and those seeking part-time work with full-time benefits. A major focus of the project was to reach and recruit nurses to fill open positions on BHD Acute Units. The program rolled out mid-February 2017 and included documentary style videos depicting current BHD nurses, a comprehensive radio and internet ad campaign, freeway billboards, bus shelter ads, banners, etc. There was significant interest from local press with requests for BHD staff to do interviews about the campaign and the benefits of a career in mental health. There has been a very positive response to the campaign, with significant traffic generated to the web page and a dramatic increase in applicants and offers. Despite a very competitive environment for psychiatric nurses, BHD has made approximately twenty-five new hires in nursing from February to May 2017. The link to the BHD Nursing Careers web page is: <http://county.milwaukee.gov/nursing>

Develop performance indicators for individuals placed on a waiting list for institutional-based care (p. 39); and develop performance indicators of the number of individuals placed on the Psychiatric Emergency Medical Services program waiting list and the amount of time they spend on the waiting list before they are served.

The “waiting list for institutional-based care” refers to patients that are being cared for at a local hospital while awaiting transfer to BHD/Psychiatric Crisis Service (PCS) for further evaluation/definitive care. When BHD faces capacity issues, priority is given to individuals that come to PCS directly, either as a walk-in or with law enforcement, since those individuals are otherwise currently receiving no treatment. Three new performance indicators related to individuals placed on the waiting list for institutional based care are:

- Hours of BHD Police Diversion Status (**Target 2017 = 0**).
- Median time of patient on Waitlist (**Target 2017 = Less than 8 hours**).
- Patients on Waitlist needing BHD Service [*Patients on Waitlist needing BHD service % = Patients post PCS Visit at BHD who physician admits to BHD Service / All "Wait list" patients*] (**Target 2017 = Less than 2%**).

These performance indicators address three notions: First, does BHD ever suspend its duties as a detention facility for police drop offs? Second, in the median, how long are patients boarded/cared for at outside facilities if they are placed on waitlist-- this is a national measure that we can benchmark our performance against. And, of the patients place on waitlist that come to PCS for further evaluation, how many actually are evaluated by PCS to need BHD service - this is a measure of system efficiency as most patients who are on waiting list can have resolution with care other than BHD facility based care (Acute Inpatient or Observation Unit).

Clearly delineate the community-based programs for adults that it administers and the services provided by each (p. 48). This recommendation is later rephrased that BHD should clearly delineate the community-based programs for adults that it administers and the services provided by each, and provide this information to Milwaukee County Mental Health Board members, service providers, and prospective recipients and their family members.

Community Access to Recovery (CARS) staff will present to the MCMHB on each community-based program administered by BHD in 2017. The most recent presentation occurred at the April 27, 2017, meeting of the MCMHB and focused on Prevention and Access. This was Item #7 on the agenda, and the materials, including audio of the presentation, are posted on the MCMHB web page. A presentation on CARS Treatment, Rehabilitation and Recovery is scheduled for the MCMHB meeting June 22, 2017 (Agenda Item #7).

CARS is also in the process of updating informational materials for each BHD community-based program and is developing a resource guide based on an example used in La Crosse, which describes BHD related programs, along with many related community resources. A parallel project is underway to establish an online BHD Provider Directory in coordination with a much

larger Milwaukee County effort to improve the County web page. The online BHD Provider Directory will provide a detailed explanation of each program administered by BHD, along with admission requirements, provider profiles, and quality data. The electronic format will allow for the materials to be easily refreshed and maintained. The project is scheduled to be completed by the end of 2017, with a tentative go-live date in early 2018.

Electronically maintain records of services provided to recipients (p. 48); electronically maintain records identifying the specific services provided to recipients and the specific program that provided each service.

Since Community Access to Recovery Services went live with the Electronic Medical Records System for all community services (Avatar and Provider Connect by Netsmart) on October 1, 2015, records of all services provided to recipients by BHD or BHD funded providers, and the specific program that provided the service, are maintained electronically within the EMR system.

Address several policy related issues: The specific LAB language with recommendations regarding policy are found in several places in the report: BHD should identify the policies that apply to each of its programs and the policies with which vendors are expected to comply (p. 48); and review 144 policies that are overdue for review. To identify in all of its program-related policies the specific programs to which the policies apply; include in its contracts, including fee-for-service agreements, the specific policies with which vendors will be expected to comply. We recommend the Behavioral Health Division conduct a review of the 144 policies that are overdue for review, update them as necessary.

In response to the issues raised regarding BHD policies overdue for review, the following explanatory document and action plan was created by the BHD Safety Officer for the MCMHB in January 2017:

History:

BHD had identified the need to improve the management of policy and procedure (P&P) content, accessibility, and accountability. BHD chartered a P&P Committee and in early 2015, through researching available options, PolicyStat was selected as the best solution for BHD's policy repository.

Features:

Policy Templates: Ensures the same format is used for all new policies. Font and layout are also specified for all new and existing policies, which assures consistency across the division.

Searching: Users can search for policies by a key word, title, policy area, and/or owner.

Dashboard: Provides a snapshot of each staff persons' policy workload. This includes a ninety (90)-day notice for what is coming due, what needs approval, and what policies need to be acknowledged.

Approving: Approval flows are standard and add consistency for each policy area. If a change is made during the course of the approval process, the process is started over, so all approvers have seen all changes. Approvals are timestamped and automatically recorded. Once an approval is completed, employees receive a notification of a new or revised policy in the system.

Editing and Collaborating: Revisions are tracked, including a timeline showing edits, approvals, red lines, or additions. Multiple staff can work from one central draft. Appropriate staff can collaborate together and leave comments/feedback on the document, which facilitates the process versus holding a meeting to review a policy.

Auditing: An audit trail of past versions is available to appropriate staff. This includes all comments entered during the editing process. This allows an old document to be retrieved, often for legal reasons, while front-line staff will only access the currently approved and active document.

Referencing: Policies can include references, so staff and auditors can notate, group, and search for documents according to a particular standard or regulation.

Acknowledgements: All employees or groups of employees can be assigned to acknowledge a policy. The acknowledgement can also include a link to a training module and/or test in (HealthStream), if desired. This results in a timestamped record for each employee indicating they have read and acknowledged the policy content.

Timeline:

An agreement was signed in May 2015, and the Build phase of the project was initiated.

The Build phase included creation of a number of required aspects within PolicyStat:

- Policy banner and header design
- Creating a new policy template that all new policies would follow
- Defining policy areas
- Creating policy approval flows for each policy area
- Provisioning and training employees in the roles of manager, editor, owner, and site administrator
- Determining which policies would be imported initially for "cleaning" and reformatting into the system
- Ongoing upload of existing policies as submitted

Once a portion of BHD policies were uploaded and made available on the system, all employees were invited to sign into the system and acknowledge the initial introduction policy. All

employees also received a basic on-line training on the basics of PolicyStat. On October 1, 2015, the system went live.

Originally, there was not one central location for all P&Ps. As a result, it was difficult to locate electronic versions of all possible documents for upload. To date, we have uploaded and/or created a total of 519 active policies. Departments have been encouraged to submit departmental procedures, forms, and policies for upload or create new items directly into PolicyStat. Initially, P&Ps were uploaded with the knowledge that some were no longer applicable to current business practices and would be retired. This, however, would preserve the historical value of the prior policy and would make record keeping simpler.

At present there are an additional seventy-eight documents in draft and fifty in the approval process. In the last ninety days, twelve policies have completed the approval process and are now live in the system.

The P&P Committee has been reviewing uploaded documents for items that can be retired. Departments are also still able to submit documents for upload. These documents may or may not be up to date, but BHD had decided that uploading an outdated policy and then revising or retiring it in the system is a preferred method to preserve the tracking of edits and discussion surrounding those edits and/or retirement decisions.

Additional training sessions will be held for owners, editors, or approvers on how to use PolicyStat. Expectations for prioritizing policy review/revision was discussed at the January 23, 2017, Managers meeting. Managers will be expected to follow up with policy owners they supervise to assure all policies are up to date. Escalation to the Senior Management and Administrator levels will occur as needed.

A specific timeline for policy review and completion by the policy area will be developed based on the results of that meeting. The final target date was May 1, 2017, for all existing policies in PolicyStat to be reviewed/revise or retired. This targeted date was intended to provide time to produce as much information possible for the report due, which is hereby submitted to the Joint Legislative Audit Committee on behalf of BHD and the MCMHB on June 1, 2017.

By May 1, 2017, BHD made significant progress on reviewing/retiring policies but had not completed the project as originally planned in January 2017. According to the report to be presented to the MCMHB Quality Committee on June 5, 2017, as of May 1, 2017, BHD had 496 active policies. Seventy-nine percent of BHD policies had been reviewed within the scheduled period. There were thirteen new policies approved in PolicyStat from January to April 2017, twenty-seven policies were revised, and forty-one were retired. Forty-nine policies will come due for review from May to August. There is a revised plan in place to review/retire all past due policies by August 1, 2017, with a significant focus on reviewing policies within the scheduled period going forward, once the backlog of retired/overdue policies has been resolved in PolicyStat.

BHD has initiated a transition from Purchase-of-Service Contracts to Fee-for-Service Contracts in a number of major program areas. Targeted Case Management and AODA Residential were the first to be completed in 2017, and there is a timeline to transition the balance of Purchase-of-Service Contracts over the next year. As part of this initiative, policy language has been added to clarify which BHD policies providers must adhere to. Additionally, all current program related policies in PolicyStat identify which programs the policy applies to, and policy requirements have been updated in all vendor contracts in 2017.

Community Access to Recovery Services

Milwaukee County Behavioral Health Division

What is CARS?

Community Access to Recovery Services (CARS) is the Behavioral Health Division entity that manages the public-sector, community-based mental health and substance abuse system for adults in Milwaukee County. Historically known as SAIL (mental health) and Wiser Choice (substance abuse), CARS is now proudly functioning as a co-occurring integrated system of care.

Focus Areas of CARS

CARS serves approximately 8,000 unique individuals annually in a variety of contexts, with an emphasis on four main areas:

- Prevention
- Access to Services
- Treatment and Rehabilitation
- Recovery

TREATMENT

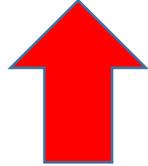
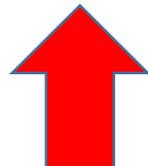
Providing people with the services they need

TREATMENT

CARS offers a comprehensive array of treatment services to meet each individual's personalized needs. Individuals may transition through a variety of programs through the course of their recovery journey and may be in more than one program at a time.

Phases of Treatment and Recovery

Phases of Illness and Recovery

Intensity	Service Band	Program	Health Promotion	Prevention	Acute	Stabilization	Stable	Recovery
 <p>High Low</p>	Treatment	Detoxification			X			
		AODA Residential				X		
		CBRF/Adult Family Home				X	X	X
		Day Treatment				X	X	
		Outpatient				X	X	X
 <p>High Low</p>	Care Management	CSP			X	X	X	X
		CCM				X		
		TCM				X	X	X
		CCS				X	X	X
		RSC				X	X	X
		CM					X	X
	Recovery Support Services	RSS- Spiritual	X	X		X	X	X
		RSS-Family	X	X		X	X	X
		RSS-Employment	X	X		X	X	X
		RSS-Housing	X	X		X	X	X
		RSS-Psych Self Management	X	X		X	X	X

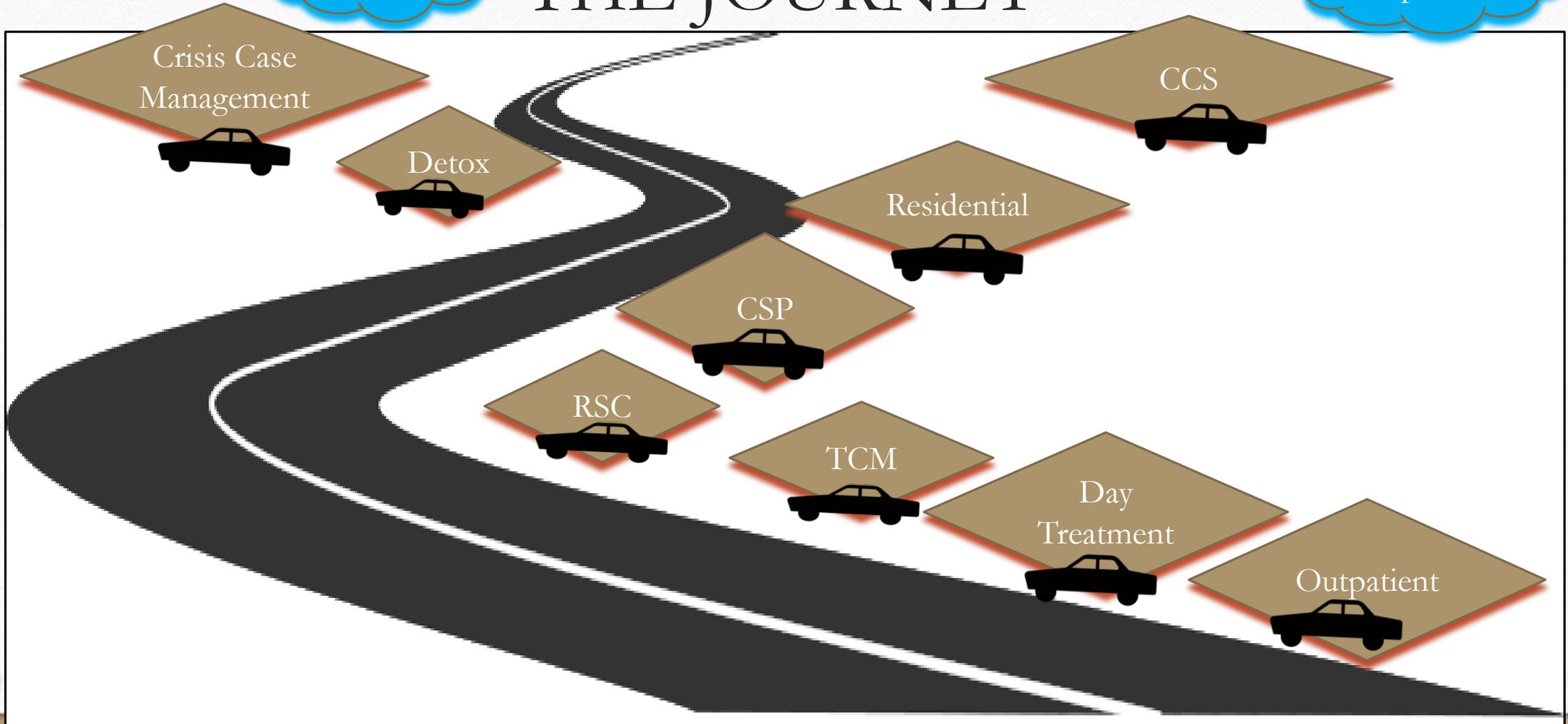
Client
Centered

Trauma
Informed

TREATMENT: THE JOURNEY

Fluid

Gender
Responsive



Crisis Case
Management

Detox

RSC

CSP

TCM

Residential

Day
Treatment

Outpatient

CCS

OUTCOMES

Intake to 6 Month Outcomes for 752 Clients Served in 2016



Pre- to Post-CARS Intake PCS and Detox Utilization:
3656 Unique Clients 1/1/2016 to 11/1/2016

44.25%

**Reduction in
PCS Visits**

20.12%

**Reduction in
Detox Visits**

EVIDENCE BASED PRACTICES

Seeking Safety
Cognitive Behavioral Therapy
Medication Assisted Treatment
Gender Responsive Treatment
Trauma Informed Care
Strategic Prevention Framework
Individual Placement and Support
Peer Specialists
Screening Brief Intervention Referral and Treatment
Integrated Dual Disorder Treatment
Matrix Model
Assertive Community Treatment
Motivational Interviewing
Dialectical Behavior Therapy

OUR PROVIDERS

- 109 unique services offered
- 73 partner organizations
- 2,946 individuals directly providing services

REHABILITATION

Restoring, redefining, and providing hope

REHABILITATION

Central to the mission of CARS is the belief that individuals living with mental illness and/or substance abuse disorders are capable of recovery. Furthermore, helping individuals make meaningful connections to their community and those around them is just as important – if not more so – than clinical treatment.

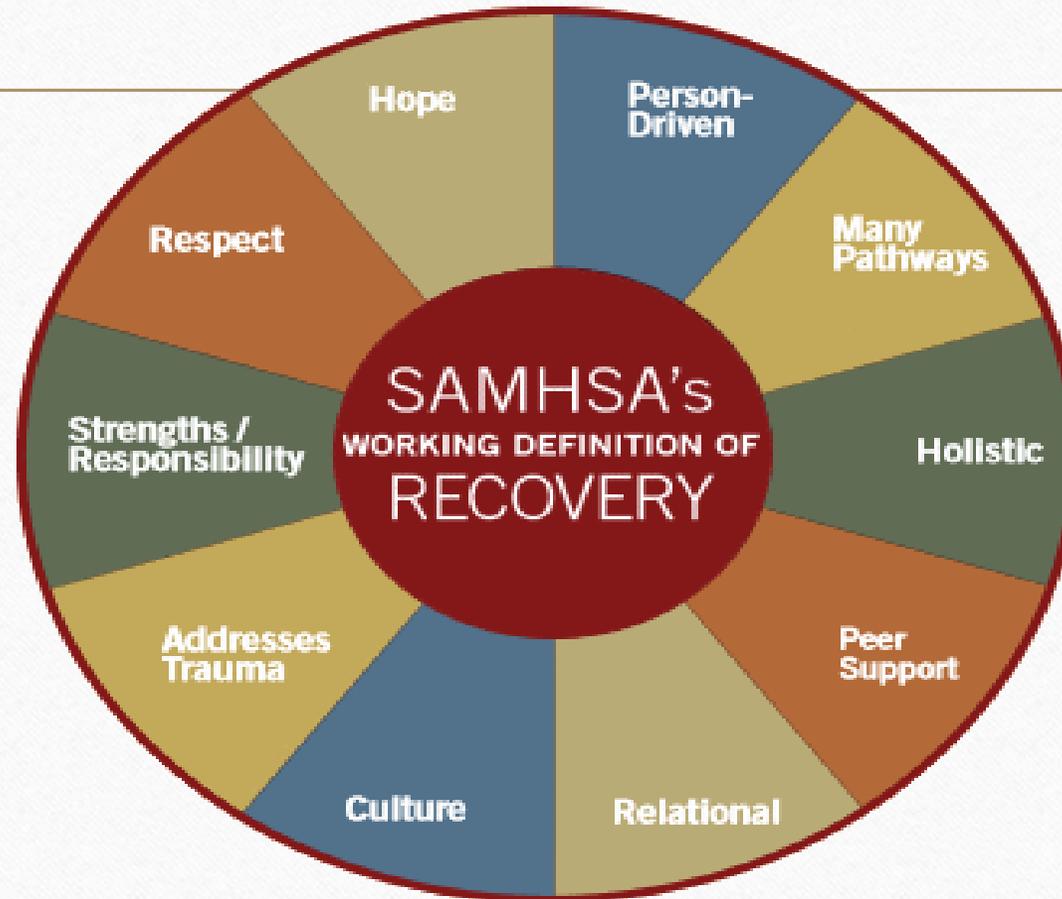
REHABILITATIVE SERVICES

- Advocacy programs
- Anger management
 - Bridge housing
 - Child care
- Clubhouse program
- Domestic violence – batterer and victim services
 - Drop-in centers
- Education/academic skills support
 - Non-traditional services
 - Parenting assistance
 - Peer run recovery center
 - Peer specialists
 - Physical health monitoring
 - Spiritual support
 - Supported employment

RECOVERY



RECOVERY COMPONENTS



OTHER CARS FUNCTIONS

Determining eligibility for and providing access to treatment and rehabilitative services is not all that CARS does. As a purchaser of services, CARS is committed to ongoing measures to ensure and improve the quality of those services through a variety of activities.

OTHER CARS FUNCTIONS

- Provide quality oversight of vendors in collaboration with Contract Management
- Conduct routine Utilization Review activities, including authorizations for service
- Serve a role of clinical consultation to providers
- Serve as experts around regulations, funding and administrative code
- Contract for consumer satisfaction surveys
- Engage in a wide variety of program evaluation activities
- Provide Technical Assistance and host a multitude of trainings
- Promote and support the use of NIATx for Continuous Quality Improvement

RECOVERY

For an inspirational story of recovery, please view the following video:

<https://vimeo.com/178379353>

Questions?



Milwaukee County Behavioral Health Division
Community Access to Recovery Services
Glossary of Services

AP - Access Points – To access the services offered by CARS, Milwaukee County offers several different access point locations. The access points utilize a comprehensive approach to the screening and assessment of both behavioral health and/or substance use disorders. The screening process, for CARS services, can take up to two hours and is based on consumer choice. The comprehensive screen identifies strengths in multiple life domains such as: family, emotional health, education and employment, living environment, etc. The screen concludes with matching the recommended service to the individual's needs for behavioral health and/or substance use disorder services.

AODA TCM – Alcohol and Other Drug Abuse Targeted 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 TCM that meets consumers where they are at and works in partnership to connect them to resources and services that will assist them in moving further along in the recovery process.

CARS - Community Access to Recovery Services - A department of Milwaukee County's Behavioral Health Division that provides a full array of supportive, recovery-oriented services for persons coping with severe and persistent mental illness and/or substance use disorders. CARS serves over 10,000 Milwaukee County residents each year. Its offered programs, work collaboratively to ensure that individuals receive trustworthy, high quality, reliable services to support them in addressing their mental health and/or substance abuse treatment needs.

CBRF – Community Based Residential Facilities – These facilities, more commonly referred to as “group homes,” offer the highest level of residential support and service intensity for adults coping with severe and persistent mental illness, outside of an inpatient setting. This level of care is intended for individuals who have struggled to live safely and successfully in the community with other types of supportive services in place. CBRFs offer 24 hour on-site supervision, monitoring, and intensive service delivery. Services include, but are not limited to: medication management, independent skill development, social skills training, physical health monitoring and management, crisis management, etc.

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.

CRS – Community Recovery Services – A Medicaid benefit that funds additional services intended to enhance levels of support for individuals coping with severe and persistent mental illness. Services are delivered in partnership with existing case management and other service providers. Three services are available under the CRS benefit: Peer Support, Community Living Supportive Services (independent skill development, social skills training, coping skill development, etc.), and Supported Employment. CRS is currently being offered within qualifying contracted CBRF facilities.

CSP – Community Support Program – The most intensive level of case management available in a person’s home or community. If necessary, CSP consumers can be seen up to seven days per week, two times per day. CSP services are available for individuals coping with a severe persistent mental illness and/or substance use disorder. Services include: supportive psychotherapy, stress reduction, medication management, social skills training, independent living skill development, crisis services, employment-related supports, symptom management. In Milwaukee County, all CSPs utilize ACT-IDDIT (Assertive Community Treatment and Integrated Dual Disorder Treatment), which are evidence-based practices.

Day Treatment – Offers therapeutic services via two separate tracks: Stabilization and Recovery or Dialectical Behavioral Therapy (DBT). Within both programs, a multi-disciplinary team of highly skilled clinicians work closely with consumers to develop coping strategies and skills that will support them in moving forward in their recovery. Services are generally offered in a group setting. Groups meet hourly Monday, Tuesday, Thursday and Friday from 10 AM- 3:00 PM. Length of participation is determined by both the team and consumer, but generally ranges from 3- 12 months. Prescriber and other medication management services are available to consumers while they are enrolled in Day Treatment. Descriptions of the two programs are listed below:

Stabilization and Recovery Program- offers a variety of groups to facilitate stabilization of symptoms from mental illnesses such as Schizophrenia, Schizoaffective disorder, Bi-polar Affective disorder, and Major Depressive disorder.

Dialectical Behavioral Therapy (DBT) Program- DBT is a nationally recognized treatment approach, and is the treatment of choice for individuals living with chronic suicidal thoughts, self-injurious and impulsive behaviors, and emotional dysregulation. The program integrates behavioral and dialectal therapy with the use of eastern mindfulness practices. DBT has proven to be effective in enhancing social and life function, reducing suicidal behaviors, reducing substance abuse, improving engagement in therapy, and reducing hospitalizations.

Detox – Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal to minimize the physical harm caused by the abuse of substances. Supervised detoxification can prevent potentially life-threatening complications that may arise in the absence of treatment. Detoxification is also a form of palliative care for persons who want to become abstinent from substance use. Detoxification is a critical component on the continuum of care that provides emergency stabilization services for a person in need, preparing that individual for engagement with appropriate substance abuse treatment commensurate with his or her ongoing needs.

IDP – Intoxicated Driver Program – The Intoxicated Driver Program, operated through IMPACT, is available through a contract with Milwaukee County Behavioral Health Division to all residents of Milwaukee County. Each county in Wisconsin has one designated facility for conducting Intoxicated Driver Assessments. The goal of the Intoxicated Driver Program is to accurately assess the client, connect the client to the most appropriate service, provide the client with the support needed to complete their program, reduce their use of alcohol or other substances, eliminate driving under the influence, and regain their driving privileges.

IPS – Individual Placement and Support – A supported employment model for individuals living with a severe and persistent mental illness. The model is guided by principles including competitive employment as the goal, a zero exclusion eligibility stance, employment being integrated with treatment, attention to client preferences, benefits counseling, a rapid job search, and time unlimited support. The IPS staff also have very specific expectations regarding systematic job development in the community.

MAT - Medication-Assisted Treatment – A combination of medication, counseling, and behavioral therapy proven to be effective in treating alcohol and opioid dependency.

OP – Outpatient – CARS contracts with agencies to provide outpatient mental health therapy, outpatient substance use treatment, and outpatient psychiatry for uninsured and underinsured persons of Milwaukee County. The goal of outpatient treatment is to ameliorate negative symptoms and restore effective functioning. Services are provided through individual, group, and/or family sessions. To access outpatient treatment, a person can present to any of the Access Points.

Residential AODA Treatment – A clinically supervised, peer supported, therapeutic environment with clinical involvement. This service offers substance abuse treatment, in the form of counseling, 3 to 11 hours 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.

RSC – Recovery Support Coordination – Recovery Support Coordination is a strength-based case management model similar to Targeted Case Management. It is the expectation that RSCs meet with their consumers at least one time per week for the purpose of service planning, coordination, and service delivery. RSCs offer an additional level of support beyond the provision of formal services. CARS offers RSC services to various target populations including, but not limited to: pregnant woman coping with a substance use disorder, families with minor children, IV drug users, and individuals receiving Medication-Assisted Treatment (MAT).

TCM- Targeted Case Management – Targeted Case Management (TCM) is the least intensive case management model offered by CARS. Within TCM, the case manager and consumer generally meet one time per week. TCM is designed to address the needs of individuals coping with mental health and/or substance use disorders. Services offered include: service linkage and consultation, system navigation, crisis assistance planning, general monitoring, and independent skill development.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: June 8, 2017

TO: Duncan Shrout, Chairperson – Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, and Department of Health and Human Services
Approved by Mike Lappen, Administrator, Behavioral Health Division

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute 2017 Professional Services Contracts for Psychiatry, Security, Grant Writing and Coordination, and Legal Services and Purchase-of-Service Contracts and Fee-for-Service Agreements with a Value in Excess of \$100,000 for the Behavioral Health Division for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least \$100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2017.

Background

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

Professional Services Contracts

Robert G. Clark, MD - \$510,600

BHD wishes to enter into a contract arrangement with Dr. Robert Clark to provide for essential psychiatry services to cover an existing full-time inpatient vacancy. BHD continues to work on permanent hire efforts, but given the current market, the average time to recruit and on-board a fulltime psychiatrist is averaging around one year. Dr. Clark has been working for BHD through a temporary staffing arrangement since May of 2016, but does not wish to enter into permanent employment. Contracting with him directly will be a savings over the current locum tenens costs and provide for greater assurance of ongoing coverage than the current temporary staffing arrangement. Dr. Clark is a fully trained and Board certified psychiatrist and is offering

his services on a contractual basis for the Acute Adult Inpatient Service for any unit need, as assigned. Services will include psychiatric evaluation, diagnosis, treatment, medication management, and consultation services as attending psychiatrist and treatment team director.

BHD is recommending a 16-month contract for psychiatry services from Dr. Clark for the period of September 1, 2017, through December 31, 2018, in a not-to-exceed amount of \$510,600. As BHD is able to permanently fill two existing inpatient psychiatrist vacancies, the use of this contract will be decreased or discontinued. \$125,800.00 will be paid in 2017 and \$394,800.00 will be paid in 2018.

U.S. Securities - \$548,052

US Securities provides Public Safety and Security Services for Milwaukee County Behavioral Health Division.

Milwaukee County Behavioral Health Division made the decision to not renew the Security Services contract with Orion and entered into a contract in an interim capacity with US Securities to provide Security Services once Orion was no longer providing services.

Reinhart Boerner Van Deuren S.C. - \$175,000

Reinhart Boerner Van Deuren is providing legal services to the Acute Task Force's evaluation of potential acute psychiatric care vendors. BHD is requesting a \$175,000 increase to the contract for a new total of \$274,000.

Medical College of Wisconsin - \$9,000

BHD is seeking to amend the current agreement (July 1, 2015 through June 30, 2017) with MCW that partially supports the Psychiatry Residency Director. It was recently discovered that when the MCW agreement was renewed for the 2013-2014 term, 2013 expenses were inadvertently paid from the 2014 encumbrance resulting in a historical deficit being carried forward. This amendment will resolve the legacy error.

Evaluation Research Services - \$173,400

Evaluation Research Services provides grant management coordination, inclusive of grant writing services to the Milwaukee County Behavioral Health Division. Using a Lifecycle management approach to grant management, processes and infrastructure is developed and implemented to manage grant proposals from beginning, or 'pre-award', stage of a project implementation, or 'post-award', through the termination, or closeout, of an award.

Purchase-of-Service Contracts

Whole Health Clinical Group - Crisis Resource Center - \$290,000

CRC serves Milwaukee County adults living with mental illness in need of crisis intervention and/or short term stabilization rather than hospitalization. It is a safe, welcoming, and recovery-oriented environment for people in need of stabilization and peer support to prevent hospitalization. In addition to the \$1,230,000 approved by the MCMHB in December, this

request is for an additional \$290,000 in expenditure authority to pass on Medicaid payments to the WHCG for services provided at the CRC. This request is budget neutral.

La Causa - Community Linkages and Stabilization Program - \$100,000

CLASP provides post-hospitalization extended support and treatment designed to support an individual's recovery, increase ability to function independently in the community, and reduce incidents of emergency room contacts and re-hospitalizations through individual support from Certified Peer Specialists under the supervision of a clinical coordinator. BHD is requesting an additional \$100,000 in expenditure authority (for a new total of \$250,000) to pass on Medicaid payments to the La Causa for services provided through the Community Linkages and Stabilization Program. This request is budget neutral.

Fee-for-Service Agreements

Verlee Home for Girls - \$142,453

Verlee Home for Girls provides group home services to youth in the Wraparound Program. They provide 24 hour supervised housing to girls between the ages of 12-19 years old who are in out of home placement. Verlee Home for Girls provides their residents assistance with high school completion, post-secondary education, daily living skills, and job placement/training.

RISE Youth and Family Services - \$120,000

Will provide therapy services to youth and families enrolled in Wraparound Milwaukee.

Meta House - \$2,952,250

Meta House provides intensive AODA residential treatment for women who may struggle with alcohol or drug addiction as part of the CARS program. This facility allows women who are enrolled in the program to have their children reside at the facility while treatment services are provided. BHD is requesting authorization for AODA residential services with Meta House through December 31, 2018.

Meta House – 1,497,000

Meta House provides clinical treatment and recovery support services for qualified individuals with a history of alcohol or drug use as part of the CARS Wiser Choice program. Additionally as part of CARS Comprehensive Community Services (CCS) program Meta House also provides an array of recovery services, treatment, and psychosocial rehabilitation services to adults.

United Community Center - \$3,489,590

United Community Center provides intensive AODA residential treatment for men and women who may struggle with alcohol or drug addiction. The women's facility also allows women who are enrolled in the program to have their children reside at the facility while treatment services are provided. BHD is requesting authorization for AODA residential services with UCC through December 31, 2018.

Genesis - \$1,702,944

Genesis provides intensive AODA residential treatment for men and women who may struggle with alcohol or drug addiction. BHD is requesting authorization for AODA residential services with Genesis through December 31, 2018.

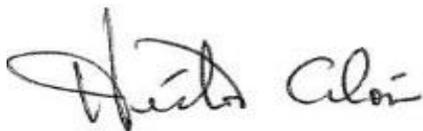
Matt Talbot – \$2,413,296

Matt Talbot provides intensive AODA residential treatment for men and women who may struggle with alcohol or drug addiction. BHD is requesting authorization for AODA residential services with Matt Talbot through December 31, 2018.

Fiscal Summary

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

Vendor	New/ Amendment/ Renewal/ Existing Contract	2017 Amount	2018 Amount
Robert G. Clark, MD	New	\$125,800	\$394,800
Medical College of Wisconsin	New	\$9,000	
Whole Health Clinical Group	Existing	\$290,000	
La Causa	Existing	\$100,000	
Verlee Home for Girls	New	\$142,453	
Reinhart Boerner Van Deuren S.C.	Existing	\$175,000	
Rise Youth & Family Services	New	\$120,000	
Meta House - AODA Residential	Renewal	\$1,476,125	\$1,476,125
Meta House	Existing	\$1,497,000	
United Community Center	Renewal	\$1,744,795	\$1,744,795
Evaluation Research Services	Existing	\$173,400	
Genesis	Renewal	\$851,472	\$851,472
U.S. Securities	Existing	\$548,052	
Matt Talbot	Renewal	\$1,206,648	\$1,206,648
Total		\$8,459,745	\$5,673,840



Hector Colon, Director
Department of Health and Human Services

Chairperson: Thomas Lutzow
Senior Executive Assistant: Jodi Mapp, 257-5202

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
FINANCE COMMITTEE**

Wednesday, June 7, 2017 - 4:30 P.M.
Hillside Terrace Family Resource Center
1452 North 7th Street

MINUTES

PRESENT: Thomas Lutzow, Jon Lehrmann, Maria Perez, and Michael Davis

SCHEDULED ITEMS:

- | | |
|----|---|
| 1. | <p>Welcome.</p> <p>Chairman Lutzow welcomed everyone to the February 23, 2017, Mental Health Board Finance Committee meeting.</p> |
| 2. | <p>2018 Budget Preliminary Overview.</p> <p>It was announced that a balanced budget would be presented in spite of a \$3 million tax levy decrease. Final allocations from the County are still outstanding. With strategic planning for the 2018 Budget beginning in February, a timeline through completion of the budget process was reviewed, with an emphasis on the June 29, 2017, Finance Committee meeting, which will include public testimony.</p> <p>2018 Budget general assumptions include adult inpatient bed capacity, child/adolescent inpatient services (CAIS) census, a comprehensive community services (CCS) increase, employee vacancy, a cost of living adjustment (COLA), and performance-based increases. The Behavioral Health Division (BHD) was informed it would be held harmless for the legacy fringe increase.</p> <p>The decrease in tax levy, Wisconsin Medicaid Cost Reporting (WIMCR) disallowance of legacy expense, and a reduction in Medicaid reimbursement are all contributing factors to the structural deficit. Closing the budget gap as a result of the structural deficit include Day Treatment and Intensive Outpatient (IOP) redesign; enhancing revenue in the areas of Targeted Case Management (TCM) Medicaid billing, Crisis billing, and PCS billing optimization; and a reduction in expenses related to community-based residential facility funding, phasing out the Community Recovery Services (CRS) program, electronic medical record optimization, workforce reduction, and the Northside Hub.</p> |

2017 Budget initiative assumptions carryover to 2018 and were explained as the creation of two additional crisis assessment and response teams (CART), expansion of resource center operations to 24/7, partnership with the Housing Division to eliminate chronic homelessness, increasing alcohol and other drug abuse (AODA) residential capacity, increasing target case management (TCM) capacity, continued investments in electronic medical records optimization, and Comprehensive Community Services (CCS) expansion.

A breakdown was provided of Operating Budget and reserve funded programmatic assumptions, revenue and full-time equivalent (FTE) assumptions, and risks and opportunities not included in the Budget assumptions. An analysis of the reserves fund was provided and the amendment process was explained.

The meeting opened for public comment on the Behavioral Health Division's 2018 Budget Preliminary Overview. The following individuals appeared and provided comments:

Jan Wilberg, Mental Health Task Force
Cindy Krahenbuhl, Guest House and Shelter Task Force

Length of meeting: 4:30 p.m. to 5:30 p.m.

Adjourned,

Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

**The next regular meeting of the Milwaukee County Mental Health Board
Finance Committee is Thursday, June 22, 2017, at 7:00 a.m.**

Finance Committee Item 2
Behavioral Health Division
2018 Preliminary Budget Request
June 7, 2017

BHD 2018 Budget

General Assumptions

- Adult inpatient bed capacity of 60 beds with a 90% occupancy factor
- CAIS average census of 12
- CCS program to increase to 1,100 by year end
- Employee vacancy factor = 6%
- COLA of 1%
- Performance Based increase of 1%
- Tax Levy decrease of \$3.0M
- BHD held harmless for legacy fringe increase
- County overhead is equal to 2017 budget amounts

2018 Tax Levy Target

Description	Dollars <i>(in millions)</i>
2017 Budget Tax Levy	57.4
Add: Fringe Change (County)*	9.3
Less: Tax Levy Reduction Target	(3.0)
2018 Tax Levy Budget	63.7

**Increase in legacy fringe of \$7.6M plus system headcount reconciliation impact of \$1.7M*

BHD 2018 Budget

Structural Deficit		Closing the Budget GAP	
Revenue		Expense Reduction	
WIMCR - Disallowance of legacy expense	\$ 1,000,000	Day Treatment & IOP Redesign	\$ (664,000)
Inpatient Revenue - Medicaid Rate Reduction	\$ 830,000	CBRF Funding Reduction	(800,000)
Total Revenue Structural Deficit	\$ 1,830,000	CRS Program Phase Out	(383,000)
		EMR Optimization	(400,000)
Expense		Reduction in Force	(1,600,000)
COLA - 1%	\$ 340,000	Northside Hub	(500,000)
Performance Based - 1%	\$ 340,000		(4,347,000)
Total Expense Structural Deficit	\$ 680,000	Revenue Enhancement	
		TCM Improved Medicaid Billing	\$ (195,000)
Tax Levy Decrease	\$ 3,000,000	Enhanced Crisis Billing	(611,000)
		PCS Billing Optimization	(280,000)
			(1,086,000)
Total Structural Deficit	\$ 5,510,000	Total	\$ (5,433,000)

2018 Budget Legacy Expense

	2014	2015	2016	2017 B	2018 Budget	17/18 Variance	
Actual FTE's	614	556	521	539	505		
Legacy Health	\$ 8,517,451	\$ 7,627,708	\$ 6,577,645	\$ 7,129,388	\$ 9,380,873	\$ 2,251,485	31.58%
Per FTE	\$ 13,872	\$ 13,719	\$ 12,625	\$ 13,227	\$ 18,576	\$ 5,349	40.44%
Legacy Pension	\$ 6,350,363	\$ 8,509,818	\$ 8,989,859	\$ 9,522,619	\$ 11,777,380	\$ 2,254,761	23.68%
Per FTE	\$ 10,343	\$ 15,305	\$ 17,255	\$ 17,667	\$ 23,322	\$ 5,654	32.00%
Total Legacy	\$ 14,867,814	\$ 16,137,526	\$ 15,567,504	\$ 16,652,007	\$ 21,158,253	\$ 4,506,246	27.06%
Per FTE	\$ 24,215	\$ 29,024	\$ 29,880	\$ 30,894	\$ 41,898	\$ 11,003	35.62%
Total Legacy \$ Year over Year		\$ 1,269,712	\$ (570,022)	\$ 1,084,503	\$ 4,506,246		

2017 Budget Assumptions Carryover

- Two additional CART Teams
- Resource Center Expansion to 24/7
- Continued Partnership with DHHS Housing Division
- Increased AODA Capacity
- Increased TCM Capacity
- Continued Investments in EMR Optimization
- CCS Expansion

BHD 2018 Budget

Programmatic Assumptions (operating budget)

- CCS Adult Enrollment Increase to 1,100
- CCS Children Enrollment Increase to 100
- TCM Unit Increase of 5%
- Intensive Outpatient Placement program implementation
- Community Placement Reduction of \$800K
- AODA Residential Investment

Programmatic Assumptions (Operating budget)

- Transit Subsidy
- State Institution Budget Expansion
- MH Board Analyst – Part Time

Programmatic Assumptions (Funded by Reserve)

- Peer Run Respite
- West Allis CART

Not Included in the 2018 Budget

- Inpatient Partnership
- Northside Hub
- Countywide Cross-charges

BHD 2018 Budget

Revenue Assumptions

- Tax Levy Reduction of \$3M
- Inpatient Revenue reduction
 - \$0.4M Adult & \$0.4M CAIS related to Medicaid rate reduction
 - \$0.9M in Adult & \$0.8 in CAIS related to updated write-off percentage experience
- WIMCR Funding Reduction of \$1M
- Crisis Revenue Increase of \$600K
- PCS Revenue

FTE Assumptions

<u>Inpatient Clinical:</u>		<u>FTE's</u>
RN	(9.5)	
CNA	(29.5)	
HUC	2.0	
<u>Sub-Total</u>		<u>(37.00)</u>
Clinical Administration		(1.25)
Community Services		(2.25)
Wraparound		1.00
Information Technology		4.00
<u>Overhead:</u>		
Finance		(4.00)
MH Board Analyst		0.50
Facilities		0.60
Project Manager		1.00
Communications		1.00
Contracts		2.00
<u>Sub-Total</u>		<u>1.10</u>
<u>Total</u>		<u>(34.40)</u>

Risks & Opportunities not included in the 2018 Budget Assumptions

Risks	Opportunities
<ul style="list-style-type: none">• American Health Care Act• Federal Budget• Badger Care Eligibility Changes• Medicaid Disproportionate Share Payments (DSH)• State/County Budget	<ul style="list-style-type: none">• AODA – CCS Funding• T19 HMO Provider Contracts• ACA/AHCA Subsidies

BHD Reserve Analysis

Reserve Balances

- General Reserve = \$19.8
- Capital Reserve = \$3.5
- WRAP Reserve = \$6.8

Reserve Guidance

- Working Day Capital Reserve
- Risk Based Reserve
- 45 day working capital reserve is equal to around \$25.5M or 12% of 2017B revenue
- Risk based approach – City of Colorado Springs = 25% (Budgetary & Emergency)

Budget Timeline

Date	Deliverable
Friday, May 26 th	Preliminary Budget Distributed
Wednesday, June 7 th	Finance Committee Meeting
Friday, June 16 th	Formal 2018 Budget Narrative Distribution
Friday, June 23 rd	MCMHB Budget Amendments Due
Thursday, June 29 th	Finance Committee
Thursday, July 6 th	Board Meeting

BHD Budget – Board Amendment Process

- Amendment Template on MH Board Website
 - Board Sponsor
 - Description
 - Financial Impact (Lisa Wozny)
- Amendment Period – June 8th – June 23rd
 - Board and/or Finance Committee could vote to accept amendments after this timeframe
- Amendments discussed and voted on at Mental Health Finance Committee on June 29th

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: June 12, 2017

TO: Duncan Shrouf, Chairperson – Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to enter into amended 2017 contracts with the State of Wisconsin for Social Services and Community Programs.**

Issue

Sections 46.031 and 49.325 of the Wisconsin Statutes require counties to execute annual contracts with the State Departments of Health Services (DHS) and Children and Families (DCF) for Social Services and Community Programs. The contracts, referred to as Community Aids, provide State and Federal funding for county services to persons with mental illness, disabilities, and substance abuse problems, and to juvenile delinquents and their families as mandated by State and/or Federal law.

The Director, Department of Health and Human Services (DHHS), is therefore requesting authorization to sign the 2017 contract amendment for Substance Abuse Treatment for Temporary Assistance to Needy Families. These services provide AODA support to pregnant women and families with one or more dependent children.

Background

In January, the Milwaukee County Mental Health Board approved \$33,743,838 in revenue related to State of Wisconsin Social Services and Community Programs. At that time, it was indicated that the Substance Abuse TANF grant was still under review. That review has been completed and Milwaukee County has been awarded the full \$4,394,595 grant for 2017.

Below is a summary of anticipated State Community Aids revenue at BHD:

**CY 2017 State/County Social Services/Community Program
 Final Revenue Allocation Compared to the 2017 Budget**

	2017 BHD Budget	2017 Final State Allocation	State Notice vs. 2017 BHD Budget
Basic County Allocation			
DHS Community Aids	22,336,586	22,336,586	-
Earmarked Revenues			
Community Mental Health Allocation	7,780,317	7,780,317	-
Mental Health Block Grant	640,910	685,914	45,004
TANF	4,394,595	4,394,595	-
AODA Block Grant	2,431,021	2,431,021	-
IV Drug	500,000	510,000	10,000
Subtotal BHD earmarked Revenues	11,352,248	11,407,252	55,004
 Grand Total Revenue	 38,083,429	 38,138,433	 55,004

Recommendation

It is recommended that the Mental Health Board authorize the Director, Department of Health and Human Services, to execute the amended 2017 Social Services and Community Programs contracts from the State Departments of Health Services and Children and Families, and any addenda to those contracts, in order for the County to obtain the State Community Aids revenue. The 2017 Social Services and Community Programs contracts provide total revenue of \$38,138,433.



 Héctor Colón, Director
 Department of Health and Human Services

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

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
 QUALITY COMMITTEE**

June 5, 2017 - 10:00 A.M.
**Milwaukee County Mental Health Complex
 Conference Room 1045**

PRESENT: Robert Chayer, Mary Neubauer, and Brenda Wesley

MINUTES

SCHEDULED ITEMS:

1.	<p>Welcome.</p> <p>Chairwoman Neubauer announced Director Hector Colon has resigned and taken a new position with Lutheran Social Services of Wisconsin and Upper Michigan with a departure date of June 30th, 2017.</p>
2.	<p>Behavioral Health Division Incident Assessment and Report Presentation.</p> <ul style="list-style-type: none"> • Dr. May provided a brief description and review of her approaches to incident report analysis. The project purpose, key observations, staff survey process, best practice research, and related findings/opportunities for improvement were shared. • The Behavioral Health Division (BHD) currently is in the testing phase of a new electronic incident report product, to include a policy revision, as well as additional education and training of staff and public safety. There is a plan to obtain a proprietary BHD staff security team, which is approved, including the sunset of a previous security contract.
3.	<p>Community Access to Recovery Services (CARS) Key Performance Indicator Dashboard and Quarterly Report.</p> <p>The quality dashboard and related key performance indicators were shared. The dashboard measures and additional core measures will continue to evolve. An update was provided to reflect the correct CARS employment target. A discussion ensued regarding how targets are established.</p>

4.	<p>Wraparound Milwaukee Quality Assurance (QA)/Quality Improvement (QI) Annual Report 2016.</p> <p>Pam Erdman reviewed numerous highlights from the 2016 Annual Report.</p> <ul style="list-style-type: none"> • New Plan of Care auditing tool (POC Rubric) and procedure and a new Plan of Care Checklist were created and implemented. • Mobile Urgent Treatment Team provided 14,000 hours of crisis services to Wraparound families and the community at large, including 900 children seen for the first time. • Wraparound and REACH youth and caregivers continue to identify improvement in functioning (internal and external) during enrollment by improved scores in the Child Behavior Checklist and Youth Self Report Evaluation tools.
5.	<p>Prevention Outcomes.</p> <p>Two main priorities of the Milwaukee County Substance Abuse Prevention Coalition were shared: reduce the use of marijuana in youth and reduce fatal overdoses, with an emphasis on prescription medication.</p> <p>Eight preventive outcomes were discussed, along with the related workgroups.</p> <p>Notable achievements include 2,495 lbs. of unwanted medications have been collected over the past year, a Drug-Free communities grant, and a collaboration with Marquette University on Dose of Reality Campaign.</p>
6.	<p>Customer Satisfaction Data.</p> <ul style="list-style-type: none"> • CARS 2016 data and related positive responses were reviewed. • The 2016 survey results of the acute adult inpatient reveal a decline in positive ratings in comparison to 2015 scores. Further discussion ensued regarding interpretation of results. • CAIS (Child and Adolescent Services) inpatient scores have increased in all domains. Progress was commended. • Press Ganey services to be piloted.
7.	<p>Sentinel Event Committee – Year End Report.</p> <p>The Behavioral Health Division’s number of Sentinel and Other Events continued to decline in 2016. An overall downward trend has been observed. Analysis shows that this downward trend is not due only to the closure of the long-term care units.</p>

8.	<p>Seclusion and Restraint (S&R) Plan of Correction Updates.</p> <p>Centers for Medicare and Medicaid Services (CMS) completed a follow up hospital survey, reviewing seclusion and restraint documentation and recovery planning. No official letter has been received, though they expressed no areas of concern at exit.</p> <p>The Seclusion and Restraint rate has decreased significantly. Refer to reports.</p>
9.	<p>Policy and Procedure Status Report.</p> <p>A June 1, 2017, policy and procedure status update report was shared. Significant progress noted.</p>
10.	<p>Status of Contract Review Timeline and Performance Indicator Development.</p> <p>Eight sets of Contract Performance Measures (CPMs) are in different stages of being revised, approved, and implemented. A contract performance measures development timeline was reviewed. Additional information for progress toward the completion of all contract revisions was requested. The matter will be referred to the contract team lead.</p>
11.	<p>2017 Quarter 1 (Q1) Psychiatric Crisis Services (PCS) Hospital Transfer Waitlist Report.</p> <ul style="list-style-type: none"> • Waitlist is still being utilized. Report summary with detail included. • No incident of police diversion in the last 8 years noted.
12.	<p>Next Scheduled Meeting Dates.</p> <ul style="list-style-type: none"> • September 11, 2017, at 10:00 a.m. • December 4, 2017, at 10:00 a.m. <p>The next meeting date was announced as September 11, 2017, at 10:00 a.m.</p>
13.	<p>Adjournment.</p> <p>Chairwoman Neubauer ordered the meeting adjourned.</p>

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

Length of meeting: 10:05 a.m. to 12:09 p.m.

Adjourned,

Kiara Abram
Executive Assistant
Milwaukee County Mental Health Board

The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is Monday, September 11, 2017, @ 10:00 a.m.

Quality Committee Item 2



Behavioral Health Division Analysis of Incidents

DATE

Prepared Feb 22, 2017

Presented to MHB: June 5, 2017

PRESENTED BY

Jeanette May, Ph. D., MPH, Patina Professional

Purpose of Engagement



To improve care and safety of patients and staff.

Approach to Analysis:

- 1) Strategy One – Updates to the 2010 Audit Tables for Trending Analysis
- 2) Strategy Two – Incident Report Analysis
- 3) Strategy Three – Staff Survey
- 4) Strategy Four – Best Practices Research

Strategy One – 2010 Audit Tables Update



Goal: To review and trend incident reports for acute units from 2010 through June 2016.
Modeled off of the 2010 Milwaukee County audit.

Strategy One – Key Observations



- 1) The incident trends indicate a statistically significant downward trend in incidents since 2014.
- 2) Incident peaks observed for 2013 and 2014 were due primarily to aggression incidents on the acute unit as demonstrated by the 49% increase from 2012 to 2013.
- 3) The downward trend since 2014 may be attributed to several process changes/improvements noted in the full report.

Strategy Two – Incident Report Analysis



Goal: Analyze a representative sample of incident reports by unit/incident type for opportunities to improve process and quality.

Sections of Analysis:

- 1) Elopement
- 2) Aggression
- 3) Injury
- 4) Other

Strategy Two – Key Observations: Elopement



- 1) The majority (66%) of incident reports for elopement were incomplete.
- 2) Incident rates decreased significantly beyond the mean observed trend.
- 3) The majority of the incidents were categorized as elopement from a locked unit.
- 4) There were significantly less elopement incidents in the evening.
- 5) The supervisor signed off on 78% of all incidents reports less than five days after the incident occurred.
- 6) Few of the elopement incidents resulted in staff education yet it would seem that education regarding escorting and transport would have been helpful.
- 7) The majority of incidents were one-time patient events, i.e., no single patient or small group of patients eloped multiple times.

Strategy Two – Key Observations: Aggression



- 1) The majority (55%) of incident reports for aggression were incomplete.
- 2) The majority of incident reports were completed in a timely manner, i.e. less than five days after the incident occurred.
- 3) A majority of reports were completed by an RN (65%) and the remainder by a CNA (8%) or unknown (25%).
- 4) The incident report notes indicate a broad range of compliance/non-compliance.
- 5) The use of restraints (47%) was the action most often taken in the A2 level aggression incidents followed by the use of medication (29%) and doing nothing specific (19%).
- 6) Restraint was the action taken most often for patient/employee (P/E) incidents while patient redirection was the action taken most often for patient/patient (P/P) incidents.
- 7) 3% of the patients were responsible for 19% of the reported aggression incidents.

Strategy Two – Key Observations: Injury



- 1) The majority of incident reports (>90%) for all types (accidental, self inflicted, seclusion and restraint) were fully completed.
- 2) A significant number (50%) of accidental injury incidents took place in the morning.
- 3) A significantly lower number (15%) of injury incidents related to S and R took place in the afternoon.
- 4) The majority of incidents related to injury are either accidental or self-inflicted. Injuries related to S and R are significantly less than the other two categories.
- 5) Two percent (2%) of the patient sample was involved in twelve percent (12%) of the injury incidents.
- 6) 75% of the incident reports were completed by an RN.
- 7) The majority (80%) of incident reports were completed in less than five days from the date of the incident.
- 8) The majority of S and R injury incidents (66%) resulted in a staff injury occurring while assisting to place a patient into restraints.

Strategy Two – Key Observations: “Other”



- 1) There were no specific trends in the incidents categorized as “other.”
- 2) Over 30% of the incidents categorized as “other” were incidents with their own category specifically aggression, injury, elopement, sexual contact.
- 3) Over 25% of the “other” incidents did not seem to be incidents.
- 4) Common themes included the broad categories of medication, misconduct, visitor issues.
- 5) There was a greater proportion of incidents in the outpatient setting than in any other incident category. Based on an analysis of the comment sections of the reports, staff members in outpatient settings are not as well educated in incident reporting and categorization.

Strategy Three – Staff Survey



Goal: Survey staff to assess the level of staff knowledge of incident reporting process.

Process: An electronic survey was developed that assessed the staff's current understanding of the BHD incident reporting process. Seven incidents were offered and staff were asked to categorize each as a reportable or non reportable incident.

Sample: 100% of BHD staff (606 total) was offered the survey in November 2016. Two hundred nine (209) responses were returned for a 34% response rate.

Strategy Three – Key Observations: Survey



- 1) The high response rate (34%) may suggest an interest among staff on the topic.
- 1) There was an equal response from direct care and non-direct care staff.
- 1) There were statistically significant differences in responses between direct care and non-direct care staff for scenarios focused on patients arguing and an incident involving a spill on floor.

Strategy Four – Best Practices Research



Goal: Identify best practices in incident reporting for consideration by BHD leadership.

Strategy Four – Key Observations: Best Practices Research



- 1) System should be objective.
- 2) System should not be under the control of one stakeholder.
- 3) System should be designed to facilitate the collection of detailed narratives in the reporter's own words.
- 4) Leadership should demonstrate that the information collected in the system is useful and appropriate.
- 5) Information gathered from the system should be used to create a shift in mindset and culture of the organization.
- 6) Impacts from the learnings should support direct improvements to procedures and broad organizational change.
- 7) If a "blame" culture exists, consider using an anonymous or confidential reporting system.
- 8) Leadership must emphasize the goal of the system is to learn.
- 9) Systems should focus on issues of most concern in a mental health setting such as incidents related to seclusion and restraints.

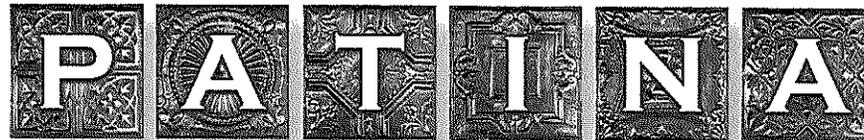


Key Findings / Opportunities for Improvement

- ✓ Increase training and education on the following topics:
 - ✓ Standardized Reporting Protocol pursuant to comments suggesting that a lack of understanding may contribute to *non*-incidents being reported as incidents.
 - ✓ Determination and Categorization of incidents to ensure accurate reporting and accounting of incidents.
 - ✓ For Security personnel regarding response to aggression incidents including use of restraints.
 - ✓ Timely and proper completion of incident reports.

*Thank you for partnering with Patina on this
critical analysis.*

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**Milwaukee County Department of Health & Human Services
Behavioral Health Division
Analysis of Incidents, January 2010 – June 2016
Prepared by: Jeanette May, Ph. D., MPH
February 2017**

Your success. Accelerated by our experience.

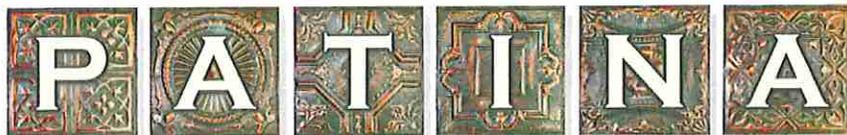


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Introduction

This report analyzes the Milwaukee County Behavioral Health Division's (BHD) incidents and reporting process from January 1, 2010, through June 30, 2016. The goals of this analysis included:

1. Supplementing the 2010 Milwaukee County audit;
2. Discovering trends in BHD inpatient incidents;
3. Discerning potential improvements in BHD processes; and
4. Summarizing best practices in incident trend process and analysis.

Scope of Work

This was a three-phase analysis of incidents occurring on BHD's inpatient and outpatient units to identify areas for potential improvements in patient and staff safety. The scope of work included: entry and discovery, evaluation and analysis, and report and exit. A description of the scope of work is included at **Appendix A**. The research protocol is included as **Appendix B**. Four strategies were employed to complete the analysis, each explained in detail below.

When a finding is characterized as "statistically significant" or "significant," it means that the relationship between two or more variables is due to something other than random chance. Significance analysis is conducted when the data being analyzed is a sample as in the case of this report.

Strategy 1 – Supplemental Audit Tables

Goal: Review and trend incident reports for acute units from 2010 through June 2016, modeled off of the 2010 Milwaukee County audit.

Process: Incident reports were gathered from the BHD Quality Department access database by type, unit and year. Reports were randomly checked to verify database numbers with actual reports gathered in the departments. The following tables represent incidents by year and by type for all acute units, aggression related incidents, and acuity related incidents. These specific categories were also reviewed in the 2010 audit report (**Appendix C**).

Sample: 100% of acute unit incident reports from 2010 – June 2016.

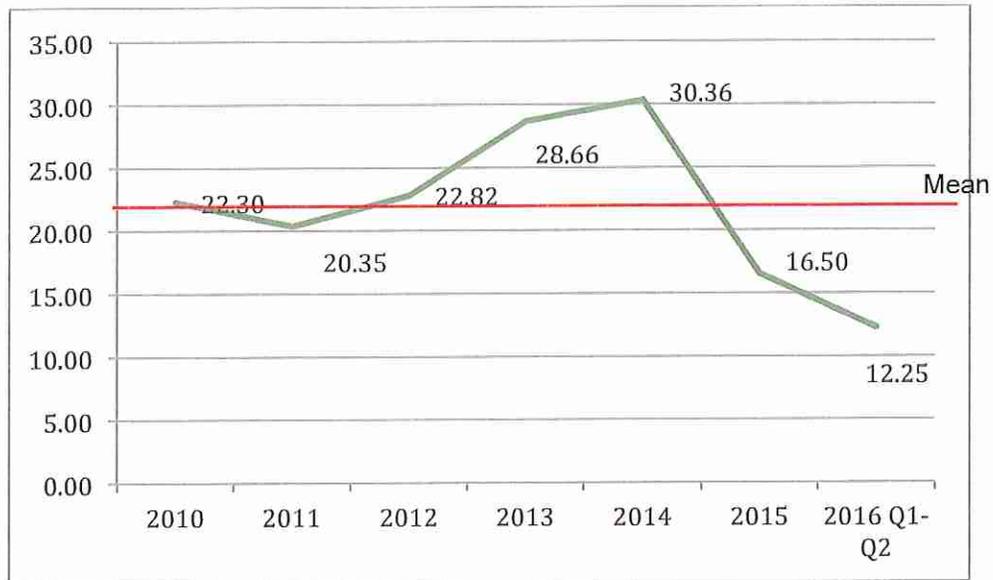


1. Table 1 - BHD Reported Incidents – All Categories Acute Adult Inpatient Units – Number of Incidents by Type by Year 2010- June 2016

Year	2010	2011	2012	2013	2014	2015	2016 Q1-Q2
Incident Type	Total						
Other	59	47	57	49	43	30	20
Fall	182	143	106	102	101	45	22
Aggression PT/EMP	73	81	71	70	74	40	15
Aggression PT/PT	73	73	60	102	110	48	13
Injury self inflicted	40	31	30	33	41	15	3
Missing property/theft	20	16	13	18	11	4	1
Injury accidental	43	37	46	33	28	19	6
Exposure to infection	4	5	6	10	6	8	2
Medical Emergency Code 4	68	60	64	45	67	44	4
Property damage	12	14	17	13	23	3	1
Caregiver misconduct allegation	24	14	17	23	24	10	4
Suicide attempt	7	0	5	1	2	2	3
Contraband	19	22	10	23	14	4	4
Elopement from locked unit	9	7	11	10	6	1	2
Elopement from escort	2	2	1	1	1	0	0
Fall-employee visitor	3	2	8	6	1	0	0
Injury - S&R injury	17	11	4	21	18	4	0
Sexually inappropriate behavior	16	14	29	12	14	6	1
Confidentiality breach	3	0	0	1	3	0	0
Choking	2	2	4	5	4	0	1
Fire	0	0	0	0	0	0	0
Medication variance causing harm	0	0	0	0	1	0	0
Medical device equipment problem	0	0	0	0	0	0	0
Death - inpatient	0	0	0	0	0	0	0
Burns	0	1	0	0	0		0
Known or suspected sexual contact	8	10	1	9	6	0	0
Adverse drug reaction	0	0	0	0	0	1	0
Failure to return to unit	2	0	0	0	0	0	0
Hazardous Materials/Environmental contamination	1	0	1	0	0	0	0
Total Incidents	687	592	561	587	598	284	102
Total Patient Days	30805	29098	24586	20480	19696	17209	8329
Incidents Per 1000 Patient Days	22.30	20.35	22.82	28.66	30.36	16.50	12.25



2. Chart 1 - BHD Reported Incidents – Adult Acute Inpatient Units – Incidents Per 1000 patient days trended from 2010- June 2016 (all incidents)



3. Table 2 – BHD Reported Incidents - Selected Incident Categories for Patient Acuity BHD Acute Adults Inpatient Units – Number of Incidents by Incident Type by Year 2010 – June 2016 (acuity related incidents only)

	2010	2011	2012	2013	2014	2015	2016 Q1-Q2
Incident Type							
Aggression PT/EMP	73	81	71	70	74	40	15
Aggression PT/PT	73	73	60	102	110	48	13
Injury self inflicted	40	31	30	33	41	15	3
Medical Emergency Code 4	68	60	64	45	67	44	4
Property damage	12	14	17	13	23	3	1
Suicide attempt	7	0	5	1	2	2	3
Injury - S&R injury	17	11	4	21	18	4	0
Sexually inappropriate behavior	16	14	29	12	14	6	1
Known or suspected sexual contact	8	10	1	9	6	1	0
Total Incidents	314	294	281	306	355	163	40
Total Inpatient Days	30805	29098	24586	20480	19696	17209	8329
Incidents Per 1000 Patient Days	10.19	10.10	11.43	14.94	18.02	9.47	4.80
Annual % Change in Incidents Per 1000 Patient - Days		-7.5	13	30.8	20.6	-47.4	-49.3



4. Chart 2 - BHD Reported Incidents - Selected by Categories for Patient Acuity Adult Acute Inpatient Units – Incidents Per 1000 patient days trended from 2010 – June 2016 (acuity related incidents only)



5. Table 3 – BHD Reported Incidents - Selected Incident Categories for Patient Aggression BHD Acute Adult Inpatient Units – Number of Incidents by Type by year 2010 – June 2016 (aggression related incidents only)

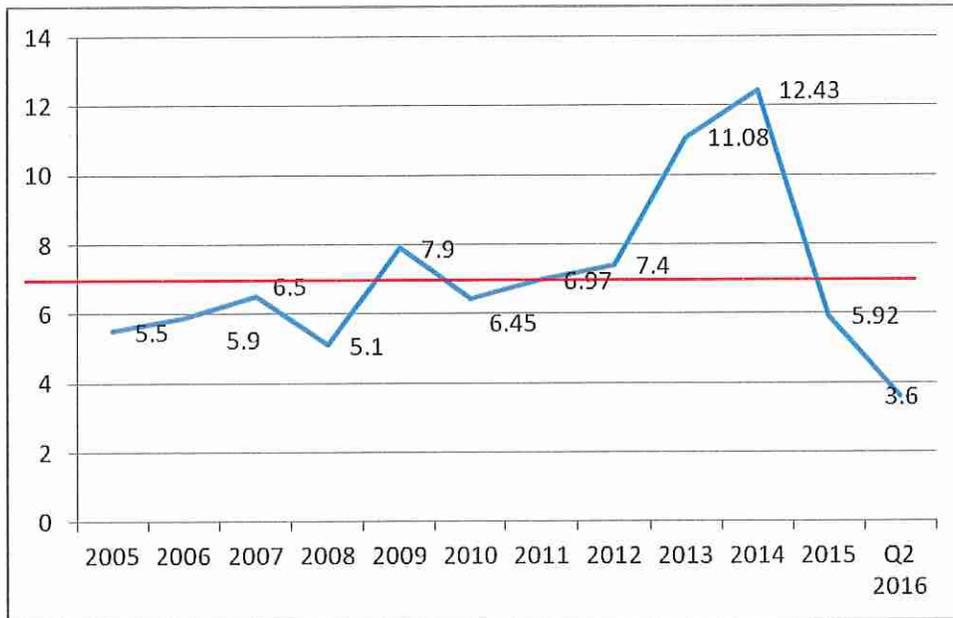
	2010	2011	2012	2013	2014	2015	2016 Q1-Q2
Incident Type							
Aggression PT/EMP	73	81	71	70	74	40	15
Aggression PT/PT	73	73	60	102	110	48	13
Property damage	12	14	17	13	23	3	1
Injury - S&R injury	17	11	4	21	18	4	0
Sexually inappropriate behavior	16	14	29	12	14	6	1
Known or suspected sexual contact	8	10	1	9	6	1	0
Total Incidents	199	203	182	227	245	102	30
Total Patient Days	30805	29098	24586	20480	19696	17209	8329
Incidents Per 1000 Patient Days	6.46	6.98	7.40	11.08	12.44	5.93	3.60
Annual % Change in Incidents Per 1000 Patient - Days		8.2	6	49.7	12.1	-52.3	-39.1



6. Chart 3 - Selected Incident Categories for Patient Aggression BHD Acute Adult Inpatient Units - Incidents Per 1000 patient days trended from 2010 – June 2016 (aggression related incidents only)

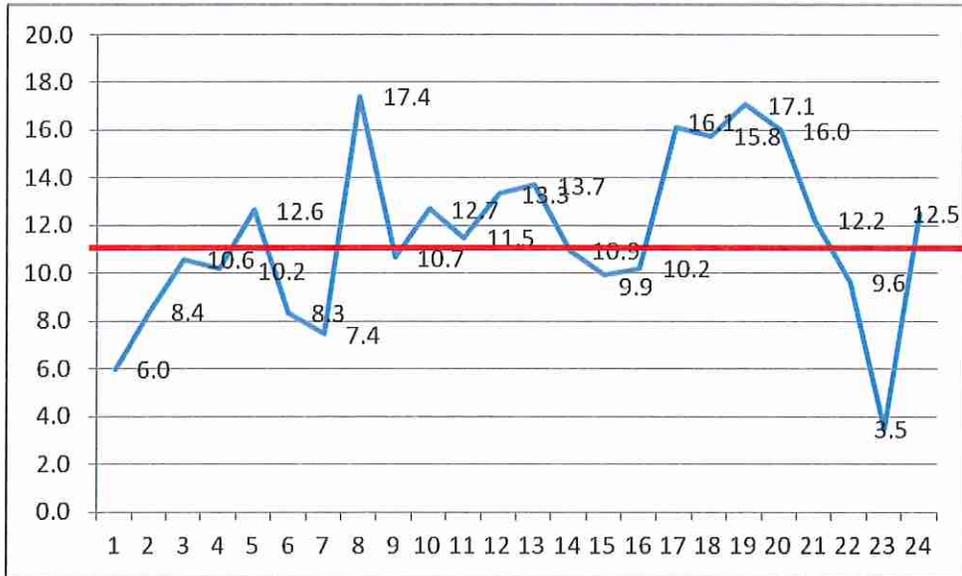


7. Chart 4 - Incident Rate Per 1000 Bed Days Trend 2005 – June 2016 (aggression related incidents only)

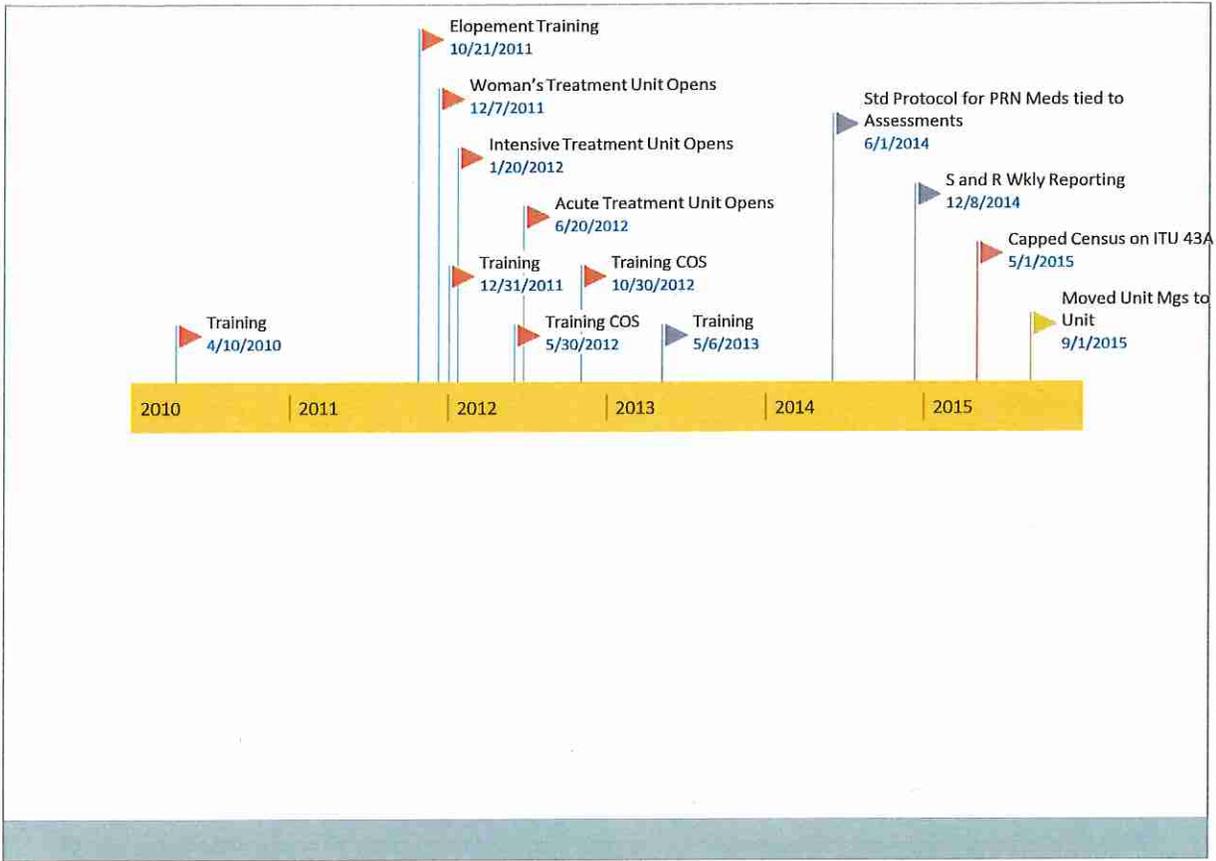


8. Chart 5 – Incident Trend by Month 2013-2014

Rates Per 1000 Beds by Month Jan 2013 - Dec 2014 (aggression Category Only)



9. Chart 6 – Timeline of BHD Process and Quality Improvement Efforts



Findings and Discussion:

The incident trends illustrated on the tables and charts above indicate a statistically significant downward trend in incidents since 2014. Incident peaks were observed for 2013 and 2014 due primarily to aggression incidents on the acute unit as demonstrated by the 49% increase from 2012 to 2013 (Table 3). Specific aggression categories as defined by the 2010 Milwaukee County audit team included the following:

- Aggression PT/EMP
- Aggression PT/PT
- Property damage
- Injury - S&R injury
- Sexually inappropriate behavior
- Known or suspected sexual contact

Chart 4 displays aggression incidents by month for 2013 and 2014. The mean for this time period was 11.53, well above the mean for the periods 2010 – 2016 (7.69) or 2005 – 2016 (7.05). The downward trend since 2014 may be attributed to several process changes/improvements that are highlighted in Chart 6.



Strategy 2 – Incident Report Analysis

Goal: Analyze a representative sample of incident reports by unit/incident type for opportunities to improve process and quality.

Process: A researchable database was developed containing all quantitative and qualitative data captured on an incident report. Random samples of incidents by year/incident type were chosen, coded and stripped of all personal health information. All data, including the incident code, were entered and analyzed for trends and impact based on historical process and quality improvement efforts. Opportunities to improve process and quality were identified through qualitative analysis of incident report findings. Suggestions were made concerning additional analysis for incidents that resulted in harm or death. Finally, comments were included regarding the need for incident tracking in community services environments as the volume of service increases and shifts to the outpatient environment.

Sample: Representative and random sample of incidents on all units from 2013 – Q2/2016 for the following incident types: elopement, injury, violence and aggression and sentinel events (excluding falls). 1,847 incidents were reported during the period but duplicate incidents, illegible reports and smaller samples from units that have since closed were excluded, resulting in a sample size of 1,499. The sample size is representative within 5%+/- of the overall total of incident reports for the period.

Sample Size

	2013	2014	2015	Jan – June 2016	Totals
Elopement	23	17	13	9	62
Other	199	135	79	44	457
Injury	210	150	79	28	467
Aggression	194	126	144	49	513
					1499

Elopement Analysis

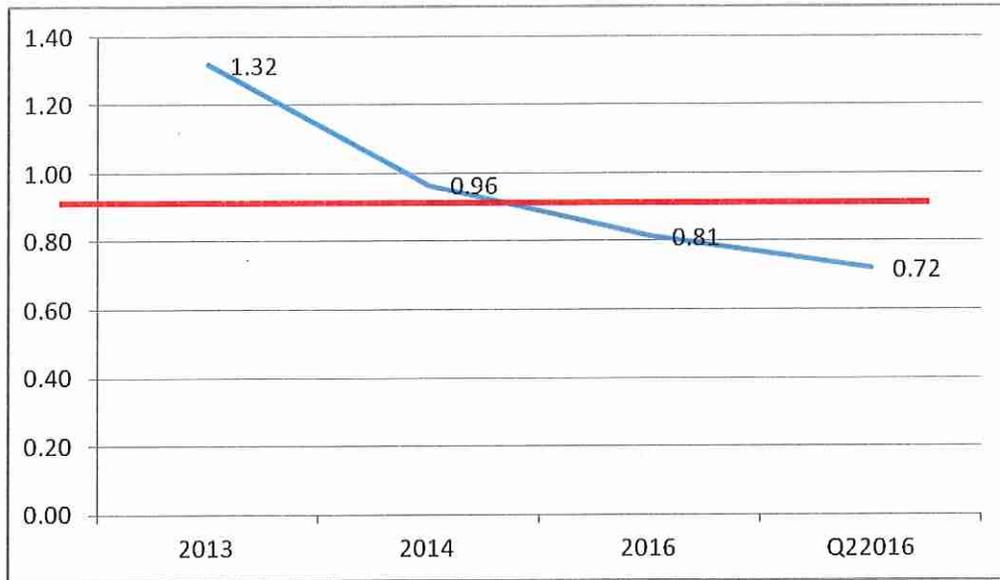
The sample for elopement included three categories:

- a) elopement from a locked unit;
- b) elopement from escort; and
- c) elopement for failure to return to the unit.

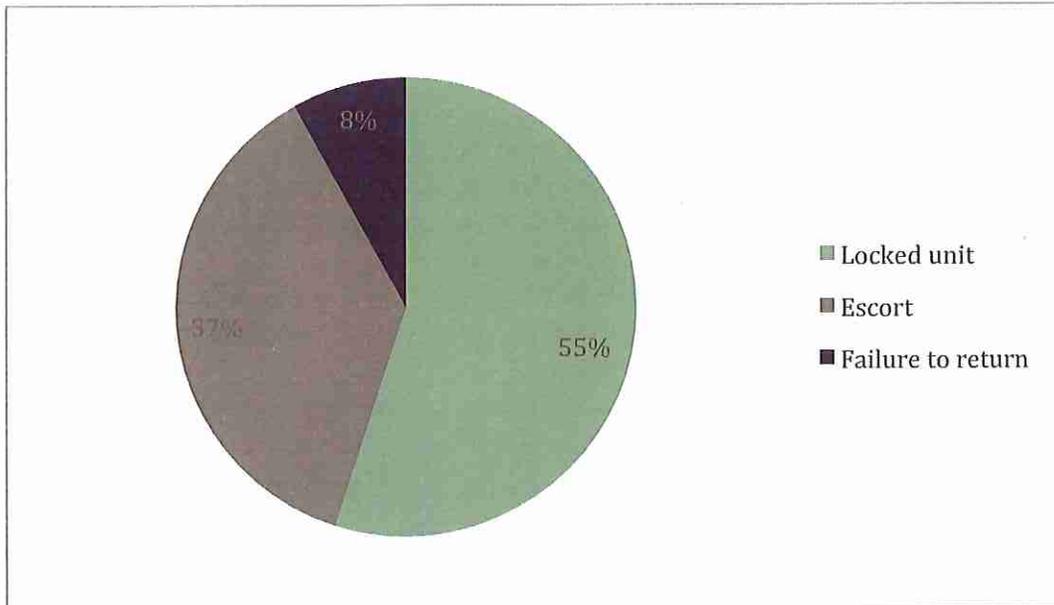
All elopement incidents were analyzed due to the small number represented (62).



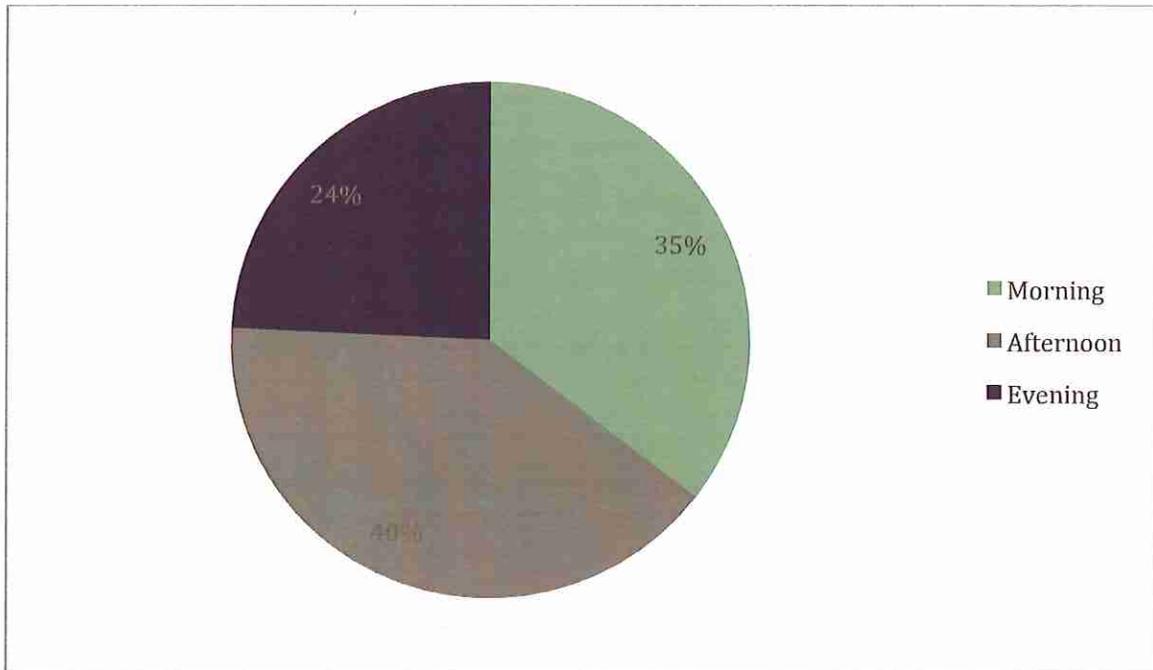
Elopement Rates per 1000 Patient Days by Year



Elopement by Type (%), 2013 – June 2016



Elopement by Time of Day (%), 2013 - June 2016



Findings and Discussion:

- The majority of incident reports for elopement were incomplete (66%).
- Incident rates decreased significantly beyond the mean observed trend.
- The majority of the incidents were categorized as elopement from a locked unit.
- There were significantly less elopement incidents in the evening.
- The supervisor signed off 78% of all incidents reports less than five days after the incident occurred.
- Few of the elopement incidents resulted in staff education yet it would seem that education regarding escorting and transport would have been helpful.
- The majority of incidents were one-time patient events, i.e., no single patient or small group of patients eloped multiple times.

Qualitative Examples of Review Notes:

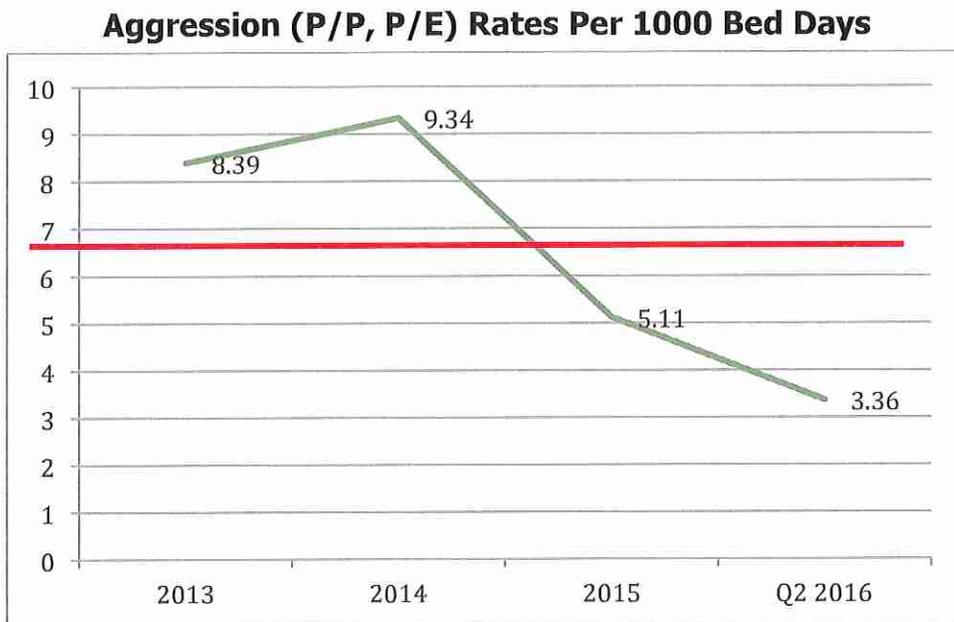
1. Medical record reviewed. Elopement risk reported to accepting facility (St. Joseph's). Transfer sheet from St. Joe's indicated mode of transport to BHD as "police." Patient was returned to BHD and admitted. This writer discussed with staff the need to place patient on precautions. Stated that U/A precautions entered on plan and staff aware.
2. Patient was found the following day at home with no injury from elopement. Review of 1:1 policy & intervention.
3. Patient escaped returned by sheriff assessed for injuries medicated placed into ambulatory restraints EE's notified of window broken, temp placement of window in place power notified of broken glass/clean up.



4. Reinforce education on monitoring door, ensuring it locks, checking behind to make sure no patients are near door or coming behind.
5. 1:1 was able and staff with security assistance was able to redirect patient back to her room. Patient began hitting the walls and swinging at staff. Patient placed into 4 patient restraints and assessed for injuries, none noted. Patient medicated.

Aggression Analysis

The sample for the aggression analysis included a representative sample of patient/patient and patient/employee data or reports from the acute, day treatment and outpatient units from 2013 to quarter 2 of 2016. The analysis was organized by measures focused on the process of reporting the incident and by the actual incident itself.



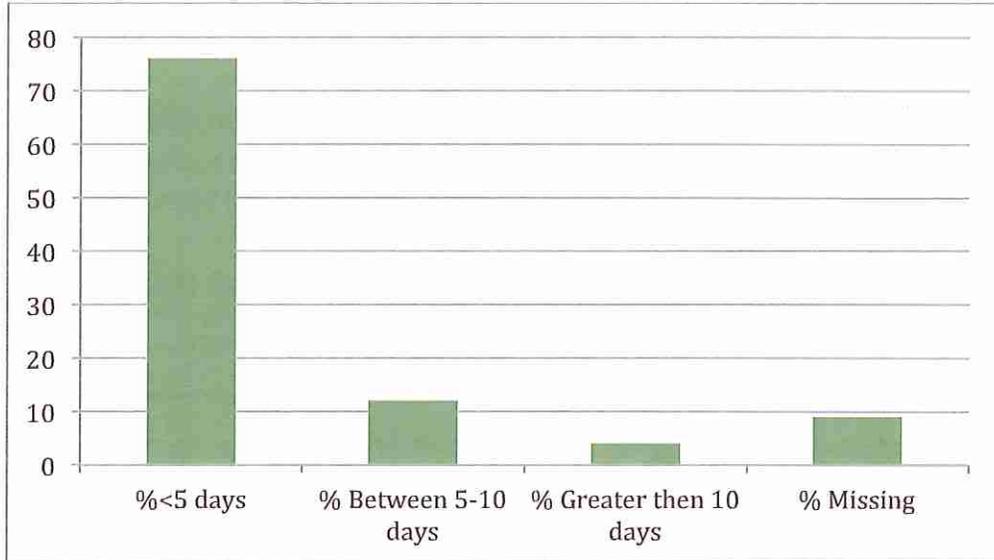
Findings and Discussion:

- The majority of incident reports for aggression were incomplete (55%).
- The majority of incident reports were completed in a timely manner, i.e. less than five days after the incident occurred.
- A majority of reports were completed by an RN (65%) and the remainder by a CNA (8%) or unknown (25%).
- The incident report notes indicate a broad range of compliance/non-compliance.
- The use of restraints (47%) was the action most often taken in the A2 level aggression incidents followed by the use of medication (29%) and doing nothing specific (19%).
- Restraint was the action taken most often for patient/employee (P/E) incidents while patient redirection was the action taken most often for patient/patient (P/P) incidents.
- 3% of the patients were responsible for 19% of the reported aggression incidents.

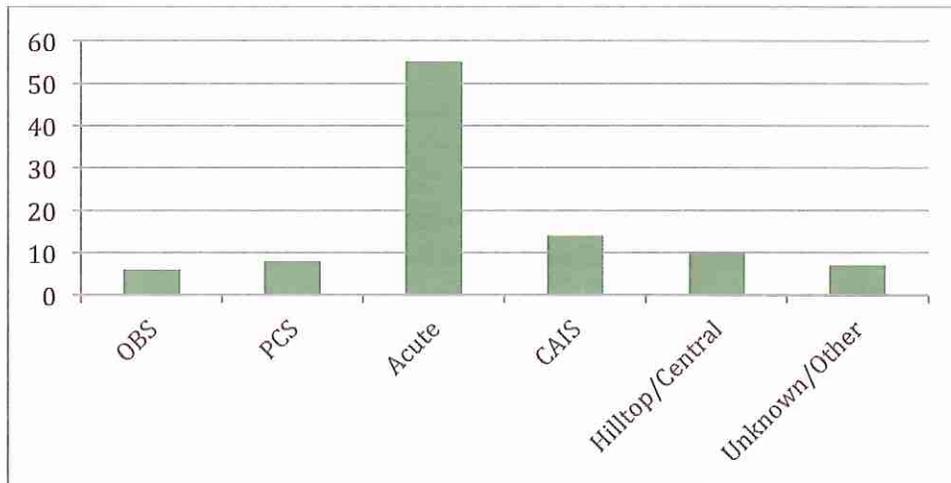


Days from Date of Incident until Supervisor Review, 2013-Q2/2016

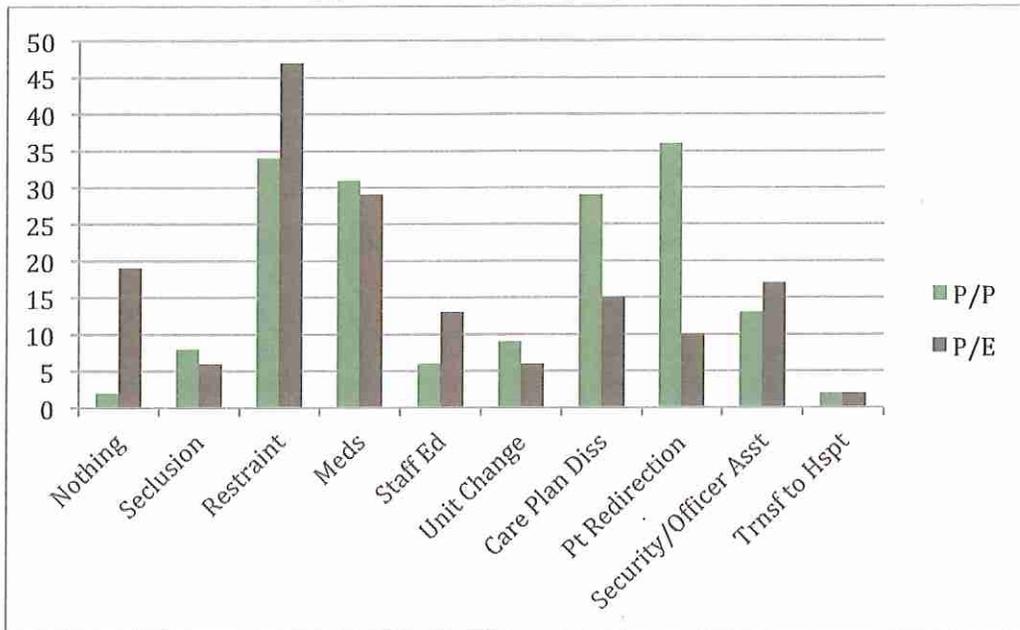
Average	Standard Deviation	Range
2.35 days	3.7 days	0-23 days



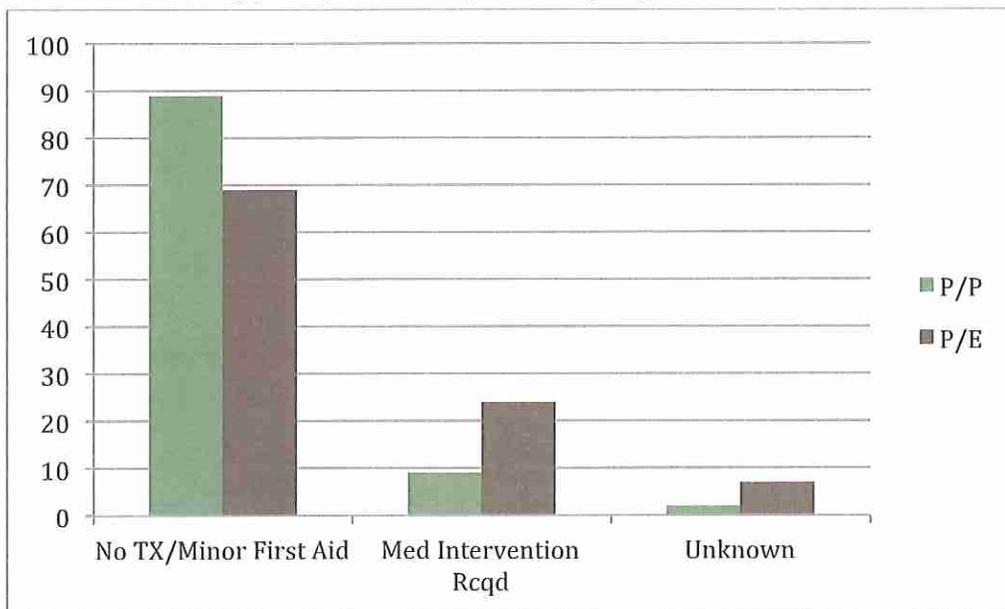
Incidents by Unit (%), 2013 – June 2016



Actions by Aggression Type (%), 2013 – June 2016



Incident Type by Severity Level (%), 2013 – June 2016



Qualitative Examples of Review Notes:

- Received safety protocol w/access clinic front desk & clinical staff. Reviewed use of panic buttons and safe escape routes. One staff expressed a desire for security swipes at the clinic.

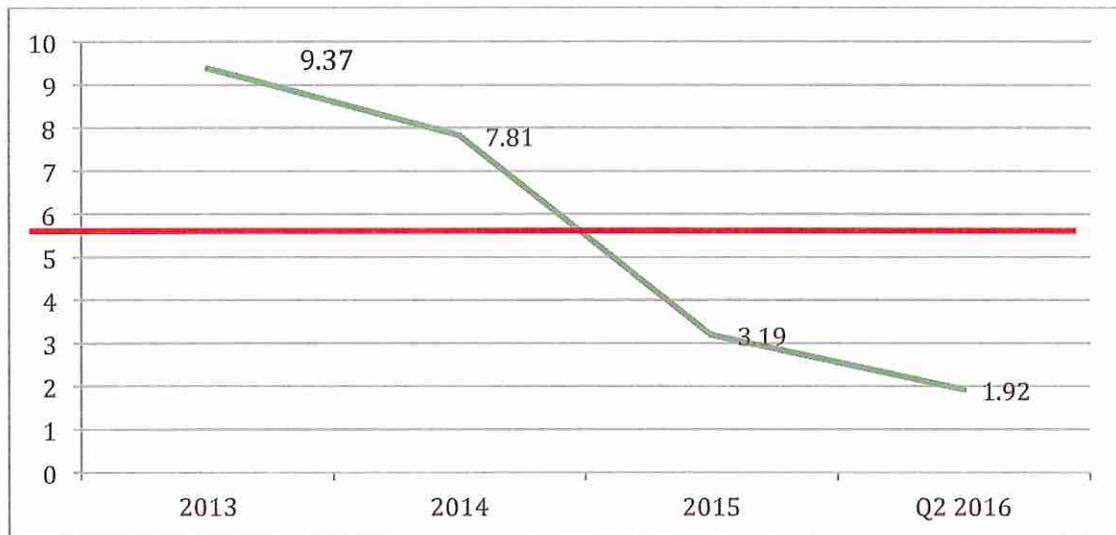


- Employee educated on importance of contacting supervisor immediately. Employee interviewed. Careline called. Injury paperwork completed. Unable to interview patient on unit. Additional staff to be interviewed due to lack of teamwork which resulted in employee injury.
- Pt A hx of bipolar currently very paranoid thoughts, disorganized. Pts(patients) had been in same room and have been separated. Pt B refuses offer of contacting sheriff. Pt will be placed on a TDA(define) and admitted to acute inpatient due to physical aggression and mood changes. Accepted unit will be made aware of potential risk of aggression.
- Staff tried to verbally redirect when was unsuccessful; staff had to physically remove residents. No injury occurred.
- Pt is known to have this type of behavior - he has precautions (within arms length when out of room) in place - he's reactions are very quick. Residents separated. Pt returned to his room offered and received medication. Guardians notified. Pt assessed. Pt no injury, washed face denied concerns regarding incident Tx(treatment) plan updated.
- Pt B delusional with increased aggression threw chair at another pt A no inj. Code 1 called pt A placed into restraints and medicated after a 1/2 hour pt reassessed medications effective pt - aware of behavior and vocalize his actions were wrong. Triggers discussed with pt tx team.

Injury Analysis

The injury analysis included a representative sample of three types of injury related incidents: accidental injuries, self-inflicted injuries, and injuries related to seclusion and restraint episodes (S and R). Overall, there was a significant decline in all injury related incidents from 2013 – June 2016.

Injury Incidents Per 1000 Patient Bed Days

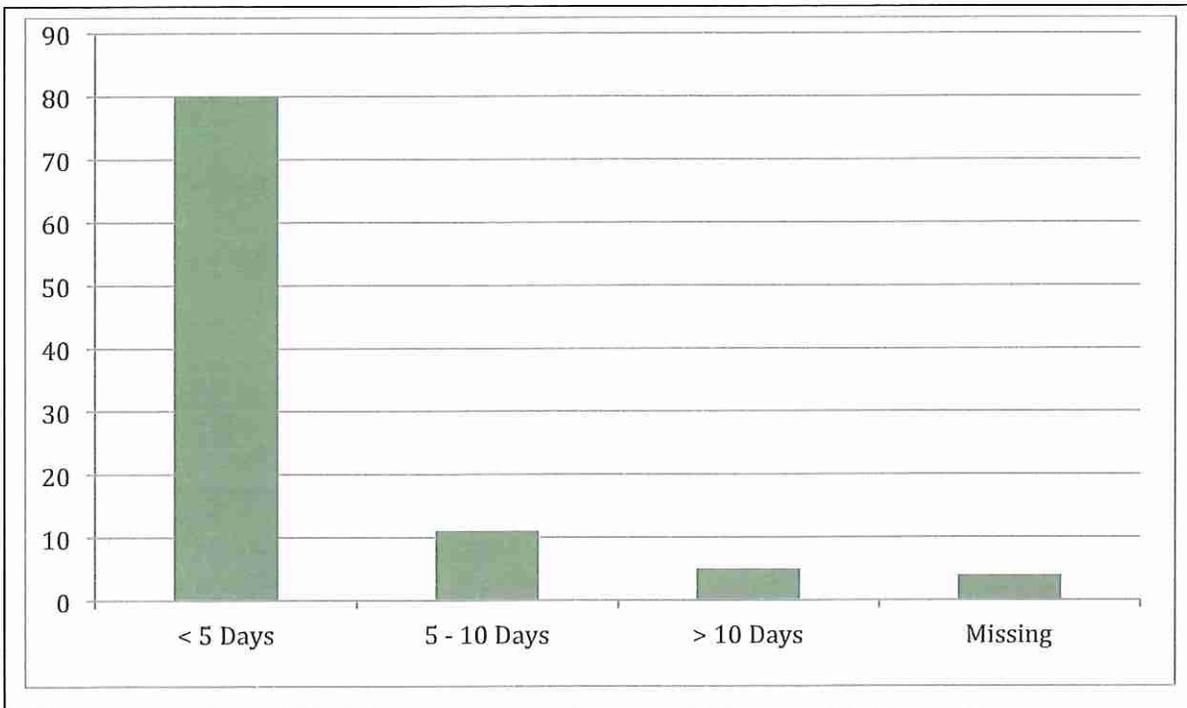


Injury Incidents by Injury Type Per 1000 Patient Bed Days



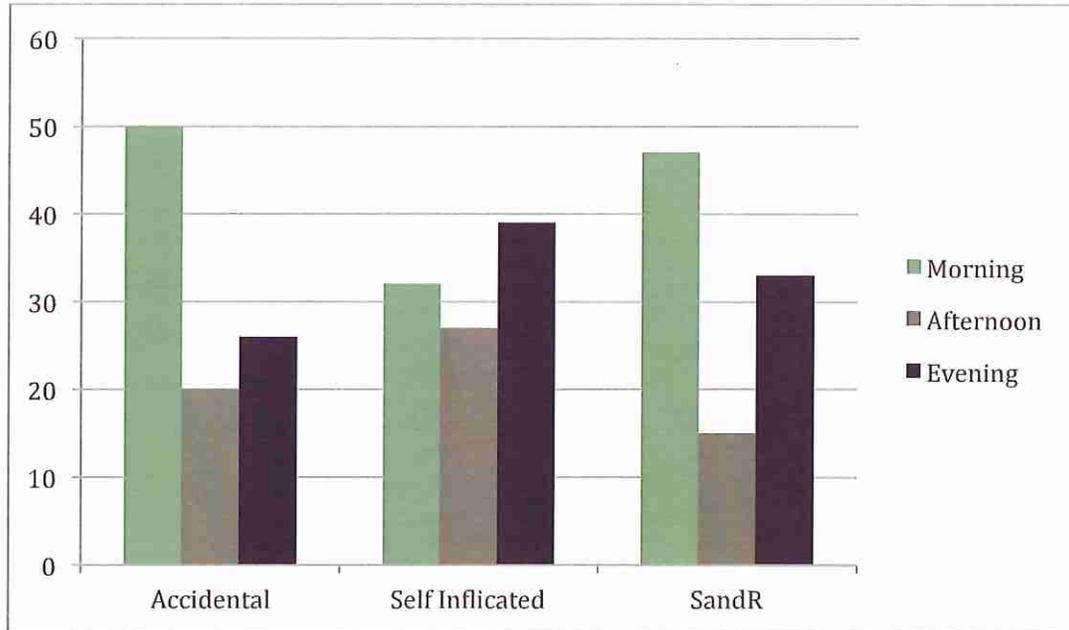
Days from Date of Incident until Supervisor Review, 2013 – June 2016

Average	Standard Deviation	Range
2.35 days	3.7 days	0-23 days



Incident Type by Time of Day (%), 2013 – June 2016





Findings and Discussion:

- The majority of incident reports for all types (accidental, self inflicted, seclusion and restraint) were fully completed (> 90%).
- A significant number of accidental injury incidents took place in the morning (50%).
- A significantly lower number of injury incidents related to S and R took place in the afternoon (15%).
- The majority of incidents related to injury are either accidental or self-inflicted. Injuries related to S and R are significantly less than the other two categories.
- Two percent (2%) of the patient sample was involved in twelve percent (12%) of the injury incidents.
- 75% of the incident reports were completed by an RN.
- The majority (80%) of incident reports were completed in less than five days from the date of the incident.
- The majority of S and R injury incidents (66%) resulted in a staff injury occurring while assisting to place a patient into restraints.

Qualitative Examples of Reviewer Notes:

- Employee was assisting another CNA with getting res up and in shower chair (protocol followed), was in proper position. Employee reports "back strain" upon completion of task, employee is known to work multiple "back to back" shifts.
- Emp completed notification of injury paperwork and called injury report # for county mutual. She declined follow up tx and said she felt better after ibuprofen. Reviewed property procedure to break down a box by cutting the tape on the seams. If this is too difficult, she should contact supervisory reminded to contact county mutual and supervisor if further attention is needed.
- RN notified at time of incident. Client held hand under cold water immediately. Next day A was scheduled for day tx groups. Per APNP, there was no sign of burn and pt had no complaints. Asked staff to remind clients not to fill cups to top with hot liquids, although it is unclear if that was a contributing factor.



- Chart reviewed. Incident report reviewed. MD appropriately notified and MD assessment complete. Mild tenderness & mild swelling noted to Rt frontal scalp. Neuro checks completed per MD orders. Pt disorganized, but was prior to injury no major trauma noted. VSS neuro checks WNL. Appropriately monitored by staff. Appropriate action taken.
- Emp B accidentally spilled water on the floor. Emp A walked into the spilled liquid. (A) Incident report completed, injury referral form and injury report form completed. Witness statements obtained. R employee A reports "to avoid falling, I strained my back and neck, but kept my balance. Emp A stated she had a chiropractor appt @ 4pm today r/t a recent fall, on ice, outside of work, off hospital grounds. Emp refused to leave work to be seen. No missing work time.
- Pt assessed for injuries, none noted assist pt in de-escalation trigger identified. Pt agreed to time out in room. Will refer to medical, tx plan updated.
- Pt A and B were fighting. Writer was in between them trying to keep them apart. B was on the phone and thought that A was coming after him. He tackled writer and A, knocking writer to the floor, injury my back left leg/calf and R wrist is sore.
- Fight broke out on the unit between female patients. While trying to break up the fight he slipped or tripped over his feet. He fell to the ground causing an abrasion to the lt elbow

Analysis of Other Incidents

Findings and Discussion:

- There were no specific trends in the incidents categorized as "other."
- Over 30% of the incidents categorized as "other" were incidents with their own category specifically aggression, injury, elopement, sexual contact.
- Over 25% of the "other" incidents did not seem to be incidents.
- Common themes included the broad categories of medication, misconduct, visitor issues.
- There was a greater proportion of incidents in the outpatient setting than in any other incident category. Based on an analysis of the comment sections of the reports, staff members in outpatient settings are not as well educated in incident reporting and categorization.

Qualitative Examples of Reviewer Notes:

Incorrectly categorized

- Pt A punched pt B in the face over disagreement of T.V., C stepped in to separate the pts by wrapping his arms around pt A from behind. Pt A struggled with C slamming him against the wall/door jamb inuring his left forearm.
- Patient opened a door of secure unit and stood in doorway when alarm activated. Staff at exit redirected promptly. Patient back into unit and reset alarm
- Pt attempted to elope when OT staff exited conference room door. Security
- Received a call from Staff A at outpatient. Staff A reported that pt threatened to kill patient B in staff's presence
- Writer met with patients on 3/13/2014 @ 20:30 due to a verbal argument. They were arguing over the tv. Pt A was watching a program. House staff gave patient B permission to change the channel. Patient A became upset because he was in the middle of his program. Patient A told patient B he would "fuck up" patient B. Patient B went into the kitchen and grabbed a butter knife.



Medication Related

- Discovered medications in WOW drawer labeled A and B. The meds were Iodipine 2.5 mg and HCTZ 25mg in the drawer labeled B. In the drawer labeled A there was a Depakote 250mg.
- Per Staff A, patient returned from outside, they suspected he had medication on him so confronted him in his room. They observed 6 Lorazepam and some Adderol were missing from the prescription that the patient did not report he had filled. Staff A called 911 per crisis mobile request

Strategy 3 – Staff Survey

Goal: Survey staff to assess the level of staff knowledge of incident reporting process.

Process: An electronic survey was developed (see Appendix D) that assessed staff understanding of the BHD incident reporting process. Analysis of the responses offered insight into the staff's level of knowledge regarding the incident reporting process and will help BHD better determine if incidents are being accurately reported. The survey included review of the BHD incident definition, as well as scenarios that staff assessed with regard to incident reporting. The survey depicted the following seven incident scenarios:

- A. A client is exiting the building with a friend after an appointment. The friend damages a light on the way out of the building.
- B. Inpatient A and inpatient B argue but no one is hurt.
- C. A person calls at your workspace and threatens the safety of an individual located in the building.
- D. You are in the common area of the front entrance and notice a spilled substance on the floor in the direct walkway.
- E. You answer the phone and the caller would like to report abuse/neglect of a client/patient.
- F. A staff member is injured lifting a patient up from the floor.
- G. A patient and a staff member argue. The staff member uses curse words towards the patient during the argument.

Sample: 100% of BHD staff (606 total) was offered the survey in November 2016. Two hundred nine (209) responses were returned for a 34% response rate.

Findings and Discussion:

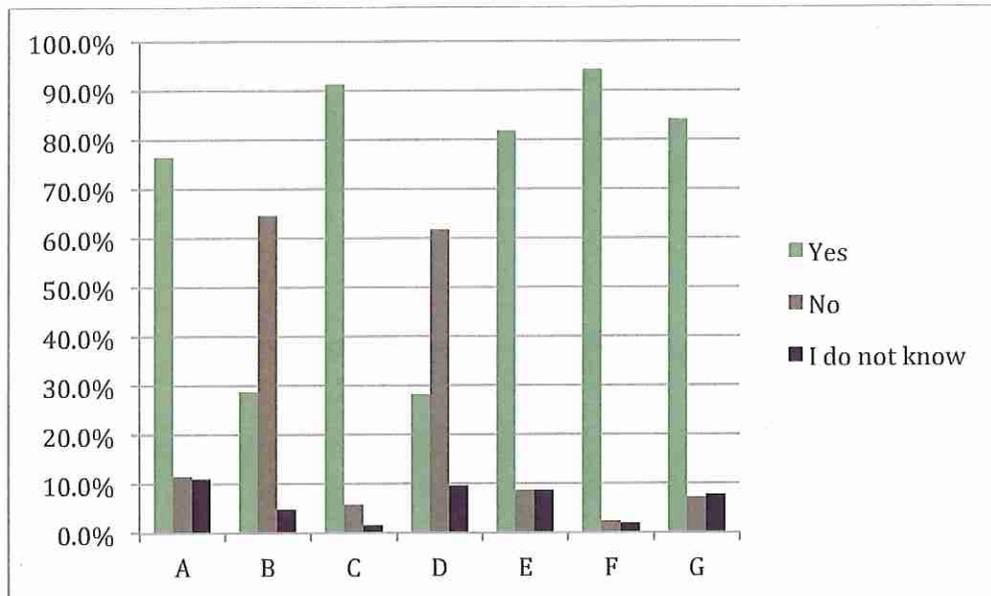
- The high response rate (34%) may suggest an interest among staff on the topic.
- There was an equal response from direct care and non-direct care staff.
- Surveys included 19 comments that were focused on:
 - Identifying the correct action based on the example.
 - Concerns regarding lack of reporting for fear of disciplinary action.
 - Concerns regarding the complexity of the reporting process.
 - Concerns regarding the impact of short staffing on incident reporting.
 - Concerns regarding lack of follow up once the incident is reported.
- The majority of respondents identified five of the scenarios as reportable incidents (A, C, E, F, G).
- The majority of the respondents identified two scenarios as non-reportable incidents: a spill in the walkway of the front entrance (B), and an argument between two patients (D). BHD incident reporting guidance is not as clear as it could be with regard to the spill scenario and this may be an opportunity for improved incident guidance and staff education. With regard to the patient argument scenario – BHD



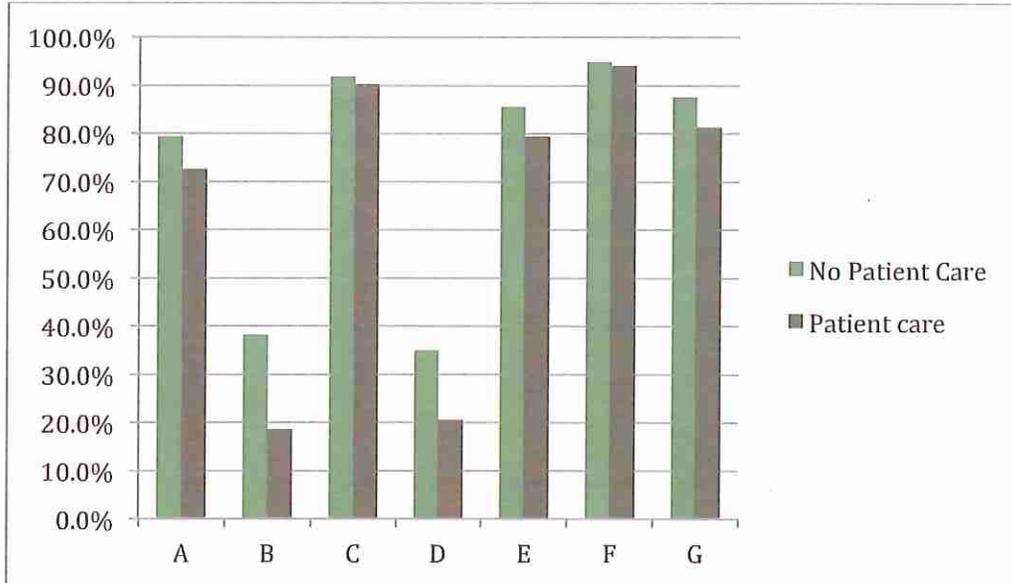
incident guidance is also not clear on this as a reportable incident but if capturing near miss incidents is important to BHD recording patient/patient arguments may be helpful.

- There were statistically significant differences in responses between direct care and non-direct care staff for scenarios B (patients arguing) and D (spill on floor). A lower percentage of direct care respondents considered these scenarios to be incidents. With regard to scenario B, because direct care staff has greater exposure to patients arguing, the difference may suggest that these providers may be desensitized to the need to report these incidents. With regard to scenario D, these findings may suggest that direct care staff is not as knowledgeable regarding the importance of reporting spills as “near miss” incidents.

All Responses



**Percentage of Respondents Indicating that a Scenario Is a Reportable Incident:
 Direct Care vs Non-Direct Care Staff**



Verbatim Qualitative Comments

Direct Patient Care	Comment
Yes	The examples left out contraband, sexual contact, unauthorized absence, self-harm...? Also, incidents still go unreported because they happen frequently or because employees fear disciplinary action. It would help for reporting to be as quick and easy as possible and for there to be an assurance that reporting will result in quality improvement that is cooperative, not punitive.
No	Sometimes, staff on 1:1 also have unit assignments when a unit is shot staffed.
Yes	A patient and staff member argue. The patient uses curse words towards the staff member during the argument.
Yes	Report behavior to supervisor, immediately.
Yes	When in doubt I will report an issue and fill out a report. After the investigation if it's unnecessary it can always be discarded.
Yes	Unsure about the I do not know answers, I think for those you would report to your supervisor and housekeeping for the spill.



No	I subscribe to the AHRQ definition of 'incident'. Each of the scenarios is a reportable 'event'.
No	4 the worker needs to clean up the spill or make sure no one falls.
Yes	The incident reports should be made as simple and "user friendly" as possible.
No	I am in Accounts Receivable and only talk to patients regarding billing.
No	A spilled substance would be reported to be cleaned up, not an incident report. If a report of abuse neglect is given, the information should be given to the nurse, pm supervisor and physician.
Yes	In some of these examples, an incident report is not the first or only thing to be done.
Yes	Most of us know this and have reported incidents. My concern is what has NOT happened when reporting has taken place
Yes	Patient delivered food to which they are allergic, i.e. peanuts.
No	As far as the spill, you should call EES to have it secured and cleaned so that no one slips and falls. It wouldn't be reported as an incident unless someone slips or falls due to the spill.
No	When patients are arguing it can be documented in chart, with spilled substance notify maintenance or and /or housekeeping, when visitor damages property the sheriff can be called.
Yes	For the pt A and B scenario--no incident report; however it needs to be documented in each individual's chart. As for the spill, I would call EES and wait for clean up, guiding people around the area. I would think EES documents they had a request for this service.
Yes	Regarding the spill, as long as someone cleans it up and no one fell or is hurt by it.
No	I answered yes to all due to each one relating to patient or possibly affecting one.

Strategy 4 – Best Practices Research

Goal: Identify best practices in incident reporting (as evidenced by literature and interviews with subject matter experts) for consideration by BHD leadership.

Process: Conduct review of literature and outreach to selected certification and accreditation organizations to understand best practices in incident reporting.



Sample: Small qualitative sample not meant to be fully representative of any one population. Interviews were conducted with representatives of The Joint Commission, the National Committee on Quality Assurance, and The National Association of County Behavioral Health and Developmental Disability Directors.

Incident reporting systems (IRS) are designed to gather information from past incidents that will provide insight into the collection process, and that will lead to improvements including a reduction in harm or the potential of harm to staff and patients. A review of an IRS should analyze the process of cataloging incidents as well as the incidents themselves. The analysis should support individual and organizational improvements in processes and outcomes.

In general, research suggests that effective incident reporting systems share the following attributes:

1. The definition of *incident* is clear and understood by all staff;
2. The system is supported and led by a clinically-oriented team; and
3. The IRS is embedded in a broader education and safety initiative.

While using an IRS for improved outcomes may seem straightforward, challenges do exist particularly with regard to behavioral health services. For example, some experts question the usefulness of incident reporting in a mental health setting where the priority should be on predicting behavior or minimizing the potential for aggressive behavior, which is different than the goal of IRS in clinical settings. Research (1) that includes a meta-analysis of systems internationally identify the following most common challenges to full implementation of IRS's:

1. Incident reporting systems collect information on incidents at a high level and tend to dilute the information to the specific incident in a summary or abstract form. This summary may lose important detail that will reduce the ability to learn from prior incidents;
2. Fear of recrimination may lead to under reporting for these systems;
3. Employee may be less likely to report and complete an incident report for a variety of reason such as lack of time, lack of knowledge, fear of consequences and a lack of understand of the purpose; and
4. A lack of clarity on who is responsible for each part of the process and who actually "owns" the incident and follow through.

There is a lack of peer reviewed literature focused on IRS for mental health services but subject matter experts suggest that research should focus on seclusion and restraint incidents, and at broader outcomes/incidents such as readmissions. Literature (1, 2, 3, 4) on general incident reporting systems (majority in clinical settings) offered the following best practice suggestions:

1. System should be objective;
2. System should not be under the control of one stakeholder;
3. System should be designed to facilitate the collection of detailed narratives in the reporter's own words;
4. Leadership should demonstrate that the information collected in the system is useful and appropriate;



5. Information gathered from the system should be used to create a shift in mindset and culture of the organization;
6. Impacts from the learnings should support direct improvements to procedures and broad organizational change;
7. If a blame culture exists, consider using an anonymous or confidential reporting system.
8. Leadership must emphasize the goal of the system is to learn; and
9. Systems should focus on issues of most concern in a mental health setting such as incidents related to seclusion and restraints.

General Thoughts and Findings:

- Incident comments suggest that a lack of understanding of the reporting protocol may be a contributing factor to incidents being reported that may not, in fact, be incidents.
- Education regarding the accurate determination and categorizing of incidents may help ensure that incidents are reported and accounted for accurately.
- There may be an opportunity to educate security with regard to the use of restraints, and to responding to unit requests during aggression incidents.
- A review is necessary for all staff on how to complete the forms generally and in the various categories, and without dissention or tone. Perhaps an explanation as to the importance of each category and how to include the appropriate information would be warranted.

References:

- (1) Incident Reporting to Improve Clinical Practice in a Medium-Secure Setting, *Mental Health Practice*, April 2013
- (2) How Effective Are Incident-Reporting Systems for Improving Patient Safety? A Systematic Literature Review, *Millbank Quarterly*, November 2015
- (3) Lessons Learned from the Evolution of Mandatory Adverse Event Reporting Systems, *Advances in Patient Safety* Volume 3, October 2016
- (4) Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting, *International Journal for Quality in Healthcare*, January 2013
- (5) Interview: NCQA Director of Measurement
- (6) Interview: Joint Commission, Past Director of Behavioral Health Certification
- (7) Interview: President and Past Director of HRSA, National Association of County Behavioral Health and Developmental Disability Directors.
- (8) Violence and Aggression in Psychiatric Units, *Psychiatric Services*, November 1998
- (9) Reducing Restraint Use in a Public Psychiatric Inpatient Service, *The Journal of Behavioral Health Services and Research*, April 2004, Vol. 31 Issue 2



Appendix A – Scope of Work

Statement of Work: Risk Management Review of Incident Reports

The Milwaukee County Behavioral Health Division (BHD) seeks to engage a healthcare risk management subject matter expert to conduct a three-phase audit and analysis of incidents occurring on the inpatient units to assess areas for potential improvements in patient and staff safety.

Phase 1 – Entry and Discovery

- Intake with BHD Executive Team
- Intake and hand-off from Mr Heer and the County Audit Team
- Review of the 2010 County Audit Work
- Review of changes at BHD since 2010

Phase 2 – Evaluation and Analysis

- Evaluate Incident Reports to validate accuracy of type of incident, adequacy of incident's description, validate reported aggregated data, and review of actions taken post incident in context of regulatory (CMS, TJC, State WI) requirements.
- Assess incident data to determine identifiable trends suggesting areas for further improvement in policy, processes and patient safety.
- Assess incident data specific to those with staff injuries to identify trends suggesting areas of further improvement related to staffing, training, procedures, staff roles and physical plant.
- Assessment of BHD's processes and categorizations compared to national best practice (literature review)
- Survey staff regarding incident report process

Phase 3 – Report and Exit (Five weeks @ 25 per week)

- Summarize Findings (report development, draft review, final)
- Make recommendations regarding workflow improvement to insure risk management reporting is disarticulated as much as feasible from sensitive clinical data
- Make recommendations regarding areas for improvement related to trends in incidents.
- Make recommendations to update and improve incident reporting processes to be consistent with national best practice. (lit review, interviews)
- Conduct exit briefing with Mr Heer and the County Audit Team
- Conduct exit briefing with BHD Executive Team
- Develop synthetic report for the Milwaukee County Mental Health Board
- Develop synthetic report summary for public press release



Appendix B – Research Protocol

Milwaukee County, Department of Health and Human Services, Behavioral Health Division
Incident Review and Analysis
Research Protocol

Goal:

Analyze BHD incident reports from 2010 – Q2 2016.

Strategies:

1. Review and trend incident reports by unit from 2010 – Q2 2016 based on 2010 audit work with manual validation
2. Analyze a representative sample of incident reports by unit/incident type for quality improvement impact and new opportunities for both process and quality improvement focusing on 2013 forward
3. Survey staff to verify staff knowledge of incident report process
4. Identify incident reporting best practices for consideration by BHD leadership

Strategy 1: Review and trend incident reports by unit from 2010 – Q2 2016 based on 2010 audit work with random manual validation of counts

Sample: 100% of incident reports from 2010 – Q2 2016

Process: High level analysis of incident reports from 2010 – Q2 2016 in order to create the following tables/graphs

6. BHD Reported Incidents – All Categories Acute Adult Inpatient Units – Number of Incidents by type by year 2010-2016
7. BHD Reported Incidents – Adult Acute Inpatient Units – Incidents Per 1000 patient days trended from 2010-2016
8. Selected Incident Categories for Patient Acuity BHD Acute Adults Inpatient Units – Number of Incidents by Incident type by year 2010-2016
9. BHD Reported Incidents Selected by Categories for Patient Acuity Adult Acute Inpatient Units – Incidents Per 1000 patient days trended from 2010-2016
10. Selected Incident Categories for Patient Aggression BHD Acute Adult Inpatient Units – Number of Incidents by Type by year 2010-2016
11. Selected Incident Categories for Patient Aggression BHD Acute Adult Inpatient Units - Incidents Per 1000 patient days trended from 2010-2016

Strategy 2: Analyze a representative sample of incident reports by unit/incident type for quality improvement impact and new opportunities for both process and quality improvement

Sample: Representative and random sample of incidents on all units from 2013 – Q2 2016 for the following incident types: violence, aggression and sentinel events not including falls. Total sample size approximately 1847. The sample size will be representative within 5%+/- of the overall total of incident reports.

Process: Develop a researchable data base of all quantitative and qualitative data captured on an incident report. Random sample of incidents by year/incident type will be chosen, coded and stripped of all personal health information. All data including the incident code will be entered into a database and analyzed for trends as well as impacts based on historical process and quality improvement efforts. In addition analysis will include identification of any opportunities for addition improvement from both a process and quality perspective. Lastly, suggestions



will be made on the need for additional analysis for incidents that resulted in harm or death. Also, include discussion regarding future need for incident tracking in community services environments as volume increases and shifts from the inpatient environment.

Strategy 3: Survey staff to verify staff knowledge of incident reporting process

Sample: 100% of BHD staff will be offered the survey

Process: Electronic survey will be developed that assesses staff understanding of the BHD incident reporting process. Analysis of responses will offer insight into the staff level of knowledge regarding the incident process and will help BHD better determine if incidents are being accurately reported. Survey will include review of the BHD incident definition as well as scenarios that staff will assess with regards to incident reporting. Anonymous results will be shared in the final BHD Incident Analysis Report. Include opportunities for staff to offer non structured comments regarding the incident process either through open ended comment section on the survey, toll free phone number, and/or focus groups.

Strategy 4: Identify incident reporting best practices for consideration by BHD leadership

Sample: Small qualitative sample not meant to be fully representative of any one population

Process: Conduct review of literature and outreach to certification and accreditation organizations to understand best practices in incident reporting.

Final Report Development and Presentation

- Key Deliverables: Summarize Findings (report development, draft review, final)
- Make recommendations regarding workflow improvement to insure risk management reporting is disarticulated as much as feasible from sensitive clinical data. (does this mean the identifiable patient information is stripped from the database for analysis?)
- Make recommendations regarding areas for improvement related to trends in incidents.
- Make recommendations to update and improve incident reporting processes to be consistent with national best practice. (lit review, interviews)

Key Presentations:

- Conduct exit briefing with Mr Heer and the County Audit Team
- Conduct exit briefing with BHD Executive Team
- Develop synthetic report for the Milwaukee County Mental Health Board
- Develop synthetic report summary for public press release



Appendix C – 2010 Audit Report

<http://county.milwaukee.gov/ImageLibrary/Groups/cntyAudit/Report1019.pdf>



Appendix D – Staff Survey

2. There are seven examples of incidents below. Please read each example and determine if an incident report should be written for the incident.

Scenario	Should an incident report be written?
A client is exiting the building with a friend after an appointment. The friend damages a light on the way out of the building.	<input type="text"/>
Inpatient A and inpatient B argue but no one is hurt.	<input type="text"/>
A person calls at your workplace and threatens the safety of an individual located in the building.	<input type="text"/>
You are in the common area of the front entrance and notice a spilled substance on the floor in the direct walkway.	<input type="text"/>
You answer the phone and the caller would like to report abuse/neglect of a client/patient.	<input type="text"/>
A staff member is injured lifting a patient up from the floor.	<input type="text"/>
A patient and staff member argue. The staff member uses curse words towards the patient during the argument.	<input type="text"/>
Other (please specify)	<input type="text"/>

Thank you for taking the time to complete this survey. All responses will be anonymous and will help us improve the incident reporting process. If you have

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2:42 PM
11/15/2016





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

Quality Committee Item 3

Program	Item	Measure	2015 Actual	2016 Actual	2017 Quarter 1	2017 Quarter 2	2017 Quarter 3	2017 Quarter 4	2017 Target	2017 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵	9,624	7,971	5,105				8,370	Green	BHD (2)
		Sample Size (Unique Clients)			2,414				-	Green	
	2	Percent with any acute service utilization ⁶	-	13.09%	16.94%				12.05%	Green	BHD (2)
	3	Percent with any emergency room utilization ⁷		12.44%	12.80%				11.20%	Green	
	4	Percent abstinence from drug and alcohol use	-	66.71%	63.34%				73.81%	Green	BHD (2)
	5	Percent homeless	-	4.74%	6.71%				4.00%	Green	BHD (2)
	6	Percent employed	-	15.80%	15.29%				14.22%	Green	BHD (2)
	Sample Size (Admissions)		6,315	1,688				-	Green		
	7	Percent of clients returning to Detox within 30 days	19.6%	55.61%	62.26%				50.61%	Green	BHD (2)
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,329	3,500	1,949				3,670	Green	BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.6	4.6	4.8				>= 4.0	Green	BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	62%	60.2	63.9%				>= 75%	Yellow	BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.2	2.86	2.68				>= 3.0	Yellow	BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	58%	53.6%	55.6%				>= 70%	Yellow	BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	42%	43.6%	45.1%				>= 50%	Yellow	BHD (2)
Crisis Service	14	PCS Visits	10,173	8,286	1,896				7,600	Green	BHD (2)
	15	Emergency Detentions in PCS	5,334	4,059	900				3,600	Green	BHD (2)
	16	Percent of patients returning to PCS within 3 days	8%	7.9%	7.8%				8%	Green	BHD (2)
	17	Percent of patients returning to PCS within 30 days	25%	24.8%	23.8%				24%	Green	CMS (4)
	18	Percent of time on waitlist status	16%	80.1%	75.6%				25%	Red	BHD (2)
Acute Adult Inpatient Service	19	Admissions	965	683	169				700	Green	BHD (2)
	20	Average Daily Census	47.2	45.8	42.7				43.0	Green	BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	3%	3.6%	2.4%				3%	Green	BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	11%	10.8%	9.6%				10%	Green	NRI (3)
	23	Percent of patients responding positively to satisfaction survey	73%	70.6%	69.6%				74%	Yellow	NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	63%	57.1%	64.1%				65%	Yellow	BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	7.2	3.32	0.45				0.66	Green	CMS (4)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.47	0.48	0.27				0.14	Red	CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	18%	18.5%	12.6%				9.5%	Red	CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	98%	95.0%	90.9%				32.8%	Green	CMS (4)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	919	617	184				750	Green	BHD (2)
	30	Average Daily Census	9.8	8.4	10.2				10.0	Green	BHD (2)
	31	Percent of patients returning to CAIS within 7 days	6%	5.2%	4.4%				5%	Green	BHD (2)
	32	Percent of patients returning to CAIS within 30 days	16%	11.8%	11.5%				11%	Yellow	BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71%	78.1%	75.7%				74%	Green	BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	74%	82.1%	80.0%				80%	Green	BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	5.2	4.51	1.46				0.22	Red	CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.42	0.20	0.29				0.34	Green	CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2%	1.6%	1.1%				3.0%	Green	CMS (4)
		38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100%	88.9%	100.0%				39.9%	Green
Financial	39	Total BHD Revenue (millions)	\$120.2	\$129.4	\$149.9				\$149.9	Yellow	
	40	Total BHD Expenditure (millions)	\$173.5	\$188.2	\$207.3				\$207.3	Yellow	

Notes:
 (1) 2017 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
 (2) Performance measure target was set using historical BHD trends
 (3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages

(4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages
(5) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.
(6) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days
(7) Includes any medical or psychiatric ER utilization in last 30 days

MENTAL HEALTH BOARD QUALITY COMMITTEE QUARTERLY REPORT

KEY PERFORMANCE INDICATORS DASHBOARD UPDATE

MAY 9, 2017

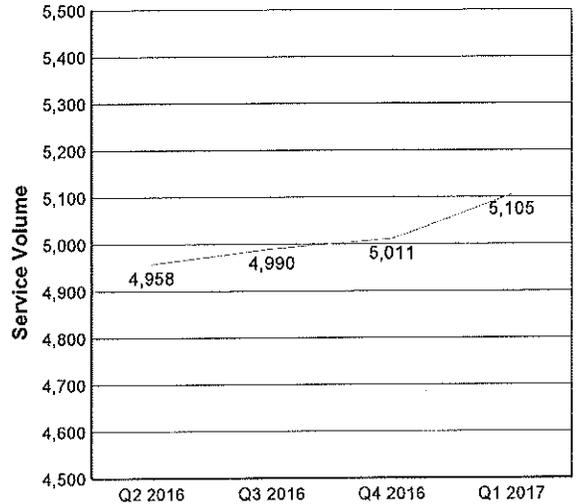
The Key Performance Indicators Dashboards (KPIs) for BHD have been updated to include the first quarter of 2017 data for the different departments within BHD. Also included are new target goals for 2017, based on benchmark data from 2016. We anticipate significant changes to the KPI for BHD in 2017, which we anticipate will be ready for release at the fall or winter meeting of the Mental Health Board Quality Committee in 2017.

These changes include a reorganization of the KPI so that they are more reflective of BHD's mission and goals, as articulated in the BHD Quality Plan. The KPIs will also have a hierarchical structure, such that the KPIs for BHD will be high level and transdepartmental with regards to their applicability and scope. Subsequent levels of this KPI hierarchy will include progressively greater levels of detail and specificity, depending on the department or program which they are designed to reflect. This reorganization will enable a greater degree alignment of the different KPIs at every level of the hierarchy recognizes their role in and contributes to the larger BHD mission. We anticipate that the Recovery Domains discussed at the Mental Health Board Quality Committee meeting in the spring of 2017 will provide part of the foundation for these discussions, but they will also be informed by principles of population health, utilization review, and processes of organizational efficiency (among others). We have also articulated a KPI development process, which we anticipate refining and ultimately utilizing for the creation of each KPI at every level within BHD to ensure that the KPIs are aligned to the mission and goals of BHD and are reproducibly consistent throughout the organization.

CARS Quarterly Report

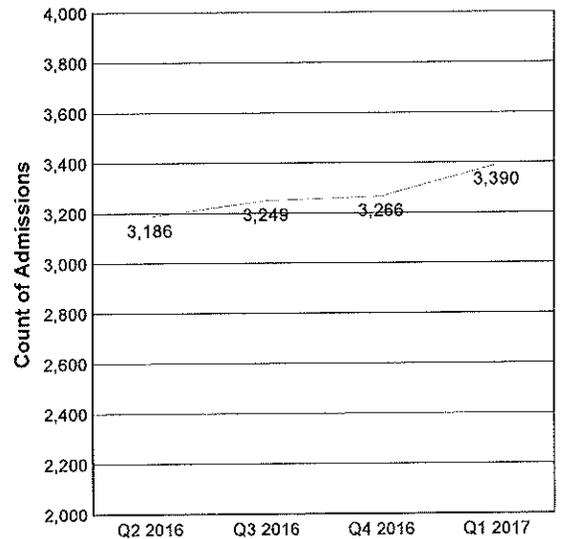
Number of Clients Receiving Service, By Program

	Q2 2016	Q3 2016	Q4 2016	Q1 2017
Adult Family Home	14	13	14	17
Case Mgmt & After Care Support	88	69	83	81
CBRF	132	138	141	134
CCS	388	486	566	619
CLASP	71	79	79	66
Community Support Program	1,292	1,301	1,286	1,276
Crisis Case Management	96	126	180	215
CRS	34	35	35	28
Day Treatment (75.12)	31	29	26	17
Detoxification (75.07)	690	726	639	642
Med. Monitor Residentl (75.11)	1	1	1	3
MH Day Treatment	24	16	17	16
Outpatient 75.13	347	352	312	278
Outpatient-MH	58	55	62	60
Recovery House Plus OP/DT	21	17	20	33
Recovery Support Coordination	473	477	499	551
RSS-Employment	128	110	112	101
RSS-Family	5	0	0	0
RSS-Housing	115	111	105	125
RSS-Psych. Self Mgmt	60	46	38	53
RSS-School and Training	80	61	79	75
Targeted Case Management	1,487	1,472	1,513	1,540
Transitional Residential (75.14)	260	309	260	299
total	4,958	4,990	5,011	5,105

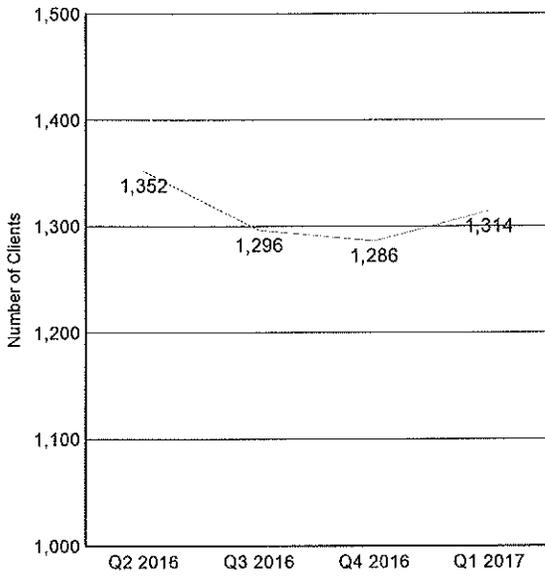


Admissions By Program

	Q2 2016	Q3 2016	Q4 2016	Q1 2017
Adult Family Home	0	0	1	3
Case Mgmt & After Care Support	27	27	35	28
CBRF	18	17	12	16
CCS	121	117	113	99
CLASP	24	25	22	13
Community Support Program	50	47	100	62
Crisis Case Management	52	68	98	113
CRS	1	2	0	0
Day Treatment (75.12)	23	30	29	17
Detoxification	1,648	1,681	1,614	1,687
MH Day Treatment	9	6	6	5
Outpatient (75.13)	227	217	181	169
Outpatient-MH	91	115	111	117
Recovery House Plus OP/DT	20	18	16	26
Recovery Support Coordination	279	296	272	358
RSS-Employment	98	66	99	85
RSS-Family	2	0	1	0
RSS-Housing	53	66	63	88
RSS-Psych Self Mgmt	26	38	15	21
RSS-School and Training	77	51	88	71
Targeted Case Management	118	127	187	184
Transitional Residential	222	235	203	228
total	3,186	3,249	3,266	3,390



Referrals/Intakes By Access Point



	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Total
Access Clinic at BHD	151	117	108	116	490
Access Clinic South	11	21	18	0	50
CARS	422	414	436	407	1,511
IMPACT	343	290	301	310	1,195
JusticePoint	40	38	32	36	137
M & S	223	226	232	250	903
UCC	43	56	46	61	202
WCS	161	166	148	160	616
Total	1,352	1,296	1,286	1,314	4,731

Time to Treatment

Average Number of Days from Intake to Admission						
Program	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Trend
CBRF	96	138	105	39	55	
CSP	63	89	83	101	86	
TCM	63	67	65	33	22	
CCS	7.1	1.0	1.9	1.6	1.2	
AODA Transitional Residential	23	23	17	18	16	
AODA Day Treatment	8	17	16	10	8	
AODA Outpatient	12	10	10	11	13	
Recovery Support Services	8	11	14	10	11	



Quality Committee Item 4

WRAPAROUND MILWAUKEE



2016

QA/QI Annual Report Summary

Highlights:

1. WRAP/REACH/CORE - Total youth served = 1,670
O'YEAH - Total new enrollments = 119
2. Both Wraparound and REACH youth and caregivers continue to identify improvement in functioning (both internal and external) during their enrollment as noted by improved scores in the Child Behavior Checklist and Youth Self Report Evaluation tools. (Page 2)
3. 90% (236 out of 262) of Wraparound youth who were not disenrolled on runaway status (n = 53) or to a correctional/detention facility (N = 84) achieved permanency. (Page 3)
4. Overall, WRAP/REACH youth are attending school 85.6% of the time. Exceeds threshold of 85%. (Page 3)
5. Family and Youth satisfaction with their Care Coordination services at 1-month, 6-months and annually overall is 4.63. Exceeds threshold of 4.0. Satisfaction at disenrollment overall is 3.85 which exceeds our threshold of 3.75. (Page 4)
6. Family satisfaction with service providers overall is at 4.3 which exceeds our threshold of 4.0. New Family Provider Satisfaction Survey process implemented in October. (Page 5)
7. Cost per month /per enrollee enrolled in Wraparound Milwaukee continues to be a more cost effective alternative to other types of care/services, i.e. – Group Homes, Corrections, Residential Care, Inpatient. (Page 6)
8. New Plan of Care auditing tool (POC Rubric) and procedure and a new Plan of Care Checklist were created and implemented. (Page 7)
9. Trained a total of 65 new Care Coordinators, Transition Coordinators and Professional Foster Parents. (Page 8) In addition, training was offered to DMCPs Ongoing Case Managers and Crisis Stabilization Providers. (Page 9) Two Trauma Informed Parenting trainings were also offered. (Page 9)
10. There was a transition of several Wraparound Provider Network responsibilities and staff to the Contract Management and Provider Network Services department. During the year Provider Philosophy trainings were offered, a fiscal Power Point presentation was created related to Provider billing in Synthesis, five Provider Forum meetings took place, the well-attended Provider Resource Fair was held in June at the Zoofari Conference Center. (Page 10)
11. Four more apartment units were added for a total of 10 that provide stable housing under a modified rental agreement for our OYEAH young adults. (Page 12)
12. Owen's Place, our young adult Resource Center in conjunction with MOVE Wisconsin, our youth-run organization, created the Young Adult Food Pantry and Hygiene Closet. In addition MOVE Wisconsin created an anti-stigma campaign called REPLACE LABELS WITH LOVE. (Page 13)
13. Eight Family Orientations were held in partnership with Families United of Milwaukee, Inc. (Page 15)
14. Our Mobile Urgent Treatment Team provided of 14,000 hours of crisis services to Wraparound families and the community at large including 900 children seen for the first time. The Trauma Response Team expanded into District 5 in addition to District 7. Two-hundred and forty referrals came in from District 7 alone. The Director of the Mobile Urgent Treatment Team assisted with training hundreds of MPD officers and other district officers utilizing the Crisis Intervention Team (CIT) model. (Page 16)

15. Wraparound continues to offer or be involved in the Wraparound Wellness Clinic, POHSEY (Proactive Outreach for the Health of Sexually Exploited Youth Project), Welcome Home Teens in Motion group, the Pregnancy Prevention Program, the Milwaukee Adolescent Health Clinic and Youth Living out Loud (YLOL). (Page 16)
16. Our CORE program (individuals experiencing their first episode of psychosis) continued to grow and we now have three teams of 5 service and clinical support persons. Thirty-three new participants entered CORE.
17. Wraparound Staff lead and/or participated in eleven different BHD or DHHS Charters, Committees or Workgroups in 2016. (Page 18)
18. Wraparound Milwaukee was awarded the “Quality Training Program Award” by the American Public Human Services Association (APHSA). The award recognizes Outstanding Training Education and Leadership in the Field of Health and Human Services. Wraparound specifically received the award for its New Care Coordinator Certification Training program. (Page 19)



WRAPAROUND MILWAUKEE

2016

QUALITY ASSURANCE/QUALITY IMPROVEMENT ANNUAL REPORT



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I. Demographics for 2016



Wraparound/REACH Enrollments = 652

Wraparound/REACH Disenrollments = 580

(Disenrollment # excludes transfers to other programs in the Wraparound System of Care)

Average Daily Census = 1,213 Total Youth Served = 1,670

Wraparound Milwaukee (WRAP) – A unique Managed Care Organization that serves youth with serious emotional, behavioral, and mental health needs and their families.

REACH Program (Reaching, Engaging and Assisting Children (and Families)) – A part of the Wraparound Milwaukee system of care that provides similar services and opportunities for youth with serious emotional, behavioral, and mental health needs and their families. The REACH program primarily differs in that the youth who are enrolled are not under a Court Order (Delinquency or Child in Need of Protective Services – CHIPS).

O'YEAH Program – (Older Youth and Emerging Adult Heroes), a program administered under the auspices of Wraparound Milwaukee designed to support older youth and young adults ages 16.5 – 24 who may be experiencing emotional and behavioral challenges, to successfully transition to adulthood. This is a voluntary program. **See Pg. 12 for details related to this program.**

GENDER (652 youth represented)

Female = 221 (34%)

Male = 431 (66%)

AGE (652 youth represented)

Average age = 14.2 years old

(WRAP = 15.1, REACH = 13)

ETHNICITY (652 youth represented)

African American = 408 (63%) (67% male – 33% female)
 Caucasian = 73 (11%) (56% male – 44% female)
 Hispanic = 96 (15%) (67% male – 33% female)
 Bi-racial = 4 (.6%) (50% male – 50% female)
 Asian = 2 (.3%) (100% male – 0% female)
 Native American = 2 (.3%) (0% male – 100% female)
 Other/Unknown = 62 (10%) (71% male – 29% female)
 Not Listed = 3 (.4%)

DIAGNOSIS (624 youth represented. Youth may have one or more diagnosis.)

ADHD (WRAP = 214, REACH = 170)
 Conduct Order (WRAP = 243, REACH = 90)
 Mood Disorder (WRAP = 96, REACH = 99)
 Anxiety Disorder (WRAP = 99, REACH = 94)
 Depressive Disorder (WRAP = 123, REACH = 56)
 AODA related (WRAP = 100, REACH = 10)
 Learning Disorder (WRAP = 57, REACH = 11)
 Developmental Disorder (WRAP = 75, REACH = 36)
 Adjustment Disorder (WRAP = 49, REACH = 21)
 Thought Disorder (WRAP = 3, REACH = 33)
 Personality Disorder (WRAP = 7, REACH = 0)

Major Depressive Disorder (WRAP = 4, REACH = 1)
 Eating Disorder (WRAP = 1, REACH = 2)
 Intellectual Disability (WRAP = 3, REACH = 1)
 Post-Traumatic Stress Disorder (WRAP = 4, REACH = 1)
 Other Trauma Disorder (WRAP = 7, REACH = 0)
 Other (WRAP = 87, REACH = 20)

YOUTH PRESENTING ISSUES (627 WRAP & REACH youth represented. Youth may have one or more issues.)

Access to Firearms = 95
 Adjudicated Sex Offender = 25
 Attention Problems = 475 *3 #3
 Bullied by Others = 215
 Bullying Others = 361
 Community Concerns and Violence = 302
 Contact Sexual Abuse = 118
 Dev. Disorder/Autism Spectrum = 203
 Drug/Alcohol Abuse = 269
 Eating Patterns/Hoarding = 189
 Experienced racism/discrimination = 129
 Felt unsafe in neighborhood = 112
 Fire setting = 138
 Gang Affiliation = 73
 H/O Sexual Misconduct & Exposure = 260
 Homicidal Ideation = 118
 Hx. Of Psychiatric Hosp. = 300
 Lived in Foster Care = 100
 Major Affective Illness/Affect Regulation = 343
 Minor Domestic Sex Trafficking Victim = 59
 Minor at Risk for Domestic Sex Trafficking = 17
 Out of Home Placement = 317
 Physical Disability/Medical/Health = 304
 Psychosis = 105
 Recurrent Emotional Abuse = 202
 Reintegration = 9
 Runaway Behavior = 293
 School Concerns = 567 #1 *1
 Self-harm = 175
 Severe Aggressiveness = 525 #2 *2
 Sexual Abuse Victim = 141
 Sleep Patterns/Nightmares = 355
 Suicidality = 250
 Victim Notification = 5
 Witnessed Violence in Community = 208
 Other = 264 (For example: stealing, manipulative behavior, traumatic events/illnesses)

* Top 3 WRAP youth issues # Top 3 REACH youth issues
 (Excludes "Other" category for WRAP/REACH)

FAMILY PRESENTING ISSUES (678 WRAP & REACH families represented. Families may have one or more issues.)

- Alcohol/Drug Abuser in Home = 228
- Adult in Home Treated Violently = 255
- Emotional Abuse/Neglect = 132
- Emotional/Mental Illness in the Family = 446 *3 #1
- Incarcerated Household Member = 333
- Physical Neglect = 144
- Previous Physical Abuse = 187
- Recurrent Physical Abuse Exposure = 170
- Single/No Parent in the Home = 416 *2 #3
- Significant Losses = 425 *1 #2
- Teenage Parent = 25

* Top 3 WRAP family issues #Top 3 REACH family issues

COURT ORDERED WRAPAROUND = 56% of enrollments

- (365 youth represented)
- 73.4% of youth were on a Delinquency order (N=268)
 - 25.2% were on a CHIPS order (N=92)
 - 1.4% were on a Dual (CHIPS/Delinquent) order (N=5)
 - 0% were on a JIPS order (N=0)

NO COURT ORDER (REACH) = 44% of enrollments

(286 youth represented)

II. Outcome Indicators

Functioning

The functioning levels of the youth in Wraparound/REACH are currently being measured by the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR). The evaluation tools are collected on every enrollee at Intake, 6 months, 1 year, annually thereafter and at disenrollment.

The CBCL is filled out by the parent/primary caregiver and provides information about the internal (mood, thought processing) and external (social/interpersonal interactions, community-based behaviors) behavioral issues of a child during the preceding six-month period. It comprises various scores consisting of symptoms of depression, anxiety, withdrawal, social problems, thought problems and delinquent and aggressive behavior. Total scores are computed and fall into three ranges: Normal, Borderline and Clinical. Scores are converted into age-standardized scores (T scores and Percentiles) so they can be compared with scores obtained from a normative sample of children within the same age range. The results can be utilized by the Child and Family Team to identify areas of need that should be addressed within the Plan of Care.

The YSR is similar to the CBCL. It is completed by youth 11 years of age and older.

Normal Range of Functioning – Scores that fall into the same range as the comparative sample group.

Borderline Clinical – Scores that suggest enough issues have been reported to be of concern, but not so many that it is a clear indicator of needing clinical professional help.

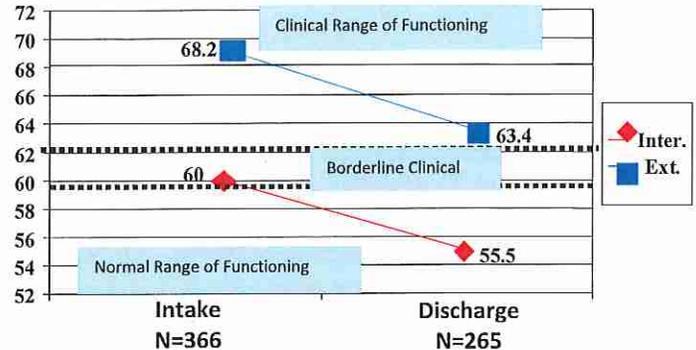
Clinical Range of Functioning – Scores that reveal sufficient issues that are significantly greater than the comparative sample group; in need of clinical intervention.

NOTE: A decrease in a score reflects improved functioning.

The following data in all graphs represents disenrollments from 1/1/16 – 12/31/16

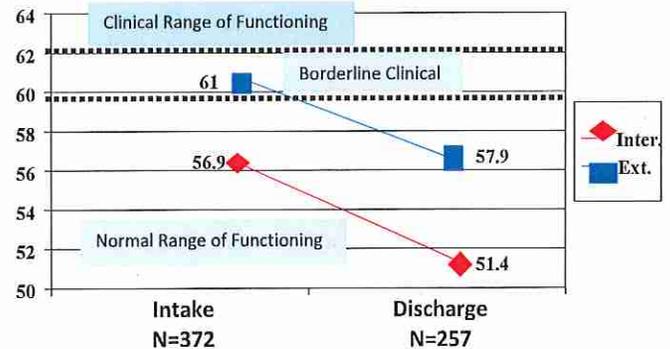
WRAPAROUND

CBCL T-Scores from Intake to Discharge



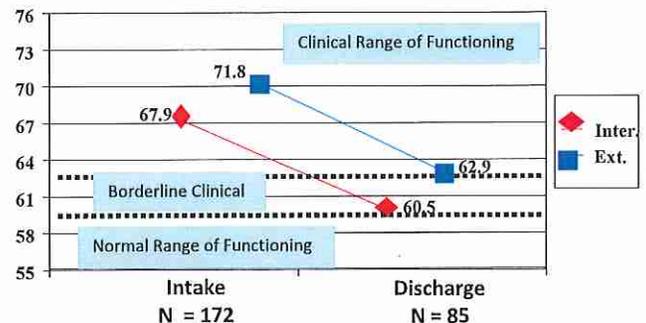
WRAPAROUND

YSR T-Scores from Intake to Discharge



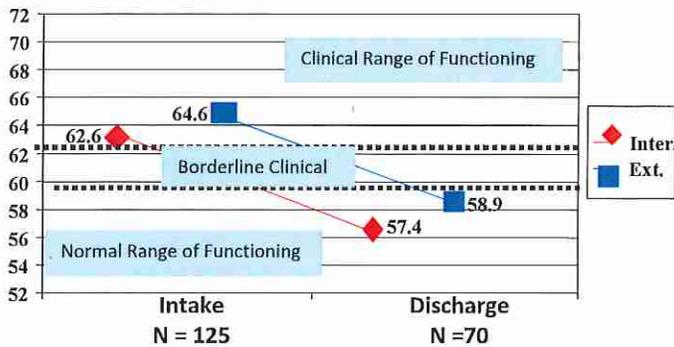
REACH

CBCL T-Scores from Intake to Discharge



REACH

YSR T-Scores from Intake to Discharge



we serve are getting the best education possible, that all educational needs are identified, and that attendance improves.

Of the enrollees for which school data was entered (N=648) into the Synthesis database (Wraparound Milwaukee's IT System) during 1/1/16-12/31/16 the following was revealed:

	#WRAP	%WRAP	#REACH	%REACH
K-5 th	23	6%	88	31%
6 th -8 th	73	20%	80	28%
9 th -12 th	268	73%	103	36%
GED/Grad.	4	1%	10	4%

Living Environment



Wraparound youth at enrollment are living in a variety of places. The level of restrictiveness of the placement varies. Wraparound is committed to getting youth into and/or keeping youth in the least restrictive environment possible and in minimizing the number of placement changes that a youth encounters.

Permanency (Wraparound Only) In defining the data below, permanency is described as:

- 1.) Youth who returned home with their parent(s)
- 2.) Youth who were adopted
- 3.) Youth who were placed with a relative/family friend
- 4.) Youth placed in subsidized guardianship
- 5.) Youth placed in sustaining care
- 6.) Youth in independent living

Total Wraparound disenrollment's = 399

Excludes 53 youth that were disenrolled as "runaway/missing" and 84 youth that were disenrolled to a correctional (n = 39) or a detention facility (n = 45)

Of the 262 remaining Wraparound youth, 236 or 90% achieved permanency as defined above.

Other disenrollment scenarios upon discharge:

- 12 – Foster Care – Transitional
- 13 - Group Home Care
- 8 - Respite Care
- 7 – Residential Care
- 3 - Other
- 2 – Inpt. Hospital

School

Wraparound Milwaukee is invested in ensuring that the youth



Youth in Wraparound are attending school approximately 82.5% of the time, while those in REACH are attending school approximately 88.6% of the time.

Our benchmark for attendance is set at 85%.

Wraparound Milwaukee provides **Special Education Advocacy (SEA)** services to any/all youth in need of support to ensure that their educational needs are being addressed and met. The SEA staff provide face-to-face consultation and support not only to those identified youth but also to the Care Coordination staff seeking to expand their knowledge about Special Ed regulations and laws in the state of Wisconsin. Care Coordinators also receive regular training in this area.

Youth and Family Satisfaction

Outcomes

Youth/Family satisfaction is measured through the surveys that are being administered by the Wraparound QA Department in conjunction with Families United of Milwaukee and the Care Coordination Agencies. These surveys inquire about the satisfaction level of the family/youth as it relates to the provision of Care Coordination and Provider Network services.



Family/Youth Satisfaction Levels related to Care Coordination Services

Surveys related to the families' satisfaction levels with Care Coordination are distributed at 1-month, 6-months, 1-year/2-year/etc. [At disenrollment, the survey is called a Disenrollment Progress Report. This "report" speaks more to perceived family outcomes vs. satisfaction.](#) A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available.

Satisfaction Benchmark for 1-month/6-month/yearly: 4.0

Satisfaction Benchmark for Disenrollment: 3.75

Survey Time Frame	# of Surveys Sent	# of Surveys Received	Return Rate	Average Overall Score
1-Month	721	98	13.5%	4.71
6mo/yearly	1406	163	11.5%	4.55
Family Disenrollment Progress Report	580	492	84.8%	3.95
Youth Disenrollment Progress Report				3.75

1-month Care Coordinator Family Survey – Overall 4.71

- 1.) My CC has been polite and respectful to me and my family. 4.88
- 2.) Meetings with my care coordinator have been scheduled at times and places that are convenient for me. 4.77
- 3.) I know how to reach my care coordinator when I need to. 4.80
- 4.) My care coordinator returns my calls within 24 hours. 4.76
- 5.) I know how to reach my care coordinator's supervisor. 4.49
- 6.) The contents of the enrollment folder were explained to me. 4.76
- 7.) My care coordinator has talked with me about a Crisis/Safety Plan for my family. 4.71
- 8.) I've been offered choices about the services my family receives. 4.56
- 9.) Overall, I feel satisfied with the services my family is receiving. 4.64

6-mo/yearly Care Coordination Family Survey - Overall 4.55

- 1.) My Care Coordinator has been polite and respectful to me and my family. 4.81
- 2.) I am seeing my Care Coordinator as often as I'd like to. 4.54
- 3.) My Care Coordinator returns my call within 24 hours. 4.60
- 4.) My Care Coordinator follows through with what she/he says she/he is going to do. 4.59
- 5.) Meetings with my care coordinator have been scheduled at times and places that are convenient for me. 4.75
- 6.) I feel Wraparound has been sensitive to my cultural, ethnic and religious needs. 4.67
- 7.) I would be comfortable calling my care coordinator's supervisor if I had any concerns. 4.61
- 8.) I've had the opportunity to include people on my team that are important in our family's life. 4.61
- 9.) I get a copy of every Plan of Care. 4.61

- 10.) I understand my Plan of Care and how it can help me and my family. 4.51
- 11.) I have been offered choices about the services my family receives. 4.43
- 12.) My team is starting to work to prepare my family for disenrollment from Wraparound. 3.69
- 13.) Overall, I feel the care provided to me/my family so far has been helpful. 4.42

Disenrollment Youth Progress Report – Overall 3.75

- 1.) I'm doing better in school than I did before. 3.78
- 2.) I am getting along better with my family than I did before. 3.91
- 3.) I feel like I'm getting along better with my friends than I did before. 3.73
- 4.) I feel my behavior has gotten better since I was enrolled in Wraparound. 4.07
- 5.) On a scale of 1 to 5 how do you feel you are doing right now? 4.01

Disenrollment Family Progress Report – Overall 3.81

- 1.) I feel my family has made significant progress in meeting the Family Vision we have been working towards. 3.88
- 2.) I feel my child's educational needs have been met. 3.48
- 3.) Overall, I feel that Wraparound/REACH helped me be better able to handle challenging situations. 4.14
- 4.) I feel that I have family, friends and community resources that will be there for me and my family if I need them. 4.16
- 5.) If my family does have a crisis, I believe the final Crisis Plan my Team developed will help us. 4.05
- 6.) After disenrollment, I will know how to get services and supports that my family may still need. 4.15
- 7.) On a scale of 1-5, how do you feel your family is doing right now? 3.81



Family Satisfaction Levels related to Provider Network Services

Families also receive surveys inquiring about their satisfaction level related to the services they receive through Wraparound Provider Network. Each survey is reflective of the specific service that a specific Network Provider provides to the family. A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available. These surveys are distributed to the families during their 4th and 9th month of enrollment.

NOTE: This survey process was only in effect until July of 2016. The results below are reflective of outcomes through that time period.

Survey Time Frame	# of Surveys Sent	# of Surveys Recv'd	Return Rate	Average Overall Score
4-Month	1,226	45	3.6%	4.31
9-Month	1,204	62	5.1%	4.26

4-month Provider Survey Results – Overall 4.31

1.)	Focuses on my family's strengths	4.27
2.)	Understands our family's needs and limits.	4.20
3.)	Is sensitive to our cultural needs	4.36
4.)	Listens to my family	4.38
5.)	Follows my family's Plan of Care	4.30
6.)	Is respectful to my family	4.49
7.)	Is available when we need him/her	4.18

9-month Provider Survey Results – Overall 4.26

1.)	Focuses on my family's strengths	4.26
2.)	Understands our family's needs and limits.	4.23
3.)	Is sensitive to our cultural needs	4.22
4.)	Listens to my family	4.19
5.)	Follows my family's Plan of Care	4.29
6.)	Is respectful to my family	4.24
7.)	Is available when we need him/her	4.24



Provider Survey Outcomes by Service

Referenced below are the overall service satisfaction outcomes per the data that has been collected and entered into Synthesis for 2016. Only those services in which at least 5 surveys have been received are reported on. A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available.

Service Name	# of Surveys Recv'd	# of Agencies Represented	Overall Average (Range)	2015 Overall Average
Crisis Stabilization	42	8	4.19 (3.0 – 5.0)	4.46
Group Home Care	9	7	3.6 (2.13 – 4.39)	3.28
In-Home Therapy	22	7	4.34 (3.57- 5.0)	4.5
Individual & Family Therapy-Office-based	12	7	3.95 (3.0 – 5.0)	4.53
Individual & Family Training and Support Services	6	2	4.83 (4.5 – 5.0)	N/A
Residential Care	5	4	2.89 (1.75 – 3.86)	3.49

New Family Provider Satisfaction Survey Process

Effective in October, a new survey and survey process was implemented seeking feedback from families and youth about the services they receive from the Providers in the Wraparound Provider Network. This change, in part, was implemented to improve the return rate, but more so to encourage a dialogue between the Care Coordinator and the Caregiver and now the Care Coordinator and the Youth about their perception of the services they are receiving.

The survey is administered (face-to-face) by the Care Coordinator on a quarterly basis after receiving the survey worksheets from Wraparound. This face-to-face dialogue increases the likelihood that the survey will be completed and that the caregiver/youth will be heard.

The caregiver and youth are each asked the two questions referenced below regarding every provider that provided services to them during the previous three months.

The survey questions consist of:

Ranking Key:

*Overall, how satisfied are you with this provider?						
1	2	3	4	5	6	7
Very Dissatisfied	Dissatisfied	Somewhat Satisfied	Satisfied	Very Satisfied	Not Applicable	Provider Too New

**How helpful has the provider been in assisting you in making progress?						
1	2	3	4	5	6	7
Never Helpful	Hardly Ever Helpful	Somewhat Helpful	Mostly Helpful	Very Helpful	Not Applicable	Provider Too New

Family and youth responses are then entered into Synthesis by the Care Coordination agency. Outcome reports will be run and analyzed beginning in 2017.

Costs/Services

The cost of providing services for the youth in Wraparound/REACH is less than the cost of care in alternative children's mental health systems and other systems of care.



The overall total number of youth serviced in some capacity in WRAP and REACH from 1/1/16 – 12/31/16 was 1,670.

The average overall cost per month/per enrollee was \$3,124.00

(This cost includes the provision of care coordination services in addition to all other authorized provider network services)

The total paid for services in 2016 was \$44,300,194.00

Listed below are several program cost comparisons as it relates to the provision of services. Please note that the monthly cost for Wraparound/REACH type services may also include providing care to other family members in addition to the identified enrollee.

PROGRAM	APPROXIMATE AVERAGE COST PER MONTH/PER YOUTH
Wraparound Milwaukee	\$3,124
Group Homes	\$5,954
Corrections	\$8,640
Residential Care	\$10,685
Psychiatric Inpt. Hospital	\$38,086

Listed below are the **top five service groups utilized** per authorizations from January through December 2016 in which the client/family were the primary recipients.

- 1.) **Crisis Stabilization/Supervision** 1,437 or 86% of the youth utilized this service in some capacity
- 2.) **In-Home Therapy (Lead-Medicaid)** 932 or 56% of the youth/families utilized this service in some capacity
- 3.) **Transportation** 805 or 48% of the youth/families utilized this type of service in some capacity
- 4.) **Outpatient Therapies** 696 or 42% of the youth/families utilized this service in some capacity
- 5.) **Psychological Assessments** 518 or 31% of the youth utilized this service in some capacity

Although not considered a specific service per se, it is important to note:

One-thousand and thirty-eight (1,038) or 62% of the youth/families utilized **Discretionary Funds** in some capacity. Discretionary funds are flex monies that are often utilized to assist the family in meeting a need that may not be connected to a specific provider-related network service.

The majority of Discretionary Fund requests (excluding Miscellaneous funds) are for assistance/support with Rent/Security Deposits, recreation, groceries/household supplies and clothing/shoes.

The **five most costly service areas** (excluding Care Coordination) for 2016 (though not necessarily the most utilized) are:

1. Crisis Services at 40.1% of the total paid
2. Residential Care at 28.3% of the total paid
3. In-Home Therapy at 18.8% of the total paid
4. Group Home Care at 13.4% of the total paid
5. Foster Care at 9.9% of the total paid

III. Process Indicators

Plan of Care

The Plan of Care (POC) is a family and needs-driven document utilizing the strengths of the child/family. The POC is comprehensive and is the driving force behind the services provided. The initial POC meeting is expected to occur within the first 30 days after enrollment. Subsequent POC meetings should be held at least every 60 - 90 days.



Wraparound uses a ranking system in which the family scores each identified "Need" on the Plan of Care.

A 1-5 ranking scale is utilized. Starting with 1 meaning minimal progress was made in that Needs area to 5 meaning that the Need has been successfully met.

Average overall 2016 "Need Ranking" score at discharge for Wraparound/REACH was 2.78 (N= 580)

In 2015 the final score was 3.24 (N = 545)

The established threshold of desired performance is a 3.75.

Audits/Evaluations/Reports & Utilization Review



Wraparound uses auditing processes, surveys, evaluation data and other reported outcomes, as an ongoing means of monitoring the quality of care being provided to youth and families and compliance with Policies and Fee for Service Agreement expectations.

Plan of Care (POC) Audits

During 2016, extensive work was given to reviewing and assessing the current POC approval and auditing process. Dialogue ensued focusing on the quality of the Plans, the approval process at both the Care Coordination Supervisor level and the Wraparound Administrative level and the best methodology to use in moving forward with auditing POC's.

An extensive/comprehensive **POC Checklist Tool** and the new **POC Rubric Auditing Tool** were finalized in 2016. The process for ongoing POC auditing was created and implemented. Several variables are assessed when choosing Plans for auditing. Efforts are being made to audit 5% of an agencies Plans in a 6-month period of time. The compliance results are then reported bi-annually on the care coordination agencies Agency Performance Report. **The current compliance threshold is 90%.**

Audits/Reviews of Provider Network Agencies

Crisis Stabilization/Supervision Audit

A **Crisis Stabilization Audit** was conducted in 2016 assessing **agency and provider indicators** such as evidence of coverage plans, staff training and driver's abstracts.

The results revealed the following:

A total of **nine agencies were in the audit sample** representing **41 staff** (10% of each agencies active crisis providers). Compliance scores with the **agency indicators ranged from 50% to 100%** with an overall **average of 94.4%**. Compliance with **provider indicators ranged from 74% to 100%** with an overall **average of 92.8%**.

Overall audit compliance score was 93.8%.

In 2017, the second half of the audit will be conducted assessing compliance with crisis documentation.

Performance Improvement Project (PIP)

Wraparound Milwaukee must engage in one Performance Improvement Project per year as mandated by our Medicaid Contract with the State of Wisconsin. The project must focus on a clinical or administrative issue that the program wants to further explore in an effort to engage in a quality improvement endeavor that impacts on client care.

The 2016 PIP was entitled, "Integration of a Health Home Model: First Steps".

Family and Community-Based Service Delivery & Collaboration



Services and support are provided in the youth's natural environment, including home, school and community. Collaboration within the Child and Family Team, meaning the network of formal and informal supports, must be evident.

Identified community-based supports/resources on the Plan of Care Strengths Discovery List are coded in Synthesis. These resources are considered to be "informal or natural" supports, i.e. - are individuals on the Team that are volunteers (unpaid supports), family members, neighbors, clergy affiliations, etc. These supports must be actively utilized, i.e. - be within the "Strategy" related to a "Need", to be calculated within the data.

Wraparound strives for at least 50% of the active members on any Team to be informal or natural supports.

From 2/1/16 – 1/31/17:

Indicator	Threshold	Wraparound	REACH
% of informal or natural supports on the Child and Family Teams	50%	41.5%	44.8%
% of at least one informal or natural support in attendance at the Child and Family Team Meeting	50%	24.6%	26.3%

In summary, the PIP focused on the implementation and tracking process of acquiring enrollee Primary Care Physician medical records in an effort to treat the youth in a more holistic fashion at the Wraparound Milwaukee Wellness Clinic.

The full PIP will be available for viewing on Wraparound's website mid 2017.

Utilization Review

Service Group – WRAP and REACH	Average Total Paid Per Child/Per Month for CY 2016		# of youth served		% of youth served	
	WRAP	REACH	WRAP	REACH	WRAP	REACH
AODA Svcs.	\$4.13	\$0.15	139	3	0.1%	0.0%
Care Coordination	\$762.86	\$534.36	979	691	23.1%	35.3%
Child Care/Rec.	\$5.57	\$9.82	29	26	0.2%	0.6%
Crisis Svcs.	\$426.08	\$410.99	855	582	12.9%	27.2%
Day Treatment	\$5.44	\$0.00	12	0	0.2%	0.0%
Discretionary Funds	\$11.79	\$8.40	456	582	0.4%	0.6%
Fam/Parent Support Services	\$23.58	\$63.22	145	300	0.7%	4.2%
Foster Care	\$325.80	\$0.00	157	0	9.9%	0.0%
Group Home	\$437.82	\$2.37	261	14	13.2%	0.2%
Independent Living	\$34.60	\$0.00	20	0	1.0%	0.0%
In-Home Therapy	\$124.50	\$226.58	483	449	3.8%	15.0%
Inpatient Hosp.	\$69.24	\$124.07	99	109	2.1%	8.2%
Life Skills	\$23.85	\$14.47	179	53	0.7%	1.0%
Med. Mngmt./Nursing	\$4.01	\$1.60	115	30	0.1%	0.1%
Occupational Therapy	\$0.0045 .17	\$3.48	0	29	0.0%	0.2%
Outpatient Therapies	\$13.09	\$35.87	451	245	1.4%	2.4%
Psychological Assess.	\$937.28	\$9.01	350	168	0.4%	0.6%
Residential Treatment	\$5.61	\$0.00	226	0	28.3%	0.0%
Respite	\$3.20	\$0.00	64	0	0.2%	0.0%
Shelter	\$3.20	\$0.00	15	0	0.1%	0.0%
Transportation	\$32.84	\$0.00	524	281	1.0%	1.8%
Youth Support Svcs.	\$10.51	\$27.55	172	202	0.3%	2.7%

IV. Structure Indicators

Wraparound Milwaukee, as a system of care, utilizes a diversified administrative team, which assesses Provider services, provides training in Wraparound philosophy, and establishes policies and procedures. A structured intake process is utilized with reference to enrolling families into the program. A Care Coordinator is assigned to work with every family. The Care Coordinator organizes and coordinates care for the youth and family. Each family has a Child and Family Team that meets regularly. The Team develops and implements the Plan of Care.

Child and Family Team Meeting



A Child and Family Team (CFT) Meeting is expected to be held once a month to discuss the status of the Plan of Care and the child/family. The CFT meeting must be documented in the Care Coordinator's Progress Notes and be coded as such.

Per Progress Notes dated 1/1/16–12/31/16, the compliance score as it relates to holding a monthly Child and Family Team Meeting was **89.2%**. The compliance score in 2015 was 87.5%.

The established threshold for compliance is 85%.

Training

Care Coordinators receive 106+ hours of initial certification training in a curriculum developed by Wraparound Milwaukee. Care Coordinators are expected to complete the training within the first six months of employment. The Training Team consists of a diverse group of individuals from different disciplines. Parents/Caregivers are also training facilitators. Ongoing mandatory and non-mandatory meetings, inservices, conferences, re-certification training, etc. are also offered throughout the year for provider staff and/or families.



Four (4) New Care Coordinator Trainings were held during 2016. The training consists of 15 Modules totaling 106.5 hours. Each of the training modules integrates Trauma Informed Care concepts around adversity and trauma exposure, biological, neurological, relational, spiritual, behavioral and worldview impact, as well as respecting experientially driven behavior as indicative of trauma related needs. **Approximately 65 new Care Coordinators, Transition Coordinators and Professional Foster Parents** participated in the trainings. In addition, several

Families United of Milwaukee parent/youth facilitators joined to share their lived experience

Training was also **extended to** the Division of Milwaukee Child Protective Services **Ongoing Case Managers and Crisis Stabilization Providers** in the Wraparound Milwaukee Provider Network. **Approximately 10-15 Crisis Providers attended one or more modules.**

Motivational Interviewing (MI) techniques were woven into several of the Modules. An MI “booster session” was conducted in March 2016 for all Care Coordinators.

Wraparound Care Coordination Supervisors and Leads went through monthly **champion building sessions** to develop a more sophisticated understanding of trauma informed care concepts and practices, coaching techniques, leadership skills and other more targeted topics identified by them including working with LGBTQ youth, Commercial Sexual Exploitation of Children (CSEC) and cross system training with the Division of Milwaukee Child Protective Services around safety assessments.

Several in-services/workshops took place, providing continuing educational opportunities for Wraparound-related staff, Crisis Stabilizers and Human Service Workers.

These consisted of:

- Motivational Interviewing Booster session
- Disability Services Inservice
- Clinical Panel Inservice
- Trauma Informed Care- Level I and Level II Training continued
- Wraparound Administrative Panel
- Community Safety Inservice
- Special Education Updates and Advocacy
- Suicide Awareness
- Commercial Sexual Exploitation of Children (CSEC) Planning and Resources

Lastly, Wraparound hosted **two Trauma Informed Parenting trainings** that were open to and attended by parents, providers and care coordinators.

Grievances/Complaints/Administrative Concerns/Violations

Wraparound Milwaukee, as a system of care, has a formal grievance procedure and a complaint investigative and reporting process. Complaints can be generated by any party within the Wraparound System of Care. Grievances are primarily generated by family members/enrollees.



Zero (0) grievances were filed in 2016. Wraparound Milwaukee identifies a grievance as the action a recipient may choose to pursue if they are not happy with the outcome of a filed complaint.

<i># of 2014 complaints/ concerns 20 out of 1,692 served or 1.1%</i>	<i># of 2015 complaints/ concerns 20 out of 1,848 served or 1.08%</i>	<i># of 2016 complaints/ concerns 27 out of 1,670 served or 1.6%</i>
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Complaints/Administrative Concerns that were logged during the time frame of 1/1/16 – 12/31/16 consisted of:

**25 written
+ 2 verbal
27 total**

***NOTE: Exposure of confidential patient information (HIPAA) is considered an administrative violation and not a complaint. Ten (10) HIPAA violations were recorded in 2016.**

Complaints/Concerns were generated from the following sources:

- One (1) from a Critical Incident
- Two (2) from System Partners
- Three (3) from Providers
- Three (3) from “Other”
- Eight (8) from Parents/Guardians
- Ten (10) from Care Coordinators/Care Coordination Supervisors

Complaints/Concerns were filed against:

- Twenty-one (21) against Service Providers
- Six (6) against Care Coordination Agencies

Those that were filed related to:

- 1 related to client safety issues
- 4 related to not following Wraparound process
- 5 related to boundaries/ethical issues
- 5 related to lack of professionalism
- 5 related to service delivery issues
- 7 related to billing for services not provided

Complaint (n=19) Outcomes

- Twelve (12) complaints were **substantiated**
- Three (3) were **unsubstantiated**
- Three (3) were coded as **“Other”** as they were unable to be processed pending further investigation by the Milwaukee Police Department and/or Child Protective Services and another source.
- Two (2) pending completion of investigation.

Note: Those issues identified as “Administrative Concerns” (n= 8) do not receive an outcome identifier of substantiated or unsubstantiated.

Wraparound Provider

Network



The Wraparound Provider Network (WPN) is a diverse group of individuals/agencies that provide mental health and support services for the children and families in Wraparound, REACH, Family Intervention and Support Services (FISS), and the O'YEAH programs.

In 2016, the Network contained, on average, **115 Provider Agencies**. Approximately one hundred and thirteen (113) unique different types of services were offered.

The total number of agencies (duplicated) that provide one or more services within the **various service categories** consisted of:

- AODA Services = 10
- Care/Transition Coordination = 10
- Child Care/Recreation = 6
- Crisis-related Services = 32
- Day Treatment = 4
- Family/Parent Support Services = 12
- Foster Care = 12
- Group Homes = 22
- Independent Living Placement = 1
- In-Home Therapy Services = 27
- Life Skills Services = 5
- Med Mngmnt./Nursing Services = 9
- Outpatient Therapies = 38
- Psychological Assessment = 11
- Residential Care = 12
- Respite Services = 17
- Transportation = 10
- Youth Support Services = 18

There were one hundred and twenty-three (**123**) "**Out of Network**" requests that were submitted during 2016. Requests were primarily submitted for services such as psychiatry/mediation review, psychological evaluations, individual and special therapies, specialized crisis care and group home care. **Sixty-four (64) or 52%** of the requests were **approved**. **Fifty-nine (59) or 48%** were **denied** primarily due to the request actually being withdrawn/not needed, not being submitted in advance of the service being provided, the service already being offered in network, or the vendor actually declining/not accepting Wraparound rates.

No **New Provider Orientations** took place during 2016.

Two (2) Level I and one (1) Level II Wraparound Provider Philosophy Trainings were held. The trainings focus on the implementation of Wraparound philosophy and the Child and Family Team process. Both levels of training are 5 hrs. each with a lunch break. A total of seventy-eight (78) individual providers participated along with several parent representatives from Families United of Milwaukee, Inc.

The Wraparound Fiscal Department Manager created a **PowerPoint presentation for new vendors/vendor billing staff** that takes a person through the **invoicing process in Synthesis**. After viewing the presentation, the Fiscal Manager is available for any questions or further guidance that may be needed.

Five (5) Provider Forum Meetings took place. This meeting provides an arena in which network vendors assemble to receive updates and general information about the Wraparound Milwaukee program, Delinquency & Court Services Division (DCSD) programs. In addition, information from the BHD Network Services and Contract Management Department and the BHD Compliance Department share any relevant information. The Providers are also offered the opportunity to share information about their programs and ask any questions or express any concerns.

The **Wraparound Milwaukee Provider Resource Fair** was held on June 17th.

The Fair was held at the Zoofari Conference Center in Milwaukee. **Sixty-seven (67) vendors** set up resource booths displaying their agencies programs and services.

Approximately 302 youth and family members, 107 Care Coordinators/Leads/Supervisors, and 79 guests/others attended!

The Fair evaluation surveys revealed that 100% of the attendees felt that the Fair was helpful in providing them with information about resources in addition to being a great forum to meet and network with service providers.

Four new vendors entered the Provider Network in 2016:

- Ascent for Life, Inc.
- Educates, LLC
- Servant Manor Strategies
- Wisconsin Community Services, Inc.

In September, a "**New Provider Networking Event**" took place that offered families and Care Coordinators the opportunity to visit with and learn more about the new providers that had joined the Wraparound Provider Network and the services they had to offer.

Several **services/service codes** were created and/or restructured in the Provider Network in 2016. The new services and/or restructuring of services were implemented in an effort to address new client and programmatic needs or increase efficiencies. Listed below are the service/service code additions/revisions:



CODE	SERVICE	EFFECTIVE DATE
5004	NMT (Neurosequential Model of Therapeutics) Assessment	3/11/16
5630	Employment Related Skill Training Service	1/28/16
5632C/5632H	Psychoeducational Support Group	2/23/16
5052	Psychiatric Review/Meds – with Therapy, Special	2/29/16
5091	Permanency Services	2/23/16
5115A	Competency Restoration	5/12/16
5131C	Equine Therapy	4/18/16
5131E/5135F	Art/Music/Dance Therapy – Ind/Grp.	2/17/16
5133	High Risk Review/Consultation	3/1/16
5135A	Occupational Therapy	2/8/16
5303G/5303J	Crisis Stabilization, Out of Home/Specialized (enhanced)	1/21/16 and 11/29/16
5311E	Treatment Foster Care (Second Child)	10/14/16
5404	Adult Family Home	6/7/16
5500I	Care Coordination - Consultation	3/1/16
5568A	Specialized Academic Support Service	4/21/16
5902/5902A	Fitness/Recreation for Mental Health – Ind/Grp.	3/24/16 and 4/27/16
5905/5905A	Yoga/meditation – Grp./Ind	3/24/16 and 4/27/16

- Milwaukee Public School collaborations
- State of Wisconsin
- Justice Point

In 2016, the following OYEAH demographics were recorded for new enrollees:

Demographics	N =
Total Screenings	225
Total New Enrollments	119
Tier I	0
Tier II	104
Tier III	11
Disenrollments	82
Gender	50% Male (N=58) 49% Female (N=56) 1% Transgender (N=1)
Average Age	19.4
Ethnicity	67% African-American (N=77) 12% Caucasian (N=14) 9% Hispanic (N=10) 2% Native American (N=2) 10% Unknown/Other (N=12)

Average cost per member/per month for 2016 = \$1,142.00

of 2016 Disenrollment's = 82

OYEAH Program

The OYEAH (Older Youth and Emerging Adult Heroes) Program, a program administered under the auspices of Wraparound Milwaukee, is designed to support older youth and young adults ages 16.5 – 24 who may be experiencing emotional and behavioral challenges, to successfully transition to adulthood. This is a voluntary program.



OYEAH, now entering its 9th year of providing service, continues to look at areas that present challenges for transitional age young adults. Several partnerships have been established over the years that provide services/support to the youth. These include:

- Milwaukee County Adult Community Services
- Milwaukee County Adult Services Liaison
- Pathfinders Milwaukee, Inc.
- Lad Lake
- Journey House
- LaCausa

The various Tiers represent different levels of programmatic intervention. Young adults are guided into a Tier that would best support their needs as identified through the screening process. Tier 1 is the most intensive.

Futures Plans

Futures Plans are the Plan that the young adult establishes based on their individual vision of adulthood. They will explore their needs and strengths and what supports may be necessary for them to achieve their hopes and dreams. Several "Life Domains" are addressed within the Plans.

Domain Category	# of times the Domain was identified in a Futures Plan in 2016
Educational/Vocational	152
Family	11
Health and Well being	27
Legal/Restoration	25
Living Situation	49
Mental Health	186
Safety	9
Social/Recreational	11
Transition to Adulthood	140
Other	4

OYEAH uses a ranking system in which the enrollee scores each identified Domain on the Futures Plan.

A 1-5 ranking scale is utilized. Starting with 1 meaning minimal progress was made in that Domain area to 5 meaning that the Domain area needs have been successfully met.

Out of the 736 Domains identified one-hundred and twelve (112) were closed out. The average change from the initial Domain Ranking value (Scale of 1-5, with 1 meaning minimal progress was made in that area, to 5 meaning maximal progress has been in that area) to the final Domain Ranking value were as follows:

Domain Category	Average Change in Value
Educational/Vocational	+1.57
Health and Well being	+2.11
Legal/Restoration	+2.36
Living Situation	+ .71
Mental Health	+2.07
Safety	+1.67
Social/Recreational	+ .33
Transition to Adulthood	+1.37

OYEAH Service Utilization

Service Group	Average Total Paid Per Enrollee/Per Month for CY 2016	# served	% served
AODA Svcs.	\$1.12	6	0.1%
Care Coordination	\$483.39	219	49.6%
Child Care/Rec.	\$0.00	0	0%
Crisis Svcs.	\$200.57	97	20.6%
Day Treatment	\$0.00	0	0%
Discretionary Funds	\$24.95	123	2.6%
Fam/Parent Support Services	\$20.38	13	2.1%
Foster Care	\$0.00	1	0%
Group Home	\$3.28	2	.3%
Independent Living	\$8.82	1	.9%
In-Home Therapy	\$104.99	73	10.8%
Inpatient Hosp.	\$24.07	18	2.5%
Life Skills	\$17.82	18	1.8%
Med. Mngmt. /Nursing	\$10.31	38	1.14%
Occupational Therapy	\$0.00	0	0%
Outpatient Therapies	\$18.63	70	1.9%
Psychological Assess.	\$7.28	37	.7%
Residential Treatment	\$0.00	0	0%

Respite	\$0.00	0	0%
Shelter	\$0.00	0	0%
Transportation	\$39.07	105	4.0%
Youth Support Svcs.	\$9.21	22	.9%

OYEAH Campus Housing

Beginning in 2015 OYEAH partnered with Journey House to provide supported apartments for young adults that were enrolled in OYEAH and in need of stable housing. In 2016 OYEAH and Journey House were able to add 4 more apartments for our young adults, bringing the total to 10 apartments. Young adults are able to live in these apartments under a modified rental agreement and monthly rent payment. Using a Housing First model, young adults are able to live in these apartments for up to 12 months while working on school and employment goals and learning the skills to live a successful independent life.



Owen's Place

Owen's Place is a resource center designed to assist young adults between the ages of 16.5 and 24 years whose mental health needs may be impacting on their ability to lead an independent life.

Owen's Place happenings in 2016:

Owen's Place is continually expanding its community partnerships and community resources in Milwaukee County to provide our young adults with a variety of programming that will help them seamlessly transition to adulthood. Our 2016 partnerships included but were not limited to:

- Mental Health of America (Stress and Anger Management Workshop)
- Know Thyself (Know Thyself Project)
- Milwaukee Center for Children and Youth (Safe and Smart Youth)
- Independence First (My Brother's Keeper Workshop)
- La Causa (My Life My Choice Workshop)
- Diverse and Resilient (414 All Campaign)

Beside collaborating with community partners to host workshops and programming at Owens Place, we have empowered our Peer Specialist and allowed him to take on a direct role as a facilitator. In 2016, our Peer Specialist hosted a plethora of workshops based on lived experiences that not only engaged young adults but also empowered them to take ownership of their own lives. The workshops that our Peer Specialist hosted were...

- **Dinner and Discussion-** This was a series of dinners and discussions that talked about community issues and

allowed for conversation about our community in a safe environment. IN addition, the program allowed for young adults to learn or become refreshed on new Independent Living skills such as using a can opener, reading the instructions on the back of a box to learn how to cook and how to set a dinner table.

- **Social Media Do's and Don'ts**- Living in a social media world, young adults were empowered to make better choices when using social media. This included having discretion when interacting with strangers online, being mindful of what you post and acknowledging that not only friends and family can see what we post but also current employers, potential employers and law enforcement.
- **Teens vs. Food**- This was our platform in which we taught young adults about budgeting and introduced couponing, meal prepping and the importance of planning ahead.
- **Family Fun Night**- This event was created to supplement our engagement with families, allow families to access Owen's Place, and serve as an introduction to the younger youth to learn about Owens Place as a future resource.
- **Mock Interviews**- This workshop was created for youth and young adults who are on an employment track. It gives them an opportunity to practice interview skills and be prepared for an actual interview.

Owens Place now can provide **work permits** to those who are under 18 years of age!



Owens Place is continuously focusing on ways to be innovative and community oriented. We are looking forward to the community relationships that we will be creating in 2017.

Submitted by:

Shannon Trzebiatowski, MS
Program Manager, O'YEAH/Owen's Place

M.O.V.E.
WISCONSIN



M.O.V.E. WISCONSIN

(Wisconsin Youth Motivating Others through Voices of Experience) **is a youth-run organization designed to empower adolescents and young adults involved in the Wraparound Milwaukee program. Community-based activities are planned and implemented focusing on leadership development and creativity. The group meets at Owen's Place the 1st and 3rd Wednesday of each month.**

In 2016, MOVE Wisconsin was the founding voice behind the **Young Adult Food Pantry** and **Hygiene Closet** at Owen's Place. This was created to help alleviate some of the stress of not having food for this age group and also to help bridge food insecurities for the 16 to 24-year-old population that we serve. The Pantry is still in the startup phase while our Owen's Place team is seeking ways to secure funding in order to sustain this effort to meet the growing need.

Also in 2016, MOVE Wisconsin **consulted with Youth MOVE Oregon** for technical assistance through their YOUTH PROGRAM BUILDER, which provided Owen's Place with innovative ways to engage and retain participation.

MOVE Wisconsin was represented at the **National Children's Mental Health research conference** where we were able to meet with and learn from other Youth MOVE Leaders from Phoenix, Illinois, Atlanta, Michigan, Oregon and DC. At the conference, MOVE Wisconsin was privy to attend a series of engagement workshops designed by Youth MOVE National where we had an opportunity to participate on a live Text Talk and Act Event.

Thanks to the many relationships formed at National Children's Mental Health Research Conference, MOVE Wisconsin was visited by Youth MOVE Indiana where we spent two days together to shared ideas and lessons learned.

In 2015, MOVE Wisconsin created an **anti-stigma campaign called REPLACE LABELS WITH LOVE**. We carried this campaign into 2016 and were able spread this message with our friends over at Youth MOVE Utah who used this as their theme for their Annual Art Show. Youth MOVE Utah incorporated this campaign by displaying pieces inspired by the Replace Labels With Love campaign.

Lastly, MOVE Wisconsin had a **variety of accomplishments** that included...

- Collaboration with the Department of Children and Families (DCF) and Juvenile Justice in creating the structural outline for the Juvenile Justice Youth Council.
- MOVE was consulted by the Department of Health Services to assist with the startup of Project YES (Youth Empowered Solutions)
- MOVE became an active member of Milwaukee Succeeds and the Opportunity Youth Initiative

Submitted by:

Wilton Johnson, State Certified Peer Specialist, Young Adult Advisor at Owen's Place and MOVE WI State Coordinator

FISS Program

The FISS (Family Intervention and Support Services) Program is a program administered through the Milwaukee County



Behavioral Health Division per a contractual agreement with the Division of Milwaukee Child Protective Services (DMCPS). Milwaukee County was awarded the contract, which began in July of 2012.

The program is designed to assess and provide services to families experiencing life challenges with their adolescent child age 12-18. The FISS program goal is to strengthen the parent/guardian's ability to support their adolescent in the home, community and school.

The FISS program has two components:

1. **Assessment** - Assessments are conducted either in the office or in the home utilizing tools provided by DMCPS. Based on the assessment results and supervisory consultation, the family is referred to the FISS services unit, DMCPS, Milwaukee County Department of Human Services Delinquency and Court Services, or programs/agencies in the community.
2. **Case Management** - The FISS services unit provides families with a case manager (contracted through St. Charles Youth and Family Services) who utilizes Wraparound Milwaukee's provider network, crisis services through the Mobile Urgent Treatment Team, and community agencies to formulate and implement a service plan with the family. Case managers utilize the Wraparound philosophy and Coordinated Service Team approach with the goals of providing stabilization, and sustainable connections to community resources. The approach is strength based, and utilizes a combination of paid network services, natural supports, and community based services.

In 2016, the following FISS demographics were recorded:

Demographic	N/% =
Assessments Completed (Individuals)	583
Assessment No Show/Cancel Rate	319/902 or 35%
Enrollments (families) into FISS Case Management	103
Disenrollment's (families) from FISS Case Management	105
Average Length of Stay (ALOS)	3 to 4 months

Submitted by:

Stacy Kozel, LCSW

2016 Program Coordinator - FISS

Associate Director - Wraparound Milwaukee

V. Other Accomplishments

Positive Recognition Announcements

A total of 53 Families/Service Providers/System Collaborators and/or Care



Coordinators were recognized in 2016 through the **Positive Recognition Announcement**. The Positive Recognition Announcement is a format that enables anyone involved in the Wraparound system of care to recognize the hard work, dedication, perseverance, etc., of another. Those recognized are identified in the monthly Wraparound Newsletter.



Some great things our families and system partners have said about Care Coordinators/Team members!

"D. went above and beyond his duties and provided my son a toddler mattress for the purpose of helping my son with gaining confidence in sleeping alone. D. took the time to bring the mattress to our home and helped set it up. D. is very knowledgeable in his field and really cares about the family as a whole".

"I just want to recognize M. for her outstanding work with families. She is very consistent and reliable and families love working with her! (As well as providers) She is so welcoming, calm, and inviting and a tremendous "team player". Thank you so much M.!"

"Mr. R. should be acknowledged because he is skilled in the services he provides. I really appreciate him listening to my concerns as a single parent coping with a child with special needs. I am always learning new ways and ideas to deal with my families situation and to treat every day as a new day".

"R. offers great advice. She has helped me to better understand my children. If it wasn't for her, I don't think I would have come this far in accomplishing everything I have. R. is a great person and great parent coach".



Research Activity

As a data driven program, Wraparound Milwaukee collects and analyzes data to assure accountability and responsiveness to the Wraparound model and the children and families we serve. In 2016, the research arm of Wraparound Milwaukee was involved with a number of initiatives. The highlights are:

- An outcome status report of the FOCUS program was completed. FOCUS is a program within the Wraparound Milwaukee System of Care for youth who exhibit high risk behaviors that place them at risk for commitment

to the Department of Juvenile Corrections. Youth enrolled in FOCUS are initially placed in a non-secure therapeutic residential facility. A variety of services are provided that are deemed necessary to meet their needs. The outcomes revealed that there appears to be a strong relationship between youth that meet criteria for the FOCUS program, as well as the amount of time invested in the therapeutic aspects of the program (including the Juvenile Cognitive Interventions Program - JCIP), and the potential for successful completion and moving back into the community without additional charges.

- A research study was conducted exploring how the mentorship relationship serves to enhance or challenge resilience from both the mentee and mentor perspective. The specific research question was: *How does the relationship that is formed by being mentored, and then participating in the act of mentoring, have an effect on the personal overall resiliency of the person?* The outcomes revealed many consistencies across mentors, which results in informing training, supervision, and support practices in the fields of mentoring, trauma/mental health and social services.

Two presentations on the mentoring research, entitled *A Path to Trauma Mastery* was delivered at the Children's Come First Conference in Wisconsin and the national Children's Mental Health Research & Policy Conference.

- Outcome data measurement information for a number of programs including OYEAH, CORE and YLOL was provided as needed.
- Conducted the 2016 Performance Improvement Project (See page 7).

Submitted By: Pnina Goldfarb, PhD
Wraparound Milwaukee Research Consultant

Family Orientations

Eight (8) Family Orientations were held. On average, five (5) Families United of Milwaukee representatives assisted with each orientation providing support and guidance.



The orientations are **sponsored by Families United of Milwaukee, Inc. in partnership with Wraparound Milwaukee.** The orientations focus on defining Wraparound and Families United roles and what they can offer the families as well as the role of the Care Coordinator. In addition, Child and Family Team Composition, MOVE Wisconsin, service provision, system partner collaboration, crisis services, paperwork/evaluation requirements and the disenrollment process are discussed.

Lunch is served and families are provided with a grocery store gift card as a welcoming and thank you for attending the orientation.

All new families entering the Wraparound system of care are invited and encouraged to attend. Families United of Milwaukee staffs continue to call families in an effort to encourage attendance at the Family Orientations.

In 2017, the Family Orientation will undergo an update to the format and location!

Visits from other Sites/Programs, Technical Assistance, Presentations



August 2016 – On August 9th Wraparounds new Medicaid Contract Monitor, Ms. Joelle Espinosa, visited Wraparound to learn about all components of the program.

October 2016 – Staff from **Choices Coordinated Care Solutions in Illinois** visited Wraparound on October 5th to learn more about provider services and network operations. They were especially interested in Crisis Services at they build their Mobile Crisis Response Team.

October 2016 – **An individual from Australia** visited Wraparound from October 3rd – 7th to learn about several components of the Wraparound Milwaukee program. These included program components, funding structure, family and educational advocacy quality assurance, crisis services, care coordination, the Wellness Clinic, Milwaukee County Children's Court Center, the OYEAH program and Owen's Place.

Mobile Urgent Treatment Team



In 2016, the **Mobile Urgent Treatment Team provided over 14,000 hours of crisis services** to children and families across the Wraparound Milwaukee programs, the community at large, and through the Trauma Response collaboration with the Milwaukee Police Department. This includes over **900 children seen for the first time**, along with hundreds of other children who have relied on mobile crisis services in the past. Some children and families used mobile crisis services only one time, while others used them more often to support their family in the community. In keeping with Wraparound Milwaukee's and the Mobile Urgent Treatment Teams crisis philosophy, the vast majority of children were seen face-to-face, in natural community settings such as home and school.

The **Trauma Response Team**, working in collaboration with the Milwaukee Police Department, added staff, and by the end of the year was poised to **expand into Police District 5** under a grant from the City of Milwaukee Office of Violence Prevention. With the full support of the County Executive's office, the program received **240 referrals from District 7** alone in 2016, and was able to individualize service to those families. With

expansion to District 5, and the continued support of both the city and the county, this unique collaboration will continue to expand services to children and families affected by violent trauma.

Mobile Crisis staff continues to bring specialized **Dialectical Behavior Therapy (DBT)** to Wraparound youth in need of those services, as well as offering DBT consultation to therapists in the provider network interested in learning more.

Dr. Dykstra, the director of Mobile Crisis Services for youth, **helped train hundreds of police officers in Milwaukee and other districts as part of the Crisis Intervention Team, or CIT.** CIT is a nationally recognized best practice model for training police officers to work more effectively with citizens in a mental health crisis. By the end of 2016, nearly every police officer in MPD had completed some level of CIT. CIT has also been incorporated into standard training for all.

In 2016, Mobile Urgent Treatment Team provided services to the following number of youth in the following locations/through the following contact types:

Contact Location/Type	Distinct Number of Youth Seen
Children’s Court/Detention	14
Home	423
Wraparound Wellness Clinic	30
Psychiatric Crisis Services (PCS)/ Acute Inpt. Hospital	18
School	222
By phone	103
Other	162
TOTAL	941

Submitted by: Steven P. Dykstra, PhD
 Director, Mobile Urgent Treatment Team
 Licensed Psychologist

Proactive Outreach for the Health of Sexually Exploited Youth Project (POHSEY)



In January 2016, Wraparound Milwaukee continued the collaborative efforts of the Proactive Outreach of Sexually Exploited Youth (POHSEY) grant via a new Healthier Wisconsin Partnership Program (HWPP) grant – POHSEY II. While POHSEY I focused on gathering data to better understand the story of youth in Milwaukee County who have been sexually exploited, POHSEY II aims to transform how these youth experience healthcare by providing tools that empower medical providers to better meet their needs; this includes access to training, and more comprehensive medical templates, as well as advancing a coordinated system response.

Partners in POHSEY II include Dr. Wendi Ehrman from the Medical College of Wisconsin (MCW), Dr. Angela Rabbitt from MCW/Children’s Hospital, Claudine O’Leary from Rethink Resources, and Stephen Gilbertson the Clinical Director of Wraparound Milwaukee.

In order to meet the goals of POHSEY II, active training efforts are underway via in-person training opportunities, as well as an online training-module option. From pre/post assessments administered by POHSEY members during these trainings, the number of participants underestimating the local prevalence of CSEC (Commercial Sexual Exploitation of Children), on average, decreased from 44% to 20% after training, and those who agree or strongly agree that they feel confident in their ability to identify and care for victims increased from 22% to 52% after training. Training will be on-going throughout the two-year life of the grant.

In addition, several templates have been developed to assist the Children’s Hospital Emergency Department in more efficiently and effectively documenting, as well as responding to youth who are risk for, or have experienced sexual exploitation/trafficking. At the moment, drafts of the templates are being incorporated into EPIC, the Electronic Medical Record system utilized by Children’s Hospital. Partners are hopeful that once the templates are in place, they can be shared with other EPIC users to allow for other systems to complete a similar transformation. Throughout this time, meetings have been occurring regularly with other stakeholders to elicit feedback, and discuss changes that could be made within their own systems of care using the already developed templates.

POHSEY II is also charged with updating the POHSEY Resource Card, which provides individuals with supportive contact information so they can make quick connections for needed resources. An updated version should be available in May 2017.

Training materials for medical providers, and additional information about the grant, including community resources for youth and families in this situation, are available at www.pohsey.org.

Submitted by: Jenna Reetz, MSW
 Program Manager, Wraparound Milwaukee

“Welcome Home Teens in Motion” Support Group



Throughout 2016, the “Welcome Home Teens in Motion” youth group continued to meet monthly at Owen’s Place to support and address the needs of youth who are challenged by running away or their whereabouts becoming unknown. Each Care Coordination Agency was responsible for coordinating two of the groups over the year period. Several community resources were able to share information during meetings, and youth also participated in art projects and games centered on run-away behavior. In addition, the group offered a safe-space for youth to share their stories. At the end of 2016, both youth and professionals reviewed the “Teens in Motion” experience and exciting changes were made to the facilitation of the group beginning in 2017.

Submitted by: Jenna Reetz, MSW
 Program Manager, Wraparound Milwaukee

Teen Parent/Pregnancy Protocol and Pregnancy Prevention Program



In Wraparound's commitment to ensuring the safety and well-being of all children and families, the "Protocol for Teen Parents/Parents-To-Be/Pregnancy Prevention" was developed and implemented. In 2016 more than 30 pregnant/teen parents/ sexually active teens received support, guidance and care from a designated Wraparound Milwaukee nursing staff as it relates to sexual health issues, i.e. – Safe Sex, Sexually Transmitted Diseases, Birth-Control Education, Pregnancy and teen parent education like Safe Sleep and Shaken Baby Syndrome and Safety issues that relate to infant care and parenting. The protocol also ensures that every teen parent has access to a Pack and Play (promotes safe sleep) and community resources that can assist with additional support and guidance to pregnant and non-pregnant teens.

The protocol can be accessed at:
<http://wraparoundmke.com/?p=1285>

Teen Pregnancy and Protocol Brochure can be accessed at:
<http://wraparoundmke.com/?p=1284>

Submitted by: Maryan Torres, MSN APNP, FNP-BC, CPN
Wraparound Milwaukee Wellness Clinic

Milwaukee Adolescent Health Clinic/Wraparound



The Milwaukee Adolescent Health Program clinic continues to serve youths who have been identified as being commercially sexually exploited, domestically sex trafficked (CSE/DST) or at high risk for being sexually exploited. This clinic is in collaboration with the Downtown Health Clinic with funding from a federal grant through the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to mentor and provide services for youth who have been CES/DST. This year the program expanded the services to all youths involved in the Wraparound Program in need of adolescent health evaluations, Sexually Transmitted Infections (STI) screenings and options for birth control.

In 2016, the clinic saw more than 30 patients who were evaluated and received STI treatment services, birth control and support services that relate to adolescent health. The Clinic is staffed by Wendi Ehrman, M.D. of the Medical College of Wisconsin and Wraparound's Maryan Torres MSN, APNP, FNP-BC, CPN

Youth can be referred to the mentoring program from the clinic or referred to the clinic through the mentoring program. However, any youth participating in the mentoring program, including non-Wrap youth, are also eligible to receive services at the MAHP Clinic. The clinic is open one day per month, Monday

afternoon from 1-5 p.m. Call Maryan Torres (414 - 257-7624) for more information.

Submitted by: Maryan Torres, MSN, APNP, FNP-BC, CPN
Wraparound Milwaukee Wellness Clinic

Wraparound Wellness Clinic



During 2016, Wraparound's Wellness Clinic continued to provide medication management and wellness/education services to the youth involved in the Wraparound and REACH programs.

In 2016 the following occurred:

- Modifications were made to several processes in an effort to further incorporate the Health Home Model of care. One of the primary modifications focused on getting and reviewing information from youth's primary care physicians in an effort to support a more holistic approach to care. Incorporating this process into the daily routine of the clinic was Wraparound Milwaukee's Performance Improvement in 2016.
- Efforts began on hiring an Advance Practice Nurse Practitioner.
- A fully functional CORE Team was providing immediate and consistent care to youth/young adults experiencing their first episode of psychosis.

CORE (Coordinated Opportunities for Recovery and Empowerment) Program



The CORE program is a newer program being offered under the Wraparound Milwaukee system of care that **offers comprehensive and specialized mental health services and support to individual's ages 15-23 years old (though sometimes younger) that are experiencing their first episode of psychosis.** Some symptoms the individual may be experiencing include hallucinations, delusions, unusual thoughts, disorganized thinking/speech or disruption of self-care.

Services are delivered by a 5-person team for up to 2 years.

Services include:

- ✓ Care Coordination
- ✓ Individual Therapy
- ✓ Peer Support
- ✓ Medication Management/Psychiatric Services
- ✓ Employment and Education Support
- ✓ Other services that may be needed to meet the individuals needs

Currently, there are three Teams providing services.

In 2016, the CORE Program enrolled 33 new participants.

GENDER

Male = 24 (73%)
Female = 8 (24%)
Transgender = 1 (3%)

AGE

Average age = 18.4 years old
Range = 15yo – 23yo

ETHNICITY

African American = 18 (55%)
Hispanic = 9 (27%)
Asian = 1 (3%)
Other/Unknown = 5 (15%)

DIAGNOSIS The majority of diagnoses of 2016 enrollees were:

- Psychotic Disorder, NOS
- Schizophrenia, Undifferentiated Type
- Schizophreniform Disorder
- Cannabis Abuse

INPATIENT HOSPITAL DAYS

In 2016, fourteen of the thirty-three enrollees were hospitalized for a total of 322 inpt. hospital days. The average length of stay was 10.7 days; the mode was 7 days, with the range being from 1 day to 46 days.

AVERAGE COST PER MONTH/PER ENROLLEE

\$2,442.00

WELL- BEING ASSESSMENT

CORE uses the Well-Being Self-Assessment (Warwick) to assess overall well-being. This tool is administered every 6 months. A scale of 1-5 is utilized with 1 generally meaning none of the time (low sense of well-being) and 5 generally meaning all of the time (high sense of well-being).

Of those enrollees that took the assessment during (9/1/16 – 2/1/17) the **overall average score was 3.45/5.0**. The scores ranged from 3.06 – 3.84. The lowest scores were reflected in those answers related to feeling close to other people and/or being interested in other people.

A referral to the program can be made by calling the REACH Intake Line at (414) 257-7607. For general information, you can contact Brian McBride at (414) 257-7158.

Youth Living Out Loud (YLOL)

YLOL is a mentoring program being administered under the Wraparound Milwaukee system of care, the works with youth who have been, or are at for being commercially sexually exploited or trafficked.



high risk

At the end of 2016, Youth Living Out Loud (YLOL) entered the third and final year of the grant initially awarded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Partners

include La Causa, Inc., Diverse & Resilient, Rethink Resources, Medical College of Wisconsin and Wraparound Milwaukee. Throughout the year, YLOL continued to provide specialized mentoring services to identified youth who are significantly at risk for, or have been sexually exploited/trafficked. These services continue to be provided within the wider context of Wraparound Milwaukee, so youth and families remain connected to additional treatment opportunities. Enrolled youth have the opportunity to participate in a clinic offered by Dr. Wendi Erhman (MCW) and Maryan Torres, RN (Wraparound) to address any on-going medical needs or concerns.

Each youth in this service completed a Mentor Action Plan (MAP), which supports them in developing skills around goal-setting, as well as ensures their voice is heard. A copy of the MAP was shared by YLOL representatives at the Grantee Meeting in Denver, CO; it was well received by other awardee sites.

A second round of comprehensive training was conducted in 2016 to bring on additional mentors to meet the needs of this population and address retention concerns. In addition to initial training modules, mentors also received ongoing weekly supervision, coaching, support groups and in-service training opportunities to ensure they could meet the needs of youth. La Causa Supervisor Tiffany Wilhelm was able to share information about YLOL at the National Mentoring Conference in Washington, D.C., which was well received. At this time, Partners are participating in detailed discussions about sustainability, as the grant ends in September 2017.

Submitted by: Jenna Reetz, MSW
Program Manager
Wraparound Milwaukee

Collaborations with other programs in the Behavioral Health Division (BHD) and the Department of Health and Human Services (DHHS)



In 2016, Wraparound Milwaukee participated in several Behavioral Health Division and/or Department of Health and Human Services (DHHS) committees and workgroups as BHD/DHHS moves forward with its strategic plans for the future. Those committees/workgroups consisted of:

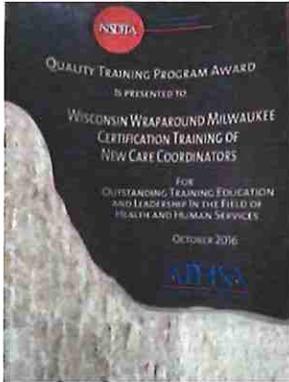
- BHD Family Advisory Council
- BHD Patient Rights Committee
- BHD PolicyStat Committee
- BHD Quality Strategic Planning Committee
- BHD Client Experience Survey Charter
- BHD Performance - Based Measures Charter
- BHD Compliments, Complaints and Grievance Charter
- BHD Incident Reporting Charter
- BHD Data Management Charter
- BHD Case Management Charter
- DHHS Strategic Planning Committees (Internal Satisfaction of County Services for Employees,

Standardized Employee Policies, High Quality and Accountable Service Delivery)

In addition, Wraparound engaged in ongoing meetings with the BHD Contract Management, Network Services and Compliance area.

Quality Training Program Award

In October of 2016, Wraparound Milwaukee was awarded the "Quality Training Program Award" by the American Public Human Services Association (APHSA). The award recognizes Outstanding Training Education and Leadership in the Field of Health and Human Services. Wraparound specifically received the award for its New Care Coordinator Certification Training program.



Coordinator of the Month Award. The winner of the award receives a traveling trophy filled with treats and goodies to display on their desk and is recognized on the Synthesis opening screen page.

• **7th Annual Wraparound Milwaukee Talent Show** – On

May 18th, Wraparound held its Annual Talent Show at Pulaski High School Auditorium. Doors opened at 4:30p.m. for the always-amazing Youth Art Show/Auction in which guests got to bid for artwork that was created by youth in the Wraparound programs. All proceeds went directly to the artist. The Talent Show began at 5:30p.m. Several youth and their families participated in sharing their talents through music, song, poetry and dance.



• **Holiday Giving Tree** – In December, Wraparound sponsored a Holiday Giving Tree to ensure that those youth in the Wraparound Milwaukee who were most likely not going to



revive a gift during the holidays did not go without. Care Coordinators decorated over one hundred ornaments to be hung in the Giving Tree discreetly identifying those in need. Gifts were delivered to Wraparound, wrapped and then distributed.

Other happenings improving the quality of life for Wraparound youth and families and our Care Coordinators:

• **Summer Family Picnic** - On August 31st, Families United of Milwaukee, Inc., M.O.V.E. Wisconsin, Wraparound Milwaukee, Wraparound Care Coordination Agencies and several other system partners collaborated to sponsor the annual Summer Family Picnic at Lincoln Park. Food, games and art and crafts were the highlights of the day!



• **Care Coordinator Appreciation Day** - On August 18th, Wraparound Milwaukee organized a special event held at the Milwaukee County Zoo/Zoo Ala Carte Event to show our appreciation to the Care Coordination Agencies serving the youth and families in Wraparound. Care Coordinators received special admission prices to the zoo and were honored with certificates of appreciation. Refreshments were served!



• **Care Coordination Holiday Event** - On December 4th, the annual Care Coordinator Holiday event was held at the Washington Park Senior Center in Milwaukee. The Care Coordinators enjoyed lunch, treats, music, the opportunity to talk with and learn about Wraparound Administrators, and a raffle drawing.



• **Care Coordinator of the Month Award** - Wraparound Milwaukee continues to sponsor the Care



Wraparound remains committed to providing quality care to the youth and families we serve. It is the responsibility of Wraparound and all its affiliated partners to be actively involved in the process of continuous quality improvement. Thank you to all the individuals who contributed to this report. Your time, expertise and dedication was greatly appreciated!

Respectfully Submitted,

Pamela A. Erdman MS, OTR

Wraparound Milwaukee Quality Assurance Director

Quality Committee Item 5



MILWAUKEE COUNTY SUBSTANCE ABUSE PREVENTION COALITION

Mission: To Improve the quality of lives in our community by preventing the harmful consequences of substance use and abuse among youth, families, and the larger community

Priorities:

- ★ Reduce Marijuana Use Among Youth
- ★ Reduce fatal drug overdose with an emphasis on Prescription Drugs

Activities:

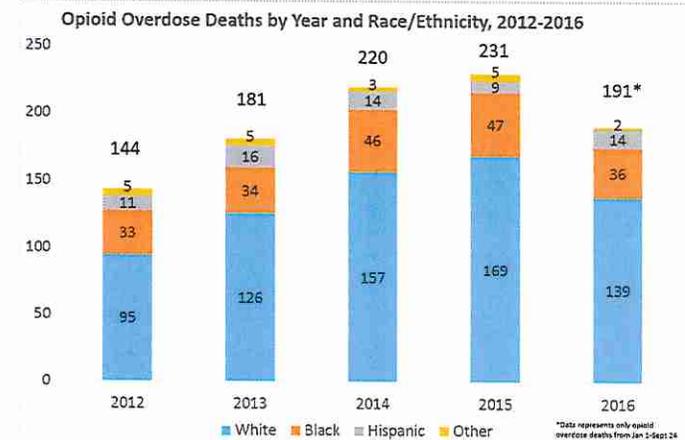
- ⇒ Coalition Convening
- ⇒ Youth Engagement
- ⇒ Community Education, Trainings and Technical Assistance
- ⇒ Safe Drug Drop Box Disposal

Partnerships:

Marquette University, Milwaukee Public Schools, Children's Community Health Plan, West Allis West Milwaukee Community Coalitions, Franklin Area Parents/Students United, Hayat Pharmacy, Milwaukee Police Department



Let's Be Blunt Campaign Bus Tail in Action!



Source: Milwaukee County Medical Examiner

Notable Achievements:

- ⇒ Collected 2,495 Pounds of unwanted medications
- ⇒ Increased capacity through Drug-Free Communities and Partnership For Success Awards
- ⇒ Collaboration with Marquette University on Dose of Reality Campaign
- ⇒ Marijuana Prevention "Let's Be Blunt Campaign" raised community awareness
- ⇒ Youth Summit provided healthy alternatives to drug use

Community Advocates, Inc.
AODA Prevention Program Report –January 1, 2016-December 30th, 2016
May 8th, 2017

C – Outputs -Workgroup holds weekly meetings during Assessment Stage -Conduct a minimum of 4 key informant interviews	C1 – Actual level of achievement Completed	
OUTCOME #1 – Milwaukee County AODA Assessment Report describes Community needs, resources, gaps, cultural competence and readiness to address AODA prevention needs		
F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES

<p>Workgroup includes at least 4 members, not including Coordinator</p>	<p>Milwaukee County Substance Abuse Prevention (MCSAP) Executive Committee sees to the ongoing assessment needs of the coalition.</p> <p>-Milwaukee County Substance Abuse Prevention (MCSAP) Data Committee has 4 workgroup members</p> <p>-RX MCSAP Disposal workgroup (10 members)</p> <p>-Marijuana Prevention Workgroup (5 members)</p>	<p>This is not currently an 'active' assessment phase. The coalition is gearing up for a new strategic planning to take place in Fall of 2017. The Executive Committee is in the process of reviewing the tools used last time and will connect with the data workgroup to ensure the coalition has the necessary data to inform the process.</p> <p>The data workgroup consists of 4 regular members who are able to remain actively engaged on an ongoing basis. This does not include our partners whom we can connect with for specific data needs and contribute that way.</p> <p>Due to the alignment with the initial PFS II grant, and now the PFS 2015 grant, the MCSAP disposal workgroup has grown significantly, and includes new collaborations with the Take Back Your Meds Coalition, and new alignment with the DEA 360 Community Initiative. It is co-chaired by staff from ARCW, and also includes strengthened partnerships with other coalitions within Milwaukee County also focusing on opiates.</p> <p>The Marijuana Prevention workgroup experienced some turnover when Dr. Michael Nunley retired from Milwaukee County, as he acted as one of the co-chairs of the group. We are pleased that we have two co-leaders for this group who come from youth-serving organizations and see youth marijuana use issues daily. In addition, with the successful application and award of the Drug Free Communities Grant, this workgroup is beginning to see a lot more opportunities for alignment with DFC and bring in new membership.</p>
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<p>Workgroup conducts at least 4 meetings during assessment stage</p>	<p>-While the initial assessment stage has been completed the workgroups continue to hold monthly meetings as well as provide continuous support of data requests</p> <p>-MCSAP Data committee has met at least 6 times since January,2016</p> <p>-MCSAP RX Disposal workgroup has met at least 7 times since January 2016</p> <p>-MCSAP Marijuana Prevention workgroup has met at least 7 times since January 2016 See Appendix B for workgroup meeting dates</p>	<p>-The data committee meets quarterly to allow adequate time to complete the work in between meetings. Several committee members maintain at least weekly communication while working with each other in this committee.</p> <p>- With the addition of a new co-chair, as well as several opportunities that allow for alignment with other initiatives, the MCSAP RX Disposal workgroup now meets bi-monthly, with some ad-hoc meeting in between as needed. MCSAP is partnering with Franklin Area Parents and Students United, West Allis-West Milwaukee Drug Free Communities Coalition, and 27th Street West Drug Free Communities Coalition to address opiate prevention and meet outside of the regular coalition meetings.</p> <p>-With two new co-chairs, this workgroup has been invigorated and has resumed the regular meetings with the incorporation into the larger MCSAP coalition meetings.</p>
<p>At least 4 interviews conducted with key informants</p>	<p>Since the assessment phase is not currently in place, a traditional 'key informant interview' has not taken place. However, key collaborative conversations and meetings have taken place, including but not limited to:</p> <ul style="list-style-type: none"> • Poison Control Center • Medical Society of Milwaukee County • Leading the Change • Medical College of Wisconsin • Dr. Chip Morris • City/County Opiate, Cocaine, Heroin Task Force • Milwaukee Health Department • Take Back your Meds Coalition 	<p>MCSAP members and staff regularly meet with new coalition partners, potential coalition partners, other initiatives, community groups, etc. to identify further ways to connect and leverage the work of the coalition.</p>

C – Outputs Coordinate quarterly coalition meetings, schedules, maintain minutes, records and reports		C1 – Actual level of achievement Ongoing
OUTCOME #2 – Capacity Building Stage mobilizes community resources to plan and implement prevention efforts and plan for sustainability		
F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
At least 4 new coalition members	<p>-MCSAP has recruited multiple new members from various organizations, some of which are: Bob Bell, DEA; Paul Biedrzycki, City of Milwaukee Health Department; Representation from Froedert Hospital; Kathy Schmitz, Milwaukee County Medical Society; Representation from the Poison Control Center;</p> <p>-The MCSAP Executive Committee has recruited a new coalition Co-chair; Kaylin Jones (Silver Spring Neighborhood Center, Youth and Teen Program Coordinator) as well as chairs for each workgroup-</p> <p>Rx Drug workgroup (Rachael Cooper, ARCW) and Marijuana workgroup (Jody Rhodes, Neu-Life Community Development Center and Raymond Rivera, United Community Center)</p>	<p>With the alignment of various initiatives to the RX Drug Workgroup, it has brought on several new members concerned with preventing prescription drug abuse and strengthened existing partnerships around opiate prevention work. In addition, with the new Drug Free Communities grant focused on the 53206 neighborhood, it has brought new membership around preventing marijuana use among youth.</p> <p>As our coalition chairs left their positions to pursue other opportunities and focus on different things, we were able to recruit from within existing membership to vote in new leadership.</p>

80% of members will attend 4 meetings annually	38 % of members attended 4 meetings annually	<p>While we have been successful in getting people to various trainings, it is not uncommon for coalitions to struggle with membership retention. What we have found is that some of our long-standing members may have struggled more with regular attendance, but we certainly saw a significant increase in new membership that has just not attended long enough to meet the '4 meetings annually' requirement.</p> <p>One key change that has been made which we think may affect this for the next reporting cycle, is that we have eliminated separate workgroup meetings. So rather than potentially having two meetings a month (assuming someone only attends one workgroup meeting), we have now made one big meeting. Every MCSAP meeting now includes breakout time for the workgroups to talk about their own workplans within the larger MCSAP meeting. We extended the meeting time to be two and a half hours, and include lunch. We feel this consolidation and streamlining also accounts for some of the new membership coming around the table</p>
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C – Outputs Conveys new information and concerns to other staff and coalition members	C1 – Actual level of achievement Ongoing	
OUTCOME #3 – AODA Prevention Project will be an active participant in the Milwaukee County Occurring Competency Cadre (MC3)		
F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
The coordinator will attend at least 90% of the MC3 meetings	Ongoing	Community Advocates staff attend all MC3 meetings. All information and materials are shared internally.

C – Outputs -Serve Marketing creates a public awareness campaign plan -Baseline user list established	C1 – Actual level of achievement -Ongoing
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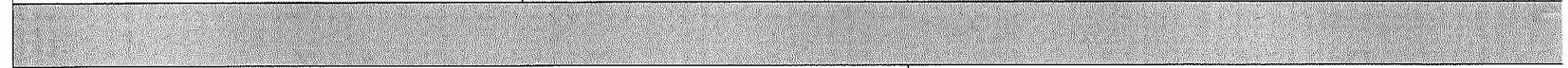
OUTCOME # 4 –
-Public Service/Marketing Campaign Increases Community awareness of AODA issues
-Simple communications system for coalition members, stakeholders, and program participants is launched

F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
Serve Marketing (or alternative) will create at least three different posters and media messages	DOJ's Dose of Reality Campaign was utilized <ul style="list-style-type: none"> • 1.82 million viewers tuned in for 17 home games • Average game attendance for home games was 13,716 • 9 radio networks aired coverage of games • Over 68,000 unique listeners tuned into radio broadcasts for the 16-17 season. 	Beginning in September of 2016, MCSAP partnered with Marquette Athletics to run the Dose of Reality Campaign. The campaign included: <ul style="list-style-type: none"> • A Banner Ad on the gomarquette.com website • Rotating Ad on court display for every home game • Outreach materials for both 8 home games and community events • MUPD agreeing to install a prescription drug drop box in their station • 3 DOJ PSA's to rotate through every game aired on radio • Interview in one game aired on radio • PSA to run on jumbotron for one home game • Development of player cards with drug facts
50% of identified stakeholders utilize communication site	CA has continued to utilize the MCSAP listserve, and prevention newsletter to communicate with grantees and the coalition regularly since July of 2013. The MCSAP Website (www.mcsapcoalition.org) launched in May, 2014.	The majority of coalition-wide communications take place via email list serve through the Prevention newsletters, and supplemental emails. The MCSAP website was unveiled during the May 15 th 2014 full coalition meeting, and officially launched in late May. The website is continuously updated to reflect current efforts, events and resources.

C – Outputs Workgroups hold weekly meetings during strategic planning stage	C1 – Actual level of achievement Achieved
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OUTCOME #5 – Comprehensive Strategic Plan identifies policies, evidence-based strategies, and goals and develops an RFP that addresses preliminary action plans and creation of effective logic models.

F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
Workgroup includes at least 4 members not including coordinator	The MCSAP Executive Team, which participated in the strategic planning, consisted of 20 members at the time of the strategic planning outside of CA staff.	<p>The coalition is planning phase II of the strategic planning session to determine what action items have been met, set new action items as well as revisit the readiness assessment to compare and determine what recommendations have been implemented. This will take place in September 2017.</p> <p>-The Data committee has continued to work closely with the CA in reviewing sub grantee plans and outcome measures. As part of this collaboration, the Data committee was instrumental in designing data-gathering tools and grantee programmatic information will be shared with the coalition.</p>
Workgroup conducts at least 4 meetings during strategic planning stage	Planning was incorporated into standing meetings, and carried out over several meetings.	Community Advocates Staff implemented standing monthly meeting dates for each of the MCSAP subcommittees which will continue to meet after strategic planning has concluded.

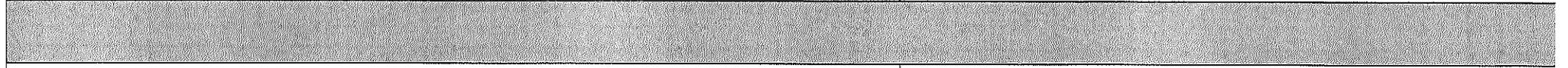


<p>C – Outputs</p> <ul style="list-style-type: none"> -RFP is issued to stakeholders and through public notice -Independent review panel reviews and scores RFP's 	<p>C1 – Actual level of achievement</p> <p>Achieved</p>
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OUTCOME # 6 – Agencies are selected to implement AODA prevention projects

F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
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<p>50 Organizations/Agencies will respond to the RFP</p>	<p>Community Advocates put together and released an RFP to the community in October of 2013. Fifteen agencies responded to the RFP, with 10 being funded. -Those chosen agencies will continue to be funded until the next competitive cycle as long as they continue to fulfill their contract goals.</p>	<p>Community Advocates worked with the coalition to incorporate emphasis on the Coalition's priorities for inclusion in the RFP. To streamline and measure success across funded partner agencies, Community Advocates worked with the Center for Self-Sufficiency to pre-determine outcome goals which were shared with all applicants.</p> <p>Community Advocates announced this opportunity on their website, via the prevention newsletter which reaches over 1,000 people, sent electronically to several different community listserves, and made announcements at different community meetings that were attended.</p> <p>Community Advocates engaged the support of 5 independent reviewers for the RFP process. Those reviewers included; Emilio DelTorre (ACLU), Genyne Edwards (Woo Connections), Terry Perry (Office of Violence Prevention), Tristan Gross (Alma Center), and John Rakowski (Medical College of Wisconsin).</p>
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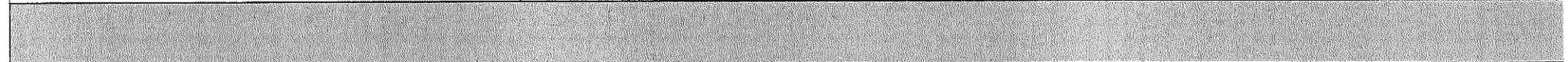


<p>C – Outputs AODA Prevention Coordinator facilitates 2 training sessions for sub-grantees</p>	<p>C1 – Actual level of achievement In progress</p>
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OUTCOME #7- Sub-grantees engage in planning stages for implementation of evidence-based programming that focuses on one or more priority areas and includes a Logic Model addressing the goals and outcomes as listed in both Milwaukee County Request for Proposal (RFP) and Community Advocates RFP

<p>F - PROJECTED LEVEL OF ACHIEVEMENT</p>	<p>G - ACTUAL LEVEL OF ACHIEVEMENT</p>	<p>H - DESCRIPTION OF CHANGES</p>
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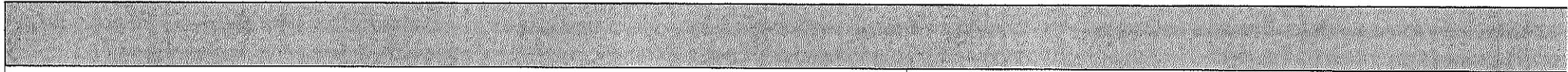
<p>100% of sub-grantee agencies will receive training on use of Strategic Prevention Framework</p>	<p>An ongoing focus on Strategic Prevention Framework is given throughout MCSAP's work</p> <p>MCSAP Coalition members offered opportunity to attend Substance Abuse Prevention Skills Training (SAPST) through AWY</p> <p>MCSAP Coalition members offered scholarships to attend the Regional Prevention Training</p>	<p>- In any new activity or initiative the coalition decides to focus on, the Strategic Prevention Framework is considered in planning and throughout said activity or initiative.</p> <p>-The SAPST Training is an intensive 4-day training geared at walking through the SPF model and how to implement that within coalition work. It is a free training, and most recently offered in January of 2017 in West Allis.</p> <p>-Annually through the Alliance for Wisconsin youth there is either a regional prevention training or statewide prevention training which includes various presentations relating to different aspects of the SPF. Through the regional center, coalitions are offered scholarships to attend. The most recent regional training was put on in June of 2016 in Brookfield.</p>
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<p>C – Outputs Milwaukee County AODA Prevention Program conducts bi-monthly meetings</p>	<p>C1 – Actual level of achievement ongoing</p>
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OUTCOME # 8-
Sub-grantees increases knowledge and involvement in Milwaukee County AODA Prevention Program

<p>F - PROJECTED LEVEL OF ACHIEVEMENT</p>	<p>G - ACTUAL LEVEL OF ACHIEVEMENT</p>	<p>H - DESCRIPTION OF CHANGES</p>
<p>100% of sub-grantees will attend and participate in Milwaukee County AODA Prevention meetings</p>	<p>In addition to group meetings, Community Advocates staff monitors and meets with grantees, collects reports and conducts focus groups.</p>	<p>Community Advocates and Center For Urban Population Health (CUPH) met with all grantees met in the beginning of 2016 as a new evaluator (CUPH) was coming on board. They reviewed logic models and evaluation plans that would be more specific to each program being implemented, rather than trying to align programs to standardized outcomes.</p> <p>When CA staff monitors grantees, training opportunities are noted, discussed and carried out for all grantees when it is something that could be applicable to everyone. Individual technical assistance is provided to grantees on an 'as-needed' basis.</p>

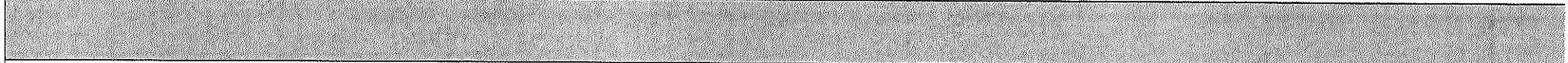


C – Outputs
 AODA prevention Coordinator and/or invited expert conducts 2 AODA-focused trainings for sub grantees

C1 – Actual level of achievement
 Ongoing

OUTCOME # 9-
 Sub-grantees increase capacity and expertise in AODA Prevention service provision

F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
100% of sub-grantees attend trainings	Cultural Competence Sustainability Evaluation Lifeskills Curriculum (Evidence-based) Substance Abuse Prevention Skills Training Drug Impairment Training for Educational Professionals Grantee Learning Collaborative Coalition Partner Agency Profiles	Several training opportunities were provided outside of the regular coalition meetings which sub-grantees were strongly encouraged to take advantage of. Part of these opportunities came through CA's position as the Southeast Alliance for Wisconsin Youth Regional Center, again identifying opportunities to leverage and align programming. We also allow for agencies to provide overviews of the prevention work they are doing for awareness and increased collaboration.



C – Outputs
 AODA Prevention Coordinator conducts scheduled/ random monitoring visits

C1 – Actual level of achievement
 Ongoing

OUTCOME # 10-
 Sub-grantees maintain program fidelity and use input or corrective measures to improve programming

F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
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100% of sub grantees comply with program fidelity or complete corrective action for compliance	Community Advocates staff conducts in-person, quarterly monitoring visits. In addition to in-person monitoring, Community Advocates collects bi-annual written reports to monitor the progress of each agency's outcome goals. We also conduct focus groups with program participants to learn more information about participant satisfaction, etc. All information is used for continual program improvement.	Mid-year and Year-end reports were collected to monitor progress and outcomes agencies were seeing with programming. Feedback from visits are documented and provided to agencies for continual program improvement. In addition, focus groups were conducted with over 100 youth in 2016.
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C – Outputs Evaluation consultant conducts OPTS training for sub-grantees	C1 – Actual level of achievement Ongoing
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OUTCOME # 11-
Evaluation system will collect and compare participant data to prepare for outcome measures

F - PROJECTED LEVEL OF ACHIEVEMENT	G - ACTUAL LEVEL OF ACHIEVEMENT	H - DESCRIPTION OF CHANGES
100% of grantees will submit process data on a quarterly basis	New in 2016 is the transfer of evaluation from the Center for Self-Sufficiency to the Center for Urban Population Health based out of the University of Wisconsin-Milwaukee. Data is submitted regularly and evaluated annually.	The OPTS system was utilized from July – December in 2015. In 2016, we switched to having the Center for Urban Population Health at UWM help evaluate the programs, and as a result we no longer use a uniform database system. By having each agency track their data internally through existing systems (or designing a data collection system if needed), we are able to more individually evaluate the programs and have a truer sense of what they are accomplishing.



C – Outputs -Sub-grantees submit program and process data quarterly -Evaluation consultant evaluates and analyses data quarterly -AODA Prevention Coordinator submits quarterly outcome reports	C1 – Actual level of achievement Ongoing
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OUTCOME # 12-

Evaluation indicates progress in meeting strategic outcomes and includes suggestions for program improvement

F - PROJECTED LEVEL OF ACHIEVEMENT**G - ACTUAL LEVEL OF ACHIEVEMENT****H - DESCRIPTION OF CHANGES**

90% of sub-grantees will meet or exceed projected outcome measures for selected evidence based program

In progress

A majority of our grantees met the threshold for meeting or exceeding outcomes for youth use of drugs or alcohol which was encouraging. However, when looking at the outcomes for efficacy to abstain from drugs and alcohol, or manage negative emotions, these percentages across the board are much lower. As a result, we are looking into the curriculum itself as well as discuss with our sub-grantees what some options might be to address this.

C – Outputs

Sub-grantees administer satisfaction surveys

C1 – Actual level of achievement

Ongoing

OUTCOME # 13-

Participants will express satisfaction with programming and activities

F - PROJECTED LEVEL OF ACHIEVEMENT**G - ACTUAL LEVEL OF ACHIEVEMENT****H - DESCRIPTION OF CHANGES**

80% of participants will express satisfaction with programs

ongoing

Community Advocates provides grantee agencies with a satisfaction survey which they are expected to administer within their grant programs. These continue to be utilized. In addition, satisfaction surveys are administered after every MCSAP meeting, and 95% of those indicate satisfaction with coalition work.

Appendix A

Milwaukee County Substance Abuse Prevention Coalition Members and Sub-Committee Members

<p>Executive Committee</p>	<p>Coalition Chair: Joyce Felker Coalition Co-Chair: Kaylin Jones Marijuana Prevention Workgroup: Chair/Co-Chair: Jody Rhodes, Raymond Rivera Data and Evaluation: Chair: Melissa Ugland, Mike Bare Rx Drug Prevention Workgroup: Chair: Rachael Cooper</p>
<p>Data and Evaluation Committee</p>	<p>Mike Bare Maria Beyer Melissa Ugland Elena Burke</p>
<p>Marijuana Prevention Workgroup</p>	<p>Elena Burke Jody Rhodes Maria Beyer Raymond Rivera Marques Hogans Kaylin Jones Karen Kolberg Kristen Ramirez Anthony Harris DeShanda Williams Vanessa Llanas Michelle Hays Lee Lewis Jewel Carter</p>
<p>Prescription Drug Prevention Workgroup</p>	<p>Rachael Cooper Tammy Molter Ellen Shiflet Patricia Edwards Cory Foster Luciana Gonzalez Crystal Johnson Joanie Luedke Marissa Tapia Kelly O'Neil Kathy Hahn Hashim Zaibak Betty Koepsel Kelly Tanel</p>

	<p>Mary Czubin Bethany Olson Elizabeth Neuens</p>
MCSAP Coalition Members	<p>Patricia Anderson Kathy Arciszewski Cathy Arney Brenda Barton Maria Beyer Lauren Blumenthal Jay Botsford Quintrell Boyles Charles Brown Elena Burke Jewel Carter Dorothy Chaney Tanisha Collins-Johnson Rachael Cooper Mary Czubin Ryan Daniels Anthony Doubek Matt Drymalski Kelly Duggan Patricia Edwards Jamie Elder Angela Ellis Mark Finne Kristina Finnel Janet Fleege Brett Fuller Rapeal Gordon Shawn Green Kathy Hahn Anthony Harris Deb Heffner Marques Hogans John Hyatt Carla Jackson Tracy Johnson Kaylin Jones Karen Kolberg Jessica Kotsaski Betty Kopsel Alderman Kovac Cassy Krueger Paul Krupski Christopher Ladwig Rochelle Landingham Kent Lovern Joanie Luedke Anthony McHenry Tammy Molter</p>

	<p>Keri Nervig Michael Nunley Zelda Okia Kelly O'Neil Kristan Ramirez Jody Rhodes Raymond Rivera Candy Robinson Jeff Roman Susan Sigl Cathy Smith Rachael Specht Scott Stokes Marissa Tapia Melissa Ugland Caitlin Vicini Diane Wagner Alderman Witkowski Hashim Zaibak</p>
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APPENDIX B

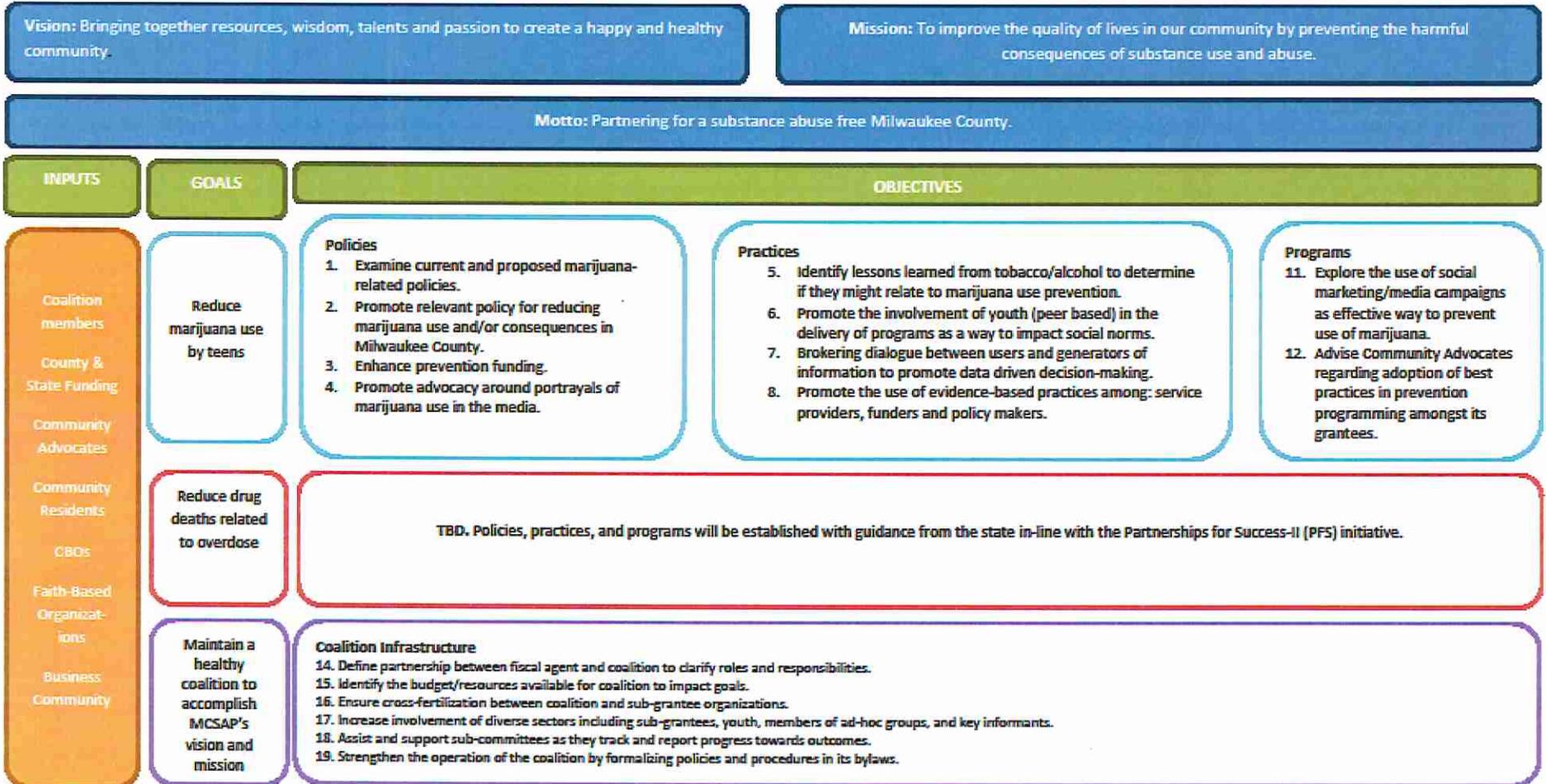
**Milwaukee County Substance Abuse
Sub-Committee Meeting Dates for 2016-17**

<p>Executive Committee</p> <p>**The Executive Committee meetings are to be attended by the Chair and Co-chairs of each committee. The meetings are held from 1:00pm-3:00pm at Community Advocates, located at: 728 N. James Lovell St, Milwaukee, WI 53233</p>	<ul style="list-style-type: none"> • January 7th, 2016 • February 4th, 2016 • March 3rd, 2016 • April 7th, 2016 • May 5th, 2016 • June 2nd, 2016 • July 7th, 2016 • August 4th, 2016 • September 1st, 2016 • October 6th, 2016 • November 3rd, 2016 • December 1st, 2016 • January 5th, 2017 • February 2nd, 2017 • March 2nd, 2017 • April 6th, 2017 • May 4th, 2017
<p>Data and Evaluation Committee</p> <p>All meetings take place from 9:00-10:30am at Coffee Makes You Black located at: 2803 N Teutonia Ave, Milwaukee, WI 53206</p>	<ul style="list-style-type: none"> • January 14th, 2016 9:30-10:30am • April 14th, 2016 9:30-10:30am • July 14th, 2016 9:30-10:30am • October 13th, 2016 • January 12th, 2017 • April 13th, 2017

<p>Rx Drug Prevention Workgroup</p> <p>All meetings will be held at the same location as the full coalition meeting.</p>	<p>All work groups will meet during the full coalition meetings</p>
<p>Marijuana Prevention Workgroup</p> <p>All meetings will be held at the same location as the full coalition meeting.</p>	<p>All work groups will meet during the full coalition meetings</p>

Appendix C

Milwaukee County Substance Abuse Prevention Coalition (MCSAP) Logic Model 2013



Stay Strong Grantees Outcome Report

Each Stay Strong Grantee has an individualized evaluation plan, specific to the intervention they are delivering. Therefore, the outcomes for each agency will vary. Below you will find outcomes for each funded agency.

COA Youth and Family Centers

COA served 143 unduplicated participants in 2016 and had the following outputs:

- 143 youth engaged in Lifeskills Training at Holton and Goldin Centers
- 31% of participants (54 of 173) attended at least 50% of the sessions

Intervention Outcomes:

- Decrease the proportion of participants who report using alcohol
 - Middle School
 - Drinking something – reduced 6%
 - Drinking until drunk – reduced 7%
- Decrease the proportion of participants who report using illegal drugs
 - Middle School
 - Smoking Marijuana – reduced by 15%
 - Sniffing glue, paint, gas or other things you inhale to get high – reduced by 20%
- Increase the proportion of participants who report the efficacy to abstain from alcohol and illegal drugs despite external pressures
 - Transitions
 - Anti-Marijuana attitudes – improved by 1%
 - Anti-Alcohol attitudes – improved by 1%
 - Anti-smoking attitudes – improved by 2%
 - Anti-hard drug attitudes – improved by 2%
 - Middle School
 - Anti-smoking attitudes – decreased by 7%
 - Anti-drinking attitudes - decreased by 3%
- Overall Knowledge – for those with greater than 50% attendance, increase in knowledge was at 75%, for those with less than 50% attendance increase in knowledge was at 58%.

Diverse and Resilient

Diverse and Resilient served 88 unduplicated participants in 2016 and had the following outputs:

- 22 youth attended quarterly Youth Advisory Board meetings
- 1 higher education partnership made with the University of Wisconsin-Milwaukee
- 7 youth were trained as Youth Health Promoters
- 216 LGBTQ reached by Youth Health Promoters
- 11 Youth Health Promoters reached 143 LGBTQ youth at Pridefest

- 76 LGBTQ youth attended “Drinks on the House” quarterly events
- 67 LGBTQ youth completed the Alcohol Skills Training Program
- 1,011 branded materials were distributed to youth

Intervention Outcomes:

- Increase in confidence of participants who report the ability to make safe choices about drinking
 - 1.79% increase
- Participant increase in knowledge about the effects of alcohol and the body
 - 12.10% increase
- Increase in confidence of participants who report the ability to recognize their own limits when drinking
 - 4.05% increase
- Participant increase in likeliness to make informed choices about their drinking
 - 6.48% increase

Neu Life Community Development

Neu Life served 156 unduplicated participants in 2016 and had the following outputs:

- 156 youth completed the Life Skills curriculum
- 156 completed at least 80% of the curriculum
- 145 of the 156 youth completed the pre/post-test (93%)

Intervention Outcomes:

- 80% of the 150 youth pre-post tested in Life Skills classes will show an increase in knowledge
 - 81% showed an increase in knowledge
- 80% of the elementary youth surveyed will show an increase in anti-smoking attitudes
 - 96% showed an increase in anti-smoking attitudes
- 80% of the middle and high school youth surveyed will show an increase in drug refusal
 - 83% showed an increase in drug refusal skills

Pathfinders

Pathfinders served 61 unduplicated participants in 2016 and had the following outputs:

- 61 youth participated in the Life Skills Transitions Curriculum
- 89 youth attended Substance Abuse Prevention Month Activities
- 12 classes were offered (72 class hours’ total)
- 2 adult and 2 youth peer facilitators were trained in Life Skills

Intervention Outcomes:

- Increase the proportion of participants who report the efficacy to abstain from alcohol and/or illegal drugs despite external pressures

- 47.4 reported the efficacy to abstain from alcohol and illegal drugs despite external pressures
- Increase the proportion of participants who report the efficacy to manage negative emotions that lead to alcohol or drug use
 - 66.7% of participants reported efficacy to manage negative emotions that lead to alcohol and/or drug use

Safe and Sound

Safe and Sound served 202 unduplicated participants in 2016 and had the following outputs:

- Hire and train 3 new staff
- Select two priority neighborhoods (set boundaries, meet with existing community resources, and meet residents)

Intervention Outcomes:

- Community Organizer, Youth Organizer, and Community Prosecution Unit Coordinator hired and on-boarded
- Westlawn Neighborhood was selected
- Evidence-based, three-pronged approach to improve public safety implemented. Adult residents engaged, youth residents engaged, and assessment of community safety issues.
*This project started later in 2016 once leveraged funding was obtained, therefore it is too early to report outcome data.

The Parenting Network

The Parenting Network served 78 unduplicated participants in 2016 and had the following outputs:

- 78 students served with the Lifeskills curriculum
- 3 series were provided in 3 different grades and schools
- 42 matched/completed surveys

Intervention Outcomes:

- Increase the proportion of participants who report the efficacy to abstain from alcohol and illegal drugs despite external pressures
 - High School – 27.3% increase
 - Middle School – 18.9% increase
- Increase the proportion of participants who report the efficacy to manage negative emotions that lead to alcohol or drug use
 - High School – 81.8% increase
 - Middle School – 45.9% increase

United Community Center

United Community Center served 43 unduplicated participants in 2016 and had the following outputs:

- 43 middle/high school students participated in the All Stars Curriculum
- 11 sessions were held

Intervention Outcomes:

- This program is implemented on a school year basis, therefore outcome data will be calculated after May, 2017

Quality Committee Item 6

2016 BHD Acute Adult Inpatient Service MHSIP Consumer Satisfaction Survey – Annual Overview

BHD has utilized the NRI MHSIP patient satisfaction survey to identify performance improvement initiatives for inpatient treatment since 2003. Consumers' perceptions of inpatient services are obtained regarding: Patient Outcomes, Environment of Care, Participation in treatment, Patient Rights, Dignity, Empowerment, and additional aspects of services received including cultural sensitivity, treatment choices, and medications.

- In 2016, 280 of the 683 consumers discharged from Acute Adult Inpatient Service completed the MHSIP Survey, yielding a 41% response rate. Over the past 2 years, Acute Adult Inpatient Service's MHSIP survey response rates have been above the target response rate of 40%.
- Acute Adult Inpatient Service's survey item domain scores are on average 4 percentage points lower than the published national averages.
- The 2016 survey results revealed a 3 percentage point average decline in positive rating for five of the six survey item domain categories in comparison to 2015's scores. The domain with an increase in positive rating was regarding Environment of Care.
- The following are *general guidelines* for interpreting the inpatient consumer survey results based on thirteen years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
 - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
 - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
 - Percentages in the 80 - 89% range can be considered 'high'
 - Percentages 90% and above can be considered 'exceptional'
- The results revealed "Good" response scores for 4 of the 6 survey item domains/categories: 76% for Dignity, 75% for Patient Outcomes, 73% for Empowerment, and 72% for Participation in treatment. Relatively low response scores were obtained for Environment of Care 69%, and Patient Rights 59%.
- Survey items with the highest positive response scores were:
 - Staff here believed that I could grow, change and recover (78%)
 - My contact with nurses and therapists was helpful (78%)
 - I am better able to deal with crisis (78%)
 - I was encouraged to use self-help/support groups (77%)
 - My symptoms are not bothering me as much (77%)
 - My contact with my doctor was helpful (76%)
 - I felt comfortable asking questions about my treatment and medications (75%)

MHSIP
Consumer
Satisfaction
Survey

Annual

2016

Prepared By:
Quality
Improvement
Department

Created 2/15/17

Overview

- In 2016, 280 of the 683 consumers discharged from Acute Adult Inpatient Service completed the MHSIP Survey, **yielding a 41% response rate**. For the past 2 years, Acute Adult Inpatient Service's MHSIP survey response rates have been above the target response rate of 40%.
- Acute Adult Inpatient Service's survey item domain scores are within 8 percentage points of the published national averages.
- The survey results for 2016 revealed a **decline** in positive rating for five of the six survey item domain categories in comparison to 2015's scores. The only domain with an increase in positive rating was the Environment domain.
- The following are *general guidelines* for interpreting the inpatient consumer survey results based on thirteen years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
 - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
 - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
 - Percentages in the 80 - 89% range can be considered 'high'
 - Percentages 90% and above can be considered 'exceptional'
- The results revealed "Good" response scores for 4 of the 6 survey item domains/categories: 76% for Dignity, 75% for Outcome, 73% for Empowerment, and 72% for Participation. Relatively low response scores were obtained for Environment 69%, and patient Rights 59%.
- Survey items with the highest positive response scores were:
 - Staff here believed that I could grow, change and recover (78%)
 - My contact with nurses and therapists was helpful (78%)
 - I am better able to deal with crisis (78%)
 - I was encouraged to use self-help/support groups (77%)
 - My symptoms are not bothering me as much (77%)
 - My contact with my doctor was helpful (76%)
 - I felt comfortable asking questions about my treatment and medications (75%)

Introduction

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

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

Method

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

Instrument

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

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

NRI/MHSIP Inpatient Consumer Survey (2001)

Outcome Domain:

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

Dignity Domain:

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

Rights Domain:

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

Participation Domain:

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

Environment Domain:

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

Empowerment Domain:

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

Other survey items:

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

Results

The following presents the results of the Inpatient MHSIP Consumer survey completed by consumers of the Acute Adult Inpatient Service in 2016. Data from 2012 – 2015 administrations of the survey are also presented in select tables of this report to allow for comparisons.

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

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

Response Rate

Completed surveys were obtained at discharge from 41% of the 683 consumers discharged from the Acute Adult Inpatient service in 2016. For the past 2 years, the Acute Adult Inpatient service MHSIP survey response rates have been above the target response rate of 40%.

Table 1 presents data on response rates by unit and the total BHD Acute Adult Inpatient Service for 2014 – 2016.

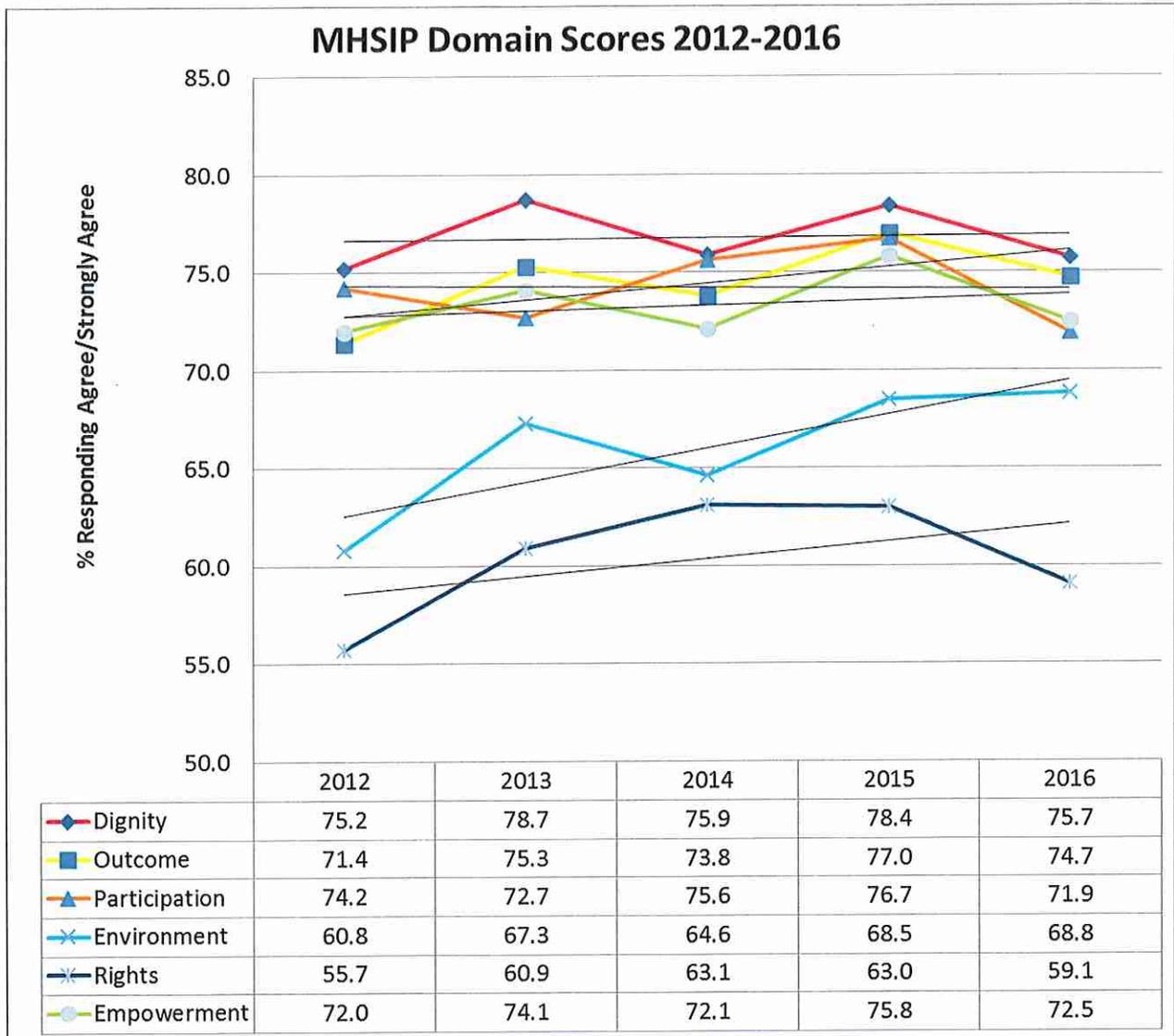
Table 1. Inpatient MHSIP Consumer Survey - Response Rate by Unit						
Unit	2014		2015		2016	
	Completed Surveys	Response Rate	Completed Surveys	Response Rate	Completed Surveys	Response Rate
43A - ITU	48	19.6%	76	27.8%	70	30.2%
43B - ATU	143	29.7%	334	77.5%	171	66.5%
43C - WTU	94	25.7%	92	35.1%	39	20.1%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

Acute Adult Inpatient Service

Table 2 presents Acute Adult Inpatient Service’s consumer positive (agree/strongly agree) responses for 2012 – 2016. In 2016, the results revealed “Good” response rates for 4 of the 6 domains: 76% for Dignity, 75% for Outcome, 73% for Empowerment, and 72% for Participation.

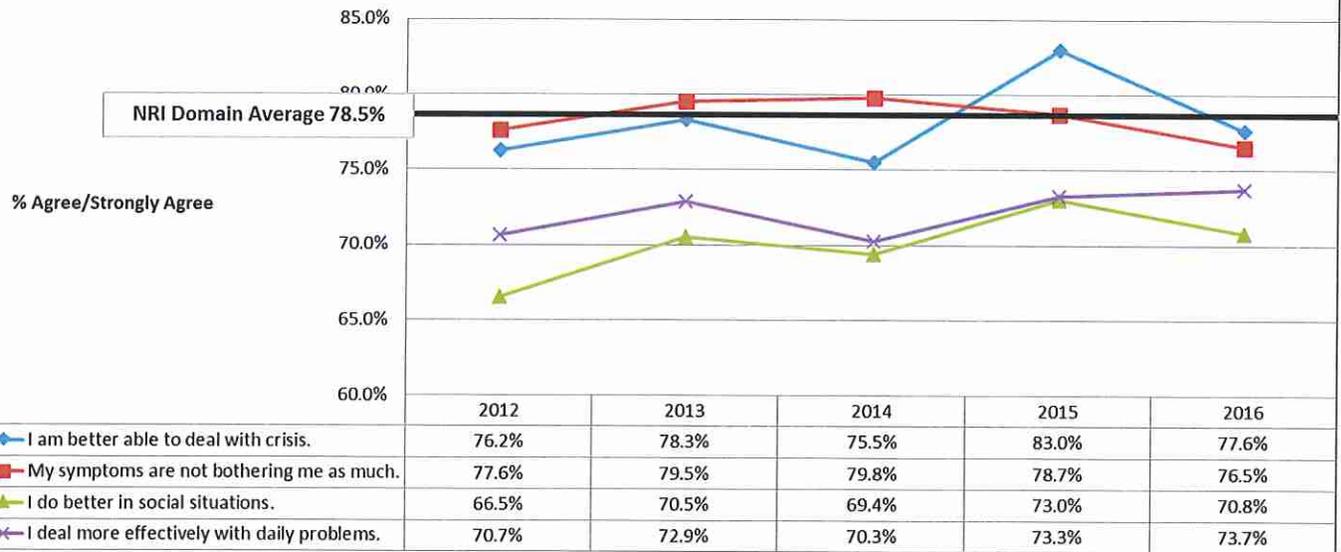
Table 2. Inpatient MHSIP Consumer Survey - All Units					
Domains	Agree/Strongly Agree Response %				
	2012	2013	2014	2015	2016
Dignity	75.2%	78.7%	75.9%	78.4%	75.7%
Outcome	71.4%	75.3%	73.8%	77.0%	74.7%
Participation	74.2%	72.7%	75.6%	76.7%	71.9%
Environment	60.8%	67.3%	64.6%	68.5%	68.8%
Rights	55.7%	60.9%	63.1%	63.0%	59.1%
Empowerment	72.0%	74.1%	72.1%	75.8%	72.5%
Additional Questions					
My family and/or friends were able to visit me.	81.8%	79.0%	78.8%	78.6%	77.9%
The Medications I am taking help me control my symptoms that used to bother me.	72.3%	73.2%	74.8%	77.0%	74.3%
My other medical conditions were treated.	65.8%	72.4%	66.3%	68.1%	67.7%
Staff were sensitive to my cultural background.	64.2%	61.9%	63.8%	67.4%	64.7%
I felt this hospital stay was necessary.	66.7%	66.0%	68.4%	65.8%	62.5%
I was given information about how to manage my medication side effects.	64.8%	64.7%	63.3%	72.1%	66.1%
If I had a choice of hospitals, I would still choose this one.	58.1%	60.3%	55.3%	63.2%	56.0%
Surveys Completed	484	487	285	502	280

The following graph presents Acute Adult Inpatient Service's 2012-2016 positive (agree/strongly agree) Domain scores.

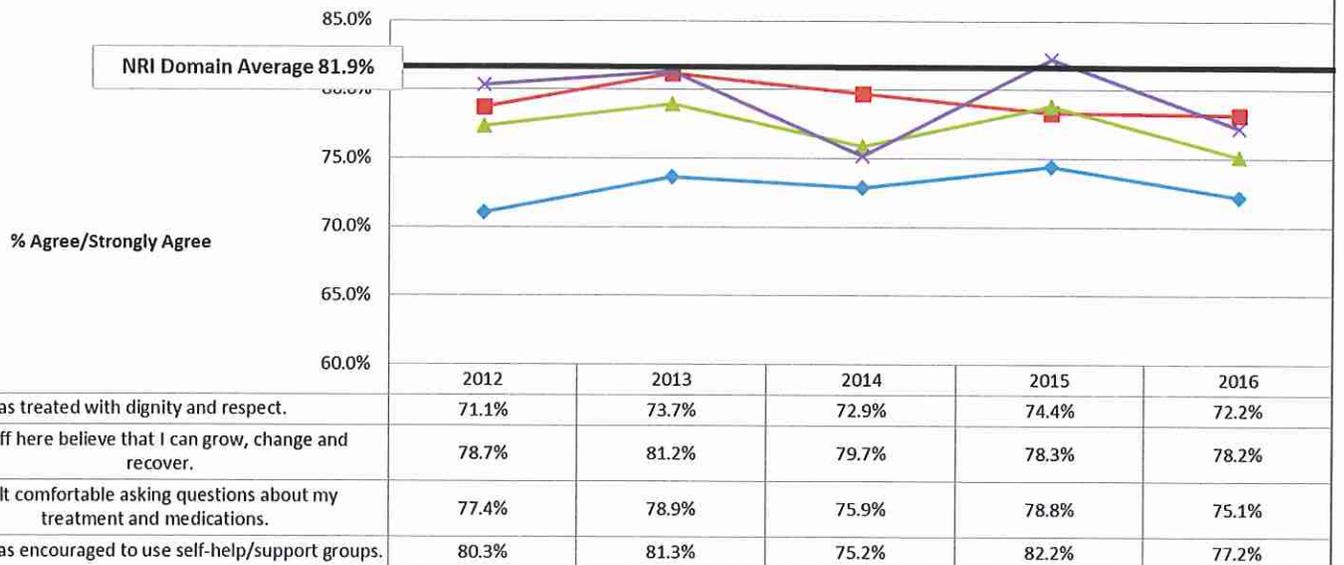


The following graphs present Acute Adult Inpatient Service's 2012-2016 positive (agree/strongly agree) survey item scores and NRI's domain average.

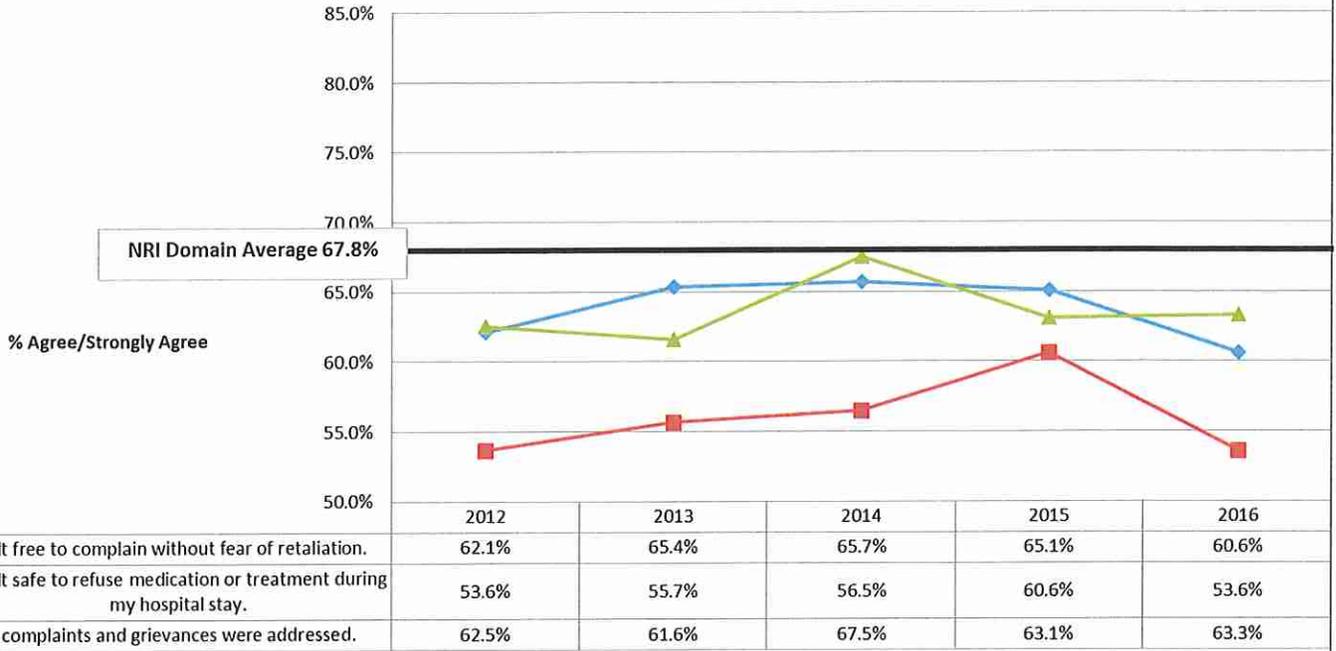
2012 - 2016 MHSIP Survey - Outcomes Domain



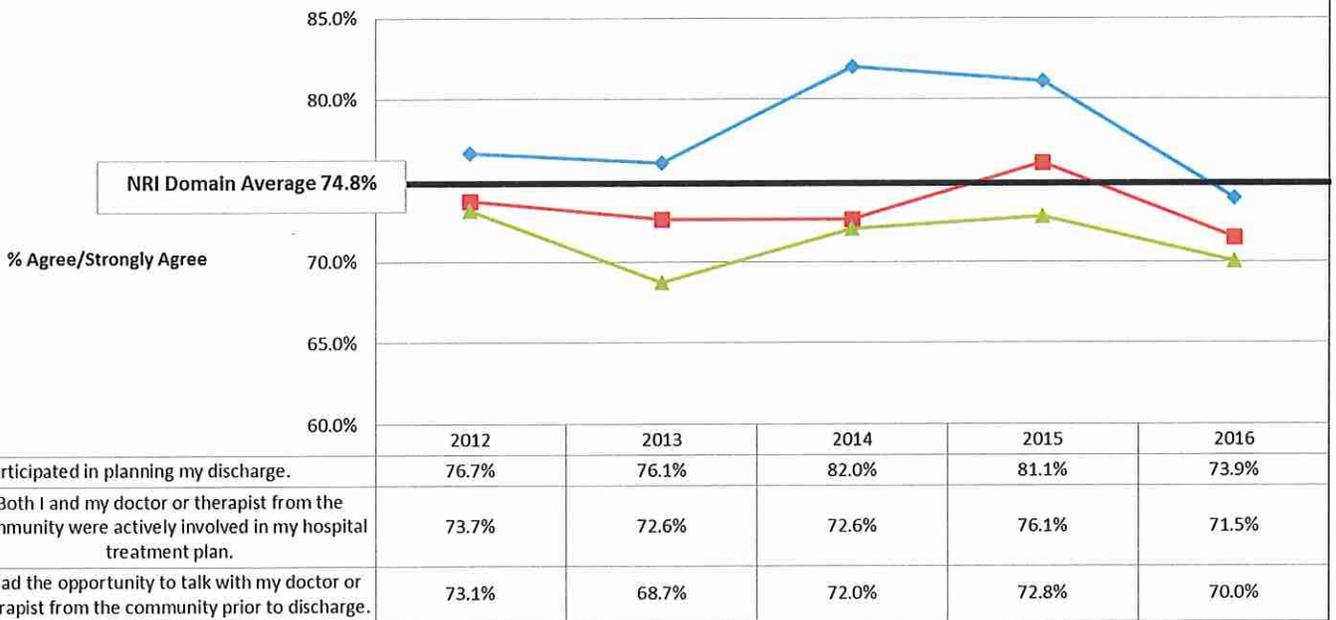
2012 - 2016 MHSIP Survey - Dignity Domain



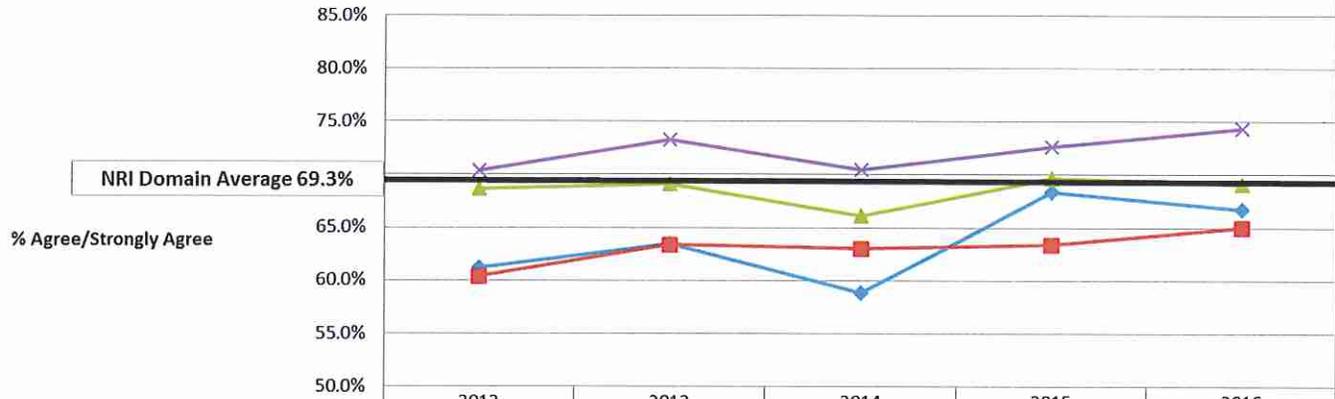
2012 - 2016 MHSIP Survey - Rights Domain



2012 - 2016 MHSIP Survey - Participation Domain

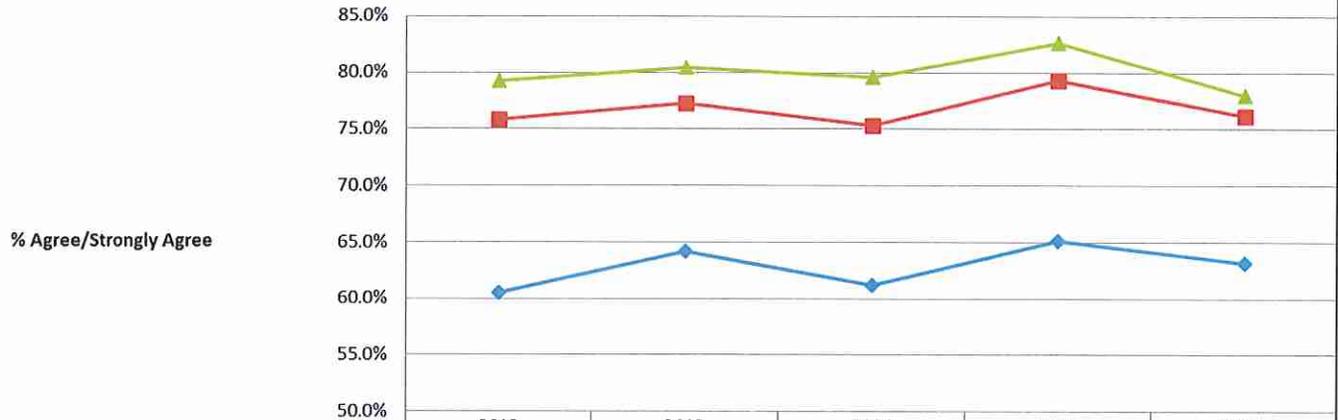


2012 - 2016 MHSIP Survey - Environment Domain



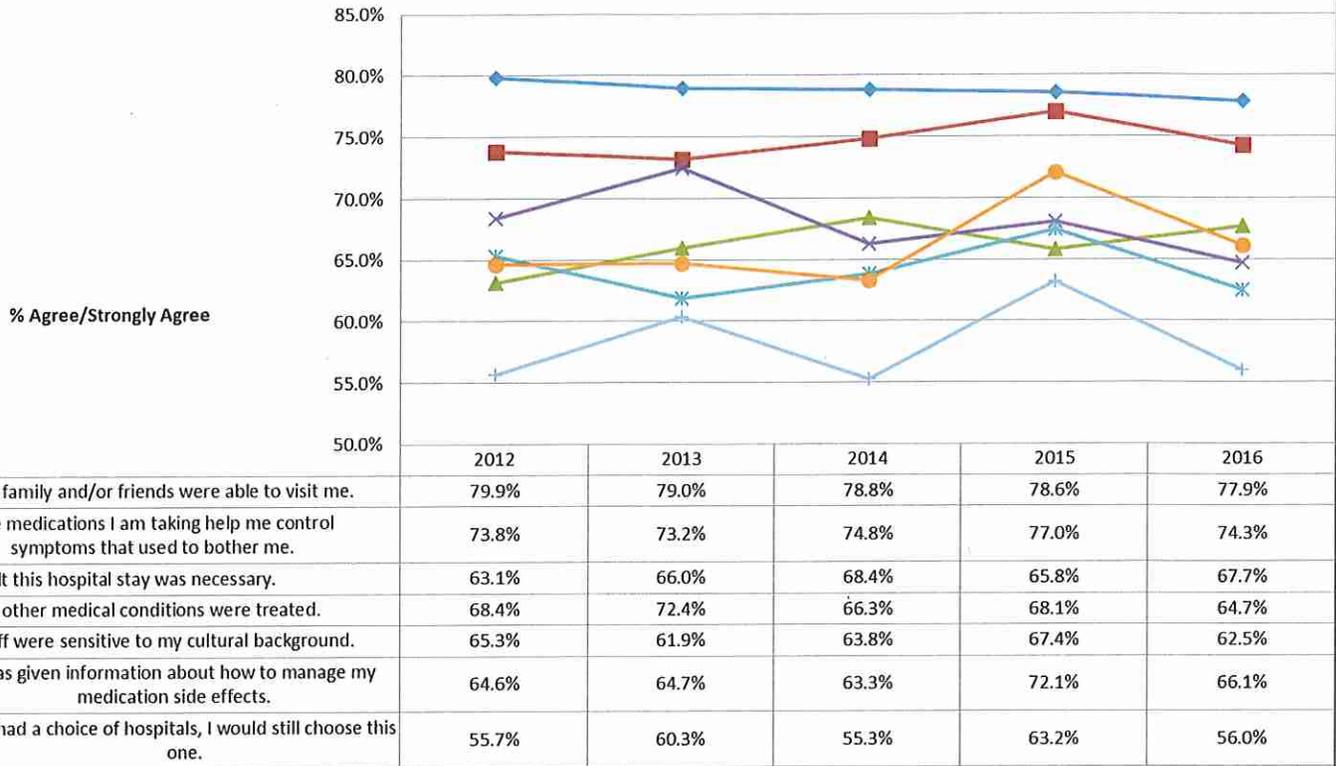
	2012	2013	2014	2015	2016
◆ The surroundings and atmosphere at the hospital helped me get better.	61.2%	63.5%	58.8%	68.4%	66.7%
■ I felt I had enough privacy in the hospital.	60.3%	63.4%	63.0%	63.4%	65.0%
▲ I felt safe while in the hospital.	68.6%	69.0%	66.1%	69.6%	69.1%
✕ The hospital environment was clean and comfortable.	70.3%	73.3%	70.4%	72.6%	74.3%

2012 - 2016 MHSIP Survey - Empowerment Domain



	2012	2013	2014	2015	2016
◆ I had a choice of treatment options.	60.5%	64.2%	61.2%	65.1%	63.2%
■ My contact with my doctor was helpful.	75.8%	77.3%	75.3%	79.3%	76.2%
▲ My contact with nurses and therapists was helpful.	79.2%	80.4%	79.6%	82.6%	78.0%

2012 - 2016 MHSIP Survey - Other Items



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

Table 3. BHD Inpatient MHSIP Agree/Strongly Agree Domain Response Scores Comparison to NRI National Average			
Domains	National Average	2016 BHD	BHD/National Avg Variance
Dignity	81.9%	75.7%	-6.2%
Outcome	78.5%	74.7%	-3.8%
Participation	74.8%	71.9%	-2.9%
Environment	69.3%	68.8%	-0.5%
Rights	67.8%	59.1%	-8.7%
Empowerment	Not Reported	72.5%	-

Table 4 presents 2016 survey results for domain and additional items by each Acute Adult Inpatient Unit. The following summarizes these comparisons and should be interpreted as a *general* measure of a unit's performance based on consumers' perceptions of their inpatient stay:

Table 4. 2016 Inpatient MHSIP Consumer Survey - By Unit			
Domains	Agree/Strongly Agree Response		
	43A	43B	43C
Dignity	76.9%	75.3%	75.0%
Outcome	72.3%	74.0%	81.8%
Participation	72.4%	71.9%	70.8%
Environment	67.9%	69.5%	67.1%
Rights	61.2%	58.0%	60.0%
Empowerment	73.8%	71.9%	73.0%
Additional Questions			
My family and/or friends were able to visit me.	78.3%	77.2%	80.0%
The Medications I am taking help me control my symptoms that used to bother me.	69.1%	75.8%	76.9%
My other medical conditions were treated.	71.9%	63.2%	80.0%
Staff were sensitive to my cultural background	73.8%	61.5%	63.9%
I felt this hospital stay was necessary	69.6%	60.0%	60.5%
I was given information about how to manage my medication side effects	72.1%	63.6%	65.8%
If I had a choice of hospitals, I would still choose this one.	61.2%	56.4%	44.4%
Surveys Completed	70	171	39

Appendix

The comments below were written on surveys administered in 2016.

43A - Positive Comments

1. After viewing my intake photo with horror. I am convinced I must make changes. This stay in the hospital afforded me the opportunity to see myself during a manic episode and after as well as protecting me from myself. I learned that I should harbor no guilt for my situation unless I don't comply with taking my medication.
2. C.N.A.'s Michael, Elizabeth, Cynthia, Angela, Sundae, Bryant, Ophelia, Bernestine, Courtney & Maurice worked wonders for me. After a rough start nurses Rebecca, Ranate, Joe, Robert, James, Jim, and Janice all helped out, Chandra showed the most dramatic changes though, she should be rewarded for it. All of the Orion security staff were wonderful especially Roscoe, Christopher, Shamir, Aries and Ryan.
3. John (peer specialist) excellent support, Mari (OTR) excellent, Rebecca, Renata, Leanne, Kim, Tracy, Ophelia, Margaret, Regina, Juanita, Micah (excellent nurses), Todd Cannon - excellent Dr.
4. Thank you for trying to help me with my illness
5. Thank you!

43A - Negative Comments

1. I think too many distraction happening in 43A ie yelling from staff and the staff is totally dishonest (nurse and C.N.A.)

43B - Positive Comments

1. I actually feel better.
2. I enjoyed working with doctors and staff members that were familiar with me.
3. It was good comfort food
4. Loralaine and Florence and all nursing aides were very respectful.
5. Thank you for your help while incarcerated
6. The first time I had a stay here I was not pleased. But this time around the staff was very helpful and kind, which made the day go by easier.
7. The nurses, therapists, doctors and social workers all worked the hardest and to the best of their abilities. The staff on the other hand seemed to be lacking certain motivation to keep us safe. This is not to say that every single staff member showed this trait but I found myself feeling unsafe and unheard on multiple occasions.
8. Your eggs are delicious!
9. Not a bad place. I'm just impatient and worried about the outrageous cost. I wish they would speed up discharge. I understand why I was kept here this long. Thank you.
10. This is a very good facility. It is much nicer than the old North Division or even in 1995. Thank you.
11. I'm glad I came here. Now I feel better.
12. The peer specialists Constance and Rebecca were awesome. The C.N.A.s were awesome.

43B - Negative Comments

1. Improve the food! Please!
2. There needs to be major improvement, with specialization for different people. Not a one size fits all approach.
3. Unit was very loud with numerous swear words and threats of violence being made.

43C - Positive Comments

1. I used the phone to keep in contact with my friends and family while here, and I enjoyed the help from the staff.
2. Will miss staff nurses.

43C - Negative Comments

1. Please treat all patients the same regardless of disability and skin color.
2. The staff need to treat patients better!

2016 BHD Child Adolescent Inpatient Service (CAIS) Youth Satisfaction Survey – Annual Overview

BHD has utilized the CAIS Youth satisfaction survey to identify performance improvement initiatives for inpatient treatment since 2007. Consumers' perceptions of inpatient services are obtained regarding: Access to Services, Appropriateness of Treatment, Participation in Treatment, Cultural Sensitivity/Respectful Treatment, and Patient Outcomes.

- In 2016, 106 of the 485 youth 13 years or older discharged from CAIS completed the CAIS Youth Survey, yielding a 22% response rate.
- The survey results for 2016 revealed a 7 percentage point average increase for all five domain categories in comparison to 2015.
- Currently, no national averages/benchmarks are publicly available for this survey. The following are *general guidelines* for interpreting the inpatient consumer survey results based on eight years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
 - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
 - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
 - Percentages in the 80 - 89% range can be considered 'high'
 - Percentages 90% and above can be considered 'exceptional'
- The results revealed "High" positive response scores for 2 of the 5 domains: Cultural Sensitivity/Respectful Treatment (87%), and Appropriateness of Treatment (83%). "Good" positive response scores were obtained for Participation in Treatment (79%), and Access to Services (70%). Relatively low positive response scores were obtained for the Outcomes domain (68%).
- Survey items with the highest positive response scores were:
 - Staff spoke with me in a way that I understood (91%)
 - Staff respected my family's religious/spiritual beliefs (88%)
 - I helped to choose my treatment goals (86%)
 - I participated in my own treatment (86%)
 - Staff were sensitive to my cultural/ethnic background (86%)
 - I received the services that were right for me (85%)
 - Overall, I am satisfied with the services I received (82%)
- The open ended survey item "Most helpful things you received during your stay" resulted in patients writing positive comments regarding: staff listening to patient (21%), caring, respectful staff (21%), treatment received (18%), groups (10%), medication received (10%), anger management techniques (8%), safe environment (7%), and coping skills taught (5%).
- The open ended survey item "What would improve the program here" resulted in patients writing comments regarding: better food (54%), more groups and activities (18%), no improvements needed (15%), respectful staff (11%), treatment (1%), and better communication between staff and patients (1%).

CAIS Youth Survey

Annual Report

2016

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

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

Prepared By:
Quality
Improvement
Department

Created 3/1/17

Overview

- In 2016, 106 of the 485 youth 13 years or older discharged from CAIS completed the CAIS Youth Survey, **yielding a 22% response rate.**
- The survey results for 2016 revealed an **increase** in all five domain categories in comparison to the past two years.
- Currently, no national averages/benchmarks are publicly available for this survey. The following are *general guidelines* for interpreting the inpatient consumer survey results based on eight years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
 - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
 - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
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- The open ended survey item "What would improve the program here" resulted in patients writing comments regarding: better food (54%), more groups and activities (18%), no improvements needed (15%), respectful staff (11%), treatment (1%), and better communication between staff and patients (1%).

Method

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

Results

The following presents the results of the CAIS Youth Survey completed by consumers of the Child/Adolescent Inpatient Service in 2016. Data from 2013 – 2015 administrations of the survey are also presented in select tables of this report to allow for comparisons.

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

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

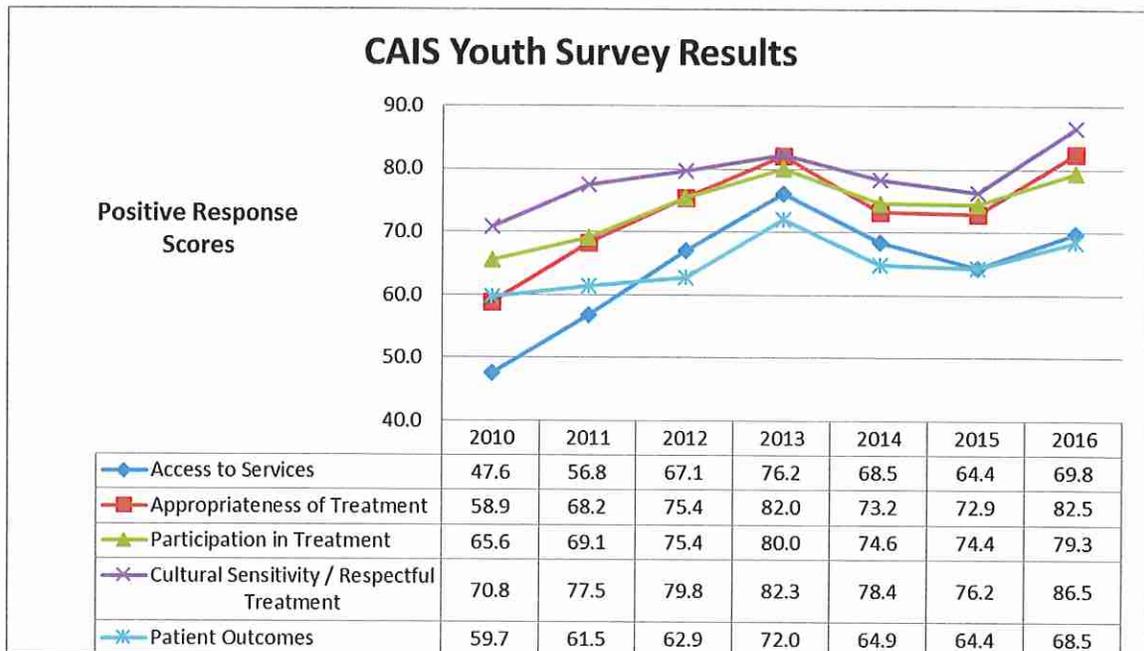
Responses were obtained from 106 of the 485 youth 13 years or older discharged from CAIS in 2016, **yielding a 22% response rate.**

Table 1 presents Child/Adolescent Inpatient Service's consumer positive (agree/strongly agree) responses for 2013 – 2016. In 2016, the results revealed "High" positive response scores for 2 of the 5 domains: Cultural Sensitivity/Respectful Treatment (87%), and Appropriateness of Treatment (83%). "Good" positive response scores were obtained for Participation in Treatment (79%), and Access to Services (70%). Relatively low positive response scores were obtained for the Outcomes domain (68%).

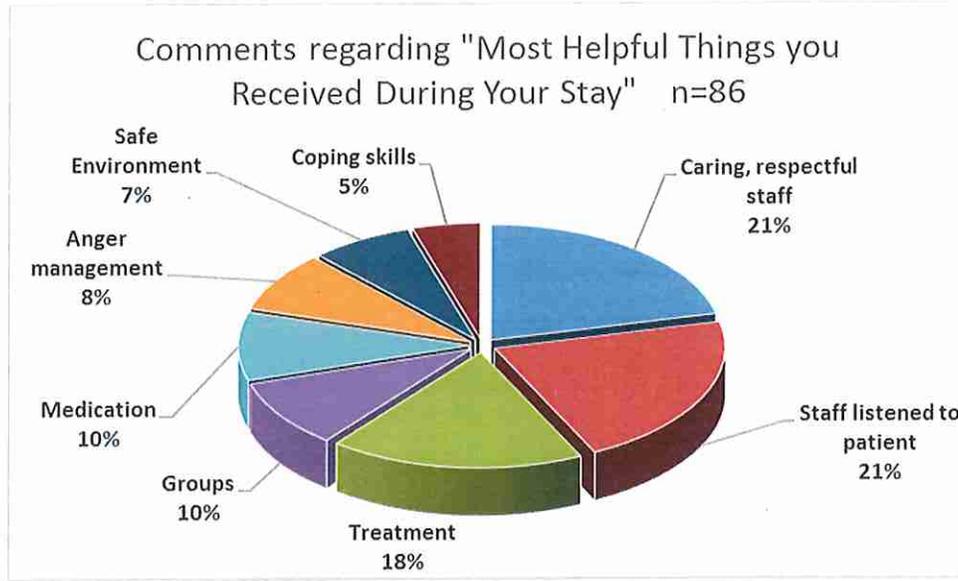
- The survey results for 2016 revealed an **increase** in all five domain categories in comparison to the past two years.

Table 1. 2013-2016 CAIS Youth Survey - Positive Response Rate Summary

Survey Item	Year				
	2013	2014	2015	2016	2015/2016
	N = 112	N = 327	N = 618	N = 106	Variance
The location of services was convenient	73.4	62.0	61.6	58.7	-2.9
Services were available at times that were convenient for me	78.9	75.0	67.2	80.8	13.6
Total Access to Services	76.2	68.5	64.4	69.8	5.3
Overall, I am satisfied with the services I received	80.4	72.8	74.0	82.1	8.1
The people helping me stuck with me no matter what	84.8	75.5	71.6	82.1	10.5
I felt I had someone to talk to when I was troubled	80.4	74.9	72.6	81.0	8.4
I received the services that were right for me	83.8	72.6	74.0	84.6	10.6
I got the help I wanted	82.9	71.0	72.0	84.0	12.0
I got as much help as I needed	79.8	72.6	73.1	81.0	7.9
Total Appropriateness of Treatment	82.0	73.2	72.9	82.5	9.6
I helped to choose my services	70.3	64.6	65.5	66.7	1.2
I helped to choose my treatment goals	87.5	79.8	76.6	85.6	9.0
I participated in my own treatment	82.1	79.4	81.2	85.6	4.4
Total Participation in Treatment	80.0	74.6	74.4	79.3	4.9
Staff treated me with respect	85.7	73.6	72.2	81.0	8.8
Staff respected my family's religious/spiritual beliefs	75.9	78.5	78.6	88.1	9.5
Staff spoke with me in a way that I understood	85.6	84.4	82.2	91.4	9.2
Staff were sensitive to my cultural/ethnic background	82.0	77.0	71.9	85.6	13.7
Total Cultural Sensitivity / Respectful Treatment	82.3	78.4	76.2	86.5	10.3
As a result of the services I received:					
I am better at handling daily life	78.4	69.6	70.9	68.9	-2.0
I get along better with family members	69.4	57.1	60.2	64.2	4.0
I get along better with friends and other people	78.0	75.7	70.5	74.3	3.8
I am doing better in school and/or work	62.7	59.4	58.8	62.5	3.7
I am better able to cope when things go wrong	74.5	69.1	65.1	74.0	8.9
I am satisfied with my family life right now	69.1	58.6	60.9	66.7	5.8
Total Outcomes	72.0	64.9	64.4	68.4	4.0

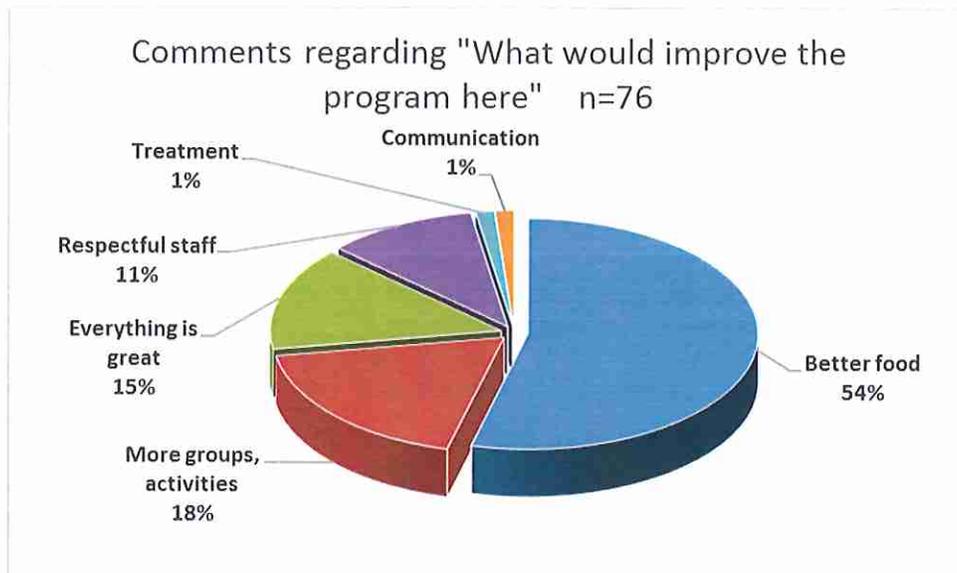


The comments below were written on surveys administered in 2016.

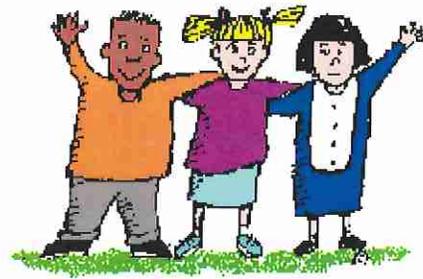
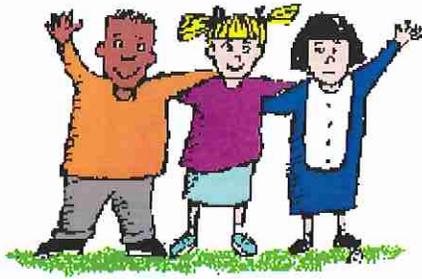


Category	Comments "Most Helpful Things You Received During Your Stay"
Anger management	<p>A sheet that shows me many ways to calm down.</p> <p>A staff member being there to listen and calm me during an anxiety attack.</p> <p>Anger management.</p> <p>Help with my anger.</p> <p>I appreciate everything everyone done with calming me down and being back focused.</p> <p>I got help with my temper. I learned some ways to not get mad and fight when my mom is yelling at me.</p> <p>When I was upset one of the staff talked to time to keep me calm and chill that was very helpful.</p>
Caring, Respectful Staff	<p>Advice.</p> <p>Everything I want to thank yall for everything yall done for me to make me a better person.</p> <p>Friends and some of the doctors and nurses didn't treat me different.</p> <p>Great staff!</p> <p>I received a bunch of attention and the staff all took care of me and they gave me the help I needed.</p> <p>Just knowing people were actually there to help me.</p> <p>Respectful staff and great treatment.</p> <p>Staff took their time out to help me.</p> <p>Thank for helping me out while I was here it means a lot to me because I feel like yall care a lot love everyone that helped out.</p> <p>Thank you for helping mel</p> <p>Thanks to the whole staff, they all deserve a raise.</p> <p>The nurses and teachers made me forget about things and become better person for myself while being here.</p> <p>The nurses helping me.</p> <p>The staff.</p> <p>The support and understanding from everyone who helped me.</p> <p>The teachers were fantastic but the food could have been better.</p> <p>To be kind to help people, be respectful.</p> <p>You guys did very good to help me.</p>
Coping skills	<p>Coping Skills.</p> <p>How to cope and find out who to express my feelings to.</p> <p>It's a lot of ways I can cope with things.</p> <p>Learning my coping skills, controlling my anger.</p>
Groups	<p>Art group.</p> <p>Art therapist.</p> <p>Groups.</p> <p>Music therapy.</p> <p>School art therapy.</p> <p>The OT groups.</p> <p>The school.</p> <p>The staff and the art therapy.</p>
Medication	<p>Medication.</p> <p>Medications helped to change thought process.</p> <p>Med's and rest.</p> <p>My medication, the staff really made sure I was medicated at the proper time.</p> <p>My meds.</p> <p>The meds was helpful and some of the staff.</p> <p>The medicine has a lot to do with my recovery.</p> <p>They gave me medicine and therapy.</p>

Category	Comments "Most Helpful Things You Received During Your Stay"
Safe environment	Just the calmness.
	Meeting new people and making friends.
	Showers, writing and talking.
	Socializing with peers.
Staff listened to patient	The most helpful things that I received during my stay at this program was making a new friend, people
	The program was very helpful by enjoying myself and being independent.
	Being able to talk to people that understood like kids and art and music therapy.
	Having someone to talk to.
	I have been told how life is and understanding the good and bad things.
	I have someone to talk to.
	I was able to talk to someone when needed.
	I was able to talk with my nurses.
	If we need to talk there was somebody there, they found out what was wrong with me.
	Information on why I was here and what works best for me.
	One on one talks, speaking with doctors and nurses.
	People tried to talk to me.
	Somebody to talk to.
	Talking and being open with my emotions to staff and other patients.
	Talking things out or writing.
	Talking to me and my Mom.
Talking to people.	
Talking to the staff.	
Treatment	That people talked with me and helped me cope with my stress and my life.
	When they took time to talk to me and understand me well.
	Getting someone to help me with my problems.
	Help from people.
	Help people willing to work with me and willing to work them.
	Help when my stomach was upset / easy access to nurses.
	I can say I received all the help I needed here and I'm well.
	I receive a good doctor and attorney.
	I think I really improved but I think some OT and CNA are kind of mean.
	It was amazing and I liked it here. And it was well educated.
	People helping as much as they could.
	The talks with the therapists and doctors.
	Therapy
	Therapy and monitored medication.
They explained any questions/concerns I had with treatment.	
Time, being understood and treatment.	
Treated and tested for STD	



Category	Comments "What would improve the program here"
Better food	<p>Better food (x24)</p> <p>Better food less awkward bathroom situation, less restrictions, age group.</p> <p>Better food, more activities!</p> <p>Better food. Better services. More groups.</p> <p>Better food-food here is horrible.</p> <p>Just the food.</p> <p>Like the food cause I wasn't eating very much.</p> <p>Needs better food and a variety of clothing an underwear (sizes to big).</p> <p>You guys need to get better food.</p> <p>Food and outside.</p> <p>I would improve the food here.</p> <p>Letting the kids have some type of say so in my opinion. Better Food.</p> <p>That they have better food and maybe worked better then how they care (some workers).</p> <p>The food and extra bedtime.</p> <p>The food and the time we got to go to bed.</p> <p>The food could be better.</p> <p>When patients are hungry to feed them!</p>
Communication	<p>Communication and goals.</p>
Everything is great	<p>Everything going good!</p> <p>I like the way it is.</p> <p>I mean everything's going great here. Staff and CAIS do there job to help.</p> <p>I would say nothing everything was good I really didn't have no hard time.</p> <p>Nothing they did good.</p> <p>Nothing, because they done everything write.</p> <p>Nothing, its great. (x5)</p>
More groups, activities	<p>Better OT group.</p> <p>Change up the schedule. Also, have different levels of math and have pods of age groups.</p> <p>Giving us a group to learn, coping skills.</p> <p>Group Therapy.</p> <p>If they had more things to do when we are just sitting in the dining room.</p> <p>More activities.</p> <p>More encouraging projects.</p> <p>More games and fun things.</p> <p>More groups.</p> <p>More music groups and food.</p> <p>More groups and engaging in groups.</p> <p>More time at staying to work on things.</p> <p>Other movies to watch.</p> <p>Religions counseling.</p>
Respectful staff	<p>Better staff in some areas of the unit.</p> <p>How people act.</p> <p>More help and understanding.</p> <p>More patient staff.</p> <p>Nurses having better control over the kids.</p> <p>Quicker services and more control.</p> <p>Showing respect to all staff.</p> <p>Staff getting to know people better.</p>
Treatment	<p>Therapy sessions.</p>



CAIS YOUTH SURVEY

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

Today's Date: ____ / ____ / ____

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

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

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

23. What would improve the program here? _____

24. Other comments: _____

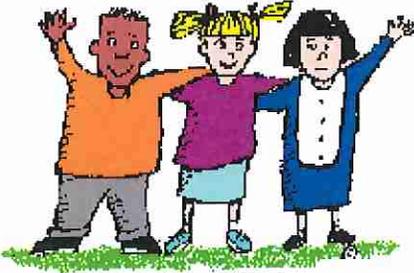
Please answer the following questions to let us know a little about you.

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

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

Age: _____ years old

Gender (mark with X): Male Female



CARS MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) SUMMARY OF RESULTS – 2016

For 2016, CARS programs maintained the target range of 70-80% positive responses for all MHSIP domains except Day Treatment's Changes domain at 67%.

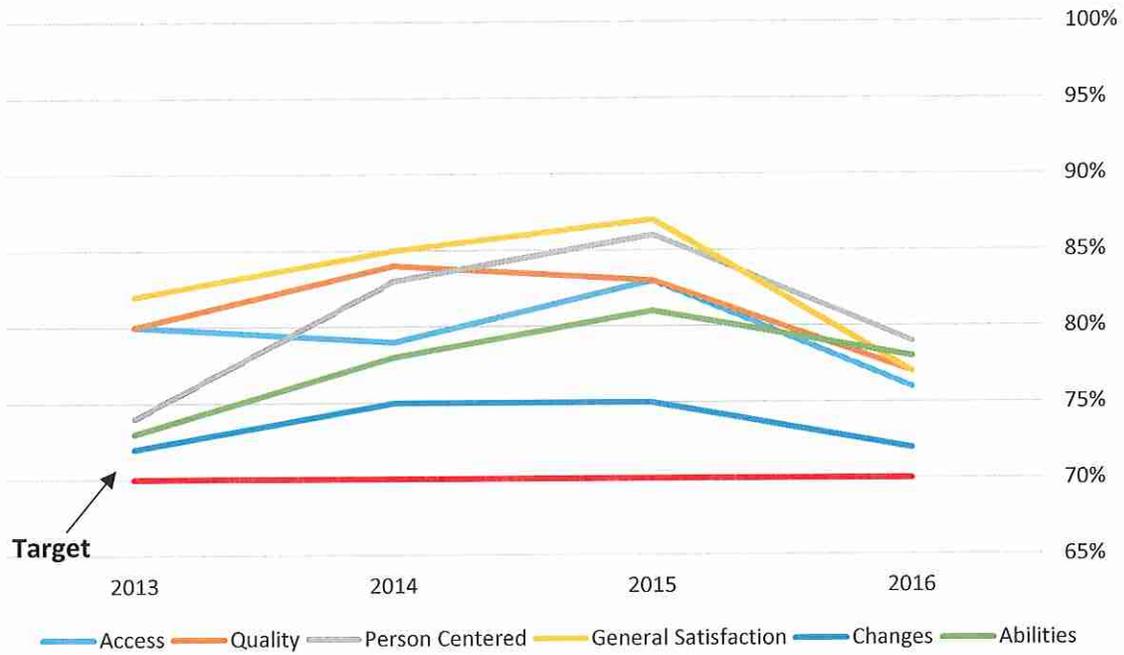
Analyses of survey responses obtained for 2016 revealed:

- All program areas met or exceeded the target range for Access to services.
- All program areas met or exceeded the target range for Quality of services.
- All program areas met or exceeded the target range for Person-Centered services.
- All program areas met or exceeded the target range for General Satisfaction with services.
- All program areas except Day Treatment met the target range for perceptions of Changes due to provision of services.
- All program areas met the target range for improvement in Abilities due to provision of services.
- For all CARS programs, Changes and Abilities, which are related to "results" of services, prefaced by the phrase "as a direct result of services I received..." had lower levels of agreement than "process" domains such as Access, Quality, Person-Centeredness, and General Satisfaction.
- Two of three programs reviewed in this report had lower levels of satisfaction with at least four domains in 2016 than in 2015.
- In the new Person-Centered services domain that appeared for the first time in 2014 on the CARS modified MHSIP, all four program areas had levels of satisfaction that were above 70% agreement on six positively-worded items. Two programs (all but CBRF) were in the ranges considered "high" or "exceptional" by CARS.

Results for the last five years of the MHSIP survey indicate persons receiving CARS mental health services generally have positive perceptions of those services and high General Satisfaction with community services. Consumer perceptions of Access to services, Quality, and General Satisfaction with services have remained above 70% for all CARS programs for the past five years. Although individuals are somewhat less satisfied with Changes that have occurred as a result of services they have received and perception of improvements in individual functional Abilities have not improved as dramatically, in aggregate respondents still have generally positive views of improvements that have occurred in their lives as a result of their participation in community-based services.

The chart on the following page represents the change over time for all six domains:

CARS Combined MHSIP Scores, 2013-2016





MARCH 31, 2017

MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) OVERALL RESULTS 2016

CARS PROGRAM EVALUATION

MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
COMMUNITY ACCESS TO RECOVERY SERVICES

MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) OVERALL RESULTS 2016

INTRODUCTION

Milwaukee County Behavioral Health Division's Community Access to Recovery Services (CARS) has annually conducted a survey of persons receiving mental health services in its community-based programs. CARS uses the revised Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, to survey persons who were actively receiving services in three community mental health program areas: Community Support Programs (CSP), Community-Based Residential Facility Programs (CBRF), and Day Treatment services (DT). The surveys are intended to address a number of key questions.

1. What are the perceptions of persons receiving services of the appropriateness and quality of the mental health services they received in the last year?
2. What are the perceptions of persons receiving services of access to the mental health services they received in the last year?
3. What are the perceptions of persons receiving services of the outcomes of the mental health services they received in the last year?
4. What are perceptions of persons receiving services of their relationships with other persons, not including their mental health service providers?
5. To what extent are persons receiving services satisfied with the mental health services they received in the last year?

Community Access to Recovery Services has established a target range of 70-80% positive responses in all MHSIP domains, an expectation that was extended to the two additional domains of Improvement in Functioning and Improvement in Social Connectedness that were added in 2010 with the use of MHSIP version 1.2.

BRIEF DESCRIPTIONS OF METHODS

SAMPLE

Separate sampling procedures were used for different CARS program areas. Procedures took into account logistical issues pertinent to data collection, with sampling procedures for each program area representing the most feasible approach to obtaining desirable sample sizes. The following approaches were used for each CARS program area:

- **Community Support Programs:** attempt to survey a convenience sample of 10-20% from each provider of persons who had received CSP services for at least three months as of September 2016 (N=154).
- **Residential:** attempt to survey the total population of persons residing in community-based facilities who had been receiving residential services for at least three months as of September 2016 (N=84).
- **Day Treatment:** attempt to survey *all* persons receiving services throughout 2016 in one of the Day Treatment programs (DBT and Recovery) during 2016 (N=10) first after four weeks of services and at discharge from services.

PROCEDURES

The consumer survey was conducted as a point-in-time measure of the perceptions of persons receiving mental health services of the particular program from which each received services in 2016. Trained surveyors from Vital Voices for Mental Health administered the MHSIP Consumer Survey utilizing a peer-to-peer methodology, and assisted individuals as necessary to complete the survey instrument in Residential and CSP programs. In-person administration was used in Day Treatment both four weeks after the start of services at a time convenient for the clients and at the time of discharge, with staff providing any needed assistance. Procedures were adopted in each setting to assure that survey respondents would not be identifiable.

INSTRUMENT

The MHSIP Consumer Survey is a 36-item instrument designed to measure six major domains of mental health services: General Satisfaction, Access, Quality/Appropriateness, Outcomes, Functioning, and Social Connectedness. Respondents indicate their level of agreement / disagreement with statements about mental health services they have received. The response range utilizes a 5-point scale: strongly agree – agree – neutral – disagree – strongly disagree. Respondents may record an item as not applicable. Respondents also complete survey items to provide basic demographic data: age, gender, and ethnicity. Respondents may choose to provide written comments on the survey form about their responses or about areas not covered by the questionnaire, but these are not required.

The following tables represent the survey items as well as the overall score (proportion agree/strongly agree) for all six domains of the Milwaukee County modified MHSIP:

Consumer Perception of Access

Statement	Percentages
A10. The location of services was convenient	79.32%
A11. Staff were willing to see me as often as I felt was necessary	80.67%
A12. Staff returned my calls within 24 hours	73.58%
A13. I was able to see a psychiatrist when I wanted to	72.34%
A14. I was able to get all the services I thought I needed	75.95%

Consumer Perception of Quality

Statement	Percentage
Q16. Staff here believe that I can grow, change and recover	85.11%
Q17. I felt comfortable asking questions about my treatment and medication	81.01%
Q18. Staff told me what side effects to watch for	66.24%
Q19. Staff respected my wishes about who is, and who is not, to be given information about my treatment	77.31%
Q20. Staff was sensitive to my cultural/ethnic background (race, religion, language, etc.)	76.92%
Q21. Staff helped me to obtain information so that I could take charge of managing my illness	77.54%

Q22. I felt free to complain	75.53%
Q23. I was given information about my rights	80.59%
Q24. Staff encouraged me to take responsibility for how I live my life	83.47%
Q25. I was encouraged to use consumer-run programs (support groups, crisis phone line, etc.)	72.46%
Q26. I, not staff, decided my treatment goals	72.22%

Consumer Perception of Person-Centeredness

Statement	Percentage
C28. I felt the rules were fair and consistent	77.77%
PC29. Staff encouraged me to have hope and high expectations for my life	77.63%
PC30. Staff welcomed my thoughts about my medication	78.99%
PC31. I am included in decisions about my money	78.03%
PC32. Staff and I work together as a team to reach my life goals	80.51%
PC33. Staff understand that I have been through a lot	81.36%

Consumer Perception of General Satisfaction

Statement	Percentage
GS35. I like the services that I received here	82.20%
GS36. If I had other choices, I would still get services from this agency	72.46%

Consumer Perception of Change

Statement	Percentage
C38. I deal more effectively with daily problems	77.54%
C39. I am better able to control my life	79.32%
C40. I am better able to deal with crisis	73.19%
C41. I am getting along better with my family	70.35%
C42. I do better in social situations	73.31%
C43. I do better in school and/or work	55.81%
C44. My symptoms are not bothering me as much	70.34%
C45. My housing situation has improved	74.47%

Consumer Perception of Abilities

Statement	Percentage
A47. I do things that are more meaningful to me	82.21%
A48. I am better able to take care of my needs	80.00%
A49. I am better able to handle things when they go wrong	72.69%
A50. I am better able to do things that I want to do	77.68%

RESULTS

Data presented include results broken out for three CARS program areas. Results for two Day Treatment programs are aggregated in this report for ease in data analysis. For purposes of quality improvement for operated and contract agencies, companion reports of the 2016 survey will also be prepared with data broken out by program.

Based on many years of conducting the MHSIP Consumer Survey, CARS suggests the following guidelines when interpreting the percentage of agree/strongly agree (positive) responses. When utilizing these guidelines, however, it is critical to take into consideration response and sample sizes when evaluating results for individual providers. When reviewing specific survey items, it also must be understood that particular items may be more germane to some program areas than to others.

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

Results of the 2016 Consumer Survey are presented in tabular form on the next several pages. Table 1 (below) presents data on sample size, respondents, and response rate. The survey response rates ranged from a low of 26% for clients receiving Day Treatment services to a high of 62% for clients receiving CSP services. The total survey response rate for all CARS programs included in this report was 58%, which is consistent with research standards that indicate a reasonable goal for response rates for this type of survey is 50-60%. It is important to note that interpretation of results from this survey cannot account for perceptions of services for those who chose not to respond nor determine whether those who did respond represent consumers with comparatively more favorable or less favorable perceptions than those who did not respond.

Table 1

Response Rate By Program			
Program	Sample Size	Number of Respondents	Response Rate %
CSP	249	154	62%
Day Treatment	39	10	26%
Residential	143	84	59%
Total	431	248	58%

Tables 2 and 3 below present 2016 demographic data on the age, gender, and ethnicity of respondents. Demographic data from the 2016 survey are generally consistent with previous years. The average age of the population served by CARS programs has been remaining steady over time, with an overall average of 48 years in this year's sample (2015 average age was 46). In general, the more intensive the service, the older the case mix. Males continued to outnumber females in all programs except Day Treatment, which at 60% had the highest percentage of female respondents. Overall, however, women comprised only 33% of all respondents from CARS programs included in this survey, continuing a long-term trend of declining female participation (2015 proportion was 43%).

Table 2

Program	Mean Age	Female		Male		Unknown		Grand Total
		N	%	N	%	N	%	
CBRF	52	27	32%	55	65%	2	2%	84
CSP	47	51	33%	103	67%			154
DT	32	6	60%	4	40%			10

Table 3

	American Indian	Native Hawaiian	Asian	White	Hispanic-Latino	Black	Other
CBRF	3.6%		1.0%	58.3%	16.7%	25.0%	11.9%
CSP	1.3%	1.3%	1.3%	24.7%	10.4%	56.5%	14.9%
DT				40.0%	10.0%	50.0%	10.0%

The proportion of clients identifying themselves as Hispanic-Latino, which had shown steady increases between 2005 and 2011, now appears to be fluctuating from year to year. In 2016, 12.5% of all respondents said they were Hispanic-Latino, 2.5% higher than 2015. Native Americans comprised 2% of respondents in 2016, similar to prior years. At 1% the proportion whose ethnic identification is Asian remained the same as previous years.

Table 4 below presents 2016 data for the Consumer Survey items organized by the six new domain titles of Access, Changes, Quality, General Satisfaction, Abilities, and Person-Centeredness for each Community Access to Recovery Services program in this report and for the total of all respondents in these CARS programs. To facilitate year-over-year comparisons, Table 5 (next page) presents Consumer Survey domain scores for the six domains included in the last four years the MHSIP or modified MHSIP has been administered.

Table 4

Program	N	Percent Agree/Strongly Agree					
		Access	Quality	Person Centered	General Satisfaction	Changes	Abilities
CBRF	84	71.60%	71.73%	72.95%	72.96%	70.33%	77.93%
CSP	154	78.69%	80.05%	82.39%	79.69%	72.51%	78.28%
DT	10	87.05%	87.85%	87.43%	85.00%	67.38%	77.50%

Table 5

2013-2016 CARS MHSIP Domain Scores (Percent Agree/Strongly Agree)																								
Service	Access				Changes				Quality				General Satisfaction				Abilities				Person-Centered			
	'13	'14	'15	'16	'13	'14	'15	'16	'13	'14	'15	'16	'13	'14	'15	'16	'13	'14	'15	'16	'13	'14	'15	'16
CSP	80	83	80	80	76	78	79	73	82	82	84	80	82	84	82	80	79	82	82	78	74	83	88	82
Day Treatment	83	83	96	87	51	75	74	67	87	94	90	88	88	91	87	85	46	74	84	78	55	95	90	87
CBRF	78	72	75	72	77	77	68	70	74	74	77	72	73	78	72	73	75	79	76	78	81	70	74	73

As discussed earlier, CARS expected each program area to be positively rated at 70-80% agree/strongly agree responses in each of the six modified MHSIP domains. Detailed results by CARS program are presented in the companion 2016 CARS MHSIP Program Reports.

- All program areas met the target range for Access to services. Day Treatment exceeded the target.
- All program areas except Day Treatment met the target range for Changes.
- All programs areas met the target range for Quality of services. Day Treatment and CSP exceeded the target.
- All program areas met the target range for General Satisfaction with services. Day Treatment and CSP exceeded the target.
- All program areas met the target range for Abilities.
- All program areas met the target range for Person-Centered services. Day Treatment and CSP exceeded the target.

Results for the last four years (2013-2016) indicate high positive perceptions of Access to CARS mental health services across all programs. For all four years, consumer satisfaction with Community Support Programs have consistently met targets in all six chosen domains. Consumer satisfaction with Residential (CBRF) services has met targets in five of six domains for all four years, with Changes in 2015 not meeting target at 68%. For Day Treatment, there were marked discrepancies in 2013 and subsequent years between satisfaction related to the Abilities, Changes, and Person-Centered domains. Since 2014, all domains have consistently met targets, with the exception of Changes in 2016.

Positive ratings (percent agree or strongly agree) were obtained from respondents for all six domains of the MHSIP Survey for 2016. The aggregate CARS domain scores met the target for satisfaction for all six domains: Access to services (76%), Quality of services (77%), Changes (72%), General Satisfaction (77%), Person-Centeredness (79%), and client improvement in Abilities (78%). Over several previous years, the all-CARS trend has been for steady improvement among all domains. However, in 2016, there was a reduction among all domains. TCM satisfaction surveys were not collected in 2016, which was a contributing factor to the overall reduction in scores. Historically, TCM represented a high volume of surveys and they consistently exceeded the target range in most domains, thus leading to a higher overall score. The fact that all six domains have over 70% agreement remains gratifying. There was one item across all CARS programs combined that was in the below 60% range of agree/strongly agree responses considered "poor" by CARS. The item, "I do better in school/work" was considerably lower in 2016 than previous years, again partly due to the lack of TCM survey collection.

A high proportion of surveys were excluded from this item's analysis due to a "not applicable" response, thus increasing the item's volatility with a low sample. In addition, a historically low proportion of clients enrolled in CSP, CBRF, and Day Treatment are employed or enrolled in school/job training. There was one item across all CARS programs combined that was in the 60-70% range of agree/strongly agree responses considered "relatively low" by CARS, which is an increase from zero in 2015 but a decrease from six in 2013 to only three in 2014. The item "I, not staff, decided my treatment goals" had received less than 70% satisfaction from consumers across all CARS programs for seven years in a row; this year it scored 72.2. This has occurred in conjunction with high ratings on items related to person-centeredness, including "Staff and I work together as a team to reach my life goals" (80.5).

SUMMARY

For 2016, the third year in which a CARS modified MHSIP was administered, CARS programs maintained the target range of 70-80% positive responses for all our modified MHSIP domains except Day Treatment's Changes domain at 67%.

Analyses of survey responses obtained for 2016 revealed:

- All program areas met or exceeded the target range for Access to services.
- All program areas met or exceeded the target range for Quality of services.
- All program areas met or exceeded the target range for Person-Centered services.
- All program areas met or exceeded the target range for General Satisfaction with services.
- All program areas except Day Treatment met the target range for perceptions of Changes due to provision of services.
- All program areas met the target range for improvement in Abilities due to provision of services.
- For all CARS programs, Changes and Abilities, which are related to "results" of services, prefaced by the phrase "as a direct result of services I received..." had lower levels of agreement than "process" domains such as Access, Quality, Person-Centeredness, and General Satisfaction.
- Two of three programs reviewed in this report had lower levels of satisfaction with at least four domains in 2016 than in 2015.
- In the new Person-Centered services domain that appeared for the first time in 2014 on the CARS modified MHSIP, all four program areas had levels of satisfaction that were above 70% agreement on six positively-worded items. Two programs (all but CBRF) were in the ranges considered "high" or "exceptional" by CARS.

Results for the last five years of the MHSIP survey indicate persons receiving CARS mental health services generally have positive perceptions of those services and high General Satisfaction with community services. Consumer perceptions of Access to services, Quality, and General Satisfaction with services have remained above 70% for all CARS programs for the past five years. Although individuals are somewhat less satisfied with Changes that have occurred as a result of services they have received and perception of improvements in individual functional Abilities have not improved as dramatically, in aggregate respondents still have generally positive views of improvements that have occurred in their lives as a result of their participation in community-based services.

RECOMMENDATIONS

The following are recommended based on the results of the 2016 MHSIP Consumer Survey:

1. Publish the results of the 2016 MHSIP on the Milwaukee County BHD – CARS website to highlight the satisfaction expressed by the recipients of community case management services.
2. Review the 2016 survey results with providers to attempt to clarify and explain those domains and items that received lower ratings by individuals receiving services within each program and consider what actions should be taken in response.
3. Utilize the 2016 survey results in discussions with BHD and CARS management, consumers, providers, and other stakeholders with the objective of identifying areas needing improvement and designing strategies to promote improvement.
4. Have each program area select at least one domain and/or item to be explicitly targeted for improvement on the 2017 MHSIP satisfaction survey.
5. Review the Person-Centered domain on the CARS modified MHSIP with regard to whether it provided useful and important information and/or whether the survey needs to be modified further to make sure issues critical to service recipients are addressed in future administrations.
6. Identify specific items on the CARS modified MHSIP that reflect client perceptions of adherence to core values of CARS identified in the overall CARS evaluation plan. Include these items in summary data made available to current and potential service recipients.
7. Include aggregate results from key MHSIP domains on the Behavioral Health Division KPI Dashboard developed in the Quality Management Services Committee.
8. Continue to consult with individuals receiving services of various kinds to allow their perceptions of satisfaction instruments, items, and results to inform decisions about how to make use of these indicators in continuous quality improvement efforts.
9. Consider other ways to effectively publicize the results of surveys of recipient satisfaction and to make them more available to the broader Milwaukee community.



MARCH 31, 2017

MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) RESULTS 2016 – DAY TREATMENT

CARS PROGRAM EVALUATION

MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
COMMUNITY ACCESS TO RECOVERY SERVICES

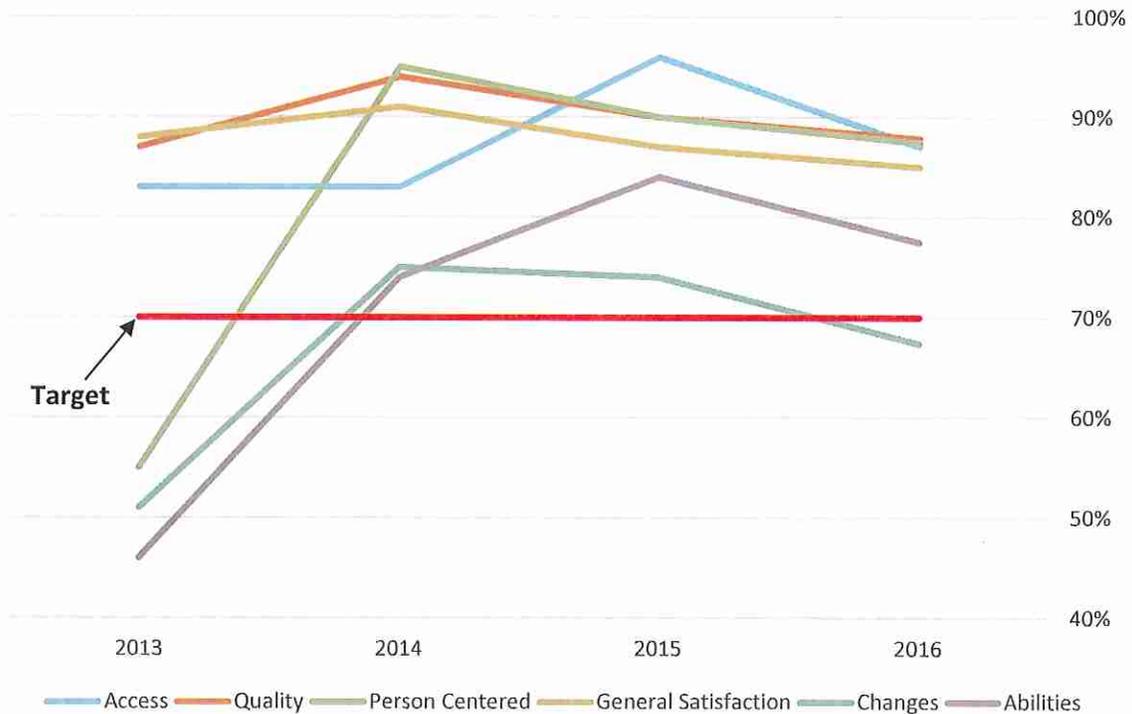
MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) RESULTS 2016 – DAY TREATMENT

SUMMARY OF RESULTS

As discussed in the 2016 Overall MHSIP Report, the MHSIP Consumer Survey is a 36-item instrument designed to measure six major domains of mental health services.

It was another good year for consumer satisfaction with services in the Day Treatment Programs. In 2016, Access to services, Quality of services, Person-centered services, General Satisfaction with services, and client improvement in Abilities, all received percentages of agree/strongly agree responses that met or exceeded the target range of 70-80% for MHSIP domains. Day Treatment agencies are also to be congratulated for three consecutive years of “good or expected” ratings on surveys collected in all but one MHSIP domain (Changes).

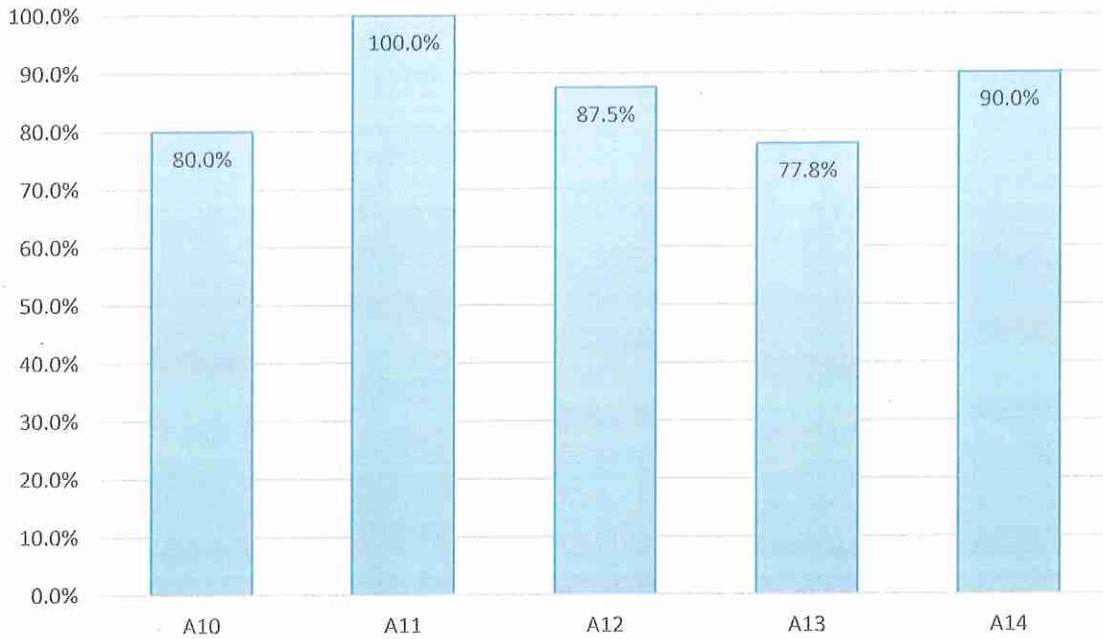
The chart below represents the change over time for all six domains:



If you seek the complete list of questions, please refer to Appendix A. Below are charts of the measured categories and their items. Specific item by item results from the 2016 survey revealed the following:

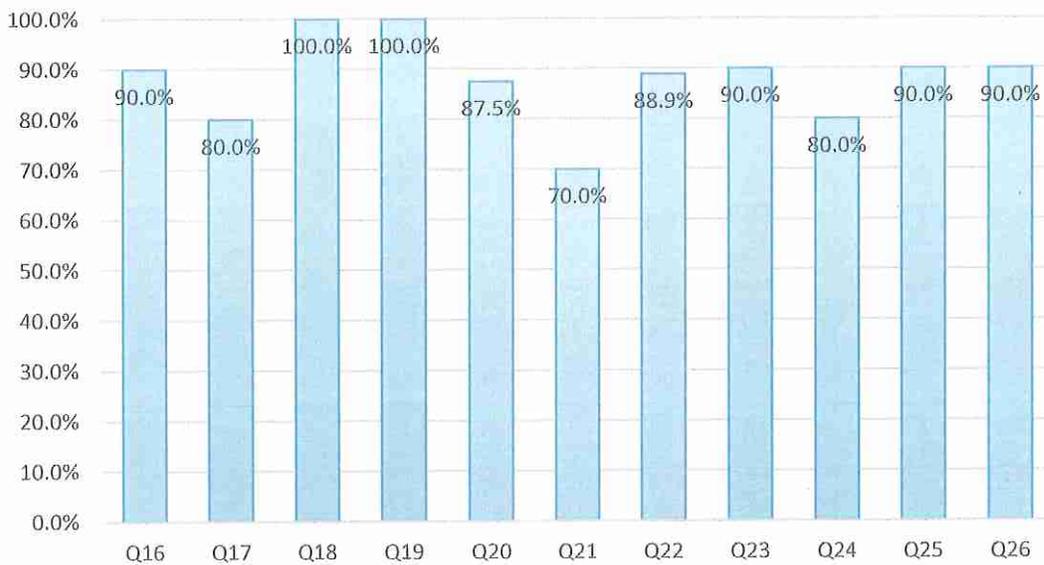
Caution should be exercised in interpreting individual results for the Day Treatment program, due to a limited number of respondents. A single client changing whether or not he or she agrees with an item can move the score for that item by 7-10%.

ACCESS



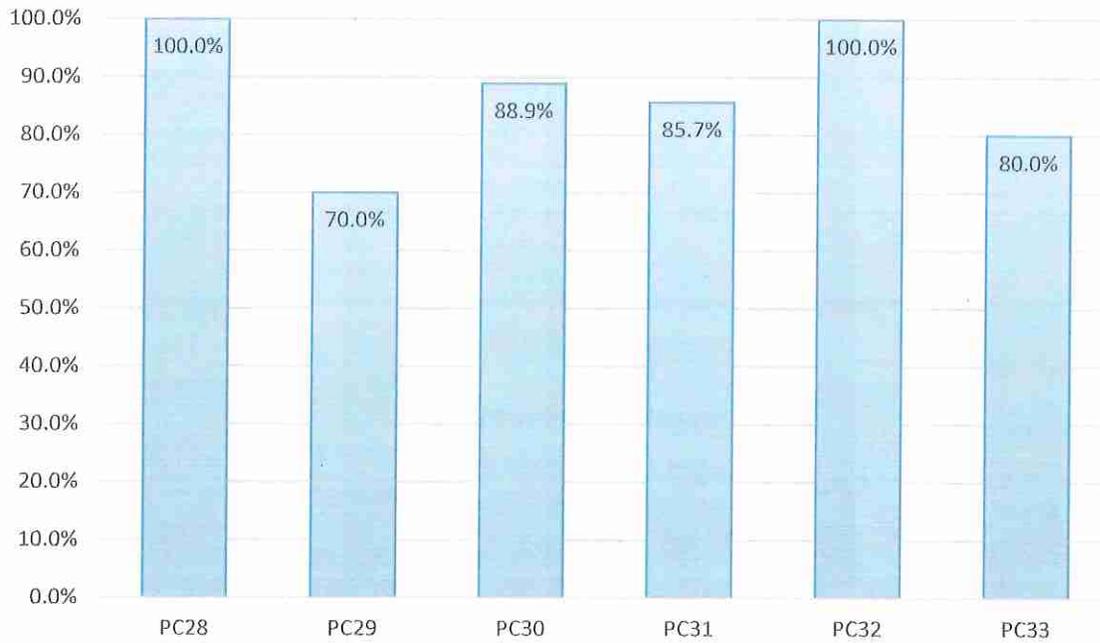
Four of five items exceeded expectations in the access category, while the remaining one item met expectations.

QUALITY & APPROPRIATENESS



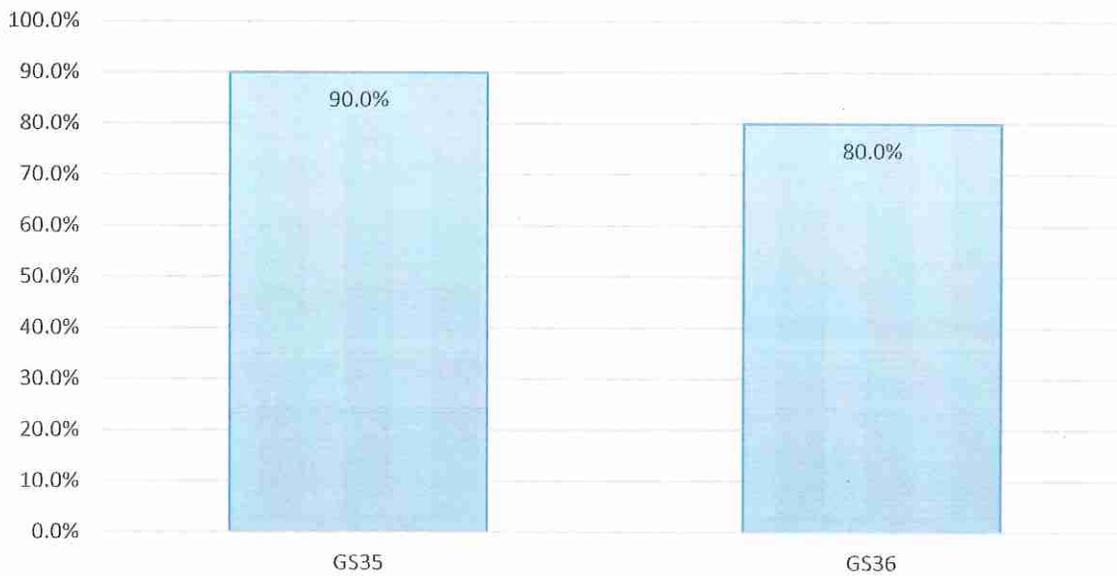
This was a very highly rated category for Day Treatment! Ten of eleven items in this section exceeded the target range. The remaining item met expectations.

PERSON CENTEREDNESS



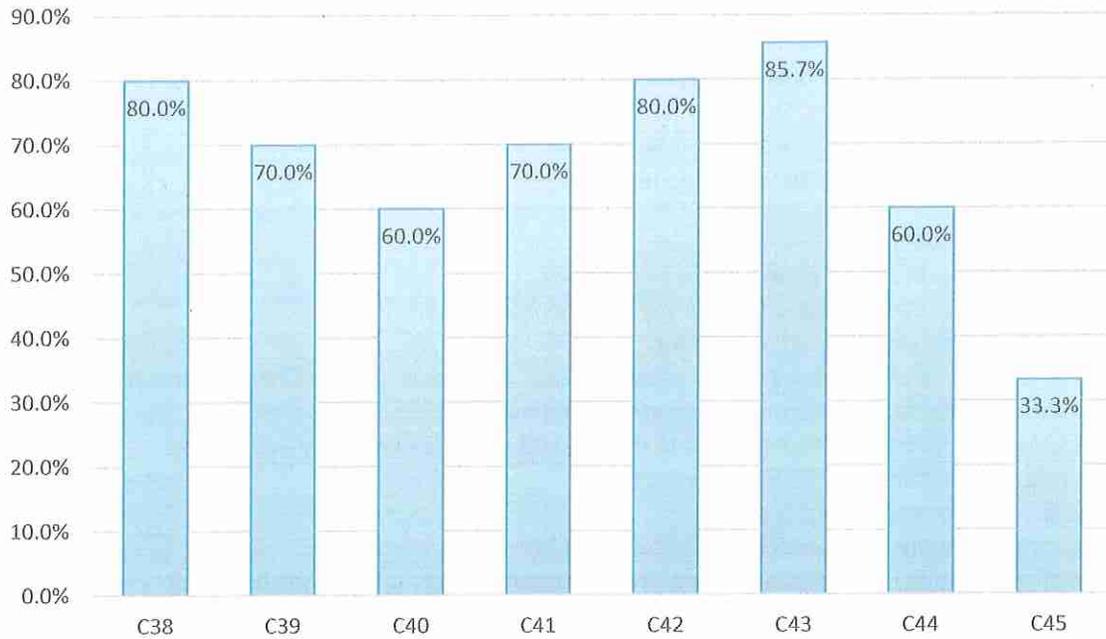
Another highly rated category for Day Treatment! Five of six items exceeded expectations, and the remaining one item met expectations.

GENERAL SATISFACTION



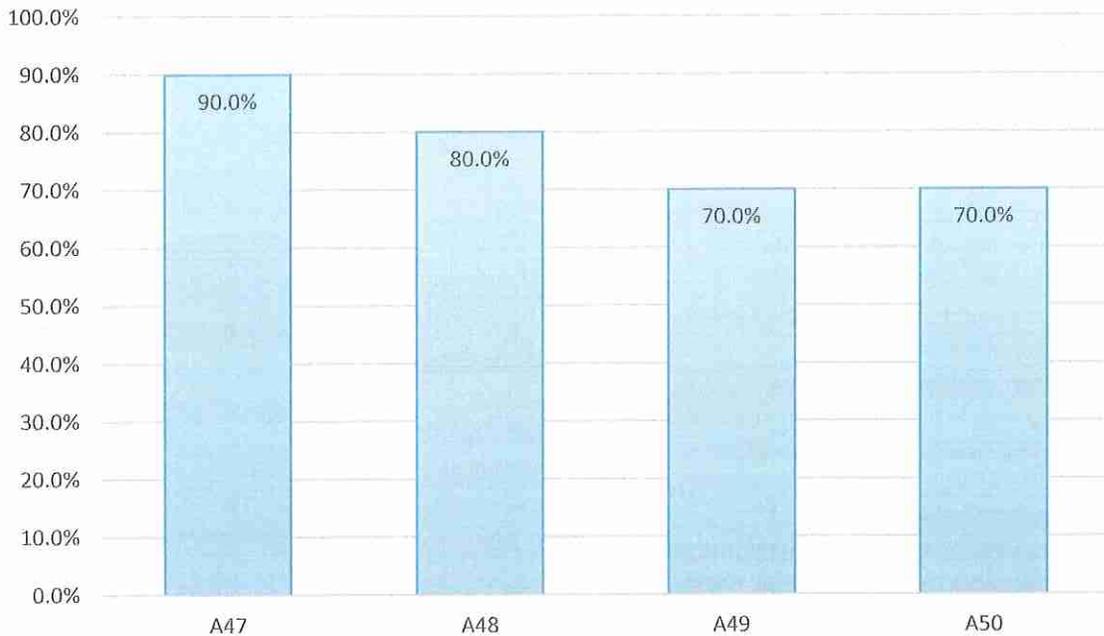
Target rates for general satisfaction were exceeded for both items!

CHANGES



Three of eight items exceeded expectations, and another two of eight met expectations for the changes category. Day Treatment's lowest scores also came from this category, with two items in the 'relatively low' category and one in the 'poor' category.

ABILITIES



Two of four items exceeded expectations, while the other two met expectations in the abilities category.

APPENDIX A

Consumer Perception of **Access**

- A10. The location of services was convenient.
- A11. Staff were willing to see me as often as I felt was necessary.
- A12. Staff returned my calls within 24 hours.
- A13. I was able to see a psychiatrist when I wanted to.
- A14. I was able to get all the services I thought I needed.

Consumer Perception of **Quality**

- Q16. Staff here believe that I can grow, change and recover.
- Q17. I felt comfortable asking questions about my treatment and medication.
- Q18. Staff told me what side effects to watch for.
- Q19. Staff respected my wishes about who is, and who is not, to be given information about my treatment.
- Q20. Staff was sensitive to my cultural/ethnic background (race, religion, language, etc.).
- Q21. Staff helped me to obtain information so that I could take charge of managing my illness.
- Q22. I felt free to complain.
- Q23. I was given information about my rights.
- Q24. Staff encouraged me to take responsibility for how I live my life.
- Q25. I was encouraged to use consumer-run programs (support groups, crisis phone line, etc.).
- Q26. I, not staff, decided my treatment goals.

Consumer Perception of **Person-Centeredness**

- PC28. I felt the rules were fair and consistent.
- PC29. Staff encouraged me to have hope and high expectations for my life.
- PC30. Staff welcomed my thoughts about my medication.
- PC31. I am included in decisions about my money.
- PC32. Staff and I work together as a team to reach my life goals.
- PC33. Staff understand that I have been through a lot.

Consumer Perception of **General Satisfaction**

- G35. I like the services that I received here.
- G36. If I had other choices, I would still get services from this agency.

Consumer Perception of **Changes**

- C38. I deal more effectively with daily problems.
- C39. I am better able to control my life.
- C40. I am better able to deal with crisis.
- C41. I am getting along better with my family.
- C42. I do better in social situations.
- C43. I do better in school and/or work.
- C44. My symptoms are not bothering me as much.
- C45. My housing situation has improved.

Consumer Perception of **Abilities**

- A47. I do things that are more meaningful to me.
- A48. I am better able to take care of my needs.
- A49. I am better able to handle things when they go wrong.
- A50. I am better able to do things that I want to do.



MARCH 31, 2017

**MENTAL HEALTH STATISTICAL
IMPROVEMENT PROGRAM (MHSIP)
RESULTS 2016 – COMMUNITY SUPPORT
PROGRAM**

CARS PROGRAM EVALUATION

MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
COMMUNITY ACCESS TO RECOVERY SERVICES

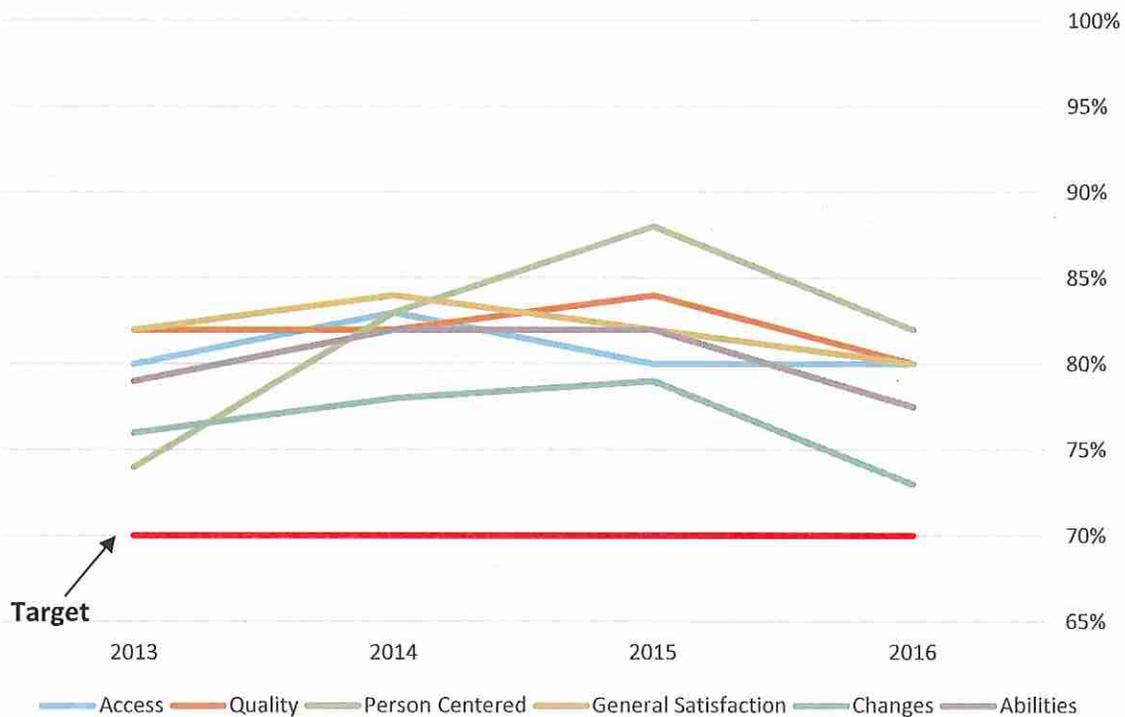
MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) RESULTS 2016 – COMMUNITY SUPPORT PROGRAM

SUMMARY OF RESULTS

As discussed in the 2016 Overall MHSIP Report, the MHSIP Consumer Survey is a 36-item instrument designed to measure six major domains of mental health services.

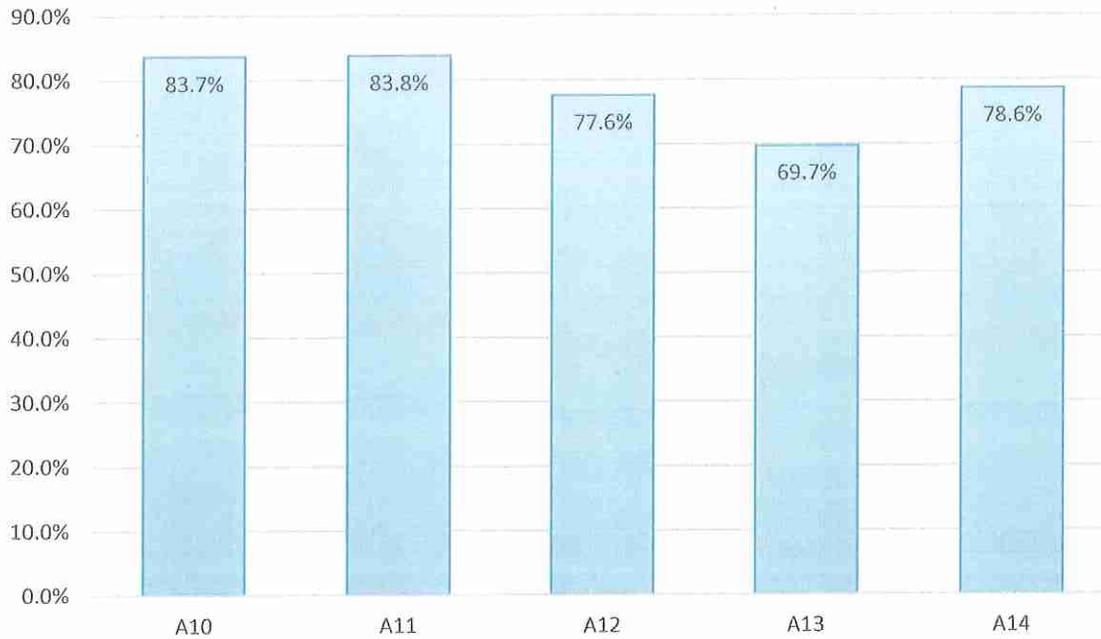
It was another very good year for consumer satisfaction with services in the Community Support Program. In 2016, all domains received percentages of agree/strongly agree responses that met or exceeded the target range of 70-80% for MHSIP domains. Three of the domains received agree/strongly agree responses in the 80-90% range considered “high” by CARS. Community Support Program agencies are also to be congratulated for nine consecutive years of satisfactory ratings in all the MHSIP domains.

The chart below represents the change over time for all six domains:



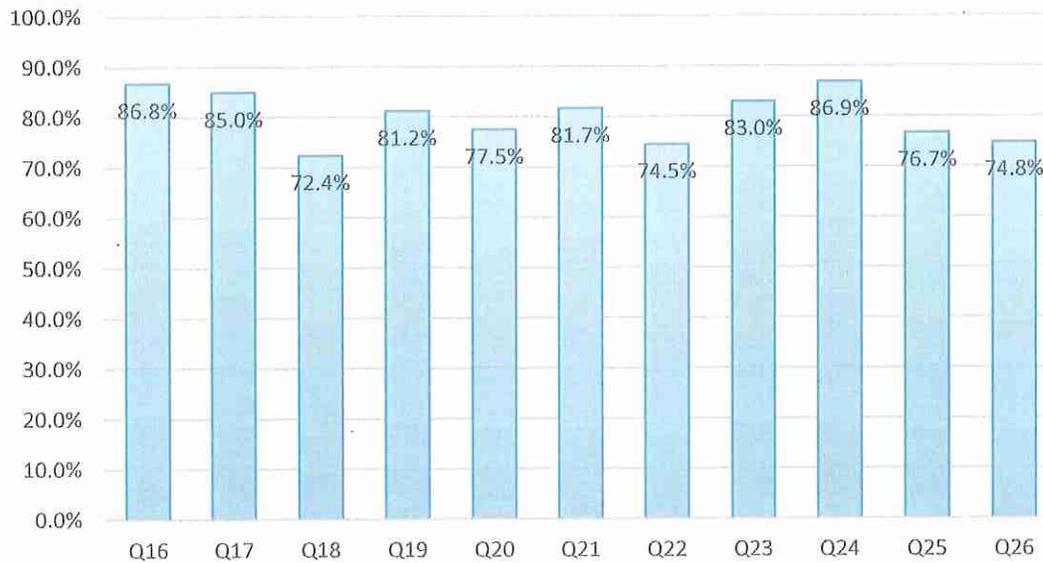
If you seek the complete list of questions, please refer to Appendix A. Below are charts of the measured categories and their items. Specific item by item results from the 2016 survey revealed the following:

ACCESS



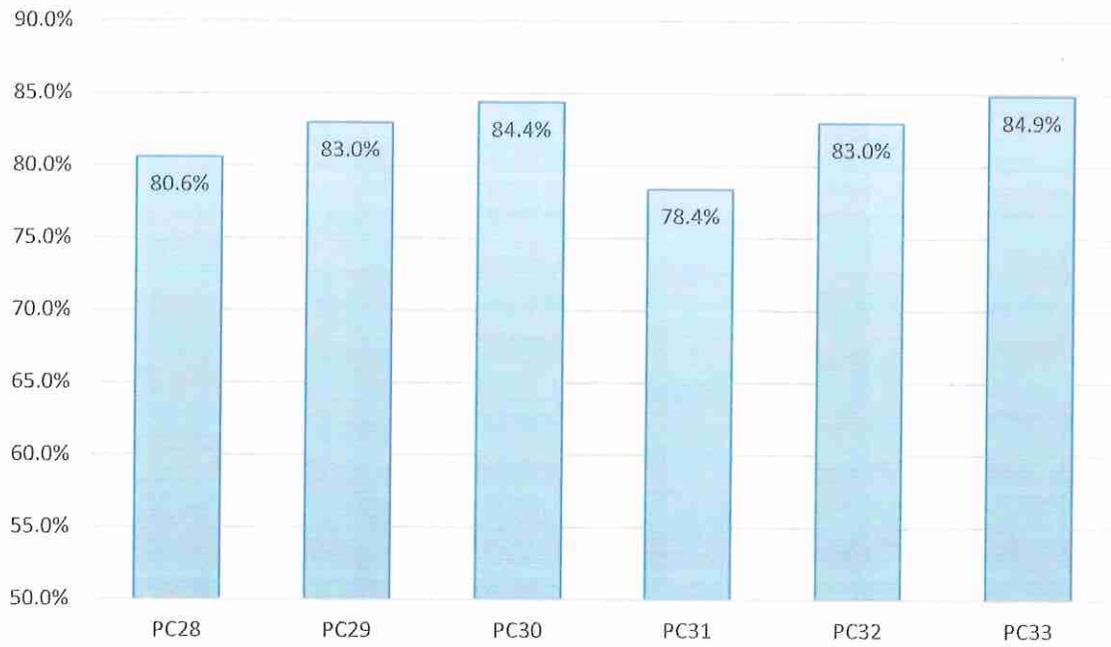
Two of five items exceeded expectations in the access category, while another two met expectations. One item did not meet the target range, A13. This item had a 'relatively low' rating because it was between 60% and 70%.

QUALITY & APPROPRIATENESS



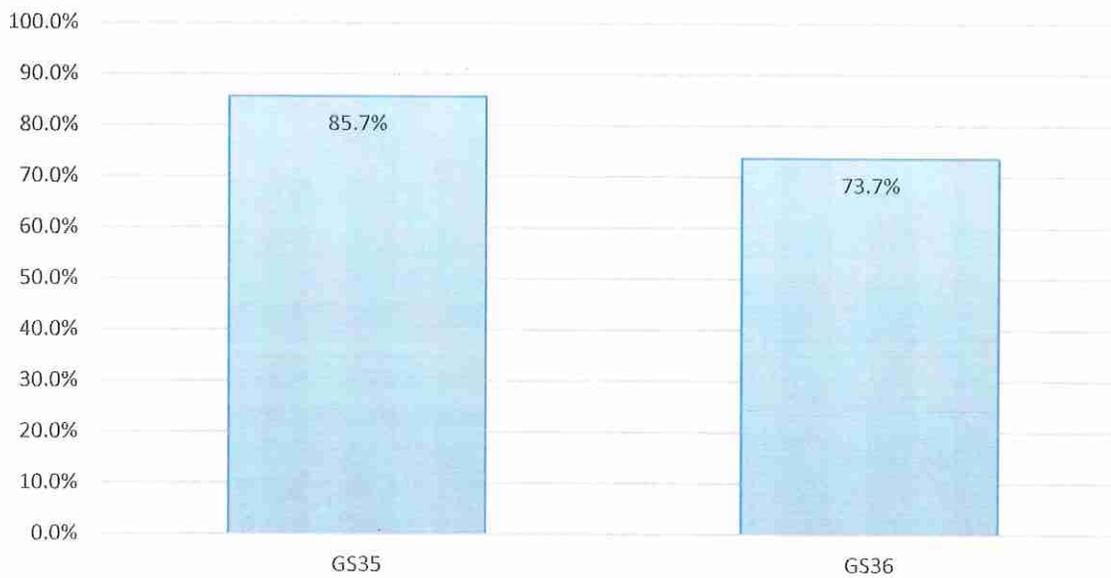
This was a very highly rated category for CSP! Six of eleven items in this section exceeded the target range. The remaining five items met targeted expectations.

PERSON CENTEREDNESS



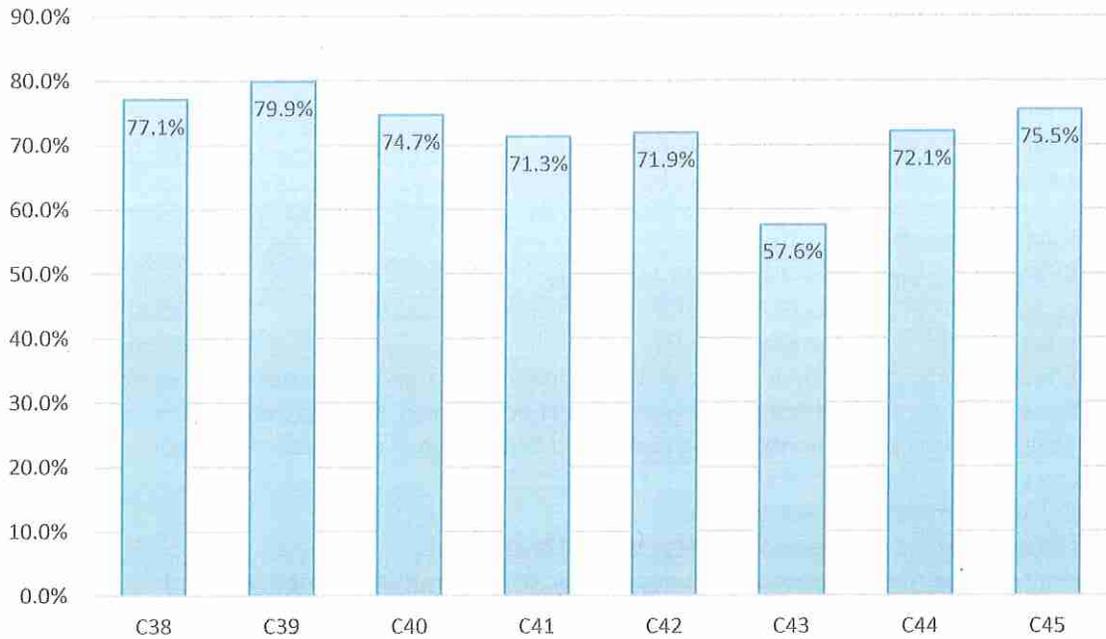
Another highly rated category for CSP! Five of six items exceeded expectations, and the remaining one item met expectations.

GENERAL SATISFACTION



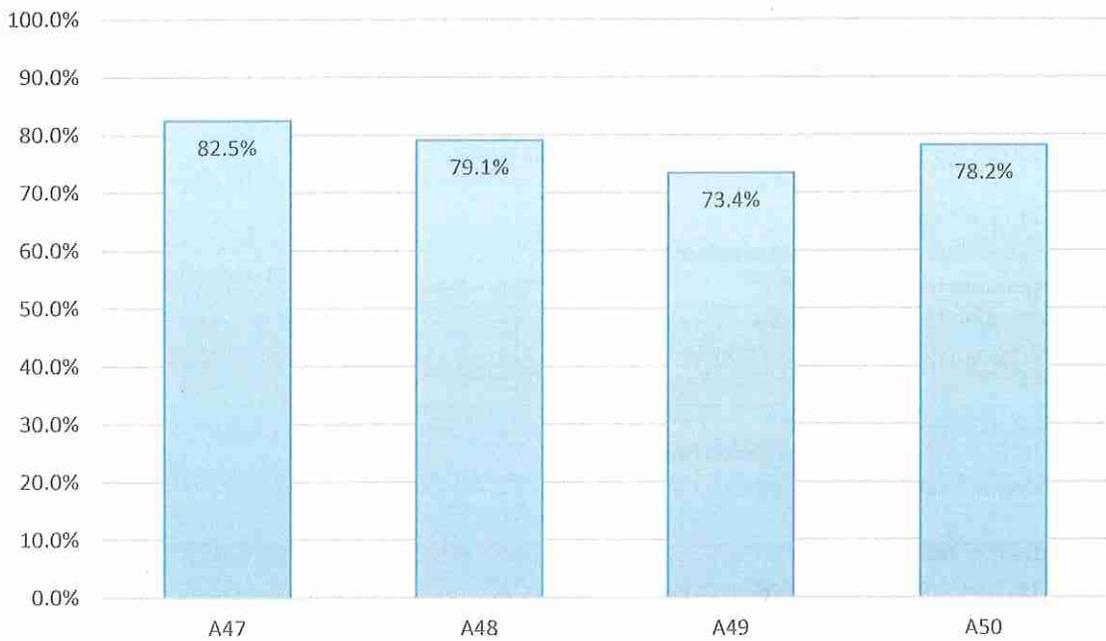
Target rates for general satisfaction were met or exceeded for both items!

CHANGES



Seven of eight items met expectations, and only one of eight was below expectations for the changes category.

ABILITIES



One of four items exceeded expectations, while the other three met expectations in the abilities category.

APPENDIX A

Consumer Perception of **Access**

- A10. The location of services was convenient.
- A11. Staff were willing to see me as often as I felt was necessary.
- A12. Staff returned my calls within 24 hours.
- A13. I was able to see a psychiatrist when I wanted to.
- A14. I was able to get all the services I thought I needed.

Consumer Perception of **Quality**

- Q16. Staff here believe that I can grow, change and recover.
- Q17. I felt comfortable asking questions about my treatment and medication.
- Q18. Staff told me what side effects to watch for.
- Q19. Staff respected my wishes about who is, and who is not, to be given information about my treatment.
- Q20. Staff was sensitive to my cultural/ethnic background (race, religion, language, etc.).
- Q21. Staff helped me to obtain information so that I could take charge of managing my illness.
- Q22. I felt free to complain.
- Q23. I was given information about my rights.
- Q24. Staff encouraged me to take responsibility for how I live my life.
- Q25. I was encouraged to use consumer-run programs (support groups, crisis phone line, etc.).
- Q26. I, not staff, decided my treatment goals.

Consumer Perception of **Person-Centeredness**

- PC28. I felt the rules were fair and consistent.
- PC29. Staff encouraged me to have hope and high expectations for my life.
- PC30. Staff welcomed my thoughts about my medication.
- PC31. I am included in decisions about my money.
- PC32. Staff and I work together as a team to reach my life goals.
- PC33. Staff understand that I have been through a lot.

Consumer Perception of **General Satisfaction**

- G35. I like the services that I received here.
- G36. If I had other choices, I would still get services from this agency.

Consumer Perception of **Changes**

- C38. I deal more effectively with daily problems.
- C39. I am better able to control my life.
- C40. I am better able to deal with crisis.
- C41. I am getting along better with my family.
- C42. I do better in social situations.
- C43. I do better in school and/or work.
- C44. My symptoms are not bothering me as much.
- C45. My housing situation has improved.

Consumer Perception of **Abilities**

- A47. I do things that are more meaningful to me.
- A48. I am better able to take care of my needs.
- A49. I am better able to handle things when they go wrong.
- A50. I am better able to do things that I want to do.



MARCH 31, 2017

MENTAL HEALTH STATISTICAL
IMPROVEMENT PROGRAM (MHSIP)
RESULTS 2016 – CBRF

CARS PROGRAM EVALUATION

MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
COMMUNITY ACCESS TO RECOVERY SERVICES

MENTAL HEALTH STATISTICAL IMPROVEMENT PROGRAM (MHSIP) RESULTS 2016 – CBRF

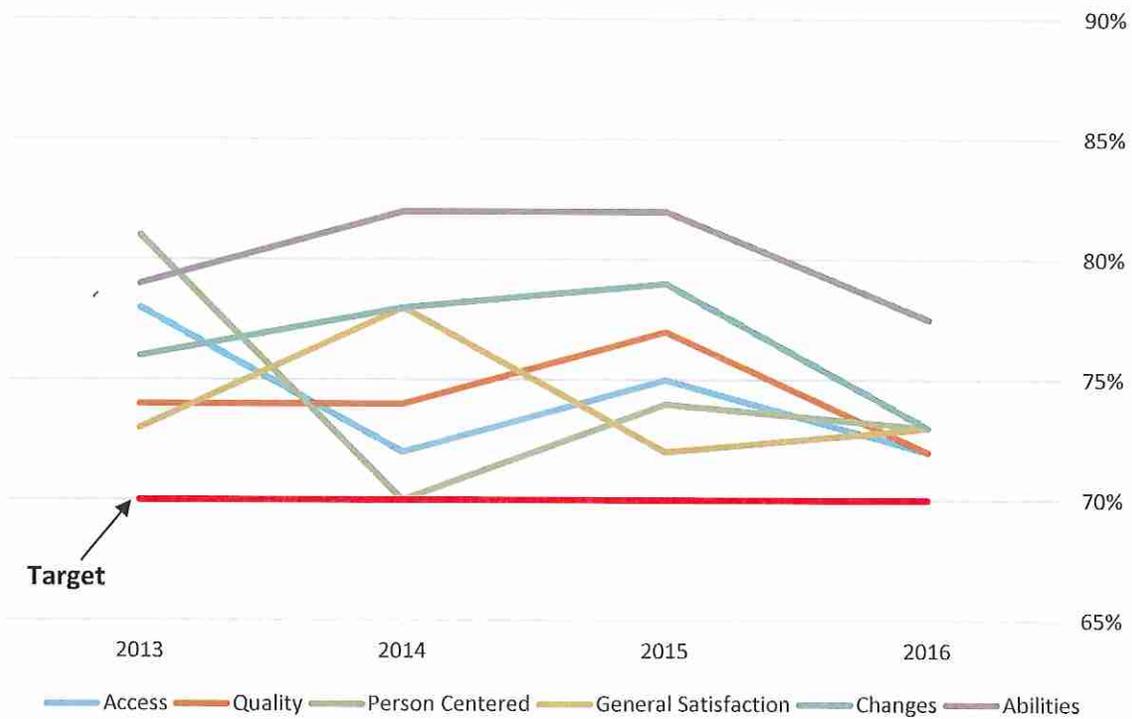
SUMMARY OF RESULTS

As discussed in the 2016 Overall MHSIP Report, the MHSIP Consumer Survey is a 36-item instrument designed to measure six major domains of mental health services.

It was another good year for consumer satisfaction with services in the Community Based Residential Services Programs, even though overall satisfaction scores trended slightly downward compared to 2015. In 2016, all domains received percentages of agree/strongly agree responses that met the target range of 70-80% for MHSIP domains. Community Based Residential Facility agencies are also to be congratulated for nine consecutive years of satisfactory ratings in all but one (Changes) MHSIP domains.

Results for the last four years (2013-2016) indicate high positive perceptions of Access to CARS mental health services across all programs. Consumer satisfaction with Residential (CBRF) services has met targets in five of six domains for all four years, with Changes in 2015 not meeting target at 68%.

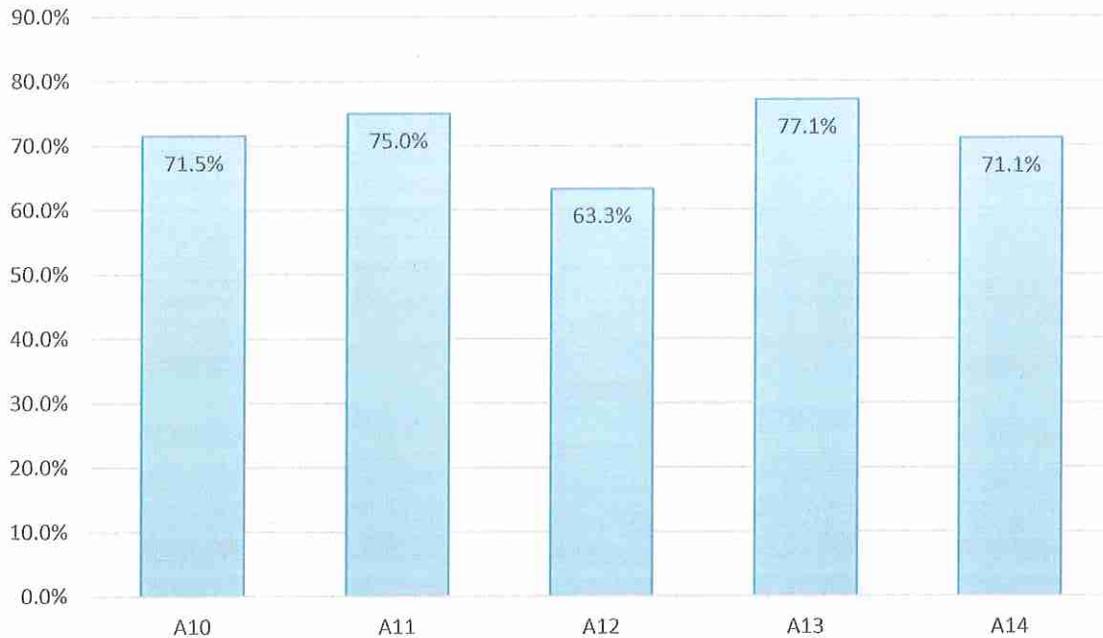
The chart below represents the change over time for all six domains:



There was a slight decrease in overall scores in 2016 compared to 2015, however, each domain had scores above the targeted percentage (70).

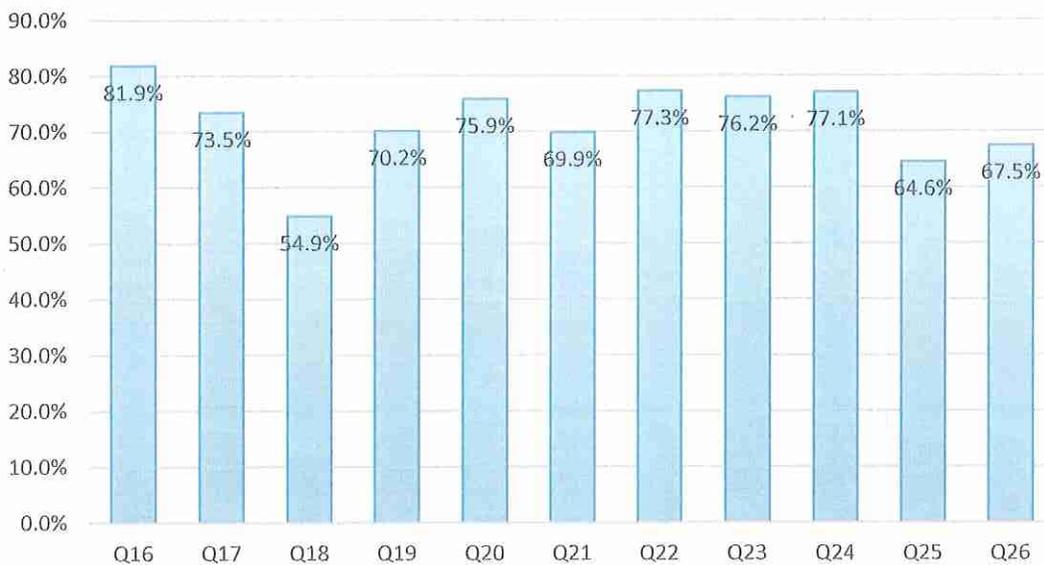
If you seek the complete list of questions, please refer to Appendix A. Below are charts of the measured categories and their items. Specific item by item results from the 2016 survey revealed the following:

ACCESS



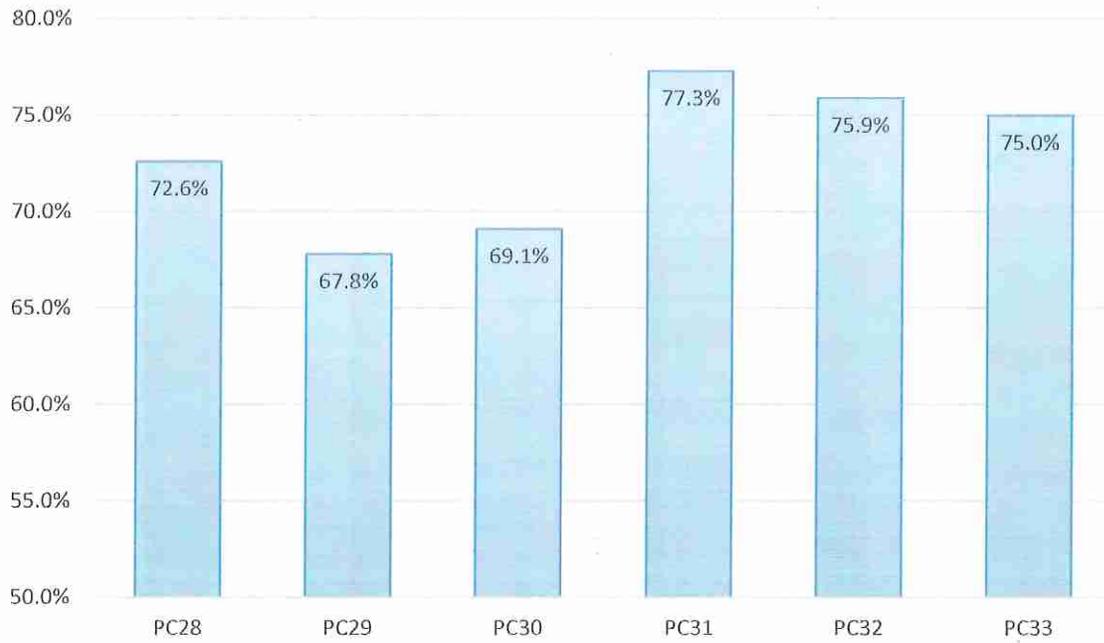
Four of five items met expectations in the access category, with the exception being A12. This item had a 'relatively low' rating because it was between 60% and 70%.

QUALITY & APPROPRIATENESS



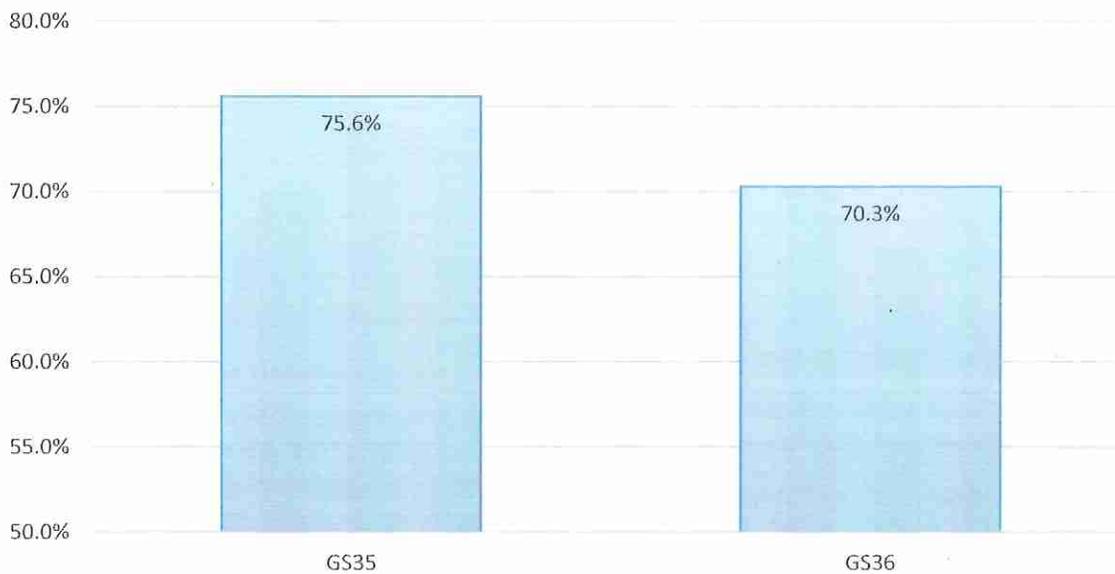
One item in this section exceeded the target range (Q16). Six of eleven items met targeted expectations, and four were below the target.

PERSON CENTEREDNESS



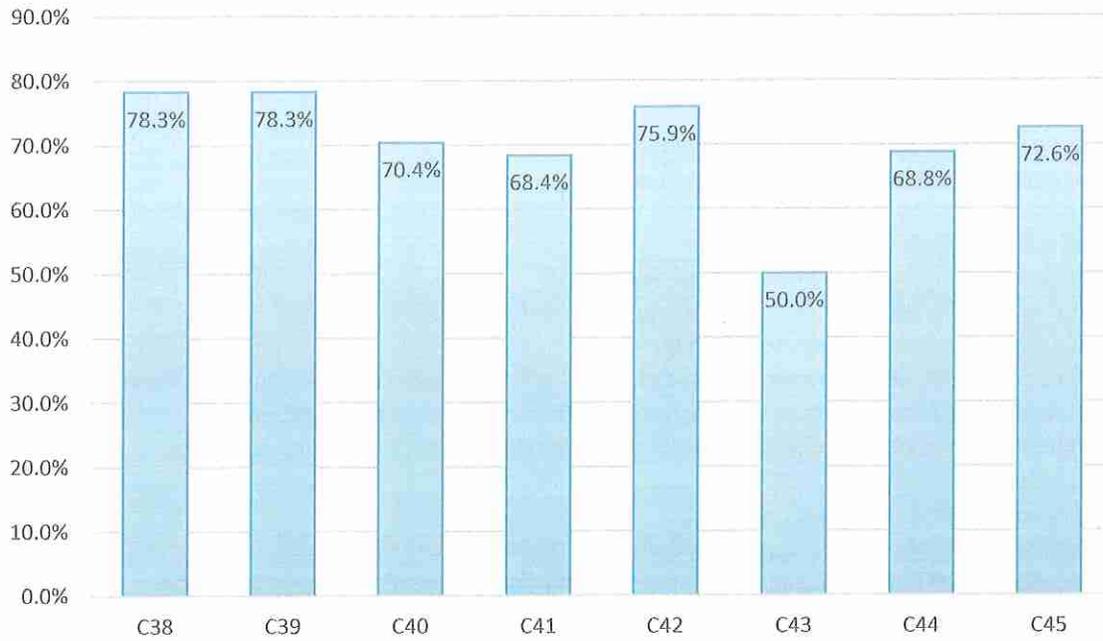
Four of six items met expectations, and only two items were below expectations.

GENERAL SATISFACTION



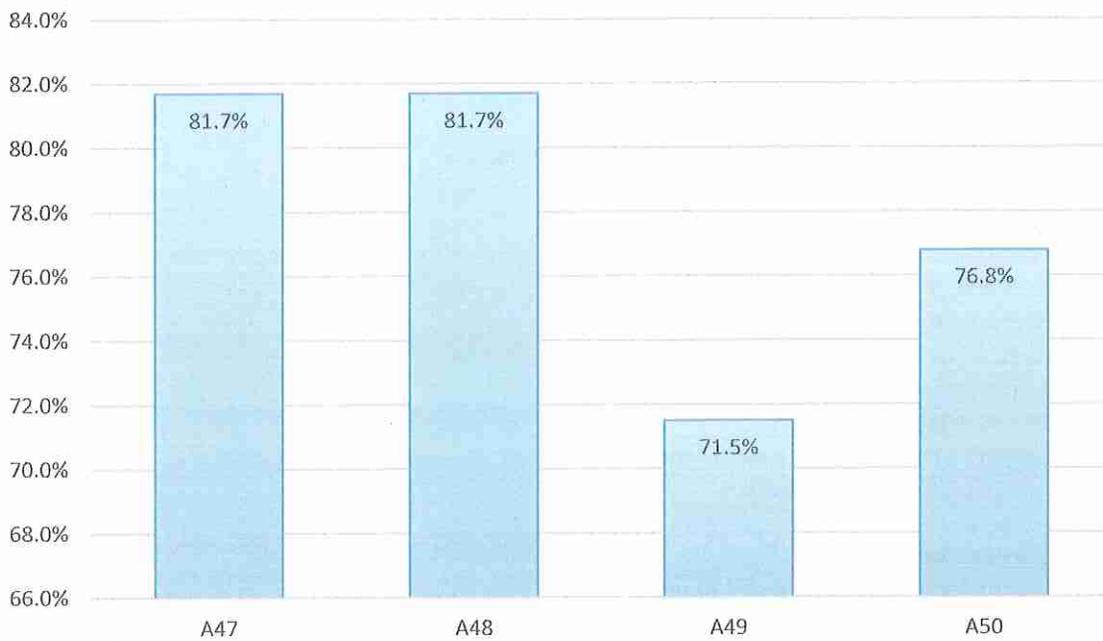
Target rates for general satisfaction were met for each item.

CHANGES



Five of eight items met expectations, and only three of eight were below expectations for the changes category.

ABILITIES



This was a very positive category for CBRF! Two of four items exceeded expectations, and the other two met expectations.

APPENDIX A

Consumer Perception of **Access**

- A10. The location of services was convenient.
- A11. Staff were willing to see me as often as I felt was necessary.
- A12. Staff returned my calls within 24 hours.
- A13. I was able to see a psychiatrist when I wanted to.
- A14. I was able to get all the services I thought I needed.

Consumer Perception of **Quality**

- Q16. Staff here believe that I can grow, change and recover.
- Q17. I felt comfortable asking questions about my treatment and medication.
- Q18. Staff told me what side effects to watch for.
- Q19. Staff respected my wishes about who is, and who is not, to be given information about my treatment.
- Q20. Staff was sensitive to my cultural/ethnic background (race, religion, language, etc.).
- Q21. Staff helped me to obtain information so that I could take charge of managing my illness.
- Q22. I felt free to complain.
- Q23. I was given information about my rights.
- Q24. Staff encouraged me to take responsibility for how I live my life.
- Q25. I was encouraged to use consumer-run programs (support groups, crisis phone line, etc.).
- Q26. I, not staff, decided my treatment goals.

Consumer Perception of **Person-Centeredness**

- PC28. I felt the rules were fair and consistent.
- PC29. Staff encouraged me to have hope and high expectations for my life.
- PC30. Staff welcomed my thoughts about my medication.
- PC31. I am included in decisions about my money.
- PC32. Staff and I work together as a team to reach my life goals.
- PC33. Staff understand that I have been through a lot.

Consumer Perception of **General Satisfaction**

- G35. I like the services that I received here.
- G36. If I had other choices, I would still get services from this agency.

Consumer Perception of **Changes**

- C38. I deal more effectively with daily problems.
- C39. I am better able to control my life.
- C40. I am better able to deal with crisis.
- C41. I am getting along better with my family.
- C42. I do better in social situations.
- C43. I do better in school and/or work.
- C44. My symptoms are not bothering me as much.
- C45. My housing situation has improved.

Consumer Perception of **Abilities**

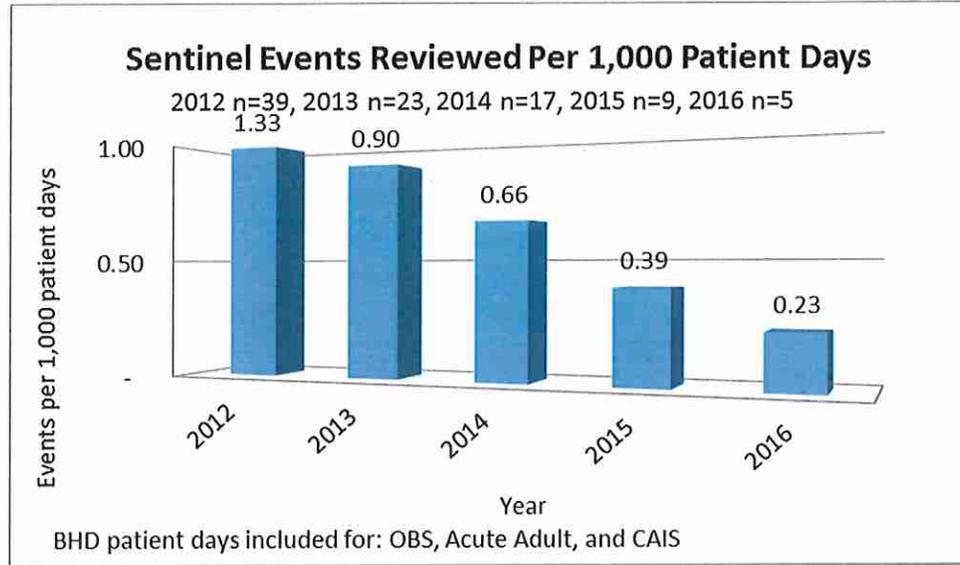
- A47. I do things that are more meaningful to me.
- A48. I am better able to take care of my needs.
- A49. I am better able to handle things when they go wrong.
- A50. I am better able to do things that I want to do.

Quality Committee Item 7

**Mental Health Board
Quality Subcommittee Meeting
June 5, 2017**

**Sentinel Event Committee
Quality Summary**

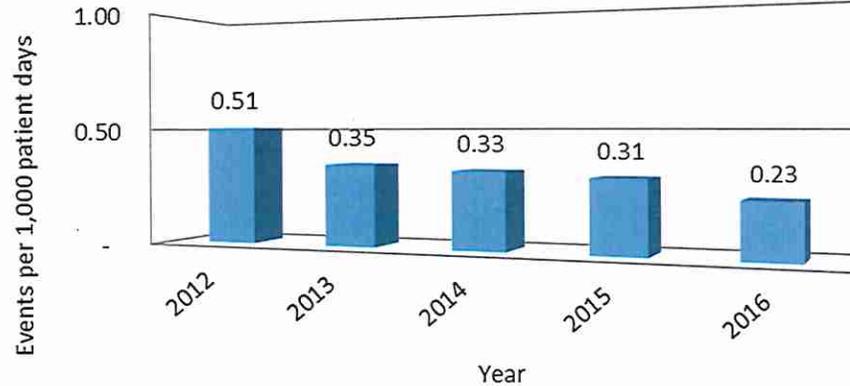
The Behavioral Health Division's number of Sentinel and Other Events continued to decline in 2016. 2016 reviewed events included 3 Sentinel Events and 2 Other Events. That total of 5 events reviewed is in comparison to 2015's 9 events, 2014's 17 events, 23 events in 2013 and 39 events in 2012. An overall sustained downward trend has been observed. Analysis shows that this downward trend is not due only to the closure of the long-term care units.



Year	Events Reviewed	Patient Days						Total Patient Days	Rate
		OBS	Acute Adult				CAIS		
			43A	43B	43C	43D			
2012	39	2,402	5,193	6,841	6,800	5,752	2,311	29,299	1.33
2013	23	2,258	5,655	7,561	7,264	-	2,682	25,420	0.90
2014	17	2,660	5,817	7,048	6,831	-	3,333	25,689	0.66
2015	9	2,170	5,481	5,861	5,867	-	3,605	22,984	0.39
2016	5	2,132	5,459	5,968	5,286	-	2,996	21,841	0.23

Sentinel Events Reviewed Per 1,000 Patient Days

2012 n=39, 2013 n=23, 2014 n=17, 2015 n=9, 2016 n=5



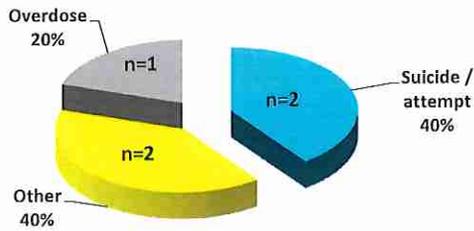
BHD patient days included for: OBS, Acute Adult, CAIS, Hilltop, and Central

Year	Events Reviewed	Patient Days												Total Patient Days	Rate
		OBS	Acute Adult				CAIS	Hilltop			Central				
			43A	43B	43C	43D		43E	43F	44E	44A	44B	44C		
2012	39	2,402	5,193	6,841	6,800	5,752	2,311	7,748	7,935	7,744	7,676	7,838	8,548	76,788	0.51
2013	23	2,258	5,655	7,561	7,264	-	2,682	6,058	7,413	6,382	5,919	6,902	7,676	65,770	0.35
2014	17	2,660	5,817	7,048	6,831	-	3,333	3,557	4,919	4,274	4,783	5,035	3,469	51,726	0.33
2015	9	2,170	5,481	5,861	5,867	-	3,605	-	-	8	3,053	3,225	-	29,270	0.31
2016	5	2,132	5,459	5,968	5,286	-	2,996	-	-	-	3	-	-	21,844	0.23

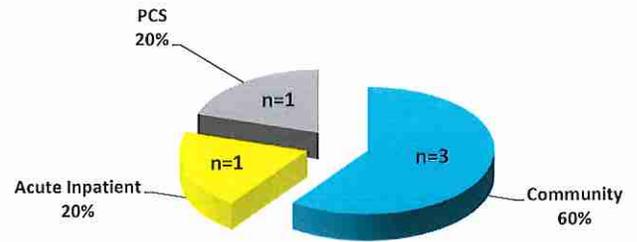
2016 BHD Sentinel Events

5 incidents reviewed

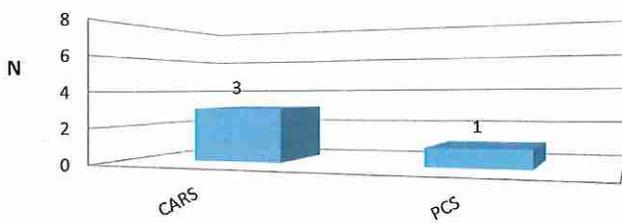
Type of Event



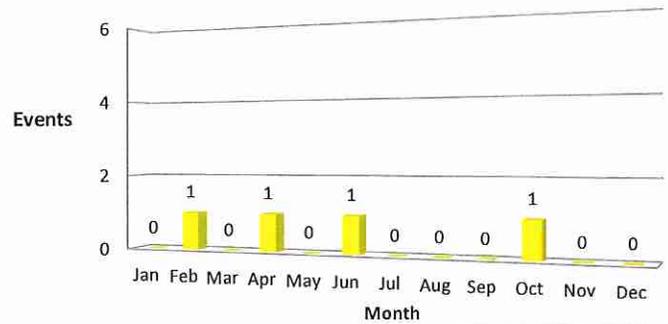
Location of Event



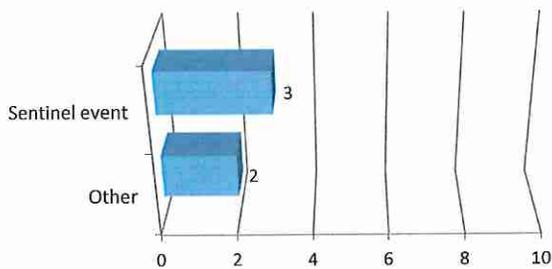
Program (Open with/last contact)



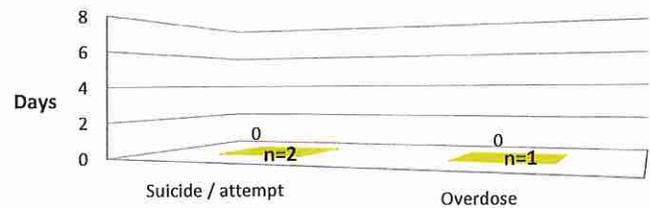
Month of Event



Level of Review

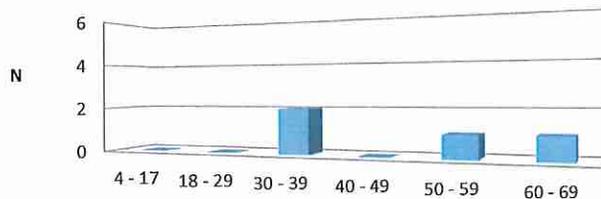


Average Days After Last BHD Contact



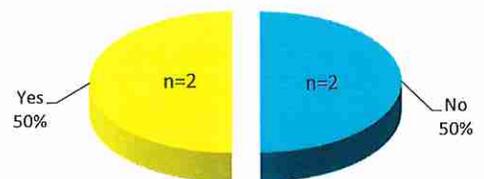
Patient Age

Average Age: 48 yrs male; Gender: 100% male 0% female



Significant AODA Component to Event

50% (n=2) of events reviewed had a significant AODA component

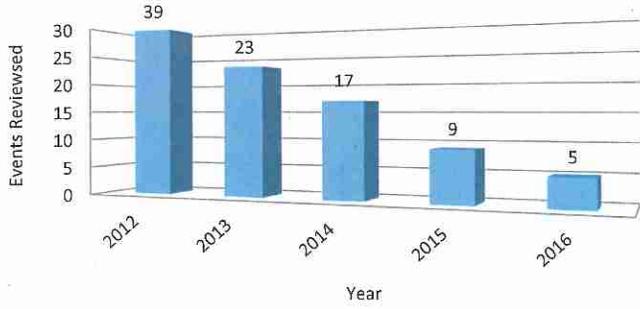


N	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69
N	0	0	2	0	1	1

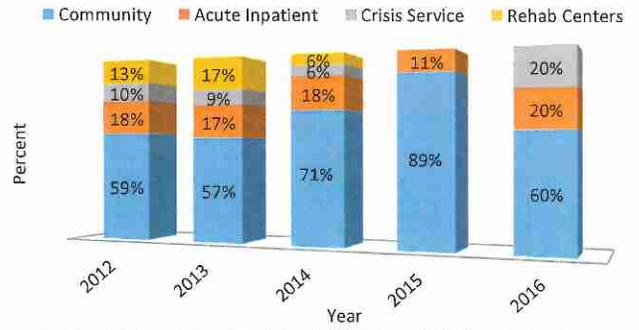
2012 - 2016 BHD Sentinel Events

93 incidents reviewed; 2012 n=39, 2013 n=23, 2014 n=17, 2015 n=9, 2016 n=5

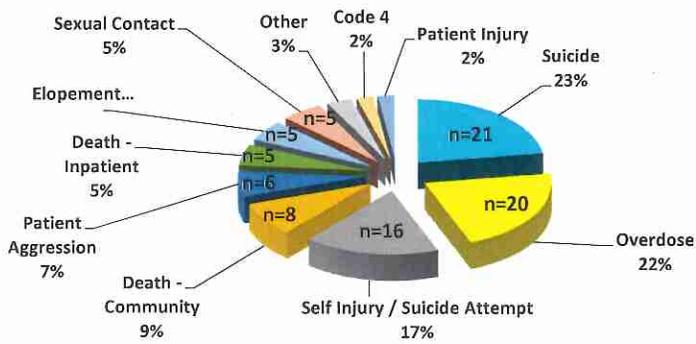
Sentinel Events Reviewed by Year



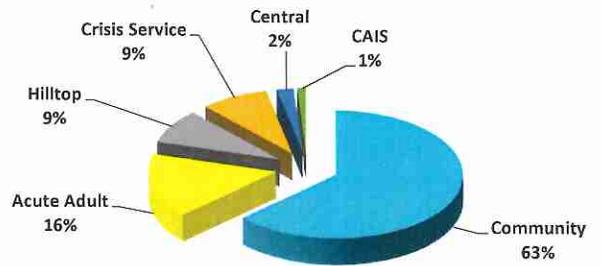
Location of Event by Year



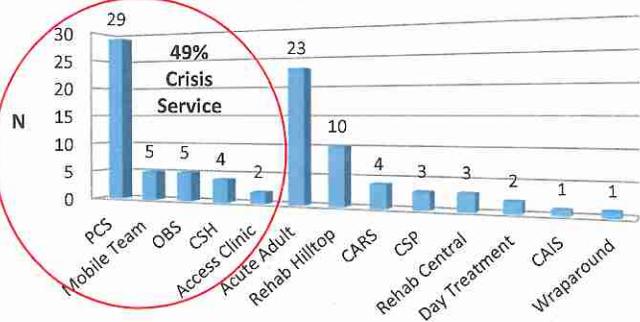
Type of Event



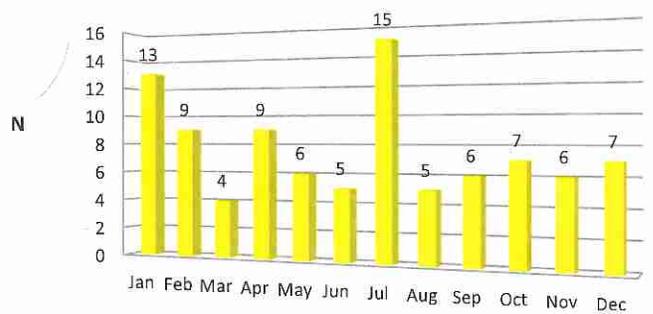
Location of Event



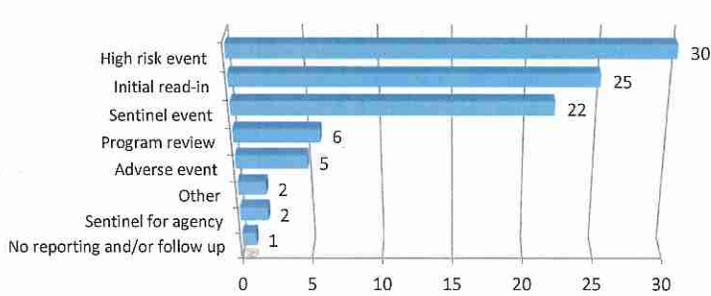
Program (Open with/last contact)



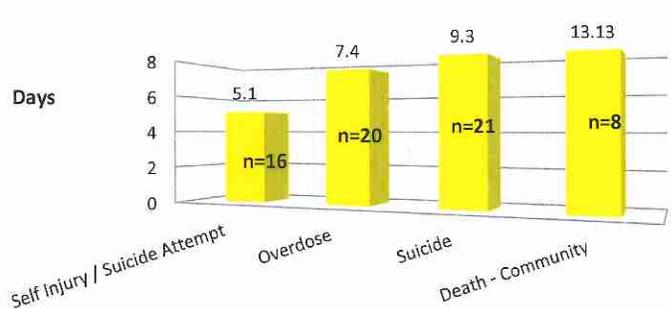
Month of Event



Level of Review

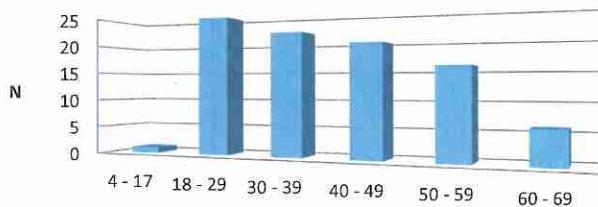


Average Days After Last BHD Contact



Patient Age

Average Age: 39 yrs male, 38 yrs female; Gender: 79% male 21% female



Age Group	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69
N	1	27	22	20	16	6

Quality Committee Item 8

Acute Inpatient Seclusion and Restraint

First Quarter Update

2017

This report contains information describing the first three (3) months of 2017 as summarized:

- Acute Adult: Restraint hourly rate decreased by 84.8% from 2016 through quarter 1 2017 while restraint incident rate decreased by 68.3% during the same time period. Seclusion incident rate decreased by 27.9% from 2016 through the first quarter 2017 while Seclusion hourly rate decreased by 40.0% during the same time period.
- CAIS: Restraint hourly rate decreased by 65.9% from 2016 through the first quarter 2017.

Prepared by: Quality
Improvement
Department

Date: May 1, 2017

Summary

43A

- 43A rate of restraint hours decreased by 87.9% from 2016 through the first quarter 2017.
- 43A had 24 reported restraint hours, 13 reported restraint hours were for 3 individuals (55% of all hours)
- 43A restraint incident rate decreased by 66.1% from 2016 through the first quarter 2017.
- 43A had 21 reported restraint incidents, 10 reported restraint incidents were for 3 individuals (48% of all incidents)
- 43A seclusion hour's rate decreased by 66.7% from 2016 to first quarter 2017, while the seclusion incident rate decreased by 60.6%.

43B

- 43B rate of restraint hours decreased by 85.7% from 2016 through first quarter 2017.
- 43B had 11 reported restraint hours, 4.6 reported restraint hours were for 2 individuals (42% of all hours)
- 43B restraint incident rate decreased by 76.4% from 2016 through the first quarter 2017.
- 43B seclusion hour's rate did not changed from 2016 to the first quarter 2017, while the seclusion incident rate increased by 20.4%.

43C

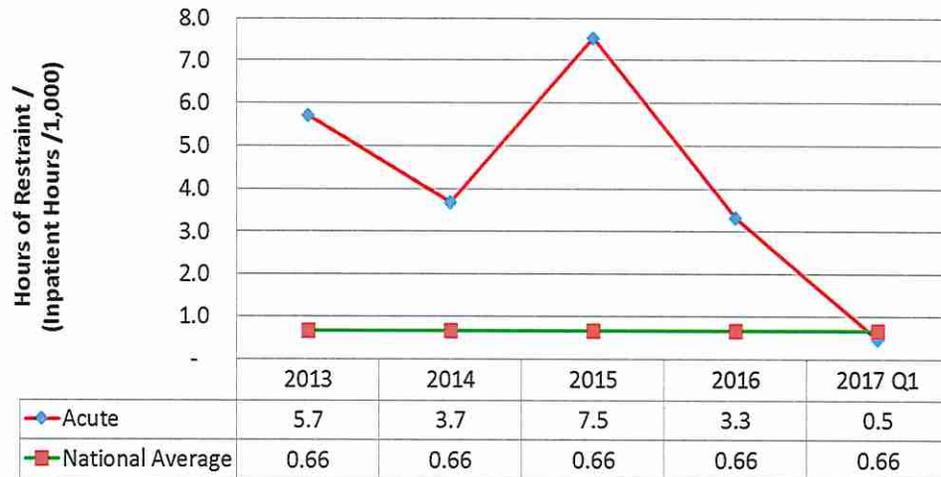
- 43C rate of restraint hours decreased by 60.0% from 2016 through the first quarter 2017.
- 43C had 6.9 reported restraint hours, 3.7 reported restraint hours were for 1 individuals (53% of all hours)
- 43C restraint incident rate decreased by 46.3% from 2016 through the first quarter 2017.
- 43C seclusion hours and incident rate increased by 25.0% from 2016 to the first quarter 2017, while the seclusion incident rate increased by 26.3%.

CAIS

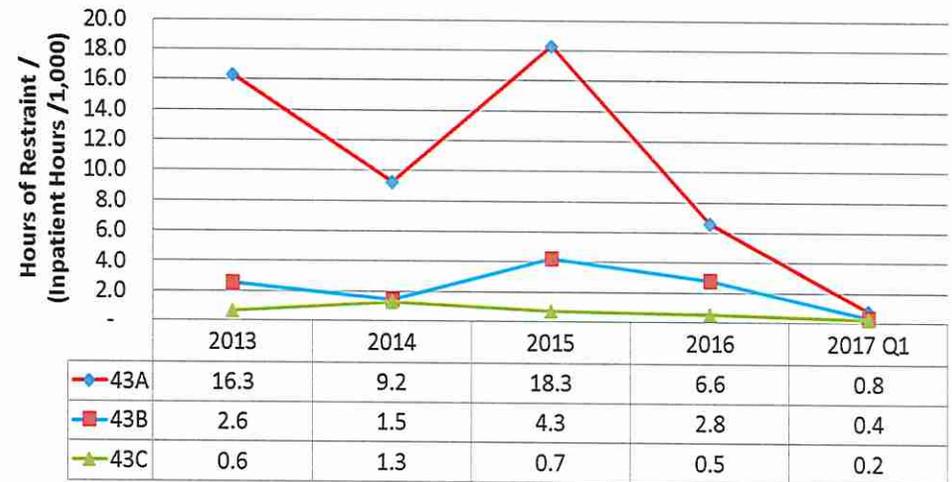
- Three (3) individuals had 16 reported restraint hours, 50% of all restraints
- CAIS restraint incident rate decreased by 64.4% from 2016 through the first quarter 2017.
- CAIS had 23 reported restraint incidents, 7 reported restraint incidents were for 2 individuals (30% of all incidents)

Acute Adult

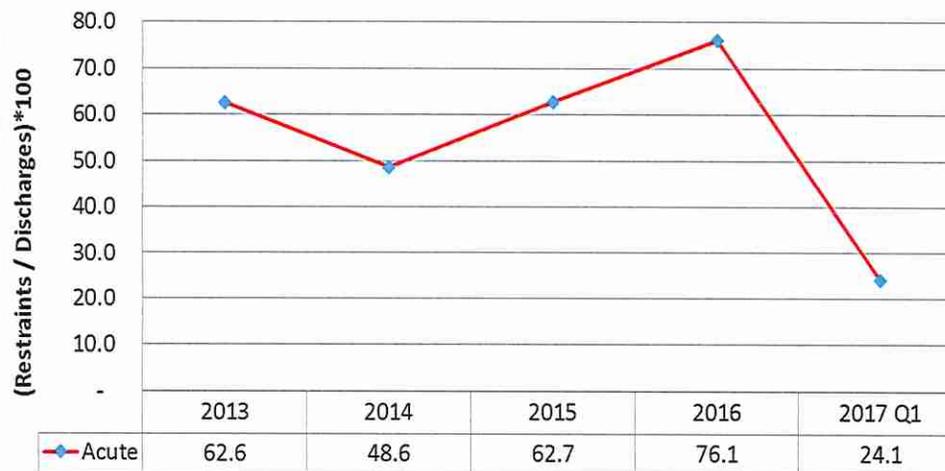
Acute Adult
2013-2017 Hours of Restraint (Aggregate)



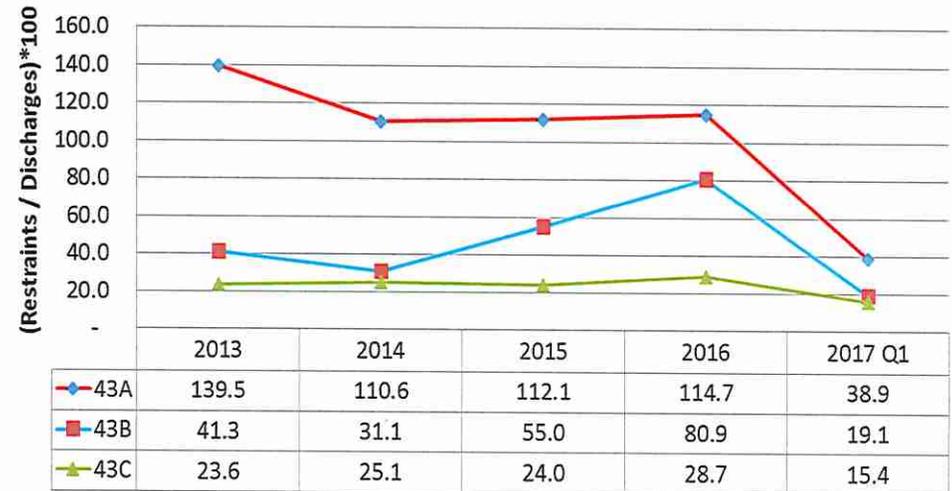
Acute Adult
2013-2017 BHD - Hours of Restraint by Unit



Acute Adult
2013-2017 Restraint Incident % (Aggregate)

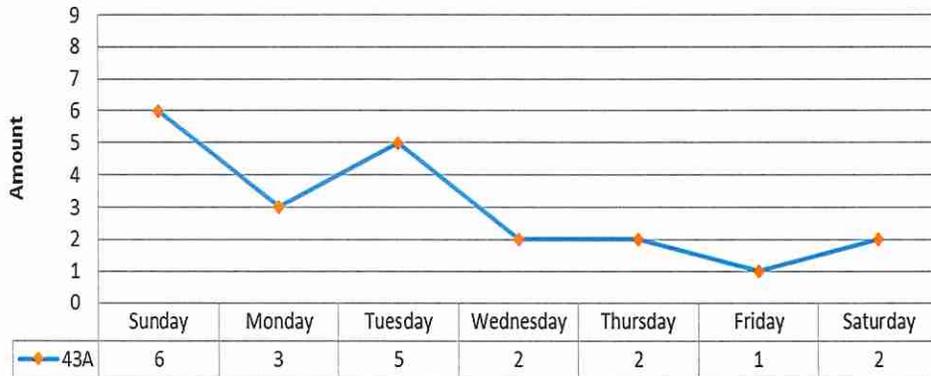


Acute Adult
2013-2017 BHD - Restraint Incident % by Unit

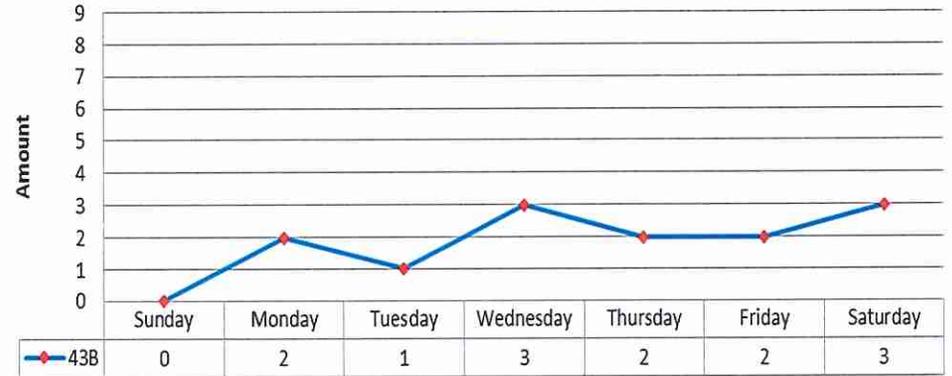


Acute Adult

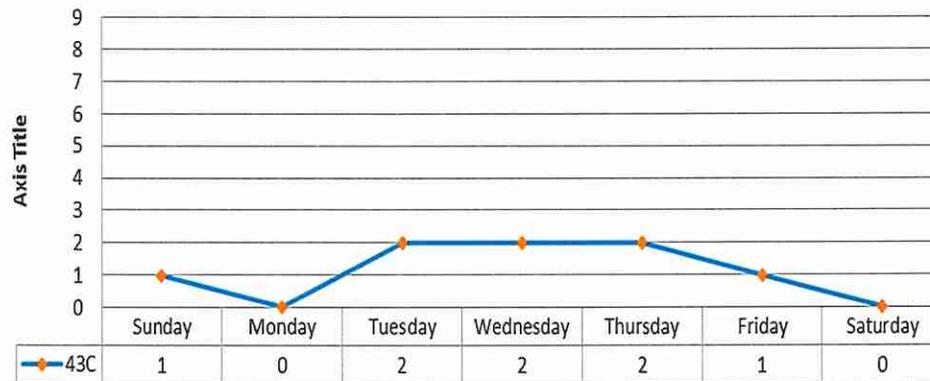
43A Restraints by Day of Week
N = 21



43B Restraints by Day of Week
N = 13

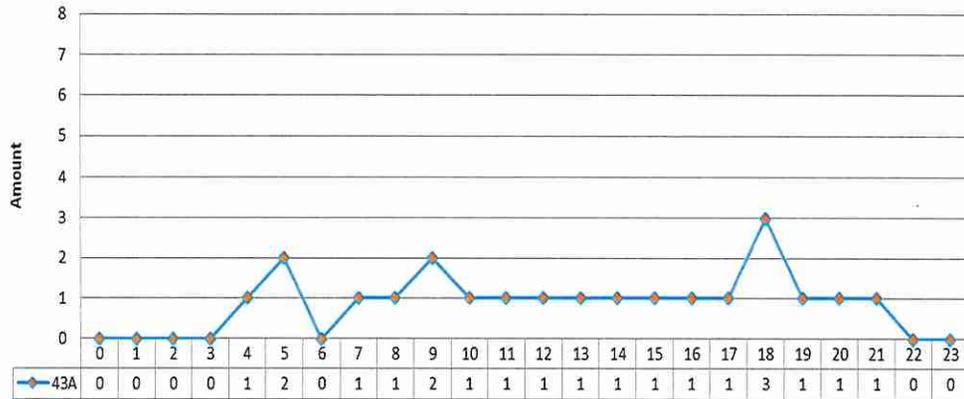


43C Restraints by Day of Week
N = 8

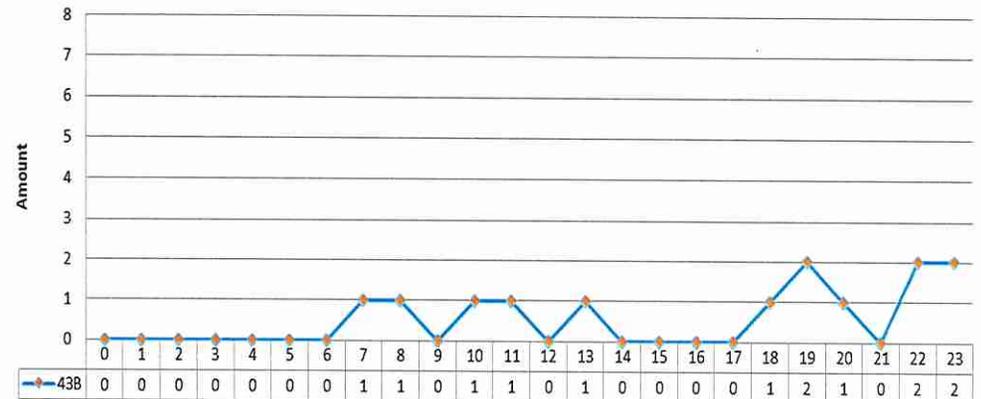


Acute Adult

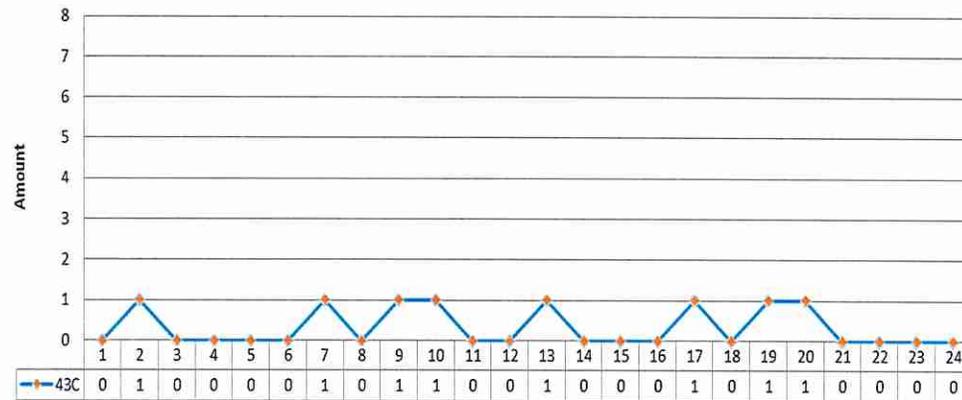
43A Restraints by Time of Day
N = 21



43B Restraints by Time of Day
N = 13



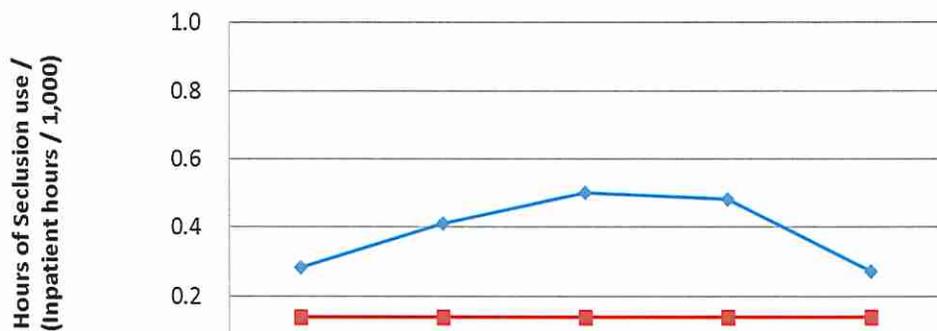
43C Restraints by Time of Day
N = 8



Acute Adult

Acute Adult

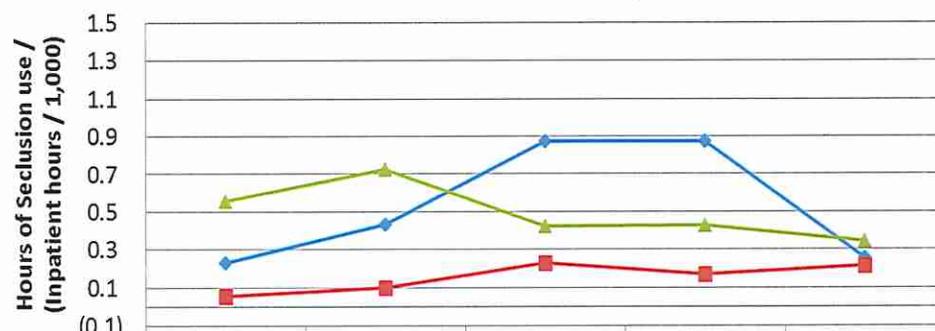
2013-2017 Hours of Seclusion Rate (Aggregate)



	2013	2014	2015	2016	2017 Q1
Acute	0.3	0.4	0.5	0.5	0.3
National Average	0.1	0.1	0.1	0.1	0.1

Acute Adult

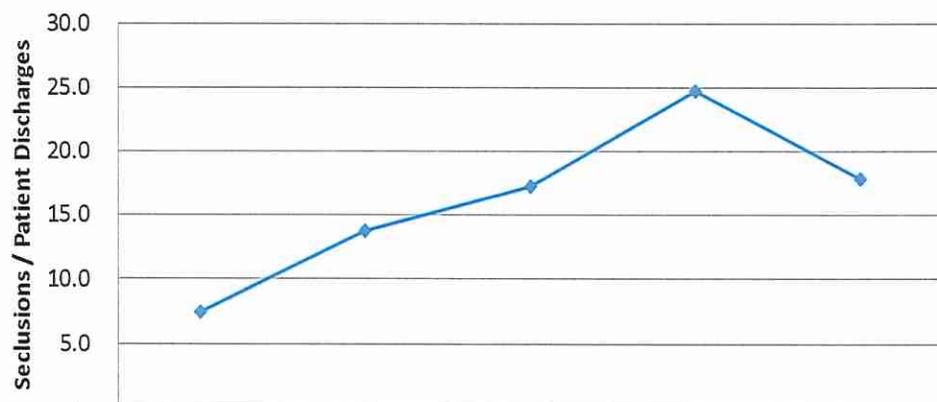
2013-2017 Hours of Seclusion Rate by Unit



	2013	2014	2015	2016	2017 Q1
43A	0.2	0.4	0.9	0.9	0.3
43B	0.1	0.1	0.2	0.2	0.2
43C	0.6	0.7	0.4	0.4	0.3

Acute Adult

2013-2017 Seclusion Incident % (Aggregate)



	2013	2014	2015	2016	2017 Q1
Acute	7.4	13.7	17.3	24.7	17.8

Acute Adult

2013-2017 Seclusion Incident % by Unit

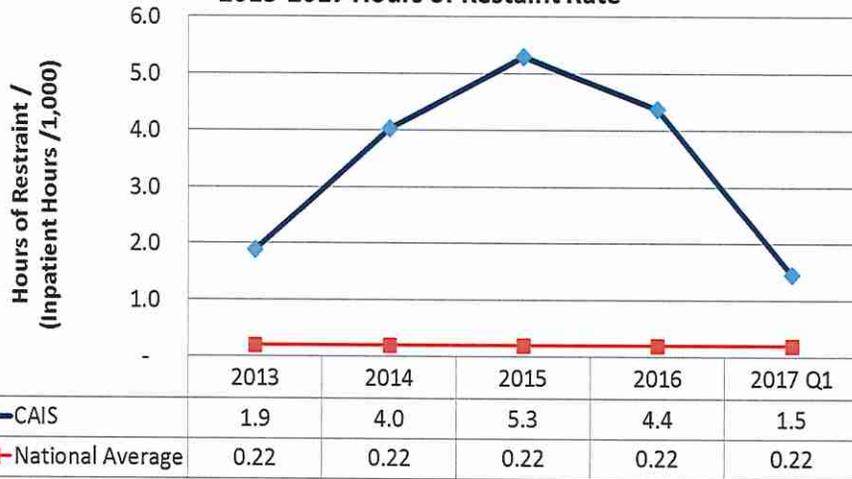


	2013	2014	2015	2016	2017 Q1
43A	4.5	14.6	30.4	47.0	18.5
43B	2.6	3.6	7.4	9.8	11.8
43C	15.6	24.6	19.8	19.8	25.0

CAIS

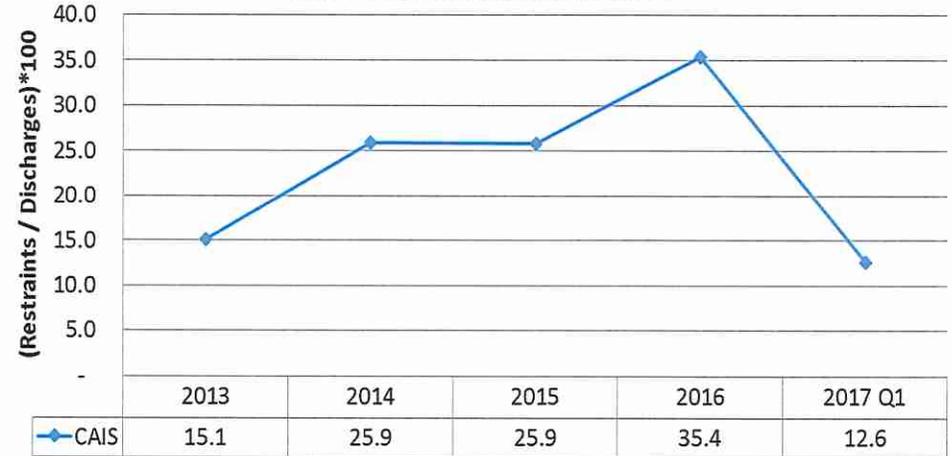
CAIS

2013-2017 Hours of Restraint Rate



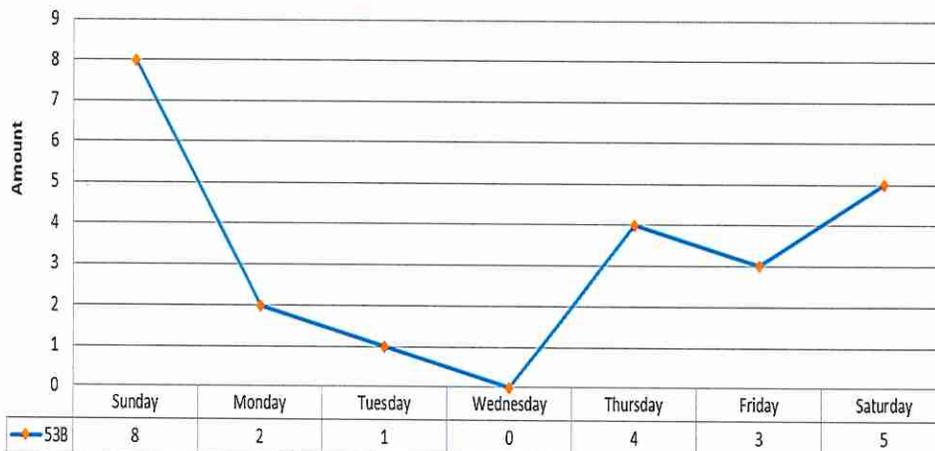
CAIS

2013-2017 Restraint Incident %



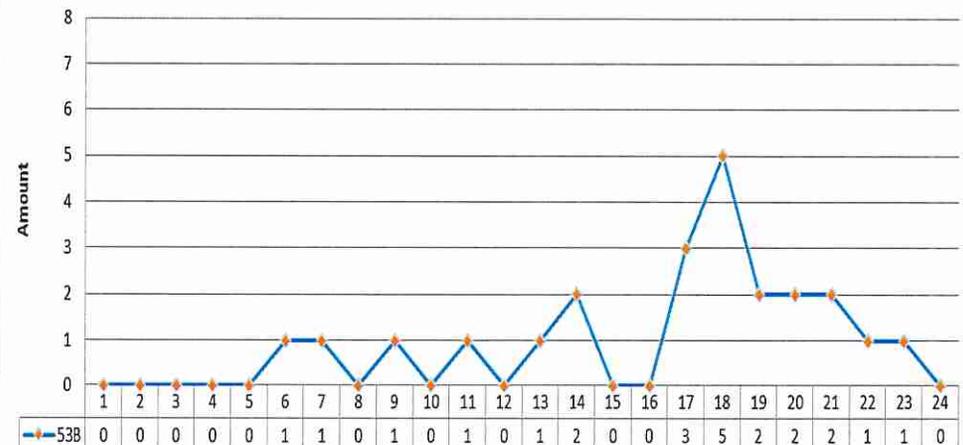
CAIS Restraints by Day of Week

N = 23



CAIS Restraints by Time of Day

N = 23



Facility Data

Program		Restraint Incidents							Restraint Hours						
		2011	2012	2013	2014	2015	2016	2017 Q1	2011	2012	2013	2014	2015	2016	2017 Q1
Acute	43A	282	367	558	303	306	249	21	1,704	1,473	2,321	1,293	2,402	864	24
	43B	78	124	236	138	237	207	13	89	139	492	259	600	399	11
	43C	173	88	112	98	63	58	8	1,602	78	113	205	104	67	7
	Total	966	775	906	539	606	514	42	4,579	2,268	2,926	1,757	3,106	1,330	42
CAIS	CAIS	173	84	124	246	238	218	23	476	98	133	314	458	323	31
Crisis	PCS	638	537	445	405	417	373	65	651	514	509	413	445	408	66
	OBS	122	76	106	146	83	74	12	190	100	179	207	117	98	8

Program/Unit		Seclusion Incidents							Seclusion Hours						
		2011	2012	2013	2014	2015	2016	2017 Q1	2011	2012	2013	2014	2015	2016	2017 Q1
Acute	43A	47	22	18	40	83	102	10	87	17	33	61	115	115	8
	43B	4	12	15	16	32	25	8	4	8	11	18	32	24	6
	43C	58	15	74	96	52	40	13	73	10	100	118	60	54	11
	Total	154	62	107	152	167	167	31	218	48	144	196	207	193	25
CAIS	CAIS	27	6	5	32	44	17	8	32	4	3	21	35	13	6

Crisis Seclusion and Restraint

First Quarter Update

2017

This report contains information describing the first three (3) months of 2017 are summarized as follows:

- 2017 first quarter PCS restraint incident rate decreased by **24.4%** from 2016.
- 2017 first quarter PCS restraint hour decreased by **29.8%** from 2016.
- 2017 first quarter Observation incident rates increased by **11.8%** from 2016.
- 2017 first quarter Observation restraint hour decreased by **40.8%** from 2016.

Prepared by: Quality
Improvement
Department

Date: May 1, 2017

Summary

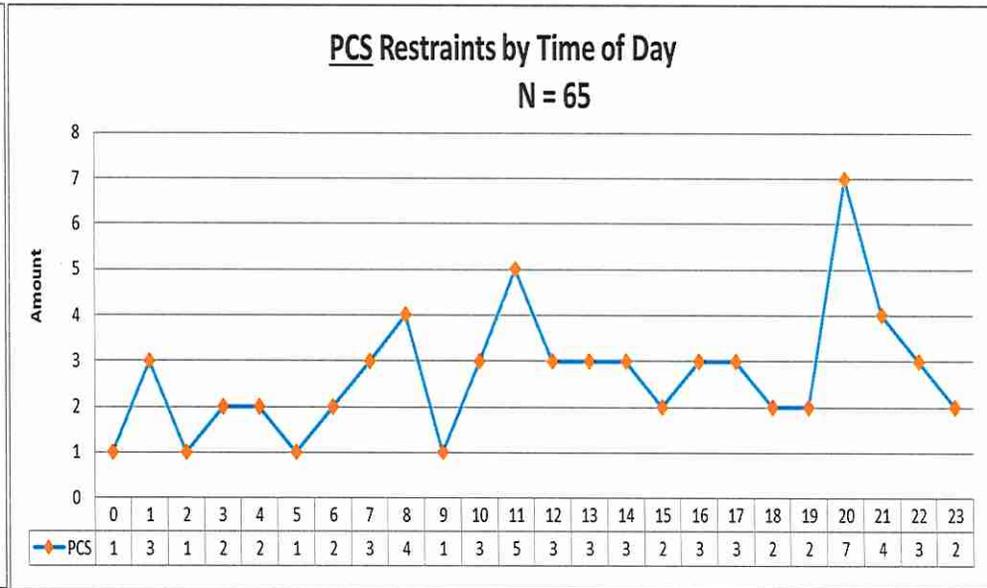
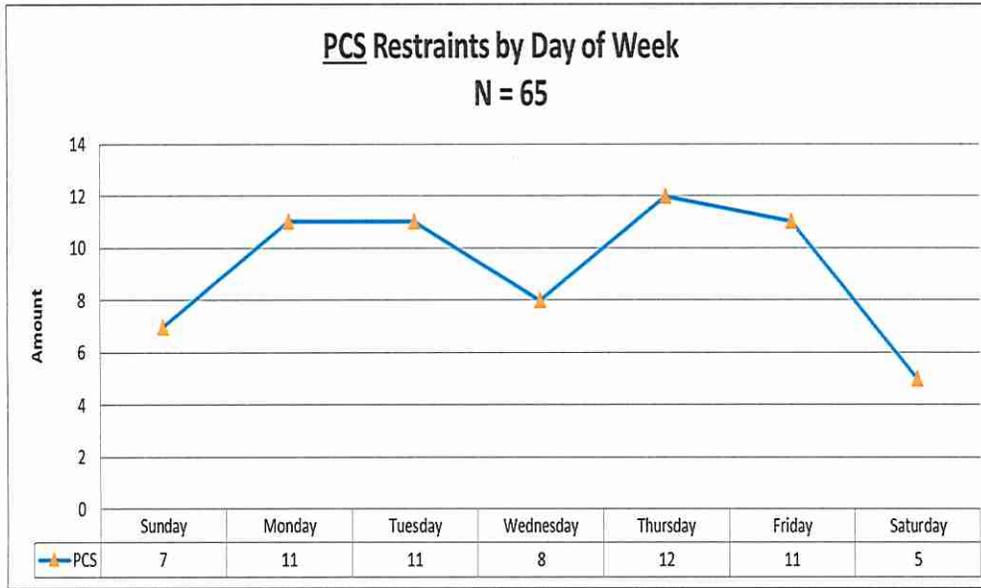
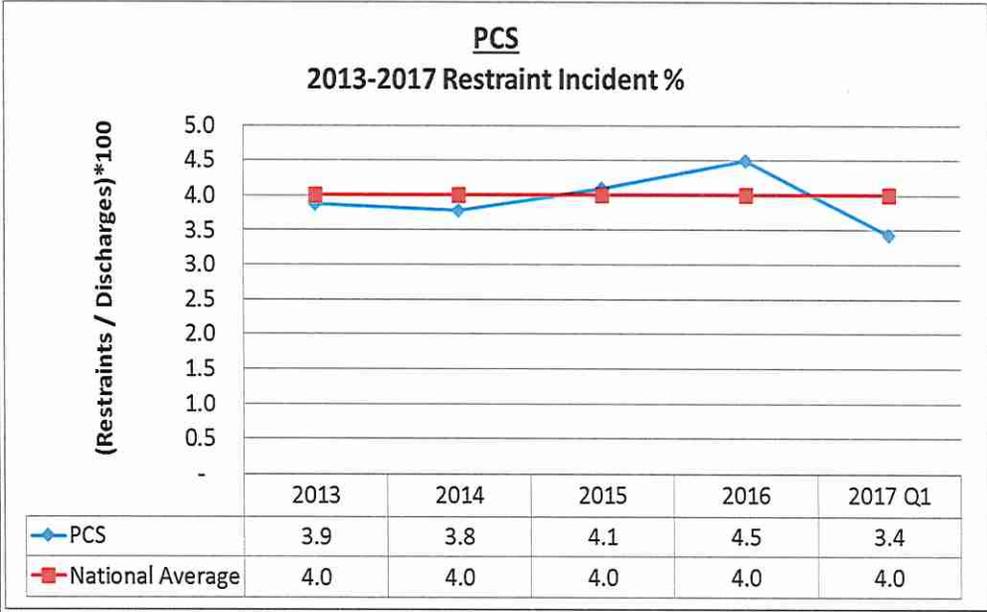
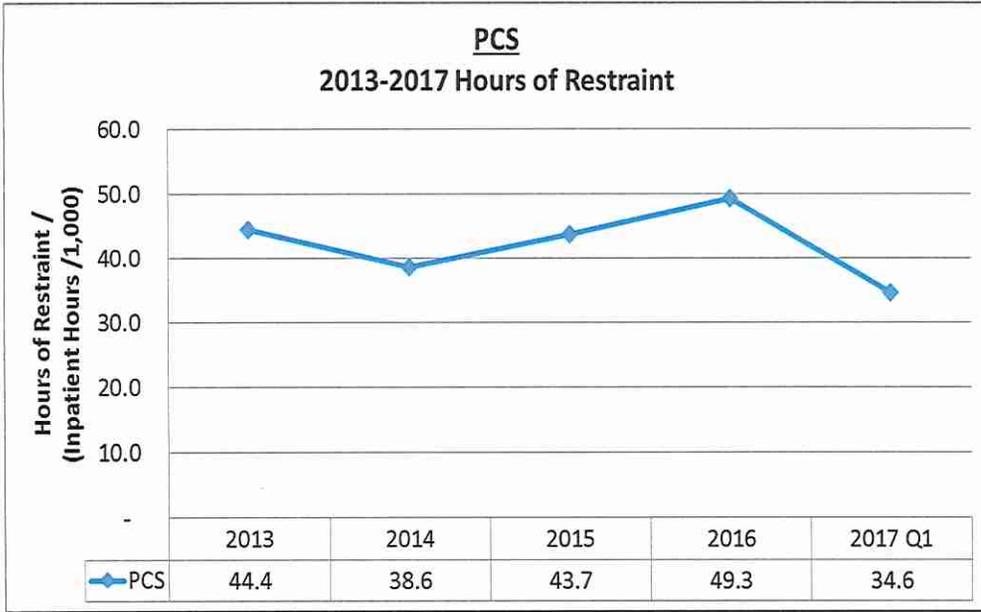
PCS

- PCS had 65.5 reported restraint hours, of which 69% of reported restraints, the patient were in restraints for less than 2 hours
- PCS had 65 reported restraint incidents, of which 69% of reported restraint incidents were patients with one (1) episode of restraint.

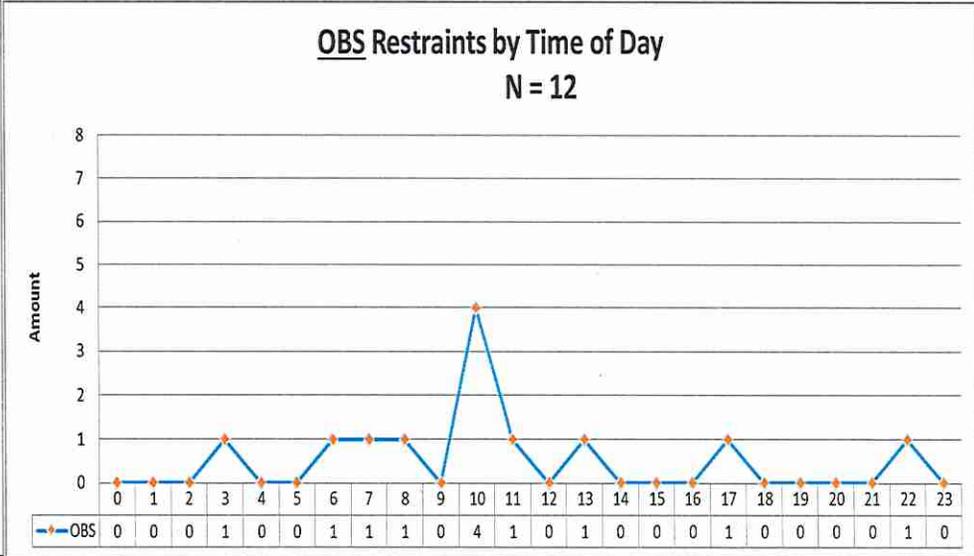
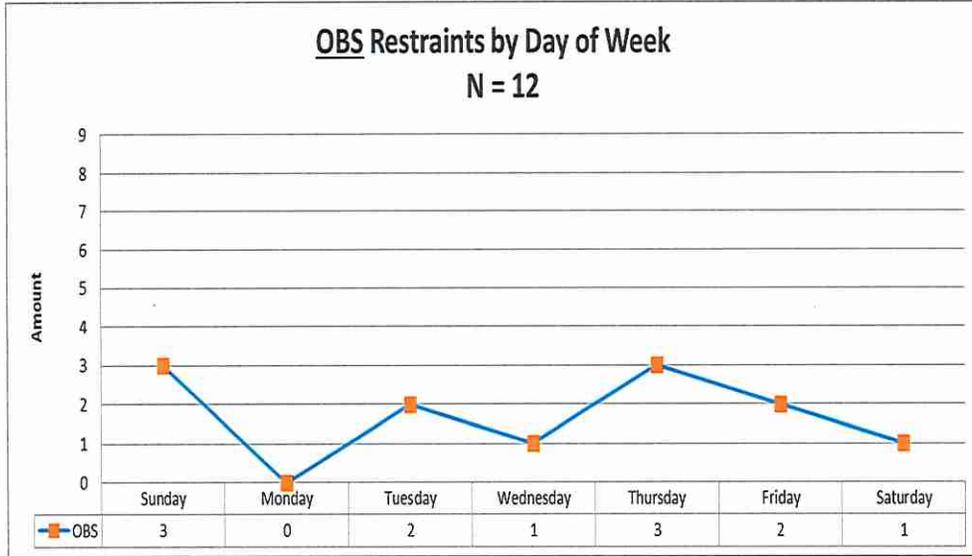
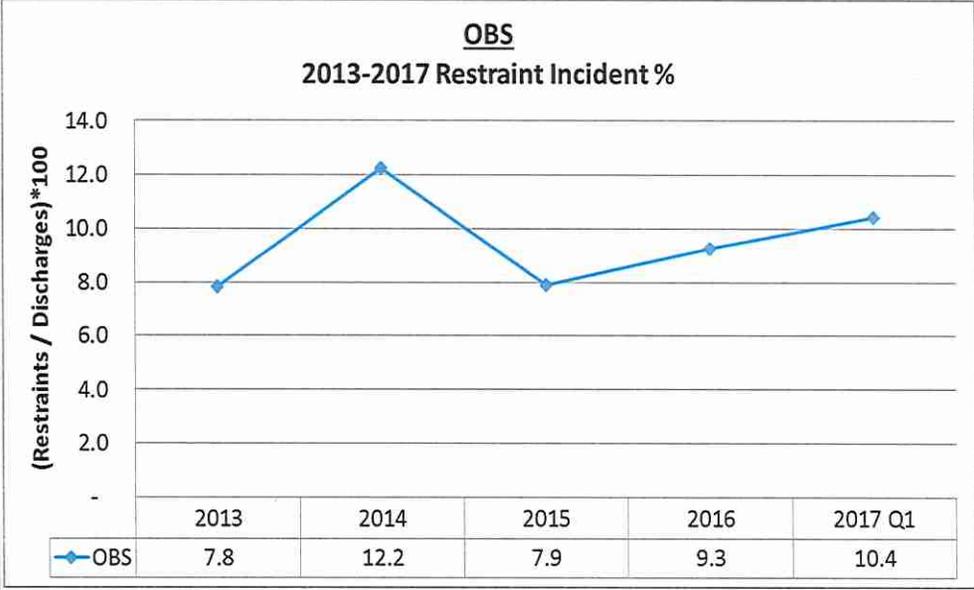
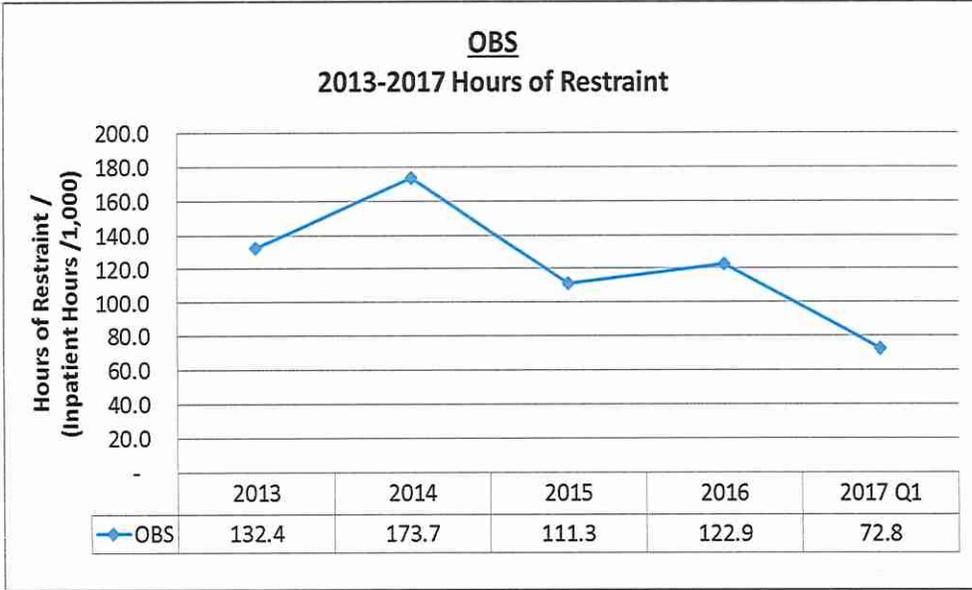
OBS

- OBS had 8.4 reported restraint hours, 4 reported restraint hours were for 2 individuals (48% of all hours)

PCS



OBS



Facility Data

Program		Restraint Incidents							Restraint Hours						
		2011	2012	2013	2014	2015	2016	2017 Q1	2011	2012	2013	2014	2015	2016	2017 Q1
Acute	43A	282	367	558	303	306	249	21	1,704	1,473	2,321	1,293	2,402	864	24
	43B	78	124	236	138	237	207	13	89	139	492	259	600	399	11
	43C	173	88	112	98	63	58	8	1,602	78	113	205	104	67	7
	Total	966	775	906	539	606	514	42	4,579	2,268	2,926	1,757	3,106	1,330	42
CAIS	CAIS	173	84	124	246	238	218	23	476	98	133	314	458	323	31
Crisis	PCS	638	537	445	405	417	373	65	651	514	509	413	445	408	66
	OBS	122	76	106	146	83	74	12	190	100	179	207	117	98	8

Program/Unit		Seclusion Incidents							Seclusion Hours						
		2011	2012	2013	2014	2015	2016	2017 Q1	2011	2012	2013	2014	2015	2016	2017 Q1
Acute	43A	47	22	18	40	83	102	10	87	17	33	61	115	115	8
	43B	4	12	15	16	32	25	8	4	8	11	18	32	24	6
	43C	58	15	74	96	52	40	13	73	10	100	118	60	54	11
	Total	154	62	107	152	167	167	31	218	48	144	196	207	193	25
CAIS	CAIS	27	6	5	32	44	17	8	32	4	3	21	35	13	6

Recovery Plan Audit

Week 3-4
2017

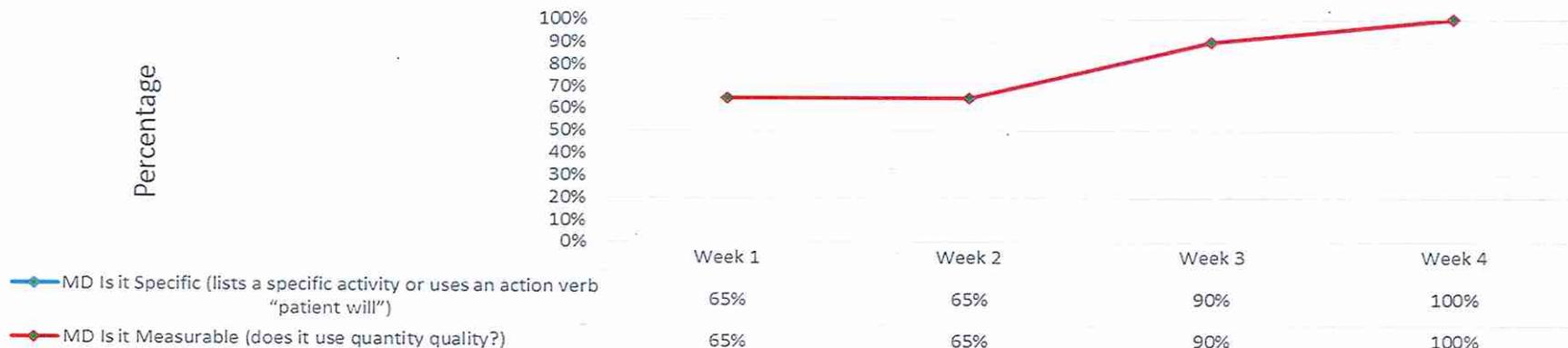
The following is a summary of the Utilization Review team recovery plan audits on each of the Acute Adult/CAIS units.

Prepared by: Quality
Improvement Department

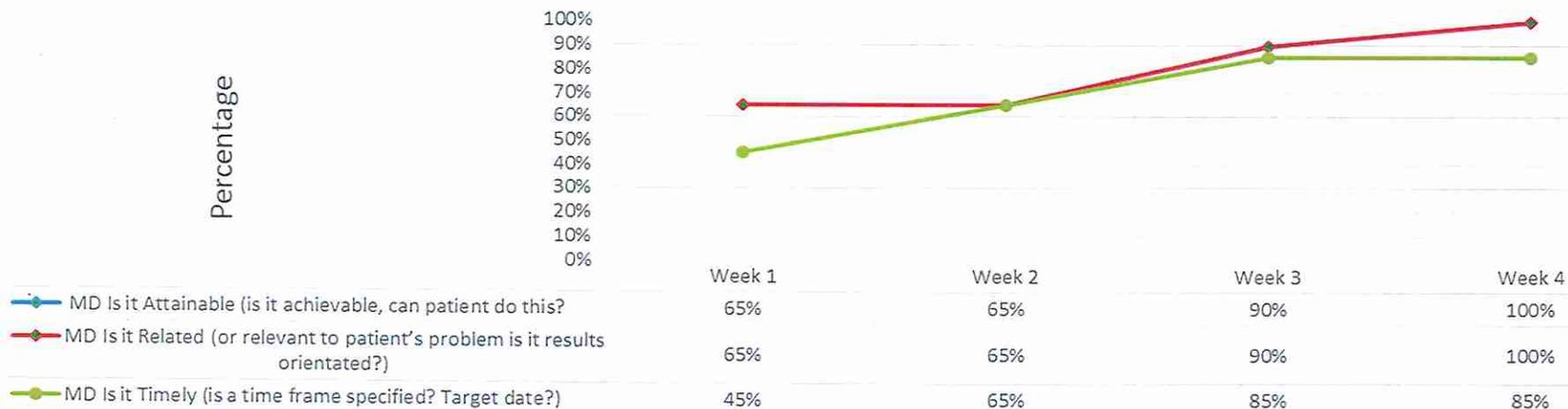
Date: May 10, 2017

Goal/Objective

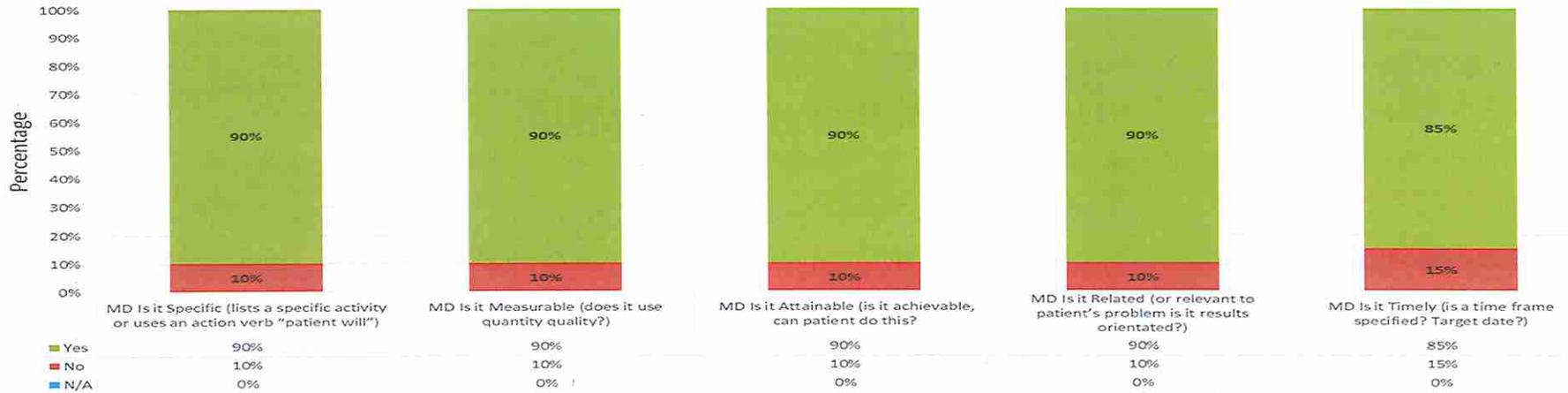
MD Goals/Objective (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



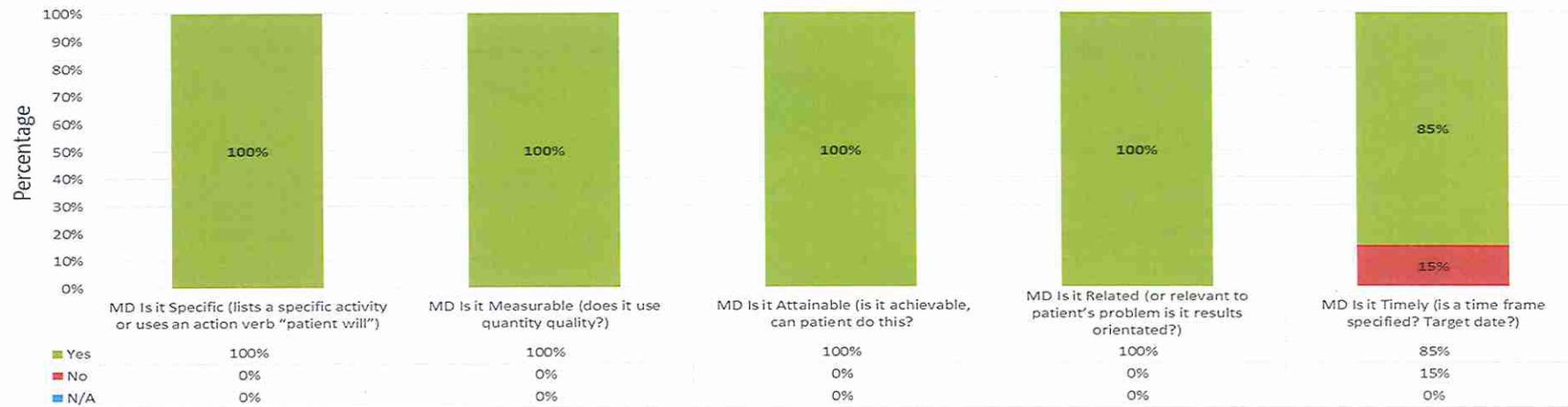
MD Goals/Objective (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



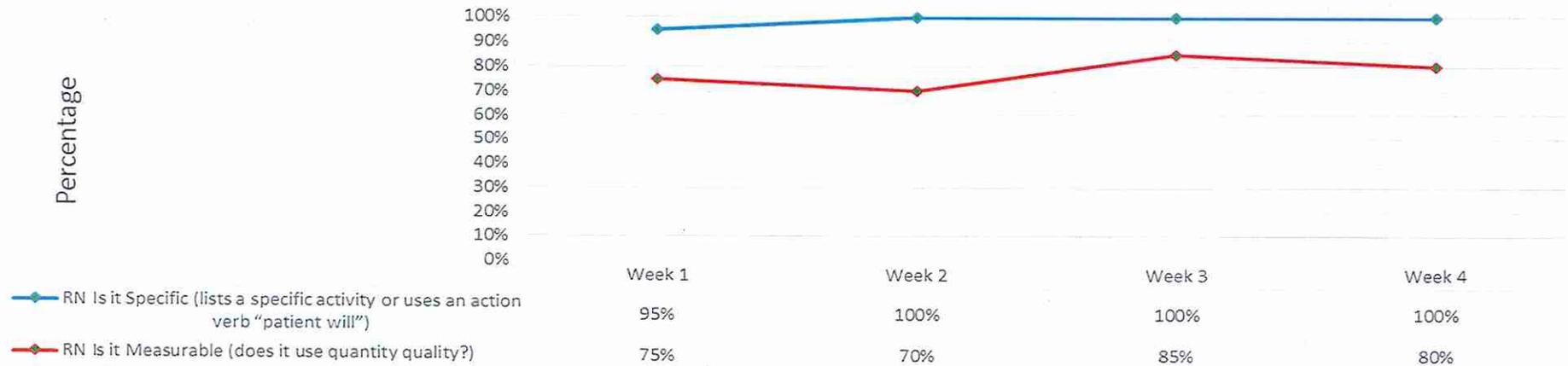
MD Goals/Objective Week 3



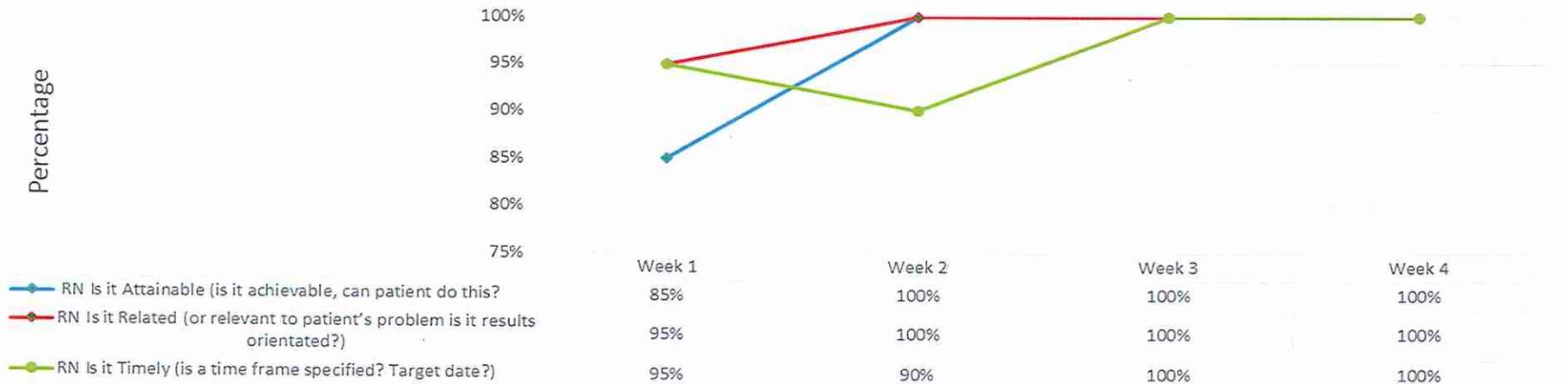
MD Goals/Objective Week 4



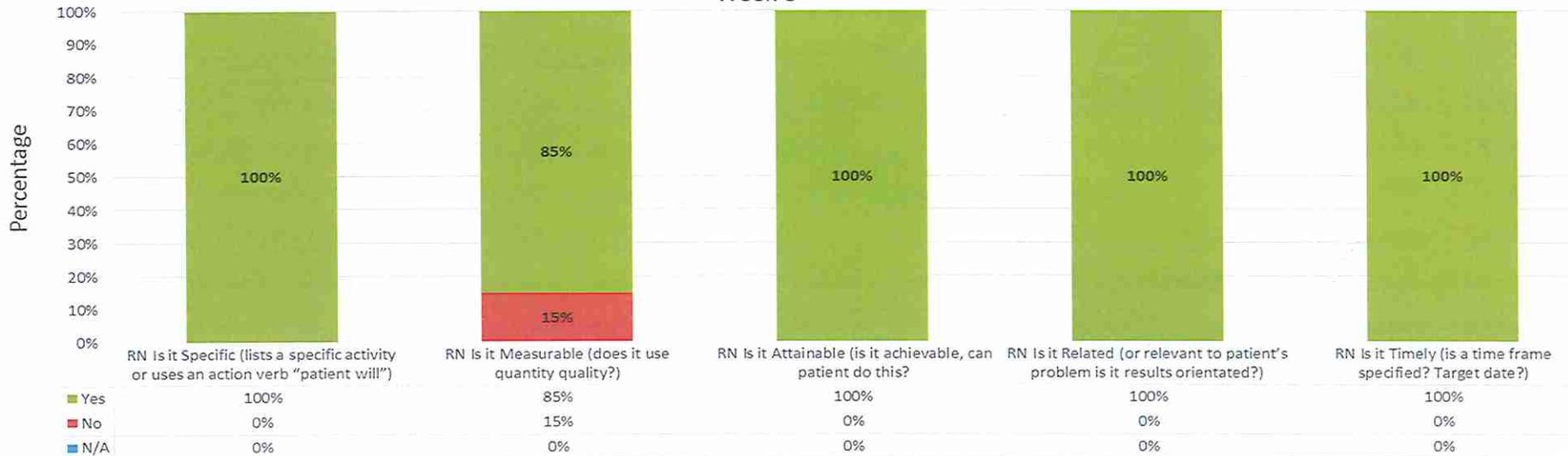
RN Goals/Objectives (Yes)
W1 N=20 W2 N=20, W3 N=20, W4 N=20



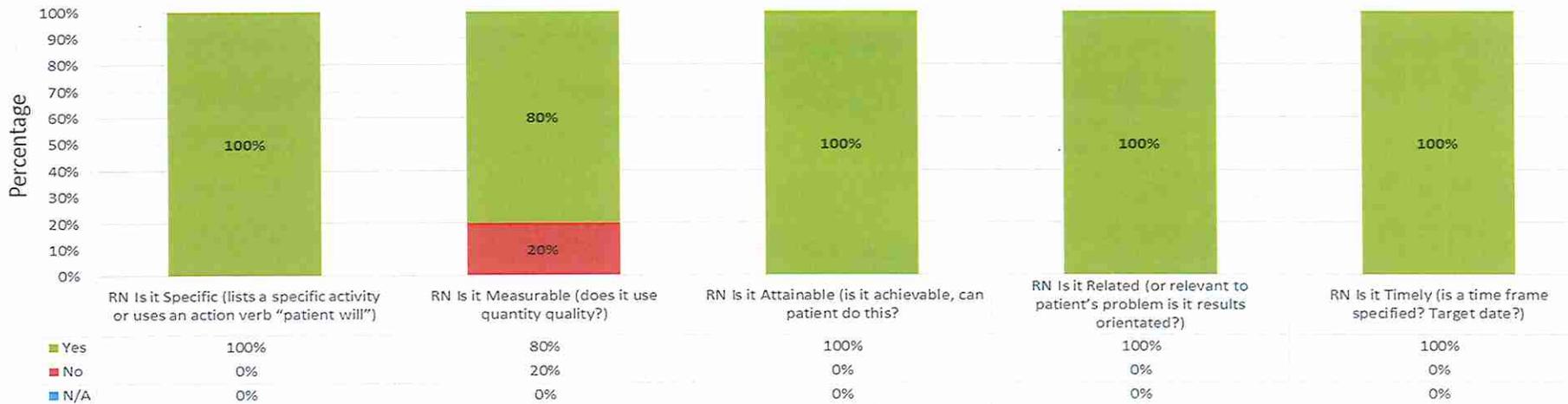
RN Goals/Objectives (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



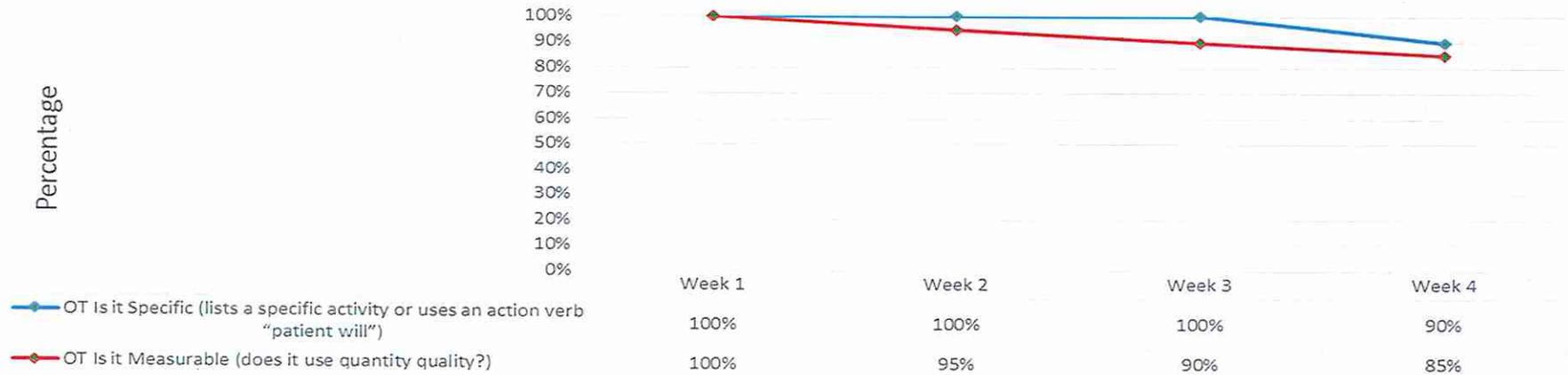
RN Goals/Objectives Week 3



RN Goals/Objectives Week 4



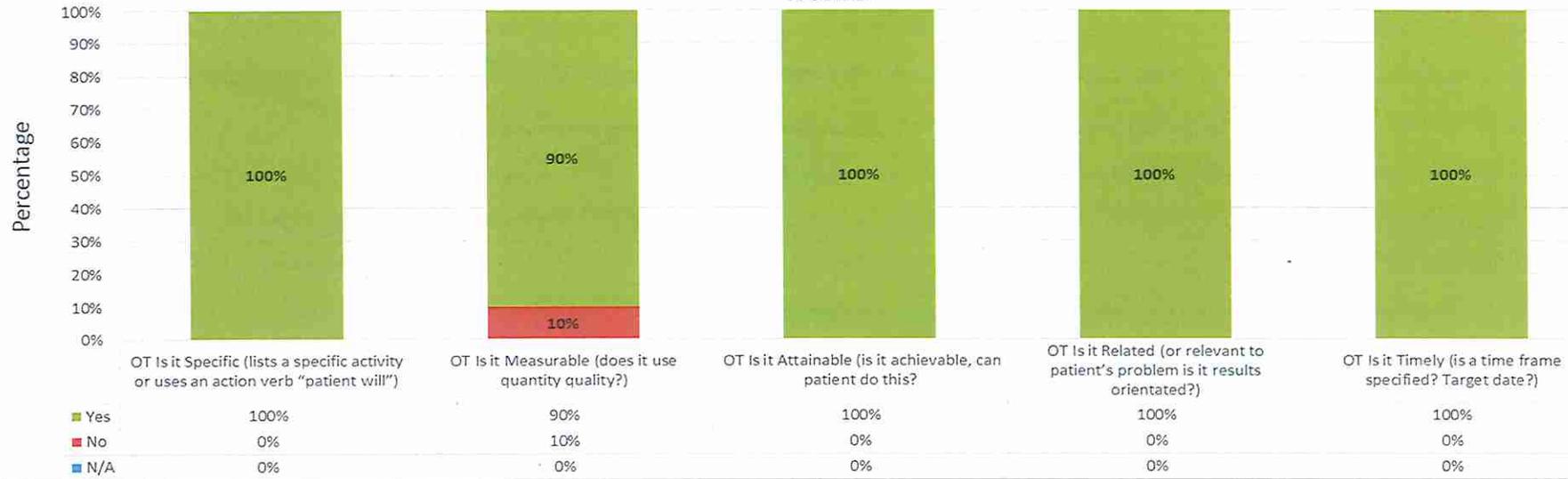
OT Goals/Objectives (Yes)
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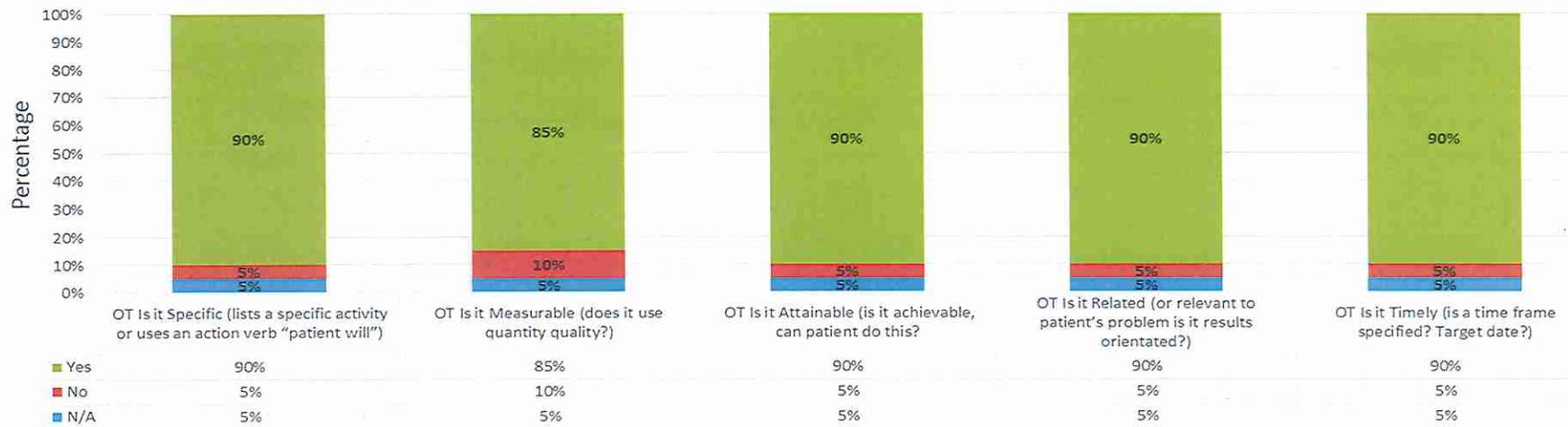
OT Goals/Objectives (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



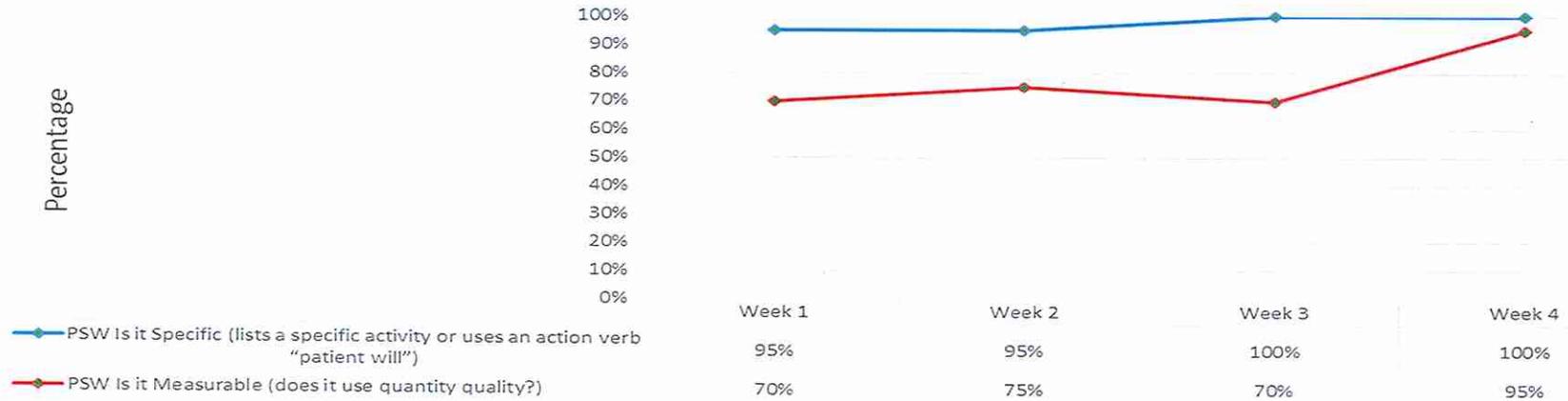
OT Goals/Objectives Week 3



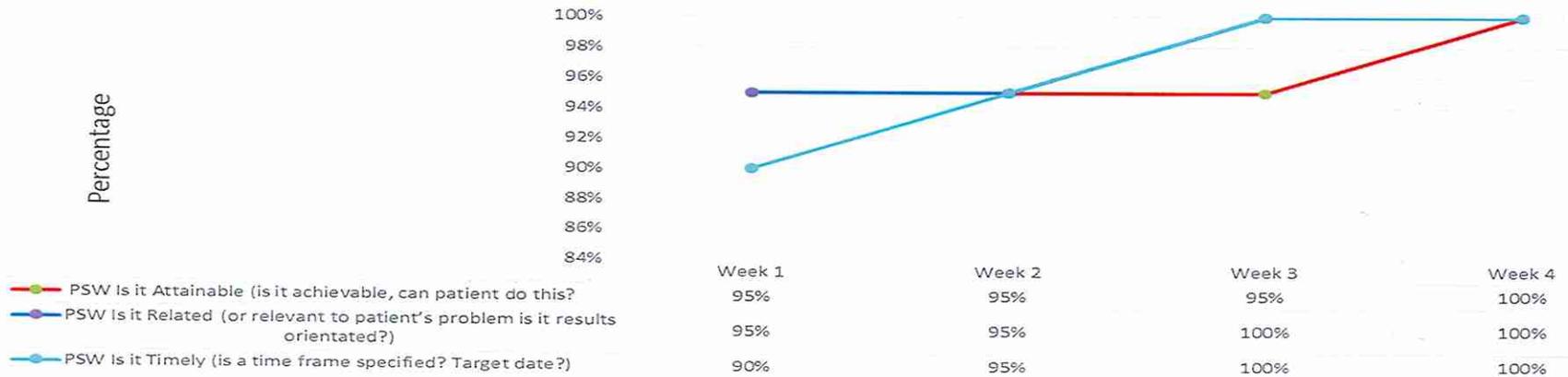
OT Goals/Objectives Week 4



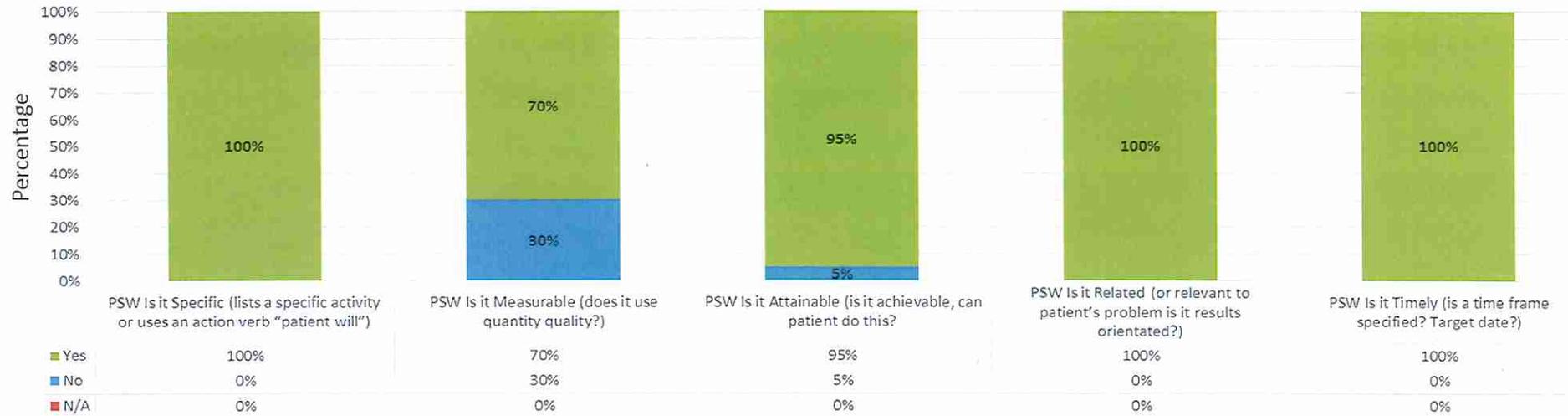
PSW Goals/Objectives (Yes)
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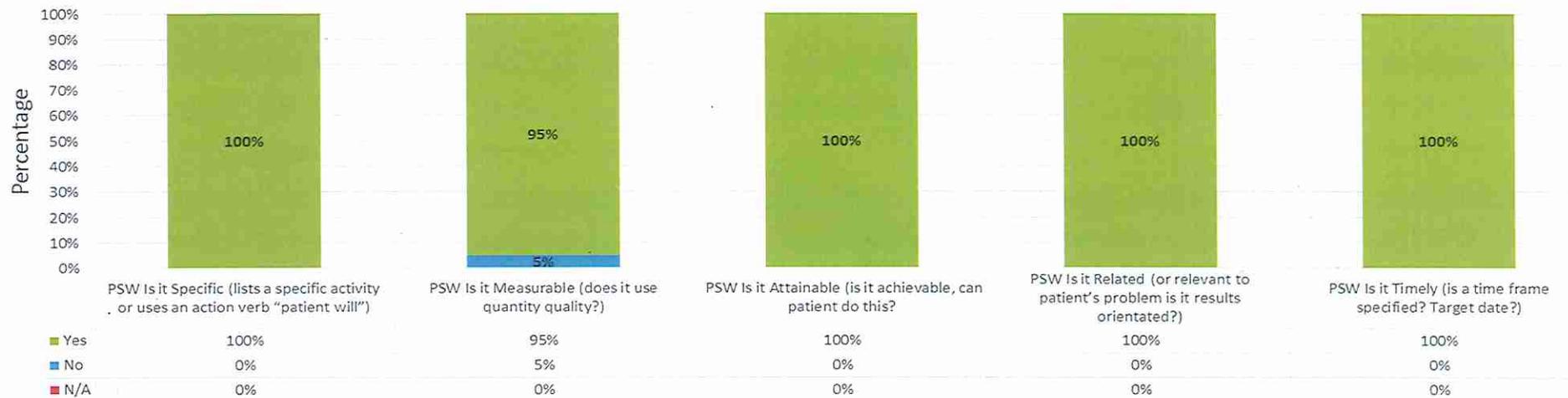
PSW Goals/Objectives (Yes)
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PSW Goals/Objectives Week 3

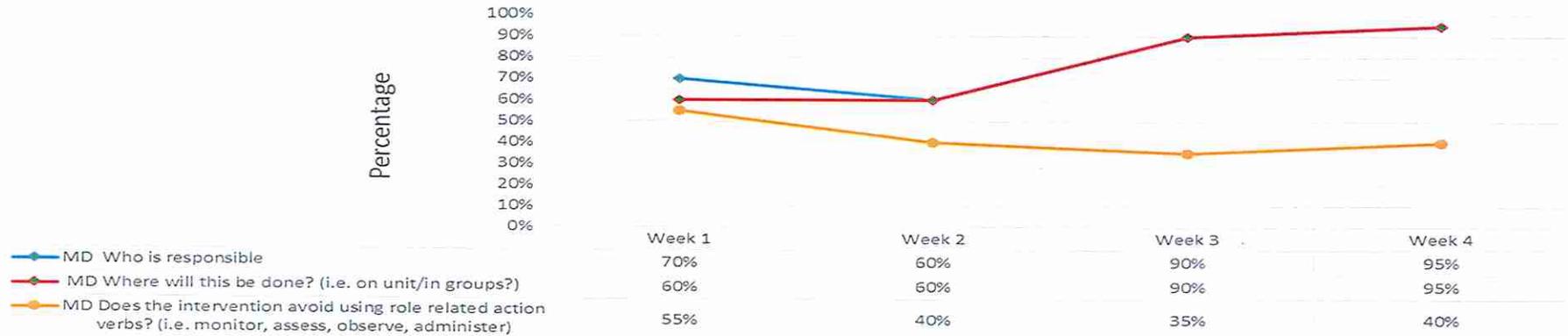


PSW Goals/Objectives Week 4

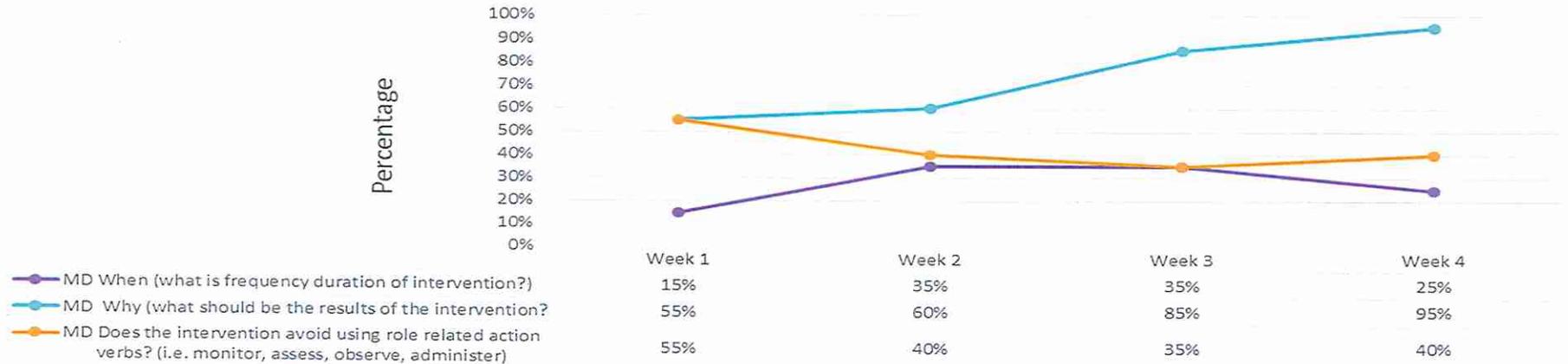


Intervention Method

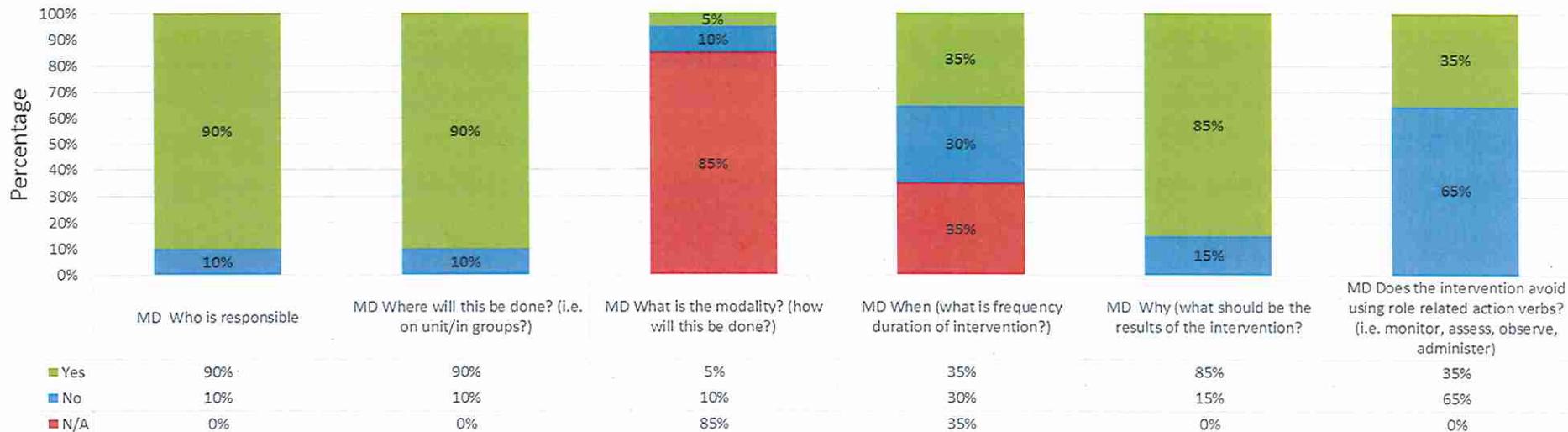
MD Interventions (Yes)
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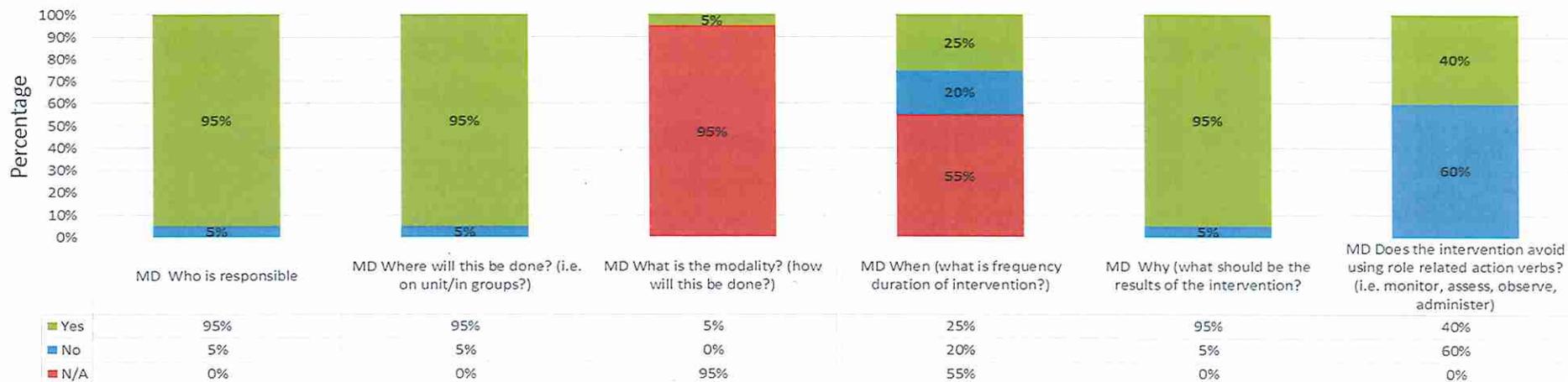
MD Interventions (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



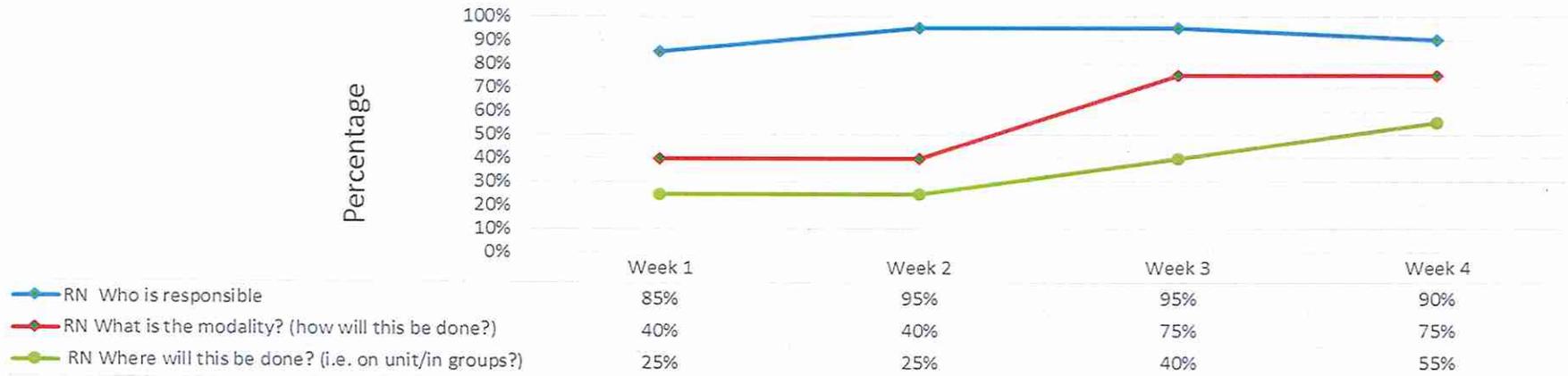
MD Intervention Week 3



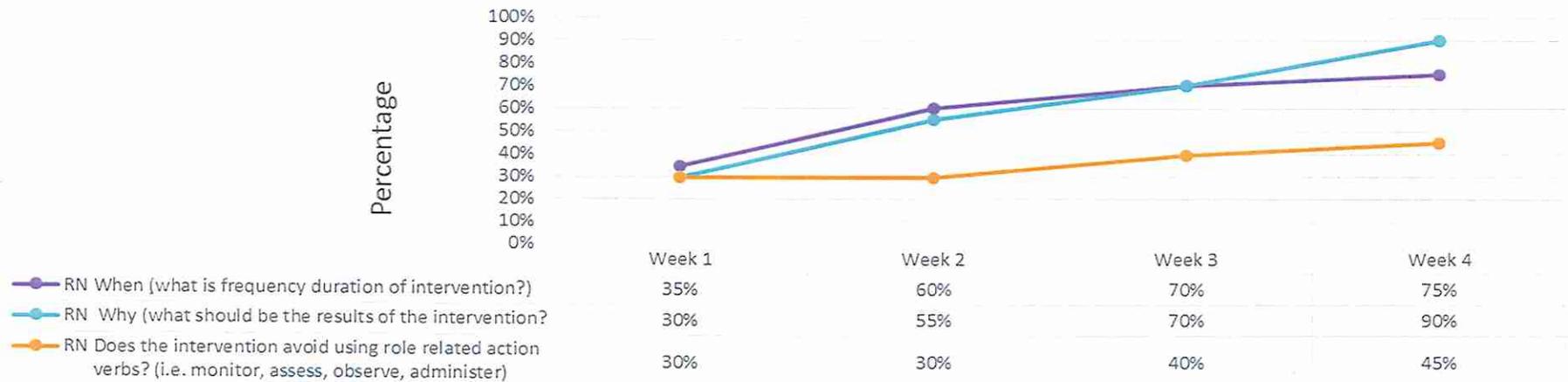
MD Intervention Week 4



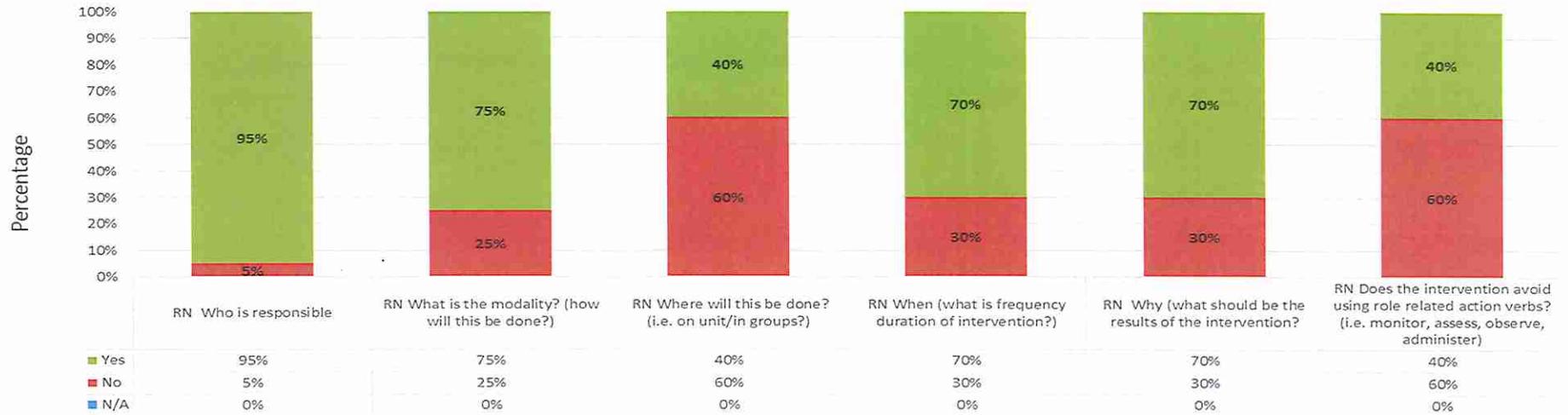
RN Interventions (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



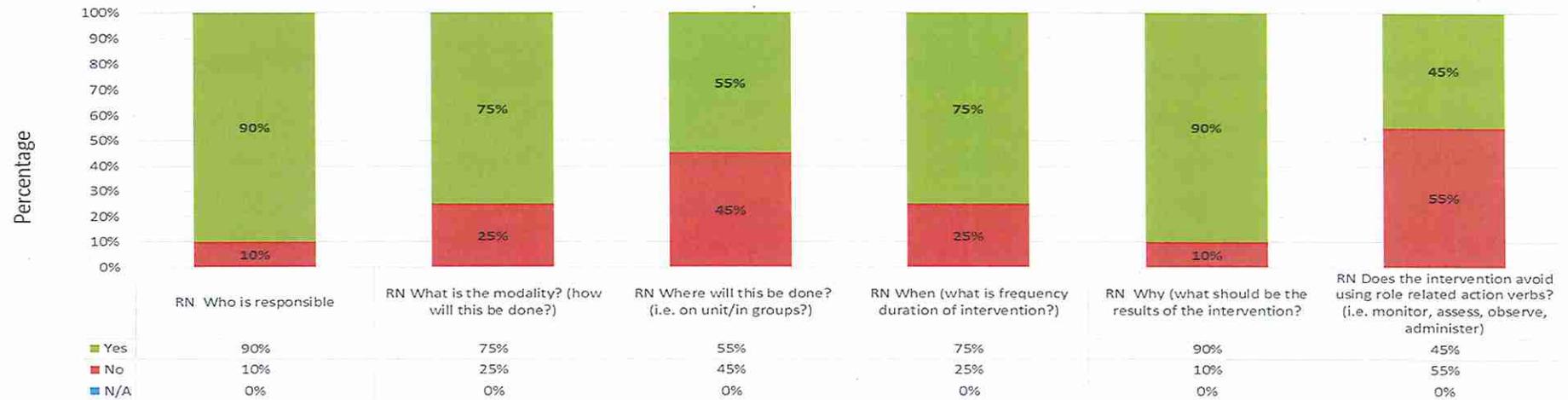
RN Interventions (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



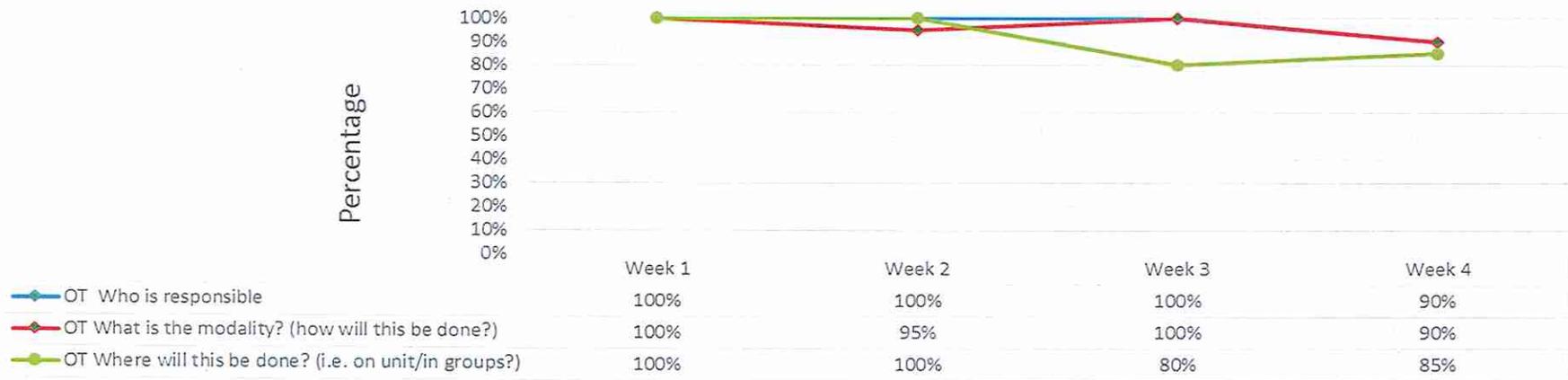
RN Intervention Week 3



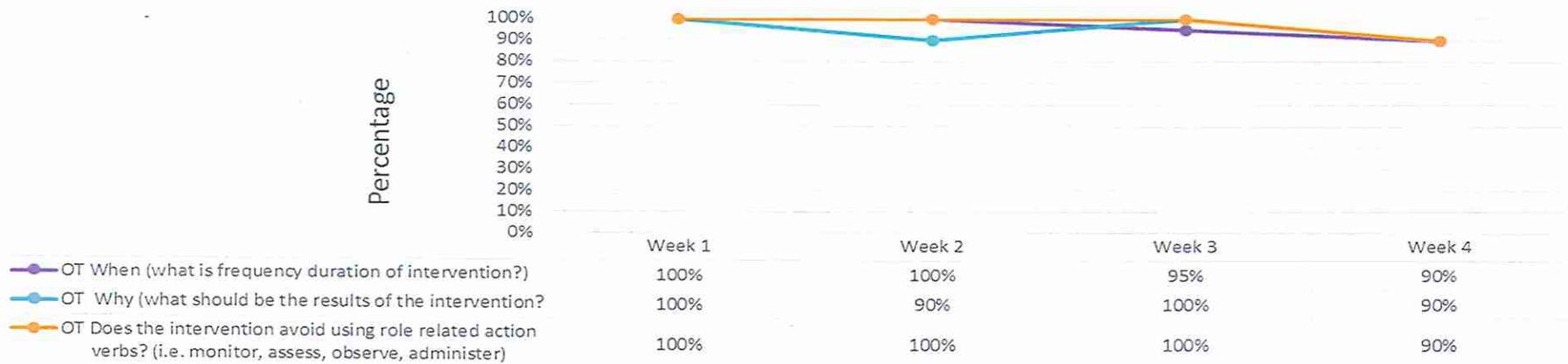
RN Intervention Week 4



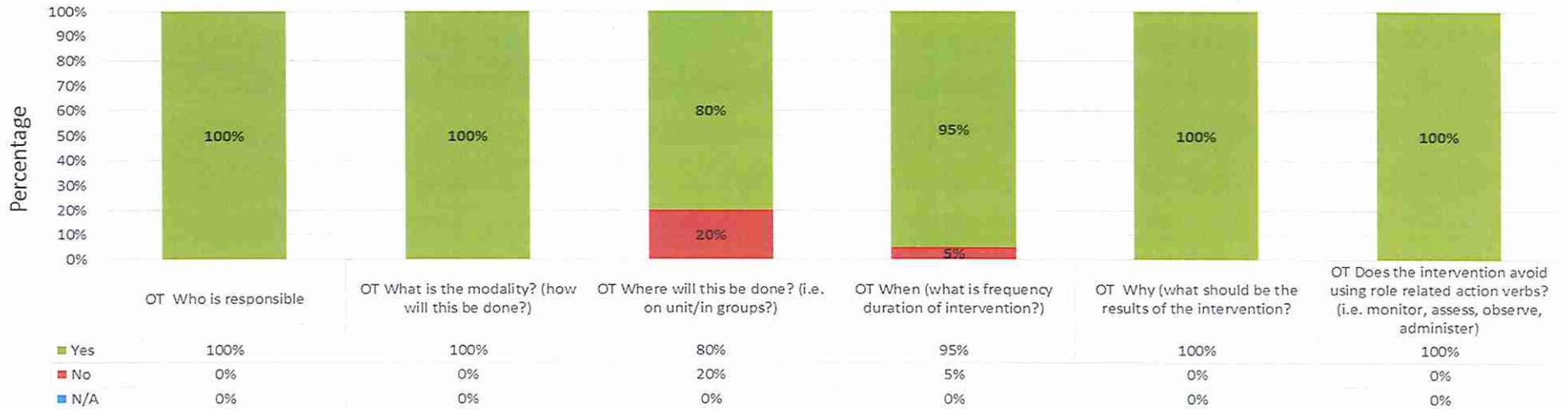
OT Interventions (Yes)
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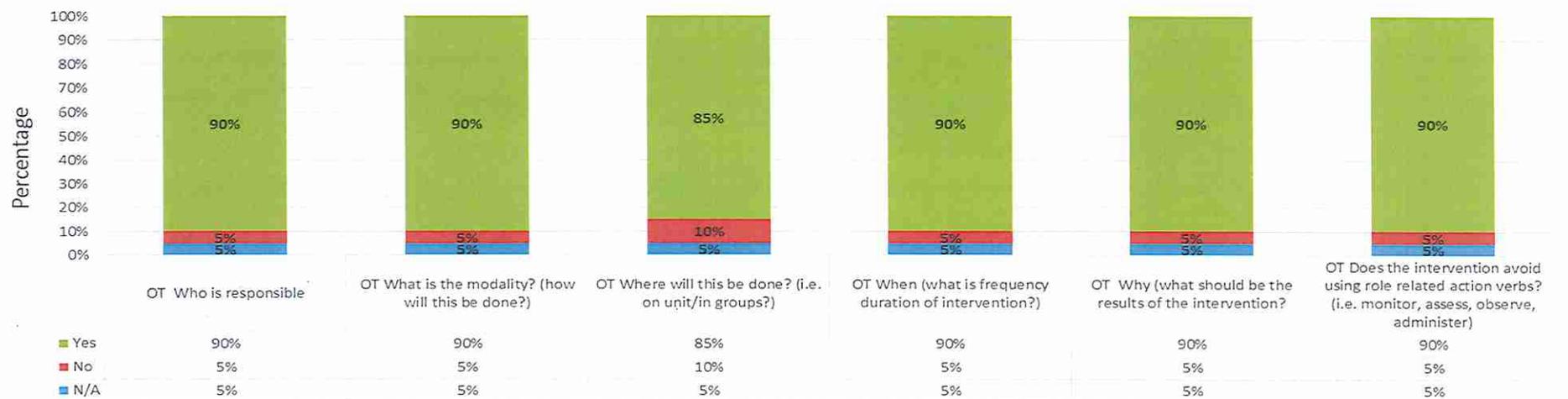
OT Interventions (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



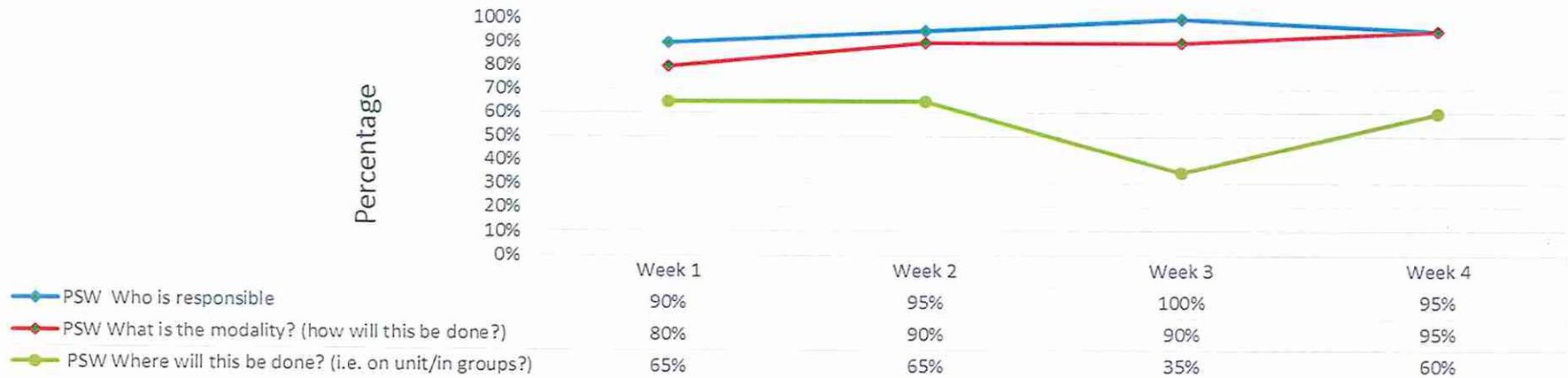
OT Intervention Week 3



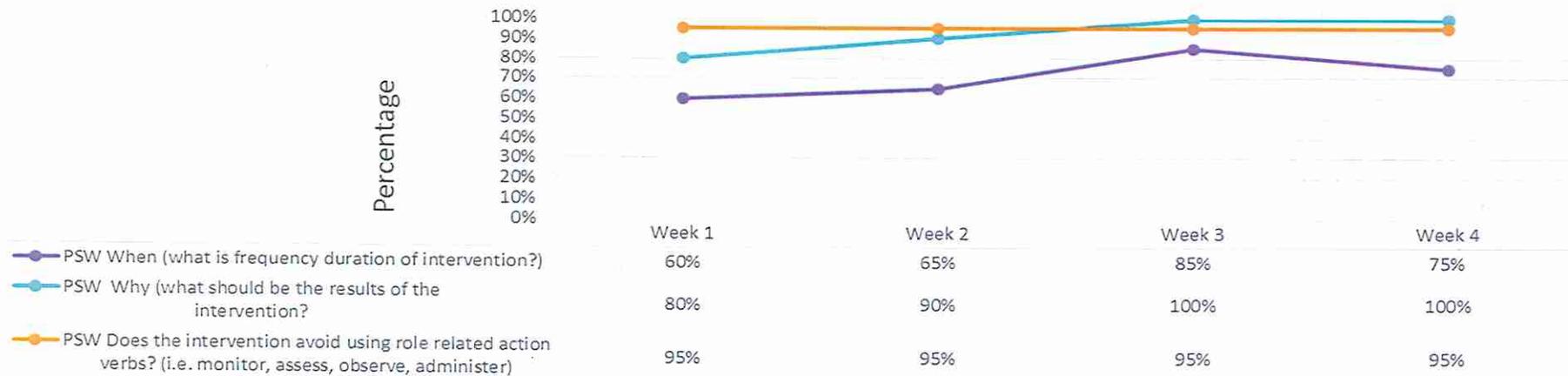
OT Intervention Week 4



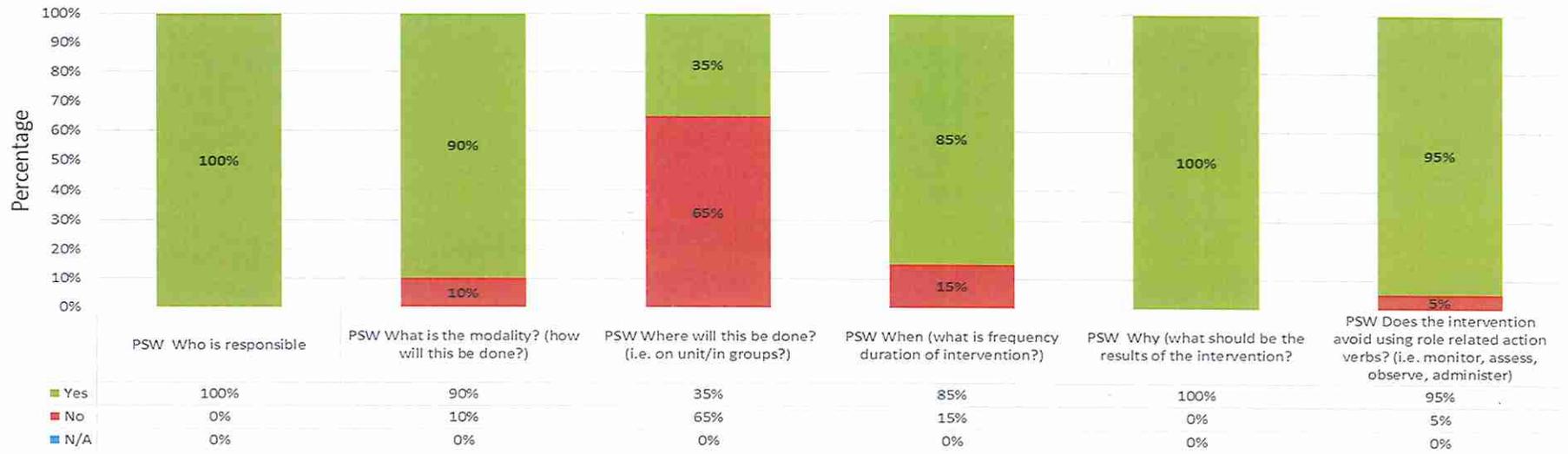
PSW Interventions (Yes)
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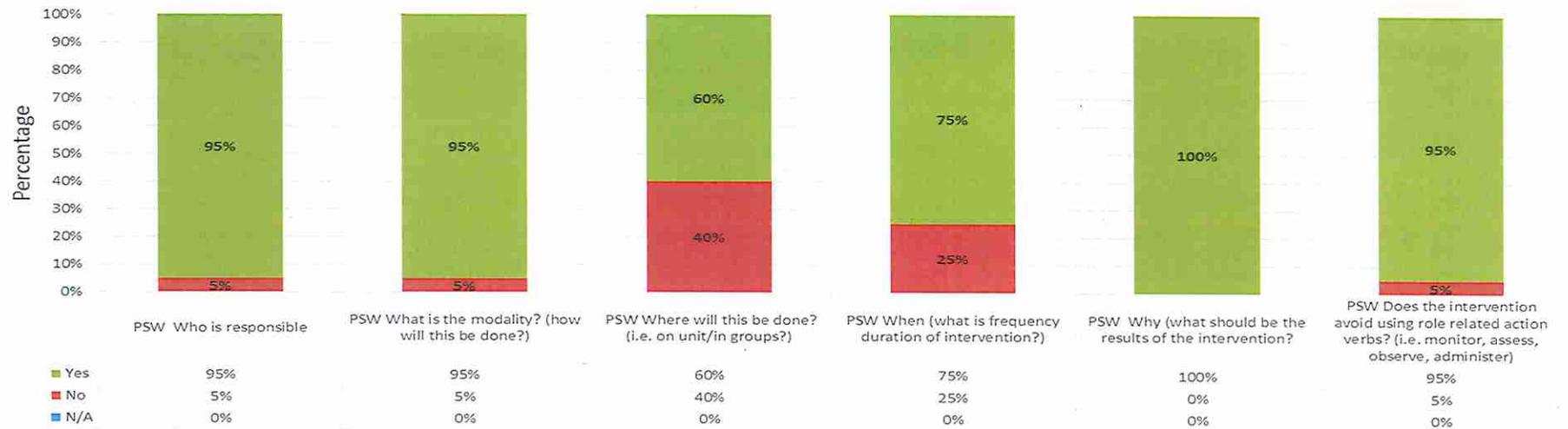
PSW Interventions (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



PSW Intervention Week 3

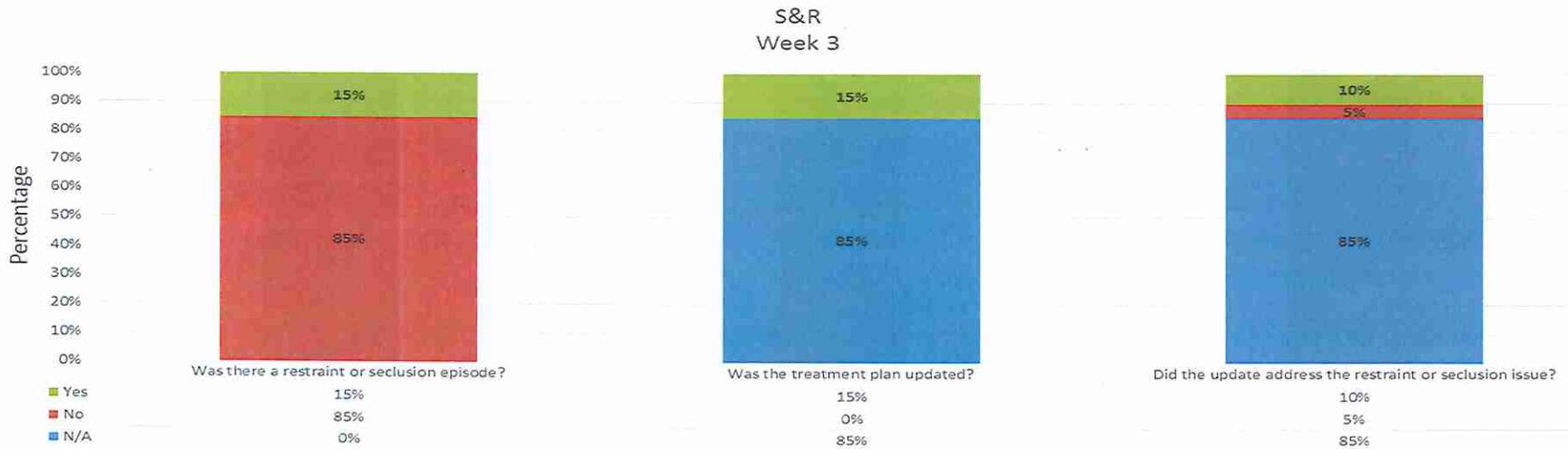
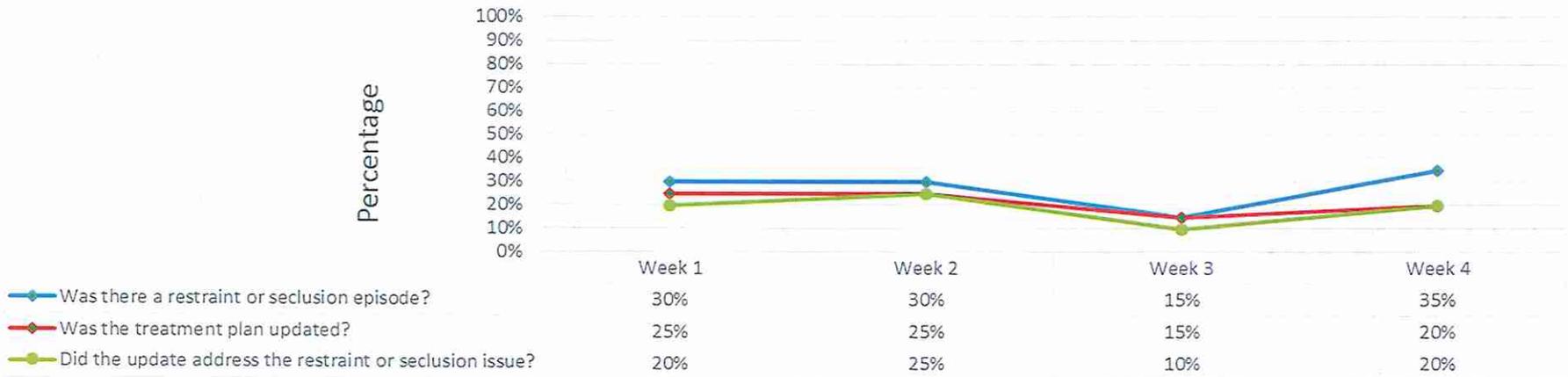


PSW Intervention Week 4

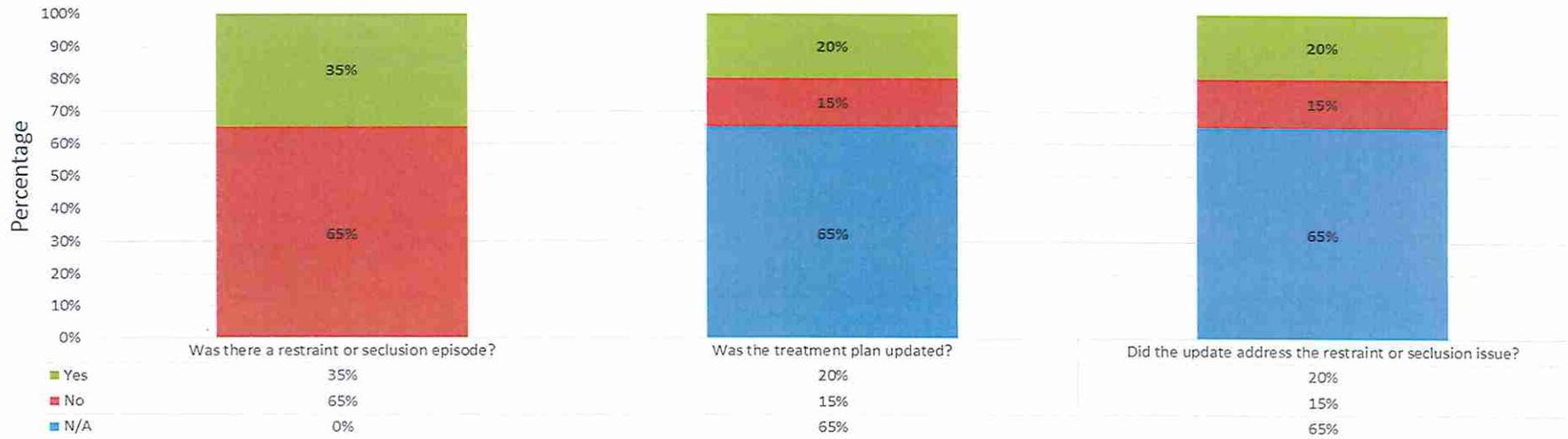


S&R

S&R (Yes)
W1 N=20, W2 N=20, W3 N=20, W4 N=20



S&R
Week 4



Quality Committee Item 9

POLICY & PROCEDURE STATUS REPORT: 05/01/17

Baseline 71.5% as of August 2016 LAB report

Review period	Number of Policies	Percentage of total
Reviewed within Scheduled Period	361	71.5%
Up to 1 year Overdue	32	6.3%
More than 1 year and up to 3 years overdue	20	4.0%
More than 3 years and up to 5 years overdue	31	6.1%
More than 5 years and up to 10 years overdue	18	3.6%
More than 10 years overdue	43	8.5%
Total	505	100.0%

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
January	2	1	28
February	9	14	2
March	2	7	7
April	0	5	4

Overall Progress 79% as of May 1, 2017

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	394	390	79%	79%
Up to 1 year Overdue	11	12	2%	2%
More than 1 yr and up to 3 years overdue	20	20	4%	3.4%
More than 3 years and up to 5 years overdue	17	13	3.5%	2.5%
More than 5 years and up to 10 years overdue	17	22	3.5%	4.5%
More than 10 years overdue	39	39	8%	8%
Total	498	496	100%	100%

Forcast Due for Review

Past Due Policies -106

Coming Due Policies

May - 24

June - 3

July - 14

August - 5

Quality Committee Item 10

MENTAL HEALTH BOARD QUALITY COMMITTEE QUARTERLY REPORT

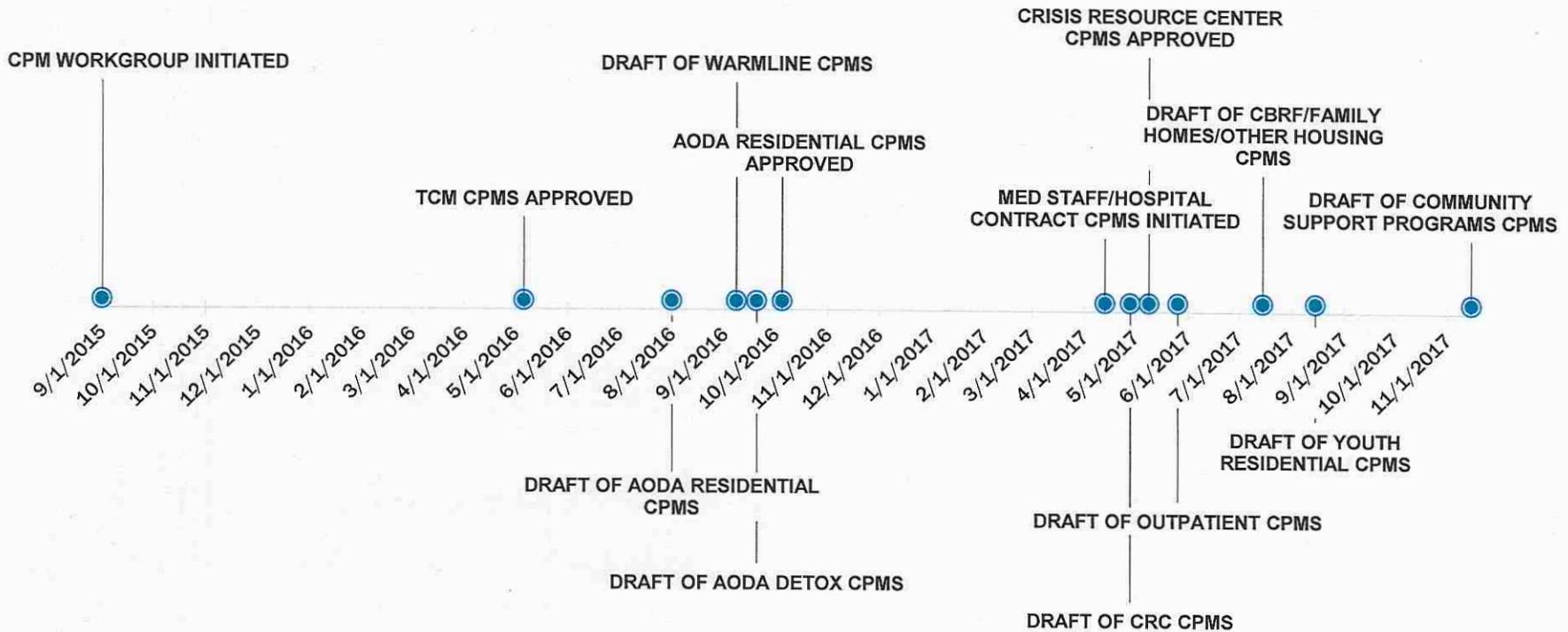
CONTRACT PERFORMANCE MEASURES UPDATE

MAY 9, 2017

The Contract Performance Measures (CPM) team has now developed 8 sets of CPMs: the Targeted Case Management program, the Detoxification program, the Warmline program, the AODA Residential program, the Outpatient Therapy program (adult), the Outpatient Therapy program (WRAP), the Outpatient Psychiatry program, and the Crisis Resource Center (CRC) program. These CPMs are at different stages of revision/approval/implementation. Further, the Medical Staff/Hospital CPMs are also under development. The Outpatient program CPMs development have been instrumental for the CPM Workgroup as they have served as a catalyst for a core data set for BHD, particularly in the area of recovery and population health. Perhaps even more importantly, the work on the Outpatient CPMs has increased the positive collaboration between the CARS and WRAP quality staff.

In addition to work on the development of these measures, an initial report on the CPMs for TCM has been built and will continue to be refined. Included in this process are reports on PPS compliance indicators which, although not part of the TCM CPMs, will be regularly included in other CPMs. Once the TCM CPM report is finalized, we will begin building the report to monitor and analyze the CPMs for AODA Residential and will continue to build new reports for each successive set of CPMs. Further, these reports are (and will be) catalogued in a spreadsheet, which will include the report name, location, build date, revision date, timing of report run, among other items. Finally, it is our intention to build the infrastructure to ensure regular processing of these reports, analysis and dissemination of the results to internal service managers and external contracted agencies, and ongoing monitoring of any quality improvement/corrective actions that are initiated based on the results.

Contract Performance Measures Development Timeline: September 2015 to November 2017



Quality Committee Item 11

PCS Hospital Transfer Waitlist Report

First Quarter Update

2017

This report contains information describing the first three (3) months of 2017 are summarized as follows:

- 2 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 75.3%
- The 358 individuals delayed comprised 18.9% of the total PCS admissions (1,896)
- The median wait time for all individuals delayed was 4.8 hours
- The average length of waitlist per patient is 8.3 hours

Prepared by:
Quality Improvement Department

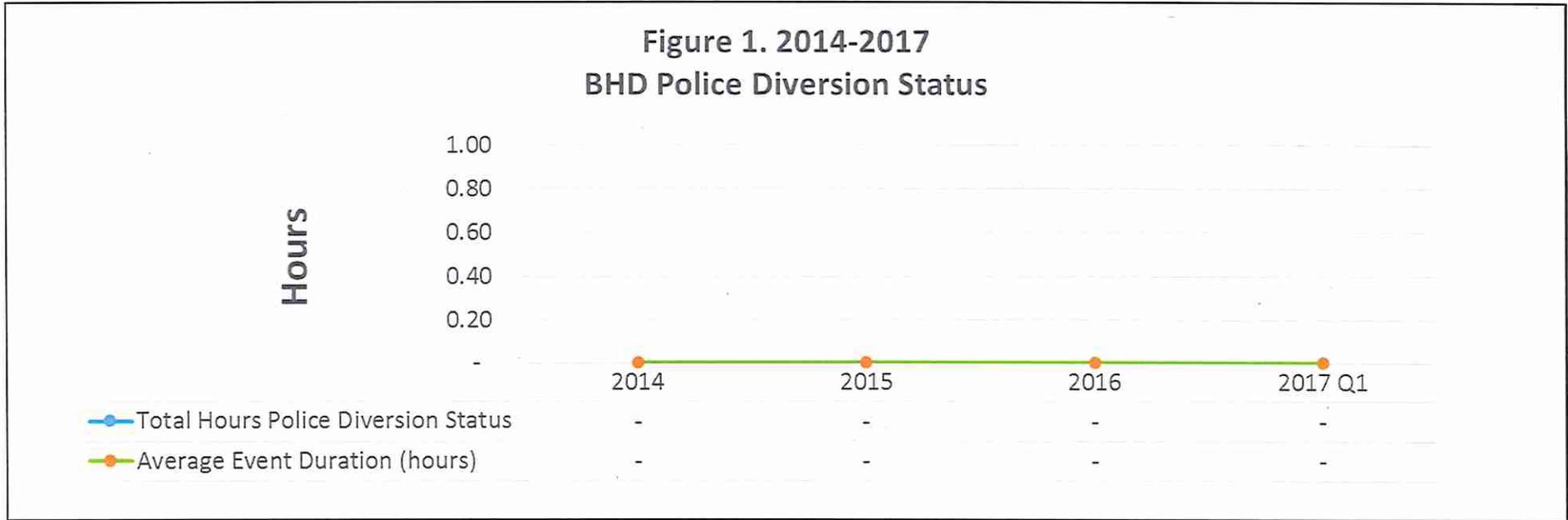
Date: April 25, 2017

Definitions:

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

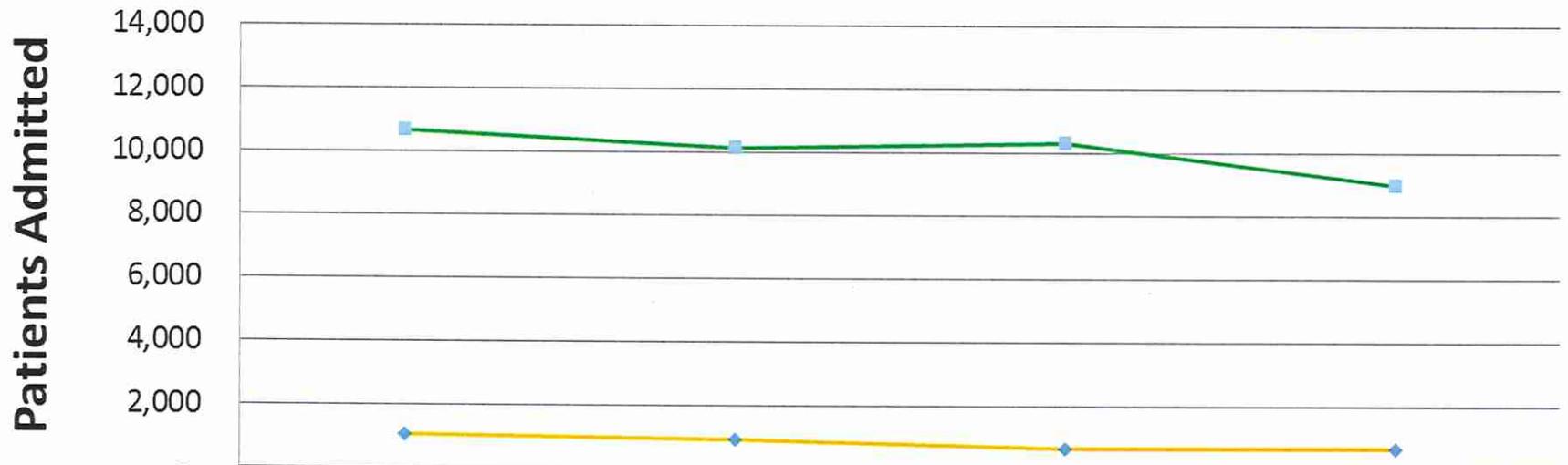
Diversion: A total lack of capacity in PCS and a lack of Acute Inpatient and Observation Unit beds. It results in actual closing of the door with no admissions to PCS allowed. Moreover, it requires law enforcement notification and Chapter 51 patients re-routed.

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



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

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



◆ Acute Adult Admissions
■ PCS Admissions

	2014	2015	2016	2017 Proj.
Acute Adult Admissions	1,093	965	683	676
PCS Admissions	10,698	10,173	10,334	9,016

*PCS Admissions = Projected Waitlist Clients + Projected PCS Clients

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



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

Figure 4. 2014-2017
Patients on Hospital Transfer Waitlist



Figure 5. Waitlist Events
2014-2017



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



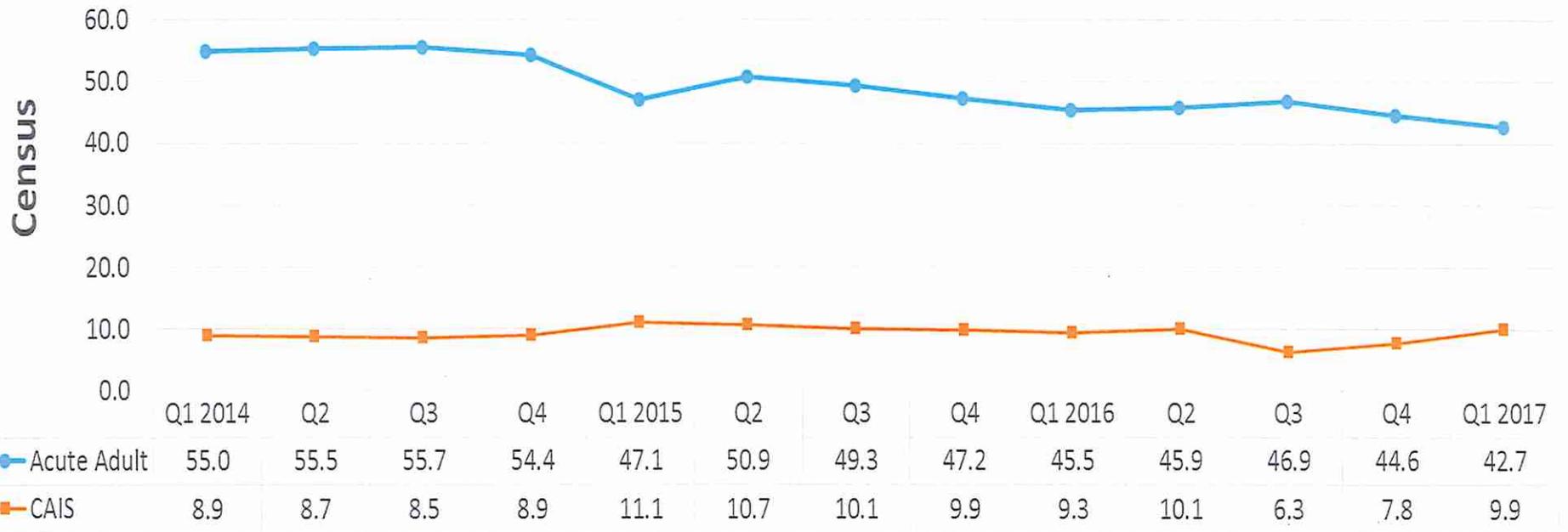
Figure 7. 2014 - 2017
Median Wait Time For Individuals Delayed
(Hours)



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

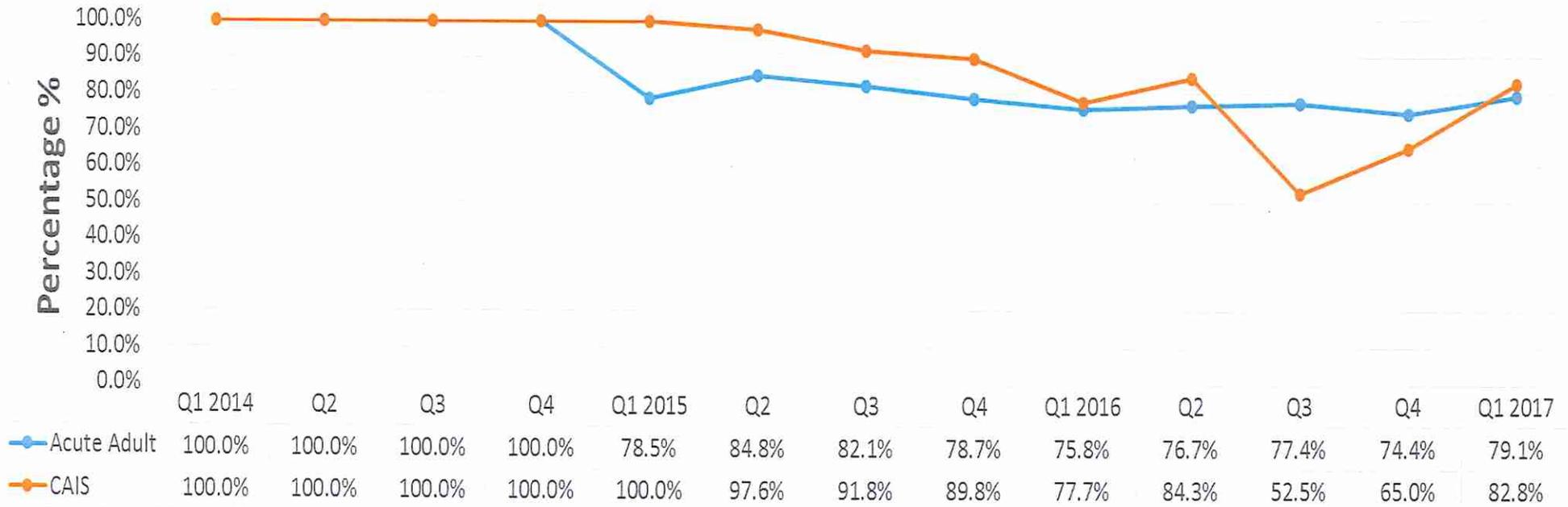


Figure 9. 2014-2017
Acute Adult/CAIS
Average Daily Census



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

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



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

*Reduced staffing impacted operation bed count

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

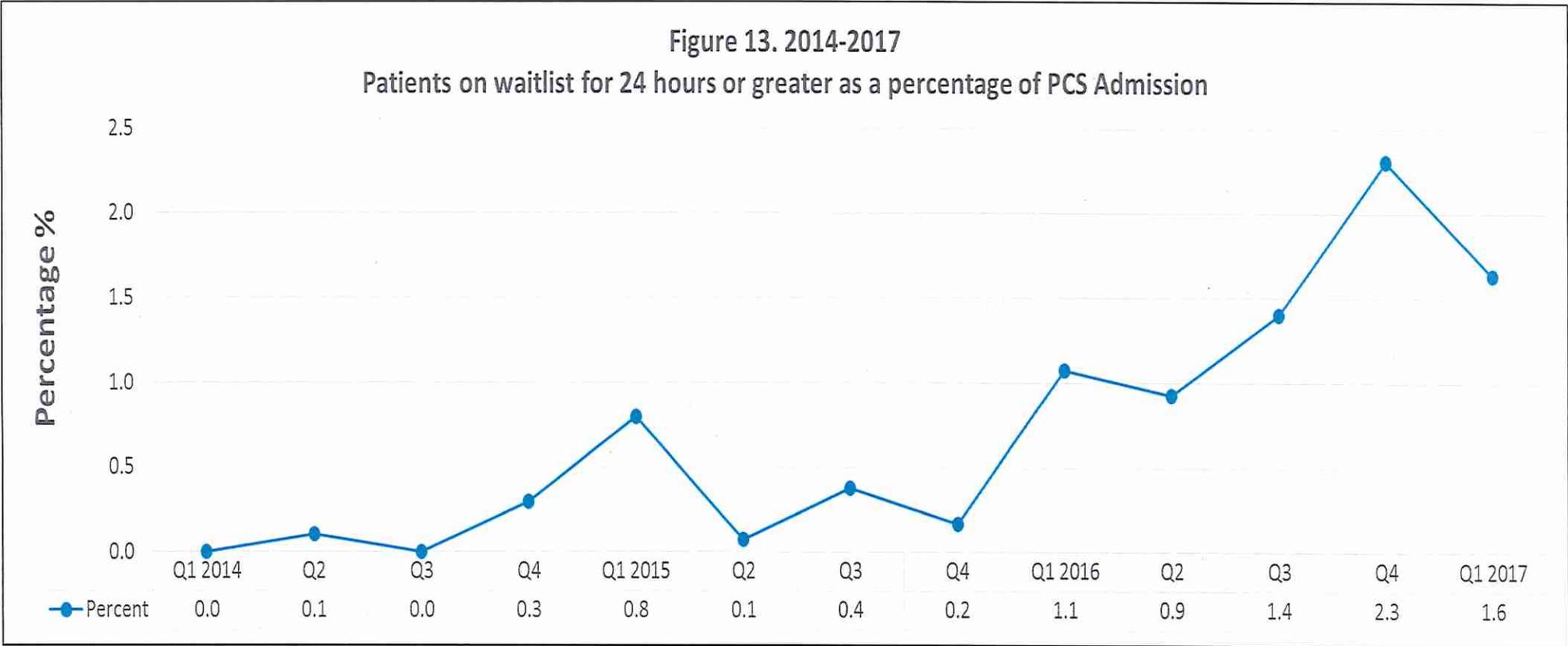


Figure 12. 2014-2017
Patients on waitlist for 24 hours or greater as a percentage of number of clients waitlisted



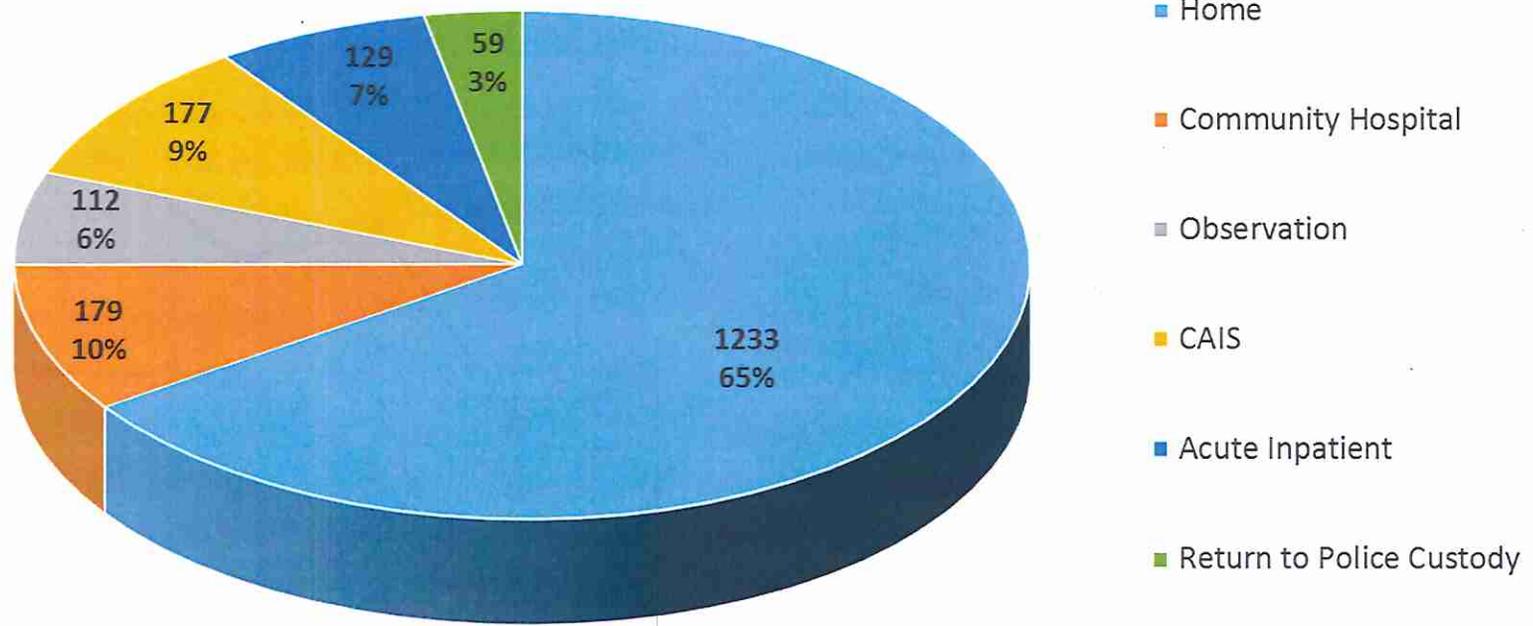
*Percent = Number of Patients on waitlist for 24 hours or greater/Number of Clients Waitlisted

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



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

**Figure 14. 2017 Q1
Disposition of all PCS admission**



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

DATE: May 31, 2017 (AMENDED ATTACHMENT)

TO: Duncan Shrout, Chairperson, Milwaukee County Mental Health Board

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

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

Background

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

Discussion

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

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

Recommendation

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

Respectfully Submitted,



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

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

Attachments

1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
MAY / JUNE 2017 (AMENDED)**

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

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 3, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 17, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Ricardo Bayola, MD	General Psychiatry; Child Psychiatry	Affiliate/ Provisional		Dr. Moisis recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
Jack Owens Jr, MD	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
Jenta O. Alexander, MSN	Advanced Practice Nurse-Family Practice	Allied Health Professional / Provisional	B	Dr. Puls recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 3, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 17, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Reono Bertagnolli, MD	Diagnostic Radiology Interpretive Services	Telemedicine Consulting / Full		Dr. Puls recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Amelia Brost, PsyD	General Psychology- Adult, Child and Adolescent	Active / Full	B	Drs. Kuehl & Moisis recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Steven Dykstra, PhD	General Psychology- Adult, Child and Adolescent	Active / Full		Drs. Kuehl & Moisis recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Michael Hinz, MD	Diagnostic Radiology Interpretive Services	Telemedicine Consulting / Full		Dr. Puls recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Gregory Jurenc, PhD	General Psychology- Adult	Affiliate / Full		Drs. Kuehl & Schneider recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	

REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 3, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 17, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Teri Kaczmarek, PsyD	General Psychology-Adult	Active / Full		Drs. Kuehl & Love recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Annaliese Koller Shumate, DO	General Psychiatry	Active / Full	B	Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Dennis Kozel, MD	General Psychiatry; Child Psychiatry	Affiliate / Full		Dr. Moiso recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
David Macherey, PsyD	General Psychology-Adult and Extended Psychology-Acute Adult Inpatient	Active / Full	M#	Drs. Kuehl & Schneider recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Kevin Murtaugh, MD	General Psychiatry	Affiliate / Full	B	Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Stephen Sponagle, MD	None Requested	Consulting / Appt Only	B/CB	Dr. Schneider recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Maitrayee Vadali, MD	Internal Medicine / Cardiology Interpretive Services	Telemedicine Consulting / Full	M#	Dr. Puls recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 3, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 17, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<i>The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.</i>							
MEDICAL STAFF							
Robert Clark, MD	General Psychiatry	Affiliate/ Provisional	Active / Full	Dr. Schneider recommends full privileges	Committee recommends change in privilege status from provisional to full and change in appointment category to Active for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Justin Gerstner, MD	General Psychiatry	Affiliate/ Provisional	Affiliate/ Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Michelle Heaton, DO	General Psychiatry	Affiliate/ Provisional	Affiliate/ Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Jennifer Lippitt, MD	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional	Affiliate/ Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Abby Noack Haggas, PsyD	General Psychology-Adult, Child and Adolescent	Active / Provisional	Active / Full	Drs. Kuehl and Moiso recommend full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Deepa Pawar, MD	General Psychiatry	Affiliate/ Provisional	Affiliate/ Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 3, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 17, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<i>The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.</i>							
Rebecca Radue, MD	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional	Affiliate/ Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
ALLIED HEALTH							
Kanisha Hayden, MSN	Advanced Practice Nurse-Family Practice	Allied Health Professional / Provisional	Allied Health Professional / Full	Dr. Puls recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Josie Veal, MSN	Advanced Practice Nurse-Family Practice	Allied Health Professional / Provisional	Allied Health Professional / Full	Dr. Puls recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	SERVICE CHIEF* RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 3, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 17, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NONE THIS PERIOD							

AMENDMENT TO MAY / JUNE REPORT

INITIAL APPOINTMENT / PRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MAY 31, 2017	MEDICAL STAFF EXECUTIVE COMMITTEE MAY 31, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Noah Jeannette, DO	General Psychiatry	Active / Provisional		Dr. Schneider recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	

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

5/31/2017
 DATE

Clarence P. Chiu (ms)
 PRESIDENT, MEDICAL STAFF ORGANIZATION
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

5/31/17
 DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

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

GOVERNING BOARD CHAIRPERSON _____

DATE _____

BOARD ACTION DATE: JUNE 22, 2017