COUNTY OF MILWAUKEE
Inter-Office Communication

Date: June 30, 2017

To: Supervisor Theodore Lipscomb, Sr., Milwaukee County Board Chairman

From: Jerome J. Heer, Director of Audits

Subject: Behavioral Health Division Patient & Staff Safety (File No. 15-237)

On June 22, 2017, the Milwaukee County Mental Health Board received an analysis of Behavioral Health Division (BHD) incidents. The report, which is attached, was prepared by Jeanette May, PhD, MPH. Ms. May was selected as the consultant for the review by BHD in consultation with our office.

The scope of Ms. May's work was to replicate and update the incident trends included in our 2010 report on patient and staff safety. We had initially planned to conduct the update as part of an audit conducted by our Division but our access to records was limited by concerns about the need for confidentiality in BHD's quality assurance peer review process. As an alternative, the Mental Health Board Executive Committee suggested that we work with the BHD Chief Medical Officer to retain a consultant to update the incident data reported in the 2010 audit. We interviewed several potential consultants and jointly agreed that Ms. May possessed the experience and knowledge to perform the work.

The report notes that incidents per 1,000 patient bed days decreased slightly in 2011 and then increased through 2014 primarily because of an increase in aggression incidents on the acute unit. However, that trend reversed dramatically in 2015. Several factors that contributed to the improvement are identified in the report. These include capping the acute unit population to enhance Staff to Patient ratios, moving Managers onto the service units, increased education and training, improved medication and assessment protocols, and increased attention to seclusion and restraint management. In addition to updated incident data, the report also provides incident report analysis and the results of a staff survey on incident reporting. BHD has continued to make program improvements that will enhance patient and staff safety and security.

We appreciate the efforts of BHD and Ms. May in conducting the update of incident data we presented in 2010.

Jerome J. Heer/JAG

Jerome J. Heer

JJH/cah

Attachment

cc: Scott B. Manske, Milwaukee County Comptroller
Chris Abele, Milwaukee County Executive
Supervisor Peggy West, Chair, Finance, & Audit Committee
Supervisor Supreme Moore Omokunde, Chair, Health & Human Needs Committee
Margaret Daun, Corporation Counsel
Jeanne Dorff, Interim Director, Department of Health & Human Services
Michael Lappen, Administrator, Behavioral Health Division
✓Dr. John Schneider, Chief Medical Officer, Behavioral Health Division
Steve Cady, Research & Policy Director, Office of the Comptroller
Janelle Jensen, Chief Committee Coordinator, County Clerk's Office

Behavioral Health Division

Date Issued:	*8/15/2017*
Last Approved Date:	*8/15/2017*
Last Revised Date:	*8/15/2017*
Next Review:	*8/14/2020*
Owner:	*Lynn Gram: 80043-Safety Officer*
Policy Area:	*Quality Management*
References:	

Incident/Safety Event Reporting

Effective Date if Other Than Approval Date: N/A

Purpose:

To accurately document an incident and staff response to it.

To provide a non-punitive environment conducive to reporting.

To learn from and use data to analyze safety issues and identify trends so improvement can be implemented

To provide education and feedback to staff to prevent and reduce future incidents.

Scope:

Any incidents under BHD's scope of services or on BHD property

- Inpatient
- Day Treatment
- Crisis Services
  - PCS
  - OBS
  - Access Clinics
  - Respite Houses
  - Mobile Team
- CARS (services provided by Milwaukee County employees)
- Wraparound Milwaukee-(services provided by Milwaukee County employees)
- Any support services associated with the above areas.

Policy:

Incident and sentinel event reporting is an important part of error prevention. MCBHD learns from patient safety events to promote system education, initiate process improvement and prevent and mitigate health care error.

Any staff member who witnesses, discovers or has direct involvement in and/or knowledge of a safety event must complete an on-line safety event incident report. More than one individual may complete a report concerning the same issue. Some situations may warrant multiple types of reports

COPY

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It is the policy of the Milwaukee County Behavioral Health Division that significant incidents and exposure to risk will be reported, monitored, and investigated if indicated. Serious incidents involving patients, staff, students, volunteers, contracted personnel, and visitors will be reported.

Definitions:

A. **Incident/Safety Event:** Any unusual event not consistent with the routine operations of the facility and its staff, or the routine care of a patient/visitor. An injury does not necessarily have to occur. Examples of occurrences include, but are not limited to the following:

- An accident, with or without injury
- Any situation which may result in injury or potential liability. This includes environmental safety hazards.
- Any situation indicating negligent action or lack of action
- Thefts or property damage occurring on the premises
- Employee work performance issues that jeopardize patient safety.
- Equipment problems that have or could have caused harm to a patient, staff or visitor.

B. **Patient Safety Event:** An event, incident or condition that could have resulted or did result in harm to a patient.

1. **Behavior Events:** Events involving patient behavior. Self-injurious behaviors, suicide and suicide attempts, physical aggression towards another patient or staff member, property damage, sexual contact between patients.
2. **Caregiver Misconduct Events:** Any observed, or reported potential caregiver misconduct including abuse, neglect, misappropriation of property, or injury of unknown source. See Caregiver Misconduct: Reporting and Investigation of Caregiver Misconduct and Injuries of Unknown Source
3. **Contraband Events**: Events involving a patient having possession of a contraband item deemed to be potentially dangerous. Examples include but are not limited to the following categories: Weapons, Medications, Alcohol/Drugs, Sharp Objects, Tobacco Products, Food/Drink, Containers, Hygiene Items, Clothing, Bags/Purses, Keys, Mobility Aids, Personal Electronics, Sewing/Craft, Recreational/ Sports items, Reading/Writing Materials
4. **Diagnostic Testing Error Events**: Any mistake or failure in the diagnostic process leading to a misdiagnosis, a missed diagnosis, or a delayed **diagnosis**.
5. **Equipment/ Medical Device Events:** Failure of equipment involved with providing patient care that results in injury or risk of injury.
6. **Elopement Events:** When a patient wanders away, walks away, runs away, escapes, or otherwise leaves the BHD environment unsupervised, unnoticed, during an escort, and/or prior to their scheduled discharge. Failure of a patient to return from a pass at the expected time. Any attempt to elope.
7. **Falls Events:** A fall is an unintended/uncontrolled event resulting in a person coming to rest on the ground/floor or other lower level (witnessed) or is reported to have landed on the floor (unwitnessed). When a person *chooses* to put himself or herself on the floor or lower level and this has been witnessed by a staff member, *this is not a fall.*
8. **Medication related Events:** Events where use of a medication resulted in or could have resulted in

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an adverse outcome in a patient; includes drug administration error,s drug incompatibility, Adverse Drug Reactions (defined below), and Medication Variance (defined below), events. See: Adverse Drug Reactions and Medication Variances (Formerly Adverse Medication Event) for more detail.

- ***Adverse Drug Reaction (ADR):*** A suspected or unintended physical and/or allergic reaction to a drug when it is prescribed and used in the approved manner.
- ***Medication Variance (MV):*** Any action that is not consistent with the routine operation of the hospital or the routine care of a particular patient. This could include:

9. **Security/Property Events:** Damage, loss/theft, motor vehicle accident/collision, vandalism, other
10. **Other:** An incident/safety event not reportable under any of the above categories.

Non-Employee Incident: A safety event that involves a contractor, visitor and does not involve a current patient.

Employee Incident: A safety event that involves a MCBHD employee.

Sentinel Event (Critical Incident): A patient safety event, not primarily related to the natural course of the patient's illness or condition, that reaches a patient and results in an outcome as defined in the MCBHD Sentinel Event Policy.

Near Miss: (Close Call or Good Catch): An event that could have had adverse consequences but did not and is indistinguishable from an actual incident in all but outcome. A near miss may occur when a chain of events is interrupted. A patient safety event that did not reach the patient.

Unsafe Condition: Any circumstance that increases the probability of a client safety incident.

Procedure:

A. Initial Reporting:

1. Staff are expected to report all Safety Events in the web-based incident reporting system. The report will be completed by:
   - the employee(s) or staff involved in the incident,
   - the staff who observed the incident,
   - in the situation where no staff are present, by the staff who interviewed the patient, visitor, contract personnel, or other individual involved,
2. Staff are expected to complete the on line report before the end of the employee's shift or work period and before leaving the premises.
3. Select the appropriate button/link depending upon the type of incident.
   a. **Patient/Client Incident**
      i. Behavior Events
      ii. Contraband Events

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iii. Diagnostic Testing Error Events

iv. Equipment/ Medical Device Events

v. Elopement Events

vi. Falls Events

vii. Medication related Events

viii. Caregiver Misconduct Events

ix. Security/Property Events

x. Other.

b. **Employee Incident** (will link to the report form)

c. **Contractor/Visitor Incident** (will link to the report form)

d. **Compliments/Complaints, Grievances/Feedback**. Refer to Patient Grievance Resolution Process policy for more information.

e. **Manager Access-** for access to open incident/safety reports for review and follow up.

f. Complete the form answering as many questions as possible. Questions marked **Required* will have to be answered to save the form.

   i. Start at the top of each page; follow up questions are based on your answers to previous questions.

   ii. Some fields include smart searches. Options will appear as you begin typing.

g. Upon completion, review your answers and click "Save form" - you will see a small window titled "Entry Saved" with a Unique ID. After clicking "Continue" you will see a screen that says "Form Submitted, Thank you! confirming submission of your entry.

h. Contact your supervisor and/or the house supervisor to verbally report any potential Sentinel Event or High Risk Event immediately (within 15 minutes) This includes events with a high likelihood of serious adverse outcome. Incidents that involve death, fires, explosions, serious injuries and assaults, substantial damage, or property loss, must be reported immediately. Allegations of caregiver misconduct and patient injuries of unknown origin must be reported

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immediately.

i. The staff and supervisor will review and take immediate corrective action where necessary to address safety risks.

ii. Supervisor will conduct a follow up investigation and report via the on line incident reporting system. (See B below)

i. Multiple incident report forms may need to be completed if the event involves two or more areas. For example:

i. If there was a physical altercation between two patients. A report would be completed for each separately.

ii. A patient behavior results in a staff injury. In this case an employee report and a patient safety-behavior report are to be completed. In the case of employee injuries, the Risk management forms also need to be completed. See Accident and Claims Reporting Procedure.

B. Investigation Phase-Area Manager Responsibilities

1. The area manager for the location selected in the Event Report Form will receive an email notification from *Verge Solutions* automated@verge-solutions.com with a subject of *Notices for you in Converge*. The email will contain the ID number, the case type, the date and time of the event, and a link to the case to complete the follow up review.
2. The area manager will edit the case report to add content as appropriate and navigate to the **Triage and Investigation** page.
3. Area manager must initiate the initial investigation within 1 to 2 days of the event.
   a. Investigation of potential Sentinel Event or High Risk Events must be initiated immediately. This includes events with a high likelihood of serious adverse outcome. Incidents that involve death, fires, explosions, serious injuries and assaults, substantial damage, or property loss, must be reported immediately.
   b. Investigations of allegations of caregiver misconduct and patient injuries of unknown origin must be initiated immediately.
4. Area manager should complete the Triage and Investigation page within 5-7 days and submit for Risk Manager review and Final Resolution.
5. Consult Administration for assistance, if necessary
6. If the event severity requires more than approximately seven (7) days to investigate and resolve, the area manager must notify department director/leadership.
7. Input all of the investigative information into the Triage and Investigation Report form.

C. Final Resolution of Incident

1. The Program/Department Leadership staff member(Risk Manager), designated by area and type of incident, will complete the Final Resolution of Incident page of the report form, generally within 15-20 days. Higher severity incidents may to go longer.

   The Risk Manager:

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a. Must make a decision as to whether additional follow up review is needed or referral to other department(s) or area manager(s).

b. Is responsible for making those referrals.

c. Documents follow up, findings, and finalizes any improvement actions.

d. Make any additional entries on the form, save and close the report.

e. Communicate decisions and action items to appropriate personnel for implementation.

References:

N/A

Monitors:

The Quality Department will:

- Monitor for timely review and closure.
- Analyze the process of cataloging incidents as well as the incidents themselves for trends and patterns.

Attachments:

Process Flow Diagrams

Approval Signatures

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	8/15/2017
	Jennifer Bergersen: 80101-Chief Clinical Officer	8/14/2017
	Lynn Gram: 80043-Safety Officer	8/14/2017

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

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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	5,276			8,370		BHD (2)
		Sample Size (Unique Clients)			2,414	2,519			-		
	2	Percent with any acute service utilization[6]	-	13.09%	16.94%	19.02%			12.05%		BHD (2)
	3	Percent with any emergency room utilization[7]		12.44%	12.80%	16.08%			11.20%		
	4	Percent abstinence from drug and alcohol use	-	66.71%	63.34%	60.82%			73.81%		BHD (2)
	5	Percent homeless	-	4.74%	6.71%	7.26%			4.00%		BHD (2)
	6	Percent employed	-	15.80%	15.29%	16.83%			17.38%		BHD (2)
		Sample Size (Admissions)		6,315	1,688	1642			-		
	7	Percent of clients returning to Detox within 30 days	19.6%	55.61%	62.26%	59.99%			50.61%		BHD (2)
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,329	3,500	1,949	2,532			3,670		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.6	4.6	4.8	4.8			> = 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	62%	60.2	63.9%	65.6%			> = 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollement (Rating scale of 1-5)	3.2	2.86	2.68	2.76			> = 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	58%	53.6%	55.6%	55.1%			> = 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	42%	43.6%	45.1%	44.3%			> = 50%		BHD (2)
Crisis Service	14	PCS Visits	10,173	8,286	1,896	2,046			7,884		BHD (2)
	15	Emergency Detentions in PCS	5,334	4,059	900	1,015			3,830		BHD (2)
	16	Percent of patients returning to PCS within 3 days	8%	7.9%	7.8%	7.5%			8%		BHD (2)
	17	Percent of patients returning to PCS within 30 days	25%	24.8%	23.8%	23.0%			24%		CMS (4)
	18	Percent of time on waitlist status	16%	80.1%	75.6%	91.7%			25%		BHD (2)
Acute Adult Inpatient Service	19	Admissions	965	683	169	155			650		BHD (2)
	20	Average Daily Census	47.2	45.8	42.7	43.9			43		BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	3%	3.6%	2.4%	2.2%			3%		BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	11%	10.8%	9.6%	9.0%			10%		NRI (3)
	23	Percent of patients responding positively to satisfaction survey	73%	70.6%	69.9%	77.5%			74%		NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	63%	57.1%	64.6%	66.0%			65%		BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	7.2	3.32	0.45	0.61			0.66		CMS (4)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.47	0.48	0.27	0.25			0.14		CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	18%	18.5%	12.6%	19.0%			9.5%		CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	98%	95.0%	92.3%	90.0%			90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	919	617	184	167			750		BHD (2)
	30	Average Daily Census	9.8	8.4	10.2	8.9			10.0		BHD (2)
	31	Percent of patients returning to CAIS within 7 days	6%	5.2%	4.4%	5.0%			5%		BHD (2)
	32	Percent of patients returning to CAIS within 30 days	16%	11.8%	11.6%	12.5%			11%		BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71%	78.1%	77.7%	72.1%			74%		BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	74%	82.1%	84.7%	81.8%			80%		BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	5.2	4.51	1.46	1.10			0.22		CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.42	0.20	0.29	0.44			0.34		CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2%	1.6%	1.1%	7.5%			3.0%		CMS (4)
	38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100%	88.9%	100.0%	100.0%			90.0%		BHD (2)
Financial	39	Total BHD Revenue (millions)	$120.2	$129.4	$149.9	$149.9			$149.9		
	40	Total BHD Expenditure (millions)	$173.5	$188.2	$207.3	$207.3			$207.3		

Notes:

(1) 2017 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)

(2) Performance measure target was set using historical BHD trends

(3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages

(4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages

(5) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.

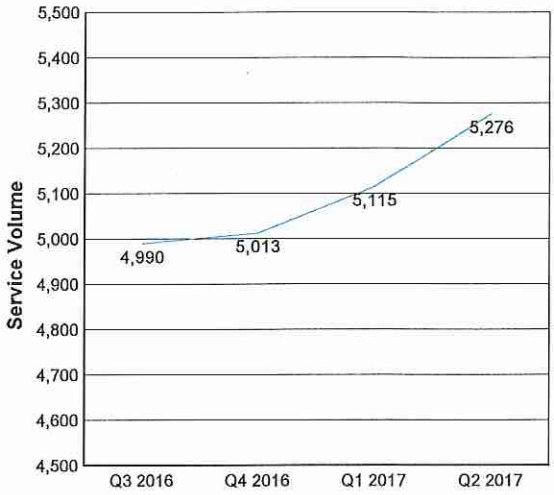
(6) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days

(7) Includes any medical or psychiatric ER utilization in last 30 days

CARS Quarterly Report

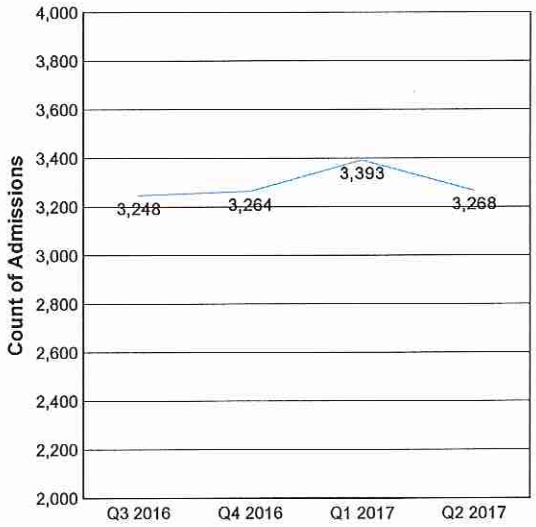
Number of Clients Receiving Service, By Program

	Q3 2016	Q4 2016	Q1 2017	Q2 2017
Adult Family Home	13	14	18	19
Case Mgmt & After Care Support	69	83	81	77
CBRF	138	141	134	127
CCS	486	567	620	664
CLASP	79	79	66	65
Community Support Program	1,301	1,286	1,276	1,284
Crisis Case Management	126	180	219	219
CRS	35	35	28	25
Day Treatment (75.12)	29	26	18	27
Detoxification (75.07)	726	639	642	667
Med. Monitor Residentl (75.11)	1	1	3	0
Medication Assisted Treatment	0	0	4	7
MH Day Treatment	16	17	16	17
Outpatient 75.13	352	313	283	316
Outpatient-MH	55	62	60	53
Recovery House Plus OP/DT	17	20	33	24
Recovery Support Coordination	477	499	552	601
RSS-Employment	110	112	101	82
RSS-Housing	111	105	125	132
RSS-Psych. Self Mgmt	46	38	53	43
RSS-School and Training	61	79	75	61
Targeted Case Management	1,472	1,513	1,542	1,640
Transitional Residential (75.14)	309	260	299	292
Total	4,990	5,013	5,115	5,276

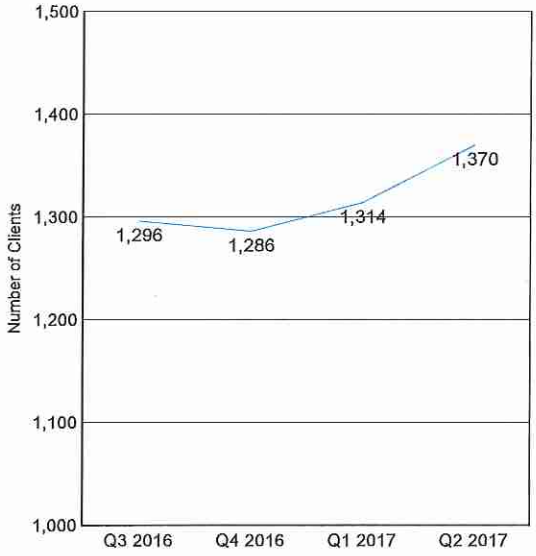


Admissions By Program

	Q3 2016	Q4 2016	Q1 2017	Q2 2017
Adult Family Home	0	1	3	0
Case Mgmt & After Care Support	27	35	28	32
CBRF	17	12	17	11
CCS	117	113	100	104
CLASP	25	22	13	20
Community Support Program	47	100	62	75
Crisis Case Management	68	99	112	78
CRS	2	0	0	1
Day Treatment (75.12)	30	29	17	32
Detoxification	1,680	1,612	1,685	1,642
MH Day Treatment	6	6	5	14
Outpatient (75.13)	217	181	173	191
Outpatient-MH	115	111	115	61
Recovery House Plus OP/DT	18	16	26	23
Recovery Support Coordination	296	272	359	329
RSS-Employment	66	98	85	72
RSS-Family	0	1	0	1
RSS-Housing	66	63	88	85
RSS-Psych Self Mgmt	38	15	21	18
RSS-School and Training	51	88	71	59
Targeted Case Management	127	187	184	211
Transitional Residential	235	203	229	209
Total	3,248	3,264	3,393	3,268



Referrals/Intakes By Access Point



	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Total
Access Clinic at BHD	117	108	116	98	438
Access Clinic South	21	18	0	0	39
CARS	414	437	407	465	1,590
IMPACT	290	301	310	339	1,196
JusticePoint	38	32	36	38	131
M & S	226	231	250	224	906
UCC	56	46	61	68	228
WCS	166	148	160	164	618
Total	1,296	1,286	1,314	1,370	4,781

Time to Treatment

Average Number of Days from Intake to Admission

Program	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Trend
CBRF	138	105	39	55	94	
CSP	89	83	101	86	73	
TCM	67	65	33	22	17	
CCS	1.0	1.9	1.6	1.2	0.5	
AODA Transitional Residential	23	17	18	16	22	
AODA Day Treatment	17	16	10	8	7	
AODA Outpatient	10	10	11	13	10	
Recovery Support Services	11	14	10	11	7	

Mental Health Board-Quality Sub-Committee

September 11, 2017

Assertive Community Treatment (ACT) and

Tool for Measurement of Assertive Community Treatment (TMACT)

ACT

ACT was first implemented in Madison, Wisconsin in the 1970s out of Winnebago Mental Health Institute. The fundamental charge of ACT is to be the first-line, if not sole-provider for all services that ACT consumers need. In its beginning, the focus of ACT and its outcomes was placed on reducing readmissions to psychiatric hospitals. ACT has since evolved, taking into consideration what ACT consumers want and need by providing the most effective services to achieve the consumer's goal. Emphasis has been placed on helping consumers obtain competitive employment and improve their self-sufficiency. ACT is most appropriate for person with a severe mental illness (i.e. Schizophrenia, Bipolar Disorder) who have continuing high service needs and significant functional impairments. ACT has three main tenets:

- Delivery of highly responsive, individualized, biopsychosocial and rehabilitative services in consumers' natural environments
- Multi-disciplinary group of providers with specific areas of expertise that share responsibility for meeting consumers' needs
- Recovery-oriented services is the focus of care, promoting self-determination and respects consumers as experts in their own right.

TMACT

The TMACT was developed to measure the adequacy of an ACT Team in their implementation of ACT as an evidenced based practice. The use of the TMACT is to determine program fidelity by comparing the current ACT Team structure, staffing, and practices to the ACT model. This comparison provides quality improvement for the ACT Team by guiding the implementation of ACT. The TMACT identifies the strengths and weaknesses of the ACT Team, targeting ongoing performance improvement efforts. The TMACT has six subscales and 47 program-specific items. Each item is rated on a 5-point scale ranging from 1 ("not implemented") to 5 ("fully implemented"). The six subscales of the TMACT:

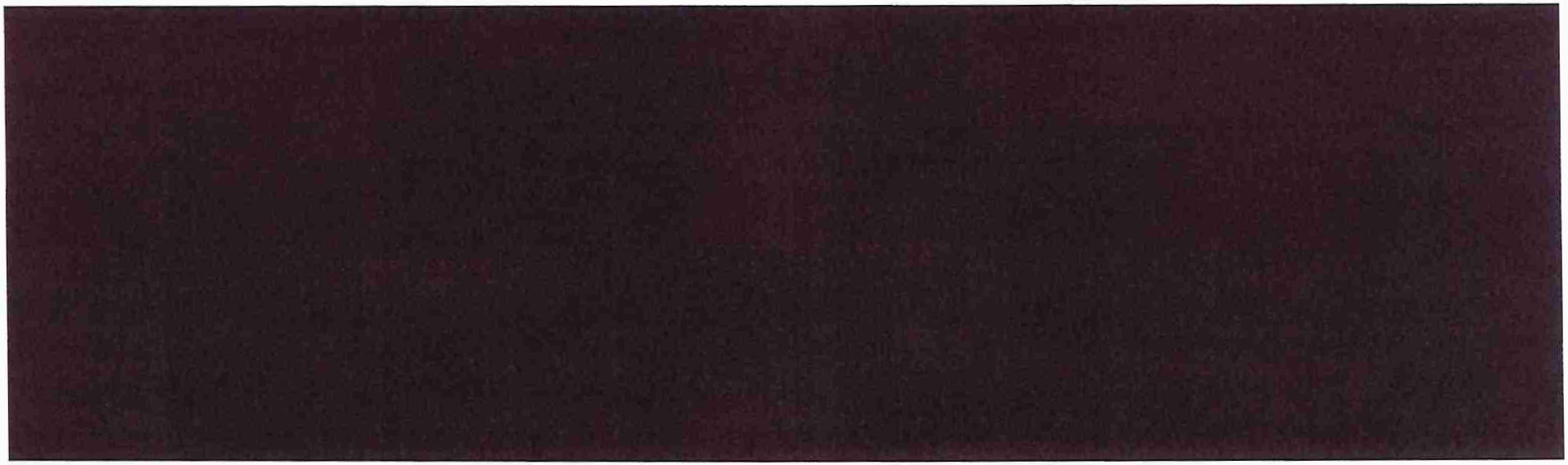
- Operations and Structure
- Core Team
- Specialist Team
- Core Practices
- Evidenced-Based Practices
- Person-Centered Planning and Practices

In 2016, CARS and ACT Team Leaders received training on how to administer the TMACT from two of the TMACT authors. A combination of CARS staff and ACT Team Leaders will complete a TMACT review every month so that each ACT Team will receive a review every 18 months.

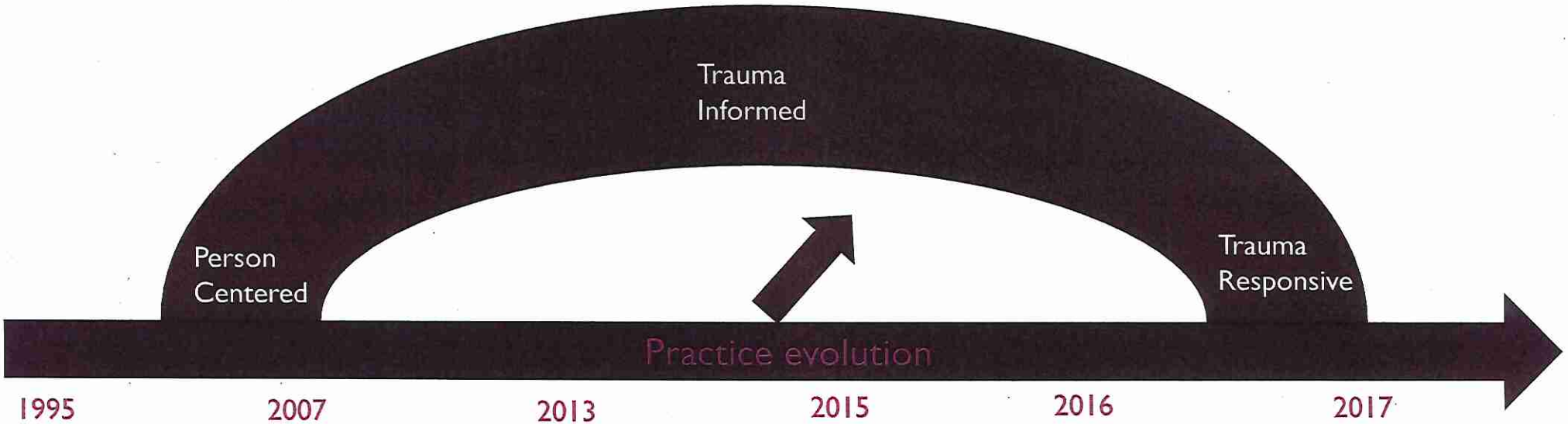
Monroe-DeVita, M., Moser, L.L. & Teague, G.B. (2013) *The tool for measurement of assertive community treatment (TMACT).* In M. P. McGovern, G. J. McHugo, R.E. Drake, G.R. Bond, &M.R. Merrens. (eds.), Implementing evidence-based practices in behavioral health. Center City, MN: Hazelden.

MOVING THE NEEDLE: THE INFUSION OF TIC IN WRAPAROUND PROCESS AND PRACTICE

QA MENTAL HEALTH BOARD MEETING 9/11/17



MOVING THE NEEDLE



1995
Mission to get kids home
Philosophy and Values established

2007
REACH expansion
Prevention and early intervention

2013
Required TIC training for CCs and Crisis Crosswalk

2015
Champion building process with leadership

2016
Stages to 4 Hs
Infusion of TIC in CC
Certification
ACE training

2017
Trauma responsive and family driven focus

VALUES IN ACTION TO ACHIEVE BENCHMARKS OF WELLBEING

Collaboration

System Integration

Refinancing

Community Based

Cultural Humility

Normalization

Family Centered

Strengths Based

Needs Driven

Unconditional Care

QUALITY IMPROVEMENT: FROM PAPER TO PRACTICE

- ACE screening and data collection
- Focus on effective intervention
- Network expansion
- Experience oriented framework
- Family driven
- Coaching and training
- Audit enhancement

CONTRACT PERFORMANCE MEASURES: PRIORITIZATION AND PROGRESS (CARS SPECIFIC)

MENTAL HEALTH BOARD QUALITY COMMITTEE

SEPTEMBER 11, 2017

[redacted]

METHODOLOGY

- Provides a summed score which is an aggregate of total clients served ***and*** dollars billed for care
- Data is weighted across programs
  - For example:

Program	People Served	Simple Ranking	Weighted Ranking
Program A	200	1	12.5 (1:1)
Program B	400	2	25 (2:1)
Program C	1000	3	62.5 (5:1)

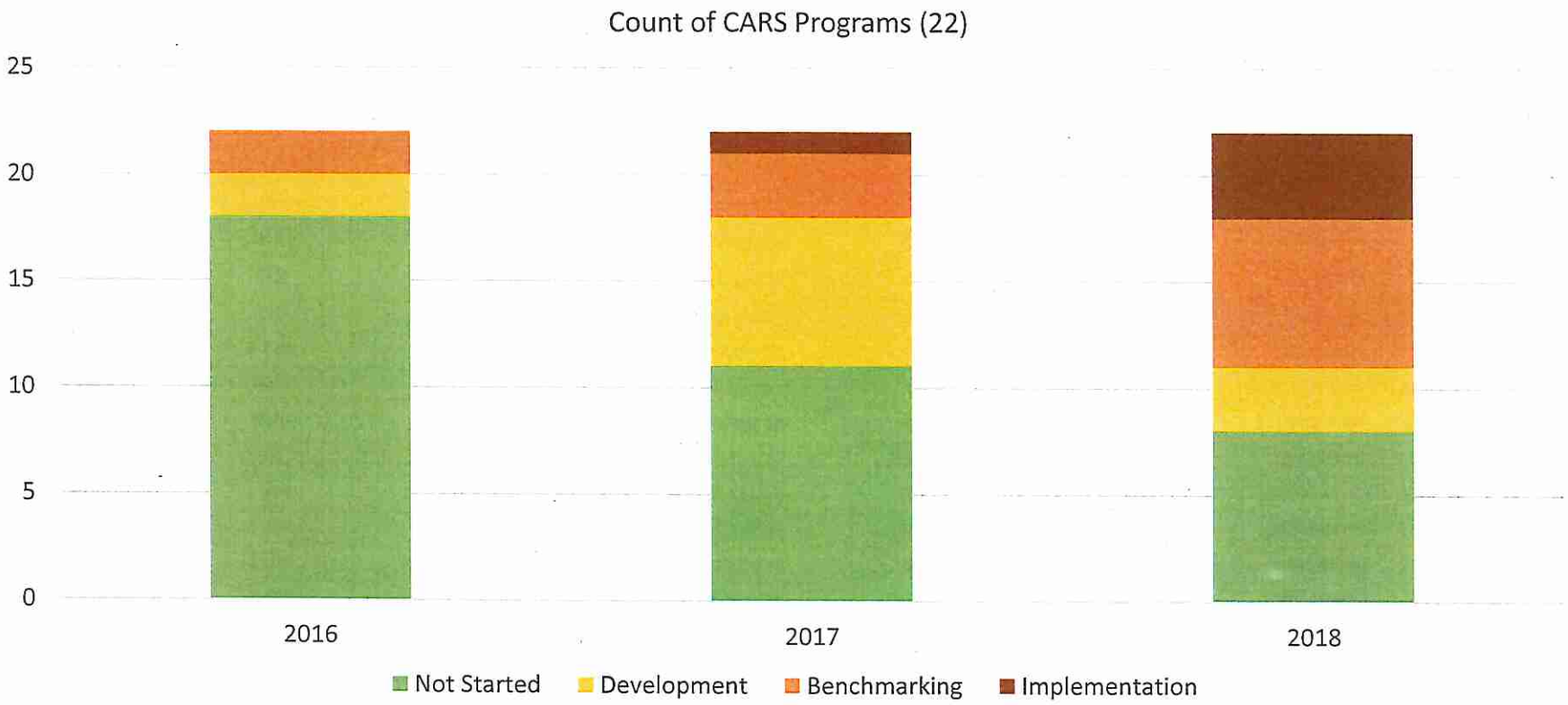
- The advantage of this approach is that it not only combines metrics, but allows for programs with relatively greater values within a given metric to achieve scores that are proportional to its impact/importance

Methodology

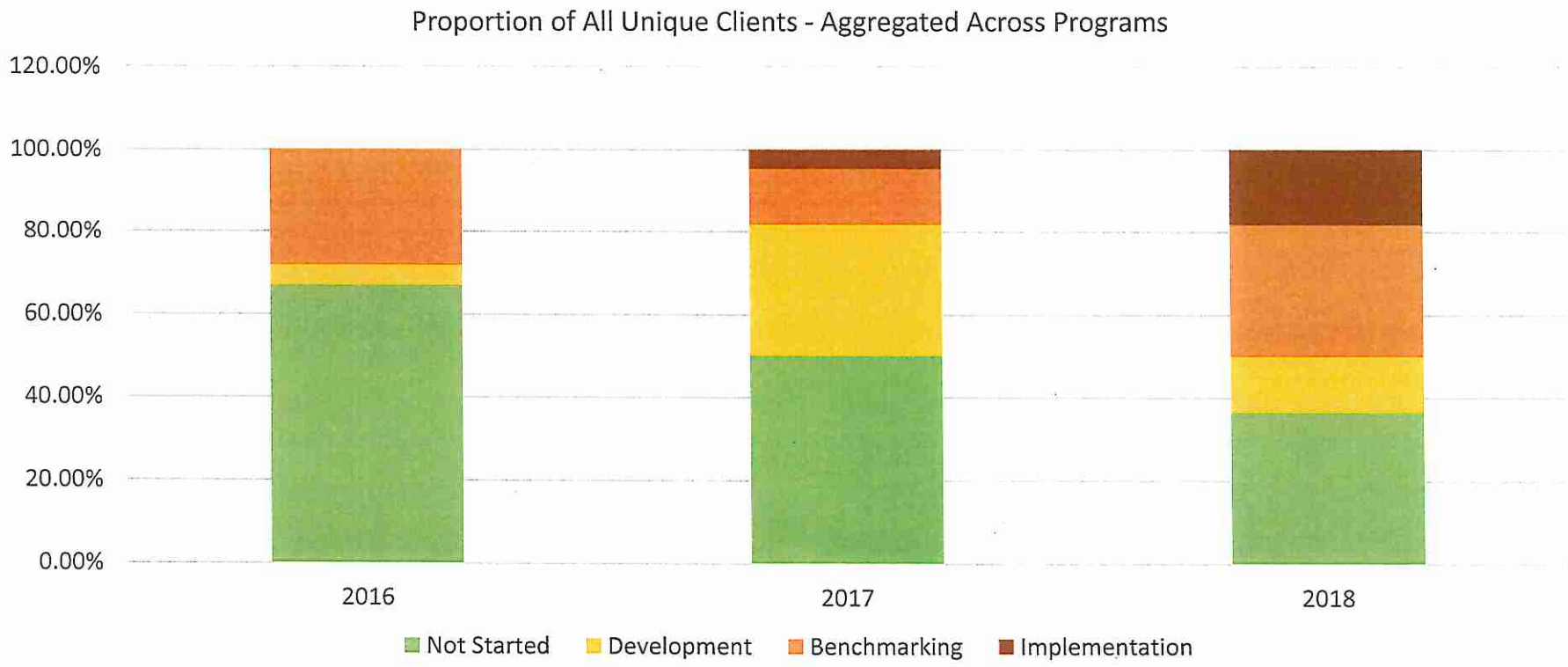
Contract Performance Measures Prioritization Process and Progress
(Based on 2016 Figures)

Program	Unique Clients	Volume Served Ranking	Cost of Care	Cost Ranking	Total Score	Overall Rank	2016	2017	2018
Community Support Program	1,423	10.24	$ 14,891,434.00	31.42	41.65	1	Not Started	Not Started	Development
Access Points	3,106	22.35	$ 1,517,624.00	3.20	25.55	2	Not Started	Not Started	Development
Detoxification	2,060	14.82	$ 2,572,145.00	5.43	20.25	3	Benchmarking	Implementation	Implementation
Targeted Case Management	1,850	13.31	$ 3,112,247.76	6.57	19.88	4	Benchmarking	Benchmarking	Implementation
CBRF	157	1.13	$ 8,258,661.95	17.42	18.55	5	Not Started	Development	Benchmarking
CCS	619	4.45	$ 6,335,231.18	13.37	17.82	6	Not Started	Not Started	Not Started
Transitional Residential	684	4.92	$ 3,598,776.64	7.59	12.51	7	Development	Benchmarking	Implementation
Recovery Support Coordination	1,116	8.03	$ 1,493,137.33	3.15	11.18	8	Not Started	Not Started	Development
Outpatient (75.13)	835	6.01	$ 455,455.80	0.96	6.97	9	Not Started	Development	Benchmarking
Crisis Case Management	275	1.98	$ 811,074.36	1.71	3.69	10	Not Started	Not Started	Not Started
RSS-Employment	374	2.69	$ 329,490.00	0.70	3.39	11	Not Started	Not Started	Not Started
CRS	36	0.26	$ 1,468,976.78	3.10	3.36	12	Not Started	Not Started	Not Started
Adult Family Home	15	0.11	$ 1,356,398.48	2.86	2.97	13	Not Started	Development	Benchmarking
RSS-School and Training	274	1.97	$ 254,222.50	0.54	2.51	14	Not Started	Not Started	Not Started
RSS-Housing	271	1.95	$ 252,580.50	0.53	2.48	15	Not Started	Development	Benchmarking
OP Psychiatry	227	1.63	$ 298,866.00	0.63	2.26	16	Not Started	Development	Benchmarking
Case Mgmt & After Care Support	190	1.37	$ 218,751.25	0.46	1.83	17	Not Started	Not Started	Not Started
Outpatient-MH	148	1.06	$ 29,799.60	0.06	1.13	18	Not Started	Development	Benchmarking
RSS-Psych Self Mgmt	118	0.85	$ 42,608.50	0.09	0.94	19	Not Started	Not Started	Not Started
Recovery House Plus OP/DT	69	0.50	$ 68,445.00	0.14	0.64	20	Not Started	Development	Benchmarking
Day Treatment (75.12)	51	0.37	$ 29,655.25	0.06	0.43	21	Not Started	Not Started	Not Started
Med Monitor Residential (75.11)	1	0.01	$ 4,392.90	0.01	0.02	22	Development	Benchmarking	Implementation
Total	13,899		$ 47,399,974.78						

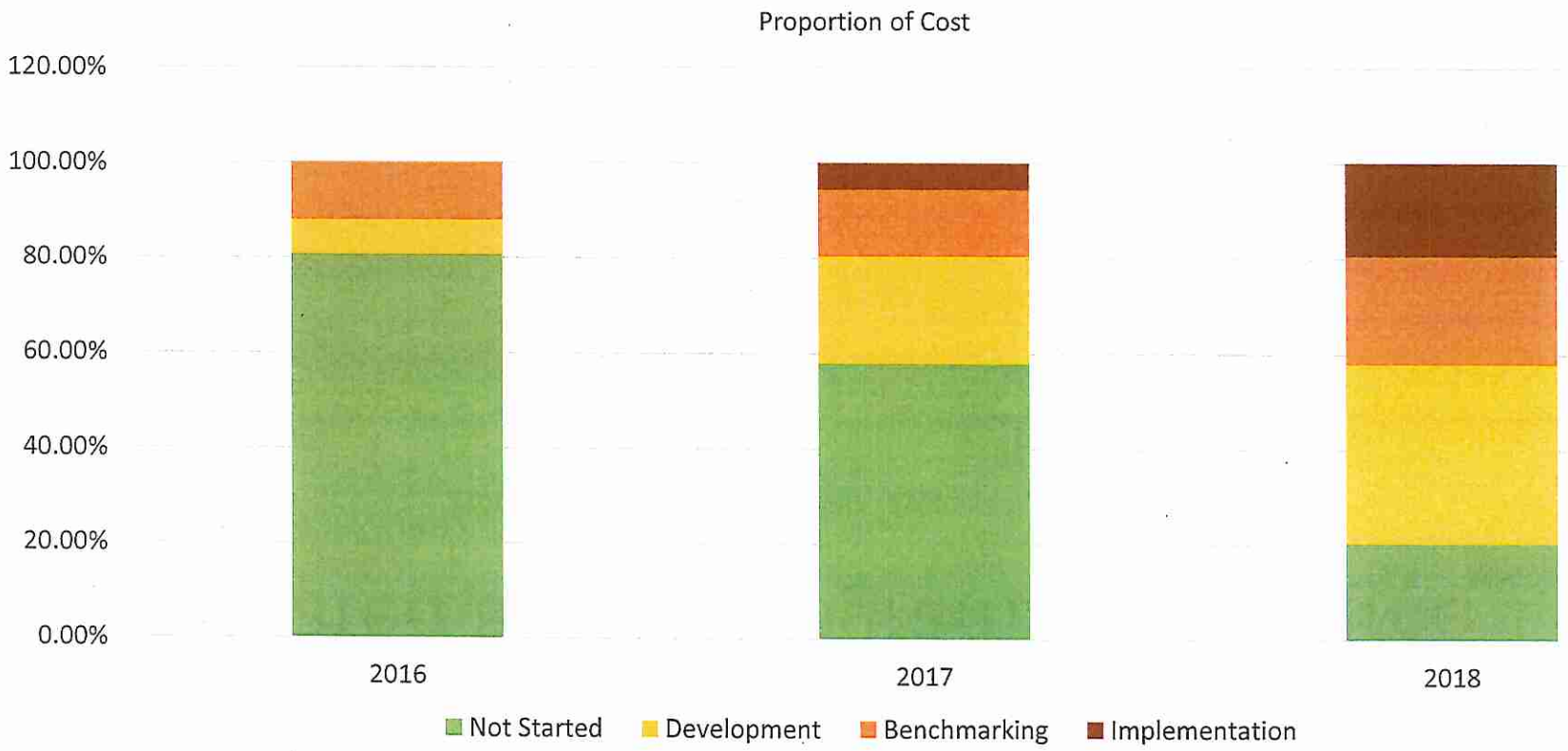
Count of CARS Programs Over Time



Proportion of Clients (unique within program, aggregated across programs) Over Time



Proportion of Total Cost Over Time



Conclusions

- We can use the same prioritization methodology to implement and track progress with other related initiatives
  - Dashboard development
  - Contracts themselves
- We will continue to provide progress reports for CPM development on a regular basis
  - This will be accomplished by tracking tasks per stage

Draft

PCS Hospital Transfer Waitlist Report

Mid-Year Report Update

2017

This report contains information describing the first six (6) months of 2017 are summarized as follows:

- 3 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 83.6%
- The 847 individuals delayed comprised 21.5% of the total PCS admissions (3,942)
- The median wait time for all individuals delayed was 4.6 hours
- The average length of waitlist per patient is 7.8 hours

Prepared by:
Quality Improvement Department

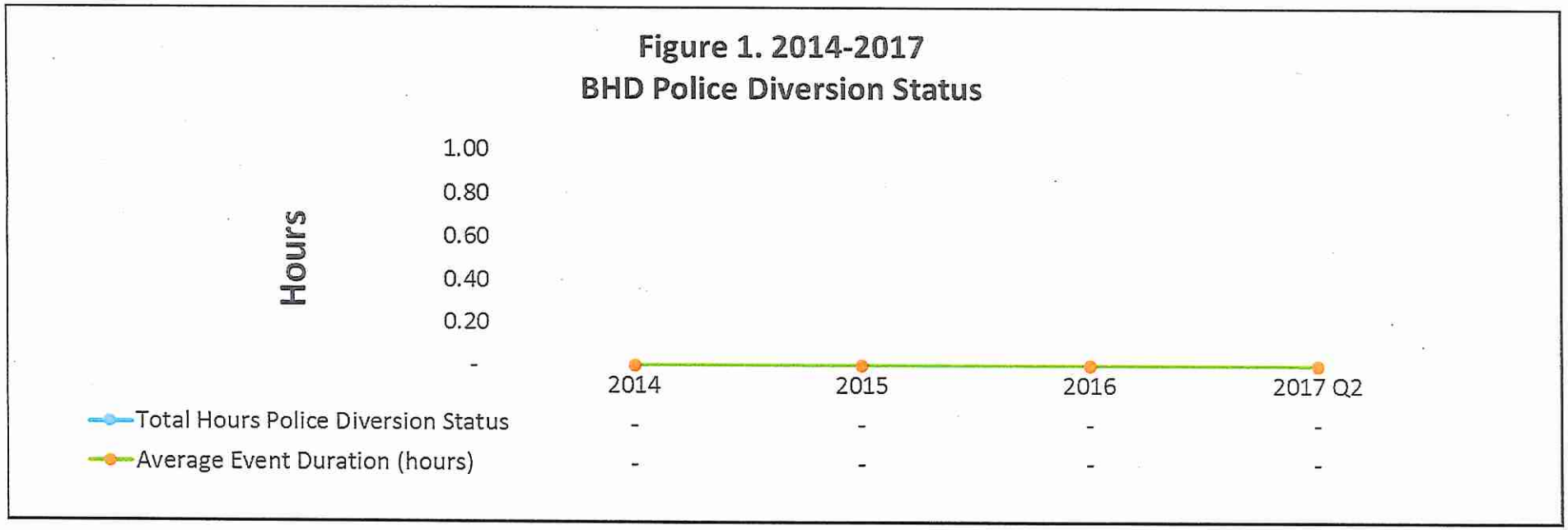
Date: July 27, 2017

Definitions:

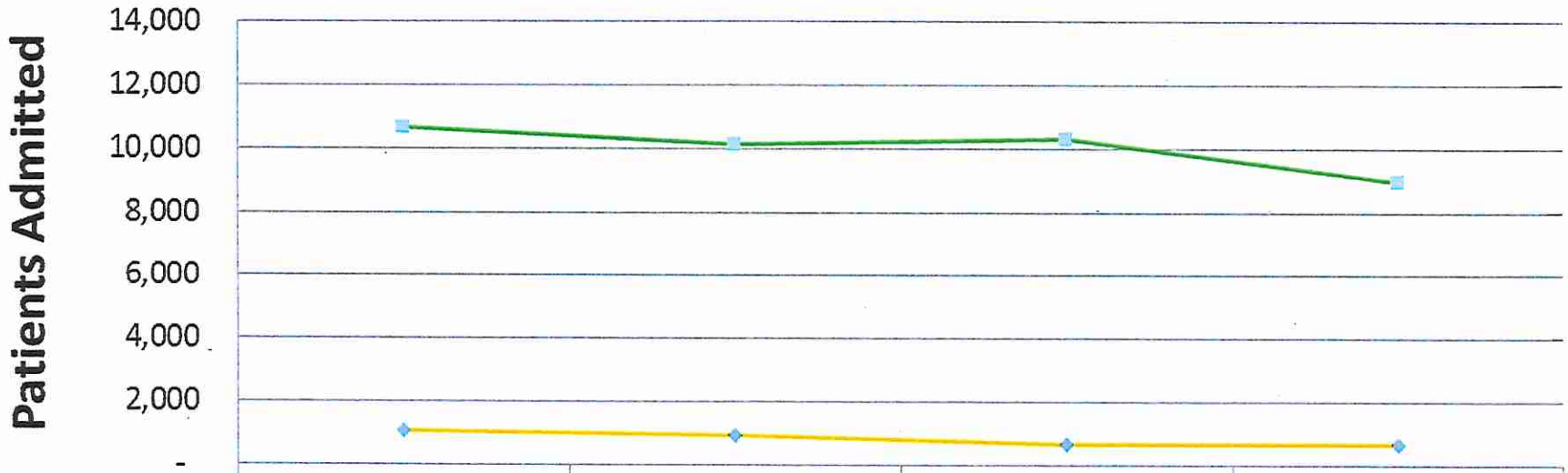
Waitlist: When there is a lack of available beds between the Acute Inpatient Units and the Observation Unit. Census cut off is 5 or less open beds. These actions are independent of acuity or volume issues in PCS.

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.

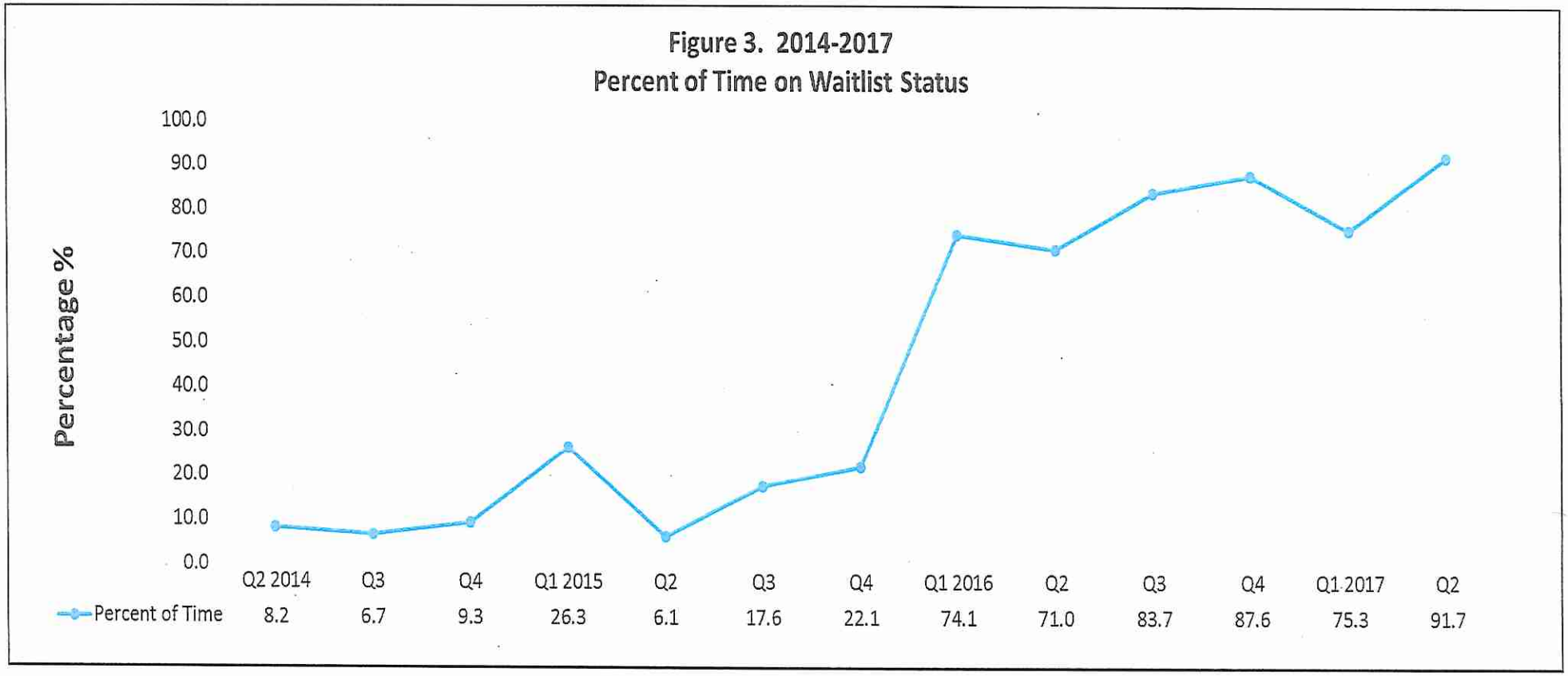


*There have been no police diversion in the last 8 year, last police diversion was in 2008



	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



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

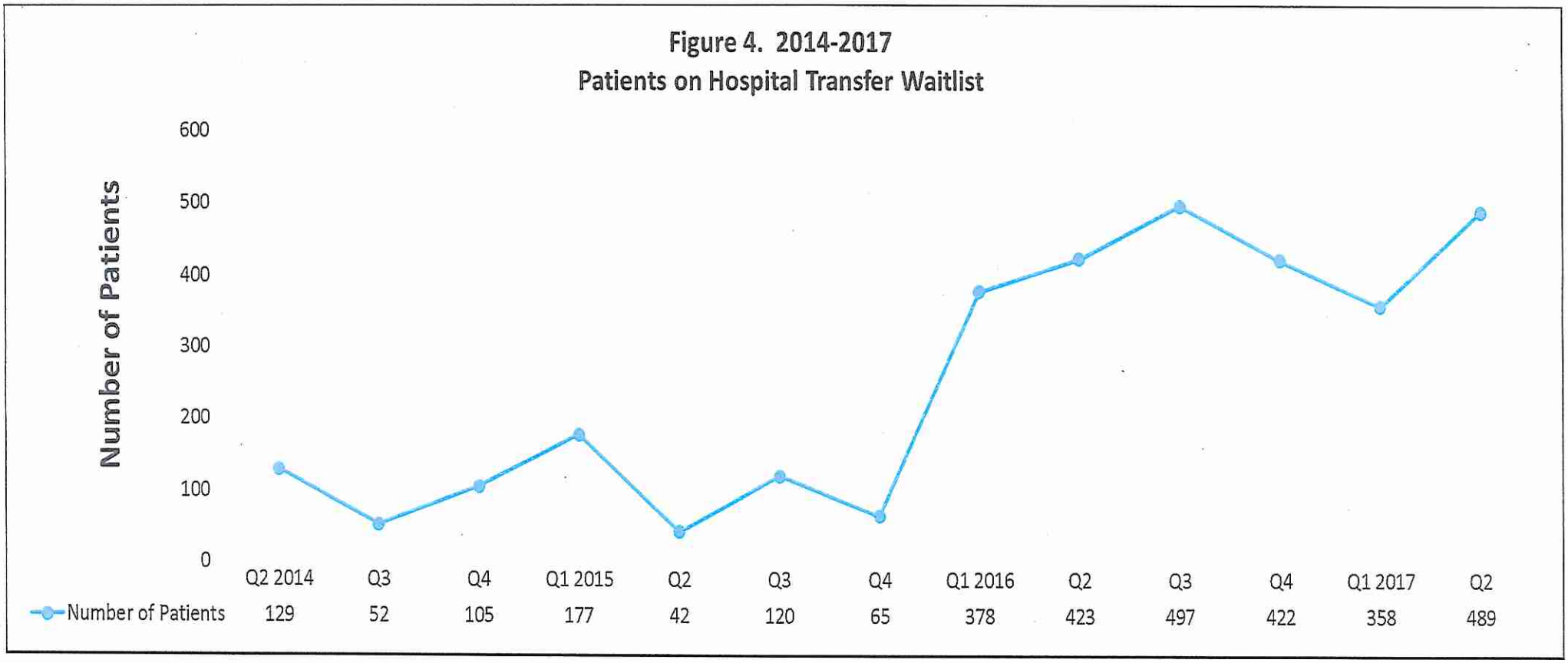


Figure 4. 2014-2017
Patients on Hospital Transfer Waitlist
Number of Patients
600
500
400
300
200
100
0
Q2 2014
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Q1 2017
Q2
Number of Patients
129
52
105
177
42
120
65
378
423
497
422
358
489

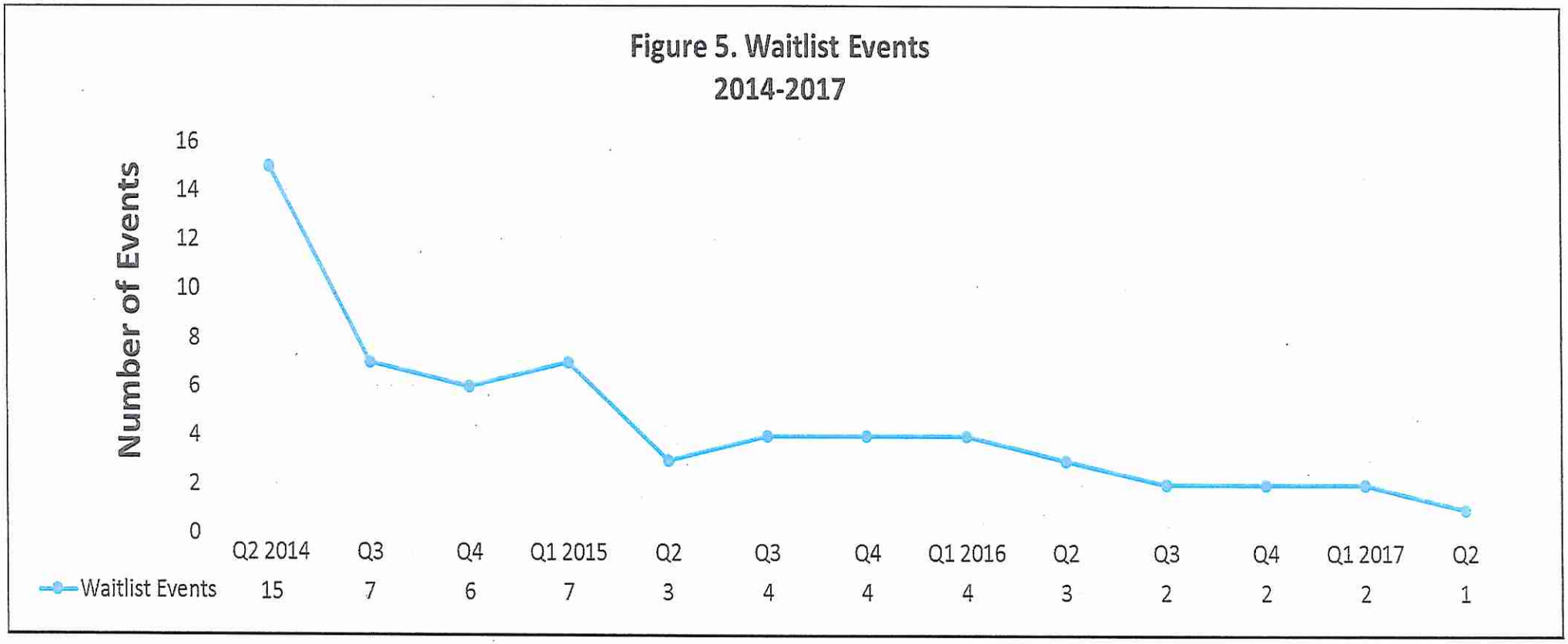


Figure 5. Waitlist Events
2014-2017
Number of Events
16
14
12
10
8
6
4
2
0
Q2 2014
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Q1 2017
Q2
Waitlist Events
15
7
6
7
3
4
4
4
3
2
2
2
1

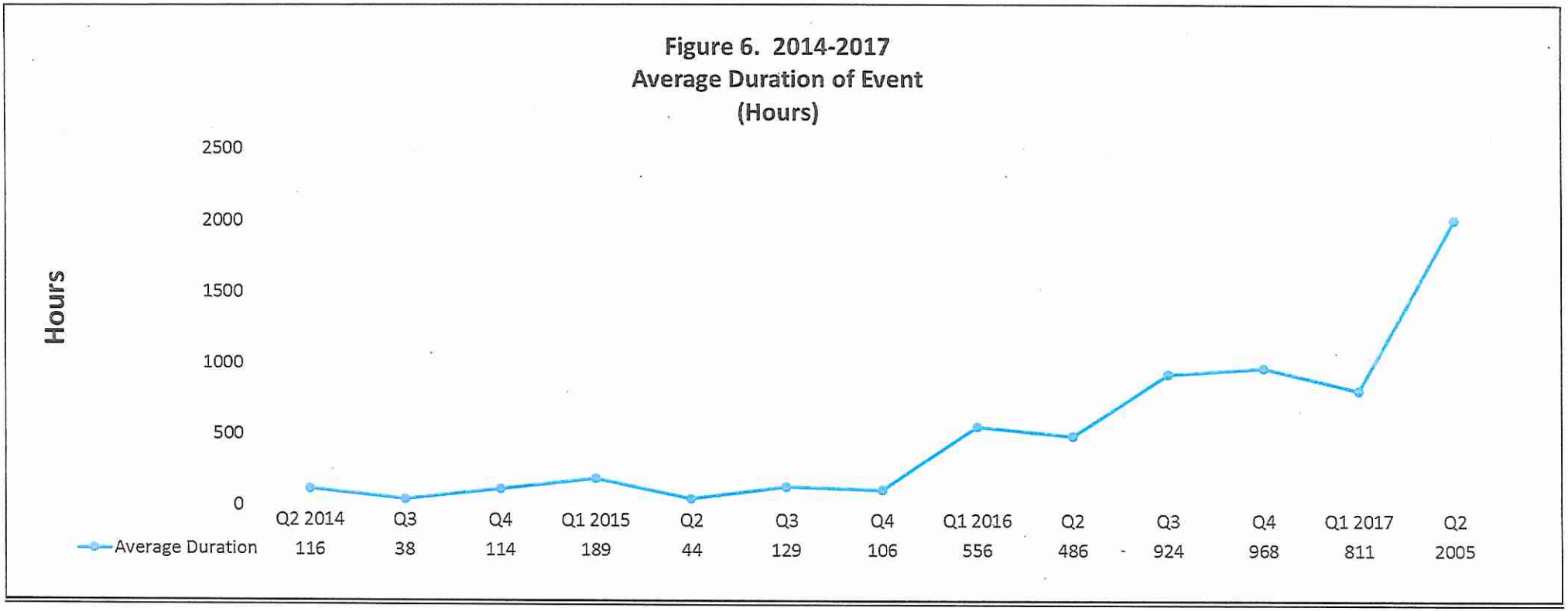


Figure 6. 2014-2017
Average Duration of Event
(Hours)
Hours
2500
2000
1500
1000
500
0
Q2 2014
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Q1 2017
Q2
Average Duration
116
38
114
189
44
129
106
556
486
924
968
811
2005

Figure 7. 2014 - 2017
Median Wait Time For Individuals Delayed
(Hours)
Hours
25
20
15
10
5
0
Q2 2014
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Q1 2017
Q2
Median Wait Time
16.5
16.5
21.1
7.3
4.9
5.7
3.3
3.4
5.3
5.2
5
4.8
4.3

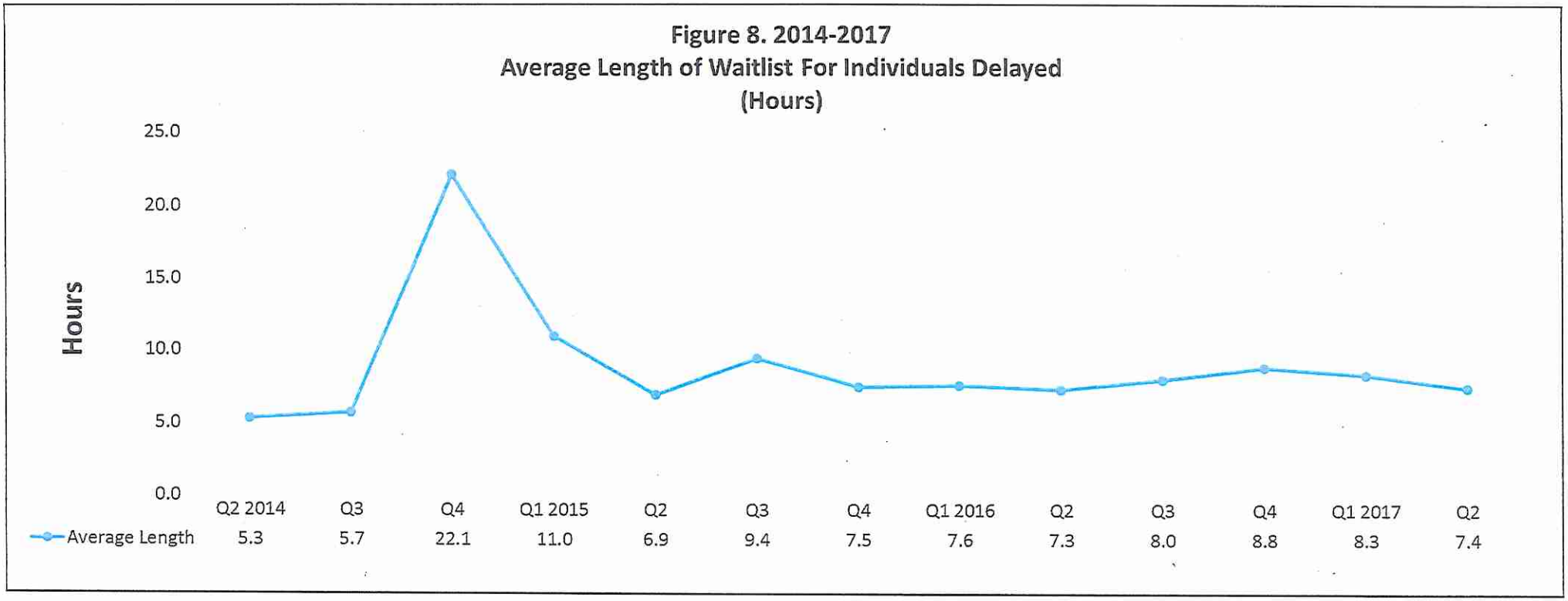
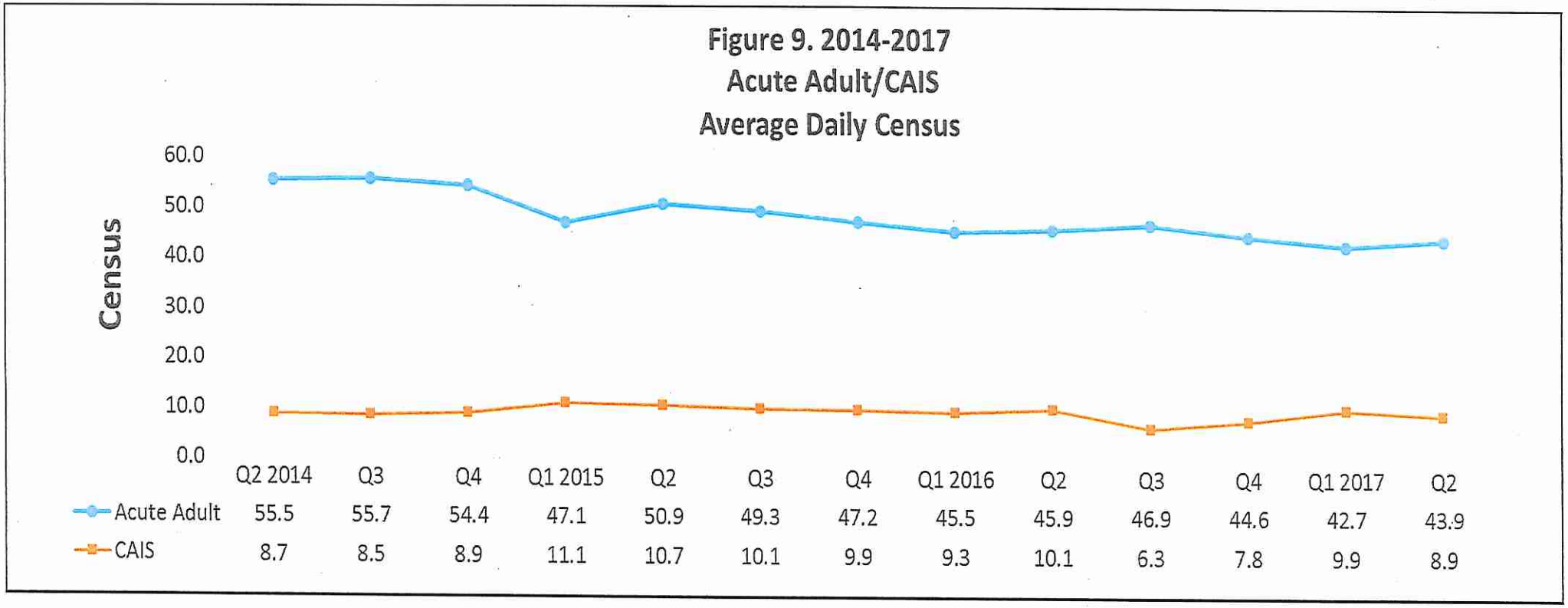
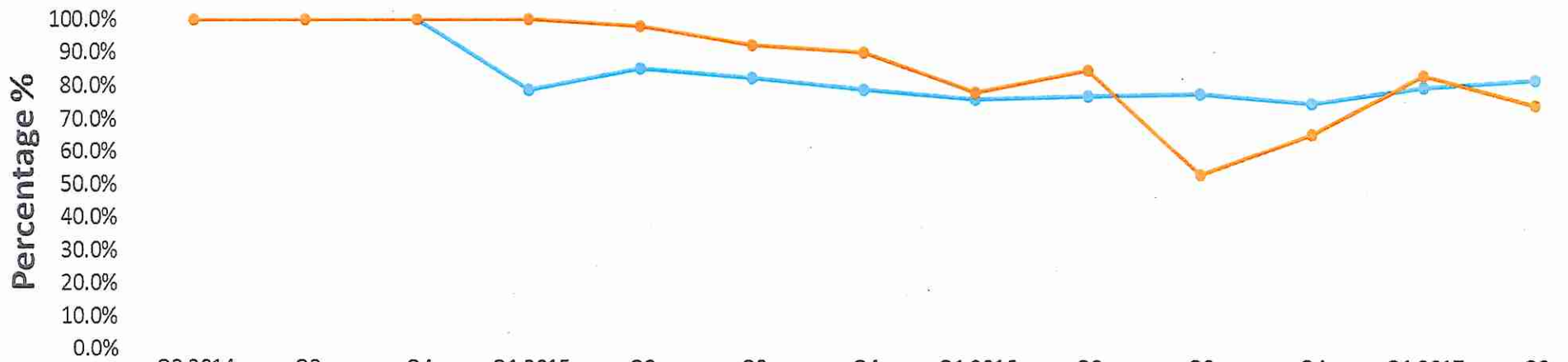


Figure 8. 2014-2017
Average Length of Waitlist For Individuals Delayed
(Hours)
Hours
25.0
20.0
15.0
10.0
5.0
0.0
Q2 2014
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Q1 2017
Q2
Average Length
5.3
5.7
22.1
11.0
6.9
9.4
7.5
7.6
7.3
8.0
8.8
8.3
7.4



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



	Q2 2014	Q3	Q4	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4	Q1 2017	Q2
Acute Adult	100.0%	100.0%	100.0%	78.5%	84.8%	82.1%	78.7%	75.8%	76.7%	77.4%	74.4%	79.1%	81.3%
CAIS	100.0%	100.0%	100.0%	100.0%	97.6%	91.8%	89.8%	77.7%	84.3%	52.5%	65.0%	82.8%	74.0%

*Occupancy Rate = Patient's Day/ (Number of day in the quarter*number of beds budgeted)
*Reduced staffing impacted operation bed count

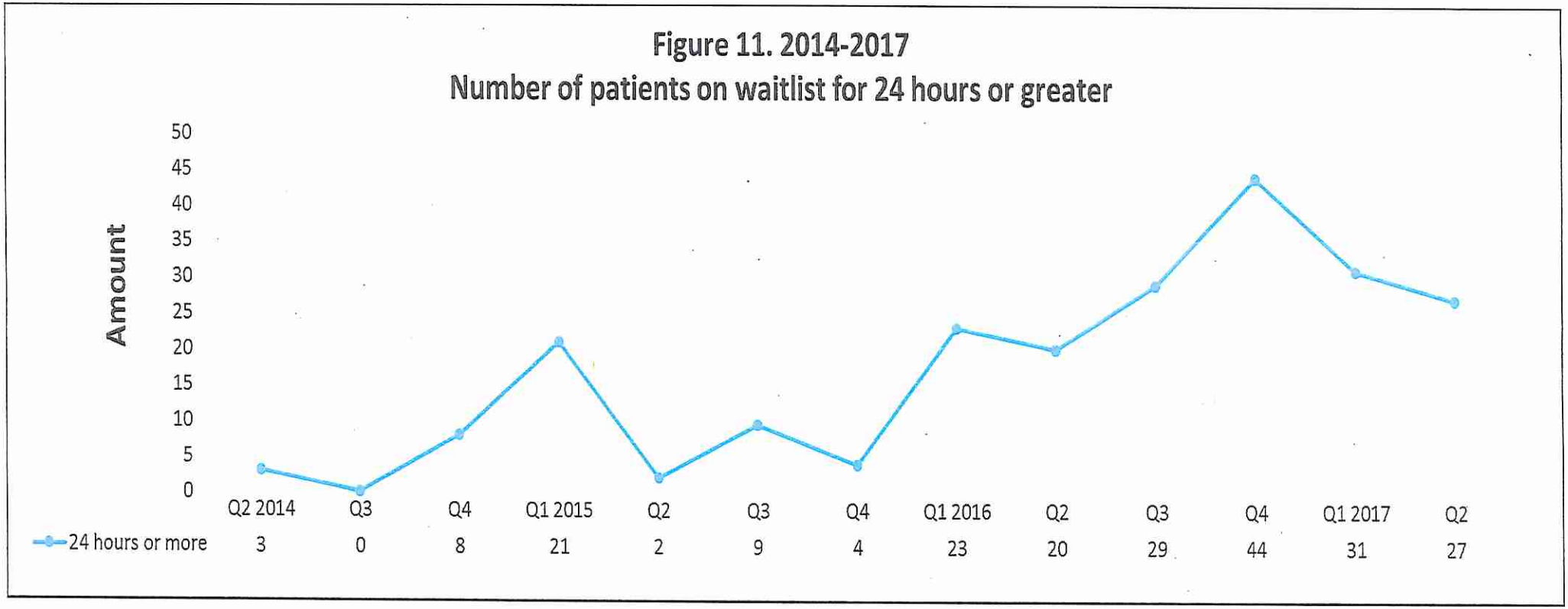
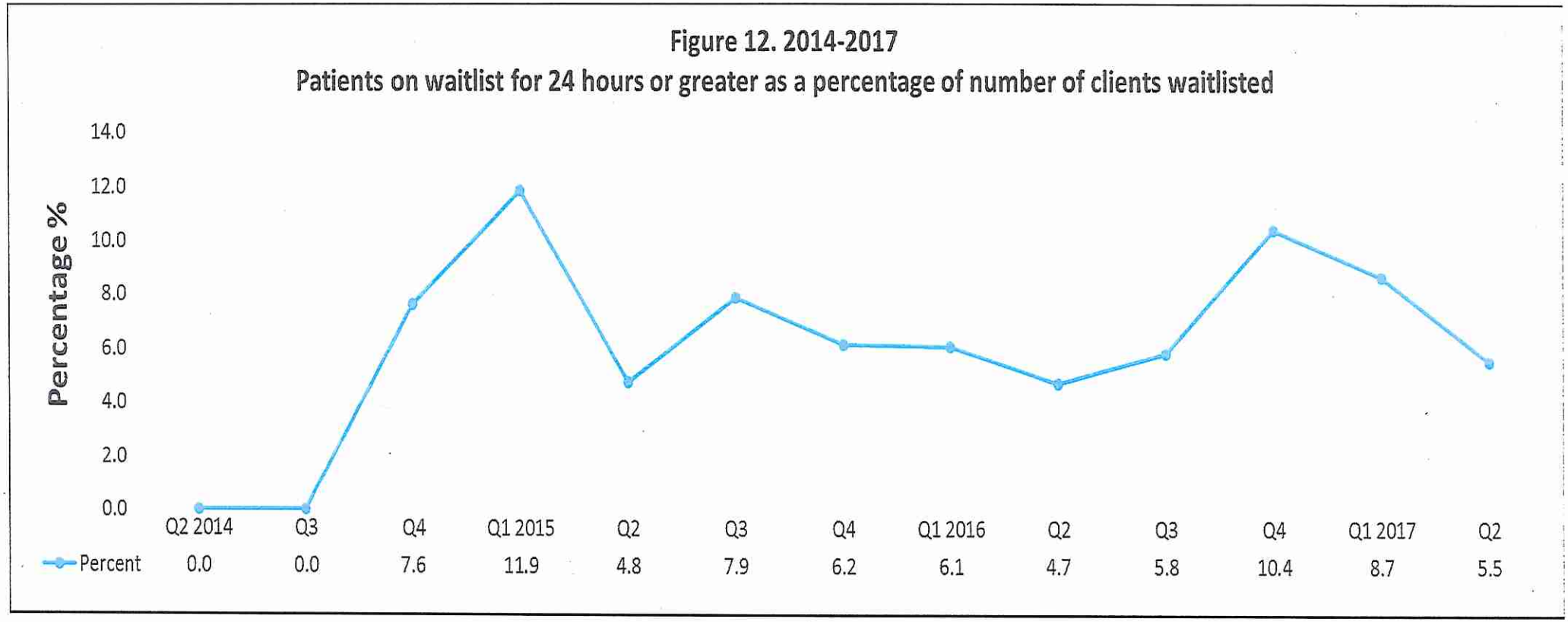
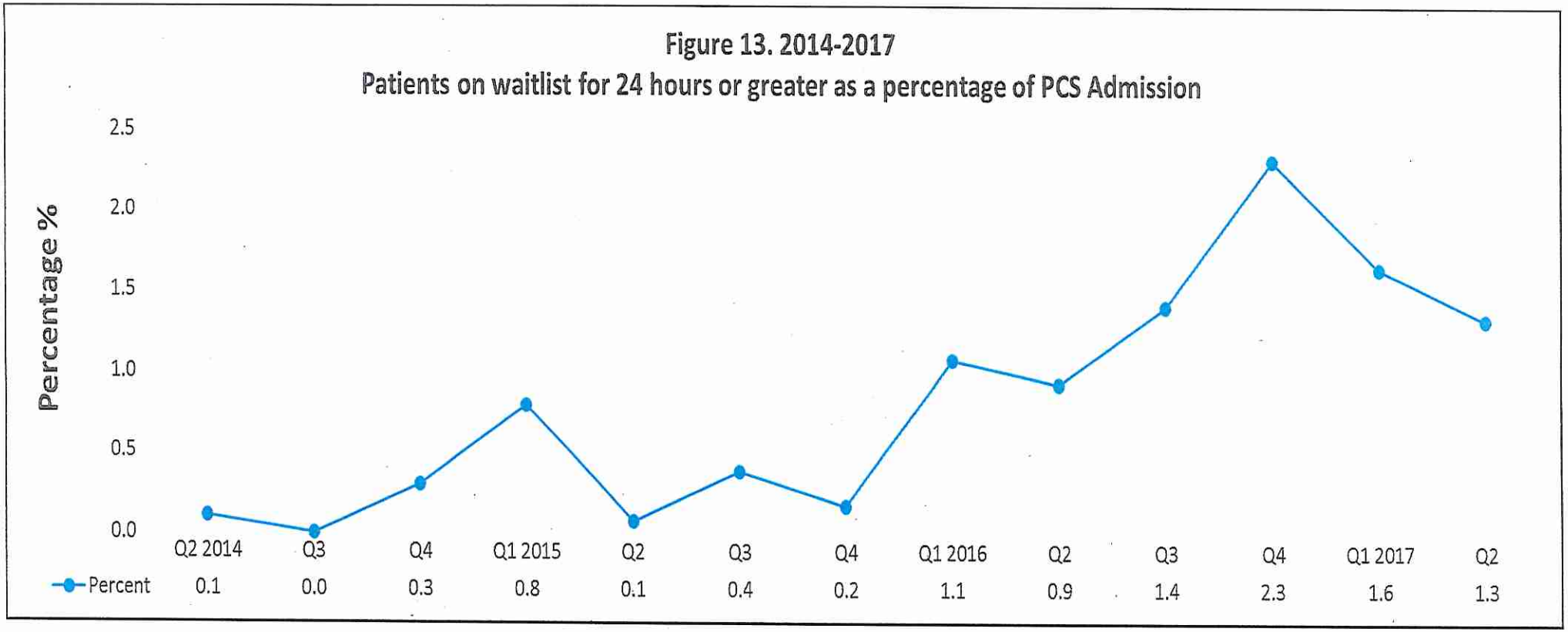


Figure 11. 2014-2017
Number of patients on waitlist for 24 hours or greater
Amount
50
45
40
35
30
25
20
15
10
5
0
Q2 2014
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Q1 2017
Q2
24 hours or more
3
0
8
21
2
9
4
23
20
29
44
31
27



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



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

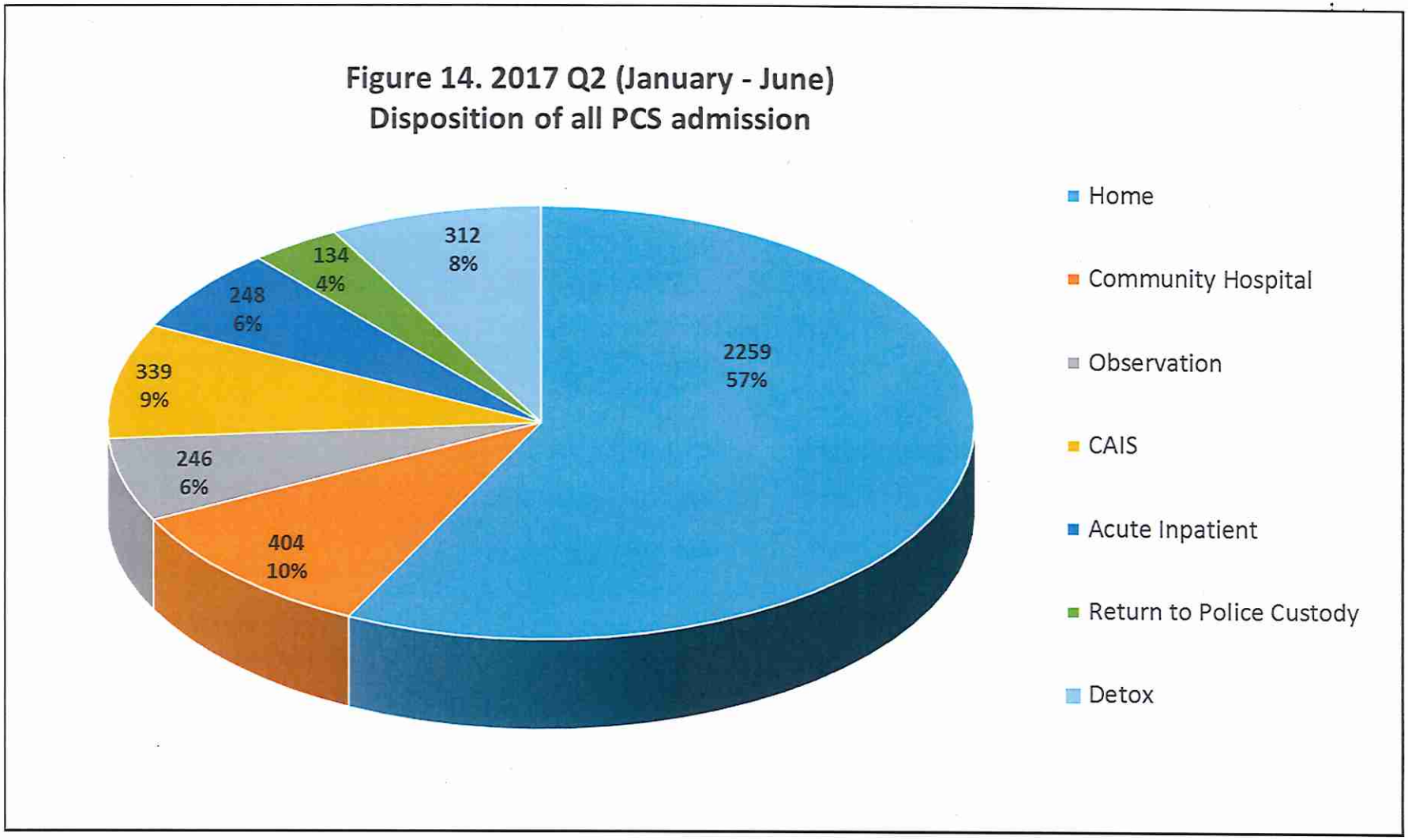


Figure 14. 2017 Q2 (January - June)
Disposition of all PCS admission
2259
57%
404
10%
246
6%
339
9%
248
6%
134
4%
312
8%
Home
Community Hospital
Observation
CAIS
Acute Inpatient
Return to Police Custody
Detox

Acute Inpatient Seclusion and Restraint

Mid-Year Update

2017

This report contains information describing the first six (6) months of 2017 as summarized:

- Acute Adult: Restraint hourly rate decreased by 84.8% from 2016 through mid-year 2017 while restraint incident rate decreased by 57.3% during the same time period. Seclusion incident rate decreased by 26.7% from 2016 through mid-year 2017 while Seclusion hourly rate decreased by 40.0% during the same time period.
- CAIS: Restraint hourly rate decreased by 70.5% from 2016 through mid-year 2017.

Prepared by: Quality Improvement Department

Date: August 1, 2017

Summary

43A

- 43A rate of restraint hours decreased by 90.9% from 2016 through mid-year 2017.
- 43A had 38 reported restraint hours, 20 reported restraint hours were for 5 individuals (53% of all hours)
- 43A restraint incident rate decreased by 72.1% from 2016 through mid-year 2017.
- 43A had 39 reported restraint incidents, 16 reported restraint incidents were for 5 individuals (41% of all incidents)
- 43A seclusion hour's rate decreased by 66.7% from 2016 to mid-year 2017, while the seclusion incident rate decreased by 63.4%.

43B

- 43B rate of restraint hours decreased by 75.0% from 2016 through mid-year 2017.
- 43B had 45 reported restraint hours, 15.4 reported restraint hours were for 1 individuals (34% of all hours)
- 43B restraint incident rate decreased by 50.2% from 2016 through mid-year 2017.
- 43B seclusion hour's rate decreased by 50.0% from 2016 to mid-year 2017, while the seclusion incident rate decreased by 6.1%.

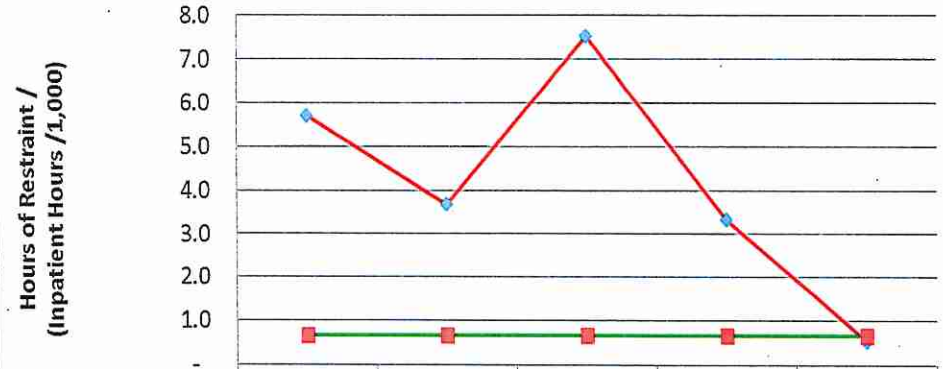
43C

- 43C rate of restraint hours decreased by 40.0% from 2016 through mid-year 2017.
- 43C had 18 reported restraint hours, 10.5 reported restraint hours were for 2 individuals (58% of all hours)
- 43C restraint incident rate decreased by 19.5% from 2016 through mid-year 2017.
- 43C seclusion hour's rate did not changed from 2016 to mid-year 2017, while the seclusion incident rate increased by 55.6%.

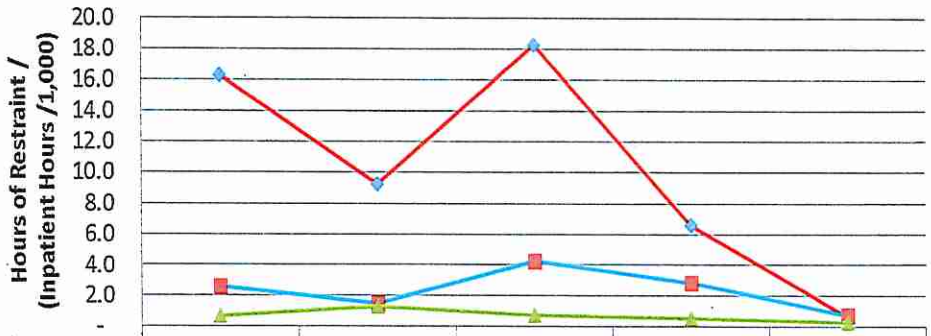
CAIS

- Five (5) individuals had 30 reported restraint hours, 57% of all restraints
- CAIS restraint incident rate decreased by 61.0% from 2016 through mid-year 2017.
- CAIS had 23 reported restraint incidents, 7 reported restraint incidents were for 2 individuals (30% of all incidents)

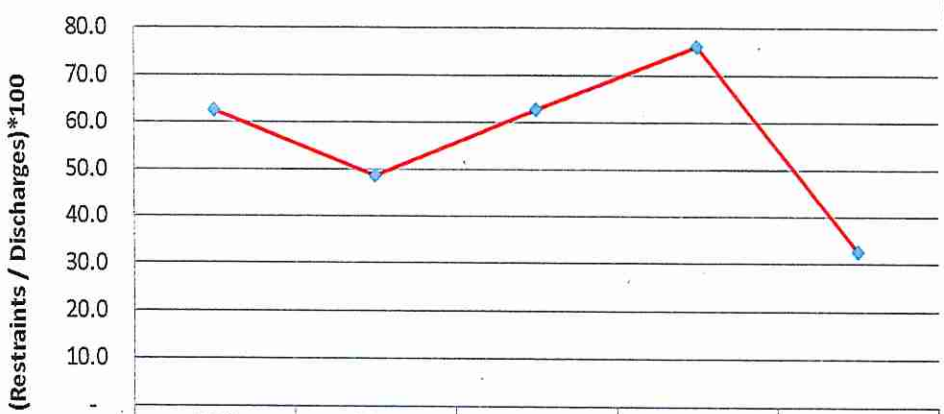
Acute Adult



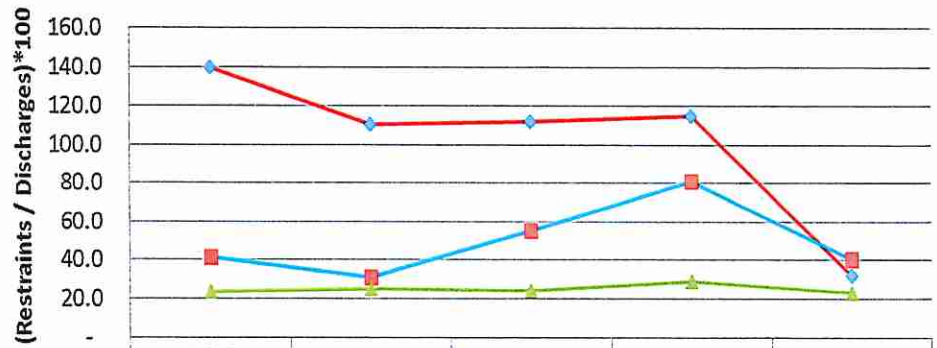
	2013	2014	2015	2016	2017 Q2
Acute	5.7	3.7	7.5	3.3	0.5
National Average	0.66	0.66	0.66	0.66	0.66



	2013	2014	2015	2016	2017 Q2
43A	16.3	9.2	18.3	6.6	0.6
43B	2.6	1.5	4.3	2.8	0.7
43C	0.6	1.3	0.7	0.5	0.3

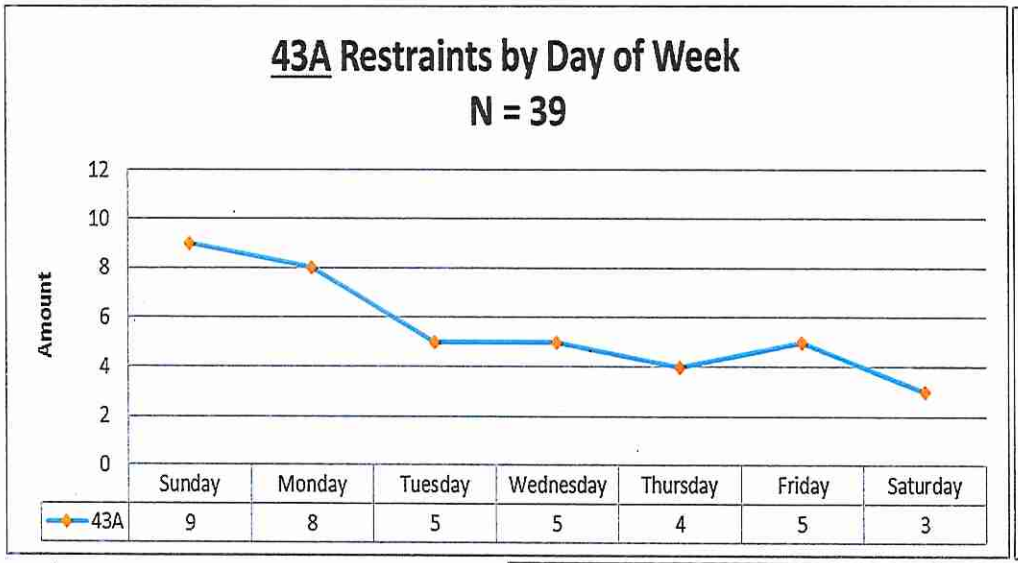


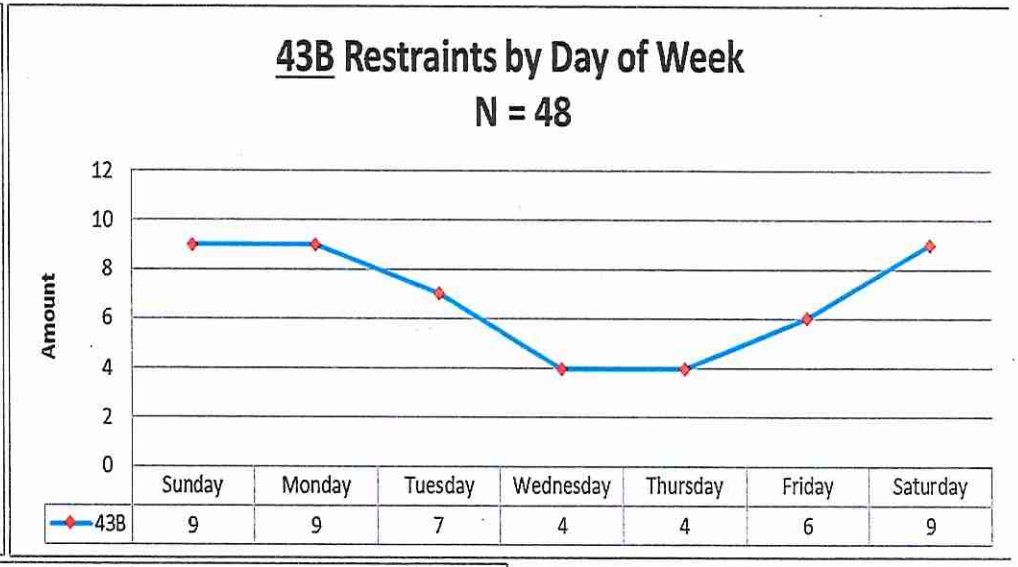
	2013	2014	2015	2016	2017 Q2
Acute	62.6	48.6	62.7	76.1	32.5

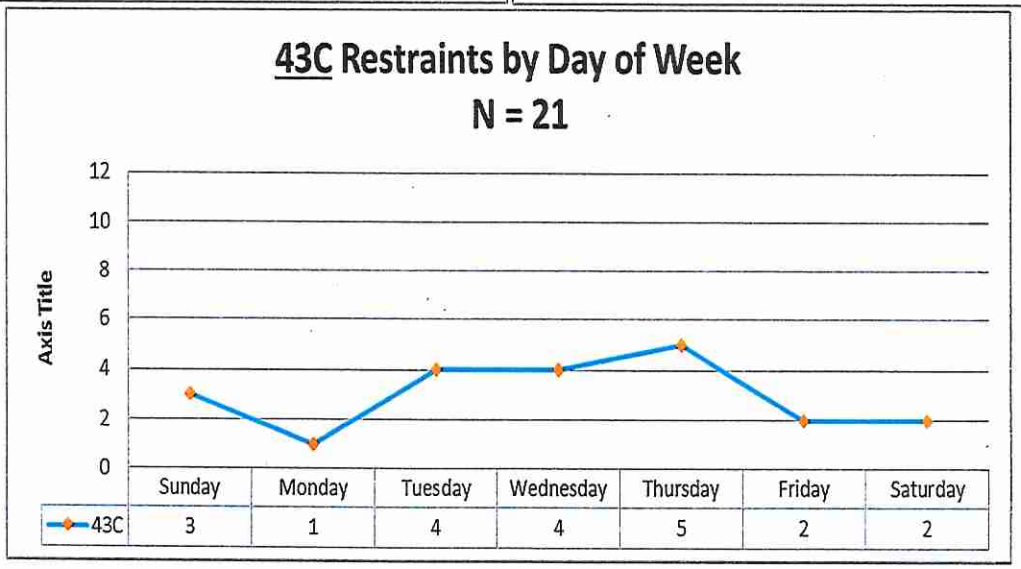


	2013	2014	2015	2016	2017 Q2
43A	139.5	110.6	112.1	114.7	32.0
43B	41.3	31.1	55.0	80.9	40.3
43C	23.6	25.1	24.0	28.7	23.1

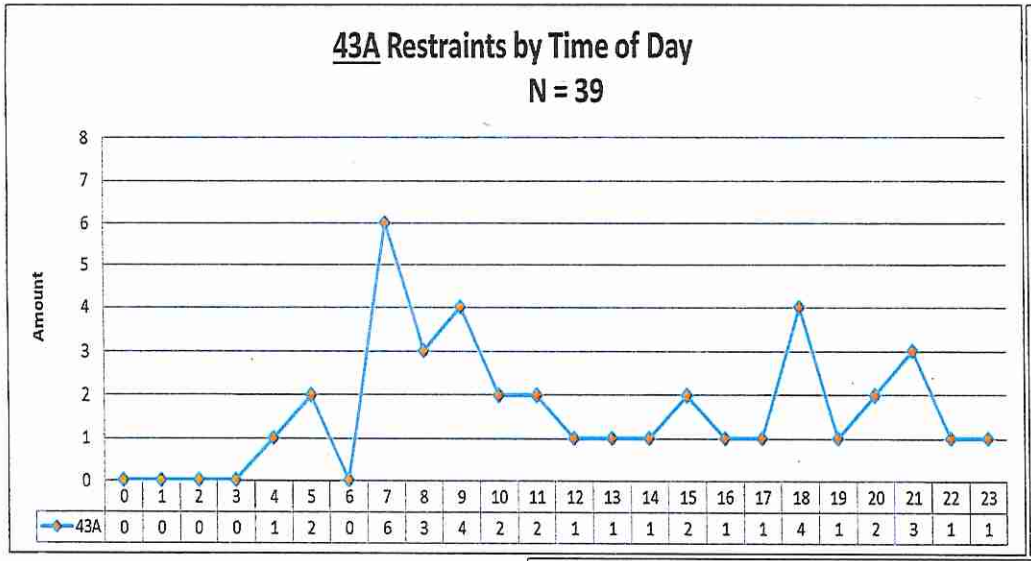
Acute Adult

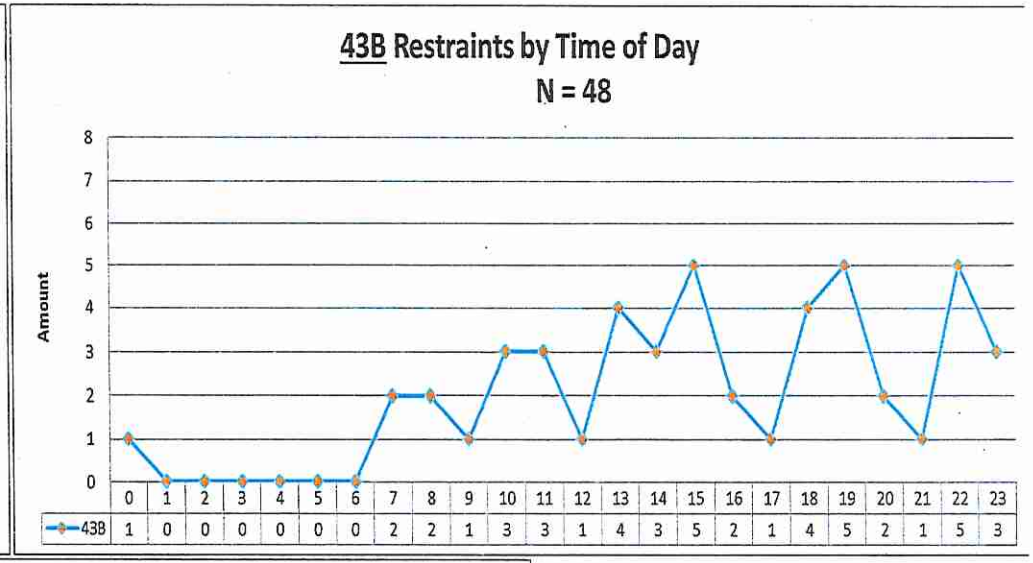

43A Restraints by Day of Week
N = 39
Amount
12
10
8
6
4
2
0
Sunday Monday Tuesday Wednesday Thursday Friday Saturday
43A 9 8 5 5 4 5 3

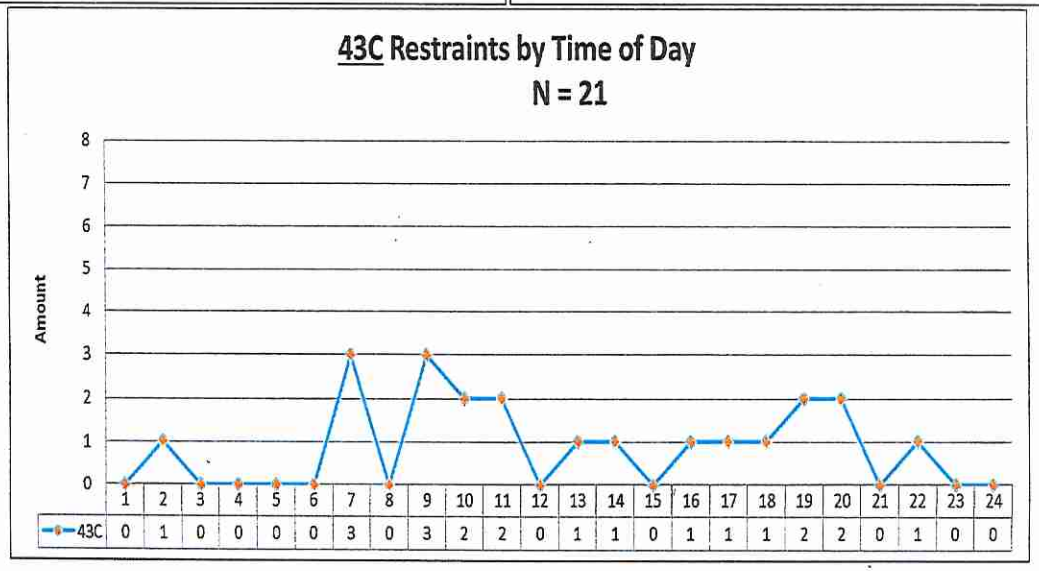

43B Restraints by Day of Week
N = 48
Amount
12
10
8
6
4
2
0
Sunday Monday Tuesday Wednesday Thursday Friday Saturday
43B 9 9 7 4 4 6 9


43C Restraints by Day of Week
N = 21
Axis Title
12
10
8
6
4
2
0
Sunday Monday Tuesday Wednesday Thursday Friday Saturday
43C 3 1 4 4 5 2 2

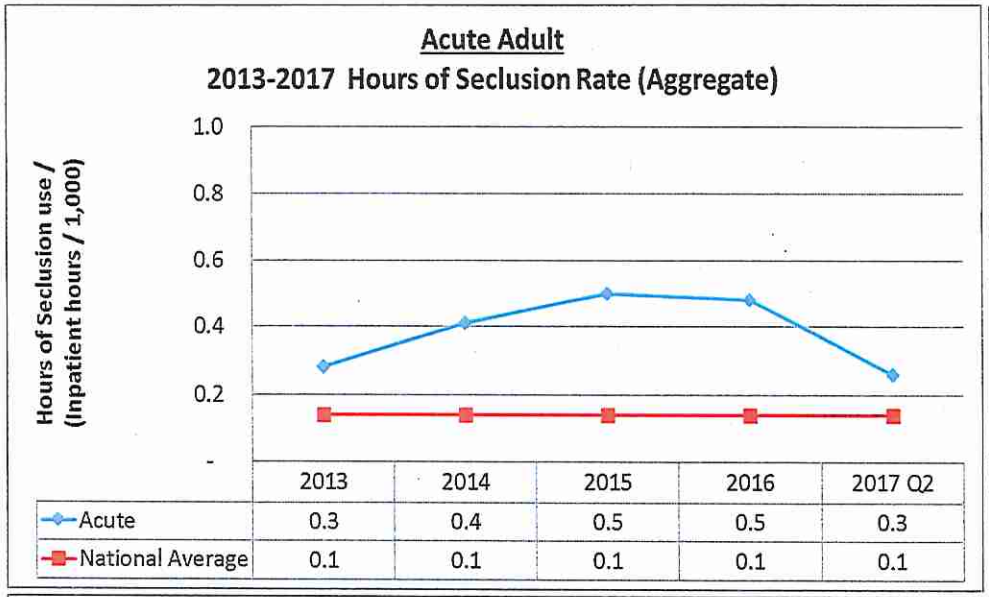
Acute Adult


43A Restraints by Time of Day
N = 39
Amount
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23
43A 0 0 0 0 1 2 0 6 3 4 2 2 1 1 1 2 1 1 4 1 2 3 1 1

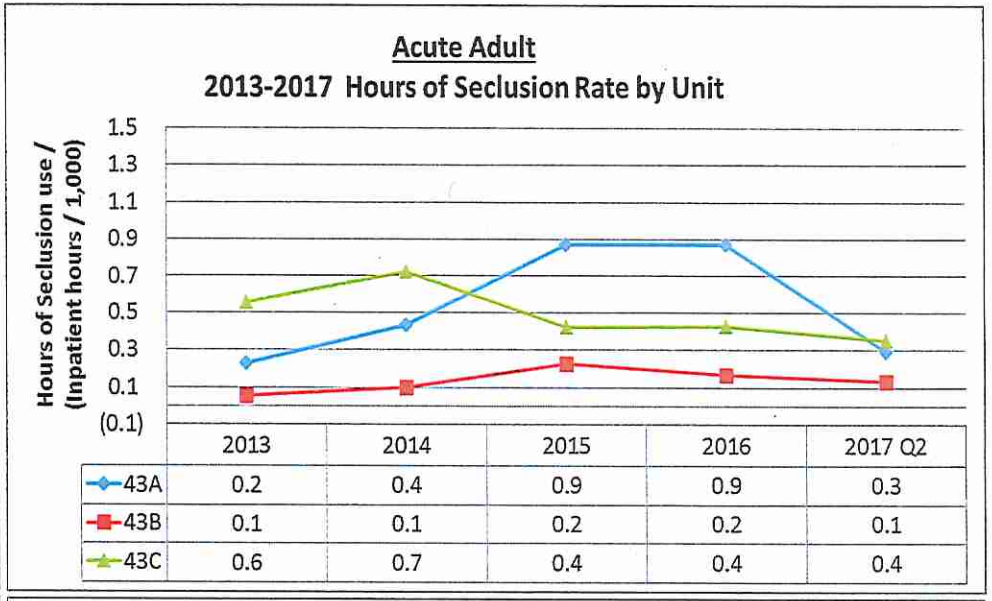

43B Restraints by Time of Day
N = 48
Amount
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23
43B 1 0 0 0 0 0 0 2 2 1 3 3 1 4 3 5 2 1 4 5 2 1 5 3


43C Restraints by Time of Day
N = 21
Amount
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
43C 0 1 0 0 0 0 3 0 3 2 2 0 1 1 0 1 1 1 2 2 0 1 0 0

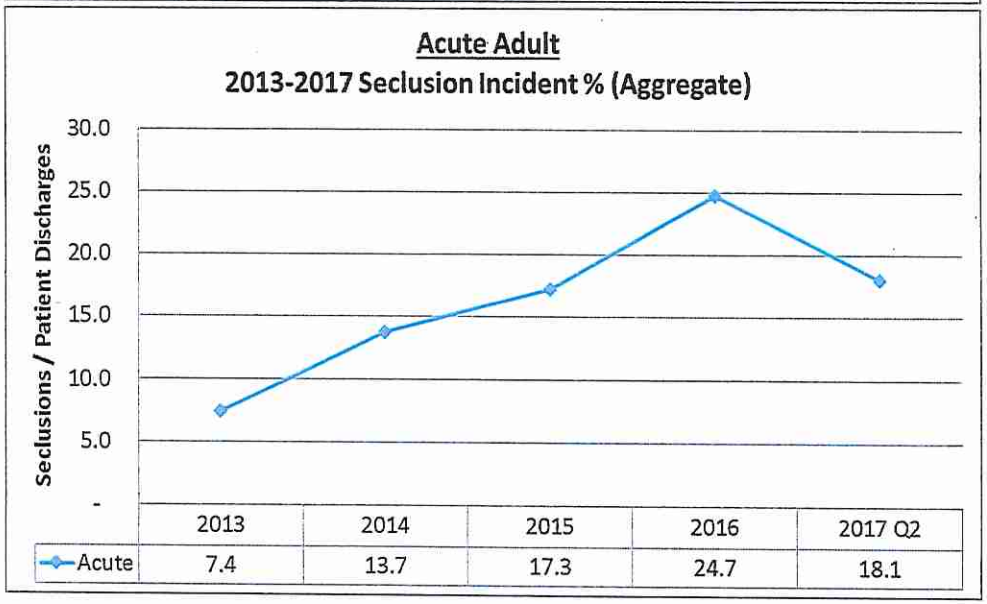
Acute Adult



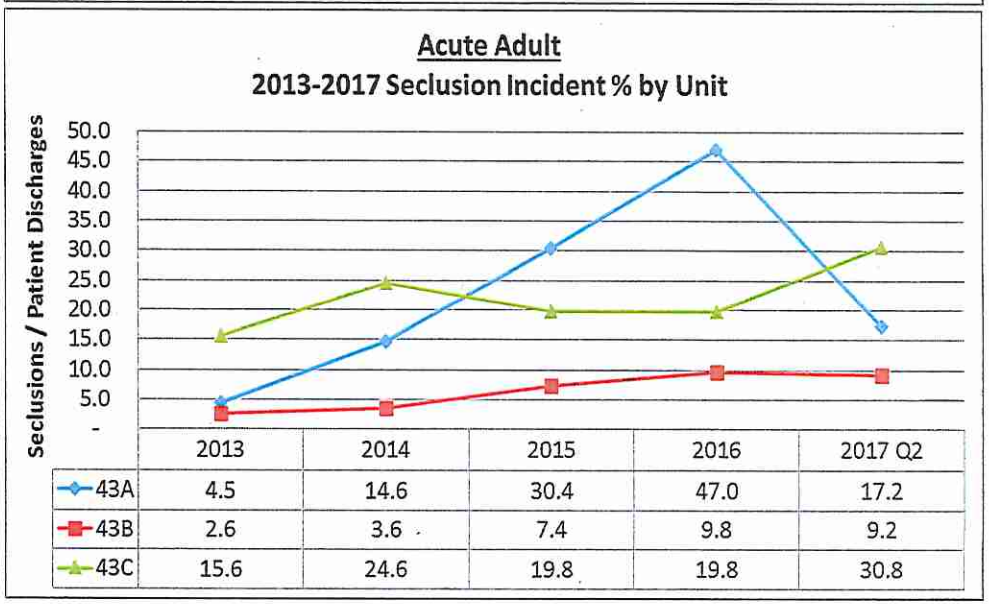
	2013	2014	2015	2016	2017 Q2
Acute	0.3	0.4	0.5	0.5	0.3
National Average	0.1	0.1	0.1	0.1	0.1



	2013	2014	2015	2016	2017 Q2
43A	0.2	0.4	0.9	0.9	0.3
43B	0.1	0.1	0.2	0.2	0.1
43C	0.6	0.7	0.4	0.4	0.4

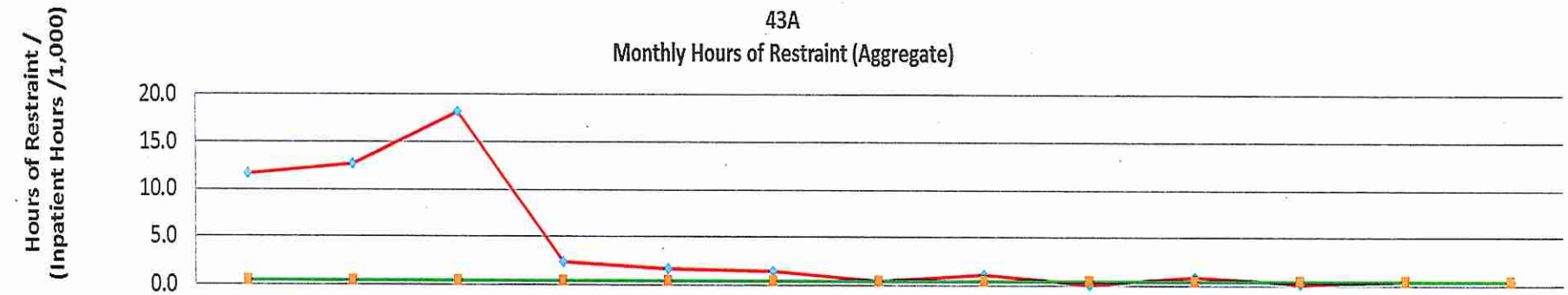


	2013	2014	2015	2016	2017 Q2
Acute	7.4	13.7	17.3	24.7	18.1

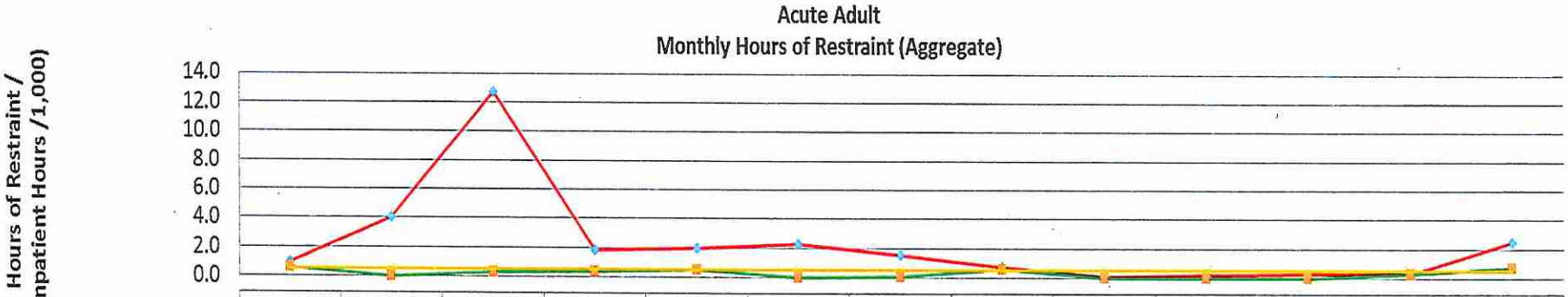


	2013	2014	2015	2016	2017 Q2
43A	4.5	14.6	30.4	47.0	17.2
43B	2.6	3.6	7.4	9.8	9.2
43C	15.6	24.6	19.8	19.8	30.8

Acute Adult

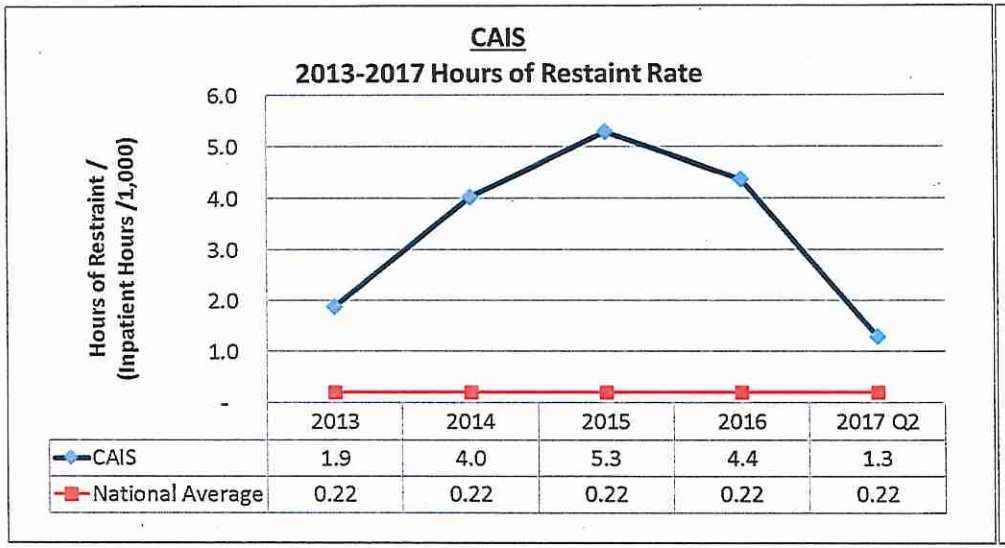


	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
43A	11.7	12.6	18.1	2.4	1.7	1.5	0.4	1.2	0.2	0.9	0.3	0.5	0.5
National Average	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49

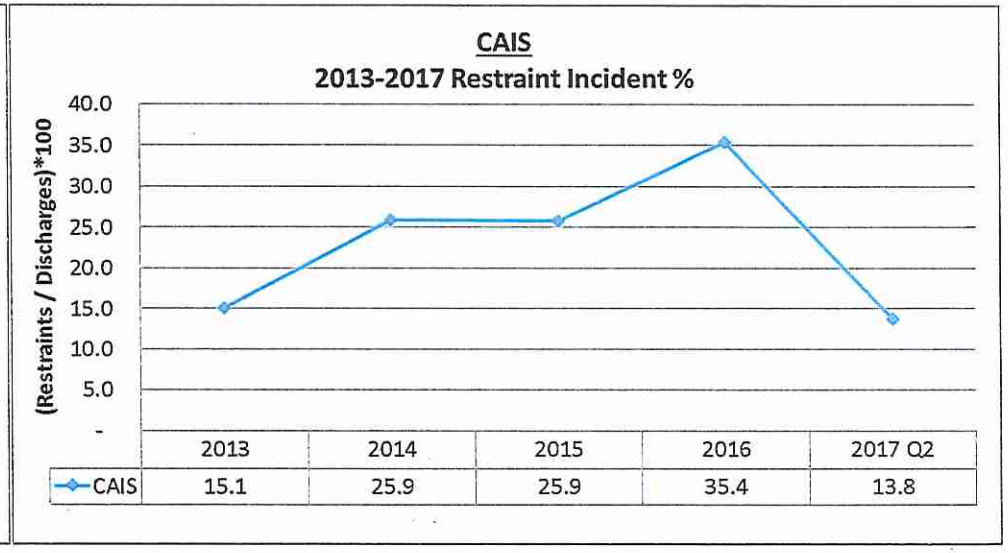


	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
43B	1.0	4.0	12.8	1.8	2.0	2.3	1.6	0.7	0.1	0.2	0.3	0.3	2.5
43C	0.6	0.0	0.3	0.4	0.5	0.0	0.1	0.6	0.0	0.0	0.0	0.3	0.8
National Average	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49

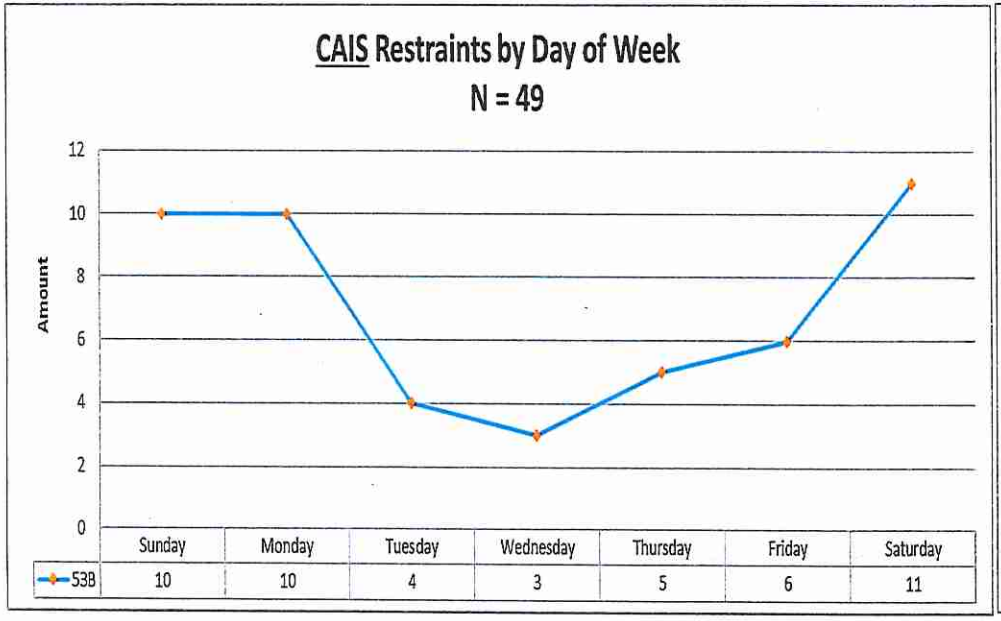
CAIS



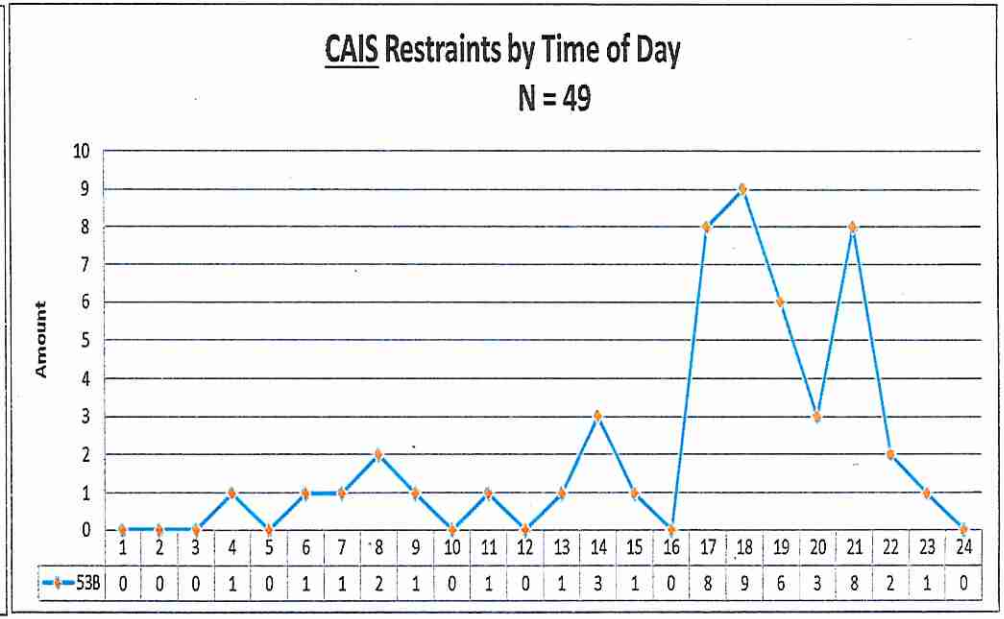
	2013	2014	2015	2016	2017 Q2
CAIS	1.9	4.0	5.3	4.4	1.3
National Average	0.22	0.22	0.22	0.22	0.22



	2013	2014	2015	2016	2017 Q2
CAIS	15.1	25.9	25.9	35.4	13.8

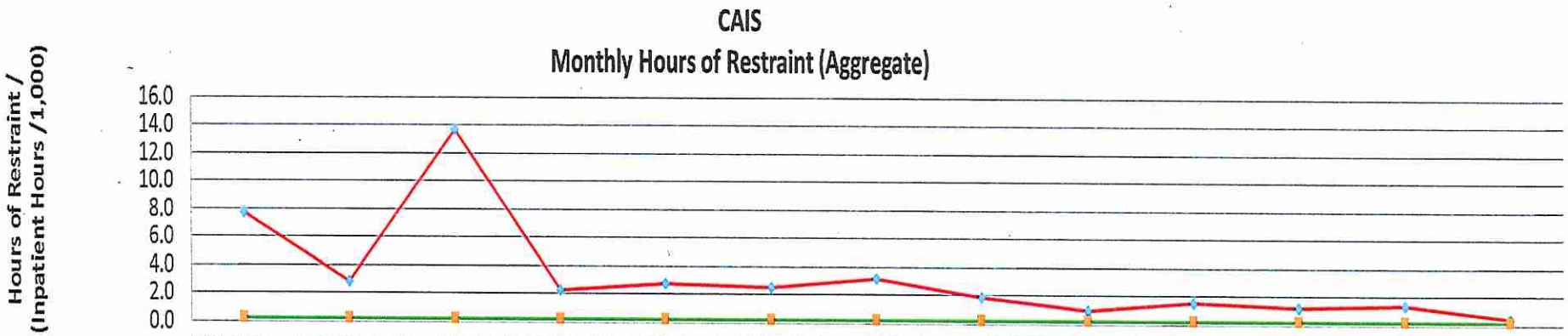


	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
53B	10	10	4	3	5	6	11



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
53B	0	0	0	1	0	1	1	2	1	0	1	0	1	3	1	0	8	9	6	3	8	2	1	0

CAIS



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
53B	7.8	2.9	13.7	2.2	2.8	2.5	3.1	1.8	0.9	1.5	1.2	1.4	0.4
National Average	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26

Facility Data

Program		Restraint Incidents							Restraint Hours						
		2011	2012	2013	2014	2015	2016	2017 Q2	2011	2012	2013	2014	2015	2016	2017 Q2
Acute	43A	282	367	558	303	306	249	39	1,704	1,473	2,321	1,293	2,402	864	38
	43B	78	124	236	138	237	207	48	89	139	492	259	600	399	45
	43C	173	88	112	98	63	58	21	1,602	78	113	205	104	67	18
	Total	966	775	906	539	606	514	108	4,579	2,268	2,926	1,757	3,106	1,330	101
CAIS	CAIS	173	84	124	246	238	218	49	476	98	133	314	458	323	53
Crisis	PCS	638	537	445	405	417	373	159	651	514	509	413	445	408	165
	OBS	122	76	106	146	83	74	23	190	100	179	207	117	98	17

Program/Unit		Seclusion Incidents							Seclusion Hours						
		2011	2012	2013	2014	2015	2016	2017 Q2	2011	2012	2013	2014	2015	2016	2017 Q2
Acute	43A	47	22	18	40	83	102	21	87	17	33	61	115	115	18
	43B	4	12	15	16	32	25	11	4	8	11	18	32	24	9
	43C	58	15	74	96	52	40	28	73	10	100	118	60	54	22
	Total	154	62	107	152	167	167	60	218	48	144	196	207	193	49
CAIS	CAIS	27	6	5	32	44	17	24	32	4	3	21	35	13	15

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: August 15, 2017

TO: Mary Neubauer, Chairwoman – MH Quality Committee
Milwaukee County Mental Health Board

FROM: Steve Delgado, Director of Operations, Jennifer Bergersen, Chief Operations Officer
Behavioral Health Division

SUBJECT: 2018 Capital Improvement Requests; Behavioral Health Division
Environment of Care; Quality and Safety

REQUEST: Informational

Behavioral Health Division Building Project Descriptions

1. **Pitched Roof Replacement: $1,528,162**

The roof system is original to the BHD building (1978) and is well past its useful life expectancy of 30 years.

2. **BHD Ventilation System Study: $50,000**

HVAC engineering study needs to be conducted to identify specific needed updates as the system is original to the building.

3. **Additional Equipment Generator $1,121,707**

In the event of the loss of main electrical power and in order to sustain patient care, the ventilation system (HVAC) needs to be powered. This would provide heating, cooling and required air exchanges.

4. **BHD Exterior Door Replacement Assembly $347,925**

The exterior doors and frames, which are original to the building construction (1978) are rotting away at the base due to weather conditions and snow/ice removal procedures. The door jackets are split and pulling away at the seams. Door replacement underway.

Refer to attached 2018 Capital Improvement Requests; side two.

	2018		2019		2020		2021		2022	
Project Description	*County Funding*	*Dept Rank*	*County Funding*	*Dept Rank*	*County Funding*	*Dept Rank*	*County Funding*	*Dept Rank*	*County Funding*	*Dept Rank*
Mental Health Complex - Repave Parking Lot X-42										
BHD Air Handling System	$ 1,382,538	2	$ 3,000,000	2	$ 3,000,000	2	$ 3,000,000	2	$ 3,000,000	2
BHD Window Replacement					$ 1,320,909	7				
BHD Bathroom Bldg Settling Repair & Replacement			$ 423,841	6						
BHD-ACT System Renewal									$ 136,812	10
BHD-VCT 4 Renewal									$ 136,812	9
BHD-Door Assembly Replacement	$ 347,925	5								
BHD-Fire Damper Replacement	$ 132,219	4								
Mental Health Complex - Repave Parking Lot X35										
MHC-Repave Parking Lots X-32 A, B, & C							$ 576,534	8		
BHD Roof Repair	$ 1,528,162	1								
Mental Health Complex New Generator	$ 1,121,707	3								
Stairwell Sprinkler Protection System										
Grand Total	**$4,512,551**		**$3,423,841**		**$4,320,909**		**$3,576,534**		**$3,273,624**	

HIPAA Compliance & Data Sharing Project – Update

Purpose: To fulfill the vision of a "No Wrong Door[1]" approach to mental health and supporting services from DHHS, and to implement clear policies and procedures for accessing and sharing protected health information, enabling secure and efficient warm handoffs between county services. The project's primary objectives are to:

- Increase capacity to share information between divisions in a compliant fashion
- Increase knowledge of the responsibilities inherent in sharing protected health information
- Understand and improve County compliance with information sharing regulations and controls

Background: The 3rd party security contractor Sword & Shield conducted a Risk Assessment and Gap Analysis of BHD in April, 2017. The objectives of this review were to compare HIPAA security requirements with the internal safeguards currently in place, and to identify areas of risk associated with the storage, transmission, and processing of electronic protected health information. The most relevant results from these studies were that:

- BHD was found to be only 66% compliant with HIPAA security requirements when counting controls that have been both implemented and documented
- BHD was determined to be at high risk for internal and external attack, with incomplete policies and business process gaps contributing to further compliance risks

Progress: Since the initial assessment, BHD has taken the following steps to provide additional security and structure to the myAvatar Electronic Medical Record (EMR)

- Ann Seltzer was designated HIPAA security officer, responsible for both technology and policy updates
- The authorization process for EMR access was streamlined and configured to include more accountability
- The password reset process moved from phone to email, now ensuring identity verification
- myAvatar password length and complexity requirements were increased to match security standards
- Terminals displaying sensitive information were directed to lock out after shorter periods of user inactivity

Following these changes, BHD formed an EMR Policy Workgroup to draft policies and implement business practices relevant to the EMR. So far, its work has included access management, change control, data requests, and Business Associate Agreements, as well as miscellaneous policies that have been developed as needed to support myAvatar optimization. To fulfill broader county goals—focusing on efficiency and clarity of data sharing in addition to regulatory compliance—BHD developed and submitted a Data Sharing Project Charter for approval in June.

Projected: BHD has effectively launched the project with internal improvement efforts, and is now engaging the Department of Health & Human Services to partner in this work. With DHHS assistance this project will recruit consultants dedicated to regulatory compliance (including HIPAA, HITECH etc.) and network integrity.

Topics to consider: Although steps toward more secure data sharing and a higher level of HIPAA compliance have been taken, it remains clear that multiple far-reaching decisions must be made to ensure this project's long-term success. Specifically, it is important that BHD clarify and propagate its definition of 'treatment', to smoothly coordinate care for clients with needs across services and organizations. In addition, BHD must work with DHHS to coordinate development of interrelated policy to better serve its clients.

Perhaps most importantly, BHD recognizes that the scope of this project is only to begin working toward HIPAA compliance and efficient data sharing. Enforced, ongoing compliance, as well as process updates to countywide data sharing, are too far-reaching to confine to any reasonable timeframe. Instead, BHD must make subjective decisions concerning the prioritization of tackling certain security or process concerns before others, whether due to their high risk, high impact, or ease of fixture. Furthermore, BHD will require additional resources to continue this process of increasing HIPAA compliance; although this project will act as an accelerator, long-term investment will be necessary to achieve the overall goal.

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[1] A "No Wrong Door" approach would ensure that any client who arrives at a County health facility—regardless of how well matched their medical concern is to said facility—would be given sufficient immediate treatment, as well as a smooth transition to an appropriate facility. This transition would require the transmission of the patient's protected health information, in order to ensure awareness of their initial symptoms and treatment.

POLICY & PROCEDURE STATUS REPORT

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
March	2	7	7
April	0	5	4
May	8	57	20
June	19	10	10
July	1	4	1

Overall Progress 86.5% as of August 1, 2017

Current

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	431	430	86.9%	86.5%
Up to 1 year Overdue	21	25	4.2%	5.0%
More than1 yr and up to 3 years overdue	9	9	1.8%	1.8%
More than 3 years and up to 5 years overdue	5	5	1.0%	1.0%
More than 5 years and up to 10 years overdue	7	6	1.4%	1.2%
More than 10 years overdue	23	22	4.6%	4.4%
Total	497	497	100%	100%

Forcast Due for Review

Past Due Policies - 67

Coming Due Policies

August - 3
September - 3
October - 8
November - 9
December - 62
January - 7