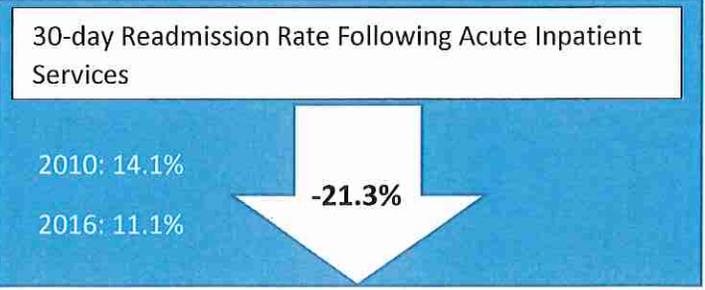
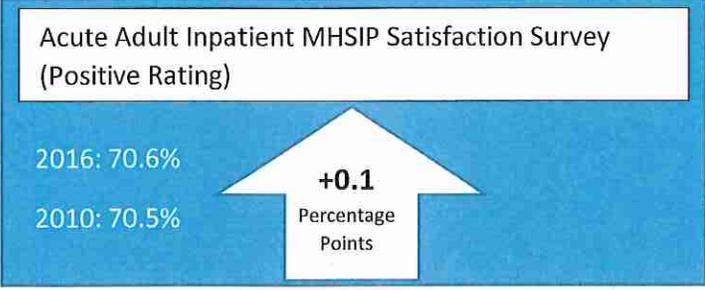
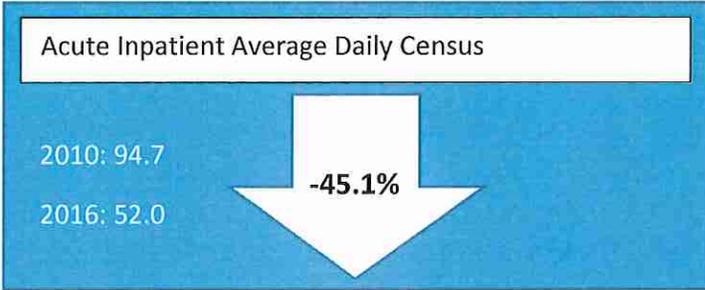
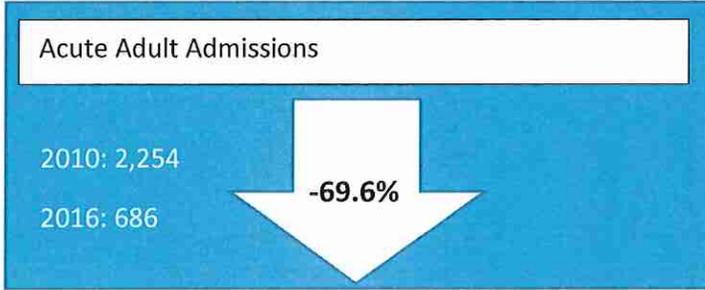
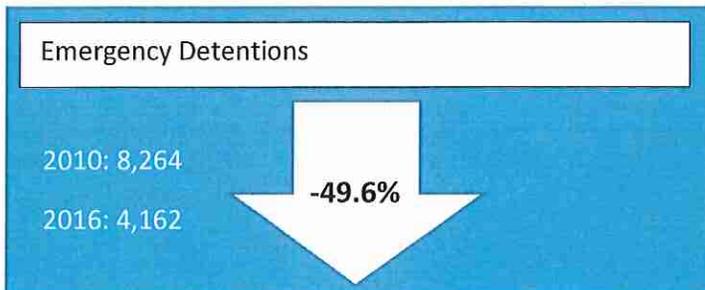
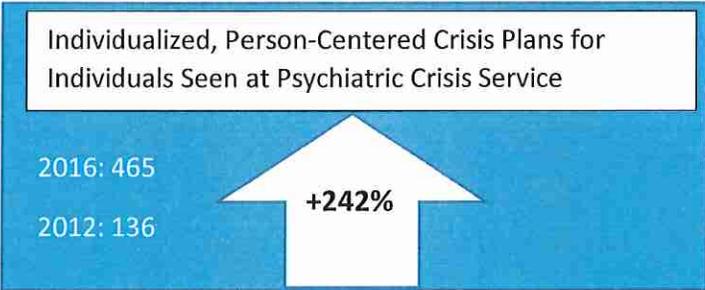
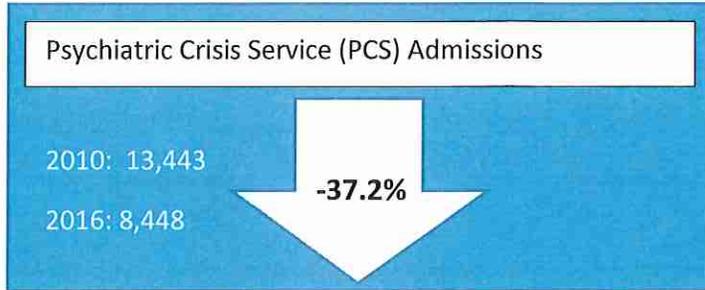
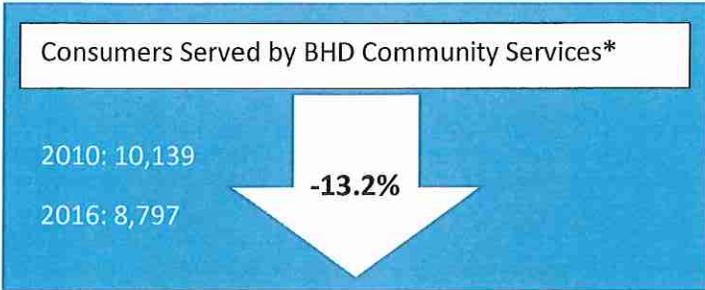


# 2010-2016 SMART Goal Accomplishments

2016 projections based on annualized data for time period 1/1/16-10/31/16.

11/8/16



**\*Consumers Served by BHD Community Services**

- 2016 saw a reduction in unique number of individuals served due to multiple factors, including:
  - Transition from 3 medical records systems to 1 has increased our ability to accurately count an individual one time
  - Multiple systems with different medical record numbers led to the possibility of duplicate counts of individuals across systems
  - Medicaid eligibility as a result of the Affordable Care Act has led to a decline in certain Medicaid covered services, e.g. AODA Outpatient
  - Reduction in AODA grant funds available from 2010 – 2016 has led to an overall reduction in primary AODA clients served
  
- The following table shows volume (unique individuals served) since 2010 as well as annual variance.

Year	Volume	One Year Difference
2010	10,139	
2011	9,883	256
2012	10,800	917
2013	10,125	675
2014	9,992	133
2015	9,624	368
2016	8,797	827

➤ Additional Discussion:

***Monday – February 2, 2015 Quality Committee Meeting***

Quality Meeting Minutes:

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“4. Quality Metrics Collection Overview.

- a. SMART Goals
- b. KPI Dashboard
- c. CMS Regulatory Reporting Items
- d. Customer Satisfaction Data

The above data and data requirements were reviewed.

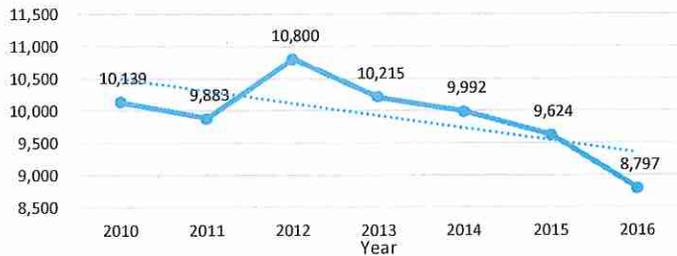
**RECOMMENDATION:**

Clarify the format for these reports to include trends, goals and benchmarks. As SMART Goal reporting continues, identify what items stay on, what items drop off and what are the targets going forward.”

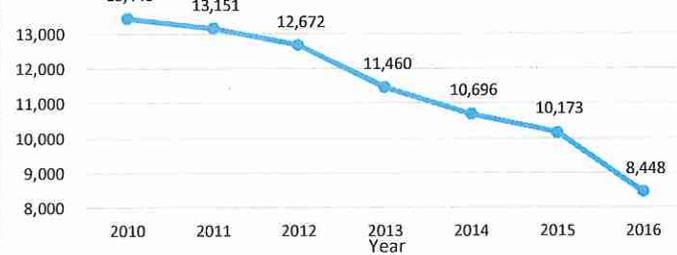
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# 2010-2016 SMART Goal Accomplishments

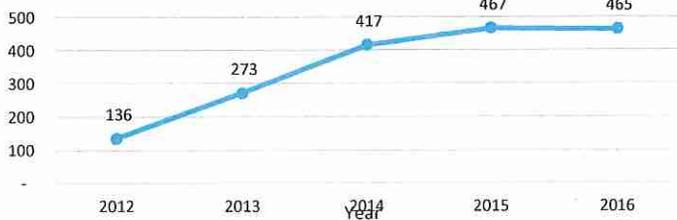
Consumers Served by BHD Community Services



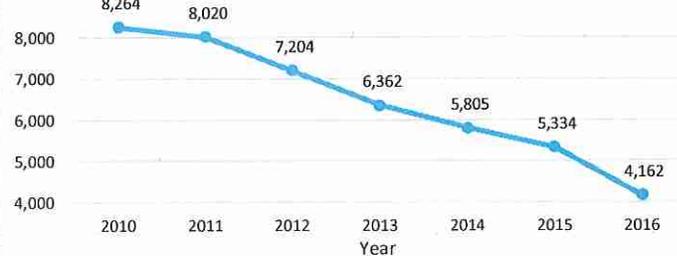
Psychiatric Crisis Service (PCS) Admissions



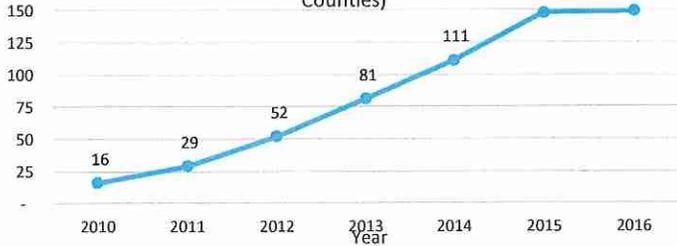
Individualized, Person-Centered Crisis Plans for Individuals Seen at PCS



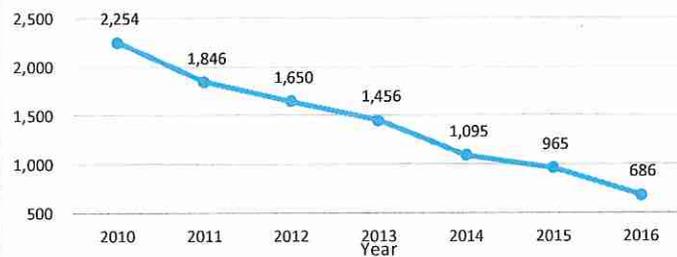
Emergency Detentions



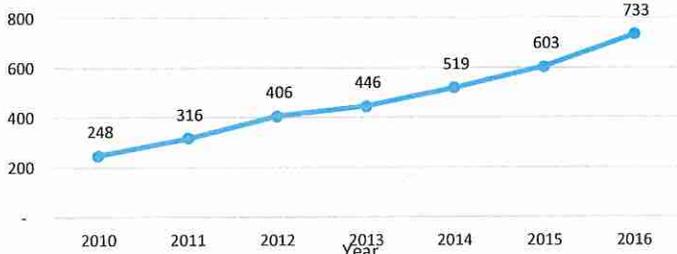
Certified Peer Specialists (Milwaukee & Waukesha Counties)



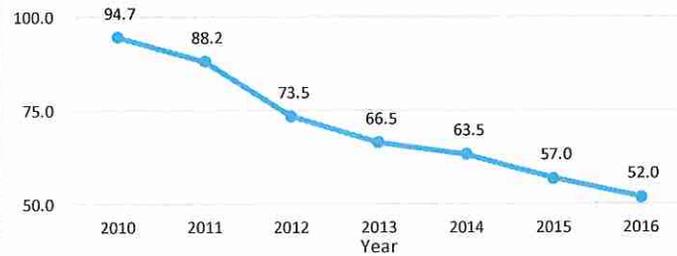
Acute Adult Admissions



Recovery-Oriented Supporting Housing



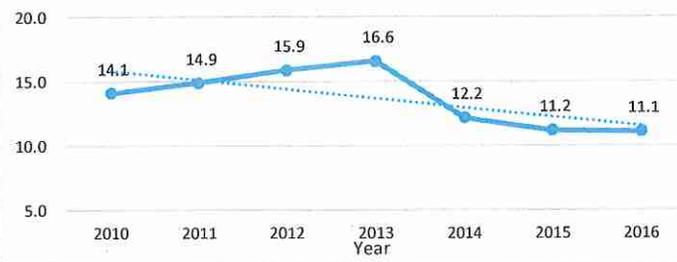
Acute Inpatient Average Daily Census



Acute Adult Inpatient MHSIP Satisfaction Survey (Positive Rating)



Acute Adult 30-Day Readmission Rate





## Milwaukee County Behavioral Health Division 2016 Key Performance Indicators (KPI) Dashboard

Program	Item	Measure	2016 Quarter 1	2016 Quarter 2	2016 Quarter 3	2016 Projection	2016 Target	2016 Status (1)	2015 Actual	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs* Discharge (Client Discharged During Quarter Who Stayed in Services 6 Months or Less)	4,777	4,955	4,984	8,797	9,742		9,624	BHD (2)
	2	Inpatient Utilization Offset	NA	27.72%	11.11%	27.72%	-		-	BHD (2)
	3	Abstinence from drug and alcohol use	26.8%	18.98%	26.00%	22.9%	-		-	BHD (2)
	4	Reduction in Homelessness or in Shelters	14.3%	21.49%	40.00%	17.9%	-		-	BHD (2)
	5	Increase in Employment* 6 Month Follow Up (First 6 Month Follow Up for Clients Open in Services During Quarter)	9.4%	40.87%	-6.67%	25.1%	-		-	BHD (2)
	6	Inpatient Utilization Offset	60.4%	75.20%	40.08%	67.8%	61.0%		60.3%	BHD (2)
	7	Abstinence from drug and alcohol use	45.5%	5.20%	-1.60%	25.3%	83.8%		82.5%	BHD (2)
	8	Reduction in Homelessness or in Shelters	50.0%	33.00%	30.00%	41.5%	78.1%		77.3%	BHD (2)
	9	Increase in Employment* By Quarter	45.5%	-22.35%	47.06%	11.6%	34.2%		33.9%	BHD (2)
	10	Percent of clients returning to Detox within 30 days	48.02%	58.52%	42.14%	53.3%	NA(s)		19.6%	BHD (2)
Wraparound	11	Families served in Wraparound HMO (unduplicated count)	1,921	2,521	3,032	3,400	3,300		3,329	BHD (2)
	12	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.5	4.5	4.6	4.6	> = 4.0		4.6	BHD (2)
	13	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	59.6	59	59.2	59.0%	> = 75%		62%	BHD (2)
	14	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.12	2.94	2.8	2.9	> = 3.0		3.2	BHD (2)
	15	Percentage of youth who have achieved permanency at disenrollment	55%	52%	55%	52.0%	> = 70%		58%	BHD (2)
16	Percentage of Informal Supports on a Child and Family Team	42.30%	42.90%	43.50%	43.0%	> = 50%		42%	BHD (2)	
Crisis Service	17	Admissions	2,138	2,169	2,073	8,507	9,000		10,173	BHD (2)
	18	Emergency Detentions	1,074	1,118	978	4,227	4,500		5,334	BHD (2)
	19	Percent of patients returning to PCS within 30 days	7.7%	7.2%	7.5%	7.5%	8%		8%	BHD (2)
	20	Percent of patients returning to PCS within 30 days	24.5%	24.4%	24.2%	24.4%	20%		25%	CMS (4)
	21	Percent of time on waitlist status	76.4%	72.3%	83.8%	77.5%	10%		16%	BHD (2)
Acute Adult Inpatient Service	22	Admissions	193	176	158	703	850		965	BHD (2)
	23	Average Daily Census	45.4	46.0	46.4	45.9	48.0		47.2	BHD (2)
	24	Percent of patients returning to Acute Adult within 30 days	11.4%	10.7%	10.9%	11.0%	7%		11%	NRI (3)
	25	Percent of patients responding positively to satisfaction survey	76.8%	69.0%	70.9%	72.2%	74%		73%	NRI (3)
	26	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	64.3%	54.4%	53.4%	57.4%	65%		63%	BHD (2)
	27	HBIPS 2 - Hours of Physical Restraint Rate	3.05	2.97	5.99	4.00	0.66		7.2	CMS (4)
	28	HBIPS 3 - Hours of Locked Seclusion Rate	0.54	0.63	0.50	0.60	0.14		0.47	CMS (4)
	29	HBIPS 4 - Patients discharged on multiple antipsychotic medications	13.7%	17.9%	24.1%	18.6%	9.5%		18%	CMS (4)
30	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96.2%	96.7%	89.7%	94.2%	32.8%		98%	CMS (4)	
Child / Adolescent Inpatient Service (CAIS)	31	Admissions	193	167	113	631	800		919	BHD (2)
	32	Average Daily Census	9.3	10.1	6.3	8.6	11.0		9.8	BHD (2)
	33	Percent of patients returning to CAIS within 30 days	15.1%	14.9%	14.2%	14.7%	11%		16%	BHD (2)
	34	Percent of patients responding positively to satisfaction survey	83.8%	79.7%	77.0%	80.2%	74%		71%	BHD (2)
	35	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	77.8%	73.7%	78.9%	76.8%	80%		74%	BHD (2)
	36	HBIPS 2 - Hours of Physical Restraint Rate	5.31	3.44	5.85	4.87	0.22		5.2	CMS (4)
	37	HBIPS 3 - Hours of Locked Seclusion Rate	0.17	0.00	0.03	0.07	0.34		0.42	CMS (4)
	38	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2.60%	1.80%	0.01%	1.5%	3.0%		2%	CMS (4)
39	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100.0%	66.6%	100.0%	88.9%	39.9%		100%	CMS (4)	
Financial	40	Total BHD Revenue (millions)	-	-	-	\$129.4	\$129.4		\$120.2	
	41	Total BHD Expenditure (millions)	-	-	-	\$188.2	\$188.2		\$173.5	

**Notes:**

(1) 2016 Status color definitions: Red (below 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) The 2016 target for detox is currently under revision for two reasons: a) We have revised the way we calculate this outcome, which has had a significant impact on the readmission rates, and

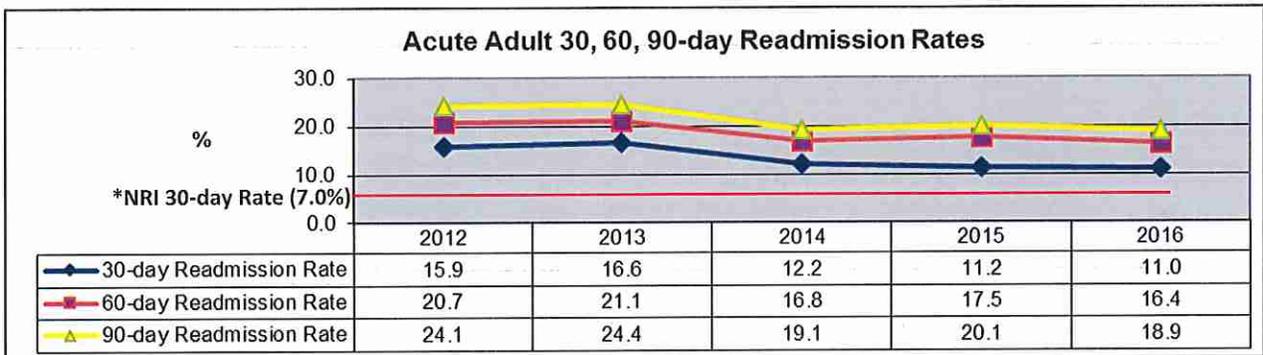
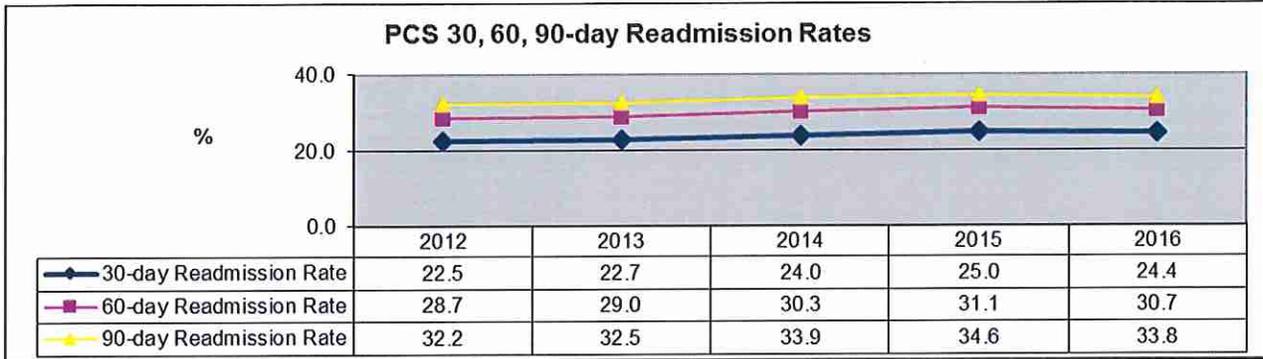
(6) We have expanded the scope of detox clients to be included in the outcome (expanding from 75.07 to both 75.07 and 75.09 levels of care)

(7) Because we now have the ability to collect uniform data on all clients, this is the first quarter in which we will be included both sheltered employment and student status as part of our overall "employed" status

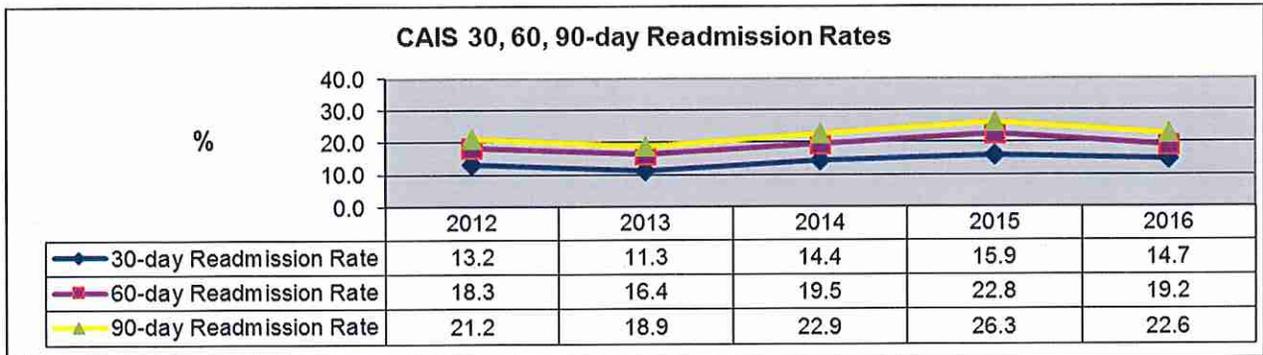
(8) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.

## 2012-2016 BHD Crisis Service & Acute Inpatient Readmission Rates

11/16/16



\*National Association of State Mental Health Program Directors Research Institute (NRI) national 30-day benchmark





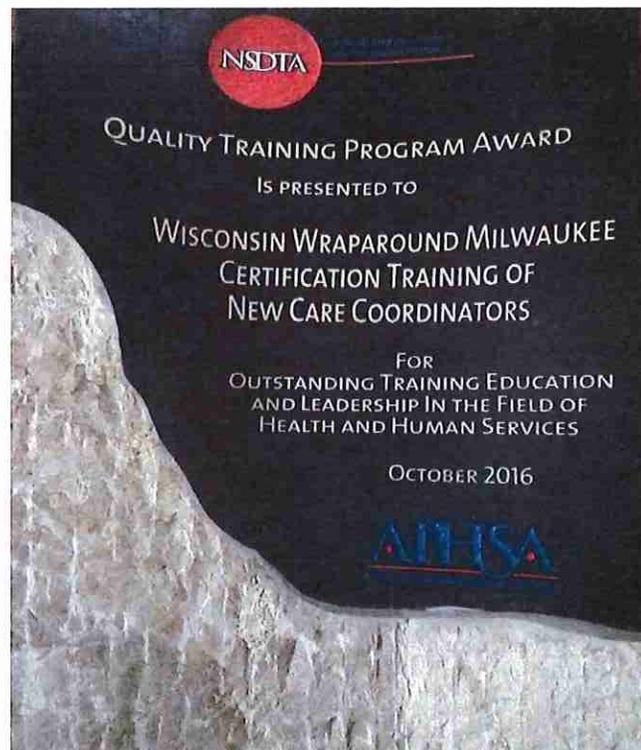
## Wraparound Milwaukee Quality Initiatives/Information

# 4

Presented at the QA Mental Health Board Meeting on 12/5/16

1. **2015 Wraparound Milwaukee Annual Report** – See report. Some “quality” highlights include:
  - No formal grievances were filed. Twenty (20) formal complaints were received representing only 1% of the families served. (Page 7)
  - 92% of the 271 youth successfully completing the program were in a permanent setting when disenrolled. (Page 9)
  - Youth in the program, on average, attended school 88% of the time. (Page 10)
  - Family Satisfaction with their Care Coordination services, on average, was 4.4 on a scale of 1-5, 5 being Very Satisfied. (Page 10)
  - Our Mobile Urgent Treatment Team provided crisis services to over 1,000 families in Milwaukee County. (Page 12)
  - The CORE Program (Coordinated Opportunities for Recovery and Empowerment) was established. CORE is designed to provide support to individuals ages 15-23 who are experiencing their first episode of psychosis. (Page 15)
2. **Wraparound Milwaukee was awarded the Quality Training Program Award** through the National Staff and Development Training Association (NSDTA). NSDTA was founded in 1983 and incorporated as an affiliate of the American Public Human Services Association (APHSA) in 1985 to support persons responsible for human service training and staff development on the local, state, or federal level. The mission of NSDTA is to build professional and organizational capacity in the human services field through a national network of membership sharing ideas and resources on organizational development, staff development, and training.

The award recognized Wraparound Milwaukee's Care Coordination Certification Training program. Over the past couple of years, our Training Coordinator, Ms. Leanne Delsart, has revamped the program to further integrate best practice standards, a Trauma Informed Care focus and Motivational Interviewing techniques. There are fifteen Modules, with over 100 hours of training, that focus on topics from wraparound philosophy and values, to best practice documentation, to transition planning, to working with the school system. We also offer additional trainings to other service providers in the Wraparound Milwaukee Provider Network.



3. **New Plan of Care Rubric and auditing process established** - See attached. The Plan of Care auditing process and auditing tool were extensively reviewed and revised. A new tool, the POC Rubric, was created, several trainings and opportunities for assessing the reliability of the tool were conducted and a pilot project to assess the functionality of the tool and quality improvement efforts began on November 7<sup>th</sup>.

# POC Best Practice Rubric

**\*\*Items in blue italics should be considered ONLY if the youth is in Out of Home Care (Prior Auth.) at the time of this review\*\***

**FINAL SCORE:** \_\_\_\_\_ out of 36 or \_\_\_\_\_ %

Youth Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of review: \_\_\_\_\_ Reviewer: \_\_\_\_\_

Care Coordinator/Agency: \_\_\_\_\_ Supr/Lead who approved: \_\_\_\_\_

POC Date/Number: \_\_\_\_\_ Program (circle): WRAP REACH CORE FOCUS High Risk? YES  NO

Associated with a Prior Auth? YES  NO  If yes, (circle): Residential Group Home Foster Care Independent Living Day Treatment

Review next POC? YES NO

POC Review Questions	Skill Development Needed (No) 1	Emerging Skills (Partial) 2	Evidence of Mastery (Yes) 3	Comments
1. Are all strengths functional?	<input type="checkbox"/> <b>None</b> of the strengths appear functional  Strengths reflect descriptions of characteristics, attributes or interests, but <b>do not</b> offer utility.  <i>Example: "she likes basketball", "is a good cook", "loves her children" "is resourceful"</i>	<input type="checkbox"/> <b>Some</b> of the strengths appear functional  <b>At least one, but not all</b> , of the strengths, outline how characteristics, attributes, or interests are helpful or can be used in action.	<input type="checkbox"/> <b>All</b> of the strengths appear functional  <b>Functional:</b> Strengths that outline how characteristics, attributes, or interests are helpful and can be used in action.  <i>Example: "she likes basketball and plays as a way to relieve stress and enjoy time with positive peers" "she loves her children and is willing to attend parenting classes to learn safe ways to discipline them".</i>	
2. Are strengths inclusive of all team members and a Community Resource?	<input type="checkbox"/> <b>None</b> of the team members have a corresponding identified strength nor is there a community resource identified	<input type="checkbox"/> <b>Some</b> of the team members have a corresponding identified strength and there may or may not be a Community Resource identified	<input type="checkbox"/> <b>All</b> team members have a corresponding identified strength. One Community Resource (CR) is identified in the strengths list. Youth and family member's strengths are numerous/pervasive	

<p>3. Does the initial family narrative include all mandated areas?</p>	<p><input type="checkbox"/> <b>None</b> of the mandated areas are present, narrative is not comprehensive, narrative does not reflect the families evolution and is not written in the families language</p>	<p><input type="checkbox"/> <b>Some</b> of the mandated areas are present and/or narrative is somewhat comprehensive and/or narrative somewhat reflects the families evolution and/or narrative is somewhat written in the families language</p>	<p><input type="checkbox"/> <b>All</b> of the mandated areas are present. Narrative is comprehensive and describes the families evolution, and is written in the family's language</p> <p><b>Mandated areas Include:</b></p> <p><b>1. Family Background</b></p> <ul style="list-style-type: none"> <li>a. Describe family composition, including extended family members.</li> <li>b. Ask the family to discuss what led them to this point, as well as the reason for referral.</li> <li>c. Discuss the family's values, beliefs, traditions, daily routines and employment.</li> <li>d. Describe any mental health history or concerns and other significant factors (<i>i.e., incarcerations, abuse history, etc.</i>) for family members.</li> <li>e. Discuss any out-of-home placements for the enrolled youth or other family members.</li> </ul> <p><b>2. Behavioral History/Concerns</b></p> <ul style="list-style-type: none"> <li>a. Describe the youth's past and present behavioral concerns.</li> <li>b. Discuss interventions tried in the past – especially what worked, but also what did not.</li> <li>c. Discuss any school-related issues.</li> <li>d. Discuss any legal involvement, charges and offense history (<i>including gang involvement or runaway history</i>).</li> <li>e. Describe any significant peer relationships.</li> </ul> <p><b>3. Permanency Planning</b></p> <ul style="list-style-type: none"> <li>a. Discuss the permanency plan for this youth and any barriers or concerns in this area (if applicable).</li> </ul>	
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POC Review Questions	Skill Development Needed (No) 1	Emerging Skills (Partial) 2	Evidence of Mastery (Yes) 3	Comments
4. Is the family vision clear, concise, in the family's words, reflects hope/purpose for the future, and inclusive of the whole family (or the youth if age 17 or older)?	<input type="checkbox"/> The family vision <b>is not</b> inclusive of any of the family members (or youth if age 17 or older), does not provide a sense of purpose/hope for the future, is not clear or concise, and is not in the families language	<input type="checkbox"/> The family vision is <b>partially inclusive</b> of all family members (or the youth if age 17 or older) and reflects some sense of hope/purpose for the future, is somewhat clear and concise and appears to be in the families language	<input type="checkbox"/> The family vision is <b>fully inclusive</b> of all family members (or the youth is age 17 or older), expresses hope/purpose for the future, is clear and concise, and is in the family's language	
<i>Does the vision reflect the Permanency Plan?</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Does the POC reflect underlying needs?	<input type="checkbox"/> <b>None</b> of the Need Statements appear to be reflective of underlying needs  Need statements reflect services, strategies, or goals rather than the root cause of the behavior, what is missing that the behavior makes up for, or what the behavior is communicating.  <b>Example:</b> Johnny needs a tutor.	<input type="checkbox"/> <b>Some</b> of the Need Statements appear to be reflective of underlying needs  <b>Some</b> need statements reflect services, strategies, or goals and <b>some</b> reflect the root cause of the behavior, what is missing that the behavior makes up for, or what the behavior is communicating.  <b>Example:</b> Johnny needs help to focus in the classroom.	<input type="checkbox"/> <b>All</b> of the Need Statements reflect underlying needs  <b>All need statements</b> reflect the root cause of the behavior, what is missing that the behavior makes up for, or what the behavior is communicating.  <b>Example:</b> Johnny needs to feel safe in the classroom so he can focus.	
<i>Does the level of care being utilized or requested match the Need(s)?</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

POC Review Questions	Skill Development Needed (No) 1	Emerging Skills (Partial) 2	Evidence of Mastery (Yes) 3	Comments
6. Do the Needs in the Plan reflect the required Domains and those Domains identified as High or Medium?	<input type="checkbox"/> <b>None</b> of the needs are reflective of any of the required domains or domains that are identified as high or medium	<input type="checkbox"/> <b>Some</b> of the needs are reflective of the required domains and/or those that are identified as high or medium	<input type="checkbox"/> <b>All</b> of the needs are reflective of the required domains and those that are identified as high or medium  <b>In the FIRST POC must have Family, Mental Health, Educational/ Vocational and Crisis/ Safety Domains. In 2<sup>nd</sup>+ POC's must at least have Mental Health and Crisis /Safety Domains.</b>  <b>At any time - If on medications, this must be addressed in a Health and Well-being Domain.</b>	
<i>If living OOH are the domains of Living Situation, Family and Legal addressed within the needs?</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
7. Are the benchmarks measurable, observable and attainable?	<input type="checkbox"/> <b>None</b> of the benchmarks are measurable, observable or attainable  <b>Example: James will interact with his family.</b>	<input type="checkbox"/> <b>Some or all</b> of the benchmarks, meet <b>some or all</b> of the criteria (measurable, observable and attainable)  <b>Example: James will eat dinner with his family.</b>	<input type="checkbox"/> <b>All</b> of the benchmarks are measurable, observable and attainable  <u>Benchmarks</u> should be written from a positive frame of reference.  To be " <b>Measurable</b> " speaks to being able to numerically quantify a change.  To be " <b>Observable</b> " means to be visible, evident, or noticeable.  To be " <b>Attainable</b> " means to be realistic, developmentally appropriate, and achievable.  <b>Example: James will eat dinner with his family four times per week.</b>	
<i>Do the benchmarks reflect movement toward a less restrictive setting for both the youth and the family?</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

POC Review Questions	Skill Development Needed (No) 1	Emerging Skills (Partial) 2	Evidence of Mastery (Yes) 3	Comments
<p>8. Do strategies reflect progression towards the benchmarks and include who will do what, where, when, how and why?</p>	<p><input type="checkbox"/> <b>None</b> of the strategies reflect progression towards the benchmarks nor do they include who will do what, where, when, how and why</p>	<p><input type="checkbox"/> <b>Some, but not all,</b> of the strategies reflect who will do what, where, when, how and why and evidence progression towards the benchmarks, <b>and/or</b> reflect <b>some, but not all,</b> of the criteria and/or evidence <b>some</b> progression towards the benchmarks</p>	<p><input type="checkbox"/> <b>All</b> of the strategies reflect who will do what, where, when, how and why and reflect progression towards the benchmarks</p> <p><b>Example:</b> Beth (tutor) will meet James at the North Avenue Library on M and W from 3:00p.m. to 4:30p.m. to tutor him in math homework in an effort to increase his math grade from a D to a C to allow him to be eligible to play football.</p>	
<p>9. Do strategies reflect a plan for task shifting and movement towards sustainability?</p>	<p><input type="checkbox"/> <b>None</b> of the strategies reflect task shifting and movement towards sustainability</p> <p>No natural/informal supports or community resources (CR's) are identified to replace the paid providers upon disenrollment nor is there a plan identified to do so</p>	<p><input type="checkbox"/> <b>Some</b> of the strategies reflect task shifting and movement towards sustainability</p> <p>Natural/Informal supports and CR's are identified to replace paid providers, but no transition plan is in place to transfer knowledge/skills and/or a transition plan is identified but no natural/informal supports or CR's are identified to transfer into that role</p>	<p><input type="checkbox"/> <b>All</b> of the strategies reflect task shifting and movement towards sustainability</p> <p>For all strategies that involve a <b>paid provider</b> who will <b>not</b> continue, a plan is clearly outlined to replace the paid provider with a natural/informal support, CR, or other Team member. The plan includes identifying, supporting, and coaching that person(s) by the provider sharing knowledge, skills, and collaborating with the person who will replace them in addition to the other Team members.</p> <p><b>Example:</b> The crisis stabilizer (CS) will call Uncle Joe on his way to responding to the school. Uncle Joe will meet CS at the school to observe CS de-escalate Johnny in order to help Johnny see Uncle Joe as someone he can rely on to help him be safe. By X date, the teachers will begin to call Uncle Joe directly. Uncle Joe will then call CS to meet him at the school as a supportive presence, but Uncle Joe will take the lead.</p>	

POC Review Questions	Skill Development Needed (No) 1	Emerging Skills (Partial) 2	Evidence of Mastery (Yes) 3	Comments
10. Is the crisis plan reflective of the relevant/identified safety/crisis needs?	<input type="checkbox"/> The crisis definitions and plan <b>do not reflect any</b> relevant/identified safety/crisis needs	<input type="checkbox"/> The crisis definitions and plan reflect <b>some</b> relevant/identified safety/crisis needs	<input type="checkbox"/> The crisis definitions and plan are <b>reflective of all</b> relevant/identified safety/crisis needs  The identified crisis definitions are tied to the reason for referral, legal history or behavioral/physical health needs, i.e. – runaway history, substance abuse, violence, panic attacks, exploitation, self-harm, suicidality. <b>If on the high-risk list, the safety related behavior is addressed in the crisis plan.</b>	
11. Does the crisis plan speak to safety and crisis management specific to home, school and/or community, and the current out of home setting (if applicable)?	<input type="checkbox"/> The crisis plan <b>does not speak to any</b> crisis and safety management plans for any settings	<input type="checkbox"/> The crisis plan speaks to a crisis and safety management plan for <b>some applicable</b> settings	<input type="checkbox"/> The crisis plan speaks to a crisis and safety management plan for <b>all</b> applicable settings in <b>both reactive and preventative sections</b> of the crisis plan	
12. Within each identified setting, does the crisis plan identify a comprehensive (specific and detailed) approach in dealing with the crisis?	<input type="checkbox"/> The crisis plan <b>does not</b> identify a comprehensive approach in resolving a crisis <b>in any setting</b>	<input type="checkbox"/> The crisis plan identifies a comprehensive approach in resolving a crisis <b>in some, but not all settings</b>	<input type="checkbox"/> The crisis plan identifies a <b>comprehensive</b> approach in resolving a crisis <b>in all identified settings</b>  A “comprehensive” approach should be safety oriented and should take into account the youths’ developmental age, the dynamics/structure of the setting, i.e. – home vs. RCC, triggers, available supports, who will do what and how.	

DO NOT include blue box scores in the final scores. →

Score: \_\_\_\_\_

Score: \_\_\_\_\_

Score: \_\_\_\_\_

Total Score: \_\_\_\_\_

22

36

Reducing Time from Referral to Admission

**Scope:** In the last 3-4 years, the number of referrals to CARS for services has increased by almost 70%. The number of staff to process referrals has not increased in a commensurate way, nor has capacity in the various programs. As such, the time from referral to enrollment in services is hovering around 65 days, and most programs have a wait list for admission.

**AIM:** Reduce time from referral to admission by at least 25%.

**Silent Idea Generation (Plan):**

- Align paper referral form to Avatar referral
- Increase responsibility of clerical staff
- One service manager responsible for intake process and supervise staff
- Determine current referral rate and set standard for number of screens and AC assignments
- Set standard for number of days to get screens done and measure it
- Minimize what is needed for a complete referral – only require what is needed for eligibility determination
- Move TCM services to a FFS environment

**Redesign Recommendations (Do):**

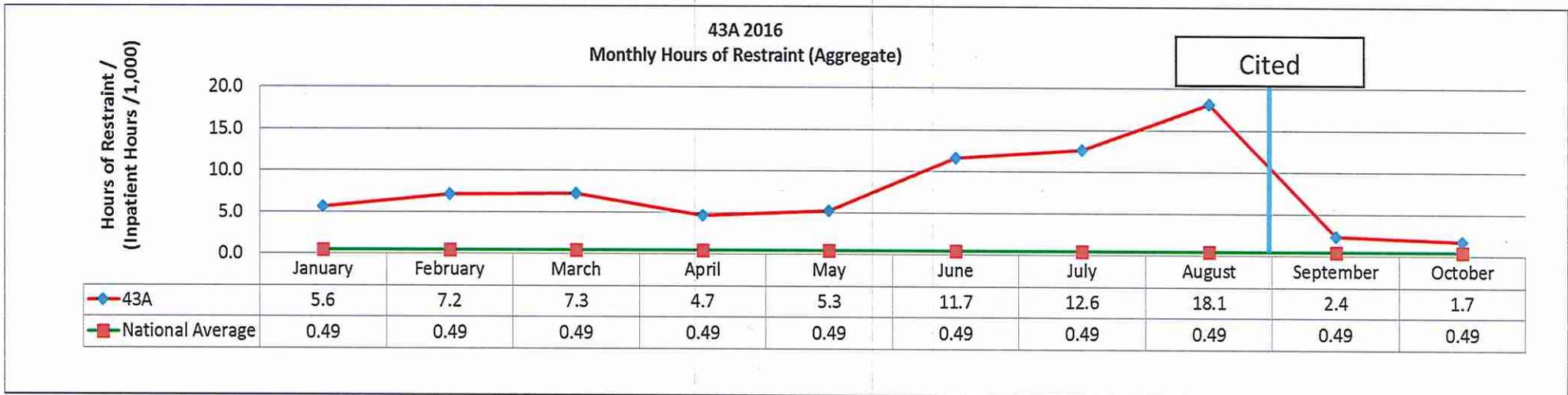
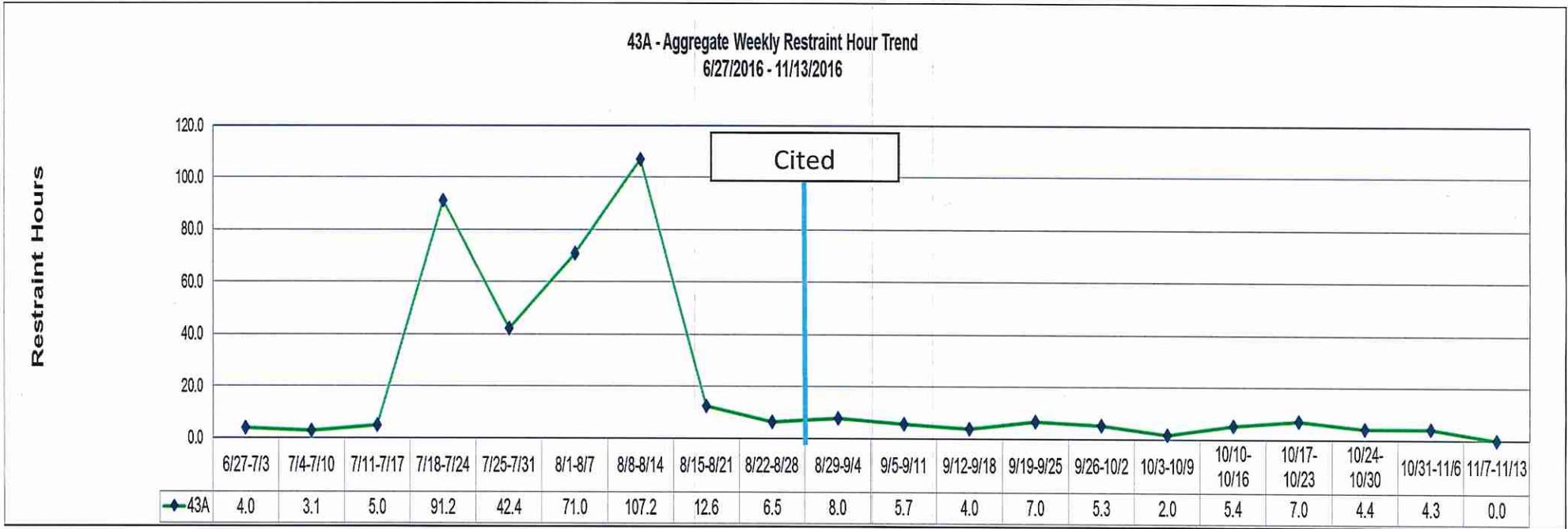
- Create a dedicated Intake Team (for TCM, CSP, Day Tx and CBRF)
  - 1 New Service Manager
  - 8 Dedicated Admin Coordinators
  - Dedicated clerical support to assist with data entry of referrals and/or sending information to providers to verify diagnosis/get records
  - Screening process is removed – ACs complete referral from start to finish
  - Set benchmarks starting with referral: face to face visit for assessment, completion of CARS referral form, completion of CARP, verify diagnosis, make LOC recommendation and place on wait list (taking client choice of agency into account)

**Analysis (Study):**

- Measure following timeframes:
  - Date referral received to date referral considered complete
  - Date completed referral is assigned to date assessment is complete
  - Date placement decision is made to date of program admission
- Compare actual results to predicted results. Has the change resulted in improvement?
  - **10 of 27 TCM referrals since 10/1 admitted in less than 30 days**
- What have we learned?

**Next Steps (Act):**

- Should the change be permanently adopted or adjusted?
- What should the next cycle be? Adopt which ideas from earlier planning?







# MENTAL HEALTH BOARD QUALITY COMMITTEE QUARTERLY REPORT

## CONTRACT PERFORMANCE MEASURES UPDATE

NOVEMBER 10, 2016

The Contract Performance Measures (CPM) team has now developed four sets of CPMs, Targeted Case Management services, Detoxification services, Warmline services, and AODA Residential services. Our team also decided that, in order to provide clearer justification and rationale for the development of the CPMs, we needed to create a standardized process for CPM development. This process, which was articulated after the four abovementioned CPMs were developed, will guide development and revision of all future CPMs. The basic highlights of this process, not exhaustive, includes:

1. Review of applicable State and Federal guidelines and regulations, evidence-based best practices in the research literature and/or in other systems of care
2. Review of our own internal data, where applicable and available
3. Feedback from internal experts, providers, and consumers in the item development/selection phase
4. Implementation and review of results and feedback for further item refinement and/or removal and selection with consideration of the consumer experience, validity, and agency performance/quality improvement targets

The following graphic presents a draft of the CPM development process, which has been reviewed by the CPM team and will be presented to the BHD Quality Committee and Executive Team for approval. This process will be applied to the development of the Outpatient CPMs, which are currently underway and are slated for completion by the end of the year.

# Contract Performance Measures Development Process



**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**

**DATE:** December 5, 2016

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

**FROM:** Matt Krueger, IMSD Project Manager

**SUBJECT:** Informational Report: Quality Technology Project updates

The Milwaukee County Behavioral Health Division has a number of technology projects focused on improving the quality of Healthcare Delivery. The following two are high priorities for the organization:

- **One Recovery Plan:** Today the Behavioral Health Division has 2 recovery plans on paper and 3 electronic forms in the Electronic Medical Record, none of which are truly integrated. This project will bring them all together on one integrated platform, aligning data elements and processes so both clinicians and patients have 'One Recovery Plan'. Day Treatment has been selected as the Pilot program, and we are wrapping up requirements and heading into the design phase. In addition, the Steering Committee has selected CSP as the Community Program to be built and tested in parallel, ensuring the solution can handle a broad range of requirements. The pilot is currently scheduled for mid-February.
- **Incident Reporting:** The Behavioral Health Division documents incidents primarily on paper, Wraparound Milwaukee being the exception. This can make it challenging to track follow through on an incident that has been reported. A solution has been selected that brings best practices and allows us to automate workflow and better manage incidents through resolution. In addition it will eventually allow us to better manage our risk, through assessing trends and being more prescriptive. Contracting is scheduled to wrap up by the end of November and we will move into implementation.

**PCS Hospital Transfer  
Waitlist Report**

Third Quarter Update

**2016**

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This report contains information describing the first nine (9) of 2016 are summarized as follows:

- 9 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 79.4%
- The 1,298 individuals delayed comprised 20.3% of the total PCS admissions (6,380)
- The median wait time for all individuals delayed was 5.2 hours
- The average length of waitlist per patient is 8.0 hours

Prepared by:  
Quality Improvement Department

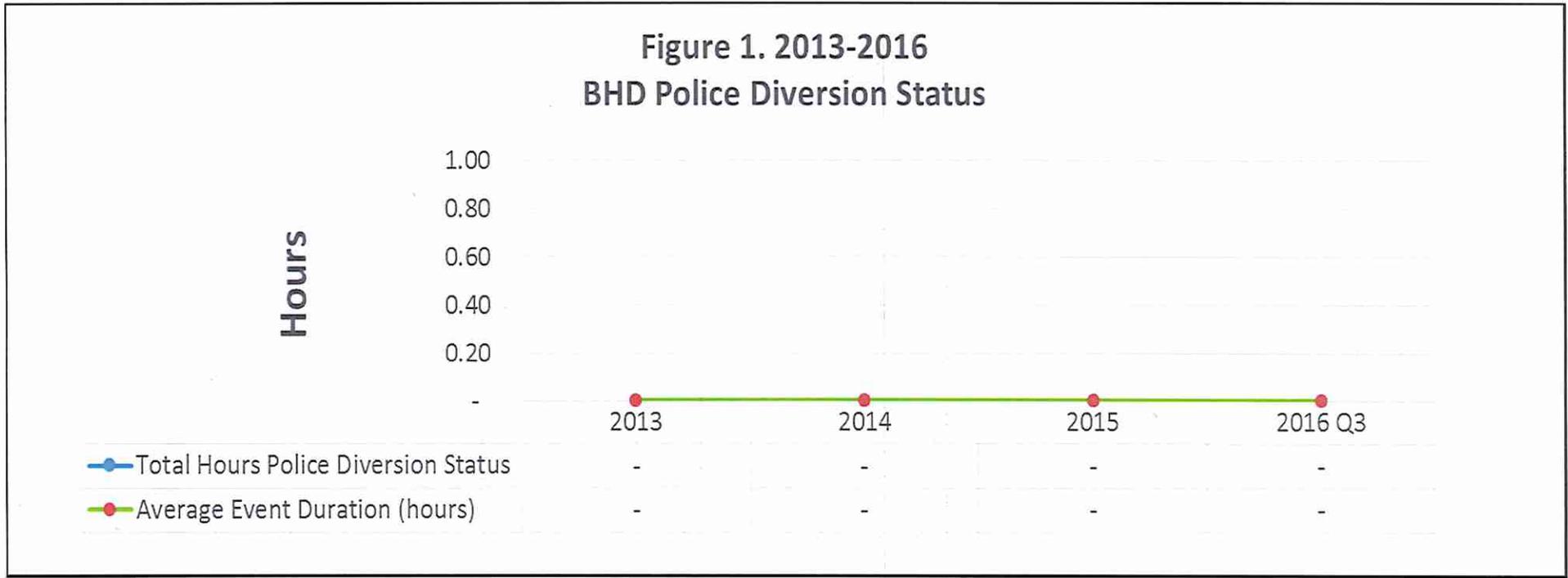
Date: October 27, 2016

### **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.

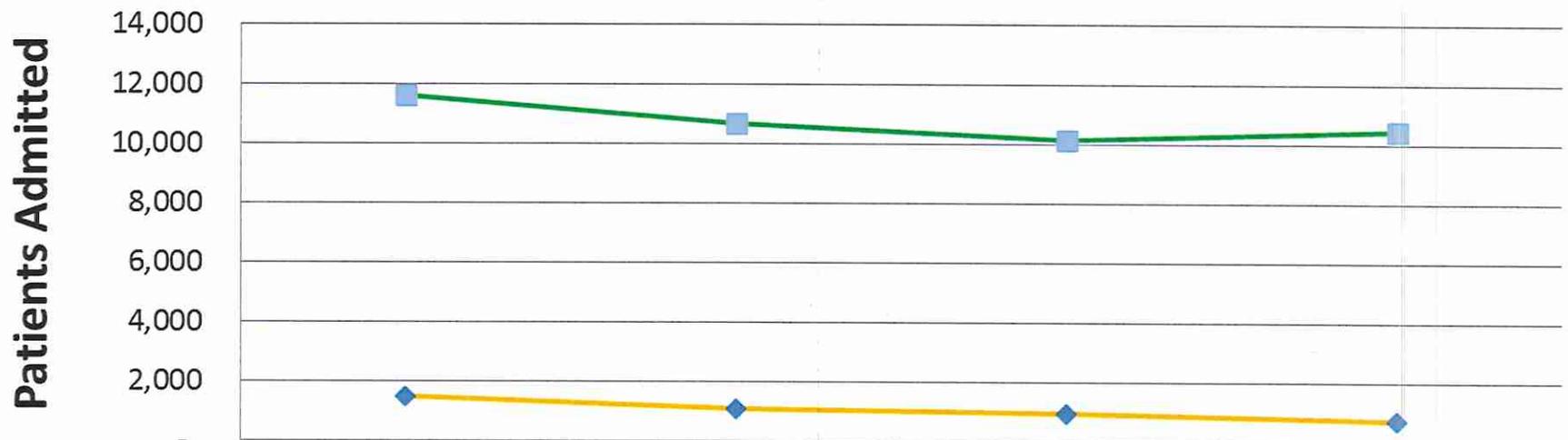
**Diversion:** A total lack of capacity in PCS and a lack of Acute Inpatient and Observation Unit beds. It results in actual closing of the door with no admissions to PCS allowed. Moreover, it requires law enforcement notification and Chapter 51 patients re-routed.

**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 7 year, last police diversion was in 2008

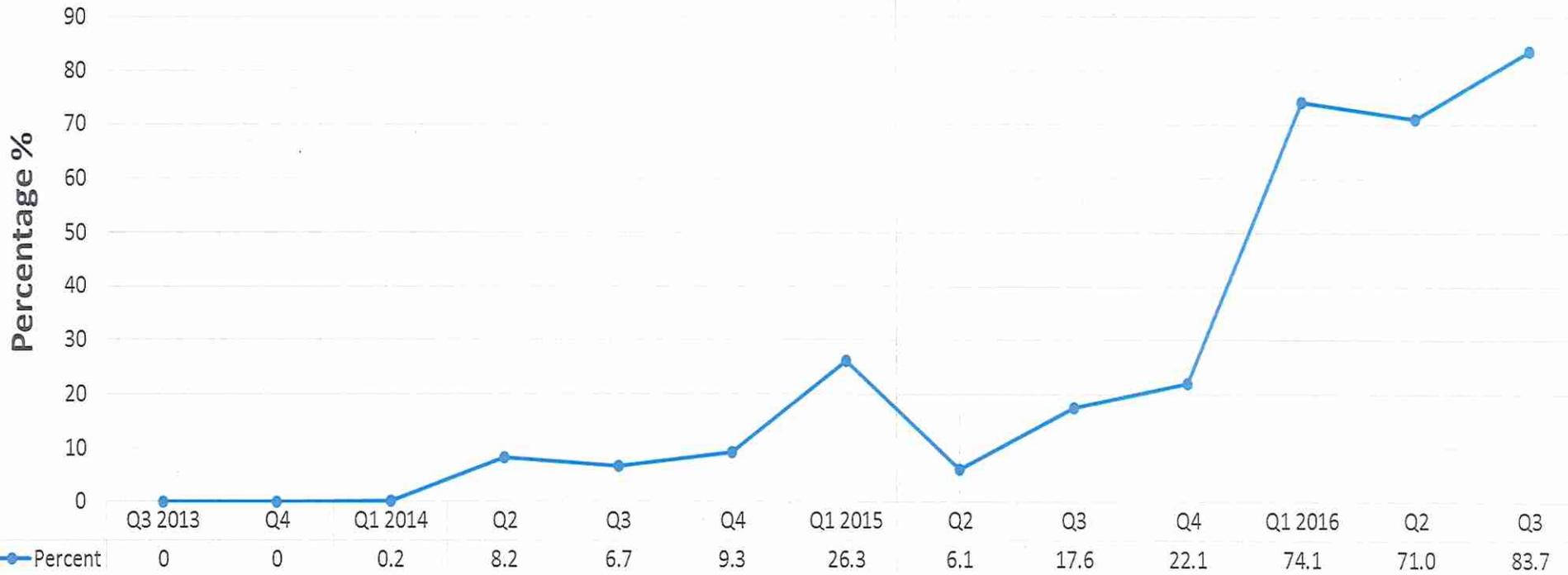
**Figure 2. 2013-2016  
PCS and Acute Adult Admissions**



	2013	2014	2015	2016 Proj.
◆ Acute Adult Admissions	1,489	1,093	965	738
■ PCS Admissions	11,644	10,698	10,173	10,464

\*Projected PCS Admissions = Projected Waitlist Clients + Projected PCS Clients

Figure 3. 2013-2016  
Percent of Time on Waitlist Status



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

Figure 4. 2013-2016  
Patients on Hospital Transfer Waitlist

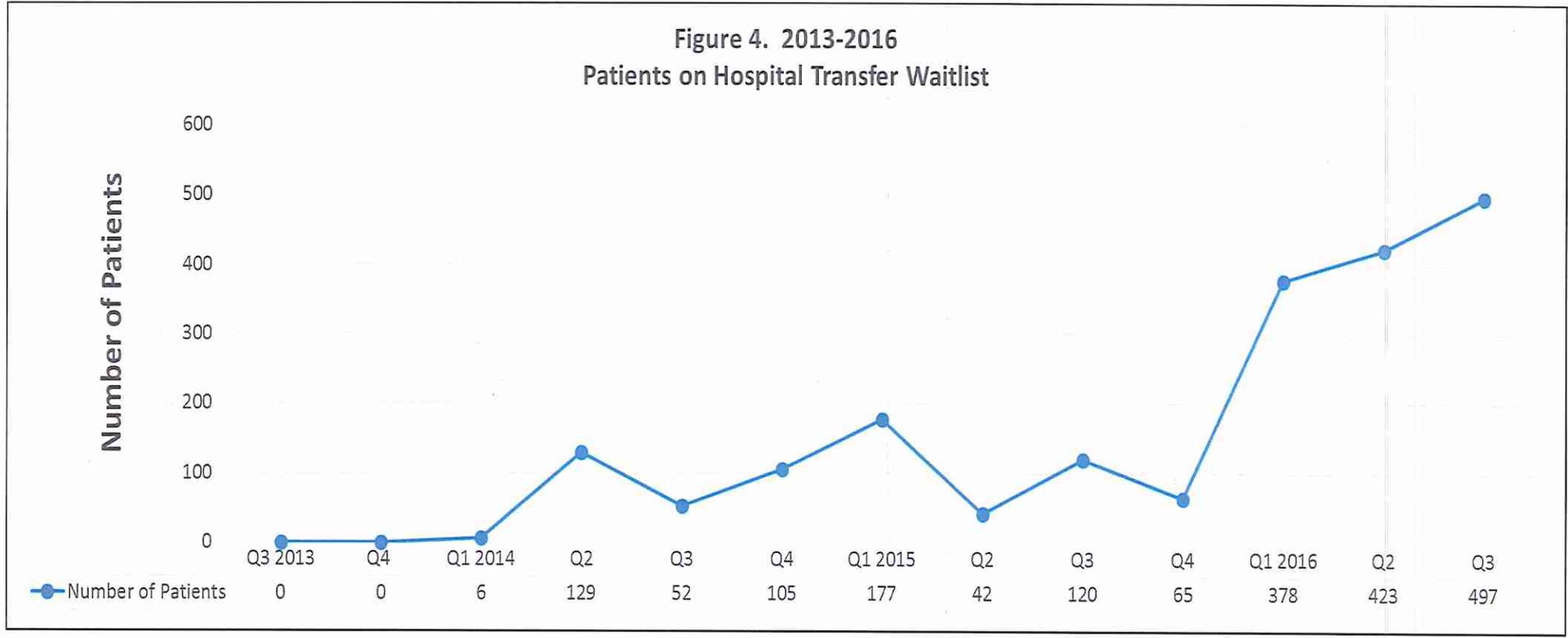


Figure 5. Waitlist Events  
2013-2016



Figure 6. 2013-2016  
Average Duration of Event  
(Hours)

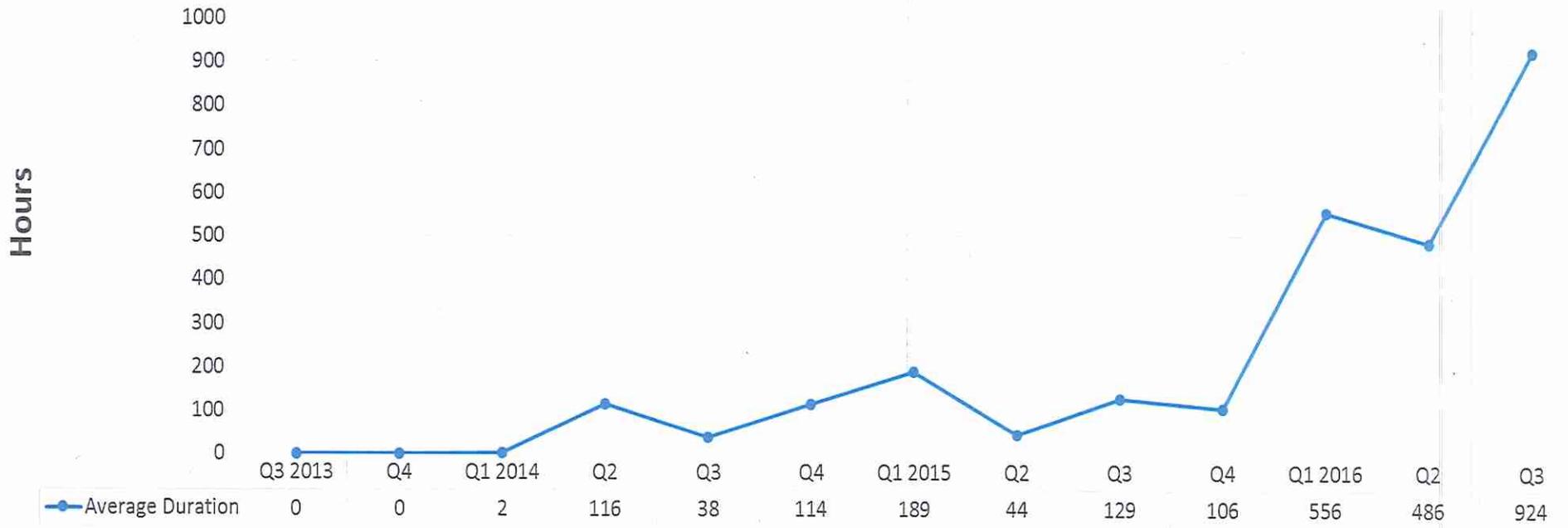


Figure 7. 2013 - 2016  
Median Wait Time For Individuals Delayed  
(Hours)



Figure 8. 2013-2016  
Average Length of Waitlist For Individuals Delayed  
(Hours)

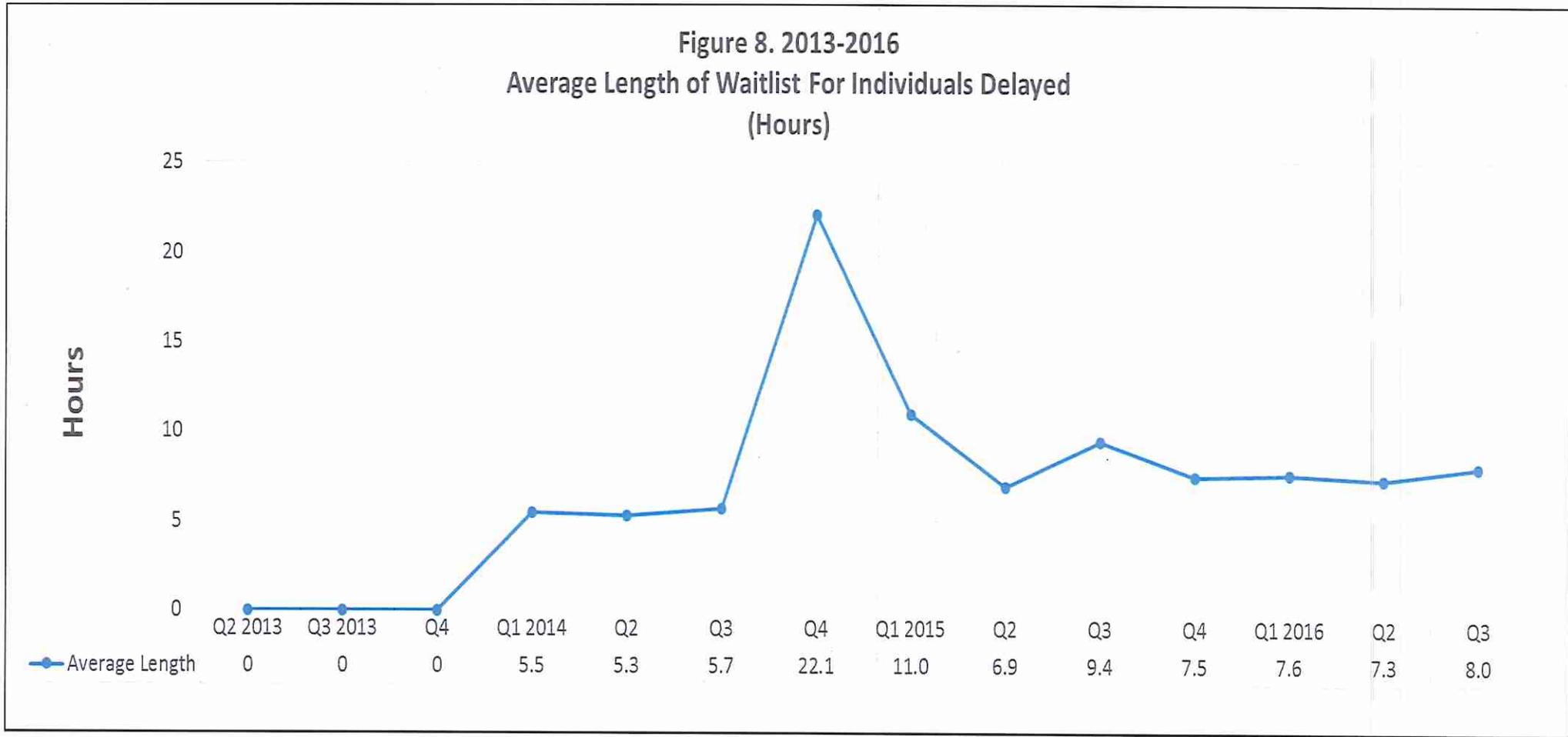
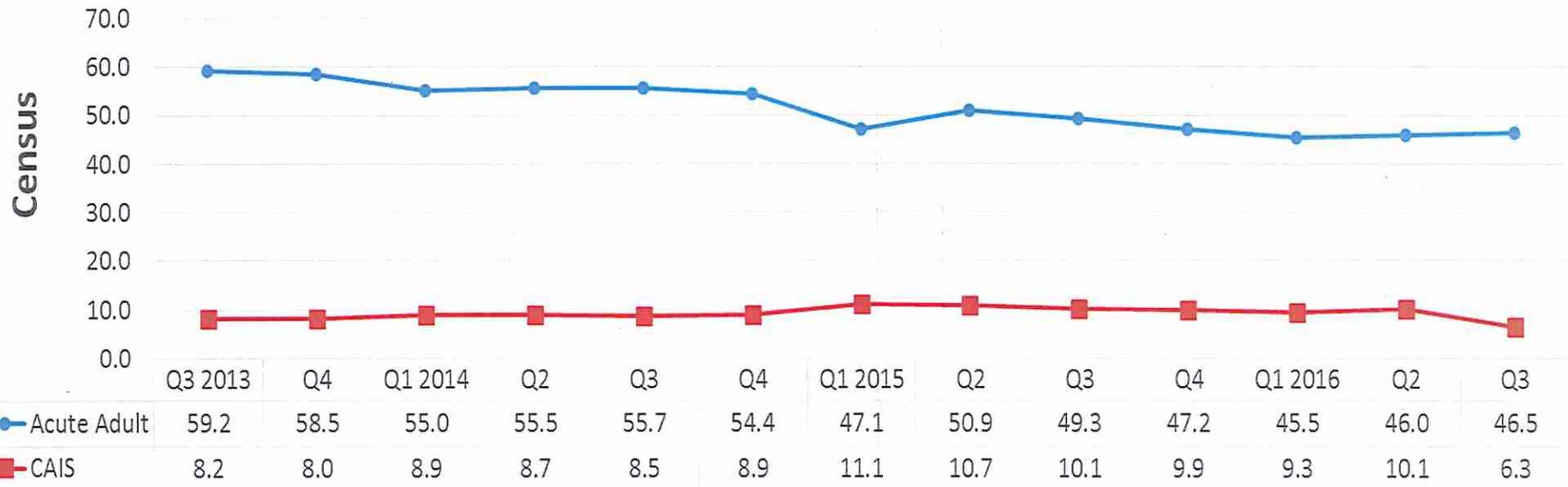
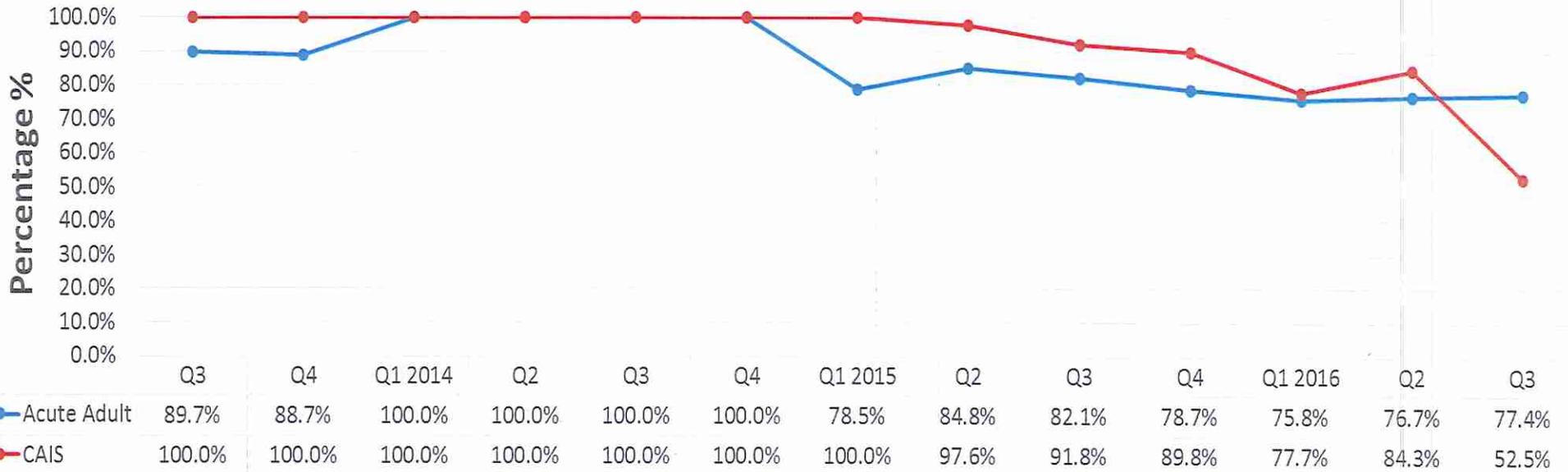


Figure 9. 2013-2016  
Acute Adult/CAIS  
Average Daily Census



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

Figure 10. 2013-2016  
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. 2013-2016**  
**Number of patients on waitlist for 24 hours or greater**

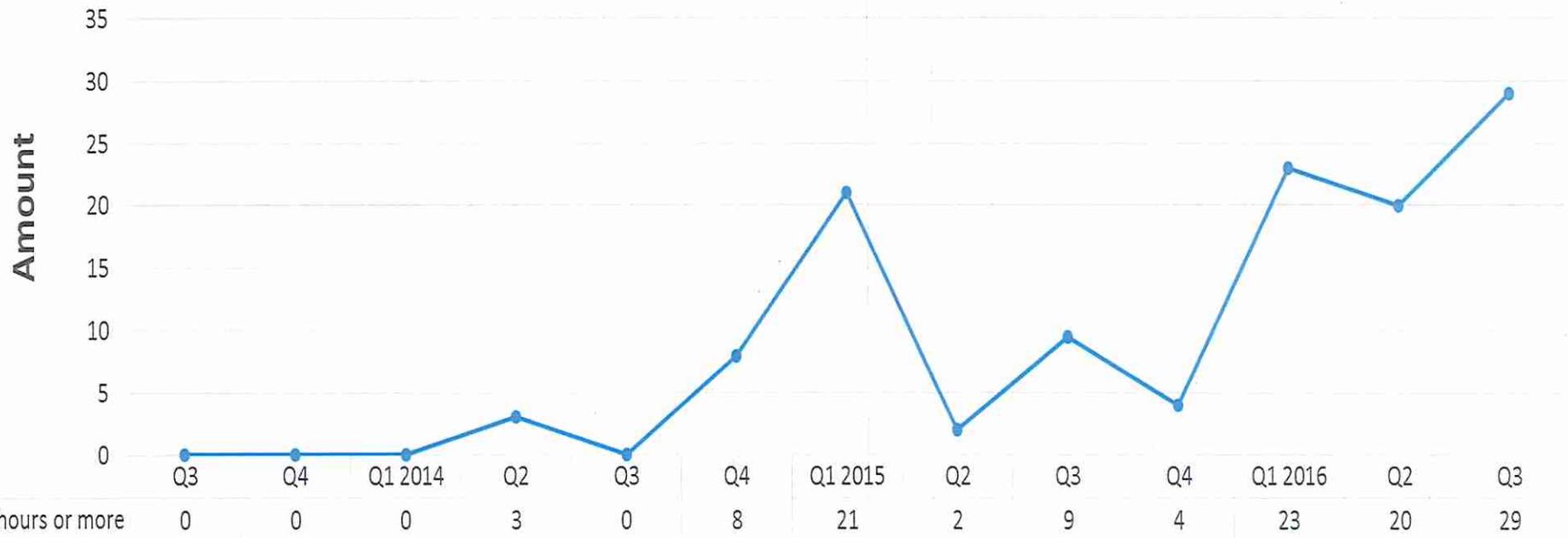
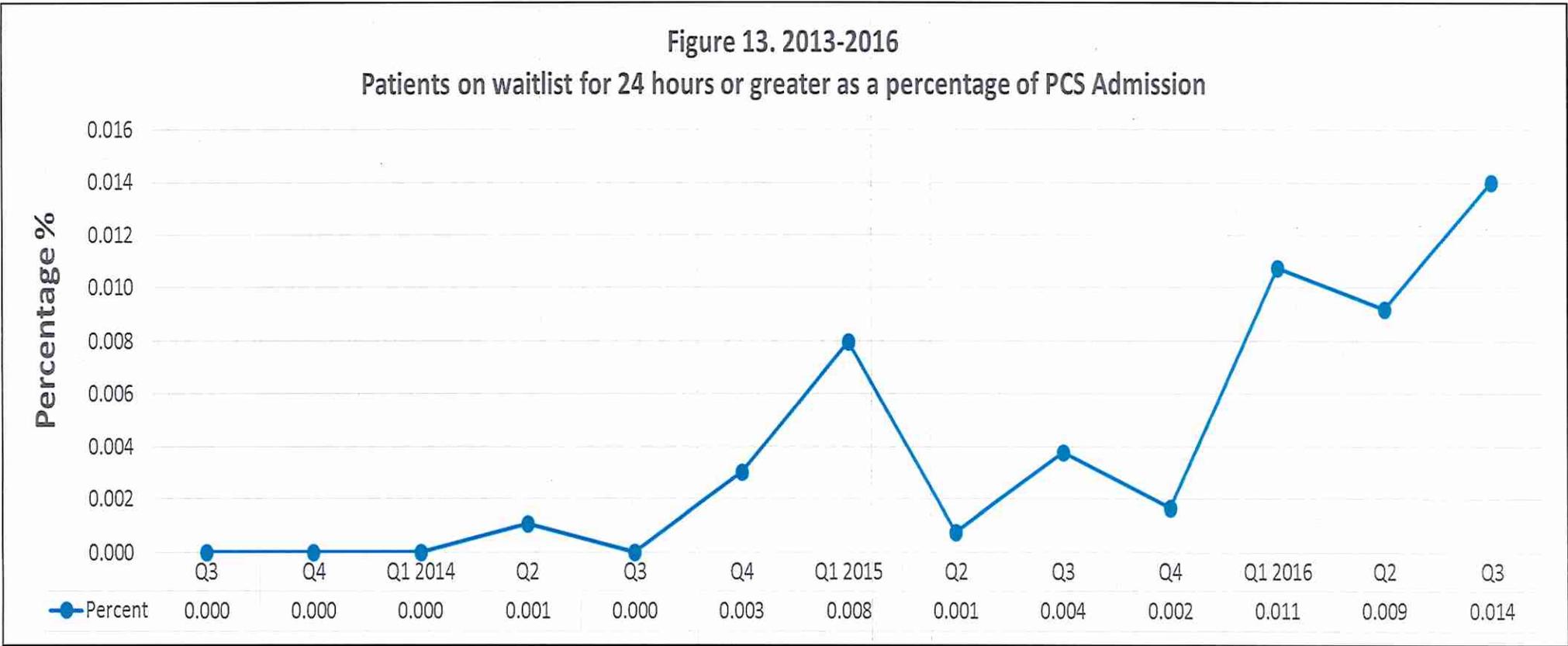


Figure 12. 2013-2016  
Patients on waitlist for 24 hours or greater as a percentage of number of clients waitlisted



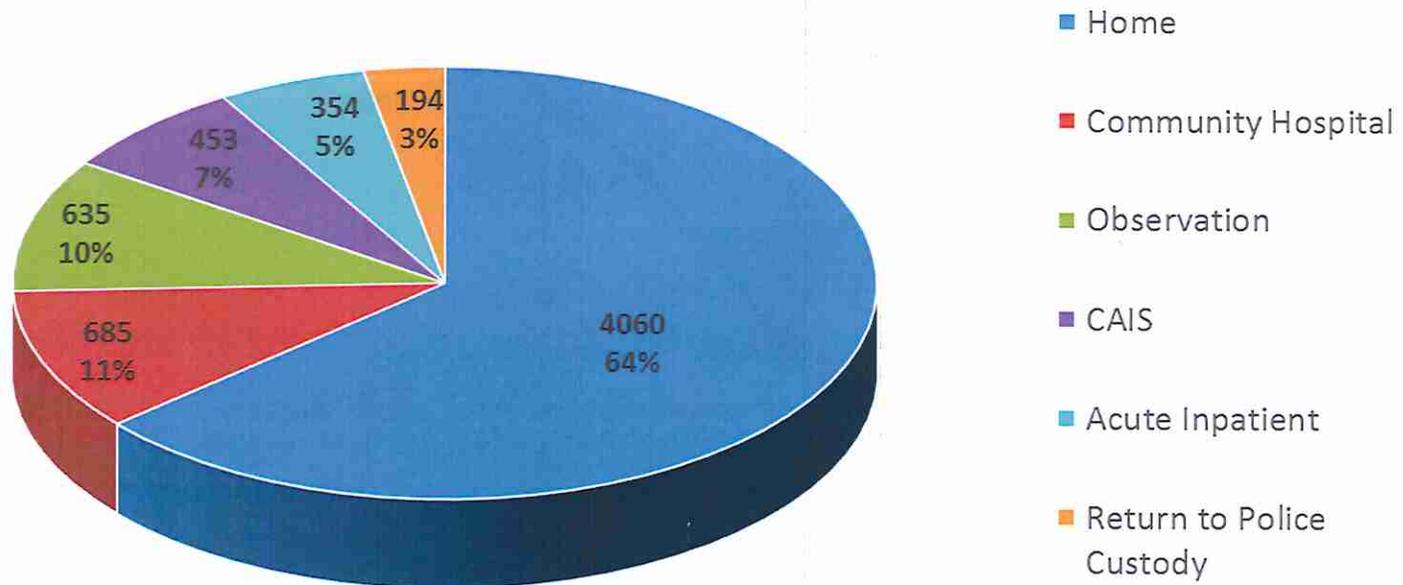
\*Percent = Number of Patients on waitlist for 24 hours or greater/Number of Clients Waitlisted

Figure 13. 2013-2016  
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. 2016 (January 1 to September 30)  
Disposition of all PCS admission



Milwaukee County Mental Health Board  
Quality Committee

2017 Meeting Schedule

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March 6, 2017

June 5, 2017

\*September 11, 2017

December 4, 2017

**All dates fall on the first Monday of the month.**

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

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