Milwaukee County Behavioral Health Division
2020 Key Performance Indicators (KPI) Dashboard

2

Program	Item	Measure	2017 Actual	2018 Actual	2019 Actual	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	2020 Actual	2020 Target	2020 YTD Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs[5]	8,346	9,393	10,049	6,362	6,266				9,500		
		Sample Size for Rows 2-6 (Unique Clients)				3,557	3,052						
	2	Percent with any acute service utilization[6]	17.40%	17.05%	20.13%	20.36%	18.96%				16.35%		
	3	Percent with any emergency room utilization[7]	13.87%	14.60%	16.37%	15.67%	14.87%				13.64%		
	4	Percent abstinence from drug and alcohol use	63.65%	63.65%	62.99%	63.25%	65.14%				64.18%		
	5	Percent homeless	7.61%	9.18%	9.60%	10.67%	9.87%				8.84%		
	6	Percent employed	18.09%	20.06%	19.04%	19.03%	16.57%				20.27%		
		Sample Size for Row 7 (Admissions)				1,726	1,770						
	7	Percent of all admissions that are 7 day readmissions	59.55%	60.12%	50.67%	53.82%	61.75%				49.00%		
Wraparound	8	Families served by Children's Mental Health Services and Wraparound (unduplicated count)	3,404	2,955	2,872	2,106	2,020				3,145		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5) (Wrap HMO)	4.8	4.60	4.5	4.4	4.8				> = 4.0		BHD (2)
	10	Out of Home Recidivism Rate (Wraparound HMO)				23	20.0%				<= 30		BHD (2)
	11	Youth and Parent Report of "How Well They Are Doing" at Disenrollment (Wrap HMO)				4.0	3.95				> = 4.0		BHD (2)
	12	Percentage of Youth who have achieved permanency at disenrollment	57.8%	58.0%	53.1%	76.2%	81.9%				> = 75%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Teams	44.1%	38.4%	33.2%	24.3%	26.6%				> = 40%		BHD (2)
	14	Average Cost per Month			$2,706	$2,602	$2,363						BHD (2)
Crisis Service	15	PCS Visits	8,001	7,375	7,492	1,730	Please refer to the new 2020 Q2 Milwaukee County Behavioral Health Division Inpatient Dashboard dated 7-15-20			6,920	8,000		BHD (2)
	16	Emergency Detentions in PCS	3,979	3,023	3,227	723				2,892	4,000		BHD (2)
	17	Percent of patients returning to PCS within 3 days	7.3%	7.5%	9.6%	6.7%				6.7%	8%		BHD (2)
	18	Percent of patients returning to PCS within 30 days	23.1%	24.0%	26.1%	22.4%				22.4%	24%		BHD (2)
	19	Percent of time on waitlist status	75.2%	83.2%	100.0%	100.0%				100.0%	50%		BHD (2)
Acute Adult Inpatient Service	20	Admissions	656	770	693	185	Please refer to the new 2020 Q2 Milwaukee County Behavioral Health Division Inpatient Dashboard dated 7-15-20			740	800		BHD (2)
	21	Average Daily Census	42.9	41.8	40.5	41.8				41.8	54.0		BHD (2)
	22	Percent of patients returning to Acute Adult within 7 days	1.4%	1.6%	2.5%	2.1%				2.1%	3%		BHD (2)
	23	Percent of patients returning to Acute Adult within 30 days	7.7%	6.6%	9.0%	8.2%				8.2%	9.6%		WI DHS
	24	Percent of patients responding positively to satisfaction survey	74.0%	74.8%	74.8%	71.5%				71.5%	75.0%		NRI (3)
	25	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	65.2%	64.7%	65.6%				65.6%	65%		BHD (2)
	26	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.51	0.51	0.38				0.38	0.38		CMS (4)
	27	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.28	0.19	0.22				0.22	0.29		CMS (4)
	28	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	21.5%	24.7%	26.7%				26.7%	9.5%		CMS (4)
	29	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	95.8%	95.3%	98.0%				98.0%	90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	30	Admissions	709	644	660	132	Please refer to the new 2020 Q2 Milwaukee County Behavioral Health Division Inpatient Dashboard dated 7-15-20			528	800		BHD (2)
	31	Average Daily Census	8.6	7.5	7.5	6.9				6.9	12.0		BHD (2)
	32	Percent of patients returning to CAIS within 7 days	5.2%	3.4%	6.6%	2.9%				2.9%	5%		BHD (2)
	33	Percent of patients returning to CAIS within 30 days	12.3%	12.4%	16.7%	9.3%				9.3%	9.6%		WI DHS
	34	Percent of patients responding positively to satisfaction survey	71.3%	71.1%	75.7%	70.2%				70.2%	75%		BHD (2)
	35	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	74.2%	83.5%	75.0%				75.0%	75%		BHD (2)
	36	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.18	1.60	0.72				0.72	0.38		CMS (4)
	37	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.47	0.33	0.08				0.08	0.29		CMS (4)
	38	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.1%	1.4%	2.9%				2.9%	3.0%		CMS (4)
	39	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	85.7%	88.9%	75.0%				75.0%	90.0%		BHD (2)
Financial	40	Total BHD Revenue (millions)	$149.9	$154.9							$149.7		
	41	Total BHD Expenditure (millions)	$207.3	$213.5							$208.2		

Notes:

(1) 2018 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

BHD KPI Report Q2 2020

Children's Community Mental Health Services and Wraparound Milwaukee

Report Overview

Unique Families Served

2,020

Children's Community Mental Health Services and Wraparound Milwaukee is a unique system of care for children with serious emotional, behavioral, and mental health needs and their families.

This report seeks to present information about quality care, costs, and outcomes framed by Wraparound values and DHHS values.

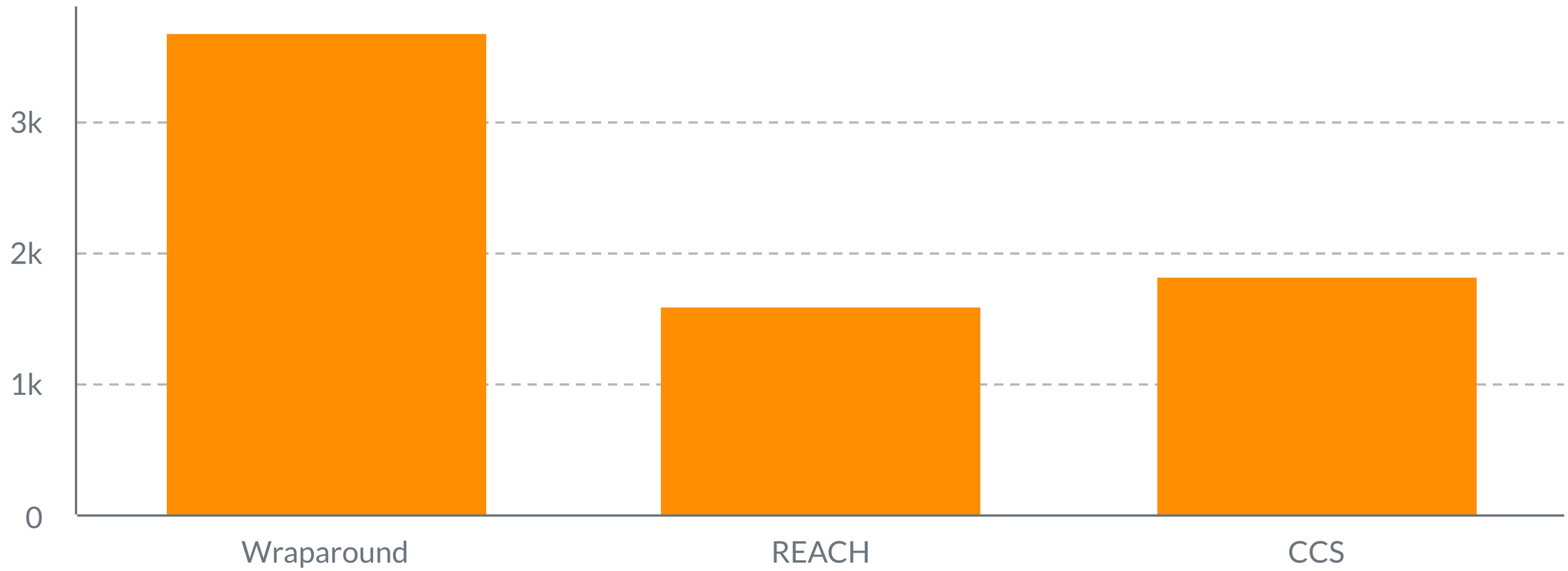
Average Cost of Care - average cost of care per family per month by program in the past quarter

Population Health Metrics - social support, home placement stability, and out-of-home recidivism

Outcomes - overall satisfactions, functionality, permanency at discharge, natural supports, and how well youth/caregiver is doing at discharge

Future iterations will include experience of care surveys which align to the following values: unconditional care, family/person-centered care, collaboration, and culturally competent care.

Average Cost Per Family

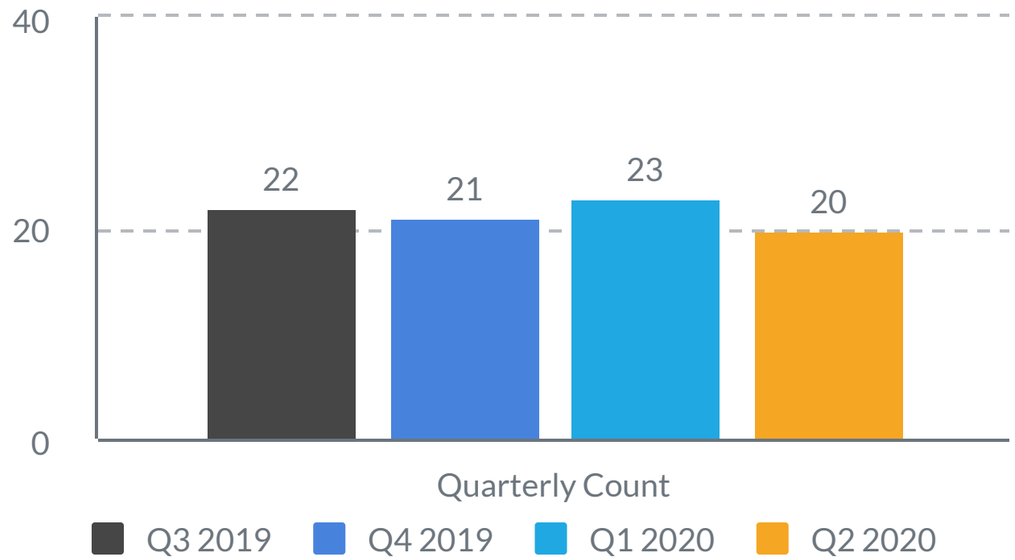


Wraparound	REACH	CCS
3,682	**1,595**	**1,814**

Average costs are based on the services utilized per family per month in the past quarter in Wraparound, REACH, and CCS.

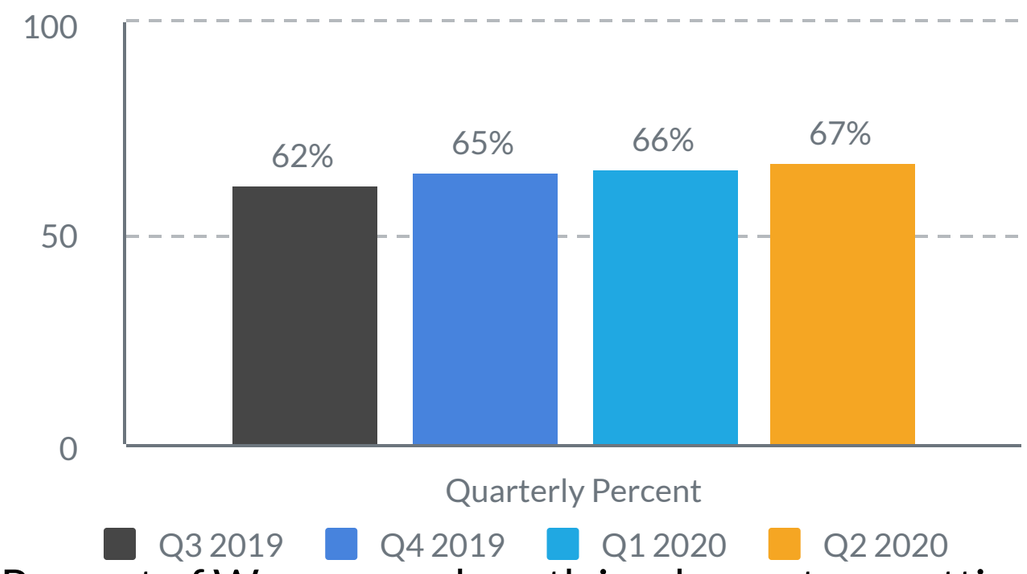
Population Health

Out of Home Recidivism Rate



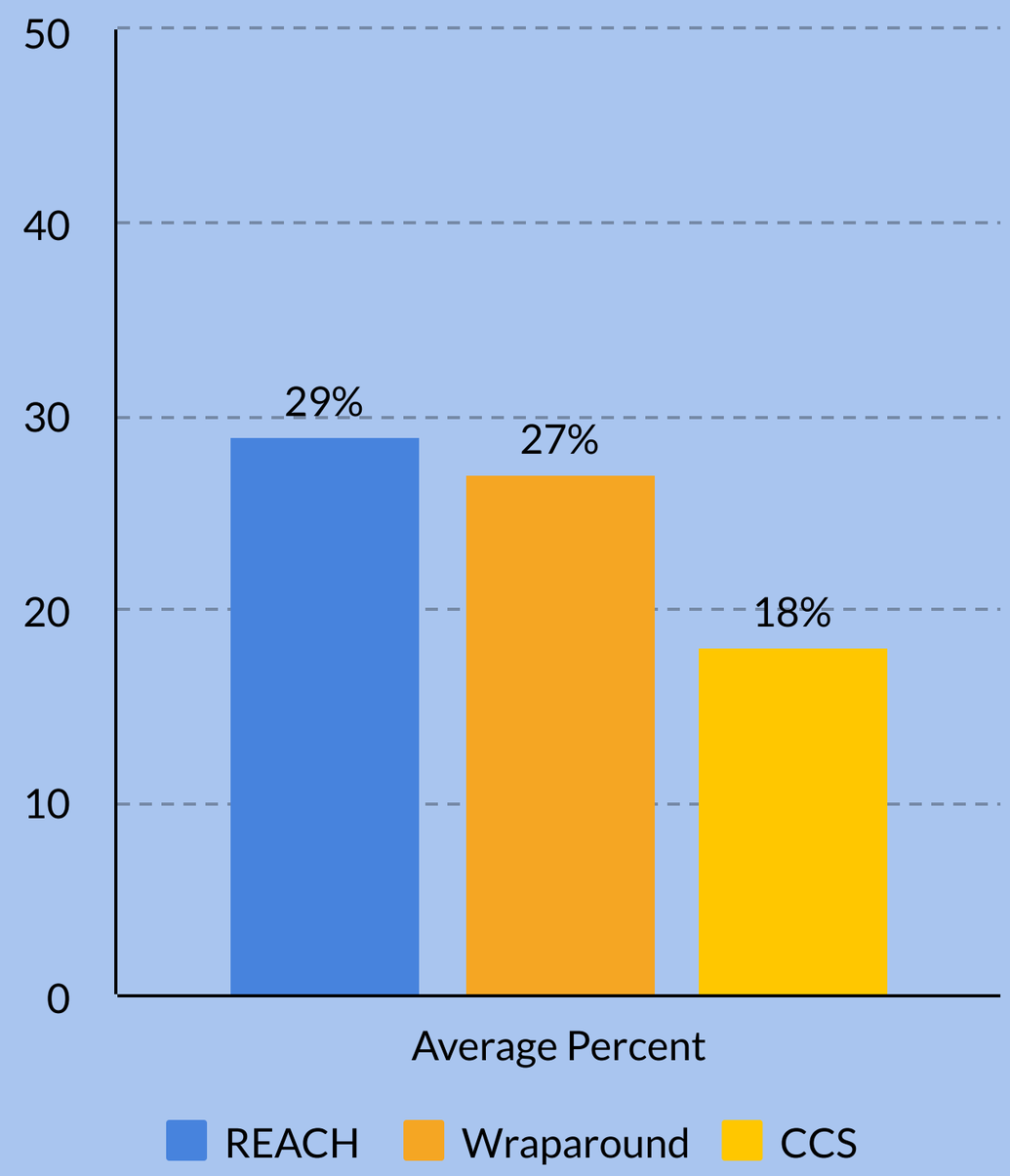
Number of youth in Wraparound and REACH who moved from a home-type setting to an out of home type setting within each quarter displayed.

Legal Permanency Stability Rate



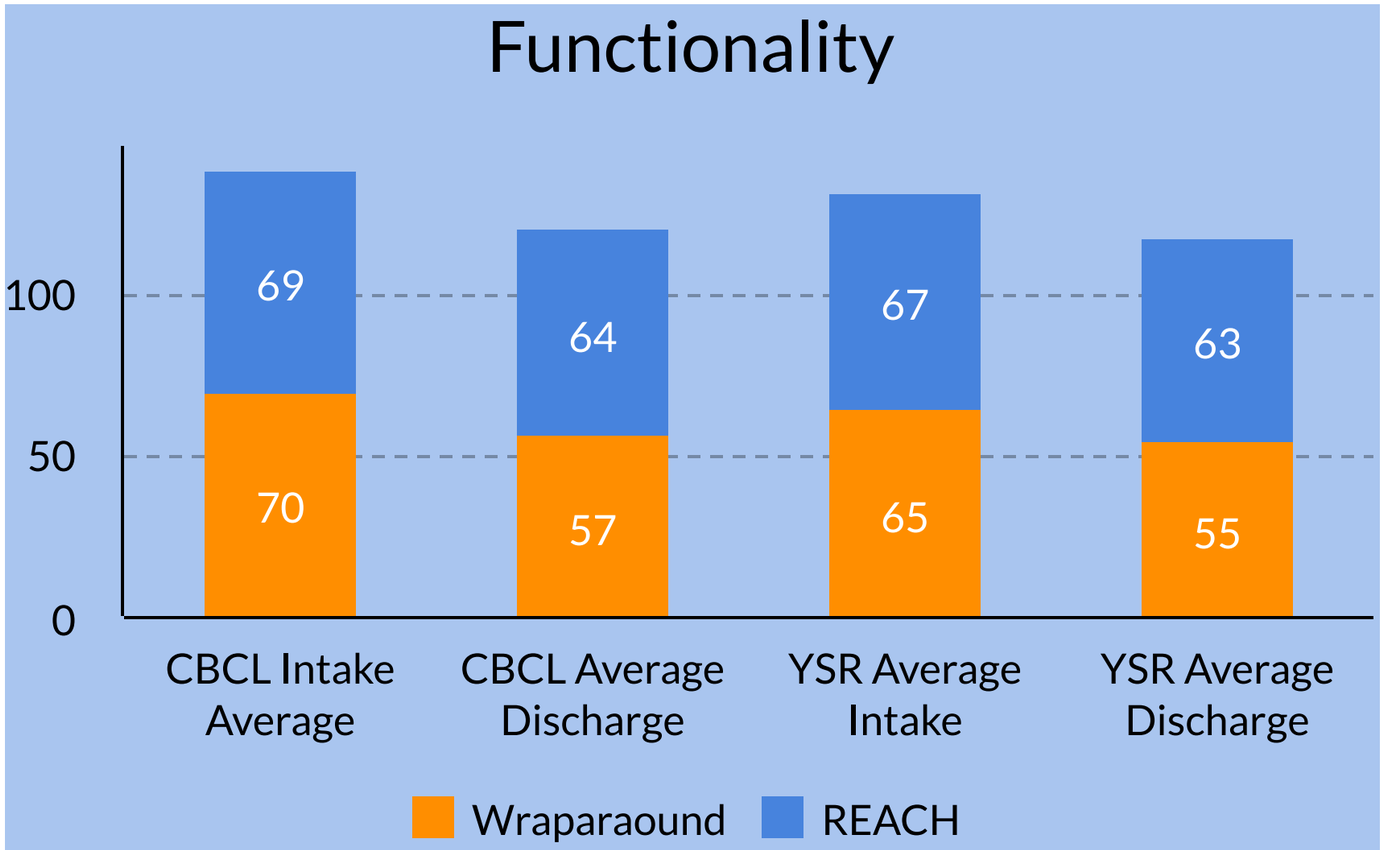
Percent of Wraparound youth in a home-type setting in the past four quarters.

Percent of Natural Supports



Average percent of informal supports on teams in the past quarter.

Outcomes



Average functionality scores of youth and their caregivers discharged in the past quarter. Data accounts for intake score averages and the last scores recorded among youth discharged from Wraparound and REACH in the past quarter. Please note that decreased scores upon discharge is good!

Permanency at Discharge

81.94%

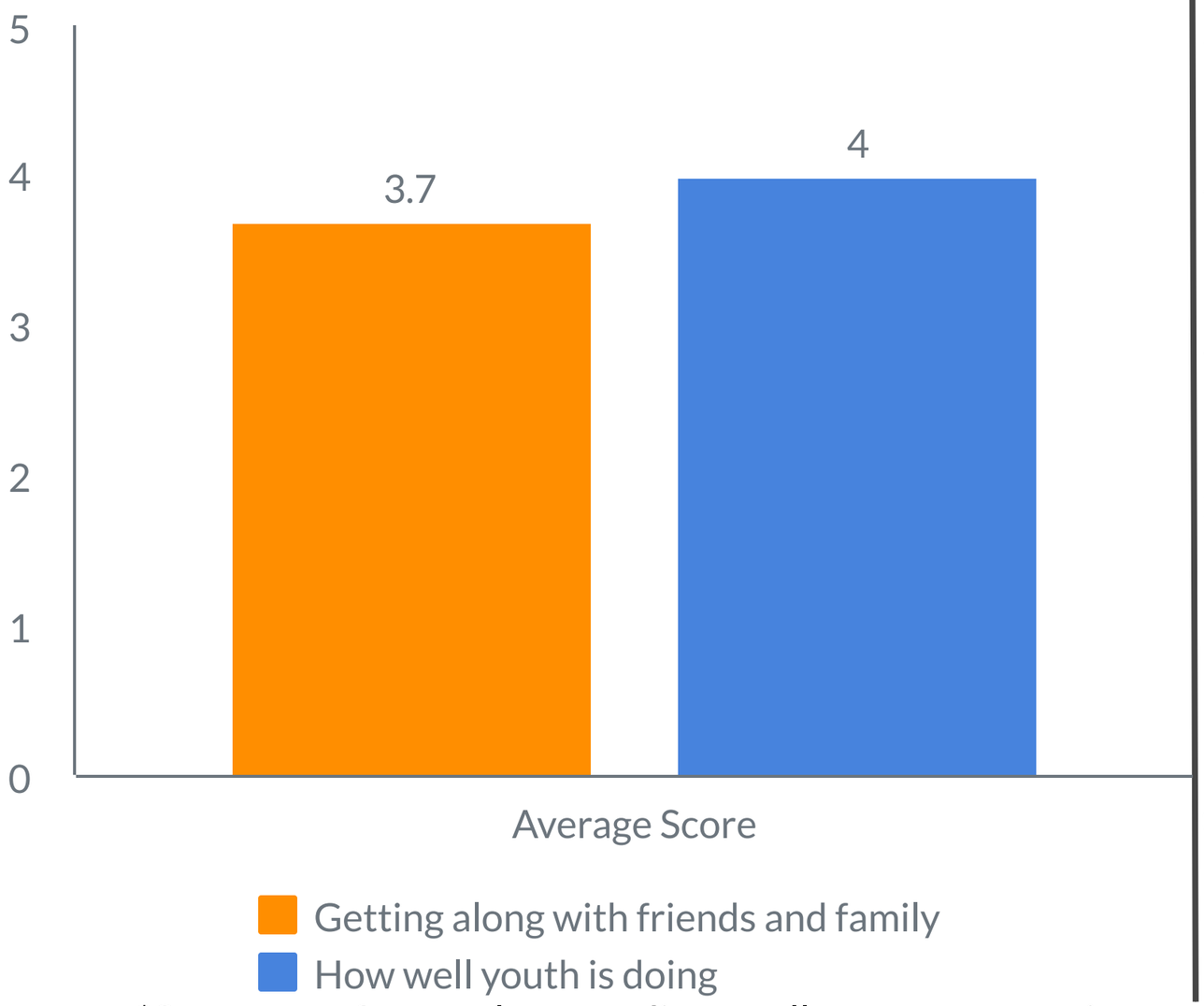
Percent of discharged youth placed in a home-type setting. Includes Wraparound, REACH, and CCS in the past quarter.

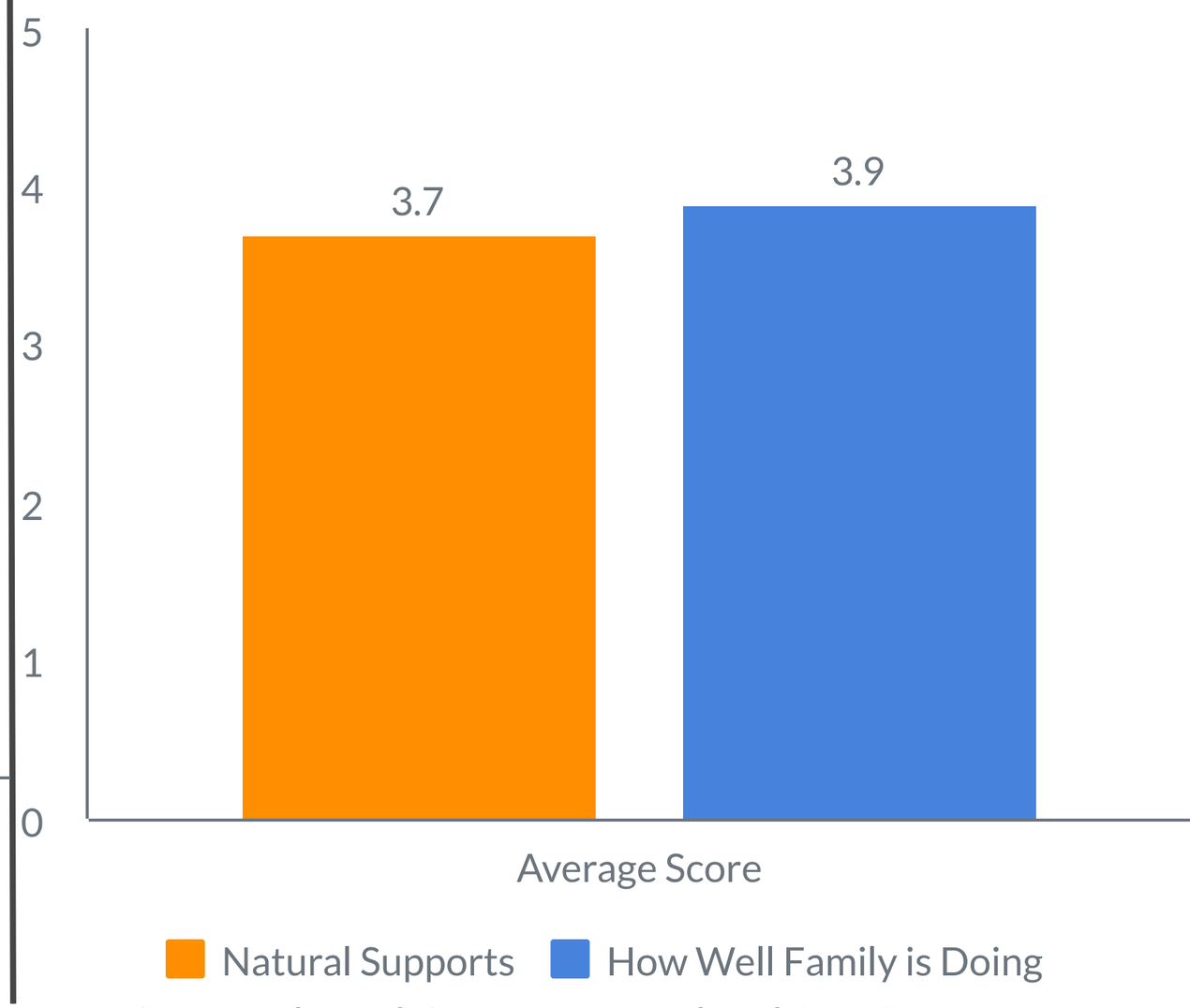
Family Satisfaction Overall Average Score

4.8

For Wraparound and REACH families in the past quarter

Wraparound and REACH Perceived Outcomes





*Scores are from voluntary dis-enrollment surveys given to caregivers and youth in Wraparound and REACH programs in the past quarter. These categories can be found on the annual CCS survey: MHSIP.

Wraparound Discharges	REACH Discharges	CCS Discharges
58	47	22

4a/b

MILWAUKEE COUNTY Behavioral Health Division

CARS Quality Dashboard Quarter 2 of 2020

CARS Research & Evaluation Team

The Framework: The Quadruple Aim

The patient experience of care encompasses the range of interactions that patients have with the healthcare system and includes several aspects of healthcare delivery, including satisfaction, timely appointments, and easy access to information, among others (AHRQ, 2017).

"Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group " (Kindig and Stoddart, 2003).

The total cost of care a patient receives across all settings and services, often presented as cost per member of the population per month (Stiefel & Nolan, 2012).

The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

CARS QUALITY DASHBOARD SUMMARY Q2 2020

A NEW FOCUS: RACIAL EQUITY

Racial disparities in health and social determinants of health are pervasive throughout the United States. Evidence indicates that, relative to whites, Blacks have higher rates of premature and infant mortality, poorer self-rated health, higher rates of unemployment, higher rates of substandard housing, lower rates of high school completion, and rates of poverty nearly three times greater. These disparities extend to healthcare, as research has found lower rates of access, poorer care quality, and even implicit racial bias among providers, which can negatively impact the experience of care for Black patients. Many of these inequities are particularly pronounced in Milwaukee County, with an average age of death for Black citizens that is nearly 14 years lower than that of whites (61.33 and 75.22, respectively) and an infant mortality rate that is more than twice that of white infants. In 2019, the Milwaukee County Executive, the Milwaukee Count Common Council, and the city of Milwaukee passed a resolution declaring racism to be a public health crisis.

In support of this resolution, the CARS Research and Evaluation Team asserts the following: 1) We believe in the inherent value and dignity of each individual we serve. 2) We believe everyone has the right to strive to achieve their best quality of life. 3) We believe everyone has a right to effective and timely health care. 4) We believe that a fair and just system of care does not systematically disadvantage one group over another. These beliefs are at the foundation of three guiding principles:

1. ***Our commitment to equity embraces all forms of diversity.***
2. ***Equity is not simply something that we do, it must reflect who we aspire to be.***
3. ***An equity gap is a quality gap that must be acknowledged and addressed.***

The realization of these principles means that we seek to cultivate a culture of equity that is explicitly embedded in our professional and organizational philosophy. We understand, however, that a verbal commitment to equity rings hollow without the actions to support it. On the CARS Research and Evaluation Team, we believe that one of the practical, immediate ways we can contribute to this vital mission is by leveraging data to identify and highlight any disparities that exist.

Therefore, beginning this quarter, the CARS Research and Evaluation Team will begin to disaggregate several key metrics by race in every category of the Quadruple Aim on the CARS Quarterly Dashboard. We intend to have this disaggregation complete by the winter meeting of the Mental Health Board Quality Committee. Further, these disaggregated metrics will be given place of preference in the Quarterly Dashboard, presented as the first set of statistics in each "Aim," rather than relegated to back page "supplementary analyses."

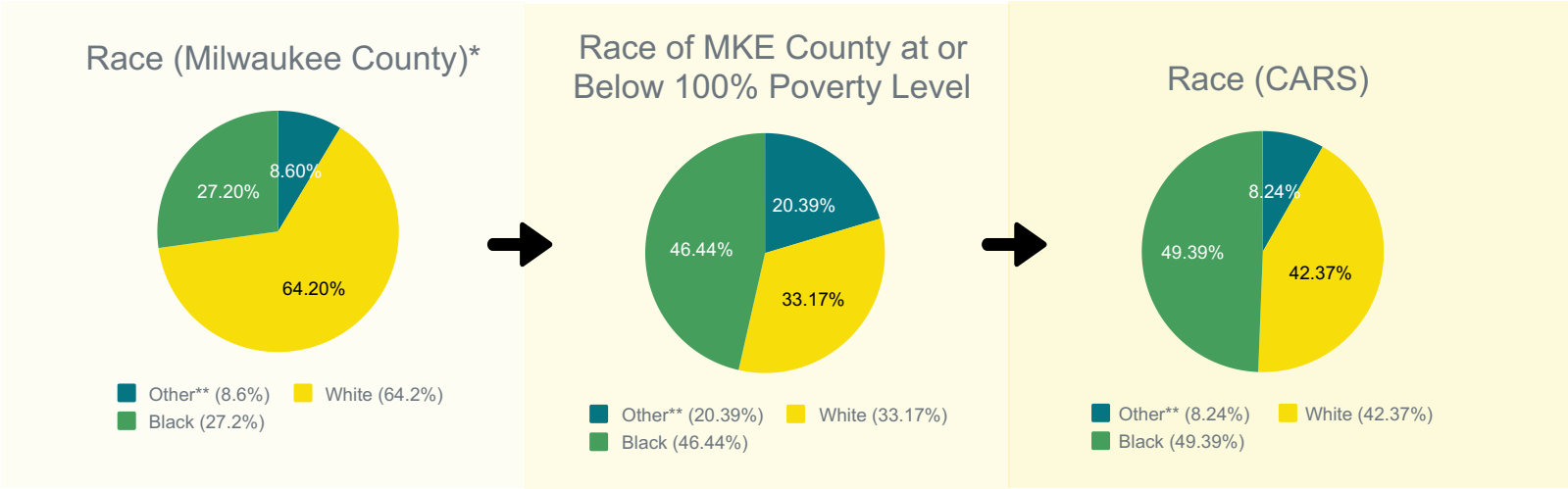
We believe these changes will help us to identify existing disparities of which we may not be aware and will allow us to monitor for the development or exacerbation in disparities in any of these key metrics over time. We hope they will raise awareness, drive quality improvement projects, and help to make the concept of equity part of our daily language and workplace culture. Perhaps most importantly, however, these revisions reflect the commitment of CARS to place equity and racial justice front and center in the work we do. It is, therefore, our perspective that equity is both a moral and scientific issue. *It is our conviction that true, comprehensive quality of care and true, universal population health cannot be achieved without equity.* Let's get to work.

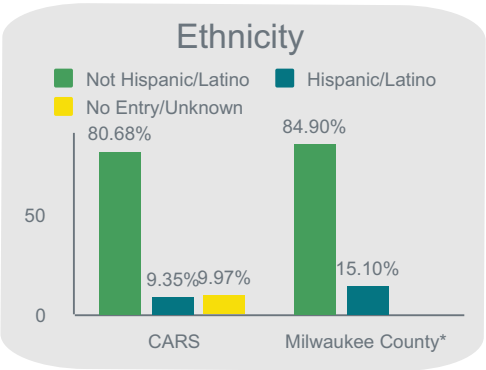
Looking at our Metrics with a Racial Equity Lens

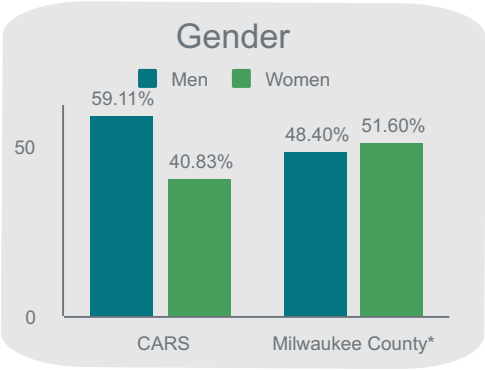
Q2-2020 data unless noted

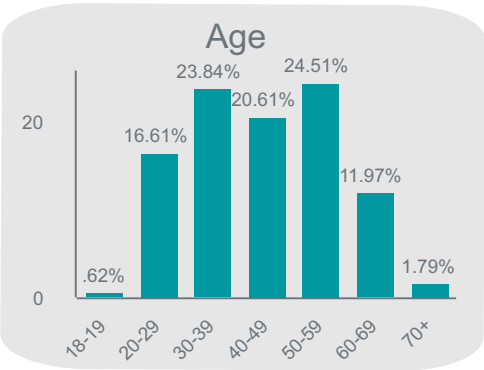
Demographic Information of the Population We Serve

This section outlines demographics of the consumers CARS served last quarter compared to the County population.









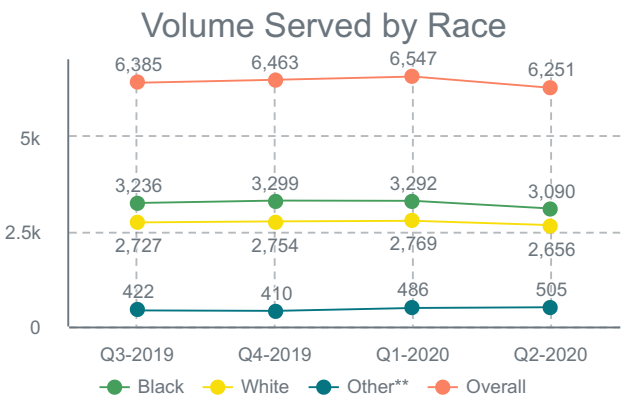
*Comparable data from United States Census Bureau, which can be found at: https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/PST045217#qf-flag-Z

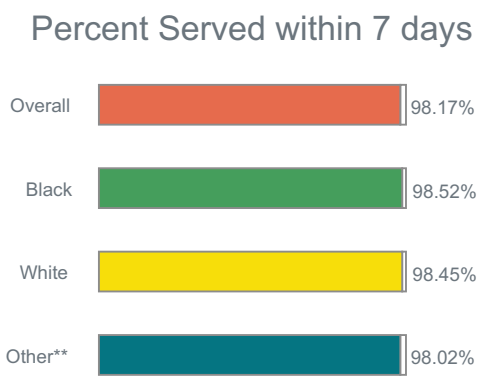
**"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Biracial", "Native Hawaiian/Pacific Islander", and "Other"

Domain: Patient Experience of Care

Volume Served

Timeliness of Access



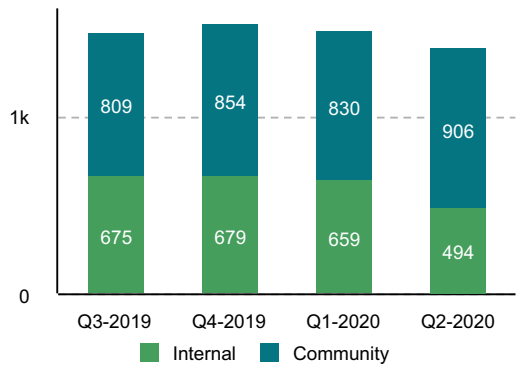


Domain: Patient Experience of Care (cont.)

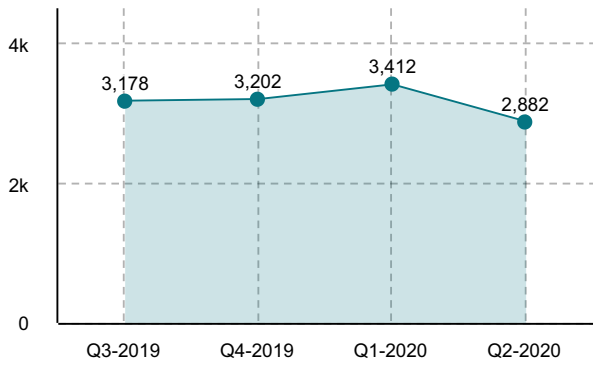
Average Consumer Satisfaction Score (Range of 1-5)

159	3.80	3.85	3.61
client experience surveys received in Q2 2020	average for all consumers (n=159)	average for Black consumers (n=92)	average for white consumers (n=48)

Referrals



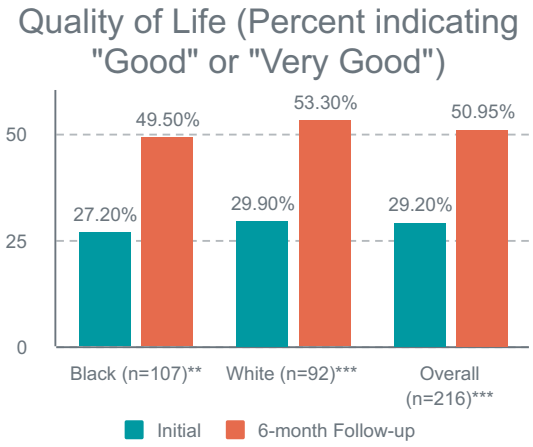
Admissions



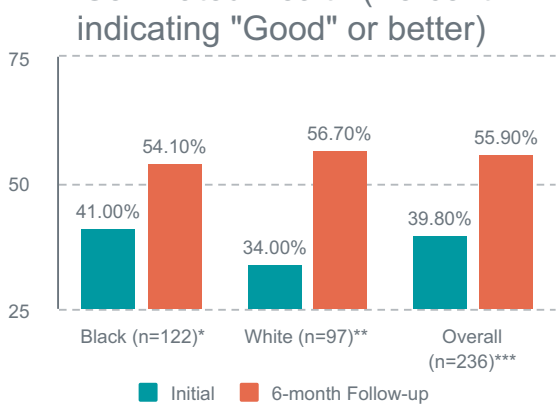
Domain: Population Health

Change Over Time

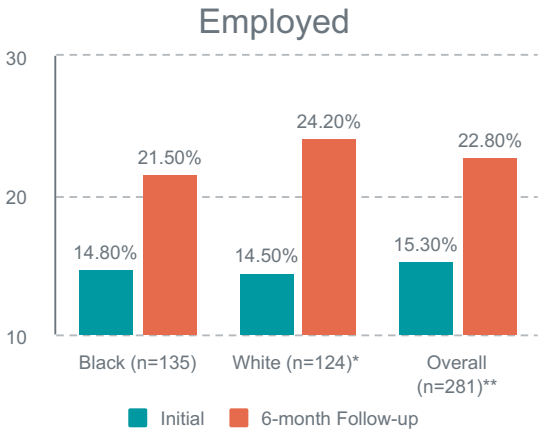
Quality of Life



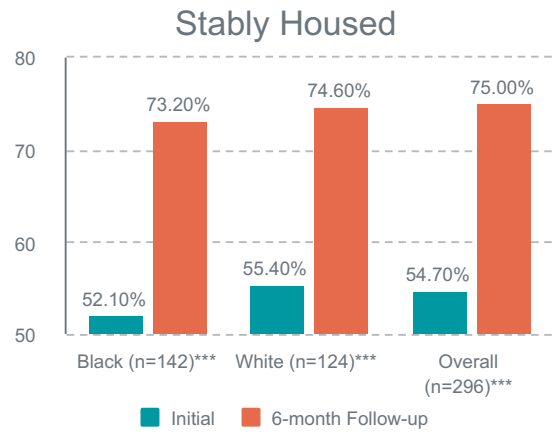
Self-Rated Health



Employed



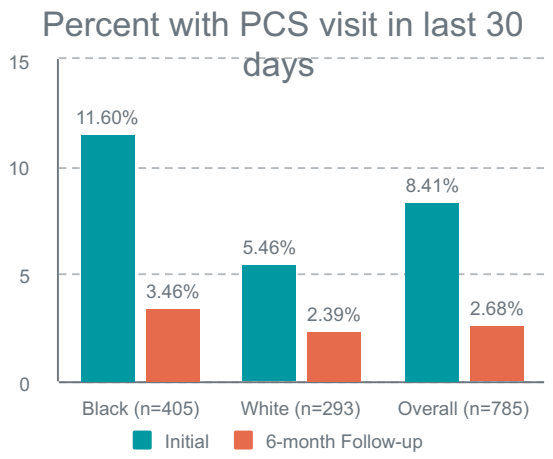
Stably Housed



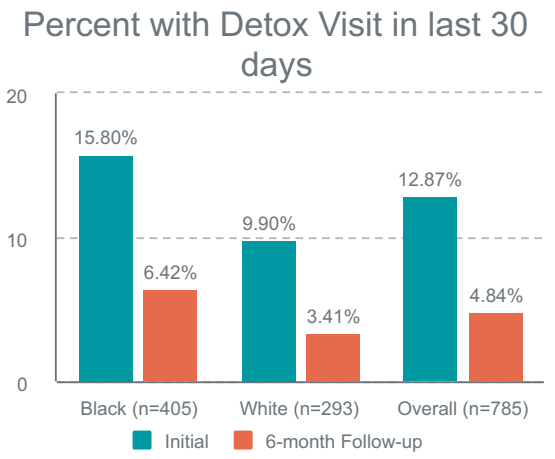
*p<.05 **p<.01 ***p<.001

Change Over Time

PCS visits

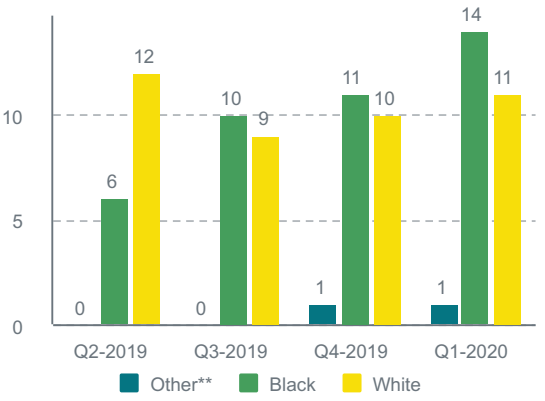


Detox Visits



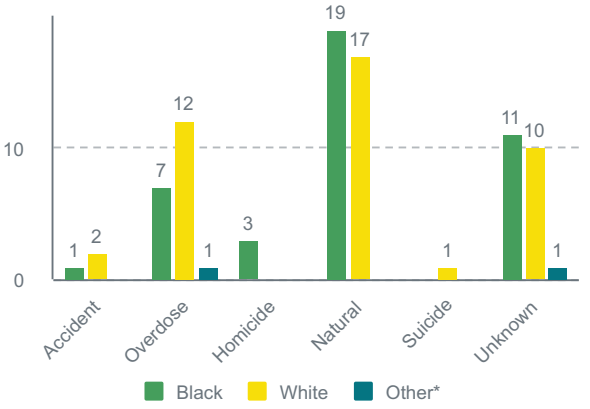
Mortality Over Time by Race

one quarter lag in reporting



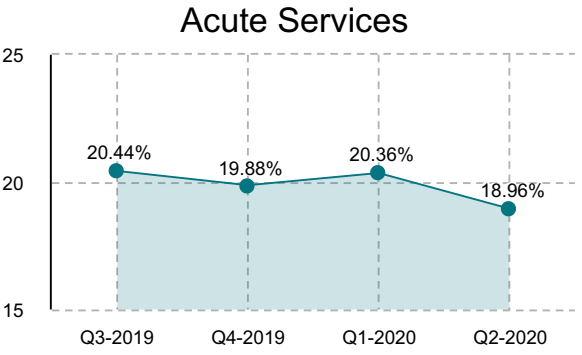
Cause of Death by Race

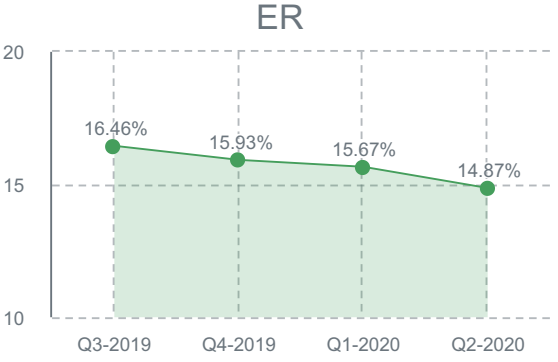
for deaths between Q2-2019 and Q1-2020



Acute Service Utilization

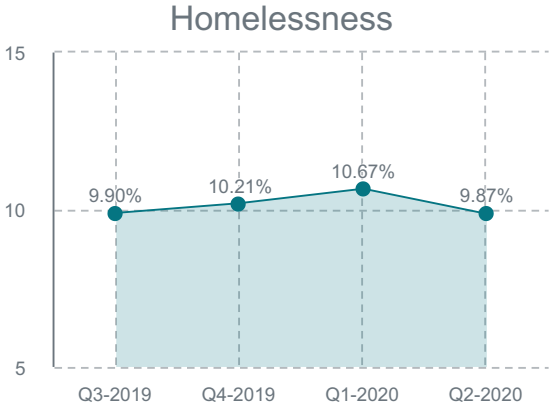
ER Utilization

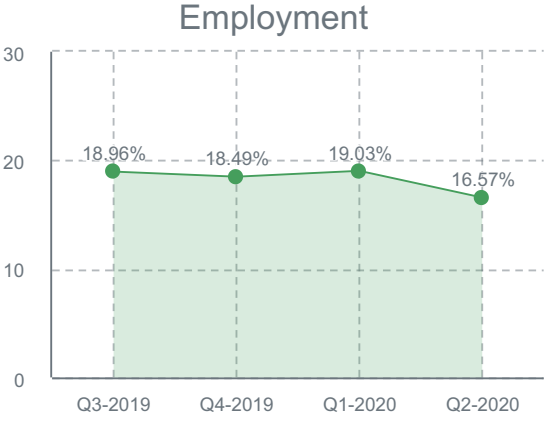




Homelessness

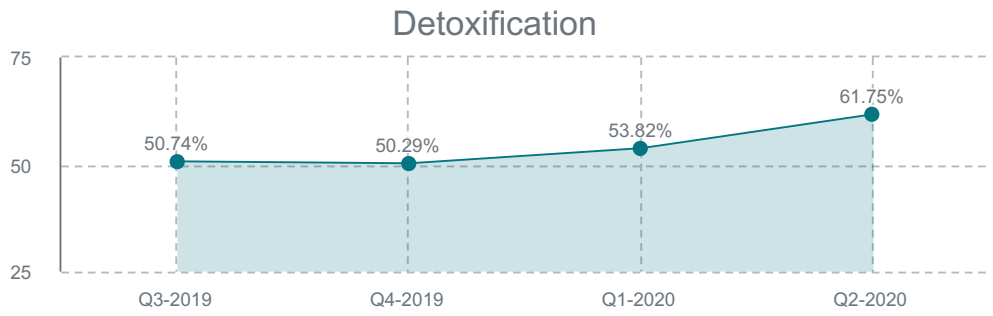
Employment



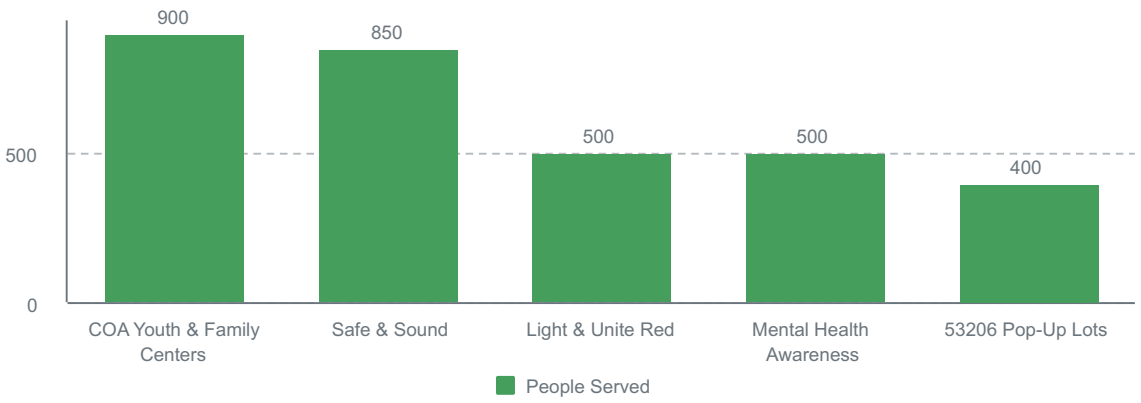


Domain: Population Health (cont.)

Detoxification 7-Day Readmissions



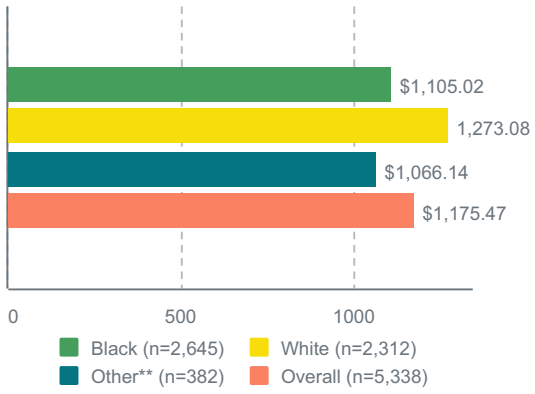
Top Prevention Initiatives



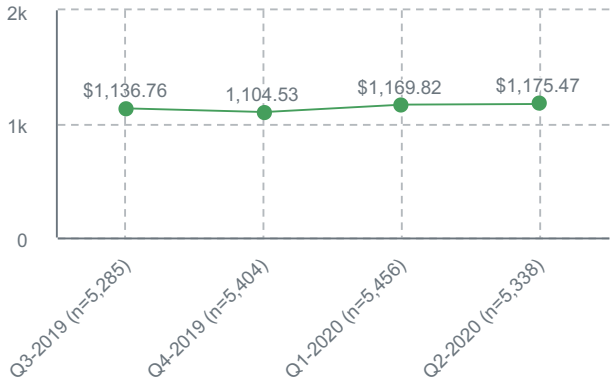
Domain: Cost of Care

Average Cost per Consumer per Month for Q2 by Race

"n" refers to an average of the number of unique consumers served per month for the quarter



Average Cost per Consumer per Month by Quarter



Domain: Staff Well-Being

Turnover

4.76%

CARS turnover rate

Staff Quality of Life

20.00%

Turnover rate for government employees (per year)*

In an effort to increase staff well-being during the COVID-19 pandemic, CARS staff have engaged in Staff Enrichment meetings. Several CARS staff have stepped up to present to their fellow colleagues on topics such as emotional intelligence, racial equity, and gratitude. These meetings have been informational and a great way for staff to connect with one another while working remotely. Staff Enrichment meetings take place every other Friday and will continue throughout the pandemic, and after we reconvene at BHD.

Metric Definitions

Acute Service Utilization	Percent of all unique clients who reported that they had received a psychiatric hospitalization, medical hospitalization, or detoxification service in the last 30 days.
Admissions	All admissions during the past four quarters (not unique clients, as some clients had multiple admissions during the quarter). This includes detoxification admissions.
Consumer Satisfaction	Implementation of the new, more succinct Client Satisfaction has begun. The survey ranges from 4-10 questions, depending on the program, and all questions range from 1="strongly disagree" to 5="strongly agree". The survey is currently being utilized in CCM, RSC, CLASP, and the Office of Consumer Affairs. CSP will begin implementing the survey in the next month.
Cost of Care	The average cost per consumer per month within each quarter for CARS services received by CARS consumers (not including inpatient and crisis). This is not separated out by funding stream or limited to those dollars spent by Milwaukee County on these services. The "n" is an average of the unique number of consumers served per month for the 3 months in the quarter in question.
Detoxification Re-admissions	Percent of consumers returning to detoxification within 7 days. This includes both Detoxification 75.07, as well as Detoxification 75.09 (Sober Up).
Employment	Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".
ER Utilization	Percent with any emergency room utilization. Includes any medical or psychiatric ER utilization in last 30 days.
Homelessness	Percent of all unique clients who reported their current living situation was "street, shelter, no fixed address, homeless".
Mortality Over Time	Mortality is a population health metric used by other institutions such as the Center for Disease Control, the U.S. Department of Health and Human Services, and the World Health Organization. The graph represents the total number of deaths by cause of death from the previous four quarters. There is a one quarter lag in death reporting.
Percent Served Within 7 days	Percentage of clientsper quarter who received a service within 7 days of their Comprehensive Assessment.
Prevention	Prevention is an important population health factor. Many prevention activities include evidence based practices and presentations. The top five prevention activities from the previous quarter are listed in the graphic.
Quality of Life	This is a self-reported measure based on the question on the Comprehensive Assessment. The graph shows the percentage of people that said that their quality of life was "good" or "very good".
Referrals	Total number of referrals at community-based and internal Access Points per quarter.
Self-Rated Health	This is a self-reported measure based on the question on the Comprehensive Assessment. The graph shows the percentage of people that said that their physical health was at least "good".
Stably Housed	Percent of clients who reported their current living situation as a permanent or supported residence.
Turnover	Turnover is calculated by looking at the total number of staff who have left over the previous four quarters, divided by the average number of employees per month, for the previous four quarters *Source: Bureau of Labor Statistics (https://www.bls.gov/news.release/jolts.t16.htm)
Volume Served	Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.

MILWAUKEE COUNTY Behavioral Health Division

BHD-Wide Dashboard

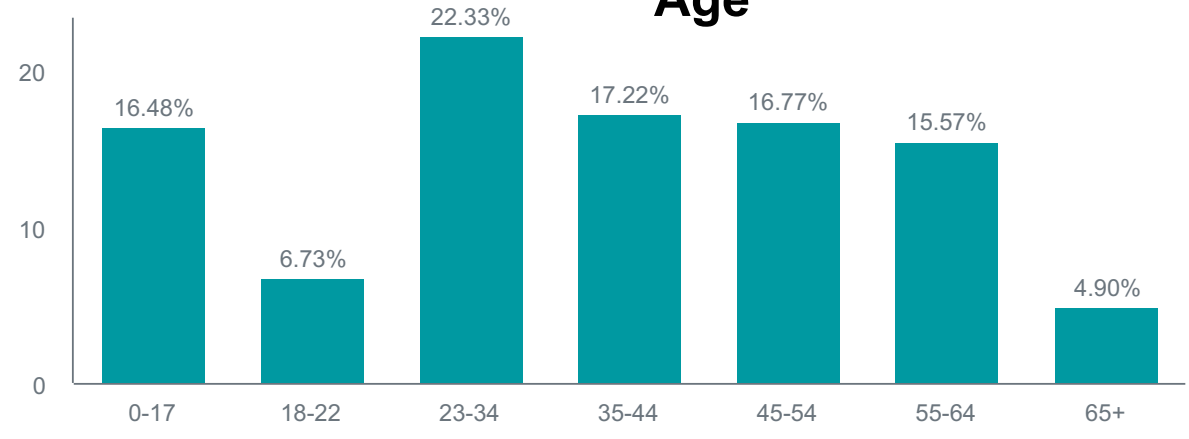
Includes all served in BHD Adult Services and Wraparound

Q2-2020

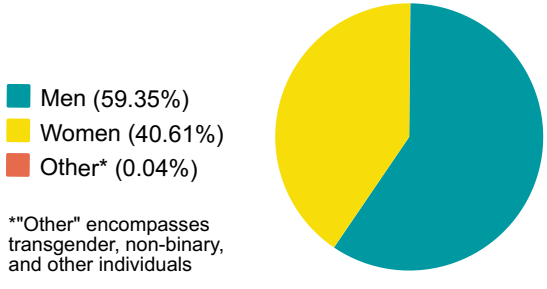
Volume Served

9,422

Age

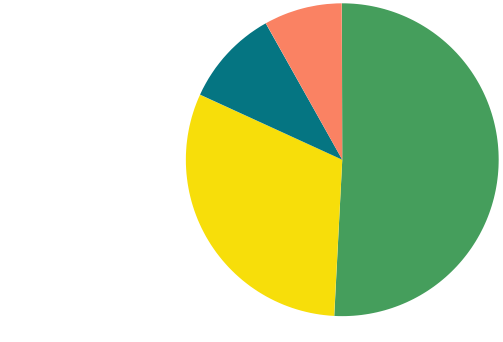


Gender



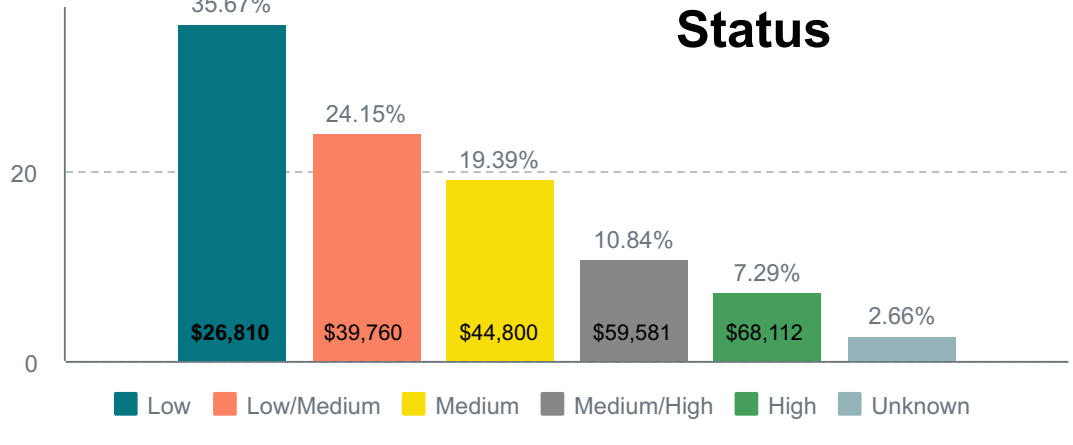
*"Other" encompasses transgender, non-binary, and other individuals

Race/Ethnicity



*"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", "Other", and N/A

Socioeconomic Status



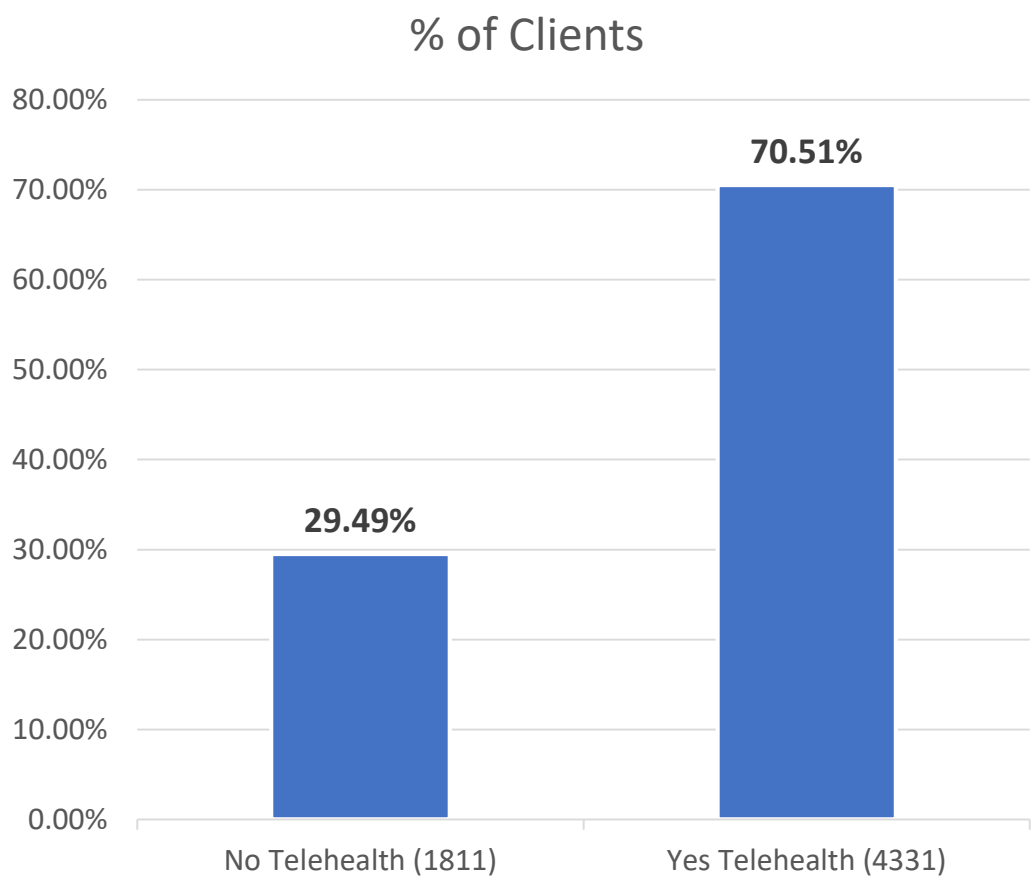
SES is determined based on income and education levels, and calculated based on zip code. Median income is listed for each group.

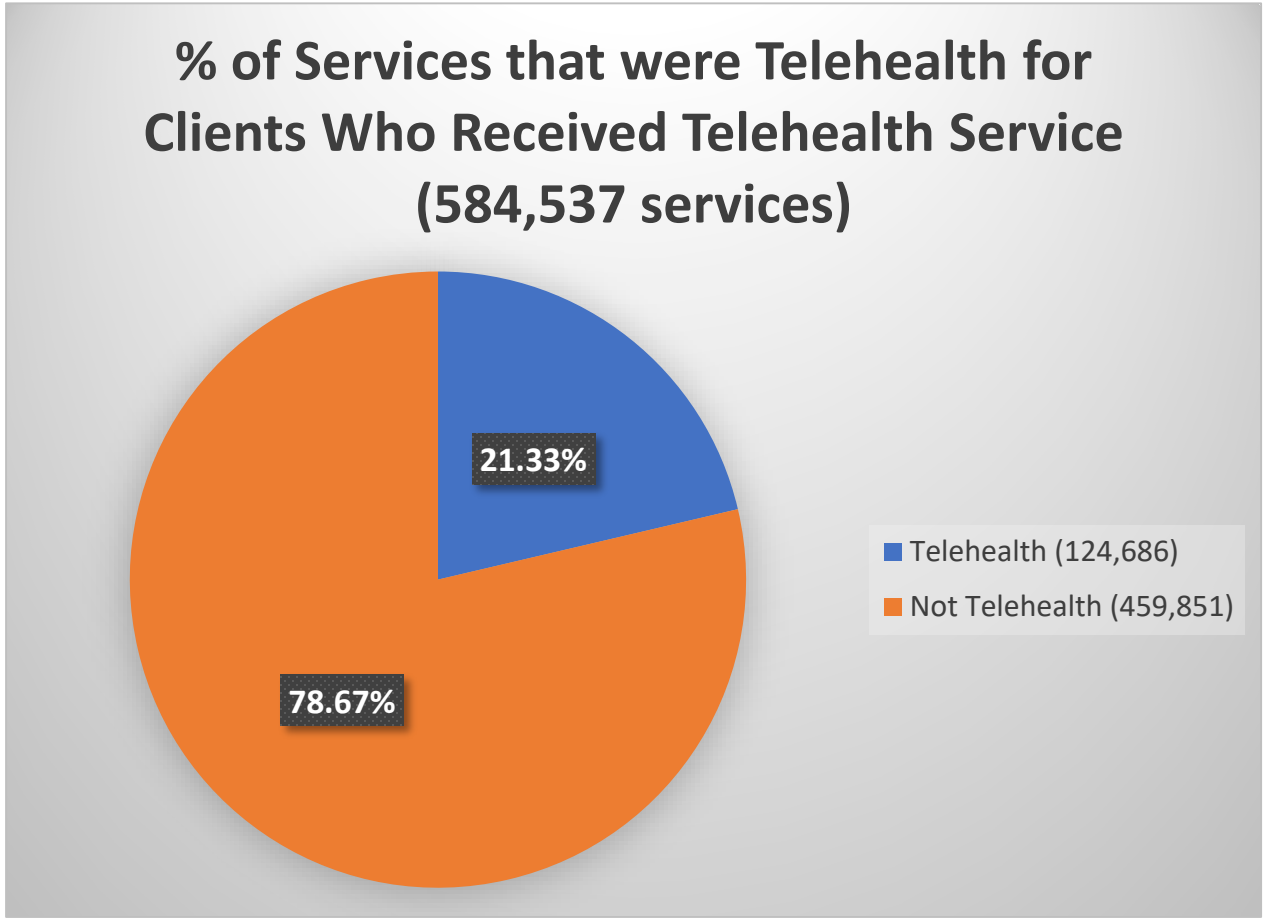
http://www.cuph.org/milwaukee-health-report.html

Telehealth Utilization in the CARS Network

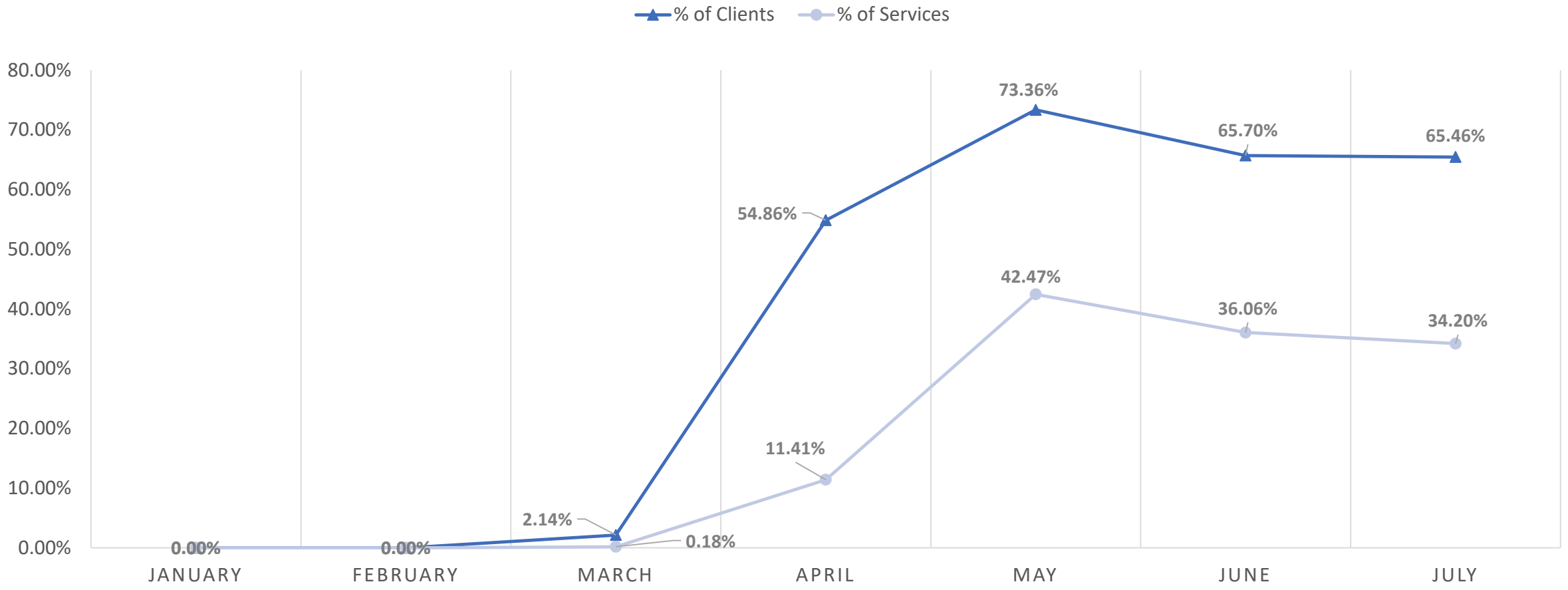
Prevalence of Telehealth – 6142 Clients

(As of 8/19/2020)





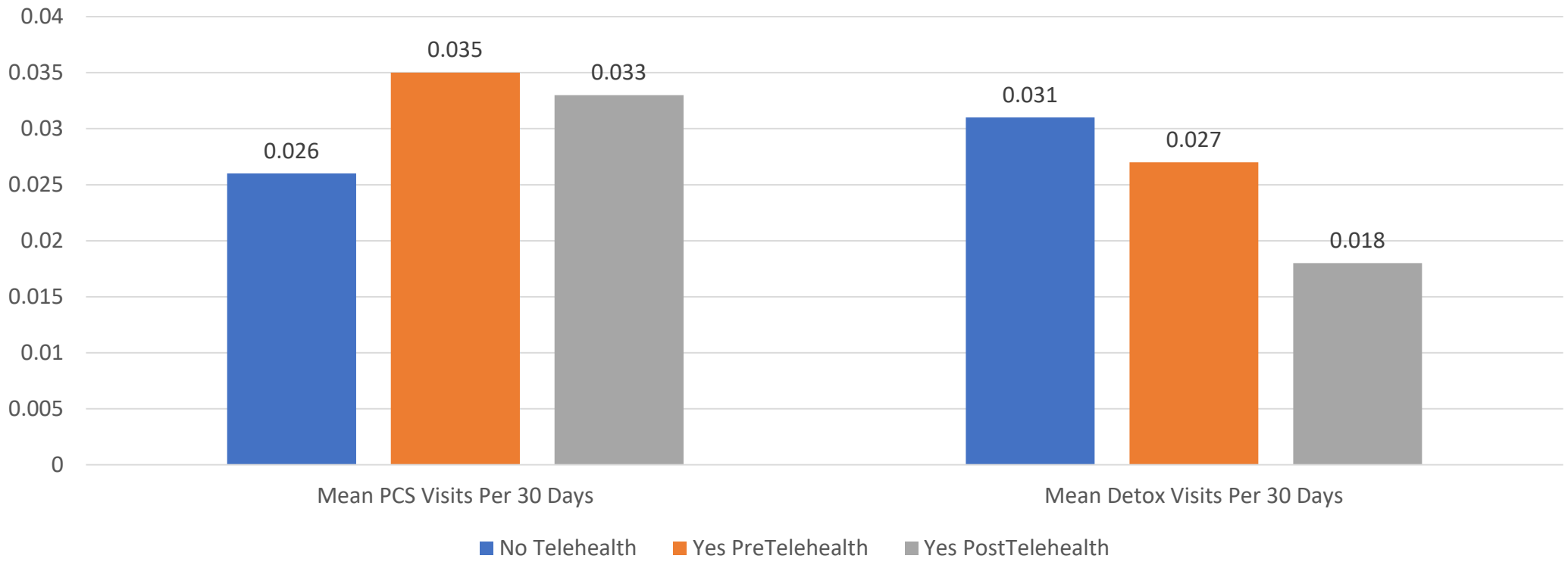
Growth of Telehealth Services Since 1/1/2020



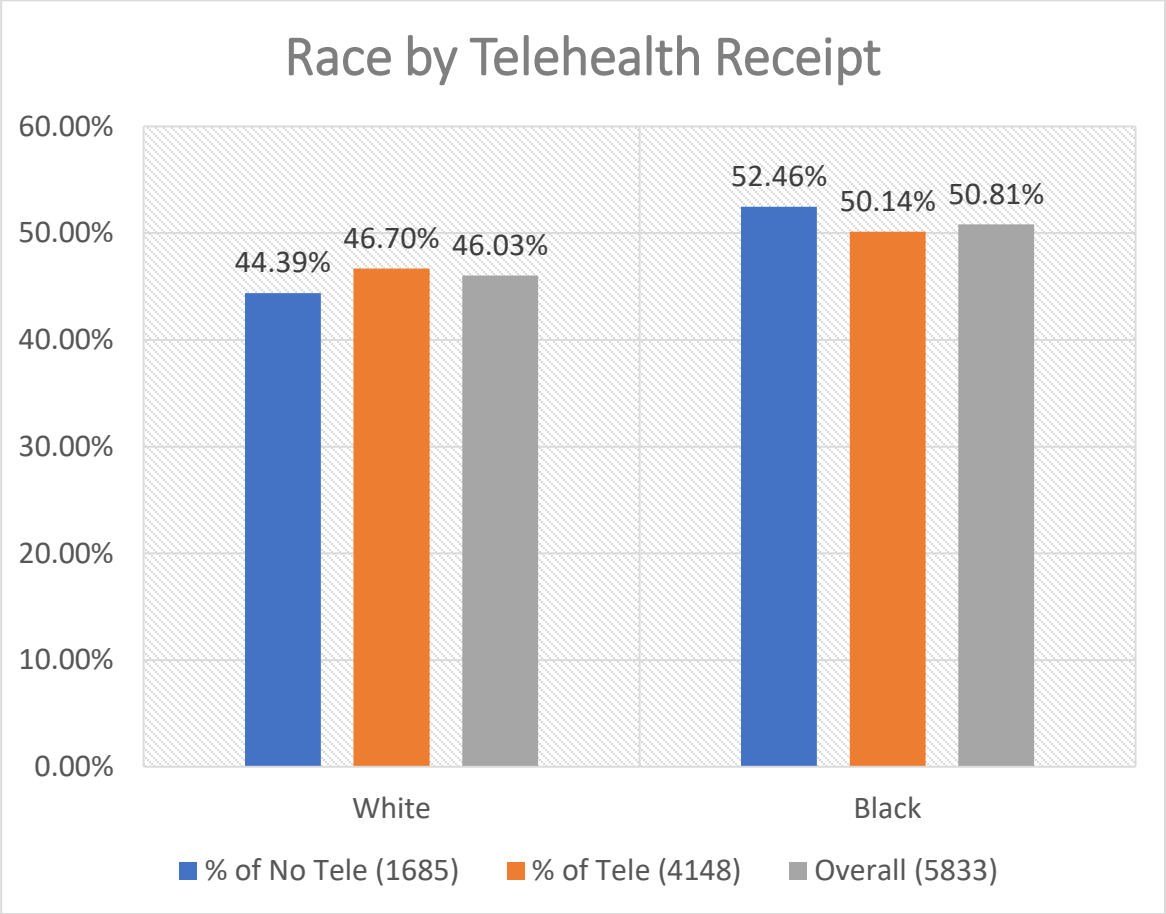
Change in PCS and Detox Use During Telehealth Conversion

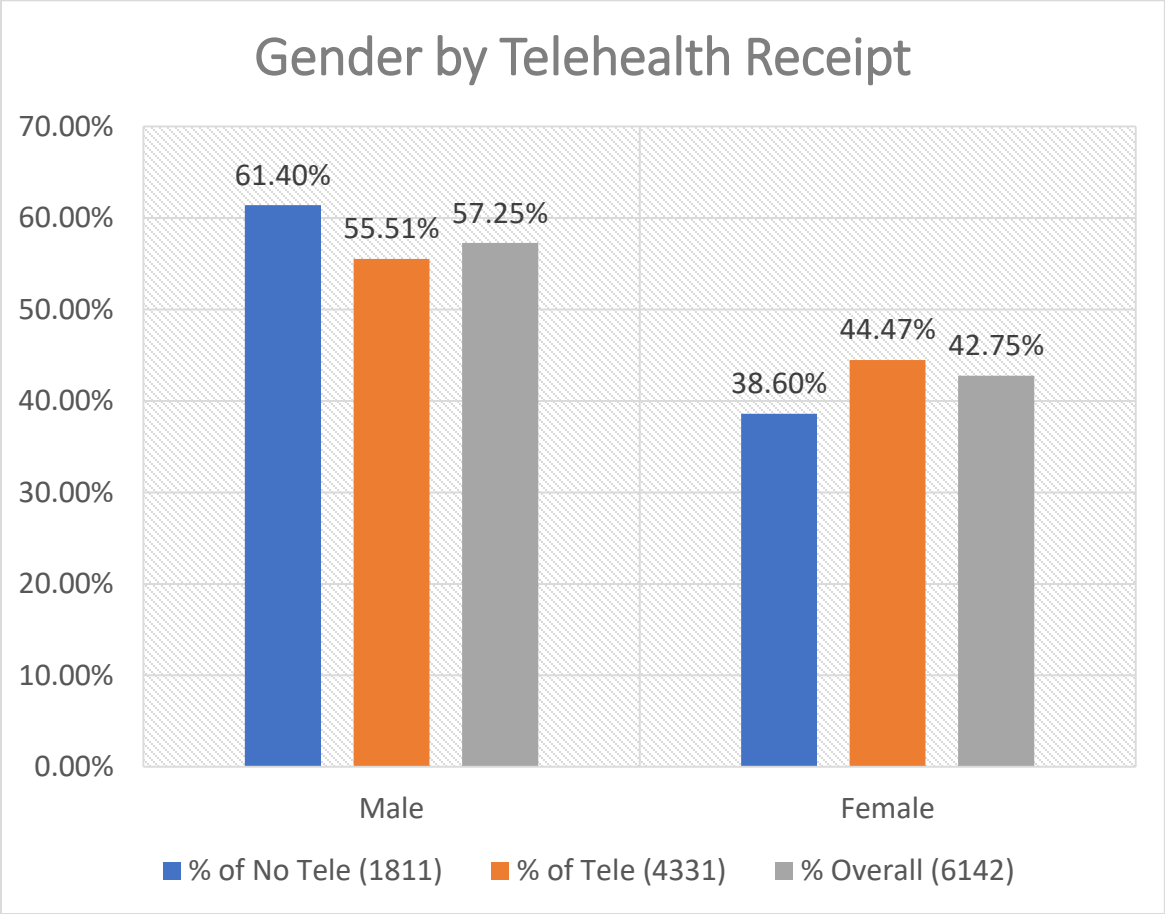
Correlations

		ClientTeleTotal	PCS PostTele	Detox PostTele
ClientTeleTotal	Pearson Correlation	1	.005	.010
	Sig. (2-tailed)		.728	.531
	N	4331	4331	4331

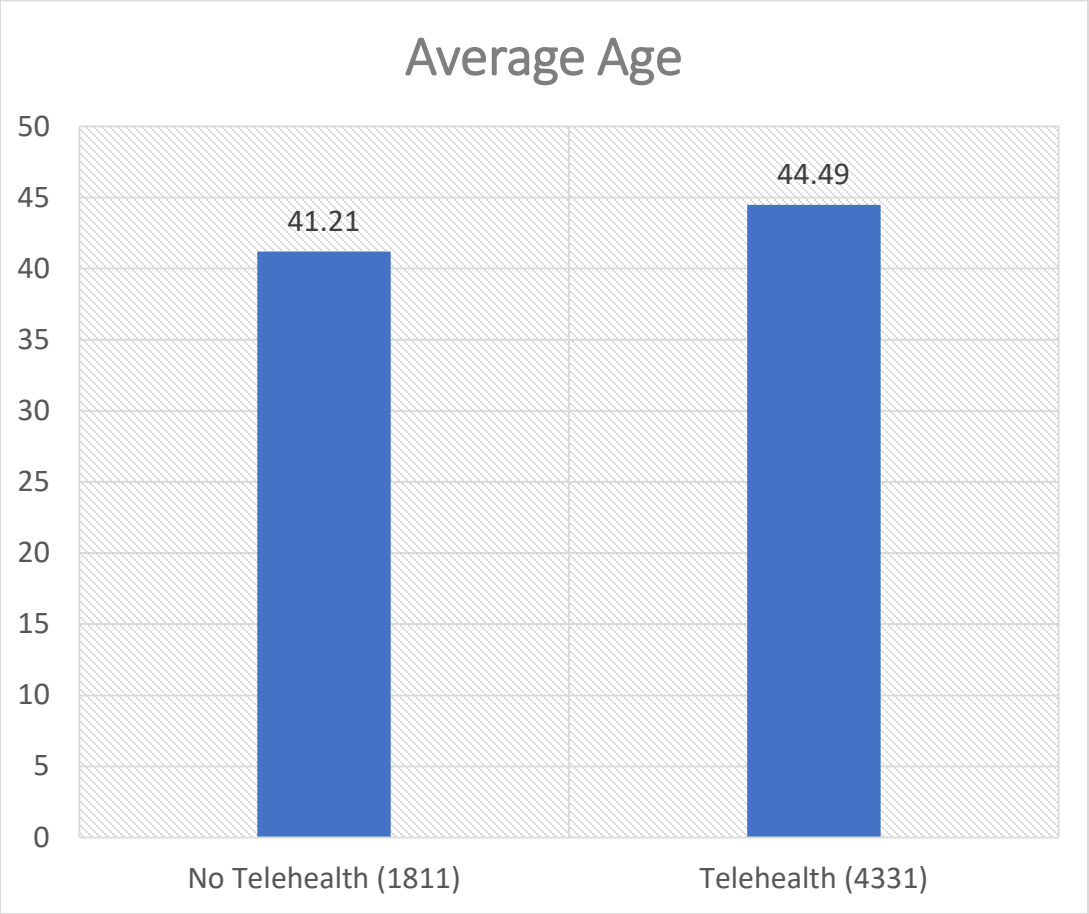


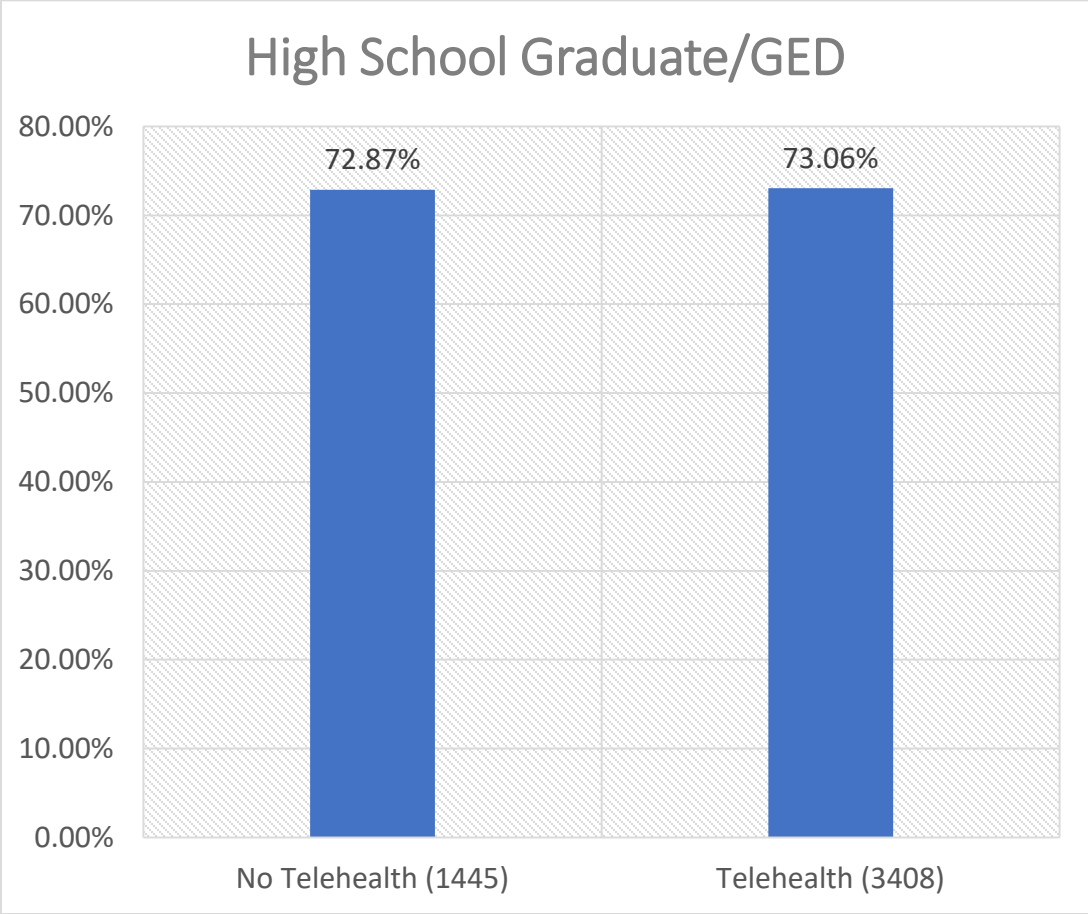
Demographic Differences



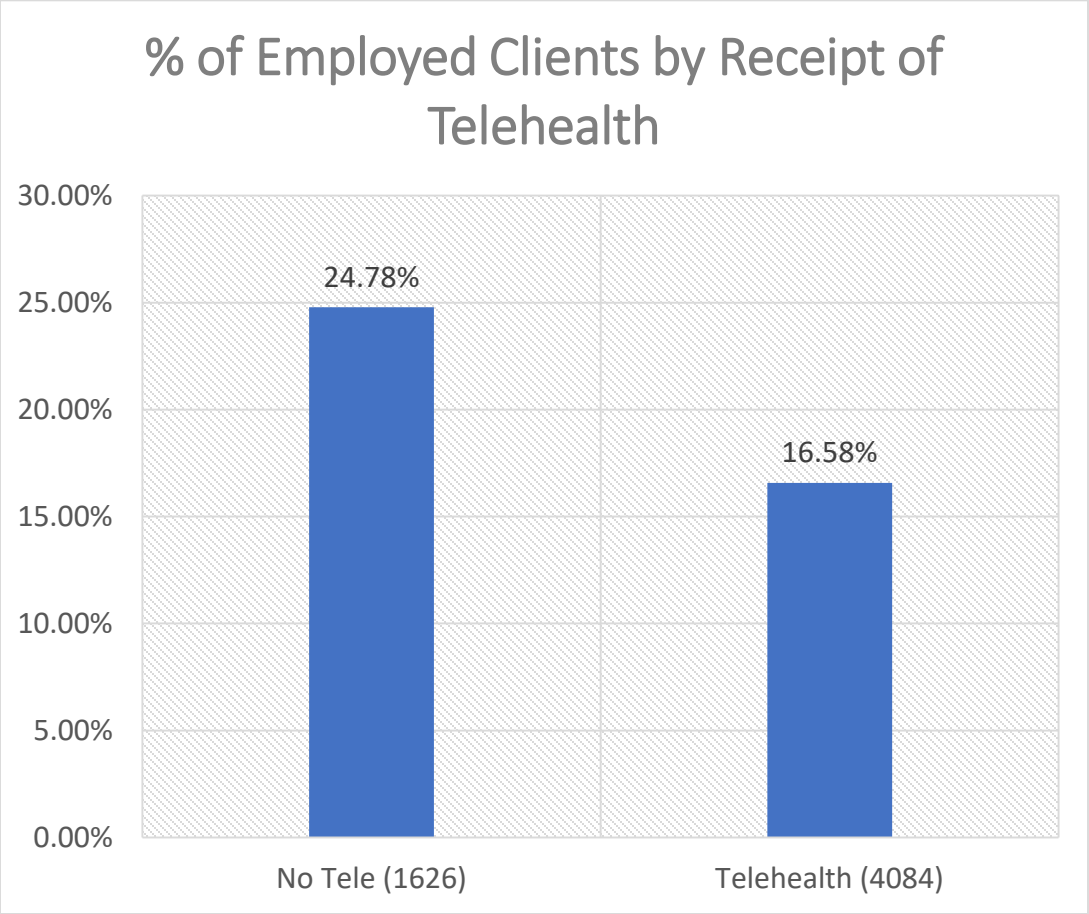


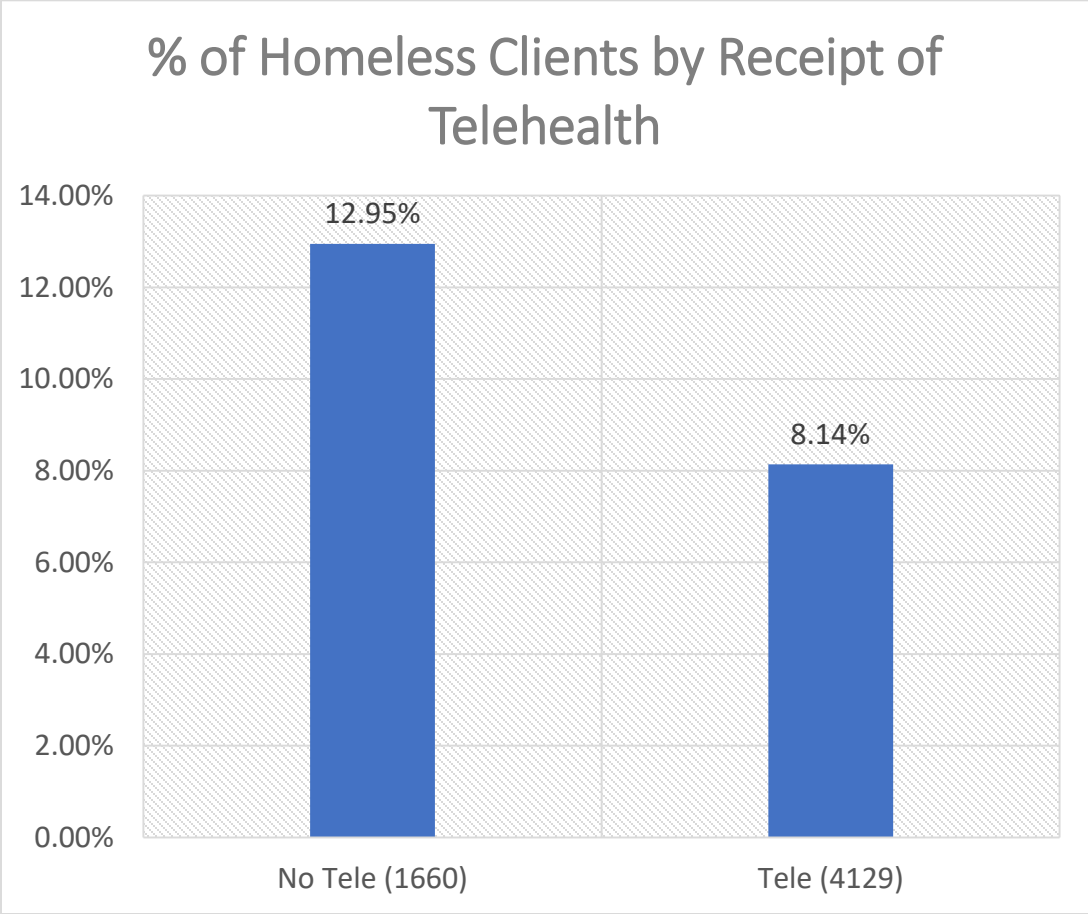
Demographic Differences



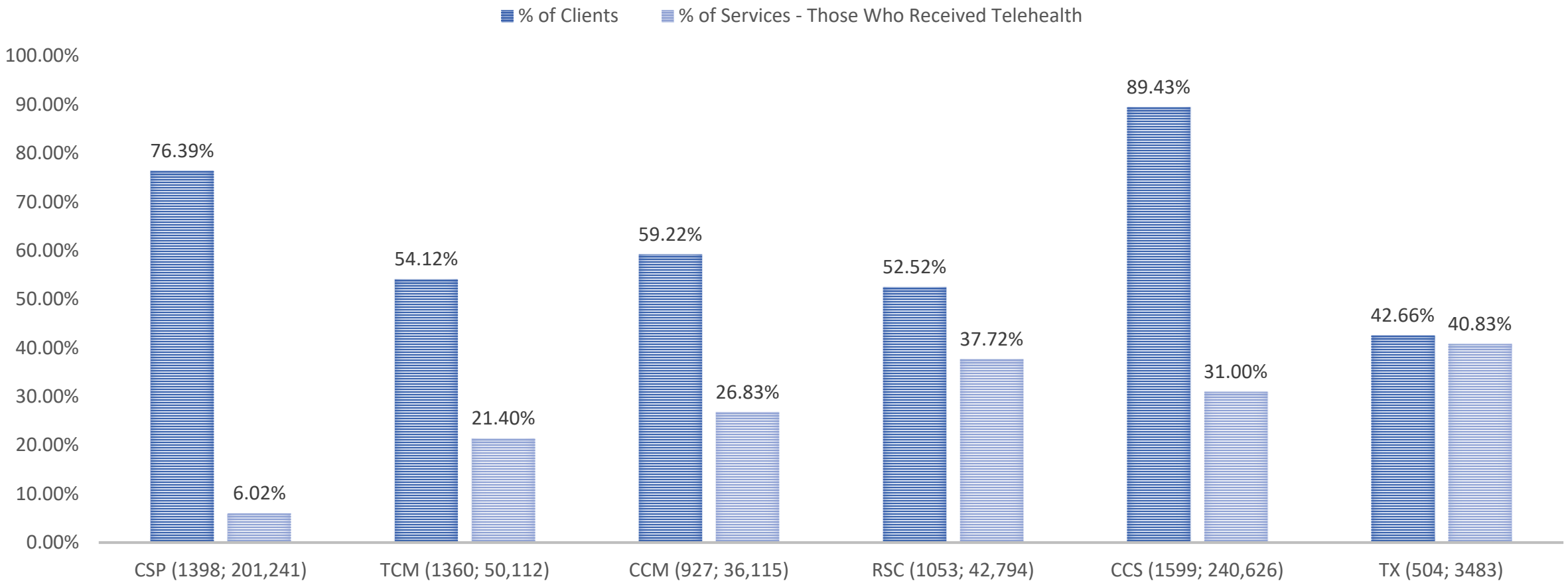


Demographic Differences





Which Programs Use Telehealth More?



Impact of Telehealth on No Shows: A Use Case from APC

Rates:
CCS: $128.56
Medicare: $90.94
Wraparound: $78
Medicaid: $82
MHOP:$93.94

	Missed Appointment Percentages						
	January	Feb	March	April	May	June	July
Total Scheduled	952	906	905	956	862	909	905
Total Missed	174	195	189	85	84	106	116
Total %	18.00%	22.00%	21.00%	9.00%	10.00%	12.00%	13.00%
Potential Revenue Generated (using median rate)	70,020	63,990	64,440	**78,390**	**70,020**	**72,270**	**71,010**

Completed and Next Steps

- Completed:
  - Client experience survey
  - Lit review
  - Data to DHS and two follow up emails
  - Initial data on telehealth utilization and outcomes
  - Change request to add internet and PC access to admissions form
- Next steps:
  - Position paper
  - Telehealth implementation plan
  - Research paper focusing on race discrepancy in satisfaction with telehealth at BHD

Milwaukee County BHD Data Literacy/Competency Plan

- Establishing priorities for performance improvement

- Oversight and accountability structure and process for improving performance

- Mental Health Board members
- BHD Executive Leadership
- Department managers
- QAPI Committee
- Quality Council

Data aggregation/compilation, analysis/interpretation, presentation and utilization

- Members of Performance Improvement teams, as assigned
- All staff who perform data interpretation
- All staff who design data display

Data collection tools and techniques

- Executive leadership (higher-level principles)
- Department managers (higher-level principles)
- Members of Performance Improvement teams, as assigned
- All staff who perform data entry or collection

Basic concepts of Quality Assessment and Performance Improvement

- All staff

Data Competency	Examples of Education Content	Frequency of Education
Basic concepts of Quality Assessment and Performance Improvement (QAPI)	• Why perform QAPI? • The value of QAPI in healthcare • BHD QAPI Plan • PDSA cycle • BHD QAPI priorities • Identifying and communicating improvement opportunities	New Employee orientation and triennially thereafter
Establishing priorities for performance improvement	• How to establish priorities for data collection	Initial orientation and ongoing development
Data collection tools and techniques	• Data collection • Data entry • Data storage • Data retrieval • Data scrubbing • Completeness of data collection • Data integrity (accuracy, consistency, completeness, reliability and validity) • Data definitions	Initial Initial As assigned to PIPs Upon initial hire/assumption of these responsibilities with annual competence assessment

Data Competency	Examples of Education Content	Frequency of Education

Data aggregation/compilation, and analysis/interpretation	• Statistical tools and techniques to analyze and display data
	• Data interpretation
	  o Data analysis and comparison internally over time to identify levels of performance, patterns, trends and variations
	  o Comparison against external benchmarks
	• Use of data analysis to identify improvement opportunities
	• Planning improvements priorities
	• Taking action when planned improvements are not achieved or sustained
		As assigned to PIPs
		
		Upon initial hire/assumption of these responsibilities and annual competence assessment

Data presentation	• Data visualization • Clinical decision support	As assigned to PIPs Initial

Data Competency	Examples of Education Content	Frequency of Education
Data utilization	• Taking action based on analyzed, presented data • Systematic/structured change management and performance improvement • Ongoing measurement/monitoring to evaluate the effectiveness of improvements • Using data to assess sustainability • Revising improvement plans in response to monitoring data	As assigned to PIPs Upon initial hire/assumption of these responsibilities
Oversight and accountability structure and process for improving performance	• Establishing expectations for data and information use • Holding the organization accountable for achieving measurable improvement	Initial orientation and ongoing development

The Top Tier

- Establishing priorities for performance improvement
- Oversight and accountability structure and process for improving performance
- Target Audience:
  - Mental Health Board members
  - BHD Executive Leadership
  - Department managers
  - QAPI Committee
  - Quality Council

Establishing Priorities

- Performance improvement activities
- Patient health outcomes
- Give priority to
  - High-volume
  - High-risk
  - Problem-prone processes
- Aligned with BHD’s goals and priorities
- Reprioritize in response to changes in the internal or external environment
- Define the frequency of data collection

Establishing Priorities – Additional Considerations

- SIA Priorities
  - Complaint &Grievance process
  - Completion of Therapeutic Passes
  - Documented Informed Consent for Psychotropic Medication
  - Interim measures to compensate for ligature risks
  - Safe and Appropriate Restraint and Seclusion use
  - Physical Care consultation
  - Patient Engagement

Establishing Priorities – Additional Considerations

- SIA Priorities
  - Medical Record documentation
  - Orders for waived testing
  - Medical gas storage
  - EMTALA Compliance
  - Medication Use
  - Infection Prevention and Control Practices

Gauging Quality at the Board Level

Impact of Improvements

↑

Improvements

↑

Conclusions

↑

Assessed Data

↑

Aggregate Data

↑

Raw Data

Governance

↑

Hospital Operations

Best Practices

- Ensure ongoing access to the requisite expertise
- Establish goals and identify appropriate metrics to assess performance
- Utilize dashboard/performance scorecards to facilitate monitoring and oversight
- Data should be presented clearly; avoid jargon and “advocacy”
- Consider both institution-specific information and relevant comparative benchmarks
  - Patient/provider satisfaction surveys
  - Leapfrog
  - Joint Commission

Best Practices

- Promote proactive risk assessment and reduction
  - Proactive problem solving should be fostered throughout the organization
- Assure thorough and credible root cause analyses
- Remedial measures are promptly developed, effectively implemented and closely monitored
- Closing the loop - Results of follow-up measurement

2020 Q2 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION INPATIENT DASHBOARD

8

Psychiatric Crisis Service (PCS)

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: Rate=6.7% Q2: Rate=10.2% Q3: Q4:	Rate=8.3%	Percent of patients returning to PCS within 3 days	Rate X < 7.8% X = 7.8% X > 7.8%	Rate=Count of client visits within 3 days of prior visit/Total client visits Q1: 116 readmissions within 3 days by 84 unique individuals Q2: 154 readmissions within 3 days by 82 unique individuals In 2020 Q2, PCS had 2 outlier patients who had 21 PCS visits each.
Q1: Rate=22.4% Q2: Rate=26.2% Q3: Q4:	Rate=24.2%	Percent of patients returning to PCS within 30 days	Rate X < 24% X = 24% X > 24%	Rate=Count of client visits within 30 days of prior visit/Total client visits Q1: 387 readmissions within 30 days by 206 unique individuals Q2: 395 readmissions within 30 days by 182 unique individuals In 2020 Q2, PCS had 2 outlier patients who had 21 PCS visits each.
Q1: Rate=100% Q2: Rate=100% Q3: Q4:	Rate=100%	Percent of time on waitlist status	Rate X < 50% X = 50% X > 50%	Rate=PCS hours on Waitlist Status / Total hours in time period x 100. Joint Commission reports that psychiatric patients board in the ED on average 6 hours. Currently, BHD waitlisted patients are on waitlist status for an average of 7.5 hours.
Q1: Rate=2.3 (n=4) Q2: Rate=6.0 (n=9) Q3: Q4:	Rate=4.1 (n=13)	Behavioral Codes (Code 1)	Rate X < 2.3 X = 2.3 X > 2.3	Rate=Behavioral codes per 1,000 PCS visits The objective of this metric is to not only to monitor the quantity/rate of codes called resulting in further treatment (Restraint and Seclusion). At the next meeting information regarding the outcomes will be reviewed.
Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=0.0 (n=0)	Physical Aggression - Patient/Patient	Incidents Zero 2 or Less > 2	Rate=Pt/Pt physical aggression incidents per 1,000 PCS visits.
Q1: Rate=1.2 (n=2) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=0.6 (n=2)	Physical Aggression - Patient/Staff	Incidents Zero 2 or Less > 2	Rate=Pt/Staff physical aggression incidents per 1,000 PCS visits.

DRAFT

Q1: Rate=.58 (n=1) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=.29 (n=1)	Patient Elopement	Incidents Zero 1 > 2	Rate=Patient elopements per 1,000 PCS visits Elopement definition: Patient eloped from locked unit and returned within the building or patient eloped from locked unit and exited the building.
Q1: Rate=0.0 (n=0) Q2: Rate=0.7 (n=1) Q3: Q4:	Rate=0.3 (n=1)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient Self Injurious Behavior Incidents per 1,000 PCS visits
Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=0.0 (n=0)	Medication Errors Identify common type, number of errors	Rate X = 0 X < 1.1 X > 1.1	Rate=Medication Errors per 10,000 Doses Dispensed

DRAFT

2020 Q2 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION INPATIENT DASHBOARD

Acute Adult Inpatient Service

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: Rate=2.1% (n=4) Q2: Rate=0.6% (n=1) Q3: Q4:	1.4% (n=5)	Percent of patients returning to Acute Adult within 7 days	Rate X < 3% X = 3% X > 3%	Rate=Percent of patient admissions occurring within 7 days of patient's prior discharge from the program
Q1: Rate=8.2% (n=16) Q2: Rate=8.2% (n=13) Q3: Q4:	8.2% (n=29)	Percent of patients returning to Acute Adult within 30 days	Rate X < 9.6% X = 9.6% X > 9.6%	Rate=Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
Q1: 71.7% positive Q2: 77.3% positive Q3: Q4:	74.0%	Percent of patients responding positively to MHSIP satisfaction survey	Rate X > 75% X = 75% X < 75%	Rate=Percent of patients selecting "Agree" or "Strongly Agree" to all survey items Q1: 96 completed surveys (49% response rate) Q2: 70 completed surveys (44% response rate) Q3: Q4:
Q1: 66.3% positive Q2: 65.6% positive Q3: Q4:	66.0%	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	Rate X > 65% X = 65% X < 65%	Rate=Percent of patients selecting "Agree" or "Strongly Agree" to survey item Q1: 96 completed surveys (49% response rate) Q2: 70 completed surveys (44% response rate) Q3: Q4:
Q1: Rate=9.2 (n=35) Q2: Rate=7.5 (n=19) Q3: Q4:	Rate=8.3 (n=54)	Behavioral Codes	Rate X < 9.2 X = 9.2 X > 9.2	Rate=Behavioral codes per 1,000 patient days The objective of this metric is to not only to monitor the quantity/rate of codes called resulting in further treatment (Restraint and Seclusion). At the next meeting information regarding the outcomes will be reviewed.
Q1: Rate=2.9 (n=11) Q2: Rate=5.1 (n=13) Q3: Q4:	Rate=4.0 (n=24)	Physical Aggression - Patient/Patient	Rate X < 2.9 X = 2.9 X > 2.9	Rate=Pt/Pt physical aggression incidents per 1,000 patient days 43A Incidents - Q1: 2 Q2: 0 43B Incidents - Q1: 9 Q2: 10 43C Incidents - Q1: 0 Q2: 3
Q1: Rate=4.7 (n=18) Q2: Rate=2.0 (n=5) Q3: Q4:	Rate=3.3 (n=23)	Physical Aggression - Patient/Staff	Rate X < 2.9 X = 2.9 X > 2.9	Rate=Pt/Staff physical aggression incidents per 1,000 patient days 43A Incidents - Q1: 0 Q2: 0 43B Incidents - Q1: 16 Q2: 4 43C Incidents - Q1: 2 Q2: 1

DRAFT

				In 2020 Q1, one female patient accounted for 14 of the 16 reported patient-to-staff physical aggression incidents on 43B.
Q1: Rate=.52 (n=2) Q2: Rate=.72 (n=2) Q3: Q4:	Rate=.62 (n=4)	Patient Elopement	Incidents Zero 1 > 2	Rate=Patient elopements per 1,000 patient days 43A Incidents - Q1: 1 Q2: 0 (patient exited the unit into hallway but was returned to unit by staff) 43B Incidents - Q1: 1 Q2: 1 (patient exited the unit to hallway but was returned by staff, patient exited the unit to Children's Hospital but was returned by Sheriff) 43C Incidents - Q1: 0 Q2: 1 (patient broke glass to exit building but returned to unit by police)
Q1: Rate=0.3 (n=1) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=.15 (n=1)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient Self Injurious Behavior Incidents per 1,000 patient days 43A Incidents - Q1: 0 Q2: 0 43B Incidents - Q1: 0 Q2: 0 43C Incidents - Q1: 1 Q2: 0
Q1: Rate=1.11 (n=5) Q2: Rate=0.37 (n=1) Q3: Q4:	Rate=.83 (n=6)	Medication Errors	Rate X < 1.1 X = 1.1 X > 1.1	Rate=Medication errors per 10,000 administered doses 43A Incidents - Q1: 2 Q2: 1 43B Incidents - Q1: 2 Q2: 0 43C Incidents - Q1: 1 Q2: 0 For 2020 YTD, Acute Adult's medication errors were: 2-incorrect doses, 1-omitted dose, 1-incorrect time, 1-incorrect course of therapy, and 1-allergen to patient
Q1: Rate=.38 (34.7 hrs) Q2: Rate=.21 (12.8 hrs) Q3: Q4:	.31 (47.5 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate X < .38 X = .38 X > .38	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care 43A Restraint Rate - Q1: .41 (12.9 hrs) Q2: .44 (7.2 hrs) 43B Restraint Rate - Q1: .54 (16.4 hrs) Q2: .11 (2.5 hrs) 43C Restraint Rate - Q1: .18 (5.4 hrs) Q2: .15 (3.1 hrs)
Q1: Rate=.22 (19.8 hrs) Q2: Rate=.14 (8.6 hrs) Q3: Q4:	.19 (28.3 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate X < .29 X = .29 X > .29	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care 43A Seclusion Rate - Q1: .41 (12.8 hrs) Q2: .34 (5.6 hrs) 43B Seclusion Rate - Q1: .00 (0.0 hrs) Q2: .04 (1.0 hrs) 43C Seclusion Rate - Q1: .23 (7.0 hrs) Q2: .09 (2.0 hrs)
Q1: Rate=26% (n=50) Q2: Rate=24% (n=38) Q3: Q4:	25% (n=88)	HBIPS 4 - Patients discharged on multiple antipsychotic medications	Rate X < 9.5% X = 9.5% X > 9.5%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications
Q1: Rate=98% (n=49) Q2: Rate=92% (n=35) Q3: Q4:	95% (n=84)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate X > 61% X = 61% X < 61%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification

DRAFT

2020 Q2 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION INPATIENT DASHBOARD

Child Adolescent Inpatient Service (CAIS)

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: 2.9% (n=4) Q2: 2.4% (n=1) Q3: Q4:	Rate=2.7% (n=5)	Percent of patients returning to Acute Adult within 7 days	Rate X < 5.0% X = 5.0% X > 5.0%	Rate=Percent of patient admissions occurring within 7 days of patient's prior discharge from the program
Q1: 9.3% (n=13) Q2: 4.8% (n=2) Q3: Q4:	Rate=8.2% (n=15)	Percent of patients returning to Acute Adult within 30 days	Rate X < 9.6% X = 9.6% X > 9.6%	Rate=Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
Q1: 70.8% positive Q2: 63.2% positive Q3: Q4:	69.7%	Percent of patients responding positively to satisfaction survey	Rate X > 75% X = 75% X < 75%	Rate=Percent of patients selecting "Agree" and "Strongly Agree" to all survey items Q1: 22 completed surveys (16% response rate) Q2: 4 completed surveys (10% response rate) Q3: Q4:
Q1: 68.2% positive Q2: 100.0% positive Q3: Q4:	73.1%	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	Rate X > 75% X = 75% X < 75%	Rate=Percent of patients selecting "Agree" and "Strongly Agree" to survey item Q1: 22 completed surveys (16% response rate) Q2: 4 completed surveys (10% response rate) Q3: Q4:
Q1: Rate=8.0 (n=5) Q2: Rate=4.3 (n=1) Q3: Q4:	Rate=6.1 (n=6)	Behavioral Codes (Code 1)	Rate X < 8.0 X = 8.0 X > 8.0	The objective of this metric is to not only to monitor the quantity of codes but of the codes called and how many of them resulted in further treatment with restraint and/or seclusion. For this meeting the only number we will have is the rate/number of codes but at the next meeting we will have the results of the codes.
Q1: Rate=4.8 (n=3) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=2.4 (n=3)	Physical Aggression - Patient/Patient	Incidents Zero 2 or Less > 2	Rate=Pt/Pt physical aggression incidents per 1,000 patient days

DRAFT

Q1: Rate=0.0 (n=0) Q2: Rate=4.3 (n=1) Q3: Q4:	Rate=2.2 (n=1)	Physical Aggression - Patient/Staff	Incidents Zero 2 or Less > 2	Rate=Pt/Staff physical aggression incidents per 1,000 patient days
Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=0.0 (n=0)	Patient Elopement	Incidents Zero 1 > 2	Rate=Patient elopements per 1,000 patient days
Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Q4:	Rate=0.0 (n=0)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient self-injurious behavior Incidents per 1,000 patient days
Q1: Rate=3.24 (n=1) Q2: Rate=7.54 (n=1) Q3: Q4:	Rate=4.53 (n=2)	Medication Errors	Rate X < 1.1 X = 1.1 X > 1.1	Rate=Medication errors per 10,000 doses administered For 2020 YTD, CAIS' medication errors were 2-omitted doses
Q1: Rate=.72 (10.8 hrs) Q2: Rate=.13 (0.7 hrs) Q3: Q4:	.56 (11.5 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate X < .38 X = .38 X > .38	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care
Q1: Rate=.08 (n=1.3 hrs) Q2: Rate=.00 (0.0 hrs) Q3: Q4:	.06 (1.3 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate X < .29 X = .29 X > .29	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care
Q1: Rate=3.6% (n=5) Q2: Rate=0.0% (n=0) Q3: Q4:	2.8% (n=5)	HBIPS 4 - Patients discharged on multiple antipsychotic medications	Rate X < 3% X = 3% X > 3%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications
Q1: Rate=80% (n=4) Q2: N/A Q3: Q4:	80% (n=4)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate X > 61% X = 61% X < 61%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification

DRAFT

2020 Q2 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION INPATIENT DASHBOARD

Acute Inpatient Performance Measures Reported to CMS

Target Key: Better Than Expected | Expected | Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
Q1: Rate=.43 (45.5 hrs) Q2: Rate=.20 (13.5 hrs) Q3: Q4:	.34 (59.0 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate X < .38 X = .38 X > .38	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care
Q1: Rate=.20 (21.0 hrs) Q2: Rate=.13 (8.6 hrs) Q3: Q4:	.17 (29.6 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate X < .29 X = .29 X > .29	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care
Q1: 96% (n=53) Q2: 92% (n=35) Q3: Q4:	95% (n=88)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate X > 61% 61% X < 61%	Rate=Patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification
Q1: 99% (n=277) Q2: 98% (n=191) Q3: Q4:	99% (n=468)	Screening for metabolic disorders	Rate X > 74% X = 74% X < 74%	Rate=Patients discharged on antipsychotic medications who had a body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year
Q1: 33% (n=78) Q2: N/A Q3: N/A Q4:	33% (n=78)	Patient influenza immunization	Rate X > 83% X = 83% X < 83%	Rate=Patients assessed and given influenza vaccination (time period 10/1 – 3/31)
Q1: 77% (n=20) Q2: 42% (n=10) Q3: Q4:	60% (n=30)	SUB 2 - Alcohol use brief intervention provided or offered	Rate X > 83% X = 83% X < 83%	Rate=Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay.
Q1: 58% (n=15) Q2: 33% (n=8) Q3: Q4:	46% (n=23)	SUB 2a - Alcohol use brief intervention provided	Rate X > 74% X = 74% X < 74%	Rate=Patients with alcohol abuse who received a brief intervention during their inpatient stay.

DRAFT

Q1:100% (n=128) Q2:100% (n=91) Q3: Q4:	100% (n=219)	SUB 3 - Alcohol and other drug use disorder treatment provided or offered at discharge	Rate X > 70% X = 70% X < 70%	Rate=Patients who screened positive for an alcohol or substance abuse disorder during their inpatient stay who, at discharge, either; received or refused a prescription for medications to treat their alcohol or drug use disorder, or received or refused a referral for addiction treatment
Q1: 35% (n=45) Q2: 57% (n=52) Q3: Q4:	44% (n=97)	SUB 3a - Alcohol and other drug use disorder treatment at discharge	Rate X > 59% X = 59% X < 59%	Rate=Patients who screened positive for an alcohol or substance abuse disorder during their inpatient stay who, at discharge, either; received a prescription for medications to treat their alcohol or drug use disorder, or received a referral for addiction treatment
Q1: 82% (n=58) Q2: 82% (n=49) Q3: Q4:	82% (n=107)	TOB 2 - Tobacco use treatment provided or offered	Rate X > 81% X = 81% X < 81%	Rate=Patients who use tobacco and who received or refused counseling to quit and received or refused medications to help them quit tobacco during their hospital stay
Q1: 52% (n=37) Q2: 52% (n=31) Q3: Q4:	53% (n=68)	TOB 2a - Tobacco use treatment (during the hospital stay)	Rate X > 46% X = 46% X < 46%	Rate=Patients who use tobacco and who received counseling to quit and received medications to help them quit tobacco during their hospital stay
Q1: 54% (n=38) Q2: 37% (n=22) Q3: Q4:	46% (n=60)	TOB 3 - Tobacco use treatment provided or offered at discharge	Rate X > 58% X = 58% X < 58%	Rate=Patients who use tobacco and at discharge received or refused a referral for outpatient counseling AND received or refused a prescription for medications to help them quit.
Q1: 6% (n=4) Q2: 2% (n=1) Q3: Q4:	4% (n=5)	TOB 3a - Tobacco use treatment provided at discharge	Rate X > 18% X = 18% X < 18%	Rate=Patients who use tobacco and at discharge received a referral for outpatient counseling AND received a prescription for medications to help them quit
2018: 29.4%		FUH 30 - Follow-up after hospitalization for mental illness	Rate X > 50% X = 50% X < 50%	Rate=Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 30 days of discharge. CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.
2018: 5.9%		FUH 7 - Follow-up after hospitalization for mental illness	Rate X > 28% X = 28% X < 28%	Rate=Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge. CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.

DRAFT

2018: 19.4% CMS reports BHD is “no different than the national rate”		READMN 30 IPF - 30 day all cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	Rate X > 20% X = 20% X < 20%	Rate=Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility CMS calculates this measure based on Medicare claims data and reports BHD’s performance on the https://data.medicare.gov/data/hospital-compare website annually.

DRAFT

Hospital QAPI – MINUTES: August 7, 2020

Topic/Facilitator	Discussion	Next Steps/Action Items Responsible Persons Timeline
Hospital QAPI June 5, 2020 Minutes Abram/Bergersen 11:00-11:02am	• Minutes Minutes approved as written.	Informational.
Milwaukee County BHD Data Literacy/Competency Plan Education/Training/Resource Needs for next month, for this committee or the organization. Dr. Drymalski, Krasker 11:03-11:25	• Refer to PPT presentation; attached to agenda. Glenn and Matt proposed a tiered plan for data literacy education at all levels including frequency addressing the following: basic concepts of QAPI, data collection tools and techniques, data aggregation, presentation and analysis, oversight and accountability and identification of priorities for performance improvement. Best practices were reviewed.	QAPI Committee unanimously approved this plan as proposed. Glenn and Matt will present the material at the Quality Committee of the MH Board, and full MH Board.
BHD QAPI Committee Departmental Reporting Schedule Bergersen & Brown 11:25-11:30 Tips: What is Being Monitored and Changed? What should be reviewed or prioritized for improvement? What are the sources of data and information relevant to our organization to use as quality assessment and quality improvement?	• June- Roll-Out Plan • July- IT/Patient Rights/ (move due to holiday) • August-Psychiatric Social Work/Contract Services • September-Pharmacy/Dietary -on deck- • October-Environment of Care/EES/IPAC • November-Contract Services/SEC • December-Contract Services • January-Nursing -AICE, CAIS, ATU • February-PCS, ITU, OBS • March-Contract Services • April-Contract Services • May-Contract Services • Other? Refer to next section.	Dietary and Pharmacy department reports scheduled next month.

Department Reports: August 11:30-11:55 p.m. Dr. Badger Sherrie-Bailey-Holland Demetrius-Anderson Nan Hillert Katie Skell, Luci Reyes-Agron	• IT and Informatics Dr. Badger: shared goals of the SIA corrective action plan including staff re-education for navigating the EHR, comprehensive training on AVATAR, and access to records. Refer to attached PPT presentation for improvement actions. • Patient Rights Bailey-Holland: One grievance has been reported since Q2. There is a new grievance process, policy and committee underway. The hospital grievance education has been rolled out to all hospital employees. Grievance committee meetings are now held bi-weekly. Anderson shared a brief review of the clinical records audit findings. Refer to monthly audit reports for detail. • Psychiatric Social Work Hillert: The PSW 60-hour assessment threshold continues to be met. All June and July PSW admission assessments were completed within 60 hours at 100% compliance. Refer to attached audit report for detail. Hillert is also reviewing the acknowledgement process of the completion of advanced directive, as additional review of the progress notes indicates attempts to gather the required information may not be reflected by only auditing the form. • Contract Service – (Monitoring Tool: September) Clean Power CPM/Rounding Skell: Clean Power is completing monthly audits to identify deficiencies and plans for improvement. Audit components, recurring deficiencies will be flagged for evaluation for continuous process improvement. Components will be scored on a 1-4 scaling system and reviewed at IPAC committee. Refer to attached report for detail.	Work plan underway. Progress noted. Further analysis is needed on the electronic patient signature component of the acknowledgement, refusal and/or the timing and dating of patient rights and advanced directives; Anderson/Bailey-Holland Nan has shared this data with the PSW team, reviewing expectations and timelines. Glenn recommended collecting a smaller amount of data, more frequently, for a larger sample size. Luci will connect with CP and Sandy.

New dashboard format and performance indicators Brown, Bergersen, Warzonek, Anderson, ALL 11:55- 12:15 pm	• Performance Indicators Areas to target for warranting further investigation and/or performance improvement. Jen B. will gather a Team to discuss findings, identify participants and areas of improvement related to the following indicators as discussed in Patient Safety: ➢ Further investigation regarding elopements ➢ Aggression on 43B ➢ Waitlist data ➢ Staff injuries relating to restraints	Work team(s) to be scheduled.
Any current PIPs to target? ALL 11:55-12:15 pm *(Reminder: Hospital should seek to prioritize PIPs that are high risk, high frequency, and/or problem prone to include issues that may affect the safety and psychosocial well-being and the rights of the patients. The PIPs will serve the greatest good or ensure better outcomes. The hospital must provide evidence to show why each project was selected.)*	Any incident data warranting immediate attention, opportunities for improvement? • Issues that pose a high risk to our patients, is frequent in nature or otherwise impacts the safety and quality of life of our patients. • Items for improvement identified at the 8/6 Patient Safety Committee. (Above) • SIA updates; Emtala/Log – Angela & Dr. Thrasher Item deferred for discussion with Angela next meeting. EMTALA progress report has been submitted by Dr. Thrasher and is attached. Risk Manager Hospital connections – Bergersen An improvement activity has been implemented relating to inappropriate transfers. A partnership has been established with local hospital Risk Managers for assistance in fact findings and investigations regarding such transfers. Glenn has provided EMTALA education to the community hospital partners.	Item deferred for discussion with Angela next meeting. Informational at this time.

Education/Compliance updates Bergersen 12:15-12:20 p.m.	• Introduction to Performance Improvement Knowledge Q 94% education compliance rate as of 8/6. • Environmental Risks in Patient Care Areas 86% education compliance rate as of 8/6. • RCA2 training 73% (8 of 11) participants have completed trainings successfully.	Quality Committee Governing Board members are also scheduled to complete the Performance Improvement Training; reminders sent by Mary Neubauer
Hospital Contracts Quality issues updates 12:20-12:30 p.m. Joint Commission Guidance: Leaders are expected to select the best methods for their hospital to oversee the quality and safety of services provided through contractual agreement. (Direct observation, audit of documentation, review of incident reports, report reviews, review of performance indicators, input from staff and patients, review of patient satisfaction, review risk management activities.) Work with the contractor to make improvements, renegotiate, or terminate agreement – need sufficient planning as to not interrupt patient services. ALL	Contracts and Improvement Actions Current contract concerns/reports: Discussion and actions • Public Safety/Security Delgado, Bergersen A communication update of actions has been distributed by leadership earlier this week. • Hospital Contracts -Impaneling challenges; sanctions? Dennis noted that monetary sanctions can be sent to those hospital contracted vendors who have not completed the required impaneling and contract expectations. • Other?	Informational. Committee agreed to impose financial forfeitures when indicated.

Next QAPI Meeting Time Virtual Microsoft Teams Meeting ALL 12:30 p.m.	• First Friday of every month.	September 4, 2020 at 11 a.m.

Attendee Requirements: Virtual meeting via Microsoft Teams

Participants are to include but not limited to: Executive Director/Administrator, Assistant Administrator, Chief Nursing Officer, Assistant Chief Nursing Officer, Director of Environmental Service, Director of Dietary Services, Director of Rehabilitation Services, Director of Social Services and/or Director of Activities.

Meeting Notes/Participants: Demetrius Anderson, Dr. Martha Badger, Sherrie Bailey-Holland, Jennifer Bergersen, Dale Brown, Steve Delgado, Glenn Krasker, Lynn Gram, Larry Johansen, Mary Neubauer, Linda Oczus, Luci Reyes- Agron, Dr. Schneider, Katie Skell, Ed Warzonek, Jeanne Wypyski, Dr. Matt Drymalski, Dennis Buesing, Dr. Elise Gropper, Peter German, John Rahilly, Vicki Wheaton & Nan Hillert

POLICY & PROCEDURE STATUS REPORT -GOAL=96%

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
April	12	25	0
May	4	14	1
June	10	22	2
July	1	22	0
August	2	18	0

Overall Progress 91.4% as of Sept. 1, 2020

Current

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	539	542	91.2%	91.4%
Up to 1 year Overdue	46	45	7.8%	7.6%
More than 1 year and up to 3 years overdue	5	5	1.0%	0.8%
More than 3 years and up to 5 years overdue	0	0	0%	0%
More than 5 years and up to 10 years overdue	1	1	0.2%	0.2%
More than 10 years overdue	0	0	0%	0%
Total	591	593	100%	100%

Forecast Due for Review

Past Due Policies - 49

Coming Due Policies

September 2020 –10
October 2020 – 15
November 2020 –7
December 2020 – 32
January 2021 – 20
February 2021 – 14
March 2021 – 17
April 2021 – 14
May 2021 – 18
June 2021 – 13
July 2021 –17
August 2021 -20