



Total Organizational Accountability

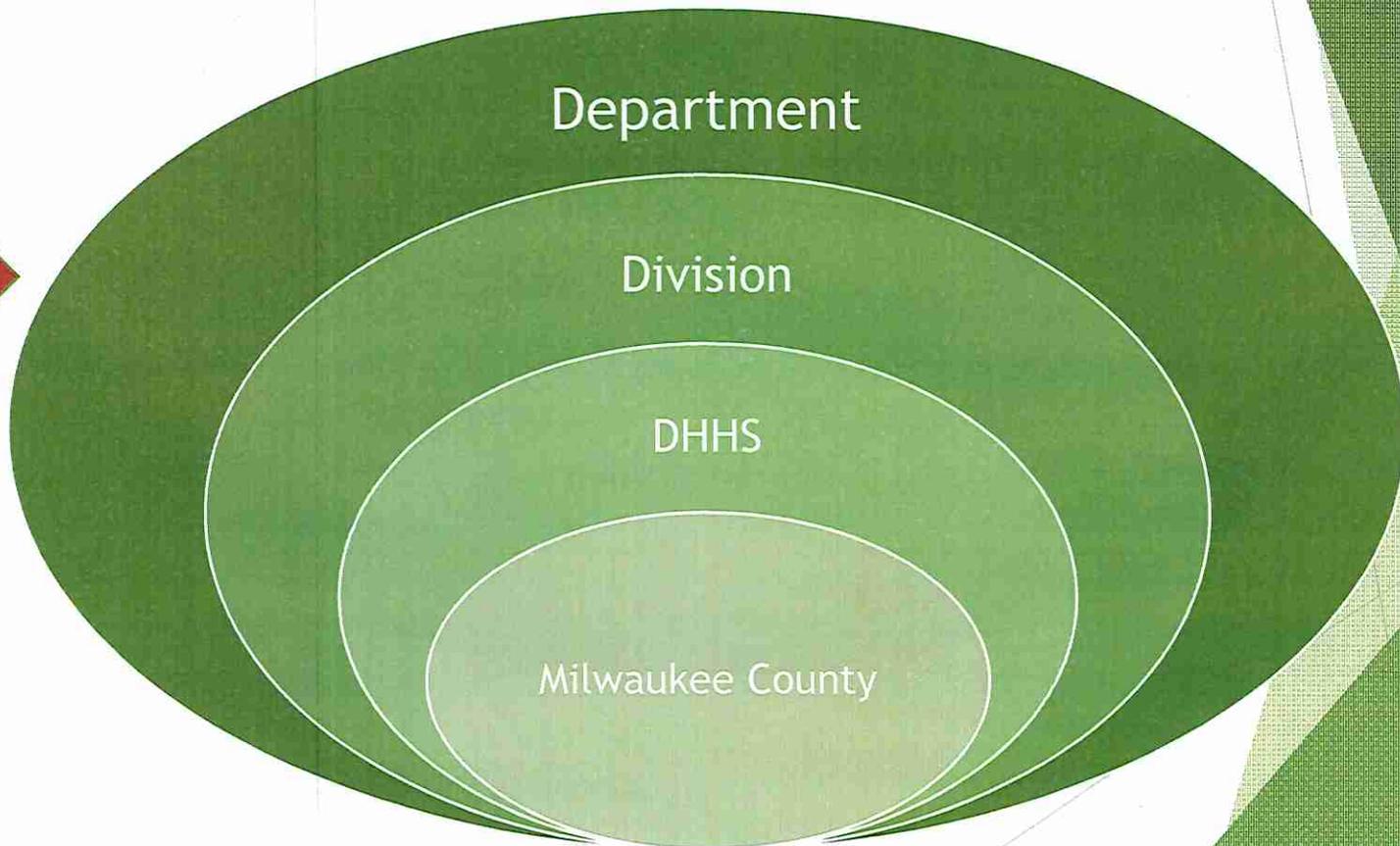
*Developing Core Domains to
Realize the Quadruple Aim*

The Current BHD KPIs

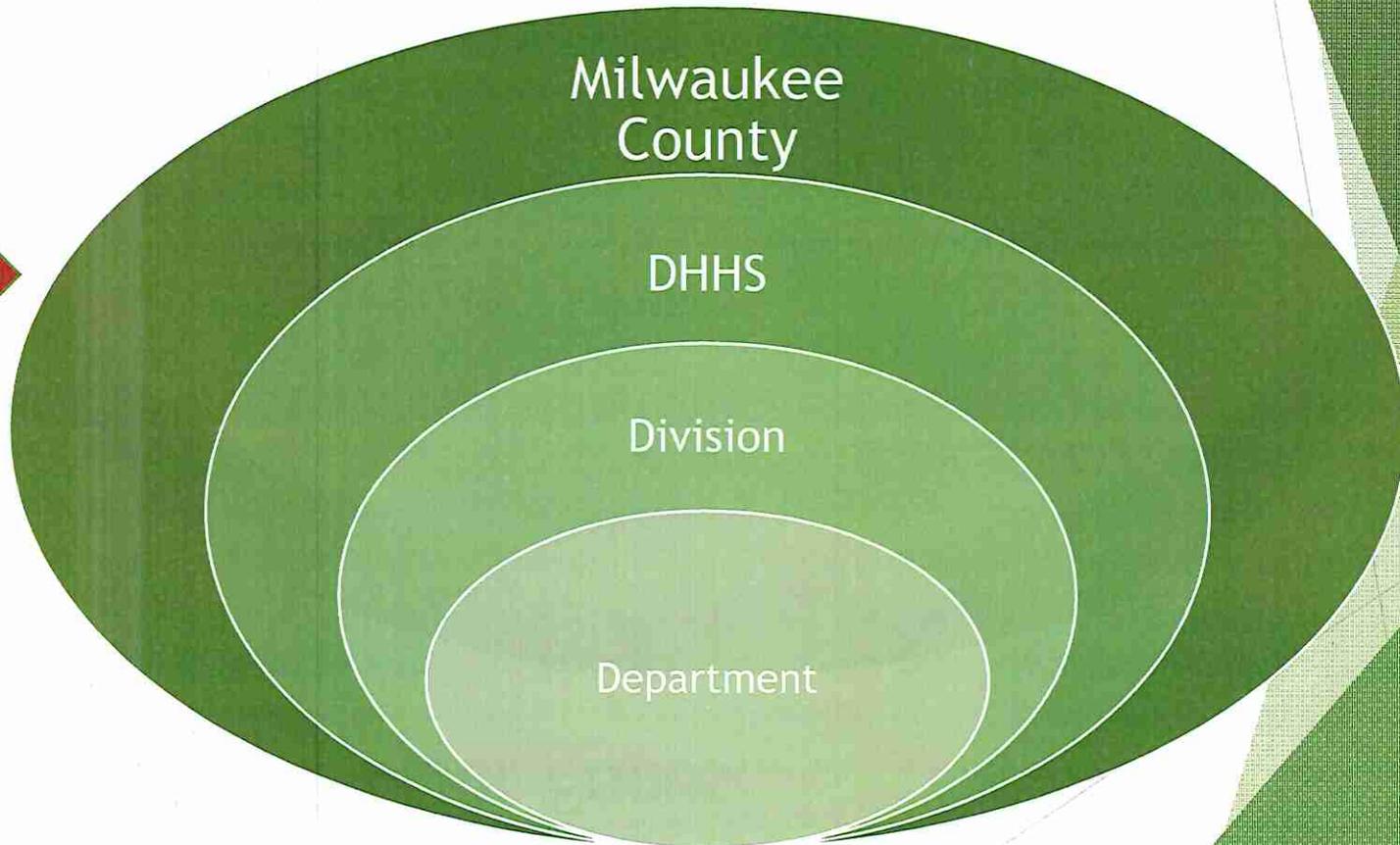
- ▶ We currently have **40** Key Performance Indicators that we report to the MHB
- ▶ Too many to be interpretable or actionable
- ▶ Not necessarily focused on the long-term, strategic objectives of BHD or DHHS



We Need to Shift Our Focus...



...as an Embedded System!!!



Moving to a Population Health Focus

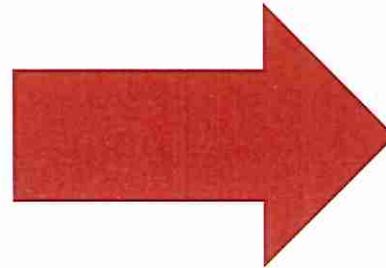
From This:

**Outcomes by
Program**



To This:

**Outcomes by
Client**

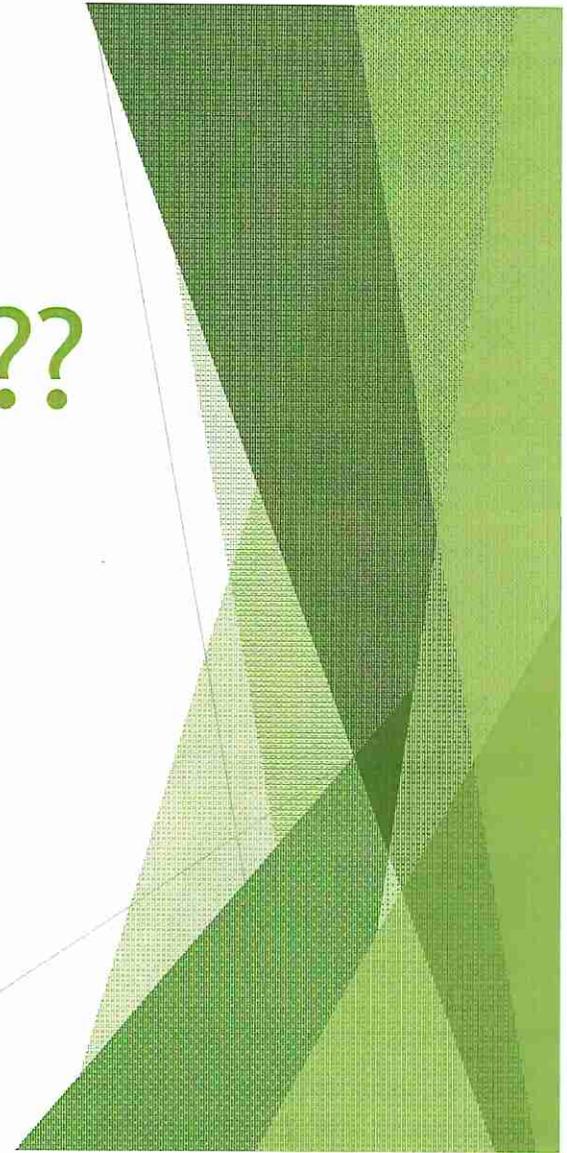


But, how do we get there?

(without doing this)



What Informs Our Core Data Domains???





Milwaukee County Department of Health and Human Services

Mission: Empowering safe, healthy, and meaningful lives. **Vision:** Together, creating healthy communities.

Values

- PARTNERSHIP – We work collaboratively, fostering trusting relationships with others
- RESPECT – We value the dignity and worth of each individual
- INTEGRITY – We adhere to the highest standards of moral and ethical principles
- DIVERSITY – We view differences of all people, values, and ideas as strengths
- EXCELLENCE – We challenge ourselves and others to innovate and achieve exceptional outcomes

Core Competencies

- DHHS is a values driven culture with societal responsibility as a motivation to Do the Right Thing
- Our workforce is dedicated to serving the most vulnerable in the community where others may not be willing or able to serve
- DHHS influences community health and well-being by leveraging partnerships to provide a broad array of critical human services through one accountable department

Department Strategies

Workforce Investment and Engagement		Community and Partner Engagement		Financial Health and Sustainability		High Quality and Accountable Service Delivery	
Make DHHS an employer of choice for employees to work, grow, and lead meaningful change		Foster trusting relationships with stakeholders to build capacity and broader solutions		Build long-term fiscal viability through maximizing revenue and improving cost efficiencies.		Cultivate a culture of continuous improvement	
Advance person-centered, preventative, and integrative health and human services strategies at the individual, family and community levels							
Employee Engagement Score	Target: TBD • Q3: 46.8% • Q4:	% Trust Score on Survey	Target: TBD • Q3: • Q4	Ratio of change of revenue to change in expense	Target: Positive ratio • Q3: • Q4:	HSVC Assessment	Target: 2.5 • Q3 & Q4: 2.3
Turnover as a % of Total Workforce	Target: TBD • Q3: • Q4:	# of Listening sessions	Target: TBD • Q3: • Q4:			Customer Satisfaction Score	Target: TBD • Q3: • Q4:

Focus areas for Divisional action plans to support the Department's Strategies:

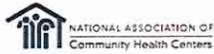
- Increase the physical, virtual and economic aspects of customer access
- Increase inter-departmental collaboration through integrated service delivery to achieve a consistent customer experience
- Pursue and lead innovative solutions that advance the Department's progress up the Human Services Value Curve
- Demonstrate greater efficiency and utilization of human and financial capital

10 year lifespan

5-10 years

3-5 year intended lifespan

Other Sources



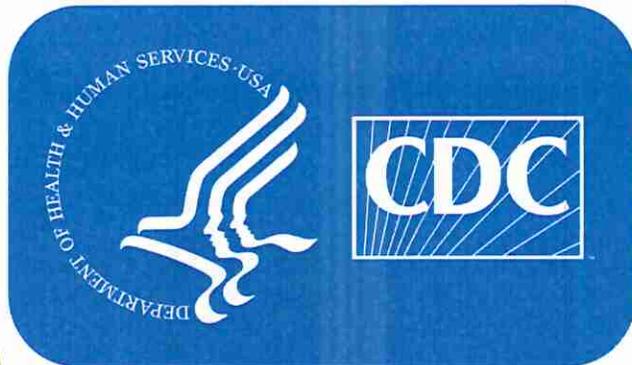
NATIONAL ASSOCIATION OF
Community Health Centers

QM

The Quality Management Plan
A Practical, Patient-Centered Template

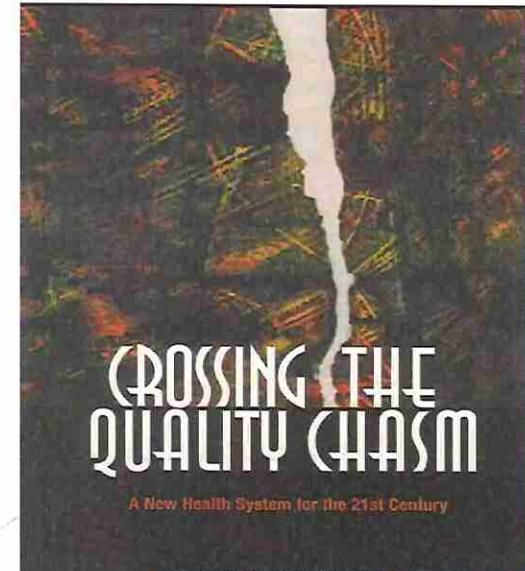
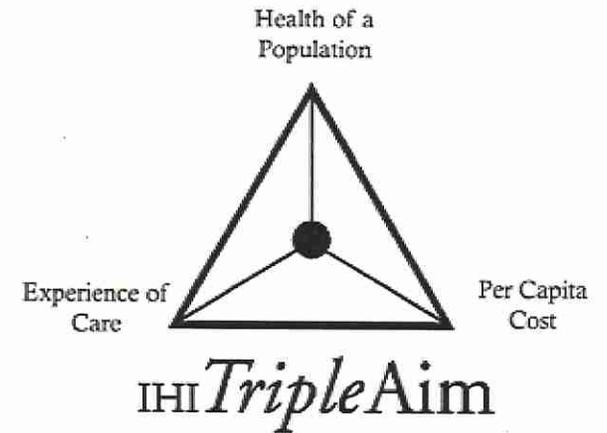
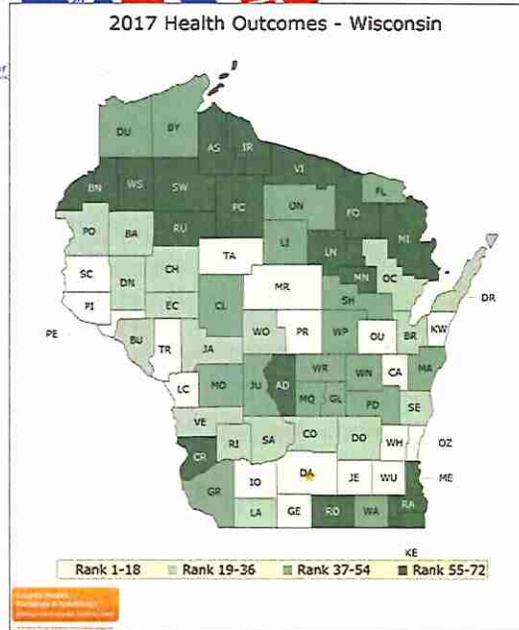
June 2011

Primary Authors
Tara S. Brennan, MD, MCHC
Harold S. Benjamin, Jr., MPA
Special Contributor
David Collins

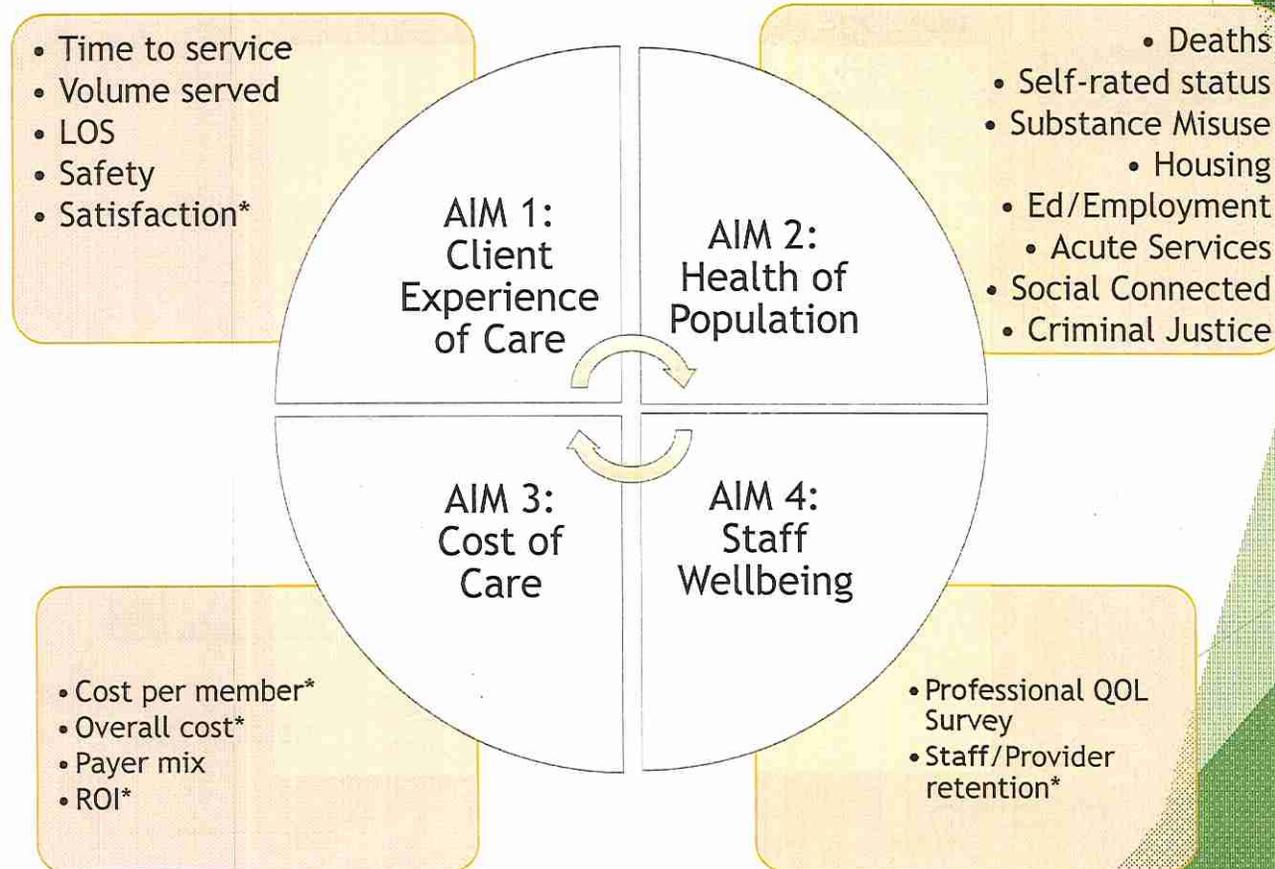


2017 Health Outcomes - Wisconsin

INSTITUTE OF
MEDICINE

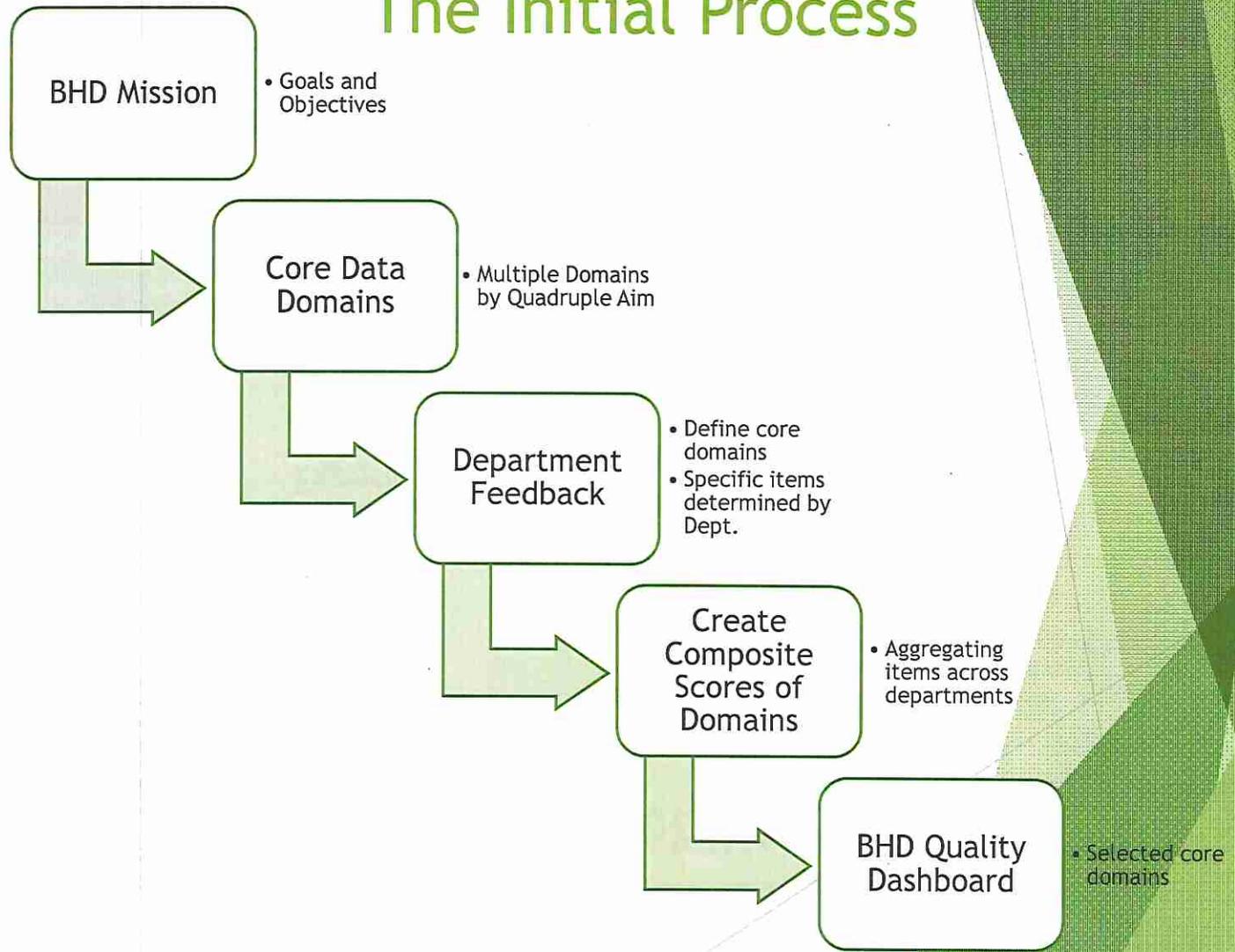


The Quadruple Aim and the Core Domains: A Framework for Quality and Accountability

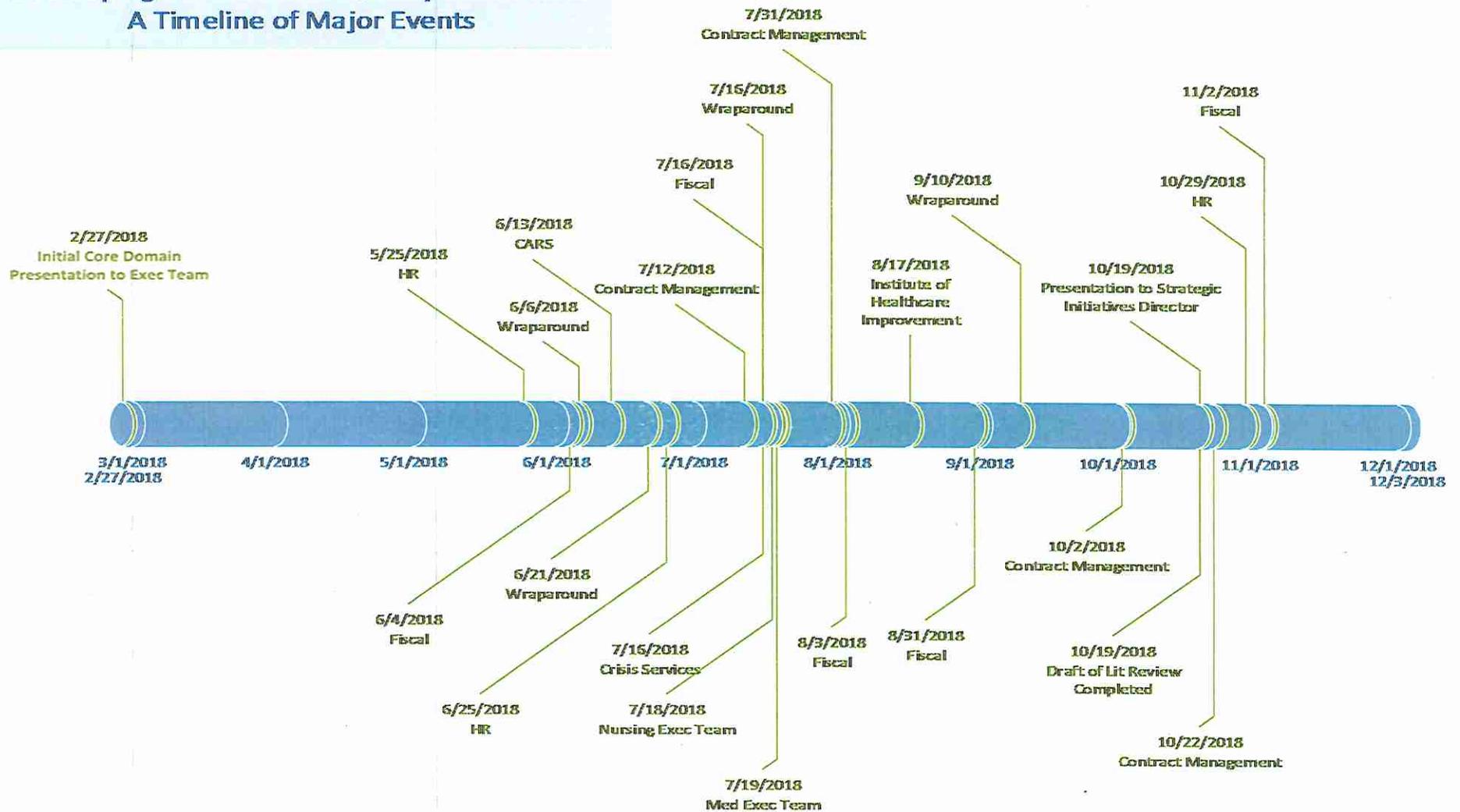


* Consistent with DHHS Strategic Pillars

The Initial Process

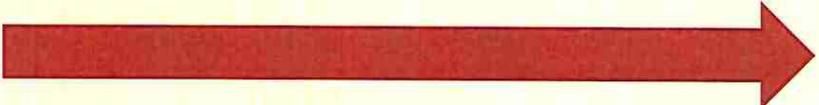


Developing the New BHD Quality Dashboard: A Timeline of Major Events



To Start:

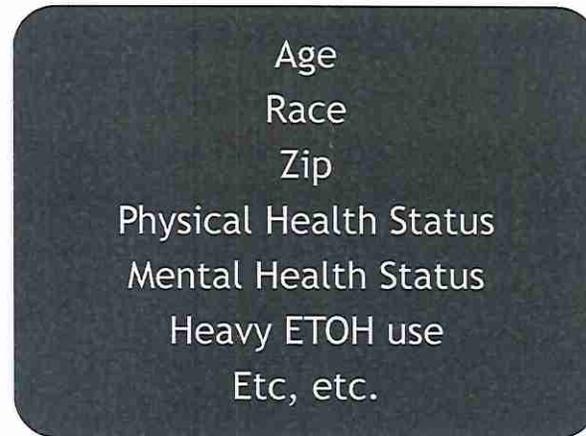
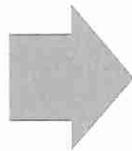
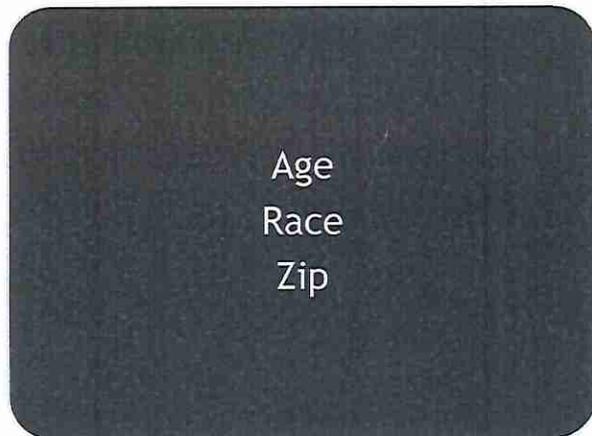
- ▶ The Domains are universal, the items by department are idiosyncratic

Domain	Focus	Shared Definition	Items by Department			
			CARS	Crisis	Wraparound	
					Wrap Dept 1	Wrap Dept 2
Employment/ Education	Employment/ Education	“Defined as...”	Unique Item 1	Unique Item 1	Unique Item 1	Unique Item 1
Housing	Homelessness		So on and so forth			
Social Support	Social Connectedness					

The Future?

Core Domains (Data) as Demographics

- ▶ Can we treat the data used to capture the Core Domains as we would our demographics data?



Milwaukee County Behavioral Health Division 2018 Key Performance Indicators (KPI) Dashboard											
Program	Item	Measure	2017 Actual	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	2018 Actual	2018 Target	2018 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵	8,346	5,771	5,861	5,995		8,323	8,555		
		Sample Size for Rows 2-6 (Unique Clients)		3,546	3,371	3,477					
	2	Percent with any acute service utilization ⁶	17.40%	15.78%	15.91%	18.19%			16.52%		
	3	Percent with any emergency room utilization ⁷	13.87%	12.26%	13.82%	16.25%			13.04%		
	4	Percent abstinence from drug and alcohol use	63.65%	65.22%	62.91%	63.14%			64.54%		
	5	Percent homeless	7.61%	8.17%	9.67%	9.39%			7.24%		
	6	Percent employed	18.09%	20.04%	20.32%	19.49%			18.58%		
		Sample Size for Row 7 (Admissions)		1,622	1,673	1,743					
	7	Percent of all admissions that are 30 day readmissions	59.55%	60.05%	62.22%	57.54%			58.47%		
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,404	1,749	2,185	2,506			3,670		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.5	4.5	4.6			>= 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	64.5%	63.6%	65.6%			>= 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.25	2.68	2.35			>= 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	57.8%	43.1%	53.0%	60.6%			>= 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	44.1%	40.8%	39.4%	38.3%			>= 50%		BHD (2)
Crisis Service	14	PCS Visits	8,001	1,866	1,844	1,821			8,000		BHD (2)
	15	Emergency Detentions in PCS	3,979	756	799	753			4,000		BHD (2)
	16	Percent of patients returning to PCS within 3 days	7.3%	6.2%	8.0%	7.6%			8%		BHD (2)
	17	Percent of patients returning to PCS within 30 days	23.1%	20.0%	26.3%	25.1%			24%		BHD (2)
	18	Percent of time on waitlist status	75.0%	54.3%	100.0%	100.0%			25%		BHD (2)
Acute Adult Inpatient Service	19	Admissions	656	189	183	195			800		BHD (2)
	20	Average Daily Census	42.9	40.6	44.1	41.1			54		BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	1.4%	0.5%	3.4%	0.5%			3%		BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	7.7%	5.2%	9.0%	4.9%			10%		NRI (3)
	23	Percent of patients responding positively to satisfaction survey	74.0%	74.5%	72.9%	80.0%			75%		NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	68.8%	62.1%	71.2%			65%		BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.26	0.94	0.38			0.44		CMS (4)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.36	0.38	0.13			0.29		CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	13.5%	21.5%	22.4%			9.5%		CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	92.3%	94.7%	100.0%			90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	709	164	152	151			800		BHD (2)
	30	Average Daily Census	8.6	8.1	7.0	6.4			12.0		BHD (2)
	31	Percent of patients returning to CAIS within 7 days	5.2%	2.4%	5.3%	4.7%			5%		BHD (2)
	32	Percent of patients returning to CAIS within 30 days	12.3%	10.0%	15.2%	14.0%			12%		BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71.3%	76.4%	67.9%	72.9%			75%		BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	75.0%	86.4%	65.4%			75%		BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.38	1.78	0.54			0.44		CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.93	0.49	0.20			0.29		CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.2%	0.7%	2.0%			3.0%		CMS (4)
	38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	100.0%	0.0%	100.0%			90.0%		BHD (2)
Financial	39	Total BHD Revenue (millions)	\$149.9	\$154.9	\$154.9	\$154.9					
	40	Total BHD Expenditure (millions)	\$207.3	\$213.5	\$213.5	\$213.5					

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

CARS QUALITY DASHBOARD SUMMARY Q3 2018

CHANGES

Further Development of the Quadruple Aim

The CARS Quality Dashboard has continued to undergo further development/refinement of the data elements organized by the Quadruple Aim.

Population Health

1. This and future iterations of the Dashboard will now include Milwaukee County demographic data as a point of comparison for the population served by CARS.
2. CARS will consider the adoption of other population health benchmarks from Milwaukee County for other data elements in the Dashboard (e.g., homelessness status, average age of death, etc.).

Patient Experience of Care

Future versions of the dashboard will include more information about patient satisfaction with care (date TBD in 2019). This will coincide with our Press Ganey satisfaction survey rollout in 2019.

Staff Wellbeing

CARS is working with BHD's Human Resources Department to obtain data on CARS staff turnover. We anticipate that this data will be available in the first quarter of 2019. CARS will also be working with Human Resources to establish appropriate turnover rate targets by department and/or staff classification that are indicative of healthy and high functioning social service organizations.

Cost of Care

The CARS Quality Dashboard has been expanded to now include an approximate cost of care metric based on a per person, per month calculation for all expenditures in CARS programs. This metric, because it is restricted to CARS programs, does not include expenditures for Inpatient or Crisis programs. These will be included in a future iteration of the BHD Quality Dashboard and will include all BHD services a patient receives, irrespective of program.

RESULTS

CARS clients generally experienced an increase in emergency department and inpatient acute service utilization in the third quarter of 2018. These rates will continue to be monitored. Other metrics, however, either remained relatively stable, such as rates of homelessness and employment, whereas others improved, such as 30 day readmission rates for detoxification services.

NEXT STEPS

One of the major initiatives in CARS currently is the development of contract performance measures (CPMs) for all CARS programs. The development of these CPMs has also provided the impetus for the creation of individual programmatic dashboards, which include both the CPMs and other operational and quality metrics of value to program management and oversight. There are now dashboards which have either been created or are in development for several of our CARS programs, with more to come. These initiatives have made data more available to our internal staff and our providers, but even more importantly, they symbolize a paradigm shift within CARS (and BHD more generally) to become a more transparent, data-driven culture. At every level within CARS, staff are utilizing data to make day-to-day decisions, to improve operations, and enhance quality of care.

2018 Wraparound Milwaukee KPI Dashboard Summary – 3rd Quarter

		2017 Actual	1 st Q	2 nd Q	3 rd Q	4 th Q	2018 Target	Status	
Wraparound	8 Families served in Wraparound HMO (unduplicated count)	3,404	1,749	2,185	2,506		3,670		BHD (2)
	9 Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.5	4.5	4.6		>= 4.0		BHD (2)
	10 Percentage of enrollee days in a home type setting (enrolled through Juvenile J	65.7%	64.5%	63.6%	65.6%		>= 75%		BHD (2)
	11 Average level of "Needs Met" at disenrollement (Rating scale of 1-5)	2.59	2.25	2.68	2.35		>= 3.0		BHD (2)
	12 Percentage of youth who have achieved permanency at disenrollment	57.8%	43.1%	53.0%	60.6%		>= 70%		BHD (2)
	13 Percentage of Informal Supports on a Child and Family Team	44.1%	40.8%	39.4%	38.3%		>= 50%		BHD (2)

8 – There was approx. a 13% increase in families served (unduplicated count) from the 2nd quarter to the 3rd quarter.

9 – On target. No comments.

10 - Achieved 87.4% of the target of "75% or greater". Improved 2% overall from 63.6% to 65.6%. Within 20% range of the benchmark. Continued efforts to have youth reside in the least restrictive setting possible.

11 – Overall decrease of .33 from the 2nd quarter. Currently at 2.35 on a scale of 5.0. Below the 20% benchmark (2.4) and below the set standard of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. Those in Wraparound court ordered programs who are disenrolled to a home type setting have a higher "Need Met" score (2.75) than those disenrolled on runaway status or to corrections (2.03). Discharge placement appears correlated with Needs Met. Those in the REACH program average a disenrollment Needs Score of 2.23.

#12 –There was a 7.6% increase in the percentage of youth achieving permanency at disenrollment compared to the 2nd quarter. This is 4.6% above the "within 20% of the benchmark" status (which would be 56%). The increase is notable. The majority were discharged from the program with an end code of "Program Completed" or "Services No Longer Desired" (34 out of 66 or 52%).

"Permanency" is defined as:

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

#13 – This item is monitored within the context of the Care Coordination Agency Performance Report (APR) that is distributed semi-annually. The data is available at all times to all Care Coordination agencies for self-monitoring. The current percentage of compliance (38.3%) just falls short of the "within the 20% of the benchmark" score which is 40%. There is a 1.1% decrease from the 2nd quarter.



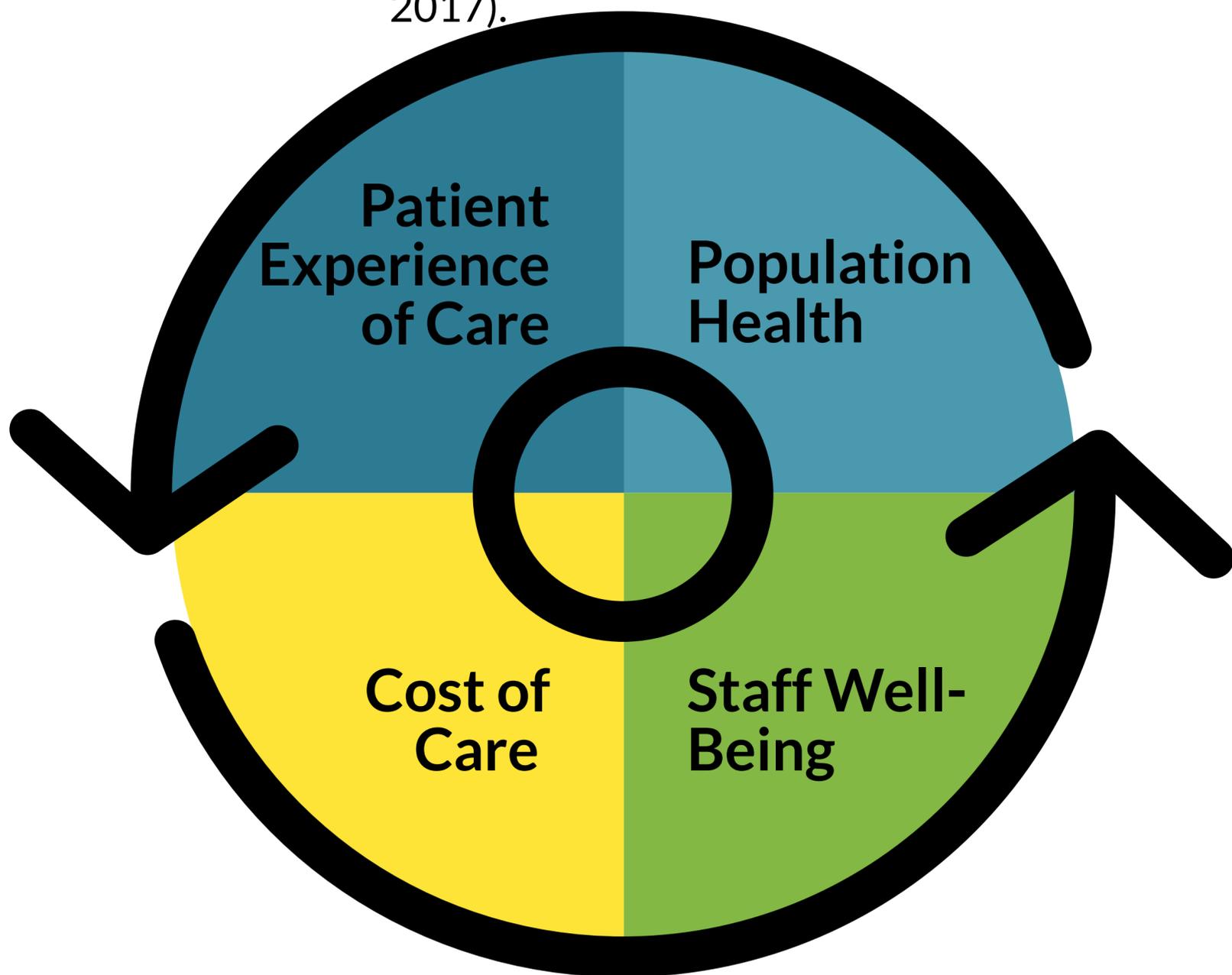
CARS Quality Dashboard

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)

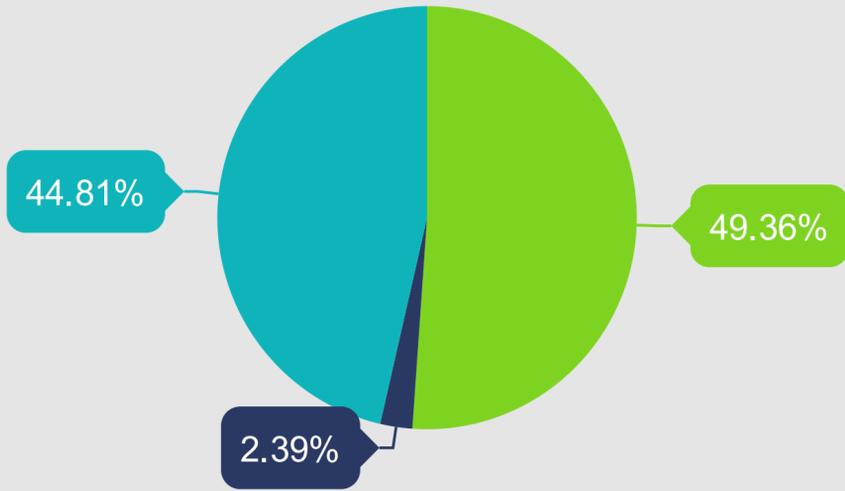
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

Demographic Information of the Population We Serve

This section outlines the demographics of the consumers CARS served or continues to serve in the past quarter.

Race (CARS)

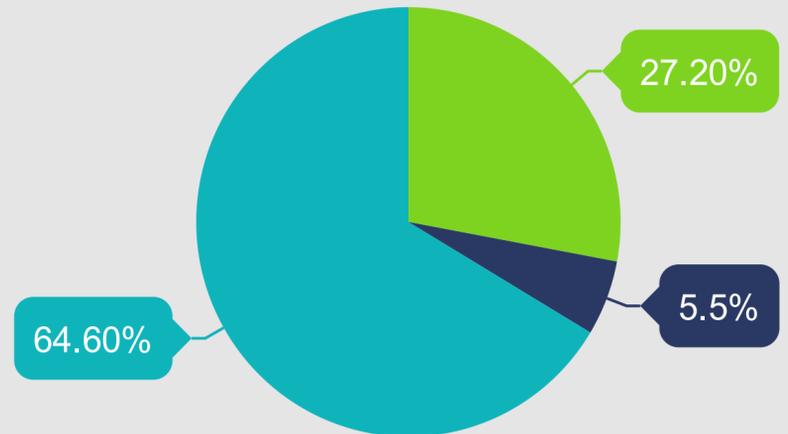
■ Black/African-American
■ White/Caucasian ■ Other



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

Race (Milwaukee County)*

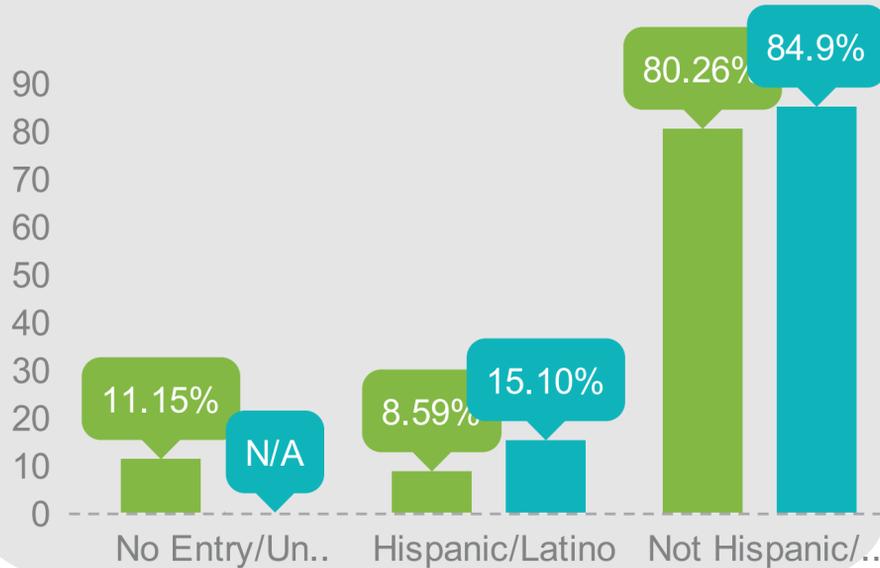
■ Black/African-American
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"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

Ethnicity*

■ CARS ■ Milwaukee County

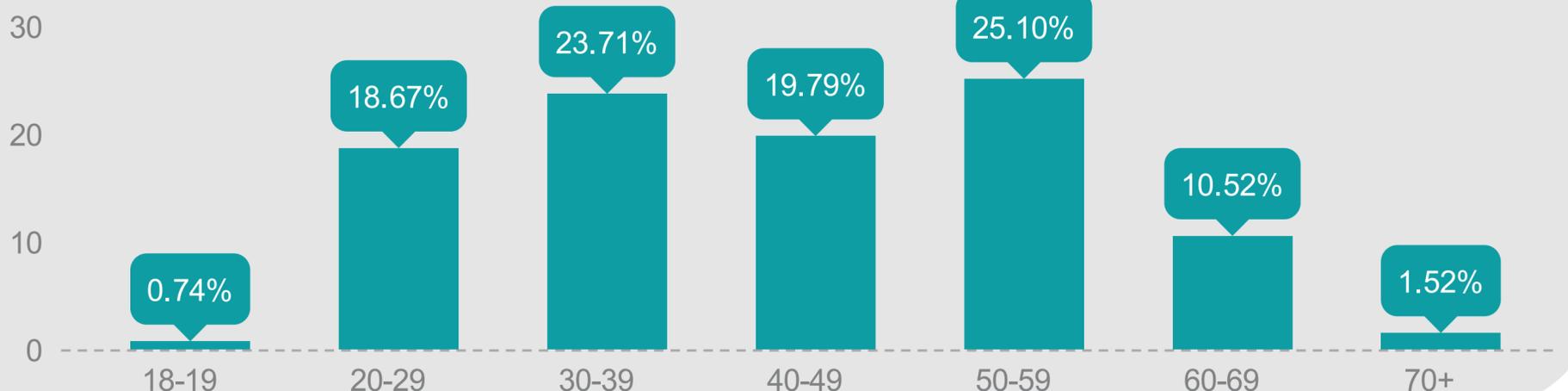


Gender*

■ CARS ■ Milwaukee County



Age



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



Domain: Patient Experience of Care

Items within this domain encompass volume, averages, and percentages. These data points compare the past four quarters in order to indicate change over time.



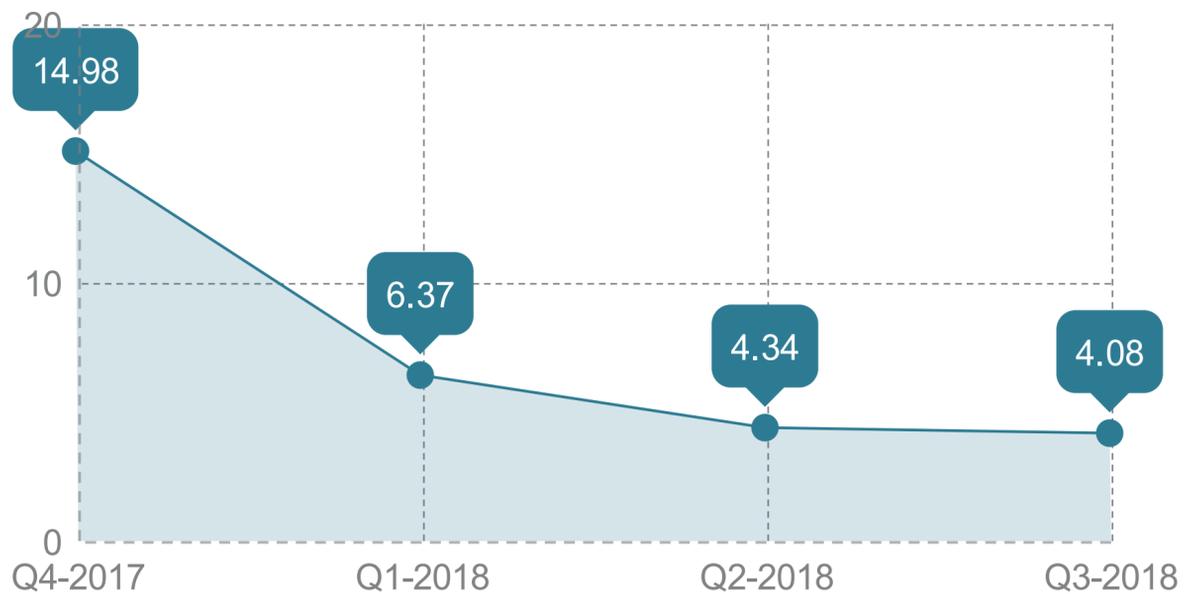
Referrals

Total number of referrals at community-based and internal Access Points per quarter.



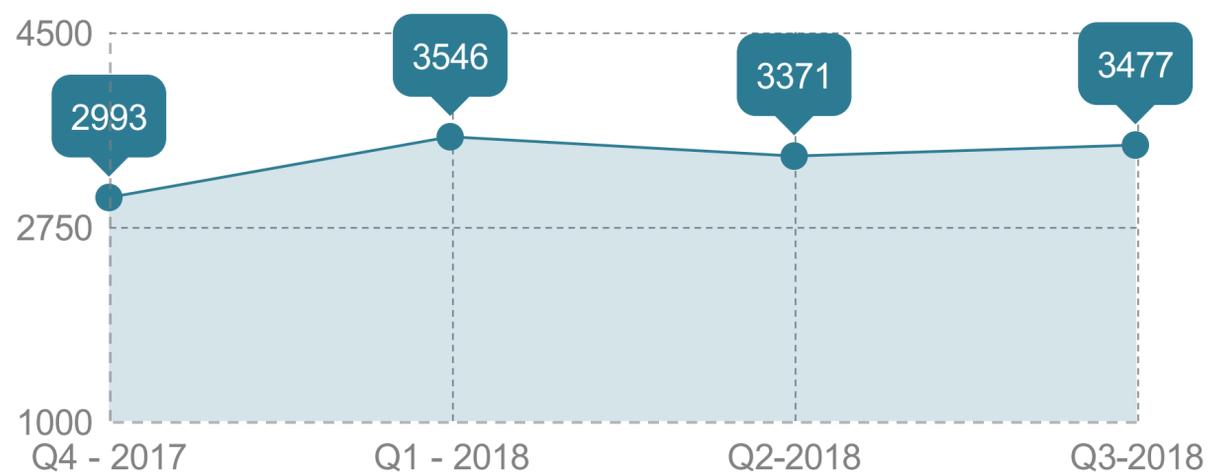
Time to Service

Average number of days between the time of referral to the first service date.



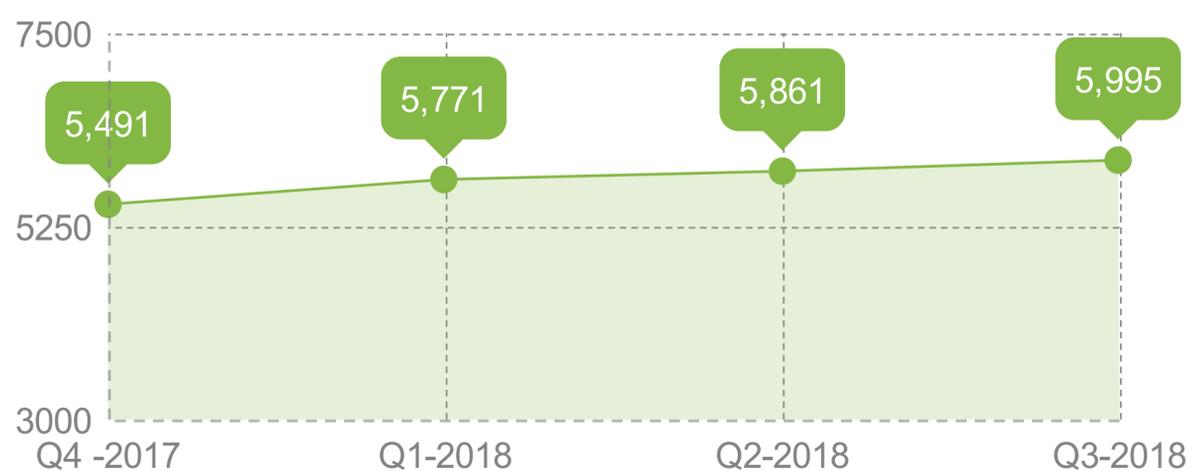
Admissions

All admissions for the past four quarters (not unique clients as some clients had multiple admissions during the quarter). This includes detoxification admissions.



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.





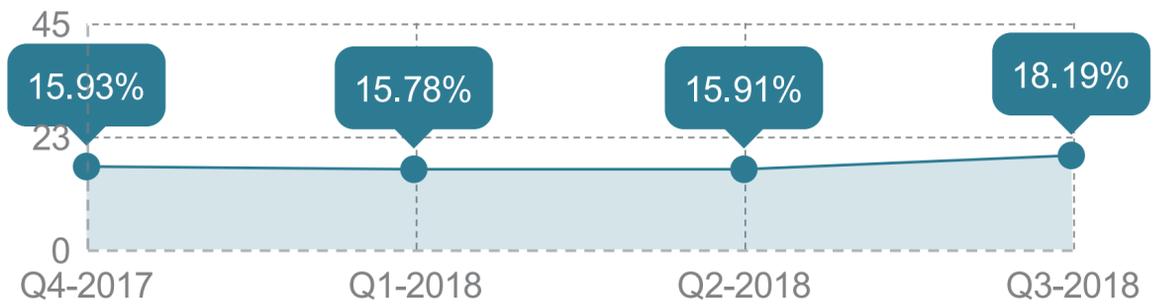
Domain: Population Health

Data informing each item is formatted as percentages based on the description. Most of the data points compare the past four quarters in order to indicate change over time.



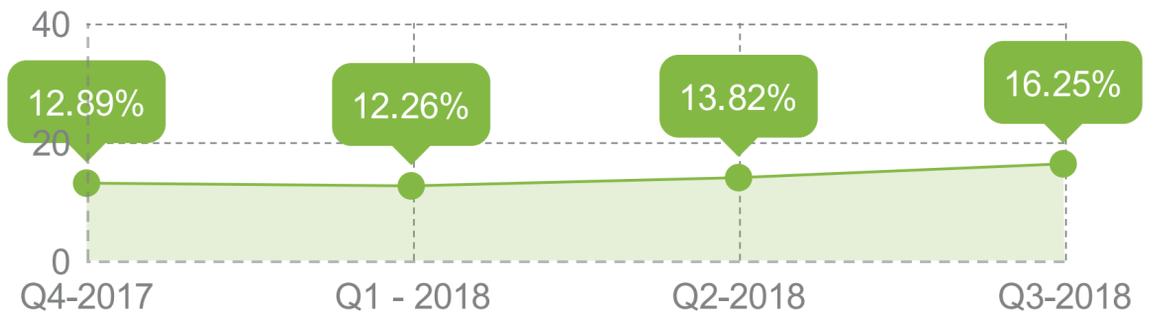
Acute Services

Percent of all unique clients who reported that they had received a psychiatric hospitalization, medical hospitalization, or detoxification service in the last 30 days.



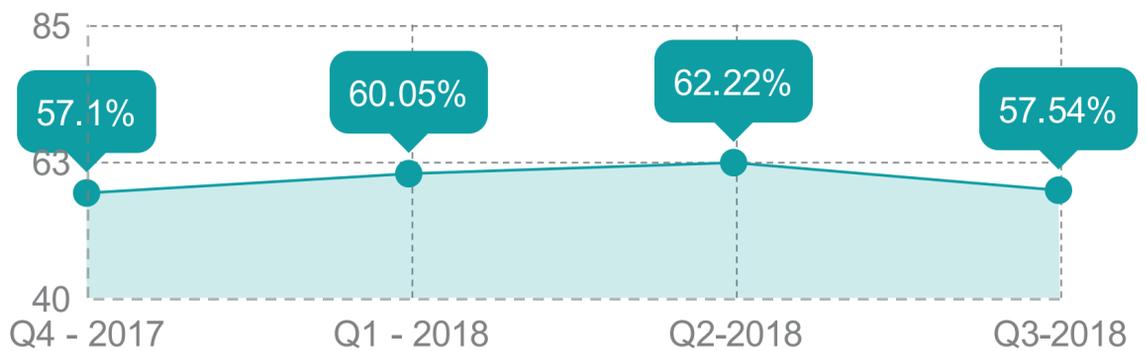
ER Utilization

Percent with any emergency room utilization. Includes any medical or psychiatric ER utilization in last 30 days.



Detoxification 30 Day Readmissions

Percent of consumers returning to detoxification within 30 days.



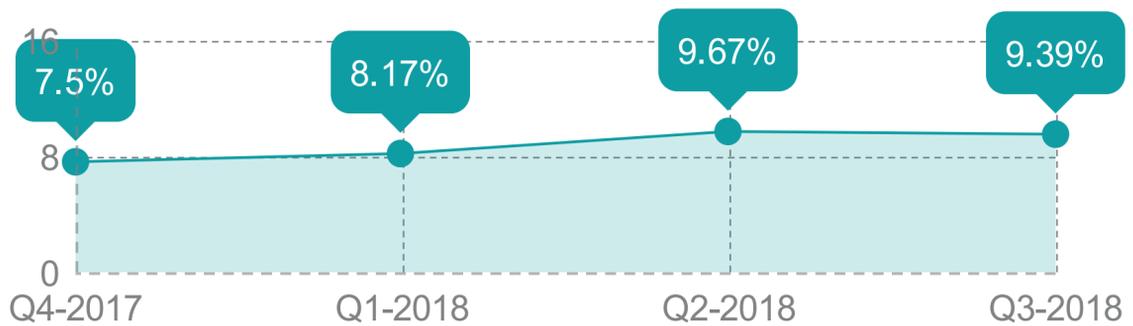
Abstinence

Percent of consumers abstinent from drug and alcohol use.



Homelessness

Percent of all unique clients who reported their current living situation was "street, shelter, no fixed address, homeless".



Employment

Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".





Domain: Population Health (Continued)

Items within this domain encompass volume, averages, and percentages. Most of the data points compare the past four quarters in order to indicate change over time.

Mortality Over Time

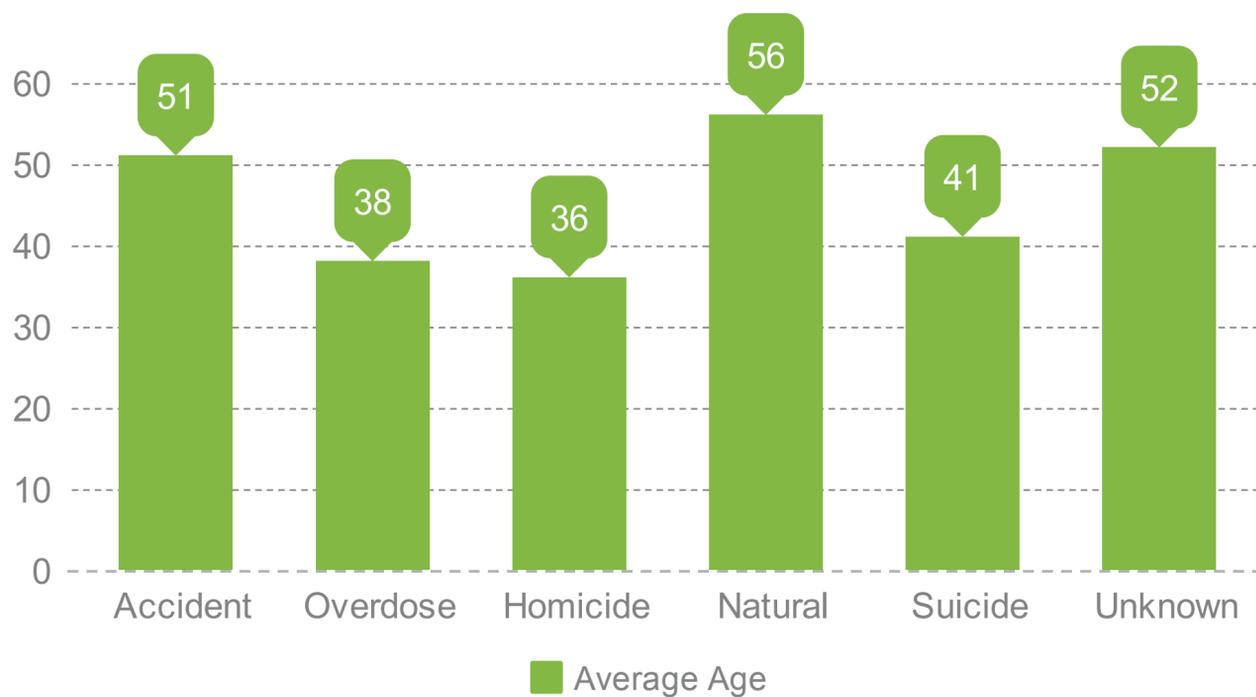
Mortality is a population health metric used by other institutions such as the Center for Disease Control, U.S. Department of Health and Human Services, the World Health Organization and more. The graph represents the total number of deaths in the past four quarters by the cause of death. The total count over time is below:

Q4 - 2017 N = 17	Q1 - 2018 N = 23
Q2 - 2018 N = 11	Q3 - 2018 N = 25



Average Age by Cause of Death

This is the reported average age at time of death by cause of death in the past four quarters.

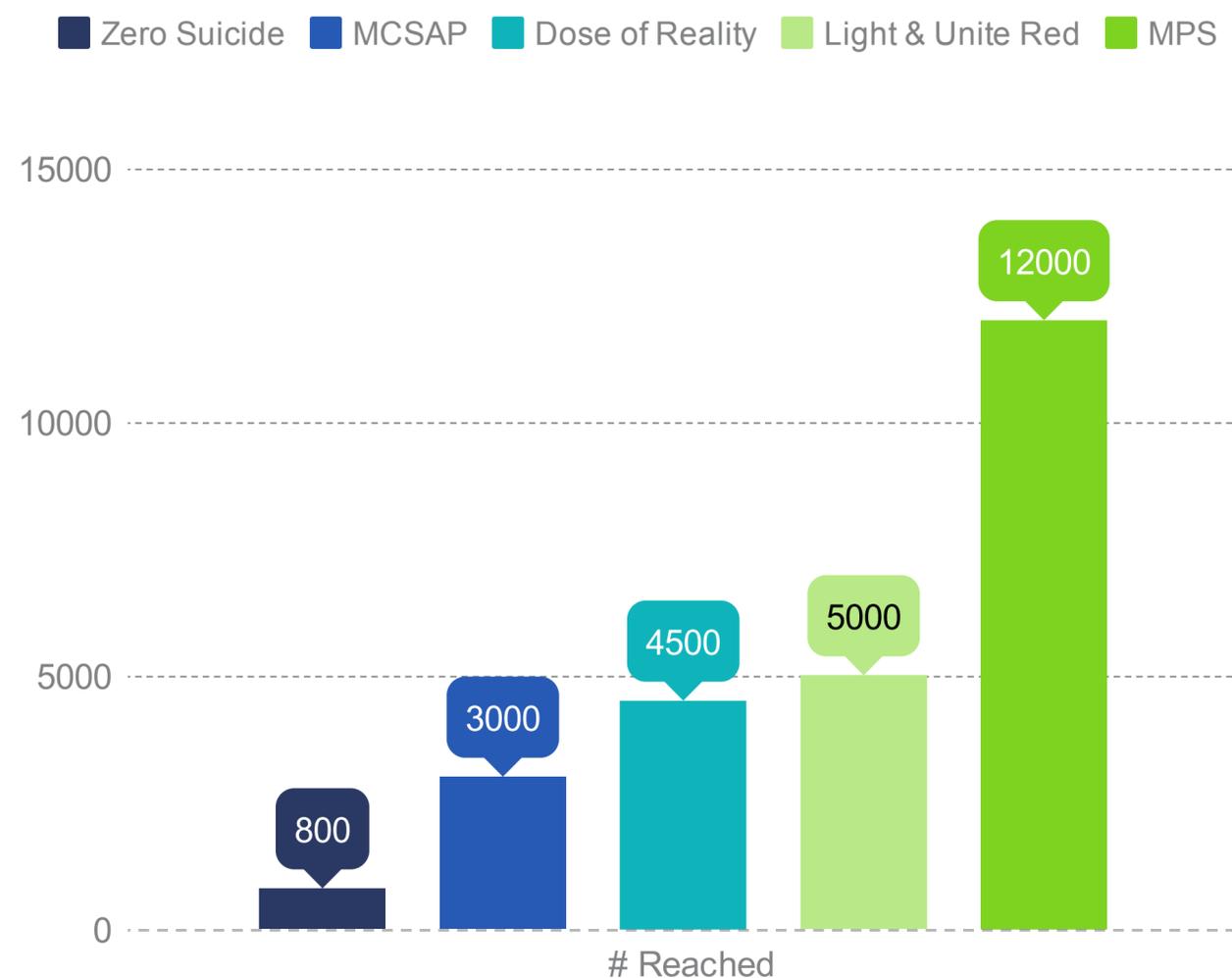


Top Prevention Activities/Initiatives

Prevention is also an important population health factor. Many prevention activities include evidence based practices, presentations, and more. The top five prevention activities are listed in the graphic. Each number is associated with the number of families reached through that initiative in 2017.



The CARS Research and Evaluation team plans to describe forms of primary, secondary, and tertiary prevention activities for topics like substance abuse prevention and suicide prevention.





Domain: Cost of Care

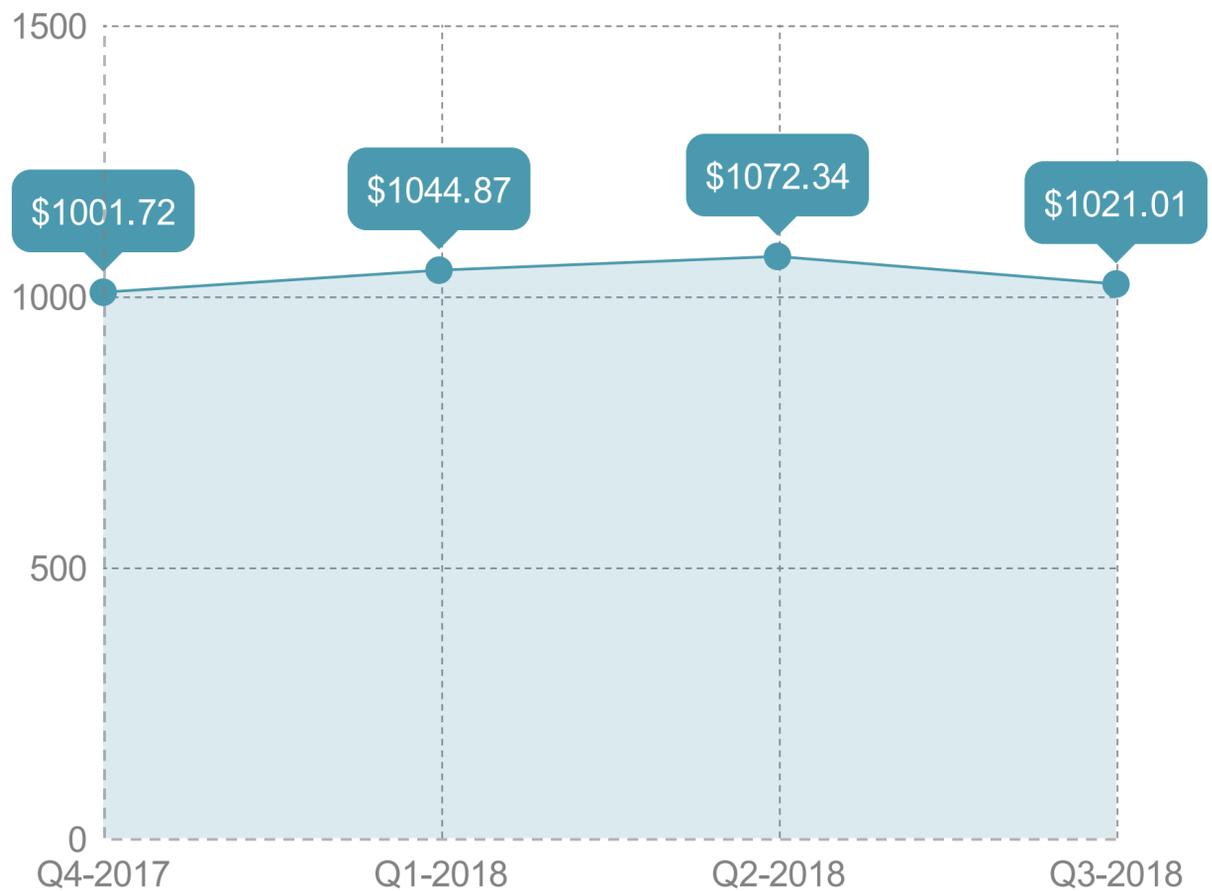
Cost of care compares average cost per month over the past four quarters in order to indicate change over time.

Average Cost Per Consumer Per Month

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 average number of consumers per month within each quarter is below:



Q4 - 2017 N = 4631	Q1 - 2018 N = 4844
Q2 - 2018 N = 4865	Q3 - 2018 N = 5031



Under Development

These are data points the CARS Research and Evaluation team plans to implement in future iterations of the Quarterly Dashboard. Each will contribute to a more comprehensive picture of each domain within The Quadruple Aim.



Staff Well-Being Domain: Staff Turnover

Future dashboards will report on the degree of turnover among CARS staff initially. Future iterations will include staff within the CARS provider network.



All Domains: Case Study

The CARS Research and Evaluation team will capture case study interviews twice a year from consumers, community providers, and other stakeholders as it relates to one of the four domains within The Quadruple Aim.



Patient Experience of Care Domain: Consumer Satisfaction

Press Ganey consumer satisfaction surveys are being adopted in many BHD departments including CARS. Future versions of this report will include overall mean scores of numerous CARS programs.



**BHD Zero Suicide Overview and the Access Clinic Pilot
Quality Management Services Committee, December 3, 2018**

Introduction:

BHD has a Zero Suicide Team. Its members are staff from CARS and Crisis Services, as well as three community members. Our Team seeks to implement evidence based practices across BHD and the provider network to improve client safety and health. Our Team finalized its most recent plan in May 2018 after a year of development. The plan implemented a package of Evidence Based Practices and Tools into the Access Clinic, a short term, walk in and crisis stabilization clinic. After six months of practice and review, there are a number of successes to celebrate, as well as improvements and next steps to pursue.

Our Plan, Our Goals:

Plan Item/ZS Intervention	Related Goal
1. Suicide Screening & Assessment using Evidence Based Tools	1. 100% of clients will be screened for suicide risk. 2. 100% of clients who respond "yes" to SI/SB Questions will receive the full SAFE-T.
2. Safety Planning and Lethal Means Restriction with clients assessed to be at Moderate or High risk	3. 100% of clients who are assessed as Moderate or High Risk for suicide will complete a Safety Plan (which includes Lethal Means Restriction).
3. Post-Visit "Caring" Outreach and Follow up for clients assessed to be at Moderate or High risk	4. 100% of clients who are assessed to be Moderate or High risk for suicide will receive a follow up call.
4. Data Collection, Team Review and Continuous Process Improvement	5. The Access Clinic Team will complete weekly reviews of plan elements. 6. The Zero Suicide Team will complete bi-monthly reviews of plan elements.



Our Outcomes:

What we planned	What we did	What we learned
1. 100% of clients will be screened for suicide risk.	Goal Met. 100% (970) clients between May-Sept. 2018 have received screens in the clinic.	Discussed using the full C-SSRS and embedding in Avatar.
2. 100% of clients who respond "yes" to SI/SB Questions will receive the full SAFE-T.	Goal Met for new clients. 194 new clients (walk ins) between May-Sept. 2018 received SAFE-Ts Goal Not met for returning clients	Clinician time not always available for follow up with returning clients due to walk in clinic needs; team to consider using client alerts in system to follow up when missed.
3. 100% of clients who are assessed as Moderate or High Risk for suicide will complete a Safety Plan (which includes Lethal Means Restriction).	Goal Not Met: 97% (90) of Total Walk ins (93) who were assessed at Moderate/High between May-Sept. 2018 received a Safety Plan with Lethal Means Restriction. Goal not met for returning clients.	Format/Agenda of session appreciated by most; paper Safety Plan not ideal for all; team will look into mobile application and provide choice; not all clients want to stay and complete Safety Plan.
4. 100% of clients who are assessed to be Moderate or High risk for suicide will receive a follow up call.	Goal Not Met: For May-Sept. 2018, 655 clients required follow up calls. Attempts (2 calls made and documented): 89% (583 clients) Completes (phone contact with client): 64% (419 clients)	Staff and clients enjoy the extra contacts; at the same time many don't interact with us by phone (would they by text?). More success with this process for new and returning clients. Large number of follow ups includes multiple, successive contacts.
5. The Access Clinic Team will complete weekly reviews 6. The Zero Suicide Team will complete bi-monthly reviews of plan elements.	Goal Not Met	Clinician card has led to a number of improvements in clinician production, awareness of expectations ZS Team met and reviewed program 1x only to date.



Our Next Steps:

1. Invest (more talent, more time) in the Zero Suicide Team and develop a Phase II:
 - a. Reboot the Zero Suicide Charter
 - b. Have ZS Team include a “working group” and an “advisory group”; have the former meet frequently and build a Phase II plan for ZS expansion across BHD
 - c. Invite members from across DHHS, MPS, VA, Our Partner FQHCs, BHD Provider Network, and more
 - d. Include suicide attempt survivors (family, friends, clients) and Certified Peer Specialists on the Team
 - e. Better connect effort to Exec Team, its high priority projects, goals, its Quality Improvement work
2. Build a better data collection and review system; develop schedule to review, plan, improve with both ZS Team and direct practice clinicians
3. Consider embedding the Zero Suicide tools fully into Avatar (as a part of Phase II)
4. Consider spreading Access Clinic interventions across BHD Crisis Services (Team Connect, Crisis Case Management, Crisis Mobile) as a key part of our Phase II
5. Consider improvements to Screening Tool, use of Safety Planning Mobile Application, Caring Follow ups by text, and use of Certified Peers to provide a portion of the Screening check ins (for returning clients) and Caring Follow ups
6. Pursue Mental Health America Grant to train BHD/Contracted Provider staff in additional Evidence Based ZS Practices

**Quality Management Committee
Institutional Review Board (IRB) Report
December 3, 2018**

The Institutional Review Board (IRB) is a committee designed to assure that the rights and welfare of individuals are protected. Its purpose is to review, approve, and monitor any research involving individuals served or employed by the Milwaukee County Behavioral Health Division (BHD). The review and approval process must occur prior to initiation of any research activities. The IRB also conducts periodic monitoring of approved research.

IRB Membership Update

- Current membership of the IRB includes: Dr. Justin Kuehl (Chair), Dr. Denis Birgenheir, Ms. Mary Casey, Ms. Shirley Drake, Dr. Matt Drymalski, Dr. Shane Moisiso, Ms. Linda Oczus, and Dr. Jaquaye Russell.
- In recent months, the committee extended invitations to two new members. Ms. Shirley Drake is the Supervisor of the BHD's Office of Consumer Affairs. Ms. Mary Casey is a community representative with no direct affiliation to the BHD, but she brings a wealth of knowledge based on her work and volunteer experiences.
- With the addition of these new members, the IRB meets the membership criteria that aligns with best practice and regulatory guidelines.

Recently Completed Research

- Ms. Leah Donovan completed her research titled, "Providing Comprehensive Contraception Counseling for Women Living with a Mental Illness: An Evidence Based Practice Project."

Existing Research

- On May 24, 2017, the IRB approved a proposal submitted by Dr. Tina Freiburger titled, "An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division." The research is ongoing and the IRB continues to receive routine semi-annual updates.

Research Proposals

- In the past six months, the IRB addressed preliminary inquiries regarding two new research proposals. The committee awaits final proposals for review.

Monthly IRB Chairs Meeting

- The Medical College of Wisconsin (MCW) hosts a monthly meeting of local IRB Chairs. The purpose of the meeting is to share information and discuss pertinent issues, which promotes best practices amongst the various IRBs. Dr. Kuehl received an invitation to participate in these meetings and he attended for the first time on 10/18/18.

IRB Training

- There is an online training curriculum offered by the Collaborative Institutional Training Initiative, which is commonly referred to as the CITI Program. It is a common for IRB members to complete this type of formal training to establish competence to serve on the committee.
- The BHD purchased an institutional membership for CITI Program and IRB members have started to access this essential training.
- With an institutional membership, other BHD employees can benefit from these training courses. Interested employees may contact Dr. Kuehl for additional information.

Frieda Brunn Mental Health Research Foundation

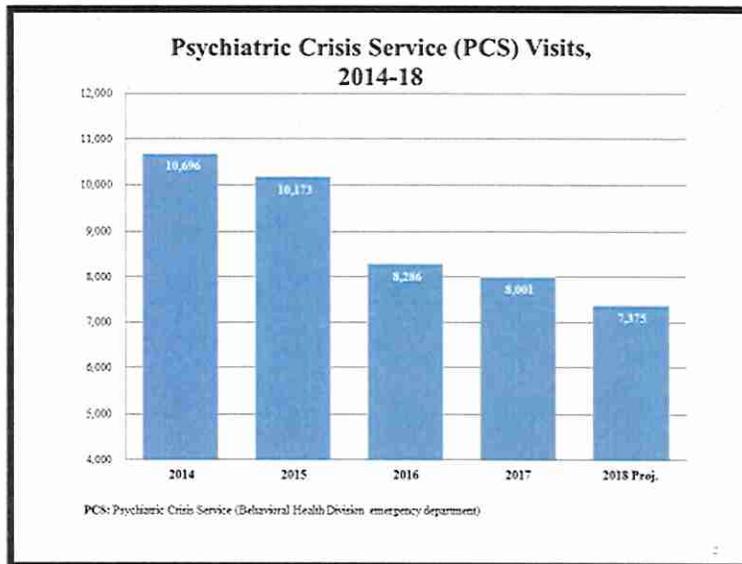
- In 1970, the Frieda Brunn Mental Health Research Foundation created a trust fund with the intent to financially support mental health research.
- As of May 2018, there was a balance of \$216,704.
- The IRB has continued to work on the development of guidelines regarding eligibility and use of the funds.

Respectfully submitted,

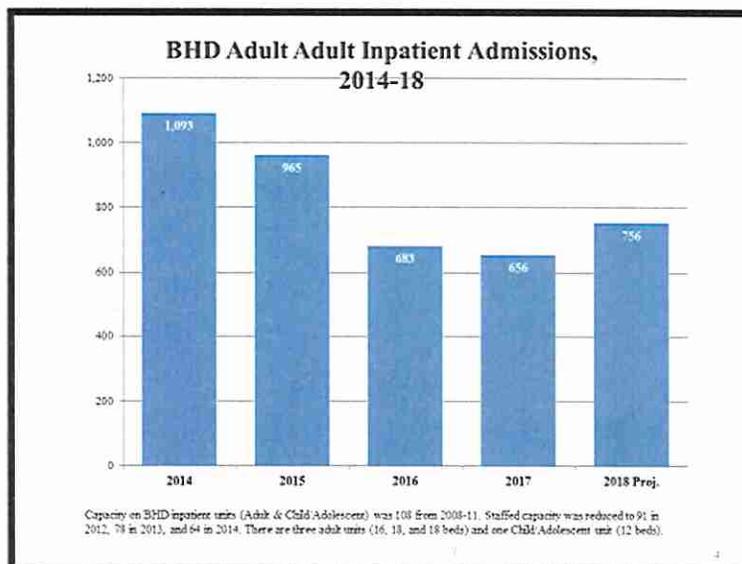
Justin Kuehl, PsyD
Chief Psychologist
IRB Chair

2018 Quarter 3 (Q3) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

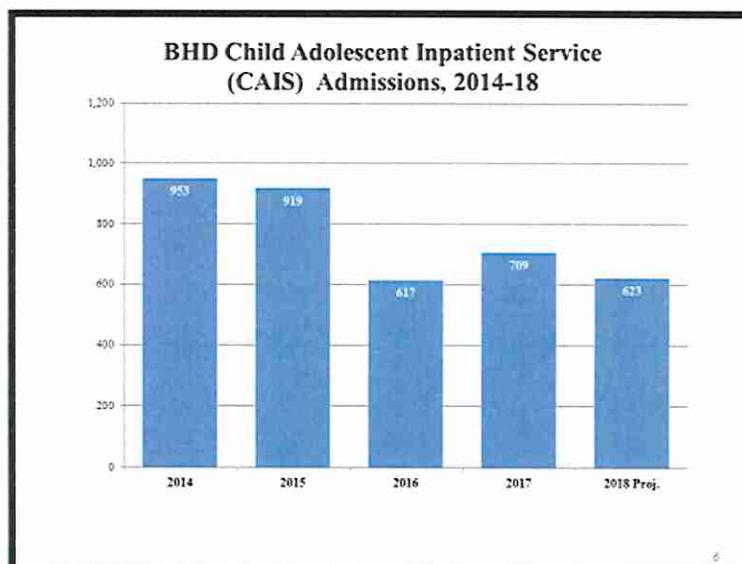
Psychiatric Crisis Service annual patient visits continue to decline from 10,696 in 2014 to 7,375 projected annual visits in 2018 (31% decline from 2014 to 2018). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (54% in 2018 Q1, 100% in Q2 & Q3).



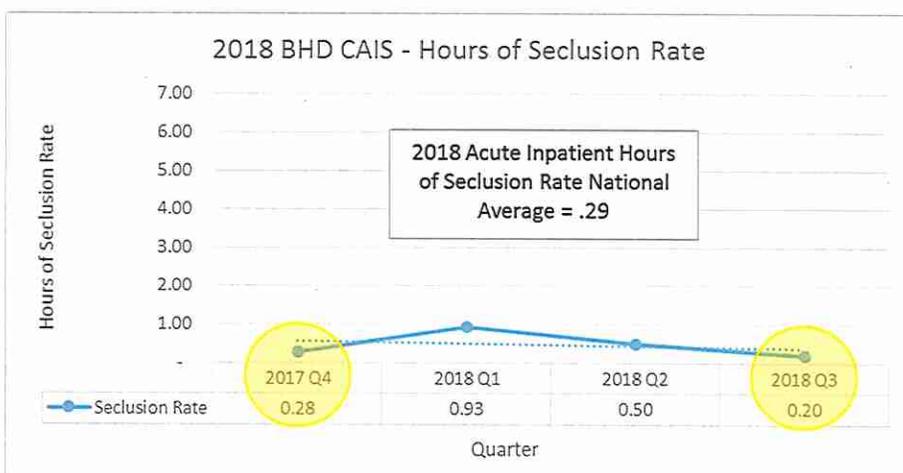
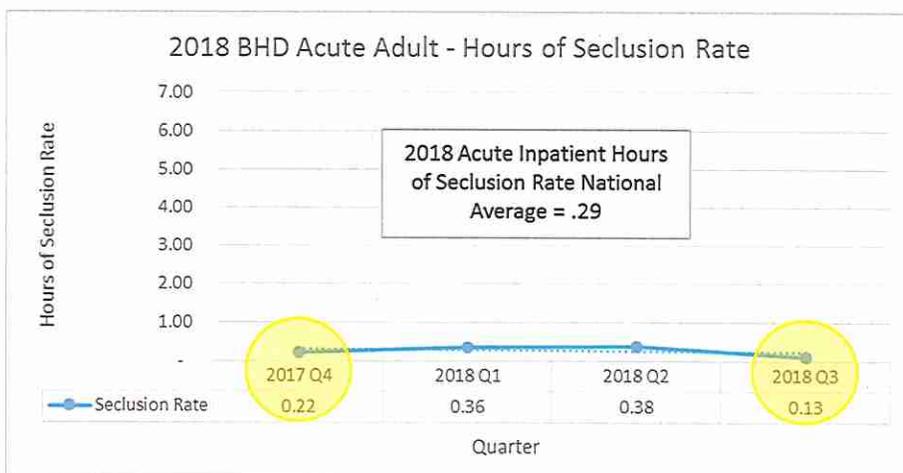
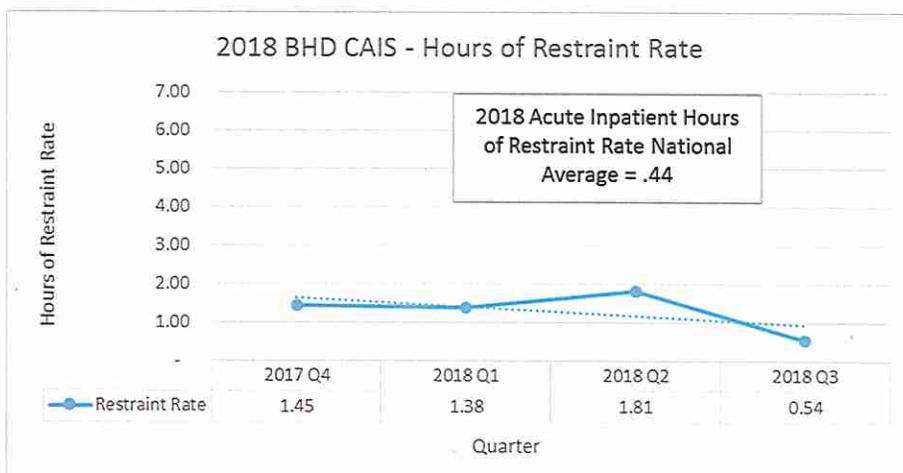
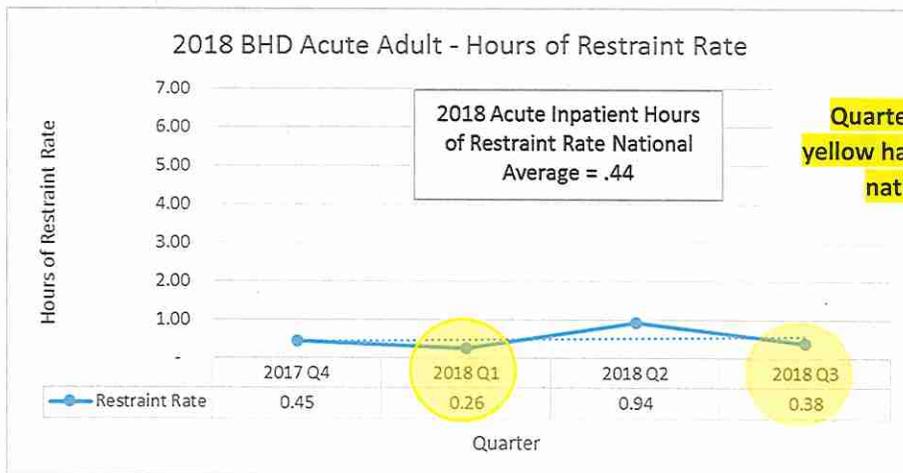
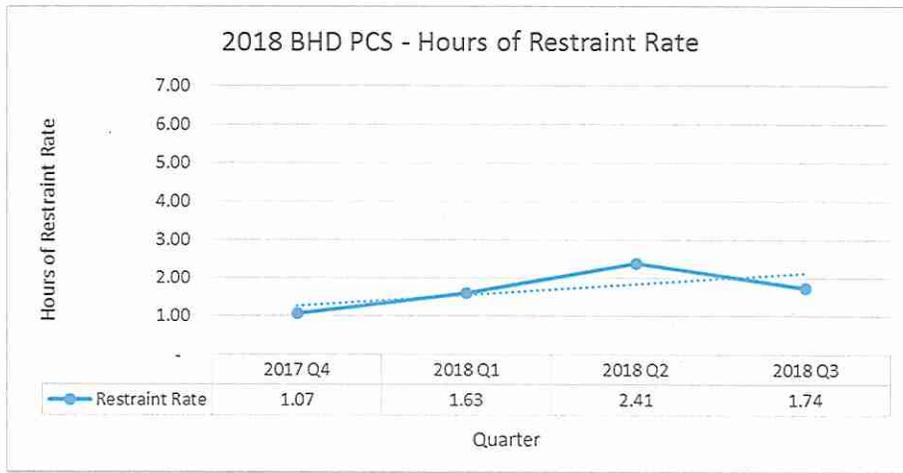
Acute Adult Inpatient Service’s annual patient admissions are projected to increase to 756, the first increase since the Redesign Task Force was established in 2010. While Acute Adult admissions are projected to rise, readmission rates have continued to decline over the past four years (30-day readmission rate: 11% in 2015, 5% in 2018 Q3). In the third quarter of 2018, Acute Adult’s hours of physical restraint rate was below CMS’ inpatient psychiatric facility national average by 14%. Acute Adult’s 2018 Q3 MHSIP overall patient satisfaction survey scores exceeded the national average by 5 percentage points (2018 Q3 BHD Acute Adult overall score 80%, NRI national average 75%)



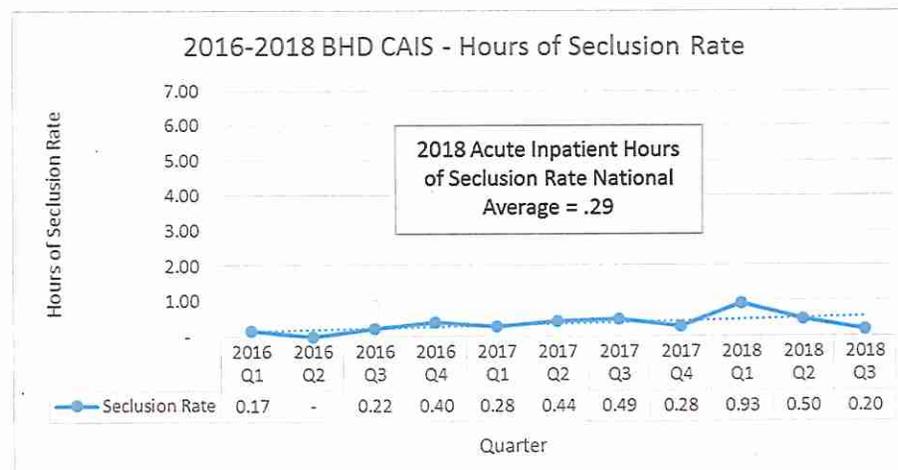
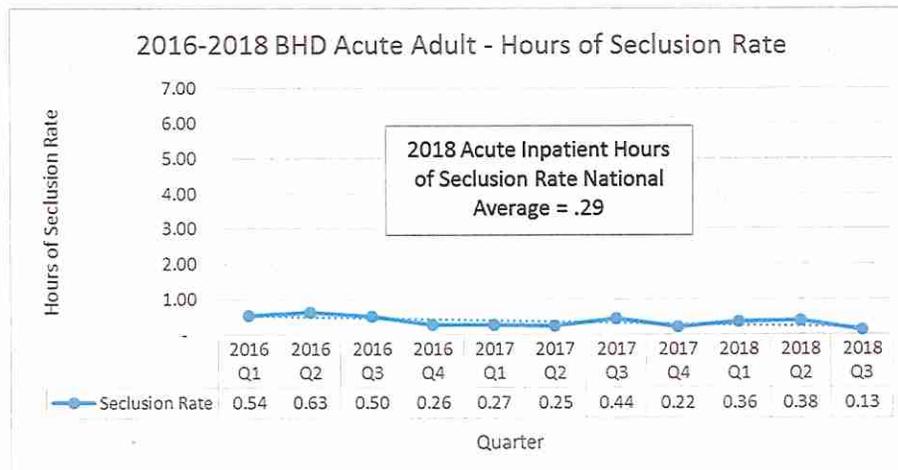
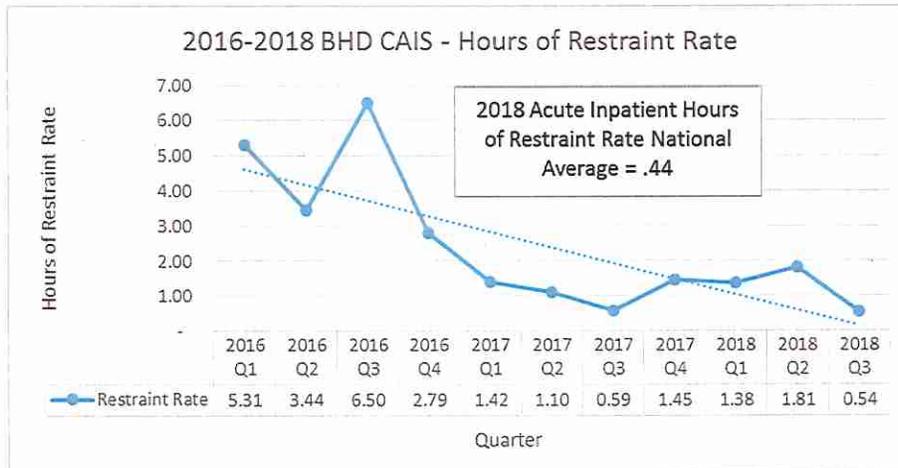
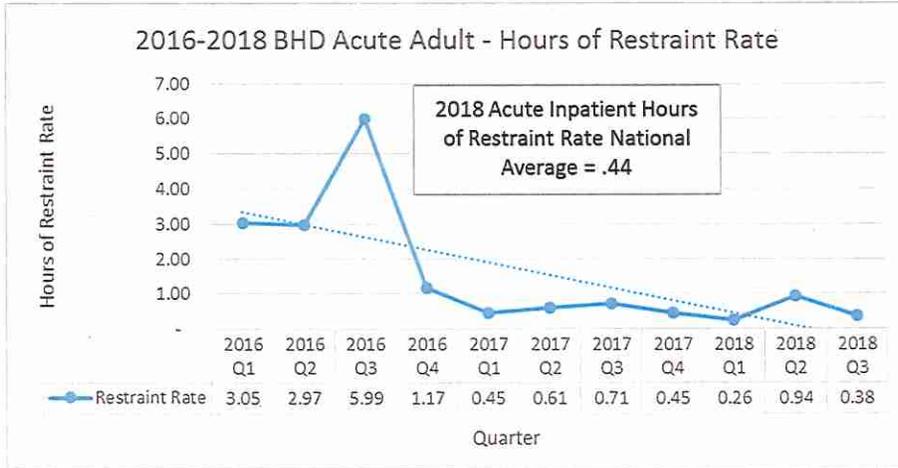
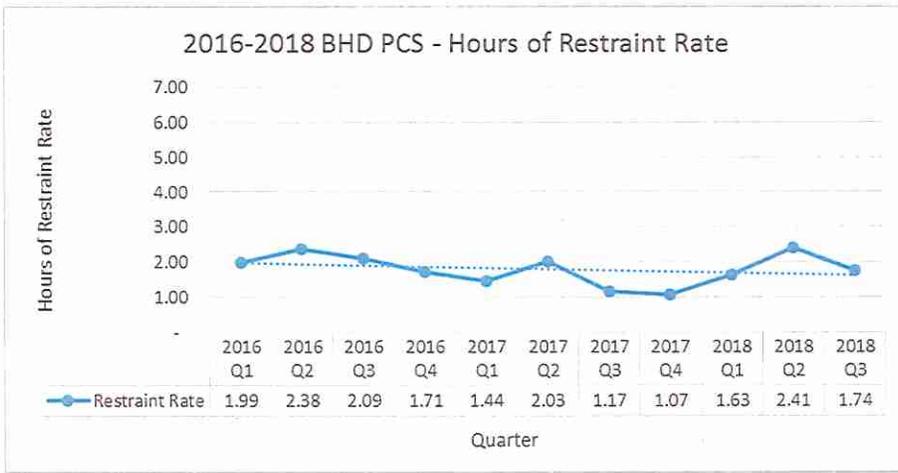
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past few years and are projected at 623 for annual 2018. Over the past four years, CAIS’ 30-day readmission rates have declined from 16% in 2015 to 14% in 2018 Q3. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to .54 in 2018 Q3, and is now only 23% higher than the national average. CAIS’ Youth Satisfaction Survey overall scores increased in 2018 Q3 and are now above BHD’s historical average.



2018 Quarter 3 (Q3) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



2016-2018 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary



Hours of Restraint Rate Formula: Restraint Hours / (Inpatient Hours/1,000)

EXECUTIVE SUMMARY
MRMC VIOLENT EVENT FULL SCALE EXERCISE
THURSDAY OCTOBER 11, 2018

Hospitals are required to conduct exercises to assess the Emergency Operations Plan's appropriateness; adequacy; and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the plan to support assessment of the organization's preparedness and performance. The design of the exercise should reflect likely disasters but should test the organization's ability to respond to the effects of emergencies on its capabilities to provide care, treatment, and services. At least one event per year should involve others in the community and one should be an escalating event.

Over the past year the Milwaukee Regional Medical Center (MRMC) members planned a full scale emergency exercise activity. This year's event was held on Thursday October 11th and simulated an active shooter event that notionally started at State Fair Park and progressed to the MRMC Campus. The scenario included over twenty simulated casualties delivered to each hospital emergency department with varying injuries. The shooter traveled through the campus area, starting at Wisconsin Lutheran College and ending at the vacant Child and Adolescent Treatment Center (CATC) building just west of (BHD). For the purposes of the exercise the vacant building was to be presumed to be a BHD operating location and was used for Police and Fire Recue Task Force and Evacuation Task Force operations.

Multiple organizations were involved in the planning and implementation of the drill as listed on page 2 of this document.

The exercise focused on the following Core Capabilities:

- Operational Coordination
- Operational Communication
- On Scene Security, Protection and Law Enforcement
- Public Information and Warning Public Health, Healthcare and EMS

BHD is part of the Milwaukee Regional Medical Center's Emergency Coordination Plan (ECP), implemented in late 2017, which focuses on coordinating efforts and resources of the 6 partner organizations. BHD provides coverage for one of two Emergency Command Positions (Duty Officer or Liaison Officer) 12 weeks per year.

BHD was responsible for the Duty Officer role on the day of the exercise. This further tested our internal incident command processes.

The event lasted about 3 hours. BHD received emergency notification from MRMC and sent internal emergency communication messages to all BHD employees through the Milwaukee County Emergency Alert system, Everbridge; Locked down the facility; and utilized the camera system to attempt to track the suspect's movements.

The BHD specific objectives included:

Mission Area: Protection

Operational coordination:

Physical Protective Measures

Objective: BHD Security and Maintenance Staff lockdown the facility within 5 minutes of being given direction to do so.

Mission Area: Mitigation

Objective: Situational assessment

1. BHD Security Dispatch staff monitoring camera system accurately assist with tracking the alleged shooter on BHD property and provide an accurate description of movements and location to law enforcement and BHD administration.

Mission Area: Response

Objective -Operational Communications

1. BHD staff assigned, calls into the Conference line for the event briefings within 5 minutes of receipt of notification.
2. BHD command staff open the Emergency Operations Center (EOC) and staff the center with key positions
3. BHD command staff assume control of internal incident command from initial reporting personnel (Security).
4. BHD command staff create an Incident Action Plan for the first operational period.

Objective: Situational assessment

1. Based on briefing information, BHD Leadership staff communicate with Security, Operations and General staff as appropriate.
2. BHD Command staff effectively communicate key information to Wauwatosa Incident Command

Mission Area: Recovery

Objective – Operational Communications

1. Communicate all clear to Security, Operations and General staff.
2. Deactivate the Emergency Operations Center and return to normal operations.

Strengths:

- Standard Operating Procedures (SOP) are in place regarding internal and external coordination.
- Internal communication went well, and necessary announcements and requests were conducted.
- BHD staff offered psychological first aid resources to other members.
- The tabletop exercise identified the need to have a group text to notify EOC personnel. This was attempted and functioned as designed.
- BHD leadership received the MRMC alert directly and opened Incident Command directly vs transferring command from security team.
- Physical lockdown occurred within target times.
- The MRMC Emergency Coordination Plan (ECP) has been fully implemented and is understood by all members and partners.
- MRMCs reoccurring Training and Exercise program continues to improve performance.
- BHD opened the Emergency Operations Center and implemented the emergency procedures in an effective and timely manner.
- The Staff responded properly to the lockdown directive until the all clear.
- Internal mass communication system test was successful at communicating the chain of events.
- BHD Public Information Officer (PIO) responded to Joint Information Center (JIC) activation and uploaded emergency alert to BHD's internal message boards.

Areas for Improvement/Analysis: The following areas require improvement to achieve full capability level:

- Review SOPs and consider clarifying roles and responsibilities and create/fine tune checklists.
- Consider additional tools/methods to track incident related actions and information.
- The Public Address notification was not audible in some locations. Consider a review of PA system coverage.
- The group text system will need to be further tested in a no-notice scenario and during off-duty hours to ensure it works under those conditions.
- Everbridge Internal Alert message call log showed multiple hang-ups and contact numbers that were out of service. Continuous updating of call list is required, and staff should add alert message sender phone number to contacts list. Coordinate with Office of Emergency Management to update lists.
- Continue to improve on communications between key parties during the incident.

Participating Organizations

- Blood Center of Wisconsin
- Children's Hospital of Wisconsin
- Curative Care Network
- Froedtert Hospital
- Medical College of Wisconsin
- Milwaukee County Behavioral

- Health Division
- 911 Communications Division
 - Milwaukee County Office of Emergency Management
 - Milwaukee Police Department

- Milwaukee Regional Medical Center
- Wauwatosa Fire Department
- Wauwatosa Police Department
- Wisconsin Lutheran College

Conclusion

The overall execution of the MRMC Emergency Coordination Plan and existing violent event protocols and lock down processes went well. Additional increased familiarity and practice will improve the efficiencies of completion of the various tasks required. The progress of the improvement actions will be reviewed in the Environment of Care Committee meetings.

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
June	2	7	3
July	4	18	0
August	1	21	0
September	5	10	1
October	4	14	1

Overall Progress 96.2% as of Nov. 1, 2018

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	500	505	95.8%	96.2%
Up to 1 year Overdue	17	15	3.3%	2.9%
More than 1 year and up to 3 years overdue	2	2	0.4%	0.4%
More than 3 years and up to 5 years overdue	0	0	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	2	2	0.4%	0.4%
Total	522	525	100%	100%

Forecast Due for Review

Past Due Policies - 25

Coming Due Policies

November - 3
 December - 24
 January - 4
 February - 3
 March - 5

April - 2
 May - 4
 June - 11
 July - 8
 August - 46
 September - 1
 October - 20