

Chairperson: Mary Neubauer
Executive Assistant: Kiara Abram, 257-7212
BHD Staff: Jennifer Bergersen

**MILWAUKEE COUNTY MENTAL HEALTH BOARD
QUALITY COMMITTEE
August 3, 2020 - 10:00 A.M.
Microsoft Teams Meeting**

A G E N D A

SCHEDULED ITEMS:

1.	Welcome (Chairwoman Neubauer)
	COMMUNITY SERVICES:
2.	Wraparound Milwaukee - Plan of Care; Pre and Post Evaluation (Dana James, Quality Assurance and Quality Improvement Manager; Adrienne Sulma, Integrated Services Manager)
3.	NIATX Project (Krista McNeil; Alternatives in Psychological Consultation)
4.	Value in Healthcare – A Phased Approach (Dr. Matt Drymalski, Clinical Program Director)
5.	Community Access to Recovery Services Mid Cycle Report (Dr. Matt Drymalski, Clinical Program Director; Justin Heller, Integrated Services Manager)
6.	Community Contract Vendor Quality Updates; A Place for Miracles Living Center, LLC (Amy Lorenz, Deputy Administrator, CARS)
	HOSPITAL SERVICES:
7.	Proposed 2020 BHD Inpatient Dashboard Q2 (Edward Warzonek, Quality Assurance Coordinator; Demetrius Anderson, Quality Improvement Manager; Dale Brown, RN, MSN; Jennifer Bergersen, COO)
8.	Sentinel Event Committee 2019 Annual Report (Dr. Sara Coleman, SEC Chair)
9.	Quality Assurance/Quality Improvement Hiring Update - Verbal (Demetrius Anderson, Quality Improvement Manager)
10.	Hospital Contracted Services Provider Update - Verbal (Luci Reyes-Agron)

11.	Annual Action Items for the Mental Health Board Quality Committee (Jennifer Bergersen, COO)
12.	Adjournment. (Chairwoman Neubauer)
<p style="text-align: center;">To Access the Meeting, Call the Number Below:</p> <p style="text-align: center;">(414) 436-3530 Conference ID: 318 289 280#</p> <p>The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is October 5, 2020 at 10:00 a.m.</p> <p style="text-align: center;">Visit the Milwaukee County Mental Health Board Web Page at:</p> <p style="text-align: center;">https://county.milwaukee.gov/EN/DHHS/About/Governance</p>	
<p style="text-align: center;"><i>ADA accommodation requests should be filed with the Milwaukee County Office for Persons with Disabilities, 278-3932 (voice) or 711 (TRS), upon receipt of this notice.</i></p>	

Plan of Care Redesign

Children's Community Mental Health
Services and Wraparound
Milwaukee

The Need

UPDATED, USER-FRIENDLY DOCUMENT

- POC is accessible, reflective of experience, and helpful to youth, young adults, and families
- Care coordinators (CCs) and providers utilize an understandable document to drive quality care consistent with program values.

IMPROVED QUALITY INDICATORS TO ASSESS QUALITY CARE

- New data points based on multiple stakeholder input
- Seeks to better inform both administration and POC teams of progress being made and needs met

Pre-Evaluation Events

Administration and Sup/Lead Feedback

- Created the initial draft of the new POC

CC and Provider Feedback Sessions

- 4 sessions
- 63 respondents
- Mixed method analysis

Parent and Young Adult Focus Group

- 1 session
- 9 respondents
- Qualitative analysis

New POC Layout

- Sent to Synthesis Developers
- Test the form before go-live

New POC training

- All staff (admin, CCs, etc.) required
- Go live August 3rd, 2020

Feedback Themes

Qualitative themes gleaned from written and vocal feedback on the original and new drafts of the POC.

Provider Themes

- New wording
- New layout
- Removal of sections due to sensitive/triggering nature
- Removal of school attendance graph

Parent/Young Adult Themes

- New plan is “straight and to-the-point”
- Inclusion/exclusion of diagnoses on full POC
- Improved layout and accessibility

Shared Themes

- More recent information displayed on full plan
- Plan is first
- New layout is family-friendly
- Positive regard for Team Plan

Next Steps

Training

- Purpose: To inform staff of new changes, instruct form utilization, and help staff understand its usefulness.

Assessment

- POC Audit: compare timeliness and content of submitted new POCs to the past iteration.
- Post-Survey among providers: 3 and 6 month survey assessing utility, knowledge, and applicability of the new POC.

Quality Improvement

- Determine if action is needed
 - If so, construct a quality improvement plan to address needs uncovered by assessment

Post-Evaluation Timeline

August 3rd, 2020

- Go live in Synthesis
- CCs begin to use new POC form

November 2020

- 1st CC survey

February 2021

- 2nd CC survey (follow-up)

March/April 2021

- POC audits completed by Wraparound QA department

AIM



90% OF APC EMPLOYEES
WILL KNOW 3 MC3 VALUES.

NIATx Change Team Members: Rorey Kroening – *Change Leader*, Pam Fleider – *Executive Director*, Abby Matthews – *CCS Consultant*, J Bell – *TCM Consultant*, Karen Drexler – *Data Collector*, Mary Moftah – *FSS Consultant*, Michele Potrikus – *Operations Consultant*, Krista McNeil – *REACH Consultant*, Rob Bergeson - *Agency Consultant*

Change Cycle #1

- Engaged APC Leadership Team to promote MC3 Values at department meetings.
- Surveyed all 180 employees asking them to list any MC3 Values they know to get baseline data.
- Results: Received 86 responses, 44/86 (51%) knew 3 or more MC3 Values, 26 responses reported not knowing any MC3 Values.

What We Learned:

- Established an aim of 90% of employees will know at least 3 MC3 Values.
- Adapted continuing to raise MC3 Values awareness for all staff through Leadership engagement at team meetings.



Change Cycle #2



- Leadership used MC3 Value ice breakers at team meetings.
- Re-surveyed all 180 employees asking them to list any MC3 Values they know to compile data.
- Results: Received 61 responses, 53/61 responses reported knowing at least 3 MC3 Values (87%), 4 responses reported not knowing any MC3 Values.
- Went from 51% of employees knowing at least 3 MC3 Values in Cycle 1 to 87% in Cycle 2
 - Shared survey results with all staff via email.

What We Learned:

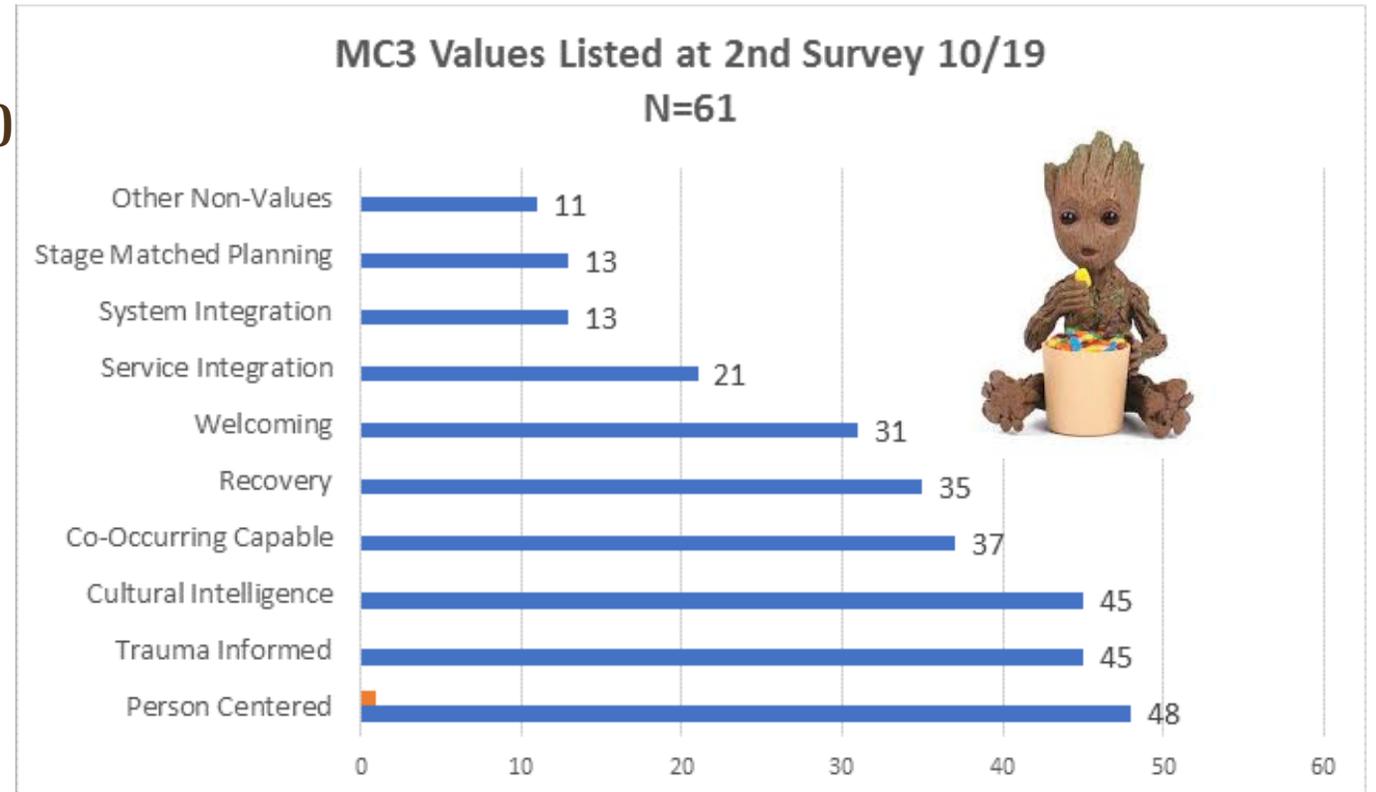
- Awareness of MC3 Values increased overall. (*see data slide*)
- Employees are operating under the MC3 Values umbrella but cannot always define their actions under a specific MC3 Value name.
- Attending current MC3 meetings does not teach the foundation of what MC3 Values are or what MC3 is at it's core.

Change Cycle #2: Data

Results: 53/61 responses knew 3 MC3 Values (87%)

- Average: **4 values**
- 4 staff didn't know ANY values (7%)
- 5 staff knew all 9 values (8%)
- 11 "Non-Values" Mentioned:

- "Strength Based" (3)
- Disorder
- Fun
- Gather info
- Helping
- Respectful
- Integrity
- Learning
- Provider Integration



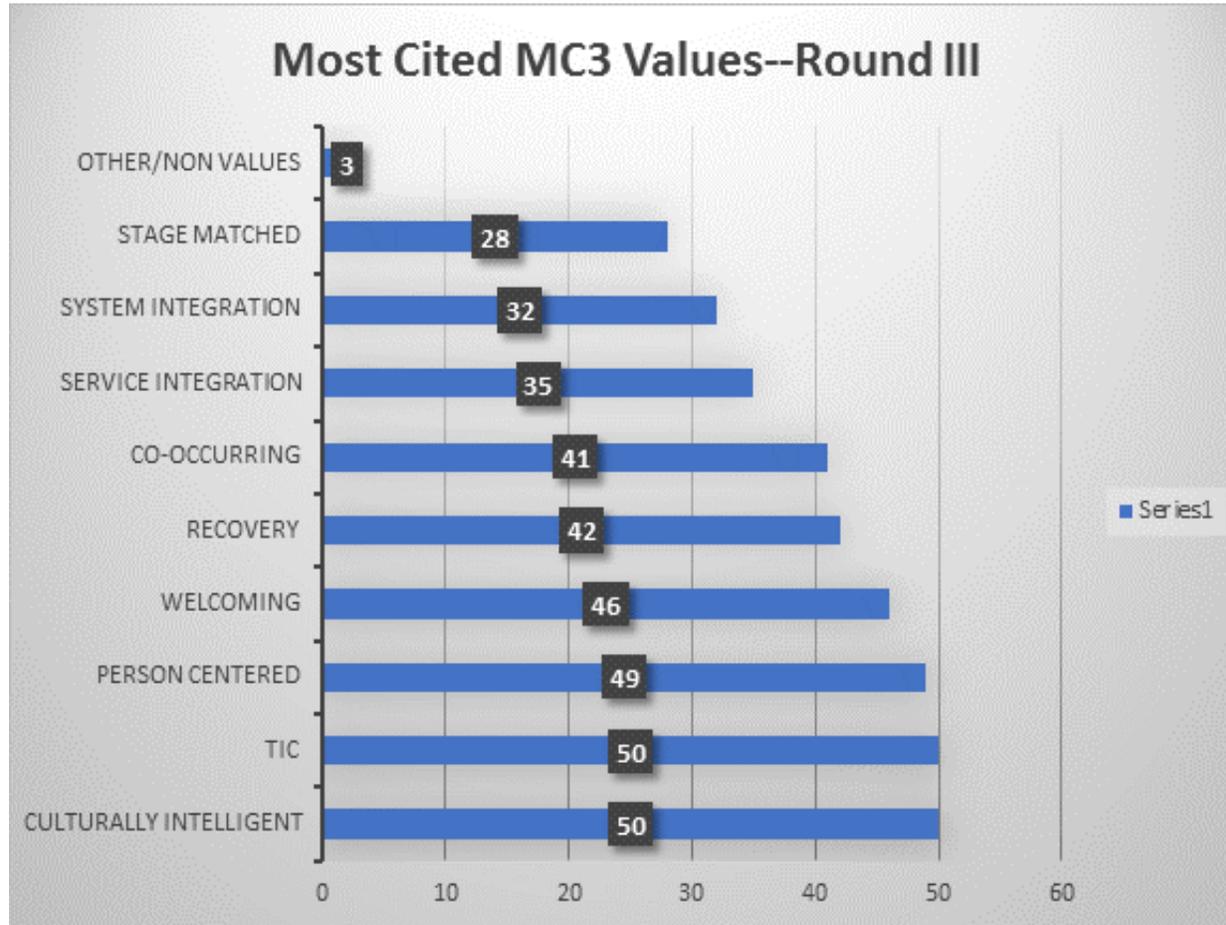
Change Cycle #3

Next Steps:

- Organize and schedule a MC3 Orientation event with Amy Moebius at APC for all employees to attend.
- Continue to have Leadership in departments raise MC3 Values knowledge through ice breaker activities at team meetings.
- Continue to survey staff for data purposes.
- Continue to share any survey results with all staff.



Change Cycle #3: Survey Results



- After Cycle #3 MC3 Orientation was done at APC, employees were surveyed again.
- Survey results were 94.5% of employees knew at least 3 MC3 Values.
- **WE EXCEEDED OUR AIM OF 90% OF EMPLOYEES KNOW AT LEAST 3 MC3 VALUES!**
- The most commonly known MC3 Values were TIC and Culturally Intelligent.





VALUE IN HEALTHCARE: A PHASED
APPROACH

VALUE IN HEALTHCARE AND THE QUADRUPLE AIM

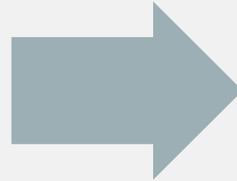
- Value in healthcare is founded upon the accurate measurement and application of the Quadruple Aim



NEXT STEPS: VALUE MODEL AS ROADMAP

Descriptive

- Quadruple Aim



Actionable

- Value Model

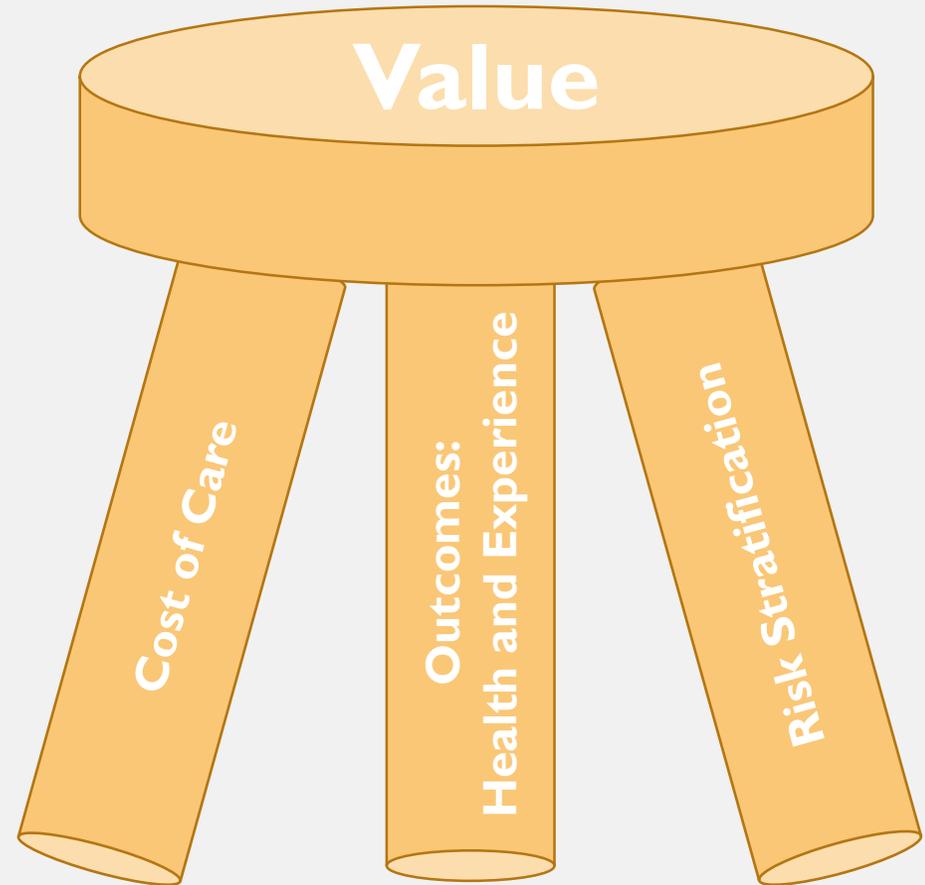
VALUE: A WORKING DEFINITION

$$= \text{Patient Outcomes} \div \text{Dollars Spent on Care}$$

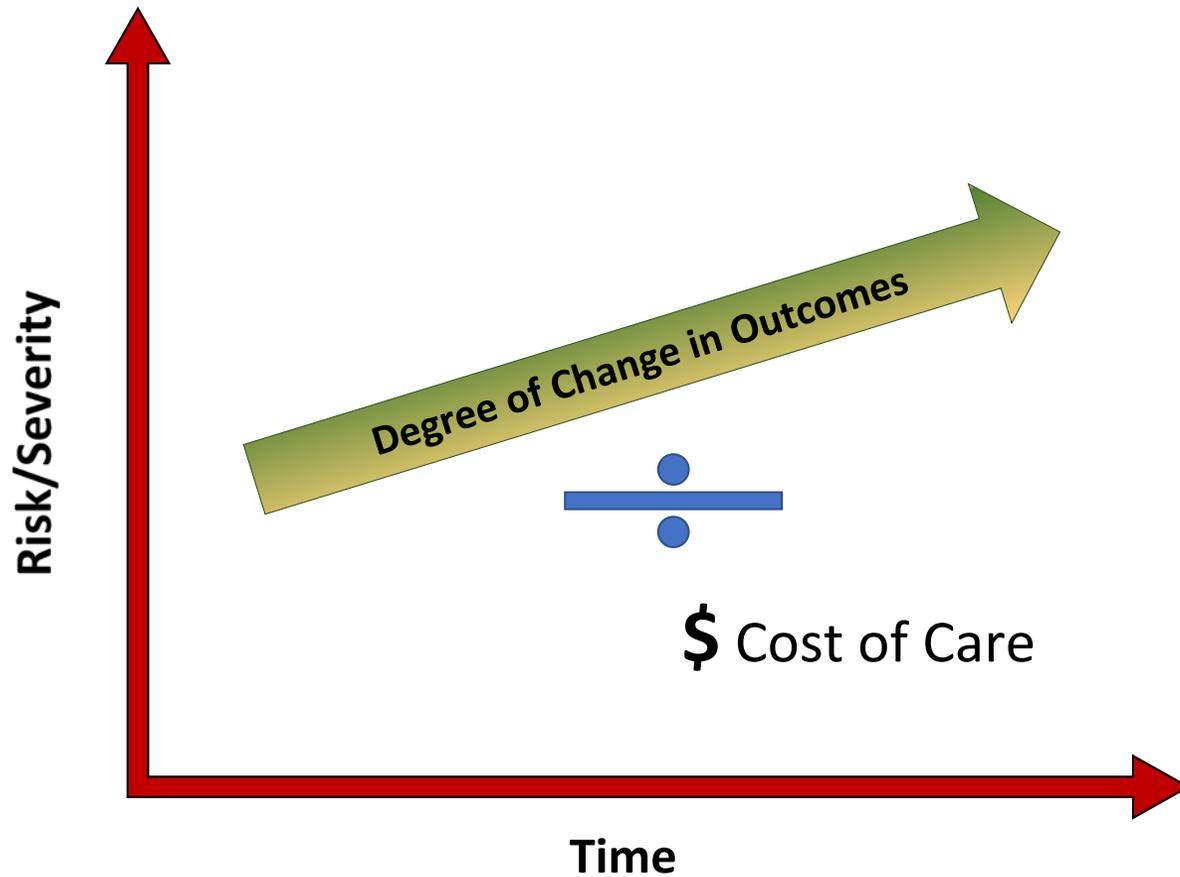
- Porter also states that “any outcome measurement should include sufficient measurement of risk factors or initial conditions to allow for risk adjustment.” (p. 2479, Porter 2010)

VALUE AS A THREE-LEGGED STOOL

- The Value-Based Proposition: A Model
 - Cost of care, stratified by severity, linked to client outcomes



THE
VALUE
MODEL



IMMEDIATE NEXT
STEPS AND PROGRESS
THUS FAR...

Phase 1

Phase 1

- Complete foundation of Quadruple Aim

Phase 2

Phase 2

- Apply the Value Model (or some other paradigm)

Phase 3

Phase 3

- Set quality goals and evaluate progress



Cost of care



Outcomes



Risk Stratification Variables
(including social
determinants)

ESTABLISH
CORE METRICS
IN QUADRUPLE
AIM

COST OF CARE

Many ways to conceptualize

Cost of care report being built in Avatar*

- Developed in consultation with Fiscal Department
- Uses cost value assigned per unit of care delivered
- Accounts for purchase of service contracts and Medicaid pass thru dollars

* Formula already being used in CARS

OUTCOMES

- Should be patient-centered and may include*:
 - Acute Services (*PCS and Detox under development!*)
 - Social Determinants
 - Client Self Report
 - Mortality

* Many of these are already reported in CARS Quarterly Dashboard

** Client experience metrics could be used as outcome as well



OUTCOMES: QUALITY OF LIFE

Quality of life (QOL) as a key outcome

Many potential benefits

- Ultra brief (single item)
- Program and client agnostic
- Broadly related to health, socio-behavioral determinants
- Client centered
- Client reported*

* Please see handout for more QOL results



RISK STRATIFICATION

The process of adjusting estimates of outcome (cost, clinical, etc.), based variables that impact that outcome

Often based on diagnosis; more recent risk adjustment efforts have incorporated social and behavioral determinants of health

RISK STRATIFICATION: CURRENT EFFORT AND NEXT STEPS

- Need to have the right variables in place
- CARS has a preliminary social determinants screen built and ready for implementation

Category	Examples of Variables
Demographic characteristics	Age, gender, origin, and ethnic group
Clinical factors	Diagnoses, comorbidities, and symptoms
Socio-economic characteristics	Education, income, and marital status
Health behaviors	Smoking, alcohol consumption, and diet
Preferences	QOL, expectations of healthcare system

NEXT STEPS

Continue

Continue to build out key, foundational data elements of Quadruple Aim



Pilot

Pilot Value Model

POSSIBLE APPLICATIONS OF VALUE MODEL?



Population health outcomes



Contract performance measures



Contract awards (initial and extensions)



Utilization Management/Utilization Review



Continued dashboard development/revision



Identifying and addressing waste/low value care



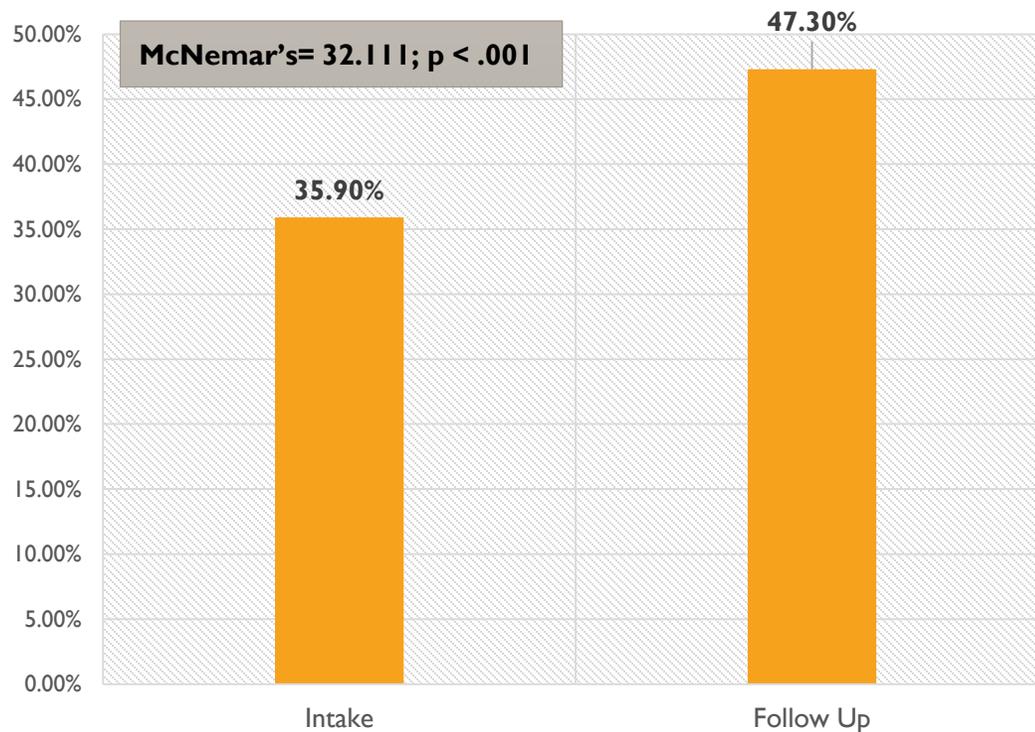
Other QI projects?

THOUGHTS?

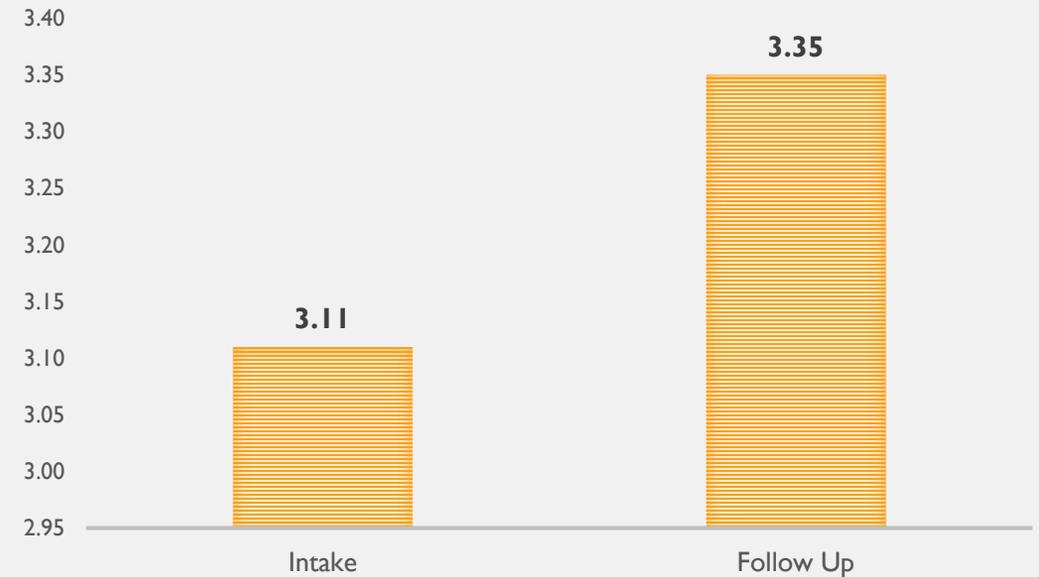
APPENDIX:
SINGLE ITEM QUALITY OF LIFE DATA

SINGLE ITEM QOL AS OUTCOME: PRELIMINARY DATA (N=969)

% of Clients Reporting Good or Very Good Quality of Life: Intake to Follow Up (N=969)



TOTAL QUALITY OF LIFE SCORE:
INTAKE TO FOLLOW UP



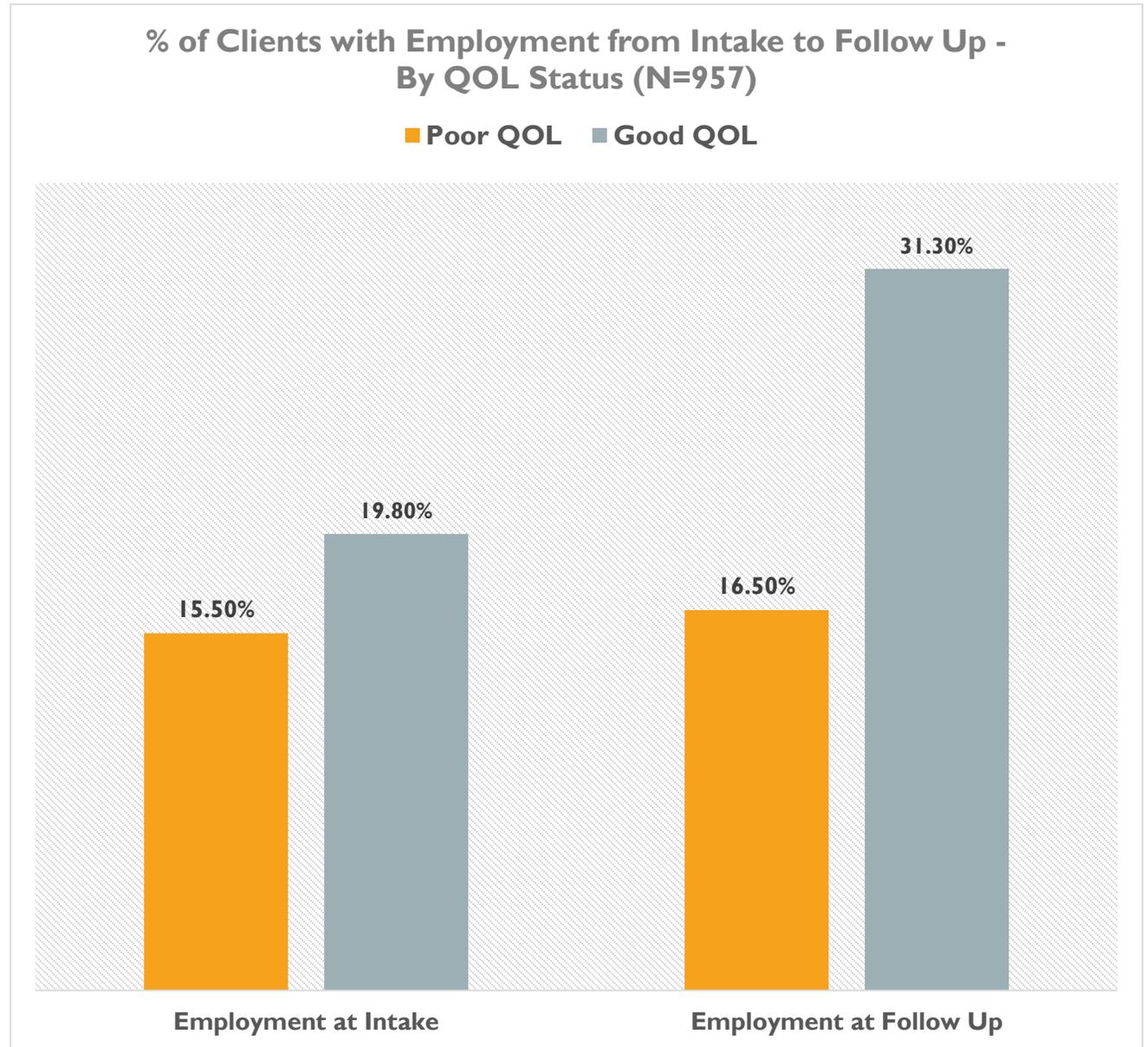
Paired Samples t-test: $t(968) = -6.530, p < .001$

Effect Size: $d = .25$

Standardized Response Mean: = .21

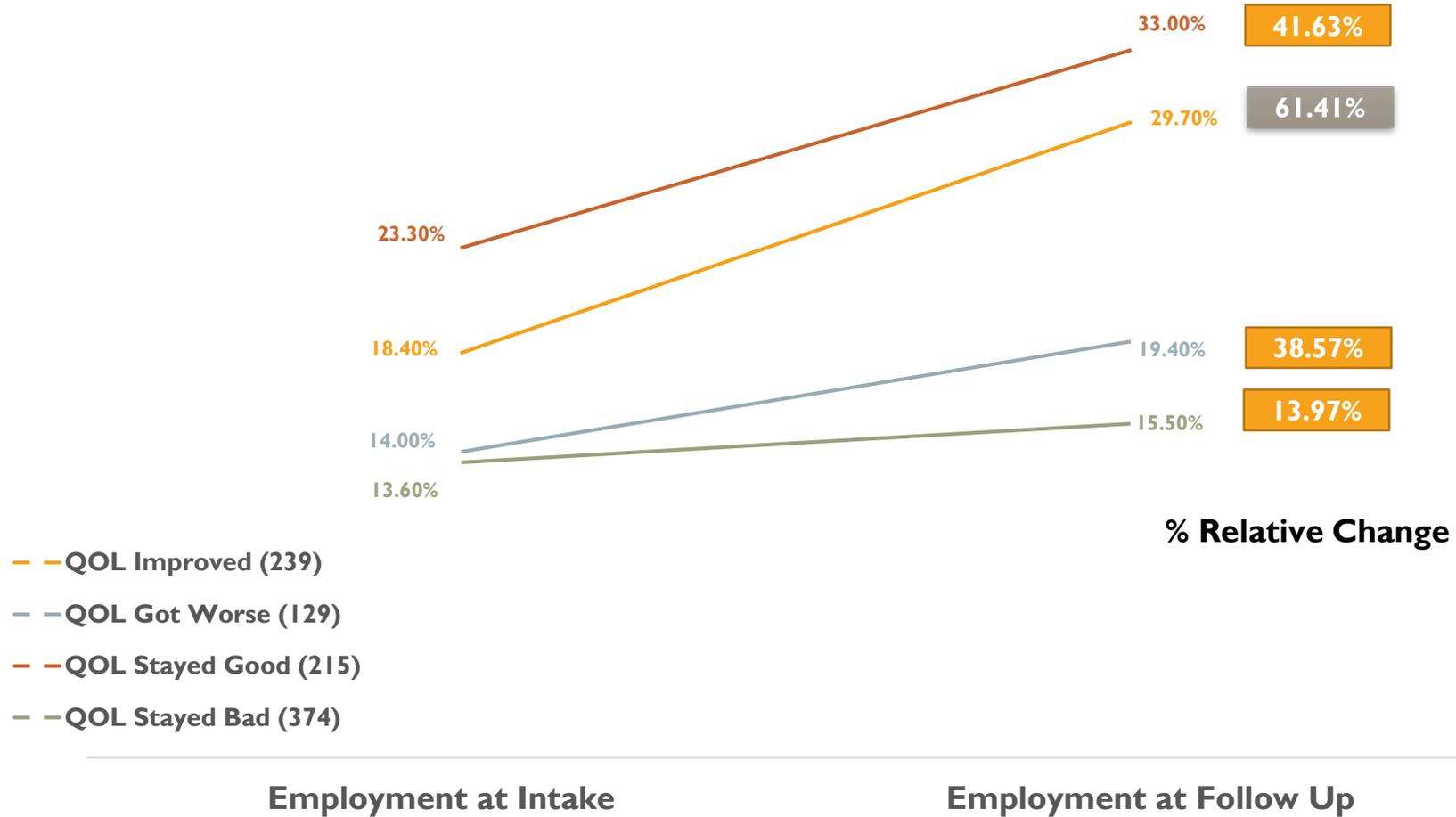
Cohen's Convention: Small $d = .2$; Medium $d = .5$; Large $d = .8$

QOL DATA: EMPLOYMENT STATUS



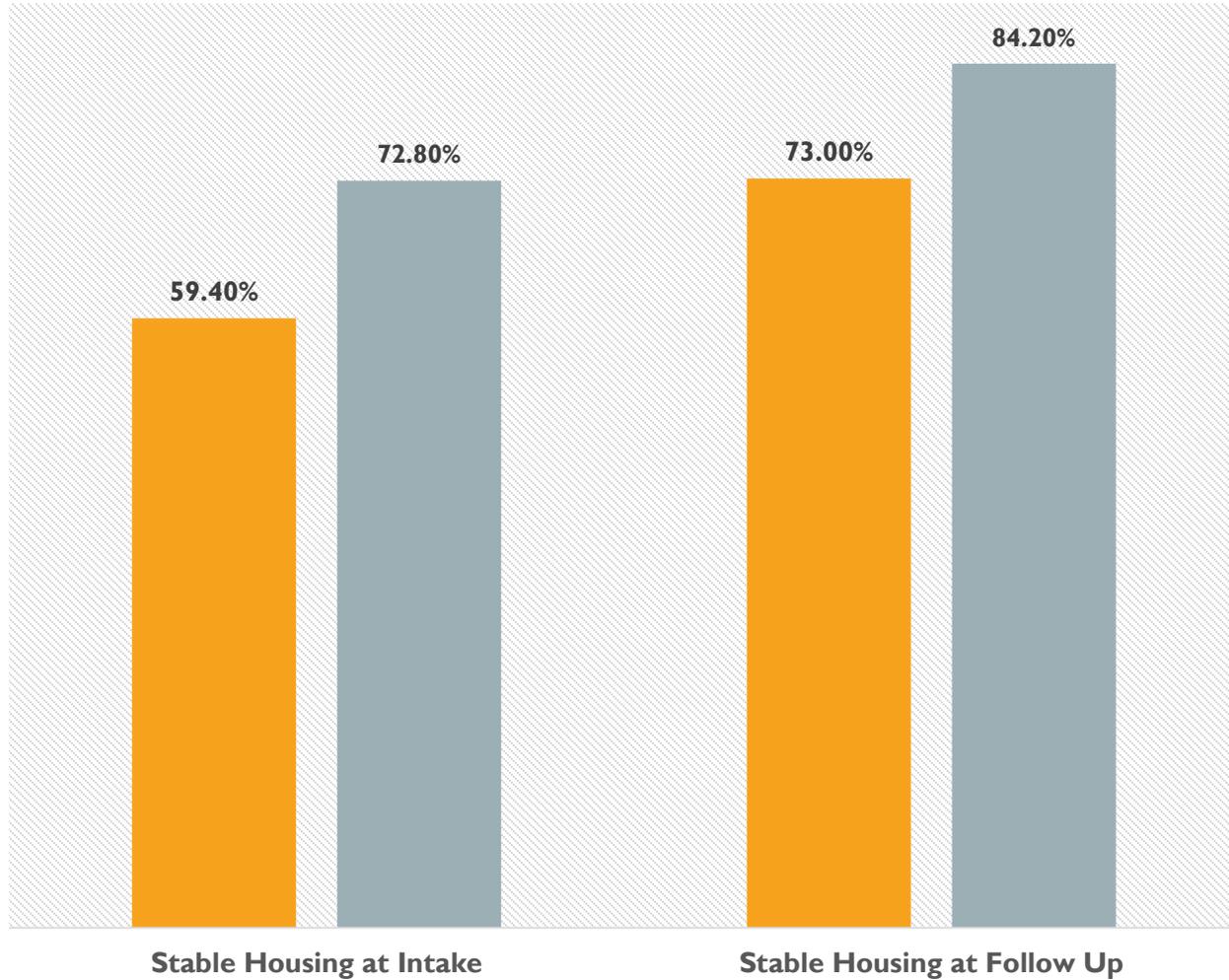
QOL DATA: EMPLOYMENT STATUS

RELATIONSHIP OF QUALITY OF LIFE CHANGE TO EMPLOYMENT CHANGE:
INTAKE TO 6 MONTH FOLLOW UP



**% of Clients with Stable Housing from Intake to Follow Up
- By QOL Status (N=952)**

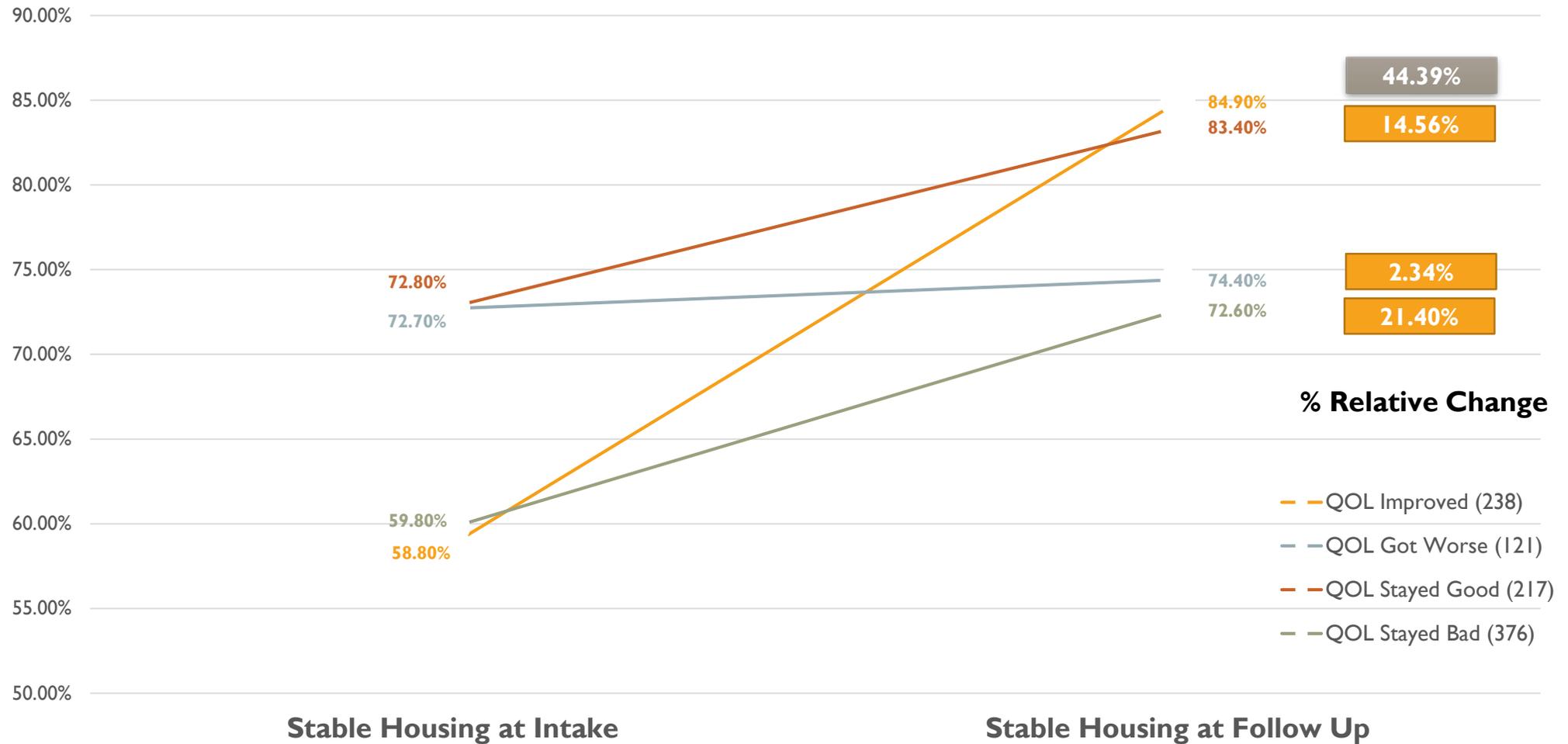
■ Poor QOL ■ Good QOL



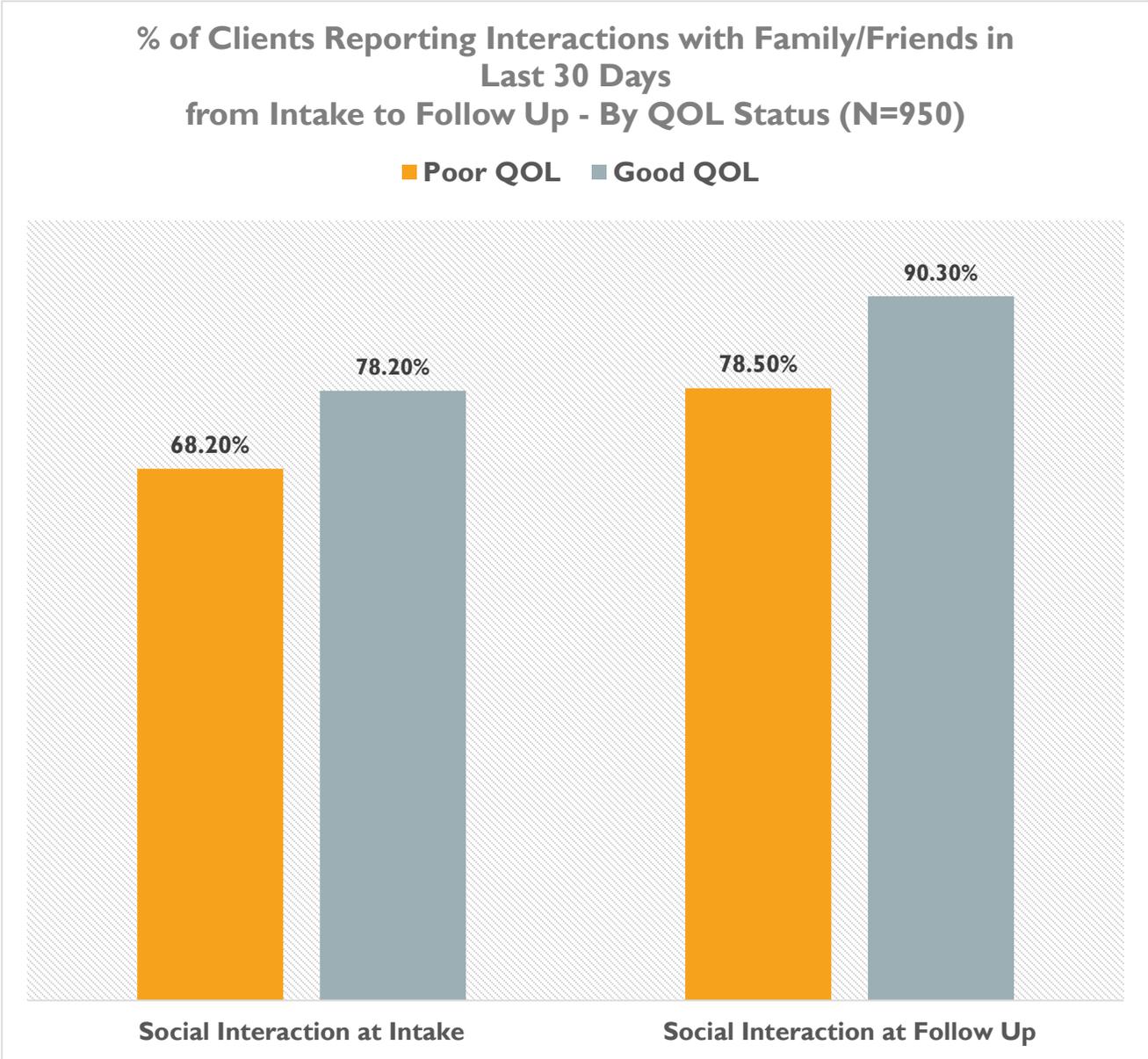
QOL DATA:
STABLE HOUSING
STATUS

QOL DATA: STABLE HOUSING STATUS

RELATIONSHIP OF QUALITY OF LIFE CHANGE TO STABLE HOUSING STATUS CHANGE:
INTAKE TO 6 MONTH FOLLOW UP

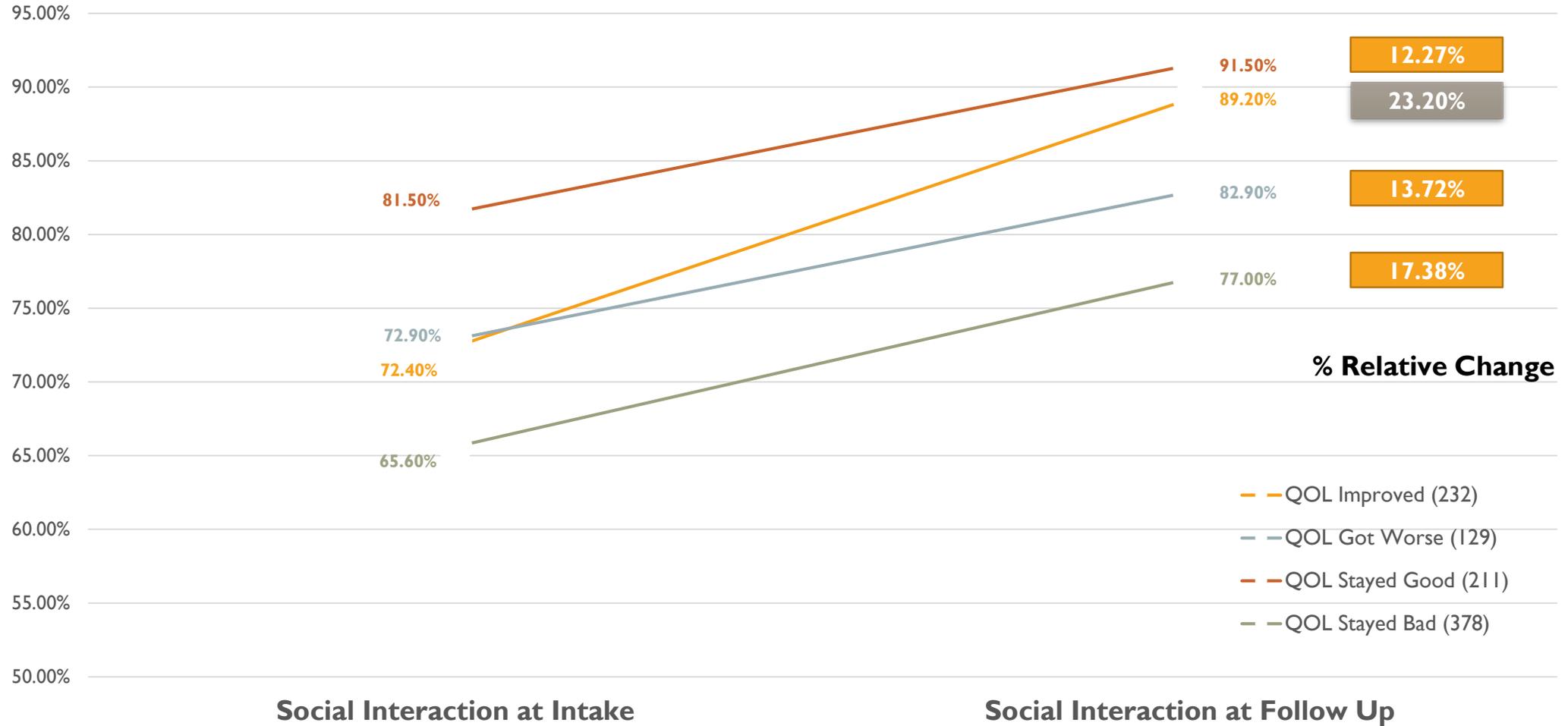


QOL DATA: SOCIAL INTERACTION STATUS



QOL DATA: SOCIAL INTERACTION STATUS

RELATIONSHIP OF QUALITY OF LIFE CHANGE TO SOCIAL INTERACTION CHANGE:
INTAKE TO 6 MONTH FOLLOW UP



QOL: SUMMARY STATS

- **24.77%** moved from “poor” to “good” quality of life by the 6 month follow up
- **36.95%** moved up at least one level on the 5 point QOL scale
- Compared to those with “poor” QOL, those with “good” QOL were:
 - 89.70% increase in likelihood of being employed
 - 15.34% increase in likelihood of having stable housing
 - 15.03% increase in likelihood of interacting with family or friends in last 30 days
- Individuals who quality of life improved from “poor” to “good” experienced a greater degree of relative improvement in every category, compared to **every other group**

QOL SUMMARY



Brief



Patient-reported, patient-centered



Program agnostic



Appears sensitive to change



Has solid criterion validity



Recovery-oriented

Community Access to Recovery Services Mid Cycle Report

Mental Health Board Quality Committee Meeting

August 3rd, 2020

Quality Initiative/Project:	Quadruple Aim Impacted			
	Population Health	Client Experience	Cost of Care	Staff Quality of Life
<p>1. Qualitative Research Process:</p> <p>This effort formalized a process of conducting Focus Groups of BHD consumers/customers to ensure that the voice of the consumer is incorporated into quality improvement measures. Current efforts include exploring “quality of life” measure with consumers and validating PPS data collection and entry with providers. Considering COVID, we are exploring telephone interviews with a sample of individuals to get the qualitative data normally obtained through in-person Focus Groups.</p>	✓	✓	✓	✓
<p>2. Value in Healthcare:</p> <p>The core premise of “value” in healthcare is the efficient allocation of resources to achieve the best possible outcomes for clients and populations, or, “health outcomes achieved per dollar spent.” This calculation is built upon effective and accurate assessment of the domains of the Quadruple Aim (health of populations, client experience, cost of care, staff quality of work life), and represents an end goal for organizations and systems attempting to realize the Quadruple Aim. For this topic, we will be reviewing a PowerPoint which details the efforts of CARS thus far to develop a model of “value” for CARS services, built upon the foundation of the Quadruple Aim.</p>	✓	✓	✓	✓

<p>3. Recovery Support Coordination Value Analysis:</p> <p>The aforementioned value in healthcare model is being used by CARS to examine a number of programs with high expenditures, beginning with RSC (case management for clients with substance use disorders). Using a combination of cost/volume metrics, outcomes, and client experience, our goal is to understand who an ideal candidate for this program and how much service leads to the best outcomes.</p>	✓	✓	✓	✓
<p>4. Dashboard Implementation:</p> <p>The Research & Evaluation Team is always working to improve its existing dashboards, and exploring new options for more efficient, and user-friendly dashboards. Team members have worked with other CARS staff to identify more limited sets of actionable metrics that can be used in a meaningful way. The team continues to explore new dashboard technology from multiple sources, in an effort to make our data more transparent and create a more data driven team in CARS and BHD.</p>	✓	✓	✓	✓
<p>5. Client Experience Survey Implementation:</p> <p>Implementation of the internally created Client Experience survey is ongoing, with 3 grants and 4 programs now utilizing the survey. Through the use of the survey platform Qualtrics, program managers will also be able to monitor their survey results in real-time and track progress toward achieving Contract Performance Measures, as well as prioritize the voice of the consumer in care delivery.</p>		✓	✓	✓
<p>6. Brief Literature Review Process to support Data-Driven Decision-Making:</p> <p>This project was initiated in early 2020 to support policy decisions and inform data-driven decision making. This discussion will center on the process CARS developed to rapidly conduct a brief, targeted literature review. We believe this method helps us to make more informed business decisions through a careful,</p>	✓	✓	✓	✓

<p>yet efficient, evaluation of existing research on a given topic, building on the efforts of others and while simultaneously determining its local feasibility. We will also discuss the application of this rapid review methodology to several recent real-world examples.</p>				
<p>7. Diversion and Readmission as Quality Metrics:</p> <p>This effort began with a desire from multiple staff to develop BHD-wide outcome metrics through a collaborative, cross-departmental workgroup. Moreover, the workgroup believed that these broader, organizational/system metrics could inform the departmental and programmatic dashboards within BHD, such that all business units throughout the organization had a shared focus on certain key quality metrics. These efforts have begun to create greater departmental cohesion and alignment to a shared vision, particularly with regards to Crisis Redesign, and has led to the development of several quality metrics that we hope to finalize and present to the MHB later this year.</p>	✓		✓	
<p>8. Detox Deep Dive:</p> <p>The Research & Evaluation team and members of the CARS AODA team have joined forces in an effort to better understand the needs of Detoxification consumers. Through review of the literature, analysis of demographic and utilization data, meetings with program managers and staff, and focus groups with consumers, this group's goal is to create performance measures that will better reflect the goals of Detoxification.</p>	✓	✓	✓	✓



A Place for Miracles Living Center, LLC
Attention: David Howard/Toni Howard
7022 North 43rd Street
Milwaukee, WI 53209

June 11, 2020

RE: Potential Contract Violations

Dear Mrs. Toni Howard, Mr. David Howard,

Milwaukee County Behavioral Health Division (MCBHD), Community Access to Recovery Services (CARS) was made aware that [REDACTED], Co-Owner of A Place for Miracles Living Center, LLC (A Place for Miracles), on or around May 11, 2020 may have been arrested in connection with injuries a resident sustained at one of your group homes.

Please be aware that while the alleged incident did not occur at a facility that is currently under contract with CARS; that per A Place for Miracles current Fee for Service Agreement (FFSA), with CARS, Policy and Procedure 005 Provider Obligations, Section Provider Obligations for DSPs and Indirect Staff, section O; states that A Place for Miracles shall notify CARS of any new arrests, charges, or convictions within 24 hours of the event for all Direct Service Providers. [REDACTED], as a Co-Owner of A Place for Miracles, is considered a Direct Service Provider; and as CARS was not notified of the arrest, and charges, A Place for Miracles is currently in violation of the terms of their agreement.

Additionally, per section Twenty-Five of the current FFSA, Corrective Action, Conditional Status, Suspension, & Milwaukee County Debarment, CARS can impose a condition of Corrective Action for a client safety related matter. As a result of A Place for Miracles' failure to notify CARS of the arrest and charges, the nature of the allegations against [REDACTED], and because they are related to the care of a client in A Place for Miracles care, CARS is suspending all referral of CARS clients to A Place for Miracles effective May 29, 2020.

Furthermore, please be aware that CARS Staff has made the Guardian of the client currently residing at A Place for Miracles facility, aware of the allegations as well, and are working with the Guardian to relocate the client to another facility.

Additionally, per your current FFSA; A Place for Miracles may file a formal grievance or otherwise appeal this decision in accordance with the Purchaser Policies and Procedures,



BHD | MILWAUKEE COUNTY
Behavioral
Health
Division

Milwaukee County Mental Health Board policy for contracts with BHD, Article 1,
Procurement Procedure Administrative Manual MCBHD, Legal & Contractual Remedies.

If you need additional information, please send inquiries to
bhdproviders@milwaukeecountywi.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Dennis B. Buesing".

Dennis B. Buesing, CPA
Contract Administrator
Milwaukee County Department
of Health and Human Services
1220 W Vliet Street, Suite 304
Milwaukee, WI 53205
Coggs Ph: 414-289-5853
BHD Ph: 414-257-7788

Cc: Brenda SJ, Amy L, Jennifer W, Janet F



2020 Q2 MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION INPATIENT DASHBOARD

7

**Psychiatric Crisis
Service (PCS)**

Target Key: ■ Better Than Expected ■ Expected ■ Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
<div style="text-align: center;">■</div> Q1: Rate=6.7% Q2: Rate=10.2% Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=22.4% Q2: Rate=26.2% Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=100% Q2: Rate=100% Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=2.3 (n=4) Q2: Rate=6.0 (n=9) Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=1.2 (n=2) Q2: Rate=0.0 (n=0) Q3: Q4:	<div style="text-align: center;">■</div> 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.

 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
<div style="text-align: center;">■</div> Q1: Rate=2.1% (n=4) Q2: Rate=0.6% (n=1) Q3: Q4:	<div style="text-align: center;">■</div> 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
<div style="text-align: center;">■</div> Q1: Rate=8.2% (n=16) Q2: Rate=8.2% (n=13) Q3: Q4:	<div style="text-align: center;">■</div> 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
<div style="text-align: center;">■</div> Q1: 71.7% positive Q2: 77.3% positive Q3: Q4:	<div style="text-align: center;">■</div> 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:
<div style="text-align: center;">■</div> Q1: 66.3% positive Q2: 65.6% positive Q3: Q4:	<div style="text-align: center;">■</div> 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:
<div style="text-align: center;">■</div> Q1: Rate=9.2 (n=35) Q2: Rate=7.5 (n=19) Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=2.9 (n=11) Q2: Rate=5.1 (n=13) Q3: Q4:	<div style="text-align: center;">■</div> 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
<div style="text-align: center;">■</div> Q1: Rate=4.7 (n=18) Q2: Rate=2.0 (n=5) Q3: Q4:	<div style="text-align: center;">■</div> 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

				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



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
<div style="text-align: center;">■</div> Q1: 2.9% (n=4) Q2: 2.4% (n=1) Q3: Q4:	<div style="text-align: center;">■</div> 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
<div style="text-align: center;">■</div> Q1: 9.3% (n=13) Q2: 4.8% (n=2) Q3: Q4:	<div style="text-align: center;">■</div> 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
<div style="text-align: center;">■</div> Q1: 70.8% positive Q2: 63.2% positive Q3: Q4:	<div style="text-align: center;">■</div> 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:
<div style="text-align: center;">■</div> Q1: 68.2% positive Q2: 100.0% positive Q3: Q4:	<div style="text-align: center;">■</div> 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:
<div style="text-align: center;">■</div> Q1: Rate=8.0 (n=5) Q2: Rate=4.3 (n=1) Q3: Q4:	<div style="text-align: center;">■</div> 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.
<div style="text-align: center;">■</div> Q1: Rate=4.8 (n=3) Q2: Rate=0.0 (n=0) Q3: Q4:	<div style="text-align: center;">■</div> 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

 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



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.

 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.

 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

**Mental Health Board
Quality Subcommittee Meeting
August 3, 2020**

Sentinel Event Committee

The Behavioral Health Division reviewed a total of two events in 2019. Both events were deaths by suicide that occurred in clients receiving case management provided by a community provider.

In 2018 the Behavioral Health Division reviewed 15 total events. Those included 8 Sentinel Events and 7 Other Events.

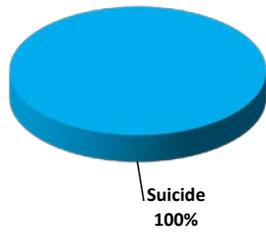
2019 Root Cause Analysis Findings Themes

- Inadequate risk assessment
- Dual diagnosis not sufficiently addressed
- Community agencies were not consistently in compliance with the BHD CARS Missed Appointment and Inability to Reach Client Policy

Current Happenings

- So far this year the Sentinel Event Committee has reviewed three cases – one death by suicide and two suicide attempts.
- Committee members are currently engaged in an RCA training program provided by the Institute for Healthcare Improvement. Their process, RCA², is endorsed by The Joint Commission for application with Event Reviews. Following completion of this training the BHD Sentinel Event Policy and procedures will be updated in accordance with recommendations identified during the current Systems Improvement Agreement.

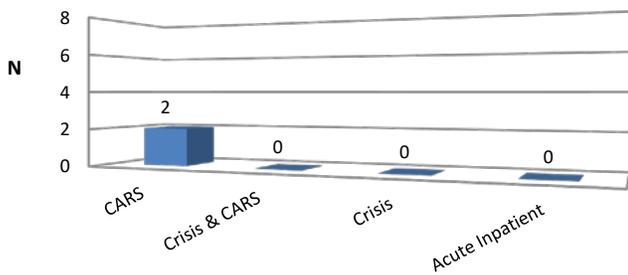
Type of Event



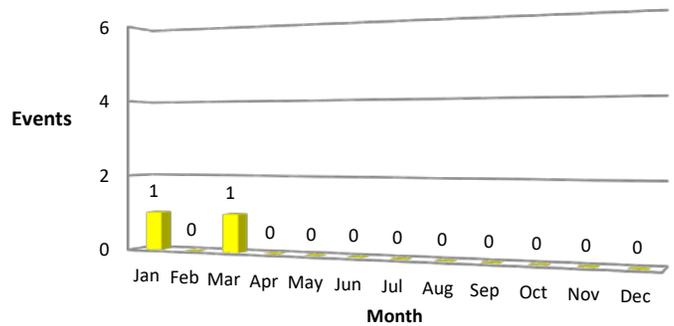
Location of Event



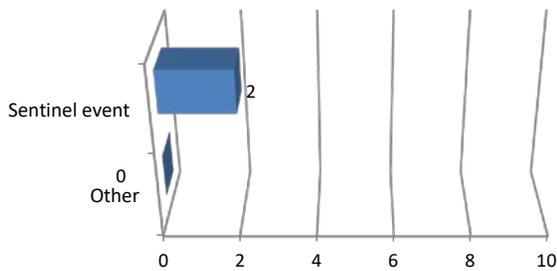
Program (Open with/last contact)



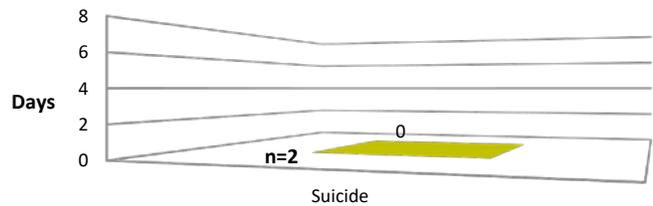
Month of Event



Level of Review

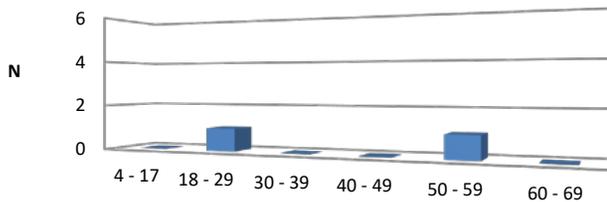


Average Days After Last BHD Contact



Patient Age

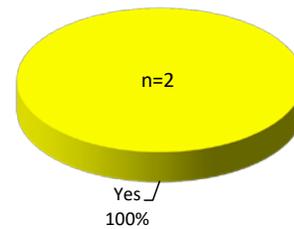
Average Age: 38 yrs male, 45 yrs female; Gender: 73% male, 27% female



	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69
N	0	1	0	0	1	0

Significant AODA Component to Event

33% (n=5) of events reviewed had a significant AODA component



Annual Action Items for the Mental Health Board Quality Committee

Refer to QAPI/Patient Safety Plan

- Reviewing, evaluating and approving the BHD Hospital QAPI/Patient Safety plan **annually**; (page 7)
 - Determination of the number and distinct improvement projects conducted **annually**; (pages 7 and 13)
 - Supporting and guiding implementation of quality improvement activities at BHD **on-going**; (pages 7 and 13)
 - Hospital Scope of Services policy and procedure is to be reviewed and updated **annually**
 - Assess needs and request financial resources to ensure quality improvement activities are properly planned and budgeted on an **annual basis** (page 8)
 - Mental Health Board Quality Committee will complete an **annual** Governance of Quality Assessment (page 9)
-

BHD QAPI Committee Meetings

- Monthly; first Friday of every month at 11:00 a.m.

BHD Patient Safety Committee Meetings

- Every other month/Six times per year; first Thursday of every other month at 9: 00 a.m.

Quality Committee of the Board (2020)

- March 2, 2020 at 10 a.m.
- June 1, 2020 at 10 a.m.
- August 3, 2020 at 10 a.m.
- October 5, 2020 at 10 a.m.
- December 7, 2020 at 10 a.m.

BHD Enterprise-Wide Quality Management Services Committee; (a rotation of operations/PI, education and data analysis/planning)

- Monthly: Fourth Friday at 8:30 a.m.

Notes:

8/03/20 jb