



Milwaukee County Behavioral Health Division 2019 Key Performance Indicators (KPI) Dashboard

Program	Item	Measure	2017 Actual	2018 Actual	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	2019 Actual	2019 Target	2019 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵	8,346	9,393	6,032				6,032	9,500		
		Sample Size for Rows 2-6 (Unique Clients)			3,531				3,531			
	2	Percent with any acute service utilization ⁶	17.40%	17.05%	19.55%				19.55%	16.35%		
	3	Percent with any emergency room utilization ⁷	13.87%	14.60%	15.33%				15.33%	13.64%		
	4	Percent abstinence from drug and alcohol use	63.65%	63.65%	64.67%				64.67%	64.18%		
	5	Percent homeless	7.61%	9.18%	8.46%				8.46%	8.84%		
	6	Percent employed	18.09%	20.06%	19.51%				19.51%	20.27%		
	Sample Size for Row 7 (Admissions)											
	7	Percent of all admissions that are 7 day readmissions	59.55%	60.12%	49.11%				49.11%	49.00%		
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,404	2,955	1,697				1,697	3,450		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.60	4.5				4.5	> = 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	65.3%	66.2%				66.2%	> = 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.38	2.35				2.35	> = 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	57.8%	58.0%	69.1%				69.1%	> = 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	44.1%	38.4%	34.3%				34.3%	> = 50%		BHD (2)
Crisis Service	14	PCS Visits	8,001	7,375	1,905				7,620	8,000		BHD (2)
	15	Emergency Detentions in PCS	3,979	3,023	795				3,180	4,000		BHD (2)
	16	Percent of patients returning to PCS within 3 days	7.3%	7.5%	11.0%				11.0%	8%		BHD (2)
	17	Percent of patients returning to PCS within 30 days	23.1%	24.0%	25.8%				25.8%	24%		BHD (2)
	18	Percent of time on waitlist status	75.2%	83.2%	100.0%				100.0%	50%		BHD (2)
Acute Adult Inpatient Service	19	Admissions	656	770	162				648	800		BHD (2)
	20	Average Daily Census	42.9	41.8	43.8				43.8	54		BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	1.4%	1.6%	1.8%				1.8%	3%		BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	7.7%	6.6%	4.1%				4.1%	10%		NRI (3)
	23	Percent of patients responding positively to satisfaction survey	74.0%	74.8%	79.6%				79.6%	75.0%		NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	65.2%	70.6%				70.6%	65%		BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.51	0.24				0.24	0.36		CMS (4)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.28	0.15				0.15	0.23		CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	21.5%	25.3%				25.3%	9.5%		CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	95.8%	92.5%				92.5%	90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	709	644	168				672	800		BHD (2)
	30	Average Daily Census	8.6	7.5	8.2				8.2	12.0		BHD (2)
	31	Percent of patients returning to CAIS within 7 days	5.2%	3.4%	7.2%				7.2%	5%		BHD (2)
	32	Percent of patients returning to CAIS within 30 days	12.3%	12.4%	16.6%				16.6%	12%		BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71.3%	71.1%	80.1%				80.1%	75%		BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	74.2%	87.9%				87.9%	75%		BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.18	1.96				1.96	0.36		CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.47	0.39				0.39	0.23		CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.1%	0.0%				0.0%	3.0%		CMS (4)
	38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	85.7%	-				-	90.0%		BHD (2)
Financial	39	Total BHD Revenue (millions)	\$149.9	\$154.9	\$149.7					\$149.7		
	40	Total BHD Expenditure (millions)	\$207.3	\$213.5	\$208.2					\$208.2		

- Notes:
- (1) 2018 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
 - (2) Performance measure target was set using historical BHD trends
 - (3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages
 - (4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages
 - (5) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.
 - (6) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days
 - (7) Includes any medical or psychiatric ER utilization in last 30 days



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

SUMMARY - 1st QUARTER/CY 2019

8 - No additional comments at this time.

9 – On target for the 1st quarter of 2019. Exceeding the threshold of 4.0.

10 - Improved .9% in the 1st quarter of 2019 as compared to the 2018 CY average of 65.3%. Within the 20% benchmark range. Efforts are ongoing to have youth reside in the least restrictive setting possible.

11 – Decrease of .03 in the 1st quarter of 2019 (2.35) compared to the 2018 CY average of 2.38. This is outside the 20% benchmark (2.4) by .05% and .65 below the target score of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. NOTE: Those in Wraparound court ordered programs who are disenrolled to a home type setting in the 1st quarter of 2019 have a higher "Needs Met" score (3.34) than those disenrolled on runaway status or to corrections (1.47).

#12 – In the 1st quarter, there was an 11.1% increase (69.1%) in the percentage of youth achieving permanency at disenrollment compared to the 2018 CY average of 58%. This is within the 20% benchmark and .9% below the 70% standard.

"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 1st quarter compliance (34.3%) is 4.1% lower than the 2018 CY average of 38.4%. This falls outside 20% benchmark of 40%, and the established target score of 50%.

CARS QUALITY DASHBOARD SUMMARY Q1 2019

CHANGES AND UPDATES

Further Development of the Quadruple Aim

The CARS Quality Dashboard continues to undergo further development/refinement of the data elements organized by the Quadruple Aim. CARS has also finished a draft of the CARS Quality Plan, which is also aligned with the Quadruple Aim. This Plan will likely be released at a future MHB Quality Committee meeting, once it has undergone an appropriate internal review. Progress towards each goal in the Plan will be reviewed by the CARS Leadership Team on a quarterly basis.

Population Health

CARS is piloting a “change over time” set of population health metrics during the first quarter of 2019 (please see attached handout). These metrics represent our initial attempt to answer the question, “Are we helping our clients in their recovery journey?” As we revise and refine metrics, they will be added to or may even supplant the metrics in our current quality dashboard. Please note that the detox readmission metric and target has been updated to reflect 7-day readmission rates.

Patient Experience of Care

The Press Ganey survey has been distributed to most CARS programs. Training in Motivational Interviewing (MI) amongst key CARS and network staff is ongoing, as is the development of an MI fidelity review process, including an assessment of the client experience and an accompanying manual.

Staff Wellbeing

CARS continues to work with BHD’s Human Resources Department to obtain data on CARS staff turnover and to establish appropriate turnover rate targets by department and/or staff classification that are indicative of healthy and high functioning social service organizations. There is also a continuing effort to develop reports on provider turnover in the CARS contracted network.

Cost of Care

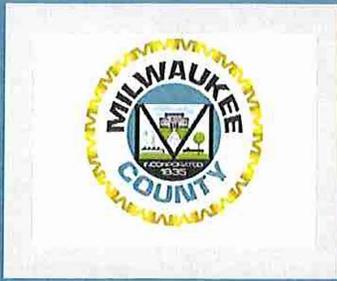
The cost per member per month metric on the CARS Quality Dashboard continues to evolve, with new quarterly figures based on revised purchase of service contracts and the transition of existing purchase of service contracts to a fee for service model.

RESULTS

Most population health metrics for CARS clients remained stable in the first quarter of 2019 relative to the last quarter of 2018. There was a slight increase in the number of clients reporting an inpatient visit in the previous 30 days, as well as a decrease in the proportion of clients reporting their housing status as “homeless”. CARS has also adjusted our performance targets for 2019, based on our 2018 performance. A description of this methodology is available upon request.

NEXT STEPS

The CARS Quality Dashboard will undergo further revisions and refinements as CARS pursues the goals of the Quality Plan and continues to create more robust mechanisms to track improvements in the experience of care and general health of the population we serve. We will also continue to link the cost of the care we deliver to the outcomes of the clients we serve, which will enable us to better determine the value of the care we are purchasing. It is important to note that there are many ongoing CARS initiatives that are focused on increasing the quality of the care our clients receive or improving their quality of life. These initiatives are too numerous to mention here, but it is only through the important work of the CARS team that any improvement noted above is and will be realized.



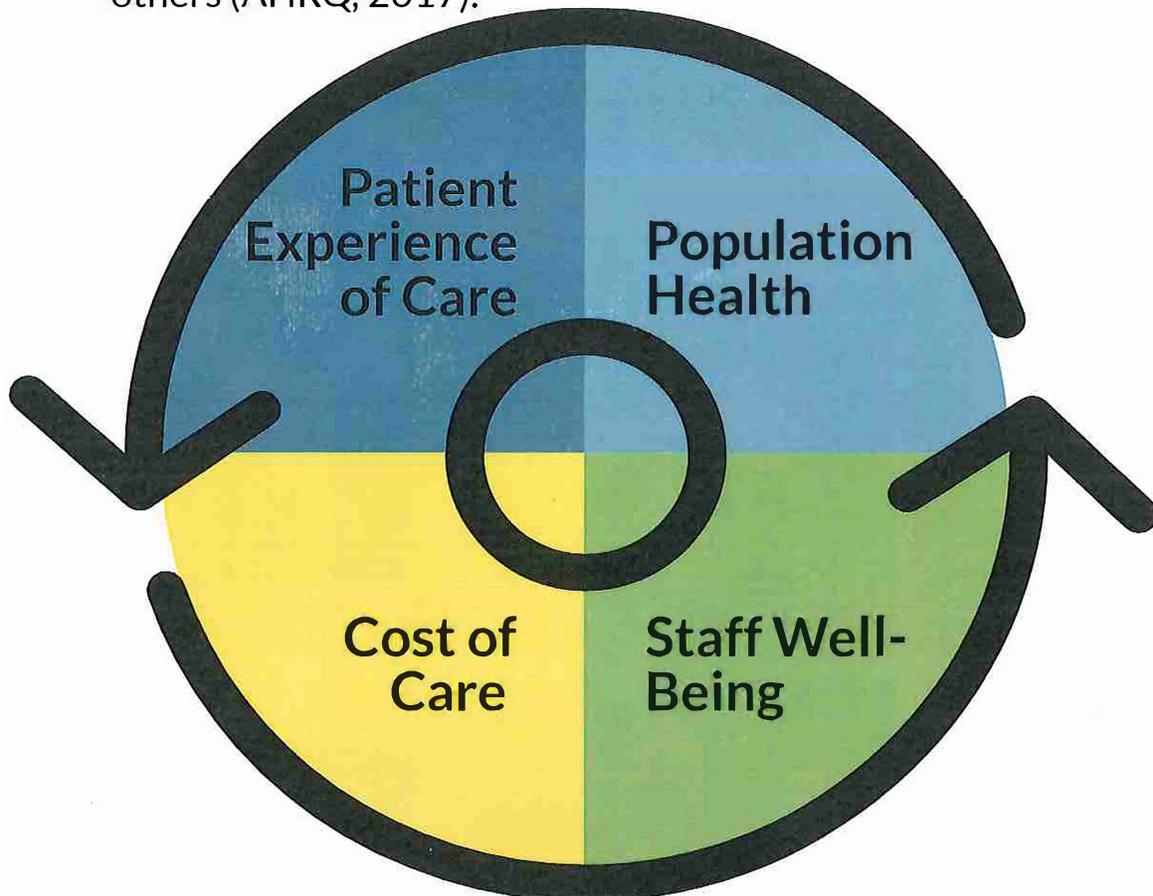
CARS Quality Dashboard

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).

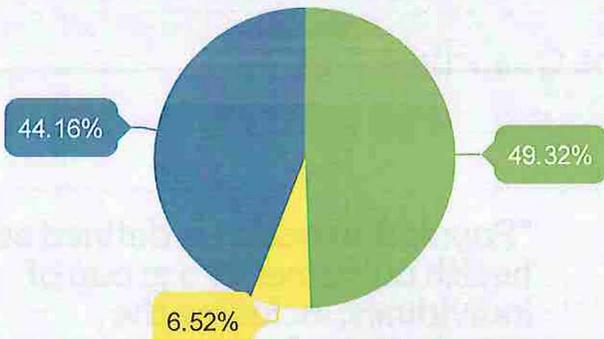
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

Demographic Information of the Population We Serve

This section outlines demographics of the consumers CARS served last quarter.

Race (CARS)

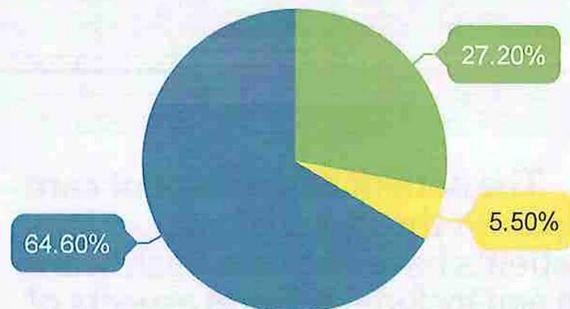
- Black/African-American
- White/Caucasian
- Other



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

Race (Milwaukee County)*

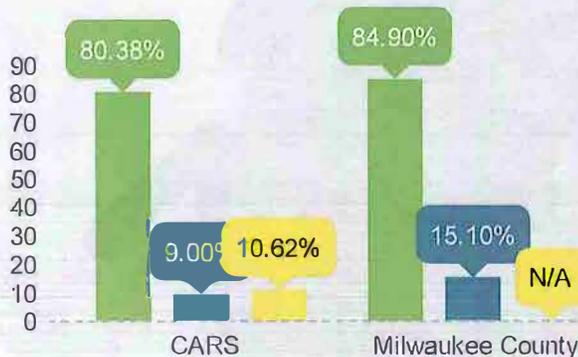
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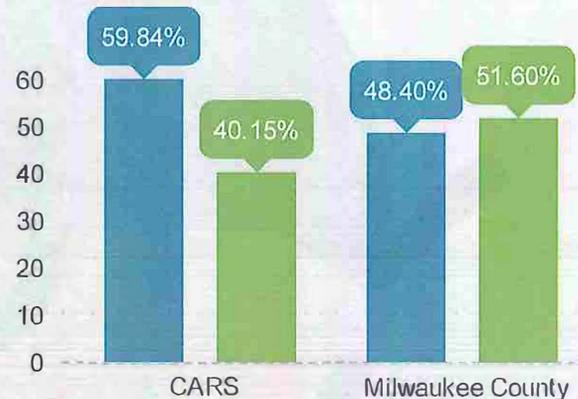
Ethnicity*

- Not Hispanic/Latino
- Hispanic/Latino
- No Entry/Unknown

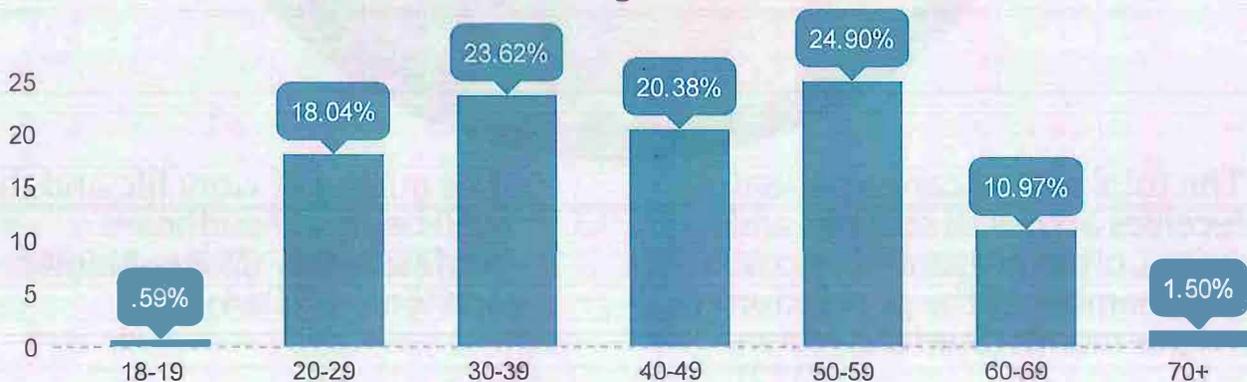


Gender*

- Males
- Females



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>



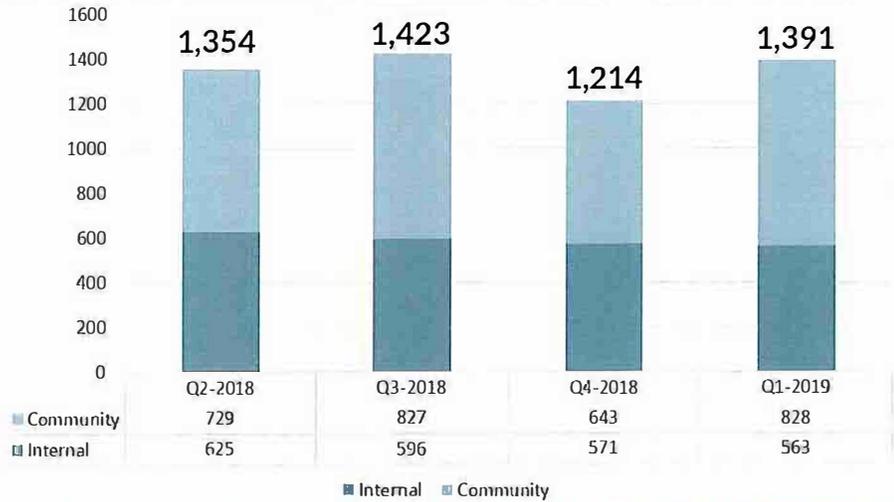
Domain: Patient Experience of Care

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



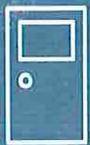
Referrals

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



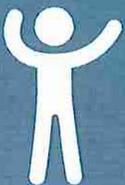
Time to Service

Average number of days between the time of the CARS Comprehensive Assessment to the first service date.



Admissions

All admissions during 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.



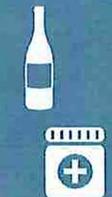
ER Utilization

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



Detoxification 7-Day Readmissions

Percent of consumers returning to detoxification within 7 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".





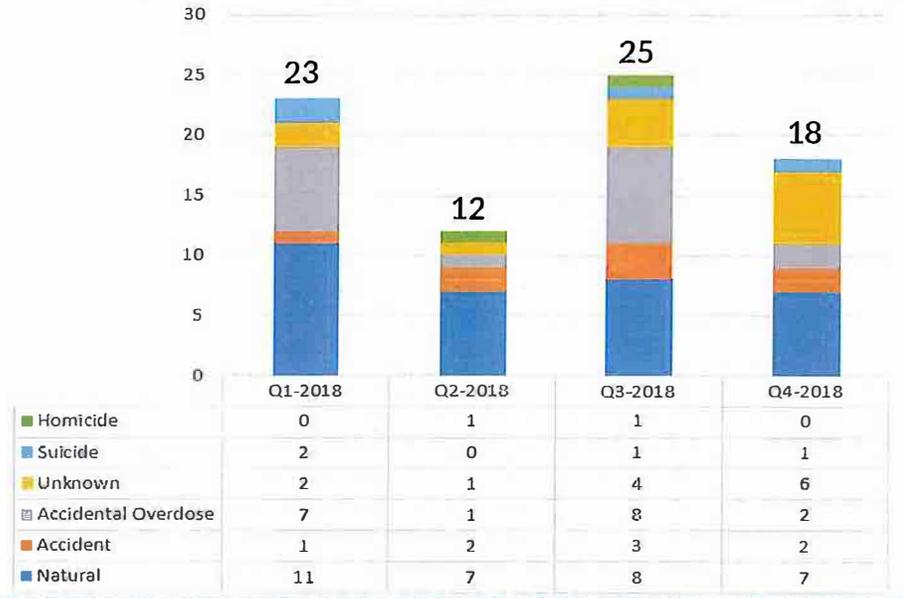
Domain: Population Health (Continued)

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, the U.S. Department of Health and Human Services, and the World Health Organization. This graph represents the total number of deaths by cause of death from Q1-2018 to Q4-2018.

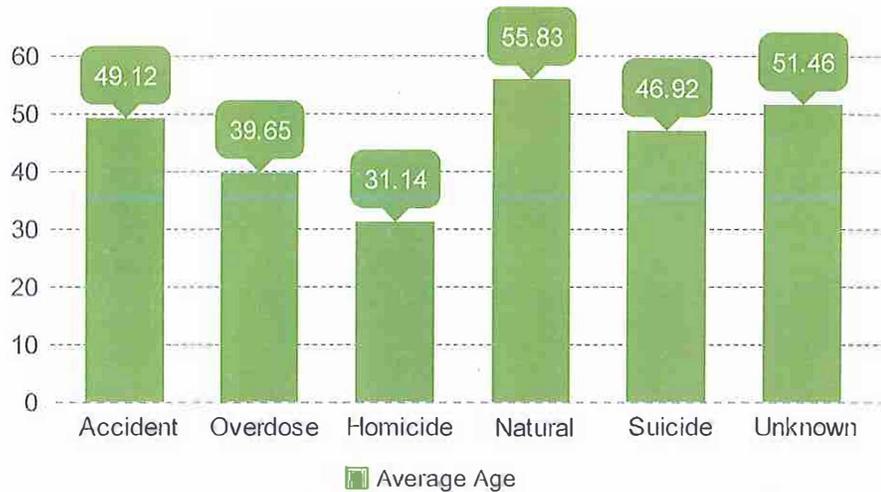
Note: There is a lag in death reporting. See note in the next item.



Average Age by Cause of Death

This is the reported average age at time of death by cause of death from Q1-2018 to Q4-2018.

Please note that there is a one quarter lag of the mortality data on the CARS Quarterly Dashboard. This decision was made to ensure that CARS has accurate cause of death data from the Milwaukee County Medical Examiner's office, a determination which can sometimes take several months for the Medical Examiner's office to render.



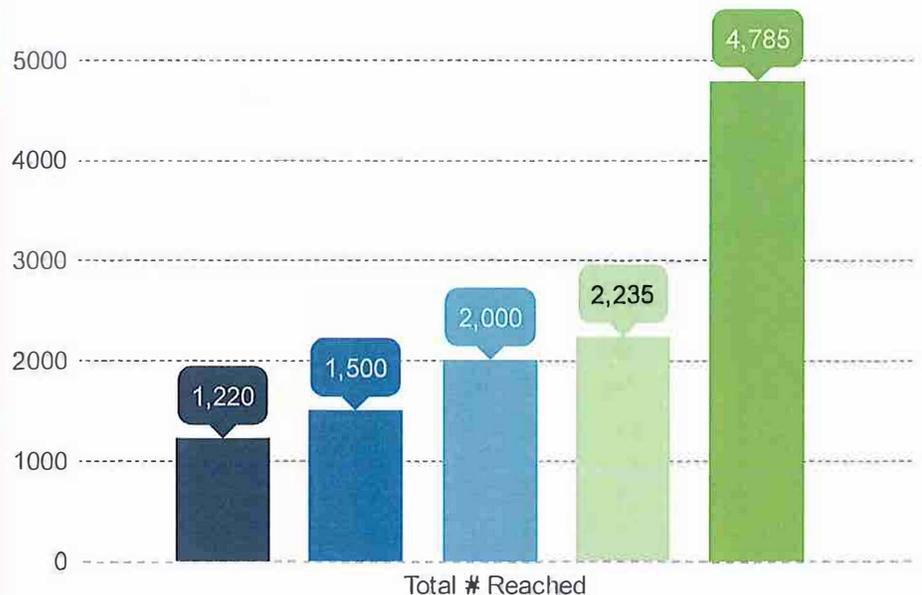
Top Prevention Activities/Initiatives

Prevention is also an important population health factor. Many prevention activities include evidence based practices, and presentations. The top five prevention activities for Q1 are listed in the graphic.



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.

■ Families Moving Forward
 ■ MPL
 ■ MPS
 ■ Dose of Reality
 ■ Light Unite Red





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:



Q2 - 2018 N = 4,865	Q3 - 2018 N = 5,042
Q4 - 2018 N = 5,056	Q1 - 2019 N = 5,096



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, starting in 2019. Subsequent iterations of the dashboard will also include staff turnover 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

The Press Ganey Consumer Satisfaction Survey is currently being distributed to all CARS providers. Results will be reported in the coming months.

[DRAFT]

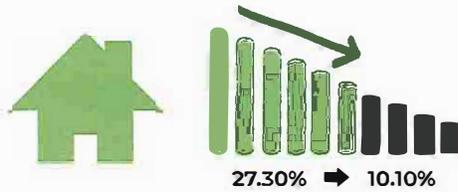
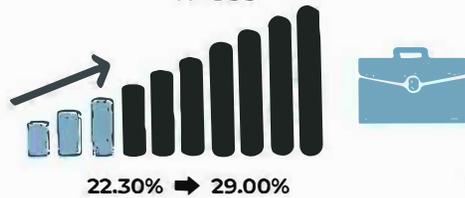
Population Health Metrics - Change Over Time

This dashboard contains preliminary measures of 6-month population health outcome data (intake to follow-up) for our consumers

Q1 2019

30.04% increase in
Employment*

n=355

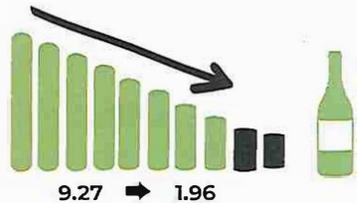
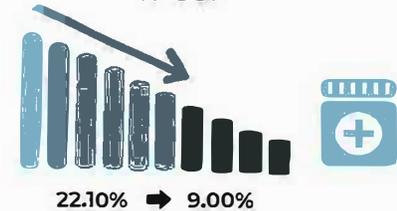


63.00% decrease in
Homelessness***

n=366

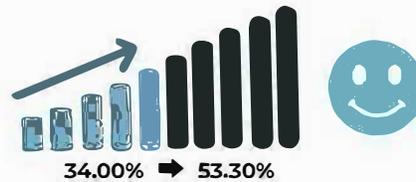
59.28% decrease in Past
30 days Detox Use***

n=367



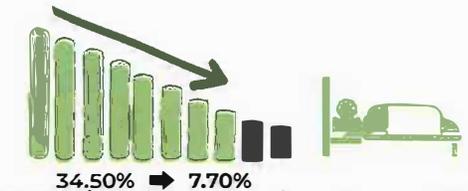
78.86% decrease in Days
of Heavy ETOH Use in
Past 30 days***

n=137



56.76% increase in Good or
Very Good Quality of Life***

n=212

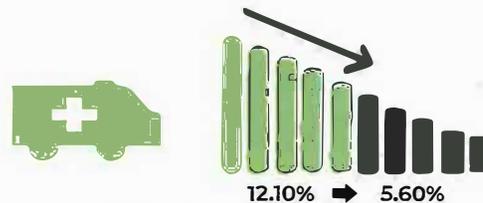
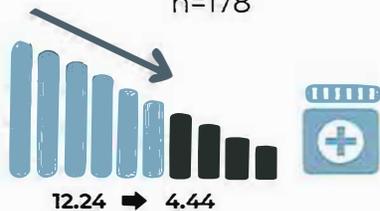


77.68% decrease in Past 30
days Psych Inpatient Use***

n=325

63.73% decrease in Past 30
days Days of Drug Use***

n=178



53.72% decrease in Past 30
days Psych ER Use**

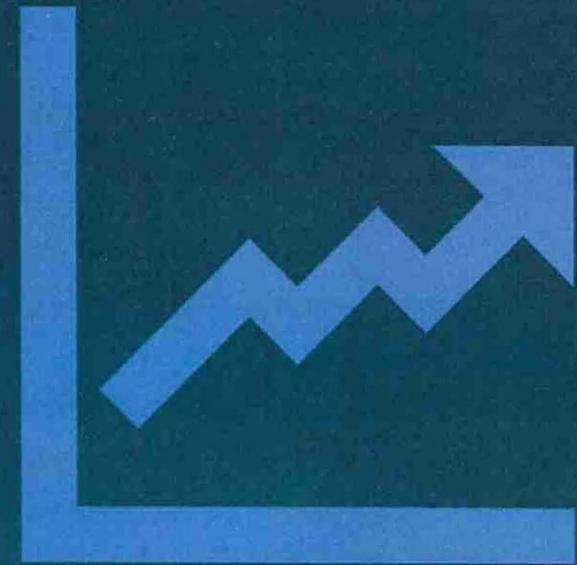
n=354

Note: Only consumers with a Comprehensive Assessment and subsequent PPS completed within 4-7 months are included in these measures.

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

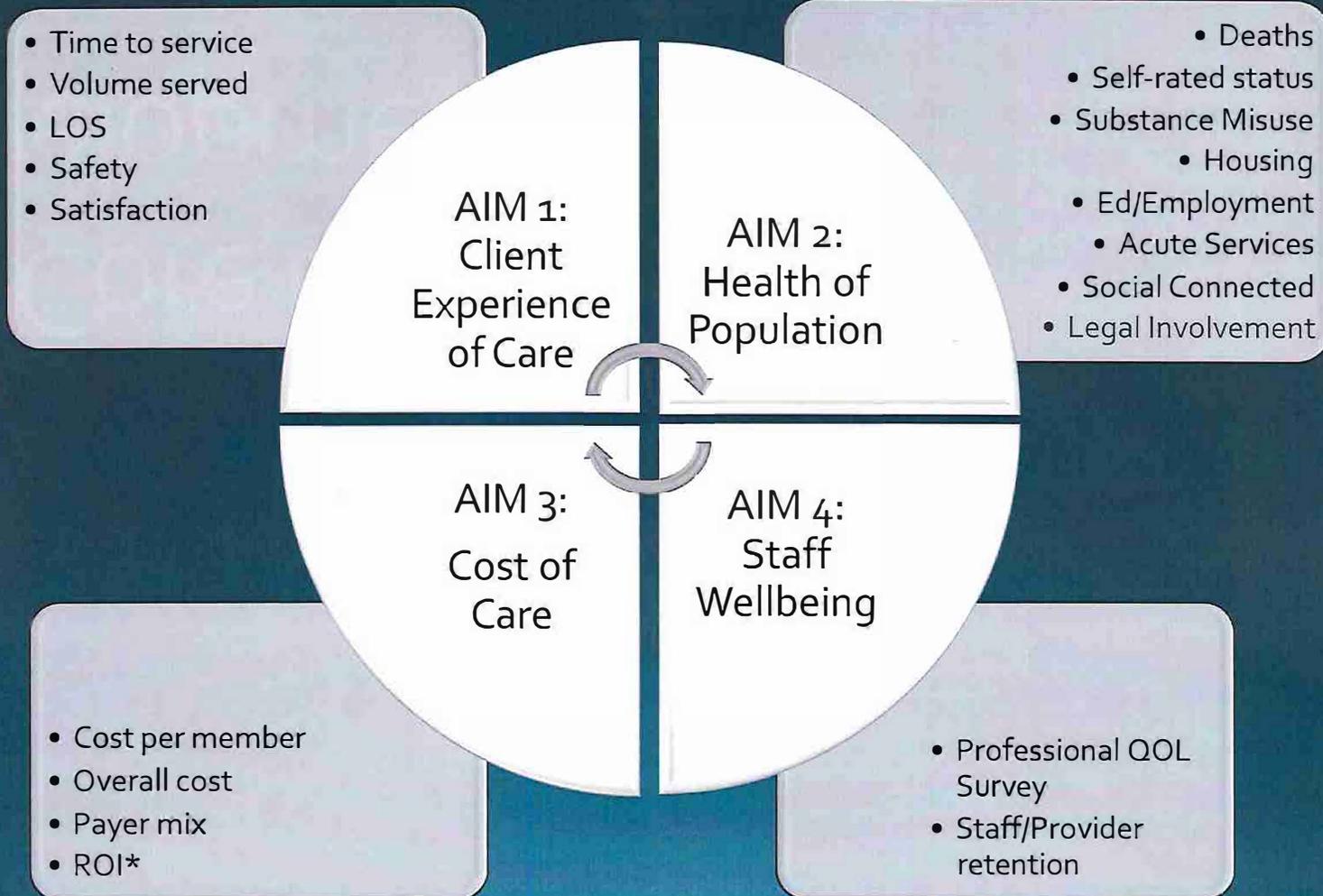
Phases I (and II)

Core Data Development

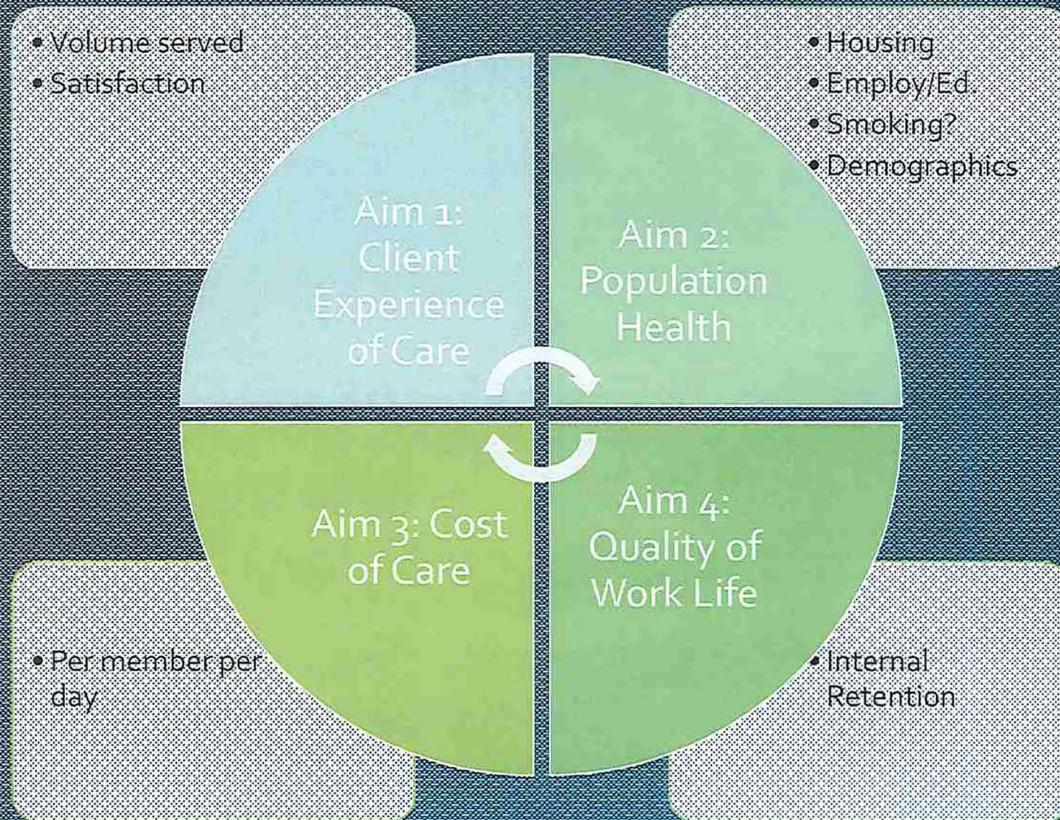


Recap of Core Domains

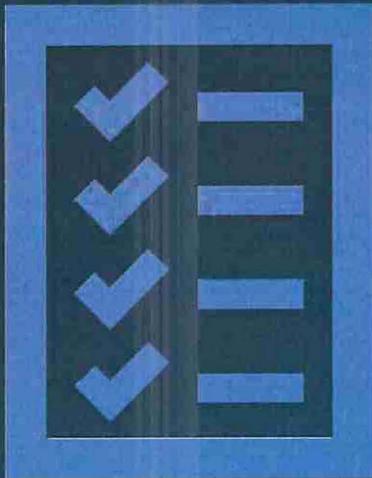
The Quadruple Aim



Phase 1: Quadruple Aim Data Elements

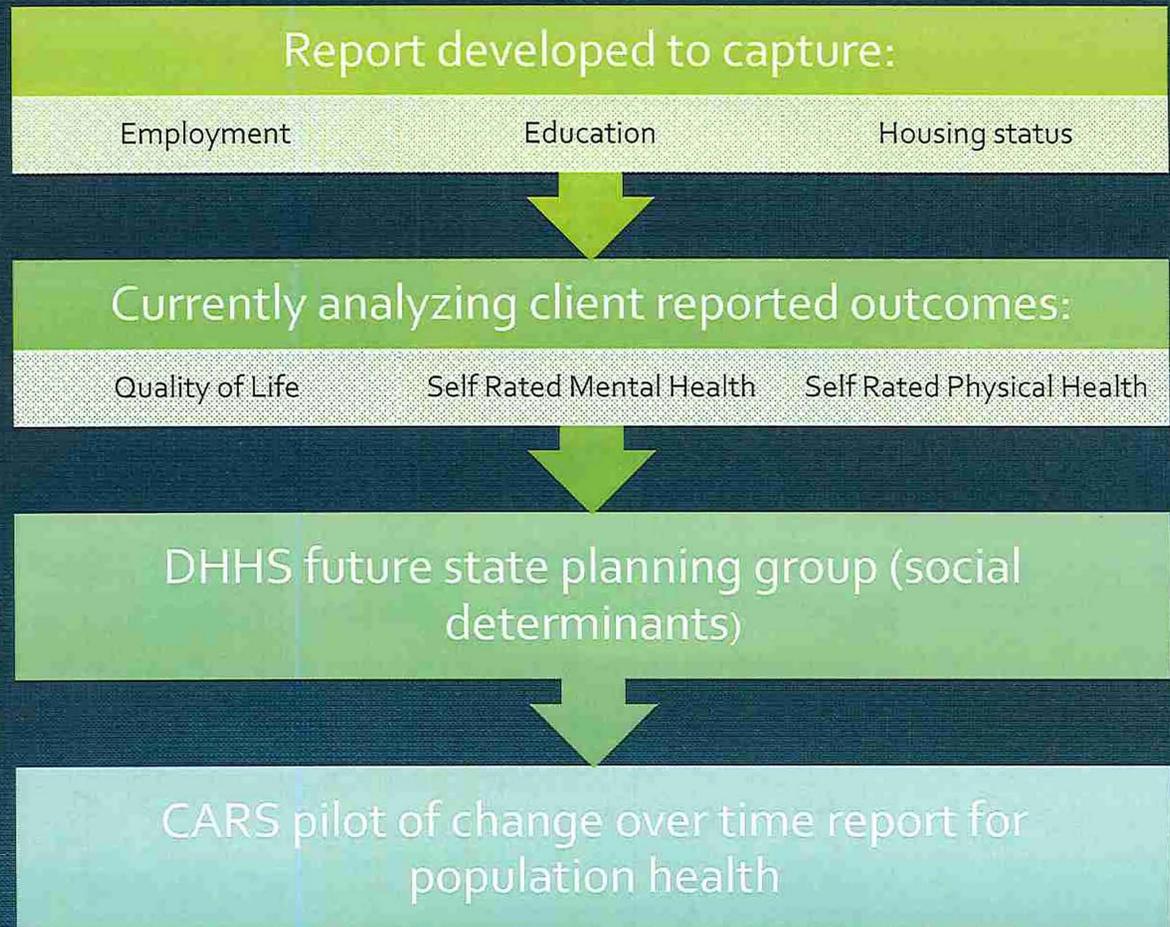


Aim 1: Client Experience of Care



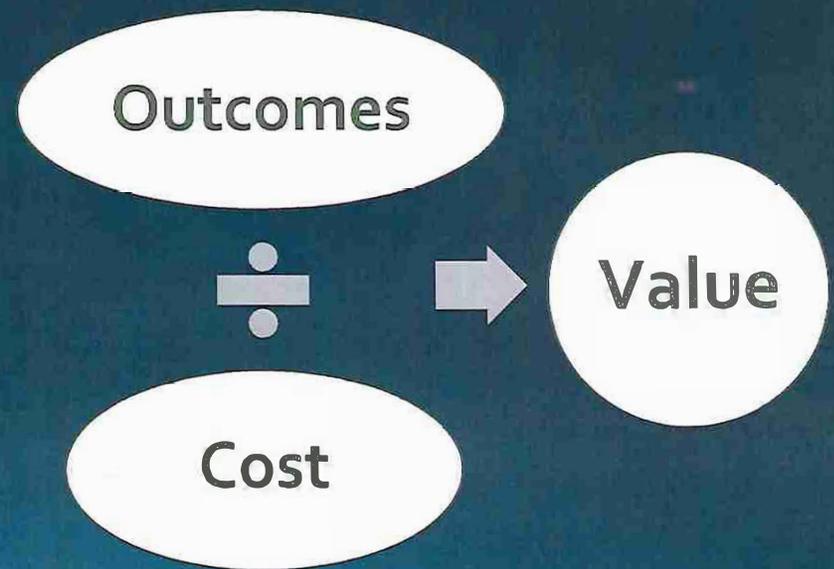
1. Client experience is focal point of BHD Quality Plan
2. Assessment of client experience near completion
 1. Will be piloted in CARS later this year or early next year
3. Press Ganey survey
4. Report developed for total volume served

Aim 2: Population Health



Aim 3: Cost of Care

- Report on cost of care on a per member per month basis exists in CARS
- Report in development of cost on a per member per day cost for all BHD clients
 - This report will be crucial for:
 - Future value-based purchasing
 - Risk adjustment
 - Identifying high risk individuals



Aim 4: Staff Quality of Work Life

Downtown HR to produce staff turnover rates for all of BHD quarterly

Turnover benchmarks under development for our employees, based on position/role, locality, etc. (thanks Peter and Lisa!)

Contract Management working to collect more complete data on turnover within the contracted network (thanks Brenda!)

Preliminary report targeted
Fall of 2019

Continued statistical analysis
of key metrics

Master Data Management
and Analytics project

DHHS future planning project
work

Next Steps

2019

Comprehensive
Community Services
Quality Plan
CCS QAPI Subcommittee

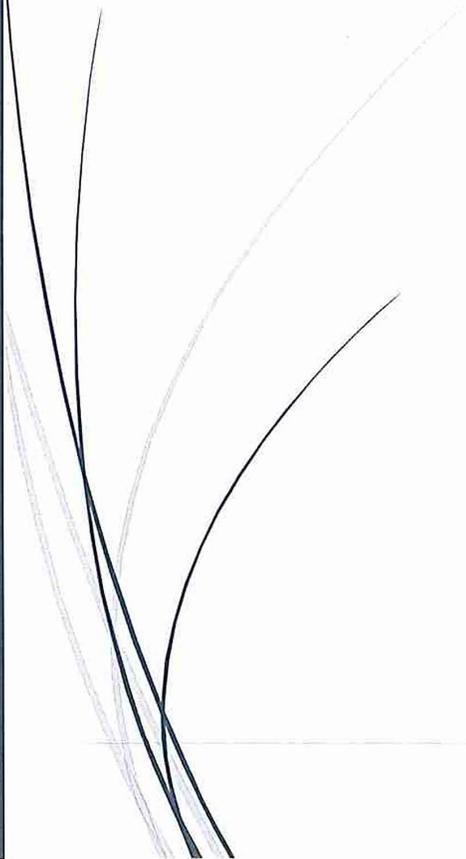


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1. PURPOSE OF THE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) PLAN

This quality improvement plan has been developed to assess Comprehensive Community Services (CCS) consumer satisfaction, progress toward desired outcomes and program adherence to the rules and regulations outlined by DHS 36. The plan includes a description of the methods for measuring participant opinion related to the services offered by CCS, assessment, service planning, service delivery and service facilitation activities. The quality improvement plan includes a description of the methods that CCS will use to evaluate the effectiveness of changes in the program based on the results of the consumer satisfaction survey and other measurements, recommendations for program improvement by the Milwaukee County CCS Recovery Advisory Committee (CCS Coordination Committee), and other relevant information (DHS 36.08).

2. CCS SCOPE OF WORK

Comprehensive Community Services (CCS) is a program that offers a wide range of psychosocial rehabilitative services and supportive activities that assist consumers with mental health and/or substance abuse conditions achieve their highest possible level of independent functioning, stability, and independence to promote long-term recovery. Services are both designed and offered to support consumers across the lifespan (minors, adults and elders). CCS is a community-based program, meaning the majority of services are provided to consumers in their homes and communities. The program is person-centered and utilizes consumer-directed service plans to outline individualized strengths, goals and desired service interventions. CCS services are provided by a wide range of professionals, paraprofessionals and natural and informal supports selected by the consumer to support them in obtaining their goals and improving their overall quality of life.

The CCS program employs the use of a care coordination model, meaning that a care coordinator is designated to provide service linkage and oversight, crisis prevention, and ongoing review of the consumer's needs. The care coordinator and consumer meet at a frequency that is jointly agreed upon by both the care coordinator and the consumer but no less than directed by DHS 36, to support the recovery planning process and assess the consumer's level of satisfaction with their services, as well as their progress toward their identified goals.

Comprehensive Community Services places primary emphasis on the therapeutic relationship and collaborative partnership between the identified care coordinator, the consumer, and their recovery team. The recovery team is defined as being the group of individuals who are identified to participate in an assessment of the needs of the consumer, service planning and delivery, and evaluation of desired outcomes.

Another important component of the CCS program is the development and inclusion of natural supports in the recovery planning and supportive process. A natural support is defined as a friend, or other person available in the community (outside of professional supports) who may assist consumers seeking stability and independence. The CCS care coordinator works directly with the

consumer to regularly explore, identify and promote the development, and inclusion, of natural supports in the recovery planning process.

A. CCS CORE VALUES

- 1) ***Family-Centered:*** A family-centered approach means that families are a family of choice defined by the consumers themselves. Families are responsible for their children and are respected and listened to as we support them in meeting their needs, reducing system barriers, and promoting changes that can be sustained overtime. The goal of a family-centered team and system is to move away from the focus of a single consumer represented in systems, to a focus on the functioning, safety, and well-being of the family as a whole.
- 2) ***Consumer Involvement:*** The consumer and their family's involvement in the recovery planning process is empowering and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives including decisions made about their service plans.
- 3) ***Builds on Natural and Community Supports:*** Recognizes and utilizes all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include an individual and/or families' relative, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately individuals and families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.
- 4) ***Strength-Based:*** Strength-based planning builds on the individual and/or family's unique qualities and identified strengths that can then be used to support strategies to meet their needs. Strengths should also be found in the individual and/or family's environment through their informal support networks as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the individual and/or family's initial needs are met and new needs emerge with strategies discussed and implemented.
- 5) ***Unconditional Care:*** Means that we care for the individual or family, not that we care "if." It means that it is the responsibility of the service team to adapt to the needs of the individual and/or family, not the individual and/or family to adapt to the needs of a program. We will coordinate services and supports for the individual and/or family that we would hope are done for us. If difficulties arise, the individualized services and supports change to meet the individual and/or family's needs.
- 6) ***Collaboration Across Systems:*** An interactive process in which people with diverse expertise, along with individuals and/or their families, generate solutions

to mutually defined needs and goals building on identified strengths. All systems working with the individual and/or family have an understanding of the role each program serves in the individual and/or family's life and a commitment and willingness to work together to assist them in achieving their goals. The substance abuse, mental health, child welfare, and other identified systems collaborate and coordinate a single system of care for individuals and families involved within their services.

- 7) ***Team Approach Across Agencies:*** Planning, decision-making, and strategies rely on the strengths, skills, mutual respect, creative, and flexible resources of a diversified, committed team. Team member strengths, skills, experience, and resources are utilized to select strategies that will support the individual and/or family in meeting their needs. Individuals, their families, formal, and informal team members share responsibility, accountability, authority, and understand and respect each other's strengths, roles, and limitations.
- 8) ***Ensuring Safety:*** When child protective services are involved, the team will maintain a focus on child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible, and whether the safety services in place are effectively controlling those threats. When safety concerns are present, a primary goal of the family team is to ensure that supervision be appropriately provided to participants to address any safety concerns.
- 9) ***Gender/Age/Culturally Responsive Treatment:*** Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity, religion and sexual orientation, and reflect support, acceptance, and understanding of cultural and lifestyle diversity.
- 10) ***Self-sufficiency:*** Individuals and/or families will be supported, resources shared, and team members held responsible in achieving self-sufficiency in essential life domains. (Domains include but are not limited to safety, housing, employment, financial, educational, psychological, emotional, and spiritual.)
- 11) ***Education and Work Focus:*** Dedication to positive, immediate, and consistent education, employment, and/or employment-related activities which results in resiliency and self-sufficiency, improved quality of life for self, family, and the community.
- 12) ***Belief in Growth, Learning and Recovery:*** Individual and/or family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals and families with compassion, dignity, and respect. Team members operate from a belief that every individual and/or family desire change and can take steps toward attaining a productive and self-sufficient life.

- 13) **Outcome-oriented:** From the onset of recovery team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports are discussed, agreed-upon, and maintained. Identified desirable outcomes are understood and shared by all team members. Legal, education, employment, safety, and other applicable mandates are considered in developing strategies, progress is monitored, and each team member participates in defining success. To achieve outcomes, desired outcomes are standardized, measurable, based on the life of the individual and/or family and its individual members.

B. TARGET POPULATION

Everyone who is interested in CCS has the opportunity to participate in a screening process that will determine whether they are eligible for CCS. There are a few criteria individuals **NEED** to meet/have in order to participate:

- 1) Milwaukee County residency
- 2) Medicaid (T-19, Forward Health) Eligible
- 3) A mental health and/or substance use disorder
- 4) Functional eligibility- determined by the State of Wisconsin Mental Health/AODA Functional Screen (for adults) or the Children's Long-Term Services (CLTS) screen (for children)
- 5) Clinical appropriateness for the program, as determined by the Mental Health Professional and documented on a Determination of Need form

C. CCS SERVICE DESCRIPTIONS

- 1) **Screening and Assessment:** Screening and assessment services include: Completion of initial and annual Functional Screens and completion of the initial comprehensive assessment and ongoing assessments as needed. The assessment must cover all the domains, including substance use, which may include using the Uniform Placement Criteria or the American Society of Addiction Medicine Criteria. The assessment must address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyles of the member and identify how to evaluate progress toward the member's desired outcomes. Assessments for minors must address the minor's and family's strengths, needs, recovery and/or resilience goals, priorities, preferences, values, and lifestyle of the member including an assessment of the relationships between the minor and his or her family. Assessments for minors should be age (developmentally) appropriate.
- 2) **Service Planning:** Service planning includes the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member. All services must be authorized by a Mental Health Professional and a Substance Abuse Professional if substance abuse services will be provided. The service plan is based on the assessed needs of the member. It must include measurable goals and the type and frequency of data that will be used to measure progress toward the desired outcomes.
- 3) **Service Facilitation:** Service Facilitation includes activities that ensure the member receives: assessment services, service planning, service delivery and

supportive activities in an appropriate and timely manner. It also includes ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning. Service facilitation includes assisting the member in self-advocacy and helping the member obtain other necessary services such as: medical, dental, legal, financial and housing services. Service facilitation for minors includes advocating and assisting the member's family in advocating for the minor to obtain necessary services. When working with the minor, service facilitation that is designated to support the family must be directly related to the assessed needs of the minor. Service facilitation includes coordinating a person's crisis services, but not actually providing crisis services.

- 4) **Diagnostic Evaluation:** Diagnostic evaluations include specialized evaluations needed by the consumer including but not limited to neuropsychological, geropsychiatric, specialized trauma, and eating disorder evaluations. For minors, diagnostic evaluations can also include functional behavioral evaluations and adolescent alcohol/drug assessments. The CCS program does not cover evaluations for autism and developmental disabilities or learning disabilities.
- 5) **Medication Management:** Medication management services administered by prescribers include: diagnosing and specifying target symptoms; prescribing medication to alleviate the identified symptoms; monitoring changes in the member's symptoms and tolerability of side effects; and reviewing data including other medications used to make medication decisions. Prescribers may also provide all services that non-prescribers can provide as noted below.

Medication management for non-prescribers include: supporting the member in taking his or her medications; increasing the consumer's understanding of the benefits of medication and the symptoms it is treating, and monitoring changes in the consumer's symptoms and tolerability of side effects.

- 6) **Physical Health Monitoring:** Physical health monitoring services focus on how the consumer's mental health and/or substance abuse issues impact his or her ability to monitor and manage physical health and health risks. Physical health monitoring services include activities related to the monitoring and management of a consumer's physical health. Services may include assisting and training the consumer and the consumer's family to: identify symptoms of physical health conditions, monitor physical health medications and treatments, and develop health monitoring and management skills. Service can be provided in both individual and group settings.
- 7) **Peer Support:** Peer Support services include a wide range of supports to assist the consumer and the consumer's family with mental health and/or substance abuse issues in the recovery process. These services promote wellness, self-direction, and recovery by enhancing the skills and abilities of members to meet their chosen goals. The services also help consumers negotiate the mental health

and/or substance use disorder systems with dignity and without trauma. Through a mutually empowering relationship, Certified Peer Specialists and consumers work as equals toward living in recovery.

- 8) ***Individual Skill Development Enhancement:*** Individual skill development and enhancement services include training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the member's service plan. Services also include training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services (including health care services), and other specific daily living needs identified in the consumer's service plan.

Services provided to minors should also focus on improving integration into and interaction with the minor's family, school, community, and other social networks. Services include assisting the minor's family in gaining skills to assist the minor with individual skill development and enhancement. Services that are designed to support the family must be directly related to the assessed needs of the minor. Skills training may be provided by various methods; including but not limited to modeling, monitoring, mentoring, supervision, assistance, and cuing. Service can be provided individually or in a group setting.

- 9) ***Employment – Related Skill Training:*** Employment-related skill training services address the consumer's illness or symptom-related issues in finding, securing, and keeping a job. Services may include but are not limited to: employment and education assessments; assistance in accessing or participating in educational and employment related services; education about appropriate job-related behaviors; assistance with job preparation activities such as personal hygiene, clothing, and transportation; onsite employment evaluation and feedback sessions to identify and manage work-related symptoms; assistance with work-related crises; and individual therapeutic support. The CCS program does not cover time spent by the consumer working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the service array, for the member if those services are identified in the consumer's service plan. Service can be provided individually or in a group setting.

- 10) ***Individual and/or Family Psychoeducation:*** Psychoeducation services include: providing education and information resources about the consumer's mental health and/or substance abuse issues; skills training, problem solving, and ongoing guidance about managing and coping with mental health and/or substance abuse issues; and social and emotional support for dealing with mental health and/or substance abuse issues. Psychoeducation may be provided individually or in a group setting to the member or the member's family and natural supports (i.e. anyone the member identifies as being supportive in his or her recovery and/or resilience process). Psychoeducation is not psychotherapy. Family psychoeducation must be provided for the direct benefit of the member.

Consultation to family members for treatment of their issues not related to the consumer is not included as part of family psychoeducation. Family psychoeducation may include anticipatory guidance when the member is a minor. If psychoeducation is provided without the other components of the wellness management and recovery service array category (#11), it should be billed under this service category. Service can be provided individually or in a group setting.

11) *Wellness Management/Recovery Supportive Services:* Wellness management and recovery services, which are generally provided as mental health services, include empowering consumers to manage their mental health and/or substance abuse issues, helping them develop their own goals, and teaching them the knowledge and skills necessary to help them make informed treatment decisions. These services include: psychoeducation; behavioral tailoring; relapse prevention; development of a recovery action plan; recovery and/or resilience training; treatment strategies; social support building; and coping skills. Services can be taught using motivational, educational, and cognitive-behavioral strategies. If psychoeducation is provided without the other components of wellness management and recovery, it should be billed under the individual and/or family psychoeducation service array under category (#10). Recovery support services, which are generally provided as substance abuse services, include emotional, informational, instrumental, and affiliated support. Services include assisting the member in increasing engagement in treatment, developing appropriate coping strategies, and providing aftercare and assertive continuing care. Continuing care includes relapse prevention support and periodic follow-ups and is designated to provide fewer intensive services as the member progresses in recovery. Service can be provided individually or in a group setting.

12) *Psychotherapy:* Psychotherapy includes the diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, or addictions through the application of methods derived from established psychological or systemic principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics, which may include the purpose of understanding unconscious processes or intrapersonal, interpersonal, or psychosocial dynamics. Service can be provided individually or in a group setting.

13) *Substance Abuse Treatment:* Substance abuse treatment services include day treatment (Wisconsin Administrative Code DHS 75.12) and outpatient substance abuse counseling (DHS 75.13). Substance abuse treatment services can be in an individual or group setting. The other categories in the services array also include psychosocial rehabilitation substance abuse services that support consumers in their recovery. Service can be provided individually or in a group setting. The CCS program does not cover Operating While Intoxicated assessments, urinalysis and drug screening, detoxification services, medically managed inpatient treatment services, or narcotic treatment services (opioid treatment

programs). Some of these services may be covered under Medicaid outside of the CCS program.

3. ADDRESSING KEY QAPI ISSUES

The outlined quality assessment and performance improvement plan will address key issues including:

- CCS consumer satisfaction
- CCS service accessibility
- Integration of adult and youth CCS services
- Development and inclusion of natural supports in the recovery planning process

4. CURRENT AND PAST QUALITY ASSURANCE ACTIVITIES

A. CCS Evaluation Dimension 1: Monitoring and Summative Evaluation for Policy-Related Compliance

Policy and state mandated compliance data for CCS are monitored through Avatar, Synthesis, and Provider Connect. These programs hold information such as medical records and other personal health information. These data sources satisfy program monitoring and compliance needs for state and policy requirements. Oftentimes, the data collected through the Electronic Health Record (HER) are analyzed to drive various performance improvement projects (PIP) (e.g. NIATx change projects, PDSA cycles, etc.) in order to enhance the quality of the CCS program.

B. BHD – CCS Evaluation Dimension 2: Monitoring and Summative Evaluation for Consumer Outcomes

The Program Participation System (PPS) form bundle is not only utilized to meet State reporting requirements, but also to support CCS monitoring of consumer-based outcomes and programmatic success. This information is used internally to identify service gaps, process change needs, program evaluation, and consumer level outcomes. In addition, the information received, may be shared externally with contracted providers or BHD stakeholders (Milwaukee County Mental Health Board) to help drive performance improvement. This is an area in which the CCS program will utilize outcome reports (i.e. dashboards, Agency Performance Reports (APR), etc.) for managers to keep track of factors like monitoring State compliance requirements, aggregate health outcomes, and contract performance measures (CPMs).

C. BHD – CCS Evaluation Dimension 3: Formative Evaluation for Processes

CCS service providers may identify “change projects” within their own agencies to improve process or attain desired programmatic outcomes. NIATx models are utilized for this purpose. The NIATx model encourages providers to identify a quality assurance change project within the agency. This is an opportunity for providers to identify an issue, plan how to fix it, use the democratically-decided change projects, study results, and act upon it in the interest of improving process, outcomes, and quality care. CCS service providers are encouraged to present their internal change projects once a year at BHD, but it is not required. CCS, as a program also engages in an annual internal PIP

projects to enhance the quality of the program. Examples of past PIP projects include: increased involvement of natural supports (family, friends, and other supports outside of traditional providers) in the recovery planning process; decreasing the length of time it takes to get into CCS services and decreasing the time it takes to refer consumers to CCS ancillary providers. Change teams are welcome to collect their own data, or request information that is provided by CCS. This mechanism may bring systemic change to processes, but it is generally on a smaller, agency level. Link to more information about the NIATx model: <https://niatx.net/Content/ContentPage.aspx?PNID=1&NID=8>.

D. Monitoring and Outcomes Evaluation for State of CCS Meetings

“State of CCS” meetings are held once a year. The following items are reviewed at the meeting in the form of a data summary:

- 1) Census by Age Over Time
- 2) CCS Census by Gender
- 3) Annual CCS Census
- 4) Cumulative Admissions and Discharges for CCS Adult and Youth Consumers
- 5) Average Duration from Inquiry to Admission for Adult Consumers
- 6) Average Duration from Admission to Prescription Attainment for Adult Consumers
- 7) Average Duration from Admission to Deemed Eligibility for Adult Consumers
- 8) Average Duration from Admission to Service Plan Entry
- 9) Average Ancillary Providers Usage in the Past Quarter
- 10) Average Number of Ancillary Services Per Consumer External to Care Coordination Providers
- 11) Count of CCS Consumers Employed at Admission and Six-Month Follow-Up
- 12) Count of CCS Consumers Attending School/Higher Education
- 13) Count of Living Situation Type for CCS Consumers at Admission and at Six-Month Follow-Up
- 14) Satisfaction Survey Results

5. USE OF BEST AVAILABLE EVIDENCE

A. Program Participation System (PPS)

The PPS form bundle is a required State reporting tool that all State/County funded programs need to complete. The PPS “bundle” (forms with a wide range of questions intended to monitor client progress and program efficacy, including the PPS/NOMS Supplemental Form for adults) are required to be completed at intake, every six months a consumer is in a particular service, and at discharge. The bundles are completed by the individual’s Care Coordinator for CCS.

B. Recovery Oriented Systems Indicators (ROSI) Survey

This is a State required (by DHS 36) evaluation tool. The ROSI survey is administered on an annual basis by Vital Voices, a local organization contracted with Milwaukee County Behavioral Health Division. Eligible consumers must have received service in the CCS

program for at least six months, and/or discharged no more than three months ago from the State of the sampling period. This survey is voluntary, but the CCS team works diligently with contracted CCS care coordination agencies to promote higher rates of consumer participation. The survey is done in person, but if the consumer cannot be reached face-to-face, then a phone interview commences. Once the ROSI is completed, service managers, administrative coordinators, the Recovery Advisory Committee, and supervisors from CCS agencies are given data summaries that cover strengths and areas in need of improvement based on consumer responses.

C. Family & Youth Mental Health Statistics Improvement (MHSIP) Surveys

The annual Family MHSIP survey gauges parent/caregiver's perceptions of the CCS services their child/children received in the past six-months, and/or discharged no more than three months from the start of the sampling period. The survey is voluntary and confidential. This is filled out by the family caregiver of children who are not able to complete the MHSIP Youth survey.

The annual Youth MHSIP survey gauges opinions of adolescents in CCS services (aged 13 – 17 years) who have been in services for six months or longer, and/or discharged no more than three months from the start of the sampling period this survey follows similar protocol to the Family MHSIP survey.

6. RESPONSIBILITY AND ACCOUNTABILITY: QAPI ACTIVITIES AND THE GOVERNING BOARD

The CCS Program Administrator or designee will perform all functions as required by statute. These responsibilities shall include overall responsibility for the CCS program, including compliance with DHS Chapter 36 and other applicable state and federal regulations to include developing policies and procedures.

BHD quality personnel, CCS program leadership and the CCS provider network team(s) will have the responsibility for championing all aspects of quality, to include the promotion of a culture of continuous improvement.

The Milwaukee County CCS Recovery Advisory Committee (CCS Coordinating Committee) is a group of individuals (service providers, mental health and substance abuse advocates, consumers, family members & interested citizens) who meet every other month to review and make recommendations and address quality issues. The CCS Recovery Advisory Committee (RAC) will ensure committee participation reflects 1/3 consumer participation and will be responsible for the oversight of planning, designing, implementing, and selection of quality improvement activities to best meet the needs of the consumers the CCS program serves. Written minutes and a membership list are maintained. Results of consumer satisfaction surveys, relevant policy and procedural changes, changes to the Quality Plan and other recommendations pertaining to programmatic improvement are reviewed, approved and often directed by the Recovery Advisory Committee.

The CCS Operations Committee will be responsible to review CCS quality improvement activities including recommendations of the RAC and performance toward established programmatic outcomes. Ultimately, the CCS Quality Plan and continuous improvement updates will be submitted annually to the Quality Committee of the Mental Health Board (and subsequently the Governing Board) for review, input and approval.

7. SOURCING OF THE QAPI PLAN

The CCS Operations Committee and Program Leadership will assess needs and request financial resources to ensure quality improvement activities are properly planned and budgeted on an annual basis. BHD Executive Personnel will ensure to establish the appropriate budget to support continuous improvement activities across the organization. These expenses may include, but not limited to; financial support for projects, resources, and training. The budget will be reviewed annually by the CCS Operations Committee, reviewed with the Chief Financial Officer, and revised as needed. Refer to the positions identified below that list the staffing that support the continuous improvement activities. Staffing and needs will be assessed and identified to support the expansion and function of future needs and adjusted accordingly. The positions involved in the CCS Program and supporting the CCS QAPI Plan for Children's Community Mental Health Services are the Director, Associate Director, CCS Program Manager, Quality Assurance Director, Quality Assurance Coordinator, and Quality Assurance Specialist. Additional positions involved in the support of the CCS Program for adults include; Associate Director, Integrated Service Coordinators, Administrative Coordinators, Program Evaluator, Chief Operations Officer, Manager of Quality Improvement, Quality Improvement Coordinators, Quality Assurance Coordinator, and Client Rights Specialist.

8. STAFF TRAINING AND ORIENTATION

Per 36.07 (5) (i) all Comprehensive Community Services (CCS) staff shall be provided with orientation and training that meets the requirements outlined under DHS 36.12. The orientation and training program will be provided, but not limited to, CCS staff, providers, peer specialists, volunteers and consumers. All CCS staff are required to review the "CCS Orientation & Training" policy found in PolicyStat and on the BHD Provider Webpage, which outlines initial and ongoing training requirements.

Additionally, staff are required to review the "CCS Quality Improvement", "CCS Revising Plan", "CCS Monitoring and Compliance" policies, and all other policies associated with the CCS program.

9. QAPI FRAMEWORK

The CCS Recovery Advisory Committee (RAC) and the BHD CCS Operations Committee are the two committees that have responsibility for the oversight of planning, designing and selection of quality improvement activities to best meet the needs of the CCS consumers. Individuals from

the organization will be selected to conduct performance improvement projects to include monitoring progress, providing input and ensuring individuals involved in projects have technical assistance and guidance.

10. IMPLEMENTATION OF A NON-PUNITIVE STAFF CULTURE

Executive Leadership and the CCS Operations Committee of the Behavioral Health Division will provide an environment that supports individual expression about the CCS Program, any quality concerns, or suggestions for areas of improvement. BHD will support practices and principles of a learning environment and a non-punitive or Just Culture. At all levels of the organization, individuals will be encouraged to bring forth opportunities to improve CCS quality without fear of retaliation. Performance improvement will be encouraged with the deliberate attention to on-going quality with input from those served.

11. DATA SOURCES UTILIZED TO ANALYZE PERFORMANCE

Below are data source for performance options that may be utilized:

Data Source	Data Collection	Benchmarks Used	Who will analyze the data	Data Analysis Frequency	Data will be communicated with	Communicate data analysis via	Frequency of communication
PPS Form Bundle	Weekly	Organizational and State Data	CARS and Wraparound Evaluator/Analyst	Monthly	Service Managers, agency supervisors	Dashboard, staff meetings, QAPI Meeting	Monthly
RPOC/Domain Based Plan of Care	Weekly	Organizational Data; Best Practices	Care Coordinators, Contract Management	Quarterly	Care coordinators, agency supervisors, service managers	Audit, staff meetings	Quarterly
ROSI	Annually	State Data	CARS Program Evaluator/Analyst	Annually	QAPI committee, RAC committee, CCS Staff	Data summary, QAPI Meeting, RAC Meeting, operations Meeting	Annually
Billing - Ancillary Services	Daily	Organizational Data	CARS and Wraparound Evaluator/Analyst	Monthly	Service Managers, agency supervisors	State of CCS Staff Meeting (Annual), operations meeting, Dashboard	Monthly
Census	Annually	Organizational Data	CARS and Wraparound Evaluator/Analyst	Annually	Service Managers, agency supervisors	Dashboard, staff meetings, QAPI Meeting	Annually
MHSIP Family Survey (Ages 12 years or younger)	Annually	State	Wraparound Analyst	Annually	Care coordinators, agency supervisors, service managers	Data summary, QAPI Meeting, RAC Meeting, operations meeting	Annually
MHSIP Youth Survey (Ages 13 - 17)	Annually	State	Wraparound Analyst	Annually	Care coordinators, agency supervisors, service managers	Data summary, QAPI Meeting, RAC Meeting, operations meeting	Annually

12. DATA SOURCES TO IDENTIFY RISK

Below are risk measurement options that may be utilized:

Data Sources	Data Collection		Who will analyze the data?	Data Analysis		Data will be communicated with	Communicate data analysis via	Frequency of communication
	Frequency	Benchmarks Used		Frequency				
Complaints/Grievances	As Identified	Organizational Data	Client Rights Specialist/Evaluator	As Needed		Service Managers, agency supervisors, QAPI Committee, and RAC	Reports, QAPI and RAC Meetings	As Needed
ROSI	Annually	State Data	BHD Evaluator, Care Coordinators, Contract Management	Annually		Care coordinators, agency supervisors, service managers	Data summary, QAPI Meeting, RAC Meeting, operations Meeting	Annually
Abuse, Neglect, Maltreatment reports	As Identified	Best Practices; Organizational Data	TBD	As Needed		QAPI committee, RAC, CCS Staff	Data summary, QAPI Meeting, RAC Meeting, operations Meeting	As Needed
PPS/NOMs	Ongoing	Organizational Data	Evaluator/Analyst	Monthly		Service Managers	Operations Meeting, Dashboard	Monthly
MHSIP Family Survey	Annually	State Data	Wraparound Analyst	Annually		Care coordinators, agency supervisors, service managers	Data summary, QAPI Meeting, RAC Meeting, operations Meeting	Annually
MHSIP Youth Survey	Annually	State Data	Wraparound Analyst	Annually		Care coordinators, agency supervisors, service managers	Data summary, QAPI Meeting, RAC Meeting, operations Meeting	Annually
Critical/Sentinel Events	As Identified	Case by case	SCC Committee	As Needed		Programs as indicated, MHB, and MHB quality committee	Data summary	Annually

13. DATA SOURCES TO COLLECT FEEDBACK/INPUT

Below are options that may be utilized for feedback/input from consumers and providers:

Data Sources	Data Collection		Who will analyze the data?	Data Analysis		Data will be communicated with	Communicate data analysis via	Frequency of communication
	Frequency	Benchmarks Used		Frequency				
ROSI	Annually	State Data	Care Coordinators, Contract Management	Annually		Care coordinators, agency supervisors at the care coordination agency, service managers	QAPI, RAC, and Operations Meetings, data summary and presentation	Annually
ROSI - CORE	Annually	State Data	Wraparound Evaluator/Analyst	Annually		TBD	TBD	TBD
Recovery Team Meeting (RPOC)/Plan of Care Meeting	Monthly	Organizational Data	CARS CCS Staff, Contract Management	Quarterly		CCS Staff, QAPI Committee	Brief Report/Scorecard, recovery team meetings and QAPI meeting	Quarterly
Focus Groups (For Contract Performance Measures (CPMs))	As Needed	Organizational Data	CARS and Wraparound Evaluator/Analyst, CPM Workgroup	As Needed		Service Managers, Executive Leaders, CCS Staff	Data summary, QAPI Meeting, CPM Workgroup Meeting	As Needed
MHSIP Family Survey	Annually	State	Wraparound Analyst	Annually		Care coordinators, agency supervisors, service managers	TBD	Annually
MHSIP Youth Survey	Annually	State	Wraparound Analyst	Annually		Care coordinators, agency supervisors, service managers	TBD	Annually
Family Provider Surveys	Quarterly	Organizational Data	Wraparound Quality Assurance Department and Evaluator	Annually		Provider agencies, internal administrative staff, identified BHD and community partners, and State partners	Data summary and reports, QAPI meeting, RAC meeting	Annually

14. CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS (PIP's)

The Comprehensive Community Services (CCS) program/Behavioral Health Division will conduct PIP's in identified areas, in an effort to improve direct client care, services, or practices that may affect client care. PIP's will be conducted that address areas of concern/need/risk that may cross both adult and children's services. PIP's may address client/staff quality of life and/or quality of care issues, service delivery, efficiencies issues, desired outcomes and satisfaction levels for the populations served.

15. IDENTIFICATION OF PIP TOPICS

PIP's will be chosen using a systematic approach that considers a topic important to the population served or service staff, one that effects a significant portion of the staff or the population served, and one that reflects a high-volume or high-risk condition of the population served. Input from clients, families, staff, stakeholders, service providers, etc., will be sought. Data and any outcome information will be analyzed to support needed improvements/topic areas. In addition, consideration will be given to the following:

- Existing standards or guidelines available to provide direction for the PIP
- Measures that can be used to monitor progress
- The ability to benchmark against community, state and national outcomes

16. PRIORITIZING AND SELECTING PIP's

Potential areas for improvement are based on the needs of the population served and the program/organization. How relevant (high-risk, high prevalence, high volume) and important is the PIP to those served? How does it relate to the health, functional status and quality of life of the population? How many will be impacted by the hopeful improvement? Does the organization have all the resources (staff, money, supplies, technology, training capacity) to implement all the identified strategies? Will the change affect the efficiencies of the organization/staff? Does the PIP support the organizations goals and strategic plan? Will any change be able to be sustained? Are there identified "champions" to lead the PIP?

All of the above will be discussed and considered in an effort to prioritize all the ideas on the table. The top identified 2-3 items will be further discussed and a team decision will be made as to the selected topic. If the Team cannot arrive at a decision, then a voting process may be implemented, and /or the ideas may need to go to an identified committee for final determination.

17. PIP CHARTER DEVELOPEMENT

PIP Charters may need to be developed if it is determined that it would be helpful to have a group/committee of individuals direct the project. A Charter can establish the goals, scope, timing, milestones, team roles and responsibilities for the PIP. The Charter will help the team/workgroup stay focused by reminding them of the hopeful outcomes and the goals to be accomplished.

18. THE DESIGNATION OF PIP TEAMS

When establishing the PIP work team, the following will be considered:

- Is the individual in a position to explore the issue, i.e. – staff/families/stakeholders/community partners closest to the problem?
- Does the individual know how to and have the authority to acquire the necessary “tools” to implement and make decisions about the project?
- Is each job role that is affected represented?
- What are the needed “characteristics” of the team, i.e. – historical knowledge, interdisciplinary membership including families and clients, level of experience/qualifications – i.e. - leader/organizer/coordinator/analyst/author, etc.

19. CONDUCTING THE PIP

If the PIP must be conducted in a designated contractually-driven fashion, then that project guideline will be followed. If the team identifies another framework to utilize, i.e. – NIATx. Model, PDSA Cycles, then that will provide guidance to the project. Some overarching guidelines to follow are:

- Select a study topic
- What information/supplies are needed?
- Define a study question
- Select study indicators
- Define a study population/sample size
- Define a timeline/action plan
- Create/locate data collection/measurement tools
- Implement improvement strategies/interventions
- Collect/analyze data
- Prepare and present results

20. DOCUMENTATION OF THE PIP

If the PIP must be documented in a designated contractually-driven fashion, then that template will be followed. If not, a template will be determined that will best highlight the project. Formats that will be considered will present the data in a structured, chronologically mindful, clear and sequential manner. The use of charts, graphs, tables, dashboards, posters, etc. will be considered.

Results of the PIP will be communicated to identified individuals/groups, i.e. – families, clients, staff, board members, stakeholders, community partners, the State, etc.

Mechanisms for communication of the project results may take the form of dashboards, posters, Power Point presentations, newsletters, board meetings, QA/QI meetings, staff meetings, community forums, etc.

21. PIP APPROACH AND TOOLS

The CCS QAPI Plan is under the larger BHD Quality Plan, which includes the usage of data informed practices, statistical tools, and continuous improvement. The NIATx protocol provides useful tool for the CCS QAPI committee and its constituents such as flowcharts, fishbone diagrams, Plan-Do-Study-Act (PDSA) cycles, swim-lane diagrams, inter-relationship digraphs, i2 charts, and more. These tools help the QAPI Committee identify and assess gaps, root causes, and other items.

22. PREVENTING NEGATIVE EVENTS AND PROMOTING SUSTAINED IMPROVEMENT

In alignment to the BHD Quality Plan, the CCS QAPI Committee instills this tenant: prevention over correction. Planning will be proactive rather than reactive. This will be done through the following mechanisms:

- A. The RAC will request updates to policies and procedures reflective of change and when necessary.
- B. Contract Performance Measures (CPMs) and other data points will be monitored as needed in the form of audits, data dashboards, and/or scorecards. CCS managers at the County level will review and share information with CCS community provider supervisors at operations meetings.
- C. The QAPI committee will help identify if a gap or problem exists through gap analysis, fishbone diagrams, flowcharts, or other quality improvement mechanisms.

23. ENSURING PLANNED CHANGES/INTERVENTIONS ARE IMPLEMENTED AND EFFECTIVE

Establish SMART Goals. SMART stands for:

- Specific
- Measurable
- Achievable
- Relevant
- Time-Bound

At least one goal should have a form of alignment to the BHD Quality Plan. This may be in alignment to the mission, vision, core values, guiding elements, service quality tenants, quality improvement principles, or continuous quality improvement activities. The QAPI Committee exists under the umbrella of the BHD Quality Plan, and thus should enact Continuous Quality Improvement (CQI) Projects, PIPS, or PDSA cycles relevant to the larger plan.

Contract Performance Measures (CPMs) will also be developed to ensure the CCS program is delivering quality, consumer focused care. The creation and implementation of CPMs is a BHD wide effort to identify quality performance indicators, monitors the achievement of indicators,

and assesses effectiveness. CPMs are supported through literature reviews and focus groups with staff and consumers, reviewed and approved by subject-matter experts, and are continuously revisited by the end of the contract period.

**Mental Health Board
Quality Subcommittee Meeting
June 3, 2019**

**Sentinel Event Committee
Quality Summary**

The Behavioral Health Division reviewed 13 total events in 2018. These included 6 Sentinel Events and 7 Other Events. In 2017 ten events were reviewed. In prior years the number of total events reviewed has been as high as 39 in 2012 and as low as 5 in 2016.

(Note: Over the years, who is being reviewed under the Sentinel Event procedure has changed. Examples include expanding the reviews to include CARS agencies in July, 2015, the closing of Acute unit 43D in December, 2012 and the closing of the Rehab Center units in December, 2015.)

This year, 46% of reviewed events were deaths by suicide. For comparison:

50% in 2017	18% in 2014
40% in 2016	0% in 2013
67% in 2015*	0% in 2012

2018 Root Cause Analysis Findings Themes and Findings of Significance

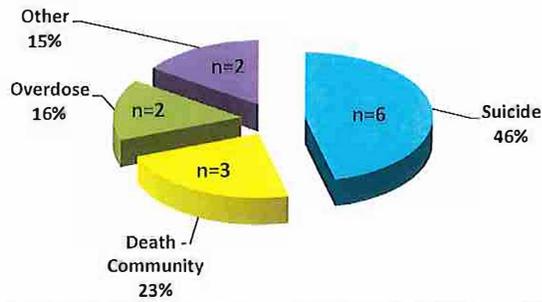
- The vast majority (92%) of events for 2018 occurred in the community. One case occurred within BHD.
- Themes found from reviewed community events include:
 - Lack of sufficient risk assessment. This includes not altering a treatment plan after identified increased risk to self.
 - Patients were not assessed for nor placed in Crisis Case Management when they met the criteria.
 - Frequency of patient contact was consistently less than recommended level.
 - Clinical documentation was too often not thorough or up-to-date.
 - TCM agencies were not consistently in compliance with the BHD Inpatient/Outpatient Collaboration Policy.
- Other themes include:
 - Not all medical record information is available to those in need of the information due to not having access to the utilized EHR.
 - The current service offerings in Milwaukee do not offer an option for true dual-diagnosis treatment. Also lacking is a means by which to offer involuntary AODA treatment.

2018 BHD Sentinel Events

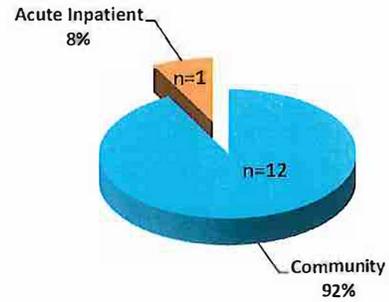
CONFIDENTIAL Peer Review Information

13 incidents reviewed

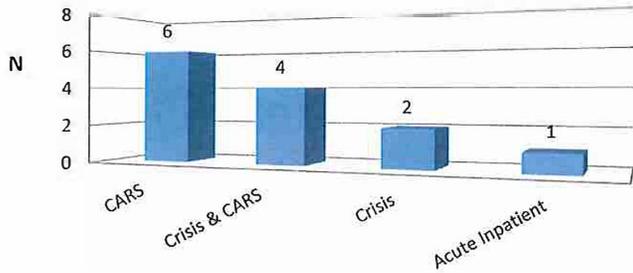
Type of Event



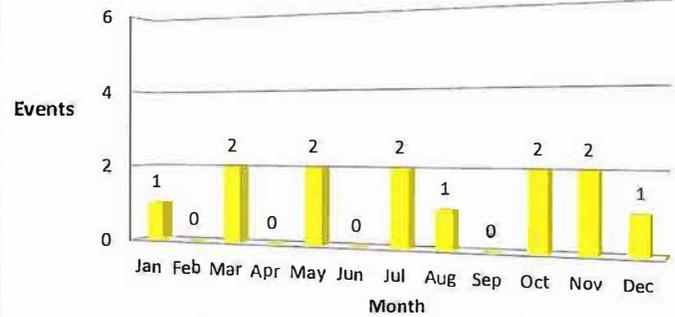
Location of Event



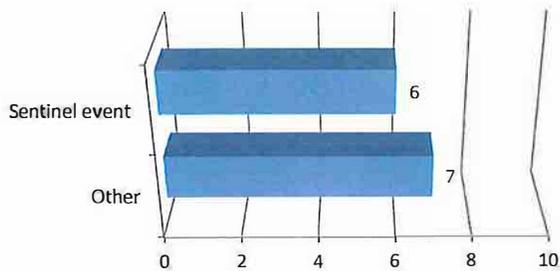
Program (Open with/last contact)



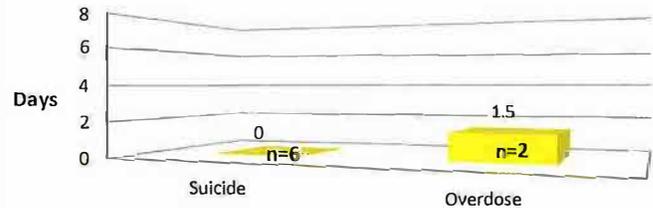
Month of Event



Level of Review

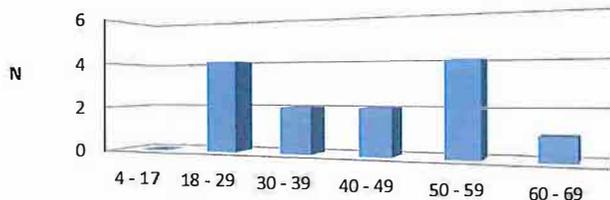


Average Days After Last BHD Contact



Patient Age

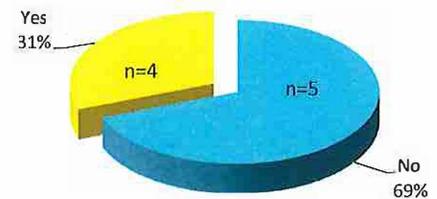
Average Age: 39 yrs male, 47 yrs female; Gender: 77% male, 23% female



N	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69
N	0	4	2	2	4	1

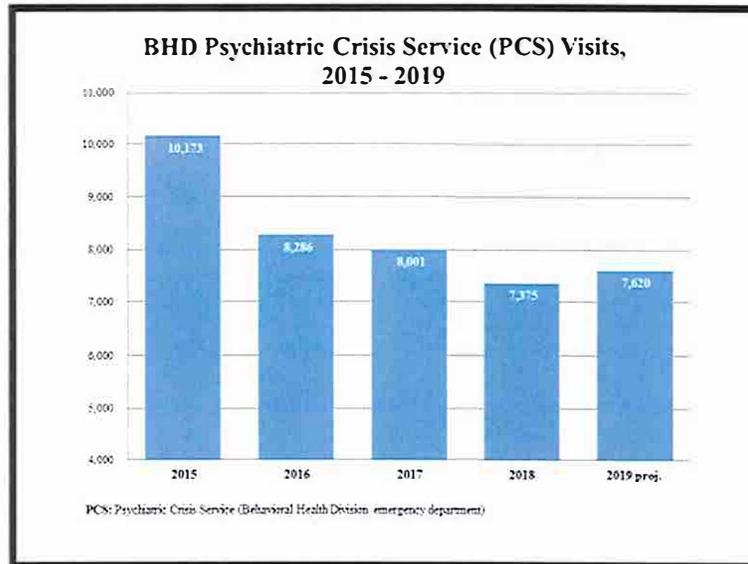
Significant AODA Component to Event

30% (n=4) of events reviewed had a significant AODA component

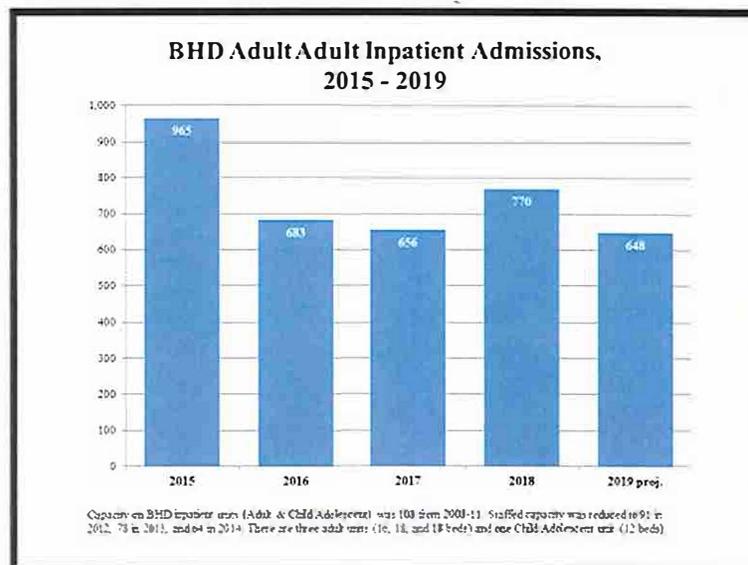


2019 Q1 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

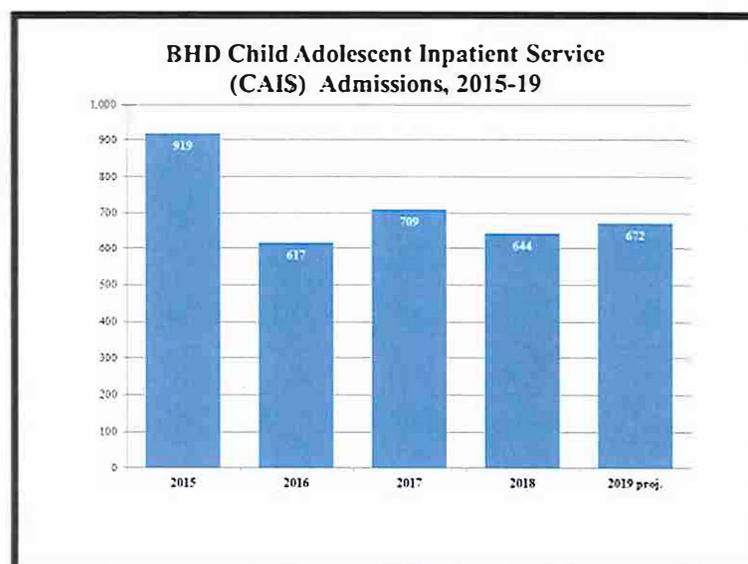
Psychiatric Crisis Service annual patient visits continue to decline from 10,173 in 2014 to 7,620 projected annual visits in 2019 (25% decline from 2015 to 2019). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (9% in 2014, 100% in 2019).



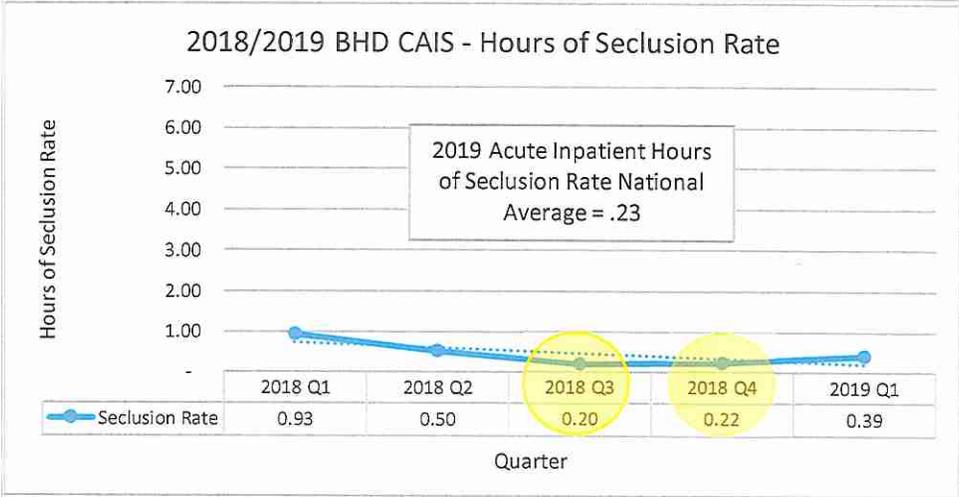
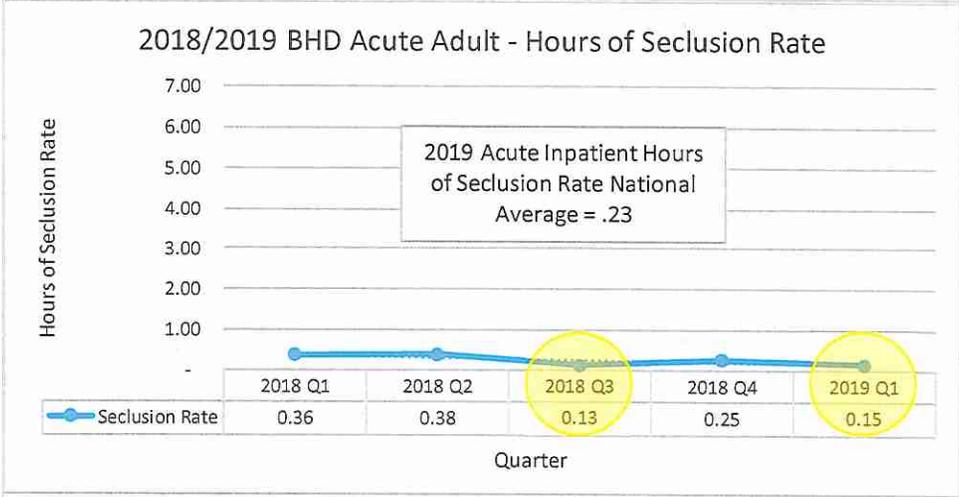
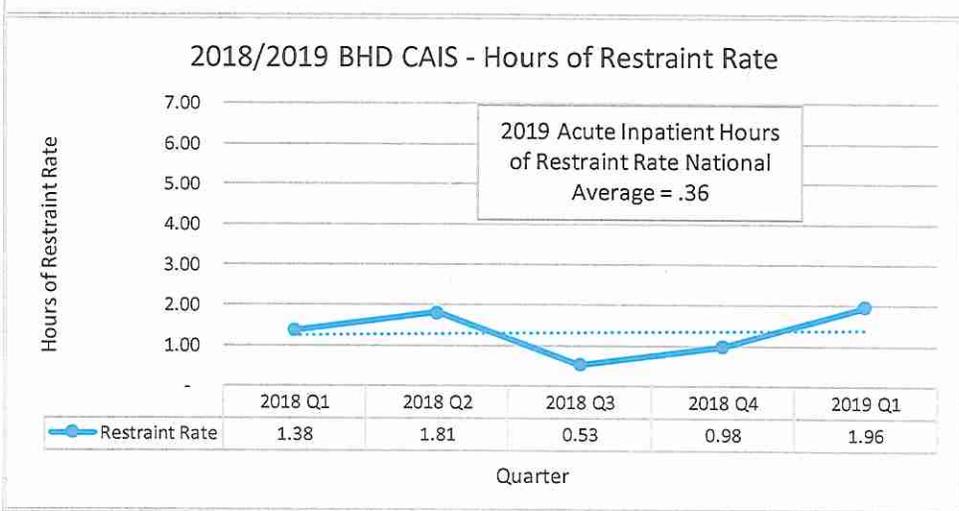
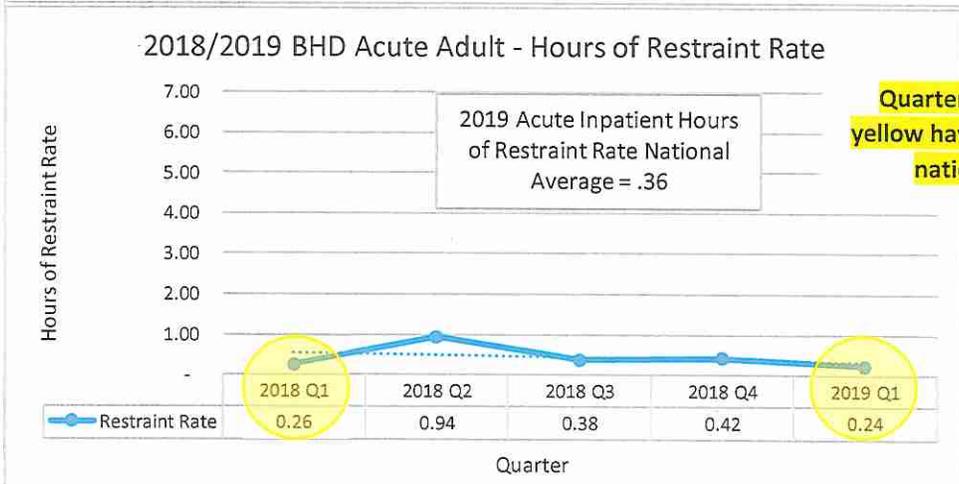
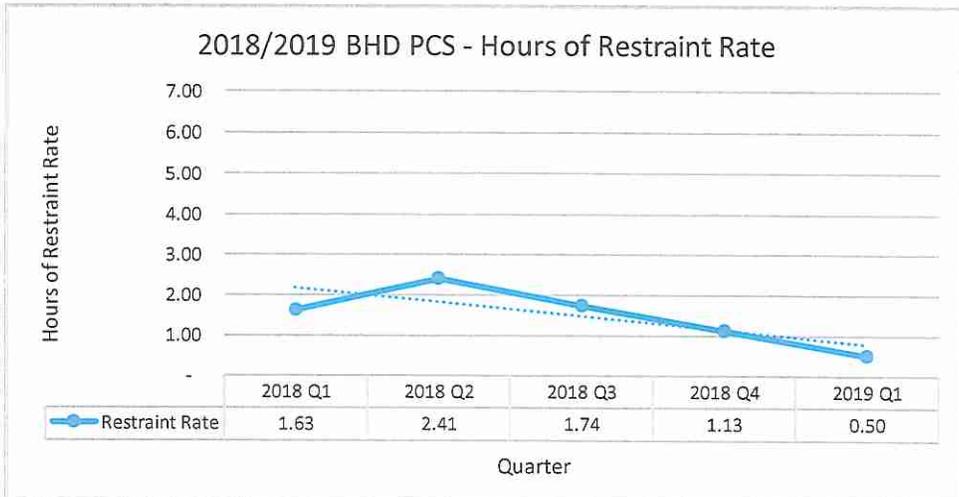
Acute Adult Inpatient Service’s annual patient admissions are projected at 649 in 2019. While Acute Adult admissions have plateaued over the past 4 years, readmission rates have continued to decline (30-day readmission rate: 11% in 2015, 4% in 2019). Acute Adult’s hours of physical restraint rate in 2019 was .24, well below CMS’ inpatient psychiatric facility national average of .36, and below Wisconsin’s average rate of .73. Acute Adult’s 2019 MHSIP overall patient satisfaction survey score of 79.6% was significantly better than NRI’s reported national average of 75%.



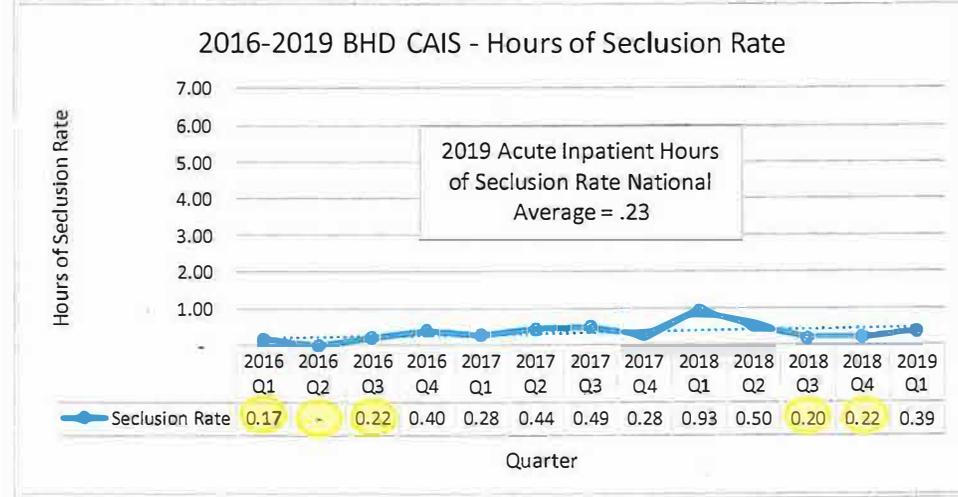
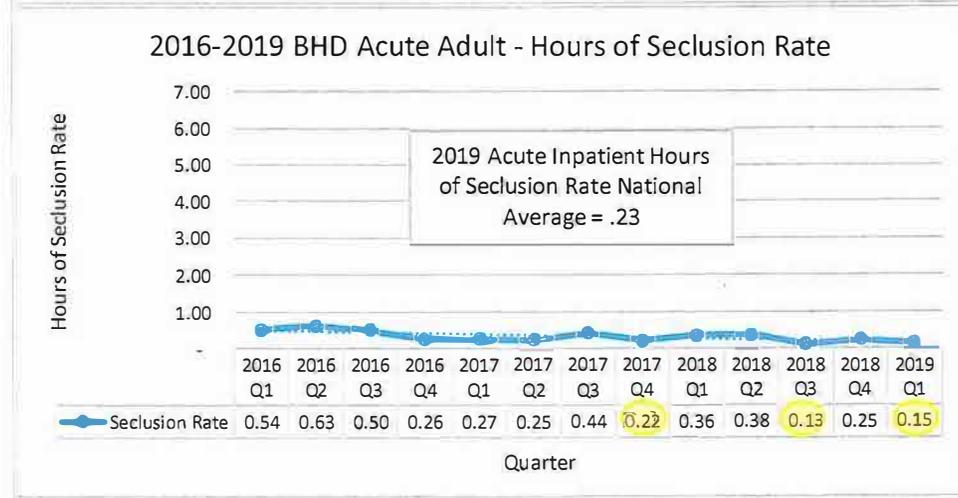
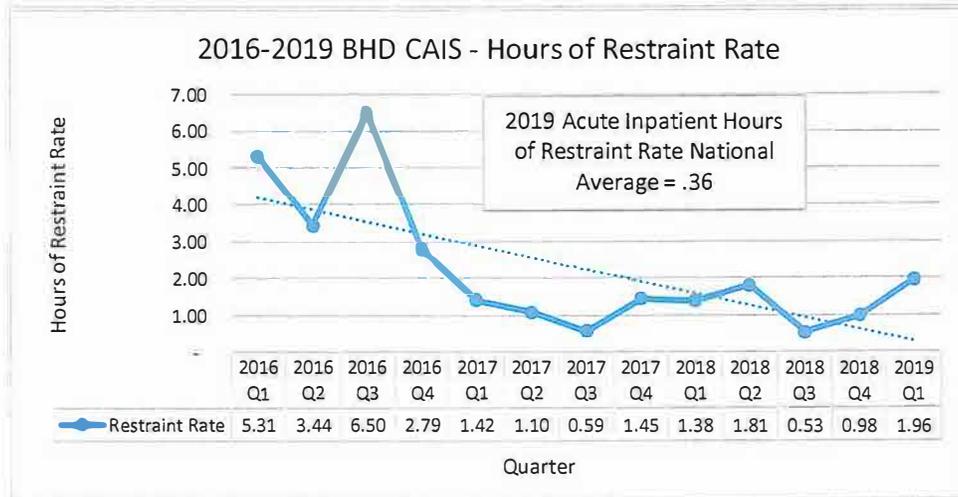
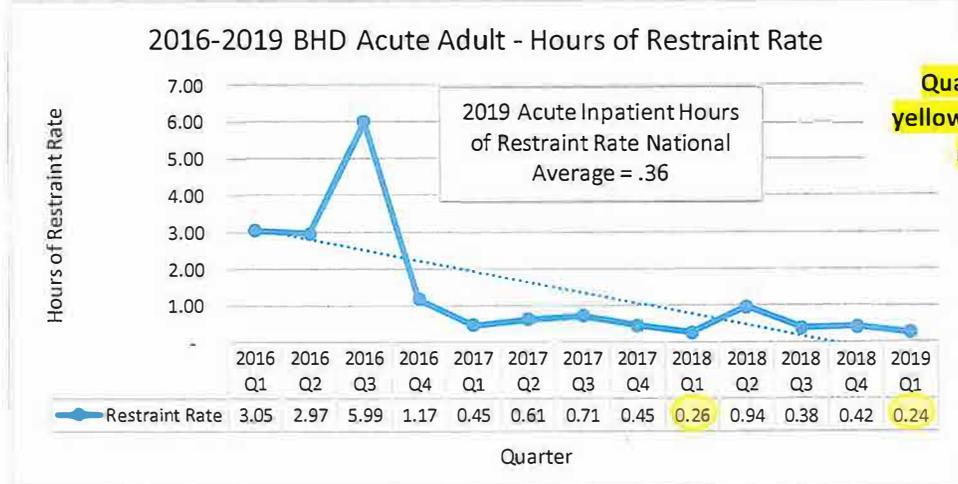
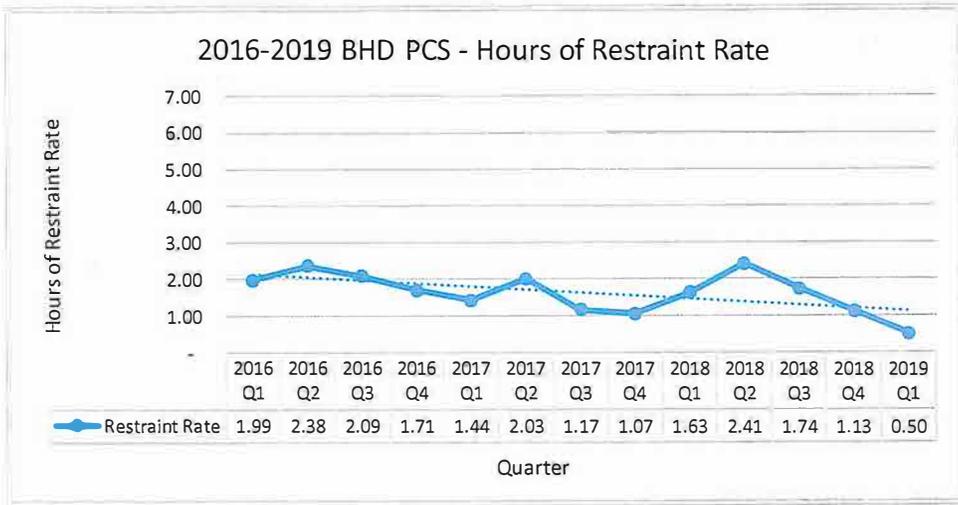
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past 4 years and are projected at 672 for annual 2019. Over the past few years, CAIS’ 30-day readmission rates have remained at 16%. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.9 in 2019, but remains above CMS’ reported average of .36. CAIS’ Youth Satisfaction Survey overall score of 80% positive rating is 5 percentage points higher than BHD’s historical average.



2019 Quarter 1 (Q1) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



2016-2019 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary



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



MARY JO MEYERS, MS • Director
MICHEAL LAPPEN MS, LPC • Division Administrator

April 23, 2019

John Chianelli
Executive Director
Whole Health Clinical Group
932 S. 60th St.
West Allis, WI 53214

Re: Notice regarding Whole Health Clinical Group (WHCG) Community Support Program (CSP)

Dear Mr. Chianelli,

Milwaukee County Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) is submitting this communication as notice that all referrals to the Whole Health Clinical Group Community Support Program (CSP) are being suspended as of this date until further notice. Milwaukee County BHD has previously had to stop referrals to WHCG CSP on February 28, 2017, and June 20, 2018, due to quality concerns.

This action is being taken due to concerns regarding deficiencies in standards of care, quality and timeliness of documentation, and billing practices. Some examples of these concerns, listed below, come from a record review, completed on documentation from October 1, 2018 to December 31, 2018:

- Only 5 of the 29 client files reviewed in this audit (17%) have evident that clients are being seen and receiving services at the frequency identified in their Recovery Plan of Care (RPOC)
- 114 of 288 clients (40%) had 2 hours/week or less of services
51 of 288 clients (18%) had 1 hour/week or less of services
28 of 288 clients (10%) had 30 minutes/week or less of services
- 48 of 142 authorizations (34%) were submitted late
- Duplicate and triplicate notes submitted that led to double and triple billing (recoupment in process)

Attached is the full agency review report from an audit that was completed in March 2019. This report includes all findings from the audit to include positive trends, qualitative findings, and quantitative findings. CARS leadership is requesting to meet with your CSP leadership team to discuss the audit findings on Monday, April 29, 2019, at 3:30pm in CARS unit 44A conference



BHD

MILWAUKEE COUNTY
Behavioral
Health
Division

room 13. If your team is unable to meet at that time, please let me know, and we will find a date and time that is more accommodating.

Please be aware that as a contracted provider of services with Milwaukee County BHD, the findings, corrections, and/or outcomes of quality and compliance audits will be reported to the Quality Committee of the Milwaukee County Mental Health Board and other applicable entities as required.

Sincerely,

A handwritten signature in black ink that reads "Amy Lorenz".

Amy Lorenz, MSSW, LCSW
Deputy Administrator
Community Access to Recovery Services
Milwaukee County Behavioral Health Division

**Quality Management Committee
Institutional Review Board (IRB) Report
June 3, 2019**

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.

Recently Completed Research

- Ms. Jessica Saldivar completed a quality improvement project titled: “Perceptions of Compassion Fatigue in Psychiatric Nurses” (2/19/19).

Existing Research

- The IRB has approved and continues to routinely monitor the following proposals:
 - i) Dr. Tina Freiburger: “An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division” (5/24/17).
 - ii) Dr. Gary Stark: “Survey of Suicidal Behavior Among Individuals with a Developmental Disability” (2/7/19).
 - iii) Dr. Pnina Goldfarb: “Building a Collaborative Care Model: An Approach for Effective Early Identification and Treatment of High School Students at Risk for Developing Psychosis” (2/18/19).
 - iv) Dr. John Schneider: “A Comparison of Adult Patient Experiences of Voluntary and Involuntary Commitment at Milwaukee’s Behavioral Health Department” (3/25/19).

Research Proposals

- The IRB recently received a proposal submitted by Ms. Chioma Anyanwu titled: “Improving the Quality of Nursing Assessment and Documentation of Patients with Suicide Risk” (4/29/19).

Monthly IRB Chairs Meeting

- The Medical College of Wisconsin (MCW) hosts a monthly meeting of IRB Chairs. The purpose of the meeting is to share information and discuss pertinent issues, which promotes best practices among the various IRBs. Dr. Kuehl continues to routinely attend these meetings.
- At a recent meeting, the MCW leadership offered to provide additional training to support the BHD IRB. The training is scheduled occur in August 2019.

Crisis Services Grand Rounds: November 4, 2019

- The IRB believes there is an opportunity to offer additional training for BHD staff. The training would discuss the basic definition of research while promoting the existence and utilization of the IRB. With these goals in mind, there will be an upcoming Crisis Services Grand Rounds presentation titled, “Research in Mental Health: An IRB Update.”

Respectfully submitted,

Justin Kuehl, PsyD
Chief Psychologist
IRB Chair

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
December	10	9	1
January	5	12	0
February	1	15	1
March	3	16	0
April	2	9	0

Overall Progress 96.2% as of May 1, 2019

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	530	534	95.8%	96.2%
Up to 1 year Overdue	18	15	3.3%	2.7%
More than 1 year and up to 3 years overdue	2	3	0.4%	0.5%
More than 3 years and up to 5 years overdue	1	1	0.2%	0.2%
More than 5 years and up to 10 years overdue	1	1	0.2%	0.2%
More than 10 years overdue	1	1	0.2%	0.2%
Total	553	555	100%	100%

Forecast Due for Review

Past Due Policies - 21

Coming Due Policies

May - 2

June - 4

July - 8

August - 44

September - 1

October - 19

November - 10

December - 18

January 2020 - 9

February 2020 - 12

March 2020 - 12

April 2020 - 4