



**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 YTD Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵	8,346	9,393	6,032	6,285			7,461	9,500	Green	
		Sample Size for Rows 2-6 (Unique Clients)			3,531	3,533						
	2	Percent with any acute service utilization ⁶	17.40%	17.05%	19.55%	20.58%			20.1%	16.35%	Red	
	3	Percent with any emergency room utilization ⁷	13.87%	14.60%	15.33%	17.74%			16.5%	13.64%	Red	
	4	Percent abstinence from drug and alcohol use	63.65%	63.65%	64.67%	63.32%			64.0%	64.18%	Yellow	
	5	Percent homeless	7.61%	9.18%	8.46%	9.87%			9.2%	8.84%	Yellow	
	6	Percent employed	18.09%	20.06%	19.51%	19.15%			19.3%	20.27%	Yellow	
	Sample Size for Row 7 (Admissions)											
	7	Percent of all admissions that are 7 day readmissions	59.55%	60.12%	49.11%	52.51%			50.8%	49.00%	Yellow	
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,404	2,955	1,697	2,104			2,104	3,450	Green	BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.60	4.5	4.5			4.5	> = 4.0	Green	BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	65.3%	66.2%	63.3%			64.8%	> = 75%	Yellow	BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.38	2.35	2.50			2.4	> = 3.0	Yellow	BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	57.8%	58.0%	69.1%	51.3%			60.2%	> = 70%	Yellow	BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	44.1%	38.4%	34.3%	33.1%			33.7%	> = 50%	Red	BHD (2)
	14	Average cost per month (families served in Wraparound HMO)				\$2,187			\$2,187		Green	BHD (2)
Crisis Service	15	PCS Visits	8,001	7,375	1,905	1,960			7,730	8,000	Green	BHD (2)
	16	Emergency Detentions in PCS	3,979	3,023	795	775			3,140	4,000	Green	BHD (2)
	17	Percent of patients returning to PCS within 3 days	7.3%	7.5%	10.0%	12.6%			11.3%	8%	Green	BHD (2)
	18	Percent of patients returning to PCS within 30 days	23.1%	24.0%	24.4%	29.5%			27.0%	24%	Yellow	BHD (2)
	19	Percent of time on waitlist status	75.2%	83.2%	100.0%	100.0%			100.0%	50%	Red	BHD (2)
Acute Adult Inpatient Service	20	Admissions	656	770	162	176			676	800	Green	BHD (2)
	21	Average Daily Census	42.9	41.8	43.8	42.4			43.1	54	Green	BHD (2)
	22	Percent of patients returning to Acute Adult within 7 days	1.4%	1.6%	1.3%	3.8%			2.6%	3%	Green	BHD (2)
	23	Percent of patients returning to Acute Adult within 30 days	7.7%	6.6%	3.2%	6.0%			4.7%	10%	Green	NRI (3)
	24	Percent of patients responding positively to satisfaction survey	74.0%	74.8%	74.2%	75.8%			75.0%	75.0%	Green	NRI (3)
	25	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	65.2%	67.3%	68.9%			68.1%	65%	Green	BHD (2)
	26	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.51	0.24	0.36			0.30	0.36	Green	CMS (4)
	27	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.28	0.15	0.10			0.12	0.23	Green	CMS (4)
	28	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	21.5%	25.3%	23.9%			24.6%	9.5%	Red	CMS (4)
29	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	95.8%	92.5%	95.5%			94.0%	90.0%	Green	BHD (2)	
Child / Adolescent Inpatient Service (CAIS)	30	Admissions	709	644	168	149			634	800	Green	BHD (2)
	31	Average Daily Census	8.6	7.5	8.2	7.0			7.6	12.0	Green	BHD (2)
	32	Percent of patients returning to CAIS within 7 days	5.2%	3.4%	7.2%	4.8%			6.0%	5%	Yellow	BHD (2)
	33	Percent of patients returning to CAIS within 30 days	12.3%	12.4%	16.6%	16.3%			16.5%	12%	Red	BHD (2)
	34	Percent of patients responding positively to satisfaction survey	71.3%	71.1%	79.6%	88.9%			84.3%	75%	Green	BHD (2)
	35	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	74.2%	73.5%	83.3%			78.4%	75%	Green	BHD (2)
	36	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.18	1.98	0.95			1.51	0.36	Red	CMS (4)
	37	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.47	0.39	0.35			0.37	0.23	Red	CMS (4)
	38	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.1%	0.0%	0.0%			0.0%	3.0%	Green	CMS (4)
39	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	85.7%	-	-			-	90.0%	Green	BHD (2)	
Financial	40	Total BHD Revenue (millions)	\$149.9	\$154.9	\$149.7	\$149.7				\$149.7	Green	
	41	Total BHD Expenditure (millions)	\$207.3	\$213.5	\$208.2	\$208.2				\$208.2	Yellow	

- 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

Program	Item	Measure	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	2019 Actual	2019 Target	2019 Status (1)	Benchmark Source
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	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	66.2%	63.3%			64.8%	>= 75%		BHD (2)
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	12	Percentage of youth who have achieved permanency at disenrollment (Wrap HMO)	69.1%	51.3%			60.2%	>= 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team (Wrap HMO)	34.3%	33.1%			33.7%	>= 50%		BHD (2)
	14	Average Cost per Month (families serviced in Wraparound HMO)		\$2,187						

Notes:

(1) 2019 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

SUMMARY - 2nd QUARTER/CY 2019

8 - This number is for those enrolled in a program with Wraparound Milwaukee. This was changed from HMO as this number includes CCS/CMC initial contacts. We will be presenting some CCS data with CARS for the meeting. For 3rd quarter, WM will explore areas that CCS data can be reported on.

9 – On target for the 2nd quarter of 2019. Exceeding the threshold of 4.0.

10 - Declined by about 3% since 1st quarter. Still within 20% of benchmark. Efforts are ongoing to have youth reside in the least restrictive setting possible.

11 – Increase by .15 since 1st quarter. This is now within 20% of the benchmark 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 2nd quarter of 2019 have a higher "Needs Met" score (3.75) than those disenrolled on runaway status or to corrections (1.96).

#12 – In the 2nd quarter, there was a significant decrease in the percentage of youth achieving permanency at disenrollment compared to the 2019 1st quarter, which had a significant increase from 2018 actual. Upon review, there was an increase in the number of youth who disenrolled to Corrections. Of those disenrolled to Corrections, they averaged 9.6 in Wraparound Milwaukee, with only one enrolled for more than 1 year. 2nd quarter data falls out of the 20% benchmark, however, 2019 actual falls within the 20%.

"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 2nd quarter compliance (33.1) is slightly lower than the 2019 1st quarter. This falls outside 20% benchmark of 40%.

#14- This item was requested by the Quality Board at the meeting in June 2019. This is the first time that this information is being reported. Further discussion needs to be had on target goal.

CARS QUALITY DASHBOARD SUMMARY Q2 2019

CHANGES AND UPDATES

Further Development of the Quadruple Aim

The CARS Quality Dashboard continues to evolve. The first draft of the CARS Quality Plan, which is organized around the Quadruple Aim and aligned to the CARS Quality Dashboard, is complete and will be presented at the September meeting of the Mental Health Board Quality Committee.

Population Health

Following the CARS pilot of the change over time metrics for population health, CARS will now move this pilot to the next phase and begin disaggregating some of these key metrics by race (other stratification variables will be deployed in future iterations). This effort helps to align CARS's evaluation activities to the Milwaukee County Executive's stated goal of addressing racial disparities in Milwaukee County. A new addition to the CARS Quality Dashboard is a measure of the distribution of male and female consumers by cause of death.

Patient Experience of Care

The Press Ganey survey has been distributed to all CARS programs and data collection is ongoing. All CARS staff are also being trained in the "Spirit of Motivational Interviewing," an educational seminar to help CARS staff learn principles of Motivational Interviewing that are designed to help foster more positive interactions and relationships with the clients we serve *and* providers with whom we work. Previous iterations of the CARS Quality Dashboard have included a measure on Time to Service. This measure has been changed to Timeliness of Access, which looks at the percentage of clients who receive service within 7 days of their Comprehensive Assessment.

Staff Wellbeing

For the first time, the CARS Quality Dashboard will begin reporting the turnover rate of CARS staff, relative to all a national turnover benchmark for all government employees. This will be a standing metric for all future CARS Quality Dashboards. CARS staff also recently held listening sessions of all CARS staff to discuss what would improve the quality of their work life. The information from these listening sessions has been summarized and recommendations are forthcoming.

Cost of Care

The cost per member per month metric on the CARS Quality Dashboard continues to evolve. The approach used by CARS to calculate cost will serve as a template to develop cost of care metrics for all of BHD in future versions of the BHD dashboards.

RESULTS

With regards to the change over time metrics, many individuals who enter CARS services through one of the community access points appear to experience improvements in the first six months of service in quality of life, social determinants of health, and health behaviors, though a smaller sample size and missing data enjoin caution when interpreting the results. One notable finding was the discrepancy in improvement in quality of life between African American and Caucasians from intake to the six-month follow up. The origins of this disparity have not yet been determined, but this finding will be discussed with the CARS leadership as CARS seeks to identify and address racial and other health disparities.

NEXT STEPS

The CARS Quality Dashboard will continue to evolve as we add/revise our metrics. We will begin disaggregating other health and operational measures by race and other key variables. The data gleaned from this exercise will not only inform future analyses, but future quality improvement initiatives as CARS seeks to do its part to reduce health care disparities. As noted above, future versions of the CARS Quality Dashboard will also include progress updates on the implementation of the CARS Quality Plan.

Health and Well-Being

This dashboard contains measures of 6-month population health outcome data (intake to follow-up) for our consumers. This dashboard was created to follow the County Health Rankings Model.

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

Q2 2019

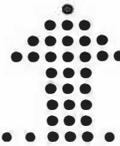


Health Outcome

30.14% increase in Good or Very Good self-reported Quality of Life**

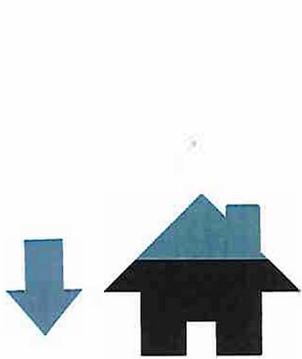
n=267

34.50% → 44.90%



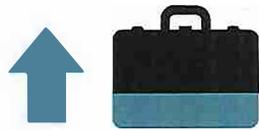
Social Determinants

Health Behaviors



41.80% decrease in Homelessness***

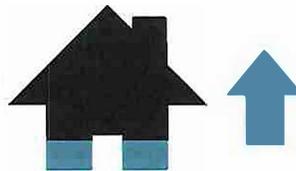
n=375



19.70% → 24.40%

23.86% increase in Employment

n=365



62.70% → 73.90%

17.86% increase in "Stable Housing"***

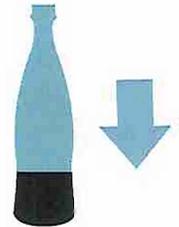
n=375



13.24 → 5.72

56.80% decrease in Past 30 days Days of Drug Use***

n=152



8.97 → 2.19

75.59% decrease in Past 30 days Days ETOH***

n=112

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

Health and Well-Being Comparison

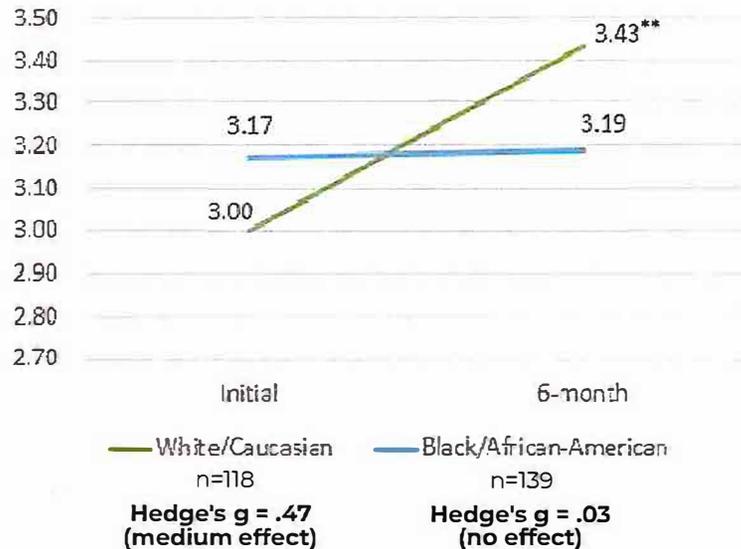
This dashboard contains measures of 6-month population health outcome data (intake to follow-up) for our consumers, comparing White/Caucasian and Black/African-American consumers.

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

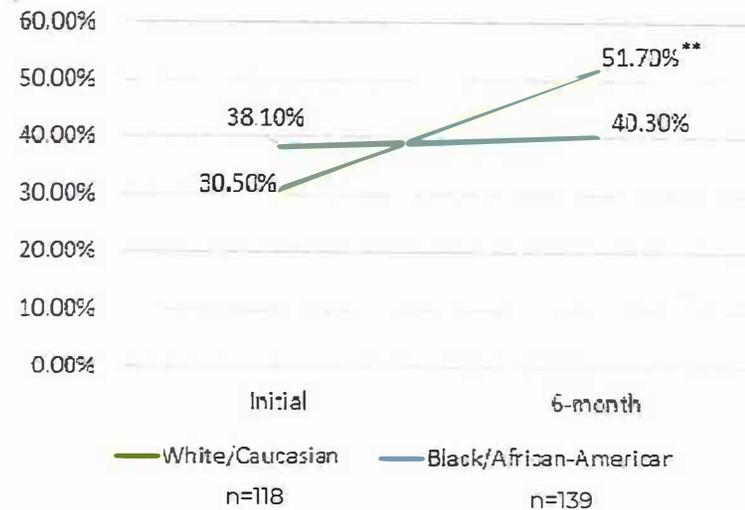
Q2 2019

Quality of Life

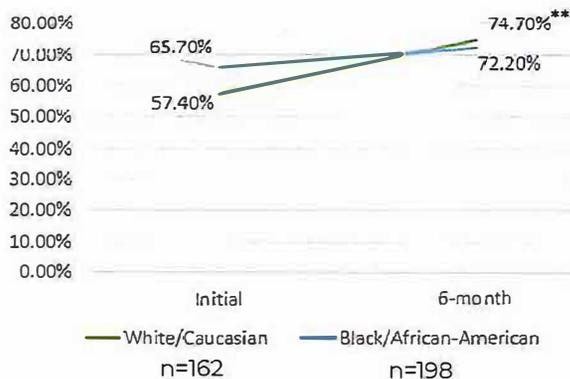
Average Score



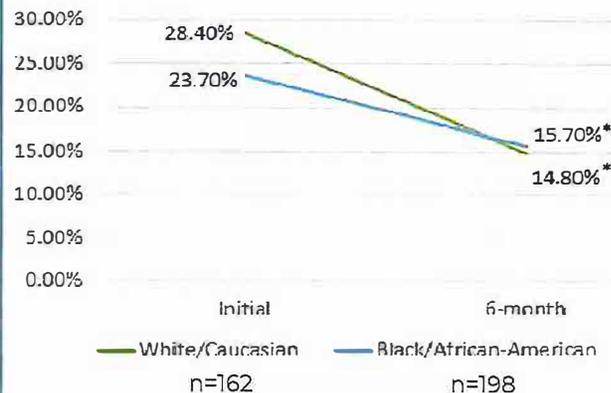
Proportion of consumers indicating "Good" or "Very Good" Quality of Life



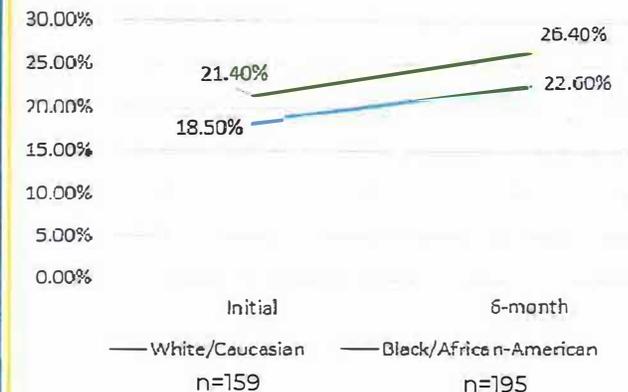
"Stable" Housing



Homelessness



Employment



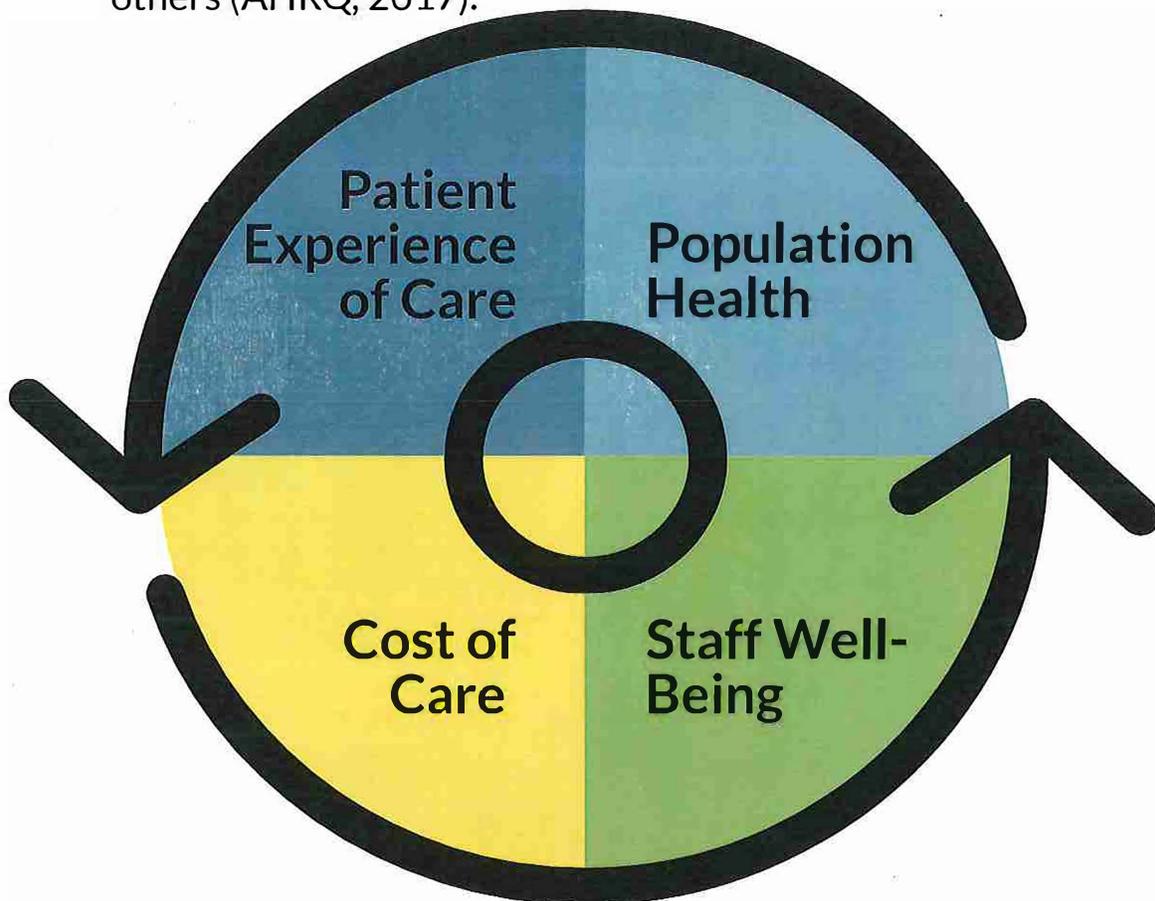
*p<.05 **p<.001



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).

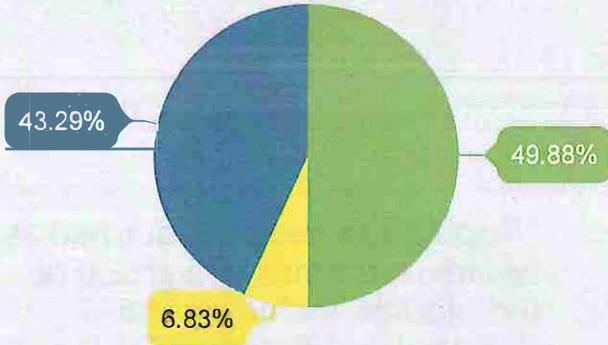
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

Demographic Information of the Population We Serve

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

Race (CARS)

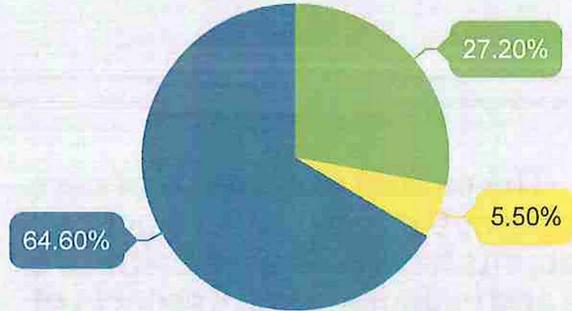
- Black/African-American
- White/Caucasian
- Other



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

Race (Milwaukee County)*

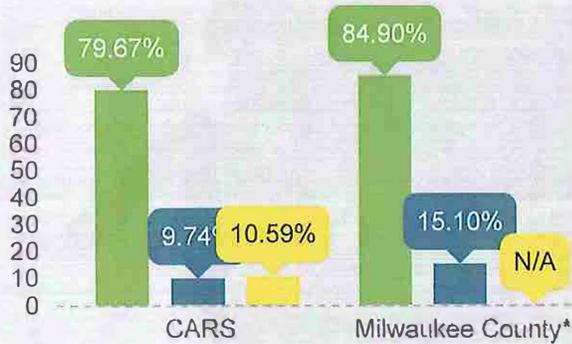
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"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

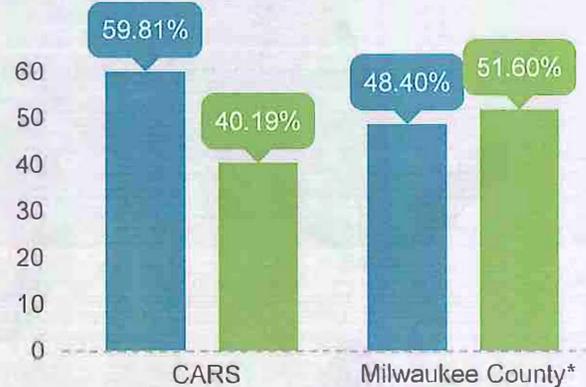
Ethnicity

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

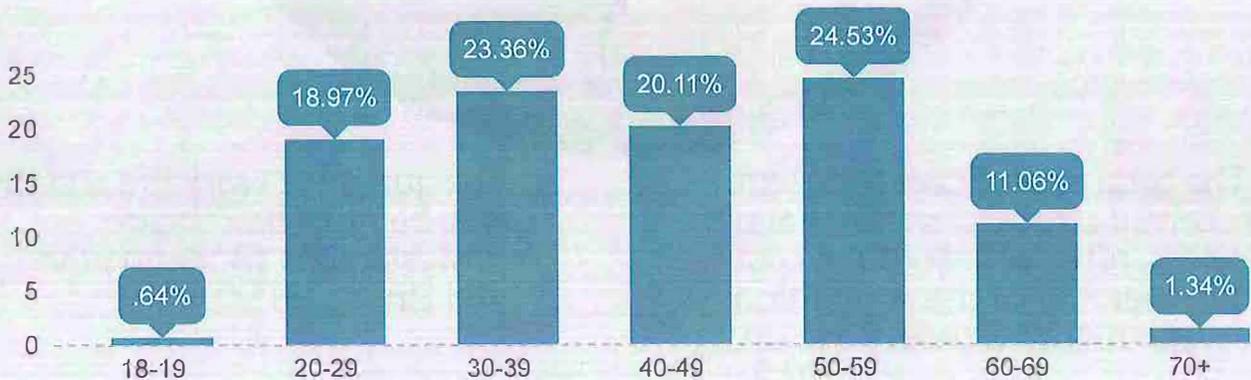


Gender

- 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.



Timeliness of Access

Percentage of clients per quarter who received a service within 7 days of their Comprehensive Assessment.



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.



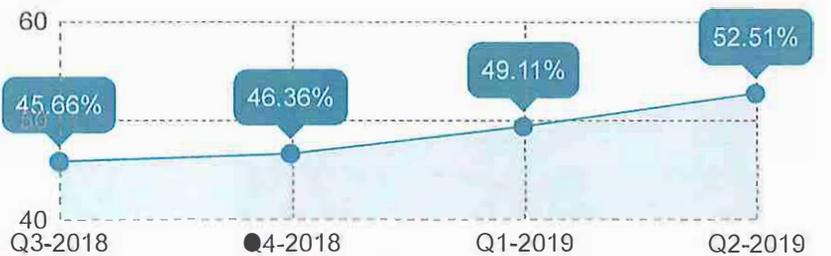
ER Utilization

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.



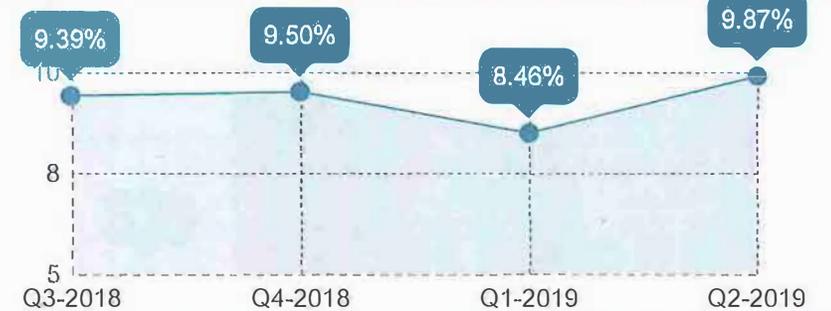
Abstinence

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".





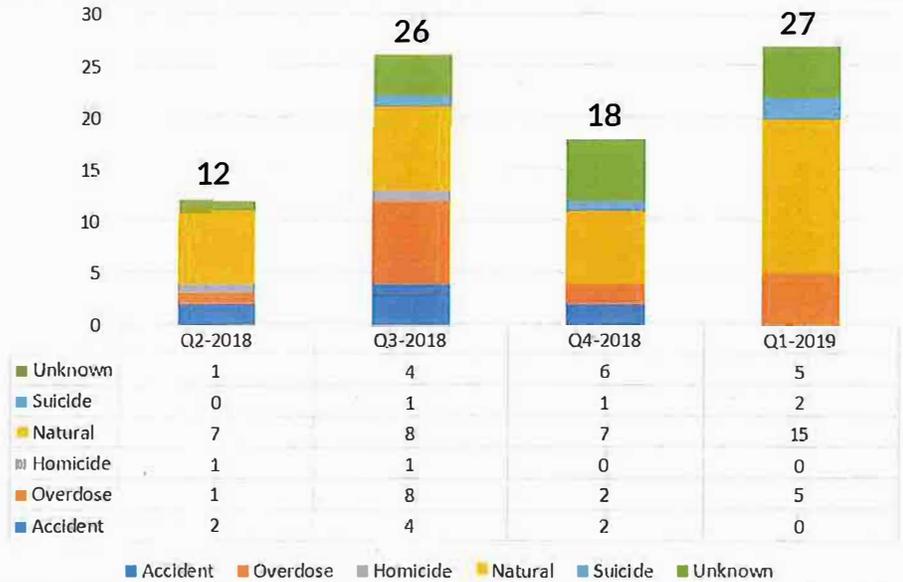
Domain: Population Health (Continued)

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 the previous four quarters.

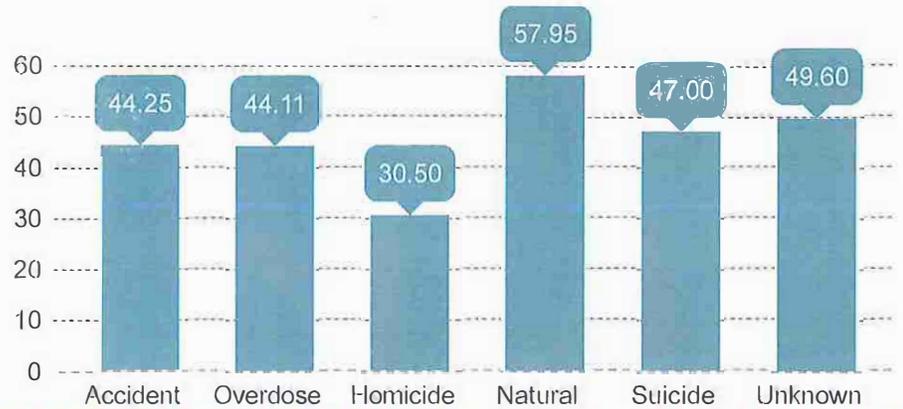
Note: There is a lag in death reporting. See note in the next item.



Cause of Death

This is the reported average age at time of death by cause of death from the previous four quarters.

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.

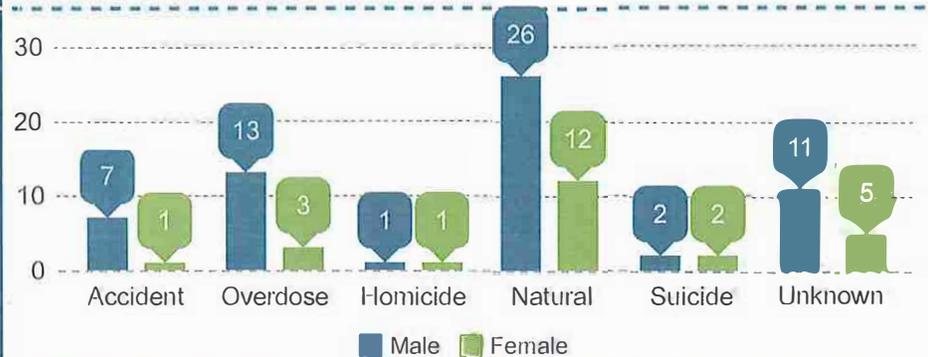


Cause of Death

Distribution of Male vs. Female consumers by cause of death for the four previous quarters.

Total Male: 60
Total Female: 23

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

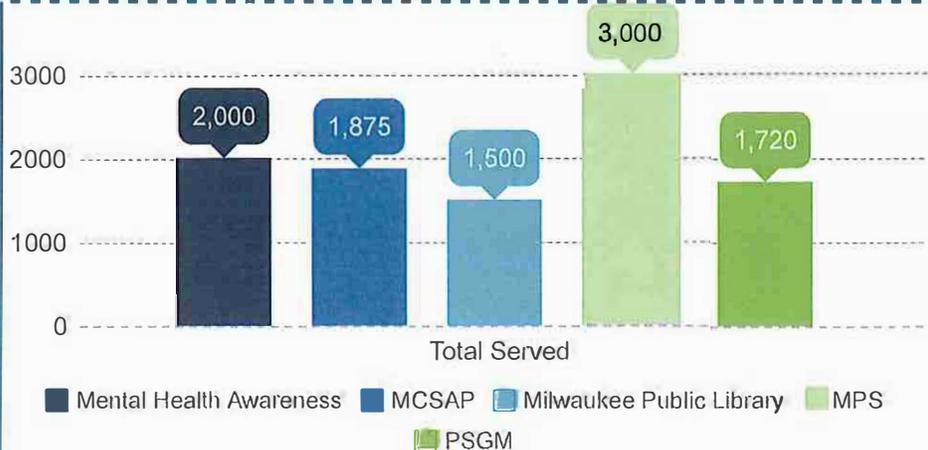


Top Prevention Activities/Initiatives

Prevention is an important population health factor. Many prevention activities include evidence based practices and presentations. The top five prevention activities from the previous quarter are listed in the graphic.

MCSAP: Milwaukee County Substance Abuse Prevention Coalition

PSGM: Prevent Suicide Greater Milwaukee





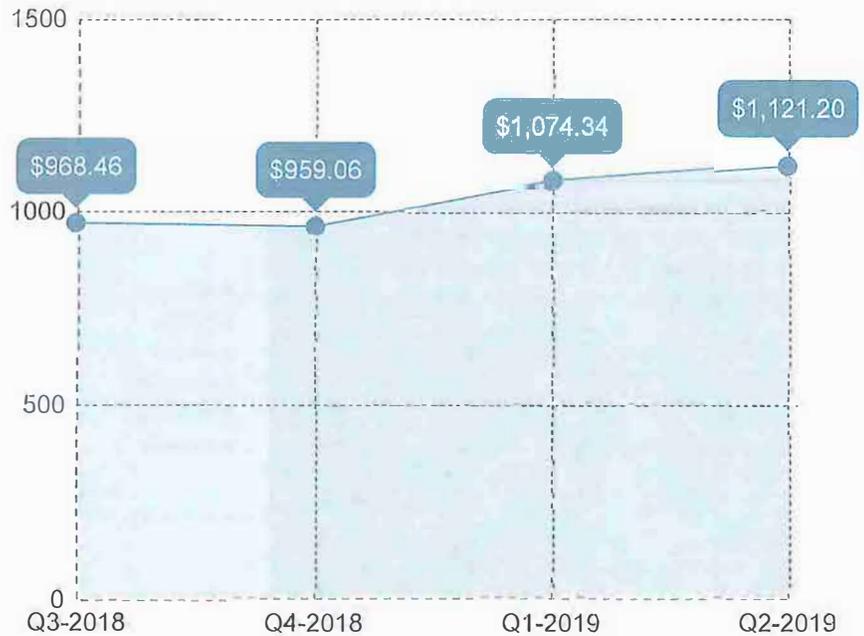
Domain: Cost of Care

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:

Q3- 2018 N = 4,865	Q4 - 2018 N = 5,042
Q1- 2019 N = 5,056	Q2 - 2019 N = 5,225



Domain: Staff Well-Being

Turnover

Turnover is calculated by looking at the total number of staff who have left year-to-date (YTD), divided by the average number of employees per month, YTD.

11.30%

CARS turnover rate (YTD)

20.0%

Turnover rate for government employees (per year)*

*Source: Bureau of Labor Statistics (<https://www.bls.gov/news.release/jolts.t16.htm>)



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.



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.



BHD

MILWAUKEE COUNTY
Behavioral
Health
Division

**THE BHD - CARS QUALITY PLAN
2019 - 2020**



The CARS Quality Plan

Introduction

A Quality Plan (QP) is a crucial component of an organization's journey to become a self-learning, data-driven entity in which quality improvement is deeply embedded in the organizational culture. Given the resource limitations with which most organizations must contend, the QP can guide more efficient allocation of both financial and staff resources toward those initiatives deemed most important by the organization. Moreover, the QP helps to orient business activities towards a set of mutually agreed upon objectives and creates unity of purpose among leaders and line staff. Thus, the QP can help change the culture of an organization, enabling staff at all levels of the organization to engage in quality improvement (QI) activities and helping to foster a culture of quality.

This document represents Milwaukee County Behavioral Health Division's Community Access to Recovery Services (CARS). This plan outlines the strategic goals for CARS for 2019 and 2020, goals which are themselves guided by and aligned to the mission and strategic goals of Milwaukee County Behavioral Health Division (BHD) and Milwaukee County Department of Health and Human Services (DHHS). The Quadruple Aim for healthcare, which proposes that healthcare systems should simultaneously seek to improve the patient's experience of care, improve the health of populations, reduce the per capita costs of care for populations, and improve the quality of work life for staff, provides the quality framework for the CARS QP. To that end, the CARS strategic goals, and the objectives and activities associated with them, are organized by these four aims.

In addition to articulating the quality goals for CARS in 2019 and 2020, this document is also intended to create a measure of accountability by identifying current and target performance metrics, assigning responsible staff, and creating reporting timeframes throughout the year to review progress towards each goal. These review timeframes depend on the stakeholder and reporting format, but allow for transparency, input, and mutual responsibility at all levels of the organization. Finally, this plan is designed such that subsequent versions should intentionally build off previous versions. This allows new goals to build off previous goals, and affords CARS the opportunity to create sequenced, stepped goals with multi-year timelines.

Development of the Plan

This QP was developed with several key principles in mind. These include:

Alignment. Effective QPs that have broad support should demonstrate that they are driven by and can support the realization of the mission and strategic goals of the larger organization. The CARS QP was designed to align to:

- a. DHHS's Strategic Goals
- b. The Quadruple Aim
- c. BHD's mission and strategic goals
- d. Best practice, where available
- e. External mandates, where applicable

Feedback. Feedback from all levels of a department or organization is critical when developing a QP. Not only can this encourage support and enthusiasm for the QP from every level of the organization but is extremely valuable when selecting the most meaningful goals and objectives on which to focus the QP. Line staff often are aware of issues of quality before management staff and can provide key insights and ideas for QI activities. The CARS QP was developed with feedback from the following sources:

- f. Executive staff
- g. Departmental leadership
- h. Line staff
- i. Clerical staff

This feedback was obtained through several different mechanisms, including focus groups, meetings with key stakeholders, and staff surveys. To that end, CARS developed a staff survey that is designed to solicit staff ideas for QI activities, and which utilizes the Quadruple Aim as its organizing framework. The survey also included questions regarding staff perceptions of and engagement in the QI at CARS and BHD. The survey will be disseminated to staff annually.

Psychological Safety. As noted above, staff engagement is extremely important to the development and implementation of QPs and QI projects, as well as to the establishment of a culture of quality in an organization. If, however, staff believe that their ideas will be maligned, or they will be personally judged when they express quality concerns or make recommendations for QI initiatives, they may be less likely to share their valuable input to or participate in an organization’s QI endeavors. CARS believes that the first step in creating a culture of quality is to first create a culture of psychological safety, where staff feel accepted and respected. Thus, CARS will strive to foster a “safe” environment where staff feel free to share their ideas and generate innovations without fear of repercussions, where they are motivated to collaboratively build the culture of quality, and where data creates opportunities for learning and growth.

Organization of Plan

The Plan is organized into four sections, one for each of the Quadruple Aims. Each section begins with a brief definition of the aim. This is followed by an overview of the current activities and initiatives in which CARS staff are engaging that are consistent with the aim in question. A table is then provided in each section which identifies the core quality dimension within each aim that is being addressed by the objective (i.e., the quality goal). The performance measure for each objective is then defined, followed by the current and target metrics for each objective, the staff member or members responsible for tracking each objective, and concluding with options for quarterly updates on progress towards the objective.

Frequency of Review

Progress reporting towards each objective specified in the plan will occur on a quarterly basis by the internal CARS leadership team. This review is designed to ensure the activities to implement each objective are occurring as appropriate and to identify problems and engage in course corrections as necessary. A formal status report on the attainment or lack thereof of the performance targets for each objective will occur on an annual basis. The audience for this report will be both internal CARS staff and other external stakeholders as appropriate, such as the BHD executive team and Mental Health Board.

Reporting	Description	2 Year QP Timeframe							
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Quarter 6	Quarter 7	Quarter 8
Internal Review	A more informal process of reviewing metrics and activities on a quarterly basis for CARS leadership to assess progress and make necessary modifications in order to attain objectives or maintain momentum.	X	X	X	X	X	X	X	X
Annual Report	This is a formal report that is intended for both internal and external stakeholders and is designed to highlight progress toward objectives and the activities in which CARS engaged to realize these objectives. This will be presented in the first quarter of a new year for the summative progress in the previous year.	X				X			
Planning Meeting	This review of progress thus far is designed to help CARS leadership review current objectives and extend these objectives and/or set new objectives for the subsequent year. This planning should begin in the third quarter in order for CARS to be prepared to implement the new QP at the start of the subsequent year.							X	
Internal Survey	This survey is designed to elicit staff ideas regarding areas for quality improvement and innovations to address them. It is also intended to gauge staff engagement in and perceptions of the quality improvement culture in CARS.			X				X	

Quadruple Aim 1: Client Experience of Care

Client Experience of Care Definition: 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).

CARS Client Experience of Care QI Goals for 2019:

Quadruple Aim 1: Client Experience of Care					
Focus	Objectives	Lead Staff	Perform. Metric	Current Perform.	Target Perform.
1. Improve Access to Information	A. Build Comprehensive and Consistently Accurate Provider Directory	Justin Heller, Matt Drymalski	Present or Absent	Absent	Present
	B. Revise/Enhance CARS Website	Jen Alfredson	Present or Absent	Absent	Present
2. Increase Opportunities for Feedback	A. Obtain Feedback from Clients and Families	Matt Drymalski, Tamara Layne	Present or Absent	Absent	Present
	B. Obtain Feedback from Providers	Lynn Shaw	Present or Absent	Absent	Present
	C. Obtain Feedback from DHHS and Other System Partners	Janet Fleege	Present or Absent	Absent	Present

Quadruple Aim 2: Population Health

Population Health Definition: "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).

CARS Population Health QI Improvement Goals for 2019:

Quadruple Aim 2: Population Health					
Focus	Objectives	Lead Staff	Perform. Metric	Current Perform.	Target Perform.
1. Improve Access for Those with Unmet Needs	A. Compare target population by zip code in MKE County to population served by CARS; determine degree of unmet needs and specific geographic locations or populations to be targeted for outreach	Nzinga Khalid, Amy Moebius	Present or Absent	Absent	Present
2. Address Stigma	A. Launch a stigma reduction campaign specific to one or more geographic areas or specific populations with unmet needs	Nzinga Khalid, Amy Moebius	Present or Absent	Absent	Present

Quadruple Aim 3: Cost of Care

Cost of Care Definition: 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).

CARS Cost of Care QI Improvement Goals for 2019:

Quadruple Aim 3: Cost of Care					
Focus	Objectives	Lead Staff	Perform. Metric	Current Perform.	Target Perform.
1. Reduce the proportion of tax levy dollars spent on the following programs: a. Access Points b. AODA Residential c. CBRFs/AFHs d. Companion Care e. RSC f. CCS expansion g. CSP	A. Reduce overall costs associated with programs in question	Jen Wittwer, Matt Drymalski, Justin Heller	Present or Absent	Absent	Present
	B. Reduce proportion of total costs of programs in question paid for by tax levy by shifting payment to other funding streams	Jen Wittwer, Sue Clark, Tamara Layne, Davide Donaldson	Present or Absent	Absent	Present

Quadruple Aim 4: Staff Quality of Work Life

Staff Quality of Work Life Definition: The quality of work life and the well-being of healthcare professionals (Bodenheimer & Sinsky, 2014).

CARS Staff Quality of Work Life QI Goals for 2019:

Quadruple Aim 4: Staff Quality of Work Life					
Focus	Objectives	Lead Staff	Perform. Metric	Current Perform.	Target Perform.
1. Positively impact the CARS workplace culture with the use of mechanisms for staff feedback and implementation of workplace innovation	A. Create multiple avenues and opportunities for CARS staff to share and implement ideas	Jim Feagles, Justin Heller	Present or Absent	Absent	Present
	B. Based on generated ideas, implement at least one innovation that positively impacts the workplace culture	Jen Wittwer	Present or Absent	Absent	Present

Quality Plan Progress Log

Quadruple Aim 1: Client Experience of Care			
Focus	Objectives	Date Reviewed	Progress Notes
1. Improve Access to Information	A. Build Comprehensive and Consistently Accurate Provider Directory	7/16/19	<ul style="list-style-type: none"> Internal versions of directories within CARS have been gathered from the various program managers for review. The team is working with Contract Management to realize the full potential of Avatar to store agency, provider, program, and performing provider information. This will then be used to create a directory that should stay current in real time.
	B. Revise/Enhance CARS Website	7/16/19	<ul style="list-style-type: none"> An internal meeting has been held to review the CARS portion of the Milwaukee County DHHS website and generate ideas. Meetings have also been held with DHHS personnel to begin making some modest modifications to the website and some of these changes have occurred already. A website "walk through" has been done to assess the ease of finding information on the website or via a web browser. With the recent changes, much of the commonly searched information was easily located. The lead for this quality plan area has received training on Titan, the system used to make web updates.
2. Increase Opportunities for Feedback	A. Obtain Feedback from Clients and Families	7/16/19	<ul style="list-style-type: none"> Meetings have occurred with Wraparound, Crisis Services, and Inpatient to discuss development of a universal tool to assess client experience.
	B. Obtain Feedback from Providers	7/16/19	<ul style="list-style-type: none"> The team met and attended the various CARS operations meetings to distribute opportunities for providers to give feedback. A number of individuals have already shared feedback. The next internal meeting for this project is 7/31/19.
	C. Obtain Feedback from DHHS and Other System Partners	7/16/19	<ul style="list-style-type: none"> The internal group has met 4 times thus far. A Survey Monkey has been sent out to a wide variety of system partners, including child welfare, Department of Corrections, hospital systems, DYFS, Housing Division, advocacy groups, Aging, and HMOs. A number of surveys have been returned. The survey closes 7/29/19 and results will be reviewed at that time.

Quadruple Aim 2: Population Health			
Focus	Objectives	Date Reviewed	Progress Notes
1. Improve Access for Those with Unmet Needs	A. Compare target population by zip code in MKE County to population served by CARS; determine degree of unmet needs and specific geographic locations or populations to be targeted for outreach	7/16/19	<ul style="list-style-type: none"> The team has met to discuss and analyze the interface between poverty, substance abuse and mental illness in an effort to determine the prevalence of need in the community. A thorough analysis will be done to review: a) assumptions on which the estimates of behavioral health need are based, adjusted for poverty level; b) stratification of need by race and location (zip code); and c) research to better understand the needs and service gaps in these underserved and/or higher need communities. The team has also brainstormed how they might accumulate innovative ways to capture prevention data by looking at other counties and organizations to see if they already have successful means we can learn from. Next steps will be sharing information and ideas formally with program staff.

2. Address Stigma	A. Launch a stigma reduction campaign specific to one or more geographic areas or specific populations with unmet needs	7/16/19	<ul style="list-style-type: none"> The team met in June to brainstorm a wide variety of ideas for a stigma reduction campaign. Team members have been charged with thinking of a creative campaign or catch phrase to depict the welcoming values of BHD services. The focus agreed upon thus far includes: a) Welcoming all communities; and b) Trauma
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Quadruple Aim 3: Cost of Care

Focus	Objectives	Date Reviewed	Progress Notes
1. Reduce the proportion of tax levy dollars spent on the following programs: a. Access Points b. AODA Residential c. CBRFs/AFHs d. Companion Care e. RSC f. CCS expansion g. CSP	A. Reduce overall costs associated with programs in question	7/16/19	<ul style="list-style-type: none"> RSC: An RFP process was completed and new awards have been made. In the new contracts, agencies will be billing a 15-minute unit rate, as opposed to the daily rate that had been paid previously. While the RSC program has seen some growth, projections of savings can be challenging. Even so it is believed that this change may result in as much as \$500K in savings annually. More importantly, this will achieve a result of a greater emphasis on service delivery. A contract is now in place between Milwaukee County BHD and My Choice Family Care to cover CSP services. This achieves a result whereby individuals in CSP can be co-enrolled in Family Care. Instead of billing Medicaid for the CSP services, My Choice Family Care will now be billed as a fund source. Enrollment is still quite low but is expected to grow over time and achieve cost savings. Additionally, this affords consumers the opportunity to “age in place” and maintain their CSP providers while accessing the Family Care array of services. Outpatient Mental Health services are now being captured in Avatar. As such, BHD can now measure actual usage of units. This will prepare for the ability to eventually move this service from a Purchase of Service to a Fee for Service environment, as we will have more information to make good rate decisions for that level of care. Access Points: An RFP will be released on 8/1/19, with new contracts in place by 1/1/20. This will move the Access Points from a Purchase of Service contract environment to a flat fee paid for completed assessments in a Fee for Service environment. It is believed this will achieve some cost savings, though it is not yet clear what those projections might be.
	B. Reduce proportion of total costs of programs in question paid for by tax levy by shifting payment to other funding streams	7/16/19	<ul style="list-style-type: none"> The CARS and BHD fiscal teams have collaborated to have a more robust and accurate verification fund source process for clients receiving substance abuse services. Accurate fund source verification ensures we are maximizing use of funds from our various grants and ultimately reduces tax levy burden. CBRF/AFHs: The CARS team has worked closely with mental health residential vendors to put a practice, policy and procedure in place to routinely review individuals who are receiving 1:1 care in these settings. In 2018, the average individual receiving 1:1 care received 19.5 hours per day on average, at a cumulative cost of \$1.05 million annually. With the newly implemented process of quarterly reviews, robust risk assessment tool use, and requirement of a physician prescription for the service, the use of 1:1 care in the first half of 2019 has decreased by 25% to an average of 14.5 hours per day, per consumer. Conservatively, we will see a commensurate cost savings of approximately \$250K, although it is likely that may be far greater as projections are based on a limited amount of data. It is noteworthy, as well, that consumers who have had reduced or eliminated 1:1 care have responded very favorably to this less restrictive care, and the vendors have noted no notable increase in incidents. The BHD fiscal team and CARS leadership for CCS, CSP and TCM review a list of consumers without Medicaid on a monthly basis and work to explore with agencies why Medicaid has been lost and identify means by which it can be reinstated.

Quadruple Aim 4: Staff Quality of Work Life

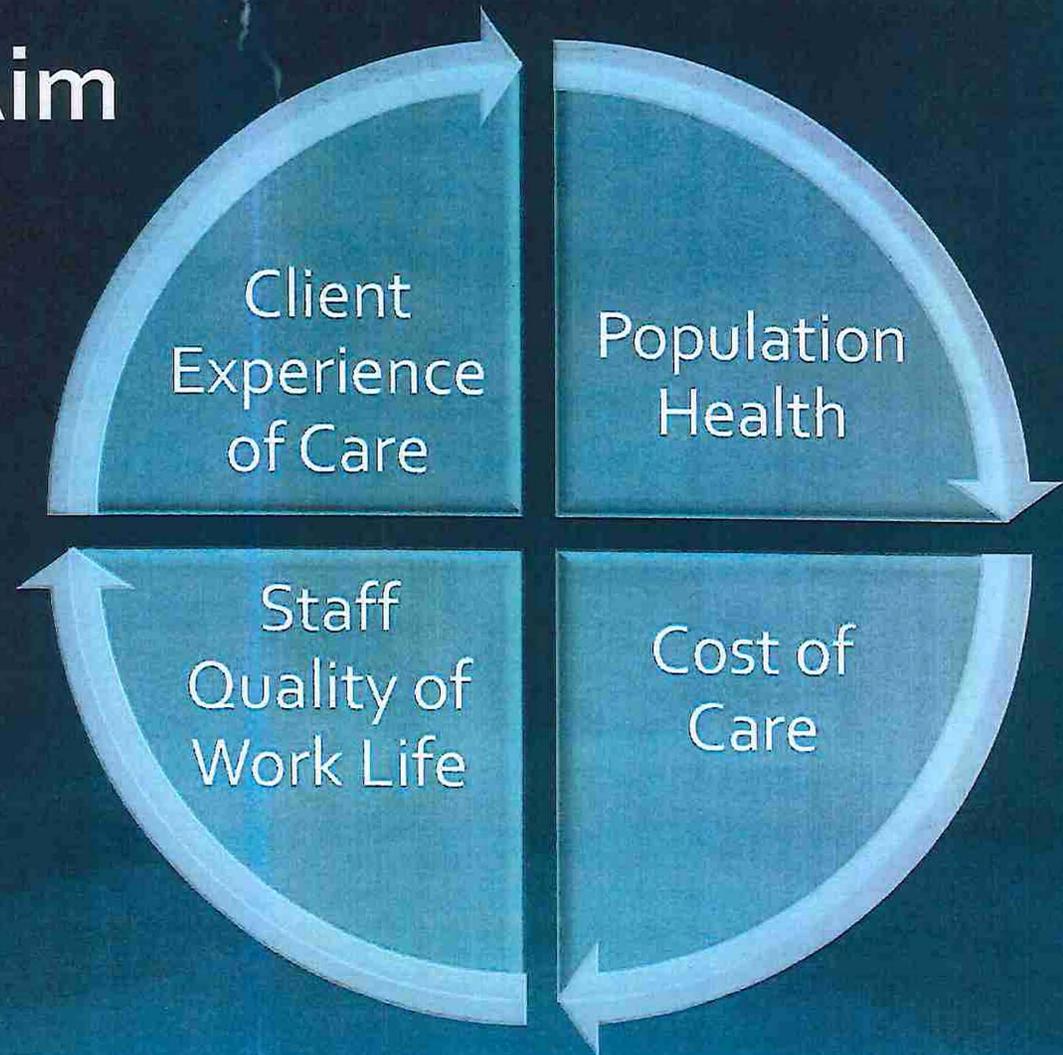
Focus	Objectives	Date Reviewed	Progress Notes
<p>1. Positively impact the CARS workplace culture with the use of mechanisms for staff feedback and implementation of workplace innovation</p>	<p>A. Create multiple avenues and opportunities for CARS staff to share and implement ideas</p>	<p>7/16/19</p>	<ul style="list-style-type: none"> A World Café was held with the CARS team on 6/5/19 to solicit ideas and feedback that may lead to addressing concerns and/or identifying possible innovations. Results have been compiled and shared with CARS executive leadership. Results will soon be shared with the whole team, with further discussion to occur. The plan will be to achieve consensus as a team on what are the next most important things to work to address. Themes identified by staff members in the World Café included Dayforce/clocking in, flexible work schedules and/or location, perceptions of trust and respect, flexibility with lunch time and use of sick hours/occurrences.
	<p>B. Based on generated ideas, implement at least one innovation that positively impacts the workplace culture</p>	<p>7/16/19</p>	<ul style="list-style-type: none"> This work has not yet begun, but will commence before the end of this fiscal year.

Third Quarter Update
BHD Quality Dashboard

Progress Thus Far...

The Quadruple Aim

BHD's Quality
Framework:
Progress by Aim

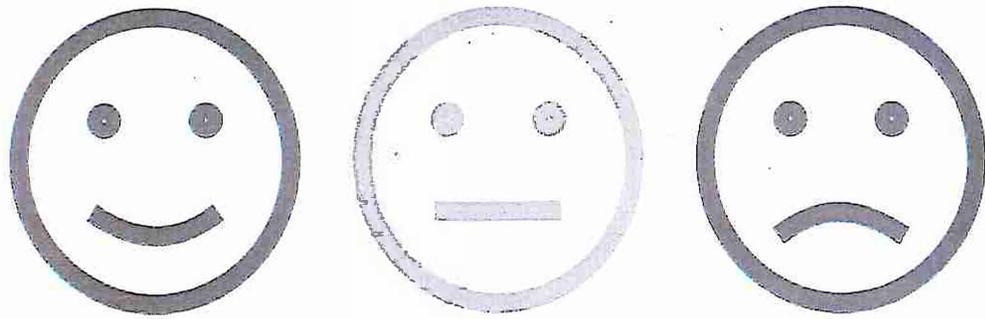


Aim 1: Population Health

- High Utilization
Turnover
- Key demographics
and social
determinants



Aim 2: Client Experience



FEEDBACK

- Press Ganey expansion
- Enterprise questions

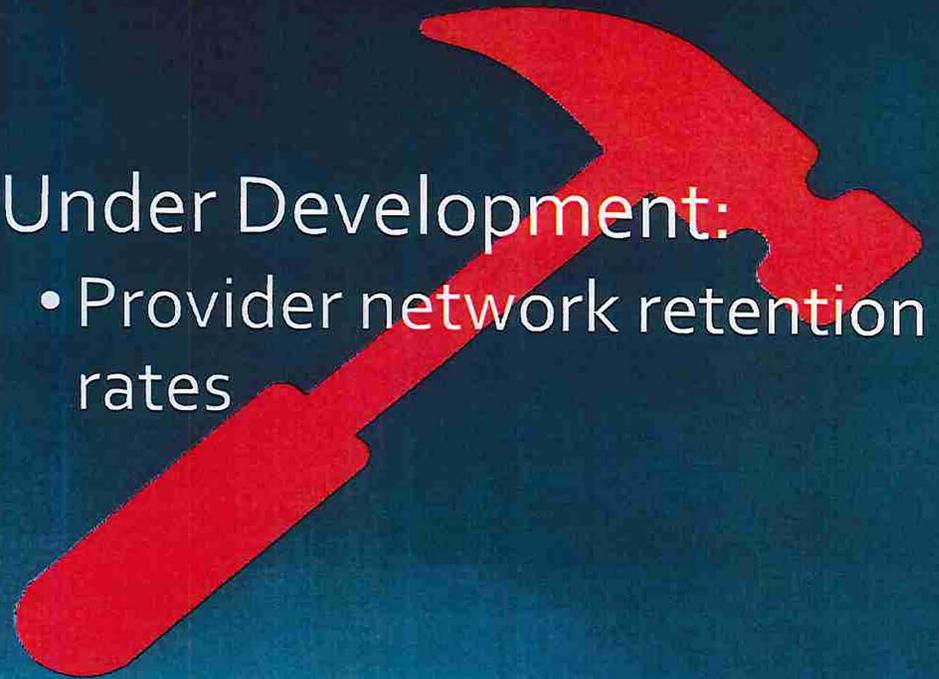
Aim 3: Cost of Care

- Cost per Enrollment
- Separate report being built as well

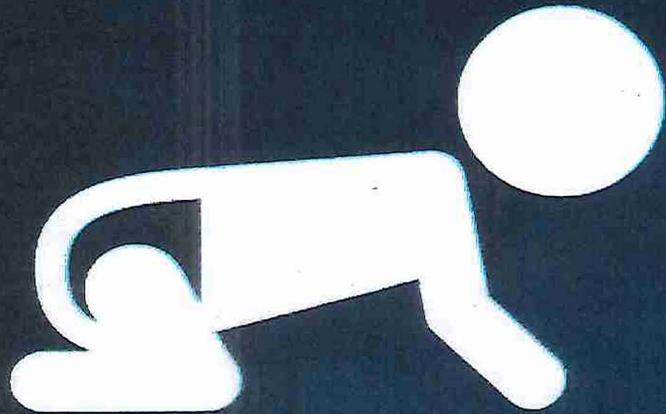


Staff Quality of Work Life

- Ready:
 - Staff retention rates from HR
- Under Development:
 - Provider network retention rates



Next Steps



- Inaugural dashboard to be presented at 4th quarter meeting
- Questions?



Wraparound Milwaukee
2018 Performance Improvement Project
Medication Adherence
Synopsis

Medication adherence has been a topic of clinical concern since the 1970's (Jing J. et.al. 2008). In particular, the high prevalence of low adherence to medication treatment during adolescence is well documented and is further compounded by specific patient-centered factors that include emotional and mental health problems, cognitive impairment, social difficulties and patient fears. Moreover, environmental factors that contribute to non-adherence are caregiver mental health issues, family conflicts and low socio-economic status. All of which are prevalent in the Wraparound Milwaukee population of youth we serve in the Wellness Clinic. With agreement from the Wellness Clinic professional staff, a study was initiated to determine if the introduction of identified interventions could positively impact the level of medication adherence with the youth that are treated and monitored at the Wellness Clinic.

Research Design:

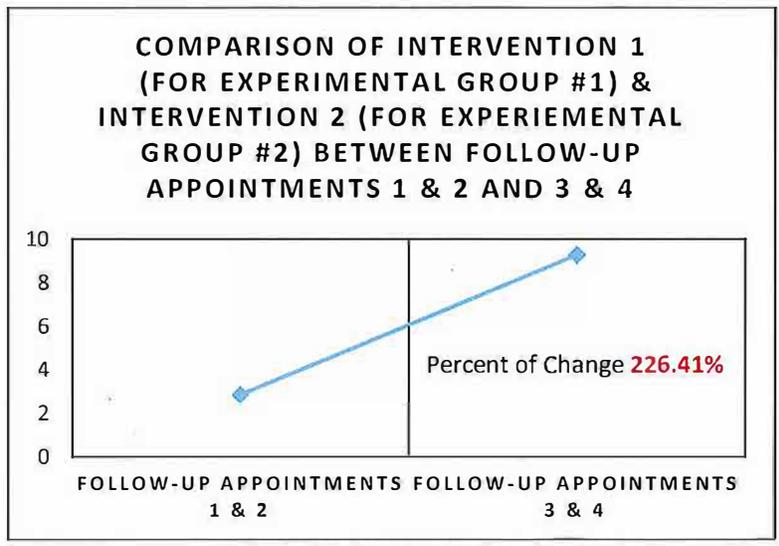
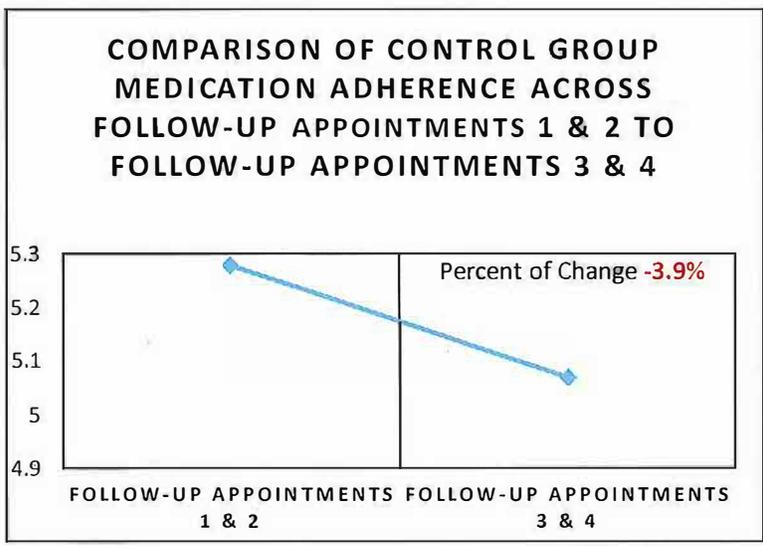
Using a control group research design, two interventions were explored to determine if they would have an impact on the level of medication adherence compared to the control group and compared to each other.

Methodology:

Two assessment tools were used to determine level of adherence at each clinic visit. Other than initial orientation and conversation at each visit, the Control Group received no additional interventions. The Experimental Group was provided with a *Medication Planning Tool* that was completed with the nurse and taken home. The original Experimental Group was broken into two Experimental Groups (1 & 2), which is identified as Phase 2. In addition to the *Medication Planning Tool*, the Experimental Group 2 was provided with a phone call one week after the appointment to discuss how the medication regimen was proceeding.

Results:

A comparison of the Control Group with the Experimental Groups revealed a modest increase in medication adherence with the use of the *Medication Planning Tool* and even greater improvement when the phone call was added to the intervention mix. Although trending in the right direction, the increase was not statistically significant. However, further analysis reveals that the Control Group's adherence decreased (-3.9% change) across time (the four follow-up appointments) while the Experimental Group's adherence increased (226% change) across the 4 follow-up appointments as identified in the charts below:



Conclusions:

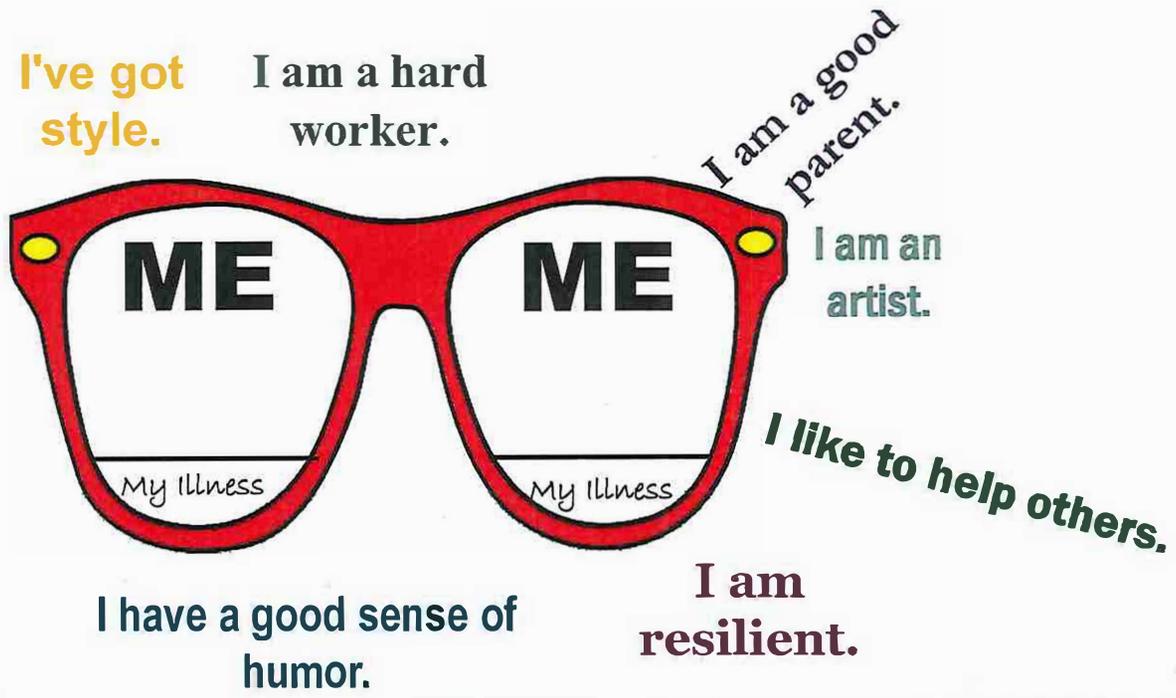
Follow-up interviews were conducted with some parents/guardians. They felt that the *Medication Planning Tool* could be helpful if used consistently across time and the phone call would perhaps be better received midway between appointments.

After reviewing the study outcomes, it was determined that some intervention is certainly valuable in improving medication adherence. However, the plans need to be more targeted and individualized as difficulties with adherence can be related to a number of reasons and each youth's situation is different. The plan moving forward addresses the individual differences and does not burden the staff when there is no adherence problem identified.

The revised plan is as follows:

1. **Have youth complete self-assessment tool while waiting for appointment**
2. **Assessment tool reviewed by prescriber**
3. **If it is determined that there is an adherence problem, the prescriber should further explore possible reasons, e.g.**
 - a. **Is it a problem of attitude/resistance to taking meds**
 - b. **Is it a problem of managing a daily routine**
 - c. **Is it a problem of how the youth feels on the meds (side effects)**
 - d. **Is it a problem with the med container**
 - e. **Is it a problem of managing more than one medication at a time**
4. **Identify a solution to match the identified problem(s).**

It is important to convey that the dispensing of medication by the prescriber and the level of compliance by the youth is a result of a partnership and collaboration between them to best find the specific drug that allows the youth to feel as best as possible when taking the drug (minimize the side effects) and also simultaneously optimize effectiveness.
5. **Examples of Strategies:**
 - a. **Use of a strong, repeated orientation to medication (explain risks and benefits, allow for youth and family to articulate their concerns, etc.)**
 - b. **Medication Planning Tool**
 - c. **Pill box**
 - d. **Reminder phone calls about meds**
 - e. **Use Child & Family team to discuss & support medication adherence**
6. **Keep closer watch of youth that are deemed to have adherence difficulties (Go back to #3 and follow process again).**



Your Illness is a very small part of you.
You are an individual with a unique personality, talents, and skills which are valuable to yourself and others.

COMPREHENSIVE COMMUNITY SERVICES (CCS)



What is CCS?

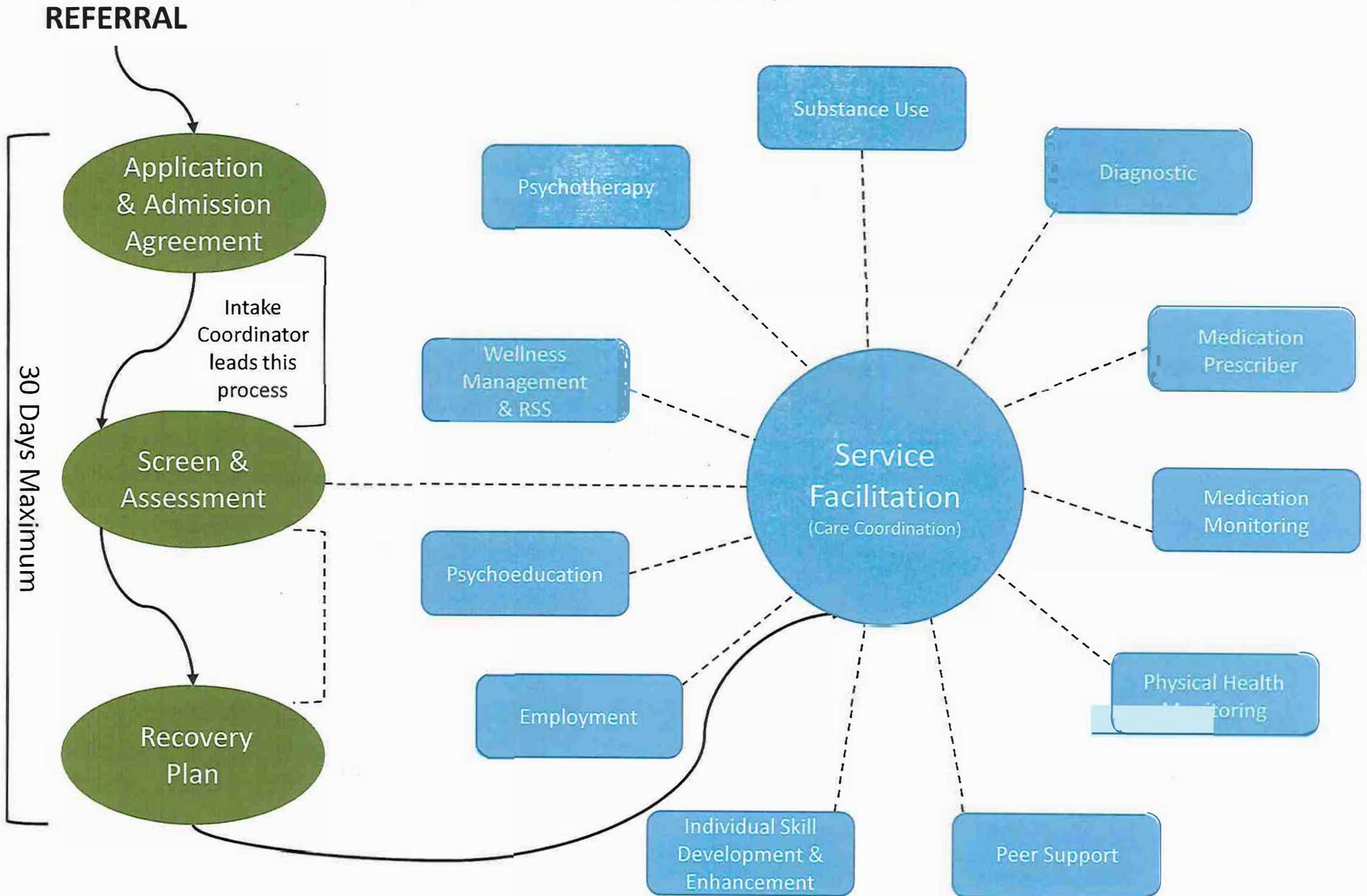
WHAT IS CCS?

- CCS is a voluntary psychosocial rehabilitative Medicaid program for eligible residents (children and adults) of Milwaukee County.
- CCS focuses on helping people who have a mental health and/or a substance use diagnosis on their journey to recovery.
- Those who qualify for CCS work with a care coordinator to design a recovery plan of their choice.
- Individuals can choose from a wide range of services and service providers intended to help them:
 - Improve Health
 - Promote wellness
 - Achieve personal goals
 - Enhance overall quality of life

HIGHLIGHTS OF CCS

- CCS offers a variety of unique rehabilitative services that are intended to support the individual in achieving their highest possible level of **independent functioning, stability and independence** and to facilitate recovery.
- The CCS service provider is teaching, coaching, and mentoring so that CCS participants are empowered to self-direct their own care and path to recovery.

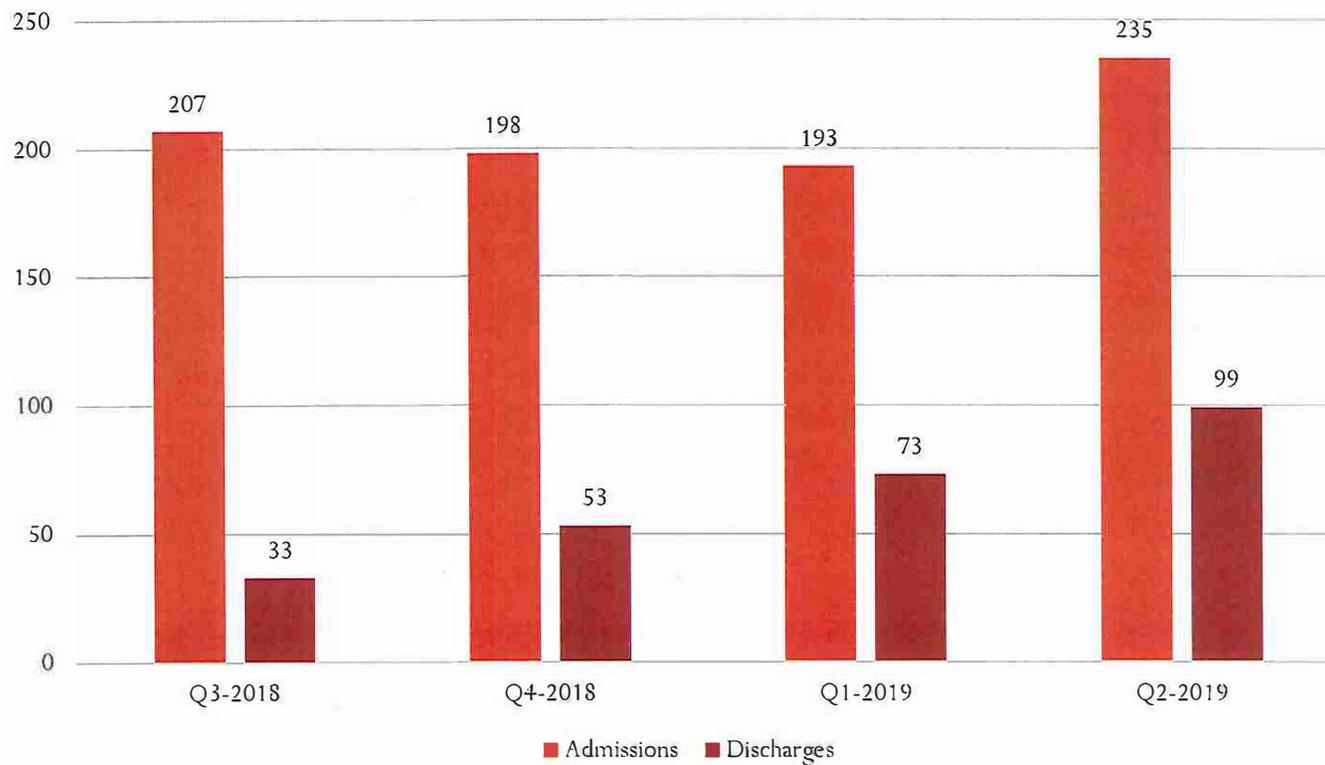
The CCS Service Array



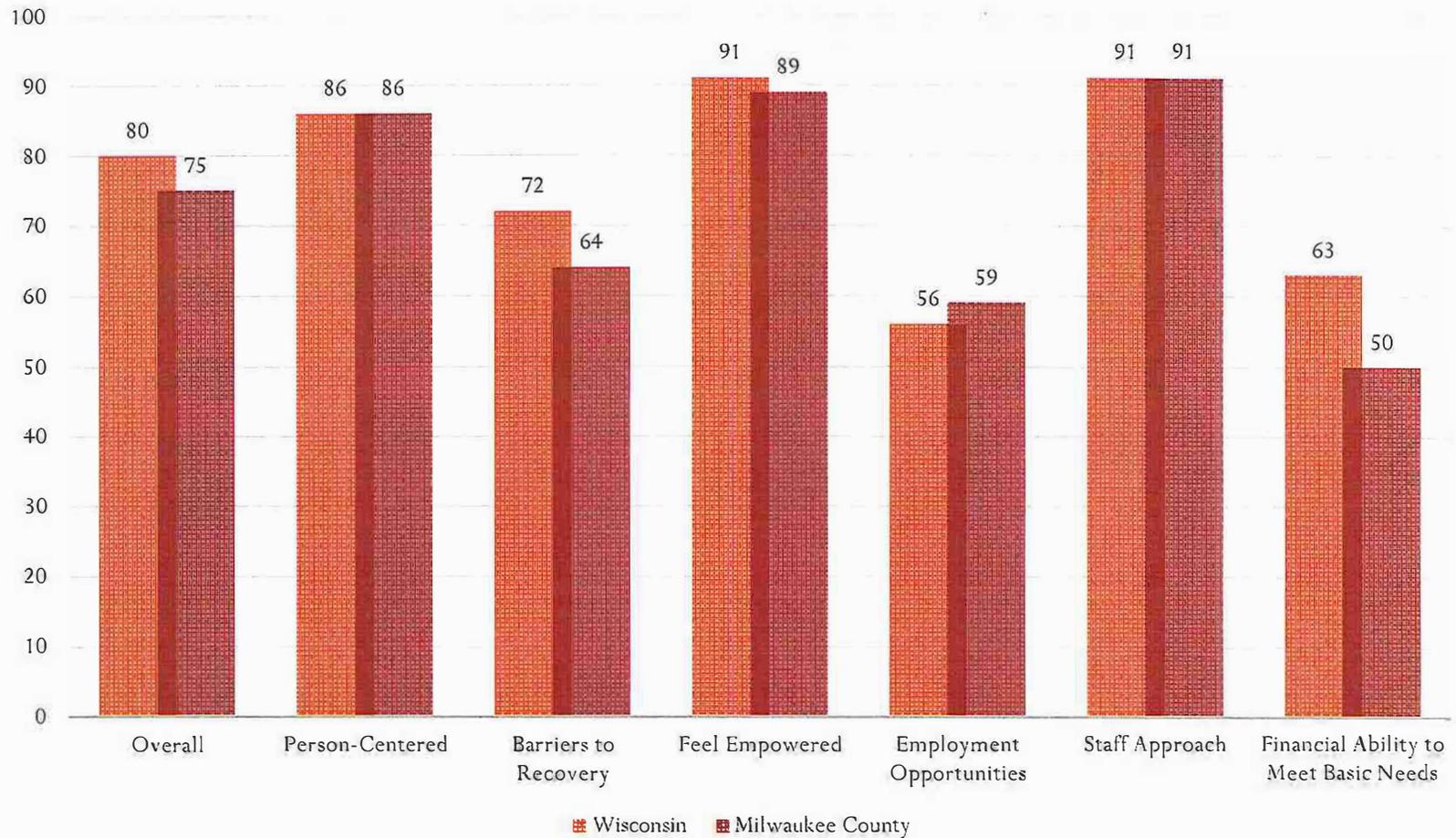
What is the Impact of CCS?

CCS DATA! (as of 6/30/2019)

- Total Served Since Inception: 2293
- Currently Enrolled Clients: 1293

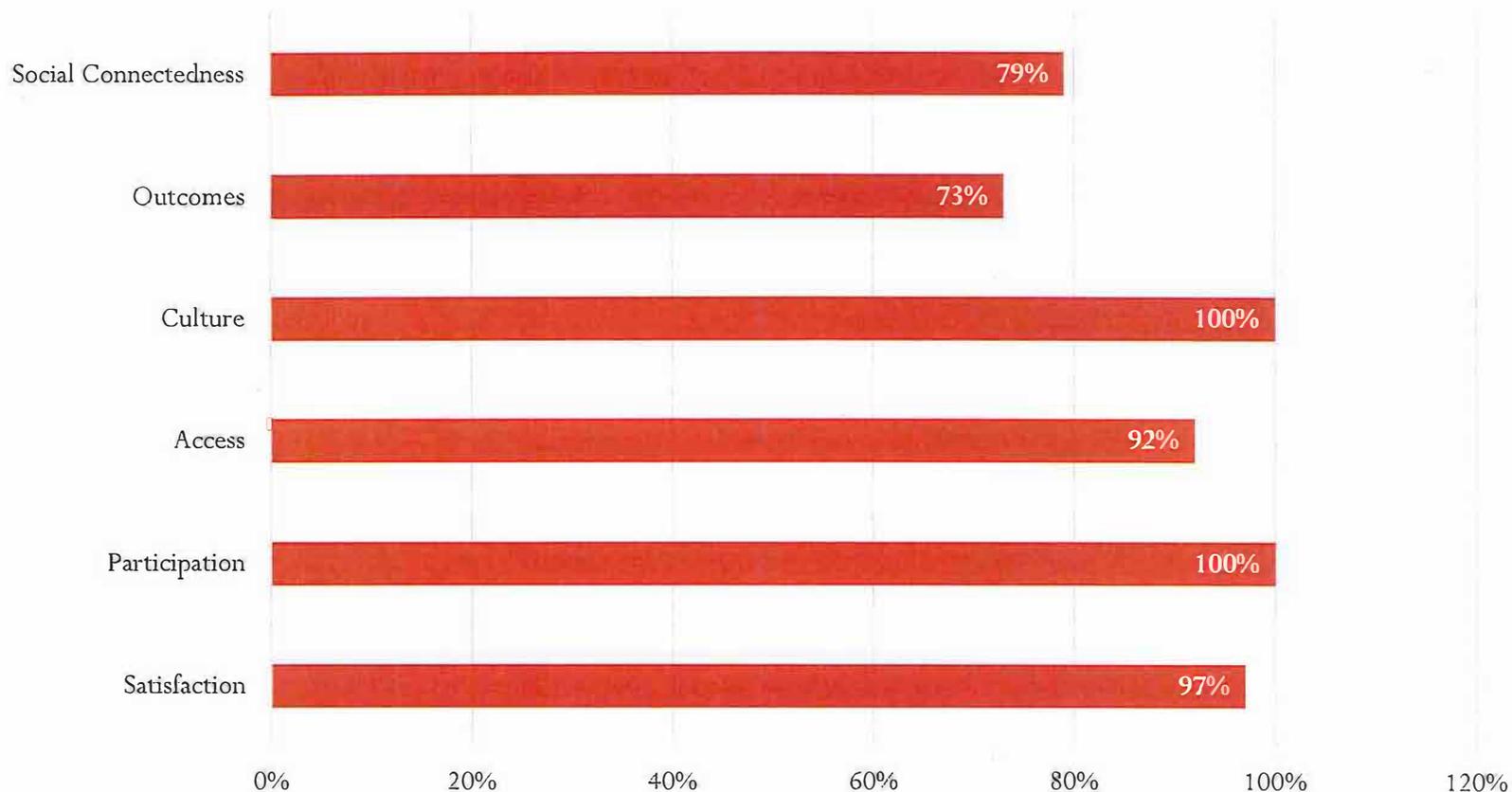


ROSI Scores (18 and Older): Milwaukee vs. Wisconsin Overall 2016-2017



MHSIP Scores (Youth 17 and Under)

MHSIP Results 2018



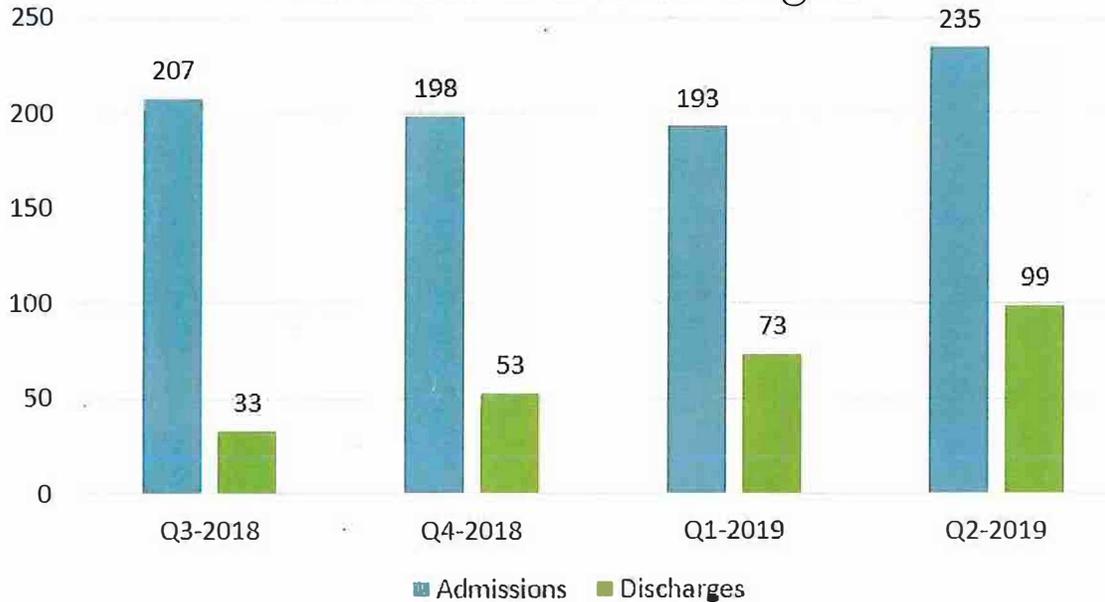


data updated 6/30/2019

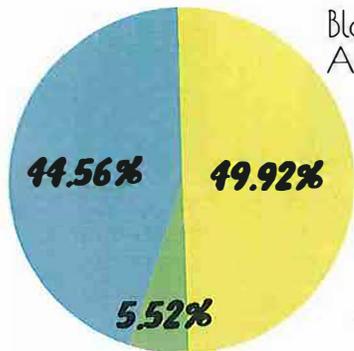
1,286 Currently Active Clients

2,293 Unique Clients All-time

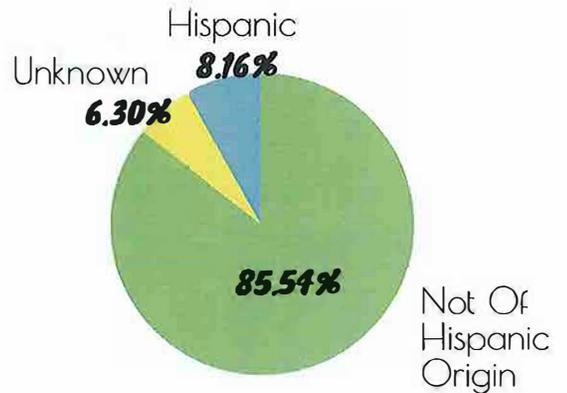
Admissions & Discharges



White/
Caucasian



Asian, Alaskan Native/American Indian, Native Hawaiian/Pacific Islander, or other descent

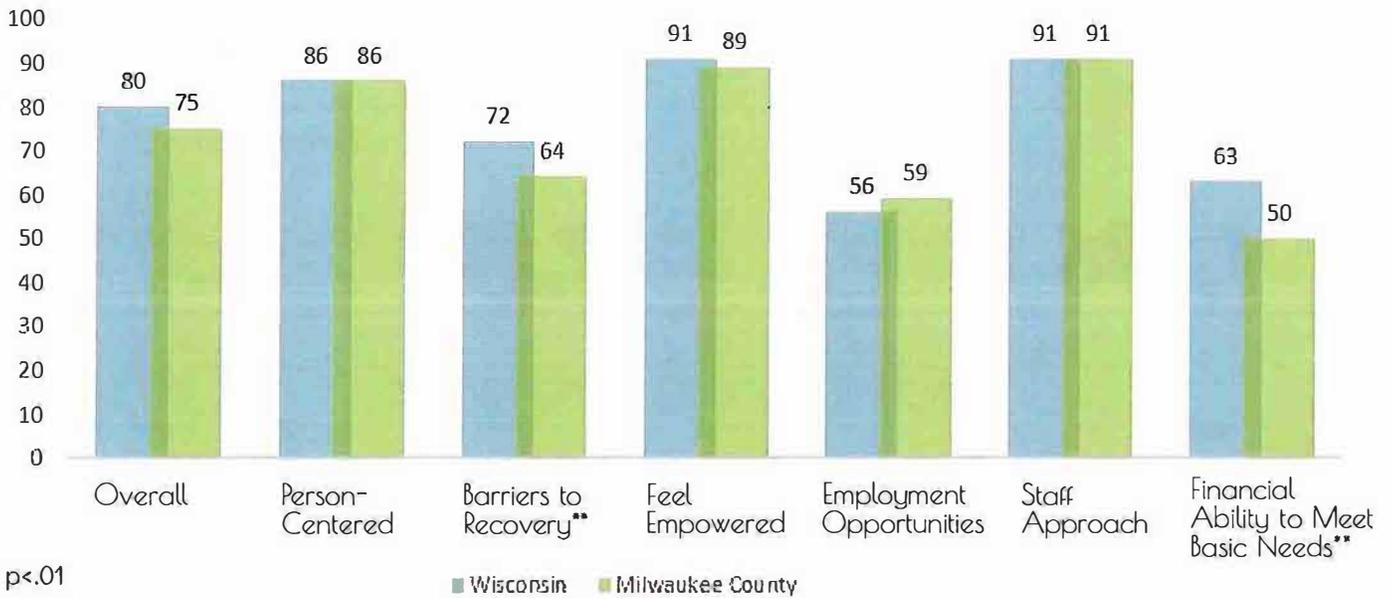


4.7 Average # of unique services received while enrolled (2018)

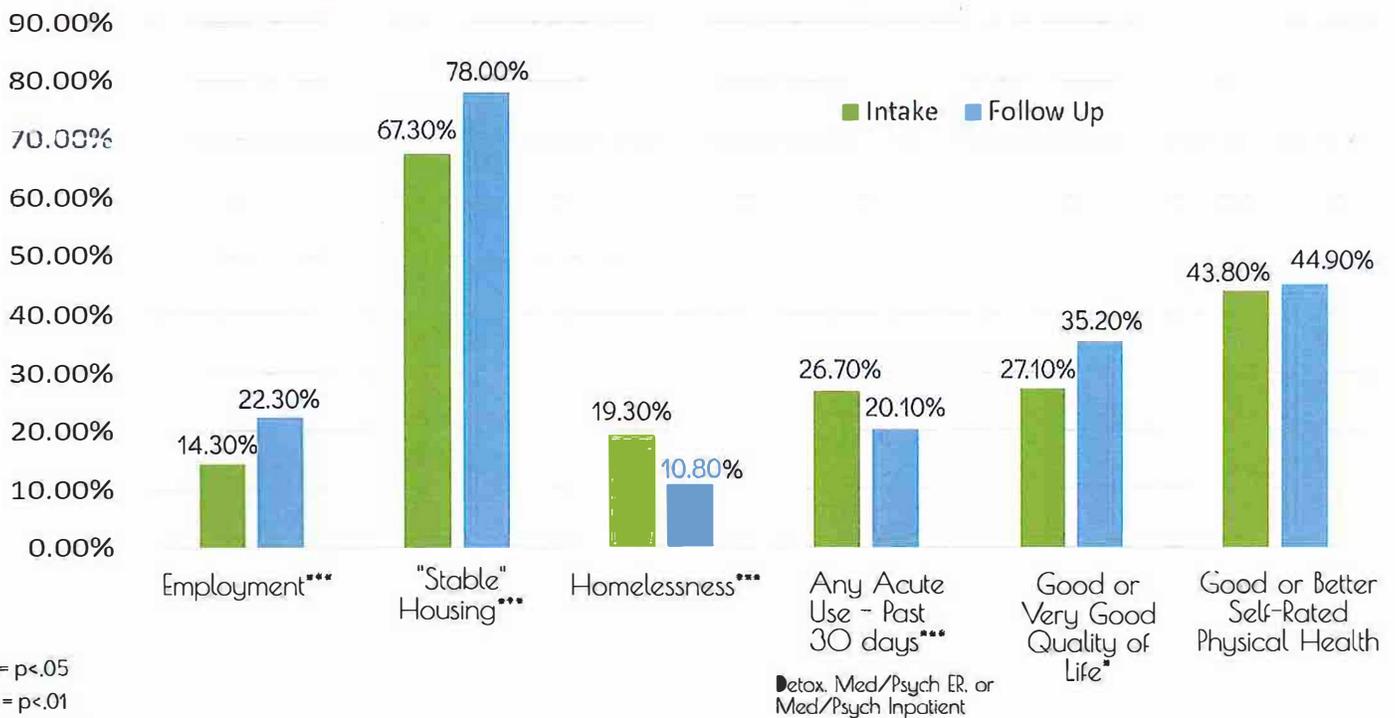
2.2 days Average time to service
Inquiry to first contact with care coordination (2018)

'16-'17 ROSI Survey

Clients who had a "More Positive Experience"



6 months post-intake changes



Audit results

Strengths

- Progress toward goals is being documented well
- Documentation reflects excellent rapport between consumers and Care Coordinators
- There is an increase in both the offering and utilization of ancillary services
- Care Coordinators are doing a great job of identifying consumers' strengths

Opportunities for Improvement

- Work to tie consumers' life vision, goal, objectives, interventions together seamlessly
- Inclusion of natural supports in Recovery Team Meetings
- Improve coordination with ancillary service providers



BHD

MILWAUKEE COUNTY
Behavioral
Health
Division

CCS Basics

- CCS is a flexible option for individuals who are looking for extra support in their recovery journey
- Meeting times and schedules are not fixed and can be adjusted based on the individual's desires and needs (ex. We don't require people to see us "x" amount of times per week)
- CCS is one of the few programs that can work in conjunction with Family Care (Family Care focuses on physical needs and CCS focuses on recovery from MH and Substance Abuse)
- The CCS network was designed to give consumers access to a wide range of services (many of which are not available via other programs) to help build skills and develop as many tools as possible to improve their quality of life and obtain personal goals
- Individuals can select from as many services and providers they want
- CCS is a voluntary program, meaning if someone doesn't want to be in it, all they need to do is let their care coordinator know and the CC can disenroll them easily. Individuals can always reapply (if they meet eligibility and decide they want to be in the program in the future)

Some of the Services Available in the Network:

Personal Trainer services

Nutrition Consultants

Yoga

Tai Chi

Music Therapy

Art Therapy

Dance/Movement Therapy (Coming Soon)

Float Therapy/Guided Meditation

Healthy Cooking Groups

Equine Therapy (horse therapy)

Animal Assisted Therapy

Trauma Informed Self Defense to increase assertiveness and decrease victimization

Therapy (In-Home and Clinic based)

Substance Abuse Tx (In-Home and Clinic based)

MD and APNP prescriber services for medication management

Employment and Education specialists

Housing specialists

Parenting Coaches

Ready access to Diagnostic Evaluations for Eating Disorders, Neuropsych Evaluations, and additional testing to clarify diagnoses (testing related to autism, intellectual and learning disabilities not available)

Peer Support- Individuals who have experience with living with a mental health or substance use condition (or both)

Use of Gardening and Horticultural in Wellness and Recovery

Spiritual Care and Reconnection

Specialists who can support individuals in applying for Social Security (and other benefits) and navigating the process

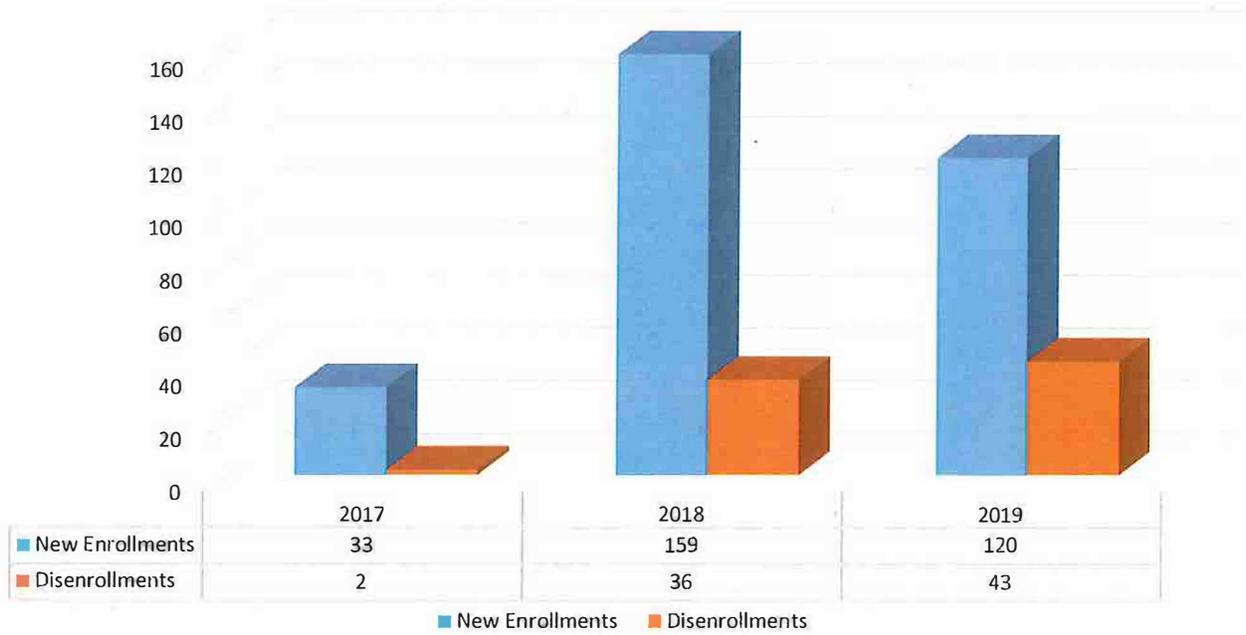
Trauma programming (individual and group)

Pharmacists and RNs to support education and skill building in both taking medications and managing physical health conditions (in-home and agency based)



MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
CHILDREN'S MENTAL HEALTH SERVICES

WRAPAROUND MILWAUKEE CCS REPORT

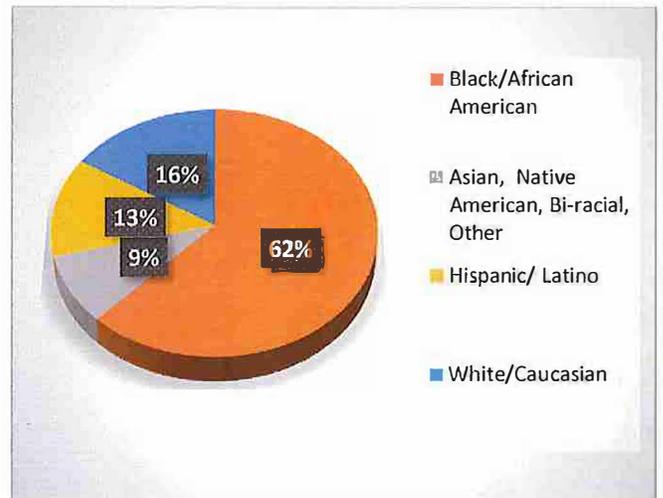


AVERAGE AGE:
15.7 years old

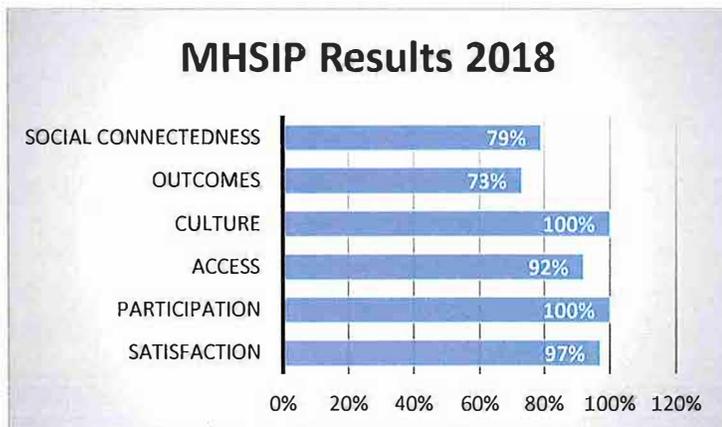
Family MHSIP- Completed by Caregiver for those 12 and under
Youth MHSIP- Completed by enrollees who are 13-17 years old

Surveys are sent to those enrolled 6 months or longer and under the age of 18: 30 total sent, 6 received

RETURN RATE: 20%

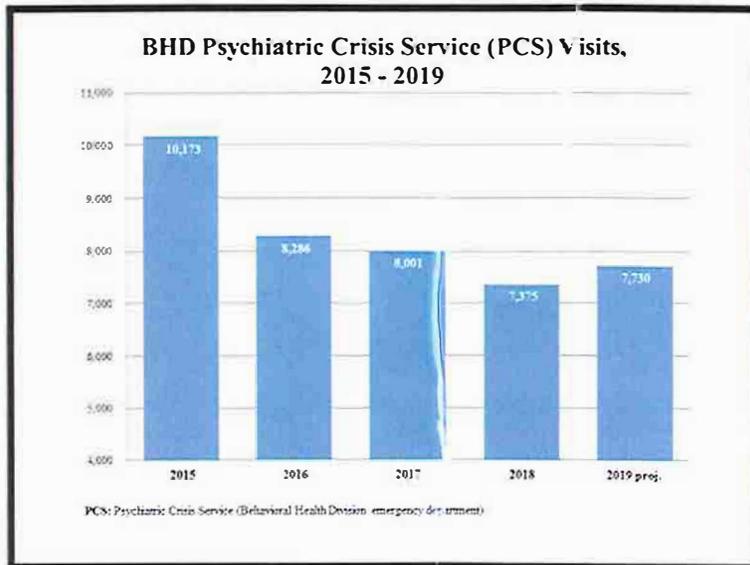


**CURRENT
ENROLLMENTS:
232**

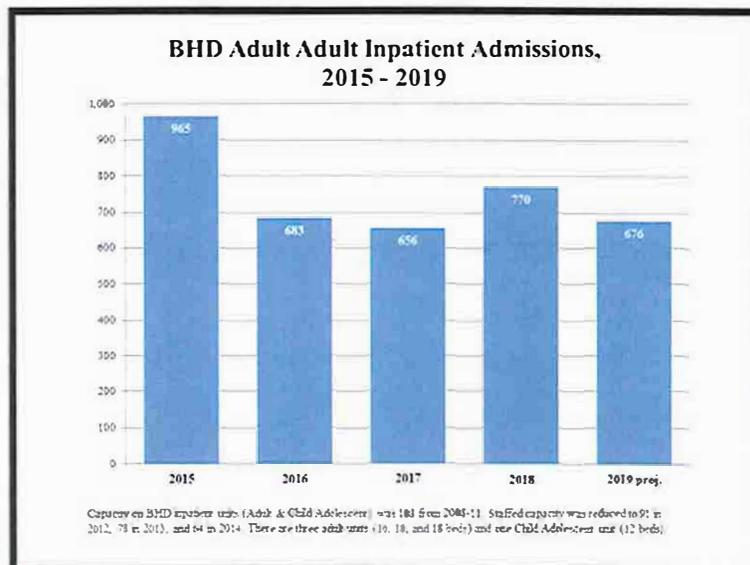


2019 Q2 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

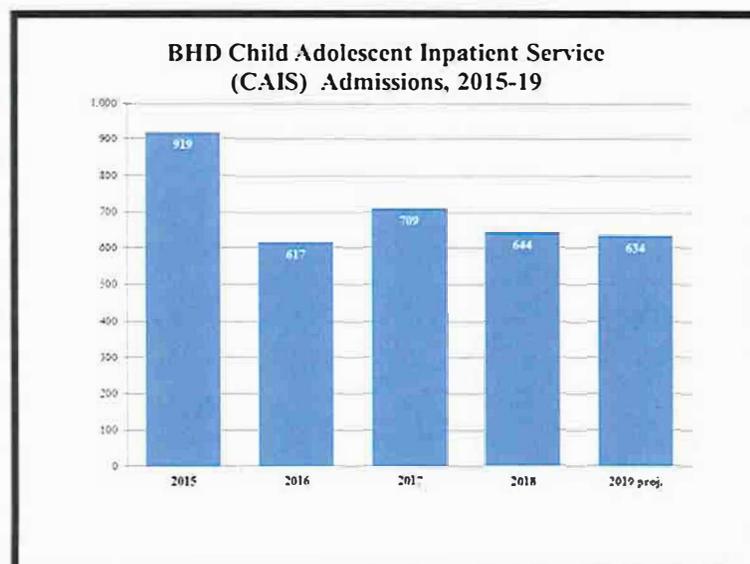
Psychiatric Crisis Service annual patient visits continue to decline from 10,173 in 2014 to 7,730 projected annual visits in 2019 (24% decline from 2015 to 2019). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (9% in 2014, 100% in 2019).



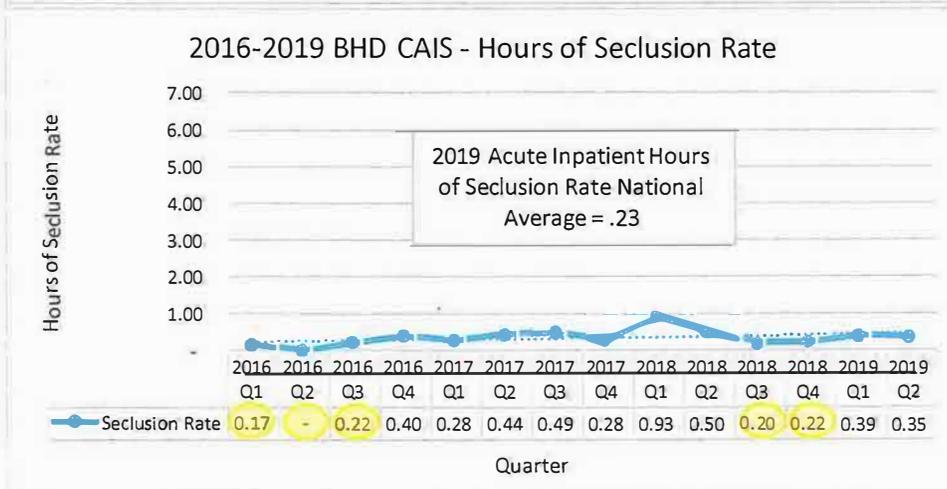
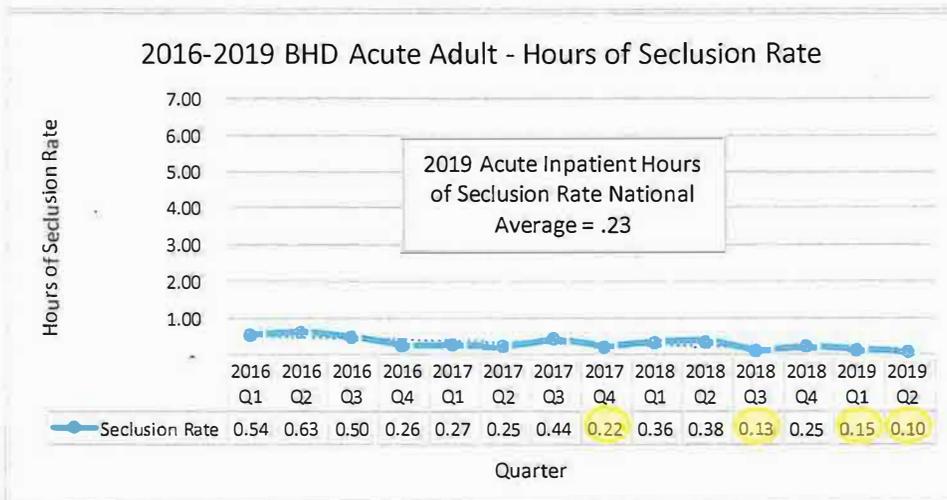
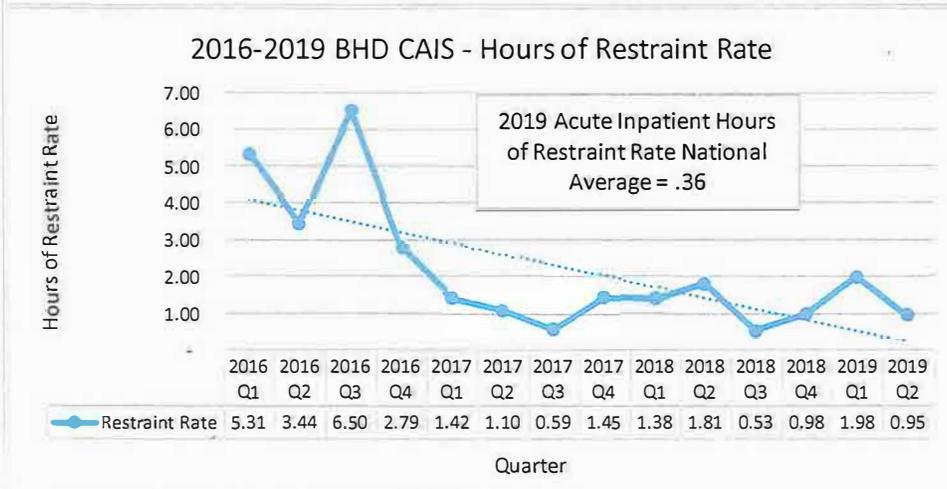
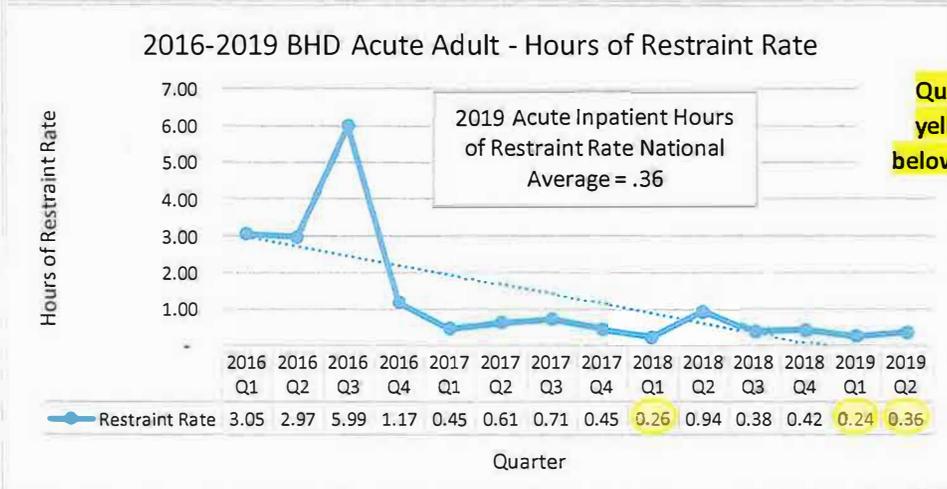
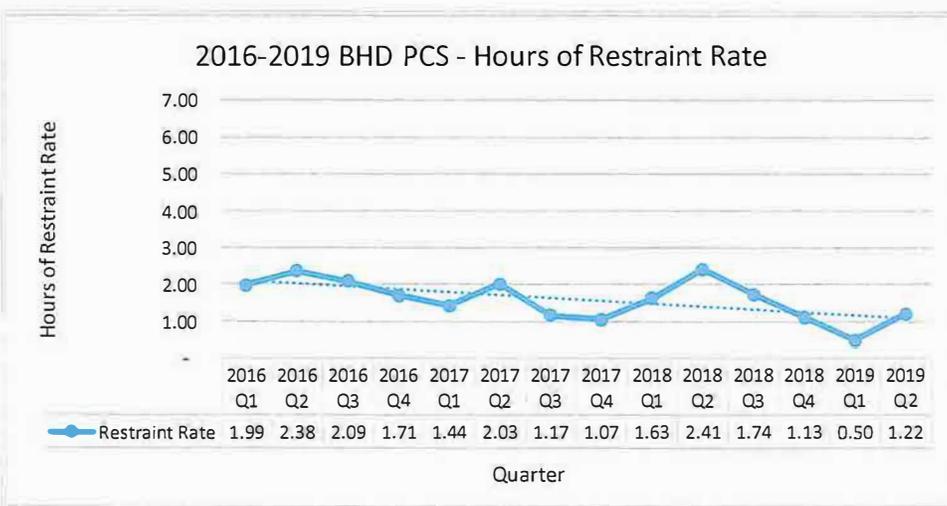
Acute Adult Inpatient Service’s annual patient admissions are projected at 676 in 2019. While Acute Adult admissions have plateaued over the past 4 years, readmission rates have continued to decline (30-day readmission rate: 11% in 2015, 4% in 2019). Acute Adult’s hours of physical restraint rate in 2019 was .30, 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 75% is at the NRI’s reported national average.



Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past 4 years and are projected at 634 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 1.5 in 2019, but remains above CMS’ reported average of .36. CAIS’ Youth Satisfaction Survey overall score of 84% positive rating is 9 percentage points higher than BHD’s historical average.

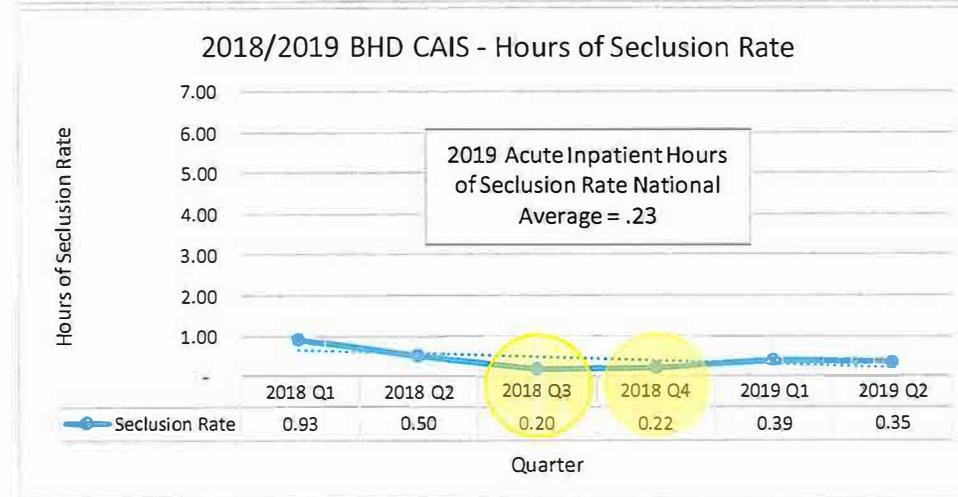
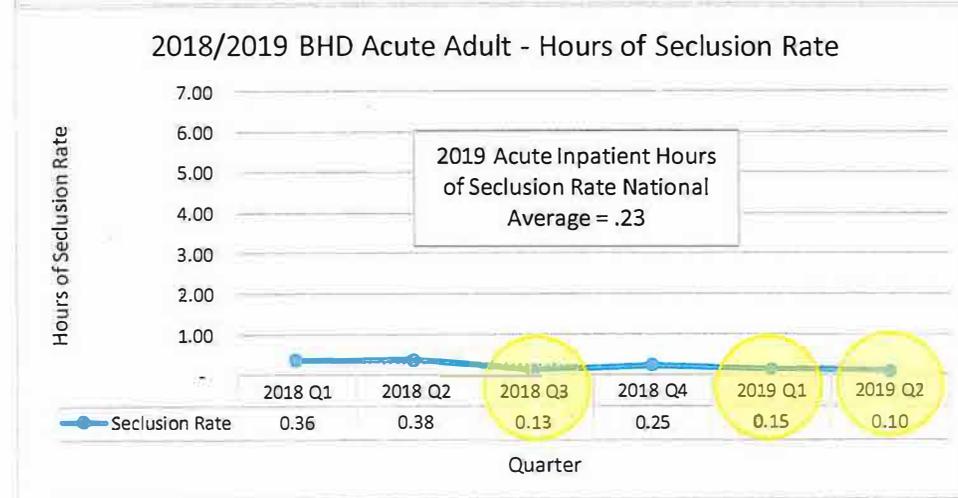
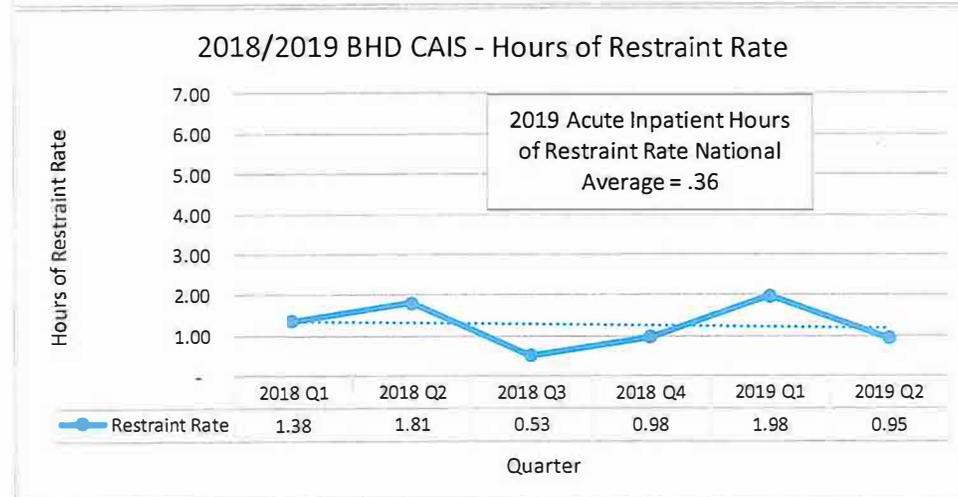
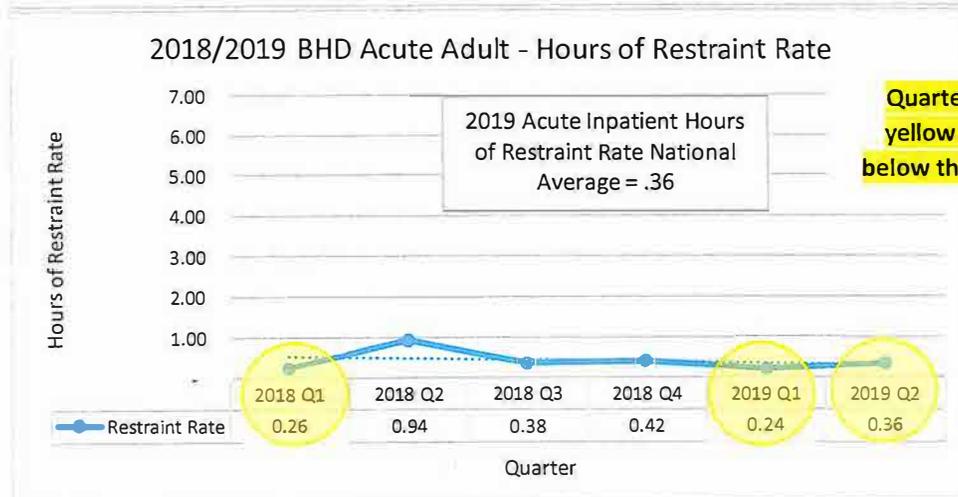
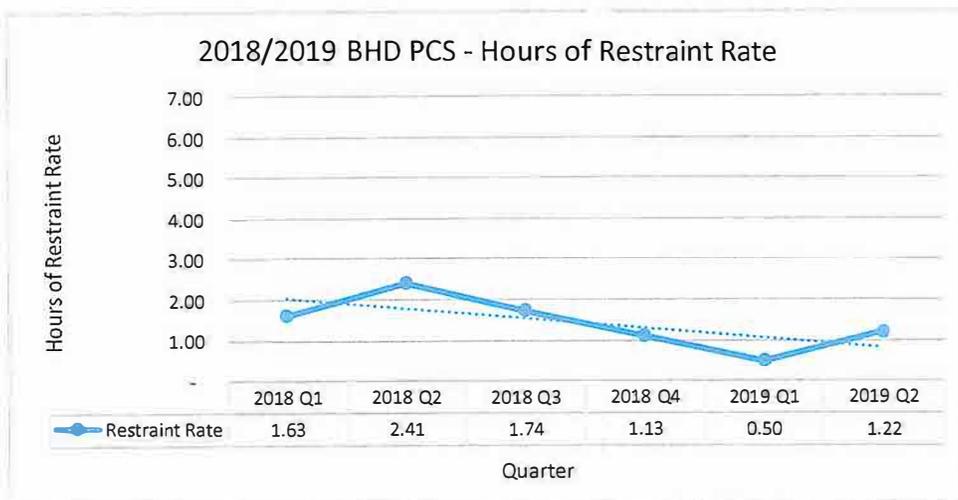


2016-2019 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary



Hours of Restraint Rate Formula: $\text{Restraint Hours} / (\text{Inpatient Hours} / 1,000)$

2019 Q2 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



**Systems Improvement Agreement
between Milwaukee County Behavioral Health Division
and the Centers for Medicare & Medicaid Services**

This Systems Improvement Agreement (SIA or the Agreement) is between the Centers for Medicare & Medicaid Services (CMS), a division of the United States Department of Health and Human Services (HHS), and Milwaukee County Behavioral Health Division (BHD or the Hospital) (collectively the Parties). BHD is a psychiatric hospital governed by the Mental Health Board of Milwaukee County (the Board) of the Milwaukee County Department of Health & Human Services (MCDHHS). BHD participates in the Medicare program under CCN #52-4001.

This Agreement is being executed and will be implemented to further the objectives of Titles XVIII and XIX of the Social Security Act; to facilitate the delivery of quality psychiatric hospital services to the community served by BHD; to promote consistent compliance by BHD with the applicable Medicare Conditions of Participation for Hospitals at 42 C.F.R. §§ 482.11 – 482.57 and for Psychiatric Hospitals at 42 C.F.R. §§ 482.61-482.62; and to promote consistent compliance with the regulations implementing the Emergency Medical Treatment and Labor Act (EMTALA).

Recitals

Whereas, numerous surveys at BHD found noncompliance with multiple Medicare Conditions of Participation and noncompliance with the regulations implementing EMTALA, as follows:

1. The Wisconsin Department of Health Services identified an immediate jeopardy to patient health and safety at BHD following a complaint survey conducted on August 9, 2018. CMS notified BHD of the immediate jeopardy finding on September 25, 2018. The immediate jeopardy finding was based on 42 C.F.R. § 489.24 for failure to perform comprehensive medical screening exams or to stabilize and provide appropriate treatment prior to discharge for patients who presented to the Emergency Department (ED) with psychiatric symptoms. CMS notified BHD that it was terminating BHD's provider agreement effective October 18, 2018. CMS received an acceptable plan of correction on October 1, 2018.
2. The Wisconsin Department of Health Services conducted a revisit on November 26, 2018. The revisit resulted in CMS removing the immediate jeopardy, but noncompliance remained at 42 C.F.R. §§ 489.20 and 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA). On December 12, 2018, CMS notified BHD that it was extending the termination date to January 23, 2019. CMS received an acceptable plan of correction on January 3, 2019.

3. The Wisconsin Department of Health Services conducted a second revisit on January 17, 2019, which found continued noncompliance at 42 C.F.R. §§ 489.20 and 489.24 under EMTALA. CMS notified BHD on January 23, 2019, that it would extend the termination date. On January 29, 2019, CMS notified BHD that the revised termination date would be March 9, 2019. CMS received an acceptable plan of correction on February 22, 2019.
4. The Wisconsin Department of Health Services conducted a third revisit on March 5, 2019, which found continued noncompliance at 42 C.F.R. §§ 489.20 and 489.24 under EMTALA. CMS notified BHD on March 7, 2019, that CMS was extending the termination date to May 6, 2019.
5. On March 13, 2019, surveyors from the Wisconsin Department of Health Services and surveyors contracted by CMS conducted a recertification survey, which found BHD out of compliance with the Medicare Conditions of Participation at 42 C.F.R. § 482.13, Patient Rights; and 42 C.F.R. § 482.61, Special Medical Record Requirements for Psychiatric Hospitals. CMS notified BHD on April 25, 2019, that it was extending the termination date to May 21, 2019. CMS also offered BHD the option to enter into a System Improvement Agreement.

Whereas, CMS has determined that, in view of the impact BHD's termination would have on the community, affording BHD an additional opportunity to achieve and maintain substantial compliance with all Medicare Conditions of Participation for Hospitals and for Psychiatric Hospitals and with the regulations implementing EMTALA is in the best interest of the Medicare program in particular and the community served by BHD, generally. CMS issued a letter to BHD on May 15, 2019, indicating CMS's agreement to enter into a System Improvement Agreement with BHD and to extend the termination date to allow the parties to develop and finalize this SIA.

Whereas, BHD does not admit to the existence of the deficiencies referenced above and does not agree that these deficiencies were cited correctly. Nevertheless, BHD has agreed to remedy these alleged deficiencies and to enter into this SIA in order to comply with all required Federal laws and evidence BHD's commitment to maintain compliance therewith.

NOW, THEREFORE, in consideration of the stipulations contained herein the Parties agree as follows:

Agreement

1. **Term of Agreement.** This Agreement is in effect for the period beginning on the date this Agreement is signed by CMS, through July 1, 2021, unless voluntary withdrawal or termination of the Medicare Provider Agreement occurs, the Parties amend the Agreement in accordance with Section 23, or the terms of the Agreement are fulfilled earlier, in accordance with the provisions contained in this Agreement. CMS will be the last party to sign the Agreement.

2. **Stay of Scheduled Termination Date.** CMS agrees to stay the scheduled termination BHD's Medicare Provider Agreement during the pendency of this Agreement and agrees to provide written notice of the same to be executed and delivered to BHD within 24 hours after execution of the Agreement.

A. During the term of the Agreement, CMS further agrees to exercise its discretion in conducting survey and enforcement activities with respect to BHD as provided below in Section 10.B.

B. In consideration for CMS's stay of the scheduled termination of BHD's Medicare Provider Agreement and exercise of discretion in survey and enforcement activities with respect to BHD, BHD agrees to perform the services and activities described in this Agreement at its expense.

3. **Retention of Independent Expert Consultant.** BHD, through MCDHHS, will obtain an Independent Expert Consultant ("Expert Consultant") to conduct an onsite review of BHD and to perform the services and activities specified in Sections 4, 5, and 6 of this Agreement.

A. **Name and Information of Expert Consultant:** Within 90 calendar days after the effective date of this Agreement, BHD shall provide CMS with written notification of the name and qualifications of at least three Expert Consultants that BHD proposes to retain to carry out the services and activities specified in Sections 4, 5, and 6 of this Agreement. The written notification to CMS shall contain the name of the Expert Consultant and the Expert Consultant's proposal submitted in response to MCDHHS' Request for Proposals ("RFP") to carry out the services and activities specified in this Agreement. If BHD does not receive at least three responses to MCDHHS' RFP for an Expert Consultant, BHD will submit to CMS all of the names and Expert Consultant proposals that it did receive.

B. **Minimum Qualifications of Expert Consultant:** At minimum, the proposed Expert Consultant shall be an organization or individual with expertise in the design, implementation, management, and evaluation of psychiatric hospital services, including, but not limited to the following:

1. Governance and leadership organizational effectiveness;
2. Human resource and organizational culture change management;
3. Quality and appropriateness of services provided to patients in accordance with the applicable Medicare Conditions of Participation for Hospitals, the Medicare Conditions of Participation for Psychiatric Hospitals, the regulations implementing EMTALA, and nationally accepted standards of practice;
4. Protection and promotion of patients' rights;
5. Maintenance of safe environment of care;
6. Assessment for the use of restraints;
7. Development of individualized treatment plans;
8. Quality assessment and performance improvement; and
9. Treatment of individuals with a prior criminal history.

C. Approval or Rejection of Expert Consultant: BHD, through MCDHHS, shall not enter into a contract with the proposed Expert Consultant to perform the duties set forth in this Agreement until BHD receives CMS's approval of the proposed Expert Consultant. Within 10 calendar days after receiving written notification of the proposed Expert Consultants as described in Section 3.A., CMS shall notify BHD in writing whether it approves or rejects each of the proposed Expert Consultants. BHD will then select an Expert Consultant from the candidates approved by CMS. If CMS rejects all three proposed Expert Consultants, BHD shall submit the names of three additional proposed Expert Consultants in accordance with the requirements set out in Section 3.A and 3.B. above. If on the third attempt at submitting names of proposed Expert Consultants, BHD fails to propose an Expert Consultant meeting the qualifications identified in Section 3.B., BHD will be in breach of this Agreement.

D. Conflict of Interest: Unless otherwise approved in writing by CMS, no proposed Expert Consultant may be an employee of BHD, Milwaukee County, or the State of Wisconsin or have worked for BHD, Milwaukee County, or the State of Wisconsin in the past 12 months. For the purposes of this Agreement, a conflict of interest means a person has a financial, private, or personal interest that may adversely affect or influence or appear to adversely affect or influence the professional and objective exercise of his or her duties and obligations as set forth in this

Agreement. If BHD proposes an Expert Consultant with a potential conflict of interest, BHD will explain in writing the nature and scope of the interests involved.

E. **Change of Expert Consultant:** If the Expert Consultant retained by BHD fails to fulfill its obligations to BHD and/or MCDHHS as specified in this Agreement, breaches a material term of a contract with BHD and/or MCDHHS, or abandons the position, BHD and/or MCDHHS may terminate, in accordance with State and/or County law and administrative processes, its relationship with the Expert Consultant after providing CMS with written notice of the basis for terminating its relationship with the Expert Consultant and obtaining CMS's comments prior to the termination. Within 14 calendar days after receiving CMS's written comments regarding the termination of the Expert Consultant, BHD shall provide CMS with information as described in Section 3.A regarding a replacement Expert Consultant. The process for approving the replacement Expert Consultant shall then proceed as set forth in Section 3.C. The Parties will amend this Agreement, if necessary, to incorporate any new deadlines required as a result of the change in Expert Consultant.

4. **Written Report: Gap and Root Cause Analyses.** The Expert Consultant will prepare a written report that includes a Gap Analysis that identifies areas of needed improvements in BHD's regulatory compliance; a Root Cause Analysis of process and system failures; and recommendations to achieve and sustain compliance based on the findings of the Gap and Root Cause analyses.

A. **Gap Analysis:** The Gap Analysis will include a comprehensive hospital-wide analysis of BHD's current operations compared to industry-accepted standards of practice that achieve and maintain compliance with all applicable Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals, including, but not limited to the following areas:

1. Governance/leadership/management accountability mechanisms;
2. BHD's governing body, management team, and leadership structure with regard to their ability to oversee a Corrective Action Plan (as described in Section 5), with any recommendations for changes to the governing body's membership or management;
3. Providing emergency services in accordance with the Emergency Medical Treatment and Labor Act (EMTALA);
4. Quality and appropriateness of services in a safe environment;
5. Patients' rights protections;

6. Qualified and supportive staffing resources;
7. Staff training and education;
8. Nursing Services;
9. Restraint use;
10. Treatment plan development;
11. BHD's current Quality Assurance and Performance Improvement (QAPI) program, including, but not limited to whether:
 - a. The program is effective in achieving increased patient safety and improved quality of care;
 - b. It is ongoing and has adequate resources;
 - c. Hospital leadership (including the governing body) is appropriately engaged in the program;
 - d. The program is hospital-wide;
 - e. It is data-driven, including the process for determining the selection of tracking measures that comply with the requirements of 42 C.F.R. § 482.21, definitions of adverse events and methods to identify them;
 - f. Data collection and analysis are adequate; and
 - g. The program includes a process to develop, implement and evaluate performance improvement activities and projects.

B. **Root Cause Analysis:** The Root Cause Analysis of process and system failures will address the following:

1. Problem identification and definition;
2. Investigation for gathering information;
3. Identification of root causes;
4. Implementation of solutions; and

5. Process for monitoring these solutions to confirm they continue to prevent the original problem identified.

C. **Recommendations:** In addition to the Gap and Root Cause Analyses, the written report shall also include recommendations for hospital-wide changes and improvement to achieve and sustain substantial compliance with all the applicable Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals and with the regulations implementing EMTALA. The recommendations must include, at a minimum, recommendations related to sustaining compliance with the Conditions of Participation at Governing Board, Patient Rights, Quality Assessment and Performance Improvement, Nursing Services, and Special Medical Record Requirements for Psychiatric Hospitals; and to sustaining compliance with regulations implementing EMTALA requirements. CMS is aware that BHD is a County owned and operated psychiatric hospital and that any recommendations submitted by the Expert Consultant may factor in BHD's need to adhere to State and/or County regulations, legislative appropriation processes and limitations, union contracts, other external factors, or market influences. BHD is aware that its status as a County owned and operated psychiatric hospital does not alleviate its obligation to comply with all applicable Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals or with the regulations implementing EMTALA.

D. **Submission and Approval of the Expert Consultant Report:**

1. The Expert Consultant will submit the written report described in this Section to CMS for review and approval and will also provide an oral briefing to CMS, at the discretion of CMS, on the report's findings. This report will be due to CMS no later than 90 calendar days after CMS has provided written notice of its approval of the Expert Consultant.
2. The Expert Consultant must submit the written report to BHD and MCDHHS at the same time the report is submitted to CMS, and BHD or MCDHHS may request an oral briefing from the Expert Consultant on the contents of the report after the report is submitted to CMS. However, the Expert Consultant must not solicit any feedback or input for inclusion or revision of the report from BHD or MCDHHS.
3. If CMS rejects the written report, CMS will notify the Expert Consultant, BHD, and MCDHHS in writing that it is rejecting the written report either in total or in part. CMS may, at its discretion, provide an oral and/or written explanation to the Expert Consultant, BHD, and MCDHHS regarding its rationale for rejecting the report. The Expert Consultant will have 30 calendar days from the date of

its receipt of CMS's written notification rejecting the report to submit a revised written report.

- a. The Expert Consultant must provide a copy of the revised written report to BHD and MCDHHS at the same time the revised written report is submitted to CMS but must not solicit any feedback or input for inclusion or revision of the report from BHD or MCDHHS.
 - b. The Expert Consultant's failure to submit an acceptable written report on the third attempt shall be deemed a breach of this Agreement. Upon such failure, CMS may, at its discretion, allow BHD to obtain a new Expert Consultant in lieu of terminating BHD's Medicare Provider Agreement pursuant to Section 24. CMS recognizes that BHD is bound by State and/or County law and administrative processes in terminating the Expert Consultant and solicitation and selection of a new Expert Consultant.
4. If CMS accepts the written report described in this Section, CMS will notify the Expert Consultant, BHD, and MCDHHS in writing (via electronic mail) that CMS accepts the report. After CMS has reviewed and accepted the written report, CMS will determine a due date for submitting a Corrective Action Plan as described below in Section 5.

5. Corrective Action Plan.

A. **Development of the Corrective Action Plan.** After CMS has approved the written report described in Section 4, the Expert Consultant, in consultation with BHD and MCDHHS, will develop and submit to CMS a detailed, written Corrective Action Plan identifying specific actions to be taken, including milestones, to achieve and sustain substantial compliance with all the applicable Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals and with the regulations implementing EMTALA. The Corrective Action Plan must include the following:

1. Identification of actions to correct identified deficiencies in each service /functional area;
2. Identification of detailed milestones related to each deficiency;
3. A proposed timeline for completion of the specific actions to be taken as identified above, including a nine-month "window" for survey activities following the completion of the Corrective Action Plan.

B. Submission and Approval of the Corrective Action Plan. The Expert Consultant will submit the Corrective Action Plan described in this Section to CMS for review and approval no later than the due date established in Section 4.D.4. A copy of the Corrective Action Plan must be provided to BHD and MCDHHS at the same time the Expert Consultant provides it to CMS.

1. If CMS rejects the Corrective Action Plan, CMS will notify the Expert Consultant, BHD, and MCDHHS in writing that it is rejecting the Corrective Action Plan either in total or in part. CMS may, at its discretion, provide an oral and/or written explanation to the Expert Consultant, BHD, and MCDHHS regarding its rationale for rejecting the Corrective Action Plan. The Expert Consultant shall have 30 calendar days from the date of its receipt of CMS's written notification rejecting the report to submit a revised written report. The Expert Consultant must provide a copy of the revised Corrective Action Plan to BHD and MCDHHS at the same time the revised written report is submitted to CMS.
2. The Expert Consultant's failure to submit an acceptable corrective action plan on the third attempt shall be deemed a breach of this Agreement. Upon such failure, CMS may, at its discretion, allow BHD to obtain a new Expert Consultant in lieu of terminating BHD's Medicare Provider Agreement pursuant to Section 24. CMS recognizes that BHD is bound by State and County law and administrative processes in terminating the Expert Consultant and solicitation and selection of a new Expert Consultant.

C. Implementation of the Corrective Action Plan. If CMS accepts the Corrective Action Plan described in this Section, CMS will notify the Expert Consultant, BHD, and MCDHHS in writing (via electronic mail) no later than seven calendar days after the date CMS accepts it. No later than 14 calendar days after receipt of CMS's notice accepting the Corrective Action Plan, BHD and MCDHHS must notify CMS in writing (via electronic mail) that they have received the Corrective Action Plan and are committed to implementing the Corrective Action Plan.

1. Any modifications of the approved Corrective Action Plan will be made and implemented only after CMS notification and approval.
2. If the timeline in the Corrective Action Plan and the nine-month survey window extend beyond the expiration date of this Agreement, CMS may, at its discretion, agree to extend the expiration date of this Agreement.

3. CMS will schedule monthly meetings with the Expert Consultant, BHD, and MCDHHS, which may be done by telephone, to discuss BHD progress in implementing the Corrective Action Plan. The Parties may agree to change the frequency of the scheduled meetings without amending this Agreement.

6. **Monthly Expert Consultant Reports.** The Expert Consultant will submit monthly written reports and updates to CMS beginning 30 calendar days after the date on which CMS has accepted the Corrective Action Plan and continuing throughout the duration of this Agreement ("Monthly Reports"). The Expert Consultant must also send a copy of the Monthly Report to BHD and MCDHHS at the same time the Expert Consultant submits the report to CMS.

A. **Content of Monthly Reports.** The Monthly Reports must include the following:

1. Progression and status of BHD's implementation of the Corrective Action Plan;
2. New areas identified that require improvement and/or expansion of the Corrective Action Plan.
3. Identification of problems that may jeopardize successful implementation of the Corrective Action Plan; and
4. Actions underway to address identified problems.
5. After the Corrective Action Plan has been fully implemented, the Monthly Report should identify any new areas that require correction as well as the actions underway to address identified problems.

B. **Option for Telephone or In-Person Meeting.** At the discretion of CMS, the Monthly Reports may be followed by face-to-face or telephone conference discussions between the Expert Consultant and CMS as needed. Any such discussions will be confidential between CMS and the Expert Consultant and conducted at the expense of BHD. BHD and MCDHHS may also request a meeting or conference with CMS and the Expert Consultant following the submission of any Monthly Report.

7. **On-Site Independent Compliance Consultant.** In addition to engaging an Independent Expert Consultant, BHD will contract with an independent, full-time on-site Compliance Consultant ("Compliance Consultant") to work closely with the Independent Expert Consultant and the BHD Chief Nursing Officer to

monitor implementation of the Corrective Action Plan. The Compliance Consultant shall not be the same as the Expert Consultant or be an independent contractor or employee of the Expert Consultant. BHD shall retain the services of a Compliance Consultant at BHD throughout the duration of this Agreement.

A. Compliance Consultant Duties. The Compliance Consultant will provide ongoing feedback to the Parties about BHD's improvements and compliance with all Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals and with the regulations implementing EMTALA, and will work directly with BHD's Chief Nursing Officer to coordinate BHD's Quality Assessment and Performance Improvement (QAPI) program. As part of this oversight, the Compliance Consultant will conduct quarterly comprehensive reviews of the QAPI program activities and the status of BHD's progress in meeting the Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals and in meeting the requirements under EMTALA, and will provide the results to CMS, BHD, MCDHHS, and the Expert Consultant.

B. Retention of the Compliance Consultant.

1. **Name and Qualifications of the Compliance Consultant.** Within 90 days after the effective date of this Agreement, BHD shall provide CMS with written notification of at least two Compliance Consultants that BHD proposes to retain to carry out the services and activities specified in this Section. The written notification to CMS shall contain the names of the Compliance Consultants and the Compliance Consultants' proposals submitted in response to MCDHHS' Request for Proposals ("RFP") to carry out the services and activities specified in this Section. If the proposed Compliance Consultant is an organization, the submission must also include the resumes for any individual that the organization is considering appointing to BHD. If BHD does not receive at least two responses to MCDHHS' RFP for a Compliance Consultant, BHD will submit to CMS the name and Compliance Consultant proposal that it did receive.
2. **Minimum Qualifications of Compliance Consultant.** At minimum, the proposed Compliance Consultant shall be an individual or organization with expertise in the design, implementation, management, and evaluation of psychiatric hospital services, with an emphasis in the areas of Quality Assessment, Performance Improvement, and EMTALA. If BHD retains an organization as its Compliance Consultant, the organization must assign one individual to BHD throughout the duration of this Agreement.

3. **Approval or Rejection of Compliance Consultant.** BHD, through MCDHHS, shall not enter into a contract with the proposed Compliance Consultant to perform the duties set forth in this Section until BHD receives CMS's approval of the proposed Compliance Consultant. Within 10 calendar days from receiving written notification of the proposed Compliance Consultants as described in Section 7.B.1., CMS shall notify BHD and MCDHHS in writing whether it approves or rejects each of the proposed Compliance Consultants. BHD shall select a Compliance Consultant from the list of candidates approved by CMS. If CMS rejects BHD's proposed Compliance Consultants, BHD shall propose two new Compliance Consultants as described in Section 7.B.1. If on the third attempt at submitting names of proposed Compliance Consultants, BHD fails to propose a Compliance Consultant meeting the qualifications specified in Section 7.B.2, BHD will be in breach of this Agreement.
4. **Conflict of Interest.** Unless otherwise approved in writing by CMS, no proposed Compliance Consultant may be an employee of BHD or MCDHHS or have been employed by BHD or MCDHHS in the past 12 months. For purposes of this Agreement, a conflict of interest means a person has a financial, private, or personal interest that may adversely affect or influence or appear to adversely affect or influence the professional and objective exercise of his or her duties and obligations as set forth in this Agreement. If BHD proposes an individual with a potential conflict of interest, BHD will explain in writing the nature and scope of the interests involved.
5. **Change of Compliance Consultant.** If the Compliance Consultant retained by BHD fails to fulfill its obligations to BHD or MCDHHS as specified in this Agreement, or abandons the position, BHD, through MCDHHS, may terminate, in accordance with State and/or County law and administrative processes, its relationship with the Compliance Consultant after providing CMS with written, explanatory notice of the basis for terminating its relationship with the Compliance Consultant and obtaining CMS's comment prior to the termination. Within 14 calendar days after receiving CMS's written comments regarding the termination of the Compliance Consultant, BHD shall propose a replacement Compliance Consultant to CMS in accordance with Section 7.B.1. The process for approving the replacement Compliance Consultant shall then proceed as set forth in Section 7.B.3.

8. **Final Surveys.** CMS will authorize two unannounced full Medicare certification surveys upon the completion of the approved Corrective Action Plan

described in Section 5 of this Agreement. The surveys will determine BHD's compliance with all applicable Medicare Conditions of Participation for Hospitals and Psychiatric Hospitals and with the regulations implementing EMTALA. The surveys will be conducted prior to the end date of this Agreement.

9. **BHD Resource Allocation.** BHD and MCDHHS agree that financial and personnel resources, within legislative appropriation, will be made available to ensure BHD's efforts to comply with the terms of this Agreement. In addition, MCDHHS and BHD agree that the availability of these financial and personnel resources, within legislative appropriation, will not negatively impact the operations of any other health care providers operated by MCDHHS.

10. **Compliance & Enforcement.**

A. Notwithstanding any provision of this Agreement, or any document generated pursuant hereto, CMS and its agents retain full legal authority and responsibility to investigate substantial allegations of noncompliance and otherwise evaluate compliance with Medicare participation requirements. To this end, CMS, or its authorized agents, may use its existing authority to survey BHD and take enforcement action, including termination of BHD's Medicare Provider Agreement.

B. Without limiting its authority to investigate substantial allegations of noncompliance and otherwise evaluate compliance with Medicare participation requirements, CMS will consider exercising discretion in conducting survey and enforcement activity at BHD while this Agreement remains in effect.

1. CMS may provide the Expert Consultant, BHD, and MCDHHS with information acquired during the course of this Agreement that may be relevant to the development or implementation of the Corrective Action Plan.
2. CMS will provide BHD with the opportunity to provide information about any deficiencies identified during any survey and to meet with CMS to discuss the deficiencies.

C. If BHD demonstrates no condition-level noncompliance with any applicable Medicare Conditions of Participation and compliance with the regulations implementing EMTALA during the two Medicare certification surveys referenced in Section 8, CMS will promptly rescind the pending termination of BHD's Medicare provider Agreement. If any other deficiencies are identified during either of the Medicare certification surveys referenced in Section 8, BHD must submit to CMS within 14 calendar days of receiving the CMS 2567, Statement of Deficiencies, an acceptable plan of correction that is approved by CMS. BHD's deemed status will be restored and the survey jurisdiction of the State will be rescinded only after BHD

successfully passes both certification surveys with no condition-level noncompliance and with compliance with the regulations implementing EMTALA after an acceptable plan of correction has been approved by CMS for any other deficiencies identified during the surveys.

D. In the event that the survey(s) referenced in Section 8 finds condition-level noncompliance in one or more of the Medicare Conditions of Participation for Hospitals or Psychiatric Hospitals or any noncompliance with the regulations implementing EMTALA, CMS will promptly notify BHD and MCDHHS of these findings and set a date for termination of BHD's Medicare Provider Agreement consistent with the notice requirements at 42 C.F.R. § 489.53(d).

1. CMS agrees that this termination decision will be based solely on the findings from the Medicare certification survey(s) referenced in Section 8. CMS may, at CMS's sole discretion, decide not to terminate BHD's Medicare Provider Agreement following condition-level noncompliance that is identified during either certification survey referenced in Section 8.
2. If CMS decides not to terminate BHD's Medicare Provider Agreement for condition-level noncompliance or for noncompliance with the regulations implementing EMTALA, identified during either certification survey referenced in Section 8, BHD must require the Expert Consultant to submit to CMS within 30 calendar days of the survey, a second written report as described in Section 4 of this Agreement that includes a Gap and Root Cause Analysis focusing on the areas for which the relevant noncompliance was found.
 - a. If CMS accepts the written report, the Expert Consultant will issue the accepted report to BHD and MCDHHS no later than two calendar days after CMS accepts it, and no later than two calendar days after receipt of the written report, BHD and MCDHHS must notify CMS in writing (via electronic mail) that they have received the report. No later than 14 calendar days after BHD and MCDHHS have received the written report, BHD must prepare, in consultation with the Expert Consultant, and submit to CMS an acceptable Corrective Action Plan that identifies the specific actions to be taken to address the condition-level noncompliance or noncompliance with the regulations implementing EMTALA (as well as any other deficiencies identified during the survey).
 - b. If CMS rejects the written report submitted by the Expert Consultant or BHD fails to submit an acceptable Corrective

Action Plan within the time frame stated above, such action shall be deemed a breach of this Agreement by BHD and CMS may proceed with termination of BHD's Medicare Provider Agreement.

11. This Agreement does not impact the Wisconsin Department of Health Services' authority to take any licensure action(s) against BHD.

12. BHD shall remain solely responsible for achieving and maintaining substantial compliance with all applicable Medicare requirements.

13. CMS is not responsible for providing BHD, MCDHHS, or its outside Expert Consultant or Compliance Consultant with technical advice in meeting BHD's obligations under its existing Medicare Provider Agreement. CMS may, however, at CMS's sole discretion, provide guidance or discuss best practices with the Expert Consultant, Compliance Consultant, BHD, or MCDHHS.

14. In fulfilling any of its duties pursuant to this Agreement, CMS may consult or seek input from the Wisconsin Department of Health Services or any contractor that performs surveys on CMS's behalf.

15. **BHD'S Right to Informal Reconsideration.** If BHD or MCDHHS wish to dispute any action taken by or on behalf of CMS under this Agreement, including possible termination of BHD's Medicare Provider Agreement at the end of this Agreement based on continued noncompliance with one or more Medicare Conditions of Participation, noncompliance with the regulations implementing EMTALA, or termination due to breach of this Agreement, it may submit a written statement with supporting evidence to CMS within 30 calendar days of receiving written notice of such action. CMS will review such submission and promptly issue a written final determination. CMS's written final determination is not subject to appeal.

16. **BHD's Waiver of Appeal Rights.** Other than requests for informal reconsideration as contemplated in Section 10.B.2 and Section 15, BHD shall neither file nor submit any action or suit against the United States, DHHS, CMS (including its officers, employees, and agents, which includes the Wisconsin Department of Health Services, but only with respect to the Wisconsin Department of Health Services in its role as an agent of CMS), or any other component of the Federal Government in any administrative or judicial forum with respect to the Medicare surveys described in the Recitals or any Medicare survey conducted while this Agreement remains in effect, including any termination action following the certification surveys referenced in Section 8 or any survey conducted in accordance with Section 10.A. This paragraph shall survive the termination of this Agreement for any reason stated here.

17. **Calendar Days.** All reference to number of days herein refers to “calendar days” rather than “business days.” All deadlines that fall on a weekend day or state and/or Federal holiday will be extended to the next full business day. Any deadlines or time parameters referenced in this Agreement may be extended for good cause at the sole discretion and approval of CMS. In the event of the need to extend any deadlines, BHD, MCDHHS, the Expert Consultant, or the Expert Compliance Consultant shall send written notice to CMS detailing the reasons for the requisite extension and the additional time needed to meet the referenced deadline or time parameters.

18. **Contract Complete.** This Agreement sets forth the full and complete basis for the resolution of this matter by the Parties. Each of the Parties shall be responsible for its own costs, including attorney fees associated with this Agreement and any amendments to the Agreement.

19. **Duplicate Copies.** This Agreement will be executed with duplicate originals signed by all Parties.

20. **Contact Notifications.** All reports and notices referenced in this Agreement are to be submitted to the Parties as follows:

For CMS:

Pam Thomas
Manager, Non-Long Term Care Certification and Enforcement Branch
Division of Survey & Certification
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601
Pam.Thomas@cms.hhs.gov

For BHD:

Linda Oczus, Chief Nursing Officer
Milwaukee County Behavioral Health Division
9455 W. Watertown Plank Road
Milwaukee, WI 53226
Linda.Oczus@milwaukeecountywi.gov

For Wisconsin Department of Health Services:

Wisconsin Department of Health
Bureau of Health Services

Attention: Ann Hansen, Section Chief, Acute Care Compliance Section
PO Box 2969
1 West Wilson Street
Madison, WI 53701-2969
Ann.Hansen@dhs.wisconsin.gov

21. **Binding.** The terms of this Agreement shall be binding on the Parties hereto, including their successors, transferees, administrators, heirs, executors, designees, assigns, agents and contractors.

22. **Authority to Execute Agreement.** Each person executing the Agreement in a representative capacity on behalf of the Parties warrants that he or she is duly authorized to do so and to bind the party he or she represents to the terms and conditions of the Agreement.

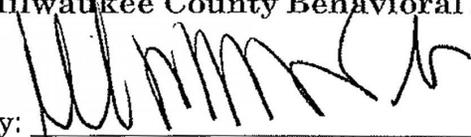
23. **Amendments.** The Parties may amend this Agreement by written agreement.

24. **Breach of Agreement.** Any terms of the Agreement not met by BHD or MCDHHS will constitute a breach of the Agreement and may result in CMS exercising its right to proceed with the termination of BHD's Medicare Provider Agreement in accordance with the notice requirements at 42 C.F.R. § 489.53(d).

25. **Public Disclosure.** In the spirit of Open Government and transparency, CMS will disclose the final terms of this Agreement, and any amendments to the Agreement when executed, in accordance with written requests for the Agreement submitted under the Freedom of Information Act, 5 U.S.C. § 552. BHD and MCDHHS will not object or administratively or judicially challenge CMS's disclosure of the Agreement or any amendments to the Agreement.

26. **Information Privacy and Security.** The Parties hereby agree all documents, information and data produced or prepared in accordance with this Agreement are subject to applicable Federal and state law privacy protections including, but not limited to, Wisconsin Statutes protecting the privilege and privacy of not public data, medical records, quality assurance, patient safety, peer review, and performance improvement activities. Consequently, the documents, information and data are protected from disclosure by exemptions to the Freedom of Information Act, including but not limited to, 5 U.S.C. § 552(b) and 45 C.F.R. §§ 5.61, 5.64, and 5.69. Exemptions protecting inter-agency or intra-agency memorandums or letters, which would not be available by law to a party other than an agency in litigation with an agency, continue to apply.

Milwaukee County Behavioral Health Division

By:  _____

8/1/2019

Date

Name: Michael Lappen

Title: Administrator _____

Centers for Medicare and Medicaid Services

By:  _____

8/5/19

Date

Associate Regional Administrator
Gregg Brandush
Division of Survey and Certification
Centers for Medicare & Medicaid Services
U.S. Dept. of Health & Human Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601

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
March	3	16	0
April	2	9	0
May	8	17	1
June	4	7	13
July	0	16	1

Overall Progress 96.0% as of August 1, 2019

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	542	530	96.2%	96.0%
Up to 1 year Overdue	13	12	2.0%	2.2%
More than 1 year and up to 3 years overdue	4	7	1.3%	1.3%
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	562	552	100%	100%

Forecast Due for Review

Past Due Policies - 22

Coming Due Policies

- August - 12
- September - 1
- October - 19
- November - 8
- December - 18

January 2020 - 8

February 2020 - 11

March 2020 - 9

April 2020 - 5

May 2020 - 38

June 2020 - 39

July 2020 - 9