



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

**2a**

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


**BHD**

 MILWAUKEE COUNTY  
 Behavioral  
 Health  
 Division

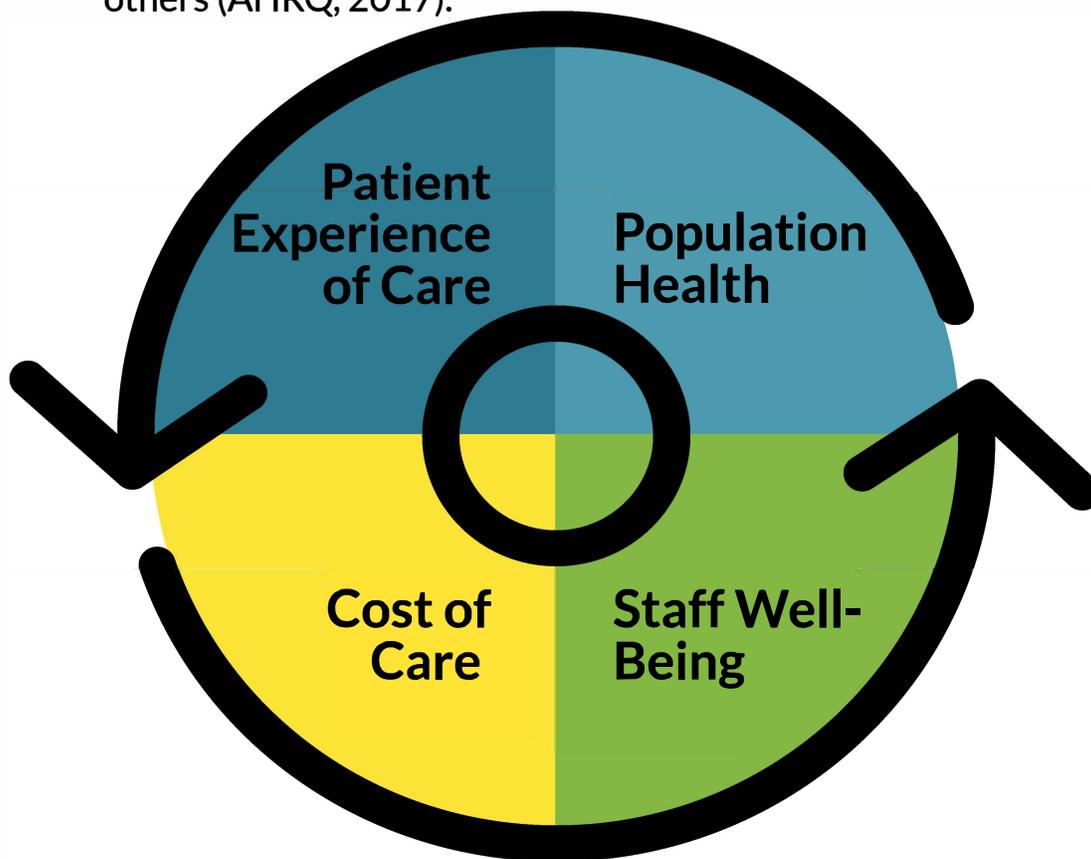
# CARS Quality Dashboard

CARS Research &amp; Evaluation Team

## The Framework: The Quadruple Aim

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

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



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

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

# CARS QUALITY DASHBOARD SUMMARY Q1 2020

## CHANGES AND UPDATES

### Further Development of the Quadruple Aim

The CARS Quality Dashboard, driven by the CARS Quality Plan, continues to be revised, refined, and enhanced. Please see below!

#### Population Health

For the first time since we began disaggregating our quality of life outcome metric by race, the rates of improvement among African American clients achieved statistical significance, though it was still lower than that of Caucasian clients. However, since we began tracking this metric approximately 1 year ago, we have seen a gradual increase in the degree of improvement among African Americans relative to Caucasian clients. We will continue to disaggregate, monitor, and further explore these data to ensure we helping to advance the County Executive's racial equality imperative. A second notable revision to this iteration of the Quarterly Dashboard is the addition of changes in Psychiatric Crisis Service and detoxification admissions in the 30 days before and after entry to CARS services.

#### Patient Experience of Care

As noted at the MHB Quality Committee meeting in March of 2020, CARS has begun the implementation of a new client experience survey. The distribution of this survey has gone even better than expected, and we have expanded its use to several CARS programs, including one program as a performance incentive. Notably, several programs in the Crisis Department at BHD have also begun to use the survey. This past quarter CARS also rapidly deployed a Satisfaction with Telehealth Services survey to assess the impact of the Stay at Home order on service provision to CARS clients; please see the attached PowerPoint for preliminary results.

#### Staff Wellbeing

The groundwork completed by the CARS Staff Quality of Life workgroup paid immediate dividends once the Stay at Home order was issued and allowed most of the CARS staff to make the transition to telework relatively seamlessly. Further, CARS has instituted a Staff Enrichment Seminar series, which is focused on staff professional development and provides a knowledge-sharing platform for all CARS staff. This Seminar series has provided the opportunity for professional growth and ongoing engagement for CARS staff, which has been of critical importance to maintain collaborative and positive relationships during this period of remote work.

#### Cost of Care

The cost per member per month has been updated for the first quarter of 2020. The process of building an automated report for this metric is temporarily on hold because of competing demands.

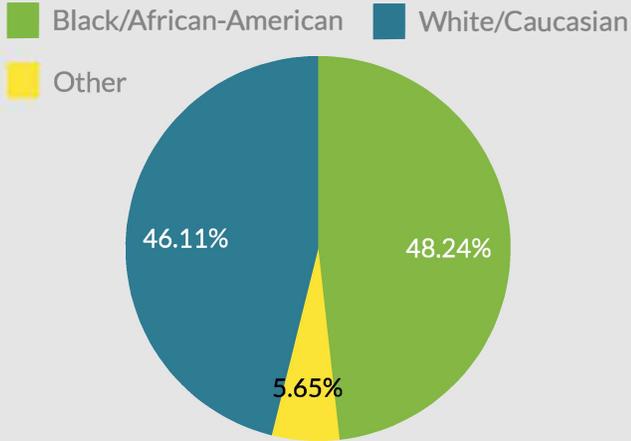
## NEXT STEPS

CARS will continue to monitor the racial disparities in our quality of life outcomes. Further, we intend to expand our distribution and use of the brief Client Experience Survey discussed above, and we also plan to further standardize our processes and guidance for performance measure implementation, analysis, and response. We will use our Telehealth Client Experience Survey results, along with our new temporary telehealth location codes, to continue to evaluate the efficacy, impact, and viability of telehealth services and position our system for potential telehealth expansion. Within the next few months, we will complete preliminary analyses for risk stratification, which we will then use in our Value model pilot project later this year. We will be expanding our use of our data visualization capabilities in CARS to help facilitate data literacy and data-driven decision making. Finally, we look forward to collaborating with our colleagues in other BHD departments to develop a set of inter-related metrics centered on crisis admissions.

# Demographic Information of the Population We Serve

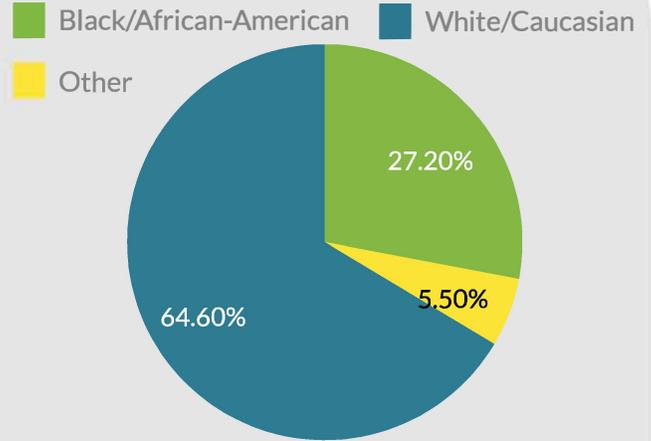
This section outlines demographics of the consumers CARS served last quarter compared to the County population.

## Race (CARS)



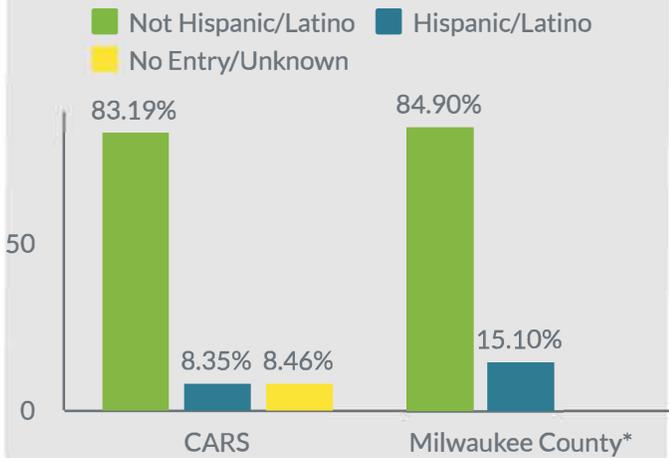
"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

## Race (Milwaukee County)\*

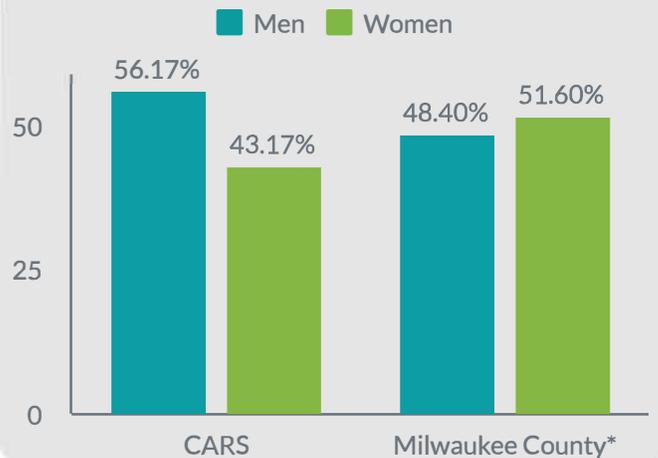


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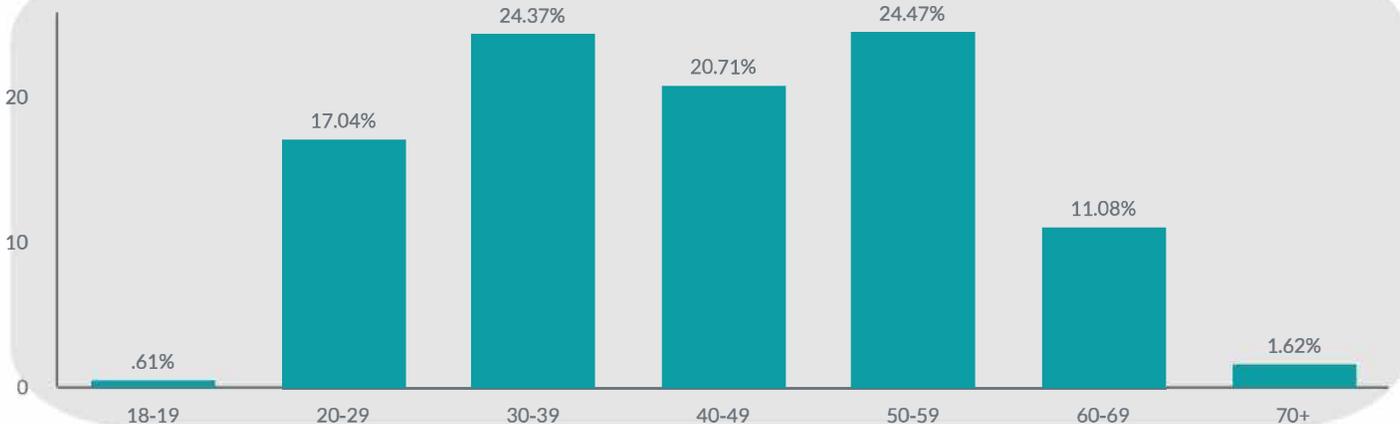
## Ethnicity



## Gender



## 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>



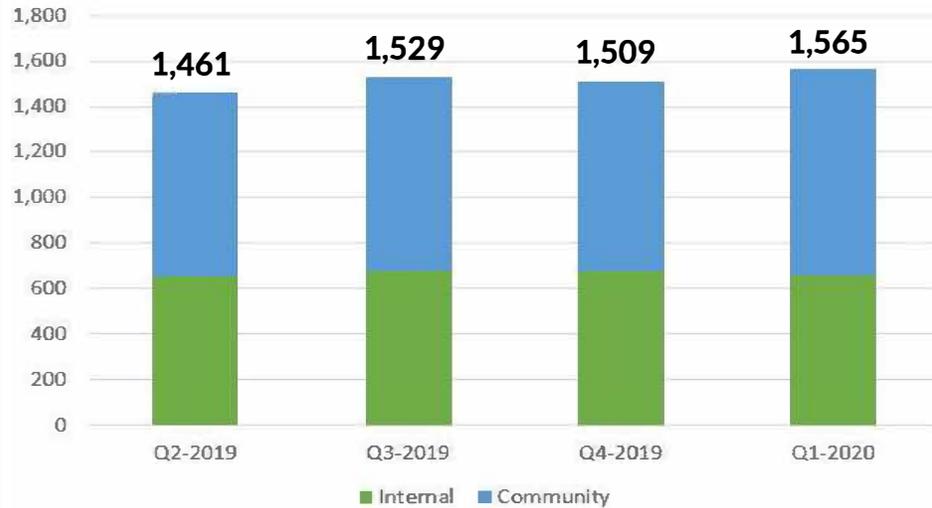
## Domain: Patient Experience of Care

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



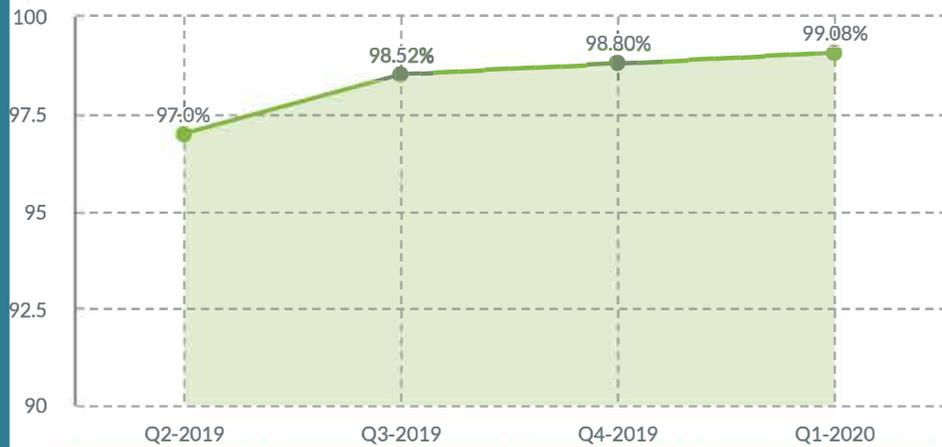
### Referrals

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.



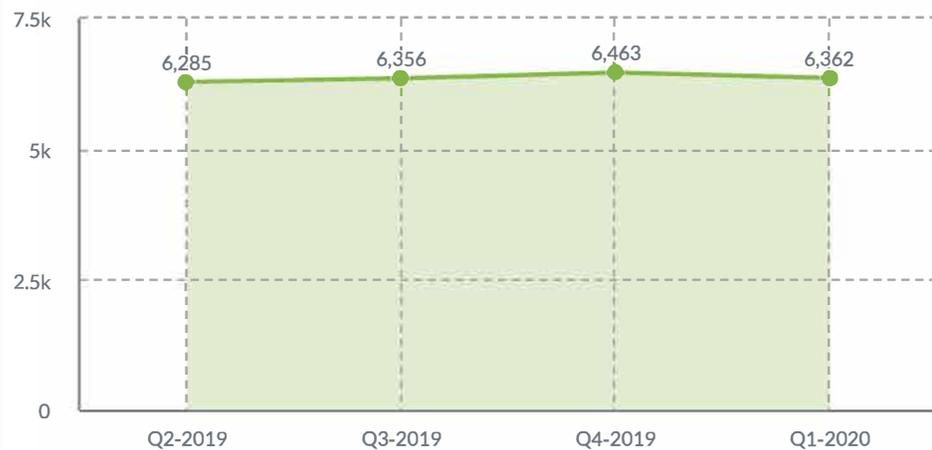
### Admissions

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.



## Consumer Satisfaction



Through the onset of telehealth services due to the COVID-19 pandemic, the CARS R&E team has become interested in client feedback regarding their satisfaction with telehealth services.

**695**  
surveys received

**61.30%** liked telehealth services more than or the same as face-to-face

**75.90%** thought telehealth services were easier, or just as easy, as face-to-face

**72.40%** thought telehealth services were more helpful, or just as helpful, as face-to-face



## 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.



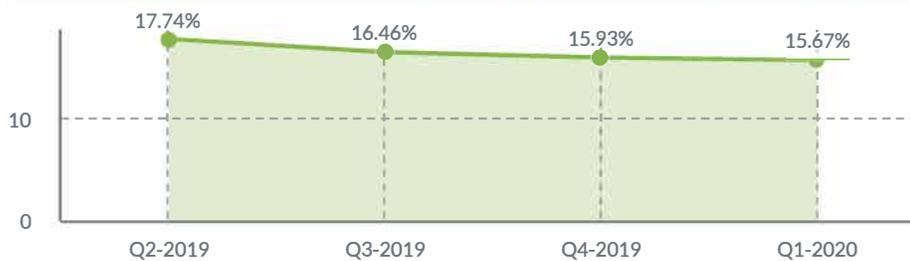
### Acute Services

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



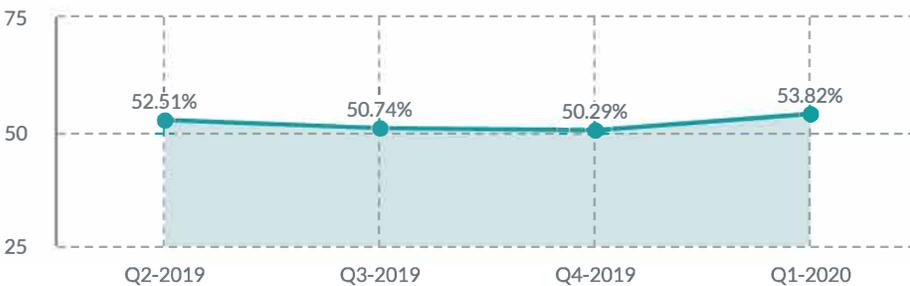
### ER Utilization

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.



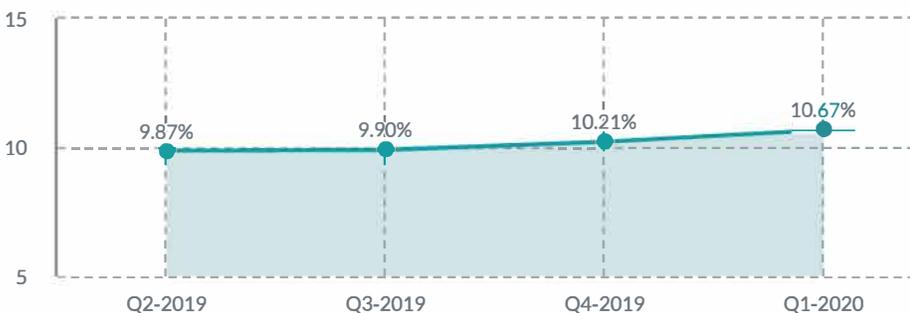
### Abstinence

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".





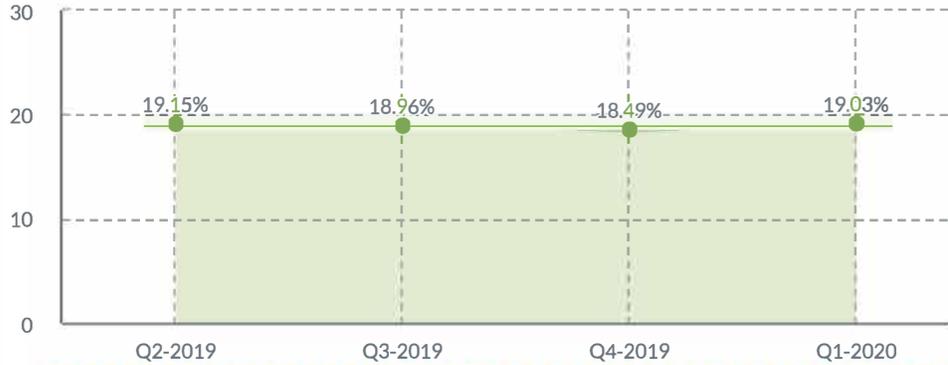
# Domain: Population Health (Continued)

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.

## Employment



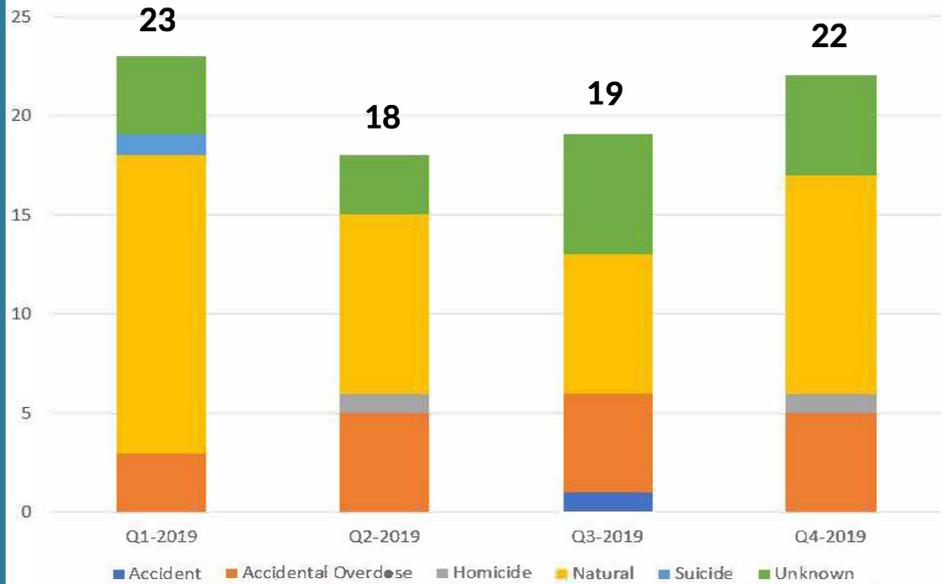
Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".



## 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.

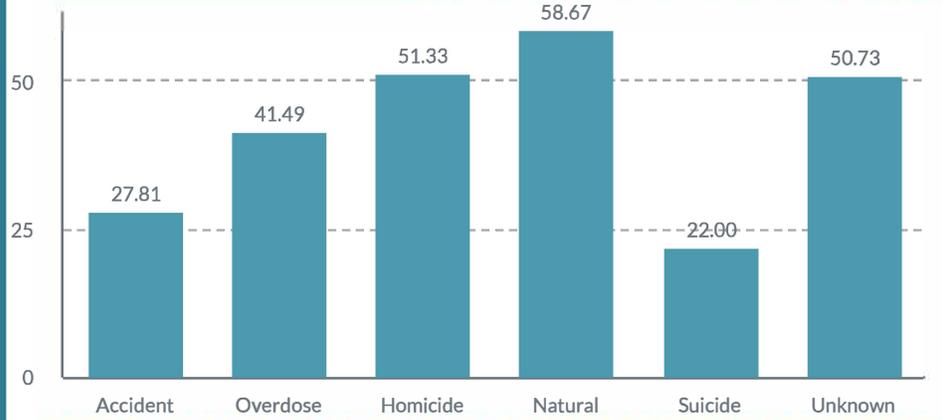
Note: There is a lag in death reporting. See note in the next item.



## 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.



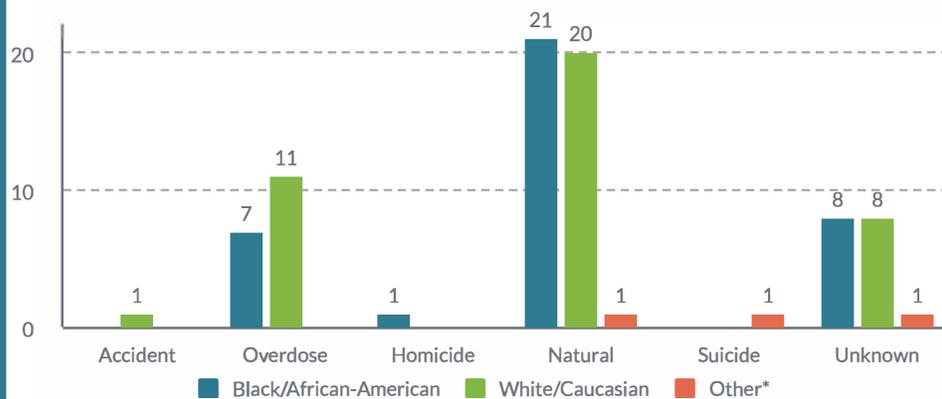
## Cause of Death

Distribution of consumers by race for each cause of death for the four previous quarters.

Total Black/African-American: 38  
Total White/Caucasian: 41  
Total Other: 3

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

\*Other includes "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"



## 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.

Data is not yet available for Q1-2020.



### Domain: Cost of Care

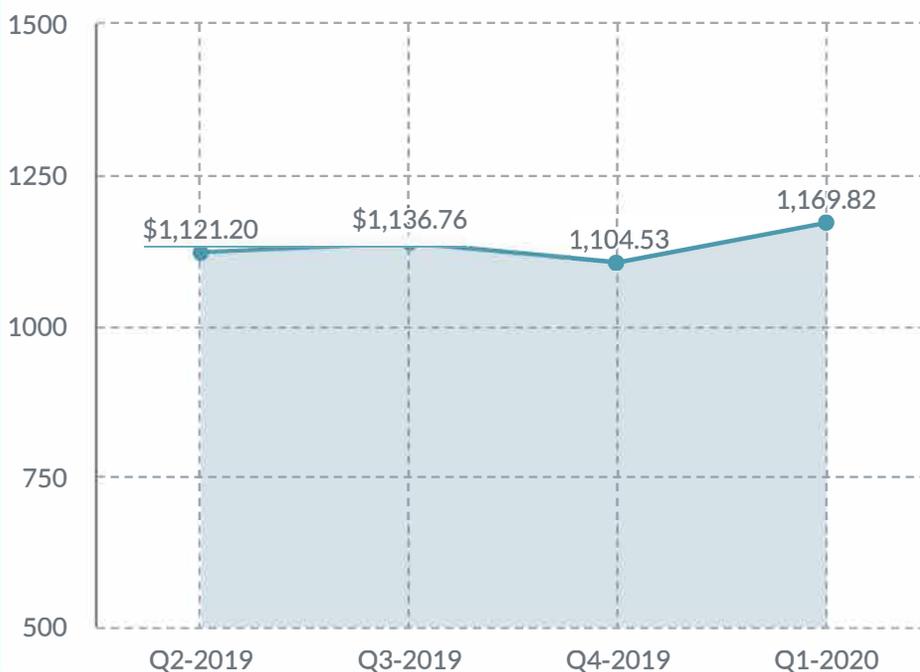
Cost of care compares average cost per month over the past four quarters in order to indicate change over time.

### Average Cost Per Consumer Per Month

The average cost per consumer per month within each quarter for CARS services received by CARS consumers (not including inpatient and crisis). This is not separated out by funding stream or limited to those dollars spent by Milwaukee County on these services. The average number of consumers per month within each quarter is below:



Q2 - 2019 N = 5,225	Q3 - 2019 N = 5,285
Q4 - 2019 N = 5,404	Q1 - 2020 N = 5,456



### Domain: Staff Well-Being

### Turnover

Turnover is calculated by looking at the total number of staff who have left over the previous four quarters, divided by the average number of employees per month, for the previous four quarters



**11.10%**

CARS turnover rate

**20.00%**

Turnover rate for government employees (per year)\*

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



### Staff Quality of Life

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

# 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.

Q1 2020



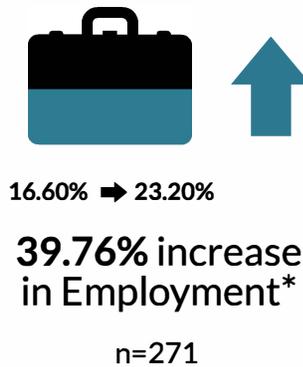
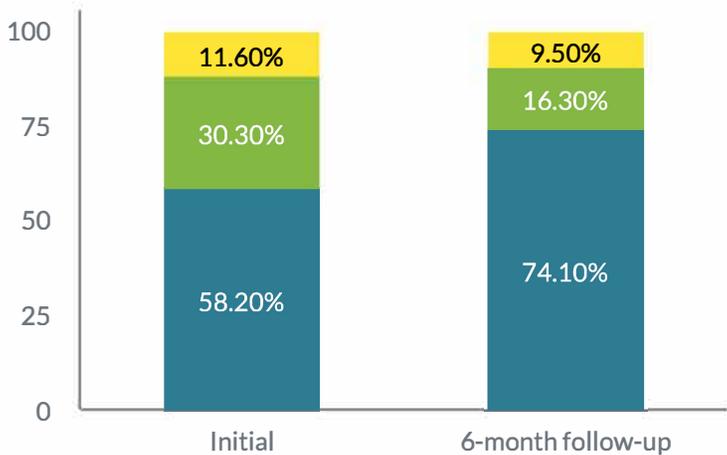
## Health Outcome

75.00% increase in Good or Very Good self-reported Quality of Life\*\*\*  
n=204

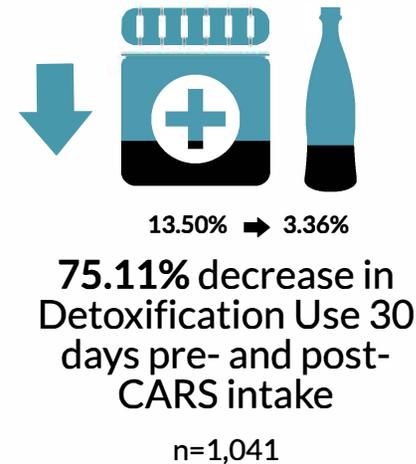
## Social Determinants

27.32% increase in "Stable Housing"  
n=294

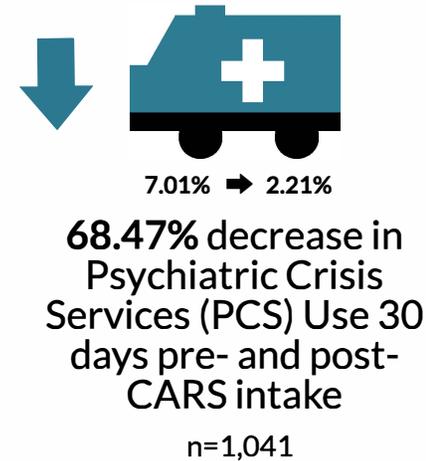
46.20% decrease in Homelessness



## Health Behaviors



## Clinical Care



■ Stable Housing (Permanent or Supportive Apartments)  
■ Homeless ■ Other

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

# Health and Well-Being

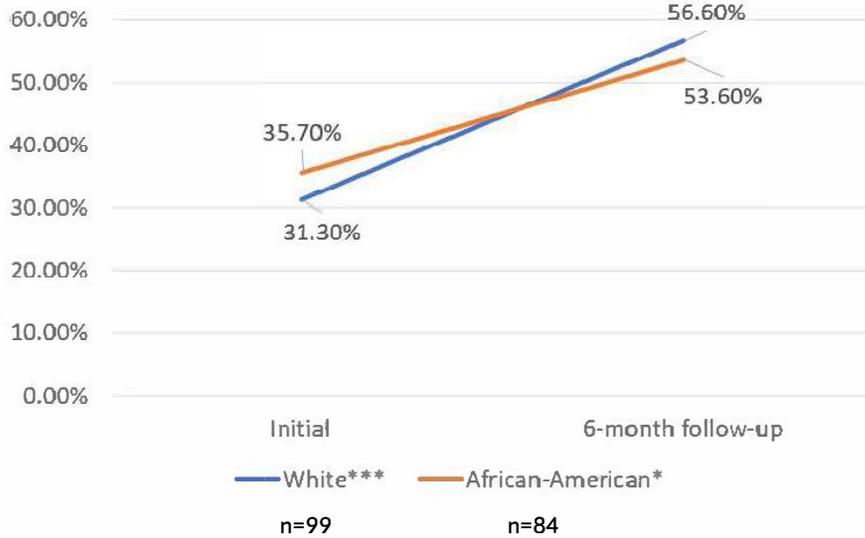
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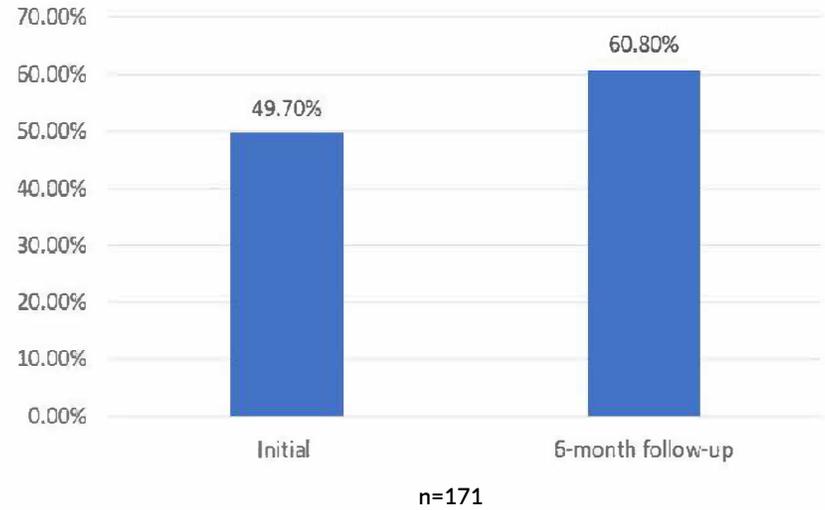
Q1 2020

## Other Metrics

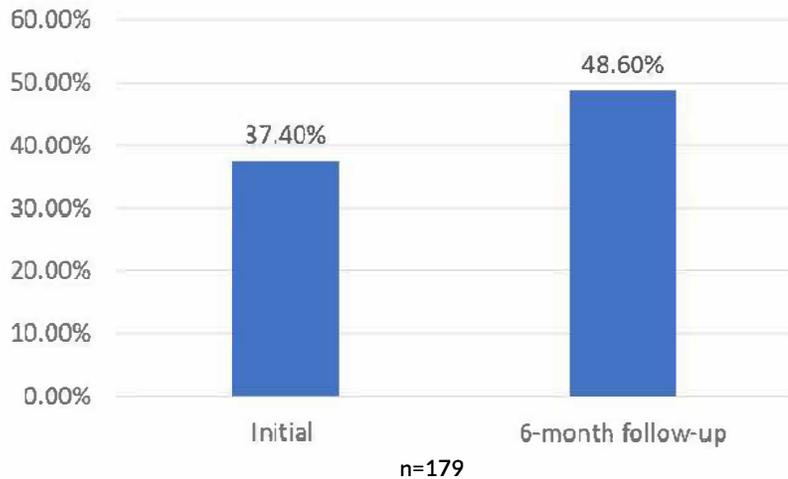
### Proportion of Consumers indicating "Good" or "Very Good" Quality of Life



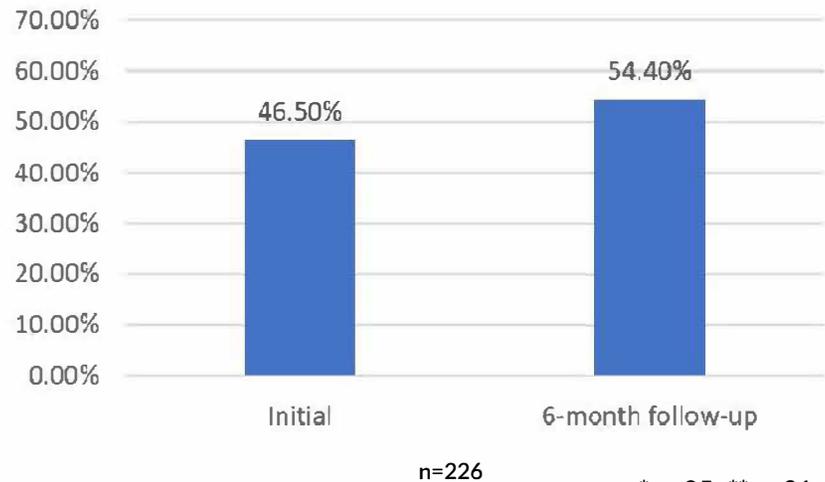
### Able to Manage Daily Tasks (Most or All of the Time)\*



### Able to Form/Maintain Close Relationships (Most or All of the Time)\*



### Self-Rated Physical Health (Good or Better)



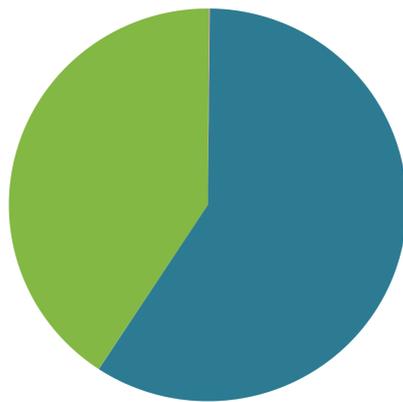
\*p<.05 \*\*p<.01 \*\*\*p<.001



**Volume Served**  
**10,224**

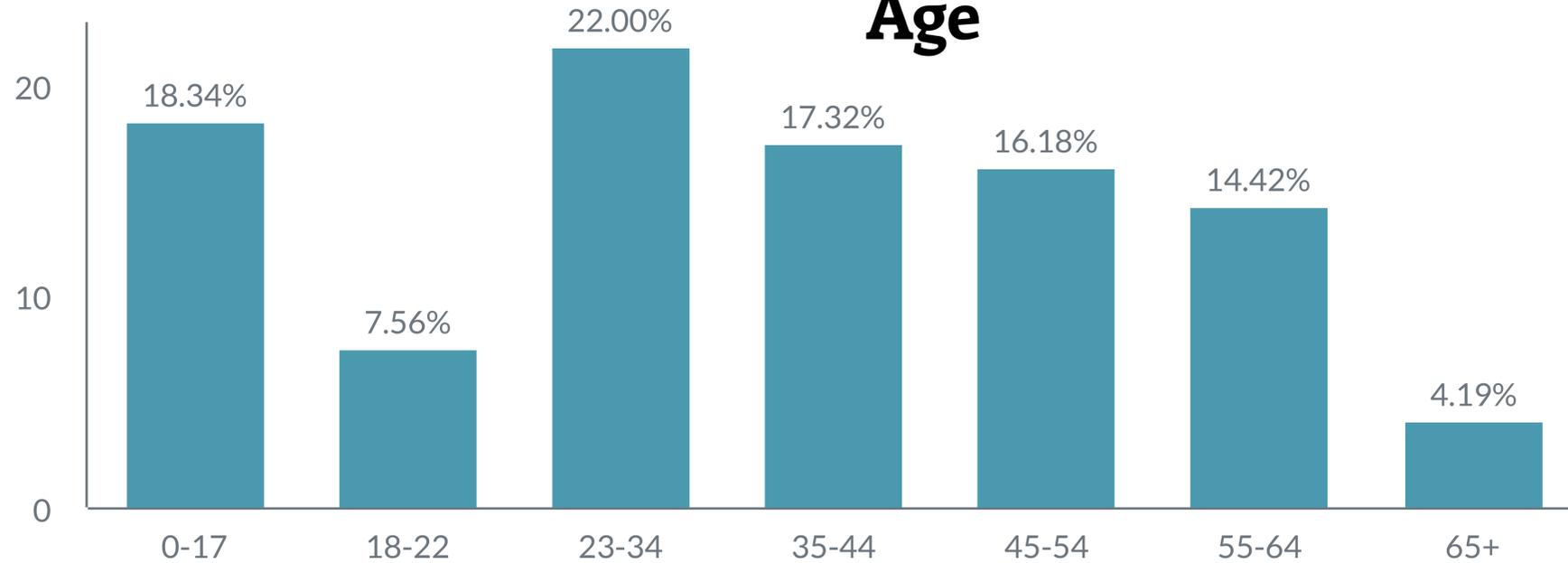
## Gender

- Men (59.09%)
- Women (40.86%)
- Other\* (0.05%)



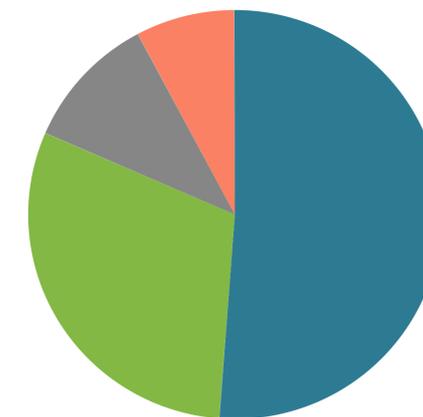
\*"Other" encompasses transgender, non-binary, and other individuals

## Age



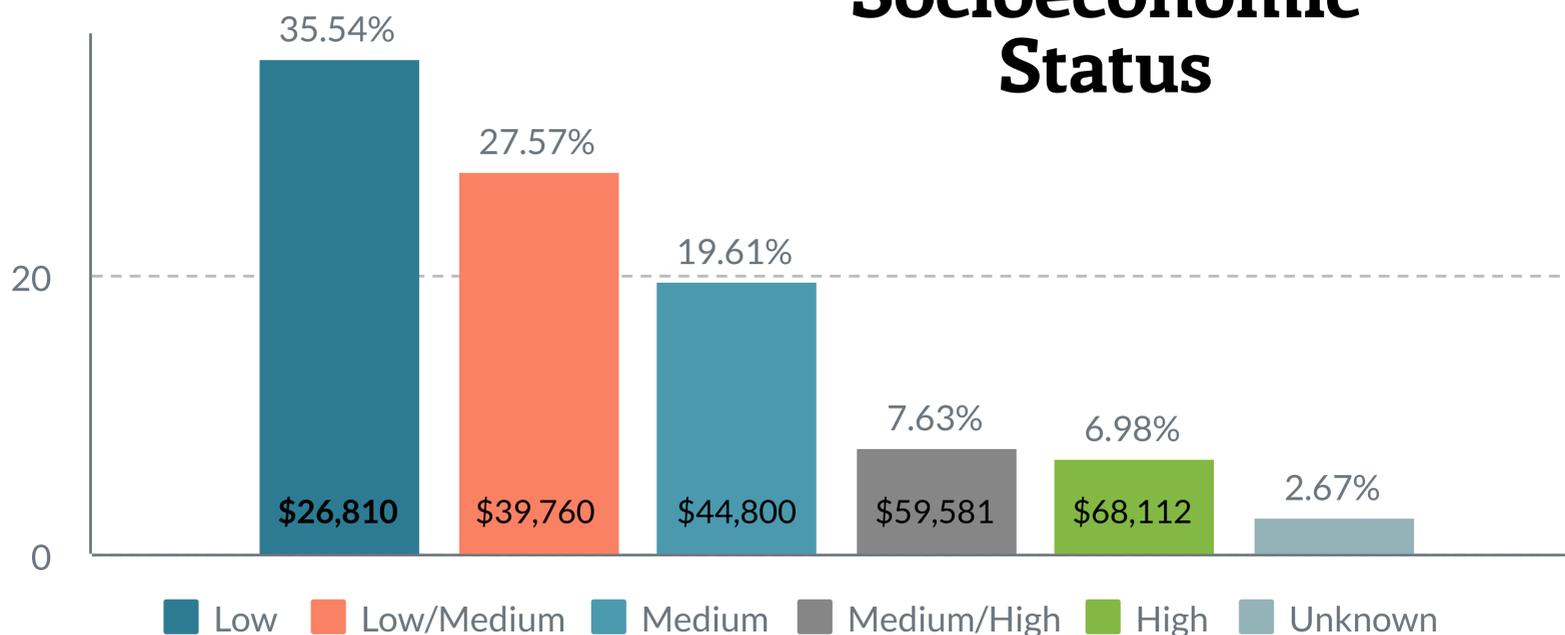
## Race/Ethnicity

- Black/African-American (51.25%)
- White/Caucasian (30.31%)
- Hispanic (10.7%)
- Other\* (7.74%)

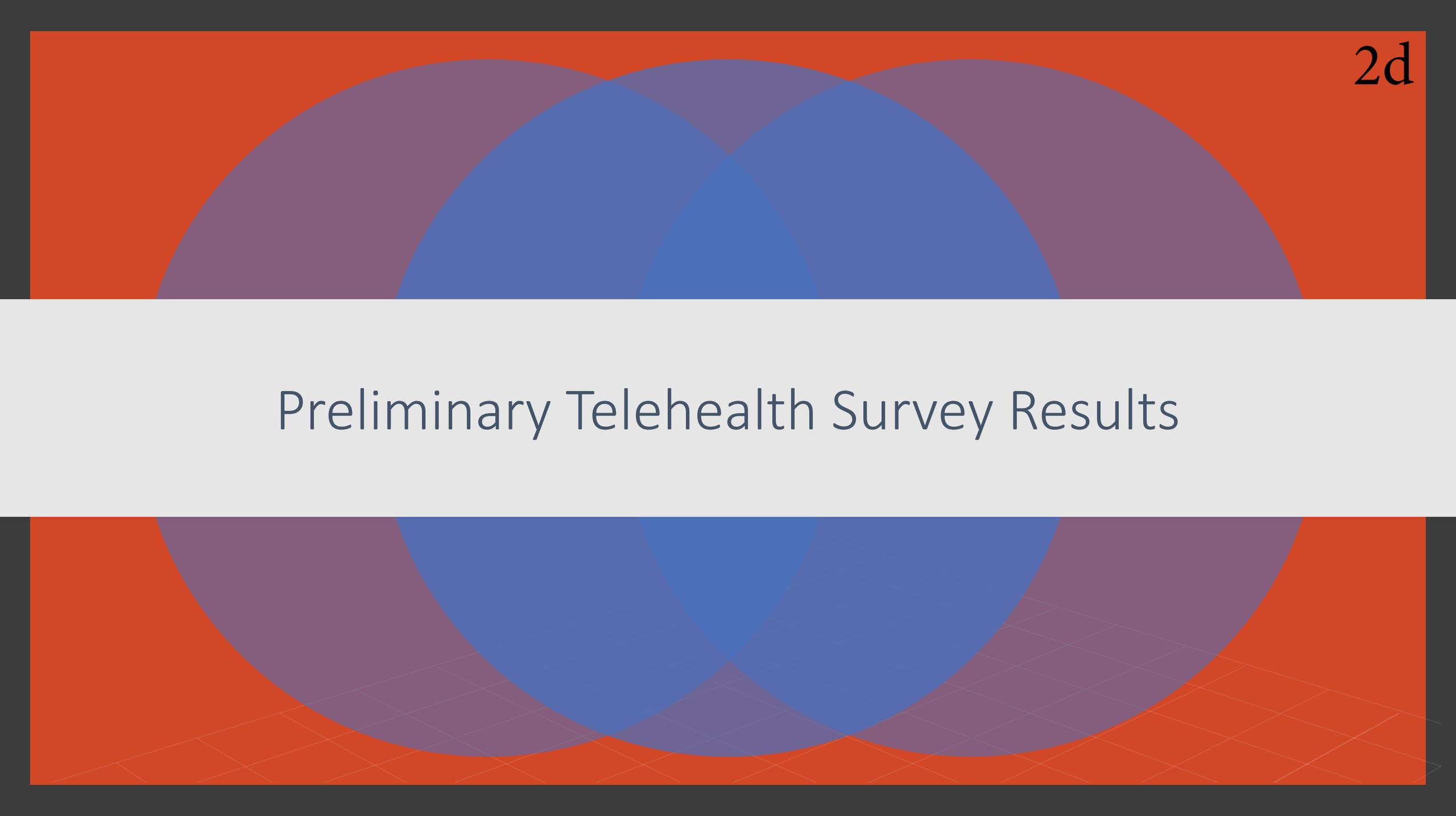


\*"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", "Other", and N/A

## Socioeconomic Status

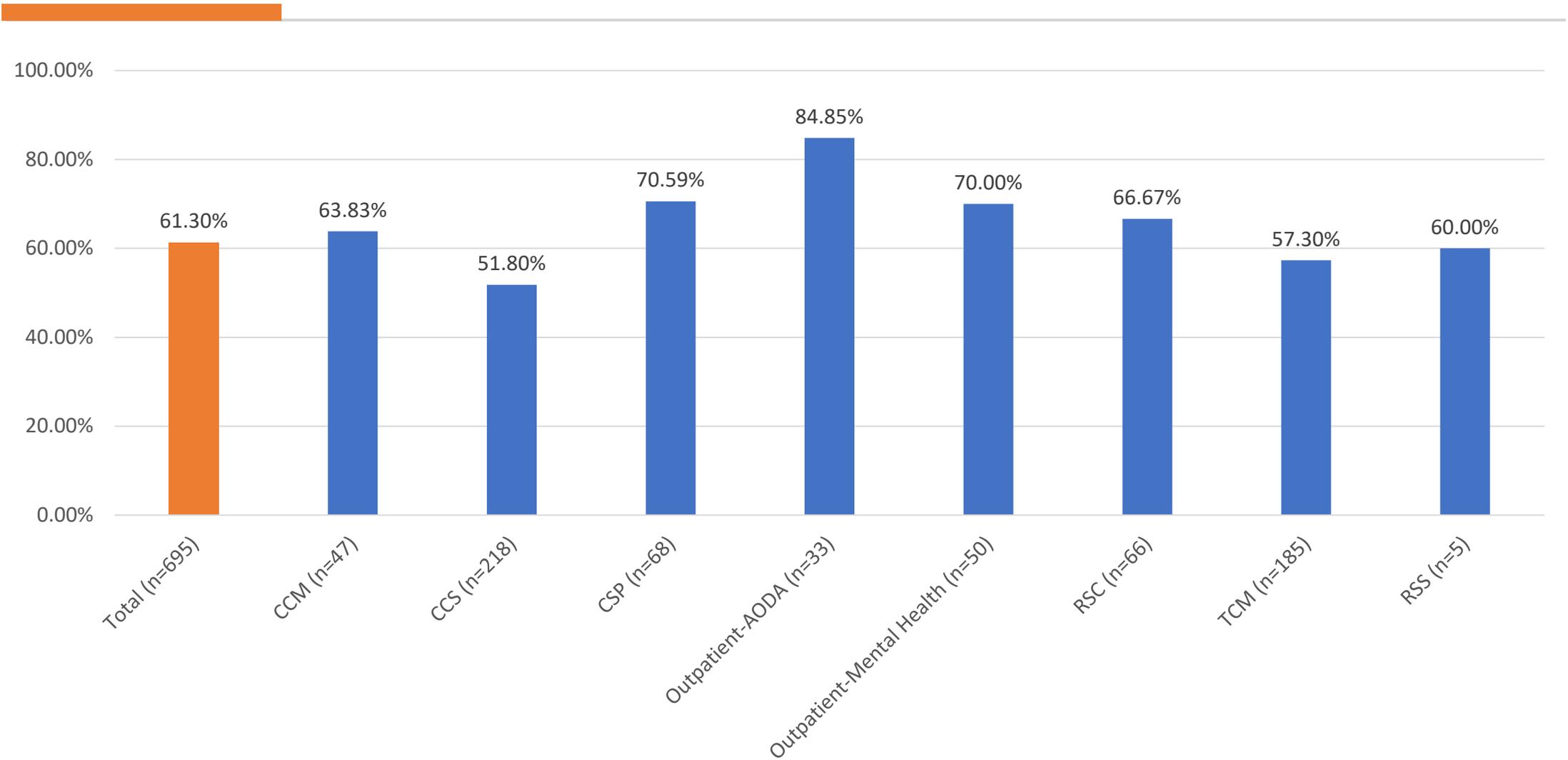


SES is determined based on income and education levels, and calculated based on zip code. Median income is listed for each group.

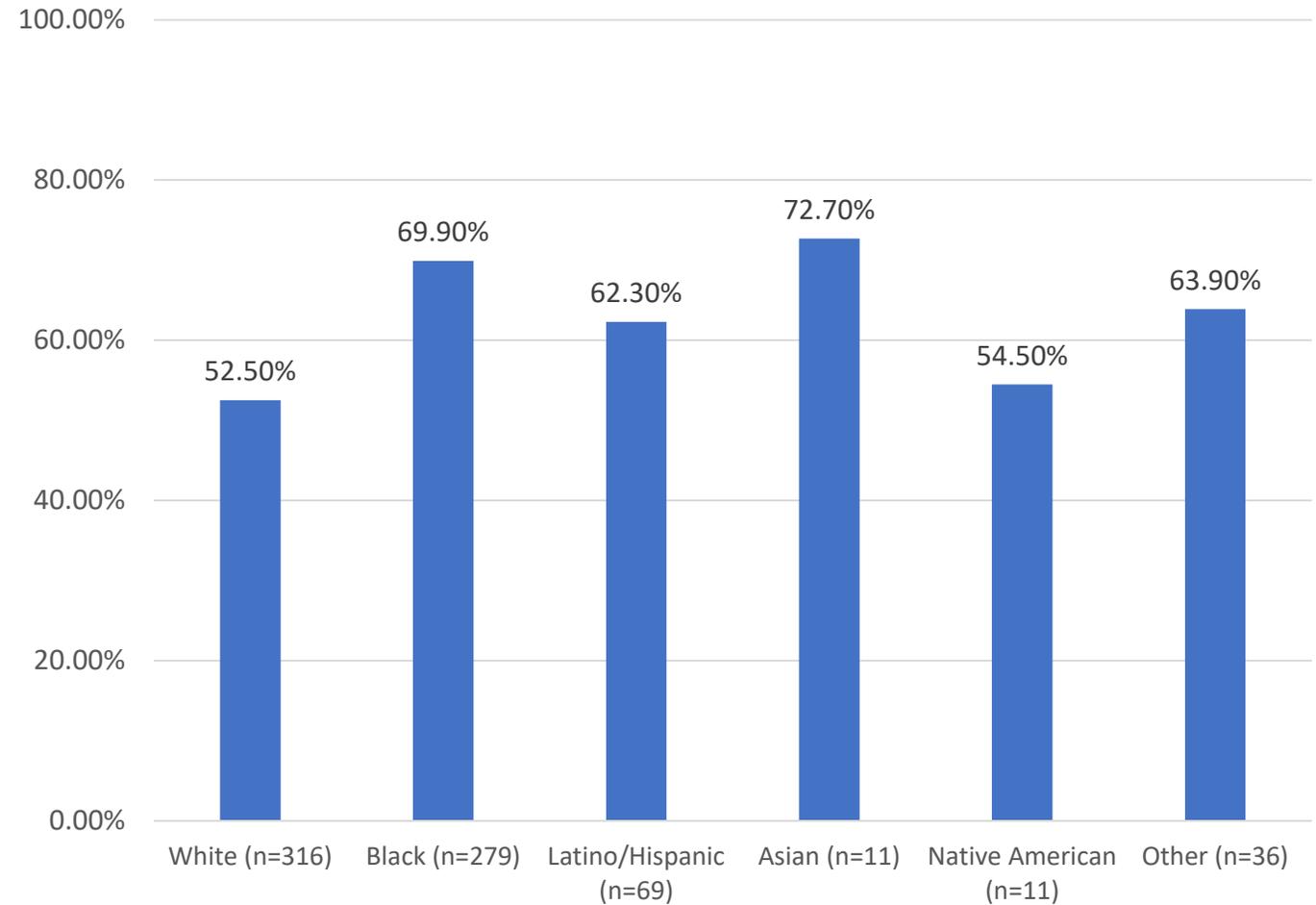
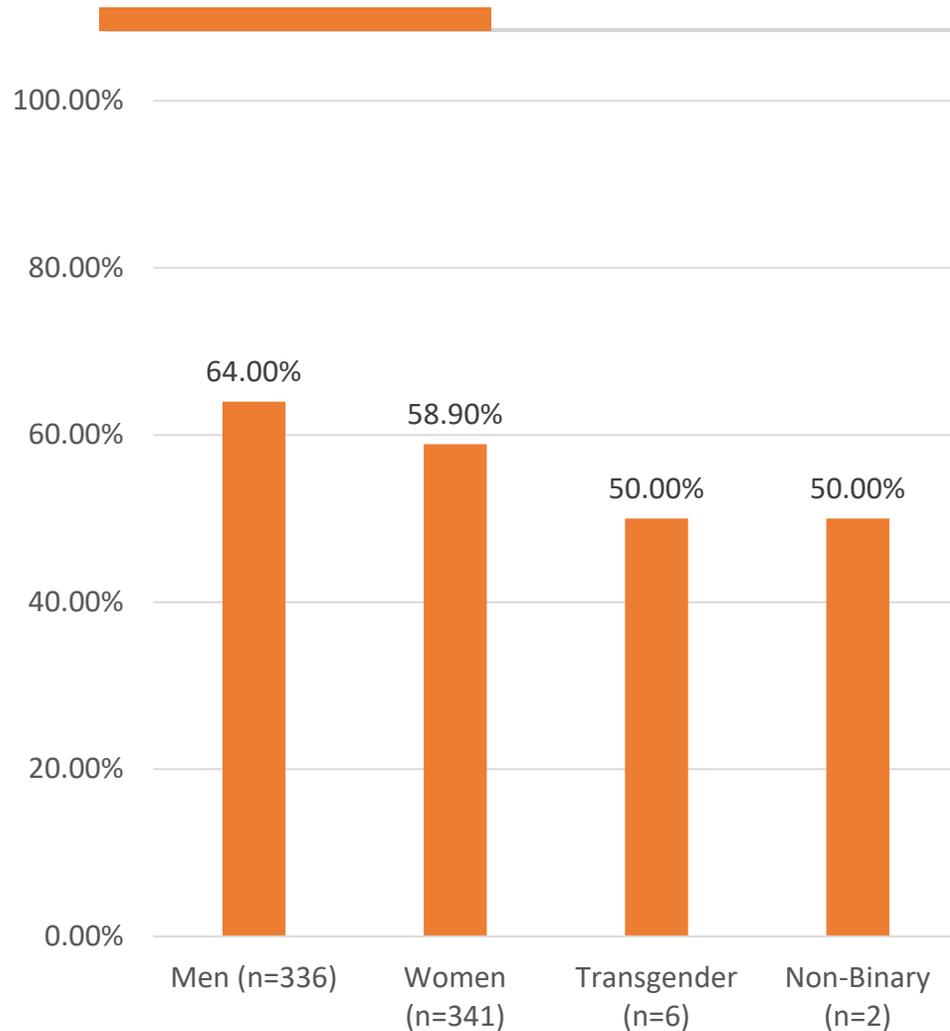
The background features a central white horizontal band containing the title. Above and below this band are orange rectangular sections. Within these orange sections, there are three overlapping semi-circles of varying shades of blue and purple. The bottom orange section also contains a faint white grid pattern.

# Preliminary Telehealth Survey Results

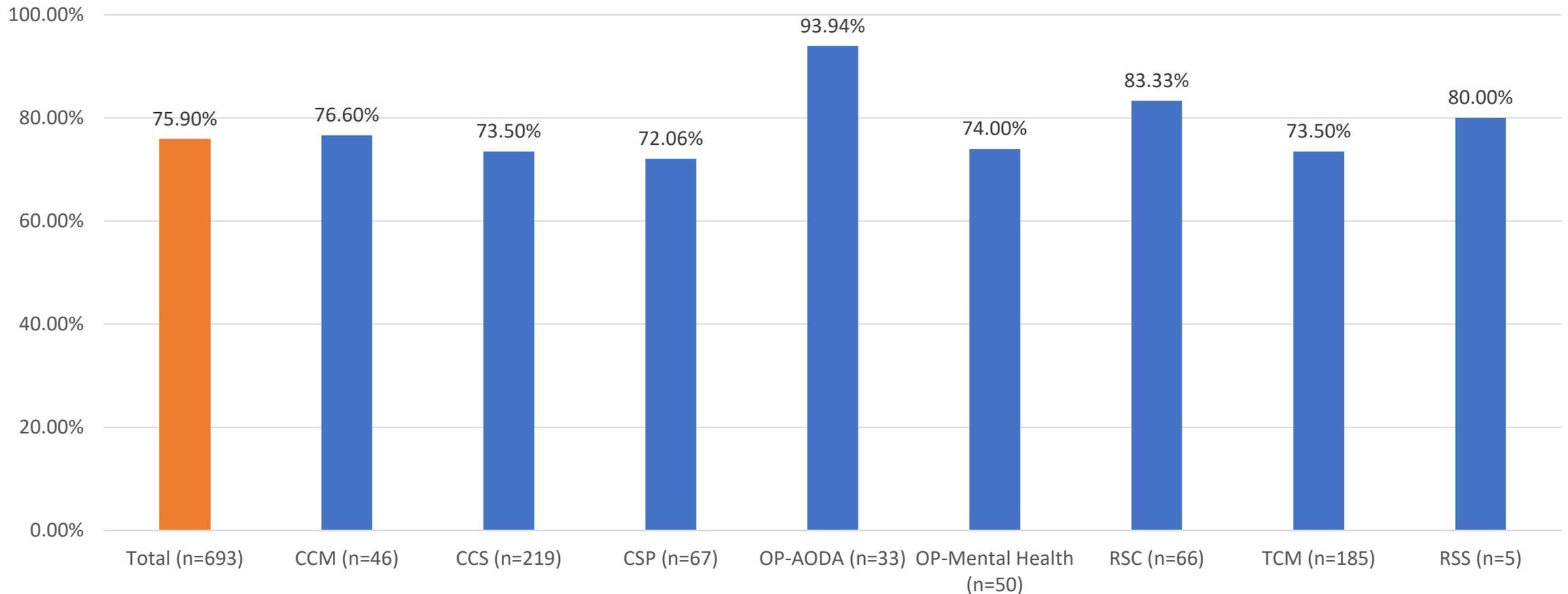
# Percent of Respondents Stating They Liked Telehealth More Than, or the Same as, Face-to-Face Services



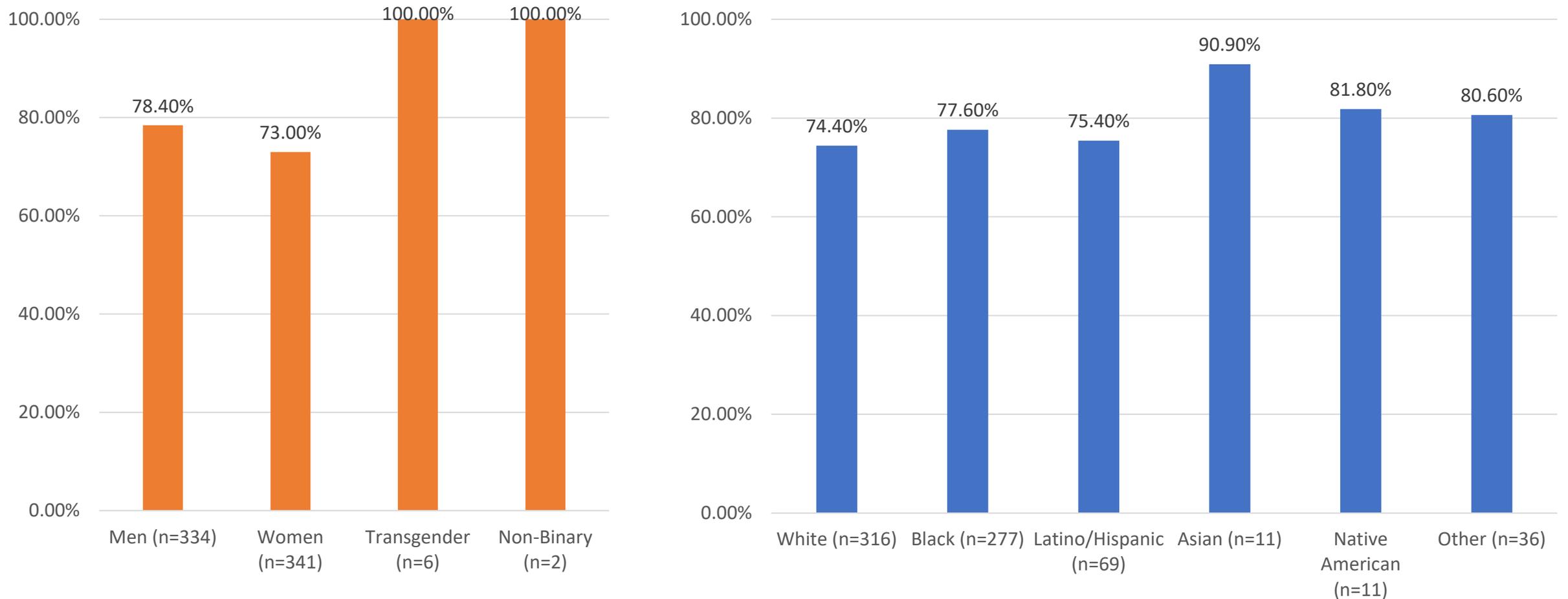
# Percent of Respondents Stating They Liked Telehealth More Than, or the Same as, Face-to-Face Services



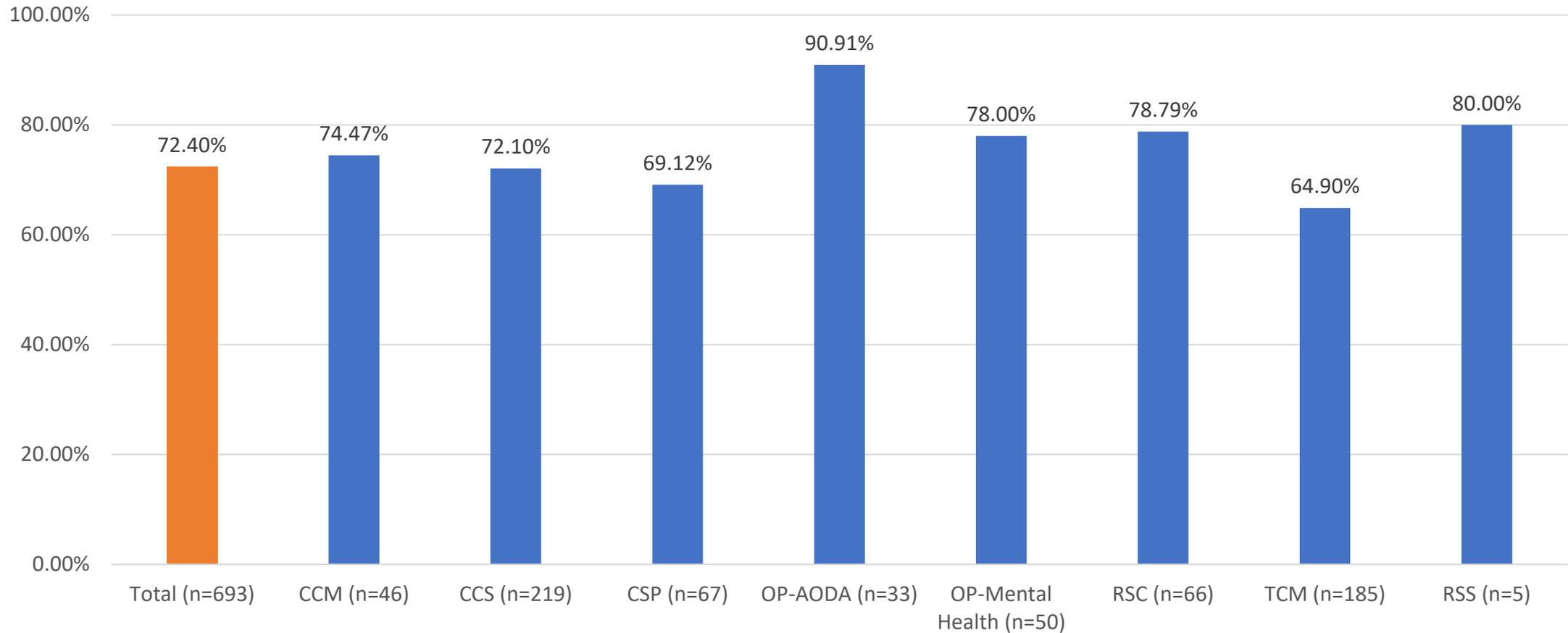
# Percent of Respondents Stating that they think Telehealth is Easier to Use than, or as Easy as, Face-to-Face Services



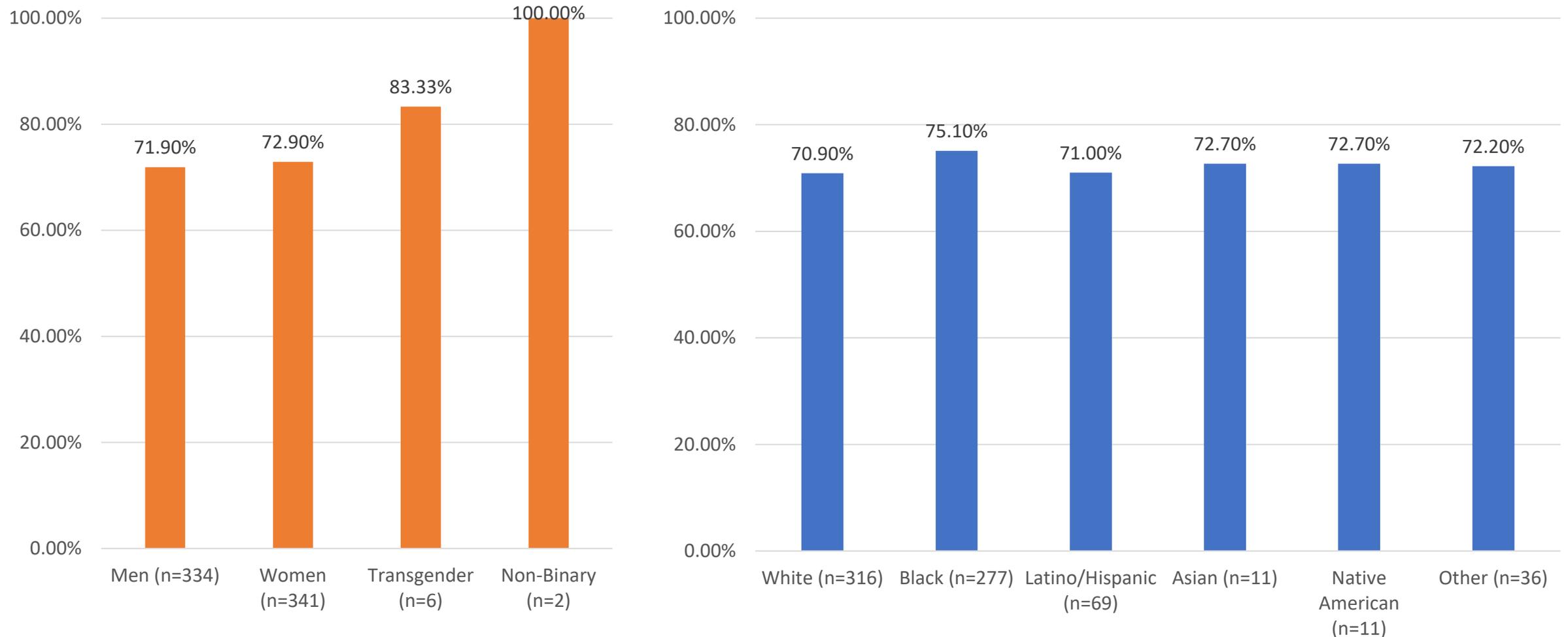
# Percent of Respondents Stating that they think Telehealth is Easier to Use than, or as Easy as, Face-to-Face Services



# Percent of Respondents Stating that they think Telehealth is More Helpful than, or Just as Helpful as, Face-to-Face Services

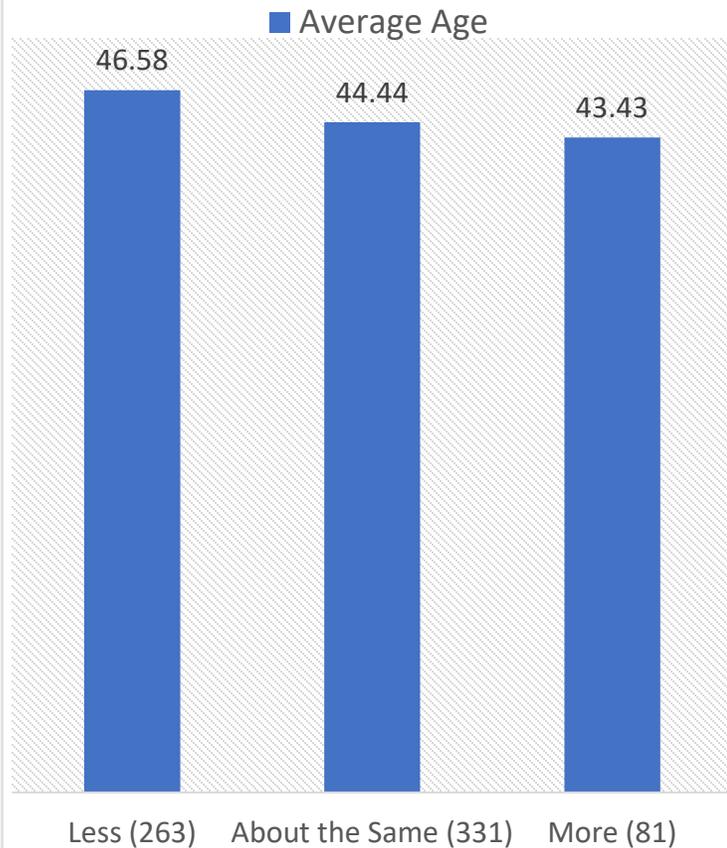


# Percent of Respondents Stating that they think Telehealth is More Helpful than, or Just as Helpful as, Face-to-Face Services

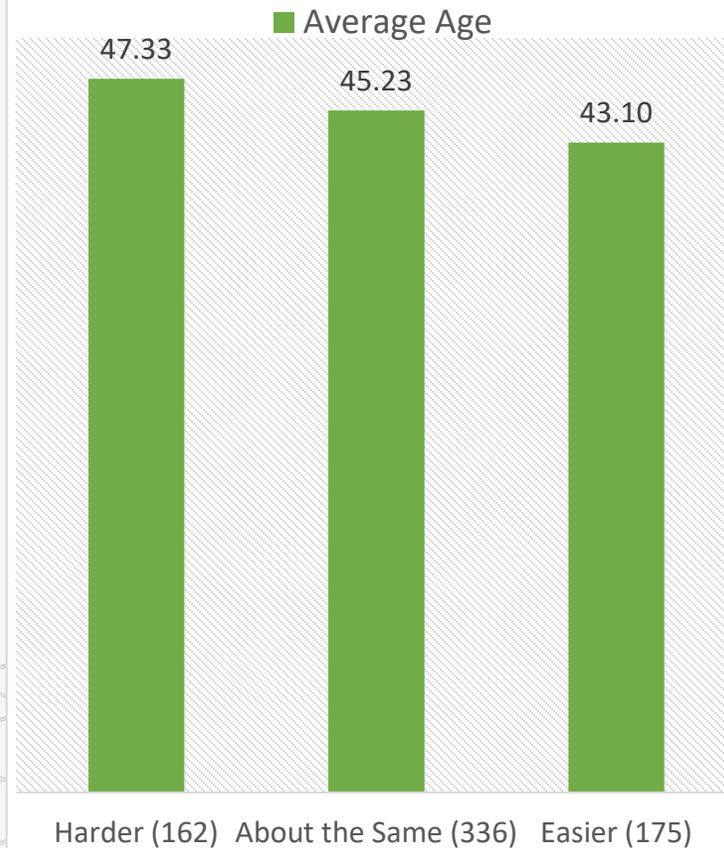


# Telehealth Experience Variable by Age

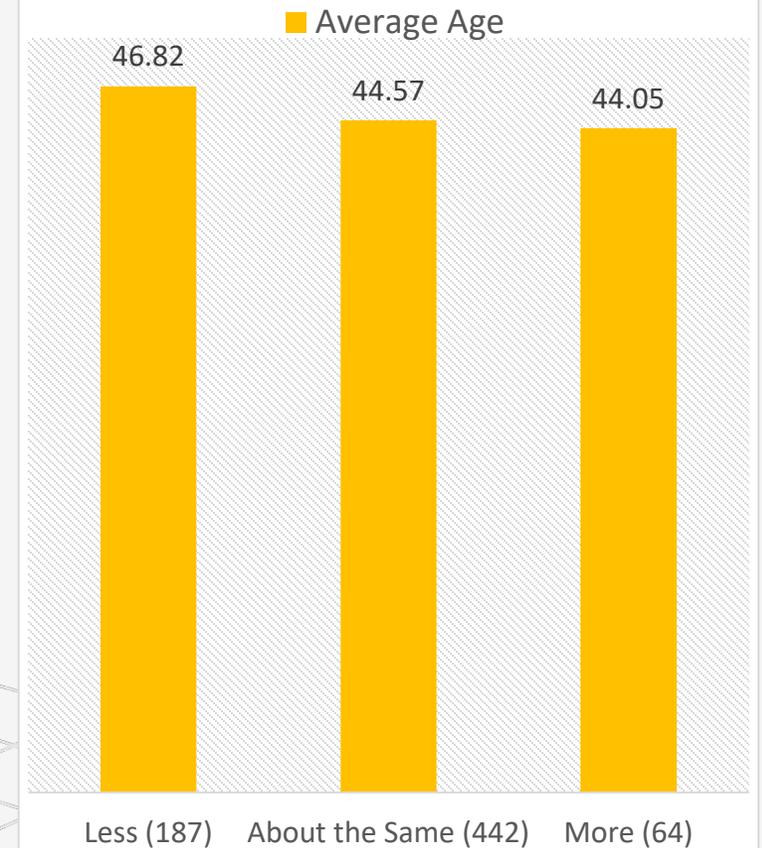
Like Telehealth Services Relative to Face to Face



Ease of Use of Telehealth Relative to Face to Face\*

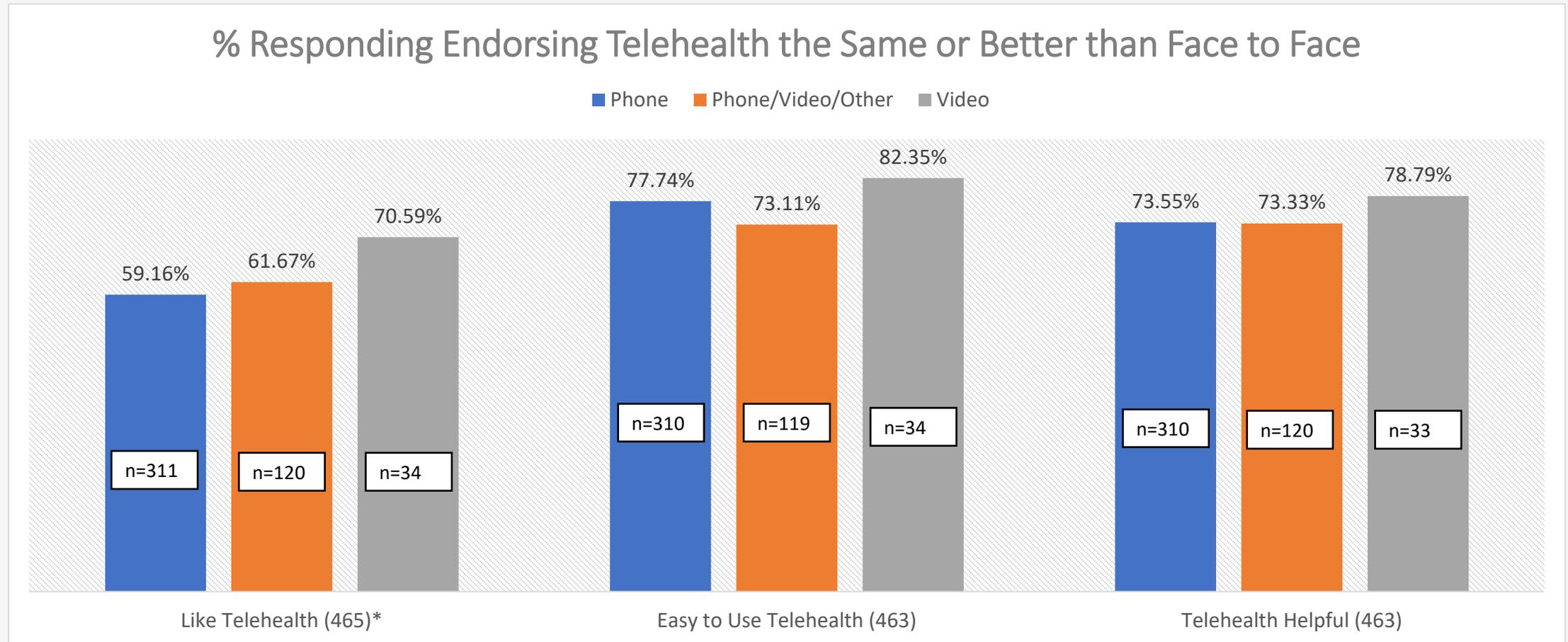


Telehealth Services as Helpful as to Face to Face



\*  $p = .017$

# Type of Telehealth Service by Experience Question



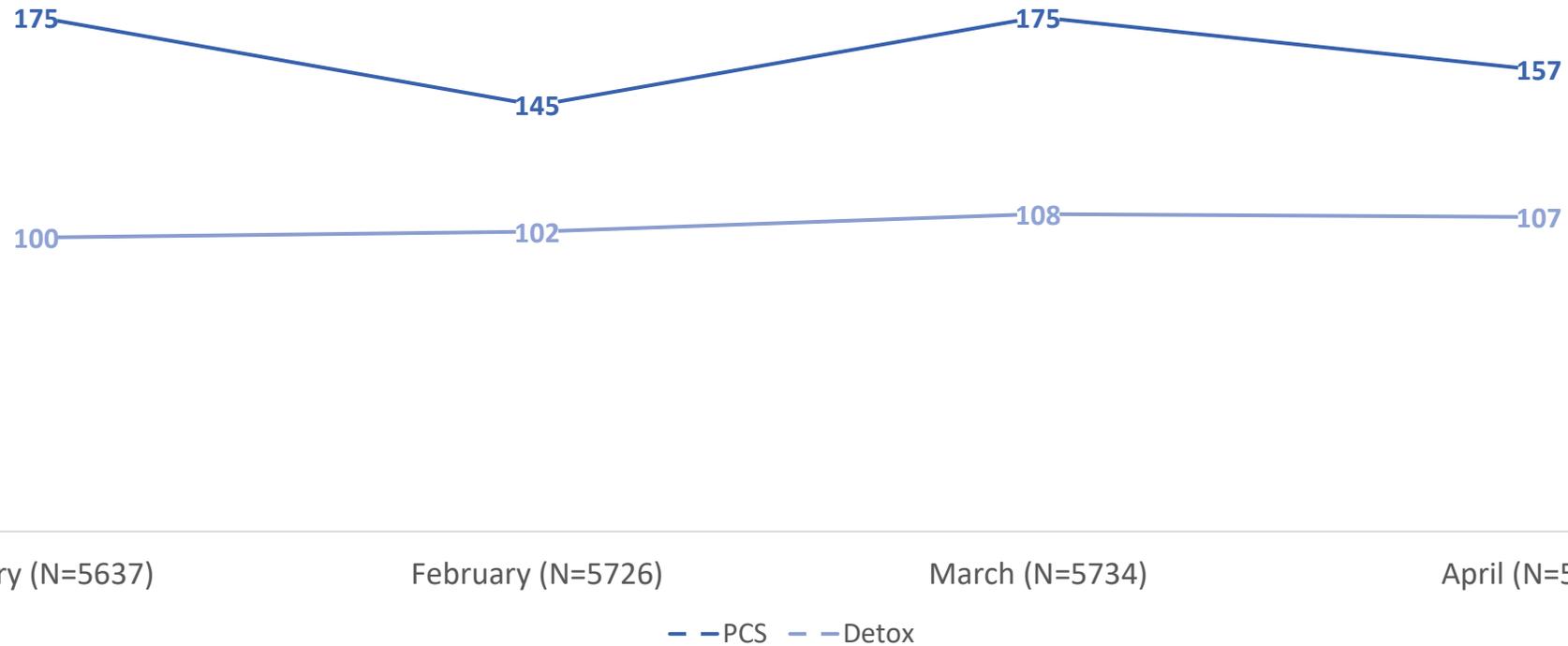
\* When examining only those who liked telehealth more, a statistically significantly greater proportion received videocalls only relative to the other two categories (26.5% vs. 11.7% and 10.6%, respectively;  $p = .026$ )

# Qualitative Feedback

---

- 268 comments were analyzed for themes
- Most common themes
  - 66 respondents stated they want or prefer face-to-face visits only
  - 38 stated they like telehealth services
  - 36 stated that they have lost and/or miss personal interaction with providers
  - 32 stated that telehealth services are convenient
  - 24 stated they like face-to-face services, but understand that telehealth is needed to due to the pandemic.
  - 20 stated that telehealth should remain an optional service going forward.

## TOTAL VISITS



Count of PCS and Detox Services:  
January 1 through April 30, 2020

# Way Too Early Conjectures



More than half of all sampled clients reported comparable or better satisfaction with telehealth



Client satisfaction did not follow an illness severity gradient



Race appears to influence satisfaction with telehealth, gender less so



Modest relationship between age and ease of use and satisfaction with telehealth and telehealth modality



There did not appear to be a demonstrable change in PCS or detox visits

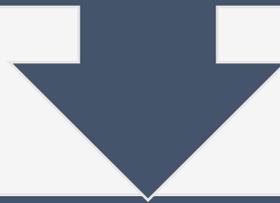


Data tentatively suggests preliminary support for telehealth service expansion

# Key Considerations

---

Does the network have the infrastructure to support such an expansion



Is telehealth more appropriate for some clients than others?

Illness severity

Longevity in service

Social determinants  
(transportation)

Within program

Within client  
factors



VALUE IN HEALTHCARE: A PHASED  
APPROACH

# VALUE IN HEALTHCARE AND THE QUADRUPLE AIM

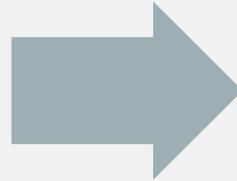
- Value in healthcare is founded upon the accurate measurement and application of the Quadruple Aim



## NEXT STEPS: VALUE MODEL AS ROADMAP

Descriptive

- Quadruple Aim



Actionable

- Value Model

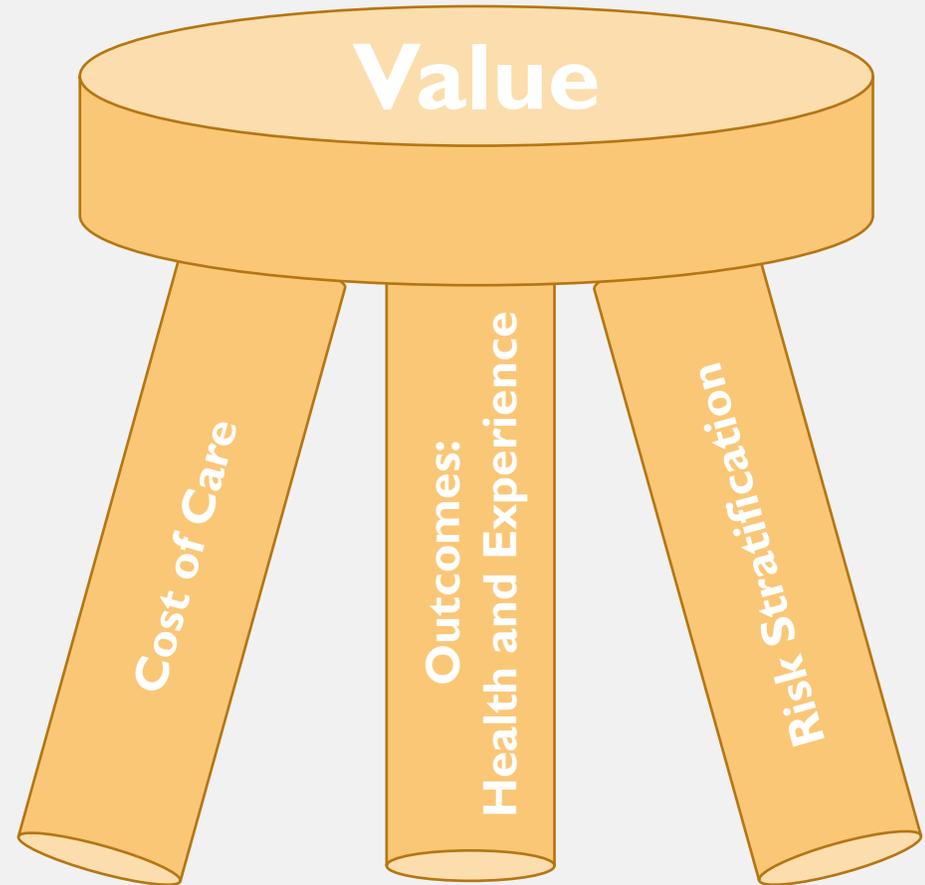
## VALUE: A WORKING DEFINITION

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

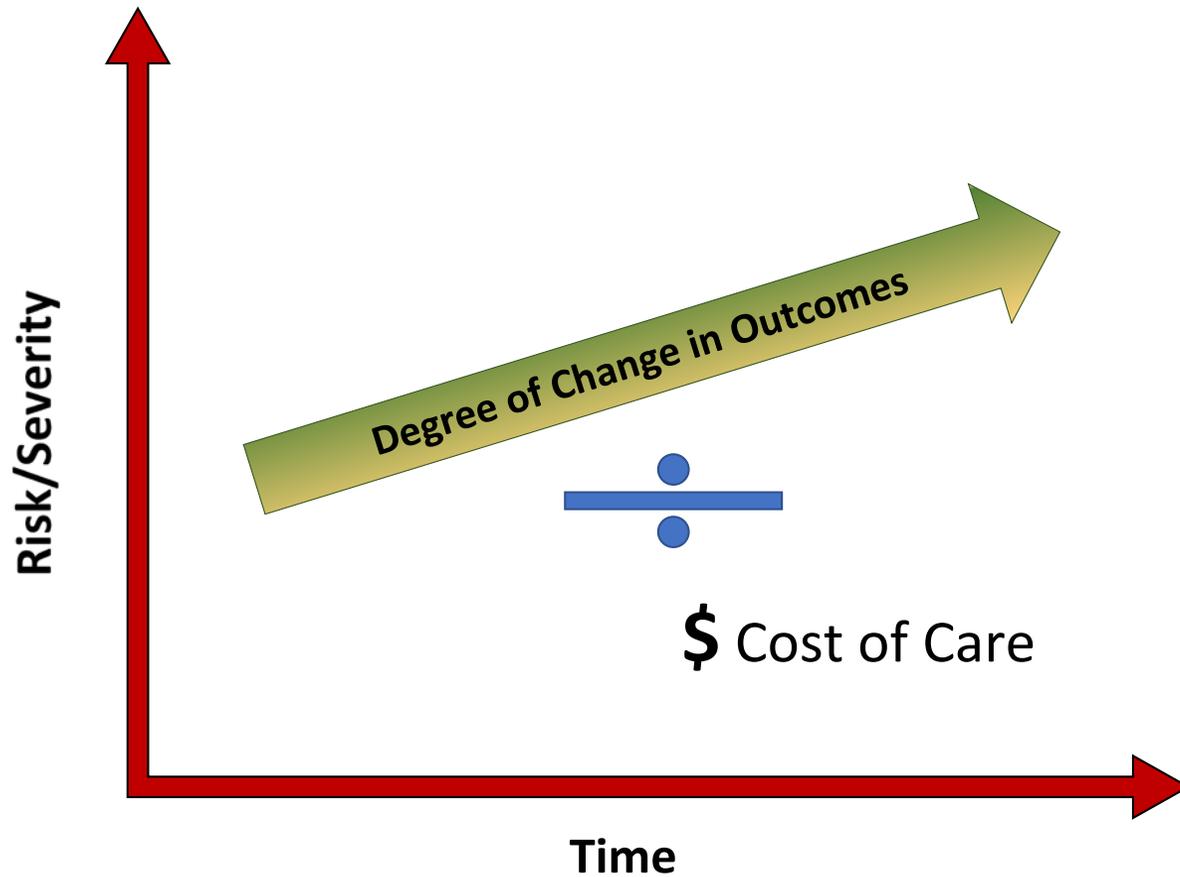
- Porter also states that “any outcome measurement should include sufficient measurement of risk factors or initial conditions to allow for risk adjustment.” (p. 2479, Porter 2010)

# VALUE AS A THREE-LEGGED STOOL

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



THE  
VALUE  
MODEL



IMMEDIATE NEXT  
STEPS AND PROGRESS  
THUS FAR...

## Phase 1

### Phase 1

- Complete foundation of Quadruple Aim

## Phase 2

### Phase 2

- Apply the Value Model (or some other paradigm)

## Phase 3

### Phase 3

- Set quality goals and evaluate progress



Cost of care



Outcomes



Risk Stratification Variables  
(including social  
determinants)

ESTABLISH  
CORE METRICS  
IN QUADRUPLE  
AIM

## COST OF CARE

Many ways to conceptualize

Cost of care report being built in Avatar\*

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

\* Formula already being used in CARS

## OUTCOMES

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

\* Many of these are already reported in CARS Quarterly Dashboard

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



## OUTCOMES: QUALITY OF LIFE

**Quality of life (QOL) as a  
key outcome**

**Many potential benefits**

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

\* Please see handout for more QOL results



## RISK STRATIFICATION

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

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

## RISK STRATIFICATION: CURRENT EFFORT AND NEXT STEPS

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

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

## NEXT STEPS

Continue

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



Pilot

Pilot Value Model

## POSSIBLE APPLICATIONS OF VALUE MODEL?



Population health outcomes



Contract performance measures



Contract awards (initial and extensions)



Utilization Management/Utilization Review



Continued dashboard development/revision



Identifying and addressing waste/low value care



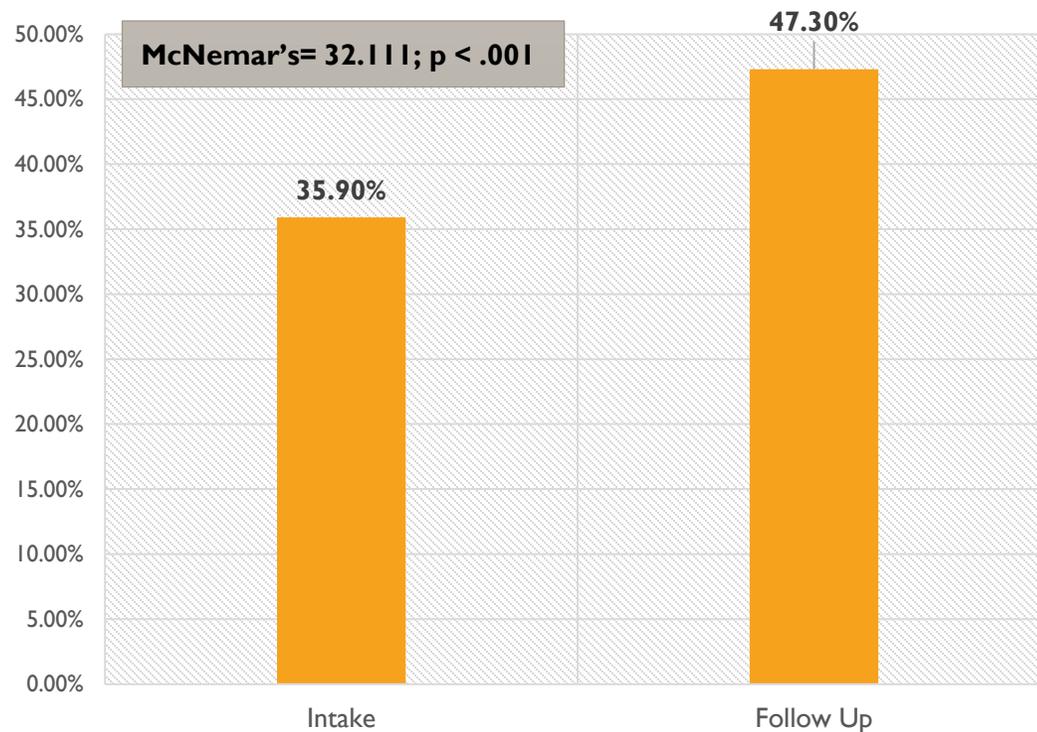
Other QI projects?

THOUGHTS?

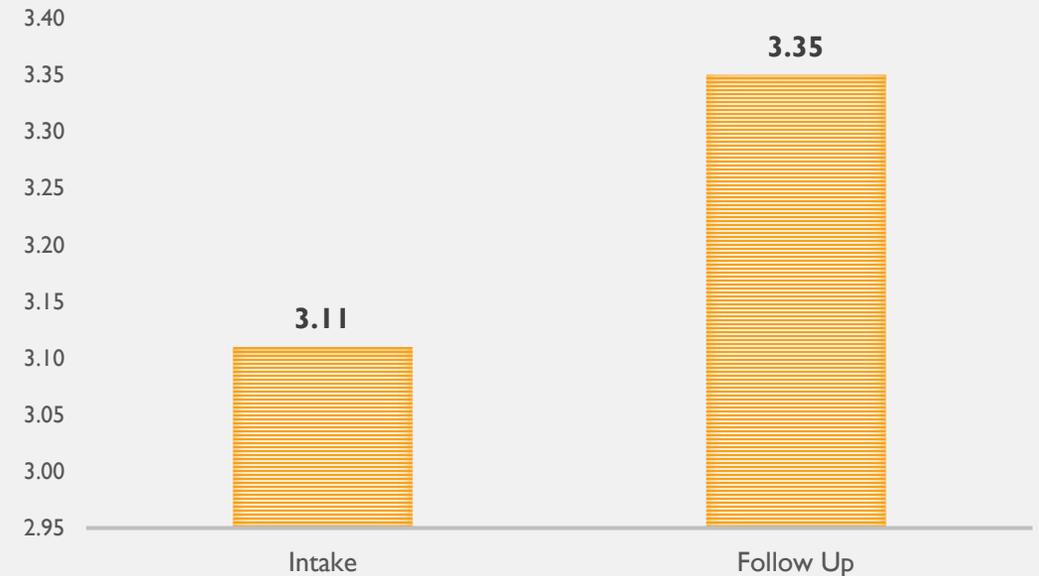
APPENDIX:  
SINGLE ITEM QUALITY OF LIFE DATA

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

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



TOTAL QUALITY OF LIFE SCORE:  
INTAKE TO FOLLOW UP



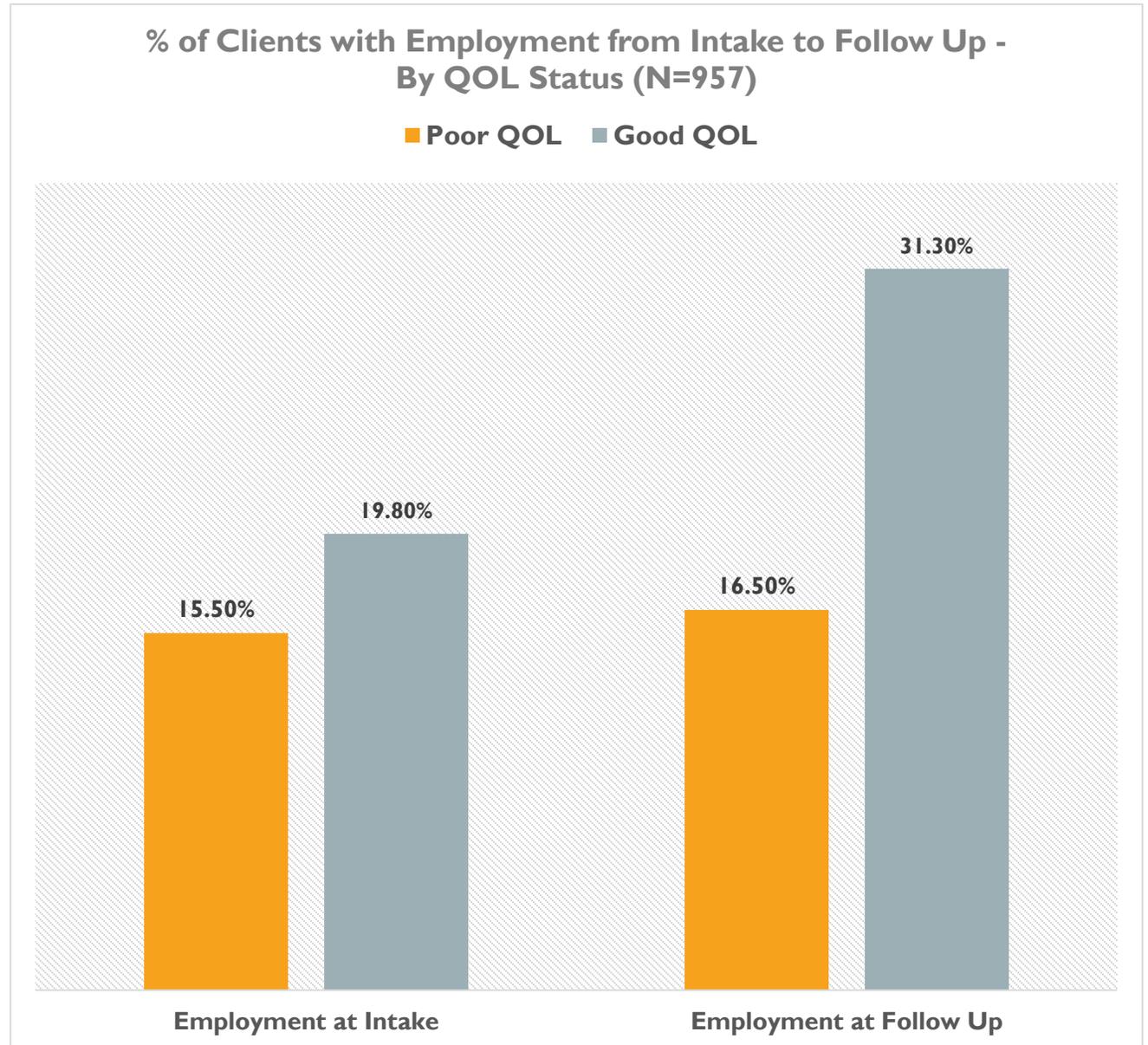
Paired Samples t-test:  $t(968) = -6.530, p < .001$

Effect Size:  $d = .25$

Standardized Response Mean:  $= .21$

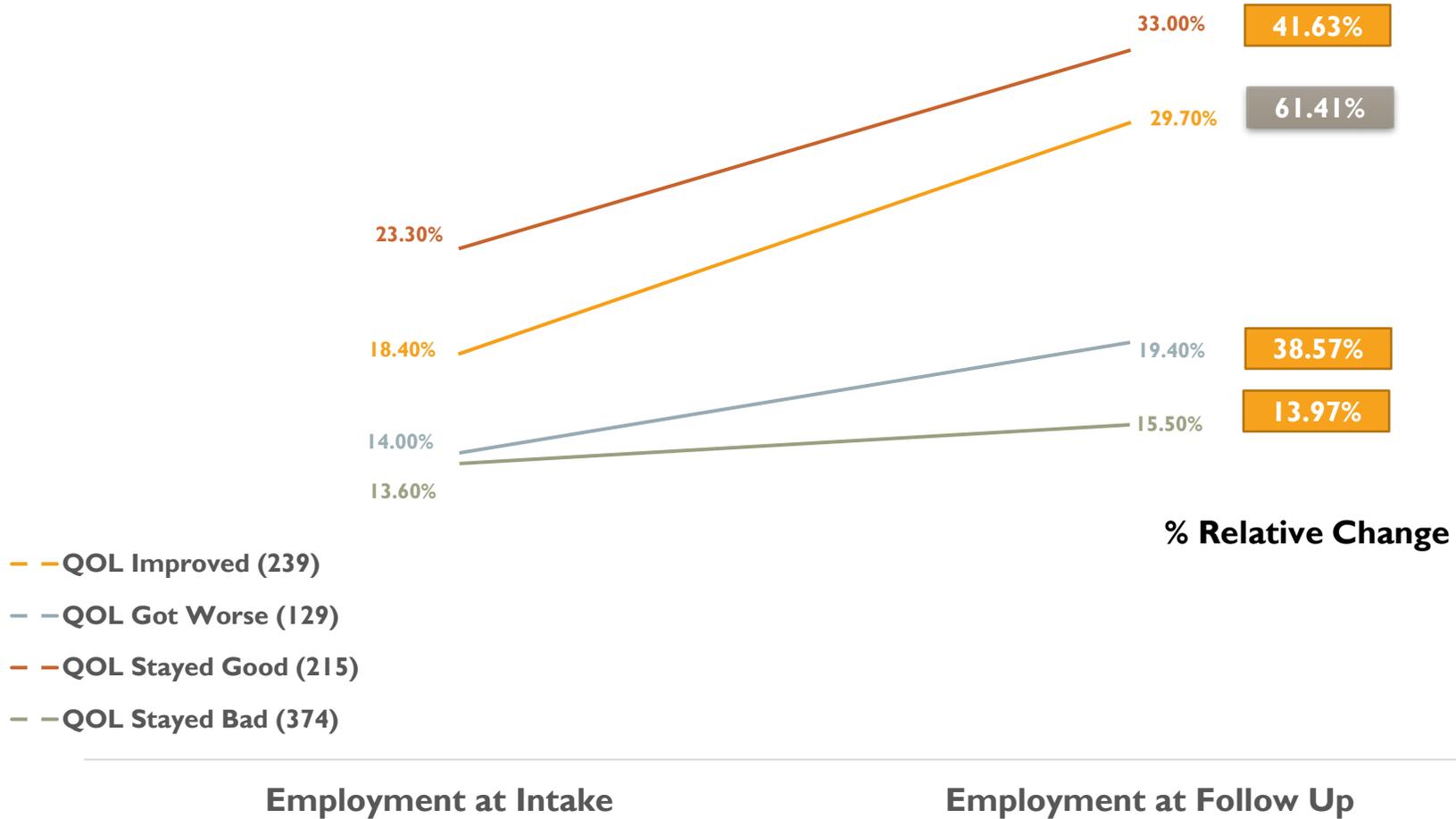
Cohen's Convention: Small  $d = .2$ ; Medium  $d = .5$ ; Large  $d = .8$

# QOL DATA: EMPLOYMENT STATUS



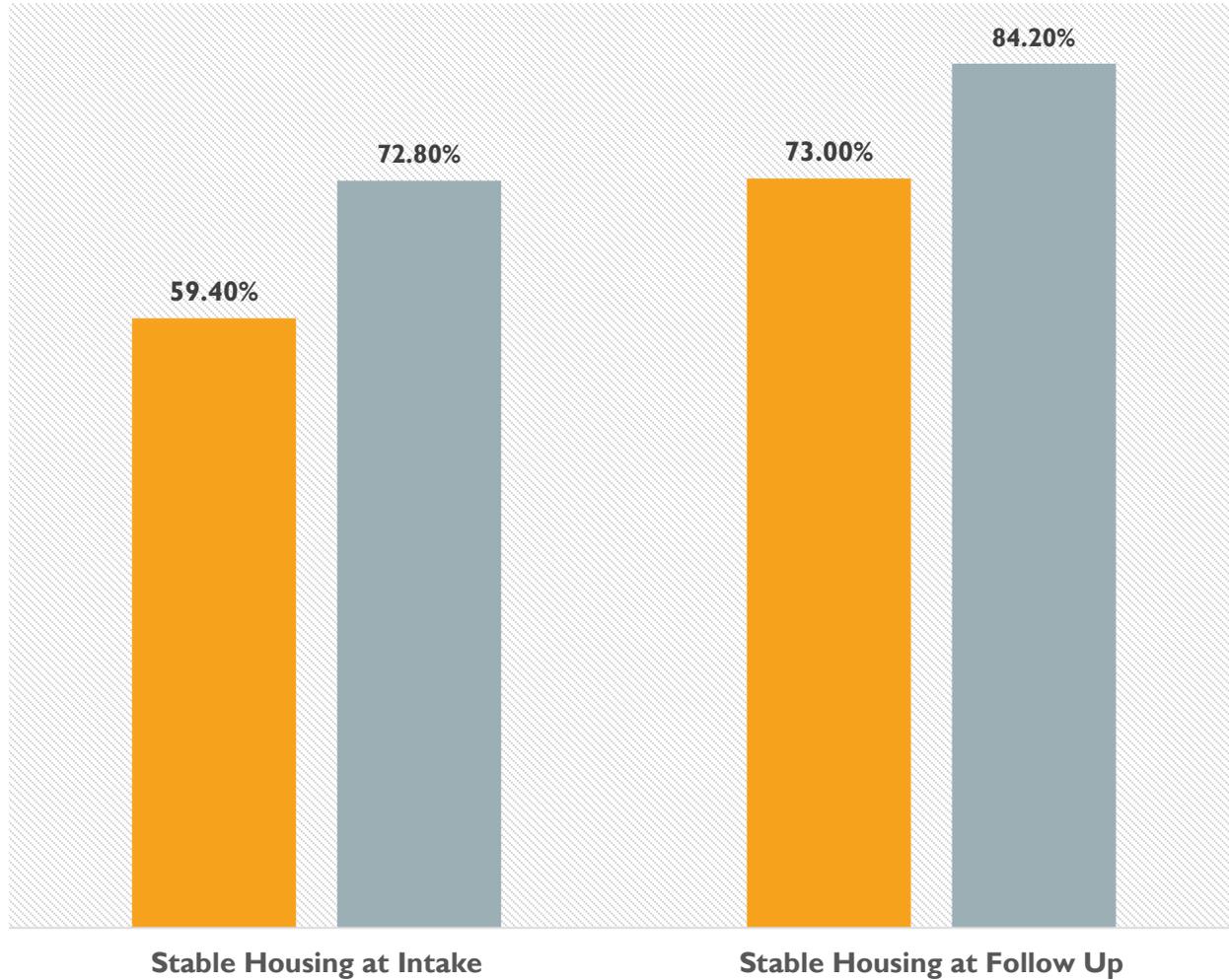
# QOL DATA: EMPLOYMENT STATUS

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



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

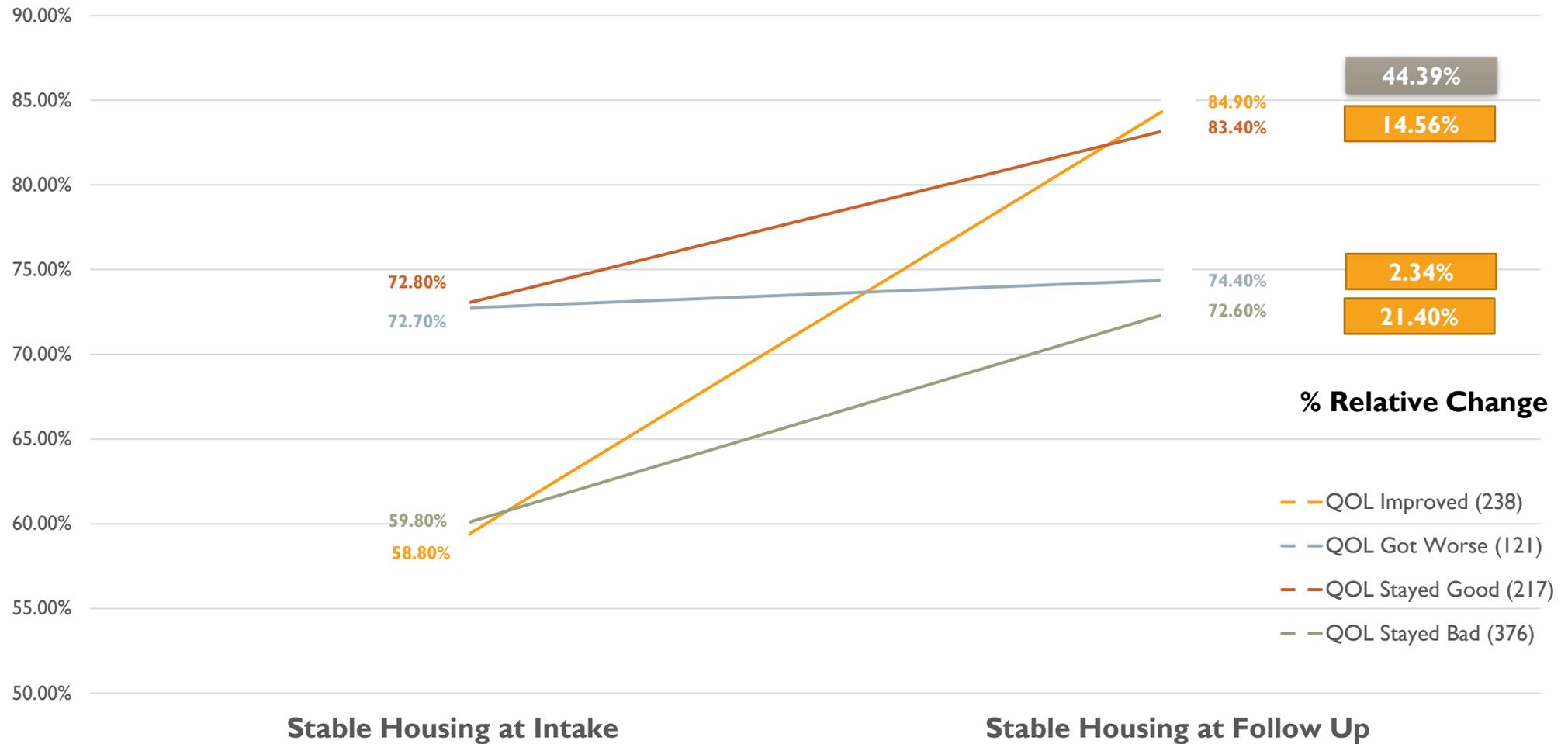
■ Poor QOL ■ Good QOL



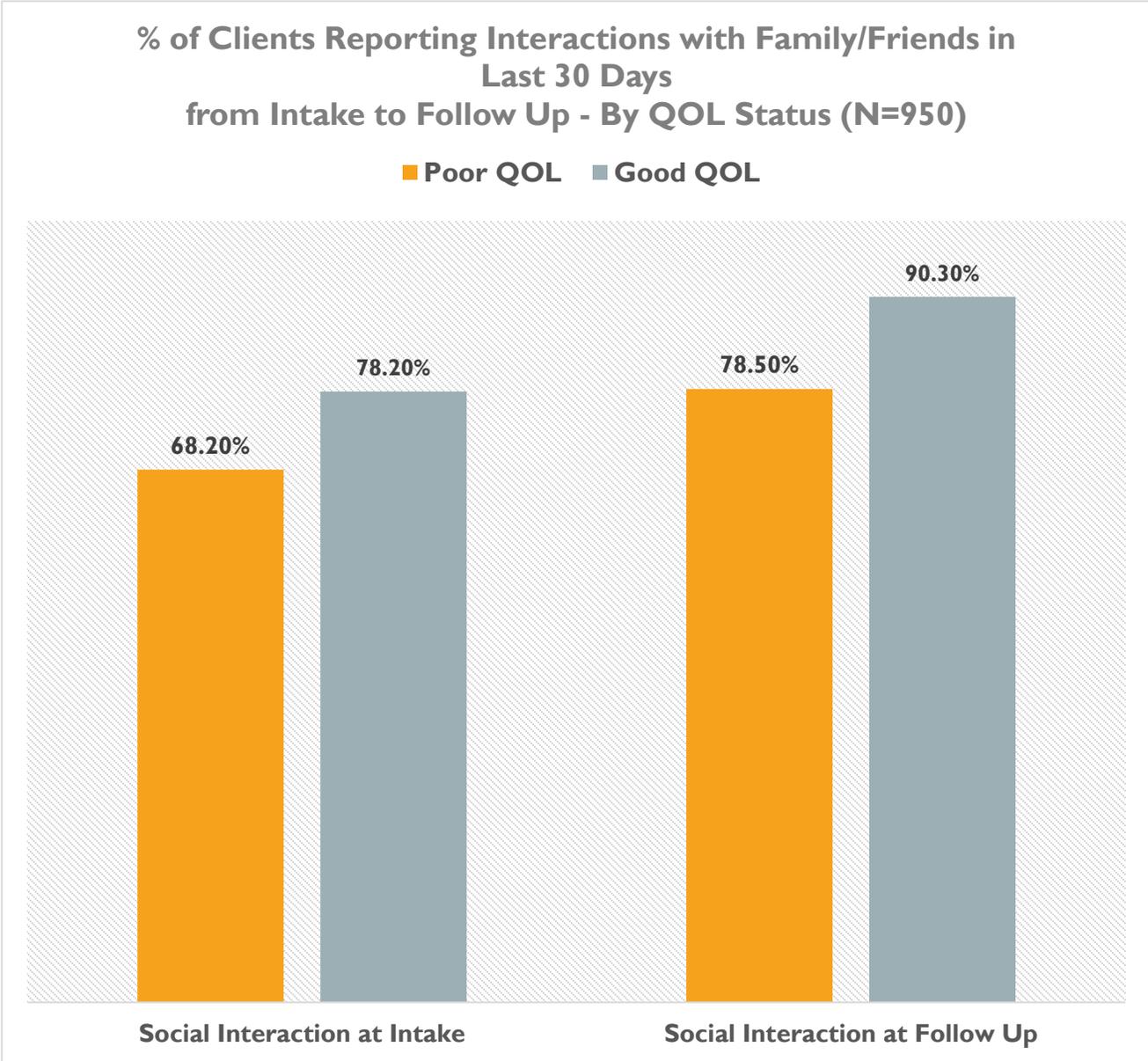
QOL DATA:  
STABLE HOUSING  
STATUS

# QOL DATA: STABLE HOUSING STATUS

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

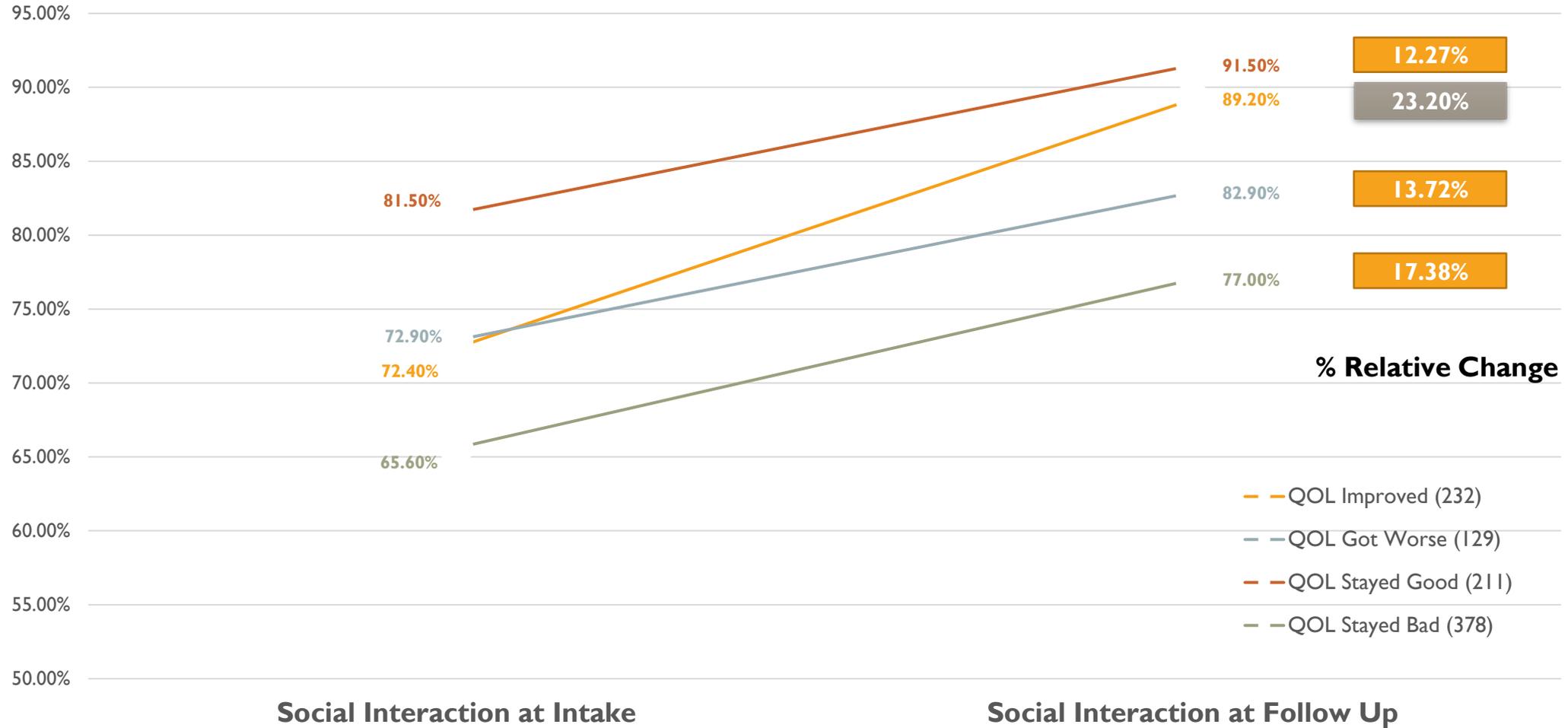


QOL DATA: SOCIAL INTERACTION STATUS



# QOL DATA: SOCIAL INTERACTION STATUS

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



## QOL: SUMMARY STATS

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

# QOL SUMMARY



Brief



Patient-reported, patient-centered



Program agnostic



Appears sensitive to change



Has solid criterion validity



Recovery-oriented

Program	Item	Measure	2020 Quarter 1	2020 Quarter 2	2020 Quarter 3	2020 Quarter 4	2020 Actual	2020 Target	2020 Status (1)
Wraparound	8	Families served by Children's Mental Health Services and Wraparound (unduplicated count)	2,106					3,145	
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5) (Wrap HMO)	4.4					> = 4.0	
	10	Out of Home Recidivism Rate (Wraparound HMO)	23					<=30	
	11	Youth and Parent Report of "How Well They Are Doing" at Disenrollment (Wrap HMO)	4.0					> = 4.0	
	12	Percentage of Youth who have achieved permanency at disenrollment	76.2%					> = 75%	
	13	Percentage of Informal Supports on a Child and Family Teams	24.3%					> = 40%	
	14	Average Cost per Month	\$2,602						

Notes:

(1) 2020 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 - 1st QUARTER/CY 2020**

# 8 - This number is for those enrolled in a program with Children's Community Mental Health Services and Wraparound Milwaukee. Please note that in review of the report, we discovered that some youth were excluded in our 2019 data and the actual served for 2019 is 2,935. This was underreported by 63 youth. Other reports were accurate, but we wanted to acknowledge that this error was discovered.

# 9 – On target for 1st quarter of 2020. Exceeding the threshold of 4.0.

# 10 - This is a new item to be reviewed for Wraparound Milwaukee HMO programs. We are looking at the number of youth who go from a home-type setting to an out-of-home type setting during the quarter. This is our first time measuring this.

# 11 - This is a new item to be reviewing and reporting on for Wraparound Milwaukee. At disenrollment, Wraparound Milwaukee asks youth and parents/guardian/caregiver to rate how they feel they are doing now, compared to enrollment on a scale of 1-5. This is specific to the Wraparound HMO youth (Wraparound and REACH). For 1st quarter of 2020 we are at the threshold of 4.0.

#12 – Traditionally we only reported on those youth enrolled in what is traditionally known as Wraparound. However, we have youth in Wraparound, REACH, and CCS who are in out-of-home placements, therefore, we want to report on all programs. We have increased our threshold at this time to 75%. For 1st quarter of 2020, we met the threshold by just over 1%.

“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 has been traditionally reported for Wraparound HMO programs, however, we have included in youth CCS. The threshold did change as well, to 40% to be in align with our current expectation of Care Coordination agencies at 40%. This is an area we stress during training and the importance of during our Agency Performance Report meetings.

#14- As requested by the Quality Board in June 2019, we have provided average cost for youth in all of programs. Last year we only reported on Wraparound and REACH, but we have been able to include CCS.

# BHD KPI Report Q1 2020

Children's Community Mental Health  
Services and Wraparound Milwaukee

# Report Overview



**Unique Families  
Served**

**2,106**

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

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

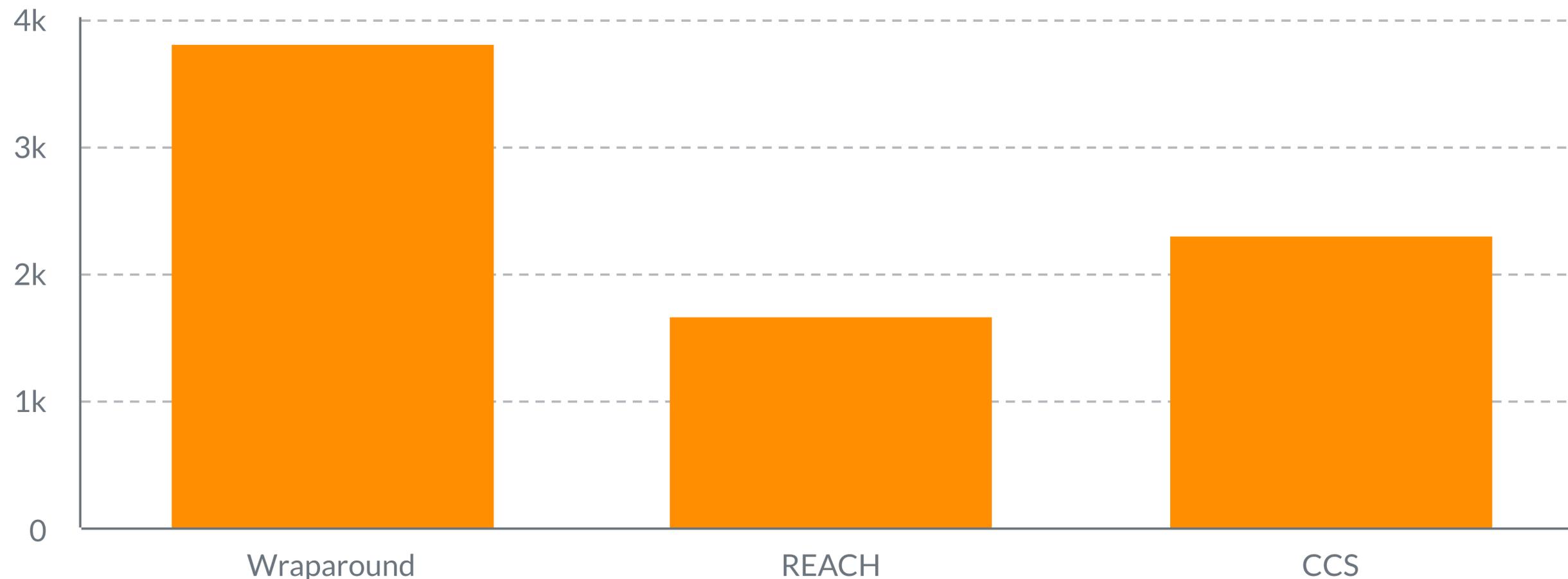
**Average Cost of Care** - average cost of care per family per month by program in the past quarter

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

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

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

# Average Cost Per Family



Wraparound  
**\$3,824**

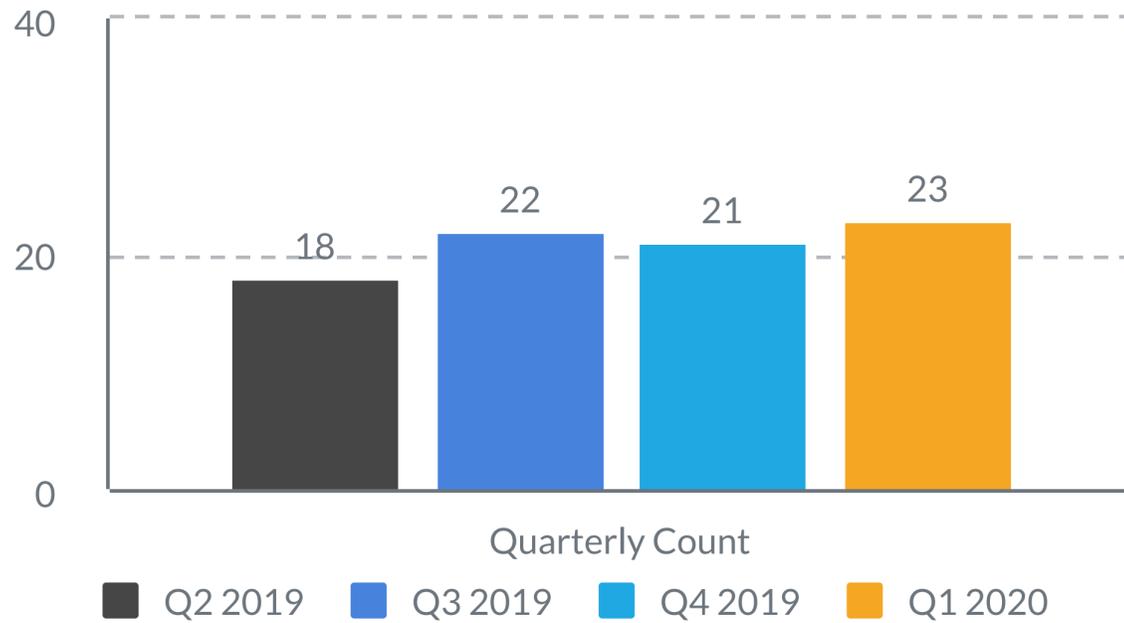
REACH  
**\$1,674**

CCS  
**\$2,307**

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

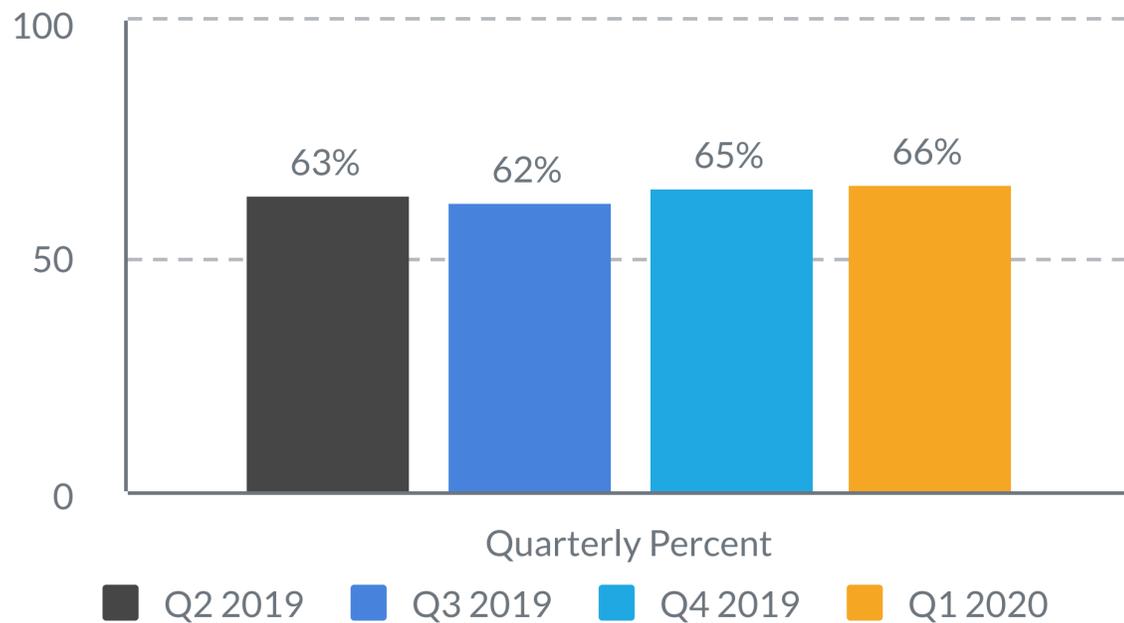
# Population Health

## Out of Home Recidivism Rate



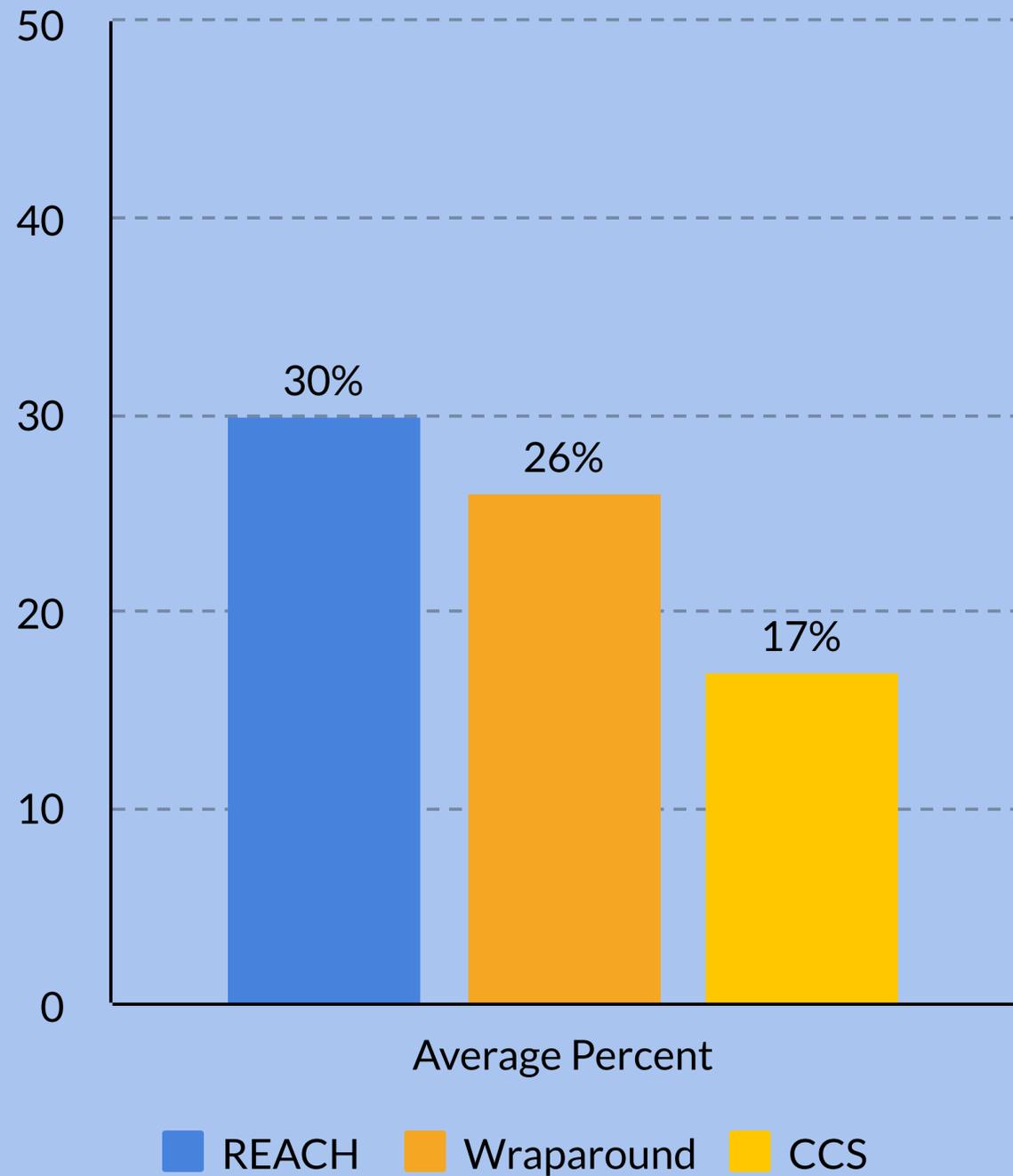
Number of youth in Wraparound and REACH who moved from a home-type setting to an out of home type setting within each quarter displayed.

## Legal Permanency Stability Rate



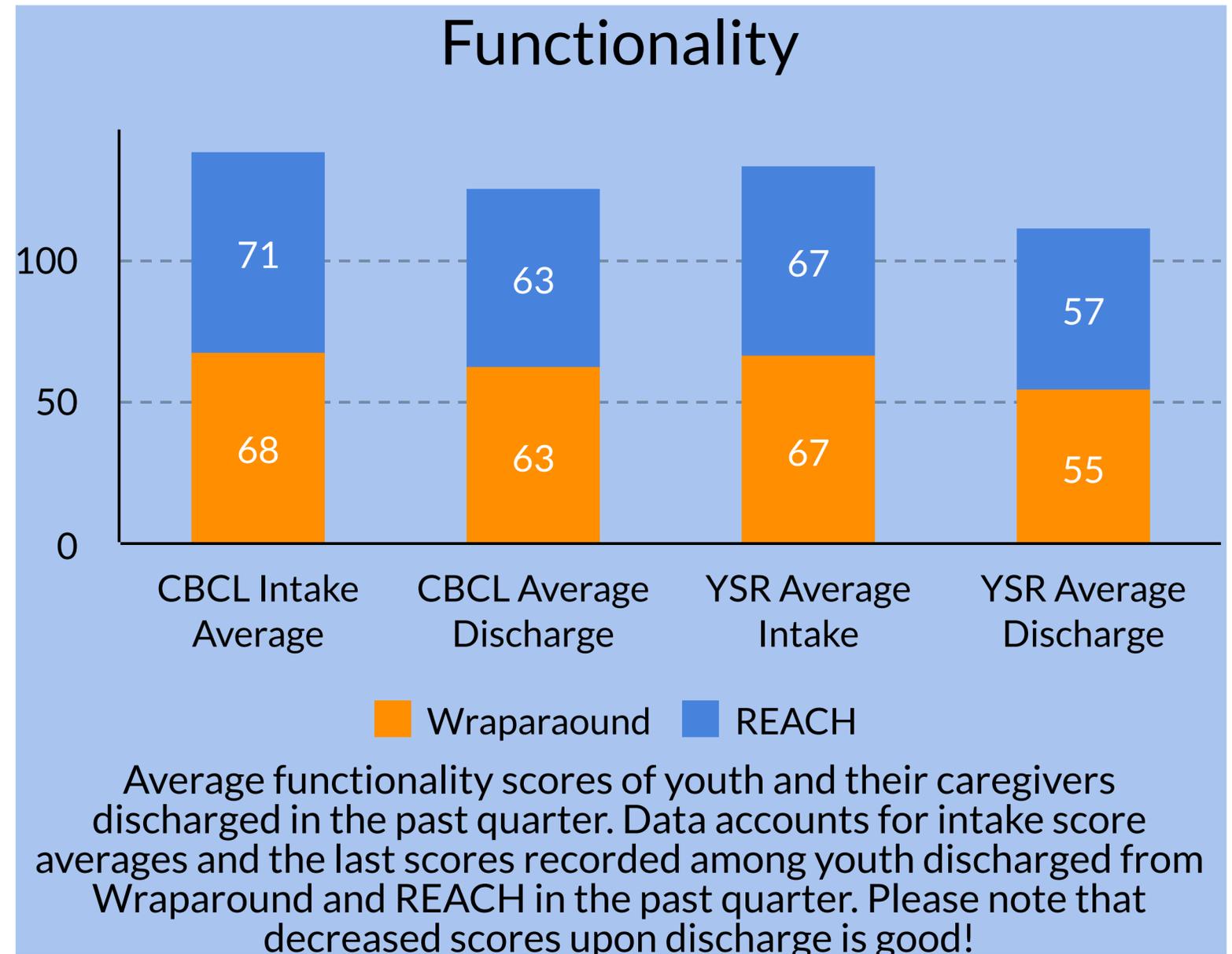
Percent of Wraparound youth in a home-type setting in the past four quarters.

## Percent of Natural Supports



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

# Outcomes



Permanency at Discharge

**76.19%**

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



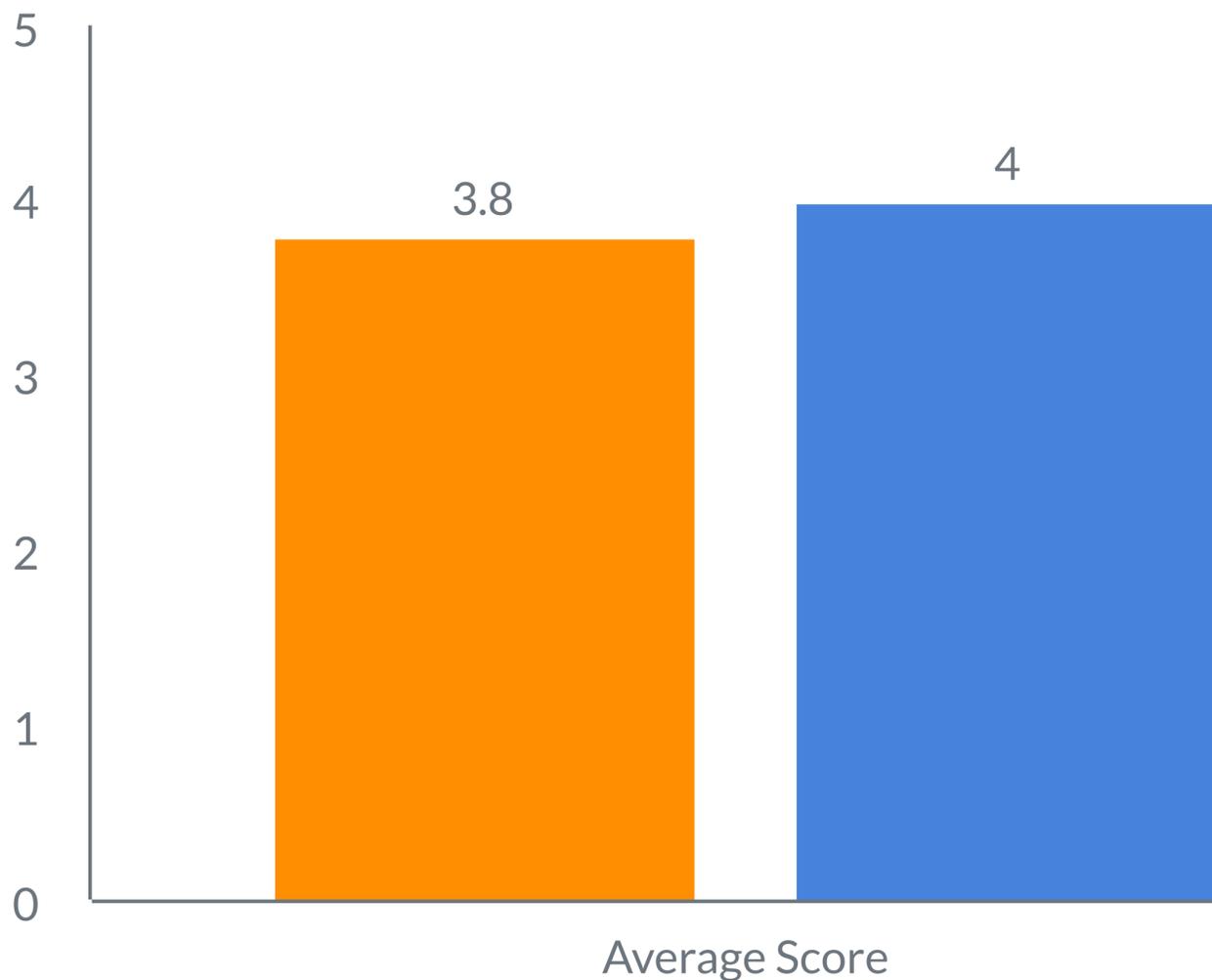
Family Satisfaction  
Overall Average  
Score

**4.4**

For Wraparound and REACH families in the past quarter

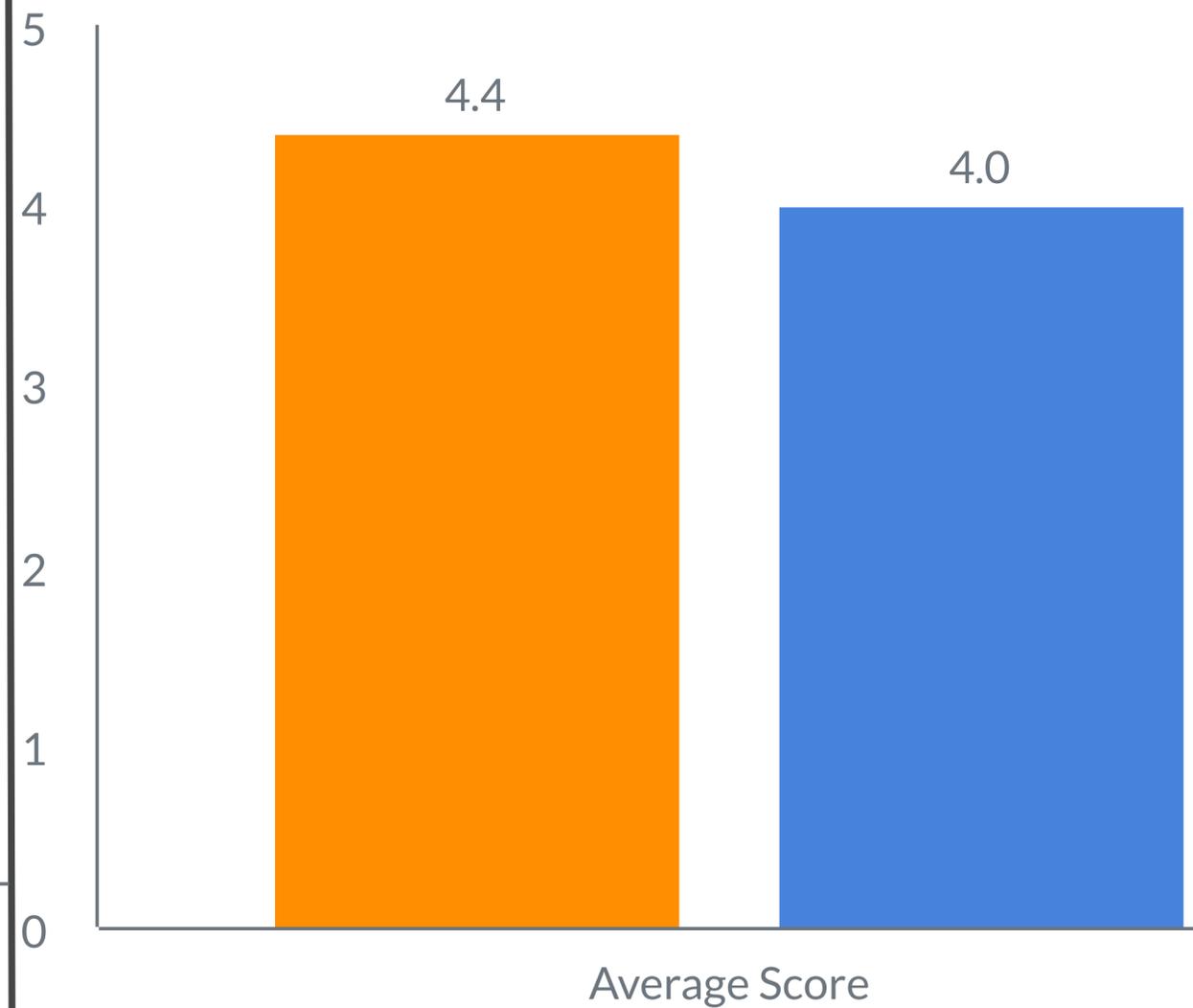
# Wraparound and REACH Perceived Outcomes

### Youth Perceptions



- Getting along with friends and family
- How well youth is doing

### Caregiver Perceptions



- Natural Supports
- How Well Family is Doing

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

Wraparound Discharges

**51**

REACH Discharges

**56**

CCS Discharges

**23**

**Resource & Referral Line  
2019 Performance Improvement Project  
Summary Report**

The Human Services community is challenged by an increased demand for services, limited financial resources, continually shifting demographics, and social barriers. With these challenges underscoring the operations of social service organizations, Milwaukee County Behavioral Health Division in collaboration with the Disability Services Division created a single point of entry for referral to services for youth and their families, the Resource & Referral Line. This *single front door point of entry* collaboration between Wraparound Milwaukee and Disabilities Services Division was the first step in creating a structure that is more user friendly for the consumer, but still effective and efficient. Given this large shift in delivery of services, it was felt that from the onset, an accountability system that includes both fidelity and outcome measures as well as a formalized PDSA cycle approach, would be critical to understanding and assuring effectiveness and efficiency of this new collaborative system of receiving referrals. This approach needed outcome data to support the model as well as provide better clarity of what qualitative indicators of the phone conversations would enhance the process.

### Study Questions

1. Ninety percent (90%) of callers into the Resource and Referral Line who have completed the Children's Services Intake Survey (All Wraparound Milwaukee programs & Disabilities Services Division (DSD) Children's Programs including Children's Long Term Service Waiver (CLTS), Children's Community Options (C-COP) and Birth-3) will indicate an overall call satisfaction rating of  $\geq 4.5$
2. Eighty percent (80%) of callers who have met enrollment criteria and have been referred to Wraparound, REACH, O-YEAH, Comprehensive Community Services for Youth Services (CCS) & Disabilities Services Division (DSD) Children's Long Term Service Waiver (CLTS) and Children's Community Options (C-COP), all subsumed under Wraparound Milwaukee & Disabilities Services Division programs, will set up an appointment with an Intake Worker to move forward with the screening process.

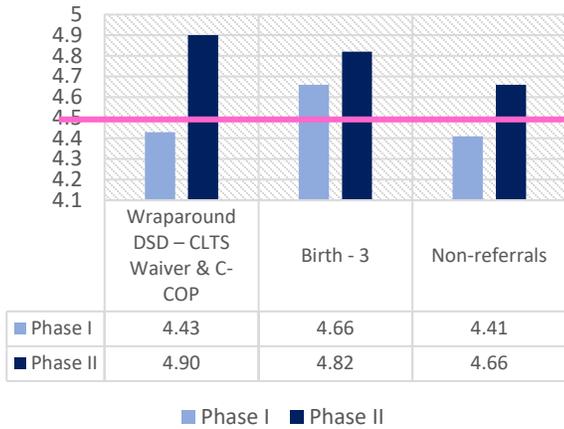
### Results

#### Study Question I

The responses to the question, *Overall, I was satisfied with this phone call* in which the callers rated overall satisfaction at the  $\geq 4.5$  level across Baseline and Phases I & II were as follows:

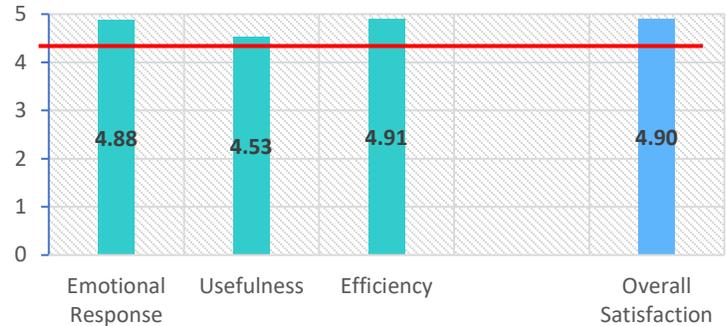
	Baseline	Phase I	Phase II
<b>Wraparound &amp; DSD (CLTS Waiver &amp; C- COP)</b>	50% (7/14)	58% (19/32)	90% (46/51)
<b>DSD, Birth - 3</b>	58% (17/29)	68% (23/36)	83% (48/58)
<b>Non-referrals</b>	N/A (no non-referrals)	42% (5/12)	67% (4/6)

Overall Mean Satisfaction  
Phase I & Phase II Comparison



The difference between overall mean outcomes from Phase I to Phase II yields highly statistical significance for Wraparound and DSD – CLTS Waiver & C-COP, ( $p=.0029$  at a 95% confidence level).

Children's Service Intake Survey Rating  
Phase II Composite Responses  
n=51



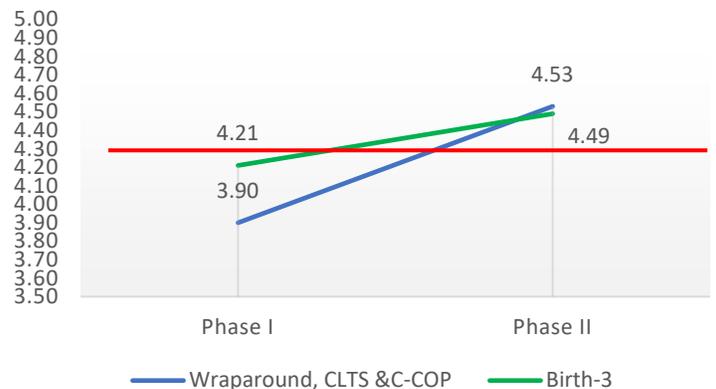
The survey was designed to address different facets of satisfaction: Emotional Response, Efficiency & Usefulness.

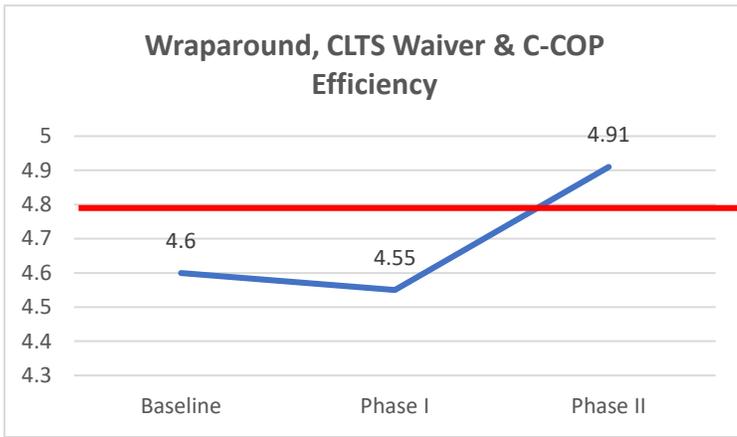
Reviewing the subscales, they revealed a consistency of response across all Phases in which general feelings of validation and hopefulness (*Emotional Response*) with the conversation were highest, followed by *Efficiency*, measuring progress moving forward in the screening process, and finally *Usefulness* that accessed the callers' immediate feelings related to getting needs met for their children. Changes in the emotional response subscale reveal a steady increase in callers' feelings heard by the screener and feeling hopeful related to the child getting his/her needs met through this process. On the Usefulness subscale, the Baseline levels averaged 3.3. The outcomes reveal a steady increase in callers feeling that the information that was given by the RRC was useful, surpassing the threshold in Phase II.

Emotional Response Comparison



Usefulness Comparison





Efficiency outcomes, measuring progress moving forward in the screening process, reveals an unexpected drop in Phase I to 4.55. This .05 drop is not significant and is most likely due to a margin of error. In Phase II, the Efficiency rating recovered and dramatically surpassed the threshold.

### Study Question II

The tabulation of the total number of youth that were potentially appropriate for in-depth screening for Wraparound and DSD (excluding Birth-3) was an average of 77% of the total number of live calls that came into the Resource & Referral Line. As seen below, the number of individuals who received a referral from the Resource & Referral Line for Wraparound, REACH, O-YEAH, CCS, CLSTS Waiver and C-COP and subsequently set up an appointment to continue the screening process exceeded the 80% threshold even at Baseline. Even though the data yielded no significant differences between Baseline, Phase I and Phase II, it did reveal a small positive increase across all phases of the study. This is consistent with the trend found in the outcome data of Study Question I. Furthermore, the results confirm the anecdotal reporting that very few callers refuse to set an appointment for the next step in the screening process (approximately .96%).

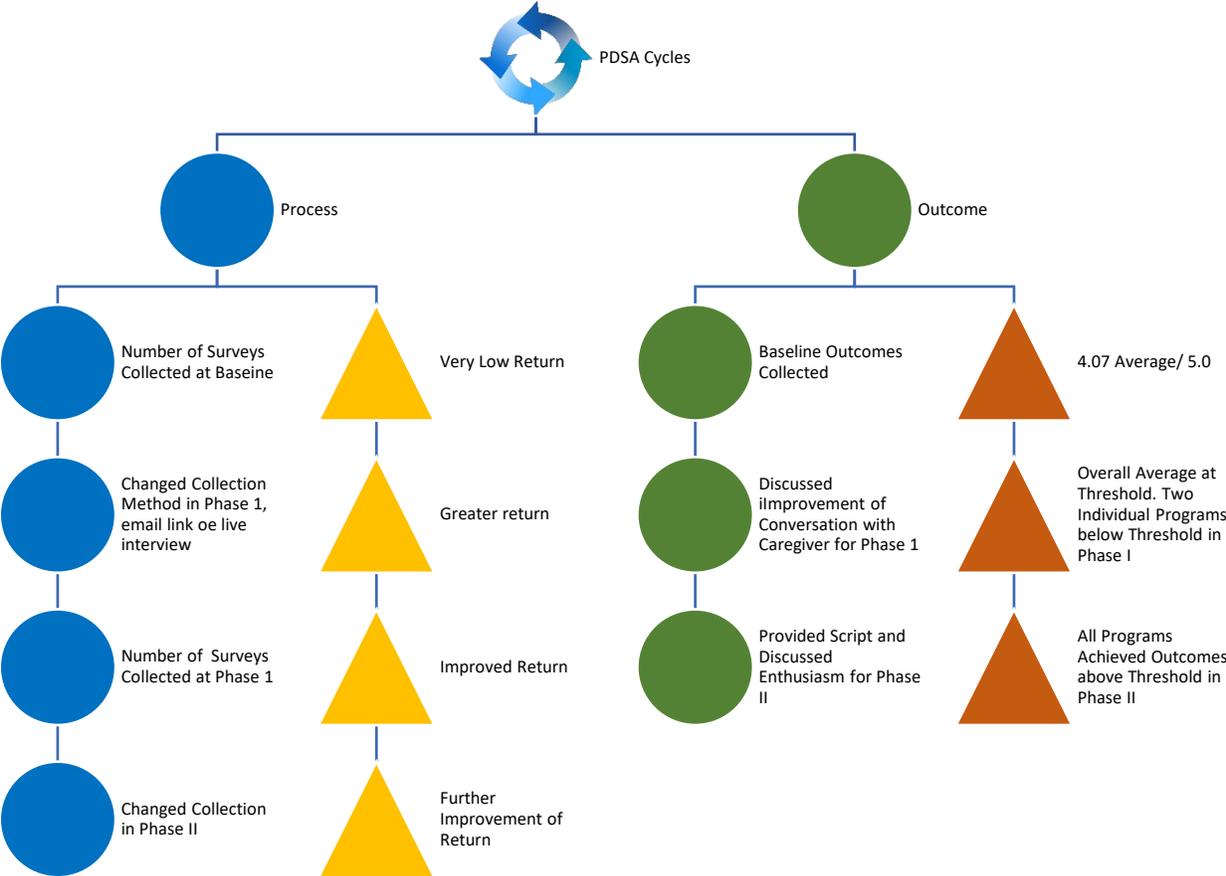
	<i>Baseline</i>	<i>Phase I</i>	<i>Phase II</i>
<i>Total Calls for Wraparound &amp; DSD (excluding Birth-3)</i>	<b>872</b>	<b>960</b>	<b>678</b>
<i>Percent &amp; Number of Callers Choosing not to Schedule an Appointment</i>	<b>1.14% (10/872)</b>	<b>.93% (9/960)</b>	<b>.74% (5/678)</b>
<i>Percent &amp; Number of Callers Scheduling an Appointment</i>	<b>98.85% (862/872)</b>	<b>99.06% (951/960)</b>	<b>99.26% (673/678)</b>

The lessons learned from this study provides direction to a sustainability plan. These include:

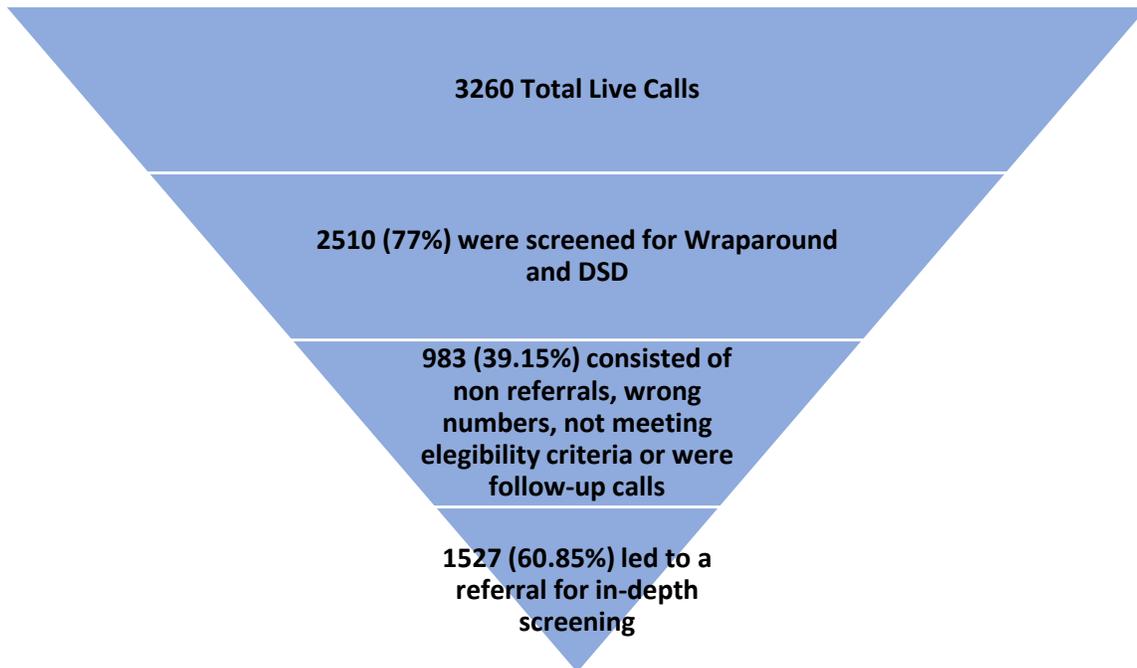
- the nuanced interview with the caller that focuses on warmth, optimism and assurances that the enrollment process will be smooth and easy
- the need to address issues, especially fears clearly and directly, and
- that timeliness matters so that the time between the call and the next step must be short

A large commitment has been made by two organizations, Wraparound Milwaukee and the Disabilities Services Division, to the single front door Resource & Referral Line. It is deemed an effective and efficient way to link families to individualized services which should happen at the very first contact. Indicated, as well, is the importance of brief, intensive engagement with the family through motivational interviewing, providing stress and coping support strategies and providing detailed and creatively presented support service information. This all can be provided by this viable approach, the single front door, deemed as best practice.

PDSA Cycles



**Total Wraparound Milwaukee and DSD (CLTS Waiver & C-COP) Calls Potentially Leading to In-depth Screening Process**



## Community Access to Recovery Services NIATx Collaborative Evaluation Highlights

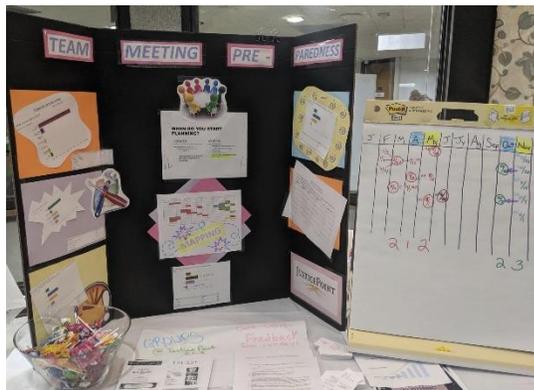
### 2019 NIATx Storyboard Marketplace Project Checklist Summary

#### Introduction

As part of the ongoing evaluation of the NIATx Collaborative, Center for Urban Population Health (CUPH) evaluators again used the brief project checklist (created in 2018) during the October 16, 2019 Storyboard Marketplace. This checklist includes criteria based on elements that support “successful” quality improvement (QI) projects. During the Marketplace, CUPH evaluators visited each storyboard and engaged in conversation with agency staff to aid in the completion of the checklist.



#### Results



Of the 28 storyboards showcased, 23 presented an implemented QI-related project. Of the remaining 5 storyboards, 3 were not QI projects and 2 were proposed QI projects. The **23 projects** were carried out across **20 organizations**. At least one staff member from **all 20 organizations attended one or more Collaborative meeting(s)** in 2019.

Of the 23 projects, **9 (39%) focused on consumer engagement/retention**, while 5 (22%) aimed to improve billing/recordkeeping, and 4 (17%) concentrated on consumer health. Environmental changes and education around MC3 values were the primary goal of each of 2 projects (9%, 9%), and the final project focused on improving staff engagement/retention (4%) (Figure 1).

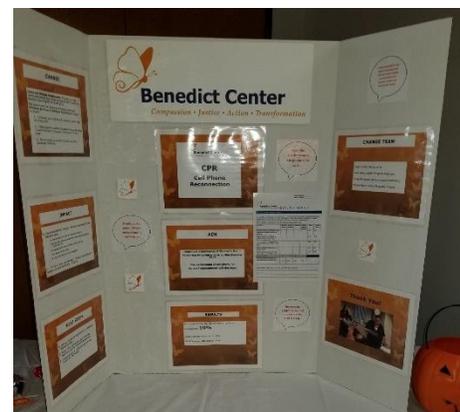
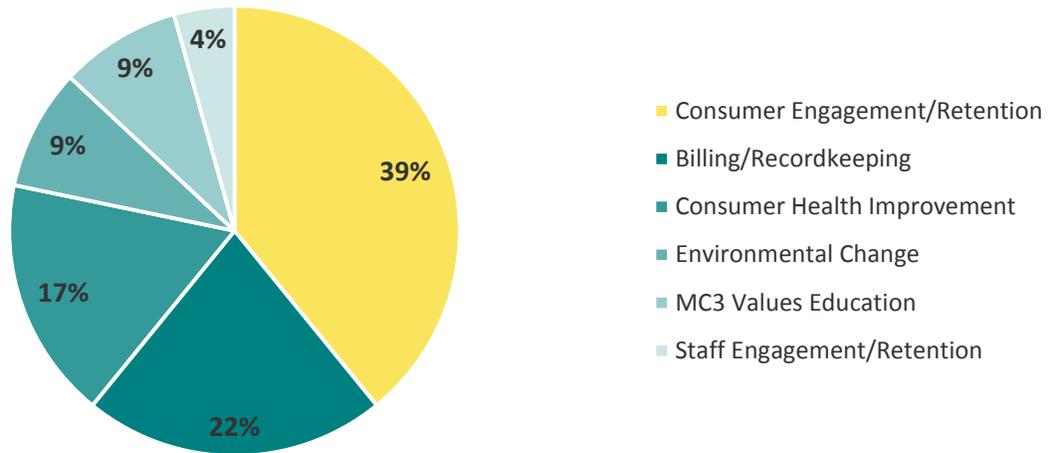
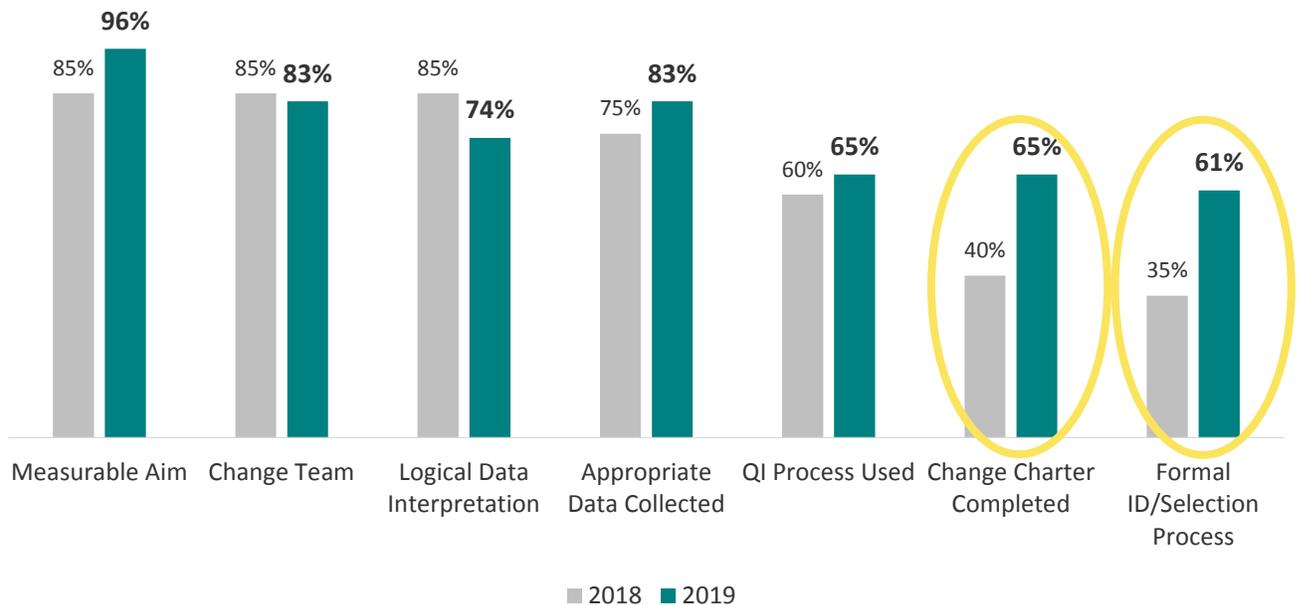


Figure 1. Primary Project Goal



All but one (96%) of the 23 projects presented a **measurable aim** and the majority (61-83%) demonstrated **use of the other QI elements** assessed. There was a **substantial increase** in the proportion of projects that reported **completing a change charter** (65% versus 40% in 2018) and using a **formal project selection process** (61% versus 35% in 2018) (Figure 2).

Figure 2. Project Elements - 2018 and 2019



# 2019 NIATx Collaborative Participant Survey Summary

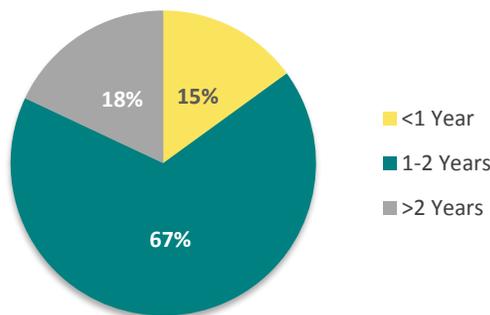
## Key Findings

- Collaborative meetings are valuable, and participants feel welcomed.
- The most-reported benefits of attending were 1) learning about QI and 2) gaining ideas from others' experiences.
- The most reported outcomes of attending include increased 1) knowledge, skills, and interest around quality improvement and 2) awareness and positive perceptions of available services/resources.
- The NIATx website is underused and not well-known.
- Collaborative meetings could be improved by 1) including more QI/NIATx information and 2) ensuring enough time to share and receive feedback.

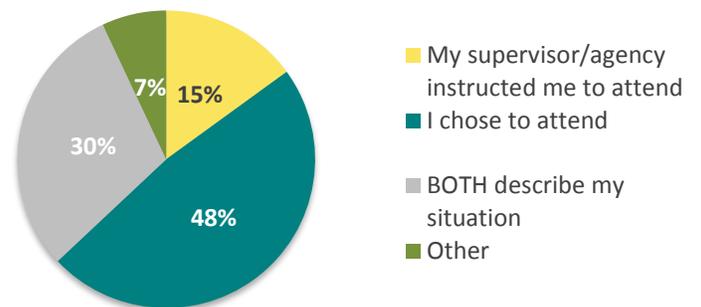
## Who took the survey?

**27** individuals completed the survey

**67%** had participated for 1-2 years.  
Average was **2.5 years**.

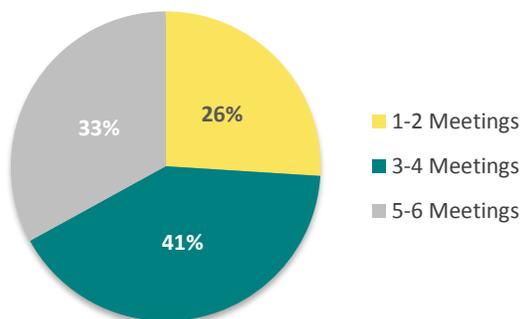


**48%** chose to participate in the Collaborative.



## Attendance

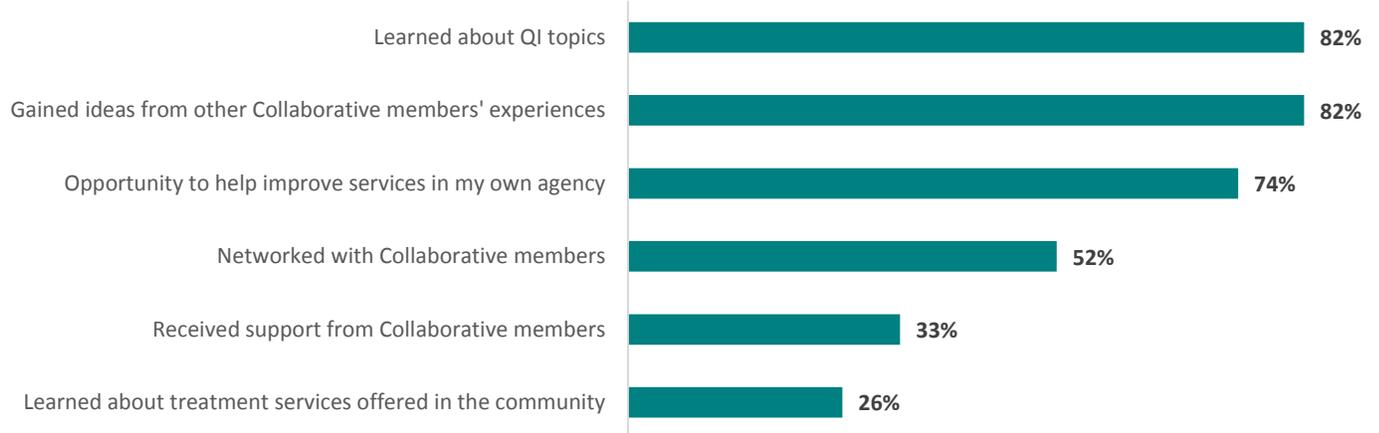
**2/3** came to at least 4 of the 6 meetings.  
Average was **4 meetings**.



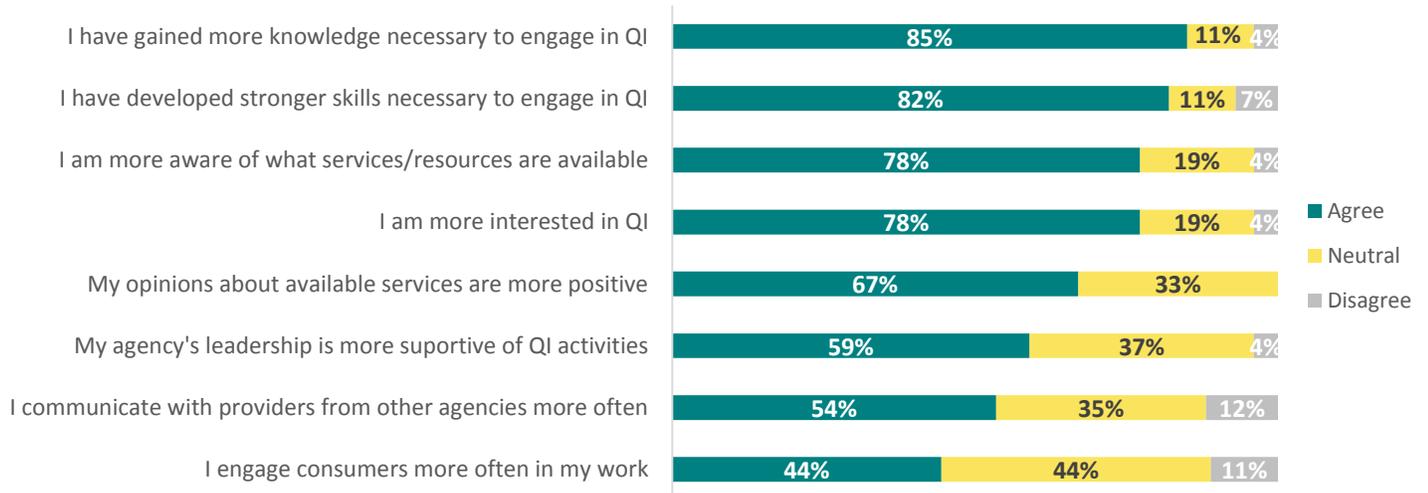
Scheduling conflicts (**52%**) and not enough time (**33%**) were the most cited reasons for not attending.



## What were the benefits of participating?



## What were the outcomes of participating?



## NIATx Website

**30%** of participants **accessed website** resources in 2019, while **45% did not**; **26% were unaware** that the website exists.

## How could the Collaborative better meet participants' needs? (selected comments)

- *"As a first timer, it would have been helpful to gain more understanding about what NIATx [is]. More general information would be helpful!"*
- *"Have some basic quality assurance projects listed that a small substance abuse service agency can pick from to improve their agency."*
- *"It may be beneficial to break into smaller groups when attendance is high to ensure members have adequate time to discuss their projects and obtain feedback."*

**For further information please contact:**

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*Professor, UWM-Helen Bader School of Social Welfare*

*Director, Center for Urban Population Health*

# Center for Urban Population Health

*Working together to improve the health of communities.*



Helen Bader  
School of Social Welfare

February 2020



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

March 11, 2020

Annette Veasey, BS, MSW, LPC, SAC-IT  
S.M.I.L.E. Inc. Mental Health & AODA Outpatient Clinic  
4222 W. Capitol Dr. #308  
Milwaukee, WI 53216

Re: Notice regarding Referrals to S.M.I.L.E. Inc. Mental Health & AODA Outpatient Clinic

Dear Ms. Veasey,

Milwaukee County Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) is submitting this communication as notice that all referrals and payments for services to S.M.I.L.E. Inc. Mental Health & AODA Outpatient Clinic are being suspended as of this date until further notice. Additionally, all treatment of current BHD funded clients must be suspended.

This action is being taken due to non-action taken by yourself and/or the agency to renew a contract with the Milwaukee County Behavioral Health Division. The Contract Management Department has been sending communications and requests for information since October 2019 and there has been no response. Therefore, there is no current contract between BHD and S.M.I.L.E. Inc. Due to this determination, all referrals and payments for services are being suspended.

If we do not receive a response from you within seven (7) days of receipt of this communication, we will proceed with termination of the contractual relationship for services and will require all funds due to Milwaukee County be paid. Please be aware that as a provider of services with Milwaukee County BHD, the findings, corrections, and/or outcomes of quality and compliance audits will be reported to the Quality Committee of the Milwaukee County Mental Health Board and other applicable entities as required.

Sincerely,

A handwritten signature in cursive script that reads "Amy Lorenz".

Amy Lorenz, MSSW, LCSW  
Deputy Administrator, CARS  
Milwaukee County Behavioral Health Division

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# Milwaukee County Behavioral Health Division (BHD)



Quality Assurance Performance Improvement  
Patient Safety Plan  
Board Oversight

June 1, 2020

# GOALS

- Familiarize Board members with the revised Quality Assurance Performance Improvement (QAPI) & Patient Safety Plan components
- Understand the CMS requirements related to QAPI and the MHB Responsibilities for Oversight
- Assist the Board in establishing expectations that information forwarded from the Hospital QAPI Committee is understandable and useful
- Provide insight and strategies to help the Board:
  - Evaluate the information provided
  - Ask the appropriate questions
  - Challenge performance
  - Hold management accountable for *measurable* improvement

# BOARD OVERSIGHT

- Quality
  - Deliver all the care that will help, and only what will help
  - The goal is 100%
- Safety
  - Do no harm
  - The goal is ZERO adverse events

## TAG A-0263

- The hospital must develop, implement, and maintain an effective ongoing, hospital-wide, data-driven quality assessment and performance improvement program.
- The governing body must ensure that the program reflects the complexity of the hospital's organization & services

## TAG A-0263

- All hospital departments including contract services must be included in the program. (Part of the proposed Hospital Contract Management Policy)
- Quality indicators have been developed for each department/service focusing on indicators related to improved outcomes and the prevention of medical errors.
- Quality indicators evolve and are refined over time.

## TAG A-0273

- Ongoing program
- Measures that lead to improved health outcomes
- Data Collection and Analysis
- Measurable improvement
- Provide analysis when the indicator outcome does not meet the established goal
- Program must provide measurement, analysis and tracking of quality indicators

## TAG A-0273

- Program must incorporate quality indicator data, including patient care data other relevant data, i.e, data submitted or received from Medicare Quality
- Data must be used to monitor the effectiveness and safety of services and quality of care

# TAG A-0273

- The frequency and detail of data collection must be specified by the hospital governing body.
- Performance improvement activities must track medical errors and adverse patient events, analyze their causes, implement preventive actions that include feedback and learning throughout the organization.
- Clear expectations for safety must be established.

# TAG A-0283

- Must use collected data to identify opportunities for improvement and changes that will lead to improvement
- Set priorities for performance improvement activities that
  - Focus on high-risk, high-volume, or problem-prone areas;
  - Consider the incidence, prevalence, and severity of problems in those areas; and
  - Affect health outcomes, patient safety, and quality of care.
- Must take actions aimed at performance improvement
- Measure success and track performance to ensure that improvements are sustained

## TAG A-0297

- Performance Improvement Projects (PIPS) must be conducted as part of the program
- The number and scope of distinct projects conducted annually should be proportional to the complexity of the hospital services. The number of projects should be directed by the Board.

## TAG A-0297

- The hospital must document the QI projects that are being conducted, the reasons for being conducted and the measurable progress achieved on these projects.

# TAGA-0309

- Executive Responsibilities to Include the Board-
- An ongoing quality improvement program is defined, implemented and maintained
- The QAPI program addresses priorities for improved quality of care and patient safety and that all improvement actions are evaluated.
- The determination of the number of distinct improvement projects is conducted annually.

## TAG A-0315

- Executive Responsibilities
- Adequate resources are allocated for measuring, assessing, improving and sustaining the hospital's performance in reducing risks to patients.

# QAPI PLAN

- As part of the Systems Improvement Agreement with CMS one of the action steps was to revise/redesign the QAPI process which included a revision to the previous plan.
- The QAPI plan was combined with the Patient Safety Plan.

## QAPI PLAN

- The revised QAPI/Patient Safety plan was approved at the last Hospital QAPI committee and will be presented for Board approval.
- The components of the SIA requirements were included in the revision of the plan.
- Departmental quality indicators were assigned to each department as well as contract service performance measures.

# QAPI PLAN

- A draft Quality dashboard has been developed to be presented for approval and as needed revision by the Board.
- Three major reasons for revising the components of the dashboard include
  - The display of the data
  - The analysis of the data to improve understanding to encourage discussion
  - The improvement of communication between the Board and the QAPI Committee

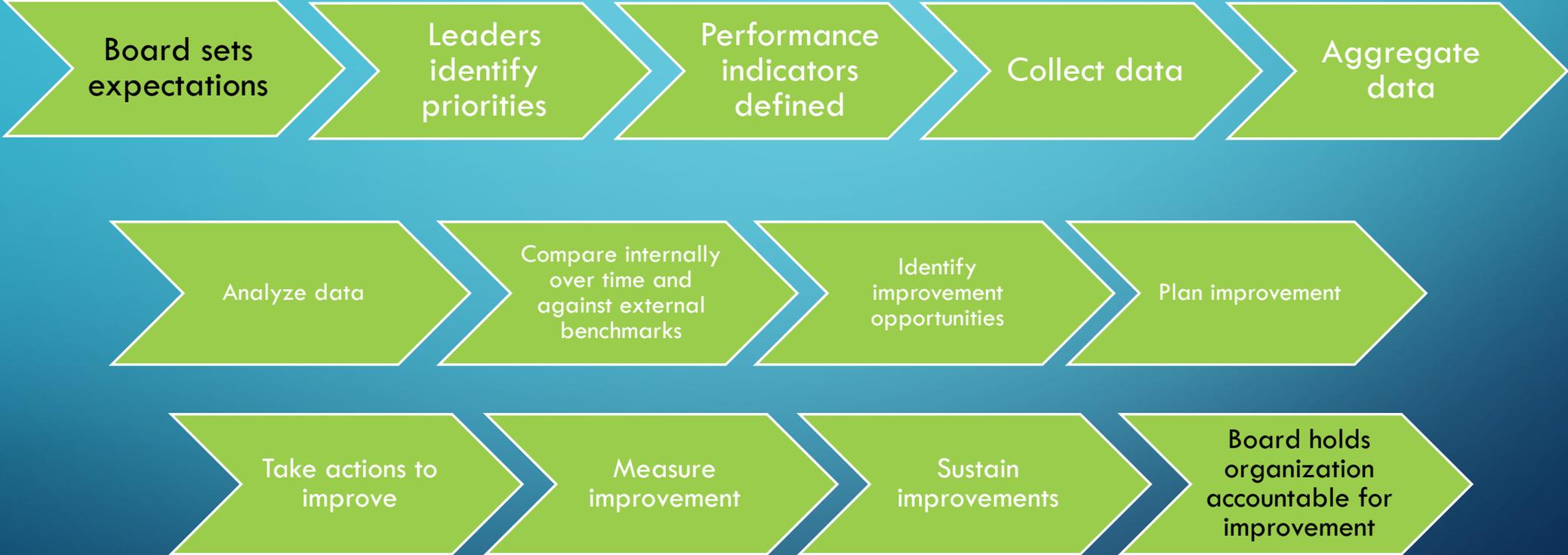
# PROPOSED DASHBOARD COMPONENTS

- HBIPS Measures from Medicare
- Behavioral Codes Called
- Elopements
- Falls
- Incident Reports
- Medication Errors
- Patient Satisfaction Data
- Patient Aggression Events
  - Patient-Patient Aggression
  - Patient-Staff Aggression
  - Resulting injury
- Patient Self-Injurious Behaviors

## PATIENT SAFETY COMMITTEE

- The first meeting of the newly chartered Patient Safety Committee occurred on Thursday, April 30, 2020.
- The Charter, Scope and Goals of the committee were identified and approved by the committee.
- Those documents are available to the Board upon request.

# QAPI PROCESS



# BOARD ROLE & RESPONSIBILITY

- Are your expectations clearly defined for management?
- Have you received sufficient information to be able to draw a conclusion(s)?
  - Quality measures
  - Patient safety measures
- Is the organization improving over time and relative to external benchmarks?
- Do improvements meet your expectations?
- Is improvement occurring at an acceptable pace?
- What actions have you taken when improvement is not achieved?
- Have improvements been sustained?

## Proposed Indicators

- Screening for metabolic disorders (SMD)-95% compliance- Part of an Order set to capture this information on inpatients.
- Patients assessed and given Influenza Vaccination-IPFQR-IMM-2, (Seasonal) 1<sup>st</sup> quarter 2020-40%
- Patients with alcohol abuse (Sub-2) received/refused a brief intervention (100% compliance) during hospitalization
- Patients with alcohol abuse (Sub-2A) received a brief intervention (75% compliance)
- Patients screening positive for alcohol or drug use(Sub-3) at D/C received or refused prescription medications or received or refused a referral (100% compliance)
- Patients screening positive for alcohol or drug use( Sub-3A) received a prescription medication or received a referral for counseling ( 38% compliance)

# Proposed Indicators

- Patients who use tobacco and received or refused counseling OR that received medication to quit or had a reason NOT to receive medication to quit (TOB-2) (100% compliance)
- Patients who use tobacco and received counseling and received medications or had a reason for not receiving (TOB 2A) (61 % compliance)
- Patients who use tobacco and at discharge received referral for outpatient counseling, and received or refused a prescription to help quit or had a reason for not receiving medication (TOB-3, 34%)
- HBIPS-2, Hours of Restraint 284.9, or .43% (Hours/divided by hours of patient care.
- HBPIS-3 Hours of Seclusion 90, or .20% (Hours/divided by hours of patient care

# Proposed Indicators

- HBIPS-5, Patients discharged on multiple antipsychotics with appropriate justification-(96 % compliance)
- FUH-7 - Patients hospitalized for mental illness who received outpatient mental health follow-up within 7 days.
- FUH-30-Patients hospitalized for mental illness who received outpatient mental health follow-up within 30 days.
- READMIN-30RPF- Readmission to a psychiatric hospital within 30 days of discharge for any reason.

# Proposed Indicators

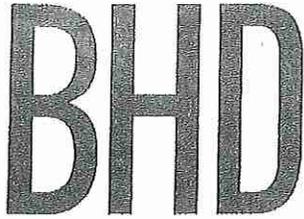
- Self-Explanatory Performance Measures
- Readmission within 7 days, 30 Days
- Patient Satisfaction
- Patient-Patient Aggression
- Patient-Staff Aggression
- Injury sustained
- Medication Errors
  - Rate of Error
  - Type of Error
- Falls
  - Number of falls
  - Repeat falls during hospitalization
  - Falls with injury

**FISCAL 2003 – THIRD QUARTER & YEAR-TO-DATE**  
 (APRIL 1, 2003 – JUNE 30, 2003)  
 REPORT OF MIDDLESEX HEALTH SYSTEM PERFORMANCE INDICATORS  
 FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2003

October 2003

Human Resources

3 <sup>rd</sup> Qtr.	YTD		3 <sup>rd</sup> Qtr.	YTD	
3.30%	10.70%	Turnover All Employees 3 <sup>rd</sup> Quarter Budget = 2.5% 3 <sup>rd</sup> Quarter 2002 = 3.0%	<2.5% 2.5% >2.5%	<12% 12% >12%	Measure of employee satisfaction/retention. Connecticut Hospital Association is beginning to track this statistic. Benchmark represents a stretch goal for improvement based on internal historical trends.
2.90%	8.75%	Turnover Staff RNs 3 <sup>rd</sup> Quarter Budget = 2.0% 3 <sup>rd</sup> Quarter 2002 = 1.59%	<2.0% 2.0% >2.0%	<10% 10% >10%	Measure of employee satisfaction/retention. Benchmark chosen based on experience in other Magnet Hospitals.
0.00%	1.60%	Turnover Radiology Technologists 3 <sup>rd</sup> Quarter Budget = 2.5% 3 <sup>rd</sup> Quarter 2002 = 3.0%	<2.5% 2.5% >2.5%	<15% 15% >15%	Measure of employee satisfaction/retention. Benchmark represents a stretch goal for improvement based on internal historical trends.
2.55%	N/A	Vacancies Staff RNs 3 <sup>rd</sup> Quarter Budget = 11.5% 3 <sup>rd</sup> Quarter 2002 = 10.2%		<11.5% 11.5% >11.5%	Measure of ability to attract new staff. Benchmark based on Connecticut Hospital Association average.  Vacancy rate is computed on of the last day of the quarter.
1.78%	N/A	Vacancies Radiology Technologists 3 <sup>rd</sup> Quarter Budget = 11.5% 3 <sup>rd</sup> Quarter 2002 = 17%		<11.5% 11.5% >11.5%	Measure of ability to attract new staff. Benchmark based on Connecticut Hospital Association average. National statistics show an 18% shortage of technologists nationwide.  Vacancy rate is computed on of the last day of the quarter.
5.04%	5.02%	Total FTEs per Adjusted Occupied Bed 3 <sup>rd</sup> Quarter Budget = 4.63 3 <sup>rd</sup> Quarter 2002 = 4.9		<Bdgt. Bdgt. >Bdgt.	This is a traditional measure used in the health care industry to measure staffing productivity. A hospital with a lower number calculated for this statistic is generally thought to be more efficient than a hospital with a higher number. An internal performance benchmark has been selected based upon the budgeted staffing level and patient volume incorporated in the hospital's current year operating budget. While Middlesex has historically performed at the state average for this measure, an internal benchmark has been selected because industry statistics have been skewed in recent years by the increased use of contracted labor which is not considered by this statistic.

<b>Current Status:</b> <i>Pending</i>		<b>PolicyStat ID:</b> 7440040	
 <b>MILWAUKEE COUNTY</b> <b>Behavioral Health Division</b>	<b>Date Issued:</b>	N/A	
	<b>Effective:</b>	Upon Approval	
	<b>Last Approved Date:</b>	N/A	
	<b>Last Revised Date:</b>	N/A	
	<b>Next Review:</b>	3 years after approval	
	<b>Owner:</b>	Jennifer Bergersen: Exdir2-Assoc Dir Clin Compl	
	<b>Policy Area:</b>	Quality Management	
	<b>References:</b>		

**BHD Quality Improvement Program Description:  
Hospital Quality Assessment Performance  
Improvement Plan (QAPI) - Patient Safety Plan**

**Purpose:**

The purpose of the Quality Improvement Program is to promote accountability for the quality of acute emergency and inpatient psychiatric delivery and services. This is accomplished through a systematic approach of assessing, defining interventions, implementing, and evaluating effectiveness of interventions with the goal of continuous improvement of clinical care and service. The Quality Improvement Program is supported by a committee structure that establishes accountability to the Milwaukee County Mental Health Board for the Behavioral Health Division (BHD) and allows for information flow to and from the Quality Committee/Board and affiliated personnel.

**Scope:**

BHD will maintain a written BHD Quality Improvement Program Description (within the Hospital QAPI Plan) outlining the Quality Improvement program structure and content, encompassing relevant aspects of psychiatric emergency and hospital based delivery and service provided to patients through Milwaukee County.

**Policy:**

Quality Assessment and Performance Improvement (QAPI) is a data driven and proactive approach to quality improvement. All members of BHD, including patients, are involved in continuously identifying opportunities for improvement. Gaps in systems are addressed through planned interventions with a goal of improving the overall quality of life and quality of care and services delivered to patients who come to our emergency room and who are admitted to our acute psychiatric hospital.

The Hospital QAPI plan will serve as a framework for BHD's hospital performance improvement efforts. The QAPI regulation requires a written plan. This plan is the framework for an effective, comprehensive, data driven program that focuses on the departmental indicators that reflect outcomes of care and quality of life. The plan assists BHD in achieving what has been identified as the purpose of QAPI in our organization. The QAPI plan also is intended to be a working document that BHD will continue to review and revise. The written Hospital QAPI plan will be made available to a state agency, federal surveyor, or CMS upon request. It reflects the way BHD has developed, implemented, and maintained our quality program.

## Definitions:

QI Definitions for Public Health: For purposes of executing this policy, the following nationally accepted public health definitions will be used.

Quality: In public health terms, quality is the degree to which policies, programs, services and research for the population increase desired health outcomes and conditions in which the population can be healthy (Public Health Quality Forum, US Department of Health & Human Services).

Quality Assurance (QA): Assurance of quality is the planned and systematic activities implemented in a quality system so that quality requirements for a product or service will be fulfilled; American Society for Quality (ASQ). Quality Assurance may also be defined as a retrospective review of processes, programs, and services. It provides for the systematic monitoring and evaluation of the various aspects of a project or service to ensure that standards of quality are being met. QA is frequently used to guarantee quality.

Quality Improvement (QI): Use of a deliberate and defined improvement process, such as Plan-Do-Study-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community (Accreditation Coalition, Public Health Foundation, et.al.). QI is frequently used to raise quality.

## Procedure:

A. The QI Program description is developed by the BHD Hospital QAPI committee in collaboration with the Medical Director. The program description includes the following, but not limited to:

- Introduction
- Scope
- Guidelines for Governance and Leadership
- Quality Improvement Principals
- Continuous Quality Assessment and Assurance Activities
- Performance and Improvement Projects (PIPS)
- Systematic Analysis and Systemic Action
- Feedback, Data Systems and Monitoring
- Patient Safety

B. The program description is approved by the BHD Hospital QAPI Committee, Medical Staff Executive Committee and the Milwaukee County Mental Health Board via the MH Quality Committee of the Board on an annual basis.

C. The program description is evaluated by the BHD Hospital QAPI Committee, Medical Staff Executive Committee, and the Milwaukee County Mental Health Board via the MH Quality Committee annually and updated as necessary.

D. The BHD Hospital QAPI Committee will be comprised of representatives from Executive Leadership as well as other departmental representatives. Each department will report their outcomes according to a designated reporting calendar established by the QAPI Committee, with those outcomes reported to other committees as necessary.

E. The members of the BHD Hospital QAPI Committee are responsible for:

1. Ensuring the use of consistent data collection methodologies of departmental indicators.
2. Accountable for the timely collection of data as well as reporting of data.
3. Dissemination of the data outcomes to appropriate staff within their respective service area(s).

## References:

Refer to attached BHD Hospital QAPI Plan.

## Monitors:

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

## Attachments

BHD-QAPI PLAN VERSION 8 .pdf

## Approval Signatures

Step Description	Approver	Date
	Jennifer Bergersen: Exdir2-Assoc Dir Clin Compl	pending
	Jennifer Bergersen: Exdir2-Assoc Dir Clin Compl	5/12/2020

QUALITY ASSESSMENT/ PERFORMANCE IMPROVEMENT  
&  
PATIENT SAFETY PLAN  
OF THE  
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
MILWAUKEE, WISCONSIN

June 01, 2020

## Table of Contents

### **Introduction**

#### **I. MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION (HOSPITAL) QAPI and Patient Safety Plan**

- Purpose
- Mission
- Vision
- Philosophy and Partnership in Care
- Culture of Safety Quality and Innovation
- Healthy Learning Environment
- Financial Resources
- Core Values

#### **II. Scope**

Services Provided

#### **III. Guidelines for Governance and Leadership**

Responsibility and Accountability.

Describe how QAPI will be adequately sourced.

Determine the plan for mandatory QAPI staff training and orientation.

Framework for QAPI

Determine how the QAPI activities will be reported to the governing body.

Describe how a fair and just culture for staff will be implemented.

#### **IV. Quality Improvement Principles**

Customer Satisfaction Focus

Recovery-Oriented Philosophy of Care

Employee Empowerment

Leadership Involvement

Data Informed Practice

Statistical Tools

Prevention of Over Correction

Actions to Improve Performance and Reduce the Risks of Sentinel Events.

#### **V. Continuous Quality Assessment and Assurance Activities.**

Patient Complaints & Grievances

Variance Reporting

Identification and Management of Sentinel Events

Addressing Key Education

#### **VI. Current Quality Assessment and Assurance Activities**

Use of Best Available Evidence

**VII. Performance Improvement Projects (PIPS)**

- Conducting Performance Improvement Projects (PIPS)
- Identification of Potential Topics for Performance Improvement Projects
- Criteria for Prioritization and Selection of Performance Improvement Projects
- Development of Performance Improvement Charters
- Designation of Performance Improvement Projects
- Conducting Performance Improvement Projects
- Process for documenting and communicating performance improvement projects

**VIII. Systematic Analysis and Systemic Action**

- Systematic Approach to Quality Assessment/Performance Improvement
- Approach to preventing future events and promoting sustained improvement
- Approach to ensure planned changes interventions are implemented and effective

**IX. Feedback, Data Systems, and Monitoring**

- Identify Data Sources to Analyze Performance, Identify Risk and Collect Feedback/Input

**X. Patient Safety**

- Patient Safety Committee
- General Objectives of the Patient Safety Committee
- Membership
- Meeting Frequency
- Patient Safety Plan Goals
- Oversight of the Committee

**ATTACHMENTS**

A-FRAMEWORK FOR QAPI

B-ADDITIONAL DATA SOURCES

C-EXAMPLE OF USE OF FRAMEWORK

D-REPORTING FLOWCHART

## **I. Hospital QAPI /Patient Safety Plan**

### **Purpose**

The Milwaukee County Behavioral Health Division's (BHD) written QAPI/Patient Safety plan is a description of the organizational, multidisciplinary, and systematic performance improvement function and patient safety function designed to support the Mission, Values, and Philosophy of the Milwaukee County Behavioral Health Division (BHD). Moreover, the Performance Improvement/Patient Safety is an ongoing program that demonstrates measurable improvement in indicators for which there is evidence that they will improve patient outcomes and identify and reduce medical errors.

Performance improvement and Patient Safety principles will drive the decision making within the organization. Decisions will be made to promote excellence in quality of care, quality of life, patient choice, person directed care, and patient transitions. Focus areas will include all systems that affect patient and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in the organization.

The Milwaukee County Behavioral Health Division (BHD) provides care and treatment for adults, children, and adolescents with serious behavioral health and substance use disorders. Care is provided through County-operated programs, and contracts with community agencies, and provider partnerships. Services include intensive short-term treatment, acute psychiatric hospital services, crisis services, and an array of supportive community behavioral health programs.

### **Mission**

Department of Health and Human Services: Empowering safe, healthy, meaningful lives.  
Behavioral Health Division: Empowering safe, healthy, meaningful lives through connections that support recovery.

### **Vision**

The Milwaukee County Behavioral Health Division, through fostering strategic community partnerships, will become an Integrated, Community Based Behavioral Health System of Care providing a dynamic, and comprehensive array of services, including community based, emergency, and acute services, to meet the behavioral health care needs of individuals and families.

### **Philosophy of and Partnership in Care**

Patients/Clients will be provided care in a person-centered, recovery oriented, trauma informed, culturally intelligent, least restrictive environment, with patient/clients and families as essential members of the care team. Partners in this vision include other stakeholders within Milwaukee County, the greater Milwaukee and Wisconsin communities, and nationally.

## **Culture of Quality, Safety and Innovation**

A culture of data driven decision making and continuous improvement, focused on quality and safety, meeting and exceeding regulatory, accrediting, best practice standards and patient and family expectations will be created. Technology will be implemented, created, effectively used and disseminated across the continuum of services.

## **Healthy Learning Environment**

A positive learning environment and a culture grounded in respectful communication, collaboration, and healthy working relationships will be created. Support of education of clinical disciplines in this organization, inter-professional educational models, and ongoing development of a behavioral health workforce will occur in partnership with others.

## **Financial Resources**

Leadership will be provided in creating lasting resources. Goals also include increasing operational efficiencies and minimizing tax levy exposure. This entity will meet the statutory obligations of Milwaukee County for the behavioral health services of its citizens, acting either as a provider or a purchaser of services.

## **Core Values**

Our Behavioral Health Hospital will support and adopt the following core values:

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed Care
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

## **II. Scope**

### **Services Provided**

#### **Acute Services**

##### **(1) Psychiatric Crisis Services/Admission Center (PCS)**

The Psychiatric Crisis Service (PCS) is a specialized psychiatric crisis emergency department open 24 hours a day 7 days a week. PCS is the state appointed emergency detention facility and provides psychiatric emergency services including face to face assessment, crisis intervention and medication for individuals who may be in psychiatric crisis and who present to the center.

A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, behavioral health emergency clinicians, psychologists, psychiatric technicians and certified nursing assistants are available on site 24/7 to provide assessments, interventions, referrals and services as appropriate. All PCS patients who are not admitted to an inpatient unit or placed on an observation status are provided a written discharge plan to include written prescriptions, discharge teaching related to medications, self-care, health care and other learning needs, referrals, appointments, community resource materials and contacts with outside providers.

## **(2) Observation Unit (OBS)**

If the PCS psychiatrist determines that there is a need for brief treatment and/or a more extended period of observation in order to evaluate the physical and mental status of an individual, the patient may be treated on Observation status and/or on the Observation Unit (OBS) up to 48 hours. This unit has the capacity for 18 beds available 24 hours a day and 7 days a week. The patient will be evaluated and may be discharged to another community setting, transferred to another facility for continuation of care, or considered for admission to a psychiatric hospital either at BHD or a private community hospital. A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, behavioral health emergency clinicians, psychologists, psychiatric technicians and certified nursing assistants are available on site to provide assessments, interventions, and discharge orders and referrals.

## **INPATIENT SERVICES**

The Milwaukee County Behavioral Health Division's Hospital Inpatient Services are provided in four-licensed psychiatric hospital units with three specialized programs for adults and one specialized unit for children and adolescents. Adult licensed units include one 24 bed adult unit called the Acute Treatment Unit (ATU), one 24 bed Adult Inpatient Co-Ed (AICE) and one 18 bed Intensive Treatment Unit (ITU). All units provide inpatient care to individuals who require safe, secure, short-term or occasionally extended hospitalization. A multi-disciplinary team approach of psychiatry, psychology, nursing, social service and rehabilitation therapy provide assessment and treatment designed to stabilize an acute psychiatric need and assist the return of the patient to his or her own community. (\*Average daily census = average for years 2018-2019).

- (1) **43-A (ITU)**-program provides a safe, supportive environment for individuals with mental health conditions who are at high risk for aggressive behavior and in need of intensive behavioral and pharmacological interventions. The capacity of this unit is 18 beds with an \*average daily census of 13.4 patients.
- (2) **43-B (ATU)**- program is a general co-ed psychiatric care and teaching unit providing specialized services for adult men and women recovering from complex and co-occurring disorders who require safe, acute psychiatric services. The capacity of this unit is 24 beds with an \*average daily census of 13.1 patients
- (3) **43-C (AICE)**- program is a general co-ed psychiatric care unit providing specialized services for adult men and women recovering from complex and co-occurring disorders who require safe, acute psychiatric services. The capacity of this unit is 24 beds with an \*average daily census of 14.0 patients.
- (4) **Child and Adolescent (CAIS) unit** is licensed for 24 beds and has an \*average daily census of 7.5 patients. Inpatient care is provided to individuals ages 7- 17. The CAIS treatment unit also provides emergency detention services for Milwaukee County as well as inpatient

screening for Children's Court including the provision of an adjacent educational school program operated by the Wauwatosa School District.

Patient census on all licensed psychiatric hospital units is adjusted based on patient needs and staffing care patterns to ensure safe, quality care. A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, psychologists, social workers, occupational therapists/music therapists, peer specialists, psychiatric technicians and certified nursing assistants are available on site on all units to provide hospital assessments, interventions, referrals, supervision and intensive psychiatric hospital services as appropriate.

Ultimately patients can expect a respectful, positive patient experience. Services can include assessment; diagnosis; individualized recovery plans; pharmacotherapy; a safe, healing environment; a caring, welcoming team; structured programming; patient education; peer support; family and support participation; consultative services; spirituality services; music and occupational therapy; and comprehensive discharge planning.

Each patient admitted to the psychiatric hospital will have an aftercare/discharge plan specifying services and referrals needed upon discharge. Treatment teams assure that individual patient's bio-psycho-social needs and strengths are addressed with interventions, referrals and education to prepare those receiving care for community living or another level of care in the least restrictive setting.

### **III. Guidelines for Governance and Leadership**

#### Responsibility and Accountability

The key to the success of the continuous quality improvement process is leadership. The following describes how leaders will provide support for quality improvement activities.

The Milwaukee County Mental Health Board is ultimately accountable for quality and safety at BHD. The MH Board Quality Committee provides governance and leadership for BHD Hospital QAPI /Patient Safety Plan by:

- Supporting and guiding implementation of quality improvement activities at BHD; and
- Reviewing, evaluating and approving the BHD Hospital QAPI /Patient Safety plan annually.
- That the determination of the number of distinct improvement projects is conducted annually

The BHD Hospital QAPI Committee will be responsible to review quality improvement activities including performance toward established programmatic outcomes. Annually, PIPs and related continuous quality improvement updates will be submitted to the Quality Committee of the Mental Health Board (and subsequently the Governing Board) for review, input and approval.

BHD Executive/Program Leadership Teams and/or Clinical Discipline Leads will collaborate with the Medical Executive Committee to develop, guide and supervise all aspects of quality within the hospital. This will include organizing teams, committees and structures to support all ongoing and developing quality activity needs and reporting requirements.

Program leadership and the clinical discipline leaders will have responsibility for championing all aspects of quality and safety, which includes participation and promotion of a BHD culture of quality and safety. Each sub-group/sub-program lead will be responsible to report their quality improvement activities and performance toward goals to their direct manager and the BHD Hospital QAPI Committee.

BHD Leadership will facilitate input, critical discussion, and coordination of all quality activities with stakeholders. This includes planned and ad hoc coordination and communication. Types of information shared would include summary data and analysis of measurement activities, quality initiative outcomes, and Dashboards of Key Performance Indicators.

BHD Leadership and staff value the process of sharing outcomes and quality results with the Mental Health Board, patients, families, advocacy groups, and the community. This helps ensure that these groups have knowledge of and input into our quality planning and improvement opportunities. The information will be shared with the staff through hospital publications and departmental/unit meetings.

BHD quality improvement personnel, hospital program leadership, and the hospital QAPI team will have the responsibility for championing all aspects of quality, including the promotion of a culture of continuous improvement.

#### Sourcing of Quality Assurance Performance Improvement Activities

The BHD Hospital QAPI Committee and program leadership will assess needs and request financial resources to ensure quality improvement activities are properly planned and budgeted on an annual basis. The BHD Executive team will establish the appropriate budget to support continuous quality improvement activities across the organization. These expenses may include, but not limited to; financial support for projects, resources, and training. The budget will be reviewed annually by the BHD Executive Committee, then reviewed with the Chief Financial Officer. Staffing and needs will be assessed and identified to support the expansion and function of future needs and adjusted accordingly.

The positions required in the BHD Hospital QAPI Program and supporting the BHD Hospital QAPI Plan are to include but not limited to: Executive Director/Administrator, Assistant Administrator, Chief Nursing Officer, Assistant Chief Nursing Officer, Director of Environmental Service, Director of Dietary Services, Director of Rehabilitation Services, Director of Social Services and/or Director of Activities.

The committee also includes, Chief Operations Officer, Chief Medical Director (or designee), Hospital/Crisis Medical Director/Managers, Safety Officer, Director of Clinical Informatics, Manager of Quality Improvement, RN Risk Management, Quality Assurance Coordinators and Client Rights Specialist, and subject matter experts as needed.

#### Plan for mandatory QAPI/Patient Safety staff training and orientation.

QAPI/Patient Safety principles and staff responsibilities related to QAPI and ongoing quality improvement will be included in orientation for all new employees. QAPI will be included in the organizational orientation that all new employees are required to attend. All staff will participate in ongoing annual QAPI/Patient Safety training which will include quality improvement principles and practices, how to identify areas for improvement, updates on current performance improvement projects, and how staff can be involved in performance improvement projects. Training may be through the use of in-person as well as on-line modules.

#### Framework for Quality Assessment and Performance Improvement

The BHD Hospital QAPI Committee and Medical Staff Executive Committee will be the two committees that have the responsibility for the oversight of planning, designing and selection of quality improvement activities to best meet the needs of BHD emergency/hospital patients. Individuals from the organization will be selected to conduct performance improvement projects to include monitoring progress, providing input, and ensuring individuals involved in projects have technical assistance and guidance. QAPI/Patient Safety activities and outcomes will be on the agenda of department staff meetings. The minutes from all meetings will be posted on a shared site. The BHD Hospital QAPI committee will report all activities to the Mental Health Board Quality Committee during their regularly scheduled meetings. Refer to committee calendar.

#### Reporting of QAPI Activities to the Governing Body

The Chief Operations Officer will facilitate discussion about hospital QAPI activities at the Mental Health Board Quality Committee meetings. QAPI will be a standing agenda item for these meetings. Input will be solicited from board members on QAPI activities. Current projects and outcomes will be reviewed at the board meetings.

The Mental Health Board Quality Committee will complete an annual Governance of Quality Assessment (GQA), in collaboration with BHD administration and senior leaders who interface with the Mental Health Board Quality Committee. The Mental Health Board Quality Committee will share the results with the Mental Health Board, the quality committee chair(s) and/or the quality committee. This will establish a baseline for assessing the Mental Health Board Quality Committee's current state of oversight of quality; identify opportunities for improvement; track the board's GQA scores over time as a measure to improving their quality oversight. Involving senior leaders in the completion of the GQA will help them understand and assess their role with respect to trustee oversight of quality and identify educational opportunities with the board.

## Implementation of an Organizational Fair and Just Culture

Executive Leadership and the BHD Hospital QAPI Committee will provide an environment that supports individual expression about the Hospital QAPI Program, any quality concerns, or suggestions for areas of improvement. BHD will support practices and principles of a learning environment and a non-punitive or Just Culture. Team members are educated at all levels of the organization, to build a system of fairness, honesty and accountability in reporting adverse events and near misses, learning from experience and preventing the notion of “blame.”

### **IV. Quality Improvement Principles**

Quality improvement is a systematic approach to assessing care and services and improving them on a priority basis. The Behavioral Health Division's approach to quality improvement is based on the following principles:

- Customer Satisfaction Focus. High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations; customer satisfaction.
- Recovery-Oriented Philosophy of Care-Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit person-centered services.
- Employee Empowerment-Effective programs involve people at all levels of the organization in improving quality.
- Leadership Involvement- Strong leadership, direction and support of quality assurance and quality improvement activities by the Governing Board, Chief Executive Officer, Executive Team and the Medical Staff Leadership are key. The involvement of organizational leadership assures that quality improvement initiatives are consistent with our mission and strategic plan.
- Data Informed Practice-Successful Quality Improvement processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions
- Statistical Tools-For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. BHD, like Continuous Quality Improvement organizations, use defined analytic tools such as run charts, cause and effect diagrams, flowcharts, histograms, and control charts to turn data into information as appropriate.
- Prevention of over Correction-Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- Continuous Improvement-Processes must be continually assessed, reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.
- Actions to Improve Performance and Reduce the Risks of Sentinel Events-The hospital Will use information from data analysis, trending and process evaluation to identify, implement and sustain changes that will improve the quality and safety of patient care services and reduce the risks of sentinel events. Action plans are developed to address contributing factors and root causes associated with adverse events.

## **V. Continuous Quality Improvement Activities**

Quality improvement activities emerge from a systematic and organized framework for improvement. The framework adopted by the BHD leadership will be understood, accepted and utilized throughout the organization. In addition, adoption is supported by continuous education and involvement of all staff in performance improvement.

Quality Improvement will involve two primary activities:

- Measuring and assessing the performance of care and service delivery through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the:
  - Design of new services, and/or
  - Improvement of existing services.

### Patient Complaints and Grievances

Patient complaints and grievances may be a source of concern related to quality safety or satisfaction. As a result, the organization has a process for registering, investigating, managing and responding to patient complaints consistent with state and federal regulations. Please refer to the policy related to Grievance/ Complaint Policy. The Patient Relations Department/Client Rights Specialist is a resource to patients and families in helping address unmet needs or complaints that have not been resolved through front-line efforts.

### Variance Reporting

BHD will utilize variance reporting to identify events or occurrences requiring rapid problem solving. Variances are forwarded to the Quality Management Department for investigation. Variances, including patient safety issues, are forwarded to the Safety Department for prompt investigation, reporting to external agencies in accordance with law and regulation, resolution, tracking and trending. All incidents will be described and categorized as behavioral, medication etc., and described when reported. Any employee or physician who witnesses an unusual or unexpected event, which has the potential to result in an undesirable outcome for the patient, may initiate variance reports through the VERGE electronic incident reporting system. Risk reduction and appropriate problem solving will be documented, tracked and trended. A Harm Score Distribution is used to assess the degree of risk (See table E.) Certain serious outcomes will be reported to the State of Wisconsin and other regulatory agencies as required. Monthly and quarterly results are reported to the QAPI Committee and action taken as appropriate.

### Identification and Management of Sentinel Events

BHD's approach to sentinel events is to utilize them as a means to identify systems issues that will improve patient safety and prevent further unanticipated outcomes. Sentinel Events and the root cause analysis process are defined in the Sentinel Event Policy. If the event is considered a sentinel event per policy and criteria the level of investigation will be determined.

Review of actual or potential sentinel events occur under the auspices of the Sentinel Event Committee as described in the Sentinel Event policy. Executive leaders review Root Cause Analyses (RCA's) of sentinel events and near misses and track and trend the nature of the event and the effectiveness of the action plans in order to develop and implement systems or to suggest actions to enhance the quality and/or safety of patient care.

#### Addressing Key Education

The principles of QAPI/Patient Safety will be taught to all staff and board members upon onboarding and on an ongoing basis. QAPI/Patient Safety activities will aim for the highest levels of safety, excellence in clinical interventions, patient and family satisfaction and management practices. All organizational decisions involving patients will be focused on their autonomy, individualized choices and preferences, and to minimize unplanned transitions of care.

BHD will partner with patients, their supports, and/or advocates to achieve their individualized goals and provide care that respects their autonomy, preferences and choices. When the need is identified, corrective action plans or performance improvement projects to improve processes, systems, outcomes, and satisfaction will be implemented.

BHD strives to employ evidence-based practices related to performance excellence in all management practices, clinical care, and patient and family satisfaction. Staff and patient input will be solicited into all aspects of our BHD Hospital QAPI and Patient Safety program.

#### **VI. Current Quality Assessment and Assurance Activities**

\*Please refer to the monitoring activities spreadsheets attached to this document.

#### Use of Best Available Evidence

BHD will use the best available evidence and data to benchmark our organization, establish goals and define measurements for improvement. The BHD Hospital QAPI Committee will review data from other psychiatric publicly funded facilities, state, and national sources to compare our organization. When establishing goals, defining measurement and choosing interventions, we will use the best available evidence-based practices and guidelines to guide our decision-making.

At BHD, Service Quality also describes the way services are provided and is used to guide our decision-making, establish goals, and define measurements. Service Quality consists of care, treatment and services that are provided in a safe, effective, patient-centered, timely, equitable, and recovery-oriented manner. BHD is committed to the ongoing improvement of the quality of care patients receive, as evidenced by the outcomes of that care.

The organization continuously strives to ensure that:

- The treatment provided incorporates evidence based, effective practices.
- The treatment and services are appropriate to each patient's needs, and available when needed.

- Risk to patients, providers and others are minimized, and errors in the delivery of services are prevented.
- Patient's individual needs and expectations are respected.
- The patient or those whom they designate have the opportunity to participate in decisions regarding their treatment.
- All care and services are provided with empathy, understanding, caring and trauma informed focus.
- Procedures, treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and with all providers of care.

## **VII. Performance Improvement Projects (PIPs)**

### Conducting Performance Improvement Projects (PIPs).

The Behavioral Health Division will conduct PIPs in identified areas in an effort to improve direct patient care, services, or practices that may affect patient care. PIPs will be conducted that address areas of concern/need/risk that may cross both adult and child acute care services. PIPs may address patient/staff quality of life and/or quality of care issues, service delivery, efficiencies issues, desired outcomes, and satisfaction levels for the populations served.

### Identification of Potential Topics for Performance Improvement Projects.

BHD will conduct performance improvement projects as part of its quality assessment and performance improvement program.

- (1) The number and scope of distinct improvement projects conducted annually will be proportional to the scope and complexity of the hospital's services and operations.
- (2) BHD may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes.
- (3) BHD must document all quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
- (4) BHD is not required to participate in a Quality Improvement Organization (QIO) cooperative project, but its own projects are required to be of comparable effort.

### Criteria for Prioritization and Selection of Performance Improvement Teams

Any issues that pose a high risk to BHD patients, are frequent in nature, or otherwise impact the safety and quality of life of our patients will be prioritized by the BHD Hospital QAPI Program. Priority will be given to areas that BHD defines as high-risk to patients and staff, high-prevalence and/or high-volume, and areas that are problem-prone.

The PIPs will serve the greater good and/or ensure better outcomes. Consideration will be given to include staff most affected by the PIP. Anticipated training needs will be discussed as well as other resources to complete the PIP. The BHD Hospital QAPI Program will provide guidance on

how to address issues that arise and need immediate corrective action. The BHD Hospital QAPI Program will provide evidence to show why each project was selected.

In addition, consideration for prioritization and selection will be given to the following:

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

#### Development of Performance Improvement Charters

PIP charters and/or multi-disciplinary workgroups that include process/system stakeholders will be identified when the BHD Hospital QAPI Program determines that it necessary to have a group/committee of individuals implement a project. A charter will be used to establish the goals, scope, timing, milestones, team roles and responsibilities for the PIP. The charter will help the team/workgroup stay focused by reminding them of the desired outcomes and the goals to be accomplished within expected time frames.

#### Designation of Performance Improvement Projects

When establishing the PIP work team, the BHD Hospital QAPI Program will consider the following:

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

#### Conducting the Performance Improvement Project

The PIP team will develop an action plan using BHD’s usual format and/or framework. The PIP team will use root cause analysis (RCA) to identify factors that contributed to need for a PIP. PDSA cycles will be used to identify and implement interventions. The PIP team will use measurement tools to ensure that the changes that are implemented are having the desired effect.

The overarching guidelines that will be followed are:

- Select a study topic
- Determine what information is needed
- Define a study question
- Select study indicators
- Define a study population/sample size

- Define a timeline/action plan
- Create/locate data collection/measurement tools
- Implement improvement strategies/interventions
- Collect/analyze data
- Prepare and present results

Process for documenting and communicating performance improvement projects and trends in performance measures.

The PIP process and trends in performance measures will be documented in a way that will best highlight the project. The data will be presented in a structured, chronologically mindful, clear, and systematic manner. Charts, graphs, tables, dashboards, posters, and narratives will be used. Results of PIPs will be communicated with the Mental Health board members, the State, community partners, and other critical stakeholders and partners. The results will be communicated as appropriate at MH board meetings, BHD QAPI committee meetings, BHD staff meetings, and community forums.

**VIII. Systematic Analysis and Systemic Action**

Systematic Approach to Quality Improvement

The BHD Hospital QAPI Plan is part of the larger BHD Quality Plan, which is guided by data-informed practices, statistical tools, and continuous improvement. BHD uses this systematic approach to determine when in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change. To get at the underlying cause(s) of an issue, BHD brings teams together to identify the root cause(s), gaps in practice, and other potential contributing factors.

Approach to preventing future events and promoting sustained improvement.

In alignment with the BHD Quality Plan, the BHD Hospital QAPI Committee instills this tenant: prevention over correction. Planning will be proactive rather than reactive. To prevent future events and promote sustained improvement, BHD will act upon and address the identified root cause(s) and/or contributing factor(s) of an issue to affect change at a systems level. The team will use Plan-Do-Study-Act cycles to test actions as well as to understand and address the “unintended” consequences of planned changes.

Approach to ensure planned changes/interventions are implemented and effective.

To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, the BHD Hospital QAPI committee will choose indicators/measures that directly relate to the planned changes/interventions and conduct ongoing periodic measurement. The BHD Hospital QAPI committee will review these indicators to ensure that the new action has been adopted and is performed consistently.

The BHD Hospital QAPI Plan exists under the umbrella of the BHD Quality Plan, and thus should enact continuous quality improvement (CQI) Projects, PIPs, or PDSA cycles relevant to the larger plan. At least one plan goal will be in alignment to at least one aspect of the BHD Quality Plan including the mission, vision, core values, guiding elements, service quality tenants, quality improvement principles, or continuous quality improvement activities.

Contract Performance Measures (CPMs) are developed to ensure that entities that contract with BHD are delivering quality, patient focused care. The creation and implementation of CPMs is a BHD-wide effort to identify quality performance indicators, monitor the achievement of indicators, and assess effectiveness. CPMs will be created based on literature reviews, focus groups with staff and consumers, review and approval by subject-matter experts, and are continuously revisited through the contract period.

## **IX. Feedback, Data Systems, and Monitoring**

### Identify Data Sources to Analyze Performance, Identify Risk and Collect Feedback/Input

BHD will effectively identify, collect, and use data and information from all departments and the facility assessment to develop and monitor performance indicators to track ongoing performance. Refer to monitoring activities.

## **X. Patient Safety**

BHD strives to achieve and maintain a Patient Safety conscious environment integrated throughout the facility. Reporting of errors involving patients, staff and visitors' errors focuses on corrective actions through staff education for those reporting the errors, rather than punitive or disciplinary responses.

### Patient Safety Committee

#### General Objectives of the 2020 Patient Safety Committee are:

- To facilitate communication, reporting, and documentation of all patient safety activities to staff, administration and appropriate governing members.
- To focus and coordinate the organization wide patient safety initiatives.
- To achieve the appropriate balance between good outcomes, excellent care and services and costs.
- To enhance effective organizational and clinical decision making.
- To promote teamwork and group responsibility in identifying and implementing opportunities for improvement.
- To encourage an environment that supports safety, encourages blame free reporting, addresses maintenance and improvement in patient safety issues in every department throughout the facility and establishes mechanisms for the disclosure of information related to errors.

## Membership

At a minimum an assigned representative from:

- Risk Manager (Chair)/Executive Lead
- Member of Executive Leadership Team
- Medical Staff Leadership
- QA/QI
- Client Rights
- Nursing
- Social Services
- Medical Staff
- Safety/Environment of Care
- Front line staff member

## Meeting Frequency

The Patient Safety Committee will meet a minimum of 6 times per year.

The hospital recognizes that to be effective in improving patient safety there must be an integrated and coordinated approach to reducing errors.

BHD has a Performance Improvement/Patient Safety list of goals that include, but are not limited to the following:

1. Achievement of a Patient Safety conscious environment integrated throughout the facility.
2. Improving the reporting of medical errors by establishing a culture focusing on corrective actions through staff education for those reporting their errors, rather than punitive or disciplinary actions
3. Implementation of a Variance/Sentinel Event reporting process that identifies a safety risk index to Analyze harm score distribution for reported incidences
4. Monitoring of hospital-wide indicators in comparison to their thresholds.
5. Reducing the number of medication errors.
6. Monitoring completion of informed consent as well as transfer forms.
7. Reducing the number of falls.
8. Identifying an area for improvement and completing a Failure Mode, Effects Analysis.
9. Monitoring and improving areas identified through Patient Satisfaction surveys and any other areas of feedback.

The Quality Management department receives inpatient satisfaction data from the Mental Health Statistics Improvement Plan survey (MHSIP) and the Youth Services survey. Inpatient patient experience of care data is reported to Mental Health Board.

Patient Satisfaction surveys are utilized to evaluate the needs and expectations of patients including safety needs as is reported to the Mental Health Board Quality Committee on a quarterly basis.

The Patient Safety Committee is integrated with all quality assessment and performance improvement activities. It encompasses risk assessment and avoidance tactics such as conducting a "Failure Mode Effect Analysis" (FMEA). FMEA is proactive risk assessment which examines a process in detail including sequencing of events, assessing actual and potential risk, failure or points of vulnerability and through a logical process, prioritizes areas for improvement based on the actual or potential impact on patient care.

#### Oversight of the Committee

The Patient Safety Committee reports to the Quality Assessment/Performance Improvement Committee to the Medical Executive Committee to the Quality Committee of the Board and ultimately to the Mental Health Board.

## ATTACHMENT A

### MONITORING ACTIVITIES SPREADSHEET

DATA SOURCES	Data Collection Frequency	Benchmarks to utilize this data source	Who will analyze the data	Data analysis frequency	Data will be communicated with	Communicate data analysis via	Frequency of Communication
	<ul style="list-style-type: none"> <li>Weekly</li> <li>Monthly</li> <li>Quarterly</li> <li>Annually</li> </ul>	<ul style="list-style-type: none"> <li>▪ Applicable clinical guidelines</li> <li>▪ Identified best Practices</li> <li>▪ National Data</li> <li>▪ Corporate Data</li> <li>▪ State Data</li> <li>▪ Facility identified performance indicators/goal</li> <li>▪ Thresholds/targets</li> </ul>	<ul style="list-style-type: none"> <li>▪ Leadership team</li> <li>▪ QAPI committee</li> <li>▪ Patient Safety Committee</li> </ul>	<ul style="list-style-type: none"> <li>▪ Weekly</li> <li>▪ Monthly</li> <li>▪ Quarterly</li> <li>▪ Annually</li> </ul>	<ul style="list-style-type: none"> <li>▪ Board members</li> <li>▪ Caregivers</li> <li>▪ Community</li> <li>▪ Executive leadership</li> <li>▪ Families</li> <li>▪ Patients</li> </ul>	<ul style="list-style-type: none"> <li>▪ Board Meetings</li> <li>▪ Bulletin Boards</li> <li>▪ Dashboards</li> <li>▪ Newsletters</li> <li>▪ Posters</li> <li>▪ QAPI Meetings</li> <li>▪ Staff Meetings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Weekly</li> <li>▪ Monthly</li> <li>▪ Quarterly</li> <li>▪ Annually</li> </ul>
Choose a data source							
Choose a data source							

## ATTACHMENT B

### Suggested Data Sources

<ul style="list-style-type: none"> <li>▪ Advanced care planning audits</li> <li>▪ CMS Quality Measures (long-stay; short-stay)</li> <li>▪ Case Mix</li> <li>▪ Community activities</li> <li>▪ Consistent assignment</li> <li>▪ Discharged patient surveys</li> <li>▪ Drug regimen review summary</li> <li>▪ Falls</li> <li>▪ Satisfaction</li> <li>▪ Fire safety deficiencies</li> </ul>	<ul style="list-style-type: none"> <li>▪ Info from providers, physicians, contractors, vendors</li> <li>▪ Licensed nurse staff hours/patient days</li> <li>▪ Medication administration audits</li> <li>▪ Medication errors</li> <li>▪ Medication room audit</li> <li>▪ Near Misses (incidents w/out serious harm)</li> <li>▪ Nursing Assistant /staff hours</li> <li>▪ Occupancy rates</li> <li>▪ Performance Indicators</li> <li>▪ Re-hospitalization rates</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient community meetings/minutes</li> <li>▪ Patient satisfaction surveys</li> <li>▪ Revenue payer sources mix</li> <li>▪ Staff retention</li> <li>▪ Staff satisfaction</li> <li>▪ State survey results</li> <li>▪ Staff turnover</li> <li>▪ Other</li> </ul>
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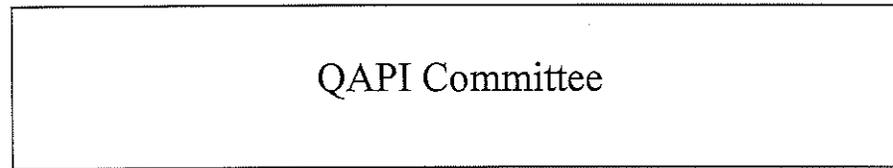
## ATTACHMENT C

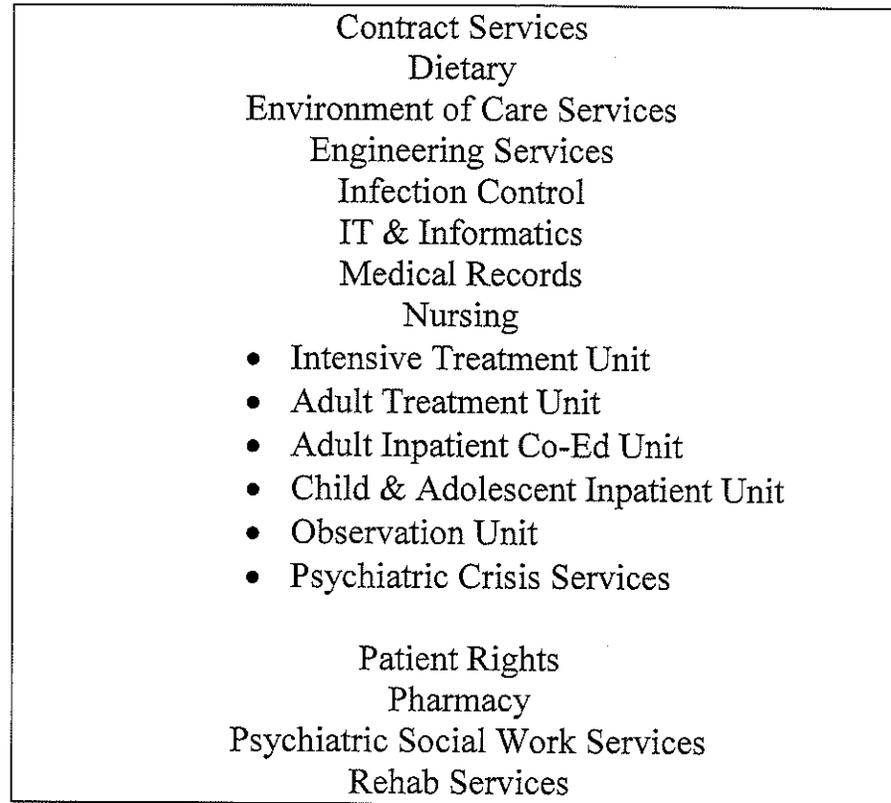
### Specific Departmental Indicators Are Available for Review in this Data Collection Format

Data Sources	Data collection frequency	Benchmarks to analyze this data source	Who will analyze the data?	Data analysis frequency	Data will be communicated to	Communicate data via	Frequency of communication
Guideline	Weekly Monthly Quarterly Annually	-Applicable clinical guidelines -Identified best Practices -National Data -Corporate Data -State Data -Facility identified performance indicators/goals -Thresholds/ targets	<ul style="list-style-type: none"> <li>▪ Leadership team</li> <li>▪ QAPI committee</li> <li>▪ Patient Safety Committee</li> </ul>	<ul style="list-style-type: none"> <li>▪ Weekly</li> <li>▪ Monthly</li> <li>▪ Quarterly</li> <li>▪ Annually</li> </ul>	<ul style="list-style-type: none"> <li>▪ Board members</li> <li>▪ Caregivers</li> <li>▪ Community</li> <li>▪ Executive leadership</li> <li>▪ Families</li> <li>▪ Patients</li> </ul>	<ul style="list-style-type: none"> <li>▪ Board Meetings</li> <li>▪ Bulletin Boards</li> <li>▪ Dashboards</li> <li>▪ Newsletters</li> <li>▪ Posters</li> <li>▪ QAPI Meetings</li> <li>▪ Staff Meetings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Weekly</li> <li>▪ Monthly</li> <li>▪ Quarterly</li> <li>▪ Annually</li> </ul>
Abuse, Neglect reports	Weekly	Identified Best Practices	Leadership Team	Weekly	Board Member, QAPI committee, State reporting agency	Reporting requirements, meetings	As needed weekly
CMS Quality Measures (long-stay and short stay)	Monthly	State and National Data	Leadership Team	Monthly	Executive Leadership, Board members, Staff	QAPI meetings	Monthly and Quarterly
Complaints	Weekly	Identified best practices, organizational data	Leadership Data	Weekly	Board members QAPI Committee	Meetings	As Needed or Weekly
Falls	Weekly	Organizational Data	Leadership Team, QAPI Committee	Weekly	Patient Safety Committee/ QAPI Committee Staff meetings, Board members	Bulletin boards, dashboard, QAPI and IDT Meetings	Monthly
Medication Errors	Monthly	Organizational Data	Leadership/QAPI Committee	Monthly or ASAP as needed	Patient Safety Committee/ QAPI Committee Staff meetings, Board members	Staff Meetings, dashboard, QAPI meetings	Monthly or sooner if needed

ATTACHMENT D

Quality Assurance/Performance Improvement Committee  
Hospital  
Reporting Flow Chart





Approved by the Milwaukee County Mental Health Board Quality Committee 6/01/20;  
Approved by BHD Medical Staff Executive Committee 5/20/20;  
Approved by BHD Quality Assessment and Performance Improvement (QAPI) Committee 5/01/20

Current Status: *Draft*

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Owner: *Jennifer Bergersen:  
Exdir2-Assoc Dir Clin  
Compl*Policy Area: *Quality Management*

References:

## BHD Clinical Contract Management Policy

### PURPOSE:

The purpose of the Milwaukee County Behavioral Health Division (MCBHD) Clinical Contract Management Process is to ensure a consistent and systematic approach to contract executions on behalf of BHD for the inpatient Hospital component of the organization in the management of clinical contracts. The Clinical Contract Management Process includes having a written process, documenting all actions and communication on behalf of contract execution, assigning specific responsibilities to Departments, Administration and Professional/Non Professional Staff, to support contract execution and ensuring the annual review and revision of the Clinical Contract Management Process and all supporting documentation is completed. The purpose of the Clinical Contract Management Process is to provide general guidance for creating and executing a contract on behalf of BHD and additional information and assistance should be sought from Corporation Counsel, Risk Management, and the Department as appropriate to ensure compliance with all County, State, and Federal Statutes, Laws, etc.

Nothing in the Clinical Contract Management Process, limits the enforceability of all terms, conditions, etc. in the BHD Contracts or restricts the execution of a contract with any provider.

### SCOPE:

The scope of the BHD Clinical Contract Management Process is a comprehensive process that includes the Request for Proposal, Request for Information, and BHD Internal Requests for the creation and execution of Contracts to support the Hospital component of the Milwaukee County Behavioral Health Division inpatient hospital. The BHD Contracting Process is reviewed and updated on an annual basis, by the BHD Contracts Manager, and approved by the DHHS/BHD Contracts Administrator.

### POLICY:

There are two levels of contract review for the purpose of this policy: (a) the contract itself; and (b) the individual competency review of the practitioners and/or staff who are providing the care, treatment or services. This policy and procedure lists the requirements for the review of the contract, after it has been approved, related to its on-going performance.

### A. DEFINITIONS

- **Contract:** A formal contract, memorandum of understanding, letter of agreement, or other written document that outlines the relationship of the contract service with the organization, and the expectations

the organization has of the contract service.

- **County:** Milwaukee County, a Wisconsin municipal body corporation represented by the Milwaukee County Department of Health and Human Services (DHHS) and its respective divisions, the Milwaukee County Audit Services Division, the Milwaukee County Behavioral Health Division, and any other applicable departments or offices of County and its designees.
- **Covered Services:** services identified in the Agreement that are rendered by the Provider and are subject to the terms and conditions of the Agreement, for which the provider may request payment or Purchaser provided the service referral.
- **Direct Service Provider:** (DSP)– Provider employee, volunteer, paid or unpaid intern, or Independent Service Provider, who provides direct care and/or Covered Services to a Participant/Service Recipient on behalf of a Provider, for which the Provider receives compensation from the Purchaser under this Agreement or Purchaser provided the service referral.
- **Independent Service Provider:** is an individual independent contractor or subcontractor with a contractual relationship with provider, who is not an employee of the provider.
- **Indirect Staff:** is an employee or individual independent contractor who is not a Direct Service provider, but is associated with Covered Services as a supervisor, billing staff, case records and/or quality assurance worker, and/or is someone (i.e.: volunteer) who has access to clients, client property, and/or client information. Agency owner, President, CEO, Executive Director, and/or Senior Staff are considered Indirect Staff if reporting to work at a site where Covered Services are provided or have access to client's information or property.
- **Milwaukee County Department of Health and Human Services:** (DHHS) – A governmental subunit of Milwaukee County created by action of the Milwaukee County Board of Supervisors as authorized by state statute to provide or purchase care or treatment services for residents of Milwaukee County. The Department of Health and Human Services consists of the following five divisions: Youth & Family Services, Disabilities Services, Management Services, Behavioral Health and Housing Division.
- **Milwaukee County Mental Health Board (MHB):** is a statutorily created board constituted under 2013 Wisconsin Act 203. The Act includes a transfer of control of all mental health functions, programs, and services in Milwaukee County, including those relating to alcohol and other substance abuse, to the MHB.
- **Policies and Procedures:** – Purchaser policies and procedures, program/service descriptions, Purchaser bulletins, memos, this Agreement, and/or other program specific written (including email) requirements and all applicable federal, state and county statutes and regulations which are in effect at the time of the delivery of Covered Services.
- **Provider/Contractor/Vendor:** The person doing the work under a contract. This is usually an employee of the contracted service. Agency worker / agency staff is the same as a contractor, entity or individual with whom this Agreement has been executed. (Provider and Contractor/Vendor have been used interchangeably throughout this document both refer entity or individual with whom this Agreement has been executed.
- **Scope of Work (SOW):** Document outlining the work that is to be carried out under a contract, broken down by specific tasks, time-lines, and schedule of deliverables. SOW, includes Statement of Work, and Scope of Services.
- **Service Documentation:** – Consents, assessments, service plans, reviews, Case Notes, health records, monthly reports, dosage data, ledgers, budgets, and all other written or electronic program and/or fiscal records relating to Covered Services.
- **Service Plan:** written document that describes the type, frequency and/or duration of the Covered Services that are to be provided to enrolled Participant and/or Participant's family.
- **Service Recipient:** person or persons identified in a service authorization or service plan as the recipient of Covered Services provided by the Direct Service Provider. Also referred to as participant, consumer,

client, or resident.

- **Targeted Business Enterprise (TBE 12/14):** TBE programs work to ensure small, Minority & Women Business Enterprises maximize their opportunity to compete for Milwaukee County contracting opportunities.

## B. EXPECTATIONS

Unless otherwise noted, and/or in addition to expectations addressed in a written contract, BHD holds forth the following expectations of any contract service. The contract service shall be expected to read and held to the following policy and procedures as appropriate:

DHHS 001 Caregiver Background Checks / Milwaukee County Resolution
Caregiver Misconduct: Reporting and Investigation of Caregiver Misconduct and Injuries of Unknown Source
DHHS 002 Emergency Management Plan
DHHS 003 Whistleblower Policy
DHHS 005 Provider Obligations
DHHS 006 Audit Requirements
DHHS 007 Provisions for Purchased or Loaned Property
DHHS 008 Payor of Last Resort
DHHS 009 Conditional Status, Suspension and Debarment
BHD 002 Provider Add/Drop
<a href="#">Reporting of Fraud, Waste, and Abuse to Office of Inspector General</a>

To access PolicyStat use the following link:

<http://milwaukeebhd.policystat.com/?lt=qhaRCXS6xPmzmujl7g3RdN>

## C. OTHER EXPECTATIONS

Additionally, the contract service shall:

- Abide by applicable law, regulation, and BHD policies on the provision of its care, treatment, and service.
- Abide by applicable standards of certifying agencies that BHD, itself must adhere to.
- Provide a level of care, treatment, and service that would be comparable had BHD, provided such care, treatment, and service itself.
- Actively participate in BHD's quality assessment/performance improvement and patient safety programs, respond to concerns regarding care, treatment, and service rendered, and undertake corrective actions necessary to address issues identified.
- Provide care, treatment, and service in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and to prevent and reduce medical errors.

## D. TYPES OF SERVICES

- a. The listing of the contract services provided are readily available on request. For the purposes of this policy the types of contracts that may be utilized are as follows:

- Cardiology
- Environmental Cleaning Services
- Food Service-Preparation and Delivery
- Laboratory
- Peer Specialist Services
- Pharmacy Service
- Radiology
- Referral Services, e.g. Detox and Treatment
- Rehab Services to include Physical Therapy and Speech
- Release of Information Services (Medical Records)
- Security Services
- Substance Use Detox Services
- Temporary Staffing Services
- Translation and Interpreter Services
- Transportation Services

## **E. EVALUATION OF THE CONTRACT**

- a. A contract service shall be evaluated in relation to the agreed upon terms including performance measures between the contractor and hospital
- b. In evaluating expectations, BHD may review any, all, or a combination of the following sources of information:
  - All contracts within the scope of this policy will have contract performance measures, compliance indicators and a scope of work within the contract that are agreed upon by the contractor and BHD prior to the contract being executed.
  - Information about the contract service's accreditation and/or certification status
  - Direct observation of patient care by contract service staff
  - Audits of medical (clinical) record documentation by contract service staff
  - Audits of quality control record documentation by contract service staff.
  - Review of incident/event reports
  - Review of periodic reports submitted by the contract service on the quality and safety of care, treatment, and services provided
  - Review of performance reports based on indicators required in the contractual agreement. The Quality Analyst (QA) will work with the Subject Matter Expert in the organization to develop data reports regarding the compliance with the agreed upon contract performance measures.
  - Review of compliance reports based on audits by contract staff, including infection control compliance indicators
  - Review of contractor's billing reports and other fiscal data by BHD fiscal and contract staff
  - Review of contractor's administrative performance including timeliness of services or required submissions and responsiveness to requests for documents, information and/or corrective actions for contract breach
  - Contractor's compliance with TBE or DBE minority participation targets and CDBP reporting requirements
  - Input from patients, families, and/or hospital staff
  - Input from clinical leaders and the medical staff
  - Review of patient satisfaction data that may be solicited related to the service

## **F. FREQUENCY OF EVALUATION**

Evaluations shall be conducted on at least an annual basis. The results of that evaluation will be reported to the Quality Assessment and Performance Improvement Committee (QAPI).

- a. A list of the contract services, their scope, and the recommendation for continuation or non-continuation from the QAPI will be submitted to the Medical Staff Executive Committee. The Medical Executive Committee's recommendations shall be provided to the BHD Mental Health Board. When negative trends are identified for two consecutive reporting periods or a pattern of non-compliance is identified, the organization must take steps to improve the contract services and document the steps taken. Examples to consider include increased monitoring, providing consultation or training, renegotiating the contract terms, and termination of the contract. In the event contractual agreements are renegotiated or terminated, continuity of care must be maintained until full transitions of service to new service provider, or for 180 days from notice of termination, whichever comes first.
- b. If BHD determines that any employee(s) or staff of the contractor fail to meet performance and/or compliance standards, BHD may unilaterally deem those contractor employees or staff ineligible to provide services for BHD.

## **G. CONTRACT MANAGEMENT**

- a. BHD Contract Management keeps a copy of the executed contracts overseen for BHD/Inpatient Hospital and also has a copy of the certificate of insurance as well as monitors to ensure that the contractor stays current with all lines of coverage.
- b. BHD Contract Management will maintain all submitted Statements of Work (SOW).
- c. A current job description for each employee classification of the contractor is kept with the Vendor and is available throughout the term of the contract to BHD upon request as outlined in terms of the contract.
- d. A current roster of the staff is provided annually by the Vendor and kept by contract management.
- e. The vendor will maintain a human resource file for all DSPs and ISPs that includes but not limited to caregiver background checks, documentation of primary source verifications of any required licenses/registrations, resumes, drug/health screens as applicable, competencies, evaluations and documentation of attestation of required training.

For those employees of the vendor who are required by law and regulation to possess a certification, license or registration, Contract Management will obtain those credentials on or before the employee reports to BHD and inform HR when the employee is approved. The Human Resources department at BHD will be responsible for verification of any required certification, licensure or registration at the time of renewal.

## **H. CONTRACT EMPLOYEE HOSPITAL ORIENTATION PROCESS**

All contracted service employees are required to complete the MCBHD Self -Study Orientation for Contracted Service Employees prior to starting at MCBHD. Training must be completed by all agencies contracted to provide services for Milwaukee County Behavioral Health Division prior to performing work at our facility. It is our priority to ensure that all staff having direct or indirect contact with consumers be provided with mandatory training modules to assist in our goal of providing outstanding quality care to our consumers.

### **Self-Study Orientation Information for Contracted Service**

## Employee

### Intended Participants for Self-Study Orientation:

1. Contracted service employees whose work may bring them to the hospital to perform a duty but who do not work primarily on the BHD premises (e.g., laboratory staff, radiology techs, interpreters, etc.).
2. A contracted service employee whose work requires them to be primarily on BHD premises that is not able to be scheduled for in-person orientation training on the first day s/he is to report to BHD (e.g., temporary staff, pharmacy staff, security staff, environmental service staff, food service staff, etc.) \*
3. Contracted Medical Staff.

\* **NOTE:** All BHD based contractors shall be required to attend the BHD New Employee Orientation (full-day in-person training). When self-study training is completed by individuals in category 2 above, the self-study training shall not take the place of the in-person orientation requirement.

Below is a link to the mandatory online training required for your staff to complete. Attached are the BHD self-study NEO instructions and post-test modules (An answer key is also provided for the use of supervisors to score the modules and are **not to be shared with direct staff**) as well as a pdf copy of the YouTube Power Point presentation.

Link: [https://youtu.be/\\_p5Htzh8i6M](https://youtu.be/_p5Htzh8i6M)

### Attachments

[BHD Clinical Contract Management Policy Attestation.docx](#)  
[BHD Contracted Inpatient Provider Monitoring Tool.docx](#)  
[Checklist for Contract Employee.docx](#)



### BHD Clinical Contract Management Policy Attestation

I confirm that I have reviewed, understand and put into practice the BHD Clinical Contract Management Policy, areas outline in the policy and attachments included. I understand that as a contracted employee, it is my responsibility to abide by Milwaukee County Behavioral Health Division's policy and procedures, in accordance with our BHD Contract.

If I have questions about the materials presented, Milwaukee County BHD's policy and procedures, I understand it is my responsibility to seek clarification from my agency's Human Resources Department or contact the Milwaukee County Behavioral Health Division's Contract Management Department.

- Definitions
- Expectations
- Other Expectations
- Types of Services
- Evaluation of the contract
- Frequency of evaluation
- Contract Management
- Contract Employee Hospital Orientation Process
- BHD Contracted Inpatient Provider Monitoring Tool
- Checklist for Contract Employee

Employee Signature \_\_\_\_\_

Print name \_\_\_\_\_

Date \_\_\_\_\_

**HR Office Staff or Training Coordinator Instructions:** Place a copy of this signature page in the employee's personnel file. To audit compliance with any required training period, track the training using local reporting systems. Make sure that the employee, supervisor, or manager is scheduled and attends refresher training within the follow-up period if applicable



MILWAUKEE COUNTY  
Behavioral  
Health  
Division

## BHD Contracted Inpatient Provider Monitoring Tool

Name of Contract Service:	Facility:
Contract Owner/Title/Extension:	
Scope of Service Provided:	
Contract Expiration Date:	

### Section I: EVALUATION

General Review Criteria		Rating			Comments
During the past 12 months:					
1.	Have the Human Resource requirements of the contract service been met?	YES	NO	N/A	
2.	Have all other requirements of the contract been met?	YES	NO	N/A	
3.	Has a patient been injured as a result of this contractor?	YES	NO	N/A	
4.	Have delays in service been experienced?	YES	NO	N/A	
5.	Has a physician(s) or staff member voiced concerns regarding this contractor?	YES	NO	N/A	
6.	Contract service provider consistently submits necessary materials within timeframes specified in the contract. (RFI, invoices, billing logs, etc.)	YES	NO	N/A	

### Section II: PERFORMANCE METRICS – BI-ANNUAL REVIEW

METRICS	FISCAL YEAR - % COMPLIANCE		OVERALL % COMPLIANCE
	1 <sup>ST</sup> SIX (6) MONTHS <span style="color: red;">(JUL – DEC)</span>	2 <sup>ND</sup> SIX (6) MONTHS <span style="color: red;">(JAN – JUN)</span>	

### CONCLUSION

- Contract service has met expectations for the review period.
- Contract service has **not met** expectations for the review period. The following action(s) has or will be taken: (check all that apply)
  - Monitoring and oversight of the contract service has been increased.
  - Training and consultation has been provided to the contract service.
  - The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of care.
  - Penalties or other remedies have been applied to the contract entity.
  - The contractual agreement has been terminated without disruption in the continuity of patient care.
  - "Suspended"/Terminated.
- Other \_\_\_\_\_
- I recommend this contract for continuation of service.
- I **do NOT** recommend this contract for continuation of service.

Person completing this form:

Print Name and Title: \_\_\_\_\_ Extension: \_\_\_\_\_

eSignature: \_\_\_\_\_ Date: \_\_\_\_\_

CHECKLIST FOR CONTRACT EMPLOYEE

Instruction: Document to be completed the first day of on-site work.

1. Name of contract employee \_\_\_\_\_
2. Contract employee start date \_\_\_\_\_
3. Evidence of Completion of MCBHD Orientation  Y  N
4. Proper identification badge  Y  N
5. Verification of evidence of applicable primary source verification of licensure, certification and registration.  Y  N  N/A
6. Unit/Department assignment \_\_\_\_\_
7. Unit Orientation (walk-through) completed  Y  N
8. Date of unit orientation completion \_\_\_\_\_
9. Forward completed form to the BHD Human Resources department.

\_\_\_\_\_  
Contract Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contract Employee Supervisor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
BHD Supervisor Signature

\_\_\_\_\_  
Date

Current Status: *Pending*

PolicyStat ID: 8048848



**Date Issued:** N/A  
**Effective:** Upon Approval  
**Last Approved Date:** N/A  
**Last Revised Date:** N/A  
**Next Review:** 3 years after approval  
**Owner:** Jennifer Bergersen:  
 Exdir2-Assoc Dir Clin  
 Compl  
**Policy Area:** Division Administration  
**References:**

## Psychiatric Hospital: Scope of Services

### Purpose:

The Milwaukee County Behavioral Health Division (BHD) is an integrated, behavioral health system of care providing a dynamic, and comprehensive array of services, including community based, emergency, and acute psychiatric hospital services. This system of care supports the behavioral health care needs of Milwaukee County residents and their families.

The purpose of this policy is to describe the scope of services for the psychiatric hospital, including the psychiatric emergency room.

### Psychiatric Hospital: Scope and Requirements

In order to qualify for a provider agreement as a hospital (other than a psychiatric hospital as defined at section 1861(f) of the Act) under Medicare and Medicaid, BHD must meet and continue to meet all of the statutory provisions of §1861(e) of the Act, including the Condition of Participation (CoP) requirements. See also 42 CFR 488.3(a)(1) and 42 CFR 489.12.

This means the hospital must:

- Be primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- Maintain clinical records on all patients[addressed in 42 CFR 482.24, Medical Records];
- Have medical staff bylaws [42 CFR 482.12, Governing Body, and 42 CFR 482.22, Medical Staff];
- Have a requirement that every patient with respect to whom payment may be made under Title XVIII must be under the care of a physician except that a patient receiving qualified psychologist services (as defined in section 1861(ii) of the Act) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law [42 CFR 482.12, Governing Body];
- Provide 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times...[42 CFR 482.23, Nursing Services];
- Have in effect a hospital utilization review plan which meets the requirements of section 1861(k) of the Act [42 CFR 482.30, Utilization Review];

- Have in place a discharge planning process that meets the requirements of section 1861(ee) of the Act [42 CFR 482.43, Discharge Planning];
- If located in a state in which state or applicable local law provides for the licensing of hospitals, be licensed under such law or be approved by the agency of the State or locality responsible for licensing hospitals as meeting the standards established for such licensing [42 CFR 482.11, Compliance with Federal, State, and Local Laws];
- Have in effect an overall plan and budget that meets the requirements of section 1861(z) of the Act [42 CFR 482.12, Governing Body]; and
- Meet any other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution [42 CFR Parts 482 and 489, among others].

The Milwaukee County Behavioral Health Division provides the following;

## **Emergency and Acute Inpatient Services:**

### **\* Psychiatric Crisis Services/Admission Center (PCS)**

The Psychiatric Crisis Service (PCS) is a specialized psychiatric crisis emergency department open 24 hours a day 7 days a week. PCS is the state appointed emergency detention facility and provides psychiatric emergency services including face to face assessment, crisis intervention and medication for individuals who may be in psychiatric crisis and who present to the center.

A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, behavioral health emergency clinicians, psychologists, psychiatric technicians and certified nursing assistants are available on site 24/7 to provide assessments, interventions, referrals and services as appropriate.

All PCS patients who are not admitted to an inpatient unit or placed on an observation status are provided a written discharge plan to include written prescriptions, discharge teaching related to medications, self-care, health care and other learning needs, referrals, appointments, community resource materials and contacts and connections with outside providers.

### **\*Observation Unit (OBS)**

If the PCS psychiatrist determines that there is a need for brief treatment and/or a more extended period of observation in order to evaluate the physical and mental status of an individual, the patient may be treated on Observation status and/or on the Observation Unit (OBS) up to 48 hours. This unit has the capacity for 18 beds available 24 hours a day and 7 days a week.

The patient will be evaluated and may be discharged to another community setting, transferred to another facility for continuation of care, or considered for admission to a psychiatric hospital either at BHD or a private community hospital.

A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, behavioral health emergency clinicians, psychologists, psychiatric technicians and certified nursing assistants are available on site to provide assessments, interventions, and discharge orders and referrals.

### **\*Inpatient Services: Acute Adult and Child and Adolescent Inpatient Services**

The Milwaukee County Behavioral Health Division's Hospital Inpatient Services are provided in four-licensed psychiatric hospital units with three specialized programs for adults and one specialized unit for children and

adolescents. Adult licensed units include one 24 bed adult unit called the Acute Treatment Unit (ATU), one 24 bed Adult Inpatient Co-Ed Unit (AICE) and one 18 bed Intensive Treatment Unit (ITU).

All units provide inpatient care to individuals who require safe, secure, short-term or occasionally extended hospitalization. A multi-disciplinary team approach of psychiatry, psychology, nursing, social service and rehabilitation therapy provide assessment and treatment designed to stabilize an acute psychiatric need and assist the return of the patient to his or her own community. Unit occupancy and patient census is adjusted and dependent upon safe and clinically determined staffing levels.

The 43-A - ITU program provides a safe, supportive environment for those individuals with mental health conditions who are at high risk for aggressive behavior and in need for intensive behavioral and pharmacological interventions.

The 43-B - ATU program is a general co-ed psychiatric care unit and teaching unit providing specialized services for adult men and women recovering from complex and co-occurring disorders who require safe, acute psychiatric services.

The 43-C - AICE program is a general co-ed psychiatric care unit providing specialized services for adult men and women recovering from complex and co-occurring disorders who require safe, acute psychiatric services.

The Child and Adolescent (CAIS) unit licensed for 24 beds, with an average daily census of 10 provides inpatient care to individuals ages 7- 17. The CAIS treatment unit also provides emergency detention services for Milwaukee County as well as inpatient screening for Children's Court including the provision of an adjacent educational school program operated by the Wauwatosa School District.

## **Procedure:**

### **Patients receiving care on psychiatric units can expect:**

- Assessment
- Diagnosis
- Individualized recovery plans
- Pharmacotherapy
- Safe, healing environment
- Caring, welcoming team
- Structured rehabilitation services-programming every day, including weekends
- Patient education
- Peer support
- Family, guardian and support participation
- Consultative services
- Spirituality services
- Music and occupational therapy
- Comprehensive discharge planning
- Respectful, patient centered experience

### **Patients can expect individualized services through the following quality contracts including but not limited to:**

- Interpretation/translation services
- Benefits application assistance and enrollment
- Transportation services

- Public safety/security services
- Dietary/food service
- Cleaning, housekeeping services
- Laboratory services
- Rehabilitative services: physical, speech therapies
- Radiology, ultrasound and EKG services
- Pharmaceutical services
- Detoxification Services

Each patient admitted to the psychiatric hospital will have an aftercare/discharge plan specifying services and referrals needed upon discharge. Treatment teams will assure that individual patient's bio-psycho-social needs and strengths are addressed with interventions, referrals and education to prepare those receiving care for community living or another level of care in the least restrictive setting.

Patient census on all of these licensed psychiatric hospital units will be adjusted based on patient needs and staffing care patterns to ensure safe, quality care.

A team of qualified staff including board certified and eligible psychiatrists, psychiatry residents, registered nurses, psychologists, social workers, occupational therapists/music therapists and other rehabilitative services, peer specialists, psychiatric technicians and certified nursing assistants are available on site on all units to provide hospital assessments, interventions, referrals, supervision and intensive psychiatric hospital services as appropriate.

## References:

Regulations identified in scope requirements as listed in this policy and psychiatric conditions of participation as well as all State and Federal laws.

## Monitors:

The scope of services for the psychiatric hospital will be reviewed and updated annually at the Medical Staff Executive Committee, QAPI Committee and Mental Health Board Quality Committee/Governing Board.

### Attachments

No Attachments

### Approval Signatures

Step Description	Approver	Date
	Michael Lappen: BHD Administrator	pending
	Jennifer Bergersen: Exdir2-Assoc Dir Clin Compl	5/11/2020
	Jennifer Bergersen: Exdir2-Assoc Dir Clin Compl	5/11/2020



Current Status: *Pending*

PolicyStat ID: 7852190



**Date Issued:** N/A  
**Effective:** Upon Approval  
**Last Approved Date:** N/A  
**Last Revised Date:** N/A  
**Next Review:** 3 years after approval  
**Owner:** Demetrius Anderson:  
 Manager-Quality  
 Improvement  
 Patient Rights  
**Policy Area:** Patient Rights  
**References:**

## Hospital Complaint and Grievance Resolution

### Purpose:

To ensure that each individual/client, family, guardian, visitor or other interested party has the opportunity and right to file a grievance that will be responded to in a timely manner and resolved, if possible. The filing of a grievance is a client right. Grievances will be addressed without reprisals to the client or person filing the grievance.

### Scope:

The scope of this policy is relevant to all staff, providers and contracted staff working in the hospital of the Milwaukee County Behavioral Health Division (MCBHD).

### Policy:

The Governing Body of Milwaukee County Behavioral Health Division (MCBHD) has delegated responsibility for the review and resolution of written complaints and grievances to the Grievance Committee which is an ad hoc committee of the Quality Assessment and Improvement Committee. The Committee will be responsible for ensuring that these policies and procedures are followed and where possible that grievances will be resolved to the satisfaction of the client and/or their representative.

The purpose of this Grievance Policy is to protect and promote each client's rights by establishing a procedure for the prompt and fair resolution of grievances. (Title 42, Sec. 482.13 Condition of Participation: Clients' Rights.)

Under federal law, the organization is required to:

- Inform each client of his or her right to file a grievance with the organization and provide each client with the name of the person the client may contact to file a grievance.
- Inform each client of his or her right to file a complaint with the State of Wisconsin, Health Services Section, Division of Quality Assurance or federal agencies, regardless of whether or not the client chooses to follow the organization's procedure for resolving client grievances.
- To provide the client with the phone number and address of the said agencies.

# Definitions:

**Definition of Grievance.:** “A **client grievance** is a formal or informal written or verbal complaint that is made to the organization by a client, or the client’s representative, regarding the client’s care (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the organization’s compliance with the CMS Organization Conditions of Participation (CoPs), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

**"Staff present"** includes any organization staff present at the time of the complaint or who can quickly be at the client’s location (i.e., nursing, administration, nursing supervisors, client advocates, etc.) to resolve the client’s complaint.

# Procedure:

## What is considered a Grievance

If a client care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance for the purposes of these requirements. A complaint is considered resolved when the client is satisfied with the actions taken on their behalf.

Billing issues are not usually considered grievances for the purposes of these requirements. However, a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 is considered a grievance.

A written complaint is always considered a grievance. This includes written complaints from an inpatient/client, an outpatient/client, a released/discharged client, or a client’s representative regarding care provided, abuse or neglect, or the organization’s compliance with CoPs. For the purposes of this requirement, an email or fax is considered "written."

Information obtained from client satisfaction surveys usually does not meet the definition of a grievance. If an identified client writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance. If an identified client writes or attaches a complaint to the survey but has not requested resolution, the organization must treat this as a grievance if the organization would usually treat such a complaint as a grievance.

Client complaints that are considered grievances also include situations where a client or a client's representative telephones the organization with a complaint regarding the client’s care or with an allegation of abuse or neglect, or failure of the organization to comply with one or more CoPs, or other CMS requirements. Those post- organization verbal communications regarding client care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.

All verbal or written complaints regarding abuse, neglect, client harm, or organization compliance with CMS requirements are considered grievances for the purposes of these requirements.

Whenever the client or the client’s representative requests that his or her complaint be handled as a formal complaint or grievance or when the client requests a response from the organization, the complaint is considered a grievance and all the requirements apply.” (from State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Organizations)

## How a Grievance is to be Handled

If a client wishes to file a grievance, the client shall contact the house supervisor, or the client's rights specialist (414 257-7469). If the client files a written complaint or grievance, the client shall state in writing the nature of the grievance and shall provide any other information necessary to enable the organization to investigate (or will be contacted by the Client's Rights Specialist to obtain further information), review, and resolve the client's grievance. If the client expresses a grievance verbally, the contacted house supervisor, or the client's rights specialist will record the information in sufficient terms to enable to Client's Rights Specialist to investigate, review, and resolve the client's grievance. All grievances will be reviewed by the Grievance Committee prior to closure.

Within 7 days of the receipt of a grievance, the Client's Rights Specialist, or designee, will acknowledge receipt of the grievance and inform the complainant that he/she will receive a response no later than within 20 working days.

All complaints and grievances will be logged for trending. Grievances and complaints will be separated, and trended.

All investigations, together with action plans, and any investigation outcome letters to be sent, will be completed within ten (10) working days and reviewed to the Chief Nursing Officer before review and approval by the Grievance Committee

Within fifteen (15) working days, the Grievance Committee will review the investigations and provide final approval of any investigative letters to be signed by the Chief Executive Officer or designee informing the complainant of the results of the investigation. The letter will include the name and contact information for the complainant if he/she wishes further discussion.

The Client Rights Specialist will maintain a file on all written complaints and formal grievances. The file will be retained for seven calendar years from the date of the final response.

Data collected regarding client grievances, as well as other complaints that are not defined as grievances, must be incorporated in the organization's Quality Assessment and Performance Improvement (QAPI) Program.

Complaints and grievances shall be reported to the Quality Assessment and Improvement Committee at least quarterly and to the Governing Body through the Quality Assessment and Improvement Committee.

## References:

State information related to patient rights and the grievance/complaint process may be reviewed at:

[https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/94/III/46](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/94/III/46)

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### **PATIENT RIGHTS AND RESOLUTION OF PATIENT GRIEVANCES**

#### **State Operations Manual Appendix A**

#### **Regulations and Interpretive Guidelines for Hospitals**

Requirements related to the Grievance Process may be viewed at:

<https://www.cms.gov/media/423601>

## Monitors:

The complaint and grievance process will be monitored by the Grievance Committee, who will provide a mechanism for timely investigation of patient concerns, regarding quality of care. The Grievance Committee will be overseen by the Quality Assurance & Performance Improvement (QAPI) Committee to monitor any trends for improvement.

## Attachments

[Grievance Form](#)

## Approval Signatures

Step Description	Approver	Date
Grievance Committee	Sherrie BaileyHolland: Client Rights Specialists	pending
Grievance Committee	Demetrius Anderson: Manager-Quality Improvement	5/8/2020
	Demetrius Anderson: Manager-Quality Improvement	5/8/2020

**Quality Management Committee  
Institutional Review Board (IRB) Report  
June 1, 2020**

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

**IRB Membership**

- Current membership of the IRB remains consistent and includes: Dr. Justin Kuehl (Chair), Ms. Mary Casey, Ms. Shirley Drake, Dr. Matt Drymalski, Dr. Shane Moisio, Ms. Linda Oczus, and Dr. Jaquaye Wakefield.

**Recently Completed Research**

- Dr. Tina Freiburger reported completion of the project titled: “An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division.”

**Existing Research**

- The IRB has approved and continues to routinely monitor the following proposals:
  - i) Dr. Gary Stark: “Survey of Suicidal Behavior Among Individuals with a Developmental Disability” (2/7/19).
  - ii) Dr. Pnina Goldfarb: “Building a Collaborative Care Model: An Approach for Effective Early Identification and Treatment of High School Students at Risk for Developing Psychosis” (2/18/19).
  - iii) Dr. Tina Freiburger: “Infrastructure Development Research for Milwaukee Wraparound” (8/29/19).
  - iv) Mr. Garrett Grainger: “Predictors of Housing Stability, Neighborhood Attainment, and Well-Being Amongst Community Care Patients” (10/22/19).
  - v) Dr. Meg McClymonds: “The Clinical Utility of Pharmacogenomic Testing in the Treatment of Mood, Behavior and Psychotic Disorders in Children and Adolescents” (1/29/20).

**Research Proposals**

- The IRB has reviewed a proposal submitted by Dr. Joshua Mersky titled: “Family Drug Treatment Court Evaluation.” Further revisions and final approval are pending.

**Standardized Research Completion Form**

- The IRB determined there should be a method of formally documenting the completion of research projects. A new “Research Project Closure Form” was drafted and approved for use.

**Monthly IRB Chairs Meeting**

- The Medical College of Wisconsin (MCW) hosts a monthly meeting of IRB Chairs. The purpose of the meeting is to share information and discuss pertinent issues, which

promotes best practices among the various IRBs. Dr. Kuehl continues to routinely attend these meetings.

IRB Training Courses

- The online training program offered by the Collaborative Institutional Training Initiative (CITI) remains accessible to all BHD employees. Information regarding available courses can be found at <https://about.citiprogram.org/en/homepage/>

Respectfully submitted,

Justin Kuehl, PsyD  
Chief Psychologist & IRB Chair

# POLICY & PROCEDURE STATUS REPORT -GOAL=96%

**Baseline 71.5% as of August 2016 LAB report**

Review period	Number of Policies	Percentage of total
Reviewed within Scheduled Period	361	71.5%
Up to 1 year Overdue	32	6.3%
More than 1 year and up to 3 years overdue	20	4.0%
More than 3 years and up to 5 years overdue	31	6.1%
More than 5 years and up to 10 years overdue	18	3.6%
More than 10 years overdue	43	8.5%
<b>Total</b>	<b>505</b>	<b>100.0%</b>

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
December	2	11	0
January	1	13	0
February	0	11	0
March	3	21	0
April	12	25	0

# Overall Progress 97.9% as of May 1, 2020 10

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	543		96.3%	97.9%
Up to 1 year Overdue	11		2.0%	0.9%
More than 1 year and up to 3 years overdue	8		1.4%	1.0%
More than 3 years and up to 5 years overdue	1		0.2%	0.0%
More than 5 years and up to 10 years overdue	1		0.2%	0.2%
More than 10 years overdue	0		0.0%	0.0%
<b>Total</b>	<b>564</b>		<b>100%</b>	<b>100%</b>

Forecast Due for Review	
<b>Past Due Policies - 21</b>	October 2020 – 18
<b>Coming Due Policies</b>	November 2020 – 7
May 2020 – 30	December 2020 – 31
June 2020 – 36	January 2021 – 22
July 2020 – 9	February 2021 – 15
August 2020 – 10	March 2021 – 19
September 2020 – 11	April 2021 – 17

**MILWAUKEE COUNTY MENTAL HEALTH BOARD  
QUALITY COMMITTEE  
2020 SUBMISSION TIMELINE CALENDAR**

MONTH	STAFF REPORT SUBMISSION DEADLINE (TO ADMINISTRATOR)	COMMITTEE MEETING DATE
MARCH	January 31, 2020 (Friday)	March 2, 2020 (Monday – 10:00 a.m.)
JUNE	May 1, 2020 (Friday)	June 1, 2020 (Monday – 10:00 a.m.)
AUGUST	*July 6, 2020 (Monday)	August 3, 2020 (Monday – 10:00 a.m.)
OCTOBER	September 4, 2020 (Friday)	October 5, 2020 (Monday – 10:00 a.m.)
DECEMBER	November 6, 2020 (Friday)	December 7, 2020 (Monday – 10:00 a.m.)
NOTE: *Due to Holiday		
		<b>DATES AND TIMES SUBJECT TO CHANGE</b>