MILWAUKEE COUNTY

MILWAUKEE COUNTY

BHD | MILWAUKEE COUNTY
Behavioral
Health
Division

CARS Quarterly Report

POPULATION HEALTH

The population health metrics by enrollment continue to mature and grow in volume, such that for several of our metrics, we are now able to report on the outcomes for nearly a thousand clients per quarter. Among the results was the positive finding that although the proportion of Black clients reporting "Good" or "Very Good" quality of life was lower than white clients at intake (29.41% vs. 39.06%, respectively), the rate of improvement for Black clients was considerably larger than that of white clients (86.33% vs. 48.82%), such that as of the last assessment, there was little difference between the two groups (54.80% vs. 58.13%). There were few differences between Black and white clients on the other population health measures. Further, consistent with our previous report, our supplemental analyses by cohort suggested that although many of our longer duration cohorts began treatment with greater severity of need/poorer self-rated status, by their most recent assessment, they had improved to the degree that their outcomes were comparable to the shorter duration cohorts.

CLIENT EXPERIENCE

We continue to expand our implementation of the BHD Client Experience survey. This brief, 4-10 item survey is now in use throughout most CARS programs. Positively, it is also being implemented in several programs in Crisis Services, with pilots underway in both the Adult Mobile Team and the CART team. The survey is currently being utilized in a pay for performance paradigm in two programs in CARS, with plans to expand to a third program in January of 2022. As a result of this expansion, the number of surveys collected from the second to the third quarter of 2021 dramatically increased, from 470 to 1016! We plan to implement the survey in our AFHs and CBRFs in early 2022.

COST OF CARE

As with previous versions of the quarterly report, there is a gap between the per member per month spend between Black and white consumers of care of approximately $128 dollars. CARS has been actively exploring the possible causes of this disparity, further disaggregating the data by gender, level of care, and agency within level of care. This finding will also be addressed in the System-Wide Continuous Quality Improvement (CQI) Project focusing on racial equity that is written into the current iteration of the CARS Quality Plan and for which initial planning has already begun. We anticipate a launch date for this initiative in early 2022.

STAFF QUALITY OF WORK LIFE

Early in the pandemic as staff began working from home, CARS instituted a staff enrichment presentation series. This series is staff-led, with different presenters on different topics every two weeks. The topics covered have ranged from prevention to program overviews to personal financial sustainability and helped to create both cohesion amongst CARS staff while teleworking, as well as provided opportunities to teach and learn from one another. During the last quarter, the CARS Mentorship Program also came to fruition. This program offers new or recently hired CARS staff members the opportunity to be "mentored" by a more seasoned CARS staff member. The goal of this initiative is to increase the work satisfaction and retention of CARS staff by more effectively integrating new staff into the CARS culture and giving longer tenured CARS staff the opportunity to share their expertise and experience.
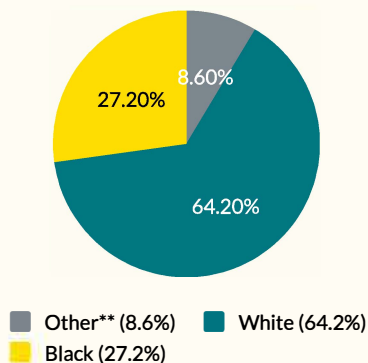
NEXT STEPS

As noted above, CARS will implement a System-Wide CQI Project focused on racial equity. This project will require extensive participation of our provider network and entail data analyses to identify disparities, quality improvement initiatives to address them, and ongoing data monitoring to track progress. We hope to showcase the results of these projects at a system wide NIATx Storyboard Marketplace, in which providers can present their projects later in 2022 or early 2023.
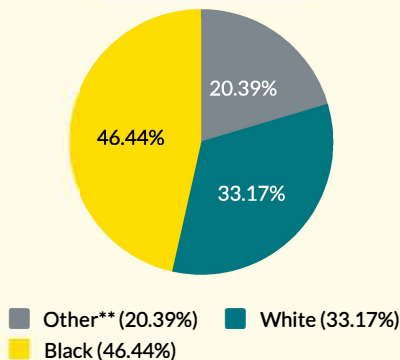
Demographic Information of the Population We Serve

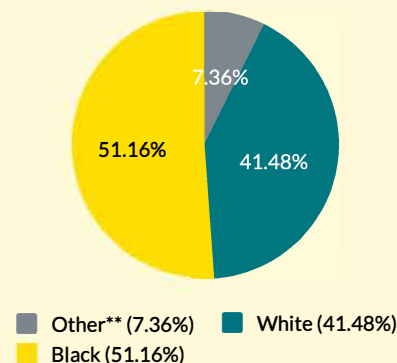This section outlines demographics of the consumers CARS served last quarter compared to the County population.
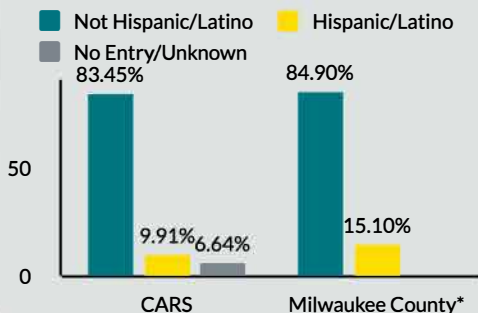
Race (Milwaukee County)*

- Other** (8.6%)
- White (64.2%)
- Black (27.2%)

8.60%
64.20%
27.20%

Race of MKE County at or Below 100% Poverty Level

- Other** (20.39%)
- White (33.17%)
- Black (46.44%)

20.39%
33.17%
46.44%

Race (CARS)

- Other** (7.36%)
- White (41.48%)
- Black (51.16%)

7.36%
41.48%
51.16%

Ethnicity

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

CARS: 83.45%, 9.91%, 6.64%
Milwaukee County*: 84.90%, 15.10%

Gender

- Men
- Women

CARS: 58.17%, 41.78%
Milwaukee County*: 48.40%, 51.60%

Age

18-24: 6.71%
25-34: 23.34%
35-44: 22.82%
45-54: 21.71%
55-64: 21.39%
65+: 5.71%
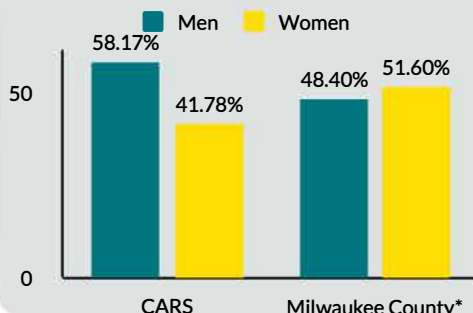
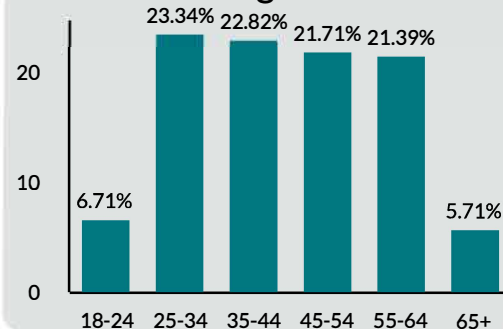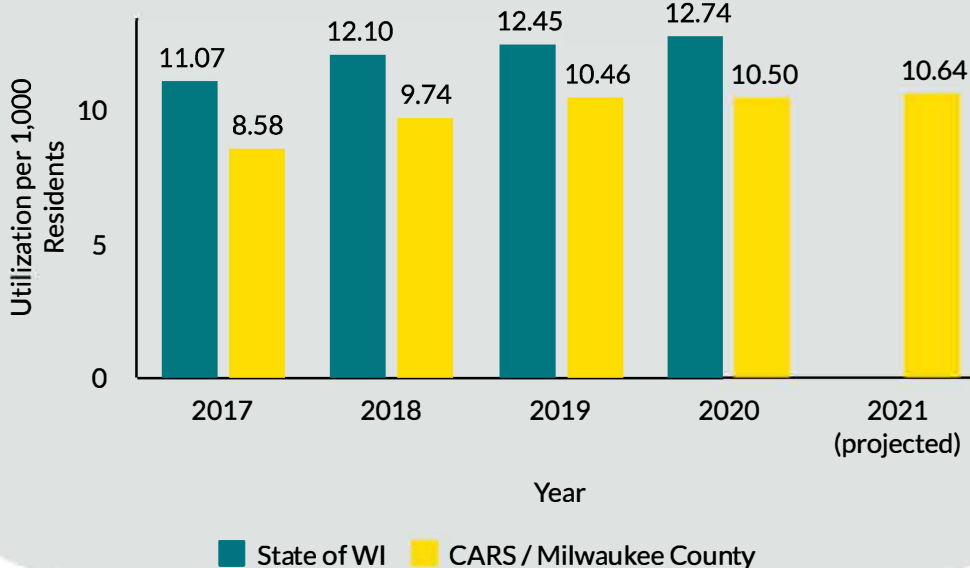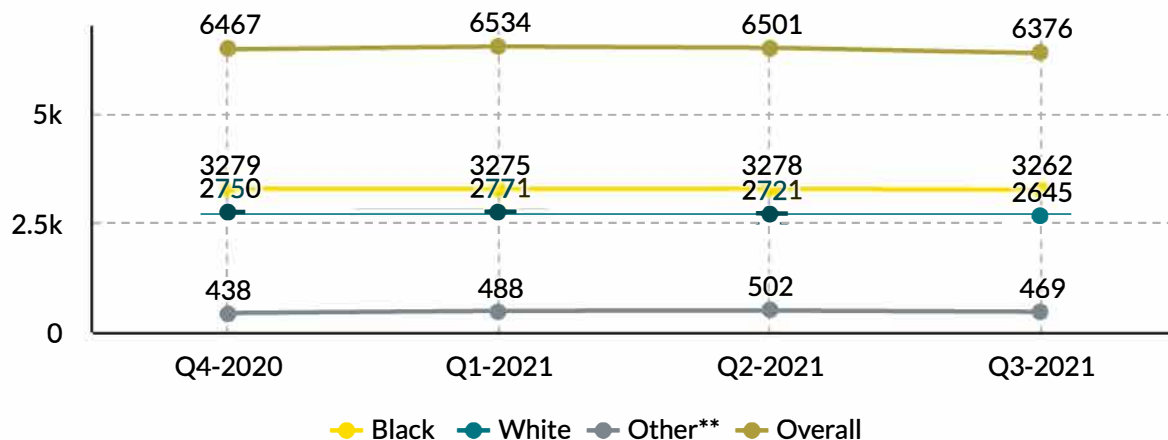## Community Utilization per 1,000 Residents

The graph to the right depicts how many individuals are served in the State of Wisconsin vs. Milwaukee County (by CARS) per 1,000 residents. Milwaukee County data was calculated by looking at how many unique clients were served in CARS and the overall Milwaukee County population. State of Wisconsin data was obtained from the Uniform Reporting System (URS). As you can see, while the State of Wisconsin is serving more individuals per 1,000 than CARS serves in Milwaukee County, the rate served by CARS has steadily increased each year. It is important to note that the CARS rates do not include Community Crisis Services, which may lead to an underestimation of total community utilization rates relative to the State rates.

Utilization per 1,000 Residents by Year:
- 2017: State of WI 11.07, CARS/Milwaukee County 8.58
- 2018: State of WI 12.10, CARS/Milwaukee County 9.74
- 2019: State of WI 12.45, CARS/Milwaukee County 10.46
- 2020: State of WI 12.74, CARS/Milwaukee County 10.50
- 2021 (projected): CARS/Milwaukee County 10.64

- State of WI
- CARS / Milwaukee County

Patient Experience of Care

Volume Served

Volume Served by Race

	Q4-2020	Q1-2021	Q2-2021	Q3-2021
Overall	6467	6534	6501	6376
Black	3279	3275	3278	3262
White	2750	2771	2721	2645
Other**	438	488	502	469

Legend: Black — White — Other** — Overall

Referrals

Referrals

	Q4-2020	Q1-2021	Q2-2021	Q3-2021
Overall	1,504	1,441	1,374	1,258
Black	761	711	668	620
White	606	571	543	513

Legend: Overall — Black — White

Time to First Service

Percent Served within 7 days

Overall	94.29%
Black	94.95%
White	93.75%
Other**	93.15%
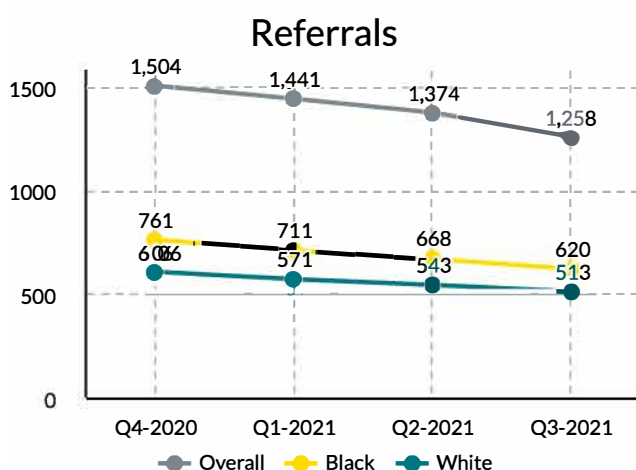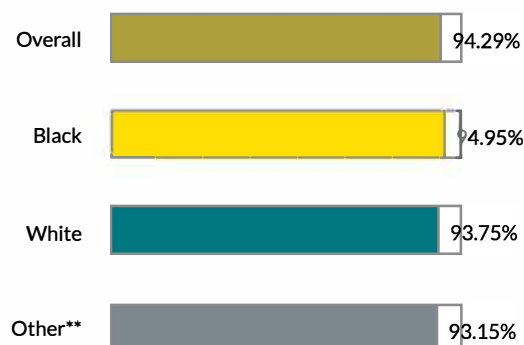
Average Consumer Satisfaction Score (Range from 1-5)

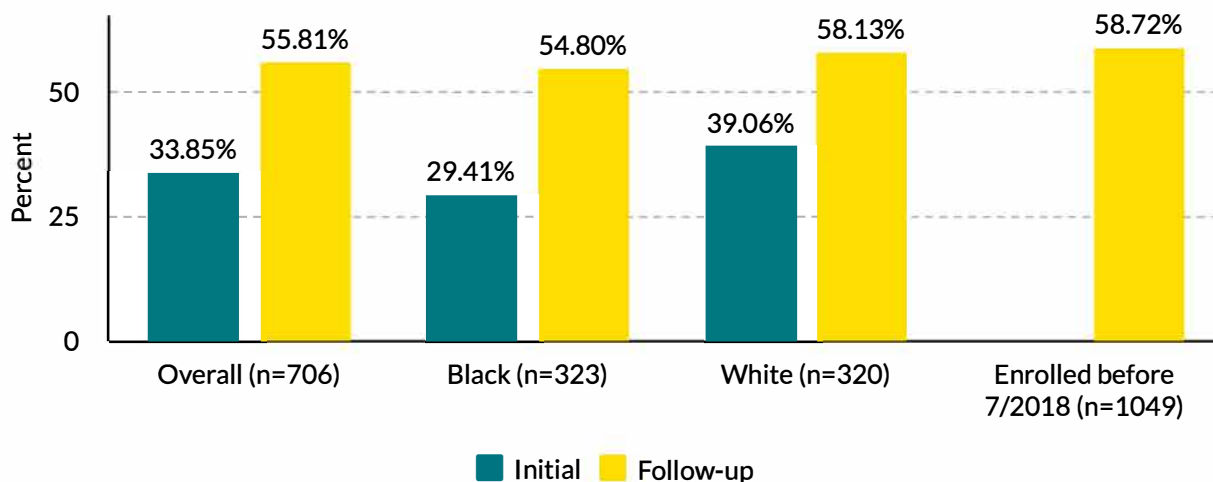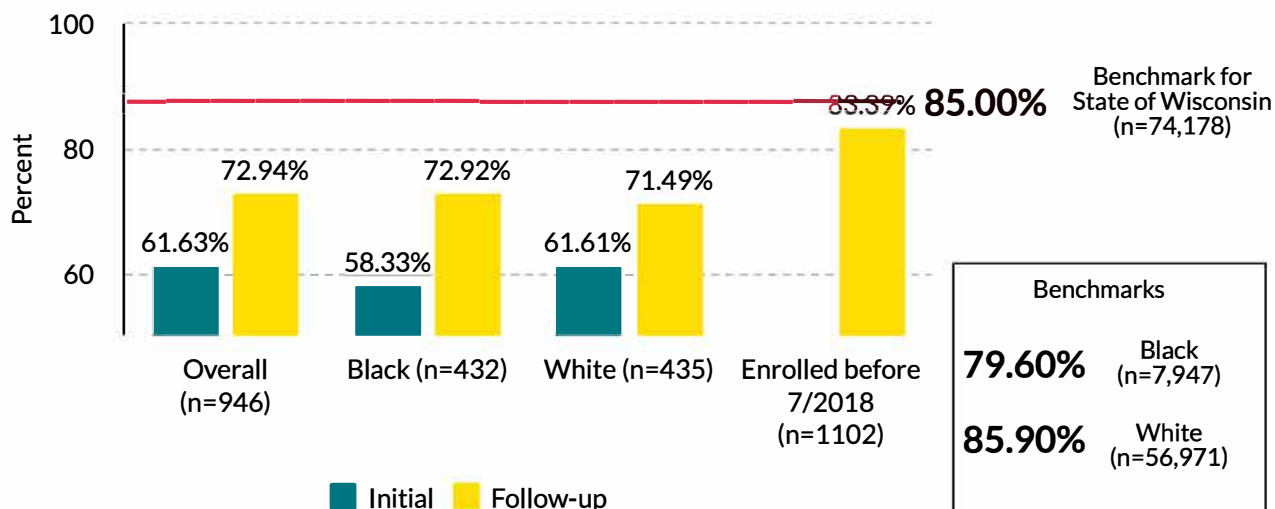| 4.49 average for all consumers (n=1016)	4.49 average for Black consumers (n=547)	4.52 average for White consumers (n=309)	4.46 average for "other" consumers (n=160)

Population Health

Change Over Time - Client Enrollment

Percent of clients selecting "Good" or "Very Good" Quality of Life Overall and by Race
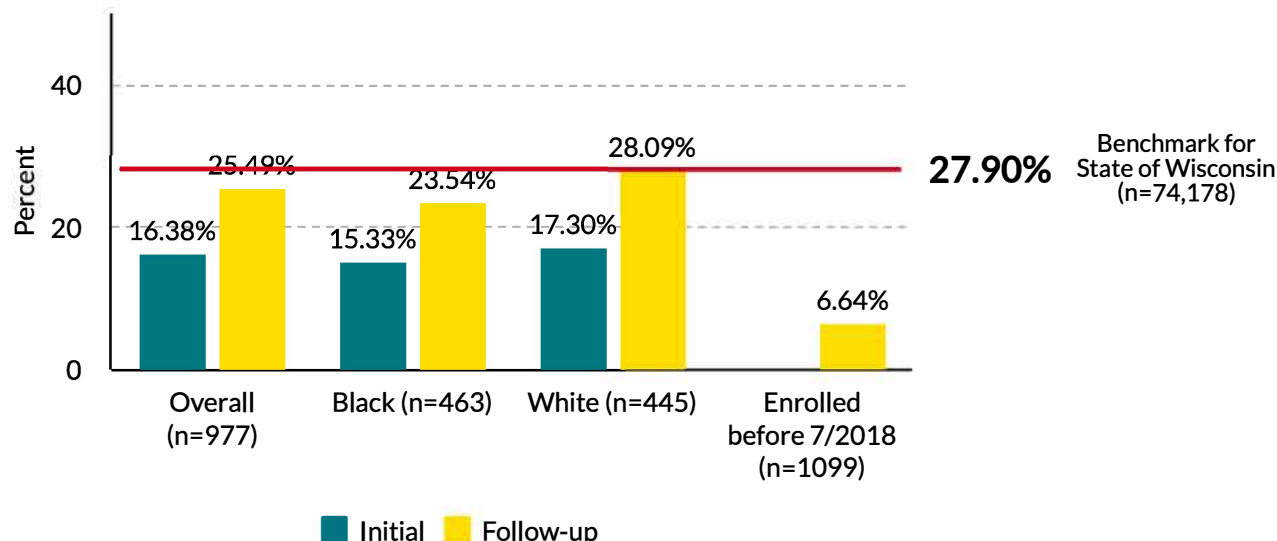
Average duration of enrollment: 465.56 days

	Initial	Follow-up
Overall (n=706)	33.85%	55.81%
Black (n=323)	29.41%	54.80%
White (n=320)	39.06%	58.13%
Enrolled before 7/2018 (n=1049)		58.72%

Legend: Initial — Follow-up

Domain: Population Health (cont.)

Percent with a Private Residence Overall and by Race

Average duration of enrollment: 444.12 days

Benchmark for State of Wisconsin (n=74,178): **85.00%**

Benchmarks	
79.60%	Black (n=7,947)
85.90%	White (n=56,971)

Overall (n=946): Initial 61.63%, Follow-up 72.94%
Black (n=432): Initial 58.33%, Follow-up 72.92%
White (n=435): Initial 61.61%, Follow-up 71.49%
Enrolled before 7/2018 (n=1102): Follow-up 83.39%

Percent Employed Overall and by Race

Average duration of enrollment: 416.85 days

Benchmark for State of Wisconsin (n=74,178): **27.90%**

Overall (n=977): Initial 16.38%, Follow-up 25.49%
Black (n=463): Initial 15.33%, Follow-up 23.54%
White (n=445): Initial 17.30%, Follow-up 28.09%
Enrolled before 7/2018 (n=1099): Follow-up 6.64%

Percent selecting "Good", "Very Good" or "Excellent" Physical Health Overall and by Race

Average duration of enrollment: 465.02 days

Percent selecting "Poor" or "Fair" Physical Health

Overall (n=666): Initial 46.70%, Follow-up 59.31%
Black (n=306): Initial 46.41%, Follow-up 57.84%
White (n=302): Initial 50.00%, Follow-up 62.91%
Enrolled before 7/2018 (n=1038): Follow-up 58.86%

Percent selecting "Poor" or "Fair" Physical Health

Overall (n=666): Initial 53.30%, Follow-up 40.69%
Benchmark for Milwaukee County: **20.00%**

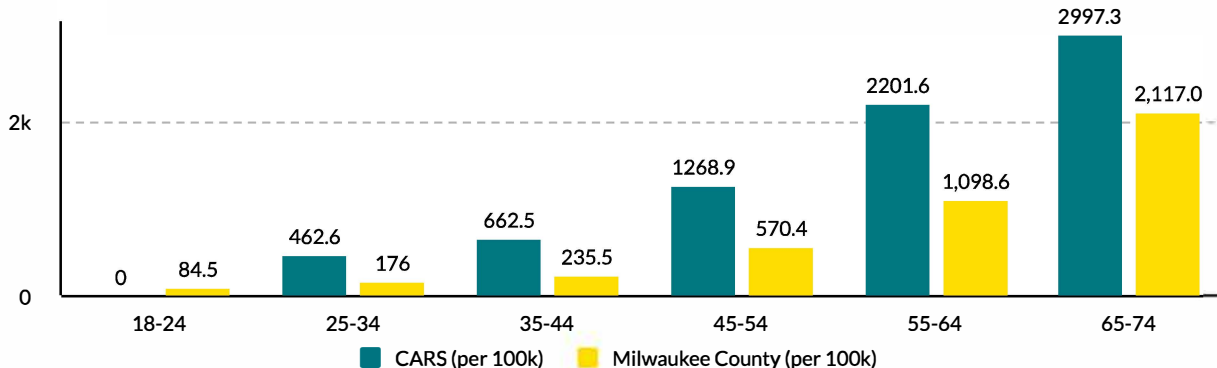# Domain: Population Health (cont.)
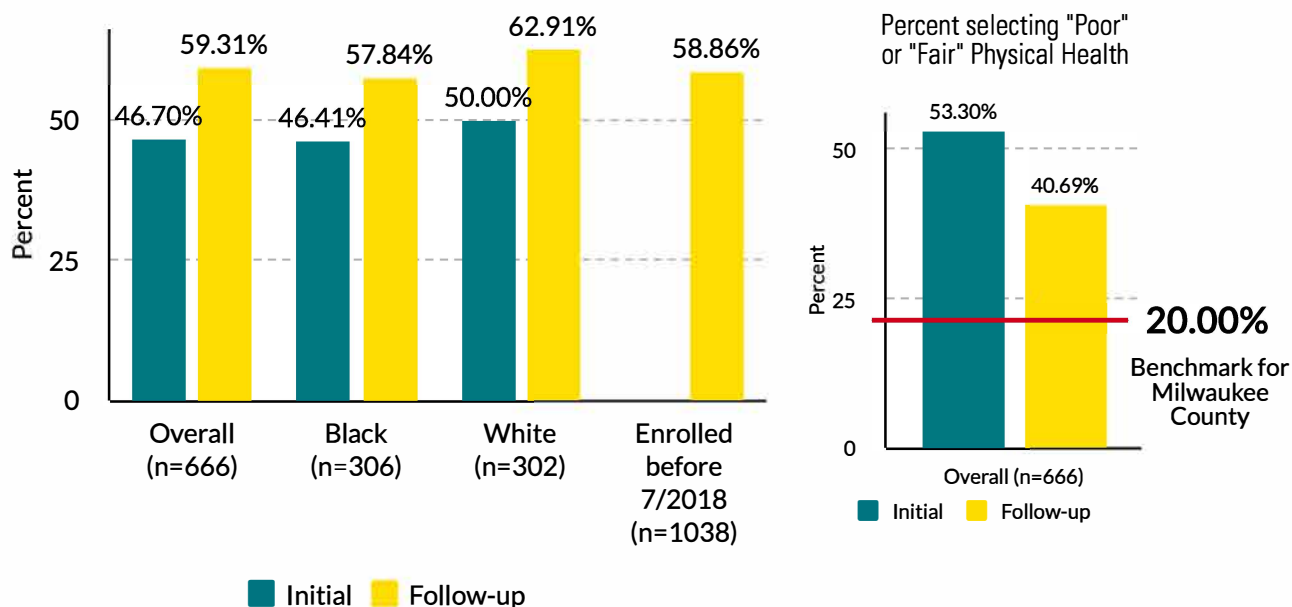
Cause of Death by Race

One quarter lag in reporting. For deaths between Q2-2020 and Q1-2021

Average Age at Death
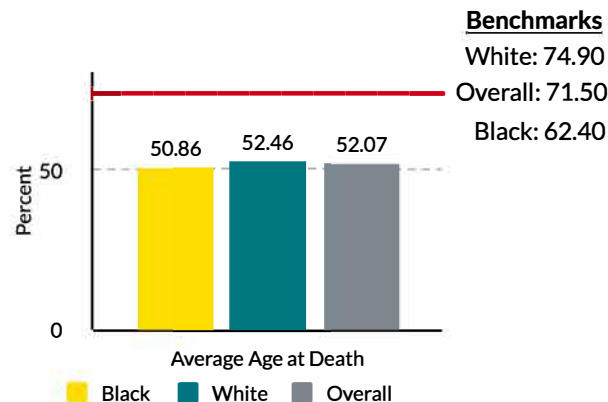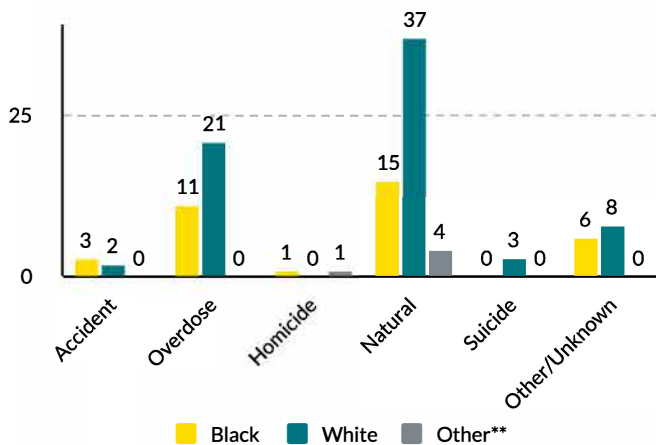
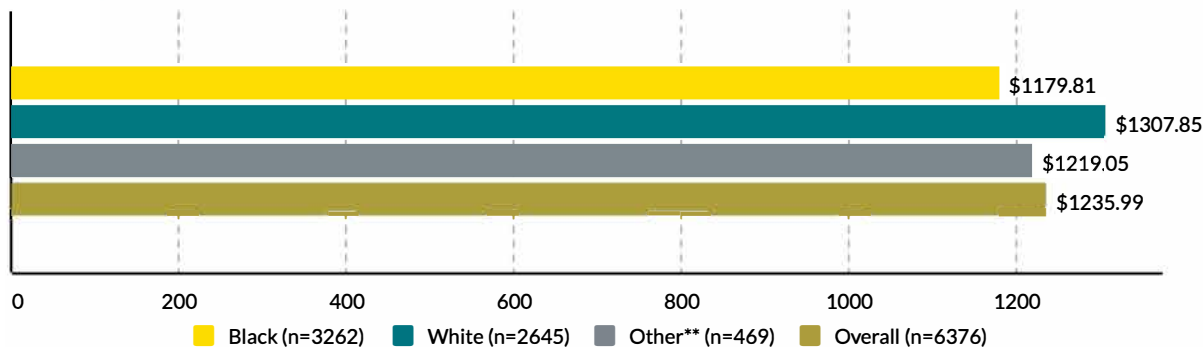## Death Rate (per 100,000) by Age Range

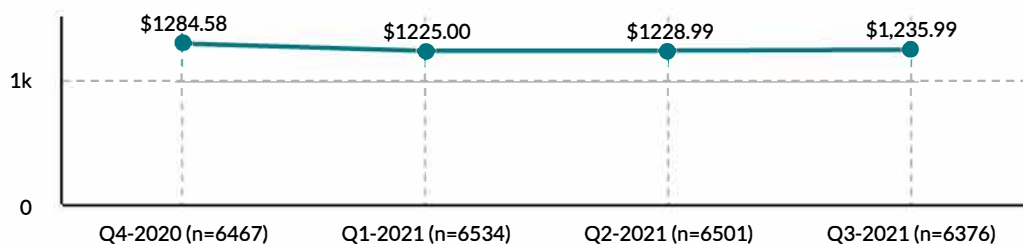CARS number adjusted for comparison against Milwaukee County^

Domain: Cost of Care

Average Cost per Consumer per Month for Q2 by Race

"n" refers to an average of the number of unique consumers served per month for the quarter

Black (n=3262): $1179.81
White (n=2645): $1307.85
Other** (n=469): $1219.05
Overall (n=6376): $1235.99

Average Cost per Consumer per Month by Quarter

Q4-2020 (n=6467): $1284.58
Q1-2021 (n=6534): $1225.00
Q2-2021 (n=6501): $1228.99
Q3-2021 (n=6376): $1,235.99

Domain: Staff Well-Being

Turnover

7.84%
CARS turnover rate

Staff Quality of Life

20.00%
Turnover rate for government employees (per year)^^

The CARS Mentorship program has been established and will have a kick-off date after Labor Day. Several CARS staff have volunteered to be mentors to new employees.

The CARS Staff Quality of Life committee put together an executive summary on hybrid work environments. The committee spent several months discussing the topic, looking at research and articles, and putting together the summary for the director to review prior to making decisions about back-to-work policies.

Metric Definitions

Average Age at Death

Death data is reported as an aggregate of the past four quarters, with a one-quarter lag. Average age at death for all causes of death.

Benchmarks from 2019 Milwaukee County Mortality Data - Wisconsin Interactive Statistics on Health (WISH)

Cause of Death

Death data is reported as an aggregate of the past four quarters, with a one-quarter lag. Causes reported by the Milwaukee County Examiner when available. For those without an examiner report, cause of death reported by CARS is used.

Change Over Time

Change over time, through client enrollment, looks at clients who had their initial PPS within 60 days of enrollment and their follow-up PPS during the observation quarter. Some metrics are broken down by cohorts, which are determined by length of enrollment between their initial PPS and their latest PPS during the observation quarter.

Benchmark data from the SAMHSA Uniform Reporting System - Mental Health Community Services Block Grant 2019 State Summary Report

Client Experience

Implementation of the new, more succinct Client Experience has begun. The survey ranges from 4-10 questions, depending on the program, and all questions range from 1="strongly disagree" to 5="strongly agree". The survey is currently being utilized in all CARS programs with the exception of CCS, CBRF, Adult Family Home, and Medication Assisted Treatment (MAT).

Cost of Care

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 "n" is an average of the unique number of consumers served per month for the 3 months in the observation quarter.

Death Rate

The CARS death rate has been adjusted to a rate per 100,000 to compare with Milwaukee County death data.

^Comparison death data from Wisconsin Interactive Statistics on Health (WISH) data query system, 2018 mortality data

Employment

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

Percent Served Within 7 days

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

Private Residence

Percent of clients who reported their current living situation as a private residence.

Quality of Life

This is a self-reported measure based on the question on the Comprehensive Assessment. Graphs shows the percentage of people that stated that their quality of life was "good" or "very good".

Referrals

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

Self-Rated Health

This is a self-reported measure based on the question on the Comprehensive Assessment. The graph shows the percentage of people that said that their physical health was "good", "very good" or "excellent".

Benchmark from County Health Rankings

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

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

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.

**"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian","Biracial", "Native Hawaiian/Pacific Islander", and "Other"
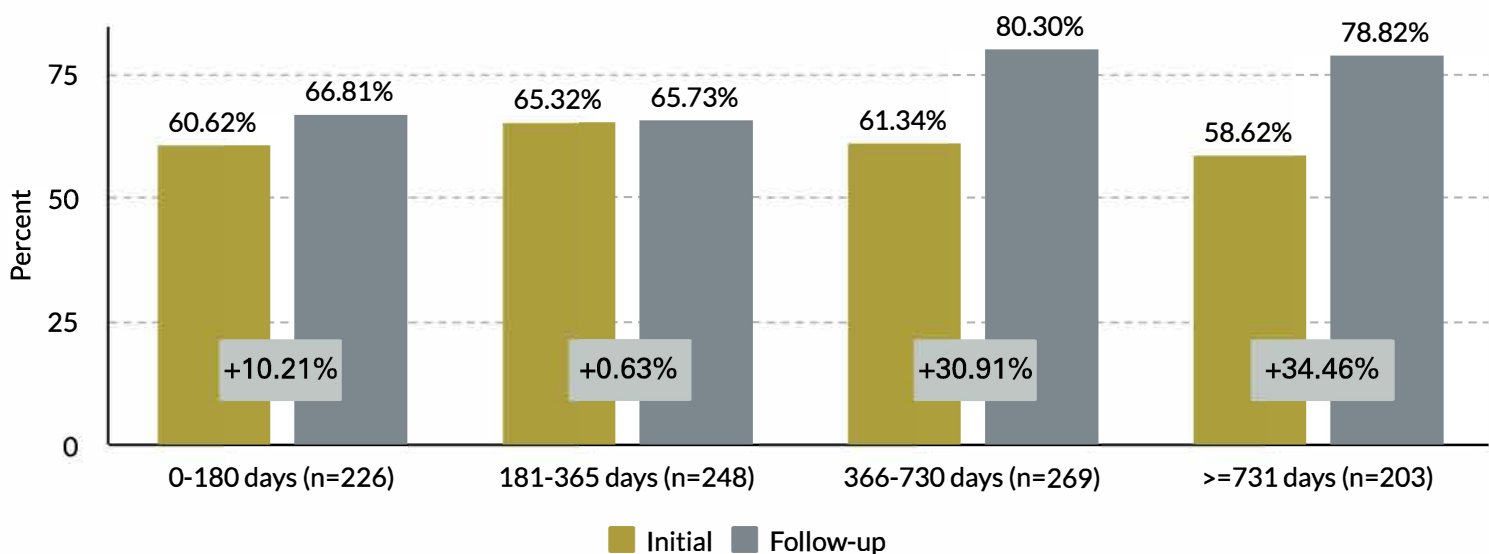
Percent of Clients selecting "Good" or "Very Good" Quality of Life by Length of Enrollment

Although the rates of change are higher in longer lengths of enrollment, this is likely due, in part, to a larger proportion of individuals in longer enrollment cohorts coming in with a poorer quality of life.
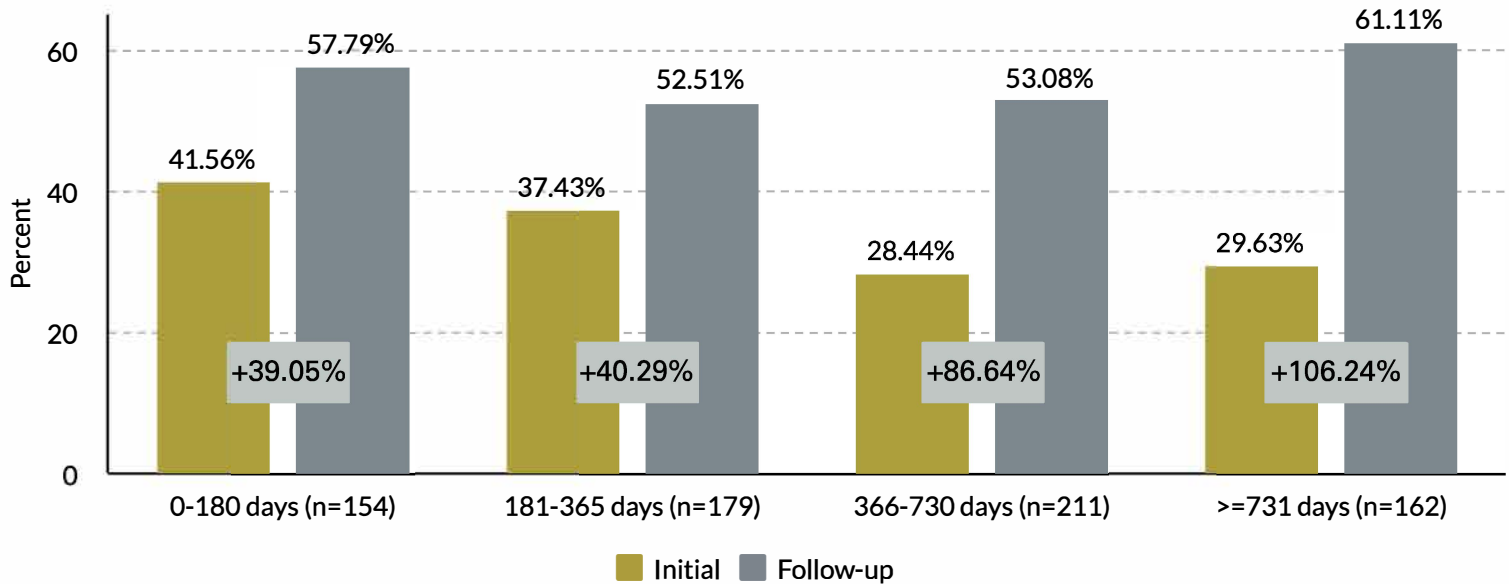

Percent of Clients with a Private Residence

Clients enrolled longer appear to have higher rates of private residence than clients enrolled for shorter lengths of time.

Percent of Clients Employed

Although the rates of change are higher in longer lengths of enrollment, this is likely due to a larger proportion of individuals in longer enrollment cohorts coming in with lower rates of employment.
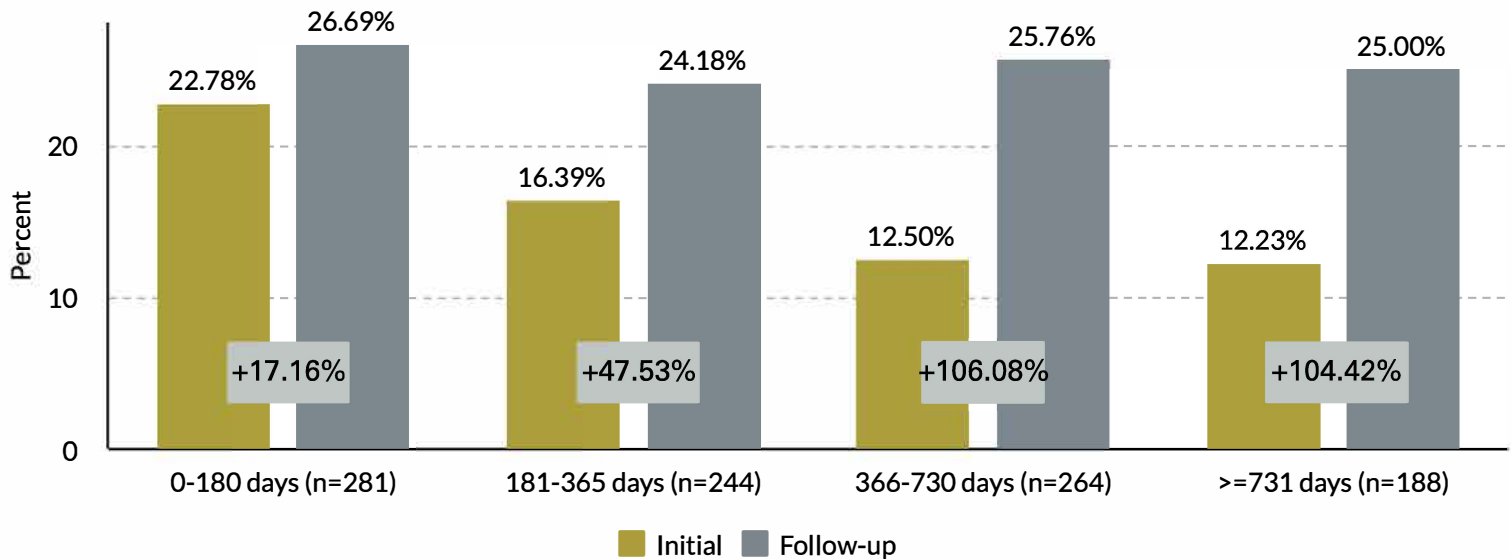
Percent of Clients selecting "Good", "Very Good" or "Excellent" Physical Health

This graph shows no clear trend in terms of rate of change between cohorts. Cohorts with longer enrollments did start with lower ratings of physical health, likely influencing their higher rates of change.
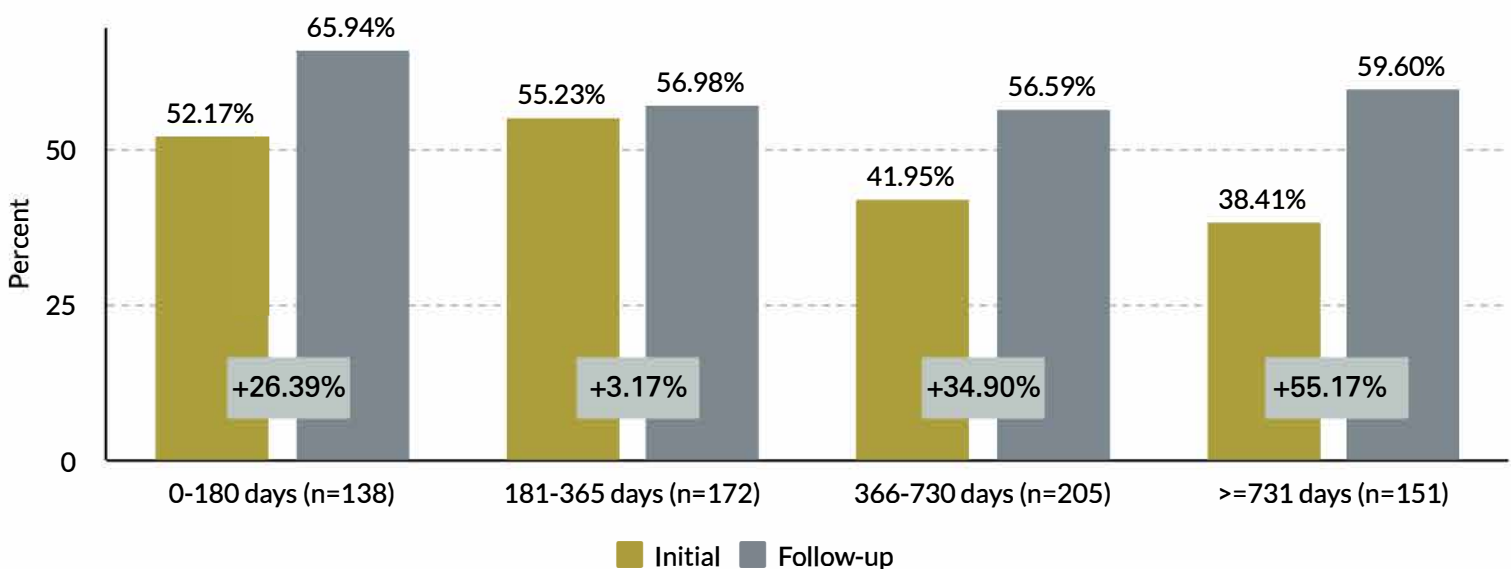
BHD KPI Report Q3 2021

Children's Community Mental Health Services and Wraparound Milwaukee

Report Overview

Unique Families Served
2,183

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 and out-of-home recidivism

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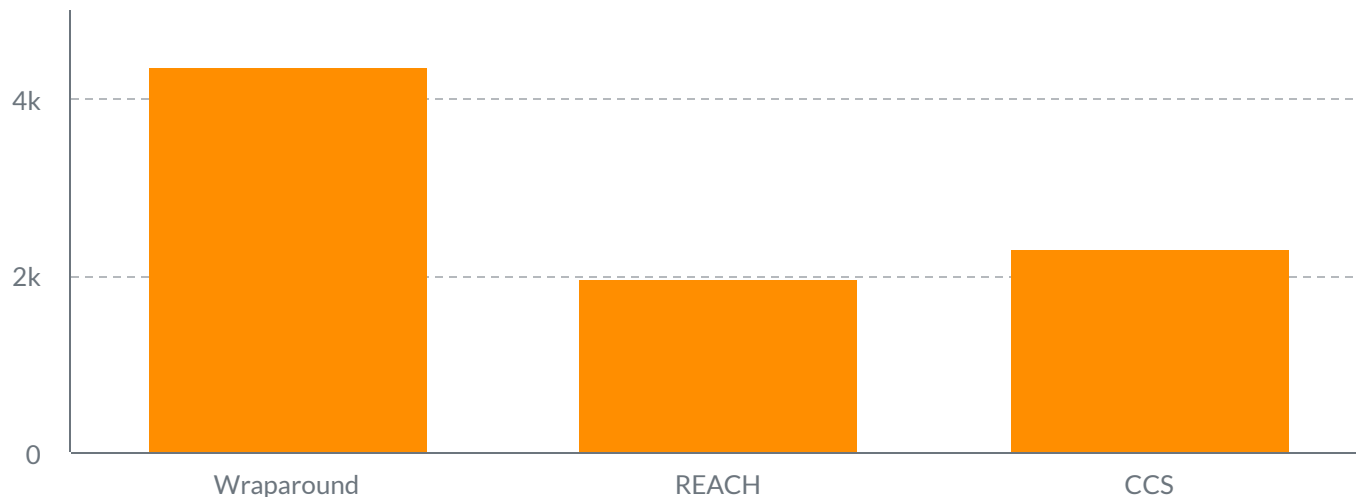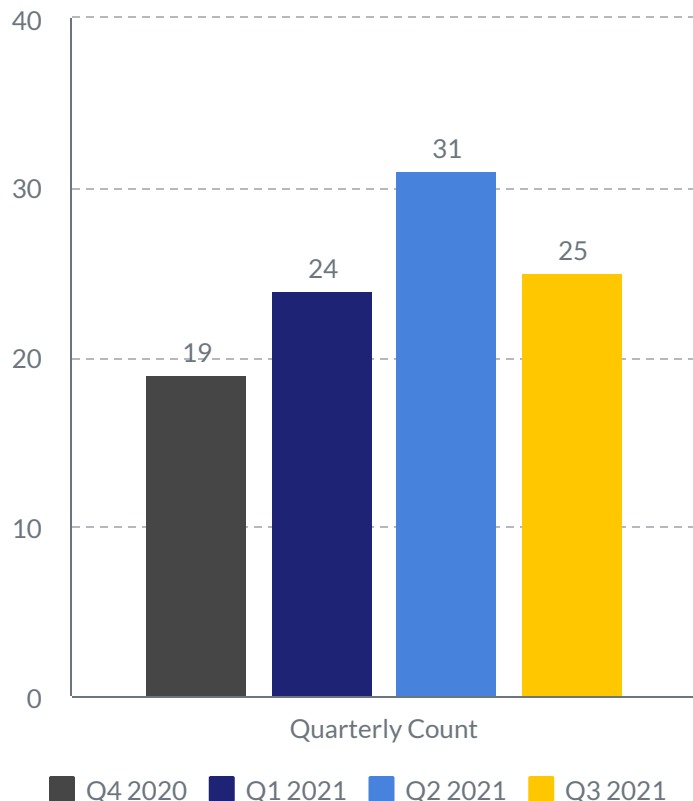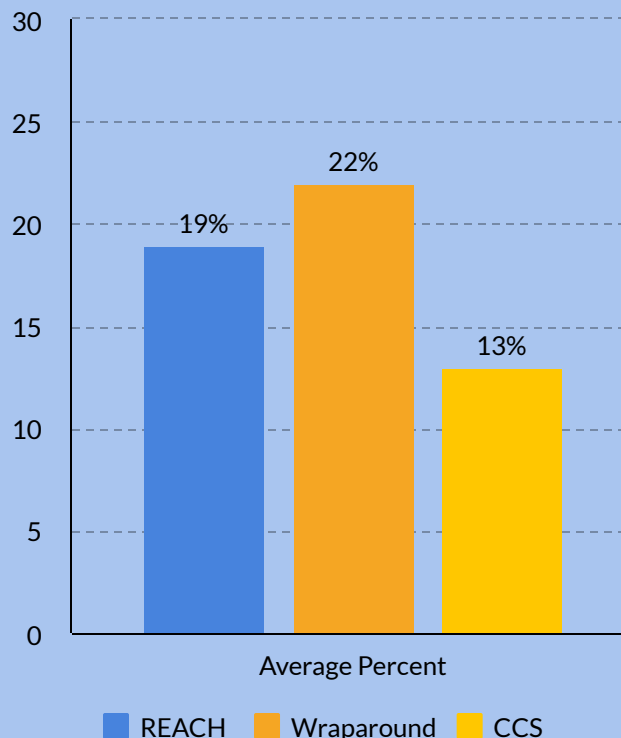
Population Health

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.
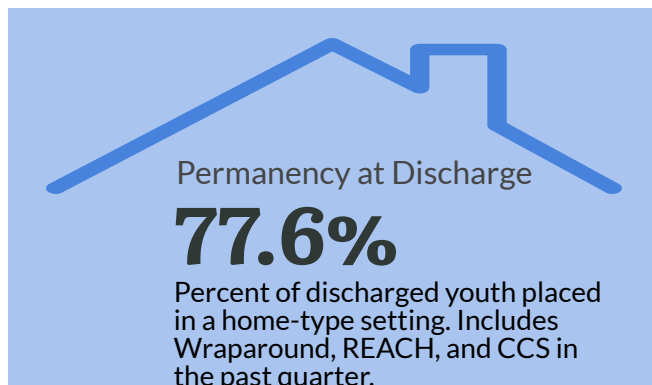
Percent of Natural Supports

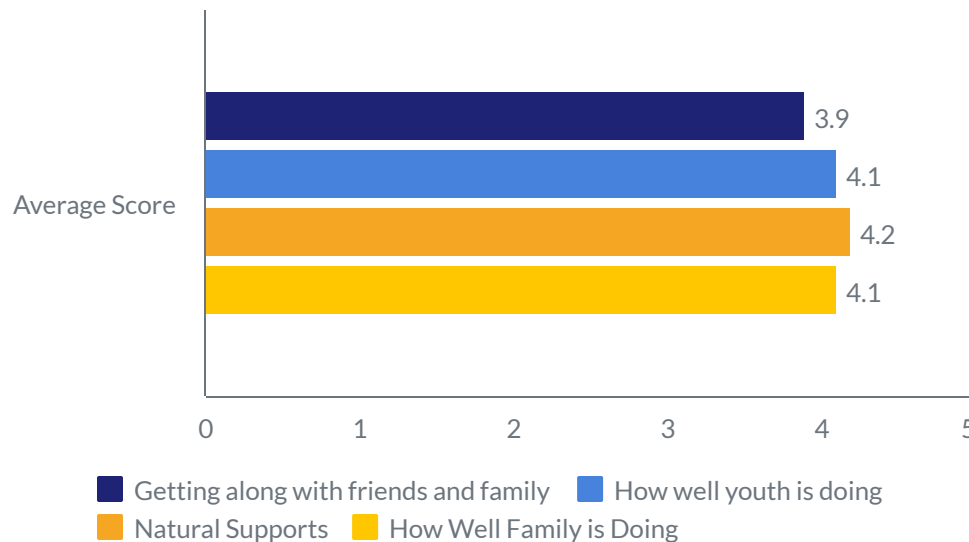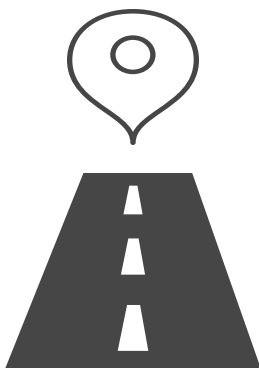Average percent of natural supports on teams in the past quarter.

Outcomes

Permanency at Discharge

77.6%

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

Family Satisfaction Overall Average Score

4.6

For Wraparound and REACH families in the past quarter

Youth and Caregiver Perceptions

Average Score

3.9	
4.1	
4.2	
4.1	

0   1   2   3   4   5

- Getting along with friends and family
- How well youth is doing
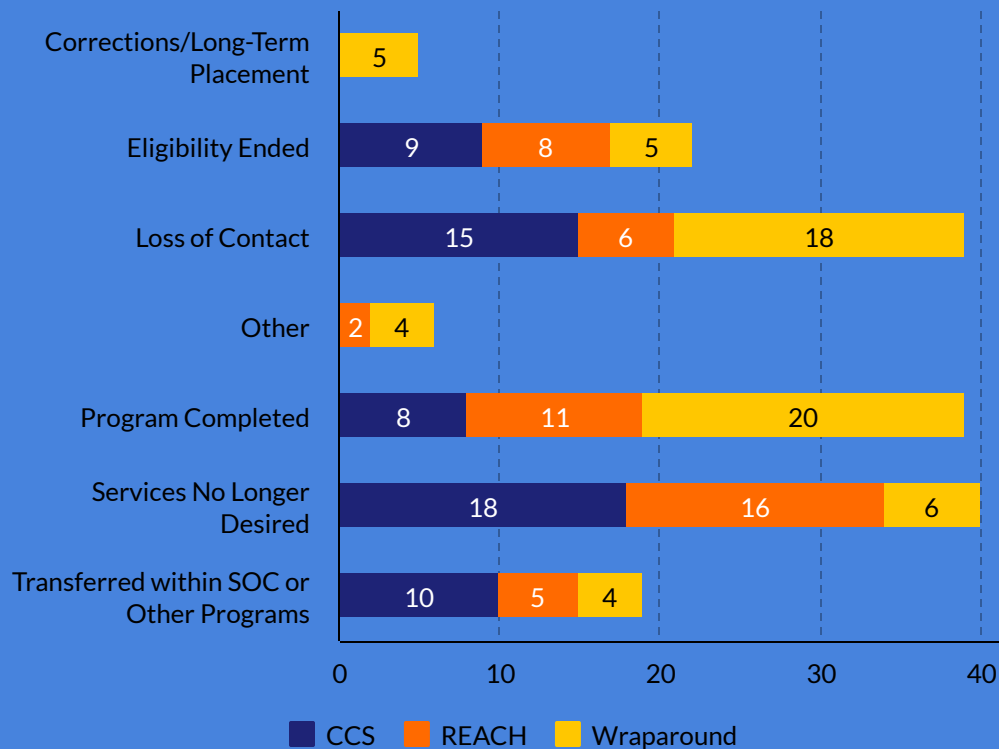- Natural Supports
- How Well Family is Doing

*Scores are from voluntary dis-enrollment surveys given to caregivers and youth in Wraparound and REACH programs in the past quarter.

Discharge Outcomes

Program	Discharges
Wraparound	62
REACH	48
CCS	60

Past Quarter Discharge Outcomes by Program

Outcome	CCS	REACH	Wraparound
Corrections/Long-Term Placement			5
Eligibility Ended	9	8	5
Loss of Contact	15	6	18
Other		2	4
Program Completed	8	11	20
Services No Longer Desired	18	16	6
Transferred within SOC or Other Programs	10	5	4

■ CCS ■ REACH ■ Wraparound

MAT Behind The Walls

Courtney Geiger, Project Director

Milwaukee County BHD

1/10/2022

Agenda

- Purpose
- Grant information
- Eligibility
- Goals
- Process
- Program benefits
- Demographics
- Q&A

Purpose: Targeted Population

- 75% of people who were in prison or jail with an OUD experience a relapse to opioid use within three months of release from custody.

- Incarcerated persons who are released to the community are between 10 and 40 times more likely to die of an opioid overdose than the general American population—especially within a few weeks after reentering society.

- Deaths from opioid overdoses have increased (126.7%) among WI DOC offenders, 34.6% of deaths occurred while under DOC supervision.

Grant Information

- **Grant**: Bureau of Justice Assistance (BJA), Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)

- **Amount**: $1.2 million over 3 years

- **Timeline**: October 2019 – September 2022

Milwaukee County BHD/CARS has partnered with the Milwaukee House of Correction (HOC), the Department of Corrections/Community Corrections (DOC), Wellpath, Community Medical Services (CMS), University of Wisconsin Milwaukee (UWM), and Wisconsin Community Services (WCS) to provide Medication Assisted Treatment Behind the Walls.

Eligibility & Requirements

- Must be at HOC or Jail

- Participants must volunteer for the program

- Have medical and substance abuse assessment (clinical opiate withdrawal scale - COWS)

- Have a release date

- Live in Milwaukee County

- Be medically cleared to take Naltrexone (Vivitrol)

- Assigned case manager from Wellpath

- Meet therapist and peer from CMS for weekly meetings

- Complete mental health questionnaire and actively participate in treatment planning

- Up to 3 Vivitrol injections and minimum of 2 weeks of Suboxone, prior to release

- Cognitive Behavioral Programming to align with evidenced based practices

- Access to Milwaukee County resources
  - Recovery Support Coordinator (RSC)

- Bus passes and Narcan provided at release

Goals

1. Provide all 3 forms of FDA approved medically assisted treatment

       - Vivitrol

       - Suboxone

       - Methadone

2. To reduce the risk of overdose death and enhance treatment and recovery service engagement among the post-trial population prior to community reentry

Pros of Program

- Trust is built while incarcerated that continues post release increasing confidence in recovery

- Participants can see the same recovery support team, i.e., PSS, mental health counselor, etc.

- MAT is started prior to release so proper dosage and stability is achieved prior to release and continues post release

- This program incorporates recommendations from all agencies involved with the participant
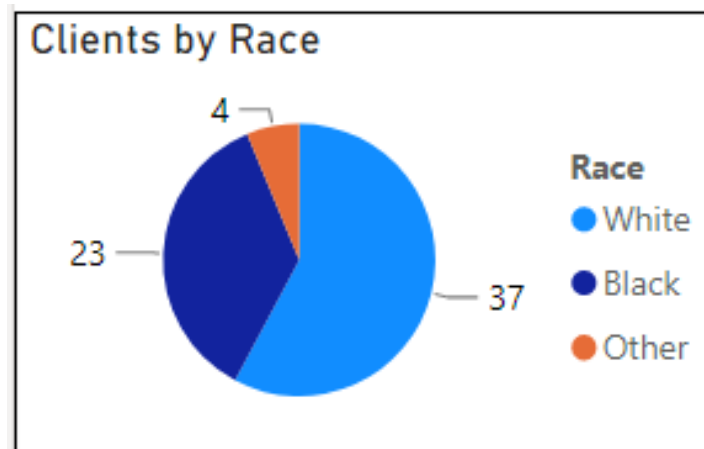
- **The risk of fatal and nonfatal OD is reduced post release**

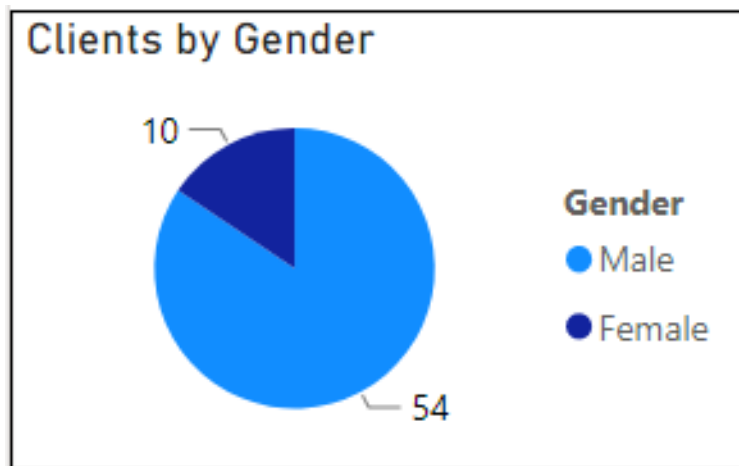# Participant Data
From June 2020 – November 2021

86 Total Participants

64 Enrolled Clients in Avatar

Clients by Race

- 4 — Other
- 23 — Black
- 37 — White

Race
- White
- Black
- Other

33.70
Ave Age

Clients by Gender

- 10 — Female
- 54 — Male

Gender
- Male
- Female

Heroin/Opiate Use indicated on PPS

- 21 — Other
- 43 — Heroin/Opiate

Substance of Abuse
- Heroin/Opiate
- Other
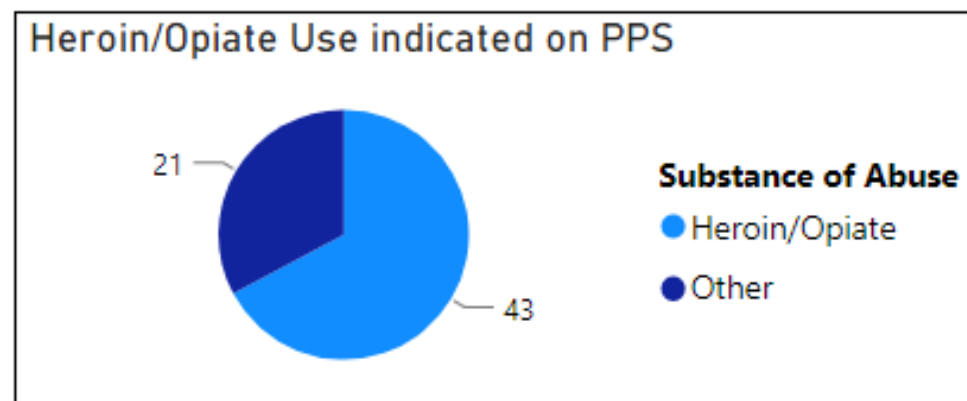
Next Steps – Year 3

- Collect and evaluate outcome data
    - Drug use and overdoses
    - Re-arrest rates
    - Quality of life
    - Other social and health metrics
    - Ongoing participant and staff survey collection by external evaluator (UWM)
- Methadone made available for participants

Q&A

Courtney Geiger

Project Director

Milwaukee County BHD

414-639-4467

Courtney.Geiger@milwaukeecountywi.gov

December 2, 2021

Mercedez Butts
Joyce's House
P.O. Box 511402
Milwaukee, WI 53203

Delivered via email to: mercedez@joyceshousemke.org

Re: Bridge Housing Program

Dear Ms. Butts,

Milwaukee County Behavioral Health Division Community Access to Recovery Services (CARS) is submitting this communication as notice that all referrals to Joyce's House bridge housing program are being suspended effective immediately and until further notice. This action is being taken due to concerns regarding deficiencies in standards, quality of care, and services to clients. Specifically, a compliance audit has made BHD aware that clients do not have access to their living quarters 24 hours a day which is in violation of your 2021 Fee for Service Agreement. Page 51 of your Fee for Service Agreement states "Bridge Housing will operate 24 hours per day, 7 days per week, including holidays, and must be staffed accordingly".

The Milwaukee County Behavioral Health Division will continue to review the findings of the recent compliance audit. Once completed, leaders will meet with you to review these concerns and discuss next steps.

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

Sincerely,

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

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MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
CHILDREN'S COMMUNITY MENTAL HEALTH SERVICES AND
WRAPAROUND MILWAUKEE

PHONE: (414) 257-7610	9455 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226	FAX: (414) 257-6825

October 7, 2021

RE: Desk Review of Harmony Social Services CPA, Inc.

Ms. Hall,

Children's Community Mental Health Services and Wraparound Milwaukee (WM) completed a desk review of Harmony Social Services CPA, Inc. (Harmony) related to the Fee-for-Service Agreement (FFSA) contracted services provided for WM. The review was initiated based on a pattern of concerns identified by WM related to Harmony's billing and invoicing submissions. The desk review commenced on April 5, 2021.

The desk review of client records consisted of a review of Service Authorization Requests (SARs) for all services paid to Harmony during a six (6) month period from August 2020 through January 2021.

WM reviewed the compliance of Harmony in accordance with the terms and conditions of the 2020-2021 FFSA as well as compliance with respective WM policies and service-related requirements. The review also addressed whether there was sufficient documentation to support the units of service that were billed to WM. While the review would not necessarily disclose all matters of noncompliance, the review procedures did disclose certain instances of noncompliance that are described in the report.

The review consisted of auditing billing and client records (i.e., referrals, signature logs).

The review included the following services:

- After School Programs (5202)
- Recreation Programming- Full Day (5526)

The findings are outlined in the enclosed report (pages 3-5), which includes two (2) parts and associated exhibits: Part I - Findings of Noncompliance: Fiscal Findings and Part II - Findings of Noncompliance: Notable Concerns. In addition, two attachments of: A- Harmony Summary of Findings-updated and B- Harmony Individual Findings-updated.

The review resulted in a fiscal disallowance of **$28,305.40.** Additional details of the findings are included in attachments A and B.

If Harmony concurs with the findings, the payment of $28,305.40 will be recouped from the agency's next scheduled payment(s) over the next 30 days. Alternately, Harmony may request a repayment plan with Wraparound Milwaukee's Finance Department. Please refer to the <u>Unearned Monies Recoupment Policy (#80)</u> for specific actions of this request and contact the <u>Finance Department</u> by Friday, October 15, 2021.

If Harmony wishes to dispute the findings and/or fiscal disallowance, an appeal must be submitted in writing within 10 calendar days of this notification to:

Milwaukee County DHHS Behavioral Health Division
Attn: Michael Lappen, Administrator
Michael.Lappen@milwaukeecountywi.gov
9455 W. Watertown Plank Road
Milwaukee, WI 53226

Please refer to the attachment, Procurement Procedure-Legal and Contractual Remedies, for the specific information regarding this appeal process. Please note, client signatures on affidavits, attesting to the provision of service, obtained subsequent to the desk review will not be accepted in an appeal.

If BHD does not receive an appeal by October 17, 2021, WM will assume that Harmony concurs with the findings and the fiscal disallowance will be recouped accordingly.

Please be advised, based on the outcome of this desk review thus far, WM has determined a Corrective Action Plan (CAP) will be required. Further instructions of the CAP will be forthcoming from WM.

Should you have any questions or would like to schedule a time to meet to review the findings with WM, please email wrapqa@milwaukeecountywi.gov.

Sincerely,

X   *Brian McBride*

Brian McBride, Director
Wraparound Milwaukee

CC: Michael Lappen, Administrator-Behavioral Health Division

Part I- Findings of Noncompliance: Fiscal Findings

Finding 01 – **All youth did not have a corresponding WM Provider Referral with the identified service codes that were billed for**: **38.2% non-compliance**

Per Wraparound Policy #054- Provider Responsibilities and Guidelines, "*program-specific "Referral Form" must be received on each service recipient prior to the provision of service(s). A Provider may not be reimbursed for services provided prior to the date of the Referral. The Referral Form must be maintained as part of the service recipient record.*"

In addition, Wraparound Policy #038- Provider Referral Form states, "*that all Provider Agencies [must] receive a completed Provider Referral Form prior to providing services to a youth/family*" and "*Providers can initiate services only upon receipt of a PROVIDER REFERRAL FORM. Services provided, prior to receiving the authorized Provider Referral Form shall not be reimbursed.*"

In addition to incidents where no referral was present, there were incidents Harmony had referrals for one specific service code, but not for the service code the agency billed and was paid for. Per Wraparound Policy #038- Provider Referral Form, "*The Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agency must obtain a new PROVIDER REFERRAL FORM if the service changes, even though the new service is similar to the service already being provided.*" In addition, the policy states, "*Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agencies are responsible for communicating this policy with individual Direct Service Providers approved to provide services on behalf of their agency (employees and contract staff) through the Fee-for-Service Agreement with Children's Community Mental Health Services and Wraparound Milwaukee.*"

Finding 02 – **Services for Recreation Programming-Full Day (5526), were billed and paid for non-eligible days: 34.9% non-compliance**

Per Wraparound Policy #052- Recreation Programs, "*This service is used when school is not in session and can only be provided in an agency setting. A minimum of 6 hours and up to 9 hours per day of service must be provided.*"

Harmony billed and was paid for days of service when school was in session.

Finding 03 – **Services for After-School Programming (5202), were billed and paid for non-eligible days: 8.8% non-compliance**

Per Wraparound Policy #051- After School Programs, "*This service can only be provided for up to four hours per day and can only be provided when school or summer school is in session.*"

Harmony billed and was paid for days of service when school was not in session.

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
CHILDREN'S COMMUNITY MENTAL HEALTH SERVICES AND
WRAPAROUND MILWAUKEE

PHONE: (414) 257-7610   **9455 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226**   **FAX: (414) 257-6825**

Finding 04- Missing Attendance on Monthly Attendance Sheet (missing sign in and out): 4.9% non-compliance

Per Wraparound Policies, #051-After-school Programs and #052- Recreation Programs, "Monthly attendance sheet/s that contain the following:
1. Date/s the youth attended the program.
2. For each day of attendance:
    a. the time the youth arrived at the program - initials/signature of staff documenting the youth's arrival at the program.
    b. the time the youth left the program – initials/signature of staff documenting the youth's departure from the program."

Harmony billed for days that that youth's attendance was not present/documented on the monthly attendance sheet.

Finding 05 – Harmony billed and was paid for duplicate service dates: 0.7% non-compliance

Per the FFSA, *"DSP is responsible for the accuracy of billings for services performed under this Agreement . . ."*

Harmony billed and was paid for multiple sessions of Recreation Programming (5526) for the same day. Recreation Programming is a full day service and can only be billed for 1 session per day.

Finding 06 – Harmony billed and was paid for over the maximum allowed units: 1.6% non-compliance

Per Wraparound Policy #051- After School Programs, "*This service can only be provided for up to four (4) hours per day and can only be provided when school or summer school is in session*".

Harmony billed and was paid for more than 4 hours per day of After School Programming for a youth.

Finding 07 - Harmony overbilled hours provided: 0.3% non-compliance

Per the FFSA, *"DSP is responsible for the accuracy of billings for services performed under this Agreement . . ."*

Harmony billed and was paid for more hours than the documented hours (example: Harmony provided/documented 1.6 hours of service, but billed and was paid for 3 hours of service).

Finding 08 - Harmony provided services outside of the request in the referral: 2.1% non-compliance

A referral form, outlines what the youth, family, and team is requesting of the Provider for a specific service. In this case, the referral form that Harmony received specifically outlines that service would not begin until after 2:30 pm. Services were billed and paid for prior to the service start time of 2:30 pm. As outlined in Wraparound Policy #038,

"The Children's Community Mental Health Services and Wraparound Milwaukee Provider Network agency must obtain a new PROVIDER REFERRAL FORM if the service changes, even though the new service is similar to the service already being provided." Harmony did not obtain a new referral form to provide services outside of the requested time.

Part II - Findings of Noncompliance: Notable Concerns

Concern #1 – There were several incidents where either a sign in or a sign out log were missing. Even though there is no fiscal disallowance, it is important that all days a youth is present that they both a sign in and out for that specific date.

Concern #2 – Harmony staff requested a referral from a Care Coordinator post service start date on several incidents. All referrals must be received prior the commencement of the service for the specific service code for each youth.

~ End of Report ~

2021 Q3 MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
INPATIENT DASHBOARD

Psychiatric Crisis Service (PCS)

Target Key:	🟦 Better Than Expected	🟩 Expected	🟥 Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
🟥 Q1: Rate=10.1% Q2: Rate=9.0% Q3: Rate=11.0% Q4: Rate=	🟥 Rate=10.1%	Percent of patients returning to PCS within 3 days	Rate 🟦 X < 7.8% 🟩 X = 7.8% 🟥 X > 7.8%	Rate=Count of client visits within 3 days of prior visit/Total client visits Q1: 155 readmissions within 3 days by 82 unique individuals Q2: 139 readmissions within 3 days by 81 unique individuals Q3: 180 readmissions within 3 days by 103 unique individuals Q4:
🟥 Q1: Rate=23.7% Q2: Rate=26.2% Q3: Rate=28.7% Q4: Rate=	🟥 Rate=26.3%	Percent of patients returning to PCS within 30 days	Rate 🟦 X < 24% 🟩 X = 24% 🟥 X > 24%	Rate=Count of client visits within 30 days of prior visit/Total client visits Q1: 363 readmissions within 30 days by 163 unique individuals Q2: 403 readmissions within 30 days by 189 unique individuals Q3: 471 readmissions within 30 days by 237 unique individuals Q4:
🟦 Q1: Rate=1.96 (n=3) Q2: Rate=2.60 (n=4) Q3: Rate=1.83 (n=3) Q4: Rate=	🟦 Rate=2.12 (n=10)	Behavioral Codes (Code 1)	Rate 🟦 X < 2.3 🟩 X = 2.3 🟥 X > 2.3	Rate=Behavioral codes per 1,000 PCS visits The objective of this metric is to not only to monitor the quantity/rate of codes called resulting in further treatment (Restraint and Seclusion).
🟩 Q1: Rate=0.0 (n=0) Q2: Rate=0.7 (n=1) Q3: Rate=0.6 (n=1) Q4: Rate=	🟩 Rate=0.42 (n=2)	Physical Aggression - Patient/Patient	Incidents 🟦 Zero 🟩 2 or Less 🟥 > 2	Rate=Pt/Pt physical aggression incidents per 1,000 PCS visits.
🟥 Q1: Rate=3.9 (n=6) Q2: Rate=2.0 (n=3) Q3: Rate=4.9 (n=8) Q4: Rate=	🟥 Rate=3.6 (n=17)	Physical Aggression - Patient/Staff	Incidents 🟦 Zero 🟩 2 or Less 🟥 > 2	Rate=Pt/Staff physical aggression incidents per 1,000 PCS visits.
🟦 Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Rate=0.0 (n=0) Q4: Rate=	🟦 Rate=0.0 (n=0)	Patient Elopement	Incidents 🟦 Zero 🟩 2 or Less 🟥 > 2	Rate = Patient elopements per 1,000 PCS visits BHD's current Elopement definition: Patient eloped from locked unit and returned within the building or patient eloped from locked unit and exited the building.

				Joint Commission's elopement definition = unauthorized departure, of a patient from an around-the-clock care setting.
Q1: Rate=3.3 (n=5) Q2: Rate=0.0 (n=0) Q3: Rate=0.0 (n=0) Q4: Rate=	Rate=1.1 (n=5)	Patient Self Injurious Behavior	Incidents Zero 1 > 2	Rate=Patient Self Injurious Behavior Incidents per 1,000 PCS visits
Q1: Rate=0.0 (n=0) Q2: Rate=10.9 (n=1) Q3: Rate=0.0 (n=0) Q4: Rate=	Rate=3.6 (n=1)	Medication Errors	Rate X = 0 X < 1.1 X > 1.1	Rate=Medication Errors per 10,000 Doses Dispensed

2021 Q3 MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
INPATIENT DASHBOARD

Acute Adult Inpatient Service

Target Key:	🟦 Better Than Expected	🟩 Expected	🟥 Worse Than Expected

Quarter	YTD	Quality Indicator	Threshold	Description
🟥 Q1: Rate=3.5% (n=5) Q2: Rate=4.4% (n=6) Q3: Rate=3.8% (n=5) Q4: Rate=	🟥 3.9% (n=16)	Percent of patients returning to Acute Adult within 7 days	Rate 🟦 X < 3% 🟩 X = 3% 🟥 X > 3%	Rate=Percent of patient admissions occurring within 7 days of patient's prior discharge from the program
🟦 Q1: Rate=7.0% (n=10) Q2: Rate=12.5% (n=17) Q3: Rate=7.6% (n=10) Q4: Rate=	🟦 9.0% (n=37)	Percent of patients returning to Acute Adult within 30 days	Rate 🟦 X < 9.6% 🟩 X = 9.6% 🟥 X > 9.6%	Rate=Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
🟥 Q1: 75.4% positive Q2: 70.5% positive Q3: 74.1% positive Q4:	🟥 73.5%	Percent of patients responding positively to MHSIP satisfaction survey	Rate 🟦 X > 75% 🟩 X = 75% 🟥 X < 75%	Rate=Percent of patients selecting "Agree" or "Strongly Agree" to all survey items Q1: 73 completed surveys (49% response rate) Q2: 51 completed surveys (36% response rate) Q3: 32 completed surveys (36% response rate) Q4:
🟦 Q1: 66.7% positive Q2: 50.0% positive Q3: 71.0% positive Q4:	🟥 62.2%	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	Rate 🟦 X > 65% 🟩 X = 65% 🟥 X < 65%	Rate=Percent of patients selecting "Agree" or "Strongly Agree" to survey item Q1: 73 completed surveys (49% response rate) Q2: 51 completed surveys (36% response rate) Q3: 32 completed surveys (36% response rate) Q4:
🟩 Q1: Rate=14.0 (n=34) Q2: Rate=13.7 (n=27) Q3: Rate=9.2 (n=17) Q4:	🟥 Rate=12.3 (n=78)	Behavioral Codes	Rate 🟦 X < 9.2 🟩 X = 9.2 🟥 X > 9.2	Rate=Behavioral codes per 1,000 patient days The objective of this metric is to not only to monitor the quantity/rate of codes called resulting in further treatment (Restraint and Seclusion). 43A Incidents - Q1: 26 Q2: 17 Q3: 8 43B Incidents - Q1: 7 Q2: 8 Q3: 0 43C Incidents - Q1: 1 Q2: 2 Q3: 3 43D Incidents - Q1: 0 Q2: 0 Q3: 6
🟥 Q1: Rate=2.5 (n=6) Q2: Rate=6.6 (n=13) Q3: Rate=4.4 (n=8) Q4:	🟥 Rate=4.5 (n=27)	Physical Aggression - Patient/Patient	Rate 🟦 X < 2.9 🟩 X = 2.9 🟥 X > 2.9	Rate=Pt/Pt physical aggression incidents per 1,000 patient days 43A Incidents - Q1: 4 Q2: 5 Q3: 0 43B Incidents - Q1: 1 Q2: 3 Q3: 0 43C Incidents - Q1: 1 Q2: 4 Q3: 2 43D Incidents - Q1: 0 Q2: 1 Q3: 6
🟥 Q1: Rate=3.7 (n=9) Q2: Rate=11.2 (n=22) Q3: Rate=7.6 (n=14) Q4:	🟥 Rate=7.5 (n=45)	Physical Aggression - Patient/Staff	Rate 🟦 X < 2.9 🟩 X = 2.9 🟥 X > 2.9	Rate=Pt/Staff physical aggression incidents per 1,000 patient days 43A Incidents - Q1: 6 Q2: 8 Q3: 3 43B Incidents - Q1: 2 Q2: 13 Q3: 0 43C Incidents - Q1: 1 Q2: 1 Q3: 1 43D Incidents - Q1: 0 Q2: 0 Q3: 10

🟥 Q1: Rate=0.83 (n=2) Q2: Rate=1.5 (n=3) Q3: Rate=1.1 (n=2) Q4:	🟥 Rate=1.1 (n=7)	Patient Elopement	Incidents 🟦 Zero 🟩 1 🟥 > 2	Rate=Patient elopements per 1,000 patient days 43A Incidents - Q1: 0 Q2: 2 (patients eloped from unit by breaking exterior windows) Q3: 1 (patient eloped from 43A main entrance to hospital corridor) 43B Incidents - Q1: 1 (patient eloped from unit after pulling the fire alarm) Q2: 1 (patient eloped from unit by breaking exterior window) 43C Incidents - Q1: 1 (patient eloped from unit by breaking exterior window) Q3: 1 (patient eloped through exterior window)
🟩 Q1: Rate=1.2 (n=3) Q2: Rate=0.5 (n=1) Q3: Rate=0.6 (n=1) Q4:	🟥 Rate=0.8 (n=5)	Patient Self Injurious Behavior	Incidents 🟦 Zero 🟩 1 🟥 > 2	Rate=Patient Self Injurious Behavior Incidents per 1,000 patient days 43A Incidents - Q1: 3 Q2: 1 Q3: 0 43B Incidents - Q1: 0 Q2: 0 Q3: 0 43C Incidents - Q1: 0 Q2: 0 Q3: 0 43D Incidents - Q1: 0 Q2: 0 Q3: 1
🟥 Q1: Rate=1.0 (n=2) Q2: Rate=2.9 (n=5) Q3: Rate=2.5 (n=4) Q4:	🟥 Rate=2.1 (n=11)	Medication Errors	Rate 🟦 X < 1.1 🟩 X = 1.1 🟥 X > 1.1	Rate=Medication errors per 10,000 administered doses 43A Incidents - Q1: 1 Q2: 2 Q3: 1 43B Incidents - Q1: 0 Q2: 3 Q3: 0 43C Incidents - Q1: 1 Q2: 0 Q3: 0 43D Incidents - Q1: 0 Q2: 0 Q3: 3 For 2021 YTD, Acute Adult's medication errors were: Omitted dose (3), Incorrect dose (2), Incorrect time (2), Medication known allergen to patient (1), Therapeutic duplication (1), Documentation (1), & Medication side effects (1).
🟥 Q1: Rate=.62 (36.1 hrs) Q2: Rate=.66 (31.3 hrs) Q3: Rate=.34 (14.9 hrs) Q4:	🟥 .55 (82.3 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate 🟦 X < .26 🟩 X = .26 🟥 X > .26	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care 43A - Q1: 28.8 hrs Q2: 21.2 hrs Q3: 2.5 hrs 43B - Q1: 4.6 hrs Q2: 5.0 hrs Q3: 2.6 hrs 43C - Q1: 2.8 hrs Q2: 5.0 hrs Q3: 1.0 hrs 43D - Q1: 0.0 hrs Q2: 0.0 hrs Q3: 8.8 hrs
🟦 Q1: Rate=.18 (10.4 hrs) Q2: Rate=.08 (3.9 hrs) Q3: Rate=.03 (1.2 hrs) Q4:	🟦 .10 (15.5 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate 🟦 X < .25 🟩 X = .25 🟥 X > .25	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care 43A - Q1: 5.1 hrs Q2: 2.3 hrs Q3: 0.0 hrs 43B - Q1: 5.3 hrs Q2: 1.7 hrs Q3: 0.0 hrs 43C - Q1: 0.0 hrs Q2: 0.0 hrs Q3: 0.0 hrs 43D - Q1: 0.0 hrs Q2: 0.0 hrs Q3: 1.2 hrs
🟥 Q1: Rate=17% (n=24) Q2: Rate=16% (n=22) Q3: Rate=26% (n=34) Q4:	🟥 19% (n=80)	HBIPS 4 - Patients discharged on multiple antipsychotic medications	Rate 🟦 X < 9.5% 🟩 X = 9.5% 🟥 X > 9.5%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications
🟦 Q1: Rate=92% (n=22) Q2: Rate=95% (n=21) Q3: Rate=88% (n=30) Q4:	🟦 91% (n=73)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate 🟦 X > 65% 🟩 X = 65% 🟥 X < 65%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification

2021 Q3 MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
INPATIENT DASHBOARD

Child Adolescent Inpatient Service (CAIS)

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

Quarter	YTD	Quality Indicator	Threshold	Description
■ (blue) Q1: 3.7% (n=3) Q2: 8.1% (n=7) Q3: 4.6% (n=3) Q4:	■ (red) Rate=5.6% (n=13)	Percent of patients returning to CAIS within 7 days	Rate ■ X < 5.0% ■ X = 5.0% ■ X > 5.0%	Rate=Percent of patient admissions occurring within 7 days of patient's prior discharge from the program
■ (red) Q1: 8.6% (n=7) Q2: 11.6% (n=10) Q3: 10.8 (n=7) Q4:	■ (red) Rate=10.3% (n=24)	Percent of patients returning to CAIS within 30 days	Rate ■ X < 9.6% ■ X = 9.6% ■ X > 9.6%	Rate=Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
■ (blue) Q1: 66.8% positive Q2: 78.8% positive Q3: 77.7% positive Q4:	■ (red) 74.7%	Percent of patients responding positively to satisfaction survey	Rate ■ X > 75% ■ X = 75% ■ X < 75%	Rate=Percent of patients selecting "Agree" and "Strongly Agree" to all survey items Q1: 35 completed surveys (43% response rate) Q2: 41 completed surveys (49% response rate) Q3: 21 completed surveys (32% response rate) Q4:
■ (blue) Q1: 71.4% positive Q2: 78.0% positive Q3: 90.5% positive Q4:	■ (blue) 78.4%	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	Rate ■ X > 75% ■ X = 75% ■ X < 75%	Rate=Percent of patients selecting "Agree" and "Strongly Agree" to survey item Q1: 35 completed surveys (43% response rate) Q2: 41 completed surveys (49% response rate) Q3: 21 completed surveys (32% response rate) Q4:
■ (blue) Q1: Rate=0.0 (n=0) Q2: Rate=14.4 (n=6) Q3: Rate=7.7 (n=3) Q4:	■ (blue) Rate=7.4 (n=9)	Behavioral Codes (Code 1)	Rate ■ X < 8.0 ■ X = 8.0 ■ X > 8.0	The objective of this metric is to not only to monitor the quantity of codes but of the codes called and how many of them resulted in further treatment with restraint and/or seclusion.
■ (green) Q1: Rate=12.0 (n=5) Q2: Rate=2.4 (n=1) Q3: Rate=2.6 (n=1) Q4:	■ (red) Rate=5.7 (n=7)	Physical Aggression - Patient/Patient	Incidents ■ Zero ■ 2 or Less ■ > 2	Rate=Pt/Pt physical aggression incidents per 1,000 patient days
■ (green) Q1: Rate=16.9 (n=7) Q2: Rate=4.8 (n=2) Q3: Rate=5.1 (n=2) Q4:	■ (red) Rate=9.0 (n=11)	Physical Aggression - Patient/Staff	Incidents ■ Zero ■ 2 or Less ■ > 2	Rate=Pt/Staff physical aggression incidents per 1,000 patient days In 2021 Q1, two patients accounted for the (7) patient-to-staff physical aggression incidents.

Q1: Rate=0.0 (n=0) Q2: Rate=0.0 (n=0) Q3: Rate=0.0 (n=0) Q4:	Rate=0.0 (n=0)	Patient Elopement	Incidents ■ Zero ■ 1 ■ > 2	Rate=Patient elopements per 1,000 patient days
Q1: Rate=4.8 (n=2) Q2: Rate=2.4 (n=1) Q3: Rate=7.7 (n=3) Q4:	Rate=4.9 (n=6)	Patient Self Injurious Behavior	Incidents ■ Zero ■ 1 ■ > 2	Rate=Patient self-injurious behavior Incidents per 1,000 patient days
Q1: Rate=0.0 (n=0) Q2: Rate=5.8 (n=1) Q3: Rate=9.8 (n=2) Q4:	Rate=5.2 (n=3)	Medication Errors	Rate ■ X < 1.1 ■ X = 1.1 ■ X > 1.1	Rate=Medication errors per 10,000 doses administered
Q1: Rate=0.80 (8.0 hrs) Q2: Rate=0.65 (6.6 hrs) Q3: Rate=0.12 (1.2 hrs) Q4:	.53 (15.7 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate ■ X < .26 ■ X = .26 ■ X > .26	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care
Q1: Rate=.42 (4.2 hrs) Q2: Rate=.00 (0.0 hrs) Q3: Rate=.24 (2.3 hrs) Q4:	.22 (6.4 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate ■ X < .25 ■ X = .25 ■ X > .25	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care
Q1: Rate=1.2% (n=1) Q2: Rate=1.1% (n=1) Q3: Rate=0.0% (n=0) Q4:	0.87% (n=2)	HBIPS 4 - Patients discharged on multiple antipsychotic medications	Rate ■ X < 3% ■ X = 3% ■ X > 3%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications
Q1: Rate=100% (n=1) Q2: Rate=100% (n=1) Q3: N/A Q4:	100% (n=2)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate ■ X > 65% ■ X = 65% ■ X < 65%	Rate=Percent of patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification

Acute Inpatient Performance Measures Reported to CMS

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

Quarter	YTD	Quality Indicator	Threshold	Description
■ (red) Q1: Rate=.65 (44.1 hrs) Q2: Rate=.66 (37.8 hrs) Q3: Rate=.30 (16.1 hrs) Q4:	■ (red) .55 (98.0 hrs)	HBIPS 2 - Hours of Physical Restraint Rate	Rate ■ X < .26 ■ X = .26 ■ X > .26	Rate=Hours that patients spent in physical restraints for every 1,000 hours of patient care
■ (blue) Q1: Rate=.21 (14.5 hrs) Q2: Rate=.07 (3.9 hrs) Q3: Rate=.06 (3.4 hrs) Q4:	■ (blue) .12 (21.9 hrs)	HBIPS 3 - Hours of Locked Seclusion Rate	Rate ■ X < .25 ■ X = .25 ■ X > .25	Rate=Hours that patients spent in seclusion for every 1,000 hours of patient care
■ (blue) Q1: 92% (n=23) Q2: 96% (n=22) Q3: 88% (n=30) Q4:	■ (blue) 91% (n=75)	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	Rate ■ X > 65% ■ X = 65% ■ X < 65%	Rate=Patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications with appropriate justification
■ (blue) Q1: 94% (n=148) Q2: 92% (n=137) Q3: 91% (n=174) Q4:	■ (blue) 92% (n=459)	Screening for metabolic disorders	Rate ■ X > 78% ■ X = 78% ■ X < 78%	Rate=Patients discharged on antipsychotic medications who had a body mass index, blood pressure, blood sugar, and cholesterol level screenings in the past year
□ (empty) Q1: 46% (n=102) Q2: N/A Q3: N/A Q4:	■ (red) 46% (n=102)	Patient influenza immunization	Rate ■ X > 79% ■ X = 79% ■ X < 79%	Rate=Patients assessed and given influenza vaccination (flu season time period 10/1 – 3/31)
■ (red) Q1: 42% (n=11) Q2: 52% (n=14) Q3: 64% (n=7) Q4:	■ (red) 50% (n=32)	SUB 2 - Alcohol use brief intervention provided or offered	Rate ■ X > 79% ■ X = 79% ■ X < 79%	Rate=Patients with alcohol abuse who received or refused a brief intervention during their inpatient stay.
■ (red) Q1: 8% (n=2) Q2: 19% (n=5) Q3: 55% (n=6) Q4:	■ (red) 20% (n=13)	SUB 2a - Alcohol use brief intervention provided	Rate ■ X > 72% ■ X = 72% ■ X < 72%	Rate=Patients with alcohol abuse who received a brief intervention during their inpatient stay.

			Rate	
Q1: 100% (n=71) Q2: 100% (n=98) Q3: 100% (n=66) Q4:	100% (n=235)	SUB 3 - Alcohol and other drug use disorder treatment provided or offered at discharge	X > 75% X = 75% X < 75%	Rate=Patients who screened positive for an alcohol or substance abuse disorder during their inpatient stay who, at discharge, either; received or refused a prescription for medications to treat their alcohol or drug use disorder, or received or refused a referral for addiction treatment
Q1: 44% (n=31) Q2: 56% (n=55) Q3: 45% (n=30) Q4:	49% (n=116)	SUB 3a - Alcohol and other drug use disorder treatment at discharge	X > 63% X = 63% X < 63%	Rate=Patients who screened positive for an alcohol or substance abuse disorder during their inpatient stay who, at discharge, either; received a prescription for medications to treat their alcohol or drug use disorder, or received a referral for addiction treatment
Q1: 94% (n=67) Q2: 93% (n=52) Q3: 84% (n=41) Q4:	90% (n=160)	TOB 2 - Tobacco use treatment provided or offered	X > 81% X = 81% X < 81%	Rate=Patients who use tobacco and who received or refused counseling to quit and received or refused medications to help them quit tobacco during their hospital stay
Q1: 83% (n=59) Q2: 84% (n=48) Q3: 76% (n=37) Q4:	81% (n=144)	TOB 2a - Tobacco use treatment (during the hospital stay)	X > 45% X = 45% X < 45%	Rate=Patients who use tobacco and who received counseling to quit and received medications to help them quit tobacco during their hospital stay
Q1: 54% (n=38) Q2: 71% (n=40) Q3: 50% (n=24) Q4:	58% (n=102)	TOB 3 - Tobacco use treatment provided or offered at discharge	X > 61% X = 61% X < 61%	Rate=Patients who use tobacco and at discharge received or refused a referral for outpatient counseling AND received or refused a prescription for medications to help them quit.
Q1: 3% (n=2) Q2: 5% (n=3) Q3: 10% (n=5) Q4:	6% (n=10)	TOB 3a - Tobacco use treatment provided at discharge	X > 22% X = 22% X < 22%	Rate=Patients who use tobacco and at discharge received a referral for outpatient counseling AND received a prescription for medications to help them quit
2018: 29.4% 2019: 27.9% 2020: 27.3%		FUH 30 - Follow-up after hospitalization for mental illness	X > 49.5% X = 49.5% X < 49.5%	Rate=Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 30 days of discharge. CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.
2018: 5.9% 2019: 8.1% 2020: 6.1%		FUH 7 - Follow-up after hospitalization for mental illness	X > 27.9% X = 27.9% X < 27.9%	Rate=Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge. CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.

		Rate	Rate=Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility
2018: 19.4% 2019: 18.6% 2020: 17.5% CMS reports BHD is "no different than the national rate"	READMN 30 IPF - 30 day all cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	X < 20.2% X = 20.2% X > 20.2%	CMS calculates this measure based on Medicare claims data and reports BHD's performance on the https://data.medicare.gov/data/hospital-compare website annually.

2014-2021 BHD Crisis Service & Acute Inpatient Reported "Aggression" Incidents

Created 11/1/21

2014-2021 BHD Acute Adult Inpatient Service Reported Patient "Aggression" Incident Trends

Incident Rate Formula = Incidents/(1,000 patient days)

	2014	2015	2016	2017	2018	2019	2020	2021 Q1	2021 Q2	2021 Q3
Self Injurious Behavior	2.2	1.1	0.5	0.8	0.7	0.5	0.3	1.2	0.5	0.5
Sexually Inappropriate Behavior	0.7	0.3	0.1	0.2	0.1	0.3	0.5	-	-	0.5
Physical Aggression - Patient/Employee	3.8	2.4	2.7	2.9	1.0	0.9	2.7	3.7	11.2	7.6
Physical Aggression - Patient/Patient	5.7	2.8	2.2	3.5	3.1	3.4	2.6	2.5	6.6	4.4
Property Damage	1.2	0.2	0.4	0.5	0.3	0.1	1.2	5.0	5.6	-
Sexual Contact	0.3	0.1	0.1	0.1	-	0.1	0.3	-	-	-
Suicide Attempt	0.1	0.1	0.2	-	0.1	0.1	-	-	-	-

2014-2021 BHD CAIS Inpatient Service Reported Patient "Aggression" Incident Trends

Incident Rate Formula = Incidents/(1,000 patient days)

	2014	2015	2016	2017	2018	2019	2020	2021 Q1	2021 Q2	2021 Q3
Self Injurious Behavior	1.5	2.2	3.7	2.9	1.5	1.1	-	4.8	2.4	7.7
Sexually Inappropriate Behavior	0.6	0.3	0.7	0.3	-	1.5	1.3	-	-	-
Physical Aggression - Patient/Employee	5.4	5.0	7.3	6.1	2.6	3.7	4.5	16.9	4.8	5.1
Physical Aggression - Patient/Patient	3.6	6.4	3.0	5.1	6.6	4.0	2.5	12.0	2.4	2.6
Property Damage	1.2	1.7	1.7	1.0	0.7	1.8	9.6	7.2	2.4	2.6
Sexual Contact	-	-	-	0.3	0.4	0.4	-	-	-	-
Suicide Attempt	0.3	-	0.7	-	-	-	0.6	2.4	-	-

2014-2021 BHD PCS Reported Patient "Aggression" Incident Trends

Incident Rate Formula = Incidents/(1,000 patient visits)

	2014	2015	2016	2017	2018	2019	2020	2021 Q1	2021 Q2	2021 Q3
Self Injurious Behavior	0.2	0.2	0.8	0.4	0.1	0.3	0.2	3.3	-	-
Sexually Inappropriate Behavior	0.2	-	0.1	-	-	0.1	-	-	-	-
Physical Aggression - Patient/Employee	0.9	1.2	2.5	1.1	0.5	0.9	1.1	3.9	2.0	4.9
Physical Aggression - Patient/Patient	0.4	0.4	0.6	0.1	0.1	0.5	-	-	0.7	0.6
Property Damage	0.3	0.2	1.0	0.4	0.8	0.8	0.8	1.3	1.3	0.6
Sexual Contact	-	-	-	-	-	-	-	-	-	-
Suicide Attempt	-	-	0.2	0.2	-	-	-	-	-	-

2014-2021 BHD OBS Reported Patient "Aggression" Incident Trends

Incident Rate Formula = Incidents/(1,000 patient days)

	2014	2015	2016	2017	2018	2019	2020	2021 Q1	2021 Q2	2021 Q3
Self Injurious Behavior	1.9	0.9	0.9	-	-	2.8	-	-	-	-
Sexually Inappropriate Behavior	0.8	0.5	-	-	-	-	-	-	-	-
Physical Aggression - Patient/Employee	4.1	4.1	2.3	0.8	1.1	-	-	-	-	-
Physical Aggression - Patient/Patient	5.6	0.5	1.4	-	1.1	1.4	-	-	-	-
Property Damage	0.4	1.8	0.5	0.8	-	-	2.7	-	-	-
Sexual Contact	-	0.5	-	0.8	-	-	-	-	-	-
Suicide Attempt	-	-	-	-	-	-	-	-	-	-
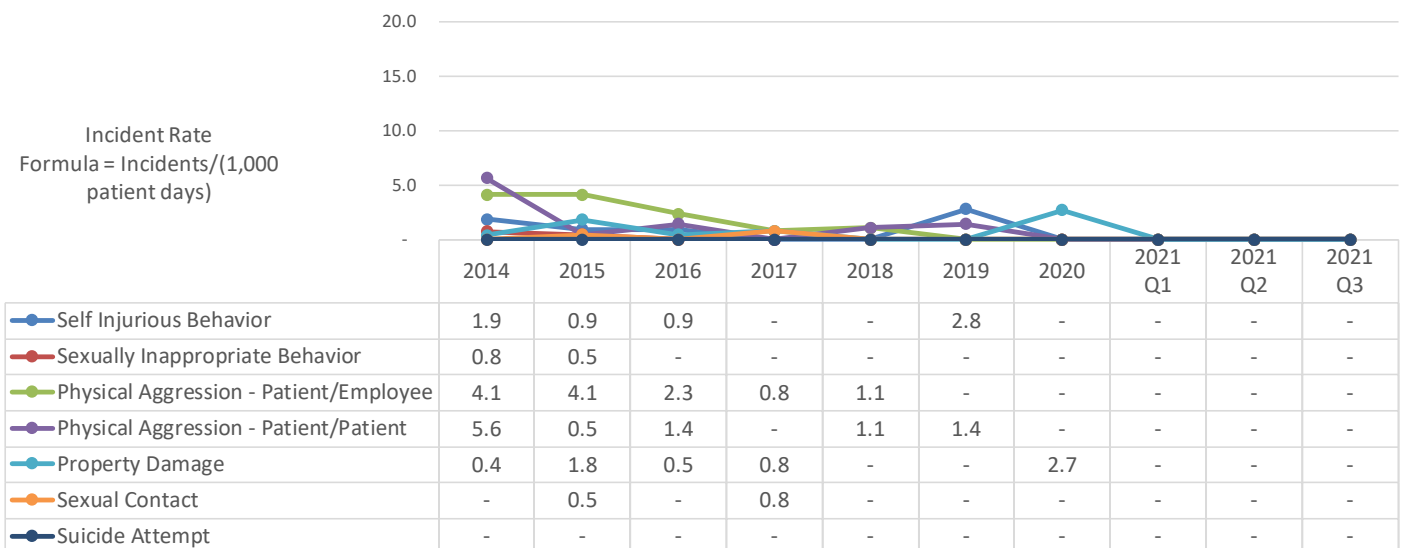
Acute Adult - Incidents

Incident Category	Year							2021 Q1	2021 Q2	2021 Q3	2021 Q4
	2014	2015	2016	2017	2018	2019	2020				
Self Injurious Behavior	43	19	8	13	11	8	3	3	1	1	
Sexually Inappropriate Behavior	14	6	2	3	1	4	6	0	0	1	
Physical Aggression - Patient/Employee	74	42	45	46	16	14	31	9	22	14	
Physical Aggression - Patient/Patient	112	48	36	54	47	50	30	6	13	8	
Property Damage	23	3	7	8	4	1	14	12	11	0	
Sexual Contact	6	1	2	2	0	1	3	0	0	0	
Suicide Attempt	2	2	3	0	1	1	-	0	0	0	

CAIS - Incidents

Incident Category	Year							2021 Q1	2021 Q2	2021 Q3	2021 Q4
	2014	2015	2016	2017	2018	2019	2020				
Self Injurious Behavior	5	8	11	9	4	3	-	2	1	3	
Sexually Inappropriate Behavior	2	1	2	1	0	4	2	0	0	0	
Physical Aggression - Patient/Employee	18	18	22	19	7	10	7	7	2	2	
Physical Aggression - Patient/Patient	12	23	9	16	18	11	4	5	1	1	
Property Damage	4	6	5	3	2	5	15	3	1	1	
Sexual Contact	0	0	0	1	1	1	-	0	0	0	
Suicide Attempt	1	0	2	0	0	0	1	1	0	0	

PCS - Incidents

Incident Category	Year							2021 Q1	2021 Q2	2021 Q3	2021 Q4
	2014	2015	2016	2017	2018	2019	2020				
Self Injurious Behavior	2	2	7	3	1	2	1	5	0	0	
Sexually Inappropriate Behavior	2	0	1	0	0	1	-	0	0	0	
Physical Aggression - Patient/Employee	10	12	21	9	4	7	7	6	3	8	
Physical Aggression - Patient/Patient	4	4	5	1	1	4	-	0	1	1	
Property Damage	3	2	8	3	6	6	5	2	2	1	
Sexual Contact	0	0	0	0	0	0	-	0	0	0	
Suicide Attempt	0	0	2	2	0	0	-	0	0	0	

OBS - Incidents

Incident Category	Year							2021 Q1	2021 Q2	2021 Q3	2021 Q4
	2014	2015	2016	2017	2018	2019	2020				
Self-Inflicted Injury	5	2	2	0	0	2	0	0	0	0	
Sexually Inappropriate Behavior	2	1	0	0	0	0	0	0	0	0	
Physical Aggression - Patient/Employee	11	9	5	1	1	0	0	0	0	0	
Physical Aggression - Patient/Patient	15	1	3	0	1	1	0	0	0	0	
Property Damage	1	4	1	1	0	0	1	0	0	0	
Sexual Contact	0	1	0	1	0	0	0	0	0	0	
Suicide Attempt	0	0	0	0	0	0	0	0	0	0	

Program	Patient Days							2021 Q1	2021 Q2	2021 Q3	2021 Q4
	2014	2015	2016	2017	2018	2019	2020				
Acute Adult	19,696	17,205	16,713	15,641	15,272	14,793	11,582	2,419	1,967	1,832	
CAIS	3,333	3,605	2,996	3,119	2,744	2,731	1,569	415	416	390	
PCS	10,696	10,173	8,286	8,001	7,375	7,492	6,471	1,531	1,536	1,639	
OBS	2,660	2,170	2,132	1,274	906	708	368	24	1	-	

2021 Q3 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary

2018-2021 BHD PCS - Hours of Restraint Rate

Quarters highlighted in yellow have rates at/or below the national average

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
PCS	1.63	2.41	1.74	1.13	0.50	1.20	1.52	1.39	0.97	0.97	1.05	1.18	0.54	0.70	0.37

2018-2021 BHD Acute Adult - Hours of Restraint Rate

2020 Acute Inpatient Hours of Restraint Rate National Average = .26

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	0.21	0.73	0.23	0.70	0.40	0.29	0.98	1.95	0.41	0.44	0.06	0.60	1.64	1.10	0.19
43B	0.22	1.80	0.54	0.39	0.26	0.63	0.43	0.17	0.54	0.28	0.62	0.18	0.23	0.24	-
43C	0.34	0.32	0.38	0.20	0.06	0.25	0.32	0.46	0.18	0.18	0.04	0.25	0.14	1.60	0.14
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.38
Acute Adult	0.26	0.94	0.38	0.42	0.24	0.36	0.58	0.87	0.38	0.29	0.26	0.32	0.62	0.66	0.34

2018-2021 BHD CAIS - Hours of Restraint Rate

2020 Acute Inpatient Hours of Restraint Rate National Average = .26

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
CAIS	1.38	1.81	0.53	0.98	1.98	0.95	2.42	1.18	0.72	0.13	1.14	1.43	0.80	0.65	0.12

2018-2021 BHD Acute Adult - Hours of Seclusion Rate

2020 Acute Inpatient Hours of Seclusion Rate National Average = .25

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	0.27	0.33	0.15	0.20	0.10	0.08	0.03	0.92	0.41	0.50	0.28	0.07	0.29	0.12	-
43B	0.07	0.28	0.19	0.03	0.20	0.10	0.14	0.04	-	0.13	0.41	-	0.26	0.08	-
43C	0.73	0.51	0.06	0.51	0.14	0.11	0.24	0.24	0.23	0.09	0.21	-	-	-	-
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.05
Acute Adult	0.36	0.38	0.13	0.25	0.15	0.10	0.14	0.41	0.22	0.22	0.30	0.02	0.18	0.08	0.03

2018-2021 BHD CAIS - Hours of Seclusion Rate

Acute Inpatient Hours of Seclusion Rate National Average = .25

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
CAIS	0.93	0.50	0.20	0.22	0.39	0.35	0.30	0.28	0.08	-	0.18	0.04	0.42	-	0.24

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

Year / Quarter	Restraint Hours		Seclusion Hours	
	Acute Adult	CAIS	Acute Adult	CAIS
2018 Q1	23.0	24.1	31.4	16.2
2018 Q2	90.1	27.7	36.3	7.7
2018 Q3	34.5	7.6	11.8	2.8
2018 Q4	38.5	18.4	22.8	4.2
2019 Q1	23.0	35.0	14.3	6.9
2019 Q2	36.4	14.5	9.1	5.3
2019 Q3	49.4	33.2	11.7	4.2
2019 Q4	71.0	22.4	33.2	5.2
2020 Q1	34.7	10.8	19.8	1.3
2020 Q2	17.7	0.7	13.2	0.0
2020 Q3	16.2	9.2	19.1	1.5
2020 Q4	20.1	12.8	1.3	0.3
2021 Q1	36.1	8.0	10.4	4.2
2021 Q2	31.3	6.6	3.9	0.0
2021 Q3	14.9	1.2	1.2	2.3
2021 Q4				

2021 BHD Reported Incidents

Time Period: 1/1/21-9/30/21

Incident Category	43A Q1	43A Q2	43A Q3	43A Q4	43A Total	43A %	43B Q1	43B Q2	43B Q3	43B Q4	43B Total	43B %	43C Q1	43C Q2	43C Q3	43C Q4	43C Total	43C %	43D Q1	43D Q2	43D Q3	43D Q4	43D Total	43D %	CAIS Q1	CAIS Q2	CAIS Q3	CAIS Q4	CAIS Total	CAIS %	PCS Q1	PCS Q2	PCS Q3	PCS Q4	PCS Total	PCS %	Other Q1	Other Q2	Other Q3	Other Q4	Other Total	Other %	Tot Q1	Tot Q2	Tot Q3	Tot Q4	Tot Total	Tot %
Device, Equipment or Supply	3	1	-		4	6.0%	-	-	-		-	0.0%	-	1	1		2	6.9%	-	-	5		5	10.4%	3	3	3		9	13.8%	-	-	-		-	0.0%	1	1	1		3	8.6%	7	6	10	-	23	6.4%
Diagnostic tests (labs/radiology/EKG)	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-	-	-	0.0%
Elopement	-	2	1		3	4.5%	1	1	-		2	3.5%	1	-	1		2	6.9%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	2		2	5.7%	2	3	4	-	9	2.5%
Falls	2	1	1		4	6.0%	-	1	-		1	1.8%	3	1	-		4	13.8%	-	4	4		8	16.7%	1	-	2		3	4.6%	3	-	1		4	6.7%	-	-	2		2	5.7%	9	7	10	-	26	7.2%
Fire	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-	-	-	0.0%
Grievances	-	2	1		3	4.5%	2	-	-		2	3.5%	1	-	-		1	3.4%	-	1	2		3	6.3%	1	-	1		2	3.1%	2	4	3		9	15.0%	-	-	2		2	5.7%	6	7	9	-	22	6.1%
Medical Emergency	-	-	1		1	1.5%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	1	1		2	5.7%	-	1	2	-	3	0.8%
Medication	1	2	1		4	6.0%	-	4	-		4	7.0%	1	-	-		1	3.4%	-	-	3		3	6.3%	-	1	2		3	4.6%	-	1	-		1	1.7%	-	-	-		-	0.0%	2	8	6	-	16	4.4%
Other	4	4	1		9	13.4%	5	9	-		14	24.6%	6	-	3		9	31.0%	-	1	2		3	6.3%	7	8	2		17	26.2%	6	8	2		16	26.7%	4	3	6		13	37.1%	32	33	16	-	81	22.4%
Physical Aggression - Patient/Employee	6	8	3		17	25.4%	2	13	-		15	26.3%	1	1	1		3	10.3%	-	-	10		10	20.8%	7	2	2		11	16.9%	6	3	8		17	28.3%	-	5	2		7	20.0%	22	32	26	-	80	22.2%
Physical Aggression - Patient/Patient	4	5	-		9	13.4%	1	3	-		4	7.0%	1	4	2		7	24.1%	-	1	6		7	14.6%	5	1	1		7	10.8%	-	1	1		2	3.3%	-	-	-		-	0.0%	11	15	10	-	36	10.0%
Property Damage	6	3	-		9	13.4%	6	7	-		13	22.8%	-	-	-		-	0.0%	-	1	-		1	2.1%	3	1	1		5	7.7%	2	2	1		5	8.3%	-	-	-		-	0.0%	17	14	2	-	33	9.1%
Search and seizure	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	2	-		2	4.2%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	2	-	-	2	0.6%
Security/Property	-	-	-		-	0.0%	1	1	-		2	3.5%	-	-	-		-	0.0%	-	-	4		4	8.3%	-	1	-		1	1.5%	-	1	-		1	1.7%	-	-	2		2	5.7%	1	2	7	-	10	2.8%
Self Injurious Behavior	3	1	-		4	6.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	2	1	3		6	9.2%	5	-	-		5	8.3%	-	1	-		1	2.9%	-	-	-		-	0.0%	10	3	4	-	17	4.7%
Sexual Contact	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-	-	-	0.0%
Sexually Inappropriate Behavior	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	1	-		1	2.1%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	1		1	2.9%	-	1	1	-	2	0.6%
Suicide Attempt	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	1	-	-		1	1.5%	-	-	-		-	0.0%	-	-	-		-	0.0%	-	-	-		-	0.0%	1	-	-	-	1	0.3%
Total	29	29	9	-	67	100.0%	18	39	-	-	57	100.0%	14	7	8	-	29	100.0%	-	10	38	-	48	100.0%	30	17	18	-	65	100.0%	24	20	16	-	60	100.0%	5	11	19	-	35	100.0%	120	133	108	-	361	100.0%

2018-2021 BHD "Grievance" Incident Rates

Incidents per 1,000 Patient Days

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	0.84	1.52	-	0.82	-	0.78	0.85	1.79	1.53	1.47	-	1.03	-	-	1.78
43B	-	-	1.66	3.12	5.08	-	0.87	-	0.80	3.08	4.17	1.03	2.38	2.29	-
43C	3.22	2.16	5.33	0.75	0.77	4.62	0.80	2.35	1.61	-	1.00	4.46	1.18	7.69	-
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	6.02	2.04
CAIS	-	1.54	-	1.27	4.09	1.58	-	-	3.18	-	-	-	2.41	2.40	2.56
PCS	1.07	1.08	3.29	1.08	2.62	1.53	0.55	1.11	0.58	1.33	-	3.83	1.31	1.30	1.83

2018-2021 BHD "Elopement" Incident Rates

Incidents per 1,000 Patient Days

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	-	-	-	-	0.90	0.77	-	-	-	-	-	-	-	2.51	1.78
43B	1.64	-	1.66	2.34	-	0.78	-	1.01	0.80	1.03	-	-	1.19	1.15	-
43C	0.81	0.72	0.76	-	1.54	0.77	1.60	-	-	1.13	-	-	1.18	-	3.44
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CAIS	-	-	-	-	-	-	2.53	-	-	-	-	-	-	-	-
PCS	-	-	-	-	0.52	1.53	-	-	0.58	-	1.20	-	-	-	-

2018-2021 BHD "Patient Fall" Incident Rates

Incidents per 1,000 Patient Days

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	2.51	-	0.79	0.82	1.53	0.78	0.85	0.90	0.77	-	1.49	4.05	2.73	1.25	1.78
43B	1.64	2.30	8.29	3.90	2.18	0.78	3.50	2.02	1.59	1.03	3.13	3.09	-	1.15	-
43C	3.22	2.16	3.04	6.02	0.77	1.54	2.40	3.13	0.80	3.39	4.02	1.11	3.55	7.69	-
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	24.10	4.08
CAIS	4.14	3.08	-	1.27	2.72	4.73	1.75	1.26	3.18	-	-	-	-	2.41	5.13
PCS	0.54	1.08	0.55	1.63	-	0.51	0.55	-	0.58	1.33	1.20	-	1.96	-	0.61

2018-2021 BHD "Medical Emergency" Incident Rates

Incidents per 1,000 Patient Days

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	-	-	-	0.82	-	0.78	1.69	-	-	1.47	-	-	-	-	1.78
43B	-	-	-	-	-	0.78	0.87	-	0.80	1.03	3.13	1.03	-	-	-
43C	-	-	-	1.51	-	4.62	3.20	-	-	3.39	2.01	-	-	-	-
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CAIS	-	-	-	-	1.36	1.58	3.50	1.26	-	-	2.96	2.69	-	-	-
PCS	-	-	-	-	0.52	0.51	-	-	-	0.66	1.20	-	-	-	-

2018-2021 BHD "Medication" Incident Rates

Incidents per 1,000 Patient Days

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
43A	-	0.76	2.38	-	2.30	2.35	4.23	-	1.53	1.47	-	1.35	1.36	2.51	1.78
43B	2.46	-	1.66	3.12	1.45	0.78	1.75	2.02	1.59	-	2.08	-	-	3.44	-
43C	0.81	2.88	2.28	3.77	3.09	2.31	2.40	3.92	0.80	-	2.01	-	1.18	-	-
43D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3.06
CAIS	5.52	-	-	1.71	-	1.36	7.89	3.50	-	1.59	4.33	2.96	-	2.40	5.13
PCS	-	-	0.55	0.54	-	-	-	-	-	-	0.60	-	-	0.65	-

Overall Progress 97.0% as of November 1, 2021

Baseline 71.5% as of August 2016 LAB report

Current Goal = 96%

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	642	651	96.5%	97.0%
Up to 1-year Overdue	18	16	2.7%	2.4%
More than 1 yr & up to 3 yrs overdue	3	2	0.5%	0.3%
More than 3 yrs & up to 5 yrs overdue	2	2	0.3%	0.3%
More than 5 yrs & up to 10 yrs overdue	0	0	0%	0.0%
Total	665	671	100%	100%

Monthly Rate Trends

Chart values: 90.5 (11/20), 90.2 (12/20), 90.2 (1/21), 88.2 (2/21), 90 (3/21), 91.9 (4/21), 91.3 (5/21), 90.4 (6/21), 93.6 (7/21), 96 (8/21), 97.1 (9/21), 96.5 (10/21), 97 (11/21)

Past Due by Policy Area	Past Due
Contract Administration	1
Emergency Management	1
Engineering & Environmental Services-Operations	1
Health Information Management	8
Mental Health Board	1
Pharmacy	1
Provision of Care – Nursing	1
Psychiatric Crisis Services –Access Clinic	1
Quality Management	1
Volunteer Services	1
Wraparound (Wrap, REACH, youth CCS)-Prov. Netwk.	1
Wraparound (Wrap, REACH, youth CCS)-Vendor	2
Total Past Due	**20**

12 Month Forecast Due for Review

Month/Year	# Due
November 2021	13
December 2021	24
January 2022	11
February 2022	4
March 2022	14
April 2022	12
May 2022	19
June 2022	29
July 2022	21
August 2022	19
September 2022	20
October 2022	20
November 2022	8

October Activity

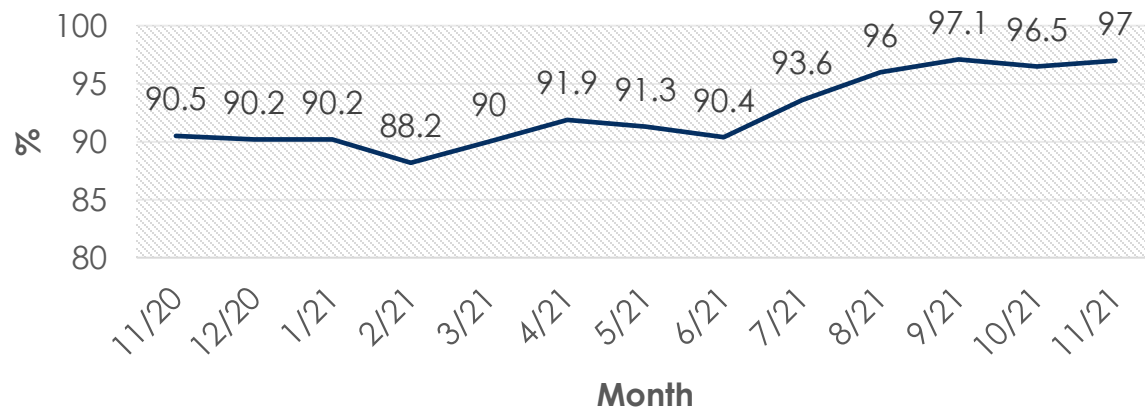|	
New Policies	2
Reviewed/Revised	16
Retired	0

Overall Progress 96.7% as of December 1, 2021

Baseline 71.5% as of August 2016 LAB report

Current Goal = 96%

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	651	649	97.0%	96.7%
Up to 1-year Overdue	16	17	2.4%	2.5%
More than 1 yr & up to 3 yrs overdue	2	3	0.3%	0.4%
More than 3 yrs & up to 5 yrs overdue	2	2	0.3%	0.3%
More than 5 yrs & up to 10 yrs overdue	0	0	0.0%	0.0%
Total	671	671	100%	100%

Monthly Rate Trends
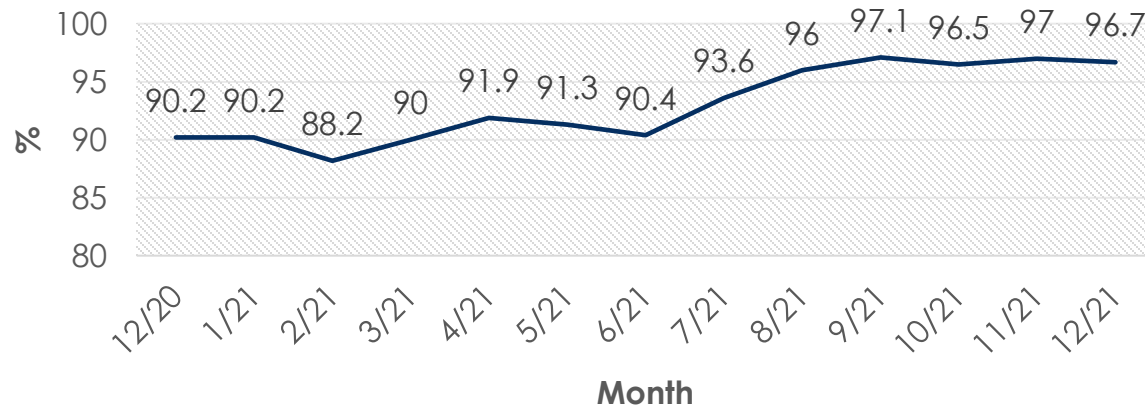
Past Due by Policy Area	Past Due
Contract Administration	2
Division Administration	2
Emergency Management	2
Engineering & Environmental Services-Operations	1
Health Information Management	2
Mental Health Board	2
Pharmacy	1
Provision of Care – Nursing	1
Psychiatric Crisis Services –Access Clinic	1
Public Safety	4
Quality Management	1
Volunteer Services	1
Wraparound (Wrap, REACH, youth CCS)-Vendor	2
Total Past Due	**22**

12 Month Forecast Due for Review

Month/Year	# Due
December 2021	24
January 2022	11
February 2022	4
March 2022	14
April 2022	12
May 2022	19
June 2022	29
July 2022	21
August 2022	19
September 2022	20
October 2022	20
November 2022	8
December 2022	6

November Activity

New Policies	3
Reviewed/Revised	11
Retired	0

COUNTY OF MILWAUKEE
Inter-Office Communication

Date: January 3, 2022

To: Mary Neubauer, Chairperson, Quality Committee

From: Shakita LaGrant-McClain, Director, Department of Health & Human
             Services

Subject: DHHS Quality Management

REQUEST

To provide a report on the DHHS vision for Quality Management designed to support
departmentwide quality functions across all service areas.

BACKGROUND

To better align with and realize the mission and future state vision of Department of Health
and Human Services, a greater interest has emerged for a more structured and
centralized quality management function across DHHS to ensure fidelity to program and
service design as well as ensure positive outcomes for our participants.

The changing landscape across the department presents a timely opportunity to build a
wider-reaching quality management system connecting all of our quality staff and
respective divisions including the Behavioral Health Division. Through several months in
2021, a workgroup of quality experts cultivated recommendations to elevate "Quality" as
a culture of DHHS and a department-level function. The recommendations prioritized
developing a departmentwide Quality Management infrastructure by establishing a
leadership commitment and investment in staff resources. Please see attached report
"DHHS Quality Management Recommendations for a Comprehensive & Participant
Driven Approach."

As a result of these recommendations, an Enterprise Quality Director (EQD) position was
hired to better align and create a more collaborative quality function across DHHS. With
consideration of the existing quality oversight across the department in varying degrees,
the EQD role directs a standardized, comprehensive approach involving all divisions. This
new position was just recently filled by TJ Cobb.

Although some preliminary steps have been initiated for this work, effective stakeholder
engagement is paramount for any next steps including communication and feedback from
the Mental Health Board Quality Committee.

The attached PowerPoint provides an overview of the scope for this departmentwide Quality Management function and the anticipated goals.

PREPARED BY:

T.J. Cobb, Enterprise Quality Director

APPROVED BY:

Shakita LaGrant-McClain
Shakita LaGrant-McClain, Director

ATTACHMENTS:

1) DHHS Quality Management Overview

2) Workgroup Report - DHHS Quality Management Recommendations for a Comprehensive & Participant-Driven Approach

cc: Maria Perez, Chairwoman, Mental Health Board
       Mike Lappen, BHD Administrator
       Matthew Fortman, Fiscal Administrator

Presented by T.J. Cobb MPH, BS, CSM, Enterprise Quality Director | tj.cobb@milwaukeecountywi.gov

DHHS Quality Management Overview

Mental Health Board Quality Committee

January 2022

MILWAUKEE COUNTY

Quality Management

Quality as a Culture and Function of the Department of Health & Human Services

MILWAUKEE COUNTY

- An **accountability** approach to ensure effective advancement of racial and health equity through **leadership commitment**.

- A mechanism for **continuous improvement** for better participant outcomes, **organizational flexibility**, and increased ability to embrace **new opportunities**.

- Promotes a culture of **"evaluative thinking"**—questioning, reflecting, learning, and modifying at all times.

- Requires continuous **collaboration** and **communication** with all staff across functions to ensure aligned strategy, effective policy, efficient processes, and valuable resources.

Quality Management | Standards

MILWAUKEE COUNTY

- **Elevates the value** and **decreases process inefficiencies** of services.

- Requires **department-wide policies and procedures** to support a service/practice delivery model driven by equitable and expanded access to services.

- Generates opportunity for **staff engagement** to improve skills and maintain consistency for **high performance**.

- **Integrates quality improvement** into routines and practices across all department areas and supports with vendors, contractors, and partners **relationship management**.

- Encourages **evidence-based decision making** with valuable data.

Quality Management | Standards

MILWAUKEE COUNTY

Enterprise Quality Director

- **An accountability partner** to ensure an effective advancement of **racial and health equity.**

- **A catalyst** for a department-wide culture where information on performance is deliberately sought in order **to better manage and deliver programs and services**.

- **A leader** who establishes and monitors **reasonable yet challenging expectations** for success, and balancing accountability with learning.

- Ensures a QM foundation that support needs of **participants over organization/political** needs.

Relationship Building for Quality Management → Quality Management Needs Assessment → Quality Management Action Plan → Formalize DHHS Quality Management → Re-Establish and Launch Quality Teams

Collaborate with Key Stakeholders

Key Priorities

MILWAUKEE COUNTY

Key Takeaways

- Supports a culture and practice of reliable planning, monitoring, evaluation, accountability and reporting.

- Emphasizes the role staff across every function has in quality management.

- Encourages transparency by avoiding penalties for programs providing poor performance information or individuals/units that make unpleasant truths known.

- Prioritize achieving important results rather than meeting indicators.

MILWAUKEE COUNTY

Presented by T.J. Cobb MPH, BS, CSM, Enterprise Quality Director | tj.cobb@milwaukeecountywi.gov

3/21/2021

DHHS Quality Management

Recommendations for a Comprehensive & Participant-Driven Approach

Report Prepared by: DHHS Quality Workgroup

DHHS Quality Management Workgroup Members

Jennifer Bergersen

Dennis Buesing

Heidi Ciske-Schmidt

TJ Cobb

Matt Drymalski

De Shell Parker

Facilitator: Clare O'Brien

Introduction

To better align with and realize the mission and future state vision of Milwaukee County's Department of Health and Human Services, a greater interest has emerged for a more structured and centralized quality assurance function across DHHS to ensure fidelity to program and service design as well as ensure positive outcomes for our participants. The 2021 Adopted DHHS Budget provides this policy direction and a position to lead it. While quality oversight exists across the department in varying degrees, there currently isn't one standardized, comprehensive approach involving all divisions. The changing landscape across the department presents a timely opportunity to build a wider-reaching quality management system connecting all of our quality staff and respective divisions.

At the heart of this desire to create a cohesive quality function is our mission – that is to ensure our participants enjoy safe, healthy, and meaningful lives. This mission aligns with Milwaukee County's overarching vision that is, "By addressing racial equity, Milwaukee is the healthiest county in Wisconsin." This necessitates the ability to consistently answer core questions such as:

➢ How do we know that our programs/services and service delivery model result in positive outcomes for our participants?
➢ What is working and what is not working?
➢ Are we making a difference in moving the needle on racial and health equity?

Through the establishment of a comprehensive quality management system, we hope to identify where changes are needed across our service delivery network to achieve better outcomes for our participants.

One of the future state strategies for achieving our departmental mission is the implementation of a "No Wrong Door" customer service approach meaning that anyone, regardless of age, disability, race, gender, or socio-economic status can and will be served no matter a person's entry point into the system. A major advancement toward this effort is the integration of the Milwaukee County Department on Aging and Department of Veteran's Services within DHHS beginning in 2021. Older adults and veterans in our community will now have more direct and seamless access to an array of services that were previously siloed.

If we are breaking down the silos among our programs and services, it also makes sense to eliminate the silos that exist within our administrative infrastructure. Over the past few years, the department has been working to centralize its fiscal function. The majority of our fiscal staff are now organizationally under one umbrella supporting all of the divisions within DHHS. Another step in this direction would be to join together the department's quality assurance functions.

Mission and Future State Alignment

An important aspect to assess before embarking on a new initiative is whether it fits within the mission and future state vision of DHHS. As demonstrated above, we have alignment with the department's mission of empowering safe, healthy, and meaningful lives. What about our future state vision? The DHHS 2025 Future State document outlines two strategies for improving health in Milwaukee County: Strategy #1 (Integrated Services & Care) focuses on individual health of residents and Strategy #2 (Population Health & System Change) focuses on collective health of the county. And the success of these two strategies hinges on the following:

> "DHHS will be pursuing these strategies while placing the **participant and community at the center** and will be guided by principles of racial equity and community investment, **addressing root causes** of participants' needs and social determinants of health in our community."

A unified quality management function is critical to not only achieving the mission of our department but our future state vision. The essence of quality management places the participant at the center and problem solves to identify root cause. This initiative also advances the following goals as outlined in the future state:

- Develop integrated systems to drive better participant outcomes and ultimately an increase in self-reported quality of life
- Need for evidenced-based approaches
- Establishing quality management as a core capability to test whether root causes of participants' needs are addressed appropriately via DHHS services

Beyond the future state goals identified above, the workgroup also stressed the importance of:
- Quality's role in reducing inefficiencies and ensuring funding is effectively spent to the benefit of our participants
- Data & research-driven decision making to create a culture of quality that is all-inclusive and a continuous learning system
- Identifying opportunities for professional development and training and ensuring standardization of Quality-related tools
- Demonstrating a commitment to racial equity by reaffirming that an equity gap is a quality gap that must be addressed
- Promoting equality and respecting diversity to ensure those seeking care and services within our community have the same access to quality care options

Quality Workgroup & Deliverables

A significant first step toward establishing a centralized quality management function was the endorsement by DHHS leadership and policymakers by including it in the 2021 Budget. Now that the department has been given the policy direction and a new position to lead it, the next step is defining the process by which to lift up this new area and define its scope. Given that DHHS is fortunate to have several dedicated staff with significant expertise in quality, it made sense to develop this new quality infrastructure by leveraging the experience of our own employees.

As a result, a small team of quality experts with representation from across DHHS was assembled and has met regularly over the past few months to develop the recommendations contained in this report. The team was tasked with identifying the scope and framework of the new section along with position requirements for the new position.

The workgroup supports the following recommendations for the creation of a comprehensive DHHS Quality Management Section.

Recommendations

1) **Quality Management (QM) Section**: There was much discussion around what the name of the new section should be – Quality Assurance, Quality Improvement or Quality Management. The workgroup landed on "Quality Management" since that encompasses both QA and QI.

2) **Enterprise Quality Director (EQD)**: The position that was included in the budget was given a temporary title of Quality Assurance Director. The workgroup preferred to change the title so that it would incorporate all functions of quality. The group agreed to a new position title of "Enterprise Quality Director."

3) **Hiring for EQD Position**: The workgroup developed a JEQ (Attachment #3) outlining the responsibilities of this position. The workgroup further recommends that DHHS work with Human Resources to ensure equity, diversity and inclusion in the hiring for this position.

4) **Organizational Structure**: The workgroup discussed the importance of organizational structure and ensuring that the EQD be empowered to make decisions and be seen as a key leader within the department. The team recommends that this position report directly to the DHHS Director and/or her designee. This creates accountability to the QM section in each of the divisions and adherence to consistent processes and procedures as well as best practice.

   Across the department, there are over two dozen positions with varying levels of responsibility across the quality management spectrum. These positions currently report up to management within their respective divisions. The workgroup discussed the advantages and disadvantages of establishing a new reporting wherein each quality position would report directly up through the new Quality Management Section. The following table summarizes the pros and cons expressed by the workgroup:

Opportunities	Risks
Greater accountability	Lack of flexibility within each division
Reducing the likelihood that quality will be diluted due to competing priorities within a division	Concern about impact of change on staff & lingering effects of attempt at centralization within BHD a few years ago
Higher likelihood that standardization of processes/procedures will be achieved	Loss of a division's unique approach to operating its programs/services
Enhanced ability to share quality resources across the department	Perceived loss of resources

Based on its assessment, the workgroup recommends a collaborative approach allowing the existing reporting structure within the divisions to remain but with enhanced accountability and uniformity built into quality management across the department. Given that a robust quality structure does not currently exist in DSD, Housing, Aging, and Veteran's Services, the team recommended potentially leveraging and redeploying BHD quality staff once the hospital is closed. An expectation of the EQD position is to conduct a needs analysis of each division as to ensure these areas are appropriately resourced.

The EQD would be responsible for establishing this basic additional structure which would include, but would not be limited to, the following:

1) Development of an overarching DHHS Quality Plan
2) Preparation of quality plans within each division outlining their specific aims and objectives which will also support the broader DHHS Quality Plan
3) Formation of quality workgroups and performance improvement activities within each division
4) A representative from each divisional quality workgroup would participate in a departmentwide quality workgroup
5) Development of performance metrics and dashboards for programs within each division, while looking at our metrics with a racial equity lens and reporting as such. Refer to the CARS (Community Access to Recovery Services) Quality Dashboard Quarter 4 of 2020 Attachment #4 as one example.
6) Analyze data by racial/ethnic demographics to prioritize practices and approaches that improve health, wellness and racial equity
7) Dashboards will not only reflect volume served, but will also be disaggregated by gender, socioeconomic status, race/ethnicity and age with attention to outcomes including but not limited to the experience of care.

The attached organizational chart (Attachment #2) identifies all of the existing positions identified by the workgroup as being responsible for "quality." Because inconsistencies exist among title codes and position descriptions, this org chart may be incomplete but it does provide a starting point. One of the responsibilities of the new EQD would be to

assess all of these variations with HR and develop a plan to create standardization among title codes and position descriptions.

5. **Frameworks:** The workgroup discussed how each of their respective areas defined quality management and its application. The group then identified a framework recognized as a best practice industry standard – International Organization for Standardization (ISO). Alignment was identified between the two frameworks with the end result being a blended framework (see Quality Framework – Attachment #1) that was faithful to what works within our current practice and considers the unique needs of our participants. Yet it also adhered to best practice within the industry. Two divisions that have long-established quality management structures include the Division of Youth and Family Services (DYFS) and the Behavioral Health Division (BHD). The expectation would be to build upon what works in these areas and apply it across the department – especially in divisions such as Housing and the Disabilities Services where a quality framework is not well established. This would link all quality staff who are independently supporting their respective divisions to a larger quality system.

6. **Governance**: The oversight of the department is unique in that the Milwaukee County Board oversees programs and services operated by DHHS but not the mental health services administered by BHD. In 2014, the Wisconsin State Legislature adopted Act 203 which created the Milwaukee County Mental Health Board. The Act made a number of changes in the way mental health services are governed, administered and funded in Milwaukee County. As a result, BHD reports to the Mental Health Board (MHB) and the County Board has no authority over BHD's programs and services or to modify its budget as directed by State statute.

   The BHD quality staff regularly reports to MHB's Quality Committee on outcomes and performance measures. For DHHS, regular reporting of performance measures and establishment of a dashboard for internal and external stakeholders would be a goal for this new area. In the near future, the County Board is expected to approve a new scope for the Health and Human Needs Committee to include strategic planning. It would seem appropriate that the new Quality area would be responsible for reporting data, outcomes and research to the County Board as it relates to the department's strategic plan.

7. **Investment in Change Management:** Unifying our approach and creating consistent processes and procedures will not be easy. The successful development of a comprehensive quality management section is dependent upon the commitment and dedication of our staff as well as effective leadership and direction. Once a plan has been developed, DHHS will need to communicate the change and regularly update employees with information around why this change is needed, the vision, and employees impacted by the change, among other factors. It will be critical to involve employees, participants, community partners, and additional stakeholders in this quality journey.
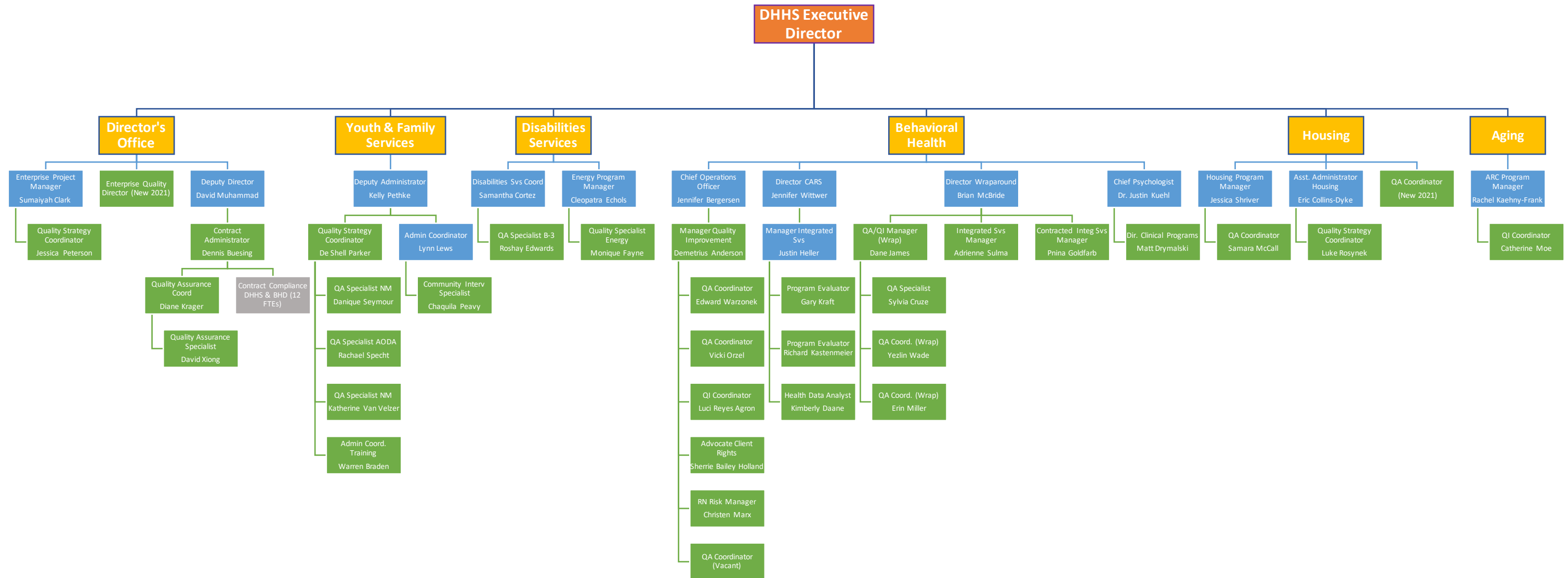
Attachments:

1) Quality Framework
2) Chart of Current DHHS Quality Positions & Reporting
3) Position Description (JEQ) for Enterprise Quality Director
4) CARS Quality Dashboard Quarter 4 of 2020

Internal & ISO Framework Alignment

ISO* Framework	Leadership	Evidence-Based Decision Making	Customer Focus		Process Approach & Engagement of People	Improvement & Relationship Management
Work Team Framework		Research	Quality Prevention	Quality Compliance	Training & Development	Quality Improvement
Team Definitions	• Creation of unity of purpose and direction and engagement of people enable an organization to align its strategies, policies, processes and resources to achieve its objectives.	• Opportunities to assess future/current practices to ensure we are providing the quality & improvement in services • Using data of all sorts – either what we generate or what comes from literature – drives decision-making • Scientific method & process for exploration i.e., PDSA cycle; using all avail data points to evaluate quality of decision we have made	• Are we just being reactive & solving the immediate problem or are we focusing on upstream? • Need to make sure there is ownership – understanding that there is impact to people we are providing services to • Create living documents to catch issues & achieve lessons learned • Are we assessing the value of services we are providing or assessing the quality of our internal processes as an organization? • What are we doing to police ourselves – reduce waste in provider network; • Assess merit/value of program & then it gets turned over to prevention & QA • Work on coord/collaboration with all the various QA roles across the dept	• Tends to be regulatory, reactive vs proactive • Frequently punitive & asks who is at fault? • Tends to focus on specific incidences; not systemic approach • Regulatory & fiscal compliance & audit; • Mechanism to ensure regulatory requirements being met; what are best practices that are above & beyond regulatory requirements; • Providers need additional technical assistance • What are external quality expectations for providers; • Checks to ensure efficiencies within our processes • Util. Management	• Efforts to align staff onboarding, training, coaching, performance evaluation • Ensure staff performance review aligned w/ values/quality; • Awareness of best practices • Internal & external training on PnPs; State changes • Expectation that training is ongoing • Empowering individuals to be part of improvements/changes; • Empowering employees/contractors to engage in QM • QM needs to be embedded in culture by ensuring staff have access to resources & information	• Practice of developing improvement plans that align with research • Compliance and development needs of both staff and providers • Focus on innovation • Focus on systemic plan of how to improve care & service provided to clients/families/patients • Corrective actions on what should be done better – issues identified through audit; can be proactive or • Framework we use to evaluate & systematically improve services/care of individuals • Focus on outcome/experience of care for people • Focus on processes/metrics/analysis • Designing system & processes of change that lead to organizational improvement & culture of quality • Change management part of this to shift the culture

*International Organization for Standardization (ISO)

DHHS Quality Management Positions & Reporting
(Current State)

DHHS Executive Director

Director's Office
- Enterprise Project Manager — Sumaiyah Clark
  - Quality Strategy Coordinator — Jessica Peterson
- Enterprise Quality Director (New 2021)
- Deputy Director — David Muhammad
  - Contract Administrator — Dennis Buesing
    - Quality Assurance Coord — Diane Krager
      - Quality Assurance Specialist — David Xiong
    - Contract Compliance DHHS & BHD (12 FTEs)

Youth & Family Services
- Deputy Administrator — Kelly Pethke
  - Quality Strategy Coordinator — De Shell Parker
    - QA Specialist NM — Danique Seymour
    - QA Specialist AODA — Rachael Specht
    - QA Specialist NM — Katherine Van Velzer
    - Admin Coord. Training — Warren Braden
  - Admin Coordinator — Lynn Lews
    - Community Interv Specialist — Chaquila Peavy

Disabilities Services
- Disabilities Svs Coord — Samantha Cortez
  - QA Specialist B-3 — Roshay Edwards
- Energy Program Manager — Cleopatra Echols
  - Quality Specialist Energy — Monique Fayne

Behavioral Health
- Chief Operations Officer — Jennifer Bergersen
  - Manager Quality Improvement — Demetrius Anderson
    - QA Coordinator — Edward Warzonek
    - QA Coordinator — Vicki Orzel
    - QI Coordinator — Luci Reyes Agron
    - Advocate Client Rights — Sherrie Bailey Holland
    - RN Risk Manager — Christen Marx
    - QA Coordinator (Vacant)
- Director CARS — Jennifer Wittwer
  - Manager Integrated Svs — Justin Heller
    - Program Evaluator — Gary Kraft
    - Program Evaluator — Richard Kastenmeier
    - Health Data Analyst — Kimberly Daane
- Director Wraparound — Brian McBride
  - QA/QI Manager (Wrap) — Dane James
    - QA Specialist — Sylvia Cruze
    - QA Coord. (Wrap) — Yezlin Wade
    - QA Coord. (Wrap) — Erin Miller
  - Integrated Svs Manager — Adrienne Sulma
  - Contracted Integ Svs Manager — Pnina Goldfarb
- Chief Psychologist — Dr. Justin Kuehl
  - Dir. Clinical Programs — Matt Drymalski

Housing
- Housing Program Manager — Jessica Shriver
  - QA Coordinator — Samara McCall
- Asst. Administrator Housing — Eric Collins-Dyke
  - Quality Strategy Coordinator — Luke Rosynek
- QA Coordinator (New 2021)

Aging
- ARC Program Manager — Rachel Kaehny-Frank
  - QI Coordinator — Catherine Moe

Blue=Supervisor/Manager   Green=Positions with quality responsibilities

Grey = DHHS & BHD Contract Compliance

March 3, 2021

MILWAUKEE COUNTY
JOB EVALUATION QUESTIONNAIRE

This form is designed to assist you in describing your departmental job. You are asked to fill this form out to outline the essential duties and responsibilities; and identify the knowledge, skills and abilities required to successfully perform the job. This form is used to request new job classifications, review current classifications, reclassification, reallocations, and general updates to the job description. **_Note:_** It is the job that is being evaluated, not the position/incumbent. Thank you for your cooperation.

GENERAL INSTRUCTIONS:

1. Before beginning, please look over the entire questionnaire. Each question should be answered completely and accurately. If a question does not apply to this job, please indicate "N/A" (Not Applicable).

2. To complete the questionnaire, please type and/or select your responses.

3. If you wish to make additional comments, please use the space available in the "Additional Comments" section on page 6 of this questionnaire.

A. JOB IDENTIFICATION INFORMATION

Department (High Org):	8000		Division (Low Org):	8110	
Contact for this Study	Name: **Clare O'Brien**		Email: **clare.obrien@milwaukeecountywi.gov**		
	Title: **Budget & Operations Manager**		Phone:		
Current Job Title:	**Enterprise Quality Director**		**Current Job Code:**	**New 2021 Create - TBD**	
Health Screen Level:			**Background Check Level:**		
Job Reports To:	Title: DHHS Director (or her designee)				
Request Type:	☒ Establish New ☐ Review ☐ Reclassification ☐ Reallocation ☐ Update Description ☐ Other, Specify				

B. JUSTIFICATION STATEMENT

1. **Attach an organizational chart.**
2. **Explain the events or changes that made this request necessary.**
To better align with and realize the mission and future state vision of DHHS, a greater interest has emerged for a more structured and centralized quality assurance function across DHHS. While quality oversight exists across the department in varying degrees, there currently isn't one standardized, comprehensive approach involving all divisions.

C. ABOUT THE JOB

Job Status:	☐ Regular Full-Time	☐ Regular Part-Time	☐ Seasonal	☐ Contract
Shift:	☐ Day	☐ Evening	☐ Night	☐ Other:
Hours Per Week:	☐ >40 Hours	☐ 32-40 Hours	☐ 20-32 Hours	☐ <20 Hours
Travel:	☒ Yes ☐ No If Yes, % Travel 25%			
Will This Job Supervise/Manage?		☒ Supervise ☐ Manage # of Direct Reports: **TBD**		☐ N/A
Fiscal Responsibility: Responsible for annual operating budget for department(s)/division(s)?		☐ Yes ☒ No If yes, please provide total amount?		

D. JOB SUMMARY:

Briefly state, in several sentences, the principle purpose or function of the job. Respond by describing **What** the job is, **What** its major objective is, and **Why** does it exist.

The Enterprise Quality Director would be responsible for building an enterprise-wide, person-centered, quality management system connecting all DHHS quality staff in an effort to fulfill the department's mission to ensure our participants enjoy safe, healthy, and meaningful lives. The expectation would be to continually assess the existing quality needs and infrastructure in the various divisions to collaboratively build a comprehensive system and provide support, guidance and strategy where necessary. This would link all quality staff who are independently supporting their respective divisions to a larger quality system.

The EQD also would be responsible for establishing a culturally intelligent and equity driven quality management system. This would include, but not be limited to, the following: preparation of quality plans within each division, formation of quality workgroups within each division, and development of performance metrics and dashboards for programs within each division. Another expectation of the EQD position is to conduct a needs analysis to ensure all areas are appropriately resourced, assess all current quality positions and develop a plan to create standardization among title codes and position descriptions. This position is critical to supporting a service delivery model driven by equitable and expanded access to services based on the needs of participants.

Job Evaluation Questionnaire (JEQ) *v.01312017*

E. ESSENTIAL DUTIES/RESPONSIBILITES:

JOB RESPONSIBILITY LIST: Please describe the major elements of the job. List only the major functions, separately, in order of importance. Provide a one or two line descriptive statement for each duty so that someone not familiar with this kind of work can understand it. Weight the approximate percentage of allocated work time for each functional work activity (Round to the nearest **10%**). We do not need to know HOW the function is to be performed, but rather, WHAT it is to be performed. **Percentages should add up to 100%**

1.	☒ Original ☐ New Job Duty: Establish, Maintain & Oversight of Enterprise Quality Management Functions	% of Time: 40
	Descriptive: Development and continued coordination of a comprehensive, customer-driven quality management system across DHHS that adheres to industry best practice and frameworks, includes the drafting of standardized policies and procedures, development and reporting of performance measures, application of continuous learning systems and quality tools such as PDSA and root cause analysis & management of special projects to advance a culture of quality .	
2.	☒ Original ☐ New Job Duty: Performance Measure Development & Continuous Improvement	% of Time: 20
	Descriptive: Direct the development of performance measures & standardized data collection methods to test whether programs/services are positively impacting participants & demonstrate the effective use of resources. And in collaboration with divisional quality staff, develop recommendations for continuous improvement in response to results generated by outcome-based measures and participant needs.	
3.	☒ Original ☐ New Job Duty: Quality Management Oversight	% of Time: 30
	Descriptive: Direct the development & continued operation of a robust quality management process in alignment with the rest of the department and establish strong collaborative relationships with quality staff in all areas. An expectation of the EQD position is to conduct a needs analysis of each division to ensure these areas are appropriately resourced.	
4.	☒ Original ☐ New Job Duty: Quality Plans & Departmental Quality Workgroup	% of Time: 10
	Descriptive: Assist in the preparation & review of divisional quality plans and lead departmental quality workgroup to ensure full representation and inclusion across the department.	
5.	☐ Original ☐ New Job Duty:	% of Time:
	Descriptive:	
6.	☐ Original ☐ New Job Duty:	% of Time:
	Descriptive:	
7.	☐ Original ☐ New Job Duty:	% of Time:
	Descriptive:	
8.	☐ Original ☐ New Job Duty:	% of Time:
	Descriptive:	
9.	☐ Original ☐ New Job Duty:	% of Time:
	Descriptive:	
10.	☐ Original ☐ New Job Duty:	% of Time:
	Descriptive:	

F. EQUIPMENT, TOOLS & MATERIALS, PERSONAL COMPUTERS, SOFTWARE

Please list all equipment, tools or materials required to perform the job along with the frequency.	Frequency			Type of Equipment
	Daily	Weekly	Monthly	
1. Machinery: (i.e. Vehicles, Motorized Equipment, Heavy Machinery, etc)		2-3 X		vehicle
2. Hand Tools/Instruments: (i.e. Power Tools, Equipment, Weapons, etc.)	X			PC

3. Driving required?	☒ Yes ☐ No	List License Types: (Required)	
		List License Types: (Preferred)	

4. Personal vehicle required?	☒ Yes ☐ No

5. Please list all Technology, Systems and Software Knowledge required to perform the job:

Basic	Intermediate	Advanced	
☐	☐	☒	Knowledge of all related computer and Microsoft Office applications such as Excel, Powerpoint
☐	☐	☐	Other:
☐	☐	☐	Other:
☐	☐	☐	Other:

G. JOB COMPETENCIES

Internal/External Contacts: Please select all that apply.	
☒	Exchange of basic information with internal and/or external contacts.
☒	Maintain sensitive or confidential information.
☒	Explain and gather information, answer queries, or provide assistance to internal and/or external contacts.
☒	Persuade, conform or recommend course of action with internal and/or external contacts.
☒	Perform with a high degree of authority in securing understanding and cooperation with internal and/or external contacts.
☒	Maintain a continuing working relationship that can have a significant effect on the success of the organization.

Communication Skills: Select the level of language (ability to read, write and speak needed to successfully accomplish the essential duties of the job.) Please select all that apply.	
☒	Read, write and comprehend simple instructions, reports, short correspondence and memos.
☒	Speak effectively before both internal and/or external groups.
☒	Read, analyze, and interpret safety rules, operating/maintenance instructions and procedure manuals, scientific/technical journals and procedures, government regulations, financial and legal documents.
☒	Prepare and/or present written communications that pertain to controversial and complex topics.

Decision-Making: Please select only one of the following:	
☐	Makes minimal decision-making responsibility.
☐	Makes decisions of responsibility involving evaluation of information; decisions may require development or application of alternatives or precedents.
☐	Makes decisions of responsibility and final results that affect more than one department or a department with multiple units; substantial analysis is required and many factors must be weighed before a decision can be reached.
☒	Makes decisions of responsibility and final recommendations, which may result in the formulation of strategic plans of action to achieve the broad objectives for the organization; involves long-range future planning including scope, direction and goals.

	Complexity, Judgment and Problem Solving: Please select all that apply.
☒	Understand and follow instructions.
☒	Execute decisions within limits of standard policy and procedures.
☒	Interpret and adapt to established practices and procedures using independent judgment to meet situations to which applications are not clearly defined.
☒	Perform within difficult or complex working conditions or situations not easily evaluated; decisions require considerable judgment, initiative and ingenuity in areas there is little precedent.
☒	Act independently in the formulation and administration of policies and programs for major departments or functions.

H. WORKING CONDITIONS

What are the physical, mental and environment demands for this job? Functions identified must coincide with the descriptive statement of essential duties and responsibilities for this job. The functions should focus on what is to be done and the processes traditionally used to achieve end results. For each of the following functional requirements, indicate the frequency in which it occurs in this job.

PHYSICAL DEMANDS	**N/A**	**Seldom (<25%)**	**Occasional (25% - 50%)**	**Frequent (50% - 75%)**	**Always (>75%)**
Standing	☐	☒	☐	☐	☐
Walking/Running	☐	☒	☐	☐	☐
Sitting	☐	☐	☐	☒	☐
Reaching	☐	☒	☐	☐	☐
Climbing	☐	☒	☐	☐	☐
Driving	☐	☐	☒	☐	☐
Bending/Kneeling	☐	☒	☐	☐	☐
Hearing	☐	☐	☐	☐	☒
Talking	☐	☐	☐	☐	☒
Visual	☐	☐	☐	☐	☒
Typing	☐	☐	☐	☐	☒
Writing	☐	☐	☐	☐	☒
Fine Dexterity	☐	☐	☒	☐	☐
Manual Dexterity	☐	☐	☐	☐	☒
Upper Extremity Repetitive Motion	☐	☐	☐	☒	☐

Lifting/Carrying (lbs.)	☒ up to 05	☐ up to 10	☐ up to 15	☐ up to 20	☐ up to 25	☐ up to 30	☐ up to ____
Pushing/Pulling (lbs.)	☒ up to 05	☐ up to 10	☐ up to 15	☐ up to 20	☐ up to 25	☐ up to 30	☐ up to ____

NON-PHYSICAL DEMANDS	**N/A**	**Seldom (<25%)**	**Occasional (25% - 50%)**	**Frequent (50% - 75%)**	**Always (>75%)**
Analysis/Reasoning	☐	☐	☐	☒	☐
Communication/Interpretation	☐	☐	☐	☐	☒
Math/Mental Computation	☐	☐	☒	☐	☐
Reading	☐	☐	☐	☐	☒
Sustained Mental Activity (i.e. auditing, problem solving, grant writing, composing reports)	☐	☐	☐	☐	☒
Other:	☐	☐	☐	☐	☐

ENVIRONMENTAL DEMANDS	N/A	Seldom (<25%)	Occasional (25% - 50%)	Frequent (50% - 75%)	Always (>75%)
Work Independently	☐	☐	☐	☒	☐
Task Changes	☐	☐	☐	☒	☐
Tedious/Exacting Work	☐	☐	☒	☐	☐
High Volume Public Contact	☒	☐	☐	☐	☐
Dust	☒	☐	☐	☐	☐
Temperature Extremes	☒	☐	☐	☐	☐
Loud Noises	☒	☐	☐	☐	☐
Physical Danger	☒	☐	☐	☐	☐
Toxic Substances (i.e. solvents, pesticides, etc.)	☒	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

WORK SCHEDULE: Please select all that apply.

☒	Routine shifts hours. Infrequent overtime, weekend, or shift rotation.
☐	Considerable irregularity of hours due to frequent overtime, weekend or shift rotation.
☐	Regular and/or frequent on-call availability; nature of work frequently requires irregular, unpredictable or particularly long hours.

DEMANDS/DEADLINES: Please select all that apply.

☐	Little or no stress created by work, employees or public.
☐	Intermittent or cyclical work pressures with occasional exposure to high stress work environments.
☒	High volume and variable work demands and deadlines that impose strain on a routine basis; frequent direct contact with individuals or exposure to highly stressful situation, demands or pressures.

I. EDUCATION, LICENSE, AND EXPERIENCE

EDUCATION

Please indicate the MINIMUM educational level required:

☐ HS Diploma/GED	
☐ Associate's Degree	Area of specialization/major:
☒ Bachelor's Degree	Area of specialization/major:
☐ Graduate Degree	Area of specialization/major:
☐ Post Graduate Degree (PhD)	Area of specialization/major:
☐ Professional Degree (Law, Medicine, etc.)	Area of specialization/major:
☐ Other:	Please indicate:

LICENSE/CERTIFICATION: (Please complete Section F on Page 3 for Driving Requirements/License(s))

What license(s), certification/certificate(s), registration(s), or other regulatory requirements/training:

None are required but the following would be preferred such as Six Sigma, LEAN or other quality-related certifications/or licensures.

WORK EXPERIENCE

Please indicate the MINIMUM number of years of practical experience required.

☐ No experience	
☐ Less than one year	*Area(s) of experience:*
☐ One to two years	*Area(s) of experience:*
☐ Two to five years	*Area(s) of experience:*
☒ Five or more years	*Area(s) of experience:* Quality role in a human services organization

SUPERVISORY/MANAGEMENT EXPERIENCE
Please indicate the MINIMUM number of years of supervisory/management experience required.

☐	No experience	
☐	Less than one year	*Area(s) of experience:*
☒	One to three years	*Area(s) of experience:*
☐	Three to five years	*Area(s) of experience:*
☐	Five or more years	*Area(s) of experience:*

Supervisory/Managerial: If applicable, select the appropriate level of responsibility.	
☐	**Level 1** General instructing, scheduling, and reviewing the work of others performing the same or directly related work. Acts as "lead worker". Functional supervision only. Recommends personnel actions (hiring, termination, pay changes, etc.) but does not independently conduct.
☒	**Level 2** Scheduling, supervision, and evaluation of work of employees who perform similar work assignments. Conducts all aspects of personnel actions (hiring, termination, pay changes, etc.).
☐	**Level 3** Scheduling, supervision and evaluation of work as a "manager" of the first line supervisors; or perform supervision of workers who perform distinct and separate blocks of work. Oversees and conducts all aspects of personnel actions (hiring, termination, pay changes, etc.). Are there subordinate supervisors reporting to this job? ☐ Yes ☐ No If yes, how many?
☐	**Level 4** Scheduling, supervision and evaluation of work as a superior of "managers". Administers through subordinate managers, departmental multi-function programs or operations. Oversees and conducts all aspects of personnel actions (hiring, termination, pay changes, etc.). Are there subordinate supervisors/managers reporting to this job? ☐ Yes ☐ No If yes, how many?
☐	**Level 5** Scheduling, supervision, and evaluation of work as a superior of those in level 4. Are there subordinate supervisors/managers reporting to this job? ☐ Yes ☐ No If yes, how many?

List the names of the Positions and/or Department(s)/Division(s) supervised/managed by this job:
• DHHS is currently reorganizing its structure and as a result, the employees to be managed by this position are still to be determined.

J. ADDITIONAL COMMENTS

Please list additional items not covered in this questionnaire that would be helpful to the <u>Compensation Department</u> in understanding this job.
•

Please provide additional information and/or language so that <u>Employment & Staffing</u> can include it in the job announcement (Providing that the Compensation Department has approved).
• While it's extremely important that this individual have the technical skills and expertise to successfully perform the duties of the position, a candidate should also exhibit strong communication, listening, and critical thinking skills, as well as a solution-oriented approach and demonstrate empathy and equity-mindedness to all.   •

K. SIGNATURES

SUPERVISOR'S/MANAGER'S CONFIRMATION: I have completed and/or reviewed the contents of this job evaluation questionnaire and consent to its accuracy.	
Supervisor/Manager Signature:	**Date:**
Department/Division Head Signature:	**Date:**

Email the completed form to: hrcompensation@milwaukeecountywi.gov. Please ensure the subject line includes the Department High Org., and (if applicable) Low Org. number, Request Type (i.e. JEQ Request, JEQ Study,) (I.e. 1140/1140 JEQ Request)

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).

- Patient Experience of Care
- Population Health
- Cost of Care
- Staff Well-Being
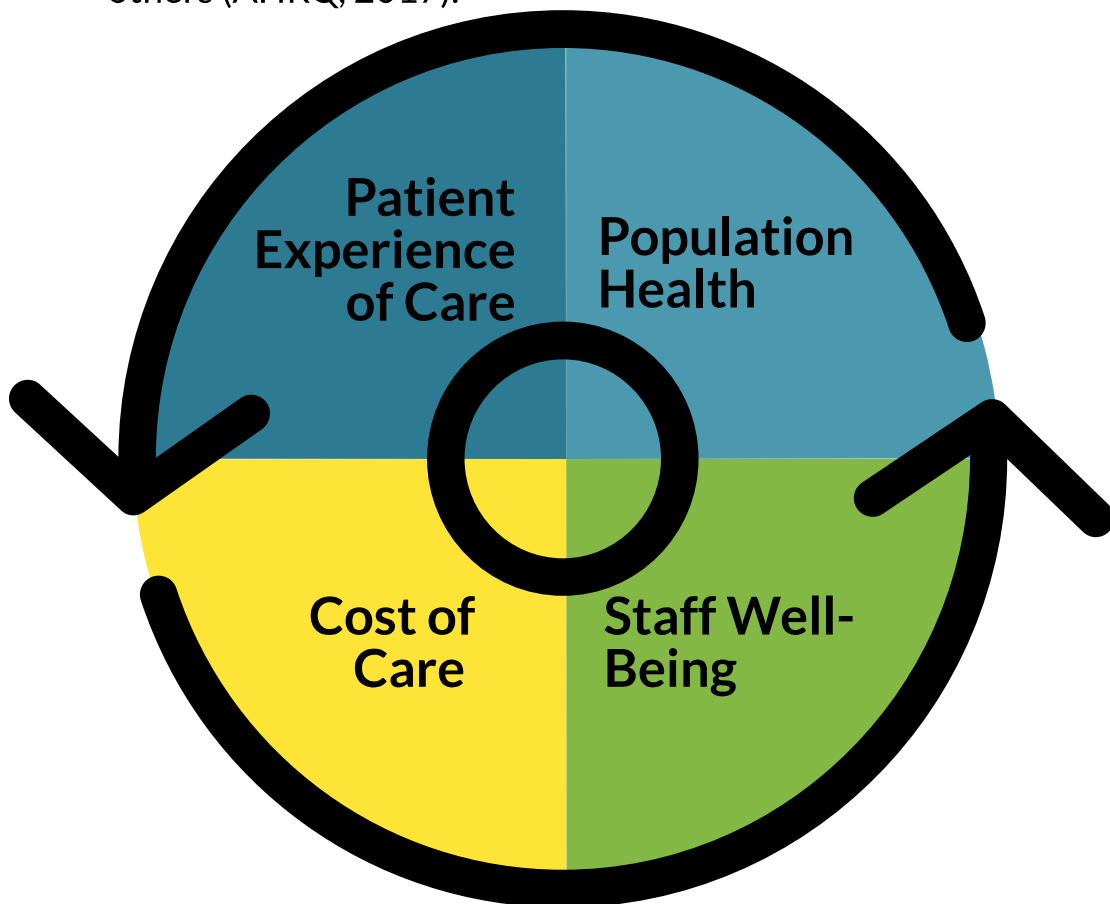
The total cost of care a patient receives across all settings and services, often presented as cost per member of the population per month (Stiefel & Nolan, 2012).

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

CONTINUED FOCUS ON RACIAL EQUITY

The Community Access to Recovery Services (CARS) is committed to racial equity and to building equity into all aspects of our department, from care provision to administrative oversight and internal operations. We reaffirm these guiding principles:

1. *Our commitment to equity embraces all forms of diversity.*
2. *Equity is not simply something that we do, it must reflect who we aspire to be.*
3. *An equity gap is a quality gap that must be acknowledged and addressed.*

As noted in the previous Quarterly Report, nearly all CARS quarterly reporting metrics have now been disaggregated by race, save our staff turnover metric (see below). The remainder of this document will highlight key developments and/or findings in each of the Aims of the Quadruple Aim, consistent with our previous reporting.

Population Health
Continuing the trend noted in quarter 3 of last year, the rates of improvement among Black clients served by CARS was greater than the rates of improvement among white clients. This iteration of the Quarterly Report also includes point in time estimates of quality of life among all CARS clients with available data (not just those who had an intake and follow up within 6 months), also disaggregated by race. This new metric gives us insight into a much larger segment of the population we serve. One final important update is that the BHD business analytic team has now developed an enrollment reporting structure that will enable better tracking and outcomes reporting of CARS and which we hope will significantly change the way in which we are able to present our change over time and impact data.

Patient Experience of Care
The implementation of the client experience survey in CARS is well underway, with 3 grants and 5 CARS programs now utilizing the survey. The survey is currently being utilized in two separate contracts as incentivized contract performance measures. Further, we recently completed our initial analysis of our second client experience with telehealth survey and have presented the results at a CARS All Provider meeting, to external stakeholders, and have used the data to supplement a recently released position paper advocating for the continued reimbursement of telephonic telehealth post-pandemic.

Staff Wellbeing
The data CARS has received from HR indicate that no staff left CARS in the fourth quarter of 2020. This brings CARS's rolling twelve-month turnover rate down to 0.00% for all of 2020 (against a national benchmark of 20.0%)! Our partners in HR will begin providing this turnover data disaggregated by race starting in the first quarter of 2021. Upcoming CARS initiatives in the Staff Wellbeing Aim include the development of a mentorship program within CARS and the implementation of an ongoing professional quality of life survey for all CARS staff on an annual basis. Further, the providers with whom CARS contracts and partners to provide most of the services in the CARS network are vital partners in our system of care. Therefore, beginning this year, BHD will begin administering an annual survey assessing the quality of the provider experience with Milwaukee County Behavioral Health Division (BHD) as a management entity. CARS will assist in the development, administration, aggregation, and interpretation of this survey and its results.

Cost of Care
The cost of care metric has already been disaggregated by race, and the gap in dollars spent per client per month between Black and white clients first noted in the 3rd quarter has persisted in the 4th quarter. We are actively investigating potential reasons for this difference and plan to explore this finding as part of the CARS Quality Plan.

NEXT STEPS
Updates to the CARS Quality Plan are nearly complete, and we hope to share the revised plan with this Committee later this year. Other key next steps for the CARS Research and Evaluation Team are efforts to make our data more available, both internally and externally, through the use of a page dedicated to quality initiatives on the BHD website and through the use of data visualization software.
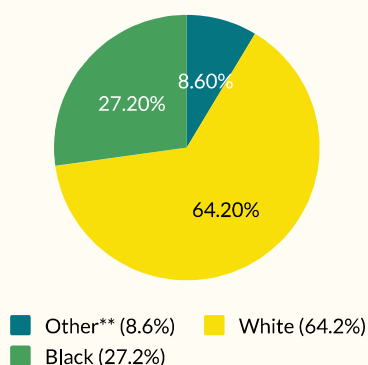
Looking at our Metrics with a Racial Equity Lens
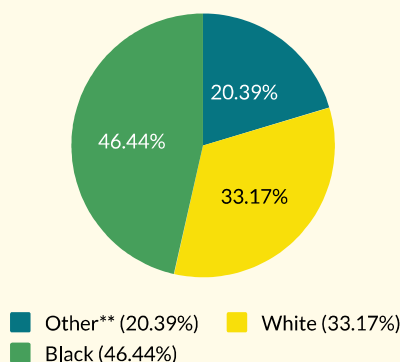### Q4-2020 data unless noted

Demographic Information of the Population We Serve
This section outlines demographics of the consumers CARS served last quarter compared to the County population.
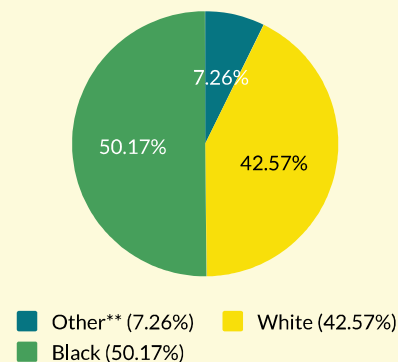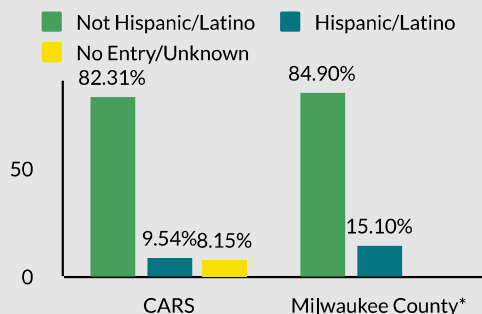
Race (Milwaukee County)*
- Other** (8.6%)
- White (64.2%)
- Black (27.2%)

8.60% / 27.20% / 64.20%

Race of MKE County at or Below 100% Poverty Level
- Other** (20.39%)
- White (33.17%)
- Black (46.44%)

20.39% / 46.44% / 33.17%

Race (CARS)
- Other** (7.26%)
- White (42.57%)
- Black (50.17%)

7.26% / 50.17% / 42.57%

Ethnicity
Not Hispanic/Latino, Hispanic/Latino, No Entry/Unknown

CARS: 82.31%, 9.54%, 8.15%
Milwaukee County*: 84.90%, 15.10%

Gender
Men, Women

CARS: 58.27%, 41.65%
Milwaukee County*: 48.40%, 51.60%

Age
18-19: .44%
20-29: 16.54%
30-39: 24.69%
40-49: 20.63%
50-59: 24.16%
60-69: 11.74%
70+: 1.72%

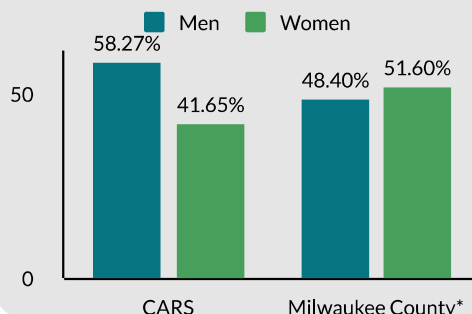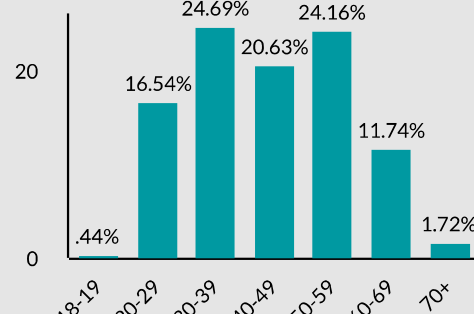### A look at poverty in Milwaukee County vs. CARS

This graph illustrates the estimated number of people living in poverty in Milwaukee County with a substance use and/or mental health disorder each year from 2016 to present, relative to the unique number of people served by CARS per year in the same timeframe. These data indicate that although the population of Milwaukee County, both overall and those living in poverty with a mental health and/or substance use disorder, is decreasing from year to year, the proportion of this community (those living in poverty with a substance use and/or mental health disorder) served by CARS is actually growing.

Legend: Projected Number of People Living in Poverty in Milwaukee County with Substance Use and/or Mental Health Disorder*
Percent of Those in Poverty with Mental Health and/or Substance Use Disorder that we Serve
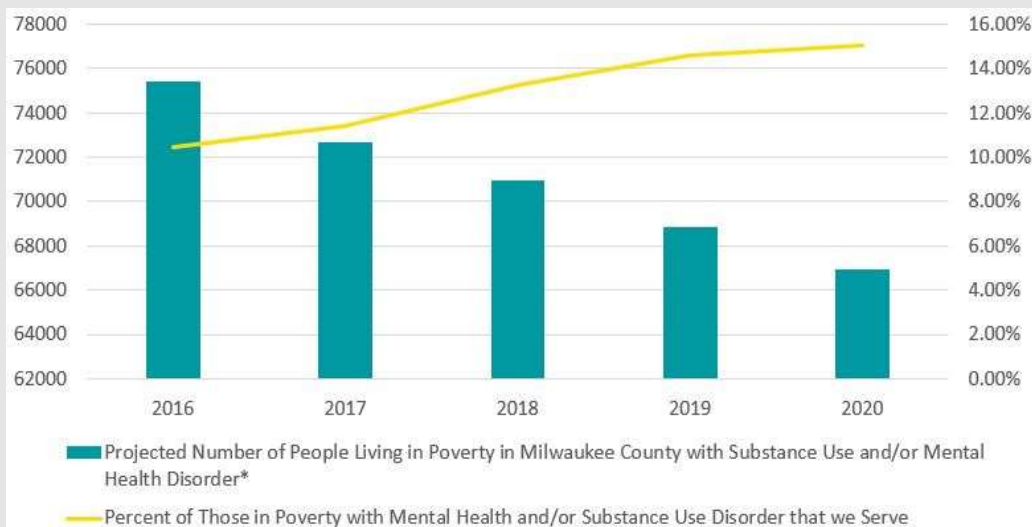
* Projected number living in poverty with a mental health and/or substance use disorder is based on the NSDUH's estimate of 24.5% of adults 18 and older with any mental health or substance use disorder in the past year and multiplied by a factor of 1.5 to account for the higher rates of behavioral health issues amongst individuals living in poverty.
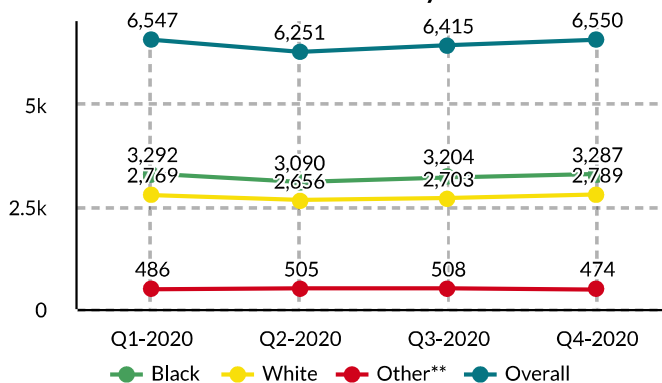
*Comparable data from United States Census Bureau, which can be found at: https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/PST045217#qf-flag-Z
**"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Biracial", "Native Hawaiian/Pacific Islander", and "Other"

Domain: Patient Experience of Care

Volume Served

Timeliness of Access

Volume Served by Race

- 6,547 — 6,251 — 6,415 — 6,550 (Overall)
- 3,292 — 3,090 — 3,204 — 3,287 (Black)
- 2,769 — 2,656 — 2,703 — 2,789 (White)
- 486 — 505 — 508 — 474 (Other**)

Q1-2020 Q2-2020 Q3-2020 Q4-2020

Legend: Black, White, Other**, Overall

Percent Served within 7 days

Overall	99.81%
Black	99.87%
White	99.84%
Other**	98.95%

Average Consumer Satisfaction Score (Range of 1-5)

331 client experience surveys received in Q4 2020

3.96 average for all consumers (n=331)

3.94 average for Black consumers (n=162)

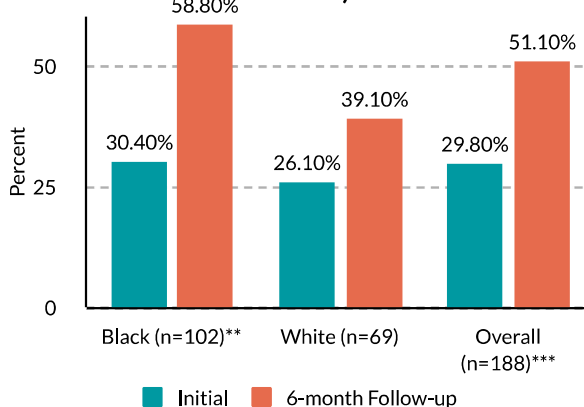**4.05** average for white consumers (n=120)

Referrals

Admissions

Referrals

- Overall: 1,566 — 1,121 — 1,301 — 1,504
- Black: 812 — 540 — 674 — 761
- White: 589 — 441 — 475 — 606

Q1-2020 Q2-2020 Q3-2020 Q4-2020

Legend: Overall, Black, White

Admissions

- Overall: 3,412 — 2,882 — 3,107 — 3,012
- Black: 2,162 — 1,870 — 2,007 — 1,899
- White: 1,030 — 857 — 922 — 980

Q1-2020 Q2-2020 Q3-2020 Q4-2020

Legend: Overall, Black, White
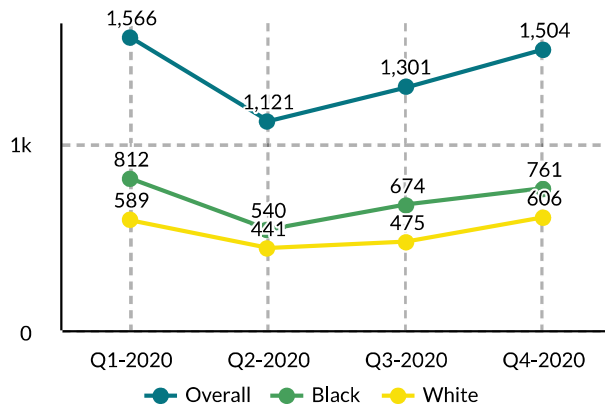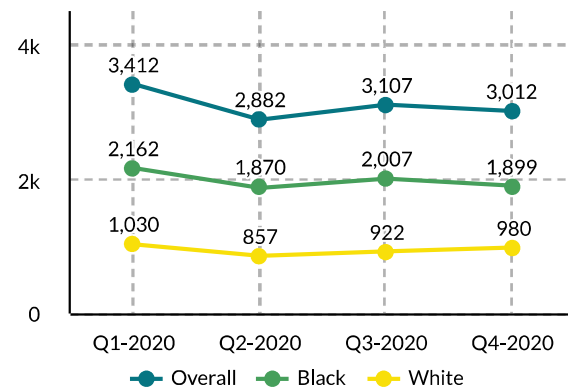
Domain: Population Health

Change Over Time

Quality of Life

Self-Rated Health

Quality of Life ("Good" or "Very Good")

- Black (n=102)**: Initial 30.40%, 6-month Follow-up 58.80%
- White (n=69): Initial 26.10%, 6-month Follow-up 39.10%
- Overall (n=188)***: Initial 29.80%, 6-month Follow-up 51.10%

Legend: Initial, 6-month Follow-up

Self-Rated Health ("Good" or better)

- Black (n=110): Initial 50.90%, 6-month Follow-up 52.70%
- White (n=79): Initial 50.60%, 6-month Follow-up 55.70%
- Overall (n=207): Initial 50.70%, 6-month Follow-up 53.60%

Legend: Initial, 6-month Follow-up

Domain: Population Health (cont.)
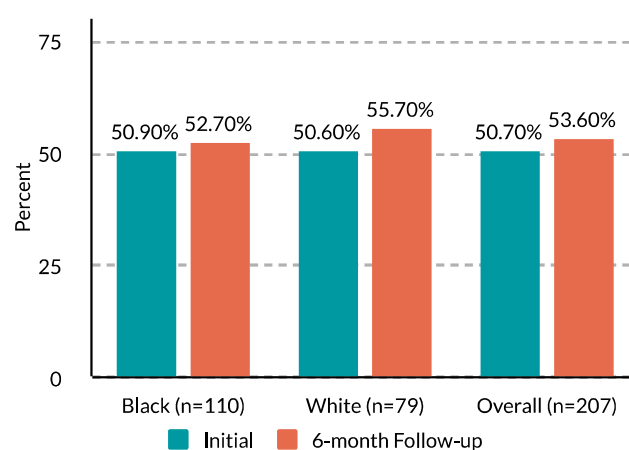
Employed

Stably Housed

PCS visits

Detox Visits

*p<.05 **p<.01   ***p<.001
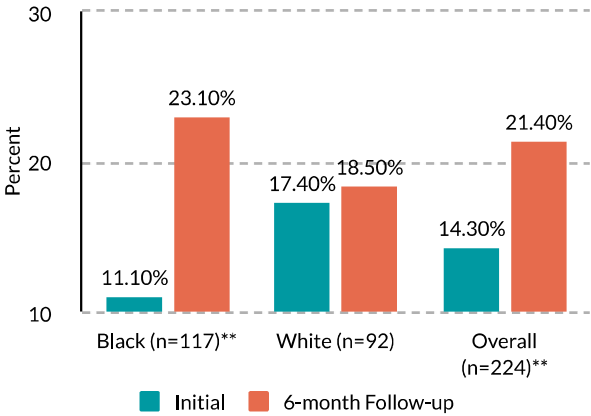
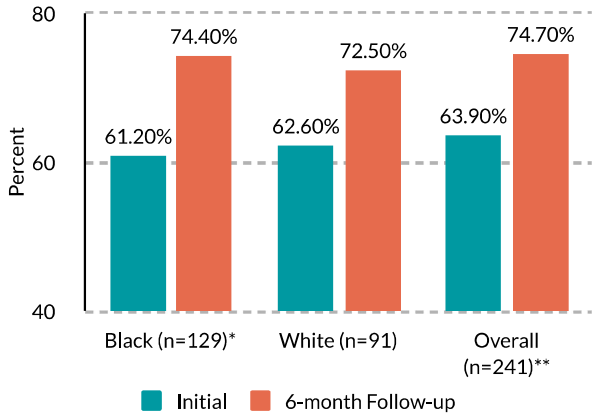**Mortality Over Time by Race**
one quarter lag in reporting

Cause of Death by Race
for deaths between Q4-2019 and Q3-2020

Quality of Life

Employed

Stably Housed

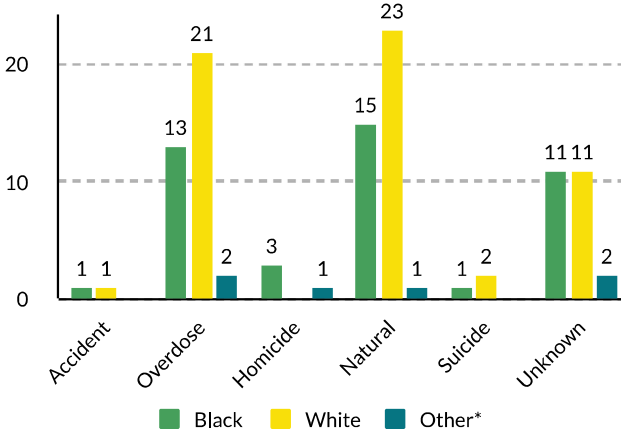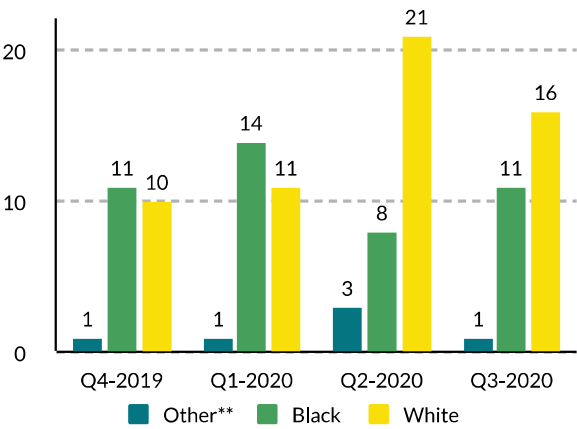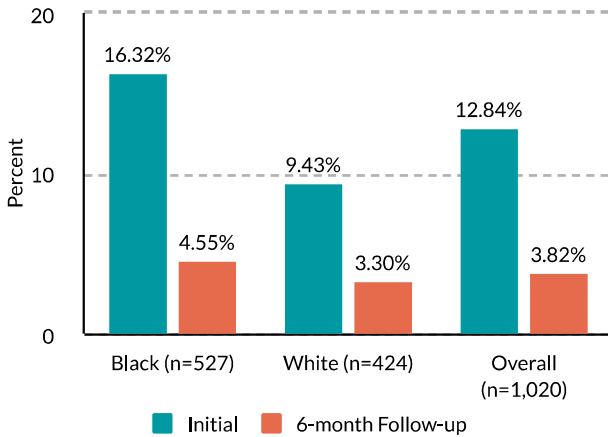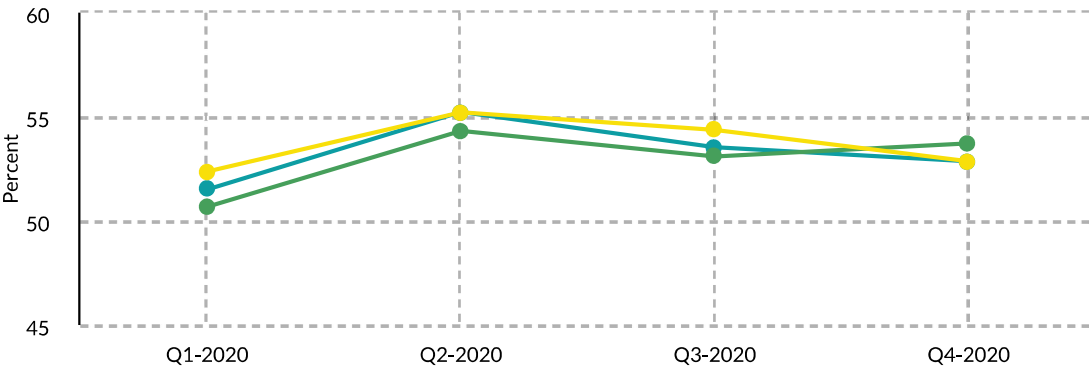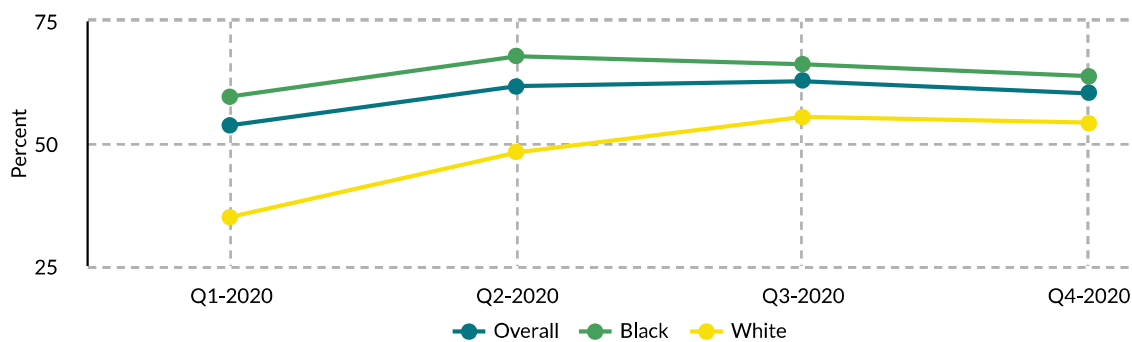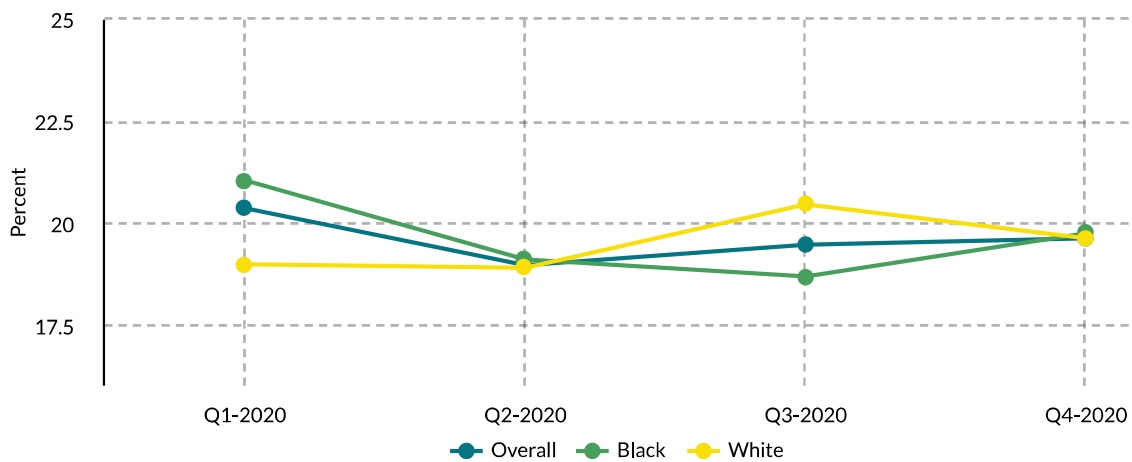### PCS visit in last 30 days
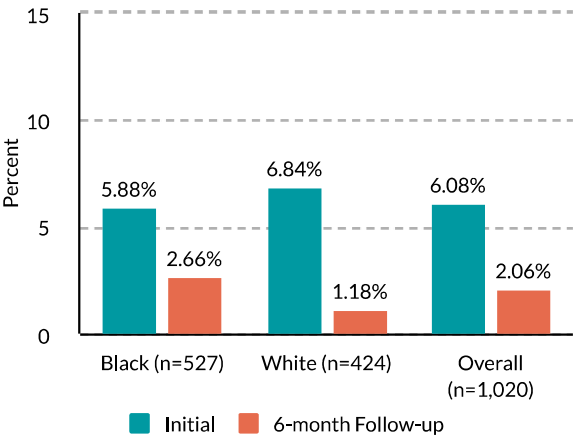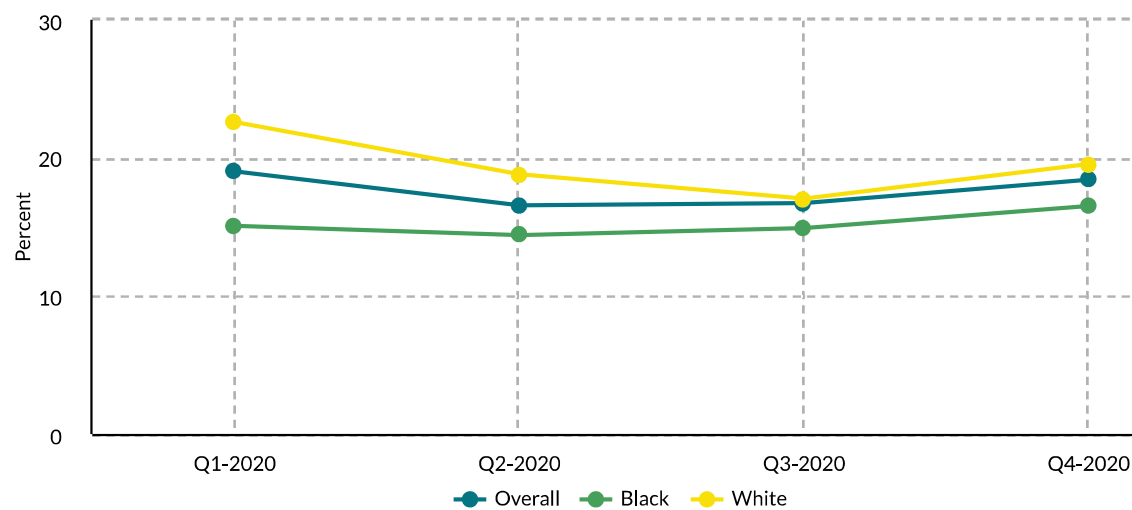

Detox Visit in last 30 days

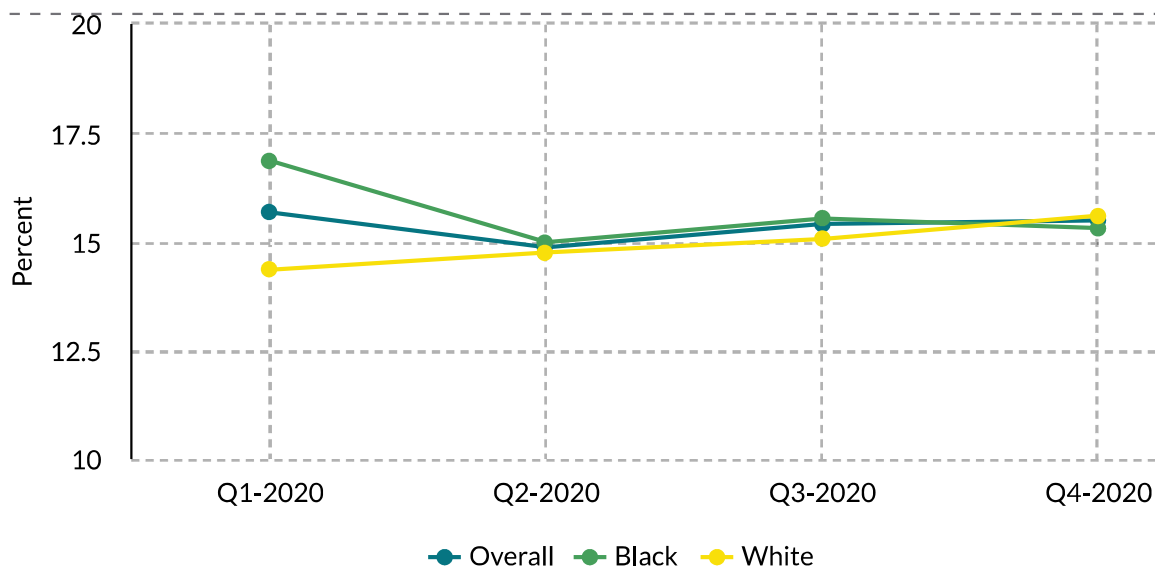

Quality of Life ("Good" or "Very Good")

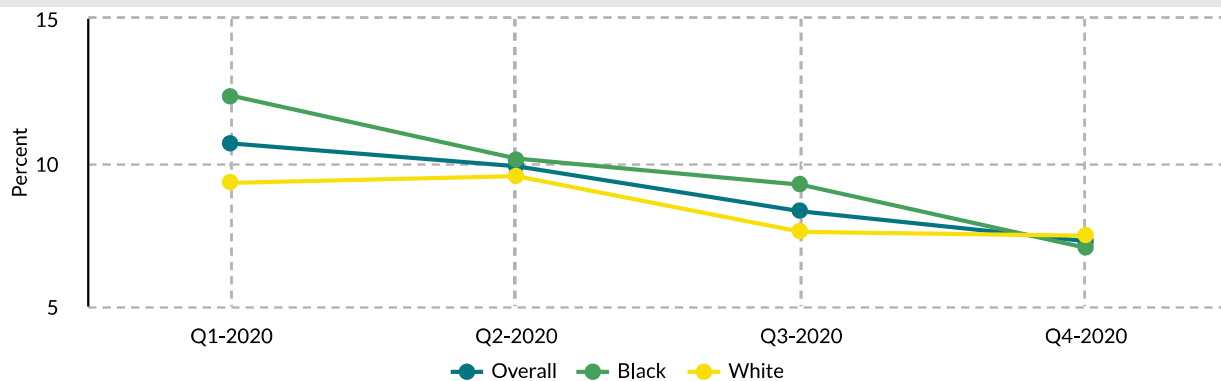## Detoxification 7-Day Readmissions

Acute Service Utilization

Employment

ER Utilization

Domain: Population Health (cont.)

Homelessness

Top Prevention Initiatives

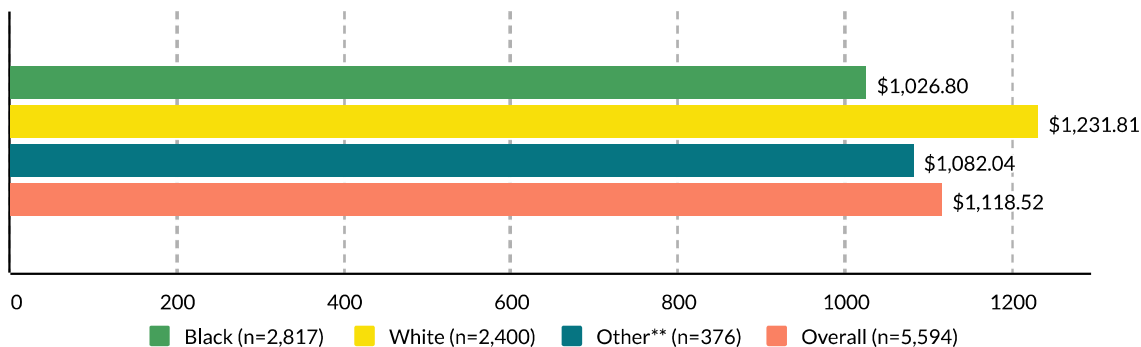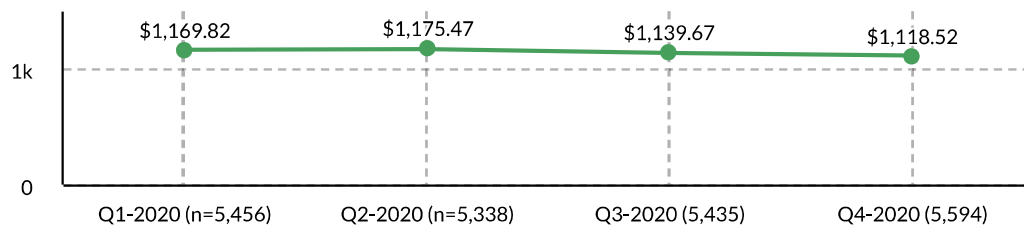|	People Served
Milwaukee Public Schools	12,000
Light Unite Red	8,500
Milwaukee County Substance Abuse Prevention Coalition (MCSAP)	7,740
Dose of Reality	3,500
Mental Health Awareness	3,280
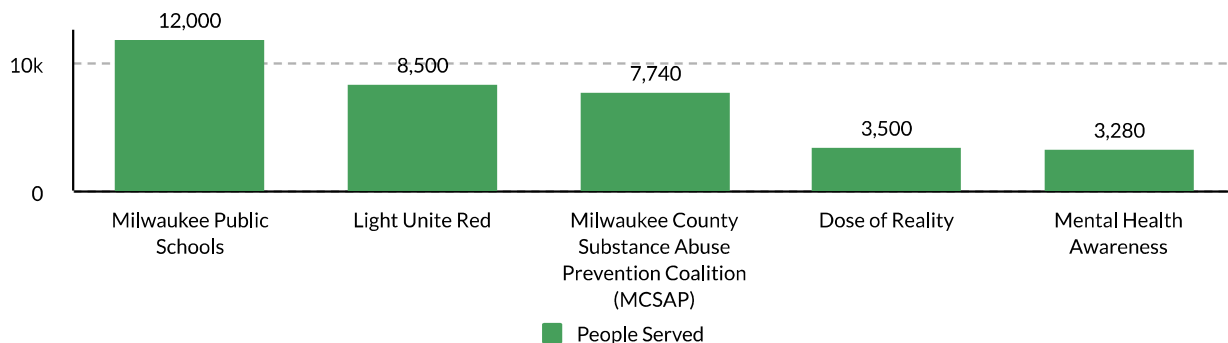
Domain: Cost of Care

Average Cost per Consumer per Month for Q3 by Race

"n" refers to an average of the number of unique consumers served per month for the quarter

- Black (n=2,817): $1,026.80
- White (n=2,400): $1,231.81
- Other** (n=376): $1,082.04
- Overall (n=5,594): $1,118.52

Average Cost per Consumer per Month by Quarter

Quarter	Cost
Q1-2020 (n=5,456)	$1,169.82
Q2-2020 (n=5,338)	$1,175.47
Q3-2020 (5,435)	$1,139.67
Q4-2020 (5,594)	$1,118.52

Domain: Staff Well-Being

Turnover

0.00%
CARS turnover rate

Staff Quality of Life

20.00%
Turnover rate for government employees (per year)*

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, racial equity, and gratitude. 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.

Metric Definitions

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

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

Consumer Satisfaction — Implementation of the new, more succinct Client Satisfaction has begun. The survey ranges from 4-10 questions, depending on the program, and all questions range from 1="strongly disagree" to 5="strongly agree". The survey is currently being utilized in CSP, CCM, RSC, AODA Residential, and Detoxification.

Cost of Care — 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 "n" is an average of the unique number of consumers served per month for the 3 months in the quarter in question.

Detoxification Re-admissions — Percent of consumers returning to detoxification within 7 days. This includes both Detoxification 75.07, as well as Detoxification 75.09 (Sober Up).

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

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

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

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. The graph shows deaths by quarter and aggregated cause of death from the previous four quarters. These data come from the CARS notification of death form and is supplemented by information from the Medical Examiner's office. There is a one quarter lag in death reporting.

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

Prevention — 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.

Quality of Life — This is a self-reported measure based on the question on the Comprehensive Assessment. Graphs shows the percentage of people that stated that their quality of life was "good" or "very good".

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

Self-Rated Health — This is a self-reported measure based on the question on the Comprehensive Assessment. The graph shows the percentage of people that said that their physical health was at least "good".

Stably Housed — Percent of clients who reported their current living situation as a permanent or supported residence.

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

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

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.

BHD-Wide Dashboard

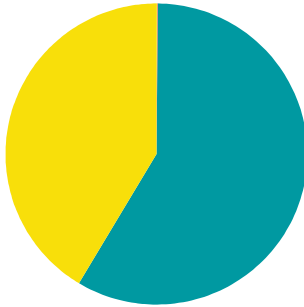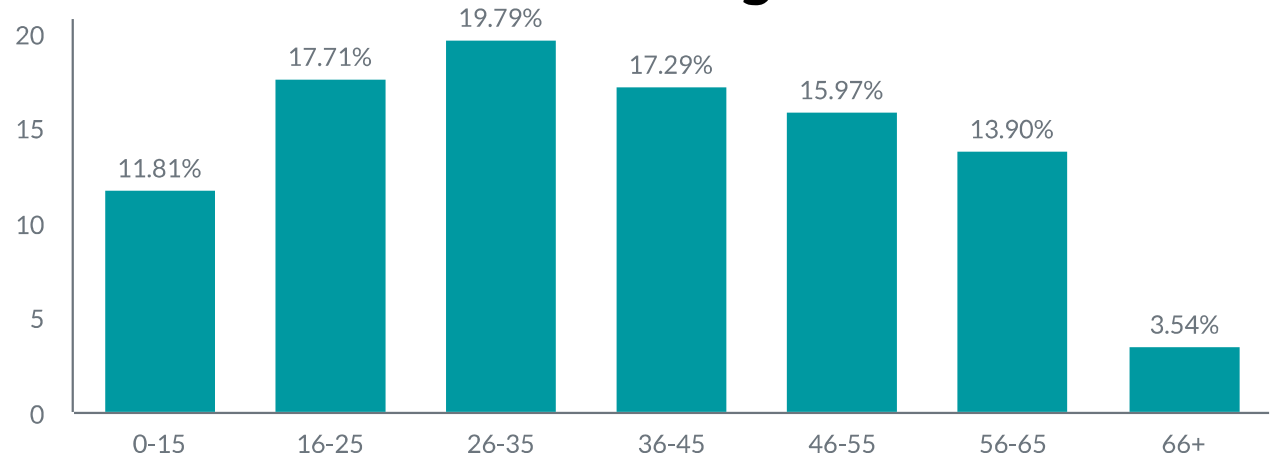Includes all served in BHD Adult Services and Wraparound

Volume Served
10,046

Gender

- Men (58.42%)
- Women (41.5%)
- Other* (0.08%)

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

Age

- 0-15: 11.81%
- 16-25: 17.71%
- 26-35: 19.79%
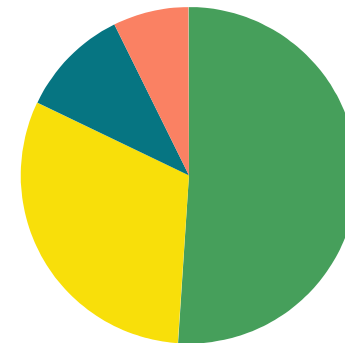- 36-45: 17.29%
- 46-55: 15.97%
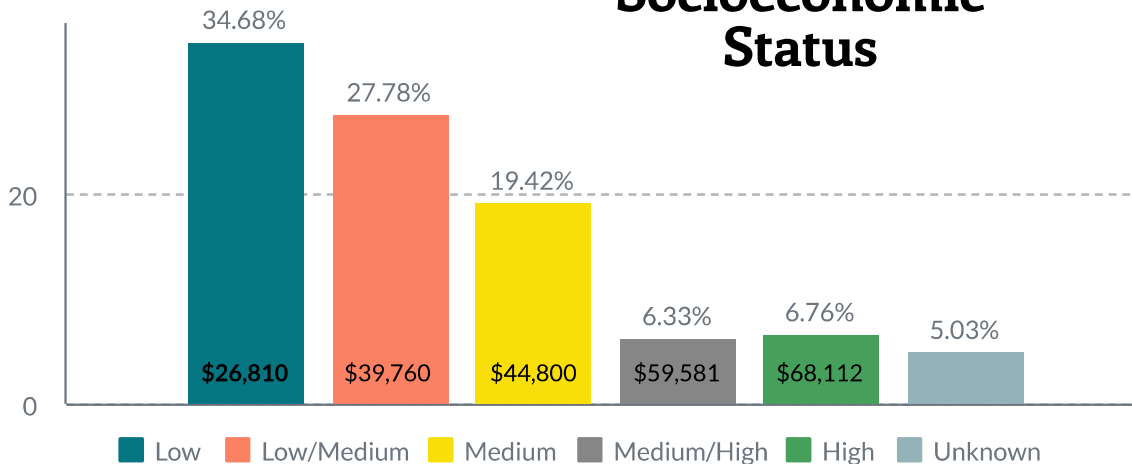- 56-65: 13.90%
- 66+: 3.54%

Race/Ethnicity

- Black (51.09%)
- White (31.07%)
- Hispanic (10.56%)
- Other* (7.28%)

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

Socioeconomic Status

- Low: 34.68% — $26,810
- Low/Medium: 27.78% — $39,760
- Medium: 19.42% — $44,800
- Medium/High: 6.33% — $59,581
- High: 6.76% — $68,112
- Unknown: 5.03%

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

http://www.cuph.org/milwaukee-health-report.html