Youth Engagement with Crisis Stabilizers

Performance Improvement Project 2021

Wraparound Milwaukee

GOAL

To increase & enhance the program and personal engagement with youth through Crisis Stabilization

Research Design & Process

The use of an experimental research design will allow the exploration of a cause/effect relationship between the use of targeted engagement strategies (independent variable) and the following dependent variables:

- **The average number contacts**
- **The duration of the contacts**

A PDSA Cycle through 2 experimental Phases

Formal Training for the use of engagement strategies that enhance Relationships and providing for Basic Needs from Buckets # 2,3 & 4 during Phase I

Creating group cohorts to discuss engagement strategies and issues of engagement during Phase II and introduce Bucket 5

Study Questions

Crisis Stabilizers will focus on using engagement strategies designed to foster Relationship Building Needs (Bucket # 2), Basic Needs (Bucket # 3), and Problem & Conflict Resolution and Safety (Bucket # 4) with 100% Wraparound Milwaukee youth receiving crisis stabilization from all Crisis Stabilization agencies that will result in an average increase of ≥5% of the number of youth contacts (virtual or in-person) in Phase I (April 1, 2021 – July 31, 2021), and an average increase of ≥10% of the number of contacts (virtual or in-person) in Phase II (August 1, 2021 – November 30, 2021), in comparison to the baseline of 1.76 average hours of youth crisis stabilization contact per week.

Crisis Stabilizers will focus on using engagement strategies designed to foster Relationship Building Needs (Bucket # 2), Basic Needs (Bucket # 3), and Problem & Conflict Resolution and Safety (Bucket # 4) with 100% Wraparound Milwaukee youth receiving crisis stabilization from all Crisis Stabilization agencies that in Phase I will result in an average increase of ≥10% of the length youth contact time (virtual or in-person) in Phase I (April 1, 2021 – July 31, 2021), and an average increase of ≥15% of the length of youth contact time (virtual or in-person) in Phase II (August 1, 2021 – November 30, 2021), in comparison to the baseline of 1.92 average hours of youth crisis stabilization contact time per week.

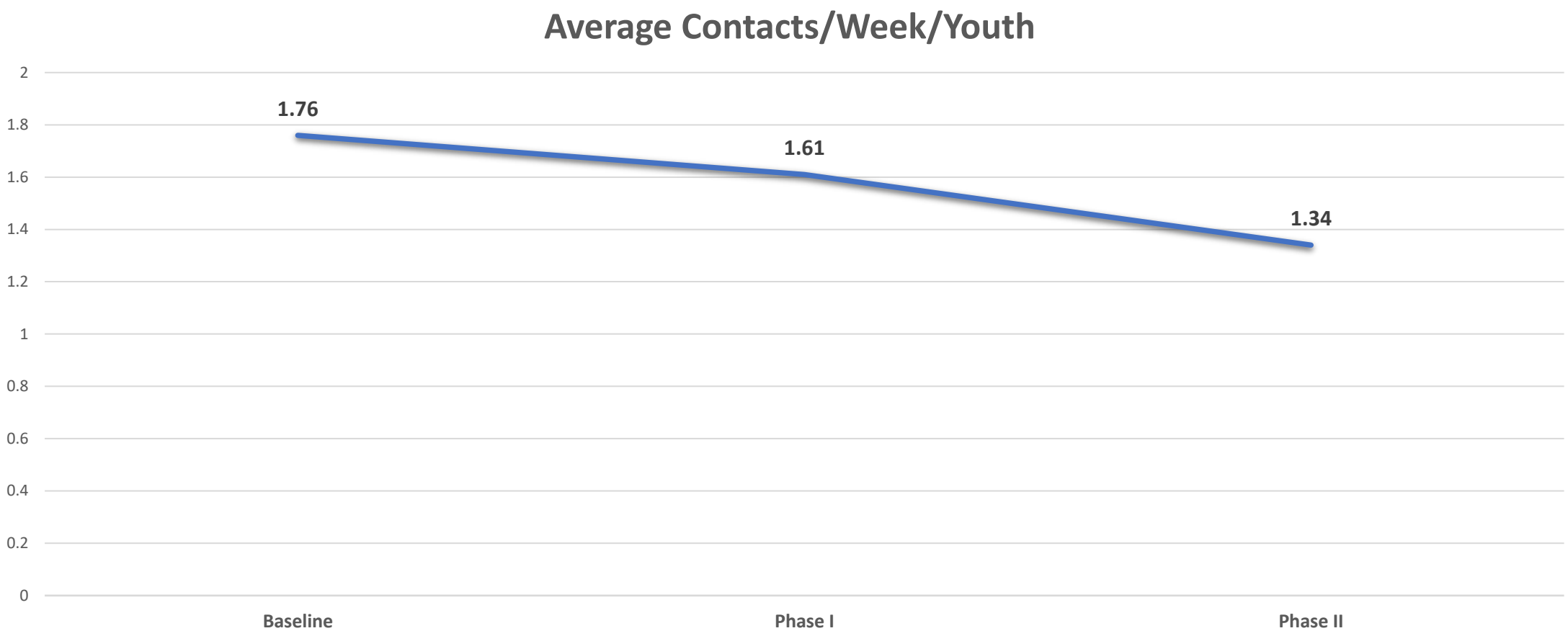
Outcomes

COVID: Setting the Stage

	Baseline	Phase I	Phase II
Youth Served	608	571	517
Crisis Stabilizers	162	151	123
Caseload Average	3.75	3.78	4.2

	Rate of Decrease of Youth Served	Rate of Decrease of Crisis Stabilizers
Baseline to Phase I	-6.1%	-6.8%
Phase I to Phase II	-9.5%	-18.5%
Baseline to Phase II	-14.9%	-24%

Study Question 1: Number of Youth Contacts Across Phases

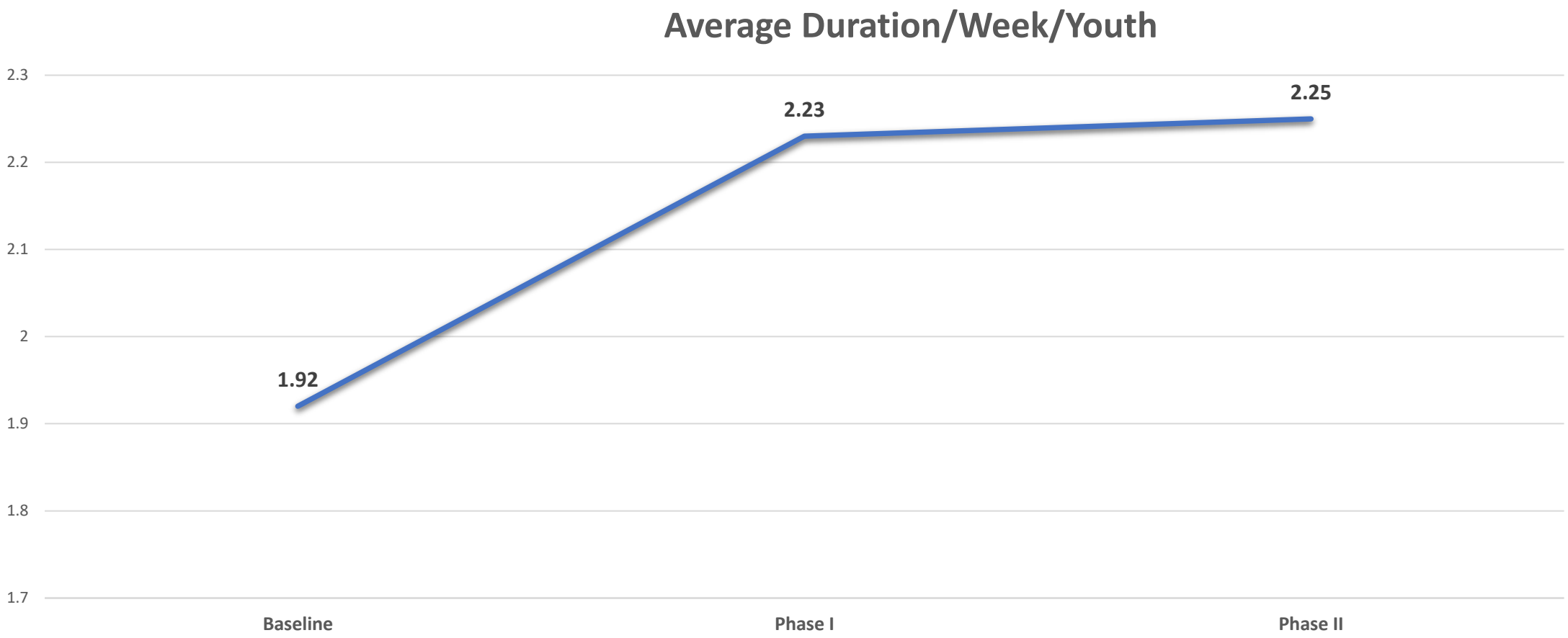


Interpreting the Results: study question I

- External variables related to COVID were so outside characteristic influences
- The pandemic became the tipping point of what has now been coined the *Great Resignation* in which roughly 33 million Americans quit their jobs since the spring of 2021
  - Fewer Crisis Stabilizers → increased caseloads → decrease in the number of contacts
  - From Baseline to Phase I the data revealed an 8.5% decrease in contacts and from Baseline to Phase II a decrease of 23.8%.

- COVID related are the limited platforms for communication
  - Prior to COVID youth would meet with their respective Crisis Stabilizers in school, community, and/or home
  - In Phase I, 43% (6354/14704) and 24% (2752/11096) in Phase II were connected by phone only
  - Only 4.6% (683/14704) and 4.8% (540/11096) in Phase I & Phase II were using video to engage with youth.

Study Question 2: Duration of Youth Contacts Across Phases

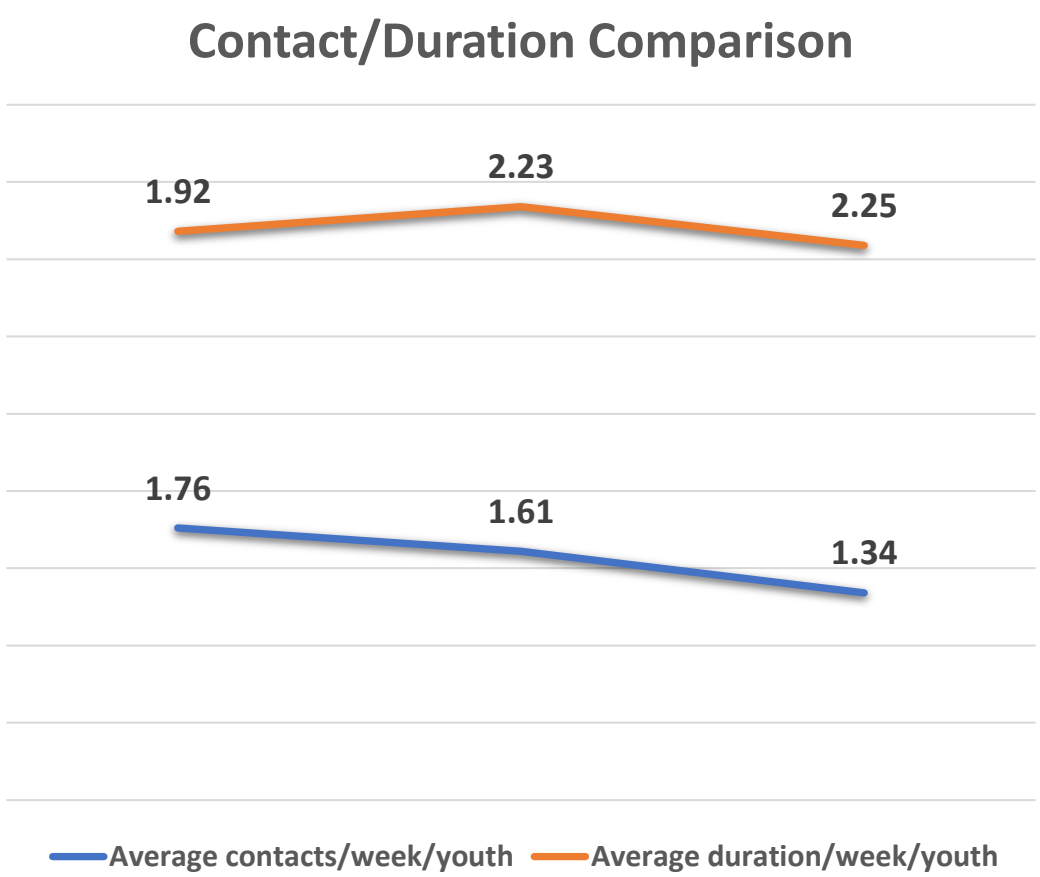


Interpreting the Results: study question II

- The amount of time Crisis Stabilizers spent with youth increased over the course of the study
  - 16.1% increase from Baseline to Phase I, well exceeding the anticipated threshold (10%)
  - 17.1% increase from Baseline to Phase II surpassed the identified 15% threshold

This outcome supports the premise that when youth and Crisis Stabilizers are engaging and relating that the time spent is most meaningful, which contributes to an increased duration of time interacting

Frequency vs Duration Outcome Comparison



- Comparing the number of contact outcomes to the duration outcomes reveals a high negative correlation (r= -0.87)
  - This suggests that as the number of times that Crisis Stabilizers met with youth decreased from Baseline through Phase II, it was **compensated with longer meeting times.**

- Important note: Compensating with longer meeting times would not have been successful if a strong engagement was not present, especially when there is a high percentage of total remote communications by phone and video (a total of 47.8% in Phase 1 and a total of 29.6% in Phase II)

The Focus Group Discussions in Phase II

- 3 sessions
- Questions:
- Session I – Sharing Successes
- Session 2 – Sharing Challenges*
- Session 3 – Engagement of the Family

* Most powerful – lent itself to the most creative thinking & allowed Crisis Stabilizers to let go of their perceived failures – appeared energized by future possibilities

Focus Group Discussion Summary

Trigger Queries	Codes/Themes	Theme Details	
What are some stories that you deemed as successful engagements? What made these engagements successful?	Engagement Techniques	Stop talking/listen Give space Open questions Ask how to help Find common ground Low pressure, low barrier games _____	Be patient Use role plays Find commonalities Tone Sensory techniques Show respect Humor Show authentic self Safety Understand their triggers
	Needs of Youth	Time Stress reduction Giving them control Take ownership Consistency	
What was the biggest engagement challenge you had with youth? What do you think was the major reason for this challenge? What could you have done differently?	Awareness of Problems	Triggers Pandemic Racism Personal issues Holidays Medication concerns _____	
	Ideas to Succeed when there are Problems	Partnering Modeling Admitting mistakes Use relaxation techniques Use music	
How do you engage with the families? How do you incorporate families into your plans with youth?	Family Constellation	Parents Moms Dads Grandmothers	Extended family Foster parent Group Home staff _____
	Family Background	Listening to their rhythms Review the big picture Cultural considerations _____	Struggles of family Understand family dynamics
	Approaches to addressing family	Include family in plan Support family Build trust with family Hearing parent voice	Talk to parent Serve as bridge for all parties Encourage dialogue between family members Have empathy

Impact of COVID

- **The impact of isolation on youth**
  - Engagement Training was modified to include an understanding of the impact of the isolation of COVID on youth in general and more specifically with youth experiencing mental health concerns
- **The challenge of using virtual platforms to engage with youth**
  - What is particularly notable is the 47.8% usage of phones during Phase I which made engagement most challenging. It also may explain why the usage of phones dropped so significantly (29.6%) as soon as the restrictions of the pandemic began to lift during Phase II
- ***The Great Resignation***
  - leaving a significant number of vacancies in every agency (24% drop from baseline).
  - Mitigated somewhat by the 14% drop in enrollees

Conclusions

- As seen in both Phase I and Phase II, the decrease in Crisis Stabilizers influenced by the external variable of COVID was the major contributor to the decrease in the amount of engagement. No training or even providing additional tools could mitigate the power of these external variables
- The duration of the meetings with youth, however, appeared to be strongly influenced by the interventions (formal training, providing the tools organized by topics in buckets, and the FGDs), well exceeding the 10% threshold set in Phase I (16%) and sustaining this a positive momentum in Phase II (17%).
- Real Improvement was evident in the post-study data as follows:

	Baseline	Phase II	Post Study
Crisis Stabilizers	162	123	88
Average Number of Contacts/Week	1.76	1.34	1.21
Average duration of Contacts/Week	1.92	2.25	2.98

The impact of the pandemic on the average number of contacts is consistent with the trend seen throughout the study. The post-study data reveals continued influence of the interventions on the behavior of Crisis Stabilizers and therefore, increased positive engagement of youth

Questions??

Thank you for the Opportunity to Share

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES
BEHAVIORAL
HEALTH SERVICES

WRAPAROUND MILWAUKEE

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES

BEHAVIORAL HEALTH SERVICES

CARS Mid Cycle Report Mental Health Board Quality Committee May 2, 2022

Client Experience of Care

- Continued expansion of Client Experience Survey
- Full implementation of incentivized survey in CSP
- Redesign of Detoxification Services 75.09 ("Sober Up")

Population Health

- Identification of high need zip codes for targeted interventions
- Expanded use of external acute services data for population health evaluation and management
- Submitted grant to provide residential treatment to individuals with co-occurring SPMI and substance use disorders

Staff Quality of Life

- Evaluation of CARS Mentorship Program
- Reassessment of CARS Staff with DISC Assessment
- Evaluation of staff retention among contracted providers

Cost of Care

- Development of additional tools to assist with utilization review
- Review of funding streams to identify opportunities for enhanced investment in social determinants of health
- Ongoing monitoring of equitable spend by race and gender

CARS Research and Evaluation Team

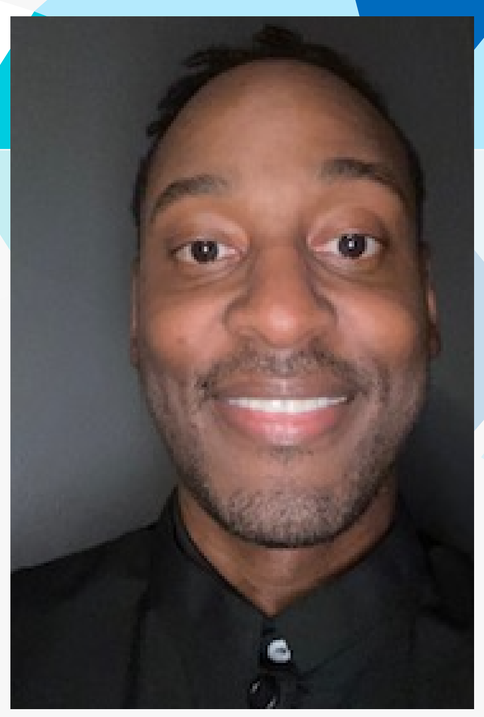
CARS
Authorization Team

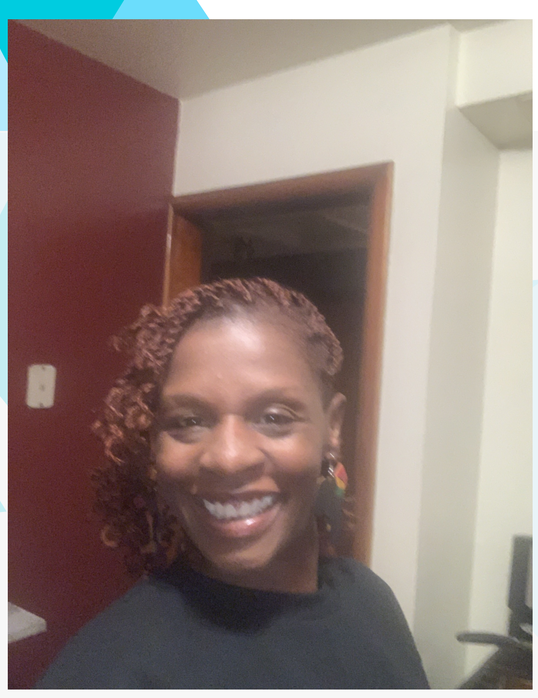
An Overview of It's Purpose, Development, and Progress Thus Far

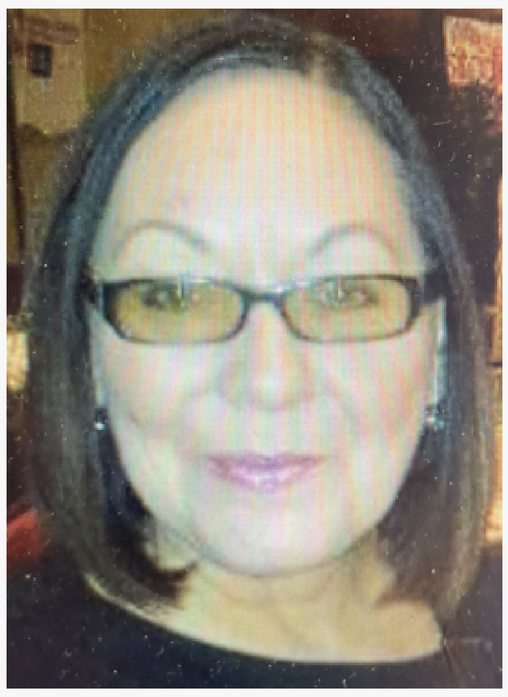
A Presentation to the MHB Quality Committee

May 2nd, 2022

Antoinette Davis and John Moran







Mary Ann Repnik

Where We Started

Prior to the creation of the Authorization Team, each CARS service level functioned relatively independently. If a staff member was out of the office there was no coverage, which delayed the processing of billing for our contracted providers. There was a desire to streamline authorization processes and improve the quality and efficiency of the work that we do.

Formation of the Team

The Authorization Team consists of staff members who perform authorizations in Targeted Case Management, Recovery Support Coordination, Recovery Support Services, AODA Residential, Community Support Program, Crisis Resource Center, Adult Family Homes, Outpatient Plus, Outpatient Treatment, Crisis Case Management and Community Based Residential Facilities. Staff members have been or will be cross-trained to provide coverage across all levels of care

Goals Achieved

Below are a list of significant enhancements that have resulted from the authorization team's efforts.

Goal 1

Created a standardized authorization process flow

Goal 2

Developed a report that provides supplemental data for more efficient utilization review

Goal 3

Developed a report that tracks the efficiency of the authorization submission and utilization review process

Goal 4

Implemented deep dive audits based on agency performance

Goal 5

Developing a widget to track status of existing or pending commitments

Key Metrics

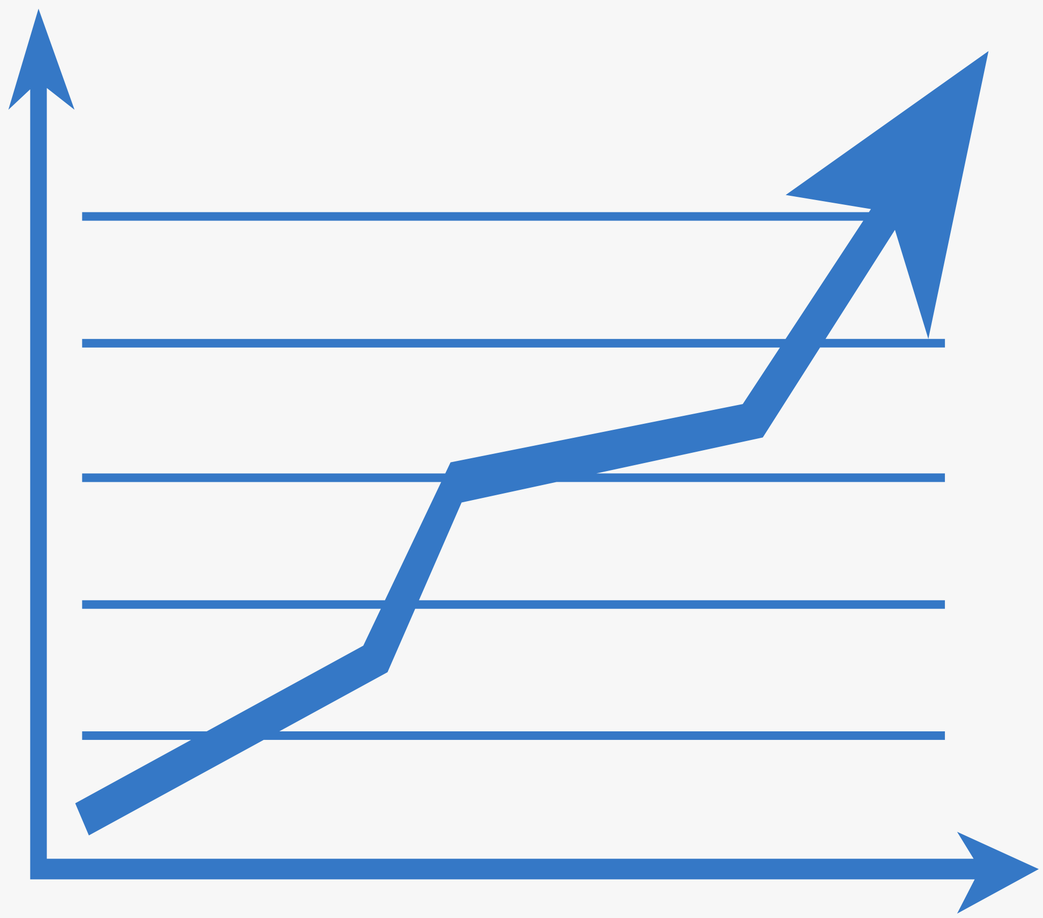
A Growing Team

The authorization team has grown from 9 to 12 team members since its inception in May of 2020.

The team started with 4 case management programs and has now expanded to include all outpatient, residential and recovery support services in CARS.

A Cross-Trained Team!

The number of authorization reviews completed by authorization team members in programs to which they are not traditionally assigned grew from **57** in 2020 to **284** in 2021**!**



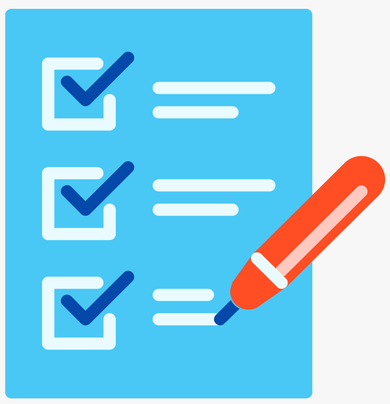
Key Metrics

Authorization Team Member Survey Results

In April of 2022, the 12 Authorization Team members completed a survey on their experiences. Their responses are listed below.

83% (n=12) report the team has helped them to be more objective in their authorization work

75% (n=12) of team members report developing closer relationships with colleagues



92% (n=12) of team members report gaining a better understanding of other programs in CARS

75% (n=12) of team members report that the team helps them to be more effective at their job

92% (n=12) of team members report they are able to more efficiently manage coverage issues

Next Steps

We will continue to cross train Authorization Team staff to provide coverage for all levels of care to enhance our customer service to our contracted providers.

"I think the Authorization Team has done great work to streamline processes and give a more consistent, meaningful and timely experience to our providers."

- Authorization team member

Summary

- The authorization team and programs included has grown
- Coverage has improved
- The authorization process has become more efficient
- The focus of authorization team's work has shifted from *volume to quality of services*
- Key tools have been developed
- The team has become a cohesive unit

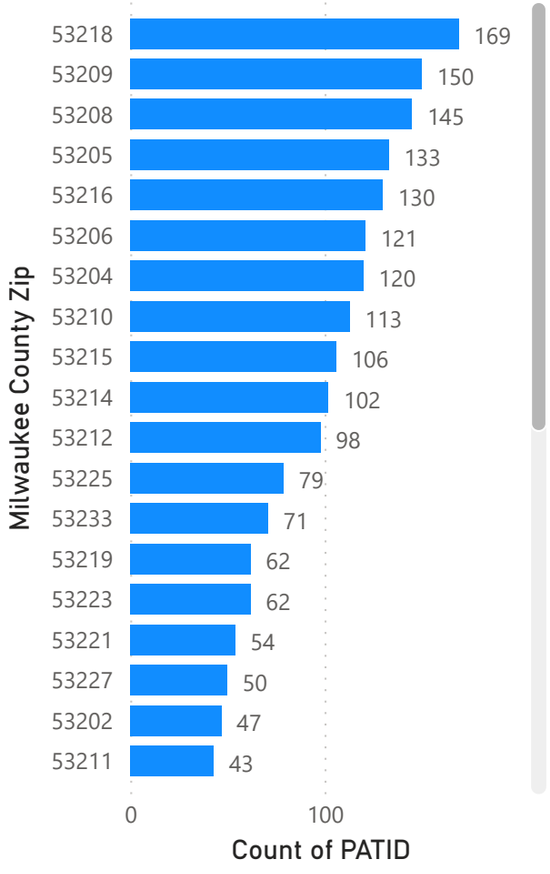
MILWAUKEE COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH SERVICES

Community Crisis Dashboard Q4 2021

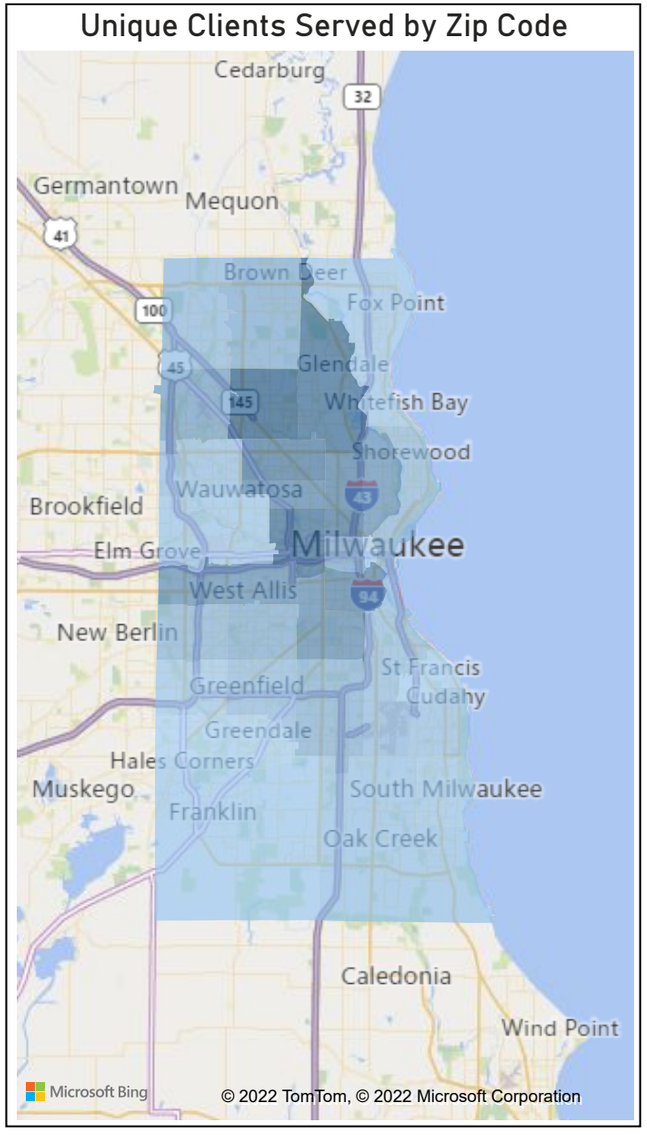
Clients with at Least One Crisis Service

2358

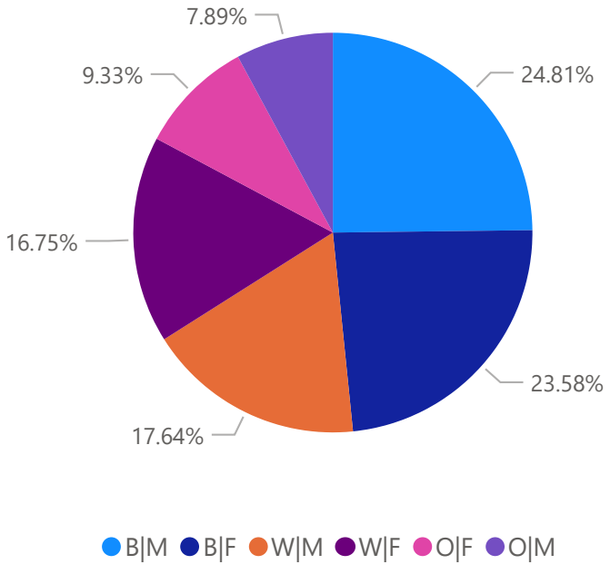
Unique Clients Served by Zip Code



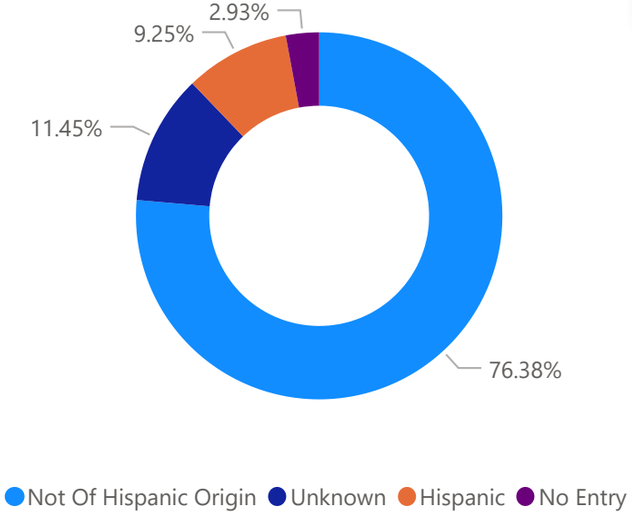
Unique Clients Served by Zip Code



Unique Clients by Race and Gender



Unique Clients by Ethnicity



Summary

This is the inaugural Community Crisis Departmental Dashboard. The dashboard currently displays disaggregated information reflecting the volume of unique clients, that received an actual service, by zip code, race, gender, and ethnicity, along with average client experience scores (OCA, CLASP, CMT). This iteration of the Community Crisis Dashboard does NOT include data from hospital-based crisis services (PCS or Observation), from anonymous crisis line callers, or from crisis line services provided by Impact Inc. Additional data points will be incorporated over time to include identified information about client outcomes, population health, and data from community partners.

Client Experience Scores

Total (N=92): **4.45**

Black (n=53): **4.41**

White (n=27): **4.61**

Other (n=12): **4.27**

MILWAUKEE COUNTY

SHAKITA LaGRANT-McCLAIN, MBA • Director
MICHAEL LAPPEN MS, LPC • Division Administrator

March 24, 2022

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

Re: Notice regarding Whole Health Clinical Group (WHCG) Comprehensive Community Services (CCS)

Dear Mr. Chianelli,

Milwaukee County Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) is submitting this communication as notice that we will resume making referrals to the Whole Health Clinical Group Comprehensive Community Services (CCS). It is the expectation that WHCG CCS will be able to begin resuming referrals and that the clinical work will continue to be conducted in accordance with all federal, state, local regulations and MCBHD policies.

CARS is pleased to recognize the improvements initiated and sustained by the WHCG CCS leadership team. Compliments to WHCG CCS on demonstrating improvement and maintaining the improvements consistently. In the first quarter of 2022, two client records were audited, and both found to be very good. A billing report was also audited, and all instances of billing travel had a Medicaid service attached. Most notable is that annual reviews are no longer occurring on the same day and that care coordinators have stopped providing direct services. Additionally, concerns regarding the over-utilization of telehealth and lacking appropriate signatures on documents due to telehealth services appears to no longer be a problem. It has also been observed that the concerns regarding the Recovery Plan of Care missing staff billing CCS services has been resolved.

It is apparent that the WHCG CCS Quality Improvement Response Plan that was created by WHCG leadership has been implemented and attention given to sustaining the improvements achieved. This has resulted in all the recognizable improvements, to include great improvement of the thoroughness and accuracy of SARs being submitted which now rarely results in a denial. Lastly, the issue of long periods of time with no case notes being entered for individual clients has improved but continues to need attention from the leadership of the WHCG CCS program. If you have any questions regarding this notification, please let me know.

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.

MILWAUKEE COUNTY

Sincerely,

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

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH
& HUMAN SERVICES
BEHAVIORAL
HEALTH SERVICES

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Milwaukee County Mental Health Board
Community Stakeholder Advisory Council
Charter

Committee's Official Designation

Mental Health Board Community Stakeholder Advisory Council ("Advisory Council")

Authority

The Advisory Council is established under Mental Health Board authority pursuant to and in accordance with the provisions of WI State Statutes Chapter 51.41. The Advisory Council is established as an advisory group of the Mental Health Board Community Engagement Committee.

Jurisdiction

The Advisory Council shall exercise its responsibilities within Milwaukee County.

Duration

The Advisory Council will serve indefinitely on a continuing basis. Start Date TBD.

Statement of Purpose

The Community Stakeholder Advisory Council has a three-fold purpose:

1. The Advisory Council strategically engages consumers, families, and communities as primary stakeholders in BHS service system planning and delivery to support Milwaukee County's vision to achieve racial and health equity.
2. The Advisory Council strengthens Milwaukee County's overall strategy to address behavioral health within the community though ongoing communication of BHS provider network services and related outcomes.
3. The Advisory Council provides an additional strategic mechanism for the Mental Health Board to proactively gather information regarding the quality of consumer, family member, and advocate experiences with BHS-supported services including Granite Hills Hospital and the Mental Health Emergency Center (MHEC).

Composition

The Advisory Council consists of no less than 11 and no more than 15 community members representing the following constituencies:

- Consumer/Peer
- Young Adult Consumer/Peer
- Family Member/Parent
- Advocate
- Caregiver
- Faith Community
- Criminal Justice System

Scope of Work

The Advisory Council centers its work upon the experiences of consumers and families with additional involvement of advocates, the faith community, and members of the non-provider public.

The Advisory Council convenes to create new opportunities for dialogue about behavioral health within Milwaukee County's diverse communities and beyond.

The Advisory Council aims to illuminate the experiences of consumers and families for Mental Health Board policy-making efforts.

Council Activities

1. Provide consumer experience reports to the Milwaukee County Mental Health Board Community Engagement and Quality Committees as well as the leadership of Granite Hills Hospital and the Mental Health Emergency Center.
2. Raise community awareness of the planned PCS closing and highlight the services to be provided by Granite Hills and the Mental Health Emergency Center.
3. Foster increased knowledge of and participation at Mental Health Board Meetings and Public Hearings to address community mental health and substance use priorities.
4. Promote BHS services and share success stories with the community to reduce mental health stigma and support access and participation.
5. Support quality initiatives by gathering information about consumer and family experiences with contracted BHS services including Granite Hills Hospital and the MHEC for Mental Health Board consideration.

Member Terms

Council members may serve staggered terms for two (2) or three (3) years with the option to be renewed for a maximum of five years of service. All members shall serve on a voluntary basis (without compensation).

Member Recruitment and Onboarding

Individuals interested in serving on the Community Stakeholder Advisory Council are asked to contact the Council Chair. Council Members will be provided with training and resources to support their service.

Description of Member Duties

1. Attend meetings regularly.
2. Be a visible presence to share ideas and concerns from consumers of mental health services and family members.
3. Actively contribute to the creation of consumer experience updates to the leadership of BHS-supported community services with a special emphasis upon the transition to Granite Hills Hospital and the Mental Health Emergency Center.
4. Share Advisory Council and BHS updates with personal and/or professional contacts.
5. Invite community members to attend Council meetings, Mental Health Board meetings and public hearings.

Agency or Official to Whom Council Reports

Advisory Council Chairperson: Brenda Wesley. Reports will be provided to the Mental Health Board Community Engagement and Quality Committees.

Meeting Schedule

The Council shall hold monthly meetings for the initial six months followed by bi-monthly meetings thereafter. Meetings will be noticed for the public to attend.

Decision-Making

Any decisions that are required will be made at the discretion of the Council Chair with input from Council members.

Budget

The annual operating costs of establishing and maintaining the Advisory Council is TBD. BHS will provide administrative support for the Council. Estimated Annual Operating Costs include meeting expenses, staffing, marketing and communications (website, social media and email communications).

Record-Keeping

The records of the Advisory Council will be kept in accordance with Milwaukee County public meeting protocols.

Adoption Date: April 18, 2022

Milwaukee County Behavioral Health Division

2022 Infection Prevention & Control Program Plan

Purpose:

The Infection Prevention and Control Program is committed to identifying and minimizing, reducing, or eliminating the endemic and epidemic risks of infections in our patients, staff, vendors, visitors, students, and others in the community.

Scope:

The scope of the Infection Prevention and Control Program includes all of Milwaukee County Behavioral Health Division including all staff, volunteers, students and independent licensed practitioners.

Plan:

A. Authority

The Infection Preventionist (IP) and the Infection Prevention Chairperson have the authority vested by the Administration and Medical staff to initiate any emergency infection control measures deemed necessary for the protection of patients, staff, vendors, visitors, students, and others in the community.

1) The Infection Preventionist (IP) and the Infection Prevention Chairperson have the authority to conduct studies of personnel or of the environment where outcome can be expected to have a beneficial effect on standards of care, or to support change in maintenance practices, personnel practices or equipment care and maintenance.
    i. All data collected through studies made as a part of process improvement will be reported out to the Infection Prevention and Control Committee and will be shared with the appropriate department leaders in the form of improvement plans as appropriate.
    ii. The Infection Preventionist, Infection Prevention Chairperson, and the Infection Prevention and Control Committee have the authority to initiate improvement plans, to work with department leaders to establish plans and monitor progress, and to inform Administration of improvement plan initiation and progress.

B. Infection Prevention and Control Management and Staffing

1) The Infection Prevention and Control Committee Chairperson is an appointed physician from the medical staff by the Medical Executive Committee

Currently, the Infection Preventionist is the Chief Nursing Officer (CNO). The CNO has direct accountability for the Infection Preventionist role and has been the backup Infection Preventionist when the position has been historically vacant. She has infection prevention and control experience in hospital, long term care, community, and home care settings. She holds a Master's Degree in Nursing and is scheduled to sit for the national Board Certification examination this year.

i. The Infection Preventionist is considered the "Infection Control Officer" responsible for developing and implementing or assisting with the implementation of policies governing prevention and control of infections and communicable diseases. In addition, this individual has the responsibility for reporting, investigating, and controlling infections and communicable diseases identified in patients and staff, and for maintaining records of incidents related to infections and communicable disease. The Infection Preventionist assists the local, state, and national Public Health Departments in outbreak investigations and reporting of required diseases and conditions.

C. Infection Prevention and Control Committee (IPAC)

1) The IPAC is an interdisciplinary team that oversees activities related to surveillance, prevention and control of infections. Membership includes, but is not limited to, representation from:
   i. Administration
   ii. Medical Staff Services
   iii. Psychology
   iv. Nursing
   v. Clinical Laboratory/Microbiology
   vi. Environmental Services
   vii. Dietary
   viii. Pharmacy
   ix. Quality Improvement
   x. Education Services
   xi. Consumer Affairs
   xii. Maintenance
   xiii. Operations
2) Responsibilities of the IPAC Committee members include, but are not limited to:
   i. Communication with the Infection Preventionist when infection prevention concerns are identified within their respective areas/departments.
   ii. Dissemination of information back to the groups they represent and keep the committee advised of areas of concerns in their areas/departments.
   iii. Development of infection prevention education as needs are identified.
   iv. Completion of required audits pertaining to infection prevention, including but not limited to hand hygiene audits.
   v. Participation in and recruiting for scheduled infection prevention rounding team activities in designated areas.
   vi. Participation in process improvement projects initiated as a part of the yearly infection prevention program goals or implemented as a part of a plan of improvement initiated from findings from rounds or incident review.
   vii. Evaluation and approval of new products or product changes applicable to Infection Preventions (e.g., cleaning or disinfection products, waste management products, or items used for sterile/aseptic technique).
   viii. Development, review, and approval of all Infection Prevention and Control Policies, Procedures, Guidelines and Plans on a yearly basis.
   ix. Participation in Root Cause Analysis (RCA) when events or near misses are identified.

x. Review of exposure events, and safeguards in place to prevent bloodborne pathogen exposures.
xi. Review and Approval of the Annual Facility Tuberculosis Risk Assessment.
xii. Review and Approval of the Annual IPAC Proactive Risk Assessment (PRA) and Hazard Vulnerability Analysis (HVA).
xiii. Review and Approval of the IPAC Program Goals based upon HVA on an annual basis.
xiv. Periodic evaluation of progress towards meeting IPAC Program Goals throughout the course of the year.

D. Surveillance Resources

1) Access to information needed to support the Infection Prevention and Control Program is made available via several sources:
   i. Patient records are assessed via Avatar, the Electronic Medical Record (EMR) for MCBHS.
   ii. Avatar is also the source for admission and patient day data.
   iii. Wisconsin Diagnostic Labs provides electronic access to laboratory data and submits notification via currier serviced to the Infection Preventionist when a lab result indicating a public health reportable condition is identified (e.g., STD). Laboratory data for public health reportable diseases is electronically reported to public health from Wisconsin Diagnostic Labs.

E. Surveillance Activities

1) The process used to determine and develop Infection Prevention and Control surveillance activities includes a targeted approach to high-risk, problem prone and preventable infections. The annual process used to determine surveillance activities has included:
   i. Data and analysis of existing issues and trends
   ii. Infection Control Proactive Risk Assessment and Hazard Vulnerability Analysis
   iii. Applicable local, state and federal regulations
   iv. Requirements by accrediting organizations
   v. Nationally recognized recommendations and guidelines
   vi. Evidence-based national guidelines
   vii. Expert consensus

2) Surveillance activities designed to minimize, reduce, or eliminate the risk of infections include:

--Monitoring high-risk organisms such as, but not limited to:
SARS CoV- 2, Mycobacterium tuberculosis, Methicillin Resistant Staphylococcus aureus, Vancomycin Resistant Enterococcus, Clostridium difficile, & Aspergillus.
--Monitoring for the presence of reportable diseases or conditions with public health significance such as sexually transmitted diseases.
--Monitoring for communicable disease incidence and implementation of transmission-based precautions for the prevention and control of disease clusters or outbreaks within the behavioral health setting.
--Review of the National Patient Safety Goals.
--Monitoring of Hand Hygiene compliance data.
--Reviewing any identified cases of unanticipated death or major permanent loss of function associated with an infection.
--Performing targeted compliance rounds and audits to assess accordance with Infection Prevention and Control principles, policies, and procedures to identify potential risks for infection from practice or the environment.
--Monitoring health care worker influenza vaccination compliance data as reported to the Centers for Disease Control and Prevention via NHSN on an annual basis.

--Monitoring of patient influenza vaccination data as communicated to Medical Staff, Nursing Leadership, and Quality Departments.

F. Outbreak and Communicable Disease Exposure Investigation

1) In addition to planned surveillance indicators, special studies are conducted in the event of an increase in infections from baseline including identification of clusters or outbreaks, or identification of an unusual or epidemiologically significant organism.
2) Any suspicion of a potential outbreak of infectious disease are reported to the Infection Preventionist by various sources, e.g., lab, physicians, nursing staff, public health, etc. Outbreak investigation and implementation of infection controls is done under the guidance of the Infection Preventionist and the Infection Prevention and Control Committee Chairperson.
3) If patients are thought to have been potentially exposed to infectious disease, the Infection Preventionist will consult with the Infection Prevention and Control Committee Chairperson, Public Health and the patient's attending as needed to determine appropriate assessment, testing, immunization, prophylaxis/treatment and counseling.

G. Influenza Prevention

1) The Infection Preventionist coordinates flu vaccine clinic availability for staff, and tracks data for completion of flu vaccination as reported to NHSN.
2) Flu vaccination is also available and encouraged for inpatients during the active flu season with data reported to CMS by the Quality Department.

H. Covid-19 Disease Monitoring and Vaccination Status

1) The Infection Preventionist coordinates in house Covid-19 vaccination clinics, tracks required Covid vaccination status of employees and vendors and reports outbreaks to a variety of sources including Public Health, the CDC through the NHSN and will coordinate future staff and vendor clinics as deemed necessary by community needs.
2) All pandemic PPE supplies and equipment are tracked, monitored, and distributed by the EES and nursing departments in conjunction with Infection Prevention.

I. Facility Tuberculosis Risk Assessment

1) The Infection Preventionist conducts surveillance for cases of latent and active tuberculosis. Data is reviewed on an ongoing and annual basis and a facility risk assessment is completed following the programs Prevention of Tuberculosis Plan. The Facility TB Risk Assessment will determine if staff are required annual testing for positive TB or screened via questionnaire.

J. Demographics

1) The IPAC Program for surveillance, prevention, and control of infections is primarily hospital based with the Infection Preventionist having a consultative role organization-wide.
2) The design of the IPAC activities include consideration of the organization's uniqueness, including the characteristics of the community, patient population, and available services.

K. IPAC Program Goals

1) IPAC Program Goals have been completed on an annual basis. As the hospital will be closing in 2022, terminal goals for the hospital are a continuation of the 2021 plan.

L. Evaluation

3) The IPAC Program is evaluated on an annual basis. A final evaluation will include a summary of the 2022 plan, as well as goal measurements and effectiveness of the program.

Milwaukee County Behavioral Health Division

2022 Infection Prevention & Control Program Plan

2021 End of Year Report and Ongoing 2022 Plan

Risk:	Goal:	Measure:	Objective Status (Met/Partially Met/Not Met:
Risk for Non-Compliance with Hand Hygiene	Goal of 80% compliance for staff Hand Hygiene Audits and a minimum of 15 audits will be completed quarterly for each unit.	House Wide 91% Hand Hygiene Compliance for 2021	Met
Risk for Non-Compliance with Hand Hygiene	Patients receive hand hygiene education upon admission.	Confirmed that hand hygiene education is currently include welcome education packets. No current method for auditing documentation of welcome education packet.	Met
Risk for Non-Compliance with Standard Precautions - PPE Use	Goal of 90% PPE use per Standard Precautions observed on Hand Hygiene Audits.	91% Compliance on Hand Hygiene Audits	Met
Risk for Non-Compliance with Standard Precautions - Safe Injections Practices *(Shadow Measure)*	Each inpatient unit will complete a minimum of one Safe Injections Practice Audit	No issues identified.	Met
Risk for Non-Compliance with Standard Precautions - Regulated Medical Waste Disposal	The MCBHD Acute Inpatient Hospital will reduce regulated medical waste (red biohazard bag) disposal to maintain under 50 pounds per month.	Consistently under 50 lbs./month	Met
Risk for Non-Compliance with Standard Precautions-Respiratory Hygiene Patients	Patients receive respiratory hygiene upon admission.	Confirmed that respiratory hygiene education is currently include welcome education packets. Patient education regarding SARS CoV-2 (Covid-19) is done for all patients. Goal: 90% compliance	Met

Milwaukee County Behavioral Health Division

2022 Infection Prevention & Control Program Plan

Risk for Non-Compliance with Standard Precautions-Handling of Patient Belongings	Standardize the practice for handling of patient belongings to minimize risk of infection.	Property room-Maintenance of policy and procedures. Goal of 90% compliance through quarterly auditing.	Met

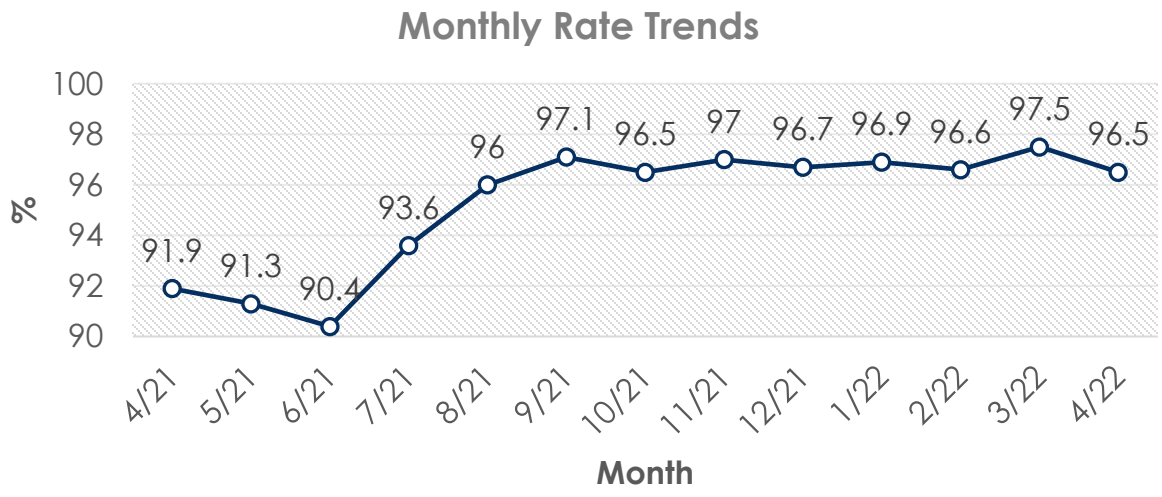
Overall Progress 96.5% as of April 1, 2022

Baseline 71.5% as of August 2016 LAB report

9

Current Goal = 96%

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	662	655	97.5%	96.5%
Up to 1-year Overdue	13	20	1.9%	2.9%
More than 1 yr & up to 3 yrs overdue	1	1	0.1%	0.1%
More than 3 yrs & up to 5 yrs overdue	3	3	0.4%	0.4%
More than 5 yrs & up to 10 yrs overdue	0	0	0.0%	0.0%
Total	675	679	100%	100%



Past Due by Policy Area	Past Due
Community Access to Recovery Services (CARS)	1
Division Administration	1
Infection Prevention	7
Medical Staff Organization	1
Medical Staff Organization	1
Mental Health Board	3
Provision of Care - Psychiatry	1
Pharmacy	1
Provider Network-Credentialing and Impaneling	1
Public Safety	5
Quality Management	1
Wraparound (Wrap, REACH, youth CCS)-Vendor	2
Total Past Due	**23**

12 Month Forecast Due for Review	
Month/Year	# Due
April 2022	5
May 2022	14
June 2022	28
July 2022	19
August 2022	18
September 2022	17
October 2022	20
November 2022	14
December 2022	19
January 2023	10
February 2023	9
March 2023	18
April 2023	20

March Activity

New Policies	0
Reviewed/Revised	8
Retired	0

MILWAUKEE COUNTY
DEPARTMENT OF HEALTH & HUMAN SERVICES

May 2022

Quality Management Strategy & Action Plan

Prepared by T.J. Cobb, Milwaukee County DHHS Enterprise Quality Director

Presented to Milwaukee County Mental Health Board Quality Committee

“Good quality management aims to unite an organization’s stakeholders in a common goal, improving processes, products, and services to achieve consistent success.”

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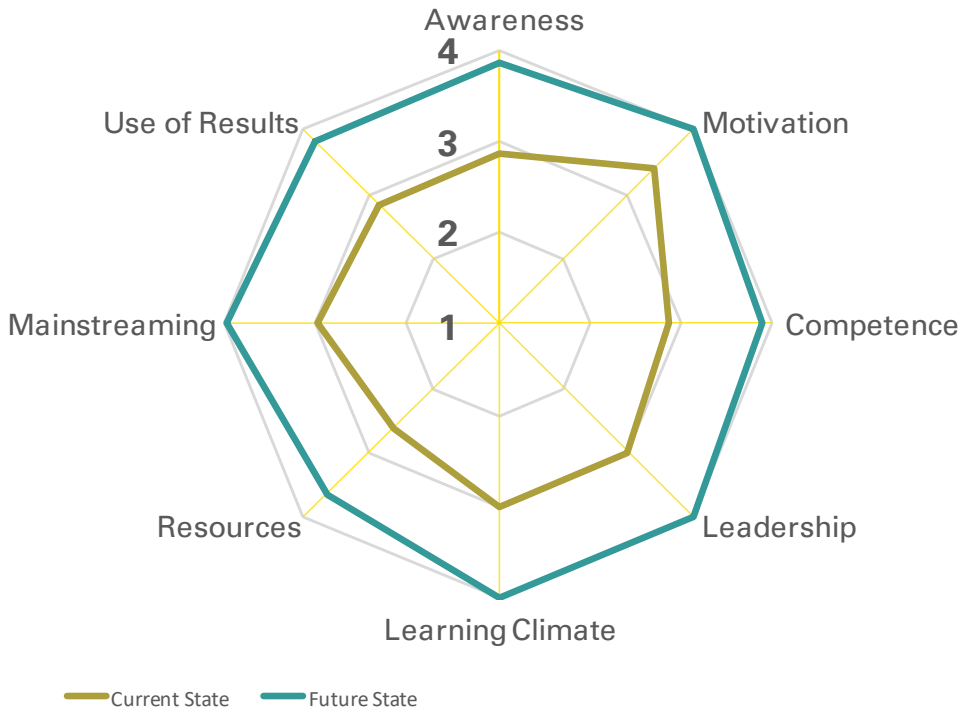
SURVEY SAYS!

Resources is the department's greatest capacity need.

Capacity Component	Current State	Future State
Individual Factors		
Awareness	2.86	3.86
Motivation	3.40	4
Competence	2.87	3.87
Organizational Factors		
Leadership	2.99	4
Learning Climate	3.01	4
Resources*	2.63	3.63
Capacity Outcomes		
Mainstreaming	2.96	3.96
Use of Results*	2.82	3.82

Overall mean scores out of 4.

**Resources and Use of Results were informed only People Leaders*



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Needs Assessment Summary Findings

The key strategic pillars help to advance DHHS efforts in developing a Quality Management System by addressing **major limitations identified in the Quality Culture and Capacity Needs Assessment are**:

1.) coordination and unity across service areas;

2.) engagement to contribution to results;

3.) standardize and streamlined data collection and reporting;

4.) capacity building;

5.) department-wide policies and procedures and,

6.) resource allocation for QM activities.

	Coordination and unity across service areas	Engagement to contribute to results	Standardized data collection and reporting	Capacity building	Resource allocation for activities
Strengths	-integration of service (ADS) -existing workplace culture efforts to develop harmony -various communication approaches (workgroups, townhalls, etc.) -BHS Quality Committee and Quality Improvements efforts	-motivated staff -various engagement efforts (e.g., Town Hall, Culture Corner, People Leaders, etc.) -various engagement techniques (e.g., Menti polls, team feedback mtgs., feedback survey, etc.)	-process existing within service and programs -DHHS Civil Rights Compliance pilot efforts -DHHS Critical Incident Policy	-dept-level training policies and strategies are in development -performance plans	-untapped technology budget -existing re-organization effort underway.
Challenges	-lack of service level goals aligned with dept goals - inefficient information sharing process and tools -duplicative quality improvement efforts -miscommunication of existing QM-related efforts	-unrealistic expectations for current capacity -policy and process created in silos -various areas lack QM-related capacity -leadership styles -staff engagement approaches -community engagement strategy	-various external requirements reporting -undefined DHHS success indicators -standardize collection criteria -data entry automation -lack of data entry capacity -standardize data reporting process	-define competencies specific to operational needs -uncertain operation needs and unclear service goals -staff resources -effective use of technical tools	-funding restrictions -existing budget deficits -low staff capacity -policy advocacy efforts
Opportunities	-better defined roles and responsibilities to align with clear program objectives and dept. goals. -develop operation plan by service areas	-understand leadership existing competencies -cross functional project teams -stakeholder engagement	-develop shared-terminology -identify dept level needs -assess lessons from pilot efforts -develop standard data collection tools -develop and implement data management strategy and policies	-learning circles -fellowships -develop a capacity building plan - resource library -Self-paced learning -Reflective practice -Public info about QM	-initiate fundraising efforts -clearly define role and responsibilities in alignment with operational need consistently across the department -prioritize policy advocacy

Need Assessment Findings

	Coordination and unity across service areas	Engagement to contribute to results	Standardized data collection and reporting	Capacity building	Resource allocation for activities
Strengths	-integration of service (ADS) -existing workplace culture efforts to develop harmony -various communication approaches (workgroups, townhalls, etc.) -BHS Quality Committee and Quality Improvements efforts	-motivated staff -various engagement efforts (e.g., Town Hall, Culture Corner, People Leaders, etc.) -various engagement techniques (e.g., Menti polls, team feedback sessions,	-process existing within service and programs -DHHS Civil Rights Compliance pilot efforts -DHHS Critical Incident Policy	-dept-level training policies and strategies are in development -performance plans	-untapped technology budget -existing re-organization effort underway.
Challenges	-lack of service level goals aligned with dept goals - inefficient process for sharing process and tools -duplicative quality improvement processes -miscommunication of existing QM-related efforts	-unrealistic expectations for current capacity -poor communication/retention in silos -various areas lack QM-related capacity -leadership styles -staff engagement approaches	-various external requirements/reporting -undefined DHHS success indicators -standardize collection criteria -data entry automation -lack of data entry capacity -standardized reporting process	-define competencies specific to operational needs -uncertain operation needs and unclear service goals -staff resources -effective use of technical tools	-funding restrictions -existing budget deficits -[illegible] capacity -policy advocacy efforts
Opportunities	-better defined roles and responsibilities to align with clear program objectives and dept. goals. -develop operation plan by service areas	-understand leadership existing competencies -cross functional project teams -stakeholder engagement	-develop shared-terminology -identify dept level needs -assess lessons from pilot efforts -develop standard data collection tools -develop and implement data management strategy and policies	-learning circles -fellowships -develop a capacity building plan - resource library -Self-paced learning -Reflective practice -Public info about QM	-initiate fundraising efforts -clearly define role and responsibilities in alignment with operational need consistently across the department -prioritize policy advocacy

The momentum to enhance coordination supports opportunity for capacity building, however—resource allocation for these activities are the greatest challenge.

Need Assessment Findings

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Quality Management Strategy

A well-functioning quality management system **prioritizes monitoring, evaluation and learning functions for accountability**. A centralized, structured, and reliable system will give means to:

- **Support program implementation**
- **Contribute to an organizational learning climate**
- **Ensure compliance and accountability**
- **Increase transparency and opportunity for organization transformation**
- **Promote and recognize accomplishments**

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Quality Management

Framework

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“

Successful quality management was never intended to be only one individual’s responsibility.

”

QUALITY MANAGEMENT

Priority

Technical Assistance
Policy Guidance
Strategy

Operational-Functions

Workforce Development
Staff Training
Employee Engagement
Performance Improvement
Capacity Building

Network Management
Community Engagement
Partnership Coordination
Critical Incidents Monitoring
Client Rights
Policy Planning
Risk Management

Communication
Report Writing
Policy Development
Information Management
Change Management

Technology
Application Development

Monitoring x Evaluation
Research x Analytics
Program Planning
Process Mapping
Data Management
Compliance/Audits

Change Management-Standardization

Information Reporting
Policy Guidance
Implementation

Service-Program Activities

Compliance
Assurance
Client Rights
Participant Satisfaction
Contract/Vendor Coordination
Data Collection
Reporting

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Difference between Monitoring and Evaluation

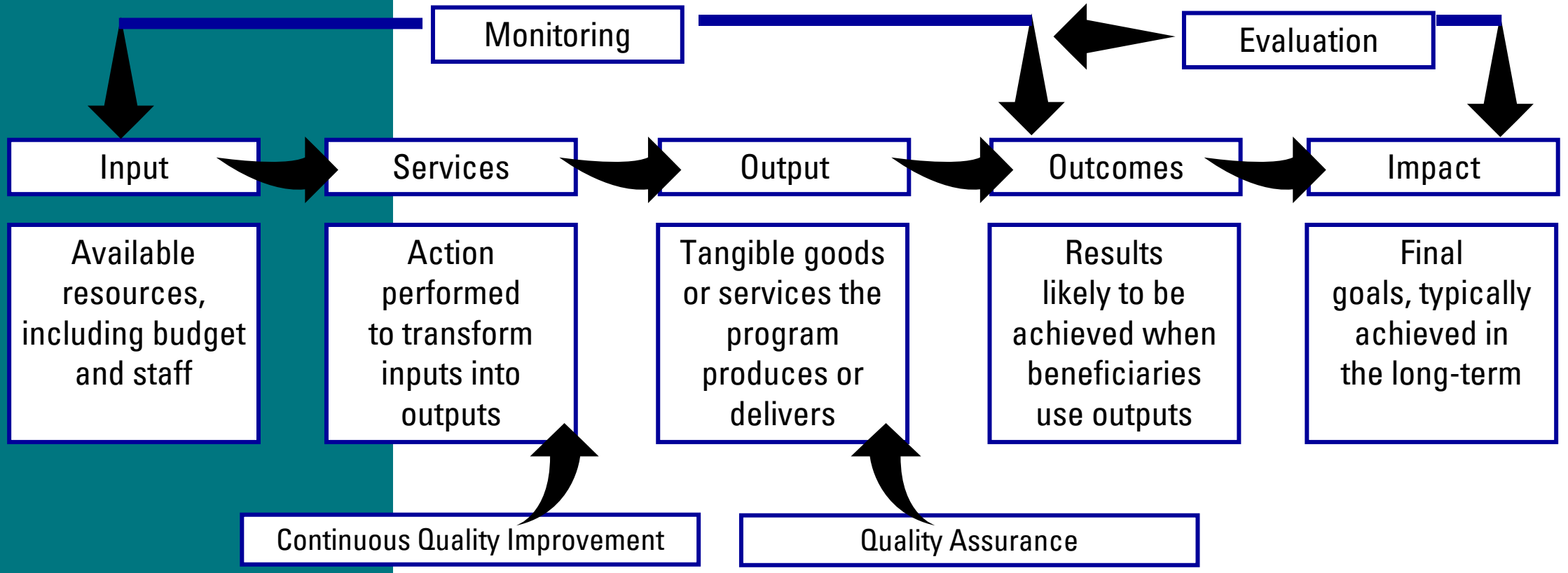
Monitoring

- **Ongoing** throughout the program cycle
- **Keeps track, reviews and reflects** on progress (or lack thereof) in relation to program or service objectives or requirements
- Usually, **internal organizational** activities carried out by program staff
- Does not usually have judgments on the performance of a project
- Let you know what activities were implemented and **what results were achieved**
- Alerts program managers to **problems and provides options** for corrective actions

Evaluation

- **Periodic**: before, at the midterm and/or after the program as needed
- In-depth **analysis** to compare planned with actual achievements in relation to program or service objectives and expected outcomes
- Can be **an internal and/or external** process conducted by staff or an independent party
- Have **value judgement** statements which give an 'opinion' of the performance of the project.
- Same things as Monitoring, but also let you **know how the results** were achieved
- **Contributes to building theories** and models for change; provides **strategy and policy options; increases accountability** to program stakeholder

Monitoring & Evaluation Function



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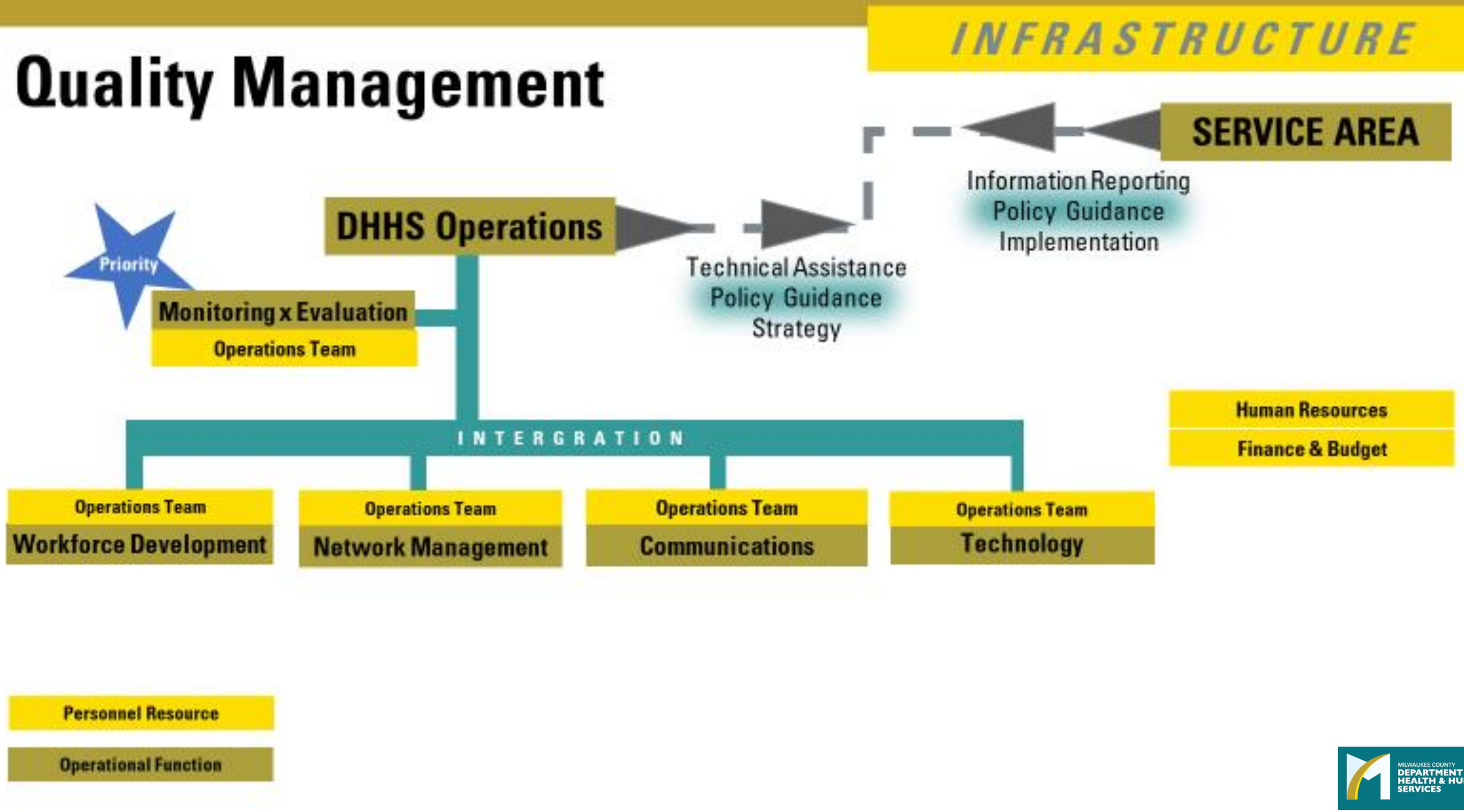
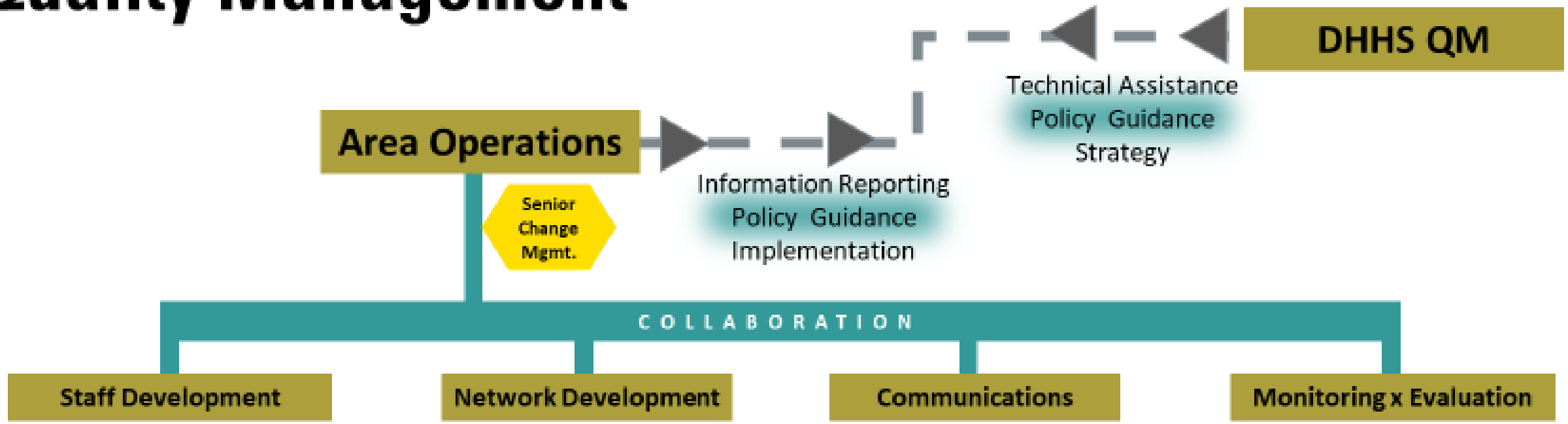
Quality Management



INFRASTRUCTURE

Quality Management



Scope of works should be defined and aligned with program needs. Each units work collaboratively to support programs/services.

Program Manager, Program Associates, Program Coordinators, Program Specialist, Program Assistants

Personnel Resource

Operational Function

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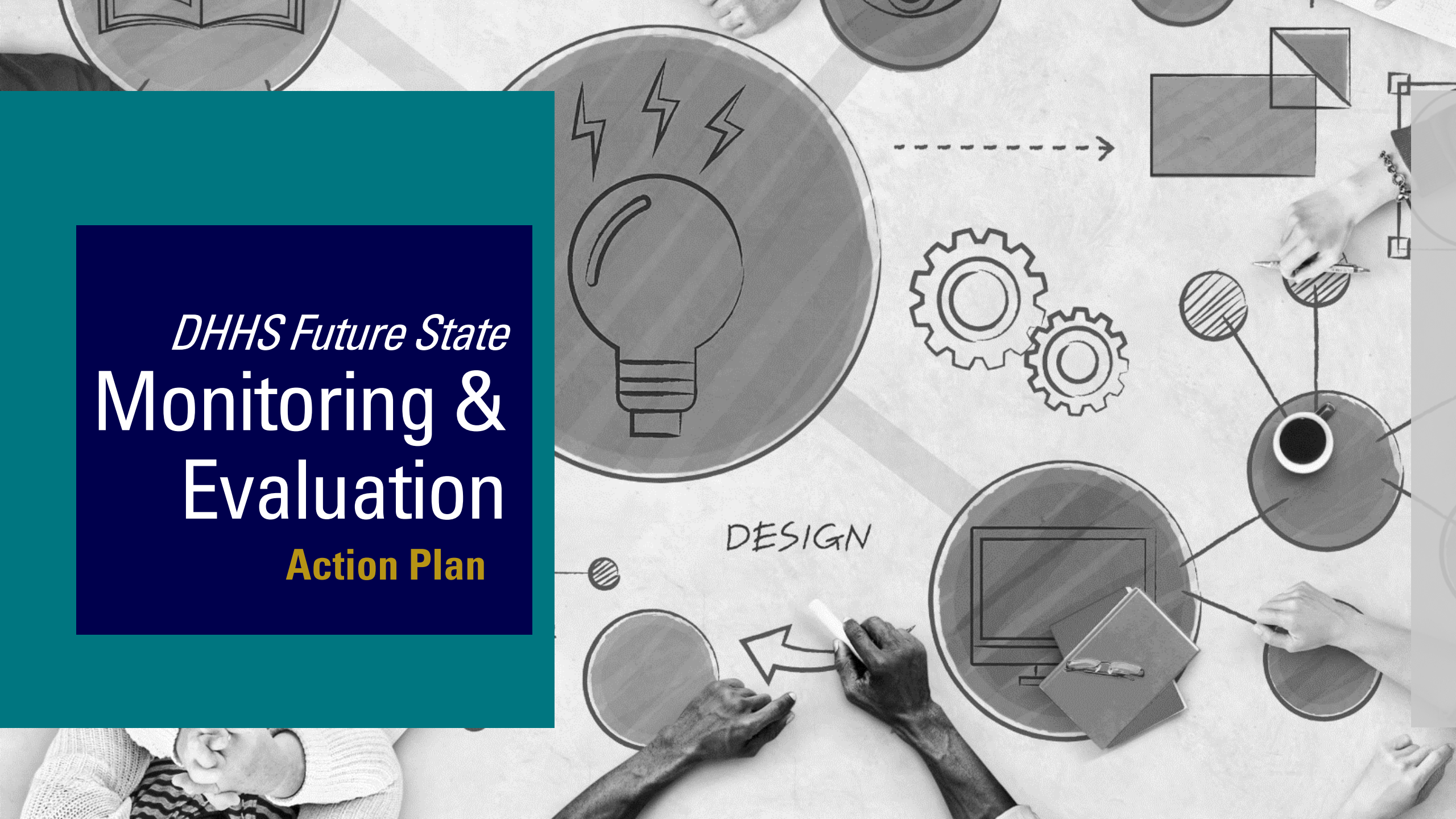

DHHS Future State

Monitoring & Evaluation

Action Plan

M&E Action Plan | Phase 1: Infrastructure

Strengthen coordination across service areas

- Develop Action Plan for DHHS (quality data, policy, training)
- Strengthen roles of DHHS QM and technical teams
- Build on learnings from pilots and scale up processes
- Develop multi-year, comprehensive M&E plan for Future State activities, including staff training
- Operationalize Data Management Information System

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M&E Action Plan | Phase 1: Infrastructure

Execute frequent performance reviews

- Conduct monthly reviews on financial and physical progress operations plans
- Prepare and disseminate 6-month progress and annual program implementation report
- Conduct periodic survey as planned for updating DHHS indicators in regular intervals
- Align staff performance indicators with operations goals and objectives

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M&E Action Plan | Phase 1: Infrastructure

Enforce data quality management mechanism

- Integrate quality assurance procedures into the existing Information Management System
- Embed frequent data quality checks
- Conduct workshops on data validation to build capacity of program managers

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M&E Action Plan | Phase 1: Infrastructure

Build capacity

- Conduct orientation of administrators and core program and operation staff
- Assess needs and develop multi-year M&E training plan for staff.
- Develop M&E training curriculum
- Facilitate regular training in M&E for leaders and service staff

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