

MILWAUKEE COUNTY
Inter-Office Communication



DATE: June 1, 2016

TO: Milwaukee County Mental Health Board, Quality Committee

FROM: Amy Pechacek, Director, Risk Management

SUBJECT: Behavioral Health Division: Five Year Analysis of Workers' Compensation Claims and Liabilities (INFORMATIONAL ONLY)

BACKGROUND

The basic principles of risk management consist of identifying all organizational exposures, analyzing these risks, controlling liabilities through a risk mitigation plan, and continually monitoring the plan for effectiveness. This report and the associated presentation is a high-level analysis of the past five years of the Milwaukee County's Behavioral Health Division's (BHD) workers' compensation claims history, classified by cause code and injury type. Several frequency and severity measures are displayed to demonstrate the financial impact of these claims, along with the corresponding liability reduction plans developed by Risk Management and BHD.

WORKERS' COMPENSATION

Workers' compensation claims are statutory wage and medical benefits for employees of Milwaukee County to compensate for injuries that occur in the course and scope of their employment. From 2010 - 2014, the five year County-wide loss experience resulted in an average of 612 claims per year with an associated incurred value of approximately \$4,000,000 annually. The loss leader departments during this timeframe are as expected given the nature of departmental functions, with Behavioral Health leading in the total number of claims filed and the Sheriff's Department leading in the highest expenses associated with their injury claims. The Parks, Airport, Department of Transportation, and House of Correction also make the list of departments with higher claim volume and expense. The top claim drivers throughout the County include the insurance industry code designation of "muscle strains" and "slip, trip, and fall" accidents, which combined represent 29% of all claim types filed and roughly 44% of the total expenses incurred.

Significant operational changes under new department leadership were implemented prior to the start of 2015. This included transitioning the model of claims handling from self-administration to a third party administrator (TPA) in November of 2014. The TPA initiative introduced new resources for County employees such as the Milwaukee County Care Line, a twenty-four hour dedicated triage nurse to assist employees in seeking the appropriate level of medical attention for their injury, and transitional work options to encourage employee engagement during recovery periods resulting in better claim outcomes. Risk Management provided a substantial influx in OSHA training and addressed accountability to safety policies and procedures and revitalized the County's Joint Safety Committee over the past two years, shifting the focus from reactive injury management to proactive injury avoidance, and renewed the County's commitment to ensuring our employees are working safely.

The outcome of all these changes resulted in 266 total new claims in 2015, compared to the previous five years which averaged 612 claims annually. This represents a 57% decrease in the number of new claims. With respect to the associated cost severity of the claims filed, 2015 total incurred costs are \$2.1 million, which is a 47% decrease in severity measures from the previous five year annual average of \$4 million.

WORKERS' COMPENSATION – BHD

Of all departments in the County, BHD experienced the most dramatic improvements in claims experience in 2015, with a 74% decrease in frequency measures compared to their previous averages in the years 2011-2014, dropping from an annual claim average of 160 claims to 42 claims. In a related trend, BHD severity measures dropped from an average annual incurred value of \$1,035,683 from the years 2011-2014, to a total incurred value of \$315,747 in 2015, representing a 70% decrease in severity measures.

The most frequent cause code for injuries at BHD is "struck by / altercation", accounting for nearly half, at 46%, of all reported losses. With respect to severity measures, "struck by / altercation" represented 42% of total incurred costs over the past five years, with a financial impact of \$1.8 million. This cause category was also the primary driver for 2015 specific claims, representing 16 of the total 42 claims filed. For incident only events, near miss events that did not require medical treatment or lost time, there were 36 additional altercation related records reported in 2015.

Improvements in the claim experience at BHD are attributed to the new claims handling resources offered County-wide, the ability to adjust claims under State law wage guidelines and outside of County Ordinance, and also to department specific operational initiatives, such as the elimination of the rehabilitation units. In addition, BHD made concerted efforts to focus on security and safety issues in 2015, such as implementing "Roll Call Updates" between clinical staff and security personnel, increasing the information exchange and adding additional accountability to ensure a safer environment for staff, patients, and visitors. Lastly, BHD employees had a high participation in annual safety training, recording a 92.5% completion rate.



Amy Pechacek, Director, Risk Management

CC: Chris Abele, County Executive
Raisa Koltun, Chief of Staff, County Executive's Office
Hector Colon, Director of Health and Human Services
Teig Whaley-Smith, Director of Administrative Services
Alicia Modjeska, Interim Administrator & Chief Administrative Officer, Behavioral Health
Colleen Foley, Corporation Counsel

Milwaukee County

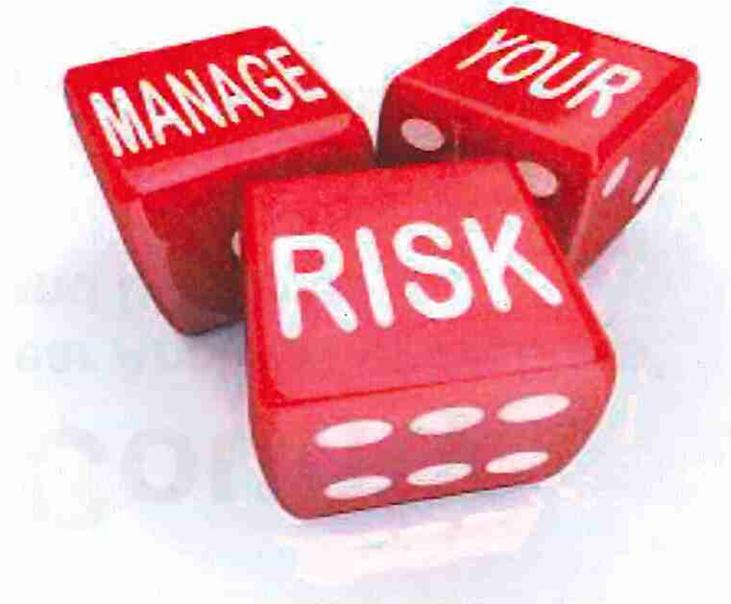
Behavioral Health Division: Five Year Analysis of Workers' Compensation Claims and Liabilities

Amy C. Pechacek - Director, Risk Management



Principles of Risk Management

1. Identify exposures
2. Analyze losses
3. Develop plan to minimize
4. Monitor and adjust plan
 - Performance measures
 - a. Frequency of claims (#)
 - b. Severity of claims (cost)
 - c. OSHA compliance



Workers' Compensation

- Statutory wage and medical benefits for individuals injured in the course and scope of their employment
- Milwaukee County has approx. 5,000 employees

Workers' Compensation - Countywide Claim Frequency

Claim Frequency | 2011 - 2015

	Claim Count
2011	537
2012	636
2013	752
2014	630
2015	266
TOTAL	2821

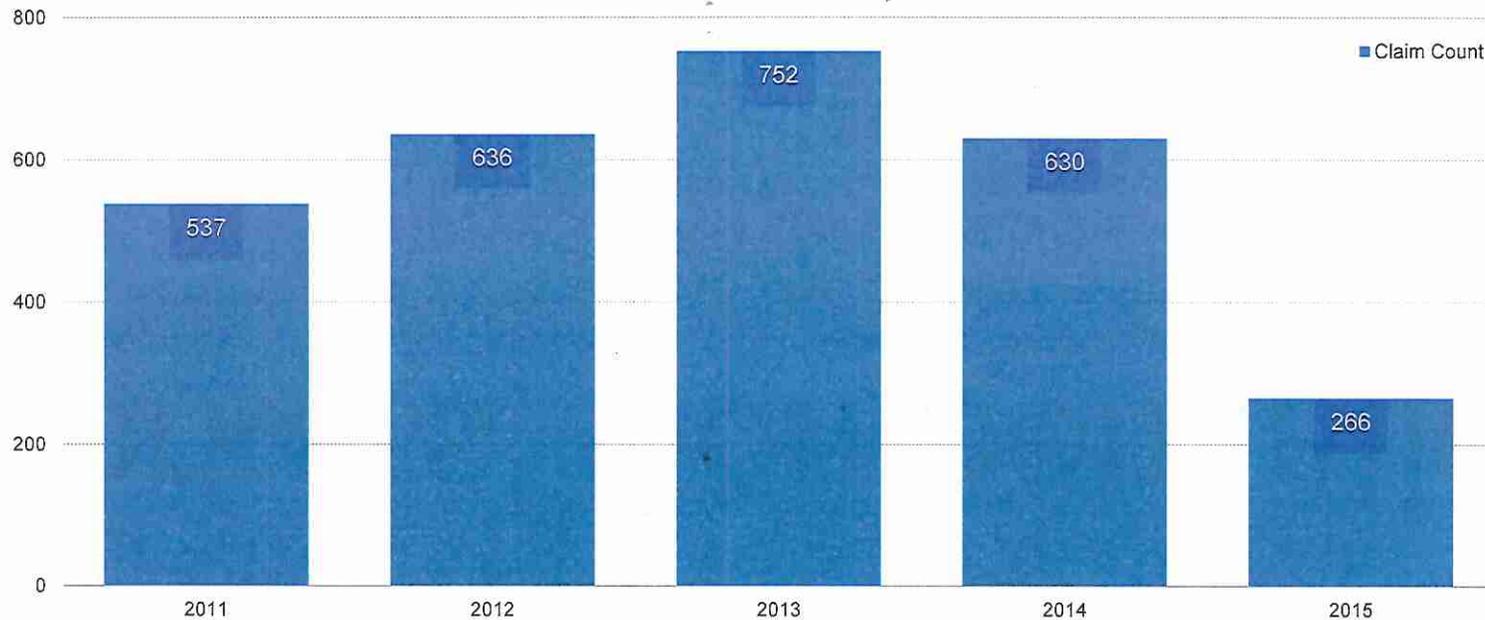


Goal: Reduce number of claims **15%** compared to 5 year historical average of **612 claims** per year



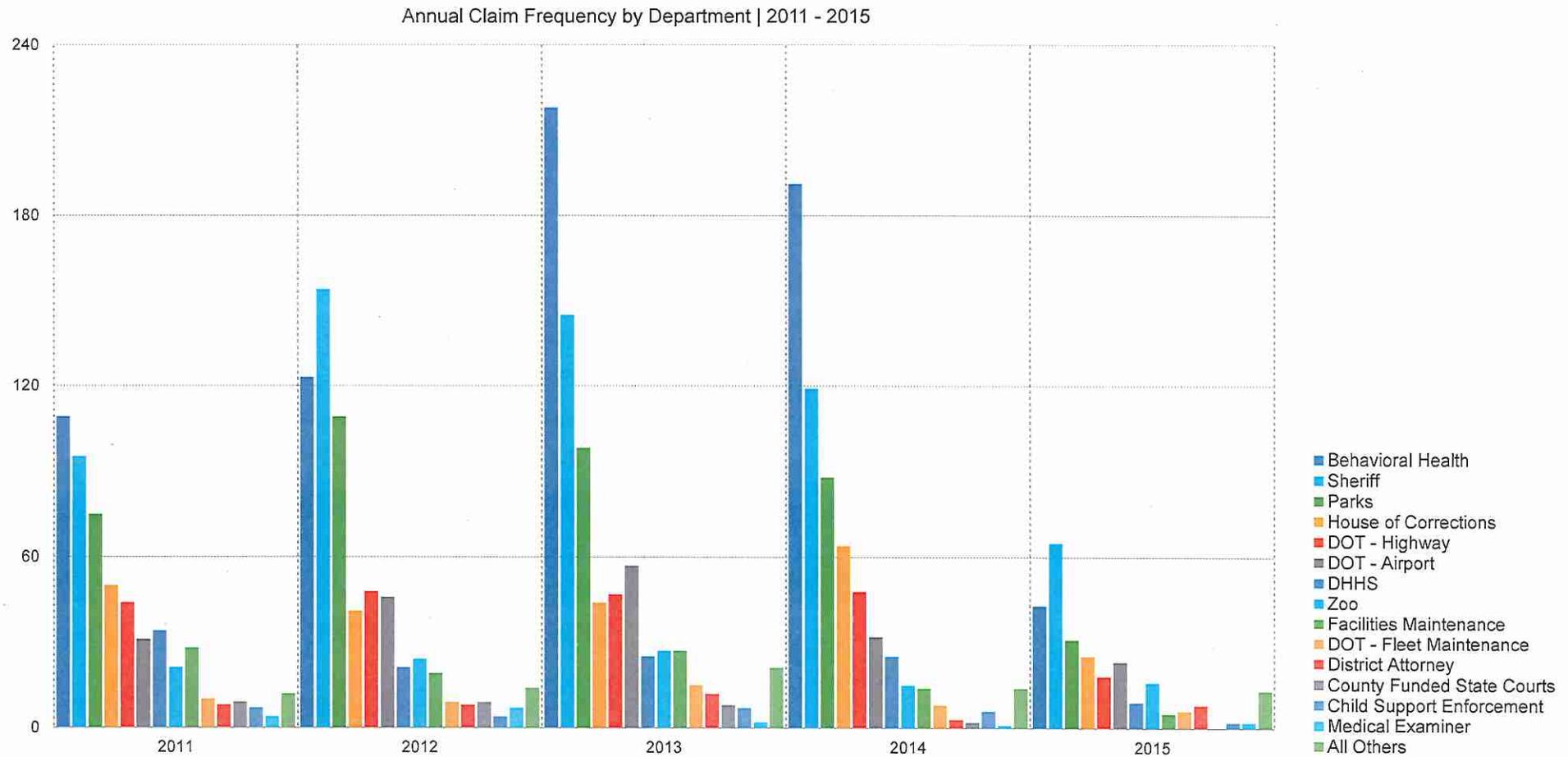
Result: **57%** reduction* **266 claims** in 2015

Claim Frequency | 2011 - 2015



Workers' Compensation

Annual Claim Frequency by Department



Workers' Compensation - Countywide Claim Financial Summary

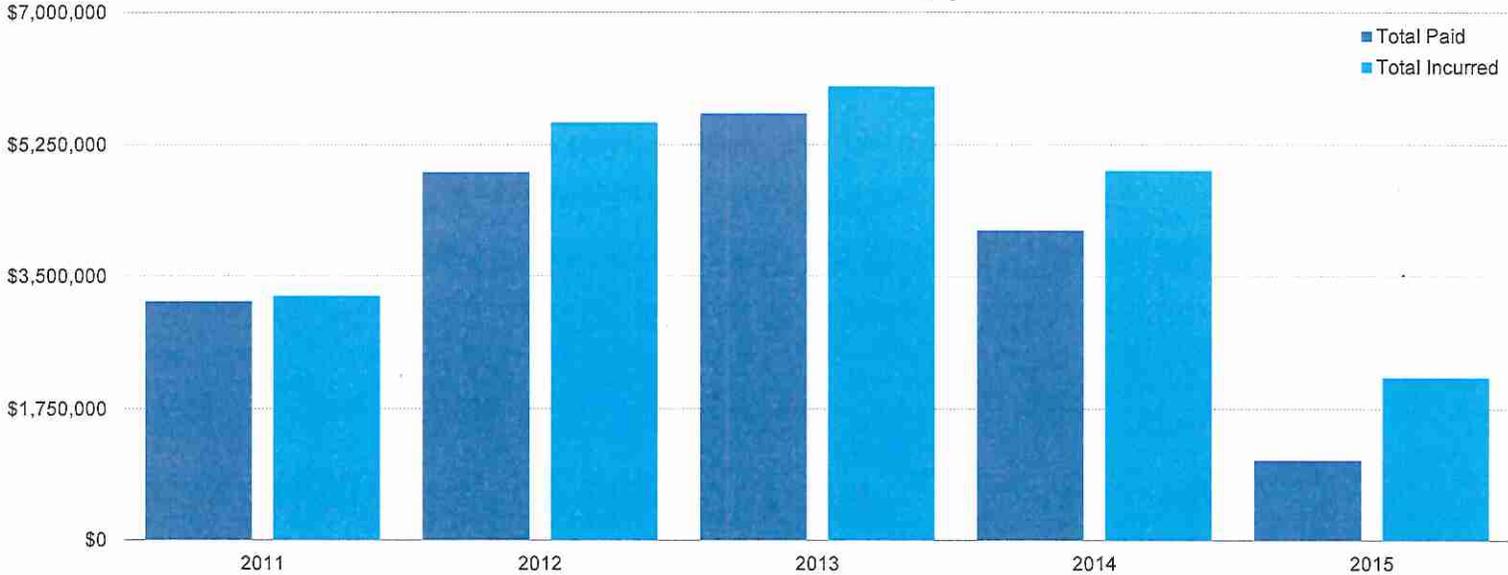
Claim Financial Summary | 2011 - 2015

	Total Paid	Total Incurred
2011	\$3,167,472	\$3,235,165
2012	\$4,874,054	\$5,539,515
2013	\$5,659,224	\$6,014,002
2014	\$4,100,832	\$4,895,580
2015	\$1,071,019	\$2,168,804
TOTAL	\$18,872,602	\$21,853,067

 **Goal:** Reduce cost severity (total incurred) of new claims **15%** compared to 5 year historical average of **\$4,046,739** per year

 **Result:** Total incurred for 2015 = **47%** reduction at **\$2,168,561**

Claim Financial Summary | 2011 - 2015



Workers' Compensation - Countywide

Top Claim Frequency & Severity Accident Types

Top 5 Most Severe Accident Types | 2011 - 2015

	Claim Count	Total Incurred
Strain	645	\$7,768,393
Altercation	185	\$2,378,944
Motor Vehicle Accident	71	\$2,259,635
Slip or Trip	189	\$1,833,409
Struck By	383	\$1,182,794

Top 5 Most Frequent Accident Types | 2011 - 2015

	Claim Count	Total Incurred
Strain	645	\$7,768,393
Struck By	383	\$1,182,792
Slip or Trip	189	\$1,833,409
Altercation	185	\$2,378,944
Exposure	142	\$169,000

Workers' Compensation - Countywide

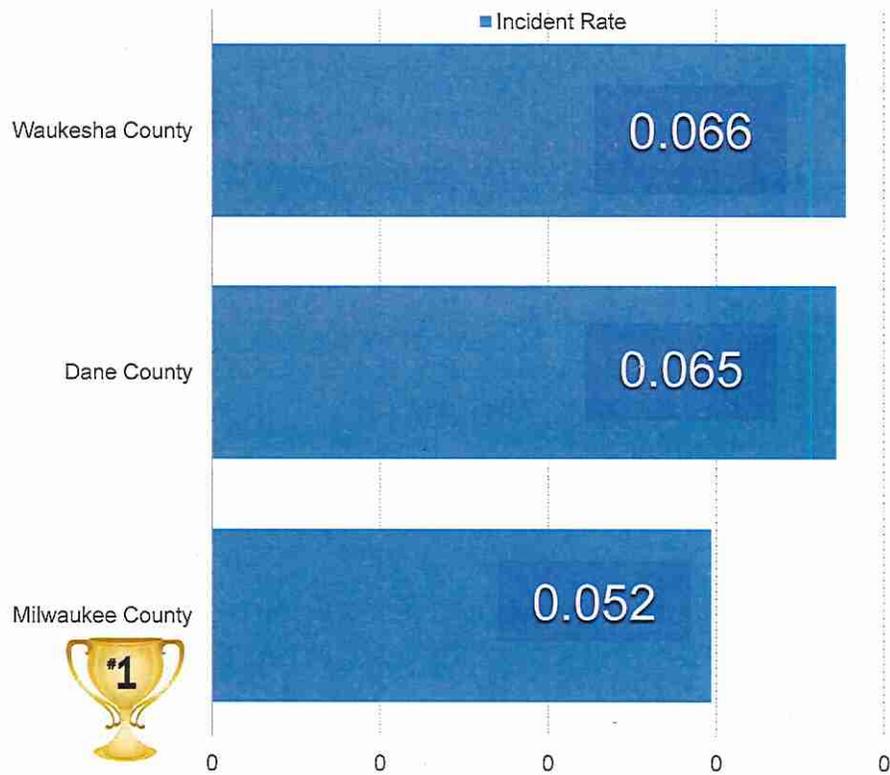
Claim Frequency & Severity by Department

Claim Frequency & Severity by Department | 2011 - 2015

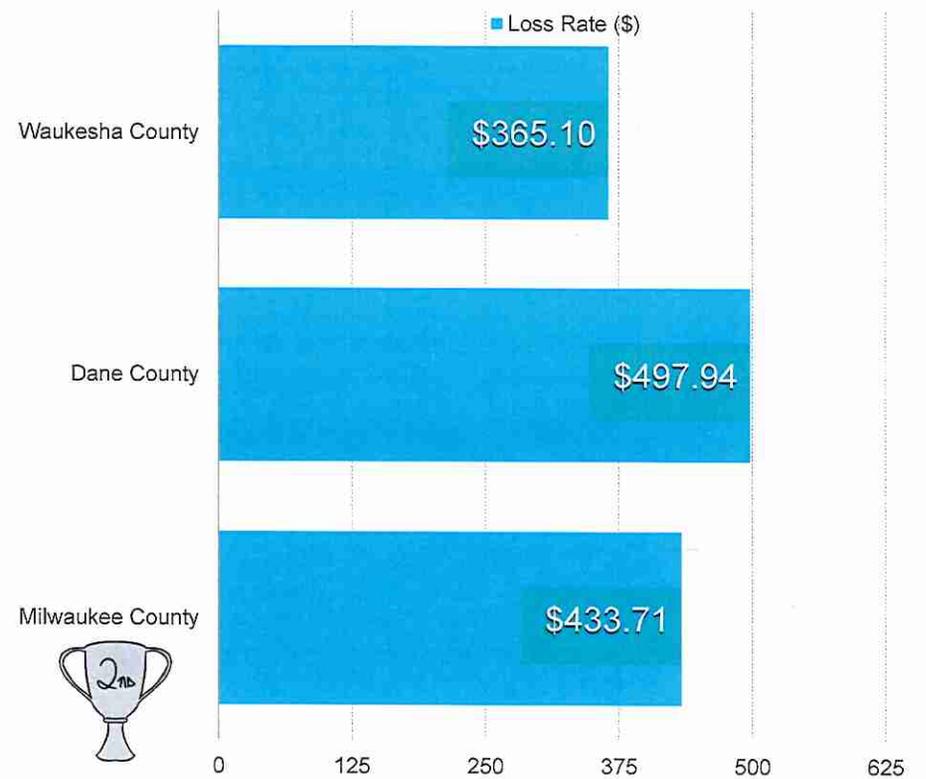
	Claim Count	Total Incurred
Behavioral Health	684	\$4,466,780
Sheriff	578	\$6,533,771
Parks	401	\$2,142,429
House of Corrections	224	\$2,010,279
DOT - Highway	205	\$1,144,258
DOT - Airport	189	\$2,327,481
DHHS	114	\$773,280
Zoo	103	\$328,488
Facilities Maintenance	93	\$636,362
DOT - Fleet Maintenance	48	\$543,485
District Attorney	39	\$122,062
County Funded State Court	28	\$84,196
Child Support Enforcement	26	\$143,856
Medical Examiner	16	\$110,844
All Others	74	\$485,496
TOTAL	2822	\$21,853,066

Workers' Compensation County Incident & Loss Rate Comparison

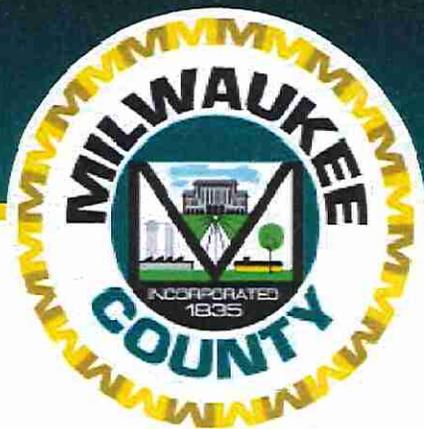
2015 Incident Rate
Among Comparable Wisconsin Counties



2015 Loss Rate (\$)
Among Comparable Wisconsin Counties



OSHA Compliance



2016 OSHA Training Sessions

Under the Occupational Safety and Health Act of 1970, employers are responsible for providing a safe and healthy workplace. No employee should ever have to suffer illness, injury or death for a paycheck.

Many OSHA standards, which have prevented countless workplace tragedies, include explicit safety and health training requirements to ensure workers have the required skills and knowledge to work safely. These requirements reflect OSHA's belief that training is an essential part of every employer's safety and health program for protecting workers from injuries and illnesses.

January 4 & 19 • February 1 & 15

Global Harmonized System – 9 to 9:45 a.m.

Bloodborne Pathogens – 9:45 to 10:30 a.m.

Lock Out Tag Out – 10:30 a.m. to 12:30 p.m.

Hearing Conservation – 1 to 1:40 p.m.

Respirator Protection – 1:40 to 2:20 p.m.

PPE – 2:20 to 3 p.m.

Class Capacity: 109 each session

Location: CATC Building, Large Auditorium

Instructor: Vance Forrest (Aegis Corporation)

Location Contact: Jason McCarthy

January 6 & 20 • February 3 & 17

Fall Protection – 9 to 11:30 a.m.

Class Capacity: 12 each session

Hoists & Slings – 12 noon to 3 p.m.

Class Capacity: 20 each session

Location: Fleet Management Building

Instructor: Vance Forrest (Aegis Corporation)

Location Contact: John Blonien

January 19 & 20

OSHA 10 Hour

2-day course consisting of 5 hours per day

8 a.m. to 12 noon, then 12:30 to 1:30 p.m. each day

Class Capacity: 40 each session

Location: Parks Administration Building

Instructor: Nick Dillion (Aegis Corporation)

Location Contact: John Nelson

April 11 & 12

OSHA 10 Hour

2-day course consisting of 5 hours per day

8 a.m. to 12 noon, then 12:30 to 1:30 p.m. each day

Class Capacity: 40 each session

Location: CATC Building, Large Auditorium

Instructor: Nick Dillion (Aegis Corporation)

Location Contact: Jason McCarthy

August 8 & 9

Workers' Compensation - BHD

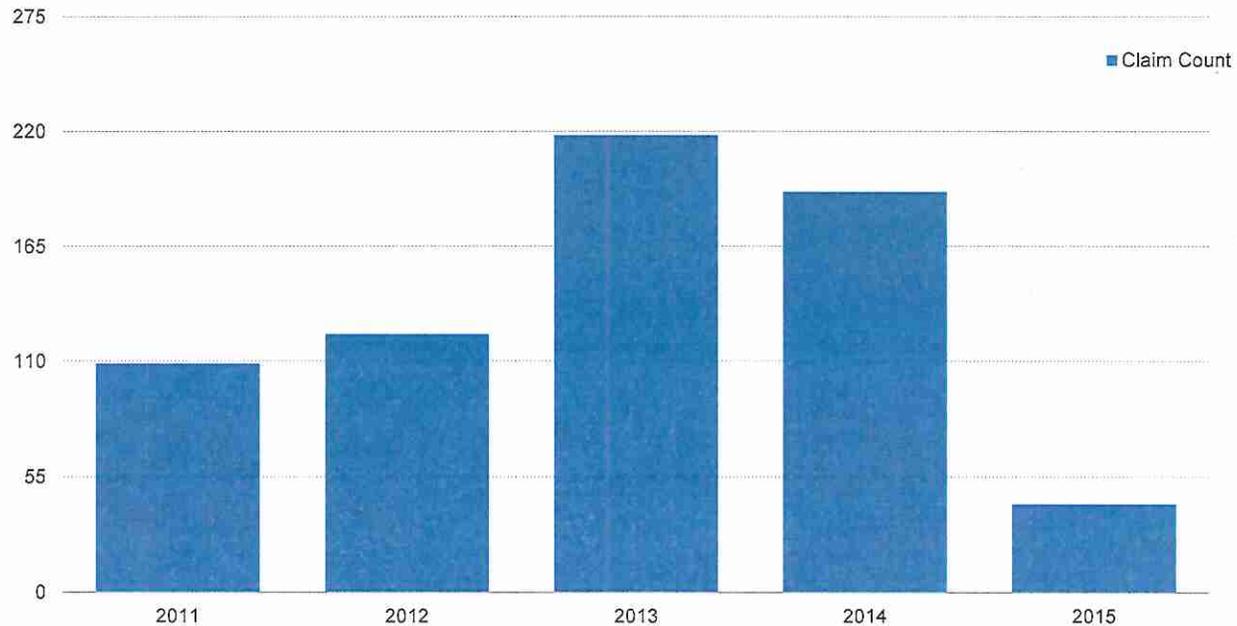
Claim Frequency

Claim Frequency | 2011 - 2015

	Claim Count
2011	109
2012	123
2013	218
2014	191
2015	42
TOTAL	683



Claim Frequency | 2011 - 2015



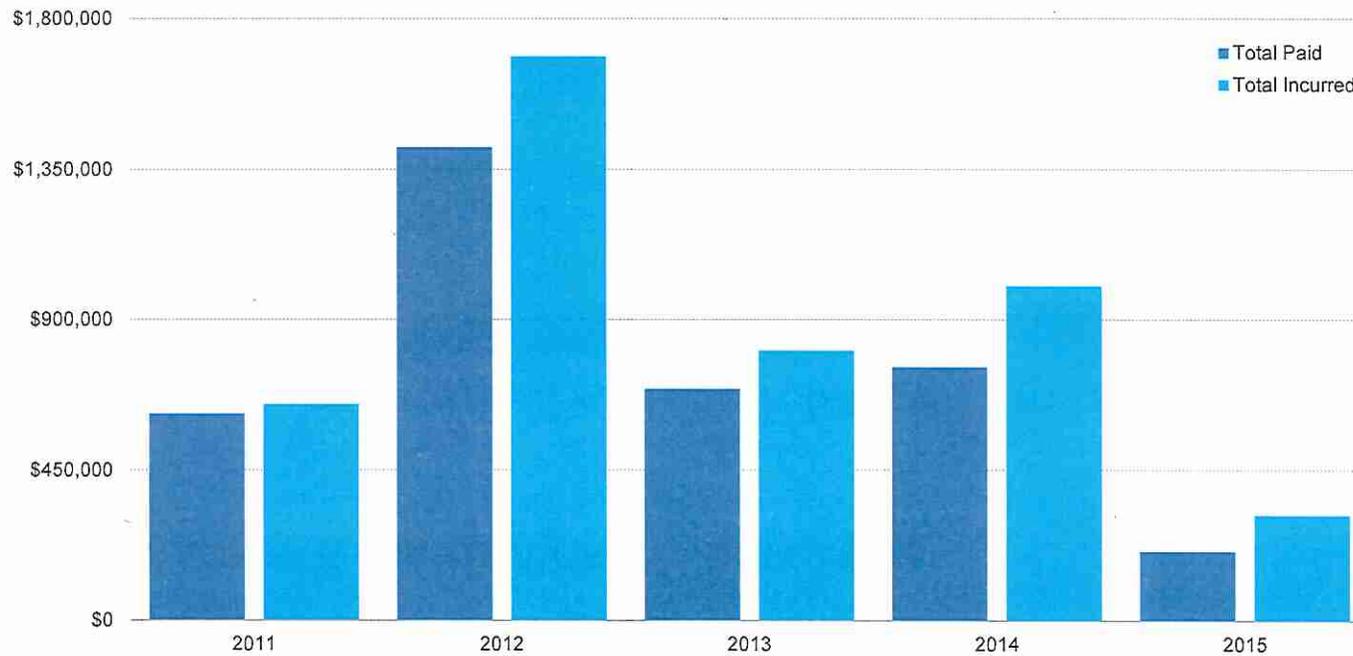
Workers' Compensation - BHD

Claim Financial Summary

Claim Financial Summary | 2011 - 2015

	Total Paid	Total Incurred
2011	\$619,141	\$647,474
2012	\$1,416,734	\$1,686,818
2013	\$693,205	\$807,502
2014	\$757,702	\$1,000,936
2015	\$206,845	\$315,747
TOTAL	\$3,693,628	\$4,458,477

Claim Financial Summary | 2011 - 2015



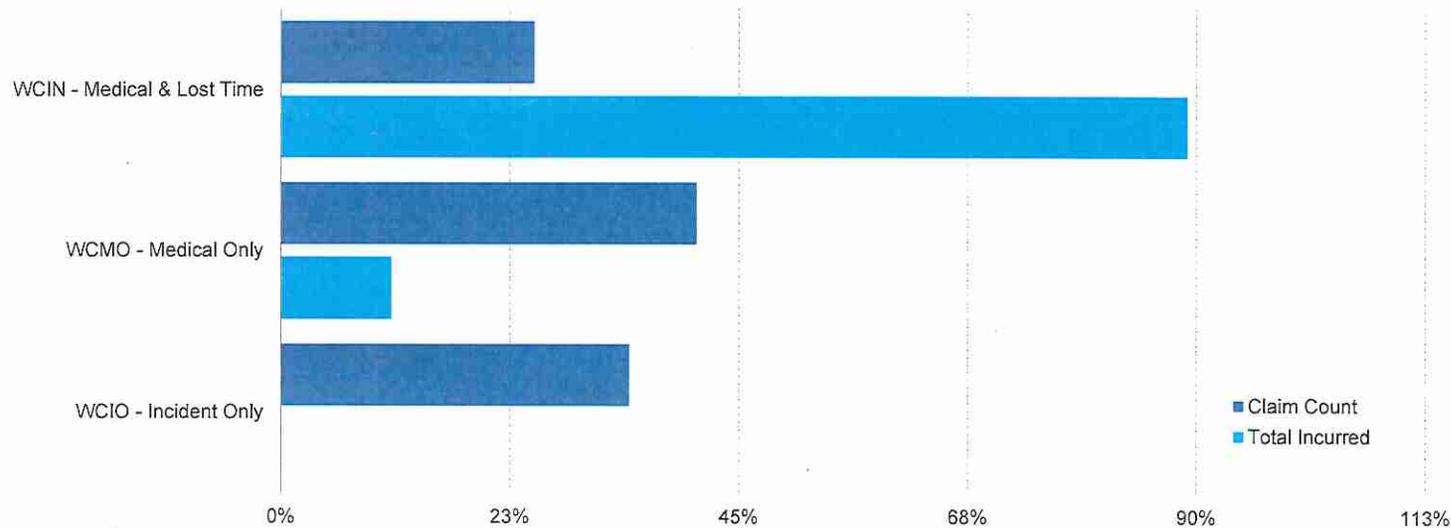
Workers' Compensation - BHD

Claim Frequency & Severity by Claim Type

Claim Frequency & Severity by Claim Type | 2011 - 2015

	Claim Count	Total Incurred
WCIN - Medical & Lost Time	170	\$3,973,451
WCMO - Medical Only	279	\$485,029
WCIO	234	\$0
TOTAL	683	\$4,458,480

Claim Frequency & Severity by Claim Identifiers | 2011 - 2015



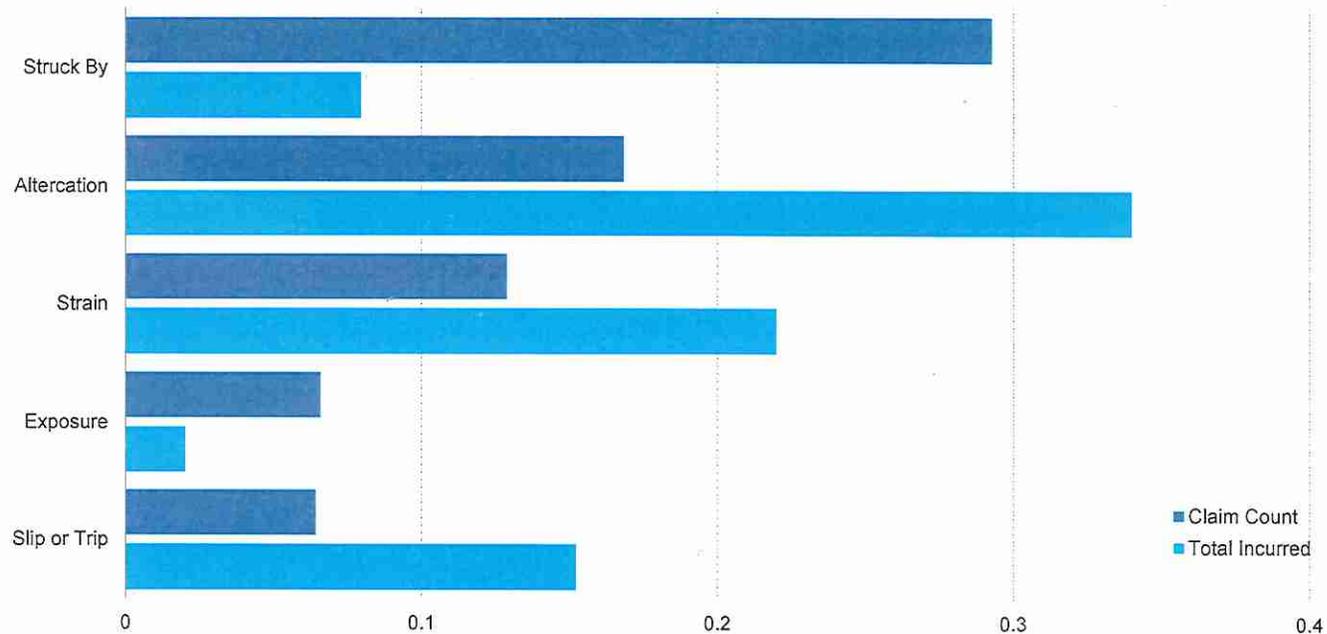
Workers' Compensation - BHD

Top 5 Most Frequent Accident Types

Top 5 Most Frequent Accident Types | 2011 - 2015

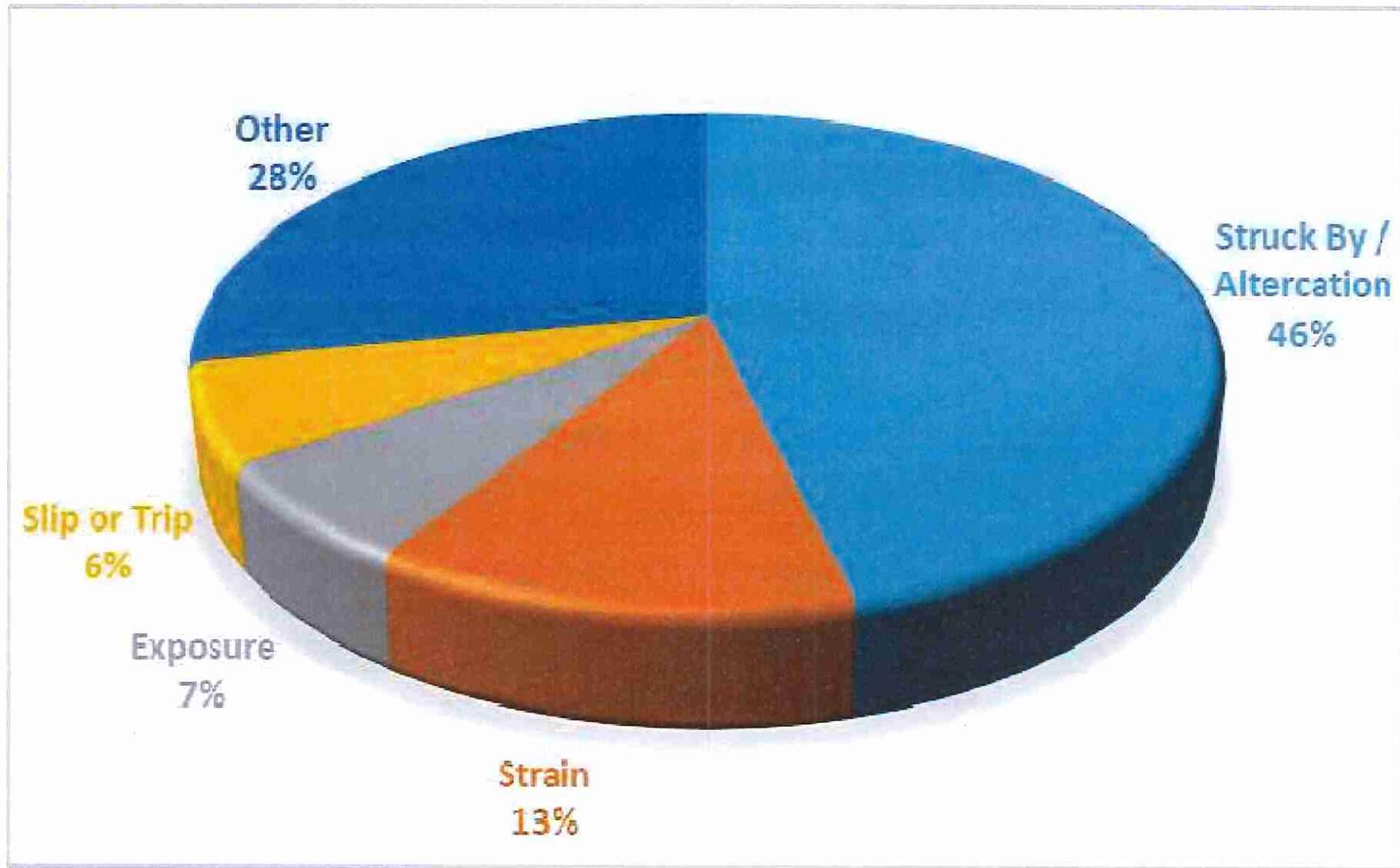
	Claim Count	Total Incurred
Struck By	200	\$354,784
Altercation	115	\$1,515,429
Strain	88	\$981,029
Exposure	45	\$90,352
Slip or Trip	44	\$678,909

Top 5 Most Frequent Accidents | 2011 - 2015



Workers' Compensation - BHD

Top 5 Most Frequent Accidents Types



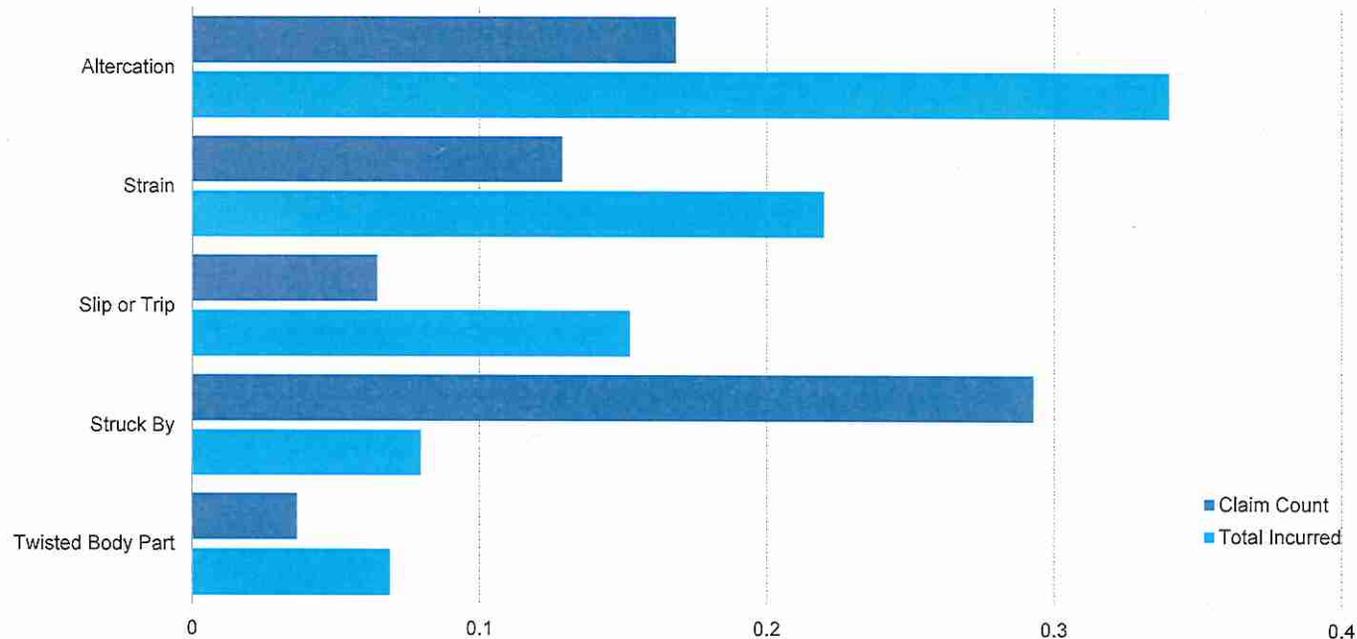
Workers' Compensation - BHD

Top 5 Most Severe Accidents Types

Top 5 Most Severe Accident Types | 2011 - 2015

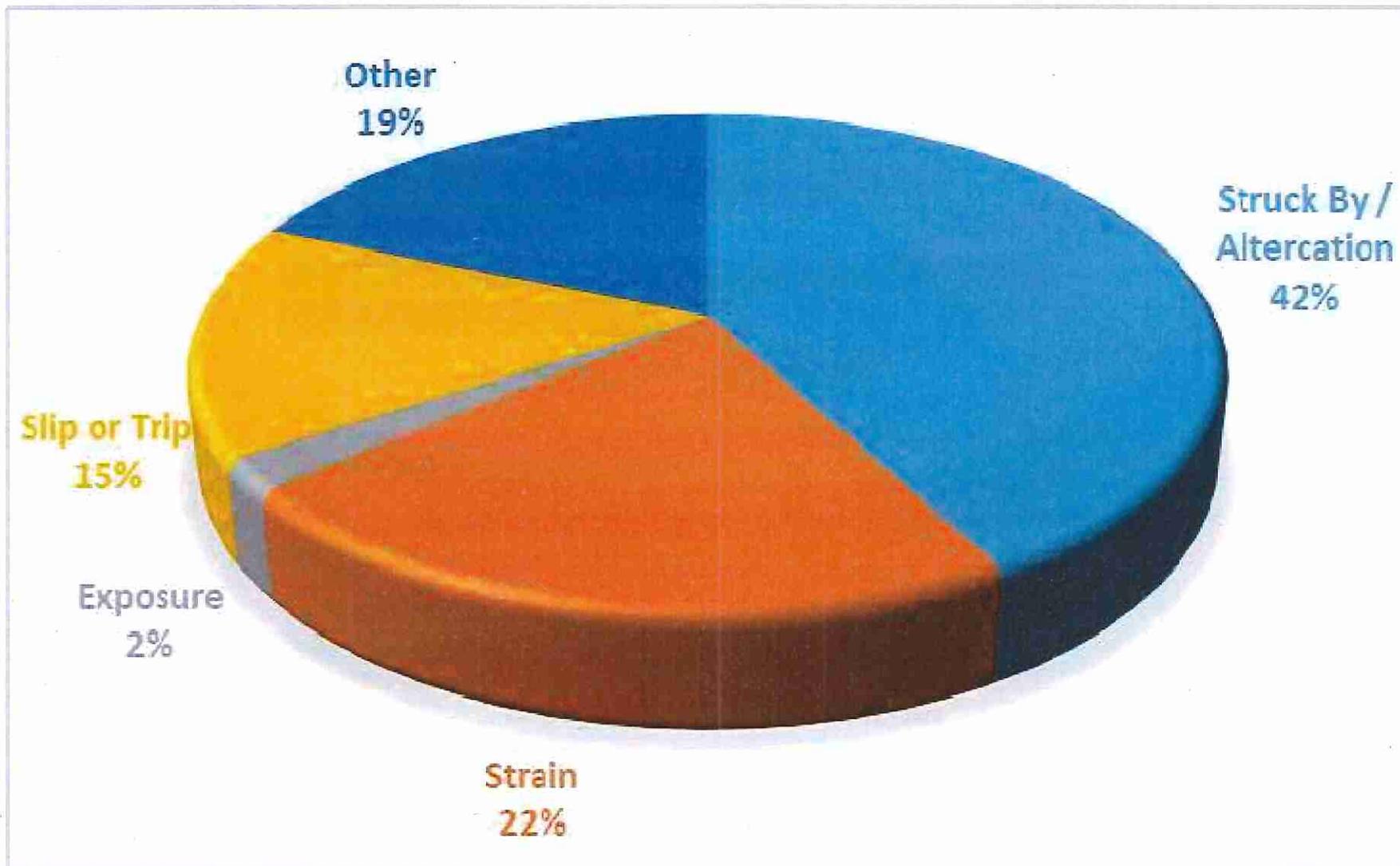
	Claim Count	Total Incurred
Altercation	115	\$1,515,429
Strain	88	\$981,029
Slip or Trip	44	\$678,909
Struck By	200	\$354,784
Twisted Body Part	25	\$307,096

Top 5 Most Severe Accident types | 2011 - 2015



Workers' Compensation - BHD

Top 5 Most Severe Accidents Types



Workers' Compensation - BHD

Experience Modification Factor

An Experience Modification Factor or "Mod" is an insurance underwriting calculation that uses payroll class codes, combined with industry loss experience rates, and workers' compensation losses to benchmark performance. The Mod is used in the industry to develop premium.

Because the county self-insures its workers' compensation program, the Mod is a tool that can be used for the purposes of benchmarking performance.

Workers' Compensation - BHD

Experience Modification Factor

BHD Experience Modification Factor: 1.28

Minimum Mod: .37

Controllable Mod: .91

The **Minimum Mod** is your payroll information multiplied by your employee's job classification rates, or loss experience rates. It is your mod without any losses.

Your **Controllable Mod**, or the portion of the mod that you affect with your losses, is determined by your specific loss history and different weighting of large and small claims, and claims involving lost time or medicals only.

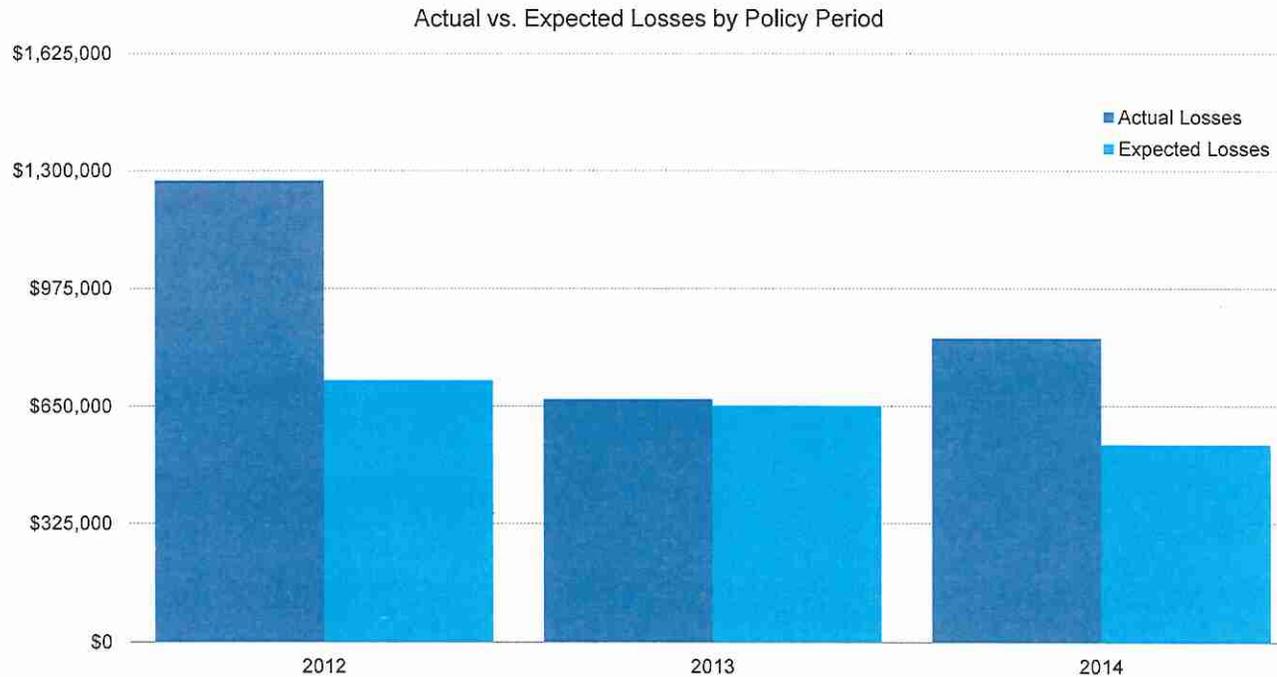
Workers' Compensation - BHD

Experience Modification Factor

The **Expected Losses** are determined first by classifying employees by job duties into payroll class codes. Payroll class codes are given an experience loss rate (ELR) based on industry loss statistics developed by the National Council on Compensation Insurance. Taking the payroll dollar amounts and multiplying them by the ELR develops the Expected Losses.

Actual vs. Expected Losses by Policy Period

	Actual Losses	Expected Losses
2012	\$1,271,813	\$723,601
2013	\$670,051	\$651,653
2014	\$838,345	\$544,264



Workers' Compensation - BHD

Loss Control Initiatives

Milwaukee County Programs & Policies

- Continuous emphasis on operational best practices for clinical safety & security
- Return-To-Work procedures, including development of transitional duty job bank.
- Update existing OSHA safety programs & policies
- Evaluation of Personal Protective Equipment (PPE) for specific job duties
- Job safety instructions

Milwaukee County Employee Engagement Initiatives

- Promotion of Find It Fix It Program – Safety and Property Issues
- Participation in Joint Safety Committee / VARC
- Total Health Newsletter

Employee Training

- De-Escalation & defense training
- Focus on safe lifting/back injury prevention
- Focus on slips, trip and falls prevention training

**COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION**

DATE: May 18, 2016

TO: Robert Chayer, MD, Chairman, Mental Health Board Quality Committee

FROM: Lynn Gram RD, C.D, - BHD Safety Officer and the Environment of Care Committee Chair

SUBJECT: Requesting acceptance and approval of the 2015 Annual Review of the Environment of Care Program, and the 2016 Environment of Care Management Plans

Issue

BHD is requesting the annual approval of the Environment of Care Annual Report and Management Plans per The Joint Commission Standards and the Mental Health Board By-laws.

Background

The Joint Commission requires a written plan for managing environmental risk, including safety, security, clinical and non-clinical equipment, handling of hazardous materials, fire prevention, and utility systems. These plans together make up the BHD Environment of Care Program. The purpose of the program is to establish a structure within which a safe environment of care is developed, maintained and improved. The effectiveness of Environment of Care program will be reviewed and evaluated annually to determine if goals have been met through ongoing improvement. The plan will be modified as needed.

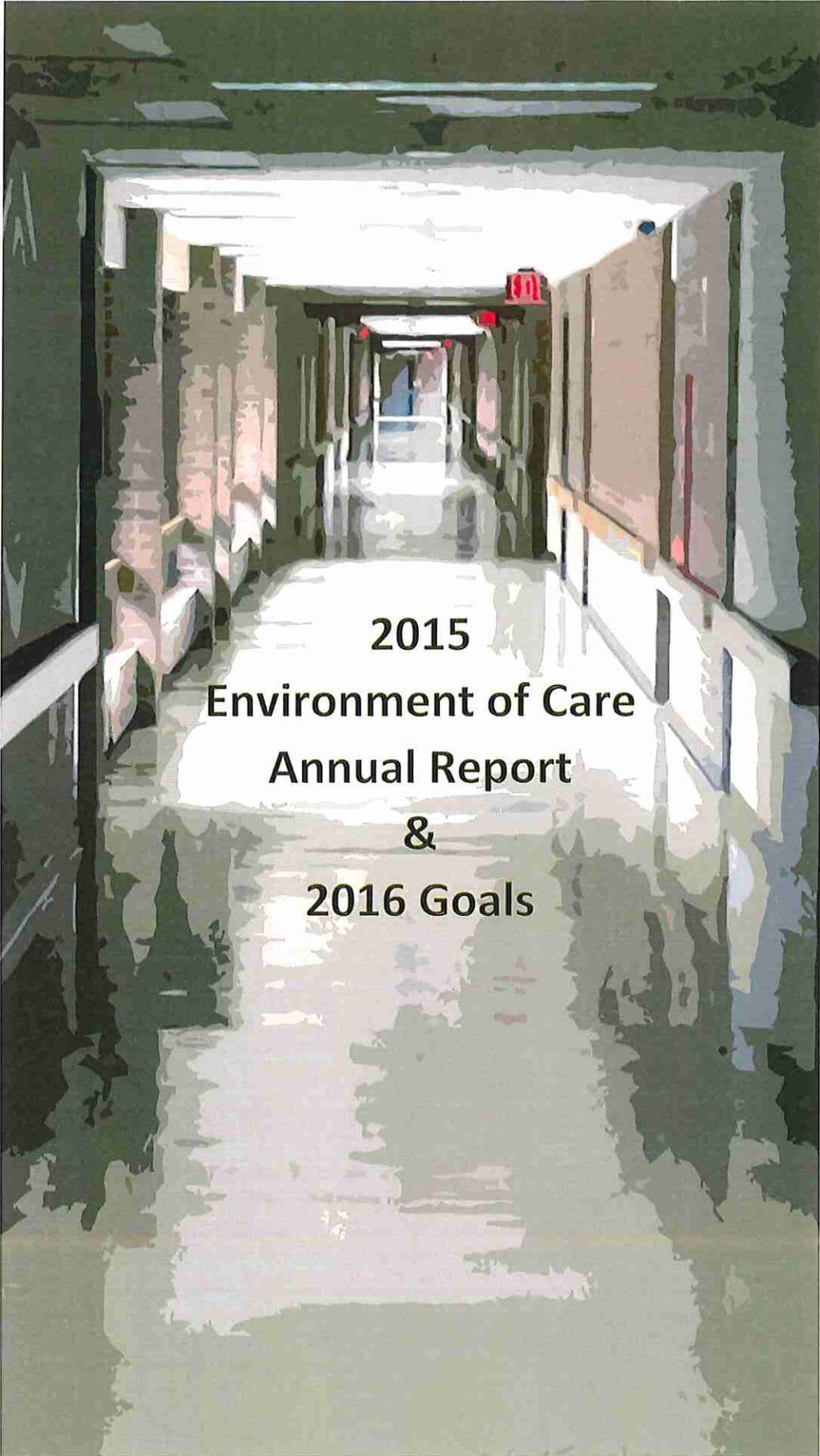
Recommendation

It is recommended that the Mental Health Board accept and approve the 2015 Annual Report of the Environment of Care program and the 2016 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.

Introduction

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached is the 2015 Annual Review of the Environment of Care Program and the 2016 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2015 major improvements were made in the area of building security through the implementation of a new master key system and limiting unlocked access points to mitigate security risks. Similarly, the installation of an emergency generator was a major step toward achieving compliance with The Joint Commission's requirements for emergency power preparedness. Additional efforts to increase safety related training for employees and contractors in 2015 provided insights into improvement opportunities for 2016.

The Joint Commission requires that the Annual Report and Management Plans be presented and approved by the governing board. BHD is requesting approval of the attached documents.



**2015
Environment of Care
Annual Report
&
2016 Goals**

Environment of Care 2015 Annual Report and 2016 Goals

The BHD Environment of Care Management Plans were all reviewed and updated for 2016. Changes made included:

- Removal of building addresses no longer occupied and references of the Rehab Centers.
- Updating committee names and position titles.
- Section on Approval was removed due to redundancy of this section in Policy Stat.
- Changes related to converting from a manual system to an electronic system. In the area of product alerts and recalls, policy maintenance, environmental rounds, work orders, and preventive maintenance items.
- Changes related to new system for reporting employee injuries along with a change in what BHD reviews and analyzes as a result of the different system. Analysis by body part is no longer available to review.

Highlights of achievements and 2016 Goals:

GENERAL SAFETY

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2014 78.4%. In 2015 85.3%. There were a total of 2680 recalls issued during 2015. Only 9 items involved in an alert or recall of an product purchased by BHD. All 9 product alerts/recalls were resolved with no negative impact on patient care.
 - The goal of responding within the 3 day timeframe 95% of the time was not achieved, however significant progress was made towards that goal. Recommend continue this goal. The Safety Officer will work with responders to improve the response time.
2. 125 Patient falls were reported according to the 2015 Year End Incident Report data. This equates to a 21.2% per 1000 patient days. This reflects an increase of 0.07% over 2014. Falls increased in CAIS and Crisis Services. Six employee and/or visitor falls which is a 47% decrease from 2014. No specific mechanical causes were identified.
 - The committee will continue to monitor falls data for environmental concerns and recommends referring this item to the Clinical Safety Committee for additional review and to determine improvement actions. The EC Committee recommends targeting CAIS and Crisis Service.
3. There were 79 incidents of patient to employee aggression which is a rate of 13.2% per 1000 patient days. This is a slight decrease from the prior year when the rate was 13.6.
 - The committee will continue to monitor this data for environmental concerns and recommends moving this item to the Clinical Safety Committee for additional review and improvement planning.
4. The number of exposures to infection increased from a rate of 0.9% to a rate of 2.0%. Typical exposures were needle sticks and spits.
 - Recommend discontinuing this goal, it is already tracked via the Infection Prevention Committee. The committee recommends that this item be moved to the Clinical Safety Committee for additional review and improvement planning.
5. Employee injuries with lost time of 3 days or more were 13. Numbers for 2014 are not available. A total number of lost days of 290 and 253 days of job transfer or restriction.
 - Recommend continue this goal. BHD will collaborate with Milwaukee County Risk Management and Wisconsin County Mutual, the outside company who handles workers compensation claims, to develop an improvement plan.

6. Annual Safety training was completed by 92.5% of employees and 96.3% of contractors. Recommend developing set training modules on safety for employees during 2016. The average for all safety related questions for RN's was 97.476%, other BHD staff 95.45% and contractors 98.8%.
 - Recommend goal be revised to have an average score of 95% or more for safety related questions. Through quarterly training program and testing. Initial target areas will be the lowest scored areas of: Regulated Medical Waste, Fire Safety and the Global Harmonized System.
7. Documentation was not available to accurately determine rounds items addressed within 30 days. There are currently 84 work order items open for greater than 30 days. Some but not all are rounds related.
 - Recommend continue this goal. The new rounding system will be able to provide more accurate tracking of deficiencies and correction timeframes.

SECURITY

Several security improvements have been made at BHD. A new master key system has been used to change the exterior door locks to significantly limit access from the outside. In conjunction with rekeying efforts, there are only 4 access points to enter the building. The main entrance, the rear employee entrance, the maintenance entrance and the operations dock entrance. All visitors are expected to sign in and out from each visit. Compliance with this process will be targeted in 2016 through education of BHD staff and follow up on visitor badges not returned. Staff without identification badges must also sign in separately. Additional security related policies and procedures are being drafted to further clarify practices and expected to be completed in 2016.

1. Security Department Roll Call Updates: In 2015, Roll Call Updates were added as a goal for BHD Security. The updates are intended to keep officers abreast of current BHD situations and procedural changes. Additionally, roll calls are used to increase officer accountability and training update opportunities. There were 37 Roll Call Updates issued throughout 2015.
 - The goal for 2016 will be to have a new Roll Call Update posted for each week of the year. Roll call updates will not only be posted for officer review, but will be verbally reviewed with officers by supervisory staff of BHD Security.
2. Theft and Larceny: In 2013 - 43 incidents, 2014 - 24 incidents. In 2015 - 7 incidents. A reduction of 71%
 - The goal for 2016 will be to maintain this current level and even lower the total number of incidents to less than or equal to 3. In 2016, Theft and Larceny and will be changed to Theft and Vandalism to more wholly reflect incidents on BHD Grounds.
3. Unauthorized absences from locked units: In 2013 - 15 unauthorized absences from the patient areas. In 2014 - 11 unauthorized absences from patient areas. In 2015 - 5 absences from locked BHD patient areas.
 - Although unauthorized absences are an inherent and recognized risk at BHD, no unauthorized absence is acceptable. As such, the goal for 2016 will be to reduce the total number of absences to zero.
4. Contraband on units: In 2013 - 36 prohibited items on the patient units. In 2014 - 15 prohibited items on the patient units. In 2015 - 5 prohibited items on patient units.
 - In 2016, BHD Security will continue to strive for no prohibited items to be allowed onto secured patient areas of BHD. Due to continued success with the reduction of reported incidents though, along with improved security measures approved by BHD Administration and implemented by BHD Security this goal is being removed for 2016. Additional goals are being implemented to more accurately reflect the current BHD Security Department's direction.
5. Unsecured Area incidents: In 2014 - 14 incidents of unsecured areas. In 2015 - 5 incidents of unsecured areas.
 - In 2016, BHD Security will continue to strive for zero incidents. Due to external human factors though, the goal will be to further reduce the number of incidents to less than or equal to 2.

6. Unauthorized persons in secure areas: In 2014 - 12 incidents of unauthorized persons in a secured area. In 2015 only 1 incident of an unauthorized person in a secured area.
 - The drastic decline of unauthorized person incidents is largely attributed to the reduction and later elimination of the long-term care units. This discontinued the practice of a portion of the patient population having unsupervised, on-grounds privileges. Due to the reduction of reported incidents along with unsupervised patient access being restricted, this goal is being removed for 2016.
7. Security Department will report any time that a security camera presents as inoperable in the Security Dispatch Camera Array. Notifications will be made according to established BHD reporting mechanisms and recorded in the Daily Log maintained by security. Once camera operation is restored, update notifications will be made and time will be recorded in log.
 - The goal for 2016 is for camera operations to be restored within 24 hours of any reported outage. The goal is for the Security Department to make proper notification to BHD contacts within 1 hour of any noticeable outage. Security Department will strive to have no more than 6 occurrences where notification takes more than 1 hour.

HAZARDOUS MATERIALS AND WASTE

In 2015, BHD was identified by the Wisconsin Department of Natural Resources (Wi DNR) rules as a generator of infectious waste. A generator produces more than 50# per month. In 2014 BHD sent 3262 # (average of 272#/month) of infectious waste out for treatment/disposal. In 2015 the amount was reduced to 1589# (average of 132#/month). Note: the 2015 values included an estimate for the December weights. Much of the reduction was likely related to the reduction in Long Term Care Patient census. An infectious waste report was filed with the Wi DNR, and a Policy and Procedure was created regarding how we manage infectious medical waste. In 2015 additional education was provided to nursing staff which may have also resulted in some reduction of the amount generated. Audits are conducted to monitor appropriate disposal during Environmental Rounds. Additional teaching will be planned for all staff on Infectious waste handling.

1. 87-95% of staff and contractors responded correctly to questions on the Annual House Wide Update Training regarding Safety Data Sheet information. RN's were asked a question on infectious waste disposal with a correct response of 88%. The incorrect responses chosen most frequently, some at a rate of 46% make this area a target for 2016 education.
 - This goal will be changed to measure the % of employees who can correctly identify regulated waste items. (Goal 95%)
2. Three of four departments submitted their annual hazardous material inventory.
 - This goal will be eliminated in 2016.
3. There was only one incident reported of biohazardous materials being disposed of incorrectly. The goal was added in 2015 due to concern that inappropriate disposal was an issue. The low number of incidents does not warrant continued measurement.
 - This goal will be eliminated for 2016

EMERGENCY MANAGEMENT

BHD participated in several community based emergency exercises in 2015. The state wide tornado drill, the MRMC Campus-wide Violent Event exercise (both a table top and a full scale exercise) Additional training for managers on Active Shooter events and incident command system (ICS) is being planned for 2016 Goal is to have at least 25% of management staff trained in ICS 100 and 700.

FIRE PREVENTION

1. The number of completed fire drills: In 2015 EES (Engineering & Environmental Services) completed 108 fire drills at the Behavioral Health Division. This number (108) of completed fire drills represents a 100 % completion rate of all necessary fire drills for the Behavioral Health Division.
 - In 2015 the goal will be to maintain the 100 % completion rate of all required fire drills at the Behavioral Health Division.
2. The average score recorded on the fire drill check sheet: In 2015 the average score recorded on the fire drill check sheets was 97%.
 - In 2016 the goal will be to maintain the 97 % or higher score on the fire drill check sheets.
3. The percentage of annual training fire questions that were answered correctly: In 2015 Educational Services asked the question on their annual house-wide training "After activating the fire alarm, you should first call? And then call?" This question was asked to 3 different user groups at the Behavioral Health Division. Group #1 were the Registered Nurses; of the 146 responses, 96 % gave the correct answer. Group #2 was the balance of the BHD / Milwaukee County employees; of the 477 responses, 95% gave the correct answer. Group #3 were the contracted staff who work at BHD; of the 130 responses, 84 % gave the correct response.
 - The goal for 2016 will be to have all BHD staff maintain a score of 95 % or better on the annual house-wide fire safety questions.
 - In order to raise the score of the contracted staff from 84% to a score of at least 95%, EES will work in conjunction with Educational Services to provide ongoing training until this result is achieved.
4. The number of fire setting contraband detected on patient units: In 2015 the total number of reported fire setting contraband items that were detected on patient units was 4.
 - In 2016 the goal will be to have less than 4 contraband items on patient units.
5. The number of fire incidents: In 2015 there were zero fire incidents reported for the Behavioral Health Division.
 - The goal will be eliminated for 2016.
6. The number of false alarms: In 2015 there were a total of 13 false alarms reported for the Behavioral Health Division.
 - The goal will be eliminated for 2016.

UTILITIES MANAGEMENT

In 2015 several different remediation efforts took place to eliminate the source of mold within the HVAC system. At present the air quality tests conducted indicated that the quantity of mold spores in the building was far less than in the outside air. Visual inspections of the system will continue to assure the problem does not recur. An emergency power generator is being installed to create a regulatory compliant redundancy of power. This will improve BHD's capabilities for business continuity in the event of an emergency.

1. Number of Utility failures: In 2015 there were zero utility failures at the Behavioral Health Complex.
 - In 2016 the goal will be eliminated for 2016
2. Number of past due P.M.'s or Preventative Maintenance work orders. In 2015 the EES department posted a completion rate of 65 % for all P.M.'s or preventative work orders performed at the Behavioral Health Complex. (1098 P.M.'s were issued and 709 were completed)
 - In 2016 the goal for EES will be to achieve a 90% completion rate of all Critical and Life Safety Systems P.M.'s or preventative maintenance work orders.
3. Percentage of Utility Components labeled and inventoried: In 2015 EES recorded 25 % of shut off valves were labeled and inventoried for the Behavioral Health Division.

- In 2016 the goal for EES will be to have the remainder of the shut off valves labeled and inventoried or to achieve a 100 % completion rate.
4. Negative Pressure Rooms tested before use: In 2015 the negative pressure rooms were not in use therefore there were zero tests performed.
 - In 2016 the goal will be eliminated. If a decision is made to reactivate the negative pressure rooms, monthly testing and prior to use testing will resume at that time.
 5. The percentage of times the emergency generator testing failed: The emergency generator for the 9201 Building failed zero times during monthly testing. The new generator for the 9455 building was not installed prior to yearend as expected so no testing was conducted.
 - Generator testing failures will be recorded for 9455 building once the installation is completed.

MEDICAL EQUIPMENT

With the exception of thermometers, no new clinical equipment was purchased in 2015. Equipment removed from service include audiometers, dental x-ray, nebulizers, and oxygen concentrators. Additional equipment available as a result of the elimination of the Rehabilitation Centers will be retired or re-deployed to other BHD areas. The existing inventory of available equipment will be reconciled as it is entered into the new Accruent work order system. Missing equipment will also be reviewed/updated at the same time.

1. Identifying and locating missing clinical equipment is difficult. There is no standardized location on each unit for items. Staff will at times store or stockpile items in less common areas.
 - The goal to decrease missing equipment by 20% was not able to be measured. This goal will be removed for 2016. The new inventory and preventive maintenance system will be utilized for tracking equipment.
2. There were no Safe Medical Device Act reportable incidents.
 - Goal met for 2015. This item will be removed for 2016
3. There were no equipment repairs required as a result of user error in 2015.
 - This goal was met and will be modified to continue to monitor and report on equipment repairs..

The Environment of Care Committee recommends the following key goals for 2016:

- **To reduce the amount of infectious waste generated to below 50# per month, by eliminating inappropriate disposal of non-infectious waste and by determine alternate products where feasible.**
- **To improve the rate of staff and contractor correct responses to quarterly trainings regarding fire safety, regulated medical waste, and global harmonized system.**



Behavioral Health Division

Date Issued: 1/1/2015
Last Approved Date: 4/25/2016
Last Revised Date: 4/25/2016
Next Review: 4/25/2019
Owner: Lynn Gram: 80043-Safety Officer
Policy Area: Environment of Care
References:

Environment of Care Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, the Behavioral Health Division Administration has established the Environment of Care (EC) Committee and supports the Environment of Care Program as described in this plan. The purpose of the EC Committee is to establish a system to reduce the risk of injury to patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD).

The EC Program establishes the structure within which a safe environment of care is developed, maintained and improved. This plan also addresses specific responsibilities, general safety, emergency management, and employee education programs.

SCOPE:

The EC Program establishes the organizational structure within which a safe environment of care is provided, maintained, and improved at MCBHD facilities. The areas included in the EC Plan are: Safety Management, Security Management, Hazardous Materials Management, Medical Equipment Management, Utilities Management, Fire/Life Safety Management and Emergency Management. Activities within these categories aim to manage the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. Separate management plans are written annually for each of these areas. (EC 01.01.01 – EP 3-8)

MCBHD locations include:

Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. Develop and implement annual plans, goals and reports for the various functions of the EC.
2. Develop and implement performance-monitoring indicators for the various functions of the EC.
3. Oversee risk mitigation of issues that impact the facilities with regards to the EC.

AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program. An Environment of Care Committee has been established to manage the EC Program. Committee members are appointed by Administration to maintain a multi-disciplinary membership. The EC Committee guides the EC Program and associated activities. All safety issues reside under the jurisdiction of the EC Committee and its ad hoc subcommittees.

The EC Committee Chair has been given authority by the Hospital Administrator to organize and implement the EC Committee. The committee will evaluate information submitted, respond accordingly, and evaluate the effectiveness of the EC Program and its components on an annual basis. Responsibilities of the committee include reporting significant findings and recommending actions to the ET along with any other program or department necessary for effective functioning. (EC 01.01.01-EP1)

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. (EC 01.01.01-EP2)

The EC Program was established and maintained to create a safe environment at each location for the provision of quality patient care. To accomplish this task, the EC Committee will meet a minimum of monthly to monitor the Management Programs identified in the EC Scope.

- Safety Management
- Security Management
- Hazardous Materials Management
- Medical Equipment Management
- Utilities Management
- Fire/Life Safety Management
- Emergency Management

ENVIRONMENT OF CARE (EC) COMMITTEE:

A. EC COMMITTEE MEMBERSHIP:

In addition to the multi-disciplinary membership appointed by administration, each Standing or Ad Hoc Committee Chairperson shall also serve on the Environment of Care Committee. Members receive a letter of appointment from the administrator annually.

B. EC COMMITTEE SUMMARY:

1. The EC Committee will provide the following:
 - A forum in which employees can raise concerns regarding safety risks within the EC management areas for discussion, assessment, and mitigation planning.
 - Focused discussions on particular issues, including creation of ad hoc subcommittees to address specific topics as necessary.
 - Reports on activities and an annual summary of achievements within the EC management categories.
2. The Hospital Administrator appoints an EC Committee Chairperson and Safety Officer, who develop, implement, and monitor the EC Program. The remaining membership of the EC Committee includes representatives from administration, clinical areas and support services. The committee member goals and responsibilities are developed and reviewed as part of the program's annual evaluation.
3. The Assistant Hospital Administrator 2, Support Services shall serve as the Chairperson of the EC Committee and oversee its membership.
4. The EC Committee Chairperson is responsible for the following issues related to Safety:
 - a. Advise Administration, Medical Staff and Management Teams on safety matters requiring their attention and action.
 - b. Make recommendations necessary to establish or modify policies to the EC Program
 - c. Monitor the effectiveness of policy or procedural changes made or recommended.
 - d. Appoint committees, as appropriate, with specific responsibilities in relation to patient, employee, facility, community or environmental safety.
 - e. Appoint the Chairperson to any EC related subcommittees (standing or ad hoc).
 - f. Ensure minutes of all EC related committees are kept and reviewed, as appropriate.
 - g. Provide leadership and consultation for any subcommittee chairpersons.

- h. Monitor subcommittees for effectiveness and compliance with regulatory agencies.
 - i. Evaluate committee and subcommittee members and chairperson's performance.
 - j. Ensure that the following receive timely information on the EC Program:
 - Executive Team
 - Medical Staff
 - Quality Management Services Committee (QMSC)
 - Department Directors/Managers
 - Program Executive Teams (Acute, Crisis, and Community)
5. Each EC Subcommittee Chairperson shall oversee the subcommittee and provide the following support:
- a. Ensure minutes are kept and submitted to the Chairperson of the EC Committee in a timely manner.
 - b. Make recommendations necessary to establish or modify policies to the EC Program.
 - c. Report recommendations for policy changes and/or safety procedures to the EC Committee Chairperson.
 - d. Evaluate the committee and membership for effectiveness.
 - e. Take all corrective actions necessary on items referred to them by an EC Committee member.
 - f. Refer safety concerns to the proper subcommittee chair and the EC Committee Chair.
6. The employee has responsibilities regarding their environment. BHD recognizes its responsibility to engineer or administrate a solution for any known hazards under Occupational Safety & Health Administration (OSHA) regulations. The employee is then to be trained and the hazard addressed at staff level. Staff responsibilities include:
- a. Report safety concerns to the department supervisor/manager/director.
 - b. Access, or make referrals to the EC Committee by contacting the appropriate committee chairperson, or member of the committee.

GENERAL RESPONSIBILITIES:

1. ADMINISTRATION

- a. Provide every employee with safe and hazard free working environment.
- b. Develop and support safety programs that will prevent or eliminate hazards.
- c. Encourage and stimulate staff involvement in activities to provide a safe and healthful working environment.
- d. Ensure all contracted service providers comply with safety policies, procedures, laws, standards, and ordinances.
- e. Appoint a Chairperson of the EC Committee and a designated Safety Officer.
- f. Appoint an EC Committee to assist in development, coordination, and implementation of the EC Plan.

2. ENVIRONMENT OF CARE COMMITTEE AND SAFETY OFFICER

a. EC Committee

- Members shall protect the confidentiality of what is said and issues in all EC Program Management Meetings.
- Develop written policies and procedures to enhance safety within BHD locations.
- Develop and promote educational programs and encourage activities, which will increase safety awareness among staff.
- Establish methods of measuring results of the EC Program.
- Be familiar/knowledgeable with local, state, and federal safety regulations as appropriate.
- Develop a reference library including all applicable building and safety code standards.
- Review Infection Control and Employee Health issues.
- Take action when a hazardous condition exists.
- Establish a standard level of attendance and participation at EC committee meetings
- Conduct an annual evaluation of the objectives, scope, performance and effectiveness of the EC Program.

b. Safety Officer

- The Safety Officer is responsible for directing the safety program, directing an ongoing, organization-wide process to collect information about deficiencies and opportunities for improvement in the EC Programs.

3. BHD DIRECTORS, MANAGERS AND SUPERVISORS

Department and Program Directors and Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate information regarding the EC Plan and are directed to maintain a current awareness of the EC Program, ensuring its effective implementation within their department. In addition:

- a. Set examples of Safety awareness and good safety practices for employees
- b. Use Incident Reports as appropriate
- c. Become familiar with all aspects of the EC Program
- d. Develop and implement Safety Policy and Procedures within their department/program.

4. BHD EMPLOYEES

Each employee is responsible for attending safety education programs and for understanding how the material relates to his or her specific job requirements. Employees are responsible for following the guidelines set forth in the EC Program and for having a basic familiarity with the EC structure. Employee training attendance is monitored and a list of non-attendance is provided to Managers for follow-up.

EC COMMITTEE FUNCTIONS

1. Meets monthly, or more frequently at the call of the chairperson;
2. Reviews/addresses issues pertaining to each of the EC Management categories at regular predetermined intervals (see individual management section for frequencies);
3. At least annually, report committee activities, pertinent committee findings and recommendations to ET, MEC and QCPS Council;

4. Monitor federal, state, city, county, and other regulatory agencies' activities and ensure compliance;
5. Assign research and development projects to the appropriate committee or temporary work group;
6. Quarterly, review actions taken by other Programs (Infection Control, Risk Management, etc) that may impact the EC Program and address as appropriate;
7. Quarterly, review educational activities provided;
8. Semi-annually, review summaries of employee/visitor injuries, illnesses and safety incidents and make appropriate recommendations or referrals;
9. Semi-annually, review summaries of security incidents involving employees, patients, visitors and property and make appropriate recommendations;
10. Quarterly, review Emergency Management activities and make appropriate recommendations for changes in procedure or education;
11. Quarterly, review summaries of the management of hazardous materials, wastes and related incidents and make appropriate recommendations for changes in policy/procedure or education;
12. Quarterly, review summaries of environmental tours and make appropriate recommendations or referrals;
13. When appropriate, review summaries of patient falls, sentinel events, and action plans and make appropriate recommendations for changes in procedure or education;
14. When appropriate, review, approve, or make recommendations for changes to policies and procedures;
15. Quarterly, review summaries of medical equipment management and related incidents and make appropriate recommendations;
16. Quarterly, review summaries of the life safety management program and make appropriate recommendations for changes in procedures/or education;
17. Quarterly, review summaries of utility and equipment management, related failures, errors or incidents to determine the need for changes in procedures and/or education;
18. Monitor and trend and analyze incidents, and prevention program effectiveness;
19. Monitor subcommittee activities and provide guidance and direction;
20. Evaluate, at least annually, the performance and effectiveness of the committee and subcommittees;
21. Review the need for continued monitoring or recommendations once the above evaluation is completed;
22. Maintain confidentiality of what is said and issues presented at all EC committee meetings;
23. Review attendance of committee members against established standard and take corrective action;
24. Other specialists will participate in EC Committee meetings as needed to address specific topics;

RESPONSIBILITIES SPECIFIC TO THE VARIOUS MANAGEMENT AREAS OF THE EC

1. **SAFETY MANAGEMENT** (EC 02.01.01 EP 1,3,5 & EC 02.01.03 EP 1, 4, 6; EC 02.06.01; EC 02.06.05; & EC 04.01.01)
 - a. Discuss topic quarterly or more frequently upon the call of the chairperson and record in minutes.
 - b. Create an annual Safety Management Plan. (EC 01.01.01 EP 3)
 - c. Incorporate all BHD departments in all related activities and Management Plans.

- d. Make appropriate recommendations for educational needs to the appropriate departments.
- e. Coordinate and cooperate in the development of departmental safety rules and practices. Conduct annual review of Department Safety Policy and Procedures (no less than every three years, if no significant change in Policy).
- f. Detect safety hazards (mechanical, physical, and/or human factors), and recommend corrections of such hazards.
- g. Semi-annually review the fall reduction program data and activities and make recommendations for changes to policies and procedures.
- h. Annually, develop goals, objectives and performance standards for Safety Management.
- i. Annually, assess the effectiveness of implemented recommendations.
- j. Report Quarterly on activities of Safety Management.
- k. Establish a process, and conduct a review of all Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- l. Conduct environmental rounds/tours every six months in all areas where patients are served and annually in locations where patients are not served, with a multi-disciplinary team including the following individuals/departments:
 - Infection Prevention
 - Facilities Maintenance
 - Housekeeping
 - Administration
- m. Analyze and trend findings reported during environmental tours.
- n. Develops criteria in which environmental round findings can be categorized and determined to be significant.
- o. Annually, evaluate the effectiveness of the environmental rounds.
- p. Analyze patient and non-patient falls, trend data and recommend appropriate prevention strategies.
- q. Analyze and trend staff occupational illnesses, injuries and incidents reported on the OSHA Log or from Risk Management Department.
- r. Analyze and trend visitor incidents reported to Risk Management.
- s. Develop criteria in which incidents can be categorized and determined to be significant.
- t. Review each of the following for trends and issues that need additional attention;
 - Employee Safety
 - Patient Safety

2. SECURITY MANAGEMENT (EC 02.01.01 EP 7-10)

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record in minutes.
- b. Create an annual Security Management Plan.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Quarterly review analysis, trending and recommendations for security incidents relative to:

- Property
 - Visitors
 - Assaults
 - Security Officer injuries, interventions
 - Key control
 - Security sensitive area accessibility
 - Other
- e. Monitor the overall Security Management Program.
- f. Establish a process, and conduct a review of all Security related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- g. Annually review the Security Management Program that includes but not limited to:
- Patient, visitor, employee and property security concerns
 - Sensitive area access control
 - Traffic control policies and vehicular access
 - Orientation and Education Programs
 - Emergency preparedness programs related to security
 - Security equipment (cameras, alarms, telephone, etc.)
- h. Annually, develop goals, objectives and performance standards for Security Management.
- i. Annually, assess the effectiveness of implemented recommendations.
- j. Report Quarterly on activities of Security Management.
3. **EMERGENCY MANAGEMENT** (EM 01.01.01; EM 02.01.01; EM 02.02.01; EM 02.02.03; EM 02.02.05; EM 02.02.09 EM 02.02.11; EM 02.02.13; EM 02.02.15; EM 03.01.01 & EM 03.01.03)
- a. Discuss topic monthly or more frequently upon the call of the chairperson and record minutes.
- b. Create and update annually the Emergency Operations Plan (EOP).
- c. Incorporate all BHD departments in all related activities and Emergency Management Policies and Procedures.
- d. Establish a process, and conduct a review of all Emergency Management related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- e. Develop and monitor internal and external emergency management programs, with multi-discipline input, affecting all departments.
- f. Evaluate and modify Emergency Operations Plans (EOP) and exercises.
- g. Coordinate and evaluate the semi-annual emergency management exercise.
- h. Monitor, evaluate, and implement changes to the disaster manual required by federal, state, local, and national organizations, as appropriate.

- i. Maintain EOP, emergency management policies and procedures and critique and approve all in-house designated disaster assignment areas and department standard operating procedures annually.
- j. Annually, develop goals, objectives and performance standards for Emergency Management.
- k. Annually, assess the effectiveness of emergency management programs.
- l. Report quarterly on activities of Emergency Management.

4. HAZARDOUS MATERIALS AND WASTE MANAGEMENT (EC 02.02.01 & EP 1, 3, 4, 5-12)

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Create an annual Hazardous Materials and Waste Management Plan.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Assist with the creation of the hospital wide right - to - know program (RTK).
- e. Ensure that an annual review of chemical inventories occurs.
- f. Evaluate the educational needs for RTK and hospital waste programs and make appropriate recommendations.
- g. Monitor and assess waste control procedures and recommend policy/procedure changes as needed.
- h. Monitor city, state, and federal environmental laws and regulations and recommend policy/procedure changes as required.
- i. Evaluate products to promote hazardous materials and waste minimization for purchase or use.
- j. Review hazardous materials and/or waste handling problems, spills or employee incidents and make recommendations for process improvement, personal protective equipment and environmental monitoring.
- k. Monitor program recommendations, changes or implementations for effectiveness.
- l. Annually, assess the effectiveness of the hazardous materials and waste management programs for selection, storage, handling, use and disposal and recommend changes as appropriate.
- m. Report quarterly on activities of Hazardous Materials and Waste Management.

5. FIRE PREVENTION/LIFE SAFETY MANAGEMENT (EC 02.03.01; EC 02.03.03; EC 02.03.05 and LS 01.01.01 through LS 03.01.70)

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Create an annual Fire Prevention Plan.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Coordinate and conduct fire drills once per quarter per shift in all patient care buildings. (Twice this if Interim Life Safety Measures are implemented.)
- e. Analyze and trend the results of fire drills, actual fire events or false alarms and recommend appropriate changes or education.
- f. Review inspection, preventive maintenance and testing of equipment related to the Life Safety Program.
- g. Review agency inspections conducted or compliance survey reports. (i.e. Fire Marshal (state and local), Insurance, State Department of Quality Assurance, etc.)

- h. Review changes/upgrades to the fire protection system; failures/problems discovered with the system, causes and corrective actions taken.
 - i. Review summaries of construction, renovation or improvement life safety rounds.
 - j. Assess Interim Life Safety Measures implemented as a result of construction or other Life Safety Deficiencies and review and plans of corrections
 - k. Monitor program recommendations, changes or implementations for effectiveness.
 - l. At each meeting, assess the status of the facility Statement of Conditions™ and compliance with the Life Safety Code.
 - m. Establish a process, and conduct a review of all Fire/Life Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
 - n. Annually, develop goals, objectives and performance standards for Fire Prevention.
 - o. Annually, assess the effectiveness of the Fire Prevention Program, policies/procedures and educational components.
 - p. Report quarterly on activities of Fire Prevention Management.
- 6. MEDICAL EQUIPMENT MANAGEMENT (EC 02.01.01 EP 10 and 02.04.03)**
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
 - b. Create an annual Medical Equipment Management Plan.
 - c. Incorporate all BHD departments in all related activities and Management Plans.
 - d. Monitor medical equipment hazard recalls. Review inspection, tests, maintenance and education policies for medical equipment and device users.
 - e. Monitor for compliance with the FDA Safe Medical Device Act.
 - f. Review medical equipment management program, problems, failures and user errors that adversely affect patient care or safety and the corrections or follow-up actions taken.
 - g. Review and analyze major problems or trends identified during preventative maintenance and make appropriate recommendations.
 - h. Monitor on-going medical equipment education programs for employees related to new equipment, replaced or recalled equipment, certification and/or recertification and user errors.
 - i. Review requests and make recommendations for the purchase of medical equipment.
 - j. Monitor the entry and use of medical equipment entering the facility from sources outside of the medical equipment program. (I.e. rental equipment).
 - k. Monitor the use of personal protective equipment associated with the use of medical equipment management, i.e. radiology services.
 - l. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the medical equipment program or needs.
 - m. Establish a process, and conduct a review of all Medical Equipment related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.

- n. Review contingency plans in the event of medical equipment disruptions and or failures, procedures for obtaining repair services and access to spare equipment.
- o. Annually, develop goals, objectives and performance standards for the committee.
- p. Annually assess the effectiveness of the medical equipment management program.
- q. Report quarterly on activities of Medical Equipment Management.

7. UTILITY MANAGEMENT (EC 02.05.01; EC 02.05.03; EC 02.05.05; & EC 02.05.07)

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Review/revise the Utility Management Plan annually.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the management of Utility Systems.
- e. Review incidents related to emergency testing, system upgrades, system shutdowns, preventative maintenance problems, major problems with emphasis on the impact on patient care and corrective actions.
- f. Review, analyze and trend problems or failures relating to:
 - Electrical Distributions Systems
 - Elevator Systems
 - HVAC Systems
 - Communication Systems
 - Water Systems
 - Sewage Systems
 - Environment Control Systems
 - Building Computer Systems
 - Security Systems
 - Other
- g. Review management plans and monitoring systems relating to utility management.
- h. Establish a process, and conduct a review of all Utility related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- i. Annually, review the effectiveness of the utility system management program.
- j. Review emergency procedures and plans to respond to utility system failures.
- k. Review patient care equipment management (beds, lighting, etc) and all non-clinical high-risk equipment problems.
- l. Report quarterly on activities of Utility Management.

8. OTHER COMMITTEES

- a. The EC Committee has a relationship with three other committees, each submit a summary report. Information from these reports is incorporated into the annual report submitted by the EC. These committees include:
 1. Infection Prevention - Although this is not a sub-committee; this existing committee has a relationship that submits information on a 'need to know' basis, identifying concerns.
 2. Risk Management - Although this is not a sub-committee, this existing department has a relationship that submits information on a 'need to know' basis, identifying concerns.
 3. Hospital Incident Command System Committee - Although this is not a sub-committee, this existing department has a relationship that submits information on a 'need to know' basis, identifying concerns.

9. EOC EDUCATION (EC 03.01.01)

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Incorporate all BHD departments in all related activities and Management Plans.
- c. Track and trend department compliance with annual in-service attendance.
- d. Review and assist in the development of educational programs for orientation and annual in-services.
- e. Develop criteria in which compliance with safety education can be effectively measured.
- f. Make appropriate recommendations to other committees/leadership regarding problematic trends and assist in implementation of final resolution plans.
- g. Develop and implement safety promotional ideas such as safety fairs, contests, and incentive programs.
- h. Promote safety issues in various communication forms at BHD (newsletter, emails, signage).
- i. Annually, develop goals, objectives and performance standards for education of EC related information.
- j. Annually, assess the effectiveness of the annual safety in-service program.

INTENT PROCESSES

1. Issue Assessment (EC 04.01.01)

BHD addresses issues identified by the EC Committee related to each of the components of the Environment of Care Management Program. Based on the committee's assessment of the situation, a decision on the best course of action to manage the issue is determined. Documentation of this evaluation process may be found in the EC Committee minutes. Results of the process are used to create or revise policies and procedures, educational programs, and/or monitoring methods.

Appropriate representatives from hospital administration clinical services, support services, and each area of the EC Management functions are involved in the analysis of data regarding safety and other issues. Verbal reports are considered appropriate to communicate time sensitive information when necessary. Written communication may follow the verbal report.

Information collection and evaluation systems are used to analyze data obtained through ad hoc, periodic, and standing monitoring activities. The analysis is then used by the EC Committee to set priorities,

identify problems and develop or approve recommendations.

2. Environmental Rounds (EC 04.01.03)

The Safety Officer or EC Committee Chair actively participates in the management of the environmental rounds process. Rounds are conducted to evaluate employee knowledge and skill, observe current practice and evaluate conditions of the environment. Results are compiled and serve as a tool for improving safety policies and procedures, orientation and education programs and employee knowledge on safety and performance. Summaries of the rounds and resulting activities or corrections are reported through the EC annual report or more frequently if necessary.

Environmental rounds are conducted twice a year in each patient care area and once a year in the non-patient care areas. Answers provided during random questioning of employees during rounds are noted and reported through the EC Committee for review and possible further action.

3. Medical, Equipment and Product Safety Recalls and Notices (EC 02.01.01 EP 11)

The EC Committee reviews compliance with monitoring and actions taken on recalls and alerts. A system to manage recalls throughout the division will be created or purchased.

4. Safety Officer Appointment (EC 01.01.01 EP 1)

The BHD Hospital Administrator is responsible for managing the Safety Officer appointment process. The appointed Safety Officer is assigned operational responsibility for the EC Management Program. If the Safety Officer position becomes vacant, the BHD Hospital Administrator is responsible for selecting a qualified individual capable of overseeing the development, implementation and evaluation of the Environment of Care Management Program. The Safety Officer reports directly to the BHD Administrator and is guided by a written Job description

5. Intervention Authority (EC 01.01.01 EP 2)

The Safety Officer and/or the individual serving as the Administrative Resource on site and the Administrator on Call have been given the authority by the BHD Hospital Administrator to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings.

ORIENTATION AND EDUCATION

- 1. New Employee Orientation:** (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01.1-10) Safety Education begins with the New Employee Orientation program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis
- 2. Annual Continuing Education:** (HR 01.05.03 EP 1-13) Safety Education is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees.
- 3. Department Specific Training:** (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3) Directors/ Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards.
- 4. Contract Employees:** (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-7) Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at

BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year.

PERFORMANCE MONITORING

(EC 04.01.05)

A. Performance monitoring is ongoing at BHD. The following performance monitors have been established for the management areas of the EC.

Safety Management

1. Actions taken for urgent recalls and alerts are documented in RASMAS within 3 days a minimum of 95% of the time
2. Measure staff score on safety training questions. (Goal = ave. 95%)
3. Measure the number of environmental rounds items addressed in 30 days (Goal = 80%)

Security Management

1. Track the frequency of weekly roll-call meetings. (Goal=52)
2. Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)
3. Number of incidents of unauthorized Access from locked unit. (Goal = 0)
4. Number of incidents where a secure area is found unsecured. (Goal ≤ 2 times)
5. Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)
6. Camera outages will be repaired within 48 hours (Goal =100%)

Hazardous Materials Management

1. Measure the percentage of employees who can correctly identify regulated waste items requiring special disposal (Goal=95%)

Emergency Management

1. Increase the number of Management Team members trained in ICS/HICS (100 & 700) by 25%
2. Measure the percentage of emergency management related questions on annual training answered correctly by staff. (Goal = 85%)

Fire Prevention

1. Measure the number of Fire drills completed (Goal = 100% completion rate)
2. Measure the average score on the fire drill check sheet. (Goal is 97%)
3. Measure the percentage of fire prevention related questions on annual training answered correctly by staff. (Goal 95%)
4. Measure the number of fire setting contraband items/incidents found on inpatient units. (Goal < 4)

Utilities Management

1. Measure the number of utility failures (Goal = 0)
2. Measure the completion rate of preventive maintenance tasks (Goal =90%)
3. Measure the percentage of utility components labeled and inventoried (Goal = 100% by year end)
4. Measure the percentage of generator testing that did not pass (Goal = 0%)

Medical Equipment Management

1. Monitor and report on the number of equipment repairs.
- B. Data from these performance monitors are discussed at the EC Committee. Performance indicators are compiled and reported to the BHD Executive Team (ET), the BHD Quality Management Services Committee (QMSC), the Medical Staff Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care. (EC 04.01.03)

ANNUAL EVALUATION

(EC 04.01.05)

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for the EC Management plans. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Environmental Management Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC and QMSC the program executive committees, and the County Wide Safety Committee. This finalizes the evaluation process.

Attachments:

No Attachments

	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/13/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/13/2016
		Lora Dooley: 38100-Medical Service Manager	4/22/2016
		Alicia Modjeska: Interim Administrator	4/25/2016



Behavioral Health Division

Date Issued: 1/1/2015
Last Approved Date: 1/1/2015
Last Revised Date: 1/1/2015
Next Review: 3 years after approval
Owner: Lynn Gram: 80043-Safety Officer
Policy Area: Environment of Care
References:

Safety Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, Behavioral Health Division Administration has established the Environment of Care (EC) Committee and supports the Safety Management Program as described in this plan.

The purpose of the Safety Management Plan is to establish a system to reduce the risk of injury to patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework within which a safe environment of care is developed, maintained and improved. This plan also addresses specific responsibilities, general safety, and employee education programs.

SCOPE:

The Safety Management Plan establishes the organizational structure within which a safe environment of care is established, maintained, and improved at MCBHD facilities. In addition to addressing specific responsibilities, general safety, and employee education programs the plan is in all efforts directed toward managing the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP3)

MCBHD locations include:

Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. Develop and implement department specific safety policies and education.
2. Monitor, track and trend employee injuries throughout the facility.
3. Effectively use environmental rounds data.
4. Develop and implement electronic rounding system.

AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program including the Safety Management Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The BHD Administrator appoints an EC Committee Chairperson and Safety Officer to develop, implement, and monitor the Safety Management Program. The EC Committee guides the Safety Management Program and associated activities. The Safety Officer is responsible for directing the safety program, and an ongoing, organization-wide process for collection of information about deficiencies and opportunities for improvement in the EC Management programs. BHD will utilize the EC Committee in lieu of a separate Safety Committee, where the Safety Officer will organize and implement inspection of all areas of the facility to identify safety hazards, and to intervene wherever conditions exist that may pose an immediate threat to life or health or pose a threat of damage to equipment or property. (EC 01.01.01-EP1)

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. (EC 01.01.01-EP2)

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable safety regulations, and evaluate the effectiveness of the safety program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. **(EC 01.01.01-EP3)**

Department/Program Directors and/or Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate safety program guidelines and are directed to maintain a current awareness of the safety program, and to ensure its effective implementation within their program/department.

Each employee is responsible for attending and/or completing safety education programs and for understanding how the material relates to his/her specific job requirements. Employees are responsible for following the safety guidelines set forth in the safety program. Employee training attendance is monitored and a list of non-attendance is provided to Managers and/or Directors for follow-up.

INTENT PROCESSES:

- A. **Risk Assessments - (EC 02.01.01 EP1, 3)** BHD performs risk assessments to evaluate the impact of proposed changes in areas of the organization. The desired outcome of completion of risk assessments is a reduction in likelihood of future incidents and other negative experiences, which hold a potential for accident, injury, or other loss to patients, employees, or hospital assets. Potential safety issues are reported, documented and discussed at the EC Committee meetings, all available pertinent data is reviewed, alternatives discussed, and a summary forwarded to management and included within the meeting minutes.

Based on the committee's evaluation of the situation, a decision by management is reached and returned to the committee. Results of this risk assessment process are used to create new, or revise existing safety policies and procedures; environmental tour elements specific to the area affected; safety orientation and education programs; or safety performance improvement standards.

- B. **Incident Reporting and Investigation – (EC 04.01.01 EP1, 3, 4, 5)** Patient and visitor incidents, employee incidents, and property damage incidents are documented and reported quarterly to the EC Committee and the individual program executive committees. The reports are prepared by the Quality Improvement Department. The report and analysis are reviewed by the EC Committee for identification of trends or patterns that can be used to make necessary changes to the Safety Management Program and control or prevent future occurrences.
- C. **Environmental Tours – (EC 04.01.01 EP12-14)** A team of staff including the Safety Officer actively participates in the management of the environmental rounds process. Environmental Rounds are conducted regularly as outlined in the EC Management Plan, to evaluate employee knowledge and skill, observe current practice, and evaluate environmental conditions. Results from environmental rounds serve as a tool for improving safety policies and procedures, orientation and education programs, and employee performance. The Safety Officer provides summary reports on activities related to the environmental tour process to the EC Committee. Rounds are conducted at least every six months in all areas where patients are served and at least annually in all areas where patients are not served.

Individual department managers are responsible for initiating appropriate action to address findings

identified in the environmental rounds process and recording those actions in the system and/or reporting them to the Safety Officer.

Environmental Rounds are used to monitor employee knowledge of safety. Answers provided during random questioning of employees, during the survey, are analyzed and summarized as part of the report to the EC Committee and used to determine educational needs.

- D. **Product/Medication/Equipment Safety Recalls – (EC 02.01.01 EP11)** Information regarding a recalled product, medications, or equipment is distributed via an internet based clearing house service (RASMAS). The EC Committee will review and report on recall and alert compliance quarterly
- E. **Examining Safety Issues - (EC 04.01.03 EP 1-2)** The EC Committee membership includes representatives from Administration, Clinical Programs, Support Services and Contract Management. The EC committee specifically discusses safety concerns and issues a minimum of six (6) times per year, and incorporates information on Safety related activities into the bi-annual report.
- F. **Policies and Procedures –** The Safety Officer is responsible for coordinating the development of general safety policies and procedures. Individual department managers are responsible for managing the development of departmental specific safety policies and procedures, which include but is not limited to, safe operations, use of hazardous equipment, and use of personal protective equipment. The Safety Officer assists department managers in the development of new department safety policies and procedures.

BHD wide safety policies and procedures are available to all staff at the following website: <https://milwaukeebhd.policystat.com>. Department Directors and/or Managers are responsible for distribution of department level policies and procedures to their employees. The Safety Officer and department managers are responsible for ensuring enforcement of safety policies and procedures. Each employee is responsible for following safety policies and procedures.

BHD wide and departmental safety policies and procedures are reviewed at least every three years or as necessary. Some policies/procedures may be reviewed more often as required or deemed necessary.

- G. **Safety Officer Appointment – (EC01.01.01-EP1)** The Hospital Administrator is responsible for managing the Safety Officer appointment process. If the position should become vacant, the Hospital Administrator is responsible for selecting a qualified individual capable of overseeing the development, implementation, and monitoring of the Safety Management Program.
- H. **Intervention Authority – (EC 01.01.01-EP2)** The Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call have been given authority by the Hospital Administrator or their designee to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings. Any suspension of activity shall immediately be reported to the Hospital Administrator, or designee, and the Medical Director when appropriate.
- I. **Grounds and Equipment – (EC02.01.01-EP5)** The Environment and Engineering Services (EES) department is responsible for scheduling and performing maintenance of hospital grounds and equipment. Policies and procedure for this function are located in the EES department.

EMPLOYEE HEALTH AND WELFARE

- A. Program Directors and Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate safety program guidelines and are directed to maintain a current awareness of the Safety Program, and to ensure its effective implementation within their department. Each employee is responsible for completing safety education programs and for understanding how the material relates to his or her specific job requirements. Employees are responsible for following the safety guidelines set forth in the Safety Program. Employee attendance at educational events is monitored and a list of non-attendance is provided to Managers/Directors for follow-up.
- B. Employees report work related injuries, occupational illnesses or exposure to contagious diseases to their supervisor, the infection preventionist, and by completing a First Notification of Injury Form. Reports of employee incidents are recorded by the Milwaukee County Risk Management Department and tabulated for trending by the Quality Management Department and/or Safety Officer for reporting to the Safety Committee.
- C. BHD reviews and analyzes the following indicators:
 - 1. Number of OSHA recordable lost workdays
 - 2. Injuries by cause
 - 3. Needle sticks and body fluid exposures

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01 EP 1-10) The Safety Education begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis
- B. **Annual Continuing Education:** Safety Education is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. (HR 01.05.03 EP 1-13)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)

PERFORMANCE MONITORING

(EC 04.01.03 EP 1-3); EC 04.01.05 EP 1-3)

- A. Ongoing performance monitoring is conducted for the following performance monitors:

1. Actions taken for urgent recalls and alerts are documented in RASMAS within 3 days a minimum of 95% of the time
 2. Measure staff score on safety training questions. (Goal = ave. 95%)
 3. Measure the number of environmental rounds items addressed in 30 days (Goal = 80%)
- B. The Safety Officer oversees the development of the Safety related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for each of the seven functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Safety Management Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC, and QMSC, the Program Executive Committees, and the County Wide Safety Committee. This finalizes the evaluation process.

SMOKING POLICY –

Reference Administrative Policy: Tobacco Free Policy (EC 02.01.03 EP 1, 4, & 6)

BHD is committed to the promotion of healthy environments in all programs. All medical evidence indicates that smoking is contrary to this objective. In support of this objective, effective November 16, 2007 the use of all tobacco products (cigarettes, e-cigarettes, vaporizing (vape) pens, cigars, pipes, chewing tobacco, and other smokeless tobaccos) was prohibited on MCBHD premises including property owned, leased, or otherwise operated by MCBHD. All staff, patients, residents, visitors, renters, vendors, and any other individuals on the MCBHD grounds are prohibited from using tobacco products.

Reviewed and approved at the 3-10-16 Environment of Care Committee meeting

Reviewed and approved at the 3-16-16 Medical Executive Committee meeting

Attachments:

No Attachments

	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/28/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/28/2016
	Medical Executive Committee	Clarence Chou: 50770-Staff Psychiatrist	pending



Behavioral Health Division

Date Issued: 1/1/2015
 Last Approved Date: 1/1/2015
 Last Revised Date: 1/1/2015
 Next Review: 3 years after approval
 Owner: Lynn Gram: 80043-Safety Officer
 Policy Area: Environment of Care
 References:

Security Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, Behavioral Health Division Administration has established the Environment of Care (EC) Committee and supports the Security Management Program as described in this plan.

The purpose of the Security Management Plan is to establish a system to provide a safe and secure environment for all patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework to minimize the risk of personal injury or property loss due to criminal activity or workplace violence.

SCOPE:

The Security Management Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. In addition to addressing specific responsibilities, general security, and employee education programs the plan is in all efforts directed toward managing the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP4)

MCBHD locations include:

1. Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. To prevent crime and to provide staff, patients, and visitors with a safe and secure environment.
2. Review and trend Incident Reports for all security related incidents.
3. To reduce the likelihood of victimization through education of patients and staff.
4. Keep, manage, and control access to sensitive areas
5. To provide a thorough, appropriate and efficient investigation of criminal activity.
6. Utilize security technology as appropriate in managing emergencies and special situations.

AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program including the Security Management Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The BHD Administrator appoints an EC Committee Chairperson and a Safety Officer to develop, implement, and monitor the Security Management Program. The EC Committee guides the Security Management Program and associated activities. The EC Chairperson and Safety Officer are responsible for directing the Security program, and an ongoing, organization-wide process for collection of information about deficiencies and opportunities for improvement in the EC Management programs. BHD will utilize the EC Committee in lieu of a separate Security Committee, where the EC Chairperson and Safety Officer will organize and implement an ongoing, organization-wide process to minimize risk and threat to the welfare of patients, visitors, and employees.

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the

Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. (EC 01.01.01-EP2)

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable security regulations, and evaluate the effectiveness of the security program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the ET along with any other program or department necessary for effective functioning. (EC 01.01.01-EP1)

INTENT PROCESSES:

- A. Emergency Security Procedures (EC 02.01.01 EP 9; EM 02.02.05 EP1-10)** – The BHD Security Department maintains policies and procedures for actions to be taken in the event of a security incident or failure. Preventive maintenance is performed on the panic alarm system, security cameras, door alarms, communication radios, and door entryways with key card access.

Security has procedures addressing the handling of civil disturbances, and other situations including child/infant abductions and patient elopements. These include managing traffic and visitor control. Additional Security Officers may be provided to control human and vehicle traffic, in and around the environment of care. During emergencies security are deployed as necessary, and report in to the base (Dispatcher Control Center) and/or Incident Command Center as appropriate.

- B. Addressing Security Issues (EC 02.01.01 EP 1&3)** – A security risk assessment will be conducted annually of the facility and out stations. The purpose of the risk assessment is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The Security Supervisor works with the Safety Officer, department managers, the Quality and Risk Manager and others as appropriate. The results of the risk assessment process are used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner. The Security Department has input into the creation of employee training sessions regarding security related issues. The Security Supervisor and Security Contract Manager maintain a current knowledge of laws, regulations, and standards of security. The Security Supervisor and Security Contract Manager also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of BHD.

- C. Reporting and Investigation (EC 04.01.01 EP 1&6; EC 04.01.03 EP 1-2)** – Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the employee's Supervisor or location supervisor for follow up and then sent to the Quality Management Services Department. The Quality and Risk Manager works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Quality and Risk Manager and the Security Supervisor collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action in order to control or

prevent future occurrences.

This incident analysis is intended to provide an opportunity to identify trends or patterns that can then be used to identify necessary changes to the Security Management Program. The findings of such analysis are reported to the Environment of Care Committee as part of the quarterly Security report, and is included as part of the Security Management Program annual report.

- D. **Identification (EC 02.01.01 EP 7)** – The current systems in place at BHD include photographic ID badges for all staff, volunteers, students and members of the medical staff worn above the waistline for visibility, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing to facilitate rapid visual recognition of critical groups of staff.

When possible, the current system includes photo identification of patients in medical records, and use of a wristband system.

The identification of others entering BHD is managed by Security, the Operations Department and the Clerical Pool Department. The Security staff takes appropriate action to remove unauthorized persons from areas and to prevent unwanted individuals from gaining access to BHD.

- E. **Access and Egress Control (EC 02.01.01 EP 8)** – Various methods of control are used based on risk levels.
- **High Risk** area controls include key pad access or lock and key methods with continuous staffing and policy governing visitor and staff access.
 - **Moderate Risk** area controls include lock and key methods with limited access per policy and key distribution.
 - **Low Risk** area controls include lock and key methods only during times outside of identified business hours
 - Security will unlock doors as scheduled and make rounds at periodic intervals to maintain a safe and orderly environment. Security is stationed in the Psychiatric Crisis Center 24 hours per day, 7 days per week, and at the Main entrance desk from 6:00 a.m. to 8:30 p.m. and the Rear Employee Entrance 53A Ramp 24 hours per day, 7 days per week.

- F. **Policies and Procedures (LD 04.01.07 EP 1-2)** – Security related policies are reviewed a minimum of every three years and distributed to departments as appropriate. The Security Supervisor assists department heads with the development of department or job specific environmental safety procedures and controls.

- G. **Vehicular Access (EC 02.02.02 EP 8)** – Vehicular access to the Psychiatric Crisis Service area is controlled by Security 24/7 and limited to emergency vehicles only.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the Security Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific security training, job-specific security training, and a series of programs required for all employees on an

annual basis (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01 EP 1-10)

- B. **Annual Continuing Education:** Education regarding security is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. (HR 01.05.03 EP 1-13)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific security related policies and procedures and specific job related hazards. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)

PERFORMANCE MONITORING

(EC 04.01.03 EP 1-3); EC 04.01.05 EP 1-3)

- A. Ongoing performance monitoring is conducted for the following performance monitors:
 1. Track the frequency of weekly roll-call meetings. (Goal=52)
 2. Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)
 3. Number of incidents of unauthorized Absence from locked unit. (Goal = 0)
 4. Number of incidents where a secure area is found unsecured. (Goal ≤ 2 times)
 5. Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)
 6. Camera outages will be repaired within 48 hours (Goal =100%)
- B. The Safety Officer and EC Committee oversee the development of the Security related performance monitors. Data from these performance monitors are discussed quarterly at the EC Committee and by the Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County-Wide Safety Committee. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

- A. The Safety Officer and Chair of the EC Committee have overall responsibility for coordinating the annual evaluation process for each of the functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Security Management Program.

B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC, and QMSC, the Program Executive Committees, and the County-Wide Safety Committee. This finalizes the evaluation process.

Reviewed and approved at the 3-10-16 Environment of Care Committee meeting

Reviewed and approved at the 3-16-16 Medical Executive Committee meeting

Attachments:		No Attachments	
	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/28/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/28/2016
	Medical Executive Committee	Clarence Chou: 50770-Staff Psychiatrist	pending

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Behavioral Health Division

Date Issued: 1/1/2013
Last Approved Date: 1/1/2015
Last Revised Date: 1/1/2015
Next Review: 3 years after approval
Owner: Lynn Gram: 80043-Safety Officer
Policy Area: Environment of Care
References:

Hazardous Materials and Waste Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, MCBHD Administration has established the Environment of Care (EC) Committee and supports the Hazardous Materials and Waste Management (HMWM) Program as described in this plan.

The purpose of the HMWM Plan is to establish a system to identify and manage materials known by a health, flammability, corrosivity, toxicity or reactivity rating to have the potential to harm humans or the environment. The plan also addresses education and procedures for the safe use, storage, disposal and management of hazardous materials and waste (HMW), including regulated medical waste (RMW).

SCOPE:

The HMWM Plan establishes the organizational structure within which HMW/RMW are handled, stored, and disposed of at MCBHD. This plan addresses administrative issues such as maintaining chemical inventories, storage, handling and use of hazardous materials, exposure monitoring, and reporting requirements. In addition to addressing specific responsibilities and employee education programs, the plan is, in all efforts, directed toward managing the activities of the employees so that the risk of injury to patients, visitors and employees is reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP5)

MCBHD locations include:

Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. To increase staff knowledge of HMW/RMW and how to protect themselves from these hazards.
2. To maintain an accurate site and area specific inventory of hazardous materials including Safety Data Sheets (SDS) and other appropriate documentation for each location of MCBHD.
3. To respond to spills, releases, and exposures to HMW/RMW in a timely and effective manner.
4. To increase staff knowledge of their role in the event of a HMW/RMW spill or release and about the specific risks of HMW that they use, or are exposed to, in the performance of their duties, and the procedures and controls for managing them.
5. To increase staff knowledge of location and use of SDSs.
6. To develop and manage procedures and controls to select, transport, store, and use the identified HMW/RMW.

AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program including the HMWM Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The MCBHD Administrator appoints an EC Committee Chairperson and Safety Officer to develop, implement, and monitor the HMWM Program. The EC Committee guides the HMWM Program and associated activities. The EC Committee Chairperson and Safety Officer are responsible for directing the HMWM Program that includes an ongoing, organization-wide process for the collection of information about deficiencies and opportunities for improvement in the EC Management programs. MCBHD will utilize the EC Committee in lieu of a separate HMWM Committee, where the Chairperson and Safety

Officer will organize and implement an ongoing, organization-wide process to minimize HMW wherever possible.

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or the environment, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. (EC 01.01.01-EP2)

The EC committee will evaluate information submitted, develop policies and procedures, and evaluate the effectiveness of the HMWM Program and its components on an annual basis based on all applicable HMW/RMW rules and regulations. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. (EC 01.01.01-EP5)

INTENT PROCESSES:

A. INVENTORY - Selecting, handling, storing, using, disposing of hazardous materials/waste – (EC 02.02.01-EP 1, 3 & 5)

HMW is handled in accordance with its SDS, MCBHD policies, and all applicable laws and regulations from the time of receipt to the point of final disposition. Department Program Directors and managers are responsible for evaluating and selecting hazardous materials. Once it is determined the materials in question are considered hazardous (i.e. is the product required to have a SDS?), the Department Program Director and/or manager, with the assistance of the Safety Officer and/or HMWM program manager(s), evaluate the risks associated with use of the product and alternative solutions. This information is summarized and presented at the monthly EC Committee. Concern is for the minimization of hazardous materials whenever possible and assuring that appropriate education regarding use, precautions and disposal takes place when needed.

Contracted employees that may potentially create chemical hazards covered under the Occupational Safety and Health Act (OSHA) Hazard Communication Standard are required to inform MCBHD of all chemical hazards to which employees, patients or visitors may be exposed to as a result of the contractor's activities. Contract/RFP language requires contractors to inform MCBHD, after selection and prior to starting the contract, of any hazardous materials that they will be using in the course of their work and to provide copies of policies regarding how they handle and dispose of any hazardous materials in addition to a copy of the SDS sheet for each product to be used. Once contractors are working in MCBHD, they must update MCBHD on hazardous inventory product changes.

The annual inventory of hazardous chemicals is used as the primary risk assessment for HMW. The inventory lists the quantities, types, and location of hazardous materials and wastes stored in each department.

MCBHD does not, as part of normal operations, use or generate any radioactive materials, hazardous energy sources or hazardous gases and vapors. (EC 02.02.01-EP 6, 7, 9, &10)

B. Applicable Law and Regulation – (EC 02.02.01-EP 1&3) MCBHD ensures that HMW are used, stored, monitored, and disposed of according to applicable law and regulation, which includes, but is not limited to, the following:

- OSHA Hazard Communication Standard

- OSHA Bloodborne Pathogens Standard
- OSHA Personal Protective Equipment (PPE) Standard
- OSHA Occupational Exposure to Hazardous Chemicals in Laboratories
- Environmental Protection Agency (EPA) Regulations
- Department of Transportation (DOT) Regulations
- Wisconsin Department of Natural Resources (WDNR)

Department or Program Directors and/or managers are responsible for conducting an annual inventory of HMW. SDS' are available and employees are instructed on their location and use. The MCBHD Hazard Communication Program establishes methods for labeling hazardous materials stored in the departments.

C. Emergency Procedures - (EC 02.01.01 EP 3 & 4) - Emergency procedures for hazardous material spills are located in the Environment of Care Manual. (See *Hazard Communication Program* policy and the *Chemical Release Control and Reporting Policy*) These policies include procedures for clean up of HMW spills within the building and grounds. A large (of such a volume that is no longer containable by ordinary measures) chemical spill or hazardous materials release would initiate an immediate request for emergency response of the local fire department.

D. Reporting of hazardous materials/waste spills, exposures, and other incidents – (EC 02.01.01 EP 3 & 4) HMW spills are reported on the MCBHD Incident/Risk Management Report form. All reported HMW spills are investigated by the HMWM program manager and/or EC Committee Chair/Safety Officer. Recommendations are made to reduce recurrences based on the investigation.

Exposures to levels of HMW in excess of published standards are documented using both the MCBHD Incident/Risk Management Report and the Accident/Loss Report. Post exposure treatment and follow up are determined by the treating physician and any recommended best practices for the type of exposure.

E. Managing Hazardous Chemicals - (EC 02.01.01 EP 5)

HMW are managed in accordance with the SDS, MCBHD policies and applicable laws and regulations from the time of receipt to the point of final disposition. The inventory of HMW is maintained by the HMWM program manager(s) and Safety Officer. The SDS corresponding to the chemicals in the inventory are available through an on-line electronic service. In addition, a complete set of current SDS is maintained in both the Psychiatric Crisis Department and Engineering and Environmental Services (EES) Department.

The manager of each department with an inventory of hazardous chemicals implements the appropriate procedures and controls for the safe selection, storage, handling, use and disposal of them. The procedures and controls will include the use of SDS to evaluate products for hazards before purchase, orientation and ongoing education and training of staff, management of storage areas, and participation in the response to and analysis of spills and releases of, or exposures to, HMW.

F. Managing Radioactive Materials - (EC 02.01.01 EP 6; EC 02.02.01 EP18)

MCBHD does not use or store any radioactive materials as part of normal operations.

G. Managing Hazardous Energy Sources - (EC 02.01.01 EP 7)

Any equipment that emits ionizing (for example: x-ray equipment) and non-ionizing (for example: ultrasound and ultraviolet light) radiation is inventoried as part of the medical equipment management program. Contracted agency staff provide mobile x-ray, ultrasound and EKG services and are responsible for managing the devices used including quality control measurement, maintenance, calibration, testing, or monitoring. Staff for contracted agencies are trained in the use of the devices and appropriate PPE necessary for safety. The MCBHD contract manager audits documentation of training at least every three years. MCBHD staff that use equipment are trained in the operation and safety precautions of the device prior to use of the equipment.

H. Managing Hazardous Medications - (EC 02.01.01 EP 8; MM 01.01.03 EP 1, 2, & 3)

As part of the HMWM program, the contracted pharmacy provider is responsible for the safe management of dangerous or hazardous medications, including chemotherapeutic materials. The pharmacy orders, stores, prepares, distributes, and disposes of medications in accordance with policy, law and regulation. MCBHD does not normally carry or prescribe chemotherapeutic materials.

I. Managing Hazardous Gases and Vapors - (EC 02.01.01 EP 9 & 10)

MCBHD does not produce any hazardous gases or vapors as a part of normal operations. Therefore MCBHD does not conduct any annual monitoring of exposure to hazardous gases and vapors. In the event of a concern regarding the presence of a hazardous gas or vapor, the area will be evaluated and/or monitored for the presence of such hazards in accordance with nationally recognized test procedures. Recommended action will be taken based on the results.

J. Managing Infectious & Regulated Medical Wastes including Sharps - (EC 02.01.01 EP 1; IC 02.01.01 EP 6)

RMW are managed for MCBHD by the contracted Housekeeping provider. The Housekeeping provider is part of the EES Department and is responsible for distribution and collection of appropriate containers for the collection of RMW including medical sharps. The containers, provided by MCBHD, are leak-proof and puncture resistant. MCBHD nursing staff is responsible for placing filled containers in appropriate trash holding area for pickup and/or calling the EES Department to arrange pick up and replacement of filled RMW containers. EES staff collects the containers and transports them to the holding room. The containers are transported bi-weekly to a processing facility where the materials are sterilized and rendered unrecognizable. Once the materials are rendered harmless they are disposed of in accordance with applicable federal, state and local waste regulations.

Any staff member, patient or visitor exposed to RMW or who becomes injured due to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.

Nursing and EES staff will work together to clean up spills of blood or body fluids. The areas affected by the release will be sanitized following appropriate procedures for the material involved.

K. Management of Required Documentation (permits, licenses, labeling and manifests) (EC 02.01.01 EP 11 & 12)

The manager of the HMWM program, Safety Officer or otherwise designated MCBHD employee will

maintain all required documentation including any permits, licenses, and shipping manifests. Manifests are reconciled with the licensed RMW hauler's records on a monthly basis and action is taken regarding unreturned copies of manifests.

All staff using hazardous materials or managing hazardous wastes are required to follow all applicable laws and regulations for labeling. The team conducting environmental tours evaluates compliance with labeling requirements. Deficiencies are reported to appropriate managers for immediate follow-up, including re-education of the staff involved.

Individuals with job responsibilities involving HMW will receive training on general awareness, function specific training, safety training, and security awareness training within 90 days of starting the HMW assignment. The training will be repeated, at least, every three years.

- L. **Storage of Hazardous Materials and Waste (EC 02.02.01 EP 19)** – Satellite areas of HMW or RMW are located within the generating department. These wastes are then transported to the HMW or RWM storage area(s) located on the soiled dock. A licensed hazardous waste or RMW disposal company transports hazardous or RMW off-site for disposal. The EC Committee performs quarterly inspections of the storage area(s).
- M. **Policies and Procedures** – HWM-related policies are reviewed a minimum of every three years and distributed to departments as appropriate.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the HMW Program begins with the New Employee Orientation Program for all new employees and continues on an ongoing basis with departmental specific training, job-specific training, and continued education required for all employees on an annual basis. Training includes generic information on the Hazard Communication Program, use and access to SDSs, labeling requirements of hazardous material containers, and the use of engineering controls, administrative controls, and PPE. (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01 EP 1-10)
- B. **Annual Continuing Education:** Education regarding HMW is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. (HR 01.05.03 EP 1-13)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific HMW related policies and procedures as well as specific training on the health effects of the substances in the work place and methods to reduce or eliminate exposure. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at MCBHD. Contracted Employees attend a New Employee Orientation program at MCBHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)

PERFORMANCE MONITORING

(EC 04.01.03 EP 1-3; EC 04.01.05 EP 1-3)

- A. Ongoing performance monitoring is conducted for the following performance indicators:
 - 1. Measure the percentage of employees who can correctly identify regulated waste items requiring special disposal (Goal=95%)
- B. The Safety Officer and EC Committee oversee the development of the HMW related performance monitors. Data from these performance monitors are discussed quarterly at the EC Committee and at the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee Countywide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of MCBHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for each of the functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the HMWM Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC, and QMSC, the Program Executive Committees, and the Countywide Safety Committee. This finalizes the evaluation process.

Reviewed and approved at the 3-10-16 Environment of Care Committee meeting

Reviewed and approved at the 3-16-16 Medical Executive Committee meeting

Attachments:

No Attachments

	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/28/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/28/2016
	Medical Executive Committee	Clarence Chou: 50770-Staff Psychiatrist	pending



Behavioral Health Division

Date Issued: 1/1/2015
Last Approved Date: 1/1/2015
Last Revised Date: 1/1/2015
Next Review: 3 years after approval
Owner: Lynn Gram: 80043-Safety Officer
Policy Area: Environment of Care
References:

Fire/Life Safety Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, Behavioral Health Division Administration has established the Environment of Care (EC) Committee and supports the Fire Prevention Program as described in this plan.

The purpose of the Fire Prevention Plan is to establish a system to provide a fire-safe environment for all patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework to minimize the risk of personal injury or property loss due to fire by the provision and maintenance of adequate and appropriate building maintenance programs and fire protection systems.

SCOPE:

The Fire Prevention Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. Fire Prevention is established to ensure that employees are educated, trained and tested in the fire prevention features of the physical environment and are able to react appropriately to a variety of emergency situations that may affect the safety of occupants or the delivery of care. **(EC 01.01.01-EP6)**

MCBHD locations include:

Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. To improve employee knowledge of fire prevention requirements.
2. To provide an environment free from fire hazards.
3. To ensure the continuous effective function of all fire and life safety features, equipment, and systems.
4. To appropriately manage any fire situation, whether an actual event or a drill.

AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program including the Fire Prevention Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The BHD Administrator appoints an EC Committee Chairperson/Safety Officer to develop, implement, and monitor the Fire Prevention Program. The EC Committee guides the Fire Prevention Program and associated activities. The EC Chairperson/Safety Officer is responsible for directing the Fire Prevention/Life Safety program, and an ongoing, organization-wide process for collection of information about deficiencies and opportunities for improvement in the EC Management programs. BHD will utilize the EC Committee in lieu of a separate Fire Prevention Committee, where the EC Chairperson/Safety Officer will organize and implement an ongoing, organization-wide process to minimize risk and threat to the welfare of patients, visitors, and employees.

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. **(EC 01.01.01-EP2)**

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable life safety regulations, and evaluate the effectiveness of the fire prevention program and its

components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Committee along with any other program or department necessary for effective functioning. (EC 01.01.01-EP1)

INTENT PROCESSES:

- A. **Protection from fire, smoke and other products of combustion** –The MCBHD occupancies are maintained in compliance with NFPA 101-2000 Life Safety Code® (LSC). The Environment and Engineering Services (EES) Department completes the electronic Statement of Conditions and manages the resolution of deficiencies through the work order system or (upon participation in The Joint Commission) a Plan for Improvement (PFI) within the identified time frames. (EC 02.03.01-EP 1; LS 01.01.01 EP 1-3)

Any remodeling or new construction is designed to maintain separations and in accordance with state and federal codes including NFPA LS 101-2000 Chapters 18/19 and 38/39;NFPA 90A and NFPA 72-1999 and maintained to minimize the effects of fire, smoke, and heat. (EC 02.01.10 EP 1-10; LS 02.01.20 EP 1-32; LS 02.01.30 EP 1-25; and LS 02.01.50 EP 12)

The hospital has a written fire response plan and a fire prevention inspection program is conducted by EES, including state and local fire inspectors, to identify and correct fire hazards and deficiencies, to ensure free and unobstructed access to all exits, to reduce the accumulation of combustible and flammable materials and to ensure that hazardous materials are properly handled and stored. Copies of any reports are kept on file in the EES office. Fire Prevention issues are also noted on the environmental rounds tours. (EC 02.03.01-EP 4, 9 & 10; LS 01.01.01 EP 4; LS 02.01.20 1-32)

Smoking is prohibited on the main MCBHD campus. (EC 02.01.03-EP 1, 4, & 6; EC 02.03.01 EP 2)

- B. **Inspection, Testing, and Maintenance** – All fire protection and life safety systems, equipment, and components at MCBHD are tested according to the requirements listed in the Comprehensive Accreditation Manual of The Joint Commission, associated NFPA Standards and state and local codes regarding structural requirements for fire safety. Systems are also tested when deficiencies have been identified and anytime work or construction is performed. The objectives of testing include:
- To minimize the danger from the effects of fire, including smoke, heat & toxic gases. (LS 02.01.10 EP 1-10;)
 - To maintain the means of egress and components (corridors, stairways, and doors) that allow individuals to leave the building or to move within the building (LS 02.01.20 EP 1-32)
 - To provide and maintain proper barriers to protect individuals from the hazards of fire and smoke. (LS 02.01.30 EP 1-25)
 - To provide and maintain the Fire Alarm system in accordance with NFPA 72-1999. (LS 02.01.34 EP 1-4)
 - To provide and maintain systems for extinguishing fires in accordance with NFPA 25-1998 (LS 02.01.35 EP 1-14)
 - To provide and maintain building services to protect individuals from the hazards of fire and smoke including a fire fighters service key recall, smoke detector automatic recall, firefighters' service

emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors **LS 02.01.50 EP 4)**

Note: The current facility is neither windowless nor a high rise (**LS 02.01.40 EP 1-2)**

Note: The facility does not have any fireplaces or utilize any linen or trash chutes (**LS 02.01.50 EP 1-3, & 5-11)**

- C. **Proposed Acquisitions** –Capital acquisitions and purchases include a process to confirm appropriate specifications and materials. This includes bedding, curtains, equipment, decorations, and other furnishings to ensure that such purchases comply with current LSC guidelines. The facility also maintains policies that specify what employees, and patients can have in the facility/work areas as a way to control and minimize hazards. Currently portable space heaters and combustible decorations that are not flame retardant are not permitted in the healthcare occupancy. (**LS 02.01.70 EP 1-4)**
- D. **Reporting and Investigation** – (**EC 04.01.01 EP 9; EC 04.01.03 EP 1-2)**– LSC and fire protection deficiencies, failures, and user errors are reported to the EES Department and, as appropriate, reviewed by the manager of the department. Summary information is presented to the EC Committee on a quarterly basis.
- E. **Interim Life Safety Measures** – (**LS 01.02.01 EP 1-4)** Interim Life Safety Measures are used whenever the features of the fire or life safety systems are compromised. BHD has an Interim Life Safety Management Policy that is used to evaluate life safety deficiencies and formulate individual plans according to the situation.
- F. **Policies and Procedures** –Fire/Life Safety related policies are reviewed a minimum of every three years and distributed to departments as appropriate.
- G. **Emergency Procedures** – (**EC 02.03.01 EP 9 & 10; EC 02.03.03 EP 1-5)** Emergency procedures are outlined in the Fire Safety Plan for each building. These plans are kept in the Environment of Care manual. The Hospital Incident Command System (HICS) may be implemented to facilitate emergency management of a fire or life safety related event.
- H. **Fire Drills** - (**EC 02.03.03-EP 1-5)** Employees are trained and drilled regularly on fire emergency procedures, including the use and function of the fire and life safety systems (i.e. pull stations, and evacuation options). The hospital conducts fire drills once per shift per quarter in each building defined as healthcare and once per year in business occupancies. A minimum of 50% of these drills are unannounced.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** (**EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01 EP 1-10)**
Education regarding the Fire Prevention Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific fire prevention training, job-specific fire prevention training, and a series of programs required for all employees on an annual basis.

The training program includes the following:

- Specific roles and responsibilities for employees, students and contractors, both at and away from the fire's point of origin;
- Use and functioning of the fire alarm system,
- Location and proper use of equipment for extinguishing the fire,
- Roles and responsibilities in preparing for building evacuation,
- Location and equipment for evacuation or transportation of patients to areas of refuge,
- Building compartmentalization procedures for containing smoke and fire,
- How and when Interim Life Safety Measures are implemented and how they may affect the workplace environment.

B. Annual Continuing Education: Education regarding fire prevention is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees including feedback obtained during fire drills. (HR 01.05.03 EP 1-13)

C. Department Specific Training: Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific fire prevention related policies and procedures and specific job related hazards. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)

D. Contract Employees: Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)

PERFORMANCE MONITORING

(EC 04.01.03 EP 1-3); EC 04.01.05 EP 1-3)

A. Ongoing performance monitoring is conducted for the following performance monitors:

1. Measure the number of Fire drills completed (Goal = 100% completion rate)
2. Measure the average score on the fire drill check sheet. (Goal is 97%)
3. Measure the percentage of fire prevention related questions on annual training answered correctly by staff. (Goal 95%)
4. Measure the number of fire setting contraband items/incidents found on inpatient units. (Goal < 4)

B. The Safety Officer and EC Committee oversees the development of the Fire prevention related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for each of the seven functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Fire Prevention Program.

- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC, and QMSC, the Program Executive Committees, and the County Wide Safety Committee. This finalizes the evaluation process.

Reviewed and approved at the 3-10-16 Environment of Care Committee meeting

Reviewed and approved at the 3-16-16 Medical Executive Committee meeting

Attachments:		No Attachments	
	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/28/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/28/2016
	Medical Executive Committee	Clarence Chou: 50770-Staff Psychiatrist	pending

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Behavioral Health Division

Date Issued: 1/1/2015
 Last Approved Date: 1/1/2015
 Last Revised Date: 1/1/2015
 Next Review: *3 years after approval*
 Owner: Lynn Gram: 80043-Safety Officer
 Policy Area: *Environment of Care*
 References:

Utilities Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person-centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, Behavioral Health Division Administration has established the Environment of Care (EC) Committee and supports the Utilities Management Program as described in this plan.

The purpose of the Utilities Management Plan is to establish a system to provide a safe and comfortable environment for all patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework to provide and maintain the appropriate utility services.

SCOPE:

The Utilities Management Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. The utilities covered in this plan included: electrical distribution, emergency power, vertical transportation systems, HVAC, steam systems, communications systems, domestic water and plumbing, and security systems (key pad access, video monitoring and panic alarm). (EC 01.01.01-EP8)

MCBHD locations include:

Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. To develop and implement equipment operational sheets for critical components of the utility system.
2. To provide utility system maintenance, inspection, and testing and document the procedures.
3. To provide data that demonstrates maintenance history for each piece of equipment, what work is (over) due, and what work is planned.
4. To provide utility failure data and emergency response procedures.
5. To conduct an annual inventory of equipment included in plans and review of maintenance history and failure trends.

AUTHORITY/REPORTING RELATIONSHIPS:

The Division Lead Team (DLT) and Medical Staff Organization (MSO) support the Environment of Care Program including the Utilities Management Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The BHD Administrator appoints an EC Committee Chairperson and a Safety Officer to develop, implement, and monitor the Utilities Management Program. The EC Committee guides the Utilities Management Program and associated activities. The EC Chairperson and Safety Officer are responsible for directing the Utilities program, and an ongoing, organization-wide process for collection of information about deficiencies and opportunities for improvement in the EC Management programs. BHD will utilize the EC Committee in lieu of a separate Utilities Committee, where the EC Chairperson and Safety Officer will organize and implement an ongoing, organization-wide process to minimize risk and threat to the welfare of patients, visitors, and employees.

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. (EC 01.01.01-EP2)

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable Utilities related codes and regulations, and evaluate the effectiveness of the Utilities program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. (EC 01.01.01-EP1)

INTENT PROCESSES:

- A. Environment of Care, Design and Installation of Utility Systems (EC 02.05.01-EP1)**– Per our mission statement, the Utilities Management Plan is designed to promote a safe, controlled and comfortable environment of care by providing and maintaining adequate and appropriate utility services and infrastructure. This is managed and supported through the Environmental and Engineering Services department. The Facilities Manager collaborates with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local state and national building and fire codes. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager also assures that the necessary parties complete a Pre-Construction Risk Assessment (PCRA), which reviews air quality requirements, infection control, utility requirements, noise, vibration, fire safety, and other hazards. Recommended precautions from the PCRA are implemented as part of the project design. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of BHD
- B. Nosocomial Infection (EC 02.05.01-EP 5 & 6; EC 02.05.05-EP4)**– Proper maintenance of utility systems contributes to the reduction of hospital-acquired illnesses. The Infection Preventionist monitors the potential for these illnesses, referred to as Nosocomial Infections. Any concerns that may be utilities related will be addressed in a timely manner.
- C. Risk Minimization and Operational Reliability (EC 02.05.01-EP 3 & 4; EC 02.05.05-EP3, 4, & 5; EC 02.05.07-EP10)**– Through specific Computerized maintenance Management Program, inspections and testing activities are conducted and recorded. Equipment is maintained to minimize the risk of failure. Intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory are based on criteria including manufacturers' recommendations, risk levels, and hospital experience. Rounds are conducted by EES and are utilized to detect and assess incipient failure conditions. In the event that any equipment fails a test, that equipment will be retested after any repairs or corrections are completed.
Note: BHD does not currently have any life support systems.
- D. Risk Assessment and Inventory (EC 02.05.01-EP2; EC 02.05.05-EP1)**– Risk based criteria will be established to identify components of utility systems that are high-risk and have significant impact on life support, infection control, environmental support, equipment support, and communication systems. New system components will be evaluated prior to start-up.
- E. Maintenance of Critical Operating Systems (EC 02.05.03-EP1-6; EC 02.05.07-EP 1, 2, & 6)**– EES monitors the effectiveness of the utility systems by conducting inspections and analyzing data received through rounds and logs and supported by departmental policies and procedures. To ensure reliable operation of emergency systems, BHD performs inspections and tests of the following:

- Monthly transfer switch testing

A summary of this monitoring is reviewed by the EC Committee quarterly.

Note: The facility does not have a piped medical gas system (EC 02.05.09-EP1, 2 &3)

Note: BHD does not use battery banks in lieu of a generator. (EC 02.05.07-EP3)

Note: The facility's back-up power system is provided by a separate electrical line from the We Energies plant located at 9250 Watertown Plank Rd., Milwaukee, WI 53226. BHD has a memorandum of understanding with We Energies including a provision to receive documentation regarding testing to verify reliability of the generators connected to the secondary line that serves BHD. In 2015 BHD will acquire 2 generators for the purpose of providing emergency power to the Life Safety branch and Critical branch components. (EC 02.05.07-EP4, 5, 7, & 8)

- F. **Managing Pathogenic Biological Agents & Controlling Airborne Contaminates (EC 02.05.01-EP 5 & 6)**– Certain pathogenic biological agents survive in water or a humid environment. BHD EES Department monitors the potential source locations such as the humidification system and domestic water supply. It is the practice of this department to react quickly to any indication of these biological agents.

Managing air movement, exchanges and pressure within BHD is achieved by properly maintaining equipment and monitoring pressure relationships. Where appropriate, high efficiency filtration is utilized.

Infection Control requests receive priority status if an issue is identified, especially in areas that serve patients diagnosed or suspected of air-borne communicable diseases and patients that are immunosuppressed.

- G. **Mapping and Labeling (EC 02.05.01-EP 7 & 8)**– Milwaukee County and EES maintains mapping and labeling of critical distribution systems and equipment operational instructions. Master copies are kept in the MC Dept of Public Works and EES Department.

Shut down procedures are located either at the equipment, in the mechanical space shared by the equipment, or in the department policy and procedure manual. Only employees that are permitted access are trained in emergency shut down of equipment/systems

- H. **Investigating Utility System Problems, Failures or User Errors (EC 02.05.01-EP 9)**– Failures, problems and user errors are reported to EES for corrections. Utility system failures are reported to EES and, when appropriate to the EC committee for evaluation and recommendations to prevent reoccurrences. Utility failures are documented on the *BHD Building System Failure Incident Report* and reported to the EC Committee quarterly.

- I. **Policies and Procedures** – Utilities related policies are reviewed a minimum of every three years and distributed to departments as appropriate.

- J. **Emergency Procedures - (EC 02.05.01-EP 9-12 & EC 02.05.07 EP 9)** – Emergency procedures for utility systems malfunctions are developed and maintained in the EES department's procedures for Utility disruptions, back up sources, shut off procedures, repair services and hours of operation are covered in

the EES departmental policies and procedures manual. Emergencies are reported twenty-four hours a day through extension 6995 and the administrator on call. Alternate sources of essential utilities are listed in the EES Department Policy Manual for each system.

1. **Alternate Source of Essential Utilities – (EC 02.05.01 EP 13; EC 02.05.03-EP 1-6; EC 02.05.09 EP 1-3)**– Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and employees are trained as part of the organization wide and department specific education. These plans are tested as part of regularly scheduled exercises and actual outages of utility systems. This includes, Fire Alarm System, Exit illumination, P.A. system, one elevator (# 5), and medication dispensing machines. Emergency power outlets are available in the event mobile life support equipment is used. At present BHD does not store any blood, bone or tissue; does not have any med gas or surgical vacuum systems; and has no built in life support systems.
2. **Backup Communication System – (EC 02.05.03 EP 3)** – Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, a satellite phone system, crisis line phone system, pagers, cellular phones, two-way radios, and ham radio system. The implementation of the emergency plan focuses on maintaining vital patient care communications. Once the initial level of the plan is in place, the Communications and/ or Telecommunications Department will work with representatives of the telephone company to determine the scope and likely duration of the outage and to identify alternatives.
3. **Clinical Interventions - (EC 02.05.01-EP 11)** – Emergency procedures and contingency plan information is available in the Environment of Care manual (Systems Failure & Basic Staff Response Quick Reference) and in the Emergency Operations Plan.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation: (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01 EP 1-10)**
Education regarding the Utilities Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific utilities training, and a series of programs required for all employees on an annual basis.
 - Emergency shutoff controls, use, and locations for each critical utility system serving the work environment
 - Appropriate process for reporting of utility system problems, failures, and user errors.
- B. **Annual Continuing Education:** regarding utilities is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. **(HR 01.05.03 EP 1-13)**
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific utilities related utility procedures or precautions. **(EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)**
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual

Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)

PERFORMANCE MONITORING

(EC 04.01.03 EP 1-3); EC 04.01.05 EP 1-3)

- A. Ongoing performance monitoring is conducted for the following performance monitors:
 1. Measure the number of utility failures (Goal = 0)
 2. Measure the completion rate of preventive maintenance tasks (Goal =90%)
 3. Measure the percentage of utility components labeled and inventoried (Goal = 100% by year end)
 4. Measure the percentage of generator testing that did not pass (Goal = 0%)
- B. The Safety Officer and EC Committee oversee the development of the Utility related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for each of the functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Utilities Management Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC, and QMSC, the Program Executive Committees, and the County Wide Safety Committee. This finalizes the evaluation process.

Reviewed and approved at the 3-10-15 Environment of Care Committee

Reviewed and approved at the 3-16-16 Medical Executive Committee Meeting.

Attachments:

No Attachments

	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/28/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/28/2016
	Medical Executive Committee	Clarence Chou: 50770-Staff Psychiatrist	pending



Behavioral Health Division

Date Issued: 1/1/2015
Last Approved Date: 1/1/2015
Last Revised Date: 1/1/2015
Next Review: 3 years after approval
Owner: Lynn Gram: 80043-Safety Officer
Policy Area: Environment of Care
References:

Medical Equipment Management Plan

BHD Mission:

The Milwaukee County Behavioral Health Division is a public sector system for the integrated treatment and recovery of persons with serious behavioral health disorders.

BHD Vision:

The Milwaukee County Behavioral Health Division will be a Center of Excellence for person-centered, quality best practice in collaboration with community partners.

BHD Core Values:

1. Patient centered care
2. Best practice standards and outcomes
3. Accountability at all levels
4. Recovery support in the least restrictive environment
5. Integrated service delivery

BHD Guiding Elements:

Patient Centered Care: All members of the organization embrace a person centered approach focused on service that is respectful, individualized and invites active participation. Treatment is goal directed toward helping persons pursue personal recovery and enjoy independent, productive and healthy lives in the community.

Safe and Cost-Effective Best Practice: Treatment and support services incorporate current best practice standards to achieve effective outcomes. All participants are committed to an environment of care that ensures safety, manages risk and meets or exceeds national patient safety standards.

Accountable Strategic Planning: Service areas participate in strategic planning with accountability for dynamic priority setting and outcome measurement. The organization employs cost-effective approaches and project management strategies that lay the foundation for financially viable, future system growth.

PURPOSE:

Consistent with the above mission, vision, values and guiding elements, Behavioral Health Division Administration has established the Environment of Care (EC) Committee and supports the Medical Equipment Management Program as described in this plan.

The purpose of the Medical Equipment Management Plan is to establish a system to promote safe and effective use of medical equipment and in so doing, reduce the risk of injury to patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). This plan also addresses specific responsibilities, general safety, and employee education programs related to medical equipment use and care.

SCOPE:

The Medical Equipment (ME) Management Plan establishes the organizational structure within which medical equipment is well maintained and safe to use. In addition to addressing specific responsibilities, general safety, and employee education programs the plan is in all efforts directed toward ensuring that all patients and employees are supported in their use of medical equipment, devices, and technology, thereby reducing the risk of injuries to patients, visitors and employees, and employees can respond effectively in the event of equipment breakdown or loss. (EC 01.01.01-EP7)

MCBHD locations include:

Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

1. To improve employee knowledge of medical equipment requirements and support the routine operational needs of equipment users.
2. Recommend equipment replacement timeframes; participate in pre-purchase equipment selection and new product evaluations.
3. Manage and track all maintenance requirements, activities, and expenses required to service, repair, and keep operational all equipment included in the plan.
4. Review Incident Reports for all Medical Equipment related incidents.

AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program including the Medical Equipment Management Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The BHD Administrator appoints an EC Committee Chairperson/ Safety Officer to develop, implement, and monitor the Medical Equipment Management Program. The EC Committee guides the Medical Equipment Management Program and associated activities. The EC Chairperson and Safety Officer is responsible for directing the Medical Equipment program, and an ongoing, organization-wide process for collection of information about deficiencies and opportunities for improvement in the EC Management programs. BHD will utilize the EC Committee in lieu of a separate Medical Equipment Committee, where the EC Chairperson and Safety Officer will organize and implement an ongoing, organization-wide process to collect information about deficiencies and opportunities for improvement in the Medical Equipment Management Program. The staff member from the Central Supply Department is responsible for overseeing the Medical Equipment Program.

In the event that conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings, the Administrator has appointed the Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call to identify and respond to high-risk situations before significant injuries, death or loss of property occurs. (EC 01.01.01-EP2)

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable Medical Equipment related codes and regulations, and evaluate the effectiveness of the Medical Equipment program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. (EC 01.01.01-EP1)

INTENT PROCESSES:

- A. **Selecting and Acquiring Equipment (EC 02.04.01 EP 1)** –As part of the capital budgeting cycle, Department Program Directors and Managers are responsible for identifying and justifying new and replacement medical equipment for their departments or areas of responsibility. Requests are subject to administrative approval. Funds for approved capital projects are released on an annual basis. As a rule a representative from the medical equipment management company will be asked to participate with the user department and MCBHD Central Supply Dept. and Maintenance Dept. staff in the evaluation of equipment alternatives and represent the equipment support issues during the selection process. The manager of the ME program along with the Safety Officer are responsible for coordinating the evaluation, purchase, installation, and commissioning processes of new equipment according to the ME purchasing policy.
- B. **Equipment Inclusion in the Medical Equipment Management Plan and Inventory (EC 02.04.01 EP 2)**
– All Medical Equipment will be inventoried and tracked in the computerized maintenance management system provided by the contracted maintenance company. The accuracy of this inventory will be verified during scheduled maintenance inspections by comparing the number of items that are no longer in service but still scheduled for inspection, to the total number of items scheduled for inspection. Missing equipment or equipment that the MCBHD Central Supply staff is not aware of being removed from service will be investigated and, if found, reviewed for functionality and either put back into service or permanently removed from service and taken off the equipment inventory listing. Items not found immediately will be put on a missing equipment list for one year and if not found will be removed from the list. The missing equipment list will be distributed to each unit on an annual basis or as needed.
- C. **Equipment Inspection, Testing, and Maintenance (EC 02.04.01 EP 3 & 4; EC 02.04.03 EP 1-5 & 14)**
–The basis for the determination of inspection frequency is risk. Equipment will be inspected upon purchase and initially at one of the following intervals, quarterly, semi-annually, annually, or 18 months. The clinical equipment contractor shall determine and document inspection procedures and intervals for inspection of clinical equipment, based on manufacturer's recommendations, regulations and standards, actual experience with the device, and known hazards and risks. All devices will receive a performance verification and safety test during the incoming inspection procedure and after completion of a major repair or upgrade. All work activities, inspection schedules, and work histories are kept in the contracted company's software inventory list and Central Supply Department. The Central Supply staff assures that the contracted company completes scheduled maintenance and other service activities as required.

Note: BHD does not currently utilize hemodialysis or nuclear medicine equipment. (EC 02.04.03 EP 5 & 14)

- D. **Monitoring and Acting on Equipment Hazard Notices and Recalls (EC 02.01.01 EP 11)** –BHD uses RASMAS for recall and alert management. When an alert or recall may be related to equipment at MCBHD, the storeroom/central supply staff are notified to investigate if any equipment is part of the alert/recall, remove it from service and document any actions taken.
- E. **Monitoring and Reporting of Incidents (Including Safe Medical Device Act (SMDA)) (EC 02.04.01 EP 5)** All equipment used by BHD staff and/or contractors in the care of BHD patients is required to comply with SMDA per contract. The Quality Improvement/Risk Management department is responsible for investigating and reporting the incident to the manufacturer and/or Food and Drug Administration as appropriate.
- F. **Reporting Equipment Management Problems, Failures and User Errors (EC 02.04.01 EP 6)** –Users report equipment problems to Central Supply Staff and/or Maintenance Department Staff per policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*. Repairs and work orders are recorded in the computerized maintenance management system. These records are reviewed by Central Supply Staff and a summary reported to the EC Committee quarterly regarding significant problem areas and trends.
- G. **Emergency Procedures and Clinical Intervention (EC 02.04.01 EP 6)** –In the event of any emergencies, the department employee's first priority is for the safety and care of patients, visitors, and employees. Replacement equipment can be obtained through the Central Supply Department during business hours. The Administrative Resource has access to Central Supply during off hours. Additional procedural information can be found in the policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*
- H. **Policies and Procedures** –Medical Equipment related policies are reviewed a minimum of every three years and distributed to departments as appropriate.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the Medical Equipment Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific training, job-specific training, and a series of programs required for all employees on an annual basis. Training includes information on where to reference the proper information to ensure the piece of medical equipment they are using is safe, how to properly tag a piece of broken medical equipment, how to report medical equipment problems and obtain replacement equipment. (EC 03.01.01 EP1-3; HR 01.04.01 EP 1-3; LD 03.01.01 EP 1-10)
- B. **Annual Continuing Education:** Education regarding medical equipment is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. The EC Committee will, as part of the annual program review, identify technical training needs and assist with the creation of any training program as identified. (HR 01.05.03 EP 1-13)

C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific medical equipment related policies and procedures and specific job related equipment procedures and precautions. Training of employees and technical staff regarding use, features, maintenance and precautions is included as a part of new equipment acquisition/purchase. Additional training/retraining will be conducted based user-related problems or trends seen in the program evaluation. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)

D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)

PERFORMANCE MONITORING

(EC 04.01.03 EP 1-3; EC 04.01.05 EP 1-3)

- A. Ongoing performance monitoring is conducted for the following performance indicators:
Monitor and report on the number of equipment repairs.
- B. The Safety Officer and EC Committee oversees the development of the Medical Equipment related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for each of the functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Medical Equipment Management Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC and QMSC, the Program Executive Committees, and the County Wide Safety Committee. This finalizes the evaluation process.

Reviewed and approved at the 3-10-16 Environment of Care Committee meeting

Reviewed and approved at the 3-16-16 Medical Executive Committee meeting

Attachments:

No Attachments

	Committee	Approver	Date
		Lynn Gram: 80043-Safety Officer	4/28/2016
	Environment of Care Committee	Lynn Gram: 80043-Safety Officer	4/28/2016
	Medical Executive Committee	Clarence Chou: 50770-Staff Psychiatrist	pending

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CARS Executive Summary for 1st Quarter of 2016: Services Provided and Clinical Outcomes

CARS Quarterly Report:

- The CARS Quarterly Report includes more data/programs than the previous iteration and presents a more comprehensive picture of services available in CARS.
- Among the more notable achievements is the continuous growth of the number of individuals enrolled in CCS, up nearly 17% since the fourth quarter of 2015, and over 400% since the first quarter of last year!
- Targeted Case Management and Community Support Programs continue to serve a high volume of clients, and both programs provided services to a greater number of clients in the first quarter of 2016 than in any other quarter in 2015.

KPI Dashboard:

- Our discharge outcomes data generally indicate less improvement than our 6 month outcomes data.¹
- Service volume data in the first quarter suggests that we are on pace to meet our 2016 targets.
- Our data indicate that while some of the clinical performance measures for 6 month outcomes in the first quarter of 2016 are consistent with or even exceed our target outcomes, others, such as our abstinence rates, are lagging behind our expectations.² Particularly notable is the approximately 23% reduction in 30 day readmissions to detoxification services!

¹ It was necessary to create a separate category for client who were discharged after less than 6 months in service during the quarter in question, particularly for many of our substance abuse services. This is the first year that we have reported on discharge data for our CARS clients and there have been issues with data entry errors and missing/incomplete data as our providers transition to this new process.

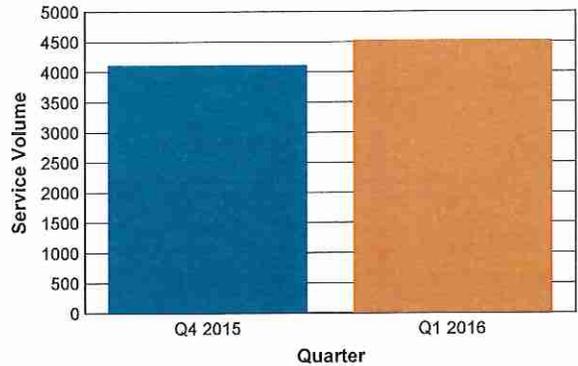
² A possible explanation for these results is that fact that in addition to transitioning to a new EHR, CARS also transferred the responsibility of data capture for our AODA services from a single agency to the providers themselves. This was done to provide greater detail at a programmatic level for the purposes of accountability and outcomes. However, this transition was not without complications and resulted in data entry errors that reduced the quantity of complete and accurate available for our analyses.

CARS Quarterly Report

Number of Clients Receiving Service, By Program

	Q4 2015	Q1 2016
Adult Family Home	16	14
CBRF	117	123
CCS	244	285
CLASP	63	80
Community Support Program	1,281	1,308
Crisis Case Management	57	77
CRS	44	37
Day Treatment (75.12)	23	21
Detoxification (75.07)	325	688
MH Day Treatment	25	26
Outpatient 75.13	304	293
Outpatient-MH	28	44
Recovery Support Coordination	380	417
Targeted Case Management	1,470	1,475
Transitional Residential (75.14)	213	217
Total	4,111	4,529

Number of Clients Receiving Service

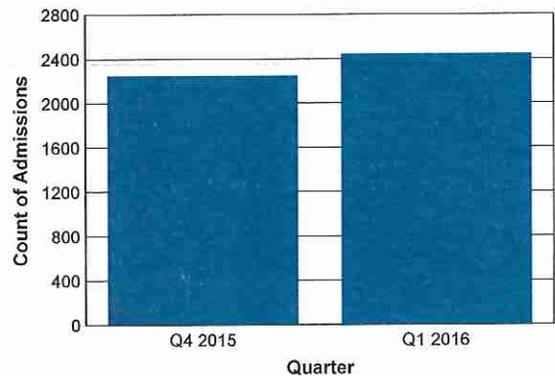


Transition to new EHR limits comparable data. Future iterations will allow observation of trends over time.

Admissions By Program

	Q4 2015	Q1 2016	Total
Adult Family Home	7	1	8
CBRF	77	12	89
CCS	126	63	189
CLASP	24	30	54
Community Support Program	119	54	173
Crisis Case Management	24	20	44
CRS	19	1	20
Day Treatment (75.12)	16	16	32
Detoxification	1,033	1,328	2,361
MH Day Treatment	8	10	18
Outpatient (75.13)	211	186	397
Outpatient-MH	61	129	190
Recovery Support Coordination	212	274	486
Targeted Case Management	118	117	235
Transitional Residential	191	201	392
Total	2,246	2,442	4,688

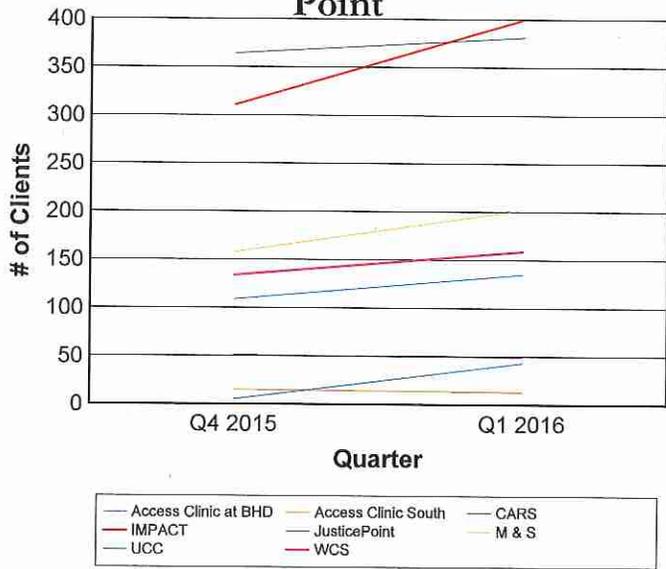
Admissions



Transition to new EHR limits comparable data. Future iterations will allow observation of trends over time. Some anomalies in Q4 2015 due to administrative episode management after go-live.

CBRF - Community Based Residential Facility
 CCS - Comprehensive Community Services
 CLASP - Community Linkages and Stabilization Program
 CRS - Community Recovery Services

Referrals/Intakes by Access Point

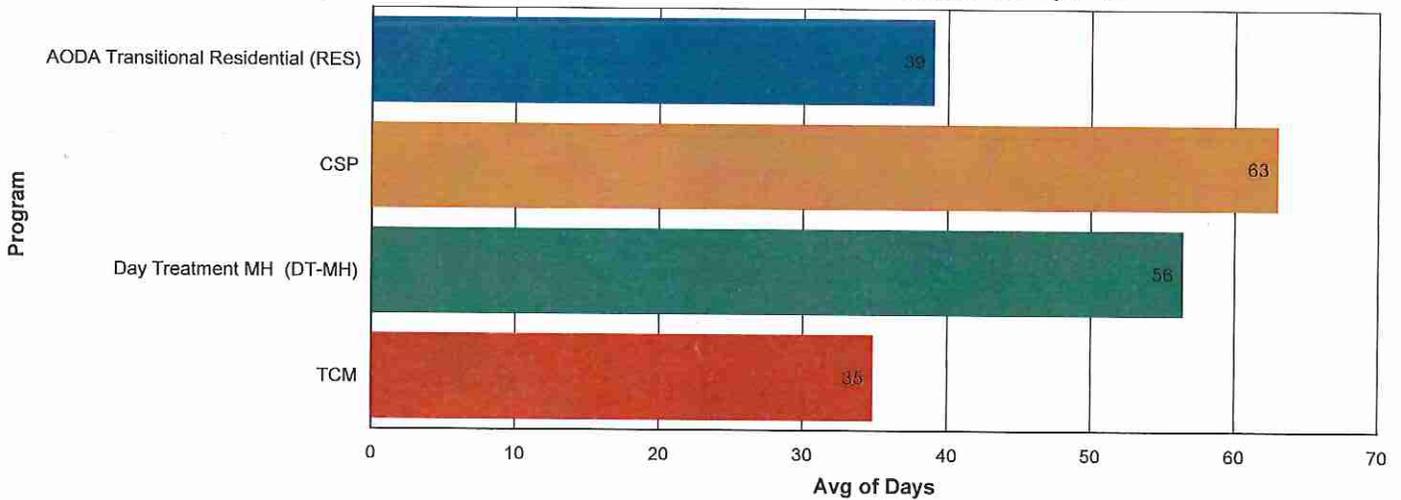


Referrals/Intakes By Access Point

	Q4 2015	Q1 2016	Total
Access Clinic at BHD	109	135	244
Access Clinic South	15	13	28
CARS	364	381	722
IMPACT	311	400	704
JusticePoint	51	49	99
M & S	158	202	358
UCC	5	43	48
WCS	134	159	291
Total	1,117	1,333	2,379

Transition to new EHR limits comparable data. Future iterations will allow observation of trends over time. Some change from Q4 2015-Q1 2016 likely due to increased fidelity to process in EHR.

Days on Waitlist, Only those Placed with Provider in Q1 2016



Transition to new EHR limits comparable data. Future iterations will allow observation of trends over time.



**Milwaukee County Behavioral Health Division
2016 Key Performance Indicators (KPI) Dashboard**

Program	Item	Measure	2016 Projection	2016 Target	2016 Status (1)	2015 Actual	Benchmark Source	Formula
Community Access To Recovery Services	1	Service Volume - AODA	6,347	5,640	Green	6,254	BHD (2)	# of clients with at least one event in any substance abuse level of care
	2	Service Volume - Mental Health	4,107	4,756	Yellow	5,010	BHD (2)	# of clients with at least one event in any mental health level of care
	3	Discharge (Client Discharged During Quarter Who Stayed in Services 6 Months or Less)						
	4	Inpatient Utilization Offset	-	-		-	BHD (2)	Relative change in average # of psychiatric bed days from admission to discharge
	5	Abstinence from drug and alcohol use	26.8%	-		-	BHD (2)	Relative change in # reporting abstinence from drugs or alcohol from admission to discharge
	6	Reduction in Homelessness or in Shelters	14.3%	-		-	BHD (2)	Relative change in # reporting living in shelters or homeless from admission to discharge
	7	Increase in Employment (Full or Part Time-Competitive)	9.4%	-		-	BHD (2)	Relative change in # reporting full or part time employment from admission to discharge
	8	6 Month Follow Up (First 6 Month Follow Up for Clients Open in Services During Quarter)						
	9	Inpatient Utilization Offset	60.4%	61.0%	Yellow	60.3%	BHD (2)	Relative change in average # of psychiatric bed days six months after admission
	10	Abstinence from drug and alcohol use	45.5%	83.8%	Red	82.5%	BHD (2)	Relative change in # reporting abstinence from drugs or alcohol six months after admission
	11	Reduction in Homelessness or in Shelters	50.0%	78.1%	Red	77.3%	BHD (2)	Relative change in # reporting living in shelters or homeless six months after admission
	12	Increase in Employment (Full or Part Time-Competitive) Within Quarter	45.5%	34.2%	Green	33.9%	BHD (2)	Relative change in # reporting full or part time employment six months after admission
	13	Percent of clients returning to Detox within 30 days	15.2%	18.5%	Green	19.6%	BHD (2)	Percent of readmissions that occurred within 30 days of discharge from the previous admission
Wraparound (5)	14	Families served in Wraparound HMO (unduplicated count)	3,300	3,300	Green	3,047	BHD (2)	Families served in Wraparound HMO (unduplicated count)
	15	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.6	> = 4.0	Green	4.6	BHD (2)	Average level of Family Satisfaction (Rating scale of 1-5)
	16	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.0%	> = 75%	Yellow	62%	BHD (2)	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)
	17	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.0	> = 3.0	Green	3.2	BHD (2)	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)
	18	Percentage of youth who have achieved permanency at disenrollment	65.0%	> = 70%	Yellow	58%	BHD (2)	Percentage of youth who have achieved permanency at disenrollment
19	Percentage of Informal Supports on a Child and Family Team	50.0%	> = 50%	Green	42%	BHD (2)	Percentage of Informal Supports on a Child and Family Team	
Crisis Service	20	Admissions	8,604	9,000	Green	10,173	BHD (2)	PCS patient admissions
	21	Emergency Detentions	4,410	4,500	Green	5,334	BHD (2)	PCS admissions where patient had a legal status of "Emergency Detention"
	22	Percent of patients returning to PCS within 3 days	7.7%	8%	Green	8%	BHD (2)	Percent of patient admissions occurring within 3 days of patient's prior discharge from the program
	23	Percent of patients returning to PCS within 30 days	24.5%	20%	Yellow	25%	CMS (4)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
24	Percent of time on waitlist status	67.9%	10%	Red	16%	BHD (2)	PCS hours on Waitlist Status / Total hours in time period x 100	
Acute Adult Inpatient Service	25	Admissions	744	850	Green	965	BHD (2)	Acute Adult Inpatient Service patient admissions
	26	Average Daily Census	45.1	48.0	Green	47.2	BHD (2)	Sum of the midnight census for the time period / Days in time period
	27	Percent of patients returning to Acute Adult within 30 days	11.4%	7%	Red	11%	NRI (3)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	28	Percent of patients responding positively to satisfaction survey	74.4%	74%	Green	73%	NRI (3)	Percent of patients selecting "Agree" or "Strongly Agree" to survey items
	29	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	61.4%	65%	Yellow	63%	BHD (2)	Percent of patients selecting "Agree" or "Strongly Agree" to survey item
	30	HBIPS 2 - Hours of Physical Restraint Rate	2.67	0.66	Red	7.2	CMS (4)	Total number of hours patients were in physical restraint per 1,000 inpatient hours
	31	HBIPS 3 - Hours of Locked Seclusion Rate	0.45	0.14	Red	0.47	CMS (4)	Total number of hours patients were in locked seclusion per 1,000 inpatient hours
	32	HBIPS 4 - Patients discharged on multiple antipsychotic medications	13.9%	9.5%	Red	18%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications
	33	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	32.8%	Green	98%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications with documented justification
	34	HBIPS 6 - Patients discharged with a continuing care plan	8.5%	82.5%	Red	15%	CMS (4)	Percent of patients for whom the post discharge continuing care plan is created and contains the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations
	35	HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	8.5%	75.4%	Red	15%	CMS (4)	Percent of patients for whom the post discharge continuing care plan was transmitted to the next level of care
Child / Adolescent Inpatient Service (CAIS)	36	Admissions	756	800	Green	919	BHD (2)	CAIS patient admissions
	37	Average Daily Census	10.0	11.0	Green	9.8	BHD (2)	Sum of the midnight census for the time period / Days in time period
	38	Percent of patients returning to CAIS within 30 days	15.1%	11%	Red	16%	BHD (2)	Percent of patient admissions occurring within 30 days of patient's prior discharge from the program
	39	Percent of patients responding positively to satisfaction survey	72.6%	74%	Yellow	71%	BHD (2)	Percent of patients selecting "Agree" or "Strongly Agree" to survey items
	40	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	94.1%	80%	Yellow	74%	BHD (2)	Percent of patients selecting "Agree" or "Strongly Agree" to survey item
	41	HBIPS 2 - Hours of Physical Restraint Rate	3.99	0.22	Red	5.2	CMS (4)	Total number of hours patients were in physical restraint per 1,000 inpatient hours
	42	HBIPS 3 - Hours of Locked Seclusion Rate	0.12	0.34	Red	0.42	CMS (4)	Total number of hours patients were in locked seclusion per 1,000 inpatient hours
	43	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2.0%	3.0%	Green	2%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications
	44	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100.0%	39.9%	Green	100%	CMS (4)	Percent of patients discharged on 2 or more antipsychotic medications with documented justification
	45	HBIPS 6 - Patients discharged with a continuing care plan	7.4%	91.3%	Red	4%	CMS (4)	Percent of patients for whom the post discharge continuing care plan is created and contains the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations
46	HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	7.4%	84.4%	Red	4%	CMS (4)	Percent of patients for whom the post discharge continuing care plan was transmitted to the next level of care	
Financial	47	Total BHD Revenue (millions)	\$129.4	\$129.4	Yellow	\$120.2		
	48	Total BHD Expenditure (millions)	\$188.2	\$188.2	Yellow	\$173.5		

Notes:

(1) 2016 Status color definitions: Red (below 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)

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

(3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages

(4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages

(5) Please note that because of different reporting requirements, Wraparound does not currently analyze their KPI data on a quarterly basis. Thus, their 2016 Projections are based on their 2015 annual data. They will transition to quarterly analysis of KPI data beginning 2nd Qtr of 2016.



2015 QA/QI ANNUAL REPORT Executive Summary

A unique Managed Care Organization that serves youth with serious emotional, behavioral and mental health needs and their families.

1. Total youth served = 1,848
2. Average cost per member/per month = \$3,124
3. Functioning levels, i.e. – mood, thought processing, social/interpersonal interactions, community-based behaviors, improved in all areas, as measured through the Child Behavior Checklist and the Youth Self Report
4. Overall Family and Youth satisfaction with their Care Coordination services is 4.23 (on a scale of 1-5)
5. Overall Family and Youth satisfaction with their Provider Network services is 4.42 (on a scale of 1-5)
6. Top 3 mental health services utilized - Crisis Stabilization, In-Home Therapy and Outpt. Therapy
7. Twenty complaints filed (only 1.08% of the total population served); no grievances filed
8. Wraparound Provider Network consists of 125 Provider Agencies with 71 different types of services offered
9. Youth/young adult Wraparound -affiliated programs/resources continue to thrive – Project O’YEAH, Owen’s Place, MOVE Wisconsin, POHSEY (See pages 12-16)
10. The Child and Adolescent Mobile Urgent Treatment Team provided services to 1,060 distinct youth
11. The Wraparound Wellness Clinic had 5,354 youth/family visits 2015



WRAPAROUND MILWAUKEE

2015

QUALITY ASSURANCE/QUALITY IMPROVEMENT ANNUAL REPORT



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I. Demographics for 2015



Wraparound/REACH Enrollments = 736

Wraparound/REACH Disenrollments = 545

(Disenrollment # excludes transfers to other programs in the Wraparound System of Care)

Average Daily Census = 1130 Total Youth Served = 1,848

Wraparound Milwaukee (WRAP) – A unique Managed Care Organization that serves youth with serious emotional, behavioral, and mental health needs and their families.

REACH Program (Reaching, Engaging and Assisting Children (and Families)) – A part of the Wraparound Milwaukee system of care that provides similar services and opportunities for youth with serious emotional, behavioral, and mental health needs and their families. The REACH program primarily differs in that the youth who are enrolled are not under a Court Order (Delinquency or Child in Need of Protective Services – CHIPS).

O'YEAH Program – (Older Youth and Emerging Adult Heroes), a program administered under the auspices of Wraparound Milwaukee designed to support older youth and young adults ages 16.5 – 24 who may be experiencing emotional and behavioral challenges, to successfully transition to adulthood. This is a voluntary program. **See Pg. 12 for details related to this program.**

GENDER (736 youth represented)

Female = 245 (33%)

Male = 491 (67%)

AGE (736 youth represented)

Average age = 14 years old

(WRAP = 14.9, REACH = 13)

ETHNICITY (736 youth represented)

African American = 444 (60%) (67% male – 33% female)

Caucasian = 70 (10%) (57% male – 43% female)

Hispanic = 111 (15%) (71% male – 29% female)

Bi-racial = 13 (1.7%) (46% male – 54% female)

Asian = 3 (.4%) (33% male – 67% female)

Native American = 2 (.3%) (50% male – 50% female)

Other/Unknown = 66 (9%) (67% male – 33% female)

Not Listed = 27 (4%)

DIAGNOSIS (706 youth represented. Youth may have one or more diagnosis)

ADHD (WRAP = 244, REACH = 195)

Conduct Order (WRAP = 245, REACH = 106)

Mood Disorder (WRAP = 137, REACH = 112)

Anxiety Disorder (WRAP = 128, REACH = 94)

Depressive Disorder (WRAP = 89, REACH = 74)

AODA related (WRAP = 122, REACH = 27)

Learning Disorder (WRAP = 95, REACH = 19)

Developmental Disorder (WRAP = 82, REACH = 37)

Adjustment Disorder (WRAP = 53, REACH = 21)

Thought Disorder (WRAP = 13, REACH = 29)

Personality Disorder (WRAP = 11 REACH = 0)

Eating Disorder (WRAP = 2, REACH = 0)

Other (WRAP = 125, REACH = 21)

YOUTH PRESENTING ISSUES (687 WRAP & REACH youth represented.

Youth may have one or more issues.)

Access to Firearms = 2

Adjudicated Sex Offender = 44

Attention Problems = 506 *2

Bullying/Peer Issues = 18

Community Concerns and Violence = 26

Contact Sexual Abuse = 151

Dev. Disorder/Autism = 174

Drug/Alcohol Abuse = 302 *3

Eating Patterns/Hoarding = 13

Fire setting = 172

Gang Affiliation = 3

H/O Sexual Misconduct & Exposure = 319

Homicidal Ideation = 10

Major Affective Illness/Affect Regulation = 413 #3

Minor Domestic Sex Trafficking Victim = 46

Minor at Risk for Domestic Sex Trafficking = 20

Physical Disability/Medical/Health = 252

Previous Physical Abuse = 184

Recurrent Emotional Abuse = 188

Runaway Behavior = 353

School Concerns = 658 #1 *1

Self harm = 19

Severe Aggressiveness = 566 #2

Sexual Abuse Victim = 170

Sleep Patterns/Nightmares = 23

Suicidality = 334

Victim Notification = 9

Other = 412 (For example: stealing, manipulative behavior, traumatic events/illnesses)

* Top 3 WRAP youth issues #Top 3 REACH youth issues
(excludes "Other" category for WRAP/REACH)

FAMILY PRESENTING ISSUES (678 WRAP & REACH families represented.

Families may have one or more issues.)

Alcohol/Drug Abuser in Home = 229

Adult in Home Treated Violently = 292 #3

Emotional Abuse/Neglect = 157

Emotional/Mental Illness in the Family = 479 *2 #1

Incarcerated Household Member = 308 *3

Physical Abuse/Neglect = 138

Recurrent Physical Abuse Exposure = 170

Single/No Parent in the Home = 472 *1 #2

Significant Losses = 20

Teenage Parent = 30

* Top 3 WRAP family issues #Top 3 REACH family issues

COURT ORDER (WRAPAROUND) = 57% of enrollments

(412 youth represented)

- 63% of youth who were enrolled into Wraparound were on a Delinquency order (N=258)
- 34% were on a CHIPS order (N=141)
- 1.4% were on a JIPS order (N=6)
- 1.7% were on a Dual (CHIPS/Delinquent) order (N=7)

NO COURT ORDER (REACH) = 43% of enrollments

(248 youth represented)

II. Outcome Indicators

Functioning

The functioning levels of the youth in Wraparound/REACH are currently being measured by the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR). The evaluation tools are collected on every enrollee at Intake, 6 months, 1 year, annually thereafter and at disenrollment.

The CBCL is filled out by the parent/primary caregiver and provides information about the internal (mood, thought processing) and external (social/interpersonal interactions, community-based behaviors) behavioral issues of a child during the preceding six-month period. It comprises various scores consisting of symptoms of depression, anxiety, withdrawal, social problems, thought problems and delinquent and aggressive behavior. Total scores are computed and fall into three ranges: *Normal, Borderline and Clinical*. Scores are converted into age-standardized scores (T scores and Percentiles) so they can be compared with scores obtained from a normative sample of children within the same age range. The results can be utilized by the Child and Family Team to identify areas of need that should be addressed within the Plan of Care.

The YSR is similar to the CBCL. It is completed by youth 11 years of age and older.

Normal Range of Functioning – Scores that fall into the same range as the comparative sample group.

Borderline Clinical – Scores that suggest enough issues have been reported to be of concern, but not so many that it is a clear indicator of needing clinical professional help.

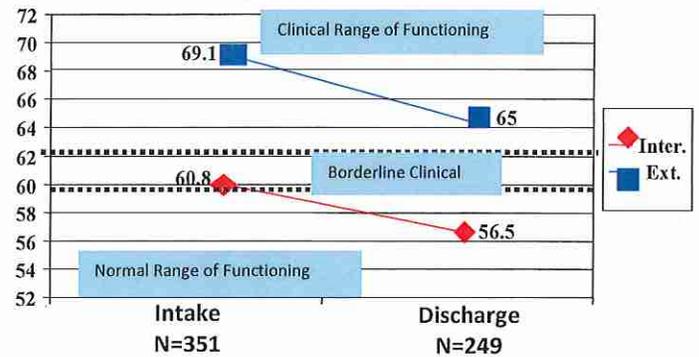
Clinical Range of Functioning – Scores that reveal sufficient issues that are significantly greater than the comparative sample group; in need of clinical intervention.

NOTE: A decrease in a score reflects improved functioning.

The following data in all graphs represents disenrollments from 1/1/15 – 12/31/15

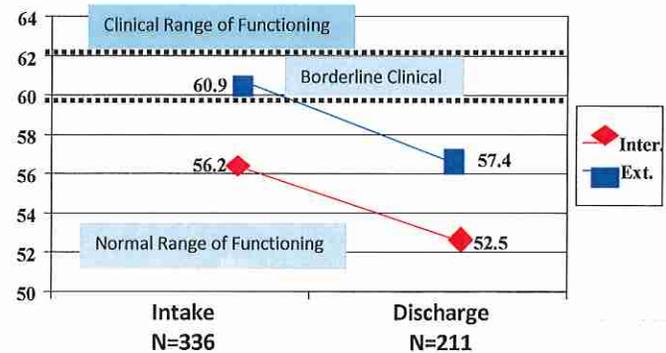
WRAPAROUND

CBCL T-Scores from Intake to Discharge



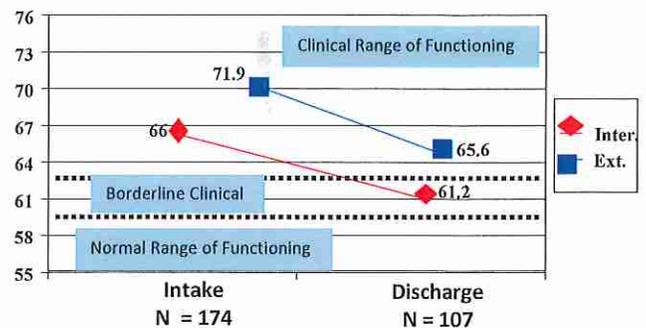
WRAPAROUND

YSR T-Scores from Intake to Discharge



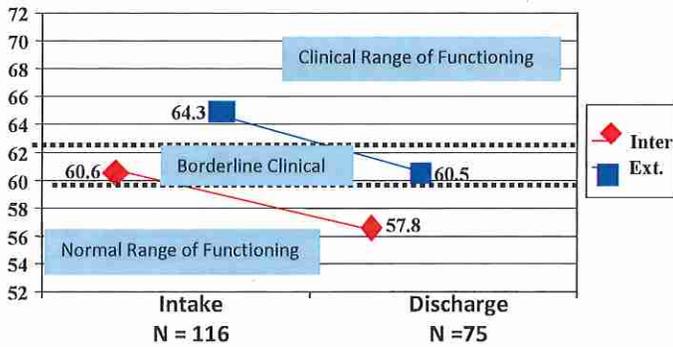
REACH

CBCL T-Scores from Intake to Discharge



REACH

YSR T-Scores from Intake to Discharge



Of the enrollees for which school data was entered (N=726) into the Synthesis database (Wraparound Milwaukee's IT System) during 1/1/15-12/31/15 the following was revealed:

	#WRAP	%WRAP	#REACH	%REACH
K-5 th	35	8%	92	30%
6 th -8 th	85	20%	92	30%
9 th -12 th	293	70%	121	39%
GED/Grad.	4	1%	4	1%

Youth in Wraparound are attending school approximately 86% of the time, while those in REACH are attending school approximately 90.5% of the time.

Our benchmark for attendance is set at 85%.

Living Environment



Wraparound youth at enrollment are living in a variety of places. The level of restrictiveness of the placement varies. Wraparound is committed to getting youth into and/or keeping youth in the least restrictive environment possible and in minimizing the number of placement changes that a youth encounters.

Permanency (Wraparound Only) In defining the data below, permanency is described as:

- 1.) Youth who returned home with their parent(s)
- 2.) Youth who were adopted
- 3.) Youth who were placed with a relative/family friend
- 4.) Youth placed in subsidized guardianship
- 5.) Youth placed in sustaining care
- 6.) Youth in independent living

Total Wraparound disenrollments - (excludes 37 youth that were disenrolled as "runaway/missing" and 82 youth that were disenrolled to a correctional (n = 60) or a detention facility (n = 22) = **256**

Of the 256 Wraparound youth, 236 or 92% achieved permanency as defined above.

Other disenrollment scenarios upon discharge:

- 5 – Foster Care – Transitional
- 4 - Group Home Care
- 6 - Respite Care
- 5 - Residential Care

School



Wraparound Milwaukee is invested in ensuring that the youth we serve are getting the best education possible, that all educational needs are identified, and that attendance improves.

Youth and Family Satisfaction

Outcomes

Youth/Family satisfaction is measured through the surveys that are being administered by the Wraparound QA Department in conjunction with Families United of Milwaukee. These surveys inquire about the satisfaction level of the family/youth as it relates to the provision of Care Coordination and Provider Network services.

Family/Youth Satisfaction Levels related to Care Coordination Services



Surveys related to the families' satisfaction levels with Care Coordination are distributed at 1-month, 6-months, 1-year/2-year/etc. [At disenrollment the survey is called a Disenrollment Progress Report. This "report" speaks more to perceived family outcomes vs. satisfaction.](#) A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available.

Satisfaction Benchmark for 1-month/6-month/yearly: 4.0

Satisfaction Benchmark for Disenrollment: 3.75

Survey Time Frame	# of Surveys Sent	# of Surveys Received	Return Rate	Average Overall Score
1-Month	877	134	15.2%	4.73
6mo/yearly	1471	149	10.1%	4.62
Family Disenrollment Progress Report	545	429	78.7%	3.81
Youth Disenrollment Progress Report				3.76

1-month Care Coordinator Family Survey – Overall 4.73

1).	My CC has been polite and respectful to me and my family.	4.90
2).	Meetings with my care coordinator have been scheduled at times and places that are convenient for me.	4.78
3).	I know how to reach my care coordinator when I need to.	4.78
4).	My care coordinator returns my calls within 24 hours.	4.73
5).	I know how to reach my care coordinator's supervisor.	4.53
6).	The contents of the enrollment folder were explained to me.	4.74
7).	My care coordinator has talked with me about a Crisis/Safety Plan for my family.	4.68
8).	I've been offered choices about the services my family receives.	4.69
9).	Overall, I feel satisfied with the services my family is receiving.	4.70

6-mo/yearly Care Coordination Family Survey - Overall 4.62

1.)	My Care Coordinator has been polite and respectful to me and my family.	4.92
2.)	I am seeing my Care Coordinator as often as I'd like to.	4.47
3.)	My Care Coordinator returns my call within 24 hours.	4.61
4.)	My Care Coordinator follows through with what she/he says she/he is going to do.	4.61
5.)	Meetings with my care coordinator have been scheduled at times and places that are convenient for me.	4.82
6.)	I feel Wraparound has been sensitive to my cultural, ethnic and religious needs.	4.83
7.)	I would be comfortable calling my care coordinator's supervisor if I had any concerns.	4.61
8.)	I've had the opportunity to include people on my team that are important in our family's life.	4.61
9.)	I get a copy of every Plan of Care.	4.69
10.)	I understand my Plan of Care and how it can help me and my family.	4.68
11.)	I have been offered choices about the services my family receives.	4.55
12.)	My team is starting to work to prepare my family for disenrollment from Wraparound.	3.94
13.)	Overall, I feel the care provided to me/my family so far has been helpful.	4.52

Disenrollment Youth Progress Report – Overall 3.76

1).	I'm doing better in school than I did before.	3.69
2).	I am getting along better with my family than I did before.	3.77
3).	I feel like I'm getting along better with my friends than I did before.	3.61
4).	I feel my behavior has gotten better since I was enrolled in Wraparound.	3.84
5).	On a scale of 1 to 5 how do you feel you are doing right	3.90

Disenrollment Family Progress Report – Overall 3.81

		3.75
1.)	I feel my family has made significant progress in meeting the Family Vision we have been working towards.	
2.)	I feel my child's educational needs have been met.	3.42
3.)	Overall, I feel that Wraparound/REACH helped me be better able to handle challenging situations.	3.95
4.)	I feel that I have family, friends and community resources that will be there for me and my family if I need them.	3.92
5.)	If my family does have a crisis, I believe the final Crisis Plan my Team developed will help us.	3.90
6.)	After disenrollment, I will know how to get services and supports that my family may still need.	3.99
7.)	On a scale of 1-5, how do you feel your family is doing right now?	3.77



Family Satisfaction Levels related to Provider Network Services

Families also receive surveys inquiring about their satisfaction level related to the services they receive through Wraparound Provider Network. Each survey is reflective of the specific service that a specific Network Provider provides to the family. A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available. These surveys are distributed to the families during their 4th and 9th month of enrollment.

Survey Time Frame	# of Surveys Sent	# of Surveys Recv'd	Return Rate	Average Overall Score
4-Month	2,025	120	5.9%	4.32
9-Month	1,946	111	5.7%	4.50

4-month Provider Survey Results – Overall 4.32

1.)	Focuses on my family's strengths	4.29
2.)	Understands our family's needs and limits.	4.27
3.)	Is sensitive to our cultural needs	4.35
4.)	Listens to my family	4.36
5.)	Follows my family's Plan of Care	4.32
6.)	Is respectful to my family	4.47
7.)	Is available when we need him/her	4.20

9-month Provider Survey Results – Overall 4.50

1.)	Focuses on my family's strengths	4.46
2.)	Understands our family's needs and limits.	4.47
3.)	Is sensitive to our cultural needs	4.56
4.)	Listens to my family	4.54
5.)	Follows my family's Plan of Care	4.53
6.)	Is respectful to my family	4.61
7.)	Is available when we need him/her	4.33



Provider Survey Outcomes by Service

Referenced below are the overall service satisfaction outcomes per the data that has been collected and entered into Synthesis for 2015. Only those services in which at least 5 surveys have been received are reported on. A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available.

Service Name	# of Surveys Recv'd	# of Agencies Represented	Overall Average	2014 Overall Average
Crisis Stabilization	83	7	4.46	4.47
Group Home Care	16	9	3.28	3.5
In-Home Therapy	47	12	4.5	4.6
Individual/Family Therapy- Office-based	29	14	4.53	4.38
Mentoring	7	3	4.45	4.28
Parent Assistance	9	2	4.37	4.66
Parent Coaching	6	1	4.83	N/A
Residential Care	49	11	3.49	3.62
Treatment Foster Care	11	5	4.23	N/A

Family Satisfaction Levels related to Out of Home Services

Families also receive surveys inquiring about their satisfaction level related to the services they received through Wraparound Provider Network Out of Home placement agencies, i.e. – residential centers, group homes. A 5-point ranking scale is utilized with 1 meaning "Very Dissatisfied" and 5 meaning "Very Satisfied". An option of "No Response" is also available. These surveys are administered by a trained Families United of Milwaukee parent representative and are completed upon the youth's discharge from the out of home facility.

Survey Time Frame	# of Surveys administered	Average Overall Score
Upon Discharge from the facility	67	3.44

Out of Home Survey Results – Overall 3.44

1.)	How satisfied were you with the care that your child received in the facility?	3.56
2.)	How easy was it to stay in contact with your child (phone and travel)?	3.91
3.)	How well did the staff keep you/your child informed through the time your child was in placement?	3.81
4.)	How well do you feel your child has improved during this placement?	3.23
5.)	How well did the staff do in terms of giving you ideas or teaching you new techniques you could use with your child at home?	3.02
6.)	How safe did you feel your child was in the facility?	3.69
7.)	How culturally sensitive do you feel the staff were to the needs of your child?	3.69
8.)	Would you utilize this placement again or recommend it to other families.	2.50

Costs/Services

The cost of providing services for the youth in

Wraparound/REACH is less than the cost of care in alternative children's mental health systems and other systems of care.



The overall total number of youth serviced in some capacity from 1/1/15 – 12/31/15 was 1,848.

The average overall cost per month/per enrollee was \$3,124.00

(This cost includes the provision of care coordination services in addition to all other authorized provider network services)

The total paid for services in 2015 was \$45,148,363.00

Listed below are several program cost comparisons as it relates to the provision of services. Please note that the monthly cost for Wraparound type services may also include providing care to other family members in addition to the identified enrollee.

PROGRAM	APPROXIMATE AVERAGE COST PER MONTH/PER YOUTH
<i>Wraparound Milwaukee</i>	<i>\$3,124</i>
<i>Group Homes</i>	<i>\$5,926</i>
<i>Corrections</i>	<i>\$8,898</i>
<i>Residential Care</i>	<i>\$10,050</i>
<i>Psychiatric Inpt. Hospital</i>	<i>\$38,100</i>

Listed below are the top five service groups utilized per authorizations from January through December 2015 in which the client/family were the primary recipients.

- 1.) **Crisis Stabilization/Supervision** 1,440 or 77.9% of the youth utilized this service in some capacity
- 2.) **In-Home Therapy (Lead-Medicaid)** 928 or 50.2% of the youth/families utilized this service in some capacity
- 3.) **Transportation** 709 or 38.4% of the youth/families utilized this type of service in some capacity
- 4.) **Outpatient Therapies** 687 or 37.2% of the youth/families utilized this service in some capacity
- 5.) **Psychological Assessments** 453 or 24.5% of the youth utilized this service in some capacity

Although not considered a specific service per se, it is important to note:

Seven hundred and seventy-eight (778) or 42.1% of the youth/families utilized **Discretionary Funds** in some capacity. Discretionary funds are flex monies that are often utilized to assist the family in meeting a need that may not be connected to a specific provider-related network service.

The majority of Discretionary Fund requests (excluding Miscellaneous funds) are for assistance/support with Rent/Security Deposits, recreation, groceries/household supplies and clothing/shoes.

The **five most costly service areas** (excluding Care Coordination) for 2015 (though not necessarily the most utilized) are:

1. Residential Care at 24.2% of the total paid
2. Crisis Services at 14.7% of the total paid
3. Group Home Care at 11.0% of the total paid
4. Foster Care at 7.4% of the total paid
5. In-Home Therapy at 6.7% of the total paid

III. Process Indicators

Plan of Care

The Plan of Care (POC) is a family and needs-driven document utilizing the strengths of the child/family. The POC is comprehensive and is the driving force behind the services provided. The initial POC meeting is expected to occur within the first 30 days after enrollment. Subsequent POC meetings should be held at least every 60 - 90 days.



Wraparound uses a ranking system in which the family scores each identified "need" on the Plan of Care.

A 1-5 ranking scale is utilized. Starting with 1 meaning minimal progress was made in that needs area to 5 meaning that the need has been successfully met.

Average overall "Need Ranking" score at discharge for 2015 was 3.24 (N= 545)

In 2014 the final score was 3.22 (N = 603).

The established threshold of desired performance is a 3.75.

Family and Community-Based Service Delivery & Collaboration



Services and support are provided in the youth's natural environment, including home, school and community. Collaboration within the Child and Family Team, meaning the network of formal and informal supports, must be evident.

Identified community-based supports/resources on the Plan of Care Strengths Discovery List are coded in Synthesis. These resources are considered to be "informal or natural" supports, i.e. - are individuals on the Team that are volunteers (unpaid supports), family members, neighbors, clergy affiliations, etc. These supports must be actively utilized, i.e. - be within the "strategy" related to a "need", to be calculated within the data.

Wraparound strives for at least 50% of the active members on any Team to be informal or natural supports.

From 2/1/15 – 1/31/16, for Wraparound Teams, an average of 40.5% of the Team members were informal/natural supports. For REACH Teams the average was 45.9%.

During the Team Meetings **at least one informal/natural support was in attendance at the Wraparound Team meetings 26% of the time and at the REACH Team meetings 29.7% of the time.** The established threshold is 50%.

Audits/Evaluations/Reports & Utilization Review

Wraparound uses auditing processes, surveys, evaluation data and other reported outcomes, as an ongoing means of monitoring the quality of care being provided to youth and families and compliance with Policies and Fee for Service Agreement expectations.



Plan of Care (POC)

During 2015, extensive work was given to reviewing and assessing the current POC approval and auditing process. Dialogue ensued focusing on the quality of the Plans, the

approval process at both the Care Coordination Supervisor level and the Wraparound Administrative level and the best methodology to use in moving forward with auditing POC's.

An extensive/comprehensive POC Checklist Tool began to be developed in addition to a POC Rubric Review Tool that would be utilized at the Care Coordination Supervisor and Wraparound Administration level. Discussions on an auditing process continued with emphasis on best practice and quality indicators, auditor consistency, and reliability. Determinations as to the auditing process and all tools/checklist will be finalized in 2016.

Audits/Reviews of Provider Network Agencies

Single Indicator Audit

Performance Measure: Provider Agency response time to Purchasers (Wraparound Milwaukee) request.

Per the Fee-For-Service Agreement that Providers have with Wraparound Milwaukee there is an expectation that *Providers have access to a computer with internet capability and a functional e-mail account that Purchaser can use for ongoing communication with provider. Provider also agrees to check e-mail account at a minimum of once per business day and respond to Purchaser within the requested time limits.*

In February 2015, a standardized e-mail was sent to all Provider agencies utilizing their e-mail address that was currently in Synthesis. The Provider response time was recorded in addition to any information sent related to the e-mail address/primary agency contact.

The results revealed the following:

A total of 108 agencies were in the audit sample. Eighty-eight (88) or 81% of the total received a compliance score of 100%. Twenty (20) or 19% received a compliance score of 0% as they did not respond within the identified time frame or did not respond at all. Agencies that scored a 0% were required to submit a corrective action plan (CAP). Seventeen (17) out of twenty (20) submitted a CAP. All submitted CAPS were reviewed and approved.

Performance Improvement Project (PIP)

Wraparound Milwaukee must engage in one Performance Improvement Project per year as mandated by our Medicaid Contract with the State of Wisconsin. The project must focus on a clinical or administrative issue that the program wants to further explore in an effort to engage in a quality improvement endeavor that impacts on client care.

The 2015 PIP was entitled, ***"Empowering Family Choice"***. Through major revisions to the Provider Network Resource Guide and training families and Care Coordinators to the concept of the *Family Driven* approach, this project addressed both the growth in knowledge and information about service options in the Wraparound Milwaukee Provider Network resulting in an increased capacity for families to make informed

service choices. This, in turn, resulted in greater feelings of empowerment in directing the renewed well-being of their children. The development of the revised Provider Resource Guide, accompanied with promotion and training to all users, resulted in an immediate upsurge of access and usage (increase of 416.6% in a 2-month period). Collectively, families (93) and Care Coordinators with families (148) represented 30% (241/814) of the total population that accessed the revised Provider Resource Guide.

Building feelings of empowerment is a slower process that will require ongoing training of Care Coordinators and Care Coordination Supervisors as well as the Providers themselves to the Family Driven approach. Over time though, this training and will transform the Child & Family Team process, giving more direct decision-making power to the families served by Wraparound.

The full PIP will be available for viewing on Wraparound’s website mid 2016.

Utilization Review

Service Group	Average Total Paid Per Child/Per Month for CY 2015	# of youth served	% of youth served
AODA Services	\$4.53	138	7.5%
Care Coordination	\$794.98	1,848	100%
Child Care/Rec.	\$4.00	34	1.8%
Crisis Services	\$458.48	1,440	77.9%
Day Treatment	\$4.36	10	.5%
Discretionary Funds	\$12.95	778	42.1%
Fam/Parent Support Services	\$36.80	321	17.4%
Foster Care	\$231.82	170	9.2%
Group Home	\$342.57	248	13.4%
Independent Living	\$22.01	20	1.1%
In-Home Therapy	\$208.88	928	50.2%
Inpatient Hosp.	\$98.97	214	11.6%
Life Skills	\$28.60	225	12.2%
Med. Mngmt./Nursing	\$3.66	132	7.1%
Occupational Therapy	\$2.71	31	1.7%
Outpatient Therapies	\$53.57	687	37.2%
Psychological Assess.	\$13.08	453	24.5%
Residential Treatment	\$756.02	295	16%
Respite	\$5.39	57	3.1%
Transportation	\$23.72	709	38.4%
Youth Support Services	\$17.14	296	16%

IV. Structure Indicators

Wraparound Milwaukee, as a system of care, utilizes a diversified administrative team, which assesses Provider services, provides training in Wraparound philosophy, and establishes policies and procedures. A structured intake process is utilized with reference to enrolling families into the program. A Care Coordinator is assigned to work with every family. The Care Coordinator organizes and coordinates care for the youth and family. Each family has a Child and Family Team that meets regularly. The Team develops and implements the Plan of Care.

Child and Family Team Meeting



A Child and Family Team (CFT)

Meeting is expected to be held once a month to discuss the status of the Plan of Care and the child/family. The CFT meeting must be documented in the Care Coordinator’s Progress Notes and be coded as such.

Per Progress Notes dated 1/1/15–12/31/15, the compliance score as it relates to holding a monthly Child and Family Team Meeting was **87.5%**. The compliance score in 2014 was 89.5%.

The established threshold for compliance is 85%.

Training

Care Coordinators receive 85+ hours of initial certification training in a curriculum developed by Wraparound Milwaukee. Care Coordinators are expected to complete the



training within the first six months of employment. The Training Team consists of a diverse group of individuals from different disciplines. Parents/Caregivers are also training facilitators. Ongoing mandatory and non-mandatory meetings, inservices, conferences, re-certification training, etc. are also offered throughout the year for provider staff and/or families.

Two New Care Coordinator Trainings were held during 2015. The training consists of 23 Modules. Each of the training modules was revised to integrate Trauma Informed Care concepts around adversity and trauma exposure, biological, neurological, relational, spiritual, behavioral and worldview impact, as well as respecting experientially driven behavior as indicative of trauma related needs. Approximately 30-50 new Care Coordinators, Transition Coordinators and Professional Foster Parents **participated** in each of the trainings. In addition,

several Families United of Milwaukee parent/youth facilitators joined to share their lived experience

One **Re-certification Training** was held for Care Coordination leadership staff in the spring of 2015. The training focused on a new way of incorporating the Wraparound philosophical base of moving from **Hello to Help to Healing to Hope** with a family.

During the year, three cohorts of Care Coordinators went through two full days of **Motivational Interviewing** training and subsequent booster sessions.

Wraparound Care Coordination Supervisors and Leads went through monthly **champion building sessions** to develop a more sophisticated understanding of trauma informed care concepts and practices.

Several in-services/workshops took place, providing continuing educational opportunities for Wraparound-related staff.

These consisted of:

- Trauma Informed Care- Level I and Level II Training continued
- Wraparound Administrative Panel
- Transition to Adulthood
- Running Effective Team Meetings
- Regulation of the Stress Response
- Suicide Awareness
- Poverty in Wisconsin

Lastly, training opportunities were extended to Crisis Stabilization Providers to join Care Coordinators in learning about working effectively with schools and special education laws and trauma informed care.

Grievances/Complaints/Administrative Concerns/Violations

Wraparound Milwaukee, as a system of care, has a formal grievance procedure and a complaint investigative and reporting process. Complaints can be generated by any party within the Wraparound system of care. Grievances are primarily generated by family members/enrollees.



Zero (0) grievances were filed in 2015. Wraparound Milwaukee identifies a grievance as the action a recipient may choose to pursue if they are not happy with the outcome of a filed complaint.

<u># of 2013 complaints/concerns</u>	<u># of 2014 complaints/concerns</u>	<u># of 2015 complaints/concerns</u>
33 out of 1,702 served or 1.9%	20 out of 1,692 served or 1.1%	20 out of 1,848 served or 1.08%

Complaints/Administrative Concerns that were logged during the time frame of 1/1/15 – 12/31/15 consisted of:

12 written
+ 8 verbal
20 total

***NOTE: Exposure of confidential patient information (HIPAA) is considered an administrative violation and not a complaint. Fourteen HIPAA violations were recorded in 2015.**

Complaints/Concerns were generated from the following sources:

- One (1) from a Youth
- One (1) from a Foster Parent
- One (1) from Wraparound Mngmt.
- Two (2) from System Partners
- Four (4) from Care Coordinators/Care Coordination Supervisors
- Four (4) from Providers
- Seven (7) from Parents/Guardians

Complaints/Concerns were filed against:

- Fifteen (15) against Service Providers
- Four (4) against Care Coordination Agencies
- One (1) against Parent Advocacy Representative

Those that were filed related to:

- 1 related to Fee For Service/policy violations
- 1 related to not following Wraparound process
- 2 related to boundaries/ethical issues
- 2 related to client safety issues
- 5 related to poor billing practices
- 7 related to lack of professionalism
- 2 were "Other"

Complaint (n=14) Outcomes

- Ten (10) complaints were substantiated
- Four (4) were unsubstantiated

Note: Those issues identified as "Administrative Concerns" (n= 6) do not receive an outcome identifier of substantiated or unsubstantiated.

Information Technology System



Wraparound Milwaukee, as a system of care, has an Information Technology System (IT) - Synthesis. Synthesis is the software program that houses our client electronic medical record (EMR), all Care Coordination and Provider Network documentation and information and Provider billing/invoicing/fiscal related information. Numerous reports/queries, including those utilized for utilization review, are generated reflecting a variety of data. These reports are analyzed for variances from desired practice both as a system and by individual client if necessary. Summary information for these reports is developed and forwarded to the QA/QI Department and the Wraparound Management Team for review. Reports are distributed to stakeholders as appropriate.

Most of the efforts in 2015 focused on migrating the system to a new software platform. This is an on-going project that is expected to be completed by the end of 2016.

During this time period the following Synthesis enhancements occurred:

1) The on-line Provider Network Resource Guide for families was completely re-written. The major focus of the change was to provide more information to families when choosing a provider – including pictures, personal statements, specialties, clinical expertise and interests.

2) Wraparound expanded the range of provider types entering contact notes into Synthesis. Previously only crisis workers entered notes. In 2015 this was expanded to include tutors, mentors, parent assistants and other individual / family support providers. This increases the amount of information available to care coordinators as well as the providers, since these providers now have on-line access to the youth's Crisis Plans and Plans of Care.

Submitted by: Aggie Hale
Wraparound Milwaukee IT Consultant

Wraparound Provider Network

The Wraparound Provider Network (WPN) is a diverse group of individuals/agencies that provide mental health and support services for the children and families in



Wraparound, REACH, Family Intervention and Support Services (FISS) and the O'YEAH programs.

In 2015, the Network contained, on average, **125 Provider Agencies**. Approximately seventy-one (71) different types of services were offered.

The total number of agencies that provide services within the various service categories consisted of:

- AODA Services = 10
- Care Coordination = 8
- Child Care/Recreation = 7
- Crisis-related Services = 31
- Day Treatment = 4
- Family/Parent Support Services = 12
- Foster Care = 13
- Group Homes = 22
- Independent Living Placement = 2
- In-Home Therapy Services = 33
- Life Skills Services = 5
- Med Mngmnt./Nursing Services = 9
- Outpatient Therapies = 45
- Psychological Assessment = 11
- Residential Care = 13
- Respite Services = 18
- Transportation = 10
- Youth Support Services = 12

There were **two hundred and nine (209) "Out of Network" requests** that were submitted during 2015. Requests were primarily submitted for services such as psychological evaluations, individual and special therapies and group home care. Thirty-nine (39) of the 209 or 19% requests were denied primarily due to the request actually being withdrawn/not needed, not being submitted in advance of the service being provided, the service already being offered in network, or the vendor actually declining/not accepting Wraparound rates.

No New Provider Orientations took place during 2015.

Four (4) Level I and three (3) Level II Wraparound Provider Philosophy Trainings were held. The trainings focus on the implementation of Wraparound philosophy and the Child and Family Team process. Both levels of training are 5 hrs. each with a lunch break. A total of ninety-nine (99) providers participated.

Provider Fiscal Training was also provided twice this year. Wraparound's Fiscal Coordinator visited the agencies and provided personal training in billing and invoicing.

Five (5) Provider Forum Meetings took place. This meeting provides an arena in which network vendors assemble to receive updates and general information about the Wraparound Milwaukee program and Delinquency & Court Services Division (DCSD) programs. The Providers are also offered the opportunity to share information about their programs and ask any questions or express any concerns.

Several **new services/service codes** were created and added to the Provider Network in 2015. The new services and/or specialized expansion of current services were created in an

effort to address new client and programmatic needs. Listed below are the new services/service codes:

CODE	SERVICE	EFFECTIVE DATE
5506A	Transitional Specialist Care Coord-Master Level	11/20/15
5522b	Individual/Family Training and Support Services	8/3/15
5303F	Mentoring, Specialized-BA/MA Crisis	4/23/15
5020	Health Clinic Appt	3/9/15
5167	In-Home AODA/Substance Abuse Counseling	2/25/15
5303E	Mentoring, Specialized Crisis	2/10/15

Project O'YEAH



Project O'YEAH (Older Youth and Emerging Adult Heroes), a program administered under the auspices of Wraparound Milwaukee, is designed to support older youth and young adults ages 16.5 – 25 who may be experiencing emotional and behavioral challenges, to successfully transition to adulthood. This is a voluntary program.

O'YEAH, now entering its 7th year of providing service, continues to look at areas that present challenges for transitional age young adults. Several partnerships have been established over the years that provide services/support to the youth. These include:

- Milwaukee County Adult Community Services
- Milwaukee County Adult Services Liaison
- Pathfinders Milwaukee, Inc.
- Lad Lake
- Journey House
- SaintA – Independent living
- LaCausa
- Milwaukee Public School collaborations
- State of Wisconsin
- Justice Point

Centralized Quality Assurance Committee



Wraparound Milwaukee actively participates in the County-wide quality assurance initiative. Centralization promotes and improves communication between several County Divisions and Departments with regards to the standardization of quality assurance issues/processes/procedures and practices.

Through September 2015, the QA Committees' efforts focused on the following:

- Continued to strategize collaboratively and collectively as issues arose within one or more programs/networks/divisions
- Continued to implement "single indicator" audits in an effort to monitor procedural compliance across more agencies. **See Audits/Evaluations/Reports and Utilization Review Section**
- Reviewed Documentation and Billing Standards, Risk Assessment Tool, Partial Disallowance Protocol, Milw. County being the Payor of Last Resort,
- Continued to utilize the tracking system to monitor provider exclusions and/or issues that rise to a substantial level of concern
- Learned about the DHHS Strategic QA Plan to be implemented over that next couple years
- Division representatives presented at various meetings providing an update on QA activities occurring in their areas

In October of 2015 the Centralized QA Committee went on a hiatus while DHHS and Divisional QA changes occur.

In 2015 (unless otherwise indicated), the following O'YEAH demographics were recorded:

Demographics	N =
Total Screenings	185
Total Enrollments	116
Tier I	1
Tier II	96
Tier III	19
Disenrollments	51
Gender (2014 – 2015)	65% Male (N=146) 35% Female (N=80)
Age (2014 – 2015)	18.75
Ethnicity (2014 – 2015)	75% African-American (N=158) 14% Caucasian (N=29) 9% Hispanic (N=19) Biracial (N=2) .04% Native American (N=1) .04% Asian (N=1)
Average cost per member /per month	\$873.00

The various Tiers represent different levels of programmatic intervention. Young adults are guided into a Tier that would best support their needs as identified through the screening process. Tier 1 is the most intensive.

Futures Plans

Futures Plans are the Plan that the young adult establishes based on their individual vision of adulthood. They will explore their needs and strengths and what supports may be necessary for them to achieve their hopes and dreams. There are several “Life Domains” that are addressed within the Plans.

In 2014-2015, two hundred and nine (209) young adults were enrolled. Of the 209, one-hundred and twenty-eight (128) had at least one domain entered on the O’YEAH Domains List. Those 128 youth had a total of 409 Domains identified within their Futures Plans.

Domain Category	# identified in Futures Plans
Educational/Vocational	119
Health and Well being	12
Legal/Restoration	23
Living Situation	34
Mental Health	111
Safety	8
Social/Recreational	6
Transition to Adulthood	79
Family	12
Other	5

Out of the 409 Domains identified fifty-three (53) were closed out. The average change from the initial Domain Ranking value (Scale of 1-5, with 1 meaning minimal progress was made in that area, to 5 meaning maximal progress has been in that area) to the final Domain Ranking value were as follows:

Domain Category	Average Change in Value
Educational/Vocational	+1.43
Health and Well being	+2.62
Legal/Restoration	+2.5
Living Situation	+3.33
Mental Health	+1.57
Safety	+5
Social/Recreational	+1
Transition to Adulthood	+1.72



Owen’s Place

Owen’s Place (in honor and memoriam of Owen Felix, the first Director of Project O’YEAH) is a resource center designed to assist young adults between the ages of 16.5 and 24 years whose mental health needs may be impacting on their ability to lead an independent life.

Owen’s Place happenings in 2015:

Owens Place continues to expand its partnership with community resources throughout Milwaukee County to provide our young adults with a variety of programming that will help guide them with their transition process as well as make lasting connections with their community.

These partnerships include:

- Mental Health of America- Parenting and Nurturing Classes
- Diamond State of Mind-Character Development series
- Knowthyself-Knowthyself Project
- Personal Responsibility Education Program-The Center for Self Sufficiency Silver Spring Neighborhood Center
- Prime Financial Credit Union- Financial Literacy and Job Readiness
- POHSEY (*Proactive Outreach for the Health of Sexually Exploited Youth*)-Focus Group

Throughout 2015, Owen’s Place underwent several changes. Owens Place expanded its operation by 4500 sq. ft. allowing for 2 additional conference rooms, offices for the O’YEAH Transitional Coordinators, a full kitchen and we now share space with SaintA’s Independent Living Team and St. Charles FISS Team.

Besides the expansion, we also made great strides in expanding the capacity in which we are using our Peer Specialists. Our Peer Specialists have taken a more active role in identifying programming to meet the needs of our ever-growing young adult population. They have also expanded their roles to facilitate different workshops each week, which provide innovative ways to engage and retain youth involvement.

As we move into 2016, our focus will be on engagement and empowerment with our young adult population.

Submitted by:

Shannon Trzebiatowski, MS
Program Manager, O’YEAH/Owen’s Place

M.O.V.E.
WISCONSIN



M.O.V.E. WISCONSIN

(Wisconsin Youth Motivating Others through Voices of Experience) is a youth-run organization designed to empower adolescents and young adults involved in the Wraparound Milwaukee program. Community-based activities are planned and implemented focusing on leadership development and creativity. The group meets at Owen’s Place the 1st and 3rd Wednesday of each month.

In January of 2015, Wilton Johnson was appointed as the new State Coordinator of MOVE WI. Wilton is a State Certified Peer Specialist and has been working tirelessly to build a presence for MOVE WI in the local community. Wilton is working towards launching the first local chapter of MOVE Milwaukee by working closely with the youth and young adults who access Owens Place.

In 2015, MOVE WI focused on educating others about MOVE WI and ways to get involved. They also accomplished a number of tasks, which include:

- Launching their own website (www.movewi.org)
- Began an anti-stigma campaign called *REPLACE LABELS WITH LOVE* which has gained international attention and support
- Hosted a Text, Talk and Act event which was a conversation about mental health
- Met with leaders of Youth Move National to expand our Chapter and amplify our young adult voice in the community
- Hosted a Question, Persuade and Respond Training for suicide prevention
- Partnered with Know Thyself Project for a PhotoVoice project and hosted a gallery night to display the photographs
- Hosted a training on Strategic Sharing
- Held a Restorative Justice Circle

As we move into 2016, MOVE WI is looking to continue to spread the word of their *REPLACE LABELS WITH LOVE* campaign through decals and t-shirts. MOVE WI hopes to expand into Milwaukee Public Schools (MPS) and develop Chapters within the schools. Their first introduction into MPS will occur later in May of 2016 when MOVE helps celebrate Children’s Mental Health Awareness Day with a goal to reach 500 students within MPS and educate them on mental health in addition to getting them to take a pledge to manage their own mental health.

Submitted by:

Wilton Johnson, State Certified Peer Specialist, Young Adult Advisor at Owen’s Place and MOVE WI State Coordinator

FISS Program

The FISS (Family Intervention and Support Services) Program is a program administered through the Milwaukee County Behavioral Health Division per a contractual agreement with the Division of Milwaukee Child Protective Services (DMCPS). Milwaukee County was awarded the contract, which began in July of 2012.



The program is designed to assess and provide services

to families experiencing life challenges with their adolescent child age 12-18. The FISS program goal is to strengthen the parent/guardian’s ability to support their adolescent in the home, community and school.

The FISS program has two components:

1. Assessment - Assessments are conducted either in the office or in the home utilizing tools provided by DMCPS. Based on the assessment results and supervisory consultation, the family is referred to the FISS services unit, DMCPS, Milwaukee County Department of Human Services Delinquency and Court Services, or programs/agencies in the community.
2. Case Management - The FISS services unit provides families with a case manager (contracted through St. Charles Youth and Family Services) who utilizes Wraparound Milwaukee’s provider network, crisis services through the Mobile Urgent Treatment Team, and community agencies to formulate and implement a service plan with the family. Case managers utilize the Wraparound philosophy and Coordinated Service Team approach with the goals of providing stabilization, and sustainable connections to community resources. The approach is strength based, and utilizes a combination of paid network services, natural supports, and community based services.

In October of 2015 the FISS staff relocated their offices to Owen’s Place located at 4610 W. Fond du Lac Ave., Milwaukee. This more central location will hopefully increase family access.

In 2015, the following FISS demographics were recorded:

Demographic	N/% =
Assessments Completed (Individuals)	698
Assessment No Show/Cancel Rate	383/35%
Enrollments (families) in Case Management	109
Disenrollments (families) from Case Management	108
Average Length of Stay (ALOS)	3 to 4 months

Submitted by:

Stacy Kozel, LCSW
 Program Coordinator - FISS
 Associate Director - Wraparound Milwaukee

V. Other Accomplishments

Positive Recognition Announcements

A total of 57 Families/Service Providers/System Collaborators and/or Care Coordinators were recognized in 2015 through the **Positive Recognition Announcement**. The Positive Recognition Announcement is a format that enables anyone



involved in the Wraparound system of care to recognize the hard work, dedication, perseverance, etc., of another. Those recognized are identified in the monthly Wraparound Newsletter.



“Ms. C is the best thing that ever happened to my family. She is such a good-hearted person. She has been a big help to me and my family and we all love her. I wish I had an award for her because she should get one. So happy to have her as my Parent Assistant. Thank you Ms. C.”

“When J. came into my home he came with understanding. He listens and intercepts when needed. He talks to my child, goes on outings and the main thing is that he has is love for my child.”

“Ms. G is well rounded, empathetic, nurturing, a great listener, attentive and understand the adversity my family is dealing with.”

“R. is dependable, helpful and available. We consider him part of our family.”

Research Activity

As a data driven program, Wraparound Milwaukee collects and analyzes data to assure accountability and responsiveness to the Wraparound model and the children and families we serve.



In 2015, the research arm of Wraparound Milwaukee was involved with a number of projects:

Dual Status Youth - Publication

Demonstrating Effectiveness of the Wraparound Model with Juvenile Justice Youth through Measuring and Achieving Lower Recidivism Bruce Kamradt, MSW & Pnina Goldfarb, PhD, Published through the Technical Assistance Network, Institute of Innovation and Implementation. University of Maryland. June 2015.

Dual status youth move between the child welfare and juvenile justice systems, and often are involved in both concurrently. An investigation of the dual status population was conducted to identify a general descriptive profile, a clinical picture and a

juvenile justice profile. The outcomes revealed that 77 Wraparound youth were identified as dual status between January 2013 and June 2015 and a disproportionately larger number are females (47%) than the general Wraparound population (20%). According to the Adverse Childhood Experiences (ACE), these youth have experienced high levels of trauma, 47% have an ACE score >4. All youth had multiple diagnoses with a great number of bipolar, depression and ADHD and the Achenbach revealed both externalization and internalization scores deep in the clinical range. Fifty five percent of the total population has had at least one hospitalization and 76.6% (59 youth) were on psychotropic medications. An analysis of Wraparound Milwaukee’s dual status youth revealed that the average age for first time charged offenses is 14.05 years and the range is from 7.07 to 16.98 years. Forty percent (31/77) were identified as high risk.

Wraparound Youth:

An Analysis of Recidivism and Vehicle Related Offenses

- The overall program recidivism rate is 18.6% (147/787 enrolled youth)
- The multiple offense rate is 45.3% (122/269 offenses were perpetrated by youth who had offended multiple times).

The breadth of offenses spans 34 separate crime types. The top high frequency offenses are *Battery, Disorderly Conduct, Robbery* and two *Vehicle Related* crimes. *Vehicle Related* offenses are more frequent than *Assault* or *Property* offenses and they constitute 24% of all offenses. There also appears to be large fluctuations in *Vehicle Related* crimes from month to month, which may be related to the seasons. Further study may reveal that the time of year may influence the incidence rate of these offenses.

Re-entry Program Status Report

The purpose of this report was to collect and analyze aggregate data of those youth who are being served by Wraparound Milwaukee in the Department of Correction (DOC) Collaboration Re-entry program in order to gain a better understanding of this population and the programmatic outcomes for these youth.

A total of 23 youth went through the program between May 2014 and November 2015. Ninety one percent (21/23) were male and nine percent (2/23) were female. In general, this population has a preponderance of males and skews older, i.e. - average age of 16. The two highest incidences of diagnostic disorders were Disruptive Disorders and Mood Disorders (both 65% of the total population.) However, the number of youth with an ADHD diagnosis is almost at the same incidence level (61% or 14/23.) The average enrollment was 168 days. Thirty-five (35) percent were determined to be successful, 22% completing the program and 13% transferring to O’YEAH. The remaining youth disenrolled because they returned to corrections. However, the data reveals that only 3/23 or 13% of the total population acquired new charges and this represents 23% (3/13) of those that returned to corrections. The remaining ten youth received sanctions. The types of behaviors

that resulted in sanctions included; parole violations (e.g. removal of the GPS monitor) and noncompliance/safety.

Submitted By: Pnina Goldfarb, PhD
Wraparound Milwaukee Research Consultant

Family Orientations

Eight (8) Family Orientations were held.
On average, five (5) Families United of Milwaukee representatives assisted with each orientation providing support and guidance.



The orientations are **sponsored by Families United of Milwaukee, Inc. in partnership with Wraparound Milwaukee.** The orientations focus on defining Wraparound and Families United roles and what they can offer the families as well as the role of the Care Coordinator. In addition, Child and Family Team Composition, MOVE Wisconsin, service provision, system partner collaboration, crisis services, paperwork/evaluation requirements and the disenrollment process are discussed. Lunch is served and families are provided with a grocery store gift card as a welcoming and thank you for attending the orientation.

All new families entering the Wraparound system of care are invited and encouraged to attend. Families United of Milwaukee staffs continue to call families in an effort to encourage attendance at the Family Orientations.

Visits from other Sites/Programs, Technical Assistance, Presentations



August 2015 – On August 25th and 26th, Wraparound hosted a **site visit** for a group from **Prince George’s County in Maryland.** The visit focused on an overview of Wraparound Milwaukee, Wraparounds financial/funding and Care Coordination Agency structure, Agency Performance Measures, MUTT, collaborating with Child Welfare and other system partners, Transition to Adulthood programing, use of an IT System to support ones work and the Role of Trainers and Coaches.

Mobile Urgent Treatment Team (MUTT)



In 2015 MUTT continued to develop new initiatives, while continuing to serve both Wraparound affiliated youth/families and the Milwaukee County community at large.

With the support of Wraparound and their partnership with the City of Milwaukee and the Milwaukee Police Department (MPD), MUTT took on the clinical role in a new program to identify and support child victims of traumatic violence. MUTT provided training to MPD in an effort to implement an

intervention model based on a program from New Haven, Connecticut. Officers identify victims and witnesses of traumatic violence and work alongside specially identified/trained MUTT clinicians to assess and support these children and families. The program is currently limited to children/families that live in the city blocks being serviced by District 7 of the Milwaukee Police Department.

In addition to the training provided to nearly every officer in District 7, Dr. Dykstra, Director of MUTT, has taken an expanded training role within the MPD Crisis Intervention Team (CIT) program as that program is now available to all Milwaukee County officers. CIT is a nationally recognized model for officers coming in contact with citizens who may be experiencing/exhibiting serious and persistent effects of mental illness.

In addition, MUTT was able to work with Wraparound to help bring Dialectical Behavior Therapy (DBT) Training to the Wraparound Provider Network. DBT was identified as a need within the network and using Wraparound resources and expertise, we made that training available to interested clinicians. MUTT staff with special expertise in DBT then started a treatment group to help support the efforts of trained clinicians providing individual therapy.

In the fall of 2015, MUTT was re-credentialed by the State of Wisconsin to continue to provide crisis services to youth and families in the Milwaukee community through 2017.

In 2015, MUTT provided services to the following number of youth in the following locations/through the following contact types:

Contact Location/Type	Distinct Number of Youth Seen
Children’s Court/Detention	7
Home	475
Wraparound Wellness Clinic	30
Psychiatric Crisis Services (PCS)/ Acute Inpt. Hospital	40
School	251
By phone	162
Other	147
TOTAL	1,060

Submitted by: Steven P. Dykstra, PhD
Director, Mobile Urgent Treatment Team
Licensed Psychologist

Proactive Outreach for the Health of Sexually Exploited Youth Project (POHSEY)



In 2014, Wraparound Milwaukee, as the primary community partner, in collaboration with the Medical College of Wisconsin and Rethink Resources & Diverse and Resilient, was awarded a Healthier Wisconsin Partnership Program (HWPP) planning grant to develop and implement the **POHSEY Project.** The goal

of this Project was to improve the identification and treatment of youth involved in human trafficking by developing policies and procedures to improve and provide comprehensive health and mental health care throughout Milwaukee.

From 1/1/14 – 12/31/15 Project dissemination efforts included:

- Outreach Materials/Events
 - Developed a resource guide, project website and protocol for contacting agencies when trafficking is reported
 - Conducted round table discussion on the needs of youth who have been sexually exploited
 - Presented early identification, risk factors and information on Commercial Sexual Exploitation of Children (CSEC) to middle and high school students and staff
 - Presented community resources to parents and children at a Community Learning Center
 - Participated in co-panelist presentation for Sigma Theta Tau, International Honor Society of Nursing
 - Developed and distributed a resource book for survivors of trafficking and over 2,000 resource cards for teens
 - Developed medical protocols and algorithms for Human Service Workers, Specialized Care Coordinators and Crisis Stabilizers
 - Conducted numerous educational presentations and information sessions reaching over 500 medical, mental health and social service providers
 - Interviewed for and quoted in Health Progress, the journal and online publication of the Catholic Health Association of the US
 - Participated in interviews for publications in The Guardian and Milwaukee Magazine
- Presentations
 - Participated in co-panelist presentation on CSEC at MCW
 - Conducted webinar presentation titled “Missed Opportunities: The Medical Response to Sex Trafficking of Minors”
 - Panel presentation at MCW
 - Workshop presentation at the North American Society of Pediatric and Adolescent Gynecology annual meeting
 - Presented at the Reviving Justice Conference
 - Presented at Children’s Hospital of Wisconsin Grand Rounds
 - Conducted workshop at the National JUST Conference

See the link below for more information:

<http://www.mcw.edu/Advancing-Healthier-WI-Endowment/HWPP-Funded-Awards/2014/Proactive-Outreach-Health-of-Sexually-Exploited-Youth.htm>

The first phase of the grant ended in December 2015. In November 2015, Wraparound was awarded a second cycle of funding through the Medical College of Wisconsin’s **Healthier Wisconsin Partnership Program**. In the second cycle, POHSEY will build on the work and discoveries from the first phase. The focus will be directed on developing curriculum, training and resource tools for health care professionals and service providers who come in contact or work with youth who have been or may be commercially sexually exploited or trafficked.

Submitted by: E. Marie Broussard, MPA
Project Manager, Grants
Wraparound Milwaukee



“Welcome Home Teens in Motion” Support Group

During 2015, the “Welcome Home Teens in Motion” youth support group continued to focus on the needs of runaway youth in Wraparound Milwaukee. The group is scheduled to meet monthly to share stories, concerns, and resources and provide anonymous support to one another. Several tools that Care Coordinators, families and youth can use to address questions and concerns about youth missing from care are available. These tools can be found on the Wraparound Milwaukee Website - <http://wraparoundmke.com/care-coordination/toolkit-for-youth-missing-from-care>



Teen Parent/Pregnancy Protocol and Pregnancy Prevention Program

In Wraparound’s commitment to ensuring the safety and well-being of all children and families, the **“Protocol for Teen Parents/Parents-To-Be/Pregnancy Prevention”** was developed and implemented. In 2015 approx. 20-30 pregnant/teen parents/sexually active teens received support, guidance and care from a designated Wraparound Milwaukee nursing staff as it relates to sexual health issues, i.e. – Safe Sex, Sexually Transmitted Diseases, Birth-Control Education, Pregnancy and teen parent education like Safe Sleep and Shaken Baby Syndrome and Safety issues that relate to infant care and parenting. The protocol also ensures that every teen parent has access to a Pack and Play (promotes safe sleep) and community resources that can assist with additional support and guidance to pregnant and non-pregnant teens.

The protocol can be accessed at:
<http://wraparoundmke.com/?p=1285>

Teen Pregnancy and Protocol Brochure can be accessed at:
<http://wraparoundmke.com/?p=1284>

Submitted by: Maryan Torres, BSN, RN, CPN
Wraparound Milwaukee

Milwaukee Adolescent Health Clinic/Wraparound



The Milwaukee Adolescent Health Program clinic continues to serve youths who have been identified as being commercially sexually exploited or domestically sex trafficked (CSE/DST). This clinic is in collaboration with the Downtown Health Clinic with funding from a federal grant through the OJJDP to mentor and provide services for youth who have been CES/DST.

In 2015, the clinic saw over 22 patients who were evaluated and received STI treatment services, birth control and support services that relate to adolescent health. The Clinic is staffed by Wendi Ehrman, M.D. of the Medical College of Wisconsin and Wraparound’s Maryan Torres BSN, RN, CPN.

Youth can be referred to the mentoring program from the clinic or referred to the clinic through the mentoring program. However, any youth participating in the mentoring program, including non-Wrap kids, will be eligible to receive services at the MAHP Clinic. The clinic is open one day per month, Monday afternoon from 1-5 p.m. Call Maryan Torres (414 - 257-7624) for more information.

Submitted by: Maryan Torres, BSN, RN, CPN
Wraparound Milwaukee

Wraparound Wellness Clinic



During 2015, Wraparounds Wellness Clinic continued to provide medication management and wellness/education services to the youth involved in the Wraparound and REACH programs.

In 2015 the following occurred:

- The clinic relocated to the west side of the Behavioral Health Complex. The new space continues to offer a family friendly experience in a warm setting.
- Modifications were made to several processes in an effort to further incorporate the Health Home Model of care. One of the primary modifications focused on getting and reviewing information from youth’s primary care physicians in an effort to support a more holistic approach to care. This is process will actually be part of Wraparound Performance Improvement Project for 2016.
- Efforts also began on hiring an Advance Practice Nurse Practitioner in 2016.

Many youth were seen in the clinic! Referenced below are clinic appts that occurred in 2015 in comparison to the two previous years:

Month	2013	2014	2015
January	203	163	310
February	119	202	287
March	177	170	288
April	160	223	227
May	183	196	243
June	209	197	280
July	164	222	336
August	229	175	240
September	142	211	303
October	201	289	286
November	203	173	252
December	184	244	287
Yearly Clinic Appt. Totals	4,187	4,479	5,354

Submitted by:
Dennis Kozel, MD
Wraparound Milwaukee Medical Director

CORE (Coordinated Opportunities for Recovery and Empowerment) Program



The CORE program is a new program being offered under the Wraparound Milwaukee system of care that offers comprehensive and specialized mental health services and support to individual’s ages 10-23 years old that are experiencing their first episode of psychosis. Some symptoms the individual may be experiencing include hallucinations, delusions, unusual thoughts, disorganized thinking/speech or disruption of self-care.

- Services offered include:
- ✓ Care Coordination
 - ✓ Therapy
 - ✓ Peer Support
 - ✓ Psychiatric Services
 - ✓ Employment and Education Support

In 2015, the CORE Program provided services to fifteen (15) youth/young adults ages 16 to 23.

A referral to the program can be made by calling the REACH Intake Line at (414) 257-7607. For general information, you can contact Brian McBride at (414) 257-7158.



Youth Living Out Loud (YLOL)

YLOL is a mentoring program being administered under the Wraparound Milwaukee system of care, the works with youth who have been, or are at high risk for being commercially sexually exploited or trafficked.

YLOL is now in the second year of a three-year grant awarded from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Last year we experienced great success in providing mentoring services to youth who have been or are at high risk for being commercially sexually exploited or trafficked. We developed a comprehensive training curriculum for mentors and specialized crisis stabilizers working with this population of youth. We also successfully enrolled boys and transgender youth who are under-reported or underserved among those who have been commercially sexually exploited or trafficked. This year we are making a targeted effort to recruit and train survivor mentors in the peer support model, as well as expanding the support options offered to youth and their families.

In 2015, forty-three (43) youth received specialized YLOL mentor services.

Submitted by: E. Marie Broussard, MPA
Project Manager, Grants
Wraparound Milwaukee

Collaborations with other programs in the Behavioral Health Division (BHD) and the Department of Health and Human Services (DHHS)



In 2015, Wraparound Milwaukee participated in several Behavioral Health Division and/or Department of Health and Human Services (DHHS) committees and workgroups as BHD/DHHS moves forward with its strategic plans for the future. Those committees/workgroups consisted of:

- BHD Family Advisory Council
- BHD Patient Rights Committee
- BHD PolicyStat Committee
- BHD Quality Strategic Planning Committee
- BHD Consumer Satisfaction Survey Workgroup
- BHD Performance –Based Measures Workgroup
- DHHS Strategic Planning Committees (Internal Satisfaction of County Services for Employees, Standardized Employee Policies, High Quality and Accountable Service Delivery)

Other happenings improving the quality of life for Wraparound youth and families and our Care Coordinators:

• **Summer Family Picnic** – On August 14th, Families United of Milwaukee, Inc., M.O.V.E. Wisconsin, Wraparound Milwaukee, Wraparound Care Coordination Agencies and several other system partners collaborated to sponsor the annual Summer Family Picnic at Lincoln Park. Food, games and art and crafts were the highlights of the day!



• **Care Coordinator Appreciation Day** – In July, Wraparound Milwaukee organized a special event held at the

MilwaukeeCounty Zoo/Zoo Ala Carte Event to show our appreciation to the Care Coordination Agencies serving the youth and families in Wraparound. Care Coordinators received special admission prices to the zoo and were honored with certificates of appreciation. Cake, soda and goodie bags for the Care Coordinators family members were a smash at the event!

• **Care Coordination Holiday Event** - On December 4th, the annual Care Coordinator Holiday event was held at the Washington Park Senior Center in Milwaukee. The Care Coordinators enjoyed lunch, treats, entertainment provided by each of the Care Coordination agencies and a door prize holiday raffle.

• **Care Coordinator of the Month Award** - Wraparound Milwaukee continues to sponsor the Care Coordinator of the Month Award. The winner of the award receives a traveling trophy filled with treats and goodies to display on their desk and is recognized on the Synthesis opening screen page.



• **6th Annual Wraparound Milwaukee Talent Show** – On May 20th, Wraparound held its Annual Talent Show at Pulaski High School Auditorium. Doors opened at 5:30p.m. for the always-amazing Youth Art Auction in which guests got to bid for artwork that was created by youth in the Wraparound programs. All proceeds went directly to the artist. The Talent Show began at 6:00p.m. Several youth and their families participated in sharing their talents through music, song, poetry and dance.

Wraparound remains committed to providing quality care to the youth and families we serve. It is the responsibility of Wraparound and all its affiliated partners to be actively involved in the process of continuous quality improvement. Thank you to all the individuals who contributed to this report. Your time is greatly appreciated!



Respectfully Submitted,

Pamela A. Erdman MS, OTR

Wraparound Milwaukee Quality Assurance Director

Mental Health Board
Quality Subcommittee Meeting
June 6, 2016

Sentinel Event Committee
Quality Summary

What we've accomplished

- Provide on-going, consistent, systemic Root Cause Analysis review of BHD's most serious events
- Achieved system-wide alignment of the Sentinel Event (SE) process by:
 - Identifying the need to incorporate the review of Community and Recovery Services' (CARS) branch events into the greater SE process.
 - Employing a CARS staff member as a member of the Sentinel Event Committee.
 - Consulting The Joint Commission in addition to all applicable state regulatory and statutory requirements in determining conditions of review.
 - Revised the Sentinel Event Policy to reflect changes.

Our current state

- Working towards finalization of the revised policy.
- Working as a part of a greater quality system to impact positive change and prevention of future negative outcomes by proactive implementation of identified improvement actions. A recent example involves exploring our ability to provide access to Narcan for our contracted community providers as a tool in heroin death prevention.

Where we need improvement

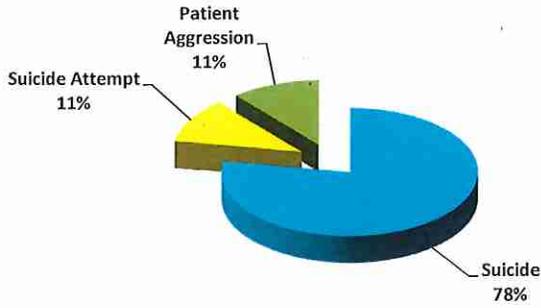
- Full dissemination and education on the Sentinel Event process for all BHD and agency staff.
- Integrating Wraparound Milwaukee's currently separate Critical Incident review process into the greater BHD Sentinel Event process.

2015 BHD Sentinel Events

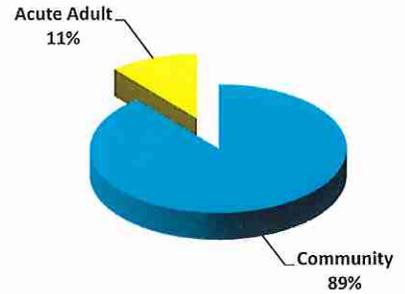
9 incidents reviewed

Quality Improvement/Healthcare

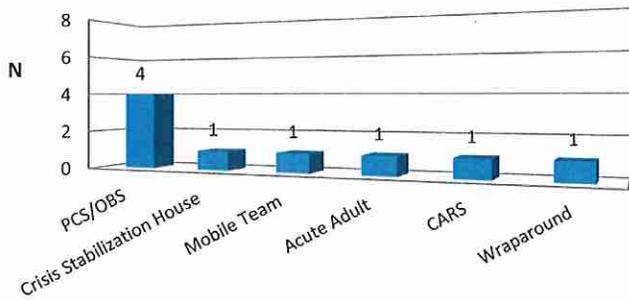
Type of Event



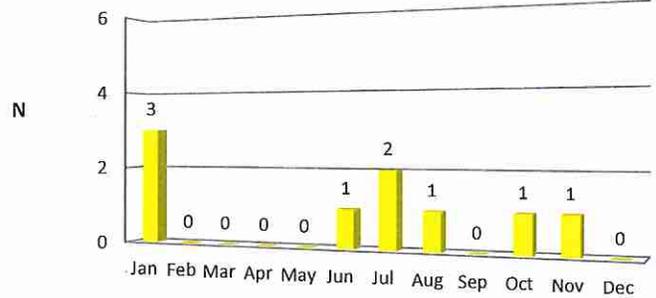
Location of Event



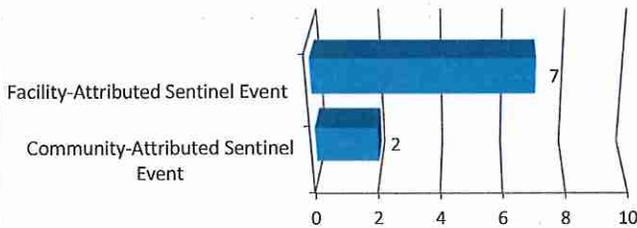
Program (Open with/last contact)



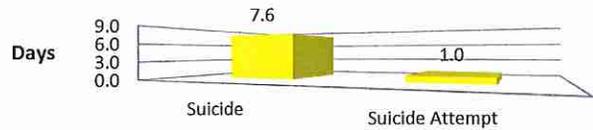
Month of Event



Level of Review



Average Days After Last BHD Contact

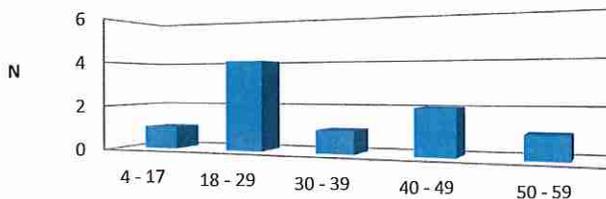


2015 BHD Sentinel Events that Occurred in the Community - Days after last contact with BHD

Event Type	N	Days after last BHD contact		
		Median	Average	Range
Suicide	7	2.0	7.6	0 - 22
Suicide Attempt	1	1.0	1	1

Patient Age

Average Age: 31 yrs male, 33 yrs female; Gender: 78% male 22% female



N	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59
■	1	4	1	2	1

Significant AODA Component to Event

67% (n=6) of events reviewed had no significant AODA component

