Chairperson: Duncan Shrout
Vice-Chairman: Thomas Lutzow
Secretary: Dr. Robert Chayer
Senior Executive Assistant: Jodi Mapp, 257-5202

2

MILWAUKEE COUNTY MENTAL HEALTH BOARD

Thursday, March 23, 2017 - 4:30 P.M.
Washington Park Senior Center
4420 West Vliet Street

MINUTES

PRESENT: Robert Chayer, Michael Davis, Rachel Forman, Walter Lanier, Thomas Lutzow, Jeffrey Miller, Mary Neubauer, Maria Perez, and Brenda Wesley
EXCUSED: Ronald Diamond, Jon Lehrmann, and Duncan Shrout

SCHEDULED ITEMS:

1. **Welcome.**

   Vice-Chairman Lutzow opened the meeting by greeting Board Members and the audience.

2. **Approval of the Minutes from the February 23, 2017, Milwaukee County Mental Health Board Meeting.**

   MOTION BY: ***(Lanier) Approve the Minutes from the February 23, 2017, Milwaukee County Mental Health Board Meeting. 9-0***
   MOTION 2ND BY: ***(Forman)***
   AYES: Chayer, Davis, Forman, Lanier, Lutzow, Miller, Neubauer, Perez, and Wesley - 9
   NOES: 0

3. **Explanation of the Budget Public Comment Process.**

   Mr. Oleszak discussed 2018 Budget assumptions, 2016 Budget results, and 2017 Budget initiatives.

   Vice-Chairman Lutzow stated the purpose of the meeting is to receive community input on what should be included in the Behavioral Health Division's 2018 Budget for both community and hospital services. The actual budget process begins in April, which by receiving input now allows room for modification. The Vice Chairman went on to state the public has three minutes each to speak. The Board's Clerk served as timekeeper.

SCHEDULED ITEMS (CONTINUED):

4.	**Milwaukee County Behavioral Health Division 2018 Budget Discussion.** The meeting opened for public comment on the Milwaukee County Behavioral Health Division 2018 Budget. The following individuals appeared and provided comments: Aime Witczak, Grand Avenue Club Kevin Ellis, Grand Avenue Club Pam Weisser, Grand Avenue Club Mike Schwieters, Grand Avenue Club David Hanson, Grand Avenue Club Frances Hanson, Grand Avenue Club Winnie Butler, Community Advocates Tom Kotowski, Uncas Park Neighborhood Susan T. Sigl, Mental Health Taskforce Barbara Beckert, Disability Rights Wisconsin Clarence Johnson, Wisconsin Community Services Todd Scharrer, Peer Run Respite Advisory Committee Amy Lindner, Meta House Cindy Krahenbuhl, Shelter Task Force and Guest House Clay Ecklund Dennis Hughes Mark Fossie, M&S Clinical Services
5.	**Adjournment.** ***MOTION BY:*** ***(Davis) Adjourn. 9-0*** ***MOTION 2ND BY:*** ***(Perez)*** ***AYES:*** Chayer, Davis, Forman, Lanier, Lutzow, Miller, Neubauer, Perez, and Wesley - 9 ***NOES:*** 0 ***EXCUSED:*** 0

SCHEDULED ITEMS (CONTINUED):

This meeting was recorded. The aforementioned agenda items were not necessarily considered in agenda order. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.

Length of meeting: 4:30 p.m. to 5:43 p.m.

Adjourned,

Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

The next regular meeting for the Milwaukee County Mental Health Board is Thursday, April 27, 2017, @ 8:00 a.m. at the Zoofari Conference Center 9715 West Bluemound Road

The March 23, 2017, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled meeting of the Milwaukee County Mental Health Board.

Dr. Robert Chayen, Secretary
Milwaukee County Mental Health Board

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: April 10, 2017

TO: Duncan Shrout, Chairperson – Milwaukee County Mental Health Board

FROM: Michael Lappen, Administrator, Behavioral Health Division

SUBJECT: **Report from the Administrator, Behavioral Health Division, Providing an Administrative Update**

Background

The purpose of this standing report is to highlight key activities or issues related to the Milwaukee County Behavioral Health Division (BHD) since the previous Board meeting and provide ongoing perspectives to the Milwaukee County Mental Health Board regarding the work of the organization and its leadership.

Discussion

Legislative Audit Bureau (LAB) Recommendations: BHD Progress, Request for Statutory Support, and Further Updates

- **Recommendation Spread Sheet**

  As requested at the previous meeting, the Behavioral Health Division (BHD) has arranged the LAB recommendations from December 2016 in a spreadsheet to track progress and priorities. (**Attachment A**).

BHD Collaborations

- **MacArthur Safety and Justice Challenge Pilot**

  BHD has been involved with this project on a number of levels. Recently, BHD agreed to join a pilot effort on Post Booking Stabilization. The idea is that individuals charged with non-violent offenses who are appropriately screened (Justice Point) could be booked and released to follow-up assistance with a Navigator who would assist them to connect with housing and whatever mental health or substance abuse services they need/meet eligibility for. Charges could be dropped/suspended as long as the individuals follow up with their treatment providers. The Pilot will target 10 individuals. BHD has committed to providing prompt assessment and placement utilizing community partners for

services like Targeted Case Management (TCM), Comprehensive Community Services (CCS), the Crisis Resource Center (CRC), etc.

The Pilot will inform a larger initiative to help individuals with mental health and substance use challenges avoid jail and access treatment. BHD also has committed to support the multi-jurisdictional Crisis Assessment and Response Team (CART) that will also support the initiative once the Milwaukee County Board approves the District Attorney (DA) investigator position (who gets paired with a BHD Crisis worker). This CART team will assist with outreach and monitoring and will assist the effort to provide assertive treatment and engagement versus incarceration and emergency detention.

- **Milwaukee County Department of Health and Human Services (DHHS) Housing**

BHD has provided funding for the Housing First initiative. Housing First is a philosophy where individuals who are chronically homeless are offered housing with "no strings attached." Efforts are made to engage participants in services after they are safely housed, with the great majority of folks willing to accept help. With BHD support, the Housing Division has housed 170 individuals—all of whom have a mental health or substance use disorder.

This project supports the effort to prevent incarceration in that the Housing Division has established relationships where a judge will throw out warrants and tickets for individuals that enter Housing First. Many folks have unpaid tickets that lead to warrants that are the barrier keeping them on the street or leading to incarceration. Once folks are housed and since so many accept treatment, the recidivism rate and the costs of providing emergency care and jail are greatly reduced.

Some recent outcome measures:

1) The previous year spent homeless compared to their first 12 months in housing as part of Housing First, residents utilized 539 fewer mental health crisis service contacts ($714,600).
2) The top four programs utilized were Crisis Mobile, Detoxification, Psychiatric Crisis Services (PCS), and Inpatient - 627 episodes (prior year) to 88.
3) From when the project began in September 2015 to date, total Municipal Court Violations among Housing First residents went from 210 to 39.

Jim Mathy will provide a more detailed presentation at a future Board meeting.

High Quality and Accountable Service Delivery

- **Northside Facility Update: Timeline and Update - Transition from Patina to BHD Staff**

  The Northside Facility project has made significant progress. The team has taken the significant community and stakeholder feedback we have received and has moved forward with "fit testing" potential sites. The search has been narrowed to two potential locations: one new build and one renovation of an existing building. The renovation site could possibly house all of our BHD community staff, in addition to the Northside "Hub." We are working through a cost analysis based on the architect's preliminary design and hope to begin negotiations on the future lease arrangement with the developers.

  The Community Access to Recovery Services (CARS) team is working closely with fiscal staff to develop financial pro formas for all of the Hub lines of business. We have also explored a Substance Abuse and Mental Health Services Administration (SAMSHA) Grant for up to $10 million for "Integrated Care" that very closely matches our scope and plans and would be very helpful in moving the project forward. The grant requires State participation, and our preliminary discussions have been very positive.

  Additionally, as we have reached a logical transition point, our contract with Patina Solutions has ended and the responsibilities for implementing the Northside Facility has been transitioned to BHD staff.

Other Topics of Interest

- **Cambio Solutions Contract**

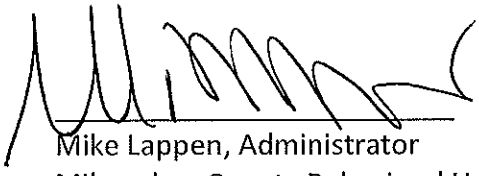
  Alicia Modjeska recently retired from the Chief Operating Officer position at BHD to care for a family member and to spend more time with her family. She had led the Acute Psychiatric Outsourcing Project since the beginning and has very significant experience with the project at BHD and with similar efforts with hospital systems in the local market.

  To assist BHD during the transition of the project and to avoid a setback in the project timeline at a crucial point in the process, BHD has entered into a Professional Services Contract with Alicia through her LLC, Cambio Solutions, to complete the process of identifying the new Acute provider and finalizing a contract with that provider. This contract is for less than $100,000.00 and does not require Board approval. It has, however, been brought to our attention that Milwaukee County ethics rules would not

allow contracting with an employee within twelve months of employment. There is no such rule in the Milwaukee County Behavioral Health Division bylaws, but in the effort to be transparent, we wanted to bring the issue to the Board's attention.

It has been suggested that the Mental Health Board should develop a policy regarding contracts with former employees, and this could be easily addressed as part of the procurement policy that has been under development for some time with support from DHHS and now the Comptroller's Office.

Respectfully Submitted,



Mike Lappen, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services

Attachment A

Milwaukee County Mental Health Board LAB Recommendations Action Plan

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
1	The LAB recommends BHD budget for mental health expenditures on a program-level basis, maintain detailed expenditure information, and regularly provide the MHB with status reports that compare budgeted to actual expenditures (p. 19).	2	Completed. BHD budgeted on a "program level" for all major programs in 2016 (78% of budget), and for the 2017 budget did so as directed by LAB with the only exceptions being "programs" operated on a single purchase of service contract, with a single vendor.	Randy Oleszak	6/1/2017	Approximately 78% in 2016 Fully implemented in 2017
2	The LAB recommends BHD to submit to the Board for its review and approval all fee-for-service contracts that are likely to total or exceed $100,000 (p. 20)	2	Completed. Fee-for-service contracts approaching $100K will also be brought forward for Board review prior to exceeding $100K. We anticipate proposing new policies for Board approval in 2017 related to Fee-For-Service contracts to make this process more efficient.	Randy Oleszak, Brit Williams-Van Klooster	6/1/207	August 2016
3	The LAB recommends BHD centrally maintain all policies adopted by the Board and make them accessible to Board members and the public (p. 67). Maintain in a central location all of the policies adopted by the MHB, Ensure all MHB members are	2	Completed. These are maintained on the MCMHB web page. http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board/Board-Policies.htm We plan to improve the page significantly as part of the more global County web page re-design in 2017.	Jodi Mapp	6/1/2017	Jan 2017

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
	provided with current copies of these policies, including information on the dates they were adopted and the dates they were revised, if applicable; and make these policies accessible to the public by posting them on the MHB website.					
4	The LAB recommends BHD develop a strategy to address staffing issues at its hospital and report on this strategy to the Joint Legislative Audit Committee and the Board by June 1, 2017 (p. 39).	2	Completed. Comprehensive recruitment and public awareness campaign, recruitment and retention incentives, temporary RN budget, severance plan for acute outsource.	Linda Oczus, Kane Communications., Human Resources, compensation	5/1/2017	
5	The LAB recommends BHD electronically maintain records of services provided to recipients, and to report on this strategy to the Joint Legislative Audit Committee and the Board by June 1, 2017 (p. 48).	2	Completed. Provider Connect went live in 2015, and tracks services provided by BHD contracted agencies. Avatar is the BHD electronic health record for Acute, Crisis, and CARS.		6/1/2017	October, 2015.

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
6	The LAB recommends BHD review the 144 policies that are overdue for review and report on this to the Joint Legislative Audit Committee and the Board by June 1, 2017 (p. 65).	2	BHD Safety Officer has created a plan to have all BHD policies current or retired as appropriate by 5/1/2017.	Lynn Gram	6/1/2017	On track for 5/1/2017
7	The LAB recommends BHD develop performance indicators specific to each of its four community-based programs for children and adolescents (p. 61).	2	Wraparound and REACH have reported on performance indicators for many years for the services they provide to children and adolescents. Performance indicators are reviewed twice a year with all contractors, with a performance improvement plan submitted each time.	Mary Jo Meyers, Jen Bergersen	6/1/2017	
8	The LAB recommends BHD submit the proposed performance indicators for community-based programs for children and adolescents to the MHB for its review and approval (p. 61).	2	BHD has reported to the Quality Committee and the full MCMHB performance indicators for Wraparound and Reach since the Board was established. Performance indicators have also been developed for OYEAH and the Mobile Urgent Treatment Team (MUTT) and were presented for Quality Committee approval March 6, 2017.	Mary Jo Meyers, Jen Bergersen	6/1/2017	3/6/2017
9	The LAB recommends BHD annually report to MHB on the results of its performance indicators	2	BHD has done this for close to 20 years for Wrap, and close to 10 years for REACH once we made the expansion to that population. It has been reported to the MCMHB Quality Committee through the	Mary Jo Meyers, Jen Bergersen	6/1/2017	March 2017

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
	for community-based programs for children and adolescents; and adequately document and maintain information on its procedures and the data used to support its measurements (for children and adolescents) for at least five years from the time the performance results are reported to the MHB (p. 61).		annual report that then gets passed on to the full board. We will add the indicators for OYEAH and MUTT approved in March 2017.			
10	The LAB recommends BHD maintain and analyze electronic data on the specific community-based services provided to all recipients who are discharged home from its psychiatric emergency room (p. 26).	2	This can be relatively easily implemented for individuals enrolled or connected to serves through BHD Community Access to Recovery Services (CARS), since the information is already available in Avatar. BHD has requested this system upgrade, and have identified it as a high priority. We will also add a field to capture non-BHD providers, so we can collect, analyze, and report this data. The latter will be more challenging, as there are many providers outside our network, but we are committed to capturing the data.	CARS/Matt Krueger (IT)	6/1/2017	
11	The LAB recommends BHD develop and submit to the Board for its approval adequate performance indicators	2	Performance indicators have been added to fee-for-service contracts and are being developed for others. The Chief Quality Officer presented to the Quality Committee in March a timeline and methodology for the implementation of such	Jen Bergersen, Brit Williams-Van Klooster	Report progress to LAB 6/1/2017	

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
	for each of its programs, modify the calculation of certain performance indicators to ensure they are accurate, maintain information on the procedures and the data used to support its measurements for at least five years, and annually report performance results to the Board (pp. 34, 52, and 61).		indicators across a number of programs throughout 2017 and into 2018.			
12	The LAB report recommends BHD modify its contracts for mental health services to include provisions establishing performance based standards, annually assess vendor performance, and annually report to the Board on these assessments (p. 64).	2	Performance indicators have been added to fee-for-service contracts and are being developed for others. The Chief Quality Officer presented to the Quality Committee in March a timeline and methodology for the implementation of such indicators across a number of programs throughout 2017 and into 2018.	Jen Bergersen, Brit Williams-Van Klooster	Report progress to LAB 6/1/2017	
13	The LAB recommends BHD clearly delineate the community-based programs for adults that it administers and the	2	Community Access to Recovery Services (CARS) staff will present to the MH Board on all programs in 2017, scheduling each of the major programs over several meetings to allow for adequate explanation. We are developing new materials describing programs, and also plan to develop a	Assigned CARS service managers/Kane Communications	12/31/2017	

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
	services provided by each (p. 48).		comprehensive guide to services based on an example provided by Barbara Beckert from the La Crosse integrated care consortium. Furthermore, we have been directed to link program descriptions and the related budget expenditures in presentations to the Board to help more clearly demonstrate how budget and services are presented.			
14	The LAB recommends identifying the policies that apply to each of its programs and the policies with which vendors are expected to comply (p. 48).	2	All BHD policies will be reviewed by May 1, 2017. Current contracts have significant reference to policies, but each will need to be reviewed as policies are amended, retired, etc.	Brit Williams Van Klooster, Lynn Gram	5/1/2017	
15	The LAB recommends developing performance indicators for individuals placed on a waiting list for institutional-based care (p. 39).	2	BHD will work with the Quality Committee to review the data related to this item, and develop meaningful KPI.	Jen Bergersen/Quality Committee PCS staff		
16	The LAB recommends that the Board comply with statutes appointing a Board of Trustees for BHD's psychiatric hospital, as specified in ins. 46.18(1), Wis. Stats. (p. 70).	1	Corporation Counsel observed that Act 203 amended certain provisions of chapter 46, including a long dormant (and ignored) clause regarding the naming of trustees for the "institution". We will work with the state audit bureau and counsel to better understand any required further obligations under this provision and report back to the Board accordingly. Corporation Counsel is reaching out to	Colleen Foley (Corp Counsel)	6/1/2017	

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
			the Attorney General's office about whether the MHB is really truly required to name trustees to perform (redundant) duties essentially now assigned to the Mental Health Board. The LAB also suggests that a change in State law might be logical to seek on this issue.			
17	The LAB recommends BHD should exclude scores of zero in calculating the average progress made by recipients who are served by community-based programs for children and adolescents (p. 61).	3	BHD believes that this is recommendation is based on a misunderstanding of the performance measure that utilizes "zero" when an agency does not address an area of need. Eliminating "zero" will lead to sloppy practice where a care coordinator could simply skip ranking some of the final scores of need on the final plan of care to enhance their overall rating of success. Wrap/REACH staff use zeros to make sure that the care coordinator is reviewing all needs in the final plan of care and allowing the family to rank their level of progress. When they fail to do this, or skip over a need, that gets scored a zero. This doesn't happen often, and the assumption is that providers know they will get a "zero" if they fail to address a need, and thus reduce their average score. Staff will review this particular issue with the Quality Committee and report back to the full Board. Board member Lutzow has recommended an economical resource to evaluate our methodology	Mary Jo Meyers	6/1/2017	
18	The LAB recommends BHD ensure that all recipients who are admitted through emergency detentions	2	The data team is working with PCS and crisis staff to improve accuracy of data related to Emergency Detentions. We will also update the KPI related to acute hospital beds to reflect actual BHD and community capacity.	BHD IT, Crisis, Quality staff.	6/1/2017	

	Action Step/Task	Priority Level (1, 2, 3)*	Status Update (Include running list of notes with date of update)	Person(s) Responsible	Target Date to Complete	Actual Date Completed
	are included when calculating whether the detentions were extended beyond 24 hours and modify its goal related to the average daily number of adult recipients in its psychiatric hospital to take into account the average daily number of hospital beds that are actually available (p. 34)					

***Priority: 1= Recommendation based on statute, administrative rule, etc. 2=Recommendation based on LAB opinion/best practice 3= MCMHB has directed BHD administration to explore other options/place priorities elsewhere.**

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: April 5, 2017

TO: Duncan Shrout, Chairperson- Milwaukee County Mental Health Board

FROM: Michael Lappen, Administrator, Behavioral Health Division
Prepared by Michelle Naples, DHHS Strategic Initiatives Director

SUBJECT: 2017 Behavioral Health Division Business Plan

Background

In 2015, the Milwaukee County Department of Health and Human Services (DHHS) established five goal areas to guide department-wide strategic planning during 2015-2017. The goal areas include: 1) Workforce Investment and Engagement; 2) Community and Partner Engagement; 3) Optimal Operations and Administrative Efficiencies; 4) Financial Health and Sustainability; and 5) High Quality and Accountable Service Delivery. As a part of its strategy development and implementation process, DHHS divisions complete annual Business Plans that outline short-term goals (up to 1 year) that align with the DHHS Strategic Plan goals. These plans are intended to guide divisions' work for the year and serve as a management tool that provides a clear picture of required tasks and responsibilities for the division's major initiatives.

Discussion

The Behavioral Health Division has prepared a 2017 Business Plan that includes the following major initiatives and related goals to be achieved during the year:

Initiative *(DHHS Strategic Goal Area)*	Initiative SMART Goals
Integrated Community Facility *(High Quality and Accountable Service Delivery)*	Identify site for Northside integrated community facility, contract with developer, and break ground by December 31, 2017.
Outsourcing of Acute *(High Quality and Accountable Service Delivery)*	Identify a partner to operate acute psychiatric facility by September 1, 2017.
Workforce Development and Diversity *(Workforce Investment and Engagement)*	Expand diversity within BHD, especially crisis mental health nursing, administration, and outpatient therapy by December 31, 2017.
Crisis Case Management *(Financial Health and Sustainability)*	Services currently funded through tax levy (Administrative Coordinators in CARS, Community Consultation Team, CART) will be 66% MA-billable for DHS 34 by June 30, 2017.

Initiative *(DHHS Strategic Goal Area)*	Initiative SMART Goals
Comprehensive Community Services *(High Quality and Accountable Service Delivery)*	50 additional youth and 200 additional adults will be served through CCS by December 31, 2017.
LAB Recommendations *(Optimal Operations and Administrative Efficiencies)*	Complete all Legislative Audit Bureau (LAB) recommendations as prioritized by the Mental Health Board and BHD Administration prior to the next LAB audit.
Performance-based Contracting *(Community and Partner Engagement)*	Develop Contract Performance Measures for four (4) service groupings by December 31, 2017.
Sustaining Reduction in Seclusion and Restraint *(High Quality and Accountable Service Delivery)*	Sustain seclusion and restraint rate at or below the national average (per 1000 patient hours) through December 2017.

The Business Plan format contains the following elements:

- Initiative SMART Goal
- Initiative Start Date, Projected End Date, Actual End Date
- DHHS Strategic Goal Alignment
- Related Performance Measures
- Budget Allotted/Spent
- Action Steps/Milestones: Actions, Action Step Target Dates, Action Step Actual Completion Date, Action Step Person(s) Responsible, Action Step Status

Progress on the overall goal and specific action steps for each initiative will be tracked on the Business Plan template. The BHD Administrator will update the Mental Health Board during the year on the status of these goals and actions through separate agenda items or as part of other updates, as applicable.

Respectfully Submitted,

Michael Lappen, Administrator
Behavioral Health Division

Community Access to Recovery Services

Milwaukee County Behavioral Health Division

What is CARS?

Community Access to Recovery Services (CARS) is the Behavioral Health Division entity that manages the public-sector, community-based mental health and substance abuse system for adults in Milwaukee County. Historically known as SAIL (mental health) and Wiser Choice (substance abuse), CARS is now proudly functioning as a co-occurring integrated system of care.

Focus Areas of CARS

CARS serves approximately 8,000 unique individuals annually in a variety of contexts, with an emphasis on four main areas:

- Prevention
- Access to Services
- Treatment and Rehabilitation
- Recovery

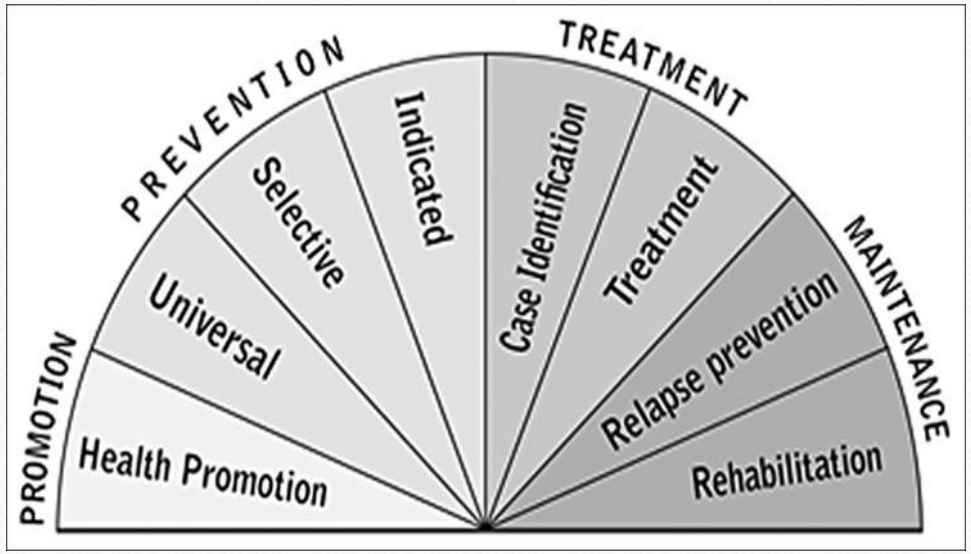
PREVENTION

Working together to address complex problems

Prevention

Continuum of Care

Prevention strategies can include strategies that address universally or a community. Selective strategies address those who are at a higher risk for a behavioral health disorder. These are indicated strategies for high-risk individuals who may have minimal but detectable signs of a behavioral health disorder.



Prevention

- $1,538,875 spent on prevention activities
- 13 providers in our prevention network
- 289,391 individuals in our community touched by our prevention programs
- Milwaukee County Substance Abuse Prevention Coalition
- Involvement in and leadership with numerous other coalitions in Milwaukee County
- Use of evidence-based SPF framework

Prevention Programs

Class Action- AODA Prevention programming for youth 13-18.

Thinking Under the Influence - Prevent and reduce underage alcohol abuse and binge drinking among LGBT youth & young adults 14-24 years.

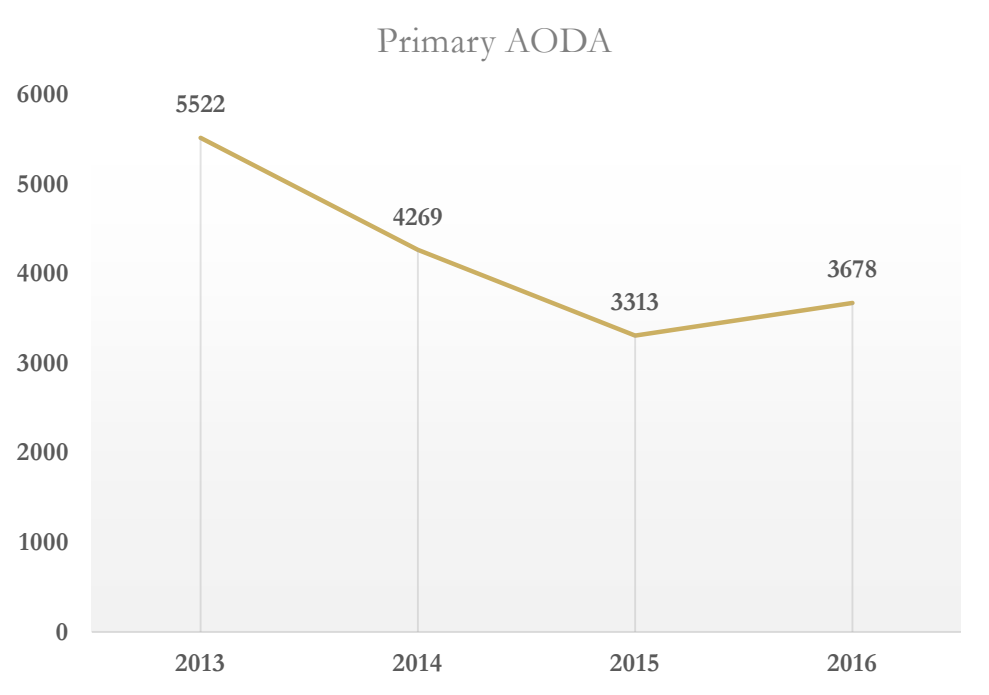
Botvin's LifeSkills Training - Life skills curriculum to youth in elementary and middle school grades.

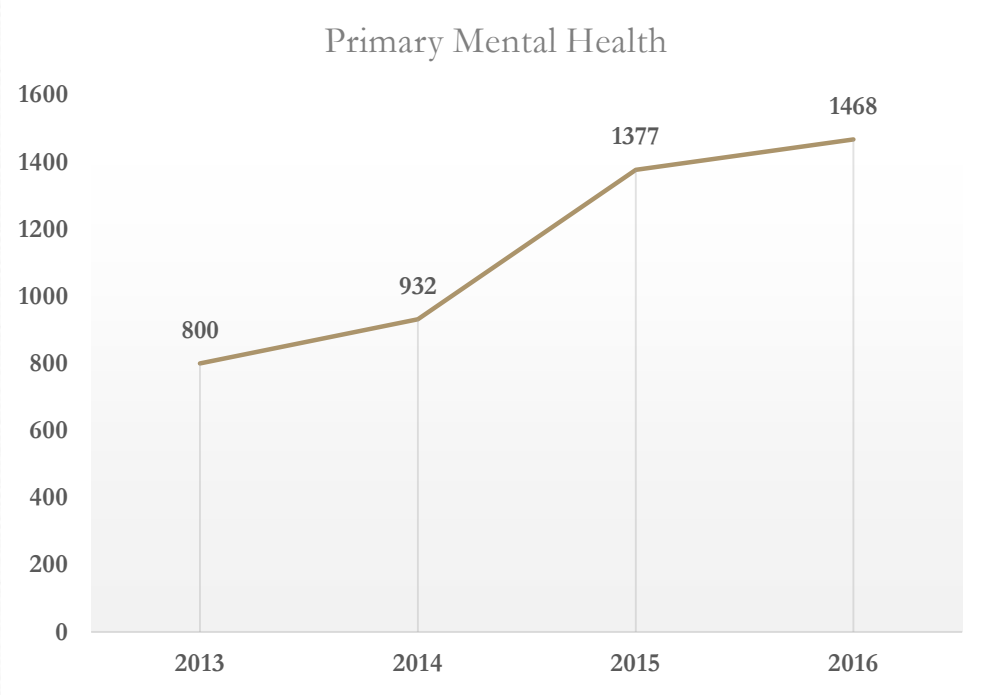
All Stars Program - Reduces the demand for AODA for 30 high risk Hispanic families.

ACCESS

Connecting with people with the services they need

Access – Who Receives Services?





Access – From Whom?

- Access Points
  - CARS
    - Rapid Mobile Response
    - Care Coordination Team
    - CCS
  - Impact
  - JusticePoint
  - M&S
  - WCS
  - BHD Access Clinic

Access – What Services?

- No Wrong Door Philosophy
  - Co-occurring capability
  - Trauma informed
  - Customer service focus
  - Value driven
  - Person-centered
- Referral Sources
- Key Partnerships

Access – What Services? (Cont.)

One of the most important keys to our success is the strength of our community partnerships. Key partnerships include:

- Crisis Services
- Corrections
- Court Systems
- Department on Aging
- Disability Services Division
- Division of Milwaukee Child Protective Services
- Family Care
- Legal Services
- Private Hospitals
- Special Needs Housing
- Wisconsin State Mental Health Institutes
- Wraparound

Access – What Services? (Cont.)

- Comprehensive Assessment
  - SAMHSA's Government Performance and Results Act (GPRA)
  - Addiction Severity Index (ASI)
  - Mental Health/AODA Functional Screen
- Use of American Society of Addiction Medicine tool
  - Description
  - Dimensions
  - Expansion

Access – What Services? (Cont.)

- Modified ASAM Criteria/BHD Domains

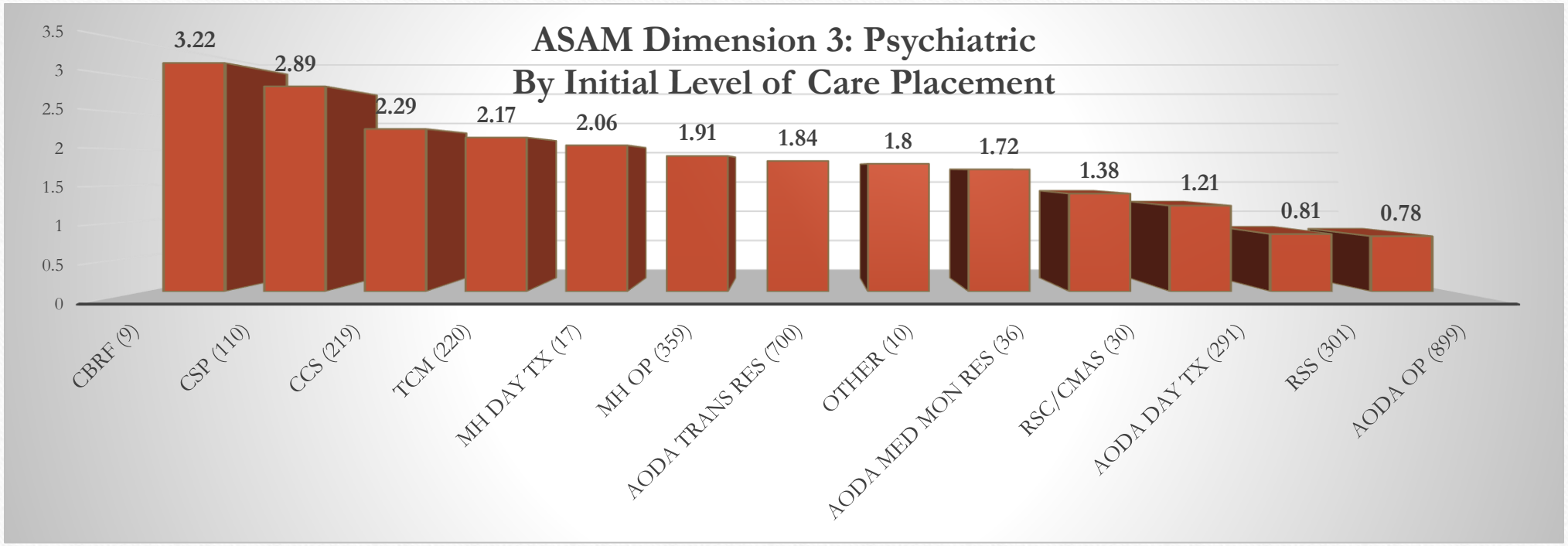
  Existing Dimensions 1-6

  - Dimension 1 – Acute Intoxication/Withdrawal Potential
  - Dimension 2 – Biomedical Complications & Conditions
  - Dimension 3 – Emotional/Behavioral/Cognitive Conditions & Complications (Psychiatric)
  - Dimension 4 – Readiness to Change
  - Dimension 5 – Relapse/Continued Use/Continued Problem Potential
  - Dimension 6 – Recovery Environment

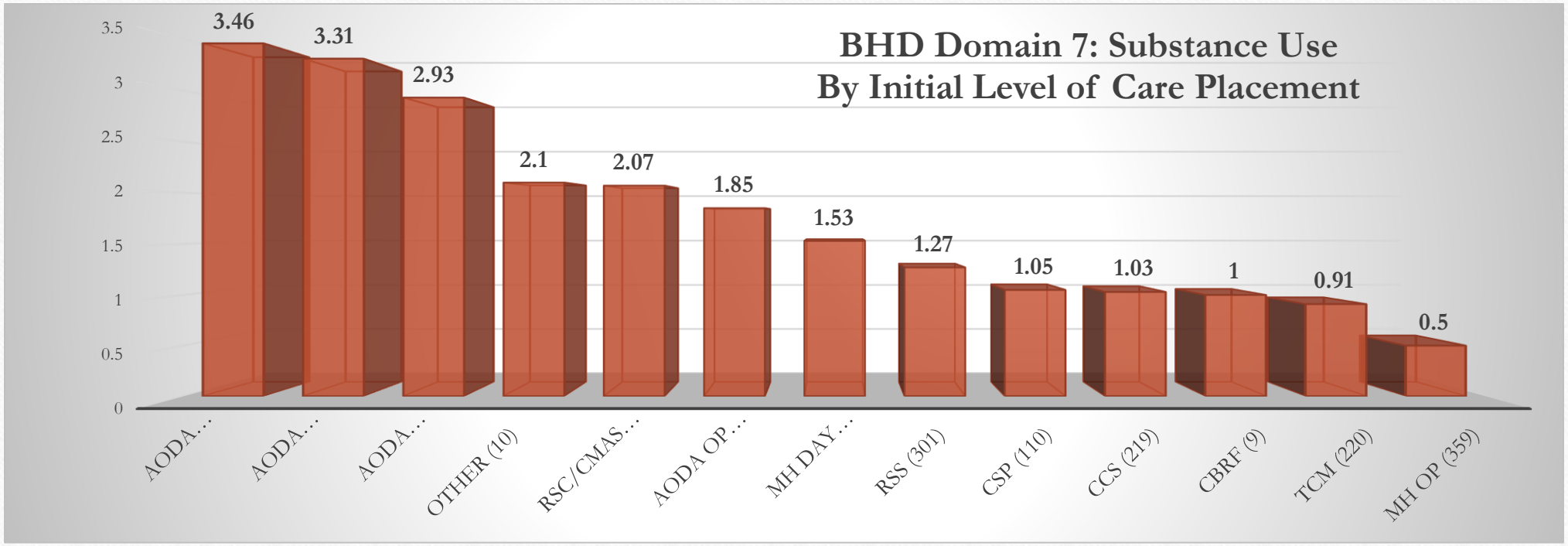
  New Domains 7-8

  - Domain 7 – Substance Use Problems
  - Domain 8 – Independent Living Skills

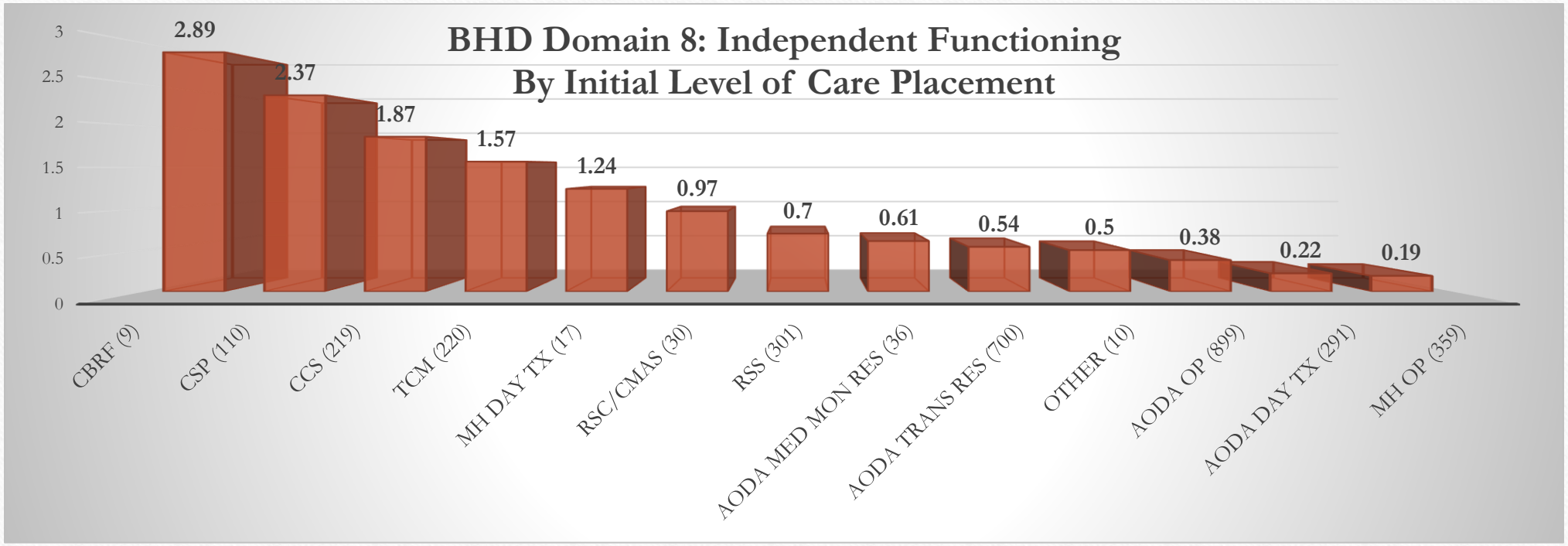
Access – What Services? (Cont.)



Access – What Services? (Cont.)



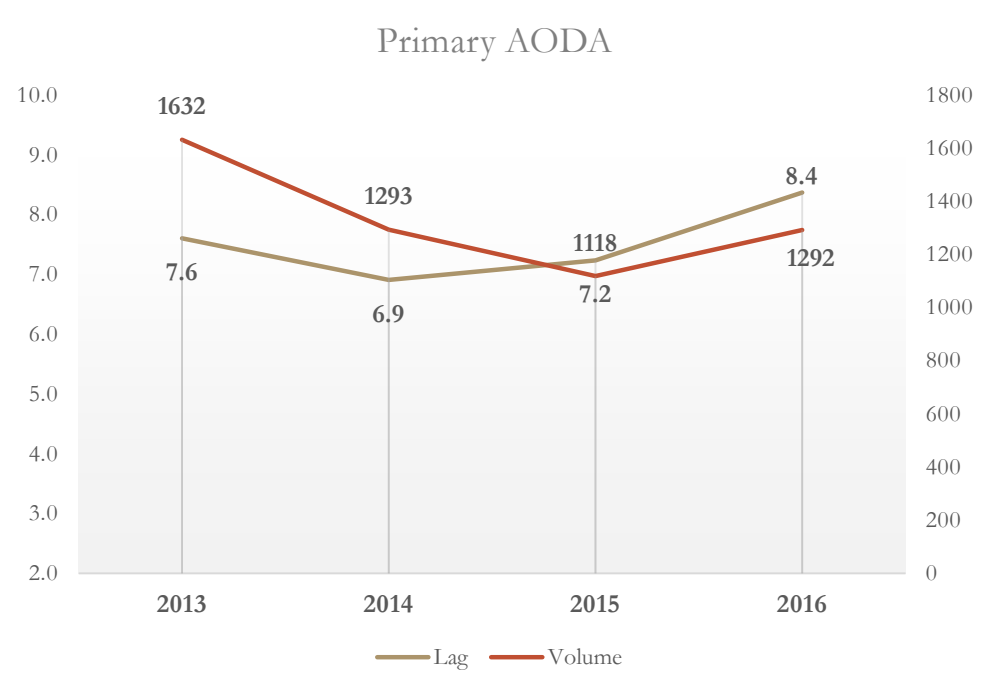
Access – What Services? (Cont.)

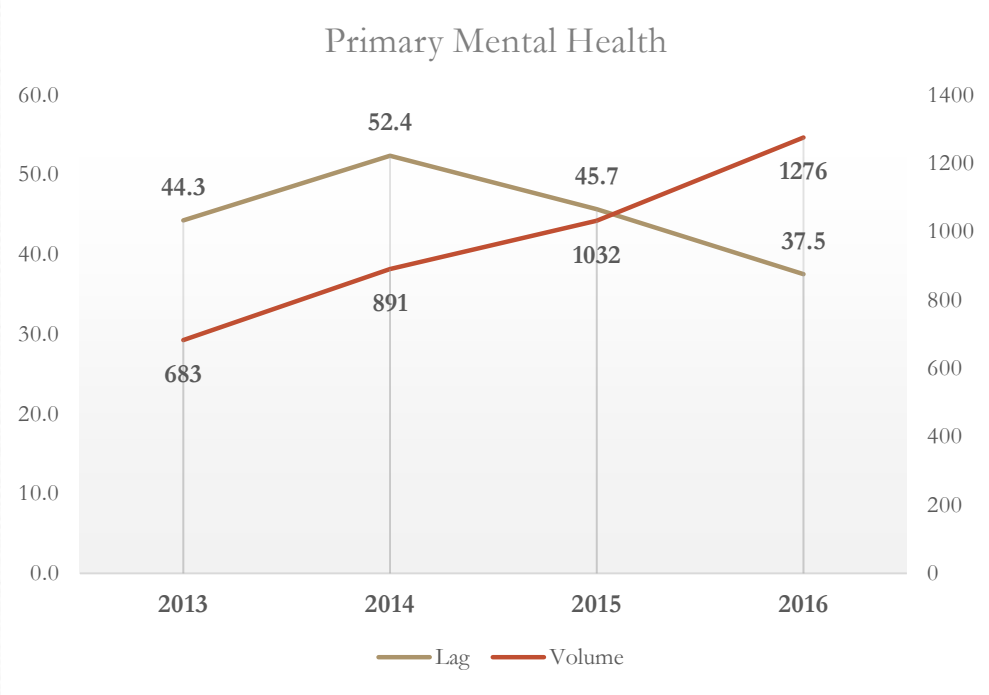


Access – At What Cost?

- "Braided" Funding
- Special Populations/Areas of Focus
  - IV Drug Users
  - Temporary Assistance for Needy Families (TANF)
  - Department of Milwaukee Child Protective Services (DMCPS)
  - Intoxicated Driver Program (IDP)
  - Adult Drug Treatment Court (including a Veterans initiative)
  - Family Drug Treatment Court

Improving Access





Questions?

More about CARS at the June Mental Health Board Meeting…

Treatment, Rehabilitation and Recovery

Behavioral Health Division

Netsmart Avatar Electronic Health Record

Agenda

- Behavioral Health Division EHR Background
- 3rd Party Assessment and Market Analysis
- Next Steps
  - Optimization of the “Avatar” EHR
- Netsmart Contract Overview

Background

Netsmart “Avatar” EHR

2011 - 2015

- Netsmart’s Suite of products purchased by BHD to address all program needs.
- BHD selected a third party vendor to implement the Netsmart software
- Solution customized to individual programs and departments on a serial basis

2015 - 2016

- Assessments of software environment made regarding current and future needs
- Independent recommendation to keep Avatar
- Netsmart knowledge expert onsite addressing critical needs and planning optimization work (2016)

2017

- Ramp up staffing for optimization
- Launch Avatar Optimization; focusing on coordinated improvement of present Avatar functionality across programs and unified policies and best practices.
- Ensure optimization facilitates future growth needs.

ASSESSMENT OVERVIEW
2012 – 2014 Implementation "Themes"

- Did not evaluate current process: Recreated existing "paper" processes without using all Avatar tools - missed efficiencies

- Outsourced Decisions – low clinical input led to poor usability

ASSESSMENT OVERVIEW - Market Analysis

- Market Research Performed
- Netsmart's "Avatar" identified as the best option in Mental Health EHR market for BHD

No Response	Higher Cost New to Field	No Mental Health 'Gold Standard'

- Next Steps - Reinvest in "Avatar" and establish Best Practice Implementation and Support Model

ASSESSMENT OVERVIEW - Additional Recommendations

Perform a Comprehensive Policy Review – in progress

- Establish and Implement Audit Controls and Processes
- Develop and Implement Access Policies for County, Community & Hospital staff
- Enhance System Security and Compliance
- Formalizing Current Procedures in Central Database (Policystat) for Staff Access

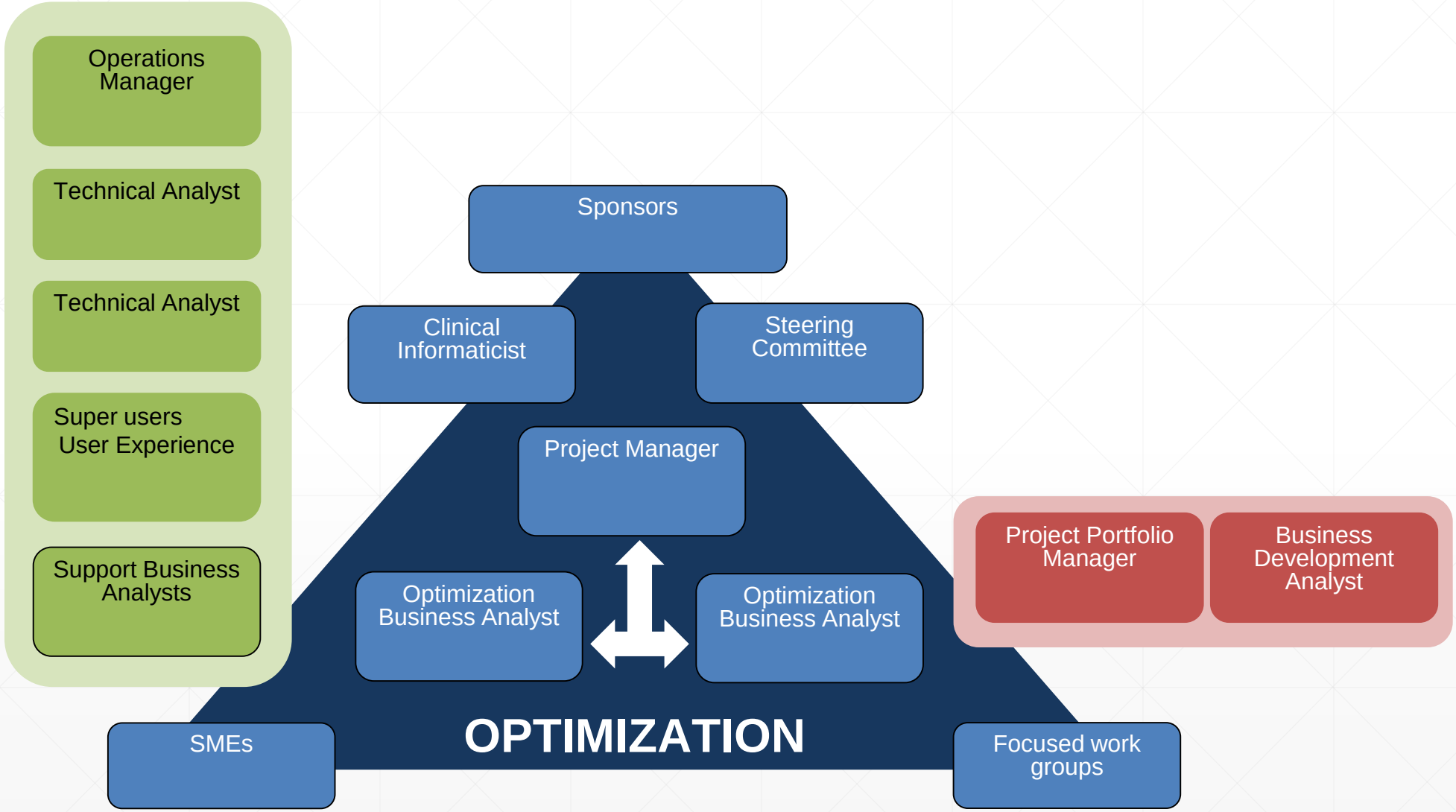
Retire “Synthesis” and Integrate Data to Avatar

- Maintaining two systems complicates maintenance, collaboration across BHD
- Synthesis works well for what it does, but incredibly high effort to incorporate Avatar features
- IMPORTANT NOTE: Synthesis will not be retired until Avatar is Optimized and configured to meet/exceed Wraparound’s needs

NEXT STEPS
New project – “EHR Optimization”

- Refine and Execute Project Charter
- Develop Project Plan including work breakdown structure and high level timeline
- Establish Change Management and Communication Plan
- On-board New Project Team resources and Project Structure
  - 100% dedicated project resources
    - Staffed a Project Manager for the Optimization effort
    - Contracted with Netsmart for additional Optimization resources
  - County resources added to support the effort
    - New BHD Role: Clinical Informaticist & User experience roles to align solutions with best practice
    - New BHD Role: Operations Manager to be the system administrator and manage support staff

Project Structure



NEXT STEPS
Near Term Tasks

- Complete Project Charter revamp and obtain sign off by sponsors and bring it to Project Steering Committee
- Engage Steering Committee and identify a Project Champion, SMEs
- Finish the Initiation and Requirements stages of the Optimization Project and complete Project Plan with supporting ancillary plans - April 2017
- On board project staff and perform knowledge transfer activities to support operations and align work assignments
- Draft and execute Communication Plan
- Commence Design Phase - May 2017

NETSMART “Avatar” CONTRACT
Overview and Scope

- Licenses and remote (cloud) hosting of core applications including:
  - Clinical Workstation
  - Practice Management
  - Managed Service Organization
  - ProviderConnect
- Improved Features
  - Data Exchange
  - Self-Service Reporting
  - Document Management
- Support and Sustainability
  - 24x7 helpdesk
  - On site IT Support Personnel

Netsmart "Avatar" Contract
Terms and Fiscal Impact

Netsmart Contract Renewal - Recurring Fees - 44 Months					
		2017	2018	2019	2020
SOLUTION CATEGORY	**DESCRIPTION**	**Payment Due Upon Contract Execution (5/1/17)**	**Payment Due 1/1/18**	**Payment Due 1/1/19**	**Payment Due 1/1/20**
Software, Hosting & Integration	Multiple modules, hosting and interfaces	$541,673.62	$830,380.46	$830,380.46	$830,380.46
HelpDesk IT Services	Level 1 24x7 HelpDesk Support	$64,000.00	$96,000.00	$96,000.00	$96,000.00
Application Management Services	2.5 FTE's for Operational	$426,666.67	$640,000.00	$640,000.00	$640,000.00
	2.0 FTE's for Project*	$341,333.33	$170,666.67	$0.00	$0.00
TOTALS		**$1,373,673.62**	**$1,737,047.13**	**$1,566,380.46**	**$1,566,380.46**

*2.0 FTEs are being funded out of the EMR Optimization budget, already approved

TERM: 44 Months: May 1st, 2017 to December 31st 2020
Two 1 year renewal options beginning in 2021.

Chairperson: Thomas Lutzow
Senior Executive Assistant: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD
FINANCE COMMITTEE

Friday, March 31, 2017 - 1:30 P.M.
Mental Health Complex
9555 West Watertown Plank Road
Conference Room 1045

MINUTES

PRESENT: Thomas Lutzow, Jon Lehrmann, Maria Perez, and Michael Davis

SCHEDULED ITEMS:

1.	**Welcome**. Chairman Lutzow welcomed everyone to the March 31, 2017, Mental Health Board Finance Committee meeting.
2.	**2018 County Budget.** An overview was provided of Milwaukee County's overall budget process and how the Behavioral Health Division's Budget is incorporated. Topics discussed included various components of the County budget, the projected gap, legacy fringe allocations, revenues by source, additional Capital Budget limitations, and successful financial reforms.
3.	**Behavioral Health Division Budget Forum.** The Zeidler Center for Public Discussion will be facilitating a community conversation on mental health services presented by the Milwaukee County Mental Health Board. The structure of the conversation was described as a listening circle format encouraging reflection with qualitative and quantitative data reporting. The date for the event was announced as Thursday, May 4, 2017, at 5:30 p.m., with the location to be determined.
4.	**2018 Behavioral Health Division Budget.** 2018 Budget Assumptions are based on a $4 million reduction in tax levy; assumes the current payor mix; and includes adult inpatient bed capacity and write-off percentage, child/adolescent inpatient services (CAIS) census; a comprehensive community services (CCS) increase, alcohol and other drug abuse (AODA) capacity, targeted case management (TCM), and community support programs (CSP). Recommendation information gathered from community input was summarized.

SCHEDULED ITEMS (CONTINUED):

5.	**Contract Approval Recommendations.**
	
	• Professional Services Contracts
	  ➢ 2016 Professional Services Contract Amendment
	  ➢ 2017 Professional Services Contracts
	• 2017 Purchase-of-Service Contracts
	• 2017 Fee-for-Service Agreements
	
	Professional Services Contracts focus on facility-based programming, supports functions that are critical to patient care, and are necessary to maintain hospital and crisis services licensure. Background information was provided on services the contracted agencies provide, which include case management redesign, Temporary Assistance for Needy Families (TANF) study/project support, medical residency and fellowship support, and Information Technology (IT).
	
	Purchase-of-Service Contracts and Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were also reviewed. An overview was provided detailing the various program contracts and agreements.
	
	Finance Committee Member Lehrmann abstained from recommending Medical College of Wisconsin contracts for approval.
	
	Remaining Committee Members agreed to recommend approval of Medical College of Wisconsin contracts to the full Board.
	
	The Finance Committee, as a whole, unanimously agreed to recommend approval of the balance of contracts contained in this Item to the full Board.

6.	**Employee Agreement.** The corresponding employment agreement is for medical staff stipulating total compensation. The Finance Committee unanimously agreed to recommend approval of the physician employment agreement to the Board.
7.	Adjournment. Chairman Lutzow ordered the meeting adjourned.

SCHEDULED ITEMS (CONTINUED):

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.

Length of meeting: 1:36 p.m. to 3:32 p.m.

Adjourned,

Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

The next meeting of the Milwaukee County Mental Health Board Finance Committee is Thursday, June 7, 2017, at 2:30 p.m.

PUBLIC COMMENT WILL BE HEARD ON THE 2018 BUDGET

Finance Committee Item 2

Legacy Cost impact on Future Milwaukee County Operations

I. Components of County Budget

II. What is the Projected Gap

III. Why is there a gap

   A. Increased Expenses (i.e. Pension Legacy)

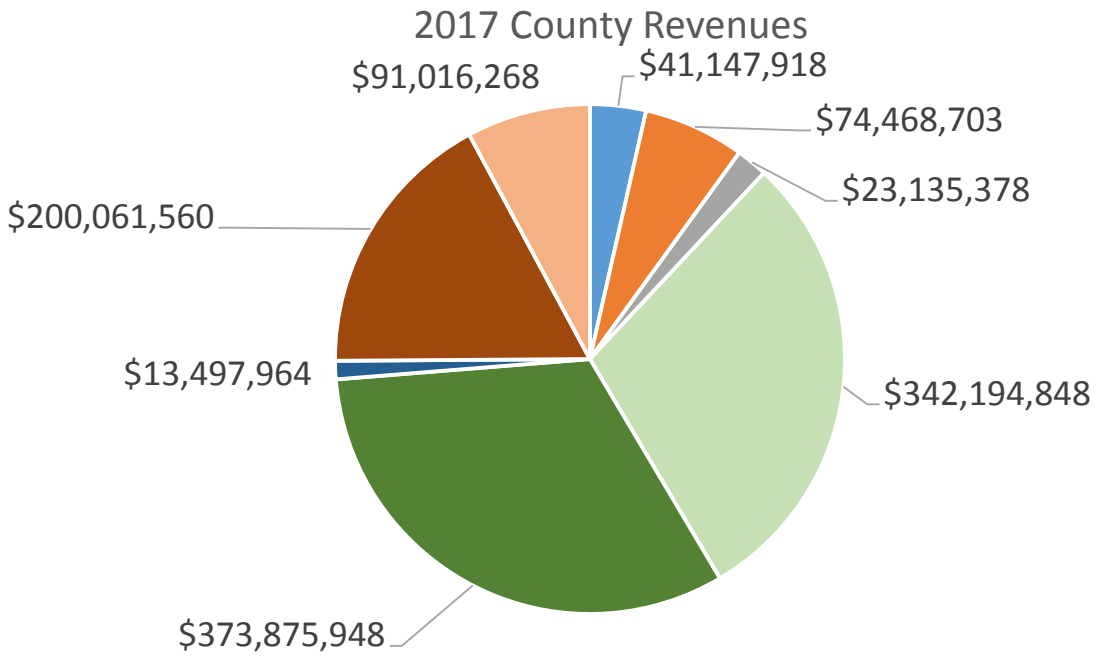
   B. Decreased Revenue (i.e. Shared Revenue)

IV. Additional Capital Budget Limitations

V. Successful Financial Reforms

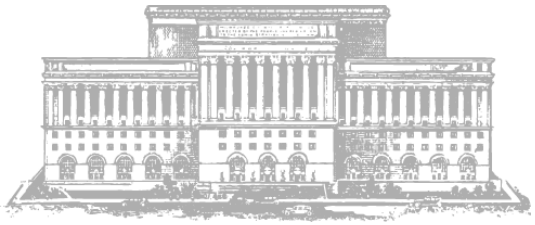
I. Components of County Budget

Where does the money the County spends come from?



- Proceeds from Borrowing
- Sales Tax
- Other
- Charges for Services
- State and Federal Revenue
- Property Tax (Operations)
- Property Tax (Debt Service)

Graphic prepared by: Milwaukee County Department of Administrative Services (Jan. 2017).
Underlying data from: Milwaukee County 2017 Budget, available at http://county.milwaukee.gov/PSB/County-Budget.htm
Note, the Operating Property Tax Levy is defined as Total Tax Levy – minus Total Debt Service. The actual Operating Property Tax levy is defined by the Department of Revenue 2016 County Levy Limit Worksheet and is typically within +/- 5% of the calculation above.



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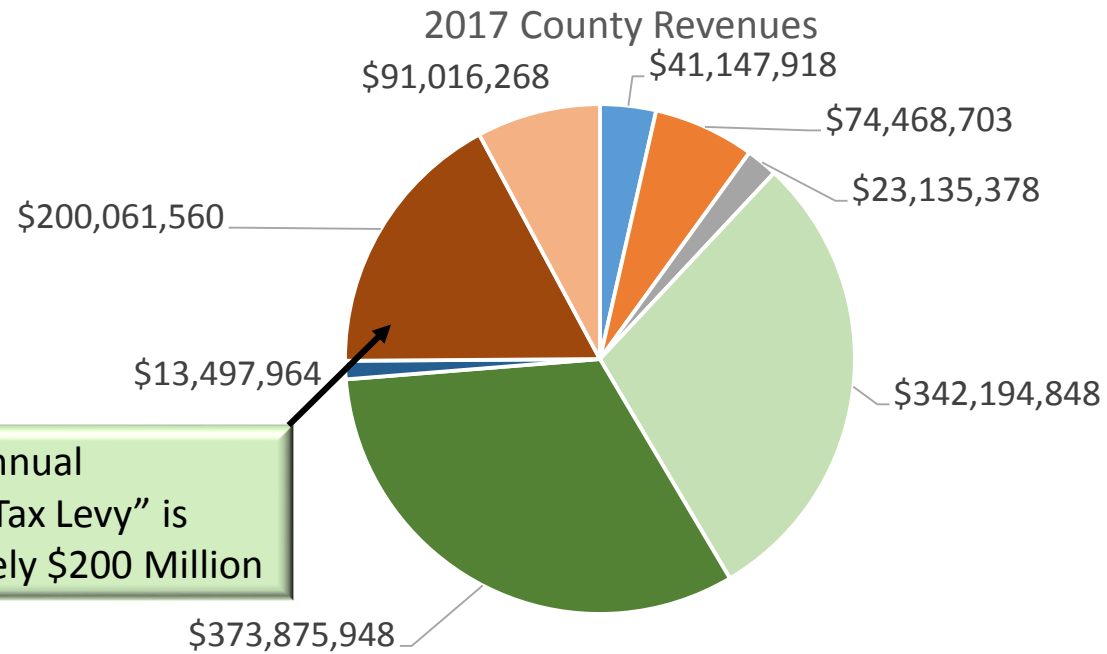

Note that annual "Operating Tax Levy" is approximately $200 Million

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- Sales Tax
- Other
- Charges for Services
- State and Federal Revenue
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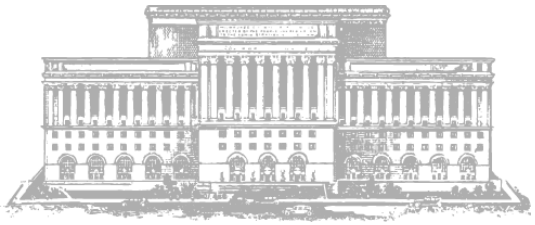

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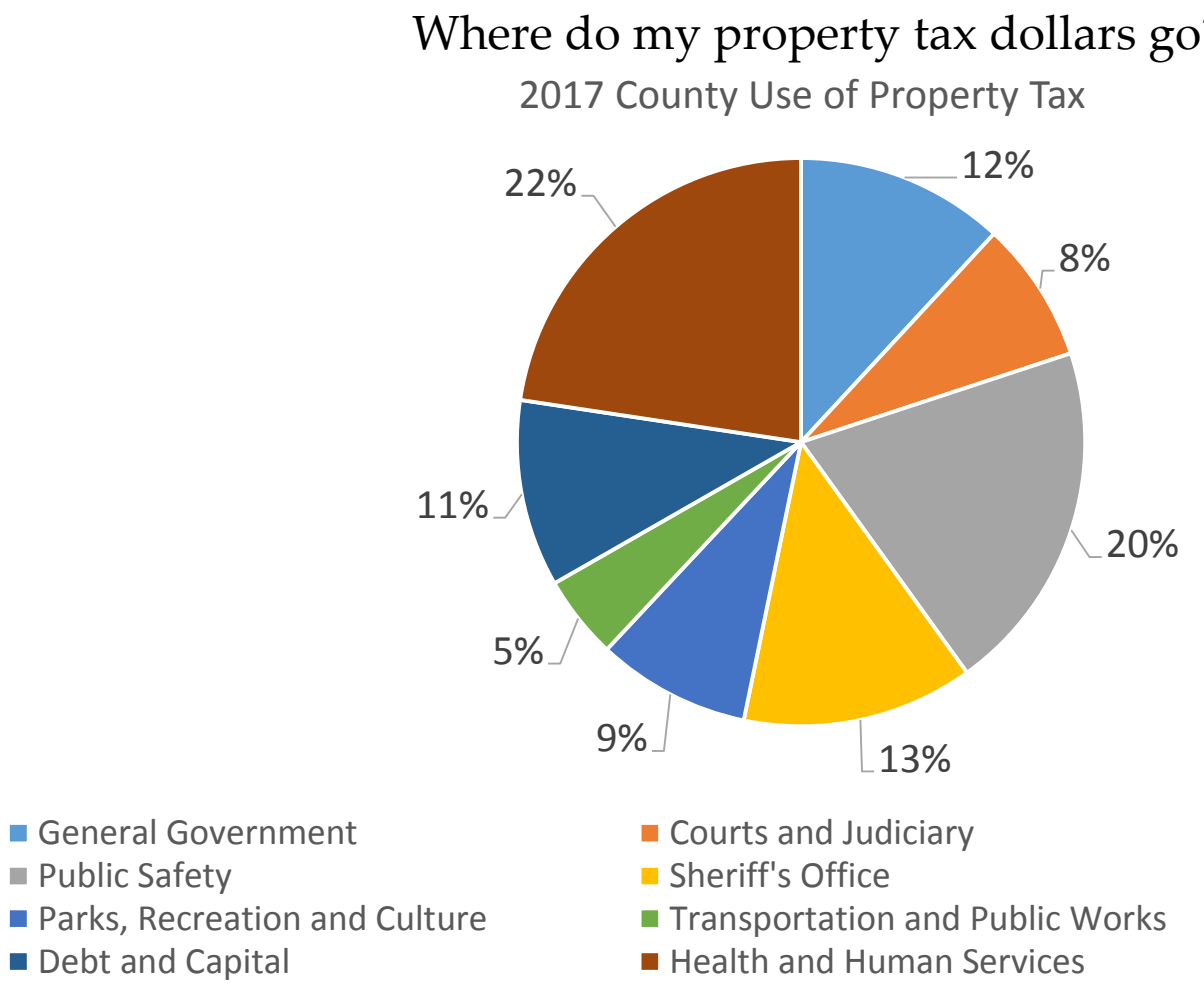

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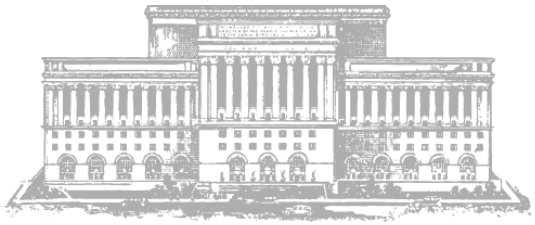

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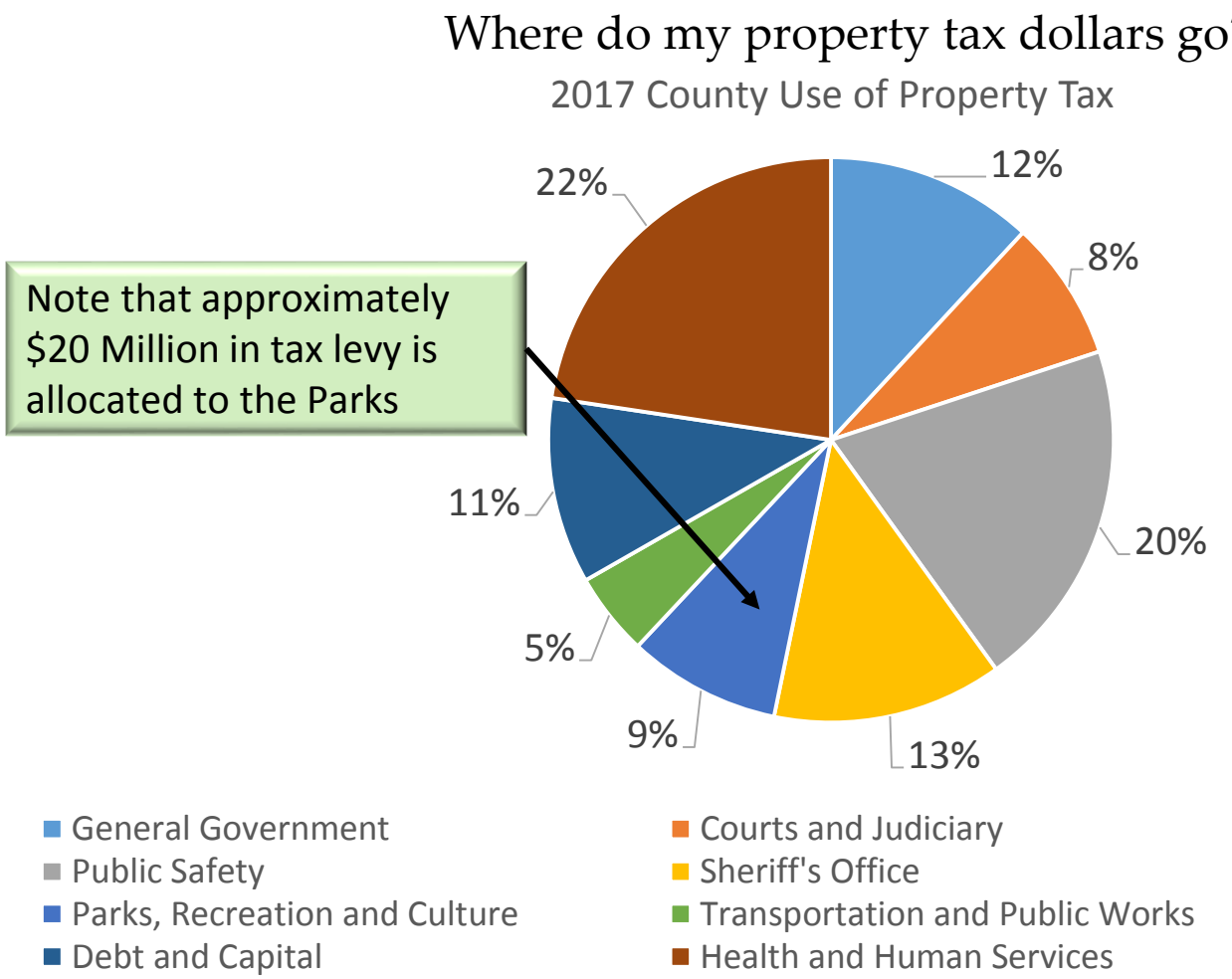

Note that approximately $20 Million in tax levy is allocated to the Parks

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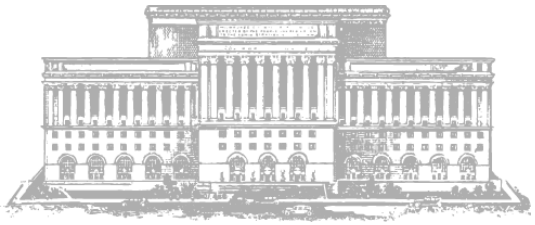
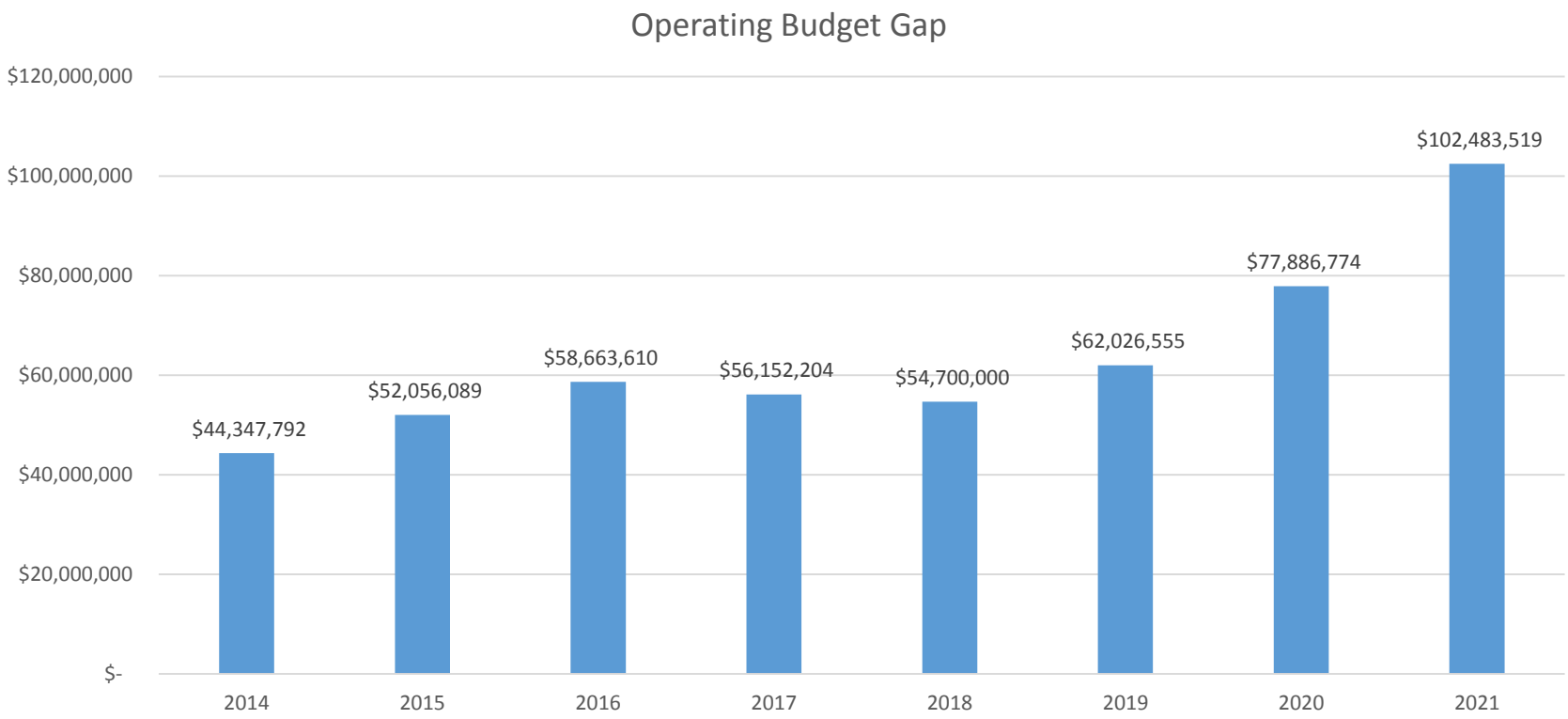


II. What is the projected gap?

What is the gap that needed to be closed?



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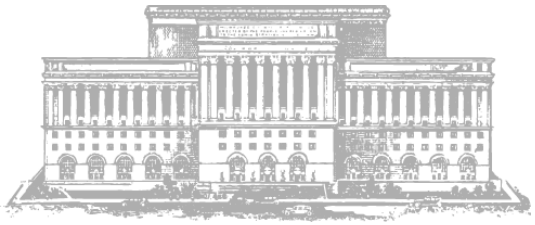
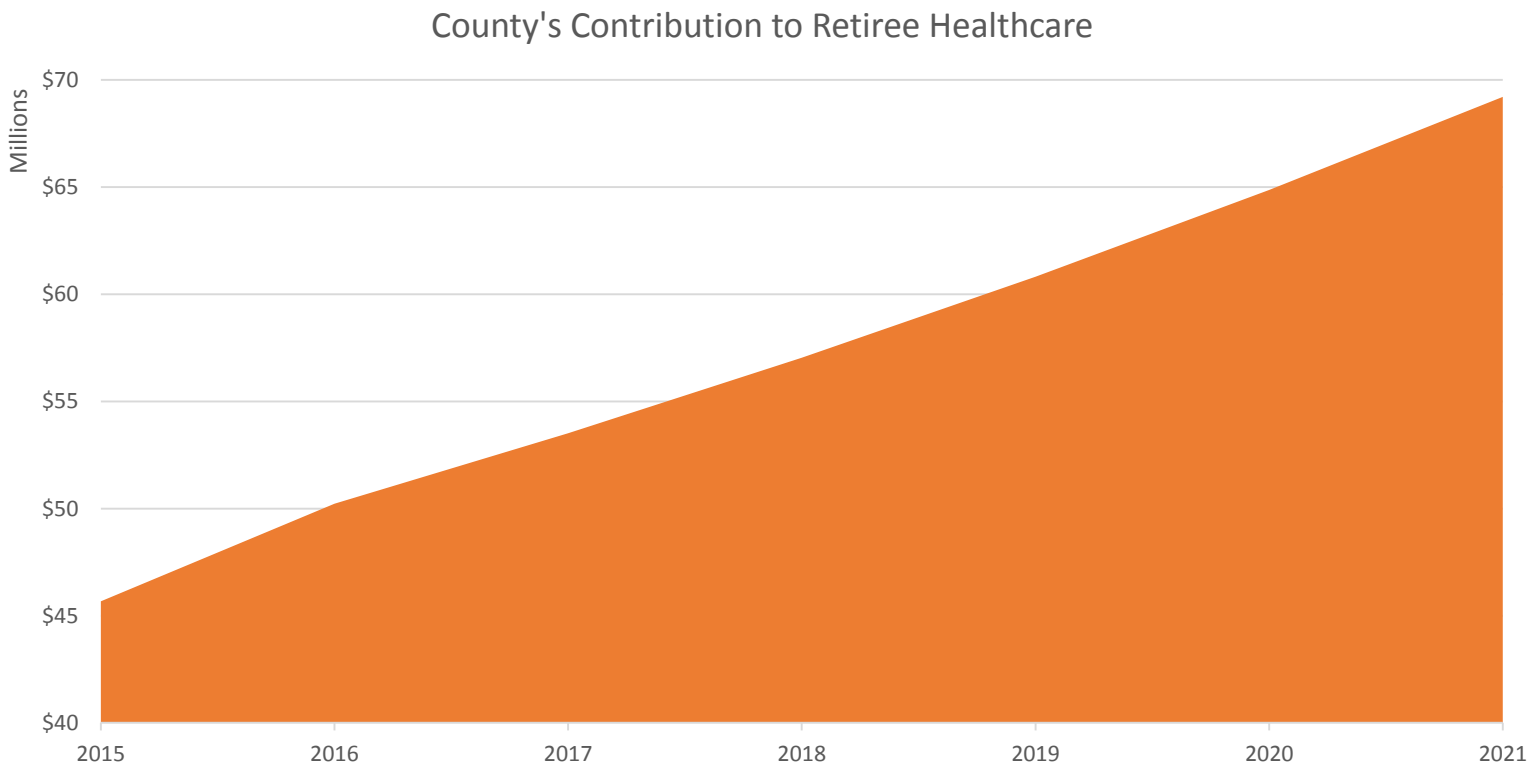


III. Why is there a gap - Expenses

Why is there a gap?



Retiree Health Care Costs
(in millions)

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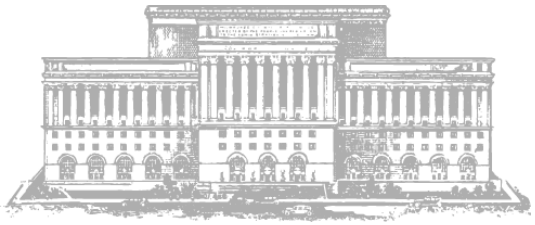

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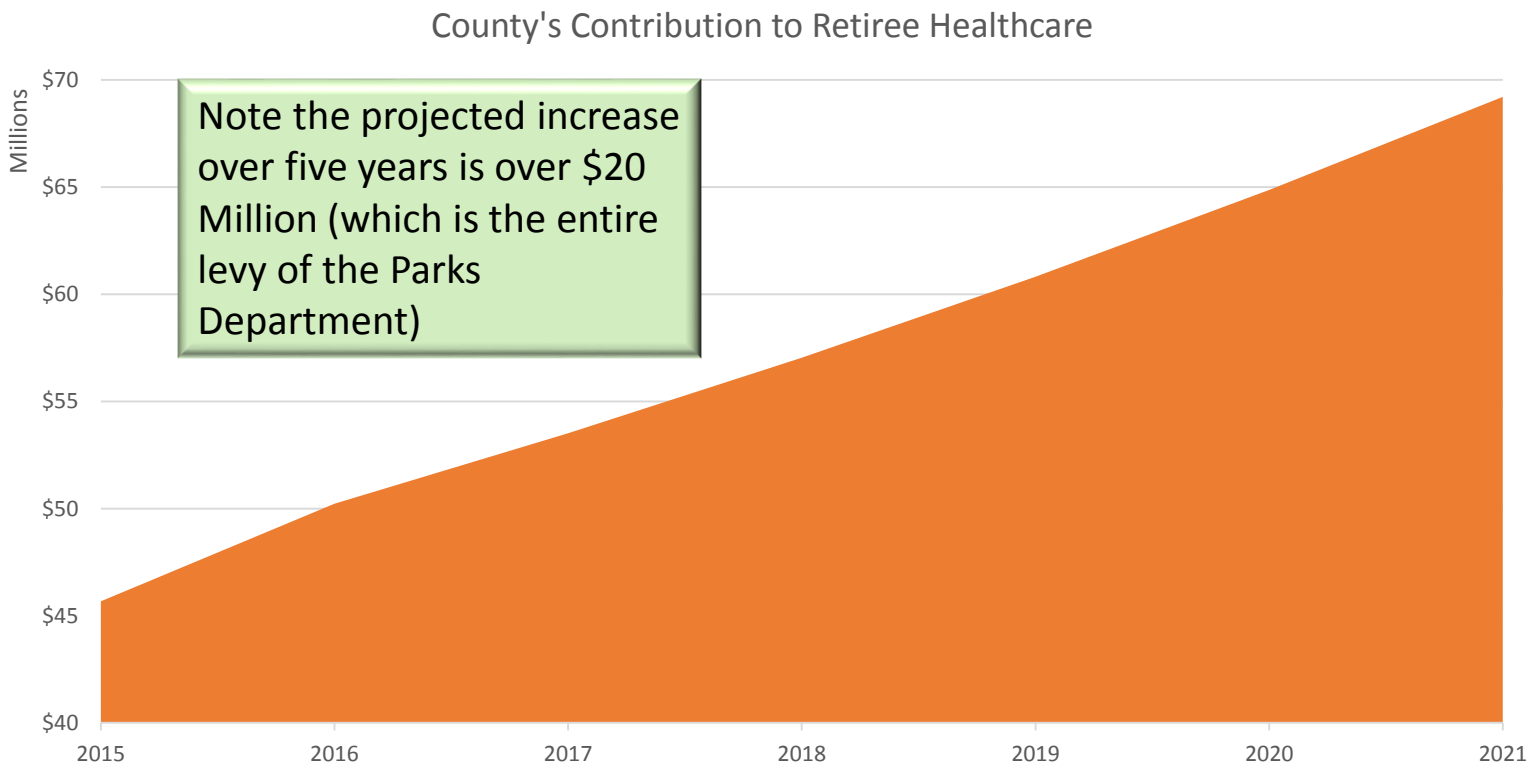

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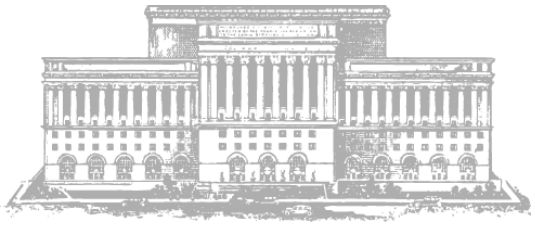

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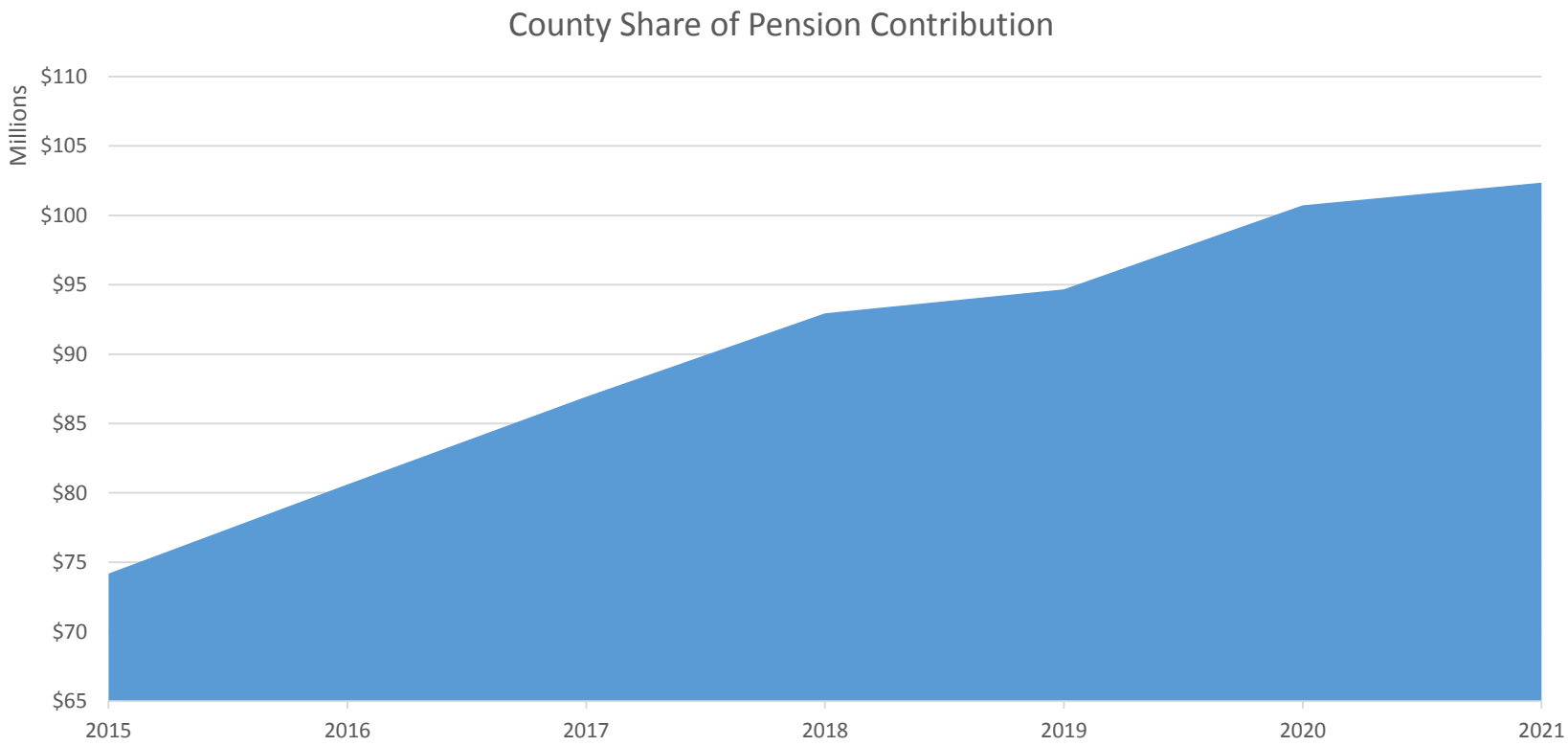
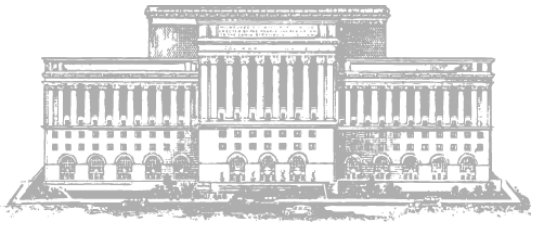


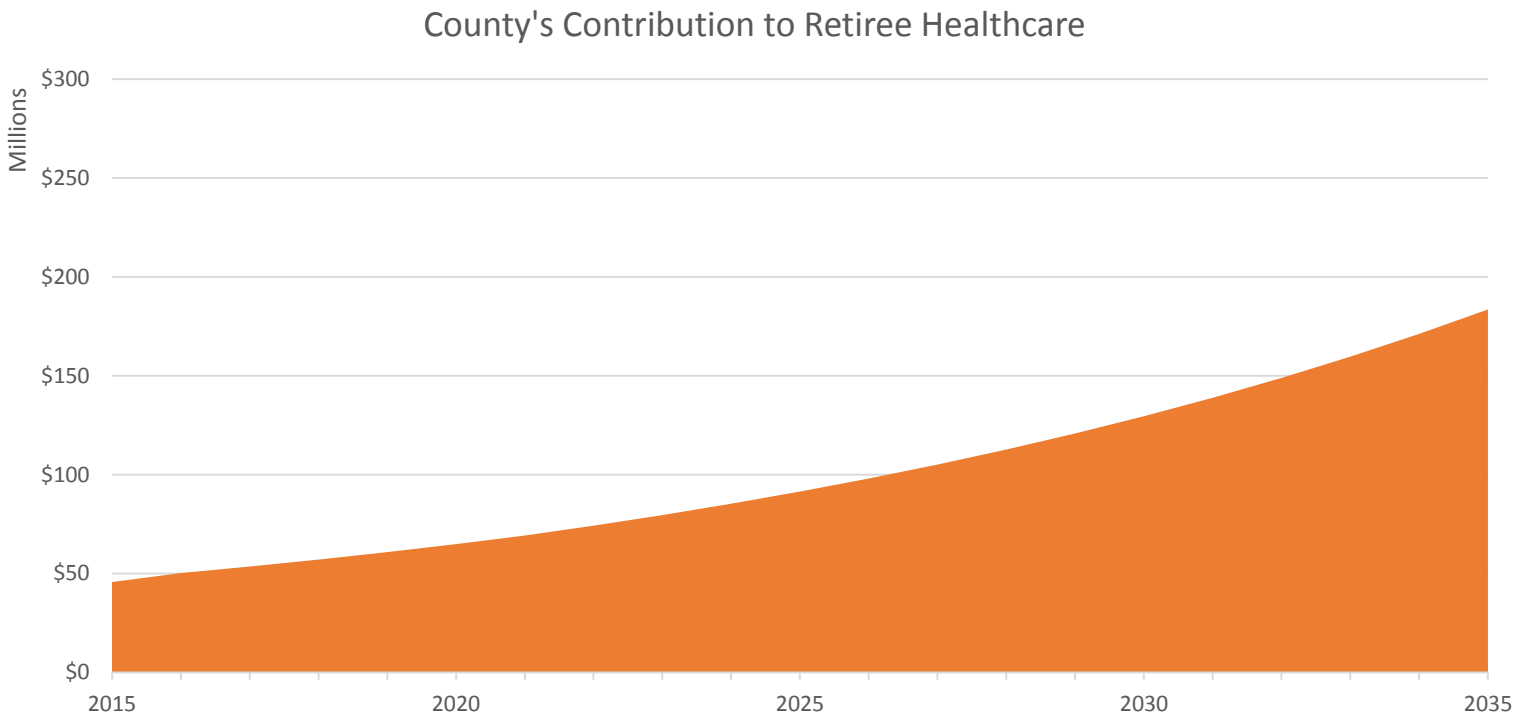
Pension Costs (Active & Inactive)
(in millions)

Graphic prepared by: Milwaukee County Department of Administrative Services (Jan. 2017).
Underlying data from: 2006 – 2017 data from Milwaukee County Department of Administrative Services – PSB Office. 2018 – 2021 projected increase from BuckConsultants, "Milwaukee County Employees' Retirement System, Investment Return Assumption Discussion." (June 15, 2016). Note, 2018-2021 projected numbers increased by $31.1 Million to represent pension obligation payments, and reduced by approximately $13 million annually to reflect employee contribution).



Operating Budget Limitations

Actuarial projections are always best but they only go out about 10 years or less. What might the picture look like in 20 years?



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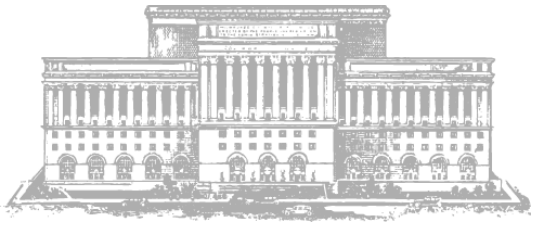

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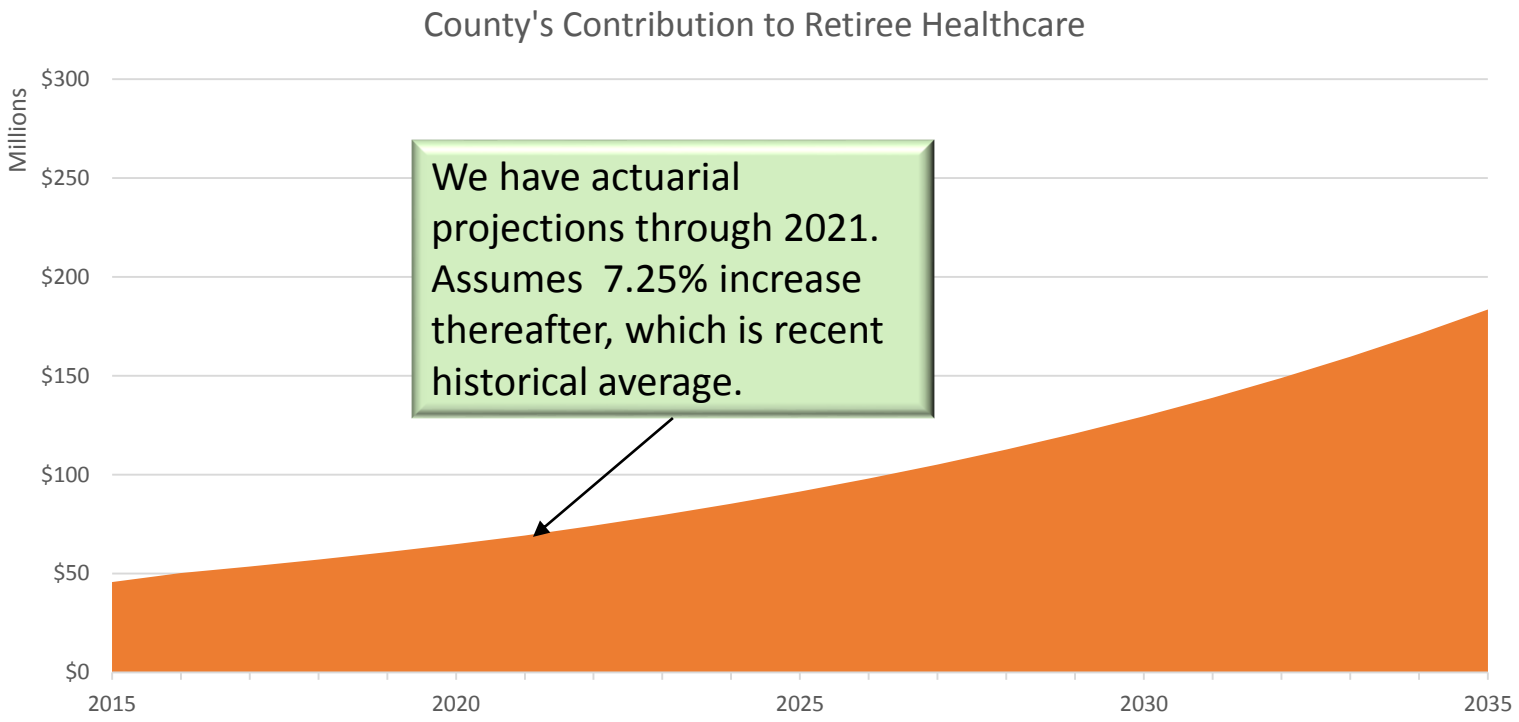

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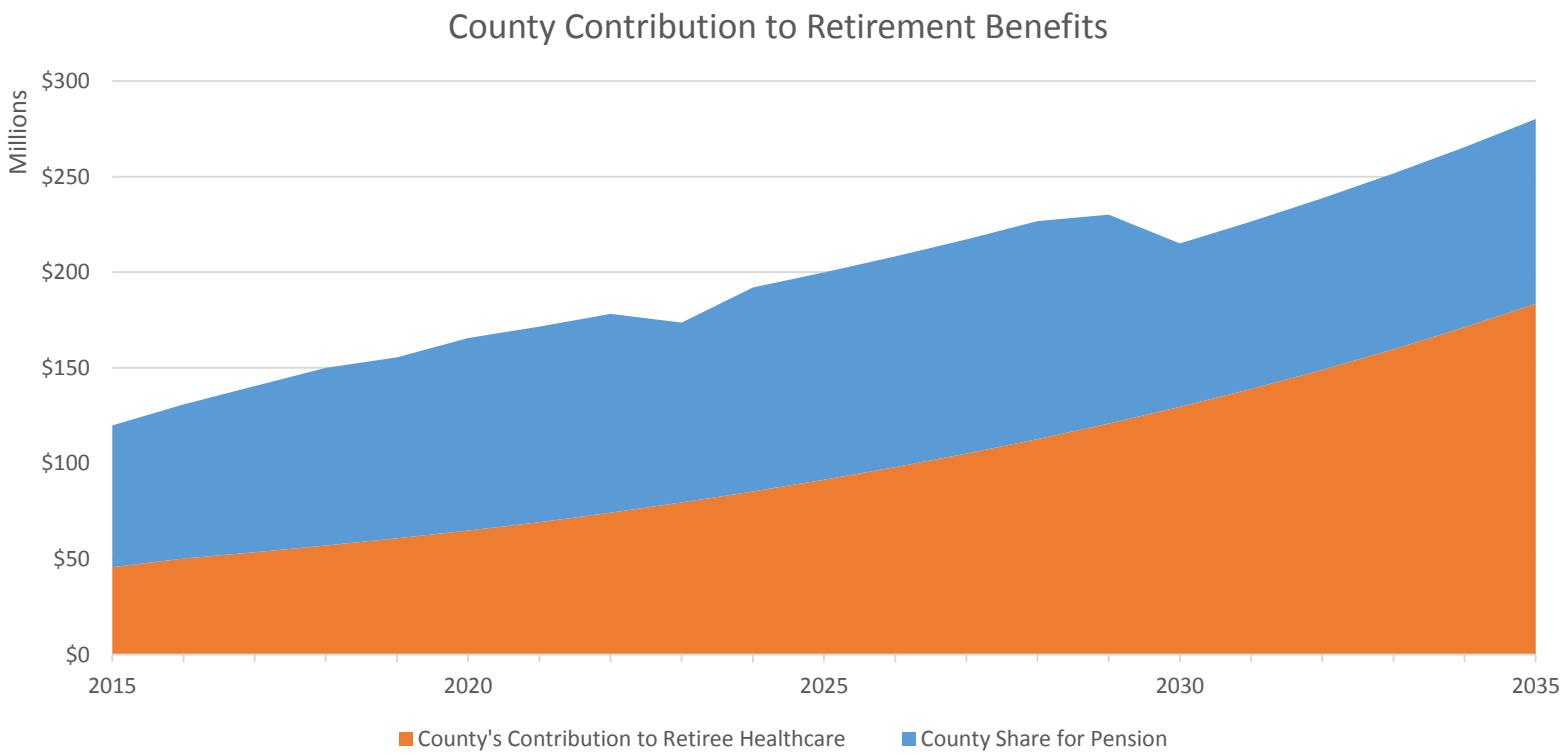

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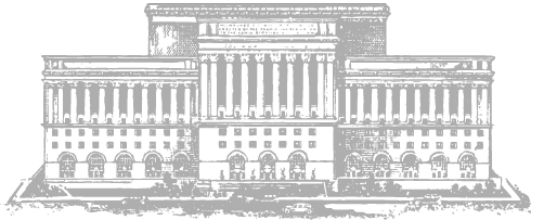

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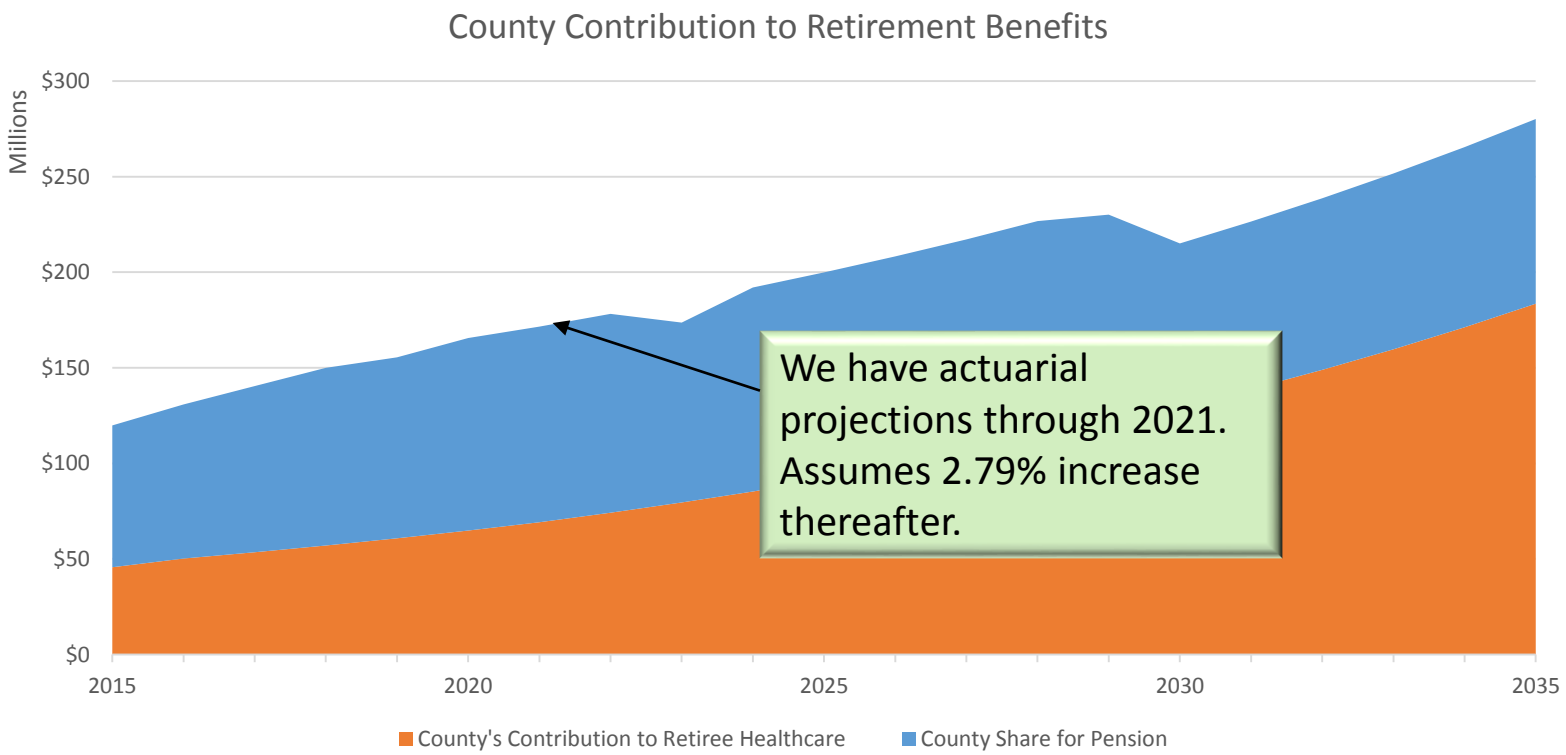

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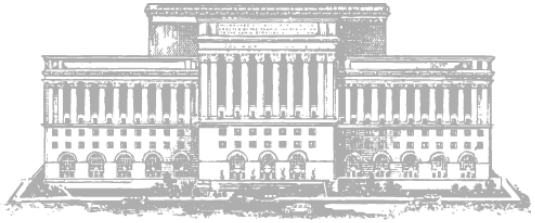

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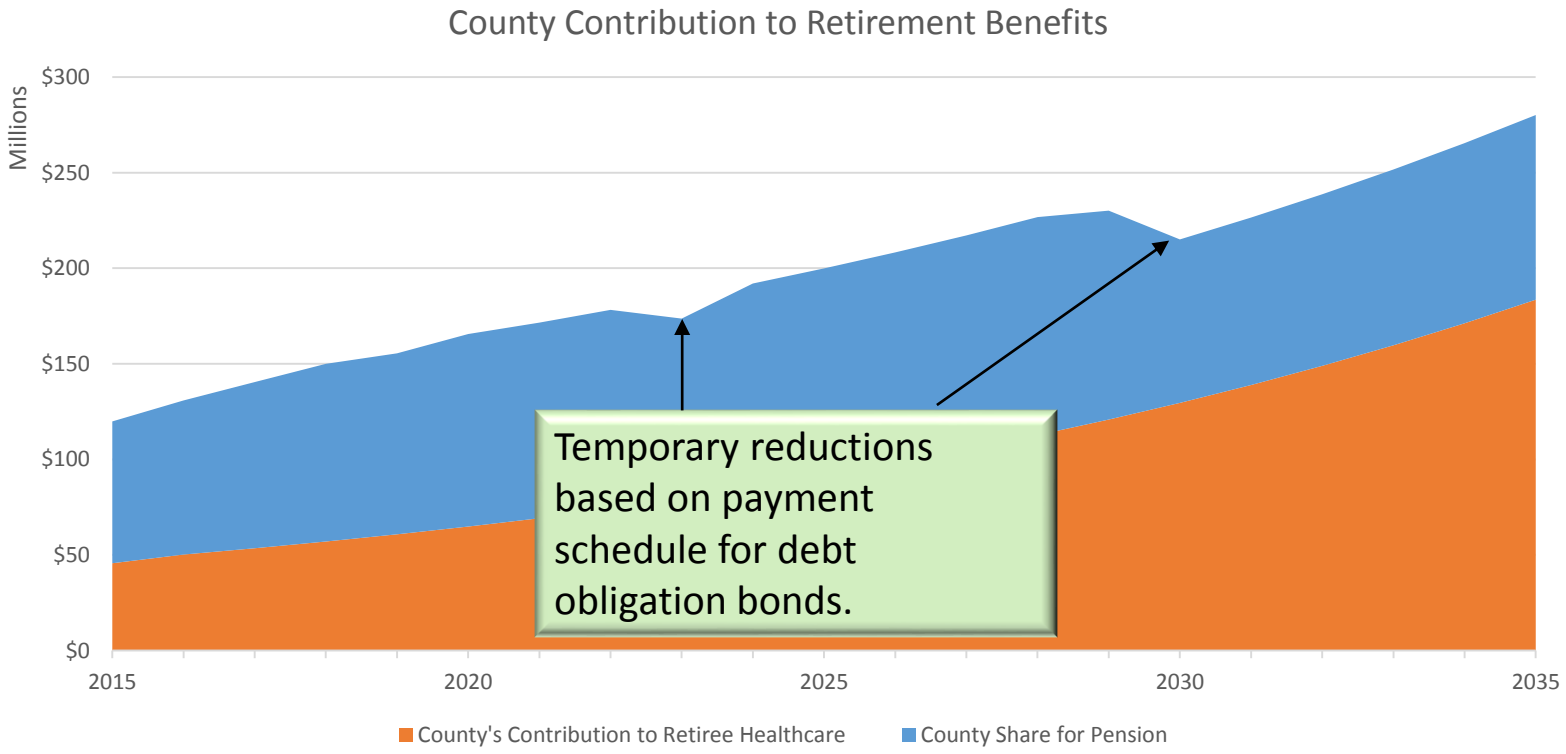

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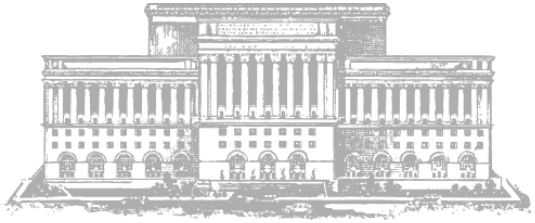
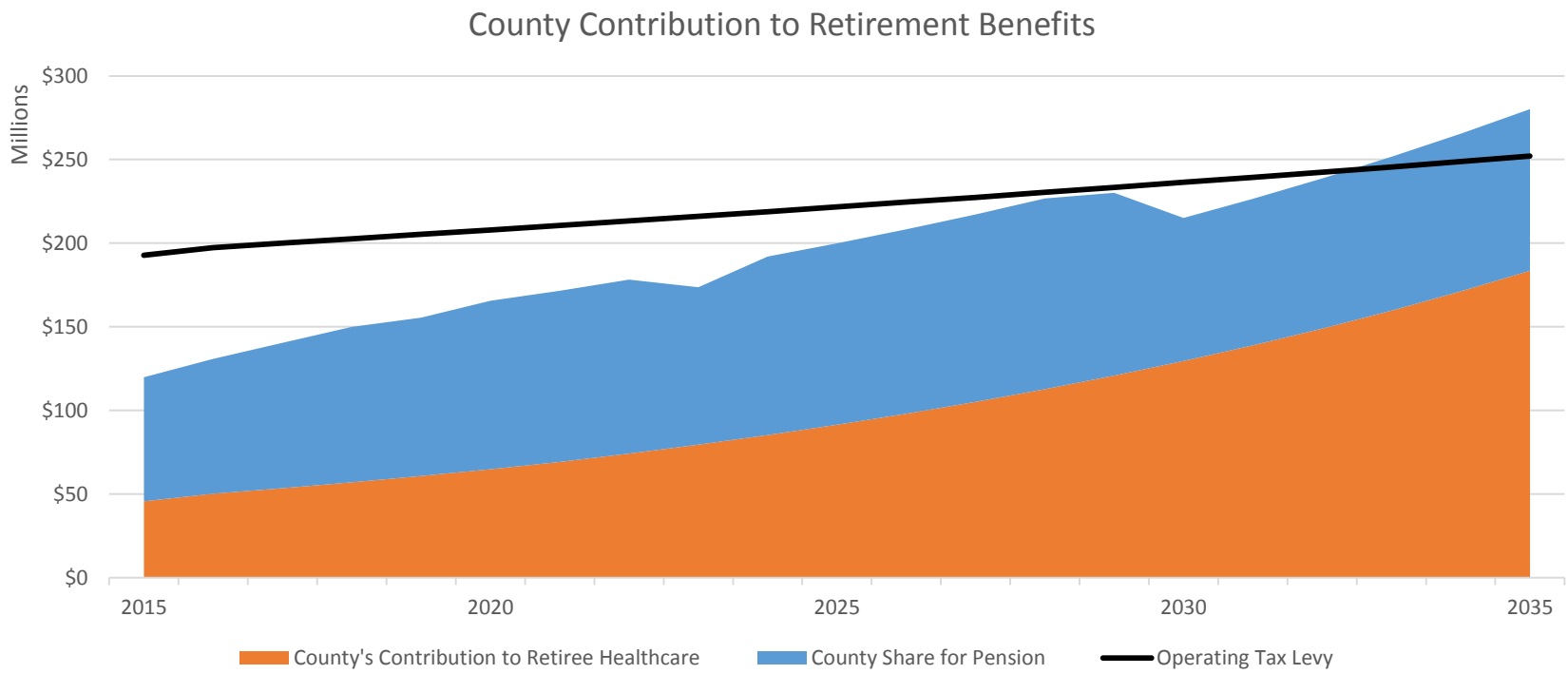


III. Why is there a gap - Expenses

To put this in perspective, we can compare it to the predicted Operating Tax Levy



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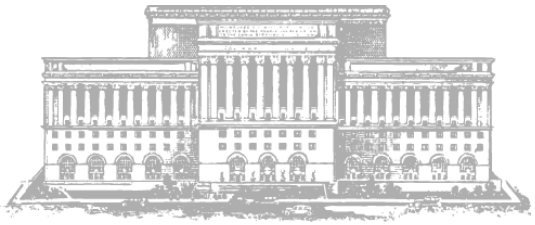

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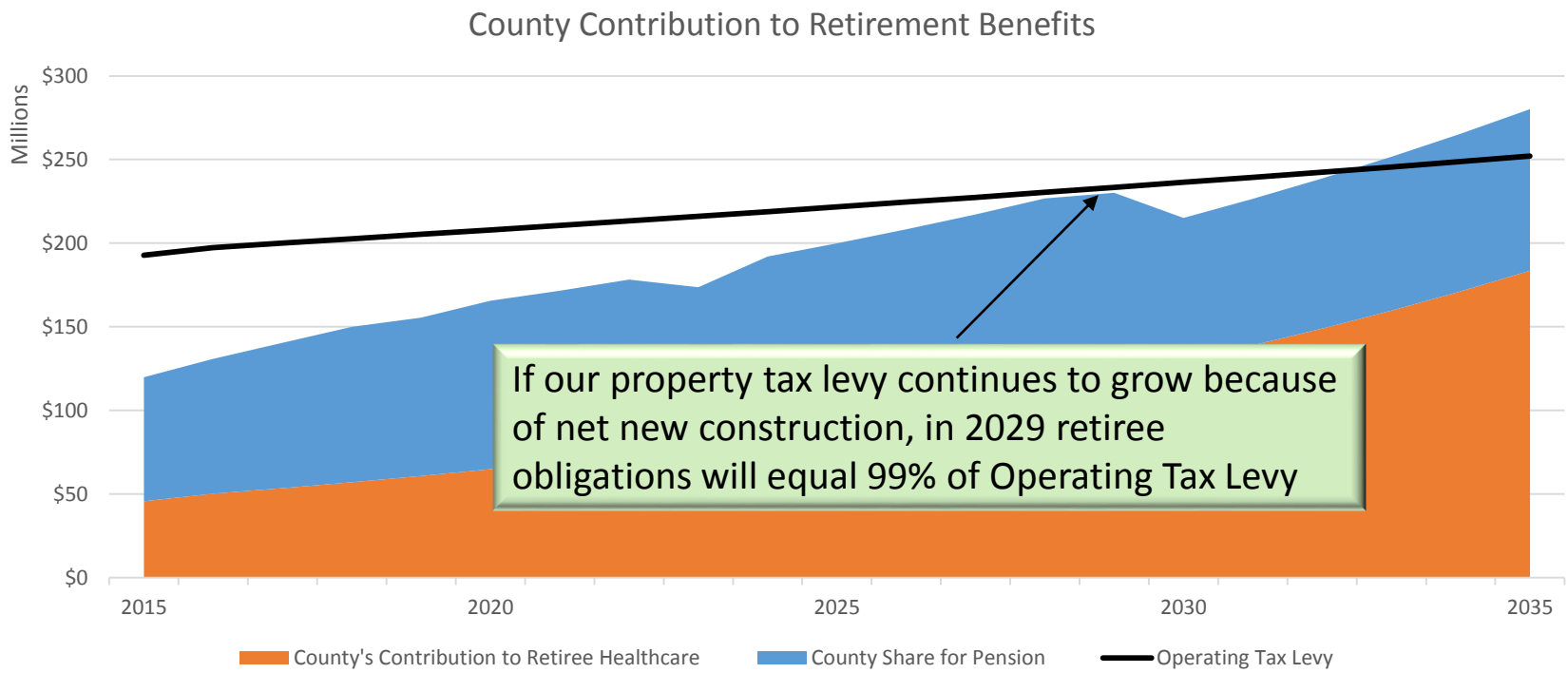

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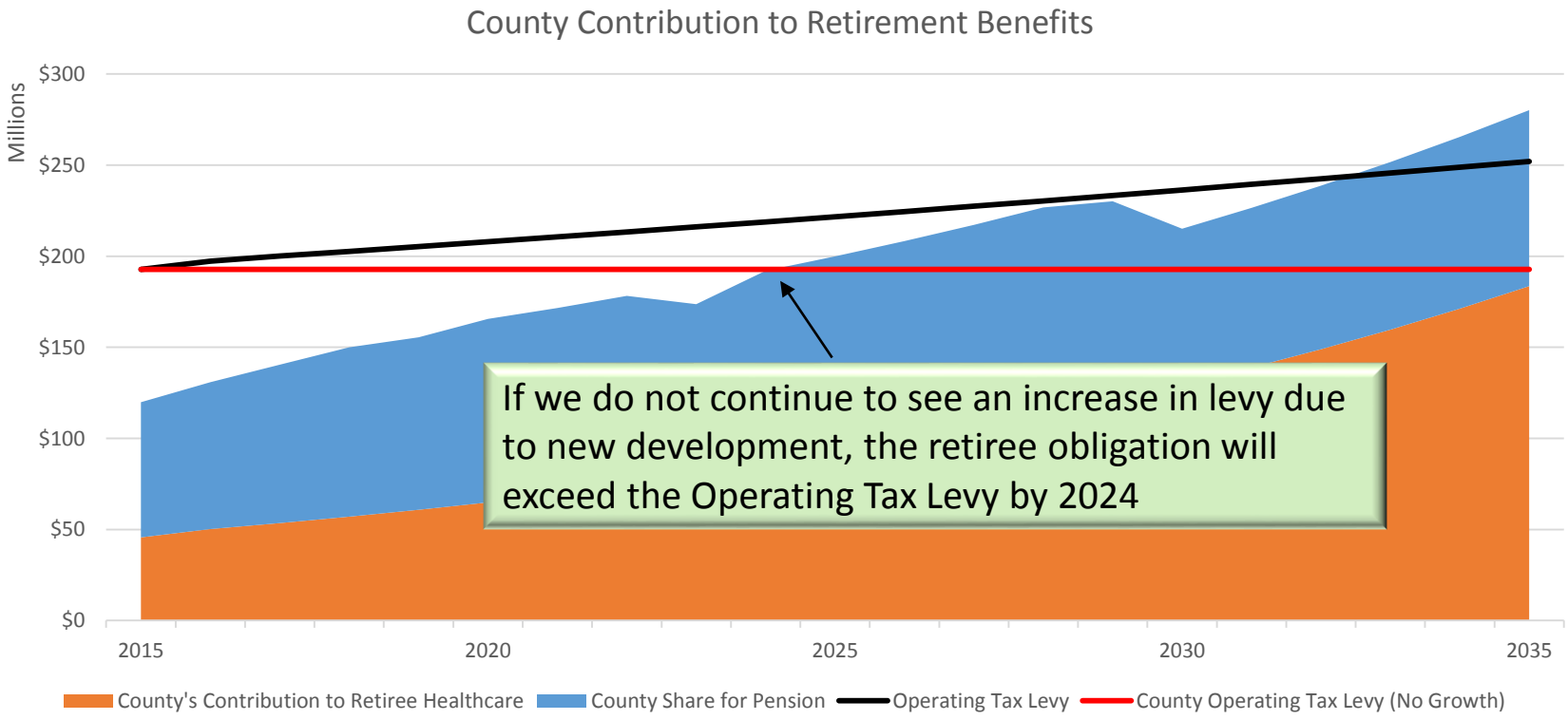

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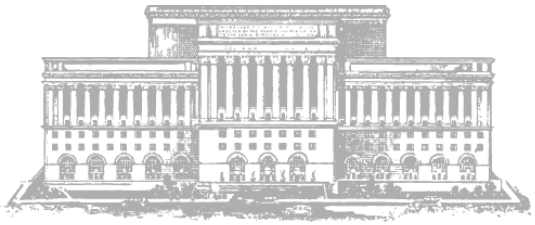


III. Why is there a gap - Expenses

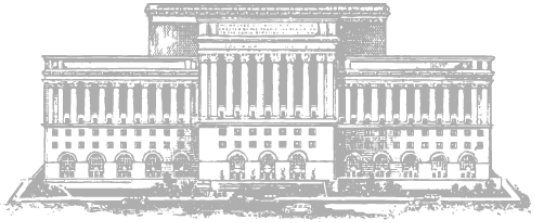
This is not a new problem. Problem has been fixed going forward. However, will only see full benefit when employees hired after 2012 retire.

	Pre 2001 Employee Example	Post-2012 Employee Example
County Paid Healthcare Premiums	Yes*	No
Pension Multiplier	2% (i.e. years of service * 2% * highest average annual salary)	1.6%
Employee Contribution	0%	Approximately 6% of salary
Buy-in-Buy-Back	Allowed purchase of service credits for part-time and seasonal work.	None
Backdrop	Allowed pension balance to accumulate while still working	None
25% Bonus	Yes**	None

* For employees starting before 1994.

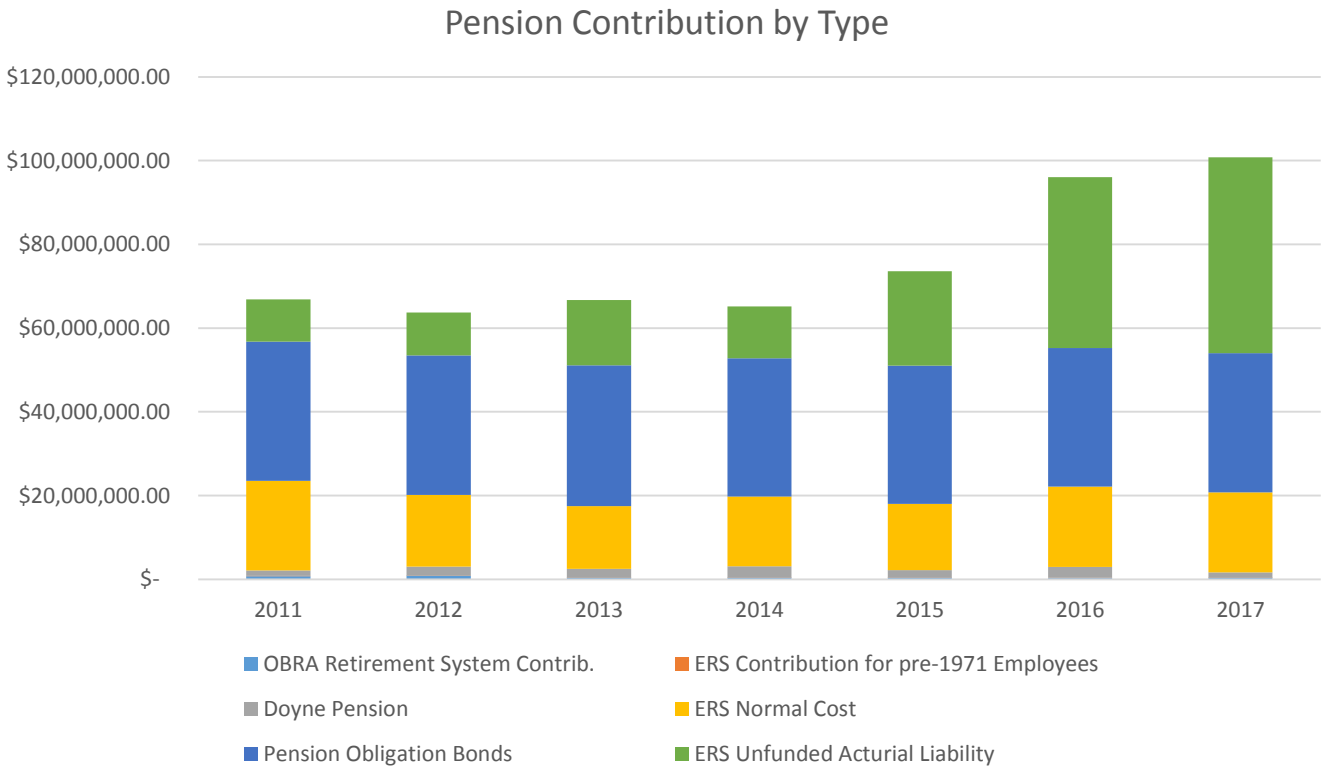
** For employees starting before 1982.

Graphic prepared by: Milwaukee County Department of Administrative Services (Jan. 2017).
Underlying data from: 2006 – 2016 Annual Report of the Pension Board



III. Why is there a gap - Expenses

Furthermore, gap is because of previous benefits offered to qualified retirees, not benefits to existing employees.



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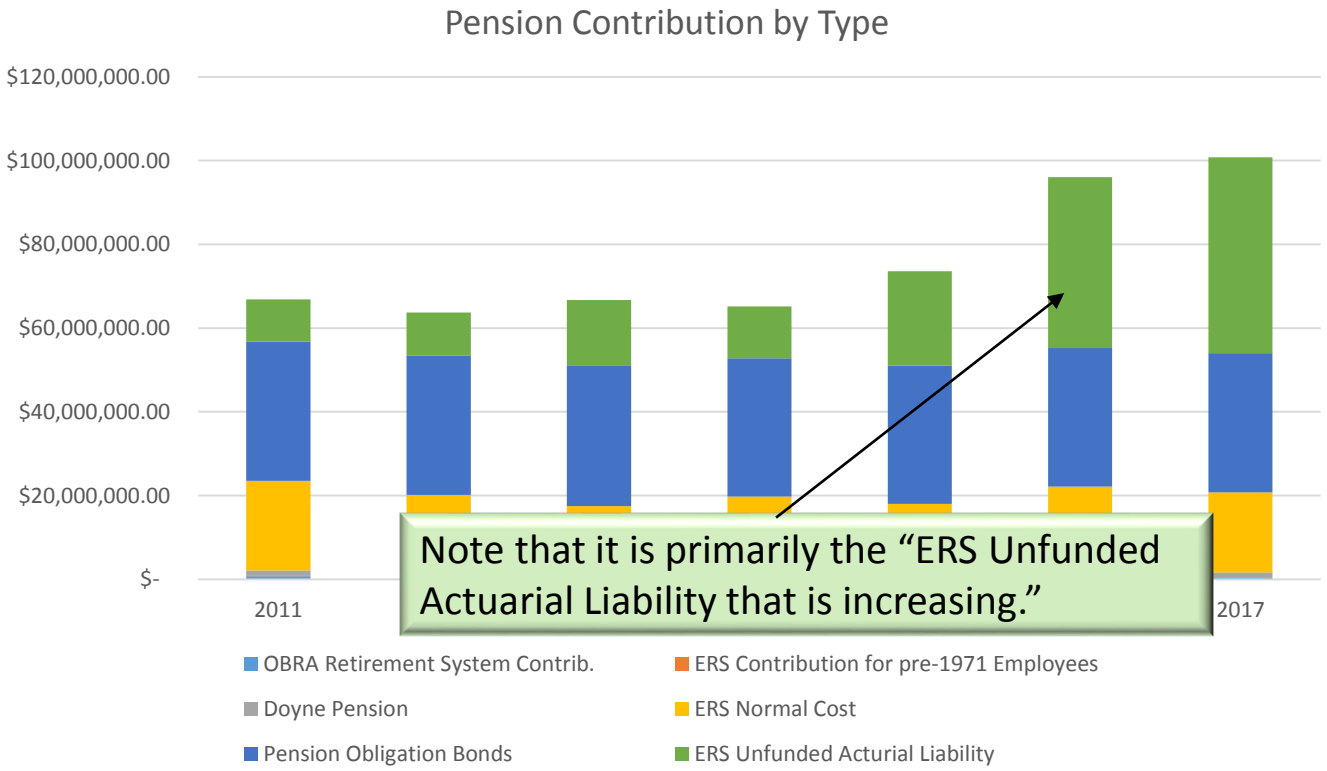

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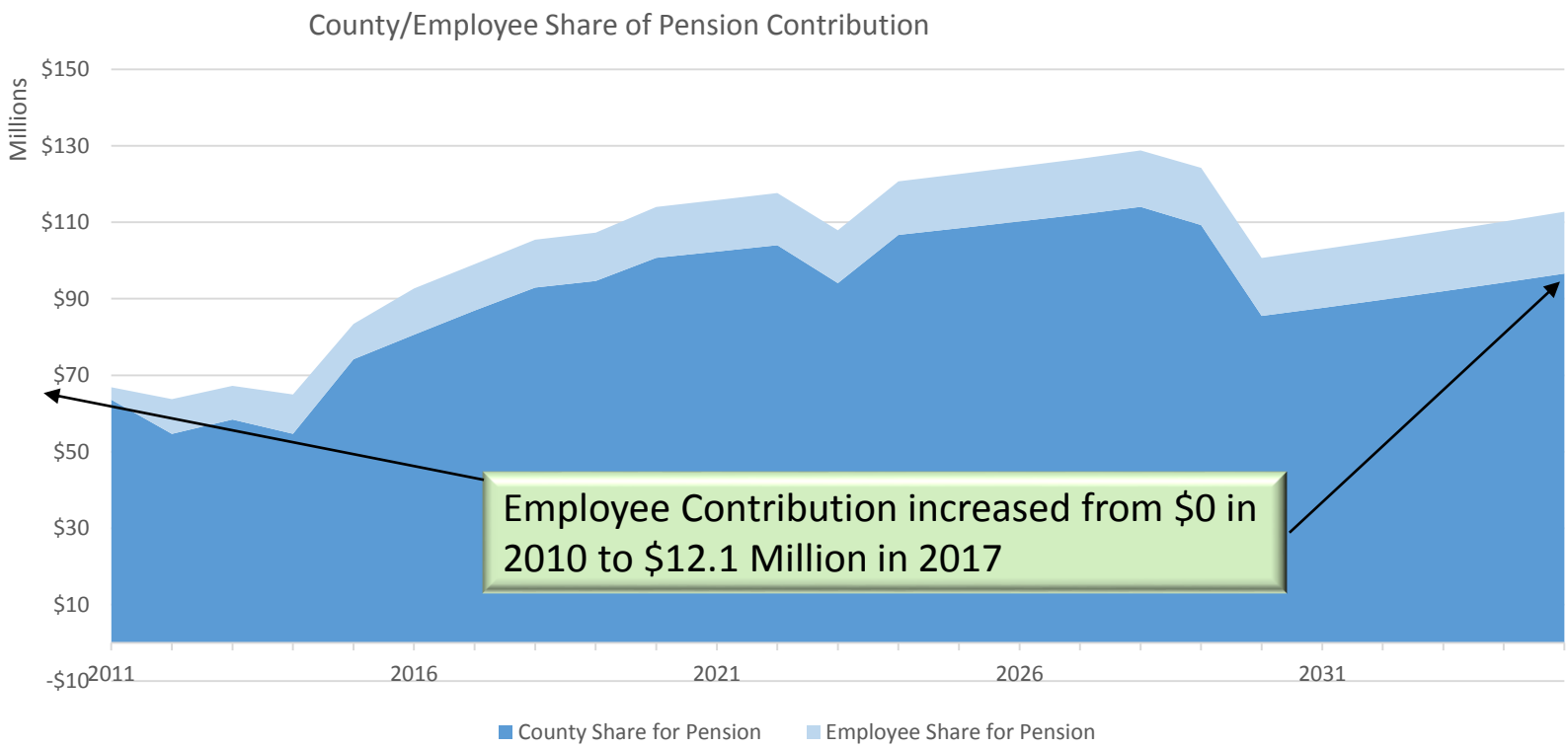
Underlying data from: 2011 – 2017 Milwaukee County Budget

III. Why is there a gap - Expenses

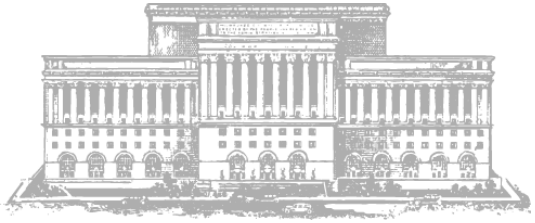
Also, need to acknowledge the contributions that Employees are making



Graphic prepared by: Milwaukee County Department of Administrative Services (Jan. 2017).
Underlying data from: 2011 – 2017 Milwaukee County Budget and Comptroller's Office.

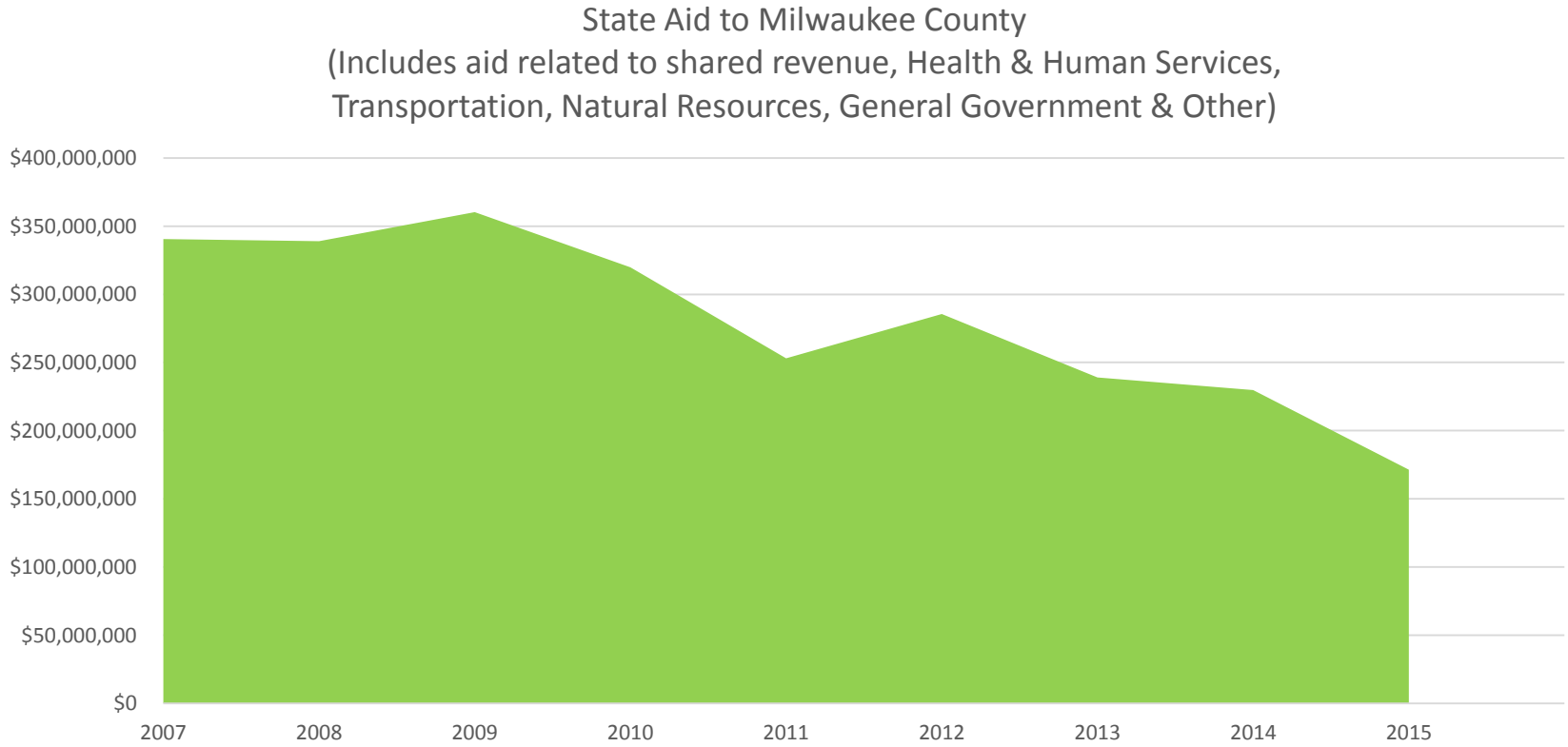
III. Why is there a gap - Expenses

Finally, need to acknowledge that these projections are not related to pension errors. These are related to the benefits that have been previously offered and earned by previous employees.



III. Why is there a gap - Revenue

Revenue Decreasing



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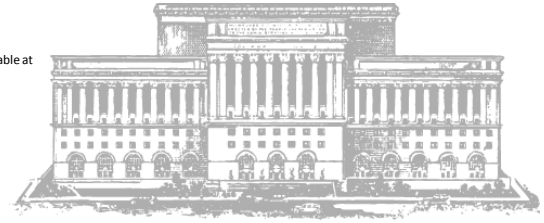

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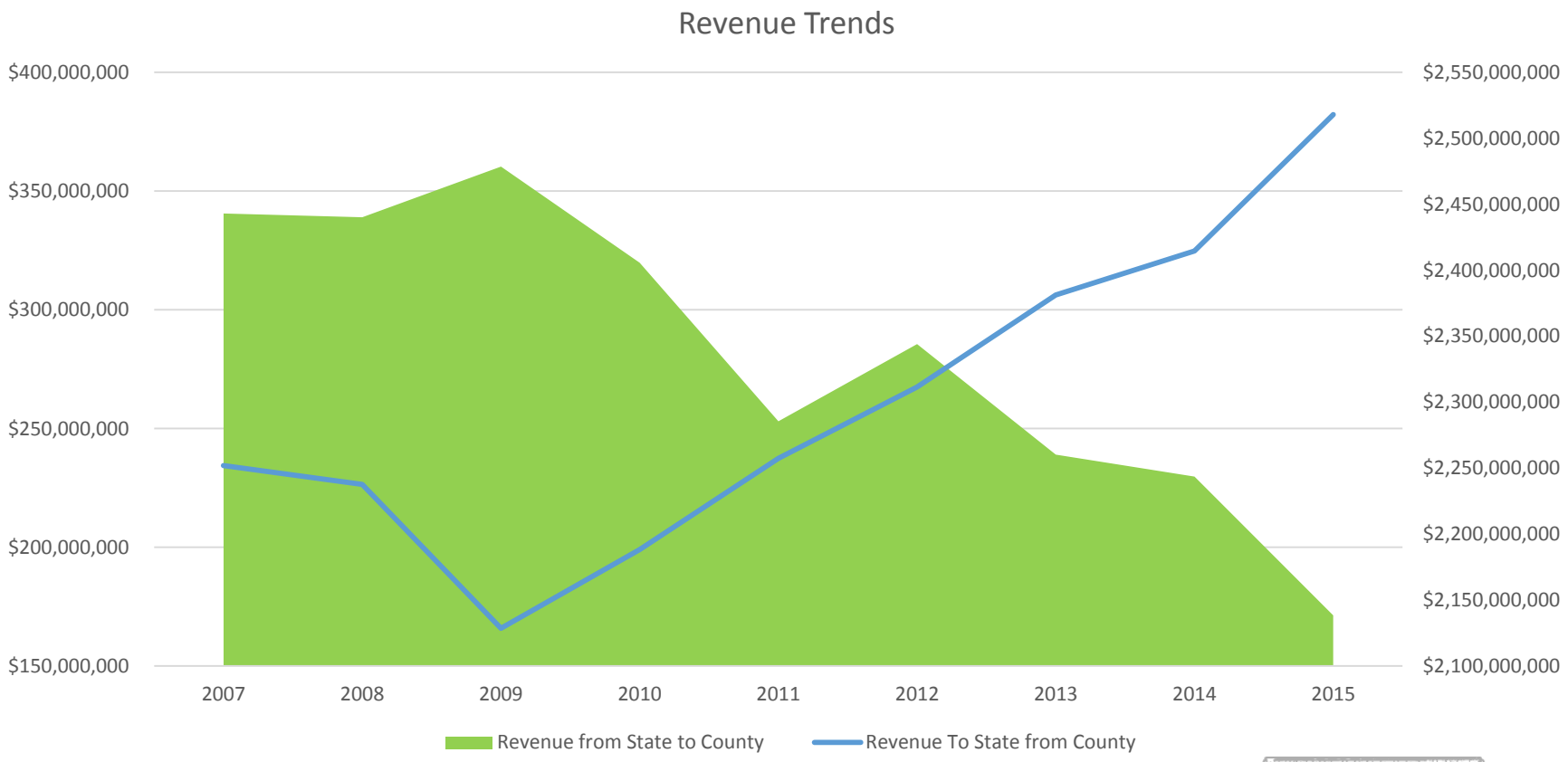
Why is there a gap?



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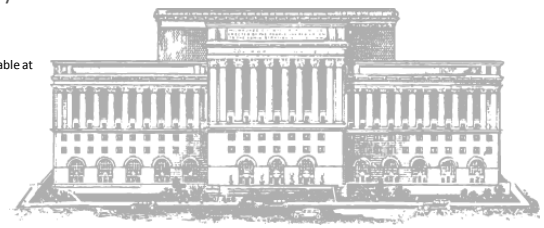

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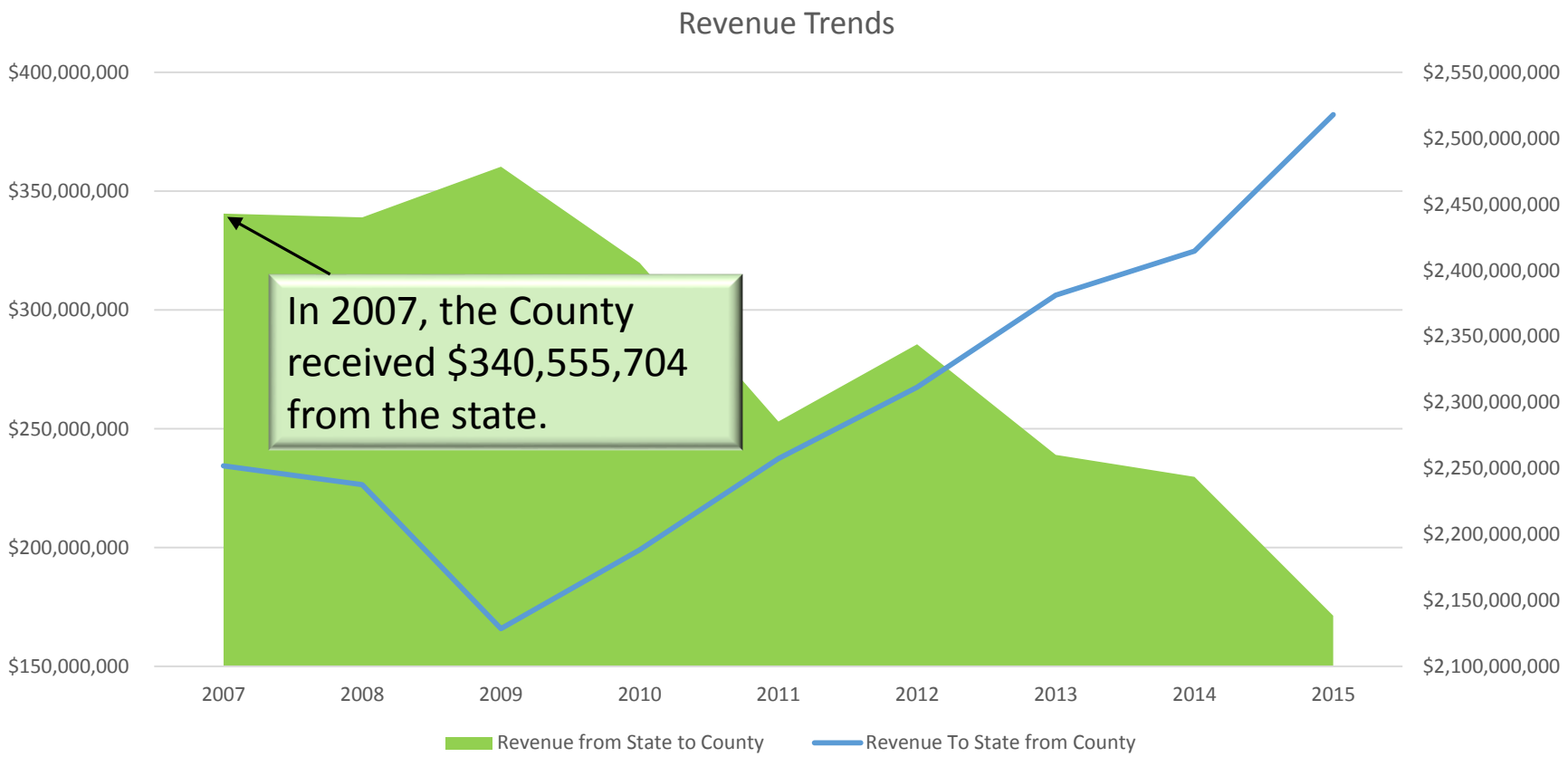

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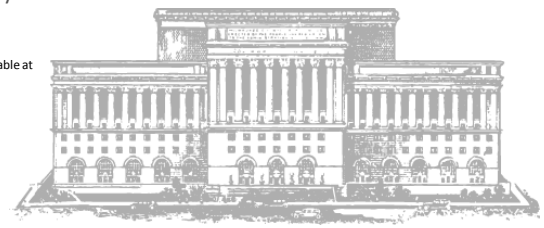

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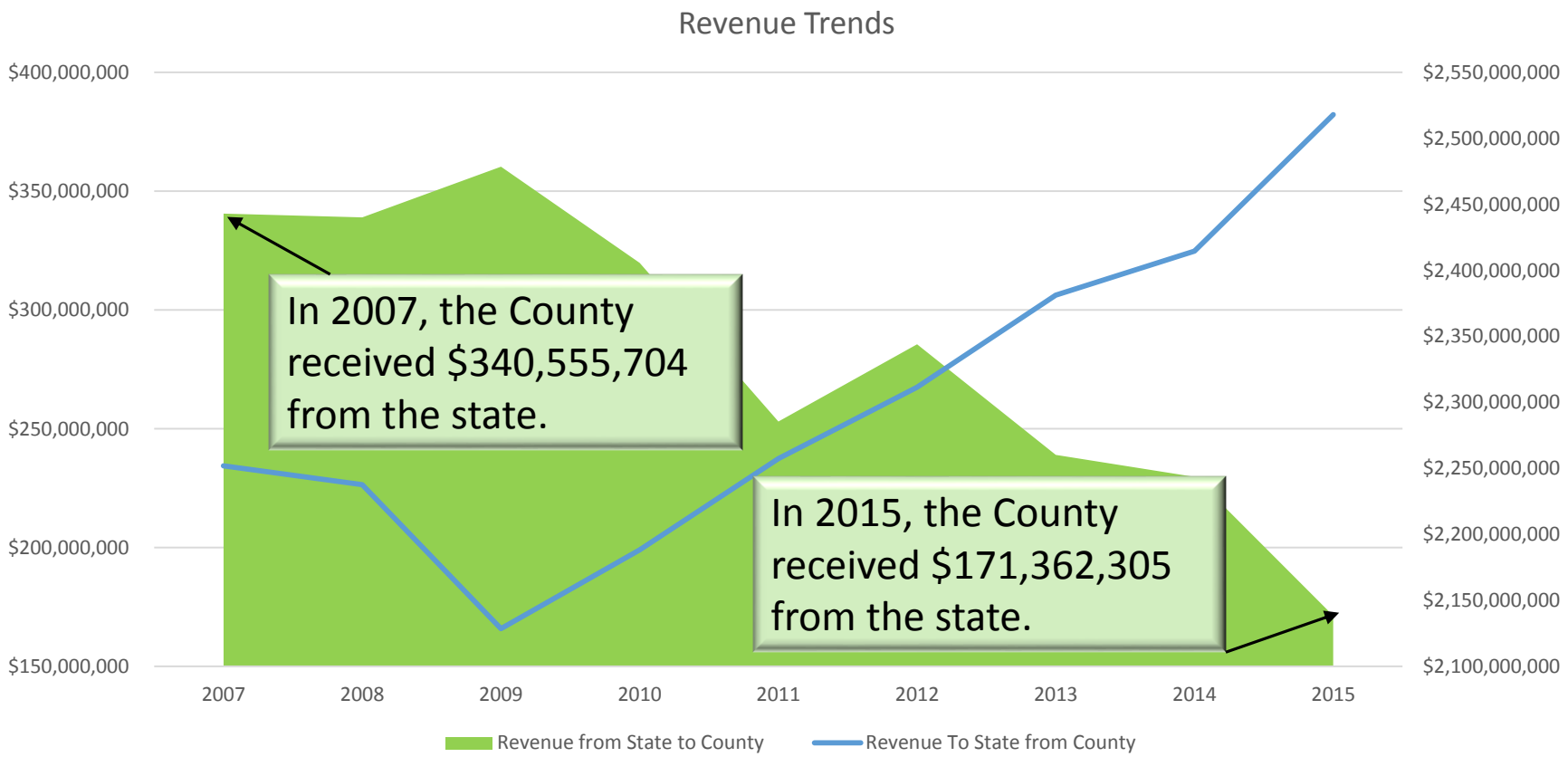

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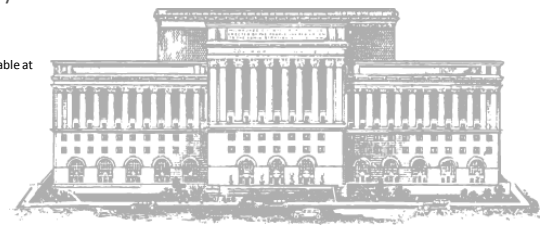

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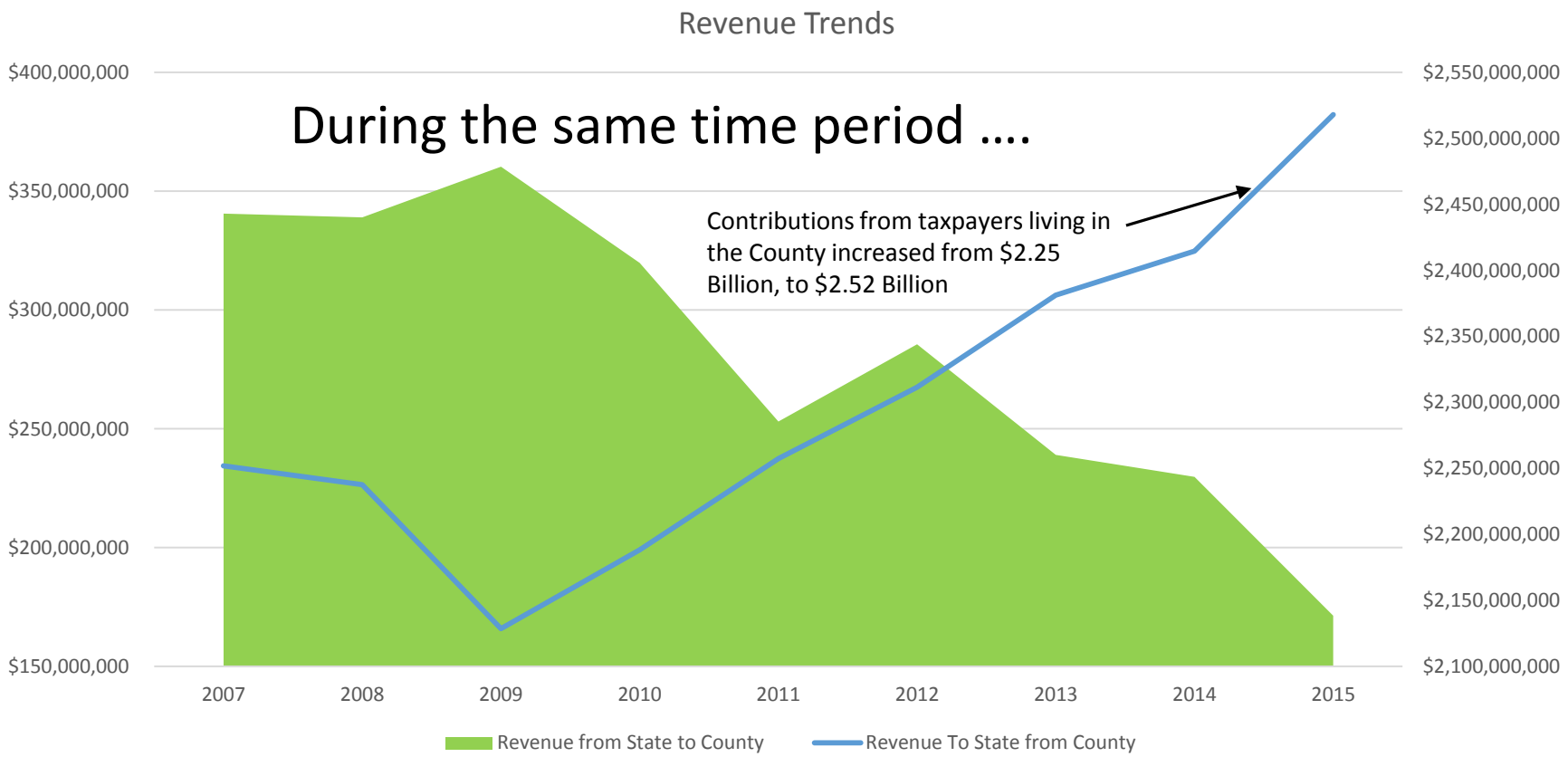

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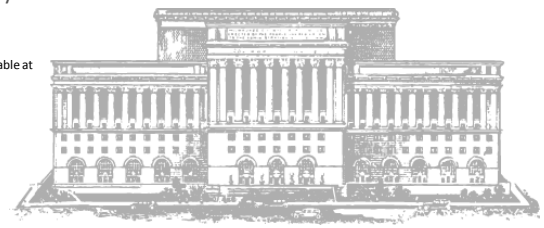
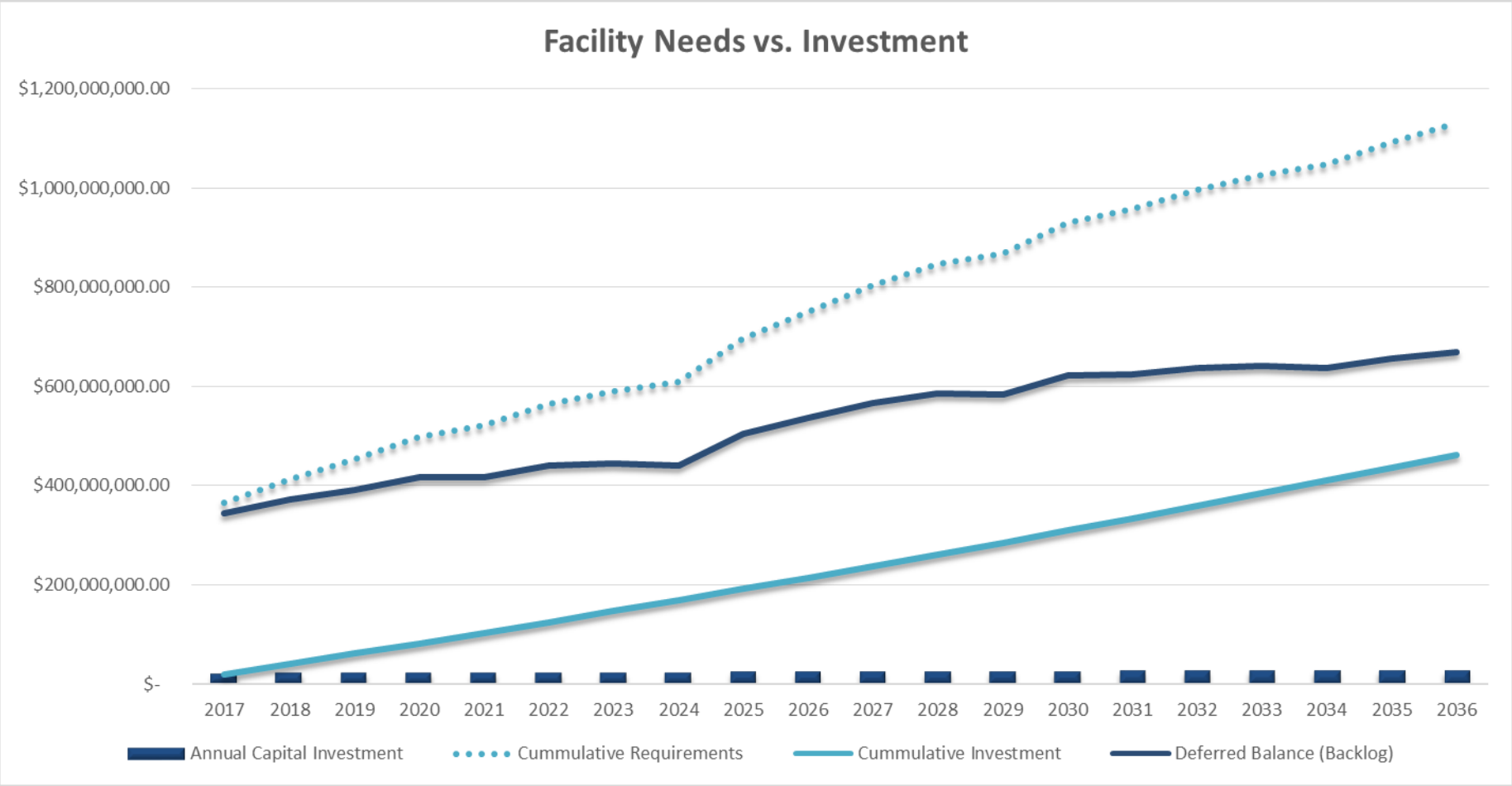


IV. Capital Budget Limitations



Source: Milwaukee County Department of Administrative Services – Facilities Division (Jan. 10, 2017). Includes buildings only, excludes transportation infrastructure and airport infrastructure.

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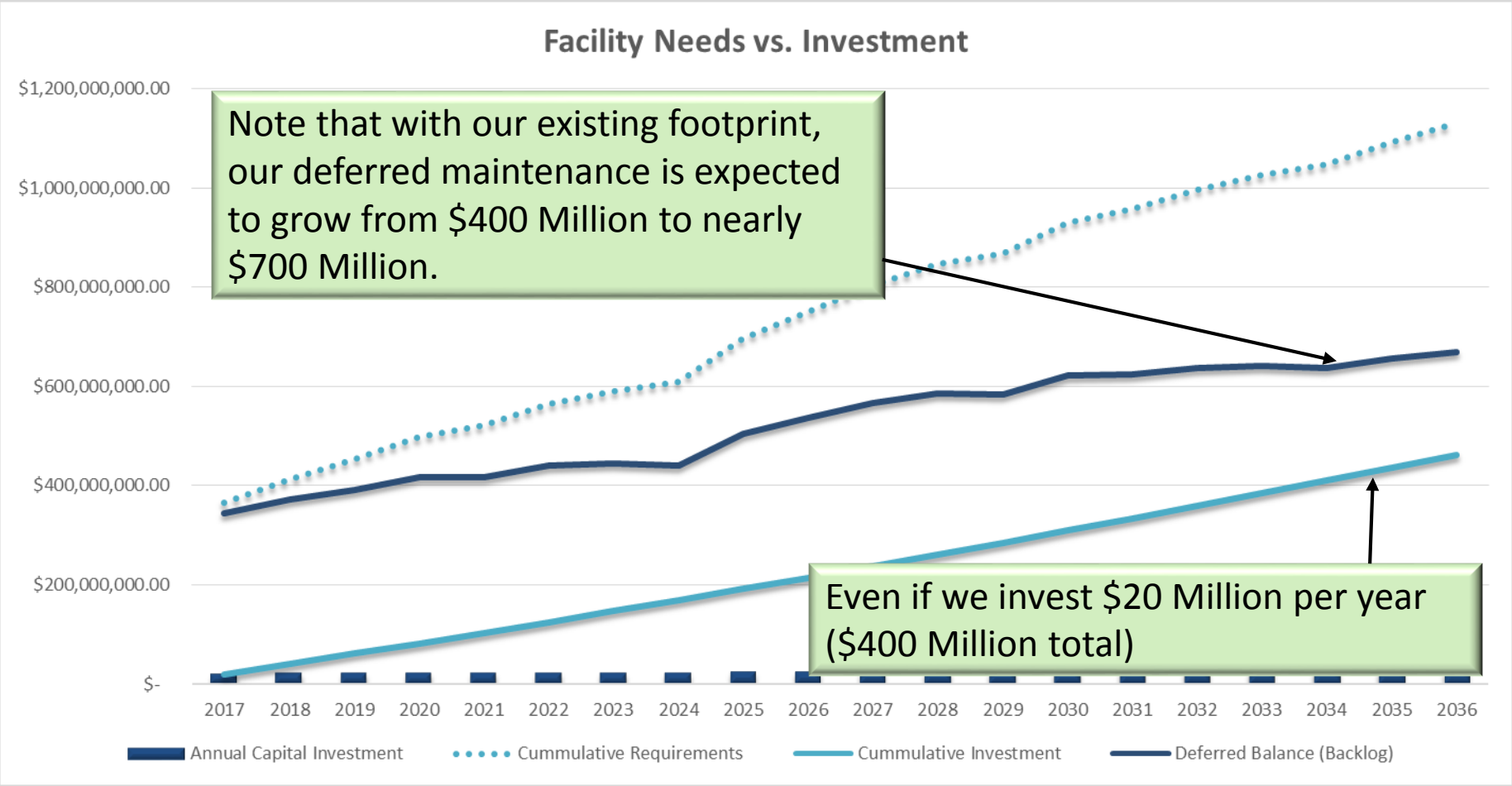

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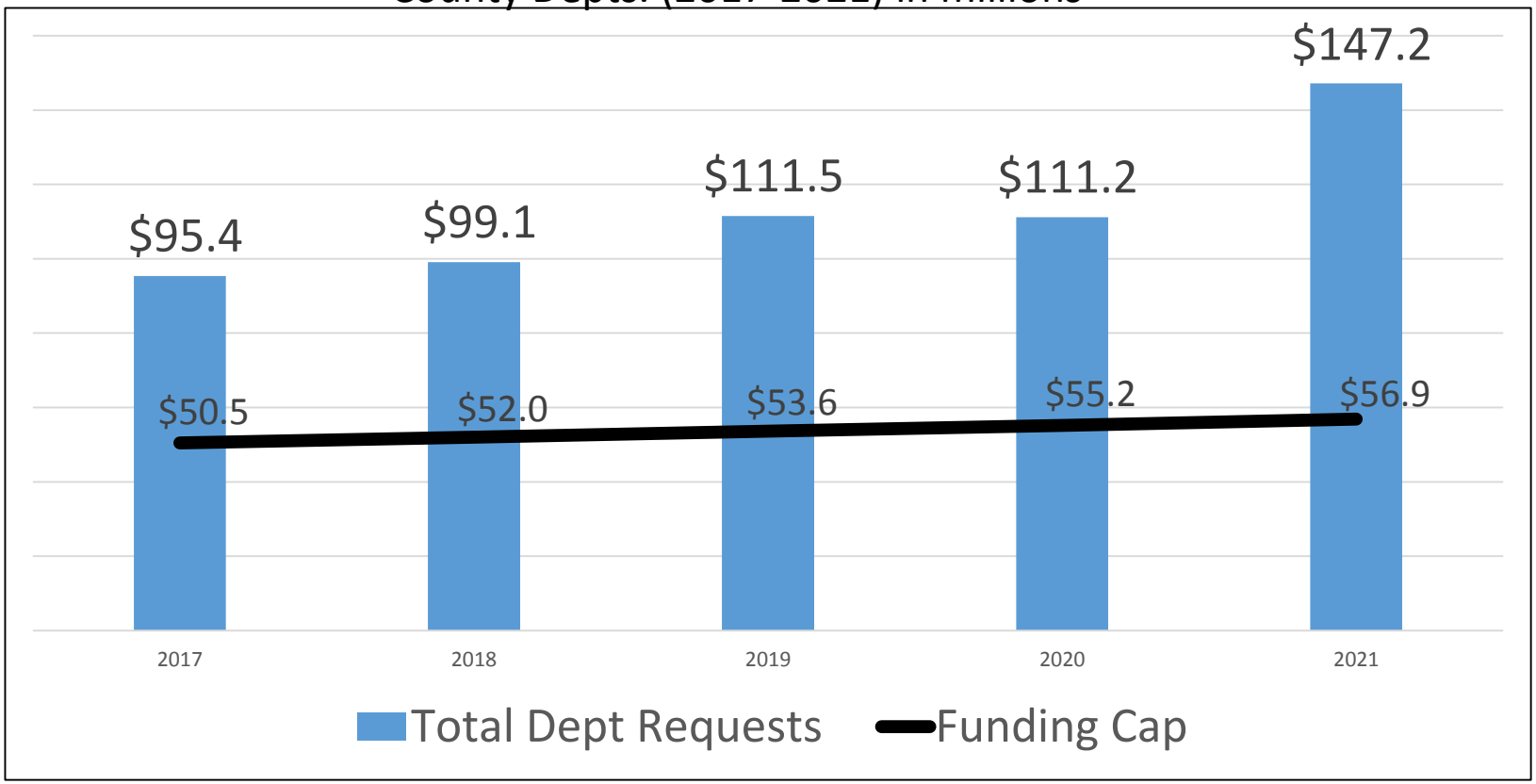
IV. Capital Budget Limitations

County Financing for Capital Requests by County Depts. (2017-2021) in millions



Source: Milwaukee County Department of Administrative Services – Performance, Strategy & Budget Division (Sept. 2016). Includes buildings, vehicles, roads and other capital infrastructure.

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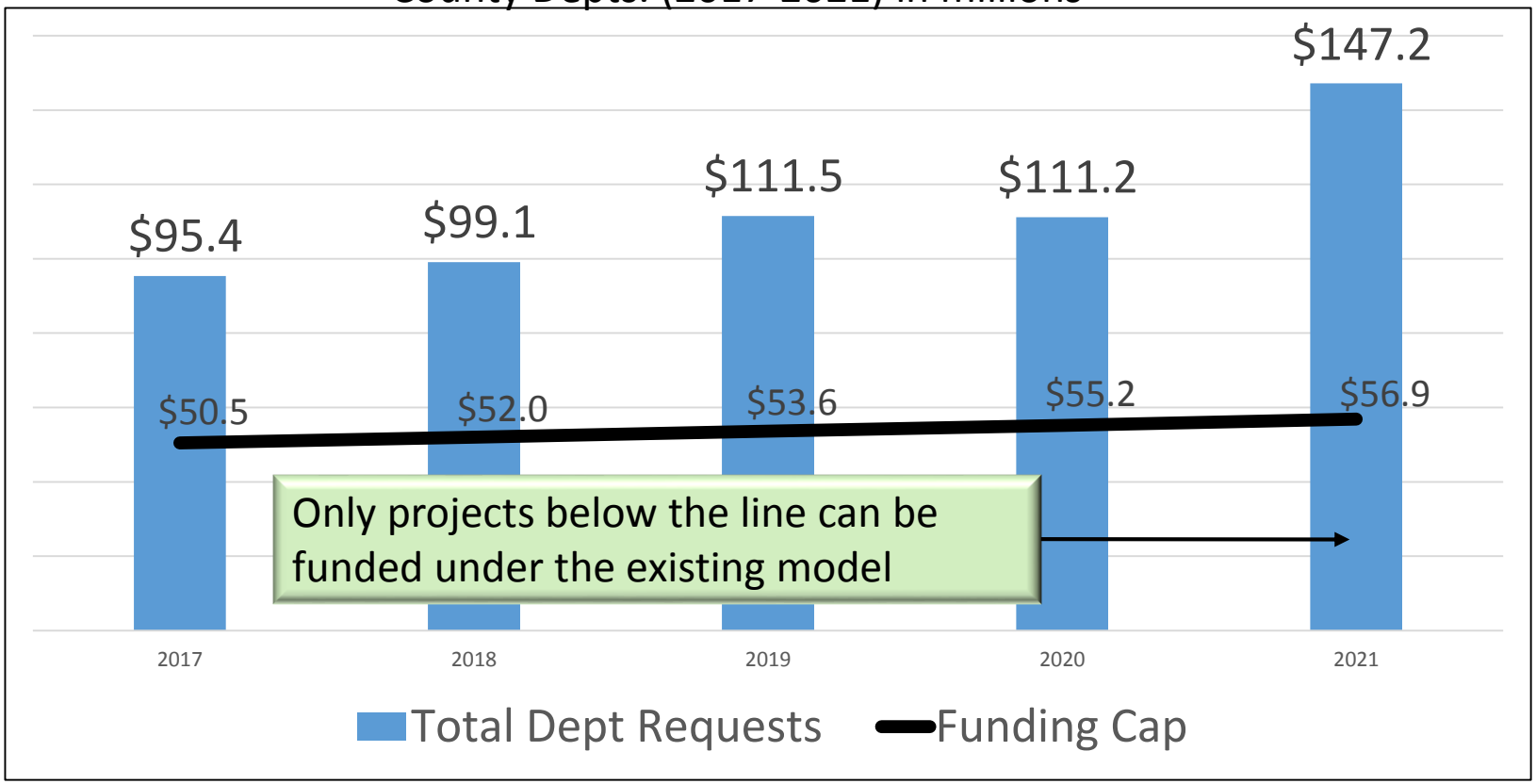


Source: Milwaukee County Department of Administrative Services – Performance, Strategy & Budget Division (Sept. 2016). Includes buildings, vehicles, roads and other capital infrastructure.

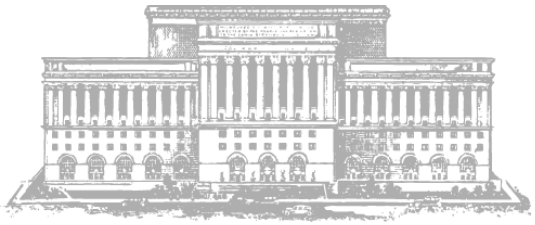
V. Successful Financial Reforms

A. Pension Reform
Contribution requirement, and reduction of multiplier will save hundreds of millions. Issuance of Pension Obligation Bonds to require consistent payments and take advantage of low market rates.

B. Restructuring of Post-Employment Benefits (OPEB).
Reduction of approximately $500 Million in liability.

C. Stabilizing Staff
FTEs down 28% since 2003. FTE Count relatively stable since 2012. Market evaluation of every job in the county.

D. Reducing Footprint
Nearly 1,000,000 Square feet of administrative space eliminated without impacting services (i.e. City Campus, DTC, Day Hospital Building, and more)



V. Successful Financial Reforms

E. Mental Health Reform
Separate Budget authority has resulted in surpluses each year

F. Reducing Energy Consumption
Tracking towards 10% reduction, $2 Million per year

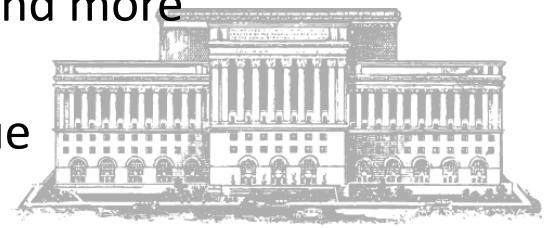
G. Operational Efficiencies
Child Support, City Works, and more

H. Building of $50 Million Reserve

I. H. Massive Reduction in Worker's Comp Claims
Over 56% reduction, savings of $4 Million + annually

I. Generating New Future Tax Base
Arena, Park East, Couture, Innovation Campus and more

J. Focus on Combination of Public Use and Revenue
Beer Gardens and more.



V. Successful Financial Reforms

K. Developing Cheaper solutions to infrastructure
For example creating natural areas and tearing down expensive dams (i.e. Estabrook)

L. Centralizing Procurement
Departments purchasing with one another, and with other municipalities to leverage purchasing power. Partnering on healthcare purchase saved $17 million.

M. Eliminating Redundancy
Partnering with Municipalities on joint services, such as Radio services and election machines.

N. Investing in Technology
Getting the most out of talented staff by providing the tools they need (i.e. 100% desktop replacement, ERP system)

V. Successful Financial Reforms

O. Vehicle Registration Fee
Offsetting the cost of transit, and reduction in federal and state funds.

P. Better service often reduces cost
Providing better service that is also more cost effective (i.e. ending chronic homelessness, community based care, alternative placement for youth) These have saved the county and others, millions per year.

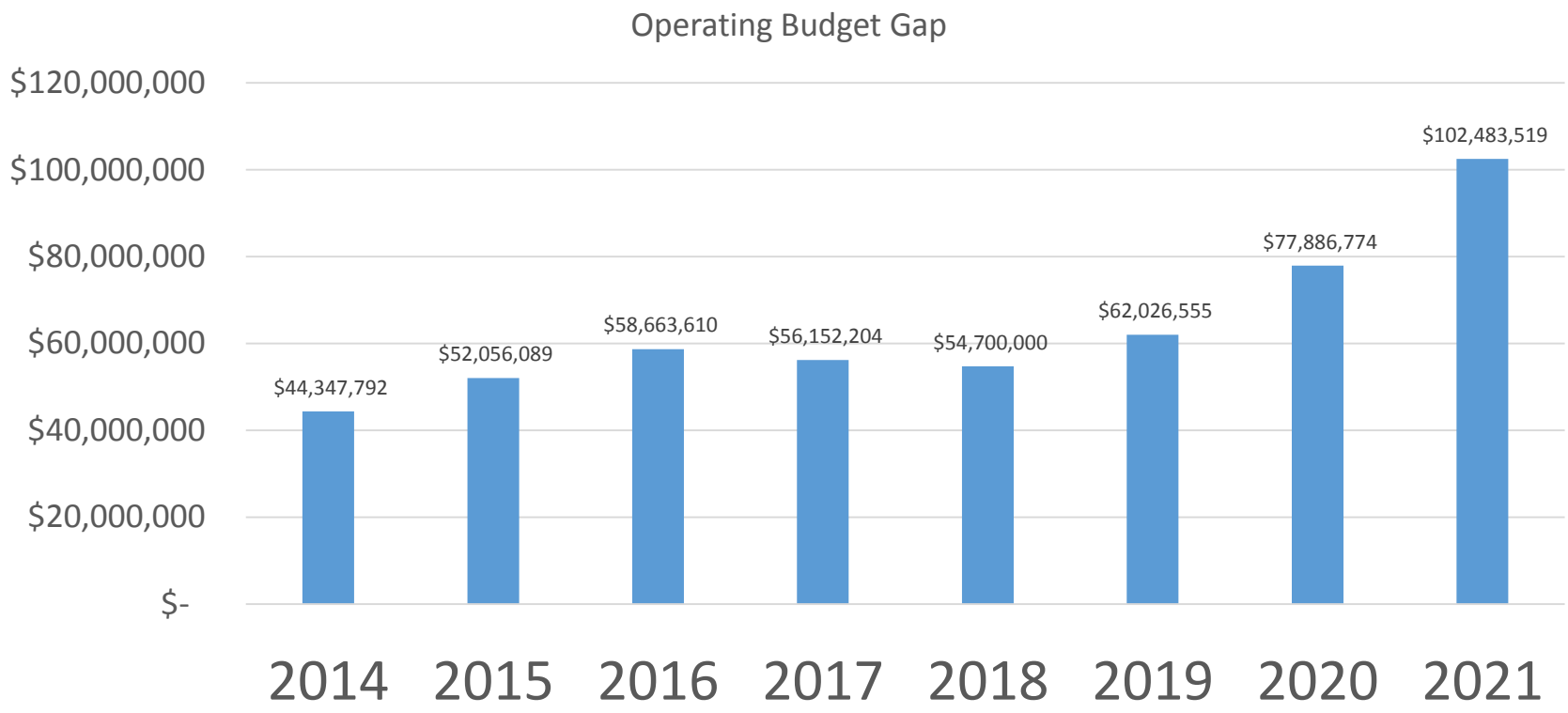
Q. Public Private Partnerships
The County continues to partner with major friends groups, corporations and individual donors (i.e. Hoyt Pool, Washington Park Band Shell, etc.)

R. Cash Financing and Maintaining Bond Rating
The County has maintained a bond rating of AA+ and continues to increase its cash financing of projects to reduce interest costs

… and more to come

V. Successful Financial Reforms

As a consequence, every year we will continue to close the gap



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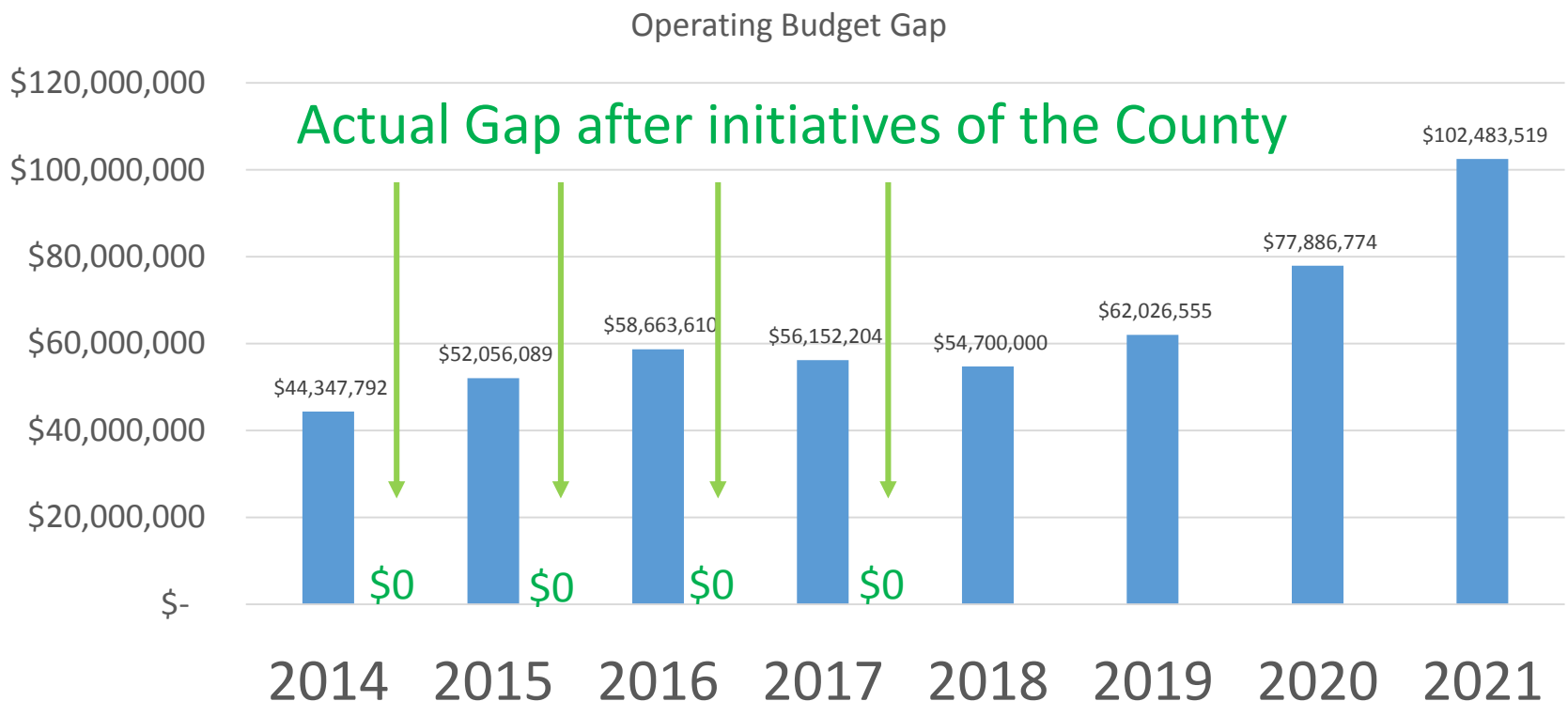

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Finance Committee Item 3

[Draft title]
The Milwaukee County Mental Health Board presents
A Zeidler Center guided Community Conversation on
Mental Health Services
Thursday, May 4, 2017, 5:30p to 7:00p (location TBA)

Zeidler Center Facilitation Services Overview

- Wide marketing network
- Proven dialogue method utilizing trained facilitators
    - Structured listening circle format encouraging reflection and deep listening to diverse voices (Introduction, structured question rounds, unstructured open conversation, feedback forms)
    - Professional facilitators (communication agreements, equal time, note taking)
- Qualitative and quantitative data reporting (representing all participant voices)

[Draft Dialogue Components]

Communication Agreements

1. We will speak for ourselves, from our personal experiences.
2. We will share airtime and not interrupt or criticize others' opinions.
3. We will "pass" or "pass for now" if we're not ready to respond to a question.
4. If asked to keep something confidential, we will honor that request.

Introduction

1. Review of budget process – forums (online and in person), opportunities
2. Review of community services (handout)
3. Review of misperceptions
4. Introduction of Listening Circles (Dr. Katherine Wilson)

Structured Question Rounds:

1. What BHD community services -- services you've seen or experienced in your personal or professional life -- have made an impact in your life or with someone you know? What was the service and what was the impact?
2. What barriers have your heard about or personally experienced in receiving services from BHD?
3. What could BHD do to make access to services and the path the treatment more clear?

Connected Conversation: What could BHD or the Mental Health Board do to improve the budget process?

Participant Feedback Form

BHD believes the path to treatment should be clear to everyone. Thank you for your feedback!

1. What's your zip code? _____ **2. Gender** _____

3. Age range? (Circle one) 18-24 / 25-34 / 35-44 / 45-54 / 55-64 / 65-74 / 75+

4. Race & Ethnicity: (Check all applicable)

☐ African-American or Black
☐ American Indian or Alaska Native
☐ Asian / Latino or Hispanic
☐ Native Hawaiian or Other Pacific Islander
☐ White or Caucasian
☐ Other: _____

5. What did you find most beneficial about this experience/format?

6. What questions or comments are you leaving with today?

7. What community services do you think BHD should be providing that they are currently not? What gaps do you see in mental health services?

8. What services does BHD provide that they should expand?

9. How have you heard about BHD services? (Check all that apply)

☐ Word of mouth
☐ Pamphlets
☐ Another agency
☐ Personal experience for self
☐ Personal experience with an adult family member
☐ Personal experience with child or adolescent
☐ I do not hear about BHD services
☐ Other: _____

10. How did you hear about this meeting? (Check one)

☐ Newspaper
☐ Email
☐ Website
☐ Social media/Facebook
☐ Word of mouth
☐ Mental Health Task Force
☐ Other professional agency/advocacy group

Finance Committee Item 5

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: **March 24, 2017**

TO: Duncan Shrout, Chairperson – Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, and Department of Health and Human Services
Approved by Mike Lappen, Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute Professional Services Contracts to Support a TANF Study, Provide Project Management and Information Technology Services, Residency Training, and Bioethical Consultation; and 2017 Purchase-of-Service Contracts and Fee-for-Service Agreements with a Value in Excess of $100,000 for the Behavioral Health Division for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least $100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS to execute mental health and substance use contracts for 2017.

Background

Approval of the recommended contract allocations will allow BHD/CARS/Wraparound to provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.

Professional Services Contracts

Patina Solutions Group, Inc. $96,000.00
In June 2016, the Mental Health Board approved $195,000 for a contract with Patina Solutions Group, Inc., to provide project management costs for the Case Management redesign effort between the Behavioral Health Division (BHD) and the Department of Health and Human Services (DHHS). At that time, there was a misunderstanding that DHHS and BHD would split the costs evenly. Upon further review of the expense allocation agreement and size of BHD compared to DHHS, management noted that DHHS agreed to pay up to $99,000 of this project. Therefore, to pay Patina for the work already rendered, BHD is requesting an additional $96,000 to cover the balance of this contract for which BHD is responsible.

UW-Milwaukee TANF Grant $170,000.00
This is an agreement with UW-Milwaukee to conduct a special project. The project will focus on process (i.e., what was done and how it was accomplished) and outcomes (i.e., results) to evaluate the Milwaukee County TANF-AODA system of care.

Medical College of Wisconsin – Affiliated Hospitals $654,000.00
BHD contracts with the Medical College of Wisconsin – Affiliated Hospitals (MCWAH) for residency and fellowship stipends as part of BHD's affiliation and training site designation with the psychiatry training programs. The residents and fellows assigned to BHD serve as house staff and provide medical care within the BHD acute inpatient, crisis and community services, with oversight and direction from BHD psychiatry staff.

BHD is recommending extending the agreement for a two-year contract term for the period of July 1, 2017 through June 30, 2019 in an amount of $654,000 annually. This is the same amount as in 2015 and 2016.

Medical College of Wisconsin $69,794.00
BHD is recommending contracts for partial support of the MCW Psychiatry Residency Director ($59,794) and for MCW bioethics consultation ($10,000) be extended for the term of July 1, 2017 through June 30, 2019.

Netsmart
After an extensive review, Milwaukee County is reinvesting in the Behavioral Health Division's Electronic Medical Record. BHD will renew its relationship with Netsmart, the vendor of Avatar and related tools, for an additional 3 years. This contract will run from May 1st, 2017 to December 31st 2020 and include two 1 year renewal options beginning in 2021. The following financial terms have been negotiated:

Netsmart Contract Renewal - Recurring Fees				
Solution Category	**2017 (remainder)**	**2018**	**2019**	**2020**
Software, Hosting, & Integration	$541,673.62	$860,380.46	$860,380.46	$860,380.46
HelpDesk IT Services	$64,000.00	$96,000.00	$96,000.00	$96,000.00
Application Management Services	$768,000.00	$810,666.67	$640,000.00	$640,000.00
Total	$1,373,673.62	$1,767,047.13	$1,596,380.46	$1,596,380.46

This includes costs for licenses and remote (cloud) hosting of core applications including Clinical Workstation, Practice Management, Managed Service Organization, ProviderConnect, Pharmacy Management, along with improved features in data exchange, self-service reporting and document management. It includes 24x7 helpdesk to support staff through all shifts, support resources to maintain and update the system, and compliance and reporting needs defined by BHD.

The 2017 amount is in addition to the $396,160 already approved in February for a new annual total of $1,769,833.62.

Purchase-of-Service Contracts

SEA Group $300,000.00
This is an agreement with Sea Group for Educational Advocacy for youth that are enrolled in the Wraparound program.

Fee-for-Service Agreements

Butterflies Home for Teen Girls $159,075.00
Butterflies Home for Teen Girls is a licensed group home with two locations on Milwaukee's Northside. They serve girls between the ages of 12-17. This vendor specializes in meeting the needs of pregnant teens and teen mothers who are in out of home care.

Willowglen $100,000.00
This is an agreement with Willowglen, a current CARS provider, for services provided as part of the CCS network.

Outreach Community Health Centers $450,000.00
Comprehensive Community Services (CCS) provides programming to people of all ages -- youth to elderly -- living with either a mental illness and/or substance use disorder. CCS is for individuals who need ongoing services beyond occasional outpatient care, but less than the intensive care provided in a hospital setting.

Fiscal Summary

The amount of 2017 spending requested in this report is summarized below. These payments will be absorbed within the Behavioral Health Division's 2017 budget.

Vendor	New/Amendment/Renewal	2017 Estimated Amount
UW-Milwaukee TANF	New	$170,000.00
Butterflies Home for Teen Girls	New	$159,075.00
Patina Solutions Group	Amendment	$96,000.00
Willoglen	New	$100,000.00
SEA Group	New	$300,000.00
Medical College of Wisconsin - Affiliated Hospitals	Renewal	$654,000.00
Medical College of Wisconsin	Renewal	$69,794.00
Netsmart	Renewal	$1,769,833.62
Outreach Community Health Centers	Renewal	$450,000.00
Total		$3,768,702.62

Hector Colon, Director
Department of Health and Human Services

Chairperson: Mary Neubauer
Senior Executive Assistant: Jodi Mapp, 257-5202

MILWAUKEE COUNTY MENTAL HEALTH BOARD
QUALITY COMMITTEE

March 6, 2017 - 10:00 A.M.
Milwaukee County Mental Health Complex
Conference Room 1045

MINUTES

PRESENT: Robert Chayer and Mary Neubauer
EXCUSED: Ronald Diamond, Rachel Forman, Jeffrey Miller, and Brenda Wesley

SCHEDULED ITEMS:

1.	**Welcome.** Chairwoman Neubauer introduced herself as the new Chairperson for the Mental Health Board Quality Committee and welcomed everyone to the March 6, 2017, meeting.
2.	**Key Performance Indicators (KPI) Updates and Analysis.** The dashboard provided continues to evolve. There will be additional quality measures as ways to enhance the dashboard are considered. Based on recommendations from previous meetings, changes were incorporated, are reflected, and were explained.
3.	**Behavioral Health Division System of Care: Enrollment and the Key Performance Indicators Dashboard Presentation.** A rationale and plan for transitioning the KPI to include identifying a more global, enrollment-based outcome was discussed. Emphasis was placed on focusing on patient-centered recovery performance indicators across service lines. Further information will be provided.
4.	**Contract Performance Measures Development Process and Performance Improvement Process.** A process for measuring contract performance has been developed and includes identifying applicable quality measures and benchmarks; professional, client, and provider consultation; obtaining approval and implementing measures and benchmarks; examining results; obtaining feedback from clients and providers; and adjusting as necessary. The timeline for contract performance development was shared.

SCHEDULED ITEMS (CONTINUED):

5.	**Community Access to Recovery Services Quarterly Report and Referral Process Improvement Project**. The CARS quarterly report includes number of clients receiving services and by program, number of admissions and by program, referrals/intakes by access point, and average days on waitlists for mental health programs and AODA residential services. The goal of this project is to reduce the time from referral to admission by at least twenty-five percent. The time from referral to enrollment in services was reviewed. Redesign recommendations, next steps, and improvement opportunities were shared.
6.	**Client Experience Workgroup.** The Client Experience Workgroup was assembled in June 2016 to evaluate the patient/client satisfaction survey process to ensure best practices. Assessments of current patient/client satisfaction survey tools, distribution and collection methods, data entry, analysis/reporting, client satisfaction survey targets, and timeliness of report creation were conducted. A decision was made to consult a third-party vendor to assist with developing an impartial and consistent client experience survey process. The Workgroup has been in discussions with the vendor, and plans to implement are underway.
7.	**Compliments, Complaints, and Grievances.** The objective is to centralize collection of compliments, complaints, grievances, and appeals and implement an electronic tracking methodology to develop mechanisms to utilize client feedback data for service enhancement and improvement. The team explored electronic tools to assist in collecting and storing data. Verge was selected, with input from the Information Management Services Division (IMSD), as the program that best fits the needs of the Behavioral Health Division and is now live. Verge's Safety Suite offers both patient relations and incident reporting modules. The team is in the process of reviewing user feedback.
8.	**Seclusion and Restraint (S&R) Reduction Initiatives Progress to Date.** There has been significant progress made, with work continuing in the areas of documentation, process, and review. Federal surveyors have returned several times since the original citation was issued. A checklist has been created and is to be completed whenever seclusion and restraint is used. Usage rates continue to decrease. Further work on treatment plan documentation is indicated.

SCHEDULED ITEMS (CONTINUED):

9.	**Wraparound Milwaukee Performance Based Measures**. Wraparound has tracked the outcomes of established performance measures for contracted Care Coordination services. As programs evolved and expanded, performance measures for new areas were necessary, some of which are still being developed. Performance is measured every six months and is reflected in an agency performance report. Agency improvement plans are created to assist agencies in meeting performance measures.
10.	**Psychiatric Crisis Services (PCS) Hospital Transfer Waitlist Report.** One of the challenges faced in the last quarter of 2016 was related to staffing. Data representative of individuals who are on emergency detention but not medically stable to be transferred to the list is embedded in the data. Questions and comments ensued.
11.	**Environment of Care 2016 Annual Report and 2017 Goals.** Written plans for managing environmental risk, which include safety, security, clinical and non-clinical equipment, handling of hazardous materials, fire prevention, and utility systems, together make up the Behavioral Health Division Environment of Care Program. Achievements for 2016 and goals for 2017 were highlighted. Questions and comments ensued. The Quality Committee unanimously agreed to recommend approval of the plans and the annual report to the Board.
12	Next Scheduled Meeting Dates. • June 5, 2017, at 10:00 a.m. • September 11, 2017 at 10:00 a.m. The next meeting date was announced as June 5, 2017, at 10:00 a.m.
13	Adjournment. Chairwoman Neubauer ordered the meeting adjourned.

SCHEDULED ITEMS (CONTINUED):

This meeting was recorded. The official copy of these minutes and subject reports, along with the audio recording of this meeting, is available on the Milwaukee County Behavioral Health Division/Mental Health Board web page.

Length of meeting: 10:03 a.m. to 12:04 p.m.

Adjourned,

Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is Monday, June 5, 2017, @ 10:00 a.m.

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

Quality Committee Item 2

Program	Item	Measure	2016 Quarter 1	2016 Quarter 2	2016 Quarter 3	2016 Quarter 4	2016 Actual	2016 Target	2016 Status (1)	2015 Actual	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs[8]	4,779	4,955	4,986	4,981	7,971	9,742		9,624	BHD (2)
		Sample Size (Unique Clients)	2,726	1,693	2,089	1,860					
	2	Percent with any acute service utilization[9]	11.70%	12.11%	13.07%	15.48%		-		-	BHD (2)
	3	Percent with any emergency room utilization[10]	10.27%	11.64%	12.35%	15.48%					
	4	Percent abstinence from drug and alcohol use	70.37%	63.33%	66.75%	66.39%		-		-	BHD (2)
	5	Percent homeless	2.86%	5.02%	4.88%	6.18%		-		-	BHD (2)
	6	Percent employed	14.27%	19.08%	15.17%	14.68%		-		-	BHD (2)
		Sample Size (Admissions)	1368	1648	1685	1614					
	7	Percent of clients returning to Detox within 30 days	48.03%	58.50%	55.61%	60.29%		NA(5)		19.6%	BHD (2)
Wraparound	11	Families served in Wraparound HMO (unduplicated count)	1,921	2,521	3,032	3,500	3,500	3,300		3,329	BHD (2)
	12	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.5	4.5	4.6	4.8	4.6	> = 4.0		4.6	BHD (2)
	13	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	59.6	59	59.2	63	60.2	> = 75%		62%	BHD (2)
	14	Average level of "Needs Met" at disenrollement (Rating scale of 1-5)	3.12	2.94	2.80	2.57	2.86	> = 3.0		3.2	BHD (2)
	15	Percentage of youth who have achieved permanency at disenrollment	55%	52%	55%	53%	53.6%	> = 70%		58%	BHD (2)
	16	Percentage of Informal Supports on a Child and Family Team	42.30%	42.90%	43.50%	45.70%	43.6%	> = 50%		42%	BHD (2)
Crisis Service	17	PCS Visits	2,138	2,169	2,073	1,906	8,286	9,000		10,173	BHD (2)
	18	Emergency Detentions in PCS	1,074	1,118	978	889	4,059	4,500		5,334	BHD (2)
	19	Percent of patients returning to PCS within 3 days	7.7%	7.5%	7.6%	7.9%	7.9%	8%		8%	BHD (2)
	20	Percent of patients returning to PCS within 30 days	24.8%	24.3%	24.3%	24.8%	24.8%	20%		25%	CMS (4)
	21	Percent of time on waitlist status	76.4%	72.3%	83.8%	87.7%	80.1%	10%		16%	BHD (2)
Acute Adult Inpatient Service	22	Admissions	193	176	158	156	683	850		965	BHD (2)
	23	Average Daily Census	45.4	46.0	47.0	44.6	45.8	48.0		47.2	BHD (2)
	24	Percent of patients returning to Acute Adult within 7 days	3.6%	3.7%	4.0%	3.6%	3.6%	-		3%	BHD (2)
	25	Percent of patients returning to Acute Adult within 30 days	11.3%	9.8%	10.9%	10.8%	10.8%	11%		11%	NRI (3)
	26	Percent of patients responding positively to satisfaction survey	76.8%	69.0%	70.9%	65.7%	70.6%	74%		73%	NRI (3)
	27	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	64.3%	54.4%	53.4%	56.1%	57.1%	65%		63%	BHD (2)
	28	HBIPS 2 - Hours of Physical Restraint Rate	3.05	2.97	5.99	1.17	3.32	0.66		7.2	CMS (4)
	29	HBIPS 3 - Hours of Locked Seclusion Rate	0.54	0.63	0.50	0.26	0.48	0.14		0.47	CMS (4)
	30	HBIPS 4 - Patients discharged on multiple antipsychotic medications	12.6%	17.1%	23.5%	22.2%	18.5%	9.5%		18%	CMS (4)
	31	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	95.7%	96.4%	88.2%	100.0%	95.0%	32.8%		98%	CMS (4)
Child / Adolescent Inpatient Service (CAIS)	32	Admissions	193	167	113	144	617	800		919	BHD (2)
	33	Average Daily Census	9.3	10.1	6.3	7.7	8.4	11.0		9.8	BHD (2)
	34	Percent of patients returning to CAIS within 7 days	6.0%	5.5%	6.1%	5.2%	5.2%	-		6%	BHD (2)
	35	Percent of patients returning to CAIS within 30 days	15.3%	15.0%	14.5%	11.8%	11.8%	11%		16%	BHD (2)
	36	Percent of patients responding positively to satisfaction survey	83.8%	78.8%	72.4%	77.2%	78.1%	74%		71%	BHD (2)
	37	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	93.3%	72.2%	80.0%	83.0%	82.1%	80%		74%	BHD (2)
	38	HBIPS 2 - Hours of Physical Restraint Rate	5.31	3.44	6.50	2.79	4.51	0.22		5.2	CMS (4)
	39	HBIPS 3 - Hours of Locked Seclusion Rate	0.17	0.00	0.22	0.40	0.20	0.34		0.42	CMS (4)
	40	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2.6%	1.8%	0.9%	0.7%	1.6%	3.0%		2%	CMS (4)
	41	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100.0%	50.0%	100.0%	100.0%	88.9%	39.9%		100%	CMS (4)
Financial	42	Total BHD Revenue (millions)	-	-	-	-	$129.4	$129.4		$120.2	
	43	Total BHD Expenditure (millions)	-	-	-	-	$188.2	$188.2		$173.5	

Notes:

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

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

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

(4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages
(5) The 2016 target for detox is currently under revision for two reasons: a) We have revised the way we calculate this outcome, which has had a significant impact on the readmission rates, and
(6) We have expanded the scope of detox clients to be included in the outcome (exanding from 75.07 to both 75.07 and 75.09 leves of care)
(7) Because we now have the ability to collect uniform data on all clients, this is the first quarter in which we will be included both sheltered employment and student status as part of our overall "employed" status
(8) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.
(9) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days
(10) Includes any medical or psychiatric ER utilization in last 30 days

Quality Committee Item 3

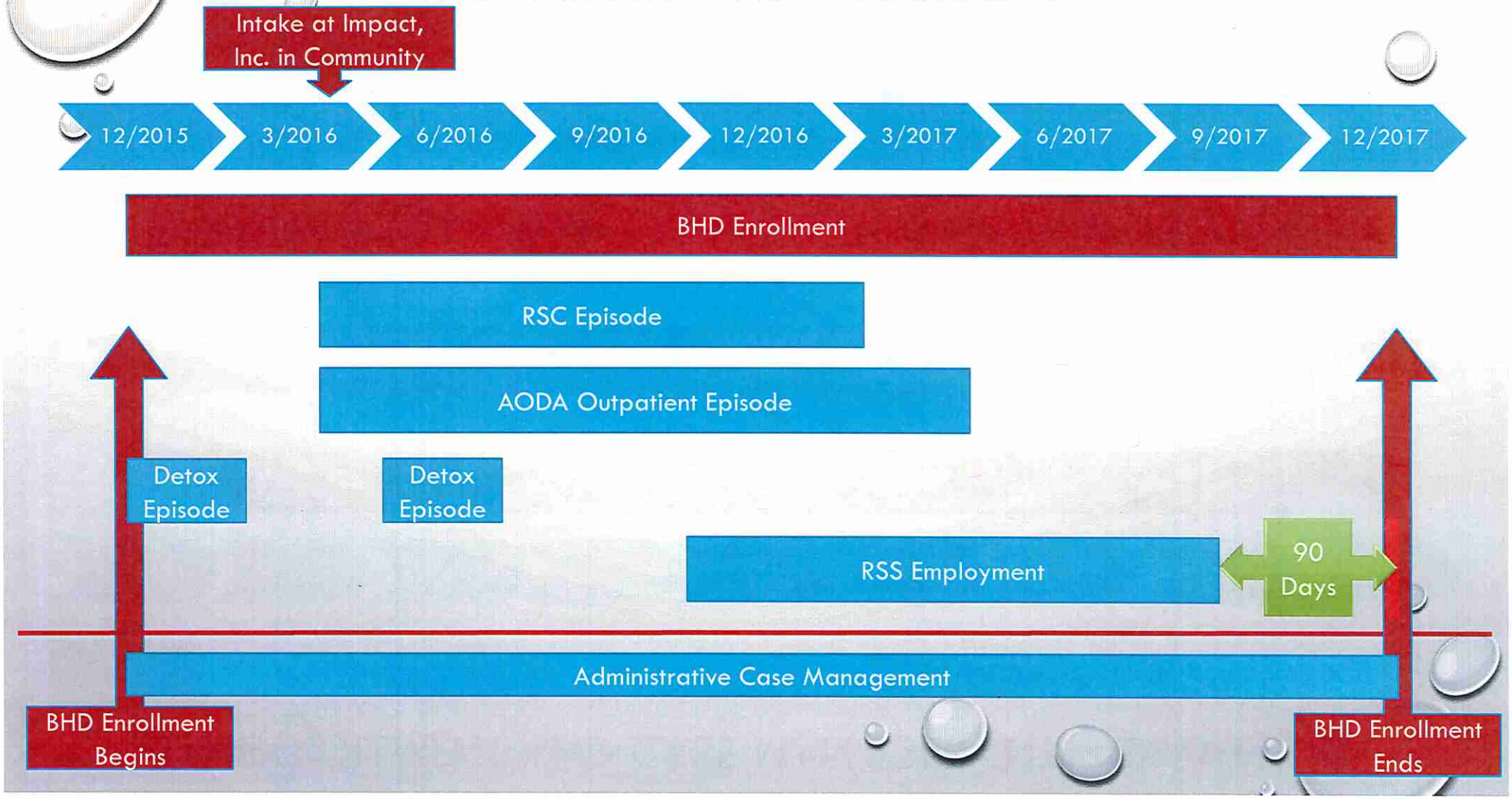
BHD's System of Care: Enrollment and the KPI Dashboard

MHB QUALITY COMMITTEE REPORT

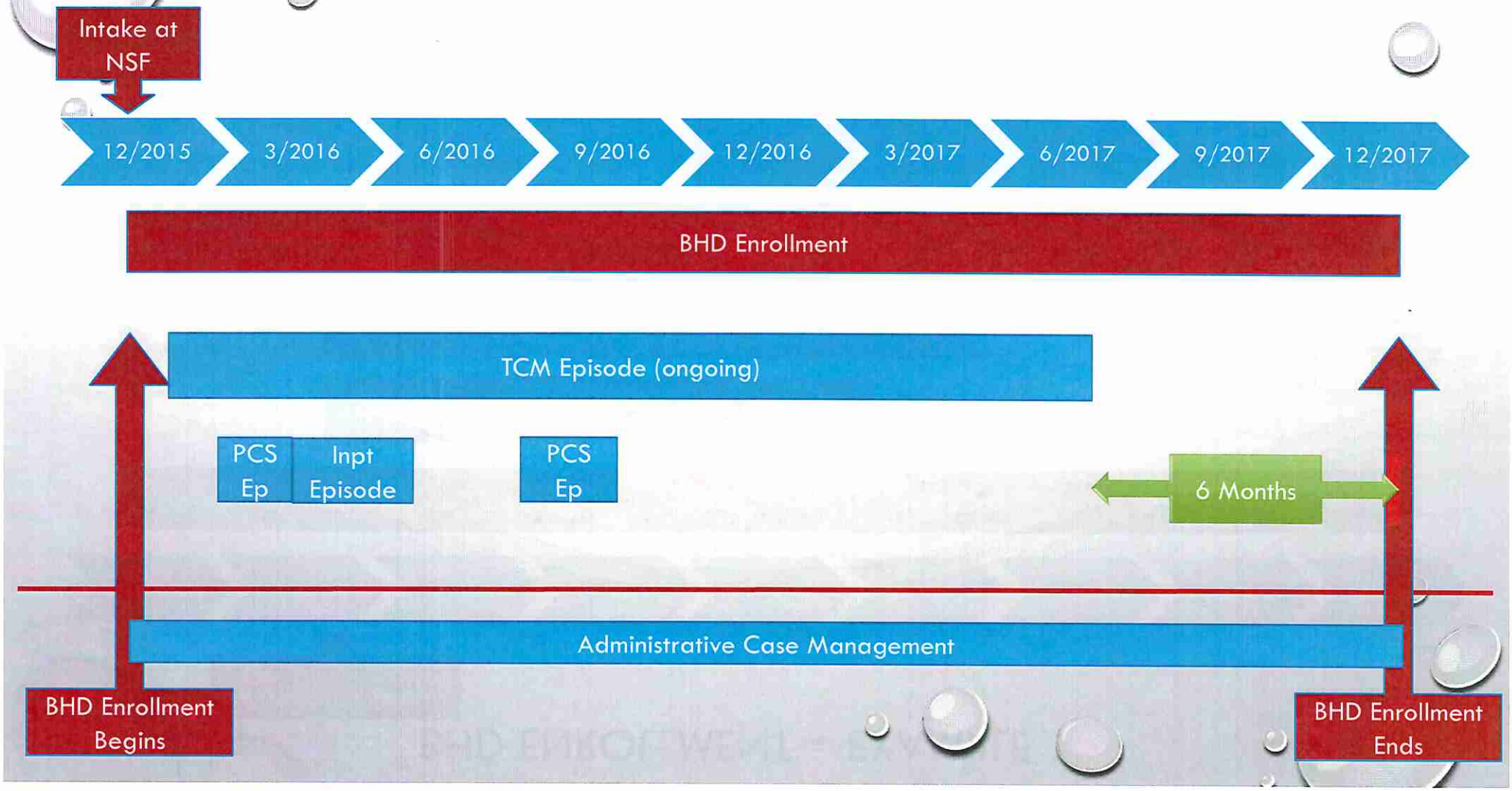
Access and Enrollments

- Consistent with State Program Participation System model of "County Episodes"
  - Episodes of care are opened by the County and all services provided during the "County Episode" are captured with SPC Codes and reported under the parent "County Episode"
- Start when a client first accesses services provided by BHD or an agency with which BHD contracts and end 90-180 days after the last service is closed

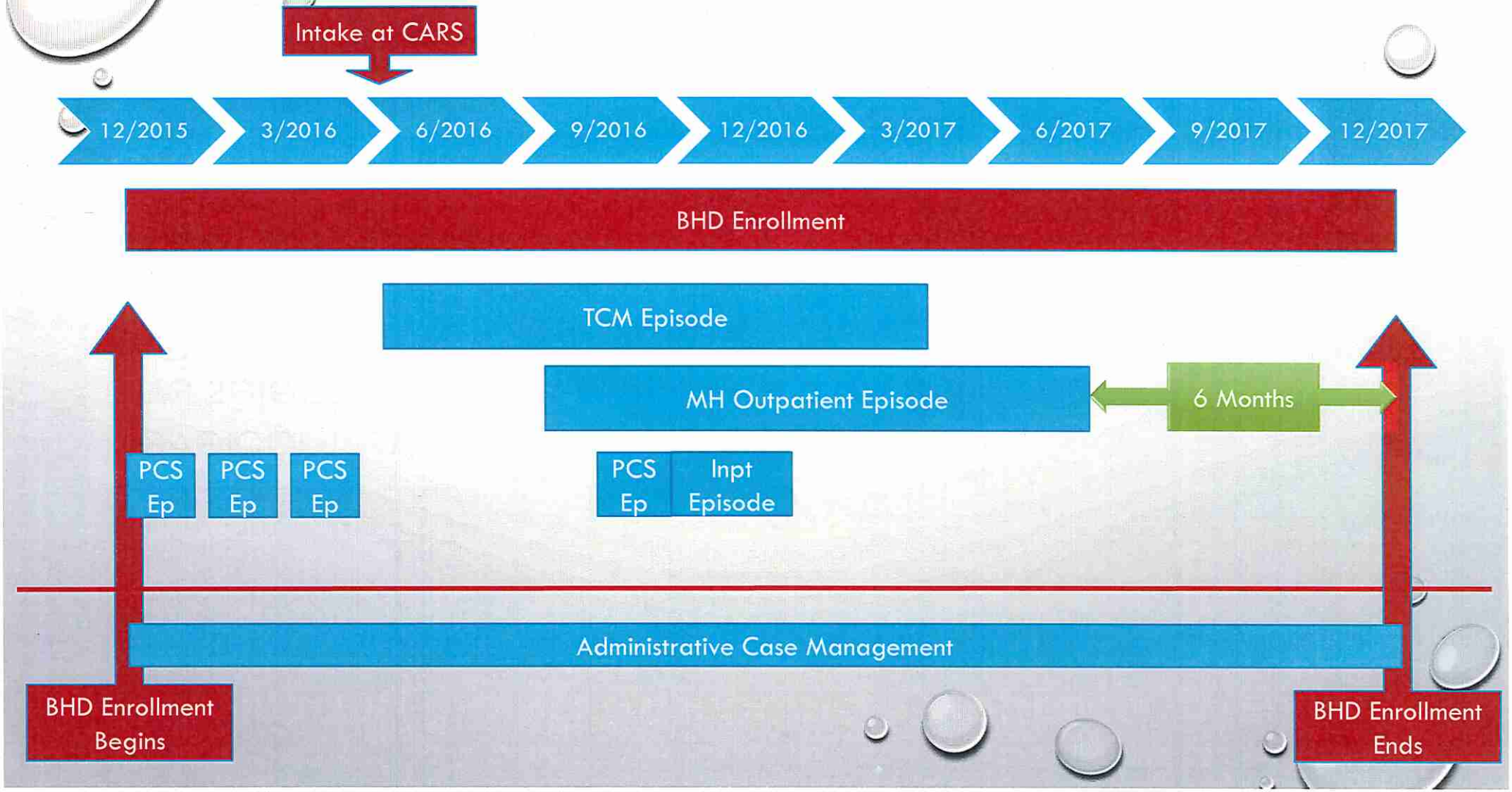
BHD ENROLLMENT – EXAMPLE 1



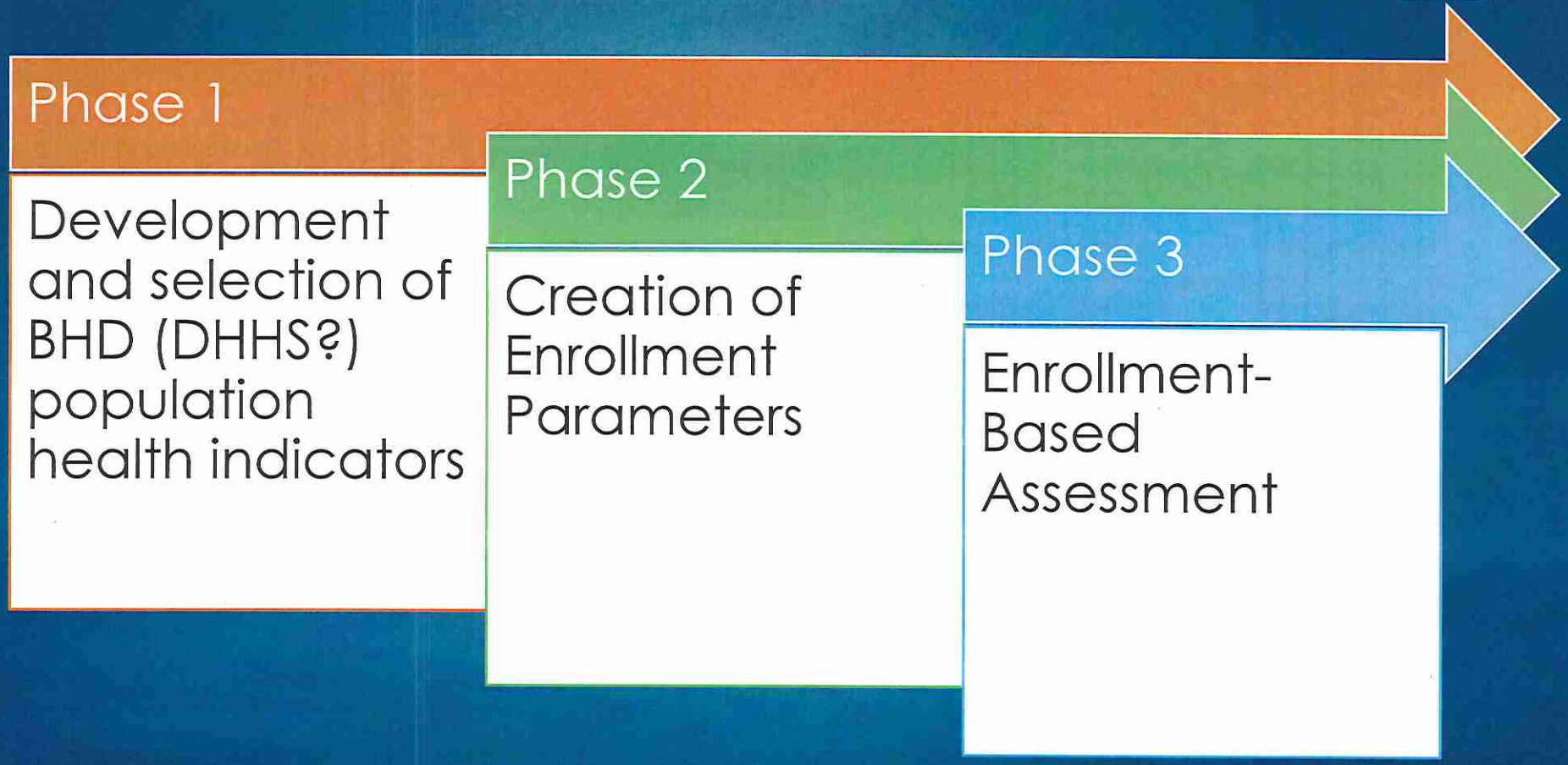
BHD ENROLLMENT AND CASE MANAGEMENT – EXAMPLE 2



BHD ENROLLMENT AND CASE MANAGEMENT – EXAMPLE 3



Enrollment and the KPI Dashboard – Proposed Evolution



3 Phase Approach

- Phase 1: Helps us to begin to conceptualize our KPIs from a population health, a BHD-wide, enrollment-based perspective
- Phase 2: Allows us to begin to examine the health of our population over time in cohorts
- Phase 3: Enables the BHD Health System to provide greater enrollment oversight

Each subsequent phase is built off the infrastructure developed in the previous phase

Cross Sectional Approach: Snapshot of Population Served at a Point in Time (an example with actual data)

KPI Dashboard

7/1/2016 to 9/30/2016

TOTAL SAMPLE: 1,903

Average Psychiatric Hospital Bed Days in Last 180

Total Psych Bed Days Sample N: 1,855

Average Days in Community: 175.98

Average Psych Bed Days 4.02

Percent of Total Sample Abstinent in Past 30 Days

Total AODA Sample N:1,836

Total Abstinent: 1,215

Percent Abstient 66.18%

Any Hospital Admission in Last 30 Days (Yes/No)

Any Hospital Admission Sample N: 1,903

Total with Any Hospital Admission: 262

Percent Any Hospital Admission: 13.77%

Percent of Total Sample Employed

Employment Sample N: 1,903

Total Employed: 260

Percent Employed: 13.66%

Percent Homeless of Total Sample

Living Status Sample N: 1,903

Total Homeless: 90

Percent Homeless 4.73%

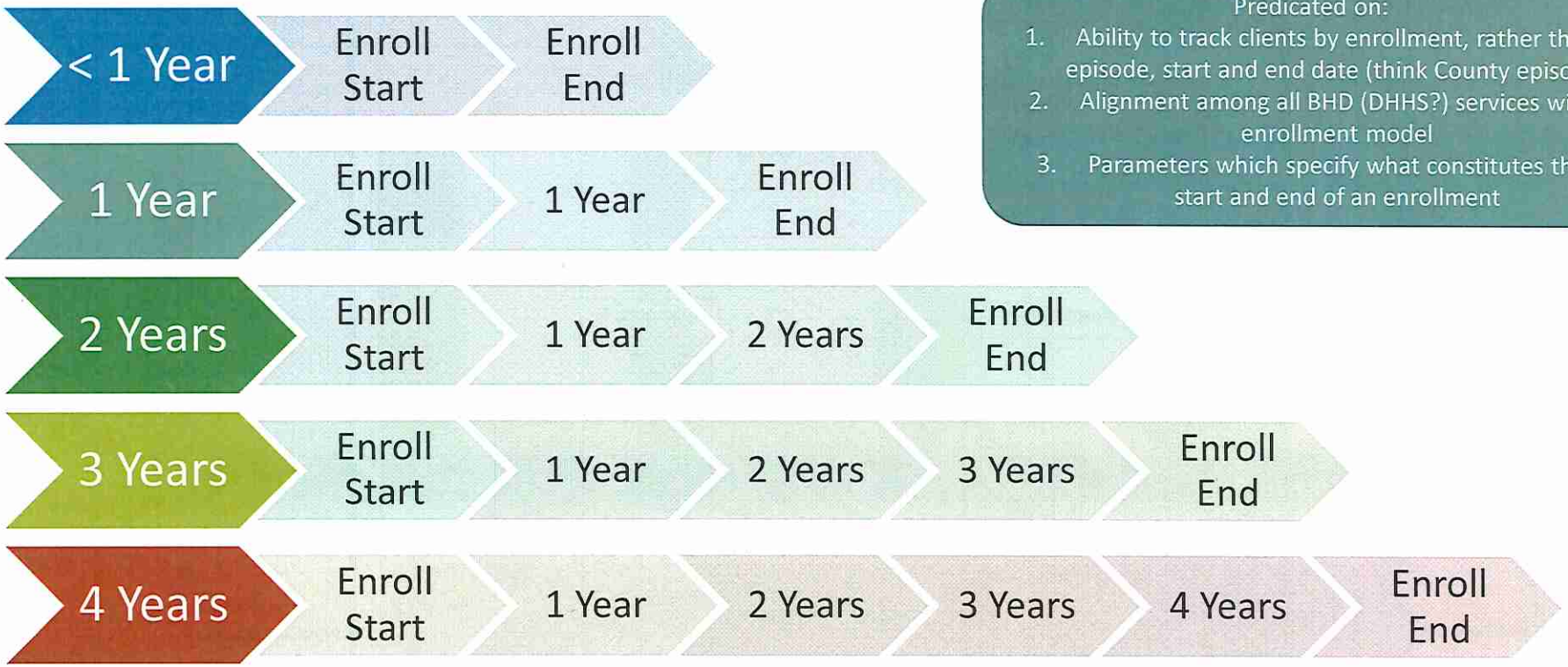
Any ER Admission in Last 30 Days (Yes/No)

Any ER Admission Sample N: 1,903

Total Any ER Admission: 248

Percent Any ER Admission: 13.03%

Longitudinal Approach: Client Cohorts Based on Length of Enrollment and Followed Over Time



Predicated on:

1. Ability to track clients by enrollment, rather than episode, start and end date (think County episode)
2. Alignment among all BHD (DHHS?) services with enrollment model
3. Parameters which specify what constitutes the start and end of an enrollment

System Outcomes – Based on Enrollment

1. All cause ED and inpatient readmission rate pre-enrollment and annually during enrollment
2. All cause inpatient readmission rate pre-enrollment and annually during enrollment
3. Client experience annually during enrollment and/or at end of enrollment
4. Behavioral health and medical screening at intake and during enrollment
5. Housing, employment, social connectedness at intake, end, and during enrollment
6. Cost effectiveness

Jan 2016 | April 2016 | July 2016 | October 2016 | Jan 2017 | April 2017 | July 2017 | October 2017 | Jan 2018 | April 2018 | July 2018 | October 2018

PPS Data

ASAM used at enrollment, as medical necessity criteria for programs, and at disenrollment

PCS

Detox

Detox

Detox

Inpatient

Detox

Inpatient

AODA TCM

AODA Residential

AODA Day Tx

AODA OP

Bridge Housing

RSS Employment

Other Candidate Enrollment Outcomes:

1. Mean number of days between authorization and first contact (by client for all programs)
2. Percent of ED and/or hospital visits with a follow up visit within 7 days of discharge
3. Percentage of clients with transmittal of a care transition record within 24 hours of discharge
4. Initiation and engagement in AODA (other?) tx

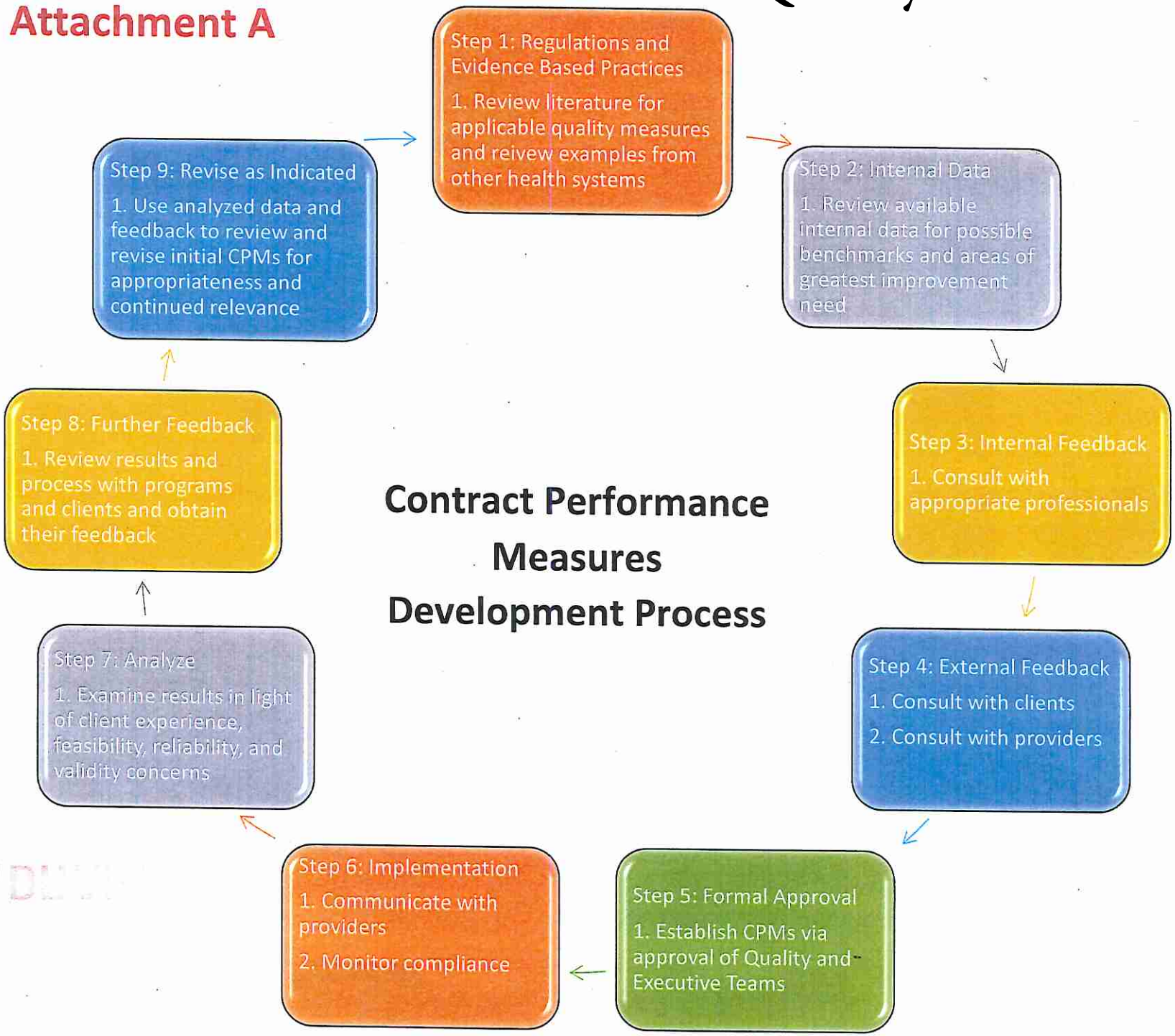
Aligned with State Model

Enrollment Begins

Overarching Case Manager

Enrollment Ends

Attachment A

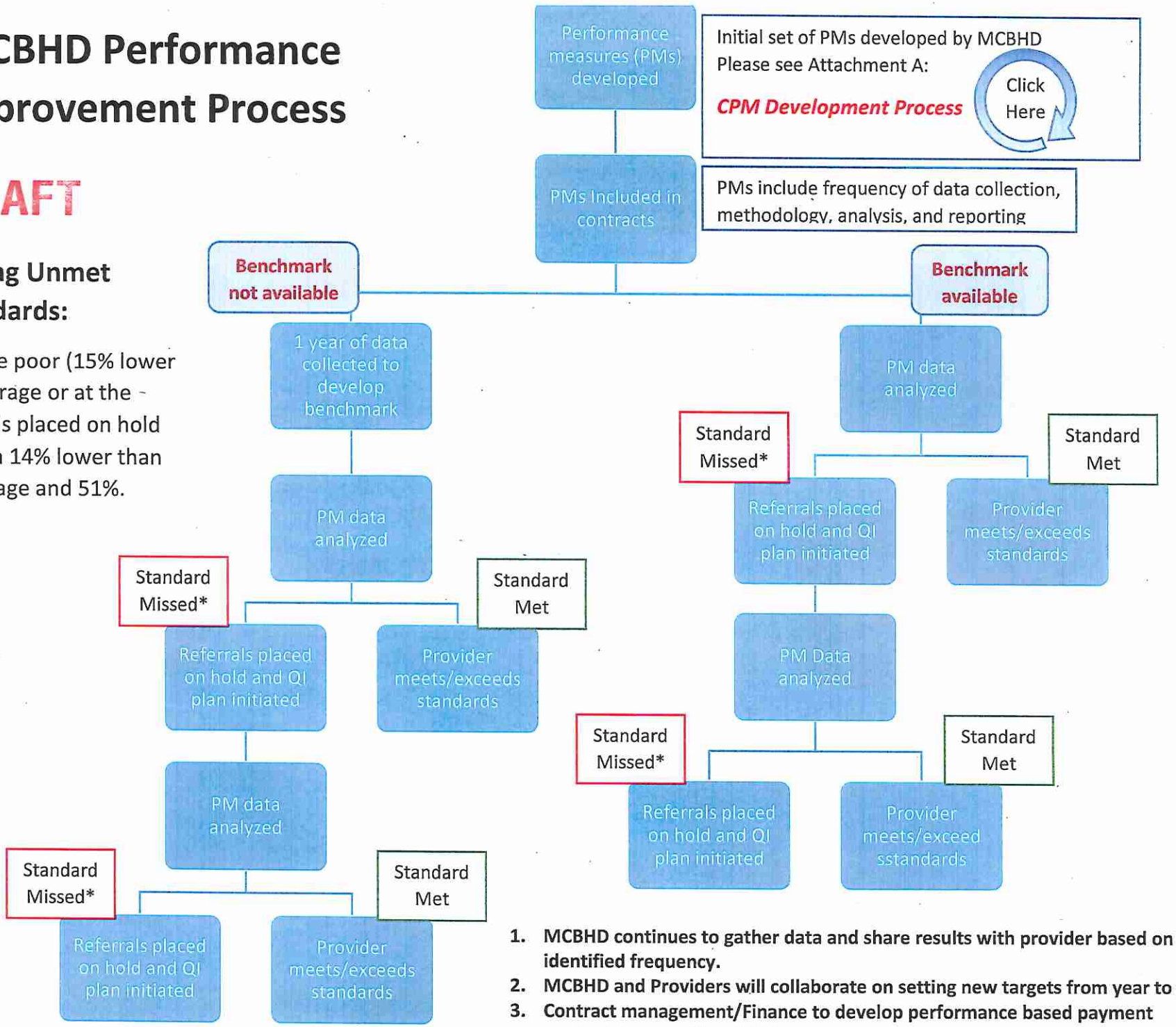


MCBHD Performance Improvement Process

DRAFT

* Defining Unmet Standards:

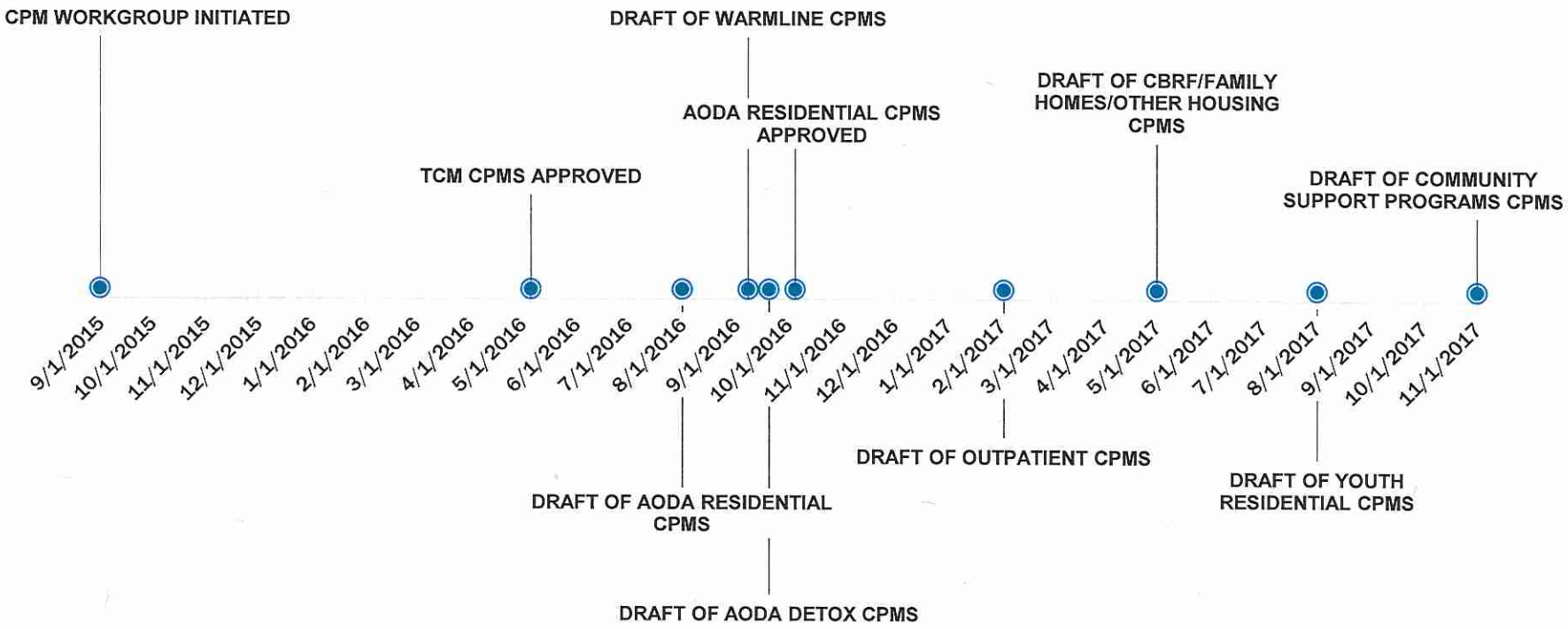
If data /results are poor (15% lower than national average or at the 50% rate) referrals placed on hold until results reach 14% lower than the national average and 51%.



1. **MCBHD continues to gather data and share results with provider based on identified frequency.**
2. **MCBHD and Providers will collaborate on setting new targets from year to year.**
3. **Contract management/Finance to develop performance based payment methodology starting 2018**

February 8, 2017

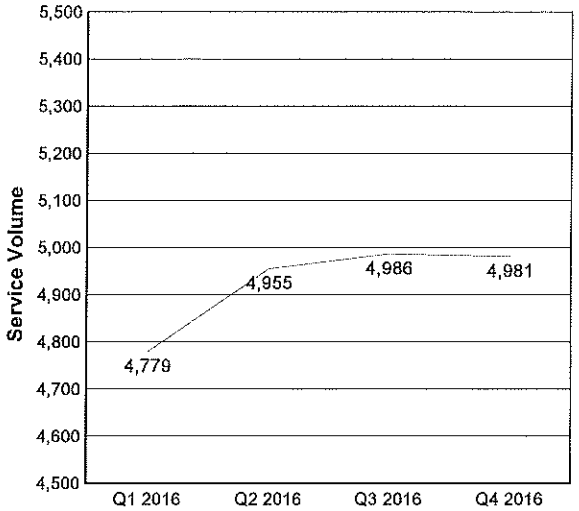
Contract Performance Measures Development Timeline: September 2015 to November 2017



CARS Quarterly Report

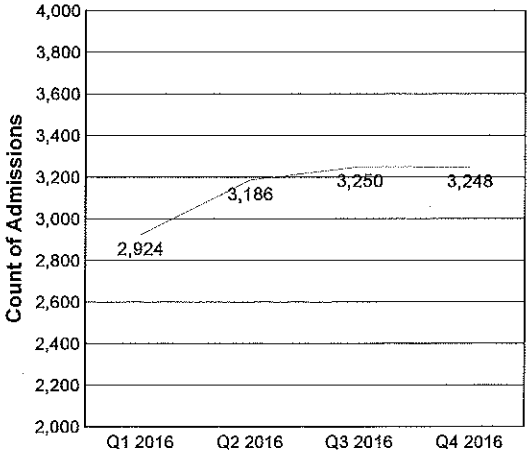
Number of Clients Receiving Service, By Program

	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Adult Family Home	14	14	13	14
Case Mgmt & After Care Support	106	88	69	83
CBRF	123	131	137	140
CCS	287	388	486	566
CLASP	80	71	79	79
Community Support Program	1,308	1,292	1,301	1,285
Crisis Case Management	77	96	126	144
CRS	37	34	35	35
Day Treatment (75.12)	24	31	29	24
Detoxification (75.07)	692	690	726	639
Med. Monitor Residentl (75.11)	2	1	1	1
MH Day Treatment	26	24	16	17
Outpatient 75.13	309	347	350	308
Outpatient-MH	45	55	53	58
Recovery House Plus OP/DT	34	21	17	20
Recovery Support Coordination	419	473	477	499
RSS-Employment	130	128	110	112
RSS-Family	4	5	0	0
RSS-Housing	110	116	112	106
RSS-Psych. Self Mgmt	60	60	46	38
RSS-School and Training	77	80	61	79
Targeted Case Management	1,476	1,487	1,472	1,513
Transitional Residential (75.14)	223	260	308	260
Total	4,779	4,955	4,986	4,981

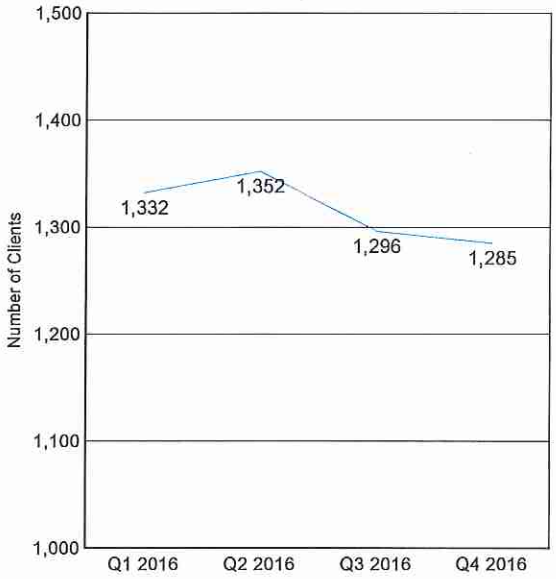


Admissions By Program

	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Adult Family Home	1	0	0	1
Case Mgmt & After Care Support	28	27	27	35
CBRF	12	18	17	12
CCS	63	121	117	113
CLASP	30	24	25	22
Community Support Program	54	50	47	100
Crisis Case Management	20	52	68	94
CRS	1	1	2	0
Day Treatment (75.12)	22	23	28	27
Detoxification	1,369	1,648	1,685	1,614
MH Day Treatment	10	9	6	6
Outpatient (75.13)	202	227	217	178
Outpatient-MH	194	91	115	111
Recovery House Plus OP/DT	44	19	18	16
Recovery Support Coordination	274	279	296	271
RSS-Employment	105	98	66	99
RSS-Family	4	2	0	1
RSS-Housing	67	53	66	63
RSS-Psych Self Mgmt	28	26	38	15
RSS-School and Training	76	77	51	88
Targeted Case Management	117	118	127	186
Transitional Residential	203	223	234	196
Total	2,924	3,186	3,250	3,248



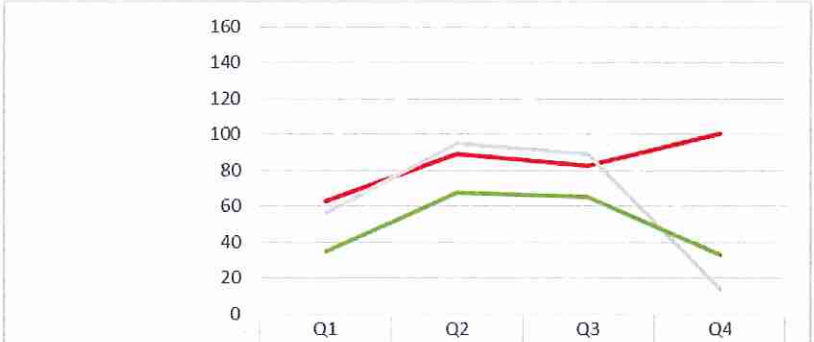
Referrals/Intakes By Access Point



	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Total
Access Clinic at BHD	135	151	117	108	509
Access Clinic South	13	11	21	18	63
CARS	380	422	414	435	1,468
IMPACT	400	343	290	301	1,283
JusticePoint	49	40	38	32	151
M & S	202	223	226	231	863
UCC	43	43	56	46	185
WCS	159	161	166	149	624
Total	1,332	1,352	1,296	1,285	4,760

Wait List - Number of Days from Referral to Admission

CSP, Day Tx, CBRF, TCM



	Q1	Q2	Q3	Q4
CBRF	96	138	104.67	39.00
CSP	63	88.83	82.67	100.57
Day Treatment MH	56.4	94.92	88.86	14.00
TCM	34.84	67.37	65.13	32.98

AODA Transitional Residential

Program	Q1	Q2	Q3	Q4
CBRF				
# of Clients	1	5	3	2
CSP				
# of Clients	24	30	24	21
Day Treatment MH				
# of Clients	5	12	7	2
TCM				
# of Clients	83	103	109	141
Total	113	150	143	166

CARS Referral Process Improvement NIATx Project - Update

Reducing Time from Referral to Admission

Scope: In the last 3-4 years, the number of referrals to CARS for services has increased by almost 70%. The number of staff to process referrals has not increased in a commensurate way, nor has capacity in the various programs. As such, the time from referral to enrollment in services is hovering around 65 days, and most programs have a wait list for admission.

AIM: Reduce time from referral to admission by at least 25%.

Silent Idea Generation (Plan):

- Align paper referral form to Avatar referral
- Increase responsibility of clerical staff
- One service manager responsible for intake process and supervise staff
- Determine current referral rate and set standard for number of screens and AC assignments
- Set standard for number of days to get screens done and measure it
- Minimize what is needed for a complete referral – only require what is needed for eligibility determination
- Move TCM services to a FFS environment

Redesign Recommendations (Do):

- Create a dedicated Intake Team (for TCM, CSP, Day Tx and CBRF)
    - 1 New Service Manager
    - 8 Dedicated Admin Coordinators
    - Dedicated clerical support to assist with data entry of referrals and/or sending information to providers to verify diagnosis/get records
    - Screening process is removed – ACs complete referral from start to finish
    - Set benchmarks starting with referral: face to face visit for assessment, completion of CARS referral form, completion of CARP, verify diagnosis, make LOC recommendation and place on wait list (taking client choice of agency into account)

Analysis (Study):

- Measure following timeframes:
    - Date referral received to date referral considered complete – **Median: 0 Mean: 4**
    - Date completed referral is assigned to date assessment is complete – **Median: 16 Mean: 17**
    - Date placement decision is made to date of program admission – **Median: 8 Mean: 18**
- Compare actual results to predicted results. Has the change resulted in improvement?
    - **Overall wait time reduction over last 3 quarters (see Quarterly Report)**
- What have we learned?

Next Steps (Act):

- Should the change be permanently adopted or adjusted?
    - **Yes, baselines established. Next step: set goal/benchmark.**
- What should the next cycle be? **Q1 2017**
- Adopt which ideas from earlier planning?
    - **TBD – will revisit old ideas, brainstorm new ideas to help achieve goals.**

Quality Committee Item 6

Milwaukee County Behavioral Health Division (BHD) Client Experience Workgroup

2/1/17

The BHD Client Experience workgroup was assembled in June 2016 to implement a consistent patient/client satisfaction survey process for Acute Inpatient Service, CARS Division, and Wraparound Milwaukee. The workgroup began by reviewing the following: current patient/client satisfaction survey tools, distribution and collection methods, data entry, analysis/reporting, client satisfaction survey targets, and timeliness of report creation.

Through the workgroup's efforts, it became apparent that the client satisfaction surveys BHD is utilizing are no longer the industry standard, and that BHD may need a 3rd party vendor to receive an impartial and consistent client experience survey process. Utilizing Modern Healthcare Magazine's 2015 list the Largest Patient Satisfaction Measurement Firms, the Client Experience workgroup received and reviewed the behavioral health client satisfaction surveys from companies on that list. Of the top 8 firms, only Press Ganey, National Research Corporation, SPH Analytics, and Professional Research Consultants offer behavioral health client satisfaction services.

The consensus of the workgroup was to further investigate the utilization of Press Ganey's services for the following reasons: Press Ganey's in/outpatient behavioral health survey templates were the closest match to BHD's services, Press Ganey surveys can be modified allowing BHD to design custom surveys with national benchmarks, Press Ganey provides a custom survey item database with benchmark capabilities, Press Ganey provides services to 45% (n=539) of U.S. inpatient psychiatric facilities and maintains a 92% market share in Modern Healthcare's 2015 Top 10 list of patient satisfaction measurement firms, and pricing is at or below its competitors.

Over the past couple of months, the workgroup has been teleconferencing with Press Ganey representatives to discuss: a potential BHD - Press Ganey in/outpatient behavioral health client satisfaction survey, survey customization for BHD programs, distribution methods, and reporting formats. Recently, BHD has obtained a quote from Press Ganey to provide client satisfaction survey services for all of BHD programs. The attached documents contain a table displaying BHD client volumes by program and a draft Press Ganey contract for their services.

Milwaukee County Behavioral Health Division - Press Ganey Proposal

1/20/2017

Survey	Survey Group	Program	Discharges
Inpatient	Acute Adult	Acute Adult Inpatient Service	680
		Observation	806
	Child/Adolescent	Child/Adolescent Inpatient Service	622
Total Inpatient Surveys (Handout Method)			**2,108**

Survey	Survey Group	Program	Clients Surveyed
Outpatient	Crisis Services	Adult Mobile Team	1,943
		CART	104
		CCT - Mobile	46
		Crisis Mobile - Adult	2,086
		Gero Mobile Team	46
		PCS	8,400
	Treatment	Access Clinic	623
		Adult Family Home	16
		CBRF	153
		Crisis Respite Bell - Martin	33
		Crisis Respite Bell - Silverlawn	97
		Crisis Respite TLS	145
		Community Recovery Services	39
		Day Treatment (75.12)	44
		Detoxification	2,064
		Med Monitor Residential (75.11)	1
		MH Day Treatment	45
		Outpatient (75.13)	827
		Outpatient-MH	133
		Transitional Residential	657
	Care Management	Case Mgmt & After Care Support	192
		CLASP	142
		Community Support Program	1,423
		Crisis Case Management	226
		Recovery Support Coordination	1,106
		Targeted Case Management	1,839
	RSS/Social Services	RSS-Employment	380
		RSS-Family	4
		RSS-Housing	278
		RSS-Psych Self Mgmt	122
		RSS-School and Training	271
	Wraparound	Wraparound	4,000
	Access Point	CARS	1,468
		IMPACT	1,283
		Justice Point	151
		M & S	863
		UCC	185
		WCS	624
Total Outpatient Surveys (Handout Method)			**32,059**
Grand Total - Clients Surveyed			**34,167**

Quality Committee Item 7

QUALITY MANAGEMENT SERVICES UPDATE
Compliment, Complaint, Grievance Team Charter
EXECUTIVE SUMMARY

Milwaukee County Mental Health Board - Quality Committee Meeting

March 6, 2017

Compliment, Complaint, Grievance Project Charter Team managed by Heidi Ciske-Schmidt, HIPAA Compliance Officer / Critical Incident Officer, Milwaukee County - Wraparound Milwaukee Quality Assurance. **Team** includes Sherrie Bailey-Holland, Quality Assurance, Client Rights Specialist, Inpatient and Community Services; Anastasia E. Vega, Contract Compliance Specialist, Contract Management Department; Yolanda Harvey, Collections Specialists, DHHS - BHD; Jasmine Greene, Peer Support Supervisor; Dr. Steve Dykstra – BHD Mobile Urgent Treatment Team Director; Jennifer Bergersen, DHHS - BHD Chief Clinical Officer

Purpose: To develop a centralized, effective electronic methodology to track *all BHD* compliments, complaints, grievances and appeals, and to develop mechanisms to utilize client feedback data for service enhancement and improvement.

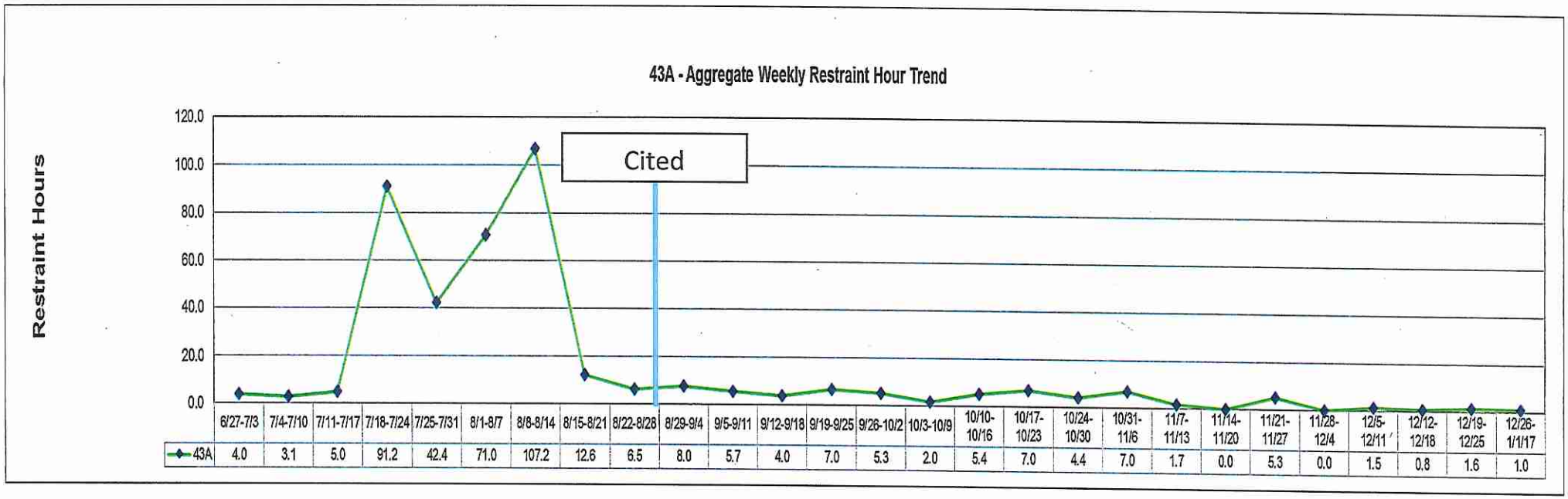
Current Progress:

- **October 2016:** Completed mapping of current processes and workflows for CARS, PCS, Acute, and Wraparound Milwaukee; engaged the State Grievance Examiner, Laura O'Flanagan, in ongoing discussions on the redesign process for Compliments, Complaints, and Grievances to ensure compliance with DHS 94 and DHS 51; participated in demonstration of Verge, along with IMSD - BHD representative.
- **November 2016:** Follow-up phone meeting with Verge representatives to better understand the "Patient Relations" module and opportunities for customization for BHD.
- **December 2016:** Secured contract with Verge for the "Safety Suite" comprised of Patient Relations (Compliment, Complaint, Grievance) and Incident Reporting modules.
- **January 2017:** Participated in review of the "Patient Relations" module with Verge. Scheduled weekly phone meetings with Verge representatives to begin "building" content; requested connection to other Wisconsin Verge clients (i.e., Aurora Health Care, Agnesian Healthcare, The Monroe Clinic, and Meriter Health Services).

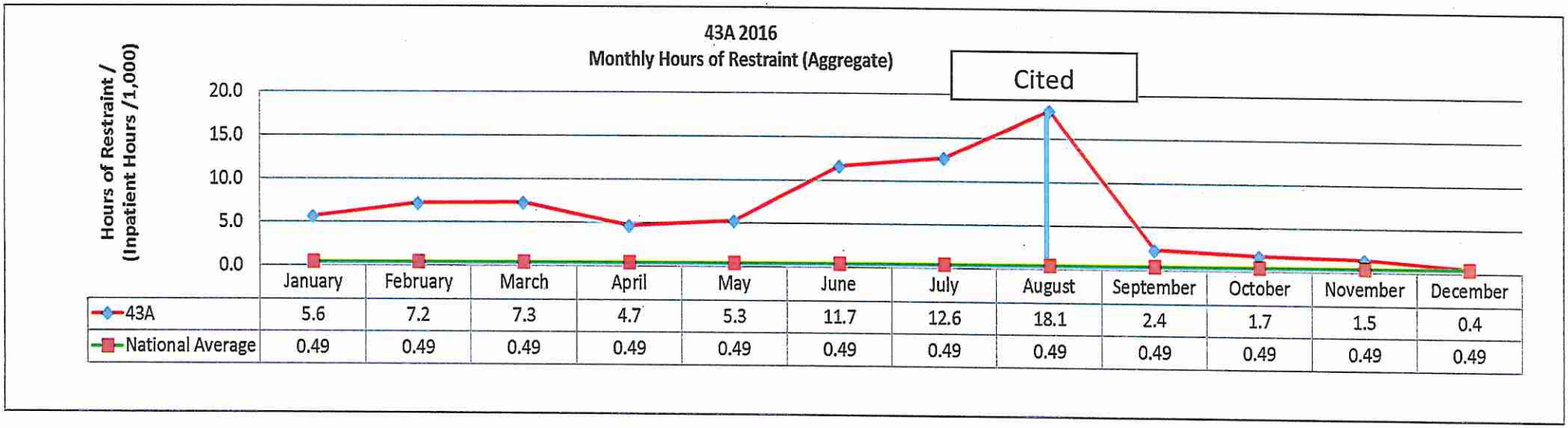
Projected Timeline:

- **February – April 2017:** Working with Verge best practice templates to customize content and work flow for BHD; training to Verge-users (manger/director of an area, a client rights specialist and/or an administrators); developing future state *work flow* for BHD staff; developing future state *client flow* for those filing Compliments, Complaints, and Grievances; updating and redesign of marketing collateral (brochures, posters, flyers) to clearly inform and education clients receiving substance use and mental health services of their client rights.
- **May 2017:** Pilot of new platform and process of collecting and responding to Compliments, Complaints, and Grievances.
- **June 2017:** Refinement of process, content, etc.... gleaned from pilot findings.
- **July 2017:** Full scale implementation of the Compliment, Complaint, Grievance protocol using the Verge platform.

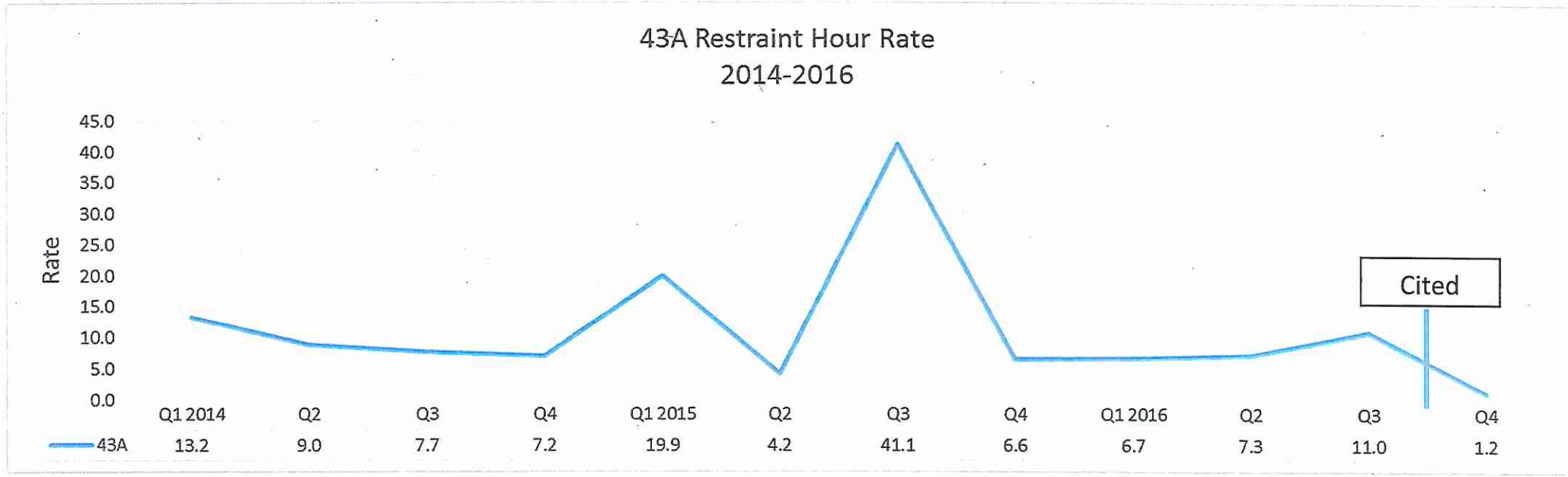
Quality Committee Item 8

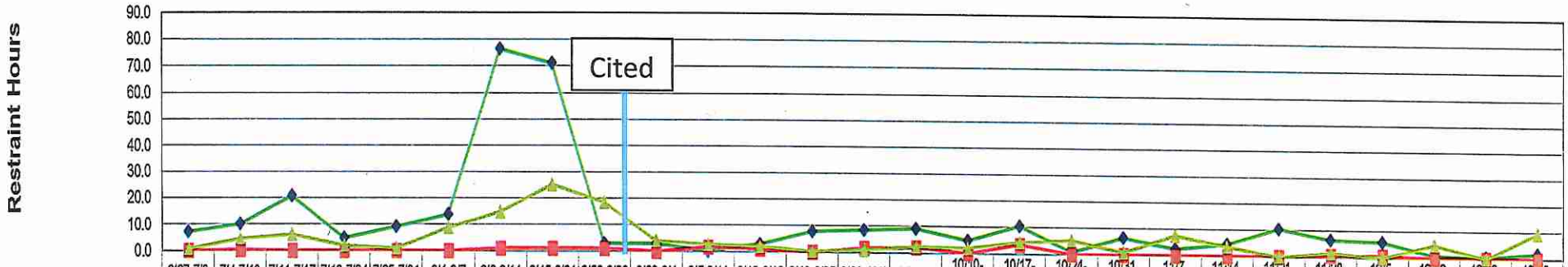


	6/27-7/3	7/4-7/10	7/11-7/17	7/18-7/24	7/25-7/31	8/1-8/7	8/8-8/14	8/15-8/21	8/22-8/28	8/29-9/4	9/5-9/11	9/12-9/18	9/19-9/25	9/26-10/2	10/3-10/9	10/10-10/16	10/17-10/23	10/24-10/30	10/31-11/6	11/7-11/13	11/14-11/20	11/21-11/27	11/28-12/4	12/5-12/11	12/12-12/18	12/19-12/25	12/26-1/1/17
43A	4.0	3.1	5.0	91.2	42.4	71.0	107.2	12.6	6.5	8.0	5.7	4.0	7.0	5.3	2.0	5.4	7.0	4.4	7.0	1.7	0.0	5.3	0.0	1.5	0.8	1.6	1.0

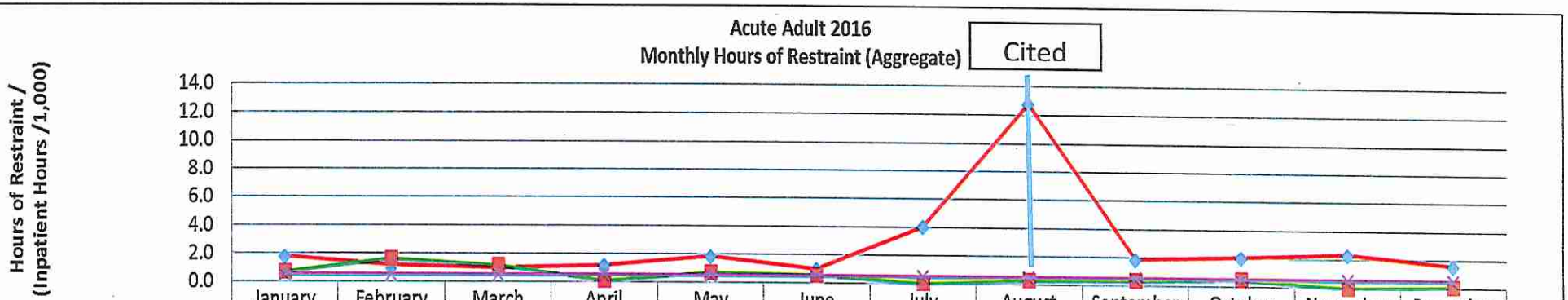


	January	February	March	April	May	June	July	August	September	October	November	December
43A	5.6	7.2	7.3	4.7	5.3	11.7	12.6	18.1	2.4	1.7	1.5	0.4
National Average	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49

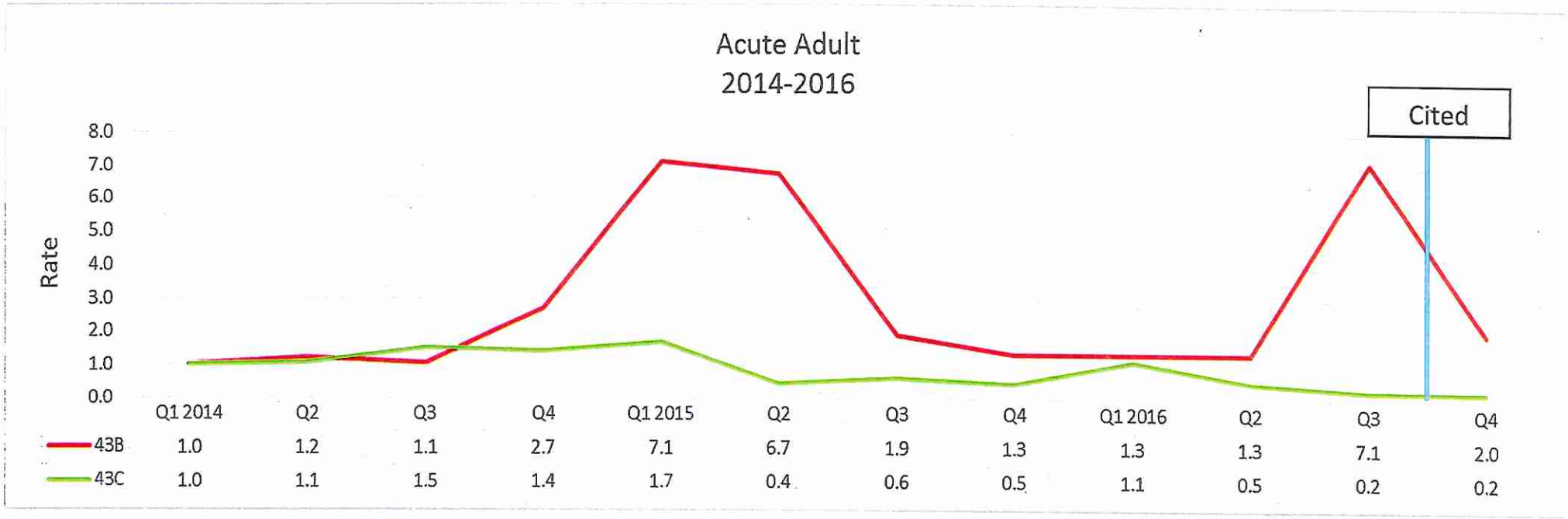

43A Restraint Hour Rate
2014-2016
Rate
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Cited
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
43A
13.2
9.0
7.7
7.2
19.9
4.2
41.1
6.6
6.7
7.3
11.0
1.2



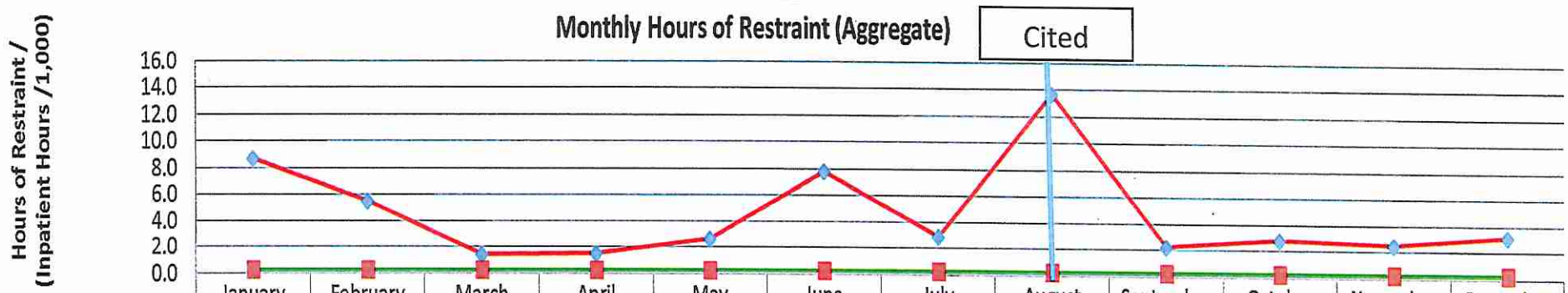
	6/27-7/3	7/4-7/10	7/11-7/17	7/18-7/24	7/25-7/31	8/1-8/7	8/8-8/14	8/15-8/21	8/22-8/28	8/29-9/4	9/5-9/11	9/12-9/18	9/19-9/25	9/26-10/2	10/3-10/9	10/10-10/16	10/17-10/23	10/24-10/30	10/31-11/6	11/7-11/13	11/14-11/20	11/21-11/27	11/28-12/4	12/5-12/11	12/12-12/18	12/19-12/25	12/26-1/1/17
43B	7.2	10.1	20.9	4.9	9.2	14.0	76.6	71.4	3.0	2.9	0.5	3.0	8.0	8.5	9.3	4.9	10.6	1.0	6.5	2.7	4.8	10.7	6.7	6.1	1.0	0.8	1.9
43C	0.0	0.3	0.0	0.0	0.0	0.1	0.9	1.0	1.1	0.0	1.8	1.0	0.0	1.6	2.0	0.0	3.4	0.1	0.0	0.0	0.0	0.0	0.7	0.6	0.0	0.0	0.0
53B	0.8	4.6	6.4	2.2	1.0	8.8	14.7	25.2	18.5	4.1	2.6	2.0	0.5	1.0	2.2	2.1	4.3	5.3	1.0	7.6	3.5	0.0	1.8	0.0	5.0	0.0	9.7



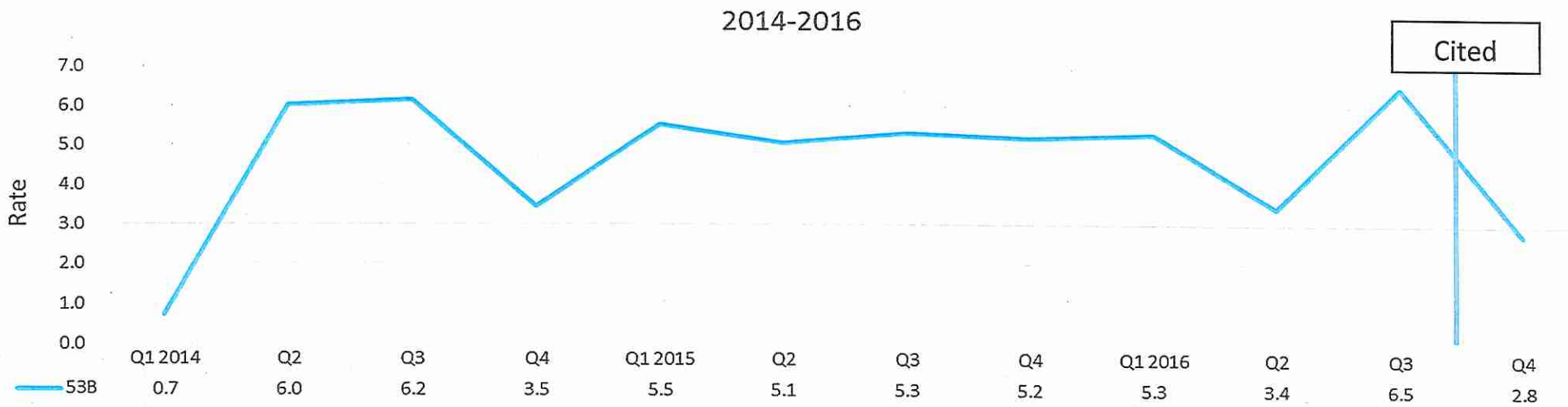
	January	February	March	April	May	June	July	August	September	October	November	December
43B	1.8	1.2	1.0	1.1	1.8	1.0	4.0	12.8	1.8	2.0	2.3	1.6
43C	0.7	1.6	1.2	0.1	0.7	0.6	0.0	0.3	0.4	0.5	0.0	0.1
National Average	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49	0.49



	Q1 2014	Q2	Q3	Q4	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4
43B	1.0	1.2	1.1	2.7	7.1	6.7	1.9	1.3	1.3	1.3	7.1	2.0
43C	1.0	1.1	1.5	1.4	1.7	0.4	0.6	0.5	1.1	0.5	0.2	0.2



	January	February	March	April	May	June	July	August	September	October	November	December
53B	8.7	5.5	1.4	1.5	2.7	7.8	2.9	13.7	2.2	2.8	2.5	3.1
National Average	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26



	Q1 2014	Q2	Q3	Q4	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4
53B	0.7	6.0	6.2	3.5	5.5	5.1	5.3	5.2	5.3	3.4	6.5	2.8

Quality Committee Item 9

WRAPAROUND MILWAUKEE

Performance Based Measures

In an effort to ensure quality and best practice, be transparent, monitor performance, ensure correct processes are being followed and desired results are being achieved, measuring performance is crucial.

Wraparound Milwaukee has been tracking the outcomes of established performance measures (PM) for our contracted Care Coordination services since 1999. These outcomes are presented bi-annually in a document called the Agency Performance Report (APR), see attached. As programs under the Wraparound Milwaukee "system of care" evolved and expanded, the need to establish PM's in these new areas became paramount.

Over the past couple years, efforts have been underway to establish PM's measures within several of the programs under the Wraparound "system of care". Attached is a graph reflecting the status of the PM's that have been established for Wraparound Milwaukee programs to this date. Many of the PM's have been tracked for years while others are newly established and still under "construction".

Also attached are two handouts defining the PM's, scoring methodology/formulas associated with the measure, how they are tracked, where they are tracked and any correlating threshold levels of performance that have been established.

Respectfully Submitted,

Pamela Erdman MS, OTR
Wraparound Milwaukee Quality Assurance Director

WRAPAROUND MILWAUKEE - PERFORMANCE INDICATORS

PROGRAM/AREA NAME	Standard	Wraparound Care Coordination Agencies	REACH Care Coordination Agencies	O'YEAH Transition Coordination Agencies	Professional Foster Care Program	Mobile Urgent Treatment Team	City Trauma Response Initiative	Wraparound Consultants/ Coaches	CORE Program
Average Number of Families Served		X	X	X					X
Percentage of High-Risk Youth Served		X	X						X
Percentage of CHIPS Youth Served		X							
Percentage of Delinquent Youth Served		X							
Percentage of PIVOT Youth Served		X							
Percentage of CORE Youth Served			X						
# of Disenrollments		X	X	X					X
# of New Enrollees			X	X					X
% of New Enrollees with Up-Front Placements		X							
% of enrolled young adults visiting Owen's Place at least 1X during APR time period				X					
Number of Positive Recognition Announcements received		X	X	X		X			X
INDICATORS									
1) Level of Family Satisfaction	>=4.0	X	X	X		X			All CORE indicators are the same and incorporated within REACH data with exception of the following: #2 - Need to create another Disenrollment formula for...
2) Level of Disenrollment Progress	>=75	X	X	X					
3A) % of Days in a Home-Type Setting	>=75%	X							
3B) % of Days in a Home-Type Setting -PIVOT ONLY	>=60%	X							
Weighted Points for 3A and 3B		X							
4) Informal Supports: Attendance at Team Meetings	>=50%	X	X						
5) % Weekly F-to-F Contacts /% of F-to-F Contacts (MUTT)	>=85%/TBD	X	X			X			
6) Informal Supports: % Included in POC Strategies	>=50%	X	X						
7) % Team/POC Meetings Held Monthly	>=85%	X	X						
8) % of POCs/Future Plans approved on time (Time to Program Approval)	>=95%	X	X	X					
9) % School Days Attended	>=85%	X	X						
10) # Families Activities	6	X	X	X					
11) Progress Note Documentation Timeliness	>=95%	X	X	X		X			
12) Evaluation Tool Submission	>=85%	X	X	X					
13) % Legal & Temp COPs Submitted on Time	>=85%	X							
14) Submission of Facilitator Reviews	3/mo. (18)	X	X						
15) % Care Coordinator/Transition Coordinator Transfers	<= 10%	X	X	X					
16) % of Staff Departures	<= 10%	X	X	X					
17) # Substantiated Complaints	0	X	X	X					
18A) Avg. Expenditures Per Month	See columns	X (<=$3,900)	X (<=$1,800)	X (>=$1,500)					
18B) Avg. Expenditures Per Month -PIVOT	<= $4,400	X							
19) Mandatory Inservice Attendance	>= 85%	X	X						
20) Audit Compliance Score	>= 90%	X	X	X					
21) % of Court Letters Sent Back to Agency	TBD	X							
22) % of Court Letters being approved at least 9 days before the court hearing	TBD	X	X						
23) % of POCs Sent Back to Agency	TBD	X	X						
24) Supv/Lead Attendance at Team Meetings for New CCs	TBD	X	X						
25) Supv/Lead Attendance at Court Hearings for New CCs	TBD	X							
26) Compliance with Consulting Psychologist / Psychiatrist Quarterly Reviews	TBD	X	X	X					
27) Officers are able to successfully contact clinician on first attempt to make a referral.	TBD						X		
28) MPD receives relevant data from MUTT on Trauma Response referrals	TBD						X		
29) Reduction in long term or more serious impact on mental health and well-being that may result from untreated response to traumatic event.	TBD						X		
30) All 140 officers in District 7 receive the training, have a working knowledge of the initiative, know how to make referrals and gain a better understanding of the impact of traumatic events and the role they play.	TBD						X		
31) MUTT clinicians gain a better understanding of the nature of incidents. MPD learn how to better identify scenarios appropriate for trauma response referral.	TBD						X		
32) % of ED (Emergency Detentions) diversions	TBD					X			
33) Employment Indicator - Madison Model/Dartmouth - Pnina	TBD								X
34) Every week the youth will meet with the therapist, peer support specialist and employment specialist.	>=85%								X
35) % of Future Plans timeliness (Initial in 30 days and every 90 days thereafter)	>=85%			X					
36) Continuing Education Attendance Compliance	100%			X					
37) Bi-weekly contact (call or face to face)	>=85%			X					
38) % of Futures Plans that have a Mental Health <u>and</u> a Transition Domain	100%			X					
39) % of Young Adults who Completed the Program	TBD			X					

Those indicators marked with a red X reflect that they are in the process of being implemented.
Those columns/programs with no X's indicate that performance measures are being finalized or established.

WRAPAROUND MILWAUKEE - AGENCY PERFORMANCE REPORT DATA

AGENCY NAME	Standard	Agency A		Agency B														Average
Average Number of Families Served		84		81														
Percentage of High-Risk Youth Served		32%		33%														
Percentage of CHIPS Youth Served		28%		40%														
Percentage of Delinquent Youth Served		72%		60%														
# of Disenrollments		21		23														
% of New Enrollees with Up-Front Placements		29%		35%														
SCORED INDICATORS			Points		Points													
1) Level of Family Satisfaction	>=4.0	4.4	20	4.8	20													
2) Level of Disenrollment Progress	>=75	69.4	18.7	76.2	20													
3A) % of Days in a Home-Type Setting	>=75%	71.0%	14.2	61.0%	12.2													
3B) % of Days in a Home-Type Setting -PIVOT ONLY	>=60%																	
Weighted Points for 3A and 3B																		
4) Informal Supports: Attendance at Team Meetings	>=50%	53.0%	10	59.0%	10													
5). % Weekly F-to-F Contacts	>=85%	87.2%	10	87.7%	10													
6) Informal Supports: % Included in POC Strategies	>=50%	37.7%	3.7	46.3%	4.6													
7) % Team/POC Meetings Held Monthly	>=85%	90.5%	5	86.0%	5													
8) POC Documentation Timeliness (Time to Program Approval)	>=95%	87.0%	4.5	95.3%	5													
9) % School Days Attended	>=85%	88.4%	5	86.3%	5													
10) # Families Activities	6	6	5	4	3.4													
TOTAL SCORE - OUT OF 100 POINTS		**96.1**		**95.2**														
ADDITIONAL REVIEW ITEMS																		
1) Progress Note Documentation Timeliness	>=95%	95.2%		98.3%														
2) Evaluation Tool Submission	>=85%	86.0%		69.0%														
3) % Legal & TempCOPs Submitted on Time	>=85%	74.6%		88.0%														
4) Submission of Team Observation Measure	3/mo. (18)	17		18														
5) # Care Coordinator Transfers	< = 10%	9%		29%														
6) # Staff Departures	< = 10%	10%		30%														
7) # Substantiated Complaints	0	1		0														
8A) Avg. Expenditures Per Month	< = $3,900	3,957		3,678														
8B) Avg. Expenditures Per Month - PIVOT	< = $4,400																	
9) Mandatory Inservice Attendance	> = 85%	90.0%		86.2%														
10) Audit Compliance Score (POC Audit)	> = 90%	87.9%		92.4%														
11) % of Court Letters Sent Back to Agency	TBD																	
12) % of POC's Sent Back to Agency	TBD																	
13) Supr./Lead Attendance at Team Meetings for New CC's	TBD																	
14) Supr./Lead Attendance at Court Hearings for New CC's	TBD																	
15) Compliance with Consulting Psychologist/Psychiatrist Quarterly Reviews	TBD																	

SAMPLE

SHADED BOXES REPRESENT THOSE INDICATORS BELOW THE SET STANDARD

APR SCORED INDICATORS - WRAPAROUND February 2016 – August 2016 (unless otherwise indicated)	Standard	Scoring	If meet threshold
1) Level of Family Satisfaction *Data taken from Family Satisfaction Surveys.(EXCLUDES Disenrollment Progress Reports).*	>=4.0	Score * 5.0	20
2) Disenrollment Level of Progress Average Score *Level of success is calculated based on: 1) Program completion; 2) Level of Needs Met Per Final POC and 3) Parent and Youth Disenrollment Progress Report Scores* **Time Frame: Dec 1, 2015 – May 31, 2016 disenrollments**	>=75	Score * .27	20
3A) % Days in a Home-Type Setting – non-PIVOT(FOCUS) youth only *Data taken from Placement tab. Home-type settings are: home, independent living, foster care (pre-adoptive and sustaining foster care only – not transitional), kinship, relative and legal guardian placements.*	>=75%	Score * .20	15
3B) % Days in a Home-Type Setting – PIVOT(FOCUS) only *Same as above – only PIVOT youth.* ***NOTE: The data for 3A and 3B will be averaged on a weighted basis when calculating the number of points earned per agency. PIVOT data is scored separately only if the agency percentage of PIVOT youth is 5% or more.*	>=60%	Score * .25	(if included – it is weighed with the above)
4) Informal Supports: Attendance at Team Meetings *Data taken from Team Meeting Progress Notes. Looking for at least one person coded as an Informal Support to be at the team meeting In Person.*	>=50%	Score * .20	10
5) % of Weekly Face to Face Contacts *Data taken from finalized progress notes. Face-to-face time is required with BOTH the youth AND parent or primary caregiver. The # of weeks a family was assigned to an agency is divided by the # of weeks with documented face-to-face contact.* **Time Frame: January 1, 2016 –June 30, 2016**	>=85%	Score * .1176	10
6) Informal Supports: % Included in POC Strategies *Data taken from "Person Responsible" section of Need Statements within POC approved by the program during the APR time frame.* ***ALL POC's are included in the data.*** *The count of unique formal & informal supports is calculated; the number of informal supports is divided into that count. Informal supports are individuals who are generally not paid to provide services, and include family members (other than youth & parent(s)), friends, neighbors, faith-based supports and kinship providers.*	>=50%	Score * .10	5
7) % Team / POC Meetings Held Monthly *Data taken from finalized progress notes. For every month an agency bills for more than 27 days of care coordination, a progress note coded as Team/POC Meeting, with at least 0.5 hours of face-to-face contact, should be present.* **Time Frame: January 1, 2016 –June 30, 2016**	>=85%	Score * .0588	5
8) POC Documentation Timeliness (Time to Program Approval) *Data taken from POCs approved by the Program during the APR time frame. POCs are to be entered and approved on Synthesis within 2 weeks of the Plan of Care meeting date. The number of days from the POC meeting date to the date of program approval is calculated for each POC. The number of POCs approved on time is then divided by the total number of POCs entered by the agency.*	>=95%	Score * .0525	5
9) % School Days Attended *Data taken from POC Statistics tab for all POCs approved by the program during the APR time frame. The # days attended is divided into the number of days possible each month to come up with an attendance percentage each month. Attendance data provided for months PRIOR TO enrollment is not included.*	>=85%	Score * .059	5
10) # Family Activities *Data will be based on flyers or other information provided to the QA Department by Supervisors. The expectation is that agencies hold one family activity monthly.*	6	# Activities *.83	5
	TOTAL IF ALL THRESH-HOLDS ARE MET		**100**

ADDITIONAL REVIEW ITEMS - WRAPAROUND	Standard
1) Progress Note Documentation Timeliness *Progress Notes must be written within seven (7) working days of contact. The number of days from contact to data entry is calculated for each progress note. The number of Progress Notes entered on time is then divided by the total number of Progress Notes entered by the agency.*	>=95%
2) Evaluation Tool Submission *All youth should have complete YSR and CBCL tool sets at the time of disenrollment (intake, 6 months, 1 year, yearly updates and disenrollment). Disenrollment tool not required if the previous tools are less than 60 days old. Tools must be completed within 30 days of the due date to be accepted.* **Time Frame: Dec 1, 2015 – May 31, 2016 disenrollments**	>=85%
3) % Legal and Temporary COPs Submitted on Time *Data will be taken from Legal and Temporary COPs approved during the APR time frame. The total number of COPs/Temp COPs approved will be divided by the # of those forms submitted outside of the time frames set forth in the Change of Placement policy.*	>=85%
4) Submission of Facilitator Reviews *Agencies will submit 3 reviews per month to the Wraparound QA Department.*	18
5) % Care Coordinator Transfers *Number of times that a youth is transferred from one Care Coordinator to another. Data includes both inter- and intra-agency transfers. Calculated by dividing the # transfers by the average number of families served during the time frame.*	<=10%
6) % Staff Departures *The percentage of staff that have left the care coordination unit. This does NOT include those CC's that transfer from WRAP to REACH or those that move into a Lead/Supervisory role. Calculated by dividing the # of departures by the average number of care coordinators during the time frame*	<= 10%
7) # Substantiated Complaints *Self-explanatory. Taken from Synthesis complaint database*	0
8A) Average Expenditures Per Month *Average amount paid by service month /per youth.* **Time Frame: Dec 1, 2015 – May 31, 2016 disenrollments**	<=$3,900
8B) Average Expenditures Per Month – PIVOT(FOCUS) *Average amount paid by service month/ per PIVOT youth.* **Time Frame: Dec 1, 2015 – May 31, 2016 disenrollments**	<=$4,400
9) Mandatory Inservice Attendance (not adjusted for excused absences) *Data is based on ACTUAL ATTENDANCE. Employee must both SIGN IN and SIGN OUT for attendance to be counted.*	>=85%
10) Audit Compliance Scores *Self-explanatory.*	>=90%
11) % of Court Letters Sent Back to Agency *Percentage of Court Letters that are sent back at least once from the Wraparound approval level prior to eventual approval*	TBD
12) % of POC's Sent Back to Agency *Percentage of POC's that are sent back at least once from the Wraparound approval level prior to eventual approval*	TBD
13) % of Supr./Lead Attendance at Team Meetings for New CC's *Self-explanatory. Data taken from CC Progress Notes for those CC's that have been employed for less than 6 months*	TBD
14) % of Supr./Lead Attendance at Court Hearings for new CC's *Self-explanatory. Data taken from CC Progress Notes for those CC's that have been employed for less than 6 months*	TBD
15) % of Compliance with Consulting Psychologist/Psychiatrist Quarterly Reviews *Self-explanatory. Data taken from notes entered by the Consultants in Synthesis*	TBD
16) % of Court Letters Approved 9 Days Before the Court Hearing *Self-explanatory. Data pulled comparing the date the court letter was CREATED in Synthesis to the Date of Court Hearing field.* **Time Frame: Jan 1, 2016 – June 30, 2016**	TBD

APR SCORED INDICATORS – O'YEAH February 1, 2017 – July 31, 2017 (unless otherwise indicated)	Standard	Scoring	If meet threshold	Report Group/Name of Report
1) Level of Enrollee Satisfaction *Data taken from Engagement and Planning Surveys. Distributed at 1 month, 6 months, 1 year and yearly thereafter.*	>=4.0	Score * 7.5	30	O'YEAH/???????
2) Disenrollment Level of Progress Average Score *Level of success is calculated based on: 1). Program completion, 2). Level of Need met per final Futures Plan, 3). Disenrollment Progress Report* **Time Frame: Dec 1, 2016 – May 31, 2017 disenrollments**	>=75	Score * .334	25	O'YEAH/???????
3) % of Bi-Weekly Contacts (call or face to face) *Data taken from finalized progress notes. The # of weeks a young adult was assigned to an agency is divided by the # of weeks with documented face-to-face or telephone contact.* **Time Frame: Jan 1, 2017 – June 30th, 2017**	>=85%	Score * .176	15	O'YEAH/Bi-Weekly Contacts
4) % of Futures Plans approved on time (time to program approval) *Data taken from Future Plans approved by the Program during the APR time frame. Future Plans are to be entered and approved on Synthesis within 2 weeks of the Futures Plan meeting date. The number of days from the Futures Plan meeting date to the date of program approval is calculated for each Futures Plan. The number of Future Plans approved on time is then divided by the total number of Future Plans entered by the agency.*	>=85%	Score * 118	10	O'YEAH-Agency/Number of Days Between Futures Plans – Summary **and** Futures Plan Timeliness (Initial Plan) – Summary by Agency
5) # Family Activities *Data will be based on flyers or other information provided to the QA Department by agencies. The expectation is that each agency must hold three activities within a 6 month time period.*	3	# Activities * 1.67	5	Data maintained by WRAP QA Dept. – Send Flyer/Info. to Sylvia Cruz
6) % of Futures Plans that have Mental Health Domain and a Transition Domain. *Data will be pulled monthly (as this is a point in time report) from all Futures Plans that were approved during the review time frame and then will be averaged for the 6 month APR period.*	100%	Score * .05	5	O'YEAH - Agency/Domain Checks (current enrollees)
7) % of Future Plans Timeliness (Initial in 30 days and every 90 days thereafter)	>=85%	Score * .117	10	O'YEAH-Agency/Number of Days between Futures Plans - Summary
	TOTAL IF ALL THRESH-HOLDS ARE MET		**100**	

ADDITIONAL REVIEW ITEMS – O'YEAH	Standard	Report Group/Name of Report
1) Progress Note Documentation Timeliness *Progress Notes must be written within seven (7) working days of contact. The number of days from contact to data entry is calculated for each progress note. The number of Progress Notes entered on time is then divided by the total number of Progress Notes entered by the agency.*	>=95%	O'YEAH -Agency/O'YEAH Progress Note Entry Timeliness
2) % Transition Coordinator Transfers *Number of times that a young adult is transferred from one Transition Coordinator to another. Data includes both inter- and intra-agency transfers. Calculated by dividing the # transfers by the average number of young adults served during the time frame.*	<=10%	O'YEAH/??????
3) % Staff Departures *The percentage of Transition Coordinators that have left the agency. This does not include a move into a Supervisory role. Calculated by dividing the # of departures by the average number of Transition Coordinators during the time frame*	<= 10%	Quality Assurance – APR/Staff Departures
4) % Evaluation Tool Submission *All enrollees should have completed the Domain Appraisal Tool (DAT) at intake (first 30 days), 6 months, 1 year, 18 months, etc. (every 6 months) and at disenrollment. Disenrollment DAT is not required if the previous tool is less than 60 days old. Tool must be completed within 30 days of the due date to be accepted.* **Time Frame: Dec 1, 2016 – May 31, 2017 disenrollments**	>=85%	O'YEAH/Tools By Month (Use for APR Tracking)
5) # Substantiated Complaints *Self-explanatory. Taken from Synthesis complaint database*	0	Vendor Admin Files/Administrative Files By Date
6) Average Expenditures Per Month *Average amount paid by service month /per young adult. Greater than $1,500.* **Time Frame: Dec 1, 2016 – May 31, 2017 disenrollments**	>=1,500	O'YEAH - Agency/O'YEAH - Average Costs for APR
7) Continuing Education Hours Compliance *Need 12 hrs. of documented CEU's every 6 months. Verification documentation must be submitted to the Wraparound QA Department after attendance at trainings/workshops/inservices.* **Time Frame: For Jan 1, 2017 – June 30, 2017 disenrollments**	100%	Data maintained by WRAP QA Dept. – Send CEU verification to Sylvia Cruz
8) Audit Compliance Scores *Self-explanatory.*	>=90%	QA Dept. to enter data per any audits conducted
9) % of Compliance with Consulting Psychologist/Psychiatrist Quarterly Reviews *Self-explanatory. Data taken from notes entered by the Consultants in Synthesis.*	TBD	O'YEAH - Agency/Psych Consult Notes – O'YEAH
10) % of Young Adults who Completed the Program *% of disenrolled clients in the six month APR time period for which the code of "Program Completed" was marked.*	TBD	O'YEAH/O'YEAH Disenrolls by Date

Quality Committee Item 10

Draft

PCS Hospital Transfer Waitlist Report

End of Year

2016

This report contains information describing all of 2016 are summarized as follows:

- 9 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 79.4%
- The 1,720 individuals delayed comprised 20.8% of the total PCS admissions (8,614)
- The median wait time for all individuals delayed was 5.0 hours
- The average length of waitlist per patient is 8.8 hours

Prepared by:
Quality Improvement Department

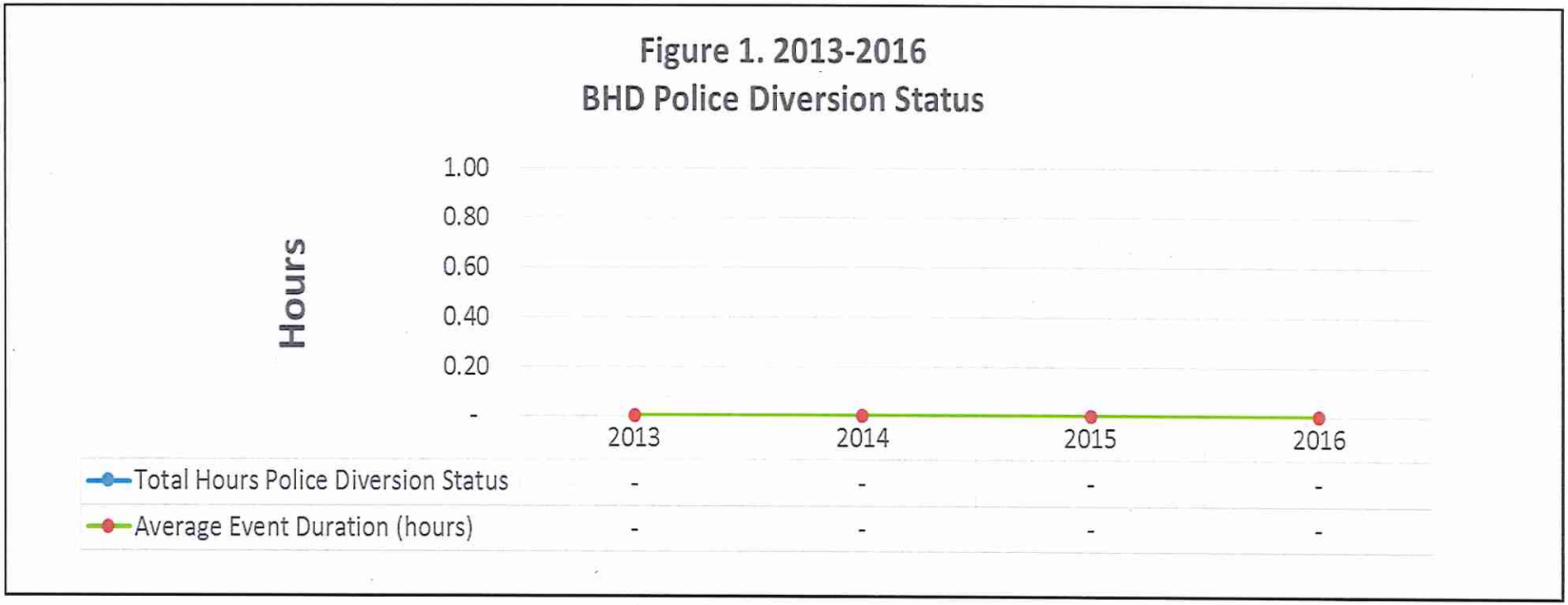
Date: January 12, 2017

Definitions:

Waitlist: When there is a lack of available beds between the Acute Inpatient Units and the Observation Unit. Census cut off is 5 or less open beds. These actions are independent of acuity or volume issues in PCS.

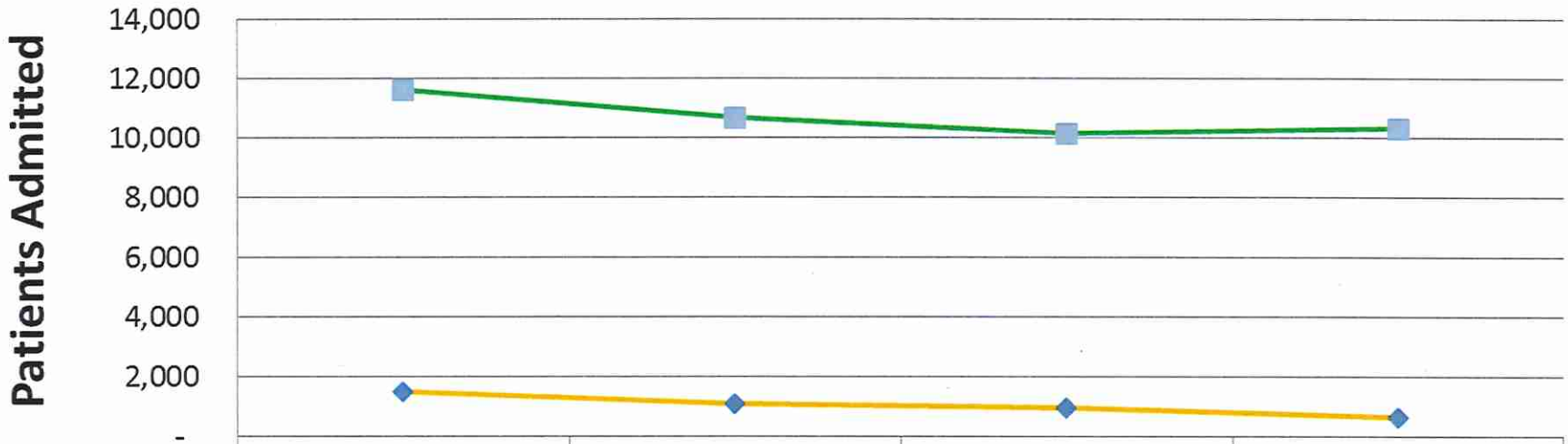
Diversion: A total lack of capacity in PCS and a lack of Acute Inpatient and Observation Unit beds. It results in actual closing of the door with no admissions to PCS allowed. Moreover, it requires law enforcement notification and Chapter 51 patients re-routed.

Reporting Time Period: The data in this report reflects three (3) years or the last twelve (12) quarters, unless specified otherwise.



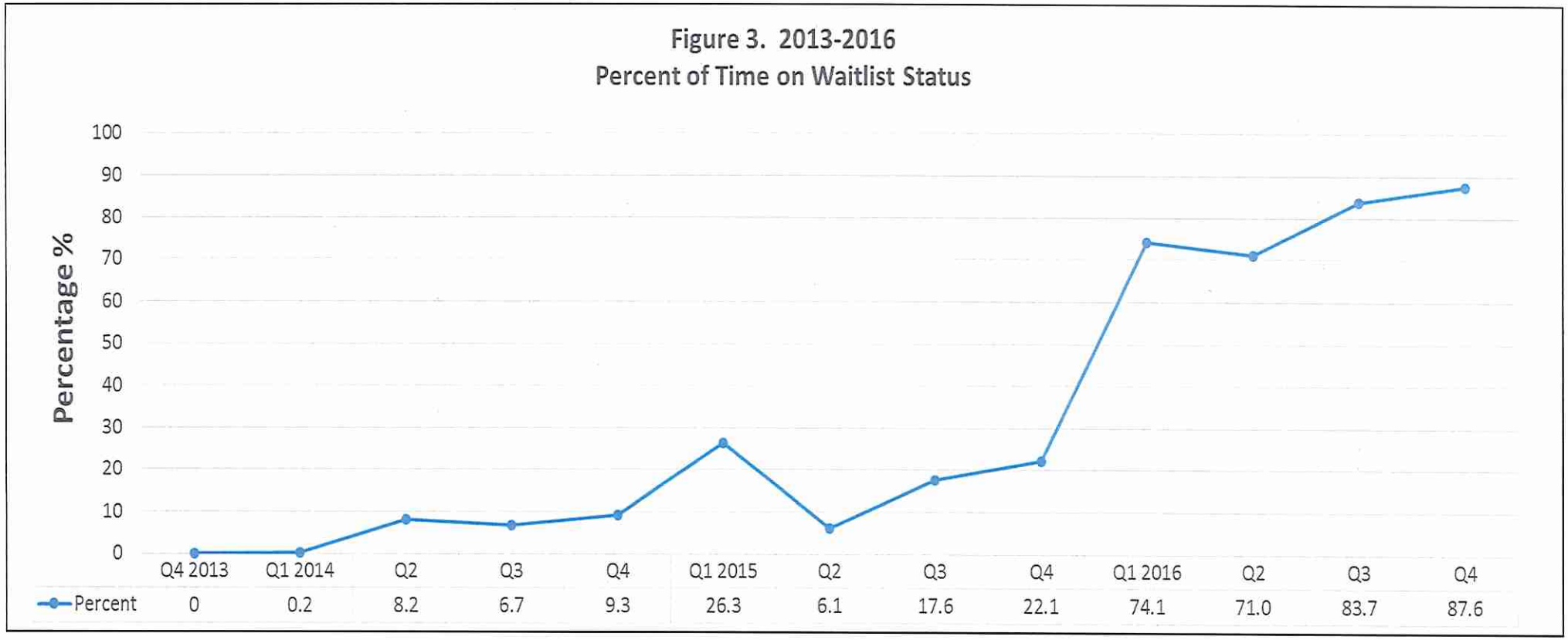
	2013	2014	2015	2016
Total Hours Police Diversion Status	-	-	-	-
Average Event Duration (hours)	-	-	-	-

*There have been no police diversion in the last 7 year, last police diversion was in 2008



	2013	2014	2015	2016
Acute Adult Admissions	1,489	1,093	965	683
PCS Admissions	11,644	10,698	10,173	10,334

*PCS Admissions = Projected Waitlist Clients + Projected PCS Clients



*Waitlist Percent = Waitlist Duration/ (Number of day in the quarter*24)

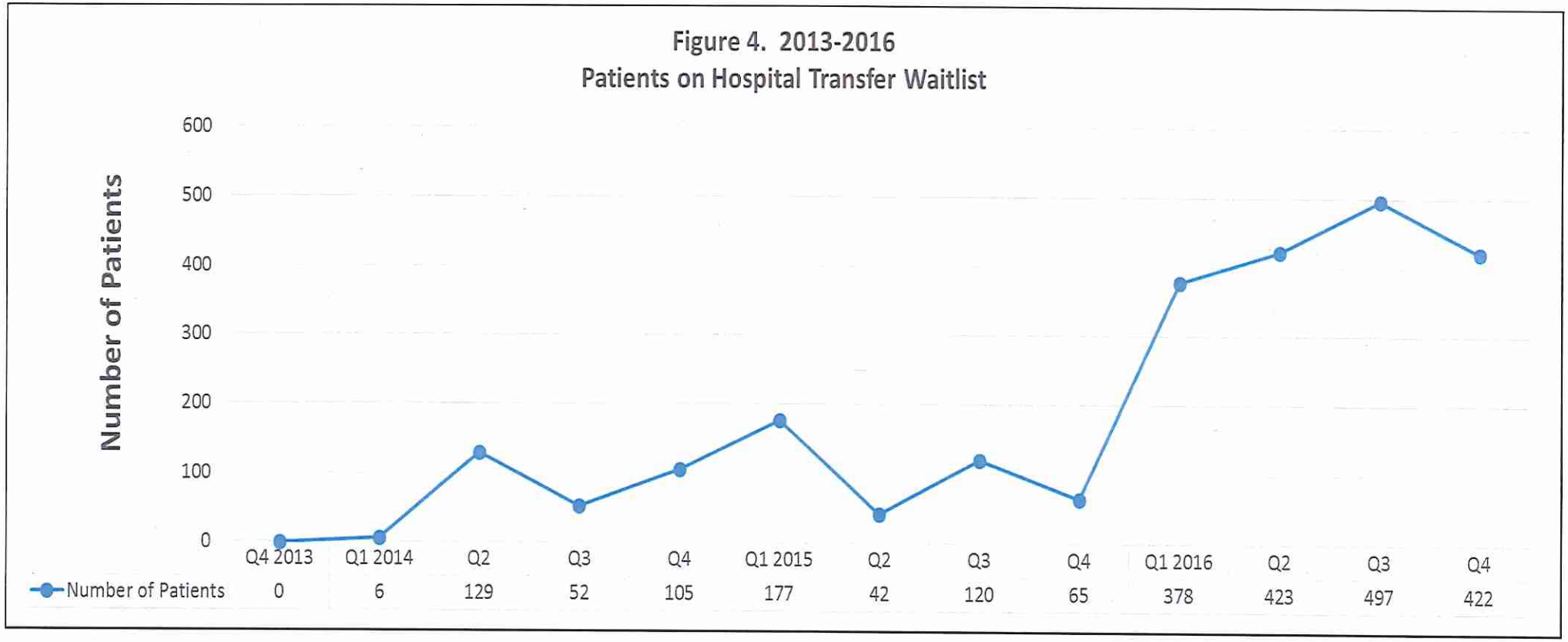


Figure 4. 2013-2016
Patients on Hospital Transfer Waitlist
Number of Patients
600
500
400
300
200
100
0
Q4 2013
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Number of Patients
0
6
129
52
105
177
42
120
65
378
423
497
422

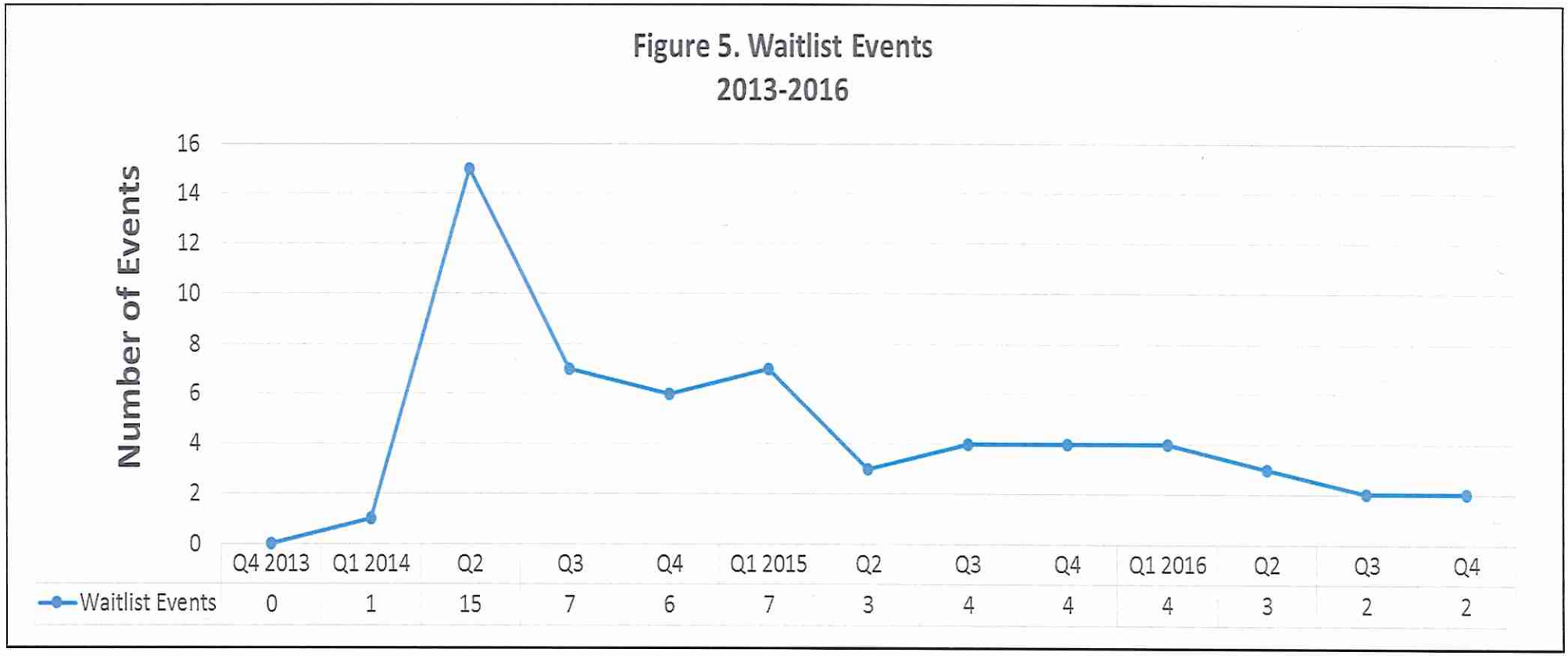


Figure 5. Waitlist Events
2013-2016
Number of Events
16
14
12
10
8
6
4
2
0
Q4 2013
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Waitlist Events
0
1
15
7
6
7
3
4
4
4
3
2
2

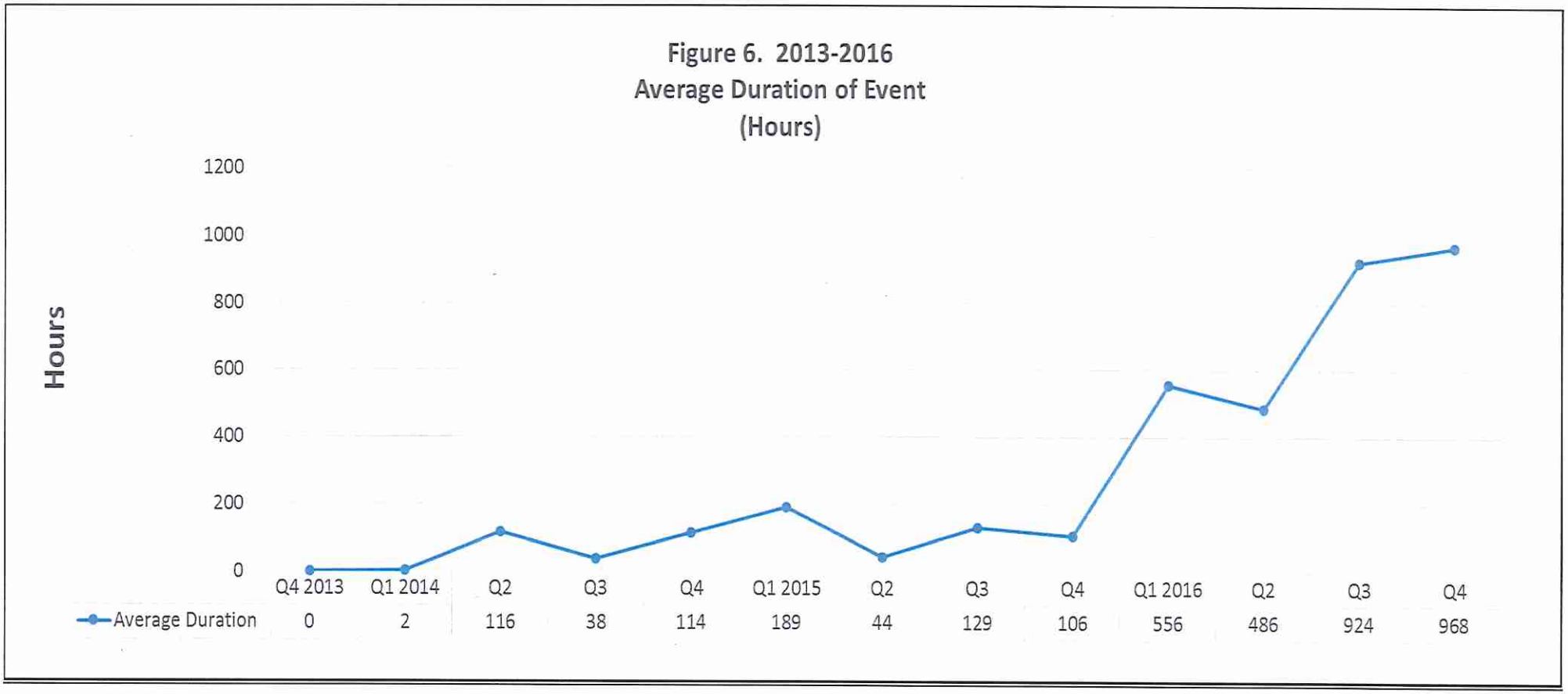


Figure 6. 2013-2016
Average Duration of Event
(Hours)
Hours
1200
1000
800
600
400
200
0
Q4 2013
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Average Duration
0
2
116
38
114
189
44
129
106
556
486
924
968

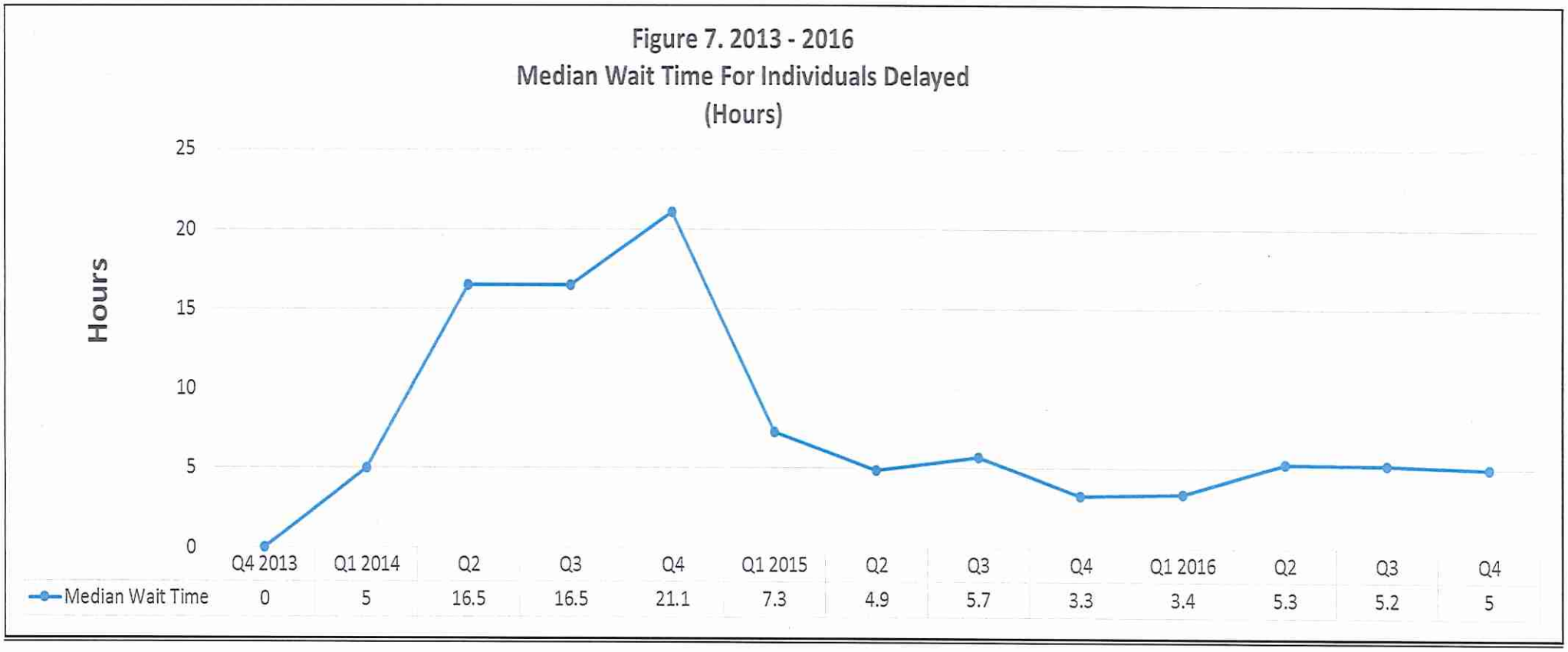


Figure 7. 2013 - 2016
Median Wait Time For Individuals Delayed
(Hours)
Hours
25
20
15
10
5
0
Q4 2013
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Median Wait Time
0
5
16.5
16.5
21.1
7.3
4.9
5.7
3.3
3.4
5.3
5.2
5

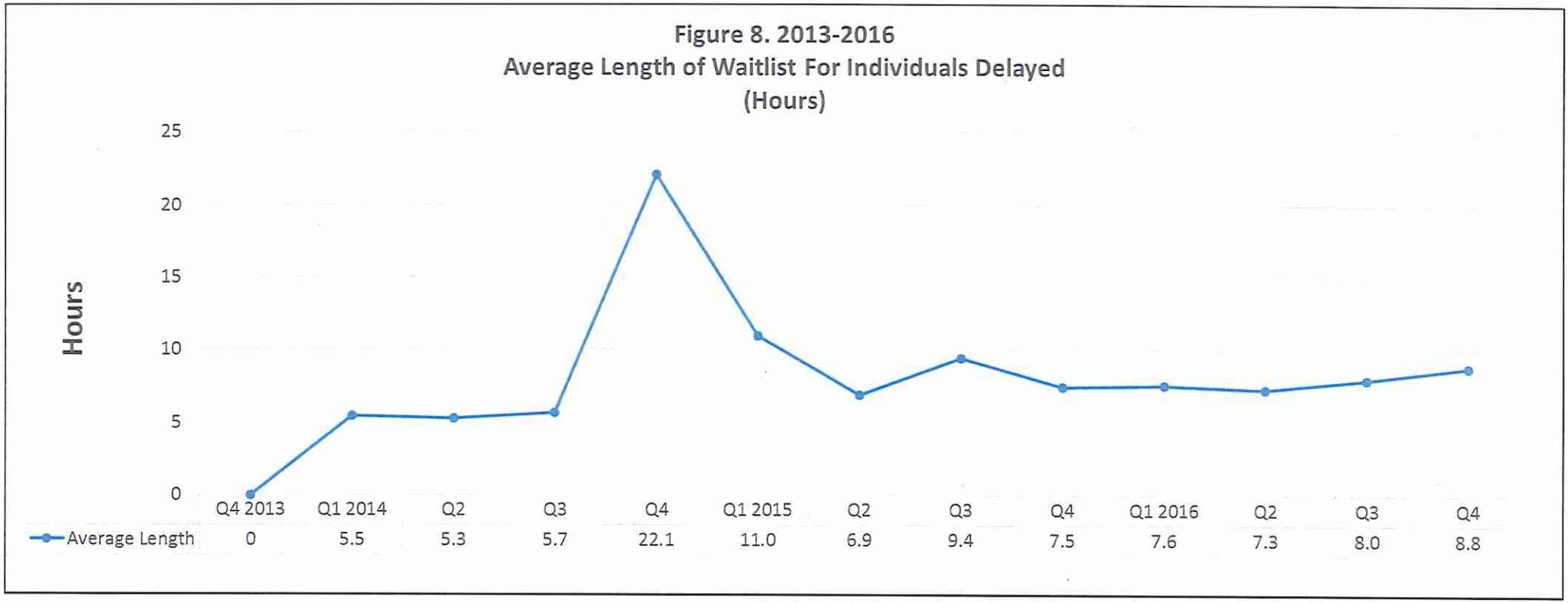
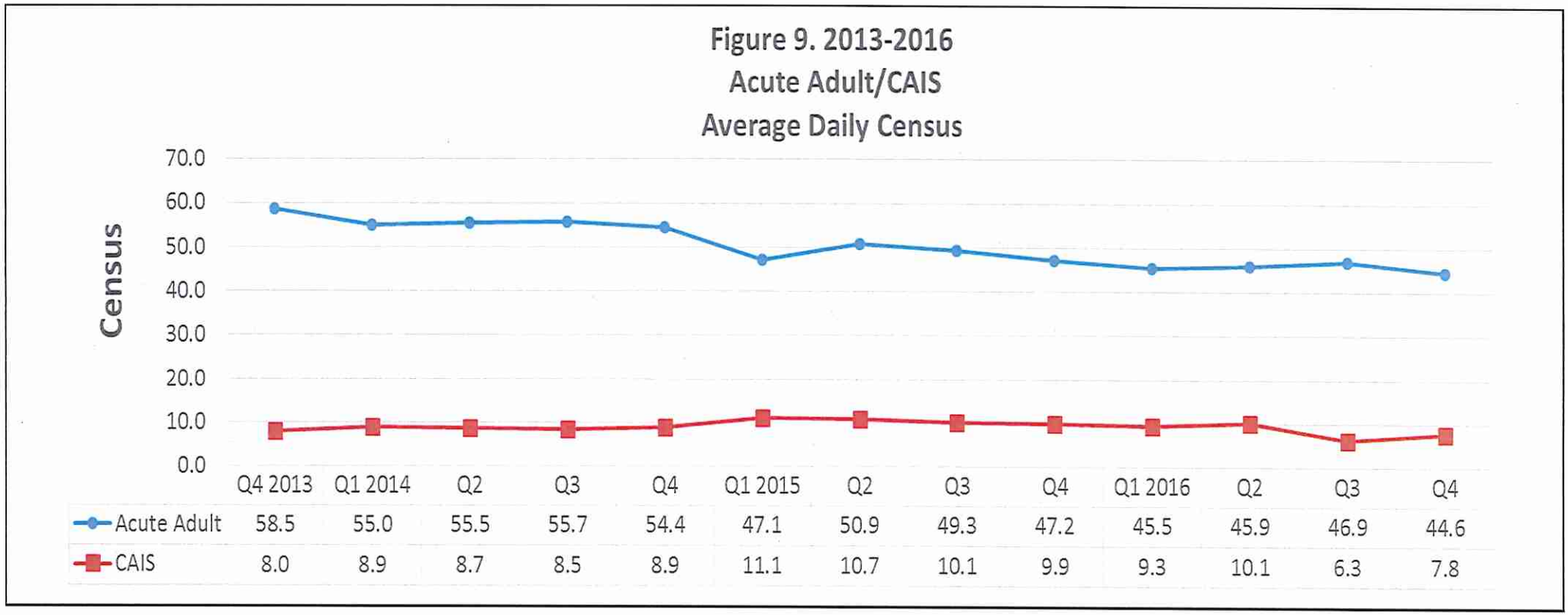
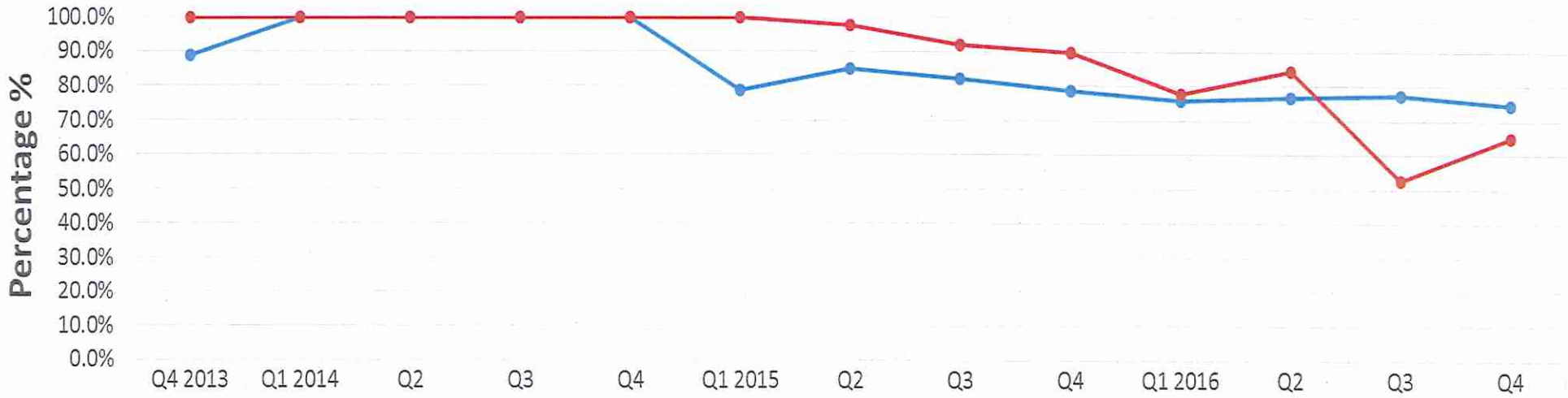


Figure 8. 2013-2016
Average Length of Waitlist For Individuals Delayed
(Hours)
Hours
25
20
15
10
5
0
Q4 2013
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
Average Length
0
5.5
5.3
5.7
22.1
11.0
6.9
9.4
7.5
7.6
7.3
8.0
8.8



	Q4 2013	Q1 2014	Q2	Q3	Q4	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4
Acute Adult	58.5	55.0	55.5	55.7	54.4	47.1	50.9	49.3	47.2	45.5	45.9	46.9	44.6
CAIS	8.0	8.9	8.7	8.5	8.9	11.1	10.7	10.1	9.9	9.3	10.1	6.3	7.8

*Average Daily Census = Patient days/amount of days per quarter



	Q4 2013	Q1 2014	Q2	Q3	Q4	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4
Acute Adult	88.7%	100.0%	100.0%	100.0%	100.0%	78.5%	84.8%	82.1%	78.7%	75.8%	76.7%	77.4%	74.4%
CAIS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	91.8%	89.8%	77.7%	84.3%	52.5%	65.0%

*Occupancy Rate = Patient's Day/ (Number of day in the quarter*number of beds budgeted)
*Reduced staffing impacted operation bed count

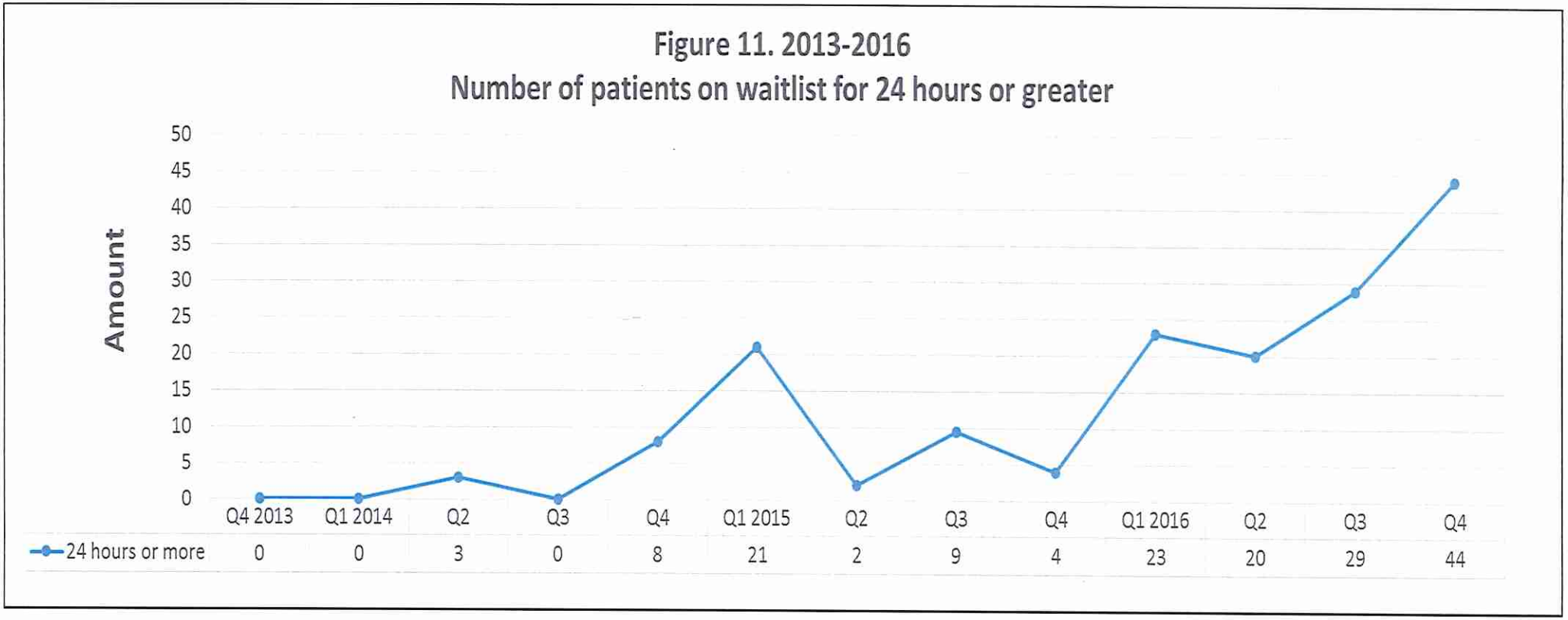
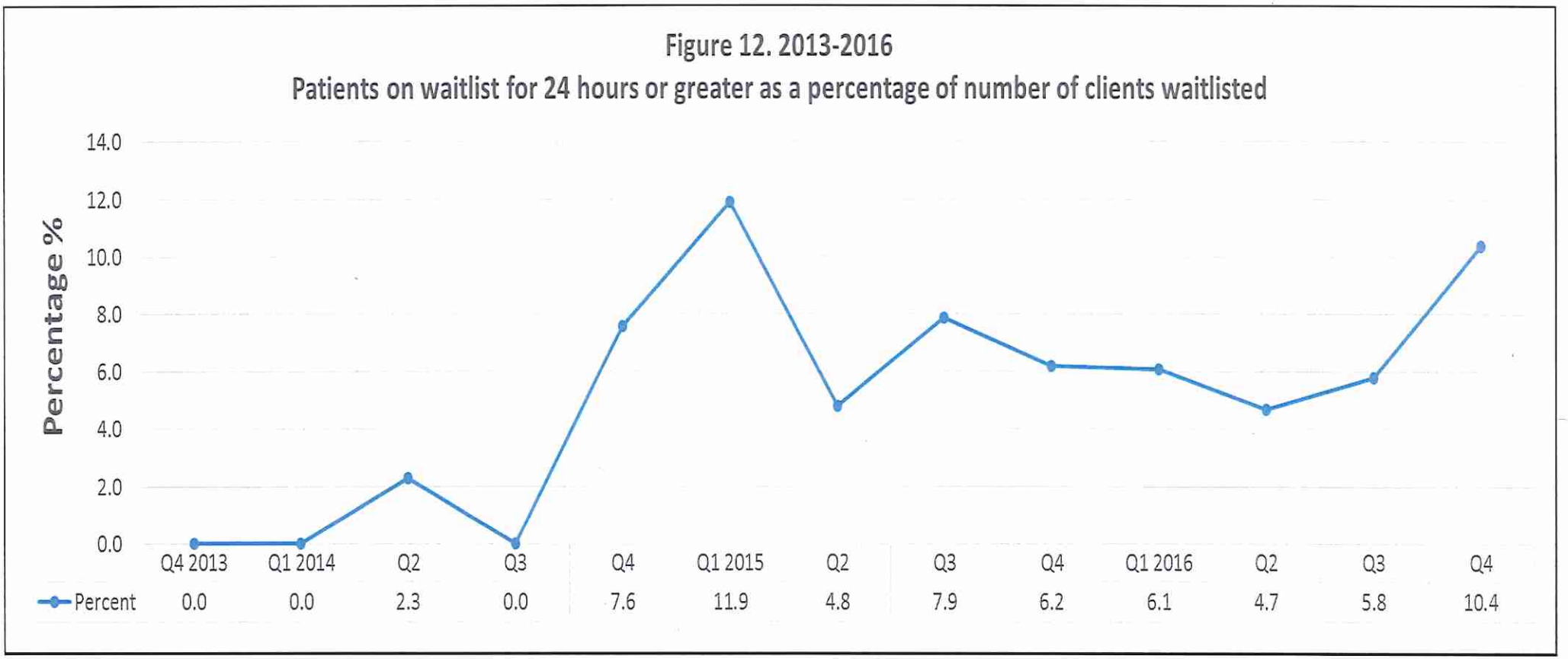
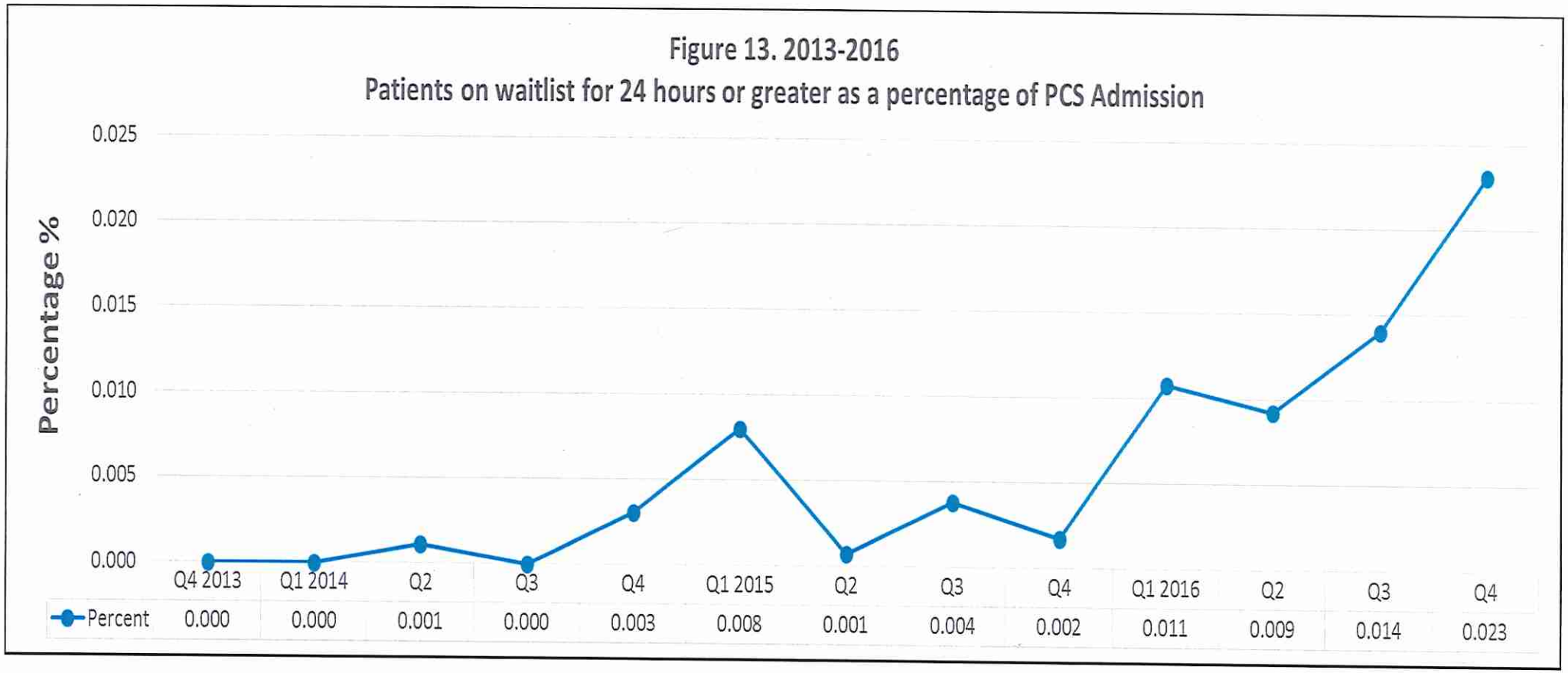


Figure 11. 2013-2016
Number of patients on waitlist for 24 hours or greater
Amount
50
45
40
35
30
25
20
15
10
5
0
Q4 2013
Q1 2014
Q2
Q3
Q4
Q1 2015
Q2
Q3
Q4
Q1 2016
Q2
Q3
Q4
24 hours or more
0
0
3
0
8
21
2
9
4
23
20
29
44



*Percent = Number of Patients on waitlist for 24 hours or greater/Number of Clients Waitlisted



*Percent = Number of Patients on waitlist for 24 hours or greater/PCS Admission

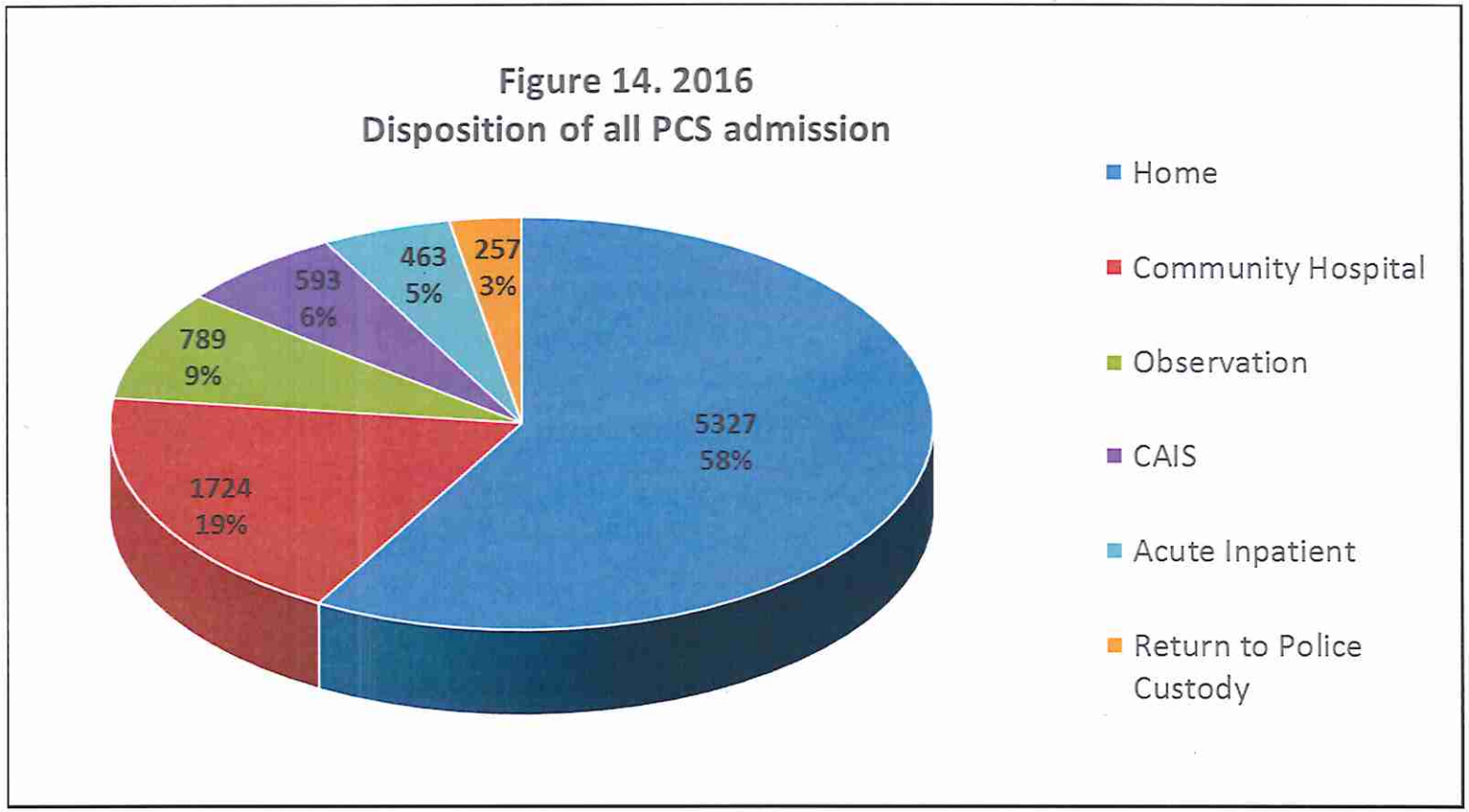


Figure 14. 2016
Disposition of all PCS admission
5327
58%
1724
19%
789
9%
593
6%
463
5%
257
3%
Home
Community Hospital
Observation
CAIS
Acute Inpatient
Return to Police Custody

Quality Committee Item 11

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: May 18, 2017

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 2016 Annual Review of the Environment of Care Program, and the 2017 Environment of Care Management Plans**

Issue

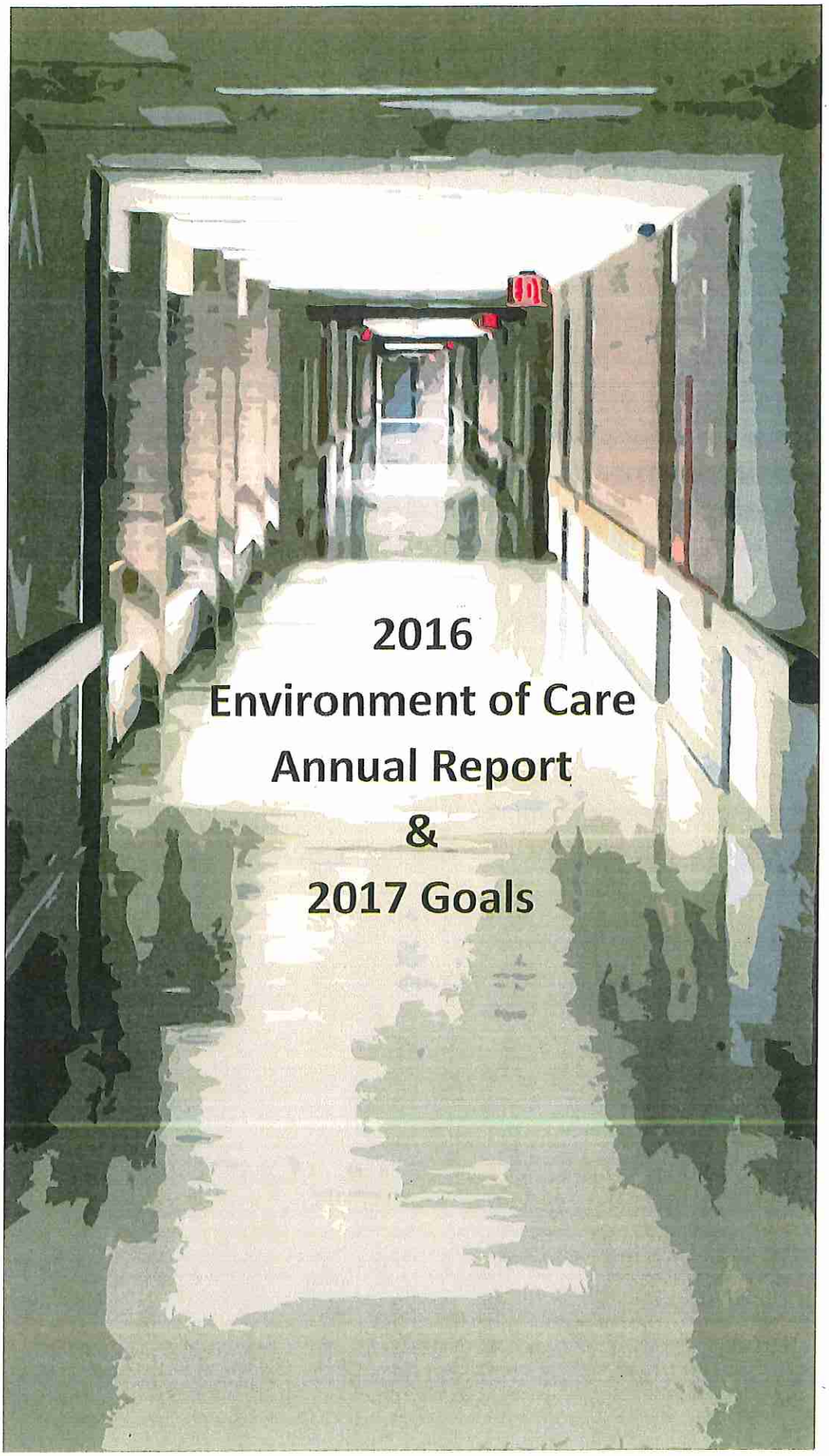
BHD is requesting the annual approval of the Environment of Care Annual Report and Management Plans per The Joint Commission Standards and the Mental Health Board By-laws.

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 2016 Annual Report of the Environment of Care program and the 2017 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.



2016 Environment of Care Annual Report & 2017 Goals

Introduction

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached are the 2017 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2016 improvements were made in the area of building security through the implementation of a new Public Safety Department that will enhance visitor experience and tracking. Additional work related to dividing the power provided by the emergency generator into the various required branches (critical, life safety, and mechanical) continues to move BHD toward compliance with The Joint Commission's requirements for emergency power preparedness.

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.

Environment of Care 2016 Annual Report and

2017 Goals

The BHD Environment of Care Management Plans were all reviewed and updated for 2017. Changes made included:

- Changes made to the BHD Mission and Vision in late 2015.

Highlights of achievements and 2017 Goals:

GENERAL SAFETY

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2015 85.3%. In 2016 98%. There were a total of 1267 recalls issued during 2016. Only 4 items involved in an alert or recall of a product purchased by BHD. All 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 achieved. Recommend continuing this goal in 2017

2. Annual Safety training was presented on various topics, including Regulated Medical Waste, Fire Safety. Results will be reviewed under the training topic area.
   - Educational goals will be identified in a separate Education section of this report.

3. Rounds documentation indicates that of the 157 findings, there are currently 94 items still pending and 63 have been completed. There continue to be issues with the interface between the work order system and the rounds system. Some items listed as pending have been completed, but not recorded.
   - The goal was not met in 2016. Recommend continuing with this goal in 2017. The new rounding system will be able to provide more accurate tracking of deficiencies and correction timeframes once working properly. Responders need additional training regarding entering corrections into the system.

SECURITY

Security improvements made at BHD include: Installation of a Key Watcher system for increased control of county vehicle keys. Separation of the entrance Safety and Security through use of a Public Safety Officer contract. In 2017 this contract will make improvements in visitor tracking. Additional security related policies and procedures continue to be drafted to further clarify practices.

1. Security Department Roll Call Updates: In 2016, 55 Roll Call Updates were issued. 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.
   - The goal for 2016 was met. The goal for 2017 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 Vandalism: In 2015 - 7 incidents. In 2016 there were 6 thefts, 3 minor property damage auto accidents.
   - The goal for 2017 will be limit the number of incidents to less than or equal to 5.

3. Unauthorized absences from locked units: In 2014 - 11 unauthorized absences from patient areas. In 2015 - 5 absences from locked BHD patient areas. In 2016 – 7 absences from locked units.
   - Although unauthorized absences are an inherent and recognized risk at BHD, no unauthorized absence is acceptable. As such, the goal for 2017 will be to reduce the total number of absences to zero.

4. Unsecured Area incidents: In 2015 - 5 incidents of unsecured areas. In 2016 there were 27 occurrences where a secured door was found unsecured. Most of these occurred when there was a damaged door and/or mechanical issue preventing the door from latching correctly.
   - In 2017, the goal will be increased to reflect the occurrence of both human factors as well as mechanical failures.. The goal will be to have 10 or fewer incidents in 2017.

5. In 2016 the Security Department tracked the number of camera outages and will report them to the Environment and Engineering Services Department (EES) within 1 hour. Additionally the outage would be repaired within 48 hours. In 2016 there were 27 camera outages reported, all were reported to EES within the 1 hour time frame. The 48 hour repair timeframe was unattainable by the service company due to a need to order replacement parts and time necessary for trouble shooting.
   - The goal for 2017 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. The repair timeframe aspect of this goal will be eliminated.

6. Additional goals may be added during the year to address aspects of the new Public Safety Services.

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. In 2016 the number was reduced to approximately 885# (average 74#/month) 2016 values included estimates for January, February and December. An infectious waste report will be filed with the Wi DNR once the site is open for submission for the year. In 2016 a change in sharps container management was made to utilize a reusable container. This may be responsible for some of the reduction in monthly weight totals. Additional education was also provided to nursing staff which may have 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. 81% of staff and contractors passed the training regarding Regulated Medical Waste. .
   - This goal will be moved to a new education section of this report.

2. A goal to achieve the 50# or less per month of regulated medical waste will be added for 2017

EMERGENCY MANAGEMENT

BHD participated in several community based emergency exercises in 2016. The state wide tornado drill, the MRMC Campus-wide Violent Event exercise (a full scale exercise).
Additional training for managers on Active Shooter events and incident command system (ICS) is being planned for 2017. The goal is to have at least 25% of management staff trained in ICS 100 and 200 by the end of the year.

FIRE PREVENTION

In 2017 BHD will be making improvements to fire safety equipment and features. These improvements include replacement of fire doors and frames that have deteriorated from weather and that take more than 5 foot pounds to open. Additionally, the sprinkler heads will be systematically changed out to a newer anti-ligature variety.

1. The number of completed fire drills: In 2016 EES (Engineering & Environmental Services) completed 54 fire drills at the Behavioral Health Division. This number (54) of completed fire drills represents a 100 % completion rate of all necessary fire drills for the Behavioral Health Division.
   - In 2017 the goal will be to complete 60 fire drills at the Behavioral Health Division.

2. The average score recorded on the fire drill check sheet: In 2016 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. Fire Safety training was conducted in quarter 1 and quarter 2. A passing score of 90% was required for each of the trainings. Due to poor results questions regarding use of fire related keys was repeated in the second quarter with an average improvement in test score of 4.8 points.
   - A goal for 2017 will be included in the education section of this report.

4. In 2016 the total number of reported fire setting contraband items that were detected on patient units was 0. This meets the goal of having less than 4 contraband items on patient units.
   - In 2017 the goal will be to maintain the 2016 level of having less than 4 incidents. This item will be moved to general safety area and be reported on via incident reporting data.

5. Due to the age of the fire alarm system, the trouble alarms will be tracked and reported out on at meetings.

UTILITIES MANAGEMENT

In 2016 remediation efforts continued 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 was installed to create a regulatory compliant redundancy of power. This will improve BHD's capabilities for business continuity in the event of an emergency. In 2017, wiring alterations will be made to separate the required branches of electricity in hospitals. Life Safety Branch (related to fire alarm and egress), Critical Branch (related to direct patient care), and Equipment branch (related to mechanical systems).

1. Number of Utility failures: In 2016 there were zero utility failures at the Behavioral Health Division.
   - In 2017 the goal will be eliminated although utility failures will continue be tracked and reported on.

2. Number of past due P.M.'s or Preventative Maintenance work orders. In 2016 the EES department posted a completion rate of 71 % for all P.M's or preventative work orders performed at the Behavioral Health Complex. (1310 P.M.'s were issued and 936 were completed)
   - In 2017 the goal for EES will be to achieve a 90% completion rate for all Critical and Life Safety Systems P.M.'s or preventative maintenance work orders.

3. Percentage of Utility Components labeled and inventoried: In 2016 100% of shut off valves were labeled and inventoried for the Behavioral Health Division.
   - In 2017 the goal for EES will be to have the branch valves labeled and inventoried or to achieve a 50 % completion by year end.

4. The percentage of times the emergency generator testing failed: The emergency generator for the 9455 building did not fail any monthly testing..
   - Generator testing failures will be recorded for 9455 building in 2017.

5. There was anecdotal information that patients may be breaking pencils and other objects off in door locks as a way to prevent staff access. This poses a significant risk to patient safety. Tampering with the mechanical door locks where repair by a locksmith is required will be tracked in 2017 as a way to determine the extent of this risk.

MEDICAL EQUIPMENT

In 2016, BHD replaced aging GE Dinamap vitals monitors with seventeen (17) new Welch Allyn Connex Spot Monitors In addition, BHD continues to refine its clinical equipment inventory by removing outdated or unused equipment including alarms, nebulizers, thermometers, suction machines and feeding pumps. As equipment is purchased and/or verified in-house, it is being re-tagged and entered into the Accruent 4 Rivers system. In this way, work orders can be submitted in the event of equipment failure.

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. BHD Operations and Nursing staff are working to standardize the equipment to be stored on a unit.

Currently the discussion surrounds the removal of crash carts and replacing same with AEDs and suction machines in each of the active unit exam rooms (PCS, OBS, 43A, 43B, 43C, 53B). The AEDs would be mounted, using the stainless steel holder currently attached to the crash cart, in each of the exam rooms while the suction machines would be installed on rolling carts. Suction supplies would be stored in the existing cart basket. All other equipment from the crash carts, and the crash carts themselves, will be removed from BHD. Procedures will be developed to ensure that expiration dates are monitored and supplies are switched out after use.

1. There were 14 reported equipment repairs requested in 2016. Of these, 12 required actual repairs (in two instances, no issue was identified). BHD continues to work with its biomedical service provider to monitor equipment and minimize the number of repairs required.
   - This goal was met and BHD will continue to monitor and report on equipment repairs.

EDUCATIONAL GOALS

Training topics for 2017 quarterly trainings through BHD or County wide training programs will include 4 of the following topics and 85% of staff will achieve a passing score.

- Regulated Medical Waste
- Active Shooter
- Workplace safety
- Cyber Security
- OSHA Safety
- Fire Safety
- Emergency Communications

The Environment of Care Committee recommends the following key goals for 2017:

- **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 staff knowledge of BHD emergency response plans, and procedures.**

Current Status: *Pending* **PolicyStat ID:** *3287916*

Behavioral Health Division

Date Issued:	*1/1/2015*
Last Approved Date:	*4/25/2016*
Last Revised Date:	*4/25/2016*
Next Review:	*3 years after approval*
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.~~

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Mission:

The Milwaukee County Behavioral Health Division through early assessment and intervention promotes hope for individuals and their families through innovative recovery programs in behavioral health, wellness, recovery, research and education.

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

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- Systems and Services Integration
- Recovery-Oriented
- Accessible

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 are 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 it's 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 it's 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)

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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.

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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 and 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.

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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 Mangers 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

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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 Mangers 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;

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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.

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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.

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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.

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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.

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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.

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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 coarse 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.

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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

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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

   ~~Measure staff score on safety training questions. (Goal = ave. 95%)~~
2. Measure the number of environmental rounds items addressed in 30 days (Goal = 80%)
3. Measure the number of fire setting contraband items/incidents found on inpatient units. (Goal < 4)

Security Management

1. Track the frequency of weekly roll-call meetings. (Goal=52)
2. Decrease the number of Theft/Vandalism incidents. Goal ≤ ~~3~~5 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~~10 times)
5. Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)

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~~Camera outages will be repaired within 48 hours (Goal =100%)~~

Hazardous Materials Management

1. Measure the ~~percentage of employees who can correctly identify~~pounds of regulated medical waste ~~items requiring special~~sent for disposal. (Goal~~=95%~~ < 50 #/month)

Emergency Management

1. Increase the number of Management Team members trained in ICS/HICS (100 & ~~700~~200) by 25%
2. ~~Measure the percentage of emergency management related questions on annual training answered correctly by staff. (Goal = 85%)~~Hold or participate in two emergency exercises per year (Goal =2)

Fire Prevention

1. Measure the number of Fire drills completed (Goal = ~~100% completion rate~~60/year)
2. Measure the average score on the fire drill check sheet. (Goal is 97%)

   ~~Measure the percentage of fire prevention related questions on annual training answered correctly by staff. (Goal 95%)~~

   ~~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~~branch valves labeled and inventoried (Goal = ~~100~~50% by year end)
4. Measure the percentage of generator testing that did not pass (Goal = 0%)
5. Measure the number of mechanical door locks requiring repair by a locksmith due to tampering. (baseline)

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,

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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.

Reviewed and approved at the Environment of Care Committee meeting on:

Reviewed and approved at the Medical Executive Committee meeting on:

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

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Behavioral Health Division

Date Issued:	*1/1/2015*
Last Approved Date:	*7/19/2016*
Last Revised Date:	*7/19/2016*
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.~~

Mission:

The Milwaukee County Behavioral Health Division through early assessment and intervention promotes hope for individuals and their families through innovative recovery programs in behavioral health, wellness, recovery, research and education.

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

- Systems and Services Integration
- Recovery-Oriented
- Accessible.

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 polices 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

   ~~Measure staff score on safety training questions. (Goal = ave. 95%)~~

2. Measure the number of environmental rounds items addressed in 30 days (Goal = 80%)
3. Measure the number of fire setting contraband items/incidents found on inpatient units. (Goal < 4)

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 on:

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

Behavioral Health Division

Date Issued:	*1/1/2015*
Last Approved Date:	*7/19/2016*
Last Revised Date:	*7/19/2016*
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.~~

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

- Systems and Services Integration
- Recovery-Oriented
- Accessible

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 Commend 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~~5 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~~10 times)
5. Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)

   ~~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 on:

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

Behavioral Health Division

Date Issued:	*1/1/2013*
Last Approved Date:	*7/19/2016*
Last Revised Date:	*7/19/2016*
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.~~

Mission:

The Milwaukee County Behavioral Health Division through early assessment and intervention promotes hope for individuals and their families through innovative recovery programs in behavioral health, wellness, recovery, research and education.

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

- Systems and Services Integration
- Recovery-Oriented
- Accessible

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 HMW M 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~~pounds of regulated medical waste ~~items requiring special~~sent for disposal. (Goal~~=95%~~ < 50 #/month)

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 on:

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

Current Status: *Pending* **PolicyStat ID:** *3287875*

Behavioral Health Division

Date Issued:	*1/1/2015*
Last Approved Date:	*7/19/2016*
Last Revised Date:	*7/19/2016*
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.~~

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Mission:

The Milwaukee County Behavioral Health Division through early assessment and intervention promotes hope for individuals and their families through innovative recovery programs in behavioral health, wellness, recovery, research and education.

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

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- Systems and Services Integration
- Recovery-Oriented
- Accessible

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

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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)**

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- 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.

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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~~60/year)
2. Measure the average score on the fire drill check sheet. (Goal is 97%)

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~~Measure the percentage of fire prevention related questions on annual training answered correctly by staff. (Goal 95%)~~

~~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 on:

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

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Behavioral Health Division

Date Issued:	*1/1/2015*
Last Approved Date:	*7/19/2016*
Last Revised Date:	*7/19/2016*
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.~~

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

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

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- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

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- Systems and Services Integration
- Recovery-Oriented
- Accessible

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

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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.

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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)**

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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

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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 on:

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

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Behavioral Health Division

Date Issued:	*1/1/2015*
Last Approved Date:	*7/19/2016*
Last Revised Date:	*7/19/2016*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 80043-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Utilities Management Plan

~~BHD Mission:~~

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2. ~~Best practice standards and outcomes~~
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- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning

- Systems and Services Integration
- Recovery-Oriented
- Accessible.

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 aquire 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 immuno-suppressed.

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~~branch valves labeled and inventoried (Goal = ~~100~~50% by year end)
4. Measure the percentage of generator testing that did not pass (Goal = 0%)
5. Measure the number of mechanical door locks requiring repair by a locksmith due to tampering. (baseline)

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 on:

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 80043-Safety Officer	pending

13

COUNTY OF MILWAUKEE
Behavioral Health Division Medical Staff Organization
Inter-Office Communication

DATE: April 19, 2017 **(AMENDED ATTACHMENT)**

TO: Duncan Shrout, Chairperson, Milwaukee County Mental Health Board

FROM: Clarence P. Chou, MD, President of the Medical Staff Organization
Prepared by Lora Dooley, Director of Medical Staff Services

SUBJECT: **A Report from the President of the Medical Staff Organization Requesting Approval of Appointment and Privilege Recommendations Made by the Medical Staff Executive Committee**

Background

Under Wisconsin and Federal regulatory requirements, all physicians and all other practitioners authorized under scope of licensure and by the hospital to provide independent care to patients must be credentialed and privileged through the Medical Staff Organization. Accepting temporary privileges for an immediate or special patient care need, all appointments, reappointments and privileges for each physician and other practitioners must be approved by the Governing Body.

Discussion

From the President of the Medical Staff and Chair of Credentialing and Privileging Review presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C[1]:

A. New Appointments

B. Reappointments

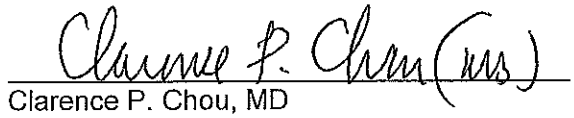
C. Provisional Period Reviews / Amendments &/or Status Changes

D. Notations Reporting (to be presented in **CLOSED SESSION** in accordance with protections afforded under Wisconsin Statute 146.38)

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve all appointments and privilege recommendations, as submitted by the Medical Staff Executive Committee.

Respectfully Submitted,



Clarence P. Chou, MD
President, BHD Medical Staff Organization

cc Michael Lappen, BHD Administrator
John Schneider, BHD Chief Medical Officer
Shane Moisio, MD, Vice-President of the Medical Staff Organization
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

Attachments
1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations - Amended

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
MARCH / APRIL 2017 (AMENDED)

The following credentials files were reviewed. Privilege recommendations/actions were made based on information related to qualifications, current competence and ability to perform privileges (health status). All requisite primary source verifications or queries were obtained and reviewed regarding professional training, professional licensure(s), registrations, National Practitioner Data Bank and OIG-List of Excluded Individuals and Entities & System Award Management. Decisions were further based on Service Chief (Medical Director and Chief Psychologist, when applicable) recommendations, criminal background check results, peer recommendations when applicable, focused or ongoing (FPPE/OPPE) professional practice evaluation data, malpractice claims history and verification of good standing with other hospitals/practices. Notations reporting shall be presented at the Board Meeting in closed session.

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 15, 2017	MEDICAL STAFF EXECUITVE COMMITTEE MARCH 15, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Wendi Ehrman, MD	Pediatrics	Affiliate/ Provisional		Dr. Puls recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
Rachel Ramaswamy, DO	Psychiatric Officer of the Day; Medical Officer of the Day	Affiliate/ Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, subject to a minimum provisional period of 6 months	Recommends appointment and privileging as per C&PR Committee.	
REAPPOINTMENT / REPRIVILEGING	**PRIVILEGE GROUP(S)**	**APPT CAT/ PRIV STATUS**	**NOTATIONS**	**SERVICE CHIEF(S) RECOMMENDATION**	**CREDENTIALING & PRIVILEGING REVIEW COMMITTEE**	**MEDICAL STAFF EXECUITVE COMMITTEE**	**GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)**
NONE THIS PERIOD							
PROVISIONAL STATUS CHANGE REVIEWS	**PRIVILEGE GROUP(S)**	**CURRENT CATEGORY/ STATUS**	**NOTATIONS**	**SERVICE CHIEF RECOMMENDATION**	**CREDENTIALING & PRIVILEGING REVIEW COMMITTEE**	**MEDICAL STAFF EXECUITVE COMMITTEE**	**GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)**
NONE THIS PERIOD							

AMENDMENT TO MARCH / APRIL REPORT

INITIAL APPOINTMENT / PRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE APRIL 14, 2017	MEDICAL STAFF EXECUITVE COMMITTEE APRIL 19, 2017	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Robert Perzacki, MD	General Psychiatry	Active / Provisional	HS	Dr. Schneider recommends appointment & privileges, as requested	Committee recommends 1-year appointment and provisional privileges	Recommends appointment and privileging as per C&PR Committee.	

CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE
(OR PHYSICIAN COMMITTEE MEMBER DESIGNEE)

4/19/2017
DATE

Clarence Chen (MS)
PRESIDENT, MEDICAL STAFF ORGANIZATION
CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

4/19/17
DATE

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
GOVERNING BODY REPORT
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS
MARCH / APRIL 2017 (AMENDED)

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

RECOMMENDATIONS OF THE MCBHD MEDICAL STAFF CREDENTIALING & PRIVILEGING REVIEW AND MEDICAL STAFF EXECUTIVE COMMITTEES WERE REVIEWED. ALL PRIVILEGE AND APPOINTMENTS ARE HEREBY GRANTED AND APPROVED, AS RECOMMENDED BY THE MEC, UNLESS OTHERWISE INDICATED ABOVE.

GOVERNING BOARD CHAIRPERSON

DATE

BOARD ACTION DATE: APRIL 27, 2017

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: March 15, 2017

TO: Duncan Shrout, Chairperson, Milwaukee County Mental Health Board

FROM: Michael Lappen, BHD Administrator
Submitted by John Schneider, MD, FAPA, BHD Chief Medical Officer

SUBJECT: Report from the Behavioral Health Division Administrator, Requesting Approval to Implement an "Employment Agreement" As Established Under BHD Personnel Policy for Specific Classified, Unclassified and Exempt Physician County Employees

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health with a value of at least $100,000. The contract shall take effect only if the Milwaukee County Mental Health Board votes to approve, or does not vote to reject, the contract within 28 days after the contract is signed or countersigned by the County Executive.

Per the above Statute, the BHD Administrator is requesting authorization to establish one (1) new "Employment Agreement" with a newly recruited physician. The salary specified within the agreement exceeds $100,000 annually.

It has been determined that "Employment Agreements" fall under BOTH personnel policy AND contract requirements.

Discussion

Due to the significant time, effort and expense associated with recruiting and retaining qualified medical staff, the Behavioral Health Division, in collaboration with the Compensation Division and Corporation Counsel, has established a personnel policy that requires employment agreements for specific classified, unclassified and exempt physician classifications within Milwaukee County employ. The purpose of these agreements is to stipulate total compensation including fringe benefits, recruitment/retention incentives and to establish a reasonable and fair "minimum resignation notice" requirement, which does not exist under Civil Service rules.

We submit the table below, with one (1) new personnel transaction that BHD will be requesting the Milwaukee County Chief Human Resources Officer to implement in connection with an Employment Agreement.

ITEM ID	HIGH/ LOW ORG	CURRENT JOB CODE / POSITION #	RECOMMENDED JOB CODE / POSITION #	NO. POSITIONS	CURRENT PAY RANGE	CURRENT ANNUAL PAY RATE		RECOMMENDED PAY RANGE	RECOMMENDED ANNUAL PAY RATE		INFORMATIIONAL: Market equitable alignment based on overall job duties/responsibilities, industry competition, competencies and education/experience requirements.		EFFECTIVE DATE
EA2017-04A	6300/ 6412	N/A	NEW CREATE	1	E012	Min		E012	Min	Market Alignment	X	Immediate Recruitment Need.	07/31/17
						Mid			Mid		X	Retention	
						Max			Max		X	Industry shortage / strong competition for profession	
						N/A			$275,000		X	Other: Training/experience exceed the minimum qualifications.	

The individual physician(s) entering into this agreement shall maintain current status as a benefit-eligible COUNTY EMPLOYEE, or if newly hired shall be established as a benefit-eligible COUNTY EMPLOYEE, including ERS enrollment, and subject to all applicable County and BHD personnel policies and Civil Service rules, where applicable.

Incumbent(s) of above position shall be eligible for recruitment/retention bonus. All bonuses shall be subject to conditions. Amount of bonus **shall not exceed $25,000 annually**.
In all cases, any funds identified through the Employment Agreement as a retention or other bonus shall not be considered eligible earnings under the Milwaukee County Pension Plan. Therefore, a retention or other bonus shall not affect in any manner any pension benefit under the Employee Retirement System (ERS), including, but not limited to, earnable compensation, final average salary, service credit, eligibility for a benefit or timing of a benefit.

Recommendation

It is recommended that the Milwaukee County Mental Health Board approve entering into "Employment Agreement" (contracts) with the incumbent of the above position(s) for the recommended total compensation amount on or after the requested effective date.

References

Wis. Stats. 46.19(4): the salaries of any superintendent of a mental health institution and the salaries of any visiting physician and necessary additional officers and employees whose duties are related to mental health shall be fixed by the county executive.

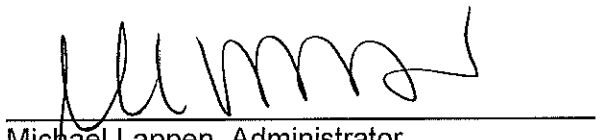
Wis. Stats. 51.41(10): MENTAL HEALTH CONTRACTS. Any contract related to mental health with a value of at least $100,000, to which Milwaukee County is a party may take effect only if the Milwaukee County mental health board votes to approve, or does not vote to reject, the contract within 28 days after the contract is signed or countersigned by the county executive.

Wis. Stats. 51.42(6m)(i): Establish salaries and personnel policies of the programs of the county department of community programs subject to approval of the county executive or county administrator and county board of supervisors, except in Milwaukee County, or the Milwaukee County mental health board in Milwaukee County unless the county board of supervisors or the Milwaukee County mental health board elects not to review the salaries and personnel policies.

Fiscal Effect

The recommended compensation contained in this report is supported within the Behavioral Health Division's 2017 operating budget. There is no tax levy associated with this request.

Respectfully Submitted,



Michael Lappen, Administrator
Behavioral Health Division

cc Thomas Lutzow, Chairperson, Milwaukee County Mental Health Board Finance Committee
Héctor Colón, Director, Department of Health and Human Services
John Schneider, MD, BHD Chief Medical Officer
Lora Dooley, BHD Director of Medical Staff Services
Jodi Mapp, BHD Senior Executive Assistant

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: **April 14, 2017**

TO: Duncan Shrout, Chairperson – Milwaukee County Mental Health Board (MCMHB)

FROM: Héctor Colón, Director, and Department of Health and Human Services
Approved by Mike Lappen, Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, Requesting Authorization to enter into a fee-for-service agreement with Jefferson Crest LLC in an amount that exceeds $100,000 annually.**

Issue

Wisconsin Statute 51.41(10) requires approval for any contract related to mental health (substance use disorder) with a value of at least $100,000. No contract or contract adjustment shall take effect until approved by the Milwaukee County Mental Health Board. Per the statute, the Director of the Department of Health and Human Services is requesting authorization for BHD/CARS to execute mental health and substance use contracts for 2017.

Fee-for-Service Agreement

Jefferson Crest, LLC $566,870
Jefferson Crest provides an array of residential services for high needs individuals who need 24-hour on site assistance. In addition to a traditional CBRF model, Jefferson Crest also offers supportive living apartments with staff available to assist clients. Milwaukee County recently made additional placements to Jefferson Crest for individuals with complex treatment needs. This necessitates additional spending and MCMHB approval.

Fiscal Summary

The amount of 2017 spending requested in this report is summarized below. These payments are anticipated in funding appropriations approved in the 2017 Adopted Budget.

Hector Colon, Director
Department of Health and Human Services

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: April 14, 2017

TO: Duncan Shrout, Chairman, Milwaukee County Mental Health Board

FROM: Héctor Colón, Director, Department of Health and Human Services

SUBJECT: Informational Report on the Department of Health and Human Services vision to develop an integrated system and practice model

The Department of Health and Human Services has a vision to develop an integrated system and practice model that is standardized and operationalized throughout the whole department and our contracted partners. The purpose of this transformation is to identify, access, and enroll participants and their families in all programs and services available in a coordinated manner, regardless of where or how they enter our department or other systems. We believe this model will yield better outcomes and, in turn, healthier communities by developing data-driven, cross-sector solutions and upstream, prevention-oriented programming.

The complexity of serving people through health and humans service organizations continues to increase and makes this new approach necessary. Individuals are presenting with multiple needs, spanning multiple organizations. Access to services for the people we serve can be like a maze with many doors, dead ends, and unlimited choices, making it too complex to navigate. Our goal is to reduce the number of doors, eliminate the dead ends, and make the path as straight and clear as possible.

Due to shrinking resources, we need to make sure we are delivering services with high quality outcomes in the most efficient and effective manner possible while demonstrating a good return on investment. Significant cuts are being proposed on a national level that could be devastating to government, hospital systems and non-profit organizations providing vital services to individuals with great needs. No longer can we think reactively to situations for the people we serve. We need to take a much more proactive approach looking at root causes and taking a population health/prevention approach while integrating and coordinating our efforts. This new approach will position our organization, partners and the people we serve with the best opportunities for success.

Below I will outline the guiding principles for a new integrated system and practice model we would like to move forward with. I will also share model examples we can learn from, illustrate an example of this vision, and provide next steps.

The Guiding Principles

- Commitment to defining and tracking a set of structure, process, and outcome measures to ensure consistency and framework fidelity
- Enhance the quality of life for individuals and their natural supports by providing the opportunity to be fully integrated and included in the community
- Execute an integrative service delivery model that emphasizes strengths, improves access, reduces barriers, and addresses root causes for DHHS individuals and families (whole family approach)
- One plan addressing physical, behavioral, emotional and social determinants of health
- Person-centered, recovery-oriented, trauma-informed, culturally intelligent and promoting safety for the individual and the community
- Prevention, early intervention and collaboration among providers
- Rigorous and focused integration of families, natural supports, providers and the physician into care/service planning
- Urgency in individual/service interaction/appointments

There are good examples of efforts that have been developed that could inform how we move this integrated system and practice model forward. For example, Accountable Care Organizations (ACO's) were developed to coordinate care to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Medical Homes were created to ensure patient centered, comprehensive, coordinated, accessible care is delivered with high quality and safety in mind. Locally, we have managed care organizations where the health care delivery system is organized to manage cost, utilization, and quality. MCOs operate the Family Care program and provide coordinated services. The Family Care benefit combines funding and services from a variety of existing programs into one flexible long-term care benefit, tailored to each individual's needs, circumstances and preferences.

Nationally, the American Public Human Services Association along with its county and state partners across the country (Milwaukee County included) is leading an effort to reform programs and operations to strengthen our organizational capacity and effectiveness. Their vision is " Within 10 years, the Local Council will transform the health and well-being of communities across the country by shifting programming and funding upstream into prevention-oriented and consumer driven cross sector solutions that improve outcomes across the lifespan and significantly reduce high cost institutional interventions within a social determinants of health framework." They have developed a tool along with Harvard University called the Human Services Value Curve to help leaders envision and create a service delivery framework that has a strong foundation to achieve regulatory requirements, is coordinated, integrated and ultimately leads to a prevention and public health focused model. In an article published by *Policy and Practice*, Phil Basso, Deputy Executive Director for the American Public Human Services Association, states that "The Value Curve gives us a true north compass for using our various maps, ensuring we don't lose sight of the ultimate destination:

sustained well-being of children and youth, healthier families and communities, opportunities for employment and economic independence, and fairness between all the places we live."

Within our department we have pockets of excellence that closely mirror the approach we envision and what others have developed. The success of these initiatives will inform this new vision, and when the integration system and practice model is implemented, their effectiveness will be enhanced even further. Examples include Wraparound Milwaukee, our Housing First approach, Juvenile Justice reforms and the Disability Resource Center. We can learn from these examples as well as other proven models identified in this report. The idea is to operationalize our pockets of excellence across the department and through our contracts with our partners.

Over the last year we have worked with a consultant and the department to examine our current state and processes. Role definitions were reviewed for case managers, care coordinators, human service workers and others that have a direct role in service delivery for the people we serve. Current processes, workflows and policy and procedures were reviewed to see how this might need to change in order to realize this new vision. A lot of work went into researching IT platforms that we could use to help us operationalize this integrated system and practice model. These efforts informed an RFP for an IT software solution for our department.

Example of the Vision

Outlined below is an example of how the integrated system and practice model vision could apply to how we would work with a youth that is involved with Delinquency and Court Services, Wraparound Milwaukee, and Child Welfare.

In working with a youth involved in these three systems, we would take a more proactive role in understanding how the social determinants of health are impacting the well-being of the youth and their family. The idea here is to serve the whole family through the initiation of the whole family assessment. We would make sure we coordinate or provide services where necessary and desired that would consider basic needs, housing, education and employment in addition to behavioral health, primary care and dental services. We would coordinate and integrate our efforts with basic needs, treatment, healthcare, criminal justice, and state and city service providers. We would work to have one treatment plan approach. For regulatory reasons, three separate treatment plans might be needed, but the new approach will ensure that all approaches are incorporated into one overarching treatment plan. We would take a more proactive approach at addressing root causes of issues and proactively incorporate prevention strategies. We also would ensure that the services provided in a way that is person-centered, recovery-oriented, trauma-informed, and culturally intelligent. We would have quality assurance and evaluation tools to ensure that there is fidelity to this comprehensive approach. The selection of a technology tool that will help operationalize and ensure fidelity and outcomes to this new approach is paramount. The technology tool will also allow for robust sharing of information within DHHS and other partner agencies.

To continue this vision forward, over the next 100 days we would like to do the following:

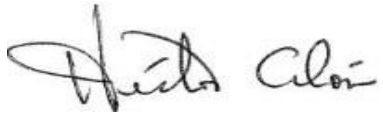
- Meet with industry experts to share our vision and get their reactions. Have industry experts provide presentations on their practice models to further our learning before moving forward.
- Meet with the following groups to share our vision and gather thoughts, perspectives, and feedback:
    - Division leaders along with their respective staff that are involved in delivering services
    - Contracted partner organizations
    - People who receive services from us
    - Stakeholders and advocacy groups

Following the completion of these next steps will be followed by working with staff and partners to operationalize the components of our vision including:

- Words, values and principles
- Job descriptions
- Policy and procedures
- Quality assurance and evaluation
- Tools and resources
- Treatment and care plans
- IT infrastructure
- Training infrastructure

This new model will help empower individuals, families and communities to be healthier. Taking a more coordinated, integrated and proactive approach will prevent costly and unnecessary interventions. Assessments and data will help us make informed decisions leading to preventative strategies. This initiative may require for us learn, grow and adapt our structures, but in the end we will have a better chance at empowering healthy communities together with our partners.

I hope this information was helpful. If you need additional information, please let us know.



Héctor Colón, DHHS Director