

**Chairperson:** Thomas Lutzow  
**Vice-Chairperson:** Maria Perez  
**Secretary:** Michael Davis  
**Senior Executive Assistant:** Jodi Mapp, 257-5202

## MILWAUKEE COUNTY MENTAL HEALTH BOARD

**Thursday, June 21, 2018 - 8:00 A.M.**  
**Zoofari Conference Center**  
**9715 West Bluemound Road**

### MINUTES

**PRESENT:** Robert Curry, \*Kathie Eilers, Rachel Forman, Sheri Johnson, Walter Lanier, Jon Lehrmann, Thomas Lutzow, Mary Neubauer, Maria Perez, and Brenda Wesley  
**EXCUSED:** Michael Davis and Duncan Shrout

\*Board Member Kathie Eilers was not present at the time the roll was called but joined the meeting shortly thereafter.

#### **SCHEDULED ITEMS:**

**NOTE: All Informational Items are Informational Only Unless Otherwise Directed by the Board.**

1. **Welcome.**

Chairman Lutzow greeted Board Members and welcomed the audience to the June 21, 2018, Mental Health Board meeting.

2. **Approval of the Minutes from the April 26, 2018, Milwaukee County Mental Health Board Meeting.**

**MOTION BY:** (Forman) Approve the Minutes from the April 26, 2018, Milwaukee County Mental Health Board Meeting. 7-0

**MOTION 2<sup>ND</sup> BY:** (Lanier)

**AYES:** Curry, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 7

**NOES:** 0

**EXCUSED:** Eilers - 1

3. **Universal Health Services Contract for the Provision of Acute Psychiatric Services Update.**

Michael Lappen, Administrator, Behavioral Health Division

Mr. Lappen indicated the update related to this item is the result of work done by the negotiation team. The final contract was loosely targeted for consideration at this meeting.

**SCHEDULED ITEMS (CONTINUED):**

	<p>However, negotiations continue. Progress is being made moving the process closer to the submission of a final product. The challenging items are few but complicated given the list of requirements added based on feedback from the Mental Health Board’s Joint Task Force, the Mental Health Task Force, and the Milwaukee Health Care Partnership. This contract is proving to be much more complicated and inclusive, especially as it relates to the provision of care, statutory responsibilities, and funding source, than anything being done elsewhere. Mr. Lappen stated there are no issues with rates or the project as a whole. Both the Behavioral Health Division and Universal Health Services are having outstanding details reviewed by their respective legal teams. At this point, no further delays are anticipated. The projected transition will occur approximately the end of 2020/beginning of 2021.</p> <p>Questions and comments ensued.</p>
4.	<p><b>Housing Division Update.</b></p> <p>Jim Mathy, Director, Housing Division, Department of Health and Human Services (DHHS) Eric Collins-Dyke, Outreach Services Manager, Housing Division, DHHS</p> <p>Mr. Mathy explained Housing First is an initiative started in 2015 that addresses and focuses on breaking the cycle of chronic homelessness without prerequisites for treatment while offering treatment support and resources with the goal of placing individuals in housing as quickly as possible. Mr. Mathy went on to discuss the key principles of Housing First, its origination, and major themes of approach.</p> <p>Mr. Collins-Dyke provided information on outreach, including shelter outreach and tracking of that data; staffing; and the Residency Advisory Council.</p> <p>Mr. Mathy continued by discussing the housing navigation model, which is a big part of the program’s success; housing assistant payment subsidy; case management services; program evaluator case studies; the reduction of mental health crisis utilization, emergency room utilization, law enforcement exposure, and emergency shelter usage; and HMO Housing First usage.</p> <p>Questions and comments ensued.</p>
5.	<p><b>Mental Health Board Governance on Strategic Planning Summary of Findings.</b></p> <p>Brett Remington, Blue Rock WI</p> <p>Mr. Remington stated over the course of several months, he consolidated a list of observations and recommendations for consideration, discussion, and action by the Board. The recommendations, if implemented, will fortify the performance and the sustainability of the Mental Health Board. The Strategic Planning Committee has met to discuss and evaluate the findings and is in the process of developing an agenda for the proposed September Board retreat, which will be the first of its kind for this group. The Strategic</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p>Planning Committee will share the objectives and planned activities of the retreat in the upcoming weeks.</p>
6.	<p><b>Bylaws Amendments.</b></p> <p>Colleen Foley, Deputy, Corporation Counsel</p> <p>Ms. Foley explained the amendments being presented are in the same vein of continuous improvement and pruning. Further refinement of the Bylaws is an attempt to provide additional clarity. The first amendment relates to specific descriptions of Board Member terms. The second amendment changes Article 7, which refers to the Board's committees, to include new language creating a Chair Emeritus who would serve on the Board's Executive Committee. In recognition of value and knowledge, the position would be held by the immediate past Chairperson of the Board.</p> <p><b>MOTION BY:</b> (Eilers) Approve the Mental Health Board's Bylaws AS AMENDED. 8-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Lanier)</p> <p><b>AYES:</b> Curry, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p><b>NOES:</b> 0</p> <p><b>EXCUSED:</b> 0</p>
7.	<p><b>Administrative Update.</b></p> <p>Michael Lappen, Administrator, Behavioral Health Division (BHD)</p> <p>Mr. Lappen highlighted key activities and issues related to BHD operations. He provided an update on two new grant awards from the State as part of the Federal initiative targeting opioids. Treatment services include residential treatment, recovery house/outpatient plus, day treatment, and individual and family counseling. Recovery support services will also be provided.</p> <p>Nurse recruitment efforts by Kane Communications, with the assistance of Human Resources and BHD's Chief Nursing Officer, have again proven successful as all positions are filled. Staffing is no longer in crisis, and mandating overtime has been reduced. Even though BHD is currently in a stable staffing pattern, recruitment continues due to the competitive nature of these positions. There will be continued focus on retention to ensure adequate staffing through closure.</p> <p>As a side note, Mr. Lappen announced that after discussions with the Sheriff's Department, the Sheriff has agreed to move forward with a collaboration with BHD and make a long-term commitment for a multi-jurisdictional Crisis Assessment and Response Team (CART). This collaboration will expand CART to six teams and include the Sheriff's Department for the first time. There is a position in place within the budget that aligns with this new effort. A Captain with mental health experience designated by the Sheriff will be assigned to the</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p>Team to assist with procedure and protocol. The new initiative is slated to move forward as quickly as July.</p> <p>Questions and comments ensued.</p> <p style="text-align: center;"><b>Item #s 8, 9, and 10 were considered together.</b></p>
8.	<p><b>Mental Health Board Finance Committee Professional Services Contracts Recommendations.</b></p> <ul style="list-style-type: none"><li>• 2017 and 2018 Contract Amendments<ul style="list-style-type: none"><li>➤ Netsmart Technologies, Inc.</li></ul></li></ul> <p>Jennifer Bergersen, Chief of Operations, Behavioral Health Division</p> <p>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 the information technology services the contracted agency provides. Approvals would be for Amendments to 2017 and 2018 Contracts.</p> <p>Ms. Bergersen shared an update on Netsmart’s contract and progress with ongoing efforts related to Electronic Medical Record Optimization. Additional information regarding the request to retroactively approve funds for services rendered in 2017 was explained.</p> <p>The Finance Committee unanimously agreed to recommend approval of the 2017 and 2018 Contract Amendments delineated in the corresponding report to the Board.</p> <p style="text-align: center;"><b>SEE ITEM 10 FOR BOARD ACTION</b></p>
9.	<p><b>Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.</b></p> <ul style="list-style-type: none"><li>• 2018 Contract Amendments</li></ul> <p>Brian McBride, Interim Director, Children’s Community Services and Wraparound Milwaukee, Behavioral Health Division (BHD) Amy Lorenz, Director, Community Access to Recovery Services, BHD</p> <p>Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. Mr. McBride and Ms. Lorenz provided an overview detailing the various program contracts. Approvals would be for 2018 Contract Amendments.</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p>The Finance Committee unanimously agreed to recommend approval of the 2018 Purchase-of-Service Contract Amendments delineated in the corresponding report to the Board.</p> <p style="text-align: center;"><b>SEE ITEM 10 FOR BOARD ACTION</b></p>
10.	<p><b>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</b></p> <p>Brian McBride, Interim Director, Children’s Community Services and Wraparound Milwaukee, Behavioral Health Division (BHD) Amy Lorenz, Director, Community Access to Recovery Services, BHD</p> <p>Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. Mr. McBride and Ms. Lorenz provided an overview detailing the various program agreements, which 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.</p> <p>The Finance Committee unanimously agreed to recommend approval of Amendments to the 2018 Fee-for-Service Agreements delineated in the corresponding report to the Board.</p> <p><b>MOTION BY:</b>            <i>(Perez) Approve the 2017 and 2018 Professional Services Contract Amendments, the 2018 Purchase-of-Service Contract Amendments, and the 2018 Fee-for-Service Agreement Amendments as Delineated in the Corresponding Reports for Item #s 8, 9, and 10. 8-0</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b>    <i>(Eilers)</i></p> <p><b>AYES:</b>                    Curry, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p><b>NOES:</b>                    0</p>
11.	<p><b>Mental Health Board Quality Committee Update.</b></p> <p>Jennifer Bergersen, Chief of Operations, Behavioral Health Division</p> <p>Board Member Neubauer, Chairwoman of the Quality Committee, reviewed topics addressed at the Quality Committee’s quarterly meeting. She discussed the analysis of the key performance indicator dashboard and how formats have been changed to make dashboards more user friendly, the Sentinel Event Committee’s annual quality summary, the seclusion and restraint first quarter report, Wraparound Milwaukee’s annual report, the hospital transfer waitlist, the Environment of Care annual report and management plans, and the status of updated policies and procedures.</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p>Ms. Bergersen informed the Board the Environment of Care annual report and management plans will be brought before the Board for consideration at the August meeting.</p> <p>Questions and comments ensued.</p>
12.	<p><b>Medical Executive Report and Credentialing and Privileging Recommendations.</b></p> <p>Dr. John Schneider, Chief Medical Officer, Behavioral Health Division</p> <p>Dr. Schneider provided a summary of the Medical Executive Committee recommendations related to medical staff credentialing.</p> <p><b>MOTION BY:</b> <i>(Perez) Adjourn into Closed Session under the provisions of Wisconsin Statutes Section 19.85(1)(c) for the purpose of considering employment or performance evaluation data for public employees over which the Board has jurisdiction and exercises responsibility. Some or all of the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item 12. At the conclusion of the Closed Session, the Board may reconvene in Open Session to take whatever action(s) it may deem necessary on the aforesaid item. 7-0</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> <i>(Lanier)</i></p> <p><b>AYES:</b> Curry, Eilers, Forman, Lanier, Lutzow, Neubauer, and Perez – 7</p> <p><b>NOES:</b> 0</p> <p><b>EXCUSED:</b> Wesley - 1</p> <p>The Board convened into Closed Session at 9:39 a.m. to discuss Item 12 and reconvened back into Open Session at approximately 9:47 a.m. The roll was taken, and all Board Members were present.</p> <p><b>MOTION BY:</b> <i>(Eilers) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 8-0</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> <i>(Neubauer)</i></p> <p><b>AYES:</b> Curry, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p><b>NOES:</b> 0</p> <p><b>EXCUSED:</b> 0</p>
13.	<p><b>Employment Agreements.</b></p> <p>Dr. Schneider, Chief Medical Officer, Behavioral Health Division</p> <p>Dr. Schneider explained the corresponding employment agreements are for the newly created position of Advanced Nurse Prescriber-Psych and stipulate total compensation and</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p>reasonable notice requirements. Due to the significant time, effort, and expense involved in recruiting psychiatric practitioners, the employment agreements serve as a means of enhancing retention for these professionals, which continue to be in high demand and short supply both locally and nationally.</p> <p>The Finance Committee unanimously agreed to recommend approval of the Employment Agreements to the Board.</p> <p><b>MOTION BY:</b> (Perez) Approve the Advanced Nurse Prescriber Psych Employment Agreements as Delineated in the Corresponding Report. 8-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Eilers)</p> <p><b>AYES:</b> Curry, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p><b>NOES:</b> 0</p> <p><b>EXCUSED:</b> 0</p>
14.	<p><b>Adjournment.</b></p> <p>Chairman Lutzow ordered the meeting adjourned.</p>
	<p>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.</p> <p>Length of meeting: 8:01 a.m. to 10:36 a.m.</p> <p>Adjourned,</p> <p><b>Jodi Mapp</b> Senior Executive Assistant Milwaukee County Mental Health Board</p>
	<p><b>The next meeting for the Milwaukee County Mental Health Board will be on Thursday, July 12, 2018, @ 8:00 a.m. at the Zoofari Conference Center 9715 West Bluemound Road</b></p> <p><b>TOPIC: 2019 Budget Presentation and Approval</b></p> <p><b>Visit the Milwaukee County Mental Health Board Web Page at:</b></p> <p><a href="http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board.htm">http://county.milwaukee.gov/BehavioralHealthDivi7762/Mental-Health-Board.htm</a></p>

**SCHEDULED ITEMS (CONTINUED):**

The June 21, 2018, meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.

A handwritten signature in black ink, appearing to read "Thomas Lutzow". The signature is fluid and cursive, with a long horizontal stroke at the end.

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Chairman Thomas Lutzow for Michael Davis, Secretary  
Milwaukee County Mental Health Board

**Chairperson:** Thomas Lutzow  
**Vice-Chairperson:** Maria Perez  
**Secretary:** Michael Davis  
**Senior Executive Assistant:** Jodi Mapp, 257-5202

**MILWAUKEE COUNTY MENTAL HEALTH BOARD  
BUDGET MEETING**

**Thursday, July 12, 2018 - 8:00 A.M.**  
**Zoofari Conference Center**  
**9715 West Bluemound Road**

**MINUTES**

**PRESENT:** Michael Davis, Rachel Forman, Sheri Johnson, \*Walter Lanier, Jon Lehrmann, Thomas Lutzow, Mary Neubauer, Maria Perez, Duncan Shrout, and Brenda Wesley

**EXCUSED:** Kathie Eilers

**ABSENT:** Robert Curry

\*Board Member Walter Lanier was not present at the time the roll was called but joined the meeting shortly thereafter.

**SCHEDULED ITEMS:**

**NOTE: All Informational Items are Informational Only Unless Otherwise Directed by the Board.**

**1. Welcome.**

Chairman Lutzow greeted Board Members and welcomed the audience to the July 12, 2018, Mental Health Board Budget meeting.

**2. Milwaukee County Behavioral Health Division 2019 Budget Narrative Presentation and Consideration.**

Michael Lappen, Administrator, Behavioral Health Division  
Jeanne Dorff, Fiscal Administrator, Department of Health and Human Services

Ms. Dorff began by directing the Board's attention to typographical errors in the Budget Narrative found on Pages 14 and 20, which are in the process of being corrected. She explained the tax levy reduction and its impact on costs to continue, including fringe benefits, cost increases, salary increases, and contracting services increases. She emphasized how rearranging priorities was necessary to achieve new initiatives resulting in increased costs being absorbed without cutting services.

**SCHEDULED ITEMS (CONTINUED):**

	<p>Ms. Dorff indicated the “Impact on Reserves” line item reflects initiatives the Board approved for implementation. Reserve funds would be used for these initiatives and are not part of the Operating Budget. She presented a detailed overview of the Division’s 2019 Budget. Significant changes highlighted include psychiatric technician (psych tech) positions, Recovery Support Coordination Case Management, the expansion of Bridge Housing, and Outpatient Plus.</p> <p>Mr. Lappen provided additional highlights on continuing initiatives, which include the Peer Respite Program, the Sheriff Department’s collaboration with the Behavioral Health Division and their long-term commitment for a multi-jurisdictional Crisis Assessment and Response Team (CART), Federally Qualified Health Center (FQHC) partnerships, and the transportation initiative.</p> <p>Changing from Purchase-of-Service Contracts to Fee-for-Service Agreements was discussed at length.</p> <p><b>MOTION BY:</b> (Perez) Approve the Behavioral Health Division’s 2019 Recommended Budget. 8-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Shrout)</p> <p><b>AYES:</b> Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8</p> <p><b>NOES:</b> 0</p>
3.	<p><b>Adjournment.</b></p> <p>Chairman Lutzow acknowledged this would be Deputy Corporation Counsel Colleen Foley’s last Board meeting. He thanked Ms. Foley for her service and support to the Board.</p> <p>Ms. Foley thanked the Board and Behavioral Health Division Administrative staff stating it has been her pleasure serving as the Board’s legal advisor.</p> <p><b>MOTION BY:</b> (Shrout) Adjourn. 8-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Lanier)</p> <p><b>AYES:</b> Davis, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley - 8</p> <p><b>NOES:</b> 0</p>

**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: 8:08 a.m. to 9:05 a.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, August 23, 2018, @ 8:00 a.m. at  
a Location to be Determined**

**Visit the Milwaukee County Mental Health Board Web Page at:**

<https://county.milwaukee.gov/EN/DHHS/About/Governance#MCMHBrecords>

The July 12, 2018, Budget meeting minutes of the Milwaukee County Mental Health Board are hereby submitted for approval at the next scheduled regular meeting of the Milwaukee County Mental Health Board.



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Michael Davis, Secretary  
Milwaukee County Mental Health Board

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** August 14, 2018

**TO:** Thomas Lutzow, 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 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**

**High Quality and Accountable Service Delivery**

- **Community Based System of Care**

The Milwaukee County Behavioral Health Division (BHD) is transforming the system of behavioral health care in Milwaukee County into a best practice model of integrated care. BHD is moving away from being a provider of inpatient acute psychiatric care to expand community-wide access to high quality care focused on prevention, treatment, intervention, and overall health. To do this, BHD is introducing a new contracting and evaluation process designed to increase access to high quality behavioral health services in Milwaukee County.

New contract performance measures and fee-for-service contract regulations are designed to ensure more people receive the highest quality services at the most affordable cost (for BHD). This initiative may require change for some providers. However, BHD believes these changes will ultimately help the system empower safe, healthy, meaningful lives through connections that support recovery. Fee-for-Service Agreements will allow BHD to use limited resources to connect more people with high quality services. The addition of contract performance metrics fulfills the Mental Health Board and Legislative Audit Bureau (LAB) requirements and ensures individuals receive high quality services through contracts that include performance measures.

The Request for Proposals (RFP)/Request for Information (RFI) process is fully transparent and an important step in our work to make high quality care accessible to more people.

- All open RFPs/RFIs are shared on the [Milwaukee County Procurement Portal](#).
- All interested providers who meet the requirements of the RFP/RFI have an equal opportunity to submit a bid.
- The RFP/RFI process ensures interested providers are aware of all expectations they will be accountable to fulfill.
- All BHD contracts are approved by the Milwaukee County Mental Health Board and rooted in BHD's mission to provide the best quality care for those in need.

BHD is doing everything we can to work closely with current and potential providers to increase access to high quality care with limited resources.

### **Other Topics of Interest**

- **City-County Heroin Opioid Cocaine Task Force (CCHOCTF)**

The Task Force has held two community engagement sessions: June 9, 2018, at St. Joseph's Hospital Klieger Auditorium and July 24, 2018, at the Mitchell Street Library. A third is scheduled for Thursday, August 16, 2018, at the Oak Creek Civic Center. The sessions were focused on getting community feedback on the draft proposal for a community work plan around prevention and treatment. I led the "Treatment" breakout session during the July 24<sup>th</sup> event. The event was very well attended.

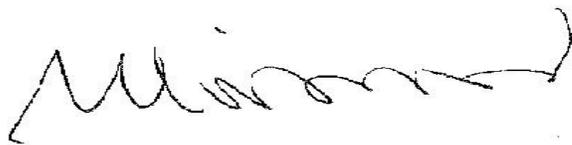
My group included six individuals in active treatment/recovery, two Child Protective Service workers from SaintA, two public health nurses, a post-graduate researcher, two community activists, two teachers, three representatives from BHD contracted treatment providers, and a number of individuals who identified themselves as concerned citizens. The group was tasked with creating a list of priorities for the work plan goal of expanding access to treatment, from which the larger group was asked to vote for their top choice. The group identified:

- Withdrawal Management - same day service, availability at all hospital emergency rooms, and specialty services for pregnant females
- Ongoing Support Post-Residential Treatment - relapse prevention and mental health care
- More treatment facilities
- Bridge Housing - especially for those with zero income and for families

- Transitional Housing - support from peers/counselors, especially for those with zero income and for families
- Parity in Reimbursement - treat Alcohol and Other Drug Abuse (AODA) needs like any other health issue; stop bed day, Intensive Outpatient (IOP) session, and Medication Assisted Treatment (MAT) limits; blood work; etc.
- Allow for longer authorizations for service, increase funding for Medical Assistance (MA) or uninsured in residential, transitional care, IOP, etc.
- Expand Dialectical Behavior Therapy (DBT) for substance use
- Improve awareness of treatment options and provide “cross system” education, i.e. child welfare workers, courts, hospital social workers, etc.
- Reduce stigma regarding people with addictions and those in treatment, fight back against “Not in My Back Yard” (NIMBY) responses to sober housing, treatment facilities
- Educate the community on the disease model of substance dependence

The larger group overwhelmingly supported expanding sober and bridge housing and same day access to Medication Assisted Treatment, both of which are currently being expanded in the BHD network and are addressed in the 2019 Proposed Budget.

Respectfully Submitted,



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

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** August 23, 2018

**TO:** Tom Lutzow, Chairperson – Milwaukee County Mental Health Board

**FROM:** Mary Jo Meyers, Director, 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 a 2018 Professional Services Contract Amendment and a 2019 Contract for Cleaning Services; and 2018 Professional Services Contract Amendments for Consultation and Fiscal Oversight 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/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018, and 2019.

**Background**

Approval of the recommended contract allocations will allow BHD/CARS/Wraparound/Inpatient Hospital 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**

**Clean Power, LLC - \$1,364,536.56**

This is an agreement for cleaning services for the Milwaukee County Behavioral Health Division, Mental Health Complex. BHD is requesting \$24,200.28 for 2018 and \$1,340,336.28 for 2019. The increase in funds are a result of the contract negotiations that resulted in BHD establishing an updated scope of work, performance measures, compliance indicators, and an employee wage increase that are now included in the contract. The total contract amount is now \$2,680,672.56.

**New Resources Consulting dba Clinical Path Consulting - \$14,375**

This was a professional services agreement that provided BHD with a Clinical Informaticist, and Principal Trainer position that was critical to the success of the Our Avatar (EMR Optimization) Project as well as training and oversight of the BHD clinical documentation tools. Clinical Path

Consulting provided the consultant to fill the two positions, and the Clinical Informaticist consultant has since been hired as a full time BHD Associate, and the Principal Trainer position is now vacant. The funds are being requested to pay the outstanding invoices that cover the time period when the Clinical Informaticist position was being transitioned from a Clinical Path Consultant to a full time BHD Associate, and the Principal Trainer position was vacated. The total contract amount is now \$224,775. The funds are being requested for 2018.

### **Trempealeau County Health Care - \$51,000**

This contract is to assure clarity of fiscal obligations for care services provided to individuals placed by Milwaukee County at the Trempealeau County Health Care Center. The total contract is now \$150,000.

### **Fiscal Summary**

The amount of spending requested in this report is summarized below.

<b>Vendor Name</b>	<b>New/Amendment</b>	<b>2018 Amount</b>	<b>2019 Amount</b>	<b>Total Contract Amount</b>
Clean Power	Amendment	\$24,200.28	\$1,340,336.28	\$2,680,672.56
Clinical Path Consulting	Amendment	\$14,375		\$224,775
Trempealeau County Health Care	Amendment	\$51,000		\$150,000
<b>Total</b>		<b>\$89,575.28</b>	<b>\$1,340,336.28</b>	<b>\$3,055,447.56</b>

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Mary Jo Meyers, Director  
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** August 23, 2018

**TO:** Tom Lutzow, Chairperson – Milwaukee County Mental Health Board

**FROM:** Mary Jo Meyer, Director, Department of Health and Human Services  
*Approved by Michael Lappen, Administrator, Behavioral Health Division*

**SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute 2018 Purchase-of-Service Contract Amendments 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/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018.

**Background**

Approval of the recommended contract allocations will allow BHD/CARS/Wraparound/Inpatient Hospital 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.

**Purchase-of-Service Contracts**

**Family Strong, LLC - \$55,000**

The Vendor provides Family Engagement and Advocacy Services for the Wraparound Milwaukee Program serving children and their families. The total contract amount is now \$280,000. The funds are being requested for 2018.

**Our Space, Inc. - \$20,833**

The Vendor provides a Psychosocial drop-in center which provides a casual environment for education, recreation, socialization, pre-vocational activities, and occupational therapy opportunities for individuals with severe and persistent mental illness and/or co-occurring disorders. The drop-in center model is based on a concept of membership and utilizes peer support as a central tenant. Our Space provides individuals with a mechanism of social connectedness so that they may further their own recovery. Our Space, Inc. will be providing an additional full time

Peer Support to assist consumers in the post booking stabilization strategy. The total contract amount is now \$271,795. An additional \$8,833.20 is being requested for 2018 and \$11,999.80 is being request for 2019.

### **Fiscal Summary**

The amount of spending requested in this report is summarized below.

<b>Vendor Name</b>	<b>New/Amendment</b>	<b>2018 Increase</b>	<b>2019 Amount</b>	<b>Total Contract Amount</b>
Family Strong, LLC	Amendment	\$55,000		\$280,000
Our Space, Inc.	Amendment	\$8,833.20	\$11,999.80	\$271,795
Total		\$63,833.20	\$11,999.80	\$551,795

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Mary Jo Meyers, Director  
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson

**COUNTY OF MILWAUKEE**  
**Behavioral Health Division Administration**  
**Inter-Office Communication**

**DATE:** August 23, 2018

**TO:** Tom Lutzow, Chairperson – Milwaukee County Mental Health Board

**FROM:** Mary Jo Meyers, Director, Department of Health and Human Services  
*Approved by Michael Lappen, Administrator, Behavioral Health Division*

**SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute 2018 and 2019 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/Wraparound/Inpatient Hospital to execute mental health and substance use contracts for 2018, and 2019.

**Background**

Approval of the recommended contract allocation **projections** will allow BHD/CARS/Wraparound/Inpatient Hospital 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.

**Fee-for-Service Agreements**

**A Clearer Vision dba Eliana Homes - \$131,510.32**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$131,510.32 for 2019. The total contract amount will be \$263,020.64.

**A Place for Miracles - \$184,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$82,000 for 2018 and \$102,000 for 2019. The total contract amount will be \$204,000.

**Access Recovery Mental Health Services - \$412,623**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$155,623 for 2018 and \$257,000 for 2019. The total contract amount will be \$514,000.

**Alternative Family Services, LLC - \$56,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$56,000 for 2019. The total contract amount will be \$155,000.

**Alternatives in Psychological Consultation, S.C. - \$2,213,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$2,213,000 for 2019. The total contract amount will be \$4,441,512.67.

**Arunaobi Integrated Medical Behavioral Health Clinic - \$54,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$54,000 for 2019. The total contract amount will be \$153,000.

**Phoenix Care Systems, Inc. dba Bell Therapy, Inc. - \$6,715,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$6,715,000 for 2019. The total contract amount will be \$13,004,724.20.

**Brotoloc South, Inc. - \$154,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$154,000 for 2019. The total contract amount will be \$346,716.70.

**Community Living Arrangements, Inc. - \$51,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$51,000 for 2019. The total contract amount will be \$168,482.

**Crossroads Behavioral Health Services - \$10,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$10,000 for 2019. The total contract amount will be \$69,130.

**East Point Residential Facility, LLC - \$137,874.37**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$32,874.37 for 2018 and \$105,000 for 2019. The total contract amount will be \$210,000.

**Easter Seals Southeast WI, Inc. - \$380,897**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$52,897 for 2018 and \$328,000 for 2019. The total contract amount will be \$656,000.

**Empathetic Counseling Services, Inc. - \$203,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$203,000 for 2019. The total contract amount will be \$971,395.

**Epitomized Living, LLC - \$99,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$99,000 for 2019. The total contract amount will be \$198,000.

**Goodwill Industries of Southeastern Wisconsin - \$301,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$301,000 for 2019. The total contract amount will be \$637,236.

**Guest House of Milwaukee - \$1,517,328.44**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$257,328.44 for 2018 and \$1,260,000 for 2019. The total contract amount will be \$2,262,671.56.

**Alternatives in Psychological Consultation, S.C. - \$1,312,000**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$1,312,000 for 2019. The total contract amount will be \$2,829,725.

**Horizon Healthcare, Inc. - \$504,000**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$504,000 for 2019. The total contract amount will be \$1,275,725.

**La Causa, Inc. - \$713,000**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$713,000 for 2019. The total contract amount will be \$1,433,276.

**MCFI dba Whole Health Medical - \$1,133,000**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$1,133,000 for 2019. The total contract amount will be \$2,429,498.

**Milwaukee Mental Health Associates - \$826,344**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$117,344 for 2018 and \$709,000 for 2019. The total contract amount will be \$1,300,656.

**Outreach Community Health Associates - \$464,000**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$464,000 for 2019. The total contract amount will be \$1,235,725.

**Wisconsin Community Service - \$1,138,000**

This vendor provides Targeted Case Management Services for CARS Consumers. BHD is requesting an additional \$1,138,000 for 2019. The total contract amount will be \$2,461,208.

**Genesis Behavioral Health Services, Inc. - \$770,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$770,000 for 2019. The total contract amount will be \$1,621,472.

**Matt Talbott - \$1,186,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$1,186,000 for 2019. The total contract amount will be \$2,392,648.

**Meta House - \$1,376,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$1,376,000 for 2019. The total contract amount will be \$2,852,125.

**United Community Center - \$3,197,205**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$726,205 for 2018 and \$2,471,000 for 2019. The total contract amount will be \$4,942,000.

**Homes for Independent Living of WI, LLC - \$802,364.20**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$159,364.20 for 2018 and \$643,000 for 2019. The total contract amount will be \$1,286,000.

**Integrity Residential Services, Inc. - \$165,906**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$165,906 for 2019. The total contract amount will be \$331,812.

**Jefferson Crest, LLC - \$679,504.92**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$89,504.92 for 2018 and \$590,000 for 2019. The total contract amount will be \$1,180,000.

**Jewish Family Services, Inc. - \$214,779.02**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$84,779.02 for 2018 and \$130,000 for 2019. The total contract amount will be \$260,000.

**JusticePoint, Inc. - \$4,069,857**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$2,008,857 for 2018 and \$2,061,000 for 2019. The total contract amount will be \$4,122,000.

**Matt Talbott Recovery Services, Inc. - \$50,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$50,000 for 2019. The total contract amount will be \$1,332,976.10.

**Meta House - \$269,860.30**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$87,860.34 for 2018 and \$182,000 for 2019. The total contract amount will be \$364,000.

**Milwaukee Mental Health Associates, Inc. - \$440,625.30**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$218,625.30 for 2018 and \$222,000 for 2019. The total contract amount will be \$444,000.

**Multicultural Community Services, Inc. - \$368,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$368,000 for 2019. The total contract amount will be \$748,313.

**Mystic Creek - \$427,115**

This vendor provides Residential Services for CARS Consumers. BHD is requesting an additional \$103,115 for 2018 and \$324,000 for 2019. The total contract amount will be \$648,000.

**Our Safe Place, Inc. - \$226,800**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$226,800 for 2019. The total contract amount will be \$453,600.

**Multicultural Community Services, Inc. - \$368,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$368,000 for 2019. The total contract amount will be \$748,313.

**Outreach Community Health Centers - \$500,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$500,000 for 2019. The total contract amount will be \$1,035,619.93.

**Professional Services Group - \$286,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$133,000 for 2018 and \$153,000 for 2019. The total contract amount will be \$306,000.

**Project Access, Inc. - \$853,740.91**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$421,740.91 for 2018 and \$432,000 for 2019. The total contract amount will be \$864,000.

**Sebastian Family Psychology Practice, LLC - \$630,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$305,000 for 2018 and \$325,000 for 2019. The total contract amount will be \$650,000.

**St. Charles - \$110,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$30,000 for 2018 and \$80,000 for 2019. The total contract amount will be \$160,000.

**United Community Center - \$133,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$133,000 for 2019. The total contract amount will be \$1,842,474.

**Wisconsin Community Services - \$1,367,924**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$1,367,924 for 2019. The total contract amount will be \$2,735,848.

**Word of Hope Ministries - \$20,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$20,000 for 2019. The total contract amount will be \$109,474.

**La Causa, Inc. - \$1,788,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$1,788,000 for 2019. The total contract amount will be \$4,309,895.

**MCFI Home Care - \$325,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting an additional \$125,000 for 2018 and \$200,000 for 2019. The total contract amount will be \$400,000.

**MCFI dba Whole Health Medical - \$1,768,000**

This vendor provides Residential Services for CARS Consumers. BHD is requesting \$1,768,000 for 2019. The total contract amount will be \$5,329,148.

**MCFI dba Whole Health Medical - \$2,280,000**

This vendor provides Behavioral Health and/or Social Services for CARS Consumers. BHD is requesting \$2,280,000 for 2019. The total contract amount will be \$4,801,895.

**Adkins Counseling Services, LLC - \$618,982**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$182,982 for 2018 and \$436,000 for 2019. The total contract amount will be \$872,000.

**Alternatives in Psychological Consultation, SC - \$7,913,296.89**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$2,913,296.89 for 2018 and \$5,000,000 for 2019. The total contract amount will be \$9,448,000.

**American United Cab - \$411,003**

This vendor provides Transportation Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$411,003,000 for 2019. The total contract amount will be \$822,006.

**Anu Family Services, Inc. - \$503,687.00**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$503,687 for 2019. The total contract amount will be \$1,007,374.

**Bell Therapy, Inc (Willowglen) - \$99,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$99,000 for 2019. The total contract amount will be \$198,000.

**Benevolence First, Inc. - \$60,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$60,000 for 2019. The total contract amount will be \$152,662.

**Bloom, Center for Art and Integrated Therapies - \$41,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$41,000 for 2019. The total contract amount will be \$101,000.

**Bracy Psychological Services and Stress Management - \$232,553**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$39,553 for 2018 and \$193,000 for 2019. The total contract amount will be \$386,000.

**Butterflyz, LLC, dba Home Away from Home - \$200,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$200,000 for 2019. The total contract amount will be \$358,047.

**Children's Service Society of Wisconsin - \$40,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$40,000 for 2019. The total contract amount will be \$193,655.

**Childynamics - \$85,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$85,000 for 2019. The total contract amount will be \$130,136.

**Chileda Institute, Inc. - \$5,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$5,000 for 2019. The total contract amount will be \$155,000.

**Choices to Change - 100,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$100,000 for 2019. The total contract amount will be \$287,845.

**Column Rehab Services, Inc. - \$50,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$50,000 for 2019. The total contract amount will be \$100,000.

**Community Harbor, LLC - \$41,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$77,653 for 2018 and \$193,000 for 2019. The total contract amount will be \$386,000.

**Connecting Youth Group Home - \$300,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$300,000 for 2019. The total contract amount will be \$449,000.

**Dominion Behavioral Health Services, LLC - \$234,312**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$49,312 for 2018 and \$185,000 for 2019. The total contract amount will be \$370,000.

**Dr. Morano Consulting - \$149,320**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$56,320 for 2018 and \$93,000 for 2019. The total contract amount will be \$186,000.

**Eau Claire Academy - \$120,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$120,000 for 2019. The total contract amount will be \$270,541.

**Educates, LLC - \$318,014**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$153,014 for 2018 and \$165,000 for 2019. The total contract amount will be \$330,000.

**Exodus Family Services, LLC - \$105,946**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$30,946 for 2018 and \$75,000 for 2019. The total contract amount will be \$150,000.

**Family Options Counseling - \$595,641**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$105,641 for 2018 and \$490,000 for 2019. The total contract amount will be \$980,000.

**Forward Choices, LLC - \$76,673**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$9,673 for 2018 and \$67,000 for 2019. The total contract amount will be \$134,000.

**Fresh Start Counseling Center - \$350,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$350,000 for 2019. The total contract amount will be \$700,187.

**Genesee Community Services, LLC - \$162,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$162,000 for 2019. The total contract amount will be \$342,000.

**Grateful Girls – Safe Haven - \$100,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$100,000 for 2019. The total contract amount will be \$312,727.

**Harmony Social Services, CPA, Inc. - \$41,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$41,000 for 2019. The total contract amount will be \$484,599.

**Harper House – Nehemiah Project - \$200,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$200,000 for 2019. The total contract amount will be \$273,008.

**Home for the Heart - \$100,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$100,000 for 2019. The total contract amount will be \$150,000.

**Hopgood Youth Home - \$450,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$450,000 for 2019. The total contract amount will be \$800,366.

**Horizon Healthcare, Inc. - \$40,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$40,000 for 2019. The total contract amount will be \$115,000.

**House of Love Youth Homes, Inc. - \$300,000**

This vendor provides Residential Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$300,000 for 2019. The total contract amount will be \$553,925.

**Human Development Center, Inc. - \$1,144,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$1,144,000 for 2019. The total contract amount will be \$2,304,038.

**Inspiring Young Women - \$60,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$60,000 for 2019. The total contract amount will be \$299,628.

**Integrity Family Services, LLC - \$1,480,080**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$185,080 for 2018 and \$1,295,000 for 2019. The total contract amount will be \$2,590,000.

**Journey House - \$150,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$150,000 for 2019. The total contract amount will be \$202,143.

**La Causa, Inc. - \$6,110,252.18**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$1,430,252.18 for 2018 and \$4,680,000 for 2019. The total contract amount will be \$9,360,000.

**Lad Lake, Inc. - \$336,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$336,000 for 2019. The total contract amount will be \$2,833,816.

**Lutheran Social Services of Wisconsin and Upper Michigan - \$320,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$320,000 for 2019. The total contract amount will be \$1,283,466.

**MCFI Home Care, LLC - \$80,013**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$130,000 for 2019. The total contract amount will be \$130,000.

**M.D. Therapy, LLC - \$460,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$460,000 for 2019. The total contract amount will be \$688,698.

**Milwaukee Center for Independence - \$26,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$26,000 for 2019. The total contract amount will be \$2,892,557.

**Mindstar Counseling, LLC - \$120,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$120,000 for 2019. The total contract amount will be \$290,035.

**Mt. Castle Transitional Living Services - \$500,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$500,000 for 2019. The total contract amount will be \$851,025.

**New Choices - \$250,159**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$72,159 for 2018 and an additional \$178,000 for 2019. The total contract amount will be \$356,000.

**New Horizon Center, Inc. - \$160,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$160,000 for 2019. The total contract amount will be \$352,631.

**New Leaf Therapies, LLC - \$50,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$50,000 for 2019. The total contract amount will be \$102,591.

**Norris Adolescent Center - \$1,280,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$1,280,000 for 2019. The total contract amount will be \$2,495,974.

**Pathfinders Milwaukee, Inc. - \$210,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$87,000 for 2018 and an additional \$123,000 for 2019. The total contract amount will be \$326,000.

**Positive Outlook Clinical Services, LLC - \$42,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$42,000 for 2019. The total contract amount will be \$109,881.

**Psychological Assessment Services, LLC - \$137,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$137,000 for 2019. The total contract amount will be \$297,600.

**Rawhide, Inc. - \$1,000,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$1,000,000 for 2019. The total contract amount will be \$1,131,890.

**Right Turn, Inc. - \$260,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$260,000 for 2019. The total contract amount will be \$469,153.

**Rise Youth and Family Services, LLC - \$397,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$236,000 for 2019. The total contract amount will be \$472,000.

**Riverstone Counseling and Crisis Services, LLC - \$1,886,480**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$581,480 for 2018 and an additional \$1,305,000 for 2019. The total contract amount will be \$2,610,000.

**Running Rebels Community Organization - \$385,128**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$44,128 for 2018 and an additional \$341,000 for 2019. The total contract amount will be \$682,000.

**Sebastian Family Psychology Practice, LLC - \$1,357,989**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$78,989 for 2018 and an additional \$1,279,000 for 2019. The total contract amount will be \$2,558,000.

**Servant Manor Strategies, Inc. - \$120,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$120,000 for 2019. The total contract amount will be \$127,545.

**Servant Manor, Inc. - \$540,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$540,000 for 2019. The total contract amount will be \$836,047.

**Southwest Key Programs, Inc. - \$73,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$73,000 for 2019. The total contract amount will be \$190,610.

**Spahn Clinical Services - \$126,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$126,000 for 2019. The total contract amount will be \$252,000.

**St. Charles Youth and Family Services, Inc. - \$6,160,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$6,160,000 for 2019. The total contract amount will be \$10,072,858.23.

**Thrive Treatment Services, LLC - \$436,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$436,000 for 2019. The total contract amount will be \$775,622.

**V.I.C. Living Center, LLC - \$200,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$200,000 for 2019. The total contract amount will be \$391,585.

**Willowglen Academy – Wisconsin, Inc. - \$2,414,032**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$597,032 for 2018 and an additional \$1,817,000 for 2019. The total contract amount will be \$3,634,000.

**Wisconsin Community Services, Inc. - \$117,000**

This vendor provides Behavioral Health and/or Social Services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$41,000 for 2018 and an additional \$76,000 for 2019. The total contract amount will be \$152,000.

## **Fiscal Summary**

The amount of spending requested in this report is summarized below.

Vendor Name	New/Amendment	2018 Increase	2019 Amount	Total Contract Amount
A Clearer Vision dba Eliana Homes	Amendment		\$131,510.32	\$263,020.64
A Place for Miracles	Amendment	\$82,000	\$102,000	\$204,000
Access Recovery Mental Health Services	Amendment	\$155,623	\$257,000	\$514,000
Alternative Family Services, LLC	Amendment		\$56,000	\$155,000
Alternative in Psychological Consultation, S.C.	Amendment		\$2,213,000	\$4,441,512.67
Arunaobi Integrated Medical Behavioral Health Clinic	Amendment		\$54,000	\$153,000
Phoenix Care Systems, Inc. dba Bell Therapy, Inc.	Amendment		\$6,715,000	\$13,004,724.20
Brotoloc South, Inc.	Amendment		\$154,000	\$346,716.70
Community Living Arrangements, Inc.	Amendment		\$51,000	\$168,482
Crossroads Behavioral Health Services	Amendment		\$10,000	\$69,130
East Point Residential Facility, LLC	Amendment	\$32,874.37	\$105,000	\$210,000
Easter Seals Southeast WI, Inc.	Amendment	\$52,897	\$328,000	\$656,000
Empathetic Counseling Services, Inc.	Amendment		\$203,000	\$971,395
Epitomized Living, LLC	Amendment		\$99,000	\$198,000
Goodwill Industries of Southeastern, WI	Amendment		\$301,000	\$637,236
Guest House of Milwaukee	Amendment	\$257,328.44	\$1,260,000	\$2,262,671.56
Alternative in Psychological Consultation, S.C.	Amendment		\$1,312,000	\$2,829,725
Horizon Healthcare, Inc.	Amendment		\$504,000	\$1,275,725
La Causa, Inc.	Amendment		\$713,000	\$1,433,276

Vendor Name	New/Amendment	2018 Increase	2019 Amount	Total Contract Amount
MCFI dba Whole Health Medical	Amendment		\$1,133,000	\$2,429,498
Milwaukee Mental Health Associates	Amendment	\$117,344	\$709,000	\$1,300,656
Outreach Community Health Centers	Amendment		\$464,000	\$1,235,725
Wisconsin Community Services	Amendment		\$1,138,000	\$2,461,208
Genesis Behavioral Health Services, Inc.	Amendment		\$770,000	\$1,621,472
Matt Talbott	Amendment		\$1,186,000	\$2,392,648
Meta House	Amendment		\$1,376,000	\$2,852,125
United Community Center	Amendment	\$726,205	\$2,471,000	\$4,942,000
Homes for Independent Living of WI, LLC	Amendment	\$159,364.20	\$643,000	\$1,286,000
Integrity Residential Services, Inc.	Amendment		\$165,906	\$331,812
Jefferson Crest, LLC	Amendment	\$89,504.92	\$590,000	\$1,180,000
Jewish Family Services, Inc.	Amendment	\$84,779.02	\$130,000	\$260,000
JusticePoint, Inc.	Amendment	\$2,008,857	\$2,061,000	\$4,122,000
Matt Talbott Recovery Services, Inc.	Amendment		\$50,000	\$1,322,976.10
Meta House	Amendment	\$87,860.34	\$182,000	\$364,000
Milwaukee Mental Health Associates, Inc.	Amendment	\$218,625.30	\$222,000	\$444,000
Multicultural Community Services, Inc.	Amendment		\$368,000	\$748,313
Mystic Creek	Amendment	\$103,115	\$368,000	\$648,000
Our Safe Place, Inc.	Amendment		\$226,800	\$453,600
Outreach Community Health Centers	Amendment		\$500,000	\$1,035,619.93
Professional Services Group	Amendment	\$133,000	\$153,000	\$306,000

Vendor Name	New/Amendment	2018 Increase	2019 Amount	Total Contract Amount
Project Access	Amendment	\$421,740.91	\$432,000	\$864,000
Sebastian Family Psychology Practice, LLC	Amendment	\$305,000	\$325,000	\$650,000
St. Charles	Amendment	\$30,000	\$80,000	\$160,000
Summit Wellness, Inc.	Amendment		\$762,000	\$1,164,252
United Community Center	Amendment		\$133,000	\$1,842,474
Wisconsin Community Service	Amendment		\$1,367,924	\$2,735,848
Wisconsin Nazarene Compassionate Center	Amendment		\$82,000	\$265,209
Word of Hope Ministries	Amendment		\$20,000	\$109,474
La Causa, Inc.	Amendment		\$1,788,000	\$4,309,895
MCFI Home Care	Amendment	\$125,000	\$200,000	\$400,000
MCFI dba Whole Health Medical	Amendment		\$1,768,000	\$5,329,148
MCFI dba Whole Health Medical	Amendment		\$2,280,000	\$4,801,895
Adkins Counseling Services, LLC	Amendment	\$182,982	\$436,000	\$872,000
Alternatives to Psychological Consultation, SC	Amendment	\$2,913,296.89	\$5,000,000	\$9,448,000
American United Cab	Amendment		\$411,003	\$822,006
Anu Family Services, Inc.	Amendment		\$503,687	\$1,007,374
Bell Therapy, Inc. (Willowglen)	Amendment		\$99,000	\$198,000
Benevolence First, Inc.	Amendment		\$60,000	\$152,662
Bloom, Center for Art and Integrated Therapies	Amendment		\$41,000	\$101,000
Bracy Psychological Services & Stress Management	Amendment		\$232,553	\$386,000
Butterflyz, LLC dba Home Away from Home	Amendment		\$200,000	\$358,047

Vendor Name	New/Amendment	2018 Increase	2019 Amount	Total Contract Amount
Children's Service Society of Wisconsin	Amendment		\$40,000	\$193,655
Childynamics	Amendment		\$85,000	\$130,136
Chileda Institute, Inc.	Amendment		\$5,000	\$150,000
Choices to Change	Amendment		\$100,000	\$387,845
Column Rehab Services, Inc.	Amendment		\$50,000	\$100,000
Community Harbor, LLC	Amendment	\$77,653	\$193,000	\$386,000
Connecting Youth Group Home	Amendment		\$300,000	\$449,000
Dominion Behavioral Health Services, LLC	Amendment	\$49,312	\$185,000	\$370,000
Dr. Morano Consulting	Amendment	\$56,320	\$93,000	\$186,000
Eau Claire Academy	Amendment		\$120,000	\$270,541
Educates, LLC	Amendment	\$153,014	\$165,000	\$330,000
Exodus Family Services, LLC	Amendment	\$30,946	\$75,000	\$150,000
Family Options Counseling	Amendment	\$105,641	\$490,000	\$980,000
Forward Choices, LLC	Amendment	\$9,673	\$67,000	\$134,000
Fresh Start Counseling Center	Amendment		\$350,000	\$700,187
Genesee Community Services, LLC	Amendment		\$162,000	\$342,000
Grateful Girls – Safe Haven	Amendment		\$100,000	\$312,727
Harmony Social Services CPA, Inc.	Amendment		\$41,000	\$484,599
Harper House – Nehemiah Project	Amendment		\$200,000	\$273,008
Home for the Heart	Amendment		\$100,000	\$150,000
Hopgood Youth Home	Amendment		\$450,000	\$800,366

Vendor Name	New/Amendment	2018 Increase	2019 Amount	Total Contract Amount
Horizon Healthcare, Inc.	Amendment		\$40,000	\$115,000
House of Love Youth Homes, Inc.	Amendment		\$300,000	\$553,925
Human Development Center, Inc.	Amendment		\$1,144,000	\$2,304,038
Inspiring Young Women	Amendment		\$60,000	\$299,628
Integrity Family Services, LLC	Amendment	\$185,080	\$1,295,000	\$2,590,000
Journey House	Amendment		\$150,000	\$202,143
La Causa, Inc.	Amendment	\$1,430,252.18	\$4,680,000	\$9,360,000
Lad Lake, Inc	Amendment		\$336,000	\$2,833,816
Lutheran Social Services of Wisconsin and Upper Michigan	Amendment		\$320,000	\$1,283,446
MCFI Home Care, LLC	Amendment	\$15,013	\$65,000	\$130,000
M.D. Therapy, LLC	Amendment		\$460,000	\$688,698
Milwaukee Academy	Amendment		\$780,000	\$1,051,357
Milwaukee Center for Independence	Amendment		\$26,000	\$2,892,557
Mindstar Counseling, LLC	Amendment		\$120,000	\$290,035
Mt. Castle Transitional Living Services	Amendment		\$500,000	\$851,025
New Choices	Amendment	\$72,159	\$178,000	\$356,000
New Horizon Center, Inc.	Amendment		\$160,000	\$352,631
New Leaf Therapies, LLC	Amendment		\$50,000	\$102,591
Norris Adolescent Center	Amendment		\$1,280,000	\$2,495,974
Pathfinders Milwaukee, Inc.	Amendment	\$87,000	\$123,000	\$326,000
Positive Outlook Clinical Services, LLC	Amendment		\$42,000	\$109,881

Vendor Name	New/Amendment	2018 Increase	2019 Amount	Total Contract Amount
Psychological Assessment Services, LLC	Amendment		\$137,000	\$297,600
Rawhide, Inc.	Amendment		\$1,000,000	\$1,131,890
Right Turn, Inc.	Amendment		\$260,000	\$469,153
Rise Youth and Family Services	Amendment	\$161,000	\$236,000	\$472,000
Riverstone Counseling and Crisis Services, LLC	Amendment	\$581,480	\$1,305,000	\$2,610,000
Running Rebels Community Organization	Amendment	\$44,128	\$341,000	\$682,000
SaintA	Amendment		\$1,405,000	\$5,100,602
Sebastian Family Psychology Practice, LLC	Amendment	\$78,989	\$1,279,000	\$2,558,000
Servant Manor Strategies, Inc.	Amendment		\$120,000	\$127,545
Servant Manor, Inc.	Amendment		\$540,000	\$836,047
Southwest Key Programs, Inc.	Amendment		\$73,000	\$190,610
Spahn Clinical Services	Amendment	\$35,915	\$126,000	\$252,000
St. Charles Youth and Family Services, Inc.	Amendment		\$6,160,000	\$10,072,858.23
Thrive Treatment Services, LLC	Amendment		\$436,000	\$775,622
V.I.C. Living Center, LLC	Amendment		\$200,000	\$391,585
Willowglen Academy – Wisconsin, Inc.	Amendment	\$597,032	\$1,817,000	\$3,634,000
Wisconsin Community Services, Inc.	Amendment	\$41,000	\$76,000	\$152,000
<b>Total</b>		<b>\$12,099,005</b>	<b>\$76,687,383.32</b>	<b>\$163,730,873.03</b>

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Mary Jo Meyers, Director  
Department of Health and Human Services  
Cc: Maria Perez, Finance Chairperson

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

**DATE:** March 22, 2018

**TO:** Mary Neubauer MSW, CPS, Chairperson, Mental Health Board Quality Committee

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

**SUBJECT:** Requesting acceptance and approval of the 2017 Annual Review of the Environment of Care Program, and the 2018 Environment of Care Management Plans

**Issue**

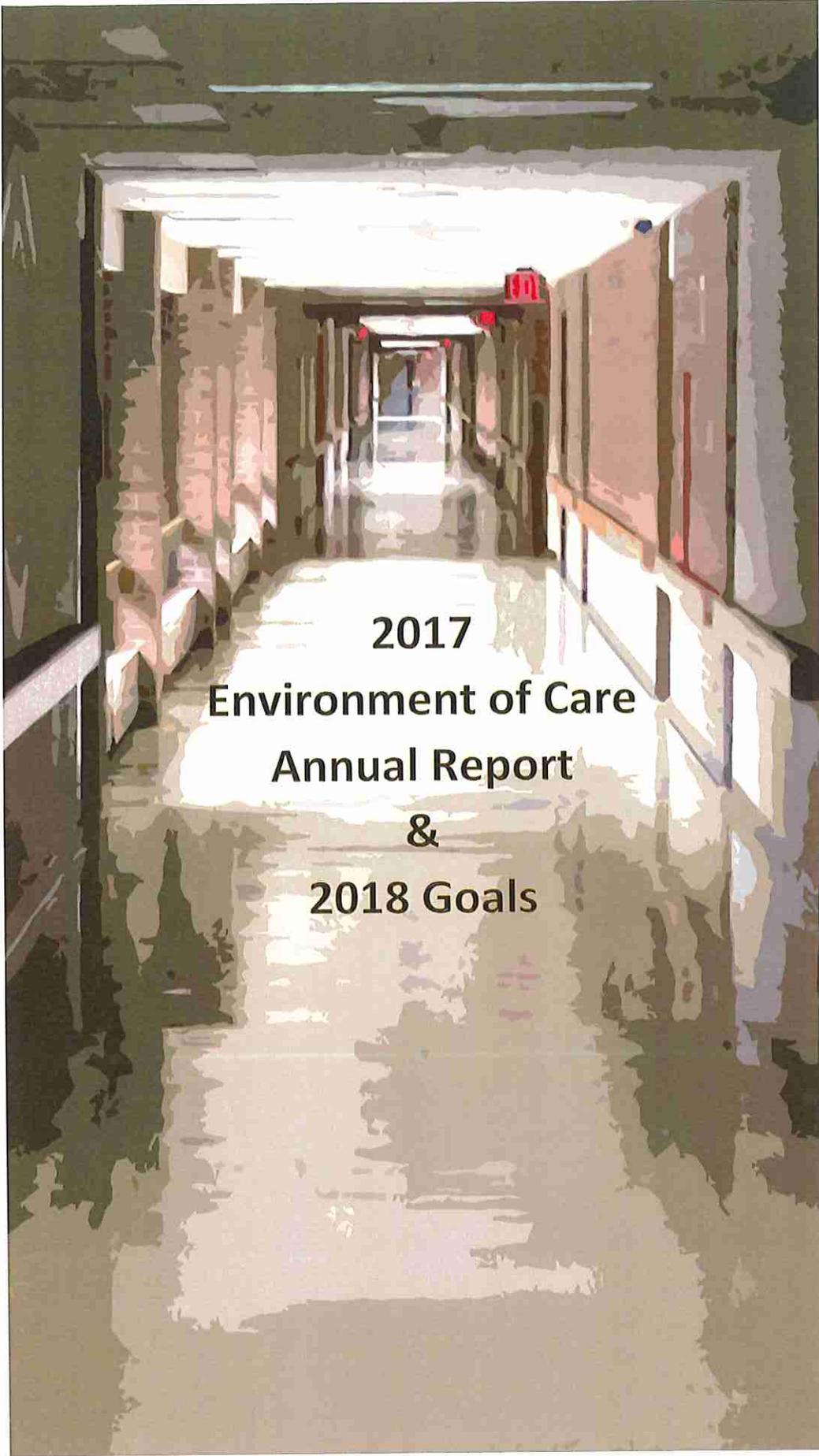
BHD is requesting the annual approval of the Environment of Care Annual Report and Management Plans per The Joint Commission Standards and the Mental Health Board By-laws.

**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 2017 Annual Report of the Environment of Care program and the 2018 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.



**2017  
Environment of Care  
Annual Report  
&  
2018 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 2017 Annual Report and 2018 Goals**

The BHD Environment of Care Management Plans were all reviewed and updated for 2018. Changes made included:

Updates related to the implementation of the electronic incident reporting system, the addition of the Public Safety Department, DNR reporting requirements for Regulated Medical Waste and changes to The Joint Commission Requirement reference numbers.

### **Highlights of achievements and 2018 Goals:**

#### **GENERAL SAFETY**

General safety improvements include resurfacing of roads and potholes, previously a source of falls and injuries.

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2017 the response rate of 97% was attained. There were a total of 1430 urgent recalls/alerts issued during 2017. Only 7 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 2018
2. Rounds documentation is still in development.
  - The goal was not met in 2017. Recommend continuing with this goal in 2018. The rounding system is being adjusted to provide more accurate tracking of deficiencies and correction timeframes. Responders need additional training regarding entering corrections into the system.
3. In 2017 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.

#### **SECURITY**

Security improvements made at BHD include: Installation of a Badge Scan/ Pass system that will be utilized by Public Safety. In 2018 this contract will make improvements in visitor tracking. Additional security related policies and procedures continue to be drafted to further clarify practices for 2018.

1. Security Department Roll Call Updates: In 2017, 52 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 2017 was met. The goal for 2018 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 2016 there were 6 thefts, 3 minor property damage auto accidents. In 2017 there were two Vandalism incidents 0 thefts.
  - The goal for 2018 will be limit the number of incidents to less than or equal to 3.

3. Unauthorized absences from locked units: In 2016 – 7 absences from locked units, In 2017 –5 absences from a locked unit.
  - Although unauthorized absences are an inherent and recognized risk at BHD, no unauthorized absence is acceptable. As such, the goal for 2018 will remain to keep the total number of absences to zero.
  
4. Unsecured Area incidents: 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. 2017 there were two incidents reported that exit door was left propped open with a safety cone and piece of paper by employee. BHD has been systematically replacing doors that have been deteriorating.
  - In 2018, the goal will continue to reflect the occurrence of both human factors as well as mechanical failures. The goal will be to have 10 or fewer incidents in 2018.
  
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. In 2017 there were 3 camera outages reported, all were reported to EES within the 1 hour time frame.
  - The goal for 2018 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.

Additional goals may be added during the year

## HAZARDOUS MATERIALS AND WASTE

In 2015, BHD was identified by the Wisconsin Department of Natural Resources (WDNR) rules as a generator of infectious waste. A generator produces more than 50# per month. Since that time, BHD, with increased surveillance and education, has reduced the amount of infectious waste generated in-house each year.

Year	Total Weight (in lbs)	Monthly Average (in lbs)
2014	3262	272
2015	1589*	132
2016	885**	74
2017	492.59	41
*2015 December weights estimate		
**2016 Jan, Feb and Dec weights estimated		

An infectious waste report for 2017 will be filed with the WDNR once the site is open for submission for the year. Reports for 2015 and 2016 were filed in 2017.

BHD's 2018 goal is to continue the downward trend and achieve the 50# or less per month of regulated medical waste generation for the twelve month period thereby eliminating the DNR reporting requirement.

## EMERGENCY MANAGEMENT

BHD participated in several community based emergency exercises in 2017. The state wide tornado drill, the MRMC tabletop event on prolonged loss of power, and the MRMC Campus-wide Violent Event exercise (a functional exercise).

6 management staff were trained in ICS 100 and 200 during 2017. The goal of 25% of management staff being trained in ICS 100 and 200 was not met. However, a shortened version of the trainings was located and is being considered for implementation in 2018. This training incorporates an effective practical application session. The goal is to have at least 50% of management staff trained in ICS 100 and 200 by the end of the year.

BHD is part of the Milwaukee Regional Medical Center's newly implemented Emergency Coordination Plan (ECP), which focuses on coordinating efforts and resources of the 6 partner organizations. BHD provides coverage for one of two Emergency Command Positions 12 weeks per year. The ECP was implemented in August of 2017.

## **FIRE PREVENTION**

In 2017 BHD made 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 were systematically changed out to a newer anti-ligature variety.

1. The number of completed fire drills: In 2017 EES (Engineering & Environmental Services) completed 60 fire drills at the Behavioral Health Division. This number (60) of completed fire drills represents a 100 % completion rate of all necessary fire drills for the Behavioral Health Division.
  - In 2018 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 2017 the average score recorded on the fire drill check sheets was 100%.
  - In 2018 the goal will be to maintain the 97 % or higher score on the fire drill check sheets.
3. In 2017 the total number of reported fire setting contraband items that were detected on patient units was 2. This meets the goal of having less than 4 contraband items on patient units.
  - In 2018 the goal will be to maintain the level of having less than 4 incidents.
4. Due to the age of the fire alarm system, the trouble alarms were tracked and reported out on at meetings. In 2017 there were zero trouble alarms.
  - In 2018 the goal will be to continue to track trouble alarms.

## **UTILITIES MANAGEMENT**

In 2017, wiring alterations were 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 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. In 2017 a 91.74% completion rate was achieved.
  - In 2018 the goal for EES will be to achieve a minimum of a 90% completion rate for all Critical and Life Safety Systems P.M.'s or preventative maintenance work orders.
2. 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 was to have the branch valves labeled and inventoried. EES achieved a 50 % completion..
  - In 2018 the goal will be to have the remainder of the branch valves labeled and inventoried.
3. The percentage of times the emergency generator testing failed: The emergency generator for the 9455 building did not fail any monthly testing. BHD had one electrical failure during the year. The emergency generator kicked in immediately and full power was restored within two hours.
  - Generator testing failures will be recorded for 9455 building in 2018.
4. 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. The tampering of mechanical door locks was limited to only one event that was immediately taken care of.

- This item will be eliminated in 2018.

## **MEDICAL EQUIPMENT**

No new clinical equipment was purchased in 2017. Equipment removed from service included emergency "crash carts" and ambulatory restraints. The carts were replaced with simple "Go Kits" that include pressure dressings, sphygmomanometers, stethoscope, gloves, pen light, scissors, face shield, CPR pocket resuscitator and spill kit. Go Kits are located throughout the facility including the exam room of each active unit. Spare/replacement kits are available in Central Supply.

The AEDs that were removed from the crash carts have been redeployed throughout the building. BHD, in conjunction with the Milwaukee County Office of Emergency Management (OEM), monitor the units and replace pads and batteries as needed. Two spare units are available in Central Supply.

Suction machines that were removed from the crash carts have also been redeployed to each unit's exam room and in various locations throughout BHD. Additional carts are available in Central Supply.

BHD continues to contract with Universal Hospital Services (UHS) to monitor / calibrate remaining clinical equipment on a regular basis. The UHS inventory of equipment managed by UHS has been updated due to the reductions noted above.

There were no significant reported equipment repairs requested in 2017. Thermometers, glucometer and other expendable items are replaced as they fail.

This goal was met and BHD will continue to monitor and report on equipment repairs.

## **EDUCATIONAL GOALS**

In 2017 trainings regarding Active Shooter, Workplace Safety, OSHA Safety, and Fire Safety were completed. Completion rates for Workplace Safety and OSHA Safety were at 47%. Fire Safety 89%, and Active Shooter 50%. These training topics will be repeated in 2018. Staff assignments have been clarified to better identify and communicate expectations.

Training topics Training topics for 2018 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 2018:**

- **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.**



Date Issued:	1/1/2015
Last Approved Date:	N/A
Last Revised Date:	3/7/2018
Next Review:	3 years after approval
Owner:	Lynn Gram: 11003002-Safety Officer
Policy Area:	Environment of Care
References:	

## Safety Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (MCBHD) 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-EP34)

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-EP34)

Department Directors and/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 and implement 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~~2)** The EC Committee membership includes representatives from Administration, Clinical Programs, Support Services and Contract Management. The EC committee specifically discusses safety concerns and issues a minimum of six (6) times per year, and incorporates information on Safety related activities into the bi-annual report.
- F. Policies and Procedures –** The Safety Officer is responsible for coordinating the development of general safety policies and procedures. Individual department managers are responsible for managing the development of departmental specific safety policies and procedures, which include but is not limited to, safe operations, use of hazardous equipment, and use of personal protective equipment. The Safety Officer assists department managers in the development of new department safety policies and procedures.

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

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

**G. Safety Officer Appointment – (EC01.01.01-EP1)** The Hospital Administrator is responsible for managing

the Safety Officer appointment process. If the position should become vacant, the Hospital Administrator is responsible for selecting a qualified individual capable of overseeing the development, implementation, and monitoring of the Safety Management Program.

- H. **Intervention Authority** – ~~(EC 01.01.01-EP2)~~ The Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call have been given authority by the Hospital Administrator or their designee to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings. Any suspension of activity shall immediately be reported to the Hospital Administrator, or designee, and the Medical Director when appropriate.
- I. **Grounds and Equipment** – (EC02.01.01-EP5) The Environment and Engineering Services (EES) department is responsible for scheduling and performing maintenance of hospital grounds and equipment. Policies and procedure for this function are located in the EES department and/or the on-line Policy repository.

## 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~~ reported to BHD Executive Team annually.
- 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 EP ~~4-31 & 2~~; HR 01.04.01 EP ~~4-31 & 3~~; LD 03.01.01 EP ~~4-401-5~~) 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 ~~4-431~~)
- 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 ~~4-31 & 2~~; HR 01.04.01 EP ~~4-31 & 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 4-31 & 2; HR 01.04.01 EP 4-71 & 3)

## PERFORMANCE MONITORING

(EC 04.01.03 EP 4-32); EC 04.01.05 EP 4-31)

- A. Ongoing performance monitoring is conducted for the following performance monitors:
1. Actions taken for urgent recalls and alerts are documented in RASMAS within 3 days a minimum of 95% of the time
  2. Measure 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. Smoking materials are removed from all patients upon admission.

Reviewed and approved at the Environment of Care Committee meeting on: 2-9-173-8-18

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-15-17~~3-21-18

**Attachments:**

No Attachments

**Approval Signatures**

Step Description	Approver	Date
	Lynn Gram: 11003002-Safety Officer	pending

COPY



Date Issued: 1/1/2015  
Last Approved Date: N/A  
Last Revised Date: 3/7/2018  
Next Review: 3 years after approval  
Owner: Lynn Gram:  
11003002-Safety Officer  
Policy Area: Environment of Care  
References:

## Security Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (MCBHD) 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 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-EP45)

The MCBHD Security Department is made up of two contracted components: Security which provides service to the Crisis and Inpatient areas and Public Safety which provides service to all public and non patient care areas and is overseen by the Engineering and Environmental Services Department (EES). The term MCBHD Security Department will refer to the combination of Security, Public Safety, services throughout this plan.

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/Safety Event 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-EP45)

## INTENT PROCESSES:

- A. **Emergency Security Procedures (EC 02.01.01 EP 9; EM 02.02.05 EP1-10)** – The BHD Security and EES 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 officers are deployed as necessary, and report in to the base (Dispatcher Control Center) and/or Incident Command Center as appropriate.

- B. **Addressing Security Issues (EC 02.01.01 EP 1&3)** – A security risk assessment will be conducted annually of the facility ~~and out stations~~. The purpose of the risk assessment is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The Security Supervisor works with the Safety Officer, department managers, the Quality and Risk Manager and others as appropriate. The results of the risk assessment process are

used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner. The Security Department has input into the creation of employee training sessions regarding security related issues. The Security Supervisor and Security Contract Manager maintain a current knowledge of laws, regulations, and standards of security. The Security Supervisor and Security Contract Manager also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of BHD.

- C. **Reporting and Investigation (EC 04.01.01 EP 1&6; EC 04.01.03 EP 4-22)** – Security and Safety events are recorded in the MCBHD electronic Incident reports are completed Safety Event Reporting System 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 and the Risk Manager conducts an investigation and recommends/initiates follow up ~~and then sent to the Quality Management Services Department. The Quality and Risk Manager works with actions as~~ 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~~ Management staff conduct an aggregate analysis of safety event/incident reports 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 ~~Supervisor collaborate to conduct an aggregate~~ Management Program. The findings of such 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~~ reported to the Environment of Care Committee as part of the quarterly 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 the Operations Department including BHD 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/Public Safety and/or operations staff** 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 EP ~~4-31~~ & 2**; **HR 01.04.01 EP ~~4-31~~ & 3**; **LD 03.01.01 EP ~~4-401-5~~**)
- 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 ~~4-431~~**)
- 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 ~~4-31~~ & 2**; **HR 01.04.01 EP ~~4-31~~ & 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 ~~4-71~~ & 3**)

## PERFORMANCE MONITORING

(**EC 04.01.03 EP ~~4-3~~2**; **EC 04.01.05 EP ~~4-31~~**)

- 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 ≤ **53** 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 ≤ 10 times)
  - 5. Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)
- 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 Environment of Care Committee meeting on: ~~2-9-17~~3-8-18

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-15-17~~3-21-18

### Attachments:

No Attachments

### Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 11003002-Safety Officer	pending



Date Issued: 1/1/2013  
 Last Approved Date: N/A  
 Last Revised Date: 3/7/2018  
 Next Review: 3 years after approval  
 Owner: Lynn Gram:  
 11003002-Safety Officer  
 Policy Area: Environment of Care  
 References:

## Hazardous Materials and Waste Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (MCBHD) 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)~~ **(EC 01.01.01-EP 6)**

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.
7. To reduce the amount of HMW/RMW generated at MCBHD by preventing the mixing of wastes and promoting practical alternatives to hazardous, regulated or disposable items.

## AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, and evaluate the effectiveness of the HMWM Program and its components on an annual basis based on all applicable HMW/RMW rules and regulations. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. ~~(EC 01.01.01-EP5)~~ (EC 01.01.01-EP6)

## 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)

MCBHD does not, as part of normal operation and with the exception of RMW, generate hazardous waste as defined by those applicable laws and regulations defined below. All hazardous materials are used in accordance with manufacturer guidelines.

**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 ([MSDSOnline](#)) 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 ~~02.02.01.04~~ 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 02.02.01 EP 3 & 4; EC 04.01.01 EP 3-4)** HMW spills are reported on the MCBHD electronic Incident/Risk Management Report form Safety Event Reporting System. 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 [electronic Incident/Risk Management Report Safety Event Reporting System](#) and the Accident/[Loss Report Claims Reporting System](#). 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 ~~02.02.01.04~~ 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 [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 ~~02.02.01.04~~ 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 [per the contracted agencies Hazard Communications Program](#). ~~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 ~~02.02.01.04~~ 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 ~~02.02.01.04~~ 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.

**Managing Infectious & Regulated Medical Wastes including Sharps - (EC 02.02.01 EP 1; IC 02.01.01 EP 6)**

Wisconsin state statute defines the following:

"infectious waste" as a "solid waste that contains pathogens with sufficient virulence and in sufficient quantity that exposure of a susceptible human or animal to the solid waste could cause the human or animal to contract an infectious disease.

"medical waste" is an "infectious waste and other waste that contains or may be mixed with infectious wastes".

As a behavioral health hospital, MCBHD does not generate the types of RMW generally associated with a medical hospital. The types of medical waste generated by MCBHD include only sharps (including syringes and lancets) and bandages (although generally not in a "saturated" condition). Further, medical equipment at MCBHD is generally limited to automated external defibrillators (AEDs), suction machines and vitals monitoring equipment. As such, the type of materials available for reprocessing is limited.

The EC Committee, in conjunction with the IP Committee and the EES Department is responsible for the evaluation and implementation of alternative waste management practices, the evaluation and implementation of alternatives to disposables, and the activities associated with monitoring and assessment. This RMW plan, and any amendments and progress reports to this plan, will be made available to BHD's medical waste disposal contractor. These may also be provided to the WDNR upon request and to any other person who requests these documents in writing or in person. A reasonable fee may be charged to cover the cost of copying and mailing these documents.

RMW minimization efforts begin at procurement as any new product purchased for use at the BHD requires the approval of the Infection Prevention (IP) Committee. To improve waste management practices, BHD's IP Committee may consider costs, probable adverse effects on staff, patients or patient care, recycling options, product availability and regulatory compliance. Additional procurement considerations may also include a cost benefit analysis (replacement, treatment and disposal), potential short or long term liabilities and applicable local, state and federal recycling and disposal regulations.

Approved items are purchased in such quantities as to maintain "par" levels on each clinical unit. MCBHD EES and nursing staff monitor expiration dates to maintain the viability of the approved products. Where practicable, MCBHD will reuse items after appropriate reprocessing (ie restraints after sterilization).

BHD also minimizes the amount of medical waste generated at its facility through the use of the waste reduction hierarchy (waste reduction, reuse, recycling (where applicable)) and staff education. Waste reduction may be accomplished by, but not be limited to, reducing the amount of packaging, reducing the amount of disposable items used, product substitution, equipment modification, purchasing policies, housekeeping practices and more effective separation practices. It is BHD's goal to reduce the volume of medical waste to below 50 pounds per month or that volume that requires reporting to the WDNR.

RMW are managed for MCBHD by the EES Department in conjunction with the contracted Housekeeping provider. The Housekeeping provider is responsible for the distribution and collection of appropriate containers for the collection of RMW including medical sharps. Sharps and other infectious wastes are accumulated at satellite locations across the clinical areas but, in the case of sharps containers, never in patient areas. The containers, provided by MCBHD, are easily identifiable as RMW or isolation containers, are leak-proof and are puncture resistant. Sharps containers, when full, can be locked to prevent inadvertent needle sticks. 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. 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.

MCBHD techniques to facilitate appropriate disposal by nursing staff will include the review of signage at disposal points, the placement of RMW disposal containers close to likely sources, the placement of non-RMW waste containers in proximity to RMW containers to easily discard items in the correct container yet far enough away from common sources of non-RMW waste (ie paper towel holders) to prevent inadvertent or inappropriate disposal. Where appropriate, patients are also instructed on correct infectious and regulated waste disposal when necessary (e.g. when on isolation precautions)

MCBHD does not treat any medical waste on-site. Collected infectious waste containers are managed through a licensed medical waste transportation and disposal (T&D) contractor who renders the RMW harmless and provides for their disposal in accordance with applicable federal, state and local waste regulations. Shipment manifests are completed by BHD and its T&D contractor prior to shipment. Manifests and Certificate of Disposals (CD) are maintained by MCBHD's EES office for a period of five (5) years. All employees signing a manifest have been trained in accordance with local, state and federal regulations, as applicable.

The BHD EES office monitors weight reports received from its contracted T&D firm and report monthly and annual volume to both the EC and IP Committees. Annual progress reports for each calendar year are submitted to the WDNR by March 1 of the following year (or at the time WDNR opens reporting for the prior year). Reported information will include the rate of medical waste generated in addition to plan information (see Wis Stat NR 526).

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**

#### **02.02.01.04 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/RMW 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 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3; LD 03.01.01 EP ~~4-40~~ 1-5)
- 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 ~~4-43~~ 1)
- 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 ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 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 ~~4-31~~ & 2; HR 01.04.01 EP ~~4-71~~ & 3)

## **PERFORMANCE MONITORING**

(EC 04.01.03 EP ~~4-32~~; EC 04.01.05 EP ~~4-31~~)

- A. Ongoing performance monitoring is conducted for the following performance indicators:
  - 1. Measure the pounds of regulated medical waste sent for disposal. (Goal < 50 #/month)
  - 2. Audits of RMW storage locations are completed during environmental rounds and reported as part of rounds data.
- 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 Environment of Care Committee meeting on: ~~2-9-17~~ 3-8-18

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-15-17~~ 3-21-18

### Attachments:

No Attachments

### Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	3/7/2018



Date Issued: 1/1/2015  
 Last Approved Date: N/A  
 Last Revised Date: 3/7/2018  
 Next Review: 3 years after approval  
 Owner: Lynn Gram:  
 11003002-Safety Officer  
 Policy Area: Environment of Care  
 References:

## Fire/Life Safety Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (MCBHD) 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 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-EP67)**

MCBHD locations include:

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

## **OBJECTIVES:**

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

## AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable life safety regulations, and evaluate the effectiveness of the fire prevention program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Committee along with any other program or department necessary for effective functioning. (EC 01.01.01-EP47)

## INTENT PROCESSES:

- A. **Protection from fire, smoke and other products of combustion** –The MCBHD occupancies are maintained in compliance with NFPA ~~401-2000~~101-2012 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 ~~4-3~~1-6)

Any remodeling or new construction is designed to maintain separations and in accordance with state and federal codes including NFPA LS ~~401-2000~~101-2012 Chapters 18/19 ~~and 38/39~~; NFPA 90A ~~2012~~ and NFPA ~~72-1999~~72-2010 and maintained to minimize the effects of fire, smoke, and heat. (ECLS 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, & ~~9-8-10~~; LS 01.01.01 EP 45; 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 ~~4-40~~1-15;)
- 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 ~~4-32~~1-42)
- To provide and maintain proper barriers to protect individuals from the hazards of fire and smoke. (LS 02.01.30 EP ~~4-25~~1-26)
- To provide and maintain the Fire Alarm system in accordance with NFPA 72-1999. (LS 02.01.34 EP ~~4-41~~1-10)
- 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 47)

**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 ~~4-33~~-6, & ~~5-44~~8-13)

- 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 ~~4-41~~1-5)
- D. **Reporting and Investigation** – (EC 04.01.01 EP 9; EC 04.01.03 EP ~~4-22~~)– 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 ~~4-41~~1-15) 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 ~~9-8~~-10; EC 02.03.03 EP 1-5) Emergency procedures are outlined in the Fire Safety Plan for each building. These plans are kept in the Environment of Care manual. The Hospital Incident Command System (HICS) may be implemented to facilitate emergency management of a fire or life safety related event.
- H. **Fire Drills** - (EC 02.03.03-EP 1-5) Employees are trained and drilled regularly on fire emergency procedures, including the use and function of the fire and life safety systems (i.e. pull stations, and

evacuation options). The hospital conducts fire drills once per shift per quarter in each building defined as healthcare and once per year in business occupancies. A minimum of 50% of these drills are unannounced.

## ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3; LD 03.01.01 EP ~~4-401-5~~) 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 ~~4-431~~)
- 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 ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 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 ~~4-31~~ & 2; HR 01.04.01 EP ~~4-71~~ & 3)

## PERFORMANCE MONITORING

(EC 04.01.03 EP ~~4-3~~ 2; EC 04.01.05 EP ~~4-31~~)

- A. Ongoing performance monitoring is conducted for the following performance monitors:
1. Measure the number of Fire drills completed (Goal = 60/year)
  2. Measure the average score on the fire drill check sheet. (Goal is 97%)
- 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

### (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 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 Environment of Care Committee meeting on: ~~2-9-17~~3-8-18

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-15-17~~3-21-18

### Attachments:

No Attachments

### Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 11003002-Safety Officer	pending



Date Issued: 1/1/2015  
Last Approved Date: N/A  
Last Revised Date: 3/7/2018  
Next Review: 3 years after approval  
Owner: Lynn Gram:  
11003002-Safety Officer  
Policy Area: Environment of Care  
References:

## Utilities Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (**MCBHD**) 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 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-EP8,9)

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~~BHD Executive Team (DLTET) and Medical Staff ~~Organization~~Executive Committee (MSOMEC) 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-EP4\_9)

## INTENT PROCESSES:

- A. **Environment of Care, Design and Installation of Utility Systems (EC 02.05.01-EP1 & 2; EC 02.05.03 EP 1)**– 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 prevention and 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 56 & 67; 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 34 & 45; EC 02.05.05-EP3, 4, 5, & 56; EC 02.05.07-EP401-10)**– 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-EP23; EC 02.05.05-EP 1)**– Risk based criteria will be established to identify components of utility systems that are high-risk and have significant impact on life support, infection prevention and 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 02.05.01 EP 19; EC 02.05.03-EP4-61-7, 13; EC 02.05.07-EP 1, 2, 4 & 67)**– 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
  - Weekly and monthly emergency generator 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 & 3-14)

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

**Note:** The facilities emergency electrical system is fed from a dedicated 24KV feed from WE Energies. This feed is backed up by an emergency 650 KVA generator. This generator is inspected and tested weekly by a contracted service, in compliance with applicable local and State CMS requirements. Additionally the contractor also performs the annual load bank testing to ensure proper operation of the generator. The facility's back-up power system electrician reviews the reports. Documentation of testing is ~~provided by a separate electrical line from the We Energies plant located at 9250 Watertown Plank Rd., Milwaukee, WI 53226. BHD has a memorandum of understanding with We Energies including a provision to receive documentation regarding testing to verify reliability of the generators connected to the secondary line that serves BHD. In 2015 BHD will acquire 2 generators for the purpose of providing emergency power to the Life Safety branch and Critical branch components kept in the EES office in binder #16.~~ (EC 02.05.07-EP4, 5, 7, & 8 5-10)

- F. **Managing Pathogenic Biological Agents & Controlling Airborne Contaminates (EC 02.05.01-EP 5 & 6, 14-16)**– 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 Prevention and 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 78 & 89, & 16)**– 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 Transportation and Public Works and Division, Architecture and Engineering Department and the 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 910; EC 04.01.01 EP11)**– 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. **Electrical Cords and Power Strips (EC 02.05.01 EP 23 & 24)** - Power strips in patient care vicinity are only used for movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UP 60601-1 Power strips used outside of patient care but with the patient care room meet UL 1363. In non-patient care rooms, power strips meet other UL standards. Extension cords are only used temporarily and are removed immediately upon completion of the task.

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

K. **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 security extension 69957395 (where the call will be routed to the EES Maintenance department via telephone or two way radio) 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 35)** – 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 4412)** – 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 EP 431 & 2; HR 01.04.01 EP 431 & 3; LD 03.01.01 EP 4401-5)** 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 4431)**
- 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 431 & 2; HR 01.04.01 EP 431 & 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 431 & 2; HR 01.04.01 EP 471 & 3)**

## PERFORMANCE MONITORING

**(EC 04.01.03 EP 432); EC 04.01.05 EP 431)**

- A. Ongoing performance monitoring is conducted for the following performance monitors:
- ~~Measure the number of utility failures (Goal = 0)~~
  - 1. Measure the completion rate of preventive maintenance tasks (Goal = 90%)
  - 2. Measure the percentage of utility branch valves labeled and inventoried (Goal = 50% by year end)
  - 3. Measure the percentage of generator testing that did not pass (Goal = 0%)
  - ~~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 Environment of Care Committee on: ~~2-9-17~~3-8-18

Reviewed and approved at the Medical Executive Committee Meeting on: ~~2-15-17~~3-21-18

## Attachments:

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: 11003002-Safety Officer	pending



Date Issued:	1/1/2015
Last Approved Date:	N/A
Last Revised Date:	3/7/2018
Next Review:	3 years after approval
Owner:	Lynn Gram: 11003002-Safety Officer
Policy Area:	Environment of Care
References:	

## Medical Equipment Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (MCBHD) 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 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)~~ (EC 01.01.01-EP 8)

MCBHD locations include:

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

## **OBJECTIVES:**

1. To improve employee knowledge of medical equipment requirements and support the routine operational needs of equipment users.
2. Recommend equipment replacement timeframes; participate in pre-purchase equipment selection and new product evaluations.

3. Manage and track all maintenance requirements, activities, and expenses required to service, repair, and keep operational all equipment included in the plan.
4. Review Incident Reports for all Medical Equipment related incidents.

## **AUTHORITY/REPORTING RELATIONSHIPS:**

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable Medical Equipment related codes and regulations, and evaluate the effectiveness of the Medical Equipment program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. (EC 01.01.01-EP4~~8~~)

## **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 4-51-3 & 4427)** –The basis for the determination of inspection frequency is risk. Equipment will be inspected upon purchase and initially at one of the following intervals, quarterly, semi-annually, annually, or 18 months. The clinical equipment contractor shall determine and document inspection procedures and intervals for inspection of clinical equipment, based on manufacturer's recommendations, regulations and standards, actual experience with the device, and known hazards and risks. All devices will receive a performance verification and safety test during the incoming inspection procedure and after completion of a major repair or upgrade. All work activities, inspection schedules, and work histories are kept in the contracted company's software inventory list and Central Supply Department. The Central Supply staff assures that the contracted company completes scheduled maintenance and other service activities as required.

**Note:** BHD does not currently utilize hemodialysis, sterilizers, or nuclear medicine equipment. (EC 02.04.03 EP 4, 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; EC 04.01.01 EP 10)** 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 & 9)** –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 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3; LD 03.01.01 EP ~~4-101-5~~)

- 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 ~~4-131~~)
- 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 ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 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 ~~4-31~~ & 2; HR 01.04.01 EP ~~4-71~~ & 3)

## PERFORMANCE MONITORING

(EC 04.01.03 EP ~~4-32~~; EC 04.01.05 EP ~~4-31~~)

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

## ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

Reviewed and approved at the Environment of Care Committee meeting on: ~~2-9-17~~3-8-18

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-15-17~~3-21-18

**Attachments:**

No Attachments

**Approval Signatures**

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	3/7/2018

COPY



MILWAUKEE COUNTY  
Behavioral  
Health  
Division

Date Issued: 1/1/2015  
 Last Approved Date: N/A  
 Last Revised Date: 3/7/2018  
 Next Review: 3 years after approval  
 Owner: Lynn Gram:  
 11003002-Safety Officer  
 Policy Area: Environment of Care  
 References:

## Environment of Care Management Plan

### ***Mission:***

The Milwaukee County Behavioral Health Division (MCBHD), 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:

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- Co-occurring Capable
- Person-Centered
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- Systems and Services Integration
- Recovery-Oriented
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## **PURPOSE:**

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

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

## **SCOPE:**

The EC Program establishes the organizational structure within which a safe environment of care is provided, maintained, and improved at MCBHD facilities. The areas included in the EC Plan are: Safety Management, Security Management, Hazardous Materials Management, Medical Equipment Management, Utilities Management, Fire/Life Safety Management and Emergency Management. Activities within these categories aim to manage the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. Separate management plans are written annually for each of these areas. ~~(EC 01.01.01 – EP 3-8)~~(EC 01.01.01 – EP 4-9)

MCBHD locations include:

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

## **OBJECTIVES:**

1. Develop and implement annual plans, goals and reports for the various functions of the EC.
2. Develop and implement performance-monitoring indicators for the various functions of the EC.

3. Oversee risk mitigation of issues that impact the facilities with regards to the EC.

## AUTHORITY/REPORTING RELATIONSHIPS:

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

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

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

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

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

## ENVIRONMENT OF CARE (EC) COMMITTEE:

### A. EC COMMITTEE MEMBERSHIP:

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

### B. EC COMMITTEE SUMMARY:

1. The EC Committee will provide the following:
  - A forum in which employees can raise concerns regarding safety risks within the EC management areas for discussion, assessment, and mitigation planning.
  - Focused discussions on particular issues, including creation of ad hoc subcommittees to address specific topics as necessary.
  - Reports on activities and an annual summary of achievements within the EC management categories.

2. The Hospital Administrator appoints an EC Committee Chairperson and Safety Officer, who develop, implement, and monitor the EC Program. The remaining membership of the EC Committee includes representatives from administration, clinical areas and support services. The committee member goals and responsibilities are developed and reviewed as part of the program's annual evaluation.
3. The ~~Assistant Hospital Administrator 2, Support Services~~ Safety Officer shall serve as the Chairperson of the EC Committee and oversee its membership.
4. The EC Committee Chairperson is responsible for the following issues related to Safety:
  - a. Advise Administration, Medical Staff and Management Teams on safety matters requiring their attention and action.
  - b. Make recommendations necessary to establish or modify policies to the EC Program
  - c. Monitor the effectiveness of policy or procedural changes made or recommended.
  - d. Appoint committees, as appropriate, with specific responsibilities in relation to patient, employee, facility, community or environmental safety.
  - e. Appoint the Chairperson to any EC related subcommittees (standing or ad hoc).
  - f. Ensure minutes of all EC related committees are kept and reviewed, as appropriate.
  - g. Provide leadership and consultation for any subcommittee chairpersons.
  - h. Monitor subcommittees for effectiveness and compliance with regulatory agencies.
  - i. Evaluate committee and subcommittee members and chairperson's performance.
  - j. Ensure that the following receive timely information on the EC Program:
    - Executive Team
    - Medical Staff
    - Quality Management Services Committee (QMSC)
    - Department Directors/Managers
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:

~~Program Executive Teams (Acute, Crisis, and Community)~~

- a. Report safety concerns to the department supervisor/manager/director.
- b. Access, or make referrals to the EC Committee by contacting the appropriate committee chairperson, or member of the committee.

## **GENERAL RESPONSIBILITIES:**

### **1. ADMINISTRATION**

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

### **2. ENVIRONMENT OF CARE COMMITTEE AND SAFETY OFFICER**

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

### **3. BHD DIRECTORS, MANAGERS AND SUPERVISORS**

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

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

#### 4. BHD EMPLOYEES

Each employee is responsible for attending safety education programs and for understanding how the material relates to his or her specific job requirements. Employees are responsible for following the guidelines set forth in the EC Program and for having a basic familiarity with the EC structure. Complete annual OSHA Safety training as distributed at the county wide level. 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/addressess 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~~ QMSC;
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 Prevention and Control, Risk Management, etc) that may impact the EC Program and address as appropriate;
7. Quarterly, review educational activities provided;
8. Semi-annually, review summaries of employee/visitor injuries, illnesses and safety incidents and make appropriate recommendations or referrals;
9. Semi-annually, review summaries of security incidents involving employees, patients, visitors and property and make appropriate recommendations;
10. Quarterly, review Emergency Management activities and make appropriate recommendations for changes in procedure or education;
11. Quarterly, review summaries of the management of hazardous materials, wastes and related incidents and make appropriate recommendations for changes in policy/procedure or education;
12. Quarterly, review summaries of environmental tours and make appropriate recommendations or referrals;
13. When appropriate, review summaries of patient falls, sentinel events, and action plans and make appropriate recommendations for changes in procedure or education;
14. When appropriate, review, approve, or make recommendations for changes to policies and procedures;
15. Quarterly, review summaries of medical equipment management and related incidents and make appropriate recommendations;
16. Quarterly, review summaries of the life safety management program and make appropriate recommendations for changes in procedures/or education;
17. Quarterly, review summaries of utility and equipment management, related failures, errors or incidents to

- determine the need for changes in procedures and/or education;
18. Monitor and trend and analyze incidents, and prevention program effectiveness;
  19. Monitor subcommittee activities and provide guidance and direction;
  20. Evaluate, at least annually, the performance and effectiveness of the committee and subcommittees;
  21. Review the need for continued monitoring or recommendations once the above evaluation is completed;
  22. Maintain confidentiality of what is said and issues presented at all EC committee meetings;
  23. Review attendance of committee members against established standard and take corrective action;
  24. Other specialists will participate in EC Committee meetings as needed to address specific topics;

## RESPONSIBILITIES SPECIFIC TO THE VARIOUS MANAGEMENT AREAS OF THE EC

1. ~~SAFETY MANAGEMENT (EC 02.01.01 EP 1,3,5 & EC 02.01.03 EP 1, 4, 6; EC 02.06.01; EC 02.06.05; & EC 04.01.01)~~ SAFETY MANAGEMENT (EC 02.01.01 EP 1,3,4,5 & 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)~~ (EC 01.01.01 EP 4)
  - 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/Operations
    - Housekeeping
    - Administration

- m. Analyze and trend findings reported during environmental tours.
- n. Develops criteria in which environmental round findings can be categorized and determined to be significant.
- o. Annually, evaluate the effectiveness of the environmental rounds.
- p. Analyze patient and non-patient falls, trend data and recommend appropriate prevention strategies.
- q. Analyze and trend staff occupational illnesses, injuries and incidents reported on the OSHA Log or from Risk Management Department.
- r. Analyze and trend visitor incidents reported to Risk Management.
- s. Develop criteria in which incidents can be categorized and determined to be significant.
- t. Review each of the following for trends and issues that need additional attention;
  - Employee Safety
  - Patient Safety

2. **SECURITY MANAGEMENT (EC 02.01.01 EP 7-10) ~~(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)~~ **EMERGENCY MANAGEMENT (EM 01.01.01; EM 02.01.01; EM 02.02.01; EM 02.02.03; EM 02.02.05; EM 02.02.07; EM 02.02.09 EM 02.02.11; EM 02.02.13; EM 02.02.15; EM 03.01.01 & EM 03.01.0; EM 04.01.01)**
- a. Discuss topic monthly or more frequently upon the call of the chairperson and record minutes.
  - b. Create and update annually the Emergency Operations Plan (EOP).
  - c. Incorporate all BHD departments in all related activities and Emergency Management Policies and Procedures.
  - d. Establish a process, and conduct a review of all Emergency Management related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/ program policies as appropriate.
  - e. Develop and monitor internal and external emergency management programs, with multi-discipline input, affecting all departments.
  - f. Evaluate and modify Emergency Operations Plans (EOP) and exercises.
  - g. Coordinate and evaluate the semi-annual emergency management exercise.
  - h. Monitor, evaluate, and implement changes to the ~~disaster manual~~ **EOP** 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 a minimum of every three years or earlier if modifications are needed.**
  - 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) EC 01.01.01 EP 6; EC 02.02.01 & EP 1, 3, 4-12,19)**
- 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. Review the Medical Waste Reduction Policy, and complete the Infectious Waste Annual Report with the DNR when required.
  - n. Conduct periodic audits of medical waste storage and disposal locations for presence of non regulated medical waste.
  - o. Report quarterly on activities of Hazardous Materials and Waste Management.
5. **FIRE PREVENTION/LIFE SAFETY MANAGEMENT** (~~EC 01.01.01 EP 7~~(~~EC 02.03.01; EC 02.03.03; EC 02.03.05 and LS 01.01.01 through LS 03.01.70~~) EC 02.03.01; EC 02.03.03; EC 02.03.05 and LS 01.01.01 through LS 03.01.70)
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
  - b. Create an annual Fire Prevention Plan.
  - c. Incorporate all BHD departments in all related activities and Management Plans.
  - d. Coordinate and conduct fire drills once per quarter per shift in all patient care buildings. (Twice this if Interim Life Safety Measures are implemented.)
  - e. Analyze and trend the results of fire drills, actual fire events or false alarms and recommend appropriate changes or education.
  - f. Review inspection, preventive maintenance and testing of equipment related to the Life Safety Program.
  - g. Review agency inspections conducted or compliance survey reports. (i.e. Fire Marshal (state and local), Insurance, State Department of Quality Assurance, etc.)
  - h. Review changes/upgrades to the fire protection system; failures/problems discovered with the system, causes and corrective actions taken.
  - i. Review summaries of construction, renovation or improvement life safety rounds.
  - j. Assess Interim Life Safety Measures implemented as a result of construction or other Life Safety Deficiencies and review and plans of corrections
  - k. Monitor program recommendations, changes or implementations for effectiveness.
  - l. At each meeting, assess the status of the facility Statement of Conditions™ and compliance with the Life Safety Code.
  - m. Establish a process, and conduct a review of all Fire/Life Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
  - n. Annually, develop goals, objectives and performance standards for Fire Prevention.
  - o. Annually, assess the effectiveness of the Fire Prevention Program, policies/procedures and educational components.

- p. Report quarterly on activities of Fire Prevention Management.
6. **MEDICAL EQUIPMENT MANAGEMENT (EC 01.01.01 EP 8; EC 02.01.01 EP 40 and 11; EC 02.04.0: and EC 02.04.03)**
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
  - b. Create an annual Medical Equipment Management Plan.
  - c. Incorporate all BHD departments in all related activities and Management Plans.
  - d. Monitor medical equipment hazard recalls. Review inspection, tests, maintenance and education policies for medical equipment and device users.
  - e. Monitor for compliance with the FDA Safe Medical Device Act.
  - f. Review medical equipment management program, problems, failures and user errors that adversely affect patient care or safety and the corrections or follow-up actions taken.
  - g. Review and analyze major problems or trends identified during preventative maintenance and make appropriate recommendations.
  - h. Monitor on-going medical equipment education programs for employees related to new equipment, replaced or recalled equipment, certification and/or recertification and user errors.
  - i. Review requests and make recommendations for the purchase of medical equipment.
  - j. Monitor the entry and use of medical equipment entering the facility from sources outside of the medical equipment program. (i.e. rental equipment).
  - ~~Monitor the use of personal protective equipment associated with the use of medical equipment management, i.e. radiology services.~~
  - k. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the medical equipment program or needs.
  - l. 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.
  - m. Review contingency plans in the event of medical equipment disruptions and or failures, procedures for obtaining repair services and access to spare equipment.
  - n. Annually, develop goals, objectives and performance standards for the committee.
  - o. Annually assess the effectiveness of the medical equipment management program.
  - p. 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)~~ UTILITY MANAGEMENT (EC 01.01.01 EP 9; 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 and Emergency Generator
  - Elevator Systems
  - HVAC Systems
  - Communication Systems
  - Water Systems
  - Sewage Systems
  - Environment Control Systems
  - Building Computer Systems
  - Security Systems
  - Other
- g. Review management plans and monitoring systems relating to utility management.
- h. Establish a process, and conduct a review of all Utility related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- i. Annually, review the effectiveness of the utility system management program.
- j. Review emergency procedures and plans to respond to utility system failures.
- k. Review patient care equipment management (beds, lighting, etc) and all non-clinical high-risk equipment problems.
- l. Report quarterly on activities of Utility Management.

#### 8. OTHER COMMITTEES

- a. The EC Committee has a relationship with ~~three~~two other committees, each ~~submit a summary share information regarding activities. Pertinent information is incorporated into the annual report. Information from these reports is incorporated into the annual report~~ submitted by the EC. These committees include:

- 1. Infection Prevention and Control- 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.

~~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~~housewide in-service attendance.
- d. Review and assist in the development of educational programs for orientation and ~~annual~~housewide

in-services.

- e. Develop criteria in which compliance with safety education can be effectively measured.
- f. Make appropriate recommendations to other committees/leadership regarding problematic trends and assist in implementation of final resolution plans.
- g. Develop and implement safety promotional ideas such as safety fairs, contests, and incentive programs.
- h. Promote safety issues in various communication forms at BHD (newsletter, emails, signage).
- i. Annually, develop goals, objectives and performance standards for education of EC related information.
- j. Annually, assess the effectiveness of the annual safety in-service program.

## INTENT PROCESSES

### 1. Issue Assessment (EC 04.01.01)

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

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

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

### 2. Environmental Rounds ~~(EC 04.01.03)~~

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

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

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

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

### 4. Safety Officer Appointment (EC 01.01.01 EP 1)

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

5. **Intervention Authority** ~~(EC 01.01.01 EP 2)~~

The Safety Officer and/or the individual serving as the ~~Administrative Resource~~ House Supervisor nurse on duty 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 EP 1-3; HR 01.04.01 EP 1-3; LD 03.01.01.1-10)~~ EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01.1-5 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); (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 EP 1&2; HR 01.04.01 EP 1&3) ~~(EC 03.01.01 EP 1-3; 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 EP 1&2; HR 01.04.01 EP 1&3) ~~(EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)~~ Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year.

## PERFORMANCE MONITORING

(EC 04.01.05)

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

### Safety Management

1. Actions taken for urgent recalls and alerts are documented in RASMAS within 3 days a minimum of 95% of the time
2. Measure 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  $\leq$  53 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  $\leq$  10 times)
5. Camera outages will be reported to Operations within 1 hour. (Goal  $\leq$  6 times)

#### **Hazardous Materials Management**

1. Measure the pounds of regulated medical waste sent for disposal. (Goal < 50 #/month)

#### **Emergency Management**

1. Increase the number of Management Team members trained in ICS/HICS (100 & 200) by 25%
2. Hold or participate in two emergency exercises per year (Goal =2)

#### **Fire Prevention**

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

#### **Utilities Management**

~~Measure the number of utility failures (Goal = 0)~~

1. Measure the completion rate of preventive maintenance tasks (Goal =90%)
2. Measure the percentage of utility branch valves labeled and inventoried (Goal = 50% by year end)
3. Measure the percentage of generator testing that did not pass (Goal = 0%)

~~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 04.01.0501)

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for the EC Management plans. The annual evaluation examines the objectives, scope, performance, and effectiveness of the Environmental Management Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The

EC Committee review and approves the report. The discussion, actions, and recommendations of the EC Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC and QMSC the program executive committees, and the County Wide Safety Committee. This finalizes the evaluation process.

Reviewed and approved at the Environment of Care Committee meeting on: ~~2-9-17~~3-8-18

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-15-17~~3-21-18

**Attachments:**

No Attachments

**Approval Signatures**

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	3/7/2018

COPY

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

**DATE:** July 18, 2018

**TO:** Thomas Lutzow, Chairperson, Milwaukee County Mental Health Board

**FROM:** Shane V. Moiso, MD, Vice-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 Organization and Chair of the Medical Executive Committee presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C:

- 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,



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Shane V. Moasio, MD  
Vice-President, BHD Medical Staff Organization

cc Michael Lappen, BHD Administrator  
John Schneider, BHD Chief Medical Officer  
Clarence Chou, MD, 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

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
GOVERNING BODY REPORT  
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS  
JULY / AUGUST 2018**

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 JULY 11, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 18, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<b>MEDICAL STAFF</b>							
Michelle Hume, MD	Psychiatric Officer; Medical Officer	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.	
Michael Lance, MD	General Psychiatry	Affiliate/ Provisional		Dr. Zincke 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.	
Quan Ta, MD	Psychiatric Officer; Medical Officer	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.	
<b>ALLIED HEALTH</b>							
Yorbalica Martin-Thomas, MSN (FNP)	Advanced Practice Nursing-Family Practice	Allied Health Professional/ Provisional		Dr. Puls recommends appointment & privileges, as requested	Committee recommends 2-year AHP appointment and privileges, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
Maryan Torres, MSN (PMHNP)	Advanced Practice Nursing-Psych/Mental Health	Allied Health Professional/ Provisional	CB	Dr. Moiso recommends appointment & privileges, as requested	Committee recommends 2-year AHP 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 JULY 11, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 18, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<b>MEDICAL STAFF</b>							
Clarence Chou, MD	General Psychiatry; Child Psychiatry	Active / Full		Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Sara Coleman, PsyD	General Psychology-Adult	Active / Full	M#	Drs. Kuehl & Thrasher recommend reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Gunjan Khandpur, MD	General Psychiatry; Child Psychiatry	Active / Full		Dr. Moiso recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Ahmed Numaan, MD	General Psychiatry	Active / Full	MA	Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Elaine Sorem, MD	General Psychiatry	Active / Full	MA	Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
Larry Sprung, MD	General Psychiatry	Active / Full	M#	Dr. Thrasher recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment 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 JULY 11, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 18, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Tony Thrasher, DO	General Psychiatry	Active / Full	M#	Dr. Schneider recommends reappointment & privileges, as requested	Committee recommends reappointment and privileges, as requested, for 2 years. No changes.	Recommends reappointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD.							

PROVISIONAL STATUS CHANGE REVIEWS	PRIVILEGE GROUP(S)	CURRENT CATEGORY/ STATUS	RECOMMENDED CATEGORY/ STATUS	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 11, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 18, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
<i>The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.</i>							
MEDICAL STAFF							
Anna Hackenmiller, MD	Psychiatric Officer; Medical Officer	Affiliate/ Provisional	Affiliate / Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
Erika Steinbrenner, MD	Psychiatric Officer; Medical Officer	Affiliate/ Provisional	Affiliate / Full	Dr. Thrasher recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends appointment and privileging status change, as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD.							

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	REQUESTED / RECOMMENDED CHANGE	NOTATIONS	SERVICE CHIEF* RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE JULY 11, 2018	MEDICAL STAFF EXECUTIVE COMMITTEE JULY 18, 2018	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
Reena Kumar, DO	Psychiatric Officer; Medical Officer	General Psychiatry		Dr. Thrasher recommends privileges, as requested	Committee recommends amending privileges, subject to a minimum provisional period of 6 months.	Recommends amending privileging as per C&PR Committee.	
Emilie Padfield, MD	Psychiatric Officer; Medical Officer	General Psychiatry		Dr. Thrasher recommends privileges, as requested	Committee recommends amending privileges, subject to a minimum provisional period of 6 months.	Recommends amending privileging as per C&PR Committee.	
Rebecca Radue, MD	Psychiatric Officer; Medical Officer	General Psychiatry		Dr. Thrasher recommends privileges, as requested	Committee recommends amending privileges, subject to a minimum provisional period of 6 months.	Recommends amending privileging as per C&PR Committee.	
Jennifer Zaspel, MD	Psychiatric Officer; Medical Officer	General Psychiatry		Dr. Thrasher recommends privileges, as requested	Committee recommends amending privileges, subject to a minimum provisional period of 6 months.	Recommends amending privileging as per C&PR Committee.	

J. Lyons  
 CHAIR, CREDENTIALING AND PRIVILEGING REVIEW COMMITTEE  
 OR PHYSICIAN COMMITTEE MEMBER DESIGNEE

7/18/2018  
 DATE

Moisio  
 VICE-PRESIDENT, MEDICAL STAFF ORGANIZATION  
 ACTING CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

07/18/18  
 DATE

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: AUGUST 23, 2018

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

MEDICAL STAFF CREDENTIALS & EXECUTIVE COMMITTEE REPORT TO GOVERNING BODY – JULY/AUGUST 2018

PAGE 2 of 2

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

**DATE:** August 1, 2018  
**TO:** Thomas Lutzow, 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 Adopted Changes to the Behavioral Health Division Medical Staff Organization Bylaws

**Background**

Under Wisconsin and Federal regulatory requirements, the Medical Staff Organization must develop and adopt Bylaws. After adoption or any amendment by the Medical Staff Organization, it is required that the proposed Bylaws be presented to the Governing Authority for action. Bylaws and amendments thereto become effective only upon Governing Authority approval. In accordance with Joint Commission standard MS.01.01.03 and CMS CoP §482.12(a)(4), neither the organized medical staff or the governing body may unilaterally amend the Medical Staff Bylaws.

**Discussion**

Proposed changes to the Behavioral Health Division Medical Staff Organization Bylaws were presented to and adopted by the voting members at their meeting of August 1, 2018. The following is a summary of the major changes:

<b>SCOPE &amp; REASON FOR CHANGE</b>
<b><u>DEFINITIONS</u></b>
Obsolete position titles/references deleted or amended throughout the Bylaws to reflect current position titles and/or to distinguish, where indicated, an authoritative individual versus authoritative body.
<b><u>3.0 ARTICLE III – APPOINTMENT, REAPPOINTMENT AND PRIVILEGING</u></b>
3.1 <u>Physician Qualifications</u> – added language specific to specialty privileging and Board Certification requirements

3.6.4 Application for membership – Category 1 application criteria

Changed in conformance with language used by the Wisconsin Department of Safety and Professional Services for assessing criminal background information and Wisconsin Caregiver statutes. Specifics of what is considered minimal malpractice are deleted from the Bylaws.

Full definitions of Category 1, 2 and 3 applications are detailed in the *Medical Staff Organization's Categorization of Applications for Appointment and/or Privileges* procedures.

*[Changes do not impact current Notations Reporting to the Mental Health Board.]*

**4.0 ARTICLE IV – APPOINTMENT CATEGORIES**

4.2 Associate Medical Staff - new category for psychologists

Change in psychologist appointment category to comply with law and/or regulation that requires practitioners appointed to the Active Staff and eligibility to be a leader of the medical staff (officers) to be a physician, dentist or podiatrist.

*The associate Medical Staff shall consist of fully licensed psychologists who are full or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division that have clinical responsibility as part of the primary treatment team, including, where appropriate, inpatient service care, emergency service care, ambulatory service care, consultation assignments, and supervisory assignments. Members of the associate Medical Staff shall be eligible to vote, to hold member-at-large positions, and to serve on Medical Staff committees. Those psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate staff for a period recommended by the Credentialing and Privileging Review Committee.*

**5.0 ARTICLE V – OFFICERS AND MEDICAL ADMINISTRATION**

5.1 Officer and Members-At-Large

Change to comply with law and/or regulation as to types of practitioners that may be Officers

5.1.3 Member-At-Large Quality Advisor – amended from Vice-President of Quality, which allows for the position to be held by a physician (Active Staff) or a psychologist (Associate Staff)

5.1.4 Member-At-Large Physician – newly created (1 position); this is in addition to the two (2) Member-At-Large Psychologist positions that currently exist

5.3.2 Credentialing and Privileging Review Committee and 5.3.3 Medical Staff Peer Review Committee

Committee descriptions amended with respect to best practice and current processes for management and oversight for matters of professional behavior (Credentialing/Privileging) versus clinical performance/competence (Peer Review).

5.4 Joint Conference Committee – description amended to conform with CMS language for compliance with current regulation [CMS 482.12(a)(10) regarding meetings between the Governing Body and Leader of the Medical Staff (President)]

The Joint Conference Committee shall consist of not ~~more~~ *less* than two members of the Governing Authority, the Administrator *or his/her designee*, the Chief Medical Officer and the President of the Medical *Staff (or the Vice-President as his/her designee)*. *Additional participants shall be invited, as deemed appropriate.*

The purpose of this committee shall *be for periodic consultation and discussion of matters related to the quality of medical care provided to patients of the hospital.* ~~provide a direct avenue of communication between the MCBHD Medical Staff and the Governing Authority and shall be responsible for resolving issues and/or disputes between the two groups and to manage critical issues.~~

This committee shall meet at least semi-annually but may convene *more frequently, at the request of the Governing Authority or President of the Medical Staff, when issues of patient safety or quality of care are identified through quality assessment and performance improvement activities, as needing the attention of the Governing Authority in consultation with the Medical Staff. All meetings shall be documented including a list of attendees.* ~~whenever deemed necessary by the Governing Authority, the Behavioral Health Division Administrator, the Chief Medical Officer, or the MCBHD Medical Staff President.~~

**6.0 ARTICLE VI – MEETINGS**

6.3 Attendance at Meetings – meeting attendance by Active Medical Staff is no longer mandatory and is replaced by required acknowledgement of receipt and review of business discussed. Will also pertain to medical staff appointed to the new Associate Staff Category.

**CORRECTIVE ACTION**

1.2 Reduction or Suspension of Clinical Privileges

Amended specific to Professional Competence vs. Professional Conduct processes.

*Professional Competence.* The Peer Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee. The Credentialing and Privileging Review Committee shall notify the affected

Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

*Professional Conduct. The Credentialing and Privileging Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges or appointment, the Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.*

1.6 Resignation While Under or to Avoid Investigation

Pertains to compliance in law and/or regulation regarding National Practitioner Data Bank mandatory reporting in such instances, as enacted in 2015

*A physician Medical Staff Member who resigns his/her Medical Staff appointment and/or clinical privileges while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action, must be reported to the National Practitioner Data Bank regardless of whether the physician was aware that they were under investigation. Non-physician Medical Staff Members and Allied Health Professionals may be reported to the National Practitioner Data Bank under these same circumstances, but it is not required.*

*A Medical Staff Member or Allied Health Professional that is reported to the National Practitioner Data Bank under the circumstances described under the aforementioned sections 1.5 or 1.6 has no right to hearing and appellate review procedures, as no professional review action was recommended or taken.*

**Recommendation**

A full copy of the amended Bylaws are enclosed. It is recommended that the Milwaukee County Mental Health Board approve the Behavioral Health Division Medical Staff Organization Bylaws, as amended and adopted on August 1, 2018 by the Medical Staff Organization.

Respectfully Submitted,

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

Enclosure

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

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
MEDICAL STAFF ORGANIZATION

BYLAWS

PREAMBLE

Whereas, the Milwaukee County Behavioral Health Division is organized under the laws of the County of Milwaukee and the State of Wisconsin and functions within the organizational framework established by the duly constituted authorities of the County of Milwaukee; and

Whereas, its purpose is to provide patient care, treatment, services, education, and research; and

Whereas, it is recognized that the Medical Staff Organization is self-governing in its responsibilities for overseeing quality medical and behavioral health care, treatment, and services provided by practitioners with privileges as well as for those providing education and research in the Milwaukee County Behavioral Health Division and within community sites; and

Whereas, the Medical Staff shall accept and discharge this responsibility subject to the Governing Authority of the Milwaukee County Behavioral Health Division; and

Whereas, the Milwaukee County Behavioral Health Division serves as a teaching resource for physicians and behavioral health professionals; and

Whereas, the cooperative efforts of the Medical Staff, the Administrative Staff and the Governing Authority are necessary to fulfill the obligations of the Behavioral Health Division to its patients and to the community;

Therefore, the Medical Staff of the Milwaukee County Behavioral Health Division hereby organize themselves in conformity with these Bylaws.

DEFINITIONS:

1. The term "Medical Staff" shall be interpreted to include licensed physicians (medical and osteopathic), licensed dentists, licensed podiatrists, and licensed psychologists. All "Medical Staff" shall have delineated clinical privileges and shall be eligible for membership in the Medical Staff Organization.
2. The term "Allied Health Professional" shall be interpreted to include licensed health care providers other than physicians, psychologists, dentists and podiatrists who are permitted by scope of license, state law AND by the Hospital to provide patient care services within approved Hospital programs/services. Allied Health Professional Staff shall be categorized as independent or dependent and shall be permitted to practice with or without direction or supervision, based on the scope of his/her license, certification and/or registration and in conjunction with hospital approval and Medical Staff approval, when applicable. "Allied Health Professional" Staff shall not be eligible for membership in the Medical Staff Organization.
  - A. Independent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, without the supervision or direction of a physician but in collaboration with a physician who is privileged and working with the same or very similar patient population and who is assigned to the same service or program. In accordance with these Bylaws and State and Federal standards, independent Allied Health Professional staff shall have delineated clinical privileges. Advanced Practice Nurses shall maintain a current collaboration agreement with a member of the Active or Affiliate staff.
  - B. Dependent Allied Health Professional: an individual who may provide care to patients, in accordance with and as permitted by state licensure laws, under the supervision or direction of a physician. It shall be determined by the Chief Medical Officer or designee whether supervision shall be direct or indirect based on BHD scope of practice. In accordance with these Bylaws and State and Federal standards, dependent Allied Health Professional staff shall have delineated clinical privileges whenever such services and supplies are furnished as an incident to a physician's service as would otherwise be covered if furnished by a physician or as an incident to a physician's service.
3. The term "Governing Authority" shall be interpreted to refer to the Milwaukee County Mental Health Board as created under Wisconsin Statute 15.195(9)
4. The term "Executive Committee" shall be interpreted to refer to the Executive Committee of the Medical Staff of the Milwaukee County Behavioral Health Division.
5. The term "Allied Staff" shall be interpreted to refer to clinical professional staff who provide service to patients under the direction of a member of the Medical Staff and do not have delineated clinical privileges. This group shall include but not be limited to registered nurses, social workers, occupational and music therapists, clinical dietitians and non-licensed psychologists.
6. The term "Chief Medical Officer" shall be interpreted to refer to the Executive Medical Director appointee of the Administrator of the Milwaukee County Behavioral Health Division who shall serve as Chief Medical Officer and have authority and responsibility for the overall medical and clinical management of the MCBHD.

7. The term "Administrator" shall be interpreted to refer to the Administrator of the Milwaukee County Behavioral Health Division appointed by the Director of Health and Human Services and confirmed by the Governing Authority and is equivalent to that of the position of Chief Executive Officer.
8. The term "Chief of Staff" shall be interpreted to refer to the President of the Medical Staff Organization.
9. The term "Chief Quality Officer ~~and/or Chief Clinical Officer~~" shall be interpreted to refer to the Deputy Administrator of the Milwaukee County Behavioral Health Division charged with overseeing quality and clinical compliance.

#### 1.0 ARTICLE I - NAME

The name of the organization shall be the "Medical Staff Organization of the Milwaukee County Behavioral Health Division (MCBHD)."

#### 2.0 ARTICLE II - PURPOSE

The purpose of this organization shall be:

- 2.1 to ensure that all patients admitted to all programs of the MCBHD receive a uniform standard of quality patient care, treatment and services through participation in the following:
  - 2.1.1 direction, review and evaluation of the quality of patient care through continuous hospital-wide and Medical Staff quality improvement monitoring activities;
  - 2.1.2 ongoing monitoring of patient care practices;
  - 2.1.3 delineation of clinical privileges for Medical Staff and Allied Health Professional Staff commensurate with individual credentials and demonstrated ability and judgment;
  - 2.1.4 provision of continuing medical and professional education based on needs identified through monitoring and review, evaluation, and planning mechanisms; and
  - 2.1.5 review of utilization of the MCBHD's resources to provide for the appropriate allocation to meet patient care needs;
- 2.2 to initiate and maintain Bylaws, Rules and Regulations and policies and procedures for self-governance of the Medical Staff, with at least biennial review of the Bylaws and Rules and Regulations. These reviews shall be more frequent, when necessary, to reflect the hospital's current practice and/or to comply with changes in law or regulation;
- 2.3 to provide a means whereby issues may be discussed by the Medical Staff with the Chief Medical Officer of MCBHD and the Governing Authority;
- 2.4 to promote educational programs and activities for staff and trainees; and
- 2.5 to promote programs in research, in order to advance knowledge and skills in the behavioral health sciences.

#### 3.0 ARTICLE III - APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

All new applicants seeking clinical privileges or current Medical Staff Members and Allied Health Professionals seeking amended clinical privileges shall be subject to the credentialing and privileging requirements in place, for privileges sought, at the time the initial privilege request or the privilege amendment is approved. Therefore, new applicants, current Medical Staff Members and Allied Health Professionals shall be held subject to any and all changes in credentialing and privileging requirements, for new privileges being sought, that are enacted during the period that the initial privilege request or privilege amendment is pending approval.

All credentialing and privileging requirements shall be as defined by these Bylaws. Methods for carrying out requirements shall be in accordance with Medical Staff policy and procedure.

- 3.1 **Physician Qualifications.** The applicant shall be a graduate of a recognized medical or osteopathic school and licensed to practice as a physician (medical or osteopathic) in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All physicians practicing within the hospital or its clinics shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. Applicants seeking tele-medicine privileges shall be licensed in the state of Wisconsin AND in the state from which the tele-service is provided, shall be privileged by the medical Staff but shall not be eligible for Active staff membership. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested. All physicians requesting and granted specialty privileges shall obtain board certification in his/her primary specialty and any subspecialty as recognized by the American Board of Medical Specialties or American Osteopathic Association within the time requirements and as recognized by the applicable ABMS or AOA specialty after the completion of his/her training. Practitioner shall remain board certified in his/her principal areas of practice at all times after the date he/she obtains or is required to obtain such board certification. Exceptions to the board certification requirements may be waived on recommendation of the Chief Medical Officer for applicants that have appropriate experience and urgent clinical need exists.
- 3.2 **Dentist Qualifications.** The applicant shall be a graduate of a recognized dental school and licensed to practice dentistry in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All dentists shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.
- 3.3 **Podiatrist Qualifications.** The applicant shall be a graduate of a recognized podiatric medical school and licensed to practice podiatry in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All podiatrists shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may include formal residency or fellowship training, commensurate to the privileges being requested.
- 3.4 **Psychologist Qualifications.** The applicant shall be a graduate of a recognized doctoral program in clinical or counseling psychology, licensed to practice psychology in the State of Wisconsin, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All psychologists who meet these qualifications shall be privileged by the Medical Staff and shall be eligible for membership in the Medical Staff Organization. All applicants must demonstrate recent (within the last two years) practice experience, which may

include formal pre- or post-doctoral internship or fellowship training, commensurate to the privileges being requested.

- 3.5 **Allied Health Professional Qualifications.** The applicant shall be a graduate of a recognized master's degree program in their professional specialty and licensed, certified and/or registered to practice independently or dependently, ~~as appropriate~~, in accordance with what scope of practice in the State of Wisconsin allows, shall provide evidence of relevant training and experience, current competence and ability to perform the privileges requested. All independent allied health professionals shall be privileged by the Medical Staff but shall not be eligible for membership in the Medical Staff Organization. Dependent allied health professionals shall be privileged when recommended by the Medical Staff and authorized by the Hospital. Allied health professional staff may include, but shall not be limited to, Advanced Practice Nurses (including Nurse Practitioners, Clinical Nurse Specialists and Nurse Midwives), Physician's Assistants, Optometrists, licensed Social Workers and Marriage and Family Therapists if permitted by the hospital to practice independently-authorized to participate in the Act 235 pilot. All applicants must demonstrate recent (within the last two years) practice experience or specialty training, commensurate to the privileges being requested.

3.6 Procedure for Appointment and/or Privileging.

3.6.1 Applicants for membership and/or privileges must meet the qualifications as specified above.

3.6.2 An applicant shall not be denied consideration for an appointment to the Medical Staff or for clinical privileges based on race, sex, age, disability, creed, color, sexual orientation, marital status, military service membership, arrest/conviction record (unless offense is substantially related to circumstances of position and/or licensed activity) or national origin or any other basis prohibited by law or any physical or mental impairment that, after any legally-required reasonable accommodation, does not preclude compliance with the Medical Staff Bylaws or Hospital policies.

3.6.2.1 Criminal Activities.

An applicant may have his or her application for membership and/or clinical privileges denied, modified or restricted and a member may have his or her Medical Staff membership or clinical privileges modified, restricted or revoked, when the individual has a conviction of, or a plea of guilty or no contest to any felony, or to any misdemeanor involving controlled substances; illegal drugs; Medicare, Medicaid, or insurance or health care fraud or abuse; violence against another; sexual misconduct; or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a healthcare program) operated or financed in whole or in part by any Federal, State or local government agency, even if not yet excluded, debarred, or otherwise declared ineligible.

(Reference Social Security Act Sec. 1128)

3.6.2.2 Administrative Denial.

The Medical Staff Office may, with the approval of the Chief Medical Officer or Credentialing and Privileging Review Chairperson, deny any application for appointment or reappointment to the Medical Staff or Allied Health Professional

Staff and/or application for clinical privileges, without further review, if it is determined that the applicant does not hold a valid Wisconsin medical/professional license and/or other registrations or certifications applicable to his/her practice and no application is pending; does not have adequate professional liability insurance, if required; is not eligible to receive payment from the Medicare or Medicaid programs or is currently excluded from any health care program funded in whole or in part by the federal government or by a state or local government; or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. Reference Wisconsin DHS 12: Caregiver Background Checks)

3.6.3 Applications for initial Medical Staff membership and/or clinical privileges shall be in writing, and the form shall include evidence of current licensure (including, registrations and/or certifications, as required), relevant training and experience (including all medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), current competence (including but not limited to names of peer references, one of which shall be directed, a chronological list of all past and present hospital appointments and practice affiliations, military history, faculty or clinical teaching appointments, recent continuing education activities), and reasonable evidence of current ability to perform privileges requested (health status). The application form shall request information relating to involvement in any professional liability action, previously successful or currently pending challenges to or any voluntary or involuntary limitation or relinquishment of any licensure or registration, any limitation, reduction, or loss of medical or professional staff membership or clinical privileges at another hospital, whether voluntary or involuntary, whether ever reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan, whether they have any present or pending guilty or no contest pleas or convictions involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol. The application form shall request names of at least two (2) peers who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding applicant's current clinical ability, ethical character, and ability to work with others. Allied Health professional references may be provided by a physician when recent work activities do not include a direct contact/observation of performance by a peer. At least one peer reference must be from the same professional discipline as the applicant. These peer recommendations and all other documentation obtained in connection with the application shall become a part of the applicant's permanent record and shall be maintained by Medical Staff Services on behalf of the Credentialing and Privileging Review Committee and Medical Staff Organization. Applicants must consent to the inspection of records and documents related to the application. Applications shall include a request for specific clinical privileges. ~~Allied Health Professional Advanced Practice Nurse applications requirements~~ shall further include an approved written collaboration agreement(s), which shall include practice guidelines defining independent and/or dependent functions for which clinical privileges are being requested. Each applicant for Medical Staff membership and/or privileges shall be provided with a copy of and be oriented to the Bylaws, Rules and Regulations, and major policies of the Medical Staff, and shall agree in writing to abide by them.

3.6.4 Application for membership and/or privileges by physicians, dentists, podiatrists, psychologists, and allied health professionals shall be submitted to the Chief Medical Officer or designee. The Chief Medical Officer or designee shall be responsible for

processing the application and obtaining all required and any additional supporting documentation. Application processing shall include the collection of at least two peer references and for verifying from the primary source or an equivalent primary source (i.e., AMA, AOA, ECFMG, ABMS, and/or FSMB) all required professional training (medical/professional schools attended, internships, residencies, fellowships and other post-doctoral programs), required current professional licensure from the appropriate State Medical Board(s), DEA registration, and for querying the National Practitioner Data Bank (NPDB) and the Office of Inspector General List of Excluded Individuals and Entities (OIG-LEIE). Additional supporting documentation, including other hospital appointment and practice affiliation verifications, malpractice claims history verifications and recent continuing education may also be collected and used in the initial evaluation process. Before assigning initial clinical responsibilities, applicant identity is verified, criminal background check is completed and all applicable health screening requirements must be satisfied. Upon completion of the credentialing verification processes, the Chief Medical Officer or designee shall transmit the application and all required and any supporting documentation to the Chief Psychologist (if applicable) and to the Service Medical Director. The Chief Psychologist's recommendation, when applicable, shall be forwarded to the Service Medical Director by Medical Staff Services. The Service Medical Director's recommendation shall be forwarded to the Medical Staff Credentialing and Privileging Review Committee. Temporary privileges, for a period of not more than 120 days, may be granted to an applicant pending appointment and/or privileging after receiving a recommendation by the Credentialing and Privileging Review Committee or by the Chair acting on behalf of the Committee, provided the application is complete and meets all Category 1 application criteria. A Category 1 application means that all required verifications as established by the Medical Staff Credentialing and Privileging Review Committee are in place, applicant has no history of corrective action (hospital/licensing board), has a clean/satisfactory criminal background check (no felony convictions or charges pending and no non-felony matters substantially related to ability to professionally practice), minimal or no malpractice history (1 or 2 dismissals and/or 1 or 2 settlements/payments of \$30,000 or less and/or no more than one (1) open claim and/or cases are older than 20 years), privilege requests are appropriate to training, and all references are good. No Medical Staff member shall be permitted to recommend approval of his/her own privileges or appointment.

3.6.5 The Credentialing and Privileging Review Committee shall review the application and supporting documentation, review and confirm the validity of the applicant's credentials and may conduct an interview with the applicant. Applicants shall be acted upon by this committee within 90 days upon application completion and verification of meeting all credentialing requirements, or reasonable attempts thereto, for all privileges requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application for appointment and/or request for clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation recommendation of acceptance or rejection to the Executive Committee. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The Chief Medical Officer or Medical Staff Services, when designated shall notify the applicant of any areas of incompleteness, question and/or failure of others to

respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information within the next ~~forty-five (45)~~ thirty (30) days. Applicants who do not make reasonable and timely attempts to resolve misstatements or omissions from the application or resolve doubts about qualifications, current abilities or credentials within ~~forty-five (45)~~ thirty (30) days, when additional information is requested by the Chief Medical Officer or Medical Staff Services may, in the sole discretion of the Chief Medical Officer, be deemed a voluntary withdrawal of the application due to incompleteness and shall not be subject to hearing rights under these Bylaws. If temporary privileges were granted pending completion of the application approval process, they will be deemed expired at this time.

- 3.6.6 The Executive Committee shall recommend to the Governing Authority that the application be accepted or rejected; and if accepted, provisional or full clinical privileges shall be granted. The Executive Committee, as represented by the Chairperson of the Credentialing and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff appointment and/or clinical privileging.
- 3.6.7 Temporary Privileges.

The Administrator, or designee, acting on behalf of the Governing Authority and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the Governing Authority. Temporary privileges shall be granted by the Administrator or by one of the following authorized designees: the Chief Medical Officer or the Chairperson of the Medical Staff Credentialing and Privileging Review Committee. No Medical Staff member shall be permitted to approve his/her own privileges.

3.6.7.1 Important Patient Care, Treatment or Service Need.

Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized Medical Staff verifies current licensure and current competence.

3.6.7.2 Clean Application Awaiting Approval (Category 1).

Temporary privileges may be granted for up to 120 calendar days when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the Medical Staff Executive Committee and approval by the Governing Authority. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the hospital: current licensure; education, training and experience; current competence; current DEA (if applicable); current professional liability insurance in the amount required (when applicable); malpractice history; one positive reference specific to the applicant's competence from an appropriate medical peer; ability to perform the privileges requested; a query to the OIG-LEIE, and results from a query to the National

Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1, ~~expedited~~ privileging consideration, as described in section 3.6.4 of these Bylaws.

- 3.6.7.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

- 3.6.7.4 Termination of temporary privileges: The Administrator, acting on behalf of the Governing Authority and after consultation with the President of the Medical Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients then will be assigned to another practitioner by the Chief Medical Officer acting as the Administrator's designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

- 3.6.7.5 Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II or Appendix III of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

- 3.6.8 Disaster privileges – Medical Staff Leadership, in collaboration with Hospital Leadership and the Governing Authority, has determined that disaster privileging shall not be utilized at the Behavioral Health Division (as a hospital specializing in psychiatric and behavioral care, instances would be too few where such volunteers would be required to come forward or would volunteer to come forward, to assist).

- 3.6.9 Telemedicine privileges - Licensed independent practitioners who are responsible for the care, treatment and/or services of an MCBHD patient via telemedicine link, including interpretive services, are subject to credentialing and privileging requirements and will be processed through one of the following mechanisms:

- 3.6.9.1 MCBHD shall fully privilege and credential the practitioner according to the processes described in sections 3.6.1 - 3.6.7 of these Bylaws; or

- 3.6.9.2 MCBHD may privilege practitioners using credentialing information from the distant site, if the distant site is a Joint Commission-accredited organization.

- 3.6.9.3 MCBHD may use the credentialing and privileging decision from the distant site if all of the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization and has a direct contract/agreement with MCBHD to provide services;
2. The practitioner is privileged at the distant site for those services to be provided at MCBHD; and
3. MCBHD has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the hospital.

3.6.10 An expedited Governing Authority approval process shall not be used.

3.7 Appointment and/or privileging. Medical Staff and Allied Health Professional appointment and/or clinical privileging shall be approved by the Governing Authority based on Medical Staff recommendations. Prior to a written decision of rejection, the Governing Authority shall meet with the President of the Medical Staff and the Chairperson of the Credentialing and Privileging Review Committee to review the recommendations and the concerns regarding the appointee's professional qualifications. The Credentialing and Privileging Review Committee Chairperson shall transmit the decision to the applicant. In cases of rejection, the applicant shall be informed and advised of his/her right to appeal in accordance with the provisions of Appendix II or Appendix III of these Bylaws. Medical Staff and Allied Health Professional appointment and/or privileging shall be for a period of no more than two (2) years. All initial appointments and privileges shall be subject to a provisional period of at least six (6) months and shall require a focused audit of practitioner performance prior to completion of the provisional privilege period. The decision to grant, limit or deny an initially requested privilege or existing privilege for renewal is communicated to the practitioner within 30 days of approval.

3.8 Reappointment and/or reprivileging. Applicants have the burden of producing accurate and adequate information for proper evaluation of professional, ethical and other qualifications for continued membership and/or clinical privileges and for resolving any doubts about such qualifications. This burden may include submission to a medical, psychiatric or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Staff Executive Committee, which may select the examining practitioner. The applicant's failure to sustain this burden shall constitute cause for recommendation that the application for reappointment and/or privileges be denied. Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging shall be approved by the Governing Authority based on Medical Staff recommendations. Any significant misstatements in, falsifications in, or omissions from the reprivileging application requirements, which shall include being current on annual dues assessments, if applicable, shall constitute cause for the application to be deemed incomplete. The Chief Medical Officer or Medical Staff Services shall notify the applicant of any areas of incompleteness and/or failure of others to respond to such information collection or verification efforts. It will then be the applicant's obligation to obtain all required information prior to the Credentialing and Privileging Review Committee meeting at which the application is scheduled for review. Applicants who do not make reasonable and timely attempts to resolve misstatements or

omissions from the application or doubts about qualifications, current abilities or credentials, or resolve dues delinquencies when requested, shall result in application being deemed incomplete and no further action shall be required. The Executive Committee, as represented by the Chairperson of the Credentialing and Privileging Review Committee, shall submit to the Governing Authority all recommendations for Medical Staff and Allied Health Professional reappointment and/or clinical reprivileging. The recommendations of the Executive Committee shall be derived, in part, from the recommendations of the Credentialing and Privileging Review Committee, who will review and reappraise the individual based on information collected. Information collection shall include the required two-year NPDB query, re-verification of current professional licensure from the appropriate State Medical Board(s), query of the OIG-LEIE and adherence to these Bylaws, the Rules and Regulations and Medical Staff Organization policies. Additional information collection shall include statements regarding the applicant's current ability to perform privileges (health status), training and experience (continuing education specifically related to privileges being requested), and current competence (professional performance, judgment and clinical/technical skills as assessed by his/her supervisor and as indicated by the results of ongoing professional practice evaluations and other Medical Staff monitors and peer review activities). A Medical Staff peer reference shall also be required, when the Service Medical Director or other supervisor is not a clinical peer. In the case of Allied Health Professionals, the physician collaborator shall also provide a reference or assessment of professional performance, judgment and clinical/technical skills, if s/he is not the supervisor. Applications for reappointment and/or reprivileging shall be acted upon prior to expiration of current appointment and/or privileges. Medical Staff and Allied Health Professional reappointment and/or reprivileging shall be for a period of no more than two (2) years.

All applicants seeking reappointment and/or reprivileging within the Active, Associate or Affiliate Medical Staff Category or Allied Health Professional Staff Category must have exercised all privileges held at least once every three months from date of last appointment (excepting applicants formally granted medical, family or other leave of absence or applicants who are assigned by the Chief Medical Officer or his/her designee to provide vacation coverage on an as needed or seasonal basis) or s/he shall not be considered eligible for reappointment and/or reprivileging within those privilege areas that have not been utilized with sufficient frequency to allow for the required performance and current competency assessments. Applicants who do not utilize privileges held at least once every three months shall remain in good standing, as appropriate, upon expiration of such privileges. S/he shall remain eligible to reapply for appointment and/or such privileges should s/he so desire, and it is evident that s/he will be able to exercise such privileges with the required minimum frequency, and a current need and position vacancy in his/her specialty exists.

Failure without good cause to timely submit a completed application for reappointment shall result in automatic termination of the Medical Staff or Allied Health Professional member's membership and privileges upon expiration of the current appointment period.

3.9 Clinical Privileges. All individuals permitted by law and by the MCBHD (as specified under sections 3.1 through 3.5 of these Bylaws) to provide patient care services independently, or dependently under the direction of a Medical Staff Member when privileging is recommended, shall have hospital specific delineated clinical privileges, whether or not they are members of the Medical Staff of the MCBHD. Physicians, Dentists, Podiatrists, Psychologists and Allied Health Professionals who are not staff members but who meet the above independent practice definition, may request privileges through the Medical Staff by submitting a written request to the Chief Medical Officer or designee, who will review credentials and transmit the application to

the appropriate Service Medical Director and to the Chief Psychologist, when applicable, and to the Credentialing and Privileging Review Committee.

3.9.1 The delineation of an individual's clinical privileges includes the limitations, if any, on the individual's privileges to treat patients or direct the course of treatment for the conditions for which the patient was admitted. Each patient cared for shall have a physical examination and/or medical history documented by a physician or authorized designee, such as an advanced practice nurse, privileged to perform such.

The physical examination shall include a thorough medical history and physical examination with all indicated laboratory examinations required to discover all structural, functional, systemic and metabolic disorders, and performance of a screening neurological exam. History shall include patient's past physical disorders, head trauma, accidents, substance dependence/abuse, exposure to toxic agents, tumors, infections, seizure or temporary loss of consciousness or headaches, and past surgeries. Screenings shall include a complete neurological exam, when indicated (i.e., system review indicates positive neurologic symptomatology); a record of mental status; the onset of illness and circumstances leading to admission; attitudes and behavior; an estimate of intellectual functioning, memory functioning and orientation; and an inventory of the patient's assets in a descriptive fashion. More than one practitioner may participate in the performance, documenting and authentication of a history and physical for a single patient. The authenticating practitioner(s) shall be responsible for its content. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

If a physical examination was completed within 30 days of the patient's admission (or readmission), an update examination to document any changes in patient's condition is required within 24 hours after admission or re-admission. If the examining practitioner finds no change in the patient's condition since the history and physical was completed, s/he shall indicate in the patient's record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. However, any noted changes in the patient's condition must be documented in an update note and placed in the patient's record within 24 hours after admission [per DHS 124.14(3)(c)(2) and CMS 482.22(c)(5)(ii)].

3.9.2 Clinical privileges to dentists shall be limited to outpatient activities only and must be specifically defined. Each patient cared for by a dentist must have a physical examination entered into the medical record by a physician, certified nurse practitioner or physician's assistant staff member. The dentist shall perform the part of his or her patient's history and physical examination that relates to dentistry. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

3.9.3 Clinical privileges to podiatrists shall be limited to outpatient activities only and must be specifically defined. Each patient cared for by a podiatrist must have a physical examination entered into the medical record by a physician, certified nurse practitioner or physician's assistant staff member. The podiatrist shall perform the part of his or her patient's history and physical examination that relates to podiatry. All procedures requiring surgery or anesthesiology shall require a history and physical update prior to the procedure.

3.9.4 Clinical privileges to allied health professionals must be specifically defined and shall be limited to activities within the individual's assigned service/program or to service provisions defined within a provider's service contract. Independent Allied Health Professional practice is permitted only in Hospital approved programs and services and must be in collaboration with the service(s)/program(s) Medical Director and/or attending physician(s). Certified nurse practitioners and physician's assistants may perform patient histories and physical examinations.

3.9.5 In an emergency, any Medical Staff member or Allied Health Professional who has clinical privileges is permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of his or her Medical Staff status or clinical privileges, provided that the care provided is within the scope of the individual's license.

3.10 Revised Clinical Privileges. The Credentialing and Privileging Review Committee shall review all applications and supporting documentation to revise or amend current privileges. Applicants are required to submit documentation as to licensure (including certifications, registrations, as applicable), training and experience, current competence and ability to perform privileges requested. All requests to revise privileges shall require primary source (or equivalent primary source) verification of required training, primary source re-verification of required license(s), registrations and/or certifications, a new NPDB query and OIG-LEIE query. Requests shall be acted upon by this committee within 90 days upon completion of the verification of the applicant's credentials and current ability to perform the privilege requested, and this committee shall recommend to the Executive Committee of the Medical Staff that the application and request for revised clinical privileges be accepted, deferred or rejected. When a recommendation to defer is made, the Credentialing and Privileging Review Committee must follow-up within 60 days with a final recommendation of acceptance or rejection to the Executive Committee. All clinical privilege revisions shall be subject to a provisional period of at least six (6) months and shall require a focused audit demonstrating satisfactory practitioner performance prior to advancing from provisional to full privilege status.

3.11 Reapplication After Adverse Action.

3.11.1 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who did not exercise any of the hearing rights provided in Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were subject of the adverse action for a period of one (1) year from the date of the final adverse action.

3.11.2 A Medical Staff Member or Allied Health Professional who has received a final adverse professional review action regarding appointment or clinical privileges or both, and who exercised some or all of the hearing rights provided under Appendix II or Appendix III, shall not be eligible to reapply for the membership category or privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.

3.12 Leave of Absence and Reappointment.

3.12.1 Any member of the Active or Associate Medical Staff or Allied Health Professional who will be absent for a period of time exceeding twelve (12) weeks must provide written notification to the President of the Medical Staff and Chief Medical Officer which may be

done through Medical Staff Services as designee for both. Such notification shall state the start and, if known, anticipated end date of the leave and the reasons for the leave (e.g., military duty, additional training, family matters, or personal health). The Medical Staff Member or Allied Health Professional shall be responsible for arranging for coverage with his or her Service Medical Director during the leave. If the practitioner fails to return following the last day of the approved leave (including any extension granted up to the end of the current term of appointment), and does not reapply as described below, the practitioner shall be considered to have resigned his or her membership and/or clinical privileges and shall not be entitled to any hearing or appellate review. A request for appointment to the Medical Staff or Allied Health Professional Staff and clinical privileges subsequently received from a practitioner so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for initial appointment.

3.12.2 Upon timely return from leave of absence prior to expiration of the practitioner's then current appointment period, the practitioner shall be required to submit a written request for reinstatement to the Credentialing and Privileging Review Committee. The practitioner may be required to submit such additional information as may be relevant to his/her request for reinstatement, including interval status information. Reinstatement of membership and privileges following a leave of absence may be granted subject to monitoring and/or a provisional period, when determined to be appropriate and recommended. The Credentialing and Privileging Review Committee will review the request and submit their recommendations to the Medical Staff Executive Committee. Thereafter, the process described for reappointment shall be followed.

3.12.3 A leave of absence may not extend beyond the term of the Medical Staff Member's or Allied Health Professional's current term of appointment. If the practitioner is not able to return from leave before his/her current appointment period and/or clinical privileges are set to expire but has submitted an application for reappointment and/or renewal of clinical privileges, action on the application will be deferred for up to two (2) years until the practitioner identifies, with reasonable certainty, the date of anticipated return from leave. Deferring the application due to continued leave of absence shall not give practitioners any rights to hearing or appeal. The practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The practitioner's membership and/or clinical privileges shall be considered expired between the time of expiration of the term in which the leave began and the date of reappointment.

### 3.13 Impaired Practitioners.

3.13.1 Because it is inevitable that from time to time, some Medical Staff Members and Allied Health Professionals will develop physical or mental conditions that may limit their ability to safely exercise the clinical privileges they have been granted, it shall be the responsibility of all Medical Staff and Allied Health Professionals to bring to the attention of the Chief Medical Officer or his/her designee or the President of the Medical Staff, such conditions. Refer to Medical Staff Policy on Health and Welfare Ad Hoc Committee Responsibilities.

3.13.2 If, as a result of a practitioner's self-reporting of a condition, the Medical Staff Executive Committee recommends modification of status or privileges, the affected practitioner shall be notified, in writing, of the recommendation. The recommendation shall not be considered a professional review action, if the practitioner voluntarily accepts the

recommendation. If the Medical Staff Executive Committee recommends modifications of appointment status or privileges due to the practitioner's condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights under Appendix II or Appendix III.

### 3.14 Ethics and Ethical Relationships.

3.14.1 The Code of Ethics as adopted by the professional organizations of each member profession shall govern the professional conduct of the membership of the Medical Staff and all individuals privileged by the Medical Staff.

3.14.2 Medical Staff and Allied Health Professionals shall sign a statement prior to appointment and/or privileging indicating an understanding of the requirement to observe the ethical principles of their profession as well as those of the Milwaukee County Behavioral Health Division.

3.14.3 The Behavioral Health Division and Governing Authority shall take steps to protect and ensure the integrity of clinical decision making of all members of the Medical Staff and privileged Allied Health Professional Staff. Medical Staff and independent Allied Health Professional clinical decisions shall be autonomous and based solely on identified needs of the patient, regardless of their ability to pay. Dependent Allied Health Professionals shall consult with and defer to their supervising physician or the unit/program/service attending physician regarding clinical decisions, as appropriate. Medical Staff and Allied Health Professional clinical decisions shall be protected from financial issues or influences such as compensation, incentives or financial risk. Ethical conflicts related to patient care decisions may be referred to the Ethics Committee.

## 4.0 ARTICLE IV – APPOINTMENT CATEGORIES

### 4.1 Active Medical Staff.

The Active Medical Staff shall consist of fully licensed physicians ~~and psychologists~~ who are full or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division who function as the primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team, including, where appropriate, emergency service care, consultation assignments, and supervisory assignments. Members of the Active Medical Staff shall be eligible to vote, to hold office, and to serve on all Medical Staff committees. Those physicians or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active staff for a period recommended by the Credentialing and Privileging Review Committee.

### 4.2 Associate Medical Staff.

The associate Medical Staff shall consist of fully licensed psychologists who are full or part-time employees of, or on contract with the Milwaukee County Behavioral Health Division that have clinical responsibility as part of the primary treatment team, including, where appropriate, inpatient service care, emergency service care, ambulatory service care, consultation

assignments, and supervisory assignments. Members of the associate Medical Staff shall be eligible to vote, to hold member-at-large positions, and to serve on Medical Staff committees. Those psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate staff for a period recommended by the Credentialing and Privileging Review Committee.

4.2 Affiliate Medical Staff.

The affiliate Medical Staff shall consist of fully licensed physicians, dentists, podiatrists and psychologists who ~~are hourly or part time employees of, or on contract with the Milwaukee County Behavioral Health Division and~~ do not function as a primary attending Medical Staff or actively assume clinical responsibility as part of the primary treatment team. They shall be employed in a manner consistent with their professional preparation and qualifications within the overall plan of the Behavioral Health Division and be subject to the Bylaws and Rules and Regulations of the Medical Staff that are applicable to their profession. Members of the Affiliate Medical Staff shall not be eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff. Those physicians, dentists, podiatrists or psychologists who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing or level of training, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Associate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

4.3 Consulting Medical Staff.

The consulting Medical Staff shall consist of fully licensed physicians, dentists, podiatrists and psychologists who may treat patients at the Behavioral Health Division, or who are only engaged in consultation with members of the Medical Staff such as for special cases or procedures, or to conduct research or for teaching and/or lecturing to medical students, psychiatric residents and fellows and/or psychology interns and fellows. The consulting Medical Staff will include those physicians, dentists, podiatrists or psychologists who do not wish to accept a regular Active or Associate appointment. Members of the consulting Medical Staff are not eligible to vote, hold office, or serve on the Medical Staff Credentialing and Privileging Review Committee or Peer Review Committee. They may serve on the Executive Committee of the Medical Staff. Appointment to the consulting Medical Staff may be with or without privileges.

4.4 Telemedicine Consulting Medical Staff.

The Telemedicine Consulting Medical Staff shall consist of fully licensed physicians who may treat patients at the Behavioral Health Division via an electronic link, but who are mainly engaged in consultation with members of the Medical Staff by providing radiological or cardiology interpretive services. Members of the Telemedicine Consulting Medical Staff shall be eligible for Medical Staff membership but do not have the rights and privileges of a member of the Medical Staff to vote or to hold office or serve on committees.

4.5 Community Affiliate Medical Staff.

The community affiliate Medical Staff shall consist of fully licensed physicians and psychologists who are engaged in community practice in conjunction with an MCBHD Community Access to Recovery Services contracted service provider. Community affiliate Medical Staff are involved in the care and treatment of behavioral health clients and have need to engage in consultation with members of the MCBHD Active, Associate or Affiliate Medical Staff. The community affiliate medical staff will include those physicians and psychologists who do not meet criteria for Active, Associate or Affiliate Staff appointment. Members of the community affiliate Medical Staff are not eligible to vote, hold office, or serve on Medical Staff committees. Appointment to the community affiliate Medical Staff may be with or without privileges.

4.6 Allied Health Professional Staff.

The allied health professional staff shall consist of fully licensed and certified Advanced Practice Nurses, Physician's Assistants, Optometrists or other licensed independent practitioners other than physicians, psychologists, dentists or podiatrists who are allied with the Medical Staff and who are permitted by law and by the hospital to practice independently or dependently. Allied health professional staff may be full or part-time employees, or employed by a Medical Staff Member on contract or independent contractors or employed by a Medical Service Contractor whose services have been authorized by Milwaukee County for the Milwaukee County Behavioral Health Division. Members of the allied health professional staff shall not be eligible for Medical Staff membership and do not have the rights and privileges of a member of the Medical Staff to vote or to hold office. Those allied health professionals who are licensed and have a history of medical impairment that may impede clinical practice or those with some limitations in their licensing, which would necessitate restriction and/or supervision of their clinical practice, will be given specific clinical responsibilities under the supervision of a designated member of the Active or Affiliate Medical Staff for a period recommended by the Credentialing and Privileging Review Committee.

Summary of Eligibilities by Appointment Category								
Appointment Category	May Hold Officer Positions	May Hold Member-at-Large Positions	May Vote for Officers	May Vote for Members-At-Large	May Vote on MSO Business Items	May Serve on Med Exec Cmt	May Serve on Other Med Staff Committees	May Be Required to Pay Dues
Active	YES*	YES*	YES	YES*	YES	YES	YES	YES
Associate	NO	YES*	YES	YES*	YES	YES	YES	YES
Affiliate	NO	NO	NO	NO	NO	YES	NO	NO
Consulting	NO	NO	NO	NO	NO	YES	NO	NO
Telemedicine-Consulting	NO	NO	NO	NO	NO	NO	NO	NO
Community Affiliate	NO	NO	NO	NO	NO	NO	NO	NO
Allied Health Professional	NO	NO	NO	NO	NO	NO	NO	NO

\*Subject to eligibilities as described under Section 5.0 Article V – Officers and Medical Administration

4.7 Appointment Amendment.

A Medical Staff Member may, at any time, request modification of his/her staff category by submitting a written request. All Medical Staff appointments are subject to the eligibility criteria, as described in sections 4.1 through 4.45.

5.0 ARTICLE V - OFFICERS AND MEDICAL ADMINISTRATION

5.1 Officers and Members-At-Large

The officers of the Medical Staff shall be the President of the Medical Staff Organization, ~~and the Vice-President of the Medical Staff Organization and the Vice-President of Quality.~~ The officers and members-at-large shall be elected biennially at a pre-determined meeting of the Medical Staff Organization or through a time-limited electronic ballot process, when more feasible, and shall hold office for the designated term or until a successor is elected. Each officer must be a member of the Active Medical Staff in good standing and shall have satisfactorily completed the requisite initial provisional appointment and privilege period. For the positions of President and Vice-President of the Medical Staff Organization, the candidate must be either a physician, dentist or podiatrist. The Chief Medical Officer and Chief Psychologist shall not be eligible to hold office.

There shall also be ~~two-four~~ (24) Members-At-Large positions. The qualifications for these positions are that each Member-At-Large must be a Member of the Active ~~or Associate~~ Medical Staff ~~and each must be a psychologist in good standing and shall have satisfactorily completed the requisite initial provisional appointment and privilege period.~~

5.1.1 The President shall be elected for a two year term. S/he shall preside at meetings of the Medical Staff Organization and be Chairperson of the Executive Committee of the Medical Staff. S/he may delegate specific duties to the Vice-President of the Medical Staff Organization. The President may be re-elected to that office to succeed himself/herself for one additional term.

5.1.2 The Vice-president of the Medical Staff Organization shall be elected for a two year term. S/he shall act in the event of any absence of the President, and when acting in this capacity, s/he shall assume all the duties, responsibilities, and authority of the President. S/he shall be responsible for keeping complete minutes of all general Medical Staff Organization meetings, Executive Committee meetings and meetings on order of the President. S/he shall make recommendations to the Executive Committee concerning dues assessments, as necessary, and shall be accountable for all funds of the Medical Staff, and s/he shall report on receipts and disbursements of such funds. The Vice-President of the Medical Staff Organization may be re-elected to that office to succeed himself/herself for one additional term. In the event that the office of the President becomes permanently vacant, the Vice-President of the Medical Staff Organization shall succeed to the Presidency for the remainder of the term and a new Vice-President of the Medical Staff Organization shall be elected. In the event that a Vice-President of the Medical Staff Organization is unable to carry out his/her duties, a special election shall be held to fill his/her office.

5.1.3 The ~~Vice-President of Member-At-Large~~ Quality Advisor shall be elected for a two year term. S/he shall be responsible for oversight of quality processes throughout MCBHD and shall work closely with the Chief Medical Officer, ~~Chief Clinical Officer and Quality Management Services and Office of Compliance~~ on projects that improve quality and support the reduction of medical/healthcare errors and other factors that could contribute to unintended adverse patient outcomes. S/he shall serve on the Medical Staff Peer Review Committee for process oversight in an ex-officio capacity, without vote, serve on hospital administrative quality committees and make recommendations to the Executive Committee and Quality Council on such matters. The ~~Vice-President of Member-At-Large~~ Quality Advisor may be re-elected to that office to succeed

himself/herself. There shall be no restriction on the number of terms that s/he may serve. In the event that a ~~Vice-President of Member-At-Large~~ Quality Advisor is unable to carry out his/her duties, a special election shall be held to fill his/her ~~office~~.

5.1.4 The Member-At-Large physician position is to represent the physician community at the Medical Staff Executive Committee. There shall be one physician Member-At-Large. She/he shall serve for a two-year term. There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be held to fill his/her seat on the Medical Staff Executive Committee.

5.1.5~~4~~ The Members-At-Large psychologist positions are to represent the psychology community at the Medical Staff Executive Committee. There shall be two psychologist Members-At-Large. Each Member-At-Large shall serve for a two-year term. One election shall take place each year, with commencement of one position beginning on January 1 (even years) and the second on January 1 (odd years). There shall be no restriction on the number of terms that a Member-At-Large may serve. In the event that a Member-At-Large is unable to carry out his/her duties, a special election shall be held to fill his/her seat on the Medical Staff Executive Committee. ~~When only one nomination is put forth for a Member-At-Large position, the President of the Medical Staff may appoint that psychologist nominee to the vacant Member-At-Large position and shall communicate such appointment to the Medical Staff Organization.~~

5.2 Election and Removal of Officers and Members-At-Large.

5.2.1 Election of the President and the Vice-President of the Medical Staff Organization shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of the offices (even years). Office terms shall be for two years beginning January 1 (odd years). Election of the Officers shall be by the Active and Associate Medical Staff.

Election of the ~~Vice-President of Member-At-Large~~ Quality Advisor shall take place at the November meeting of the Medical Staff Organization that directly precedes the expiration of the term of office (odd years). The office term shall be for two years beginning January 1 (even years). Election of the Member-At-Large Quality Advisor shall be by the Active and Associate Medical Staff.

Election of the first Member-At-Large physician shall take place at the November 2018 meeting of the Medical Staff Organization and shall take place thereafter at the November meeting that directly precedes the expiration of the term of office (even years). The office term shall be for two years beginning January 1 (odd years). Election of the Member-At-Large physician shall be by the Active Medical Staff

There shall be one Member-At-Large psychologist election held each year at the November meeting of the Medical Staff Organization and each Member-At-Large term shall be for two-years. Election of the Members-At-Large shall be by the psychology members of the ~~active-Associate~~ Medical Staff.

Special elections shall be held within sixty days for elected positions vacant due to disability, ineligibility, or unavailability. Elections shall be by simple majority vote, including absentee ballots. Elections may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff.

When only one nomination is put forth for a Member-At-Large position, the President of the Medical Staff may appoint that nominee to the vacant Member-At-Large position and shall communicate such appointment to the Medical Staff Organization.

- 5.2.2 In the event that an officer is unable to carry out his/her duties, and following a review by the Peer Review Committee or Credentialing and Privileging Review Committee, as appropriate, an officer may be removed from office by two-thirds majority vote of the Active and Associate Medical Staff-as-a-whole. The removal of an officer shall be initiated by the joint recommendation of the Chief Medical Officer or designee and Chief Psychologist or designee or on written request of ~~any ten~~ 25% or more of the voting members of the Medical Staff.

In the event that a Member-At-Large is unable to carry out his/her duties, the procedure for removal of Executive Committee members in section 5.3.1 of these Bylaws shall be followed.

### 5.3 Committees of the Medical Staff.

The committees of the Medical Staff shall be the Executive, Credentialing and Privileging Review, and Medical Staff Peer Review. The President of the Medical Staff shall have the right upon taking office to appoint Chairpersons in collaboration with the Chief Medical Officer and/or Chief Psychologist, as appropriate, and members unless specified otherwise in committee descriptions. The President of the Medical Staff and the Chief Medical Officer shall be Ex-Officio members of all Medical Staff committees, as well as any special ad hoc committees, if not appointed as regular members. For purposes of conducting business, a membership quorum with a physician majority must be present for all committees. If a quorum is not present, the chairperson may entertain a motion to recess, to fix the time to which to adjourn to allow selection of a new date and time, or to adjourn the meeting.

#### 5.3.1 The Medical Staff Executive Committee.

The Medical Staff Executive Committee shall consist of the ~~three-two~~ three elected officers of the Medical Staff, ~~two-four~~ two ~~psychologist~~ Members-At-Large, the Chairperson of the Credentialing and Privileging Review Committee, the Chairpersons of the Medical Staff Peer Review Committee, the Chief Medical Officer, the Service Medical Directors, and the Chief Psychologist. A majority of voting Medical Staff Executive Committee members shall be fully licensed physicians within the Active Staff. Selection and appointment of Medical Staff members, in addition to the aforementioned automatic appointments, may be made upon the joint recommendation by the Chief Medical Officer, Chief Psychologist and Medical Staff President, subject to maintaining majority composition requirements, and shall be approved by the Committee. All members of the Medical Staff shall be eligible for membership on the Executive Committee. The Administrator, the ~~Chief Clinical Officer, the~~ Chief Nursing Officer and the Director of Medical Staff Services shall attend each meeting on an ex-officio basis. The President of the Medical Staff shall chair the

Medical Staff Executive Committee. The Medical Staff Executive Committee has the primary authority for activities related to self-governance of the Medical Staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the Medical Staff process. Functions of the Medical Staff Executive Committee shall be as follows:

1. it shall be empowered to act for and represent the Medical Staff in the intervals between the general Medical Staff Organization Meetings. Such authority shall include the review, and recommendations for amendment of Medical Staff Bylaws and Rules and Regulations, the assessment of dues, and development, review, amendment and adoption of Medical Staff policies and procedures that form the system of rights, responsibilities, and accountabilities between the organized Medical Staff and the Governing Authority and between the organized Medical Staff and its members;
2. it shall review and make Medical Staff committee appointments and Medical Staff committee chairperson appointments at the first meeting of each year, and at any other time it is deemed necessary;
3. it shall receive quarterly reports from the hospital-wide Quality Improvement Program and shall concern itself with programmatic, departmental and support service quality improvement activities as well as the results and corrective actions taken from such activities;
4. it shall concern itself with all matters affecting the delivery and quality of professional services and medical services in the hospital, the organization of the Medical Staff, and with reports and recommendations from the Credentialing and Privileging Review Committee, the Medical Staff Peer Review Committee, and any hospital committees or services that recommend actions that impact individuals with privileges;
5. it shall ensure Medical Staff representation and participation in any hospital deliberation affecting the discharge of Medical Staff responsibilities;
6. it shall ensure Medical Staff representation for the opportunity to participate and provide advice in any hospital leadership deliberation concerning the selection of medical services to be provided through a contractual arrangement (e.g., laboratory, radiological, pharmacy, rehabilitative, etc.) and in the selection of any medical or clinical staffing contractual arrangements [e.g., for dentists, podiatrists, physicians, psychiatrists, psychologists, advanced practice nurses, optometrists, physician's assistants or any other licensed independent practitioners (LIPs) or non-LIPs if privileges are required];
7. it shall provide liaison between the Medical Staff, the Chief Medical Officer, and the Administrator of MCBHD as well as the Governing Authority;
8. it shall ensure that the Medical Staff is kept abreast of the accreditation/ regulatory compliance program and informed of the accreditation status of the hospital, and it shall direct the Medical Staff concerning its responsibilities in this area;
9. it shall coordinate the activities and policies governing the Medical Staff;

10. it shall communicate with the Allied Staff (defined in the Preamble of these Bylaws) through acceptable mechanisms as determined by their respective Clinical Discipline Heads and through mechanisms as determined by the appropriate Service Administrator for those Allied Staff who are not members of discipline departments;
11. it shall make recommendations directly to the Governing Authority for its approval, on matters relating to the following and other matters, as relevant:
  - a. the structure of the Medical Staff;
  - b. the participation of the Medical Staff in organization performance-improvement activities;
  - c. the mechanisms used for evaluating individual professional practice;
  - d. the mechanism used to review credentials and to delineate individual clinical privileges;
  - e. recommendations of individuals for Medical Staff membership;
  - f. recommendations for delineated clinical privileges for each eligible individual;
  - g. the mechanism by which membership on the Medical Staff may be terminated;
  - h. the mechanism by which clinical privileges may be terminated;
  - i. the mechanism for fair hearing procedures; and
  - j. other medical-administrative matters including sentinel events;
12. it shall take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical Staff Members and Allied Health Professional Staff and shall request evaluation, by an appropriate body, in instances where there is doubt about an applicant's ability to perform privileges requested or privileges currently granted;
13. it shall review the Medical Staff Bylaws and Rules and Regulations at least every two years and make recommendations for revisions, as necessary, and shall review Medical Staff policies and procedures at least every three years and make revisions, as necessary:
  - a. if the voting members of the Medical Staff Organization propose to adopt a rule, regulation or policy or an amendment thereto, they first communicate the proposal to the Medical Staff Executive Committee;
  - b. if the Medical Staff Executive Committee proposes to adopt a rule, regulation or an amendment thereto, they first communicate the proposal to the Medical Staff;

- c. when the Medical Staff Executive Committee adopts a policy or an amendment thereto, they shall communicate this to the Medical Staff Organization;
- d. in cases of documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Staff Executive Committee may provisionally adopt and the Governing Authority may provisionally approve an urgent amendment without prior notification of the Medical Staff. The Medical Staff shall be notified and have opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Staff Organization and the Medical Staff Executive Committee, the provisional amendment shall stand.

e. There shall be a defined process to manage and resolve conflicts between the Medical Staff and the Medical Staff Executive Committee regarding proposals to adopt Rules, Regulations, policies, or procedures of the Medical Staff Organization. Such conflicts may be identified by a petition signed by at least ~~ten~~ 25% of the members of the Active and Associate Medical Staff. When such conflicts are identified, the President of the Medical Staff must call a special meeting of the Medical Staff Organization, as provided in section 6.2 of these Bylaws. The sole issue for any such special meeting will be discussion of the issue in conflict, which shall be resolved as provided in Section 6.2 of these Bylaws. The MCBHD Conflict Management policy and procedure shall be utilized for conflict between the Governing Authority and the Medical Staff and for all other issues of significant importance to the Medical Staff. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Authority on a rule, regulation, or policy adopted by the Medical Staff Organization or the Medical Staff Executive Committee. The Governing Authority shall determine the method of communication. No conflict management or dispute resolution process can amend the Medical Staff Bylaws, Rules and Regulations, or policies of the Medical Staff Organization. Bylaws, rules, regulations and policy amendments proposed as a result of a dispute management process must be acted upon by the Medical Staff and Governing Authority, in accordance with the requirements of these Bylaws.

e.f. The process for managing and resolving disputes or conflict between the Medical Staff Executive Committee and the Governing Authority shall be in accordance with the Governing Authority Conflict Management policy and procedure.

14. it shall receive and act on reports and recommendations from Medical Staff committees, hospital committees, clinical services, and assigned activity groups and make recommendations directly to the Governing Authority;
15. the Administrator or designee shall attend each Executive Committee Meeting on an ex-officio basis and may vote if s/he is a member of the Medical Staff;
16. it shall assure the provision of a single level of care to all patients, irrespective of the staff providing the care, by means of institution-wide and program specific standards of care, policies and procedures, monitors and corrective actions.

The Executive Committee shall meet as often as needed, but at least ten times per year, to represent the Medical Staff in the intervals between the general Medical Staff

Organization meetings. All meetings shall be documented and made available to the Medical Staff as a whole. Regular attendance by all Committee members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by two-thirds majority vote of the Executive Committee. The removal of a member shall be initiated, with cause cited, by the joint recommendation of any two members of the Executive Committee.

### 5.3.2 The Credentialing and Privileging Review Committee.

The Credentialing and Privileging Review Committee shall consist of at least six members of the Active and Associate Medical Staff to be comprised of a physician majority but with at least two psychologists. The Chairperson shall be a physician. The members and Chairperson shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer and Chief Psychologist. The Director of Medical Staff Services shall attend each meeting on an ex-officio basis. This committee shall be responsible for establishing credentialing and privileging requirements for each profession, in conjunction with recommendations from the Service Medical Directors and the Chief Psychologist, when applicable, subject to Medical Staff Executive Committee and Governing Authority approval, and for evaluating and recommending all applicants for Medical Staff appointment, privileging, reappointment, reprivileging and privilege revisions to the Medical Staff Executive Committee and for conveying all recommendations of the Medical Staff Executive Committee to the Governing Authority for approval. It shall further be responsible for the delineation of privileges, recommending promotions to Active Staff and other changes in appointment or privileges and for making recommendations thereon to the Executive Committee of the Medical Staff. It shall review credentials, reports and references, as well as reports and records from Peer Review, Medical Records, Quality Management, and other Medical Staff committees, when appropriate, in order to formulate its decisions and recommendations. It shall act as the review body for all matters involving medical staff professional behavior including, but not limited, to professional and personal conduct, professional ethics, compliance with established Medical Staff and hospital rules, regulations and policies that relate to professional conduct, and initiation of corrective action, when indicated. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff.

This committee shall meet as often as needed, but at least quarterly, and shall present written reports of all appointment and privileging recommendations, in summary fashion, to the Medical Staff Executive Committee, with notations reporting presented verbally and in closed session only. All meetings shall be documented. Records of reviews and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails to carry out his/her duties, a member may be removed from the committee by request of the Chairperson to the Medical Staff President and Chief Medical Officer and to the Chief Psychologist, as applicable.

### 5.3.3 Medical Staff Peer Review Committee.

There shall be a Medical Staff Peer Review Committee. A physician and a psychologist shall be selected to serve as Co-Chairpersons and shall be appointed by the President of the Medical Staff in collaboration with the Chief Medical Officer and Chief Psychologist, as

appropriate. The Chairpersons shall select three additional physicians and two additional psychologists from the Active and Associate Medical Staff to serve as members. The Vice-President of Quality shall serve ex-officio, without vote. This committee shall be responsible for carrying out quality improvement activities including, but not limited to, the review of clinical performance of members of their discipline to assess compliance with discipline established standards of practice ~~and codes of ethics~~, the review of Medical Staff monitors, compliance with established Medical Staff rules, regulations and policies that pertain to clinical performance, and initiation of corrective action, when indicated. This committee shall further be responsible for carrying out the same or similar review activities and initiation of corrective action, when indicated, for Allied Health Professional Staff. This committee may conduct a professional practice evaluation when questions arise through focused or ongoing professional practice evaluation activities, or through other mechanisms, regarding a practitioner's quality of care, treatment and service, professional competence, clinical judgment, ability to perform privileges held ~~or professional ethics~~, or when concerns regarding the provision of safe, high quality patient care are identified through clinical practice trends evidenced during the course of focused or ongoing professional practice evaluation or are triggered by single incident. In these instances, the committee shall assign one or more of its members to serve as peer investigator(s) for the specific practice concern. The Committee may consult with or seek assistance from other members of the Medical Staff or from an external source, in some circumstances, such as need for specialty review, when there are a limited number or no Medical Staff members within the required specialty or with the appropriate technical expertise on the Medical Staff or when the Medical Staff Peer Review Committee and/or Credentialing and Privileging Review Committee is/are unable to make a determination and requests an external opinion. Upon completion and committee discussion of the investigator(s) findings, the committee shall make a recommendation as to whether or not any action is required. Recommendations may be that no action is warranted, a self-acknowledged action plan, education, an informal or formal time-limited improvement plan or referral to the Credentialing and Privileging Review Committee, establish a monitoring plan, when appropriate, and set a time-limited duration. Whenever corrective action could result in consideration for reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee.

Ongoing professional review and required focused professional review activities associated with initial and provisional privileging may be delegated to members of the Medical Staff who are not members of this committee. All practitioners upon initial privilege approval or upon revised privilege approval shall be subject to a period of focused professional practice evaluation by his/her immediate supervisor or designee. Focused professional practice evaluation guidelines and evaluation monitors, for this purpose, shall be program or service specific and approved by the Medical Staff Peer Review Committee.

(Note: Per Wisconsin Stat. 146.37-Healthcare Services Review; civil Immunity and 146.38-Healthcare Services Review; confidentiality of Information and Title IV-Health Care Quality Improvement Act SEC 411 (42 U.S.C. sec 13111 et seq) Professional Review.

The Peer Review Committee shall meet as often as needed, but at least quarterly/semi-annually, and shall report in statistical or summary fashion only to the Medical Staff Executive Committee. All meetings of the Peer Review Committee shall be documented. Records of reviews, inquiries, proceedings and conclusions shall be maintained in accordance with State and Federal laws governing confidentiality of information acquired in connection with the review and evaluation of a healthcare provider. Regular attendance by all members is expected. In the event that a member is unable to or fails

to carry out his/her duties, a member may be removed from the committee at the discretion of the Co-chairpersons.

#### 5.4 Committees (Other).

##### 5.4.1 Joint Conference Committee.

The Joint Conference Committee shall consist of not ~~more-less~~ than two members of the Governing Authority ~~one of whom must be an Officer, the Administrator or his/her designee, the Chief Medical Officer, and the President of the Medical Staff (or the Vice-President as his/her designee). Additional participants shall be invited, as deemed appropriate, the Vice-President of the Medical Staff Organization, the Vice-President of Quality, the Chief Psychologist and the Chief Nursing Officer. This Committee shall be co-chaired by the President of the Medical Staff and a Governing Authority Officer.~~

~~This The purpose of this committee shall be for periodic consultation and discussion of matters related to the quality of medical care provided to patients of the hospital, provide a direct avenue of communication between the MCBHD Medical Staff and the Governing Authority and shall be responsible for resolving issues and/or disputes between the two groups and to manage critical issues.~~

This committee shall meet at least semi-annually but may convene more frequently, at the request of the Governing Authority or President of the Medical Staff, when issues of patient safety or quality of care are identified through quality assessment and performance improvement activities, as needing the attention of the Governing Authority in consultation with the Medical Staff. All meetings shall be documented including a list of attendees, whenever deemed necessary by the Governing Authority, the Behavioral Health Division Administrator, the Chief Medical Officer, or the MCBHD Medical Staff President. (Note: Required per CMS 482.131(a)(10))

##### 5.4.2 Nominating Committee.

The Nominating Committee shall consist of ~~three-two~~ physician members of the Active Medical Staff and one psychologist member of the Associate Medical Staff ~~shall include two physicians and one psychologist~~, selected by the Medical Staff at large at the May meeting of the Medical Staff Organization in the year when the biennial election of the President is scheduled (even years). The Nominating Committee shall serve as an ad hoc committee for a period of two years and shall reconvene, as necessary during the two year period for all other regularly scheduled elections or if should there be a need for a special election. Should there be a need to replace a member of the nominating committee, a new physician or psychologist, as appropriate, shall be selected by the Medical Staff at large at the next regular meeting of the Medical Staff Organization.

The Nominating Committee shall have the duty of preparing and presenting to the Medical Staff membership a slate of recommended candidates for the office(s) of the Medical Staff and the candidates for Member-At-Large at each meeting when an election is scheduled to take place or for any special election held. The Officers and Members-At-Large shall be nominated by any member of the Active or Associate Medical Staff.

##### 5.4.3 Ad Hoc Committees.

Ad Hoc Committees, as recommended by the Medical Staff Executive Committee, shall be formed through appointment by the President of the Medical Staff to address Medical Staff issues not within the responsibilities of the Medical Staff committees.

#### 5.5 Medical Administrative Organization.

The Medical Administrative Organization shall include the positions of Chief Medical Officer, the Service Medical Directors (Adult Inpatient, Child and Adolescent, Crisis, Community and Physical Care Services) and the Chief Psychologist.

All Medical Directors shall be certified by an appropriate specialty board or affirmatively establish comparable competence through the credentialing process. The Chief Psychologist shall be certified by an appropriate psychology board or affirmatively establish comparable competence through the credentialing process. All Medical Directors and the Chief Psychologist, as applicable to psychological services, shall be responsible or collaboratively responsible with Service Administrator(s) for the following, as appropriate to position and function within his/her MCBHD service:

1. all clinical related activities of his/her department;
2. administratively related activities of the department ~~(service medical directors and clinical program directors shall be collaboratively responsible);~~
3. continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
4. recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
5. recommending clinical privileges for each member of the department;
6. assessing and recommending to the Administrator and/or Governing Authority off-site sources for needed patient care, treatment and services not provided by the department or MCBHD;
7. integration of the department into the primary functions of the organization;
8. the coordination and integration of inter-departmental and intra-departmental services;
9. the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
10. recommending sufficient numbers of qualified and competent persons to provide care, treatment or service;
11. determining qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

12. the continuous assessment and improvement of the quality of care, treatment and services provided;
  13. the maintenance of quality control programs, as appropriate;
  14. the orientation and continuing education of all persons in the department; and
  15. recommendations for space and other resources needed by the department.
- 5.5.1 Additional authority and responsibilities to the Medical Staff Organization shall be as follows:
1. serve as a voting member of the Medical Staff Executive Committee;
  2. chair and/or serve on other Medical Staff committees, as appointed
  3. be responsible for the Medical Staff Organization's adherence to State and Federal regulations as well as the monitoring and evaluation of required standards and shall work in conjunction with the Medical Staff Organization and MCBHD to facilitate compliance;
  4. formulate recommendations for rules, policies and responsibilities reasonably necessary for proper discharge of Medical Staff and service responsibilities, subject to the approval of the Medical Staff Executive Committee and Governing Authority, when appropriate; and
  5. request, through the President, that special meetings of the Medical Staff Organization be called, when deemed necessary for the proper clinical functioning of the MCBHD.

#### 6.0 ARTICLE VI – MEETINGS

##### 6.1 Regular Meetings and Agenda.

There shall be general meetings of the full Medical Staff Organization held at least quarterly. The agenda at each of these meetings shall be:

1. call to order;
2. reading of the minutes of the last regular meeting and of any special meetings held during the quarter and approval of said minutes;
3. unfinished business;
4. report from the Medical Staff Executive Committee regarding activities and actions including the results of Medical Staff and hospital quality management monitors and follow-up;
5. reports from chairpersons of other Medical Staff committees;

6. reports from hospital committee chairpersons and by representatives from the various programs and services;
7. reports from the Vice President and Vice-President of Quality
8. reports from the Administrator, ~~and~~ Chief Medical Officer ~~and Chief Clinical Officer~~;
9. new business; and
10. adjournment.
11. The last meeting of each calendar year shall be designated as the meeting at which election of officers and Members-At-Large shall occur in accordance with the office terms defined in section 5.1 of these Bylaws. Newly elected officers and Members-At-Large shall take office as of the first of the new year after the election. This item will be added to the agenda, as appropriate.

##### 6.2 Special Meetings and Agenda.

Special meetings of the Medical Staff Organization may be called at any time by the President, at the request of the Medical Staff Executive Committee, at the request of the Chief Medical Officer, at the request of the Governing Authority Chair and/or Administrator of MCBHD, or on written request of ~~any ten~~ 25% or more of the voting members of the Medical Staff. Notification of a special meeting shall be published to the entire Medical Staff five days prior to the date set for the meeting.

The agenda at special meetings shall be limited to the reading of the notice calling the meeting, the transaction of only that business for which the meeting was called, and adjournment.

##### 6.3 Attendance at Meetings.

Active Medical Staff - All Active Medical Staff ~~are encouraged who are assigned to a work week of 20 hours or more are required to attend all 75% of the~~ regularly scheduled quarterly meetings during each calendar year, ~~unless excused by the President. Active Medical Staff who are assigned to a work week of less than 20 hours are required to attend at least one of the regularly scheduled quarterly meetings during each calendar year in order to maintain voting rights, unless excused by the President.~~

Associate Medical Staff - All Associate Medical Staff ~~are encouraged to attend all regularly scheduled quarterly meetings during each calendar year.~~

Affiliate Medical Staff - ~~Affiliate Medical Staff~~ may, but are not required to, attend meetings.

Consulting Medical Staff - ~~Consulting Medical Staff~~ may, but are not required to, attend meetings.

Telemedicine Consulting Medical Staff – may, but are not required to, attend meetings

Community Affiliate Medical Staff – may, but are not required to, attend meetings

Allied Health Professional Staff - ~~Allied Health Professional Staff~~ may, but are not required to, attend meetings.

The Administrator, Chief Nursing Officer, ~~Chief Clinical Officer~~ and Director of Medical Staff Services shall attend each meeting on an ex-officio basis.

Members of the Medical Staff, Allied Health Professional Staff and ex-officio attendees shall receive minutes from all regular and special meetings held. All Active Medical Staff and Associate Medical Staff shall be required to submit acknowledgement of receipt and review of information within the timeline designated.

~~The President of the Medical Staff or his/her designee shall send a letter of reprimand to any Medical Staff Member not meeting the above requirements with copy of such letter placed in member's permanent record, with an additional copy sent to the Credentialing and Privileging Review Committee to be considered during the reappointment process.~~

#### 6.4 Conduct of Meeting.

All meetings of the Medical Staff Organization and its Medical Staff committees shall be conducted according to the rules contained in "Robert's Rules of Order, Newly Revised" when they are appropriate and consistent with the Bylaws and Rules and Regulations of the Medical Staff.

### 7.0 ARTICLE VII - CORRECTIVE ACTION AND RIGHT OF APPEAL

7.1 Whenever the professional conduct or other activities of a Medical Staff Member are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Medical Staff appointment and/or privileges are detailed in Appendix I and Appendix II of these Bylaws.

7.2 Whenever the professional conduct or other activities of an Allied Health Professional are considered deviant from the standards or are inconsistent with the aims of the Medical Staff, corrective action may be initiated. The manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Allied Health Professional appointment and/or privileges are detailed in Appendix I and Appendix III of these Bylaws.

### 8.0 ARTICLE VIII - HEARING AND APPELLATE REVIEW

#### 8.1 Right to Hearing and to Appellate Review.

Whenever a Medical Staff Member or prospective Medical Staff Member is notified by the Credentialing and Privileging Review Committee of a recommendation that may adversely affect his/her Medical Staff appointment and/or clinical privileges, s/he shall be entitled to a hearing and appellate review, as outlined in Appendix II of these Bylaws.

Allied Health Professionals shall have a right to fair hearing but have no right to formal appellate review.

### 9.0 ARTICLE IX - RULES AND REGULATIONS

9.1 The Medical Staff Executive Committee shall adopt by a simple majority of quorum vote subject to physician majority of all voting members such Rules and Regulations as may be necessary for the proper conduct of its work. Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. Amendments shall be communicated, considered and acted upon in accordance with Section 5.3.1, subsection 13 of these Bylaws. Amendments so made shall become effective when approved by the Governing Authority.

### 10.0 ARTICLE X - BYLAWS

#### 10.1 Amendments.

All voting members of the Medical Staff Organization shall be given written notice of any proposed amendment to these Bylaws at least ten days prior to the meeting at which a vote is scheduled to take place. The affirmative vote of two-thirds of the voting membership subject to physician majority shall be required for adoption of the proposed amendment(s). Members may vote by proxy, if not able to be present at a meeting where a vote is to take place. An amendment vote may be held at a regular or special meeting of the Medical Staff Organization or may be conducted outside of a meeting by ballot, including electronic means, as directed by the President of the Medical Staff. Amendments so made shall become effective when approved by the Governing Authority.

Proposed amendments to these Bylaws may be originated by the Medical Staff Executive Committee or by a petition signed by ~~ten~~25% or more members of the Active and Associate Medical Staff.

#### 10.2 Adoption.

These Bylaws, together with the appended Rules and Regulations, shall replace any previous Bylaws and Rules and Regulations. They shall, when adopted and approved, be equally binding on the Governing Authority, Medical Staff and privileged Allied Health Professional Staff.

### 11.0 ARTICLE XI - DUES

#### 11.1 Authority.

Dues, as determined by the Executive Committee of the Medical Staff, may be assessed to voting members of the Medical Staff.

#### 11.2 Assessment.

All members of the Medical Staff Organization holding appointment within the Active or Associate Staff Category (voting members) shall be required to pay dues within 45 days of receiving an assessment.

1. All new applicants who apply for and are formally appointed to the Active Staff or Associate Staff on or before July 1 shall be required to pay dues during his/her initial appointment year, unless no dues are assessed for that year.
2. All new applicants who apply for and are formally appointed to the Active Staff or Associate Staff after July 1 shall not be subject to a dues assessment until the following calendar year.
3. If a Medical Staff member is delinquent, payment of any outstanding dues assessment(s) must be made at time of application for reappointment or application shall be deemed incomplete.

APPENDIX I

CORRECTIVE ACTION:

Section 1.0 General Procedures:

1.1 Initiation of Corrective Action.

Whenever the activities or professional conduct of a Medical Staff Member or Allied Health Professional deviates from the standards, are inconsistent with the aims of the Medical Staff or are disruptive to the operations of the hospital, corrective action against such Medical Staff Member or Allied Health Professional may be requested by an officer of the Medical Staff, the Chief Medical Officer, a Service Medical Director or the Chief Psychologist, when applicable, or by the Administrator of MCBHD or Governing Authority Chair. Applicants have the burden of producing adequate information for proper evaluation of professional, ethical and other qualifications for membership and/or clinical privileges and for resolving any doubts about such qualifications. If an application is found to contain significant misstatements or omissions following appointment and/or privileging, this shall constitute cause for automatic relinquishment of membership and/or privileges with no right to hearing or appeal. All requests for corrective action shall be in writing, shall be made to the Peer Review Committee or Credentialing and Privileging Review Committee, as appropriate to the matter, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. Appropriate Civil Service procedures shall be followed, when indicated.

1.2 Reduction or Suspension of Clinical Privileges.

Professional Competence. The Peer Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges, the Peer Review Committee shall forward its findings and recommendations to the Credentialing and Privileging Review Committee. The Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

Professional Conduct. The Credentialing and Privileging Review Committee shall conduct a thorough investigation of the charges against the Medical Staff Member or Allied Health Professional. Whenever the corrective action could result in a reduction or suspension of clinical privileges or appointment, the Credentialing and Privileging Review Committee shall notify the affected Medical Staff Member or Allied Health Professional, in writing, that charges were filed against him/her.

11.3 Reporting.

In accordance with 5.0 Article V, Section 5.1.2, the Vice-president of the Medical Staff Organization shall be accountable for all funds of the Medical Staff. S/he shall report on receipts and disbursements of such funds to the Medical Staff Organization, at least annually. Dues accumulated within the treasury fund may be used for, but not limited to, the following purposes:

1. Bereavements
2. Birth/adoption of child by Medical Staff Member
3. Awards/Recognitions/Appreciations – Individual or Group
4. Scholarships/Education
5. Medical Staff Organization gatherings/functions
6. Other events/circumstances deemed to be appropriate

1.3 Credentialing and Privileging Review Committee Interview:

Within ten (10) days after the Credentialing and Privileging Review Committee's receipt of Peer Review Committee findings or by its own findings, the committee shall present a report to the Medical Staff Executive Committee. Prior to the presentation of such report, the Medical Staff Member or Allied Health Professional against whom corrective action has been requested shall have an opportunity for an interview with the Credentialing and Privileging Review Committee. At such interview, s/he shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing and shall be preliminary in nature. A record of such interview shall be made by the Credentialing and Privileging Review Committee and included with its report to the Executive Committee.

1.4 Withdrawal of Initial Application for Medical Staff Appointment or Clinical Privileges:

A Medical Staff Member or Allied Health Professional may voluntarily withdraw his/her initial application for Medical Staff appointment or clinical privileges prior to a final action. Right to hearing and appellate review shall be forfeited at that time. Such withdrawals are generally not reportable to the National Practitioner Data Bank.

1.5 Withdrawal of Application for Renewal of Medical Staff Appointment or Clinical Privileges While Under Investigation:

A Medical Staff Member or Allied Health Professional who applies for renewal of Medical Staff appointment or clinical privileges and voluntarily withdraws that application while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, must be reported to the National Practitioner Data Bank.

1.6 Resignation While Under or to Avoid Investigation:

A physician Medical Staff Member who resigns his/her Medical Staff appointment and/or clinical privileges while under investigation for possible professional incompetence, improper professional conduct, or in return for not conducting such an investigation or not taking a professional review action, must be reported to the National Practitioner Data Bank regardless of whether the physician was aware that they were under investigation. Non-physician Medical Staff Members and Allied Health Professionals may be reported to the National Practitioner Data Bank under these same circumstances, but it is not required.

1.7 A Medical Staff Member or Allied Health Professional that is reported to the National Practitioner Data Bank under the circumstances described under the aforementioned sections 1.5 or 1.6 has no right to hearing and appellate review procedures, as no professional review action was recommended or taken.

Section 2.0 Medical Staff Executive Committee Authority:

2.1 The action of the Medical Staff Executive Committee on a request for corrective action may be to reject or modify the request for corrective action, to issue a warning, a letter of admonition or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend: a.) reduction, b.) suspension or c.) revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that a Medical Staff Member's membership be suspended or revoked. Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff shall entitle the affected practitioner to the procedural rights provided in Appendix II (Hearing and Appellate Procedure: Medical Staff). Any recommendation by the Executive Committee for reduction, suspension, or revocation of clinical privileges, or for suspension or expulsion shall entitle the affected Allied Health Professional to the procedural rights provided in Appendix III (Fair Hearing and Appeal Procedure: Allied Health Professionals).

2.2 Responsibilities.

The President of the Medical Staff shall promptly notify the Administrator of MCBHD, in writing, of all requests for corrective action received by the Medical Staff Executive Committee and shall continue to keep the Administrator of MCBHD fully informed of all action taken. After the Medical Staff Executive Committee has made its recommendation in the matter, the procedure to be followed shall be as provided in Appendix II or Appendix III of these Bylaws.

Section 3.0 Suspensions:

3.1 Summary.

Any one of the following--the President of the Medical Staff, the Chief Medical Officer, the Chief Psychologist (limited to psychologists), the Administrator, the chairperson of the Credentialing and Privileging Review Committee, or the Governing Authority ~~Chair-~~ shall each have the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend all or any portion of the clinical privileges of a practitioner, and such summary suspension shall become effective immediately upon imposition and amendment.

Circumstances which would lead to immediate summary suspensions would include ~~inebriation-any form of impairment~~ while on duty, sexual misconduct with patients or other caregiver misconduct, conviction of a felony involving violence to others, or any other intentional act performed that endangers patient safety or is considered to be in clear violation of professional ethics.

3.2 Temporary.

A Medical Staff Member whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request that the Credentialing and Privileging Review Committee of the Medical Staff hold a hearing on the matter. The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within 30 days shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter under Appendix II of these Bylaws. The Credentialing and Privileging Review Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Credentialing and Privileging Review Committee does not recommend immediate termination of the summary suspension, the affected Medical Staff member shall be entitled to request an appellate review by the Governing Authority. The summary suspension, as sustained or as modified by the Credentialing and Privileging Review Committee, shall remain in effect pending a final decision by the Governing Authority.

An Allied Health Professional whose clinical privileges have been summarily suspended for a period of more than 14 days shall be entitled to request a meeting on the matter before two physicians and one peer, appointed by the President. The failure of an Allied Health Professional to request a meeting from the President to which s/he is entitled by these Bylaws, within (30) days shall be deemed a waiver of his/her right to such a fair hearing and to any appeal to which s/he might otherwise have been entitled on the matter in under Appendix III of these Bylaws.

3.3 Automatic.

A temporary suspension in the form of a withdrawal of a Medical Staff Member's or Allied Health Professional's clinical privileges, effective until medical records are

completed, shall be imposed automatically seventy-two (72) hours after final warning of delinquency for failure to complete medical records within the time allotted by the hospital. Notification of such suspension to the Medical Staff Member or Allied Health Professional and appropriate hospital authorities shall be made by the Chief Medical Officer or designee.

Action by the State Board of Examiners revoking or suspending a Medical Staff Member's or Allied Health Professional's license, or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain current professional licensure shall automatically suspend all of his/her hospital privileges.

Action by the federal Drug Enforcement Administration revoking or suspending a Medical Staff Member's or Allied Health Professional's registration or placing him/her on probation, or failure by a Medical Staff Member or Allied Health Professional to maintain registration, when required, shall automatically suspend his/her prescriptive authority. Automatic suspension of all hospital privileges shall be considered whenever circumstances warrant.

Action by Medicare/Medicaid resulting in exclusion or suspension from participating in these programs or becoming subject to conviction or offense under DHS 12 Wisconsin Caregiver Laws shall automatically suspend all of his/her hospital privileges.

It shall be the duty of the President of the Medical Staff to cooperate with the Administrator of MCBHD in enforcing all automatic suspensions.

APPENDIX II

HEARING AND APPELLATE REVIEW: PROCEDURE (MEDICAL STAFF)

Section 1.0 Right to Hearing and to Appellate Review:

- 1.1 Whenever a Medical Staff Member or Medical Staff privilege applicant receives a notice of a recommendation by the Credentialing and Privileging Review Committee which, if approved by decisions of the Medical Staff Executive Committee and the Governing Authority, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges or is summarily suspended for a period of more than 14 days, s/he shall be entitled to a hearing before the Medical Staff Executive Committee. If the recommendation of the Medical Staff Executive Committee following such hearing is still adverse to the affected practitioner, s/he shall then be entitled to an appellate review by the Governing Authority before s/he makes a final decision on the matter.

Rights of the practitioner with temporary privileges: A practitioner is not entitled to the procedural rights afforded in Appendix II of these Bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

- 1.2 When any Medical Staff Member receives notice of a decision by the Governing Authority that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges and such decision is not based on a prior adverse recommendation by the Credentialing and Privileging Review Committee of the Medical Staff, s/he shall be entitled to a hearing. Such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Active or Associate Medical Staff who are discipline peers appointed by the Chair of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee. If such a hearing does not result in a favorable recommendation, s/he shall be entitled to an appellate review by the Governing Authority, before a final decision on the matter is made.

- 1.3 All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this Appendix II to assure that the affected practitioner is accorded all rights to which s/he is entitled.

The notice of hearing shall state in concise language the acts or omissions with which the Medical Staff Member is charged, a list of specific or representative medical records being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

Section 2.0 Request for Hearing:

- 2.1 The President of the Medical Staff or his/her designee shall be responsible for giving prompt written notice, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, of an adverse recommendation or decision to any affected Medical Staff Member who is entitled to a hearing or to an appellate review.
- 2.2 The failure of a Medical Staff Member to request a hearing, from the President of the Medical Staff or designee to which s/he is entitled by these Bylaws, within thirty (30) days of receipt of the written notice by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, shall be deemed a waiver of his/her right to such a hearing and to any appellate review to which s/he might otherwise have been entitled on the matter.
- 2.3 When the waiver of hearing or appellate review relates to an adverse recommendation recommendation of the Credentialing and Privileging Review Committee of the Medical Staff or of a hearing committee appointed by the Medical Staff Executive Committee, the same shall thereupon become and remain effective against the staff member pending decision on the matter. When the waived hearing or appellate review relates to an adverse decision by the Governing Authority, the same shall thereupon become and remain effective against the Medical Staff Member in the same same manner as a final decision of the Governing Authority, provided for in Section 7.0 of this Appendix II. The President of the Medical Staff shall promptly notify the affected Medical Staff Member of this status by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery.

Section 3.0 Notice of Hearing:

- 3.1 Within ten (10) days after receipt of a request for hearing from a Medical Staff Member, the Medical Staff Executive Committee or the Credentialing and Privileging Review Committee, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President of the Medical Staff, notify the Medical Staff Member of the time, place and date so scheduled, by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery. The hearing date shall not be less than fifteen (15) days, nor more than thirty (30) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Medical Staff Member who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, but not later than fifteen (15) days from the date of receipt of such staff member's request for hearing.
- 3.2 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the Administrator, in conjunction with the President of the Medical Staff, shall schedule the hearing and shall give written notice to the practitioner who requested the hearing. The notice shall include:

- a) The time, place and date of the hearing;
- b) A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the Medical Staff Executive Committee, (or Governing Authority), at the hearing;
- c) The names of the hearing panel members and presiding officer or hearing officer, if known; and
- d) A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to, in writing, by both parties.

Section 4.0 Composition of Hearing Committee:

- 4.1 When a hearing relates to an adverse recommendation of the Credentialing and Privileging Review Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than three (3) members of the Active or Associate Medical Staff who are discipline peers appointed by the Chairperson of the Credentialing and Privileging Review Committee, and one of the members so appointed shall be designated as Chairperson. No Medical Staff Member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this hearing committee.
- 4.2 When a hearing relates to an adverse decision of the Medical Staff Executive Committee that is contrary to the recommendation of the Credentialing and Privileging Review Committee, the Medical Staff President shall appoint a hearing committee of not less than three (3) individuals to conduct such hearing and shall designate one of the members of said committee as Chairperson. At least one representative from the Medical Staff shall be included on this committee.

Section 5.0 Conduct of Hearing:

- 5.1 There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.
- 5.2 An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of minutes.

- 5.3 The presence of the Medical Staff Member for whom the hearing has been scheduled shall be required. A Medical Staff Member who fails without good cause to appear at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 2.0 of this Appendix II and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 2.0 of this Appendix II.
- 5.4 Postponement of hearing beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc hearing committee. Granting of such postponement shall only be for cause shown and at the sole discretion of the hearing committee.
- 5.5 The affected Medical Staff Member shall be entitled to be accompanied by and/or represented at the hearing by an attorney, a member of the Medical Staff in good standing or by a member of his/her local professional association.
- 5.6 The Chairperson of the hearing committee or his/her designee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.
- 5.7 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.
- 5.8 The Credentialing and Privileging Review Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff Member to represent it at the hearing, to present the facts in support of its adverse recommendation and to examine witnesses. The Medical Staff Executive Committee, when its action has prompted the hearing, shall appoint one of its members to represent the committee at the hearing, to present the facts in support of the adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected Medical Staff Member shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved a lack of any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.
- 5.9 The affected Medical Staff Member shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness or any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the Medical Staff Member does not testify in his/her own behalf, s/he may be called and examined as if under cross-examination.

5.10 The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct. Accordingly, both sides shall be entitled to be represented by counsel of their choosing, in connection with preparation for the hearing or for a possible appeal.

5.11 The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon conduct its deliberations outside the presence of the staff member for whom the hearing was convened.

5.12 Within five (5) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Credentialing and Privileging Review Committee or to the Medical Staff Executive Committee, whichever appointed it. The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Credentialing and Privileging Review Committee or decision of the Medical Staff Executive Committee.

Section 6.0 Appeal to the Governing Authority:

6.1 Within seven (7) days after receipt of a notice by an affected Medical Staff Member of an adverse recommendation or decision made or adhered to after a hearing as above provided, s/he may, by

- a. written notice to the Governing Authority Chair, then
- b. delivered through the President of the Medical Staff by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery
- c. request an appellate review by the Governing Authority.

Such written notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Medical Staff Member's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

6.2 If such appellate review is not requested within seven (7) days, the affected Medical Staff Member shall be deemed to have waived his/her right to the same and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 7.2 of this Appendix II.

6.3 Within ten (10) days after receipt of such notice of request for appellate review, the Governing Authority Chair (or his/her designee) shall schedule a date for such review, including a time and place for oral argument if such has been requested and shall, through the President of the Medical Staff by written notice sent by certified mail

(return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, notify the affected Medical Staff Member of the same. The date of the appellate review shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request for appellate review, except that when the Medical Staff Member requesting the review is under a suspension which is currently in effect, such review shall be scheduled as soon as the arrangements can reasonably be made but not more than ten (10) days from the date of receipt of such notice.

6.4 The appellate review shall be conducted by the Governing Authority or by a duly appointed appellate review committee appointed by the Governing Authority Chair of not less than three (3) members with one designated as Chairperson.

6.5 The affected Medical Staff Member shall have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her. S/he shall have seven (7) days to submit a written statement in his/her own behalf, in which those factual and procedural matters with which s/he disagrees, and his/her reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing Authority Chair through the President of the Medical Staff by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery, at least five (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Credentialing and Privileging Review Committee of the Medical Staff. The President of the Medical Staff shall provide a copy thereof to the Medical Staff Member at least five (5) days prior to the date of such appellate review by certified mail (return receipt requested), by email (delivery receipt and read receipt requested) or by hand delivery.

6.6 The Governing Authority or its appointed review committee shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statements submitted pursuant to subparagraph 6.5 of this Section 6, for the purpose of determining whether the adverse recommendation or decision against the affected Medical Staff Member was justified and was not arbitrary or capricious. If oral argument is requested as part of the review procedure, the affected Medical Staff Member shall be present at such appellate review, s/he shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body. The Credentialing and Privileging Review Committee or the Medical Staff Executive Committee, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the appellate review body.

6.7 New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, may be introduced at the appellate review under unusual circumstances, and the Governing Authority or the

committee thereof appointed to conduct the appellate review shall, in its sole discretion, determine whether such new matters shall be accepted.

6.8 If the appellate review is conducted by the Governing Authority, it may affirm, modify or reverse its prior decision, or, in its discretion, refer the matter back to the Credentialing and Privileging Review Committee of the Medical Staff for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve specified disputed issues.

6.9 If the appellate review is conducted by a committee appointed by the Governing Authority Chair, such committee shall, within seven (7) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing Authority affirm, modify or reverse its prior decision or refer the matter back to the Credentialing and Privileging Review Committee for further review and recommendation within thirty (30) days. Such referral may include a request that the Credentialing and Privileging Review Committee of the Medical Staff arrange for a further hearing to resolve disputed issues. Within seven (7) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Authority as above provided.

6.10 The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6.0 have been completed or waived.

Section 7.0 Final Decision by the Governing Authority:

7.1 Within ten (10) days after the conclusion of the appellate review, the Governing Authority shall make ~~his/her/their~~ final decision in the matter and shall send notice thereof to the Credentialing and Privileging Review Committee and, through the President of the Medical Staff, to the affected Medical Staff Member, by certified mail (return receipt requested), ~~by email (delivery receipt and read receipt requested)~~ or by hand delivery. This decision shall be immediately effective and final and shall not be subject to further hearing or appellate review. All final decision adverse actions shall be reported to the National Practitioner Data Bank.

7.2 Notwithstanding any other provision of these Bylaws, no Medical Staff Member shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MCBHD, or by a duly authorized committee appointed by the Governing Authority Chair.

FAIR HEARING AND APPEAL: PROCEDURE (ALLIED HEALTH PROFESSIONALS)

Section 1.0 Right to Fair Hearing:

1.1 Allied Health Professional Staff are not entitled to the hearing and appeals procedures set forth in Appendix II of these Bylaws. In the event an Allied Health Professional receives notice of a recommendation by the Medical Staff Executive Committee that will adversely affect his/her exercise of clinical privileges, the Allied Health Professional and his/her supervising physician shall have the right to meet personally with two physicians and one peer assigned by the President of the Medical Staff to discuss the recommendation.

1.2 The Allied Health Professional and the supervising physician must request such a meeting, in writing, to the Administrator within ten (10) business days from the date of receipt of such notice. At the meeting, the Allied Health Professional and the supervising physician must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing as specified for Medical Staff members and none of the procedural rules set forth in Appendix II of these Bylaws with respect to such hearings shall apply. The meeting shall take place as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the request for meeting unless an earlier date has been specifically agreed to, in writing, by both parties

1.3 Within five (5) days after the fair hearing meeting, findings from this review body will be forwarded to the affected Allied Health Professional, the Medical Staff Executive Committee and the Governing Authority.

Section 2.0 Right to Appeal:

2.1 The Allied Health Professional and the supervising physician may request an appeal, in writing, to the Administrator within ten (10) calendar days of receipt of the findings of the review body. The Administrator shall so notify the Governing Authority Chair of the request.

2.2 Within ten (10) calendar days after receipt of such notice of request for appeal, the Governing Authority shall schedule a date for such review, including a time and place through the Administrator, who shall by written notice sent by certified mail (return receipt requested), ~~by email (delivery receipt and read receipt requested)~~ or by hand delivery notify the affected Allied Health Professional and supervising physician of the same. The date of the appeal shall not be less than fifteen (15) days nor more than thirty (30) days from the date of receipt of the notice of request.

2.3 Two members of the Governing Authority assigned by the Governing Authority Chair shall hear the appeal from the Allied Health Professional and the supervising physician. A representative from the Medical Staff leadership (~~Officer/President, Vice-President,~~

Chief Medical Officer or Service Medical Director) may be present. The decision of the appeal body will be forwarded to the Governing Authority for final decision within five (5) days of hearing the appeal.

Section 3.0 Final Decision:

- 3.1 The Allied Health Professional and the supervising physician will be notified within ten (10) calendar days of the final decision of the Governing Authority.
- 3.2 Notwithstanding any other provision of these Bylaws, no Allied Health Professional shall be entitled as a right to more than one hearing and one appeal on any matter which shall have been the subject of action by the Credentialing and Privileging Review Committee of the Medical Staff, by the Medical Staff Executive Committee or by the Administrator of MCBHD, or by a duly authorized committee appointed by the Governing Authority Chair.

BYLAWS  
OF THE  
MEDICAL STAFF ORGANIZATION  
OF THE  
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

Approved and Adopted by the Medical Staff Organization  
of the Milwaukee County Behavioral Health Division  
in accordance with existing Bylaws  
~~August 3, 2016~~ August 1, 2018

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clarence P. Chou, MD, President of the Medical Staff  
Milwaukee County Behavioral Health Division

And

Approved and Adopted by the Milwaukee County Mental Health Board as Governing Authority  
of the Milwaukee County Behavioral Health Division  
in accordance with existing Bylaws  
~~August 25, 2016~~ 23, 2018

\_\_\_\_\_  
Date

\_\_\_\_\_  
~~Thomas Lutzow~~ Duncan M. Shrout, Chairperson  
Milwaukee County Mental Health Board

Reviewed and Supported by Hospital Administration

\_\_\_\_\_  
Date

\_\_\_\_\_  
John H. Schneider, MD, FAPA, Chief Medical Officer  
Milwaukee County Behavioral Health Division

\_\_\_\_\_  
Date

\_\_\_\_\_  
Michael Lappen, MS, LPC, Administrator  
Milwaukee County Behavioral Health Division

References: (REGULATORY PUBLICATION DATES BELOW TO BE UPDATED)

- ✔ Joint Commission CAMH, Refreshed Core, Effec. July 1, 2018
- ✔ CMS Conditions of Participation, State Operations Manual - Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 176, 12-29-17)
- ✔ CMS Subpart E—Requirements for Specialty Hospitals, Sec 482.60 – 482.62
- ✔ Wisconsin State Statutes: 15.195(9); 50.36; 146.37, 146.38
- ✔ Title IV-Health Care Quality Improvement Act SEC 411 [42 U.S.C.sec 11111 et seq] Professional Review
- ✔ National Practitioner Data Bank Guidebook (rev. 2015)
- ✔ "Robert's Rules of Order"
- ✔ Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment Medicaid Integrity Group
- ✔ Social Security Act, Sec 1128
- ✔ Wisconsin Administrative Code, DHS 12 (Caregiver Background Checks) and DHS 124 (Hospitals)
- ✔ National Association of Medical Staff Services – Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals, February 2014

DATES REVISED:  
(Previous revision dates not kept)

June, 1986  
December, 1989; Addenda July, 1990 and March, 1991  
December 1991; Addenda April, 1992 and June, 1993  
April 1994  
July 1994  
September 1994  
November 1996  
August 1997  
November 1998  
November 2000  
January 2002  
September 2002  
September 2004  
March 2008  
October 2010  
December 2011  
May 2012  
February 2013  
November 2014  
February 2016  
August 2016  
August 2018

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