

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

**MILWAUKEE COUNTY MENTAL HEALTH BOARD**

Thursday, February 27, 2020 - 9:00 A.M.  
Milwaukee County Zoo  
Peck Welcome Center Pavilion  
10001 West Bluemound Road

**MINUTES**

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

**SCHEDULED ITEMS:**

- |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
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| 1. | <p><b>Welcome.</b></p> <p>After the Roll Call, the Board was informed Board Member Johnson reached out to Chairman Lutzow and Mr. Lappen regarding a fall semester class, which she teaches in Madison, conflicting with the Board schedule. Chairman Lutzow stated Board Member Johnson is a very valuable asset and therefore, accommodating her schedule is appropriate.</p> <p>Chairman Lutzow greeted Board Members and welcomed everyone to the February 27, 2020, Mental Health Board meeting.</p>                                                                                                                                                                                                                                                                                                                                                                  |
| 2. | <p><b>Election of Board Officers – Chair, Vice-Chair, and Secretary.</b></p> <p><b>MOTION #1 BY:</b> <i>(Forman) Nominate Thomas Lutzow for Chairman of the Milwaukee County Mental Health Board.</i></p> <p><b>MOTION #2 BY:</b> <i>(Neubauer) Keep the Current Officers in Place as Follows: Thomas Lutzow – Chairman, Maria Perez – Vice-Chairperson, and Michael Davis - Secretary for the 2020 Term. 8-0</i></p> <p>Upon hearing Motion #2, Board Member Forman withdrew her motion (Motion #1) and seconded Board Member Neubauer’s motion to keep the current officers in place.</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> <i>(Forman)</i></p> <p><b>AYES:</b> Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8</p> <p><b>NOES:</b> 0</p> <p><b><i>The motion to keep the current Board Officers in place was unanimously approved.</i></b></p> |

**SCHEDULED ITEMS (CONTINUED):**

3.	<p><b>Approval of the Minutes from the December 12, 2019, and January 23, 2020, Milwaukee County Mental Health Board Meeting and Public Hearing.</b></p> <p>Board Member Neubauer requested the January 23, 2020, meeting minutes be corrected to accurately reflect Speaker Sue Gadacz' organization affiliation on Page 1, Item 2.</p> <p><b>MOTION BY:</b> (Eilers) Approve the December 12, 2019, Meeting Minutes and the January 23, 2020, Public Hearing Minutes AS CORRECTED. 6-0-2</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Perez)</p> <p><b>AYES:</b> Davis, Eilers, Lutzow, Neubauer, Perez, and Wesley – 6</p> <p><b>NOES:</b> 0</p> <p><b>ABSTENTIONS:</b> Forman and Lanier – 2</p>
4.	<p><b>Public Hearing Follow-Up Discussions.</b></p> <p>Kimberly Payne, Perceptivity, Inc.</p> <p>Board Member Neubauer explained the reason she suggested to add this topic as a standing agenda item for the Board after every public hearing is so the Board can have a discussion surrounding and be responsive to concerns raised by the community.</p> <p>She addressed and provided insight, from a Quality perspective, on comments made at the January 23, 2020, Public Hearing related to terminated contracts with minority providers.</p> <p>Ms. Payne addressed communications postings related to Mental Health Board Public Hearings. She stated the hearings are routinely posted to numerous community calendars online and via email. The list of community calendars compiled continues to grow and is used to promote the hearings. They are also in the process of crafting a social media plan by exploring a recommendation made for the Board to establish its own social media page, which would be another resource to assist with getting information out to the community.</p> <p>Questions and comments ensued at length.</p> <p>Board Member Eilers suggested the Board develop a way to encourage engagement with the community in real time at the hearings.</p> <p>Board Members Forman and Lanier indicated they would be willing to be part of a solution. Board Member Lanier recommended a Community Engagement Ad Hoc Committee could be appointed to address the issues raised by the Board and the community.</p> <p>Chairman Lutzow agreed there are different ways to look at how the hearings are currently structured, and the Board needs to decide whether the hearings should be dialogue centered as opposed to the current listening session format.</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p><b>MOTION BY:</b> (Lanier) <i>Establish a Community Engagement Ad Hoc Committee of the Mental health Board to Address the Board's Responsiveness to the Community.</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Eilers)</p> <p>Chairman Lutzow recommended delaying this discussion to Item 9 under which the Board will consider establishing an ad hoc committee.</p> <p>Board Member Lanier withdrew his motion.</p>
5.	<p><b>Department of Administrative Services Quarterly Update on the State of Milwaukee County's Interests and Matters Related to the Behavioral Health Division.</b></p> <p>Joseph Lamers, Director, Office of Performance, Strategy, and Budget (PSB), Department of Administrative Services</p> <p>Mr. Lamers stated the County is currently preparing for the 2021 Budget process. The preliminary projections are not that different from 2020's projections and includes a budget gap of \$21.3 million. The gap is part of an ongoing structural deficit. Growth in revenue is not enough to keep pace with inflationary operating costs on an annual basis.</p> <p>Mr. Lamers provided an overview of expenditures, revenues, potential options for closing the budget gap, and strategic planning.</p> <p>Questions and comments ensued.</p>
6.	<p><b>2019 Collective Bargaining Agreement with the Wisconsin Federation of Nurses and Health Professionals (WFNHP) Base Wage Negotiation.</b></p> <p>Lisa Ruiz, Manager, Department of Human Resources</p> <p>Ms. Ruiz explained under Wisconsin Employment Relations Commission rules and Act 10, non-public safety bargaining units such as the Wisconsin Federation of Nurses and Health Professionals are only allowed to negotiate for base wage increases on an annual basis and only up to a maximum of the Consumer Price Index (CPI), which is 2%. This will keep Behavioral Health Division positions aligned with the market. It is an across-the-board increase effective as of June 2, 2019. Upon the Board's vote of approval, the increase will be immediately processed and paid retroactively.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2019 Collective Bargaining 2% Base Wage Increase Agreement with the Wisconsin Federation of Nurses and Health Professionals (WFNHP) to be paid retroactively.</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p><b>MOTION BY:</b> (Perez) Approve the 2019 Collective Bargaining Agreement's 2% Wage Increase for the Wisconsin Federation of Nurses and Health Professionals. 8-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Eilers)</p> <p><b>AYES:</b> Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p><b>NOES:</b> 0</p>
7.	<p><b>Mental Health Board Executive Committee Update.</b></p> <p>Chairman Lutzow reviewed items discussed at the February 3, 2020, Executive Committee Meeting including the Mental Health Complex land sale, which will be addressed in Item 8; the Critical Management Solutions initial report and costs associated to the corrective action plan; the establishment of a Governance Ad Hoc Committee; which will be addressed in Item 9; and the Board staff position.</p> <p style="text-align: center;"><b>After Item 9, the Board moved RECONSIDERATION of Item 7.</b></p> <p><b>MOTION BY:</b> (Eilers) Reconsider Item 7 for Further Discussion. 8-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Davis)</p> <p><b>AYES:</b> Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8</p> <p><b>NOES:</b> 0</p> <p>Board Member Neubauer provided additional information on the plan to move forward with the staff position that will report to the Board. She referenced a meeting held with the County Comptroller and Chairman Lutzow. The County Comptroller's Office provides research support services to the Milwaukee County Board of Supervisors. The meeting was an effort to see if the County would provide those same services to the Mental Health Board.</p> <p>At the meeting, the Comptroller referenced a change in legislation, which placed the Research Division of the County under his Office's organizational unit. The legislation is written in a way that statutorily prohibits his office from providing the same services to the Mental Health Board. Board Member Neubauer indicated efforts are now focused on hiring independently of the County. Human Resources provided the County's Research Analyst Job Evaluation Questionnaire for the Board to use as a guide when drafting the job description for the position.</p> <p>Board Member Neubauer and Chairman Lutzow, with input from Board Member Perez, are currently in the process of preparing the job position description.</p>
8.	<p><b>Review of Milwaukee County Mental Health Complex Land Sale.</b></p> <p>Aaron Hertzberg, Director, Division of Economic and Community Development, Department of Administrative Services Michael Lappen, Administrator, Behavioral Health Division</p>

**SCHEDULED ITEMS (CONTINUED):**

Mr. Hertzberg stated the County is looking to move the sale of the facility forward within the next couple of months. The timeline is purely coincidental and not specifically related to the forthcoming transition in County Administration. This project has, in fact, been in process for many years. Milwaukee County recently completed an option agreement for sale of the Mental Health Complex land.

Mr. Hertzberg provided a brief history of how the grounds were used for numerous purposes. Over time, the County's presence on the Medical Region Campus has diminished. A lot of the area owned by the County has been sold for private development.

The section of land and topic of this item is the southeast quadrant, which is the land the Behavioral Health Division (BHD) occupies. About a year-and-a-half ago, Milwaukee County signed an option agreement with Milwaukee Regional Medical Center (MRMC) partners, which gives them the right to acquire the land their facilities occupy but still owned by Milwaukee County. The option agreement terms state the buyer/purchaser has the option to evaluate the land, do environmental testing, work out any side agreements among the partners, and takes responsibility of subdividing the property to create individual parcels for their facilities.

The buyer recently did what is called exercising their option to move forward and acquire the land. The County is now working on a sixty-day process to close. This triggers a timeline to complete due diligence, finalize the subdivision of land, and close the sale. There are several reasons why the partners have an interest in acquiring all the land at the same time. Mr. Hertzberg discussed those reasons in detail. BHD is using less square footage, and the carrying costs associated with the entirety of the space remain very high. It was about figuring out how to get out from under the undue burden associated.

The State Legislature, when creating the Mental Health Board, referenced the Mental Health Complex. It states Milwaukee County may not sell the Mental Health Complex without approval from the Mental Health Board. This Body has authority over the sale of the land. Reasons to sell include getting out of the underutilized, extremely costly, and inefficient building; following direction of Mental Health Board efforts already in place to transition to more community-based models; changing the inpatient model by implementing the Universal Health Services agreement; and the incorporation of access clinics. Vacating the space is included in those initiatives as well.

Mr. Lappen described the challenges of operating the facility and its overhead.

Mr. Hertzberg explained upon closing, the partners would immediately take control of the 9201 Building, which is vacant, and the Children's and Adolescent Treatment Center (CATC) Building. Demolition then becomes their responsibility. The County is anxious to get out from under the liability associated with those two spaces. At closing, the partners would also acquire the 9455 Building. The County will lease the facility for \$1. The lease states the County would retain responsibility for maintenance and operation of the building. It also comes with the right to occupy the facility for as long as it's needed. There are small incentives to vacate within ten years, which from a real estate perspective is a good thing. Of course, the timeline in place to vacate falls well before the ten-year incentives expire.

**SCHEDULED ITEMS (CONTINUED):**

Additional goals and the timeline for the campus set forth by the County were identified. If approved, it is anticipated the closing of the land would be complete in the first quarter. The buyers of the Mental Health Complex land are the Medical College of Wisconsin, Froedtert Hospital, and Children's Hospital. The sale was discussed from a cost benefit standpoint including market and land values versus demolition costs. The way the transaction is set up in terms of the actual sale value state the County retains the land value while eliminating the costs of demolition, in addition to other credits. By County Ordinance, when conducting a real estate transaction, a portion of the proceeds stay with Economic Development to fund a portion of the department's operations. The balance of funds falls under the discretion of the Milwaukee County Board of Supervisors.

The Board was informed the Executive Committee, at their meeting on February 3, 2020, unanimously agreed to recommend approval of the land sale for the Milwaukee County Mental Health Complex.

Questions and comments ensued.

**MOTION BY:** *(Perez) Move, as Required by Wisconsin State Statute 51.08, to APPROVE the Sale of the Milwaukee County Mental Health Complex as Submitted by the Milwaukee County Executive Pursuant to the Option Agreement Presented to the Milwaukee County Mental Health Board. 8-0*

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

**AYES:** Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8

**NOES:** 0

9. **Establishing a Governance Committee.**

Chairman Lutzow explained as previously stated, this item was discussed at the Executive Committee meeting. Originally, the idea of forming the Governance Ad Hoc Committee was to assist with identifying potential members within the community and providing recommendations to the appointing authorities, onboarding and orientation of new members, and addressing the recommendations included in the report provided by Brett Remington, the consultant, in terms of the Board's function and structure, i.e. review of bylaws, member expectations, etc. As the conversation continued and with additional information from the Critical Management Solutions report, the scope has become bigger. It has evolved into the Board functioning at its maximum authority.

After the robust conversation related to the structure of the Board's public hearings, it all speaks to a scope of work needing definition. A decision is also warranted as to whether a committee on community engagement is needed. Chairman Lutzow stated his recommendation would be establish two ad hoc committees with Board Member Eilers as Chairperson of Governance and Board Member Wesley as Chairperson of Community Engagement. The Chairpersons of the Board's Subcommittees would make up the membership of the Governance Committee.

**SCHEDULED ITEMS (CONTINUED):**

	<p>Board Member Eilers stated the important areas of focus where the Board could be more effective include structure, scope of work, authority/powers exercised, and responsiveness to public comment. Now more than ever, it is important to determine a way to communicate the value and effectiveness the Board brings to the service delivery system. She expressed her support for ad hoc committees.</p> <p>Questions and comments ensued.</p> <p>The Board came to a consensus on the need for two ad hoc committees to address the scope discussed.</p> <p>Chairman Lutzow directed the creation of two ad hoc committees, Governance and Community Engagement, to be chaired by Board Members Eilers and Wesley, respectively. Members of the Governance Ad Hoc Committee will be Board Members Perez, Shrouf, Neubauer, and Lanier. Members of the Community Engagement Ad Hoc Committee will be Board Members Forman, Neubauer, and Lanier. Chairman Lutzow will be ex officio to both.</p> <p>Chairman Lutzow also directed both committees to have their first meeting in March where the first order of business will be to create a charter.</p>
10.	<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 a Systems Improvement Agreement update and discussed the Request for Proposals appeals recently submitted.</p> <p>For the Board's information, Mr. Lappen referenced the Kane Communications Update (<b>Attachment A</b>) attached to the report.</p>
11.	<p><b>Corporation Counsel Legal Opinion on Milwaukee County's Statutorily Mandated Obligation to Provide Crisis Services.</b></p> <p>Anne Kearney, Deputy, Corporation Counsel</p> <p>Attorney Kearney indicated the Office of Corporation Counsel (OCC) understands the Mental Health Board, County departments, and the private health systems have been working collaboratively on creating a new model for providing crisis mental health services permissible under the state law. The OCC intends to hire outside counsel to advise the Board and County departments on the Emergency Medical Treatment and Labor Act (EMTALA), the model itself, as well as any other issues arising from this effort.</p> <p>Chairman Lutzow stated the timeline to create the model is tight. If the mark is missed, it will cost a significant amount of money. There is a sense of urgency to move this forward.</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p>Chairman Lutzow requested the work be completed no later than July. Attorney Kearney stated the OCC will make July the goal.</p>
12.	<p><b>The Behavioral Health Division's Funding Allocations and Program Efficiencies Report for Mental Health Programs in Compliance with Chapter 51 of Wisconsin Statutes.</b></p> <p>Michael Lappen, Administrator, Behavioral Health Division</p> <p>Mr. Lappen explained the Funding Allocations and Program Efficiencies for Mental Health Programs report, in compliance with Chapter 51 of Wisconsin Statutes, is a statutory obligation and required on an annual basis. It includes a description of the funding allocations for mental health functions; services; and programs; as well as describes improvements and efficiencies in these areas; and is an overall summary of 2019 activities.</p> <p>He drew the Board's attention to the 2019 SMART Goals put in place in 2010. Over a ten-year period, there has been a dramatic increase in peer specialists and the number of individuals being provided recovery oriented supportive housing; and the average in-patient census, acute adult admissions, and emergency detentions have all gone down. This reflects the successes of alternatives such as the Crisis Assessment and Response Team (CART) and Crisis Resource Centers. Crisis Redesign goals are an extension of those successes.</p> <p>The report will be forwarded to the County Board, the County Executive, and the State Department of Health and Human Services.</p> <p>Questions and comments ensued.</p>
13.	<p><b>Mental Health Board Finance Committee Professional Services Contracts Recommendation.</b></p> <p>Jennifer Bergersen, Chief of Operations, Behavioral Health Division</p> <ul style="list-style-type: none"><li>• 2019 Contract Amendment(s)<ul style="list-style-type: none"><li>➤ Column Rehab</li><li>➤ MobileX USA</li><li>➤ Pharmacy Systems, Inc.</li><li>➤ Verge Solutions, LLC</li><li>➤ Wisconsin Diagnostic Laboratories, Inc.</li><li>➤ Evaluation Research Services, LLC</li><li>➤ The Medical College of Wisconsin</li><li>➤ UW Milwaukee</li></ul></li><li>• 2020 Contracts<ul style="list-style-type: none"><li>➤ The Greeley Company</li><li>➤ Vistelar, LLC</li></ul></li></ul>

**SCHEDULED ITEMS (CONTINUED):**

	<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. An overview was presented on all services provided.</p> <p>The Finance Committee, at its meeting on December 5, 2019, approved a contract for Barrins Consulting and Associates to provide full-time compliance consulting services for ongoing monitoring related to the Systems Improvement Agreement. Due to unforeseen staffing issues, Barrins declined the contract. Greeley Company, LLC, who was second in the competitive bid process and Centers for Medicare and Medicaid Services (CMS) approved, was subsequently awarded the contract.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2020 Professional Services Contracts except for Board Member Lehrmann, who abstained from recommending the 2020 Medical College of Wisconsin contract for approval.</p> <p><b>MOTION BY:</b> (Perez) Approve the 2019 Professional Services Contract Amendments and 2020 Contracts Delineated in the Corresponding Report. 7-0</p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Davis)</p> <p><b>AYES:</b> Davis, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 7</p> <p><b>NOES:</b> 0</p> <p><b>EXCUSED:</b> Eilers – 1</p>
14.	<p><b>Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.</b></p> <p>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services (CARS), Behavioral Health Division (BHD) Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</p> <ul style="list-style-type: none"><li>• 2020 Contract Amendment</li><li>• 2020 Contracts</li></ul> <p>Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the various adult and children program contracts and amendments.</p> <p>As reflected, 2019 contracts for Community Access Points are extended until June 30, 2020, as the BHD continues to work on the previously posted Request for Proposals (RFP) appeals. Once the appeal process is complete, determinations will be made related to awarding 2020 contracts for these services.</p> <p>Board Member Wesley requested separate action be taken on Wisconsin Community Services, Inc., contracts.</p>

**SCHEDULED ITEMS (CONTINUED):**

	<p><b>MOTION BY:</b> <i>(Neubauer) Approve the TWO Wisconsin Community Services, Inc., Contracts Delineated in the Corresponding Report. 6-0-1</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> <i>(Davis)</i></p> <p><b>AYES:</b> Davis, Forman, Lanier, Lutzow, Neubauer, and Perez - 6</p> <p><b>NOES:</b> 0</p> <p><b>ABSTENTIONS:</b> Wesley - 1</p> <p><b>EXCUSED:</b> Eilers - 1</p> <p><b>MOTION BY:</b> <i>(Perez) Approve the Balance of 2019 Purchase-of-Service Contract Amendments and 2020 Contracts Delineated in the Corresponding Report Pending a CORRECTION to Reflect the Our Space, Inc., Contract as a THREE-Year Award. 8-0</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> <i>(Davis)</i></p> <p><b>AYES:</b> Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8</p> <p><b>NOES:</b> 0</p> <p><b>ABSTENTIONS:</b> 0</p> <p><b>EXCUSED:</b> 0</p>
15.	<p><b>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</b></p> <p>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services (CARS), Behavioral Health Division (BHD)          Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</p> <p>Fee-for-Service Agreements for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. An overview was provided detailing the program agreements, which provide a broad range of support services to adults and children with serious emotional disturbances.</p> <p>The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2019 Fee-for-Service Agreement Amendments and 2020 Agreements delineated in the corresponding report.</p> <p><b>MOTION BY:</b> <i>(Perez) Approve the 2019 Fee-for-Service Agreement Amendments and 2020 Agreements Delineated in the Corresponding Report. 8-0</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> <i>(Neubauer)</i></p> <p><b>AYES:</b> Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8</p> <p><b>NOES:</b> 0</p>
16.	<p><b>State of Wisconsin Contracts for Social Services and Community Programs Recommendation.</b></p> <p>Matt Fortman, Fiscal Administrator, Department of Health and Human Services</p> <ul style="list-style-type: none"> <li>• 2020 Contract Amendments</li> </ul>

**SCHEDULED ITEMS (CONTINUED):**

State Contracts for Social Services and Community Programs, also referred to as Community Aids, provide State and Federal funding for County services to persons with mental illness, disabilities, and substance abuse problems, and to juvenile delinquents and their families as mandated by State and/or Federal law.

State grant funding was contained within the previously approved 2020 Budget for the allocations reflected in the report except for the Urban Youth Prevention and Specialty Care First Episode Psychosis grants. The Behavioral Health Division is also in the process of requesting funds through a Strategic Opioid Response/State Targeted Response grant. If awarded the additional funds, an update will be brought back before this Body in April.

The Board was informed the Finance Committee unanimously recommended approval of the 2020 Social Services and Community Programs Contract Amendments delineated in the corresponding report to the Board.

**MOTION BY:** (Perez) *Approve the Social Services and Community Programs 2020 Contract Amendments Delineated in the Corresponding Report. 8-0*

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

**AYES:** Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8

**NOES:** 0

17. **Employment Agreements.**

Dr. John Schneider, Chief Medical Officer, Behavioral Health Division

The Department of Human Resources, Corporation Counsel, and the Compensation Division established a personnel policy allowing for employment agreements for specific classified, unclassified, and exempt physician, psychologist, and advanced practice nurse classifications within Milwaukee County.

The Behavioral Health Division is requesting authorization to establish employment agreements with the thirteen individuals identified in the corresponding report.

The Finance Committee unanimously agreed to recommend approval of the Employment Agreements to the Board.

**MOTION BY:** (Perez) *Approve the Employment Agreement. 8-0*

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

**AYES:** Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley - 8

**NOES:** 0

**SCHEDULED ITEMS (CONTINUED):**

***Pursuant to 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 they relate to the following matter(s):***

**18. Medical Executive Credentialing and Privileging Recommendations Report.**

Dr. Shane Moisio, Medical Staff President, Behavioral Health Division

**MOTION BY:** *(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 the information discussed may also be subject to confidentiality under Section 146.38, Stats. as it relates to Item 18. 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. 8-0*

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

**AYES:** Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8

**NOES:** 0

The Board convened into Closed Session at 11:29 a.m. to discuss Item 18 and reconvened back into Open Session at approximately 11:42 a.m. The roll was taken, and all Board Members were present.

**MOTION BY:** *(Neubauer) Approve the Medical Staff Credentialing Report and Medical Executive Committee Recommendations. 8-0*

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

**AYES:** Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8

**NOES:** 0

**19. Adjournment.**

**MOTION BY:** *(Neubauer) Adjourn. 8-0*

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

**AYES:** Davis, Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Wesley – 8

**NOES:** 0

**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: 9:04 a.m. to 11:56 a.m.

Adjourned,

*Jodi Mapp*

**Jodi Mapp**

Senior Executive Assistant  
Milwaukee County Mental Health Board

**The next meeting for the Milwaukee County Mental Health Board will be a Public Hearing  
on Thursday, March 19, 2020, @ 4:30 p.m. at a  
Location to be Determined**

**PUBLIC COMMENT WILL BE HEARD ON  
THE 2021 BUDGET**

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

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

The February 27, 2020, 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.

*Michael G. Davis*

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Michael Davis, Secretary  
Milwaukee County Mental Health Board

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

**DATE:** April 15, 2020

**TO:** Thomas Lutzow, Chairman – Milwaukee County Mental Health Board

**FROM:** Michael Lappen, Administrator, Behavioral Health Division

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

**Background**

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

**Discussion**

**Other Topics of Interest**

- **Journal Sentinel Article**

There was a JS Online story published Saturday, March 11, 2020, with a “front page” newspaper story citing some of the same information the following day. There were some inaccurate statements regarding the Behavioral Health Division (BHD) and allegations BHD was not prepared or did not move quickly enough to protect staff from COVID19. The actual timeline of the impact of COVID19 on BHD is as follows:

- The Governor declared the State of Emergency on Thursday March 12, 2020.
- On Saturday, March 14, 2020, at 1630, the Nurse-House Supervisor at BHD received a call from the Wauwatosa Health Department indicating a BHD employee who had recently returned from an out-of-state conference had been tested and was positive for Covid-19.
- At 1630, BHD Leadership was informed. Upon further review, it was determined that the employee had worked at BHD from March 9, 2020, to March 12, 2020, including on the Child and Adolescent Inpatient Services (CAIS) on March 11<sup>th</sup> and

March 12<sup>th</sup> as well as spending time in a personal office, a shared office suite, and an isolated location within the medical records department.

- Based on guidance from the Health Department, a decision was made to stop all new admissions to the CAIS. Communication was made by the Chief Medical Officer with our partner health systems for notification of the issue.
- At 1900, BHD initiated their incident command to further delineate next steps, including a plan to further evaluate current patients and those caring for them. A plan to move forward and reach out to our community partners to explore all discharge options for the youth on inpatient at the time was identified for March 15, 2020. A plan to ensure all protective equipment and supplies were in place was identified, including access to current pandemic storage materials on site as well as connection and assistance via Office of Emergency Management. A plan to obtain rosters of all those individuals with contact with the affected employee was identified, including discussion of all relevant staffing plans and needs. Access to the inpatient unit was limited to only those caring for individuals.
- At 2200, Health Department recommendations were discussed among the team as well as a timeline of where the employee had worked. A plan to safely assess each remaining child on the unit and to pursue discharge was targeted for Sunday, March 15, 2020. For those individuals who were able, the plan was to return to a safe home environment, with a recommended 14-day quarantine per Health Department guidance.
- At 2330, BHD leadership began the notification to current patients' parents/family supports as to inform them of the potential exposure. The task of identifying who was working in close contact with the affected employee as well as already discharged clients at the time of risk was generated and forwarded to the Health Department.
- On March 15, 2020, at 8:41 a.m., a notification of the event was provided to all BHD employees and shared that day with the Milwaukee County Mental Health Board. Additionally, contracted providers were notified and are continuing to be notified. All children in the hospital setting were assessed and those able to be discharged to safe settings were discharged with one individual patient yet remaining.

We were directed to perform a "Level Two" cleaning of the CAIS Unit, which took some time to arrange through our contracted cleaning service. Once the unit was cleaned and ready to open, there was a decision by the administrative team to keep that unit ready to be used as a quarantine unit for COVID19 positive adult cases, and to assist BHD in getting

to single occupancy on all units without dramatically reducing our capacity. This was based on thoughtful discussion around a shortage of staff related to 14 day quarantine, and that the community partner hospitals had managed inpatient need for youth with the assistance of Children's Mobile Crisis (CMC) for about 10 days by that point.

We have had one hospital patient test positive for COVID-19. They were admitted to 43A on March 23, 2020, and their positive test came back March 25, 2020. We were advised by the Health Department to assume they were positive at admission. When this individual showed symptoms, the individual was tested immediately, and 43A became our isolation unit as it would not have made sense to move the patient. All staff caring for this individual received guideline-compliant PPE. After several days of treatment, the patient was stabilized and discharged from BHD to finish self-quarantine at home. All staff and patients that had contact with this individual were quarantined according to Health Department guidelines, and several individuals remained in isolation on 43A based on concerns about their ability to safely complete the required 14 day quarantine at home. There have been several BHD patients displaying respiratory symptoms that have been tested through the Milwaukee Health Department Lab, but to date there have been no more positive cases.

There was a statement released on April 14, 2020, to the BHD Provider Network with a response to the JS Online story. Please see it attached as it shows what was shared regarding the interventions that have been put in place at BHD in response to COVID19.

BHD has had an adequate supply of PPE throughout the COVID19 Crisis and have made it available to staff and patients as dictated by the most current guidelines. Those guidelines have been changing almost continuously since March 14<sup>th</sup>. The interventions that were put in place were:

- Not allowing visitors
- Creating a central hospital entrance where all patients are screened before entering the Mental Health Complex
- Screening all in-patients daily for emergent symptoms
- Transitioning a unit into a COVID-19 isolation unit
- Transitioning to single-patient rooms to reduce exposure and increase social distancing
- Instituting social distancing measures on all in-patient units
- Screening all staff pre- and post-shift for emergent symptoms
- Allowing telework for non-essential staff
- Hosting daily leadership meetings and weekly all-staff meetings (Virtual Town Halls) to share COVID-19 updates

There have been a large number of inpatient, PCS, and crisis staff that have been quarantined over the past month due to travel, contact with COVID19 positive individuals, respiratory symptoms, etc. There have been challenges to staffing, especially for CAIS and

the crisis services. Many staff have stepped up and worked tirelessly and selflessly to make sure no person experiencing a mental health crisis went unserved. We have done everything possible to keep up with changing guidelines, manage day to day challenges, and keep all patients and staff safe. The team performed with calm and professionalism, and executed our emergency BHD response plan, which included plans for a pandemic response. Thoughtful planning, including a stockpile of PPE, has allowed BHD to maintain operations throughout the crisis with careful attention to staff and patient safety.

Milwaukee County has provided daily email updates to all staff including the latest developments regarding COVID19. BHD has also provided regular updates using our "BHD All" Distribution list, and has held weekly virtual Town Halls on Thursdays at 1:45 with as many as 105 participants. There is a link to pose questions anonymously, as well as an active "Live Chat" with very robust participation.

All Mental Health Board Members are welcome to attend, and should be receiving the invitations through their County email accounts along with all other "BHD All" updates.



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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:** March 9, 2020

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

**FROM:** Michael Lappen, Administrator, Behavioral Health Division  
*Submitted by Jennifer Bergersen, Chief of Operations, Behavioral Health Division*

**SUBJECT: Report from the Behavioral Health Division Administrator, Requesting Authorization to Draw from the Behavioral Health Division Building Reserve Fund for Expenses Related to the Systems Improvement Agreement**

**Issue**

The condition of the physical plant and the overall hospital environment of care must be developed and maintained in such a manner that the safety and well-being of patients, staff and visitors are assured. The hospital must meet all applicable codes as to ensure life safety from fire, also including but not limited to, the assurance that facilities, supplies and equipment are maintained to meet an acceptable level of both safety and quality. State and Federal regulations require hospitals to now achieve a ligature resistant environment in all psychiatric units of acute care hospitals, including locked emergency departments. The presence of an unmitigated ligature risk in a psychiatric hospital is a significant health and safety violation and if left unmitigated, may jeopardize patient safety and continued participation and funding from the Centers for Medicare and Medicaid Program.

**Background**

Upon assessment and review, the hospital's current physical environment of care does not meet standards as required. The hospital is currently participating in a System Improvement Agreement to address all deficiencies with a targeted completion date September 2020. Immediate approval from the governing body is being requested to obtaining funding, to pursue contracted work, obtain permits for physical changes and or obtain products, supplies and labor to correct deficiencies and ensure timely completion of corrective actions.

BHD has a Building Reserve Fund, with a current balance of \$5.1 million.

46.18 (13) BUILDING RESERVE FUND. The Except in Milwaukee County, the county board shall maintain as a segregated cash reserve an annual charge of 2% of the original cost of new construction or purchase or of the appraised value of existing infirmary structures and equipment. In Milwaukee County, the Milwaukee County mental health board, for mental health infirmary structures and equipment, shall ensure the maintenance, as a segregated cash reserve, of an annual charge of 2 percent of the original cost of new construction or purchase or of the

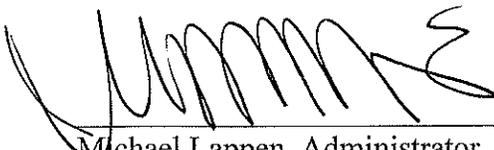
appraised value of existing mental health infirmary structures and equipment. If the infirmary or any of its equipment is replaced, any net cost of replacement in excess of the original cost is subject to an annual charge of 2%. No contributions to the cash reserve in excess of the amount required under this subsection may be included in the calculation under s. 49.726 (1). The county board, except the Milwaukee County board, may from time to time appropriate from such reserve sums to be expended solely for the enlargement, modernization or replacement of such infirmary and its equipment. In Milwaukee County, the Milwaukee County mental health board may require to be appropriated from reserve sums for mental health infirmaries to be expended for the enlargement, modernization, or replacement of a mental health infirmary and its equipment.

### **Recommendation**

BHD administration respectfully requests the Executive Committee of the Mental Health Board to approve an amount not to exceed \$3,000,000.00 to be drawn from the Building Reserve Fund, as it will not be possible to meet the deadlines imposed under the Systems Improvement Agreement if each required contract must be approved by the Mental Health Board in advance of the work beginning. BHD Administration will bring any contracts related to the SIA to the Finance Committee and full Board at the next scheduled meeting April 23, 2020, and will seek approval from the full Board at that time to extend this temporary measure.

### **Fiscal Summary**

Please see **Attachment A**.



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Michael Lappen, Administrator  
Behavioral Health Division

cc: Maria Perez, Chairperson  
Mental Health Board Finance Committee

## Attachment A

### 2020 BHD SIA - ESTIMATED CAPITAL COSTS as of March 2020

		Cost Estimate
<b>All Patient Units</b>		
<b>DOORS</b>		
Locks, hardware, hinges etc.	\$	150,475
<b>FLOORING</b>	\$	300,000
<b>LIGHTING</b>	\$	452,482
<b>CEILINGS (Tiles/Grid)</b>	\$	144,000
<b>TOILETS</b>	\$	746,400
<b>SHOWERS</b>		
Shower & Bathroom doors	\$	126,720
<b>FURNITURE</b>		
Beds	\$	163,200
Dining / Day Room		Unknown
Nurses Stations	\$	120,000
<b>"LIGATURE RESISTANT PROJECT - 5 UNITS"</b>		
Doors, Shower Doors, Hinges etc.	\$	154,800
<b>Children's Unit</b>		
<b>FURNITURE</b>		
Nurse Call	\$	75,000
Med Room	\$	30,000
<b>ANTI-LIGATURE (53B ONLY)</b>		
Sprinklers/Desks / Wardrobes	\$	24,870
<b>MISCELLANEOUS</b>		
High Security Carts	\$	7,420
Pick Proof Caulk		Unknown
Outlets		Unknown
Glass		Unknown
Corner Guards		Unknown
Hand Rails		Unknown
Cameras / Camera License	\$	6,000
Data Wiring		Unknown
Phone Wiring		Unknown
Courtyards / Screening		Unknown
Clock Domes	\$	1,862
<b>UNIDENTIFIED COSTS IN ABOVE DETAIL</b>	\$	500,000
<b>Total</b>	<b>\$</b>	<b>3,003,229</b>

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

**DATE:** April 16, 2020

**TO:** Thomas 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 2019 Professional Services Contract Amendments and 2020 Contracts for Consulting, Communications, Staffing and Software Applications 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 2020.

**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**

**Adult Service Contracts**

**University of Wisconsin Milwaukee (UWM) - \$146,600**

UWM provides program evaluation of the State of Wisconsin Temporary Assistance for Needy Families (TANF) Alcohol and Other Drug Abuse (AODA) grant. The grant will focus on the process (what was done and how it was accomplished), and the outcomes (i.e. results) of the Milwaukee County TANF/AODA system of care. BHD is requesting \$146,000 for 2020. The one-year contract amount will be \$146,000.

### Hospital/Operations Contracts

#### **Kane Communications Group - \$350,000**

BHD Communications Services was opened for Competitive proposals on October 21, 2019, via the Request for Proposal (RFP) process. The purpose of the communication services described in the RFP was to ensure that BHD employees, community partners and stakeholders are provided input, consistent communication, messaging, and information about BHD's strategic initiatives and activities to transition BHD through 2022. Based on the results of the solicitation Kane Communications is being awarded the contract. The one-year contract amount will be \$350,000.

#### **LocumTenens.com LLC - \$421,500**

The Behavioral Health Division is seeking an amendment to the current Agreement with LocumTenens.com LLC. This firm is utilized to fulfill required psychiatrist staffing for the Behavioral Health Division inpatient services on a temporary basis. Services include sourcing, screening, presenting and facilitating psychiatrist candidate assignments for essential vacation, leaves of absence and/or vacancy coverage. Due to the recent resignation of one full-time inpatient psychiatrist, additional funding is required while we make attempts to recruit for a replacement. This shall be the ninth amendment, since the agreement was initially executed on 11/16/2015. The need to utilize temporary staffing decreased between 2017 and 2019 as a result of permanent hires. However, the need to utilize temporary psychiatrist staffing will continue until the UHS transition occurs. We are seeking to amend the existing agreement by an additional \$421,500 for 2020. The five-year contract amount will increase to \$3,948,250.

#### **Netsmart Technologies, Inc. - \$9,800**

BHD is requesting \$9,800 for Netsmart to move Program Participation System (PPS) data collection from Episodic to Non-Episodic in our Electronic Health Record (EHR) system. This change will create efficiency and reduce burden for the Behavioral Health Division (BHD), community partners, and clients through reductions in PPS volume. By reducing the volume the goal is to have higher quality data. This change has been reviewed and approved by BHD's executive team and Change Request Management group. BHD is requesting the \$9,800 for 2020. The three-year contract amount will increase to \$3,785,158.

### Youth Services Contracts

#### **Kane Communications Group - \$15,000.00**

Kane Communications Group provides community outreach, advertising and public information communications to assist Wraparound Milwaukee to increase the number of individuals served through the Coordinated Opportunities for Recovery and Empowerment (CORE) program. Kane Communications Group will assist in the creation and video a series of FEP training videos that cover various FEP topics to be added to the Technical Assistance Website. BHD is requesting \$15,000.00 for 2020. The one-year contract will be \$144,000.00

### Fiscal Summary

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

Vendor Name	Existing Amount/New	2019 Amount Requested	2020 Amount Requested	2021 Amount Requested	2022 Amount Requested	2023 Amount Requested	Total Contract Amount
University of Wisconsin Milwaukee*	New	N/A	\$146,600	N/A	N/A	n/a	\$146,600
Kane Communications Group	New	\$0	\$350,000	\$0	\$0	\$0	\$350,000
LocumTenens.com, Inc.	\$3,526,750	\$0	\$421,500	\$0	\$0	\$0	\$3,948,250
Netsmart Technologies, Inc.	\$3,775,358	\$0	\$9,800	\$0	\$0	\$0	\$3,785,158
Kane Communications Group*	\$129,000	\$0	\$15,000	\$0	\$0	\$0	\$144,000
<b>TOTAL</b>	<b>\$7,431,108</b>	<b>\$0</b>	<b>\$942,900</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$8,374,008</b>

\*Denotes a Vendor whose funding is supported by a grant.

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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:** April 16, 2020

**TO:** Thomas 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 2020 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 2020

**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**

**Adult Service Contracts**

**Impact, Inc. - \$60,000**

The Vendor provides the IMPACT 211 service, which is the free, confidential helpline and online resource directory to make it easy for residents to get connected to information and assistance. As a result of the COVID-19 Public Health Crisis the vendor has seen a significant increase in the need for assistance. BHD is requesting an additional \$50,000 for 2020. The one-year contract will be increased to \$375,000.

**Milwaukee Center for Independence, Inc. - \$250,000**

The Vendor provides Crisis Resource Centers that serve adults with mental health needs who are in need of crisis intervention and/or short-term crisis stabilization versus hospitalization. BHD is

requesting an additional \$250,000 for 2020 start-up funds for a third location. The one-year contract will be increased to \$2,570,000.

**Wisconsin Community Services - \$50,000**

Wisconsin Community Services will run the Outpatient Plus program for BHD, which is a new program to the CARS network. Outpatient Plus services are designed to meet the substance abuse treatment needs to uninsured and underinsured Milwaukee County residents; combining safe, sober, temporary housing with a clinical level of care, Outpatient Plus allows for a gradual reduction in treatment intensity, degree of structure and support, and allows for increasing independence and responsibility based on the consumers' treatment progress. This contract covers the start-up costs for the program. BHD is requesting \$50,000 for 2020. The three-year contract amount will be increased to \$250,000.

**Youth Services Contracts**

**Christine Shafer DBA SEA Group - \$22,500**

The Vendor provides educational advocacy services to help enrolled youth obtain an Individual Education Plan (IEP), achieve appropriate school placements, and reduce unnecessary residential and day treatment for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting \$22,500 for 2020. The one-year contract amount will be increased to \$547,500.

**Moving Families Forward, Inc. - \$50,000**

The Vendor provides Family Engagement and Advocacy services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$50,000 for 2020. The one-year contract amount will be increased to \$140,000.

**Fiscal Summary**

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

Vendor Name	Existing Amount/New	2019 Amount Requested	2020 Amount Requested	2021 Amount Requested	2022 Amount Requested	2023 Amount Requested	Total Contract Amount
Christine Shafer DBA SEA Group*	\$525,000	\$0	\$22,500	\$0	\$0	\$0	\$547,500
Impact, Inc.*	\$315,000	\$0	\$60,000	\$0	\$0	\$0	\$375,000
Milwaukee Center for Independence, Inc.	\$2,320,000	\$0	\$250,000	\$0	\$0	\$0	\$2,570,000
Moving Families Forward, Inc.*	\$90,000	\$0	\$50,000	\$0	\$0	\$0	\$140,000
Wisconsin Community Services, Inc.	\$200,000	\$0	\$50,000	\$0	\$0	\$0	\$250,000
	<b>\$3,450,000</b>	<b>\$0</b>	<b>\$422,500</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$3,882,500</b>

\*Denotes a Vendor whose funding is supported by a grant.

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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:** April 16, 2020

**TO:** Thomas 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 2020 Fee-for-Service Agreement 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 2020.

## 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

### Adult Service Contracts

#### **Goodwill Industries of Southeastern Wisconsin - \$135,000**

The Vendor provides Individual Education Plan (IEP) services to assist CARS Consumers. BHD is requesting an additional \$135,000 for 2020. The two-year contract amount will be increased to \$579,000.

#### **Wisconsin Community Services, Inc. - \$400,000**

The Vendor runs the Outpatient Plus program for BHD, which is a new program to the CARS network. Outpatient Plus services are designed to meet the substance abuse treatment needs to uninsured and underinsured Milwaukee County residents; combining safe, sober, temporary

housing with a clinical level of care, Outpatient Plus allows for a gradual reduction in treatment intensity, degree of structure and support, and allows for increasing independence and responsibility based on the consumers' treatment progress. BHD is requesting an additional \$400,000 for 2020. The two-year contract amount will be increased to \$5,809,000.

### Youth Services Contracts

#### **Educates, LLC - \$70,000**

This Vendor provides specialized academic support services for Wraparound Milwaukee Program serving children/youth and their families. BHD is requesting an additional \$70,000 for the 2020 contract. The two-year contract amount will be increased to \$291,000.

### Fiscal Summary

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

Vendor Name	Existing Amount/New	2020 Amount Requested	Total 2020 Contract Amount
Goodwill Industries of Southeastern Wisconsin	\$444,000	\$135,000	\$579,000
Wisconsin Community Services, Inc.*	\$5,409,000	\$400,000	\$5,809,000
Educates, LLC	\$221,000	\$70,000	\$291,000
	<b>\$6,074,000</b>	<b>\$605,000</b>	<b>\$6,679,000</b>

\*Denotes a Vendors whose funding is supported by a grant

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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:** February 13, 2020

**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 2019 Annual Review of the Environment of Care Program, and the 2020 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 2019 Annual Report of the Environment of Care program and the 2020 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.



**2019  
Environment of Care  
Annual Report  
&  
2020 Goals**

## **Introduction**

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached is the 2019 Annual Review of the Environment of Care Program and the 2020 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2019 major improvements were made in the area of building safety and security through parking lot resurfacing and increased lot lighting and replacement of deteriorating doors and frames. Implementation of a separate property room to assure patient belongings remain secure throughout the length of stay.

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 2019 Annual Report and 2020 Goals**

The BHD Environment of Care Management Plans were all reviewed and updated for 2020. Changes made to management plan content were minimal. Dates and goals were modified where appropriate.

## **Highlights of achievements and 2020 Goals:**

### **GENERAL SAFETY**

General safety improvements included parking lot resurfacing and increased lot lighting. Increased reconciliation of panic alarm system for low battery and missing devices. An off unit property room was created and implemented to safe-guard patient belongings and limit on unit access unsupervised access.

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2019 the response rate of 99% was attained. There were a total of 1315 urgent recalls/alerts issued during 2019. Only 1 alert/recall was purchased by BHD and had to be removed from the supply chain. All product alerts/recalls were resolved with no negative impact on patient care. When benchmarked against similar facilities, and region, BHD had a much lower average number of days to close alerts and a much lower percentage with delays.
  - The goal of responding within the 3 day timeframe 95% of the time was achieved. Recommend continuing this goal in 2019.
2. Rounds documentation is still in development.
  - The goal was not met in 2019. Although 64% of the 264 reported items have been corrected, only 30% were addressed within the 30 day timeframe. Recommend continuing with this goal in 2020. The rounding system has been adjusted to provide more accurate tracking of deficiencies and correction timeframes. A partial set of rounds was completed in late 2019. In 2020 the checklists will be reviewed/revised to include criteria from additional disciplines and use may be expanded in 2020.
3. In 2019 the total number of reported fire setting contraband items that were detected on patient units was 5 This does not meet the goal of having less than 4 fire setting contraband items on patient units.
  - In 2020 the goal will be to maintain the level of having less than 4 incidents.
4. Other activities included completion of an Environmental Suicide Risk Assessment using a tool from the Veterans Administration. Items are being prioritized and mitigation options are being developed and implemented in 2020. The assessment will be repeated when a new version of the tool is published.

### **SECURITY**

Security improvements made at BHD include: Enhancement of the camera system and a system to monitor the camera server for breakdowns.

1. Unsecured areas found during tours either due to human factors or mechanical failures. The goal of having 10 or fewer incidents in 2019. Was not met. The main issue is staff propping emergency doors open, or leaving them open. A specific number of incidences where doors were unsecured was not determined. Public Safety will continue to check all exits and ensure that such incidences are found and rectified. This goal will not be carried forward into 2020.
2. The goal for 2019 was to limit the number of incidences of theft/vandalism to less than or equal to 3.
  - There were 11 incidents of vandalism where features of the building were damaged. (Furniture, television, unit telephone, signature pad, and windows). The new patient property room was put into full operation during 2019 and the incidents of missing property claims have decreased. This goal will be removed for 2020. These types of events will continue to be tracked through the Quality Management Incident Report Summary.

3. Unauthorized absences from locked units: the goal for 2019 was to keep the number of absences to zero.
  - This Goal was not met. There were a total of 13 elopements during the year. In 12 cases the individual was returned to BHD. One person eloped during transport to a residential care site and was then discharged AMA. This goal will also be carried into 2020.
  
5. Quarterly Mock Lockdown procedures: The goal for 2019 was to have Public Safety/Security Staff perform a silent mock lockdown of the facility every quarter to ensure that all department staff is prepared to perform their given duties during such an occurrence. Public Safety/Security will work alongside Maintenance and EES to ensure that these exercises are performed without disrupting the daily operations that take place on site.
  - In 2019 2 Mock Lockdown drills were conducted. This goal will be carried into 2020 with a more specific description.

**2020 Goals:**

1. Meet minimum Public Safety and Security staffing each shift. (Baseline)
2. Decrease the number of incidents of non-fire setting contraband that reaches the patient care units. Goal ≤ 8 times
3. Decrease the number of incidents of unauthorized Absence from locked unit. (Goal □ 0)
4. Conduct a mock lock down exercise per shift per quarter (3 total) for Security and Maintenance staff (Goal □ 3 per quarter for a total of 12 per year)

**HAZARDOUS MATERIALS AND WASTE**

In 2019, BHD continued to expand its recycling program to more areas. Changes were made to reduce the amount of Styrofoam products used. Staff were provided with a reusable closed drinking bottle to help reduce the use of disposables. Additionally, more hard goods, such as furniture are being recycled. Pharmacy and Nursing are also working on the new National Institute for Occupational Safety and Health (NIOSH) requirements regarding hazardous medication.

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 lbs per month. Since that time, BHD, with increased surveillance and education, and environmental controls 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
2018	490.35	40.86
2019	286.9	23.9
□2015 December weights estimate		
□2016 Jan, Feb and Dec weights estimated		

An infectious waste report for 2019 will be filed with the WDNR when the report is opened for completion.

BHD's 2019 goal was 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. BHD exceeded the 50% limit in both January and February, triggering the reporting requirement. However, all subsequent month totals were below the 50% reporting limit. As such, our 2020 goal is to maintain this trend, keeping levels below the 50% reporting limit.

## EMERGENCY MANAGEMENT

1. Four additional management staff were trained in ICS 100 and 200 during 2019. The goal of 25% of management staff being trained in ICS 100 and 200 was revised to have 25% increase in managers trained in the ICS systems. The Administrators on Call (AOC) have been identified for this training and there are currently 10 of 11 AOC staff trained. There are additional staff throughout the facility who are also trained and/or experienced with the Incident Command System.
  
2. Hold or Participate in 2 exercises per year. 2 Drills/Exercises are required annually. Drills completed in 2019 include:
  - Tornado Drill in April in conjunction with Statewide event
  - May table top exercise with Wauwatosa and West Allis Health Departments including various community healthcare partners and emergency services was held regarding a Public Health Outbreak and the use of Closed points of distribution to deliver needed medication to staff and families.
  - Campus wide table top exercise in August provided insight into BHD and campus capabilities for a violent event. The exercise focused on potential issues related to the Democratic National Convention being held in Milwaukee in 2020.
  - October – Full Scale Exercise on MRMC Campus simulating a shooter on campus. This will test the campus wide Emergency Coordination Plan. Multiple organizations are involved in the planning and implementation of the drill, including:
 

<ul style="list-style-type: none"> <li>Blood Center of Wisconsin</li> <li>Curative Care Network</li> <li>Medical College of Wisconsin</li> <li>911 Communications Division</li> <li>Milwaukee Police Department,</li> <li>Wauwatosa Fire Department,</li> <li>Wisconsin Lutheran College</li> </ul>	<ul style="list-style-type: none"> <li>Children's Hospital of Wisconsin</li> <li>Froedtert Hospital</li> <li>Milwaukee County Behavioral Health Division</li> <li>Milwaukee County Office of Emergency Management</li> <li>Milwaukee Regional Medical Center,</li> <li>Wauwatosa Police Department,</li> </ul>
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  - BHD will be testing internal and external communication systems including the Everbridge system, the establishment of an Incident Command Center, Joint Information Center, and security response/lockdown processes.
  - December Regional Table top Exercise regarding the Public Health Outbreak plan mentioned earlier but takes the plan a step further regarding providing vaccination vs medication.
  
3. Other Emergency Management activities
  - Fire Alarm and other emergency announcement have been revised and recorded. The changes incorporate clear text requirements and communicate the expectation to evacuate in the event of a fire. The revised messages will be shorter than the existing announcements.
  - Work continues on the Emergency Operations Plan components
  - Hazard Vulnerability Assessment was completed by the committee in July and will be used to prioritize the revision of the emergency response plans.
  - Office of Emergency Management template for a one page Emergency Action Plan was revised for use at BHD. This may be blended with the existing BHD Emergency response guide flip chart.
  - The Closed Point of Dispensing Plan was completed and signed by both Wauwatosa Health Department and BHD.

**2020 Goals:**

- 1. Train one additional staff in ICS 100 and 200 to be Duty and Liaison officers.
- 2. Update emergency plans that would most likely be needed during an emergency related to the Democratic National Convention. Multiple campus and regional workgroups have been created to unify the healthcare networks response
- 3. Hold or participate in two emergency exercises per year (Goal 2)

**FIRE PREVENTION**

In 2019 BHD continued to make 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. Due to loss of maintenance staff some goals were not attained.

- 1. The goal of 100% of scheduled fire drills (60) being performed was not achieved. Drills were only conducted on first shift.
- 2. The goal of having the average score of on the fire drill check sheets being 90% or greater was achieved.
- 3. The goal of having zero fire panel / trouble alarms was achieved.

All of these goals will be carried forward into 2020. The goal number of fire drills was increased from 60 to 120 and the following additional goal was added:

- 4. The goal of training staff and implementing the new fire panel announcements.

**UTILITIES MANAGEMENT**

- 1. The goal of having 100% of scheduled P.M.'s being performed was not achieved.
- 2. The goal of having 100% utility branch valves labeled and inventoried was not achieved
- 3. The goal of having zero emergency generator failures was achieved.

Goals 1 and 2 will continue through 2020 with the addition of the following:

- 4. Develop a new manual on Major Utility failures.

**MEDICAL EQUIPMENT**

No new clinical equipment was purchased in 2019. 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 is updated as clinical equipment is removed from service.

Rubbermaid Workstations on Wheels (WOWs), equipped with laptops and used by clinical staff to update records, generally require the most upkeep at BHD. Determined by the EC Committee to be clinical (medical) equipment, downtime is monitored both by the Environmental and Engineering Service (EES) and Information Technology (IT) departments at MCBHD. These WOWs are not, however, equipped with any vitals monitoring or other life safety components.

Most often, WOWs are removed from service due to failing batteries. Issues are generally addressed within 24 hours unless additional (non-stocked) parts are required.

BHD did not remove any additional equipment from service in 2019, but maintained its current inventory.

**EDUCATIONAL GOALS**

In 2019 the following trainings were completed:

- First Responder Philosophy-based on istelar and American Heart Association standards for responding to Behavioral Emergencies-met 100 individuals achieved a score of 100.
- Medication Administration/Safety-for BHD hospital nurses to ensure safe handling and preparation for administration of medications-met
- Use of Personal Protective Equipment at BHD- met 100 individuals completed the training
- Parking Lot/Personal Safety-to incorporate personal safety/awareness of environment topics, ID badges-partially met
- Panic Alarm Use/Response-Reinforce need to use/wear panic alarm; who should be responding to alarms; review of the policy-not met; awaiting revision of policy
- Inpatient Elopement-Review of the policy; techniques to avoid elopements from occurring-not met
- Hazardous Medication Handling-Training for hospital based nurses regarding commonly used psychiatric medications requiring special handling-on hold until final version of regulation, USP 800, is published
- Fire Safety-Depth of hands on training to be determined-not met
  
- Additional county wide mandatory trainings were also completed by 90.34% of staff. Those trainings included:
  - OSHA Safety including Emergency Preparedness, Blood borne Pathogens, Global Hazard Communication, Personal Protective Equipment, Safe Lifting, and Safety Essentials for the Workplace)
  - Milwaukee County Ethics Overview
  - IS- 906 Workplace Security
  - ALICE (Alert, Lockdown, Inform, Counter, Evacuate)
  - Introduction to Racial Equity for County Employees
  - Administrative Directive  Passphrases and passphrase creation.

**EDUCATIONAL CALENDAR 2020**

<input type="checkbox"/> uarter 1	<input type="checkbox"/> uarter 2	<input type="checkbox"/> uarter 3	<input type="checkbox"/> uarter 4
Elopement <input type="checkbox"/>	Fire Safety	Medication Administration/Safety	Elopement <input type="checkbox"/>
Panic Alarm	Hazardous Medication Handling (hospital nursing only)	Infection Prevention	Personal Safety <input type="checkbox"/>
Personal Safety <input type="checkbox"/>	Ligature Risks (associated with the SIA)		

To be done every 6 months

istelar sustainability modules every two months adjusted to job roles-i.e., community staff won't do things which are pertinent only to hospital staff.

Additional mandatory trainings including OSHA training as deployed by Milwaukee County through the LMS system throughout the year.

**The Environment of Care Committee recommends the following key goals for 2020:**

- **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.**
- **To increase awareness of ligature risks in the environment and mitigate the risks previously identified.**



Current Status: Pending

PolicyStat ID: 7647752



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**Effective:** Upon Approval  
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**Next Review:** 3 years after approval  
**Owner:** Lynn Gram:  
 Exdir2-Asstthospadm2-Mhc  
**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:

- 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, 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 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)**

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.

The EC Program was established and maintained to create a safe environment for the provision of quality patient care. To accomplish this task, the EC Committee will meet 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.

### **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 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:
    - 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 Managers for follow-up.

## EC COMMITTEE FUNCTIONS

1. Meets monthly, or more frequently at the call of the chairperson;
2. Reviews/addresses issues pertaining to each of the EC Management categories at regular predetermined intervals (see individual management section for frequencies);
3. At least annually, report committee activities, pertinent committee findings and recommendations to ET, MEC and 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 1,3,4,5 & 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 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)**

- 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 02.02.07; 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 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 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 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)**

- 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 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).
- 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 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 two other committees, each share information regarding activities. Pertinent information 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.

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

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.

## 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.

## 5. Intervention Authority

The Safety Officer and/or the individual serving as the 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 EP1 & 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)** Safety Education is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees.
3. **Department Specific Training: (EC 03.01.01 EP1&2; HR 01.04.01 EP 1&3)** Directors/ Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards.
4. **Contract Employees: (EC 03.01.01 EP1&2; HR 01.04.01 EP 1&3)** 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

~~Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)~~

~~Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)~~

1. Meet minimum Public Safety and Security staffing each shift (Baseline).
2. Decrease the number of incidents of non-fire setting contraband that reaches the patient care units. Goal ≤ 8 times
3. ~~Number~~ Decrease the number of incidents of unauthorized Absence from locked unit. (Goal = 0)
4. Conduct ~~quarterly~~ mock lockdown procedures lock down exercise per shift per quarter (3 total) for Security and Maintenance staff. (Goal = 43 per quarter for a total of 12 per yr)

### Hazardous Materials Management

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.

### Emergency Management

4. ~~Train three additional staff in ICS 100 and 200 to be Duty and Liaison officers~~

- ~~2. Complete the Emergency Action Plan (template provided by Milwaukee County Office of Emergency Management)~~
- ~~3. Complete the Closed Point of Distribution Plan with the Wauwatosa Health Department~~
- ~~4. Hold or participate in two emergency exercises per year (Goal =2)~~
- 1. Train one additional staff in ICS 100 and 200 to be Duty and Liaison officers.
- 2. Update emergency plans that would most likely be needed during an emergency related to the Democratic National Convention. Multiple campus and regional workgroups have been created to unify the healthcare networks response
- 3. Hold or participate in two emergency exercises per year (Goal =2)

#### Fire Prevention

- 1. Measure the number of Fire drills completed (Goal = ~~60~~120/year)
- 2. Measure the average score on the fire drill check sheet. (Goal is 97%)
- 3. Measure the number of fire panel / trouble alarms (Goal is 0)
- 4. The goal of training staff on and implementing the new fire panel announcements.

#### Utilities Management

- 1. Measure the completion rate of preventive maintenance tasks (Goal =100%)  
Develop a new manual on Major Utility failures.  
Measure the percentage of generator testing that did not pass (Goal = 0%)  
~~Measure the percentage of utility branch valves labeled and inventoried (Goal = 100% by year end)~~  
~~Measure the percentage of generator testing that did not pass (Goal = 0%)~~

#### Medical Equipment Management

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

## ANNUAL EVALUATION

### (EC 04.01.01)

- 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: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Asstthospadm2-Mhc	pending

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Current Status: *Pending*

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**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**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-EP4)

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.

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-EP4)**

Department 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 –** 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 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** – 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 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 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)** 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 1)**

C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual

Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)

## PERFORMANCE MONITORING

(EC 04.01.03 EP 2); EC 04.01.05 EP 1)

- 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, 2000 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: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Asstospadm2-Mhc	pending

COPY



**Date Issued:** 1/1/2015  
**Effective:** Upon Approval  
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**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**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-EP5)

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.

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-EP5)

## **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. 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 2)** – Security and Safety events are recorded in the MCBHD electronic Incident Safety Event Reporting System by a witness or the staff member to whom a patient or visitor incident is reported. The employee's Supervisor or location supervisor and the Risk Manager conducts an investigation and recommends/initiates follow up actions as appropriate.

In addition, Quality 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 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. 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** – Vehicular access to the Psychiatric Crisis Service area is controlled by Security 24/7 and limited to emergency vehicles only.

## ORIENTATION AND EDUCATION

A. **New Employee Orientation:** Education regarding the Security Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific security training, job-specific security training, and a series of programs required for all employees on an annual basis **(EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)**

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 1)**

C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific security related policies and procedures and specific job related hazards. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

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

## PERFORMANCE MONITORING

**(EC 04.01.03 EP 2; EC 04.01.05 EP 1)**

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

~~Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)~~

~~Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)~~

1. Meet minimum Public Safety and Security staffing each shift (Baseline).

2. Decrease the number of incidents of non-fire setting contraband that reaches the patient care units. Goal ≤ 8 times

3. ~~Number~~Decrease the number of incidents of unauthorized Absence from locked unit. (Goal = 0)

4. Conduct ~~quarterly~~a mock lockdown procedureslock down exercise per shift per quarter (3 total) for Security and Maintenance staff. (Goal = 43 per quarter for a total of 12 per yr)

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: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Asstthospadm2-Mhc	pending

COPY



**Date Issued:** 1/1/2013  
**Effective:** Upon Approval  
**Last Approved Date:** N/A  
**Last Revised Date:** 2/10/2020  
**Next Review:** 3 years after approval  
**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**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-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 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.

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-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 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 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 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 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 8)** HMW spills are reported on the MCBHD electronic Incident/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/Safety Event Reporting System and the Accident 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 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 02.02.01 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 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. 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 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 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 Waste 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 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 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 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 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 1 & 2; HR 01.04.01 EP 1 & 3)**
- D. **Contract Employees:** Assessment and education is done at the time of assignment at MCBHD. Contracted Employees attend a New Employee Orientation program at MCBHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

# PERFORMANCE MONITORING

**(EC 04.01.03 EP 2; EC 04.01.05 EP 1)**

- 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: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Assthospadm2-Mhc	pending

COPY



Current Status: Pending

PolicyStat ID: 7639889



**Date Issued:** 1/1/2015  
**Effective:** Upon Approval  
**Last Approved Date:** N/A  
**Last Revised Date:** 2/13/2020  
**Next Review:** 3 years after approval  
**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**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-EP7)**

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.

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-EP7)**

## INTENT PROCESSES:

- A. **Protection from fire, smoke and other products of combustion** –The MCBHD occupancies are maintained in compliance with NFPA 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 1-6)**

Any remodeling or new construction is designed to maintain separations and in accordance with state and federal codes including NFPA LS 101-2012 Chapters 18/19; NFPA 90A 2012 and NFPA 72-2010 and maintained to minimize the effects of fire, smoke, and heat. **(LS 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; LS 01.01.01 EP 5; LS 02.01.20 1-32)**

Smoking is prohibited on the MCBHD campus. **(EC 02.01.03-EP 1, 4, & 6)**

- B. **Inspection, Testing, and Maintenance** – All fire protection and life safety systems, equipment, and components at MCBHD are tested according to the requirements listed in the Comprehensive

Accreditation Manual of The Joint Commission, associated NFPA Standards and state and local codes regarding structural requirements for fire safety. Systems are also tested when deficiencies have been identified and anytime work or construction is performed. The objectives of testing include:

- To minimize the danger from the effects of fire, including smoke, heat & toxic gases. **(LS 02.01.10 EP 1-15;)**
- 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 1-42)**
- To provide and maintain proper barriers to protect individuals from the hazards of fire and smoke. **(LS 02.01.30 EP 1-26)**
- To provide and maintain the Fire Alarm system in accordance with NFPA 72-1999. **(LS 02.01.34 EP 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 7)**

**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 3-6, & 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 1-5)**
- D. **Reporting and Investigation** – **(EC 04.01.01 EP 9; EC 04.01.03 EP 2)**– LSC and fire protection deficiencies, failures, and user errors are reported to the EES Department and, as appropriate, reviewed by the manager of the department. Summary information is presented to the EC Committee on a quarterly basis.
- E. **Interim Life Safety Measures** – **(LS 01.02.01 EP 1-15)** 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; EC 02.03.03 EP 1-5)** Emergency procedures are outlined in the Fire Safety Plan for each building. These plans are kept in the Environment of Care manual. The Hospital Incident Command System (HICS) may be implemented to facilitate emergency management of a fire or life safety related event.
- H. **Fire Drills** - **(EC 02.03.03-EP 1-5)** Employees are trained and drilled regularly on fire emergency procedures, including the use and function of the fire and life safety systems (i.e. pull stations, and

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

## ORIENTATION AND EDUCATION

### A. **New Employee Orientation: (EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)**

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 1)**

C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific fire prevention related policies and procedures and specific job related hazards. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

## PERFORMANCE MONITORING

**(EC 04.01.03 EP 2; EC 04.01.05 EP 1)**

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

1. Measure the number of Fire drills completed (Goal = ~~60~~120/year)
2. Measure the average score on the fire drill check sheet. (Goal is 97%)
3. Measure the number of fire panel / trouble alarms (Goal is 0)
4. The goal of training staff on and implementing the new fire panel announcements.

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: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Assthospadm2-Mhc	pending



Current Status: Pending

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**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**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-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.

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-EP8)**

## **INTENT PROCESSES:**

- A. **Selecting and Acquiring Equipment** – As part of the capital budgeting cycle, Department Program Directors and Managers are responsible for identifying and justifying new and replacement medical equipment for their departments or areas of responsibility. Requests are subject to administrative approval. Funds for approved capital projects are released on an annual basis. As a rule a representative from the medical equipment management company will be asked to participate with the user department and MCBHD Central Supply Dept. and Maintenance Dept. staff in the evaluation of equipment alternatives and represent the equipment support issues during the selection process. The manager of the ME program along with the Safety Officer are responsible for coordinating the evaluation, purchase, installation, and commissioning processes of new equipment according to the ME purchasing policy.
- B. **Equipment Inclusion in the Medical Equipment Management Plan and Inventory (EC 02.04.01 EP 2)**  
– All Medical Equipment will be inventoried and tracked in the computerized maintenance management system provided by the contracted maintenance company. The accuracy of this inventory will be verified during scheduled maintenance inspections by comparing the number of items that are no longer in service but still scheduled for inspection, to the total number of items scheduled for inspection. Missing equipment or equipment that the MCBHD Central Supply staff is not aware of being removed from service will be investigated and, if found, reviewed for functionality and either put back into service or permanently

removed from service and taken off the equipment inventory listing. Items not found immediately will be put on a missing equipment list for one year and if not found will be removed from the list. The missing equipment list will be distributed to each unit on an annual basis or as needed.

C. **Equipment Inspection, Testing, and Maintenance (EC 02.04.01 EP 3 & 4; EC 02.04.03 EP 1-3 & 27)**

–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 House Supervisor has access to Central Supply during off hours. Additional procedural information can be found in the policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*

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

## ORIENTATION AND EDUCATION

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

on an annual basis. Training includes information on where to reference the proper information to ensure the piece of medical equipment they are using is safe, how to properly tag a piece of broken medical equipment, how to report medical equipment problems and obtain replacement equipment. **(EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)**

- 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 1)**
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific medical equipment related policies and procedures and specific job related equipment procedures and precautions. Training of employees and technical staff regarding use, features, maintenance and precautions is included as a part of new equipment acquisition/purchase. Additional training/retraining will be conducted based user-related problems or trends seen in the program evaluation. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

## PERFORMANCE MONITORING

**(EC 04.01.03 EP 2; EC 04.01.05 EP 1)**

- 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: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Assthospadm2-Mhc	pending

COPY



Current Status: *Pending*

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**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**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-EP 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 BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) 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.

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-EP 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 6 & 7; 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 4 & 5; EC 02.05.05-EP 4, 5, & 6; EC 02.05.07-EP1-10)**– 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-EP3; 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-EP1-7, 13; EC 02.05.07-EP 1, 2, 4 & 7)**– 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

**Note:** The facility does not have a piped medical gas system (EC 02.05.09-EP1-14)

**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 electrician reviews the reports. Documentation of testing is kept in the EES office in binder #16..(EC 02.05.07-EP 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 8 & 9, & 16)**– Milwaukee County and EES maintains mapping and labeling of critical distribution systems and equipment operational instructions. Master copies are kept in the MC Transportation and Public Works 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 10; 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* .
- 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 7395 (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 5)** – 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 12)** – Emergency procedures and contingency plan information is available in the Environment of Care manual (Systems Failure & Basic Staff Response Quick Reference) and in the Emergency Operations Plan,

# ORIENTATION AND EDUCATION

## A. **New Employee Orientation:** (EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)

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 1)

## C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific utilities related utility procedures or precautions. (EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)

## D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)

# PERFORMANCE MONITORING

(EC 04.01.03 EP 2); EC 04.01.05 EP 1)

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

1. Measure the completion rate of preventive maintenance tasks (Goal =100%)
2. ~~Measure the percentage of utility branch valves labeled and inventoried (Goal = 100% by year end)~~Develop a new manual on Major Utility failures.
3. Measure the percentage of generator testing that did not pass (Goal = 0%)

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

# ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

## B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The

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

Reviewed and approved at the Environment of Care Committee on: ~~2-14-19~~2-13-20

Reviewed and approved at the Medical Executive Committee Meeting on: ~~2-20-19~~2-19-20

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
	Lynn Gram: Exdir2-Assthospadm2-Mhc	pending

COPY

# Workforce Development for Diversity and Inclusion



**Justin Kuehl, PsyD**  
*Chief Psychologist*

**Dávide Donaldson, MSSW**  
*Integrated Service Manager*



# Milwaukee Comprehensive Care Collaborative (MC3)

- BHD is part of the Academic Partnership Committee
- BHD is part of the MC3 alues Training Program



# □ **orkforce Development for Diversity & Inclusion**

- One of the eight strategic projects sponsored by BHD leadership
- Initial project plan completed in December 2018
- Team members started to align with MC3's training program-February 2019

# MC3 Internship



- Established central email
  - [BHDProfessionalTrainingRequests@milwaukeecountywi.gov](mailto:BHDProfessionalTrainingRequests@milwaukeecountywi.gov)

**From:** Joe Smith [jsmith2019@gmail.com]  
**Sent:** Monday, April 29, 2019 3:39 PM  
**To:** Hubbard, Lauren  
**Subject:** Child and Adolescent Mobile Crisis Unit

Hello Lauren,

It was wonderful talking to you at the NAMI conference. Thank you for informing me about the Child and Adolescent mobile crisis unit and possible internships.

I am interested in learning more about the internships: are the internships per semester? During the summer? Longer than that? I remember you saying that was in the process of being reworked, so if you don't have these answers, I totally understand. I am planning on taking classes for the fall 2019 semester: 2 online and 2 in person. The in person classes will be held from 2-3:15 on Tuesdays and Thursdays and 4:30-10 pm on Thursdays.

It was nice to meet you, and I hope I can intern at with Milwaukee County Behavioral Health Division.

Sincerely,  
Joe Smith  
(414) 321-1234

- Affiliation agreements
- Policies
- Disciplines working together

# Office of Professional Training Program (OPTP)



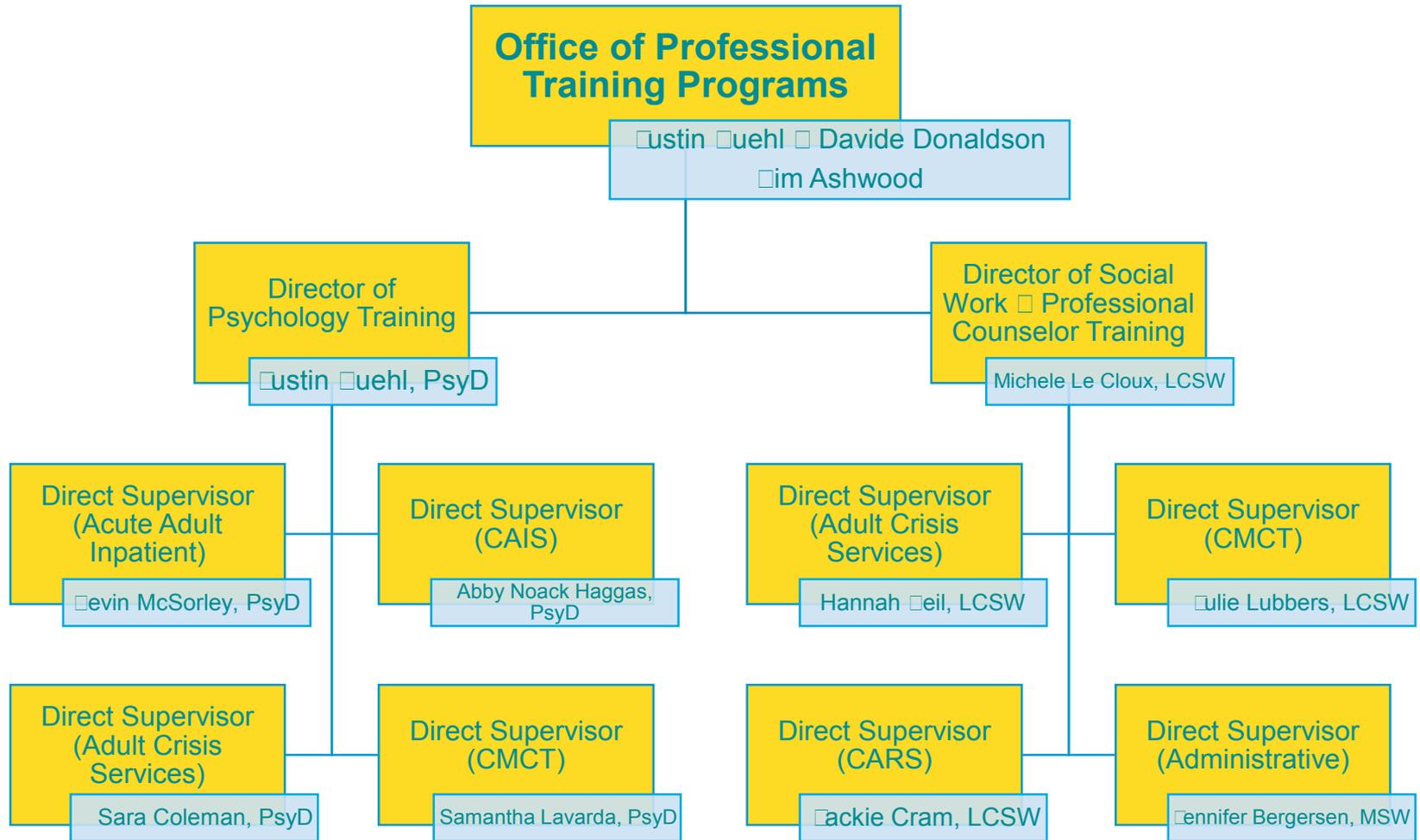


# Disciplines that are Working Together

- Psychology
- Psychiatry
- Counseling
- Social Work
- Nursing
- Music Therapy
- Occupational Therapy



# Disciplines continued....



# Increasing Training Opportunities



**BHD** | MILWAUKEE COUNTY  
Behavioral  
Health  
Division



Nursing, Crisis Services  CARS



# Affiliation Agreements

- Herzing University
- Concordia University
- Alverno University
- Marquette University
- University of Wisconsin – Milwaukee
- University of Wisconsin – Oshkosh
- Walden University
- Wisconsin School of Professional Psychology
- Milwaukee School of Engineering
- Carroll University

# Raising Awareness



**BHD** | MILWAUKEE COUNTY  
Behavioral  
Health  
Division

- Office of African-American Affairs
- YWCA
- Hispanic Chamber of Commerce
- Hmong Friendship Association
- MIRACLE Network
- Milwaukee Public Schools
- University of Wisconsin-Milwaukee

eliminating racism  
empowering women  
**ywca**  
Southeast Wisconsin



**HMONG AMERICAN  
FRIENDSHIP ASSOCIATION INC.**  
MILWAUKEE, WI. EST. 1983



**MILWAUKEE  
PUBLIC SCHOOLS**



# Working Together

- Steering Committee is held on the second Tuesday of the month
- The Work Group is held on the third Wednesday of the month

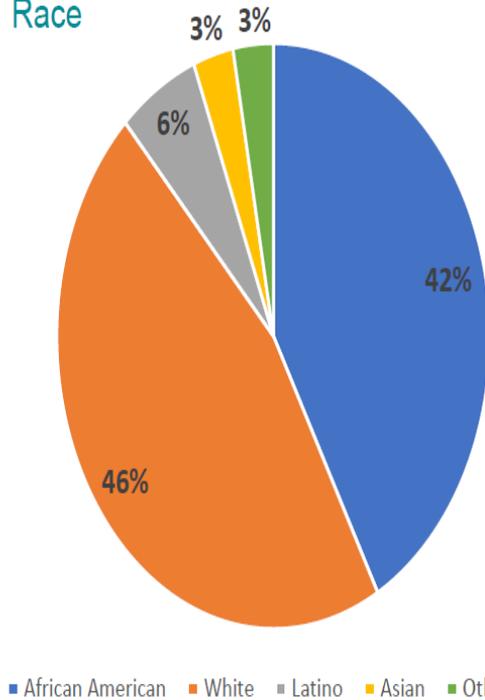


# Current State

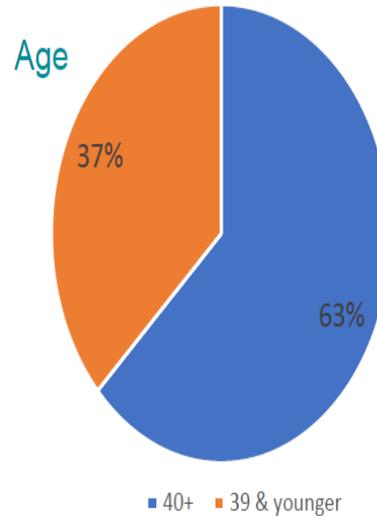


## DHHS Race, Age & Gender Profile

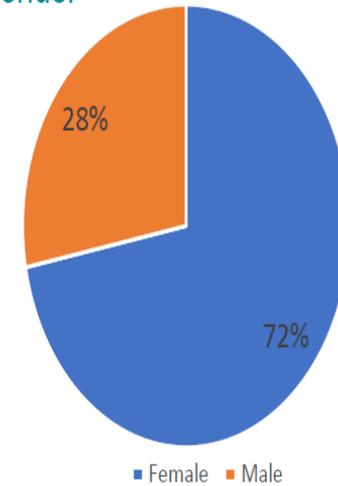
Race



Age



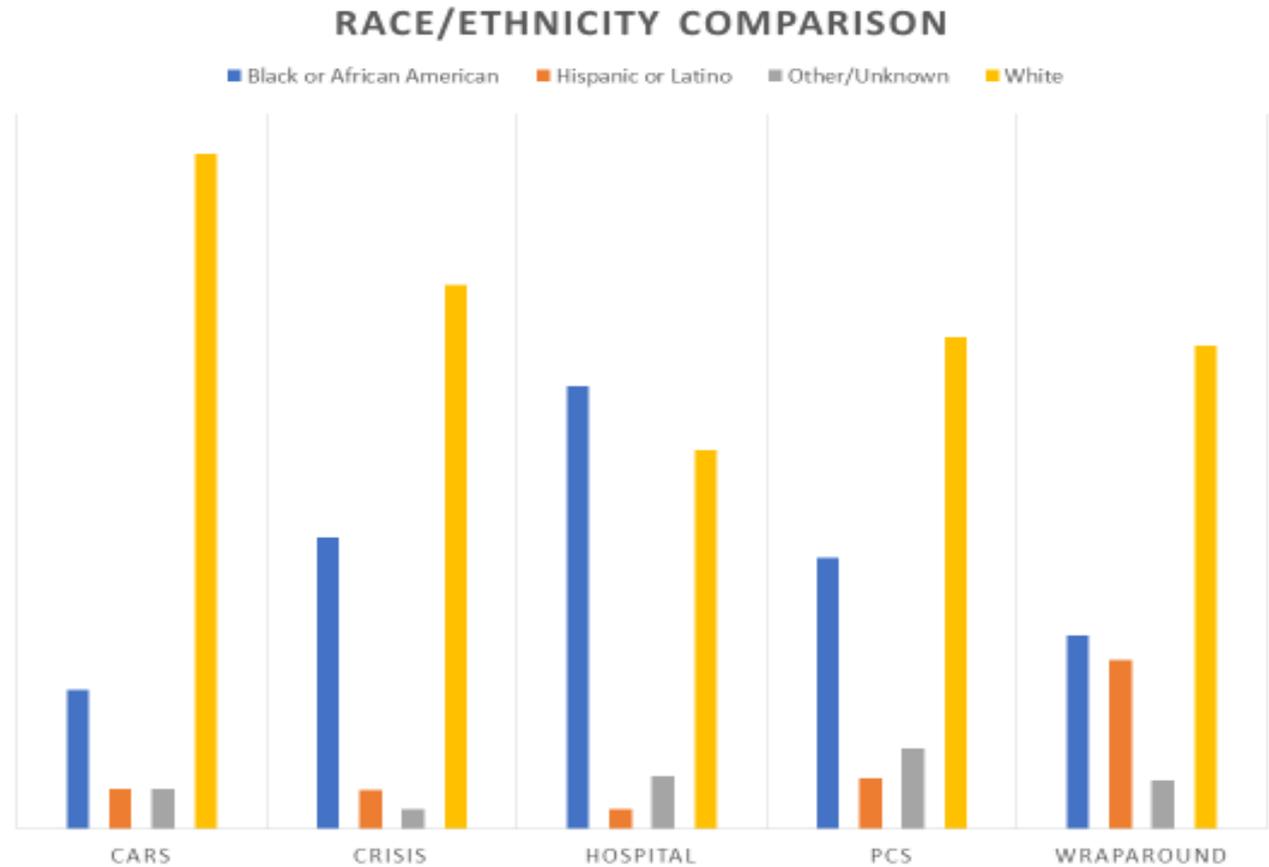
Gender





# Current State

Demographics –  
All BHD



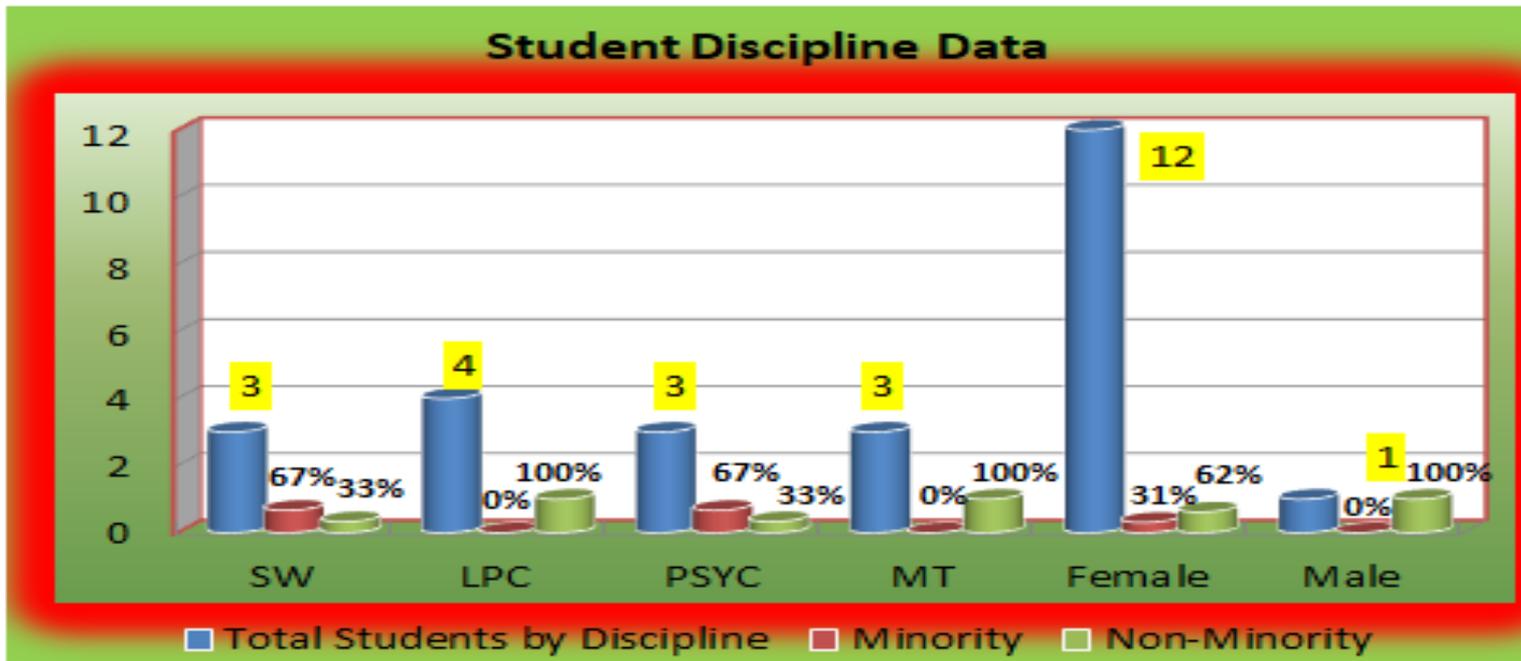


# Demographics

Demographics –  
All BHD



# BHD Workforce Development for Diversity & Inclusion



# Current Projects



- MATC Affiliation Agreement
- MPS – Lead
- Supervisor Handbook
- MC3 Trainees
- Marketing/Website Development

# BHD's Commitment

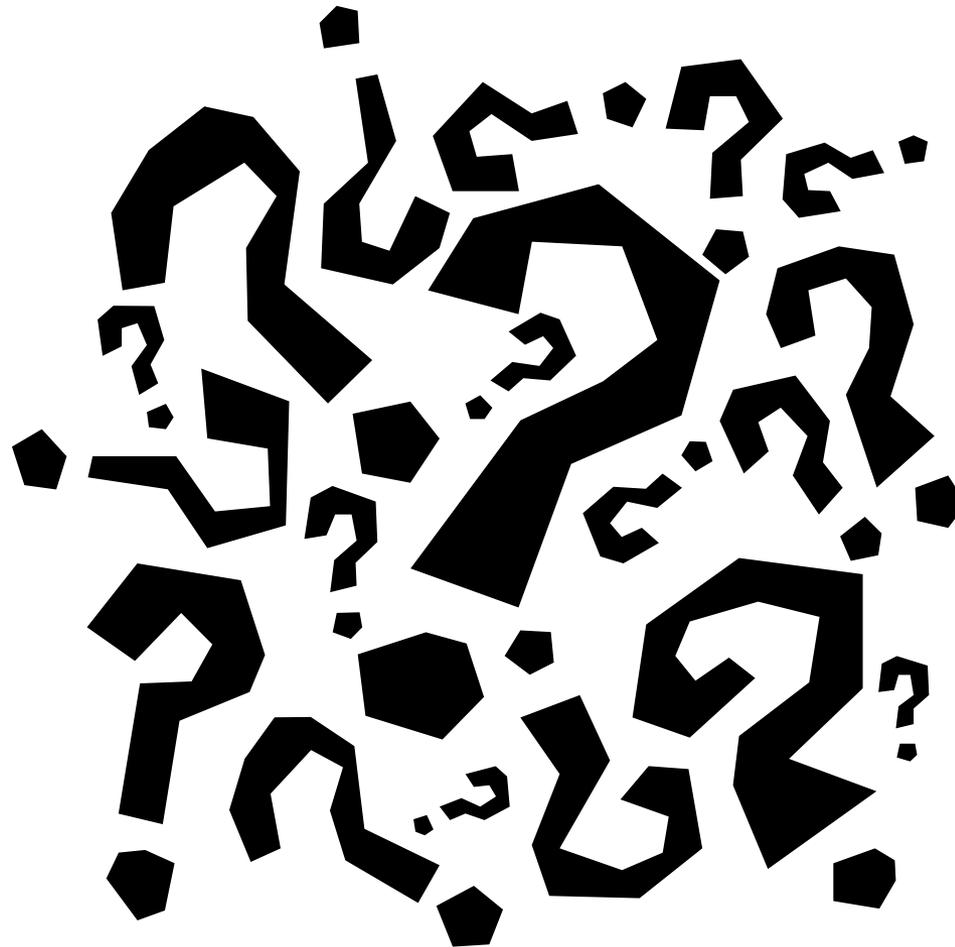


**BHD** MILWAUKEE COUNTY  
Behavioral  
Health  
Division

- Executive Assistant
- Free Flu Shots
- Ongoing Collaboration



# Questions



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

**MILWAUKEE COUNTY MENTAL HEALTH BOARD  
EXECUTIVE COMMITTEE**

Thursday, March 12, 2020 - 10:00 A.M.  
Milwaukee County Mental Health Complex  
Conference Room 1045

**MINUTES**

**PRESENT:** Thomas Lutzow and Maria Perez  
**EXCUSED:** Michael Davis and Duncan Shrout

**SCHEDULED ITEMS:**

1. **Welcome.**

Chairman Lutzow greeted Committee Member Perez and welcomed everyone to the March 12, 2020, Mental Health Board Executive Committee meeting.

2. **Milwaukee County Mental Health Board Goals and Vision for 2020.**

Chairman Lutzow referenced a report Administrator Lappen and Governance Ad Hoc Committee Chairperson Kathie Eilers are writing. It will be instrumental in developing a plan for the Board ensuring its role is being fulfilled under Chapter 51.41, layout a blueprint or road map for the future, and should be aspirational as well as inspiring. Crisis redesign and strengthening community services will be part of that road map. It can then be used as the basis of a retreat and formation of a vision. A consensus on the direction the Board is headed is timely given the upcoming change in the County's administration. A snapshot of the information gathered to this point was presented at the iCare Conference Forum held last week.

The plan should have input from the community, advocates, and the County Executive. The goal is to end up with a product everyone can agree on.

The Committee was informed a meeting of the Governance Ad Hoc Committee has been scheduled. Administrator Lappen and Board Member Eilers are working closely on the issues described by Chairman Lutzow. An update with recommendations will be presented to the Board at the April meeting.

**SCHEDULED ITEMS (CONTINUED):**

**3. Report on the Fiscal Impact of the Systems Improvement Agreement and Request for Funds.**

Jennifer Bergersen, Chief of Operations, Behavioral Health Division (BHD)  
Matt Fortman, Fiscal Administrator, Department of Health and Human Services

Ms. Bergersen stated attached to the report is a list of items in need of repair in the facility to bring it up to the appropriate standards. There is a lot of work to accomplish within a very short timeframe. Repairs must begin immediately. Operations has been actively planning and have acquired estimates on some of the costs. BHD is requesting the Executive Committee approve an amount not to exceed \$3 million, drawn from the Building Reserve fund, to move forward. Deadlines and Systems Improvement Agreement requirements must be met, but more importantly, ensuring an anti-ligature free environment is created for the health and safety of those that are being served is a priority.

The Committee was cautioned the attached list is preliminary. As labor is identified and people are brought in to do the work, efficiencies will be sought. There are other areas requiring attention not reflected in the total cost at this time, including enhancements and/or related build outs regarding the emergency room to meet Emergency Medical Treatment and Labor Act (EMTALA) requirements.

In order to do the improvements, renovations will be done two units at a time. A plan has been devised on moving units around while maintaining operations. Areas are being vacated and patients are being safely moved. Once repairs are satisfactorily completed, BHD will participate in two subsequent Centers for Medicare and Medicaid Services (CMS) surveys to gage progress and inspect corrections made towards the plan.

The intent is to keep the Finance Committee and Board updated on progress made and bring forth any related contracts for consideration. Today's approval will allow purchases to be made and work to begin immediately. The County has a program under which a project manager will be provided to oversee the job.

Questions and comments ensued.

Mr. Fortman explained the Building Reserve fund by statute is described as an Infirmary Reserve fund. There have been multiple interpretations over the years as to what happens to those funds after BHD no longer operates an infirmary. The funds, however, were intended for a purpose exactly like this. If the funds are not used by the time the building is vacated, it is the Comptroller's opinion the funds do not stay with BHD. In a future state, BHD could operate psychiatric crisis services and an emergency department with a micro hospital associated, which could possibly be defined as an infirmary. One would argue the funds apply to that future state structure. Otherwise, there is very limited use of these funds outside of the BHD facility.

Mr. Fortman described four possible options to address BHD's current situation, both attractive and unattractive.

**SCHEDULED ITEMS (CONTINUED):**

	<p><b>MOTION BY:</b> (Lutzow) <i>*Approve the Funds Requested to Address Systematic Hospital Improvements as Described in the Corresponding Report. 2-0</i></p> <p><b>MOTION 2<sup>ND</sup> BY:</b> (Perez)</p> <p><b>AYES:</b> Lutzow and Perez – 2</p> <p><b>NOES:</b> 0</p> <p><b>*NOTE:</b> This approval is provisional only and binding until the next regularly scheduled Board meeting at which time the Board must consider the Executive Committee's action.</p>
4.	<p><b>Potential Third-Party Fiscal Agents for the Provision of Mental Health Board Support Staff Oversight.</b></p> <p>Chairman Lutzow indicated Board Member Neubauer, at the last Board meeting, mentioned the possibility of using a third-party fiscal agent to provide oversight of the Board staff position, which is the perfect solution. Chairman Lutzow researched agencies in the business of providing employer of record services. The vendors listed in the attachment are State Department of Health Services Recognized, provide third-party fiscal agent services to various organizations, and are relatively inexpensive. The State may even be willing to share their evaluation of the vendors in terms of quality scores.</p> <p>Selection should be done by a Request for Information (RFI) to include evidence of certification proving ability to practice as a fiscal agent, their terms and conditions, an example of a contract with a payor/co-employer, their fees and charges, and whether or not they provide services to public entities. The RFI should not be confused with a Request for Proposals (RFP). This is not a bid but a request for information.</p> <p>Chairman Lutzow directed the Fiscal Administrator to vet and perform due diligence on the agencies delineated in the corresponding report for viability. Once the process is complete and the best option is identified, the Board can move forward with a contract.</p>
5.	<p><b>Crisis Services Legal Opinion Update.</b></p> <p>Anne Kearney, Deputy, Office of Corporation Counsel (OCC)</p> <p>Attorney Kearney stated the OCC is currently proceeding on two tracks. The first consists of taking a robust look at outside counsel to deal with specific issues identified related to the Emergency Medical Treatment and Labor Act (EMTALA). Interviews with at least three law firms are being scheduled over the next couple of weeks. The second is working with the people who have already been on the ground putting together the infrastructure. This track is running through the County, private health systems, and the State by way of the collaboratively formed workgroup.</p> <p>Attorney Kearney assured the Committee the OCC understands the directive given and the time sensitivity associated with the project resulting in the time constraints the workgroup is</p>

**SCHEDULED ITEMS (CONTINUED):**

facing. The OCC will be part of the conversation organizationally to make sure everything stays on track. The goal is to get the work done by the date identified by the Board.

Chairman Lutzow stated legal experts representing the private systems are skilled when it comes to EMTALA. They do not need BHD to inform them on the subject. Guidance and legal assistance are needed for the private health systems as it relates to Chapter 51 and understanding BHD's obligation under Chapter 51. Hand holding is not likely needed with EMTALA; however, it will be likely needed with Chapter 51.

Attorney Kearney indicated the OCC can accommodate Chapter 51 requirements. There are a variety of options to satisfy the County's Chapter 51 responsibilities, including what this venture will look like and how it will be set up physically. The OCC plans to address Chapter 51 but is not there yet. She stated currently, the focus is on how the joint venture will be structured and who will have control. When it comes to the EMTALA piece, there are various perspectives related to the definition of EMTALA stabilization. The private systems' interpretation appears to be different from the County's interpretation. EMTALA counsel can help bridge the gap. The idea is to make sure the County and the Board has the information to communicate effectively with the private health systems.

Chairman Lutzow requested the OCC provide regular updates at upcoming Board meetings.

6. **Adjournment.**

Chairman Lutzow ordered the meeting adjourned.

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

Length of meeting: 10:07 a.m. to 11:00 a.m.

Adjourned,

*Jodi Mapp*

**Jodi Mapp**

Senior Executive Assistant  
Milwaukee County Mental Health Board

**SCHEDULED ITEMS (CONTINUED):**

The next meeting for the Milwaukee County Mental Health Board Executive Committee  
Will be on Thursday, August 13, 2020, at 1:30 p.m. at the  
Mental Health Complex  
9455 W. Watertown Plank Rd.

Visit the Milwaukee County Mental Health Board Web Page at:  
<https://county.milwaukee.gov/EN/DHHS/About/Governance>

The March 12, 2020, meeting minutes of the Milwaukee County Mental Health Board Executive Committee have been reviewed and are hereby approved.



---

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

# Executive Committee Item 4

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
Inter-Office Communication

**DATE:** March 10, 2020  
**TO:** The Mental Health Board Executive Committee  
**FROM:** Thomas Lutzow, Chairman  
Mental Health Board  
**SUBJECT:** State Department of Health Services Recognized Third Party Fiscal Agents

## Issue

The Mental Health Board approved a staff position in the 2018 Budget to support the Board, which is yet to be filled. The position will be contracted and require oversight by a non-County entity to be the “employer of record.”

## Background

A meeting was held with the Milwaukee County Comptroller to discuss his office providing staff support to the Mental Health Board as it does for the County Board of Supervisors. The Comptroller indicated its inability to provide the services of a support person is due to how the related legislation is written. The Department of Human Resources has provided a job evaluation questionnaire to use as a guide when drafting the job description for the full-time position.

## Recommendation

Perform due diligence on the following agencies for viability:

Consumer Direct for Wisconsin, LLC  
744 Ryan Dr., Ste, 201  
Hudson, WI 54016  
(877) 785-9991

Equality Payee Services of Wisconsin, Inc.  
12605 W. North Ave.  
Brookfield, WI 53005  
(414) 375-4760

Fiscal Assistance, Inc.  
4646 S. Baltimore Ln.  
Madison, WI 53718  
(855) 201-4230

Milwaukee Center for Independence, Inc.  
3333 S. Howell Ave.  
Milwaukee, WI 53207  
(414) 431-5422

Northwoods Inc. of Wisconsin  
N6510 US Hwy 51  
Portage, WI 53901  
(608) 742-7114

QHO Financial Services  
7425 Harwood Ave.  
Wauwatosa, WI 53213  
(414) 257-4377

Societys Assets, Inc.  
5200 Washington Ave., Ste 225  
Mount Pleasant, WI 53406  
(262) 637-9128

**Fiscal Summary**

Monies to support the position was included in the 2018 Budget.

A handwritten signature in black ink, appearing to read "Thomas Lutzow". The signature is written in a cursive style with a horizontal line extending from the end.

---

Thomas Lutzow, Chairman  
Milwaukee County Mental Health Board

**Chairperson:** Kathie Eilers  
**Staff:** Michael Lappen/Jennifer Bergersen  
**Senior Executive Assistant:** Jodi Mapp, 257-5202

**MILWAUKEE COUNTY MENTAL HEALTH BOARD  
GOVERNANCE AD HOC COMMITTEE**

March 27, 2020 – 11:30 A.M.  
Teleconference Meeting

**MINUTES**

**PARTICIPANTS:** Kathie Eilers, Walter Lanier, Thomas Lutzow, Mary Neubauer, and Maria Perez

**EXCUSED:** Duncan Shrout

**SCHEDULED ITEMS:**

**1. Welcome.**

Chairperson Eilers welcomed participants to the first meeting of the Mental Health Board's Governance Ad Hoc Committee.

**2. Role of Governance in Centers for Medicare and Medicaid Services (CMS) Plan of Correction.**

The role of the Governance Committee as established ties directly to the Behavioral Health Division's Systems Improvement Agreement (SIA). Critical Management Solutions identified areas out of compliance with the Conditions of Participation related to governance. The fix includes better documentation and coordination with the Governing Board, the Quality Assurance Performance Improvement Committee (QAPI), and the Quality Committee.

The feedback from CMS stated these directives must come from the Board. The Governance Committee would make recommendations on the processes and/or prioritization to the full Board for a vote, which then makes it part of the hospital's bylaws. The Board is to communicate very clearly its expectations for the hospital and its administration. The quality structure needs improvement. A series of new policies and procedures are to be drafted by the Governance Committee and approved by the Board for compliance.

Additional areas of consideration include the Board's meeting structure related to fulfilling requirements set forth in statutes governing public meetings and clarification of the Board's fiduciary responsibility. Corporation Counsel previously provided a legal opinion on the Board's fiduciary responsibility, but it needs further examination. Open meetings and Robert's Rules training and outside counsel to assist with understanding the Board's fiduciary oversight, framework of the Board's authority, and governance in general are optimal solutions.

# Governance Committee Item 2

## A-0043

(Rev. 122, Issued: 09-26-14, Effective: 09-26-14, Implementation: 09-26-14)

### **§482.12 Condition of Participation: Governing Body**

**There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.**

#### **Interpretive Guidelines §482.12**

The hospital must have a governing body which is effective in carrying out its responsibilities for the conduct of the hospital. In the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are legally responsible for the conduct of the hospital operations.

If the hospital is part of a healthcare system that includes several separately certified hospitals, each with its own Medicare provider agreement and CMS Certification Number, the governing body of the healthcare system has the option to act as the governing body of each separately certified hospital, unless doing so would conflict with State law. A hospital system also has the option to form several governing bodies, each of which is responsible for several separately certified hospitals. For example, a health system operating hospitals in many States might choose to form regional sub-boards each responsible for the hospitals in its region, or a health system that has a mixture of types of hospitals may choose to form one sub-board responsible for its short-term acute care hospitals and another for its long term care hospitals.

When deciding whether or not to exercise the option to have a single governing body for multiple hospitals in the system, another factor for systems to consider might be Medicare payment requirements at §§412.22(e) - (h) applicable to certain types of hospitals, i.e., non-grandfathered Hospitals-within-Hospitals and Hospital Satellites. In such cases where the hospital system owns both the tenant and the host hospital, using a single governing body for both hospitals would jeopardize the payment status of a hospital that is being paid by Medicare under a payment system excluded from the Hospital Inpatient Prospective Payment System (IPPS). However, surveyors do not assess compliance with or enforce the Medicare payment regulations that govern Hospitals-within-Hospitals or Hospital Satellites.

The Medicare program offers hospital facilities considerable flexibility regarding how they choose to participate. Based on the geographic and other institutional limitations set out in the "provider-based" regulation at §413.65, which addresses provider-based status for hospital facilities in multiple locations, hospital governing bodies make business decisions about how they want to participate in Medicare, and they indicate on their Medicare enrollment application the choices they have made. It is not uncommon to find multiple hospital campuses with one owner located in the same geographic area enrolled in Medicare as one hospital. It is also not uncommon to see a hospital system choosing to enroll its various facilities as separately certified hospitals. Various factors enter into consideration when the governing body of a system makes these decisions.

For example, some governing bodies prefer to enroll various campuses as separate hospitals, out of a concern that problems at one hospital's campus might jeopardize the Medicare participation of the other campuses if they were a multi-campus hospital covered under one Medicare provider agreement. In other cases a governing body may see the benefits of integrating clinical services on multiple campuses into one integrated hospital. In still other cases, the deciding factor might be the

# DRAFT

## **Plan of Correction to Address Shortcomings in Governing Body Related Conditions of Participation for the Milwaukee County Behavioral Health Division Acute Hospital: A0043, and A-0309 through A-03017**

At the 2/27/2020 meeting of the Milwaukee County Mental Health Board, the body moved to establish a “Governance Committee”. This standing committee will be Chaired by Kathie Eilers, RN who was the Behavioral Health Division Administrator for many years, and has significant knowledge and expertise in hospital governance.

Kathie Eilers and Mike Lappen held a conference call on March 24<sup>th</sup> from 1000 to 1100 to prepare for the Fri 3/27/2020 Meeting of the MH Board Governance committee. This initial meeting must be held online secondary to COVID19 related social distancing requirements. We reviewed the Hospital Governing Body related A-tags, and Mike Lappen agreed to prepare a draft scope document to be reviewed by the Governance Committee and with recommendations to be eventually ratified by the full Mental Health Board.

Mary Neubauer Chairs the Mental Health Board Quality Committee. She has attended the most recent hospital Quality Assurance and Performance Improvement (QAPI) meeting and will attend these going forward. She will become the liaison of information flowing from QAPI to the Quality committee and from there up to the full Board, presenting recommendations related to quality and safety for action by the full Mental Health Board as needed.

The Governance Committee will review a scope of work specific to the Systems Improvement Agreement Plan of Correction (POC) March 27, 2020. This meeting will be held on a “virtual platform” secondary to COVID19 related social distancing requirements. Under the guidance of the Chair and in collaboration with the BHD Administrator, the committee will establish a BHD Hospital Governance scope document which identifies their roles and responsibilities to the BHD Hospital under the Conditions of Participation. This scope will include a process for addressing the prioritization of QAPI efforts, and will include a program for patient safety, including the reduction of medication errors. (A-0311, 12, 13)

### Mental Health Board Governance Committee Scope

The Mental Health Board Governance Committee (MHBGC) was established at the February 27, 2020 Milwaukee County Mental Health Board meeting. A significant task for this new committee will be to recommend for ratification by the full Board several governance procedures that address items required under the Medicare Conditions of Participation required of the Hospital Governing Board—the so-called “A Tags” A-0043, and A-0309 through A-3017.

The Plan of Correction (POC) established under the guidance of Critical Management Solutions, based on their Gap Analysis, states that in order to be compliant with the requirements of A-0043, the mental health Board and the BHD Administrator shall:

1. Define the scope and content of patient safety and quality assessment and performance improvement information that flows to the Board.
2. Establish a BHD Hospital “Governance Committee” that will develop a scope document which identifies their roles and responsibilities to the BHD Hospital under the Conditions of Participation.
3. Clarify the role and function of the Mental Health Board as the governing body for Milwaukee County BHD through the Governance Committee that will establish a BHD Hospital Governance scope document which identifies their roles and responsibilities to the BHD Hospital under the Conditions of Participation. This scope will include a process for addressing the prioritization of QAPI efforts, and will include a program for patient safety, including the reduction of medication errors.
4. Educate the Mental Health Board on their stated authority versus actual practice.
5. Restructure meeting agendas of the Mental Health Board to devote a sufficient length of time to receive, discuss and make decisions on patient safety and quality assessment and performance improvement issues.
6. Increase the frequency of meetings of the Quality Committee, a subcommittee of the governing body.
7. Educate the Mental Health Board on what to hold BHD leadership accountable for relative to patient safety and quality of care.
8. Coach the Mental Health Board on holding BHD leadership accountable for relative to patient safety and quality of care.
9. Educate and coach the Mental Health Board on strategies to more effectively assess the quality and safety of patient care and how to hold BHD leadership accountable for quantified improvement.
10. Improve its effectiveness given the requirement as a public agency to hold open public meetings.
11. Develop formal mechanisms for the Mental Health Board to navigate “Sunshine laws”.
12. Coach the Mental Health Board in navigating “Sunshine laws”.
13. Clarify the role of the Board regarding having input into the Administrator’s performance evaluation.
14. Develop the Board's fiduciary responsibility (versus a strong advisory role), control, and working relationship with the County Board.

15. Coach the Mental Health Board in establishing expectations of BHD management to provide information and reports on appropriate patient safety and quality of care issues and indicators.

16. Coach the Mental Health Board in fulfilling their fiduciary responsibility, asserting control, and developing a working relationship with the County Board.

17. Educate the Mental Health Board and BHD leadership on the appropriate scope, substance and frequency of reporting quality assessment and performance improvement.

**The MHBGC shall make recommendations to the full Board on April 23, 2020 to address the specific governance shortcomings identified in the SIA POC for A-0311 through A-0317:**

**A-0311.** Based on review of the Mental Health Board (the hospital's governing body) and Quality Committee meeting minutes, minimal information on the organization's quality assessment and performance improvement efforts are being presented. Consequently, the hospital's governing body is unable to fulfill its responsibility and accountability for ensuring that an ongoing program for patient safety, including the reduction of medical errors, is defined, implemented and maintained.

To address this the POC requires:

1. A structured process will be designed to facilitate the Chair of the Mental Health Board Quality Committee presenting items of concern or improvement discussed in the QAPI Committee meeting to the Mental Health Board. This structured process will consist of a list of current QAPI projects, their current status, planned process improvements, and accomplishments. This standardized report will also include conclusions drawn from analyzed data and the plan to improve whenever performance does not meet expected thresholds.

2. The Board will subsequently assign specific actions or priorities for the QAPI program or BHD Administration to execute and report back on progress.

**A-3012.** While the organization's governing body ("Mental Health Board") conducts meetings monthly, the organization's Quality Committee, one of two subcommittees of the governing body and whose membership includes four (4) members of the Mental Health Board, is only scheduled to meet quarterly. The Mental Health Board Quality Committee is scheduled to meet on the following dates in 2020: March 2, June 1, September 14 and December 7. Consequently, the governing body is only receiving reports and information on the organization's quality and safety of patient care on a quarterly frequency. This infrequent reporting on quality and patient safety issues hampers the governing body's ability to fulfill its fiduciary responsibility relative to the oversight of patient safety and quality of patient care.

Based on review of the Mental Health Board and Quality Committee meeting minutes, minimal information on the organization's quality assessment and performance improvement efforts are being presented. As a result, the Mental Health Board (the hospital's governing body) is not

provided the information that would allow it to fulfill its responsibility and accountability for ensuring that the hospital-wide quality assessment and performance improvement (QAPI) efforts address priorities for improved quality of care and that all improvement actions are evaluated. During the October 24, 2019 and December 12, 2019 meetings of the Mental Health Board, the QAPI update was limited to the following quality-related information:

"Update on the CMS Systems Improvement Agreement (SIA);

Update on the CMS Systems Improvement Agreement (SIA);

# of hospital admissions;

The 2019 Key Performance Indicator Dashboard, including Hospital-Based Inpatient Psychiatric Services (HBIPS) Measure Set data, patient visit volume statistics, financial performance, readmission data (% of patients returning within 7 and 30 days), hours of restraint rate, and hours of seclusion rate."

There was no QAPI report to the Mental Health Board on August 22, 2019.

To address this the POC requires:

1. The Mental Health Board will establish an expectation for meeting frequency that allows for them to effectively assess quality and safety of patient care, and enables them to hold leadership accountable for quantified improvement. A recommended solution would be for the MHBGC to ask the full MCMHB delegate the authority to the Chair of the Quality Committee to recommend for approval a meeting schedule for the Quality Committee.

**A0313** The organization-wide quality assessment and performance improvement process does not address priorities for improved patient safety result in the evaluation of improvement actions.

Addressed under recommendations under **A0043**.

**A0314** The organization's quality assessment and performance improvement process does not result in the establishment of clear expectations for safety.

1. Design a formal, written process to align QAPI initiatives and data with Mental Health Board expectations, including clear expectations for safety.

2. Implement the process to align QAPI initiatives and data with Mental Health Board expectations, including clear expectations for safety.

**Recommendation requested from MHBGC:**

**The Chair of the Quality shall recommend for approval to the full MCMHB a documented formal written process that aligns QAPI initiatives and data with Mental Health Board expectations, including clear expectations for safety. This will be evidenced by Mental Health Board meeting minutes from April 23 2020 showing evidence that the process to align QAPI initiatives and data with Mental Health Board expectations, including clear expectations for safety has been implemented.**

**A0315** Adequate resources have not been allocated for measuring, assessing, improving and sustaining the hospital's performance.

To address this the POC requires

1. Using National benchmarks, assess the number of resources appropriate for BHD to effectively measure, assess, improve and sustain the hospital's performance.
2. Based on the assessment, present to BHD Leadership approval to adjust the number of resources allocated to BHD 's QAPI program.
3. Present a formal request to the Mental Health Board for approval of increased resources dedicated to the QAPI program.

Satisfaction of this requirement will be demonstrated through:

1. Documented evidence of the assessment of the number of resources necessary for BHD to sustain an effective QAPI process.
2. Documented evidence of the request to BHD Leadership to approve an adjustment in the number of resources allocated to BHD 's QAPI program.
4. Documented evidence of the request submitted to the Mental Health Board for approval of increased resources dedicated to the QAPI program.

**A0316** Adequate resources have not been allocated for reducing risk to patients.

Addressed in **A0043**

**A0317** The quality assessment and performance improvement process has not resulted in an annual determination of the number of distinct improvement projects.

To address this the POC requires:

1. Chair of the Mental Health Board Quality Committee will solicit feedback from the Mental Health Board to establish the number of distinct improvement projects to be conducted annually.
2. The approved number of distinct QAPI improvement projects will be included in the QAPI plan.

Satisfaction of this element will be documented by:

1. Mental Health Board meeting minutes showing evidence of feedback from the Mental Health Board to BHD establishing the number of distinct improvement projects to be conducted annually.

2. Documentation in the QAPI Plan of the approved number of distinct QAPI improvement projects approved by the Mental Health Board.

This additional information is included in the POC by the BHD Administrator acting as executive sponsor of the “Governing Body” related Conditions of Participation. There are several items that overlap with Quality Committee and QAPI initiatives and are synthesized in other areas of the POC.

The BHD administrator will provide coaching and education as needed and per the request of the Board, and can make available training materials and subject matter experts regarding IMD/public hospitals and hospital operations in general.

During the April 23<sup>rd</sup> Board meeting, The MH Board will be presented with their responsibilities regarding hospital governance, will receive a briefing from Chair Neubauer on QAPI updates, will seek Board feedback on improvement projects, and relevant data and analysis they would direct us to prepare for future meetings. Specific to A-0311, items of concern or improvement discussed in QAPI will be presented by Ms. Neubauer, and specific actions or priorities for QAPI or BHD Administration would be assigned. The Governing Board will establish an expectation for meeting frequency with which they feel comfortable allows for them to effectively assess quality and safety of patient care, and enables them to hold leadership accountable for quantified improvement. (A-0312, A-0313) The Quality Chair will solicit feedback on the number of distinct improvement projects to be conducted annually, and the approved number will be included in the QAPI plan. (A-0317)

A-0314 Mike and Jennifer will align QAPI initiatives and data with MH Board expectations, including clear expectations for safety.

The QPI plan will be revised to include the presence of Quality Committee Chair Neubauer at QAPI meetings, and will assign her the responsibility to become the liaison for information to flow from the QAPI committee to the Quality Committee, and from the Quality Committee to the full Board. The Board will be tasked with approving allocations of resources for measuring, assessing, improving and sustaining hospital performance, and that adequate resources are allocated to reduce risk to patients (A-0315,A-0316)

implications for Medicare reimbursement of graduate medical education, the ease of adding satellite locations, etc.

CMS defers to the governing bodies of hospitals to weigh the pertinent factors and permissible options, and to make business decisions in their best interest when applying to participate in Medicare. CMS's hospital certification decisions and issuance of a provider agreement and associated CCN follow from these business decisions by a hospital's governing body. But once the "hospital," with whatever component parts, has been certified, that hospital must independently demonstrate its compliance with the CoPs, independent of any other facility. (77 FR 29040, May 16, 2012)

If a hospital system has chosen to have a one body act as the governing body for multiple separately certified hospitals (i.e., a system governing body), this does not alter the fact that each hospital must independently demonstrate compliance with the CoPs. Examples of what this means include, but are not limited to, the following:

- Each separately certified hospital must be separately and independently assessed for its compliance with the CoPs, through either State Survey Agency or approved Medicare hospital accreditation program surveys. There is no survey of a hospital "system," since the Medicare provider agreement and its terms are specific to each certified hospital.
- A system governing body may wish to adopt identical policies and procedures for many aspects of a hospital's operations across all of its hospitals within the system. It has the flexibility to do so, but the documentation of such policies and procedures must be clear that the governing body has chosen to apply them to specifically named hospitals. Also, each hospital must be able to present for inspection the system governing body policies and procedures that clearly apply to that hospital. For example:

A document that says "XX Healthsystem has adopted the following policy" is **not** acceptable. Instead, the document must be more specific, such as, "XX Healthsystem adopts the following policy and procedure for Hospital A, Hospital B, and Hospital C." Furthermore, the names of each hospital (Hospitals A, B, and C in this example) must correspond to the names used for their provider agreements. For example, if Hospital C is one Medicare-certified hospital with two inpatient campuses, one called "East" and one called "West," it is **not** acceptable for the policy document to state, "XX Healthsystem adopts the following policy and procedure for Hospital A, Hospital B, and Hospital East and Hospital West." It would be acceptable to state, "XX Healthsystem adopts the following policy and procedure for Hospital A, Hospital B, and Hospital C."

It also is **not** acceptable for the policy document to state, "XX Healthsystem adopts the following policy and procedure for Hospital A, Hospital B, and Hospital East, but not Hospital West." Since "Hospitals" East and West refer to separate campuses of Hospital C, which participates in Medicare as one multi-campus hospital, it is not appropriate to refer to these separate campuses of C as "hospitals," since the XX Healthsystem made a business decision to enroll them as parts of one multi-campus hospital in Medicare. CMS recognizes that, depending on the particular policy topic, it may be acceptable to have policies that vary by type of unit/department within a hospital. The system governing body could achieve this as follows: "XX Healthsystem adopts the following policy and procedure requiring that a physician be on-site 24 hours per day, seven days per week on the inpatient campuses of Hospital A and Hospital B, but within Hospital C, only for the East inpatient campus."

- Likewise, the minutes of the governing body must be written in such a manner so that it is clear when the governing body has taken actions that apply to a specific certified hospital.

On the other hand, the policies and procedures the governing body has adopted for the nursing service in each hospital may be identical, so long as the services operate separately. It is also permissible for the same individual to be the Director of Nursing for each hospital, provided that he or she is able to carry out all of the duties of the position in each hospital, such as managing each hospital's separate nursing staff. It is also permissible for one nurse to work at multiple hospitals within the system, in the same way that a nurse may work for multiple hospitals that do not share ownership, but the nurse must have separate work schedules for each hospital. Such schedules cannot overlap.

- Likewise, although the system may choose to operate a quality assessment/performance improvement (QAPI) program at the system level which standardizes indicators measured across system hospitals, each separately-certified hospital in the system must have a QAPI program that is specific to that hospital. This is required not only to demonstrate compliance, but also for the governing body to function effectively, since reviewing QAPI program results only at the system level would make it difficult for the governing body to identify and act upon problems that are localized to one hospital.

For example, the system may choose to use the same quality indicators or the same methodology to track adverse events across all system hospitals. But each certified hospital must have its own QAPI data with respect to these indicators and adverse events. If a system is tracking readmission rates across all of its hospitals, it must be able to separate out the hospital-specific results for the governing body's review and possible action.

The governing body must be functioning effectively and holds the ultimate responsibility for the hospital's compliance not only with the specific standards of the governing body CoP, but also with all of the CoPs. This is the case regardless of whether the regulatory text for a particular condition or standard within a condition specifically mentions responsibilities of the governing body. Substantial, i.e., condition-level, non-compliance with one of the other hospital CoPs may be an indicator that the governing body is not functioning effectively. However, it is not the policy of CMS that condition-level noncompliance with any other CoP automatically results in a condition-level citation of the governing body CoP. Surveyors must consider whether the manner and degree of the other deficiencies provide sufficient evidence to conclude that the governing body is not functioning effectively.

#### **Survey Procedures §482.12**

- Verify that the hospital has an organized governing body or has written documentation that identifies the individual or individuals that are responsible for the conduct of the hospital operations.

- If the hospital is part of a hospital system which uses one governing body for several of the hospital's separately certified within the system:
- Review the governing body minutes to determine if it is clear which actions pertain to which hospitals.
- Select for review several policy and procedure documents adopted by the system governing body to determine if it is clear that they apply to the hospital being surveyed.

# Governance Committee Item 3

## MENTAL HEALTH BOARD GOVERNANCE COMMITTEE CHARTER

Date: <b>February 2020</b>	Committee ID: <b>Milwaukee County Mental Health Board</b>
Committee Title: <b>Governance</b>	
Committee Chair: <b>Kathie Eilers</b>	
Committee Start Date: <b>March 2020</b>	End Date: <b>Ad Hoc</b>

### Business Case:

[A brief 1-3 paragraph explanation of why the committee was formed ... for what purpose, responding to what need, why is it important]

### Committee Description:

[A narrative description of what the committee does, how it will conduct its affairs, ... 1-2 paragraphs]

[Provide examples of the work performed, bulleted list]

- 

Members of the Ad Hoc Committee include the following:

#### Core Members

- Walter Lanier
- Mary Neubauer
- Maria Perez
- Duncan Shroul
- Jennifer Bergersen (Staff)

#### Ex Officio Ad-Hoc Member

- Thomas Lutzow

### Objectives:

[What will the committee try to accomplish of benefit to the organization?]

- 

### Scope:

[What are the core committee issues.]

- 

### Milestones:

[A brief topical calendar of committee products.]


Completed by: \_\_\_\_\_

Version Adoption Date:  
(Version Acceptance Date)

Version Review Date:  
(Version Reconsideration Date – Every 2 Yrs)

# Attachment A

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# Milwaukee County Behavioral Health Division



# Governance Oversight

April 7, 2020

# Systems Improvement Agreement (SIA)

- CMS has determined that BHD has been unable to achieve and sustain compliance with all CoPs
- Mental Health Board (MHB) pledges to correct deficiencies
  - Commit additional resources to achieve and sustain compliance
  - Commitment to support *sustainable* improvements to induce BHD to deliver quality care in a safe setting that meets all CoPs

# Systems Improvement Agreement

- Engage expert consultants
- Typical term: 12-18 months
- CMS rescinds termination
- CMS will closely monitor in the interim
- Other specific conditions
- Looking for progress towards achieving full compliance
- CMS retains its survey certification and enforcement authority
- CMS reserves the right to reissue termination

# Mental Health Board

- Scope
  - Inpatient psychiatric hospital
  - Community Access to Recovery Services (CARS)
  - Wraparound Milwaukee
- Pro:
  - Provides MHB with view of entire continuum of mental health services
  - Enhances Board's effectiveness
- Con:
  - Limits amount of time dedicated to inpatient care

# SIA Gap Analysis - Governance

- Quality Assessment and Performance Improvement (QAPI)
  - Limited quality information submitted to MHB
  - MHB has not established expectations
  - Quality Committee only meets quarterly
  - Oversight of contracted services
- Quality Committee

# Mental Health Board

- Chapter 51, Section 41 of the Wisconsin State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act
- Duties and function
  - Oversee the provision of mental health programs and services
  - Allocate moneys for mental health functions, programs, and services
  - Make the final determination on mental health policy

# Mental Health Board

- Duties and function - continued
  - Replace the Board of Supervisors in all mental health functions
  - Facilitate delivery of mental health services in an efficient and effective manner
  - Cooperate and consult with the Department on recommendations for and establishing policy

# Mental Health Board

- Approval of BHD Administrator
- Approve any contract  $\geq$  \$100,000
- Board of Supervisors has no jurisdiction over any mental health policy, functions, programs, or services
- Propose total amount of the mental health budget, community aids amount, and tax levy amount to the County Executive

# Quality Oversight

- Assess the quality of care and implementation of any necessary changes
- Quality Committee reports results of their analysis and any recommendations to the full Mental Health Board
- Meets quarterly

# Challenges

- Open public meetings
- Hinders ability to openly discuss quality of care issues and concerns

# Mental Health Board

- Role and responsibility
- Fulfilling these duties

## §482.12 Condition of Participation: Governing Body

- There must be an effective governing body that is legally responsible for the conduct of the hospital

# Governing Body

- Steward of the organization's culture
- Ultimately responsible for the quality of care provided, patient safety, and legal and regulatory compliance
- Appoint CEO
- Oversight of
  - Medical Staff
  - Care of patients
  - Institutional plan and budget
  - Contracted services
  - Emergency services

# The Duty of Care

- Obligation to act in good faith
  - Decisions should be well informed, rational and made independently
- Reliance on information received from management must be well-placed
  - Does an adequate information and reporting system exist?
  - Reasonable inquiry

# Oversight of Quality and Patient Safety

- Ensure that you are adequately informed
- May rely on data and other information provided by management and advice from outside professionals
- If not satisfied with responses, continue to press for information until concerns have been addressed
- Always be able to convey to stakeholders the processes the Governing Body has established for ensuring that it receives the requisite information

# Oversight of Quality and Patient Safety

- Basic obligation to guide and support executive leadership is an ongoing task
- Increasingly expected to assess organizational performance on emerging quality of care concepts and arrangements
- All components of the oversight function

# Best Governance Practices

- Ensure that the Governing Body has ongoing access to the requisite expertise
- Form standing board committee that focuses on quality of care, patient safety and performance improvement
- Establish goals and identify appropriate metrics to assess performance

# Best Governance Practices

- Develop a dashboard and performance scorecards to facilitate monitoring and oversight
  - Data should be presented clearly; avoid jargon and “advocacy”
- Consider both institution-specific information and relevant comparative benchmarks
  - Patient/physician satisfaction surveys
  - Leapfrog; Joint Commission

# Best Governance Practices

- Include quality, safety and performance improvement as relevant factors in employee evaluations
- Address quality, safety and performance improvement during every Governing Body meeting; the Chair of the Committee should provide a comprehensive report

# Best Governance Practices

- Agenda topics to consider:
  - Falls
  - Use of restraints
  - Hospital-acquired infections
  - Medication errors
  - Missed diagnoses
  - Unanticipated adverse outcomes

# Best Governance Practices

- Responsibility to ensure that thorough and credible root cause analyses are performed, as warranted
- Appropriate remedial measures are promptly developed, effectively implemented and carefully monitored
- Oversight of Medical Staff credentialing and the Peer Review process

# Oversight of Quality of Care and Patient Safety

- Lines of inquiry to consider
  - *What are the goals of our quality improvement program?*
  - *What metrics and benchmarks are used to measure performance and assess progress?*
  - *Are we periodically reevaluating and, as warranted, revising them based on comparative information from other institutions and professionals?*
  - *How are management and staff held accountable?*

## Lines of Inquiry - continued

- *Have we adopted and effectively communicated appropriate policies and procedures?*
- *Are we enforcing them consistently?*
- *Are they being reviewed and revised periodically?*
- *Have we developed effective training programs?*

## Lines of Inquiry - continued

- *How are we evaluating their effectiveness?*
- *Are our quality of care, patient safety and performance improvement processes fully coordinated with our compliance program?*
- *How are quality of care and patient safety issues addressed in our risk assessment and corrective action processes?*

## Lines of Inquiry - continued

- *What processes have we developed to promote the reporting of quality of care and patient safety concerns; to protect those who comply with our duty to report; and to ensure that all relevant information is timely presented to the Governing Body?*
- *Have we established, and are we promoting, an optimal institutional culture?*

## Lines of Inquiry - continued

- *How are adverse patient events and other medical errors identified, analyzed and reported? Are we receiving sufficient information regarding significant adverse events? Do they inform our performance improvement activities?*
- *Are our staff fully supported?*
- *Are the key functions adequately resourced with respect to both personnel and technology?*

# Lines of Inquiry - continued

- *How do we interact with patients and their families?*

# Operational Governance Suggestions

- Meeting materials should:
  - Include:
    - Draft meeting minutes and proposed resolutions;
    - An Executive Summary;
    - Relevant background information; and
    - Dashboards, scorecards and analyses of relevant data
- Be circulated 3 to 5 days in advance to ensure that Governing Body members have sufficient time to review them

# Operational Governance Suggestions

- Meetings
  - Agendas should be developed thoughtfully with realistic time estimates
  - Chair should lead; ensure that all members and guests have an opportunity to express their views concisely, without dominating the discussion
  - Presenters should frame the discussion conceptually or thematically, not get lost in data and resist the temptation to read PowerPoint slides

# Operational Governance Suggestions

- Governing Body members should:
  - Review meeting materials carefully;
  - Prioritize meeting attendance;
  - Ask questions;
  - Not dominate a discussion;
  - Be respectful of the views of others;
  - Treat as confidential all materials, discussions and votes; and
  - Support the Governing Body's decisions

## Contact Information

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[www.kraskerhc.com](http://www.kraskerhc.com)

**Chairperson:** Maria Perez  
**Senior Executive Assistant:** Jodi Mapp, 257-5202

**CANCELLED**

**MILWAUKEE COUNTY MENTAL HEALTH BOARD  
FINANCE COMMITTEE**

Thursday, March 26, 2020 - 1:30 P.M.  
Mental Health Complex  
9455 West Watertown Plank Road  
Conference Room 1045

**A G E N D A**

**SCHEDULED ITEMS:**

1.	Welcome. <b>(Chairwoman Perez)</b>
2.	2019 Year-End Financial Reporting Package and Dashboard. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
3.	Quarterly Reserve Fund Update. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
4.	Quarterly Fund Transfers Update. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
5.	Fiscal Impact of the Systems Improvement Agreement and Capital Cost Report. <b>(Matt Fortman and Jennifer Bergersen, Behavioral Health Division/Informational)</b>
6.	2020 Wraparound Milwaukee Future Fiscal Forecast and Expectations. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
7.	Wraparound Milwaukee Audit Report. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
8.	2021 Preliminary Behavioral Health Division Budget Assumptions. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
9.	2021 Budget Timeline. <b>(Matt Fortman, Behavioral Health Division/Informational)</b>
10.	Wisconsin Medicaid Cost Reporting (WIMCR). <b>(Matt Fortman, Behavioral Health Division/Informational)</b>

**SCHEDULED ITEMS (CONTINUED):**

11.	Adjournment.
<p style="text-align: center;"><b>The next meeting of the Milwaukee County Mental Health Board Finance Committee is TENTATIVELY Scheduled for Thursday, April 23, 2020, at 8:00 a.m.</b></p> <p style="text-align: center;"><b>Visit the Milwaukee County Mental Health Board Web Page at:</b></p> <p style="text-align: center;"><b><a href="https://county.milwaukee.gov/EN/DHHS/About/Governance">https://county.milwaukee.gov/EN/DHHS/About/Governance</a></b></p>	
<p style="text-align: center;"><i>ADA accommodation requests should be filed with the Milwaukee County Office for Persons with Disabilities, 278-3932 (voice) or 711 (TRS), upon receipt of this notice.</i></p>	

# Finance Committee Item 2

	2019 Budget				2019 Annual Projection				2019 Projected Surplus/(Deficit)			
	Hospital	Community Services	Mgmt/ Ops/Fiscal	Total BHD	Hospital	Community Services	Mgmt/ Ops/Fiscal	Total BHD	Hospital	Community Services	Mgmt/ Ops/Fiscal	Total BHD
<b>Revenue</b>												
BCA	7,700,026	14,636,560	-	22,336,586	7,700,026	14,636,559	-	22,336,585	-	(1)	-	(1)
State & Federal	-	21,373,198	-	21,373,198	-	21,768,011	-	21,768,011	-	394,813	-	394,813
Patient Revenue	18,024,127	95,918,263	50,000	113,992,390	18,805,246	90,221,214	66,981	109,093,440	781,119	(5,697,049)	16,981	(4,898,950)
Other	-	1,778,578	252,997	2,031,575	85,267	1,597,964	210,197	1,893,428	85,267	(180,614)	(42,800)	(138,147)
Sub-Total Revenue	25,724,153	133,706,599	302,997	159,733,749	26,590,539	128,223,748	277,178	155,091,465	866,386	(5,482,851)	(25,819)	(4,642,284)
<b>Expense</b>												
Salary	15,687,788	10,114,724	7,123,421	32,925,933	15,100,840	8,516,959	6,793,915	30,411,713	586,948	1,597,765	329,506	2,514,220
Overtime	477,048	3,144	137,808	618,000	2,418,860	174,881	232,141	2,825,882	(1,941,812)	(171,737)	(94,333)	(2,207,882)
Fringe	16,248,071	9,566,452	6,797,893	32,612,415	15,756,875	8,596,938	7,654,689	32,008,503	491,196	969,513	(856,796)	603,912
Services/Commodities	3,235,560	1,551,508	8,851,474	13,638,542	3,287,318	1,379,314	7,630,451	12,297,082	(51,758)	172,195	1,221,023	1,341,460
Other Charges/Vendor	2,500,000	130,313,720	-	132,813,720	3,530,435	128,070,964	(0)	131,601,399	(1,030,435)	2,242,756	0	1,212,321
Capital	-	1,069	200,000	201,069	-	2,004	59,422	61,426	-	(935)	140,578	139,643
Cross Charges	16,492,614	18,269,358	7,250,060	42,012,032	13,701,124	17,193,201	6,916,485	37,810,810	2,791,490	1,076,158	333,575	4,201,222
Abatements	-	(6,347,467)	(32,769,727)	(39,117,194)	-	(5,739,347)	(29,009,206)	(34,748,553)	-	(608,120)	(3,760,521)	(4,368,641)
Total Expense	54,641,081	163,472,508	(2,409,071)	215,704,517	53,795,453	158,194,913	277,896	212,268,262	845,628	5,277,594	(2,686,968)	3,436,255
<b>Tax Levy</b>	28,916,928	29,765,909	(2,712,068)	55,970,768	27,204,914	29,971,166	718	57,176,798	1,712,014	(205,257)	(2,712,786)	(1,206,029)

Hospital includes Adult Inpatient, Child and Adolescent Inpatient and Crisis ER/Observation.

Mgmt/Ops/Fiscal includes administrative functions includes all support functions such as: management, quality, contracts, legal, dietary, fiscal, admissions, medical records and facilities.  
 The projected cost of these functions which is allocated out to the BHD programs is: \$ 29,009,206

Community includes Wraparound, AODA and Community Mental Health.

Community Mental Health includes major programs: TCM, CCS, CSP and CRS in addition to CBRF, CCC, IOP, Day Treatment, Community Administrative functions and Community Crisis programs including Mobile Teams, Access Clinic and contracted crisis services.

there are budget changes to CARS/AODA/Wrap that must be updated

	2019 Budget				2019 Annual Projection				2019 Projected Surplus/(Deficit)			
	AODA	Mental Health	WRAP	Total CARSD	AODA	Mental Health	WRAP	Total CARSD	AODA	Mental Health	WRAP	Total CARSD
<b>Revenue</b>												
BCA	2,333,731	12,302,829	-	14,636,560	3,759,368	10,877,191	-	14,636,559	1,425,637	(1,425,638)	-	(1)
State & Federal	10,366,899	9,245,839	1,760,460	21,373,198	10,703,450	9,083,324	1,981,238	21,768,011	336,551	(162,515)	220,778	394,813
Patient Revenue	-	37,980,835	57,937,428	95,918,263	0	35,748,802	54,472,411	90,221,214	-	(2,232,033)	(3,465,017)	(5,697,049)
Other	550,000	1,138,578	90,000	1,778,578	519,459	838,778	239,727	1,597,964	(30,541)	(299,800)	149,727	(180,614)
Sub-Total Revenue	13,250,630	60,668,081	59,787,888	133,706,599	14,982,277	56,548,095	56,693,376	128,223,748	1,731,647	(4,119,986)	(3,094,512)	(5,482,851)
<b>Expense</b>												
Salary	94,575	6,659,680	3,360,469	10,114,724	71,009	5,726,862	2,719,087	8,516,959	23,566	932,818	641,382	1,597,765
Overtime	-	-	3,144	3,144	0	142,925	31,956	174,881	-	(142,925)	(28,812)	(171,737)
Fringe	91,614	6,561,074	2,913,763	9,566,452	79,311	5,881,041	2,636,586	8,596,938	12,303	680,034	277,177	969,513
Services/Commodities	326,019	994,892	230,597	1,551,508	38,346	578,483	762,484	1,379,314	287,673	416,409	(531,887)	172,195
Other Charges/Vendor	15,458,593	62,000,174	52,854,953	130,313,720	14,665,809	62,250,337	51,154,819	128,070,964	792,784	(250,163)	1,700,134	2,242,756
Capital	-	-	1,069	1,069	0	-	2,004	2,004	-	-	(935)	(935)
Cross Charges	1,352,413	10,637,606	6,279,339	18,269,358	1,041,586	9,991,279	6,160,335	17,193,201	310,827	646,327	119,004	1,076,158
Abatements	-	-	(6,347,467)	(6,347,467)	-	-	(5,739,347)	(5,739,347)	-	-	(608,120)	(608,120)
Total Expense	17,323,214	86,853,426	59,295,867	163,472,508	15,896,062	84,570,927	57,727,924	158,194,913	1,427,152	2,282,499	1,567,943	5,277,594
<b>Tax Levy</b>	4,072,584	26,185,345	(492,021)	29,765,909	913,785	28,022,832	1,034,548	29,971,166	3,158,799	(1,837,487)	(1,526,569)	(205,257)

Community Mental Health includes the following major programs: TCM, CCS, CSP and CRS in addition to CBRF, CCC, IOP, Day Treatment, Community Administrative functions,

Behavioral Health Division

Inpatient - Hospital

Year End 2019 - 2019 Annual Projection

	2019 Budget				2019 Annual Projection				2019 Projected Surplus/(Deficit)			
	Adult	CAIS	Crisis ER/Obs	Total Inpatient	Adult	CAIS	Crisis ER/Obs	Total Inpatient	Adult	CAIS	Crisis ER/Obs	Total Inpatient
<b>Revenue</b>												
BCA	-	-	7,700,026	7,700,026	-	-	7,700,026	7,700,026	-	-	-	-
State & Federal	-	-	-	-	-	-	-	-	-	-	-	-
Patient Revenue	12,744,737	3,743,875	1,535,515	18,024,127	13,873,171	3,530,831	1,401,243	18,805,246	1,128,434	(213,044)	(134,272)	781,119
Other	-	-	-	-	-	85,267	-	85,267	-	85,267	-	85,267
Sub-Total Revenue	12,744,737	3,743,875	9,235,541	25,724,153	13,873,171	3,616,098	9,101,269	26,590,539	1,128,434	(127,777)	(134,272)	866,386
<b>Expense</b>												
Salary	7,682,112	2,094,748	5,910,928	15,687,788	7,142,530	1,897,749	6,060,560	15,100,840	539,582	196,999	(149,632)	586,948
Overtime	255,480	41,544	180,024	477,048	1,332,923	120,834	965,103	2,418,860	(1,077,443)	(79,290)	(785,079)	(1,941,812)
Fringe	8,316,545	2,321,301	5,610,225	16,248,071	7,847,776	2,141,315	5,767,784	15,756,875	468,769	179,986	(157,559)	491,196
Services/Commodities	2,461,140	260,743	513,677	3,235,560	2,535,797	260,555	490,967	3,287,318	(74,657)	188	22,710	(51,758)
Other Charges/Vendor	2,500,000	-	-	2,500,000	3,530,435	-	-	3,530,435	(1,030,435)	-	-	(1,030,435)
Capital	-	-	-	-	-	-	-	-	-	-	-	-
Cross Charges	8,231,066	2,726,474	5,535,074	16,492,614	7,234,327	2,325,408	4,141,389	13,701,124	996,739	401,066	1,393,685	2,791,490
Abatements	-	-	-	-	-	-	-	-	-	-	-	-
Total Expense	29,446,343	7,444,810	17,749,928	54,641,081	29,623,788	6,745,861	17,425,804	53,795,453	(177,445)	698,949	324,124	845,628
<b>Tax Levy</b>	16,701,606	3,700,935	8,514,387	28,916,928	15,750,617	3,129,762	8,324,535	27,204,914	950,989	571,172	189,853	1,712,014

Behavioral Health Division

Management/Operations/Fiscal

Year End 2019 - 2019 Annual Projection

	2019 Budget	2019 Annual Projection	2019 Projected Surplus/(Deficit)
<b>Revenue</b>			
BCA	-	-	-
State & Federal	-	-	-
Patient Revenue	50,000	66,981	16,981
Other	252,997	210,197	(42,800)
Sub-Total Revenue	302,997	277,178	(25,819)
<b>Expense</b>			
Salary	7,123,421	6,793,915	329,506
Overtime	137,808	232,141	(94,333)
Fringe	6,797,893	7,654,689	(856,796)
Services/Commodities	8,851,474	7,630,451	1,221,023
Other Charges/Vendor	-	(0)	0
Capital	200,000	59,422	140,578
Cross Charges	7,250,060	6,916,485	333,575
Abatements	(32,769,727)	(29,009,206)	(3,760,521)
Total Expense	(2,409,071)	277,896	(2,686,968)
<b>Tax Levy</b>	<b>(2,712,068)</b>	<b>718</b>	<b>(2,712,786)</b>

County targeted reduction of BHD levy

BEHAVIORAL HEALTH DIVISION

DASHBOARD REPORT

Year End 2019

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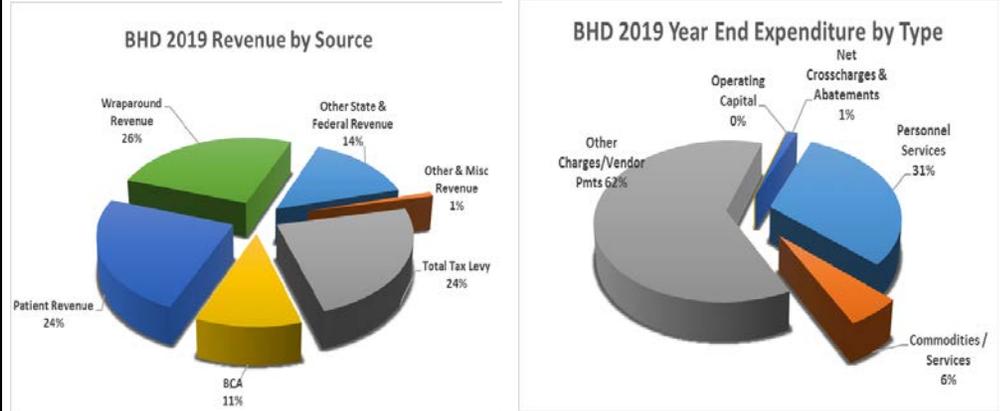
<b>PAGE 2</b>	<b>Table of Contents</b>
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# BHD COMBINED DASHBOARD

Year End 2019

	Actual Dec YTD	2019 Annual Projection		
		Projection	Budget	Variance
<b>Revenue</b>	155,091,465	155,091,465	159,733,749	(4,642,284)
<b>Expense</b>				
Personnel	65,246,098	65,246,098	66,156,348	910,250
Svcs/Commodities	12,297,082	12,297,082	13,638,542	1,341,460
Other Chgs/Vendor	131,601,399	131,601,399	132,813,720	1,212,321
Capital	61,426	61,426	201,069	139,643
Cross Charges	37,810,810	37,810,810	42,012,032	4,201,222
Abatements	(34,748,553)	(34,748,553)	(39,117,194)	(4,368,641)
<b>Total Expense</b>	212,268,262	212,268,262	215,704,517	3,436,255
Tax Levy	57,176,797	57,176,797	55,970,768	(1,206,029)

## 2019 Year End Revenues & Expenses by Percentage



Note: "Other Charges" in Expenditures include all Provider Payments - Fee For Service, Purchase of Service and other contracted services.

## Financial Highlights

- Inpatient revenue surplus (\$0.7m) due to higher proportion of T19 HMO clients
- State Institutions (\$1.2m) deficit
- CCS (youth & adult) deficit (\$1.4m) due to lag in claims payments & WIMCR withholding
- AODA surplus (\$1.7m) due to RSC model change and increased grant revenue
- TCM surplus due to lower claims volume and increased WIMCR payment (\$0.8m)
- Structural deficit due to expenditure reduction (\$2.0m)

## 2019 Budget Initiatives

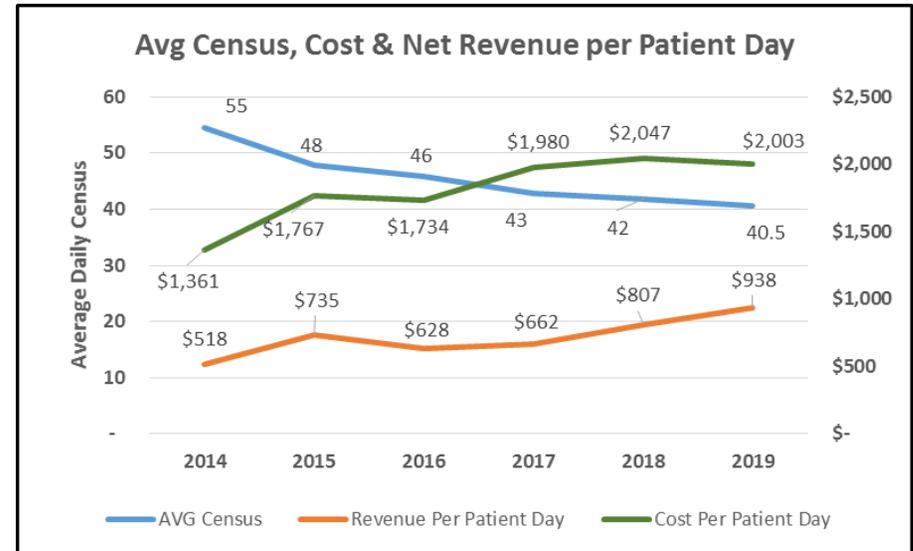
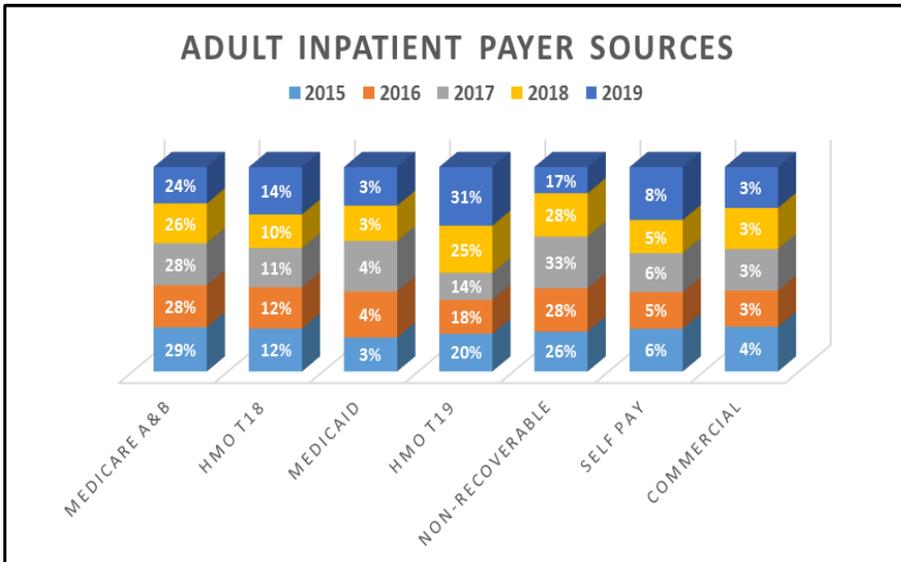
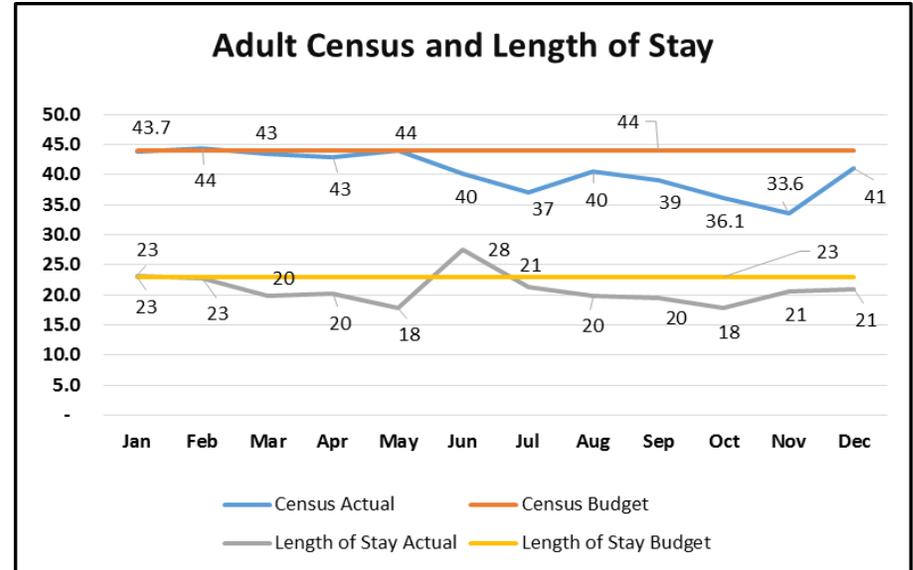
Initiative	Status	Description
FQHC Partnership	➡	In progress
CCS Expansion	⬆	Enrollment increase on track
Outpatient Plus	➡	Anticipated go-live early 2020
RSC Cost Increase	➡	Anticipating surplus due to adjusted reimbursement model

Complete	⬆	Not Done	⬇	Progressing	➡
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# ACUTE ADULT INPATIENT DASHBOARD

Year End 2019

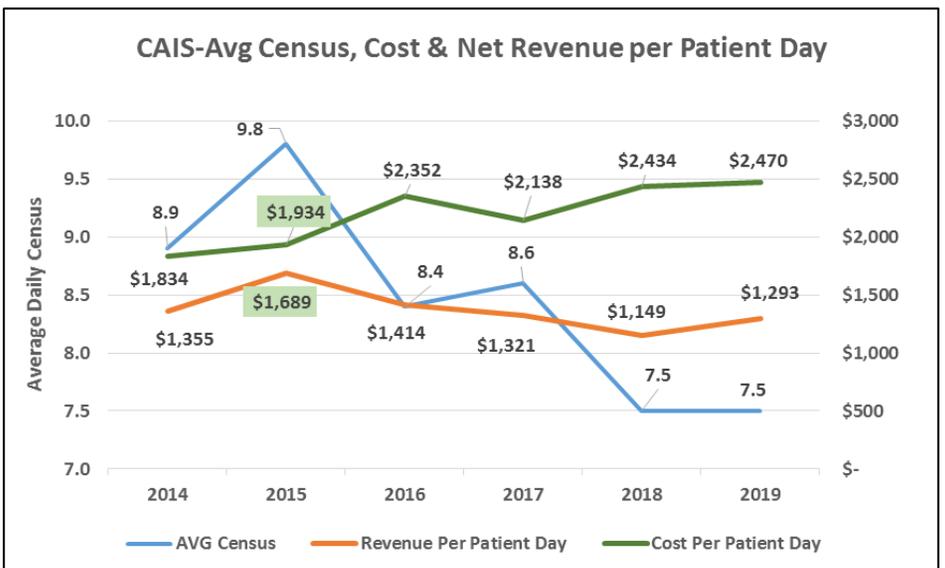
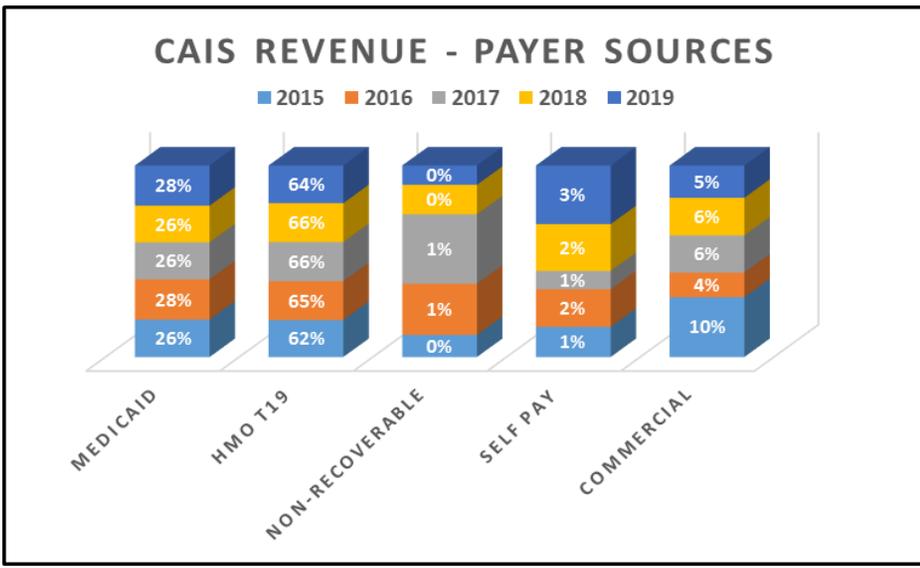
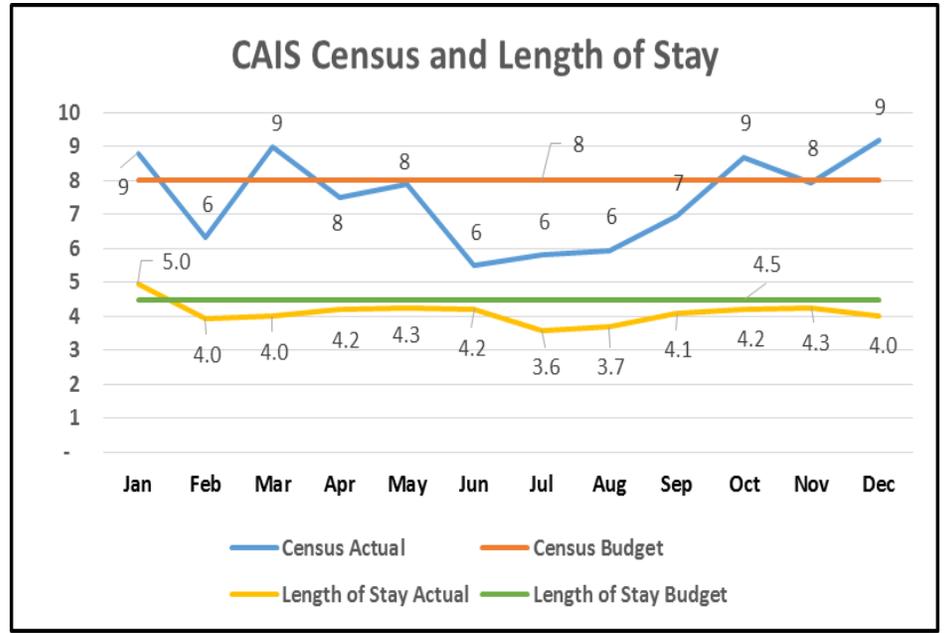
	Actual Dec YTD	2019 Annual Projection		
		Projection	Budget	Variance
<b>Revenue</b>	13,873,171	13,873,171	12,744,737	1,128,434
<b>Expense</b>				
Personnel	16,323,230	16,323,230	16,254,137	(69,093)
Svcs/Commodities	2,535,797	2,535,797	2,461,140	(74,657)
Other Chgs/Vendor	3,530,435	3,530,435	2,500,000	(1,030,435)
Capital	-	-	-	-
Cross Charges	7,234,327	7,234,327	8,231,066	996,739
Abatements	-	-	-	-
<b>Total Expense</b>	29,623,789	29,623,789	29,446,343	(177,446)
Tax Levy	15,750,618	15,750,618	16,701,606	950,988



# CAIS (Child & Adolescent Inpatient) DASHBOARD

Year End 2019

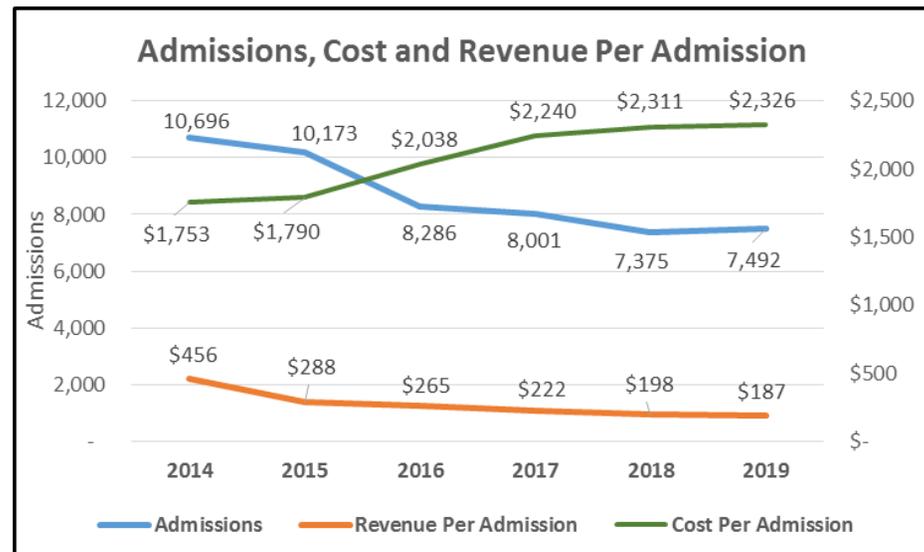
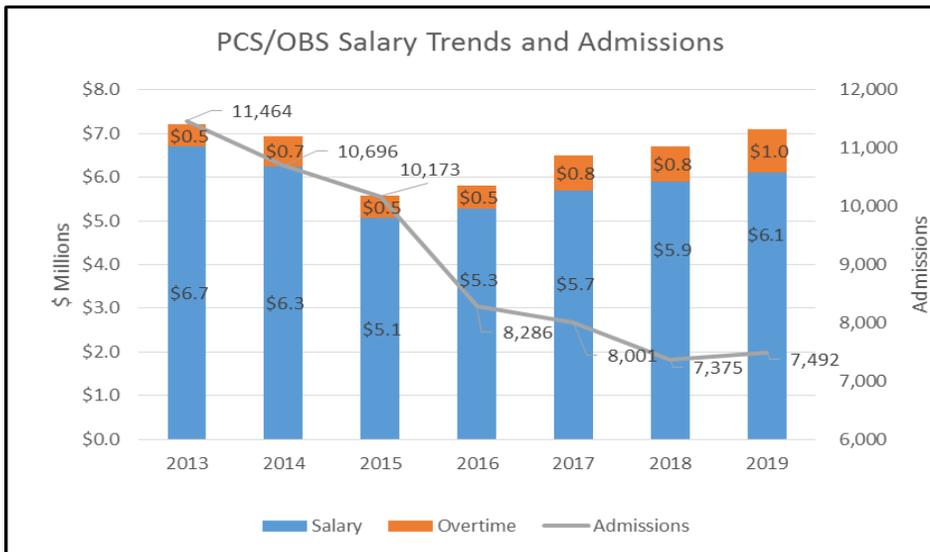
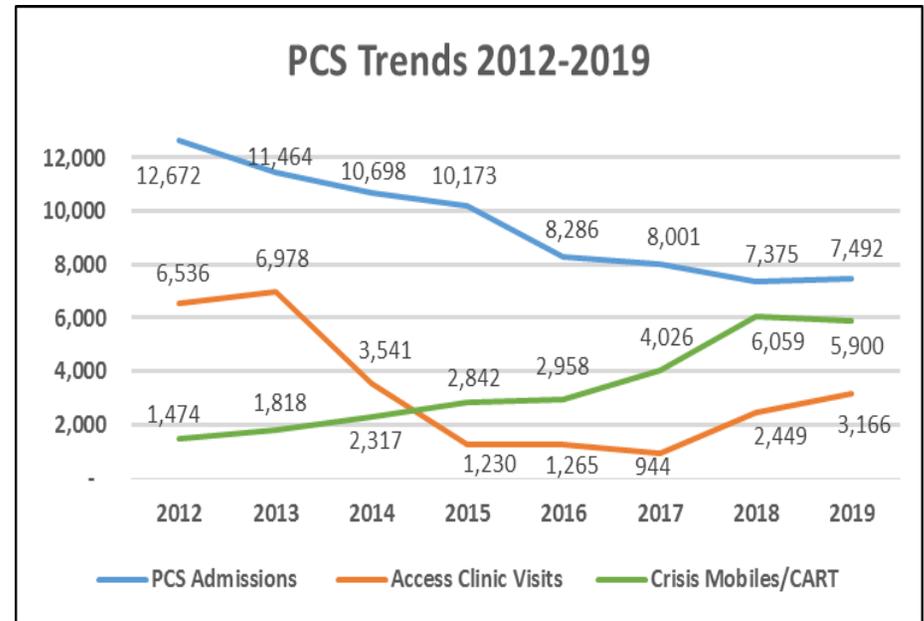
	Actual Dec YTD	2019 Annual Projection		
		Projection	Budget	Variance
<b>Revenue</b>	3,616,098	3,616,098	3,743,875	(127,777)
<b>Expense</b>				
Personnel	4,159,898	4,159,898	4,457,593	297,695
Svcs/Commodities	260,555	260,555	260,743	188
Other Chgs/Vendor	-	-	-	-
Capital	-	-	-	-
Cross Charges	2,325,408	2,325,408	2,726,474	401,066
Abatements	-	-	-	-
<b>Total Expense</b>	6,745,861	6,745,861	7,444,810	698,949
Tax Levy	3,129,763	3,129,763	3,700,935	571,172



# PCS - ER and Observation DASHBOARD

Year End 2019

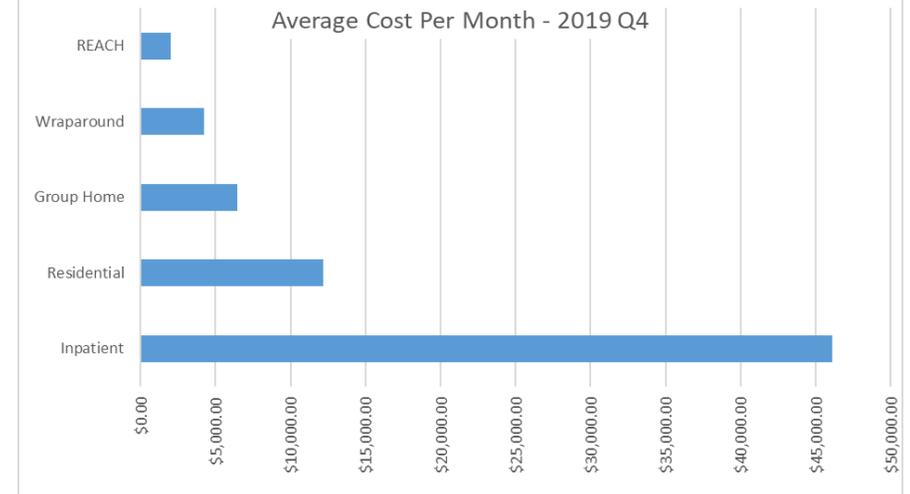
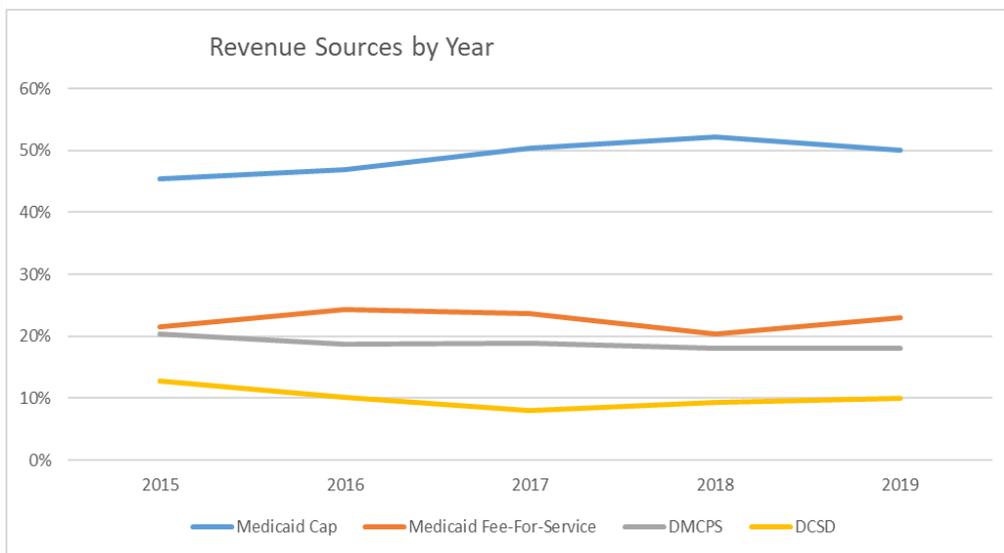
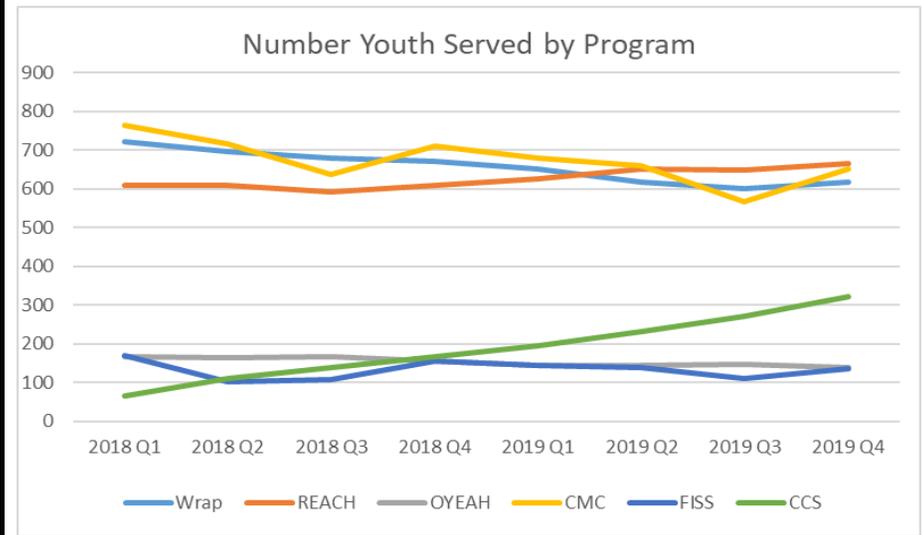
	Actual Dec	2019 Annual Projection		
	YTD	Projection	Budget	Variance
<b>Revenue</b>	9,101,269	9,101,269	9,235,541	(134,272)
<b>Expense</b>				
Personnel	12,793,448	12,793,448	11,701,177	(1,092,271)
Svcs/Commodities	490,967	490,967	513,677	22,710
Other Chgs/Vendor	-	-	-	-
Capital	-	-	-	-
Cross Charges	4,141,389	4,141,389	5,535,074	1,393,685
Abatements	-	-	-	-
<b>Total Expense</b>	17,425,804	17,425,804	17,749,928	324,124
Tax Levy	8,324,535	8,324,535	8,514,387	189,852



## WRAPAROUND DASHBOARD Year End 2019

	Actual Dec YTD	2019 Annual Projection		
		Projection	Budget	Variance
<b>Revenue</b>	56,693,376	56,693,376	59,787,888	(3,094,512)
<b>Expense</b>				
Personnel	5,387,629	5,387,629	6,277,376	889,747
Svcs/Commodities	762,484	762,484	230,597	(531,887)
Other Chgs/Vendor	51,154,819	51,154,819	52,854,953	1,700,134
Capital	2,004	2,004	1,069	(935)
Cross Charges	6,160,335	6,160,335	6,279,339	119,004
Abatements	(5,739,347)	(5,739,347)	(6,347,467)	(608,120)
<b>Total Expense</b>	57,727,924	57,727,924	59,295,867	1,567,943
Tax Levy	1,034,548	1,034,548	(492,021)	(1,526,569)

Wraparound will contribute approximately \$263,742 to their reserve of capitated funds; the remainder of the program is experiencing a deficit, primarily driven by a lag in CCS claim payments



\*\*\* Inpatient services are clients in CAIS

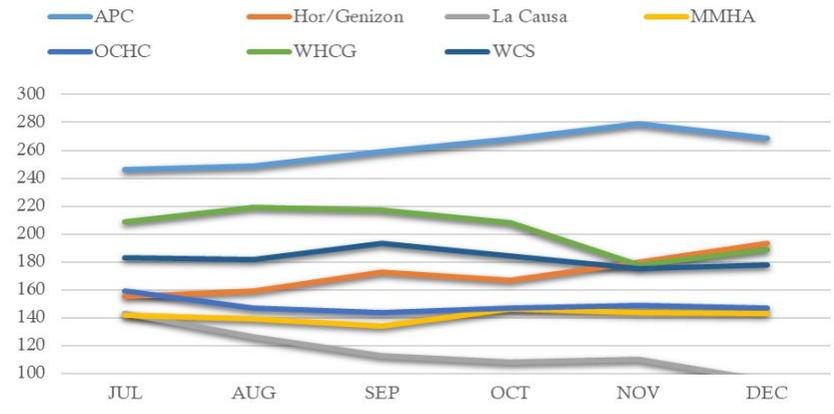
\*\*\* Wraparound and REACH services are outpatient services

## TCM (Targeted Case Management) DASHBOARD Year End 2019

	2019 Annual Projection			
	Actual Dec YTD	Projection	Budget	
<b>Revenue</b>	3,640,161	3,640,161	3,553,778	86,383
<b>Expense</b>				
Personnel	253,045	253,045	242,712	(10,333)
Svcs/Commodities	-	-	6,659	6,659
Other Chgs/Vendor	5,856,391	5,856,391	6,452,933	596,542
Capital	-	-	-	-
Cross Charges	452,206	452,206	606,194	153,988
Abatements	-	-	-	-
<b>Total Expense</b>	6,561,642	6,561,642	7,308,498	746,856
<b>Tax Levy</b>	2,921,481	2,921,481	3,754,720	833,239

Average Enrollment                      1,254                      1,254                      1,610

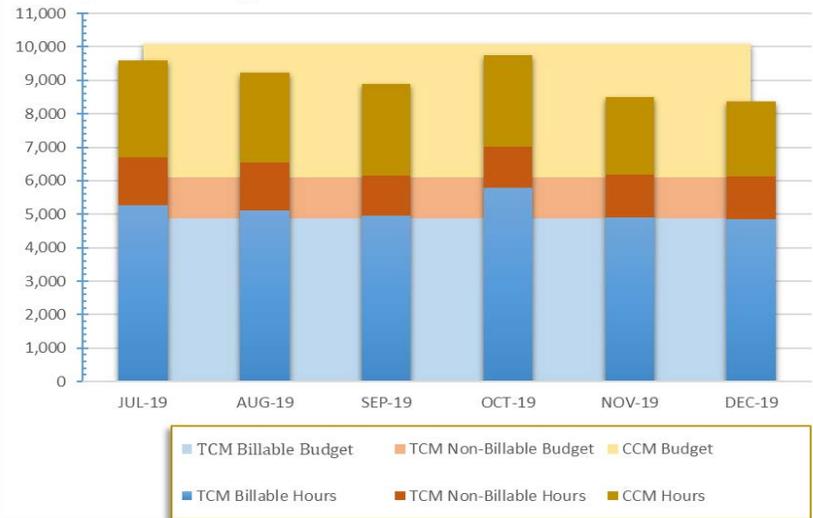
### TCM Distinct Clients by Provider



	2019 Q4			2019 YTD		
	Billable	Non-billable	% Non-billable	Billable	Non-billable	% Non-billable
APC	15,717	5,243	25%	58,077	20,909	26%
Horizon	10,925	1,999	15%	35,509	8,062	19%
La Causa	4,394	964	18%	26,255	5,468	17%
MMHA	7,714	3,256	30%	30,350	12,033	28%
OCHC	6,000	598	9%	28,933	3,120	10%
Whole Health	9,377	702	7%	38,374	5,752	13%
WCS	7,987	2,484	24%	34,000	11,503	25%
<b>Total</b>	<b>62,113</b>	<b>15,246</b>	<b>20%</b>	<b>251,498</b>	<b>66,846</b>	<b>21%</b>

\*\*\* Non-billable services are paid to Providers, but not billable to Medicaid

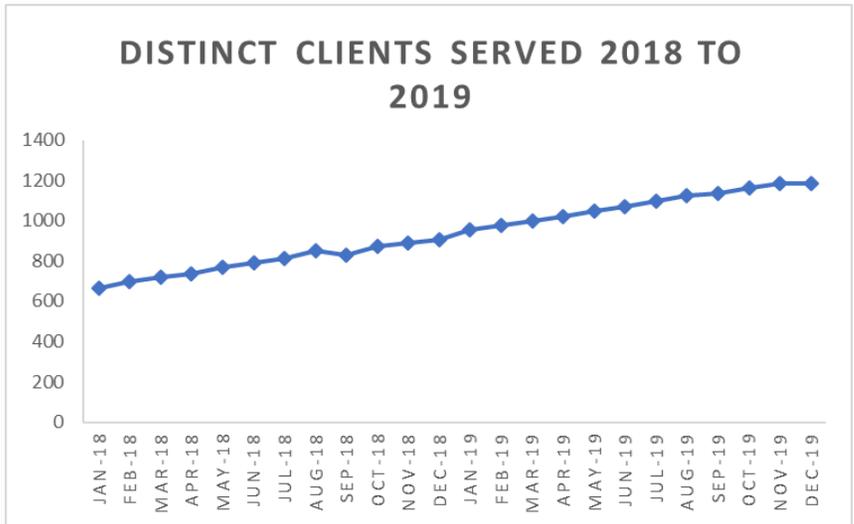
### Total TCM and CCM HOURS Compared Budget over Time



# CCS (Comprehensive Community Services) DASHBOARD

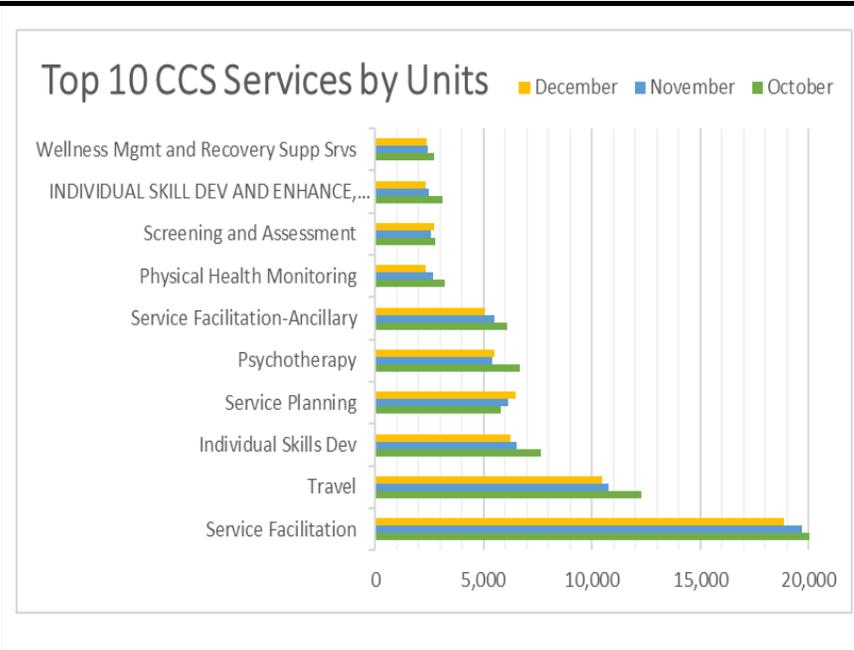
Year End 2019

	Actual Dec YTD	2019 Annual Projection		
		Projection	Budget	Variance
<b>Revenue</b>	20,070,811	20,070,811	21,079,424	(1,008,613)
<b>Expense</b>				
Personnel	722,166	722,166	765,424	43,258
Svcs/Commodities	1,378	1,378	-	(1,378)
Other Chgs/Vendor	20,837,142	20,837,142	20,611,049	(226,093)
Capital	-	-	-	-
Cross Charges	1,482,193	1,482,193	1,740,491	258,298
Abatements	-	-	-	-
<b>Total Expense</b>	23,042,879	23,042,879	23,116,964	74,085
Tax Levy	2,972,068	2,972,068	2,037,540	(934,528)
<b>Average Enrollment</b>	1,079	1,079	1,100	



### Number of Billable to Nonbillable Units - Top 10 Providers

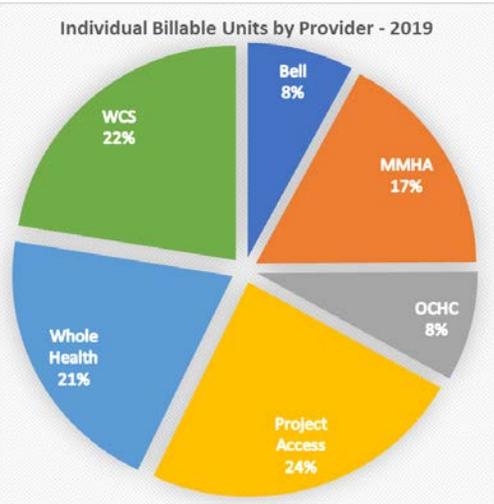
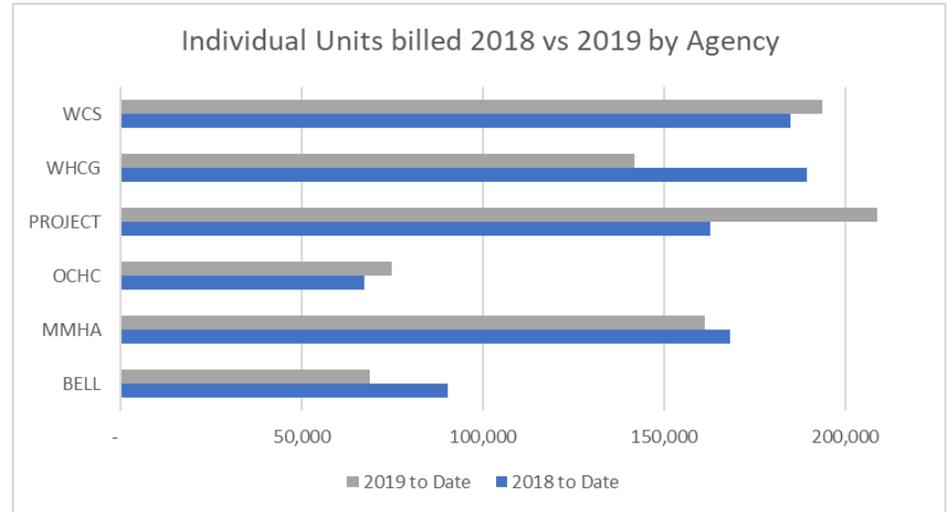
	2019 Q4 Totals			2019 YE Totals		
	Billable	Non-Billable	% Non-Billable	Billable	Non-Billable	% Non-Billable
WHCG	23,406	319	1.4%	96,189	1189	1.2%
APC	24,454	372	1.5%	94,130	1713	1.8%
Guest House	19,801	82	0.4%	88,058	748	0.8%
JusticePoint	19,974	288	1.4%	85,686	1142	1.3%
Bell Therapy	14,140	169	1.2%	55,990	470	0.8%
Summit	13,420		0.0%	52,469		0.0%
Project	16,597	292	1.8%	45,578	1079	2.4%
OCHC	9,361	156	1.7%	34,517	558	1.6%
WCS	12,273	563	4.6%	31,158	869	2.8%
MMHA	9,988		0.0%	31,045	190	0.6%



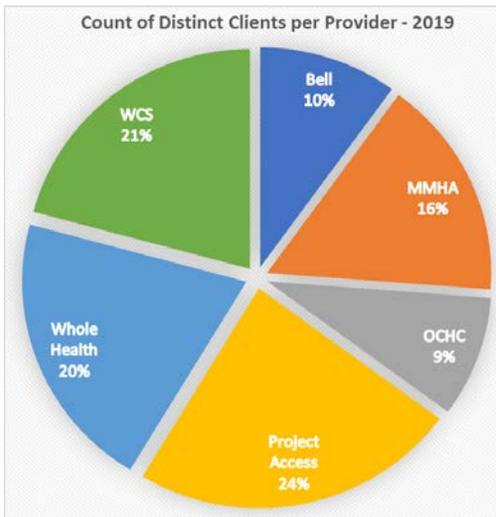
## CSP (Community Support Program) DASHBOARD Year End 2019

	Actual Dec YTD	2019 Annual Projection		
		Projection	Budget	Variance
<b>Revenue</b>	8,033,566	8,033,566	9,095,234	(1,061,668)
<b>Expense</b>				
Personnel	298,694	298,694	296,139	(2,555)
Svcs/Commodities	1,339	1,339	-	(1,339)
Other Chgs/Vendor	14,491,220	14,491,220	14,966,091	474,871
Capital	-	-	-	-
Cross Charges	1,179,889	1,179,889	1,316,108	136,219
Abatements	-	-	-	-
<b>Total Expense</b>	15,971,142	15,971,142	16,578,338	607,196
Tax Levy	7,937,576	7,937,576	7,483,104	(454,472)

Average Enrollment	1,289	1,289	1,267
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Agency	December	YTD Total
Bell	5,521	68,661
MMHA	12,169	160,971
OCHC	5,803	74,832
Project Access	19,760	208,650
Whole Health	10,234	141,682
WCS	15,887	193,589
<b>Grand Total</b>	<b>69,374</b>	<b>848,385</b>



Agency	December	YTD Ave per Month
Bell	135	135
MMHA	219	215
OCHC	114	118
Project Access	305	299
Whole Health	235	250
WCS	266	273
<b>Grand Total</b>	<b>1,274</b>	<b>1,289</b>

# Finance Committee Item 3

## 2019 Projected BHD Reserve Balances

	Year End 12/31/2017	2018 Contribution	2018 Balance	2019 Contribution	2019 Balance (Pro.)
0085 Encumbrance Reser	91,901	1,31,256	2,649,220	-	2,649,220
0904 Wrap Reserve	8,288,238	803,515	9,091,752	263,442	9,355,495
0906 Capital Reserve	4,20,000	434,333	5,154,333	-	5,154,333
0905 Surplus Reserve	21,285,469	-	21,285,469	(1,90,311)	19,495,158
<b>Total Reserves</b>	<b>35,211,608</b>	<b>2,969,504</b>	<b>38,181,182</b>	<b>(1,526,569)</b>	<b>36,654,613</b>

## Reserve Commitments

	Surplus Reserve	Capital Reserve
<b>Committed</b>		
Employment Initiative	\$ 75,000	
CART Annual Expense	\$ 300,000	
Board Analyst Annual Expense	\$ 100,000	
SIA Consultants	\$ 1,500,000	
SIA Captial Improvements		\$ 3,000,000
<b>Future Commitments</b>		
Retention / Severance Payments	\$ 5,100,000	
Relocation Costs	\$ 4,700,000	
2020 Expenditure Reduction	\$ 2,000,000	
<b>Total</b>	<b>\$ 13,775,000</b>	<b>\$ 3,000,000</b>

# Finance Committee Item 4

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
Inter-Office Communication

**DATE:** March 10, 2019

**TO:** Maria Perez, Chairperson – Finance Committee  
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:** **An Informational Report from the Director, Department of Health and Human Services, Notifying the Milwaukee County Mental Health Board of Fund Transfers Processed in the Previous Quarter**

## Issue

Per the “BHD Fund Transfer Policy” adopted by the Mental Health Board, the BHD Fiscal Administrator will provide a quarterly informational report notifying the MHB as to any administrative fund transfers that have occurred during the previous quarter.

## Background

Wisconsin Statutes 51.41 authorizes the Milwaukee County Mental Health Board (MHB) to propose an annual budget to the County Executive for the Behavioral Health Division (BHD). Once this budget is approved by the County Executive, the budget provides the total spending authority for BHD for one calendar year. This budget reflects total expenditures, revenues and property tax levy required for the operation of programs and services within BHD.

Throughout the course of the year, certain adjustments to the budget may be necessary to better reflect BHD’s actual experience. In most cases, these adjustments, or appropriation transfers, would increase or decrease BHD’s expenditures and revenues compared to its base budget while maintaining the same tax levy as established in the original budget.

**Q4 2019 Fund Transfers**

<b>Title</b>	<b>Description</b>	<b>Total Funds Transferred</b>
Adult Drug Treatment Court	This transfer increases budgeted revenue and expense accounts related to BHD's Adult Drug Treatment Court grant. Increased expenses are entirely offset by grant revenue.	\$150,000
AODA Inner City	This transfer increases budgeted revenue and expense accounts related to BHD's AODA Inner City grant. Increased expenses are entirely offset by grant revenue.	\$49,898
CCS	This transfer increases budgeted revenue and expense accounts related to BHD's Comprehensive Community Services program for adults (low org 6411) and youth (low org 6477). Expenses are higher than anticipated due to increased enrollment and increased cost per client. These expenses are offset by Medicaid revenue.	\$7,759,336
CORE-FEP	This transfer increases budgeted revenue and expense accounts related to BHD's CORE-First Episode Psychosis grant. Increased expenses are entirely offset by grant revenue.	\$545,460
Health Community Grant	This transfer increases budgeted revenue and expense accounts related to BHD's Min Health Community grant award for education and prevention activities. Increased expenses are entirely offset by grant revenue.	\$25,000
STR/SOR	This transfer increases budgeted revenue and expense accounts related to BHD's Adult State Targeted Response to the Opioid Crisis (STR) grant award. Services funded under this award focus on expanding access to treatment and recovery options to reduce opioid-related deaths. Increased expenses are entirely offset by grant revenue.	\$1,441,198



# Finance Committee Item 6

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
Inter-Office Communication

**DATE:** March 10, 2020

**TO:** Maria Perez, Chairperson, Finance Committee  
Mental Health Board  
Thomas 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:** **From the Director, Department of Health and Human Services, Submitting an Informational Report on 2020 Financial Expectations for the Wraparound Milwaukee Program**

**Issue**

For the past two consecutive rate-setting cycles, Wraparound has received a decreased in per member per month capitated rate. Below is a summary of expected financial results for the Wraparound Milwaukee Program in 2020 based on a 3% rate reduction, no change in rate, or a 3% increase in capitated rate. Based on current assumptions, the only situation where Wraparound would not require additional tax levy funding (or a contribution from reserves) to support operations is 3%+ increase in capitated rate.

**2020 Wraparound Milwaukee Capitated Rate Scenarios**

	2020	2020	2020
	-3%	no change	3%
<b>Wraparound Totals</b>			
Personal Services	5.5	5.5	5.5
Commodities/Services	0.6	0.6	0.6
Other Charges	45.1	45.1	45.1
Crosscharges - Service Chgs	6.0	6.0	6.0
Crosscharges - Abatements	(5.7)	(5.7)	(5.7)
<b>Total Expenditures</b>	<b>51.4</b>	<b>51.4</b>	<b>51.4</b>
DMCPS Case Rate	9.5	9.5	9.5
Crisis Revenue	11.3	11.3	11.3
<b>HMO Revenue</b>	<b>25.5</b>	<b>26.3</b>	<b>27.1</b>
Other Direct Revenue	2.9	2.9	2.9
State and Federal Revenue	0.6	0.6	0.6
<b>Total Revenues</b>	<b>49.8</b>	<b>50.6</b>	<b>51.4</b>
<b>Property Tax Levy</b>	<b>1.6</b>	<b>0.8</b>	<b>0.0</b>

Respectfully Submitted,

Mary Jo Meyers, Director  
Department of Health and Human Services

# Finance Item 7

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

**DATE:** March 10, 2020

**TO:** Maria Perez, Chairperson – Finance Committee  
Milwaukee County Mental Health Board  
Thomas 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:** **From the Director, Department of Health and Human Services, Submitting an Informational Report on the Three-Year Financial Audit of the Wraparound Milwaukee Program**

## Issue

Wraparound is a managed care entity governed under 42 CFR 438. 42 CFR 438.3(m) contains the following language:

***Audited financial reports.** The contract must require MCOs, PIHPs, and PAHPs to submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.*

Milwaukee County contracted with Baker Tilly to conduct an audit of the Wraparound Program's Financial Report of for three years ending December 31, 2016, 2017, and 2018 to meet the audit requirement. The Financial Report was prepared by BHD financial staff under direction of DHS. These files are used by DHS for rate-setting purposes.

The audit found the submitted Financial Report “presents fairly, in all material respects, the total claim payments to providers and administrative expenses” described therein.

A copy of the audit report is attached for the Committee's review.



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Mary Jo Meyers, Director  
Department of Health and Human Services

# Finance Committee Item 8

COUNTY OF MILWAUKEE  
Behavioral Health Division Administration  
Inter-Office Communication

**DATE:** March 3, 2020

**TO:** Maria Perez, Chairperson, Finance Committee  
Milwaukee County Mental Health Board

**FROM:** Mary Jo Meyers, Director, Department of Health and Human Services  
*Prepared by Matt Fortman, Chief Financial Officer, Behavioral Health Division*

**SUBJECT:** **From the Director, Department of Health and Human Services, Submitting an Informational Report Detailing Preliminary Assumptions Used in Building the 2021 Behavioral Health Division Operating Budget**

## Discussion

Below is a list of operational assumptions included in the preparation of the budget:

1. BHD will continue to operate a psychiatric emergency room and a child and adult psychiatric inpatient facility at current levels throughout 2021. Transition to UHS may begin in late 2021, but budget will include full operational costs.
2. Capital and consulting needs related to BHD's Service Improvement Agreement will not be included in the 2021 operating budget. Costs in these areas, if any, will be funded through BHD's general reserve funds in 2021.
3. Continued expansion of Comprehensive Community Service capacity for both adults and children
4. Continued expansion of Crisis Intervention services.
5. Full implementation of Community Health Center partnerships, co-location.
6. Wraparound Milwaukee capitated rate will increase to cover gap between Wraparound's costs and HMO funding.

Based on a recent updated from the Milwaukee County Department of Administrative Services, BHD is anticipating a reduction in tax levy funds for 2021.

The 2021 budget is a collaborative process that encourages public input. There will be additional opportunities for public feedback on June 16<sup>th</sup> at 4:30 PM at the Sojourner Center. Budget amendments are due June 19<sup>th</sup>. Amendments will be discussed and voted on at the June 25<sup>th</sup> meeting at 1:30 PM at the Behavioral Health Division.

Respectfully Submitted:



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Mary Jo Meyers, Director  
Department of Health and Human Services

Behavioral Health Division  
2021 Budget  
Board/Committee Dates & Deliverables

# Finance Committee Item 9

Date	Mental Health Board	Finance Committee	Other Deliverables
March 19, 2020	<b>Public Comments – Budget</b>		
March 26, 2020		2021 Budget Assumptions	
April 23, 2020	2021 Budget Assumptions		
June 4, 2020		➤ CFO/Finance Chair to present 2021 Preliminary Budget	
June 16, 2020		➤ <b>Public Comments - Budget</b>	Budget request narrative posted for public review
June 19, 2020			Budget amendments due
June 25, 2020		<ul style="list-style-type: none"> <li>➤ DHHS Director presents 2021 Recommended Budget</li> <li>➤ <b>Public Comments - Budget</b></li> <li>➤ Committee reviews and votes on amendments</li> <li>➤ Committee makes recommendation on 2021 Recommended Budget</li> </ul>	
July 9, 2020	<ul style="list-style-type: none"> <li>➤ DHHS Director presents final 2021 Recommended Budget</li> <li>➤ Finance Committee Chair presents the Committee’s Budget recommendations to Board</li> <li>➤ Board votes on 2021 Budget</li> </ul>		
July 15, 2020			Formal Budget Submission

**The Board will be notified when the feedback/suggestions link on the Mental Health Board website/page regarding the 2021 Budget is active.**

# Finance Committee Item 10

## Milwaukee County WIMCR & Cost Report Payments

Program Name	<i>Budget (Receipt) Year</i>	2018	2019	2019
	<i>Settlement Year</i>	2017	2018	
	WIMCR Payment	WIMCR Payment		Surplus/ (Deficit) 2019
Crisis Intervention and Stablization	3,430,761	3,655,146	1,920,000	1,735,146
Day Treatment	117,809	58,416	0	58,416
TCM- Targeted Case Management	1,048,603	1,152,821	580,000	572,821
CSP - Community Support Program	(988,048)	181,334	630,000	(448,666)
CRS - Community Recovery Services	263,345	-	-	-
CCS - Comprehensive Community Services	2,430,890	100,519	2,050,000	(1,949,481)
<b>Total State Settlement Funds</b>	<b>6,303,360</b>	<b>5,148,236</b>	<b>5,180,000</b>	<b>(31,764)</b>

**Chairperson:** Mary Neubauer  
**Executive Assistant:** Kiara Abram, 257-7212  
**BHD Staff:** Jennifer Bergersen

**MILWAUKEE COUNTY MENTAL HEALTH BOARD  
 QUALITY COMMITTEE  
 March 02, 2020 - 10:00 A.M.  
 Milwaukee County Mental Health Complex  
 Conference Room 1045**

**MINUTES**

**SCHEDULED ITEMS:**

1.	<p>Welcome. <b>(Chairwoman Neubauer)</b></p> <p>Chairwoman Neubauer welcomed everyone to the March 2, 2020 meeting.</p>
2.	<p>Quarter 4 - 2019 Community Based Key Performance Indicators (KPI) Dashboard, Wraparound Milwaukee &amp; Community Access to Recovery Services (CARS) <b>(Dana James, Quality Assurance Manager; Justin Heller, Integrated Services Manager; Dr. Matt Drymalski, Clinical Program Director)</b></p> <p>Wraparound highlighted the increase for percentage of enrollee days in a home setting from Q3 to Q4; average level of "needs met" at disenrollment remained consistent. Quarter 4 data reported a slight increase in the percentage of youth achieving permanency at disenrollment in comparison to Q3. The team is examining trends and education opportunities.</p>
3.	<p>CARS Quality Dashboard Summary Q4 - 2019, Health and Well-Being Metrics and BHD Services Dashboard <b>(Dr. Matt Drymalski, Clinical Program Director; Justin Heller, Integrated Services Manager)</b></p> <p>CARS continues to explore the disparities in terms of quality of life improvements between clients served; a slight improvement has been noted from African-American clients compared from previous quarters. CARS intends to continue to solidify collected data to represent each of the Quadruple Aims including the costs as to measure the health and well-being of the clients being served. A plan to engage clients in evaluating quality through the use of focus groups is also being pursued.</p>
4.	<p>Children's Mobile Crisis Team Program Re-Certification and Improvement - Verbal Update <b>(Dana James, Quality Assurance Manager)</b></p> <p>Children's Mobile Crisis Team has received a two-year certification following completion of the re-certification review. A correction action plan has been submitted and accepted by the State in response to a single finding. A progress update will be forthcoming.</p>

5.	<p>Client Experience of Care Data – 2019 Year End Data: Children’s Community Mental Health Services &amp; Wraparound Milwaukee, MHSIP Consumer Satisfaction Survey, CAIS Youth Survey, Recovery-Oriented System Indicators (ROSI) Survey Results (<b>Dana James, Quality Assurance Manager; Edward Warzonek, Quality Assurance Coordinator, and Justin Heller, Integrated Services Manager</b>)</p> <p>Refer to CCS Youth and Family MHSIP Survey Report for 2019 additional detail; 34% Family Response Rate and 14% Youth Response Rate. The Acute Adult inpatient survey response rate (49%) is significantly above the national average. The 2019 survey results revealed a positive rating increase for the "Dignity" and "Environment of Care" domains in comparison to 2018's scores. The CAIS Youth Survey, yielded a 23.3% response rate with survey results revealing an increase in areas of "Participation in Treatment", "Access to Services" and "Appropriateness of Treatment." ROSI Survey results from 2017-2019 and related mean percentages were distributed.</p>
6.	<p>Contract Quality Monitoring: Crossroads Behavioral Services and Crossroads Bridge Housing; Suspension (<b>Amy Lorenz, Deputy Administrator, CARS</b>)</p> <p>Referrals are currently suspended to Crossroads Behavioral Services and Crossroads Bridge Housing due to notification received from the Office of Inspector General (OIG) of a pending investigation. Services will remain suspended upon determination of the investigation and outcome.</p>
7.	<p>Inpatient, Emergency Services Hospital System Improvement Agreement; High Priority Issues, including QAPI (Quality Assurance Performance Improvement) - Verbal Update (<b>Jennifer Bergersen, Chief Operations Officer; Dr. John Schneider, Chief Medical Officer; Linda Oczus, Chief Nursing Officer</b>)</p> <p>Critical Management Solutions (CMS) has completed a BHD gap analysis. A corrective action plan to address areas for improvement will be due by early March 2020. Jeanne Wypyski was introduced as the compliance consultant. Next steps include the redesign of the QAPI program, and QAPI Plan including identifying data driven opportunities for improvement. A plan to restructure Quality Committee agendas as to ensure feedback and relevant data is forwarded to the Governing Body for related action is underway. Board members were provided a list of quality focus issues targeted for improvement. A New QAPI Plan will be developed and submitted to this body for review and approval by June 1, 2020. Action Plans are under development for all issues including the top priority items: Ligature Risks/Safety, EMTALA, QAPI, Active Treatment, Treatment Planning, Medical Record and Project Management. Chairwoman Neubauer is participating in the BHD QAPI meetings.</p>
8.	<p>Psychiatric Hospital Reports Q4: KPI Dashboard Summary: Crisis Services &amp; Acute Inpatient, Seclusion &amp; Restraint Summaries by Unit (<b>Edward Warzonek, Quality Assurance Coordinator</b>)</p>

	<p>Acute Adult hours of physical restraint rate through Q4 in 2019 was above the national average yet below the State's average at .51. CAIS 30-day readmission rate remained the same through Q4 of 2019 at 16%; hours of physical restraint rate declined from Q3 to Q4, yet still above the national average.</p> <p>Performance improvement related actions to be reported in the future.</p>
9.	<p><b>2019 Environment of Care: Annual Report and 2020 Goals – Action Item (Lynn Gram, Safety Officer)</b></p> <p>The Quality Committee unanimously agreed to recommend approval of both the 2019 Annual Review of the Environment of Care Program and the 2020 Environment of Care Management Plans and related goals. Documents will be forwarded to the Mental Health Board for final approval.</p>
10.	<p><b>Milwaukee County Crisis Services: Crisis Resource Center (CRC) Collaborative (Lauren Hubbard, Director of Community Crisis Services)</b></p> <p>The CRC collaborative was implemented to reduce recidivism in ER visits and inpatient hospitalization for adults, while ensuring client-driven recovery focused resources. Of the clients selected to participate in focus groups, data showed a significant decrease in PCS readmissions and hospitalizations. An overview of the collaborative indicated clients were able to achieve long-term comprehensive connections in least restrictive environments. Next steps include increase capacity of CRCs, increase community knowledge of the program and referral sources.</p>
11.	<p><b>Quarterly Policy &amp; Procedure Update (Luci Reyes-Agron, Quality Improvement Coordinator)</b></p> <p>An updated report as of March 2020 was distributed. The overall policy and procedure progress status continues to improve; 95.4%. Status updates will continue to be reported quarterly.</p>
12.	<p><b>Adjournment. (Chairwoman Neubauer)</b></p> <p>Chairwoman Neubauer ordered the meeting adjourned.</p>
<p>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.</p> <p>Length of meeting: 10:00 a.m. – 11:45 a.m.</p>	

Adjourned,

Kiara Abram

Executive Assistant

Milwaukee County Mental Health Board

**The next regular meeting for the Milwaukee County Mental Health Board Quality Committee is June 01, 2020 at 10:00 a.m.**

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

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

***ADA accommodation requests should be filed with the Milwaukee County Office for Persons with Disabilities, 278-3932 (voice) or 711 (TRS), upon receipt of this notice.***



Milwaukee County Behavioral Health Division  
2019 Key Performance Indicators (KPI) Dashboard

# Quality Committee Item 2

Program	Item	Measure	2017 Actual	2018 Actual	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	2019 Actual	2019 Target	2019 YTD Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs <sup>5</sup>	8,346	9,393	6,044	7,468	8,802	10,049	10,049	9,500	Green	
		Sample Size for Rows 2-6 (Unique Clients)			3,531	3,533	3,406	3,471				
	2	Percent with any acute service utilization <sup>6</sup>	17.40%	17.05%	19.55%	20.58%	20.44%	19.96%	20.13%	16.35%	Red	
	3	Percent with any emergency room utilization <sup>7</sup>	13.87%	14.60%	15.33%	17.74%	16.46%	15.95%	16.37%	13.64%	Yellow	
	4	Percent abstinence from drug and alcohol use	63.65%	63.65%	64.67%	63.32%	61.22%	62.75%	62.99%	64.18%	Yellow	
	5	Percent homeless	7.61%	9.18%	8.46%	9.87%	9.90%	10.18%	9.60%	8.84%	Yellow	
	6	Percent employed	18.09%	20.06%	19.51%	19.15%	18.96%	18.54%	19.04%	20.27%	Yellow	
	Sample Size for Row 7 (Admissions)					1,560	1,558					
	7	Percent of all admissions that are 7 day readmissions	59.55%	60.12%	49.11%	52.51%	50.74%	50.32%	50.67%	49.00%	Yellow	
Wraparound	8	Families served by Children's Mental Health Services and Wraparound (unduplicated count)	3,404	2,955	1,697	2,104	2,456	2,872	2,872	3,450	Green	BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.60	4.5	4.5	4.6	4.6	4.5	>= 4.0	Green	BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	65.3%	66.2%	63.3%	61.6%	65.0%	64.0%	>= 75%	Yellow	BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.4	2.4	2.5	2.3	2.3	2.4	>= 3.0	Yellow	BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	57.8%	58.0%	69.1%	51.3%	45.8%	46.1%	53.1%	>= 70%	Red	BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	44.1%	38.4%	34.3%	33.1%	34.3%	31.2%	33.2%	>= 50%	Red	BHD (2)
	14	Average cost per month (families served in Wraparound HMO)				\$2,187	\$2,937	\$2,996	\$2,706		Red	BHD (2)
Crisis Service	15	PCS Visits	8,001	7,375	1,905	1,960	1,815	1,812	7,492	8,000	Green	BHD (2)
	16	Emergency Detentions in PCS	3,979	3,023	795	775	825	832	3,227	4,000	Green	BHD (2)
	17	Percent of patients returning to PCS within 3 days	7.3%	7.5%	10.0%	12.6%	6.9%	8.5%	9.6%	8%	Yellow	BHD (2)
	18	Percent of patients returning to PCS within 30 days	23.1%	24.0%	24.4%	29.5%	23.5%	26.7%	26.1%	24%	Yellow	BHD (2)
	19	Percent of time on waitlist status	75.2%	83.2%	100.0%	100.0%	100.0%	100.0%	100.0%	50%	Red	BHD (2)
Acute Adult Inpatient Service	20	Admissions	656	770	162	176	178	177	693	800	Green	BHD (2)
	21	Average Daily Census	42.9	41.8	43.8	42.4	38.9	36.8	40.5	54.0	Green	BHD (2)
	22	Percent of patients returning to Acute Adult within 7 days	1.4%	1.6%	1.3%	3.8%	2.8%	1.7%	2.5%	3%	Green	BHD (2)
	23	Percent of patients returning to Acute Adult within 30 days	7.7%	6.6%	6.3%	10.9%	11.9%	6.4%	9.0%	10%	Green	NRI (3)
	24	Percent of patients responding positively to satisfaction survey	74.0%	74.8%	74.4%	74.9%	74.6%	76.5%	74.8%	75.0%	Yellow	NRI (3)
	25	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	65.2%	66.0%	65.2%	62.8%	67.6%	64.7%	65%	Yellow	BHD (2)
	26	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.51	0.24	0.36	0.58	0.87	0.51	0.38	Red	CMS (4)
	27	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.28	0.15	0.10	0.14	0.41	0.19	0.29	Red	CMS (4)
	28	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	21.5%	25.3%	23.9%	22.0%	27.7%	24.7%	9.5%	Red	CMS (4)
29	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	95.8%	92.5%	95.5%	97.4%	95.8%	95.3%	90.0%	Green	BHD (2)	
Child / Adolescent Inpatient Service (CAIS)	30	Admissions	709	644	168	149	152	191	660	800	Green	BHD (2)
	31	Average Daily Census	8.6	7.5	8.2	7.0	6.2	8.6	7.5	12.0	Red	BHD (2)
	32	Percent of patients returning to CAIS within 7 days	5.2%	3.4%	9.1%	4.8%	5.3%	6.8%	6.6%	5%	Red	BHD (2)
	33	Percent of patients returning to CAIS within 30 days	12.3%	12.4%	18.8%	16.3%	15.2%	16.2%	16.7%	12%	Red	BHD (2)
	34	Percent of patients responding positively to satisfaction survey	71.3%	71.1%	79.6%	73.5%	74.2%	75.1%	75.7%	75%	Red	BHD (2)
	35	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	74.2%	88.9%	83.3%	78.9%	77.8%	83.5%	75%	Red	BHD (2)
	36	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.18	1.98	0.95	2.42	1.18	1.60	0.38	Red	CMS (4)
	37	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.47	0.39	0.35	0.30	0.28	0.33	0.29	Yellow	CMS (4)
	38	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.1%	0.0%	0.0%	0.7%	4.2%	1.4%	3.0%	Green	CMS (4)
39	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	85.7%	-	-	100.0%	87.5%	88.9%	90.0%	Yellow	BHD (2)	
Financial	40	Total BHD Revenue (millions)	\$149.9	\$154.9	\$149.7	\$149.7	\$149.7	\$149.7		\$149.7	Yellow	
	41	Total BHD Expenditure (millions)	\$207.3	\$213.5	\$208.2	\$208.2	\$208.2	\$208.2		\$208.2	Yellow	

Notes:

- (1) 2018 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)
- (2) Performance measure target was set using historical BHD trends
- (3) Performance measure target was set using National Association of State Mental Health Directors Research Institute national averages
- (4) Performance measure target was set using Centers for Medicare & Medicaid (CMS) Hospital Compare national averages
- (5) Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.
- (6) Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days
- (7) Includes any medical or psychiatric ER utilization in last 30 days

Program	Item	Measure	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	2019 Actual	2019 Target	2019 Status (1)	Benchmark Source
Wraparound	8	Families served by Children's Mental Health Services and Wraparound (unduplicated count)	1,697	2,104	2,456	2,872	2,872	3,450		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5) (Wrap HMO)	4.5	4.5	4.6	4.6	4.5	> = 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice System)	66.2%	63.3%	61.6%	65.0%	64.0%	> = 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5) (Wrap HMO)	2.35	2.5	2.3	2.3	2.4	> = 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment (Wrap HMO)	69.1%	51.3%	45.8%	46.1%	53.1%	> = 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team (Wrap HMO)	34.3%	33.1%	34.3%	31.2%	33.2%	> = 50%		BHD (2)
	14	Average Cost per Month (families serviced in Wraparound HMO)		\$2,187	\$2,937	\$2,996	\$2,706			

**Notes:**

(1) 2019 Status color definitions: Red (outside 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)

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

**SUMMARY - 4TH QUARTER/CY 2019**

# 8 - This number is for those enrolled in a program with Children's Community Mental Health Services and Wraparound Milwaukee.

# 9 - On target for the 4th quarter of 2019 and for 2019 actual. Exceeding the threshold of 4.0.

# 10 - There was an increase from 3rd quarter to 4th quarter. Our 2019 actual was within 20% of our target goal.

# 11 - There was no change from 3rd quarter to 4th quarter of 2019, The 2019 actual is within 20% of the benchmark of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. **NOTE:** Those in Wraparound court ordered programs who are disenrolled to a home type setting in the 3rd quarter of 2019 have a higher "Needs Met" score (3.42) than those disenrolled on runaway status or to corrections (1.90).

#12 - In the 4th quarter, there was a slight increase in the percentage of youth achieving permanency at disenrollment compared to the 2019 3rd quarter. Our 2019 actual falls out of the 20% of the benchmark by 3%. This continues to be an area that the Wraparound Milwaukee Research and Evaluation Team is reviewing and looking for trends to help inform practice or potential educational moments with Judges, system partners, etc.

"Permanency" is defined as:

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

#13 - This item is monitored within the context of the Care Coordination Agency Performance Report (APR) that is distributed semi-annually. The data is available at all times to all Care Coordination agencies for self-monitoring. The 4th quarter compliance is slightly lower than the 2019 3rd quarter. This falls outside 20% benchmark of 40%.

#14- This item was requested by the Quality Board at the meeting in June 2019.

# Quality Committee Item 3



**BHD** MILWAUKEE COUNTY  
Behavioral  
Health  
Division

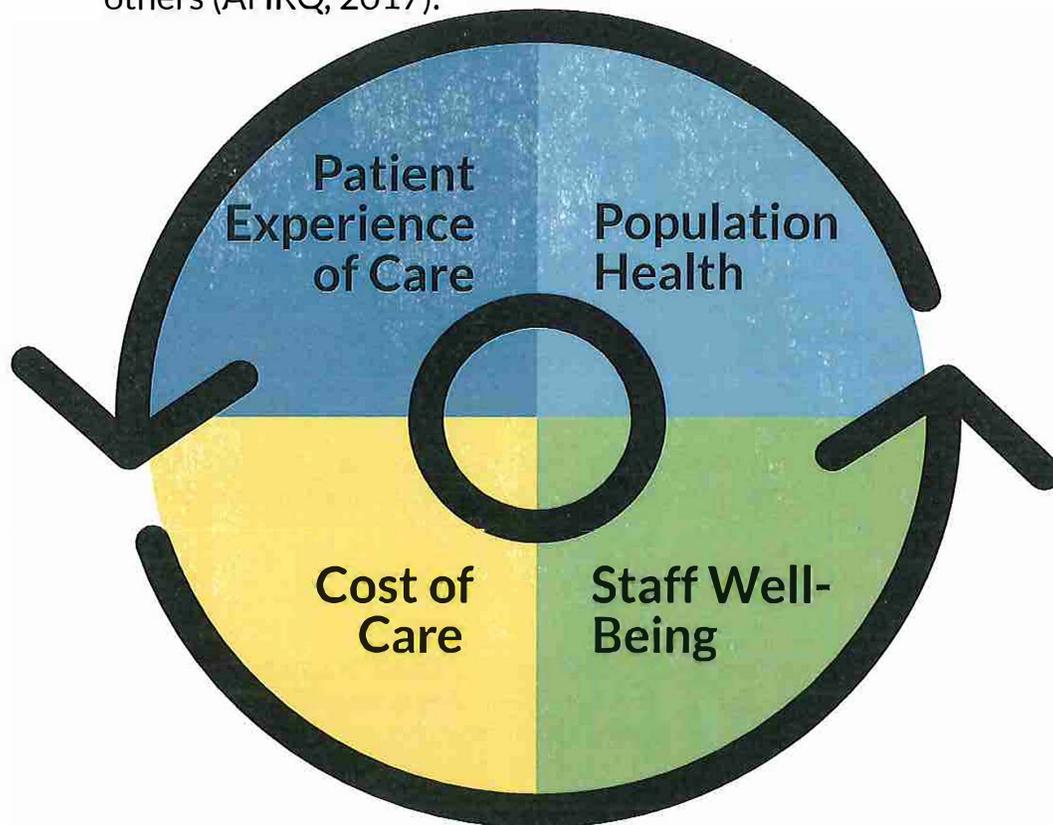
## CARS Quality Dashboard

CARS Research & Evaluation Team

### The Framework: The Quadruple Aim

The patient experience of care encompasses the range of interactions that patients have with the healthcare system and includes several aspects of healthcare delivery, including satisfaction, timely appointments, and easy access to information, among others (AHRQ, 2017).

"Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group." (Kindig and Stoddart, 2003)



The total cost of care a patient receives across all settings and services, often presented as cost per member of the population per month (Stiefel & Nolan, 2012).

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

# CARS QUALITY DASHBOARD SUMMARY Q4 2019

## CHANGES AND UPDATES

### Further Development of the Quadruple Aim

The CARS Quality Dashboard, driven by the CARS Quality Plan, continues to be revised, refined, and enhanced. Please see below!

#### Population Health

As noted before, we are now disaggregating some of our outcomes by race. This effort helps to align CARS's evaluation activities to the Milwaukee County Executive's stated goal of addressing racial disparities in Milwaukee County. We will continue to explore this issue through several investigative mediums (further analyses, surveys, focus groups, etc.). We have also recently completed additional analyses on quality of life a key population health metric, including its correlation with other important social determinants of health. These are presented in the Health and Well-Being section of the dashboard.

#### Patient Experience of Care

CARS is happy to announce the development and adoption of a new, brief client experience survey that we believe will not only be more client-centered but will allow us to explore multiple methods of distribution in order to reach and give voice to as many of our clients as possible. We have begun preliminary distribution of this survey and will provide updates in future quarterly meetings.

#### Staff Wellbeing

The CARS Staff Quality of Life workgroup is hard at work crafting a proposal and a policy to enable CARS staff to adopt a flexible work schedule, which they believe will have multiple benefits for the staff who work in CARS and for Milwaukee County Behavioral Health Division more generally. Please see updates and next steps in the CARS Quality Dashboard!

#### Cost of Care

The cost per member per month has been updated for the fourth quarter, the results of which indicate a slight decrease. We anticipate using this metric in our value modeling, which we hope to begin later this year.

## RESULTS

With regards to the change over time metrics, the disparity in terms of quality of life improvements between African-Americans and Caucasian clients within CARS remains consistent, though contrary to the previous two quarters, African-American clients did show a slight, albeit not statistically significant, improvement. As noted in the Health and Well-Being Report, CARS is actively exploring this disparity through additional analyses, data collection, and client focus groups.

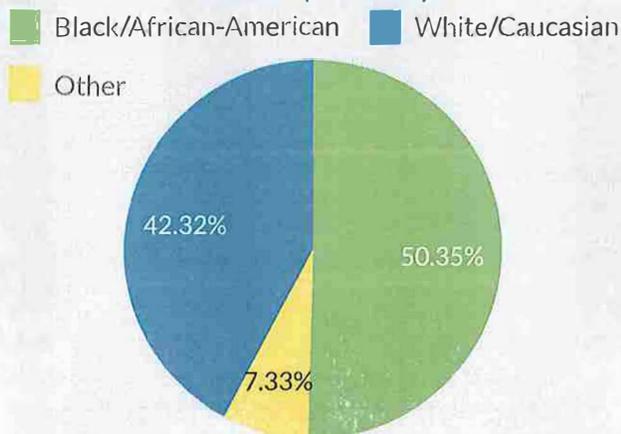
## NEXT STEPS

CARS will continue to monitor the racial disparities in our quality of life outcomes and examine the underlying reasons for this finding. CARS also intends to continue to solidify the data we collect to represent each of the aims in the Quadruple Aim. This effort will be critical to the eventual development of our value model, in which we will explore the costs required to improve the health and well-being of the clients we serve. We believe this model will enable us to better evaluate whether we are providing the most efficient, cost-effective care possible for the clients we serve. We plan to present this model to the Mental Health Board Quality Committee later this year.

## Demographic Information of the Population We Serve

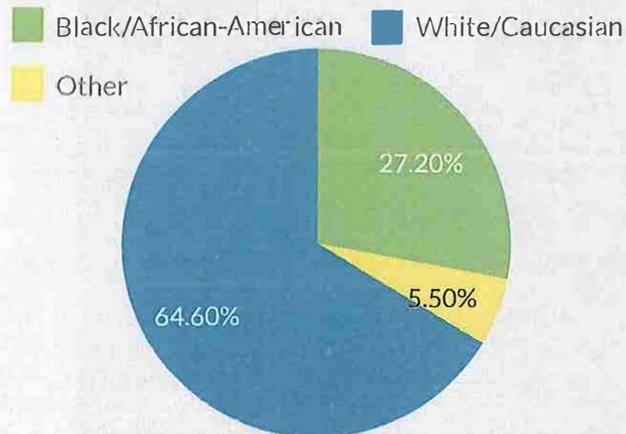
This section outlines demographics of the consumers CARS served last quarter compared to the County population.

### Race (CARS)



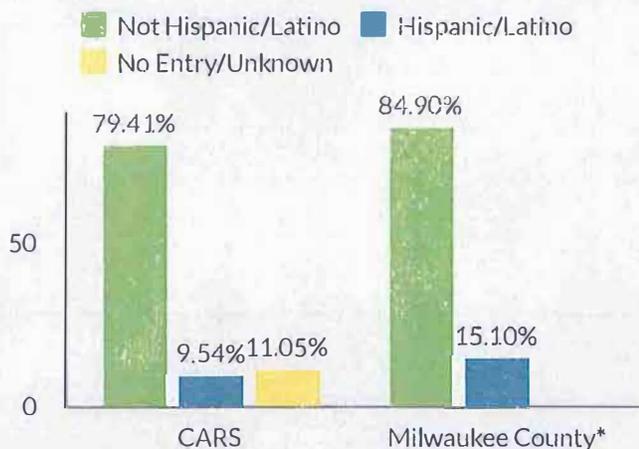
"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

### Race (Milwaukee County)\*

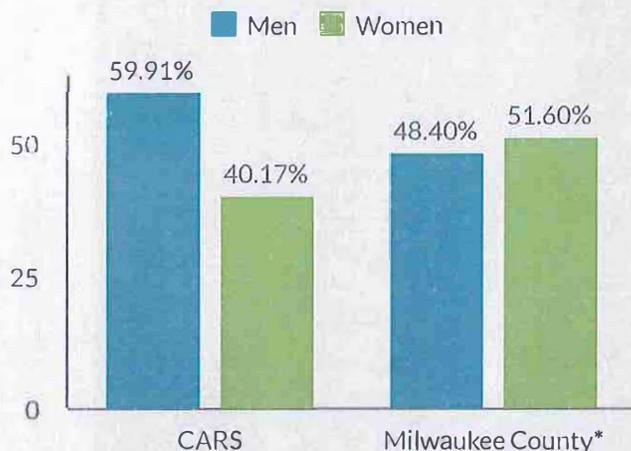


"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

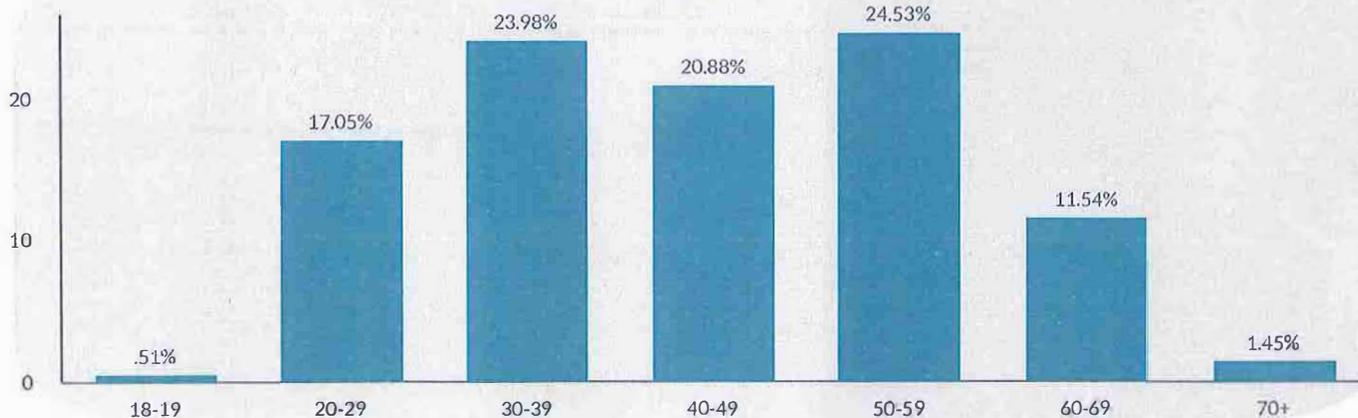
### Ethnicity



### Gender



### Age



\*Comparable data has been pulled from the United States Census Bureau, which can be found at: <https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/PST045217#qf-flag-Z>



# Domain: Patient Experience of Care

Items within this domain encompass volume, averages, and percentages. These data points compare the past four quarters in order to show change over time.



## Referrals

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



## Timeliness of Access

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



## Admissions

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



## Volume Served

Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.



### Consumer Satisfaction



The Press Ganey Consumer Satisfaction Survey has been distributed to all CARS providers. Response rate as of the end of the quarter. Results will be reported at a later date.

\*Results from the CCS ROSI Survey are attached.

12.90%

Response Rate

7,234

surveys distributed

933

surveys received



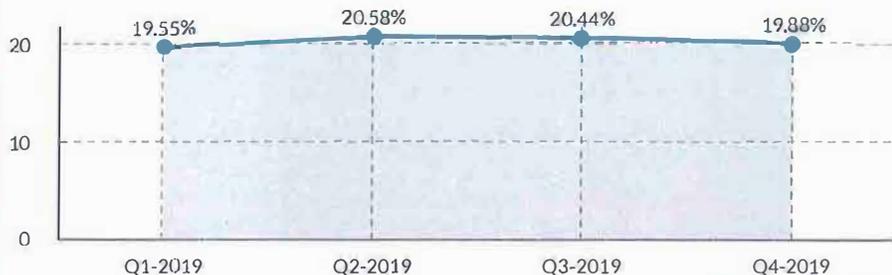
### Domain: Population Health

Data informing each item is formatted as percentages based on the description. Most of the data points compare the past four quarters in order to indicate change over time.



#### Acute Services

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



#### ER Utilization

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



#### Detoxification 7-Day Readmissions

Percent of consumers returning to detoxification within 7 days.



#### Abstinence

Percent of consumers abstinent from drug and alcohol use.



#### Homelessness

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





## Domain: Population Health (Continued)

Items within this domain encompass volume, averages, and percentages. Most of the data points compare the past four quarters in order to indicate change over time.

### Employment



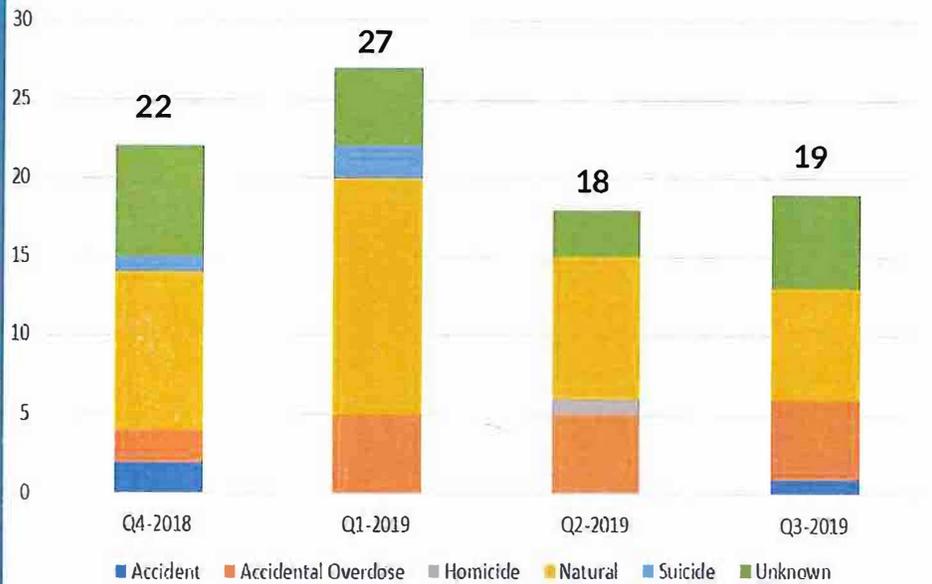
Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".



### Mortality Over Time

Mortality is a population health metric used by other institutions such as the Center for Disease Control, the U.S. Department of Health and Human Services, and the World Health Organization. This graph represents the total number of deaths by cause of death from the previous four quarters.

Note: There is a lag in death reporting. See note in the next item.



### Cause of Death

This is the reported average age at time of death by cause of death from the previous four quarters.

Please note that there is a one quarter lag of the mortality data on the CARS Quarterly Dashboard. This decision was made to ensure that CARS has accurate cause of death data from the Milwaukee County Medical Examiner's office, a determination which can sometimes take several months for the Medical Examiner's office to render.



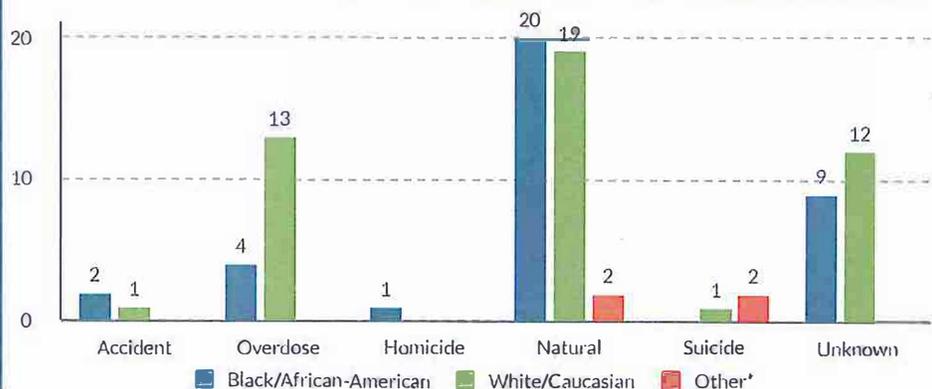
### Cause of Death

Distribution of consumers by race for each cause of death for the four previous quarters.

Total Black/African-American: 36  
Total White/Caucasian: 46  
Total Other: 4

Note: There is a lag in death reporting. See note in the previous item.

\*Other includes "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

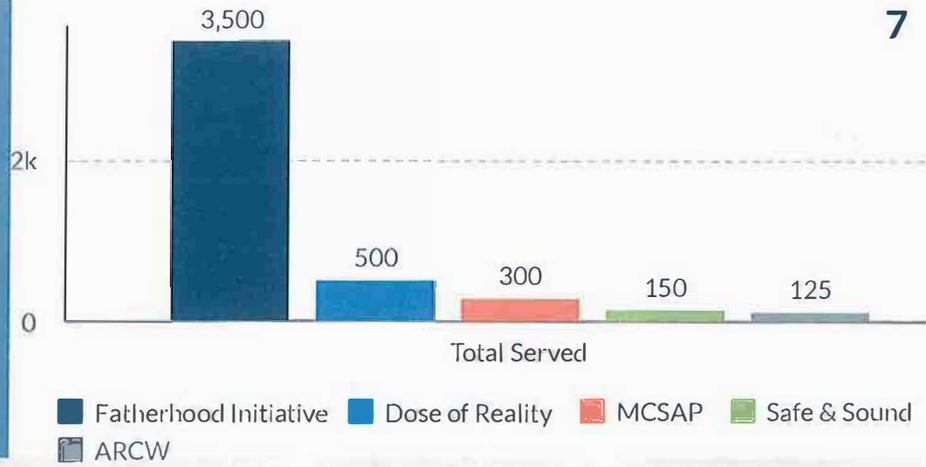


### Top Prevention Activities/Initiatives

Prevention is an important population health factor. Many prevention activities include evidence based practices and presentations. The top five prevention activities from the previous quarter are listed in the graphic.

**MCSAP:** Milwaukee County Substance Abuse Prevention Coalition

**ARCW:** AIDS Resource Center of WI



### Domain: Cost of Care

Cost of care compares average cost per month over the past four quarters in order to indicate change over time.

### Average Cost Per Consumer Per Month

The average cost per consumer per month within each quarter for CARS services received by CARS consumers (not including inpatient and crisis). This is not separated out by funding stream or limited to those dollars spent by Milwaukee County on these services. The average number of consumers per month within each quarter is below:

Q1- 2019 N = 5,056	Q2 - 2019 N = 5,225
Q3- 2019 N = 5,285	Q4 - 2019 N = 5,404



### Domain: Staff Well-Being

### Turnover

Turnover is calculated by looking at the total number of staff who have left over the previous four quarters, divided by the average number of employees per month, for the previous four quarters



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

**15.70%**

CARS turnover rate

**20.00%**

Turnover rate for government employees (per year)\*



### Staff Quality of Life

A group of CARS staff have been working to positively impact the workplace culture. Initial efforts have been focused on gathering employee feedback, and that feedback has told us the biggest priorities for staff are related to flexible benefits, e.g. telecommuting, flex time, etc. Based on this feedback, the team is working on a proposal to create new policy that will allow for a more flexible work environment, which we anticipate will have a positive impact on staff quality of life and also make BHD-CARS a more competitive employer.

# Health and Well-Being

This dashboard contains measures of 6-month population health outcome data (intake to follow-up) for our consumers. This dashboard was created to follow the County Health Rankings Model. Only consumers with a Comprehensive Assessment and subsequent PPS completed within 4-7 months are included in these measures.

Q4 2019



36.00% → 44.30%

## Health Outcome

23.06% increase in Good or Very Good self-reported Quality of Life\*

n=289



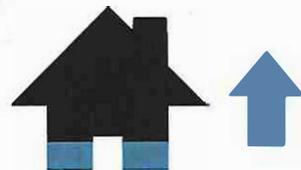
### Social Determinants



15.90% → 22.80%

43.40% increase in Employment\*\*

n=395

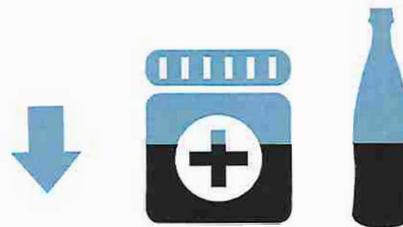


58.20% → 71.50%

22.85% increase in "Stable Housing"\*\*\*

n=407

### Health Behaviors

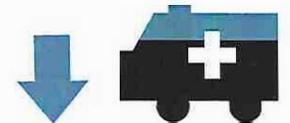


17.70% → 9.40%

46.89% decrease in Past 30 days Detoxification Use\*\*\*

n=417

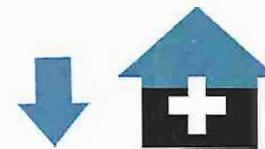
### Clinical Care



12.60% → 8.30%

34.13% decrease in Psych ER Use\*

n=433



26.20% → 12.30%

53.05% decrease in Past 30 days Psych. Inpatient\*\*\*

n=424

\*p<.05 \*\*p<.01 \*\*\*p<.001

# Health and Well-Being

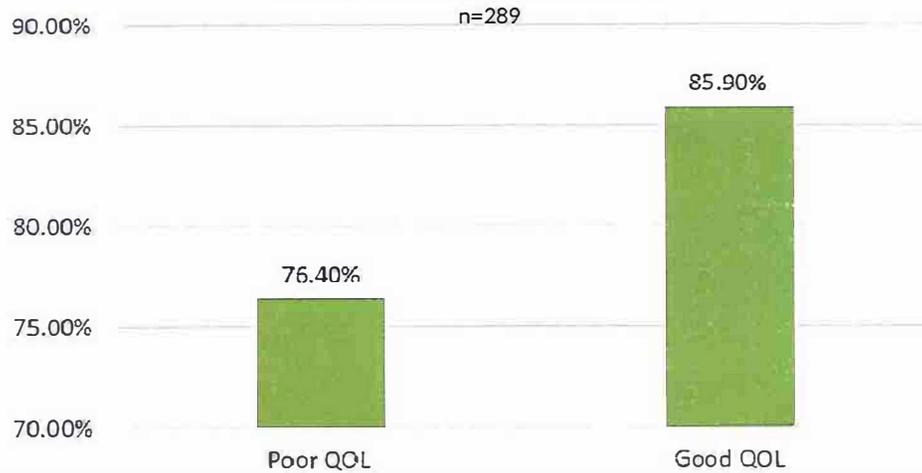
This dashboard contains measures of 6-month population health outcome data for our consumers

Only consumers with a Comprehensive Assessment and subsequent PPS completed within 4-7 months are included in these measures.

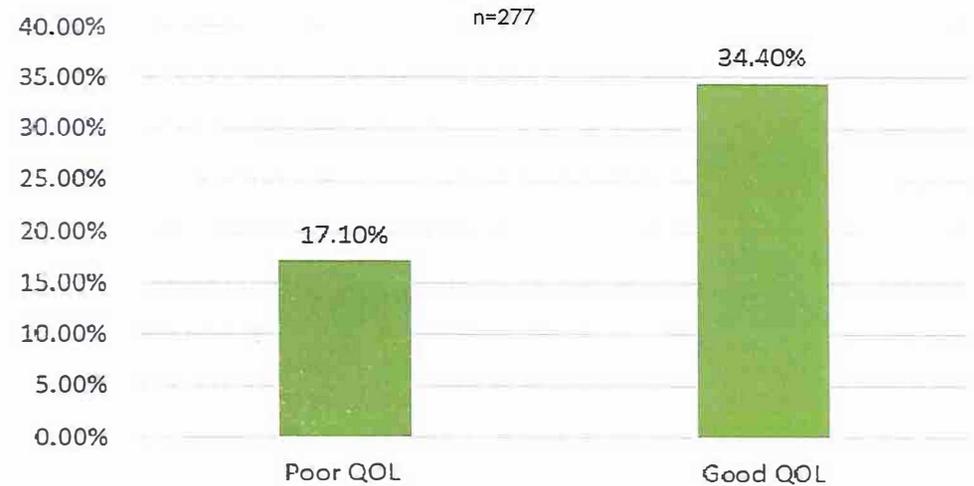
Q4 2019

## Quality of Life at Follow-Up

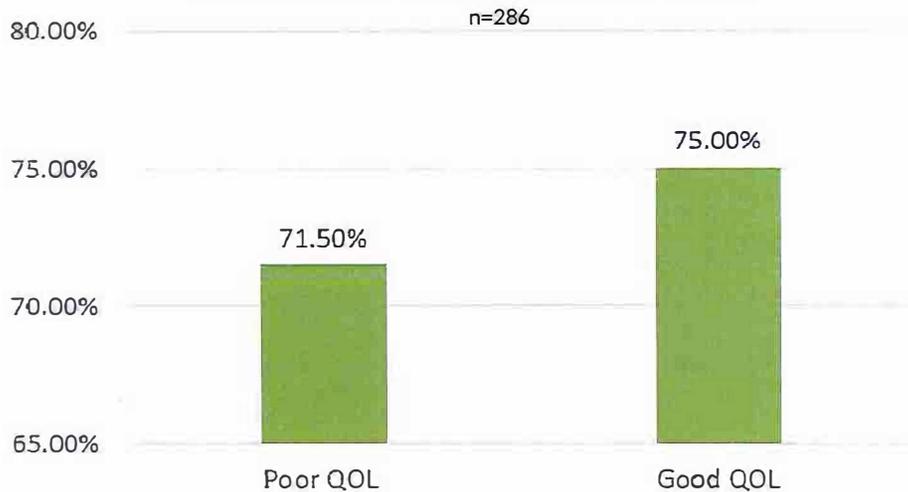
Percent of Individuals that had Social Interaction with Family/Friends in Past 30 days\*



Percent of Employed Individuals\*\*



Percent of Individuals in Stable Housing



Percent of Individuals Utilizing Acute Services\*



\*p<.05 \*\*p<.01

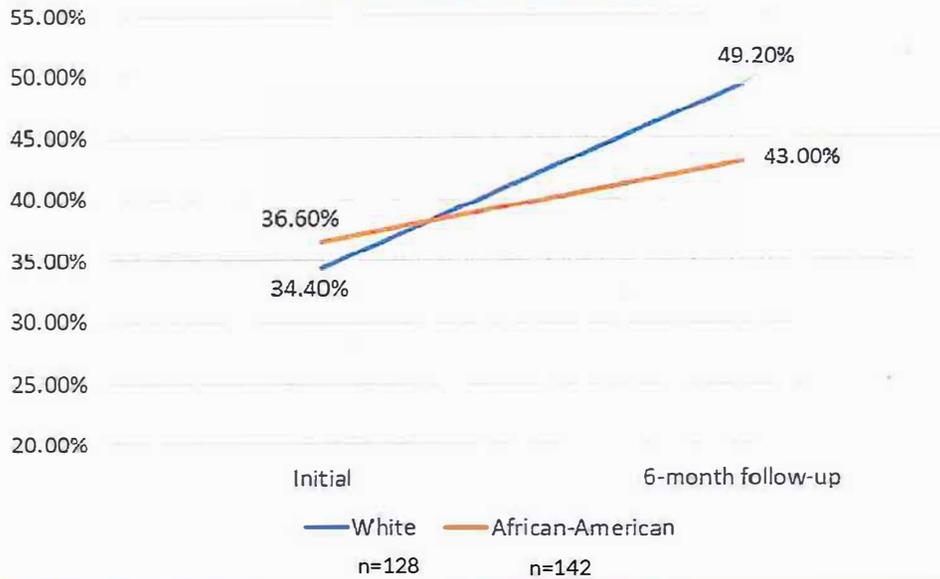
# Health and Well-Being

This dashboard contains measures of 6-month population health outcome data (intake to follow-up) for our consumers, comparing White/Caucasian and Black/African-American consumers.

Only consumers with a Comprehensive Assessment and subsequent PPS completed within 4-7 months are included in these measures.

Q4 2019

Proportion of Consumers indicating "Good" or "Very Good" Quality of Life



## Next Steps

For the third quarter in a row, the rates of improvement in quality of life for African-American (AA) clients lagged behind that of Caucasian clients, though the difference was less pronounced than in previous quarters. Additional analyses with other demographic variables in this and previous reports revealed few differences between AA and Caucasian clients in terms of age or gender, though AA clients were more likely to identify as "single, never married" compared to Caucasian clients.

Given the lack of statistically significant findings with the majority of the demographic and social variables we've analyzed, there are several additional steps we will take to better understand this disparity. First, we will look to augment our existing data set with other key sociodemographic variables that we believe might have better explanatory power. Second, we will gather additional data through surveys and focus groups with providers and clients to both corroborate our quantitative findings and give us deeper insights into the results. We believe this information will help us better understand how to address this important issue.

Average Age by Race

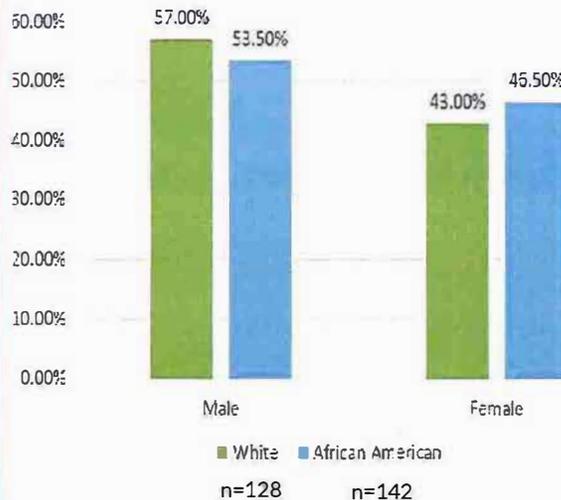
42.50

African-American  
n=128

41.40

White  
n=142

Gender by Race



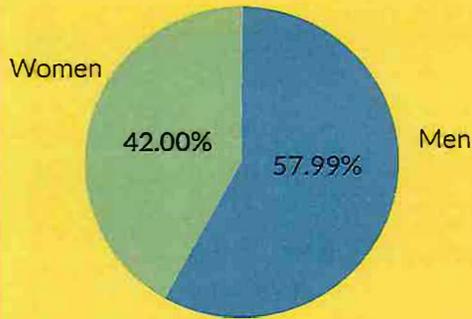
Marital Status by Race





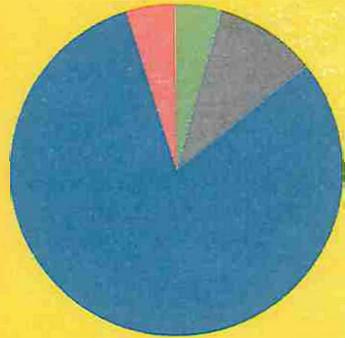
Includes all Adult Services, as well as CAIS and youth served in PCS

## Volume Served 8,395



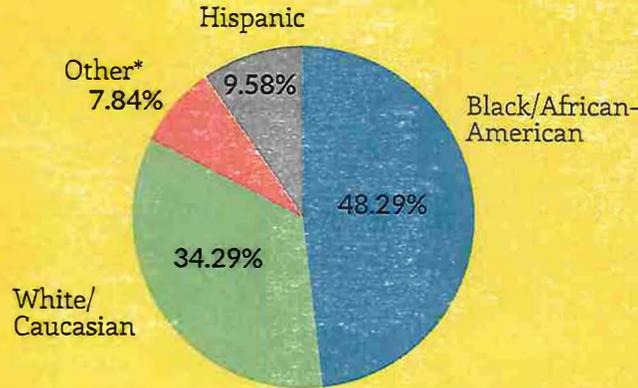
### Gender

- 0-17 (4.46%)
- 18-24 (9.88%)
- 25-64 (80.85%)
- >65 (4.82%)



### Age

## Race/Ethnicity



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

## Socioeconomic Status



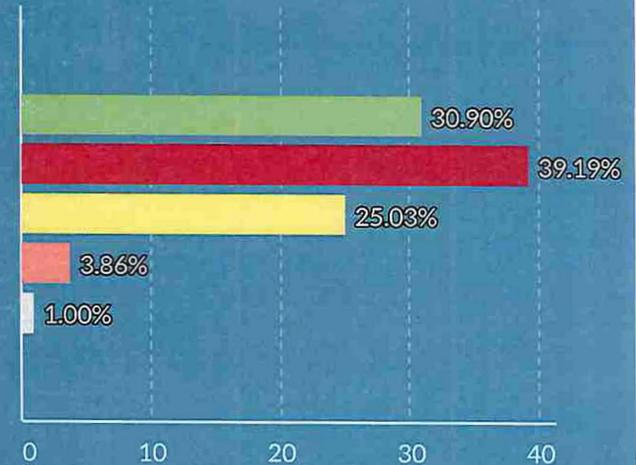
SES is determined based on income and education levels, and calculated based on zip code. Median income is listed for each group.

For more information, please visit:

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

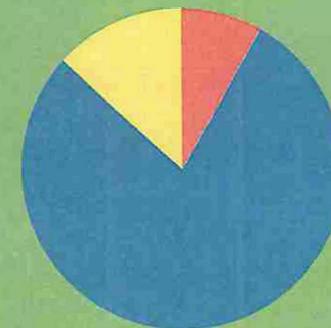
## Education

n=6,297



- Less than High School Diploma
- High School Diploma or GED
- Some College or Tech School
- Bachelor's Degree
- Advanced Degree (Masters, PhD)

## Service Distribution



This chart is a depiction of the proportion of consumers who received "Community" or "Acute" services, or both. "Acute" includes Inpatient, PCS, Observation, and Detoxification services. All other services are classified as "Community" services.

- Acute (8.16%)
- Community (78.61%)
- Both (13.23%)

# Quality Committee Item 5

Milwaukee  
County  
BHD



## Children's Community Mental Health Services and Wraparound Milwaukee

### CCS Youth and Family MHSIP Survey Report

Prepared by: Adrienne Sulma

# 2019

MHSIP -F  
Response Rate

**34%**

MHSIP -  
Y Response Rate

**14%**

### Description

The Mental Health Statistical Improvement Plan Survey (MHSIP) Family (F) and Youth (Y) are both administered once a year to youth and caregivers of youth who have been involved in CCS for at least six months or more, or have been recently discharged from services. The intent of these surveys is to gauge satisfaction with CCS services, and improve service provision.

#### Average Age

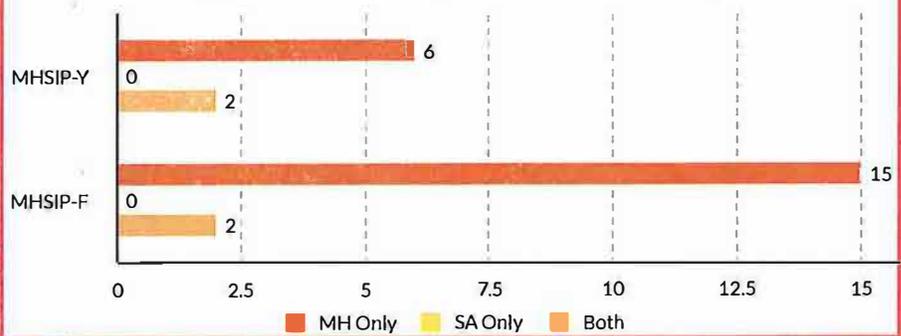


MHSIP-F  
10

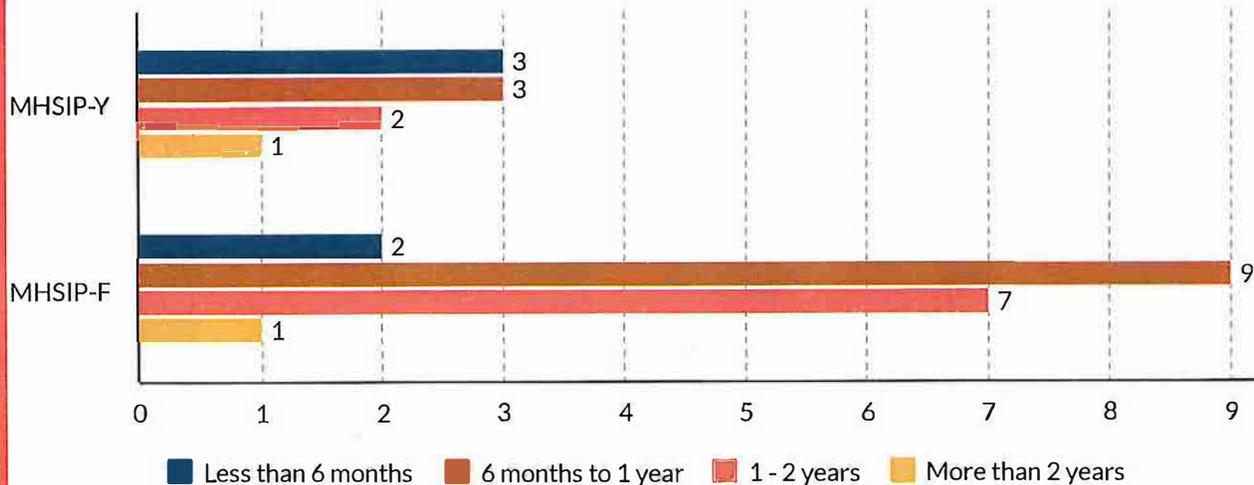


MHSIP-Y  
15

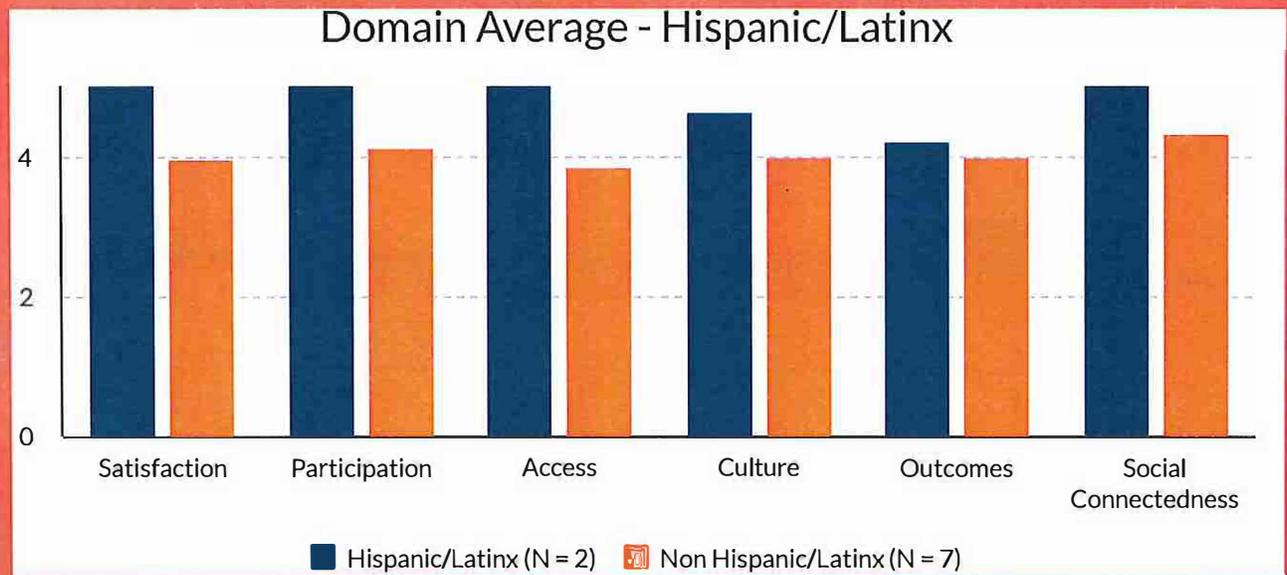
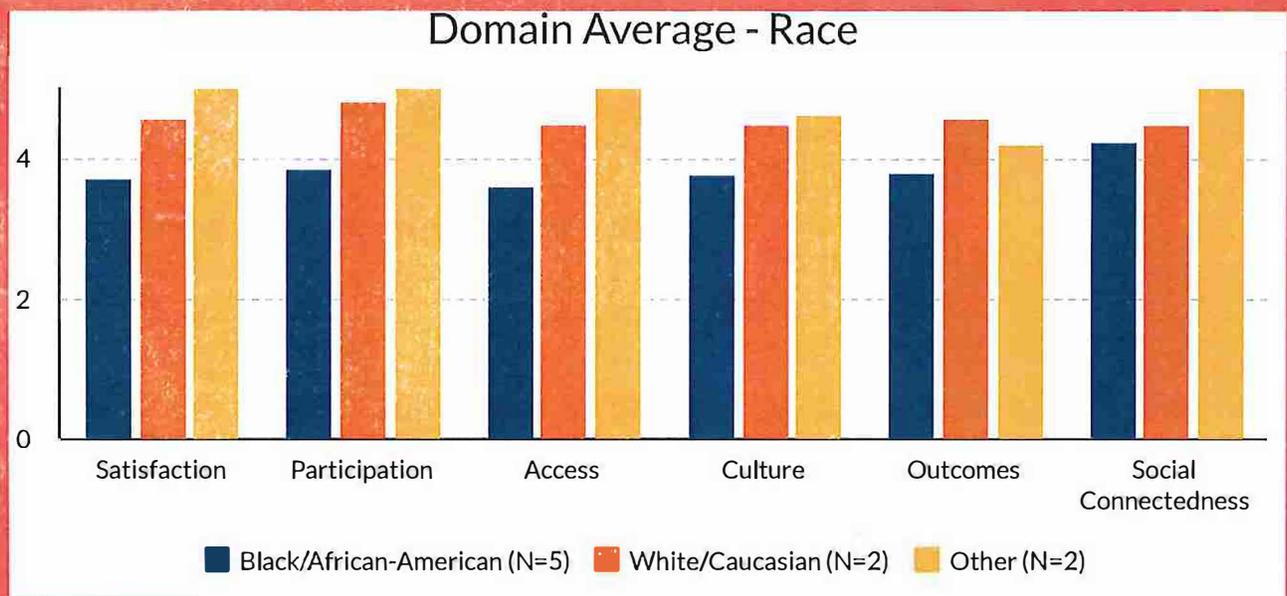
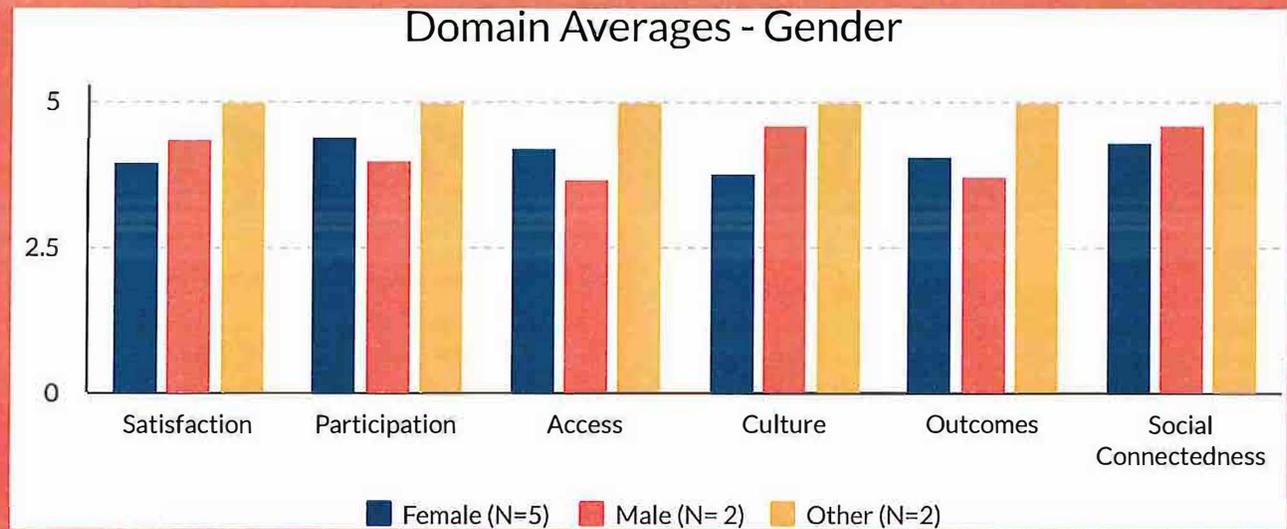
#### Types of Service (MH/SA/MH & SA)



#### Length of Time in CCS



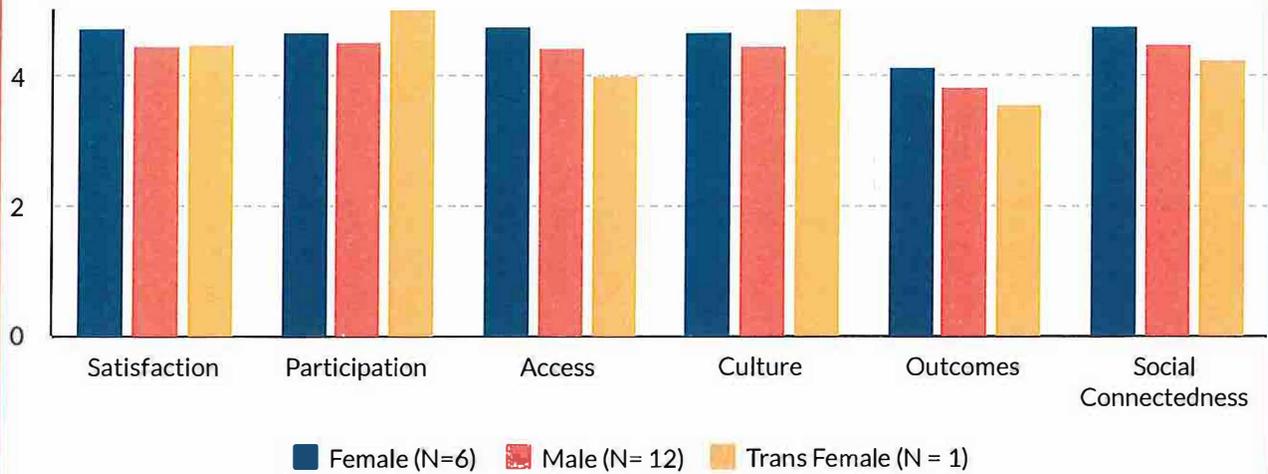
# MHSIP-Y (Surveys Completed: 10)



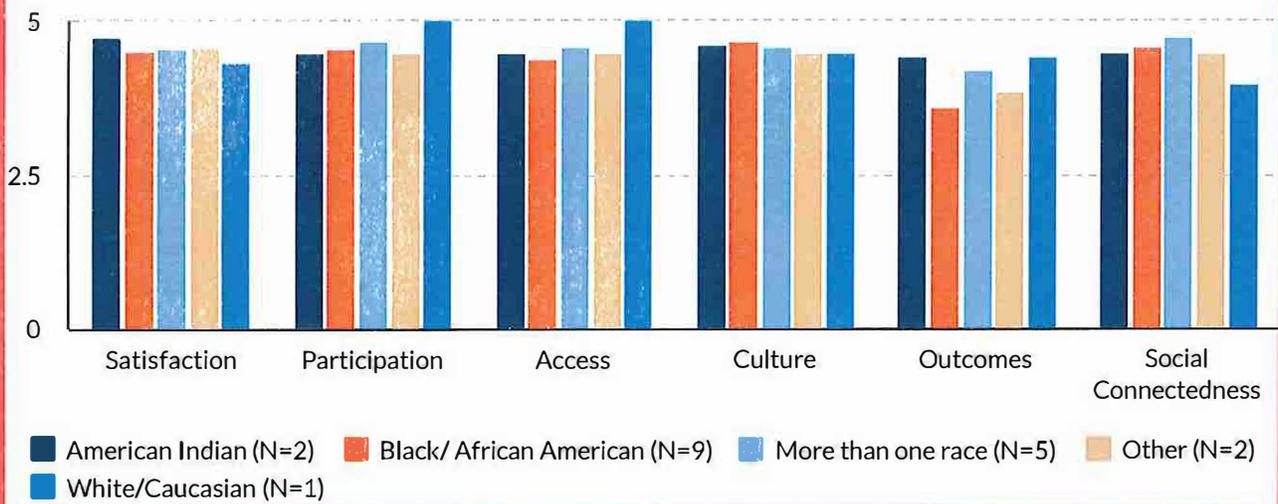
\*Domains in these graphs have reverse calculation for reporting consistency across this data summary

# MHSIP-F (Surveys Completed: 19)

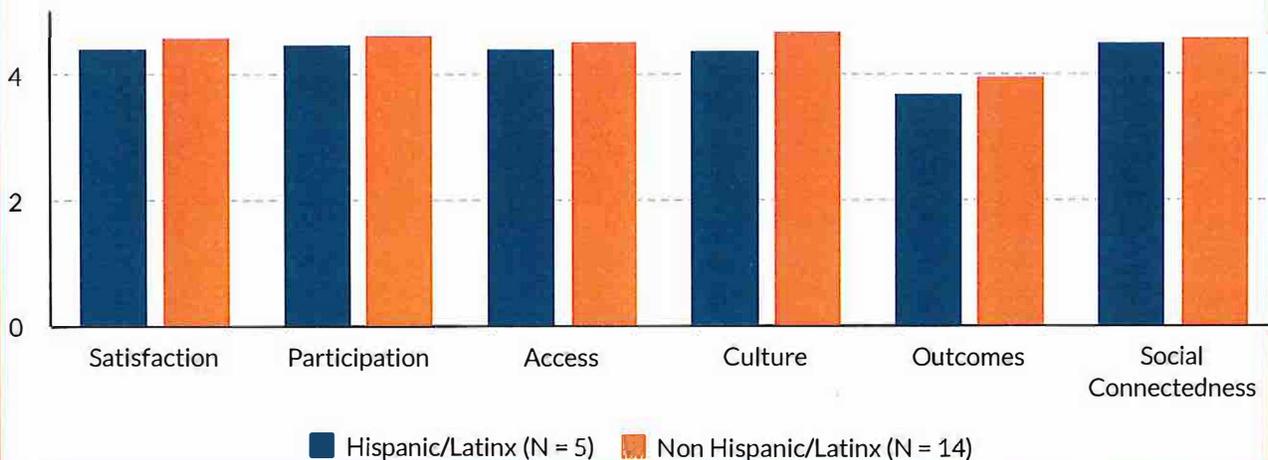
## Domain Averages By Gender



## Domain Average by Race



## Domain Average - Hispanic/Latinx



\*Domains in these graphs have reverse calculation for reporting consistency across this data summary

MHSIP  
Consumer  
Satisfaction  
Survey

Annual

2019

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Prepared By:  
Quality  
Improvement  
Department

Created 2/4/20

## Overview

- In 2019, 338 of the 692 consumers discharged from Acute Adult Inpatient Service completed the MHSIP survey. Acute Adult Inpatient Service's 2019 MHSIP survey response rate of 49% is significantly above the 27% national average response rate for inpatient behavioral health patient satisfaction surveys.
- Acute Adult Inpatient Service's survey item domain scores are above or within 2 percentage points of the published national averages.
- The 2019 survey results revealed a positive rating increase for the "Dignity" and "Environment of Care" domains in comparison to 2018's scores. Both domains received their highest positive rating in the 17 year history of administering this survey.
- The following are *general guidelines* for interpreting the inpatient consumer survey results based on thirteen years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
  - Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
  - Percentages in the 70 - 79% range can be considered 'good' or 'expected'
  - Percentages in the 80 - 89% range can be considered 'high'
  - Percentages 90% and above can be considered 'exceptional'
- The results revealed a "High" response score for the Dignity domain (81%), "Good" response scores for 4 of the 6 survey item domains: 78% for Participation, 77% for Outcome, 76% for Empowerment, and 75% for Environment. Relatively low response scores were obtained for the patient Rights domain 66%.
- Survey items with the highest positive response scores were:
  - I was encouraged to use self-help/support groups (84%)
  - My contact with nurses and therapists was helpful (83%)
  - Staff here believe that I could grow, change and recover (82%)
  - I participated in planning my discharge (82%)
  - My symptoms are not bothering me as much (81%)
  - I felt comfortable asking questions about my treatment and medications (80%)
  - I am better able to deal with crisis (80%)
  - The hospital environment was clean and comfortable (80%)
  - My contact with my doctor was helpful (79%)
  - I was treated with dignity and respect (78%)

## Introduction

The survey of Acute Adult Inpatient consumers is intended to obtain consumers' perceptions of services received during their inpatient episode of care. The survey is an ongoing performance improvement project that utilizes the information obtained to identify performance improvement initiatives for inpatient treatment. Consumers' perceptions of inpatient services are obtained regarding:

- Outcomes attained
- The environment in which services were provided
- Participation in treatment planning and discharge
- Protection of rights
- Being treated with dignity
- Empowerment
- Additional aspects of services received including cultural sensitivity, treatment choices, and medications

## Method

At the time of discharge, unit social workers present the survey to all consumers and emphasize that the BHD values consumer input to the evaluation of services provided in its programs. They also explain to consumers that survey participation is voluntary, and assure consumers that analyses of the information obtained is summarized and does not identify any individual's responses. Individuals with multiple inpatient episodes are provided opportunities to respond to the survey after each inpatient stay.

## Instrument

The MHSIP Inpatient Consumer Survey (2001) contains a total of 28 items. Twenty-one items are designed to measure six domains: *Outcome, Dignity, Rights, Participation, Environment and Empowerment*. Seven additional items ask respondents to rate other aspects of services received including treatment options, medications, cultural sensitivity, and staff. Respondents indicate their level of agreement/disagreement with statements about the inpatient mental health services they have received utilizing a 5-point scale: strongly agree – agree – neutral – disagree – strongly disagree. Respondents may also record an item as not applicable.

Additional survey items are completed to provide basic demographic and descriptive information: age, gender, marital status, ethnicity, length of stay, and legal status. Respondents may choose to provide written comments on the survey form about their responses or about areas not covered by the questionnaire. The following lists the consumer survey items.

## NRI/MHSIP Inpatient Consumer Survey (2001)

### **Outcome Domain:**

- I am better able to deal with crisis.
- My symptoms are not bothering me as much.
- I do better in social situations.
- I deal more effectively with daily problems.

### **Dignity Domain:**

- I was treated with dignity and respect.
- Staff here believe that I can grow, change and recover.
- I felt comfortable asking questions about my treatment and medications.
- I was encouraged to use self-help/support groups.

### **Rights Domain:**

- I felt free to complain without fear of retaliation.
- I felt safe to refuse medication or treatment during my hospital stay.
- My complaints and grievances were addressed.

### **Participation Domain:**

- I participated in planning my discharge.
- Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.
- I had the opportunity to talk with my doctor or therapist from the community prior to discharge.

### **Environment Domain:**

- The surroundings and atmosphere at the hospital helped me get better.
- I felt I had enough privacy in the hospital.
- I felt safe while in the hospital.
- The hospital environment was clean and comfortable.

### **Empowerment Domain:**

- I had a choice of treatment options.
- My contact with my doctor was helpful.
- My contact with nurses and therapists was helpful.

### **Other survey items:**

- The medications I am taking help me control symptoms that used to bother me.
- I was given information about how to manage my medication side effects.
- My other medical conditions were treated.
- I felt this hospital stay was necessary.
- Staff were sensitive to my cultural background.
- My family and/or friends were able to visit me.
- If I had a choice of hospitals, I would still choose this one.

## Results

The following presents the results of the Inpatient MHSIP Consumer survey completed by consumers of the Acute Adult Inpatient Service in 2019. Data from 2015 – 2018 administrations of the survey are also presented in select tables of this report to allow for comparisons.

The following are *general guidelines* for interpreting the inpatient consumer survey results based on twelve years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:

- Percentages less than 70% can be considered 'relatively low' and below 60% can be considered 'poor'
- Percentages in the 70 - 79% range can be considered 'good' or 'expected'
- Percentages in the 80 - 89% range can be considered 'high'
- Percentages 90% and above can be considered 'exceptional'

## Response Rate

Completed surveys were obtained at discharge from 338 of the 692 consumers discharged from the Acute Adult Inpatient service in 2019. Acute Adult Inpatient Service's 2019 MHSIP survey response rate of 49% is significantly above the 27% national average response rate for inpatient behavioral health patient satisfaction surveys.

Table 1 presents data on response rates by unit and the total BHD Acute Adult Inpatient Service for 2017 – 2019.

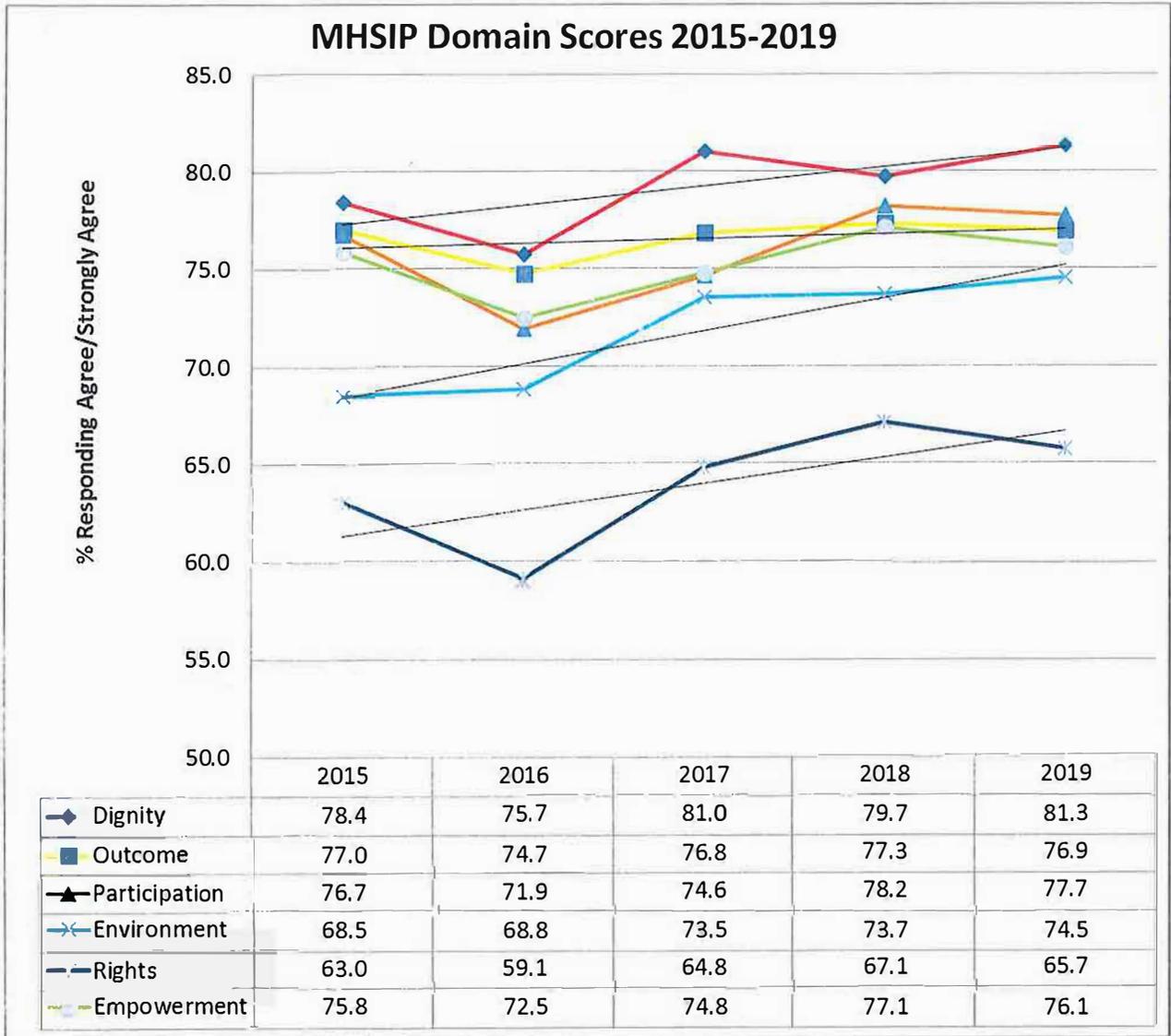
Table 1. Inpatient MHSIP Consumer Survey - Response Rate by Unit						
Unit	2017		2018		2019	
	Completed Surveys	Response Rate	Completed Surveys	Response Rate	Completed Surveys	Response Rate
43A - ITU	48	21.6%	42	17.7%	110	49.1%
43B - ATU	154	59.5%	164	49.5%	142	52.4%
43C - WTU	16	9.0%	93	45.4%	86	43.4%
<b>Total</b>	<b>218</b>	<b>33.1%</b>	<b>299</b>	<b>38.7%</b>	<b>338</b>	<b>48.8%</b>

## Acute Adult Inpatient Service

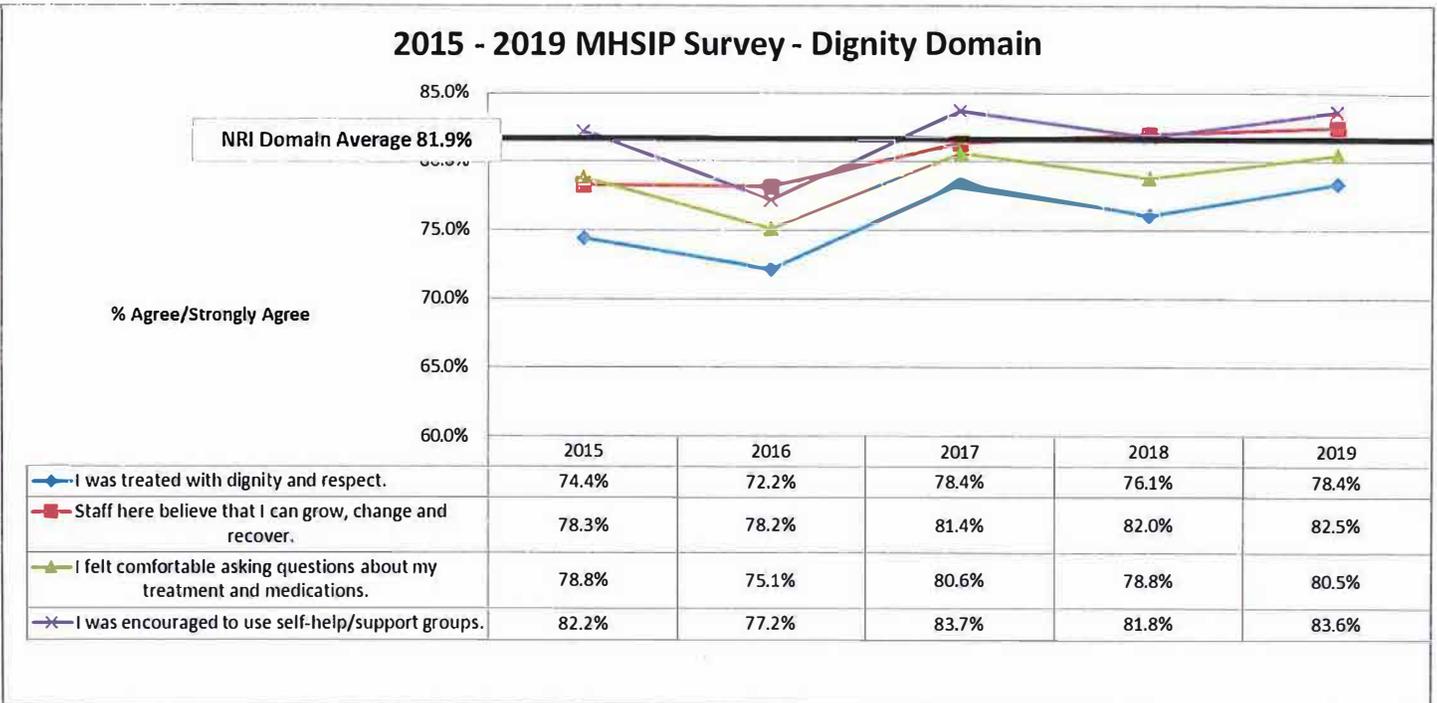
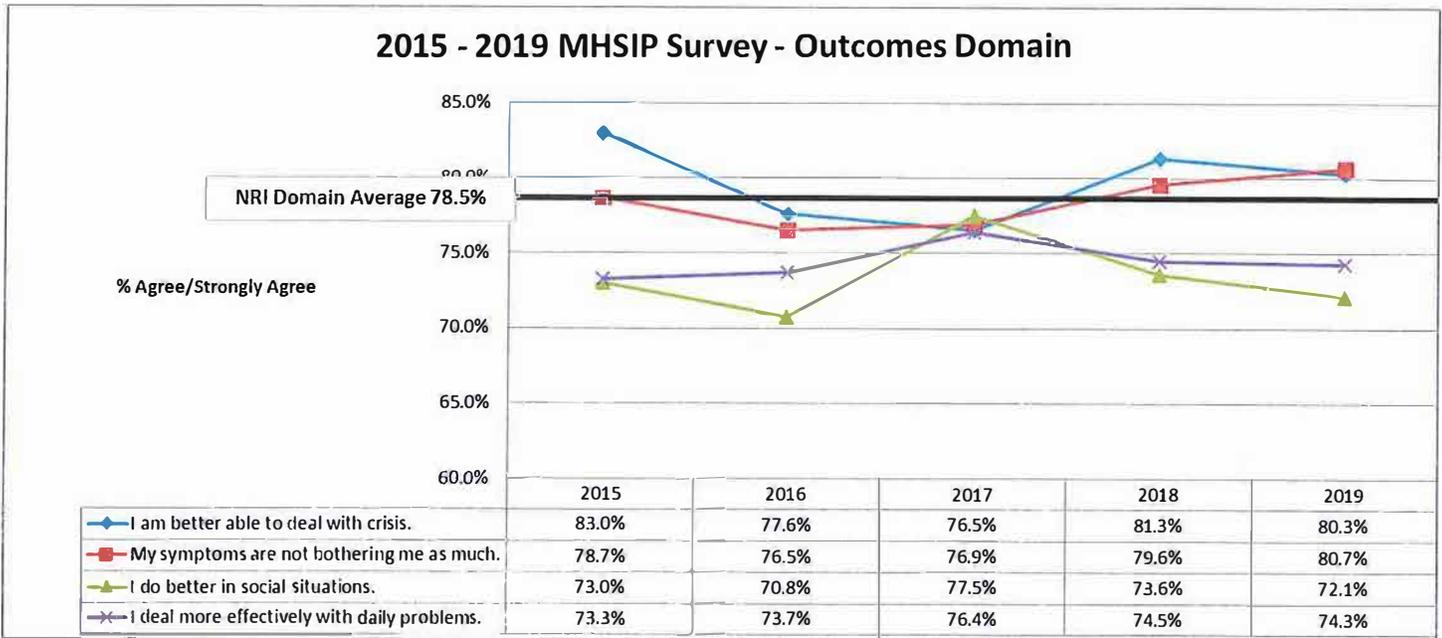
**Table 2** presents Acute Adult Inpatient Service’s consumer positive (agree/strongly agree) responses for 2015 – 2019. In 2019, the results revealed a “High” response score for the Dignity domain (81%), “Good” response scores for 4 of the 6 survey item domains: 78% for Participation, 77% for Outcome, 76% for Empowerment, and 75% for Environment. Relatively low response scores were obtained for the patient Rights domain 66%.

<b>Table 2. Inpatient MHSIP Consumer Survey - All Units</b>					
<b>Domains</b>	<b>Agree/Strongly Agree Response %</b>				
	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Dignity	78.4%	75.7%	81.0%	79.7%	81.3%
Outcome	77.0%	74.7%	76.8%	77.3%	76.9%
Participation	76.7%	71.9%	74.6%	78.2%	77.7%
Environment	68.5%	68.8%	73.5%	73.7%	74.5%
Rights	63.0%	59.1%	64.8%	67.1%	65.7%
Empowerment	75.8%	72.5%	74.8%	77.1%	76.1%
<b>Additional Questions</b>					
My family and/or friends were able to visit me.	78.6%	77.9%	81.8%	84.4%	82.5%
The Medications I am taking help me control my symptoms that used to bother me.	77.0%	74.3%	76.9%	77.1%	76.1%
My other medical conditions were treated.	68.1%	67.7%	72.5%	71.0%	68.7%
Staff were sensitive to my cultural background.	67.4%	64.7%	71.3%	71.9%	72.4%
I felt this hospital stay was necessary.	65.8%	62.5%	66.0%	67.1%	68.2%
I was given information about how to manage my medication side effects.	72.1%	66.1%	69.2%	69.7%	72.4%
If I had a choice of hospitals, I would still choose this one.	63.2%	56.0%	65.4%	65.6%	64.7%
<b>Surveys Completed</b>	502	280	218	299	338

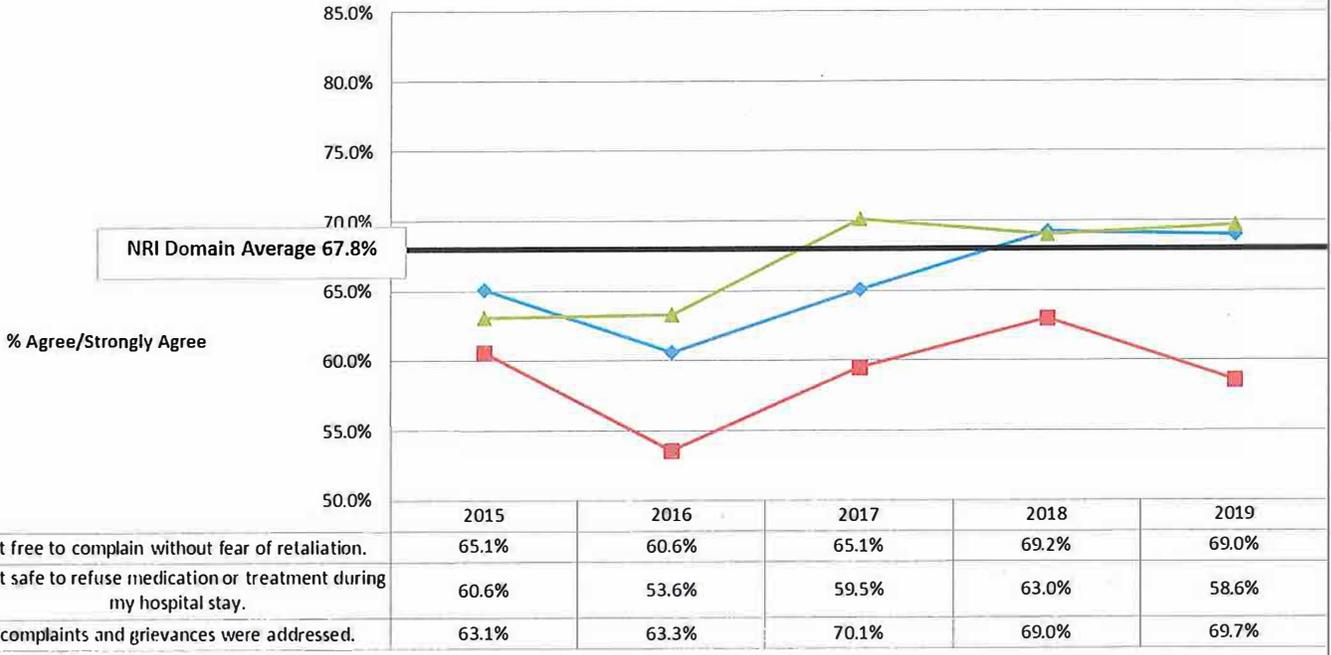
The following graph presents Acute Adult Inpatient Service's 2015-2019 positive (agree/strongly agree) Domain scores.



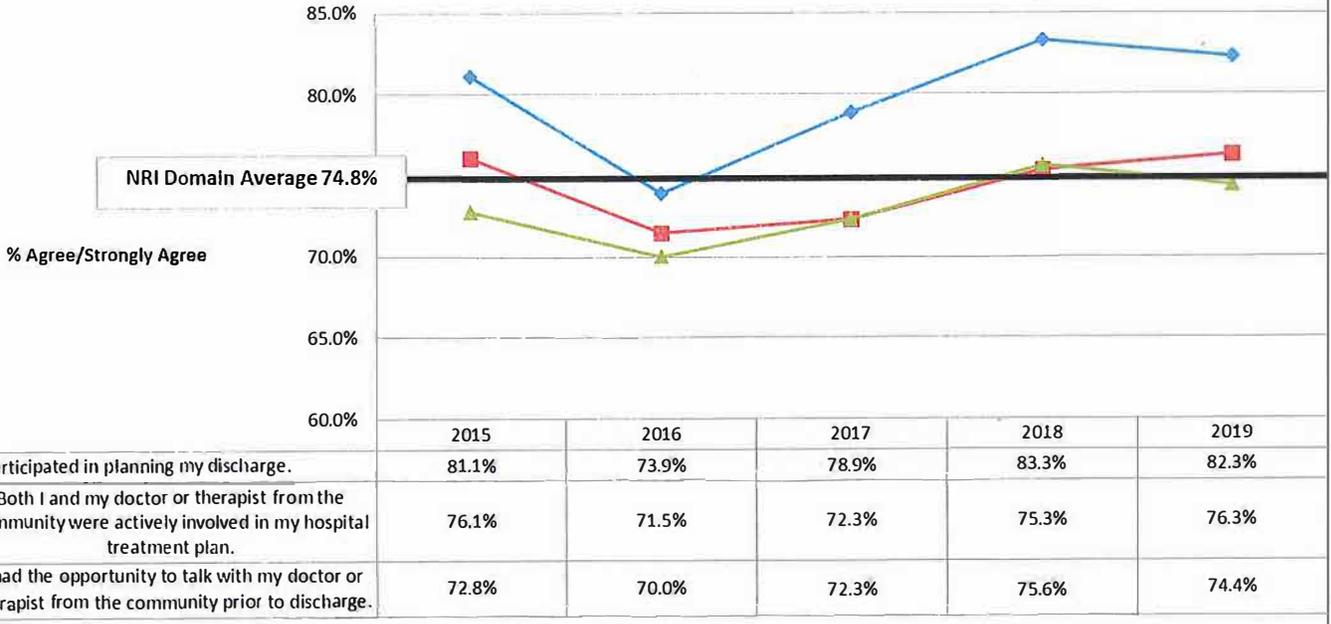
The following graphs present Acute Adult Inpatient Service's 2015-2019 positive (agree/strongly agree) survey item scores and NRI's domain average.



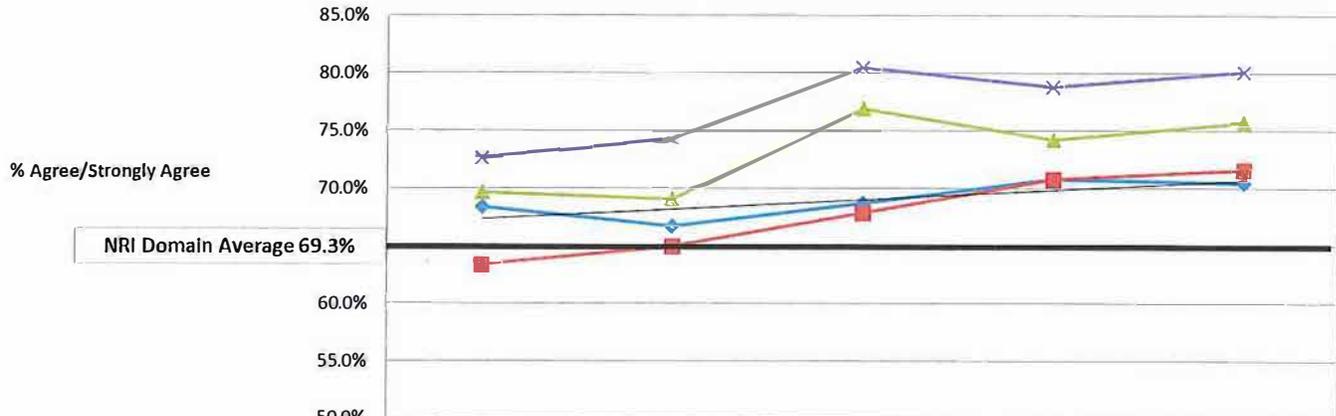
### 2015 - 2019 MHSIP Survey - Rights Domain



### 2015 - 2019 MHSIP Survey - Participation Domain

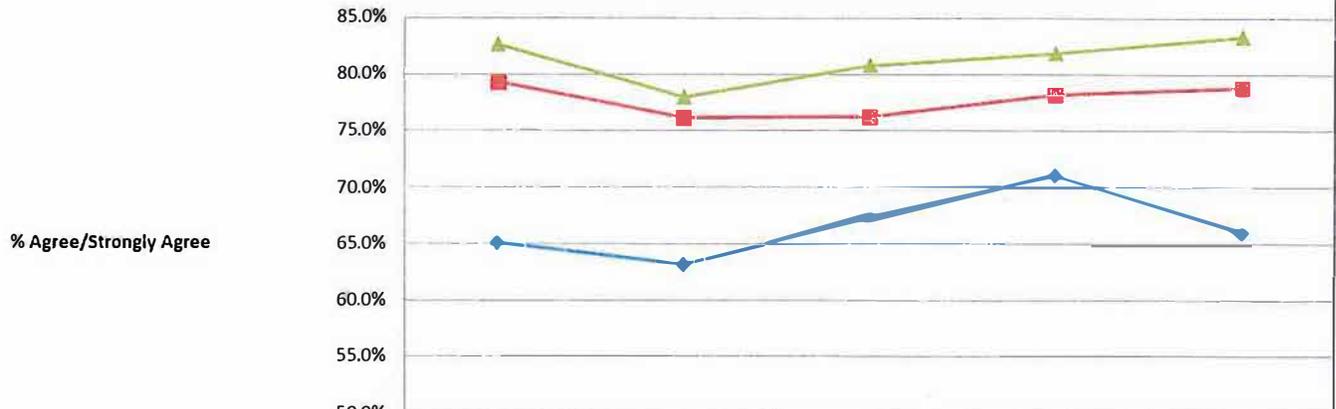


### 2015 - 2019 MHSIP Survey Item - Environment Domain



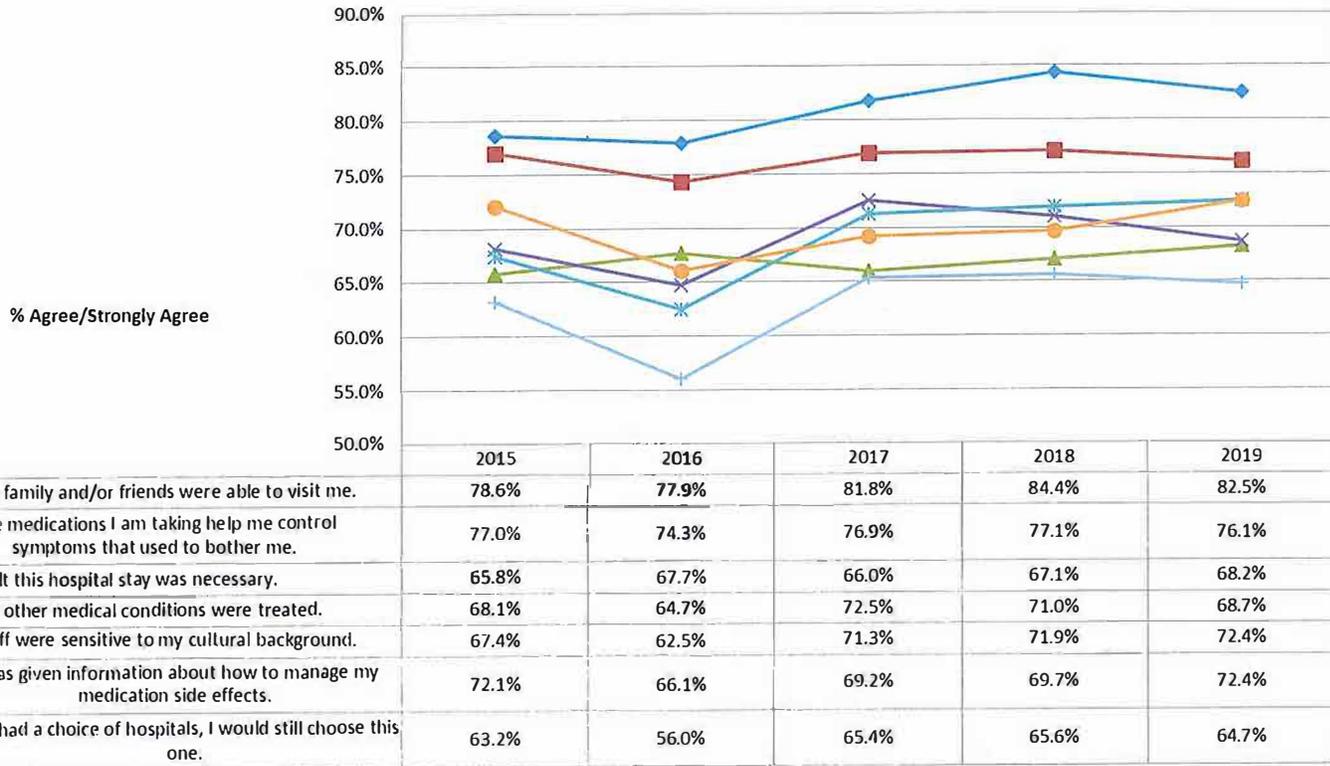
	2015	2016	2017	2018	2019
◆ The surroundings and atmosphere at the hospital helped me get better.	68.4%	66.7%	68.7%	70.8%	70.5%
■ I felt I had enough privacy in the hospital.	63.4%	65.0%	67.9%	70.8%	71.6%
▲ I felt safe while in the hospital.	69.6%	69.1%	76.9%	74.2%	75.7%
✕ The hospital environment was clean and comfortable.	72.6%	74.3%	80.5%	78.8%	80.1%

### 2015 - 2019 MHSIP Survey - Empowerment Domain



	2015	2016	2017	2018	2019
◆ I had a choice of treatment options.	65.1%	63.2%	67.3%	71.1%	66.0%
■ My contact with my doctor was helpful.	79.3%	76.2%	76.3%	78.2%	78.8%
▲ My contact with nurses and therapists was helpful.	82.6%	78.0%	80.8%	81.9%	83.3%

### 2015 - 2019 MHSIP Survey - Other Items



The NRI published national public rates from approximately 70 state inpatient psychiatric facilities that include MHSIP data as part of its Behavioral Healthcare Performance Measurement System. Due to possible differences in organizational and patient population characteristics, these aggregate data may not appropriately compare to BHD data.

**Table 3. BHD Inpatient MHSIP Agree/Strongly Agree Domain Response Scores Comparison to NRI National Average**

Domains	National Average	2019 BHD	BHD/National Avg Variance
Dignity	81.9%	81.3%	-0.6%
Outcome	78.5%	76.9%	-1.6%
Participation	74.8%	77.7%	2.9%
Environment	69.3%	74.5%	5.2%
Rights	67.8%	65.7%	-2.1%
Empowerment	Not Reported	76.1%	-

**Table 4** presents 2019 survey results for domain and additional items by each Acute Adult Inpatient Unit. The following summarizes these comparisons and should be interpreted as a *general* measure of a unit's performance based on consumers' perceptions of their inpatient stay:

<b>Table 4. 2019 Inpatient MHSIP Consumer Survey - By Unit</b>			
<b>Domains</b>	<b>Agree/Strongly Agree Response</b>		
	<b>43A</b>	<b>43B</b>	<b>43C</b>
Dignity	74.2%	84.6%	84.5%
Outcome	74.8%	76.5%	80.1%
Participation	65.9%	84.5%	81.0%
Environment	65.0%	80.7%	76.2%
Rights	56.4%	68.6%	72.3%
Empowerment	65.7%	79.1%	84.3%
<b>Additional Questions</b>			
My family and/or friends were able to visit me.	83.3%	80.3%	85.0%
The Medications I am taking help me control my symptoms that used to bother me.	72.9%	76.3%	80.0%
My other medical conditions were treated.	53.9%	73.0%	77.6%
Staff were sensitive to my cultural background	61.9%	74.2%	82.4%
I felt this hospital stay was necessary	64.2%	70.7%	69.0%
I was given information about how to manage my medication side effects	62.1%	76.5%	78.3%
If I had a choice of hospitals, I would still choose this one.	52.9%	67.4%	75.0%
<b>Surveys Completed</b>	<b>110</b>	<b>142</b>	<b>86</b>

## Appendix

*The comments below were written on surveys administered in 2019.*

### **43A - Positive Comments**

1. I am now better.
2. I feel great, and I like my improvement.
3. Stay could have been shorter, but I'm grateful!
4. Thank you!
5. This visit went very well.
6. Food was really good.
7. I really appreciate the help I received from the team.
8. My stay here was great.
9. Thanks for all your help!
10. Thanks for the stay and help. God Bless!
11. The entire staff and the way they worked together played a major role in my recovery. The extreme respect and attention to detail was a crucial aide in my recovery outside of medication.
12. Therapy staff very good as well as helpful. Medical part (daily) nurses etc., very stressful, but the doctors are excellent; other patients are very out of order.

### **43A - Negative Comments**

1. Some nurse totally ignore patients at times it would be best to help them.

### **43B - Positive Comments**

1. Everything was ok. Everything was very good. The surroundings, everything.
2. I just want to say that everyone was real supportive of me and worked with me. I got support from all the doctors and the nurses who helped me through my GI symptoms.
3. Thank you all!
4. Albert was very good to me. He made my first couple of days a little bit easier.
5. I had a good stay at the hospital and all members at the unit were very helpful and kind hearted.
6. Peer Support really helped me and a lot of the patients here. M.H.T. Techs really took time to talk to a lot of patients and myself. It's really helped me find myself more and bring the unit together for patient for patient support.
7. The stay was very good. At one time this was the best Behavioral Health Center in the America. Still is.

### **43B - Negative Comments**

1. The units need to feel more like a safe space where patients look forward to receiving help. It feels too much like jail. Food seriously needs an upgrade; color throughout the building wouldn't hurt.

### **43C - Positive Comments**

1. Everyone at BHD was very professional and nice.

# CAIS Youth Survey

Annual Report

# 2019

The CAIS Youth Survey collects demographic data about the age, gender, and race/ethnicity of respondents in addition to obtaining their opinions about the services received during the inpatient stay. In completing the youth survey, respondents indicate their level of agreement / disagreement with statements utilizing a 5-point scale: strongly agree- agree- neutral- disagree- strongly disagree. The CAIS Youth Survey contains 21 items measuring five aspects of the mental health services provided in the program:

- Access to Services
- Appropriateness of Treatment
- Participation in Treatment
- Cultural Sensitivity/ Respectful Treatment
- Outcomes

Prepared By:  
Quality  
Improvement  
Department

2/12/20

## Overview

- In 2019, 121 of the 520 youth (aged 13 years or older) discharged from CAIS completed the CAIS Youth Survey, **yielding a 23.3% response rate.**
- The survey results for 2019 (in comparison to 2018) revealed an 8 percentage point increase in the “Participation in Treatment” domain’s satisfaction score, 6 percentage point increase in the “Access to Services” domain, 5 percentage point increase in the “Appropriateness of Treatment” domain, and stable satisfaction results for the “Patient Outcomes” and “Cultural Sensitivity/Respectful Treatment” domains.
- Currently, no national averages/benchmarks are publicly available for this survey. The following are *general guidelines* for interpreting the inpatient consumer survey results based on nine years of administering the survey. The percentage of agree/strongly agree (positive) responses may be interpreted as:
  - Percentages less than 70% can be considered ‘relatively low’ and below 60% can be considered ‘poor’
  - Percentages in the 70 - 79% range can be considered ‘good’ or ‘expected’
  - Percentages in the 80 - 89% range can be considered ‘high’
  - Percentages 90% and above can be considered ‘exceptional’
- The results revealed a “High” positive response score for the Participation in Treatment (85%) and Cultural Sensitivity/Respectful Treatment (83%) domains, “Good” positive response scores were obtained for the Appropriateness of Treatment (79%) domain. Relatively low positive response scores were obtained for the Access to Services (67%) and Patient Outcomes (64%) domains.
- Survey items with the highest positive response scores were:
  - I participated in my own treatment (94%)
  - Staff spoke with me in a way that I understood (88%)
  - Staff respected my family’s religious/spiritual beliefs (88%)
  - I helped to choose my treatment goals (87%)
  - Overall, I am satisfied with the services I received (84%)
  - Staff treated me with respect (83%)
  - I felt I had someone to talk to when I was troubled (82%)
  - I received the services that were right for me (80%)
  - The people helping me stuck with me no matter what (77%)
  - I got the help I wanted (76%)
- The open ended survey item “Most helpful things you received during your stay” resulted in patients writing comments regarding: staff listening to patient (23%), coping skills (17%), caring, respectful staff (15%), groups (14%), treatment received (11%), medication received (9%), anger management (9%), and safe environment (2%)
- The open ended survey item “What would improve the program here” resulted in patients writing comments regarding: better food (56%), no improvements needed (15%), respectful staff (15%), more groups and activities (8%), better treatment (4%), and better communication between staff and patients (2%).

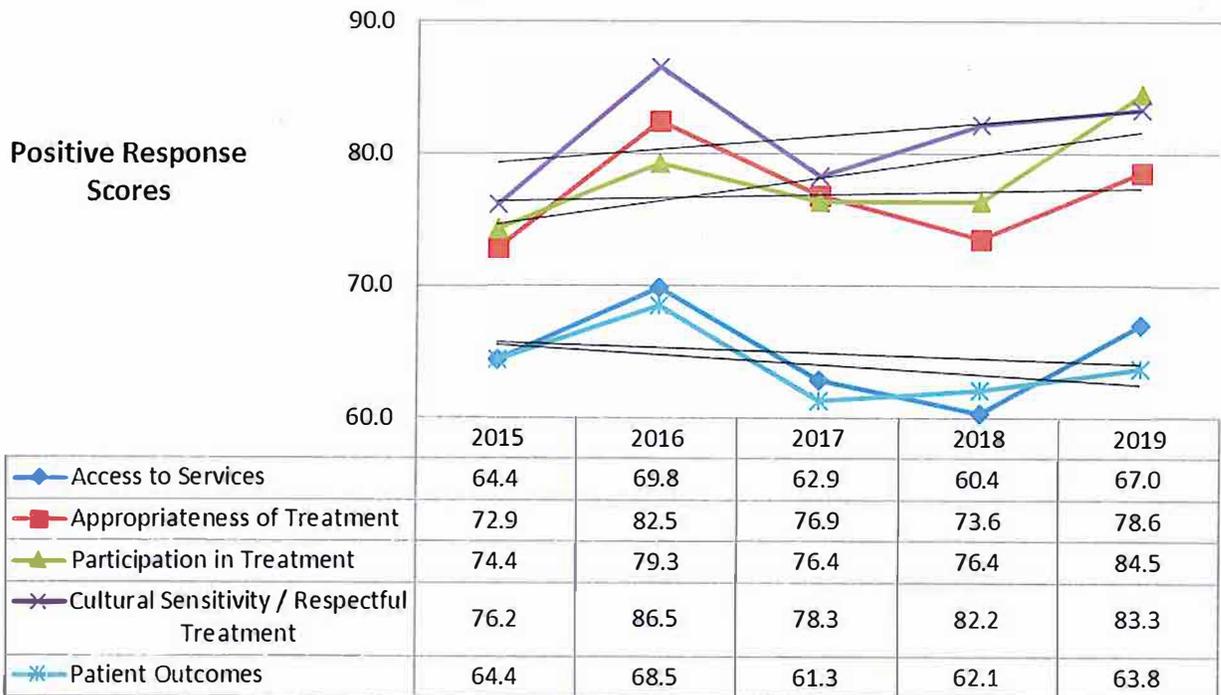
## Method

Youth served in CAIS were requested to participate in the CAIS Youth Survey prior to discharge. Staff administering the survey explained that the Milwaukee County Behavioral Health Division values their input in the evaluation of the CAIS program, and would use the information to help improve the program. The patients filled out the surveys understanding that it was voluntary, confidential and anonymous. Additionally, staff determined whether assistance was needed to complete the survey (e.g. reading comprehension, following instructions, etc.). Assistance was provided as necessary, while maintaining the confidentiality of the responses.

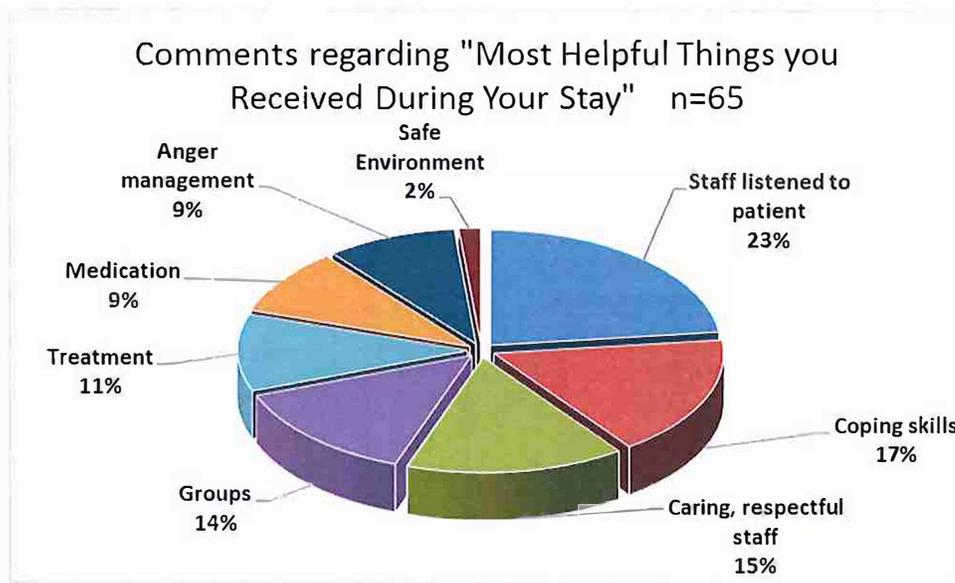
**Table 1** presents CAIS' consumer positive (agree/strongly agree) response scores for 2015 – 2019.

<b>Table 1. 2015-2019 CAIS Youth Survey - Agree/Strongly Agree Response %</b>						
<b>Survey Item / Domain</b>	<b>Year</b>					
	<b>2015 N = 618</b>	<b>2016 N = 106</b>	<b>2017 N = 182</b>	<b>2018 N = 209</b>	<b>2019 N = 121</b>	<b>2018/2019 Variance</b>
The location of services was convenient	61.6	58.7	54.0	46.3	59.7	13.4
Services were available at times that were convenient for me	67.2	80.8	71.8	74.4	74.2	-0.2
<b>Access to Services Domain</b>	<b>64.4</b>	<b>69.8</b>	<b>62.9</b>	<b>60.4</b>	<b>67.0</b>	<b>6.6</b>
Overall, I am satisfied with the services I received	74.0	82.1	76.8	74.2	83.5	9.3
The people helping me stuck with me no matter what	71.6	82.1	79.0	73.4	76.7	3.3
I felt I had someone to talk to when I was troubled	72.6	81.0	81.9	77.3	81.7	4.4
I received the services that were right for me	74.0	84.6	76.4	75.7	79.7	4.0
I got the help I wanted	72.0	84.0	72.4	72.1	76.0	3.9
I got as much help as I needed	73.1	81.0	75.1	69.1	73.9	4.8
<b>Appropriateness of Treatment Domain</b>	<b>72.9</b>	<b>82.5</b>	<b>76.9</b>	<b>73.6</b>	<b>78.6</b>	<b>4.9</b>
I helped to choose my services	65.5	66.7	68.0	62.2	71.9	9.7
I helped to choose my treatment goals	76.6	85.6	77.2	83.6	87.4	3.8
I participated in my own treatment	81.2	85.6	84.0	83.3	94.1	10.8
<b>Participation in Treatment Domain</b>	<b>74.4</b>	<b>79.3</b>	<b>76.4</b>	<b>76.4</b>	<b>84.5</b>	<b>8.1</b>
Staff treated me with respect	72.2	81.0	78.9	79.5	82.5	3.0
Staff respected my family's religious/spiritual beliefs	78.6	88.1	80.9	84.3	88.1	3.8
Staff spoke with me in a way that I understood	82.2	91.4	84.1	89.3	88.3	-1.0
Staff were sensitive to my cultural/ethnic background	71.9	85.6	69.3	75.7	74.4	-1.3
<b>Cultural Sensitivity / Respectful Treatment Domain</b>	<b>76.2</b>	<b>86.5</b>	<b>78.3</b>	<b>82.2</b>	<b>83.3</b>	<b>1.1</b>
I am better at handling daily life	70.9	68.9	70.4	66.7	73.6	6.9
I get along better with family members	60.2	64.2	53.9	50.2	60.5	10.3
I get along better with friends and other people	70.5	74.3	65.7	72.2	71.1	-1.1
I am doing better in school and/or work	58.8	62.5	53.4	57.3	50.0	-7.3
I am better able to cope when things go wrong	65.1	74.0	65.0	70.5	66.9	-3.6
I am satisfied with my family life right now	60.9	66.7	59.4	55.8	60.8	5.0
<b>Patient Outcomes Domain</b>	<b>64.4</b>	<b>68.4</b>	<b>61.3</b>	<b>62.1</b>	<b>63.8</b>	<b>1.7</b>

## 2015-2019 CAIS Youth Survey Results

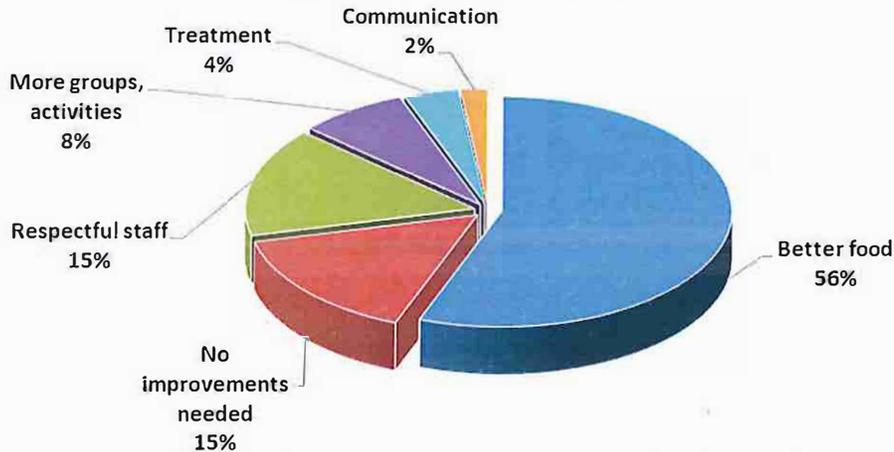


*The comments below were written on surveys administered in 2019.*

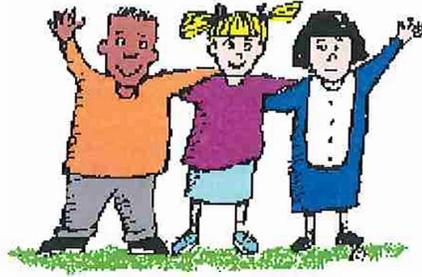
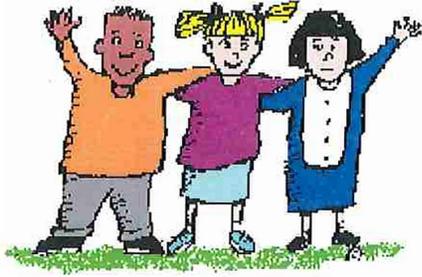


Category	Comments "Most Helpful Things You Received During Your Stay"
Anger management	<p>Helping me cope with my anger.  I got to learn about different ways to help me calm down.  Learning how to stay calm and realize that suicide isn't the option.  Learning to walk away.  My anger and when I needed to talk.  They showed me different ways to let out my anger that will positive and safe.</p>
Caring, Respectful Staff	<p>Everything the staff was great.  Help and support from my nurses.  I got treated with respect.  I trusted the staff and staff were reliable.  Just the help from all the nice people and having people to talk to.  People were respectful and kind.  Respect, considerate people, therapeutic treatment, my medication.  Support in all areas.  The constant check ins and people who seemed interested.  This was a lesson learned experience. The people helped me a lot and made sure they stayed with me.</p>
Coping skills	<p>Being given more coping skills.  Coping skills.  Coping skills.  I guess patience.  More coping skills.  Sheets of coping skills to use.  The coping skills I learned while I was here.  The doctors helped me with my coping skills.  The most helpful things were coping skills and all the specialists.  The way the doctors help me cope better with my anger.  To be more understanding in situations and coping with others in the problem.</p>
Groups	<p>Art was really helpful  Group Therapy.  I think that the most helpful things were coloring in the group class.  Keeping occupied with the other children.  School.  Stress ball, music, group.  Talking in groups, help me learn.  The group they had.  Therapy groups.</p>
Medication	<p>Medication, people to talk to.  Med's  My sleeping pills  The medication. I believe it can help me when I use it.  The meds.  The most helpful things I received during my stay were my medication, coping mechanisms, and school.</p>
Safe environment	<p>A place to feel safe.</p>
Staff listened to patient	<p>Advice and talks.  Being able to talk.  I get to talk to a lot of people here and do a lot peaceful things.  I learned that talking to people helps with our everyday problems and it's okay to cry.  I like the fact that I can relate to some people here not only that the staff was very helpful to me.  I'm not the only one.  I've had someone to talk too and make me feel good about myself.  People to talk to about what was going on in my life.  Someone to talk to.  Someone to talk to. They don't judge me.  Talking to adults.  Talking to somebody.  Talking to staff.  The most helpful thing I received was advice. Also tips and goals were set.  The talks. Dr. A helped a lot and it helped even more that she spoke to me as a person not as a patient.</p>
Treatment	<p>I befitted a lot while being here and got/received professional treatment that will make me feel/do better.  I received help and treatment and services I needed.  I received the right health help that I needed.  Learning how to do things different and some people and the staff helped me out.  They talked to me about how I could leave and do better so I could not come back.  This place has helped me so much and I am very thankful for that.  Tips and remaining on recovery.</p>

Comments regarding "What would improve the program here" n=52



Category	Comments "What would improve the program here"
<b>Better food</b>	<p>Better food (kitchen) and more outside activities.</p> <p>Better food (x17).</p> <p>Better food and more things to do to keep us busy.</p> <p>Better food, and heat and animal therapy, and to stop staring at the kids so much.</p> <p>Better food, clocks in the rooms.</p> <p>Food and more respectful nurses.</p> <p>I think people should be able to go to sleep whenever they want and it should be better food.</p> <p>I think the food could improve other than that its pretty helpful.</p> <p>Making it hospital food instead of jail food.</p> <p>More food for the kids.</p> <p>No response... actually better food.</p> <p>The food and more things to entertain us.</p> <p>The Food! And school program for the older kids and bedtime for the older kids.</p>
<b>Communication</b>	<p>I would improve communication between the nurses and the patients.</p>
<b>No Improvements Needed</b>	<p>In my opinion I think it's a good program I don't think there anything to add on it.</p> <p>Its already improved.</p> <p>Nothing because it's good.</p> <p>Nothing, satisfied. Better food.</p> <p>Nothing (x3).</p> <p>Nothing the program is great!</p>
<b>More groups, activities</b>	<p>More activities.</p> <p>More games.</p> <p>More groups.</p> <p>Outdoor equipment</p>
<b>Respectful staff</b>	<p>CNA Staff</p> <p>More African American staff.</p> <p>More respect towards patients.</p> <p>Nice Staff.</p> <p>Nurses that have a little more respect and going to bed so early.</p> <p>Some of the staff were mean and disrespectful.</p> <p>The people.</p> <p>The staff are really rude and lazy. I hope they get it together.</p>
<b>Treatment</b>	<p>More treatment.</p> <p>Better medical help available. Better food. Some staff were just terrible.</p>



CAIS YOUTH SURVEY

Please help CAIS be a better program by answering the following questions. Your answers are confidential.  
 Directions: Put a cross (X) in the box that best describes your answer. Thank you!

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. Overall, I am satisfied with the services I received.					
2. I helped to choose my services.					
3. I helped to choose my treatment goals.					
4. The people helping me stuck with me no matter what.					
5. I felt I had someone to talk to when I was troubled.					
6. I participated in my own treatment.					
7. I received services that were right for me.					
8. The location of CAIS was convenient.					
9. Services were available at convenient times for me.					
10. I got the help I wanted.					
11. I got as much help as I needed.					
12. Staff treated me with respect.					
13. Staff respected my family's religious/spiritual beliefs.					
14. Staff spoke with me in a way that I understood.					
15. Staff were sensitive to my cultural/ethnic background.					
<b>As a result of the CAIS program:</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Undecided</b>	<b>Agree</b>	<b>Strongly Agree</b>
16. I am better at handling daily life.					
17. I get along better with family members.					
18. I get along better with friends and other people.					

19. I am doing better in school and/or work.					
20. I am better able to cope when things go wrong.					
21. I am satisfied with my family life right now.					

22. What were the most helpful things you received during your stay in the program? \_\_\_\_\_

23. What would improve the program here? \_\_\_\_\_

24. Other comments: \_\_\_\_\_

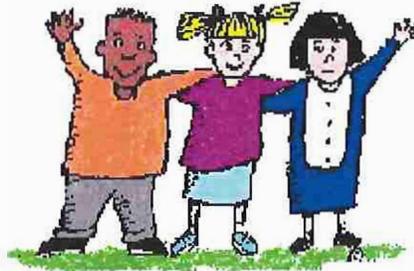
**Please answer the following questions to let us know a little about you.**

**Race / Ethnicity (mark with an X the category that applies to you):**

- American Indian/Alaskan Native  White (Caucasian)
- Black (African American)  Asian/Pacific Islander
- Spanish/Hispanic/Latino  Other

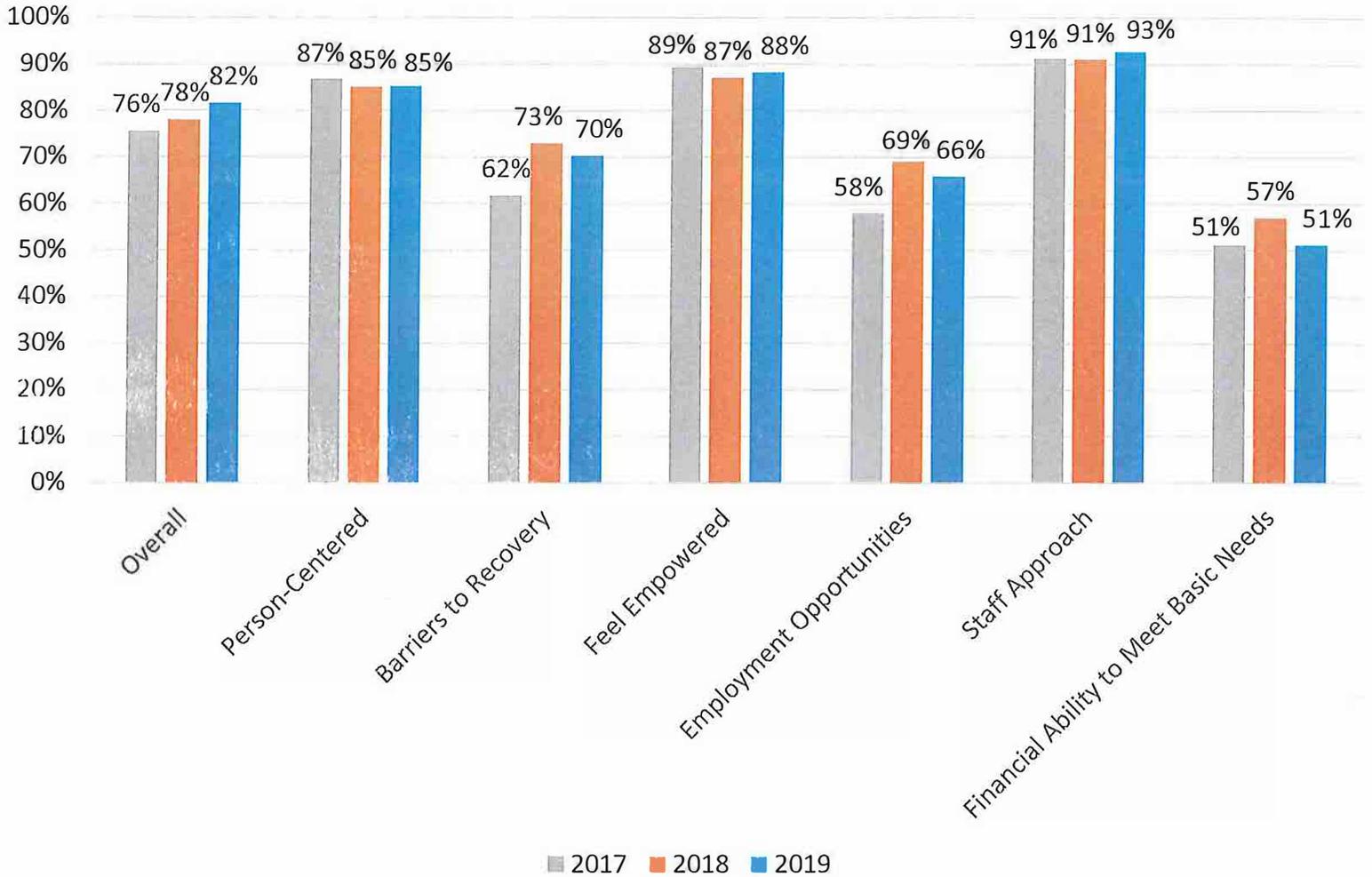
Age: \_\_\_\_\_ years old

Gender (mark with X):  Male  Female



## Recovery-Oriented System Indicators (ROSI) Survey Results

Recovery Oriented System Indicators (ROSI) Survey  
 "Mostly Recovery-Oriented Experience" Mean Percentages  
 2017-2019



Scale 1 – Person-Centered: These items describe whether clinical staff have a person-centered focus and allow for person-centered decision-making.

Scale 2 – Barriers: These items describe passive barriers to recovery that participants may experience.

Scale 3 – Empower: These items describe the degree to which participants feel empowered by staff and others.

Scale 4 – Employ: These items describe the degree to which educational/employment opportunities are available to the individual participant or participants in general.

Scale 5 – Staff Approach: These items describe the degree to which agency staff use a paternalistic and/or coercive approach working with participants.

Scale 6 – Basic Needs: These items describe the participant's current financial ability to meet his/her basic needs.



MARY JO MEYERS, MS • Director  
MICHEAL LAPPEN MS, LPC • Division Administrator

December 16, 2019

Dereck McClendon  
Crossroads Cognitive Behavioral Services  
Crossroads Bridge Housing  
2454 W. Lisbon Ave.  
Milwaukee, WI 53205

Re: Notice regarding Referrals to Crossroads

Dear Mr. McClendon,

Milwaukee County Behavioral Health Division (BHD) Community Access to Recovery Services (CARS) is submitting this communication as notice that all referrals to the Crossroads Behavioral Services and Crossroads Bridge Housing are being suspended as of this date until further notice.

This action is being taken due to notification from the Office of the Inspector General (OIG) that all Medicaid payments to your organization have been suspended pending an investigation of a credible allegation of fraud with an effective suspension date of 11/15/2019. These payment suspensions are in accordance with federal law, pursuant to 42 C.F.R. 455.23. Milwaukee County was therefore directed to suspend all Medicaid payments until notification by OIG to release the suspension or terminate your agency as a provider. Due to this determination, all referrals for services are being suspended

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

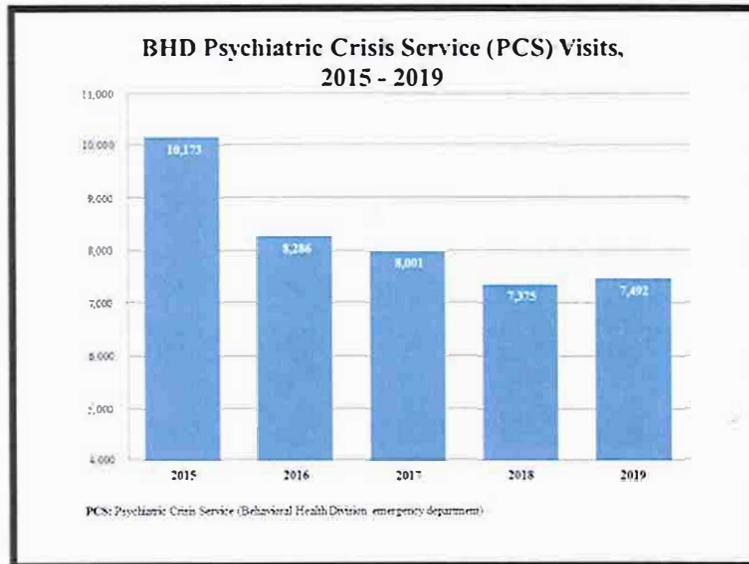
Sincerely,

A handwritten signature in black ink that reads "Amy Lorenz".

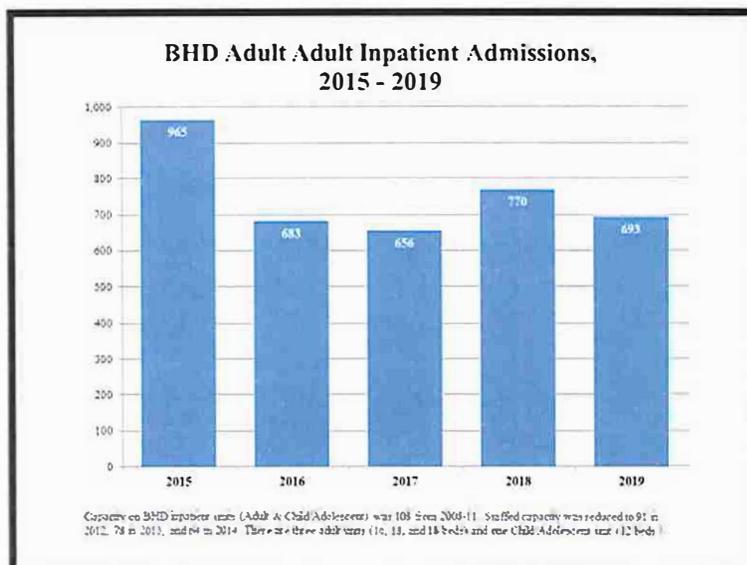
Amy Lorenz, MSSW, LCSW  
Deputy Administrator  
Community Access to Recovery Services  
Milwaukee County Behavioral Health Division

# 2019 Q4 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary **Quality Committee Item 8**

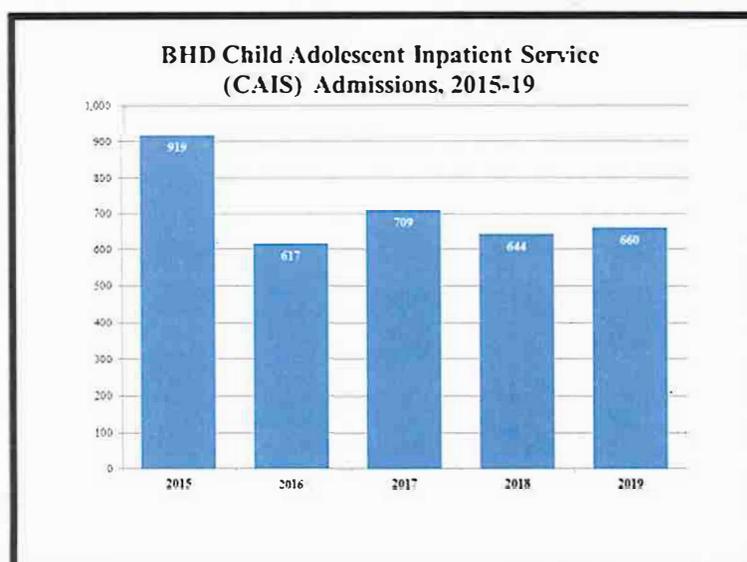
Psychiatric Crisis Service’s annual patient visits continue to decline from 10,173 in 2015 to 7,492 annual visits in 2019 (26% decline from 2015 to 2019). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (9% in 2014, 100% in 2019).



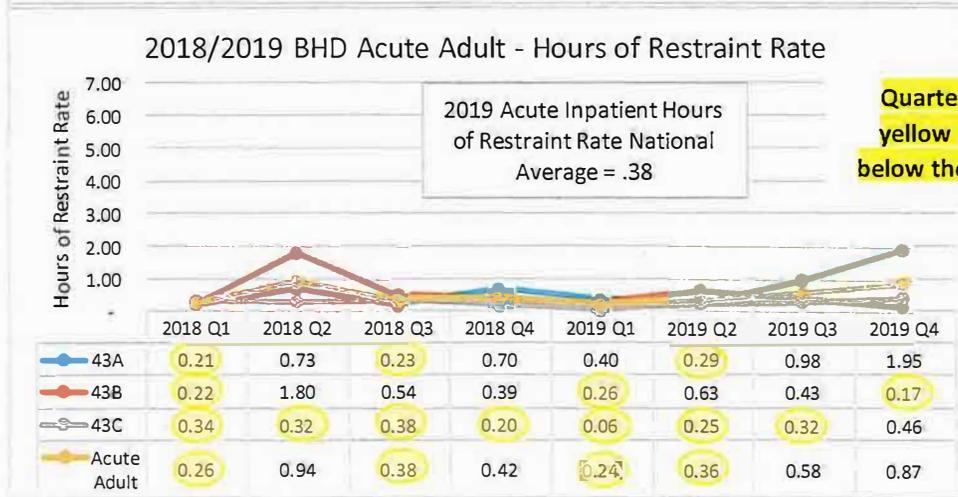
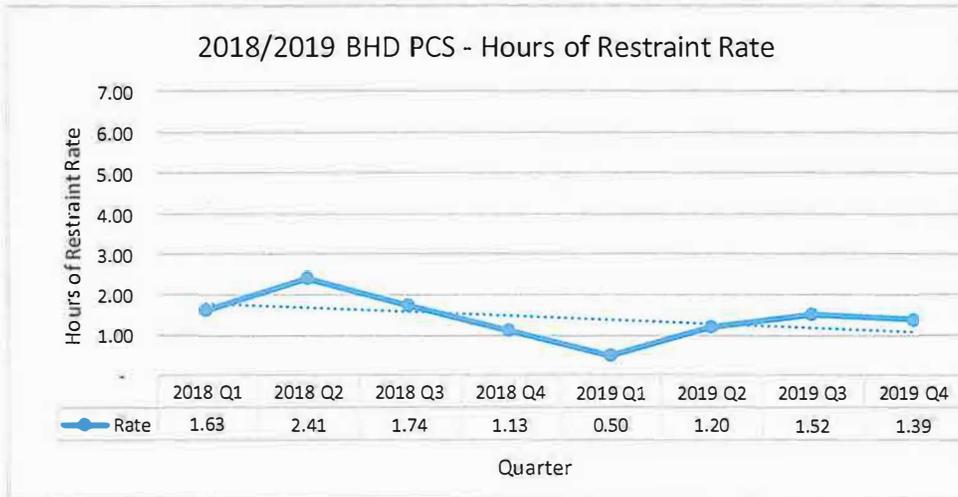
Acute Adult Inpatient Service’s patient admissions have plateaued over the past 4 years and were 693 in 2019. Readmission rates continue to decline (30-day readmission rate: 11% in 2015, 9% in 2019). Acute Adult’s hours of physical restraint rate in 2019 was .51, above CMS’ inpatient psychiatric facility national average of .38, but below Wisconsin’s average rate of .73. Acute Adult’s 2019 MHSIP overall patient satisfaction survey score of 75% is at the NRI’s reported national average.



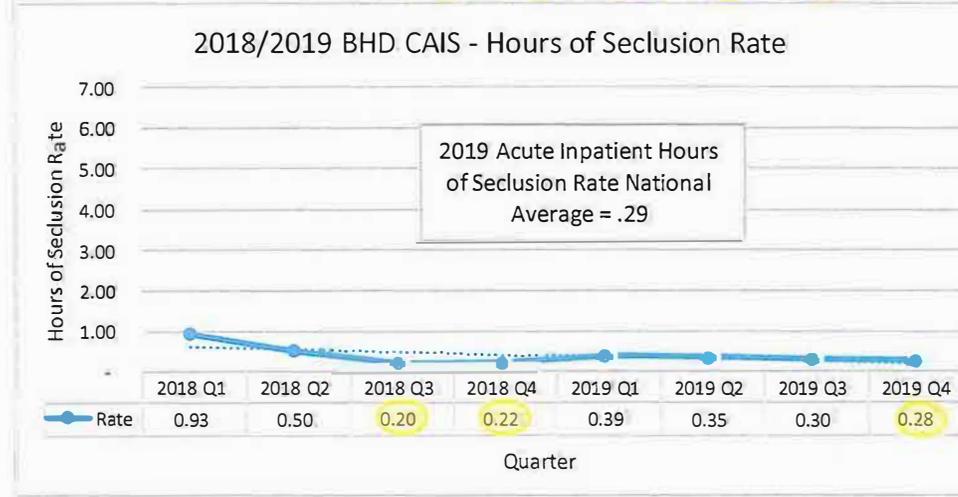
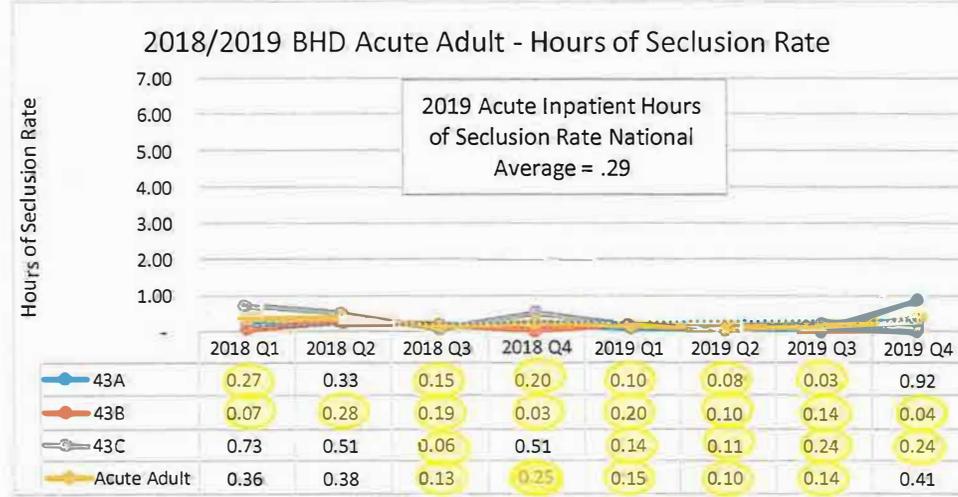
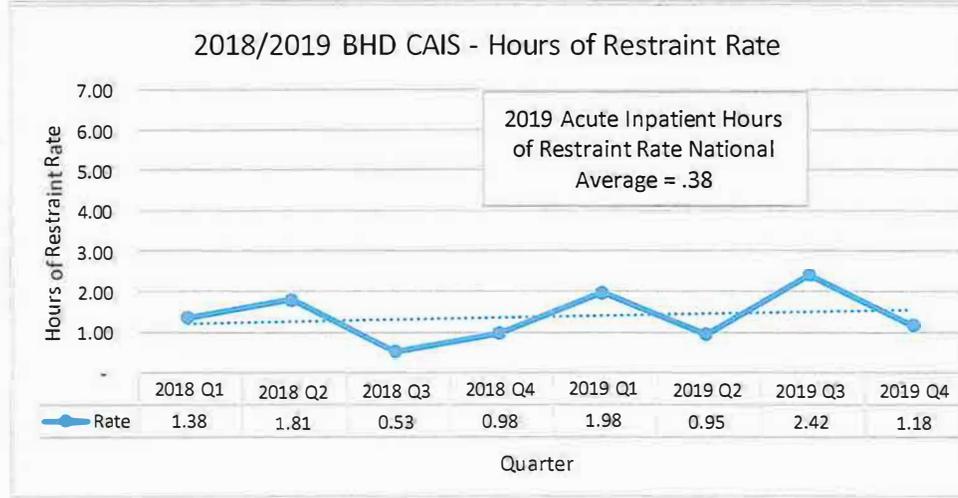
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past 4 years and were 660 in 2019. Over the past few years, CAIS’ 30-day readmission rates have remained at 16%. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.6 in 2019, but remains above CMS’ reported average of .38. CAIS’ Youth Satisfaction Survey overall score of 75.7% positive rating is 4 percentage points higher than BHD’s historical average.



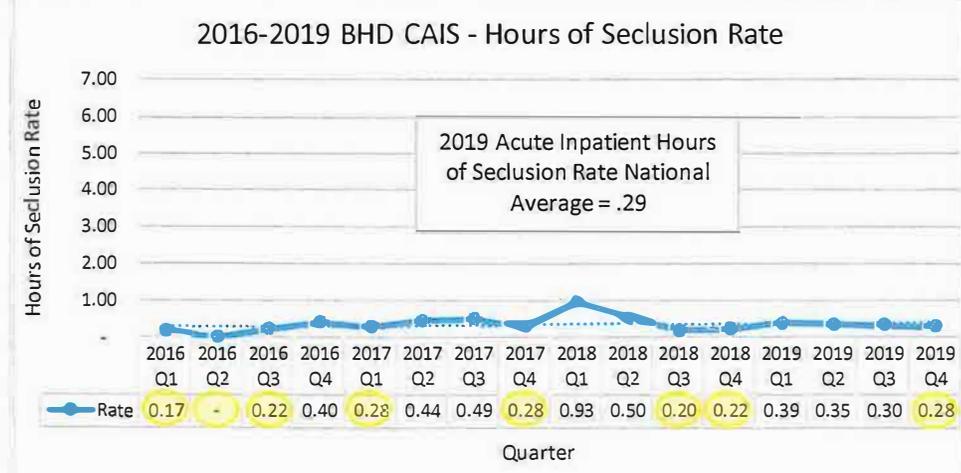
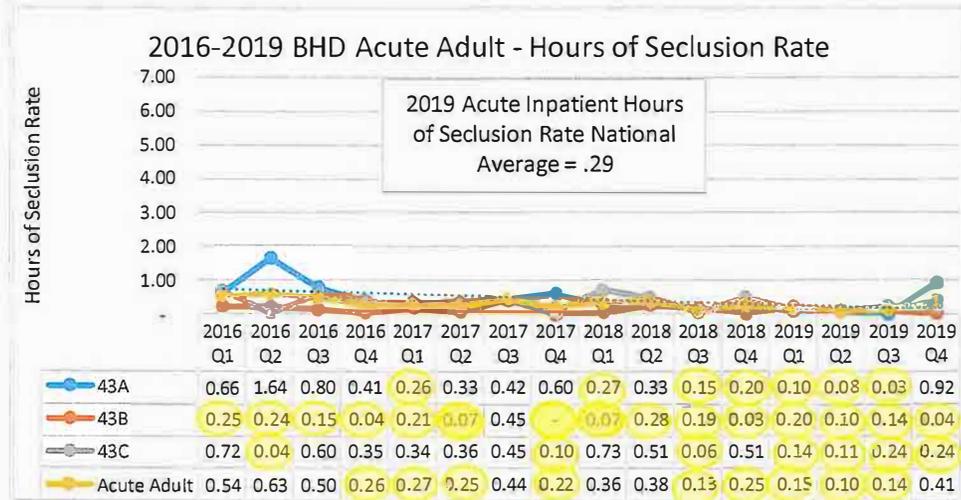
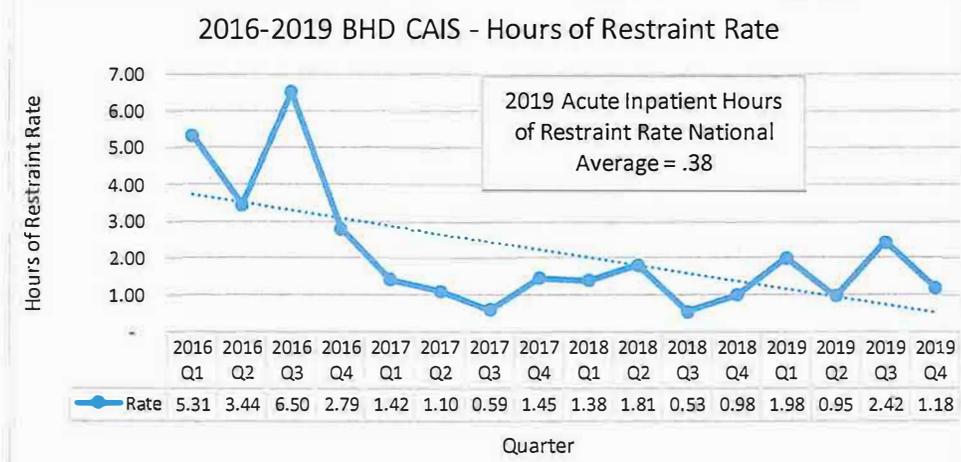
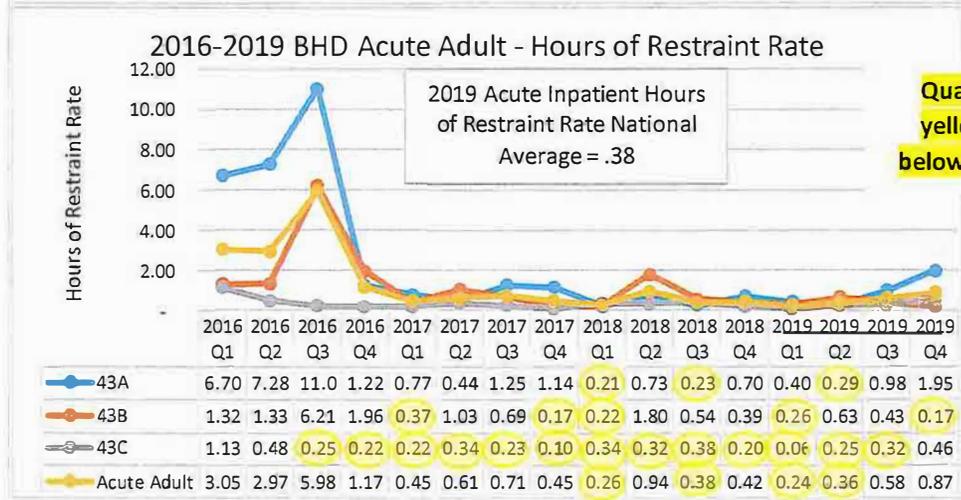
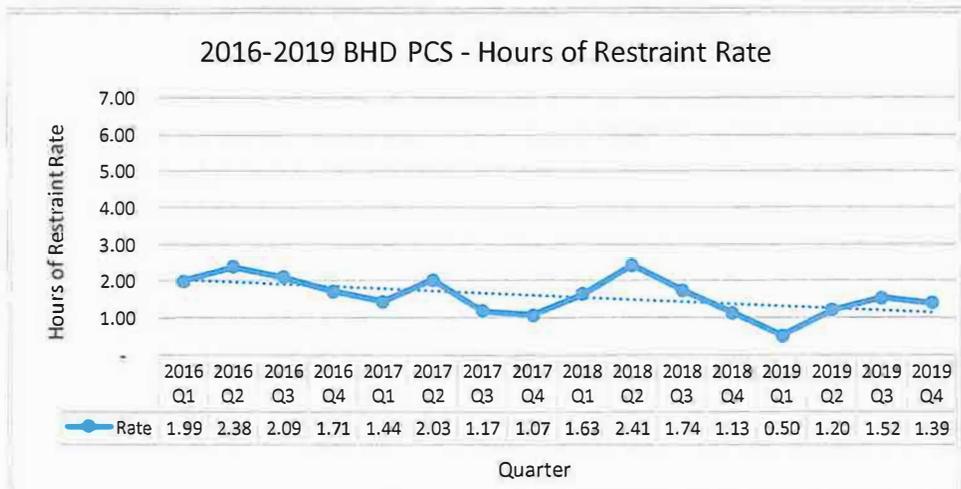
# 2019 Q4 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



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



# 2016-2019 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary



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



## Milwaukee County Crisis Services

### Crisis Resource Center (CRC) Collaborative

#### Overview

**Big Aim:** To reduce recidivism for Emergency Room visits and inpatient hospitalizations for adults with behavioral health and co-occurring needs in Milwaukee County.

**Small Aim:** To provide crisis intervention services in a welcoming community environment while ensuring that warm connections to client-driven recovery focused resources occur on site.

**Change:** 2 groups of 10 clients were selected, all who were currently receiving care and services at the Crisis Resource Center (CRC) for the first time. Those 10 clients received warm connections to self-directed recovery services while on site at the CRC. Readmissions to PCS or inpatient units were monitored for 30 days post discharge from CRC.

#### Data:

Group 1: 89% decrease in PCS admissions, 81% decrease in hospitalizations

Group 2: 83% decrease in PCS admissions, 96% decrease in hospitalizations

\*\*Clients self-referred to CRC 20+ times following this intervention for aftercare services and readmissions to CRC.

**Adopt!** Clients were able to achieve long-term comprehensive connections in a least restrictive environment.

#### Next Steps/Recommendations:

- Increase capacity for CRCs to continue to empower individuals to engage in recovery through making comprehensive connections to community programs and services.
- Increase community knowledge about the program.
- Increase referral sources.



**BHD** MILWAUKEE COUNTY  
Behavioral  
Health  
Division

# Milwaukee County Crisis Services

Crisis Resource Center (CRC)  
Collaborative



**WHOLE HEALTH**  
CLINICAL GROUP

a service of the  
Milwaukee Center for Independence



# AIM (Plan)

- **Big Aim:** To reduce recidivism for Emergency Room visits and inpatient hospitalizations for adults with behavioral health and co-occurring needs in Milwaukee County.
- **Small Aim:** To provide crisis intervention services in a welcoming community environment while ensuring that warm connections to client-driven recovery focused resources occur on site.



# CHANGE

- 10 clients were selected, all who were currently receiving care and services at the Crisis Resource Center (CRC) for the first time
- Those 10 clients received warm connections to self-directed recovery services while on site at the CRC
- Comprehensive support from CRC staff to assist clients in achieving goals
  - On-site access to care and services
  - Warm-hand offs
  - After-care options and individualized follow-up
- Readmissions to PCS or inpatient units were monitored for 30 days post discharge from CRC
- A second group of 10 unique clients were selected and followed for 30 days post discharge from CRC to test the success of the first focus group

# Crisis Resource Center (CRC)

Subacute Psychiatric Treatment Recovery Center



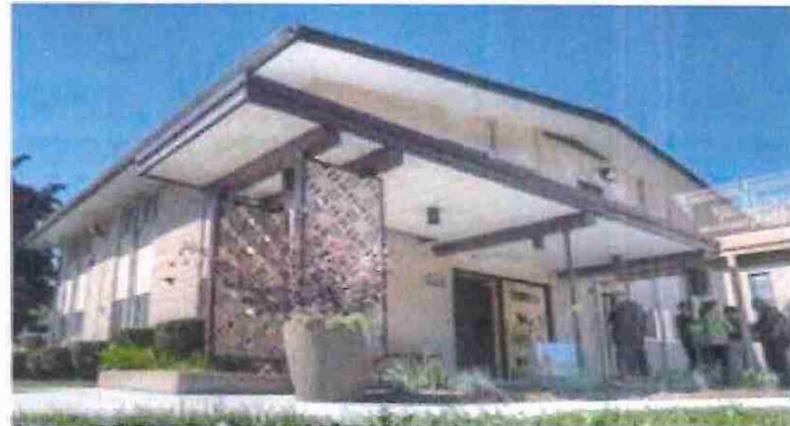
**BHD** MILWAUKEE COUNTY  
Behavioral  
Health  
Division

- Comprehensive interdisciplinary Mental Health Assessment
- Crisis assessment, stabilization, and resolution
- Medication review and education
- Peer Support
- Individual counseling and group education
- Access to providers and consultation
- Discharge planning and community linkage
- Aftercare support

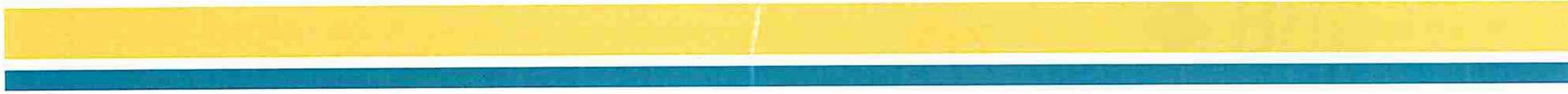
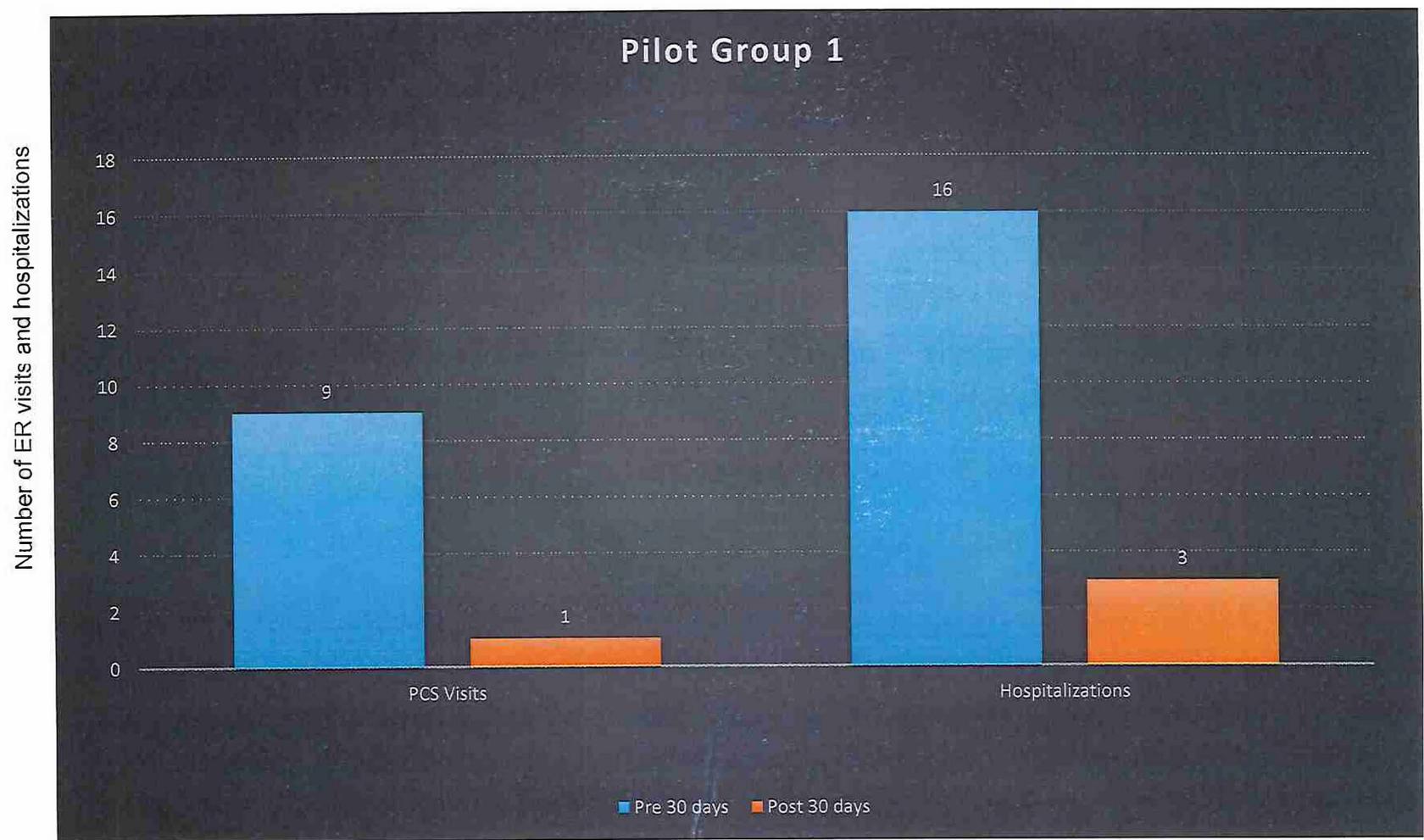


**WHOLE HEALTH**  
CLINICAL GROUP

A service of the  
Milwaukee Center for Independence

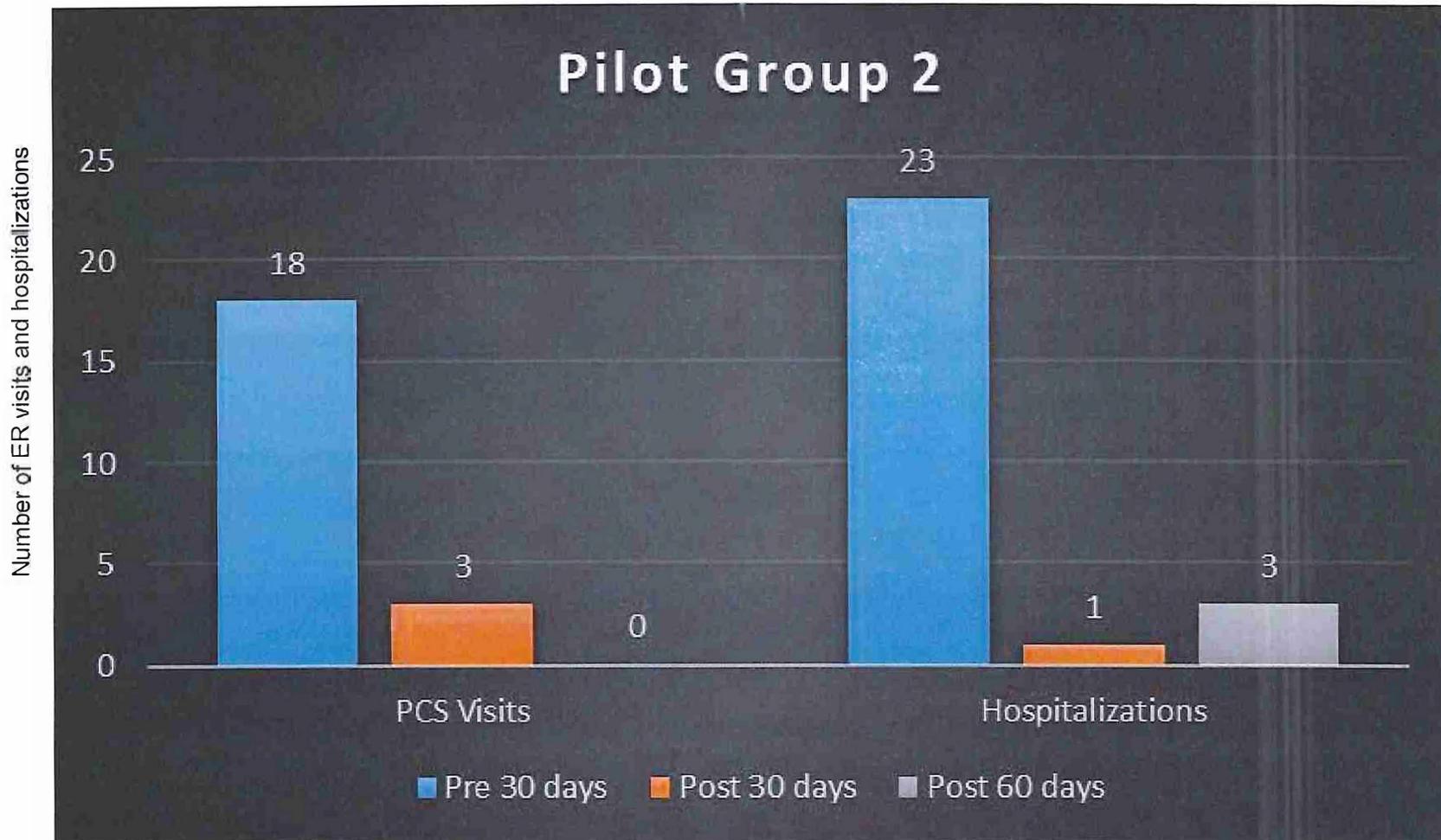


# Results





# Results





# COMPARISON DATA

Group 1: 89% decrease in PCS admissions  
81% decrease in hospitalizations

Group 2: 83% decrease in PCS admissions  
96% decrease in hospitalizations

\*\*Clients self-referred to CRC 20+ times following this intervention for aftercare services and readmissions to CRC.





# NEXT STEPS: Adopt, Adapt or Abandon?

- **Adopt!**
- Clients were able to achieve long-term comprehensive connections in a least restrictive environment.
- Next Steps: Increase capacity for CRCs to continue to empower individuals to engage in recovery through making comprehensive connections to community programs and services.
- Increase community knowledge about the program.
- Increase referral sources.



# IMPACT

- Clients were able to choose a less restrictive setting to stabilize, receive supportive services, and gain connections to on-going recovery services
- Bringing services to the client on site:
  - Psychiatry
  - Medical
  - Housing
  - Case Management
  - Crisis Stabilization
  - Aftercare and follow-up
- Self Referral to CRC continued after the 1<sup>st</sup> admission
- Clients choose to go back to CRC instead of ERs!

# Quality Committee Item 11

## POLICY & PROCEDURE STATUS REPORT -GOAL=96%

Baseline 71.5% as of August 2016 LAB report

Review period	Number of Policies	Percentage of total
Reviewed within Scheduled Period	361	71.5%
Up to 1 year Overdue	32	6.3%
More than 1 year and up to 3 years overdue	20	4.0%
More than 3 years and up to 5 years overdue	31	6.1%
More than 5 years and up to 10 years overdue	18	3.6%
More than 10 years overdue	43	8.5%
<b>Total</b>	<b>505</b>	<b>100.0%</b>

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
September	6	15	0
October	8	16	0
November	2	9	9
December	2	11	0
January	1	13	0

## Overall Progress 95.2% as of February 1, 2020

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	538	535	95.9%	95.2%
Up to 1 year Overdue	13	17	2.3%	3.0%
More than 1 year and up to 3 years overdue	8	8	1.4%	1.4%
More than 3 years and up to 5 years overdue	1	1	0.2%	0.2%
More than 5 years and up to 10 years overdue	1	1	0.2%	0.2%
More than 10 years overdue	0	0	0.0%	0.0%
<b>Total</b>	<b>561</b>	<b>562</b>	<b>100%</b>	<b>100%</b>

Forecast Due for Review	
<b>Past Due Policies - 23</b>	July 2020 – 9
<b>Coming Due Policies</b>	August 2020 – 10
February 2020 – 5	September 2020 – 11
March 2020 – 8	October 2020 – 18
April 2020 – 4	November 2020 – 7
May 2020 – 38	December 2020 – 32
June 2020 – 38	January 2021 – 25

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

**DATE:** March 18, 2020

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

**FROM:** Shane V. Moisio, 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 Changes to the Behavioral Health Division Medical Staff Organization Rules and Regulations**

**Background**

Under Wisconsin and Federal regulatory requirements, the Medical Staff Organization must develop and adopt Bylaws, Rules and Regulations. After adoption or amendment by the Medical Staff Organization, it is also required that these governing documents, and any changes thereto, be presented to the Governing Authority for action. All Bylaws and Rules and Regulations amendments become effective only upon both Medical Staff and 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 or Rules and Regulations. As is permitted, the Bylaws grant authority to the Medical Staff Executive Committee (MEC) to adopt rules and regulations on behalf of the Medical Staff Organization, with appropriate advance notification to medical staff members. The required advance notification regarding the amendment contained herein was provided on March 12, 2020 prior to approval action by the MEC on March 18, 2020.

**Discussion**

The following Rules and Regulation change was recommended and approved by the Medical Executive Committee:

<b>SCOPE &amp; REASON FOR CHANGE</b>
<p>This change is being made to comply with CMS regulation [§ CFR(s):482.22(d)] and Joint Commission standard [MS.05.01.01, EP 17].</p> <p>2.5 MEDICAL RECORD DOCUMENTATION AND CONTENT</p> <p>2.5.1 The medical record must identify the patient; support the diagnosis; justify the treatment; <u>include a comprehensive history and physical examination; reports and consultations; clinical laboratory, radiology and other special reports;</u> and document the course and results of treatment and facilitate continuity of care; <u>and include final diagnosis; discharge summary; autopsy report; and other pertinent information such as Patient Advance Directives and Consent Forms.</u> The medical record is sufficiently detailed and organized to enable:</p>

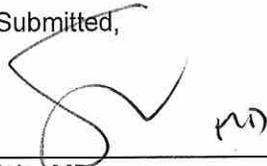
2.5.5.3 autopsies – unless otherwise required by the Medical Examiner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. In the event of a patient death in the hospital and in all cases of unusual death and of medical-legal and educational interest, the physician/Service shall attempt to obtain permission to perform an autopsy from the appropriate legally authorized person and in accordance with State law. wWhen an autopsy is performed, the Medical Staff, and specifically the attending physician, should be notified. and When the report is available, provisional anatomic diagnoses are shall be recorded in the medical record within three (3) days, as per guidelines of the Medical Examiner's Office and/or the agency performing the autopsy. The Medical Records Director or designee upon receiving the completedan autopsy report shall enter it into the medical record within 60 days and notify the Chief Medical Officer or designee.

2.5.5.3.1 Deaths which are defined as "Medical Examiner cases" by State law, must be reported to the Medical Examiner, who may order an autopsy, which does not require consent of the deceased's legally authorized relative or other person. The determination of whether an autopsy will be done on patients who fall under the jurisdiction of the Medical Examiner shall be made by the Medical Examiner.

### Recommendation

It is recommended that the Milwaukee County Mental Health Board approve the Rules and Regulation amendment as adopted by the Medical Staff Executive Committee, on behalf of the Medical Staff Organization on March 18, 2020.

Respectfully Submitted,



---

Shane V. Moiso, MD  
President, BHD Medical Staff Organization

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

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

**DATE:** March 18, 2020

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

**FROM:** Shane V. Moisis, MD, President of the Medical Staff Organization  
*Prepared by Lora Dooley, Director of Medical Staff Services*

**SUBJECT:** **A Report from the President of the Medical Staff Organization Requesting Approval of Appointment and Privilege Recommendations Made by the Medical Staff Executive Committee and an Informational Report Regarding a Policy and Procedure Update**

**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<sup>1</sup> :

- 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.

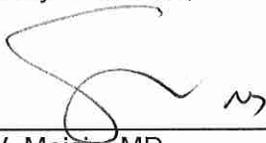
**Informational Item(s)**

The following Medical Staff Organization policy and procedure was revised and approved by the Medical Staff Executive Committee. In accordance with authority granted to the Medical Staff Executive Committee in the MSO Bylaws for policy and procedure approval, the following revised policy is being presented to the Mental Health Board, as informational only, unless otherwise directed.

A. Medical Staff and Advanced Practice Professional/Licensed Independent Practitioner (LIP)  
Appointment, Reappointment and Privileging

Three-year review and update. Minor changes made to reflect and clarify current processes, Joint Commission nomenclature and credentialing industry best practices.

Respectfully Submitted,



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Shane V. Moisio, MD  
President, BHD Medical Staff Organization

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

**Attachment(s)**

- 1 Medical Staff Credentialing Report & Medical Executive Committee Recommendations
- 2 Policy Update: Medical Staff and Advanced Practice Professional/Licensed Independent Practitioner (LIP)  
Appointment, Reappointment and Privileging

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
GOVERNING BODY REPORT  
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS  
MARCH-APRIL 2020**

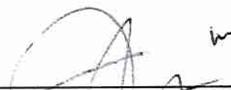
The following credentials files were reviewed. Privilege recommendations/actions were made based on information related to qualifications, current competence and ability to perform privileges (health status). All requisite primary source verifications or queries were obtained and reviewed regarding professional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

INITIAL APPOINTMENT	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 4, 2020	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 18, 2020	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
Kayla Schenheit, MD	Psychiatric Officer and Medical Officer	Affiliate / Provisional		Dr. Thrasher recommends appointment & privileges, as requested	Committee recommends 2-year appointment and privileges, as requested, subject to a minimum provisional period of 6 months.	Recommends appointment and privileging as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD							

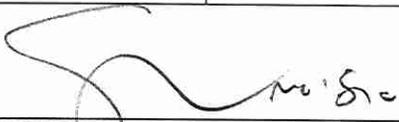
REAPPOINTMENT / REPRIVILEGING	PRIVILEGE GROUP(S)	APPT CAT/ PRIV STATUS	NOTATIONS	SERVICE CHIEF(S) RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 4, 2020	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 18, 2020	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
MEDICAL STAFF							
NONE THIS PERIOD							
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 MARCH 4, 2020	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 18, 2020	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 appointments and/or new privileges.</i>							
MEDICAL STAFF							
Makenzie Hatfield Kresch, MD	Psychiatric Officer and 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 privileging status change, as per C&PR Committee.	
Guy Katz, MD	Tele-Diagnostic Cardiology-EKG & Doppler Echocardiogram Interpretation	Consulting Telemedicine / Provisional	Affiliate / Full	Dr. Puls recommends full privileges	Committee recommends change in privilege status from provisional to full for remainder of 2-year appointment period.	Recommends privileging status change, as per C&PR Committee.	
ALLIED HEALTH							
NONE THIS PERIOD							

AMENDMENTS / CHANGE IN STATUS	CURRENT PRIVILEGE GROUP(S) OR APPOINTMENT CATEGORY	RECOMMENDED CHANGE	SERVICE CHIEF RECOMMENDATION	CREDENTIALING & PRIVILEGING REVIEW COMMITTEE MARCH 4, 2020	MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 18, 2020	GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)
NONE THIS PERIOD						

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

3/18/2020  
 DATE

  
 PRESIDENT, MEDICAL STAFF ORGANIZATION  
 CHAIR, MEDICAL STAFF EXECUTIVE COMMITTEE

3/18/20  
 DATE

BOARD COMMENTS / MODIFICATIONS / OBJECTIONS TO MEC PRIVILEGING RECOMMENDATIONS:

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

GOVERNING BOARD CHAIRPERSON \_\_\_\_\_ DATE \_\_\_\_\_

BOARD ACTION DATE: APRIL 23, 2020



Date Issued: 9/15/1985  
 Effective: N/A  
 Last Approved Date: N/A  
 Last Revised Date: N/A  
 Next Review: N/A  
 Owner: *Lora Dooley: Medical Service Manager*  
 Policy Area: *Medical Staff Organization*  
 References:

## Medical Staff and Advanced Practice Professional/Licensed Independent Practitioner (LIP) Appointment, Reappointment and Privileging

### POLICY:

It is the policy of the Medical Staff Organization of the Milwaukee County Behavioral Health Division, in accordance with federal and state regulatory requirements, to request, obtain, and verify the credentials, qualifications, character ~~and~~, ability and current competence of each applicant seeking appointment and/or privileges and to require each Medical Staff Member, Advanced Practice Professional or other licensed independent practitioner (LIP) who is granted appointment and/or privileges to seek reappointment and/or reprivileging at least every two years.

The Medical Staff Organization shall evaluate all applications to ensure that each applicant meets minimum credentials, privileging and performance standards and that privileges recommended are within the scope of the applicant's license, training, experience, competence and ability to perform the privileges requested. Privileges that cannot be utilized and/or supported at MCBHD shall not be considered. Medical Staff, other LIPs and Advanced Practice Professionals shall be credentialed and privileged in accordance with mechanisms specified in the Bylaws. All recommendations for appointment and ~~privileging~~ or privileges made by the Medical Staff shall be subject to approval by the Governing Authority.

Each applicant shall attest that all information submitted for the credentialing and privileging process is accurate and complete and agree to report immediately any change in status of the information maintained in the credentials file. If any submitted items differ from documentation disclosed through the verification process, the Chief Medical Officer, the Credentialing and Privileging Review Chair or Medical Staff Services may consult with the practitioner to resolve discrepancies.

### SCOPE:

All physicians (medical and osteopathic), dentists, and podiatrists

All licensed psychologists that have completed a doctoral program in clinical or counseling psychology

All advanced practice nurses

Other licensed independent practitioners, when assigned responsibilities that would otherwise be performed by a physician

## PURPOSE:

To ensure that Medical Staff, Advanced Practice Professionals and other LIP applicants seeking initial appointment and/or privileges are properly credentialed and authorized to perform only those diagnostic, therapeutic, assessment and/or clinical procedures which they are competent to perform.

To ensure that all Medical Staff Members, Advanced Practice Professionals and other LIPs seeking reappointment and/or repriviliging have maintained current competence relevant to all privileges requested.

To ensure that all Medical Staff Members, Advanced Practice Professionals and other LIPs maintain current professional licensure and all other required registrations and certifications relevant to appointment and privileges.

To provide credentialing services to Medical Staff, Advanced Practice Professionals and other LIPs in a professional and timely manner and ensure efficient methods for processing information.

To ensure that confidentiality of personal and protected information is maintained.

To ensure essential legal, professional, regulatory and accreditation requirements are met.

To provide the Medical Staff Organization and the Governing Authority with the necessary information on which to formulate decisions and recommendations for appointment and/or privileges.

## DEFINITION(S):

Licensed Independent Practitioner (LIP) - An individual permitted by law and by the organization to provide care, treatment and services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges (as defined by The Joint Commission).

## PROCEDURE:

### APPOINTMENT AND PRIVILEGING – NEW APPLICANT

At the request of the Chief Medical Officer (or designee), Medical Staff Services will send a prospective Medical Staff or Advanced Practice Professional applicant all applicable forms and list of required supporting credentials, essential documentation, Medical Staff Bylaws and Rules and Regulations.

1. Applicants shall be required to submit the fully completed application along with supporting documents to Medical Staff Services. Required forms shall include the following:
  - a. **Medical Staff/Advanced Practice Professional Staff Application and Instructions:** content shall include but not be limited to, information on any active or inactive licenses, DEA registrations (as applicable), medical/professional education and training, Board eligibility/certification, professional affiliations and work history, military service, health status and past and present liability coverage.
  - b. **Disclosure Questionnaire Form:** applicant disclosures and attestation shall include, but not be limited to, challenges to any licensure or registration; voluntary and involuntary relinquishment of any license or registration; voluntary and involuntary termination or denial of medical staff/professional staff membership, privileges or employment; voluntary or involuntary limitation, reduction or loss of clinical privileges; malpractice history; Medicare, Medicaid, CLIA or other sanctions/exclusions; felony, serious or gross misdemeanor charges and convictions; history of chemical dependency,

alcohol or substance abuse.

- c. Consent for the Release of Information and to Background Check
- d. Peer Reference Contact List Form
- e. Ethical Pledge and Affirmation to Abide by Medical Staff Bylaws, Rules and Regulations and Policies
- f. Wisconsin Caregiver Background Information Disclosure Form
- g. ~~Federal~~ Consent to Out-of-State Background Check-Forms(s), if currently or in the last three years has resided or worked outside of Wisconsin
- h. Privilege Request Form(s)
- i. ~~Statement of Current Health~~ Attestation that no health problems exist that could affect his or her ability to perform the privileges requested
- j. Private Practice Statement (medical staff employment applicants only)
- k. Notice to Physicians re: **Medicare Payment to Hospitals** (physicians only)
- l. Identity Information Form
- m. Practice Guidelines/Collaboration Agreement (advanced practice nurses only)

2. **CREDENTIALS AND DOCUMENTATION:** Applicants shall be required to provide credentials and documentation that support the application statements, appointment and privileges requested. Required credentials shall include the following:

- a. Current Wisconsin Medical/Professional Licensure
- b. Other Current State Medical/Professional Licensure, when applicable (i.e., tele-medical practice requires license where patient is located AND where provider is located)
- c. Current Drug Enforcement Administration (DEA) Registration (as applicable)
- d. Doctoral/Professional School Diploma
- e. Internship/Residency/Fellowship/Other Post-Graduate Training Certificate(s)
- f. Medical/Professional School Transcript(s) (for U.S. and Canadian Medical/Professional School Graduates, transcript must be a certified and a non-student issued copy sent directly to the MCBHD Medical Staff Office from the School; for Foreign Medical School Graduates, a photocopy will be accepted with ECFMG)
- g. Education Commission for Foreign Medical Graduates (ECFMG) Certificate (required for graduates from medical schools other than those in the United States or Canada)
- h. Curriculum Vitae
- i. Board Certification(s) (ABMS, AOA, ANCC, ABPP, etc., as applicable)
- j. CPR Certification - required for advanced practice nurses (minimum requirement is BLS or Healthcare Provider certification through an American Red Cross or American Heart Association approved course); certification is not required by the Medical Staff Organization for physicians as a requirement for privileging, but courses are made available by BHD to any physicians wishing to maintain CPR certification
- k. Continuing Education Documentation ~~{~~[a CME/CE tracker printout or photocopies of certificates for activities completed during the past two years; evidence of relevant current or recent professional training satisfies requirement; evidence of currently meeting maintenance of Board certification in

privilege ~~category~~group(s) requested satisfies ~~requirements~~ requirement]

- I. Current Malpractice Coverage (proof of coverage is required for all ~~contractors~~non-employees--copy of facesheet or certificate of insurance of **current** coverage showing amount of coverage, period of coverage and company name, in accordance with ~~contract and~~ state mandated minimums; all employees are covered under the Milwaukee County Professional Liability Self-Insurance Program)

## REAPPOINTMENT AND REPRIVILEGING

The reappointment and repriviling process shall take place at least every two years for each Medical Staff Member, Advanced Practice Professional or other LIP.

1. Approximately four (4) months prior to expiration of current appointment and/or privileges, each Medical Staff Member and Advanced Practice Professional shall be sent notice that they need to apply for reappointment and/or repriviling. Notification shall state that request for reappointment and repriviling must be made by a specified date. All necessary reappointment and repriviling forms and requirements will be sent with the notification and shall include the following:
  - a. Application for Reprivileging and Reappointment
  - b. Disclosure Questionnaire
  - c. Consent for the Release of Information and to Background Check
  - d. Ethical Pledge and Affirmation to Abide by Medical Staff Bylaws, Rules and Regulations and Policies
  - e. Wisconsin Caregiver Background Disclosure form
  - f. ~~Federal~~Consent to Out-of-State Background Check ~~forms~~, as applicable
  - g. Privilege Request Form
  - h. ~~Statement of Current Health~~Attestation that no health problems exist that could affect his or her ability to perform the privileges requested
  - i. Private Practice Statement (employed medical staff only)
  - j. Relevant and Sufficient Continuing Education for the past two years
  - k. Practice Guidelines/Collaboration Agreement renewal (advanced practice nurses only)

## APPLICATION PROCESSING AND VERIFICATION

Credentialing involves the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability and current competence to perform the requested privilege(s). Verification is sought to minimize the possibility of granting privilege(s) based on the review of fraudulent documents.

Medical Staff Services shall be responsible for providing oversight and direction to credentialing and privileging operations and for monitoring the Credentialing and Privileging program for compliance with State and Federal requirements. Medical Staff Services shall maintain credentialing and privileging binders on each Medical Staff member, shall implement and maintain databases necessary to meet standards set forth for the credentialing and privileging process, and shall be responsible for assuring application completeness and obtaining Medical Director recommendations and Chief Psychologist recommendations, when applicable, prior to presentation to Committees for consideration. The National Association Medical Staff Services "Ideal Credentialing Standards: Best Practice Criteria and Protocol for Hospitals" shall be the basis for performing an evidence-based evaluation of each applicant. The credentialing process shall be objective, systematic and without

discrimination or bias.

1. Upon receipt of application and request for privileges, Medical Staff Services shall review the application for completeness, including attachments or written explanations, perform a gap analysis, review for any irregularities on questions about practice issues, legal matters or health status and make a preliminary assessment as to whether the applicant satisfies all threshold criteria for the appointment category and/or privileges requested.
2. The application must be complete and submitted in entirety. Applicants that fail to return complete applications or fail to meet threshold criteria shall be notified that their application cannot be processed, as submitted.
  - a. If it is found that any submitted items differ from documentation disclosed through the verification process, Medical Staff Services shall notify the applicant to provide opportunity to resolve discrepancies. The applicant has the burden of producing adequate information, in a timely manner, and for resolving any doubts about information and statements made.
  - b. For initial applications, applicant shall be given a time limited opportunity to submit additional information. If after the time limit, the application remains incomplete, does not meet threshold criteria, or applicant makes no attempt to resolve a discrepancy(s), applicant shall be notified that the application will not be processed.
  - c. Procedural rights as set forth in the Medical Staff Bylaws shall not apply to an applicant that fails to submit a complete application, makes no attempt to resolve a discrepancy(s) or fails to obtain the required Wisconsin medical/professional license.
3. If the request for reappointment and repriviliging is not received from a Medical Staff Member or Advanced Practice Professional by the date specified, a second request shall be made.
4. If the request for reappointment and repriviliging is not received by the date specified in the second request, a third request shall be made. The third and final request shall be sent by mail, e-mail or fax, with copy to the Service Medical Director and/or Chief Psychologist, when applicable, and shall include notification that:

"The applicant has three business days in which to submit a completed application for reappointment and repriviliging and meet all other requirements, as specified in the initial reappointment notice."
5. If the applicant fails to submit a complete application by the day stated on the final written notice, she/he shall be deemed to have voluntarily resigned his/her membership and privileges. The procedural rights set forth in the Medical Staff Bylaws shall not apply to a voluntary resignation under this circumstance.
6. Medical Staff Services shall oversee the process of gathering and verifying all relevant information and material, which supports the application for appointment, reappointment and privileges. Evidence of an unusual pattern or an excessive number of professional liability actions resulting in final judgment against the applicant shall be evaluated. Documentation as to the applicant's health status shall be evaluated. Medical Staff Services shall also be responsible for confirming that references, other appointments/work history including gaps of greater than 30 days, and other practitioner-specific data deemed pertinent has been received and evaluated. Evidence of the applicant's identity, character, professional competence, qualifications, behavior and ethical standing shall be examined. This information may be contained in the application, references, and from other available sources, including from the applicant's past or current department chair and standing at other health care facilities, residency training director, and others that may have knowledge about the applicant's education, training, experience, current clinical competence, character and ability to work with others. Information will be sought through the most appropriate and acceptable mechanisms, which may include written correspondence or documented verbal

communications. Internet, e-mail and faxed communications are acceptable.

- a. The following shall be verified from the primary source or through a ~~recognized~~ Centers for Medicare and Medicaid/Joint Commission (CMS/TJC) deemed equivalent source:
  1. Medical School/Dental/Professional School completion
  2. Internship/Residency/Fellowship/Other Post-Graduate Professional Training
  3. ECFMG Certification
  4. Wisconsin Medical/Profession License(s)
  5. Other State Medical/Professional License(s), as applicable
  6. Drug Enforcement Administration (DEA) Registration
  7. Board Certification
- b. The following data banks shall be queried:
  1. National Practitioner Data Bank (NPDB-HIPDB)
  2. The Office of Inspector General-List of Excluded Individuals and Entities (OIG-LEIE)
  3. The System for Award Management (SAM)
- c. Consistent with The Joint Commission (TJC), ~~and~~ and the Centers for Medicare and Medicaid (CMS) ~~and the National Center for Quality Assurance (NCQA)~~ standards, the following are considered to be an equivalent for primary source verification of education and/or Board Certification:
  1. The American Medical Association (AMA) Physician Masterfile
  2. The American Osteopathic Association (AOA) Physician Database
  3. The Education Council for Foreign Medical Graduates (ECFMG)
  4. American Board of Medical Specialties (ABMS) through the on-line data base (CertiFACTS)
  5. Federation of State Medical Boards (FSMB)
  6. National Student Clearinghouse
- d. **Clinical competence, professionalism and character shall be evaluated through the following sources:**
  1. References (a minimum of 2 peer references shall be required for initial applications; one directed reference shall be obtained for initial applications; at least 1 peer reference shall be required at time of reappointment, which may be provided by a supervising peer)
  2. Other Hospital/Clinical Affiliation(s) (verification of recent past and present for initial appointment shall be attempted; for tele-practitioners, the greater of ten or ~~40~~5% of current and recent affiliations shall be ~~verified~~attempted; affiliations lapsed for greater than ~~ten~~five years shall not be queried)
  3. Faculty Appointments, when recent or current
  4. Military Service (DD214, if recently discharged)
  5. Local, State and/or Federal Background Check Results
  6. Malpractice Claims History – claims history for up to the past ten years shall be assessed on new applicants. Verification from current and previous carriers shall be attempted for initial applicants. If after three attempts and with applicant's assistance, the carrier does not respond,

the NPDB report shall be used as verification. Current carrier(s) or carriers from the past two years shall be queried for reappointment.

7. Continuing Education (as per initial appointment and privileging criteria)
8. ~~Results of Ongoing Professional Practice Evaluation (for reappointment)~~ Results of Ongoing Professional Practice Evaluation (for reappointment).
  - i. When insufficient practitioner-specific data are available, recommendations from a peer(s) in the same professional discipline with personal knowledge of the applicant's current ability to practice shall be obtained and evaluated.
  - ii. Applicants may additionally be asked to provide results of OPPE from his/her other current or recent practice site(s).

e. **Practitioner Identity**

At time of initial application, Medical Staff Services shall verify that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing a current government issued photo identification (e.g., driver's license, passport, visa or employment verification card) or other current hospital identification badge presented, in-person, by the applicant. In the case of telemedicine staff, the verification shall be done remotely whereby the applicant shall present his/her government issued identification to a notary public at one of his/her home state practice sites along with the identification information form. Evidence of identity verification completion shall be documented in the applicant's credentialing file by a Medical Staff Services Professional who shall confirm by signature and date the type of photo identification presented in-person by the applicant and that the identity documentation s/he viewed is current or confirm by signature/initials and date that the remote verification was received and meets requirements. Identity verification shall be made prior to first privilege utilization ~~by~~for all new applicants.

7. **For initial appointment**, Medical Staff Services shall red flag any concerns, including but not limited to, adverse NPDB queries, history of limited/restricted licensure or other Board Order history, positive and/or excessive malpractice claims history, disciplinary actions by medical staff organizations, hospitals, state medical boards or professional societies, exclusions or sanctions, positive criminal background check results or any other notable findings received. If there is any information contained in the application that requires verification that cannot be verified due to extraordinary circumstances, this shall be documented in the file and flagged for Medical Director and Credentialing and Privileging Review Committee review. The file may then move through the evaluation process without this piece of documentation.
8. **For reappointment**, Medical Staff Services shall red flag any new concerns, since previous appointment, including but not limited to, adverse NPDB queries, limited/restricted licensure, positive malpractice claims (open or closed), disciplinary actions by medical staff organizations, hospitals, state medical boards or professional societies, sanctions, positive background check results or any other notable findings or changes, since previous appointment. Historical items shall be noted, as such.
9. The Service Medical Director and Chief Psychologist, when applicable, shall review each application to the Medical Staff following completion of the verification process by Medical Staff Services. All such reviews shall include a recommendation to approve or disapprove the application prior to presentation to the Credentialing and Privileging Review Committee. Recommendations shall be authenticated by signature and date.
10. Upon completion of the application processing and review by the Service Medical Director (and Chief Psychologist, when applicable), each Medical Staff or Advanced Practice Professional application shall be presented to the MCBHD Medical Staff Credentialing and Privileging Review Committee for

recommendations pertaining to the delineation of requested privileges and/or for determination of appropriate Appointment Category. All license, DEA, NPDB and OIG/SAM queries shall be dated within 90 days of the date that application is presented to the Credentialing and Privileging Review Committee or queries shall be repeated prior to the meeting date.

- a. The Credentialing and Privileging Review Committee shall meet as needed, but at least quarterly, to discuss applications for appointment, reappointment and/or privileges. Recommendations for appointment, reappointment and/or privileges will be based on review of the completed application.
  - b. All recommendations made by the Credentialing and Privileging Review Committee will be forwarded to the Executive Committee of the MCBHD Medical Staff for review of recommendations.
  - c. The Medical Staff Executive Committee shall indicate concurrence or may recommend modifications or rejection and shall convey its recommendations to the Governing Authority for approval of recommendations.
11. Recommendations for appointment and privileging shall be for a period of no more than two years. Initial privileges shall be subject to a provisional period of at least six months.
  12. Recommendations for appointment, reappointment or privileges shall become effective upon approval by the Governing Authority.
  13. **Temporary Privileges for Clean Application Awaiting Approval** – On recommendation of the Medical Staff President, temporary privileges may be considered following Credentialing and Privileging Review and recommendation or on review and recommendation of the Chair, acting on behalf of the Committee, when permitted by law or regulation and as described within the Bylaws. Temporary privilege authorization shall not exceed 120 days.

## REVISED CLINICAL PRIVILEGES OR APPOINTMENT CATEGORY

1. Any member of the Medical Staff may petition the Credentialing and Privileging Review Committee to amend their current privileges or appointment status, at any time. Appointment status changes may also be initiated by request of the Chief Medical Officer (or designee) or by the Credentialing and Privileging Review Committee, to assure that the member meets the current qualifications and threshold criteria for Medical Staff appointment under his/her membership category.
2. Applicant's request for new privileges shall be examined in a manner consistent with assessing qualifications for initial privileges.  
Medical Staff Services shall re-verify or query the following for all privilege amendments:
  - a. Medical/Professional License(s)
  - b. NPDB
  - c. OIG Sanctions and Exclusions
3. Appointment amendments shall be subject to eligibility for change in status based on change to current position with BHD and current threshold criteria for the appointment category.
4. The Service Medical Director and Chief Psychologist, when applicable, shall review each application for amendment following completion of the verification process by Medical Staff Services. All such reviews shall include a recommendation to approve or disapprove the application for amendment prior to presentation to the Credentialing and Privileging Review Committee. Recommendations shall be authenticated by signature and date.
5. Privilege and appointment amendment requests shall be acted upon by the Credentialing and Privileging

Review Committee within 90 days upon completion of the verification requirements for the new privilege(s) requested or verification of threshold criteria for appointment category change.

6. The Credentialing and Privileging Review Committee shall meet as needed, but at least quarterly, to discuss requests for privilege or appointment amendment.
7. Recommendations made by the Credentialing and Privileging Review Committee will be forwarded to the Executive Committee of the MCBHD Medical Staff for review of recommendations.
8. The Medical Staff Executive Committee shall indicate concurrence or may recommend modifications and shall convey its recommendations to the Governing Authority for review and approval.
  - a. Recommendations to approve a petition to amend privileges shall be for
    1. a provisional period of at least six months, ~~if privilege was not previously held, or~~
    2. a period no more than that which remains within the applicant's current privilege biennium, if privilege was not requested at time of most recent reappointment but was held during the previous appointment period and there is evidence of practitioner competence in performing the privilege during that period at MCBHD.
  - b. Recommendations to approve a petition to amend appointment category shall be for the period remaining in the current biennium.
  - c. Recommendations for appointment or privilege amendment shall become effective upon approval by the Governing Board.

## BACKGROUND CHECKS

The MCBHD Medical Staff Organization engages in background checks as a verification element within the credentialing process. Any and all background reports shall be marked confidential and will be stored and protected in the credentialing folder. All adverse information found on background checks shall be evaluated by the Chief Medical Officer (or designee) as well as the appropriate Medical Staff Committees. A statement of explanation by the applicant shall be required for any all criminal charges or convictions.

## PROVIDER RIGHTS TO AMEND APPLICATION AND RECEIVE UPDATES

1. Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked via written request (email or certified letter) to resolve this discrepancy and will be expected to do so within 10 business days of the request. Any and all corrections should be submitted in writing to the Medical Staff Services Department for adequate review of revised documentation. Applicants that do not make reasonable attempts to resolve misstatements or omissions from the application or doubts about qualifications, credentials or current abilities when requested, 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 the Bylaws.
2. Providers have the right to contact Medical Staff Services at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to by the appropriate Medical Staff Services Professional, within a reasonable period of time, not to exceed five business days, in most instances.

## CONFIDENTIALITY OF CREDENTIALING FILE INFORMATION

All credentialing information obtained and maintained by Medical Staff Services, on behalf of the Medical Staff Organization, shall be considered confidential. Accordingly, appropriate measures to safe guard both hard copy files and electronically stored information shall be taken. Credentialing files shall be maintained in a locked environment (room or file cabinet). Medical Staff Committees and Medical Staff Services personnel shall be oriented to the importance of maintaining credentialing information confidentiality, and all parties that have access to such information shall be required to sign a Confidentiality Agreement. Committee attendees shall further sign an attestation to that affect at the start of each meeting. Confidentiality requirements shall be reviewed with Medical Staff Services personnel annually during the evaluation process.

### ***Policy Information***

#### **A. Gatekeeper/Owner**

The Director of Medical Staff Services (or designee) shall be responsible for initiating review and revision of this policy. The Policy will reside in the Medical Staff Organization section of the BHD Policy and Procedure e-Manual.

#### **B. Distribution and Training Requirements**

The distribution and training requirements for this Policy will be handled through the Medical Staff Office.

#### **C. Requirements For Review and Renewal**

This Policy will be reviewed and/or revised every three years or as required by change of regulation, law or practice.

## REFERENCES:

Joint Commission MS.06.01.03; MS.06.01.05; MS.06.01.07; MS.06.01.09; MS.06.01.11;MS.06.01.13; MS.07.01.01; MS.07.01.03; MS.13.01.01; MS.13.01.03 (CAMH ~~04/2015~~01/2020); Centers for Medicare/Medicaid; Wisconsin Chapter DHS 124; Wisconsin Statute Chapter 50.36; National Association Medical Staff Services "Ideal Credentialing Standards (05/2014)

~~‡Delegated policy and procedure approval authority granted to MEC by the Governing Authority in MCBHD Bylaws section 5.3.1 (13c); presented to Board as informational only with no objections noted.~~

### **APPROVALS**

Recommended for approval by the Credentialing and Privileging Review Committee, 03-04-2020

Approved by Action of the Medical Staff Executive Committee, 03-18-2020

Informational Report to the Mental Health Board, 04-23-2020

## **Attachments**

No Attachments