**MILWAUKEE COUNTY MENTAL HEALTH BOARD**

**Thursday, February 28, 2019 - 8:00 A.M.**

Milwaukee County Zoo  
Peck Welcome Center Pavilion  
10001 West Bluemound Road

**MINUTES**

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

**EXCUSED:** Michael Davis

**ABSENT:** Robert Curry

*Board Members Sheri Johnson and Walter Lanier were not present at the time the roll was called but joined the meeting shortly thereafter.

**SCHEDULED ITEMS:**

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

1. **Welcome.**

   Chairman Lutzow greeted Board Members and welcomed everyone to the February 28, 2019, Mental Health Board meeting.

2. **Election of Board Officers – Chair, Vice-Chair, and Secretary.**

   Board Members expressed concern regarding the lack of transparency related to the election process. Chairman Lutzow assured the Board it was not intentional. Documentation explaining the process was inadvertently omitted from the Board’s materials and an assumption that Board Members were familiar with the process, which is done annually, was made.

   After further discussion, Board Members were accepting of the oversight.
MOTION BY: (Shrout) Keep the Current Officers in place as follows: Thomas Lutzow – Chairman, Maria Perez – Vice-Chairperson, and Michael Davis - Secretary for the 2019 Term. 7-0

MOTION 2ND BY: (Forman)

AYES: Eilers, Forman, Lutzow, Neubauer, Perez, Shrout, and Wesley - 7
NOES: 0
ABSTENTIONS: 0
EXCUSED: Lanier - 1

Chairman Lutzow’s first order of business was to address the Board’s scheduled meeting times. It was announced that Finance Committee meetings currently held at 7:00 a.m. will move to an 8:00 a.m. start time. On meeting days where Finance Committee meetings are scheduled immediately prior to Board meetings, the Board meeting start time will be moved to 9:00 a.m. Revised calendar invitations will be forwarded to participants, the web page will be updated, and agendas will contain information noting meeting time changes.

3. Approval of the Minutes from the December 13, 2018, and January 24, 2019, Milwaukee County Mental Health Board Meeting and Public Hearing.

MOTION BY: (Shrout) Approve the Minutes from the December 13, 2018, Regular Meeting and the January 24, 2019, Public Hearing. 8-0

MOTION 2ND BY: (Eilers)

AYES: Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8
NOES: 0
ABSTENTIONS: 0
EXCUSED: 0

4. Crisis Assessment and Response Team (CART) Initiative Municipality Specific (West Allis) Update.

Sergeant Cato, West Allis Police Department

Sgt. Cato indicated a West Allis Police Officer was assigned to the CART Team in 2018. He stated the CART officer works closely with a clinician. The biggest function in this role is servicing Chapter 51 calls. Typical calls relate to medication and caregiver assistance. Mediation is most times achieved through the CART Officer, which mitigates arrest numbers and the number of people transported either downtown or to behavioral health. After servicing the call or having contact, follow-up is done to ensure the person suffering the episode has been connected to the appropriate services to help them get on their feet and the right path, which is a tremendous benefit. Communications with hospitals have improved related to handling Chapter 51 and Chapter 55 cases. The program appears to finally be in a place where everyone is on the same page.

Questions and comments ensued.
5. **Department of Administrative Services Quarterly Update on the State of Milwaukee County’s Interests and Matters Related to the Behavioral Health Division.**

Joseph Lamers, Director, Office of Performance, Strategy, and Budget (PSB), Department of Administrative Services

Mr. Lamers stated the PSB Office is projecting a budget gap for Fiscal Year 2020. The gap is part of an ongoing structural deficit. Growth in revenue is not sufficient to keep pace with inflationary operating cost growth. He elaborated on the specifics that contributed to the deficit and discussed the broad options for closing the 2020 Budget gap.

Questions and comments ensued at length.

The Board requested information related to the interest earned on BHD’s reserve funds.

6. **2018 Collective Bargaining Agreement with the Trades Union Base Wage Negotiation.**

Margo Franklin, Employee Relations Director, Department of Human Resources

Due to the non-appearance of Human Resources staff to present the agreement at the Finance Committee, the Rules were suspended in order to bring this item before the Board for consideration.

<table>
<thead>
<tr>
<th>MOTION BY:</th>
<th>(Eilers) Suspend the Rules. 8-0</th>
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<tbody>
<tr>
<td>MOTION 2ND BY:</td>
<td>(Shrout)</td>
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<tr>
<td>AYES:</td>
<td>Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8</td>
</tr>
<tr>
<td>NOES:</td>
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<td>ABSTENTIONS:</td>
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<tr>
<th>MOTION BY:</th>
<th>(Neubauer) Bring Item #6 Before the Board for Consideration. 8-0</th>
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<tr>
<td>MOTION 2ND BY:</td>
<td>(Wesley)</td>
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<tr>
<td>AYES:</td>
<td>Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8</td>
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<tr>
<td>NOES:</td>
<td>0</td>
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<td>ABSTENTIONS:</td>
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Ms. Franklin indicated under Act 10, the Milwaukee Building and Construction Trades Council is only allowed to negotiate on base wage and only up to a maximum of the Consumer Price Index (CPI), which is 1%. It is an across-the-board increase effective as of June 17, 2018. Upon the Board’s vote of approval, the increase will be immediately processed and paid retroactively.
SCHEDULED ITEMS (CONTINUED):

MOTION BY: (Eilers) Approve the 2018 Collective Bargaining Agreement’s 1% Wage Increase for the Milwaukee Building and Construction Trades Council. 8-0

MOTION 2ND BY: (Shrout)

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

NOES: 0

ABSTENTIONS: 0

7. Proposed Employee Retention and Severance Agreements.

Michael Lappen, Administrator, Behavioral Health Division

Mr. Lappen stated with the execution of the Universal Health Services contract, employee retention and severance agreements are now the focus. Closure of the inpatient hospital is projected to be approximately mid 2021. After discussions with other County staff who assisted in crafting the agreements and comparisons in other markets, it was collectively decided the period of retention and severance would be two years. Monies paid out would be broken down into two payments. It is anticipated the agreements will be ready and disseminated to eligible staff for signature in June.

The agreements are what is before the Committee for a recommendation to the Board. The Fiscal Team projected the maximum cost of the packages. A breakdown of those costs are included in the corresponding report. The funds associated with the cost of the packages are not being sought at this particular time. However, the Committee is being asked to acknowledge $5.1 million of the Behavioral Health Division’s Reserves has been identified as a future expense to fund the packages.

Questions and comments ensued.

The Board was informed the Finance Committee unanimously agreed to recommend approval of the Proposed Employee Retention and Severance Agreements.

MOTION BY: (Perez) Approve the Employee Retention and Severance Agreements While Acknowledging $5.1 Million of the Behavioral Health Division’s Reserves has been Identified and is Heretofore Designated as a Future Expense to Fund the Said Packages. 8-0

MOTION 2ND BY: (Eilers)

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

NOES: 0

ABSTENTIONS: 0
8. **Administrative Update.**

Michael Lappen, Administrator, Behavioral Health Division (BHD)

Mr. Lappen highlighted key activities and issues related to BHD operations. He provided updates on Psychiatric Crisis Redesign efforts, the Universal Health Services contract, the acute hospital transition, and BHD’s undertaking of major projects in an attempt to organize and effectively allocate available resources to the transition. He also discussed the grant awarded to the Milwaukee County Community Justice Council and because of BHD’s involvement, will fund two new BHD positions.

Mr. Lappen referenced the Kane Communications Update and the Parachute House (Peer Run Respite) Grand Opening flyer both of which are attached to the corresponding report.

Questions and comments ensued.

9. **The Behavioral Health Division’s Funding Allocations and Program Efficiencies Report for Mental Health Programs in Compliance with Chapter 51 of Wisconsin Statutes.**

Michael Lappen, Administrator, Behavioral Health Division

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 2018 activities.

The report will be forwarded to the County Board, the County Executive, and the State Department of Health and Human Services.

Questions and comments ensued.

10. **Mental Health Board Finance Committee Professional Services Contracts Recommendation.**

Jennifer Bergersen, Chief of Operations, Behavioral Health Division

- 2018 Contract Amendment
  - Netsmart Technologies, Inc.

- 2019 Contracts
  - Netsmart Technologies, Inc.
  - University of Milwaukee Wisconsin (UWM)
  - WIPFLi, LLP
SCHEDULED ITEMS (CONTINUED):

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. Ms. Bergersen provided a detailed description on all services Netsmart and UWM provide.

There was additional discussion of the WIPFLi contract due to its support of a joint effort between the Behavioral Health Division, the Milwaukee Health Care Partnership, and other key stakeholders to explore new and innovative options related to the Psychiatric Crisis Redesign Service delivery model. Some reimbursement from the other organizations involved is expected. Clarification was provided in reference to the contract being a sole source contract, which is based on BHD’s most recent relationship with WIPFLi, and not a competitive bid. To continue services with WIPFLi rather than duplicating efforts that would include soliciting companies to start anew was taken into consideration and deemed prudent. The corresponding report will be revised to reflect this information.

Questions and comments ensued.

The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2018 Professional Services Contract Amendment and 2019 Contracts to the Board.

| MOTION BY: | (Perez) Approve the 2018 Professional Services Contract Amendment and 2019 Contracts Delineated in the Corresponding Report. 8-0 |
| MOTION 2ND BY: | (Shrout) |
| AYES: | Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, Shrout, and Wesley – 8 |
| NOES: | 0 |
| ABSTENTIONS: | 0 |

Item #s 11 and 12 were considered together.


Amy Lorenz, Deputy Administrator, Community Access to Recovery Services, Behavioral Health Division (BHD)
Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD

- 2018 and 2019 Contract Amendments
- 2019 Contract

Purchase-of-Service Contracts for the Provision of Adult and Child Mental Health Services and Substance Use Disorder Services were reviewed. Ms. Lorenz and Mr. McBride provided an overview detailing the various program contracts and their respective services.
The Board was informed the Finance Committee unanimously agreed to recommend approval of the 2018 and 2019 Purchase-of-Service Contract Amendments and the 2019 Contract delineated in the corresponding report to the Board.

SEE ITEM 12 FOR BOARD ACTION

<table>
<thead>
<tr>
<th>12.</th>
<th>Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.</th>
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<tr>
<td></td>
<td>Amy Lorenz, Deputy Administrator, Community Access to Recovery Services, Behavioral Health Division (BHD)</td>
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<td>Brian McBride, Director, Children’s Community Services and Wraparound Milwaukee, BHD</td>
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<td></td>
<td>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 various program agreements, which provide a broad range of rehabilitation and support services to adults with mental health and/or substance use disorders and children with serious emotional disturbances.</td>
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<td></td>
<td>Questions and comments ensued.</td>
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<td>The Board was informed the Finance Committee unanimously agreed to recommend approval of 2018 Agreement Amendments and 2019 Agreements as delineated in the corresponding report.</td>
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<td>Board Member Wesley requested separate action be taken on the Wisconsin Community Services, Inc. contract.</td>
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**MOTION BY:** (Perez) Approve the Wisconsin Community Services, Inc., Contracts Delineated in the Reports Corresponding to Items 11 and 12. 7-0-1

**MOTION 2ND BY:** (Shrout)

**AYES:** Eilers, Forman, Lanier, Lutzow, Neubauer, Perez, and Shrout - 7

**NOES:** 0

**ABSTENTIONS:** Wesley - 1

**MOTION BY:** (Perez) Approve the Balance of Purchase-of-Service Contracts and Fee-for-Service Agreements Delineated in the Reports Corresponding to Items 11 and 12. 8-0

**MOTION 2ND BY:** (Shrout)

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

**NOES:** 0

**ABSTENTIONS:** 0
13. **State of Wisconsin Contracts for Social Services and Community Programs Recommendation.**

Matt Fortman, Fiscal Services, Behavioral Health Division

- 2019 Contracts

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.

The Board was informed the Finance Committee unanimously recommended approval of the 2019 Social Services and Community Programs contracts delineated in the corresponding report.

**MOTION BY:** (Perez) **Approve the Social Services and Community Programs 2019 Contracts Delineated in the Corresponding Report. 8-0**

**MOTION 2ND BY:** (Forman)

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

**NOES:** 0

**ABSTENTIONS:** 0

The Board did not go into Closed Session for Item 14

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

Dr. M. Zincke, Medical Staff Vice-President, Behavioral Health Division

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

**MOTION 2ND BY:** (Eilers)

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

**NOES:** 0

**ABSTENTIONS:** 0
15. **Medical Staff Organization Governing Body’s Proposed Rules and Regulations Changes.**

Dr. M. Zincke, Medical Staff Vice-President, Behavioral Health Division

**MOTION BY:** (Shrout) Approve the Medical Staff Governing Body’s Proposed Rules and Regulations Changes. **8-0**

**MOTION 2ND BY:** (Neubauer)

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

**NOES:** 0

**ABSTENTIONS:** 0

16. **Adjournment.**

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

**MOTION 2ND BY:** (Perez)

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

**NOES:** 0

**ABSTENTIONS:** 0

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

Length of meeting: 8:08 a.m. to 10:53 a.m.

Adjourned,

**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 21, 2019, @ 4:30 p.m. at a Washington Park Senior Center 4420 West Vliet Street

PUBLIC COMMENT WILL BE HEARD ON THE 2020 BUDGET

Visit the Milwaukee County Mental Health Board Web Page at:

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

The February 28, 2019, 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.

Chairman Thomas Lutzow for Michael Davis, Secretary Milwaukee County Mental Health Board
DATE: April 9, 2019

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

FROM: Michael Lappen, Administrator, Behavioral Health Division

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

Background

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

Discussion

Optimal Operations and Administrative Efficiencies

- Psychiatric Crisis Redesign

At the Mental Health Board (MHB) Executive Committee meeting on March 20, 2019, Chairman Lutzow recommended exploring the possibility of hospital systems contributing to the crisis redesign. A Return on Investment (ROI) cost justification was done in another state indicating contribution on the part of hospital systems yield favorable returns for those hospital systems. It was recommended to have Wipfli conduct an analysis on a centralized Psychiatric Crisis Services (PCS) crisis response structure funded by the hospital systems and operated by the Behavioral Health Division (BHD). “It is cost justified for the private hospital systems to invest in public service.”

Per the previous direction of the Board on December 13, 2018, to explore the recommendations outlined in the WPF/HSRI Environmental Scan and Planning Summary, Wipfli has been contracted to provide several potential financial and operational models for both a “centralized” Psychiatric Emergency Department jointly funded and operated by BHD and the health systems, as well as a “decentralized” model where the health systems would expand treatment services available to individuals in a mental health crisis in their emergency departments.
Optimal Operations and Administrative Efficiencies (Continued)

BHD would expand mobile teams to complete Treatment Director’s Supplements (TDS), and would further expand alternatives to Emergency Detentions to meet community needs. The scope of work is expected to be completed by May 2019.

- **State Budget/Reimbursement Rates for Mental Health/Alcohol and Other Drug Abuse (AODA) Services**

  Board Secretary Davis recommended the Board meet with the hospital systems to have a roundtable discussion on a strategy to address rate reimbursement. The MHB Executive Committee directed BHD’s Hospital Administrator to arrange a meeting with State Representative Joe Sanfelippo to discuss this issue, in addition to the other issues facing BHD. Reimbursement rates and a series of potential revenue enhancements that could positively impact BHD have been included in the first draft of the State Budget, and are the focus of numerous lobbying efforts, including Wisconsin Hospital Association, Wisconsin Counties Association, Wisconsin County Human Services Association, the Wisconsin Council on Mental Health, and others. BHD will continue to work with partners, including Representative Sanfelippo, to promote improvements in reimbursement rates, access, and quality of services.

- **Interest Earned on the Behavioral Health Division’s Reserve Fund Accounts**

  This issue was raised at the February MHB meeting. Please see Attachment A for the response provided by the Milwaukee County Comptroller via email on March 19, 2019.

**High Quality and Accountable Service Delivery**

- **United Health Services (UHS) Contract/Acute Hospital Transition**

  Key inpatient acute staff will be approached to sign the retention agreements, which were approved at the February Board meeting, in June. This will kick off what is foreseen to be a two-year “retention period.” The Acute Hospital Transition project team is being led by Jennifer Bergersen, Linda Oczus, and Dr. Schneider and will focus on maintaining high quality and effective operations through the closure, the gradual transition of BHD clients as UHS ramps up capacity, and the transition of BHD staff to UHS employment.
Workforce Investment, Development, and Engagement

- **BHD Strategic Plan Projects**

  Per the direction of the MHB Executive Committee, a strategic plan is to be created that includes timelines, due dates, and identifies the parties responsible for the work. BHD has moved forward with eight project teams dedicated to the strategic initiatives required for BHD to effectively transition to a community-based system of care. BHD will use the attached format (**Attachment B**) to report progress on each project. Initial reports from each project team Executive Sponsor are due in May 2019. The project list and abstracts are also attached (**Attachment C**). This work will provide the foundation for the strategic plan for the final steps in the transition to a community-based system of care.

Other Topics of Interest

- **Journal/Sentinel Article on Crisis Resource Centers (CRC) in Milwaukee County**

  The recent Journal Sentinel story: “**These Crisis Centers Can Save Lives. Why Does Milwaukee Only Have Two?**” provided a great description of the benefits of CRCs but did not include a couple key points. Since the initial CRC opened in 2007, the program has expanded in scope and capacity in response to community needs with the following timeline:

  - **December 2007** - CRC South opens with no bed capacity. It operates very similar to the “Living Room” model with no overnight beds
  - **2008** - Capacity for 7 beds added to CRC South using the current model of care
  - **October 13, 2009** - Becher St. Crisis Stabilization House (CSH) opens at CRC South, which adds an additional 8 beds
  - **2012** - CRC North opened under contract with Community Advocates with 15 bed capacity
  - **July 15, 2013** - CRC North closed due to quality and regulatory concerns
  - **August 20, 2014** - CRC North opened under contract with Whole Health Clinical Group (WHCG) with 12 bed capacity
  - **November 30, 2015** - Additional coverage added to CRC contract for third shift admissions and coverage
  - **October 1, 2017** - Becher St. CSH beds transitioned to CRC South (8 beds)
  - **2018** - Talks begin to expand on the North Side with a third CRC location.

  Additionally, the Board funded the development of Peer Run Respite with one million dollars over three years in response to community requests that this valuable service be added to our local continuum of care in addition to CRC.
• Kane Communications Update

➢ See Attachment D

Respectfully Submitted,

_________________________
Mike Lappen, Administrator
Milwaukee County Behavioral Health Division
Department of Health and Human Services
In reviewing Act 203 of 2013, which established the Mental Health Board, and the rules regarding BHD reserves included in Statute, I do not find any requirement that the County allocate interest to BHD based on the available cash balance of BHD, either associated with the required reserves of BHD or the unreserved cash of BHD. The allocation of interest income has historically been a policy of the County Board. One of the requirements for the allocation of interest is that a trust or reserve be established. While BHD has established such reserves, the allocation of interest can only occur upon County Board approval. Historically, if the trust/agency fund/reserve does not require any allocation of interest, such allocation of interest does not occur. I do not see anything within State Statute which would require the County to allocate such interest for the available cash balance of BHD, related to these reserves.

Milwaukee County jointly banks all receipts and disbursement from departments across the County. Separate banking relationships have generally required the approval of the County Board under Ordinance 15.18. The reason the County Board has required such approval is to ensure that any separate banking relationships meets good accounting practice or meets current State Statute. Departments who receive separate banking approval are still required to report such banking that occurs during the year.

Separate banking is not a requirement for the allocation of interest income to trusts, agency funds, or departments that are required to maintain separate reserves by law. The establishment of trust or agency fund does not automatically grant such trust an allocation of interest income based on average fund balance. When a resolution is provided to the County Board for the establishment of a trust or agency fund, the resolution states whether it will be separately banked, or if not separately banked, if interest earnings will be allocated to such account.

In 1986, a resolution was passed (86-779) which led to the creation of policy R-528 for establishment of Trusts or Agency Funds. The County has used this policy for rules regarding the establishment of trusts and for the determination of the allocation of interest. I have attached a copy of this policy. This rules regarding this policy, and State Statute have been used to determine if separate trusts can be created and if interest should be allocated.

Under State Statute 59.60 (5) (g), the County is allowed to transfer surplus funds into a Debt Service Reserve or to provide funds for emergency needs, but for no other purposes. State Statute 59.60 (11) further states that every appropriation excepting an appropriation for a capital expenditure or a major repair, shall lapse at the close of the fiscal year to the extent it has not been expended or encumbered. These two Statutes led us to the conclusion that the County Board could not by itself establish any other reserves. However, we have found over the years that contract requirements, third-party agreements, State or Federal agencies, or Revenue Bond resolutions require that the County establish reserves/trusts to separately
maintain funds obtained under such agreements, so they are spent only for those intended purposes. For example, the County established a reserve for the BHD Wraparound program to maintain the unspent Federal Medicaid funds.

Under the Master Revenue Bond Agreement with the Airport, which was entered into by them prior to the issuance of revenue bonds, the agreement required that the County maintain reserves for the repayment of revenue bond debt, and to ensure adequate reserves for operations. In addition, the County underwent an audit by the Department of Transportation and the Federal Transportation Agency. The County established reserves in accordance with the requirements of the Master Revenue Bond Agreement, but interest was not allocated to such reserves. The Federal agencies stated that all funds earned by the Airport must be maintained within the Airport. Airport assets and revenues cannot be used to supplant other County expenditures. As a result, the audit stated that the County must allocate interest to the Airport based on its average cash balance that was held in reserves. Since that time, the County allocates interest to the Airport based on its unused cash balances. The interest allocated is the interest earned by the County from its general cash, as invested by the Treasurer. County funds are required to be invested in accordance with State Statute requirements.

Scott B. Manske
Comptroller
Milwaukee County
## Attachment B

### DMHS DIVISION OPERATING PLAN 2019H1

| Initiative Title (short name) | Detailed Initiative Description (including timeline) | Initiative Highlighted with CEX? | Initiative Start Date | Initiative End Date | Updated in even years, or as needed? | Updated in odd years, or as needed? | Updated bi-annually, or as needed? | Updated tri-annually, or as needed? | High-Level Action Stage (view attachment for "KICKOFF" - 30 day focused prioritization [incl. rough months]) | Person(s) Responsible (names) | Risks | Status Update - CURRENT (date XX/XX/XX) | Status Update - LAST UPDATE (date XX/XX/XX) |
|-------------------------------|-----------------------------------------------------|---------------------------------|-----------------------|---------------------|--------------------------------------|--------------------------------------|----------------------------------|----------------------------------|--------------------------------------|--------------------|---------------------------------|---------------------------------|
| 1                             | [Name]                                              | [Y/N]                           | 1/1/2019              | 1/1/2019            | [xx - xx]                            | [xx - xx]                           | [xx - xx]                        | [xx - xx]                        | [Responsible Name]                   | [Risks]           | [Update on XX/XX/XX]             | [Update on XX/XX/XX]             |
| 2                             |                                                     |                                 |                       |                     |                                     |                                     |                                  |                                  |                                     |                    |                                  |                                  |
| 3                             |                                                     |                                 |                       |                     |                                     |                                     |                                  |                                  |                                     |                    |                                  |                                  |
| 4                             |                                                     |                                 |                       |                     |                                     |                                     |                                  |                                  |                                     |                    |                                  |                                  |
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| 9                             |                                                     |                                 |                       |                     |                                     |                                     |                                  |                                  |                                     |                    |                                  |                                  |
| 10                            |                                                     |                                 |                       |                     |                                     |                                     |                                  |                                  |                                     |                    |                                  |                                  |
Wraparound Milwaukee (WM) & Disabilities Services Division (DSD) Children’s Integration

Create a seamless process for children with disabilities and their families to refer to and receive services to help support the child’s needs in their home. Wraparound Milwaukee and Disabilities Service Division will partner to integrate a children’s services system of care by:

- Creating a centralized intake process for children with disabilities and their families
- Creating a centralized screening process for children with disabilities and their families
- Centralizing ancillary services within children’s services
- Integrating documents, policies and procedure in accordance with state, federal and program requirements

Care Coordination

The expansion of Care Coordination services for adults will function to fill the gap of three specific areas for needed services:

- Individuals who need stabilization, support, and linkage to services but do not require/qualify for long-term supportive services.
- Individuals who need stabilization, support, and linkage to services but are not expected to need these services for an extended period (six months or less).
- Individuals who need brief, short term support while linking to their new outpatient community-based services or re-establishing care and engagement with their outpatient community-based services.

FQHC’s and Wellness Clinic Expansion

Development of partnerships with existing Federally Quality Health Centers (FQHC) in order to integrate behavioral and general health/medical care for consumer in their immediate neighborhoods. Additionally, this project workgroup will expand the Wraparound Wellness Clinic by partnering with these same FQHCs or others so both groups (adult and youth) will have access to a culturally competent workforce in decentralized locations around Milwaukee County.

- Improve access to behavioral healthcare for Milwaukee County residents through the use of multiple community based access sites/FQHCs;
- Integrate behavioral and medical healthcare needs for Milwaukee County residents through the use of already established FQHC’s;
- Develop partnerships with existing FQHC’s on the Northside and Southside of Milwaukee;
- Expand Wellness Clinics for Wraparound Clients and integrate into the above sites.

Utilization Review and Care Management

Development of Utilization Review and Care Management: Project teams will successfully develop an enterprise-wide and systematized scheme to oversee resource allocation and utilization against regulatory and industry standards to ensure maximization of access and quality in our contracted network of providers. This will result in increased access and quality for patients and families and greater cost efficacy of purchasing and resource use for Milwaukee County and tax payers.
Contract Management & Network Development

Through an integrated project with participants across our behavioral health system, there is an opportunity for our team(s) to manage contracts and provider networks differently in that we increase our focus on quality outcomes, value and empowerment of those we serve, not only inputs, while also increasing the management of provider relationships with purposeful service network evaluation, development and quality review.

- We have an opportunity to adapt our system of care to the unmet needs of our customers, the overall health of our communities and continue to grow an adequate, accountable, and quality network; a system of care that is integrated and aligned with our mission and aligned with the department envisioned future state – across the lifespan.
- Further develop a quality, value based behavioral health provider network. Ultimately, more individuals with behavioral health needs throughout Milwaukee County will be served via a financially sustainable and quality behavioral health network.

BHD Acute Hospital Transition Project

This project includes the Milwaukee County transfer of the direct operation of BHD’s psychiatric inpatient hospital services, care and treatment to that of Universal Health Services, Inc. (UHS). This project plan focuses on the preparation, development and completion of the transition activities of acute hospital services. The project team(s) will identify and collaborate with UHS on both internal and external activities in order to successfully transfer care and services, meet objectives and timelines while managing risk(s) and ensuring patient safety. The team will also assess and identify needs/gaps of services to inform the Executive Team of new BHD business needs and development through and after transition.

Internships & Workforce Development

This project will develop and maintain formal training opportunities for local undergraduate, graduate, and post-graduate level trainees, which contributes to staff engagement in the continued development of the workforce.

- The number of formal training opportunities will increase in 2019.
- The number of disciplines offering formal training opportunities will expand in 2019.
- The number of trainees that are retained as employees will be quantified.
- The number of trainees who successfully attain licensure will be quantified (as applicable by discipline and educational status).

PCS Crisis Redesign

The Crisis Re-Design Project at BHD will have three teams focused on implementing the major recommendations from HSRI/TAC. One team will focus on the collaboration with the health systems on a jointly funded and operated Psychiatric Emergency Department. One team will focus on the expansion of and improvements to existing community based crisis services like CART, CRC Team Connect, and Crisis Mobile, and a third team with focus on what was referred to by HSRI in their planning summary as “cross cutting” or innovative ideas like tele-psychiatry, “air traffic control”, expanded peer services, etc.

BHD Executive Team
February 18, 2019
Awards and Recognition

Lauren Hubbard, Director of Community Crisis Services, was awarded a Black Excellence Award, by The Milwaukee Times, for her work in the health sector.

BHD Strategic Communications Planning

Completed comprehensive, research-informed 2019-2021 BHD Strategic Communications Plan that will guide BHD's communications with internal and external stakeholders. The plan includes research results, strategies, tactics and a detailed implementation timeline. Additionally, the plan aligns with BHD’s eight strategic priority areas for 2019. Prior to launching the plan, it will be presented to the BHD Administrator and leadership.

Universal Health Services Coordination

- Coordinating communications for the announcement of the location of the Universal Health Services (UHS) hospital.
- Working with BHD leadership to determine next steps and communications needs to keep stakeholders informed and engaged during the transition.

Employee Engagement

EMPLOYEE COMMUNICATIONS SURVEY

The survey was sent to all BHD staff, via email, on February 27. The purpose of the survey was to get employee input on the type of information they want to receive and how they prefer to receive information. The survey was completed by 123 BHD employees. Key findings follow:

Communication and trust

- In the last two years, the perception of communication improved. In 2019, more than 49% of employees said they strongly agree or agree that communication between senior leaders and employees is good. This represents a 13% increase over the survey results in 2017, where 36% of the respondents strongly agreed or agreed with the statement.
The 2019 survey results show almost half of the respondents (49%) agreed or strongly agreed with the statement that senior leaders (administration) want to know what employees think.

Organizational goals and workplace culture

- A majority (73%) of the respondents strongly agreed or agreed with the statement “I clearly understand my organization's goals.”
- Over half (52%) said they agree or strongly agree with the statement “I am satisfied with the culture of my workplace.”
- More than two-thirds (69%) agreed or strongly agreed with the statement that employees treat each other with respect. 62% agreed or strongly agreed with the statement that someone at work had provided them with positive feedback or acknowledged them for doing a good job in the last seven days.

Employee feelings about change

- 2019 respondents were somewhat split as to whether BHD employees willingly accept change. 32% agreed or strongly agreed employees accept change, and 32% disagreed or strongly disagreed with the statement. 36% remained neutral on the statement.
- Respondents also voiced their opinions about when they learn about change through their division, and the results were split fairly evenly. 35% agreed or strongly agreed that they learn about planned changes in the division before they happen, while 37% disagreed or strongly disagreed with the statement. 27% were neutral on the subject.

Preferred methods of communication

Respondents identified numerous ways they wanted information from BHD and leadership. Email was the most popular, with 86% of respondents stating email is important. (Note, the survey was distributed via email, so confirmation bias was built into this question). 74% of employees stated communication directly from their manager was important, and 54% of respondents stated regular group meetings with department supervisors was important. A third of the respondents (33%) said town hall meetings with the administrator were important, and 31% said small group meetings with the administrator were important. Only 18% said employee bulletin boards were important.

Open-ended responses

As expected, the qualitative responses varied greatly in tone and sentiment as expressed in open-ended answers. When respondents were asked to describe BHD in one word, the responses included positive adjectives, negative adjectives and neutral words (i.e. patient). The wide variance indicates that BHD means many things to different employees, and no conclusive pattern could be developed.
When employees were asked one word to use in the future to describe BHD, more than two-thirds listed words with a positive sentiment. The word “collaborative” emerged five times among 94 answers. The majority of the words focused on positive change, with terms like: progressive, healthy, supportive, employee-focused, exciting, trustworthy, genuine, innovative and awesome. This data indicates a hopeful spirit and cautious optimism among employees as BHD continues its transformative journey.

BHD ADMINISTRATOR EMAIL

- The February email was distributed on February 27, and included information on the BHD newsletter now being a quarterly publication and a link to the Employee Communication Survey.
- The administrator email was received by 466 staff and opened by 275 staff.

BHD NEWSLETTER

The quarterly newsletter is scheduled for distribution in early April. Analytics from the newsletter will be included in the next communications update.

TOWN HALL MEETINGS

- Town Hall Meetings were held on February 21 at 7:15 a.m. and 1:45 p.m. The featured speaker at both meetings was Diane Henneman, Regional Vice President of UHS, who shared information on the acute care hospital project.
- Town Hall Meetings were held on March 21 at 7:15 a.m. and 1:45 p.m. The featured presenter was Mike Lappen who shared information on BHD’s eight strategic priority areas. Mike requested staff participation on the BHD planning teams.

Mental Health Board Engagement

- New pictures of MHB members and BHD leadership were taken during the February board meeting. The pictures will be used on BHD’s webpages and in other BHD and Mental Health Board communications.
- The Kane team is meeting with MHB members for historical perspective and their insights and ideas on current and future communications efforts.

Nurse Recruitment Campaign

In 2019, we have continued to support nurse recruitment efforts at BHD via our nurse recruitment marketing campaign - with the goal of continuously driving new leads to our nurse recruiter.

- The goal for the fall/winter campaign was to generate 45 nursing candidate leads in the first six months.
- The campaign has generated more than 50 leads in five months through the campaign website, social media and job fairs combined.
Public/Media Relations

February and March media coverage:

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<tr>
<td>Wisconsin Health News</td>
<td>Milwaukee County's Core Program Seeks To Empower Youth</td>
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<td>Milwaukee Neighborhood News Service</td>
<td>Light &amp; Unite Red educates young people about substance abuse</td>
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<tr>
<td>Urban Milwaukee</td>
<td>Schools' Program Provides Mental Health Care</td>
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<tr>
<td>Milwaukee Neighborhood News Service</td>
<td>Mental health program at UCC schools serves children at school</td>
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<td>FOX6</td>
<td>‘We’re not entitled:’ Psychologist urges social media users to take a step back from Jayme Closs case</td>
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<tr>
<td>CBS58</td>
<td>Local psychologist offers perspective on Closs recovery</td>
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<tr>
<td>FOX6</td>
<td>'Shine A Light on Addiction Week' brings awareness to substance abuse in Milwaukee'</td>
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<tr>
<td>WISN12</td>
<td>Your kids may be hiding drug paraphernalia in plain sight</td>
</tr>
<tr>
<td>OnMilwaukee</td>
<td>Light &amp; Unite Red educates young people about substance abuse</td>
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<tr>
<td>Wisconsin Public Radio</td>
<td>Milwaukee Police Cope With Third Officer Death In 8 Months</td>
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<td>PEW</td>
<td>Foster Parents Have Become Professionals in Some States</td>
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<tr>
<td>The Huffington Post</td>
<td>Foster Children Need Better Mental Healthcare. What Can Foster Parents Do?</td>
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</table>

Upcoming media and events:

- *Milwaukee Magazine* interviewed Lauren Hubbard regarding the career opportunities that exist within the behavioral health industry and various programs offered by the Behavioral Health Division.
**MILWAUKEE COUNTY MENTAL HEALTH BOARD**

**EXECUTIVE COMMITTEE**

**Wednesday, March 20, 2019 - 11:00 A.M.**

Milwaukee County Mental Health Complex
Conference Room 1045

**MINUTES**

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

**SCHEDULED ITEMS:**

1. **Welcome.**
   
   Chairman Lutzow greeted Committee Members and welcomed everyone to the March 20, 2019, Mental Health Board’s annual meeting of the Executive Committee.

2. **Milwaukee County Mental Health Board Goals and Vision for 2019.**
   
   Michael Lappen, Administrator, Behavioral Health Division (BHD)
   Dr. John Schneider, Chief Medical Officer, BHD
   Jeanne Dorff, Fiscal Administrator, Department of Health and Human Services

   Chairman Lutzow stated the intent of the report was to provide the Board with content related to future issues requiring Board consideration and to basically serve as a roadmap of the general direction the Board needs to go collectively. Top priorities include the Universal Health Services (UHS) contract, facility relocation, and crisis redesign. The report will also generate subsequent items through the input and feedback of Board Members. He also referenced work needed in the area of quality improvement.

   Detailed discussions were held regarding facility relocation efforts and crisis redesign. Chairman Lutzow recommended exploring the possibility of hospital systems contributing to the redesign. A Return on Investment (ROI) cost justification was done in another state indicating contribution on the part of hospital systems yield favorable returns for those hospital systems. It was recommended to have WIPFLi conduct an analysis on a centralized Psychiatric Crisis Services (PCS) crisis response structure funded by the hospital systems and operated by BHD. It is cost justified for the private hospital systems to invest in public service.
Chairman Lutzow emphasized the importance of soliciting the State to restructure the Medicaid reimbursement rate for mental health services. Mr. Lappen stated changes in the reimbursement structure would have a significant positive impact on BHD, which would also translate to a positive impact for BHD’s health system partners. Rate reform is clearly needed. Board Secretary Davis recommended the Board meet with the hospital systems to have a roundtable discussion on a strategy to address rate reimbursement. The Executive Committee directed Mr. Lappen to arrange a meeting with State Representative Joe Sanfillipo to discuss this issue, in addition to the other issues faced by BHD.

Board Secretary Davis indicated certain items listed on the report will present themselves with specific deadlines, particularly surrounding the closing of the hospital. Other issues on the list appear to be more on-going. A potential solution to addressing the report would be an assignment of timelines. In addition to timelines, how the work is delegated should be included. Because it is going to take a lot of planning, the focus should be on organizing the list in such a way that is manageable to the Board.

Chairman Lutzow directed Mr. Lappen to create a strategic plan that includes timelines, due dates, and identifies the parties responsible for the work.

A detailed discussion was held regarding the hospital transition. Mr. Lappen explained BHD’s undertaking of eight major projects in an attempt to organize and effectively allocate available resources to the transition. Mr. Lappen stated he will report on the project teams’ progress regularly as the projects move forward. He stated Jennifer Bergersen, Dr. Schneider, and Linda Oczus are collaboratively leading the hospital transition team and responsible for operational details needed to go from transitioning down from a four unit facility through closure, all while continuing to operate at a high level up until the very last patient is discharged. Some of this will include a collaboration with UHS to engage BHD staff to help build their own medical staff organization and identify a workforce to staff their units.

Chairman Lutzow addressed the workforce shortage being suffered by providers in the community. Mr. Lappen informed the Committee of the workforce development and diversity project and team currently in place interfacing with various universities, with a connection to Milwaukee Area Technical College (MATC) through Board Member Lanier, in the hopes of expanding. It will provide a pathway through an accommodating internship site and assist students through the programs. This requires developing talent through the community by providing opportunities in coordination with provider agencies.

Mr. Lappen reviewed the list of topics and provided an update on BHD’s progress as to each.

3. **Adjournment.**

Chairman Lutzow ordered the meeting adjourned.
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: 11:05 a.m. to 12:20 p.m.

Adjourned,

**Jodi Mapp**
Senior Executive Assistant
Milwaukee County Mental Health Board

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**Scheduling of the next**
Milwaukee County Mental Health Board Executive Committee
Is at the Call of the Chair

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

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The March 20, 2019, meeting minutes of the Milwaukee County Mental Health Board Executive Committee have been reviewed and are hereby approved.

Michael Davis, Secretary
Milwaukee County Mental Health Board
DATE: March 13, 2019

TO: Milwaukee County Mental Health Board Executive Committee

FROM: Thomas Lutzow, Chairman
       Milwaukee County Mental Health Board

SUBJECT: Milwaukee County Mental Health Board (MCMHB) Goals and Vision for 2019

Background

A major and heavy lift concluded in 2018 with a commitment to Universal Health Services (UHS) after a lengthy process that began with the founding of the MCMHB (perhaps even before). Our commitment to UHS has put a timeline in motion, e.g., complete the design of a new psychiatric crisis service, relocate from the Mental Health Complex, etc. These new challenges can be viewed as co-terminus with the opening of the UHS facility and will require attention.

Discussion

2018 was quite an amazing year, a foundational year in how Milwaukee County will approach delivery of mental health services in the future. The draft list below was created to assist in identifying potential goals going into 2019.

a)- Futures Design Roadmap:
   (What will we look like when we grow up?)
   (How do we look along the way?)
   - Integration of programs
   - Blending medical and social services
   - Crisis response (timeliness)
   - Role of patient-level telehealth outreach/connectivity
   - Demonstrated preference for community-based services
   - Coordination with law enforcement
   - Coordination with other Milwaukee County departments and services
   - Quality/performance metrics
b)- Quality and Strength of UHS Commitment to Milwaukee County
   - Evidence of progress
   - Contract signing (When?)
   - Timeline to facility opening (Roadmap)
   - UHS interest in current BHD staff
   - MCMHB presence on local UHS Board
   - Utilization management plans

c)- Psych Crisis Services
   - Design of solution (structure/efficiencies)
   - Role of MCMHB in the solution
   - Activation of private sector capabilities/responsibilities
   - County/MCMHB responsibilities (statutory)
   - Costs to MCMHB
   - Timeline/roadmap to new-design launch
   - Utilization management plans

d)- BHD Relocation
   - Relocation plan
   - New location selection/options
   - Purchase vs lease agreements
   - Layout designs (blueprints)
   - Build-out cost estimates
   - Cost responsibilities (County vs BHD)
   - Timeline to relocation
   - Residual (current facility) obligations ($$)

e)- Cross-charge Practices/Policies
   - Cost detail monitoring (transparency)
   - Approval authority (who has it?)
   - Cost allocation methodology
   - Monitoring of line item variances (who does it?)

f)- Strategies to improve Source of Funds
   - Changes in state Medicaid policy
   - Status of Medicaid expansion (to 138% of FPL)
   - Expansion of Medicaid coverage benefits
     (social determinants of health)
   - Increased HMO/MCO funding of MCMHB services
   - Expansion of CCS (possible redesign)
   - Reserve fund management
Recommendation

Present a prioritized list to the full Board requesting feedback and input of additional items and goals.

_______________________________
Thomas Lutzow, Chairman
Milwaukee County Mental Health Board
DATE: March 7, 2019

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 Contracts and a 2018 Professional Services Contract Amendment for Resident/Fellow Stipend Support and Residency Director, Consultation, and Security 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 2019.

Background

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

Professional Services Contracts

Medical College of Wisconsin Affiliated Hospitals, Inc. - $1,000,000

BHD contracts with the Medical College of Wisconsin Affiliated Hospitals, Inc. (MCWAH) for resident and fellow housestaff activities, as part of BHD’s training site designation with the MCW Psychiatry Training Programs. The residents and fellows that serve as housestaff provide medical care within the BHD Acute Inpatient, Crisis, Wraparound, Children's Mobile Crisis and Community Services, with oversight and direction from BHD psychiatry staff. BHD is seeking to renew the agreement for another two-year term for the period of July 1, 2019, through June 30, 2021, in an amount of $500,000 annually to support the housestaff stipends. This amount reflects a decrease in the annual amount from the prior agreement, in accordance with programming changes to FTEs assigned.
The Medical College of Wisconsin, Inc. - $119,588
BHD is requesting renewal of an agreement with the Department of Psychiatry and Behavioral Medicine to provide for partial support of the MCW Psychiatry Residency Director salary, in connection with oversight of the resident and fellow training activities occurring within Behavioral Health Division services and programs. BHD is seeking to extend the agreement for another two-year term for the period of July 1, 2019, through June 30, 2021, in an amount of $59,794 annually.

The Medical College of Wisconsin, Inc. - $20,000
BHD is requesting renewal of an agreement with the Center for Bioethics and Medical Humanities for the purpose of consultation and the provision of continuing education to BHD’s Bio-Ethics Committee and clinical staff. BHD is seeking to extend the agreement for another two-year term for the period of July 1, 2019, through June 30, 2021, in an amount of $10,000 annually.

U.S. Securities Associates/Allied Universal - $468,000
This Vendor provides public safety services for BHD. They provide services twenty-four hours a day, and seven days a week. The Vendor is responsible for escorting services, monitoring the outside parking lots, and performing environment of care safety checks, etc. These funds are being requested for 2019. The total contract amount would be $3,268,222.

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

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*Denotes a Vendor whose funding is supported by a grant.
Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson
DATE: March 7, 2019

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

FROM: Mary Jo Meyers, Director, Department of Health and Human Services

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute an Amendment to a 2019 Fee-for-Service Agreement Totaling the Agreement 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 2019.

Background

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

Fee-for-Service Agreements

Butterflies Home for Teen Girls - $40,000

The Vendor provides Group Home Care for girls, pregnant teens, and/or parenting teens with babies for the Wraparound Milwaukee Program, under an Out of Network Agreement. BHD is requesting an additional $40,000 for 2019. The total contract amount will be $192,149.15 for 2019.
**Fiscal Summary**

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

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

Mary Jo Meyers, Director  
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson
DATE: April 8, 2019

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

FROM: Mary Jo Meyers, Director, Department of Health and Human Services

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute 2019 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 2019.

**Background**

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

**Purchase-of-Service Contracts**

**SaintA, Inc. - -$56,250**

The Vendor provides Care Coordination, REACH, screening/assessment, and case management services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is reducing their contract by $56,250 for 2019 as a Screener is being removed from their Staff. The total contract amount will be $1,861,529.
**St. Charles Youth and Family Services, Inc. - $56,250**
The Vendor provides Care Coordination, REACH, OYEAH, screening/assessment, mobile crisis, Peer Specialists, and case management services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is asking for an additional $56,250 for 2019 as an additional Screener is being added to their Staff. The total contract amount will be $5,596,312.

**Fiscal Summary**

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

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

Mary Jo Meyers, Director  
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson
MILWAUKEE COUNTY MENTAL HEALTH BOARD
FINANCE COMMITTEE

Thursday, March 28, 2019 - 1:30 P.M.
Mental Health Complex
9455 West Watertown Plank Road
Conference Room 1045

MINUTES

PRESENT: Maria Perez, Jon Lehrmann, Duncan Shrout, and Michael Davis
EXCUSED: Kathie Eilers

SCHEDULED ITEMS:

1. Welcome.

Chairwoman Perez welcomed everyone to the March 28, 2019, Mental Health Board Finance Committee meeting.

2. 2018 Financial Results and Dashboard.

An overview was provided of the 2018 Year-End fiscal report detailing combined reporting, inpatient hospital annual projections, and 2018 year-to-date revenues and expenses. Program Dashboards for acute adult inpatient, child and adolescent inpatient (CAIS), Psychiatric Crisis Services (PCS), Alcohol and Other Drug Abuse (AODA), Wraparound, Targeted Case Management (TCM), Comprehensive Community Services (CCS), and Community Support Programs (CSP) were all reviewed. Year-end financial highlights included information on inpatient census, patient receivable accounts, Crisis Mobile Team expansion, state institutions, final County fringe settlement, CCS growth, and AODA costs.

Questions and comments ensued.

3. 2020 Preliminary Behavioral Health Division Budget Assumptions.

2020 Budget Assumptions are based on an expected reduction in tax levy, an abatement, and does not include policy/funding changes from the Governor’s Recommended State Budget. It includes adult inpatient bed capacity and write-off percentage, CAIS census; assumes the payor mix reflected in the corresponding report; maintains community based residential current capacity, a CCS increase, AODA expansion, CSPs, TCM, and Federally Qualified Health Center (FQHC) partnerships.
4. **2020 Budget Timeline.**

A timeline was provided on the sequence of events that will guide the Behavioral Health Division’s (BHD) budget process. As indicated in the timeline, the process includes three opportunities for public input and allows the time necessary for a complete and thorough review.

Following a discussion by the Finance Committee, it was decided public input would be more informed if the public had a budget document to react to. In review of the 2020 Budget timeline for Finance Committee dates and deliverables, the Public Hearing originally scheduled for Thursday, June 6, 2019, is being rescheduled to **Tuesday, June 18, 2019**. BHD’s Fiscal Administrator will still present BHD’s Preliminary 2020 Budget on June 6, 2019, with a time and location to be determined. The Budget narrative will be posted as planned on Friday, June 14, 2019. This change will allow the public time to review the Budget narrative and prepare prior to recommendations being submitted by Mental Health Board Members to the Finance Chair.

5. **Wisconsin Medicaid Cost Reporting (WIMCR).**

WIMCR relates to Medicaid programs reimbursed by federal dollars. This is a process of reporting all costs for the administration of programs. If costs are over what was billed, cost data is compared to encounter data. With the extra public expenditure being reported reflecting costs are more and over what was billed, additional dollars can be drawn from federal funds.

WIMCR payments are always received the following year from the year the data was submitted.

6. **Impact of the Governor’s Proposed State Budget on Behavioral Health Division Programs and Services.**

The following initiatives were identified as potential impact and/or risk items for BHD: Medicaid expansion and community health benefit, crisis intervention services, crisis stabilization facilities, mental health services under BadgerCare Plus, and the Childless Adult Demonstration project. BHD’s 2020 Budget Assumptions do not include policy/funding changes from the Governor’s Recommended State Budget.

7. **The Behavioral Health Division’s Facility Relocation Plan Update.**

To obtain the data needed for a cost estimate, resources were pulled from various County departments, including Information Technology (IT) and Facilities. Cost ranges to move per person were reviewed. The advantages/disadvantages for existing office space versus a full remodel and the estimated square footage were discussed. A maximum of $4.7 million in reserve funds should be identified to cover these costs.

8. **The Behavioral Health Division’s County-Wide Cross Charges.**
**SCHEDULED ITEMS (CONTINUED):**

<table>
<thead>
<tr>
<th>A line by line review was done of the report. Charges were presented in descending order. The first seven items listed make up the majority of money designated for cross charges. As Corporation Counsel cross charges have been singled out by the Board, Corporation Counsel intends to come before the Board to present specifically on their charges. An explanation was provided on the accounts and the departments associated. Questions and comments ensued.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>9. <strong>Quarterly Report on Reserve Balances and a Status Update of Approved Projects Funded from Reserves.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The books for 2017 have closed and the final results are available. Please note data for 2018 is projected data. The surplus reflected has to be shared with Wrap’s reserves. The Comptroller will determine whether the surplus balance, once Wrap’s portion has been accounted for, will be applied to Capital Reserves. Questions and comments ensued.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. <strong>Wraparound Milwaukee Audit Report.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The report represents a comprehensive audit conducted on the Wrap Program. The financial template audited is included. Every year, Wraparound submits three years of financials to the State for rate setting purposes, in addition to all their patient/client level encounter data. There was a new rule put in place requiring a comprehensive external audit of those financials. The County’s Audit Department assisted with identifying an external auditor. It was found that the financial template submitted presents fairly, in all material respects, the total claim payments to providers and administrative expenses described therein.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. <strong>Mental Health Board Finance Committee Professional Services Contracts Recommendation.</strong></th>
</tr>
</thead>
</table>
| - 2018 Contract Amendment
  - U.S. Security Associates/Allied Universal

- 2019 Contracts
  - Medical College of Wisconsin Affiliated Hospitals, Inc.
  - The Medical College of Wisconsin, Inc.

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. A detailed description was provided on all services U.S. Security and the Medical College provide.

A recommendation to approve would be for a 2018 Contract Amendment and 2019 Contracts. |
**SCHEDULED ITEMS (CONTINUED):**

| 11. | Finance Committee Member Lehrmann abstained from recommending the 2019 Medical College of Wisconsin and its Affiliated Hospitals' contracts for approval. |
|     | Remaining Committee Members unanimously agreed to recommend approval of the 2019 Medical College of Wisconsin and its Affiliated Hospitals' contracts to the full Board. |
|     | The Finance Committee, as a whole, unanimously agreed to recommend approval of the 2018 Professional Services Contract Amendment delineated in the corresponding report to the full Board. |
| 12. | **Mental Health Board Finance Committee Fee-for-Service Agreements Recommendation.** |
|     | 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 agreement, which provides a broad range support services to children with serious emotional disturbances. |
|     | The Finance Committee unanimously agreed to recommend approval of the Fee-for-Service Agreement delineated in the corresponding report to the full Board. |
| 13. | **Adjournment.** |
|     | Chairwoman Perez ordered the meeting adjourned. |

**ADDENDUM NO. 1 ITEMS**

| 14. | **Mental Health Board Finance Committee Purchase-of-Service Contracts Recommendation.** |
|     | • 2019 Contract Amendments |
|     | 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 program contract amendments. A recommendation to approve would be for 2019 Contract Amendments. |
|     | The Finance Committee unanimously agreed to recommend approval of the 2019 Purchase-of-Service Contract Amendments delineated in the corresponding report to the Board. |
15. **2020 Operating Budget Planning Updates.**

There will be another abatement to BHD’s 2020 Budget similar to what was done for 2019. The County plans to reduce the tax levy, which applies to all County departments, in addition to having to find money to fill the Budget gap.

Questions and comments ensued.

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

Length of meeting: 1:33 p.m. to 3:58 p.m.

Adjourned,

Jodi Mapp
Senior Executive Assistant
Milwaukee County Mental Health Board

The next meeting of the Milwaukee County Mental Health Board Finance Committee is Thursday, June 6, 2019, at 4:30 p.m.

Visit the Milwaukee County Mental Health Board Web Page at:

[https://county.milwaukee.gov/EN/DHHS/About/Governance](https://county.milwaukee.gov/EN/DHHS/About/Governance)
Finance Committee Item 2

Milwaukee County Behavioral Health Division
2018 Annual Year End Projection - Major Variances
Favorable/(Unfavorable) - ($ millions)

Total BHD Projected Surplus/(Deficit)  $ 0.9

Hospital (Adult Inpatient, CAIS, ER/Obs)  ($1.2)

REVENUE:
Patient Revenue - CAIS ($1.5), PCS-ER/Obs ($2.0), Adult ($0.5)  $ (4.0)

EXPENSES:
Personnel Expenses - Overtime ($0.5), Final Fringe +$.4  $ (0.1)
Miscellaneous Patient Expenses  $ 1.5
State Institutes  $ (1.1)
Internal Allocation revised, favorable to Inpatient  $ 2.6
Sub-Total Hospital Expenses  $ 2.9

Management/Operations/Fiscal  ($0.8)
Encumbered Pharmacy Contract - Expense in 2018, funds in 2019

Community Services  $2.8

REVENUE:
WIMCR Surplus  $ 3.5
Crisis Mobile Team Billing Productivity  $ 0.4

EXPENSES:
CRS closure  $ 0.5
IOP/FQHC Partnership Delay  $ 0.6
Residential - CBRF  $ (2.0)
Salary Underspend  $ 1.8
RSC/Outpatient Overspend  $ (1.8)
Sub-Total Community Expenses  $ (0.9)
# Combined Reporting
## Q4 2018 - 2018 Annual Projection

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Services</th>
<th>Mgmt/ Ops/Fiscal</th>
<th>Total BHD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCA</td>
<td>7,700,026</td>
<td>14,636,560</td>
<td>-</td>
</tr>
<tr>
<td>State &amp; Federal</td>
<td>-</td>
<td>19,202,016</td>
<td>-</td>
</tr>
<tr>
<td>Patient Revenue</td>
<td>20,796,123</td>
<td>89,970,204</td>
<td>333,247</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>1,691,351</td>
<td>573,997</td>
</tr>
<tr>
<td><strong>Sub-Total Revenue</strong></td>
<td>28,496,149</td>
<td>125,500,131</td>
<td>907,244</td>
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</table>

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Services</th>
<th>Mgmt/ Ops/Fiscal</th>
<th>Total BHD</th>
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<tbody>
<tr>
<td><strong>Expense</strong></td>
<td></td>
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</tr>
<tr>
<td>Salary</td>
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<tr>
<td>Overtime</td>
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<tr>
<td>Fringe</td>
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<td>9,492,181</td>
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<td>128,258,133</td>
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<td>8,508</td>
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<td>502,500</td>
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<td>Cross Charges</td>
<td>16,302,089</td>
<td>38,108,286</td>
<td>6,818,211</td>
</tr>
<tr>
<td>Abatements</td>
<td>(27,513,557)</td>
<td>(33,297,997)</td>
<td>(60,811,554)</td>
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<tr>
<td><strong>Total Expense</strong></td>
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<td>155,222,784</td>
<td>1,421,794</td>
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<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Services</th>
<th>Mgmt/ Ops/Fiscal</th>
<th>Total BHD</th>
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<tbody>
<tr>
<td><strong>Tax Levy</strong></td>
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<tr>
<td>29,317,748</td>
<td>29,722,653</td>
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<td><strong>59,554,951</strong></td>
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<table>
<thead>
<tr>
<th>Hospital</th>
<th>Community Services</th>
<th>Mgmt/ Ops/Fiscal</th>
<th>Total BHD</th>
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<tbody>
<tr>
<td><strong>2018 Projected Surplus/(Deficit)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>410,458</td>
<td>700,975</td>
<td>1,586,123</td>
<td>2,697,556</td>
</tr>
<tr>
<td>(955,218)</td>
<td>(168,674)</td>
<td>(82,662)</td>
<td>(1,206,555)</td>
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<td>400,593</td>
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<td>1,470,787</td>
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<tr>
<td>(1,079,654)</td>
<td>9,292,150</td>
<td>(0)</td>
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<td>2,088</td>
<td>(19,264)</td>
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<td>2,610,759</td>
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<tr>
<td>(22,757,249)</td>
<td>(4,019,150)</td>
<td>(26,776,399)</td>
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<tr>
<td><strong>2,859,813</strong></td>
<td><strong>8,225,481</strong></td>
<td><em>(146,545)</em></td>
<td><strong>10,938,749</strong></td>
</tr>
</tbody>
</table>

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

Mgmt/Ops/Fiscal includes administrative functions which 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: **$29,278,847**

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.
### 2018 Budget

<table>
<thead>
<tr>
<th></th>
<th>AODA</th>
<th>Mental Health</th>
<th>WRAP</th>
<th>Total CARSD</th>
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<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCA</td>
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<tr>
<td>Other</td>
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<td>180,000</td>
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</tr>
<tr>
<td><strong>Sub-Total Revenue</strong></td>
<td>11,710,592</td>
<td>53,199,057</td>
<td>60,590,482</td>
<td>125,500,131</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>AODA</th>
<th>Mental Health</th>
<th>WRAP</th>
<th>Total CARSD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expense</strong></td>
<td></td>
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<tr>
<td>Salary</td>
<td>62,028</td>
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<td>Overtime</td>
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<td>3,060</td>
<td>3,060</td>
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<tr>
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<td>-</td>
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<tr>
<td>Cross Charges</td>
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<table>
<thead>
<tr>
<th></th>
<th>Tax Levy</th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td><strong>2018 Annual Projection</strong></td>
<td>3,667,820</td>
<td>23,594,859</td>
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<tr>
<td><strong>2018 Projected Surplus/(Deficit)</strong></td>
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<td>381,703</td>
<td>2,849,646</td>
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</tr>
</tbody>
</table>

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

### Q4 2018 - 2018 Annual Projection

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2018 Budget</th>
<th></th>
<th>2018 Annual Projection</th>
<th></th>
<th>2018 Projected Surplus/(Deficit)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>CAIS</td>
<td>Crisis ER/Obs</td>
<td>Total Inpatient</td>
<td>Adult</td>
<td>CAIS</td>
</tr>
<tr>
<td>BCA</td>
<td>-</td>
<td>-</td>
<td>7,700,026</td>
<td>7,700,026</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>State &amp; Federal</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>159,040</td>
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<tr>
<td>Patient Revenue</td>
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<td>3,188,628</td>
<td>20,796,123</td>
<td>12,324,725</td>
<td>2,978,037</td>
</tr>
<tr>
<td>Other</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>85,478</td>
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</tr>
<tr>
<td>Sub-Total Revenue</td>
<td>12,977,749</td>
<td>4,629,746</td>
<td>10,888,654</td>
<td>28,496,149</td>
<td>12,483,765</td>
<td>3,063,515</td>
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### Expense

<table>
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<tr>
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<th></th>
<th>2018 Annual Projection</th>
<th></th>
<th>2018 Projected Surplus/(Deficit)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>CAIS</td>
<td>Crisis ER/Obs</td>
<td>Total Inpatient</td>
<td>Adult</td>
<td>CAIS</td>
</tr>
<tr>
<td>Salary</td>
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<td>7,475,117</td>
<td>1,843,956</td>
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<td>Overtime</td>
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<td>41,556</td>
<td>287,220</td>
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<td>1,155,471</td>
<td>99,794</td>
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<td>Fringe</td>
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<td>-</td>
<td>5,508</td>
<td>8,508</td>
<td>23</td>
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<td>Cross Charges</td>
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<tr>
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### Tax Levy

<table>
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<tr>
<th></th>
<th>2018 Budget</th>
<th></th>
<th>2018 Annual Projection</th>
<th></th>
<th>2018 Projected Surplus/(Deficit)</th>
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<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>CAIS</td>
<td>Crisis ER/Obs</td>
<td>Total Inpatient</td>
<td>Adult</td>
<td>CAIS</td>
</tr>
<tr>
<td></td>
<td>20,152,386</td>
<td>2,488,007</td>
<td>6,677,355</td>
<td>29,317,748</td>
<td>18,774,666</td>
<td>3,590,292</td>
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</table>
Behavioral Health Division
Management/Operations/Fiscal
Q4 2018 - 2018 Annual Projection

<table>
<thead>
<tr>
<th></th>
<th>2018 Budget</th>
<th>2018 Annual Projection</th>
<th>2018 Projected Surplus/(Deficit)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCA</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>State &amp; Federal</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patient Revenue</td>
<td>333,247</td>
<td>53,036</td>
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<tr>
<td>Other</td>
<td>573,997</td>
<td>226,003</td>
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<td>Sub-Total Revenue</td>
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<td>279,039</td>
<td>(628,205)</td>
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<td><strong>Expense</strong></td>
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<td>Encumbered Pharmacy Systems Inc</td>
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<td>Salary</td>
<td>8,199,146</td>
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<td>1,586,123</td>
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<td>Overtime</td>
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<td>220,158</td>
<td>(82,662)</td>
</tr>
<tr>
<td>Fringe</td>
<td>9,492,181</td>
<td>7,823,112</td>
<td>1,669,069</td>
</tr>
<tr>
<td>Services/Commodities</td>
<td>9,570,257</td>
<td>10,183,170</td>
<td>(612,913)</td>
</tr>
<tr>
<td>Other Charges/Vendor</td>
<td>-</td>
<td>0</td>
<td>(0)</td>
</tr>
<tr>
<td>Capital</td>
<td>502,500</td>
<td>131,933</td>
<td>370,567</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>6,818,211</td>
<td>5,875,789</td>
<td>942,422</td>
</tr>
<tr>
<td>Abatements</td>
<td>(33,297,997)</td>
<td>(29,278,847)</td>
<td>(4,019,150)</td>
</tr>
<tr>
<td>Total Expense</td>
<td>1,421,794</td>
<td>1,568,339</td>
<td>(146,545)</td>
</tr>
<tr>
<td><strong>Tax Levy</strong></td>
<td>514,550</td>
<td>1,289,300</td>
<td>(774,750)</td>
</tr>
</tbody>
</table>

Surplus/(Deficit) before allocating out: 3,244,400
BEHAVIORAL HEALTH DIVISION

DASHBOARD REPORT

Year End 2018
# Table of Contents

<table>
<thead>
<tr>
<th>PAGE</th>
<th>Section</th>
</tr>
</thead>
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<td>2</td>
<td>Table of Contents</td>
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<td>BHD Combined</td>
</tr>
<tr>
<td>4</td>
<td>Acute Adult Inpatient</td>
</tr>
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<td>Child and Adolescent Inpatient (CAIS)</td>
</tr>
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<td>Psychiatric Crisis Services</td>
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<td>AODA</td>
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<td>Wraparound</td>
</tr>
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<td>9</td>
<td>TCM (Targeted Case Management)</td>
</tr>
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<td>10</td>
<td>CCS (Comprehensive Community Services)</td>
</tr>
<tr>
<td>11</td>
<td>CSP (Community Support Program)</td>
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</table>
## BHD COMBINED DASHBOARD
### Year End 2018

#### 2018 Year End

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>144,872,153</td>
<td>144,872,153</td>
<td>154,903,524</td>
<td>(10,031,371)</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>15,489,332</td>
<td>15,489,332</td>
<td>15,910,123</td>
<td>420,791</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>120,045,637</td>
<td>120,045,637</td>
<td>128,258,133</td>
<td>8,212,496</td>
</tr>
<tr>
<td>Capital</td>
<td>238,047</td>
<td>238,047</td>
<td>511,008</td>
<td>272,961</td>
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<tr>
<td>Cross Charges</td>
<td>37,322,676</td>
<td>37,322,676</td>
<td>61,228,586</td>
<td>23,905,910</td>
</tr>
<tr>
<td>Abatements</td>
<td>(34,035,155)</td>
<td>(34,035,155)</td>
<td>(60,811,554)</td>
<td>(26,776,399)</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>203,519,725</td>
<td>203,519,725</td>
<td>214,458,475</td>
<td>10,938,750</td>
</tr>
<tr>
<td>Tax Levy</td>
<td>58,647,573</td>
<td>58,647,573</td>
<td>59,554,951</td>
<td>907,378</td>
</tr>
<tr>
<td>Wraparound</td>
<td>(389,672)</td>
<td>(7,969)</td>
<td>381,703</td>
<td></td>
</tr>
<tr>
<td>BHD Excluding Wraparound</td>
<td>59,037,245</td>
<td>59,562,920</td>
<td>525,675</td>
<td></td>
</tr>
</tbody>
</table>

## 2018 YEAR END Revenues & Expenses by Percentage

#### BHD Year End Realized Revenue by Source

- **BHA Revenue**: 25%
- **Other State & Federal Revenue**: 14%
- **Other & Misc Revenue**: 2%

#### BHD Year End Expenditure by Type

- **Patient Revenue**: 20%
- **Operating Capital**: 30%
- **Total Tax Levy**: 30%
- **Other Charges**
  - Net Crosscharges & Abatements: 1%
  - Personnel Services: 12%
  - Commodities & Services: 7%

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

## Year End Financial Highlights

- Inpatient Census below budget offset by better payer mix
- Patient receivable writeoff doubtful accounts ($1.2m)
- Successful Crisis Mobile Team productivity expansion
- State Institutions ($1.1m) deficit
- Final County Fringe Settle Up $2.3m surplus
- Slow initial CCS growth in 2018 now on target for 2019
- AODA deficit ($1.3m) due high RSC costs (RFP underway)

## 2018 Budget Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC Partnership</td>
<td>Delayed</td>
</tr>
<tr>
<td>CCS Expansion</td>
<td>Continued growth</td>
</tr>
<tr>
<td>Crisis Mobile Productivity</td>
<td>$0.5m revenue increase</td>
</tr>
<tr>
<td>Add West Allis CART team</td>
<td>Progressing</td>
</tr>
</tbody>
</table>

Complete 🔺 Not Done 🔴 Progressing 🔵
### ACUTE ADULT INPATIENT DASHBOARD

#### Year End 2018

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td>12,483,765</td>
<td>12,483,765</td>
<td>12,977,749</td>
<td>(493,984)</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>17,181,686</td>
<td>17,181,686</td>
<td>18,437,184</td>
<td>1,255,498</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>3,332,596</td>
<td>3,332,596</td>
<td>3,633,673</td>
<td>301,077</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>3,579,654</td>
<td>3,579,654</td>
<td>2,500,000</td>
<td>(1,079,654)</td>
</tr>
<tr>
<td>Capital</td>
<td>23</td>
<td>23</td>
<td>3,000</td>
<td>2,977</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>7,164,473</td>
<td>7,164,473</td>
<td>8,556,278</td>
<td>1,391,805</td>
</tr>
<tr>
<td>Abatements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>31,258,432</td>
<td>31,258,432</td>
<td>33,130,135</td>
<td>1,871,703</td>
</tr>
<tr>
<td><strong>Tax Levy</strong></td>
<td>18,774,667</td>
<td>18,774,667</td>
<td>20,152,386</td>
<td>1,377,719</td>
</tr>
</tbody>
</table>

Percentage Spent: 94%
Percentage Yr Elapsed: 100%

#### Adult Census and Length of Stay

![Graph showing Adult Census and Length of Stay]

- Census Actual
- Census Budget
- Length of Stay Actual
- Length of Stay Budget

#### ADULT INPATIENT PAYER SOURCES

![Graph showing Adult Inpatient Payer Sources]

- **Medicare A&B**: 26% 2015, 10% 2016, 4% 2017, 3% 2018
- **HMO TIS**: 12% 2015, 4% 2016, 12% 2017, 6% 2018
- **Medicaid**: 28% 2015, 4% 2016, 28% 2017, 3% 2018
- **Non-Recoverable**: 28% 2015, 4% 2016, 23% 2017, 3% 2018
- **Self Pay**: 3% 2015, 6% 2016, 5% 2017, 3% 2018
- **Commercial**: 3% 2015, 3% 2016, 3% 2017, 3% 2018

#### Avg Census, Cost & Net Revenue per Patient Day

- **Average Daily Census**
- **Revenue Per Patient Day**
- **Cost Per Patient Day**

![Graph showing Avg Census, Cost & Net Revenue per Patient Day]

- **2014**: $1,361, $518
- **2015**: $1,767, $535
- **2016**: $1,734, $628
- **2017**: $1,980, $662
- **2018**: $2,049, $859
CAIS (Child & Adolescent Inpatient) DASHBOARD
Year End 2018

<table>
<thead>
<tr>
<th></th>
<th>2018 Year End</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec YTD</td>
<td>Projection</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td>3,063,515</td>
<td>3,063,515</td>
<td>4,629,746</td>
<td>(1,566,231)</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>4,031,637</td>
<td>4,031,637</td>
<td>4,112,923</td>
<td>81,286</td>
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<td>Svcs/Commodities</td>
<td>273,939</td>
<td>273,939</td>
<td>480,969</td>
<td>207,030</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>2,348,231</td>
<td>2,348,231</td>
<td>2,523,861</td>
<td>175,630</td>
</tr>
<tr>
<td>Abatements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>6,653,807</td>
<td>6,653,807</td>
<td>7,117,753</td>
<td>463,946</td>
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<tr>
<td>Tax Levy</td>
<td>3,590,292</td>
<td>3,590,292</td>
<td>2,488,007</td>
<td>(1,102,285)</td>
</tr>
</tbody>
</table>

Percentage Spent: 93%
Percentage Yr Elapsed: 100%

CAIS Census and Length of Stay

CAIS REVENUE - PAYER SOURCES

CAIS-Avg Census, Cost & Net Revenue per Patient Day
PCS - ER and Observation DASHBOARD

Year End 2018

<table>
<thead>
<tr>
<th></th>
<th>2018 Year End</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dec YTD</td>
<td>Projection</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td>8,921,538</td>
<td>8,921,538</td>
<td>10,888,654</td>
<td>(1,967,116)</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>12,400,873</td>
<td>12,400,873</td>
<td>10,919,922</td>
<td>(1,480,951)</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>455,950</td>
<td>455,950</td>
<td>1,418,629</td>
<td>962,679</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>6,397</td>
<td>6,397</td>
<td>5,508</td>
<td>(889)</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>4,178,626</td>
<td>4,178,626</td>
<td>5,221,950</td>
<td>1,043,324</td>
</tr>
<tr>
<td>Abatements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>17,041,846</td>
<td>17,041,846</td>
<td>17,566,009</td>
<td>524,163</td>
</tr>
<tr>
<td>Tax Levy</td>
<td>8,120,308</td>
<td>8,120,308</td>
<td>6,677,355</td>
<td>(1,442,953)</td>
</tr>
</tbody>
</table>

Percentage Spent: 97%
Percentage Yr Elapsed: 100%

PCS Trends 2012-2018

PCS/ OBS Salary Trends and Admissions

Admissions, Cost and Revenue Per Admission
**AODA DASHBOARD**

**Year End 2018**

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12,500,736</td>
<td>12,500,736</td>
<td>11,710,592</td>
<td>790,144</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>146,934</td>
<td>146,934</td>
<td>126,213</td>
<td>(20,721)</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>139,508</td>
<td>139,508</td>
<td>115,000</td>
<td>(24,508)</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>14,804,958</td>
<td>14,804,958</td>
<td>12,228,695</td>
<td>(2,576,263)</td>
</tr>
<tr>
<td>Capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>1,077,155</td>
<td>1,077,155</td>
<td>1,526,457</td>
<td>449,302</td>
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<tr>
<td>Abatements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>16,168,555</td>
<td>16,168,555</td>
<td>13,996,365</td>
<td>(2,172,190)</td>
</tr>
<tr>
<td>Tax Levy</td>
<td>3,667,819</td>
<td>3,667,819</td>
<td>2,285,773</td>
<td>(1,382,046)</td>
</tr>
</tbody>
</table>

Percentage Spent: 116%
Percentage Yr Elapsed: 100%

**Spending & Clients Served by Program**

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
<th>Individuals Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional Residential</td>
<td>6</td>
<td>7500</td>
</tr>
<tr>
<td>Recovery Support Coordination</td>
<td>6</td>
<td>6000</td>
</tr>
<tr>
<td>Outpatient (75.13)</td>
<td>4</td>
<td>4500</td>
</tr>
<tr>
<td>Bridge Housing</td>
<td>2</td>
<td>3000</td>
</tr>
<tr>
<td>Detoxification</td>
<td>1</td>
<td>1500</td>
</tr>
</tbody>
</table>

**AODA Revenue**

Tax Levy / Block Grant
TANF
IV Drug Abuse Treatment
STR Opioid Grant
DMCP
Adult Drug Treatment Court
Intoxicated Driver Program
Family Drug Treatment Court

**Spend Per Client**

Detoxification
Bridge Housing
Outpatient (75.13)
Recovery Support Coordination
Transitional Residential
WRAPAROUND DASHBOARD
Year End 2018

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>4,676,969</td>
<td>4,676,969</td>
<td>5,211,210</td>
<td>534,241</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>539,613</td>
<td>539,613</td>
<td>221,209</td>
<td>(318,404)</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>49,139,005</td>
<td>49,139,005</td>
<td>57,661,228</td>
<td>8,522,223</td>
</tr>
<tr>
<td>Capital</td>
<td>1,779</td>
<td>1,779</td>
<td>(1,779)</td>
<td></td>
</tr>
<tr>
<td>Cross Charges</td>
<td>6,147,909</td>
<td>6,147,909</td>
<td>16,167,728</td>
<td>10,019,819</td>
</tr>
<tr>
<td>Abatements</td>
<td>(4,756,308)</td>
<td>(4,756,308)</td>
<td>(18,678,862)</td>
<td>(13,922,554)</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>55,748,968</td>
<td>55,748,968</td>
<td>60,582,513</td>
<td>4,833,545</td>
</tr>
</tbody>
</table>

### Expense

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Levy</td>
<td>(389,672)</td>
<td>(389,672)</td>
<td>(7,969)</td>
<td>381,703</td>
</tr>
</tbody>
</table>

Percentage Spent: 92%
Percentage Yr Elapsed: 100%

### Number Youth Served by Program

#### Percent of Revenue Sources by Year

- Medicaid-Capitation
- Medicaid-Fee-for-Service
- DMCP
- DCSD

#### Cost Effectiveness

- REACH
- Wraparound
- Group Home
- Residential
- Inpatient

*** Inpatient services are clients in CAIS
*** Wraparound and REACH services are outpatient services
## TCM (Targeted Case Management) DASHBOARD

**Year End 2018**

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>260,806</td>
<td>260,806</td>
<td>352,810</td>
<td>92,004</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>17,024</td>
<td>17,024</td>
<td>1,559</td>
<td>(15,465)</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>5,780,562</td>
<td>5,780,562</td>
<td>5,541,284</td>
<td>(239,278)</td>
</tr>
<tr>
<td>Capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>461,071</td>
<td>461,071</td>
<td>771,866</td>
<td>310,795</td>
</tr>
<tr>
<td>Abatements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>6,519,463</td>
<td>6,519,463</td>
<td>6,667,519</td>
<td>148,056</td>
</tr>
</tbody>
</table>

| Tax Levy | 3,504,094 | 3,504,094 | 4,251,055 | 746,961 |

**Average Enrollment**

<table>
<thead>
<tr>
<th></th>
<th>2018 Q4</th>
<th>2018 Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billable</strong></td>
<td><strong>Non-billable</strong></td>
<td><strong>% Non-billable</strong></td>
</tr>
<tr>
<td>APC</td>
<td>15,578</td>
<td>4,709</td>
</tr>
<tr>
<td>Horizon</td>
<td>6,042</td>
<td>2,980</td>
</tr>
<tr>
<td>La Causa</td>
<td>7,493</td>
<td>1,537</td>
</tr>
<tr>
<td>MMHHA</td>
<td>7,809</td>
<td>2,043</td>
</tr>
<tr>
<td>OCHC</td>
<td>6,603</td>
<td>696</td>
</tr>
<tr>
<td>Whole Health</td>
<td>10,962</td>
<td>2,048</td>
</tr>
<tr>
<td>WCS</td>
<td>9,656</td>
<td>4,227</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>64,201</td>
<td>18,240</td>
</tr>
</tbody>
</table>

***Non-billable is paid to Provider, but not billable to Medicaid***
## CCS (Comprehensive Community Services) DASHBOARD
### Year End 2018

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>15,378,461</td>
<td>15,378,461</td>
<td>16,513,433</td>
<td>(1,134,972)</td>
</tr>
<tr>
<td>Svcs/Commodities</td>
<td>672,088</td>
<td>672,088</td>
<td>610,892</td>
<td>(61,196)</td>
</tr>
<tr>
<td>Other Chgs/Vendor</td>
<td>13,313,023</td>
<td>13,313,023</td>
<td>16,930,000</td>
<td>3,616,977</td>
</tr>
<tr>
<td>Capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cross Charges</td>
<td>1,491,624</td>
<td>1,491,624</td>
<td>2,270,720</td>
<td>779,096</td>
</tr>
<tr>
<td>Abatements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>15,477,500</td>
<td>15,477,500</td>
<td>19,811,612</td>
<td>4,334,112</td>
</tr>
</tbody>
</table>

### Tax Levy

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Levy</td>
<td>99,039</td>
<td>99,039</td>
<td>3,298,179</td>
<td>3,199,140</td>
</tr>
</tbody>
</table>

### Average Enrollment

<table>
<thead>
<tr>
<th></th>
<th>Dec YTD</th>
<th>Projection</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Enrollment</td>
<td>795</td>
<td>795</td>
<td>1,100</td>
<td>1,100</td>
</tr>
</tbody>
</table>

### Distinct Clients Served 2018

![Graph showing distinct clients served over time]

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

<table>
<thead>
<tr>
<th></th>
<th>2018 Q4 Totals</th>
<th>2018 YTD Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Billable</td>
<td>Non-Billable</td>
</tr>
<tr>
<td>TLS</td>
<td>19,882</td>
<td>56</td>
</tr>
<tr>
<td>APC</td>
<td>18,903</td>
<td>572</td>
</tr>
<tr>
<td>Gue</td>
<td>19,937</td>
<td>88</td>
</tr>
<tr>
<td>Bel + Wil</td>
<td>14,133</td>
<td>151</td>
</tr>
<tr>
<td>Asc + Sum</td>
<td>12,853</td>
<td>151</td>
</tr>
<tr>
<td>Jus</td>
<td>13,773</td>
<td>333</td>
</tr>
<tr>
<td>WCS</td>
<td>6,318</td>
<td>47</td>
</tr>
<tr>
<td>La</td>
<td>3,848</td>
<td>0</td>
</tr>
<tr>
<td>Pro</td>
<td>6,583</td>
<td>107</td>
</tr>
<tr>
<td>OCH</td>
<td>3,952</td>
<td>0</td>
</tr>
</tbody>
</table>

### TOP 7 CCS Services by Units

- Physical Health Monitoring
- INDIVIDUAL SKILL DEV AND ENHANCE...
- Psychotherapy
- Individual Skills Dev
- Service Planning
- Travel
- Service Facilitation

![Graph showing top 7 CCS services by units]
General Assumptions

1. Adult Inpatient capacity of 48 with average census of 43 or 90% Capacity

2. CAIS capacity of 10 with average census of 8 or 80% Capacity

3. Payer mix

<table>
<thead>
<tr>
<th>Financial Class</th>
<th>% Gross Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial/Private</td>
<td>4.5%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>4.0%</td>
</tr>
<tr>
<td>Medicaid HMO</td>
<td>27.6%</td>
</tr>
<tr>
<td>Medicare A/B</td>
<td>35.8%</td>
</tr>
<tr>
<td>Medicare HMO</td>
<td>10.7%</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>2.7%</td>
</tr>
<tr>
<td>Non-Recoverable/Charity</td>
<td>14.7%</td>
</tr>
</tbody>
</table>

4. CBRF – Maintain current capacity

5. CCS – Continue to increase capacity

6. AODA – Expand services based on grant opportunities and restructuring rates on RSC’s

7. CSP – no increase to existing capacity, contracts structured as fee for service

8. TCM – no increase to existing capacity

9. FQHC partnerships with anticipated 3 community locations

10. Will not to include any policy/funding changes from Governor Evers’ recommended budget

11. Tax Levy – 2020 target will be a reduction and include another $2m abatement
<table>
<thead>
<tr>
<th>Date</th>
<th>Mental Health Board</th>
<th>Finance Committee</th>
<th>Other Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 21st</td>
<td><em>Public Comments – Budget</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 28th</td>
<td></td>
<td>2020 Budget Assumptions</td>
<td></td>
</tr>
</tbody>
</table>
| April 25th | ➢ CFO/Finance Chair to present preliminary budget assumptions  
            ➢ MH board members discuss budget assumptions |                                    |                                              |
| June 6th   | ➢ *Public Comments - Budget*                          |                                    |                                              |
|            | ➢ BHD CFO presents preliminary 2020 budget           |                                    |                                              |
| June 14th  |                                                      |                                    | Budget request narrative posted for public review |
| June 20th  |                                                      |                                    | MH Board members submit budget recommendations to finance chair |
| June 27th  | ➢ DHHS Director presents requested 2020 budget        |                                    |                                              |
|            | ➢ *Public Comments - Budget*                          |                                    |                                              |
|            | ➢ Committee votes on recommendations and budget       |                                    |                                              |
| July 11th  | ➢ DHHS Director presents final budget request         |                                    |                                              |
|            | ➢ Finance committee chair presents recommendations to board  
            ➢ Board votes on 2020 budget                       |                                    |                                              |
| July 15th  |                                                      |                                    | Formal Budget Submission                     |

Feedback/suggestions regarding the 2020 Budget may be left at the Mental Health Board website listed below:

https://www.surveymonkey.com/r/2020BHDBudget
## Milwaukee County WIMCR Payments

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Settlement Year</th>
<th>WIMCR Payment 2013</th>
<th>WIMCR Payment 2014</th>
<th>WIMCR Payment 2015</th>
<th>WIMCR Payment 2016</th>
<th>WIMCR Payment 2017</th>
<th>WIMCR Payment 2018</th>
<th>2019 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Stabilization Services</td>
<td>2013</td>
<td>1,985,601</td>
<td>1,055,935</td>
<td>763,838</td>
<td>1,565,191</td>
<td>3,430,761</td>
<td>2,100,000</td>
<td></td>
</tr>
<tr>
<td>Day Treatment</td>
<td>2014</td>
<td>149,305</td>
<td>237,923</td>
<td>71,110</td>
<td>121,413</td>
<td>117,809</td>
<td>400,000</td>
<td></td>
</tr>
<tr>
<td>TCM- Targeted Case Management</td>
<td>2015</td>
<td>488,676</td>
<td>76,852</td>
<td>574,940</td>
<td>1,048,603</td>
<td>400,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSP - Community Support Program</td>
<td>2016</td>
<td></td>
<td>777,419</td>
<td>0</td>
<td>(988,048)</td>
<td>630,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRS - Community Recovery Services</td>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>263,345</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCS - Comprehensive Community Services</td>
<td>2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,000,000</td>
<td></td>
</tr>
</tbody>
</table>

| Total                              |                 | 4,726,338          | 1,370,710          | 1,742,300          | 4,467,748          | 6,303,360          | 5,130,000         |
DATE: March 8, 2019

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 Health and Human Services, Detailing Potential 2019-2021 State Governor’s Proposed Budget Impacts on the Behavioral Health Division

Issue

On February 28, 2019, Gov. Evers introduced the 2019-2021 State Biennial Budget proposal. Fiscal and program staff for the Behavioral Health Division have reviewed the budget and identified potential risks and opportunities that could conceivably impact programs and services provided by the Milwaukee County Behavioral Health Division.

These budget initiatives are not yet finalized. There is a high likelihood that some or all budget proposals will not be included in the final 2019-2021 State Biennial Budget.

Discussion

The following are initiatives identified as potential impact and/or risk items for BHD:

Medicaid Expansion:

The Governor’s budget proposes an expansion of Medicaid eligibility under the Affordable Care Act by covering all Wisconsin residents who earn incomes up to 138 percent of the federal poverty level. This is expected to insure an additional 82,000 Wisconsinites, many of whom reside in Milwaukee County. We estimate $1.2 million additional revenue on inpatient units if current uninsured clients enroll in BadgerCare Plus. Additional savings are expected for outpatient services. It is also anticipated that expansion of healthcare coverage will reduce reliance on emergency room psychiatric services for this population.
Medicaid Community Health Benefit:

The governor’s budget creates a Medicaid community health benefit that invests $45 million for non-medical services to reduce and prevent health disparities that result from economic and social determinants of health. Major services included in the Community Health Benefit are housing referral services, stress management, and nutritional counseling.

Crisis Intervention Services:

The Governor’s budget recommends the state pay for a portion of the nonfederal share of Medicaid Crisis Intervention services currently funded by counties in Wisconsin. Under the proposal, counties will provide a 75% maintenance of effort payment based on CY17 expenditures. This is expected to free up over $0.6 million in local funding in the short term and could result in over $1.0 million savings in local funds as Milwaukee County redesigns and expand crisis services.

Crisis Stabilization Facilities:

The Governor’s budget establishes a new grant program to create five regional crisis stabilization programs. These facilities are designed to help individuals in crisis and reduce involuntary commitments at state-run institutions.

Mental Health Services Under BadgerCare Plus:

The Governor’s budget recommends increasing noninstitutional rates for physicians and medical clinics that provide mental health, behavioral health, and psychiatric services. Milwaukee County does not directly provide these services, however increasing rates for these services will increase access to the Medicaid enrollees.

Childless Adult Demonstration Project:

The governor’s budget repeals the childless adult demonstration project. This would remove work requirements, premiums, copayments, and health risk assessments for childless adult BadgerCare enrollees.

Respectfully submitted,

Mary Jo Meyers, Director
Department of Health and Human Services
Finance Committee Item 7

Relocation Cost – BHD Employees

Moving Cost:

<table>
<thead>
<tr>
<th>Low Estimate</th>
<th>High Estimate</th>
<th>Range of Costs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 550</td>
<td>$ 600</td>
<td>$500 - $600 per person</td>
</tr>
<tr>
<td>$ 100</td>
<td>$ 100</td>
<td>$100 per person</td>
</tr>
<tr>
<td>$ 1,000</td>
<td>$ 1,200</td>
<td>$800 to $1,200 /workstation</td>
</tr>
<tr>
<td>$ 275</td>
<td>$ 400</td>
<td>$150 to $400 /workstation</td>
</tr>
<tr>
<td>$ 600</td>
<td>$ 700</td>
<td>$500 to $700 per person</td>
</tr>
<tr>
<td>$ 2,525</td>
<td>$ 3,000</td>
<td>Moving cost furniture &amp; belongings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moving computers/phones (service desk team - break down and reset up hardware only) 1 hr/person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Purchase and installation refurbished cubicles</td>
</tr>
</tbody>
</table>
|              |               | Cubicle delivery and installation (in Milwaukee)

Average Cost/Staff

Estimated number of staff includes Wraparound, CARS and Administrative personnel

<table>
<thead>
<tr>
<th>Estimated # of Staff</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>230</td>
<td>$ 580,750</td>
<td>$ 690,000</td>
</tr>
</tbody>
</table>

Total Moving Cost

Notes:
1 BHD and DHHS have some existing cubicle parts and most office furnishings
2 Wiring & Network- $100,000 - $135,000 - Internet, Phone, and Printing capabilities at the new location (200 EEs, 30,000 sq. ft. (fiber runs, server cabinets, switches, UPS power systems, cabling, etc.)

Lease Build out:

$50 to $100 per square foot (existing office space versus full remodel)

Estimate of 175 sq feet per staff - includes unusable floor space

<table>
<thead>
<tr>
<th>Estimated # of Staff</th>
<th>Estimated Sq Ft</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>230</td>
<td>40,250</td>
<td>$ 2,012,500</td>
<td>$ 4,025,000</td>
</tr>
</tbody>
</table>

Total Lease Build Out

Total Cost

$2,593,250 $ 4,715,000
## Finance Committee Item 8

### 2018 Actual/2019 Budget for County Cross Charges

<table>
<thead>
<tr>
<th>Account</th>
<th>2016 Actual</th>
<th>2017 Actual</th>
<th>2018 Actual</th>
<th>2019 Budget</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Service Allocation</td>
<td>1,904,748</td>
<td>1,750,615</td>
<td>1,860,729</td>
<td>2,418,893</td>
<td>HR, Procurement, Accounting, Audit &amp; Budget</td>
</tr>
<tr>
<td>Technology</td>
<td>1,444,703</td>
<td>1,858,452</td>
<td>1,545,797</td>
<td>1,574,257</td>
<td>See accounts included</td>
</tr>
<tr>
<td>Administrative Services</td>
<td>1,185,974</td>
<td>728,770</td>
<td>635,646</td>
<td>1,514,677</td>
<td>DHHS Director's Office and Contract Dept</td>
</tr>
<tr>
<td>Housing Div Services</td>
<td>750,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>CARS - Support homeless initiative</td>
</tr>
<tr>
<td>Worker Comp Med and WC Pay</td>
<td>901,145</td>
<td>773,525</td>
<td>1,109,172</td>
<td>805,585</td>
<td>Risk Admin monthly charge</td>
</tr>
<tr>
<td>DAS Services</td>
<td>296,703</td>
<td>222,710</td>
<td>297,983</td>
<td>627,952</td>
<td>MSD Direct Service Charge for FTE's</td>
</tr>
<tr>
<td>Corporation Counsel Services</td>
<td>624,759</td>
<td>656,360</td>
<td>667,361</td>
<td>496,025</td>
<td>Based on hours used</td>
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<td>Insurance Services</td>
<td>127,270</td>
<td>124,425</td>
<td>285,218</td>
<td>256,899</td>
<td>Risk Insurance-monthly charge</td>
</tr>
<tr>
<td>Telephone Allocation</td>
<td>408,312</td>
<td>420,008</td>
<td>274,977</td>
<td>205,757</td>
<td>Charged to Fiscal Admin and CARS admin</td>
</tr>
<tr>
<td>Fleet Management Services</td>
<td>50,768</td>
<td>72,704</td>
<td>69,298</td>
<td>60,703</td>
<td>Vehicle leases and repairs</td>
</tr>
<tr>
<td>Risk Management Services</td>
<td>109,510</td>
<td>74,022</td>
<td>60,420</td>
<td>56,452</td>
<td>Risk Admin monthly charge</td>
</tr>
<tr>
<td>HOC Laundry Services</td>
<td>54,579</td>
<td>45,893</td>
<td>45,893</td>
<td>45,893</td>
<td>Based on pounds of laundry</td>
</tr>
<tr>
<td>Gsmids Mnc Traffic Div</td>
<td>38,892</td>
<td>39,768</td>
<td>40,228</td>
<td>40,000</td>
<td>Cost sharing quarterly charge</td>
</tr>
<tr>
<td>Radio Comm Serv</td>
<td>31,541</td>
<td>26,218</td>
<td>36,742</td>
<td>36,434</td>
<td>OEM Monthly Charge</td>
</tr>
<tr>
<td>Power Plant Water</td>
<td>28,131</td>
<td>31,040</td>
<td>30,413</td>
<td>30,803</td>
<td>Utilities</td>
</tr>
<tr>
<td>Fire Protection</td>
<td>22,421</td>
<td>16,527</td>
<td>20,664</td>
<td>20,935</td>
<td>Fire Charge quarterly</td>
</tr>
<tr>
<td>HOC Graphics</td>
<td>5,783</td>
<td>18,141</td>
<td>25,320</td>
<td>18,040</td>
<td>Dept print materials to order - calendars, signage</td>
</tr>
<tr>
<td>Facility Asmt Inspect</td>
<td>3,321</td>
<td></td>
<td>13,891</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Plant Sanitary Sewer</td>
<td>12,118</td>
<td>11,027</td>
<td>10,715</td>
<td>10,855</td>
<td>Utilities</td>
</tr>
<tr>
<td>Utility Storm Sewer</td>
<td>3,161</td>
<td>6,430</td>
<td>1,546</td>
<td>1,567</td>
<td>Utilities</td>
</tr>
<tr>
<td>Pool Vehicle Rental</td>
<td>639</td>
<td>1,203</td>
<td>810</td>
<td>1,151</td>
<td>Vehicle rental</td>
</tr>
<tr>
<td>GIS Records</td>
<td></td>
<td></td>
<td>947</td>
<td>965</td>
<td>Quarterly Records charge</td>
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<tr>
<td>Prof Serv Div Services</td>
<td>3,006</td>
<td>4,472</td>
<td>12,859</td>
<td></td>
<td>In 2016 used for Wraparound/Delinquency charges</td>
</tr>
<tr>
<td>Other County Services</td>
<td>368,842</td>
<td>5,133</td>
<td>4,275</td>
<td></td>
<td>In 2017 used for Wraparound/Delinquency charges</td>
</tr>
<tr>
<td>Medical Service Fees</td>
<td></td>
<td></td>
<td>250</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>Vehicle/Equipment Accident Rep</td>
<td></td>
<td></td>
<td>70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Services # 5</td>
<td></td>
<td></td>
<td></td>
<td>323,364</td>
<td></td>
</tr>
<tr>
<td>Computer Access Info Svcs Charges</td>
<td>87,734</td>
<td>86,135</td>
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<td></td>
</tr>
<tr>
<td>Prof. Serv. -Data Process Charges</td>
<td>1,834,699</td>
<td>2,056,868</td>
<td></td>
<td></td>
<td>EMR Annual License and Support - Netsmart ($1.7m 2018)</td>
</tr>
<tr>
<td>HRIS Allocation</td>
<td>284,282</td>
<td>257,525</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP Software Lease/Lon Charges</td>
<td>63,951</td>
<td>66,203</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMSD Central Purchases</td>
<td>26,073</td>
<td>72,236</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R/M Computer Equip Charges</td>
<td>59,325</td>
<td>9,975</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engineering Bldg Maintenance</td>
<td>249,089</td>
<td></td>
<td></td>
<td></td>
<td>Previously used County Tradesman-Electrical/Plumbing/Painting</td>
</tr>
<tr>
<td>Inst. Traffic Div</td>
<td>20,538</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Plant Electric</td>
<td>10,221</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>10,988,935</strong></td>
<td><strong>10,680,001</strong></td>
<td><strong>8,041,794</strong></td>
<td><strong>9,235,925</strong></td>
<td></td>
</tr>
</tbody>
</table>

---

1 Central Service Allocation is BHD's share of county costs for Human Resources, Procurement, Accounting, Audit and Budget. See page 2 for details.

2 Technology is allocated across all departments by equipment and usage, therefore, some savings may result from the downsizing.

3 Allocation of DHHS Directors Office and Contracts. 2018 Budget was $1.1m.
BHD Overhead Analysis
Central Service Allocation 2019 Budget

Human Resources
This is a combination of the Human Resources, Payroll, Employee Benefits, and Labor Relations Areas. They have a similar allocation method based on employees.

Procurement
This is a combination of the Procurement, Accounts Payable and Treasurer Areas. They have a similar allocation method which is based on payment documents.

Accounting
This is Central Accounting and County Wide Audit. Allocation is based on departmental expenditures.

Audit
Audit costs represent the allocation of the Department of Audit, based on audit hours and departmental expenditures.

Budget
Budget costs are allocated based on departmental expenditures.

Carryforward Charge
Each year the Cost Allocation Plan is compared to the budgeted estimate. Any variance is returned to departments in the next budgeted year. The 2017 variance is included in 2019 budget year.

<table>
<thead>
<tr>
<th>Expense Category:</th>
<th>County Department:</th>
<th>2017 Actual Costs</th>
<th>2017 Carryforward</th>
<th>2019 Plan Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2017 Actual Costs</td>
<td>2017 Carryforward</td>
<td>2019 Plan Amount</td>
</tr>
<tr>
<td>DHHS-BEHAVIORAL HEALTH DIVISION</td>
<td></td>
<td>2,172,946</td>
<td>243,947</td>
<td>2,416,893</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expense Category:</th>
<th>County Department:</th>
<th>BHD</th>
<th>County</th>
<th>% BHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit</td>
<td>Audit</td>
<td>404,181</td>
<td>2,185,785</td>
<td>18.5%</td>
</tr>
<tr>
<td>HUMAN RESOURCES</td>
<td>Personnel</td>
<td>713,221</td>
<td>5,483,813</td>
<td>13.0%</td>
</tr>
<tr>
<td></td>
<td>Labor Relations</td>
<td>548</td>
<td>4,218</td>
<td>13.0%</td>
</tr>
<tr>
<td></td>
<td>Payroll/His</td>
<td>409,784</td>
<td>3,150,747</td>
<td>13.0%</td>
</tr>
<tr>
<td>PROCUREMENT</td>
<td>Procurement</td>
<td>104,419</td>
<td>1,459,471</td>
<td>7.2%</td>
</tr>
<tr>
<td></td>
<td>Accounts Payable</td>
<td>40,224</td>
<td>578,101</td>
<td>7.0%</td>
</tr>
<tr>
<td></td>
<td>Treasurer</td>
<td>64,348</td>
<td>858,340</td>
<td>7.5%</td>
</tr>
<tr>
<td>ACCOUNTING</td>
<td>County-Wide Audit</td>
<td>63,291</td>
<td>405,598</td>
<td>15.6%</td>
</tr>
<tr>
<td></td>
<td>Central Accounting</td>
<td>114,783</td>
<td>735,590</td>
<td>15.6%</td>
</tr>
<tr>
<td></td>
<td>Central Capital</td>
<td>59,351</td>
<td>380,350</td>
<td>15.6%</td>
</tr>
<tr>
<td>BUDGET</td>
<td>Budget</td>
<td>198,796</td>
<td>1,273,986</td>
<td>15.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,172,946</td>
<td>16,515,999</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>BHD</th>
<th>County</th>
<th>% BHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>532</td>
<td>4,201</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>BHD</th>
<th>County</th>
<th>% BHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>192,763,210</td>
<td>1,354,070,623</td>
<td>14.2%</td>
</tr>
</tbody>
</table>

R:\DHSS Budget Team\MHB Reports\OverheadAnalysis 2018_2019.xlsxCentralSvc
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0904 Wrap Reserve</td>
<td>2,310,717</td>
<td>6,860,245</td>
<td>1,427,993</td>
<td>8,288,238</td>
<td>381,703</td>
<td>8,669,941</td>
</tr>
<tr>
<td>0906 Capital Reserve</td>
<td>1,180,000</td>
<td>3,540,000</td>
<td>1,180,000</td>
<td>4,720,000</td>
<td>4,720,000</td>
<td></td>
</tr>
<tr>
<td>0905 Surplus Reserve</td>
<td>13,719,328</td>
<td>19,568,857</td>
<td>1,744,030</td>
<td>21,312,887</td>
<td>525,675</td>
<td>21,838,562</td>
</tr>
<tr>
<td>Total Reserves</td>
<td>17,210,046</td>
<td>29,969,101</td>
<td>4,352,023</td>
<td>34,321,124</td>
<td>907,378</td>
<td>35,228,502</td>
</tr>
</tbody>
</table>
Date: February 27, 2019

To: Maria Perez, Finance Committee Chair – 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: Report from the Director, Department of Health and Human Services,
         Submitting an Informational Report on a 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, 2017, 2016, and 2015 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.

________________________
Mary Jo Meyers, Director
Department of Health and Human Services
COUNTY OF MILWAUKEE
Milwaukee, Wisconsin

WRAPAROUND MILWAUKEE INCURRED YEAR
FINANCIAL REPORTING SUMMARY

Including Independent Auditors’ Report

For the Years Ended December 31, 2017, 2016 and 2015
COUNTY OF MILWAUKEE

TABLE OF CONTENTS
For the Years Ended December 31, 2017, 2016 and 2015

Independent Auditors' Report 1 – 2
Financial Report 3 – 11
Notes to the Financial Report 12
INDEPENDENT AUDITORS’ REPORT

To the Milwaukee County Mental Health Board
and to the Management of the Milwaukee
County Department of Health and Human
Services and Behavioral Health Division
Milwaukee, Wisconsin


We have audited the accompanying Wraparound Milwaukee Incurred Year Financial Reporting Summary – Exhibits 3 and 4 of the County of Milwaukee, Wisconsin, for each of the three years ended December 31, 2017, 2016 and 2015, and the related notes (the financial report).

Management’s Responsibility for the Financial Report

Management is responsible for the preparation and fair presentation of the financial report in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the historical summaries that are free from material misstatement, whether due to fraud or error.

Auditor’s Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor’s judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial report referred to above presents fairly, in all material respects, the total claim payments to providers and administrative expenses described in Note 1 of the Notes to the Financial Report for each of the three years ended December 31, 2017, 2016 and 2015, in accordance with accounting principles generally accepted in the United States of America.
Emphasis of Matter

We draw attention to Note I to the financial report, which describes that the accompanying financial report was prepared for the purpose of complying with CMS Citation 438.3(m) and is not intended to be a complete presentation of the County of Milwaukee's revenues and expenses. Our opinion is not modified with respect to this matter.

Baker Tilly Virchow Krause, LLP

Milwaukee, Wisconsin
January 30, 2019
FINANCIAL REPORT
Version 1 Initial version

Version 2 Changed reporting dates, updated member months in Exhibit 2 to report the numbers included versus exclude from state capitation, updated the columns in Exhibits 3 and 4 to identify services fully covered, partially covered, and not covered by state capitation, added Treatment Foster Home and case management / care coordination to Exhibit 3, added the Exhibit 5 blank documentation tab, locked model so only the green input cells and Exhibit 5 documentation tab can be completed, and made other minor updates.

Version 3 Changed reporting dates, added flexibility to labels for CY or SFY reporting, added waived member cost sharing and a claims allocation description box in Exhibit 3, added more detailed rows in Exhibit 4, added an Exhibit 6 tab to compare to financial statements, added MLR calculation in Exhibit 7, clarified some instructions (claims reserves or recovery estimates, administrative expenses for sub-capitated contracts, and specific WAM services provided by Milwaukee County staff), and other minor updates.
The purpose of this template is to capture incurred year financial information for the CCF and WAM program as contracted entities with the Wisconsin Department of Human Services.

1. Financial information should be completed with claims paid through February 28, 2018 and submitted to DHS by March 23, 2018 for use by SPFY 2019 rate development. Preferably, we would like state fiscal year (i.e., July to June) information entered for the years ending 2015, 2016 and 2017. However, calendar year information can be entered, if needed, by entering 'CY' in cell B31 of Exhibit 1. Prior year amounts (i.e., 2015 and 2016) only need to be re-submitted if there are changes from the prior financial template submitted.

2. Submit completed electronic copies to the BFM email box: DSH03CAGAAFBM@dhs.wisconsin.gov.

3. Only enter information in cells that are shaded green with blue text.

4. The data used to create these reports should be stored and may be audited by DHS.

5. Version tab tracks each version of the file used.

6. In the Exhibit 1 certification statement, fill in the organization name, CEO or CFO information and signature. Signatures can be handled in two ways. Exhibit 1 can be signed and submitted electronically in PDF format separately from the Excel file. Alternatively, the Exhibit 1 tab may contain an electronic signature with only that tab password protected. This tab also contains the preparer's information and assigns the reporting period (including state fiscal year versus calendar year) for the other tabs. In subsequent years, the dates on this tab can be updated to reflect future reporting time periods. You may also add notes.

7. In Exhibit 2, enter incurred year member months for members covered versus not covered under state capitation, revenue by various groupings, and surplus by year, along with the methodology used for any.

8. In Exhibit 3, enter incurred year claims by various groupings by year for services covered under the state capitation versus services not covered under the state capitation. The incurred year is the service year of the claim regardless of when the claim was paid. Enter claims net of any third party liability. Include any estimates for claim reserves or future recoveries (e.g., subrogation) for the incurred year, as appropriate, based on historical results and document any of these amounts in Exhibit 5. Please use the following definitions:
   - Internal Department Cost Allocation: These are claim costs allocated from internal providers employed by CCF or WAM (e.g., based on time).
   - Related Party Cost Allocation: These are claim costs allocated from related parties.
   - Related Party Fee-For-Service (FFS) Claims: These are claims paid to related parties based on services incurred.
   - Related Party Sub-Capitated Claims: These are claims where a related party receives a fixed amount (e.g., an amount per member per month) to take the financial risk of the actual claims incurred. Claim amounts should be excluded any portion of sub-capitation for administrative purposes. Any administrative expense portion should be excluded from Exhibit 3 and reported in Exhibit 4.
   - External Provider FFS Claims: These are claims paid to external providers based on services incurred.
   - External Provider Sub-Capitated Claims: These are claims where an external provider receives a fixed amount to take the financial risk of actual claims incurred. Claim amounts should be excluded any portion of sub-capitation for administrative purposes. Any administrative expense portion should be excluded from Exhibit 3 and reported in Exhibit 4.

Waived member cost sharing for Medicaid covered benefits should only be reported when cost sharing is intentionally not collected by providers through agreement with CCF or WAM.

WAM specific instructions: Report claims for ‘WAM services’ (wellness clinic visits, eligibility, and screening by Milwaukee County staff) in the appropriate rows (e.g., internal or related party in the ‘care coordination / case management’ and ‘other covered services’ columns and exclude these amounts from the administrative expense tab.

9. In Exhibit 4, enter incurred year administrative expense by year for covered and partially covered services under the state capitation versus services not covered under the state capitation. Please use the following definitions for administrative costs in Exhibit 4, along with generally accepted accounting principles (GAAP):
   - MLR Qualified Care Coordination and Care Management: These are expenses that qualify as activities that improve health care quality in a minimum medical loss ratio (MLR) calculation.
   - Related Party FFS Claims: These are claims paid to related parties based on services incurred.
   - Related Party Sub-Capitated Claims: These are claims where a related party receives a fixed amount (e.g., an amount per member per month) to take the financial risk of the actual claims incurred. Claim amounts should be excluded any portion of sub-capitation for administrative purposes. Any administrative expense portion should be excluded from Exhibit 3 and reported in Exhibit 4.
   - External Provider FFS Claims: These are claims paid to external providers based on services incurred.
   - External Provider Sub-Capitated Claims: These are claims where an external provider receives a fixed amount to take the financial risk of actual claims incurred. Claim amounts should be excluded any portion of sub-capitation for administrative purposes. Any administrative expense portion should be excluded from Exhibit 3 and reported in Exhibit 4.

MLR: Direct Expense: These are expenses directly related to the recovery of fraud related claims.
- Fraud Prevention Activities: These expenses are defined in Section 438.6(2)(c) of the Medicaid regulation. The inclusion of fraud prevention activities is contingent on their inclusion in the commercial market MLR which is currently not allowed. These amounts are excluded from the MLR calculation in this file, however, we are tracking any amounts available in case they can be included in future. These amounts exclude expenses directly related to the recovery of fraud related claims.
- Direct Expense: These are expenses related to the member. Examples include, but are not limited to, customer service, enrollment, claims administration, and medical management expenses allocated to the Medicaid line of business.
- Indirect Expense: These are expenses indirectly related to the member and may be considered overall company overhead costs. Examples include, but are not limited to, salaries and benefits for the CEO, human resources, accounting, actuarial, and legal expenses allocated to the Medicaid line of business. Facility Related Costs include costs such as rent, utilities, janitorial, maintenance, and depreciation allowed under accounting standards.
- Other (please explain): These are administrative expenses that do not fit into one of the other categories. Please explain any amounts entered into this category.

Also, enter the methodology used for any administrative expense allocations.

10. Please use the Exhibit 5 tab, as needed, to enter any documentation or calculations since the template is locked except for the cells shaded green throughout the template and the Exhibit 5 tab. Use of the Exhibit 5 tab is optional.

11. Please use the Exhibit 6 tab to compare the financial template results for member months, revenue, claims, and administrative expenses to financial statements and explain any material differences. Preferably, audited GAAP financial statements should be used. Please document any alternative financial statement type used.

12. Exhibit 7 shows medical loss ratio results. We included residential cost center (RCC) and treatment foster home (TFH) Medicaid coverage percentages in this exhibit, which are both currently set to the draft 2016 RCC cost report results based on the files DHS provided to us on December 12, 2017. We will update these values as needed. We summarized MLR amounts and incorporated the Medicaid credibility.
Exhibit 1
Wisconsin Department of Health Services
Wraparound Milwaukee Incurred Year Financial Reporting
Services Provided in CY 2015, CY 2016, and CY 2017 and Paid Through 2/28/2018
Certification Statement

After conducting a reasonably diligent review of the data, documentation and information, I attest that it is accurate, complete and truthful. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a "plan’s agreement or contract with the Wisconsin Department of Human Services (DHS). Failure to sign a Certification Statement may result in DHS non-acceptance of the attached reports.

Organization: Wraparound Milwaukee
By: Program Administrator
Print name

Interim Director
Signature & Title

Preparer's Contact Information:
Name Greg Flegel
Title Sr Revenue Analyst
Email greg.flegel@milwaukeecountywi.gov
Phone # 414-257-7158

Years of Financial Data to Include:
Year 1 2015
Year 2 2016
Year 3 2017
Paid Through 2/28/2018
Enter CY (Calendar Year) or SFY (State Fiscal Year) CY

Add notes for any exhibit in the box below:

Reported by Calendar year: 1/1 to 12/31
### Exhibit 2
Wisconsin Department of Health Services
Wraparound Milwaukee Incurred Year Financial Reporting
Services Provided in CY 2015, CY 2016, and CY 2017 and Paid Through 2/28/2018

**Member Months**

<table>
<thead>
<tr>
<th></th>
<th>CY 2015</th>
<th>CY 2016</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Covered by State Capitation</td>
<td>13,254</td>
<td>13,895</td>
<td>13,688</td>
</tr>
<tr>
<td>(2) Not Covered by State Capitation</td>
<td>654</td>
<td>840</td>
<td>999</td>
</tr>
<tr>
<td><strong>Total Member Months</strong></td>
<td><strong>13,908</strong></td>
<td><strong>14,735</strong></td>
<td><strong>14,687</strong></td>
</tr>
</tbody>
</table>

**Revenue For Services Covered by State Capitation:**

<table>
<thead>
<tr>
<th></th>
<th>CY 2015</th>
<th>CY 2016</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Capitation Revenue</td>
<td>$25,276,510</td>
<td>$27,330,362</td>
<td>$26,162,359</td>
</tr>
<tr>
<td>(5) Other Revenue Sources (Please Explain)¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$25,276,510</strong></td>
<td><strong>$27,330,362</strong></td>
<td><strong>$26,162,359</strong></td>
</tr>
</tbody>
</table>

**Revenue For Services Not Covered by State Capitation:**

<table>
<thead>
<tr>
<th></th>
<th>CY 2015</th>
<th>CY 2016</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>(7) Crisis Intervention</td>
<td>$10,643,337</td>
<td>$13,433,147</td>
<td>$13,405,944</td>
</tr>
<tr>
<td>(8) Other Revenue Sources</td>
<td>$19,181,212</td>
<td>$17,426,670</td>
<td>$14,488,723</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$55,101,059</strong></td>
<td><strong>$58,190,180</strong></td>
<td><strong>$56,057,027</strong></td>
</tr>
</tbody>
</table>

¹For "other" revenue associated with covered services under the state capitation (including any reinsurance offsets to premium), provide a description of each revenue source and its amount by year:

- **(7) CRISIS INTERVENTION:** Wraparound has only billed through July of 2017 and is estimating the annualized yearly total based on the first 7 months of payments. Annualized = YTD*12/7
- **(8) OTHER REVENUE SOURCES:** The Division of Milwaukee Child Protective Services and The Delinquency and Court Services Division (DCSD) pay Wraparound Milwaukee on a case-rate basis for youth under court orders. 2015 $8,392,188; 2016 $7,121,164; 2017 $5,142,874
- WAM also reports revenue from the CHIPS program as OTHER: 2015 $10,789,024; 2016 $10,305,506; 2017 $9,345,850

Provide a description of how any revenues were allocated between various components:

Revenue reported based on Medicaid Eligible percentage of clients. This impacts row 20, (8) Other Revenue Sources: 2015 = 95.3%, 2016 = 94.3%, 2017 = 93.2%. Revenue is allocated by date of service provided, regardless of date of payment.
### Services Fully Covered by State Capitation

<table>
<thead>
<tr>
<th>Case Coordination/Case Management $</th>
<th>Other Covered Services $</th>
<th>Peer in Lieu of Services $</th>
<th>Other In Lieu of Services ($ Please Explore) $</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2015</td>
<td>$720,573</td>
<td>$720,573</td>
<td>$0</td>
<td>$1,441,146</td>
</tr>
<tr>
<td>Related Party Cost Allocation</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Related Party Fee for Service (FFS) Claims</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Related Party Sub-Capitalized Claims</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>External Provider/FFS Claims</td>
<td>$11,716,024</td>
<td>$5,410,045</td>
<td>$3,261</td>
<td>$17,217,080</td>
</tr>
<tr>
<td>Total</td>
<td>$12,436,047</td>
<td>$5,410,045</td>
<td>$3,261</td>
<td>$17,217,080</td>
</tr>
</tbody>
</table>

### Services Partially Covered by State Capitation

<table>
<thead>
<tr>
<th>Case Coordination/Case Management $</th>
<th>Other Covered Services $</th>
<th>Peer in Lieu of Services $</th>
<th>Other In Lieu of Services ($ Please Explore) $</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Care Centers (RCC)</td>
<td>$683,562</td>
<td>$683,562</td>
<td>$0</td>
<td>$1,367,124</td>
</tr>
<tr>
<td>Treatment Foster Home (TFH)</td>
<td>$1,088,462</td>
<td>$1,088,462</td>
<td>$0</td>
<td>$2,176,924</td>
</tr>
<tr>
<td>Total</td>
<td>$1,772,024</td>
<td>$1,772,024</td>
<td>$0</td>
<td>$3,544,048</td>
</tr>
</tbody>
</table>

### Services Not Covered by State Capitation

<table>
<thead>
<tr>
<th>Case Coordination/Case Management $</th>
<th>Other Covered Services $</th>
<th>Peer in Lieu of Services $</th>
<th>Other In Lieu of Services ($ Please Explore) $</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Home</td>
<td>$649,057</td>
<td>$649,057</td>
<td>$0</td>
<td>$1,298,114</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>$2,666,728</td>
<td>$2,666,728</td>
<td>$0</td>
<td>$5,333,456</td>
</tr>
<tr>
<td>Other Non-Covered Services</td>
<td>$4,809,728</td>
<td>$4,809,728</td>
<td>$0</td>
<td>$9,619,456</td>
</tr>
<tr>
<td>Total</td>
<td>$5,532,833</td>
<td>$5,532,833</td>
<td>$0</td>
<td>$11,065,666</td>
</tr>
</tbody>
</table>

### Cost Sharing for Medicaid Covered Beneftis

- For “other” claims associated with services covered by the state capitation (including any non-exempted services), provide a description of each claim source and its amount by year.

### NOTE:

- With the exception of External Provider FFS Claims, amounts are reported using the Total payments for the year times the average Medicaid-eligible percentage each year.
- One-hundred percent of External Provider FFS Claims were included, as 100% of the encounter data is for Medicaid-eligible enrollees, as reported in the State Data Exhibit 5. Documentation for the specifics is to which costs are included in each category.
- The Other Covered Services category includes those codes with "MA" in Exhibit 5.

### Provide a description of low cost claims

- Claims were allocated between various sources.

### Related Party Cost Allocation

- Related Party Cost Allocation, Crisis includes staffing on our Children’s Mobile Crisis Team by contracted staff.

### Related Party Fee for Service (FFS) Claims

- Related Party Fee for Service (FFS) Claims includes costs for certain patients and/or services.

### Related Party Sub-Capitalized Claims

- Related Party Sub-Capitalized Claims includes costs for certain patients and/or services.

### External Provider/FFS Claims

- External Provider/FFS Claims includes costs for certain patients and/or services.

### External Provider/Sub-Capitalized Claims

- External Provider/Sub-Capitalized Claims includes costs for certain patients and/or services.

### Cost Sharing for Medicaid Covered Beneftis

- Cost Sharing for Medicaid Covered Beneftis includes costs for certain patients and/or services.

### Total

- Total includes costs for certain patients and/or services.
<table>
<thead>
<tr>
<th>Administrative Expense Category</th>
<th>Services Fully Covered by State Capitation</th>
<th>Services Partially Covered by State Capitation</th>
<th>Services Not Covered by State Capitation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUR Qualified Quality Improvement Expense</td>
<td></td>
<td></td>
<td></td>
<td>$375,714</td>
</tr>
<tr>
<td>MUR Qualified Taxes, Licensing, and Regulatory Fees;</td>
<td></td>
<td></td>
<td></td>
<td>$125,412</td>
</tr>
<tr>
<td>Licensing and Regulatory Fees;</td>
<td></td>
<td></td>
<td></td>
<td>$29,068</td>
</tr>
<tr>
<td>Community Benefit Expenses1</td>
<td></td>
<td></td>
<td></td>
<td>$31,946</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>$576,725</td>
</tr>
<tr>
<td>MUR Qualified Direct Fraud Recovery Expenses2</td>
<td></td>
<td></td>
<td></td>
<td>$22,526</td>
</tr>
<tr>
<td>Fraud Prevention Activities</td>
<td></td>
<td></td>
<td></td>
<td>$576,725</td>
</tr>
<tr>
<td>Sales and Marketing</td>
<td></td>
<td></td>
<td></td>
<td>$1,166,277</td>
</tr>
<tr>
<td>Direct Expense:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management (not already reported in claims)</td>
<td></td>
<td></td>
<td></td>
<td>$750,714</td>
</tr>
<tr>
<td>Claims Administration</td>
<td></td>
<td></td>
<td></td>
<td>$151,628</td>
</tr>
<tr>
<td>Customer Service</td>
<td></td>
<td></td>
<td></td>
<td>$31,946</td>
</tr>
<tr>
<td>Enrollment</td>
<td></td>
<td></td>
<td></td>
<td>$576,725</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>$22,526</td>
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<tr>
<td>Indirect Expense:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounting and Finance</td>
<td>$22,677</td>
<td>$27,643</td>
<td>$33,263</td>
<td>$21,428</td>
</tr>
<tr>
<td>Executive</td>
<td>$165,043</td>
<td>$190,049</td>
<td>$237,405</td>
<td>$140,301</td>
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<td>Compliance and Legal</td>
<td>$2,726</td>
<td>$17,432</td>
<td>$28,777</td>
<td>$38,924</td>
</tr>
<tr>
<td>Facility Related Costs</td>
<td>$229,771</td>
<td>$221,862</td>
<td>$223,760</td>
<td>$174,130</td>
</tr>
<tr>
<td>Human Resources</td>
<td>$258,178</td>
<td>$419,411</td>
<td>$608,927</td>
<td>$195,647</td>
</tr>
<tr>
<td>Information Technology</td>
<td>$12,146</td>
<td>$11,704</td>
<td>$38,020</td>
<td>$8,200</td>
</tr>
<tr>
<td>Other</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Total Administrative Expense</td>
<td>$2,242,135</td>
<td>$2,822,211</td>
<td>$3,223,109</td>
<td>$1,130,167</td>
</tr>
</tbody>
</table>

1 Community Benefit Expenses can only be reported for plans exempt from federal income taxes and cannot exceed its Wisconsin Medicaid earned premium for the incurred year multiplied by the greater of 3% or the highest premium tax in Wisconsin
2 MUR Qualified Direct Fraud Recovery Expenses are expenses directly used to recover fraud related claims and cannot exceed fraud related claim recoveries
3 Please describe any "Other" administrative expenses in the comment box below.

"Other" Administrative Expense Description:

Description of Methodologies Used to Allocate Administrative Expense Expenditures:

- Direct Administration expenses are from WAM records for services paid MWRA/NIC vector.
- Expenditures related to internal WAM CU staff include fringe benefits. These expenses were multiplied by the statewide average % of salaries per year, 2015 to 2017.
- Other expenses include contracted provider services.
- Community Benefit Expenses are reported under the "Community Benefit Expenses" line in this table.
- The category Direct Expense: Care Management (row 18) includes the following Fully Covered services provided directly to clients:
  - 1) Internal Dept Cost including Wellness Clinic and Eligibility Screening assessments done by Milwaukee County staff
  - 2) Related Contract Allocation including Care Coordination/Care Management services contracted by WAM
  - 3) All other costs not included in Encounter data: 1) Internal Dept Cost including Wellness Clinic and Eligibility Screening assessments done by Milwaukee County staff

Note: These are WAM Services that were not included in Encounter data:

- 1) Internal Dept Cost including Wellness Clinic and Eligibility Screening assessments done by Milwaukee County staff
- 2) Related Contract Allocation including Care Coordination/Care Management services contracted by WAM
- 3) All other costs not included in Encounter data

All other expenses on this tab were then allocated to "Fully Covered", "Partially Covered", and "Not Covered" based on the % of direct service expenses in each category in Exh 3 for Exh 4 Services. Services Not Covered by State Capitation, Services Partially Covered Services Not Covered by State Capitation.
**ARPA Health Service Plan**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Expenditures</th>
<th>Financial Results</th>
<th>Actuarial Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022-2023</td>
<td>$1,250,000</td>
<td>$1,125,000</td>
<td>$375,000</td>
</tr>
<tr>
<td>2021-2022</td>
<td>$1,400,000</td>
<td>$1,280,000</td>
<td>$600,000</td>
</tr>
<tr>
<td>2020-2021</td>
<td>$1,500,000</td>
<td>$1,350,000</td>
<td>$750,000</td>
</tr>
</tbody>
</table>

**Note:**
- All figures are in USD.
- Expenditures include all administrative and operational costs.
- Financial results reflect net income or loss for the respective fiscal year.

**Actuarial Information:**
- Expected claims for the fiscal year are estimated at 90% of actual claims.
- Reserves for future claims are set aside at 10% of total claims.

---

**ARPA Health Service Plan**

**Financial Statement:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Fiscal Year</th>
<th>Revenue</th>
<th>Expenses</th>
<th>Net Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022-2023</td>
<td>$1,500,000</td>
<td>$1,125,000</td>
<td>$375,000</td>
<td>$125,000</td>
</tr>
<tr>
<td>2021-2022</td>
<td>$1,700,000</td>
<td>$1,420,000</td>
<td>$280,000</td>
<td>$280,000</td>
</tr>
<tr>
<td>2020-2021</td>
<td>$1,800,000</td>
<td>$1,500,000</td>
<td>$300,000</td>
<td>$300,000</td>
</tr>
</tbody>
</table>

**Note:**
- Revenue includes premium income and other income sources.
- Expenses include all administrative expenses, medical expenses, and other operating costs.
- Net income reflects the profitability of the plan for the respective fiscal year.

---

**ARPA Health Service Plan**

**Risk Management:**

- The plan has implemented a risk management strategy to mitigate financial risks.
- Regular audits and compliance checks are conducted to ensure adherence to regulatory requirements.

---

**ARPA Health Service Plan**

**Operational Highlights:**

- Enrollee satisfaction rates have increased by 10% over the past fiscal year.
- The plan has launched a new online portal for enrollees to manage their health records.
- Cost containment measures have resulted in a 5% reduction in healthcare expenses.

---

**ARPA Health Service Plan**

**Financial Statement Notes:**

- Additional details and footnotes are provided in the linked document.
- Refer to the ARPA Health Service Plan's official website for the full financial report.
## Exhibit 7
Wisconsin Department of Health Services
Wraparound Milwaukee Incurred Year Financial Reporting
Services Provided in CY 2015, CY 2016, and CY 2017 and Paid Through 2/28/2018
Medical Loss Ratio (MLR) Reporting

<table>
<thead>
<tr>
<th></th>
<th>CY 2015</th>
<th>CY 2016</th>
<th>CY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months Covered by State Capitation</td>
<td>13,254</td>
<td>13,895</td>
<td>13,888</td>
</tr>
<tr>
<td>MLR Numerator</td>
<td>$23,349,905</td>
<td>$23,400,078</td>
<td>$22,975,952</td>
</tr>
<tr>
<td>MLR Denominator</td>
<td>$25,276,510</td>
<td>$27,330,362</td>
<td>$28,162,359</td>
</tr>
<tr>
<td>Unadjusted MLR</td>
<td>92.4%</td>
<td>85.6%</td>
<td>81.6%</td>
</tr>
<tr>
<td>Credibility Adjustment</td>
<td>5.5%</td>
<td>5.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Adjusted MLR</td>
<td>97.9%</td>
<td>91.1%</td>
<td>87.0%</td>
</tr>
</tbody>
</table>

| Residential Care Center (RCC) Medicaid Covered % | 46.0% | 46.0% | 46.0% |
| Treatment Foster Home (TFH) Medicaid Covered %   | 38.2% | 38.2% | 38.2% |
| Combined RCC and TFH Medicaid Covered %           | 44.2% | 44.0% | 43.8% |

**Note:** These amounts will be determined from cost report results.

### Credibility Adjustment Table
From CMS bulletin Dated July 31, 2017

<table>
<thead>
<tr>
<th>Member Months Covered</th>
<th>Credibility Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5,400</td>
<td>non-credible</td>
</tr>
<tr>
<td>5,400</td>
<td>8.4%</td>
</tr>
<tr>
<td>12,000</td>
<td>5.7%</td>
</tr>
<tr>
<td>24,000</td>
<td>4.0%</td>
</tr>
<tr>
<td>48,000</td>
<td>2.9%</td>
</tr>
<tr>
<td>96,000</td>
<td>2.0%</td>
</tr>
<tr>
<td>192,000</td>
<td>1.5%</td>
</tr>
<tr>
<td>380,000</td>
<td>1.0%</td>
</tr>
<tr>
<td>&gt; 380,000</td>
<td>fully credible</td>
</tr>
</tbody>
</table>

### MLR Numerator Components:
- Claims: $23,349,905
- MLR Qualified Quality Improvement Expense: $0
- MLR Qualified Direct Fraud Recovery Expenses¹: $0

### MLR Denominator Components:
- Capitation Revenue: $25,276,510
- MLR Qualified Taxes, Licensing, and Regulatory Fees: $0
- Waived Member Cost Sharing for Medicaid Covered Benefits: $0

¹ Expenses directly related to fraud recoveries may not exceed the amount of fraud recoveries.
NOTE I – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accounting policies of the County of Milwaukee, Wisconsin conform to generally accepted accounting principles as applicable to governmental units.

Through its contract with the State of Wisconsin Department of Health Services, the County of Milwaukee is required to submit a financial report which meets the requirements of Title 42 U.S. Code of Federal Regulations, CMS Citation 438.3(m). This financial report includes the revenues and expenditures incurred in relation to the County of Milwaukee’s Wraparound Milwaukee program, which represents only a portion of the activities of the County of Milwaukee.

Expenditures and revenues presented in the financial report are recorded by the County of Milwaukee using the modified-accrual basis of accounting.
DATE: March 7, 2019

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 Contracts and a 2018 Professional Services Contract Amendment for Resident/Fellow Stipend Support and Residency Director, Consultation, and Security 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 2019.

Background

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

Professional Services Contracts

Medical College of Wisconsin Affiliated Hospitals, Inc. - $1,000,000
BHD contracts with the Medical College of Wisconsin Affiliated Hospitals, Inc. (MCWAH) for resident and fellow housestaff activities, as part of BHD’s training site designation with the MCW Psychiatry Training Programs. The residents and fellows that serve as housestaff provide medical care within the BHD Acute Inpatient, Crisis, Wraparound, Children's Mobile Crisis and Community Services, with oversight and direction from BHD psychiatry staff. BHD is seeking to renew the agreement for another two-year term for the period of July 1, 2019, through June 30, 2021, in an amount of $500,000 annually to support the housestaff stipends. This amount reflects a decrease in the annual amount from the prior agreement, in accordance with programming changes to FTEs assigned.
The Medical College of Wisconsin, Inc. - $119,588
BHD is requesting renewal of an agreement with the Department of Psychiatry and Behavioral Medicine to provide for partial support of the MCW Psychiatry Residency Director salary, in connection with oversight of the resident and fellow training activities occurring within Behavioral Health Division services and programs. BHD is seeking to extend the agreement for another two-year term for the period of July 1, 2019, through June 30, 2021, in an amount of $59,794 annually.

The Medical College of Wisconsin, Inc. - $20,000
BHD is requesting renewal of an agreement with the Center for Bioethics and Medical Humanities for the purpose of consultation and the provision of continuing education to BHD’s Bio-Ethics Committee and clinical staff. BHD is seeking to extend the agreement for another two-year term for the period of July 1, 2019, through June 30, 2021, in an amount of $10,000 annually.

U.S. Securities Associates/Allied Universal - $468,000
This Vendor provides public safety services for BHD. They provide services twenty-four hours a day, and seven days a week. The Vendor is responsible for escorting services, monitoring the outside parking lots, and performing environment of care safety checks, etc. These funds are being requested for 2019. The total contract amount would be $3,268,222.

Fiscal Summary

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical College of Wisconsin Affiliated Hospitals, Inc.</td>
<td>New</td>
<td>$250,000</td>
<td>$500,000</td>
<td>$250,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>The Medical College of Wisconsin, Inc.</td>
<td>New</td>
<td>$29,897</td>
<td>$59,794</td>
<td>$29,897</td>
<td>$119,588</td>
</tr>
<tr>
<td>The Medical College of Wisconsin, Inc.</td>
<td>New</td>
<td>$5,000</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>U.S. Security Associates/Allied Universal</td>
<td>Amendment</td>
<td>468,000</td>
<td>N/A</td>
<td>N/A</td>
<td>$3,268,222</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Amendment</strong></td>
<td><strong>$752,897</strong></td>
<td><strong>$569,794</strong></td>
<td><strong>$284,897</strong></td>
<td><strong>$4,407,810</strong></td>
</tr>
</tbody>
</table>

*Denotes a Vendor whose funding is supported by a grant.
DATE: March 7, 2019

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

FROM: Mary Jo Meyers, Director, Department of Health and Human Services

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute an Amendment to a 2019 Fee-for-Service Agreement Totaling the Agreement 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 2019.

**Background**

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

**Fee-for-Service Agreements**

**Butterflies Home for Teen Girls - $40,000**

The Vendor provides Group Home Care for girls, pregnant teens, and/or parenting teens with babies for the Wraparound Milwaukee Program, under an Out of Network Agreement. BHD is requesting an additional $40,000 for 2019. The total contract amount will be $192,149.15 for 2019.
Fiscal Summary

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Butterflies Home for Teen Girls</td>
<td>Amendment</td>
<td>N/A</td>
<td>$40,000</td>
<td>$192,149.15</td>
</tr>
<tr>
<td>Total</td>
<td>N/A</td>
<td>$40,000</td>
<td></td>
<td>$192,149.15</td>
</tr>
</tbody>
</table>

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

Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson
DATE: March 20, 2019

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

FROM: Mary Jo Meyers, Director, Department of Health and Human Services

SUBJECT: Report from the Director, Department of Health and Human Services, Requesting Authorization to Execute 2019 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 2019.

**Background**

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

**Purchase-of-Service Contracts**

**SaintA, Inc. - -$56,250**

The Vendor provides Care Coordination, REACH, OYEAH, screening/assessment, mobile crisis, Peer Specialists, and case management services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is reducing their contract by $56,250 for 2019 as a Screener is being removed from their Staff. The total contract amount will be $1,861,529.
St. Charles Youth and Family Services, Inc. - $56,250
The Vendor provides Care Coordination, REACH, OYEAH, screening/assessment, mobile crisis, Peer Specialists, and case management services for the Wraparound Milwaukee Program serving children/youth and their families. BHD is asking for an additional $56,250 for 2019 as an additional Screener is being added to their Staff. The total contract amount will be $5,596,312.

Fiscal Summary

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

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>New/Amendment</th>
<th>2019 Decrease Amount</th>
<th>2019 Increase Amount</th>
<th>2019 Amount</th>
<th>Total Contract Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>SaintA, Inc.</td>
<td>Amendment</td>
<td>-$56,250</td>
<td></td>
<td>1,861,529</td>
<td>$1,861,529</td>
</tr>
<tr>
<td>St. Charles Youth and Family Services, Inc.</td>
<td>Amendment</td>
<td></td>
<td>$56,250</td>
<td>$5,596,312</td>
<td>$5,596,122</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>-$56,250</td>
<td>$56,250</td>
<td>$7,457,841</td>
<td>$7,457,841</td>
</tr>
</tbody>
</table>

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

Mary Jo Meyers, Director
Department of Health and Human Services

Cc: Maria Perez, Finance Chairperson
IN THE COUNTY OF MILWAUKEE
INTEROFFICE COMMUNICATION

DATE: 2/8/2019
TO: Supervisor Theodore Lipscomb Sr., Chair, County Board of Supervisors
FROM: Joe Lamers, Director, Office of Performance, Strategy, and Budget (PSB)
SUBJECT: 2020 Operating Budget Planning Updates

Background/Discussion

In the January cycle, PSB provided the County Board a report (File 19-26) on the estimated 2020 Operating budget gap of approximately $26.5 million. The report also indicated that in March 2019, DAS-PSB will follow up on budget gap closing strategies, including levy targets and potential revenue options. This report provides additional information on these items.

The below chart, which was included in the January report, provides major factors leading to the projected budget gap. At this time there are no changes to the projected gap amount. PSB will continue to review these projections and provide updates if there are significant changes.

<table>
<thead>
<tr>
<th>Estimated 2020 Operating Budget Gap</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation Increase</td>
<td>$ 5.7</td>
</tr>
<tr>
<td>Health Care</td>
<td>$ 2.8</td>
</tr>
<tr>
<td>Pension</td>
<td>$ 6.6</td>
</tr>
<tr>
<td>Debt Service P&amp;I</td>
<td>$ 1.0</td>
</tr>
<tr>
<td>Other Operating Cost to Continue</td>
<td>$10.7</td>
</tr>
<tr>
<td>Inmate Medical Cost Increase</td>
<td>$ 5.0</td>
</tr>
<tr>
<td>Court Appointed Attorney Fees</td>
<td>$ 1.5</td>
</tr>
<tr>
<td><strong>Total Expense Change</strong></td>
<td><strong>$ 33.3</strong></td>
</tr>
</tbody>
</table>

Revenue Change - Lost Revenues

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt Service Reserve</td>
<td>$ 3.3</td>
</tr>
<tr>
<td>Unclaimed Revenue</td>
<td>$ 1.3</td>
</tr>
</tbody>
</table>

Revenue Change - Increased Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property Tax</td>
<td>$ (3.9)</td>
</tr>
<tr>
<td>Sales Tax</td>
<td>$ (2.6)</td>
</tr>
<tr>
<td>GTA</td>
<td>$ (0.5)</td>
</tr>
<tr>
<td>VRF</td>
<td>$ (0.4)</td>
</tr>
<tr>
<td>Other/Reimbursement Revenue</td>
<td>$ (4.1)</td>
</tr>
<tr>
<td><strong>Total Revenue Change</strong></td>
<td><strong>$ (6.8)</strong></td>
</tr>
<tr>
<td><strong>Gap Total</strong></td>
<td><strong>$ 26.5</strong></td>
</tr>
</tbody>
</table>
Three broad options for closing the budget gap were also presented in the January report as shown below. This report update provides additional detail regarding these budget options.

<table>
<thead>
<tr>
<th>2020 Gap Closing Options</th>
<th>Divest</th>
<th>Temp Fix</th>
<th>Sustain</th>
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<td>Department Levy Targets</td>
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<td>New Revenues</td>
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</tr>
<tr>
<td>Total</td>
<td>$ 26.5</td>
<td>$ 26.5</td>
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</table>

**Divest Option / Levy Targets**

If the Divest strategy is followed for the 2020 budget process, levy reduction targets totaling $10 million will be distributed to departments. The amount is subject to change based on updates to the budget gap analysis, decisions around capital funding, the use of debt service reserves and other factors. A $10 million reduction in levy targets would amount to an approximately 1.6% reduction to the total budget for departments.

The below chart provides preliminary draft tax levy targets by department, which add up to $10.0 million. A similar methodology that was applied to 2019 levy targets was used. This methodology included across-the-board percentage reductions to most departments, although some revenue generating and high risk departments are exempted (as detailed in the chart).

For the 2020 draft levy targets, two changes are included from methodology that was used in 2019. The cost of providing inmate medical services is excluded from the House of Correction levy reduction calculation, and the Emergency Medical Service function in the Office of Emergency Management is also removed since any levy savings in that area would be offset by a reduction in the levy limit per state statute.

All departments will be expected to follow the levy target instructions in the requested budget process. If departments do not meet their levy target within their request, the County Executive’s recommended budget will make adjustments accordingly to ensure that all departments participate in efforts to achieve a balanced budget.
Temporary Fix Option

Under the temporary fix option, $10 million of new revenues and or non/departmental cost savings need to be identified, in order to avoid further departmental budget reductions.

County taxing authority is granted by State Statute, and the County has limited options for generating new revenues. Property tax for operating purposes is limited to the percentage of growth in net new construction; this growth rate is already factored into the budget gap analysis. The County share of sales tax receipts is limited to 0.5%; growth in sales tax is also factored into the above budget gap analysis.

The County does have an option to increase the Vehicle Registration Fee (VRF) from the current rate of $30 up to approximately $60 to replace tax levy for all transportation services. The below table shows the additional amount of VRF could be generated with fee increases ranging from $5 to $30. A fee increase of approximately $20 would be needed in order to generate $10 million.
Transit Budget Detail

It is important to note that VRF revenue can only be used for Transit and Transportation related expenses, including operating and capital costs. The Transit department in particular is a significant tax levy cost center. Transit’s 2019 operating budget includes $9.4 million in tax levy funding. Transit’s estimated cost-to-continue is $3.2 million for 2020, representing approximately 2% growth in operating costs. In addition, Transit’s 2019 operating budget included $1.6 million of one-time revenues which are not expected to be available in 2020. Also, the preliminary tax levy reduction target chart shown above indicates that Transit may be faced with a $1.647 million reduction target for 2020. When combining the cost-to-continue, one-time revenues, and a potential levy reduction target, the Transit operating budget is estimated to have a potential shortfall of $6.4 million in 2020.

If a VRF increase were to be pursued, decisions would need to be made regarding how the funds are allocated, including whether the fee increase would support the Transit budget and/or other areas of operations, as well as the capital budget.

Sustainability Option

The sustainability option would require $26.5 million or more in additional revenues. Current State Statutes largely prevent the County from raising revenues of this magnitude.

The “Fair Deal for Milwaukee County Workgroup” was created to identify and propose options for enhancing the long-term fiscal stability of Milwaukee County, and to increase State funding of mandated services. This Workgroup has held meetings and recommended a platform for lobbying activity and legislative change. Changes at the State level will be needed to meet a sustainable budget.

For the 2020 budget process, DAS-PSB will operate under a status quo set of revenue assumptions unless new information is made available. This means that most State revenues are currently projected to remain flat in 2020.

RECOMMENDATION

*VRF increases become effective three months after an ordinance change. If a VRF change were to be included in the budget that is adopted in November, it would not be collected for the full fiscal year in 2020. In order to be effective for the full year, the ordinance would need to be changed in September.
This report is for informational purposes only. No action is needed. However, as part of the budget process, feedback from the Finance and Audit Committee and the County Board will be taken into consideration in regards to budget planning items such as levy targets and new revenues. The administration looks forward to continuing work with the Board to develop a long term fiscal sustainability plan for the County.

_________________________
Joseph Lamers, Director
Office of Performance, Strategy and Budget
Department of Administrative Services

Cc: Chris Abele, Milwaukee County Executive
    James “Luigi” Schmitt, Chair, Finance and Audit Committee
    Willie Johnson, Co-chair, Finance and Audit Committee
    Sheldon Wasserman, Finance Committee
    Supreme Moore Omokunde, County Supervisor
    Jason Haas, County Supervisor
    Sequanna Taylor, County Supervisor
    Eddie Cullen, County Supervisor
    Scott Manske, County Comptroller
    Steven Cady, Research and Policy Director, Office of the Comptroller
    Teig Whaley-Smith, DAS Director
    Raisa Koltun, Chief of Staff, Office of the County Executive
    Kelly Bablitch, Chief of Staff, County Board
    Dan Laurila, DAS-PSB Operating Budget Manager
DATE: March 4, 2019

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 2018 Annual Review of the Environment of Care Program, and the 2019 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 2018 Annual Report of the Environment of Care program and the 2019 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.
2018 Environment of Care Annual Report & 2019 Goals
Introduction

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached are the 2019 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2018 improvements were made in the area of building security through the replacement of deteriorating doors and frames. In August and October BHD played a leading role in the Milwaukee Regional Medical Center’s Full Scale Emergency Exercise.

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 2018 Annual Report and 2019 Goals

The BHD Environment of Care Management Plans were all reviewed and updated for 2019. Changes made included:

Updates were minimal to the various management plan content. Dates and goals were modified where appropriate.

Highlights of achievements and 2019 Goals:

GENERAL SAFETY

General safety improvements included expansion of the incident reporting system to include some non-patient related events related to fire events, medical emergencies and security events impacting employees.

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2018 the response rate of 96% was attained. There were a total of 1330 urgent recalls/alerts issued during 2018. Only 7 items involved in an alert or recall of a product purchased by BHD. All product alerts/recalls were resolved with no negative impact on patient care. 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 2017. Recommend continuing with this goal in 2018. The rounding system has being adjusted to provide more accurate tracking of deficiencies and correction timeframes. A partial set of rounds was completed in late 2018. Additionally a special set of rounds was completed in patient care areas to assess suicide risks in the environment. A report of the findings was submitted to the executive team.

3. In 2018 the total number of reported fire setting contraband items that were detected on patient units was 3. This meets the goal of having less than 4 contraband items on patient units.
   - In 2018 the goal will be to maintain the level of having less than 4 incidents. This item will be moved to general safety area and be reported on via incident reporting data.

SECURITY

Security improvements made at BHD include: Increase in staffing to accommodate requests made by medical staff to have more active roving officers on site, improvement in accountability of equipment used by Public Safety Staff, and increase performance with regards to emergency situations that may occur on site.

Previous Goals made:

1. The goal for 2018 will be to have a new Roll Call Update posted for each week of the year. Roll call updates will not only be posted for officer review but will be verbally reviewed with officers by supervisory staff of BHD Security.
   - Until new leadership was established, Roll Call updates did not appear to have been made before the month of October. Beginning with the month of October, new protocols were established to ensure that Roll Call updates were made on a daily basis. Though, this goal will not be listed in the goals for 2019, improvements will be continually made to ensure that accountability of all staffing and equipment is maintained.
2. The goal for 2018 was to limit the number of incidences of theft/vandalism to less than or equal to 3.
   • There were four incidents of vandalism were features of the building were damaged. (ceiling panel, security camera, and two window breaks) The latest incident involved damage to both the sliding door in PCS and a window directly next to the PCS entrance. Such incidences will continue to be recorded going into the new year. There was one theft of bus tickets and 3 reported incidents of missing patient property that could not be refuted.

3. Unauthorized absences from locked units: the goal for 2018 was to keep the total number of absences to zero.
   • This Goal was not met. There were a total of 10 elopements during the year. In all cases the individual was returned to BHD. This goal will also be carried into 2019.

4. Unsecured Area incidents: In 2018, the goal will continue to reflect the occurrence of both human factors as well as mechanical failures. The goal will be to have 10 or fewer incidents in 2018.
   • The Goal for 2018 was not met. The main concern observed is staff propping emergency doors open, or leaving them completely open. Though, there is not a specific number of incidences where emergency doors were left unsecured, the increase in Public Safety staffing will allow more opportunities for staff to check all exits and ensure that such incidences are kept at a minimal. This goal will also be carried into 2019.

5. The goal for 2018 is for the Security Department to make proper notification to BHD contacts within 1 hour of any noticeable outage. Security Department will strive to have no more than 6 occurrences where notification takes more than 1 hour.
   • Beginning with the month of October, there were only two recorded incidences of camera malfunctions. Both occurrences were reported to EES, along with myself, within an hour of it taking place.

2019 Goals:

1. Unsecured areas: In 2019, the goal will continue to reflect the occurrence of both human factors as well as mechanical failures. The goal will be to have 10 or fewer incidents in 2019.

2. The goal for 2019 is to, again, limit the number of incidences of theft/vandalism to less than or equal to 3.

3. Unauthorized absences from locked units: the goal for 2019 is to keep the total number of absences to zero.

4. Quarterly Mock Lockdown procedures: The goal for 2019 is to have Public Safety Staff perform a silent mock lockdown of the facility every quarter to ensure that all staff is prepared to perform their given duties during such an occurrence. Public Safety will work alongside Maintenance and EES to ensure that these exercises are performed without disrupting the daily operations that take place on site.

HAZARDOUS MATERIALS AND WASTE

In 2018, BHD expanded its recycling program to include various metal, plastics and glass bottles. Special recycling containers have been located throughout the facility to collect items for recycling.

In 2015, BHD was identified by the Wisconsin Department of Natural Resources (WDNR) rules as a generator of infectious waste. A generator produces more than 50# per month. Since that time, BHD, with increased surveillance and education, has reduced the amount of infectious waste generated in-house each year.
<table>
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<th>Year</th>
<th>Total Weight (in lbs)</th>
<th>Monthly Average (in lbs)</th>
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</tr>
<tr>
<td>2015</td>
<td>1589*</td>
<td>132</td>
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<tr>
<td>2016</td>
<td>885**</td>
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<td>492.59</td>
<td>41</td>
</tr>
<tr>
<td>2018</td>
<td>490.35</td>
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*2015 December weights estimate  
**2016 Jan, Feb and Dec weights estimated

An infectious waste report for 2018 was filed with the WDNR in January.

BHD’s 2019 goal is to continue the downward trend and achieve the 50# or less per month of regulated medical waste generation for the twelve month period thereby eliminating the DNR reporting requirement.

**EMERGENCY MANAGEMENT**

1. Two Drills/Exercises are required. Drills completed in 2018 include:
   - Tornado Drill in April in conjunction with Statewide event
   - June – Table top exercise regarding a public health outbreak and the option for BHD to become a closed point of distribution for employees and their families so that we can remain functional during a public health outbreak.
   - August – Table top exercise with BHD leadership regarding a violent event on campus in preparation for the Campus wide table top. A repeat practice session is planned for October.
   - Campus wide table top exercise provided insight into BHD and campus capabilities for a violent event.
   - September – Office of Emergency Management is conducting a county table top exercise for departments to test the Continuity of Operations Plan (COOP) Sept 24th.
   - October – Full Scale Exercise on MRMC Campus simulating a shooter on campus. This tested the campus wide Emergency Coordination Plan. BHD was one of the lead staff for the event and the culmination was simulated to be at BHD but took place at the old CATC building. Multiple organizations were involved in the planning and implementation of the drill. The six partner facilities along with the following agencies participated:

   - 911 Communications Division
   - Milwaukee Police Department
   - Wauwatosa Police Department
   - Milwaukee County Office of Emergency Management
   - Wauwatosa Fire Department
   - Wisconsin Lutheran College

   BHD tested internal and external communication systems including the Everbridge system, the establishment of an Incident Command Center, Joint Information Center, and security response/lockdown processes.

2. Two additional management staff were trained in ICS 100 and 200 during 2018. 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 targeted for this training and there are currently 7 of 10 AOC staff have been trained. There are additional staff throughout the facility who are also trained and/or experienced with the Incident Command system.

3. Other activities:
   - Continuity of Operations Plan (COOP) was updated for 2018 to include back up plans for computer application failures, and contract contact information.
   - Work continues on the Emergency Operations Plan (EOP) components.
   - Hazard Vulnerability Assessment was completed by the committee and will be used to prioritize the revision of the emergency response plans of the EOP.
2019 Goals:
1. 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) for use at BHD. This may be blended with the existing BHD Emergency response guide flip chart.
3. Complete the Closed Point of Distribution Plan partnering with the Wauwatosa Health Department to provide
mass prophylaxis to our staff and their families in the event of a public health outbreak.
4. Hold or participate in two emergency exercises per year (Goal = 2)

FIRE PREVENTION
In 2018 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.
1. The goal of 100 % of scheduled fire drills (60) being performed was achieved.
2. The goal of having the average score of on the fire drill check sheets being 97% or greater was achieved.
3. The goal of having zero reported accounts of fire setting contraband found on patient units was achieved.
4. The goal of having zero fire panel / trouble alarms was achieved.

All of these goals will be carried forward into 2019 with no adjustments.

UTILITIES MANAGEMENT
1. The goal of having 90% of scheduled P.M.'s being performed was achieved. For 2019 this goal will be
increased to 100% of scheduled P.M.'s accomplished.
2. The goal of having 100 % of the branch valves labeled and inventoried was not achieved; 75 % of the branch valves were labeled and inventoried. This goal will remain for 2019
3. The goal of having the emergency generator tested on a weekly basis was achieved and the goal of
having zero emergency generator failures was achieved. This goal will continue through 2019.

MEDICAL EQUIPMENT
No new clinical equipment was purchased in 2018. 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.

Medical equipment removed from service during 2018 include geriatric chairs and air mattresses.

EDUCATIONAL GOALS
In 2018 trainings regarding General BHD Safety, Active Shooter, Workplace Safety, OSHA Safety, and Fire Safety were completed. Completion rates for these trainings are still being tabulated.
EDUCATIONAL CALENDAR 2019

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
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<tr>
<td>First Responder Philosophy</td>
<td>Panic Alarm Use/Response</td>
<td>Elopement</td>
<td>Fire Safety</td>
</tr>
<tr>
<td>Medication Administration/Safety</td>
<td>Use of Personal Protective Equipment</td>
<td>Hazardous Medication Handling (hospital nursing staff only)</td>
<td>Fire Safety</td>
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<td>(hospital nursing staff only)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Parking Lot/Personal Safety</td>
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</tbody>
</table>

- First Responder Philosophy-based on Vistelar and American Heart Association standards for responding to Behavioral Emergencies
- Medication Administration/Safety-for BHD hospital nurses to ensure safe handling and preparation for administration of medications
- Parking Lot/Personal Safety-to incorporate personal safety/awareness of environment topics, ID badges
- Panic Alarm Use/Response-Reinforce need to use/wear panic alarm; who should be responding to alarms; review of the policy
- Inpatient Elopement-Review of the policy; techniques to avoid elopements from occurring
- Hazardous Medication Handling-Training for hospital based nurses regarding commonly used psychiatric educations requiring special handling
- Fire Safety-Depth of “hands on” training to be determined
- The above would be in addition to the yearly trainings such as those required by OSHA

The Environment of Care Committee recommends the following key goals for 2019:

- 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.
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/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.
   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.
   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.)
   i. Annually, assess the effectiveness of implemented recommendations.

3. EMERGENCY MANAGEMENT (EM 01.01.01; EM 02.01.01; EM 02.02.01; EM 02.02.03; EM 02.02.05;
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.
k. Annually, assess the effectiveness of emergency management programs.

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.
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.
I. 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.


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.


o. Annually, assess the effectiveness of the Fire Prevention Program, policies/procedures and educational components.


6. MEDICAL EQUIPMENT MANAGEMENT (EC 01.01.01 EP B; 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
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.


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 EP 1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01.1-5)** Safety Education begins with the New Employee Orientation program for all new employees, and continues on
an ongoing basis with departmental specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis.

2. **Annual Continuing Education:** (HR 01.05.03 EP 1) 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**

1. Track the frequency of weekly roll call meetings. (Goal = 52)
2. Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)
3. Number of incidents of unauthorized Absence from locked unit. (Goal = 0)
   - Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)
   - Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)
4. Conduct quarterly mock lockdown procedures for Security and Maintenance staff. (Goal = 4)

**Hazardous Materials Management**

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

**Emergency Management**

1. Increase the number of Management Team members trained in ICS/HICS (100 & 200) by 25%
2. Hold or participate in two emergency exercises per year. (Goal = 2)
3. 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)

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

Utilities Management
1. Measure the completion rate of preventive maintenance tasks (Goal = 90 -100%)
2. Measure the percentage of utility branch valves labeled and inventoried (Goal = 50 -100% by year end)
3. 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: 3-8-18-2-14-19
Reviewed and approved at the Medical Executive Committee meeting on: 3-24-18-2-20-19

Attachments: No Attachments
### Approval Signatures

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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, 2007 the use of all tobacco products (cigarettes, e-cigarettes, vaporizing (vape) pens, cigars, pipes, chewing tobacco, and other smokeless tobaccos) was prohibited on MCBHD premises including property owned, leased, or otherwise operated by MCBHD. All staff, patients, residents, visitors, renters, vendors, and any other individuals on the MCBHD grounds are prohibited from using tobacco products. Smoking materials are removed from all patients upon admission.

Reviewed and approved at the Environment of Care Committee meeting on: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee meeting on: 3-24-182-20-19
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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 EP 1 & 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:

1. **Track the frequency of weekly roll call meetings**. (Goal = 62) Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)

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

3. **Number of incidents of unauthorized Absence from locked unit**. (Goal = 0)

   - **Number of incidents where a secure area is found unsecured**. (Goal ≤ 10 times)
   - **Camera outages will be reported to Operations within 1 hour**. (Goal ≤ 6 times)

4. **Conduct quarterly mock lockdown procedures for Security and Maintenance staff**. (Goal = 4)

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.

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Reviewed and approved at the Environment of Care Committee meeting on: 3-8-182-14-19

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### Attachments:

| No Attachments |

### Approval Signatures

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- 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 HMWRMW 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.

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 EP 18)
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 Wastes including Sharps - (EC 02.02.01 EP 1; IC 02.01.01 EP 6)
Wisconsin state statute defines the following:

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

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

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

RMW minimization efforts begin at procurement as any new product purchased for use at the BHD requires the approval of the Infection Prevention (IP) Committee. To improve waste management practices, BHD's IP Committee may consider costs, probable adverse effects on staff, patients or patient care, recycling options, product availability and regulatory compliance. Additional procurement considerations may also include a cost benefit analysis (replacement, treatment, and disposal), potential short or long term liabilities and applicable local, state and federal recycling and disposal regulations. Approved items are purchased in such quantities as to maintain "par" levels on each clinical unit. MCBHD EES and nursing staff monitor expiration dates to maintain the viability of the approved products. Where practicable, MCBHD will reuse items after appropriate reprocessing (ie restraints after sterilization).

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

RMW are managed for MCBHD by the EES Department in conjunction with the contracted Housekeeping provider. The Housekeeping provider is responsible for the distribution and collection of appropriate containers for the collection of RMW including medical sharps. Sharps and other infectious wastes are accumulated at satellite locations across the clinical areas but, in the case of sharps containers, never in patient areas. The containers, provided by MCBHD, are easily identifiable as RMW or isolation containers, are leak-proof and are puncture resistant. Sharps containers, when full, can be locked to prevent inadvertent needle sticks. MCBHD nursing staff is responsible for placing filled containers in appropriate trash holding area for pickup and/or calling the EES Department to arrange pick up and replacement of filled RMW containers. Any staff member, patient or visitor exposed to RMW or who becomes injured due to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.
MCBHD techniques to facilitate appropriate disposal by nursing staff will include the review of signage at disposal points, the placement of RMW disposal containers close to likely sources, the placement of non-RMW waste containers in proximity to RMW containers to easily discard items in the correct container yet far enough away from common sources of non-RMW waste (ie paper towel holders) to prevent inadvertent or inappropriate disposal. Where appropriate, patients are also instructed on correct infectious and regulated waste disposal when necessary (e.g. when on isolation precautions).

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

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

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

K. Management of Required Documentation (permits, licenses, labeling and manifests) (EC 02.02.01 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 – HMW-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 workplace 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: 3-8-182-14-19

Reviewed and approved at the Medical Executive Committee meeting on: 3-21-182-20-19

**Attachments:**

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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/year)
2. Measure the average score on the fire drill check sheet. (Goal is 97%)
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
Reviewed and approved at the Medical Executive Committee meeting on: 3-21-18-20-19

Attachments: No Attachments

Approval Signatures

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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 the 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 MCBH, 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: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee meeting on: **3-21-182-20-19**

**Attachments:**

No Attachments

## Approval Signatures

<table>
<thead>
<tr>
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<th>Date</th>
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<td>pending</td>
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<td></td>
<td>Lynn Gram: 11003002-Safety Officer</td>
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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
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 EP 1 & 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)
   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: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee Meeting on: 3-24-182-20-19

Attachments: No Attachments

Approval Signatures

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**MINUTES**

**SCHEDULED ITEMS:**

1. **Welcome.  (Chairwoman Neubauer)**
   
   Chairwoman Neubauer welcomed everyone to the March 4, 2019 meeting.

2. **Community Based Key Performance Indicators (KPI) Dashboard, Fourth Quarter 2018 Summaries and CARS Quality Dashboard (Pam Erdman, Quality Assurance Director; Justin Heller, Integrated Services Manager; and Dr. Matt Drymalski, Clinical Program Director)**

   CARS report most population health metrics remained stable in the fourth quarter of 2018; detox readmissions rose slightly from the third quarter. As more quarters of data are accumulated, data trends will be evaluated to determine baselines levels and targets adjusted accordingly. Further workforce development and the impact on quality was identified as a strategic priority. Wraparound is in the process of examining agency performance indicators, thresholds, methodology and targets. Discussion ensued regarding attention to the client experience and the quality of service provided to clients and their families.

3. **Supported Employment/Education Services & Individual Placement and Support (IPS) Model (Tamara Layne, Integrated Services Coordinator)**

   CARS implemented the use of a supported employment/education evidenced based model known as Individual Placement and Support (IPS); individualized vocation and education related supports based on the needs and desires of the consumer being served with a focus on supporting individuals in finding competitive employment or returning to school. This model is currently offered within the CCS program and has also been expanded with youth care coordination teams. The program was reviewed, and a discussion ensued.

4. **Psychiatric Hospital Reports: Q4 Inpatient KPI Metrics, Seclusion & Restraint Summary, CMS Analysis of Readmission Rates, & CMS Survey Update (Dr. John Schneider, Chief Medical Officer; Dr. M. Tanja Zincke, AAI Medical Director; Linda Oczus, Chief Nursing Officer; Edward Warzonek, Quality Assurance Coordinator)**
Psychiatric Crisis Service annual patient visits have declined 31% from 2014 to 2018. Acute Adult and CAIS readmission rates have continued to decline over the past four years. CMS analysis of BHD Acute Inpatient Readmission rates were reviewed and identified to not be outside the national rate in ‘15-‘17. Acute Adult hours of physical restraint rate in 2018 was above CMS’ national average, yet below Wisconsin’s average rate of 1.0. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.2 in 2018.

There is no additional survey update; awaiting correction validation survey.

5. Annual 2018 MHSIP Consumer Satisfaction Survey Results – Adult and Youth (Edward Warzonek, Quality Assurance Coordinator)

Acute Adult Inpatient Service’s 2018 MHSIP survey response rate is 12% above the national average response rate for inpatient behavioral health patient satisfaction surveys. A quality improvement initiative to increase survey completion rates was successful. In 2018, the Participation, Outcome, Empowerment, Environment and Rights domains received the highest positive rating in the 16-year history of administering the survey.

The CAIS Youth Survey received a 41.5% response rate. Positive response score domains included Cultural Sensitivity/Respectful Treatment, Participation in Treatment, and Appropriateness of Treatment. Refer to reports for all related detail.

6. Compliments, Complaints & Grievance Executive Summary (Sherrie Bailey-Holland, Client Rights Specialist; Demetrius Anderson, Manager Quality Improvement; Heidi Ciske-Schmidt, Integrated Services Manager)

The implementation of the electronic system has increased BHD’s ability to reliably track and record incidents, compliments and complaint data. The 2018 data and trends by case type report was reviewed including top 3 patient concerns and related improvement activities.


The Quality Committee unanimously agreed to recommend approval of both the 2018 Annual Review of the Environment of Care Program and the 2019 Environment of Care Management Plan and related goals. Documents will be forwarded to the Mental Health Board for final approval.

8. BHD Policy & Procedure Status Report (Lynn Gram, Safety Officer)
An updated report as of March 2019 was distributed. The overall policy and procedure progress status continues to improve. Status updates will continue to be reported quarterly.

9. Adjournment. (Chairwoman Neubauer)

Chairwoman Neubauer ordered the meeting adjourned.

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

Length of meeting: 10:05 a.m. – 11:41 a.m.

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 3, 2019 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.
## Performance measure target was set using historical BHD trends

- **2018 Status color definitions:**
  - Red (outside 20% of benchmark)
  - Yellow (within 20% of benchmark)
  - Green (meets or exceeds benchmark)

## Includes any medical or psychiatric ER utilization in last 30 days

- **Crisis Service**
  - Emergency Detentions in PCS
    - 2016: 7,863
    - 2017: 7,916
    - 2018: 7,979

## Includes medical inpatient, psychiatric inpatient, and detoxification utilization in the last 30 days

### Notes:
- **Service Volume - All CARS Programs**
  - 2018: 5,635 clients
- **Sample Size for Raw 7 (Admissions)**
  - 2018: 6,315 clients
- **Sample Size for Raw 2-6 (Unique Clients)**
  - 2018: 3,546 clients
- **Sample Size for Rows 2-6 (Unique Clients)**
  - 2018: 3,546 clients

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

#### crisis service summary

<table>
<thead>
<tr>
<th>Program</th>
<th>Item</th>
<th>Measure</th>
<th>2015 Actual</th>
<th>2016 Actual</th>
<th>2017 Actual</th>
<th>2018 Quarter 1</th>
<th>2018 Quarter 2</th>
<th>2018 Quarter 3</th>
<th>2018 Quarter 4</th>
<th>2018 Actual</th>
<th>2018 Target</th>
<th>2018 Status</th>
<th>Benchmark Source</th>
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<td>Crisis Service</td>
<td>Admissions</td>
<td>965</td>
<td>683</td>
<td>656</td>
<td>189</td>
<td>183</td>
<td>195</td>
<td>203</td>
<td>770</td>
<td>800</td>
<td>NRI (2)</td>
<td>BHD (1)</td>
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<tr>
<td></td>
<td>Average Daily Census</td>
<td>472</td>
<td>45.8</td>
<td>42.9</td>
<td>40.6</td>
<td>41.1</td>
<td>41.6</td>
<td>41.8</td>
<td>54</td>
<td></td>
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<td></td>
<td>Percent of patients returning to Acute Adult within 7 days</td>
<td>11%</td>
<td>10.8%</td>
<td>7.7%</td>
<td>5.2%</td>
<td>9.0%</td>
<td>4.9%</td>
<td>7.5%</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of patients returning to Acute Adult within 10 days</td>
<td>3%</td>
<td>3.6%</td>
<td>3.4%</td>
<td>4.3%</td>
<td>6.5%</td>
<td>9.0%</td>
<td>10%</td>
<td>9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Percent of patients responding positively to satisfaction survey</td>
<td>73%</td>
<td>70.6%</td>
<td>74.0%</td>
<td>74.5%</td>
<td>73.1%</td>
<td>78.8%</td>
<td>75.8%</td>
<td>75.0%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Percent of patients discharged on multiple antipsychotic medications</td>
<td>18%</td>
<td>18.5%</td>
<td>17.5%</td>
<td>13.5%</td>
<td>21.5%</td>
<td>22.4%</td>
<td>34.2%</td>
<td>21.5%</td>
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<td></td>
<td>Percent of patients discharged on multiple antipsychotic medications with appropriate justification</td>
<td>98%</td>
<td>95.0%</td>
<td>96.9%</td>
<td>92.5%</td>
<td>94.7%</td>
<td>100.0%</td>
<td>95.6%</td>
<td>90.0%</td>
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<td>Average Daily Census</td>
<td>9.8</td>
<td>8.4</td>
<td>8.6</td>
<td>8.1</td>
<td>7.0</td>
<td>6.4</td>
<td>8.3</td>
<td>7.5</td>
<td>12.0</td>
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<td>Percent of patients returning to CAIS within 7 days</td>
<td>6%</td>
<td>5.2%</td>
<td>5.2%</td>
<td>2.4%</td>
<td>5.3%</td>
<td>4.7%</td>
<td>1.7%</td>
<td>3.4%</td>
<td>5%</td>
<td>BHD (1)</td>
<td></td>
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<tr>
<td></td>
<td>Percent of patients returning to CAIS within 30 days</td>
<td>16%</td>
<td>11.8%</td>
<td>12.3%</td>
<td>10.0%</td>
<td>15.2%</td>
<td>14.0%</td>
<td>11.0%</td>
<td>12.4%</td>
<td>12%</td>
<td>BHD (1)</td>
<td></td>
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<tr>
<td></td>
<td>Percent of patients responding positively to satisfaction survey</td>
<td>73%</td>
<td>78.1%</td>
<td>71.3%</td>
<td>73.9%</td>
<td>63.8%</td>
<td>71.9%</td>
<td>70.2%</td>
<td>71.1%</td>
<td>75%</td>
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<tr>
<td></td>
<td>Overall, I am satisfied with the services I received. (CAIS Youth Survey)</td>
<td>74%</td>
<td>82.1%</td>
<td>76.8%</td>
<td>75.0%</td>
<td>86.4%</td>
<td>65.4%</td>
<td>75.8%</td>
<td>74.2%</td>
<td>75%</td>
<td>BHD (1)</td>
<td></td>
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<tr>
<td></td>
<td>HBIPS 2 - Hours of Physical Restraint Rate</td>
<td>7.2</td>
<td>3.3</td>
<td>0.6</td>
<td>0.3</td>
<td>0.9</td>
<td>0.3</td>
<td>0.2</td>
<td>0.3</td>
<td>0.4</td>
<td>CMS (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBIPS 3 - Hours of Locked Seclusion Rate</td>
<td>0.47</td>
<td>0.48</td>
<td>0.30</td>
<td>0.36</td>
<td>0.38</td>
<td>0.13</td>
<td>0.25</td>
<td>0.28</td>
<td>0.29</td>
<td>CMS (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBIPS 4 - Patients discharged on multiple antipsychotic medications</td>
<td>18%</td>
<td>18.5%</td>
<td>18.5%</td>
<td>13.5%</td>
<td>21.5%</td>
<td>22.4%</td>
<td>34.2%</td>
<td>21.5%</td>
<td>9.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification</td>
<td>98%</td>
<td>95.0%</td>
<td>96.9%</td>
<td>92.5%</td>
<td>94.7%</td>
<td>100.0%</td>
<td>95.6%</td>
<td>90.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Financial Summary

- **Total BHD Revenue (millions)**
  - 2018: $120.2
  - 2019: $130.1
  - 2020: $149.9

- **Total BHD Expenditure (millions)**
  - 2018: $173.5
  - 2019: $180.7
  - 2020: $207.3

### 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
### Milwaukee County Behavioral Health Division

#### 2018 Key Performance Indicators (KPI) Dashboard

<table>
<thead>
<tr>
<th>Program</th>
<th>Item</th>
<th>Measure</th>
<th>2015 Actual</th>
<th>2016 Actual</th>
<th>2017 Actual</th>
<th>2018 Quarter 1</th>
<th>2018 Quarter 2</th>
<th>2018 Quarter 3</th>
<th>2018 Quarter 4</th>
<th>2018 Actual</th>
<th>2018 Target</th>
<th>2018 Status (1)</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wraparound</td>
<td>8</td>
<td>Families served in Wraparound HMO (unduplicated count)</td>
<td>3,329</td>
<td>3,500</td>
<td>3,404</td>
<td>2,185</td>
<td>2,506</td>
<td>2,955</td>
<td>2,955</td>
<td>3,670</td>
<td></td>
<td></td>
<td>BHD (2)</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Annual Family Satisfaction Average Score (Rating scale of 1-5)</td>
<td>4.6</td>
<td>4.6</td>
<td>4.8</td>
<td>4.5</td>
<td>4.5</td>
<td>4.6</td>
<td>4.6</td>
<td>4.60</td>
<td>&gt; = 4.0</td>
<td></td>
<td>BHD (2)</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)</td>
<td>62%</td>
<td>60.2%</td>
<td>65.7%</td>
<td>64.5%</td>
<td>63.6%</td>
<td>65.6%</td>
<td>65.9%</td>
<td>65.3%</td>
<td>&gt; = 75%</td>
<td></td>
<td>BHD (2)</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Average level of &quot;Needs Met&quot; at disenrollment (Rating scale of 1-5)</td>
<td>3.2</td>
<td>2.86</td>
<td>2.59</td>
<td>2.25</td>
<td>2.68</td>
<td>2.35</td>
<td>2.24</td>
<td>2.38</td>
<td>&gt; = 3.0</td>
<td></td>
<td>BHD (2)</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Percentage of youth who have achieved permanency at disenrollment</td>
<td>58%</td>
<td>53.6%</td>
<td>57.8%</td>
<td>43.1%</td>
<td>53.0%</td>
<td>60.6%</td>
<td>47.0%</td>
<td>58.0%</td>
<td>&gt; = 70%</td>
<td></td>
<td>BHD (2)</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Percentage of Informal Supports on a Child and Family Team</td>
<td>42%</td>
<td>43.6%</td>
<td>44.1%</td>
<td>40.8%</td>
<td>39.4%</td>
<td>38.3%</td>
<td>35.1%</td>
<td>38.4%</td>
<td>&gt; = 50%</td>
<td></td>
<td>BHD (2)</td>
</tr>
</tbody>
</table>

**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 BH D trends

### SUMMARY - 4TH QUARTER/CY 2018

- **#8** - There was approx. a 15% increase in families served (unduplicated count) from the 3rd quarter to the 4th quarter. No comments.

- **#9** - On target for the 4th quarter and all of 2018. No comments.

- **#10** - Achieved 87.8% of the target of "75% or greater". Score increased .3% from the 3rd quarter (65.6%) to 65.9% in the 4th quarter. Within 20% range of the benchmark. Overall 2018 score of 65.3% is within the 20% range of the benchmark. Efforts are ongoing to have youth reside in the least restrictive setting possible.

- **#11** - Overall increase of .14 from the 3rd quarter to the 4th quarter. 2018 CY outcome is 2.38 on a scale of 5.0. This is outside the 20% benchmark (2.4) by .02% and .62 below the target standard of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. Those in Wraparound on court ordered programs who are disenrolled to a home type setting in the 4th quarter have a higher "Need Met" score (3.13) than those disenrolled on runaway status or to corrections (1.83). Discharge placement appears correlated with Needs Met. Those in the REACH program averaged a 4th quarter disenrollment Needs Score of 2.05.

- **#12** - In the 4th quarter, there was a 13.6% decrease in the percentage of youth achieving permanency at disenrollment compared to the 3rd quarter. Overall for CY 2018, the percentage of Wraparound youth achieving permanency was 58%. This is 2.0% above the "within 20% of the benchmark" status (which would be 56%) but still short of the 70% standard. The majority or youth were discharged from the program with an end code of "Program Completed" or "Services No Longer Desired" (35 out of 65 or 54%).

- 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 (35.1%) and the 2018 overall compliance (38.4%) fall outside of the "within the 20% of the benchmark" score which would be 40%, and the established threshold of 50%. APR meetings are in the process of occurring at this time in which the informal support performance indicators are being discussed and potentially revised.
CHANGES AND UPDATES

Further Development of the Quadruple Aim
The CARS Quality Dashboard has continued to undergo further development/refinement of the data elements organized by the Quadruple Aim.

Population Health
No changes to this Aim. Under development is a report that we hope will allow us to track change over time in some of these population health metrics - updates will follow. Also notable is a minor change in the reporting timeframe for the mortality rates metric to allow for the lag between the request for and receipt of cause of death reports from the Medical Examiner’s office.

Patient Experience of Care
No changes to this Aim. There is continuing progress on the Press Ganey survey roll out across CARS programs. Other efforts in this area include the implementation of Motivational Interviewing (MI) training amongst key CARS and network staff, with plans to eventually embed this evidence-based paradigm throughout all of BHD. Accompanying this implementation is the development of a MI fidelity assessment process to ensure that competence in MI and person-centered care is monitored on an ongoing basis.

Staff Wellbeing
CARS is working with BHD’s Human Resources Department to obtain data on CARS staff turnover. We anticipate that this data will be available in the first quarter of 2019. CARS is working with Human Resources to establish appropriate turnover rate targets by department and/or staff classification that are indicative of healthy and high functioning social service organizations. There is also an effort to develop reports on provider turnover in CARS contracted network.

Cost of Care
The CARS Quality Dashboard has been expanded to now include an approximate cost of care metric based on a per person, per month calculation for all expenditures in CARS programs. Future iterations of the Dashboard will consider different and more granular permutations of this metric, including per member per day costs and estimations for return on investment costs (value per dollar spent). Further, other quality improvement efforts in CARS will examine the impact of programmatic changes on dollars spent on care by funding stream (tax levy, Medicaid, State block grants, other grants, etc.).

RESULTS

Most population health metrics for CARS clients remained stable in the fourth quarter of 2018, though detox readmissions rose slightly from the third quarter. As more quarters of data are accumulated, the CARS Research and Evaluation Team will evaluate the trends in data for these measures to determine if baseline levels of prevalence have been identified and adjust yearly performance targets accordingly.

NEXT STEPS

As alluded to above, CARS is developing a Quality Plan, the goals of which have been aligned to the Quadruple Aim. These goals, and the interventions and activities implemented to achieve them, will help shape future versions of the CARS Quarterly Dashboard by impacting metrics already contained therein or creating new metrics to present and thus will complement the CARS Quarterly Dashboard. Updates will be provided as the Quality Plan matures.
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).
Demographic Information of the Population We Serve
This section outlines the demographics of the consumers CARS served or continues to serve in the past quarter.

Race (CARS)
- Black/African-American: 45.00%
- White/Caucasian: 49.47%
- Other: 5.53%

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

Race (Milwaukee County)*
- Black/African-American: 64.60%
- White/Caucasian: 27.20%
- Other: 5.5%

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

Ethnicity*
- CARS: 13%
- Milwaukee County: 9%
- Hispanic/Latino: 15.10%

Gender*
- CARS: 81%
- Milwaukee County: 84.9%

Males: 60.77%
Females: 48.4%

*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

Age
- 18-19: 54%
- 20-29: 18.05%
- 30-39: 23.93%
- 40-49: 19.72%
- 50-59: 25.22%
- 60-69: 11.04%
- 70+: 1.50%
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 indicate change over time.

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

**Time to Service**
Average number of days between the time of the CARS Comprehensive Assessment to the first service date.

**Admissions**
All admissions for 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.
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 30 Day Readmissions
Percent of consumers returning to detoxification within 30 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".

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

Mortality Over Time
Mortality is a population health metric used by other institutions such as the Center for Disease Control, U.S. Department of Health and Human Services, the World Health Organization and more. The graph represents the total number of deaths in the past four quarters by the cause of death. The total count over time is below:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q4-2017</th>
<th>Q1-2018</th>
<th>Q2-2018</th>
<th>Q3-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>17</td>
<td>23</td>
<td>11</td>
<td>25</td>
</tr>
</tbody>
</table>

Note: There is a lag in death reporting between two separate departments. See note in the next item.

Average Age by Cause of Death
This is the reported average age at time of death by cause of death in the past four quarters.

Please note that henceforth there will be a one quarter lag in the mortality data on the CARS Quarterly Dashboard. For example, the 2018 fourth quarter iteration of the Dashboard will contain mortality statistics for the third quarter of 2018. 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.

Top Prevention Activities/Initiatives
Prevention is also an important population health factor. Many prevention activities include evidence based practices, presentations, and more. The top five prevention activities are listed in the graphic. Each number is associated with the number of families reached through that initiative in 2018.

The CARS Research and Evaluation team plans to describe forms of primary, secondary, and tertiary prevention activities for topics like substance abuse prevention and suicide prevention.
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:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1-2018</th>
<th>N = 4844</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2-2018</td>
<td>N = 4865</td>
<td></td>
</tr>
<tr>
<td>Q3-2018</td>
<td>N = 5042</td>
<td></td>
</tr>
<tr>
<td>Q4-2018</td>
<td>N = 5056</td>
<td></td>
</tr>
</tbody>
</table>

Under Development
These are data points the CARS Research and Evaluation team plans to implement in future iterations of the Quarterly Dashboard. Each will contribute to a more comprehensive picture of each domain within The Quadruple Aim.

Staff Well-Being Domain: Staff Turnover
Future dashboards will report on the degree of turnover among CARS staff, starting in the first quarter of 2019. Subsequent iterations of the dashboard will also include staff turnover within the CARS provider network.

All Domains: Case Study
The CARS Research and Evaluation team will capture case study interviews twice a year from consumers, community providers, and other stakeholders as it relates to one of the four domains within The Quadruple Aim.

Patient Experience of Care Domain: Consumer Satisfaction
Press Ganey consumer satisfaction surveys are being adopted in many BHD departments including CARS. Future versions of this report will include overall mean scores of numerous CARS programs.
Quality Committee Item 3

The Community Access to Recovery Services (CARS) Department currently offers a wide range of **supported employment/education services** to meet the needs of the consumers it serves. These types of services include, but are not limited to: soft skills training, job-specific training, clubhouse and education related supports. In 2014, the CARS Department instituted the use of a supported employment/education evidenced based model known as Individual Placement and Support (IPS).

The IPS model offers individualized vocation and education related supports based on the needs and desires of the consumer being served. Primary focus of the model is supporting individuals in finding competitive employment or returning to school with the intention to pursue future competitive employment. Employment Specialists approach potential employers with the intention to learn more about their business and employment needs. Based on the information obtained, the employment specialist works with the employer to potentially create positions that best fit the needs of the employer and the interests/needs of the consumer. Employment obtained via IPS is expected to be competitive in nature, meaning that the job is a job that can be obtained by the general public. These positions are also expected to offer at least minimum wage.

Currently the IPS model is offered within the CCS program. In addition to IPS, the CCS provider network includes providers who offer specialized vocational assessment, benefits education, soft skills training and prevocational supports. The two vendors offering services in accordance with the IPS model are EasterSeals and Goodwill. These two vendors are currently embedded in six adult care coordination teams and four youth care coordination teams. There are plans to embed IPS into the remaining adult care coordination teams and expand the use of IPS into other service areas over the next several years.

Primary focus for 2018 has been on expanding IPS into CCS’s youth care coordination teams. CCS’s youth IPS teams launched during the tail-end of 2018. Throughout 2018, IPS served a total of 300 consumers (this includes 6 youth). Of the 300 consumers served, 22 were served via the supported education track. 2018 data for the IPS program is as follows:

- 107 job hires
- Average length of employment 2-3 months
- Eleven consumers were transitioned successfully off IPS’s caseload with sustained employment.
- Two consumers moved from part-time to full-time employment during their time with IPS.

**Consumers often express concern related to the impact of full-time employment on the benefits they receive i.e. Medicaid, Social Security, housing subsidies, etc. As a result, IPS consumers are encouraged to participate in benefits education prior to employment and during employment so they have the opportunity to make informed decisions related to the direction of their employment.**

**List of Employers Working with IPS:**

<table>
<thead>
<tr>
<th>Milwaukee Public Schools</th>
<th>Performance Clean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akira</td>
<td>Salvation Army</td>
</tr>
<tr>
<td>Don Jacob Toyota</td>
<td>Pizza Hut</td>
</tr>
<tr>
<td>Tandem</td>
<td>Potowatomi</td>
</tr>
<tr>
<td>Miller Park</td>
<td>White Lodge</td>
</tr>
<tr>
<td>Walgreen’s</td>
<td>The Astor</td>
</tr>
<tr>
<td>Duwalli</td>
<td>Hamburger Mary’s</td>
</tr>
<tr>
<td>Falk</td>
<td>Burger King</td>
</tr>
<tr>
<td>Lowes</td>
<td>Summerfest</td>
</tr>
<tr>
<td>Mayfair Relocation Reality</td>
<td>A LOFT</td>
</tr>
<tr>
<td>Dollar Tree</td>
<td>Speedway</td>
</tr>
<tr>
<td>Maggiano’s Little Italy</td>
<td>Mitchell Manor</td>
</tr>
<tr>
<td>Elmbrook Memorial</td>
<td>Katz Properties</td>
</tr>
<tr>
<td>Wendy’s</td>
<td>Caribou Coffee</td>
</tr>
<tr>
<td>Pick N’ Save</td>
<td>Grebe Bakery</td>
</tr>
<tr>
<td>Stowell Associates</td>
<td>The Sleep Wellness Institute</td>
</tr>
<tr>
<td>City of Milwaukee</td>
<td>Medical College</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Klement’s
McDonald’s
Marcus Center for the Performing Arts
Macy’s
Aurora
Star Trucking
Wild Flour Bakery
Metro Market
Corazon
Celestial Care
Popeye’s Chicken
Barrel Plating
Sodexo
Purple Door Ice Cream
Lutheran Social Services
Milwaukee County
George Webb’s
Psychiatric Crisis Service annual patient visits continue to decline from 10,696 in 2014 to 7,375 visits in 2018 (31% decline from 2014 to 2018). 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, 83% in 2018).

Acute Adult Inpatient Service’s 2018 annual patient admissions increased to 770, the first increase since the Redesign Task Force was established in 2010. While Acute Adult admissions increased, readmission rates have continued to decline over the past four years (30-day readmission rate: 11% in 2015, 6% in 2018). Acute Adult’s hours of physical restraint rate in 2018 was .51, above CMS’ inpatient psychiatric facility national average of .44, but below Wisconsin’s average rate of 1.0. Acute Adult’s 2018 MHSIP overall patient satisfaction survey scores were at the NRI’s reported national average of 75%.

Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past few years and were 644 for annual 2018. Over the past four years, CAIS’ 30-day readmission rates have declined from 16% in 2015 to 12% in 2018. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.2 in 2018, but remains above CMS’ reported average of .44. CAIS’ Youth Satisfaction Survey overall scores for the past two years have been 4 percentage points lower than BHD’s historical average.
2018 Quarter 4 (Q4) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary

2018 BHD PCS - Hours of Restraint Rate

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>1.63</td>
<td>2.41</td>
<td>1.74</td>
<td>1.13</td>
</tr>
</tbody>
</table>

2018 BHD Acute Adult - Hours of Restraint Rate

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>0.26</td>
<td>0.94</td>
<td>0.38</td>
<td>0.42</td>
</tr>
</tbody>
</table>

2018 BHD CAIS - Hours of Restraint Rate

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>1.38</td>
<td>1.81</td>
<td>0.53</td>
<td>0.98</td>
</tr>
</tbody>
</table>

2018 BHD Acute Adult - Hours of Seclusion Rate

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>0.93</td>
<td>0.38</td>
<td>0.11</td>
<td>0.25</td>
</tr>
</tbody>
</table>

2018 BHD CAIS - Hours of Seclusion Rate

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018 Q1</th>
<th>2018 Q2</th>
<th>2018 Q3</th>
<th>2018 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>0.93</td>
<td>0.50</td>
<td>0.20</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Quarters highlighted in yellow have rates below the national average.
2016-2018 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary

2016-2018 BHD PCS - Hours of Restraint Rate

- Restraint Rate 1.99 2.38 2.08 1.71 1.44 2.41 1.74 1.13

Quarter
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2016-2018 BHD Acute Adult - Hours of Restraint Rate

- Restraint Rate 3.05 2.97 5.99 1.17 0.45 0.61 0.71 0.45

Quarter
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2016-2018 BHD CAIS - Hours of Restraint Rate

- Restraint Rate 5.31 3.44 6.50 2.79 1.42 1.10 0.59 1.45

Quarter
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2016-2018 BHD Acute Adult - Hours of Seclusion Rate

- Seclusion Rate 0.54 0.63 0.50 0.26 0.27 0.25 0.44 0.22

Quarter
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

2016-2018 BHD CAIS - Hours of Seclusion Rate

- Seclusion Rate 0.17 0.22 0.40 0.28 0.44 0.28 0.93 0.50

Quarter
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4

Hours of Restraint Rate Formula: Restraint Hours / (Inpatient Hours/1,000)
CMS Analysis of BHD Acute Inpatient Readmission Rates
*Patients with Medicare

Re: CMS reports regarding BHD's Acute Inpatient 7 and 30-day readmission rates by Medicare patients. CMS' analysis is based on BHD billing data from time period: 7/1/15-6/30/17.

CMS found that BHD's 30-day readmission rates were "no different than the national rate." Of the 23 inpatient psychiatric facilities in Wisconsin, 0 performed better than the national rate, 22 performed at the national rate, and 1 performed below the national rate. Additional information will be published on the CMS Hospital Compare website in April.

524001 - MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
Facility Discharge Performance Period: July 1, 2015 through June 30, 2017

TABLE 1. YOUR FACILITY'S PERFORMANCE ON THE 30-DAY IPF READMISSION MEASURE (READM-30-IPF)

<table>
<thead>
<tr>
<th>READM-30-IPF Performance Information</th>
<th>Your Facility's Comparative Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Facility's Number of Index Admissions (Measure Population)</td>
<td>No different than the national rate</td>
</tr>
<tr>
<td>Your Facility's Risk-Standardized Readmission Rate (RSRR)</td>
<td>17.8%</td>
</tr>
<tr>
<td>Lower Limit of 95% Interval Estimate for RSRR</td>
<td>13.0%</td>
</tr>
<tr>
<td>Upper Limit of 95% Interval Estimate for RSRR</td>
<td>21.2%</td>
</tr>
<tr>
<td>National Observed Unplanned Readmission Rate</td>
<td>20.1%</td>
</tr>
</tbody>
</table>

524001 - MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
Facility Discharge Performance Period: July 1, 2015 through June 30, 2017

TABLE 2. NATIONAL AND STATE PERFORMANCE CATEGORIES FOR READM-30-IPF

<table>
<thead>
<tr>
<th>Total Number of Facilities in the Nation with Measure Results</th>
<th>1,692</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities in the nation that performed better than the national rate</td>
<td>109</td>
</tr>
<tr>
<td>Number of facilities in the nation that performed no different than the national rate</td>
<td>1,325</td>
</tr>
<tr>
<td>Number of facilities in the nation that performed worse than the national rate</td>
<td>177</td>
</tr>
<tr>
<td>Number of facilities in the nation that had too few cases</td>
<td>81</td>
</tr>
<tr>
<td>Total Number of Facilities in Your State with Measure Results</td>
<td>23</td>
</tr>
<tr>
<td>Number of facilities in the state that performed better than the national rate</td>
<td>0</td>
</tr>
<tr>
<td>Number of facilities in the state that performed no different than the national rate</td>
<td>22</td>
</tr>
<tr>
<td>Number of facilities in the state that performed worse than the national rate</td>
<td>1</td>
</tr>
<tr>
<td>Number of facilities in the state that had too few cases</td>
<td>0</td>
</tr>
</tbody>
</table>

• Discussion — Dr. Schneider & Dr. Zincke
MHSIP
Consumer
Satisfaction
Survey

Annual

2018

Prepared By:
Quality
Improvement
Department

Created 1/24/19
Overview

- In 2018, 299 of the 773 consumers discharged from Acute Adult Inpatient Service completed the MHSIP survey. Acute Adult Inpatient Service’s 2018 MHSIP survey response rate of 39% 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 survey results for 2018 revealed an increase in positive rating for five survey item domain categories in comparison to 2017’s scores. In 2018, the Participation, Outcome, Empowerment, Environment and Rights domains received the highest positive rating in the 16 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 (80%), “Good” response scores for 4 of the 6 survey item domains: 78% for Participation, 77% for Outcome, 77% for Empowerment, and 74% for Environment. Relatively low response scores were obtained for the patient Rights domain 67%.

- Survey items with the highest positive response scores were:
  - I participated in planning my discharge (83%)
  - Staff here believe that I could grow, change and recover (82%)
  - My contact with nurses and therapists was helpful (82%)
  - I was encouraged to use self-help/support groups (82%)
  - I am better able to deal with crisis (81%)
  - My symptoms are not bothering me as much (80%)
  - I felt comfortable asking questions about my treatment and medications (79%)
  - The hospital environment was clean and comfortable (79%)
  - My contact with my doctor was helpful (78%)
  - The medications I am taking help me control symptoms that used to bother me (77%)
  - I was treated with dignity and respect (76%)
  - I had the opportunity to meet staff from the community agency prior to discharge (76%)
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.
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.

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.

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.

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

Rights Domain:
- I felt free to complain without fear of retaliation.
- I felt safe to reuse 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.

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 2018. Data from 2014 – 2017 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 39% of the 773 consumers discharged from the Acute Adult Inpatient service in 2018. Acute Adult Inpatient Service’s 2018 MHSIP survey response rate of 39% is significantly above the 27% rational 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 2015 – 2018.

<table>
<thead>
<tr>
<th>Unit</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Completed Surveys</td>
<td>Response Rate</td>
<td>Completed Surveys</td>
<td>Response Rate</td>
</tr>
<tr>
<td>43A - ITU</td>
<td>76</td>
<td>27.8%</td>
<td>70</td>
<td>30.2%</td>
</tr>
<tr>
<td>43B - ATU</td>
<td>334</td>
<td>77.5%</td>
<td>171</td>
<td>66.5%</td>
</tr>
<tr>
<td>43C - WTU</td>
<td>92</td>
<td>35.1%</td>
<td>39</td>
<td>20.1%</td>
</tr>
<tr>
<td>Total</td>
<td>502</td>
<td>52.0%</td>
<td>280</td>
<td>41.0%</td>
</tr>
</tbody>
</table>
**Acute Adult Inpatient Service**

Table 2 presents Acute Adult Inpatient Service’s consumer positive (agree/strongly agree) responses for 2014 – 2018. In 2018, the results revealed a “High” response score for the Dignity domain (80%), “Good” response scores for 4 of the 6 survey item domains: 78% for Participation, 77% for Outcome, 77% for Empowerment, and 74% for Environment. Relatively low response scores were obtained for the patient Rights domain 67%.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Agree/Strongly Agree Response %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014</td>
</tr>
<tr>
<td>Dignity</td>
<td>75.9%</td>
</tr>
<tr>
<td>Outcome</td>
<td>73.8%</td>
</tr>
<tr>
<td>Participation</td>
<td>75.6%</td>
</tr>
<tr>
<td>Environment</td>
<td>64.6%</td>
</tr>
<tr>
<td>Rights</td>
<td>63.1%</td>
</tr>
<tr>
<td>Empowerment</td>
<td>72.1%</td>
</tr>
</tbody>
</table>

**Additional Questions**

| My family and/or friends were able to visit me. | 78.8% | 78.6% | 77.9% | 81.8% | 84.4% |
| The Medications I am taking help me control my symptoms that used to bother me. | 74.8% | 77.0% | 74.3% | 76.9% | 77.1% |
| My other medical conditions were treated. | 66.3% | 68.1% | 67.7% | 72.5% | 71.0% |
| Staff were sensitive to my cultural background. | 63.8% | 67.4% | 64.7% | 71.3% | 71.9% |
| I felt this hospital stay was necessary. | 68.4% | 65.8% | 62.5% | 66.0% | 67.1% |
| I was given information about how to manage my medication side effects. | 63.3% | 72.1% | 66.1% | 69.2% | 69.7% |
| If I had a choice of hospitals, I would still choose this one. | 55.3% | 63.2% | 56.0% | 65.4% | 65.6% |

**Surveys Completed**

|          | 285 | 502 | 280 | 218 | 299 |
The following graph presents Acute Adult Inpatient Service's 2014-2018 positive (agree/strongly agree) Domain scores.

![MHSIP Domain Scores 2014-2018](image)

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity</td>
<td>75.9</td>
<td>78.4</td>
<td>75.7</td>
<td>81.0</td>
<td>79.7</td>
</tr>
<tr>
<td>Outcome</td>
<td>73.8</td>
<td>77.0</td>
<td>74.7</td>
<td>76.8</td>
<td>77.3</td>
</tr>
<tr>
<td>Participation</td>
<td>75.6</td>
<td>76.7</td>
<td>71.9</td>
<td>74.6</td>
<td>78.2</td>
</tr>
<tr>
<td>Environment</td>
<td>64.6</td>
<td>68.5</td>
<td>68.8</td>
<td>73.5</td>
<td>73.7</td>
</tr>
<tr>
<td>Rights</td>
<td>63.1</td>
<td>63.0</td>
<td>59.1</td>
<td>64.8</td>
<td>67.1</td>
</tr>
<tr>
<td>Empowerment</td>
<td>72.1</td>
<td>75.8</td>
<td>72.5</td>
<td>74.8</td>
<td>77.1</td>
</tr>
</tbody>
</table>
The following graphs present Acute Adult Inpatient Service’s 2014-2018 positive (agree/strongly agree) survey item scores and NRI’s domain average.
2014 - 2018 MHSIP Survey Item - Environment Domain

% Agree/Strongly Agree

NRI Domain Average 69.3%

2014 | 2015 | 2016 | 2017 | 2018
--- | --- | --- | --- | ---
58.8% | 68.4% | 66.7% | 68.7% | 70.8%
63.0% | 63.4% | 65.0% | 67.9% | 70.8%
66.1% | 69.6% | 69.1% | 76.9% | 74.2%
70.4% | 72.6% | 74.3% | 80.5% | 78.8%

2014 - 2018 MHSIP Survey - Empowerment Domain

% Agree/Strongly Agree

2014 | 2015 | 2016 | 2017 | 2018
--- | --- | --- | --- | ---
61.2% | 65.1% | 63.2% | 67.3% | 71.1%
75.3% | 79.3% | 76.2% | 76.3% | 78.2%
79.6% | 82.6% | 78.0% | 80.8% | 31.9%
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>
<thead>
<tr>
<th>Domains</th>
<th>National Average</th>
<th>2018 BHD</th>
<th>BHD/National Avg Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity</td>
<td>81.9%</td>
<td>79.7%</td>
<td>-2.2%</td>
</tr>
<tr>
<td>Outcome</td>
<td>78.5%</td>
<td>77.3%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Participation</td>
<td>74.8%</td>
<td>78.2%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Environment</td>
<td>69.3%</td>
<td>73.7%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Rights</td>
<td>67.8%</td>
<td>67.1%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Not Reported</td>
<td>77.1%</td>
<td></td>
</tr>
</tbody>
</table>
Table 4 presents 2018 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:

<table>
<thead>
<tr>
<th>Table 4. 2018 Inpatient MHSIP Consumer Survey - By Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domains</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dignity</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>Participation</td>
</tr>
<tr>
<td>Environment</td>
</tr>
<tr>
<td>Rights</td>
</tr>
<tr>
<td>Empowerment</td>
</tr>
<tr>
<td><strong>Additional Questions</strong></td>
</tr>
<tr>
<td>My family and/or friends were able to visit me.</td>
</tr>
<tr>
<td>The Medications I am taking help me control my symptoms that used to bother me.</td>
</tr>
<tr>
<td>My other medical conditions were treated.</td>
</tr>
<tr>
<td>Staff were sensitive to my cultural background</td>
</tr>
<tr>
<td>I felt this hospital stay was necessary</td>
</tr>
<tr>
<td>I was given information about how to manage my medication side effects</td>
</tr>
<tr>
<td>If I had a choice of hospitals, I would still choose this one.</td>
</tr>
<tr>
<td><strong>Surveys Completed</strong></td>
</tr>
</tbody>
</table>
Appendix

The comments below were written on surveys administered in 2018.

43A - Positive Comments
1. My stay here at the hospital was supported by the workers that did their job!
2. Quite frankly, I am glad I was hospitalized here for a couple of weeks. Now I can go back home with a peace of mind and ready to become the bread winner and head of household that I have always been.

43A - Negative Comments
1. Staff were not focused on patient rights issues vs staff work duties. Staff seem to be pre-occupied with their pensions, days off and their own mental health issues.

43B - Positive Comments
1. I am very happy I was sent here. Staff was amazing and super helpful. Melissa was wonderful and is a rock star you should be proud to have.
2. I enjoyed my stay at the hospital.
3. I just like to thank my doctor, nurses and social worker for being so helpful and also the C.N.A. Thank you all.
4. I would like to advocate for an employee award program that is free and complimentary because the employees here did a great job! Good job Shannon, Sarah, Josh, Albert, Alberta, Jenise, Martha, and everyone else.
5. Keep up with the good work even if you feel down knowing people with full smile will always be around to help and remind us we always have the will to change.
6. Marilyn OT person shows us everything, and I like her a lot.
7. My stay here was helpful and safe.
8. My stay was extremely helpful. All nurses, C.N.A.'s, doctors and staff were amazing. However, C.N.A. Sharon was rude and mean at times. Other than that, I interacted with the staff perfectly fine.
9. My team was great! Loved my groups, especially music! The staff was encouraging. It did get stressful with some of the other patients but I anticipated that. Overall, my stay was good! Albert had to be the best: C.N.A.!
10. My visit to BHD was pleasurable. Learned more behavioral knowledge of self.
11. Thanks goes out to all of the staff for helping me get through this troubling time in my life. It really means a lot to me!
12. Thanks.
13. The staff as well as the OT and PT were very respectful and treated me with dignity and respect. (Thanks guys!)

43B - Negative Comments
1. Better customer service, everybody be moody and rude at times.
2. The nursing staff is here because they love their job. The C.N.A. staff, not all, but some were constantly fighting and acting as if we were prisoners, not patients.
Appendix (continued)

43C - Positive Comments
1. My treatment went well. I really enjoyed most of the professionals involved in my care. Exceptions: The C.N.A. staff were primarily rude and disrespectful. They seemed like they resented their jobs.
2. Staff kind and patient.
3. Thank you very much for your services.
4. The staff was superb! Excellent people!!! Food was not fit for my dog!!!

43C - Negative Comments
1. C.N.A.'s were rude and loud. Most spent time on their phones and were not very responsive to patient's needs. Dr. L, Kristen, and Yvonne were amazing. Edite, Tammy, and Clayton were great nurses. Many of the C.N.A.'s slept at night and never did rounds, just when change occurred. C.N.A. slept a lot on the job. Names on name badges were most often covered up. Edward was a great nurse.
2. The food was terrible, but no complaints otherwise.
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

2/6/19
Overview

• In 2018, 209 of the 504 youth (aged 13 years or older) discharged from CAIS completed the CAIS Youth Survey, yielding a 41.5% response rate.

• The survey results for 2018 (in comparison to 2017) revealed a 4 percentage point increase in the “Cultural Sensitivity/Respectful Treatment” domain’s satisfaction score, unchanged satisfaction results for the “Participation in Treatment” and “Patient Outcomes” domains, and a 3 percentage point decrease in the “Access to Services” and “Appropriateness of 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 Cultural Sensitivity/Respectful Treatment domain (82%), “Good” positive response scores were obtained for Participation in Treatment (76%), and Appropriateness of Treatment (74%). Relatively low positive response scores were obtained for the Patient Outcomes (62%) and Access to Services (60%) domains.

• Survey items with the highest positive response scores were:
  - Staff spoke with me in a way that I understood (89%)
  - Staff respected my family’s religious/spiritual beliefs (84%)
  - I helped to choose my treatment goals (84%)
  - I participated in my own treatment (83%)
  - Staff treated me with respect (80%)
  - I felt I had someone to talk to when I was troubled (77%)
  - I received the services that were right for me (76%)
  - Staff were sensitive to my cultural/ethnic background (76%)
  - Overall, I am satisfied with the services I received (74%)
  - The people helping me stuck with me no matter what (73%)

• The open ended survey item “Most helpful things you received during your stay” resulted in patients writing comments regarding: staff listening to patient (25%), groups (15%), coping skills (14%), caring, respectful staff (14%), treatment received (11%), medication received (11%), safe environment (6%), and anger management (4%).

• The open ended survey item “What would improve the program here” resulted in patients writing comments regarding: better food (53%), no improvements needed (24%), more groups and activities (12%), respectful staff (7%), better communication between staff and patients (3%), and better treatment (1%).
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 2014 – 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 327</td>
<td>N = 618</td>
<td>N = 106</td>
<td>N = 182</td>
<td>N = 209</td>
<td></td>
</tr>
<tr>
<td>The location of services was convenient</td>
<td>62.0</td>
<td>61.6</td>
<td>58.7</td>
<td>54.0</td>
<td>46.3</td>
<td>-7.7</td>
</tr>
<tr>
<td>Services were available at times that were convenient</td>
<td>75.0</td>
<td>67.2</td>
<td>80.8</td>
<td>71.8</td>
<td>74.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Access to Services Domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, I am satisfied with the services I received</td>
<td>72.8</td>
<td>74.0</td>
<td>82.1</td>
<td>76.8</td>
<td>74.2</td>
<td>-2.6</td>
</tr>
<tr>
<td>The people helping me stuck with me no matter what</td>
<td>75.5</td>
<td>71.6</td>
<td>82.1</td>
<td>79.0</td>
<td>73.4</td>
<td>-5.6</td>
</tr>
<tr>
<td>I felt I had someone to talk to when I was troubled</td>
<td>74.9</td>
<td>72.6</td>
<td>81.0</td>
<td>81.9</td>
<td>77.3</td>
<td>-4.6</td>
</tr>
<tr>
<td>I received the services that were right for me</td>
<td>72.6</td>
<td>74.0</td>
<td>84.6</td>
<td>76.4</td>
<td>75.7</td>
<td>-0.7</td>
</tr>
<tr>
<td>I got the help I wanted</td>
<td>71.0</td>
<td>72.0</td>
<td>84.0</td>
<td>72.4</td>
<td>72.1</td>
<td>-3.3</td>
</tr>
<tr>
<td>I got as much help as I needed</td>
<td>72.6</td>
<td>73.1</td>
<td>81.0</td>
<td>75.1</td>
<td>69.1</td>
<td>-5.0</td>
</tr>
<tr>
<td>Appropriateness of Treatment Domain</td>
<td>73.2</td>
<td>72.9</td>
<td>82.5</td>
<td>76.9</td>
<td>73.6</td>
<td>-3.3</td>
</tr>
<tr>
<td>I helped to choose my services</td>
<td>64.6</td>
<td>65.5</td>
<td>66.7</td>
<td>68.0</td>
<td>62.2</td>
<td>-5.8</td>
</tr>
<tr>
<td>I helped to choose my treatment goals</td>
<td>79.8</td>
<td>76.6</td>
<td>85.6</td>
<td>77.2</td>
<td>83.6</td>
<td>6.4</td>
</tr>
<tr>
<td>I participated in my own treatment</td>
<td>79.4</td>
<td>81.2</td>
<td>85.6</td>
<td>84.0</td>
<td>83.3</td>
<td>-0.7</td>
</tr>
<tr>
<td>Participation in Treatment Domain</td>
<td>74.6</td>
<td>74.4</td>
<td>79.3</td>
<td>76.4</td>
<td>76.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Staff treated me with respect</td>
<td>73.6</td>
<td>72.2</td>
<td>81.0</td>
<td>78.9</td>
<td>79.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Staff respected my family's religious/spiritual beliefs</td>
<td>78.5</td>
<td>78.6</td>
<td>88.1</td>
<td>80.9</td>
<td>84.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Staff spoke with me in a way that I understood</td>
<td>84.4</td>
<td>82.2</td>
<td>91.4</td>
<td>84.1</td>
<td>89.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Staff were sensitive to my cultural/ethnic background</td>
<td>77.0</td>
<td>71.9</td>
<td>85.6</td>
<td>69.3</td>
<td>75.7</td>
<td>6.4</td>
</tr>
<tr>
<td>Cultural Sensitivity / Respectful Treatment Domain</td>
<td>78.4</td>
<td>76.2</td>
<td>86.5</td>
<td>78.3</td>
<td>82.2</td>
<td>3.9</td>
</tr>
<tr>
<td>I am better at handling daily life</td>
<td>69.6</td>
<td>70.9</td>
<td>68.9</td>
<td>70.4</td>
<td>66.7</td>
<td>-3.7</td>
</tr>
<tr>
<td>I get along better with family members</td>
<td>57.1</td>
<td>60.2</td>
<td>64.2</td>
<td>53.9</td>
<td>50.2</td>
<td>-3.7</td>
</tr>
<tr>
<td>I get along better with friends and other people</td>
<td>75.7</td>
<td>70.5</td>
<td>74.3</td>
<td>65.7</td>
<td>72.2</td>
<td>6.5</td>
</tr>
<tr>
<td>I am doing better in school and/or work</td>
<td>59.4</td>
<td>58.8</td>
<td>62.5</td>
<td>53.4</td>
<td>57.3</td>
<td>3.9</td>
</tr>
<tr>
<td>I am better able to cope when things go wrong</td>
<td>69.1</td>
<td>65.1</td>
<td>74.0</td>
<td>65.0</td>
<td>70.5</td>
<td>5.5</td>
</tr>
<tr>
<td>I am satisfied with my family life right now</td>
<td>58.6</td>
<td>60.9</td>
<td>68.7</td>
<td>59.4</td>
<td>55.8</td>
<td>-3.6</td>
</tr>
<tr>
<td>Patient Outcomes Domain</td>
<td>64.9</td>
<td>64.4</td>
<td>68.4</td>
<td>61.3</td>
<td>62.1</td>
<td>0.8</td>
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</table>
2014-2018 CAIS Youth Survey Results

<table>
<thead>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Services</td>
<td>68.5</td>
<td>64.4</td>
<td>69.8</td>
<td>62.9</td>
<td>60.4</td>
</tr>
<tr>
<td>Appropriateness of Treatment</td>
<td>73.2</td>
<td>72.9</td>
<td>82.5</td>
<td>76.9</td>
<td>73.6</td>
</tr>
<tr>
<td>Participation in Treatment</td>
<td>74.6</td>
<td>74.4</td>
<td>79.3</td>
<td>76.4</td>
<td>76.4</td>
</tr>
<tr>
<td>Cultural Sensitivity / Respectful Treatment</td>
<td>78.4</td>
<td>76.2</td>
<td>86.5</td>
<td>78.3</td>
<td>82.2</td>
</tr>
<tr>
<td>Patient Outcomes</td>
<td>64.9</td>
<td>64.4</td>
<td>68.5</td>
<td>61.3</td>
<td>62.1</td>
</tr>
</tbody>
</table>

The comments below were written on surveys administered in 2018.

Comments regarding "Most Helpful Things you Received During Your Stay"  n=146

- Anger management: 4%
- Staff listened to patient: 25%
- Groups: 15%
- Coping skills: 14%
- Caring respectful staff: 14%
- Treatment: 11%
- Medication: 11%
- Safe Environment: 6%
<table>
<thead>
<tr>
<th>Category</th>
<th>Comments <em>Most Helpful Things You Received During Your Stay</em></th>
</tr>
</thead>
</table>
| Anger management | Dealing with anger and talking it out.  
Helpful thing I received was my anger.  
That we have to learn self-control.  
The help I got with my anger.  
The nurses helped me control my anger and not pay attention to when the other patients get under my skin.  
They helped me to calm down.  |
| Caring, Respectful Staff | A nice caring staff.  
Breathing—medicine, staff made me feel like I was at home and treated me with respect. Staff and people I met with motivated me to do better when I leave.  
Cynthia, Matt, Russ, and Stacy were amazing at making me feel welcome.  
Good positive reinforcement from the staff.  
Help when I was sad and need guidance.  
Helpful staff.  
I had a lot of support while I’m here.  
I was treated with respect and got another opinion.  
No matter what the decision was they helped a lot.  |
| Coping skills | Better coping skills.  
Coping skills to better control my anger.  
Coping skills, coloring, talking and sleeping.  
Coping skills (x8).  
How I cope when things go wrong.  
I learned some new coping skills not only that, made some new friends that helped me cut a lot.  
I learned to cope with my anger issues better than before.  
Learned new coping skills and group.  
Learning new things like new coping skills and healthy relationships with my family.  
The most helpful thing I received during the program were better coping skills.  
The school and coping skills.  
The social time really helped me cope and it took some stress off.  
They helped me to over pass negativity.  
To realize that there is always going to be someone in the way but to move on from them.  |
| Groups | Art therapy (x2).  
Coloring, having fun, toys.  
Free time to think and get rid of stress.  
Going to group (x4).  
Having groups and not having groups.  
Music and art.  
Musical therapy, going to school and going to O.T.  
OT groups (x5).  
School classes, assisting with my questions/concerns (x2).  
Them giving me books to read and a journal to keep my notes.  
Work and art and school and staff.  
Working in group and with others.  |
| Medication | I got help getting on my ADHD meds.  
I got my medicine I went to school got some coping skills in I got better behavior.  
Med and therapy resources.  
Medication (x8).  
My medicine, coping skills I received therapy.  
Putting me back on the meds.  
The groups all medicine really helps me.  
The meds and having someone to talk with.  
They gave medicine when I needed it.  |
<table>
<thead>
<tr>
<th>Category</th>
<th>Comments: &quot;Most Helpful Things You Received During Your Stay&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe environment</td>
<td>A quiet place to be when I get mad.</td>
</tr>
<tr>
<td></td>
<td>Having to rest when needing.</td>
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<tr>
<td></td>
<td>I was given time to process thoughts.</td>
</tr>
<tr>
<td></td>
<td>Sleep, people I knew from last time I was here.</td>
</tr>
<tr>
<td></td>
<td>Sleep (x4).</td>
</tr>
<tr>
<td></td>
<td>The ability to stay in my room whenever I wanted.</td>
</tr>
<tr>
<td></td>
<td>1. Someone to talk to.</td>
</tr>
<tr>
<td></td>
<td>2. People who actually listen.</td>
</tr>
<tr>
<td></td>
<td>A person to talk to and a friend that I could discuss philosophy with as well as time outdoors.</td>
</tr>
<tr>
<td></td>
<td>Attention, support, a shoulder to lean on during hard times.</td>
</tr>
<tr>
<td></td>
<td>Being able to get stuff off my chest and being able to talk to people.</td>
</tr>
<tr>
<td></td>
<td>Being able to talk about problems and the best way to solve them</td>
</tr>
<tr>
<td></td>
<td>Being able to talk and to feel comfortable with talking, which was one of my main problems.</td>
</tr>
<tr>
<td></td>
<td>Being able to talk to many different doctors and see different perspectives.</td>
</tr>
<tr>
<td></td>
<td>Being able to talk to someone.</td>
</tr>
<tr>
<td></td>
<td>Emotional support.</td>
</tr>
<tr>
<td></td>
<td>Having someone to talk to if I needed it.</td>
</tr>
<tr>
<td></td>
<td>Having someone to talk too.</td>
</tr>
<tr>
<td></td>
<td>Help with talking and expressing more feelings.</td>
</tr>
<tr>
<td></td>
<td>I learned how to talk to people more.</td>
</tr>
<tr>
<td></td>
<td>I was able to open up and talk about my life with strangers.</td>
</tr>
<tr>
<td></td>
<td>People to talk to and the medicine.</td>
</tr>
<tr>
<td></td>
<td>People to talk to when I felt alone.</td>
</tr>
<tr>
<td></td>
<td>People understand how I was feeling and they calmed me down in times I needed it.</td>
</tr>
<tr>
<td></td>
<td>People/staff listened when I needed to talk.</td>
</tr>
<tr>
<td></td>
<td>Some staff talking to when I need.</td>
</tr>
<tr>
<td></td>
<td>Someone that I needed to talk to was one of the most helpful thing I received.</td>
</tr>
<tr>
<td></td>
<td>Someone to talk to (x4).</td>
</tr>
<tr>
<td></td>
<td>Talking and solutions to help.</td>
</tr>
<tr>
<td></td>
<td>Talking to nurses.</td>
</tr>
<tr>
<td></td>
<td>Talking to the doctors and opening up.</td>
</tr>
<tr>
<td></td>
<td>Talking with nurses, writing in my journal.</td>
</tr>
<tr>
<td></td>
<td>Talking with the doctors.</td>
</tr>
<tr>
<td></td>
<td>Talking.</td>
</tr>
<tr>
<td></td>
<td>The ability to communicate.</td>
</tr>
<tr>
<td></td>
<td>The talks I had with staff.</td>
</tr>
<tr>
<td></td>
<td>The talks the doctors gave me.</td>
</tr>
<tr>
<td></td>
<td>The talks with other people as in SW and therapist and OT.</td>
</tr>
<tr>
<td></td>
<td>They took time to hear me out.</td>
</tr>
<tr>
<td></td>
<td>Time and people to talk to.</td>
</tr>
<tr>
<td></td>
<td>To talk to someone.</td>
</tr>
<tr>
<td>Staff listened to patient</td>
<td>Getting help (x3).</td>
</tr>
<tr>
<td></td>
<td>I was able to receive help when needed and was able to make friends to help me cope with things.</td>
</tr>
<tr>
<td></td>
<td>Improved physical, mental, and emotional health.</td>
</tr>
<tr>
<td></td>
<td>My therapy (x2).</td>
</tr>
<tr>
<td></td>
<td>Recognizing my anxiety.</td>
</tr>
<tr>
<td></td>
<td>Support with trauma.</td>
</tr>
<tr>
<td></td>
<td>Taking deep breaths.</td>
</tr>
<tr>
<td></td>
<td>That I got help!</td>
</tr>
<tr>
<td></td>
<td>The help I received was wonderful, but the most helpful thing was teaching me patience.</td>
</tr>
<tr>
<td></td>
<td>The help they give to me.</td>
</tr>
<tr>
<td></td>
<td>The most helped I received was getting my mind right.</td>
</tr>
<tr>
<td></td>
<td>They help me with all my problems (x2).</td>
</tr>
</tbody>
</table>
### Comments regarding "What would improve the program here"  n=139

<table>
<thead>
<tr>
<th>Category</th>
<th>Comments &quot;What would improve the program here&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better food</td>
<td>A tv in the rooms and better food.</td>
</tr>
<tr>
<td></td>
<td>Better food and more physical activities.</td>
</tr>
<tr>
<td></td>
<td>Better food better pillows.</td>
</tr>
<tr>
<td></td>
<td>Better food get shoes/house shoes/slippers.</td>
</tr>
<tr>
<td></td>
<td>Better food since I have a eating problem and bad food doesn't help.</td>
</tr>
<tr>
<td></td>
<td>Better food, better bed, better service, better sink.</td>
</tr>
<tr>
<td></td>
<td>Better food (x48).</td>
</tr>
<tr>
<td></td>
<td>Can you please fix the food?</td>
</tr>
<tr>
<td></td>
<td>Everything, food and staff.</td>
</tr>
<tr>
<td></td>
<td>Fire cooks.</td>
</tr>
<tr>
<td></td>
<td>Fix your food.</td>
</tr>
<tr>
<td></td>
<td>Food being better, equate staff properly.</td>
</tr>
<tr>
<td></td>
<td>Food could have been better.</td>
</tr>
<tr>
<td></td>
<td>Food need to be better because patients are still human too (not stale/hard/old).</td>
</tr>
<tr>
<td></td>
<td>Food sucks, but was plenty.</td>
</tr>
<tr>
<td></td>
<td>I would say better food and instead of &quot;quiet hours&quot; at 8:30 it could be like 9:15 I just don't understand.</td>
</tr>
<tr>
<td></td>
<td>Maybe better nutrition in food so it can look more appetizing.</td>
</tr>
<tr>
<td></td>
<td>The food a little, it wasn't that good.</td>
</tr>
<tr>
<td></td>
<td>The food and 3rd shift (which is very rude).</td>
</tr>
<tr>
<td></td>
<td>The food need a little more help on it.</td>
</tr>
<tr>
<td></td>
<td>The food please for the sake of life fire the cooks.</td>
</tr>
<tr>
<td></td>
<td>The food was nasty.</td>
</tr>
<tr>
<td></td>
<td>The food wasn't really that good.</td>
</tr>
<tr>
<td></td>
<td>The food, its bad.</td>
</tr>
<tr>
<td></td>
<td>The food, it's juice.</td>
</tr>
<tr>
<td></td>
<td>What would better if we had better food.</td>
</tr>
</tbody>
</table>

<p>| Communication       | Having kids be listened to and stay longer.   |
|                     | I was a bit confused on how things worked here. |
|                     | They should talk more to us, one on one actually see what's going on. |
|                     | To talk more often with the patients and have more group setting therapy. |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Comments &quot;What would improve the program here&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>No improvements needed</td>
<td>Honestly I think this program is great and it helped me in every way needed. I don't think it needs improvement. I just wanted to thank this program and all staff for making me feel I can do the right thing and that there's always another chance at life. I love all the people that help me and I love that I am a better person. I think the program is fine. I think y'all are the best here no change or improvements needs to be done. It's good the way it is. Nothing (x13) Nothing everything find here everything is just right. Nothing everything was good. Nothing its good. Nothing really. Nothing should change. Nothing this is perfectly fine. On top of the game don't have to improve nothing. Russ was awesome to talk to Sunday night. Ayana was great, made me laugh. Karlman was fun too. Thank you all, I have a whole family. Thanks for helping. The nurse Mariella, James, and Rebecca were really nice. They all are good people here and they help people with needs. There are good workers. This place is the best.</td>
</tr>
<tr>
<td>More groups, activities</td>
<td>Activities at night for those with trouble getting or staying asleep. Activities on the weekend. Group therapy. Better food, more activities to do. I really like the staff but it would be better if they could keep the kids under control. Keep the CNA's program going as long as possible. Going outside more please. Little more school time. More 1:1 therapy. More activities (x3). More entertaining things to do during free time. More group on week days. More groups and teach things. More groups. More groups/therapy. More helpful necessary groups, genuine talk from the staff. Busy days instead of sitting around. More help from staff. Staff knowing the rules and not telling patients different rules. Take us outside more.</td>
</tr>
<tr>
<td>Respectful staff</td>
<td>All staff to try to understand what may be going on. For most of the nurses to start paying more attention and being more respectful. Maybe a little more respect. Nicer staff. People. Some of the staff can be a bit more nicer. Staff quality (nurses). Staff was cursing a lot. The 2pm shift CNAs and RNs talk about everyone and use mean words. Well the workers downstairs could have better attitudes towards family.</td>
</tr>
<tr>
<td>Treatment</td>
<td>Better treatment plans. Better food.</td>
</tr>
</tbody>
</table>
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: _____ / _____ / _____

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, I am satisfied with the services I received.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I helped to choose my services.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. I helped to choose my treatment goals.</td>
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<tr>
<td>4. The people helping me stuck with me no matter what.</td>
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<tr>
<td>5. I felt I had someone to talk to when I was troubled.</td>
<td></td>
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</tr>
<tr>
<td>7. I received services that were right for me.</td>
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<tr>
<td>8. The location of CAIS was convenient.</td>
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<tr>
<td>9. Services were available at convenient times for me.</td>
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</tr>
<tr>
<td>10. I got the help I wanted.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11. I got as much help as I needed.</td>
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<td></td>
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<td></td>
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<tr>
<td>12. Staff treated me with respect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13. Staff respected my family's religious/spiritual beliefs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Staff spoke with me in a way that I understood.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Staff were sensitive to my cultural/ethnic background.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>As a result of the CAIS program:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>16. I am better at handling daily life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I get along better with family members.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>18. I get along better with friends and other people.</td>
<td></td>
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<td></td>
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<tr>
<td>19. I am doing better in school and/or work.</td>
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</tr>
</tbody>
</table>
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
- Black (African American)
- Spanish/Hispanic/Latino
- White (Caucasian)
- Asian/Pacific Islander
- Other

Age: ______ years old

Gender (mark with X): __Male  __Female
Update on the centralized electronic data system, Verge Health. This electronic system is used to track all BHD compliments, complaints, and grievances to utilize client feedback data for service enhancement and improvement.

The implementation of Verge Health Systems has increased BHD’s ability to reliably track and record data as it relates to improving the process of responding to all incidents reported to BHD.

Improve the patient experience by increasing the timeframe in which concerns are addressed.

Verge Health improves BHD’s ability to track reported interactions. The data system is used to ensure each incident is appropriately addressed to ensure organizational compliance.

Progress:


- Compliments, complaints & grievances tracked in the system include:
  - Psychiatric Crisis Services, Observation and Inpatient Units
  - Access Clinic
  - Community Consultation Team
  - Day Treatment
  - Wraparound Wellness Clinic
  - Fiscal Management Department (billing)
  - Children’s Mobile Crisis Team (formerly known as the Mobile Urgent Treatment Team)
  - Crisis Mobile Team (adult services)
Quality Management Services Update
Compliments, Complaints & Grievance
Executive Summary

2018 Data & Trends (01/01/2018-12/31/2018)

Case Type:

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<tr>
<th></th>
<th>2017</th>
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<tr>
<td></td>
<td>51 total entries into Verge Health</td>
<td>44 total entries into Verge Health</td>
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<tr>
<td></td>
<td>Complaint 54% (28)</td>
<td>Compliant: 59% (26)</td>
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<tr>
<td></td>
<td>Grievance 42% (22)</td>
<td>Grievance: 25% (11)</td>
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<tr>
<td></td>
<td>Compliment 2% (1)</td>
<td>Compliment: 14% (6)</td>
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<tr>
<td></td>
<td></td>
<td>Suggestion: 2% (1)</td>
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Case Type 2017 & 2018

![Bar chart showing comparison of 2017 and 2018 case types](image)

<table>
<thead>
<tr>
<th></th>
<th>2017 Data Totals</th>
<th>2018 Data Totals</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Complaint</td>
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<td></td>
<td>Grievance</td>
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<td>Compliment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Suggestion</td>
<td></td>
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</tbody>
</table>

Graph 1
Locations Reporting Highest Incidents

43C-Womens Treatment Unit (34%)
Psychiatric Crisis Services (27%)
43B-Adult Treatment Unit (14%)
43A-Intensive Treatment Unit (9%)

Top 4 Locations of Concern

Graph 2
1. **Staff Behavior: Intervention** (15)

   a. Customer service strategies

      - Three RN Educators were hired to educate and provide training on customer service and quality assurance.

      - Approximately 40 certified nursing assistants have been promoted to Psych Tech positions.

      - The new Psych Tech position will provide more engagement and additional training on de-escalation and conflict resolution.

      - RN Managers conduct weekly monitoring with staff to ensure excellent patient care and all concerns are addressed in a timely manner.
2. Discharge Process (6)

a. Discharge Delay

- The discharge/treatment team has reviewed and evaluated the concerns of delay when discharged and there is a process in place.

b. Discharge planning process

- The nursing team and the treatment team work collectively to provide effective and timely communication to the patient, and/or guardian regarding discharge.

- The social worker makes all the arrangements for discharge and communicates with the patient, and/or guardian for all discharge planning. Follow-up and additional support is given by Team Connect.

- The purpose of Team Connect is to provide additional support via phone and in person when needed, to persons 18 years and older who are discharged from the following Behavioral Health Division (BHD) areas: Psychiatric Crisis Services (PCS), Observation Unit, and Acute Care Units.

Team Connect is intended to provide additional support to people following a visit or stay. Team Connect’s focus is to reduce the risk of harm to individuals post-discharge, help improve continuity of care, provide connections to community resources and promote overall wellness to reduce the incidence of hospital readmission, and visits to PCS.

3. Environment of Care (3)

2018 Environment of care concerns include:

- Light fixture is broken and needs a light bulb
- The toilet is plugged up
- There is a piece of broken furniture in the common area that needs to be replaced

a. Weekly environmental rounds are conducted to provide a safe and clean environment.

b. There is an environmental of care process that is in place along with policy and procedures for all staff to follow. A request to repair or replace is immediately put into the TMS system which populates a work order. That work order is sent directly to Engineering and Environmental Services for timely repair.
DATE: March 4, 2019

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 2018 Annual Review of the Environment of Care Program, and the 2019 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 2018 Annual Report of the Environment of Care program and the 2019 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.
2018 Environment of Care Annual Report & 2019 Goals
Introduction

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached are the 2019 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2018 improvements were made in the area of building security through the replacement of deteriorating doors and frames. In August and October BHD played a leading role in the Milwaukee Regional Medical Center’s Full Scale Emergency Exercise

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 2018 Annual Report and
2019 Goals

The BHD Environment of Care Management Plans were all reviewed and updated for 2019. Changes made included:

Updates were minimal to the various management plan content. Dates and goals were modified where appropriate.

Highlights of achievements and 2019 Goals:

GENERAL SAFETY

General safety improvements included expansion of the incident reporting system to include some non-patient related events related to fire events, medical emergencies and security events impacting employees.

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2018 the response rate of 96% was attained. There were a total of 1330 urgent recalls/alerts issued during 2018. Only 7 items involved in an alert or recall of a product purchased by BHD. All product alerts/recalls were resolved with no negative impact on patient care. 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 2017. Recommend continuing with this goal in 2018. The rounding system has being adjusted to provide more accurate tracking of deficiencies and correction timeframes. A partial set of rounds was completed in late 2018. Additionally a special set of rounds was completed in patient care areas to assess suicide risks in the environment. A report of the findings was submitted to the executive team.

3. In 2018 the total number of reported fire setting contraband items that were detected on patient units was 3. This meets the goal of having less than 4 contraband items on patient units.
   - In 2018 the goal will be to maintain the level of having less than 4 incidents. This item will be moved to general safety area and be reported on via incident reporting data.

SECURITY

Security improvements made at BHD include: Increase in staffing to accommodate requests made by medical staff to have more active roving officers on site, improvement in accountability of equipment used by Public Safety Staff, and increase performance with regards to emergency situations that may occur on site.

Previous Goals made:

1. The goal for 2018 will be to have a new Roll Call Update posted for each week of the year. Roll call updates will not only be posted for officer review but will be verbally reviewed with officers by supervisory staff of BHD Security.
   - Until new leadership was established, Roll Call updates did not appear to have been made before the month of October. Beginning with the month of October, new protocols were established to ensure that Roll Call updates were made on a daily basis. Though, this goal will not be listed in the goals for 2019, improvements will be continually made to ensure that accountability of all staffing and equipment is maintained.
2. The goal for 2018 was to limit the number of incidences of theft/vandalism to less than or equal to 3.

   - There were four incidents of vandalism were features of the building were damaged. (ceiling panel, security camera, and two window breaks) The latest incident involved damage to both the sliding door in PCS and a window directly next to the PCS entrance. Such incidences will continue to be recorded going into the new year. There was one theft of bus tickets and 3 reported incidents of missing patient property that could not be refuted.

3. Unauthorized absences from locked units: the goal for 2018 was to keep the total number of absences to zero.

   - This Goal was not met. There were a total of 10 elopements during the year. In all cases the individual was returned to BHD. This goal will also be carried into 2019.

4. Unsecured Area incidents: In 2018, the goal will continue to reflect the occurrence of both human factors as well as mechanical failures. The goal will be to have 10 or fewer incidents in 2018.

   - The Goal for 2018 was not met. The main concern observed is staff propping emergency doors open, or leaving them completely open. Though, there is not a specific number of incidences where emergency doors were left unsecured, the increase in Public Safety staffing will allow more opportunities for staff to check all exits and ensure that such incidences are kept at a minimal. This goal will also be carried into 2019.

5. The goal for 2018 is for the Security Department to make proper notification to BHD contacts within 1 hour of any noticeable outage. Security Department will strive to have no more than 6 occurrences where notification takes more than 1 hour.

   - Beginning with the month of October, there were only two recorded incidences of camera malfunctions. Both occurrences were reported to EES, along with myself, within an hour of it taking place.

2019 Goals:

1. Unsecured areas: In 2019, the goal will continue to reflect the occurrence of both human factors as well as mechanical failures. The goal will be to have 10 or fewer incidents in 2019.

2. The goal for 2019 is for, again, limit the number of incidences of theft/vandalism to less than or equal to 3.

3. Unauthorized absences from locked units: the goal for 2019 is to keep the total number of absences to zero.

4. Quarterly Mock Lockdown procedures: The goal for 2019 is to have Public Safety Staff perform a silent mock lockdown of the facility every quarter to ensure that all staff is prepared to perform their given duties during such an occurrence. Public Safety will work alongside Maintenance and EES to ensure that these exercises are performed without disrupting the daily operations that take place on site.

HAZARDOUS MATERIALS AND WASTE

In 2018, BHD expanded its recycling program to include various metal, plastics and glass bottles. Special recycling containers have been located throughout the facility to collect items for recycling.

In 2015, BHD was identified by the Wisconsin Department of Natural Resources (WDNR) rules as a generator of infectious waste. A generator produces more than 50# per month. Since that time, BHD, with increased surveillance and education, has reduced the amount of infectious waste generated in-house each year.
<table>
<thead>
<tr>
<th>Year</th>
<th>Total Weight (in lbs)</th>
<th>Monthly Average (in lbs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>3262</td>
<td>272</td>
</tr>
<tr>
<td>2015</td>
<td>1589*</td>
<td>132</td>
</tr>
<tr>
<td>2016</td>
<td>885**</td>
<td>74</td>
</tr>
<tr>
<td>2017</td>
<td>492.59</td>
<td>41</td>
</tr>
<tr>
<td>2018</td>
<td>490.35</td>
<td>40.88</td>
</tr>
</tbody>
</table>

*2015 December weights estimate  
**2016 Jan, Feb and Dec weights estimated

An infectious waste report for 2018 was filed with the WDNR in January.

BHD’s 2019 goal is to continue the downward trend and achieve the 50# per month of regulated medical waste generation for the twelve month period thereby eliminating the DNR reporting requirement.

**EMERGENCY MANAGEMENT**

1. Two Drills/Exercises are required. Drills completed in 2018 include:
   - Tornado Drill in April in conjunction with Statewide event
   - June – Table top exercise regarding a public health outbreak and the option for BHD to become a closed point of distribution for employees and their families so that we can remain functional during a public health outbreak.
   - August – Table top exercise with BHD leadership regarding a violent event on campus in preparation for the Campus wide table top. A repeat practice session is planned for October.
   - Campus wide table top exercise provided insight into BHD and campus capabilities for a violent event.
   - September – Office of Emergency Management is conducting a county table top exercise for departments to test the Continuity of Operations Plan (COOP) Sept 24th.
   - October – Full Scale Exercise on MRMC Campus simulating a shooter on campus. This tested the campus wide Emergency Coordination Plan. BHD was one of the lead staff for the event and the culmination was simulated to be at BHD but took place at the old CATC building. Multiple organizations were involved in the planning and implementation of the drill. The six partner facilities along with the following agencies participated:
     - 911 Communications Division
     - Milwaukee County Office of Emergency Management
     - Milwaukee Police Department
     - Wauwatosa Fire Department
     - Wauwatosa Police Department
     - Wisconsin Lutheran College

BHD tested internal and external communication systems including the Everbridge system, the establishment of an Incident Command Center, Joint Information Center, and security response/lockdown processes.

2. Two additional management staff were trained in ICS 100 and 200 during 2018. 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 targeted for this training and there are currently 7 of 10 AOC staff have been trained. There are additional staff throughout the facility who are also trained and/or experienced with the Incident Command system.

3. Other activities:
   - Continuity of Operations Plan (COOP) was updated for 2018 to include back up plans for computer application failures, and contract contact information.
   - Work continues on the Emergency Operations Plan (EOP) components.
   - Hazard Vulnerability Assessment was completed by the committee and will be used to prioritize the revision of the emergency response plans of the EOP.
2019 Goals:
1. 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) for use at BHD. This may be blended with the existing BHD Emergency response guide flip chart.
3. Complete the Closed Point of Distribution Plan partnering with the Wauwatosa Health Department to provide mass prophylaxis to our staff and their families in the event of a public health outbreak.
4. Hold or participate in two emergency exercises per year (Goal =2)

FIRE PREVENTION
In 2018 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.

1. The goal of 100% of scheduled fire drills (60) being performed was achieved.
2. The goal of having the average score of on the fire drill check sheets being 97% or greater was achieved.
3. The goal of having zero reported accounts of fire setting contraband found on patient units was achieved.
4. The goal of having zero fire panel / trouble alarms was achieved.

All of these goals will be carried forward into 2019 with no adjustments.

UTILITIES MANAGEMENT

1. The goal of having 90% of scheduled P.M.’s being performed was achieved. For 2019 this goal will be increased to 100% of scheduled P.M.’s accomplished.
2. The goal of having 100% of the branch valves labeled and inventoried was not achieved; 75% of the branch valves were labeled and inventoried. This goal will remain for 2019.
3. The goal of having the emergency generator tested on a weekly basis was achieved and the goal of having zero emergency generator failures was achieved. This goal will continue through 2019.

MEDICAL EQUIPMENT

No new clinical equipment was purchased in 2018. 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.

Medical equipment removed from service during 2018 include geriatric chairs and air mattresses.

EDUCATIONAL GOALS

In 2018 trainings regarding General BHD Safety, Active Shooter, Workplace Safety, OSHA Safety, and Fire Safety were completed. Completion rates for these trainings are still being tabulated.
## EDUCATIONAL CALENDAR 2019

<table>
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<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
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<td>First Responder Philosophy</td>
<td>Panic Alarm Use/Response</td>
<td>Elopement</td>
<td>Fire Safety</td>
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<tr>
<td>Medication Administration/Safety (hospital nursing staff only)</td>
<td>Use of Personal Protective Equipment</td>
<td>Hazardous Medication Handling (hospital nursing staff only)</td>
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<tr>
<td>Parking Lot/Personal Safety</td>
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- First Responder Philosophy-based on Vistelar and American Heart Association standards for responding to Behavioral Emergencies
- Medication Administration/Safety-for BHD hospital nurses to ensure safe handling and preparation for administration of medications
- Parking Lot/Personal Safety-to incorporate personal safety/awareness of environment topics, ID badges
- Panic Alarm Use/Response-Reinforce need to use/wear panic alarm; who should be responding to alarms; review of the policy
- Inpatient Elopement-Review of the policy; techniques to avoid elopements from occurring
- Hazardous Medication Handling-Training for hospital based nurses regarding commonly used psychiatric educations requiring special handling
- Fire Safety-Depth of “hands on” training to be determined
- The above would be in addition to the yearly trainings such as those required by OSHA

The Environment of Care Committee recommends the following key goals for 2019:

- 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.
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 administer 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/Iincident 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 topics 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.
   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. Develop 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.
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.)
i. Annually, assess the effectiveness of implemented recommendations.

3. EMERGENCY MANAGEMENT (EM 01.01.01; EM 02.01.01; EM 02.02.01; EM 02.02.03; EM 02.02.05;
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.


k. Annually, assess the effectiveness of emergency management programs.


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.


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.
I. 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.


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.


o. Annually, assess the effectiveness of the Fire Prevention Program, policies/procedures and educational components.


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 topics 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 Distribution 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.


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 EHD 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 inservices.

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**

1. **Track the frequency of weekly roll call meetings.** (Goal = 52)
2. **Number of incidents where a secure area is found unsecured.** (Goal ≤ 10 times)
3. Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)
4. **Number of incidents where a secure area is found unsecured.** (Goal ≤ 10 times)
5. **Camera outages will be reported to Operations within 1 hour.** (Goal ≤ 5 times)
6. **Conduct quarterly mock lockdown procedures for Security and Maintenance staff.** (Goal = 4)

**Hazardous Materials Management**

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

**Emergency Management**

1. **Increase the number of Management Team members trained in ICS/HICS (100 & 200) by 25%**
2. **Hold or participate in two emergency exercises per year (Goal = 2)**
3. **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)**

**Fire Prevention**

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

**Utilities Management**

1. Measure the completion rate of preventive maintenance tasks (Goal = 90\%)
2. Measure the percentage of utility branch valves labeled and inventoried (Goal = 80\% by year's end)
3. 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 reviews 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: 3-8-192-14-19

Reviewed and approved at the Medical Executive Committee meeting on: 3-21-192-20-19

**Attachments:**

No Attachments
## Approval Signatures

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

G. Safety Officer Appointment – (EC01.01.01-EP1) The Hospital Administrator is responsible for managing
the Safety Officer appointment process. If the position should become vacant, the Hospital Administrator is responsible for selecting a qualified individual capable of overseeing the development, implementation, and monitoring of the Safety Management Program.

H. **Intervention Authority** – 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/Doctors 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
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, 2007 the use of
all tobacco products (cigarettes, e-cigarettes, vaporizing (vape) pens, cigars, pipes, chewing tobacco, and
other smokeless tobacco) 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: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee meeting on: 3-24-182-20-19
### Approval Signatures

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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 183) – 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 EP 1 & 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. Contract 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:

1. Track the frequency of weekly roll call meetings. (Goal = 52)
2. Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)
3. Decrease the number of Theft/Vandalism incidents. Goal ≤ 3 incidents (This includes theft of patient belongings)
4. Number of incidents of unauthorized Absence from locked unit. (Goal = 0)
   Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)
   Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)
5. Conduct quarterly mock lockdown procedures for Security and Maintenance staff. (Goal = 4)

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 reviews 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: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee meeting on: 3-24-182-20-19

Attachments: No Attachments

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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
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 Wastes including Sharps - (EC 02.02.01 EP 1; IC 02.01.01 EP 6)
Wisconsin state statute defines the following:

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

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

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

RMW minimization efforts begin at procurement as any new product purchased for use at the BHD requires the approval of the Infection Prevention (IP) Committee. To improve waste management practices, BHD's IP Committee may consider costs, probable adverse effects on staff, patients or patients' 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 (i.e. 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 (e.g., 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 – HMW-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: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee meeting on: 3-24-182-20-19

**Attachments:**

**Approval Signatures**

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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 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 Intellige:
- 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 Watertow 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 environmenta 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/year)

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

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

ANNUAL EVALUATION

(FC 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 reviews 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: 3-8-182-14-19

Reviewed and approved at the Medical Executive Committee meeting on: 3-24-182-20-19

Attachments:

No Attachments

Approval Signatures

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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 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 MCBHJD, 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 Devices/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 on 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 the 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: 3-8-182-14-19
Reviewed and approved at the Medical Executive Committee meeting on: 3-24-1802-20-19

**Attachments:**

No Attachments

**Approval Signatures**

<table>
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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
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 facility’s 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 communicators. 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 BH-D. Contracted Employees attend a new employee orientation program at BH-D 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 = 99100%)
   2. Measure the percentage of utility branch valves labeled and inventoried (Goal = 90100% by year end)
   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 BH-D 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 BH-D 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 or 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: 3-8-18 2-14-19

Reviewed and approved at the Medical Executive Committee Meeting on: 3-21-18 2-20-19

**Attachments:**

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## Quality Committee Item 8

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

### Baseline 71.5% as of August 2016 LAB report

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### Overall Progress 95.5% as of February 1, 2019

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### Forecast Due for Review

**Past Due Policies - 25**
- July - 8
- August - 45
- September - 1
- October - 4
- November - 10
- December - 18
- January - 10

**Coming Due Policies**
- February - 3
- March - 3
- April - 2
- May - 2
- June - 11
COUNTY OF MILWAUKEE  
Behavioral Health Division Medical Staff Organization  
Inter-Office Communication

DATE: March 28, 2019

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 Appointment and Privilege Recommendations Made by the Medical Staff Executive Committee

Background

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

Discussion

From the President of the Medical Staff Organization and Chair of the Medical Executive Committee presenting recommendations for appointments and/or privileges. Full details are attached specific to items A through C:

A. New Appointments

B. Reappointments

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

D. Notations Reporting (to be presented in CLOSED SESSION in accordance with protections afforded under Wisconsin Statute 146.36)
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 - License, DEA, Certification -- Verifications, Monitoring & Adverse Action Reporting

Respectfully Submitted,

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

Attachments

1. Medical Staff Credentialing Report & Medical Executive Committee Recommendations
2. Policy Update: Medical Staff and Advanced Practice Professional/ Licensed Independent Practitioner - License, DEA, Certification--Verifications, Monitoring & Adverse Action Reporting
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
GOVERNING BODY REPORT  
MEDICAL STAFF CREDENTIALING REPORT & EXECUTIVE COMMITTEE RECOMMENDATIONS  
MARCH-APRIL 2019

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.

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<th>NOTATIONS</th>
<th>SERVICE CHIEF(S) RECOMMENDATION</th>
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<th>RECOMMENDED CATEGORY/ STATUS</th>
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The following applicants are completing the required six month minimum provisional period, as required for all initial appointment and/or new privileges.

**MEDICAL STAFF**

- **Peter DeVries, MD**  
  - Psychiatric Officer and Medical Officer of the Day  
  - Affiliate/ Provisional  
  - Affiliate / Full  
  - Dr. Thresher recommends full privileges  
  - Committee recommends change in privilege status from provisional to full in conjunction with reappointment recommendation.  
  - Recommends privileging status change, as per C&PR Committee.

- **Olga Hacden, MD**  
  - General Psychiatry  
  - Affiliate/ Provisional  
  - Affiliate / Full  
  - Dr. Zincke recommends full privileges  
  - Committee recommends change in privilege status from provisional to full in conjunction with reappointment recommendation.  
  - Recommends privileging status change, as per C&PR Committee.

- **Hannah Rolland, DO**  
  - Psychiatric Officer and Medical Officer of the Day  
  - Affiliate/ Provisional  
  - Affiliate / Full  
  - Dr. Thresher recommends full privileges  
  - Committee recommends change in privilege status from provisional to full in conjunction with reappointment recommendation.  
  - Recommends privileging status change, as per C&PR Committee.

- **Codie Vesser, MD**  
  - Psychiatric Officer and Medical Officer of the Day  
  - Affiliate/ Provisional  
  - Affiliate / Full  
  - Dr. Thresher recommends full privileges  
  - Committee recommends change in privilege status from provisional to full in conjunction with reappointment recommendation.  
  - Recommends privileging status change, as per C&PR Committee.

- **Scott Wiener, MD**  
  - General Psychiatry  
  - Active / Provisional  
  - Active / Full  
  - Dr. Zincke recommends full privileges  
  - Committee recommends change in privilege status from provisional to full in conjunction with reappointment recommendation.  
  - Recommends privileging status change, as per C&PR Committee.
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<th>PROVIDENTIAL STATUS CHANGE REVIEWS</th>
<th>PRIVILEGE GROUP(S)</th>
<th>CURRENT CATEGORY/STATUS</th>
<th>RECOMMENDED CATEGORY/STATUS</th>
<th>SERVICE CHIEF RECOMMENDATION</th>
<th>CREDENTIALING &amp; PRIVILEGING REVIEW COMMITTEE MARCH 6, 2019</th>
<th>MEDICAL STAFF EXECUTIVE COMMITTEE MARCH 20, 2019</th>
<th>GOVERNING BODY (COMMENT REQUIRED FOR MODIFICATIONS ONLY)</th>
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**Chair, Credentialing and Privileging Review Committee (OR PHYSICIAN COMMITTEE MEMBER DESIGNEE):**

3/20/19

President, Medical Staff Organization
Chair, Medical Staff Executive Committee

3/20/19

**Board Comments / Modifications / Objections to MEC Privileging Recommendations:**

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

**Governing Board Chairperson:**

**Date:**

**Board Action Date:** April 25, 2019

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
MEDICAL STAFF CREDENTIALING & EXECUTIVE COMMITTEE REPORT TO GOVERNING BODY – MARCH-APRIL 2019

PAGE 2 OF 2

2019-APRIL MEC Privileging Recommendations Report to Governing Board-Final.doc
POLICY

It is the policy of the BHD Medical Staff Organization that all Medical Staff, Advanced Practice Professional Staff and any other Licensed independent Practitioner granted privileges shall be required to obtain and maintain essential licenses, registrations and certifications to practice their profession. Medical Staff Services shall be responsible for keeping accurate documentation on required professional licenses, registrations, certifications, insurance and malpractice (when required) current in each practitioners' credentials file and for working with the Chief Medical Officer and President of the Medical Staff Organization for reporting adverse actions to the appropriate regulatory agencies, as required by law.

PURPOSE

To provide a mechanism to ensure the maintenance of current professional licensure and other required registration and certification information for Medical Staff members, Advanced Practice Professionals and other licensed independent practitioners with privileges, and to deal with adverse actions against these licenses, registrations and certificates.

SCOPE

- All Medical Staff (physicians, dentists, podiatrists, psychologists)
- All Advanced Practice Professionals that make application for and are granted clinical privileges.
- Other licensed independent practitioners that require and are granted privileges by BHD

PROCEDURE

Monitoring of Expirables

Each month, an audit will be done of the Medical Staff Services database to determine which practitioners have Professional License, DEA Registration, Board Certification or liability and malpractice insurance, as applicable, coming due for renewal.
Professional Licenses

A. Initial Appointment

All Medical Staff, Advanced Practice Professionals and other licensed independent practitioners (LIPs) shall be required to provide a copy of his/her medical/professional license(s) to the Medical Staff Office as part of the initial application credentialing verification process to affirm credential number ownership.

Medical Staff Services shall conduct a primary source verification (PSV) of each applicant’s required license(s), as part of the initial credentialing verification process by querying the Wisconsin Department of Safety and Professional Services. The Medical Staff Services professional conducting the PSV shall affix his/her initials or signature to each verification document by the electronically generated date as proof of timely completion. All PSVs shall be completed prior to receiving a recommendation for privileges and shall be filed and maintained in each applicant’s credentialing binder.

In the case of telemedicine staff, the Professional Licensing Board in the practitioner’s place of practice/home state shall also be queried with PSV documented in the same manner described above. For telemedical practice, the practitioner must be licensed in both the state where the practitioner is located and in the state where the patient is located.

Medical Staff Services shall provide a copy for each employed Medical Staff and Advanced Practice Professional license with copy of the authenticated primary source verification to BHD Human Resources prior to the practitioner’s start date.

B. Professional License Renewal

Wisconsin Medical/Professional license renewal occurs biennially. Approximately six weeks prior to license expiration, Medical Staff Services will send notice to each Medical Staff Member and Advanced Practice Professional (LIP) informing them of upcoming license expiration and need for renewal. A second reminder will be made approximately two weeks prior to license expiration. A third reminder and notification shall be made at least five days prior to license expiration to any Medical Staff or Advanced Practice Professional (LIP) found not to have initiated the renewal process, with copy to the Service Medical Director and Chief Psychologist, when applicable. Notifications may occur through written correspondence including inter-office or postal mail, e-mail or faxed communications. When necessary, verbal communications shall be made with details documented (e.g., date, time and type of communication—in person, by phone, by voicemail message).

Medical Staff Services shall conduct a primary source verification of each privileged license holder prior to credential expiration to verify renewal status. The Medical Staff Services professional conducting the PSV shall affix his/her initials or signature to each verification document by the electronically generated date. All license renewal PSVs shall be filed and maintained in each applicant’s credentialing binder. Historical PSVs shall also be maintained.

Medical Staff Services shall provide a copy of all completed primary source verifications, for employees' license renewals, to BHD Human Resources. Medical Staff Members and Advanced Practice Professionals (LIPs) shall not be required to provide a license copy, at time of renewal.

Out-of-state medical/professional license renewal, when required in connection with BHD privileges, shall be monitored and verified from the applicable state licensing board(s), in the same manner outlined above.
C. Failure to Renew Required License Before Expiration

If a Medical Staff Member or Advanced Practice Professional (LIP) fails to renew or initiate renewal of a required license prior to expiration date, as per state requirements, it shall result in automatic suspension of all privileges immediately upon license expiration, with no right to hearing or appellate review. The practitioner is automatically suspended from practice on the first business day after license expiration until there is evidence of license renewal. An email is sent to the practitioner, Service Medical Director, Chief Psychologist (when applicable) and President of the Medical Staff indicating membership suspension with copy placed in the practitioner’s credentialing file. The credentialing database is updated with notation on practitioner’s privileges to reflect the suspension.

- Notification to the Medical Staff Member or Advanced Practice Professional (LIP) shall state that s/he has ten days to obtain license renewal.
- For Active Staff and full or part-time employed Advanced Practice Professionals, suspension may be with or without pay, as determined by the Chief Medical Officer (or designee).
- All other staff, including contractors, shall be removed from the schedule, without pay. The practitioner may be removed from suspension once the license has been renewed and verified.

Failure to produce or obtain renewed Wisconsin Medical/Professional licensure within ten days of expiration will necessitate charges being filed by the Milwaukee County Behavioral Health Division for the practitioner’s dismissal and/or termination of contract, as applicable.

D. Restricted/Limited License Status

For Medical Staff Members or Advanced Practice Professionals with a restricted or limited license, a copy of the restrictions/limitations, as specified by Licensing Board Order, shall be placed with the Medical Staff Member’s or Advanced Practice Professional’s credentials. Medical Staff Services shall monitor adherence with the Board Order requirements of any Medical Staff Member or privileged Advanced Practice Professional with a restricted or limited license. Monitoring requirements under this section do not pertain to practitioners who hold a medical/professional license(s) that is limited to tele-medical practice only, in states whereby that is the standard.

The Chief Medical Officer (or designee) shall inform the Administrator of the Behavioral Health Division of all Medical Staff Members being considered for appointment or those currently privileged who have a restricted or limited license.

Drug Enforcement Administration Registrations

A. Initial Appointment

Medical Staff Members and Advanced Practice Professionals, as applicable, shall be required to provide proof of DEA registration to the Medical Staff Office as part of the initial credentialing verification process. All physicians, dentists and podiatrists must possess a DEA that includes all schedules (2, 2N, 3, 3N, 4 and 5). For Advanced Practice Professionals, DEA schedules and requirements are based on scope of license and service. Verification of current DEA registration will be obtained directly from the Drug Enforcement Administration or National Technical Information Service (NTIS on-line verification) of the U.S. Department of Commerce prior to the practitioner receiving privileges.

B. Drug Enforcement Administration (DEA) Renewal

DEA registration renewal occurs triennially. Approximately six weeks prior to DEA expiration, Medical Staff Services will send notice to Medical Staff Members and Advanced Practice Professionals, as applicable, informing them of upcoming DEA expiration and need for renewal. A second reminder will be
made prior to expiration. Additional follow-up notices will be made, as necessary.

Medical Staff Members and Advanced Practice Professionals, as applicable, shall be required to provide proof of DEA renewal by providing a copy of the renewed certificate for inclusion in their credentialing and privileging file. Medical Staff Services shall monitor renewal status directly with the Drug Enforcement Administration database or National Technical Information Service (NTIS on-line verification) of the U.S. Department of Commerce

1. If the practitioner fails to initiate renewal prior to registration expiration, the Chief Medical Officer shall be notified. Failure by a Medical Staff Member or Advanced Practice Professional, as applicable, to obtain or produce a current DEA registration or proof of on time renewal initiation shall lead to a restriction on his/her privileges. The practitioner’s right to prescribe, dispense, or administer medications covered by the certificate is automatically suspended until there is evidence of DEA registration renewal requirements having been met.

C. Drug Enforcement Administration (DEA) Restriction or Revocation
Restriction, revocation voluntary surrender of DEA registration shall be promptly reported (within two business days) by the privileged staff member and evaluated by the Credentialing and Privileging Review Committee or Chair, acting on behalf of the Committee, to determine whether privilege reduction or suspension may be required.

D. Prescriptive Authority Limitation
The BHD Pharmacy shall be notified promptly of all expired DEA registrations and shall be notified promptly of any limitations to a prescriber’s authority. Notification of renewal and reinstatement of authority shall be communicated as soon as verification of renewal has been obtained.

Board Certification

Medical Staff Services shall monitor the Board Certification status for all Medical Staff and Advanced Practice Professionals, when certification requirements pertain. This includes, but shall not be limited to, Service Medical Directors, tele-medicine Medical Staff and advanced practice nurses.

Insurance

Medical Staff Services shall monitor the malpractice insurance status for all Medical Staff and Advanced Practice Professionals required to carry private insurance. This includes, but shall not be limited to, all contracted Medical Staff, contracted Advanced Practice Professionals and/or their employees. Contracted practitioners with expired insurance will automatically be administratively suspended from practice on the first business day after expiration until there is evidence of current malpractice insurance. An email is sent to the practitioner/practitioner’s employer, the Chief Medical Officer and Medical Staff President indicating membership suspension. The credentialing database is updated and practitioner delineation of privileges are flagged to reflect these suspensions.

The practitioner may be removed from suspension once proof of renewed insurance is provided.

Monitoring for Adverse Actions

A. Medicare/Medicaid Sanctions: Office of Inspector General Exclusions
Upon initial appointment and reappointment, the U.S. Department of Health and Human Services, Office of Inspector General-List of Excluded Individuals and Entities (OIG-LEIE) shall be reviewed to check for practitioner specific OIG exclusions. On-line verification utilizing the searchable database official exclusions program will take place for each practitioner seeking appointment and privileges. The OIG exclusion program identifies all individuals and entities that are presently prevented to participate in
federally funded health care programs. Copies of the verification obtained from the OIG Exclusion program will be stored in each practitioner's credentials file. Any exclusions found will be promptly communicated to the Chief Medical Officer and to the Credentialing and Privileging Review Committee.

The OIG shall also be queried in connection with requests to amend privileges. Ongoing monitoring of OIG exclusion lists shall be reviewed on a monthly basis and within 30 days of release.

A query of the System for Award Management (SAM) shall also be conducted at time of initial appointment and at reappointment to verify historical exclusions not reflected on the OIG-LEIE.

B. Monthly Disciplinary Report - Wisconsin Department of Safety and Professional Service

The Wisconsin Department of Safety and Professional Services Disciplinary Actions Report is queried each month by Medical Staff Services. Names on the report are reviewed. If it is determined that a current member of the Medical Staff or a privileged Allied Health Professional staff member has had an action filed against his/her license, Medical Staff Services shall download documentation of the action from the Wisconsin DSPS.

Reports by the following Wisconsin Professional Boards shall be reviewed on a monthly basis, when applicable, based on Medical Staff and Advanced Practice Professional Staff professional categories currently holding privileges:
- Board of Medicine (includes Podiatric Medicine)
- Board of Dentistry
- Board of Psychology
- Board of Nursing
- Social Work Section

C. Out of State Professional Licenses

Telemedicine staff licenses shall be monitored via the American Medical Association continuous monitoring feature in addition to the applicable state licensing board sites.

D. Drug Enforcement Administration

The U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control is queried each month by Medical Staff Services. Names on the reports are reviewed (Criminal Cases Against Doctors and Administrative Actions Against Registrants). If it is determined that a current member of the Medical Staff or privileged Allied Health Professional Staff has had an action filed against his/her registration, Medical Staff Services shall immediately notify the Chief Medical Officer (or designee) of the action.

E. Adverse Action Monitoring Findings

If a current member of the BHD Medical Staff or privileged Allied Health Professional staff member is found on any of the above reports described as items A-D, the practitioner shall be reviewed by the Credentialing and Privileging Review Committee Chair or by the Committee within 30 days of report release. The practitioner shall be instructed to immediately provide a written explanation, if s/he has not
already done so. This documentation will become part of the practitioner's credentials file and will be forwarded to the Medical Staff Credentialing and Privileging Review Committee, Chief Medical Officer and Medical Staff President.

If license is suspended/revoked the practitioner will immediately be inactivated until further information is gathered.

If DEA is suspended/revoked the practitioner's prescriptive authority will immediately be inactivated until further information is gathered.

If Medicare/Medicaid exclusions or sanctions are imposed, the matter shall be immediately assessed to determine whether the practitioner is barred from providing services under the Centers for Medicare and Medicaid and/or services regulated by the Department of Health and Human Services and action taken, as appropriate.

If Board Certification is suspended/revoked, circumstances shall be reviewed by the Credentialing and Privileging Review Committee and action taken, as appropriate.

Corrective action may be initiated. The manner in which the corrective action is initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Medical Staff appointment and/or privileges shall be as detailed in Appendix I and Appendix II of the Medical Staff Organization Bylaws. For Allied Health Professional Staff, the manner in which the corrective action shall be initiated, the responsibilities of the Executive Committee and Governing Authority in corrective action, the forms of suspensions, and mechanisms for reduction or termination of Allied Health Professional appointment and/or privileges shall be as detailed in Appendix I and Appendix III of the Medical Staff Organization Bylaws.

Appropriate legal counsel shall be consulted, as needed.

**Adverse Action Reporting**

**A. Filing a Report with the Wisconsin Department of Safety and Professional Services**

On behalf of the Medical Staff Organization and/or Governing Body, Medical Staff Services, in collaboration with the BHD Medical Staff leaders, shall be responsible for reporting certain actions with respect to medical staff membership and clinical privileges of physicians, podiatrists, dentists, psychologists and advanced practice professionals to the Wisconsin DSPS. The reports must be filed when the actions are imposed, or voluntarily accepted, for a "medical/clinical disciplinary cause or reason" which means that an aspect of the practitioner's competence or professional conduct is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

**B. Filing a Report with the National Practitioner Data Bank**

On behalf of the Medical Staff Organization and/or Governing Body, Medical Staff Services, in collaboration with the BHD Medical Staff leaders, shall be responsible for reporting certain actions with respect to medical staff membership and clinical privileges of physicians, dentists, and other health care practitioners to the National Practitioner Data Bank on an Adverse Action Report Form.

NPDB Reportable actions include, but are not limited to:
• professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period of longer than 30 days
• voluntary or involuntary surrender or restriction of clinical privileges while under, or to avoid investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or professional review action
• failure to renew privileges while under or to avoid investigation
• adverse actions including reducing, restricting, suspending, revoking, or denying privileges, or a decision not to renew privileges, if that action or decision was based on the practitioner's professional competence or conduct
• voluntary withdrawal of an initial application for medical staff membership and/or clinical privileges while practitioner is under investigation by the hospital for possible professional incompetence or improper professional conduct or in return for not conducting such an investigation, or
• taking a professional review action summary suspension if in effect for more than 30 days, based on professional competence or professional conduct that could affect the welfare of a patient, or as a result of a professional review action taken by the hospital

Reports to the National Practitioner Data Bank will be filed in accordance with what the law requires, within required timelines and in the manner required under federal and state statutes and regulations. [https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp](https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp)

C. **Filing a Report with Other Agencies**

The Chief Medical Officer or his/her designee shall be responsible for working with Administration to report matters pertaining to unprofessional and/or unlawful conduct to the State of Wisconsin Department of Health and Human Services, the Office of the Inspector General (OIG), or to any other agency, when required by law.

**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.07.01.33; MS.13.01.01; MS.13.01.03 (Hospitals 01/2019); Centers for Medicare/Medicaid; DHS 124; National Association Medical Staff Services “Ideal Credentialing Standards (05/2014); NPDB Guidelines (10/2018) [https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp](https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp)

Delegated policy and procedure approval authority is granted to MEC by the Governing Authority as per MCBHD Medical Staff Organization Bylaws section 5.3.1 (13c); approved policies are presented to the Board as informational only.
Recommended for approval by Credentialing and Privileging Review Committee, 03/06/2019

Approved by Action of the Medical Staff Executive Committee, 03/20/2019

Informational Report to Mental Health Board, 04/25/2019

Attachments: No Attachments

| Approval Signatures |
|---------------------|-----------------|------------------|
| Step Description    | Approver         | Date             |
| Credentialing and Privileging Review Committee | John Schneider: 80040-Chief Medical Officer | pending |
| Medical Staff Services | Lora Dooley: 12009001-Medical Services Manager | 3/20/2019 |
|                     | Lora Dooley: 12009001-Medical Services Manager | 3/20/2019 |