Milwaukee County Behavioral Health Division
2018 Key Performance Indicators (KPI) Dashboard

2

Program	Item	Measure	2015 Actual	2016 Actual	2017 Actual	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	2018 Actual	2018 Target	2018 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs[5]	9,624	7,971	8,346	5,771	5,861	5,995	6,017	9,393	8,555		
		Sample Size for Rows 2-6 (Unique Clients)				3,546	3,371	3,477	3,515				
	2	Percent with any acute service utilization[6]	-	13.09%	17.40%	15.78%	15.91%	18.19%	18.30%	17.05%	16.52%		
	3	Percent with any emergency room utilization[7]		12.44%	13.87%	12.26%	13.82%	16.25%	16.05%	14.60%	13.04%		
	4	Percent abstinence from drug and alcohol use	-	66.71%	63.65%	65.22%	62.91%	63.14%	63.3%	63.65%	64.54%		
	5	Percent homeless	-	4.74%	7.61%	8.17%	9.67%	9.39%	9.50%	9.18%	7.24%		
	6	Percent employed	-	15.80%	18.09%	20.04%	20.32%	19.49%	20.40%	20.06%	18.58%		
		Sample Size for Row 7 (Admissions)		6,315		1,622	1,673	1,743	1,674				
	7	Percent of all admissions that are 30 day readmissions	19.6%	55.61%	59.55%	60.05%	62.22%	57.54%	60.66%	60.12%	58.47%		
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,329	3,500	3,404	1,749	2,185	2,506	2,955	2,955	3,670		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.6	4.6	4.8	4.5	4.5	4.6	4.6	4.60	> = 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	62%	60.2	65.7%	64.5%	63.6%	65.6%	65.9%	65.3%	> = 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.2	2.86	2.59	2.25	2.68	2.35	2.24	2.38	> = 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	58%	53.6%	57.8%	43.1%	53.0%	60.6%	47.0%	58.0%	> = 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	42%	43.6%	44.1%	40.8%	39.4%	38.3%	35.1%	38.4%	> = 50%		BHD (2)
Crisis Service	14	PCS Visits	10,173	8,286	8,001	1,866	1,844	1,821	1,844	7,375	8,000		BHD (2)
	15	Emergency Detentions in PCS	5,334	4,059	3,979	756	799	753	715	3,023	4,000		BHD (2)
	16	Percent of patients returning to PCS within 3 days	7.8%	7.9%	7.3%	6.2%	8.0%	7.6%	8.0%	7.5%	8%		BHD (2)
	17	Percent of patients returning to PCS within 30 days	25.0%	24.8%	23.1%	20.0%	26.3%	25.1%	24.5%	24.0%	24%		BHD (2)
	18	Percent of time on waitlist status	15.6%	80.1%	75.2%	54.3%	100.0%	95.7%	82.7%	83.2%	25%		BHD (2)
Acute Adult Inpatient Service	19	Admissions	965	683	656	189	183	195	203	770	800		BHD (2)
	20	Average Daily Census	47.2	45.8	42.9	40.6	44.1	41.1	41.6	41.8	54		BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	3%	3.6%	1.4%	0.5%	3.4%	0.5%	2.0%	1.6%	3%		BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	11%	10.8%	7.7%	5.2%	9.0%	4.9%	7.5%	6.6%	10%		NRI (3)
	23	Percent of patients responding positively to satisfaction survey	73%	70.6%	74.0%	74.5%	73.1%	78.8%	75.8%	74.8%	75.0%		NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	63%	57.1%	65.4%	68.8%	62.3%	67.7%	61.4%	65.2%	65%		BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	7.2	3.32	0.56	0.26	0.94	0.38	0.42	0.51	0.44		CMS (4)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.47	0.48	0.30	0.36	0.38	0.13	0.25	0.28	0.29		CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	18%	18.5%	17.5%	13.5%	21.5%	22.4%	34.2%	21.5%	9.5%		CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	98%	95.0%	89.6%	92.3%	94.7%	100.0%	95.6%	95.8%	90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	919	617	709	164	152	151	177	644	800		BHD (2)
	30	Average Daily Census	9.8	8.4	8.6	8.1	7.0	6.4	8.3	7.5	12.0		BHD (2)
	31	Percent of patients returning to CAIS within 7 days	6%	5.2%	5.2%	2.4%	5.3%	4.7%	1.7%	3.4%	5%		BHD (2)
	32	Percent of patients returning to CAIS within 30 days	16%	11.8%	12.3%	10.0%	15.2%	14.0%	11.0%	12.4%	12%		BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71%	78.1%	71.3%	73.9%	63.8%	71.9%	70.2%	71.1%	75%		BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	74%	82.1%	76.8%	75.0%	86.4%	65.4%	75.8%	74.2%	75%		BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	5.2	4.51	1.17	1.38	1.81	0.53	0.98	1.18	0.44		CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.42	0.20	0.37	0.93	0.50	0.20	0.22	0.47	0.29		CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2%	1.6%	5.0%	1.2%	0.7%	2.0%	0.6%	1.1%	3.0%		CMS (4)
	38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100%	88.9%	97.1%	100.0%	0.0%	100.0%	100.0%	85.7%	90.0%		BHD (2)
Financial	39	Total BHD Revenue (millions)	$120.2	$130.1	$149.9	$154.9	$154.9	$154.9	$154.9		$154.9		
	40	Total BHD Expenditure (millions)	$173.5	$180.7	$207.3	$213.5	$213.5	$213.5	$213.5		$213.5		

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

REVISED

Milwaukee County Behavioral Health Division
2018 Key Performance Indicators (KPI) Dashboard

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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.

 # 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 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.

CARS QUALITY DASHBOARD SUMMARY Q4 2018

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.

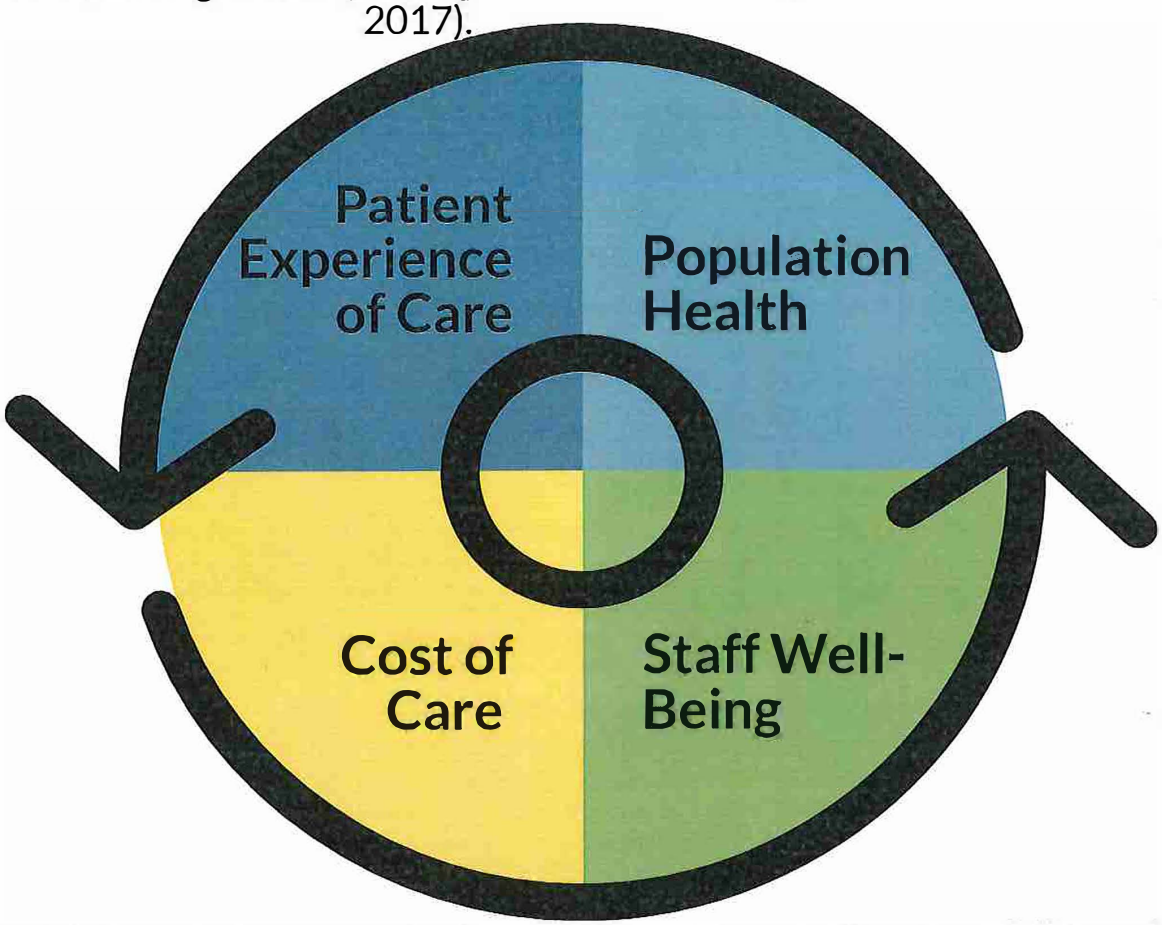
CARS Quality Dashboard

CARS Research + Evaluation Team

The Framework: The Quadruple Aim

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

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

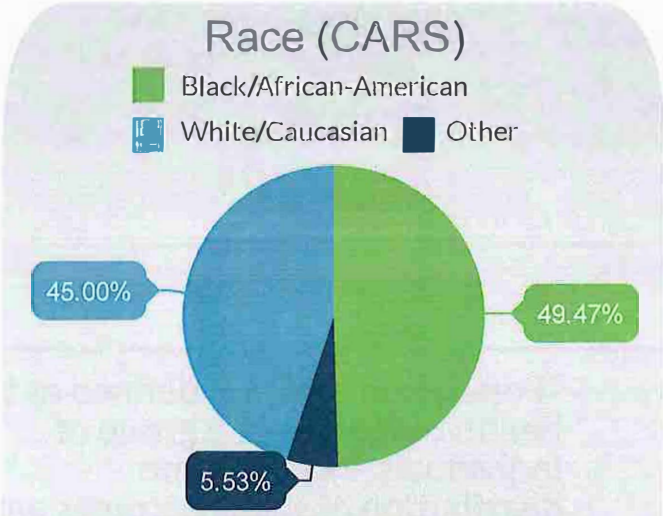


The total cost of care a patient receives across all settings and services, often presented as cost per member of the population per month. (Stiefel & Nolan, 2012)

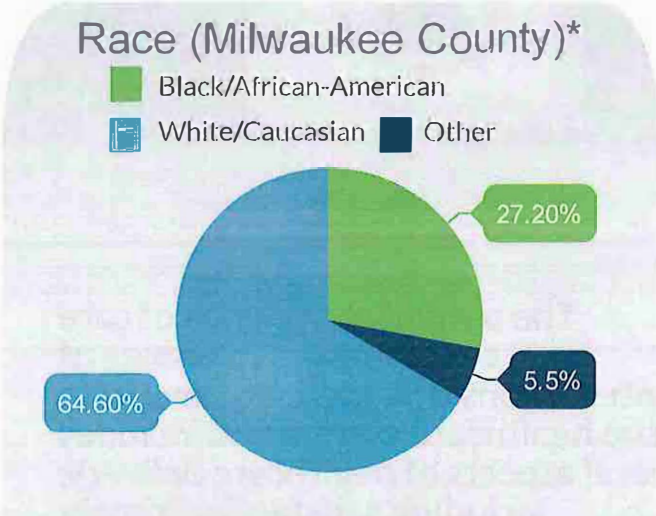
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

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.



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



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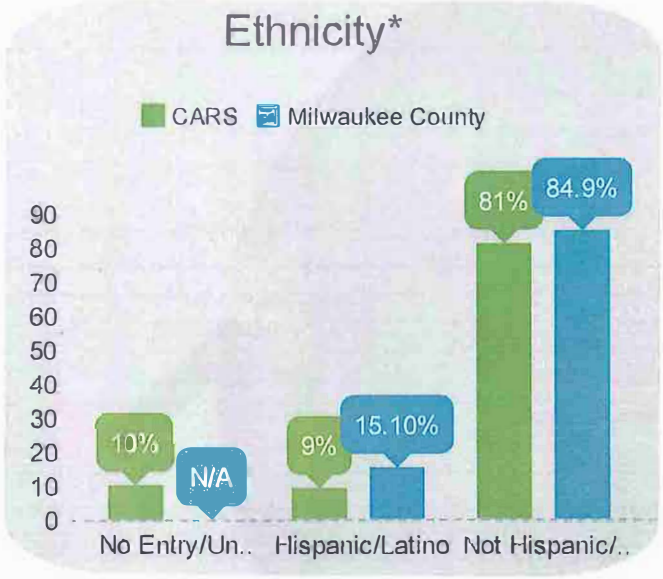
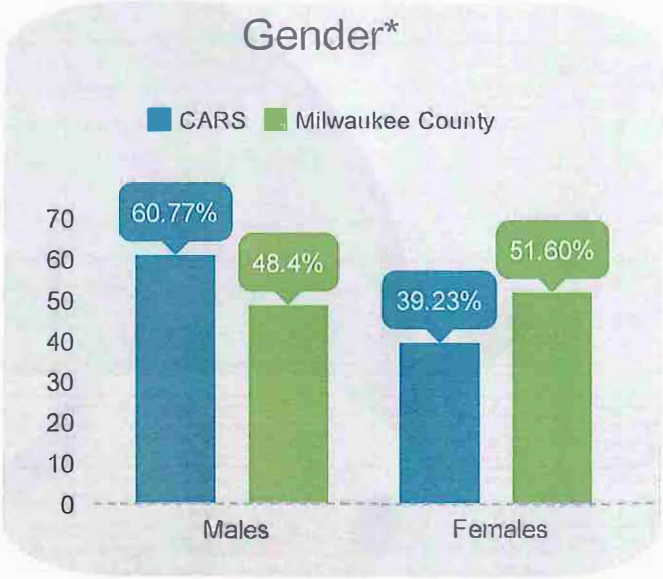
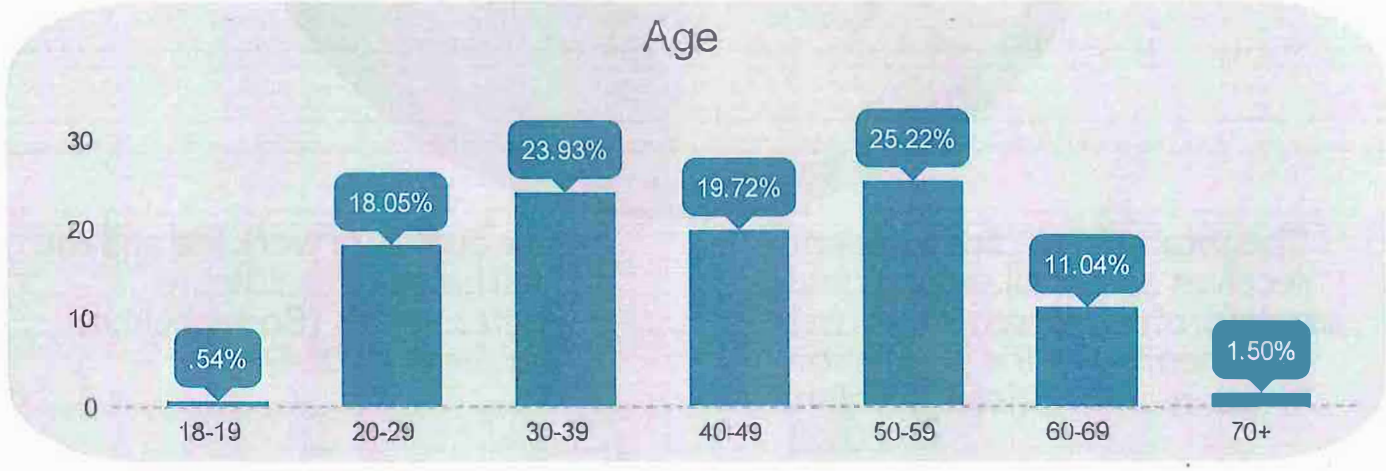






*Comparable data has been pulled from the United States Census Bureau, which can be found at: https://www.census.gov/quickfacts/fact/table/milwaukeecountywisconsin/PST045217#qf-flag-Z

Domain: Patient Experience of Care

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

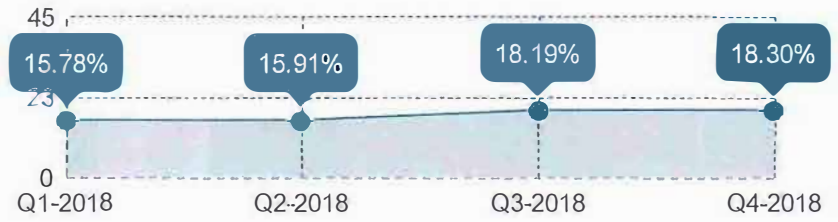
Service volume has been consolidated into one category to avoid potential duplication of client counts due to involvement in both MH and AODA programs.

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.

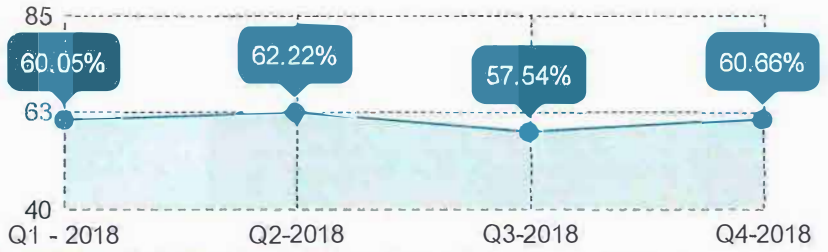


ER Utilization

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

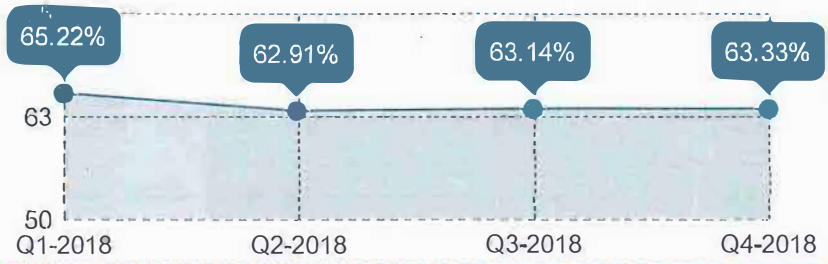
Detoxification 30 Day Readmissions

Percent of consumers returning to detoxification within 30 days.



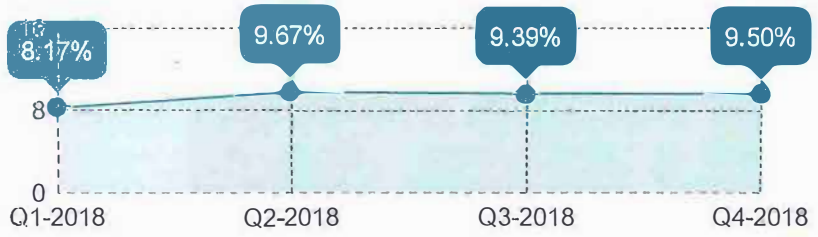
Abstinence

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)

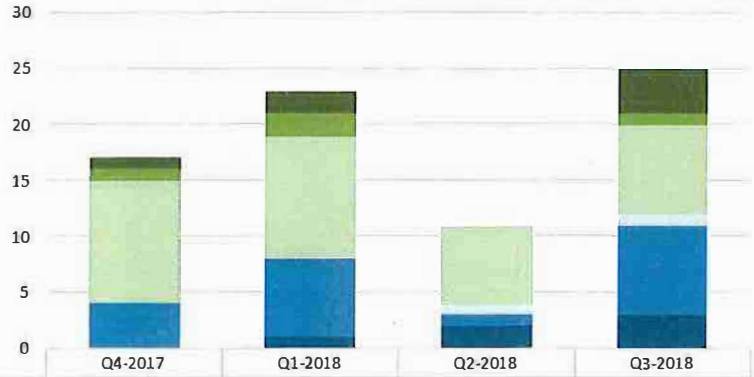
Items within this domain encompass volume, averages, and percentages. Most of the data points compare the past four quarters in order to indicate change over time.

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:

Q4 - 2017 N = 17	Q1- 2018 N = 23
Q2- 2018 N = 11	Q3- 2018 N = 25

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

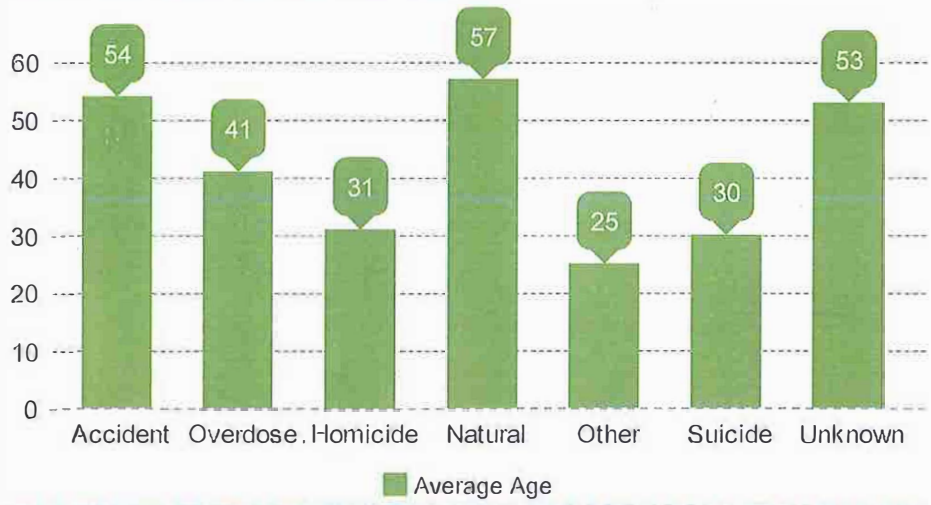


	Q4-2017	Q1-2018	Q2-2018	Q3-2018
Unknown	1	2		4
Suicide	1	2		1
Other				
Natural	11	11	7	8
Homicide			1	1
Accidental Overdose	4	7	1	8
Accident		1	2	3

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.

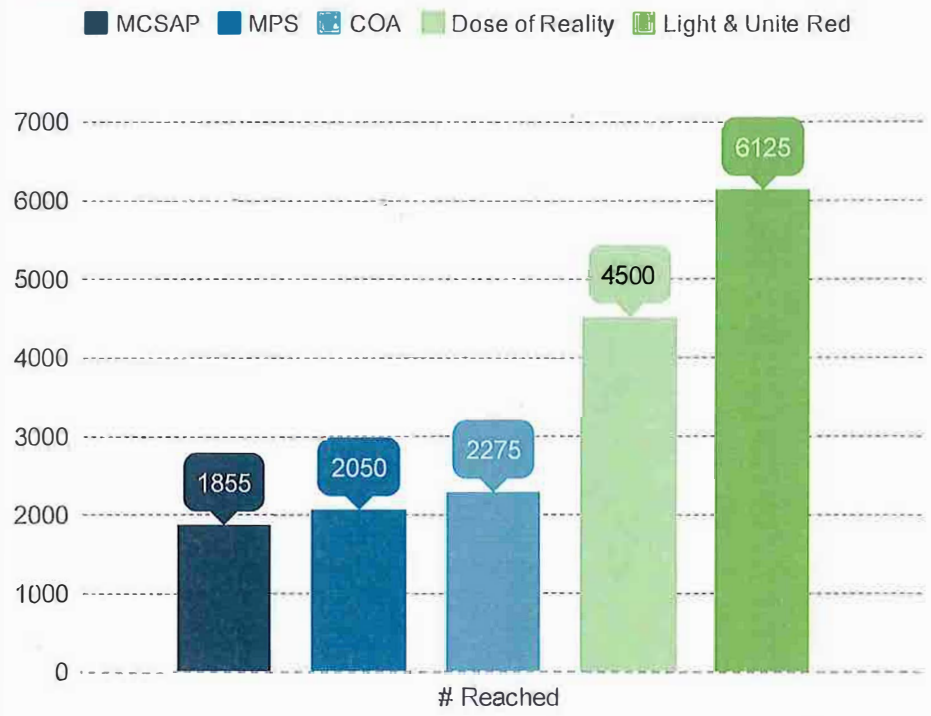
Please note that henceforth there will be a one quarter lag of the mortality data on the CARS Quarterly Dashboard. For example, the 2018 fourth quarter iteration of the Dashboard will contain mortality statistics for the third quarter of 2018. This decision was made to ensure that CARS has accurate cause 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.



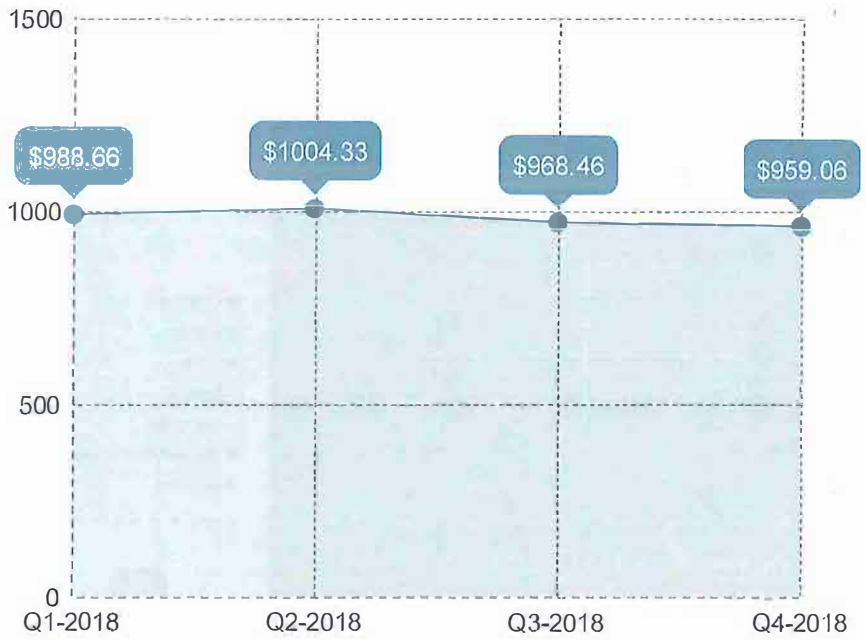
Domain: Cost of Care

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:

Q1 - 2018 N = 4844	Q2 - 2018 N = 4865
Q3 - 2018 N = 5042	Q4- 2018 N = 5056



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.

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.

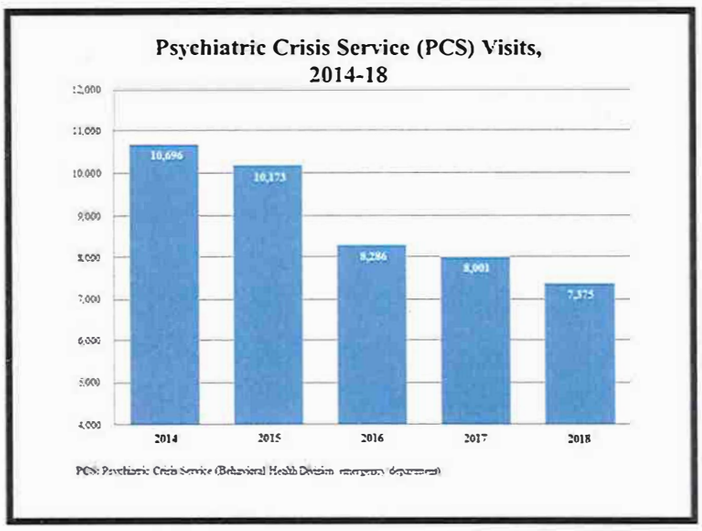
Consumers often express concern related to the impact of full-time employment on the benefits they receive i.e. Medicaid, Social Security, housing subsidies, etc. As a result, IPS consumers are encouraged to participate in benefits education prior to employment and during employment so they have the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

List of Employers Working with IPS:

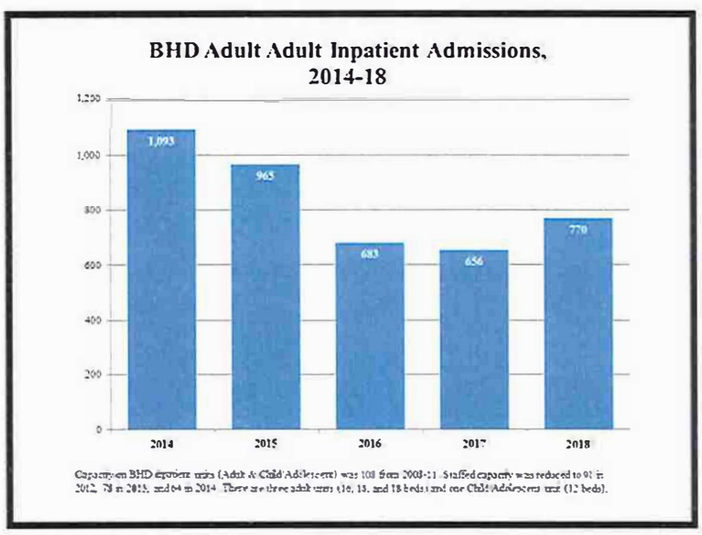
Milwaukee Public Schools
Akira
Don Jacob Toyota
Tandem
Miller Park
Walgreen's
Duwall
Falk
Lowes
Mayfair Relocation Reality
Dollar Tree
Maggiano's Little Italy
Elmbrook Memorial
Wendy's
Pick N' Save
Stowell Associates
City of Milwaukee
Performance Clean
Salvation Army
Pizza Hut
Potowatomi
White Lodge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

2018 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

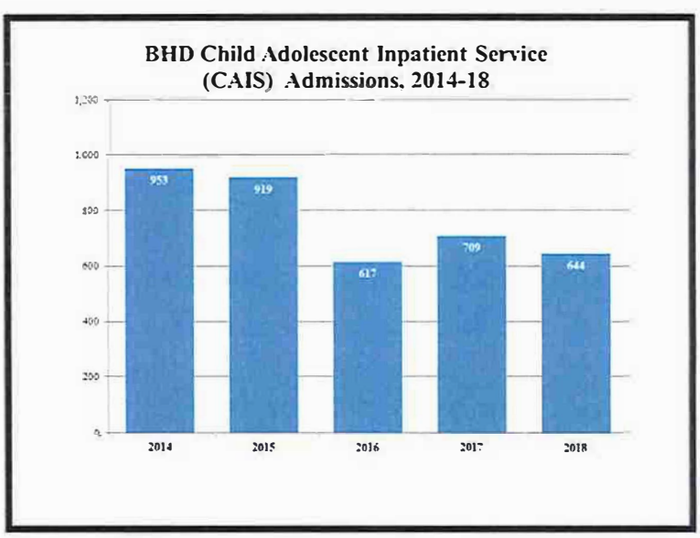
Psychiatric Crisis Service annual patient visits continue to decline from 10,696 in 2014 to 7,375 visits in 2018 (31% decline from 2014 to 2018). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (9% in 2014, 83% in 2018).



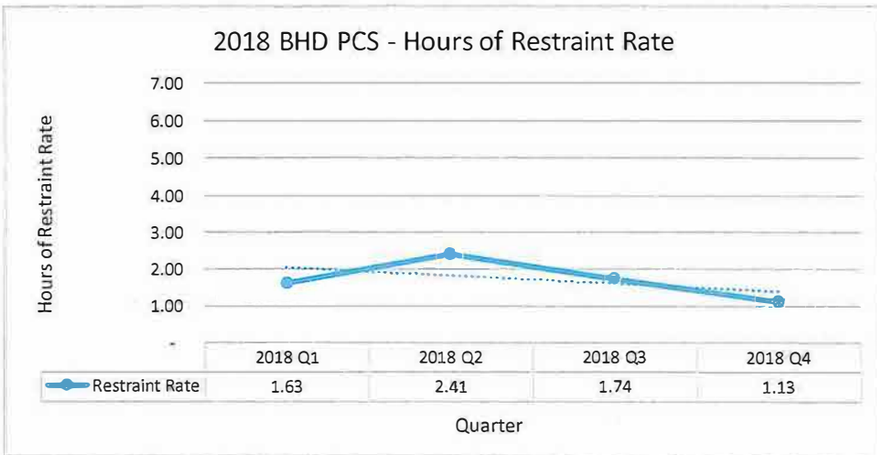
Acute Adult Inpatient Service's 2018 annual patient admissions increased to 770, the first increase since the Redesign Task Force was established in 2010. While Acute Adult admissions increased, readmission rates have continued to decline over the past four years (30-day readmission rate: 11% in 2015, 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%.

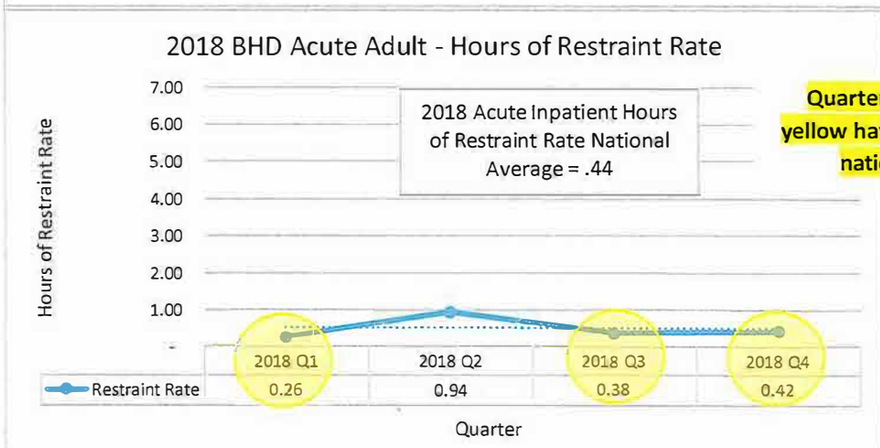


Child Adolescent Inpatient Service's annual patient admissions have plateaued over the past few years and were 644 for annual 2018. Over the past four years, CAIS' 30-day readmission rates have declined from 16% in 2015 to 12% in 2018. CAIS' hours of physical restraint rate declined from 5.2 in 2015 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.

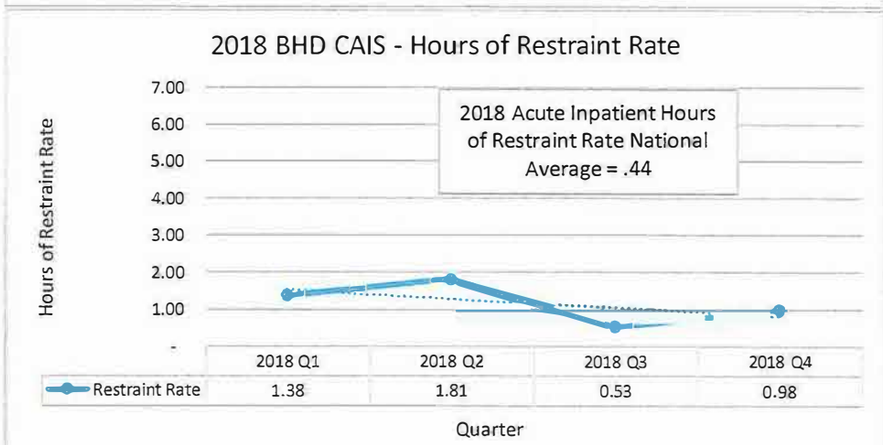


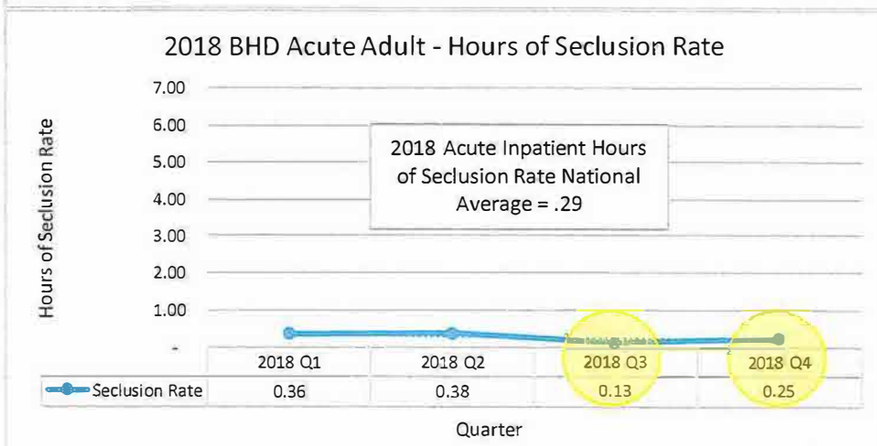
2018 Quarter 4 (Q4) Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary

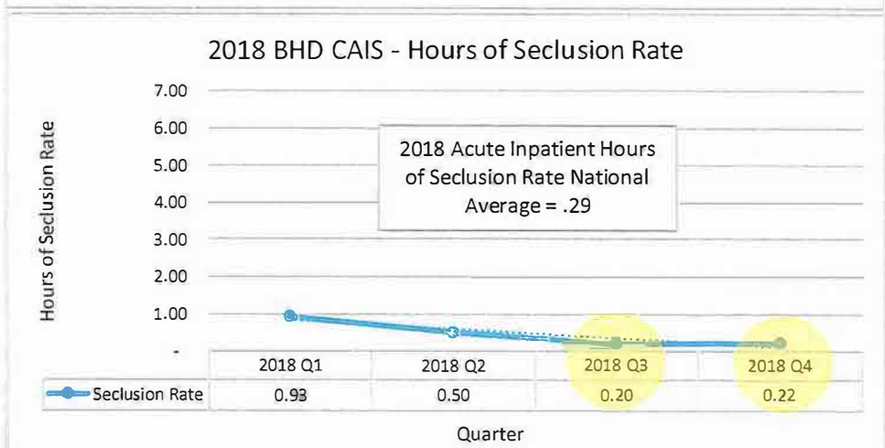




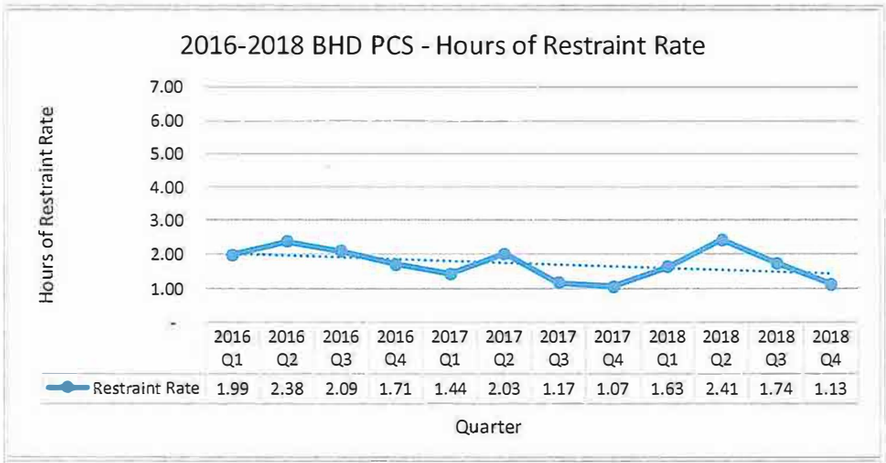
Quarters highlighted in yellow have rates below the national average

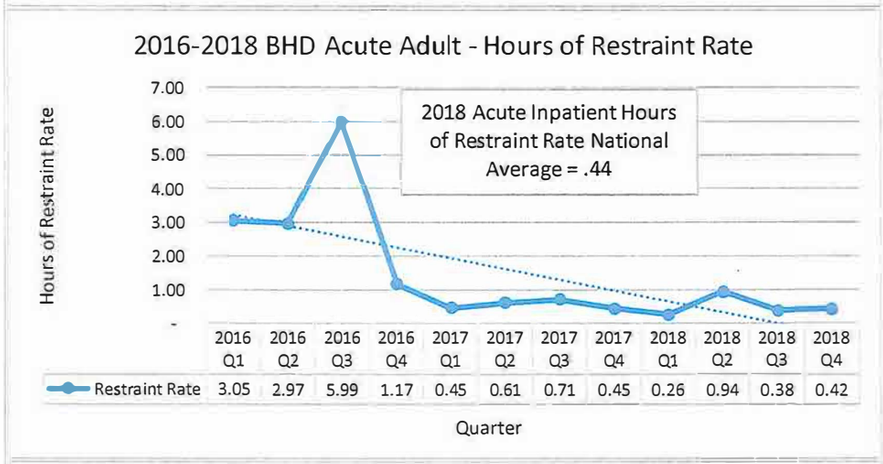


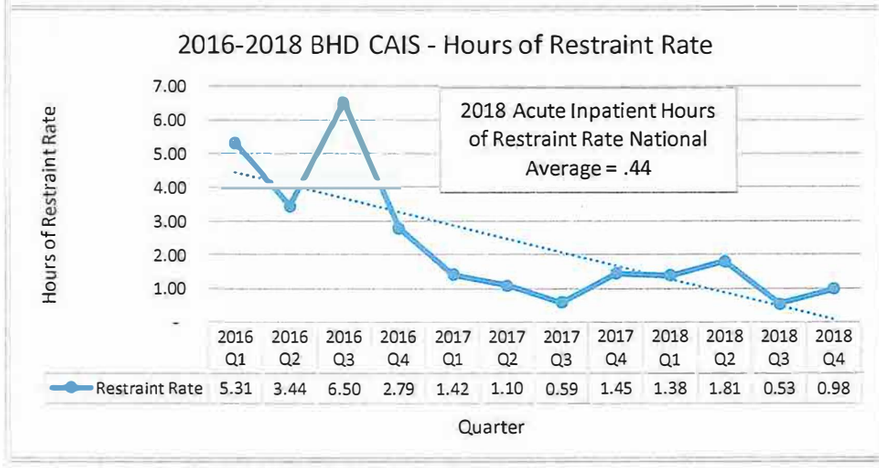


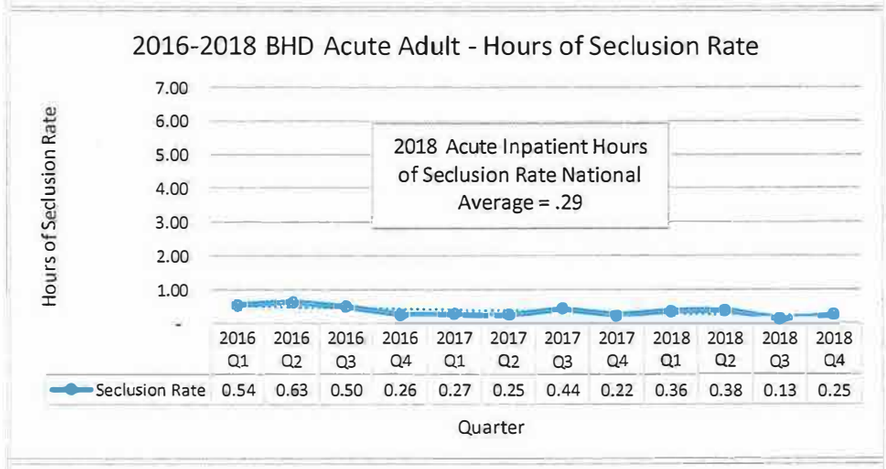


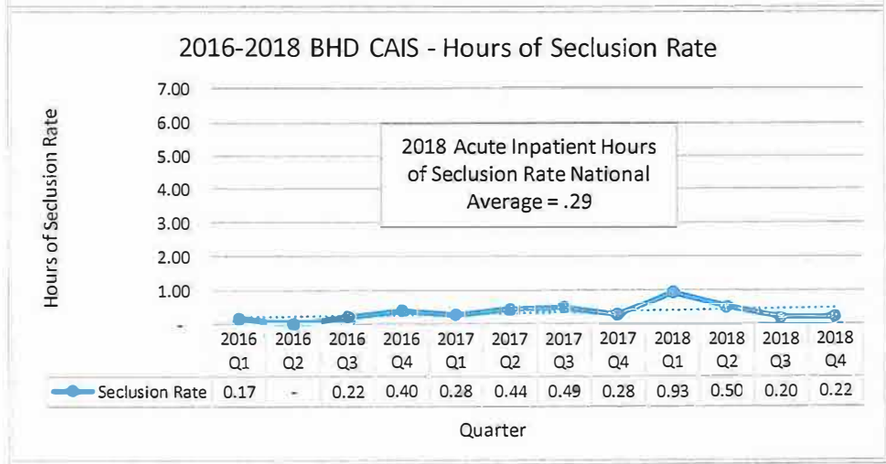
2016-2018 BHD Crisis Service and Acute Inpatient Seclusion and Restraint Summary











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)

READM-30-IPF Performance Information	--
Your Facility's Comparative Performance	No different than the national rate
Your Facility's Number of Index Admissions (Measure Population)	178
Your Facility's Risk-Standardized Readmission Rate (RSRR)	16.7%
Lower Limit of 95% Interval Estimate for RSRR	13.0%
Upper Limit of 95% Interval Estimate for RSRR	21.2%
National Observed Unplanned Readmission Rate	20.1%

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

Total Number of Facilities in the Nation with Measure Results	**1,692**
Number of facilities in the nation that performed better than the national rate	109
Number of facilities in the nation that performed no different than the national rate	1,325
Number of facilities in the nation that performed worse than the national rate	177
Number of facilities in the nation that had too few cases	81
Total Number of Facilities in Your State with Measure Results	**23**
Number of facilities in the state that performed better than the national rate	0
Number of facilities in the state that performed no different than the national rate	22
Number of facilities in the state that performed worse than the national rate	1
Number of facilities in the state that had too few cases	0

- 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.

NRI/MHSIP Inpatient Consumer Survey (2001)

Outcome Domain:

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

Dignity Domain:

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

Rights Domain:

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

Participation Domain:

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

Environment Domain:

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

Empowerment Domain:

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

Other survey items:

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

Results

The following presents the results of the Inpatient MHSIP Consumer survey completed by consumers of the Acute Adult Inpatient Service in 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% national average response rate for inpatient behavioral health patient satisfaction surveys.

Table 1 presents data on response rates by unit and the total BHD Acute Adult Inpatient Service for 2015 – 2018.

Table 1. Inpatient MHSIP Consumer Survey - Response Rate by Unit

Unit	2015		2016		2017		2018	
	Completed Surveys	Response Rate	Completed Surveys	Response Rate	Completed Surveys	Response Rate	Completed Surveys	Response Rate
43A - ITU	76	27.8%	70	30.2%	48	21.6%	42	17.7%
43B - ATU	334	77.5%	171	66.5%	154	59.5%	164	49.5%
43C - WTU	92	35.1%	39	20.1%	16	9.0%	93	45.4%
Total	502	**52.0%**	280	**41.0%**	218	**33.1%**	299	**38.7%**

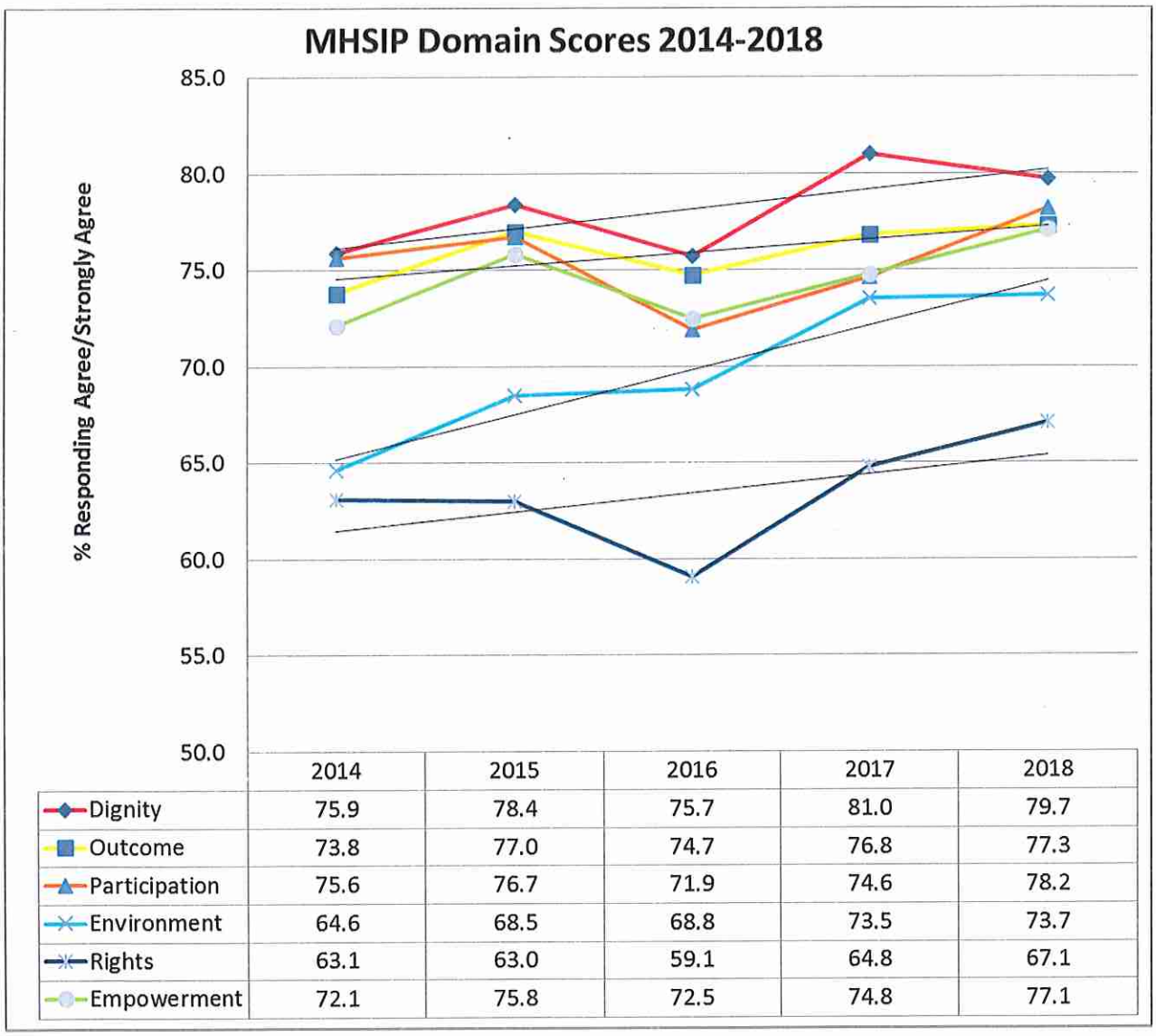
Acute Adult Inpatient Service

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 2. Inpatient MHSIP Consumer Survey - All Units

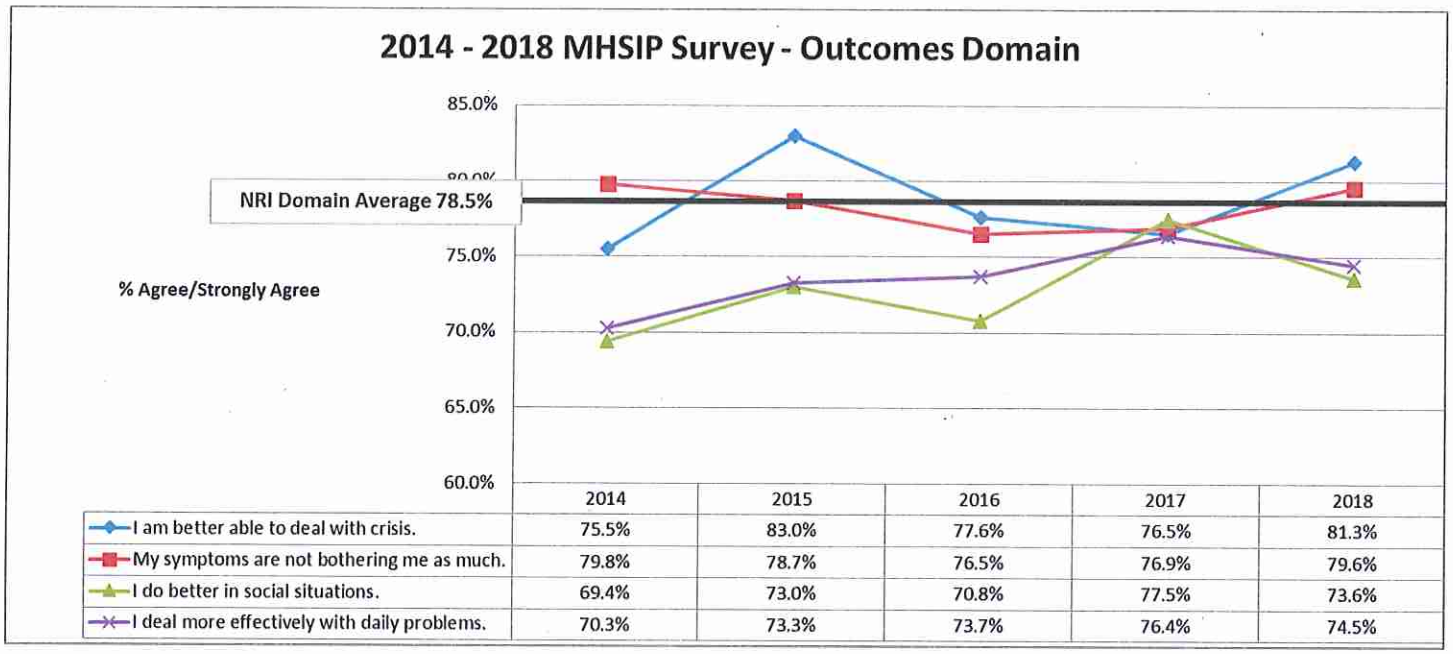
Domains	Agree/Strongly Agree Response %				
	2014	2015	2016	2017	2018
Dignity	75.9%	78.4%	75.7%	81.0%	79.7%
Outcome	73.8%	77.0%	74.7%	76.8%	77.3%
Participation	75.6%	76.7%	71.9%	74.6%	78.2%
Environment	64.6%	68.5%	68.8%	73.5%	73.7%
Rights	63.1%	63.0%	59.1%	64.8%	67.1%
Empowerment	72.1%	75.8%	72.5%	74.8%	77.1%
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.

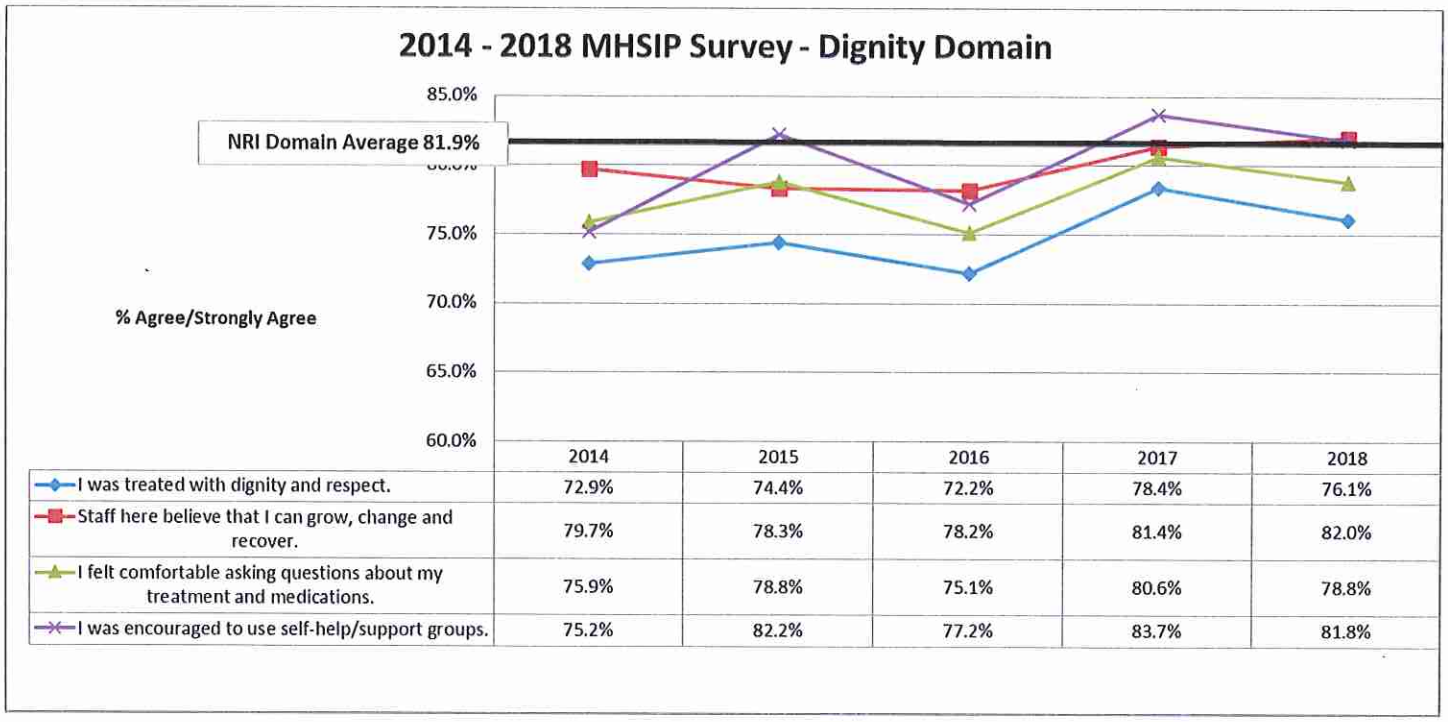


	2014	2015	2016	2017	2018
Dignity	75.9	78.4	75.7	81.0	79.7
Outcome	73.8	77.0	74.7	76.8	77.3
Participation	75.6	76.7	71.9	74.6	78.2
Environment	64.6	68.5	68.8	73.5	73.7
Rights	63.1	63.0	59.1	64.8	67.1
Empowerment	72.1	75.8	72.5	74.8	77.1

The following graphs present Acute Adult Inpatient Service's 2014-2018 positive (agree/strongly agree) survey item scores and NRI's domain average.

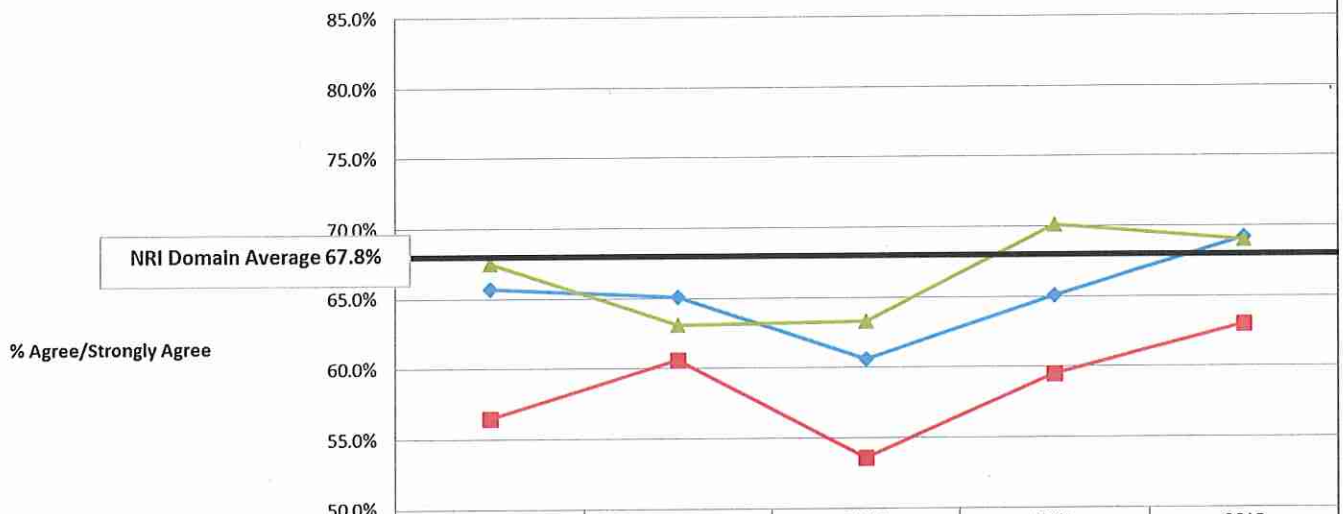


	2014	2015	2016	2017	2018
I am better able to deal with crisis.	75.5%	83.0%	77.6%	76.5%	81.3%
My symptoms are not bothering me as much.	79.8%	78.7%	76.5%	76.9%	79.6%
I do better in social situations.	69.4%	73.0%	70.8%	77.5%	73.6%
I deal more effectively with daily problems.	70.3%	73.3%	73.7%	76.4%	74.5%



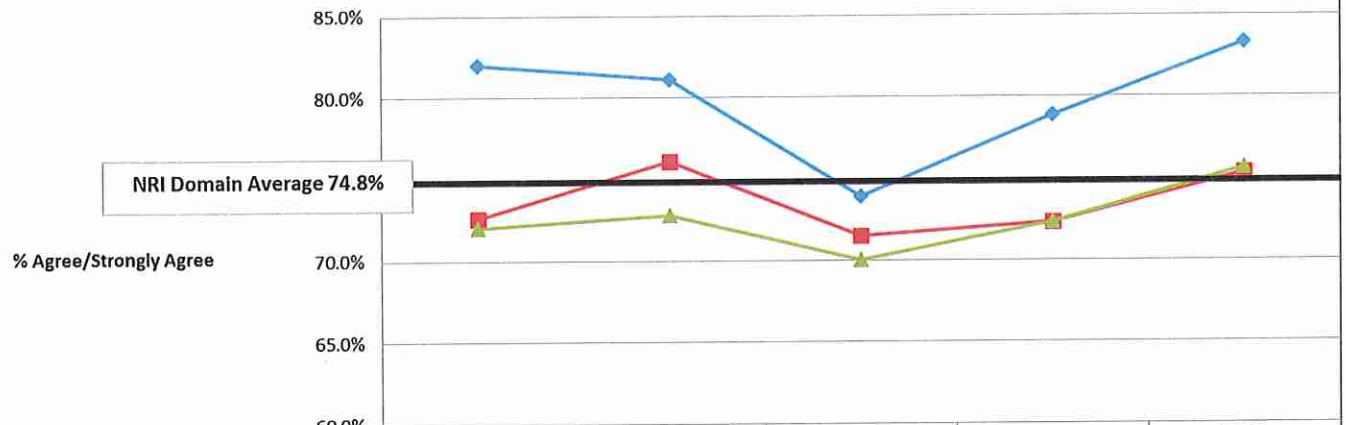
	2014	2015	2016	2017	2018
I was treated with dignity and respect.	72.9%	74.4%	72.2%	78.4%	76.1%
Staff here believe that I can grow, change and recover.	79.7%	78.3%	78.2%	81.4%	82.0%
I felt comfortable asking questions about my treatment and medications.	75.9%	78.8%	75.1%	80.6%	78.8%
I was encouraged to use self-help/support groups.	75.2%	82.2%	77.2%	83.7%	81.8%

2014 - 2018 MHSIP Survey - Rights Domain



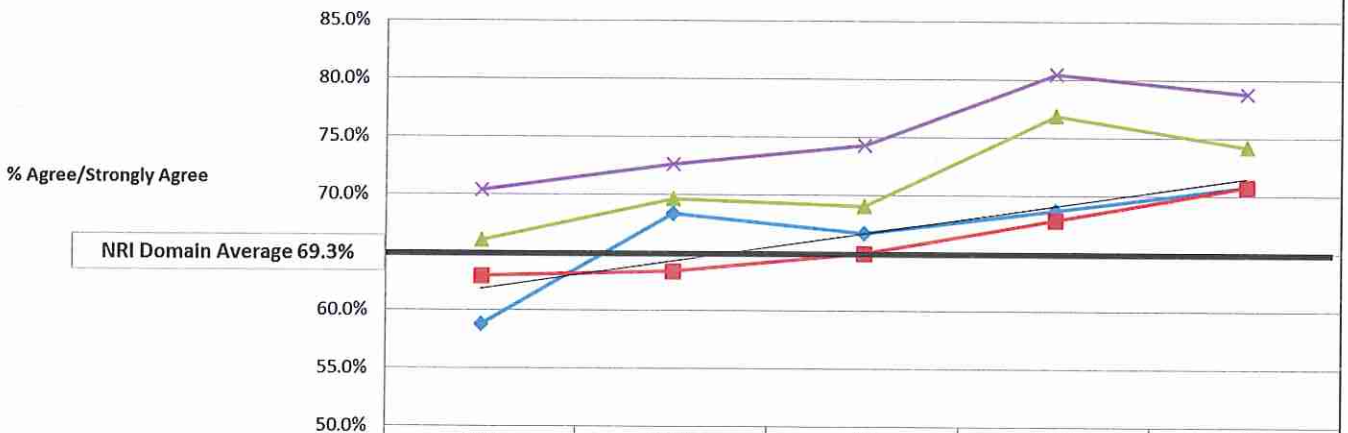
	2014	2015	2016	2017	2018
I felt free to complain without fear of retaliation.	65.7%	65.1%	60.6%	65.1%	69.2%
I felt safe to refuse medication or treatment during my hospital stay.	56.5%	60.6%	53.6%	59.5%	63.0%
My complaints and grievances were addressed.	67.5%	63.1%	63.3%	70.1%	69.0%

2014 - 2018 MHSIP Survey - Participation Domain



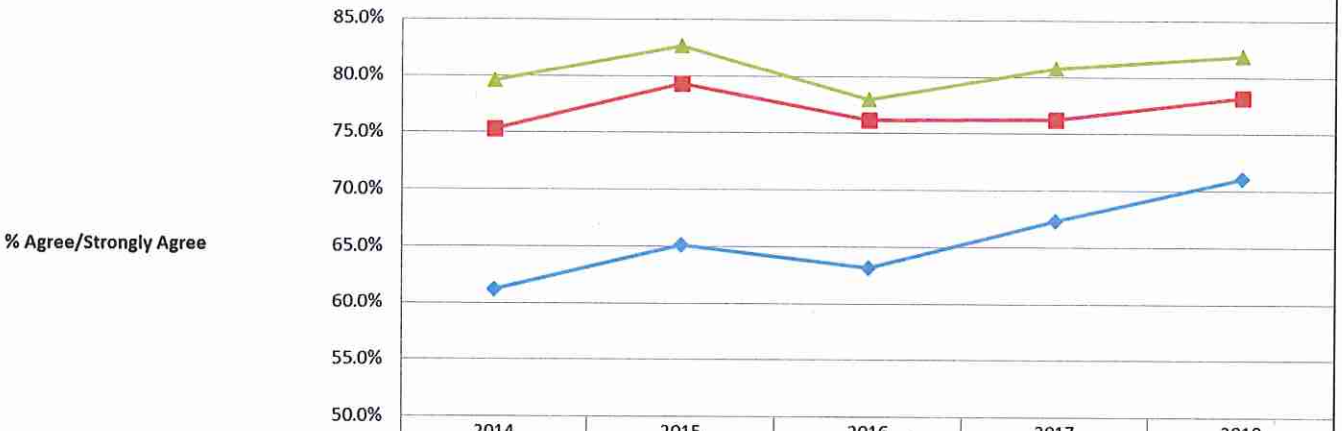
	2014	2015	2016	2017	2018
I participated in planning my discharge.	82.0%	81.1%	73.9%	78.9%	83.3%
Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	72.6%	76.1%	71.5%	72.3%	75.3%
I had the opportunity to talk with my doctor or therapist from the community prior to discharge.	72.0%	72.8%	70.0%	72.3%	75.6%

2014 - 2018 MHSIP Survey Item - Environment Domain

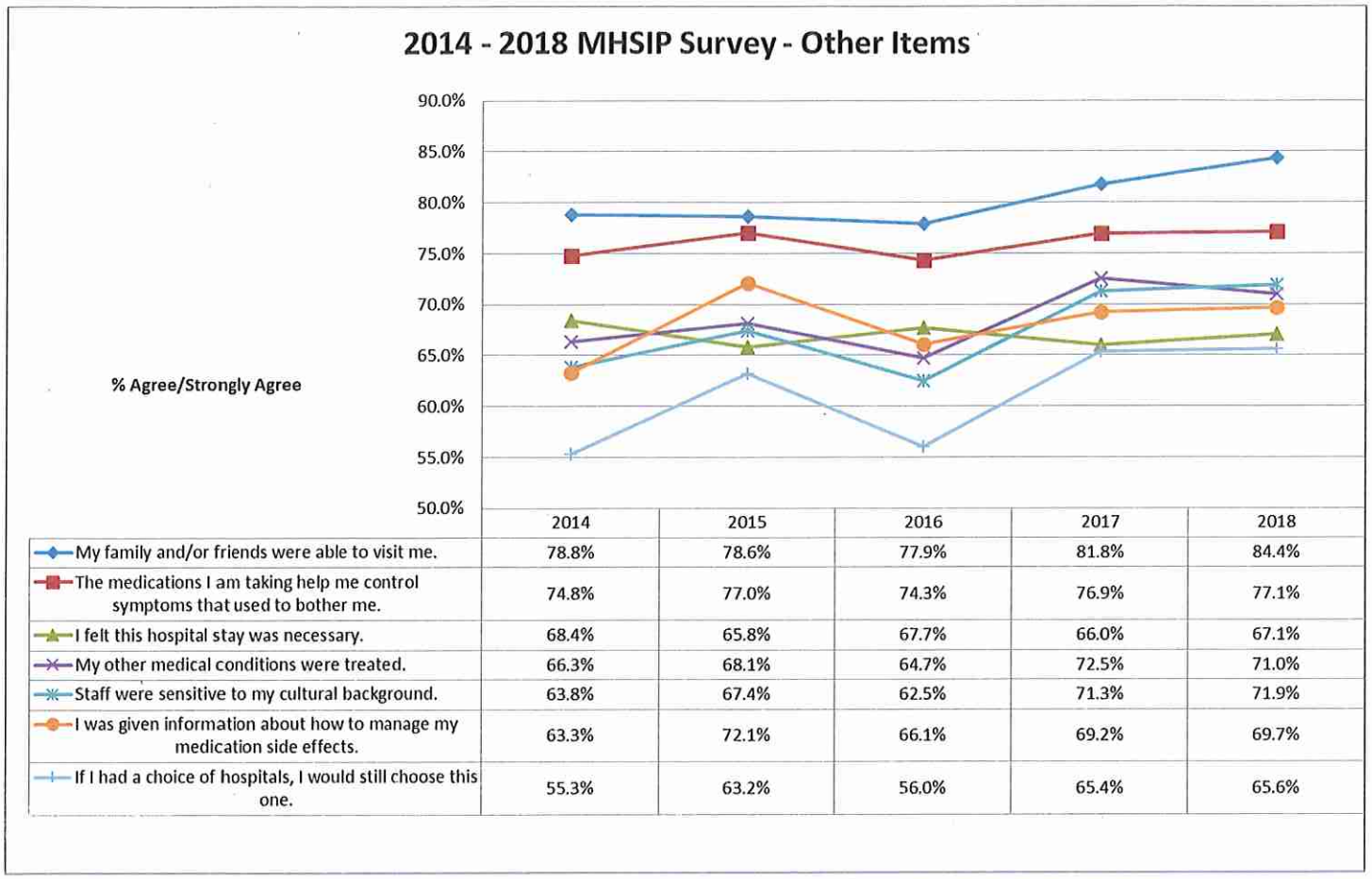


	2014	2015	2016	2017	2018
The surroundings and atmosphere at the hospital helped me get better.	58.8%	68.4%	66.7%	68.7%	70.8%
I felt I had enough privacy in the hospital.	63.0%	63.4%	65.0%	67.9%	70.8%
I felt safe while in the hospital.	66.1%	69.6%	69.1%	76.9%	74.2%
The hospital environment was clean and comfortable.	70.4%	72.6%	74.3%	80.5%	78.8%

2014 - 2018 MHSIP Survey - Empowerment Domain



	2014	2015	2016	2017	2018
I had a choice of treatment options.	61.2%	65.1%	63.2%	67.3%	71.1%
My contact with my doctor was helpful.	75.3%	79.3%	76.2%	76.3%	78.2%
My contact with nurses and therapists was helpful.	79.6%	82.6%	78.0%	80.8%	81.9%



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

Domains	National Average	2018 BHD	BHD/National Avg Variance
Dignity	81.9%	79.7%	-2.2%
Outcome	78.5%	77.3%	-1.2%
Participation	74.8%	78.2%	3.4%
Environment	69.3%	73.7%	4.4%
Rights	67.8%	67.1%	-0.7%
Empowerment	Not Reported	77.1%	-

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 4. 2018 Inpatient MHSIP Consumer Survey - By Unit			
Domains	**Agree/Strongly Agree Response**		
	43A	**43B**	**43C**
Dignity	71.3%	79.3%	84.1%
Outcome	65.2%	77.8%	81.6%
Participation	71.0%	78.8%	80.4%
Environment	66.7%	74.9%	74.7%
Rights	54.2%	67.5%	72.0%
Empowerment	66.7%	77.3%	81.4%
Additional Questions			
My family and/or friends were able to visit me.	87.5%	81.1%	88.6%
The Medications I am taking help me control my symptoms that used to bother me.	65.9%	75.5%	85.2%
My other medical conditions were treated.	52.8%	71.1%	78.2%
Staff were sensitive to my cultural background	60.5%	73.1%	74.4%
I felt this hospital stay was necessary	50.0%	70.1%	69.2%
I was given information about how to manage my medication side effects	56.4%	69.6%	75.6%
If I had a choice of hospitals, I would still choose this one.	50.0%	66.9%	70.5%
Surveys Completed	42	164	93

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.

CAIS Youth Survey

Annual Report

2018

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%).

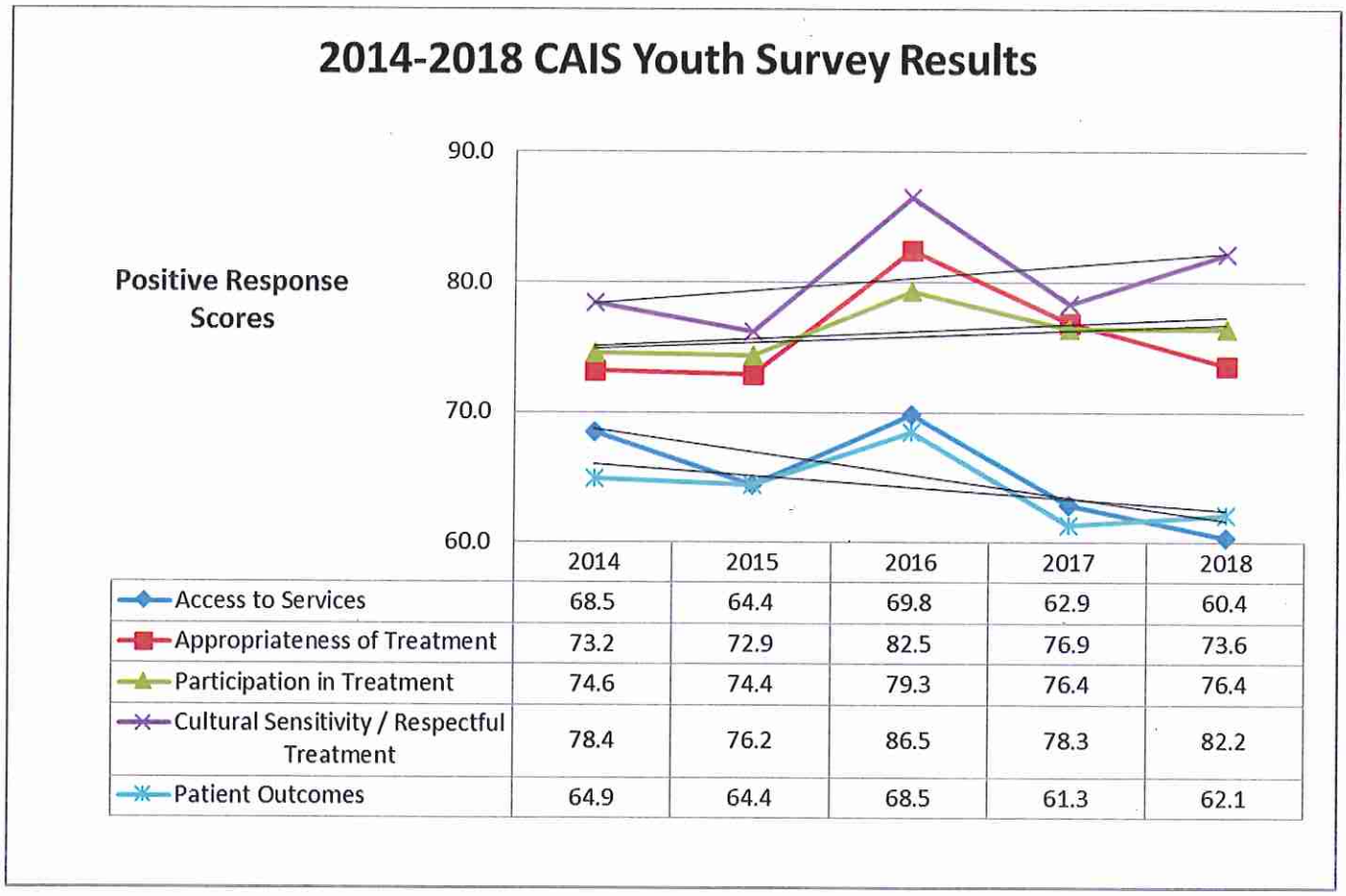
Method

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.

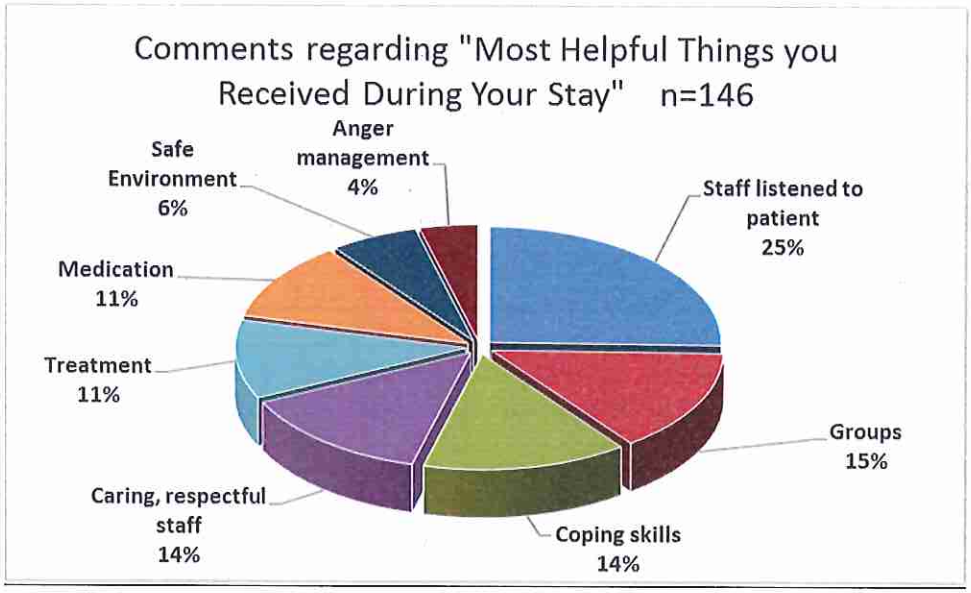
Table 1. 2014-2018 CAIS Youth Survey - Agree/Strongly Agree Response %

Survey Item / Domain	Year					
	2014 N = 327	2015 N = 618	2016 N = 106	2017 N = 182	2018 N = 209	2017/2018 Variance
The location of services was convenient	62.0	61.6	58.7	54.0	46.3	-7.7
Services were available at times that were convenient for me	75.0	67.2	80.8	71.8	74.4	2.6
Access to Services Domain	**68.5**	**64.4**	**69.8**	**62.9**	**60.4**	**-2.6**
Overall, I am satisfied with the services I received	72.8	74.0	82.1	76.8	74.2	-2.6
The people helping me stuck with me no matter what	75.5	71.6	82.1	79.0	73.4	-5.6
I felt I had someone to talk to when I was troubled	74.9	72.6	81.0	81.9	77.3	-4.6
I received the services that were right for me	72.6	74.0	84.6	76.4	75.7	-0.7
I got the help I wanted	71.0	72.0	84.0	72.4	72.1	-0.3
I got as much help as I needed	72.6	73.1	81.0	75.1	69.1	-6.0
Appropriateness of Treatment Domain	**73.2**	**72.9**	**82.5**	**76.9**	**73.6**	**-3.3**
I helped to choose my services	64.6	65.5	66.7	68.0	62.2	-5.8
I helped to choose my treatment goals	79.8	76.6	85.6	77.2	83.6	6.4
I participated in my own treatment	79.4	81.2	85.6	84.0	83.3	-0.7
Participation in Treatment Domain	**74.6**	**74.4**	**79.3**	**76.4**	**76.4**	**0.0**
Staff treated me with respect	73.6	72.2	81.0	78.9	79.5	0.6
Staff respected my family's religious/spiritual beliefs	78.5	78.6	88.1	80.9	84.3	3.4
Staff spoke with me in a way that I understood	84.4	82.2	91.4	84.1	89.3	5.2
Staff were sensitive to my cultural/ethnic background	77.0	71.9	85.6	69.3	75.7	6.4
Cultural Sensitivity / Respectful Treatment Domain	**78.4**	**76.2**	**86.5**	**78.3**	**82.2**	**3.9**
I am better at handling daily life	69.6	70.9	68.9	70.4	66.7	-3.7
I get along better with family members	57.1	60.2	64.2	53.9	50.2	-3.7
I get along better with friends and other people	75.7	70.5	74.3	65.7	72.2	6.5
I am doing better in school and/or work	59.4	58.8	62.5	53.4	57.3	3.9
I am better able to cope when things go wrong	69.1	65.1	74.0	65.0	70.5	5.5
I am satisfied with my family life right now	58.6	60.9	66.7	59.4	55.8	-3.6
Patient Outcomes Domain	**64.9**	**64.4**	**68.4**	**61.3**	**62.1**	**0.8**



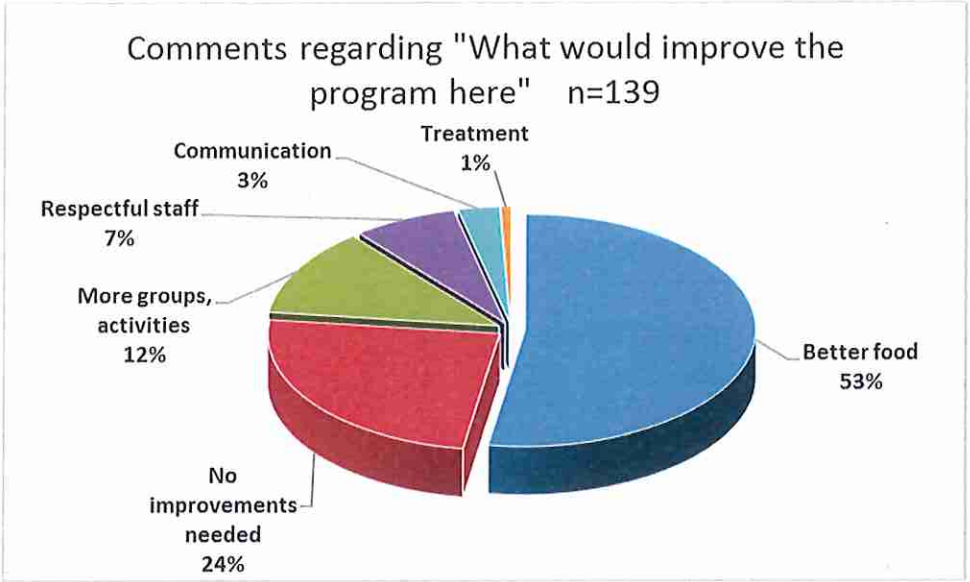
	2014	2015	2016	2017	2018
Access to Services	68.5	64.4	69.8	62.9	60.4
Appropriateness of Treatment	73.2	72.9	82.5	76.9	73.6
Participation in Treatment	74.6	74.4	79.3	76.4	76.4
Cultural Sensitivity / Respectful Treatment	78.4	76.2	86.5	78.3	82.2
Patient Outcomes	64.9	64.4	68.5	61.3	62.1

The comments below were written on surveys administered in 2018.



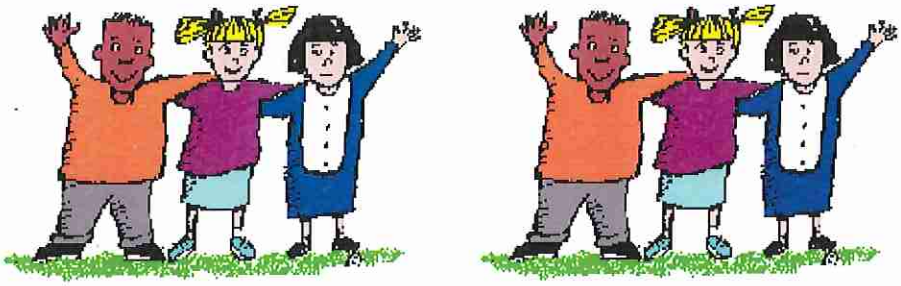
Category	Comments "Most Helpful Things You Received During Your Stay
Anger management	Dealing with anger and talking it out. Helpful thing I received was my anger. That we have to learn self-control. The help I got with my anger. The nurses helped me control my anger and not pay attention to when the 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. People being understanding. Respect, snack, and I got to talk to adults that understand. Staff spoke with me in the way I understood. The doctors and social workers being there for me when I needed it. The fact that people knew what I was going through. The people here were nice to me and treated me with respect which was helpful. The respect I got from the people here (staff). The staff and venting to them. The staff members that genuinely cared and helped me the most. The staff was very helpful. The therapist here Mr. C he really helped and understood me great choice to choose him!
Coping skills	Better coping skills. Coping skills to better control my anger. Coping skills, coloring, talking and sleeping. Coping skills (x8). How too cope when things go wrong. I learned some new coping skills not only that, made some new friends that helped me out a lot. I learned to cope with my anger issues better than before. Leaned 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.

Category	Comments "Most Helpful Things You Received During Your Stay
Safe environment	A quiet place to be when I get mad. Having to rest when needing. I was given time to process thoughts. Sleep, people I knew from last time I was here. Sleep (x4). The ability to stay in my room whenever I wanted.
Staff listened to patient	1. Someone to talk to. 2. People who actually listen. A person to talk to and a friend that I could discuss philosophy with as well as time outdoors. Attention, support, a shoulder to lean on during hard times. Being able to get stuff off my chest and being able to talk to people. Being able to talk about problems and the best way to solve them Being able to talk and to feel comfortable with talking, which was one of my main problems. Being able to talk to many different doctors and see different perspectives. Being able to talk to someone. Emotional support. Having someone to talk to if I needed it. Having someone to talk too. Help with talking and expressing more feelings. I learned how to talk to people more. I was able to open up and talk about my life with strangers. People to talk to and the medicine. People to talk to when I felt alone. People understand how I was feeling and they calmed me down in times I needed it. People/staff listened when I needed to talk. Some staff talking to when I need. Someone that I needed to talk to was one of the most helpful thing I received. Someone to talk to (x4). Talking and solutions to help. Talking to nurses. Talking to the doctors and opening up. Talking with nurses, writing in my journal Talking with the doctors. Talking. The ability to communicate. The talks I had with staff. The talks the doctors gave me. The talks with other people as in SW and therapist and OT. They took time to hear me out. Time and people to talk to. To talk to someone.
Treatment	Getting help (x3). I was able to receive help when needed and was able to make friends to help me cope with things. Improved physical, mental, and emotional health. My therapy (x2). Recognizing my anxiety. Support with trauma. Taking deep breaths. That I got help! The help I received was wonderful, but the most helpful thing was teaching me patience. The help they give to me. The most helped I received was getting my mind right. They help me with all my problems (x2).



Category	Comments "What would improve the program here"
Better food	A tv in the rooms and better food.
	Better food and more physical activities.
	Better food better pillows.
	Better food get shoes/house shoes/slippers.
	Better food since I have a eating problem and bad food doesn't help.
	Better food, better bed, better service, better sink.
	Better food (x48).
	Can you please fix the food?
	Everything, food and staff.
	Fire cooks.
	Fix your food.
	Food being better, equate staff properly.
	Food could have been better.
	Food need to be better because patients are still human too (not stale/hard/old).
	Food sucks, but was plenty.
	I would say better food and instead of "quiet hours" at 8:30 it could be like 9:15 I just don't understand.
	Maybe better nutrition in food so it can look more appetizing.
	The food a little, it wasn't that good.
	The food and 3rd shift (which is very rude).
	The food need a little more help on it.
	The food please for the sake of life fire the cooks.
	The food was nasty.
	The food wasn't really that good.
	The food, its bad.
	The food, no joke.
	What would better if we had better food.
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.

Category	Comments "What would improve the program here"
No Improvements Needed	Honestly I think this program is great and it helped me in everyway needed. I don't think it needs improvement. I just wanted to thank this program and all staff for making me feel like 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 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. Its 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. Karlan 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.
More groups, activities	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.
Respectful staff	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 2nd shift CNAs and RNs talk about everyone and use mean words. Well the workers downstairs could have better attitudes towards family.
Treatment	Better treatment plans. Better food.



CAIS YOUTH SURVEY

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

Today's Date: _____ / _____ / _____

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

20. I am better able to cope when things go wrong.					
21. I am satisfied with my family life right now.					

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

_____

23. What would improve the program here? _____

_____

_____

24. Other comments: _____

_____

_____

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

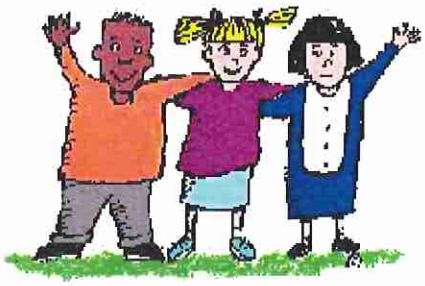
Race / Ethnicity (mark with an X the category that applies to you):

American Indian/Alaskan Native ___ White (Caucasian)

Black (African American) ___ Asian/Pacific Islander

_____Spanish/Hispanic/Latino ___ Other

Age: _____ years old **Gender (mark with X):** ___Male ___ Female



Quality Management Services Update
Compliments, Complaints & Grievance
Executive Summary

Milwaukee County Mental Health Board – Quality Committee Meeting

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:

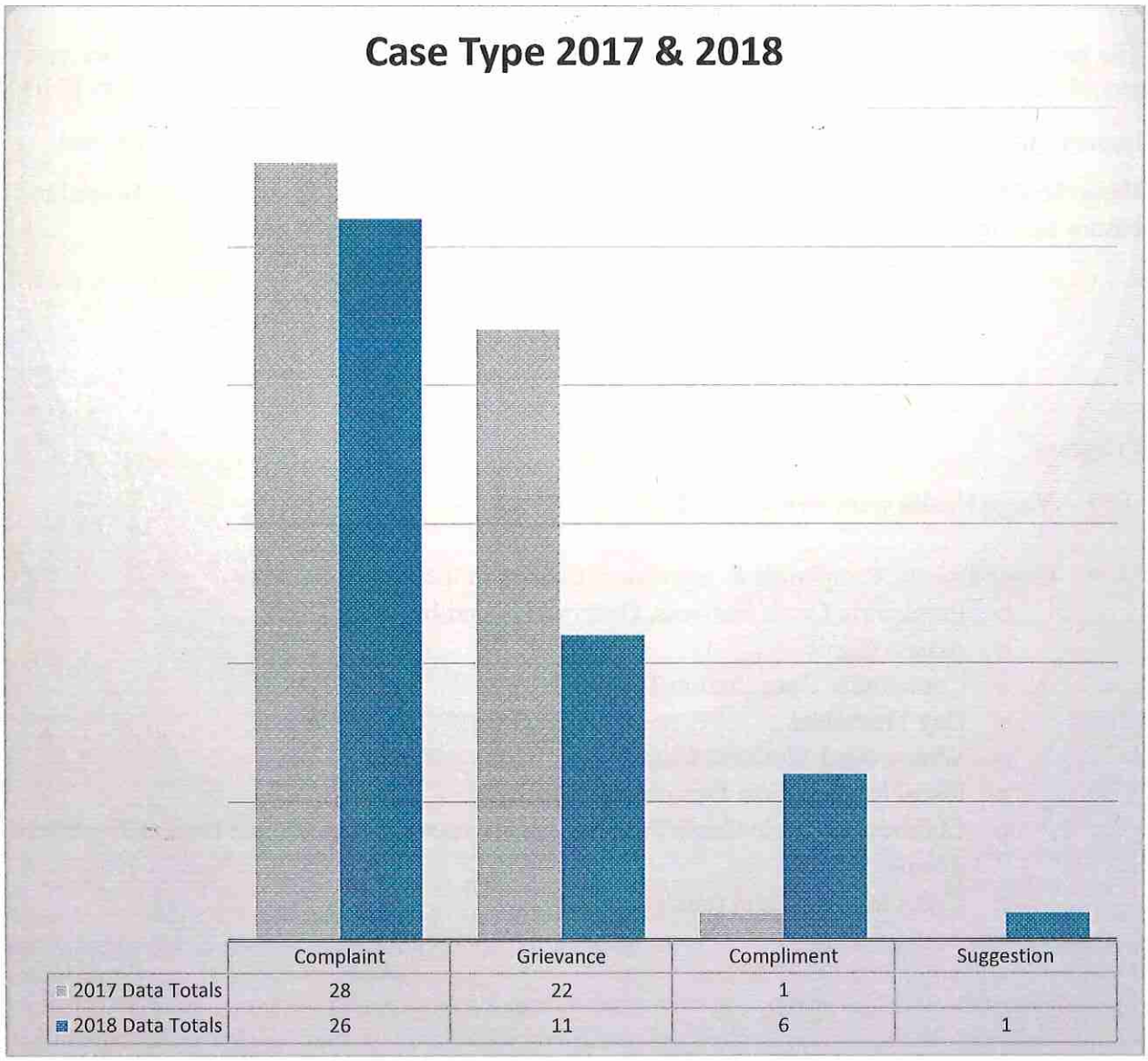
- Verge Health went live March 2017.

- 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)

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

Case Type:

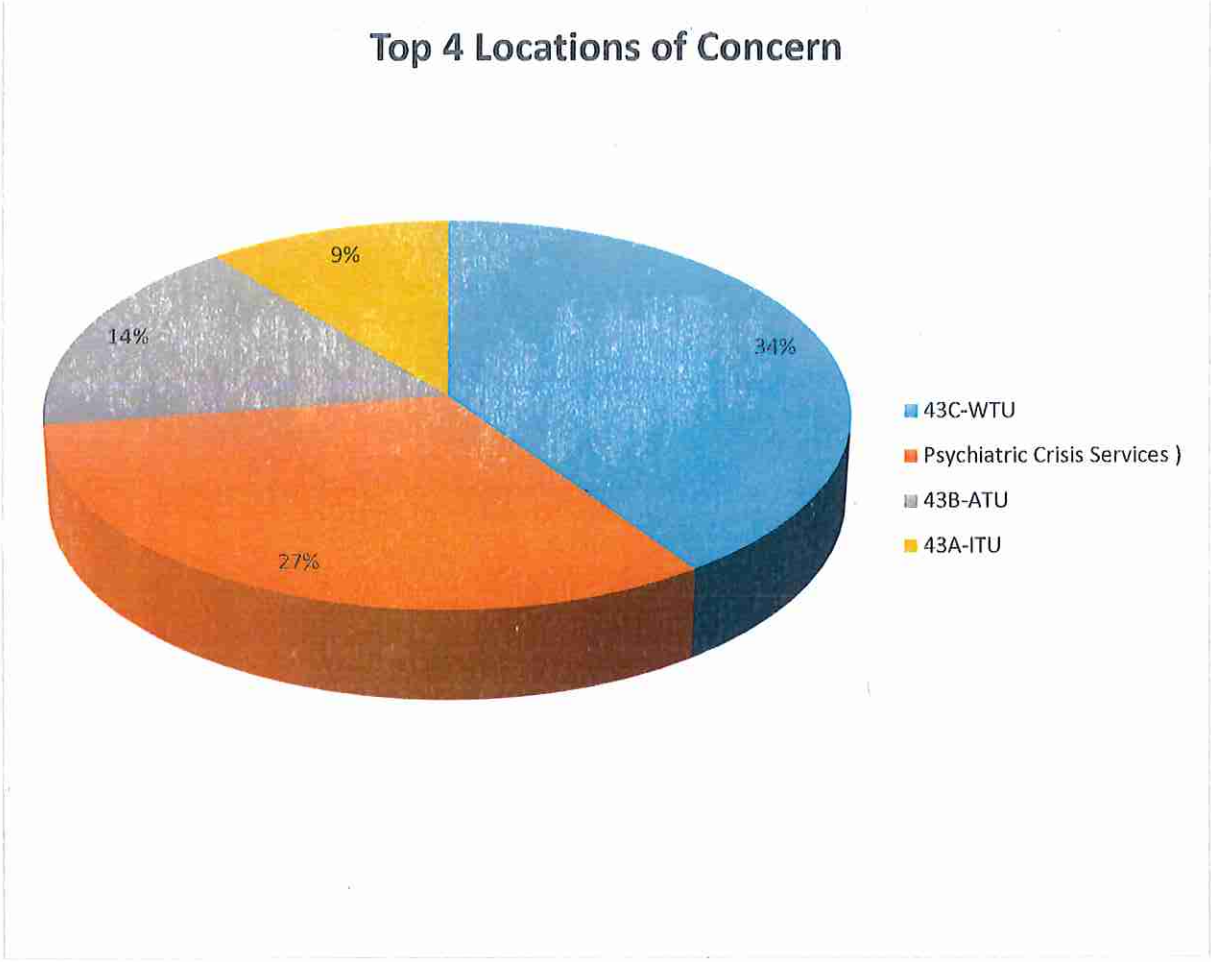
2017	**2018**
51 total entries into Verge Health	44 total entries into Verge Health
Complaint 54% (28)	Compliant: 59% (26)
Grievance 42% (22)	Grievance: 25% (11)
Compliment 2% (1)	Compliment: 14% (6)
	Suggestion: 2% (1)



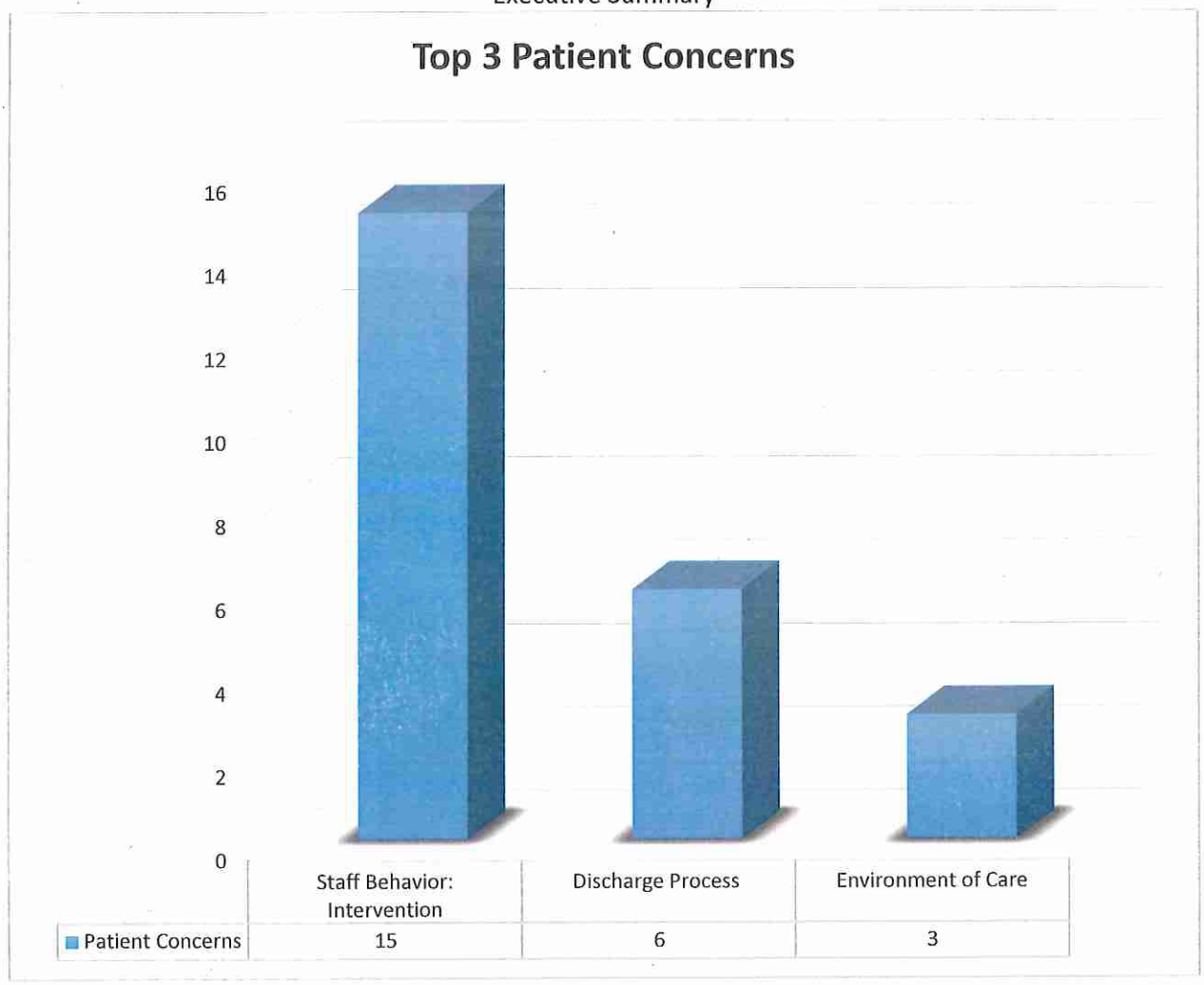
Graph 1

Locations Reporting Highest Incidents

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



Graph 2



Graph 3

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.

REVISED

7

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

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

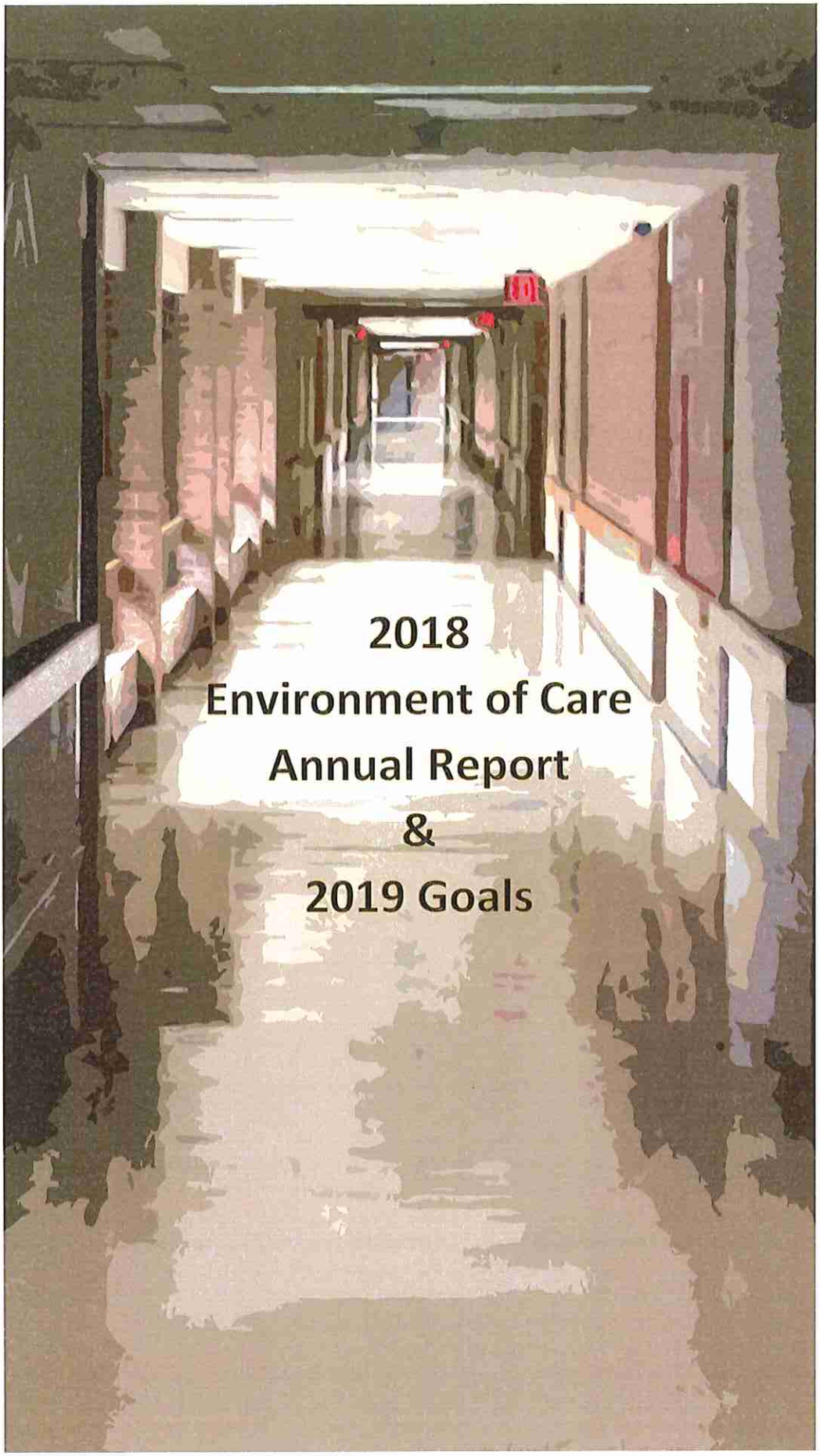
BHD is requesting the annual approval of the Environment of Care Annual Report and Management Plans per The Joint Commission Standards and the Mental Health Board By-laws.

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.

Year	Total Weight (in lbs)	Monthly Average (in lbs)
2014	3262	272
2015	1589*	132
2016	885**	74
2017	492.59	41
2018	490.35	40.86
*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

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

- 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.**

Date Issued:	*1/1/2015*
Effective:	*Upon Approval*
Last Approved Date:	*N/A*
Last Revised Date:	*2/7/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Environment of Care Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

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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 are included in the EC Plan are: Safety Management, Security Management, Hazardous Materials Management, Medical Equipment Management, Utilities Management, Fire/Life Safety Management and Emergency Management. Activities within these categories aim to manage the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced; and employees can respond effectively in an emergency. Separate management plans are written annually for each of these areas. **(EC 01.01.01 – EP 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 it's ad hoc subcommittees.

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

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.

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- 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.

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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 Mangers are provided with appropriate information regarding the EC Plan and are directed to maintain a current awareness of the EC Program, ensuring its effective implementation within their department. In addition:
   a. Set examples of Safety awareness and good safety practices for employees
   b. Use Safety/Incident Event Reports as appropriate

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c. Become familiar with all aspects of the EC Program

d. Develop and implement Safety Policy and Procedures within their department/program.

4. **BHD EMPLOYEES**

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

EC COMMITTEE FUNCTIONS

1. Meets monthly, or more frequently at the call of the chairperson;
2. Reviews/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;

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

RESPONSIBILITIES SPECIFIC TO THE VARIOUS MANAGEMENT AREAS OF THE EC

1. **SAFETY MANAGEMENT (EC 02.01.01 EP 1,3,4,5 & EC 02.01.03 EP 1, 4, 6; EC 02.06.01; EC 02.06.05; & EC 04.01.01)**
   a. Discuss topic quarterly or more frequently upon the call of the chairperson and record in minutes.
   b. Create an annual Safety Management Plan. **(EC 01.01.01 EP 4)**
   c. Incorporate all BHD departments in all related activities and Management Plans.
   d. Make appropriate recommendations for educational needs to the appropriate departments.
   e. Coordinate and cooperate in the development of departmental safety rules and practices. Conduct annual review of Department Safety Policy and Procedures (no less than every three years, if no significant change in Policy).
   f. Detect safety hazards (mechanical, physical, and/or human factors), and recommend corrections of such hazards.
   g. Semi-annually review the fall reduction program data and activities and make recommendations for changes to policies and procedures.
   h. Annually, develop goals, objectives and performance standards for Safety Management.
   i. Annually, assess the effectiveness of implemented recommendations.
   j. Report Quarterly on activities of Safety Management.
   k. Establish a process, and conduct a review of all Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
   l. Conduct environmental rounds/tours every six months in all areas where patients are served and annually in locations where patients are not served, with a multi-disciplinary team including the following individuals/departments:
      - Infection Prevention
      - Facilities Maintenance/Operations
      - Housekeeping
      - Administration
   m. Analyze and trend findings reported during environmental tours.
   n. Develops criteria in which environmental round findings can be categorized and determined to be significant.

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o. Annually, evaluate the effectiveness of the environmental rounds.

p. Analyze patient and non-patient falls, trend data and recommend appropriate prevention strategies.

q. Analyze and trend staff occupational illnesses, injuries and incidents reported on the OSHA Log or from Risk Management Department.

r. Analyze and trend visitor incidents reported to Risk Management.

s. Develop criteria in which incidents can be categorized and determined to be significant.

t. Review each of the following for trends and issues that need additional attention;

- Employee Safety
- Patient Safety

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

a. Discuss topic quarterly or more frequently upon the call of the chairperson and record in minutes.

b. Create an annual Security Management Plan.

c. Incorporate all BHD departments in all related activities and Management Plans.

d. Quarterly review analysis, trending and recommendations for security incidents relative to:

- Property
- Visitors
- Assaults
- Security Officer injuries, interventions
- Key control
- Security sensitive area accessibility
- Other

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e. Monitor the overall Security Management Program.

f. Establish a process, and conduct a review of all Security related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.

g. Annually review the Security Management Program that includes but not limited to:

- Patient, visitor, employee and property security concerns
- Sensitive area access control
- Traffic control policies and vehicular access
- Orientation and Education Programs
- Emergency preparedness programs related to security
- Security equipment (cameras, alarms, telephone, etc.)

h. Annually, develop goals, objectives and performance standards for Security Management.

i. Annually, assess the effectiveness of implemented recommendations.

j. Report Quarterly on activities of Security Management.

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

EM 02.02.07; EM 02.02.09 EM 02.02.11; EM 02.02.13; EM 02.02.15; EM 03.01.01 & EM 03.01.0; EM 04.01.01)

a. Discuss topic monthly or more frequently upon the call of the chairperson and record minutes.

b. Create and update annually the Emergency Operations Plan (EOP).

c. Incorporate all BHD departments in all related activities and Emergency Management Policies and Procedures.

d. Establish a process, and conduct a review of all Emergency Management related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/ program policies as appropriate.

e. Develop and monitor internal and external emergency management programs, with multi-discipline input, affecting all departments.

f. Evaluate and modify Emergency Operations Plans (EOP) and exercises.

g. Coordinate and evaluate the semi-annual emergency management exercise.

h. Monitor, evaluate, and implement changes to the EOP required by federal, state, local, and national organizations, as appropriate.

i. Maintain EOP, emergency management policies and procedures and critique and approve all in-house designated disaster assignment areas and department standard operating procedures a minimum of every three years or earlier if modifications are needed.

j. Annually, develop goals, objectives and performance standards for Emergency Management.

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

l. Report quarterly on activities of Emergency Management.

4. **HAZARDOUS MATERIALS AND WASTE MANAGEMENT (EC 01.01.01 EP 6; EC 02.02.01 & EP 1, 3, 4-12,19)**

a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.

b. Create an annual Hazardous Materials and Waste Management Plan.

c. Incorporate all BHD departments in all related activities and Management Plans.

d. Assist with the creation of the hospital wide right - to - know program (RTK).

e. Ensure that an annual review of chemical inventories occurs.

f. Evaluate the educational needs for RTK and hospital waste programs and make appropriate recommendations.

g. Monitor and assess waste control procedures and recommend policy/procedure changes as needed.

h. Monitor city, state, and federal environmental laws and regulations and recommend policy/procedure changes as required.

i. Evaluate products to promote hazardous materials and waste minimization for purchase or use.

j. Review hazardous materials and/or waste handling problems, spills or employee incidents and make recommendations for process improvement, personal protective equipment and environmental monitoring.

k. Monitor program recommendations, changes or implementations for effectiveness.

l. Annually, assess the effectiveness of the hazardous materials and waste management programs for selection, storage, handling, use and disposal and recommend changes as appropriate.

m. Review the Medical Waste Reduction Policy, and complete the Infectious Waste Annual Report with the DNR when required.

n. Conduct periodic audits of medical waste storage and disposal locations for presence of non regulated medical waste.

o. Report quarterly on activities of Hazardous Materials and Waste Management.

5. **FIRE PREVENTION/LIFE SAFETY MANAGEMENT (EC 01.01.01 EP 7; EC 02.03.01; EC 02.03.03; EC 02.03.05 and LS 01.01.01 through LS 03.01.70)**

a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.

b. Create an annual Fire Prevention Plan.

c. Incorporate all BHD departments in all related activities and Management Plans.

d. Coordinate and conduct fire drills once per quarter per shift in all patient care buildings. (Twice this if Interim Life Safety Measures are implemented.)

e. Analyze and trend the results of fire drills, actual fire events or false alarms and recommend appropriate changes or education.

f. Review inspection, preventive maintenance and testing of equipment related to the Life Safety Program.

g. Review agency inspections conducted or compliance survey reports. (i.e. Fire Marshal (state and local), Insurance, State Department of Quality Assurance, etc.)

h. Review changes/upgrades to the fire protection system; failures/problems discovered with the system, causes and corrective actions taken.

i. Review summaries of construction, renovation or improvement life safety rounds.

j. Assess Interim Life Safety Measures implemented as a result of construction or other Life Safety Deficiencies and review and plans of corrections

k. Monitor program recommendations, changes or implementations for effectiveness.

l. At each meeting, assess the status of the facility Statement of Conditions™ and compliance with the Life Safety Code.

m. Establish a process, and conduct a review of all Fire/Life Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.

n. Annually, develop goals, objectives and performance standards for Fire Prevention.

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

p. Report quarterly on activities of Fire Prevention Management.

6. **MEDICAL EQUIPMENT MANAGEMENT (EC 01.01.01 EP 8;EC 02.01.01 EP 11; EC 02.04.0; and EC 02.04.03)**

a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.

b. Create an annual Medical Equipment Management Plan.

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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

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- Sewage Systems
- Environment Control Systems
- Building Computer Systems
- Security Systems
- Other

g. Review management plans and monitoring systems relating to utility management.

h. Establish a process, and conduct a review of all Utility related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.

i. Annually, review the effectiveness of the utility system management program.

j. Review emergency procedures and plans to respond to utility system failures.

k. Review patient care equipment management (beds, lighting, etc) and all non-clinical high-risk equipment problems.

l. Report quarterly on activities of Utility Management.

8. **OTHER COMMITTEES**

a. The EC Committee has a relationship with two other committees, each share information regarding activities. Pertinent information is incorporated into the annual report submitted by the EC. These committees include:

1. Infection Prevention and Control- Although this is not a sub-committee; this existing committee has a relationship that submits information on a ' need to know' basis, identifying concerns.
2. Risk Management - Although this is not a sub-committee, this existing department has a relationship that submits information on a 'need to know' basis, identifying concerns.

9. **EOC EDUCATION (EC 03.01.01)**

a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.

b. Incorporate all BHD departments in all related activities and Management Plans.

c. Track and trend department compliance with housewide in-service attendance.

d. Review and assist in the development of educational programs for orientation and housewide in-services.

e. Develop criteria in which compliance with safety education can be effectively measured.

f. Make appropriate recommendations to other committees/leadership regarding problematic trends and assist in implementation of final resolution plans.

g. Develop and implement safety promotional ideas such as safety fairs, contests, and incentive programs.

h. Promote safety issues in various communication forms at BHD (newsletter, emails, signage).

i. Annually, develop goals, objectives and performance standards for education of EC related information.

j. Annually, assess the effectiveness of the annual safety in-service program.

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INTENT PROCESSES

1. **Issue Assessment (EC 04.01.01)**
   BHD addresses issues identified by the EC Committee related to each of the components of the Environment of Care Management Program. Based on the committee's assessment of the situation, a decision on the best coarse of action to manage the issue is determined. Documentation of this evaluation process may be found in the EC Committee minutes. Results of the process are used to create or revise policies and procedures, educational programs, and/or monitoring methods.

   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)~~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)

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)~~

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

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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)**

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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: ~~3-21-18~~2-20-19

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/7/2019

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Date Issued:	*1/1/2015*
Effective:	*Upon Approval*
Last Approved Date:	*N/A*
Last Revised Date:	*2/7/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Safety Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

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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:

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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.

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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.

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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

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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

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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: ~~3-8-18~~2-14-19

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

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Attachments: No Attachments

Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/7/2019

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Date Issued:	*1/1/2015*
Effective:	*Upon Approval*
Last Approved Date:	*N/A*
Last Revised Date:	*2/7/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Security Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

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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.

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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 Commend Center as appropriate.

B. **Addressing Security Issues (EC 02.01.01 EP 1&3)** – A security risk assessment will be conducted annually of the facility. 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

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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

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8:30 p.m. and the Rear Employee Entrance 53A Ramp 24 hours per day, 7 days per week.

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

G. **Vehicular Access** – Vehicular access to the Psychiatric Crisis Service area is controlled by Security 24/7 and limited to emergency vehicles only.

ORIENTATION AND EDUCATION

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

B. **Annual Continuing Education:** Education regarding security is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. **(HR 01.05.03 EP 1)**

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

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

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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)~~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

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in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

Reviewed and approved at the Environment of Care Committee meeting on: ~~3-8-18~~2-14-19

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/7/2019

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Date Issued:	*1/1/2013*
Effective:	*Upon Approval*
Last Approved Date:	*N/A*
Last Revised Date:	*2/4/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Hazardous Materials and Waste Management Plan

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- 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

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electronic Incident/Safety Event Reporting System and the Accident Claims Reporting System. Post exposure treatment and follow up are determined by the treating physician and any recommended best practices for the type of exposure.

E. **Managing Hazardous Chemicals - (EC 02.02.01 EP 5)**
HMW are managed in accordance with the SDS, MCBHD policies and applicable laws and regulations from the time of receipt to the point of final disposition. The inventory of HMW is maintained by the HMWM program manager(s) and Safety Officer. The SDS corresponding to the chemicals in the inventory are available through an on-line electronic service. In addition, a complete set of current SDS is maintained in both the Psychiatric Crisis Department and Engineering and Environmental Services (EES) Department.

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

F. **Managing Radioactive Materials - (EC 02.02.01 EP 6; EC 02.02.01 EP18)**
MCBHD does not use or store any radioactive materials as part of normal operations

G. **Managing Hazardous Energy Sources - (EC 02.02.01 EP 7)**
Any equipment that emits ionizing (for example: x-ray equipment) and non-ionizing (for example: ultrasound and ultraviolet light) radiation is inventoried as part of the medical equipment management program. Contracted agency staff provide mobile x-ray, ultrasound and EKG services and are responsible for managing the devices used including quality control measurement, maintenance, calibration, testing, or monitoring. Staff for contracted agencies are trained in the use of the devices and appropriate PPE necessary for safety per the contracted agencies Hazard Communications Program. MCBHD staff that use equipment are trained in the operation and safety precautions of the device prior to use of the equipment.

H. **Managing Hazardous Medications - (EC 02.02.01 EP 8; MM 01.01.03 EP 1, 2, & 3)**
As part of the HMWM program, the contracted pharmacy provider is responsible for the safe management of dangerous or hazardous medications, including chemotherapeutic materials. The pharmacy orders, stores, prepares, distributes, and disposes of medications in accordance with policy, law and regulation. MCBHD does not normally carry or prescribe chemotherapeutic materials.

I. **Managing Hazardous Gases and Vapors - (EC 02.02.01 EP 9 & 10)**
MCBHD does not produce any hazardous gases or vapors as a part of normal operations. Therefore MCBHD does not conduct any annual monitoring of exposure to hazardous gases and vapors. In the event of a concern regarding the presence of a hazardous gas or vapor, the area will be evaluated and/or monitored for the presence of such hazards in accordance with nationally recognized test procedures. Recommended action will be taken based on the results.

J. **Managing Infectious & Regulated Medical 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, andthe 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 reducation heirarchy (waste reduction, reuse, recycling (where applicable)) and staff education. Waste reduction may be accomplished by, but not be limited to, reducing the amount of packaging, reducing the amount of disposable items used, product substitution, equipment modification, purchasing policies, housekeeping practices and more effective separation practices. It is BHD's goal to reduce the volume of medical waste to below 50 pounds per month or that volume that requires reporting to the WDNR.

RMW are managed for MCBHD by the EES Department in conjunction with the contracted Housekeeping provider. The Housekeeping provider is responsible for the distribution and collection of appropriate containers for the collection of RMW including medical sharps. Sharps and other infectious wastes are accumulated at satellite locations across the clinical areas but, in the case of sharps containers, never in patient areas. The containers, provided by MCBHD, are easily identifiable as RMW or isolation containers, are leak-proof and are puncture resistant. Sharps containers, when full, can be locked to prevent inadvertent needle sticks. MCBHD nursing staff is responsible for placing filled containers in appropriate trash holding area for pickup and/or calling the EES Department to arrange pick up and replacement of filled RMW containers. Any staff member, patient or visitor exposed to RMW or who becomes injured due to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.

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

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

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

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

K. **Management of Required Documentation (permits, licenses, labeling and manifests) (EC 02.02.01 EP 11 & 12)**
The manager of the HMWM program, Safety Officer or otherwise designated MCBHD employee will maintain all required documentation including any permits, licenses, and shipping manifests. Manifests are reconciled with the licensed RMW hauler's records on a monthly basis and action is taken regarding unreturned copies of manifests.

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

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

L. **Storage of Hazardous Materials and Waste (EC 02.02.01 EP 19)** – Satellite areas of HMW or RMW are located within the generating department. These wastes are then transported to the HMW or RWM storage area(s) located on the soiled dock. A licensed hazardous waste or RMW disposal company transports hazardous or RMW off-site for disposal. The EC Committee performs quarterly inspections of the storage area(s).

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

ORIENTATION AND EDUCATION

A. **New Employee Orientation:** Education regarding the HMW/RMW Program begins with the New Employee Orientation Program for all new employees and continues on an ongoing basis with departmental specific training, job-specific training, and continued education required for all employees on an annual basis. Training includes generic information on the Hazard Communication Program, use and access to SDSs, labeling requirements of hazardous material containers, and the use of engineering controls, administrative controls, and PPE. **(EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)**

B. **Annual Continuing Education:** Education regarding HMW is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. **(HR 01.05.03 EP 1)**

C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific HMW related policies and procedures as well as specific training on the health effects of the substances in the work place and methods to reduce or eliminate exposure. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

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

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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: ~~3-8-18~~2-14-19

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/4/2019

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Date Issued:	*1/1/2015*
Effective:	*Upon Approval*
Last Approved Date:	*N/A*
Last Revised Date:	*2/7/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Fire/Life Safety Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

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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%)

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

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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: ~~3-8-18~~2-14-19

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

Attachments:

No Attachments

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Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/7/2019

Date Issued:	*1/1/2015*
Effective:	*Upon Approval*
Last Approved Date:	*N/A*
Last Revised Date:	*2/4/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Medical Equipment Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

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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:

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

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

SCOPE:

The Medical Equipment (ME) Management Plan establishes the organizational structure within which medical equipment is well maintained and safe to use. In addition to addressing specific responsibilities, general safety, and employee education programs the plan is in all efforts directed toward ensuring that all patients and employees are supported in their use of medical equipment, devices, and technology, thereby reducing the risk of injuries to patients, visitors and employees, and employees can respond effectively in the event of equipment breakdown or loss. **(EC 01.01.01-EP 8)**

MCBHD locations include:
Behavioral Health Division – 9455 Watertown Plank Rd, Wauwatosa, WI 53226

OBJECTIVES:

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

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable Medical Equipment related codes and regulations, and evaluate the effectiveness of the Medical Equipment program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. **(EC 01.01.01-EP8)**

INTENT PROCESSES:

A. **Selecting and Acquiring Equipment** – As part of the capital budgeting cycle, Department Program Directors and Managers are responsible for identifying and justifying new and replacement medical equipment for their departments or areas of responsibility. Requests are subject to administrative approval. Funds for approved capital projects are released on an annual basis. As a rule a representative from the medical equipment management company will be asked to participate with the user department and MCBHD Central Supply Dept. and Maintenance Dept. staff in the evaluation of equipment alternatives and represent the equipment support issues during the selection process. The manager of the ME program along with the Safety Officer are responsible for coordinating the evaluation, purchase, installation, and commissioning processes of new equipment according to the ME purchasing policy.

B. **Equipment Inclusion in the Medical Equipment Management Plan and Inventory (EC 02.04.01 EP 2)** – All Medical Equipment will be inventoried and tracked in the computerized maintenance management system provided by the contracted maintenance company. The accuracy of this inventory will be verified during scheduled maintenance inspections by comparing the number of items that are no longer in service but still scheduled for inspection, to the total number of items scheduled for inspection. Missing equipment or equipment that the MCBHD Central Supply staff is not aware of being removed from service will be investigated and, if found, reviewed for functionality and either put back into service or permanently

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

C. **Equipment Inspection, Testing, and Maintenance (EC 02.04.01 EP 3 & 4; EC 02.04.03 EP 1-3 & 27)** –The basis for the determination of inspection frequency is risk. Equipment will be inspected upon purchase and initially at one of the following intervals, quarterly, semi-annually, annually, or 18 months. The clinical equipment contractor shall determine and document inspection procedures and intervals for inspection of clinical equipment, based on manufacturer's recommendations, regulations and standards, actual experience with the device, and known hazards and risks. All devices will receive a performance verification and safety test during the incoming inspection procedure and after completion of a major repair or upgrade. All work activities, inspection schedules, and work histories are kept in the contracted company's software inventory list and Central Supply Department. The Central Supply staff assures that the contracted company completes scheduled maintenance and other service activities as required.

   Note: BHD does not currently utilize hemodialysis, sterilizers, or nuclear medicine equipment. **(EC 02.04.03 EP 4, 5 & 14)**

D. **Monitoring and Acting on Equipment Hazard Notices and Recalls (EC 02.01.01 EP 11)** –BHD uses RASMAS for recall and alert management. When an alert or recall may be related to equipment at MCBHD, the storeroom/central supply staff are notified to investigate if any equipment is part of the alert/ recall, remove it from service and document any actions taken.

E. **Monitoring and Reporting of Incidents (Including Safe Medical Device Act (SMDA)) (EC 02.04.01 EP 5; EC 04.01.01 EP 10)** All equipment used by BHD staff and/or contractors in the care of BHD patients is required to comply with SMDA per contract.The Quality Improvement/Risk Management department is responsible for investigating and reporting the incident to the manufacturer and/or Food and Drug Administration as appropriate.

F. **Reporting Equipment Management Problems, Failures and User Errors (EC 02.04.01 EP 6 & 9)** –Users report equipment problems to Central Supply Staff and/or Maintenance Department Staff per policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*. Repairs and work orders are recorded in the computerized maintenance management system. These records are reviewed by Central Supply Staff and a summary reported to the EC Committee quarterly regarding significant problem areas and trends.

G. **Emergency Procedures and Clinical Intervention (EC 02.04.01 EP 6)** –In the event of any emergencies, the department employee's first priority is for the safety and care of patients, visitors, and employees. Replacement equipment can be obtained through the Central Supply Department during business hours. The House Supervisor has access to Central Supply during off hours. Additional procedural information can be found in the policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*

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

ORIENTATION AND EDUCATION

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

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

B. **Annual Continuing Education:** Education regarding medical equipment is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. The EC Committee will, as part of the annual program review, identify technical training needs and assist with the creation of any training program as identified. **(HR 01.05.03 EP 1)**

C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific medical equipment related policies and procedures and specific job related equipment procedures and precautions. Training of employees and technical staff regarding use, features, maintenance and precautions is included as a part of new equipment acquisition/purchase. Additional training/retraining will be conducted based user-related problems or trends seen in the program evaluation. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

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

PERFORMANCE MONITORING

(EC 04.01.03 EP 2; EC 04.01.05 EP 1)

A. Ongoing performance monitoring is conducted for the following performance indicators: Monitor and report on the number of equipment repairs.

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

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

Reviewed and approved at the Environment of Care Committee meeting on: ~~3-8-18~~2-14-19

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

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/4/2019

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Date Issued:	*1/1/2015*
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Last Revised Date:	*2/7/2019*
Next Review:	*3 years after approval*
Owner:	*Lynn Gram: 11003002-Safety Officer*
Policy Area:	*Environment of Care*
References:	

Utilities Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

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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

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failure trends.

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable Utilities related codes and regulations, and evaluate the effectiveness of the Utilities program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. **(EC 01.01.01-EP 9)**

INTENT PROCESSES:

A. **Environment of Care, Design and Installation of Utility Systems (EC 02.05.01-EP1 & 2; EC 02.05.03 EP 1)–** Per our mission statement, the Utilities Management Plan is designed to promote a safe, controlled and comfortable environment of care by providing and maintaining adequate and appropriate utility services and infrastructure. This is managed and supported through the Environmental and Engineering Services department. The Facilities Manager collaborates with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local state and national building and fire codes. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager also assures that the necessary parties complete a Pre-Construction Risk Assessment (PCRA), which reviews air quality requirements, infection prevention and control, utility requirements, noise, vibration, fire safety, and other hazards. Recommended precautions from the PCRA are implemented as part of the project design. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of BHD

B. **Nosocomial Infection (EC 02.05.01-EP 6 & 7; EC 02.05.05-EP4)–** Proper maintenance of utility systems contributes to the reduction of hospital-acquired illnesses. The Infection Preventionist monitors the potential for these illnesses, referred to as Nosocomial Infections. Any concerns that may be utilities related will be addressed in a timely manner.

C. **Risk Minimization and Operational Reliability (EC 02.05.01-EP 4 & 5; EC 02.05.05-EP 4, 5, & 6; EC 02.05.07-EP1-10)–** Through specific Computerized maintenance Management Program, inspections and

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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

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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.

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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,

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ORIENTATION AND EDUCATION

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

- Emergency shutoff controls, use, and locations for each critical utility system serving the work environment
- Appropriate process for reporting of utility system problems, failures, and user errors.

B. **Annual Continuing Education:** regarding utilities is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. **(HR 01.05.03 EP 1)**

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

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

PERFORMANCE MONITORING

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

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

1. Measure the completion rate of preventive maintenance tasks (Goal =~~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%)

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

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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:

No Attachments

Approval Signatures

Step Description	Approver	Date
Environment of Care Committee	Lynn Gram: 11003002-Safety Officer	pending
	Lynn Gram: 11003002-Safety Officer	2/7/2019

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POLICY & PROCEDURE STATUS REPORT -GOAL=96%

Baseline 71.5% as of August 2016 LAB report

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

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
September	5	10	1
October	4	14	1
November	10	14	0
December	10	9	1
January	5	12	0

Overall Progress 95.5% as of February 1, 2019

Current

Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	520	525	95.4%	95.5%
Up to 1 year Overdue	20	20	3.7%	3.6%
More than 1 year and up to 3 years overdue	1	2	0.2%	0.4%
More than 3 years and up to 5 years overdue	1	1	0.2%	0.2%
More than 5 years and up to 10 years overdue	1	1	0.2%	0.2%
More than 10 years overdue	2	1	0.4%	0.2%
Total	545	545	100%	100%

Forecast Due for Review

Past Due Policies - 25

Coming Due Policies

February – 3
March – 3
April – 2
May – 2
June -11
July – 8
August – 45
September – 1
October – 19
November – 10
December – 18
January - 10