



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

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

**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

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	13	Percentage of Informal Supports on a Child and Family Team (Wrap HMO)	34.3%	33.1%	34.3%	31.2%	33.2%	> = 50%		BHD (2)
	14	Average Cost per Month (families serviced in Wraparound HMO)		\$2,187	\$2,937	\$2,996	\$2,706			

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

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

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

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

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

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

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

"Permanency" is defined as:

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

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

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



**BHD** MILWAUKEE COUNTY  
Behavioral  
Health  
Division

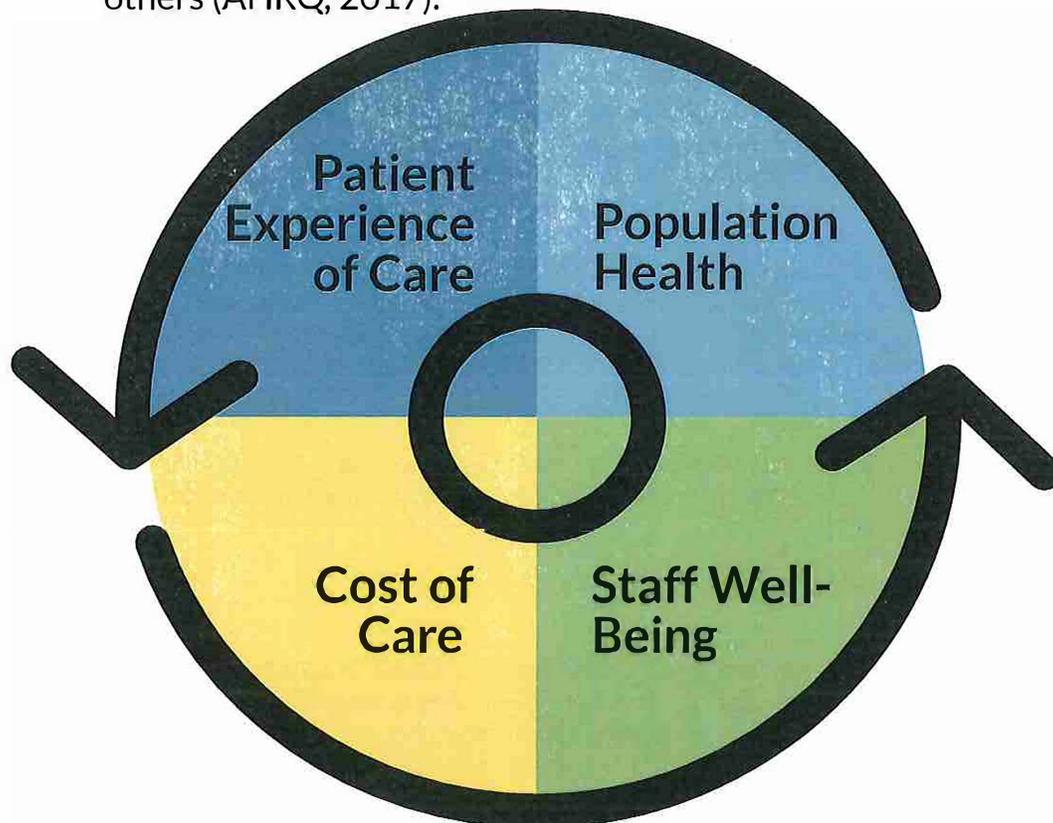
## CARS Quality Dashboard

CARS Research & Evaluation Team

### The Framework: The Quadruple Aim

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

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



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

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

# CARS QUALITY DASHBOARD SUMMARY Q4 2019

## CHANGES AND UPDATES

### Further Development of the Quadruple Aim

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

#### Population Health

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

#### Patient Experience of Care

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

#### Staff Wellbeing

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

#### Cost of Care

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

## RESULTS

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

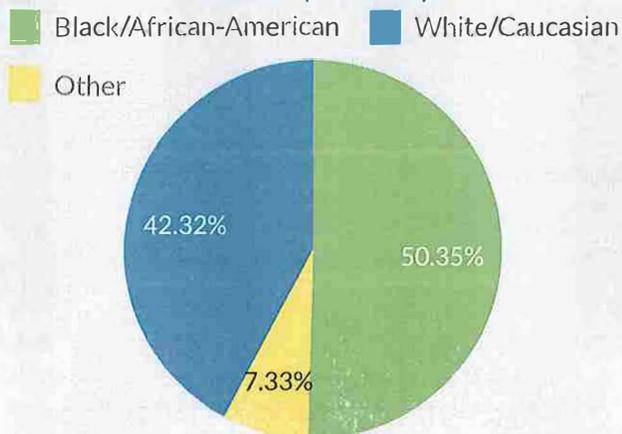
## NEXT STEPS

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

## Demographic Information of the Population We Serve

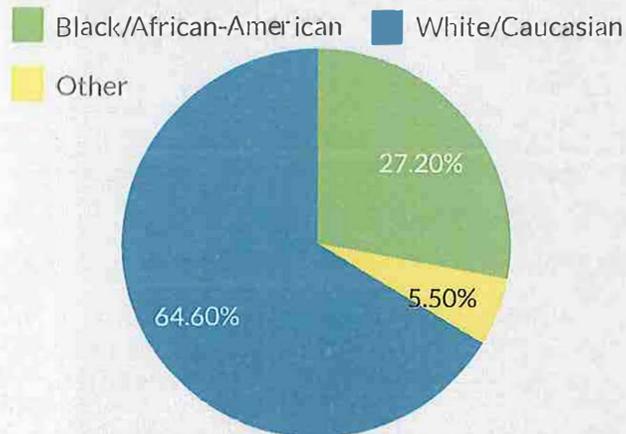
This section outlines demographics of the consumers CARS served last quarter compared to the County population.

### Race (CARS)



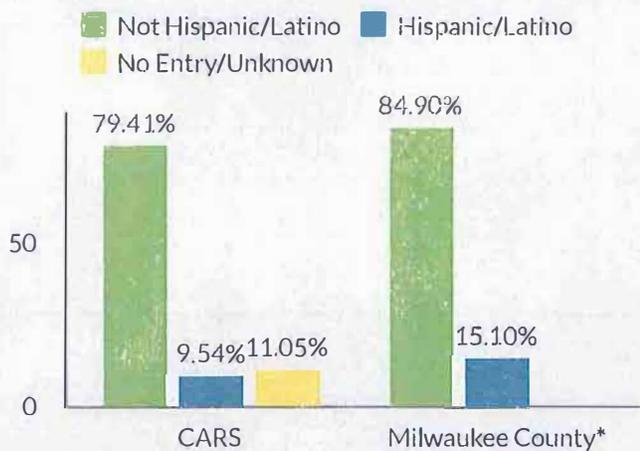
"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

### Race (Milwaukee County)\*

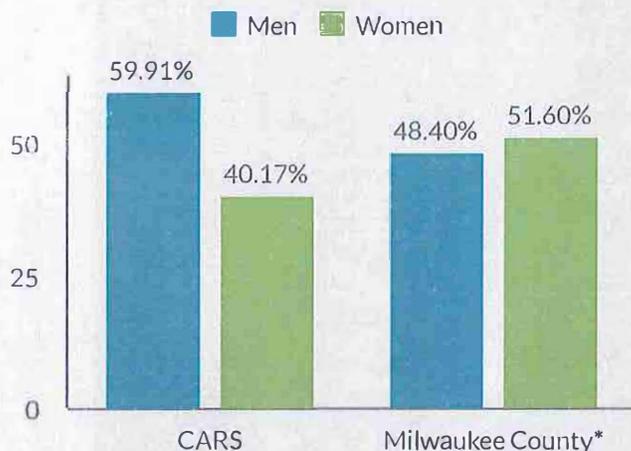


"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", and "Other"

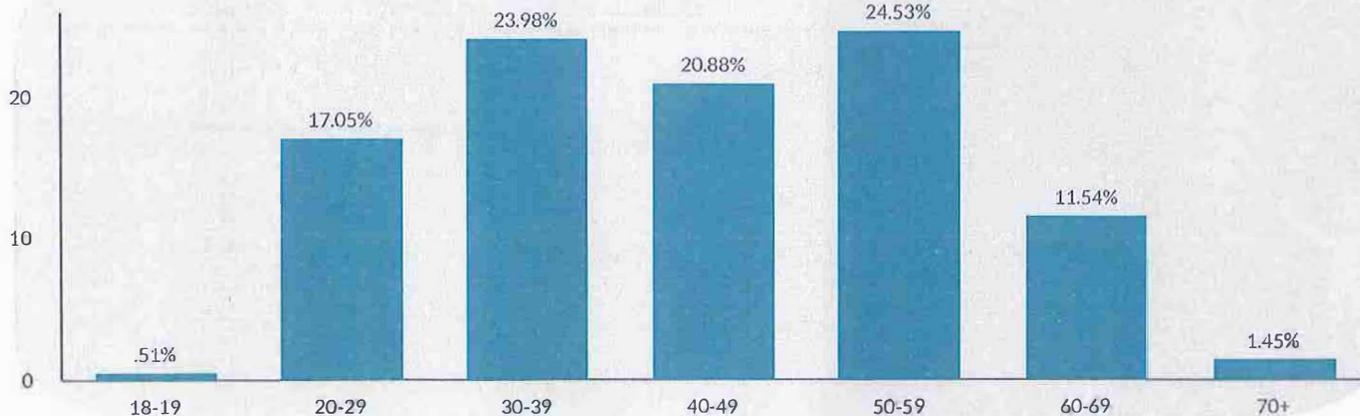
### Ethnicity



### Gender



### Age



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



# Domain: Patient Experience of Care

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



## Referrals

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



## Timeliness of Access

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



## Admissions

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



## Volume Served

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



### Consumer Satisfaction



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

\*Results from the CCS ROSI Survey are attached.

12.90%

Response Rate

7,234

surveys distributed

933

surveys received



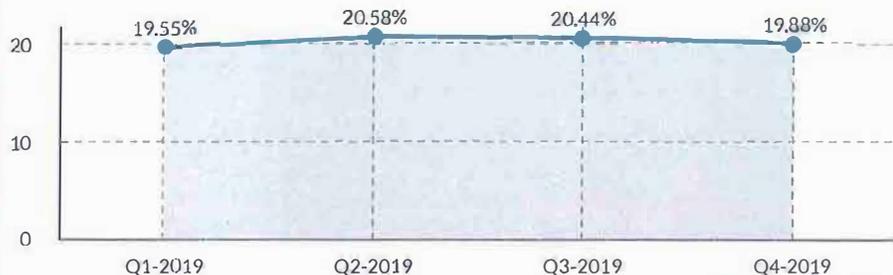
### Domain: Population Health

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



#### Acute Services

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



#### ER Utilization

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



#### Detoxification 7-Day Readmissions

Percent of consumers returning to detoxification within 7 days.



#### Abstinence

Percent of consumers abstinent from drug and alcohol use.



#### Homelessness

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





## Domain: Population Health (Continued)

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

### Employment



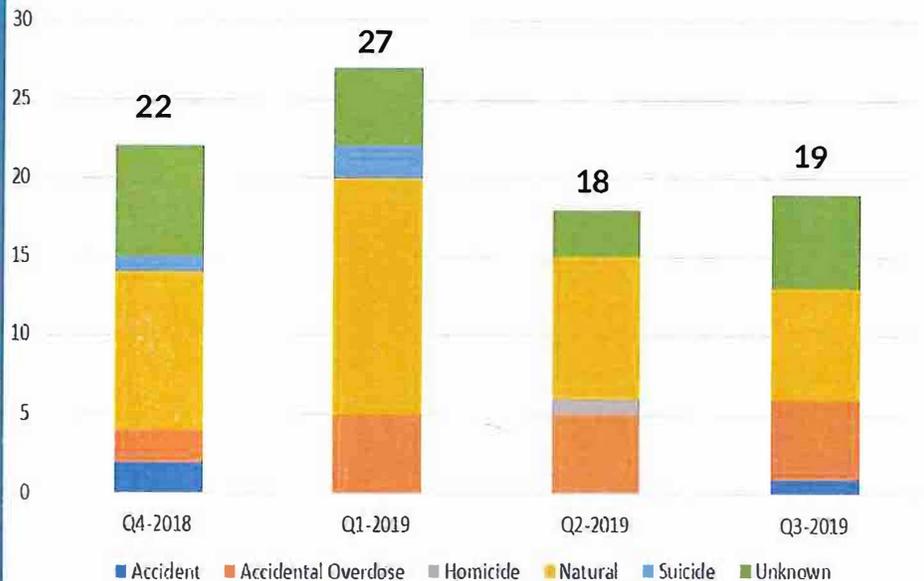
Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".



### Mortality Over Time

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

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



### Cause of Death

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

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



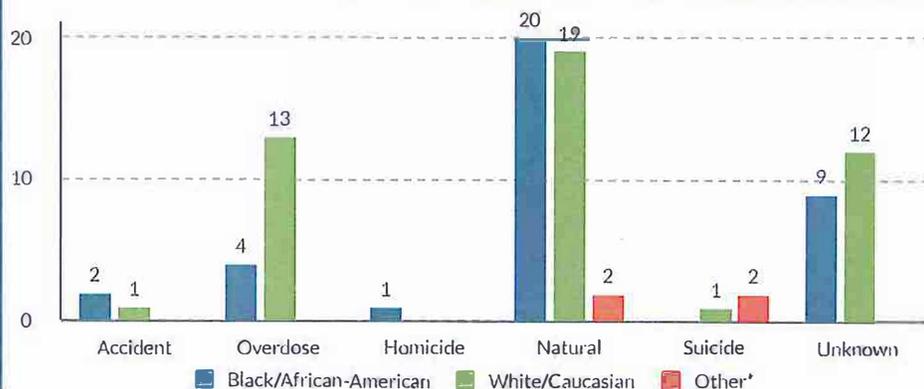
### Cause of Death

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

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

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

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

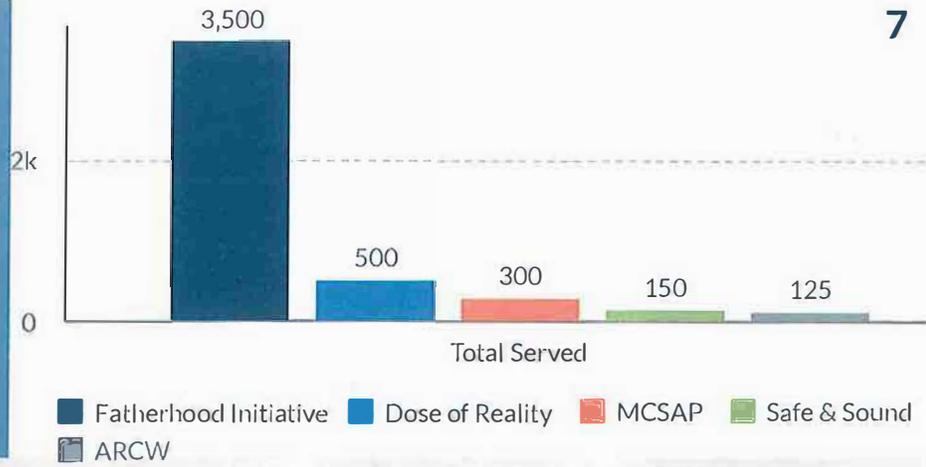


### Top Prevention Activities/Initiatives

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

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

**ARCW:** AIDS Resource Center of WI



### Domain: Cost of Care

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

### Average Cost Per Consumer Per Month

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

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



### Domain: Staff Well-Being

### Turnover

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



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

**15.70%**

CARS turnover rate

**20.00%**

Turnover rate for government employees (per year)\*



### Staff Quality of Life

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

# Health and Well-Being

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

Q4 2019



36.00% → 44.30%

## Health Outcome

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

n=289



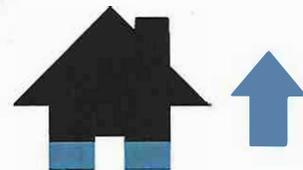
### Social Determinants



15.90% → 22.80%

43.40% increase in Employment\*\*

n=395

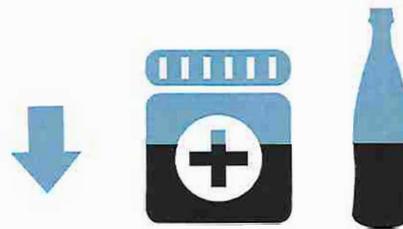


58.20% → 71.50%

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

n=407

### Health Behaviors

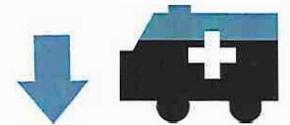


17.70% → 9.40%

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

n=417

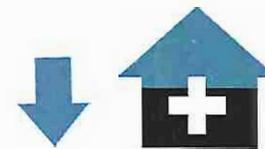
### Clinical Care



12.60% → 8.30%

34.13% decrease in Psych ER Use\*

n=433



26.20% → 12.30%

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

n=424

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

# Health and Well-Being

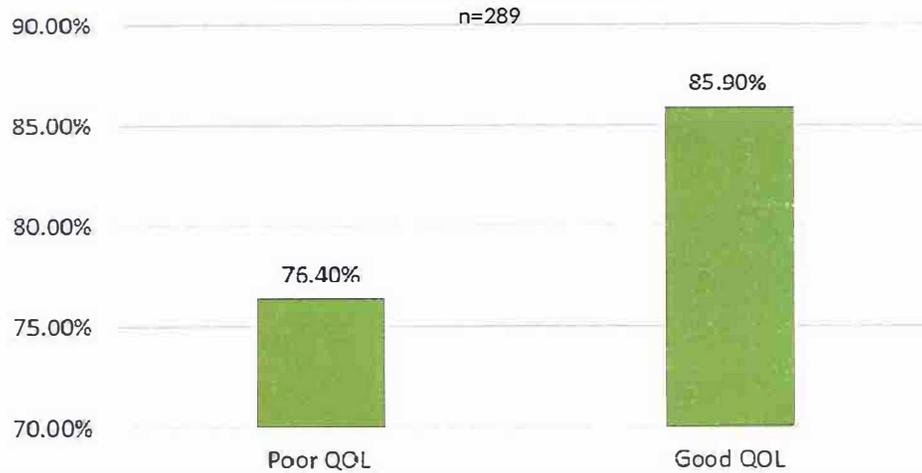
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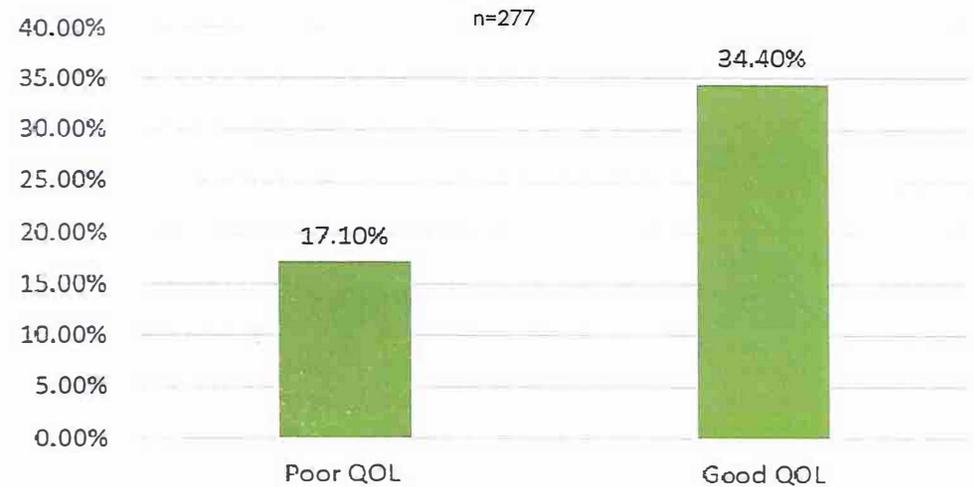
Q4 2019

## Quality of Life at Follow-Up

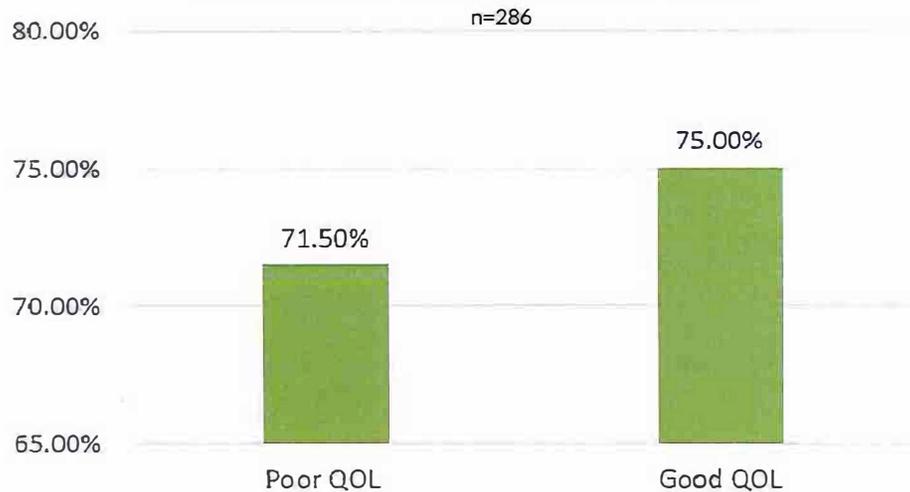
Percent of Individuals that had Social Interaction with Family/Friends in Past 30 days\*



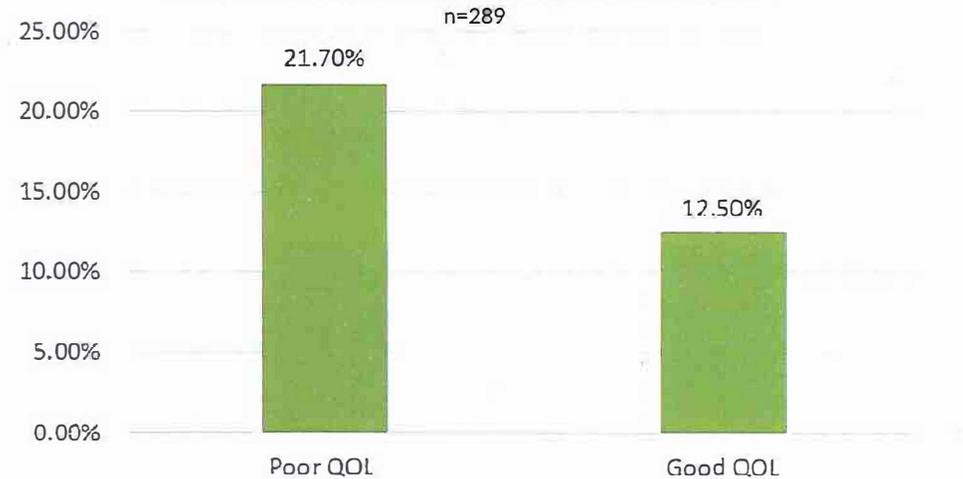
Percent of Employed Individuals\*\*



Percent of Individuals in Stable Housing



Percent of Individuals Utilizing Acute Services\*



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

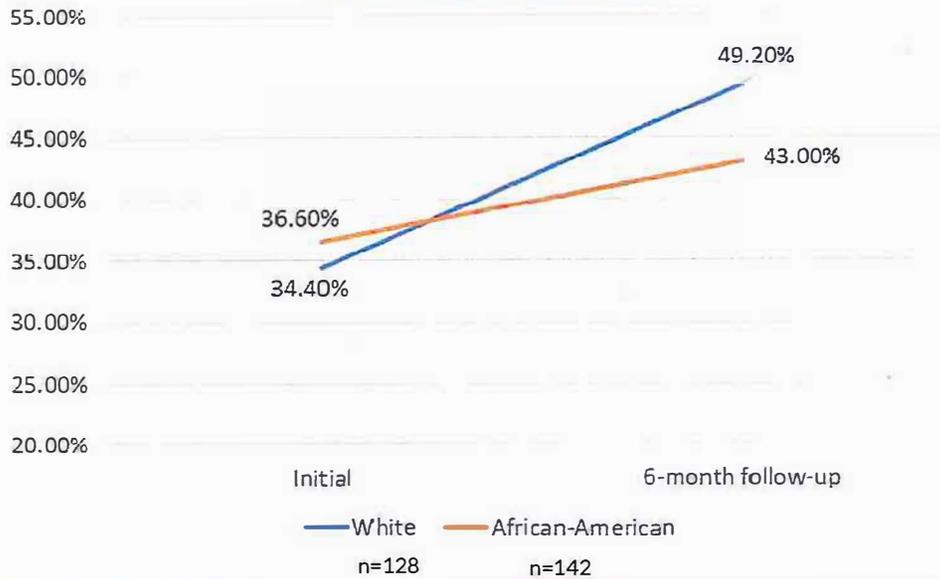
# Health and Well-Being

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

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Q4 2019

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



## Next Steps

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

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

Average Age by Race

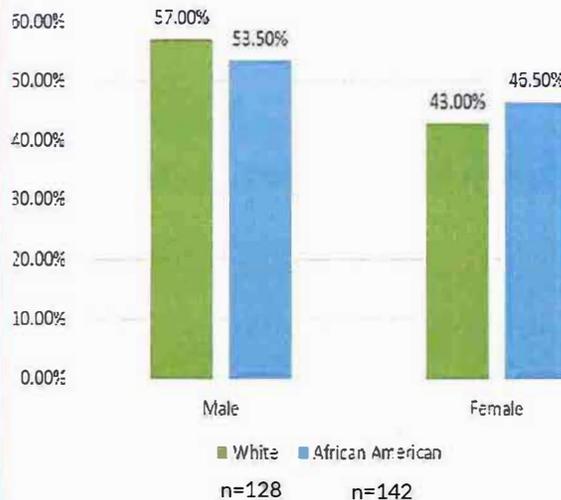
42.50

African-American  
n=128

41.40

White  
n=142

Gender by Race



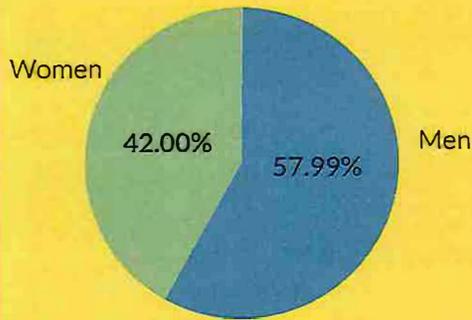
Marital Status by Race



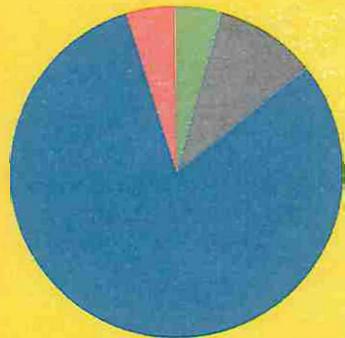
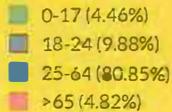


Includes all Adult Services, as well as CAIS and youth served in PCS

## Volume Served 8,395

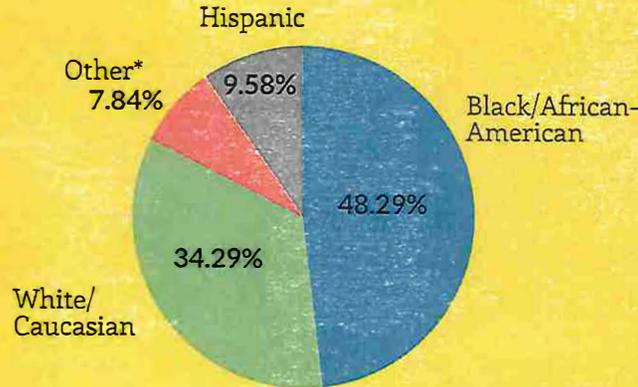


### Gender



### Age

## Race/Ethnicity



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

## Socioeconomic Status



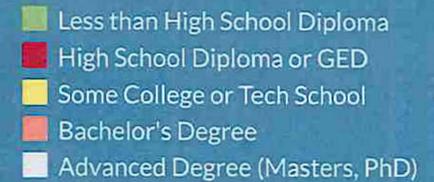
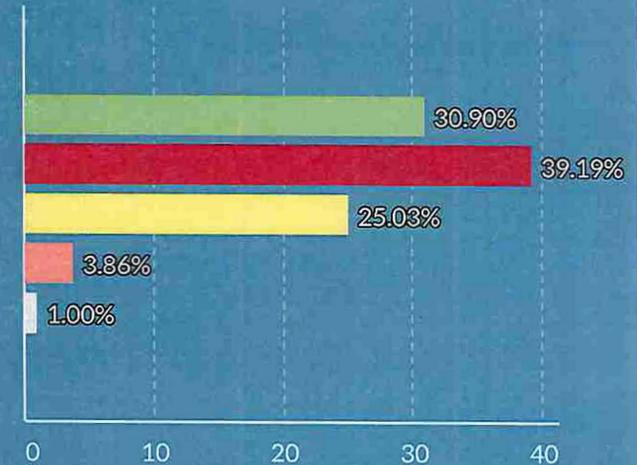
SES is determined based on income and education levels, and calculated based on zip code. Median income is listed for each group.

For more information, please visit:

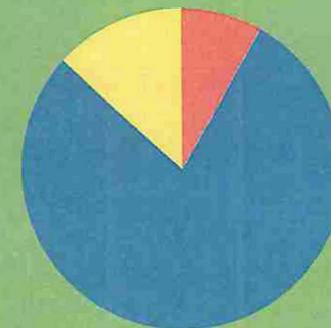
<http://www.cuph.org/milwaukee-health-report.html>

## Education

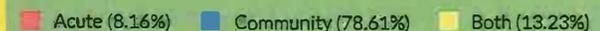
n=6,297



## Service Distribution



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



# Children's Community Mental Health Services and Wraparound Milwaukee

## CCS Youth and Family MHSIP Survey Report

Prepared by: Adrienne Sulma

# 2019

MHSIP -F  
Response Rate

**34%**

MHSIP -Y  
Response Rate

**14%**

### Description

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

### Average Age

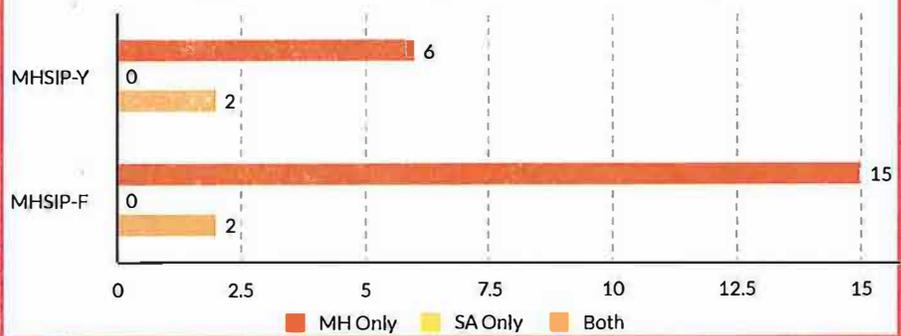


MHSIP-F  
10

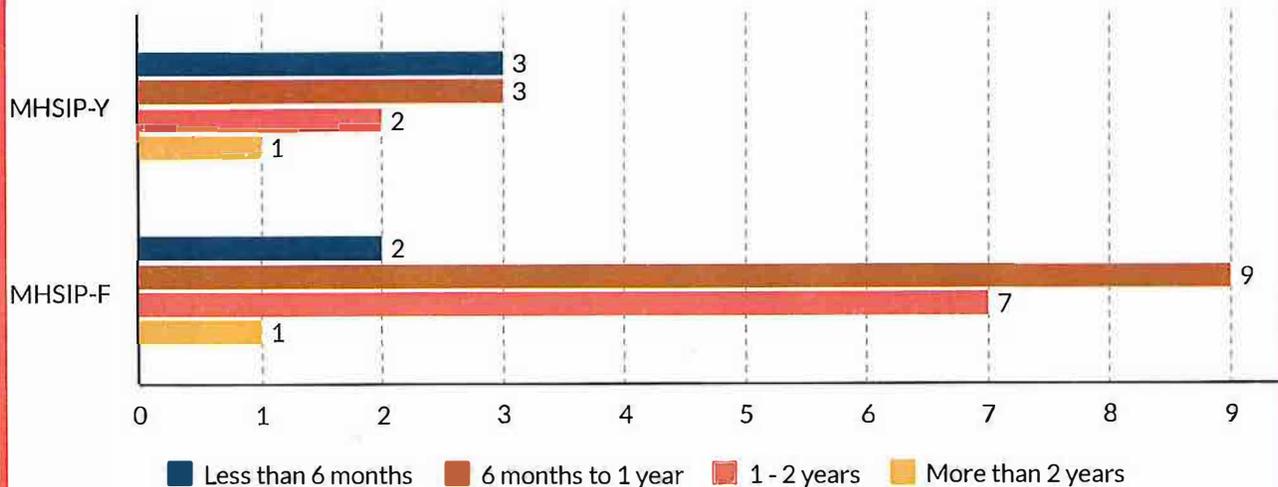


MHSIP-Y  
15

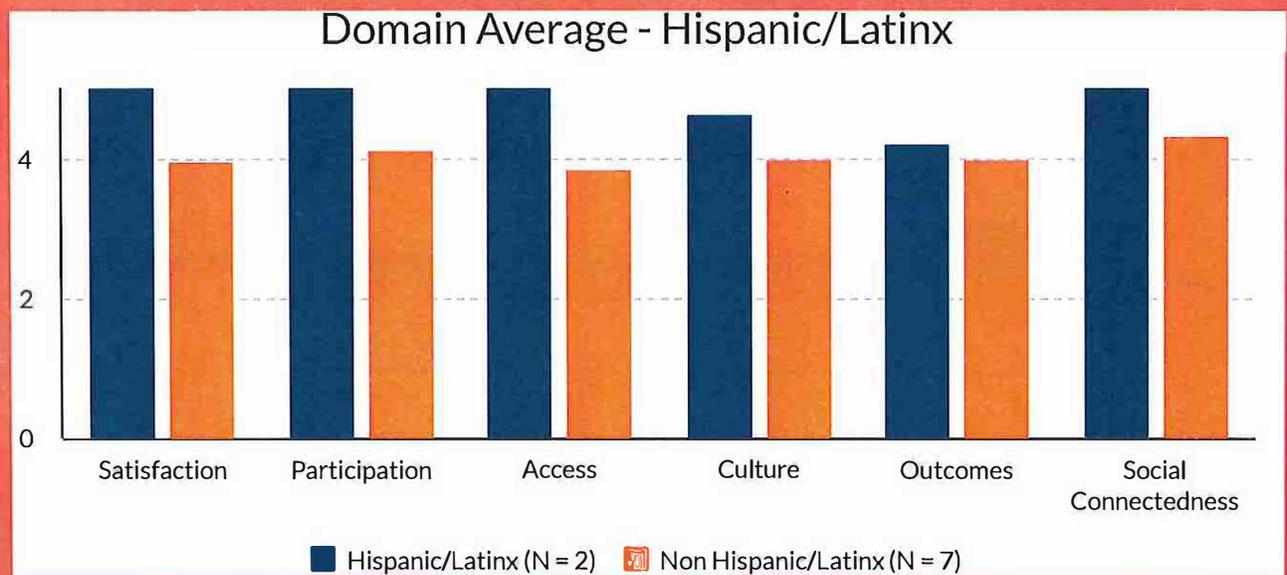
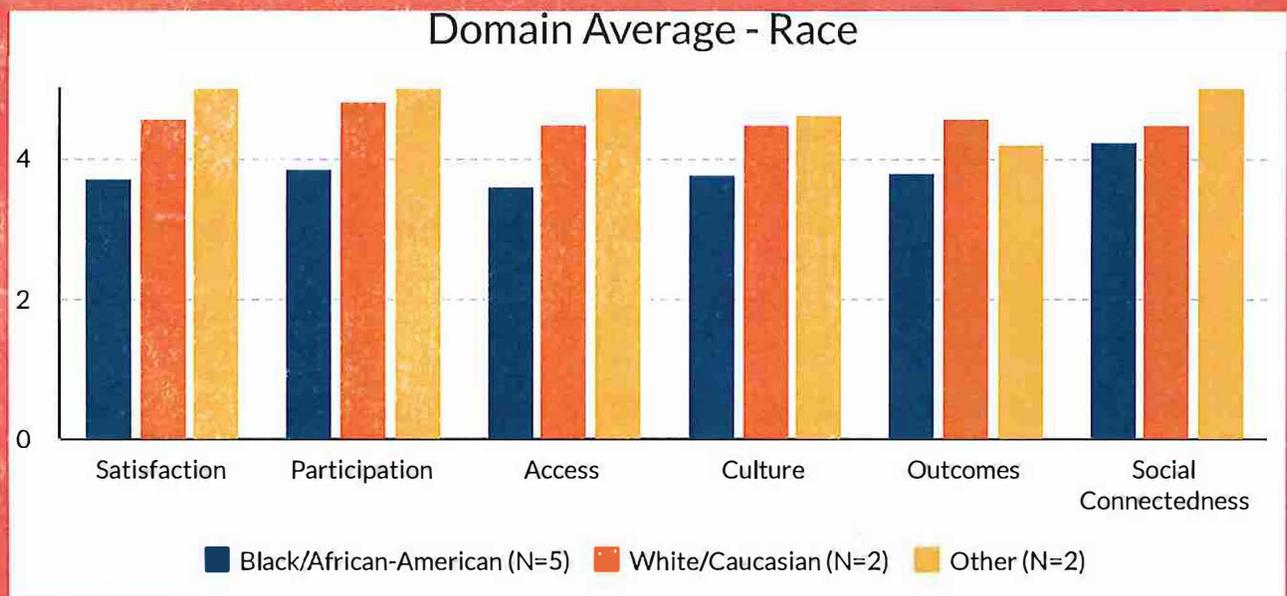
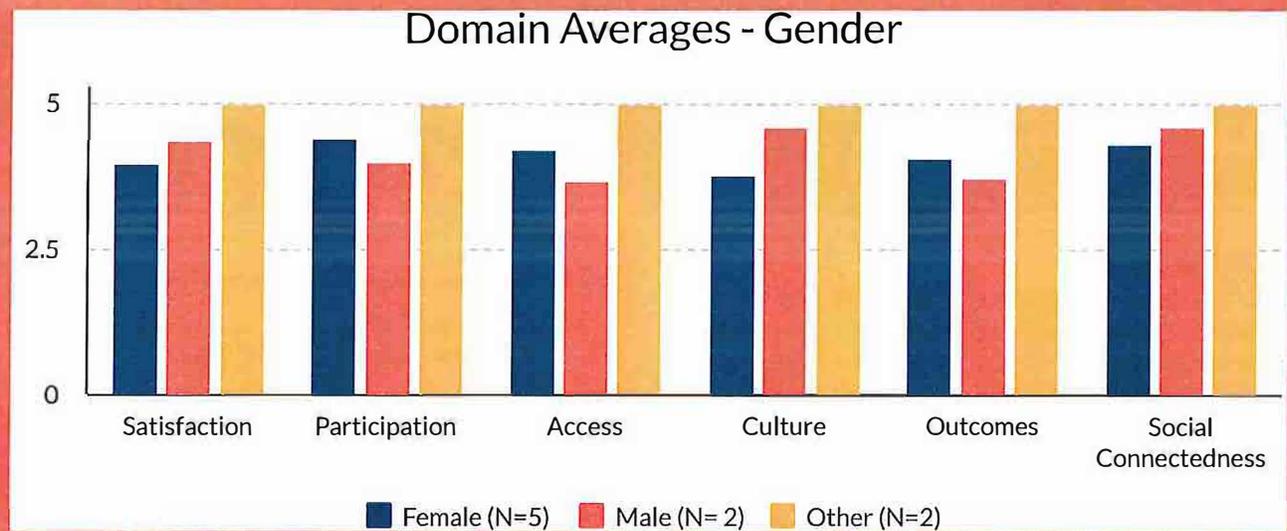
### Types of Service (MH/SA/MH & SA)



### Length of Time in CCS



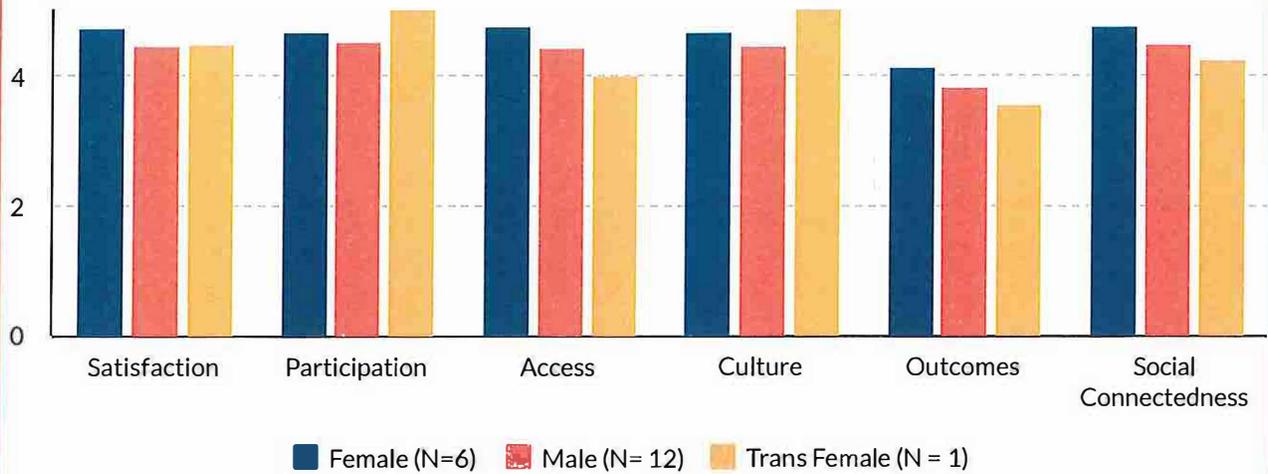
# MHSIP-Y (Surveys Completed: 10)



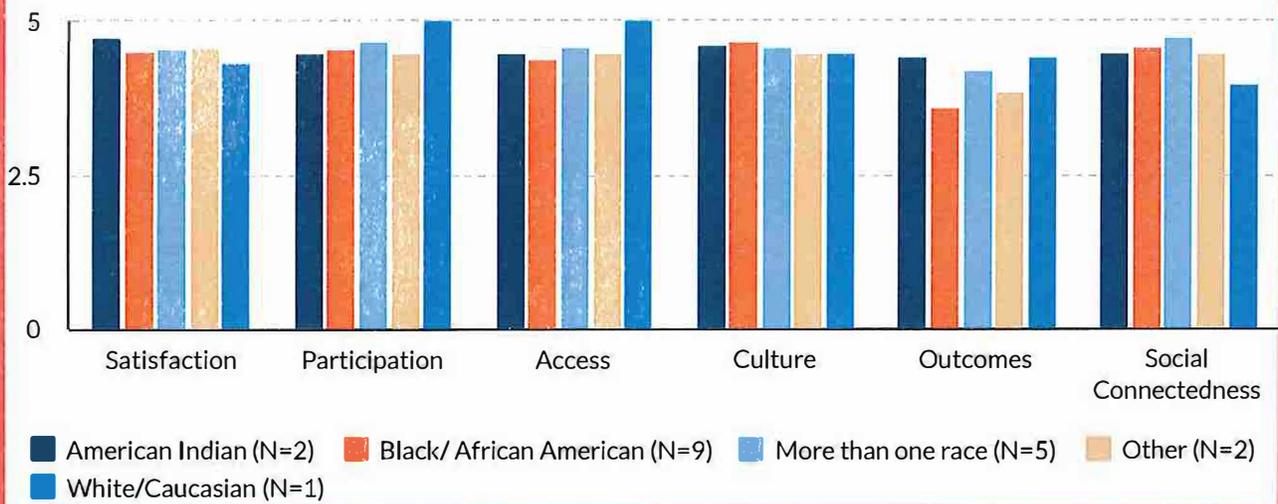
\*Domains in these graphs have reverse calculation for reporting consistency across this data summary

# MHSIP-F (Surveys Completed: 19)

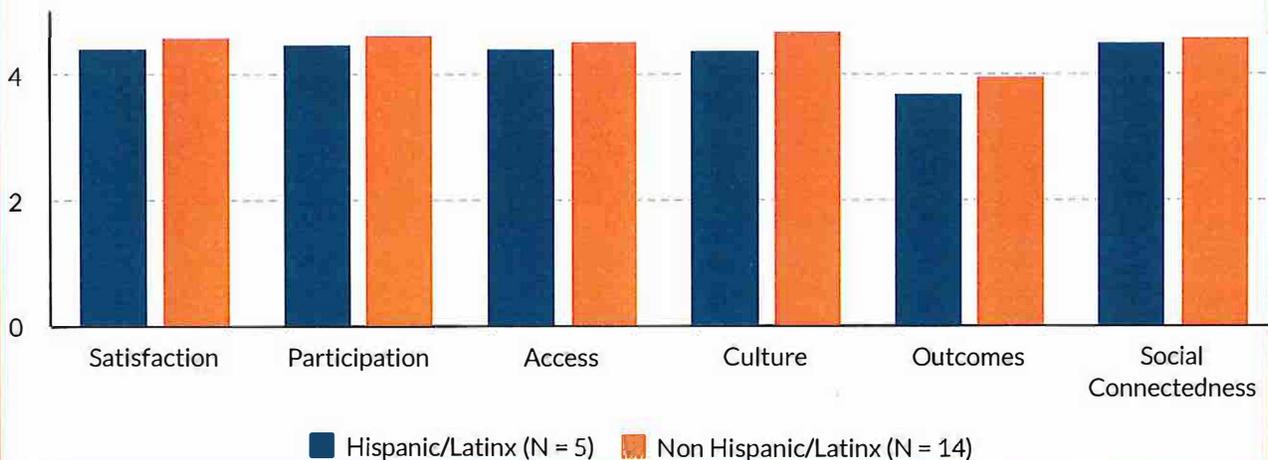
## Domain Averages By Gender



## Domain Average by Race



## Domain Average - Hispanic/Latinx



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

MHSIP  
Consumer  
Satisfaction  
Survey

Annual

2019

---

Prepared By:  
Quality  
Improvement  
Department

Created 2/4/20

## Overview

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

## Introduction

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

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

## Method

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

## Instrument

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

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

## NRI/MHSIP Inpatient Consumer Survey (2001)

### **Outcome Domain:**

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

### **Dignity Domain:**

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

### **Rights Domain:**

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

### **Participation Domain:**

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

### **Environment Domain:**

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

### **Empowerment Domain:**

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

### **Other survey items:**

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

## Results

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

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

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

## Response Rate

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

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

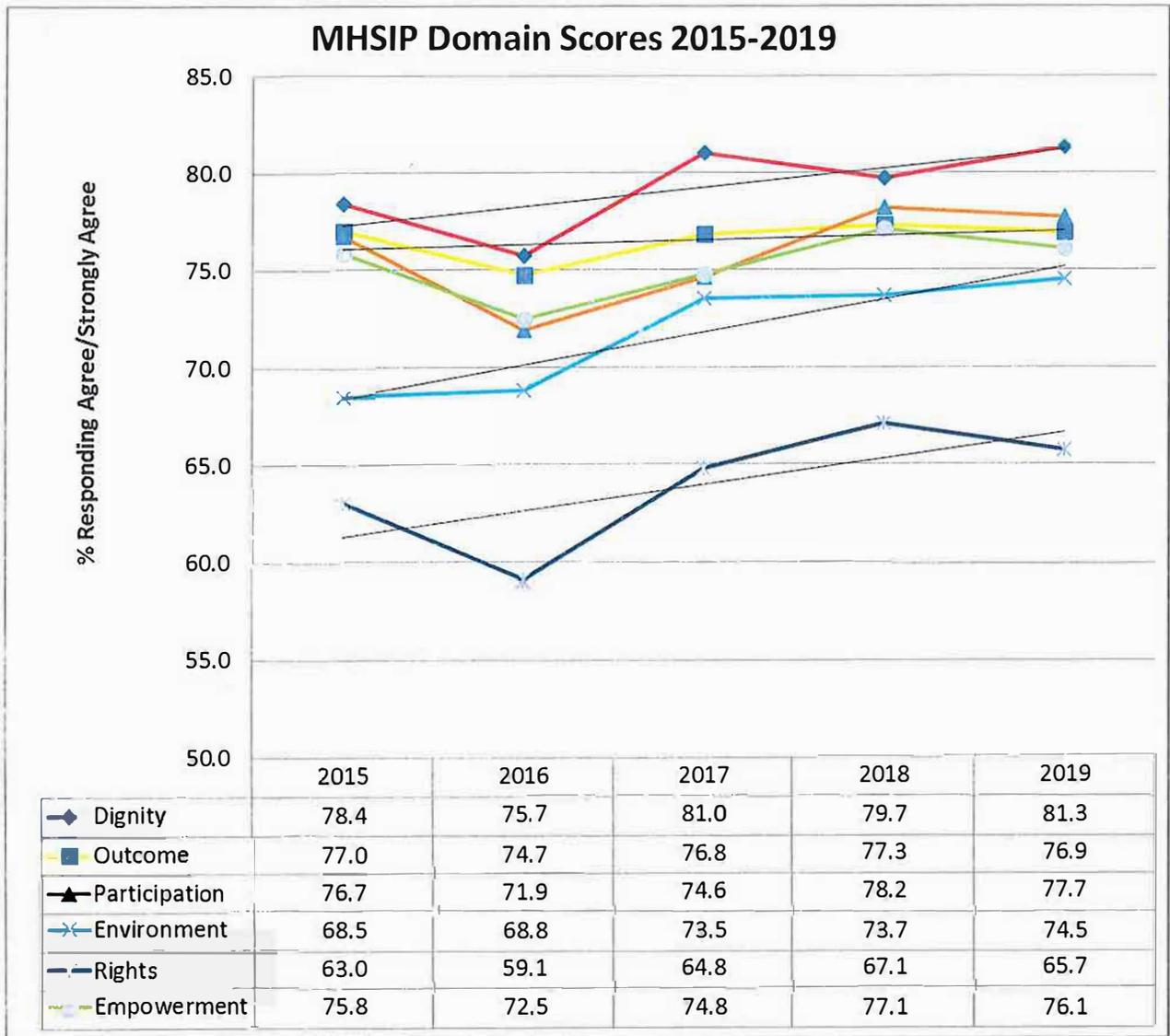
Table 1. Inpatient MHSIP Consumer Survey - Response Rate by Unit						
Unit	2017		2018		2019	
	Completed Surveys	Response Rate	Completed Surveys	Response Rate	Completed Surveys	Response Rate
43A - ITU	48	21.6%	42	17.7%	110	49.1%
43B - ATU	154	59.5%	164	49.5%	142	52.4%
43C - WTU	16	9.0%	93	45.4%	86	43.4%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

**Acute Adult Inpatient Service**

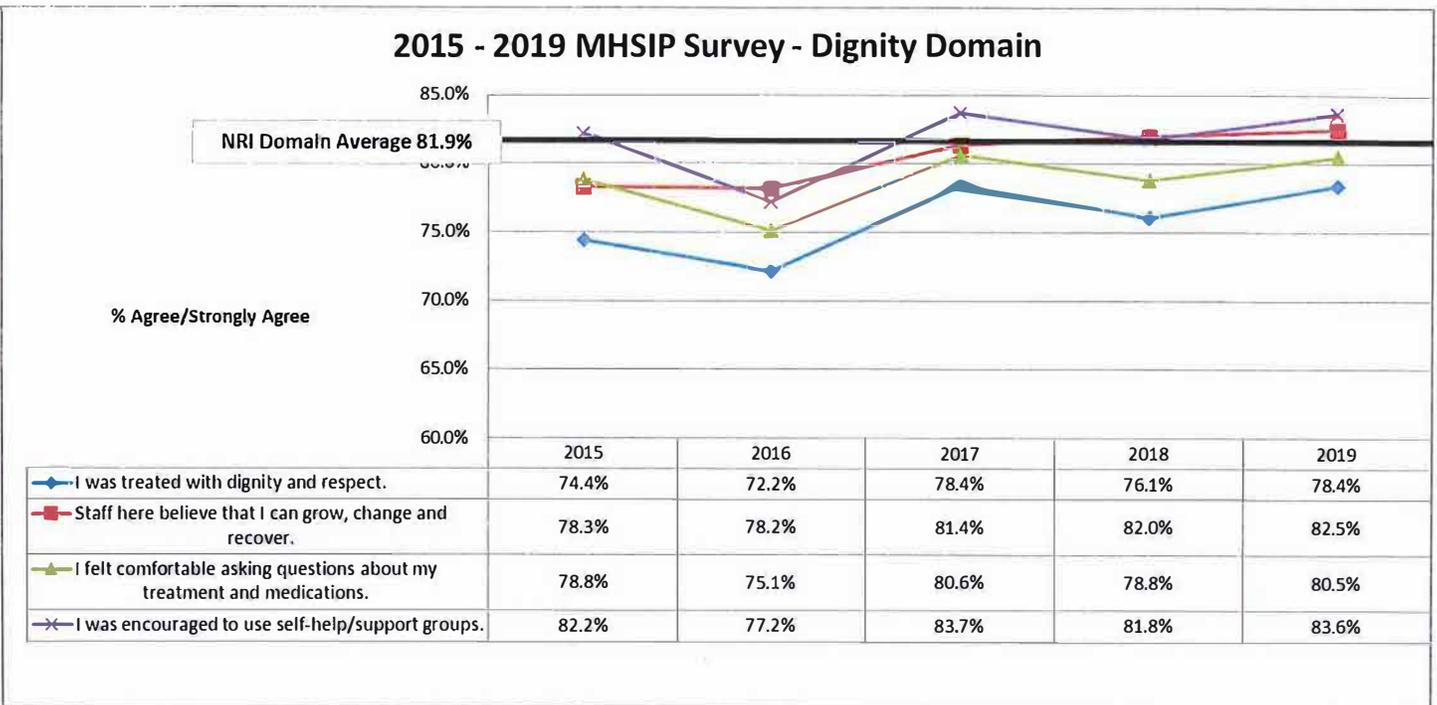
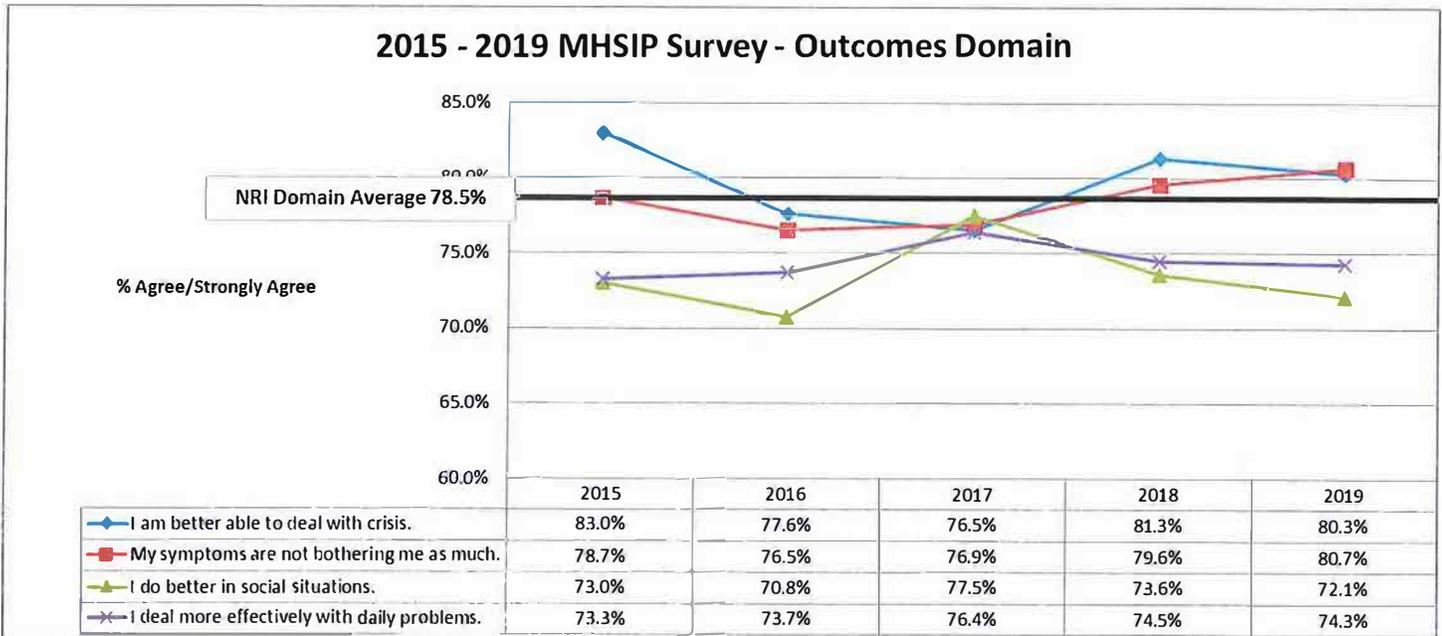
**Table 2** presents Acute Adult Inpatient Service’s consumer positive (agree/strongly agree) responses for 2015 – 2019. In 2019, the results revealed a “High” response score for the Dignity domain (81%), “Good” response scores for 4 of the 6 survey item domains: 78% for Participation, 77% for Outcome,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

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

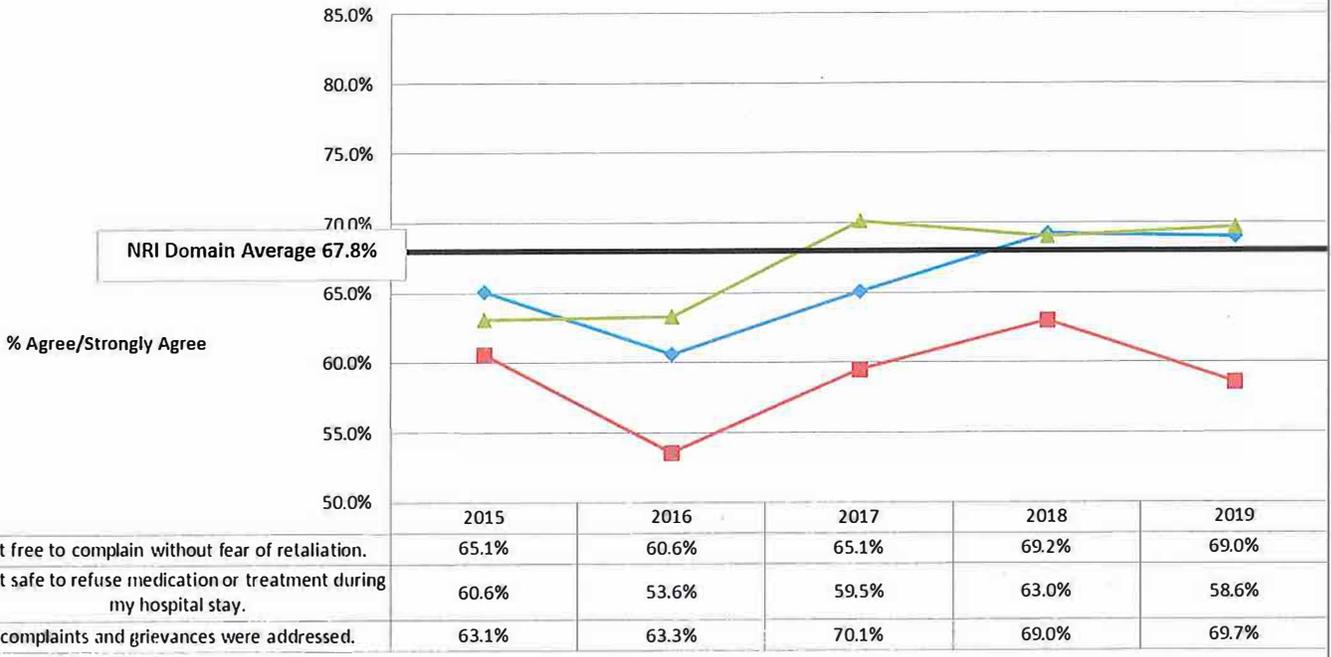
The following graph presents Acute Adult Inpatient Service's 2015-2019 positive (agree/strongly agree) Domain scores.



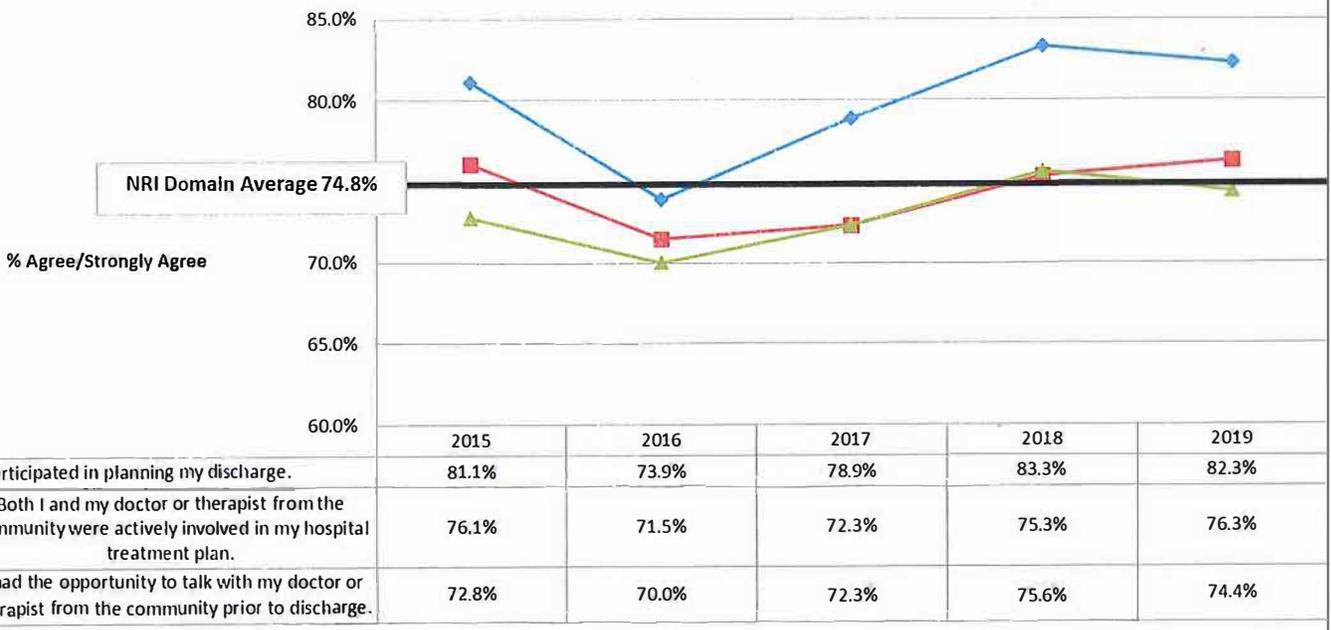
The following graphs present Acute Adult Inpatient Service's 2015-2019 positive (agree/strongly agree) survey item scores and NRI's domain average.



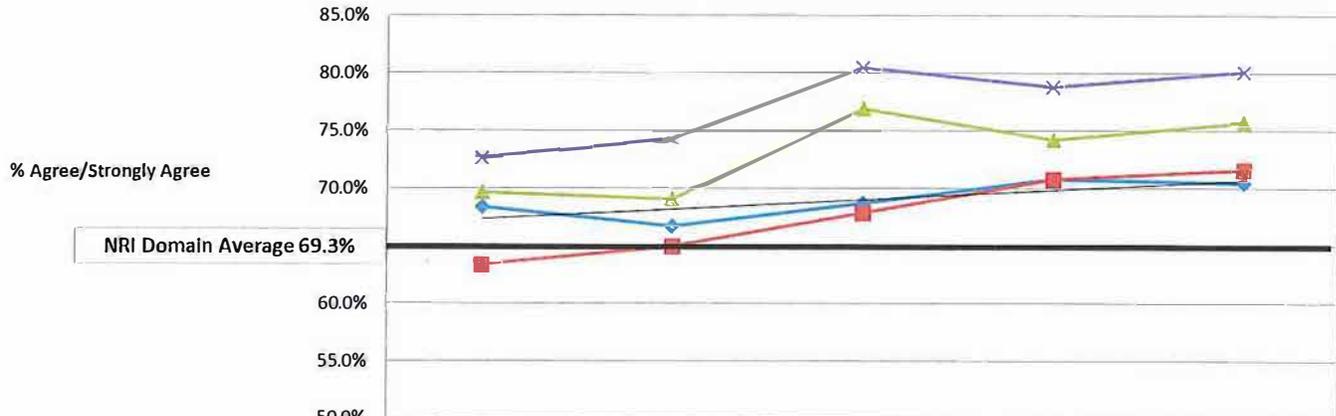
### 2015 - 2019 MHSIP Survey - Rights Domain



### 2015 - 2019 MHSIP Survey - Participation Domain

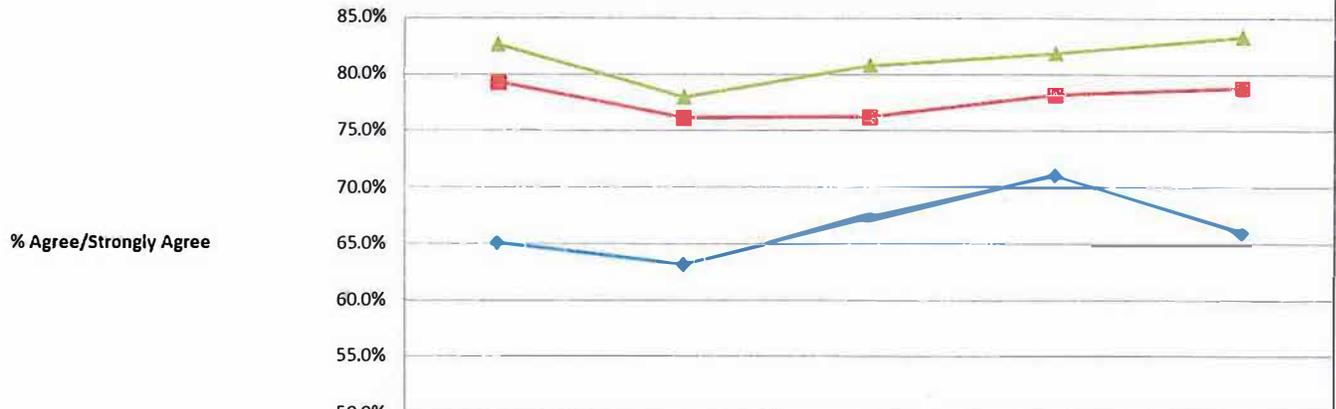


### 2015 - 2019 MHSIP Survey Item - Environment Domain



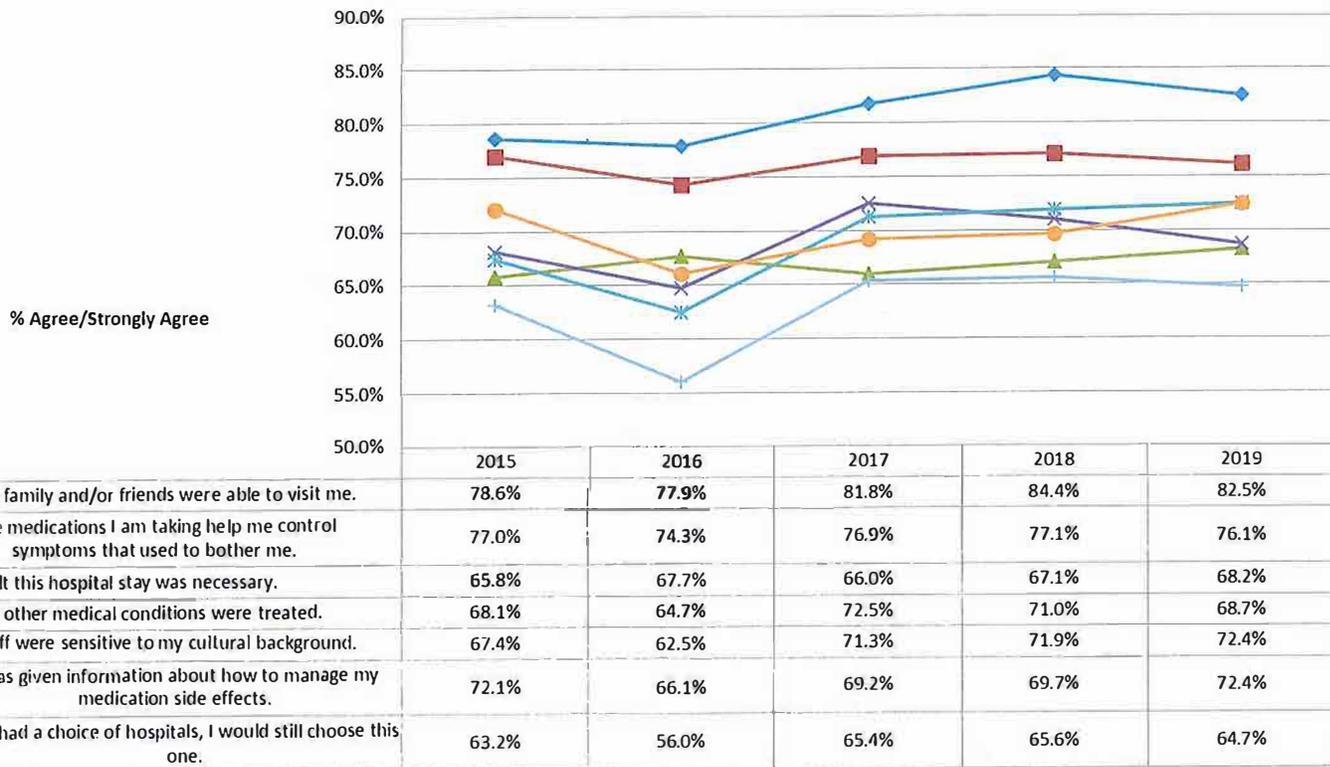
	2015	2016	2017	2018	2019
◆ The surroundings and atmosphere at the hospital helped me get better.	68.4%	66.7%	68.7%	70.8%	70.5%
■ I felt I had enough privacy in the hospital.	63.4%	65.0%	67.9%	70.8%	71.6%
▲ I felt safe while in the hospital.	69.6%	69.1%	76.9%	74.2%	75.7%
✕ The hospital environment was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

### 2015 - 2019 MHSIP Survey - Empowerment Domain



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

### 2015 - 2019 MHSIP Survey - Other Items



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

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

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

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

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

## Appendix

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

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

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

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

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

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

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

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

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

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

1. Everyone at BHD was very professional and nice.

# CAIS Youth Survey

Annual Report

# 2019

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

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

Prepared By:  
Quality  
Improvement  
Department

2/12/20

## Overview

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

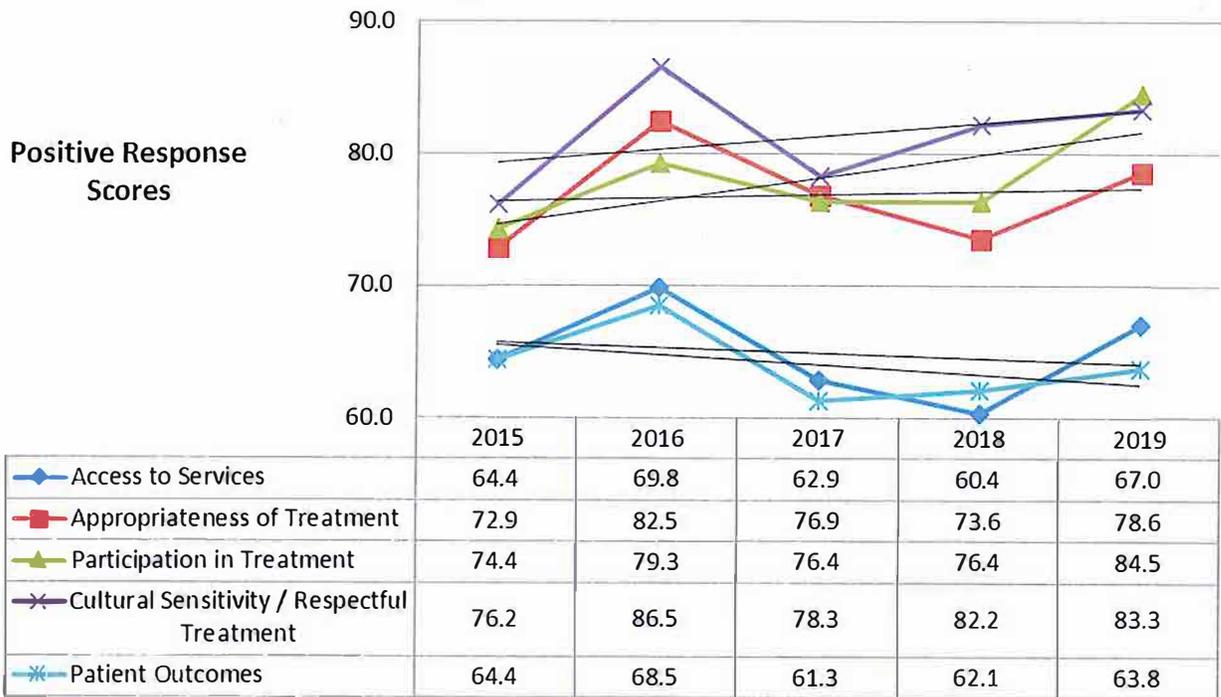
## Method

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

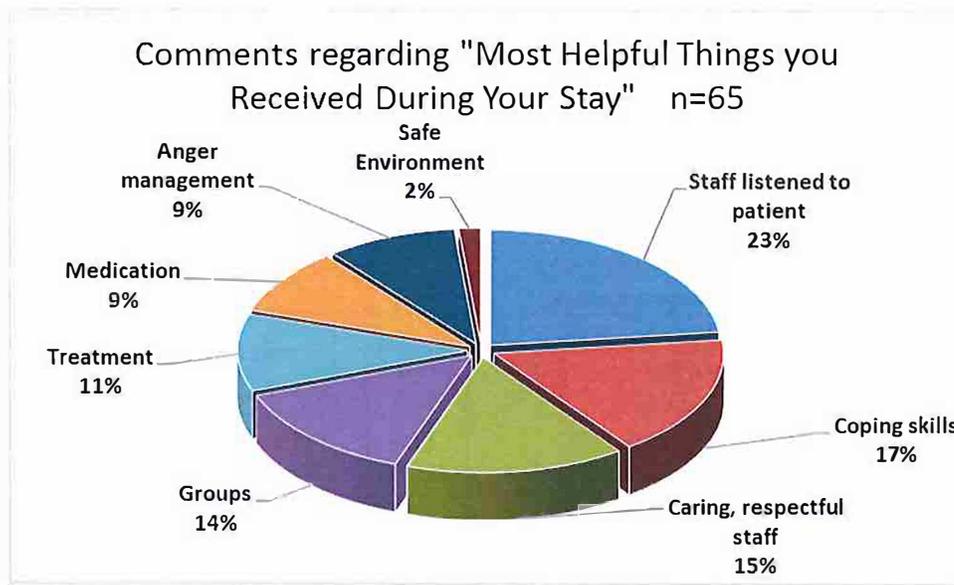
**Table 1** presents CAIS' consumer positive (agree/strongly agree) response scores for 2015 – 2019.

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

## 2015-2019 CAIS Youth Survey Results

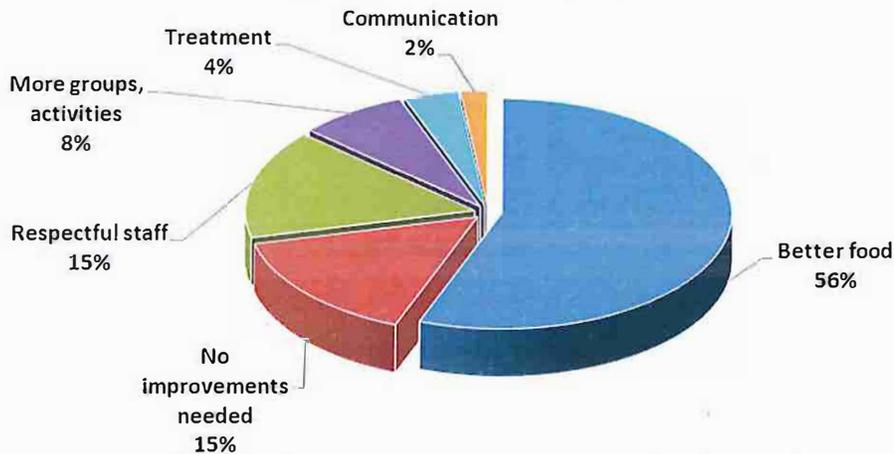


*The comments below were written on surveys administered in 2019.*

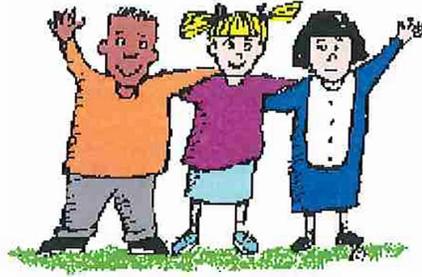
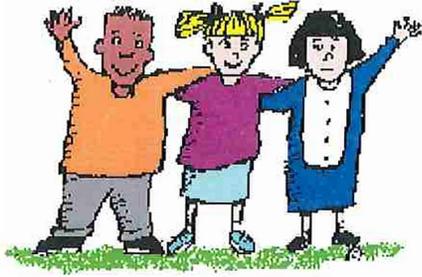


Category	Comments "Most Helpful Things You Received During Your Stay"
Anger management	<p>Helping me cope with my anger.            I got to learn about different ways to help me calm down.            Learning how to stay calm and realize that suicide isn't the option.            Learning to walk away.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

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



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



CAIS YOUTH SURVEY

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

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

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

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

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

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

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

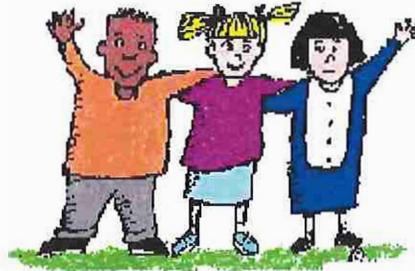
**Please answer the following questions to let us know a little about you.**

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

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

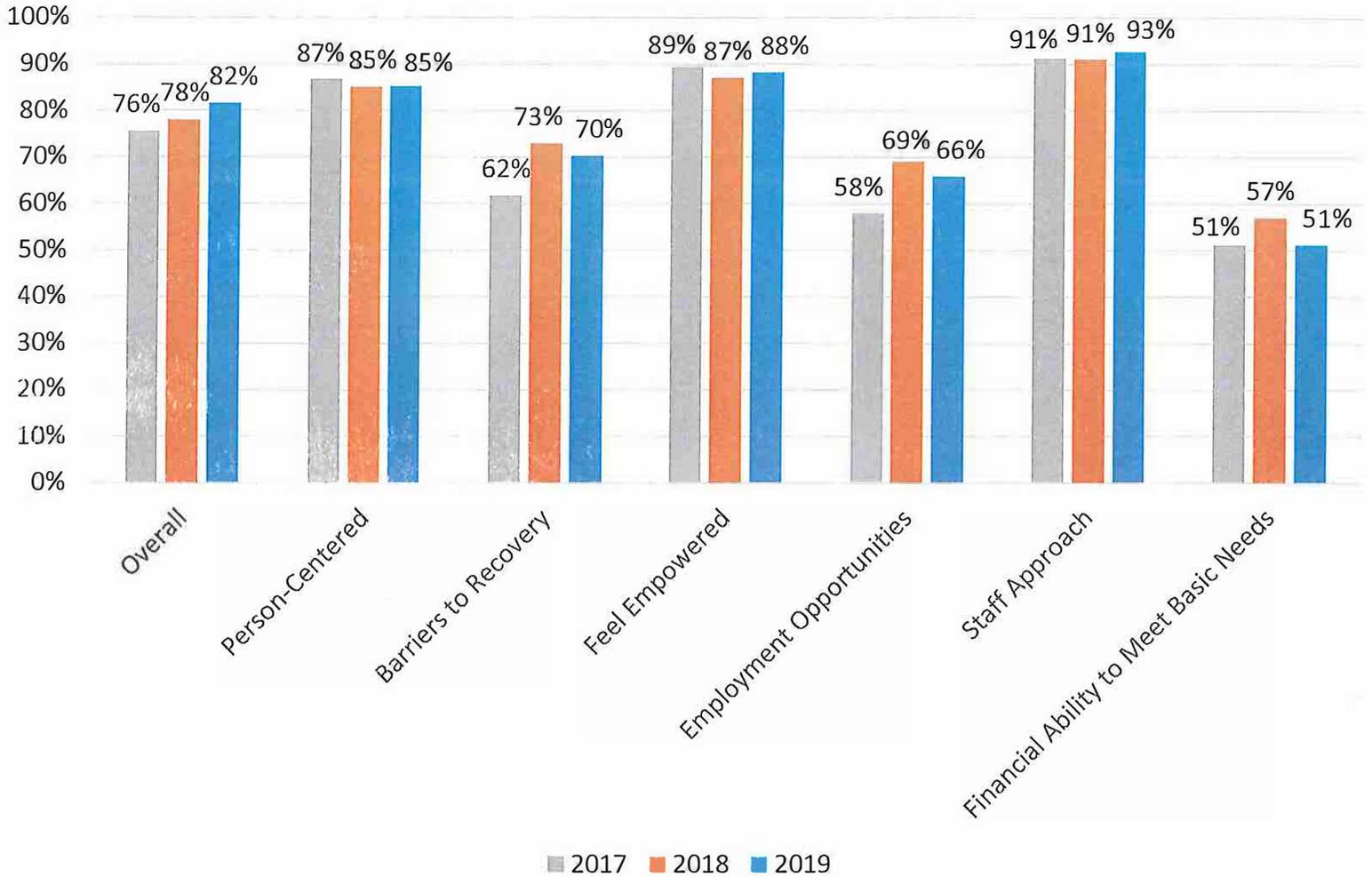
Age: \_\_\_\_\_ years old

Gender (mark with X):  Male  Female



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

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



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

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

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

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

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

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



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

December 16, 2019

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

Re: Notice regarding Referrals to Crossroads

Dear Mr. McClendon,

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

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

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

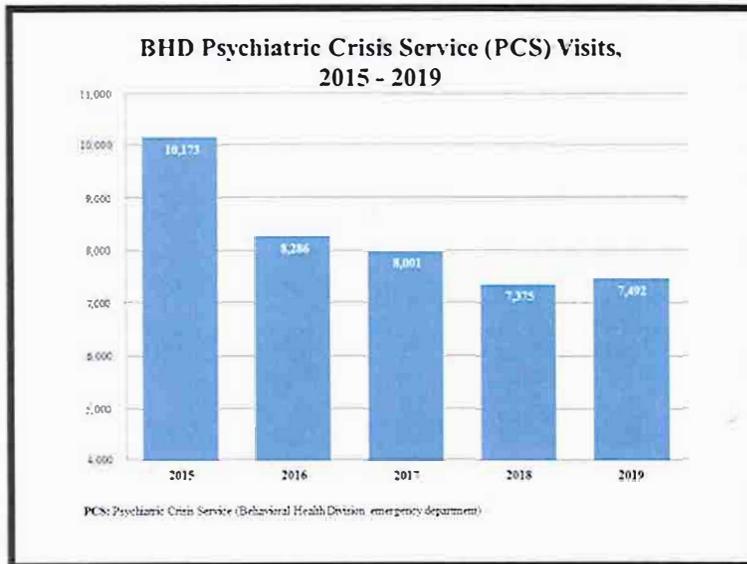
Sincerely,

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

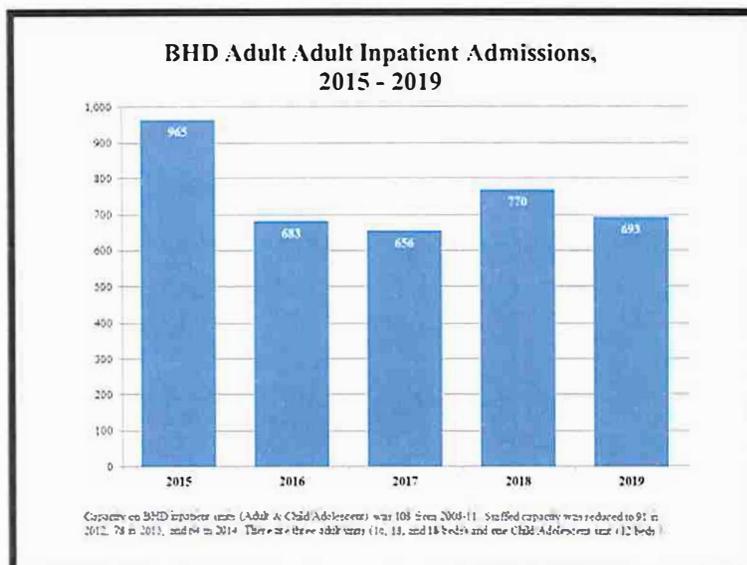
Amy Lorenz, MSSW, LCSW  
Deputy Administrator  
Community Access to Recovery Services  
Milwaukee County Behavioral Health Division

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

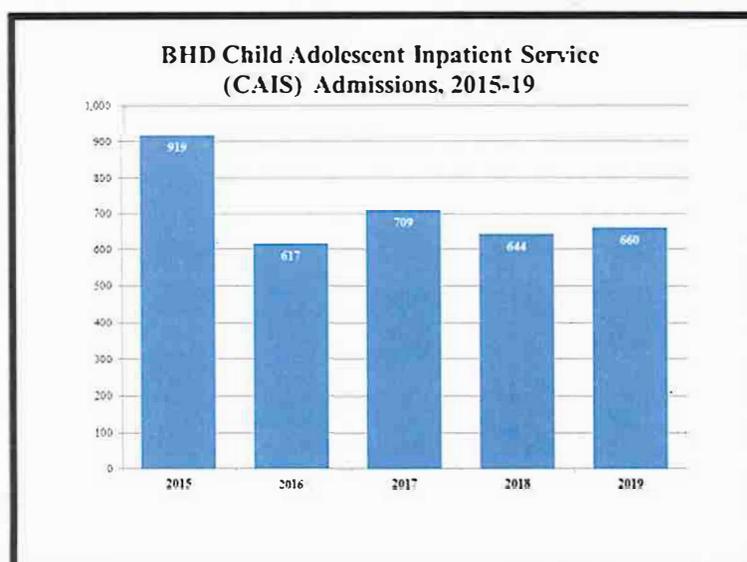
Psychiatric Crisis Service’s annual patient visits continue to decline from 10,173 in 2015 to 7,492 annual visits in 2019 (26% decline from 2015 to 2019). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions,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



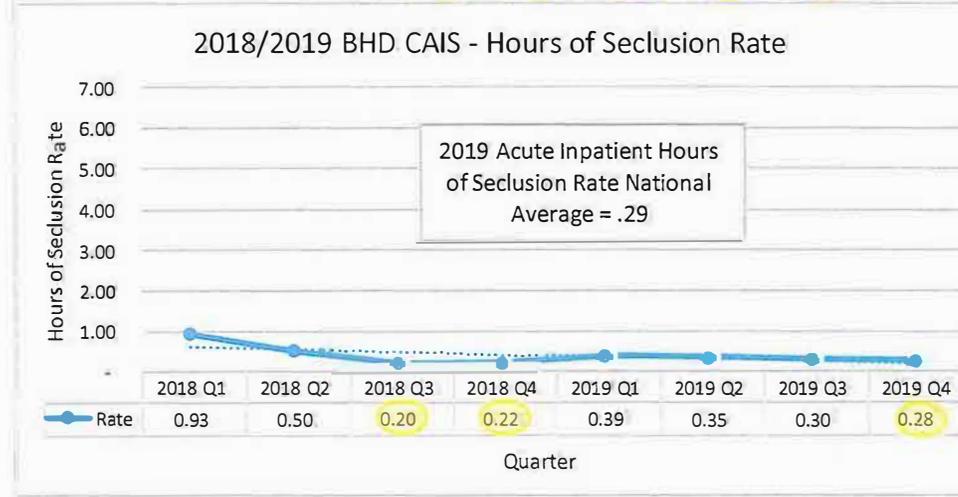
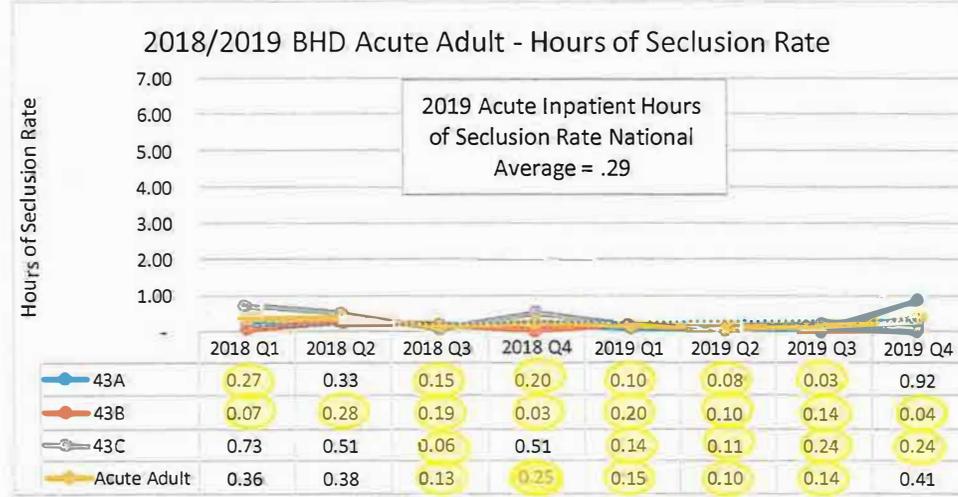
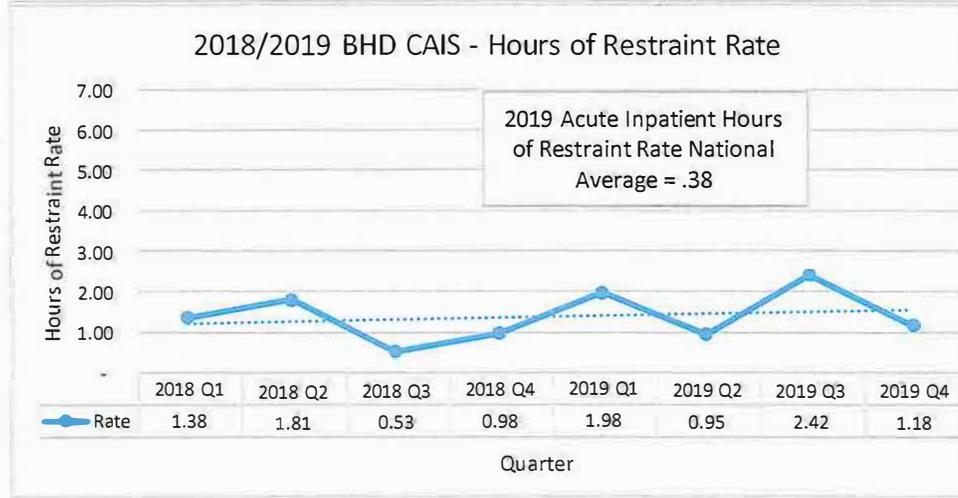
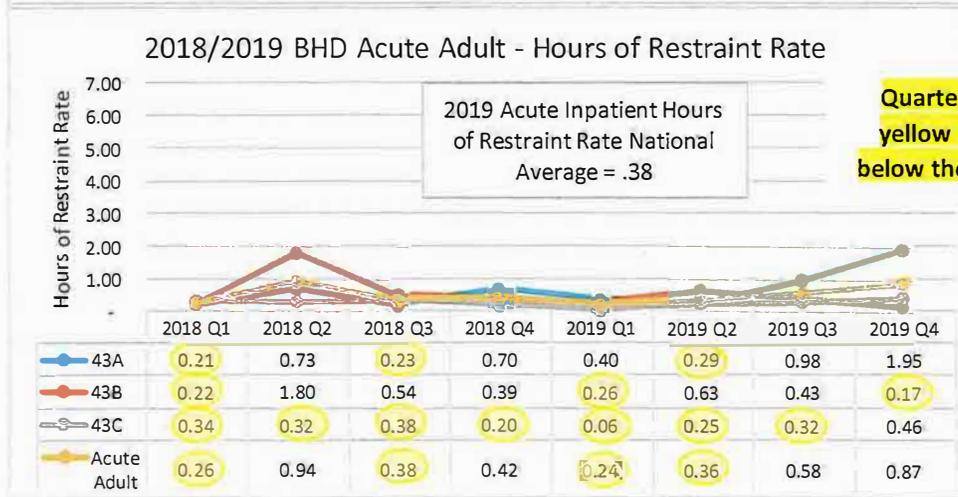
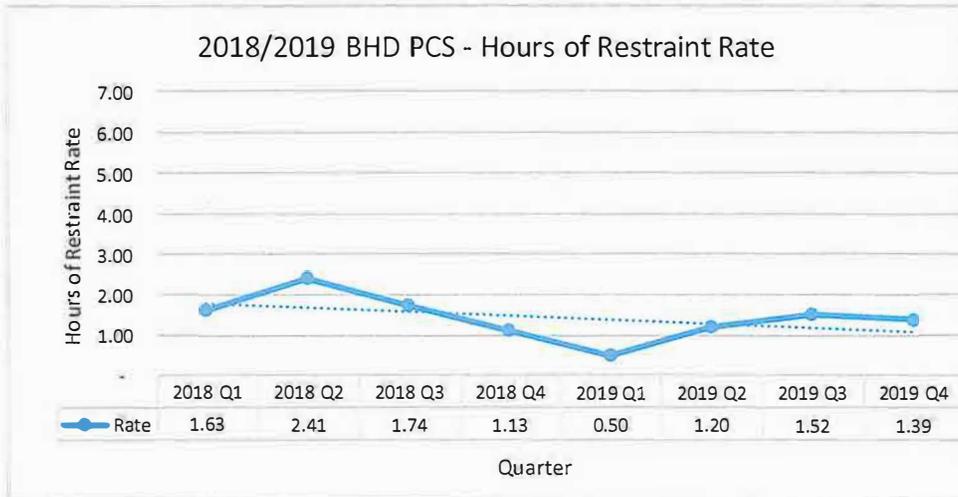
Acute Adult Inpatient Service’s patient admissions have plateaued over the past 4 years and were 693 in 2019. Readmission rates continue to decline (30-day readmission rate: 11% in 2015, 9% in 2019). Acute Adult’s hours of physical restraint rate in 2019 was .51, above CMS’ inpatient psychiatric facility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



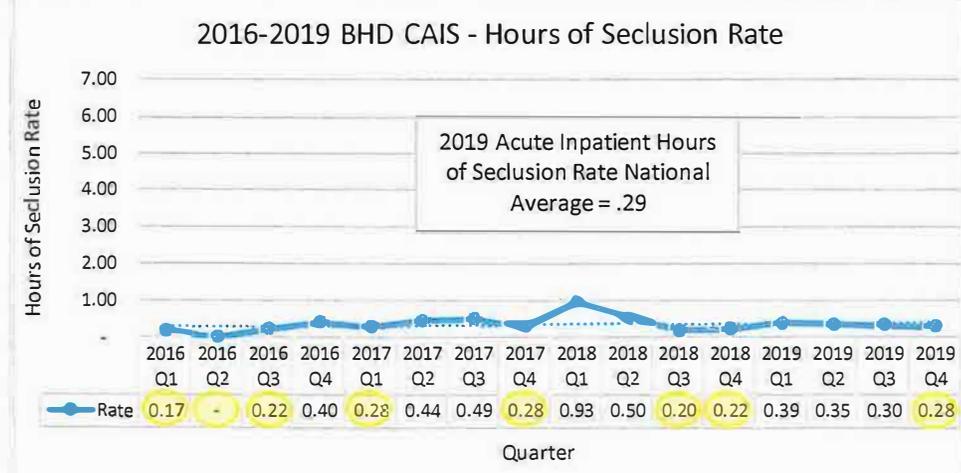
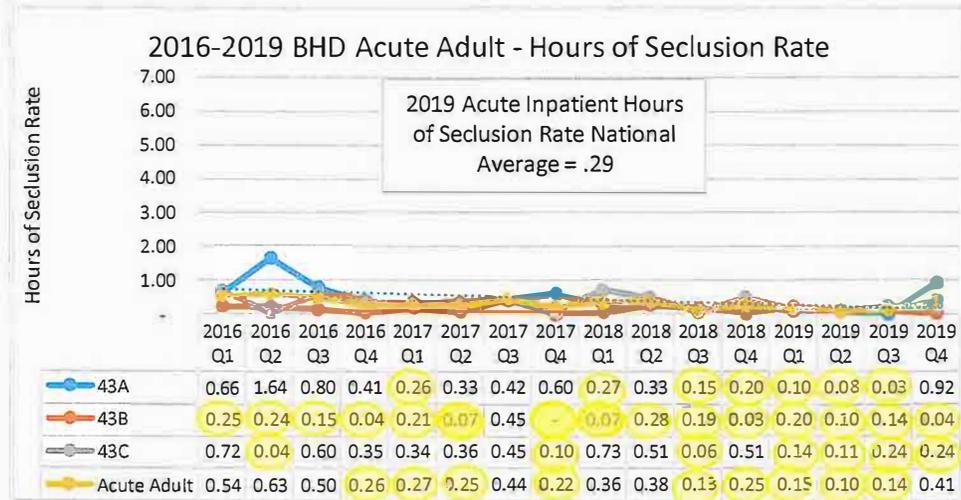
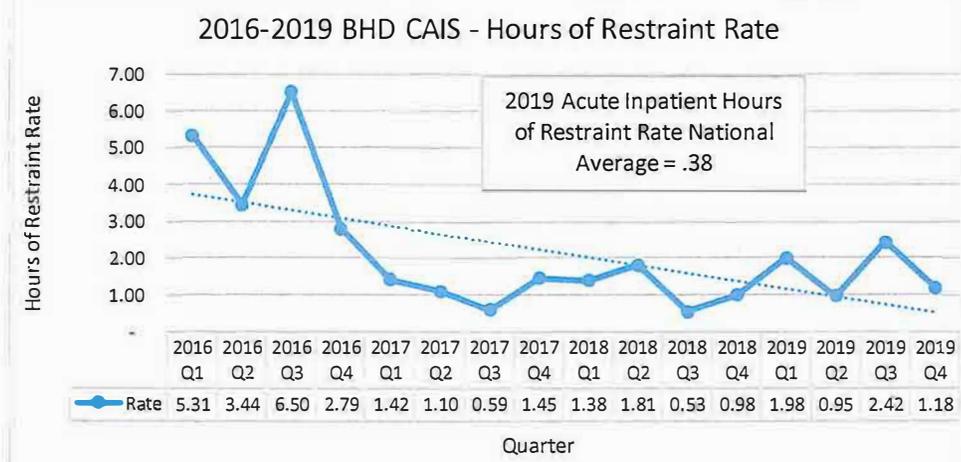
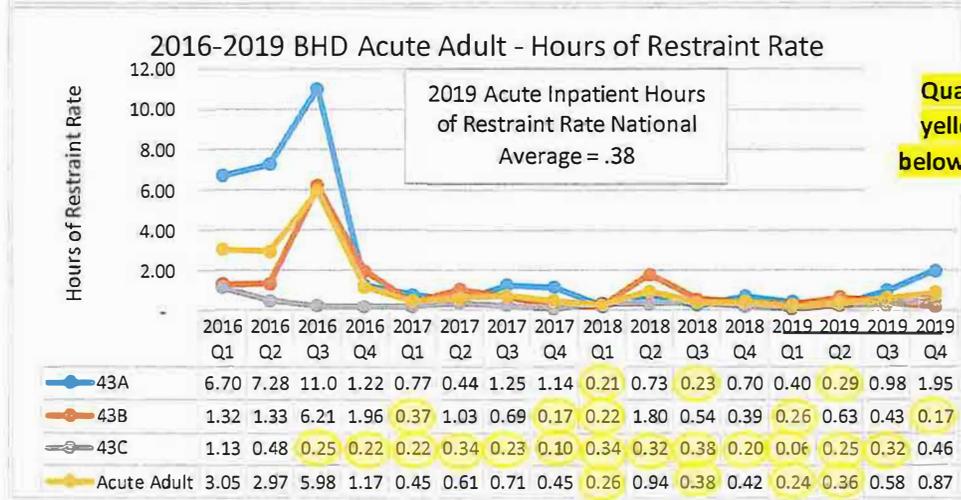
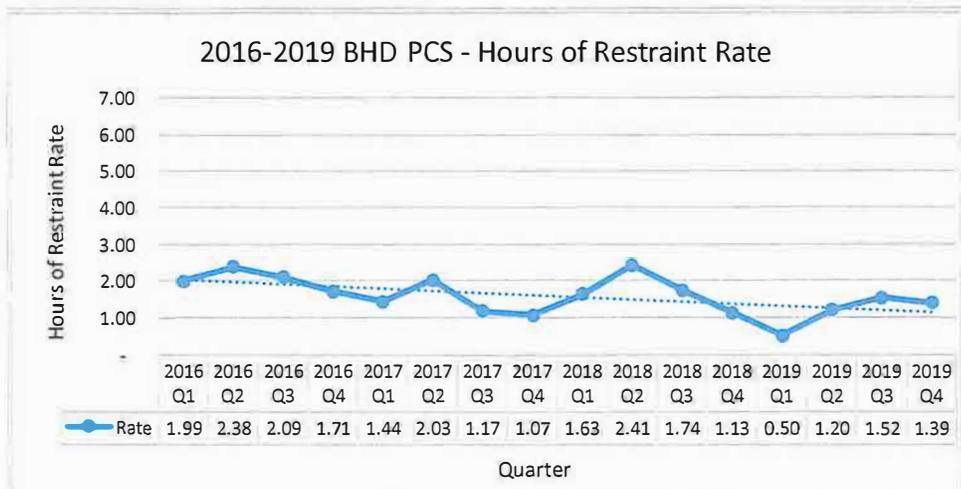
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past 4 years and were 660 in 2019. Over the past few years, CAIS’ 30-day readmission rates have remained at 16%. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.6 in 2019, but remains above CMS’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



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



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



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

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

**DATE:** February 13, 2020

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

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

**SUBJECT:** **Requesting acceptance and approval of the 2019 Annual Review of the Environment of Care Program, and the 2020 Environment of Care Management Plans**

**Issue**

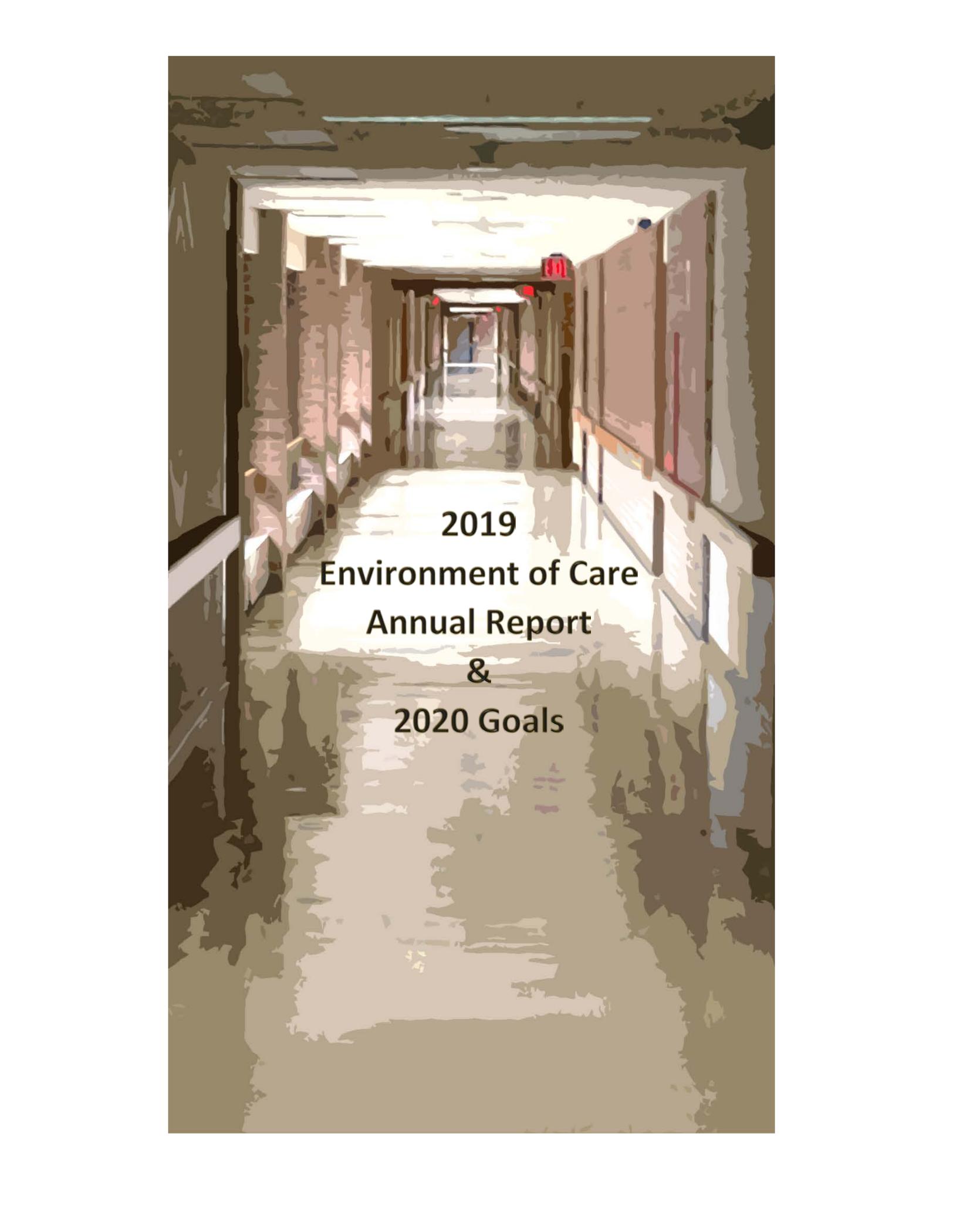
BHD is requesting the annual approval of the Environment of Care Annual Report and Management Plans per The Joint Commission Standards and the Mental Health Board By-laws.

**Background**

The Joint Commission requires a written plan for managing environmental risk, including safety, security, clinical and non-clinical equipment, handling of hazardous materials, fire prevention, and utility systems. These plans together make up the BHD Environment of Care Program. The purpose of the program is to establish a structure within which a safe environment of care is developed, maintained and improved. The effectiveness of Environment of Care program will be reviewed and evaluated annually to determine if goals have been met through ongoing improvement. The plan will be modified as needed.

**Recommendation**

It is recommended that the Mental Health Board accept and approve the 2019 Annual Report of the Environment of Care program and the 2020 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.



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

## **Introduction**

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

The Joint Commission requires that the Annual Report and Management Plans be presented and approved by the governing board. BHD is requesting approval of the attached documents.

## **Environment of Care 2019 Annual Report and 2020 Goals**

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

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

#### **GENERAL SAFETY**

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

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

#### **SECURITY**

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

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

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

**2020 Goals:**

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

**HAZARDOUS MATERIALS AND WASTE**

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

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

Year	Total Weight (in lbs)	Monthly Average (in lbs)
2014	3262	272
2015	1589	132
2016	885	74
2017	492.59	41
2018	490.35	40.86
2019	286.9	23.9
□2015 December weights estimate □2016 Jan, Feb and Dec weights estimated		

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

BHD's 2019 goal was to continue the downward trend and achieve the 50 or less per month of regulated medical waste generation for the twelve month period thereby eliminating the DNR reporting requirement. BHD exceeded the 50 limit in both January and February, triggering the reporting requirement. However, all subsequent month totals were below the 50 reporting limit. As such, our 2020 goal is to maintain this trend, keeping levels below the 50 reporting limit.

## EMERGENCY MANAGEMENT

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

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

## **2020 Goals:**

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

## **FIRE PREVENTION**

In 2019 BHD continued to make improvements to fire safety equipment and features. These improvements include replacement of fire doors and frames that have deteriorated from weather and that take more than 5 foot pounds to open. Due to loss of maintenance staff some goals were not attained.

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

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

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

## **UTILITIES MANAGEMENT**

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

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

4. Develop a new manual on Major Utility failures.

## **MEDICAL EQUIPMENT**

No new clinical equipment was purchased in 2019. BHD continues to contract with Universal Hospital Services (UHS) to monitor / calibrate remaining clinical equipment on a regular basis. The UHS inventory of equipment managed by UHS is updated as clinical equipment is removed from service.

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

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

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

**EDUCATIONAL GOALS**

In 2019 the following trainings were completed:

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

**EDUCATIONAL CALENDAR 2020**

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

To be done every 6 months

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

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

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

- **To reduce the amount of infectious waste generated to below 50□ per month, by eliminating inappropriate disposal of non-infectious waste and by determine alternate products where feasible.**
- **To improve staff knowledge of BHD emergency response plans, and procedures.**
- **To increase awareness of ligature risks in the environment and mitigate the risks previously identified.**



Current Status: Pending

PolicyStat ID: 7647752



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**Next Review:** 3 years after approval  
**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**Policy Area:** Environment of Care  
**References:**

## Environment of Care Management Plan

### ***Mission:***

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

### ***Vision:***

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

### ***Philosophy of and Partnership in Care:***

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

### ***Culture of Quality, Safety and Innovation:***

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

### ***Healthy Learning Environment:***

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

## **PURPOSE:**

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

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

## **SCOPE:**

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

MCBHD locations include:

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

## **OBJECTIVES:**

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

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

## **AUTHORITY/REPORTING RELATIONSHIPS:**

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

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

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

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

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

## **ENVIRONMENT OF CARE (EC) COMMITTEE:**

### **A. EC COMMITTEE MEMBERSHIP:**

In addition to the multi-disciplinary membership appointed by administration, each Standing or Ad Hoc Committee Chairperson shall also serve on the Environment of Care Committee.

### **B. EC COMMITTEE SUMMARY:**

1. The EC Committee will provide the following:
  - A forum in which employees can raise concerns regarding safety risks within the EC management areas for discussion, assessment, and mitigation planning.
  - Focused discussions on particular issues, including creation of ad hoc subcommittees to address specific topics as necessary.
  - Reports on activities and an annual summary of achievements within the EC management categories.
2. The Hospital Administrator appoints an EC Committee Chairperson and Safety Officer, who develop, implement, and monitor the EC Program. The remaining membership of the EC Committee includes

- representatives from administration, clinical areas and support services. The committee member goals and responsibilities are developed and reviewed as part of the program's annual evaluation.
3. The Safety Officer shall serve as the Chairperson of the EC Committee and oversee its membership.
  4. The EC Committee Chairperson is responsible for the following issues related to Safety:
    - a. Advise Administration, Medical Staff and Management Teams on safety matters requiring their attention and action.
    - b. Make recommendations necessary to establish or modify policies to the EC Program
    - c. Monitor the effectiveness of policy or procedural changes made or recommended.
    - d. Appoint committees, as appropriate, with specific responsibilities in relation to patient, employee, facility, community or environmental safety.
    - e. Appoint the Chairperson to any EC related subcommittees (standing or ad hoc).
    - f. Ensure minutes of all EC related committees are kept and reviewed, as appropriate.
    - g. Provide leadership and consultation for any subcommittee chairpersons.
    - h. Monitor subcommittees for effectiveness and compliance with regulatory agencies.
    - i. Evaluate committee and subcommittee members and chairperson's performance.
    - j. Ensure that the following receive timely information on the EC Program:
      - Executive Team
      - Medical Staff
      - Quality Management Services Committee (QMSC)
      - Department Directors/Managers
  5. Each EC Subcommittee Chairperson shall oversee the subcommittee and provide the following support:
    - a. Ensure minutes are kept and submitted to the Chairperson of the EC Committee in a timely manner.
    - b. Make recommendations necessary to establish or modify policies to the EC Program.
    - c. Report recommendations for policy changes and/or safety procedures to the EC Committee Chairperson.
    - d. Evaluate the committee and membership for effectiveness.
    - e. Take all corrective actions necessary on items referred to them by and EC Committee member
    - f. Refer safety concerns to the proper subcommittee chair and the EC Committee Chair.
  6. The employee has responsibilities regarding their environment. BHD recognizes its responsibility to engineer or administrate a solution for any known hazards under Occupational Safety & Health Administration (OSHA) regulations. The employee is then to be trained and the hazard addressed at staff level. Staff responsibilities include:
    - a. Report safety concerns to the department supervisor/manager/director.
    - b. Access, or make referrals to the EC Committee by contacting the appropriate committee chairperson, or member of the committee.

# GENERAL RESPONSIBILITIES:

## 1. ADMINISTRATION

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

## 2. ENVIRONMENT OF CARE COMMITTEE AND SAFETY OFFICER

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

## 3. BHD DIRECTORS, MANAGERS AND SUPERVISORS

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

- a. Set examples of Safety awareness and good safety practices for employees
- b. Use Safety/Incident Event Reports as appropriate

- c. Become familiar with all aspects of the EC Program
- d. Develop and implement Safety Policy and Procedures within their department/program.

#### 4. BHD EMPLOYEES

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

## EC COMMITTEE FUNCTIONS

1. Meets monthly, or more frequently at the call of the chairperson;
2. Reviews/addressess issues pertaining to each of the EC Management categories at regular predetermined intervals (see individual management section for frequencies);
3. At least annually, report committee activities, pertinent committee findings and recommendations to ET, MEC and QMSC;
4. Monitor federal, state, city, county, and other regulatory agencies' activities and ensure compliance;
5. Assign research and development projects to the appropriate committee or temporary work group;
6. Quarterly, review actions taken by other Programs (Infection Prevention and Control, Risk Management, etc) that may impact the EC Program and address as appropriate;
7. Quarterly, review educational activities provided;
8. Semi-annually, review summaries of employee/visitor injuries, illnesses and safety incidents and make appropriate recommendations or referrals;
9. Semi-annually, review summaries of security incidents involving employees, patients, visitors and property and make appropriate recommendations;
10. Quarterly, review Emergency Management activities and make appropriate recommendations for changes in procedure or education;
11. Quarterly, review summaries of the management of hazardous materials, wastes and related incidents and make appropriate recommendations for changes in policy/procedure or education;
12. Quarterly, review summaries of environmental tours and make appropriate recommendations or referrals;
13. When appropriate, review summaries of patient falls, sentinel events, and action plans and make appropriate recommendations for changes in procedure or education;
14. When appropriate, review, approve, or make recommendations for changes to policies and procedures;
15. Quarterly, review summaries of medical equipment management and related incidents and make appropriate recommendations;
16. Quarterly, review summaries of the life safety management program and make appropriate recommendations for changes in procedures/or education;
17. Quarterly, review summaries of utility and equipment management, related failures, errors or incidents to determine the need for changes in procedures and/or education;
18. Monitor and trend and analyze incidents, and prevention program effectiveness;

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

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

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

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

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

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record in minutes.
- b. Create an annual Security Management Plan.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Quarterly review analysis, trending and recommendations for security incidents relative to:
  - Property
  - Visitors
  - Assaults
  - Security Officer injuries, interventions
  - Key control
  - Security sensitive area accessibility
  - Other
- e. Monitor the overall Security Management Program.
- f. Establish a process, and conduct a review of all Security related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- g. Annually review the Security Management Program that includes but not limited to:
  - Patient, visitor, employee and property security concerns
  - Sensitive area access control
  - Traffic control policies and vehicular access
  - Orientation and Education Programs
  - Emergency preparedness programs related to security
  - Security equipment (cameras, alarms, telephone, etc.)
- h. Annually, develop goals, objectives and performance standards for Security Management.
- i. Annually, assess the effectiveness of implemented recommendations.
- j. Report Quarterly on activities of Security Management.

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

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

- a. Discuss topic monthly or more frequently upon the call of the chairperson and record minutes.
- b. Create and update annually the Emergency Operations Plan (EOP).
- c. Incorporate all BHD departments in all related activities and Emergency Management Policies and Procedures.
- d. Establish a process, and conduct a review of all Emergency Management related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/ program policies as appropriate.
- e. Develop and monitor internal and external emergency management programs, with multi-discipline input, affecting all departments.
- f. Evaluate and modify Emergency Operations Plans (EOP) and exercises.
- g. Coordinate and evaluate the semi-annual emergency management exercise.
- h. Monitor, evaluate, and implement changes to the EOP required by federal, state, local, and national organizations, as appropriate.
- i. Maintain EOP, emergency management policies and procedures and critique and approve all in-house designated disaster assignment areas and department standard operating procedures a minimum of every three years or earlier if modifications are needed.
- j. Annually, develop goals, objectives and performance standards for Emergency Management.
- k. Annually, assess the effectiveness of emergency management programs.
- l. Report quarterly on activities of Emergency Management.

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

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Create an annual Hazardous Materials and Waste Management Plan.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Assist with the creation of the hospital wide right - to - know program (RTK).
- e. Ensure that an annual review of chemical inventories occurs.
- f. Evaluate the educational needs for RTK and hospital waste programs and make appropriate recommendations.
- g. Monitor and assess waste control procedures and recommend policy/procedure changes as needed.
- h. Monitor city, state, and federal environmental laws and regulations and recommend policy/procedure changes as required.
- i. Evaluate products to promote hazardous materials and waste minimization for purchase or use.
- j. Review hazardous materials and/or waste handling problems, spills or employee incidents and make recommendations for process improvement, personal protective equipment and environmental monitoring.
- k. Monitor program recommendations, changes or implementations for effectiveness.

- l. Annually, assess the effectiveness of the hazardous materials and waste management programs for selection, storage, handling, use and disposal and recommend changes as appropriate.
- m. Review the Medical Waste Reduction Policy, and complete the Infectious Waste Annual Report with the DNR when required.
- n. Conduct periodic audits of medical waste storage and disposal locations for presence of non regulated medical waste.
- o. Report quarterly on activities of Hazardous Materials and Waste Management.

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

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Create an annual Fire Prevention Plan.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Coordinate and conduct fire drills once per quarter per shift in all patient care buildings. (Twice this if Interim Life Safety Measures are implemented.)
- e. Analyze and trend the results of fire drills, actual fire events or false alarms and recommend appropriate changes or education.
- f. Review inspection, preventive maintenance and testing of equipment related to the Life Safety Program.
- g. Review agency inspections conducted or compliance survey reports. (i.e. Fire Marshal (state and local), Insurance, State Department of Quality Assurance, etc.)
- h. Review changes/upgrades to the fire protection system; failures/problems discovered with the system, causes and corrective actions taken.
- i. Review summaries of construction, renovation or improvement life safety rounds.
- j. Assess Interim Life Safety Measures implemented as a result of construction or other Life Safety Deficiencies and review and plans of corrections
- k. Monitor program recommendations, changes or implementations for effectiveness.
- l. At each meeting, assess the status of the facility Statement of Conditions™ and compliance with the Life Safety Code.
- m. Establish a process, and conduct a review of all Fire/Life Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- n. Annually, develop goals, objectives and performance standards for Fire Prevention.
- o. Annually, assess the effectiveness of the Fire Prevention Program, policies/procedures and educational components.
- p. Report quarterly on activities of Fire Prevention Management.

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

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Create an annual Medical Equipment Management Plan.

- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Monitor medical equipment hazard recalls. Review inspection, tests, maintenance and education policies for medical equipment and device users.
- e. Monitor for compliance with the FDA Safe Medical Device Act.
- f. Review medical equipment management program, problems, failures and user errors that adversely affect patient care or safety and the corrections or follow-up actions taken.
- g. Review and analyze major problems or trends identified during preventative maintenance and make appropriate recommendations.
- h. Monitor on-going medical equipment education programs for employees related to new equipment, replaced or recalled equipment, certification and/or recertification and user errors.
- i. Review requests and make recommendations for the purchase of medical equipment.
- j. Monitor the entry and use of medical equipment entering the facility from sources outside of the medical equipment program. (i.e. rental equipment).
- k. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the medical equipment program or needs.
- l. Establish a process, and conduct a review of all Medical Equipment related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
- m. Review contingency plans in the event of medical equipment disruptions and or failures, procedures for obtaining repair services and access to spare equipment.
- n. Annually, develop goals, objectives and performance standards for the committee.
- o. Annually assess the effectiveness of the medical equipment management program.
- p. Report quarterly on activities of Medical Equipment Management.

**7. UTILITY MANAGEMENT (EC 01.01.01 EP 9; EC 02.05.01; EC 02.05.03; EC 02.05.05; & EC 02.05.07)**

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Review/revise the Utility Management Plan annually.
- c. Incorporate all BHD departments in all related activities and Management Plans.
- d. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the management of Utility Systems.
- e. Review incidents related to emergency testing, system upgrades, system shutdowns, preventative maintenance problems, major problems with emphasis on the impact on patient care and corrective actions.
- f. Review, analyze and trend problems or failures relating to:
  - Electrical Distributions Systems and Emergency Generator
  - Elevator Systems
  - HVAC Systems
  - Communication Systems
  - Water Systems

- Sewage Systems
  - Environment Control Systems
  - Building Computer Systems
  - Security Systems
  - Other
- g. Review management plans and monitoring systems relating to utility management.
  - h. Establish a process, and conduct a review of all Utility related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
  - i. Annually, review the effectiveness of the utility system management program.
  - j. Review emergency procedures and plans to respond to utility system failures.
  - k. Review patient care equipment management (beds, lighting, etc) and all non-clinical high-risk equipment problems.
  - l. Report quarterly on activities of Utility Management.

#### 8. OTHER COMMITTEES

- a. The EC Committee has a relationship with two other committees, each share information regarding activities. Pertinent information is incorporated into the annual report submitted by the EC. These committees include:
  1. Infection Prevention and Control- Although this is not a sub-committee; this existing committee has a relationship that submits information on a 'need to know' basis, identifying concerns.
  2. Risk Management - Although this is not a sub-committee, this existing department has a relationship that submits information on a 'need to know' basis, identifying concerns.

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

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Incorporate all BHD departments in all related activities and Management Plans.
- c. Track and trend department compliance with housewide in-service attendance.
- d. Review and assist in the development of educational programs for orientation and housewide in-services.
- e. Develop criteria in which compliance with safety education can be effectively measured.
- f. Make appropriate recommendations to other committees/leadership regarding problematic trends and assist in implementation of final resolution plans.
- g. Develop and implement safety promotional ideas such as safety fairs, contests, and incentive programs.
- h. Promote safety issues in various communication forms at BHD (newsletter, emails, signage).
- i. Annually, develop goals, objectives and performance standards for education of EC related information.
- j. Annually, assess the effectiveness of the annual safety in-service program.

# INTENT PROCESSES

## 1. Issue Assessment (EC 04.01.01)

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

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

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

## 2. Environmental Rounds

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

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

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

The EC Committee reviews compliance with monitoring and actions taken on recalls and alerts.

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

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

## 5. Intervention Authority

The Safety Officer and/or the individual serving as the House Supervisor nurse on duty on site and the Administrator on Call have been given the authority by the BHD Hospital Administrator to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings.

# ORIENTATION AND EDUCATION

1. **New Employee Orientation: (EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01.1-5)** Safety Education begins with the New Employee Orientation program for all new employees, and continues on

an ongoing basis with departmental specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis

2. **Annual Continuing Education: (HR 01.05.03 EP 1)** Safety Education is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees.
3. **Department Specific Training: (EC 03.01.01 EP1&2; HR 01.04.01 EP 1&3)** Directors/ Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards.
4. **Contract Employees: (EC 03.01.01 EP1&2; HR 01.04.01 EP 1&3)** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year.

## PERFORMANCE MONITORING

(EC 04.01.05)

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

### Safety Management

1. Actions taken for urgent recalls and alerts are documented in RASMAS within 3 days a minimum of 95% of the time
2. Measure the number of environmental rounds items addressed in 30 days (Goal = 80%)
3. Measure the number of fire setting contraband items/incidents found on inpatient units. (Goal < 4)

### Security Management

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

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

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

### Hazardous Materials Management

1. Measure the pounds of regulated medical waste sent for disposal. (Goal < 50 #/month)
2. Audits of RMW storage locations are completed during environmental rounds and reported as part of rounds data.

### Emergency Management

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

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

#### Fire Prevention

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

#### Utilities Management

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

#### Medical Equipment Management

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

## ANNUAL EVALUATION

### (EC 04.01.01)

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

evaluation process.

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

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

## Attachments

No Attachments

## Approval Signatures

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

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**References:**

## Safety Management Plan

### ***Mission:***

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

### ***Vision:***

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

### ***Philosophy of and Partnership in Care:***

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

### ***Culture of Quality, Safety and Innovation:***

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

### ***Healthy Learning Environment:***

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible.

## **PURPOSE:**

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

The purpose of the Safety Management Plan is to establish a system to reduce the risk of injury to patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework within which a safe environment of care is developed, maintained and improved. This plan also addresses specific responsibilities, general safety, and employee education programs.

## **SCOPE:**

The Safety Management Plan establishes the organizational structure within which a safe environment of care is established, maintained, and improved at MCBHD facilities. In addition to addressing specific responsibilities, general safety, and employee education programs the plan is in all efforts directed toward managing the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP4)

MCBHD locations include:

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

## **OBJECTIVES:**

1. Develop and implement department specific safety policies and education.
2. Monitor, track and trend employee injuries throughout the facility.
3. Effectively use environmental rounds data.
4. Develop and implement electronic rounding system.

# AUTHORITY/REPORTING RELATIONSHIPS:

The BHD Executive Team (ET) and Medical Staff Executive Committee (MEC) support the Environment of Care Program including the Safety Management Plan. EC Committee members are appointed by Administration to maintain a multi-disciplinary membership. The BHD Administrator appoints an EC Committee Chairperson and Safety Officer to develop, implement, and monitor the Safety Management Program. The EC Committee guides the Safety Management Program and associated activities. The Safety Officer is responsible for directing the safety program, and an ongoing, organization-wide process for collection of information about deficiencies and opportunities for improvement in the EC Management programs. BHD will utilize the EC Committee in lieu of a separate Safety Committee, where the Safety Officer will organize and implement inspection of all areas of the facility to identify safety hazards, and to intervene wherever conditions exist that may pose an immediate threat to life or health or pose a threat of damage to equipment or property. **(EC 01.01.01-EP1)**

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

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

Department Directors and/or Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate safety program guidelines and are directed to maintain a current awareness of the safety program, and to ensure its effective implementation within their program/department.

Each employee is responsible for attending and/or completing safety education programs and for understanding how the material relates to his/her specific job requirements. Employees are responsible for following the safety guidelines set forth in the safety program. Employee training attendance is monitored and a list of non-attendance is provided to Managers and/or Directors for follow-up.

## INTENT PROCESSES:

- A. **Risk Assessments - (EC 02.01.01 EP1, 3)** BHD performs risk assessments to evaluate the impact of proposed changes in areas of the organization. The desired outcome of completion of risk assessments is a reduction in likelihood of future incidents and other negative experiences, which hold a potential for accident, injury, or other loss to patients, employees, or hospital assets. Potential safety issues are reported, documented and discussed at the EC Committee meetings, all available pertinent data is reviewed, alternatives discussed, and a summary forwarded to management and included within the meeting minutes.

Based on the committee's evaluation of the situation, a decision by management is reached and returned to the committee. Results of this risk assessment process are used to create and implement new, or revise existing safety policies and procedures; environmental tour elements specific to the area affected; safety orientation and education programs; or safety performance improvement standards.

- B. **Incident Reporting and Investigation – (EC 04.01.01 EP1, 3, 4, 5)** Patient and visitor incidents, employee incidents, and property damage incidents are documented and reported quarterly to the EC Committee and the individual program executive committees. The reports are prepared by the Quality Improvement Department. The report and analysis are reviewed by the EC Committee for identification of trends or patterns that can be used to make necessary changes to the Safety Management Program and control or prevent future occurrences.
- C. **Environmental Tours –** A team of staff including the Safety Officer actively participates in the management of the environmental rounds process. Environmental Rounds are conducted regularly as outlined in the EC Management Plan, to evaluate employee knowledge and skill, observe current practice, and evaluate environmental conditions. Results from environmental rounds serve as a tool for improving safety policies and procedures, orientation and education programs, and employee performance. The Safety Officer provides summary reports on activities related to the environmental tour process to the EC Committee. Rounds are conducted at least every six months in all areas where patients are served and at least annually in all areas where patients are not served.

Individual department managers are responsible for initiating appropriate action to address findings identified in the environmental rounds process and recording those actions in the system and/or reporting them to the Safety Officer.

Environmental Rounds are used to monitor employee knowledge of safety. Answers provided during random questioning of employees, during the survey, are analyzed and summarized as part of the report to the EC Committee and used to determine educational needs.

- D. **Product/Medication/Equipment Safety Recalls – (EC 02.01.01 EP11)** Information regarding a recalled product, medications, or equipment is distributed via an internet based clearing house service (RASMAS). The EC Committee will review and report on recall and alert compliance quarterly
- E. **Examining Safety Issues - (EC 04.01.03 EP 2)** The EC Committee membership includes representatives from Administration, Clinical Programs, Support Services and Contract Management. The EC committee specifically discusses safety concerns and issues a minimum of six (6) times per year, and incorporates information on Safety related activities into the bi-annual report.
- F. **Policies and Procedures –** The Safety Officer is responsible for coordinating the development of general safety policies and procedures. Individual department managers are responsible for managing the development of departmental specific safety policies and procedures, which include but is not limited to, safe operations, use of hazardous equipment, and use of personal protective equipment. The Safety Officer assists department managers in the development of new department safety policies and procedures.

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

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

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

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

H. **Intervention Authority** – The Safety Officer, the House Supervisor nurse on duty, and the Administrator on Call have been given authority by the Hospital Administrator or their designee to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings. Any suspension of activity shall immediately be reported to the Hospital Administrator, or designee, and the Medical Director when appropriate.

I. **Grounds and Equipment – (EC02.01.01-EP5)** The Environment and Engineering Services (EES) department is responsible for scheduling and performing maintenance of hospital grounds and equipment. Policies and procedure for this function are located in the EES department and/or the on-line Policy repository.

## EMPLOYEE HEALTH AND WELFARE

A. Program Directors and Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate safety program guidelines and are directed to maintain a current awareness of the Safety Program, and to ensure its effective implementation within their department. Each employee is responsible for completing safety education programs and for understanding how the material relates to his or her specific job requirements. Employees are responsible for following the safety guidelines set forth in the Safety Program. Employee attendance at educational events is monitored and a list of non-attendance is provided to Managers/Directors for follow-up.

B. Employees report work related injuries, occupational illnesses or exposure to contagious diseases to their supervisor, the infection preventionist, and by completing a First Notification of Injury Form. Reports of employee incidents are recorded by the Milwaukee County Risk Management Department and reported to BHD Executive Team annually.

C. BHD reviews and analyzes the following indicators:

1. Number of OSHA recordable lost workdays
2. Injuries by cause
3. Needle sticks and body fluid exposures

## ORIENTATION AND EDUCATION

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

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

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

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

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

## PERFORMANCE MONITORING

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

- A. Ongoing performance monitoring is conducted for the following performance monitors:
1. Actions taken for urgent recalls and alerts are documented in RASMAS within 3 days a minimum of 95% of the time
  2. Measure the number of environmental rounds items addressed in 30 days (Goal 80%)
  3. Measure the number of fire setting contraband items/incidents found on inpatient units. (Goal 4)
- B. The Safety Officer oversees the development of the Safety related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

## ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

## SMOKING POLICY –

Reference Administrative Policy: Tobacco Free Policy (EC 02.01.03 EP 1, 4, & 6)

BHD is committed to the promotion of healthy environments in all programs. All medical evidence indicates that smoking is contrary to this objective. In support of this objective, effective November 16, 2000 the use of all tobacco products (cigarettes, e-cigarettes, vaporizing (vape) pens, cigars, pipes, chewing tobacco, and other smokeless tobaccos) was prohibited on MCBHD premises including property owned, leased, or otherwise operated by MCBHD. All staff, patients, residents, visitors, renters, vendors, and any other individuals on the MCBHD grounds are prohibited from using tobacco products. Smoking materials are removed from all patients upon admission.

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

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

## Attachments

No Attachments

## Approval Signatures

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	Lynn Gram: Exdir2-Asstospadm2-Mhc	pending

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## Security Management Plan

### **Mission:**

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

### **Vision:**

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

### **Philosophy of and Partnership in Care:**

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

### **Culture of Quality, Safety and Innovation:**

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

### **Healthy Learning Environment:**

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

## **PURPOSE:**

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

The purpose of the Security Management Plan is to establish a system to provide a safe and secure environment for all patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework to minimize the risk of personal injury or property loss due to criminal activity or workplace violence.

## **SCOPE:**

The Security Management Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. In addition to addressing specific responsibilities, general security, and employee education programs the plan is in all efforts directed toward managing the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP5)

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

MCBHD locations include:

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

## **OBJECTIVES:**

1. To prevent crime and to provide staff, patients, and visitors with a safe and secure environment.

2. Review and trend Incident/Safety Event Reports for all security related incidents.
3. To reduce the likelihood of victimization through education of patients and staff.
4. Keep, manage, and control access to sensitive areas.
5. To provide a thorough, appropriate and efficient investigation of criminal activity.
6. Utilize security technology as appropriate in managing emergencies and special situations.

## **AUTHORITY/REPORTING RELATIONSHIPS:**

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable security regulations, and evaluate the effectiveness of the security program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the ET along with any other program or department necessary for effective functioning. **(EC 01.01.01-EP5)**

## **INTENT PROCESSES:**

- A. **Emergency Security Procedures (EC 02.01.01 EP 9; EM 02.02.05 EP1-10)** – The BHD Security and EES Department maintains policies and procedures for actions to be taken in the event of a security incident or failure. Preventive maintenance is performed on the panic alarm system, security cameras, door alarms, communication radios, and door entryways with key card access.

Security has procedures addressing the handling of civil disturbances, and other situations including child/infant abductions and patient elopements. These include managing traffic and visitor control. Additional Security Officers may be provided to control human and vehicle traffic, in and around the environment of care. During emergencies security officers are deployed as necessary, and report in to the base (Dispatcher Control Center) and/or Incident Command Center as appropriate.

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

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

- C. **Reporting and Investigation (EC 04.01.01 EP 1&6; EC 04.01.03 EP 2)** – Security and Safety events are recorded in the MCBHD electronic Incident Safety Event Reporting System by a witness or the staff member to whom a patient or visitor incident is reported. The employee's Supervisor or location supervisor and the Risk Manager conducts an investigation and recommends/initiates follow up actions as appropriate.

In addition, Quality Management staff conduct an aggregate analysis of safety event/incident reports to determine if there are patterns of deficiencies in the environment or staff behaviors that require action in order to control or prevent future occurrences.

This incident analysis is intended to provide an opportunity to identify trends or patterns that can then be used to identify necessary changes to the Security Management Program. The findings of such analysis are reported to the Environment of Care Committee as part of the quarterly Security report, and is included as part of the Security Management Program annual report.

- D. **Identification (EC 02.01.01 EP 7)** – The current systems in place at BHD include photographic ID badges for all staff, volunteers, students and members of the medical staff worn above the waistline for visibility, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing to facilitate rapid visual recognition of critical groups of staff.

When possible, the current system includes photo identification of patients in medical records, and use of a wristband system.

The identification of others entering BHD is managed by the Operations Department including BHD Security. Security staff takes appropriate action to remove unauthorized persons from areas and to prevent unwanted individuals from gaining access to BHD.

- E. **Access and Egress Control (EC 02.01.01 EP 8)** – Various methods of control are used based on risk levels.

- **High Risk** area controls include key pad access or lock and key methods with continuous staffing and policy governing visitor and staff access.
- **Moderate Risk** area controls include lock and key methods with limited access per policy and key distribution.
- **Low Risk** area controls include lock and key methods only during times outside of identified business hours
- Security/Public Safety and/or operations staff will unlock doors as scheduled and make rounds at periodic intervals to maintain a safe and orderly environment. Security is stationed in the Psychiatric Crisis Center 24 hours per day, 7 days per week, and at the Main entrance desk from 6:00 a.m. to

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

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

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

## ORIENTATION AND EDUCATION

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

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

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

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

## PERFORMANCE MONITORING

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

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

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

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

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

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

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

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

B. The Safety Officer and EC Committee oversee the development of the Security related performance monitors. Data from these performance monitors are discussed quarterly at the EC Committee and by the Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County-Wide Safety Committee. The data from all EC performance monitors is analyzed and prioritized to select at

least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

# ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

## Attachments

No Attachments

## Approval Signatures

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

COPY



Current Status: Pending

PolicyStat ID: 7639832



**Date Issued:** 1/1/2013  
**Effective:** Upon Approval  
**Last Approved Date:** N/A  
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**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**Policy Area:** Environment of Care  
**References:**

## Hazardous Materials and Waste Management Plan

### **Mission:**

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

### **Vision:**

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

### **Philosophy of and Partnership in Care:**

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

### **Culture of Quality, Safety and Innovation:**

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

### **Healthy Learning Environment:**

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

## **PURPOSE:**

Consistent with the above mission, vision, values and guiding elements, MCBHD Administration has established the Environment of Care (EC) Committee and supports the Hazardous Materials and Waste Management (HMWM) Program as described in this plan.

The purpose of the HMWM Plan is to establish a system to identify and manage materials known by a health, flammability, corrosivity, toxicity or reactivity rating to have the potential to harm humans or the environment. The plan also addresses education and procedures for the safe use, storage, disposal and management of hazardous materials and waste (HMW), including regulated medical waste (RMW).

## **SCOPE:**

The HMWM Plan establishes the organizational structure within which HMW/RMW are handled, stored, and disposed of at MCBHD. This plan addresses administrative issues such as maintaining chemical inventories, storage, handling and use of hazardous materials, exposure monitoring, and reporting requirements. In addition to addressing specific responsibilities and employee education programs, the plan is, in all efforts, directed toward managing the activities of the employees so that the risk of injury to patients, visitors and employees is reduced, and employees can respond effectively in an emergency. **(EC 01.01.01-EP 6)**

MCBHD locations include:

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

## **OBJECTIVES:**

1. To increase staff knowledge of HMW/RMW and how to protect themselves from these hazards.
2. To maintain an accurate site and area specific inventory of hazardous materials including Safety Data Sheets (SDS) and other appropriate documentation for each location of MCBHD.
3. To respond to spills, releases, and exposures to HMW/RMW in a timely and effective manner.

4. To increase staff knowledge of their role in the event of a HMW/RMW spill or release and about the specific risks of HMW that they use, or are exposed to, in the performance of their duties, and the procedures and controls for managing them.
5. To increase staff knowledge of location and use of SDSs.
6. To develop and manage procedures and controls to select, transport, store, and use the identified HMW/RMW.
7. To reduce the amount of HMW/RMW generated at MCBHD by preventing the mixing of wastes and promoting practical alternatives to hazardous, regulated or disposable items.

## **AUTHORITY/REPORTING RELATIONSHIPS:**

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

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

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

## **INTENT PROCESSES:**

### **A. INVENTORY - Selecting, handling, storing, using, disposing of hazardous materials/waste – (EC 02.02.01-EP 1, 3 & 5)**

HMW is handled in accordance with its SDS, MCBHD policies, and all applicable laws and regulations from the time of receipt to the point of final disposition. Department Directors and managers are responsible for evaluating and selecting hazardous materials. Once it is determined the materials in question are considered hazardous (i.e. is the product required to have a SDS?), the Department Director and/or manager, with the assistance of the Safety Officer and/or HMWM program manager(s), evaluate the risks associated with use of the product and alternative solutions. This information is summarized and presented at the monthly EC Committee. Concern is for the minimization of hazardous materials whenever possible and assuring that appropriate education regarding use, precautions and disposal takes place when needed.

Contracted employees that may potentially create chemical hazards covered under the Occupational

Safety and Health Act (OSHA) Hazard Communication Standard are required to inform MCBHD of all chemical hazards to which employees, patients or visitors may be exposed to as a result of the contractor's activities. Contract/RFP language requires contractors to inform MCBHD, after selection and prior to starting the contract, of any hazardous materials that they will be using in the course of their work and to provide copies of policies regarding how they handle and dispose of any hazardous materials in addition to a copy of the SDS sheet for each product to be used. Once contractors are working in MCBHD, they must update MCBHD on hazardous inventory product changes.

The annual inventory of hazardous chemicals is used as the primary risk assessment for HMW. The inventory lists the quantities, types, and location of hazardous materials and wastes stored in each department.

MCBHD does not, as part of normal operations, use or generate any radioactive materials, hazardous energy sources or hazardous gases and vapors. **(EC 02.02.01-EP 6, 7, 9, &10)**

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

**B. Applicable Law and Regulation – (EC 02.02.01-EP 1&3)** MCBHD ensures that HMW are used, stored, monitored, and disposed of according to applicable law and regulation, which includes, but is not limited to, the following:

- OSHA Hazard Communication Standard
- OSHA Bloodborne Pathogens Standard
- OSHA Personal Protective Equipment (PPE) Standard
- OSHA Occupational Exposure to Hazardous Chemicals in Laboratories
- Environmental Protection Agency (EPA) Regulations
- Department of Transportation (DOT) Regulations
- Wisconsin Department of Natural Resources (WDNR)

Department Directors and/or managers are responsible for conducting an annual inventory of HMW. SDS' are available ([MSDSOnline](#)) and employees are instructed on their location and use. The MCBHD Hazard Communication Program establishes methods for labeling hazardous materials stored in the departments.

**C. Emergency Procedures - (EC 02.02.01 EP 3 & 4)** - Emergency procedures for hazardous material spills are located in the Environment of Care Manual. (See *Hazard Communication Program* policy and the *Chemical Release Control and Reporting Policy*) These policies include procedures for clean up of HMW spills within the building and grounds. A large (of such a volume that is no longer containable by ordinary measures) chemical spill or hazardous materials release would initiate an immediate request for emergency response of the local fire department.

**D. Reporting of hazardous materials/waste spills, exposures, and other incidents – (EC 02.02.01 EP 3 & 4; EC 04.01.01 EP 8)** HMW spills are reported on the MCBHD electronic Incident/Safety Event Reporting System. All reported HMW spills are investigated by the HMWM program manager and/or EC Committee Chair/Safety Officer. Recommendations are made to reduce recurrences based on the investigation.

Exposures to levels of HMW in excess of published standards are documented using both the MCBHD

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

**E. Managing Hazardous Chemicals - (EC 02.02.01 EP 5)**

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

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

**F. Managing Radioactive Materials - (EC 02.02.01 EP 6; EC 02.02.01 EP18)**

MCBHD does not use or store any radioactive materials as part of normal operations

**G. Managing Hazardous Energy Sources - (EC 02.02.01 EP 7)**

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

**H. Managing Hazardous Medications - (EC 02.02.01 EP 8; MM 01.01.03 EP 1, 2, & 3)**

As part of the HMWM program, the contracted pharmacy provider is responsible for the safe management of dangerous or hazardous medications, including chemotherapeutic materials. The pharmacy orders, stores, prepares, distributes, and disposes of medications in accordance with policy, law and regulation. MCBHD does not normally carry or prescribe chemotherapeutic materials.

**I. Managing Hazardous Gases and Vapors - (EC 02.02.01 EP 9 & 10)**

MCBHD does not produce any hazardous gases or vapors as a part of normal operations. Therefore MCBHD does not conduct any annual monitoring of exposure to hazardous gases and vapors. In the event of a concern regarding the presence of a hazardous gas or vapor, the area will be evaluated and/or monitored for the presence of such hazards in accordance with nationally recognized test procedures. Recommended action will be taken based on the results.

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

Wisconsin state statute defines the following:

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

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

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

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

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

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

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

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

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

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

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

**K. Management of Required Documentation (permits, licenses, labeling and manifests) (EC 02.02.01 EP 11 & 12)**

The manager of the HMWM program, Safety Officer or otherwise designated MCBHD employee will maintain all required documentation including any permits, licenses, and shipping manifests. Manifests are reconciled with the licensed RMW hauler's records on a monthly basis and action is taken regarding unreturned copies of manifests.

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

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

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

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

# ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the HMW/RMW Program begins with the New Employee Orientation Program for all new employees and continues on an ongoing basis with departmental specific training, job-specific training, and continued education required for all employees on an annual basis. Training includes generic information on the Hazard Communication Program, use and access to SDSs, labeling requirements of hazardous material containers, and the use of engineering controls, administrative controls, and PPE. **(EC 03.01.01 EP1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01 EP 1-5)**
- B. **Annual Continuing Education:** Education regarding HMW is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. **(HR 01.05.03 EP 1)**
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific HMW related policies and procedures as well as specific training on the health effects of the substances in the work place and methods to reduce or eliminate exposure. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**
- D. **Contract Employees:** Assessment and education is done at the time of assignment at MCBHD. Contracted Employees attend a New Employee Orientation program at MCBHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

# PERFORMANCE MONITORING

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

- A. Ongoing performance monitoring is conducted for the following performance indicators:
  - 1. Measure the pounds of regulated medical waste sent for disposal. (Goal < 50 #/month)
  - 2. Audits of RMW storage locations are completed during environmental rounds and reported as part of rounds data.
- B. The Safety Officer and EC Committee oversee the development of the HMW related performance monitors. Data from these performance monitors are discussed quarterly at the EC Committee and at the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee Countywide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of MCBHD for a performance improvement activity in the environment of care.

# ANNUAL EVALUATION

**(EC 04.01.01 EP 15)**

- A. The Safety Officer and Chair of the EC Committee has overall responsibility for coordinating the annual evaluation process for each of the functions associated with the management of the EC. The annual evaluation examines the objectives, scope, performance, and effectiveness of the HMWM Program.
- B. The annual evaluation is presented at the EC Committee by the end of the first quarter of each year. The EC Committee review and approves the report. The discussion, actions, and recommendations of the EC

Committee are documented in the minutes. The annual evaluation is then distributed to ET, MEC, and QMSC, the Program Executive Committees, and the Countywide Safety Committee. This finalizes the evaluation process.

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

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

## Attachments

No Attachments

## Approval Signatures

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

COPY



Current Status: Pending

PolicyStat ID: 7639889



**Date Issued:** 1/1/2015  
**Effective:** Upon Approval  
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**Next Review:** 3 years after approval  
**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**Policy Area:** Environment of Care  
**References:**

## Fire/Life Safety Management Plan

### ***Mission:***

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

### ***Vision:***

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

### ***Philosophy of and Partnership in Care:***

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

### ***Culture of Quality, Safety and Innovation:***

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

### ***Healthy Learning Environment:***

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

## **PURPOSE:**

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

The purpose of the Fire Prevention Plan is to establish a system to provide a fire-safe environment for all patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework to minimize the risk of personal injury or property loss due to fire by the provision and maintenance of adequate and appropriate building maintenance programs and fire protection systems.

## **SCOPE:**

The Fire Prevention Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. Fire Prevention is established to ensure that employees are educated, trained and tested in the fire prevention features of the physical environment and are able to react appropriately to a variety of emergency situations that may affect the safety of occupants or the delivery of care. **(EC 01.01.01-EP7)**

MCBHD locations include:

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

## **OBJECTIVES:**

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

# AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable life safety regulations, and evaluate the effectiveness of the fire prevention program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Committee along with any other program or department necessary for effective functioning. **(EC 01.01.01-EP7)**

## INTENT PROCESSES:

- A. **Protection from fire, smoke and other products of combustion** –The MCBHD occupancies are maintained in compliance with NFPA 101-2012 Life Safety Code ® (LSC). The Environment and Engineering Services (EES) Department completes the electronic Statement of Conditions and manages the resolution of deficiencies through the work order system or (upon participation in The Joint Commission) a Plan for Improvement (PFI) within the identified time frames. **(EC 02.03.01-EP 1; LS 01.01.01 EP 1-6)**

Any remodeling or new construction is designed to maintain separations and in accordance with state and federal codes including NFPA LS 101-2012 Chapters 18/19; NFPA 90A 2012 and NFPA 72-2010 and maintained to minimize the effects of fire, smoke, and heat. **(LS 02.01.10 EP 1-10; LS 02.01.20 EP 1-32; LS 02.01.30 EP 1-25; and LS 02.01.50 EP 12)**

The hospital has a written fire response plan and a fire prevention inspection program is conducted by EES, including state and local fire inspectors, to identify and correct fire hazards and deficiencies, to ensure free and unobstructed access to all exits, to reduce the accumulation of combustible and flammable materials and to ensure that hazardous materials are properly handled and stored. Copies of any reports are kept on file in the EES office. Fire Prevention issues are also noted on the environmental rounds tours. **(EC 02.03.01-EP 4 & 9; LS 01.01.01 EP 5; LS 02.01.20 1-32)**

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

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

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

- To minimize the danger from the effects of fire, including smoke, heat & toxic gases. **(LS 02.01.10 EP 1-15;)**
- To maintain the means of egress and components (corridors, stairways, and doors) that allow individuals to leave the building or to move within the building **(LS 02.01.20 EP 1-42)**
- To provide and maintain proper barriers to protect individuals from the hazards of fire and smoke. **(LS 02.01.30 EP 1-26)**
- To provide and maintain the Fire Alarm system in accordance with NFPA 72-1999. **(LS 02.01.34 EP 1-10)**
- To provide and maintain systems for extinguishing fires in accordance with NFPA 25-1998 **(LS 02.01.35 EP 1-14)**
- To provide and maintain building services to protect individuals from the hazards of fire and smoke including a fire fighters service key recall, smoke detector automatic recall, firefighters' service emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors **LS 02.01.50 EP 7)**

**Note:** The current facility is neither windowless nor a high rise **(LS 02.01.40 EP 1-2)**

**Note:** The facility does not have any fireplaces or utilize any linen or trash chutes **(LS 02.01.50 EP 3-6, & 8-13)**

- C. **Proposed Acquisitions** –Capital acquisitions and purchases include a process to confirm appropriate specifications and materials. This includes bedding, curtains, equipment, decorations, and other furnishings to ensure that such purchases comply with current LSC guidelines. The facility also maintains policies that specify what employees, and patients can have in the facility/work areas as a way to control and minimize hazards. Currently portable space heaters and combustible decorations that are not flame retardant are not permitted in the healthcare occupancy. **(LS 02.01.70 EP 1-5)**
- D. **Reporting and Investigation** – **(EC 04.01.01 EP 9; EC 04.01.03 EP 2)**– LSC and fire protection deficiencies, failures, and user errors are reported to the EES Department and, as appropriate, reviewed by the manager of the department. Summary information is presented to the EC Committee on a quarterly basis.
- E. **Interim Life Safety Measures** – **(LS 01.02.01 EP 1-15)** Interim Life Safety Measures are used whenever the features of the fire or life safety systems are compromised. BHD has an Interim Life Safety Management Policy that is used to evaluate life safety deficiencies and formulate individual plans according to the situation.
- F. **Policies and Procedures** –Fire/Life Safety related policies are reviewed a minimum of every three years and distributed to departments as appropriate.
- G. **Emergency Procedures** – **(EC 02.03.01 EP 9; EC 02.03.03 EP 1-5)** Emergency procedures are outlined in the Fire Safety Plan for each building. These plans are kept in the Environment of Care manual. The Hospital Incident Command System (HICS) may be implemented to facilitate emergency management of a fire or life safety related event.
- H. **Fire Drills** - **(EC 02.03.03-EP 1-5)** Employees are trained and drilled regularly on fire emergency procedures, including the use and function of the fire and life safety systems (i.e. pull stations, and

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

## ORIENTATION AND EDUCATION

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

Education regarding the Fire Prevention Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific fire prevention training, job-specific fire prevention training, and a series of programs required for all employees on an annual basis.

The training program includes the following:

- Specific roles and responsibilities for employees, students and contractors, both at and away from the fire's point of origin;
- Use and functioning of the fire alarm system,
- Location and proper use of equipment for extinguishing the fire,
- Roles and responsibilities in preparing for building evacuation,
- Location and equipment for evacuation or transportation of patients to areas of refuge,
- Building compartmentalization procedures for containing smoke and fire,
- How and when Interim Life Safety Measures are implemented and how they may affect the workplace environment.

B. **Annual Continuing Education:** Education regarding fire prevention is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees including feedback obtained during fire drills. **(HR 01.05.03 EP 1)**

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

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

## PERFORMANCE MONITORING

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

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

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

B. The Safety Officer and EC Committee oversees the development of the Fire prevention related

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

# ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

## Attachments

No Attachments

## Approval Signatures

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



Current Status: Pending

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**Date Issued:** 1/1/2015  
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**Next Review:** 3 years after approval  
**Owner:** Lynn Gram:  
 Exdir2-Assthospadm2-Mhc  
**Policy Area:** Environment of Care  
**References:**

## Medical Equipment Management Plan

### ***Mission:***

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

### ***Vision:***

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

### ***Philosophy of and Partnership in Care:***

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

### ***Culture of Quality, Safety and Innovation:***

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

### ***Healthy Learning Environment:***

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible

## **PURPOSE:**

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

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

## **SCOPE:**

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

MCBHD locations include:

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

## **OBJECTIVES:**

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

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

## **AUTHORITY/REPORTING RELATIONSHIPS:**

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

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

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

## **INTENT PROCESSES:**

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

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

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

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

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

D. **Monitoring and Acting on Equipment Hazard Notices and Recalls (EC 02.01.01 EP 11)** –BHD uses

RASMAS for recall and alert management. When an alert or recall may be related to equipment at MCBHD, the storeroom/central supply staff are notified to investigate if any equipment is part of the alert/recall, remove it from service and document any actions taken.

E. **Monitoring and Reporting of Incidents (Including Safe Medical Device Act (SMDA)) (EC 02.04.01 EP 5; EC 04.01.01 EP 10)**

All equipment used by BHD staff and/or contractors in the care of BHD patients is required to comply with SMDA per contract. The Quality Improvement/Risk Management department is responsible for investigating and reporting the incident to the manufacturer and/or Food and Drug Administration as appropriate.

F. **Reporting Equipment Management Problems, Failures and User Errors (EC 02.04.01 EP 6 & 9)**

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

G. **Emergency Procedures and Clinical Intervention (EC 02.04.01 EP 6)** –In the event of any

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

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

## ORIENTATION AND EDUCATION

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

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

- B. **Annual Continuing Education:** Education regarding medical equipment is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. The EC Committee will, as part of the annual program review, identify technical training needs and assist with the creation of any training program as identified. **(HR 01.05.03 EP 1)**
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific medical equipment related policies and procedures and specific job related equipment procedures and precautions. Training of employees and technical staff regarding use, features, maintenance and precautions is included as a part of new equipment acquisition/purchase. Additional training/retraining will be conducted based user-related problems or trends seen in the program evaluation. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. **(EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3)**

## PERFORMANCE MONITORING

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

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

## ANNUAL EVALUATION

**(EC 04.01.01 EP 15)**

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

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

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

## Attachments

No Attachments

## Approval Signatures

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

COPY



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 Exdir2-Assthospadm2-Mhc  
**Policy Area:** Environment of Care  
**References:**

## Utilities Management Plan

### ***Mission:***

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

### ***Vision:***

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

### ***Philosophy of and Partnership in Care:***

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

### ***Culture of Quality, Safety and Innovation:***

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

### ***Healthy Learning Environment:***

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

## ***Financial Resources:***

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

## ***Core Values:***

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

- Welcoming
- Co-occurring Capable
- Person-Centered
- Culturally Intelligent
- Trauma-Informed
- Stage Matched Recovery Planning
- Systems and Services Integration
- Recovery-Oriented
- Accessible.

## **PURPOSE:**

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

The purpose of the Utilities Management Plan is to establish a system to provide a safe and comfortable environment for all patients, employees, and visitors of the Milwaukee County Behavioral Health Division (MCBHD). The plan establishes the framework to provide and maintain the appropriate utility services.

## **SCOPE:**

The Utilities Management Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. The utilities covered in this plan included: electrical distribution, emergency power, vertical transportation systems, HVAC, steam systems, communications systems, domestic water and plumbing, and security systems (key pad access, video monitoring and panic alarm). (EC 01.01.01-EP 9)

MCBHD locations include:

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

## **OBJECTIVES:**

1. To develop and implement equipment operational sheets for critical components of the utility system.
2. To provide utility system maintenance, inspection, and testing and document the procedures.
3. To provide data that demonstrates maintenance history for each piece of equipment, what work is (over) due, and what work is planned.
4. To provide utility failure data and emergency response procedures.
5. To conduct an annual inventory of equipment included in plans and review of maintenance history and

failure trends.

## **AUTHORITY/REPORTING RELATIONSHIPS:**

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

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

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

## **INTENT PROCESSES:**

- A. **Environment of Care, Design and Installation of Utility Systems (EC 02.05.01-EP1 & 2; EC 02.05.03 EP 1)**– Per our mission statement, the Utilities Management Plan is designed to promote a safe, controlled and comfortable environment of care by providing and maintaining adequate and appropriate utility services and infrastructure. This is managed and supported through the Environmental and Engineering Services department. The Facilities Manager collaborates with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local state and national building and fire codes. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager also assures that the necessary parties complete a Pre-Construction Risk Assessment (PCRA), which reviews air quality requirements, infection prevention and control, utility requirements, noise, vibration, fire safety, and other hazards. Recommended precautions from the PCRA are implemented as part of the project design. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of BHD
- B. **Nosocomial Infection (EC 02.05.01-EP 6 & 7; EC 02.05.05-EP4)**– Proper maintenance of utility systems contributes to the reduction of hospital-acquired illnesses. The Infection Preventionist monitors the potential for these illnesses, referred to as Nosocomial Infections. Any concerns that may be utilities related will be addressed in a timely manner.
- C. **Risk Minimization and Operational Reliability (EC 02.05.01-EP 4 & 5; EC 02.05.05-EP 4, 5, & 6; EC 02.05.07-EP1-10)**– Through specific Computerized maintenance Management Program, inspections and

testing activities are conducted and recorded. Equipment is maintained to minimize the risk of failure. Intervals for inspecting, testing, and maintaining all operating components of the utility systems on the inventory are based on criteria including manufacturers' recommendations, risk levels, and hospital experience. Rounds are conducted by EES and are utilized to detect and assess incipient failure conditions. In the event that any equipment fails a test, that equipment will be retested after any repairs or corrections are completed.

**Note:** BHD does not currently have any life support systems.

- D. **Risk Assessment and Inventory (EC 02.05.01-EP3; EC 02.05.05-EP 1)**– Risk based criteria will be established to identify components of utility systems that are high-risk and have significant impact on life support, infection prevention and control, environmental support, equipment support, and communication systems. New system components will be evaluated prior to start-up.
- E. **Maintenance of Critical Operating Systems (EC 02.05.01 EP 19; EC 02.05.03-EP1-7, 13; EC 02.05.07-EP 1, 2, 4 & 7)**– EES monitors the effectiveness of the utility systems by conducting inspections and analyzing data received through rounds and logs and supported by departmental policies and procedures. To ensure reliable operation of emergency systems, BHD performs inspections and tests of the following:
- Monthly transfer switch testing
  - Weekly and monthly emergency generator testing

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

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

**Note:** The facilities emergency electrical system is fed from a dedicated 24KV feed from WE Energies.

This feed is backed up by an emergency 650 KVA generator. This generator is inspected and tested weekly by a contracted service, in compliance with applicable local and State CMS requirements.

Additionally the contractor also performs the annual load bank testing to ensure proper operation of the generator. The facility electrician reviews the reports. Documentation of testing is kept in the EES office in binder #16..(EC 02.05.07-EP 5-10)

- F. **Managing Pathogenic Biological Agents & Controlling Airborne Contaminates (EC 02.05.01-EP 5, 6, 14-16)**– Certain pathogenic biological agents survive in water or a humid environment. BHD EES Department monitors the potential source locations such as the humidification system and domestic water supply. It is the practice of this department to react quickly to any indication of these biological agents.

Managing air movement, exchanges and pressure within BHD is achieved by properly maintaining equipment and monitoring pressure relationships. Where appropriate, high efficiency filtration is utilized.

Infection Prevention and Control requests receive priority status if an issue is identified, especially in areas that serve patients diagnosed or suspected of air-borne communicable diseases and patients that are immuno-suppressed.

- G. **Mapping and Labeling (EC 02.05.01-EP 8 & 9, & 16)**– Milwaukee County and EES maintains mapping and labeling of critical distribution systems and equipment operational instructions. Master copies are kept in the MC Transportation and Public Works Division, Architecture and Engineering Department and the EES Department.

Shut down procedures are located either at the equipment, in the mechanical space shared by the equipment, or in the department policy and procedure manual. Only employees that are permitted access are trained in emergency shut down of equipment/systems

- H. **Investigating Utility System Problems, Failures or User Errors (EC 02.05.01-EP 10; EC 04.01.01 EP11)**– Failures, problems and user errors are reported to EES for corrections. Utility system failures are reported to EES and, when appropriate to the EC committee for evaluation and recommendations to prevent reoccurrences. Utility failures are documented on the *BHD Building System Failure Incident Report* .
- I. **Electrical Cords and Power Strips (EC 02.05.01 EP 23 & 24)** - Power strips in patient care vicinity are only used for movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UP 60601-1 Power strips used outside of patient care but with the patient care room meet UL 1363. In non-patient care rooms, power strips meet other UL standards. Extension cords are only used temporarily and are removed immediately upon completion of the task.
- J. **Policies and Procedures** – Utilities related policies are reviewed a minimum of every three years and distributed to departments as appropriate.
- K. **Emergency Procedures - (EC 02.05.01-EP 9-12 & EC 02.05.07 EP 9)** – Emergency procedures for utility systems malfunctions are developed and maintained in the EES department's procedures for Utility disruptions, back up sources, shut off procedures, repair services and hours of operation are covered in the EES departmental policies and procedures manual. Emergencies are reported twenty-four hours a day through security extension 7395 (where the call will be routed to the EES Maintenance department via telephone or two way radio) and the administrator on call. Alternate sources of essential utilities are listed in the EES Department Policy Manual for each system.
1. **Alternate Source of Essential Utilities – (EC 02.05.01 EP 13; EC 02.05.03-EP 1-6; EC 02.05.09 EP 1-3)**– Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and employees are trained as part of the organization wide and department specific education. These plans are tested as part of regularly scheduled exercises and actual outages of utility systems. This includes, Fire Alarm System, Exit illumination, P.A. system, one elevator (# 5), and medication dispensing machines. Emergency power outlets are available in the event mobile life support equipment is used. At present BHD does not store any blood, bone or tissue; does not have any med gas or surgical vacuum systems; and has no built in life support systems.
  2. **Backup Communication System – (EC 02.05.03 EP 5)** – Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, a satellite phone system, crisis line phone system, pagers, cellular phones, two-way radios, and ham radio system. The implementation of the emergency plan focuses on maintaining vital patient care communications. Once the initial level of the plan is in place, the Communications and/or Telecommunications Department will work with representatives of the telephone company to determine the scope and likely duration of the outage and to identify alternatives.
  3. **Clinical Interventions - (EC 02.05.01-EP 12)** – Emergency procedures and contingency plan information is available in the Environment of Care manual (Systems Failure & Basic Staff Response Quick Reference) and in the Emergency Operations Plan,

# ORIENTATION AND EDUCATION

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

Education regarding the Utilities Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific utilities training, and a series of programs required for all employees on an annual basis.

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

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

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

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

# PERFORMANCE MONITORING

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

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

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

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

# ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

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

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

## Attachments

No Attachments

## Approval Signatures

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

COPY



# Milwaukee County Crisis Services

## Crisis Resource Center (CRC) Collaborative

### Overview

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

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

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

#### Data:

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

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

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

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

#### Next Steps/Recommendations:

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



**BHD** MILWAUKEE COUNTY  
Behavioral  
Health  
Division

# Milwaukee County Crisis Services

Crisis Resource Center (CRC)  
Collaborative



**WHOLE HEALTH**  
**CLINICAL GROUP**

a service of the  
Milwaukee Center for Independence



# AIM (Plan)

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



# CHANGE

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

# Crisis Resource Center (CRC)

Subacute Psychiatric Treatment Recovery Center



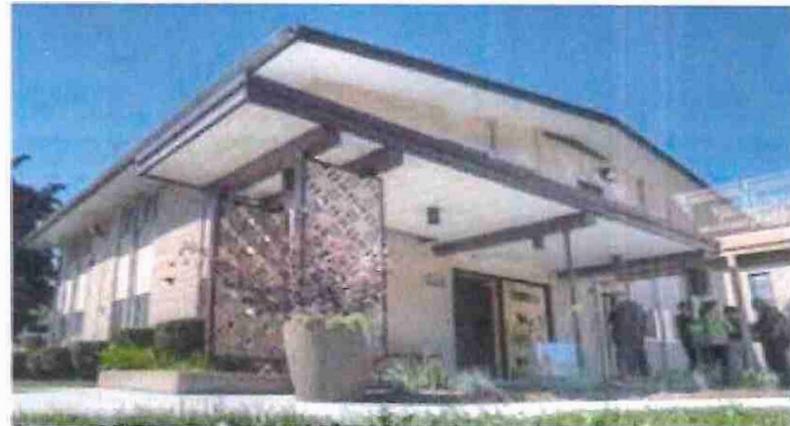
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Behavioral  
Health  
Division

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

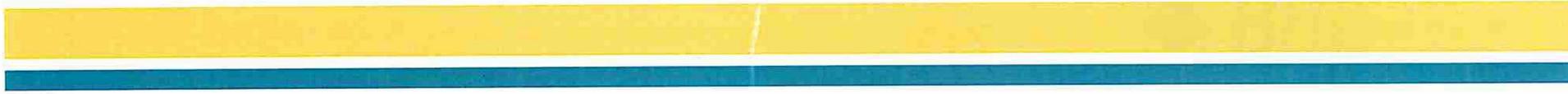
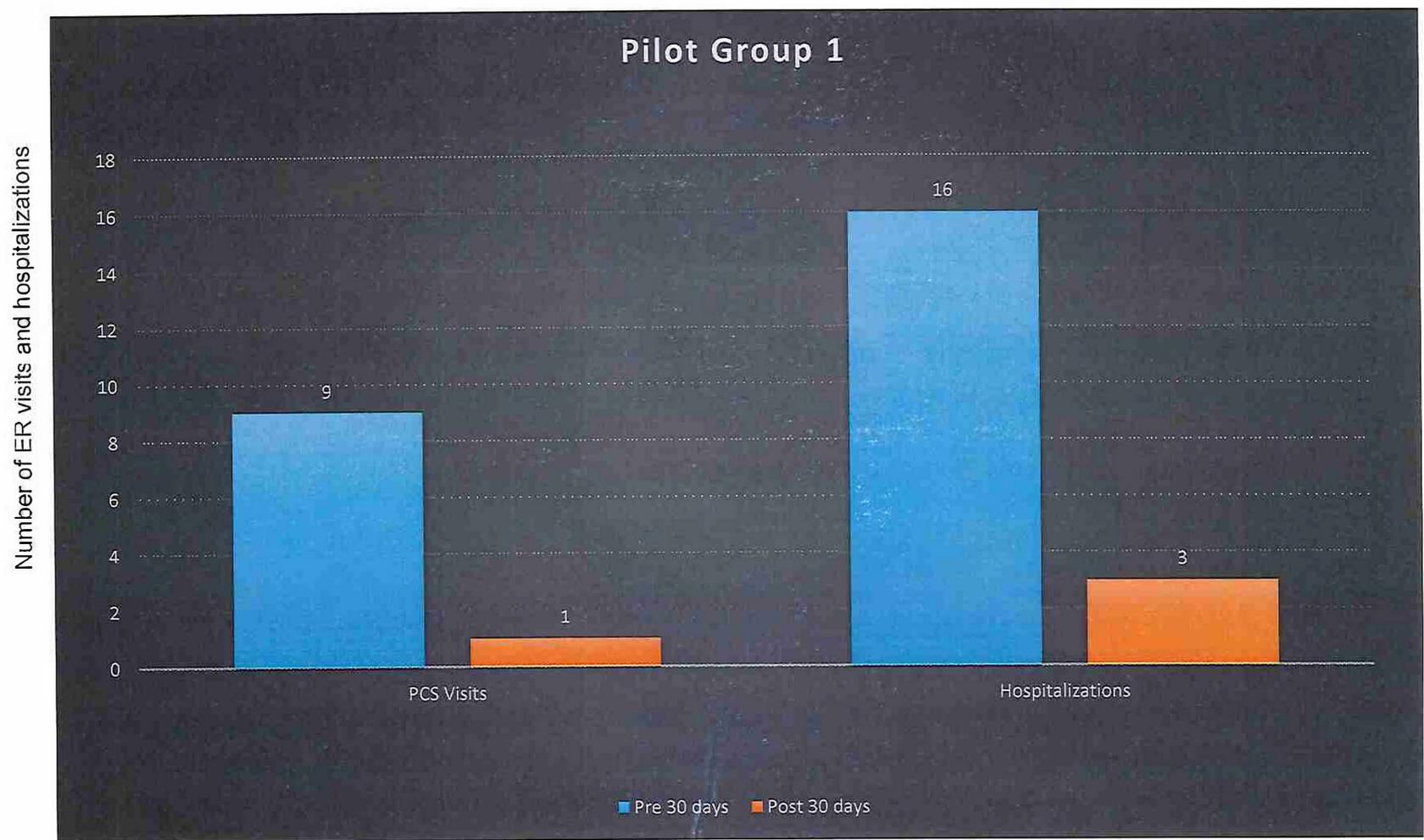


**WHOLE HEALTH**  
CLINICAL GROUP

A service of the  
Milwaukee Center for Independence

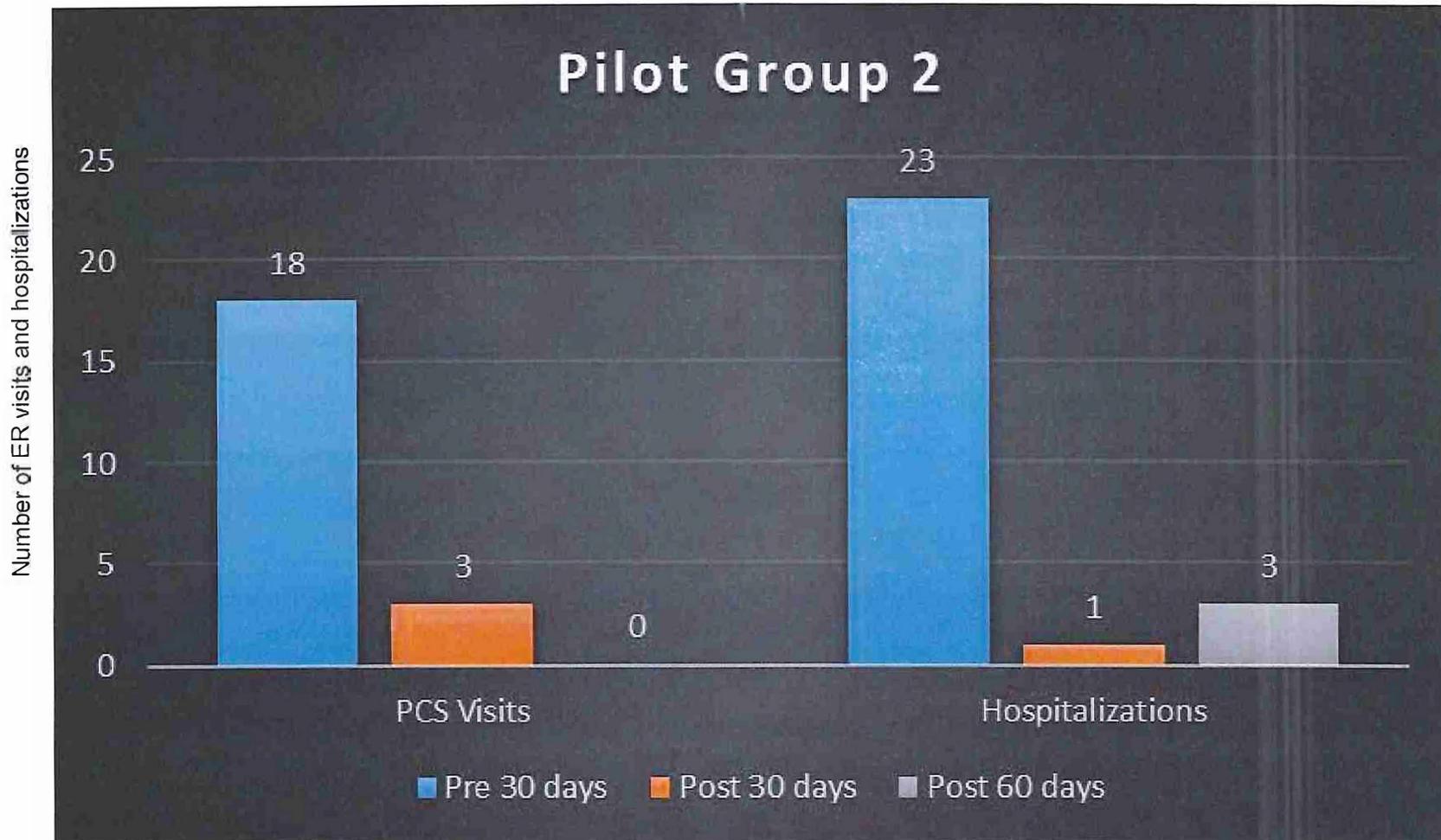


# Results





# Results





# COMPARISON DATA

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

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

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





# NEXT STEPS: Adopt, Adapt or Abandon?

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





# IMPACT

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



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

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

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

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

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

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

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