



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

Program	Item	Measure	2015 Actual	2016 Actual	2017 Actual	2018 Quarter 1	2018 Quarter 2	2018 Quarter 3	2018 Quarter 4	2018 Actual	2018 Target	2018 Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵ Sample Size for Rows 2-6 (Unique Clients)	9,624	7,971	8,346	5,758					8,763		BHD (2)
	2	Percent with any acute service utilization ⁶	-	13.09%	18.18%	16.16%					-		BHD (2)
	3	Percent with any emergency room utilization ⁷		12.44%	14.53%	12.52%					16.67%		BHD (2)
	4	Percent abstinence from drug and alcohol use	-	66.71%	62.30%	64.09%					63.51%		BHD (2)
	5	Percent homeless	-	4.74%	7.44%	8.01%					6.72%		BHD (2)
	6	Percent employed	-	15.80%	16.35%	17.74%					17.06%		BHD (2)
	7	Sample Size for Row 7 (Admissions)		6,315		1,622							
	7	Percent of clients returning to Detox within 30 days	19.6%	55.61%	59.55%	60.05%					57.38%		BHD (2)
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,329	3,500	3,404	1,749					3,670		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.6	4.6	4.75	4.5					> = 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	62%	60.2	65.7%	64.5%					> = 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.2	2.86	2.59	2.25					> = 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	58%	53.6%	57.8%	43.1%					> = 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	42%	43.6%	44.1%	40.8%					> = 50%		BHD (2)
Crisis Service	14	PCS Visits	10,173	8,286	8,001	1,866					8,000		BHD (2)
	15	Emergency Detentions in PCS	5,334	4,059	3,979	764					4,000		BHD (2)
	16	Percent of patients returning to PCS within 3 days	8%	7.9%	7.3%	6.4%					8%		BHD (2)
	17	Percent of patients returning to PCS within 30 days	25%	24.8%	23.1%	20.1%					24%		BHD (2)
	18	Percent of time on waitlist status	16%	80.1%	75.0%	54.3%					25%		BHD (2)
Acute Adult Inpatient Service	19	Admissions	965	683	656	189					800		BHD (2)
	20	Average Daily Census	47.2	45.8	42.9	40.6					54		BHD (2)
	21	Percent of patients returning to Acute Adult within 7 days	3%	3.6%	1.4%	0.5%					3%		BHD (2)
	22	Percent of patients returning to Acute Adult within 30 days	11%	10.8%	7.7%	4.2%					10%		NRI (3)
	23	Percent of patients responding positively to satisfaction survey	73%	70.6%	74.0%	75.3%					75%		NRI (3)
	24	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	63%	57.1%	65.4%	69.0%					65%		BHD (2)
	25	HBIPS 2 - Hours of Physical Restraint Rate	7.2	3.32	0.56	0.26					0.44		BHD (2)
	26	HBIPS 3 - Hours of Locked Seclusion Rate	0.47	0.48	0.30	0.36					0.29		CMS (4)
	27	HBIPS 4 - Patients discharged on multiple antipsychotic medications	18%	18.5%	17.5%	13.5%					9.5%		CMS (4)
	28	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	98%	95.0%	89.6%	92.3%					90.0%		BHD (2)
Child / Adolescent Inpatient Service (CAIS)	29	Admissions	919	617	709	164					800		BHD (2)
	30	Average Daily Census	9.8	8.4	8.6	8.1					12.0		BHD (2)
	31	Percent of patients returning to CAIS within 7 days	6%	5.2%	5.2%	2.4%					5%		BHD (2)
	32	Percent of patients returning to CAIS within 30 days	16%	11.8%	12.3%	10.0%					12%		BHD (2)
	33	Percent of patients responding positively to satisfaction survey	71%	78.1%	71.3%	77.0%					75%		BHD (2)
	34	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	74%	82.1%	76.8%	75.6%					75%		BHD (2)
	35	HBIPS 2 - Hours of Physical Restraint Rate	5.2	4.51	1.17	1.38					0.44		CMS (4)
	36	HBIPS 3 - Hours of Locked Seclusion Rate	0.42	0.20	0.37	0.93					0.29		CMS (4)
	37	HBIPS 4 - Patients discharged on multiple antipsychotic medications	2%	1.6%	5.0%	1.2%					3.0%		CMS (4)
	38	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	100%	88.9%	97.1%	100.0%					90.0%		BHD (2)
Financial	39	Total BHD Revenue (millions)	\$120.2	\$130.1	\$149.9	\$154.9							
	40	Total BHD Expenditure (millions)	\$173.5	\$180.7	\$207.3	\$213.5							

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

CARS QUARTERLY DASHBOARD SUMMARY

The following will give a brief overview of the major modifications made to the CARS Quarterly Dashboard (formerly the CARS Quarterly Report) and will highlight some significant data elements contained therein.

HIGHLIGHTS

Adoption of the Quadruple Aim

The Dashboard was reorganized so that it corresponds to the Quadruple Aim, which is a statement of purpose for health care systems in which they focus on four major domains: consumer experience, cost of care, population health, and staff wellbeing. This was done to better align the data points and reporting structure to the larger changes envisioned for the BHD Quality Dashboard (which will be modelled on the Quadruple Aim) and is consistent with the Strategic Goals of Milwaukee County's Department of Health and Human Services. The data elements for the domains of cost of care and staff wellbeing are currently under development, and it is our intention to present some preliminary options to the Mental Health Board Quality Subcommittee at the fall meeting this year.

Streamlined Data Reporting

Another modification made to the CARS Quarterly Dashboard is the simplification of the volume served and length of time to first service metrics by collapsing the over 20 CARS programs into a single CARS enrollment. We believe this not only increases the ease of interpretation of the data, but reflects the broader philosophical shift within CARS and BHD to view our consumers holistically (as a total population enrolled in BHD's care), rather than provincially (consumers served within specific BHD Departments). For example, previous iterations of the quarterly report measured time to service for each CARS program. The current iteration combines all programs together from the time of the latest referral to the first service date of any service. It is crucial to keep in mind that although waitlists exist for certain programs combined in this measurement, most consumers are being actively engaged quickly by other programs as a bridge between their initial referral and their recommended level of care.

New Targets for 2018

With a year of more timely data collected in 2017, we adjusted our 2018 targets to reflect what we believe are more realistic goals based on data that more accurately reflect the status of the CARS population. Considering these readjusted targets, there are several notable metrics:

1. The number of admissions and consumers served within CARS in any given quarter has continued to increase as CARS continues its focus on increasing access to and capacity of CARS services.
2. With the exception of increases in the rates of homelessness and readmission to detoxification in the 1st quarter of 2018, most of the health metrics for the CARS population continued their modest improvement of the last several quarters. Further, the number of unique completed assessments, on which these figures were based, reached their highest quarterly total since the inception of the KPIs in 2015.

Next Steps

As noted above, further changes will be forthcoming for the CARS Quarterly Dashboard. Among these will be the further development and expansion of the data reported, including data on staff wellbeing, cost of care, and other metrics related to the consumer experience of care and population health. The CARS Research and Evaluation Team is also considering alternative methods for presenting the data (point in time, change over time, by cohort, etc.), the timeframe under observation, and whether there are national standards against which to benchmark our data.

2018 Wraparound Milwaukee KPI Dashboard Summary – 1st Quarter

		2017	1 st Q	2018 Target	Status
8	Families served in Wraparound HMO (unduplicated count)	3,404	1,749	3,670	
9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.75	4.5	> = 4.0	
10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	64.5%	> = 75%	
11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.25	> = 3.0	
12	Percentage of youth who have achieved permanency at disenrollment	57.8%	43.1%	> = 70%	
13	Percentage of Informal Supports on a Child and Family Team	44.1%	40.8%	> = 50%	

8 – Enrollment trends will be analyzed and addressed next quarter as it relates to projected target.

9 – On target. No comments.

10 - Achieved 86% of the target of 75% or greater. Within 20% range of the benchmark. Continued efforts to have youth reside in the least restrictive setting possible.

11 - Outside the 20% benchmark (2.4) and below the standard set of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. Those in Wraparound court ordered programs who are disenrolled to a home type setting have a higher "Needs Met" score (2.82) than those disenrolled on runaway or to corrections (1.78). Discharge placement appears correlated with Needs Met. Those in the REACH program average a disenrollment Needs Score of 1.99. Reported initial engagement and/or closure/transitional issues may contribute to this score. Wraparound Team Coaches are encouraged to be utilized in these situations.

#12 – Noted trends of placement at disenrollment related to permanency for Wraparound youth on Court Orders:

"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

Status at disenrollment	2015	2016	2017
Runaway	37	53	26
Corrections	82	84	58
Permanency achieved as defined above	92% (236 youth)	90% (236 youth)	76% (211 youth)

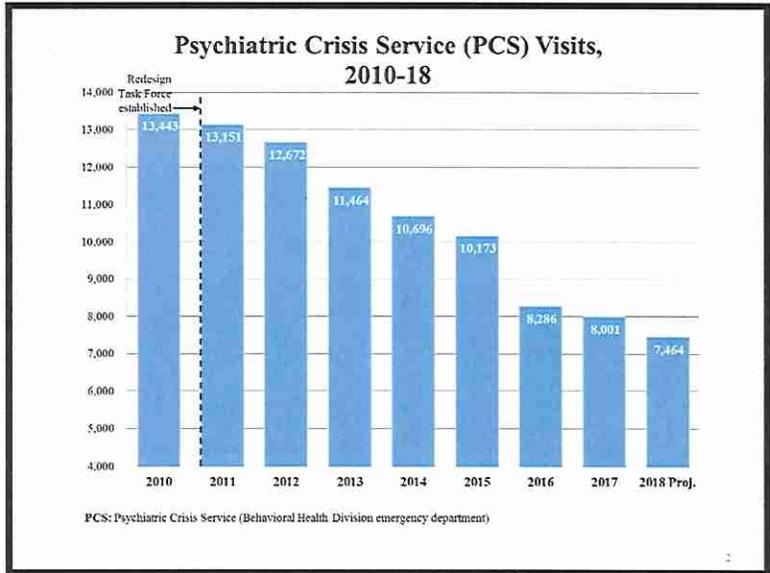
As there was a significant drop in 2017 related to youth leaving the program on runaway status and corrections, other trends representing the decrease in permanency may be associated with the following:

Status of Wraparound court ordered youth at disenrollment	2015	2016	2017
Group Home Care	4	13	21
Residential Care	5	8	19

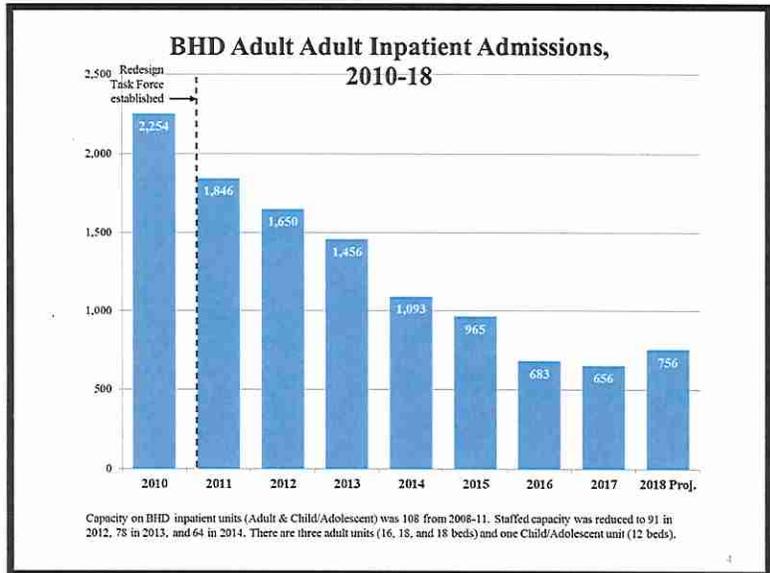
#13 - Within 20% range of the benchmark. Aggressively monitored and addressed monthly and in trainings.

2018 Q1 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

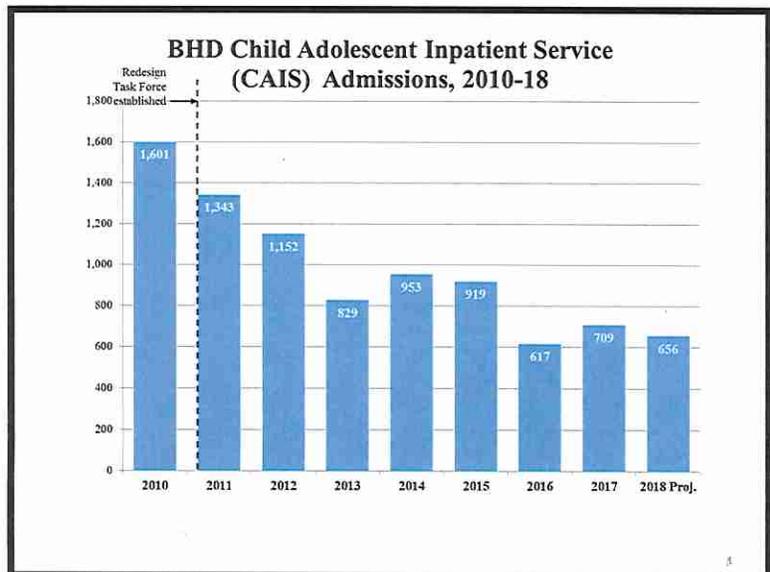
Psychiatric Crisis Service annual patient visits continue to decline from a high of 13,443 in 2010 to 7,464 projected annual visits in 2018 (45% decline from 2010 to 2018). The continued downward trend of PCS utilization can be attributed in part to readmission rate reduction (30-day readmission rate: 25% in 2015, 20% in 2018), the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community.



Acute Adult Inpatient Service's annual patient admissions are projected to increase to 756, the first increase since the Redesign Task Force was established in 2010 (67% decline from 2010 to 2018). While Acute Adult admissions are projected to rise, readmission rates have continued to decline over the past four years (30-day readmission rate: 11% in 2015, 4% in 2018). Acute Adult's 2018 hours of physical restraint rate has reduced by 54% in comparison to 2017's rate and continues to be below the national average for the 2nd year in a row. Acute Adult's MHSIP patient satisfaction survey scores are at historical BHD highs and are now at the national overall satisfaction survey score average.



Child Adolescent Inpatient Service's annual patient admissions have plateaued over the past few years and are projected at 656 for annual 2018 (59% reduction from 2010 to 2018). Over the past four years, CAIS' 30-day readmission rates have declined from 16% in 2015 to 10% in 2018. While CAIS' 2018 hours of physical restraint rate is 2.1 times the national average, their hours of physical restraint rate has declined from 5.2 in 2015 to 1.4 in 2018. CAIS' Youth Satisfaction Survey overall scores have improved in 2018 and are now at/near historical BHD highs.



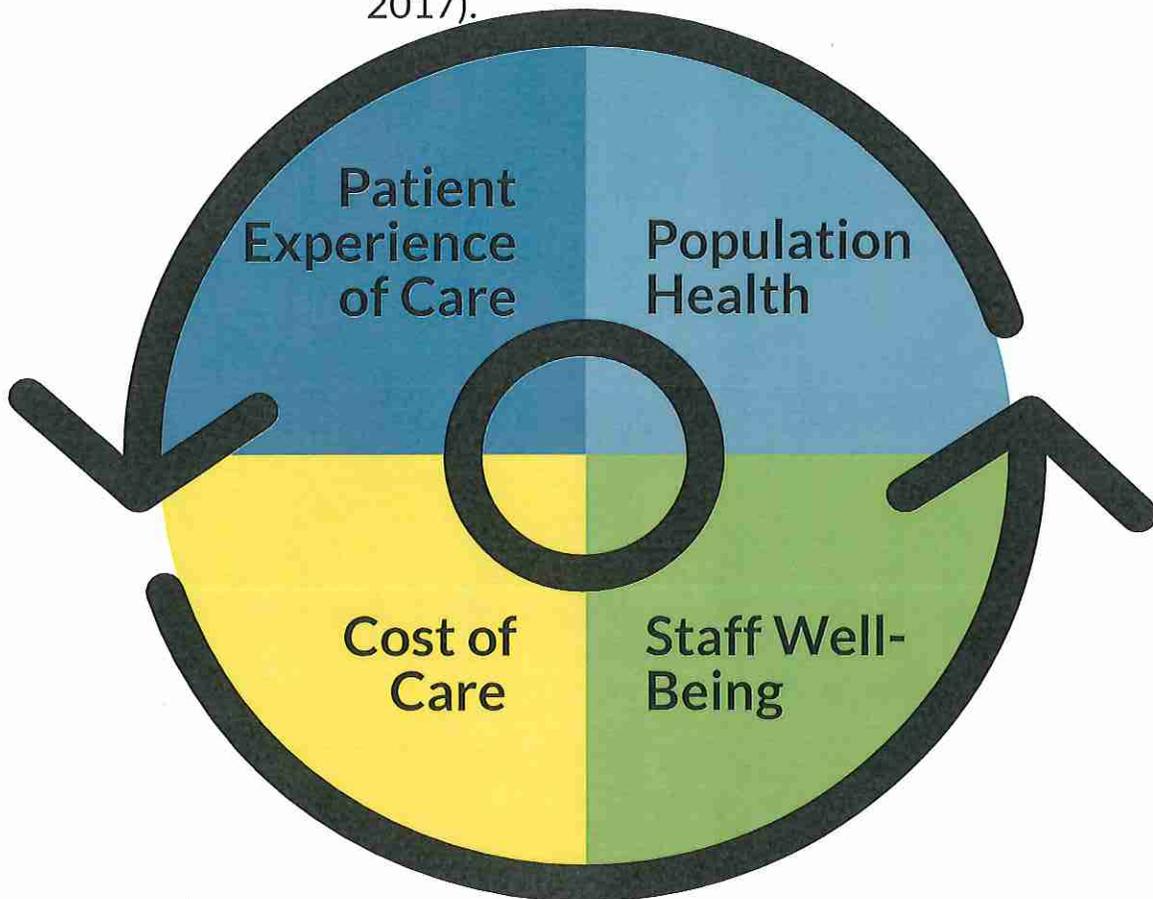


CARS Quality Dashboard

CARS Research + Evaluation Team

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).



Domain: Patient Experience of Care

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



Referrals/Intakes

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



Time to Service

Average number of days between the time of referral to the first service date.



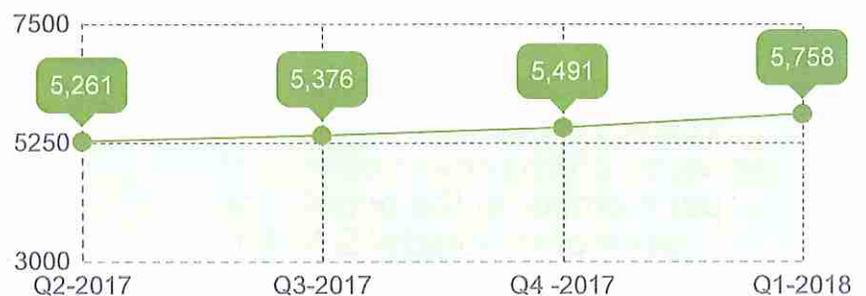
Admissions

All admissions during the quarter in question (not unique clients as some clients had multiple admissions during the quarter). This includes detoxification admissions.



Volume Served

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





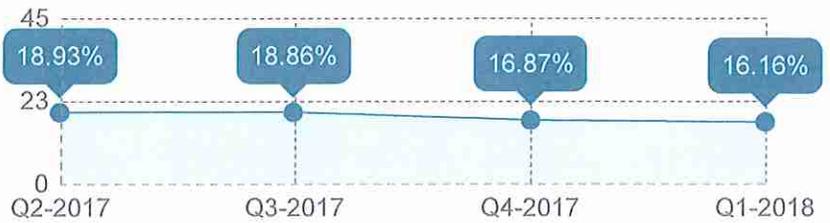
Domain: Population Health

Data informing each item is formatted as percentages based on the description. These 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.



Detox 30 Day Readmissions

Percent of consumers returning to detox within 30 days.



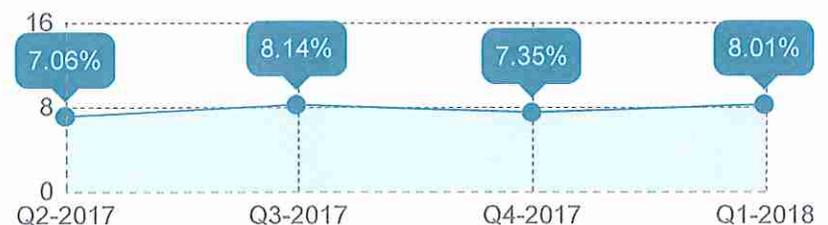
Abstinence

Percent of consumers abstinent from drug and alcohol use.



Housing

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



Employment

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



**Mental Health Board
Quality Subcommittee Meeting
June 4, 2018**

**Sentinel Event Committee
Quality Summary**

The Behavioral Health Division reviewed 10 Sentinel and Other Events in 2017. These included 6 Sentinel Events and 4 Other Events.

For comparison, we reviewed:

5 events in 2016
9 events in 2015
17 events in 2014
23 events in 2013
39 events in 2012

This year, 50% of reviewed events were deaths by suicide.

For comparison:

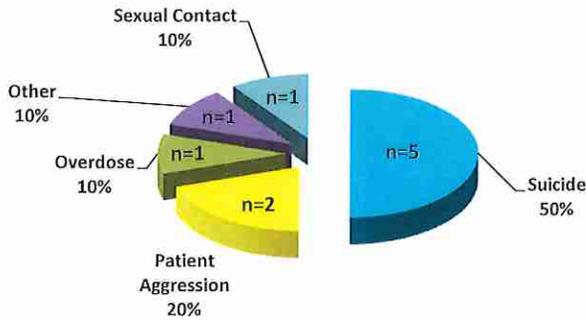
40% in 2016
67% in 2015
18% in 2014
0% in 2013
0% in 2012

2017 BHD Sentinel Events

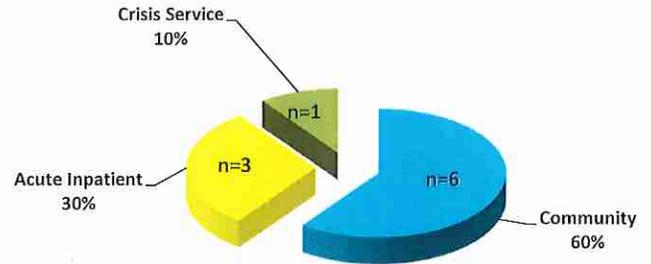
10 incidents reviewed

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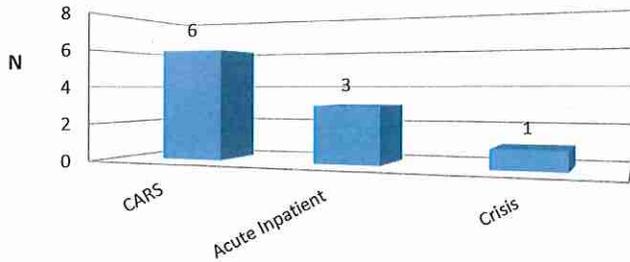
Type of Event



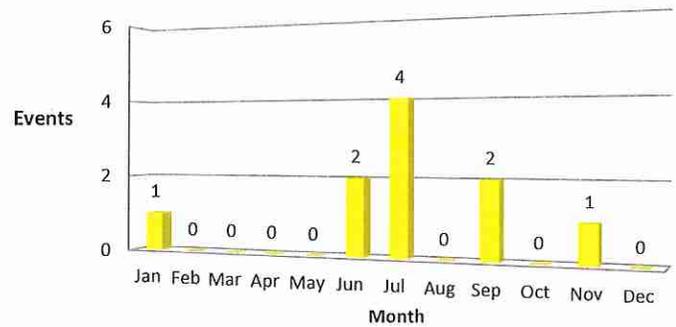
Location of Event



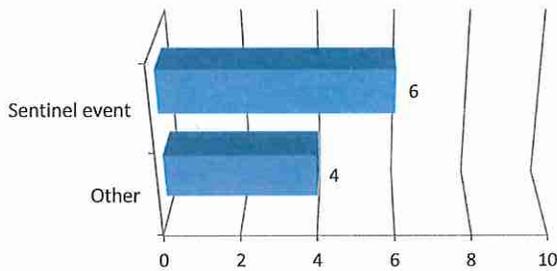
Program (Open with/last contact)



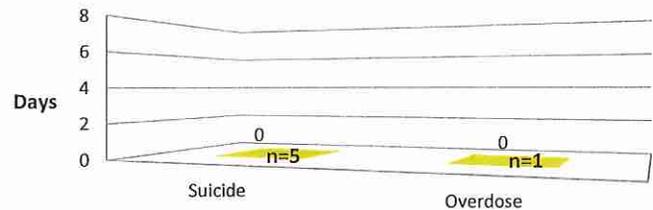
Month of Event



Level of Review

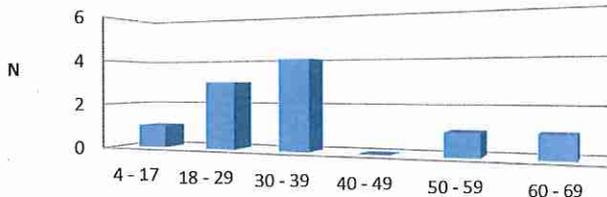


Average Days After Last BHD Contact



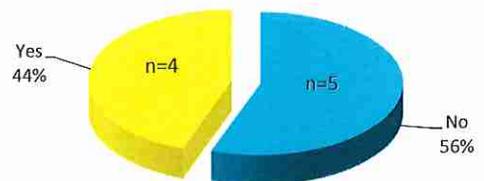
Patient Age

Average Age: 33 yrs male, 37 yrs female; Gender: 70% male, 30% female



Significant AODA Component to Event

44% (n=4) of events reviewed had a significant AODA component



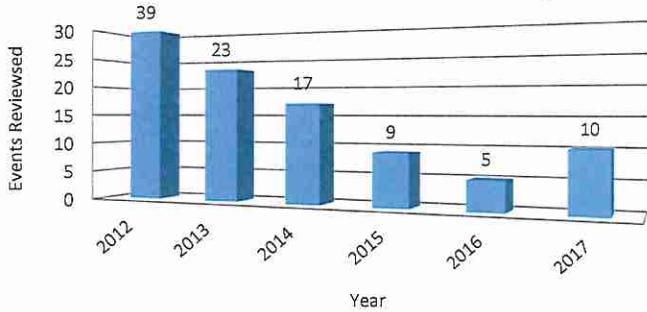
N	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69
N	1	3	4	0	1	1

2012 - 2017 BHD Sentinel Events

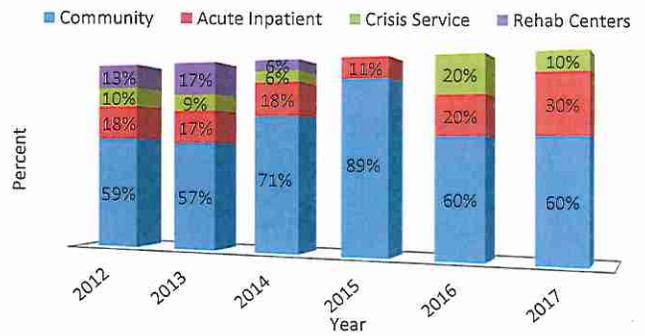
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103 incidents reviewed; 2012 n=39, 2013 n=23, 2014 n=17, 2015 n=9, 2016 n=5, 2017 n=10

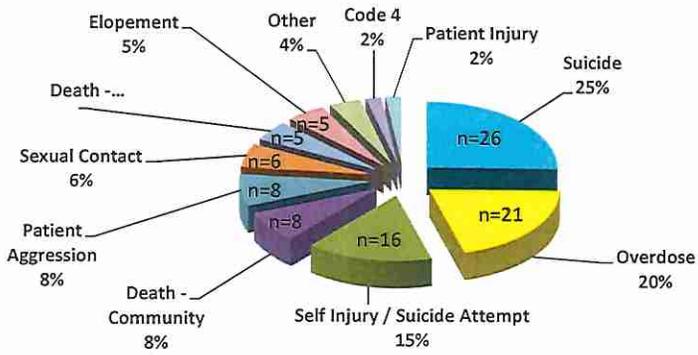
Sentinel Events Reviewed by Year



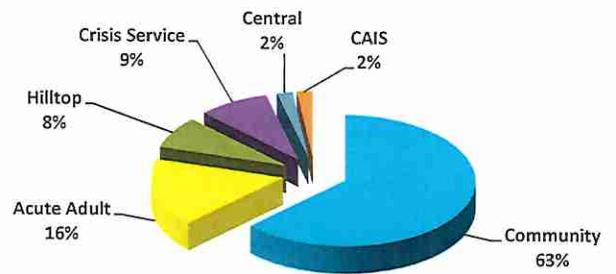
Location of Event by Year



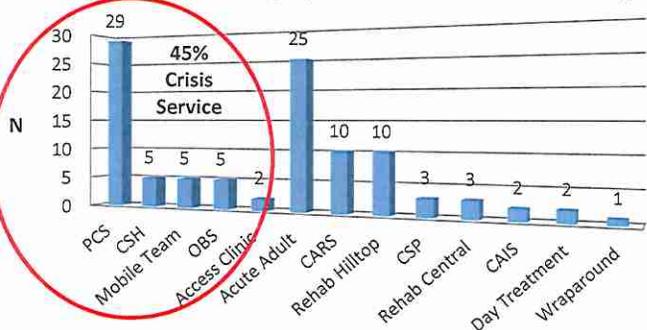
Type of Event



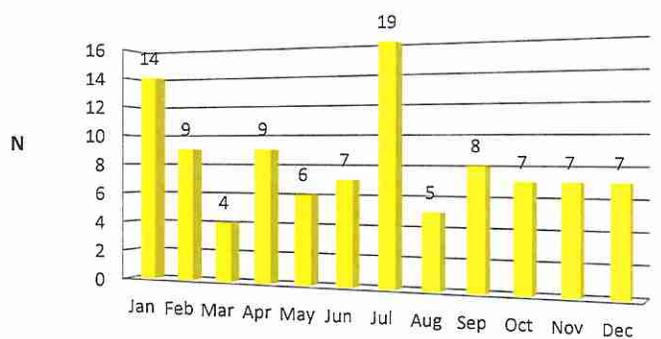
Location of Event



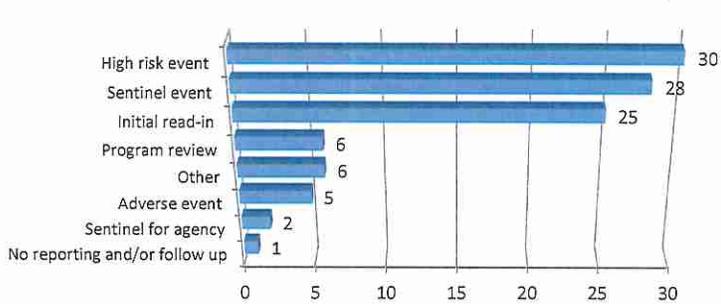
Program (Open with/last contact)



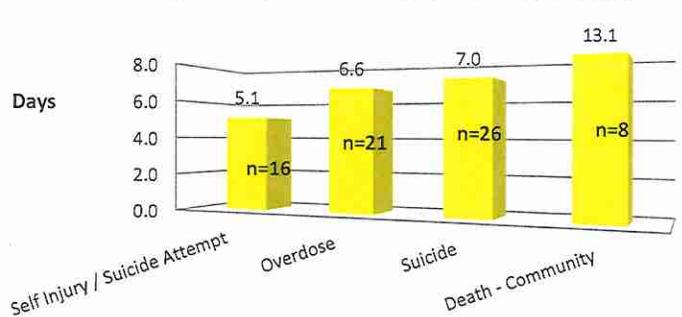
Month of Event



Level of Review

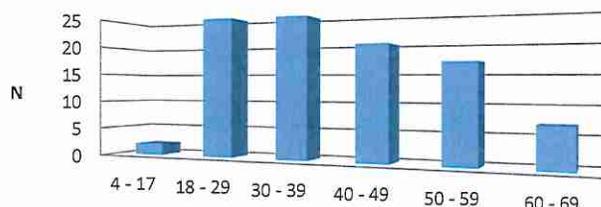


Average Days After Last BHD Contact



Patient Age

Average Age: 38 yrs male, 38 yrs female; Gender: 78% male 22% female



Age Group	4 - 17	18 - 29	30 - 39	40 - 49	50 - 59	60 - 69
N	2	30	26	20	17	7

**Quality Management Committee
Institutional Review Board (IRB) Report
June 4, 2018**

The Institutional Review Board (IRB) is a committee designed to assure that the rights and welfare of individuals are protected. Its purpose is to review, approve, and monitor any research involving individuals served or employed by the Milwaukee County Behavioral Health Division (BHD). The review and approval process must occur prior to initiation of any research activities. The IRB also conducts periodic monitoring of approved research.

IRB Membership Update

- Current membership of the IRB includes: Dr. Justin Kuehl (Chair), Dr. Matt Drymalski, Dr. Shane Moisio, Ms. Linda Oczus, and Dr. Jaquaye Russell.
- Following the recent departure of Dr. Teri Kaczmarek, the committee agreed to extend an invitation to Dr. Denis Birgenheir. He currently works as a psychologist in CARS and offers a wealth of experience as a former IRB member during his previous employment with the VA Nebraska-Western Iowa Health Care System.
- In order to align with best practice and regulatory guidelines, the IRB will be seeking additional members to address needs in the following areas:
 - At least one member with primary concerns in the nonscientific area.
 - At least one member who will not be directly affiliated with the BHD and who does not have an immediate family member affiliated with the BHD.
 - At least two members are consumers or represent either an agency or organization that advocates for the rights of patients.

Recently Completed Research

- A psychology doctoral student submitted a request to survey BHD Psychologists as part of his dissertation research. The proposal was reviewed and approved on December 12, 2017. The survey was disseminated to BHD staff.
- Dr. Matt Drymalski completed his research titled, “Expanding the Use of the ASAM Criteria to Include Mental Health Level of Care Placements.” The manuscript was accepted for publication in the journal, *Advances in Dual Diagnosis*.

Existing Research

- On May 24, 2017, the IRB approved a proposal submitted by Dr. Tina Freiburger titled, “An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division.” The research is ongoing and the IRB continues to receive routine semi-annual updates.
- On April 22, 2018, the IRB received a request for an expedited review from Ms. Leah Donovan. The proposal was titled, “Providing Comprehensive Contraception Counseling for Women Living with a Mental Illness: An Evidence Based Practice Project.” The proposal was approved on May 10, 2018.

IRB Policy & Procedure

- The IRB created and approved a new Policy and Procedure effective January 2, 2018. It can be found in PolicyStat.

IRB Training

- There is an online training offered by the Collaborative Institutional Training Initiative, which is commonly referred to as the CITI Program. In the past, the BHD IRB members had completed relevant coursework to establish competence. As a best practice, it would seem reasonable to pursue such training for all current members. This request and the associated financial impact will be reviewed by administration.

Quality Management Committee Outreach

- The IRB determined that the ongoing work of the committee parallels the efforts of the broader BHD Quality Management Committee. As Chair of the IRB, Dr. Kuehl participated in the Quality Management meeting on April 13, 2018 and provided a brief summary of the IRB's purpose and ongoing work. The decision was made to include IRB updates as part of the quality reports to the Mental Health Board.

Frieda Brunn Mental Health Research Foundation

- In 1970, the Frieda Brunn Mental Health Research Foundation created a trust fund with the intent to financially support mental health research.
- As of May 2018, there is a balance of \$216,704.
- The IRB has continued to work on the development of guidelines regarding eligibility and use of the funds.

Respectfully submitted,



Justin Kuehl, PsyD
Chief Psychologist
IRB Chair

Acute Inpatient Seclusion and Restraint

First Quarter Update

2018

This report contains information describing the first three (3) months of 2018 as summarized:

- Acute Adult: Restraint hourly rate decreased by 50.0% from 2017 through quarter 1 2018 while restraint incident rate decreased by 54.8% during the same time period. Seclusion incident rate decreased by 21.5% from 2017 through the first quarter 2018 while Seclusion hourly rate increased by 33.3% during the same time period.
- CAIS: Restraint hourly rate increased by 16.7% from 2017 through the first quarter 2018.

Prepared by: Quality
Improvement
Department

Date: April 24, 2018

Summary

43A

- 43A rate of restraint hours decreased by 77.8% from 2017 through the first quarter 2018.
- 43A had 6.2 reported restraint hours
- 43A restraint incident rate decreased by 73.0% from 2017 through the first quarter 2018.
- 43A had 6 reported restraint incidents
- 43A seclusion hour's rate decreased by 25.0% from 2017 to first quarter 2018, while the seclusion incident rate decreased by 69.8%.

43B

- 43B rate of restraint hours decreased by 66.7% from 2017 through first quarter 2018.
- 43B had 6.57 reported restraint hours
- 43B restraint incident rate decreased by 66.5% from 2017 through the first quarter 2018.
- 43B seclusion hour's rate decreased by 50% from 2017 to the first quarter 2018, while the seclusion incident rate decreased by 66.3%.

43C

- 43C rate of restraint hours increased by 50.0% from 2017 through the first quarter 2018.
- 43C had 10.23 reported restraint hours, 4.2 reported restraint hours were for 1 individuals (40.8% of all hours)
- 43C restraint incident rate increased by 7.1% from 2017 through the first quarter 2018.
- 43C seclusion hours rate increased by 133.3% from 2017 to the first quarter 2018, while the seclusion incident rate increased by 49.0%.

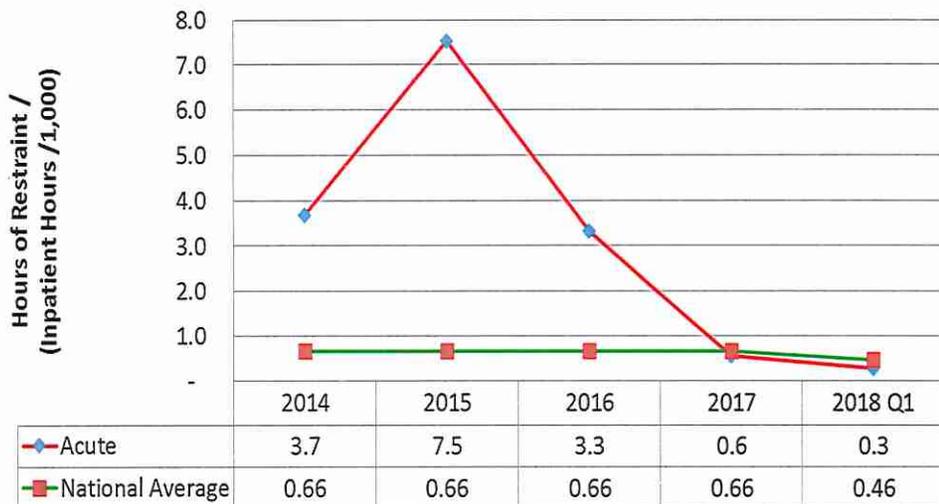
CAIS

- Three (4) individuals had 12.01 reported restraint hours, 50% of all restraints
- CAIS restraint incident rate increased by 16.7% from 2017 through the first quarter 2018.
- CAIS had 30 reported restraint incidents, 10 reported restraint incidents were for 2 individuals (33% of all incidents)

Acute Adult

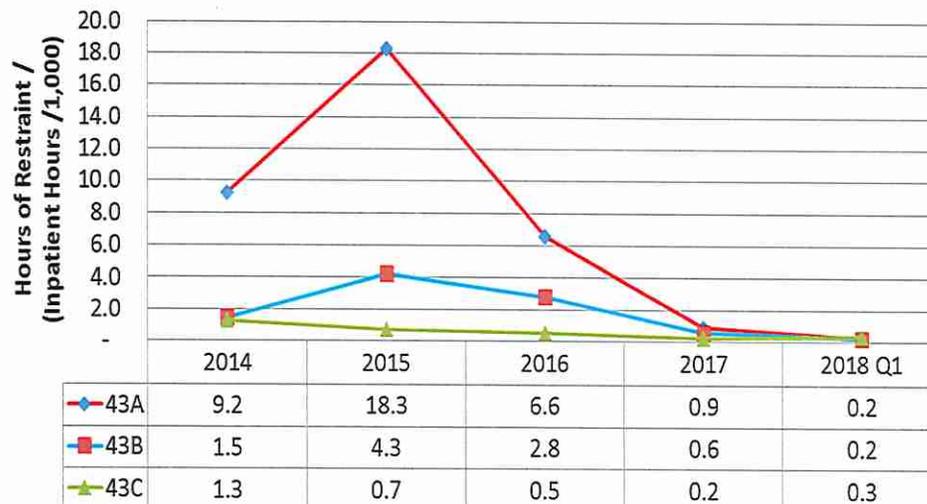
Acute Adult

2014-2018 Hours of Restraint (Aggregate)



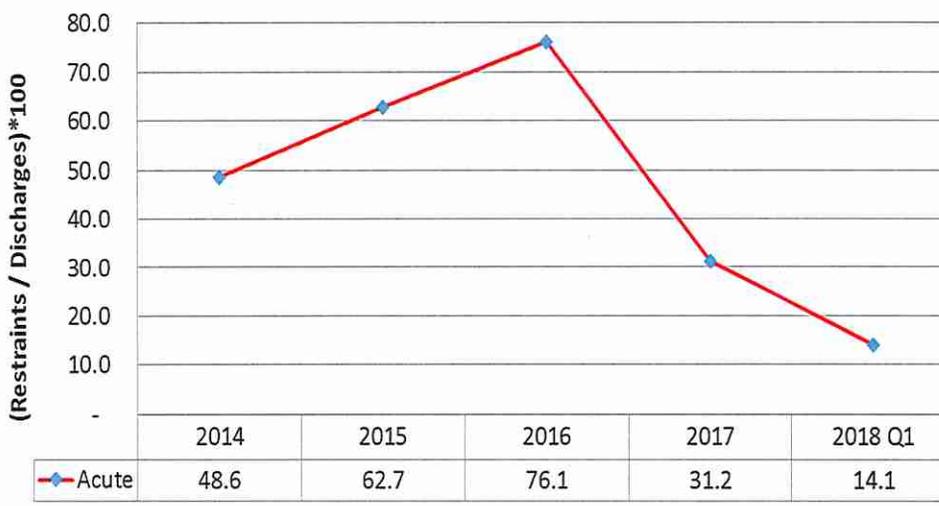
Acute Adult

2014-2018 BHD - Hours of Restraint by Unit



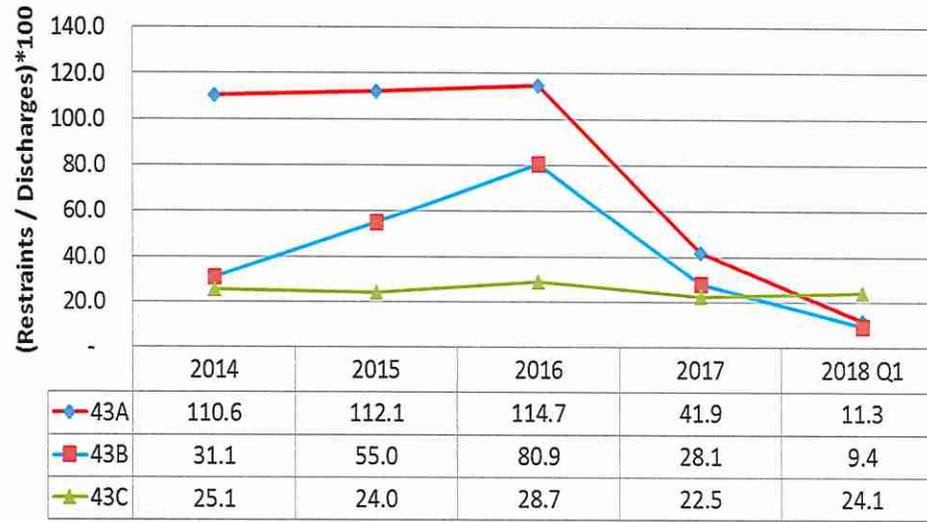
Acute Adult

2014-2018 Restraint Incident % (Aggregate)



Acute Adult

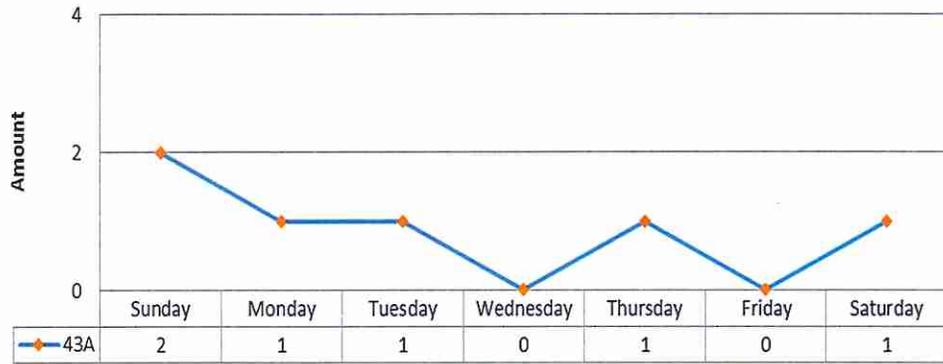
2014-2018 BHD - Restraint Incident % by Unit



Acute Adult

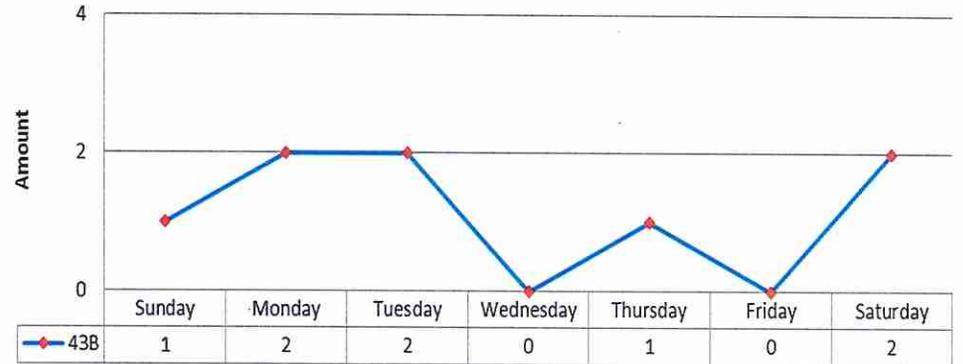
43A Restraints by Day of Week

N = 6



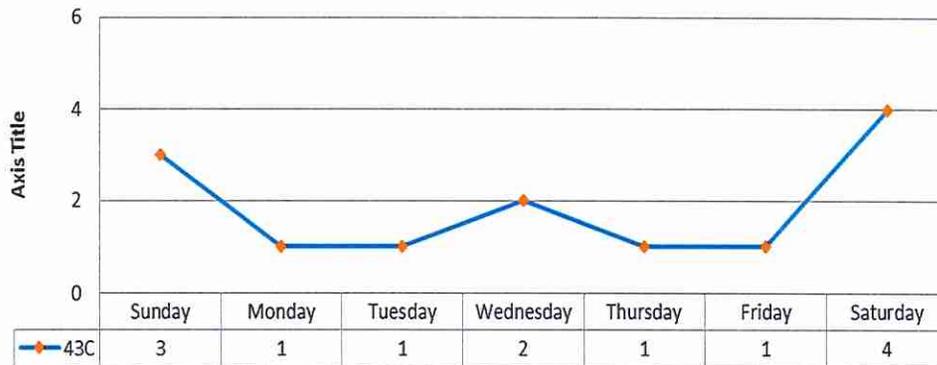
43B Restraints by Day of Week

N = 8



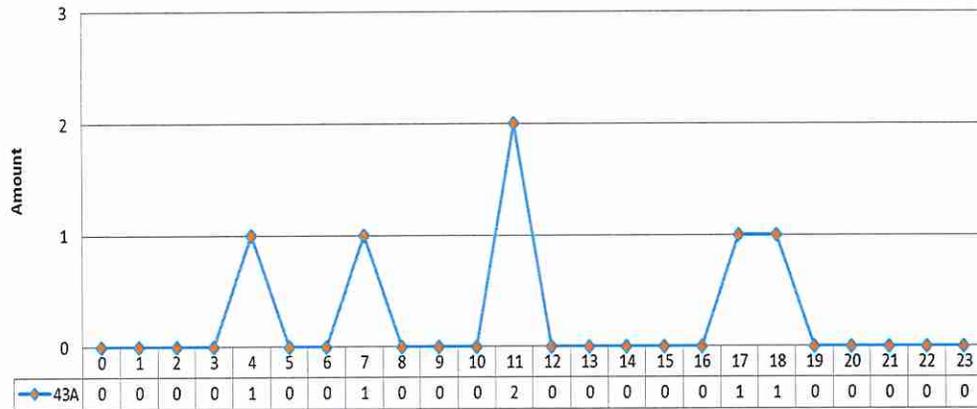
43C Restraints by Day of Week

N = 13

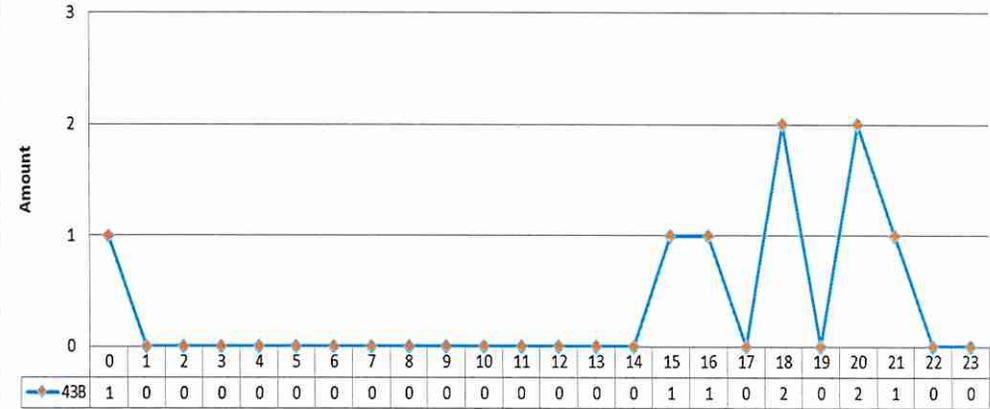


Acute Adult

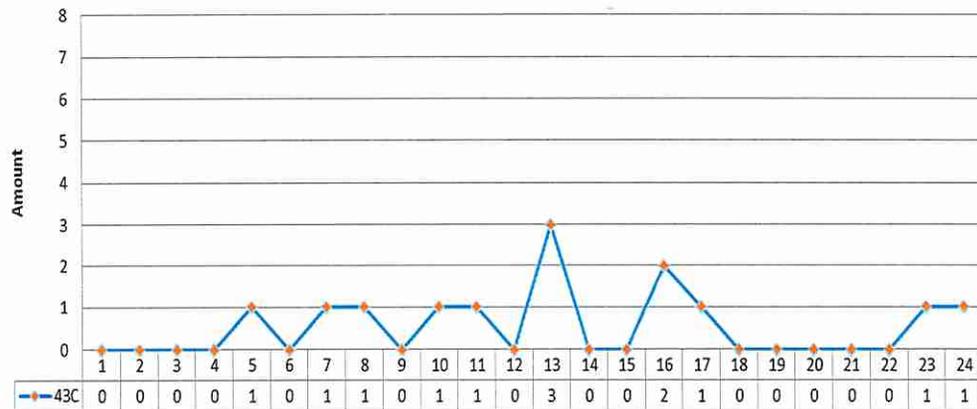
43A Restraints by Time of Day
N = 6



43B Restraints by Time of Day
N = 8



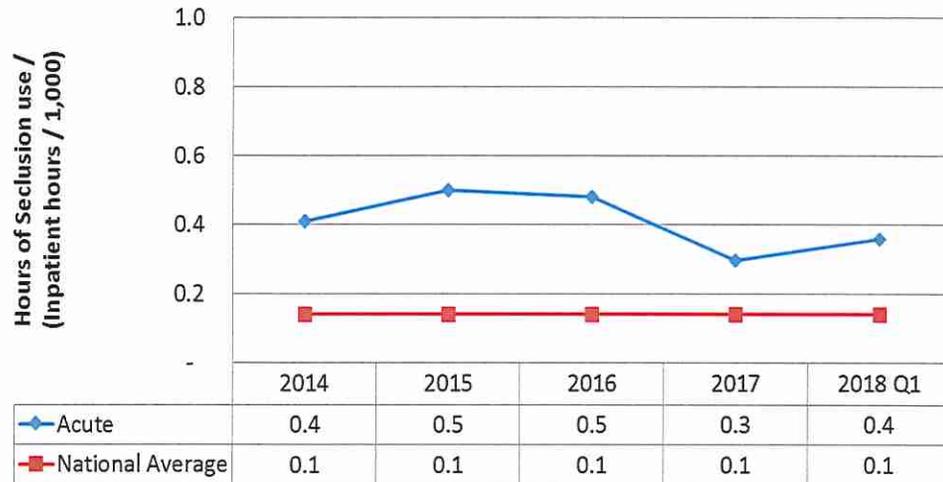
43C Restraints by Time of Day
N = 13



Acute Adult

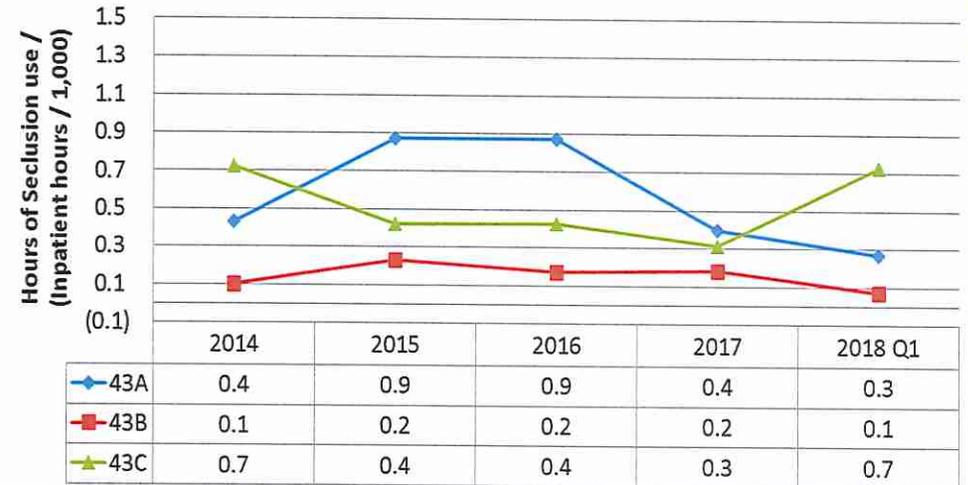
Acute Adult

2014-2018 Hours of Seclusion Rate (Aggregate)



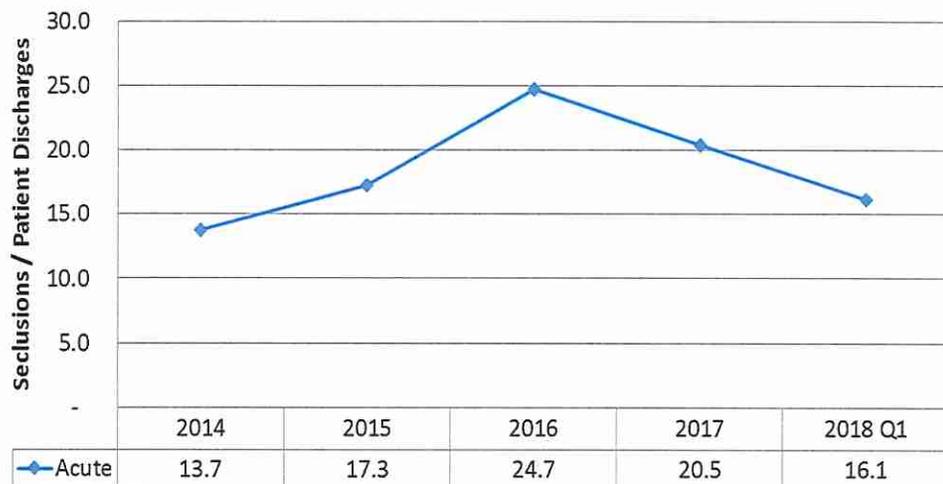
Acute Adult

2014-2018 Hours of Seclusion Rate by Unit



Acute Adult

2014-2018 Seclusion Incident % (Aggregate)



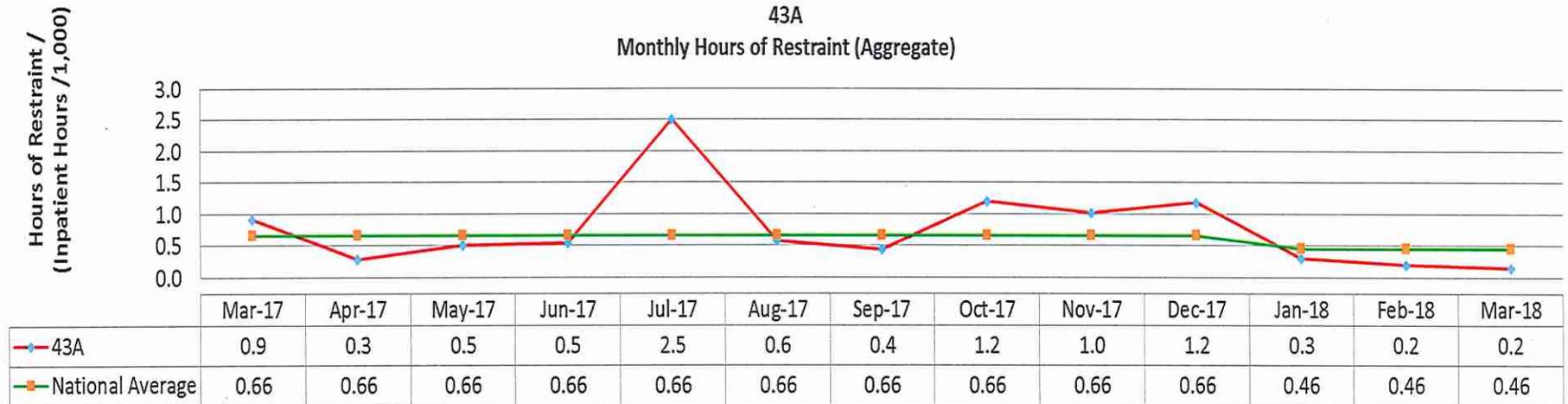
Acute Adult

2014-2018 Seclusion Incident % by Unit

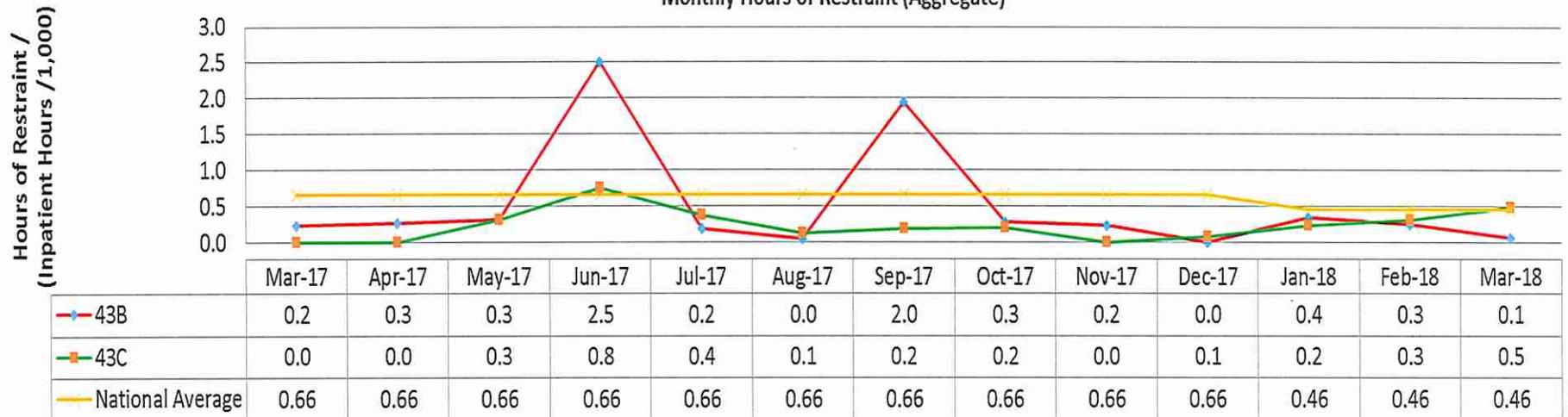


Acute Adult

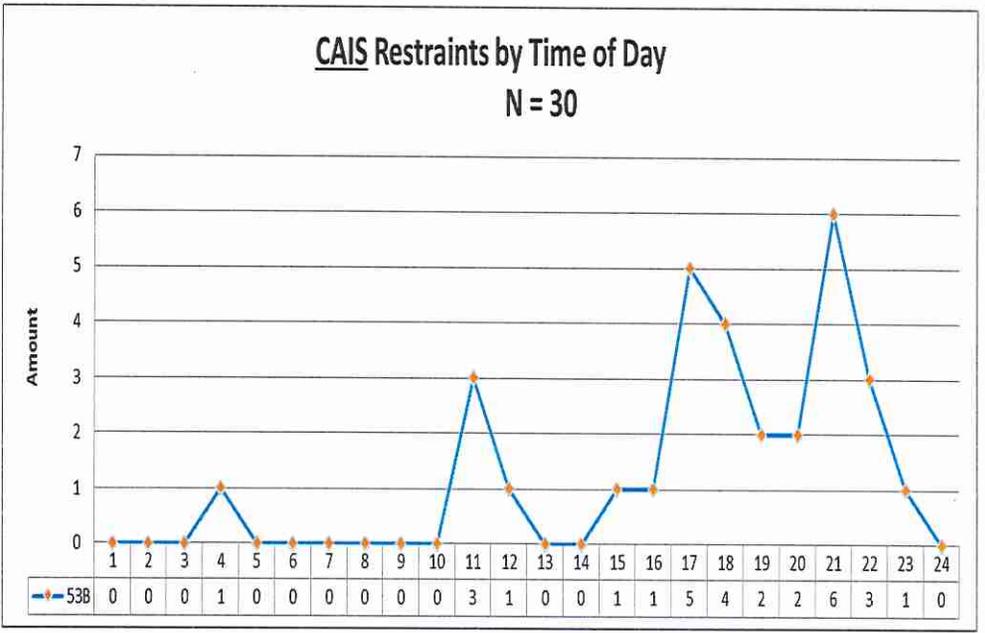
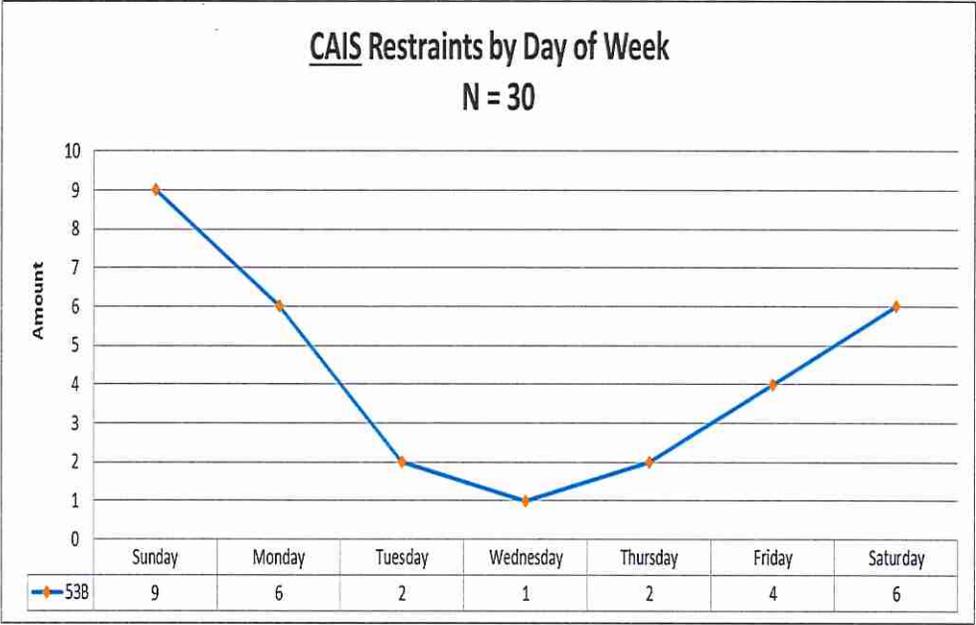
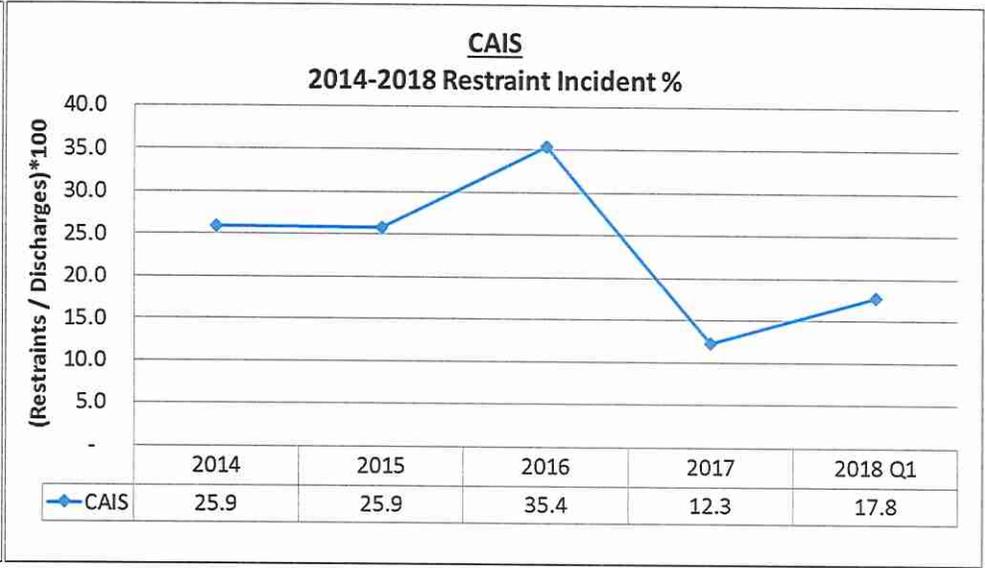
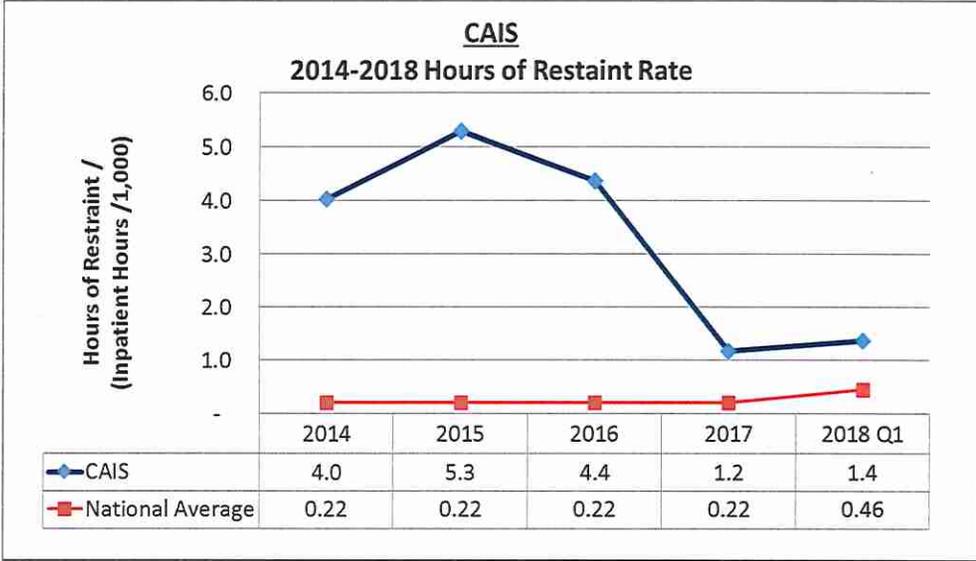
43A
Monthly Hours of Restraint (Aggregate)



Acute Adult
Monthly Hours of Restraint (Aggregate)

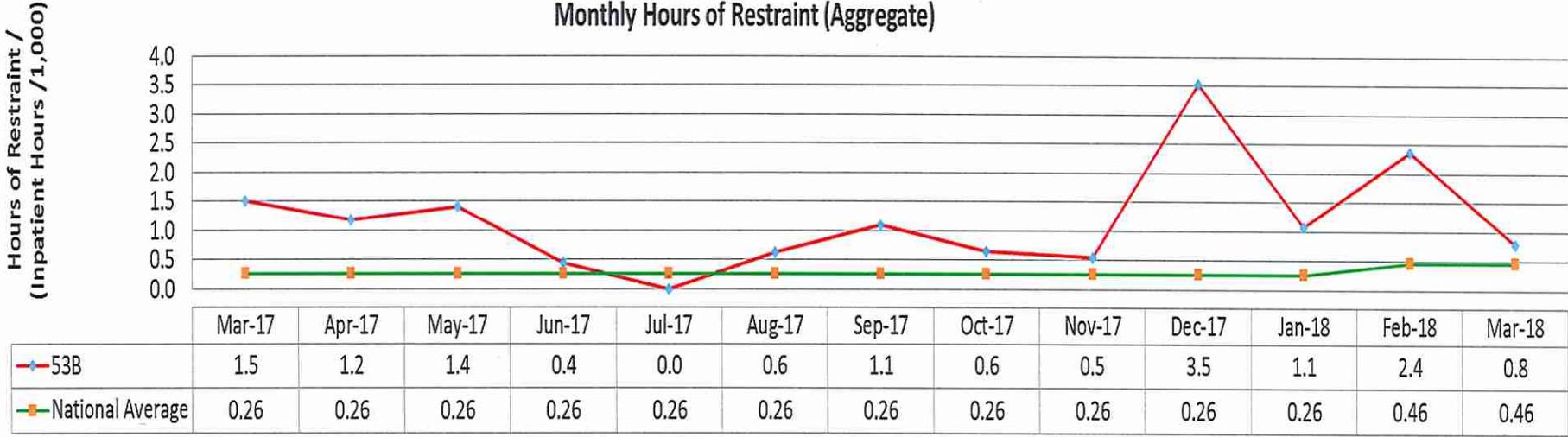


CAIS



CAIS

CAIS
Monthly Hours of Restraint (Aggregate)



Facility Data

Program		Restraint Incidents								Restraint Hours							
		2011	2012	2013	2014	2015	2016	2017	2018 Q1	2011	2012	2013	2014	2015	2016	2017	2018 Q1
Acute	43A	282	367	558	303	306	249	93	6	1,704	1,473	2,321	1,293	2,402	864	109	6
	43B	78	124	236	138	237	207	73	8	89	139	492	259	600	399	72	7
	43C	173	88	112	98	63	58	40	13	1,602	78	113	205	104	67	28	10
	Total	966	775	906	539	606	514	206	27	4,579	2,268	2,926	1,757	3,106	1,330	210	23
CAIS	CAIS	173	84	124	246	238	218	87	30	476	98	133	314	458	323	88	24
Crisis	PCS	638	537	445	405	417	373	275	74	651	514	509	413	445	408	269	73
	OBS	122	76	106	146	83	74	63	5	190	100	179	207	117	98	46	3

Program/Unit		Seclusion Incidents								Seclusion Hours							
		2011	2012	2013	2014	2015	2016	2017	2018 Q1	2011	2012	2013	2014	2015	2016	2017	2018 Q1
Acute	43A	47	22	18	40	83	102	55	4	87	17	33	61	115	115	49	8
	43B	4	12	15	16	32	25	27	3	4	8	11	18	32	24	23	2
	43C	58	15	74	96	52	40	53	24	73	10	100	118	60	54	40	22
	Total	154	62	107	152	167	167	135	31	218	48	144	196	207	193	111	31
CAIS	CAIS	27	6	5	32	44	17	45	30	32	4	3	21	35	13	28	16

Crisis Seclusion and Restraint

First Quarter Update

2018

This report contains information describing the first three (3) months of 2018 are summarized as follows:

- 2018 first quarter PCS restraint incident rate increased by **17.6%** from 2017.
- 2018 first quarter PCS restraint hour increased by **16.4%** from 2017.
- 2018 first quarter Observation incident rates decreased by **55.9%** from 2017.
- 2018 first quarter Observation restraint hour decreased by **66.2%** from 2017.

Prepared by: Quality
Improvement
Department

Date: May 3, 2018

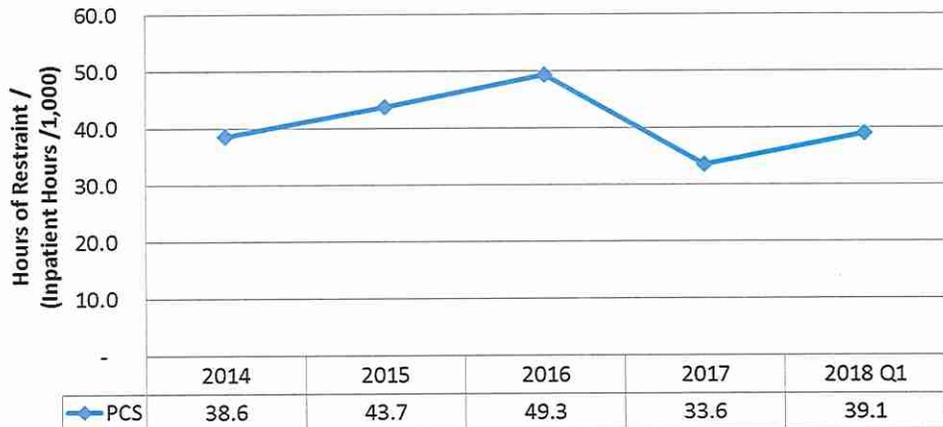
Summary

PCS

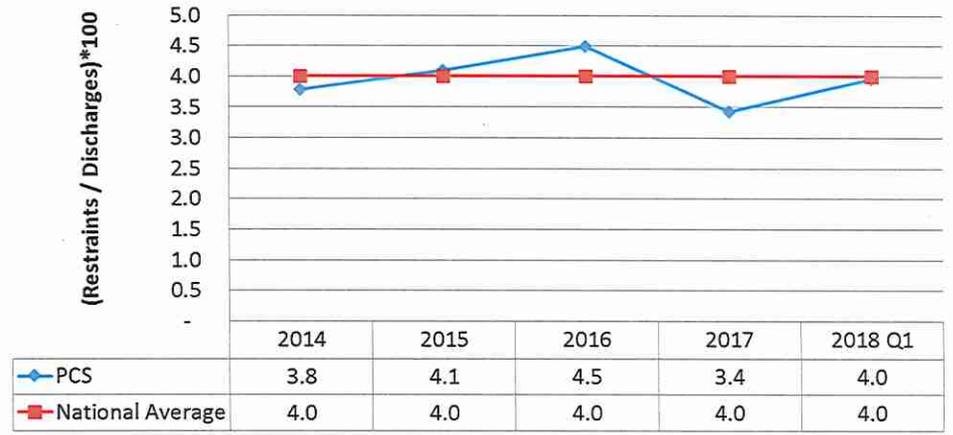
- PCS had 72.9 reported restraint hours, of which 83.2% of reported restraints, the patient were in restraints for less than 2 hours
- PCS had 74 reported restraint incidents, of which 85% of reported restraint incidents were patients with one (1) episode of restraint.

PCS

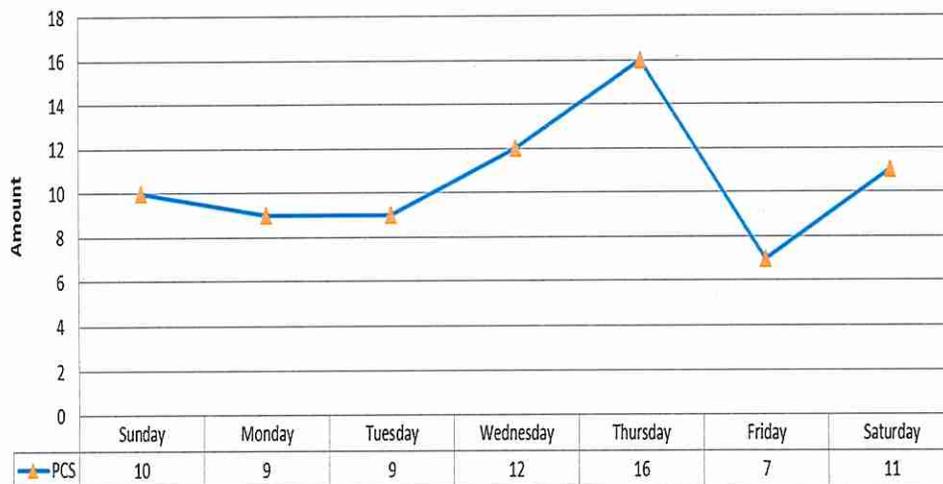
PCS
2014-2018 Hours of Restraint



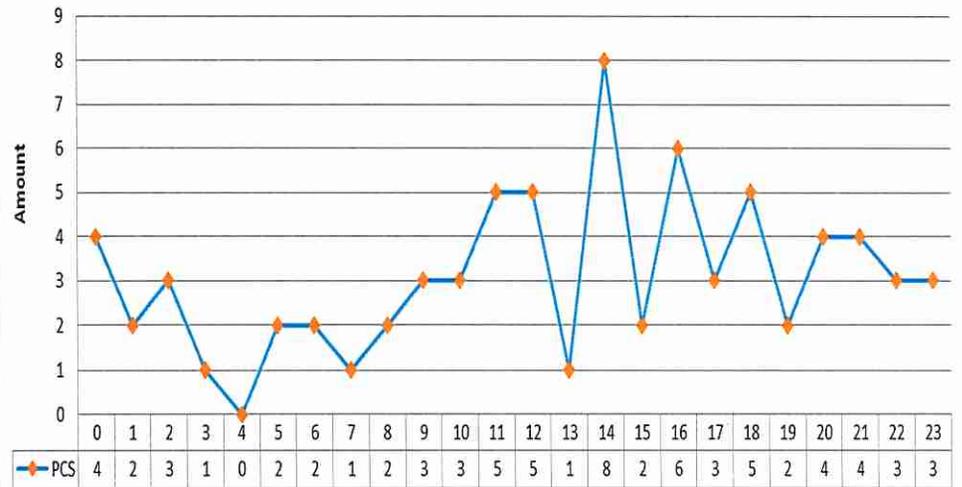
PCS
2014-2018 Restraint Incident %



PCS Restraints by Day of Week
N = 74



PCS Restraints by Time of Day
N = 74



Facility Data

Program		Restraint Incidents								Restraint Hours							
		2011	2012	2013	2014	2015	2016	2017	2018 Q1	2011	2012	2013	2014	2015	2016	2017	2018 Q1
Acute	43A	282	367	558	303	306	249	93	6	1,704	1,473	2,321	1,293	2,402	864	109	6
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WRAPAROUND MILWAUKEE



2017

QA/QI Annual Report Summary

1. WRAP/REACH/CORE - Total youth served = 1,622
O-YEAH - Total new enrollments = 104
2. Both Wraparound and REACH youth and caregivers continue to identify improvement in youth functioning (both internal and external) during their enrollment as noted by improved scores in the Child Behavior Checklist and Youth Self Report Evaluation tools. (Page 3)
3. Overall, WRAP/REACH youth are attending school 83.6% of the time. Threshold is 85%. (Page 4)
4. Family and Youth satisfaction with their Care Coordination services at 1-month, 6-months and annually overall is 4.74. Exceeds threshold of 4.0. Satisfaction at disenrollment overall is 3.94 which exceeds our threshold of 3.75. (Page 4)
5. Family satisfaction with Service Providers overall is at 3.87. Threshold is 4.0. (Page 6)
6. Cost per month /per enrollee enrolled in Wraparound Milwaukee continues to be a more cost effective alternative to other types of care/services, i.e. – Group Homes, Corrections, Residential Care, Inpatient. (Page 6)
7. New Plan of Care auditing tool (POC Rubric) was implemented throughout 2017. Rubric approvals are currently associated with Care Coordination Certification and are used in coaching/education in an effort to promote greater compliance and best practice. (Page 8)
8. Wraparound certified a total of 75 new Care Coordinators, Transition Coordinators and Professional Foster Parents. (Page 8) In addition, training was offered to/conducted with DMCPs Ongoing Case Managers, DYFS, Crisis Stabilization Providers and CARS. Two Trauma Informed Parenting trainings were also offered in addition to a training that focused on assisting parents learn how to advocate for their children in the educational arena. (Page 10)
9. Two (2) Provider Philosophy trainings were offered, four (4) Provider Fiscal trainings took place, four (4) Provider Forum meetings took place in collaboration with DYFS, nine (9) new provider agencies joined the Network, two (2) new services were developed, and several new services related to the provision of the new Comprehensive Community Services (CCS) program for youth were implemented. (Page 11-12)
10. Owen's Place, our young adult Resource Center offered numerous programs, workshops and activities. (Page 13)
11. Wraparound continued to produce/analyze the wealth of data that we collect through the programs that are offered. Research studies/reports/presentations focused on recidivism, CORE program outcomes, *Data Driven Coaching*, Special Education Support outcomes and Trauma Response Team outcomes. (Page 15)
12. Four (4) Family Luncheons/Orientations were held. (Page 16)

13. Our Mobile Urgent Treatment Team got a new name! They are now called the Children's Mobile Crisis (CMC) Team. They provided 15,500+ hours of crisis services to Wraparound families and the community at large. This is a 9% increase over 2016. A client satisfaction survey process was initiated for those individuals receiving their first contact with CMC. The overall satisfaction score was a 4.5 out of 5.0. (Page 16)
14. Wraparound continues to offer or be involved in the Wraparound Wellness Clinic, POHSEY (Proactive Outreach for the Health of Sexually Exploited Youth Project), Welcome Home Teens in Motion group, the Pregnancy Prevention Program, and the Milwaukee Adolescent Health Clinic. (Page 17-18)
15. Our CORE program (individuals experiencing their first episode of psychosis) continued to grow and we now have 4 teams of five service and clinical support persons. The program grew 40% from 2016 serving 70 youth in 2017. (Page 18)
16. Wraparounds community outreach efforts greatly expanded in 2017. We took part in 60 events/meetings to provide information about what the Wraparound System of Care has to offer. All the brochures for each of our programs were revised and updated. (Page 19)
17. Wraparound Staff lead and/or participated in fourteen different BHD or DHHS Charters, Committees or Workgroups. (Page 19)
18. Wraparound Milwaukee was the recipient of the "2017 Eisenberg Award" presented by the Wisconsin State Public Defenders Office. The award recognizes Wraparounds work in providing youth with an alternative to correctional placements by providing individualized and community-based care and keeping families together. (Page 19)





WRAPAROUND MILWAUKEE

2017

QUALITY ASSURANCE/QUALITY IMPROVEMENT ANNUAL REPORT



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Wraparound Milwaukee QA/QI Department Mission

To ensure quality care and promote continuous quality improvement of services and processes in order to meet the needs of the youth, families and young adults being served

Wraparound Milwaukee System of Care Programs/Services

Wraparound Milwaukee (WRAP): A unique Managed Care Organization that serves youth with serious emotional, behavioral, and mental health needs and their families. Youth will enter the program under a Division of Youth and Family Services (DYFS) delinquency order or Division of Milwaukee Child Protectives (DMCPS) Child in Need of Protective Services (CHIPS) order.

REACH Program (Reaching, Engaging and Assisting Children (and Families)): A part of the Wraparound Milwaukee system of care that provides similar services and opportunities for youth with serious emotional, behavioral, and mental health needs and their families. The REACH program primarily differs in that the youth who are enrolled are not under a Court Order (Delinquency or Child in Need of Protective Services – CHIPS).

O - YEAH Program (Older Youth and Emerging Adult Heroes): a program administered under the auspices of Wraparound Milwaukee designed to support older youth and young adults ages 16.5 – 24 who may be experiencing emotional and behavioral challenges, to successfully transition to adulthood. This is a voluntary program. **See Pg. 12 for details related to this program.**

Additional Associated Resources:

- **Owens Place** – A community drop-in resource center for young adults age 16-23 whose mental health needs may be affecting their ability to become independent.
- **M.O.V.E Wisconsin** – A youth-run organization designed to empower adolescents and young adults to advocate for themselves around causes that are important to them and their respective community.

Professional Foster Parent (PFP) Program: Provides a transitional home environment for youth with a history of running away. Foster parents are licensed/certified as both treatment foster parents and care coordinators. Serving one girl in a home at a time, the ultimate goal is to help the youth achieve permanency with their respective family.

Family Intervention and Support Services (FISS): Targets adolescents who are exhibiting behavioral issues in home and community, but have not been diagnosed. This is a voluntary assessment short-term intervention program aimed at stabilization and prevention and is designed to assist families in preventing court and system involvement.

Comprehensive Community Services (CCS): An option for families in Milwaukee County which provides support and services to youth and young adults who are coping with either a mental health and/or substance abuse diagnosis. As a voluntary community based program, CCS addresses needs throughout a person's lifespan, with a coordinated and comprehensive array of recovery, treatment and psychosocial rehabilitation services.

Coordinated Opportunities for Recovery and Empowerment (CORE): Serves 10-23 year olds who are experiencing their first episode with psychosis. Services include Care Coordination, Individual Therapy, Employment and Education Support, Peer Support and Medication Management.

Children's Mobile Crisis (CMC): Provides 24/7 crisis intervention services to any family in Milwaukee County with a child who is experiencing a mental health emergency in which the behavior of the child threatens his/her removal from home, a community placement and/or, school. The team can also provide short-term case management and can link the child and family to crisis stabilization and community resources.

Trauma Response Team (TRT): In collaboration with the Milwaukee Police Department, Children's Mobile Crisis (CMC) provides support services to children & their families when they have witnessed or have been exposed to potentially traumatic events such as serious accidents, sudden death, shootings, violence, or domestic violence.

Wraparound Wellness Clinic: Provides medication management and overall wellness care and education for the mental and physical health of children and youth in Wraparound Milwaukee.

Additional Associated Resources:

- **Milwaukee Adolescent Health Clinic** – Provides services to youth in need of a health evaluation, STI screening and pregnancy prevention options.
- **Teen Parent Prevention Initiative** – A support group that addresses sexual health, safety and parenting education.

Family Intervention and Support Services (FISS): Targets adolescents who are exhibiting behavioral issues in home and community, but have not been diagnosed. This is a voluntary assessment short-term intervention program aimed at stabilization and prevention and is designed to assist families in preventing court and system involvement.

Family Advocacy Services: Run by families with lived experience, this provider offers family support, advocacy services, family-run support groups, and family events. They also train providers, and are the voice of families on committees and in the community.

Educational Liaisons: Serves youth & young adults involved in Wraparound Milwaukee System of Care. Addresses school issues including placement, special education needs & services and possible suspensions and expulsions.



I. Demographics for 2017

Wraparound/REACH Enrollments = 694

Wraparound/REACH Disenrollments = 605

(Disenrollment # excludes transfers to other programs in the Wraparound System of Care)

Average Daily Census = 1,185 Total Youth Served = 1,622

GENDER (694 youth represented)

Female = 246 (35%)
Male = 448 (65%)

AGE (694 youth represented)

Average age = 13.7 years old
(WRAP = 14.4, REACH = 13.1)

ETHNICITY (694 youth represented)

African American = 457 (66%) (63% male – 37% female)
Caucasian = 62 (9.2%) (65% male – 35% female)
Hispanic = 106 (15.2%) (69% male – 31% female)
Bi-racial = 13 (1.8%) (62% male – 38% female)
Asian = 1 (.1%) (100% male – 0% female)
Native American = 6 (.86%) (33% male – 67% female)
Other/Unknown = 46 (7%) (74% male – 26% female)
Not Listed = 3 (.4%)

DIAGNOSIS (656 youth represented. Youth may have one or more diagnosis.)

Adjustment Disorder (WRAP = 44, REACH = 29)
Anxiety Disorder (WRAP = 102, REACH = 134)
AODA related (WRAP = 64, REACH = 23)
Attention Disorder (WRAP = 181, REACH = 243)
Conduct Disorder (WRAP = 189, REACH = 109)
Depressive Disorder (WRAP = 101, REACH = 97)
Developmental Disorder (WRAP = 65, REACH = 56)
Eating Disorder (WRAP = 0, REACH = 4)
Generalized Anxiety Disorder (WRAP = 3, REACH = 5)
Learning Disorder (WRAP = 35, REACH = 18)
Major Depressive Disorder (WRAP = 2, REACH = 3)
Mood Disorder (WRAP = 82, REACH = 136)
Personality Disorder (WRAP = 0, REACH = 3)
Thought Disorder (WRAP = 4, REACH = 32)
Other (WRAP = 95, REACH = 85)

YOUTH PRESENTING ISSUES (691 WRAP & REACH youth represented.)

Youth may have one or more issues.)

Access to Firearms = 78
Adjudicated Sex Offender = 32
Attention Problems = 533 #3
Basic Needs = 56
Bullied by Others = 315
Bullying Others = 440
Community Concerns and Violence = 293
Contact Sexual Abuse = 96
Crisis Prevention = 253
Daily Hygiene = 127
Developmental Issues/Autism Spectrum = 177
Drug/Alcohol Abuse = 274
Eating Patterns/Hoarding = 239
Experienced racism/discrimination = 188
Felt unsafe in neighborhood = 169

Fire setting = 180
Gang Affiliation = 59
H/O Sexual Misconduct & Exposure = 278
Homicidal Ideation = 166
Hx. Of Psychiatric Hosp. = 370
Lived in Foster Care = 134
Major Affective Illness/Affect Regulation = 424
Minor Domestic Sex Trafficking Victim = 69
Minor at Risk for Domestic Sex Trafficking = 24
Out of Home Placement = 348 *3
Physical Disability/Medical/Health = 366
Psychosis = 168
Recurrent Emotional Abuse = 170
Reintegration = 18
Runaway Behavior = 338
School Concerns = 633 #1 *1
Self-harm = 244
Severe Aggressiveness = 612 #2 *2
Sexual Abuse Victim = 161
Sleep Patterns/Nightmares = 417
Suicidality = 320
Teenage Parent = 29
Victim Notification = 18
Witnessed Violence in Community = 321
Other = 303 (For example - stealing, manipulative behavior, traumatic events/illnesses)

* Top 3 WRAP youth issues #Top 3 REACH youth issues
(Excludes "Other" category for WRAP/REACH)

FAMILY PRESENTING ISSUES (691 WRAP & REACH families represented.)

Families may have one or more issues.)

Alcohol/Drug Abuser in Home = 240
Adult in Home Treated Violently = 276
Emotional Abuse/Neglect = 133
Emotional/Mental Illness in the Family = 489 *3 #1
Incarcerated Household Member = 365
Physical Neglect = 155
Previous Physical Abuse = 228
Recurrent Physical Abuse Exposure = 250
Single/No Parent in the Home = 418 *2 #3
Significant Losses = 484 *1 #2

* Top 3 WRAP family issues #Top 3 REACH family issues

YOUTH ON COURT ORDERS = 56% of enrollments

(316 youth represented)

- 64% of youth were on a Delinquency order (N=201)
- 34% were on a CHIPS order (N = 107)
- 1% were on a Dual (CHIPS/Delinquent) order (N=4)
- 1% were on a JIPS order (N=4)

NON COURT ORDERED YOUTH = 44% of enrollments

(374 represented)

II. Outcome Indicators

Functioning

The functioning levels of the youth in Wraparound/REACH are currently being measured by the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR). The evaluation tools are collected on every enrollee at Intake, 6 months, 1 year, annually thereafter and at disenrollment.

The **CBCL** is filled out by the parent/primary caregiver and provides information about the internal (mood, thought processing) and external (social/interpersonal interactions, community-based behaviors) behavioral issues of a child during the preceding six-month period. It comprises various scores consisting of symptoms of depression, anxiety, withdrawal, social problems, thought problems and delinquent and aggressive behavior. Total scores are computed and fall into three ranges: *Normal*, *Borderline* and *Clinical*. Scores are converted into age-standardized scores (T scores and Percentiles) so they can be compared with scores obtained from a normative sample of children within the same age range. The results can be utilized by the Child and Family Team to identify areas of need that should be addressed within the Plan of Care.

The **YSR** is similar to the CBCL. It is completed by youth 11 years of age and older.

Normal Range of Functioning – Scores that fall into the same range as the comparative sample group.

Borderline Clinical – Scores that suggest enough issues have been reported to be of concern, but not so many that it is a clear indicator of needing clinical professional help.

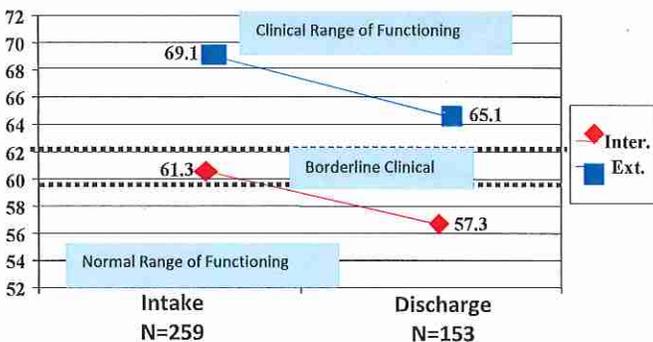
Clinical Range of Functioning – Scores that reveal sufficient issues that are in need of clinical intervention that are significantly greater than the comparative sample group.

NOTE: A decrease in a score reflects improved functioning.

The following data in all graphs represents disenrollments from 1/1/17 – 12/31/17

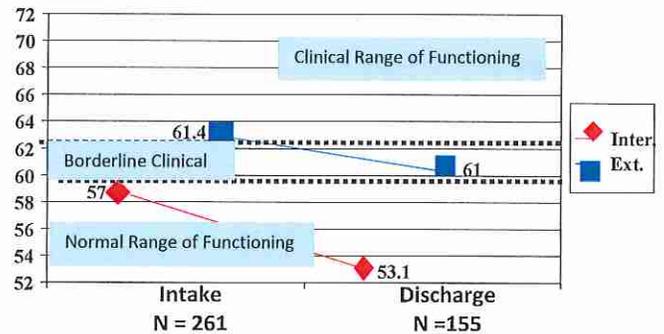
WRAPAROUND

CBCL T-Scores from Intake to Discharge



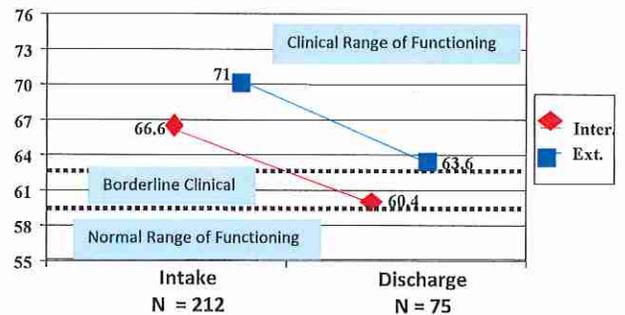
WRAPAROUND

YSR T-Scores from Intake to Discharge



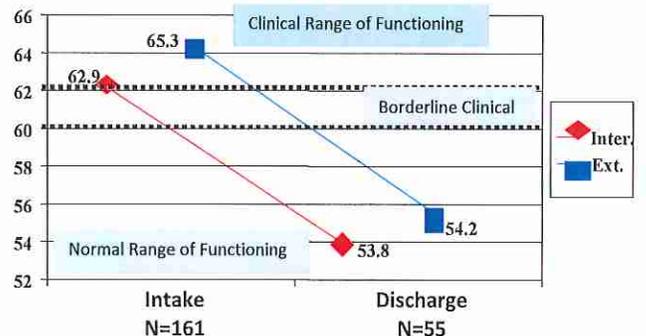
REACH

CBCL T-Scores from Intake to Discharge



REACH

YSR T-Scores from Intake to Discharge



Living Environment



Wraparound youth at enrollment are living in a variety of places.

The level of restrictiveness of the placement varies. Wraparound is committed to getting youth into and/or keeping youth in the least restrictive environment possible and in minimizing the number of placement changes that a youth encounters.

Permanency (Wraparound Only) In defining the data below, permanency is described 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

Total Wraparound disenrollment's = 363

Excludes 26 youth that were disenrolled as "runaway/missing" and 58 youth that were disenrolled to a correctional (n = 13) or a detention facility (n= 45)

Of the 279 remaining Wraparound youth, 211 or 76% achieved permanency as defined above.

Other disenrollment scenarios upon discharge:

- 10 – Foster Care – Transitional
- 21 - Group Home Care
- 6 - Respite Care
- 19 – Residential Care
- 8 - Other

School



Wraparound Milwaukee is invested in ensuring that the youth we serve are getting the best education possible, that all educational needs are identified, and that attendance improves.

Of the enrollees for which school data was entered (N=687) into the Synthesis database (Wraparound Milwaukee's IT System) during 1/1/17-12/31/17 the following was revealed:

	<u>#WRAP</u>	<u>%WRAP</u>	<u>#REACH</u>	<u>%REACH</u>
K-5 th	30	10%	112	30%
6 th - 8 th	74	23%	104	28%
9 th -12 th	210	66%	141	38%
GED/Grad.	3	1%	9	3%
College			2	1%

Youth in Wraparound are attending school approximately 80.5% of the time, while those in REACH are attending school approximately 86.7% of the time.

Our benchmark for attendance is set at 85%.

Wraparound Milwaukee provides special education advocacy services through the SEA (Special Education Advocacy) Group. These services are available for any/all youth in need of support to ensure that their educational needs are being addressed and met. The SEA Group staff provide face-to-face consultation and support not only to those identified youth but also to the Care Coordination staff seeking to expand their knowledge about Special Ed regulations and laws in the state of Wisconsin. Care Coordinators also receive regular training in this area.

Youth and Family Satisfaction

Outcomes

Youth/Family satisfaction is measured through the surveys that are being administered by the Wraparound QA Department in conjunction with Families United of Milwaukee and the Care Coordination Agencies. These surveys inquire about the satisfaction level of the family/youth as it relates to the provision of Care Coordination and Provider Network services.



Family/Youth Satisfaction Levels related to Care Coordination Services

Surveys related to the families' satisfaction levels with Care Coordination are distributed at 1-month, 6-months, 1-year/2-year/etc. [At disenrollment, the survey is called a Disenrollment Progress Report. This "report" speaks more to perceived family outcomes vs. satisfaction.](#) A 5-point ranking scale is utilized with 1 meaning "Strongly Disagree" and 5 meaning "Strongly Agree". An option of "Not Applicable" is also available.

Satisfaction Benchmark for 1-month/6-month/yearly: 4.0

Satisfaction Benchmark for Disenrollment: 3.75

Survey Time Frame	# of Surveys Sent	# of Surveys Received	Return Rate	Average Overall Score
1-Month	784	106	13.5%	4.77
6mo/yearly	1,342	128	9.5%	4.71
Family Disenrollment Progress Report	605	474	78.3%	3.97
Youth Disenrollment Progress Report				3.91

1-month Care Coordinator Family Survey – Overall 4.77

1).	My CC has been polite and respectful to me and my family.	4.94
2).	Meetings with my care coordinator have been scheduled at times and places that are convenient for me.	4.86
3).	I know how to reach my care coordinator when I need to.	4.78
4).	My care coordinator returns my calls within 24 hours.	4.79
5).	I know how to reach my care coordinator's supervisor.	4.63
6).	The contents of the enrollment folder were explained to me.	4.77
7).	My care coordinator has talked with me about a Crisis/Safety Plan for my family.	4.74
8).	I've been offered choices about the services my family receives.	4.70
9).	Overall, I feel satisfied with the services my family is receiving.	4.67

Disenrollment Youth Progress Report – Overall 3.91

1).	I'm doing better in school than I did before.	3.81
2).	I am getting along better with my family than I did before.	3.96
3).	I feel like I'm getting along better with my friends than I did before.	3.78
4).	I feel my behavior has gotten better since I was enrolled in Wraparound.	4.00
5).	On a scale of 1 to 5, how do you feel you are doing right now?	4.00

Disenrollment Family Progress Report – Overall 3.97

1.)	I feel my family has made significant progress in meeting the Family Vision we have been working towards.	3.93
2.)	I feel my child's educational needs have been met.	3.54
3.)	Overall, I feel that Wraparound/REACH helped me be better able to handle challenging situations.	4.16
4.)	I feel that I have family, friends and community resources that will be there for me and my family if I need them.	4.07
5.)	If my family does have a crisis, I believe the final Crisis Plan my Team developed will help us.	4.06
6.)	After disenrollment, I will know how to get services and supports that my family may still need.	4.15
7.)	On a scale of 1-5, how do you feel your family is doing right now?	3.90

6-mo/yearly Care Coordination Family Survey - Overall 4.71

1.)	My Care Coordinator has been polite and respectful to me and my family.	4.92
2.)	I am seeing my Care Coordinator as often as I'd like to.	4.62
3.)	My Care Coordinator returns my call within 24 hours.	4.68
4.)	My Care Coordinator follows through with what she/he says she/he is going to do.	4.67
5.)	Meetings with my care coordinator have been scheduled at times and places that are convenient for me.	4.87
6.)	I feel Wraparound has been sensitive to my cultural, ethnic and religious needs.	4.83
7.)	I would be comfortable calling my care coordinator's supervisor if I had any concerns.	4.66
8.)	I've had the opportunity to include people on my team that are important in our family's life.	4.75
9.)	I get a copy of every Plan of Care.	4.80
10.)	I understand my Plan of Care and how it can help me and my family.	4.78
11.)	I have been offered choices about the services my family receives.	4.59
12.)	My team is starting to work to prepare my family for disenrollment from Wraparound.	4.22
13.)	Overall, I feel the care provided to me/my family so far has been helpful.	4.69



Youth/Family Satisfaction Levels related to Provider Network Services

In late 2016, the family/youth provider satisfaction survey process was reviewed and revised. At this time, youth/families receive surveys on a quarterly basis inquiring about their satisfaction level related to the services they receive through Wraparound Provider Network. Each survey is reflective of the specific service that a specific Network Provider provides to the family. A ranking scale is utilized to measure satisfaction. These surveys are administered by the family's Care Coordinator. The caregiver and youth are each asked the two questions regarding every provider that provided services to them during the previous three months. See below:

Ranking Key:

*Overall, how satisfied are you with this provider?						
1	2	3	4	5	6	7
Very Dissatisfied	Dissatisfied	Somewhat Satisfied	Satisfied	Very Satisfied	Not Applicable	Provider Too New

**How helpful has the provider been in assisting you in making progress?						
1	2	3	4	5	6	7
Never Helpful	Hardly Ever Helpful	Somewhat Helpful	Mostly Helpful	Very Helpful	Not Applicable	Provider Too New

Family and youth responses are then entered into Synthesis by the Care Coordination agency.

The 2017 results are referenced below:

Ninety-six (96) agencies were represented in the 2017 provider survey results for a total of **1,297 surveys completed/received**.

Parent/Caregiver Results – Overall 3.97

1.)	Overall, how satisfied are you with this provider?	3.90
2.)	How helpful has the provider been in assisting you in making progress?	3.84

Youth Results – Overall 3.77

1.)	Overall, how satisfied are you with this provider?	3.81
2.)	How helpful has the provider been in assisting you in making progress?	3.73



Provider Survey Outcomes by Service

Surveys were completed/received on ninety-six (96) agencies representing **sixty-six (66) different services**. The reports to analyze each service category are in the process of being created. Only those services in which at least 5 surveys have been received will be reported on in future reports.

Costs/Services

The cost of providing services for the youth in Wraparound/REACH is less than the cost of care in alternative children's mental health systems and other systems of care.



The overall total number of youth serviced in some capacity in WRAP and REACH from 1/1/17 – 12/31/17 was 1,622.

The average overall cost per month/per Wraparound enrollee was \$4,686.00. The average overall cost per month/per REACH enrollee was \$2,031.00

(This cost includes the provision of care coordination services in addition to all other authorized provider network services)

The total paid for services in 2017 was \$41,888,525.00

Listed below are several program cost comparisons as it relates to the provision of services. Please note that the monthly cost for Wraparound/REACH type services may also include providing care to other family members in addition to the identified enrollee.

PROGRAM	APPROXIMATE AVERAGE COST PER MONTH/PER YOUTH
<i>Wraparound Milwaukee</i>	\$3,359
<i>Group Homes</i>	\$6,353
<i>Corrections</i>	\$10,230
<i>Residential Care</i>	\$11,134
<i>Psychiatric Inpt. Hospital</i>	\$45,040

Listed below are the top five service groups utilized per authorizations from January through December 2017 in which the client/family were the primary recipients.

- 1.) **Crisis Stabilization/Supervision** 1,318 or 81% of the youth utilized this service in some capacity
- 2.) **In-Home Therapy (Lead-Medicaid)** 885 or 54% of the youth/families utilized this service in some capacity
- 3.) **Transportation** 818 or 50% of the youth/families utilized this type of service in some capacity
- 4.) **Outpatient Therapies** 595 or 37% of the youth/families utilized this service in some capacity
- 5.) **Psychological Assessments** 346 or 21% of the youth utilized this service in some capacity

Although not considered a specific service per se, it is important to note:

Six hundred and fifty-Seven (657) or **41%** of the youth/families utilized **Discretionary Funds** in some capacity. Discretionary funds are flex monies that are often utilized to assist the family in meeting a need that may not be connected to a specific provider-related network service.

The majority of Discretionary Fund requests (excluding Miscellaneous funds) are for assistance/support with Rent/Security Deposits, recreation, groceries/household supplies and clothing/shoes.

The **five most costly service areas** (excluding Care Coordination) for 2017 (though not necessarily the most utilized) are:

1. Residential Care at 20% of the total paid
2. Crisis Services at 14% of the total paid
3. Group Home Care at 10% of the total paid
4. Foster Care at 8% of the total paid
5. In-Home Therapy at 7% of the total paid

Performance – Based Measures/Outcomes

Wraparound Milwaukee establishes and monitors performance indicators/outcomes both within its internal programs in the Wraparound System of Care, in addition to the Providers that are authorized and contracted with Wraparound through the Provider Network.



During 2017, Wraparound Quality Assurance Staff worked with internal Wraparound program staff and Behavioral Health Division/Community Access to Recovery Services (CARS) staff in continuing to establish performance measures for both internal Wraparound programs and external Provider Network contracted vendors. Wraparound/CARS and BHD Inpatient Services Groupings were reviewed and started to be consolidated in an effort to establish uniform performance measures for similar services. In addition, broad indicator areas were established to provide a framework for the performance measures. These areas include: **Access, Process, Outcome and Client Experience**. Each of these areas were further broken down into specific measurement categories:

ACCESS	PROCESS	OUTCOME	CLIENT EXPERIENCE
Service Initiation	Daily Activities	Quality of Life	Satisfaction
	Therapeutic Environment	Discharges	

A protocol for establishing the performance measures for the Provider Network vendors was put into place. This consists of a literature review of same/similar services in an effort to identify already established/tested service performance indicators, national trends and outcomes. FOCUS/discussion groups are then held with consumers, providers and internal staff to acquire feedback on best practices/quality care as it relates to that service. All information gathered then contributes to the establishment of performance measures for specific service groups. In addition to the performance measures, **Scopes of Work** (a basic description of the service and service expectations) and **Compliance Indicators** (audit/review type items that are addressed during vendor site visits and client chart reviews) are established and become contractual expectations.

Currently Wraparound Milwaukee is finalizing Scopes of Work, Compliance Indicators and Performance Measures for Outpatient types of services, In-Home services and Residential/Group Home services.

In 2018, the BHD Contact Performance Measures Committee will continue to develop, implement and track performance measures for other established service groups.

Process Indicators

Plan of Care

The Plan of Care (POC) is a family and needs-driven document utilizing the strengths of the child/family. The POC is comprehensive and is the driving force behind the services provided. The initial POC meeting is expected to occur within the first



30 days after enrollment. Subsequent POC meetings should be held at least every 60 - 90 days.

Wraparound uses a ranking system in which the family scores each identified "Need" on the Plan of Care.

A 1-5 ranking scale is utilized. Starting with 1 meaning minimal progress was made in that Needs area to 5 meaning that the Need has been successfully met.

Average overall 2017 "Need Ranking" score at discharge for Wraparound/REACH was 2.6 (N= 605)

In 2016 the final score was 2.78 (N = 580)

The established threshold of desired performance is a 3.75.

Family and Community-Based Service Delivery & Collaboration



Services and support are provided in the youth's natural environment, including home, school and community. Collaboration within the Child and Family Team, meaning the network of formal and informal supports, must be evident.

Identified community-based supports/resources on the Plan of Care Strengths Discovery List are coded in Synthesis. These resources are considered to be "informal or natural" supports, i.e. - are individuals on the Team that are volunteers (unpaid supports), family members, neighbors, clergy affiliations, etc. These supports must be actively utilized, i.e. – be within the "Strategy" related to a "Need", to be calculated within the data.

Wraparound strives for at least 50% of the active members on any Team to be informal or natural supports.

From 1/1/17 – 12/31/17:

Indicator	Threshold	Wraparound	REACH
% of informal or natural supports on the Child and Family Teams	50%	40.8%	45.2%
% of at least one informal or natural support in attendance at the Child and Family Team Meeting	50%	25.4%	22.1%

Audits/Evaluations/Reports & Utilization Review



Wraparound uses auditing processes, surveys, evaluation data and other reported outcomes, as an ongoing means of monitoring the quality of care being provided to youth and families and compliance with Policies and Fee for Service Agreement expectations.

Plan of Care (POC) Audits

An extensive/comprehensive POC Checklist Tool and the new POC Rubric Auditing Tool were finalized in late 2016. In 2017, the process for ongoing POC auditing was implemented. Several variables are assessed when choosing Plans for auditing. Efforts are made to audit 5% of an agencies Plans in a 6-month period of time. The compliance results are then reported bi-annually on the care coordination agencies Agency Performance Report.

The current compliance threshold is 85%.

From 2/1/17 – 1/31/18:

Indicator	Threshold	Wraparound	REACH
POC Rubric Audit Overall Compliance Score	85%	69.8%	74.2%

Audits/Reviews of Provider Network Agencies

Crisis Stabilization/Supervision Audit

A Crisis Stabilization Audit was conducted in 2017 assessing client quality/fiscal indicators such as referral form being in the file prior to the start of service, referral form reflecting the need for Service, Consent for Service/Transportation Consent in file and signed/dated appropriately, quality progress notes, Agency Verification Log present and complete, dates billed match service dates.

Ten agencies were in the audit sample representing 127 Clients (10% of each agencies active crisis providers or a minimum of 5). Data is currently still being compiled.

Performance Improvement Project (PIP)

Wraparound Milwaukee must engage in one Performance Improvement Project per year as mandated by our Medicaid Contract with the State of Wisconsin. The project must focus on a clinical or administrative issue that the program wants to further explore in an effort to engage in a quality improvement endeavor that impacts on client care.

The 2017 PIP was entitled, **"Bridging the Gap: Connections and Support after Disenrollment via Owen's Place"**.

In summary, the PIP focused on efforts to engage with older adolescents/young adults transitioning from the more children

driven programs in the Wraparound Milwaukee System of Care. It was hoped that through identified interventions that individuals who did not formally enroll into the OYEAH Program (program for young adults experiencing mental health challenges) within the Wraparound System of Care would at least access Owen's Place – our young adult resource center.

The PIP was due to the State in March 2018. Final approval of the study results are pending.

Utilization Review

Service Group – WRAP and REACH	Average Total Paid Per Child/Per Month for CY 2017		# of youth served		% of youth served	
	WRAP	REACH	WRAP	REACH	WRAP	REACH
AODA Svcs.	\$4.38	\$0.39	77	310	9.3%	1.3%
Care Coordination	\$1,086	\$694.56	831	791	100%	100%
Child Care/Rec.	\$13.21	\$7.12	50	21	6.0%	2.7%
Crisis Svcs.	\$495.48	\$443.02	690	628	83%	79.4%
Day Treatment	\$4.28	\$5.37	5	2	0.6%	0.3%
Discretionary Funds	\$13.08	\$11.51	361	296	43.4%	37.4%
Fam/Parent Support Services	\$35.29	\$86.78	114	228	13.7%	28.8%
Foster Care	\$519.92	\$1.67	149	1	17.9%	0.1%
Group Home	\$622.67	\$48.54	171	15	20.6%	1.9%
Independent Living	\$66.44	\$0.00	16	0	1.9%	0.0%
In-Home Therapy	\$173.92	\$282.93	410	475	49.3%	60.1%
Inpatient Hosp.	\$136.68	\$210.36	106	137	12.8%	17.3%
Life Skills	\$32.33	\$16.68	114	41	13.7%	5.2%
Med. Mngmt. /Nursing	\$7.62	\$8.07	113	96	13.6%	12.1%
Occupational Therapy	\$0.00	\$2.46	0	17	0%	2.1%
Outpatient Therapies	\$61.77	\$47.61	316	279	38%	35.3%
Psychological Assess.	\$9.06	\$11.79	162	184	19.5%	23.3%
Residential Treatment	\$1,274	\$62.31	190	6	22.9%	0.8%
Respite	\$43.83	\$96	86	2	10.3%	0.3%
Shelter	\$22.07	\$2.30	32	5	3.9%	0.6%

Transportation	\$49.67	\$28.01	486	332	58.5%	42%
Youth Support Svcs.	\$14.55	\$58.41	110	209	13.2%	26.4%

III. Structure Indicators

Wraparound Milwaukee, as a system of care, utilizes a diversified administrative team, which assesses Provider services, provides training in Wraparound philosophy, and establishes policies and procedures. A structured intake process is utilized with reference to enrolling families into the program. A Care Coordinator is assigned to work with every family. The Care Coordinator organizes and coordinates care for the youth and family. Each family has a Child and Family Team that meets regularly. The Team develops and implements the Plan of Care.

Child and Family Team Meeting



A Child and Family Team (CFT) Meeting is expected to be held once a month to discuss the status of the Plan of Care and the child/family. The CFT meeting must be documented in the Care Coordinator's Progress Notes and be coded as such.

Per Progress Notes dated 1/1/17–12/31/17, the compliance score as it relates to holding a monthly Child and Family Team Meeting was 87.3%. The compliance score in 2016 was 89.2%.

The established threshold for compliance is 85%.

Training

Care Coordinators receive 106+ hours of initial certification training in a curriculum developed by Wraparound Milwaukee. Care Coordinators are expected to complete the training within the first six months of employment. The Training Team consists of a diverse group of individuals from different disciplines. Parents/Caregivers are also training facilitators. Ongoing mandatory and non-mandatory meetings, inservices, conferences, re-certification training, etc. are also offered throughout the year for provider staff and/or families.



Four (4) New Care Coordinator Trainings were held during 2017. The training consists of 15 Modules totaling 103.5 hours. One module is now presented through an electronic program.

Each of the training modules integrates Trauma Informed Care concepts around adversity and trauma exposure, biological, neurological, relational, spiritual, behavioral and worldview impact, as well as respecting experientially driven behavior as indicative of trauma related needs. **Approximately 75 new Care Coordinators, Transition Coordinators and Professional Foster Parents participated in the trainings.** In addition, several Families United of Milwaukee parent/youth facilitators joined to share their lived experience

Training for Parents: An on-boarding training was created for families who participate as co-facilitators in the philosophy and process training for new CCs. **Two Trauma Informed parenting trainings** were offered for families and providers who work with parents as a shared learning opportunity. Additionally, an **advocacy training, "Learn How to be Your Child's Champion,"** was provided specifically to parents to help them learn how to advocate for their children in the educational arena.

Cross training with the Division of Milwaukee Child Protective Services (DMCPS), the Division of Youth and Family Services (DYFS) and network providers has continued and extended to respective leadership levels through system Leadership Summits that focus on shared learning and collaboration.

Non-Violent Crisis Intervention (CPI) training has been provided for **crisis stabilization workers.**

Wraparound has partnered with the **Community Access to Recovery services (CARS)** program to provide training for CARS staff, and CARS staff have joined CC Certification trainings to **learn more about team meeting facilitation, conflict resolution, and community resources.**

The Wraparound Milwaukee Training and Crisis Coordinator has been providing **Adverse Childhood Experiences (ACEs) training** as a regular component of the Behavioral Health Divisions on-boarding process for all staff. ACEs training has also been offered to community groups such as MC3 (Milwaukee Comprehensive Care Collaborative) and PAN (Prison Aftercare Network).

Wraparound Care Coordination Supervisors and Leads went through monthly **champion building sessions** to develop a more sophisticated understanding of trauma informed care concepts and practices, coaching techniques, leadership skills and other more targeted topics identified by them including coaching to advocacy in the court process and building compassion resilience in the workforce.

Several in-services/workshops took place, providing continuing educational opportunities for Wraparound-related staff, Crisis Stabilizers and Human Service Workers.

These consisted of:

- Wraparound Administrative Panel
- Suicide Awareness and Response
- Opioid and Other Substance Abuse
- A personal account of a healing journey

- Milwaukee 53206 Documentary
- Trauma informed crisis debriefing - How to Repair and Reconnect
- Special Education Advocacy
- Domestic Violence
- ACEs

Grievances/Complaints/Administrative Concerns/Violations

Wraparound Milwaukee, as a system of care, has a formal grievance procedure and a complaint investigative and reporting process. Complaints can be generated by any party within the Wraparound System of Care. Grievances are primarily generated by family members/enrollees.



Zero (0) grievances were filed in 2016. Wraparound Milwaukee identifies a grievance as the action a recipient may choose to pursue if they are not happy with the outcome of a filed complaint.

Complaints/Administrative Concerns that were logged during the time frame of 1/1/17 – 12/31/17 consisted of:

30 written
+ 2 verbal
32 total

***NOTE: Exposure of confidential patient information (HIPAA) is considered an administrative violation and not a complaint. Seven (7) HIPAA violations were recorded in 2017.**

Complaints/Concerns were generated from the following sources:

- One (1) from a Youth
- One (1) from an Audit
- Two (2) from System Partners
- Two (2) from Providers
- Eight (8) from Care Coordinators/Care Coordination Supervisors
- Eight (8) Wraparound Administration
- Ten (10) from Parents/Guardians

Complaints/Concerns were filed against:

- Two (2) against Other
- Six (6) against Care Coordination Agencies
- Twenty-four (24) against Service Providers

Those that were filed related to:

- 3 related to client safety issues
- 1 related to not following Wraparound process

- 3 related to boundaries/ethical issues
- 9 related to lack of professionalism
- 3 related to service delivery issues
- 6 related to billing for services not provided
- 7 related to HIPAA (see red verbiage above)

- Independent Living Placement = 1
- In-Home Therapy Services = 28
- Life Skills Services = 6
- Med Mngmnt./Nursing Services = 9
- Outpatient Therapies = 38
- Psychological Assessment = 9
- Residential Care = 9
- Respite Services = 15
- Shelter = 2
- Transportation = 9
- Youth Support Services = 19

Complaint (n=15) Outcomes

- **Eight (8)** complaints were **Substantiated**
- **Three (3)** were **Unsubstantiated**
- **Two (2)** were **Partially Substantiated**
- **Two (2)** were coded as **“Other”**

Note: Those issues identified as “Administrative Concerns” (n= 17) do not receive an outcome identifier of substantiated, partially substantiated or unsubstantiated

<i># of 2015 complaints/ concerns</i>	<i># of 2016 complaints/ concerns</i>	<i># of 2017 complaints/ concerns</i>
<i>20 out of 1,848 served or 1.08%</i>	<i>27 out of 1,670 served or 1.6%</i>	<i>32 out of 1,622 served or 1.9%</i>

There were one hundred and ten (110) “Out of Network” requests that were submitted during 2017. Requests were primarily submitted for services such as psychiatry/mediation review, psychological evaluations, individual and special therapies, specialized crisis care and group home care. **Fifty-seven (57) or 52%** of the requests were **approved**. **Forty-four (44) or 40%** were **never approved or denied** primarily due to the request actually being withdrawn/not needed, not being submitted in advance of the service being provided, the service already being offered in network, or the vendor actually declining/not accepting Wraparound rates.

No **New Provider Orientations** took place during 2017 although individual trainings were offered at the Provider’s request.

Wraparound Provider

Network

The Wraparound Provider Network (WPN) is a diverse group of individuals/agencies that provide mental health and support services for the children and families in Wraparound, REACH, Family Intervention and Support Services (FISS), O-YEAH, CORE and CCS programs.



In 2017, Theresa Randall, MBA – Program Manager, joined the Wraparound Milwaukee Team and will be the Provider Relations administrative representative. Welcome Theresa!

In 2017, the Network contained, on average, **112 Provider Agencies**. Approximately one hundred and four (104) unique, different types of services were offered.

The total number of agencies (duplicated) that provide one or more services within the **various service categories** consisted of:

- AODA Services = 7
- Care/Transition Coordination =12
- Child Care/Recreation = 5
- Crisis-related Services = 31
- Day Treatment = 2
- Family/Parent Support Services = 9
- Foster Care = 12
- Group Homes = 21

One (1) Level I and one (1) Level II Wraparound Provider Philosophy Trainings were held. The trainings focus on the implementation of Wraparound philosophy and the Child and Family Team process. Both levels of training are five hrs. each with a lunch break. A total of forty-six (46) individual providers participated along with several parent representatives from Families United of Milwaukee, Inc.

The Wraparound Fiscal Department Manager created a **PowerPoint presentation for new vendors/vendor billing staff** that takes a person through the **invoicing process in Synthesis**. After viewing the presentation, the Fiscal Manager is available for any questions or further guidance that may be needed. Four individual agency trainings were facilitated in 2017.

Four (4) Provider Forum Meetings took place. This meeting provides an arena in which network vendors assemble to receive updates and general information about the Wraparound Milwaukee program and the Division of Youth and Family Services (formerly known as the Delinquency & Court Services Division). The Providers are also offered the opportunity to share information about their programs and ask any questions or express any concerns.

Nine new vendors entered the Provider Network in 2017:

- Community Harbor, LLC
- Grateful Girls – Safe Haven II
- Honey Creek Counseling and Recovery Services, LLC
- LifeStriders Therapeutic Riding Center
- Milwaukee Center For Independence Home Care
- Myles Logistics

- RISE Youth and Family Services, LLC
- SWITS, Ltd.
- True American Transport, LLC

Two new **services/service codes** were created in the Provider Network in 2017. The new services were implemented in an effort to address new client and programmatic needs or increase efficiencies. Listed below are the service/service code additions:

CODE	SERVICE	EFFECTIVE DATE
5535	Non-Certified Peer Specialist	9/18/17
5055	Med Management Support (Non-Prescriber)	7/20/17

Lastly, Comprehensive Community Services (CCS) for Youth, the newest programmatic addition to the Wraparound System of Care, transitioned the services offered in this program into the Provider Network area of Synthesis – Wraparound Milwaukee’s IT system. The services offered for Youth CCS are:

CODE	CCS SERVICE
5352	CSP Coordination
H2017D	Diagnostic Evaluation
H2017E	Employment-Related Skill Training
H2107S	Individual Skill Development Enhancement
H2017PE	Individual/Family Psychoeducation
H2017M	Medication Management
H2017P	Peer Support
H2017 H	Physical Health Monitoring
H2017T	Psychotherapy
H2017A	Screening and Assessment
H2017F	Service Facilitation
H2017SP	Service Planning
H2017SA	Substance Abuse Treatment
H2017W	Wellness Mgmt/Recovery Supportive Services

O-YEAH Program



The O-YEAH (Older Youth and Emerging Adult Heroes) Program, a program administered under the auspices of Wraparound Milwaukee, is designed to support older youth and young adults ages 16 through 23 who may be experiencing emotional and behavioral challenges, to successfully transition to adulthood. This is a voluntary program.

O-YEAH, now entering its 10th year of providing service, continues to look at areas that present challenges for transitional age young adults. Several partnerships have been established over the years that provide services/support to the youth. These include:

- Milwaukee County Adult Community Services
- Milwaukee County Adult Services Liaison
- Pathfinders Milwaukee, Inc.

- Lad Lake
- Journey House
- LaCausa
- Milwaukee Public School collaborations
- State of Wisconsin
- Justice Point
- Milwaukee County Housing Division

In 2017, the following O-YEAH demographics were recorded for new enrollees:

Demographics	N =
Total Screenings	136
Total New Enrollments	104
Tier I	0
Tier II	96
Tier III	8
Disenrollments	77
Gender	51% Male (N=52) 49% Female (N=49)
Average Age	19.3
Ethnicity	65.4% African-American (N=66) 17.8% Caucasian (N=18) 6.9% Hispanic (N=7) 3.9% Bi-racial (N=4) 6% Unknown/Other (N=6)

Average cost per member/per month for 2016 = \$1,070

The various Tiers represent different levels of programmatic intervention. Young adults are guided into a Tier that would best support their needs as identified through the screening process. Tier 1 is the most intensive.

Futures Plans

Futures Plans are the Plan that the young adult establishes based on their individual vision of adulthood. They will explore their needs and strengths and what supports may be necessary for them to achieve their hopes and dreams. Several “Life Domains” are addressed within the Plans.

Domain Category	# of times the Domain was identified in a Futures Plan in 2017
Educational/Vocational	179
Family	7
Health and Well being	23
Legal/Restoration	18
Living Situation	32
Mental Health	227
Safety	5
Social/Recreational	8
Transition to Adulthood	220
Other	4

O-YEAH uses a ranking system in which the enrollee scores each identified Domain on the Futures Plan.

A 1-5 ranking scale is utilized. Starting with 1 meaning minimal progress was made in that Domain area to 5 meaning that the Domain area needs have been successfully met.

Out of the 723 Domains identified forty-five (45) were closed out. The average change from the initial Domain Ranking value (Scale of 1-5, with 1 meaning minimal progress was made in that area, to 5 meaning maximal progress has been in that area) to the final Domain Ranking value were as follows:

Domain Category	Average Change in Value
Educational/Vocational	+0.97
Health and Well being	+1.75
Legal/Restoration	+1.0
Living Situation	+2.0
Mental Health	+1.4
Safety	N/A
Social/Recreational	+3.0
Transition to Adulthood	+2.77

O-YEAH Service Utilization

Service Group	Average Total Paid Per Enrollee/Per Month for CY 2017	# served	% served
AODA Svcs.	\$1.41	6	2.6%
Care Coordination	\$587.48	229	100%
Child Care/Rec.	\$0.00	0	0%
Crisis Svcs.	\$227.78	100	43.7%
Day Treatment	\$0.00	0	0%
Discretionary Funds	\$33.59	128	55.9%
Fam/Parent Support Services	\$26.46	20	8.7%
Foster Care	\$0.00	1	0%
Group Home	\$13.99	1	.4%
Independent Living	\$0.00	0	0%
In-Home Therapy	\$136.17	73	31.9%
Inpatient Hosp.	\$23.77	18	7.9%
Life Skills	\$19.58	15	6.6%
Med. Mngmt./Nursing	\$12.55	39	17%
Outpatient Therapies	\$33.72	62	27.1%
Psychological Assess.	\$12.59	54	23.6%
Residential Treatment	\$0.00	0	0%
Respite	\$1.99	1	.4%

Shelter	\$0.00	0	0%
Transportation	\$51.10	137	59.8%
Youth Support Svcs.	\$10.36	18	7.9%

O-YEAH Campus Housing

Beginning in 2015 O-YEAH partnered with Journey House to provide supported apartments for young adults that were enrolled in O-YEAH and in need of stable housing. In 2016 O-YEAH and Journey House were able to add 4 more apartments for our young adults, bringing the total to 10 apartments. In 2017, young adults continued to be able to live in these apartments under a modified rental agreement and monthly rent payment. Using a Housing First model, young adults are able to live in these apartments for up to 18 months (an increase from 12 months in 2016) while working on school and employment goals and learning the skills to live a successful independent life.



Owen's Place

Owen's Place is a resource center designed to assist young adults between the ages of 16 through 23 years whose mental health needs may be impacting on their ability to lead an independent life.

Owen's Place happenings in 2017:

While Owen's Place is always continuing to build upon our partnerships within the community and Wraparound Milwaukee, in 2017 we focused on programming within that was created and facilitated by our own Peer Support staff. Besides our two popular ongoing groups, Cooking with Christine and Teens in Motions, our Peer Support staff have facilitated numerous programs/events for our young adult population. These programs included:

- Career and Education Planning
- Mock Interviews
- Self-Expression
- Music and Chill Family Fun Night
- Independent Skill Building
- G.I.R.L.S Group
- Open Mic Night
- Creative Writing Workshops
- Workout Wednesdays
- Real Talk Sessions
- Paint and Popcorn
- Food Drive
- Talent Show
- Food Share Applications

Owen's Place continues to get input from our young adult population on various groups and workshops that they feel would be most beneficial to them. As 2017 came to a close, we added a new component that we look forward to expanding into 2018. We now employ an Outreach Coordinator who is working to build positive relationships with local businesses in an effort to create jobs for our youth. We look forward to establishing these partnerships directed towards youth employment and other services that local businesses in the neighborhood have to offer.

Submitted by:

Shannon Trzebiatowski, MS
 Vice President of Community Programs – St. Charles,
 O-YEAH/Owen's Place

M.O.V.E.
WISCONSIN



M.O.V.E. WISCONSIN

(Wisconsin Youth Motivating Others through Voices of Experience) is a youth-run organization designed to empower adolescents and young adults involved in the Wraparound Milwaukee program. Community-based activities are planned and implemented focusing on leadership development and creativity. The group meets at Owen's Place.

For most of 2017, MOVE Wisconsin programming was on a hiatus as staff/programmatic restructuring occurred.

FISS Program

The FISS (Family Intervention and Support Services) Program is a program administered through the Milwaukee County Behavioral Health Division per a contractual agreement with the Division of Milwaukee Child Protective Services (DMCPS). Milwaukee County was awarded the contract, which began in July of 2012.



The program is designed to assess and provide services to families experiencing life challenges with their adolescent child age 12-18. The FISS program goal is to strengthen the parent/guardian's ability to support their adolescent in the home, community and school.

The FISS program has two components:

1. Assessment - Assessments are conducted either in the office or in the home utilizing tools provided by DMCPS. Based on the assessment results and supervisory consultation, the family is referred to the

FISS services unit, DMCPS, Milwaukee County Department of Human Services Delinquency and Court Services, or programs/agencies in the community.

2. Case Management - The FISS services unit provides families with a case manager (contracted through St. Charles Youth and Family Services) who utilizes Wraparound Milwaukee's provider network, crisis services through the Mobile Urgent Treatment Team, and community agencies to formulate and implement a service plan with the family. Case managers utilize the Wraparound philosophy and Coordinated Service Team approach with the goals of providing stabilization, and sustainable connections to community resources. The approach is strength based, and utilizes a combination of paid network services, natural supports, and community based services.

In 2017, the following FISS demographics were recorded:

Demographic	N/% =
Assessments Completed (Individuals)	645
Assessment No Show/Cancel Rate	34%
Enrollments (families) into FISS Case Management	593
Disenrollment's (families) from FISS Case Management	93
Average Length of Stay (ALOS)	3 to 4 months

Other 2017 FISS Accomplishments

OUTREACH

The FISS team is consistently looking to increase accessibility and referrals to the program. In 2017, a new advertisement was created by way of a "flyer" to further the awareness of the FISS program throughout the community, Division of Youth and Family Services and the Division of Child Protective Services.

SERVICE DELIVERY

The FISS program also aimed to increase the number of Assessments and serve families under the Case Management component. To lower the no show/cancellation rate, the FISS team, developed a follow up procedure when families missed an Assessment appointment or were referred to a community resource. This included sending a letter to the family informing them of the missed appointment and to attempt to schedule another appointment. A follow up call within 60-90 days was made to the families who were referred to a community resource to inquire if they connected to the recommended resource and if they needed further assistance.

Submitted by:

Christine Robinson, MS
 FISS Program Coordinator

IV. Other Accomplishments

Positive Recognition Announcements

A total of 22 Families/Service Providers/System Collaborators and/or Care Coordinators were recognized in 2017 through the **Positive Recognition Announcement**. The Positive Recognition Announcement is a format that enables anyone involved in the Wraparound system of care to recognize the hard work, dedication, perseverance, etc., of another. Those recognized are identified in the monthly Wraparound Newsletter.



“Thankful for Ms. P. and her continued care and guidance for a young lady we are working with. Ms. P. goes above and beyond and advocates wholeheartedly for this young lady and her newborn baby. Thank you Ms. P. for your passion and heart for the kids we are privileged to walk alongside with!”.

“H. has dedicated his time and personal resources to ensure families receive items needed to make their house a home. His kindness and generosity has allowed families to receive donated beds and other large furniture. His donation of time and transportation is a testament to his commitment to the families we serve and the Wraparound spirit”.

“I wanted to send you a message to let you-know how extremely happy I am with the training, experience and service that I have been receiving from G.W., my Parent Assistant. She is an exceptional employee and has been a true asset to me and my son. I am forever grateful for everything she has provided to me, sometimes just being a good listener, but often is being a great advocate for me. She has been a huge ray of hope for me personally as a single parent of a special-needs child. She deserves as many platitudes as you can provide her because she truly is an exceptional employee and a true asset to you and your company!”.

“Since L. became my family’s care coordinator, just a few short months ago, she has been a warm caring and very helpful person to us. She goes above and beyond to try to meet my family’s needs and when times are tough in our family she is encouraging and reassuring. She is such a hard worker and always finds an answer of solution to our

problems, in a prompt manner. We feel very fortunate to have her on our team. She deserves to be recognized for all her hard work! Wraparound is also very lucky to have her on staff.”

Research Activity

As a data driven program, Wraparound Milwaukee collects and analyzes data to assure accountability and responsiveness to the Wraparound model and the children and families we serve. In 2017, the research arm of Wraparound Milwaukee was involved with a number of initiatives. The highlights are:



- A recidivism report was completed that addressed the overall recidivism rate in the Wraparound population, the re-offending pattern across time in Wraparound, a discrete look at the high risk populations and a deeper investigation of multiple offenders. Due to the use of adjudication data rather than arrest data, the recidivism rate was at an all-time low.
- An analysis of outcomes for youth in CORE that have been in the program for the past two years was conducted. Outcomes were conflated with costs and sustainability factors, the results demonstrating a cost effective quality program. This study was presented by three CORE staff at the 31st Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health.
- Wraparound was well represented at this National Research Conference as two additional staff presented *Data Driven Coaching*, explaining how data can be used to develop policy and monitor implementation, guide coaching and training to ensure Trauma Informed practice, and drive the creation of tools to support Trauma Informed service delivery within the Wraparound model.
- A Division of Milwaukee Child Protective Services (DMCPS) Education Liaison status report is conducted annually to analyze program growth and service delivery patterns. This data was analyzed across 3 distinct age groups in order to address age appropriate needs.
- Quarterly, data is collected and analyzed to determine the status of the work of the Trauma Response Team. This is an initiative of the Children’s Mobile Crisis Team in which they partner with the City of Milwaukee and Milwaukee Police Department to provide trauma response and support to youth who may have been exposed or witnessed a potentially traumatic event such as battery, child abuse, domestic violence, fire, a shooting, and sudden death. This data provides a gauge of how effective this program is and how it can continually improve and grow.

Submitted By: Pnina Goldfarb, PhD
Wraparound Milwaukee Research Analyst/Evaluator

Family Luncheons/Orientations

Four (4) Family Luncheons/Orientations were held.

On average, five (5) Families United of Milwaukee representatives assisted with each orientation providing support and guidance.



The luncheon/orientations were sponsored by Families United of Milwaukee, Inc. in partnership with Wraparound Milwaukee. The orientations focus on defining Wraparound and Families United roles and what they can offer the families as well as the role of the Care Coordinator. In addition, Child and Family Team Composition, service provision, system partner collaboration, crisis services, paperwork/evaluation requirements and the disenrollment process are discussed. Lunch is served and families are provided with a grocery store gift card as a welcoming and thank you for attending the orientation. Supervised children’s activities are offered.

All new families entering the Wraparound system of care are invited and encouraged to attend. Families United of Milwaukee staffs continue to call families in an effort to encourage attendance at the Family Orientations.

Visits from other Sites/Programs, Technical Assistance, Presentations

August 2017 – From August 9 – 11th Wraparound was visited by representatives from Saipan in an effort to learn about our system of care programs, evaluation, quality assurance, care coordination, crisis services, coaching and consultation.



September 2017 – Staff from Bridges to the Future – Montgomery County – Maryland, from visited Wraparound from Sept. 20th – 22nd to learn more about our system of care programs, Owen’s Place, transitional services, our funding model, Futures Plans, evaluation and quality assurance.

November 2017 – Representatives from Delaware visited Wraparound from November 15th – 16th to learn about Wraparound Milwaukee’s history, quality assurance, provider network services, screening and assessment, care coordination and training and staff development.

Children’s Mobile Crisis (CMC)

In 2017, the Children’s Mobile Crisis Team provided over 15,500 hours of crisis services to children and families across the Wraparound Milwaukee programs, the community at large, and through the Trauma Response collaboration with the Milwaukee Police Department. This is a 9% increase from 2016. Some children and families used mobile crisis services only one time, while others used them more often to support their family in the community. In keeping with Wraparound Milwaukee and CMC’s crisis philosophy, the vast majority of children were seen face-to-face, in natural community settings such as home and school.



Other significant events:

- The crisis team changed its name from the Mobile Urgent Treatment Team (MUTT) to the Children’s Mobile Crisis Team (CMC). Over time, the word MUTT reportedly lent itself to some service recipients expressing concern regarding the implications of the acronym. In an effort to alleviate any misgivings and to reflect the majority of the population served, it was decided to change our name.
- Partnerships with the Division of Milwaukee Child Protective Services (DMCPS) were reinforced when DMCPS staff joined CMC for calls in the community to better understand our role. This led to proposals for more ways we can collaborate and serve children in out of home care.
- The Trauma Response Team (TRT) successfully expanded to District 5 and began plans to expand to the Milwaukee Fire department as well. The TRT is a component of a much larger and more involved plan to raise the awareness of trauma in the community, and to increase and improve the ability to address it.

Children’s Mobile Crisis staff continues to offer specialized Dialectical Behavior Therapy (DBT) to Wraparound youth, including their caregiver and/or a primary service provider, in need of those services. DBT consultation is also offered to therapists in the provider network interested in learning more. DBT focuses on decreasing self-harming behaviors while increasing emotional regulation and distress tolerance skills, resulting in fewer incidences of self-destructive behaviors and fewer hospitalizations.

In 2017, the Wraparound QA Department continued to administer satisfaction surveys to those youth/young adults who experienced their first encounter with the Children’s Mobile Crisis Team. Surveys were sent out with a self-addressed stamped return envelope 1-2 weeks post the initial contact. The results are referenced below:

# of Surveys Sent	# of Surveys Recv’d	Return Rate	Average Overall Score
823	54	7%	4.50
1.)	Staff was courteous and respectful		4.74
2.)	Staff responded in a timely manner		4.57
3.)	Staff was sensitive to our cultural, ethnic and spiritual needs		4.57
4.)	The support we received was helpful		4.52
5.)	The support we received help maintain my child in the home, school or community		4.33
6.)	I was satisfied with the results of my		4.50

Submitted by: Steven P. Dykstra, PhD
 Director, Mobile Urgent Treatment Team
 Licensed Psychologist

Proactive Outreach for the Health of Sexually Exploited Youth Project (POHSEY)



In 2017, Wraparound Milwaukee continued the collaborative efforts of Proactive Outreach of Sexually Exploited Youth (POHSEY) via a Healthier Wisconsin Partnership Program (HWPP) grant; this was the second and final year of funding. POHSEY II aimed to transform how youth who have experienced commercial sexual exploitation/trafficking (CSE) interact with healthcare entities by providing tools that empower medical providers to better meet their needs; this includes access to training, and more comprehensive medical templates, as well as advancing a coordinated system response. Partners in POHSEY II included Dr. Wendi Ehrman from the Medical College of Wisconsin (MCW), Dr. Angela Rabbitt from MCW/Children’s Hospital, Claudine O’Leary from Rethink Resources, and Stephen Gilbertson the Clinical Director of Wraparound Milwaukee.

In order to meet the goals of POHSEY II, active training efforts occurred via in-person training opportunities, as well as an online training-module option. In addition, several templates have been developed to assist the Children’s Hospital Emergency Department in more efficiently and effectively documenting, as well as responding to youth who are risk for, or have experienced sexual exploitation/trafficking. The templates have been incorporated into EPIC, the Electronic Medical Record system utilized by Children’s Hospital. Copies of the templates and protocols have also be shared with over ten local healthcare providing entities in the hopes of spreading the work to create overall system change.

POHSEY also supported the efforts of Collaborative Rapid Advocacy for Youth (CRAY), a collaborative response entity formed in an effort to provide more consistent access for youth and medical providers to specially trained advocates who can effectively support youth within local Emergency Departments who may have experienced CSE. Throughout this time, meetings regularly occurred with other stakeholders to elicit feedback, and discuss changes that could be made within their own systems of care using the already developed templates.

POHSEY II was also charged with updating the POHSEY Resource Card, which provides individuals with supportive contact information so they can make quick connections for needed resources. An updated version has been made available, and can be accessed on the grant’s website. Training materials for medical providers, and additional information about the grant, including community resources for youth and families in this situation, are available at www.pohsey.org.

An extension was allowed for POHSEY II to continue through March 2018, and talks are underway - facilitated by Dr. Rabbitt and Dr. Erdman - to create a healthcare partnership to better support local medical providers in a coordinated response to the needs of both youth and adults with these experiences.

View this short article/radio interview highlighting some of the work that had been done by POHSEY:

<http://wuum.com/post/childrens-hospital-wisconsin-helps-health-care-providers-detect-trafficked-youth#stream/0>

Submitted by: Jenna Reetz, MSW
Interim Associate Director
Wraparound Milwaukee

“Welcome Home Teens in Motion” Support Group



Throughout 2017, the “Welcome Home Teens in Motion” youth group continued to meet monthly at Owen’s Place to support and address the needs of youth are challenged by running away or their whereabouts becoming unknown. During 2017, the decision was made to have one agency – Alternatives in Psychological Counseling – facilitate the meetings to offer a consistent experience for attendees. Youth and supportive adults worked together to create a map of Wisconsin to highlight the movement that young people experience. After much discussion, it was determined that 2017 would be the last year of Teens in Motion to make way for a more youth driven process.

Submitted by: Jenna Reetz, MSW
Interim Associate Director
Wraparound Milwaukee

Teen Parent/Pregnancy Protocol and Pregnancy Prevention Program



In Wraparound’s commitment to ensuring the safety and well-being of all children and families, the “Protocol for Teen Parents/Parents-To-Be/Pregnancy Prevention” was developed and implemented. Every year, on average, 25-30 pregnant/teen parents/ sexually active teens receive support, guidance and care from a designated Wraparound Milwaukee nursing staff as it relates to sexual health issues, i.e. – Safe Sex, Sexually Transmitted Diseases, Birth-Control Education, Pregnancy and teen parent education like Safe Sleep and Shaken Baby Syndrome and Safety issues that relate to infant care and parenting. The protocol also ensures that every teen parent has access to a Pack and Play (promotes safe sleep) and community resources that can assist with additional support and guidance to pregnant and non-pregnant teens.

The protocol can be accessed at:
<http://wraparoundmke.com/?p=1285>

Teen Pregnancy and Protocol Brochure can be accessed at:
<http://wraparoundmke.com/?p=1284>

Submitted by: Maryan Torres, MSN APNP, FNP-BC, CPN
Wraparound Milwaukee Wellness Clinic

Wraparound Wellness Clinic

During 2017, Wraparounds Wellness Clinic continued to provide medication management and wellness/education services to the youth involved in the Wraparound and REACH programs.



In 2017 the following occurred:

- Educational Training initiative for CC: The clinic psychiatrists have facilitated several educational trainings for our Care Coordinators to learn and understand more about medication management.
- Educational Training initiative for Clinic Staff: The clinic staff has participated in educational trainings about the Wraparound process and philosophy to continue to incorporate this philosophy into their practice with youth and families.
- The 2018 Wraparound Milwaukee Performance Improvement Project began in December 2017. The focus will be on improving client medication adherence.
- To further incorporate the Health Home Model of care, the clinic has implemented the practice of referencing the medical information, when available, into the appointment. The clinical staff ensures they are utilizing the information to more accurately assess the youth with complex medical needs and make follow-up recommendations for the family as it relates to the youth's medical needs.

CORE (Coordinated Opportunities for Recovery and Empowerment) Program

The CORE program offers comprehensive and specialized mental health services and support to individual's ages 15-23 years old (though sometimes younger), that are experiencing their first episode of psychosis. Services are delivered by a 5-person team for up to 2 years. Some symptoms the individual may be experiencing include hallucinations, delusions, unusual thoughts, disorganized thinking/speech or disruption of self-care.



In 2017, the CORE program expanded from three Teams to four Teams. This program has had the largest percentage of growth within the Wraparound Milwaukee System of Care, an increase of 40% from 2016 (from 50 to 70 youth enrolled). In addition, in 2017 a staff member was designated to focus on outreach activities and educate the community about the CORE Program. This staff member's primary focus for outreach is with mental health/behavioral health inpatient services and community services.

Services include:

- ✓ Care Coordination
- ✓ Individual Therapy
- ✓ Peer Support

- ✓ Medication Management/Psychiatric Services
- ✓ Employment and Education Support
- ✓ Other services that may be needed to meet the individuals needs

In 2017, the CORE Program enrolled **37 new participants.**

Gender

Male = 30 (81%) Female = 7 (19%)

Age

Average age = 19.2 years old

Ethnicity

African American = 28 (76%)

Hispanic = 7 (19%)

Caucasian = 2 (5%)

Diagnosis

The majority of diagnoses of 2017 enrollees were:

- Psychotic Disorder, NOS
- Schizophrenia, Undifferentiated Type
- Schizophreniform Disorder
- Schizoaffective D/O
- Cannabis Abuse

Inpatient Hospital Stays

In 2017, ten of the seventy enrollees were hospitalized for a total of 213 inpt. hospital days. The average length of stay was 19.4 days; the mode was 9 days, with the range being from 2 days to 53 days.

Average Cost Per Month/Per Enrollee

\$2,776.00

Well-Being Assessment

CORE uses the Well-Being Self-Assessment (Warwick) to assess overall well-being. This tool is administered every 6 months. A scale of 1-5 is utilized with 1 generally meaning none of the time (low sense of well-being) and 5 generally meaning all of the time (high sense of well-being).

Of those enrollees that took the assessment during (1/1/17 – 12/31/17) the overall average score was 3.67/5.0. The scores ranged was from 3.33 – 3.90. The lowest scores were reflected in those answers related to feeling interested in other people and having energy. The highest scores spoke to enrollees feeling good about themselves and feeling loved.

Submitted by: Maria Castillo, MA Ed.
CORE Assessment
Community Outreach Coordinator
Wraparound Milwaukee

Youth Living Out Loud (YLOL)

YLOL is a mentoring program being administered under the Wraparound Milwaukee system of care, the works with youth who have been, or are at high risk for being commercially sexually exploited or trafficked.



In October 2017, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) three-year grant supporting Youth Living Out Loud ended as planned. Partners included La Causa, Inc., Diverse & Resilient, Rethink Resources, Medical College of Wisconsin and Wraparound Milwaukee. After October, YLOL continued to provide specialized mentoring services to identified youth who were significantly at risk for, or have been sexually exploited/trafficked, through a sustainable funding model. These services are offered within the wider context of Wraparound Milwaukee, so youth and families remain connected to additional treatment opportunities.

Each youth in this service completed a Mentor Action Plan (MAP), which supports them in developing skills around goal setting, as well as ensures their voice is heard. In addition to initial training modules, mentors also received ongoing weekly supervision, coaching, support groups and in-service training opportunities to ensure they could meet the needs of youth. La Causa Program Coordinator Tiffany Wilhelm, Claudine O’Leary of Rethink Resources, and Jenna Reetz of Wraparound were able to present information at the Cook County Anti-Human Trafficking Conference in Chicago, IL which was well-attended by individuals at a national level. Specialized Mentoring continues to be an available service within the Wraparound Network, and is open to other interested provider agencies.

Submitted by: Jenna Reetz, MSW
Interim Associate Director
Wraparound Milwaukee

Community Outreach

From July 3rd, 2017 thru December 31st, 2017, there



were over **60 opportunities/contacts to inform community partners** about Wraparound Milwaukee programming. This included specific outreach for the newest programs - CORE and CCS. Outreach included attending resource fairs, speaking events, training opportunities, providing informational materials to already established partners and reaching out to agencies/vendors who are having contact with youth, young adults and families. **Average number of visitors** to the Wraparound Milwaukee **resource booth** during a resource fair is **69** visitors per event.

Outreach will continue to expand in 2018 in an effort to get information out into the community about all Wraparound Milwaukee programs. Future planned outreach will include connecting with the Milwaukee Fire and Police Departments, as well as a continued on-going connection with area mental health providers and inpatient providers for CORE.

A team of staff worked diligently to re-create/update program specific brochures. The current versions can be found on the Wraparound website: <http://wraparoundmke.com> Spanish versions of these brochures are in process.

Submitted by: Maria Castillo, MA Ed.
CORE Assessment
Community Outreach Coordinator
Wraparound Milwaukee

Collaborations with other programs in the Behavioral Health Division (BHD) and the Department of Health and Human Services (DHHS)



In 2017, Wraparound Milwaukee participated in several Behavioral Health Division and/or Department of Health and Human Services (DHHS) committees and workgroups as BHD/DHHS moves forward with its strategic plans for the future. Those committees/workgroups consisted of:

- BHD Family Advisory Council
- BHD Patient Rights Committee
- BHD PolicyStat Committee
- BHD Quality Strategic Planning Committee
- BHD Client Experience Workgroup
- BHD Performance - Based Measures Workgroup
- BHD Compliments, Complaints and Grievance Charter
- BHD Incident Reporting Charter
- BHD Intake, Assessment and Enrollment Charter
- BHD Data Request/Management Workgroup
- BHD Case Management Charter
- BHD Quality Management Committee
- BHD Sentinel Event Committee
- DHHS Strategic Planning Committees (Internal Satisfaction of County Services for Employees, Standardized Employee Policies, High Quality and Accountable Service Delivery)

In addition, Wraparound engaged in ongoing meetings with the BHD Contract Management, Network Services and Compliance area.

2017 Eisenberg Award Recipient

In November, Wraparound Milwaukee was the recipient of the Eisenberg Award. The award was presented to Wraparound by the Wisconsin State Public Defender’s Office. This award is in recognition of Wraparound’s work to support youth with an alternative to a correctional placement by providing individualized and community-based care, and keeping families together. Public Defender Board Chair Daniel Berkos stated, “We are pleased to recognize the work of Wraparound Milwaukee, which reaches well beyond the children it serves and also helps entire families and communities”.



[Link to the Wraparound Milwaukee Award video:](https://www.vimeo.com/245061050)
Vimeo.com/245061050

Introduction of Comprehensive Community Services (CCS) for Youth in Milwaukee

CCS for Youth is a voluntary program that provides support and services to Milwaukee County youth, young adults and their families, who are coping with mental health or substance abuse diagnosis. Utilizing a strength based and individual process, CCS coordinates resources to help people achieve their life goals.

Services Offered:

- Care Coordination
- Employment Supports
- Peer Support
- Therapy (must be in network)
- Medication Management
- Wellness Management
- Education Supports
- Daily Living Assistance
- Assessment and Evaluations
- Life Skill Development

Program Benefits:

- Every individual who participates in CCS works with a Care Coordinator to design a wellness plan that is intended to help build the skills needed to improve health, promote wellness, attain personal goals and enhance overall quality of life.
- Individuals who enroll will have a Functional Screen completed annually to determine eligibility. CCS can be a lifetime benefit through Medicaid if the individual remains eligible.

Other happenings improving the quality of life for Wraparound youth, families and our Care Coordinators:

- **Summer Family Cookout**
On June 22nd, Families United of Milwaukee, Inc., Wraparound Milwaukee, Wraparound Care Coordination Agencies and several other system partners collaborated to sponsor the annual Summer Family Cookout at Washington Park. Food, games and art and crafts were the highlights of the day!

- **Care Coordinator Appreciation Day**
On August 17th, Wraparound Milwaukee organized a special event held at the Milwaukee County Zoo/Zoo Ala Carte Event to show our appreciation to the Care Coordination Agencies serving the youth and families in Wraparound. Care Coordinators received special admission prices to the zoo and were honored with certificates of appreciation. Refreshments were served!

- **Administration Panel/Care Coordination Holiday Event** On January 4th, the annual


Administration Panel/Care Coordinator Holiday event was held at the Washington Park Senior Center in Milwaukee. The Care Coordinators enjoyed lunch, treats, the opportunity to talk with Wraparound Administrators, and a raffle drawing .

- **8th Annual Wraparound Milwaukee Talent Show** – On May 17th, Wraparound held its Annual Talent Show at Pulaski High School Auditorium. Doors opened at 4:30p.m. for the always amazing, Youth Art Show/Auction in which guests got to bid for artwork that was created by youth in the Wraparound programs. All proceeds went directly to the artist. The Talent Show began at 5:30p.m. Several youth and their families participated in sharing their talents through music, song, poetry and dance.



Wraparound remains committed to providing quality care to the youth and families we serve. It is the responsibility of Wraparound and all its affiliated partners to be actively involved in the process of continuous quality improvement. Thank you to all the individuals who contributed to this report. Your time, expertise and dedication was greatly appreciated!

Respectfully Submitted,

Pamela A. Erdman MS, OTR

Wraparound Milwaukee Quality Assurance Director

PCS Hospital Transfer Waitlist Report

First Quarter Update

2018

This report contains information describing the first three (3) months of 2018 are summarized as follows:

- 3 hospital transfer waitlist events occurred
- PCS was on hospital transfer waitlist status 54.5%
- The 224 individuals delayed comprised 12.0% of the total PCS admissions (1,896)
- The median wait time for all individuals delayed was 5.0 hours
- The average length of waitlist per patient is 7.1 hours

Prepared by:
Quality Improvement Department

Date: May 1, 2018

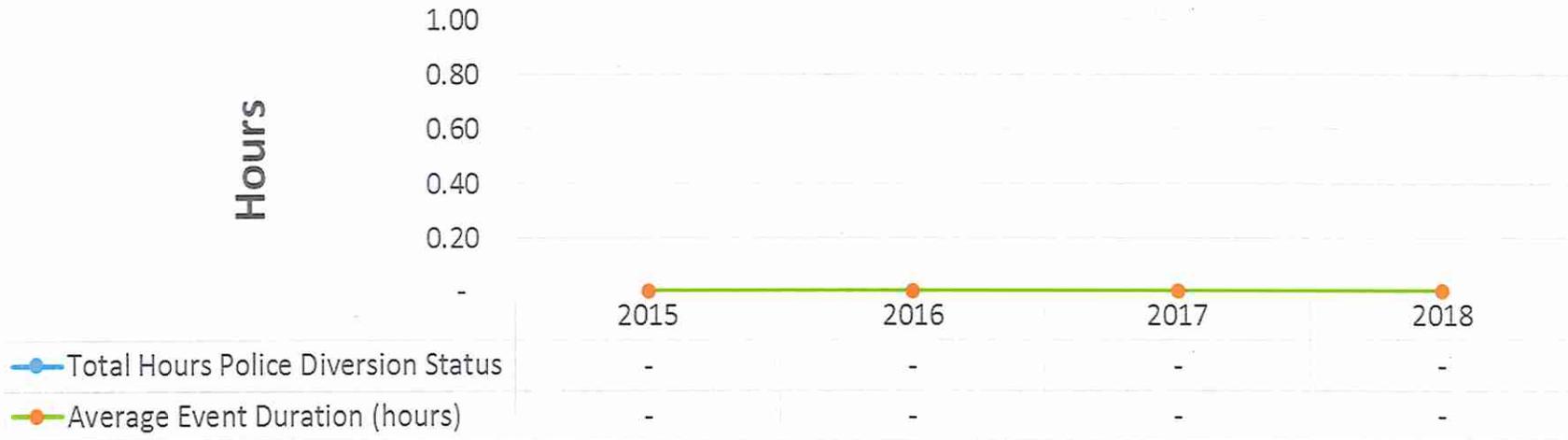
Definitions:

Waitlist: When there is a lack of available beds between the Acute Inpatient Units and the Observation Unit. Census cut off is 5 or less open beds. These actions are independent of acuity or volume issues in PCS.

Diversion: A total lack of capacity in PCS and a lack of Acute Inpatient and Observation Unit beds. It results in actual closing of the door with no admissions to PCS allowed. Moreover, it requires law enforcement notification and Chapter 51 patients re-routed.

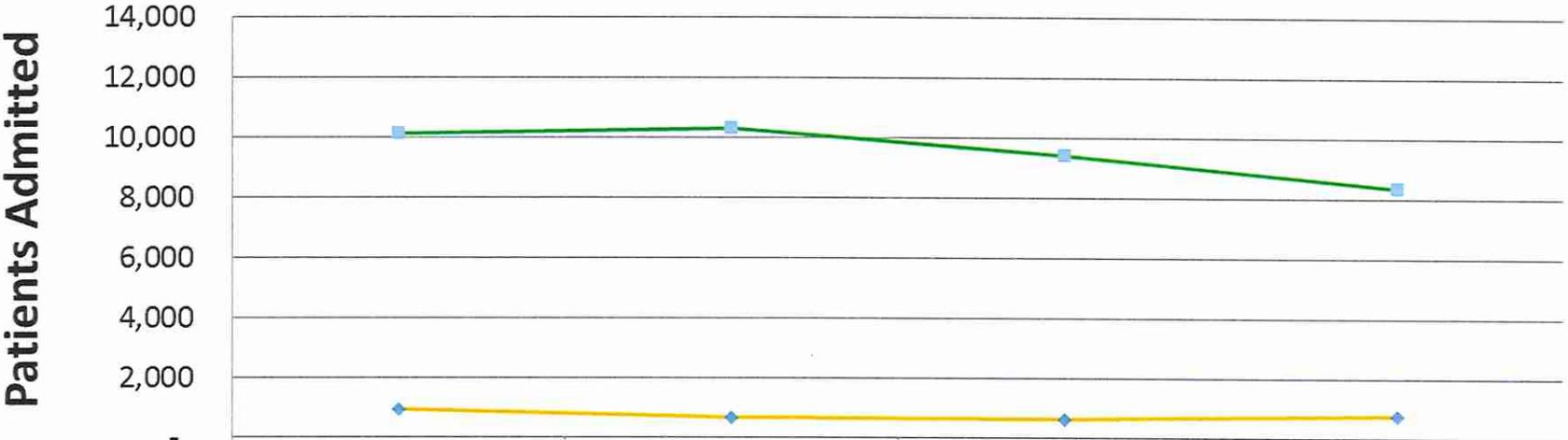
Reporting Time Period: The data in this report reflects three (3) years or the last twelve (12) quarters, unless specified otherwise.

Figure 1. 2015-2018
BHD Police Diversion Status



*There have been no police diversion in the last 8 year, last police diversion was in 2008

**Figure 2. 2015-2018
PCS and Acute Adult Admissions**



	2015	2016	2017	2018 Proj.
Acute Adult Admissions	965	683	656	756
PCS Admissions	10,173	10,334	9,429	8,360

*PCS Admissions = Projected Waitlist Clients + Projected PCS Clients

Figure 3. 2015-2018
Percent of Time on Waitlist Status



*Waitlist Percent = Waitlist Duration/ (Number of day in the quarter*24)

Figure 4. 2015-2018
Patients on Hospital Transfer Waitlist



Figure 5. Waitlist Events
2015-2018

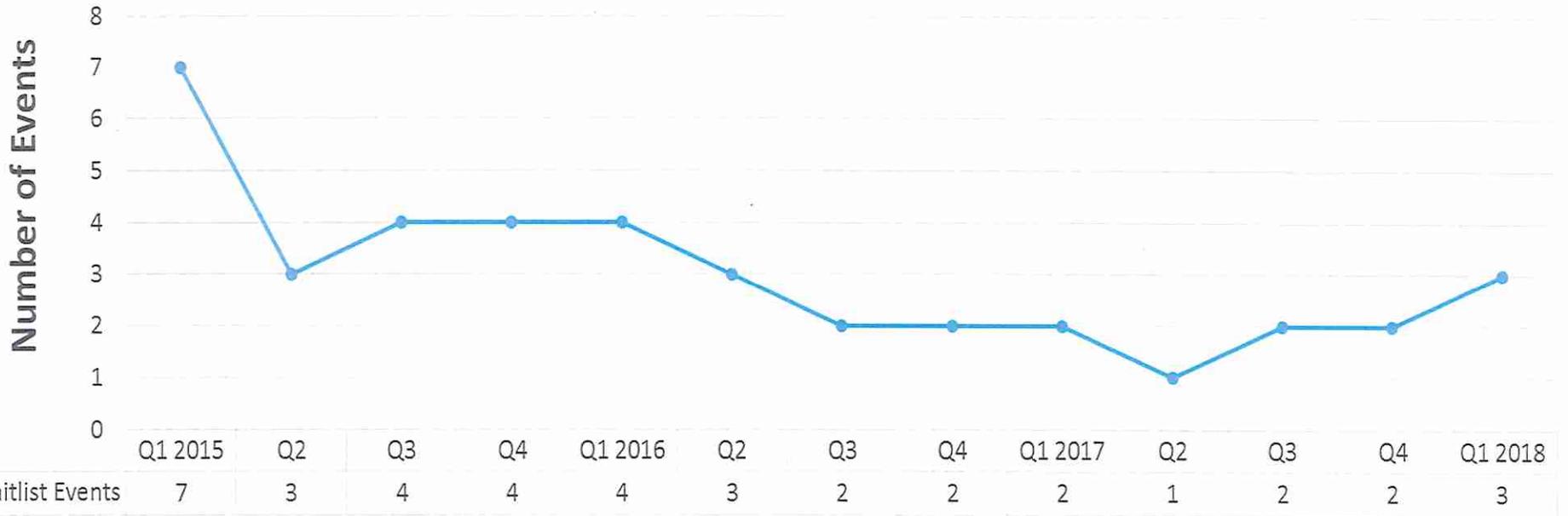


Figure 6. 2015-2018
Average Duration of Event
(Hours)

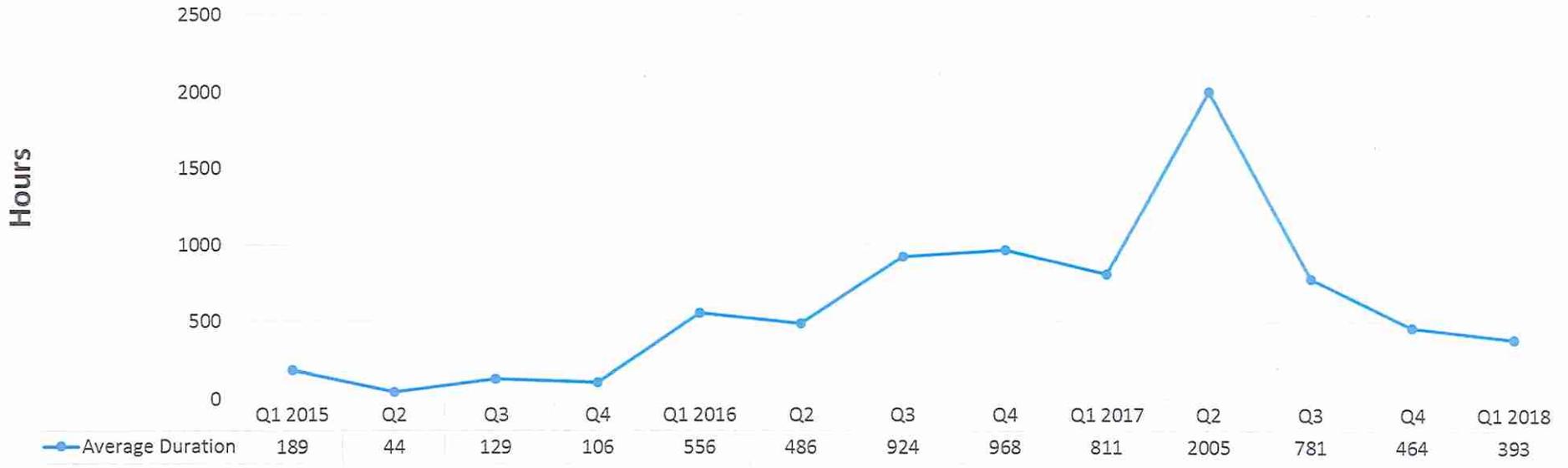
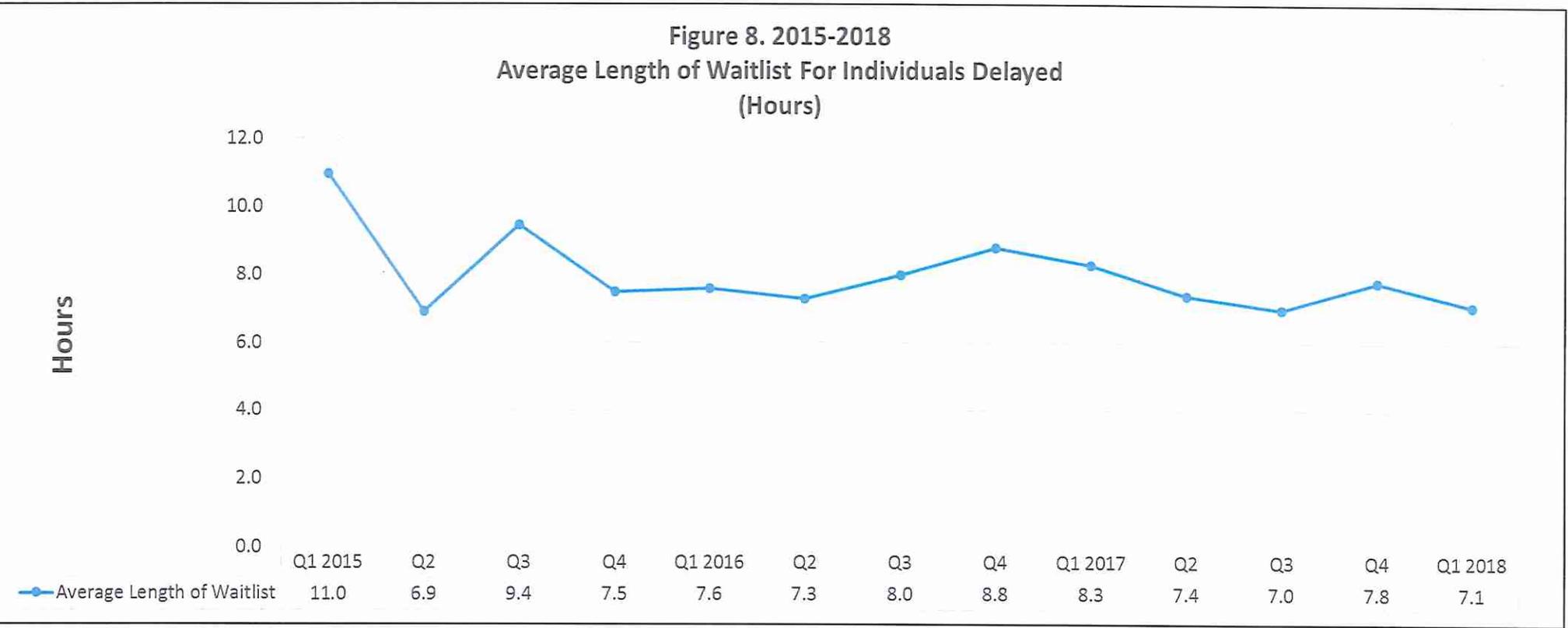


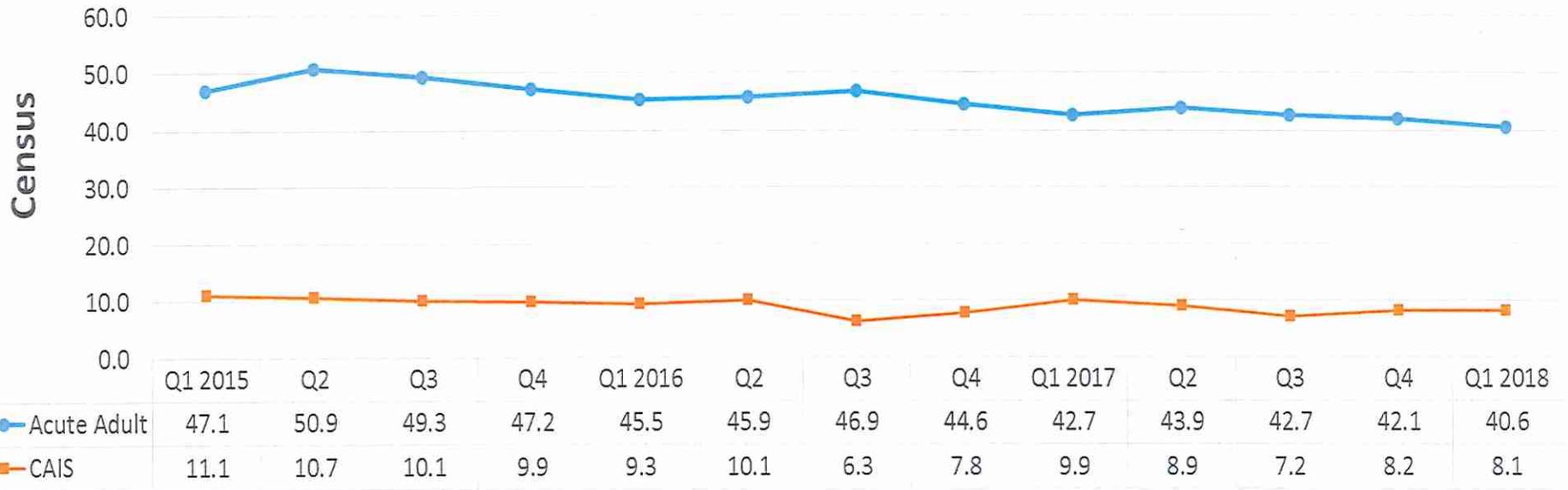
Figure 7. 2015 - 2018
Median Wait Time For Individuals Delayed
(Hours)



Figure 8. 2015-2018
Average Length of Waitlist For Individuals Delayed
(Hours)

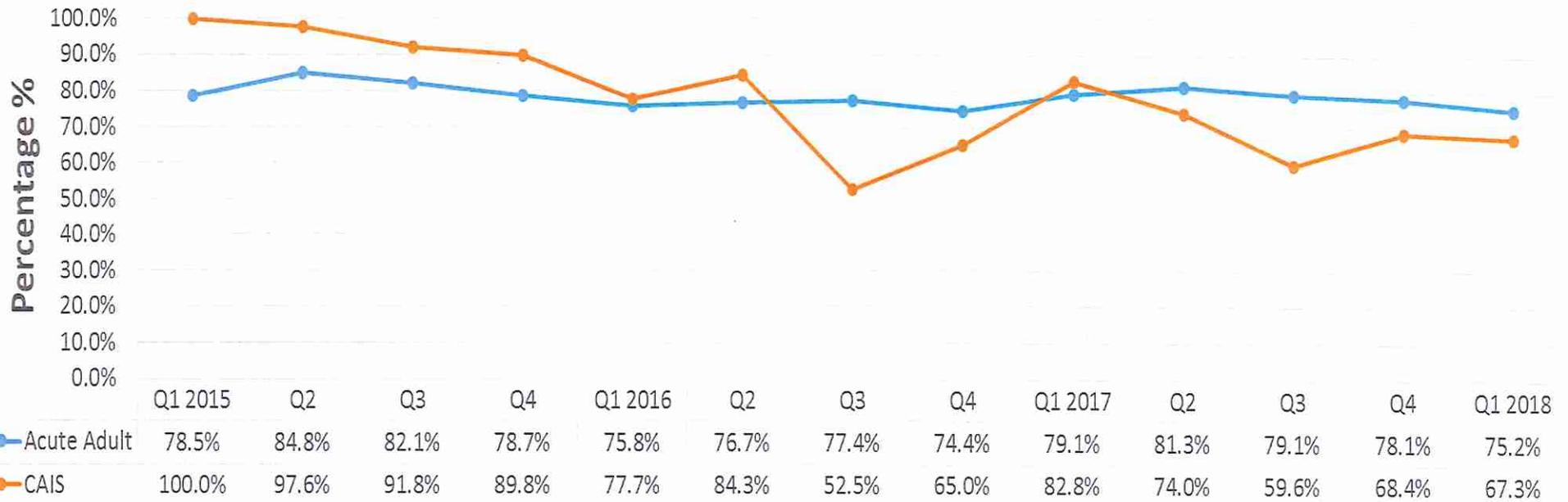


**Figure 9. 2015-2018
Acute Adult/CAIS
Average Daily Census**



*Average Daily Census = Patient days/amount of days per quarter

Figure 10. 2015-2018
Acute Adult/CAIS
Budgeted Occupancy Rate



*Occupancy Rate = Patient's Day/ (Number of day in the quarter*number of beds budgeted)

*Reduced staffing impacted operation bed count

Figure 11. 2015-2018
Number of patients on waitlist for 24 hours or greater



Figure 12. 2015-2018
Patients on waitlist for 24 hours or greater as a percentage of number of clients waitlisted



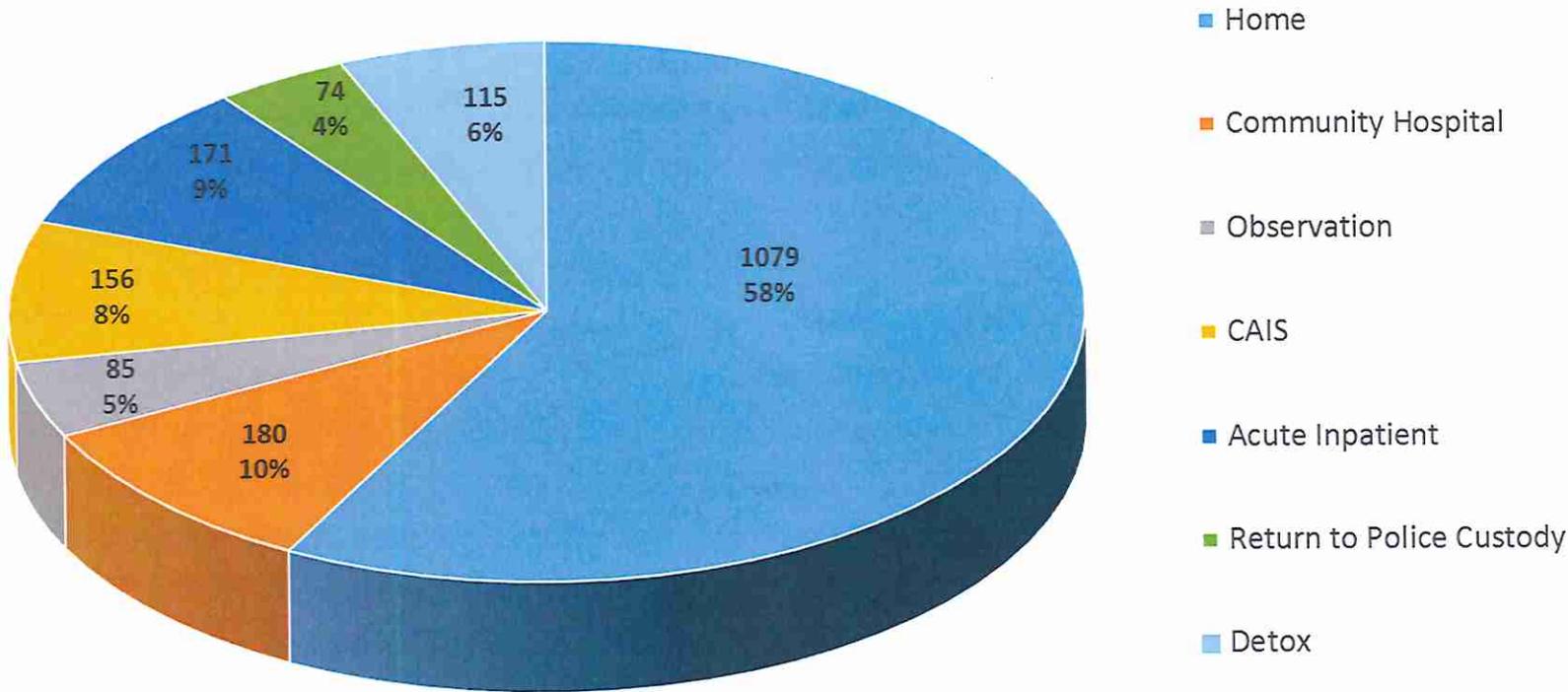
*Percent = Number of Patients on waitlist for 24 hours or greater/Number of Clients Waitlisted

Figure 13. 2015-2018
Patients on waitlist for 24 hours or greater as a percentage of PCS Admission



*Percent = Number of Patients on waitlist for 24 hours or greater/PCS Admission

Figure 14. 2018 Q1
Disposition of all PCS admission



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

DATE: March 22, 2018

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

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

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

Issue

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

Background

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

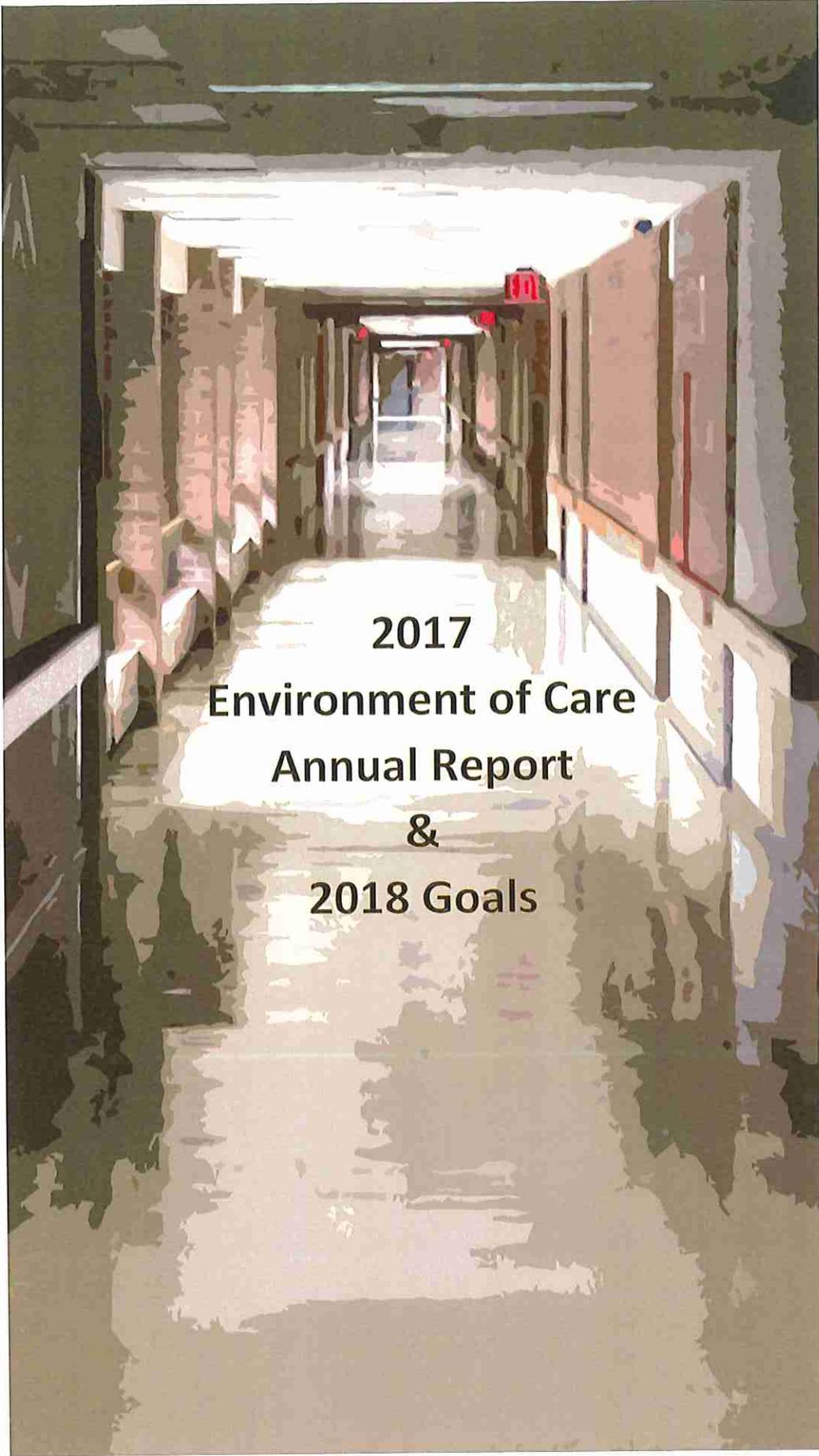
Recommendation

It is recommended that the Mental Health Board accept and approve the 2017 Annual Report of the Environment of Care program and the 2018 Environment of Care Management Plans as the basic framework for managing risks and improving safety in the environment.

Introduction

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached is the 2017 Annual Review of the Environment of Care Program and the 2018 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2017 major improvements were made in the area of building security through the replacement of deteriorating doors and frames. Wiring alterations were made to separate the required branches of electricity in hospitals. Life Safety Branch (related to fire alarm and egress), Critical Branch (related to direct patient care), and Equipment branch (related to mechanical systems). In August, BHD began a rotating on call roll as part of the Milwaukee Regional Medical Center's newly implemented Emergency Coordination Plan (ECP), which focuses on coordinating efforts and resources of the 6 partner organizations.

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.



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

Introduction

The Environment of Care Committee focuses on general safety and regulatory requirement compliance of the environment of care. Attached are the 2017 Management Plans that operationalize the standards and set forth monitoring activities as well as target areas for improvement. In 2016 improvements were made in the area of building security through the implementation of a new Public Safety Department that will enhance visitor experience and tracking. Additional work related to dividing the power provided by the emergency generator into the various required branches (critical, life safety, and mechanical) continues to move BHD toward compliance with The Joint Commission's requirements for emergency power preparedness.

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

Environment of Care 2017 Annual Report and 2018 Goals

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

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

Highlights of achievements and 2018 Goals:

GENERAL SAFETY

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

1. A response time of 3 days is expected for urgent product recalls and alerts per the RASMAS system. In 2017 the response rate of 97% was attained. There were a total of 1430 urgent recalls/alerts issued during 2017. Only 7 items involved in an alert or recall of a product purchased by BHD. All product alerts/recalls were resolved with no negative impact on patient care.
 - The goal of responding within the 3 day timeframe 95% of the time was achieved. Recommend continuing this goal in 2018
2. Rounds documentation is still in development.
 - The goal was not met in 2017. Recommend continuing with this goal in 2018. The rounding system is being adjusted to provide more accurate tracking of deficiencies and correction timeframes. Responders need additional training regarding entering corrections into the system.
3. In 2017 the total number of reported fire setting contraband items that were detected on patient units was 0. This meets the goal of having less than 4 contraband items on patient units.
 - In 2017 the goal will be to maintain the 2016 level of having less than 4 incidents. This item will be moved to general safety area and be reported on via incident reporting data.

SECURITY

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

1. Security Department Roll Call Updates: In 2017, 52 Roll Call Updates were issued. The updates are intended to keep officers abreast of current BHD situations and procedural changes. Additionally, roll calls are used to increase officer accountability and training update opportunities.
 - The goal for 2017 was met. The goal for 2018 will be to have a new Roll Call Update posted for each week of the year. Roll call updates will not only be posted for officer review, but will be verbally reviewed with officers by supervisory staff of BHD Security.
2. Theft and Vandalism: In 2016 there were 6 thefts, 3 minor property damage auto accidents. In 2017 there were two Vandalism incidents 0 thefts.
 - The goal for 2018 will be limit the number of incidents to less than or equal to 3.

3. Unauthorized absences from locked units: In 2016 – 7 absences from locked units, In 2017 –5 absences from a locked unit.
 - Although unauthorized absences are an inherent and recognized risk at BHD, no unauthorized absence is acceptable. As such, the goal for 2018 will remain to keep the total number of absences to zero.

4. Unsecured Area incidents: In 2016 there were 27 occurrences where a secured door was found unsecured. Most of these occurred when there was a damaged door and/or mechanical issue preventing the door from latching correctly. 2017 there were two incidents reported that exit door was left propped open with a safety cone and piece of paper by employee. BHD has been systematically replacing doors that have been deteriorating.
 - In 2018, the goal will continue to reflect the occurrence of both human factors as well as mechanical failures. The goal will be to have 10 or fewer incidents in 2018.

5. In 2016 the Security Department tracked the number of camera outages and will report them to the Environment and Engineering Services Department (EES) within 1 hour. In 2017 there were 3 camera outages reported, all were reported to EES within the 1 hour time frame.
 - The goal for 2018 is for the Security Department to make proper notification to BHD contacts within 1 hour of any noticeable outage. Security Department will strive to have no more than 6 occurrences where notification takes more than 1 hour.

Additional goals may be added during the year

HAZARDOUS MATERIALS AND WASTE

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

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

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

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

EMERGENCY MANAGEMENT

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

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

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

FIRE PREVENTION

In 2017 BHD made improvements to fire safety equipment and features. These improvements include replacement of fire doors and frames that have deteriorated from weather and that take more than 5 foot pounds to open. Additionally, the sprinkler heads were systematically changed out to a newer anti-ligature variety.

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

UTILITIES MANAGEMENT

In 2017, wiring alterations were made to separate the required branches of electricity in hospitals. Life Safety Branch (related to fire alarm and egress), Critical Branch (related to direct patient care), and Equipment branch (related to mechanical systems).

1. Number of past due P.M.'s or Preventative Maintenance work orders. In 2016 the EES department posted a completion rate of 71 % for all P.M.'s or preventative work orders performed at the Behavioral Health Complex. In 2017 a 91.74% completion rate was achieved.
 - In 2018 the goal for EES will be to achieve a minimum of a 90% completion rate for all Critical and Life Safety Systems P.M.'s or preventative maintenance work orders.
2. Percentage of Utility Components labeled and inventoried: In 2016 100% of shut off valves were labeled and inventoried for the Behavioral Health Division. In 2017 the goal for EES was to have the branch valves labeled and inventoried. EES achieved a 50 % completion..
 - In 2018 the goal will be to have the remainder of the branch valves labeled and inventoried.
3. The percentage of times the emergency generator testing failed: The emergency generator for the 9455 building did not fail any monthly testing. BHD had one electrical failure during the year. The emergency generator kicked in immediately and full power was restored within two hours.
 - Generator testing failures will be recorded for 9455 building in 2018.
4. There was anecdotal information that patients may be breaking pencils and other objects off in door locks as a way to prevent staff access. This poses a significant risk to patient safety. Tampering with the mechanical door locks where repair by a locksmith is required will be tracked in 2017 as a way to determine the extent of

this risk. The tampering of mechanical door locks was limited to only one event that was immediately taken care of.

- This item will be eliminated in 2018.

MEDICAL EQUIPMENT

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

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

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

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

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

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

EDUCATIONAL GOALS

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

Training topics Training topics for 2018 quarterly trainings through BHD or County wide training programs will include 4 of the following topics and 85% of staff will achieve a passing score.

- Regulated Medical Waste
- Active Shooter
- Workplace Safety
- Cyber Security
- OSHA Safety
- Fire Safety
- Emergency Communications

The Environment of Care Committee recommends the following key goals for 2018:

- **To reduce the amount of infectious waste generated to below 50# per month, by eliminating inappropriate disposal of non-infectious waste and by determine alternate products where feasible.**
- **To improve staff knowledge of BHD emergency response plans, and procedures.**



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

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 3-8)~~(EC 01.01.01 – EP 4-9)

MCBHD locations include:

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

OBJECTIVES:

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

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

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

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

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

ENVIRONMENT OF CARE (EC) COMMITTEE:

A. EC COMMITTEE MEMBERSHIP:

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

B. EC COMMITTEE SUMMARY:

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

2. The Hospital Administrator appoints an EC Committee Chairperson and Safety Officer, who develop, implement, and monitor the EC Program. The remaining membership of the EC Committee includes representatives from administration, clinical areas and support services. The committee member goals and responsibilities are developed and reviewed as part of the program's annual evaluation.
3. The ~~Assistant Hospital Administrator 2, Support Services~~ Safety Officer shall serve as the Chairperson of the EC Committee and oversee its membership.
4. The EC Committee Chairperson is responsible for the following issues related to Safety:
 - a. Advise Administration, Medical Staff and Management Teams on safety matters requiring their attention and action.
 - b. Make recommendations necessary to establish or modify policies to the EC Program
 - c. Monitor the effectiveness of policy or procedural changes made or recommended.
 - d. Appoint committees, as appropriate, with specific responsibilities in relation to patient, employee, facility, community or environmental safety.
 - e. Appoint the Chairperson to any EC related subcommittees (standing or ad hoc).
 - f. Ensure minutes of all EC related committees are kept and reviewed, as appropriate.
 - g. Provide leadership and consultation for any subcommittee chairpersons.
 - h. Monitor subcommittees for effectiveness and compliance with regulatory agencies.
 - i. Evaluate committee and subcommittee members and chairperson's performance.
 - j. Ensure that the following receive timely information on the EC Program:
 - Executive Team
 - Medical Staff
 - Quality Management Services Committee (QMSC)
 - Department Directors/Managers
5. Each EC Subcommittee Chairperson shall oversee the subcommittee and provide the following support:
 - a. Ensure minutes are kept and submitted to the Chairperson of the EC Committee in a timely manner.
 - b. Make recommendations necessary to establish or modify policies to the EC Program.
 - c. Report recommendations for policy changes and/or safety procedures to the EC Committee Chairperson.
 - d. Evaluate the committee and membership for effectiveness.
 - e. Take all corrective actions necessary on items referred to them by and EC Committee member
 - f. Refer safety concerns to the proper subcommittee chair and the EC Committee Chair.
6. The employee has responsibilities regarding their environment. BHD recognizes its responsibility to engineer or administrate a solution for any known hazards under Occupational Safety & Health Administration (OSHA) regulations. The employee is then to be trained and the hazard addressed at staff level. Staff responsibilities include:

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

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

GENERAL RESPONSIBILITIES:

1. ADMINISTRATION

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

2. ENVIRONMENT OF CARE COMMITTEE AND SAFETY OFFICER

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

3. BHD DIRECTORS, MANAGERS AND SUPERVISORS

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

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

4. BHD EMPLOYEES

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

EC COMMITTEE FUNCTIONS

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

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

RESPONSIBILITIES SPECIFIC TO THE VARIOUS MANAGEMENT AREAS OF THE EC

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

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

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

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

- i. Annually, assess the effectiveness of implemented recommendations.
 - j. Report Quarterly on activities of Security Management.
3. ~~EMERGENCY MANAGEMENT (EM 01.01.01; EM 02.01.01; EM 02.02.01; EM 02.02.03; EM 02.02.05; EM 02.02.09 EM 02.02.11; EM 02.02.13; EM 02.02.15; EM 03.01.01 & EM 03.01.03)~~ **EMERGENCY MANAGEMENT (EM 01.01.01; EM 02.01.01; EM 02.02.01; EM 02.02.03; EM 02.02.05; EM 02.02.07; EM 02.02.09 EM 02.02.11; EM 02.02.13; EM 02.02.15; EM 03.01.01 & EM 03.01.0; EM 04.01.01)**
- a. Discuss topic monthly or more frequently upon the call of the chairperson and record minutes.
 - b. Create and update annually the Emergency Operations Plan (EOP).
 - c. Incorporate all BHD departments in all related activities and Emergency Management Policies and Procedures.
 - d. Establish a process, and conduct a review of all Emergency Management related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/ program policies as appropriate.
 - e. Develop and monitor internal and external emergency management programs, with multi-discipline input, affecting all departments.
 - f. Evaluate and modify Emergency Operations Plans (EOP) and exercises.
 - g. Coordinate and evaluate the semi-annual emergency management exercise.
 - h. Monitor, evaluate, and implement changes to the ~~disaster manual~~ **EOP** required by federal, state, local, and national organizations, as appropriate.
 - i. Maintain EOP, emergency management policies and procedures and critique and approve all in-house designated disaster assignment areas and department standard operating procedures **annually a minimum of every three years or earlier if modifications are needed.**
 - j. Annually, develop goals, objectives and performance standards for Emergency Management.
 - k. Annually, assess the effectiveness of emergency management programs.
 - l. Report quarterly on activities of Emergency Management.
4. **HAZARDOUS MATERIALS AND WASTE MANAGEMENT (EC 02.02.01 & EP 1, 3, 4, 5-12) EC 01.01.01 EP 6; EC 02.02.01 & EP 1, 3, 4-12,19)**
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
 - b. Create an annual Hazardous Materials and Waste Management Plan.
 - c. Incorporate all BHD departments in all related activities and Management Plans.
 - d. Assist with the creation of the hospital wide right - to - know program (RTK).
 - e. Ensure that an annual review of chemical inventories occurs.
 - f. Evaluate the educational needs for RTK and hospital waste programs and make appropriate recommendations.
 - g. Monitor and assess waste control procedures and recommend policy/procedure changes as needed.
 - h. Monitor city, state, and federal environmental laws and regulations and recommend policy/procedure changes as required.
 - i. Evaluate products to promote hazardous materials and waste minimization for purchase or use.

- j. Review hazardous materials and/or waste handling problems, spills or employee incidents and make recommendations for process improvement, personal protective equipment and environmental monitoring.
 - k. Monitor program recommendations, changes or implementations for effectiveness.
 - l. Annually, assess the effectiveness of the hazardous materials and waste management programs for selection, storage, handling, use and disposal and recommend changes as appropriate.
 - m. Review the Medical Waste Reduction Policy, and complete the Infectious Waste Annual Report with the DNR when required.
 - n. Conduct periodic audits of medical waste storage and disposal locations for presence of non regulated medical waste.
 - o. Report quarterly on activities of Hazardous Materials and Waste Management.
5. **FIRE PREVENTION/LIFE SAFETY MANAGEMENT** (EC 01.01.01 EP 7 ~~(EC 02.03.01; EC 02.03.03; EC 02.03.05 and LS 01.01.01 through LS 03.01.70)~~ EC 02.03.01; EC 02.03.03; EC 02.03.05 and LS 01.01.01 through LS 03.01.70)
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
 - b. Create an annual Fire Prevention Plan.
 - c. Incorporate all BHD departments in all related activities and Management Plans.
 - d. Coordinate and conduct fire drills once per quarter per shift in all patient care buildings. (Twice this if Interim Life Safety Measures are implemented.)
 - e. Analyze and trend the results of fire drills, actual fire events or false alarms and recommend appropriate changes or education.
 - f. Review inspection, preventive maintenance and testing of equipment related to the Life Safety Program.
 - g. Review agency inspections conducted or compliance survey reports. (i.e. Fire Marshal (state and local), Insurance, State Department of Quality Assurance, etc.)
 - h. Review changes/upgrades to the fire protection system; failures/problems discovered with the system, causes and corrective actions taken.
 - i. Review summaries of construction, renovation or improvement life safety rounds.
 - j. Assess Interim Life Safety Measures implemented as a result of construction or other Life Safety Deficiencies and review and plans of corrections
 - k. Monitor program recommendations, changes or implementations for effectiveness.
 - l. At each meeting, assess the status of the facility Statement of Conditions™ and compliance with the Life Safety Code.
 - m. Establish a process, and conduct a review of all Fire/Life Safety related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
 - n. Annually, develop goals, objectives and performance standards for Fire Prevention.
 - o. Annually, assess the effectiveness of the Fire Prevention Program, policies/procedures and educational components.

- p. Report quarterly on activities of Fire Prevention Management.
6. **MEDICAL EQUIPMENT MANAGEMENT (EC 01.01.01 EP 8; EC 02.01.01 EP 40 and 11; EC 02.04.0: and EC 02.04.03)**
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
 - b. Create an annual Medical Equipment Management Plan.
 - c. Incorporate all BHD departments in all related activities and Management Plans.
 - d. Monitor medical equipment hazard recalls. Review inspection, tests, maintenance and education policies for medical equipment and device users.
 - e. Monitor for compliance with the FDA Safe Medical Device Act.
 - f. Review medical equipment management program, problems, failures and user errors that adversely affect patient care or safety and the corrections or follow-up actions taken.
 - g. Review and analyze major problems or trends identified during preventative maintenance and make appropriate recommendations.
 - h. Monitor on-going medical equipment education programs for employees related to new equipment, replaced or recalled equipment, certification and/or recertification and user errors.
 - i. Review requests and make recommendations for the purchase of medical equipment.
 - j. Monitor the entry and use of medical equipment entering the facility from sources outside of the medical equipment program. (i.e. rental equipment).
 - ~~Monitor the use of personal protective equipment associated with the use of medical equipment management, i.e. radiology services.~~
 - k. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the medical equipment program or needs.
 - l. Establish a process, and conduct a review of all Medical Equipment related Policies and Procedures for BHD, and make recommendations for revisions or new facility wide or departmental/program policies as appropriate.
 - m. Review contingency plans in the event of medical equipment disruptions and or failures, procedures for obtaining repair services and access to spare equipment.
 - n. Annually, develop goals, objectives and performance standards for the committee.
 - o. Annually assess the effectiveness of the medical equipment management program.
 - p. Report quarterly on activities of Medical Equipment Management.
7. **~~UTILITY MANAGEMENT (EC 02.05.01; EC 02.05.03; EC 02.05.05; & EC 02.05.07)~~ UTILITY MANAGEMENT (EC 01.01.01 EP 9; EC 02.05.01; EC 02.05.03; EC 02.05.05; & EC 02.05.07)**
- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
 - b. Review/revise the Utility Management Plan annually.
 - c. Incorporate all BHD departments in all related activities and Management Plans.
 - d. Review compliance survey reports conducted by regulatory agencies and changes in regulations that may affect the management of Utility Systems.
 - e. Review incidents related to emergency testing, system upgrades, system shutdowns, preventative maintenance problems, major problems with emphasis on the impact on patient care and corrective

actions.

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

8. OTHER COMMITTEES

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

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

~~Hospital Incident Command System Committee—Although this is not a sub-committee, this existing department has a relationship that submits information on a 'need to know' basis, identifying concerns.~~

9. EOC EDUCATION (EC 03.01.01)

- a. Discuss topic quarterly or more frequently upon the call of the chairperson and record minutes.
- b. Incorporate all BHD departments in all related activities and Management Plans.
- c. Track and trend department compliance with annual~~housewide~~ in-service attendance.
- d. Review and assist in the development of educational programs for orientation and annual~~housewide~~

in-services.

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

INTENT PROCESSES

1. Issue Assessment (EC 04.01.01)

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

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

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

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

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

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

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

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

4. Safety Officer Appointment (EC 01.01.01 EP 1)

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

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

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

ORIENTATION AND EDUCATION

1. **New Employee Orientation:** ~~(EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3; LD 03.01.01.1-10)~~ EC 03.01.01 EP 1 & 2; HR 01.04.01 EP 1 & 3; LD 03.01.01.1-5 Safety Education begins with the New Employee Orientation program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis
2. **Annual Continuing Education:** ~~(HR 01.05.03 EP 1); (HR 01.05.03 EP 1-13)~~ Safety Education is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees.
3. **Department Specific Training:** (EC 03.01.01 EP 1&2; HR 01.04.01 EP 1&3) ~~(EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-3)~~ Directors/ Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards.
4. **Contract Employees:** (EC 03.01.01 EP 1&2; HR 01.04.01 EP 1&3) ~~(EC 03.01.01 EP 1-3; HR 01.04.01 EP 1-7)~~ Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year.

PERFORMANCE MONITORING

(EC 04.01.05)

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

Safety Management

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

Security Management

1. Track the frequency of weekly roll-call meetings. (Goal=52)

2. Decrease the number of Theft/Vandalism incidents. Goal \leq 53 incidents (This includes theft of patient belongings)
3. Number of incidents of unauthorized Absence from locked unit. (Goal = 0)
4. Number of incidents where a secure area is found unsecured. (Goal \leq 10 times)
5. Camera outages will be reported to Operations within 1 hour. (Goal \leq 6 times)

Hazardous Materials Management

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

Emergency Management

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

Fire Prevention

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

Utilities Management

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

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

~~Measure the number of mechanical door locks requiring repair by a locksmith due to tampering- (baseline)~~

Medical Equipment Management

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

ANNUAL EVALUATION

(EC 04.01.0501)

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

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

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

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

Attachments:

No Attachments

Approval Signatures

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

COPY



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

Safety Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

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

PURPOSE:

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

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

SCOPE:

The Safety Management Plan establishes the organizational structure within which a safe environment of care is established, maintained, and improved at MCBHD facilities. In addition to addressing specific responsibilities, general safety, and employee education programs the plan is in all efforts directed toward managing the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP34)

MCBHD locations include:

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

OBJECTIVES:

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable safety regulations, and evaluate the effectiveness of the safety program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. (EC 01.01.01-EP34)

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

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

INTENT PROCESSES:

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

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

B. Incident Reporting and Investigation – (EC 04.01.01 EP1, 3, 4, 5) Patient and visitor incidents, employee incidents, and property damage incidents are documented and reported quarterly to the EC Committee and the individual program executive committees. The reports are prepared by the Quality Improvement Department. The report and analysis are reviewed by the EC Committee for identification of trends or patterns that can be used to make necessary changes to the Safety Management Program and control or prevent future occurrences.

C. Environmental Tours – (~~EC 04.01.01 EP12-14~~) A team of staff including the Safety Officer actively participates in the management of the environmental rounds process. Environmental Rounds are conducted regularly as outlined in the EC Management Plan, to evaluate employee knowledge and skill, observe current practice, and evaluate environmental conditions. Results from environmental rounds serve as a tool for improving safety policies and procedures, orientation and education programs, and employee performance. The Safety Officer provides summary reports on activities related to the environmental tour process to the EC Committee. Rounds are conducted at least every six months in all areas where patients are served and at least annually in all areas where patients are not served.

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

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

- D. Product/Medication/Equipment Safety Recalls – (EC 02.01.01 EP11)** Information regarding a recalled product, medications, or equipment is distributed via an internet based clearing house service (RASMAS). The EC Committee will review and report on recall and alert compliance quarterly
- E. Examining Safety Issues - (EC 04.01.03 EP ~~1-2~~2)** The EC Committee membership includes representatives from Administration, Clinical Programs, Support Services and Contract Management. The EC committee specifically discusses safety concerns and issues a minimum of six (6) times per year, and incorporates information on Safety related activities into the bi-annual report.
- F. Policies and Procedures –** The Safety Officer is responsible for coordinating the development of general safety policies and procedures. Individual department managers are responsible for managing the development of departmental specific safety policies and procedures, which include but is not limited to, safe operations, use of hazardous equipment, and use of personal protective equipment. The Safety Officer assists department managers in the development of new department safety policies and procedures.

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

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

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

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

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

EMPLOYEE HEALTH AND WELFARE

- A. Program Directors and Managers are responsible for implementing and enforcing employee workplace safety. Directors and Managers are provided with appropriate safety program guidelines and are directed to maintain a current awareness of the Safety Program, and to ensure its effective implementation within their department. Each employee is responsible for completing safety education programs and for understanding how the material relates to his or her specific job requirements. Employees are responsible for following the safety guidelines set forth in the Safety Program. Employee attendance at educational events is monitored and a list of non-attendance is provided to Managers/Directors for follow-up.
- B. Employees report work related injuries, occupational illnesses or exposure to contagious diseases to their supervisor, the infection preventionist, and by completing a First Notification of Injury Form. Reports of employee incidents are recorded by the Milwaukee County Risk Management Department and ~~tabulated for trending by the Quality Management Department and/or Safety Officer for reporting to the Safety Committee~~ reported to BHD Executive Team annually.
- C. BHD reviews and analyzes the following indicators:
1. Number of OSHA recordable lost workdays
 2. Injuries by cause
 3. Needle sticks and body fluid exposures

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** (EC 03.01.01 EP ~~4-31 & 2~~; HR 01.04.01 EP ~~4-31 & 3~~; LD 03.01.01 EP ~~4-401-5~~) The Safety Education begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific safety training, and a series of programs required for all employees on an annual basis
- B. **Annual Continuing Education:** Safety Education is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. (HR 01.05.03 EP ~~4-431~~)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific safety policies and procedures and specific job related hazards. (EC 03.01.01 EP ~~4-31 & 2~~; HR 01.04.01 EP ~~4-31 & 3~~)

- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 4-31 & 2; HR 01.04.01 EP 4-71 & 3)

PERFORMANCE MONITORING

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

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

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

SMOKING POLICY –

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

BHD is committed to the promotion of healthy environments in all programs. All medical evidence indicates that smoking is contrary to this objective. In support of this objective, effective November 16, 2007 the use of all tobacco products (cigarettes, e-cigarettes, vaporizing (vape) pens, cigars, pipes, chewing tobacco, and other smokeless tobaccos) was prohibited on MCBHD premises including property owned, leased, or otherwise operated by MCBHD. All staff, patients, residents, visitors, renters, vendors, and any other individuals on the MCBHD grounds are prohibited from using tobacco products. Smoking materials are removed from all patients upon admission.

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

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

Attachments:

No Attachments

Approval Signatures

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

COPY



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

Security Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

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

PURPOSE:

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

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

SCOPE:

The Security Management Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. In addition to addressing specific responsibilities, general security, and employee education programs the plan is in all efforts directed toward managing the activities of the employees so that the risk of injuries to patients, visitors and employees are reduced, and employees can respond effectively in an emergency. (EC 01.01.01-EP45)

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

MCBHD locations include:

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

OBJECTIVES:

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

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable security regulations, and evaluate the effectiveness of the security program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the ET along with any other program or department necessary for effective functioning. (EC 01.01.01-EP45)

INTENT PROCESSES:

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

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

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

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

- C. **Reporting and Investigation (EC 04.01.01 EP 1&6; EC 04.01.03 EP 4-22)** – Security and Safety events are recorded in the MCBHD electronic Incident reports are completed Safety Event Reporting System by a witness or the staff member to whom a patient or visitor incident is reported. ~~The completed reports are forwarded to the~~ employee's Supervisor or location supervisor for and the Risk Manager conducts an investigation and recommends/initiates follow up ~~and then sent to the Quality Management Services Department. The Quality and Risk Manager works with actions as~~ appropriate ~~staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.~~

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

This incident analysis is intended to provide an opportunity to identify trends or patterns that can then be used to identify necessary changes to the Security ~~Supervisor collaborate to conduct an aggregate~~ Management Program. The findings of such analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action in order to control or prevent future occurrences.

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

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

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

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

- E. **Access and Egress Control (EC 02.01.01 EP 8)** – Various methods of control are used based on risk levels.
- **High Risk** area controls include key pad access or lock and key methods with continuous staffing and policy governing visitor and staff access.
 - **Moderate Risk** area controls include lock and key methods with limited access per policy and key distribution.
 - **Low Risk** area controls include lock and key methods only during times outside of identified business hours
 - **Security/Public Safety and/or operations staff** will unlock doors as scheduled and make rounds at periodic intervals to maintain a safe and orderly environment. Security is stationed in the Psychiatric Crisis Center 24 hours per day, 7 days per week, and at the Main entrance desk from 6:00 a.m. to 8:30 p.m. and the Rear Employee Entrance 53A Ramp 24 hours per day, 7 days per week.
- F. **Policies and Procedures (LD 04.01.07 EP 1-2)** – Security related policies are reviewed a minimum of every three years and distributed to departments as appropriate. The Security Supervisor assists department heads with the development of department or job specific environmental safety procedures and controls.
- G. **Vehicular Access (~~EC 02.02.02 EP 8~~)** – Vehicular access to the Psychiatric Crisis Service area is controlled by Security 24/7 and limited to emergency vehicles only.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the Security Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific security training, job-specific security training, and a series of programs required for all employees on an annual basis (**EC 03.01.01 EP ~~4-31~~ & 2**; **HR 01.04.01 EP ~~4-31~~ & 3**; **LD 03.01.01 EP ~~4-401-5~~**)
- B. **Annual Continuing Education:** Education regarding security is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. (**HR 01.05.03 EP ~~4-431~~**)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific security related policies and procedures and specific job related hazards. (**EC 03.01.01 EP ~~4-31~~ & 2**; **HR 01.04.01 EP ~~4-31~~ & 3**)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (**EC 03.01.01 EP 1-3**; **HR 01.04.01 EP ~~4-71~~ & 3**)

PERFORMANCE MONITORING

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

- A. Ongoing performance monitoring is conducted for the following performance monitors:
1. Track the frequency of weekly roll-call meetings. (Goal=52)
 2. Decrease the number of Theft/Vandalism incidents. Goal ≤ **53** incidents (This includes theft of patient belongings)

- 3. Number of incidents of unauthorized Absence from locked unit. (Goal = 0)
 - 4. Number of incidents where a secure area is found unsecured. (Goal ≤ 10 times)
 - 5. Camera outages will be reported to Operations within 1 hour. (Goal ≤ 6 times)
- B. The Safety Officer and EC Committee oversee the development of the Security related performance monitors. Data from these performance monitors are discussed quarterly at the EC Committee and by the Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County-Wide Safety Committee. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

Attachments:

No Attachments

Approval Signatures

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



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

Hazardous Materials and Waste Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

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

PURPOSE:

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

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

SCOPE:

The HMWM Plan establishes the organizational structure within which HMW/RMW are handled, stored, and disposed of at MCBHD. This plan addresses administrative issues such as maintaining chemical inventories, storage, handling and use of hazardous materials, exposure monitoring, and reporting requirements. In addition to addressing specific responsibilities and employee education programs, the plan is, in all efforts, directed toward managing the activities of the employees so that the risk of injury to patients, visitors and employees is reduced, and employees can respond effectively in an emergency. ~~(EC 01.01.01-EP5)~~ **(EC 01.01.01-EP 6)**

MCBHD locations include:

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

OBJECTIVES:

1. To increase staff knowledge of HMW/RMW and how to protect themselves from these hazards.
2. To maintain an accurate site and area specific inventory of hazardous materials including Safety Data Sheets (SDS) and other appropriate documentation for each location of MCBHD.

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

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

INTENT PROCESSES:

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

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

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

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

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

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

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

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

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

C. Emergency Procedures - (EC ~~02.02.01.04~~ EP 3 & 4) - Emergency procedures for hazardous material spills are located in the Environment of Care Manual. (See *Hazard Communication Program* policy and the *Chemical Release Control and Reporting Policy*) These policies include procedures for clean up of HMW spills within the building and grounds. A large (of such a volume that is no longer containable by ordinary measures) chemical spill or hazardous materials release would initiate an immediate request for emergency response of the local fire department.

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

reduce recurrences based on the investigation.

Exposures to levels of HMW in excess of published standards are documented using both the MCBHD [electronic Incident/Risk Management Report Safety Event Reporting System](#) and the Accident/[Loss Report Claims Reporting System](#). Post exposure treatment and follow up are determined by the treating physician and any recommended best practices for the type of exposure.

E. Managing Hazardous Chemicals - (EC ~~02.02.01.04~~ EP 5)

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

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

F. Managing Radioactive Materials - (EC ~~02.01.01 EP 6~~; EC 02.02.01 [EP 6](#); EC 02.02.01 EP18)

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

G. Managing Hazardous Energy Sources - (EC ~~02.02.01.04~~ EP 7)

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

H. Managing Hazardous Medications - (EC ~~02.02.01.04~~ EP 8; MM 01.01.03 EP 1, 2, & 3)

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

I. Managing Hazardous Gases and Vapors - (EC ~~02.02.01.04~~ EP 9 & 10)

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

J. ~~Managing Infectious & Regulated Medical Wastes including Sharps - (EC 02.01.01 EP 1; IC 02.01.01 EP 6)~~

~~RMW are managed for MCBHD by the contracted Housekeeping provider. The Housekeeping provider is~~

~~part of the EES Department and is responsible for distribution and collection of appropriate containers for the collection of RMW including medical sharps. The containers, provided by MCBHD, are leak-proof and puncture resistant. MCBHD nursing staff is responsible for placing filled containers in appropriate trash holding area for pickup and/or calling the EES Department to arrange pick up and replacement of filled RMW containers. EES staff collects the containers and transports them to the holding room. The containers are transported bi-weekly to a processing facility where the materials are sterilized and rendered unrecognizable. Once the materials are rendered harmless they are disposed of in accordance with applicable federal, state and local waste regulations.~~

~~Any staff member, patient or visitor exposed to RMW or who becomes injured due to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.~~

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

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

Wisconsin state statute defines the following:

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

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

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

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

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

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

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

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

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

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

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

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

K. Management of Required Documentation (permits, licenses, labeling and manifests) (EC

02.02.01.04 EP 11 & 12)

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

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

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

- L. **Storage of Hazardous Materials and Waste (EC 02.02.01 EP 19)** – Satellite areas of HMW or RMW are located within the generating department. These wastes are then transported to the HMW or RWM storage area(s) located on the soiled dock. A licensed hazardous waste or RMW disposal company transports hazardous or RMW off-site for disposal. The EC Committee performs quarterly inspections of the storage area(s).
- M. **Policies and Procedures** – HWM-related policies are reviewed a minimum of every three years and distributed to departments as appropriate.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the HMW/RMW Program begins with the New Employee Orientation Program for all new employees and continues on an ongoing basis with departmental specific training, job-specific training, and continued education required for all employees on an annual basis. Training includes generic information on the Hazard Communication Program, use and access to SDSs, labeling requirements of hazardous material containers, and the use of engineering controls, administrative controls, and PPE. (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3; LD 03.01.01 EP ~~4-40~~ 1-5)
- B. **Annual Continuing Education:** Education regarding HMW is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. (HR 01.05.03 EP ~~4-43~~ 1)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific HMW related policies and procedures as well as specific training on the health effects of the substances in the work place and methods to reduce or eliminate exposure. (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at MCBHD. Contracted Employees attend a New Employee Orientation program at MCBHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-71~~ & 3)

PERFORMANCE MONITORING

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

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

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

Attachments:

No Attachments

Approval Signatures

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



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

Fire/Life Safety Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

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

PURPOSE:

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

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

SCOPE:

The Fire Prevention Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. Fire Prevention is established to ensure that employees are educated, trained and tested in the fire prevention features of the physical environment and are able to react appropriately to a variety of emergency situations that may affect the safety of occupants or the delivery of care. **(EC 01.01.01-EP67)**

MCBHD locations include:

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

OBJECTIVES:

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

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

INTENT PROCESSES:

- A. **Protection from fire, smoke and other products of combustion** –The MCBHD occupancies are maintained in compliance with NFPA ~~401-2000~~101-2012 Life Safety Code ® (LSC). The Environment and Engineering Services (EES) Department completes the electronic Statement of Conditions and manages the resolution of deficiencies through the work order system or (upon participation in The Joint Commission) a Plan for Improvement (PFI) within the identified time frames. (EC 02.03.01-EP 1; LS 01.01.01 EP ~~4-3~~1-6)

Any remodeling or new construction is designed to maintain separations and in accordance with state and federal codes including NFPA LS ~~401-2000~~101-2012 Chapters 18/19 ~~and 38/39~~; NFPA 90A ~~2012~~ and NFPA ~~72-1999~~72-2010 and maintained to minimize the effects of fire, smoke, and heat. (ECLS 02.01.10 EP 1-10; LS 02.01.20 EP 1-32; LS 02.01.30 EP 1-25; and LS 02.01.50 EP 12)

The hospital has a written fire response plan and a fire prevention inspection program is conducted by EES, including state and local fire inspectors, to identify and correct fire hazards and deficiencies, to ensure free and unobstructed access to all exits, to reduce the accumulation of combustible and flammable materials and to ensure that hazardous materials are properly handled and stored. Copies of any reports are kept on file in the EES office. Fire Prevention issues are also noted on the environmental rounds tours. (EC 02.03.01-EP 4, & ~~9-8-10~~; LS 01.01.01 EP 45; LS 02.01.20 1-32)

Smoking is prohibited on the ~~main~~-MCBHD campus. (EC 02.01.03-EP 1, 4, & 6; ~~EC 02.03.01-EP 2~~)

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

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

- To minimize the danger from the effects of fire, including smoke, heat & toxic gases. (LS 02.01.10 EP ~~4-40~~1-15;)
- To maintain the means of egress and components (corridors, stairways, and doors) that allow individuals to leave the building or to move within the building (LS 02.01.20 EP ~~4-32~~1-42)
- To provide and maintain proper barriers to protect individuals from the hazards of fire and smoke. (LS 02.01.30 EP ~~4-25~~1-26)
- To provide and maintain the Fire Alarm system in accordance with NFPA 72-1999. (LS 02.01.34 EP ~~4-41~~1-10)
- To provide and maintain systems for extinguishing fires in accordance with NFPA 25-1998 (LS 02.01.35 EP 1-14)
- To provide and maintain building services to protect individuals from the hazards of fire and smoke including a fire fighters service key recall, smoke detector automatic recall, firefighters' service emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors LS 02.01.50 EP 47)

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

Note: The facility does not have any fireplaces or utilize any linen or trash chutes (LS 02.01.50 EP ~~4-33~~6, & ~~5-44~~8-13)

- C. **Proposed Acquisitions** –Capital acquisitions and purchases include a process to confirm appropriate specifications and materials. This includes bedding, curtains, equipment, decorations, and other furnishings to ensure that such purchases comply with current LSC guidelines. The facility also maintains policies that specify what employees, and patients can have in the facility/work areas as a way to control and minimize hazards. Currently portable space heaters and combustible decorations that are not flame retardant are not permitted in the healthcare occupancy. (LS 02.01.70 EP ~~4-41~~1-5)
- D. **Reporting and Investigation** – (EC 04.01.01 EP 9; EC 04.01.03 EP ~~4-22~~)– LSC and fire protection deficiencies, failures, and user errors are reported to the EES Department and, as appropriate, reviewed by the manager of the department. Summary information is presented to the EC Committee on a quarterly basis.
- E. **Interim Life Safety Measures** – (LS 01.02.01 EP ~~4-41~~1-15) Interim Life Safety Measures are used whenever the features of the fire or life safety systems are compromised. BHD has an Interim Life Safety Management Policy that is used to evaluate life safety deficiencies and formulate individual plans according to the situation.
- F. **Policies and Procedures** –Fire/Life Safety related policies are reviewed a minimum of every three years and distributed to departments as appropriate.
- G. **Emergency Procedures** – (EC 02.03.01 EP ~~9-8~~10; EC 02.03.03 EP 1-5) Emergency procedures are outlined in the Fire Safety Plan for each building. These plans are kept in the Environment of Care manual. The Hospital Incident Command System (HICS) may be implemented to facilitate emergency management of a fire or life safety related event.
- H. **Fire Drills** - (EC 02.03.03-EP 1-5) Employees are trained and drilled regularly on fire emergency procedures, including the use and function of the fire and life safety systems (i.e. pull stations, and

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

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** (EC 03.01.01 EP 4-31 & 2; HR 01.04.01 EP 4-31 & 3; LD 03.01.01 EP 4-401-5) Education regarding the Fire Prevention Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific fire prevention training, job-specific fire prevention training, and a series of programs required for all employees on an annual basis.

The training program includes the following:

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

- B. **Annual Continuing Education:** Education regarding fire prevention is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees including feedback obtained during fire drills. (HR 01.05.03 EP 4-431)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific fire prevention related policies and procedures and specific job related hazards. (EC 03.01.01 EP 4-31 & 2; HR 01.04.01 EP 4-31 & 3)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP 4-31 & 2; HR 01.04.01 EP 4-71 & 3)

PERFORMANCE MONITORING

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

- A. Ongoing performance monitoring is conducted for the following performance monitors:
1. Measure the number of Fire drills completed (Goal = 60/year)
 2. Measure the average score on the fire drill check sheet. (Goal is 97%)
- B. The Safety Officer and EC Committee oversees the development of the Fire prevention related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Executive

Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

Attachments:

No Attachments

Approval Signatures

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



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

Medical Equipment Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

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

PURPOSE:

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

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

SCOPE:

The Medical Equipment (ME) Management Plan establishes the organizational structure within which medical equipment is well maintained and safe to use. In addition to addressing specific responsibilities, general safety, and employee education programs the plan is in all efforts directed toward ensuring that all patients and employees are supported in their use of medical equipment, devices, and technology, thereby reducing the risk of injuries to patients, visitors and employees, and employees can respond effectively in the event of equipment breakdown or loss. ~~(EC 01.01.01-EP7)~~ (EC 01.01.01-EP 8)

MCBHD locations include:

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

OBJECTIVES:

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

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

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

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

INTENT PROCESSES:

- A. **Selecting and Acquiring Equipment** ~~(EC-02.04.01-EP-1)~~ – As part of the capital budgeting cycle, Department Program Directors and Managers are responsible for identifying and justifying new and replacement medical equipment for their departments or areas of responsibility. Requests are subject to administrative approval. Funds for approved capital projects are released on an annual basis. As a rule a representative from the medical equipment management company will be asked to participate with the user department and MCBHD Central Supply Dept. and Maintenance Dept. staff in the evaluation of equipment alternatives and represent the equipment support issues during the selection process. The manager of the ME program along with the Safety Officer are responsible for coordinating the evaluation, purchase, installation, and commissioning processes of new equipment according to the ME purchasing policy.
- B. **Equipment Inclusion in the Medical Equipment Management Plan and Inventory (EC 02.04.01 EP 2)** – All Medical Equipment will be inventoried and tracked in the computerized maintenance management system provided by the contracted maintenance company. The accuracy of this inventory will be verified during scheduled maintenance inspections by comparing the number of items that are no longer in service but still scheduled for inspection, to the total number of items scheduled for inspection. Missing equipment or equipment that the MCBHD Central Supply staff is not aware of being removed from service

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

- C. **Equipment Inspection, Testing, and Maintenance (EC 02.04.01 EP 3 & 4; EC 02.04.03 EP 4-51-3 & 4427)** –The basis for the determination of inspection frequency is risk. Equipment will be inspected upon purchase and initially at one of the following intervals, quarterly, semi-annually, annually, or 18 months. The clinical equipment contractor shall determine and document inspection procedures and intervals for inspection of clinical equipment, based on manufacturer's recommendations, regulations and standards, actual experience with the device, and known hazards and risks. All devices will receive a performance verification and safety test during the incoming inspection procedure and after completion of a major repair or upgrade. All work activities, inspection schedules, and work histories are kept in the contracted company's software inventory list and Central Supply Department. The Central Supply staff assures that the contracted company completes scheduled maintenance and other service activities as required.

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

- D. **Monitoring and Acting on Equipment Hazard Notices and Recalls (EC 02.01.01 EP 11)** –BHD uses RASMAS for recall and alert management. When an alert or recall may be related to equipment at MCBHD, the storeroom/central supply staff are notified to investigate if any equipment is part of the alert/recall, remove it from service and document any actions taken.
- E. **Monitoring and Reporting of Incidents (Including Safe Medical Device Act (SMDA)) (EC 02.04.01 EP 5; EC 04.01.01 EP 10)** All equipment used by BHD staff and/or contractors in the care of BHD patients is required to comply with SMDA per contract. The Quality Improvement/Risk Management department is responsible for investigating and reporting the incident to the manufacturer and/or Food and Drug Administration as appropriate.
- F. **Reporting Equipment Management Problems, Failures and User Errors (EC 02.04.01 EP 6 & 9)** –Users report equipment problems to Central Supply Staff and/or Maintenance Department Staff per policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*. Repairs and work orders are recorded in the computerized maintenance management system. These records are reviewed by Central Supply Staff and a summary reported to the EC Committee quarterly regarding significant problem areas and trends.
- G. **Emergency Procedures and Clinical Intervention (EC 02.04.01 EP 6)** –In the event of any emergencies, the department employee's first priority is for the safety and care of patients, visitors, and employees. Replacement equipment can be obtained through the Central Supply Department during business hours. The Administrative Resource has access to Central Supply during off hours. Additional procedural information can be found in the policy *Medical Device/Equipment Failure (Safe Medical Device Act Compliance)*
- H. **Policies and Procedures** –Medical Equipment related policies are reviewed a minimum of every three years and distributed to departments as appropriate.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation:** Education regarding the Medical Equipment Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with

departmental specific training, job-specific training, and a series of programs required for all employees on an annual basis. Training includes information on where to reference the proper information to ensure the piece of medical equipment they are using is safe, how to properly tag a piece of broken medical equipment, how to report medical equipment problems and obtain replacement equipment. (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3; LD 03.01.01 EP ~~4-101-5~~)

- B. **Annual Continuing Education:** Education regarding medical equipment is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. The EC Committee will, as part of the annual program review, identify technical training needs and assist with the creation of any training program as identified. (HR 01.05.03 EP ~~4-131~~)
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific medical equipment related policies and procedures and specific job related equipment procedures and precautions. Training of employees and technical staff regarding use, features, maintenance and precautions is included as a part of new equipment acquisition/purchase. Additional training/retraining will be conducted based user-related problems or trends seen in the program evaluation. (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-31~~ & 3)
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. (EC 03.01.01 EP ~~4-31~~ & 2; HR 01.04.01 EP ~~4-71~~ & 3)

PERFORMANCE MONITORING

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

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

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

Attachments:

No Attachments

Approval Signatures

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

COPY



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

Utilities Management Plan

Mission:

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

Vision:

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

Philosophy of and Partnership in Care:

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

Culture of Quality, Safety and Innovation:

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

Healthy Learning Environment:

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

Financial Resources:

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

Core Values:

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

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

PURPOSE:

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

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

SCOPE:

The Utilities Management Plan establishes the organizational structure within which a safe and secure environment of care is established, maintained, and improved at MCBHD facilities. The utilities covered in this plan included: electrical distribution, emergency power, vertical transportation systems, HVAC, steam systems, communications systems, domestic water and plumbing, and security systems (key pad access, video monitoring and panic alarm). (EC 01.01.01-EP8,9)

MCBHD locations include:

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

OBJECTIVES:

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

failure trends.

AUTHORITY/REPORTING RELATIONSHIPS:

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

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

The EC committee will evaluate information submitted, develop policies and procedures, understand applicable Utilities related codes and regulations, and evaluate the effectiveness of the Utilities program and its components on an annual basis. Responsibilities of the EC Committee include reporting significant findings and recommending actions to the Executive Team along with any other program or department necessary for effective functioning. (EC 01.01.01-EP4_9)

INTENT PROCESSES:

- A. **Environment of Care, Design and Installation of Utility Systems (EC 02.05.01-EP1 & 2; EC 02.05.03 EP 1)**— Per our mission statement, the Utilities Management Plan is designed to promote a safe, controlled and comfortable environment of care by providing and maintaining adequate and appropriate utility services and infrastructure. This is managed and supported through the Environmental and Engineering Services department. The Facilities Manager collaborates with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local state and national building and fire codes. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager also assures that the necessary parties complete a Pre-Construction Risk Assessment (PCRA), which reviews air quality requirements, infection prevention and control, utility requirements, noise, vibration, fire safety, and other hazards. Recommended precautions from the PCRA are implemented as part of the project design. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of BHD
- B. **Nosocomial Infection (EC 02.05.01-EP 56 & 67; EC 02.05.05-EP4)**— Proper maintenance of utility systems contributes to the reduction of hospital-acquired illnesses. The Infection Preventionist monitors the potential for these illnesses, referred to as Nosocomial Infections. Any concerns that may be utilities related will be addressed in a timely manner.
- C. **Risk Minimization and Operational Reliability (EC 02.05.01-EP 34 & 45; EC 02.05.05-EP3, 4, 5, & 56; EC 02.05.07-EP401-10)**— Through specific Computerized maintenance Management Program,

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

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

- D. **Risk Assessment and Inventory (EC 02.05.01-EP23; EC 02.05.05-EP 1)**– Risk based criteria will be established to identify components of utility systems that are high-risk and have significant impact on life support, infection prevention and control, environmental support, equipment support, and communication systems. New system components will be evaluated prior to start-up.
- E. **Maintenance of Critical Operating Systems (EC 02.05.01 EP 19; EC 02.05.03-EP4-61-7, 13; EC 02.05.07-EP 1, 2, 4 & 67)**– EES monitors the effectiveness of the utility systems by conducting inspections and analyzing data received through rounds and logs and supported by departmental policies and procedures. To ensure reliable operation of emergency systems, BHD performs inspections and tests of the following:
- Monthly transfer switch testing
 - Weekly and monthly emergency generator testing

~~A summary of this monitoring is reviewed by the EC Committee quarterly.~~

Note: The facility does not have a piped medical gas system (EC 02.05.09-EP1, 2 & 3-14)

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

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

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

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

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

G. **Mapping and Labeling (EC 02.05.01-EP 78 & 89, & 16)**– Milwaukee County and EES maintains mapping and labeling of critical distribution systems and equipment operational instructions. Master copies are kept in the MC Dept of Transportation and Public Works and Division, Architecture and Engineering Department and the EES Department.

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

H. **Investigating Utility System Problems, Failures or User Errors (EC 02.05.01-EP 910; EC 04.01.01 EP11)**– Failures, problems and user errors are reported to EES for corrections. Utility system failures are reported to EES and, when appropriate to the EC committee for evaluation and recommendations to prevent reoccurrences. Utility failures are documented on the *BHD Building System Failure Incident Report* ~~and reported to the EC Committee quarterly.~~

I. **Electrical Cords and Power Strips (EC 02.05.01 EP 23 & 24)** - Power strips in patient care vicinity are only used for movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UP 60601-1 Power strips used outside of patient care but with the patient care room meet UL 1363. In non-patient care rooms, power strips meet other UL standards. Extension cords are only used temporarily and are removed immediately upon completion of the task.

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

K. **Emergency Procedures - (EC 02.05.01-EP 9-12 & EC 02.05.07 EP 9)** – Emergency procedures for utility systems malfunctions are developed and maintained in the EES department's procedures for Utility disruptions, back up sources, shut off procedures, repair services and hours of operation are covered in the EES departmental policies and procedures manual. Emergencies are reported twenty-four hours a day through security extension 69957395 (where the call will be routed to the EES Maintenance department via telephone or two way radio) and the administrator on call. Alternate sources of essential utilities are listed in the EES Department Policy Manual for each system.

1. **Alternate Source of Essential Utilities – (EC 02.05.01 EP 13; EC 02.05.03-EP 1-6; EC 02.05.09 EP 1-3)**– Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and employees are trained as part of the organization wide and department specific education. These plans are tested as part of regularly scheduled exercises and actual outages of utility systems. This includes, Fire Alarm System, Exit illumination, P.A. system, one elevator (# 5), and medication dispensing machines. Emergency power outlets are available in the event mobile life support equipment is used. At present BHD does not store any blood, bone or tissue; does not have any med gas or surgical vacuum systems; and has no built in life support systems.

2. **Backup Communication System – (EC 02.05.03 EP 35)** – Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, a satellite phone system, crisis line phone system, pagers, cellular phones, two-way radios, and ham radio system. The implementation of the emergency plan focuses on maintaining vital patient care communications. Once the initial level of the plan is in place, the Communications and/or Telecommunications Department will work with representatives of the telephone company to determine the scope and likely duration of the outage and to identify alternatives.

3. **Clinical Interventions - (EC 02.05.01-EP 4412)** – Emergency procedures and contingency plan information is available in the Environment of Care manual (Systems Failure & Basic Staff Response Quick Reference) and in the Emergency Operations Plan.

ORIENTATION AND EDUCATION

- A. **New Employee Orientation: (EC 03.01.01 EP 431 & 2; HR 01.04.01 EP 431 & 3; LD 03.01.01 EP 4401-5)** Education regarding the Utilities Program begins with the New Employee Orientation Program for all new employees, and continues on an ongoing basis with departmental specific safety training, job-specific utilities training, and a series of programs required for all employees on an annual basis.
- Emergency shutoff controls, use, and locations for each critical utility system serving the work environment
 - Appropriate process for reporting of utility system problems, failures, and user errors.
- B. **Annual Continuing Education:** regarding utilities is conducted annually for all employees. Content is based on recommendations and analysis of educational needs of the employees. **(HR 01.05.03 EP 4431)**
- C. **Department Specific Training:** Directors/Managers are responsible for ensuring that new employees are oriented to departmental specific utilities related utility procedures or precautions. **(EC 03.01.01 EP 431 & 2; HR 01.04.01 EP 431 & 3)**
- D. **Contract Employees:** Assessment and education is done at the time of assignment at BHD. Contracted Employees attend a new employee orientation program at BHD and are also included in the Annual Continuing Education and other educational initiatives as needed during the year. **(EC 03.01.01 EP 431 & 2; HR 01.04.01 EP 471 & 3)**

PERFORMANCE MONITORING

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

- A. Ongoing performance monitoring is conducted for the following performance monitors:
- ~~Measure the number of utility failures (Goal = 0)~~
 - 1. Measure the completion rate of preventive maintenance tasks (Goal = 90%)
 - 2. Measure the percentage of utility branch valves labeled and inventoried (Goal = 50% by year end)
 - 3. Measure the percentage of generator testing that did not pass (Goal = 0%)
 - ~~Measure the number of mechanical door locks requiring repair by a locksmith due to tampering. (baseline)~~
- B. The Safety Officer and EC Committee oversee the development of the Utility related performance monitors. Data from these performance monitors are discussed at the EC Committee quarterly and are reported bi-annually to the BHD Quality Management Services Committee (QMSC). Performance indicators are compiled and reported to the Executive Team (ET), Medical Staff Executive Committee (MEC), and the Milwaukee County Wide Safety Committee annually. The data from all EC performance monitors is analyzed and prioritized to select at least one recommendation to be made to the leadership of BHD for a performance improvement activity in the environment of care.

ANNUAL EVALUATION

(EC 04.01.01 EP 15)

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

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

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

Attachments:

No Attachments

Approval Signatures

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

POLICY & PROCEDURE STATUS REPORT -GOAL=95%

Baseline 71.5% as of August 2016 LAB report

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

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
December	10	46	7
January	3	42	5
February	1	18	
March	13	28	3
April	5	8	1

Overall Progress 96.4% as of May 1, 2018

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	484	489	96.4%	96.4%
Up to 1 year Overdue	7	8	1.4%	1.6%
More than 1 year and up to 3 years overdue	3	3	0.6%	0.6%
More than 3 years and up to 5 years overdue	2	2	0.4%	0.4%
More than 5 years and up to 10 years overdue	0	0	0%	0%
More than 10 years overdue	6	5	1.2%	1.0%
Total	502	507	100%	100%

Forecast Due for Review

Past Due Policies - 18

Coming Due Policies

- May - 8
- June - 4
- July - 3
- August - 13
- September - 1

- October - 2
- November - 5
- December - 26
- January - 6
- February - 8
- March - 7
- April - 2

POLICY & PROCEDURE STATUS REPORT -GOAL=95%

Overall Progress 96.1% as of June 1, 2018

Baseline 71.5% as of August 2016 LAB report

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

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
January	3	42	5
February	1	18	
March	13	28	3
April	5	8	1
May	5	20	0

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	489	494	96.4%	96.1%
Up to 1 year Overdue	8	9	1.6%	1.8%
More than 1 year and up to 3 years overdue	3	5	0.6%	1.0%
More than 3 years and up to 5 years overdue	2	1	0.4%	0.2%
More than 5 years and up to 10 years overdue	0	0	0%	0%
More than 10 years overdue	5	5	1.0%	1.0%
Total	507	514	100%	100%

Forecast Due for Review	
Past Due Policies - 20	November - 4
Coming Due Policies	December - 7
June - 4	January - 6
July - 0	February - 7
August - 2	March - 7
September - 1	April - 0
October - 1	May - 5