



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

2

Program	Item	Measure	2017 Actual	2018 Actual	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	2019 Actual	2019 Target	2019 YTD Status (1)	Benchmark Source
Community Access To Recovery Services	1	Service Volume - All CARS Programs ⁵	8,346	9,393	6,032	6,285	6,356		7,461	9,500		
		Sample Size for Rows 2-6 (Unique Clients)			3,531	3,533	3,406					
	2	Percent with any acute service utilization ⁶	17.40%	17.05%	19.55%	20.58%	20.44%		20.2%	16.35%		
	3	Percent with any emergency room utilization ⁷	13.87%	14.60%	15.33%	17.74%	16.46%		16.5%	13.64%		
	4	Percent abstinence from drug and alcohol use	63.65%	63.65%	64.67%	63.32%	61.22%		63.1%	64.18%		
	5	Percent homeless	7.61%	9.18%	8.46%	9.87%	9.90%		9.4%	8.84%		
	6	Percent employed	18.09%	20.06%	19.51%	19.15%	18.96%		19.2%	20.27%		
	Sample Size for Row 7 (Admissions)					1,560						
	7	Percent of all admissions that are 7 day readmissions	59.55%	60.12%	49.11%	52.51%	50.74%		50.80%	49.00%		
Wraparound	8	Families served in Wraparound HMO (unduplicated count)	3,404	2,955	1,697	2,104	2,456		2,456	3,450		BHD (2)
	9	Annual Family Satisfaction Average Score (Rating scale of 1-5)	4.8	4.60	4.5	4.5	4.6		4.5	> = 4.0		BHD (2)
	10	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	65.7%	65.3%	66.2%	63.3%	61.6%		63.7%	> = 75%		BHD (2)
	11	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	2.59	2.4	2.4	2.5	2.3		2.4	> = 3.0		BHD (2)
	12	Percentage of youth who have achieved permanency at disenrollment	57.8%	58.0%	69.1%	51.3%	45.8%		55.40%	> = 70%		BHD (2)
	13	Percentage of Informal Supports on a Child and Family Team	44.1%	38.4%	34.3%	33.1%	34.3%		33.90%	> = 50%		BHD (2)
	14	Average cost per month (families served in Wraparound HMO)				\$2,187	\$2,937		\$2,562			BHD (2)
Crisis Service	15	PCS Visits	8,001	7,375	1,905	1,960	1,815		7,573	8,000		BHD (2)
	16	Emergency Detentions in PCS	3,979	3,023	795	775	825		3,193	4,000		BHD (2)
	17	Percent of patients returning to PCS within 3 days	7.3%	7.5%	10.0%	12.6%	6.9%		9.8%	8%		BHD (2)
	18	Percent of patients returning to PCS within 30 days	23.1%	24.0%	24.4%	29.5%	23.5%		25.8%	24%		BHD (2)
	19	Percent of time on waitlist status	75.2%	83.2%	100.0%	100.0%	100.0%		100.0%	50%		BHD (2)
Acute Adult Inpatient Service	20	Admissions	656	770	162	176	178		688	800		BHD (2)
	21	Average Daily Census	42.9	41.8	43.8	42.4	38.9		41.7	54		BHD (2)
	22	Percent of patients returning to Acute Adult within 7 days	1.4%	1.6%	1.3%	3.8%	2.8%		2.6%	3%		BHD (2)
	23	Percent of patients returning to Acute Adult within 30 days	7.7%	6.6%	3.2%	6.0%	9.6%		6.3%	10%		NRI (3)
	24	Percent of patients responding positively to satisfaction survey	74.0%	74.8%	74.4%	74.9%	77.9%		75.7%	75.0%		NRI (3)
	25	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	65.4%	65.2%	66.0%	65.2%	64.4%		65.2%	65%		BHD (2)
	26	HBIPS 2 - Hours of Physical Restraint Rate	0.56	0.51	0.24	0.36	0.58		0.39	0.38		CMS (4)
	27	HBIPS 3 - Hours of Locked Seclusion Rate	0.30	0.28	0.15	0.10	0.14		0.13	0.29		CMS (4)
	28	HBIPS 4 - Patients discharged on multiple antipsychotic medications	17.5%	21.5%	25.3%	23.9%	22.0%		23.7%	9.5%		CMS (4)
29	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	89.6%	95.8%	92.5%	95.5%	97.4%		95.1%	90.0%		BHD (2)	
Child / Adolescent Inpatient Service (CAIS)	30	Admissions	709	644	168	149	152		625	800		BHD (2)
	31	Average Daily Census	8.6	7.5	8.2	7.0	6.2		7.2	12.0		BHD (2)
	32	Percent of patients returning to CAIS within 7 days	5.2%	3.4%	7.2%	4.8%	4.0%		5.3%	5%		BHD (2)
	33	Percent of patients returning to CAIS within 30 days	12.3%	12.4%	16.6%	16.3%	15.2%		16.0%	12%		BHD (2)
	34	Percent of patients responding positively to satisfaction survey	71.3%	71.1%	79.6%	73.5%	74.2%		75.8%	75%		BHD (2)
	35	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	76.8%	74.2%	88.9%	83.3%	78.9%		83.7%	75%		BHD (2)
	36	HBIPS 2 - Hours of Physical Restraint Rate	1.17	1.18	1.98	0.95	2.42		1.78	0.38		CMS (4)
	37	HBIPS 3 - Hours of Locked Seclusion Rate	0.37	0.47	0.39	0.35	0.30		0.35	0.29		CMS (4)
	38	HBIPS 4 - Patients discharged on multiple antipsychotic medications	5.0%	1.1%	0.0%	0.0%	0.7%		0.2%	3.0%		CMS (4)
39	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	97.1%	85.7%	-	-	100.0%		100.0%	90.0%		BHD (2)	
Financial	40	Total BHD Revenue (millions)	\$149.9	\$154.9	\$149.7	\$149.7	\$149.7			\$149.7		
	41	Total BHD Expenditure (millions)	\$207.3	\$213.5	\$208.2	\$208.2	\$208.2			\$208.2		

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

Program	Item	Measure	2019 Quarter 1	2019 Quarter 2	2019 Quarter 3	2019 Quarter 4	2019 Actual	2019 Target	2019 Status (1)	Benchmark Source
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	14	Average Cost per Month (families serviced in Wraparound HMO)		\$2,187	\$2,937		\$2,562			

Notes:

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

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

SUMMARY - 3rd QUARTER/CY 2019

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

9 – On target for the 3rd quarter of 2019. Exceeding the threshold of 4.0.

10 - There was a slight decline from Quarter 2. This indicator is within 20% of the threshold. This is an area Wraparound Milwaukee continues to look into and review the numbers on a weekly basis.

11 – There was a slight decrease from 2nd quarter, The 2019 actual is within 20% of the benchmark of 3.0. Data is specific to those youth in Wraparound on court orders and those in the REACH program. **NOTE:** Those in Wraparound court ordered programs who are disenrolled to a home type setting in the 3rd quarter of 2019 have a higher "Needs Met" score (3.09) than those disenrolled on runaway status or to corrections (1.70).

#12 – In the 3rd quarter, there was a decrease in the percentage of youth achieving permanency at disenrollment compared to the 2019 2nd quarter. 3rd quarter data falls out of the 20% benchmark, and the 2019 actual falls outside that 20% by .6%. This continues to be an area that the Wraparound Milwaukee Research and Evaluation Team is reviewing and looking for trends to help inform practice or potential educational moments with Judges, system partners, etc.

"Permanency" is defined as:

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

#13 – This item is monitored within the context of the Care Coordination Agency Performance Report (APR) that is distributed semi-annually. The data is available at all times to all Care Coordination agencies for self-monitoring. The 3rd quarter compliance (34.3) is slightly higher than the 2019 2nd quarter. This falls outside 20% benchmark of 40%.

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

2019

CHANGES AND UPDATES

Further Development of the Quadruple Aim

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

Population Health

Some of the key CARS change over time metrics for population health are now disaggregated by race. Our current efforts to address some of our identified disparities include utilization of statistical methods to uncover the source of these disparities, as well as a review of the research literature to help inform our root cause analyses. This effort helps to align CARS's evaluation activities to the Milwaukee County Executive's stated goal of addressing racial disparities in Milwaukee County. Future iterations of the CARS Quality Dashboard will include other health and care quality metrics disaggregated by key variables.

Patient Experience of Care

The Press Ganey survey has been distributed to all CARS programs and data collection is ongoing. We are happy to announce that the 3rd quarter CARS Quality Dashboard presents preliminary aggregate data on the Press Ganey surveys collected to date. These data will be disaggregated per disparity variable and per other variables of interest in future iterations.

Staff Wellbeing

The 3rd quarter CARS Quality Dashboard does include an update to the CARS retention rates, year to date. CARS staff also recently held listening sessions of all CARS staff to discuss what would improve the quality of their work life. The CARS Quality Dashboard therefore contains a brief update from the Staff Quality of Work Life Committee's efforts to date to create a more flexible work environment, with more updates to follow!

Cost of Care

The cost per member per month metric on the CARS Quality Dashboard is now actively being used as a template for a cost of care metric for all of BHD adult services. It is anticipated that this cost of care metric will be utilized in our value-based purchasing analyses in the future. Also notable within this aim is the CARS Quality Plan-driven reduction in tax levy reliance in some of our services, such as our one to one companion service in our Community Based Residential Facilities.

RESULTS

With regards to the change over time metrics, the disparity in terms of quality of life improvements between African-Americans and White clients within CARS remains consistent. As noted above, we are actively engaged in attempting to understand this disparity, including examining whether SES might be a factor in the lack of improvement. Further analyses and findings will be presented at future meetings.

NEXT STEPS

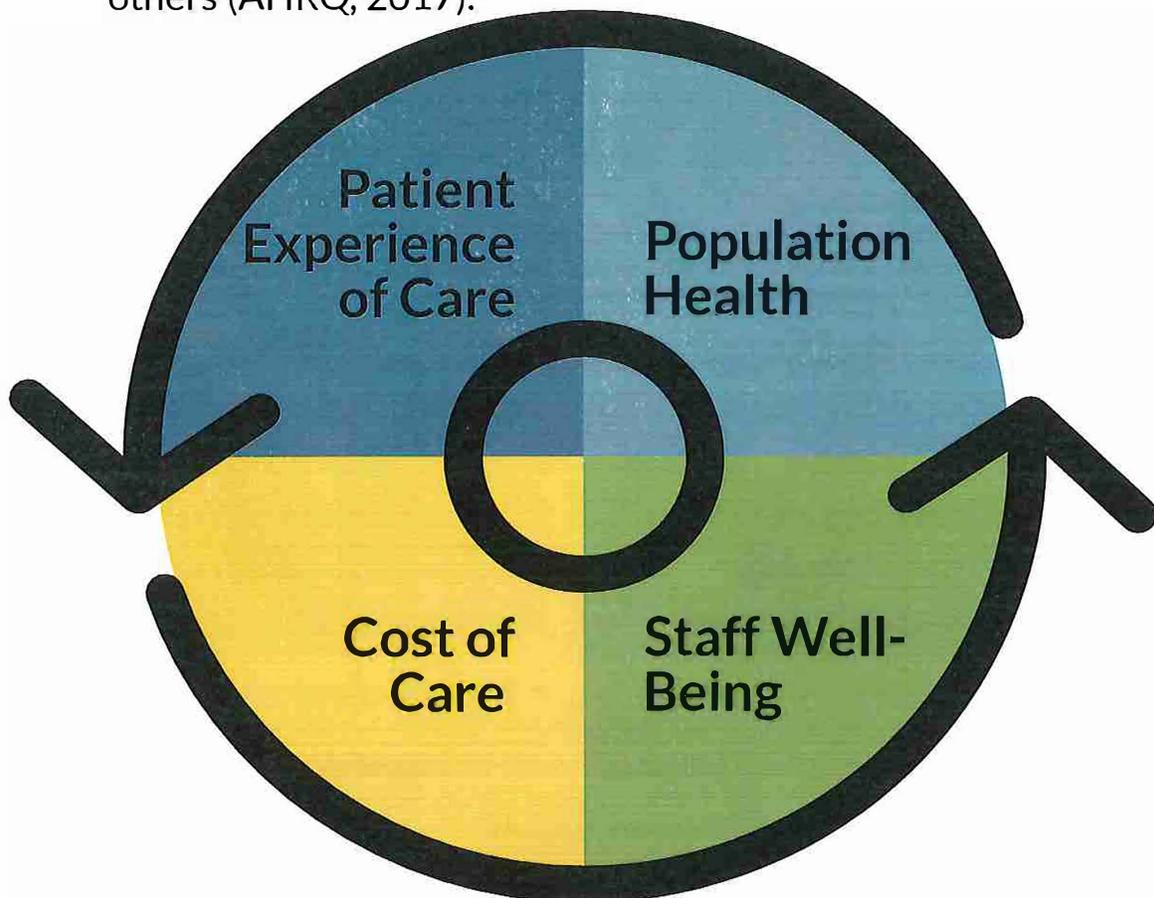
Future versions of the CARS Quality Dashboard will continue to include progress updates on the implementation of the CARS Quality Plan, which informs and drives our quality improvement activities. We anticipate presenting more complex analyses with regards to quality metrics as we attempt to better understand and utilize our data to drive our decisions and hold both our providers and ourselves accountable for the care we provide to the residents of Milwaukee County.



The Framework: The Quadruple Aim

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

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



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

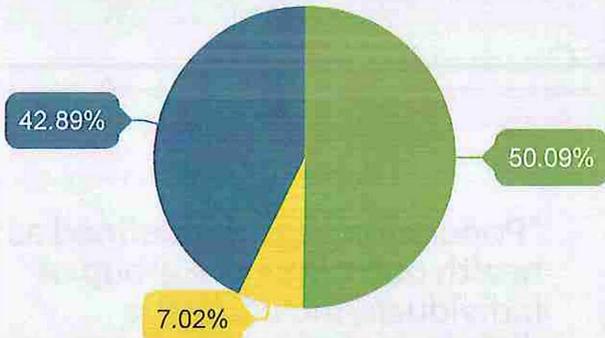
The quality of work life and the well being of healthcare professionals (Bodenheimer and Sinsky, 2014).

Demographic Information of the Population We Serve

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

Race (CARS)

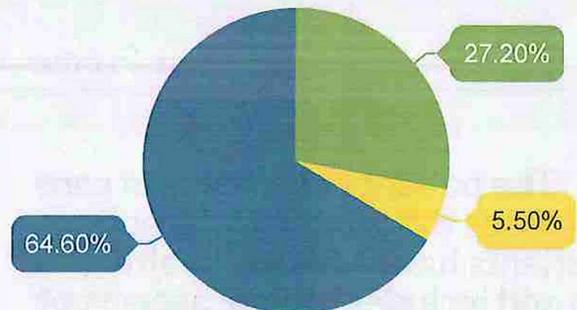
- Black/African-American
- White/Caucasian
- Other



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

Race (Milwaukee County)*

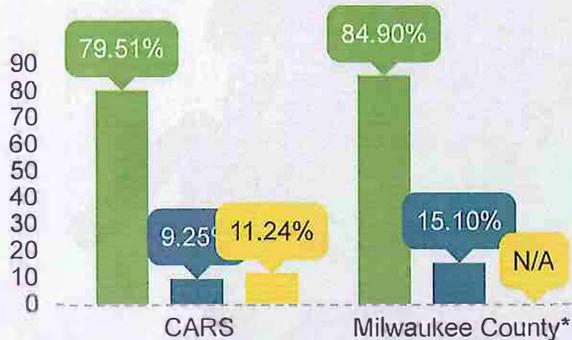
- Black/African-American
- White/Caucasian
- Other



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

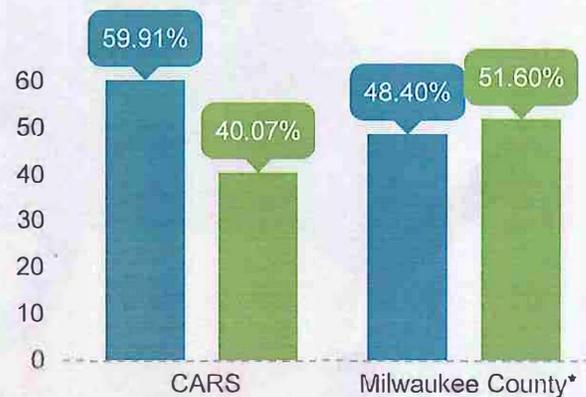
Ethnicity

- Not Hispanic/Latino
- Hispanic/Latino
- No Entry/Unknown

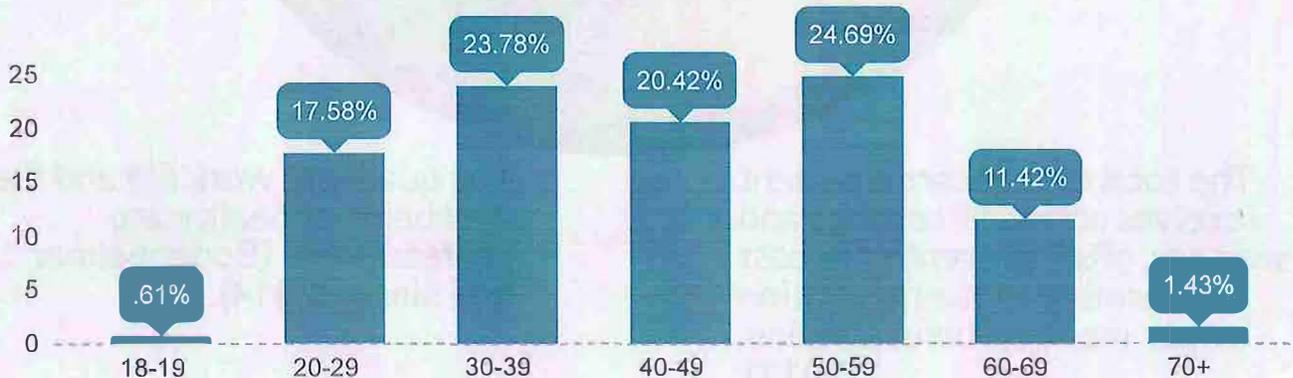


Gender

- Men
- Women



Age



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



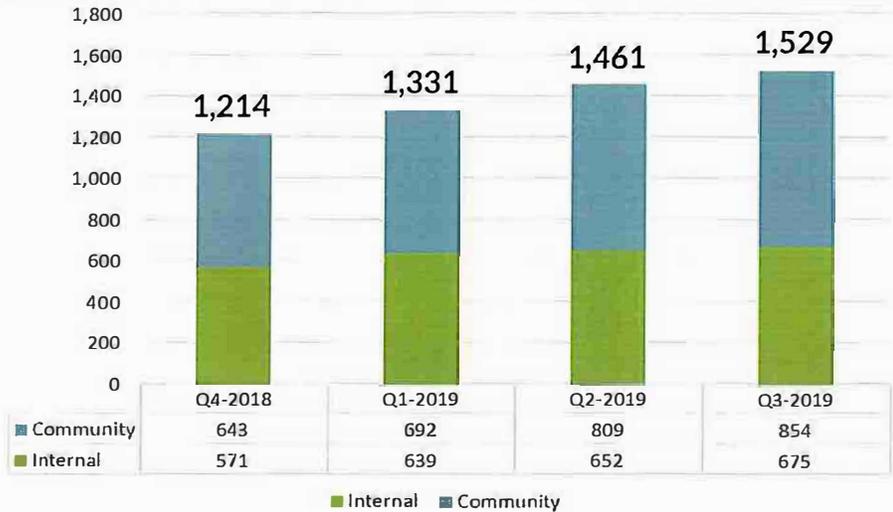
Domain: Patient Experience of Care

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



Referrals

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



Timeliness of Access

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



Admissions

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



Volume Served

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



Consumer Satisfaction



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

10.22%

Response Rate

7,214

surveys distributed

737

surveys received



Domain: Population Health

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



Acute Services

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



ER Utilization

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



Detoxification 7-Day Readmissions

Percent of consumers returning to detoxification within 7 days.



Abstinence

Percent of consumers abstinent from drug and alcohol use.



Homelessness

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





Domain: Population Health (Continued)

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

Employment



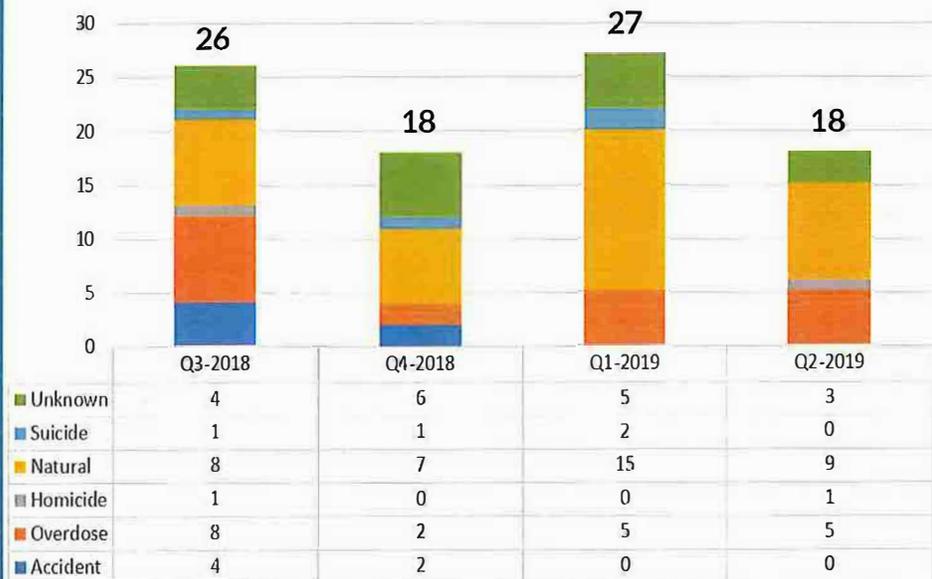
Percent of current employment status of unique clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status".



Mortality Over Time

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

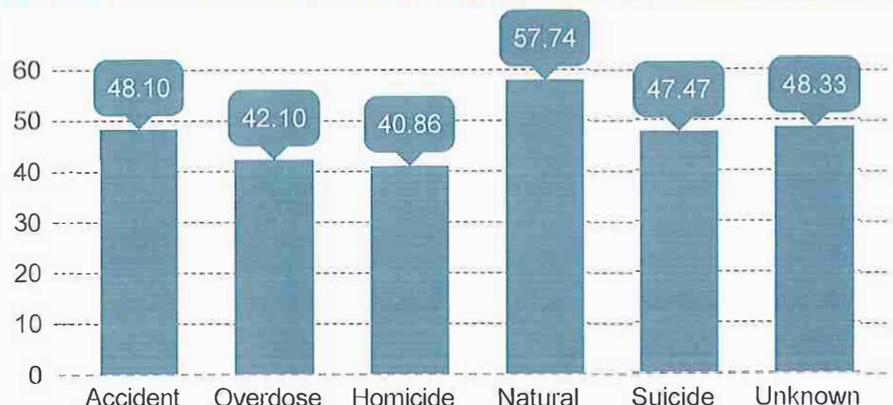
Note: There is a lag in death reporting. See note in the next item.



Cause of Death

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

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



Cause of Death

Distribution of Male vs. Female consumers by cause of death for the four previous quarters.

Total Male: 67
Total Female: 25

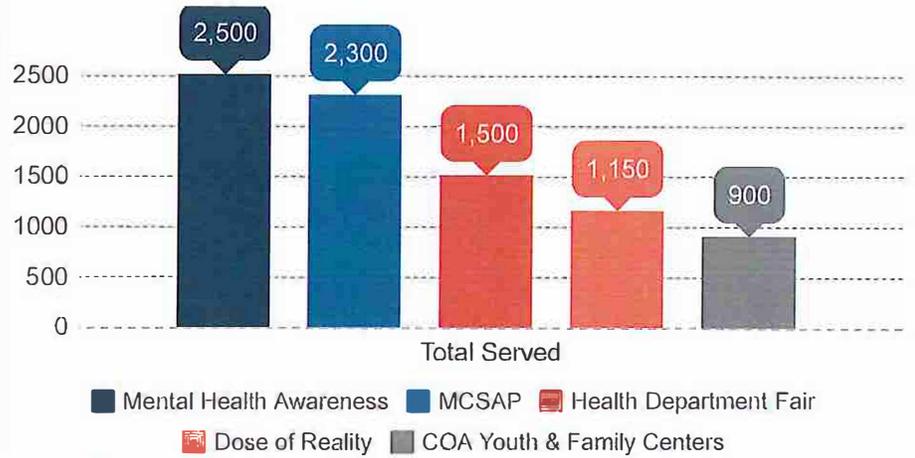
Note: There is a lag in death reporting. See note in the previous item.



Top Prevention Activities/Initiatives

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

MCSAP: Milwaukee County Substance Abuse Prevention Coalition



Domain: Cost of Care

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

Average Cost Per Consumer Per Month

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

Q4 - 2018 N = 5,042	Q1 - 2019 N = 5,056
Q2 - 2019 N = 5,225	Q3 - 2019 N = 5,285



Domain: Staff Well-Being

Turnover

Turnover is calculated by looking at the total number of staff who have left year-to-date (YTD), divided by the average number of employees per month, YTD.



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

13.50%

CARS turnover rate (YTD)

20.00%

Turnover rate for government employees (per year)*



Staff Quality of Life

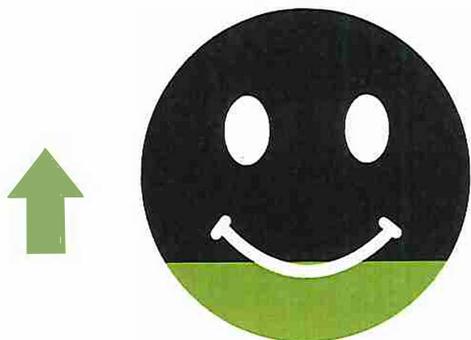
A group of CARS staff have been working to positively impact the workplace culture. Initial efforts have been focused on gathering employee feedback, and that feedback has told us the biggest priorities for staff are related to flexible benefits, e.g. telecommuting, flex time, etc. Based on this feedback,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

Health and Well-Being

This dashboard contains measures of 6-month population health outcome data (intake to follow-up) for our consumers. This dashboard was created to follow the County Health Rankings Model.

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

Q3 2019



37.20% → 45.40%

Health Outcome

22.04% increase in Good or Very Good self-reported Quality of Life*

n=282



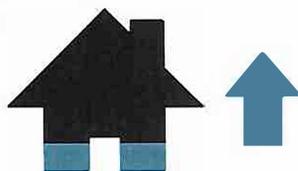
Social Determinants



14.20% → 18.40%

29.58% increase in Employment*

n=408



64.70% → 76.10%

17.62% increase in "Stable Housing"****

n=375

Health Behaviors



16.00% → 8.30%

48.13% decrease in Past 30 days Detoxification Use***

n=432

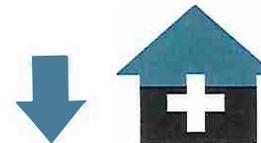
Clinical Care



13.60% → 9.50%

30.15% decrease in Psych ER Use*

n=433



30.50% → 12.70%

58.36% decrease in Past 30 days Psych. Inpatient***

n=433

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

Health and Well-Being Comparison

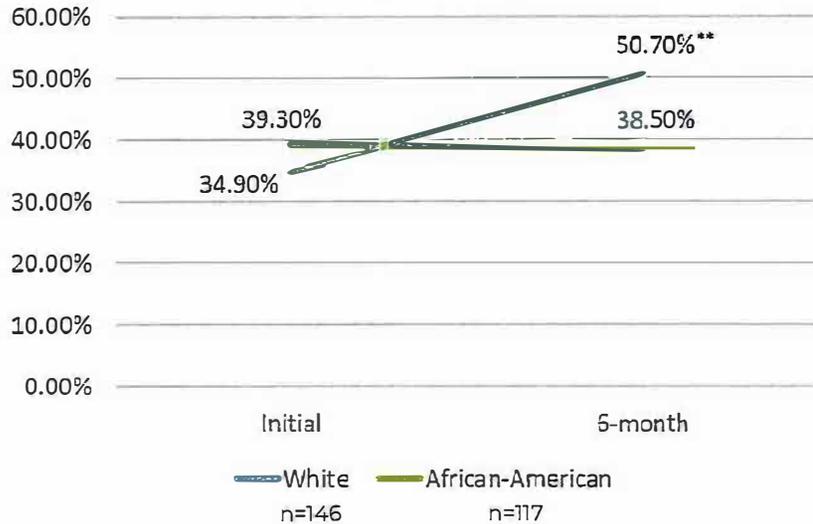
This dashboard contains measures of 6-month population health outcome data (intake to follow-up) for our consumers, comparing White/Caucasian and Black/African-American consumers.

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

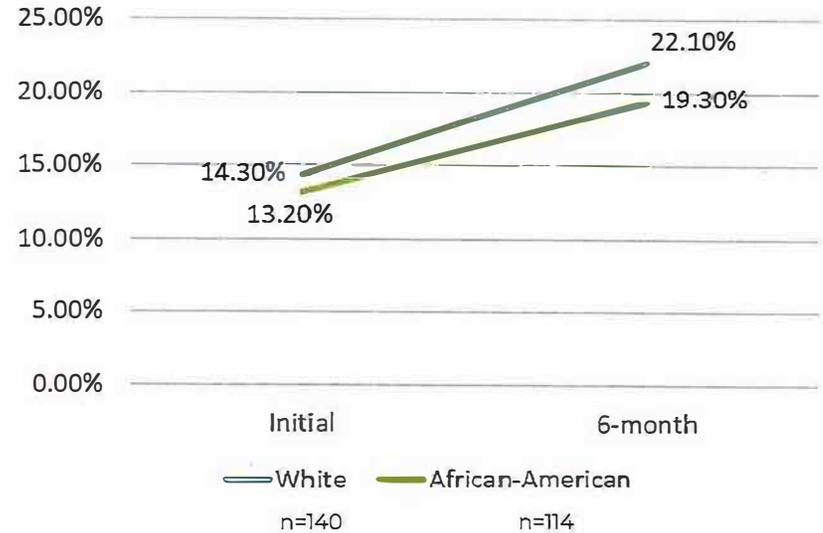
Q3 2019

Quality of Life

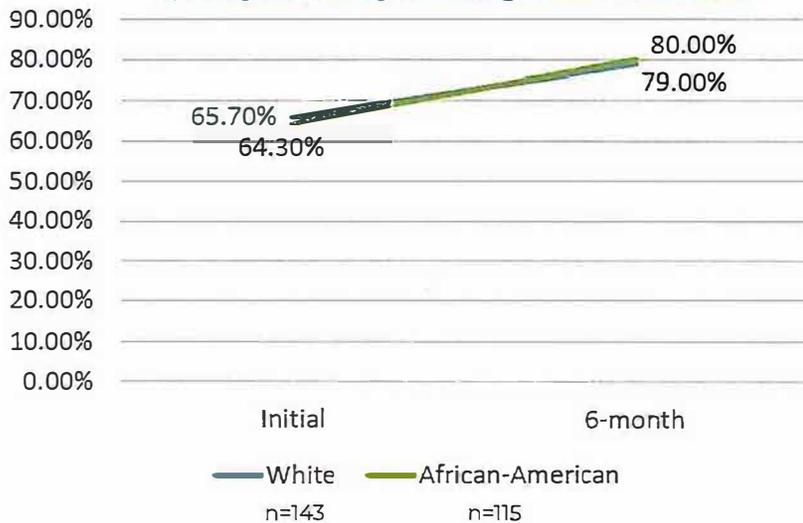
Proportion of consumers indicating "Good" or "Very Good" Quality of Life



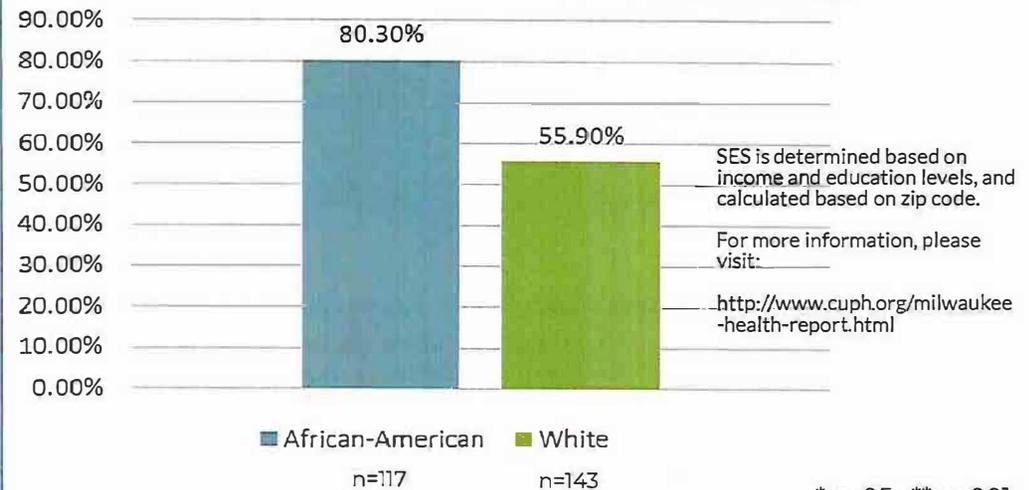
Quality of Life by Employment Status and Race



Quality of Life by Housing Status and Race



Percent of Consumers with "Low" or "Medium Low" SES Status**

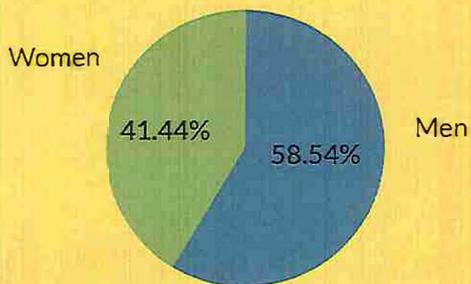


*p<.05 **p<.001



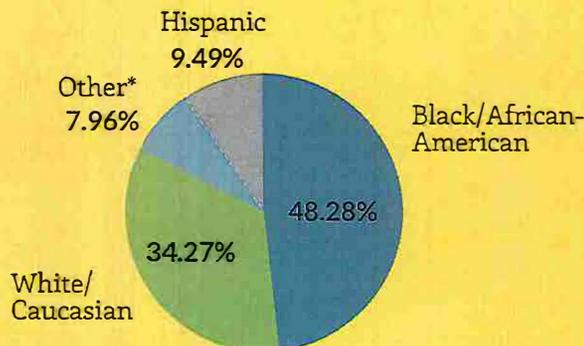
Volume Served

8,334



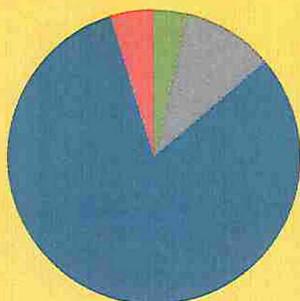
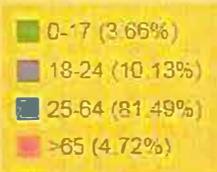
Gender

Race/Ethnicity

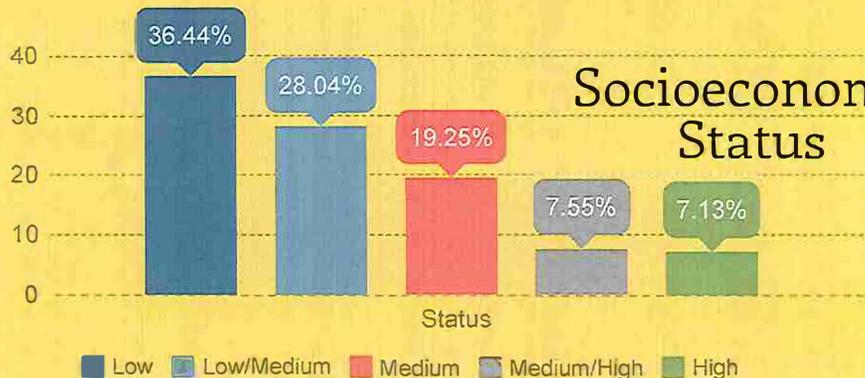


"Other" encompasses small percentages of indicated racial identity including "Alaskan Native/American Indian", "Asian", "Native Hawaiian/Pacific Islander", "Other", and N/A

Age



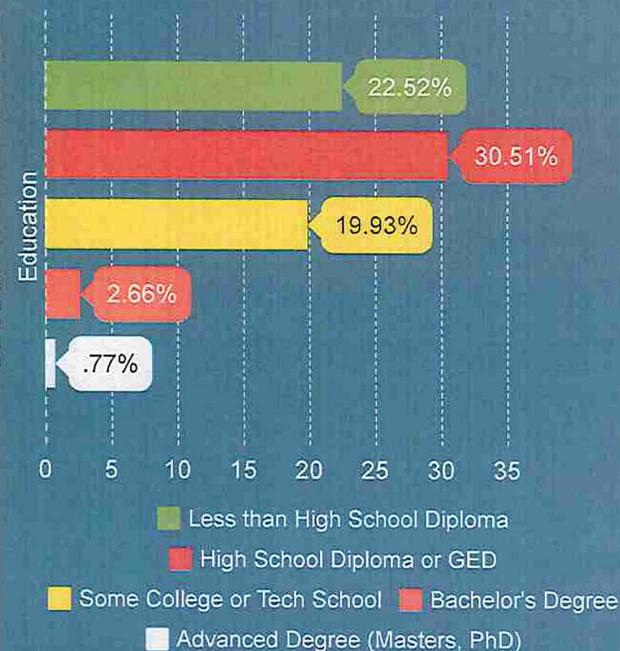
Socioeconomic Status



SES is determined based on income and education levels, and calculated based on zip code.

For more information, please visit:
<http://www.cuph.org/milwaukee-health-report.html>

Education



Employment

14.13%

percent of clients reported as "full or part time employment, supported competitive employment, sheltered employment, or student status"



An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division: Final Survey Report

Tina Freiburger, Ph.D. & Danielle Romain Dagenhardt, Ph.D.
Department of Criminal Justice & Criminology, University of Wisconsin-Milwaukee



Improving lives and strengthening communities through research, education, and community partnerships

Executive Summary

In May of 2017, the Milwaukee County Behavioral Health Division (BHD) implemented a new training program for all staff to address conflict in the workplace. The training was conducted by Vistelar, a global consulting firm that specializes in trainings to address conflict in a variety of areas. Researchers from the University of Wisconsin-Milwaukee were contracted to complete an outcome evaluation of the program. This evaluation involved the collection of baseline data prior to the training and follow-up data one month, one year, and two years after the training. This report presents the findings of this evaluation.

The outcomes examined in this report were 1) role conflict, 2) conflict resolution skills, 3) perceptions of participants' abilities to protect themselves and others from physically and verbally aggressive situations, 4) experiences with horizontal violence, 5) feelings of safety while at work, 6) burnout, and 7) turnover. Additional outcomes for direct healthcare workers included 1) role conflict with security, 2) moral sensitivity, 3) perceptions of patients, 4) confidence working with behavioral health patients, and 5) employer constraints in providing appropriate care.

The results indicated that the training was successful in:

- Decreasing role conflict through the two-year study period.
- Improving conflict resolution skills in the short-term.
- Improving participants' perceptions of their abilities to protect themselves and others in physically and verbally aggressive situations. This effect was sustained over the two-year study period.
- Reducing experiences with horizontal violence over the two-year study period.
- Increasing feelings of safety at work.
- Decreasing burnout amount of direct-care employees.
- Increasing direct-care employees' confidence in working with patients after one year.
- Reducing perceptions that employers constrained direct-care workers' abilities to provide appropriate care to patients.

Perceptions of the training, whether staff viewed the skills as useful, and the effectiveness of the skills acquired during the training were also assessed at the one-month follow-up. The results indicated that:

- Participants felt the training was a good use of their time and taught them new skills.
- Most direct care staff felt the training increased practicing empathy, awareness of conflict triggers, and awareness of physical distance.
- Most non-direct care staff felt the training made them aware of physical distance.
- Most staff continued to utilize the non-escalation and de-escalation skills two years after training, with direct care staff using these skills at a higher frequency than non-direct care staff.
- Of those who utilized the skills, the vast majority felt the skills were effective at reducing conflict.
- Participants felt the training led to improvements in the work culture at BHD and led to an increased emphasis on showing respect.

- Participants felt the training led to an increased focus on teamwork in direct care units, better communication among staff, and more support among employees when handling conflict.

Based on these findings, we make the following recommendations:

- BHD continue training their employees in conflict management.
- The program had many long-term successes; however, some of the positive impacts decreased between year one and year two. This iterates the importance of continued training and reinforcement of these skills.
- Consult with Vistelar to ensure subsequent training by BHD staff adheres to the same curriculum and standards.

Introduction

In May of 2017, the Milwaukee County Behavioral Health Division (BHD) implemented a new training program for all staff to address conflict in the workplace. The training was conducted by Vistelar, a global consulting firm that specializes in trainings to address conflict in a variety of areas. Vistelar developed the Gatekeeper Training Program to specifically address conflict in behavioral health centers to include conflict between coworkers and staff and clients. The initial goal was to have all existing employees trained by September 2017, with continued sessions held for any new hires. Healthcare workers who work directly with patients on units (e.g., RNs, CNAs) also were required to attend a two-day workshop for additional training on proper procedures for client stabilization.

The evaluators (Drs. Freiburger and Romain Dagenhardt) were asked to determine whether the program met its intended goals – namely if conflict within the workplace was reduced, role clarification improved, and a cultural change toward non-escalation was achieved. This report presents a description of the training, the results of a process evaluation to address program fidelity, and the results from the one-month, one-year, and two-year follow-ups of those who completed the training as of August 2018.¹ It presents a comparison between baseline data and follow-up data for the following outcomes: 1) role conflict, 2) conflict resolution skills, 3) perceptions of participants' abilities to protect themselves and others from physically and verbally aggressive situations, 4) experiences with horizontal violence, 5) feelings of safety while at work, 6) burnout, and 7) turnover intention. Additional outcomes for direct care workers include 1) moral sensitivity, 2) perceptions of patients, 3) confidence working with behavioral

¹ Approximately 100 employees had not completed Gatekeeper Training by August 2018. Analyses include only those who completed the training by this cutoff point. Agency records for some measures were not available at the time of the final report (i.e. turnover, restraint use).

health patients, and 4) employer constraints in providing appropriate care. The report further includes summaries of perceptions of the training, whether staff viewed the skills as useful, and the effectiveness of the skills acquired during the training. Lastly, recommendations for the trainers (e.g., Vistelar, BHD trainers) and Milwaukee County BHD based on these results are discussed.

Overview of the Gatekeeper Training

The Gatekeeper Training Program was developed as an eight-hour training for all employees of Milwaukee County BHD to provide non-escalation and de-escalation skills. Much of the training focused on non-escalation skills, including utilizing a *Universal Greeting* to introduce oneself to new clients, families, or visitors, *Five Ways to Show Respect*, and the *Empathy Triad*. In the *Respect* module, the aspects of asking someone to do something, providing options, and explaining why were emphasized as a method of not escalating a conflict. In the *Empathy Triad*, staff learned that acknowledging the other person's perspective and seeing the world through their eyes were important to demonstrate empathy for someone's situation. Employees watched a video on the importance of *Establishing a Social Contract* (e.g., unwritten rules of how everyone should act within the hospital) and thought about *Conflict Triggers*. Participants were told to examine and identify their personal conflict triggers and build *Conflict Trigger Guards* to maintain *Emotional Equilibrium*. Staff learned ways to *Establish Equilibrium* such as being aware of one's conflict triggers, remembering that actions are typically recorded on camera and thinking about who they represent in their community. With this focus on *Conflict Triggers*, staff also were required to think about the conflict triggers of others, including posture, facial expressions, tone of voice, and language that can create conflict.

Another component to the non-escalation training focused on how one enters a situation, recomposing oneself when feeling stressed, and awareness of *Proxemics*. The *First Responder Philosophy* emphasized the need to assess the situation before entering a room for both safety issues and to properly respond to crises. With this, staff were taught to recognize physical and verbal cues from a client that may be indicative of violence. The *Showtime Mindset* technique taught participants to think of themselves as stepping onto a stage whenever they enter a room, answer a phone, or meet with a client. The physical and mental steps can refocus an employee who may have had a bad day or a stressful previous experience. Another skillset that participants were taught related to paying attention to *Proxemics* between themselves and another person. Staff were taught what they can do to keep themselves safe at certain distances (10-5-2), hand placement, and assertive seating to keep themselves safe if a person were to physically attack them (i.e., emergency timeout, guiding hands, tactical sitting). Finally, staff were trained on tools for *Beyond Active Listening*, which were six techniques for gathering more information from a person in order to solve a problem and avoid conflict (i.e., clarify, paraphrase, reflect, mirror, advocate, and summarize).

The last two modules for the training focused on three de-escalation skills to be used when a conflict emerged. The first was *Redirections*, which demonstrated acknowledging what the other person is saying while redirecting them back to what needs to be accomplished (e.g., filling out an intake form) and diverting attention when someone is extremely upset (e.g., asking an unrelated benign question). Second, staff were taught the *Persuasion Sequence*, to be used when someone is resisting or refusing a request in order to obtain cooperation. The steps mirror the components of the *Five Ways of Showing Respect* module – namely explaining why they are being asked to do something, offering them options (framed as positive and less positive), letting

them choose, and, if necessary, allowing them time to reconsider. The final de-escalation skill was the *Crisis Intervention* technique when someone is demonstrating the potential for physical aggression. This technique was used to de-escalate a person who may be excitable by using reverse yelling, meeting unmet needs (e.g., offering water, a snack), reducing stimulation (e.g., turning down lights, fewer people in the room), and separating them from the area. Together, these skills were aimed at reducing conflict that has already occurred and promoting the safety of both staff and clients. The emphasis on non-escalation skills in both the number of skills provided and the amount of time spent on these skills was indicative of the focus for BHD – that conflict often can be prevented if non-escalation skills are used consistently.

Program Fidelity Observations

Five sessions of the Gatekeeper Training Program were observed to examine whether the curriculum of the program was being implemented as intended. Four of the observations occurred during the summer of 2017, when most trainings were held. From these observations, it was discovered that the main trainer and the staff of Vistelar were very consistent in delivering the curriculum, with minor variations across trainings. BHD employees appeared to be engaged in the lecture content, and the use of activities for role playing and small group work aided in a high level of engagement throughout the one-day trainings. Some staff (e.g., Katie) gave examples from their work experience that resonated more with direct care employees, while others seemed to emphasize law enforcement examples more often. After Vistelar trained BHD nurse educators to administer the program, one session was observed. Coincidentally, this session was the first to condense the Gatekeeper Training Program into a half-day morning session. Two main concerns are highlighted. First, it was difficult for the educators to cover all the material by noon; indeed, they ended approximately a half hour over schedule in order to fit

all the modules into the session. Second, with the condensed format, there were fewer activities to foster teamwork and practice skills. The goal of a cultural change and actual utilization of skills may become lost if there is less time for these activities.

Methods

Sample

All BHD employees who were not new hires at the time of Gatekeeper Training were included in the evaluation and asked to complete a survey. The vast majority of staff agreed to participate in the baseline survey, with a 98.4% response rate. As of September 1, 2018, 447 Milwaukee County BHD employees completed the Vistelar training, with 226 completing the one-month follow-up survey. Of the individuals who completed the training, the majority were direct care workers (66.4% trained). For the yearly follow-ups, 123 employees completed the one-year survey and 99 employees completed the two-year survey.

Obtaining follow-up surveys was challenging, as the process of follow-up procedures changed since the beginning of the evaluation. Initially, all direct care workers were to receive the Phase Two training one-month after the first training, at which time they would receive the first follow-up survey, leading to high response rates from a captive audience. However, with trainings scheduled as part of new employee orientation after fall 2017, several direct care workers received all three days in the same week. Because of this change, all non-direct care workers and most direct care workers participating in Phase Two from December 2017 through August 2018 were administered follow-up surveys through interdepartmental mail. Despite this challenge, 59 (26.1%) non-direct care staff and 167 direct care staff (73.9%) completed the one-month follow-up survey, for a total follow-up response rate of 50.6%.² For the one-year survey,

² Babbie (1990 & 1998) argues that a response rate of 50% can be considered representative of the larger population.

76 (61.8%) non-direct care staff and 47 (38.2%) direct care staff completed the survey, with a 27.52% response rate. The two-year survey yielded 99 responses, of which 66 (66.7%) were non-direct care and 33 (33.3%) were direct care staff, with a 22.15% response rate.

Table 1 reports the demographic information for the sample of employees for the pre-test. The 447 staff who completed the baseline survey before Gatekeeper Training included a wide array of both clinical and non-clinical staff. The average length of time staff had been employed at BHD was 7.86 years, with a standard deviation of 7.99 years. While some staff had been employed for only a few months, others were employed with BHD for over 20 years. The most frequent positions for those who completed Gatekeeper Training were healthcare specialist (18.3%), followed by administration (11.6%) and care worker (8.9%). Most employees at baseline were female (63.1%) and White (44.3%), with the most common age groups represented of 45-54 years of age (24.4%) and 55 and older (23%).

Table 1. Pre-Test Demographics for BHD.

Variable	Direct Care Worker		Non-Direct Care Worker		Total Sample	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Gender						
Male	53	17.8	56	37.3	109	24.4
Female	195	65.7	87	58	282	63.1
Transgender	4	1.3	--	--	4	.9
Other	1	.3	1	.7	2	.4
Missing	44	14.8	6	4	50	11.2
Age						
18-24	5	1.7	6	4	11	2.5
25-34	52	17.5	24	16	76	17
35-44	70	23.6	21	14	91	20.4
45-54	60	20.2	49	32.7	109	24.4
55+	60	20.2	43	28.7	103	23
Missing	50	16.8	7	4.7	57	12.8
Race/Ethnicity						
Black	106	35.7	41	27.3	147	32.9
White	114	38.4	84	56	198	44.3
Asian	6	2.0	2	1.3	8	1.8
Hispanic	7	2.4	8	5.3	15	3.4
Multiracial	7	2.4	5	3.3	12	2.7

Other	5	1.7	2	1.3	7	1.6
Missing	52	17.5	8	5.3	60	13.4
Position						
Healthcare Specialist	82	27.6	--	--	82	18.3
Supervisor/Coord.	--	--	--	--	--	--
Care Worker	40	13.5	--	--	40	8.9
Clerical/Administration	2	.7	50	33.3	52	11.6
Maintenance/Custodial	--	--	4	2.7	4	.9
Security	--	--	13	8.7	13	2.9
Quality Assurance	--	--	1	.7	1	.2
Human Resources	--	--	2	1.3	2	.4
IT/Analyst	--	--	3	2	3	.7
Other	5	1.7	17	11.3	22	4.9
Missing	168	56.6	60	40	228	51
Length of Employment	Mean	SD	Mean	SD	Mean	SD
	8.70	8.22	6.46	7.43	7.86	7.99

Table 2 reports the demographic information of the 226 respondents for the one-month follow-up. As can be seen, the average length of employment at BHD was 8.26 years (SD=8.20). Again, the most common positions reported were healthcare specialist (21.2%), followed by administration (9.7%) and care worker (7.5%). Most of the staff were female (66.4%), White (39.4%), and within the 45-54 age group (28.8%). Additional descriptive information is delineated by direct care staff and non-direct care staff.

Table 2. Post-Test Demographics for BHD at One-Month.

Variable	Direct Care Worker		Non-Direct Care Worker		Total Sample	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Gender						
Male	27	16.2	16	27.1	43	19
Female	113	67.7	37	62.7	150	66.4
Transgender	--	--	1	1.7	1	.4
Other	--	--	--	--	--	--
Missing	27	16.2	5	8.5	32	14.2
Age						
18-24	2	1.2	1	1.7	3	1.3
25-34	30	18	10	16.9	40	17.7
35-44	28	16.8	8	13.6	36	15.9
45-54	48	28.7	17	28.8	65	28.8
55+	34	20.4	16	27.1	50	22.1
Missing	25	15	7	11.9	32	14.2
Race/Ethnicity						
Black	63	37.7	11	18.6	74	32.7
White	56	33.5	33	55.9	89	39.4

Asian	6	--	--	--	6	2.7
Hispanic	4	3.6	3	5.1	7	3.1
Multiracial	--	2.4	2	3.4	2	.9
Other	8	4.8	3	5.1	11	4.9
Missing	30	18	7	11.9	37	16.4
Position						
Healthcare Specialist	48	28.7	--	--	48	21.2
Supervisor/Coord.	--	--	--	--	--	--
Care Worker	17	10.2	--	--	17	7.5
Clerical/Administration	1	.6	21	35.6	22	9.7
Maintenance/Custodial	--	--	--	--	--	--
Security	--	--	2	3.4	2	.9
Quality Assurance	--	--	--	--	--	--
Human Resources	--	--	--	--	--	--
IT/Analyst	--	--	--	--	--	--
Other	8	4.8	7	11.9	15	6.6
Missing	93	55.7	29	49.2	122	54
Length of Employment						
	Mean	SD	Mean	SD	Mean	SD
	9.31	8.56	5.41	6.39	8.26	8.20

Table 3 includes the demographic information for the 123 respondents who completed the one-year survey. The mean length of employment was 7.39 years (SD=6.67) for direct care employees and 7.95 (SD=7.91) for non-direct care employees. Most respondents were employed as healthcare specialist (4.1%), followed by clerical/administration (3.7%). The most common demographics for the one-year survey were female, 45-54 years of age, and White. The table also presents descriptive statistics for direct and non-direct care workers separately.

Table 3. Post-Test Demographics for BHD at One-Year.

Variable	Direct Care Worker		Non-Direct Care Worker		Total Sample	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Gender						
Male	8	17	22	28.9	30	24.4
Female	32	68.1	42	55.3	74	60.2
Transgender	--	--	--	--	--	--
Other	--	--	--	--	--	--
Missing	7	14.9	12	15.8	19	15.4
Age						
18-24	1	2.1	--	--	1	.8
25-34	11	23.4	6	7.9	17	13.8
35-44	10	31.3	17	22.4	27	22.0
45-54	11	23.4	26	34.2	37	30.1
55+	9	19.1	16	21.1	25	20.3
Missing	5	10.6	11	14.5	357	13.0

Race/Ethnicity						
Black	19	40.4	13	17.1	32	26.0
White	17	36.2	42	55.3	59	48.0
Asian	--	--	--	--	--	--
Hispanic	2	4.3	2	2.6	4	3.3
Multiracial	2	4.3	1	1.3	3	2.4
Other	1	2.1	3	3.9	4	3.3
Missing	6	12.8	15	19.7	362	17.1
Position						
Healthcare Specialist	19	40.4	--	--	19	4.1
Supervisor/Coord.	--	--	--	--	--	--
Care Worker	7	14.9	--	--	7	1.5
Clerical/Administration	--	--	17	22.4	17	3.7
Maintenance/Custodial	--	--	--	--	--	--
Security	--	--	3	3.9	1	.6
Quality Assurance	--	--	1	1.3	1	.2
Human Resources	--	--	--	--	--	--
IT/Analyst	--	--	--	--	--	--
Other	--	--	1	1.3	1	.2
Missing	21	44.7	54	71.1	416	89.7
Length of Employment	Mean	SD	Mean	SD	Mean	SD
	7.39	6.67	7.95	7.91	7.72	7.40

Table 4 presents the demographic information for the sample of 99 respondents at year two. As can be seen, respondents had worked at BHD for an average of 8.34 years (SD=8.12), and the most common positions reported were clerical/administration (24.2%) and care worker (16.2%). Most of the sample was female (58.6%), 45 and older (57.6%), and White (57.6%).

Table 4. Post-Test Demographics for BHD at Two-Years.

Variable	Direct Care Worker		Non-Direct Care Worker		Total Sample	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Gender						
Male	7	21.2	19	28.8	26	26.3
Female	21	63.6	37	69.2	58	58.6
Transgender	--	--	--	--	--	--
Other	--	--	--	--	--	--
Missing	5	15.2	10	15.2	15	15.2
Age						
18-24	--	--	--	--	--	--
25-34	5	15.2	6	9.1	11	11.1
35-44	7	21.2	9	13.6	16	16.2
45-54	8	24.2	22	33.3	30	30.3
55+	8	24.2	19	28.8	27	27.3
Missing	5	15.2	10	15.2	15	15.2

Race/Ethnicity						
Black	13	39.4	11	16.7	24	24.2
White	15	45.5	42	63.6	57	57.6
Asian	--	--	--	--	--	--
Hispanic	1	3	3	4.5	4	4
Multiracial	1	3	--	--	1	1
Other	--	--	--	--	--	--
Missing	3	9.1	10	15.2	13	13.1
Position						
Healthcare Specialist	13	39.4	--	--	13	13.1
Supervisor/Coord.	--	--	--	--	--	--
Care Worker	6	18.2	10	15.2	16	16.2
Clerical/Administration	--	--	24	36.4	24	24.2
Maintenance/Custodial	--	--	--	--	--	--
Security	--	--	--	--	--	--
Quality Assurance	--	--	--	--	--	--
Human Resources	--	--	--	--	--	--
IT/Analyst	--	--	--	--	--	--
Other	--	--	9	13.6	9	9.1
Missing	14	42.4	23	34.8	37	37.4
Length of Employment	Mean	SD	Mean	SD	Mean	SD
	7.96	7.95	8.53	8.28	8.34	8.12

In comparing the pre-test demographic statistics with the one-month, one-year, and two-year BHD employee demographic statistics, the groups appear to be similar. Chi-square tests for age, gender, race/ethnicity, and job position and an ANOVA for how long each employee had worked at MCBHD were conducted to determine whether there were significant differences between respondents at the pre-test and the three post-tests. The only variable that was significantly different between the two sets of data was the distribution of direct care versus non-direct care employees. Gender, race/ethnicity, age, position held, and years worked at BHD did not differ significantly between the pre-and post-samples.

Design and Analysis

The design for this program evaluation is to compare baseline survey responses from existing employees to a one-month, one-year, and two-year follow-up. At the beginning of each Gatekeeper Training, the evaluators or a research assistant would explain the purpose of the

evaluation and would administer the paper-and-pen survey to eligible employees. For most direct care workers, they were asked to complete the one-month follow-up survey by the evaluators and research assistants at the end of Phase Two training. Non-direct care workers and direct care workers, who completed both phases of the training within the same week, were administered the one-month follow-up survey via interdepartmental mail. All surveys were anonymous; no names or identifiers were collected. Year one surveys were administered from September through October 2018, corresponding to the year marker for two-thirds of employees. Year two surveys were administered from July through August 2019, as the grant period ended in September 2019.

To increase response rates for these individuals, the evaluators utilized a modification of the Dillman method of survey administration (Dillman, Smyth, & Christian, 2009). Three mailings were used for the one-month surveys; four mailings were used for the one-year and two-year surveys. The first mailing contained the initial anonymous survey and a blue post card containing the employee's name. Employees were directed to return the survey to a locked box for which only the evaluation team had keys. The postcard was to be returned in a separate locked box so there would be no link between a staff member's survey and their postcard. This allowed the survey to remain anonymous while allowing for follow-ups to be administered to those who had not yet completed the survey. Those who refused participation were instructed to simply return the post-card to avoid receiving follow-ups. The second mailing was an orange post card reminder to complete the survey, and the third was another copy of the survey and a green post card to track responses and refusals. The fourth mailing was a pink postcard as a final reminder urging employees to complete their survey.

Quantitative Outcome Measures

This evaluation included measures for role conflict, conflict resolution skills, perceptions of confidence in keeping oneself and others safe, horizontal violence at work, burnout, turnover intention, and feelings of safety at Milwaukee County BHD. In addition, direct care workers were asked questions about role conflict with security, moral sensitivity, perceptions of patients, confidence in working with behavioral health patients, and employer constraints in providing adequate care. At the one-month follow-up, four outcome measures were examined for all employees – conflict resolution skills, perceptions of confidence in keeping oneself and others safe, horizontal violence at work, and feelings of safety at Milwaukee County BHD. In addition, four outcome measures were examined for direct care workers – moral sensitivity, perceptions of patients, confidence in working with behavioral health patients, and employer constraints in providing adequate care. At the one-year and two-year follow-up, the measures for role conflict, conflict resolution skills, perceptions of confidence in keeping oneself and others safe, horizontal violence at work, feelings of safety at Milwaukee County BHD, burnout, and turnover intention were examined. The four measures specific to direct care workers at the one-month survey were also included, as well as a scale of role conflict for direct care workers in relation to security’s role. See Table 5 for a summary of the outcomes at each time point.

Table 5. Outcomes Measured in Follow-Up Surveys.

	All Employees	Direct Care Employees Only
One-Month Outcomes	1) Conflict resolution skills 2) Confidence in keeping oneself and others safe 3) Horizontal violence at work 4) Feelings of safety at MCBHD	1) Moral sensitivity 2) Perceptions of patients 3) Confidence in working with BH patients 4) Employer constraints in providing adequate care
Additional Outcomes in One- and Two-Year	5) Role conflict 6) Burnout 7) Turnover intention	5) Role conflict in relation to security’s role

Universal Outcomes

The first universal outcome was measured through a six-question scale regarding role conflict within the workplace, adapted from Rizzo, House, and Lirtzman (1970).³ This scale contained questions such as “I have to do things that should be done differently” and “I receive requests from two or more people that are at odds with each other.” The Cronbach alpha for this measure was adequately reliable at each time point (.794 pre, .847 one-year, .871 two-years). Higher values on this scale indicate greater role conflict.

The second universal outcome was measured through a five-question scale regarding conflict resolution skills. This scale contained questions such as, “During a conflict, it is important to listen to the other person’s point of view” and “When I negotiate, I think about everyone’s needs.” The Cronbach alpha for this measure was .796 on the pre-test, .564 at one-month, .7 at one-year, and .666 at two-years, indicating that the scale was adequately reliable. Higher scores on this scale indicate stronger conflict resolution tactics.

The third outcome examined respondents’ confidence in their abilities to keep themselves and others safe during a physical or verbal altercation at work. This ten-item scale contained items such as, “I am confident that I can handle a verbal conflict with a person,” “I am confident that I can handle a physical conflict with a person,” “I am confident that if a person tried to physically assault me, I could keep myself safe,” and “I am confident that if a person tried to physically assault me, I could keep the person safe.” The Cronbach alpha for this measure was .823 on the pre-test, .88 at one-month, .866 at one-year, and .892 at two-years, indicating that the

³ This outcome measure was not asked of respondents at the one-month survey.

scale was adequately reliable. Higher values on this scale indicate greater confidence in keeping oneself and others safe.

For these first three outcomes (i.e., role conflict, conflict resolution skills, and confidence in keeping self and others safe), respondents indicated their level of agreement for each item on a Likert scale ranging from “Strongly Agree” to “Strongly Disagree.” Responses were coded from five to one, with five indicating “Strongly Agree” and one indicating “Strongly Disagree.” Negative items were appropriately reverse coded and an average of all items on the scale was calculated.

For the fourth outcome, respondents were asked to report their experiences with horizontal violence in the last month. Respondents were asked how often they personally experienced or witnessed the following: harsh criticism of someone without having heard both sides of the story, making hurtful remarks to or about coworkers in front of others, complaining about a coworker to others instead of attempting to resolve a conflict, and raising eyebrows or rolling eyes at another coworker. This scale was adopted from Dumont, Riggelman, Meisinger, and Lein (2011). Respondents indicated their experiences with each behavior in the past month on a scale of never, once, a few times, monthly, weekly, and daily. Responses were coded so that a higher number indicated more frequent experiences with the behaviors. An average was then calculated for each respondent. The Cronbach alpha for this measure was .9 on the pre-test, .852 at one-month, .884 at one-year, and .918 at two-years, indicating that the scale was adequately reliable.

Feelings of safety while working at MCBHD were examined for the fifth outcome. This consisted of comparing pre- and post-responses to the following question, “How often do you feel safe (free from violence) while working at the Milwaukee County Behavioral Health

Division.” Respondents indicated their level of agreement to this statement on a scale of never, once, a few times, monthly, weekly, and daily. Responses were coded so that a higher number indicates more frequent feelings of safety.

Two additional sets of outcomes were asked of employees at the pre-test and each year. The sixth outcome examined turnover intention and asked respondents whether they occasionally think of leaving Milwaukee County BHD, as well as if they intend to leave in the next few months or years. This scale was adapted from Nissly, Mor Barak, & Levin (2005). Respondents were asked to indicate their level of agreement on a five-point scale ranging from “Strongly Agree” to “Strongly Disagree,” and an average was calculated for each respondent. The Cronbach alpha for this scale was .768 at the pre-test, .716 at one-year, and .81 at two-years, indicating that the scale was adequately reliable. Responses were coded so that a higher number indicates greater intention of turnover.

The seventh outcome examines burnout among direct care workers and non-direct care workers separately. The Oldenburg Inventory was used for non-direct care workers and is a 12-item scale that includes statements such as “There are days I feel tired before I arrive to work” and “I find my work to be a positive challenge” (Demerouti, Bakker, Vardakou, & Kantas, 2003). Responses for this scale were on a four-point Likert scale ranging from “Strongly Agree” to “Strongly Disagree.” The Cronbach alpha for this scale was .831 at the pre-test, .856 at one-year, and .849 at two-years, indicating that the scale is adequately reliable. For direct care workers, the Malash Burnout Inventory was used, which is an 18-item scale (Malasch, Jackson & Leiter, 1996). Statements on this scale included “I feel used up at the end of the workday” and “I have become more callous toward people since I took this job.” Respondents were asked to circle a number that corresponded to their attitudes, ranging from 0 (Never) to 6 (Daily). The Cronbach alpha for this scale was .848 at the pre-test, .837 at one-year, and .896 at two-years, indicating that the scale

was adequately reliable. For both burnout scales, *higher* numbers indicate *less* burnout among employees, responses were reverse coded for applicable items, and an average was calculated for each respondent.

Additional Healthcare Worker Outcomes

Five additional outcome measures were examined for direct care workers. The first assessed moral sensitivity towards behavioral healthcare patients. This four-item scale was adopted from Lutzen, Dahlqvist, Eriksson, and Norberg (2006) and contained items such as, “When caring for patients, I am always aware of the balance for doing good and the risk of causing harm” and “I always feel a responsibility for the patient receiving good care even if the resources are inadequate.” Cronbach alpha statistics of .72 on the pre-test, .619 at one-month, .732 at one-year, and .557 at two-years indicate the scale was adequately reliable.

The second measure examined direct care workers’ perceptions of behavioral health patients. This outcome was assessed with an eight-item scale adopted from Gibb, Beautrais, and Surgenor (2010). It contained items such as, “Behavioral health patients are difficult to work with,” “Behavioral health patients are a waste of my time,” and “I think my contact with behavioral health patients is helpful to them.” Cronbach alpha statistics of .765 on the pre-test, .633 at one-month, .584 at one-year, and .79 at two-years indicate the scale was adequately reliable. Each scale was coded so that higher numbers indicate greater moral sensitivity and more positive perceptions of patients, respectively.

Two survey items assessed the third outcome, respondents’ confidence in working with behavioral health patients. The first asked respondents their level of agreement with the following statement, “I think I am adequately trained to deal with behavioral health patients.” The second asked level of agreement with, “I feel confident in assessing the risks of violent outburst in behavioral health patients.” Cronbach alpha statistics of .704 on the pre-test, .703 at

one-month, and .715 at two-years indicate the scale was adequately reliable. Unfortunately, at one-year the alpha was .258, which suggests some issues with reliability based on respondents' answers. For this scale, responses were coded so that higher numbers indicate greater confidence in working with behavioral health patients. The last outcome was assessed through one question, "MCBHD makes it difficult to deal with patients." This item was coded so that higher values indicate more perceived difficulty in working with patients in Milwaukee County BHD.

Finally, direct care workers were asked about role conflict specific to working with security to keep patients safe.⁴ A five-item scale was asked of respondents, including items such as, "If I have to call security for assistance with a patient, I know what decisions should be made by me as the health care specialist" and "I have confidence that the security at MCBHD will listen to me when it concerns the health of a patient." The Cronbach alpha for the scale was .774 at the pre-test, .726 at one-year, and .803 at two-years, indicating that the scale was adequately reliable. This scale was coded so that higher numbers indicate greater role conflict between direct care workers and security.

For all four outcomes, respondents indicated their level of agreement on a Likert scale ranging from "Strongly Agree" to "Strongly Disagree." Responses were coded from five to one, with five indicating "Strongly Agree" and one indicating "Strongly Disagree." For outcomes that were scaled (e.g., moral sensitivity, perceptions of patients, confidence in working with patients) negative items were appropriately reverse coded and an average of all items on the scale was calculated.

⁴ This scale was not included in the one-month survey.

Quantitative Results of Outcome Measures

For each of the outcomes examined, ANOVAs were conducted to determine whether the survey responses differed across any time points. The following section presents the results of these statistical tests and whether there were significant differences between each time point.

Universal Outcome Results

Results for universal outcomes measures are presented in Table 6. As shown in the table, respondents indicated decreased role conflict when comparing the pre-test to the one-year post-test and two-year post-test. There were no significant differences in comparing the one-year to two-year averages for role conflict, suggesting the effect was sustained over time. Similarly, employees' conflict resolution skills and confidence in keeping themselves and others safe changed over the course of the evaluation. When comparing the pre-test to the one-month period, respondents' conflict resolution skills significantly improved, yet there were no significant differences when comparing the pre-test to the one-year or two-year time periods. Interestingly, respondents' conflict resolution skills decreased between the one-month to two-year time periods, suggesting that changes in conflict resolution skills were short-term in nature. Employees' confidence in keeping themselves and others safe, however, increased when comparing the pre-test to the one-month follow-up, the one-year follow-up, and the two-year follow-up, suggesting that training had a long-term impact on these perceptions. The comparisons between other time points demonstrate that the greatest change was between the pre-test and one-month after the training, as there were decreases in these perceptions when comparing one-month to one-year and one-year to two-year.

The second set of outcomes examines coworker conflict and general feelings of safety. There were significant changes in employees' perceptions of horizontal violence at work in the anticipated direction. Staff reported less experience with various forms of staff conflict and aggression when comparing the pre-test to one-month, as well as comparing the pre-test to one-year and two-years. General feelings of safety increased over time; although there were no significant differences between the pre-test and the one-month survey, this increase was significant when comparing the pre-test to one-year and two-years.

The third set of outcomes relates to burnout and turnover intentions. When looking at non-direct care workers, there were no significant differences in burnout over time, suggesting the training had no impact on burnout. For direct care workers, by contrast, there were significant differences over time in their burnout. These employees had decreased burnout over time when comparing the pre-test to one-year and two-year follow-ups, yet there were no differences when comparing the one-year to two-year time periods. The largest change occurred between the pre-test and one-year follow-up. Finally, there were significant differences in turnover intention across time. Turnover intention was higher at the one-year and two-year time points compared to the pre-test, demonstrating that turnover attitudes actually increased over the duration of the evaluation.

Table 6: Quantitative Results for MCBHD Employees

Measure	Mean for Groups	Mean Difference Between Groups
Role Conflict F= 11.525***	Pre-test= 2.972 One-year= 2.639 Two-year= 2.663	Pre-test to One-year= .333*** Pre-test to Two-year= .309** One-year to Two-year= -.025
Conflict Resolution Skills F= 11.731***	Pre-test= 4.132 One-month= 4.382 One-year= 4.274 Two-year= 4.206	Pre-test to One-month= -.251*** Pre-test to One-year= -.143^ Pre-test to Two-year= -.075 One-month to One-year= .108 One-month to Two-year= .176* One-year to Two-year= .068

Confidence in Safety Skills F= 37.743***	Pre-test= 3.634 One-month= 4.169 One-year= 3.906 Two-year= 3.845	Pre-test to One-month= -.536*** Pre-test to One-year= -.273*** Pre-test to Two-year= -.211* One-month to One-year= .263** One-month to Two-year= .324*** One-year to Two-year= .061
Experience with Horizontal Violence F= 8.841***	Pre-test= 1.692 One-month= 1.224 One-year= 1.275 Two-year= 1.239	Pre-test to One-month= .469*** Pre-test to One-year= .417* Pre-test to Two-year= .453* One-month to One-year= -.051 One-month to Two-year= -.015 One-year to Two-year= .036
Feelings of Safety at Work F= 5.862**	Pre-test= 3.471 One-month= 3.662 One-year= 4.091 Two-year= 4.071	Pre-test to One-month= -.189 Pre-test to One-year= -.620** Pre-test to Two-year= -.599* One-month to One-year= -.430 One-month to Two-year= -.410 One-year to Two-year= .020
Burnout Among Non-Direct Care Employees F= 1.523	Pre-test= 2.625 One-year= 2.778 Two-year= 2.792	Pre-test to One-year= -.153 Pre-test to Two-year= -.167 One-year to Two-year= -.014
Burnout Among Direct Care Employees F= 147.479***	Pre-test= 2.627 One-year= 4.122 Two-year= 4.154	Pre-test to One-year= -1.495*** Pre-test to Two-year= -1.527*** One-year to Two-year= -.032
Turnover Attitudes F= 37.801***	Pre-test= 1.692 One-year= 2.585 Two-year= 2.633	Pre-test to One-year= -.892*** Pre-test to Two-year= -.940*** One-year to Two-year= -.048

Note: ^p=05, *p<.05, **p<.01, ***p<.001

Direct Care Worker Outcome Results

Results for the five direct care worker outcomes are presented in Table 7. As shown in the table, there were no significant differences over time in role conflict for direct care workers with regards to their interactions with security, nor were there differences in moral sensitivity. Direct care workers reported greater confidence in working with patients at the one-month and one-year time periods compared to the pre-test; however, there were no significant differences when comparing the pre-test to two-years. Additionally, staff perceptions that BHD makes it difficult to care for patients effectively decreased when comparing the pre-test to one-month,

one-year, and two-year time periods. One outcome measure changed in unanticipated directions. Direct care workers reported lower perceptions of patients at the one-month and one-year time periods compared to the pre-test, while there were no significant differences between the pre-test and two-years.

Table 7: Quantitative Results for MCBHD Direct Care Employees

Measure	Mean for Groups	Mean Difference Between Groups
Role Conflict Among Direct Care-Workers F= 2.968	Pre-test= 3.543 One-year= 3.804 Two-year= 3.752	Pre-test to One-year= -.261 Pre-test to Two-year= -.208 One-year to Two-year= -.025
Moral Sensitivity F= 1.149	Pre-test= 4.523 One-month= 4.346 One-year= 4.201 Two-year= 4.152	Pre-test to One-month= -.094 Pre-test to One-year= .051 Pre-test to Two-year= .101 One-month to One-year= .145 One-month to Two-year= .194 One-year to Two-year= .050
Perceptions of Patients F= 9.474***	Pre-test= 4.159 One-month= 3.971 One-year= 3.782 Two-year= 3.943	Pre-test to One-month= .188** Pre-test to One-year= .377** Pre-test to Two-year= .216 One-month to One-year= .189 One-month to Two-year= .023 One-year to Two-year= -.161
Confidence in Working with Patients F= 18.911***	Pre-test= 3.789 One-month= 4.235 One-year= 4.065 Two-year= 4.015	Pre-test to One-month= -.445*** Pre-test to One-year= -.276* Pre-test to Two-year= -.226 One-month to One-year= .169 One-month to Two-year= .219 One-year to Two-year= .050
Difficulty in Dealing with Patients Appropriately F= 60.568***	Pre-test= 3.802 One-month= 2.469 One-year= 2.489 Two-year= 2.469	Pre-test to One-month= 1.333*** Pre-test to One-year= 1.312*** Pre-test to Two-year= 1.333*** One-month to One-year= -.021 One-month to Two-year= .000 One-year to Two-year= .021

Note: *p<.05, **p<.01, ***p<.001

Quantitative Results on Perceptions of Training

Perception of Training

Statistics for the survey responses asking about direct care employees’ perceptions of the training at one-month are provided in Table 8. When asked if individuals felt the training was a

good use of their time, about 90% “agreed” or “strongly agreed” to the statement. Approximately 94% also “agreed” or “strongly agreed” that they learned a lot from the Vistelar training. The majority of the direct care employees (91%) answered “agree” or “strongly agree” when asked if they felt like they can apply the skills they learned in the training to their job. Most direct care employees felt the trainers were easy to understand (95.2%) and that the trainers were knowledgeable about the content they were presenting (96.4%). When asked if direct care employees were engaged during the training, 93.5% of the employees answered “agree” or “strongly agree.” The majority (86.8%) either “agreed” or “strongly agreed” when asked if the training had taught them skills they never learned before.

Table 8: Perceptions of Training for Direct Care Workers

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I felt the training was a good use of my time	109 (65.3)	40 (24.0)	9 (5.4)	4 (2.4)	1 (0.6)
I learned a lot from the training	115 (68.9)	42 (25.1)	4 (2.4)	1 (0.6)	1 (0.6)
I feel like I can apply the skills I learned in the training to my job	108 (64.7)	44 (26.3)	6 (3.6)	4 (2.4)	1 (0.6)
The trainers were easy to understand	114 (68.3)	45 (26.9)	3 (1.8)	0 (0)	1 (0.6)
The trainers were knowledgeable about the content they were presenting.	133 (79.6)	28 (16.8)	1 (0.6)	0 (0)	1 (0.6)
I felt engaged during the training	120 (71.9)	36 (21.6)	3 (1.8)	1 (0.6)	1 (0.6)
This training taught me skills I have never learned before	99 (59.3)	46 (27.5)	7 (4.2)	8 (4.8)	2 (1.2)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

Statistics for the survey responses asking about non-direct care employees’ perceptions of the training at one-month are provided in Table 9. When asked if individuals felt the training was a good use of their time, about 72% “agreed” or “strongly agreed” to the statement. Approximately 68% also “agreed” or “strongly agreed” that they learned a lot from the Vistelar training. The majority of the non-direct care employees (70%) answered “agree” or “strongly

agree” when asked if they feel like they can apply the skills they learned in the training to their job. Most non-direct care employees felt the trainers were easy to understand (86%) and that the trainers were knowledgeable about the content they were presenting (93%). When asked if non-direct care employees were engaged during the training, 86% of the employees answered “agree” or “strongly agree.” The majority (64.9%) either “agreed” or “strongly agreed” when asked if the training had taught them skills they never learned before.

Table 9: Perceptions of Training for Non-Direct Care Workers

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
I felt the training was a good use of my time.	13 (22.8)	28 (49.1)	9 (15.8)	5 (8.8)	1 (1.8)
I learned a lot from the training.	10 (17.5)	29 (50.9)	12 (21.1)	4 (7.0)	1 (1.8)
I feel like I can apply the skills I learned in the training to my job.	10 (17.5)	30 (52.6)	13 (22.8)	3 (5.3)	0 (0)
The trainers were easy to understand.	23 (40.4)	26 (45.6)	4 (7.0)	3 (5.3)	0 (0)
The trainers knew a lot about the information they were presenting.	29 (50.9)	24 (42.1)	1 (1.8)	1 (1.8)	0 (0)
I felt engaged during the training.	22 (38.6)	27 (47.4)	5 (8.8)	1 (1.8)	1 (1.8)
This training taught me skills I have never learned before.	8 (14.0)	29 (50.9)	10 (17.5)	8 (14.0)	1 (1.8)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

Usefulness of Skills

One-Month

As shown in Table 10, approximately 66% of direct care employees “agreed” or “strongly agreed” that the training caused them to practice empathy more often at work (65.8%). The majority of healthcare employees “agreed” or “strongly agreed” that the training made them more aware of their conflict triggers (74.2%). Approximately 77% of the employees “agreed” or “strongly agreed” that the training made them more aware of other people’s conflict triggers (76.6%). When asked if direct care employees built trigger guards to respond to their conflict

triggers, 67.7% “agreed” or “strongly agreed.” Employees were asked if they have used the non-escalation skills taught in training and about 87% “agreed” or “strongly agreed” with the statement. The majority of the direct care employees (86.8%) also reported using the de-escalation techniques. The training also helped most direct care employees become more aware of their physical presence when interacting with people at work (88.6%).

Table 10: Usefulness of Skills for Direct Care Workers at One Month.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The training caused me to practice empathy more often at work.	42 (25.1)	68 (40.7)	42 (25.1)	7 (4.2)	4 (2.4)
The training has made me more aware of my conflict triggers.	49 (29.3)	75 (44.9)	26 (15.6)	10 (6.0)	2 (1.2)
The training has made me more aware of others people’s conflict triggers.	46 (27.5)	82 (49.1)	26 (15.6)	9 (5.4)	0 (0)
I have built trigger guards to respond to my conflict triggers.	35 (21.0)	78 (46.7)	38 (22.8)	10 (6.0)	1 (.6)
I have used the non-escalation skills taught in the training.	59 (35.3)	87 (52.1)	12 (7.2)	4 (2.4)	1 (.6)
I have used the de-escalation skills taught in the training.	57 (34.1)	88 (52.7)	15 (9.0)	2 (1.2)	1 (.6)
The training has made me more aware of my physical presence when interacting with people at work.	63 (37.7)	85 (50.9)	12 (7.2)	3 (1.8)	0 (0)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

Approximately 46% of non-direct care employees “agreed” or “strongly agreed” that the training caused them to practice empathy more often at work (45.6%). Just over half of non-direct care employees “agreed” or “strongly agreed” that the training made them more aware of their conflict triggers (50.9%). Nearly half of the employees agreed or strongly agreed that the training made them more aware of other people’s conflict triggers (46.1%). When asked if non-direct care employees built trigger guards to respond to their conflict triggers, 42.1% “agreed” or “strongly agreed.” Non-direct care employees were asked if they have used the non-escalation skills taught in training and about 40% “agreed” or “strongly agreed” with the statement. Just

over a third of the non-direct care employees (35.1%) reported using de-escalation techniques. The training also helped the majority of non-direct care employees become more aware of their physical presence when interacting with people at work (66.7%). These statistics are presented in Table 11. Additional descriptive statistics for perceptions of the usefulness of skills at years one and two are presented in Appendix B. In general, the results at years one and two follow the descriptive statistics presented here for direct care workers and non-direct care workers, with most respondents finding the skills helpful or neutral.

Table 11: Usefulness of Skills for Non-Direct Care Workers at One Month.

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The training caused me to practice empathy more often at work.	6 (10.5)	20 (35.1)	23 (40.4)	5 (8.8)	2 (3.5)
The training has made me more aware of my conflict triggers.	9 (15.8)	20 (35.1)	21 (36.8)	4 (7.0)	2 (3.5)
The training has made me more aware of others people's conflict triggers.	10 (17.5)	22 (28.6)	19 (33.3)	3 (5.3)	2 (3.5)
I have built trigger guards to respond to my conflict triggers.	7 (12.3)	17 (29.8)	27 (47.4)	4 (7.0)	1 (1.8)
I have used the non-escalation skills taught in the training.	8 (14.0)	15 (26.3)	20 (35.1)	12 (21.1)	1 (1.8)
I have used the de-escalation skills taught in the training.	8 (14.0)	12 (21.1)	22 (38.6)	10 (17.5)	4 (7.0)
The training has made me more aware of my physical presence when interacting with people at work.	11 (19.3)	27 (47.4)	12 (21.1)	6 (10.5)	0 (0)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

Effectiveness

One-Month

In examining perceptions of the effectiveness of the Gatekeeper Training skills at one-month, overall, most of the direct care employees used the non-escalation techniques and found that they were effective. The majority of employees used the *Universal Greeting* (88%) and all employees found it effective when they used it. In addition, the *Five Approaches to Showing*

Respect demonstrated similar results with 89.2% of direct care employees using the skill, and of those, 98.6% found it to be effective. A majority of direct care employees used the *Establish a Social Contract* skill (83.2%) and *Proxemics* techniques (87.4%), and of those, about 99% found the *Establish a Social Contract* to be effective and 98.6% found *Proxemics* to be effective.

Employees who used the *Showtime Mindset* (83.2%) found it effective about 97.8% of the time.

An even higher percentage of direct care employees used the beyond active listening technique (89.8%), and approximately 98% found it effective. For the de-escalation techniques, employees used these skills the majority of the time and found them to be effective in almost all of the instances they were used. The majority of employees (90%) used the *Re-direct* technique, and it was rated effective 98% of the time. Most also used the *Persuasion Sequence* (84.4%) and the *Crisis Intervention* techniques (86.2%), with 100% effectiveness for the *Persuasion Sequence* and about 99% effectiveness for *Crisis Intervention*.

For non-direct care employees, the majority of employees used the *Universal Greeting* (77.2%), and 97.7% found it effective. In addition, the *Five Approaches to Showing Respect* demonstrated similar results, with 86% reporting using it and 97.9% finding it effective.

Approximately 58% of non-direct care employees used the *Establish a Social Contract* technique and 53% used the *Proxemics* techniques. Of those who utilized these skills, about 88% found *Establish a Social Contract* to be effective and 82.8% found *Proxemics* effective. Although fewer employees reported using the *Showtime Mindset* (63.1%), those who used the skill found it effective about 89% of the time. Finally, the *Beyond Active Listening* technique was used almost 80% of the time (78.9%), and approximately 96% found it effective. De-escalation techniques were less commonly used by non-direct care employees, yet when used, they demonstrated high ratings of effectiveness. *Re-direct* was used by approximately 58% of non-direct care employees

(57.9%), and 100% of employees who tried the skill found it effective. As for the *Persuasion Sequence*, just over half of the employees used the technique, with 93.1% reporting that they found it effective. The *Crisis Intervention* technique was used by only 40.4% of non-direct care workers, yet 100% of those who tried this skill found it effective.

One-Year

Perceptions of the effectiveness of the Gatekeeper Training skills at one-year demonstrate that generally direct care employees have used the skills and, when used, mainly find them to be effective. All direct care employees used the *Universal Greeting*, and 97.9% found it effective. Similarly, all staff used the *Five Approaches to Showing Respect*, again with 97.9% rating it as effective. Almost 90% (89.4%) of direct care staff have used *Establish a Social Contract*, of whom 92.9% rated it as effective. Most staff have used *Proxemics* (85.7%) and the majority of these individuals (94.4%) found it to be effective. Slightly less commonly used was the *Showtime Mindset* (79.1%), yet 82.4% rated it as effective. *Beyond Active Listening* was used by all direct care workers at one-year, with 90.2% rating it as effective. For the de-escalation techniques, a similar trend of use and effectiveness rating emerged. *Re-direct* was used by almost all direct care workers (97.8%), with 93.3% rating it as effective at reducing conflict. Most used the *Persuasion Sequence* (88.9%), with 92.5% finding it helpful. Lastly, *Crisis Intervention* skills were used by 93.5% of direct care workers, with 95.3% rating it as effective.

As with the one-month results, non-direct care workers used the non-escalation and de-escalation skills less frequently. Skills that were used more often by non-direct care workers included the *Universal Greeting* (80.8%), *Five Approaches to Showing Respect* (86.5%), and *Beyond Active Listening* (87.5%). These skills were found to generally be effective when applied in non-direct care settings (98.3%, 96.9%, and 96.8%, respectively). Fewer staff had used the

Social Contract skill (63.8%), yet 97.7% found it helpful. Even less frequently used was *Proxemics* (54.3%), yet again 97.4% of those who used the skill found it effective. The *Showtime Mindset* was used by just over two-thirds of non-direct care staff (68.6%) at one-year, with 97.9% finding it effective. For de-escalation skills, a similar picture of less common use of skills emerged. *Re-direct* was used by 73.6% of non-direct care staff, yet 90.6% found it effective. *Persuasion Sequence* and *Crisis Intervention* skills were used less commonly (57.7% and 58.8%), yet they tended to be rated as helpful when used (80.5% and 90.5%).

Two-Years

Direct care workers tended to report utilizing the skills from Gatekeeper Training through the second year of the evaluation. All staff reported using the *Universal Greeting* and *Five Approaches to Showing Respect*, with the vast majority rating these skills as effective (90.9% and 93.9%). Most direct care workers have used *Establish a Social Contract* and *Beyond Active Listening* (90.3% and 93.9%), again with high ratings of effectiveness (96.4% and 93.5%). *Proxemics* was used by 84.8% of direct care workers, with 78.6% rating it as helpful. Over 80% (81.8%) of staff reported using the *Showtime Mindset*, and 85.2% found it effective. Similar findings emerge for the de-escalation skills. *Persuasion Sequence* was used by 87.9% of direct care workers through year two, with 93.1% rating the skill as helpful for reducing conflict. All direct care workers reported using *Re-direct*, and 97% of those rated it as effective. Finally, the vast majority of direct care workers used *Crisis Intervention* skills (97.0%); of those, 93.8% rated it as effective.

A similar trend emerges for non-direct care workers at two-years for utilizing skills compared to the one-month and one-year surveys. Just under 70% (69.8%) of non-direct care workers reported using the *Universal Greeting*, with 97.7% rating it as effective. More

commonly used was the *Five Approaches to Showing Respect* (77.8%), with 95.9% feeling it was effective. *Beyond Active Listening* was also used more frequently among non-direct care workers (73.8%); of which, 97.8% of staff felt the skill was helpful. Less commonly utilized were *Establish a Social Contract*, *Proxemics*, and *Showtime Mindset* (59.0%, 58.3% and 61.0%, respectively). When used, these skills were rated as highly effective (94.4%, 97.1%, and 94.4%, respectively). The de-escalation skills have similar results. 75% of non-direct care workers reported using *Re-direct*, with 97.9% rating the skill as effective when used. Just under 60% (58.7%) of non-direct care staff used the *Persuasion Sequence* at least once by the second year; of which, 97.3% rated it as helpful in reducing conflict. Finally, 60.9% reported using *Crisis Intervention* skills, with 97.4% stating the skill was effective.

From the above findings at one-month, one-year, and two-years, direct care workers report using the non-escalation and de-escalation skills more commonly than non-direct care workers. Utilization of these skills is relatively consistent over time for each group of employees, suggesting that the training has influenced approaches to conflict and potential conflict.

Qualitative Measures of Perceptions of Training

Two focus groups were conducted with existing employees after they completed the Gatekeeper Training to better capture their thoughts on the training content and flow, utility of skills learned, and any recommendations they had for improving the training or implementation across Milwaukee County BHD. Appendix A contains the list of interview questions that were asked of participants. One group was a mix of direct care workers; the other a mix of non-direct care workers – whether in administration positions or serving clients in the community. Focus groups were conducted by a research assistant and transcribed. The evaluators analyzed the

transcripts for key themes emerging from each group, with comparisons made between groups. Four themes were prevalent across groups, which will be outlined below.

Qualitative Results on Perceptions of Training and Implementation

The focus groups elicited a variety of perceptions about the training and whether changes had been made across Milwaukee County BHD. Four main themes emerged from these focus groups: two focused on recommendations specific to the training (Vistelar or BHD trainers) and BHD administrators, while the other two emphasized the aspects of the training most useful and how the training has changed the culture at Milwaukee County BHD. A discussion of each theme follows.

Key Training Takeaways

The feedback from employees on the training was generally quite positive, with most expressing how useful the skills were when applied to their positions. One focus group participant stated, “The presenters were incredibly knowledgeable on the training they were providing. I also think that it is very useful for anybody on a unit or having active engagement with consumers.” One of the biggest strengths of the training was the emphasis on teamwork and communication between coworkers as key for reducing conflict. Second, participants appreciated the emphasis on assessing the situation before entering a room, as well as role clarification on who is to take charge in a de-escalation situation. Staff mentioned that because everyone had gone through the training, regardless of department or unit, they felt comfortable with handling any crisis. In terms of which tools or tactics were seen as most helpful, both groups mentioned the *Showtime Mindset*, *Five Ways to Show Respect*, and *Universal Greeting* were the tools they used daily whether working with clients or interacting with coworkers. One focus group participant commented on her common use of the *Showtime Mindset*, “... by the time I got to

Friday, I was exhausted. And right before I got into that, I thought, *Showtime*. And that is something I will always keep. Stop, put things back together for a moment, and *Showtime*, let's do this." For those who went through Phase 2 training, they appreciated the hands-on training, particularly the direction of who should be taking charge, what positions should be assumed in a stabilization technique, and the importance of assessing a situation before acting. Participants mentioned that these techniques increased their feelings of safety while working at BHD and that they felt empowered in the work they do. Several praised the instructors from Vistelar for demonstrating modifications for the stabilization and hands-on techniques that could be done across different strength and ability levels.

Cultural Changes

In addition to discussing strengths of the training, many participants emphasized that the training had led to changes across departments and the organization as a whole. Some mentioned that historically there was less emphasis on showing respect, but they noticed a distinct change since the training. When discussing respect as a cultural change, participants often emphasized that the skills they learned in Gatekeeper Training were part of how their department or unit acted with one another and toward clients. Some emphasized that there was more of a focus on teamwork in the units that provided direct patient care, better communication among staff, and more support among employees when handling conflict. One focus group participant commented, "I can go to a code and be comfortable because I know everyone is going to communicate." Some felt that the mixed seating at the trainings helped foster this culture of teamwork, as they were able to connect with employees with whom they normally do not work.

Although many cited a positive change in the culture at BHD, several voiced concerns that the change may not be long-lived. Some felt that the high rates of turnover, coupled with

delays in having everyone, and supervisors in particular, trained dampened the impact of the training on changing the culture. Others felt that employees who had worked at the organization for longer periods, or physicians, may not work as a team when handling a crisis, particularly if hands-on tactics are needed.

Training Recommendations

While there were many positive perceptions of the training, areas for improvement were also discussed. Many of the staff interviewed felt that the training sessions for both Gatekeeper and Phase 2 Trainings were drawn out, with too many breaks or too much repetition. Some recommended condensing Gatekeeper Training into a half day training and Phase 2 into two half-day sessions, as they felt that 8 hours of training became too long to remain focused and engaged. Others would like more practice opportunities for some of the hands-on positions, including practicing with coworkers while trainers observed, corrected, and offered suggestions. Still others wanted more time for applied questions and felt as though questions raised were at times brushed off as “what ifs,” yet were applicable to experiences they had in the past. Employees who work in the community also recommended more examples to their environment, where they often do not work in team settings. Others voiced the need for specialized training to address their unique experiences with clients. Participants were also concerned that not having a module on documenting situations with clients (e.g., hand sweep, escape to a safe zone) could still lead to problems if everyone was not instructed on the language to use when writing reports. Additionally, some felt that the trainers were not clearly explaining role expectations when a crisis emerged – including the “one voice” concept and who should be the leader in assessing the situation.

BHD Recommendations

Finally, participants recommended changes specific to Milwaukee County BHD policies in conjunction with Gatekeeper and Phase 2 Trainings. The first recommendation was to clearly define who should be required to take all phases of training – as some administrative staff were required to take Phase 2 and others were only required to take Gatekeeper Training. This also reflected the concern about who should be involved in responding to crises requiring de-escalation tactics, particularly for staff who do not typically work on a unit but may pass through. Second, participants recommended a faster pace of training for all employees, including requiring supervisors and administration to take Gatekeeper Training sooner. They expressed the challenges of trying to implement some of the skills requiring assessing a situation before acting and hands-on tactics when only part of a shift or unit had been trained. Similarly, there was a concern that because supervisors had been trained later than most line-level direct care staff, supervisors may not know that certain procedures were correct, resulting in fear of job security when policies and procedures were being rewritten to reflect the training that staff were receiving. Finally, almost all participants emphasized the need for ongoing support, whether through refresher trainings every few months or shift meetings to plan or debrief on tactics used. They felt that without these mechanisms in place, skills may be lost or forgotten

Conclusions

The results from the two years of follow-up demonstrate the program was successful in achieving most of its goals. First, employees had reduced role conflict and felt they had greater confidence in their ability to keep themselves and others safe after they completed the training. Second, staff reported less coworker conflict, or horizontal violence, after completing the training. Third, employees felt safer at Milwaukee County BHD after one year, which was sustained for the two-year follow-up. Fourth, direct care workers reported less burnout. Fifth,

direct care workers also reported greater confidence in working with clients and higher agreement that Milwaukee County BHD made it easy to work with clients. Unfortunately, the non-direct care workers' burnout was not impacted during the study period, and turnover intentions increased over time. Similarly, the training did not have an impact on direct care workers' role conflict with security, moral sensitivity toward patients, and their perceptions of patients became more negative at one-month and one-year. Table 12 provides a summary of these findings.

Table 12. Summary of Findings across Employee Categories.

All Employees	Direct Care Employees	Non-Direct Care Employees
1) Reduced role conflict	1) Less burnout	1) No impact on burnout
2) Greater confidence in ability to keep self and others safe	2) Greater confidence working with BH patients	
3) Less horizontal violence	3) Less feelings of employer constraints in providing adequate care	
4) Greater feelings of safety at MCBHD	4) No impact on role conflict with security	
5) Turnover intentions increased	5) No impact on moral sensitivity	
	6) Perceptions of patients fluctuated	

Despite some mixed findings of the outcomes, the results indicate that the Vistelar training was effective in achieving its broad goals to reduce conflict in the workplace and incite a cultural change toward non-escalation. Furthermore, BHD employees used the skills taught to them in the trainings and found them to be effective when they used them.

When Vistelar staff delivered the training, there was a consistency in the content and quality of the content across trainings. When BHD staff were observed, the change of scheduling to a 4-hour training impacted the ability of trainers to cover every aspect of the training, as well as explain each aspect sufficiently. Finally, results from the focus groups and the survey questions demonstrate that most staff felt the training was a valuable use of their time, that they had learned skills that could be used in their roles within Milwaukee County BHD, and that a cultural change had taken place. Some concerns were expressed about refresher trainings, ensuring all staff on a unit were trained, and that supervisors were aware of changes to policies and procedures that reflect the current training.

Recommendations

Based on the results from the focus groups and the process evaluation, we make the following recommendations:

- Milwaukee County BHD continue training their employees in conflict management.
- Consult with Vistelar to ensure subsequent training by BHD staff adheres to the same curriculum and standards. The researchers noted that several changes have been made to the curriculum to save time. Refresher “train the trainer” trainings for nurse educators may be helpful in this regard.
- Continue to reinforce skills and techniques acquired during the training through subsequent “refresher” trainings for staff.

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Appendix A. Focus Group Interview Questions

Interview Schedule

1. What are your general thoughts about the training by Vistelar?
2. Do you believe the Vistelar training was a good use of your time? Did they address things that you are concerned about/thought were useful?
3. What part of the training stood out as the most useful for your daily work with patients/coworkers?
4. What part of the training was least useful in your daily work?
5. Was there any part of the training that was difficult to follow?
6. Was there any part of the training that you felt was unhelpful, or not applicable to your work with patients/coworkers?

(Questions 7-9 applicable only to those interviewed after completing Gatekeeper Training i.e. follow-ups)

7. Can you think of a time when you have used a concept or tactic from the training? Can you explain the incident? Do you think it changed the outcome of the situation? (Did it deescalate the situation?)
8. Have you witnessed others using a concept or tactic from the training? Can you explain the incident? Do you think it changed the outcome of the situation? (Did it deescalate the situation?)
9. In your opinion has the training had an impact on the people that work at MCBHD? If yes, what impact?
10. Is there anything else you would like to share with me about the Vistelar training?

Appendix B. Perceptions of the Usefulness of Skills and One- and Two-Years.

Table 13: Usefulness of Skills for Direct Care Workers at One-Year

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The training caused me to practice empathy more often at work	9 (19.1)	16 (34.0)	15 (31.9)	5 (10.6)	2 (4.3)
The training has made me more aware of my conflict triggers	11 (23.4)	21 (44.7)	10 (21.3)	3 (6.4)	2 (4.3)
The training has made me more aware of other people's conflict triggers	13 (27.7)	19 (40.4)	12 (25.5)	2 (4.3)	1 (2.1)
I have built trigger guards to respond to my conflict triggers	7 (14.9)	16 (34.0)	17 (36.2)	4 (8.5)	2 (4.3)
I have used the non-escalation skills taught in the training	16 (34.0)	25 (53.2)	5 (10.6)	0 (0)	1 (2.1)
I have used the de-escalation techniques taught in the training	16 (34.0)	23 (48.9)	6 (12.8)	1 (2.1)	1 (2.1)
This training has made me more aware of my physical presence when interacting with people at work	16 (34.0)	21 (44.7)	8 (17.0)	1 (2.1)	1 (2.1)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

Table 14: Perceptions of Usefulness of Skills for Direct Care Workers at Two-Years

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The training caused me to practice empathy more often at work	4 (12.1)	18 (54.5)	9 (27.3)	2 (6.1)	0 (0)
The training has made me more aware of my conflict triggers	6 (18.2)	13 (39.4)	8 (24.2)	6 (18.2)	0 (0)
The training has made me more aware of other people's conflict triggers	6 (18.2)	16 (48.5)	9 (27.3)	2 (6.1)	0 (0)
I have built trigger guards to respond to my conflict triggers	3 (9.1)	10 (30.3)	14 (42.4)	5 (15.2)	1 (3.0)
I have used the non-escalation skills taught in the training	9 (27.3)	14 (42.4)	8 (24.2)	2 (6.1)	0 (0)
I have used the de-escalation techniques taught in the training	9 (27.3)	13 (39.4)	8 (24.2)	2 (6.1)	0 (0)
This training has made me more aware of my physical presence when interacting with people at work	5 (15.2)	17 (51.5)	8 (24.2)	1 (3.0)	2 (6.1)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

Table 15: Perceptions of Usefulness of Skills for Non-Direct Care Workers at One-Year

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The training caused me to practice empathy more often at work	5 (6.6)	32 (42.1)	30 (39.5)	6 (7.9)	1 (1.3)
The training has made me more aware of my conflict triggers	4 (5.3)	39 (51.3)	22 (28.9)	9 (11.8)	0 (0)
The training has made me more aware of other people's conflict triggers	5 (6.6)	39 (51.3)	22 (28.9)	8 (10.5)	0 (0)
I have built trigger guards to respond to my conflict triggers	4 (5.3)	28 (36.8)	31 (40.8)	10 (13.2)	1 (1.3)
I have used the non-escalation skills taught in the training	7 (9.2)	32 (42.1)	23 (30.3)	12 (15.8)	0 (0)
I have used the de-escalation techniques taught in the training	7 (9.2)	30 (39.5)	23 (30.3)	14 (18.4)	0 (0)
This training has made me more aware of my physical presence when interacting with people at work	6 (7.9)	44 (57.9)	20 (26.3)	4 (5.3)	0 (0)

Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

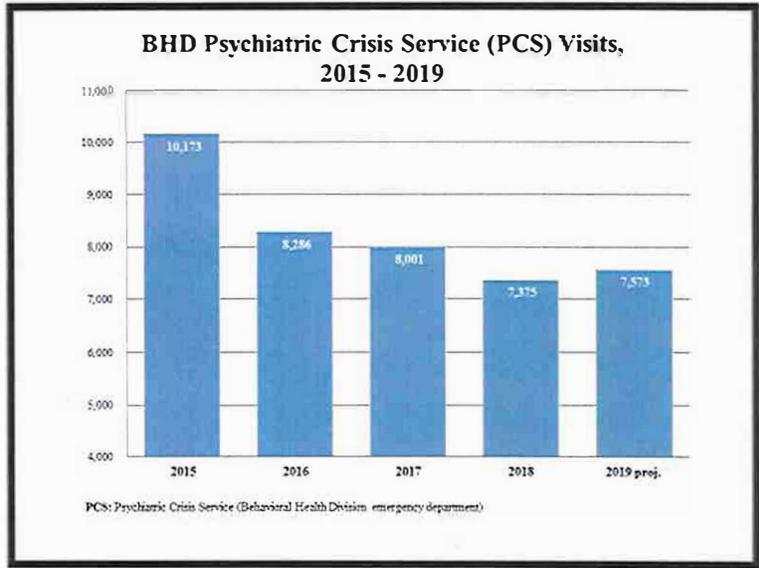
Table 16: Perceptions of Usefulness of Skills for Non-Direct Care Workers at Two-Years

	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
The training caused me to practice empathy more often at work	2 (3.0)	28 (42.4)	25 (37.9)	8 (12.1)	0 (0)
The training has made me more aware of my conflict triggers	3 (4.5)	28 (42.4)	23 (34.8)	9 (13.6)	0 (0)
The training has made me more aware of other people's conflict triggers	2 (3.0)	35 (53.0)	19 (28.8)	7 (10.6)	0 (0)
I have built trigger guards to respond to my conflict triggers	1 (1.5)	31 (47.0)	25 (37.9)	6 (9.1)	0 (0)
I have used the non-escalation skills taught in the training	2 (3.0)	29 (43.9)	22 (33.3)	7 (10.6)	2 (3.0)
I have used the de-escalation techniques taught in the training	3 (4.5)	30 (45.5)	19 (28.8)	8 (12.1)	2 (3.0)
This training has made me more aware of my physical presence when interacting with people at work	2 (3.0)	35 (53.0)	19 (28.8)	7 (10.6)	0 (0)

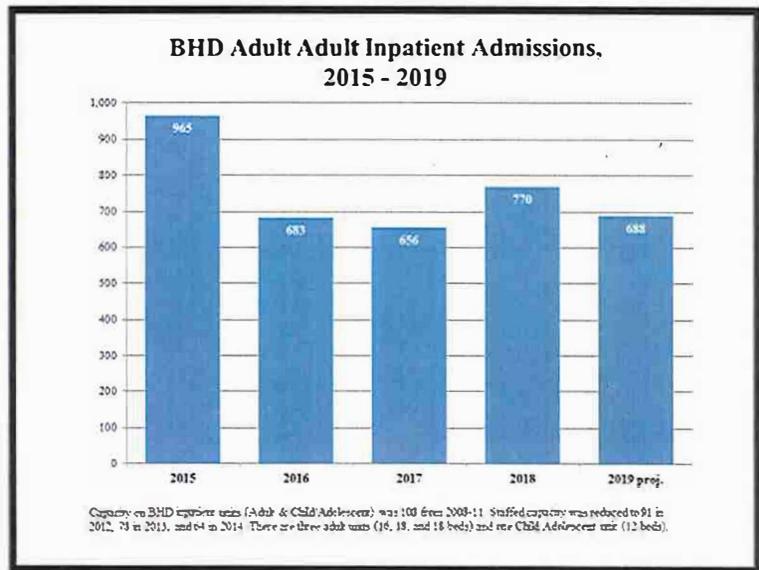
Note. Percentages in parenthesis. Percentages may not add up to 100% due to missing data.

2019 Q3 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient KPI Dashboard Summary

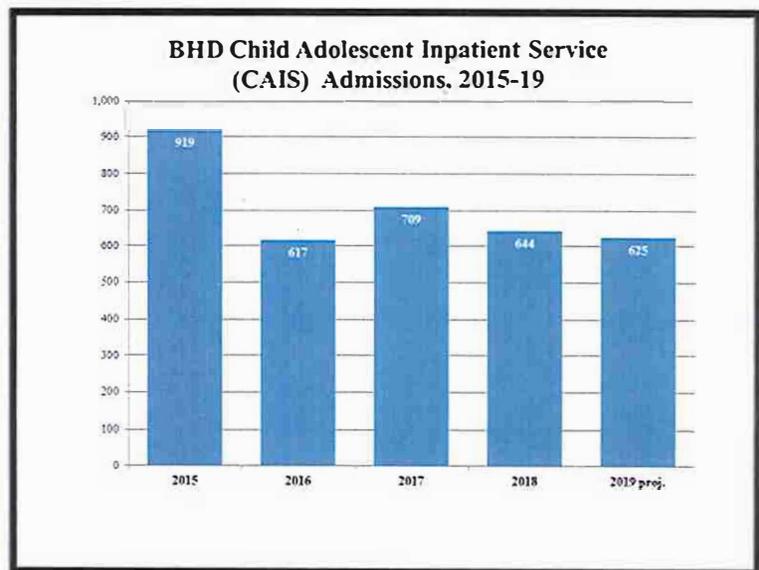
Psychiatric Crisis Service annual patient visits continue to decline from 10,173 in 2015 to 7,573 projected annual visits in 2019 (26% decline from 2015 to 2019). The continued downward trend of PCS utilization can be attributed in part to the inception of Team Connect, Crisis Mobile and CART Team expansions, and additional resources in the community. While PCS utilization is declining, PCS waitlist status is increasing (9% in 2014, 100% in 2019).



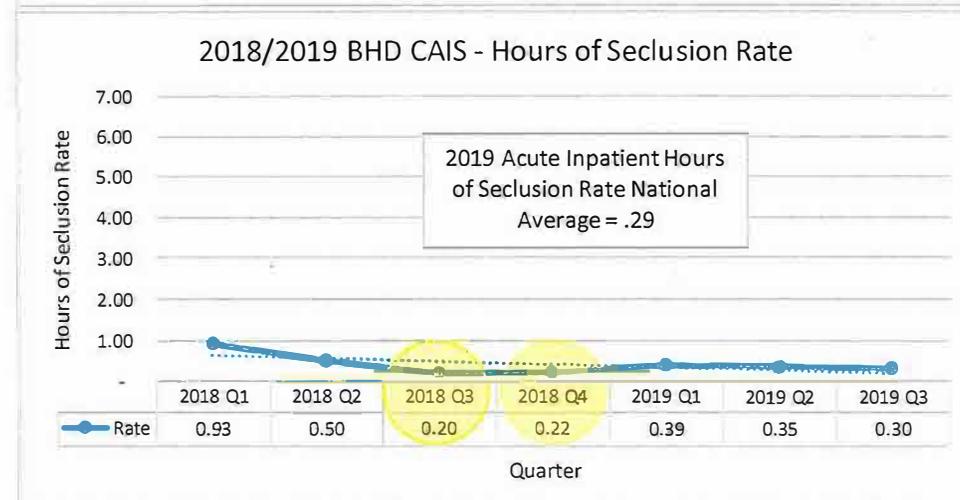
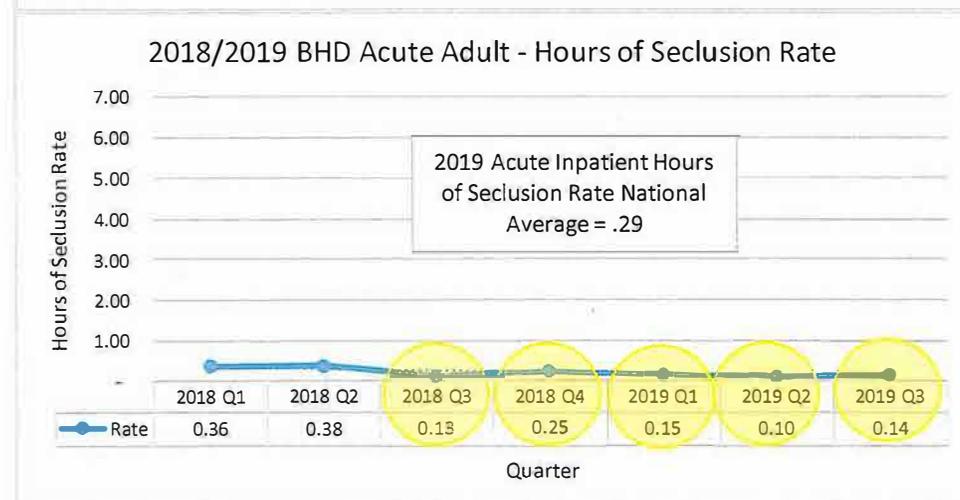
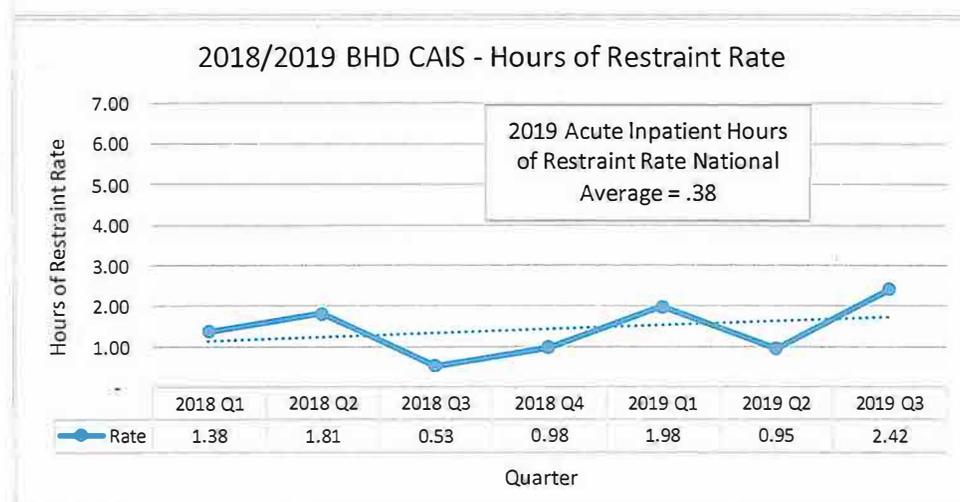
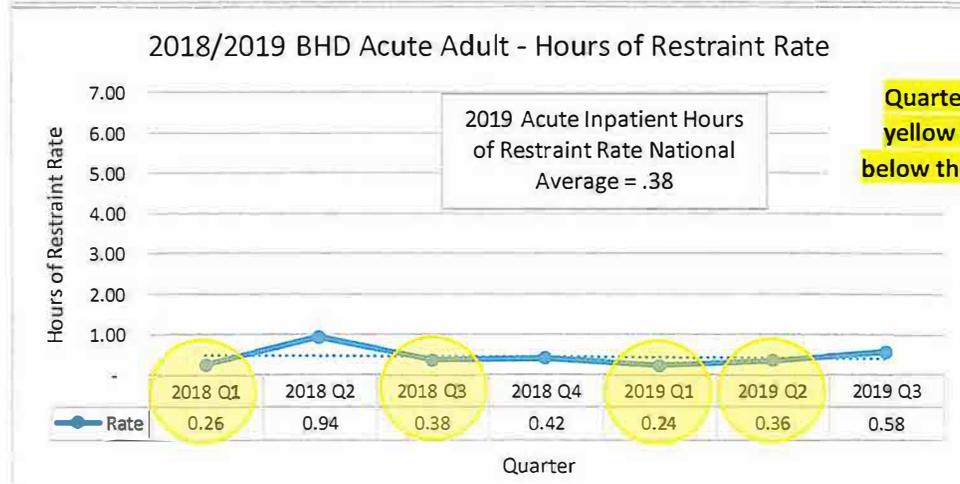
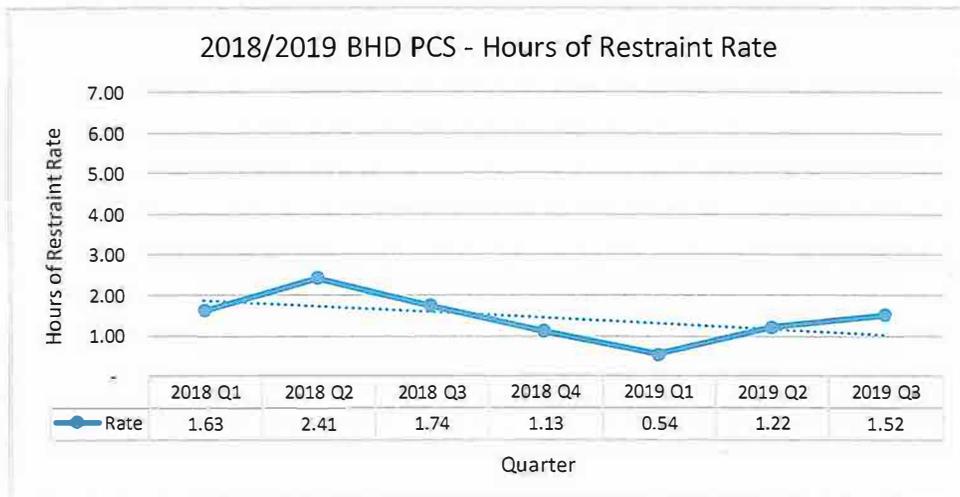
Acute Adult Inpatient Service’s annual patient admissions are projected at 688 in 2019. While Acute Adult admissions have plateaued over the past 4 years, readmission rates have continued to decline (30-day readmission rate: 11% in 2015, 6% in 2019). Acute Adult’s hours of physical restraint rate in 2019 was .39, close to CMS’ inpatient psychiatric facility national average of .38, and below Wisconsin’s average rate of .73. Acute Adult’s 2019 MHSIP overall patient satisfaction survey score of 75% is at the NRI’s reported national average.



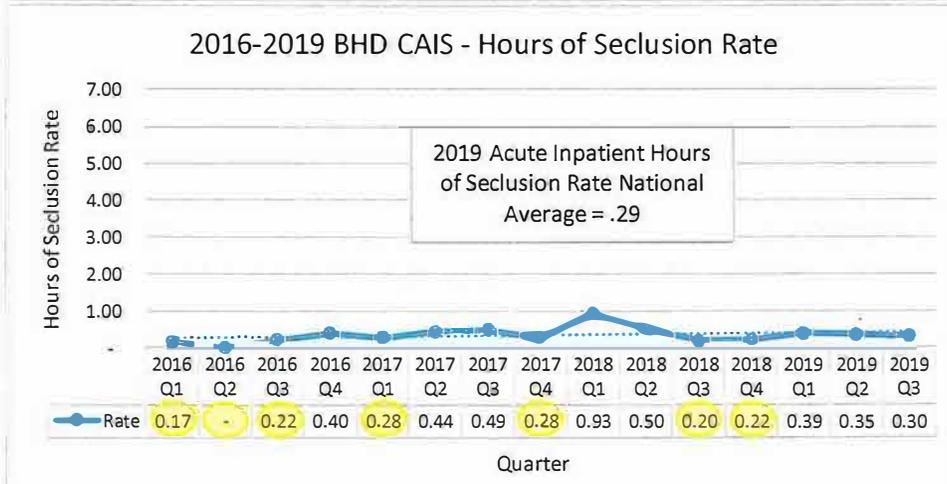
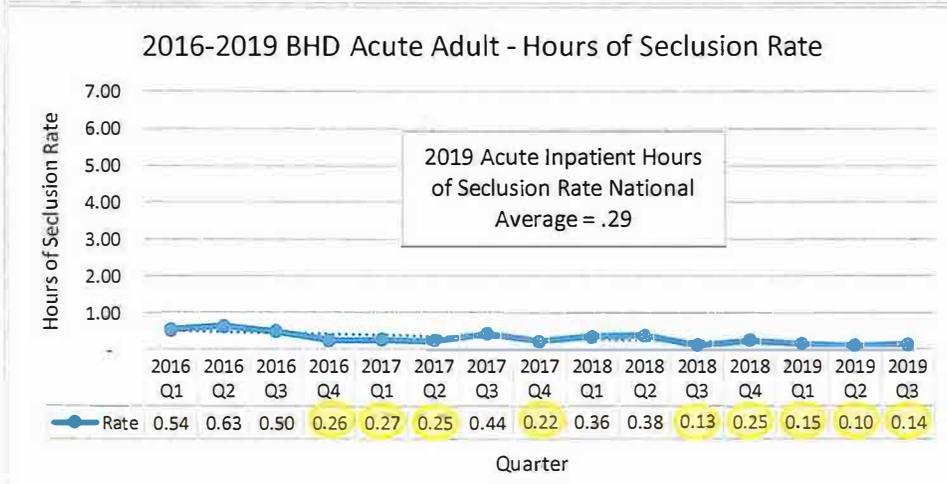
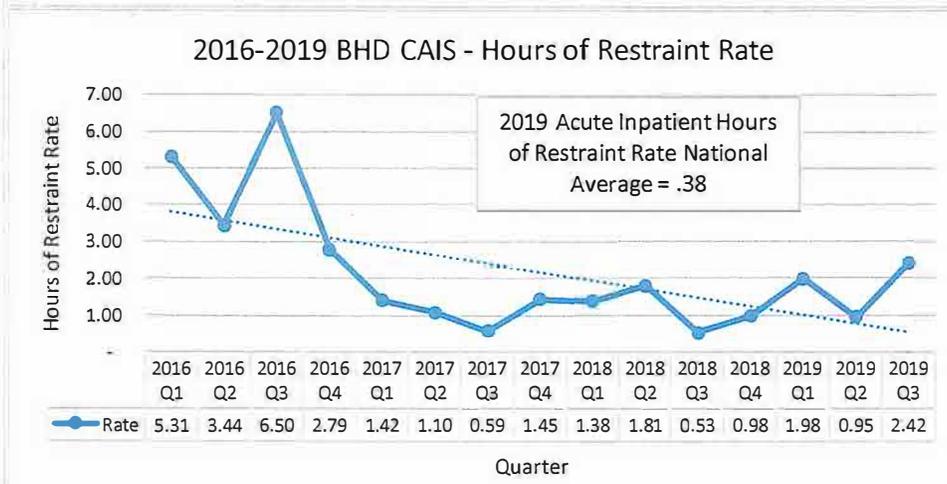
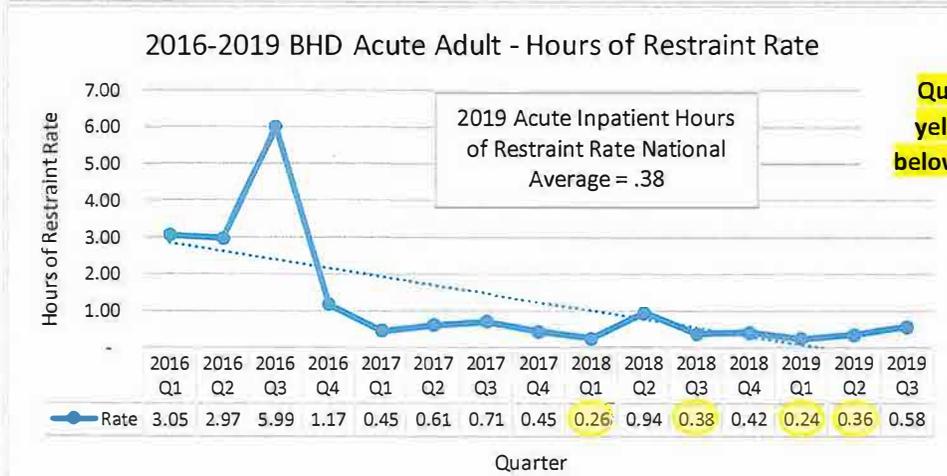
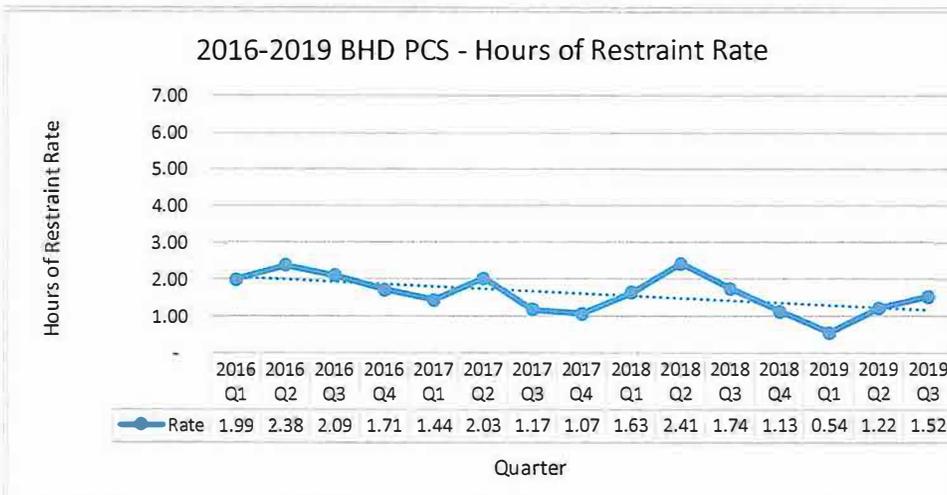
Child Adolescent Inpatient Service’s annual patient admissions have plateaued over the past 4 years and are projected at 625 for annual 2019. Over the past few years, CAIS’ 30-day readmission rates have remained at 16%. CAIS’ hours of physical restraint rate declined from 5.2 in 2015 to 1.7 in 2019, but remains above CMS’ reported average of .38. CAIS’ Youth Satisfaction Survey overall score of 75.8% positive rating is 4 percentage points higher than BHD’s historical average.



2019 Q3 Milwaukee County Behavioral Health Division (BHD) Crisis Service and Acute Inpatient Seclusion and Restraint Summary



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



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

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2019
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NAME OF PROVIDER OR SUPPLIER MILWAUKEE COUNTY BEHAV HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 9455 WATERTOWN PLANK ROAD MILWAUKEE, WI 53226
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	<p>Initial Comments</p> <p>On 10/08/2019, an on-site recertification survey was completed for Milwaukee County Behavioral Health, 1632.</p> <p>The provider holds certification under Wisconsin Administrative Code(s): DHS 61.79 Mental Health Adolescent Inpatient DHS 34.3 Mental Health Emergency Service 3 DHS 61.71 Mental Health Inpatient.</p> <p>A random sample of 22 client records and 8 personnel files were reviewed.</p> <p>No deficiencies were identified. No plan of correction is required.</p>	X 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

POLICY & PROCEDURE STATUS REPORT -GOAL=96%

Baseline 71.5% as of August 2016 LAB report

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

Recently Approved Policies	New Policies	Reviewed/ Revised Policies	Retired Policies
June	4	7	13
July	0	16	1
August	0	7	0
September	6	15	0
October	8	16	0

Overall Progress 93.6% as of Nov. 1, 2019

Current				
Review period	Number of Policies		Percentage of total	
	Last Month	This Month	Last Month	This Month
Within Scheduled Period	535	530	95.9%	93.6%
Up to 1 year Overdue	10	23	1.8%	4.1%
More than 1 year and up to 3 years overdue	10	10	1.8%	1.8%
More than 3 years and up to 5 years overdue	1	1	0.2%	0.2%
More than 5 years and up to 10 years overdue	1	1	0.2%	0.2%
More than 10 years overdue	1	1	0.2%	0.2%
Total	558	566	100%	100%

Forecast Due for Review

Past Due Policies - 36

Coming Due Policies

- November – 6
- December – 18
- January 2020 – 8
- February 2020 – 10
- March 2020 – 9

- April 2020 – 4
- May 2020 – 38
- June 2020 – 39
- July 2020 – 9
- August 2020 – 11
- September 2020 – 12
- October 2020 - 19

**Quality Management Committee
Institutional Review Board (IRB) Report
November 22, 2019**

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

- Current membership of the IRB includes: Dr. Justin Kuehl (Chair), Ms. Mary Casey, Ms. Shirley Drake, Dr. Matt Drymalski, Dr. Shane Moisio, Ms. Linda Oczus, and Dr. Jaquaye Wakefield.

Recently Completed Research

- Ms. Chioma Anyanwu completed a quality improvement project titled: “Improving the Quality of Nursing Assessment and Documentation for Patients at Risk for Suicide.”

Existing Research

- The IRB has approved and continues to routinely monitor the following proposals:
 - i) Dr. Tina Freiburger: “An Evaluation of the Vistelar Training Initiative at Milwaukee County Behavioral Health Division” (5/24/17).
 - ii) Dr. Gary Stark: “Survey of Suicidal Behavior Among Individuals with a Developmental Disability” (2/7/19).
 - iii) Dr. Pnina Goldfarb: “Building a Collaborative Care Model: An Approach for Effective Early Identification and Treatment of High School Students at Risk for Developing Psychosis” (2/18/19).
 - iv) Dr. John Schneider: “A Comparison of Adult Patient Experiences of Voluntary and Involuntary Commitment at Milwaukee’s Behavioral Health Department” (3/25/19).
 - v) Dr. Tina Freiburger: “Infrastructure Development Research for Milwaukee Wraparound” (8/29/19)
 - vi) Mr. Garrett Grainger: “Predictors of Housing Stability, Neighborhood Attainment, and Well-Being Amongst Community Care Patients” (10/22/19)

Research Proposals

- The IRB recently received a proposal submitted by Dr. Megan McClymonds titled: “The Clinical Utility of Pharmacogenomic Testing in the Treatment of Mood, Behavior and Psychotic Disorders in Children and Adolescents” (10/17/19)

Monthly IRB Chairs Meeting

- The Medical College of Wisconsin (MCW) hosts a monthly meeting of IRB Chairs. The purpose of the meeting is to share information and discuss pertinent issues, which promotes best practices among the various IRBs. Dr. Kuehl continues to routinely attend these meetings.

- The MCW leadership offered to provide additional training to support the BHD IRB. This training occurred on August 9, 2019.

Crisis Services Grand Rounds: November 4, 2019

- Dr. Kuehl offered a presentation to increase awareness of the BHD IRB and to provide basic information regarding human subjects research. This presentation was titled: “Research in Mental Health: An IRB Update.”

Respectfully submitted,

Justin Kuehl, PsyD
Chief Psychologist
IRB Chair