

BHD Quality Plan Goals and Objectives 2015-2016

The BHD Quality, Compliance and patient Safety Council will identify and define goals and specific objectives to be accomplished each year. Goals and objectives will be embedded in all aspects of operational and clinical planning in all parts of BHD. Alignment of Goals and Objectives will cascade down into each leadership committee and every staff annual performance review. Progress in meeting these goals and objectives will be periodically reviewed, reported and progress adjusted as needed.

Quality Plan Goals for 2015-2016

1. Ensuring all services enable people's ability to have maximum quality of life and health while living in the community.
2. Improving the patient experience in all services.
3. Evolving state of the art quality structures, processes and a culture of safety in all we do.

Quality Plan Objectives for 2015

1. Simplify the "Front Door" access and ability to navigate health care options in Milwaukee County.
 - North side strategy
2. Focus all services on engaging patients around their self-selection of health outcomes
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3. Develop programming and coordination for in creating family/support system involvement and engagement in all services.
 - Family Advisory Council
4. Increase staff competency around human interactions.
 - Educational sessions offered
5. Train all staff on basic quality improvement principles
 - Progress toward quality staff working together across the continuum of BHD
6. Implement Key Performance Indicators for all programs and leadership committees.
 - Data reports structured for PCS, Acute, CARS, Wrap

Quality Improvement Initiatives for 2015

1. Develop a Community Key Performance Indicator Dashboard of meaningful patient outcome measures
 - KPIs for community added to the overall performance dashboard. Continuing to refine

2. Develop a best practice update of our Suicide Assessment and Prevention Interventions in support of the Zero Suicide in Health and Behavioral Health Care goal of the National Action Alliance.
 - Progress to be discussed in Quality Committee meeting.
3. Develop and implement integration of pharmacy, electronic health record and staff practice for an updated state of the art medication management policy and procedure.
 - Implementation of closed loop med system, along with advanced in EHR for med management
 - Impressive implementation approaches and outcomes



Milwaukee County Behavioral Health Division 2015 Key Performance Measure (KPM) Dashboard

Program	Measure	2015 (1)	2015 Status (2)	2015 Target (3)
Community Access To Recovery Services	Number Served - AODA	6,080		5,529 *
	Number Served - Mental Health	5,097		4,663 *
	Comprehensive Community Service (CCS) Enrollees	236		236 *
	Reduction in past 6 months psychiatric bed days, admission to six months after admission	52%		64% *
	Reduction in past 30 days alcohol or drug use, admission to six months after admission	85%		79% *
	Reduction in homeless or in shelters, admission to six months after admission	79%		82% *
	Increase in employment (full or part time-competitive), admission to six months after admission	41%		54% *
Percent of clients returning to Detox within 30 days	24%		18% *	
Wraparound	Families served in Wraparound HMO (unduplicated count)	2,648		2,650 *
	Average level of Family Satisfaction (Rating scale of 1-5)	4.7		> = 4.0 *
	Percentage of enrollee days in a home type setting (enrolled through Juvenile Justice system)	68%		> = 75% *
	Average level of "Needs Met" at disenrollment (Rating scale of 1-5)	3.3		> = 3.0 *
	Percentage of youth who have achieved permanency at disenrollment	72%		> = 70% *
Percentage of Informal Supports on a Child and Family Team	43%		> = 50% *	
Crisis Service	Admissions	10,562		10,500 *
	Emergency Detentions	5,558		5,400 *
	Percent of patients returning to PCS within 3 days	8%		8%
	Percent of patients returning to PCS within 30 days	25%		20%
	Percent of time on waitlist status	20%		10% *
Acute Adult Inpatient Service	Admissions	1,002		1,125 *
	Mean Daily Census	48.7		52.0 *
	Percent of patients returning to Acute Adult within 30 days	12%		7%
	Percent of patients responding positively to satisfaction survey	72%		74%
	If I had a choice of hospitals, I would still choose this one. (MHSIP Survey)	55%		65% *
	HBIPS 1 - Admission screen for violence risk, substance abuse, trauma history, & patient strengths	95%		95% *
	HBIPS 2 - Hours of Physical Restraint Rate	9.0		0.72
	HBIPS 3 - Hours of Locked Seclusion Rate	0.41		0.31
	HBIPS 4 - Patients discharged on multiple antipsychotic medications	16%		10%
	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96%		30%
HBIPS 6 - Patients discharged with a continuing care plan	10%		75%	
HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	10%		68%	
Child / Adolescent Inpatient Service (CAIS)	Admissions	1,066		1,100 *
	Mean Daily Census	10.8		11.0 *
	Percent of patients returning to CAIS within 30 days	16%		11%
	Percent of patients responding positively to satisfaction survey	69%		74% *
	Overall, I am satisfied with the services I received. (CAIS Youth Survey)	73%		80% *
	HBIPS 1 - Admission screen for violence risk, substance abuse, trauma history, & patient strengths	95%		95% *
	HBIPS 2 - Hours of Physical Restraint Rate	5.6		0.23
	HBIPS 3 - Hours of Locked Seclusion Rate	0.80		0.30
	HBIPS 4 - Patients discharged on multiple antipsychotic medications	3%		3%
	HBIPS 5 - Patients discharged on multiple antipsychotic medications with appropriate justification	96%		36%
HBIPS 6 - Patients discharged with a continuing care plan	10%		88%	
HBIPS 7 - Post discharge continuing care plan transmitted to next level of care provider	10%		81%	
Financial	Total BHD Revenue (millions)	\$120.5		120.5 *
	Total BHD Expenditure (millions)	\$179.6		179.6 *

Notes:

(1) 2015 estimates are based on annualized 2015 mid-year data

(2) 2015 Status color definitions: Red (below 20% of benchmark), Yellow (within 20% of benchmark), Green (meets or exceeds benchmark)

(3) * notes that performance measure target was set using historical BHD trends

Joint Commission on Accreditation of Hospitals—Behavioral Health

Background:

Milwaukee County Behavioral Health Division maintained accreditation of acute services by the Joint Commission until about 2000. Over the past several years, there has been engagement to pursue Joint Commission standards and actually seek accreditation. An external consultant, Critical Management Solutions, was contracted to do periodic site visits to educate, counsel and assess. Their latest visits were in August, 2014, and now August 18-20, 2015.

Summary of Findings:

Two of the three surveyors onsite were present in 2014 as well as now. They identified

Significant improvements over the past year related to:

- General workplace environment has successfully shifted to being more proactive and stable, rather than reactive and crisis oriented.
- Improvement in qualified and competent staff and their engagement in improving care delivery.
- Significant improvements in aspects of medication management including the closed loop medication system
- Multiple other processes were improved based on previous review.

And beyond.

Additional improvements are needed in:

- Environment of care aspects throughout the facility
- Maintaining and in creating life safety measures
- Contract management processes to include expansion of performance measures and assurance that vendor staff are qualified, oriented and competent
- Improved HR processes and completeness of employee records
- enhanced processes and quality controls in use of point-of-care testing
- improved infection control plans

And beyond.

Related to Joint Commission standards for the governing board, there is a need for:

- Annual Board self evaluation
- Annual completion of conflict of interest declarations by all board members
- Board policy on conflict management and resolution

Multiple steps and improvements have already been taken since the time of the survey and the feedback report.

Recommendations

- Improve and sustain performance with all Joint Commission standards
- Apply for Joint Commission accreditation in December 2015
- Initial survey to be carried out, unannounced, in the following 12 months
- Anticipated cost of this survey is about \$48,000

Transition to Closed Loop Medication System Quality Update

9/15/2015

The BHD Pharmacy department strives to deliver clinical expertise related to pharmaceutical distribution, storage, dispensing, and administration for the hospital to meet the needs of the patients served. The process should be completed efficiently and cost effectively while maintaining optimal patient outcomes. To meet this goal a Closed Loop Medication System, was put into action on June 17th, 2015. Automated Dispensing Cabinets by Pyxis were installed throughout the facility in June 2015 to enhance the Closed Loop Medication System.

The Closed Loop Medication System process at BHD:

1. Computer Physician Order Entry by which physicians enter orders electronically.
2. Pharmacy verifies the Physician Electric Order with an electronic interface.
3. Confirmed order information is electronically sent from the interface to Automated Dispensing Cabinet for nurse medication accessibility.
4. Nurse accesses medication from the Automated Dispensing Cabinet electronically.
5. Nurse scans bar-code of medication with wrist band of patient to confirm right medication, right dose, right time, and right patient.
6. Confirmation of patient identity before administration,
7. Nurse confirms administration electronically.

Since start-up BHD Pharmacy department, with appropriate BHD services, began to evaluate the Closed Loop Medication System as it related to patient outcomes.

The bar code-scanning system and Closed Loop Medication System is a safeguard that helps prevent medication errors from the time a prescription is ordered through each time a drug is given.

Three months of Micromedex and software (Medication database) updates were installed in the BHD electronic medication systems. This combined effort improved nurse scanning of doses at time of medication administration from an estimated 60- 65% at startup to over 90%. Current industry standards indicate scanning of medications to ensure right medication, right dose, and right patient is about 95% Prior to startup no medication doses were scanned.

The Closed Loop Medication System has proven to be beneficial to physicians, nursing, the clinical staff, and patient safety in providing timely administration of medications and improving patient outcomes.

Overall, the Closed Loop Medication System implementation has been successful in reducing medication variances and has promoted a more efficient pharmaceutical process with positive patient outcomes.

Variations

Since start up there has been a reduction in medication variations from 1st quarter 2015 of 33 to 4. (Since startup June 17th, 2015).

This is a reduction of medication variations by 90% in units currently served.

All variations rated as Category A or B (Lowest severity rankings)

Additional Services by BHD Pharmacy

Forty-Two Clinical Pharmacist interventions to improve patient safety

Weekly Clinical Pharmacist attendance on patient care rounds.

BHD Pharmacy passed State of Wisconsin inspection with no variations

Conclusion

Automated Dispensing Cabinets have proven to be beneficial to nursing, the clinical staff, and patient safety in providing timely administration of medications and improving patient outcomes. Overall, the Closed Loop Medication System implementation has been successful in reducing medication variations and has promoted a more efficient pharmaceutical process with positive patient outcomes as the primary goal.

The number of variations has been significantly reduced.

Over 90% of doses dispensed are confirmed through the Closed Loop Medication System process.

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
INTER-OFFICE COMMUNICATION

DATE: September 16, 2015

TO: Dr. Robert Chayer, Chairperson, Quality Sub-Committee,
Mental Health Board

FROM: Patricia Schroeder, Administrator, Behavioral Health Division (BHD)
Prepared by Jennifer Bergersen, MSW, Chief Clinical Officer, (BHD)

SUBJECT: Informational Report: Update Rehabilitation Centers – Hilltop and Central

In April 2012, the Milwaukee County Department of Health and Human Services notified the State Division of Long Term Care the intention to begin closure of the Rehabilitation Center Hilltop facility. Hilltop and approximately sixty-five residents that had resided at the BHD were relocated to community settings and the program closed end of year 2014.

In August 2013, the BHD also filed intent to close the skilled nursing facility, Rehabilitation Center Central (RCC). As of September 10, 2015, fourteen residents remain from the total of approximately sixty-five at the BHD Rehabilitation Center Central with several more community transitions of individuals targeted within the next several weeks. Twenty-Eight residents had been residing at RCC at the start of year 2015. Rehab Center Central is targeted for closure end of year 2015. The two remaining RCC resident care units 44A and 44B will soon be consolidated as census reduces.

The Behavioral Health Division (BHD) continues to be actively engaged in comprehensive resident community relocation activities. This includes the bi-weekly oversight from participants of the Rehab Center Central Relocation Team in the review of all discharge planning elements including attention to individual resident strengths and planning for potential obstacles, while engaging each resident and their support system, facility team and providers to secure an appropriate community home setting. Careful attention to resident rights, health, safety and welfare are considered by all in the development and implementation of these plans.

Plans are in place to transition the remaining residents upon the conclusion of new site construction, community provider readiness, and participation by residents and/or guardians in the final selection of services, locations and funding agreements. The BHD facility staff continue to participate with the planning, preparation and transition of each resident as to ensure a successful and safe move. Special attention to resident reaction and preparation for relocation

is a priority as to best address the emotional, physical and behavioral health needs of each resident, many who have resided in this facility for some many years.

There continues to be incident and stories of successful initial community transitions. Staff from BHD have also assisted in ensuring residents have participated in the transition activities including engaging with community providers and case managers, facilitating home tours and overnight passes for residents and families, visiting after discharge, and ensuring residents have special items to ensure a warm and welcoming move while under the continued oversight of the clinical treatment team. As a measure of further quality, the BHD is eagerly anticipating the results of the quality reviews of these community placements conducted by advocacy agency (DRW) in conjunction of a grant to review resident progress both at thirty days and six months post-discharge. Further measures of quality are being determined.

The BHD continues to monitor these individuals who have utilized Crisis and Inpatient Services as well, also understanding that use and access to these services may not in itself be identified as an indicator of a treatment failure rather a potential opportunity for improvement or a necessary step in some residents recovery paths. The graph below is a general overview to monitor the frequency individuals from Hilltop and Central accessed Crisis Mobile Services Psychiatric Crisis Services (PCS), Observation and admission to an Acute Inpatient unit respectively. An individual may have accessed several levels of service within a particular time frame. Readmission rates have been calculated and included. Further detail by individual resident is available for additional analysis and quality review.

2013 - 2015 BHD Crisis Service & Acute Adult Admissions from Discharged Rehab Center Residents (Discharged after 4/1/13) – Update 9/3/15

Program	Year	Resident Discharges	Admissions From Discharged Rehab Center Residents						Inpatient Readmission Rate
			Crisis Service			Acute Adult			
			Crisis Mobile	PCS	Observation	43A	43B	43C	
Central	2013	19	1	3	1	0	1	0	5.3%
	2014	23	5	12	3	1	4	0	14.3%
	2015	13	5	23	9	2	3	1	10.9%
	Total	55	11	38	13	3	8	1	10.2%
Hilltop	2013	8	0	0	0	0	0	0	0.0%
	2014	45	6	9	4	1	0	0	2.2%
	2015	1	7	18	7	0	0	0	0.0%
	Total	54	13	27	11	1	0	0	0.7%

Informational item only.



WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

» LEAD

» TRAIN

» IDENTIFY

» ENGAGE

» TREAT

» TRANSITION

» IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential elements of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs). These elements include:

- 1 LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
- 2 TRAIN** » Develop a competent, confident, and caring workforce.
- 3 IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
- 4 ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
- 5 TREAT** » Use effective, evidence-based treatments that directly target suicidality.
- 6 TRANSITION** » Provide continuous contact and support, especially after acute care.
- 7 IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

If we do not set big goals, we will never achieve them. In the words of Thomas Priselac, president and CEO of Cedars-Sinai Medical Center:

“It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you’re only designing for 90 percent may not materialize. It’s about purposefully aiming for a higher level of performance.”

Better performance and accountability for suicide prevention and care should be core expectations of health care programs and systems. While we do not yet have proof that suicide can be eliminated in health systems, we do have strong evidence that system-wide approaches are more effective.

To assist health and behavioral health plans and organizations, the Suicide Prevention Resource Center (SPRC) offers an evolving online toolkit that includes modules and resources to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com.



FOR MORE INFORMATION, PLEASE CONTACT:

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Phase 1: Organization structure and assessment (April – December 2015)

Strategy	Action Steps	Staff Responsible	Due Date	Updates
1) Organization of Zero Suicide Task Force (ZSTF)	1) Identify team to attend ZS Academy 2) Review ZS Self Assessment. 3) Review ZS Workplan. 4) Develop BHD workplan. 5) Set target goals and evaluation plan to determine growth and success.	Amy ZSTF ZSTF ZSTF ZSTF	April 2015 June 2015 July 2015 August 2015 September 2015	Have gone through Self-Assessment and Workplan. Need to review workplan and establish goals and evaluation plan.
2) Build capacity of ZSTF	1) Consider internal groups to partner with. 2) Engage external partner groups i.e. PSGM 3) Identify attempt survivors and family members who lost someone to suicide	Amy Annie Heather, Darrell	September 2015 October 2015 October 2015	Amy will determine groups that oversee policies that can help with policy assessment see if we can sit in on that group. Started outreach to external organizations for partnership. Will present at Oct. PSGM Quarterly Meeting.
3) Assess organization's current policies for suicide management	1) Ensure policies and procedures assess and screen individuals at risk for suicide on a suicide care management plan and develop clear protocols around documentation of patient status and when patient is no longer considered suicidal. 2) Policies and procedures should include support for staff who have experience the suicide death of a patient. 4) Determine a valid and reliable screening measure is used by appropriate staff. 5) Staff are routinely documenting suicide risk screenings. 6) Outline frequency of screening and assessment. 7) Establish workflows on screening and identification process. 8) Ensure facility has a written policy and procedure stating suicide risk assessment is completed during the same visit whenever a patient screens positive for suicide risk. 9) Ensure facility has a written policy and procedure stating patients are provided timely	Matt, Andre, Sylvia, Brian (Consider Ad-hoc group to include Lynn Gramm, Mel or that we sit in on groups)	October 2015	Need to review all policies and then determine 3-5 we want to address with the understanding it may take awhile to address all and implement. Also need to think about anything we want as qualifiable data as reviewing policies so we will know how to measure. Amy will determine groups that ZS committee members could be a part of as policies are being reviewed.

	access to clinically trained staff after screening positive for suicide risk. 10) Establish a template for lethal means and safety planning.			
4) Assess workforce for skills and confidence in providing suicide care.	1) Create survey (or does ZS have one) 2) Utilize healthstream to survey internal staff 3) Utilize MC3 to survey contracted providers and include question about policy around suicide care (screening/assessment) 4) Utilize United Way/PSGM to survey community orgs. 5) VA/healthcare partnership and medical society	Annie, Andre, Amy M.	December 2015	Check to see if ZS has a workforce survey.

Phase 2: Build Support and Planning (January – June 2016)

5) Review and develop plan	1) Review results from the assessment of policies and staff confidence	ZSTF	February 2016	
	2) Develop a plan for policy changes, training, and implementation	ZSTF	February 2016	
	3) Start to identify better practices for warm hand-offs between organizations	ZSTF	April 2016	
6) Board and management support	1) Present assessment findings 2) Present plan for implementation 3) Determine others who may need to be on ZSTF	Amy	March 2016	
7) Partner with Discharge team for best practices and assessment of services	1) Establish a discharge team.	Amy	April 2016	
	2) Establish protocols for discharge team.	Sylvia, Matt	April 2016	
	3) Establish an engagement plan for patients who are hard to reach.	Discharge/Care	April 2016	
	4) Discharge team to help determine which tools are best for document linking, bridging strategies and follow-up.	Coordination	July 2016	
8) Design an evaluation plan to assess impact	1) Create evaluation plan to track progress of policy implementation and trainings. 2) Establish a review team of internal/external data to report on-going progress and success.	Matt, Andre	February 2016	

Phase 3: Communication and Training

Phase 4: Implementation

Phase 5: Evaluation and On-going improvement practices

UPDATE ON ENVIRONMENTAL SAFETY

EXECUTIVE SUMMARY

THREAT EVENT: AUGUST 2015

The Milwaukee County Behavioral Health Division (BHD) received two threatening telephone calls between 1430 and 1530 on August 20, 2015. The Milwaukee County Sheriff's Office (MCSO) was notified, and responded to the unit to conduct the investigation. The nurse managers reported the incident to leadership who, in the interest of safety, declared an "essential movement only condition", which is a modified form of a lockdown. The announcement for "essential movement only condition" was communicated via overhead page and the Emergency Operations Center was established.

Within the first 25 minutes of the lockdown a BHD staff texted a message to a family member informing them of the lockdown and communicated a farewell message in case the situation became grave. The family member proceeded to call the Milwaukee Police Department (MPD) to report his daughters' message, that there was an active shooter in the building, and an unknown number of shots had already been fired. MPD relayed that shots had been fired to MCSO. As a result additional law enforcement responded including the Wauwatosa Police Department and SWAT team who responded based on the information of an "active shooter" present in the building. Responders entered and proceeded to conduct a partial sweep of the building until 1715 at which time it was determine there was not an active shooter. After further discussion with the MCSO, BHD provided an all clear announcement via overhead page. BHD security completed the sweep of the inside and exterior of the building. Visiting hours were cancelled for the remainder of the evening. MCSO was able to obtain the caller's identity who made the threats through a telephone trace and arrested the individual at his home later that night.

Overall the event response was successful. Individuals displayed good teamwork in accomplishing the necessary tasks in a timely fashion. Future exercise involving similar situations should test the initiation of the Emergency Operations Center, Command team response, and communication within the organization.

Strengths

- ✓ BHD staff implemented the emergency procedures in an effective and timely manner to ensure everyone's safety.
- ✓ The Emergency Operations Center was successfully opened and utilized to centralize and coordinate activities.
- ✓ The majority of the staff responded to the essential movement only directive until the all clear.
- ✓ Security Officers responded by checking and ensuring all exterior doors were locked.
- ✓ The Emergency Operations Center had all the necessary equipment available to monitor radio communications between the Sheriff's department and Wauwatosa Policy department.
- ✓ Leadership staff utilized cell phones and text messaging as necessary.

Improvement Opportunities

- ✓ Milwaukee County Behavioral Health Division's Emergency Operations Plan (EOP) needs to be revised to include more detailed instructions.
- ✓ Additional training of the revised plan is to be provided to the leadership, management team and staff.
- ✓ The location of the Emergency Operations Center needs to be adaptable rather than static. One identified location may not be viable based on the type of emergency as the identified EOC location where all the equipment is currently stored may not be reachable.
- ✓ Telephone number directory for necessary response staff needs to be readily available and revised frequently as phone numbers and personnel change.
- ✓ Improve the process for allowing access to the facility by law enforcement during partial or full lockdown events.
- ✓ Improve emergency notification protocols beyond a house wide announcement to include other on-site and offsite individuals using radios and cell phones as secondary means of communication.
- ✓ Additional practice and development of protocols to establishing the EOP.
- ✓ Create a response guide for staff use for threatening callers that allows for improved information gathering and instructions on tracing a call.
- ✓ Work with IMSD to develop emergency protocols and response guides.

Event Overview

Event Name: MCBHD Essential Movement Only Condition: Threatening Call.

Type of Event: Threat to Violence

Event Start Date: August 20, 2015 1430

Event End Date: August 20, 2015 2300

Duration: 8 hours and 30 minutes

Location: 9455 Watertown Plan Road, Milwaukee WI

Capabilities

- On-site Incident Management
- Communication
- Emergency Operations Center Management

Participating Organizations

- Milwaukee County Behavioral Health Division
- Milwaukee County Sheriff's Office
- Milwaukee Police Department
- Wauwatosa Police Department

Recommendations

1. On site Incident Management:

- a. Review the BHD emergency operations plan (EOP) for this type of event and the full lockdown type event, and update as needed. Create additional detailed procedures where needed.
 - b. Create a response guide for staff to use when receiving threatening calls, include a process for tracing the caller's phone number if possible.
 - c. Train staff on the emergency operations plan, including contracted staff.
 - d. Conduct drills and exercises to practice implementation of the EOP
 - e. Train staff on operation of sliding doors when locked or during other emergency situations.
2. Communication:
- a. Complete the implementation of Send Word Now (SWN) as an internal mass communication tool. Use of SWN may have provided additional factual information.
 - b. Train additional staff on use of EM Notify system for campus wide communication.
 - c. Consider use of radios on inpatient units.
 - d. Distribute list of key person's names and phone numbers with expectation that management staff enter these into cell phones for emergency use.
3. Emergency Operations Center Management
- a. Train management staff on Incident Command System.
 - b. Orient them to the existing Emergency Operations Center (EOC).
 - c. Create mobile or area kits to have flexibility in the location used for an EOC.
 - d. Conduct drills and exercises to practice the opening and use of an EOC during emergencies.

Conclusion

The overall execution of the existing violent event protocols and essential movement situation lock down processes went well. Additional increased familiarity and practice will improve the efficiencies of completion of the various tasks required. Although communication was provided to staff via overhead announcement additional information may have been beneficial in controlling the situation and may have eliminated the escalation of the event. The existing Emergency Operations Plans (EOP) will be reviewed and modified to enhance the various emergency process. Education on the modified plans will be conducted for all staff including contracted in house staff. Management staff will be provided with additional training on incident command and how to open and utilize an Emergency Operations Center (EOC). Knowledge regarding both the EOP and EOC will be tested through drills and exercises. The progress of the improvement actions will be reviewed in the Environment of Care Committee meetings.

Milwaukee County Mental Health Board
Quality Committee

2016 Meeting Schedule

November 2, 2015

March 7, 2016

June 6, 2016

*September 6, 2016

December 5, 2016

All dates fall on the first Monday of the month.

Meeting time is 10:00 a.m. – 12:00 noon.

****Note: The first Monday of the month in September is a holiday, therefore, the meeting date falls on that following Tuesday.***