# Montana State Hospital

January 22 & 23

# 2014

A Report of the Observations, Suggestions and Recommendations for the Site Inspection Conducted at the Montana State Hospital in Warm Springs

Mental Disabilities Board of Visitors

# Contents

# Overview

Mental Health Facility Inspected

Montana State Hospital
Warm Springs, Montana
John Glueckert, Administrator

Authority for Inspection

Montana Code Annotated, 53-21-104

Purpose of the Inspection

- To inspect the services and facility at Montana State Hospital
- To assess the degree to which the services provided by Montana State Hospital are humane, consistent with professional standards and incorporate Board of Visitor Standards for mental health services
- To recognize excellence
- To make recommendations to Montana State Hospital for enhancing and/or improving mental health services
- To report to the Governor and the Montana Legislature regarding the services provided at Montana State Hospital

Board of Visitors Site Inspection Team

| **Board:** | **Consultants:** | **Staff:** |
|---|---|---|
| Brodie Moll, Board Chair<br>Miriam Hertz | Pat Frawley, LCSW<br>Dr. Jack Hornby, MD<br>Dr. Jennifer Elison, Ed.D<br>Sarah Norman, PharmD | Alicia Pichette |

Inspection Process

- Interviews with Montana State Hospital staff
- Informal discussions with residents
- Observation of treatment activities
- Inspection of physical plant/Hospital campus
- Review of written descriptions of treatment programs
- Review of treatment records

# Standards for Site Reviews of Mental Health Services

## *Organizational Planning and Quality Improvement*

**Montana State Hospital (MSH) has a Quality Assurance office to monitor quality improvement activities and coordinate the work of the Quality Improvement Committee. A document titled *"Montana State Hospital Organizational Performance Improvement Plan Fiscal Year 2013-2014"* provides evidence that MSH utilizes a process for quality improvement.**

**The Quality Assurance office and Quality Improvement Committee share responsibility for developing, implementing and evaluating the Performance Improvement Plan for MSH. Minutes from a recent meeting identified twenty-two members of the Quality Improvement Committee (QI). All members named appeared to be at the manager/leadership level. When the Board of Visitors Inspection Team (BOV) inquired about the membership and how members are selected to serve, one staff responded *"…we select members who are actively doing something to improve the process; we want to brag about what people are doing."* Another staff member reported expressing interest in being appointed to the committee, but was told that staff other than management/ leadership are not included on the committee.**

**Montana State Hospital is the largest, most complex state funded institution under Department of Public Health and Human Services (DPHHS). BOV identified one staff member with singular responsibility for gathering information about services, then coordinating and translating that data into an effective plan for improving services at MSH. BOV believes that quality assurance at the hospital would benefit from an additional qualified staff member specifically trained in quality assurance. To achieve a strong QA/QI process, BOV recommends DPHHS review the QA/QI departments of all four state facilities under its jurisdiction. Establish a QA/QI process that is consistent across those facilities and identify a QA staff member at DPHHS who can coordinate those activities and assist the QA/QI staff at all four facilities.**

**A snapshot survey of patient satisfaction is conducted annually and when patients leave MSH they complete another survey. MSH does an adequate job of collecting data. However, BOV could not identify consistent evidence of a closed-loop system of quality improvement. In addition, BOV could not identify how the data is analyzed or linked to functional outcomes for serving individual patients. As an example, 98% of the staff are trained on Mandt[1] and de-escalation procedures, yet data collected indicates the number of restraint and seclusion incidences has increased since 2012. The Performance Improvement Plan does not appear to contain a goal to address the increased number of seclusions/restraint incidents.**

**<u>Suggestions:</u>**

- **Identify criteria for types of evidence to be utilized when determining remediation interventions. The motto "doing the right thing and doing the right thing well" and the model "plan, do, check, and act" are vague and open to a variety of interpretations. For example, when asked how MSH determines the "right thing" staff responded with "we look to ourselves to make decisions. We are the best teachers and we use ourselves as the experts." While clinical expertise should certainly be considered in remediation planning, BOV suggests MSH consider evidence-based practice guidelines when creating improvement interventions.**
- **Consider adding representation to the Quality Improvement Committee from all staff levels and reduce the number of members of the committee for an effective workgroup.**

**<u>Recommendations:</u>**

- **Link the guiding principles in the Performance Improvement Plan to specific national guidelines, industry standards, and research-based evidence of "best practices" for the industry.**

[1] The Mandt System
http://www.mandtsystem.com/

- **Identify specific benchmarks for evaluation of interventions. The document entitled "Vision and Priorities for Montana State Hospital – January 22, 2014" identifies a variety of priorities. However, they are vague and do not include benchmarks for evaluation. For example, "improve staff morale and resilience" is an admirable goal….how will you know what this looks like? How can this be measured?**
- **Identify individual staff who will take responsibility for the specific benchmarks in the preceding bullet point, with specific timetables for implementation.**

## *Rights Responsibilities and Safety*

**MSH provides patients with rights and responsibilities information including information about the advocacy provided by the Mental Disabilities Board of Visitors (BOV) and other advocacy services. BOV has an office on campus at MSH and by statute that office provides full-time legal counsel to act on behalf of all patients.**

**At the time of the site inspection MSH was at licensed capacity. Several staff positions were open and staff reported to BOV that staff shortages combined with a capacity census creates a concern for patient and staff safety.**

**BOV observed that MSH staff to patient ratio may not always provide patients the option to access preferred staff of their own gender. When asked, staff responded that gender balance is unnecessary because staff can manage therapeutic issues regardless of type of problem or patient gender. Gender neutrality is an admirable aspiration and BOV urges MSH to meet patient requests for access to preferred gender neutral staff.**

**Note: BOV observed that all of the professional staff from physicians and nurse practitioners, through nursing staff, social workers, psychologists, and psychiatric technicians are stretched to the limit. Some staff interviewed reported they have felt unsafe at work on more than one occasion during the past two months because of staff shortages. Staff at MSH is to be commended for the good work that they do in extremely difficult circumstances.**

**Allegations of abuse, neglect and/or exploitation are investigated and reported to BOV as required by state statute[2]. Staff interviewed indicated to BOV that analysis of incidents from a quality assurance/improvement perspective could be more effective. An effective quality assurance/improvement process would include analyzing data from incident reports to identify whether staff actions or non-actions could have been employed to decrease the potential for future recurrence of serious incidents. In addition, an effective quality assurance/improvement process should provide staff training specifically designed to anticipate and avoid serious incidents.**

**Mandt Training[3] is required at new employee orientation for new hires and the training is updated annually for all staff. This training teaches staff de-escalation techniques including effective communication, healthy interactions with patients, and appropriate use of physical holds[4]. Training in seclusion and restraint procedures is required and direct care staff receives the training annually.**

**MSH has a solid process for justifying and reviewing the use of restraints. A registered nurse can initiate a restraint and the licensed mental health professional must write an order to authorize the use and release from a restraint. The occurrence is documented in the patient's chart. BOV observed compassionate attitudes in all professionals interviewed, and notes that a thoughtful consideration process is applied before seclusion/restraint is implemented.**

**Seclusion and restraint hours hospital-wide have tripled from the last site inspection in 2010 with the largest spike occurring in 2013/2014. This increase appears to be due primarily to seclusion hours on one unit that has five seclusion**

[2] Montana Code Annotated
http://data.opi.mt.gov/bills/mca/53/21/53-21-107.htm
[3] The Mandt System Training
http://www.mandtsystem.com/solutions/direct-care-pro/the-mandt-system-training-foundation/
[4] *Note: BOV recommended to the Mental Health Nursing Care Center that de-escalation training would be useful for all staff, including housekeeping and maintenance staff that is always in the milieu.

**beds where patients are secluded for up to 24 hours a day. Individuals on this unit are extremely ill and have the propensity for aggression or violence, on occasion often beyond self-awareness or as a result of developmental disability. BOV is concerned that frequent use of seclusion at this level appears dehumanizing and punitive. It does not promote self-awareness or a desire to manage dyscontrol issues and creates dependency on others to intervene when a person is out of control. Staff reported that this method of lengthy seclusion is used only as a last resort. BOV notes that this practice may not meet the standard that seclusion is *'implemented only to the least extent necessary to protect safety and health of the patients'.* Apparently adequate medical interventions to prevent or lessen maladaptive behaviors in these individuals have been unsuccessful or exhausted. BOV observes that adequate staff numbers may reduce the need for the extended confinement. Overall, the unit appears to be properly monitored, the staff appropriately trained.**

**Staff interviewed describes a lack of confidence in the complaint/grievance process referring to it as inconsistent and ineffective. The process is not transparent, the grievance committee members responsible for reviewing and responding to patient complaints often work without complete information about the grievance. Patients often do not receive a response after the committee completes a review and the complaint moves into an investigation process. Staff also reported to BOV that direct-care staff is not given enough immediate and regular feedback when a patient files a grievance. The grievance committee's process does not in every instance complete the cycle of communicating with all involved parties when a grievance/complaint is reviewed and resolved.**

**Recommendation:**

- **Assure that the grievance process is always thoroughly applied and completed.**
    - **The grievance committee members should be completely briefed regarding grievances**
    - **Patients must always receive a response when they have filed a grievance**

## *Patient and Family Member Participation*

**Charts reviewed did not contain documentation describing patient preferences for release of information and family member communication. Staff interviews and chart reviews confirm that patients participate in their assessments, treatment planning and treatment reviews. Staff interviews and chart reviews did not provide evidence regarding the information provided to patients about diagnosis or different options for treatment and prognosis for recovery. Patients report receiving handouts that describe new medications when they are prescribed, although BOV could not determine the source of the information or if the information is consistently provided to every patient.**

**MSH has a resident council. Ideally this forum for patients would be used to evaluate services at MSH and make recommendations to hospital leadership for improving those services. BOV encourages MSH leadership to use the resident council more effectively.**

**A snapshot satisfaction survey is offered to patients at the hospital once a year. In 2012 the patient response rate represented about 35-40% of the patients who were at MSH that day. Questions on the survey are not well designed to deliver information about the services provided and the data collected does not appear to link to quality assurance/improvement activities.**

**Recommendation:**

- **Review patient charts to assure that they contain documentation describing patient preferences for release of information and family member communication.**
- **Review the patient satisfaction survey instrument.**
    - **Identify the purpose for the collection of the information**
    - **Determine the quality assurance/improvement objectives for gathering the data**
    - **Link the data to measurable quality assurance/improvement activities.**

## *Cultural Effectiveness*

**MSH has not developed a Cultural Effectiveness Plan (CEP) using established Substance Abuse and Mental Health Services Administration (SAMHSA)[5] and the American Evaluation Association[6] guidelines.**

**BOV observed that MSH leadership has improved performance in the area of cultural effectiveness since the 2010 BOV site inspection. Cultural preferences are noted in social work documentation. BOV could not determine if the MSH quality assurance/improvement process tracks the information gathered about cultural preferences of patients for purposes of treatment planning or if cultural preferences are integrated into the treatment plans.**

**MSH has a cultural committee, new employee orientation includes a cultural competency component, and MSH has invited advisors in Native American culture to design and present Indian cultural activities for patients.**

**Suggestion:**

- **Create a cultural competency plan to assure consistent access to cultural activities and treatment for patients that are effective.**

## *Staff Competence, Training, Supervision and Relationships with Patients*

**Each position description reviewed contained knowledge and competence expectations specific to working with individuals who have mental illnesses. BOV observed that several position descriptions the team reviewed have not been updated since 2002 and others did not have revision dates. The LPN position knowledge and skills description is generic and basic and would be improved if it were revised to be more comprehensive and descriptive.**

**Human Resources staff interviewed reported that despite understaffing issues at MSH, MSH does not recruit or hire just any "Tom, Dick, or Harry" off the streets. Applicants are screened by several processes/people and are interviewed prior to hire. In contrast to that statement, staff reported that competencies of the direct care staff depend on the 'luck of the draw' and newly hired staff require additional and on-going training in therapeutic communication skills.**

**Staff interviewed noted that MSH has a shortage of licensed psychologist and APRN staff. BOV also observed that the scope of practice of professional nurses does not seem to be utilized to its fullest extent at MSH.**

**Social work at MSH is more therapeutic and complex than found in many other social work positions in state agencies/facilities. To determine whether MSH has the social work staff to adequately provide needed services, BOV urges DPHHS to review the retention and turnover rates over the last several years for social workers to assess whether the existing market comparison fits the work demands and complexity of the social work duties and responsibilities at Montana State Hospital. To determine possible solutions to the staffing challenges, MSH might examine the costs and benefits of creating a two-tiered system for social work. Currently, some social work staff do not have advanced degrees and are not licensed. If a tier system could be established, one tier would be bachelor prepared social workers who are unlicensed and function as case managers and discharge planners for many patients. The other tier would be social workers who were licensed and therefore master prepared to perform case management but also would provide more advanced services such as treatment planning, diagnosis, assessments, provide testimony and offer groups.**

**MSH has a written training curriculum for nursing staff to achieve competencies required to serve individuals who have serious mental illness. Staff reported that the competencies are determined according to CMS standards and by the nurse managers. Staff interviewed reported to BOV that MSH has an active Nurse Preceptor Program, MSH leadership**

[5] Substance Abuse and Mental Health Services Administration-Office of Minority Health
http://minorityhealth.hhs.gov/templates/content.aspx?lvl=1&lvlid=45&ID=9358

[6] American Evaluation Association
http://www.eval.org/ccstatement.asp

**describes the program as two-fold; student nursing staff is mentored by experienced MSH registered nurses, and RN's are invited to participate in the mentoring program.**

**Mental health staff are provided with opportunities for ongoing training: Examples include ADA training, Mandt training[7], Trauma Informed Care[8], fall prevention, "learn at lunch" continuing education opportunities, continuing education opportunities via the Billings Clinic, long-distance "Grand Rounds" learning and educational information is sent to employees over MSH computer system via *The Communicator*. Off-site training is typically approved if the topic is pertinent to the employee's duties.**

**BOV was informed that the chronic staffing shortage issues complicate staff access to training and make it difficult for staff to leave the units for continuing education and training. Additionally, staff reported to BOV that additional training for nurses who "float" between different units is needed.**

**Quality assurance/improvement reported to BOV that staff performance is assessed periodically and a variety of competencies for direct care staff are assessed on a regular basis by supervisors. Nursing skills are assessed annually. MSH utilizes the State of Montana Progressive Discipline Model as an accountability model although some staff interviewed reported that this model is not consistently applied.**

**As BOV toured each unit at MSH, team members witnessed a variety of staff-patient interactions that appeared to be caring and correct. As an example, when BOV entered one unit on the tour, an LPN immediately questioned if providing access to BOV might violate HIPAA[9] regulations. She was concerned about patient rights to privacy. Additionally, BOV observed examples of staff de-escalating behaviors, providing comfort measures, using therapeutic communication techniques, and validating patient concerns.**

**It is very clear in the many documents provided to BOV that staff is expected to treat patients with respect and dignity, and supervisors have high expectations with regards to interactions with patients. In many observations throughout the two day visit it was very apparent that staff is caring, calm, respectful and positive in their dealings with patients.**

**Safety, both for staff and patients was a concern expressed by staff. One challenge facing MSH is the nature, complexity, and acuity of the mental illnesses staff and patients are treating. Patients are acutely ill, and treatment is occurring in tight quarters. Units have a mixture of individuals who have varying problems which on occasion can yield heightened anxiety and dyscontrol reactions. The most specific example of this is D Unit, the forensic area. The unit is over-crowded, genders are mixed, and many of the patients are young adults with a history of violent or victimizing behaviors; all receiving treatment in a secured, confined space. The fact that continuous catastrophes and violence do not occur is a tribute to excellent staff who work on the unit and the consistent, well defined treatment program they implement.**

**The nursing staff is commended for their commitment to mentoring nursing students from across the state of Montana. Additionally, social work students and psychology students also learn at Warm Springs. A total of 265 students rotated through MSH during the 2012-2013 academic year. The Director of Nursing and the nursing staff appear committed to providing holistic, patient-centered care. Staff interviewed report they have adequate supervision and support from managers. RN's supervise the units; all receive management training from the Human Resources office. However, BOV was also told that nursing management staff is not always able to be on the floor to role-model appropriate interaction with patients.**

[7] The Mandt System Training
http://www.mandtsystem.com/solutions/direct-care-pro/the-mandt-system-training-foundation/
[8] Psychiatric Services – Trauma Informed Care
http://ps.psychiatryonline.org/searchresults.aspx?q=Trauma%20Iinformed%20Care&t=J18&p=1&s=1&c=0&journalid=18
[9] Health Insurance Portability and Accountability Act – US Department of Health and Human Services
http://www.hhs.gov/ocr/privacy/

**MSH is commended for the commitment it has shown to the peer support programs, two Peer Support staff members on campus who are trained to provide support and assistance to patients during their hospitalization. MSH also welcomes volunteers from Montana Peer Network who lead Peer Support Recovery Groups and has an active Resident Council program.**

**It appeared to BOV that implementation of the Recovery Center has resulted in a decrease in the number and types of professional staff consistently present in all treatment environments. One staff member described the direct care as "fractured" and that the distance from the Recovery Center to the main hospital makes treatment planning and role-modeling difficult. The Recovery Center has apparently not lived up to the expectations of providing support and services back to the units for people who cannot leave those units. Evidently, scheduling conflicts for classes offered at the Recovery Center and Therapeutic Learning Center (TLC) exist. Patients may need a certain group program, but cannot access it because another needed class is scheduled at the same time across campus. Staff on the units report not having adequate input into the Recovery Center/TLC offerings schedule in terms of what patients need and when during the day groups are scheduled. The move to providing services at the Recovery Center has left the units with less active engagement and therapy that would be beneficial to patients. The concern is that there are fewer staff, fewer therapeutic/professional staff, and therefore greater opportunities for patients to become involved in non-productive activities.**

**Suggestions:**

- **Review the concepts behind the Recovery Center to assure that the programs offered there do not take treatment away from the units and interactions with all staff. Treatment should take place everywhere on campus.**
- **Review the Nurse Preceptor Program to assure that every new nurse is aware of it and has access to it**
    - **If such a program is not being actively provided to nursing staff consider options to make the program available to more nursing staff**

**Recommendations:**

- **Provide nursing staff who 'float' with adequate training to address the unique treatment needs of patients on each of the units.**
- **Through the quality assurance/improvement process examine serious incident reporting to evaluate staff and patient safety on the units, and analyze the need for infrastructure and/or staffing changes to address staff and patient safety.**
- **Create access for patients who must remain on the units to the supports and groups that are offered at the Recovery Center.**

## *Treatment and Support*

**Each patient chart reviewed by BOV included a treatment plan, confirmation that patients receive a physical assessment within 48 hours of admission, and access to a medical provider as needed for health care needs that are present at admission or that may arise after admission. Patients receive a complete workup at admission to rule out any medical conditions that could be responsible for psychiatric symptoms. Patients have access to a dentist for dental care needs.**

**BOV heard mixed reviews regarding treatment planning. MSH's use of locum physicians and turnover of psychiatrists was an area of concern. Turnover and inconsistent philosophies of care hinder recovery and consistency in treatment. On one unit a psychologist works half time, and of 26 patients on one of the units just six receive individual therapy by the psychologist. That being said, patients interviewed had only positive feedback about their care providers.**

**The treatment planning process has recently undergone changes however the process still varies from unit to unit. On some units social workers have been assigned the responsibility for drafting the treatment plan, on other units nursing staff write the plan. Effective treatment requires a holistic perspective, nurses and other clinical staff are specifically educated to assess, plan, intervene, and evaluate at this level. The process should be improved. Ideally the process**

**for creating individualized treatment plans should be consistent from unit to unit. Treatment teams should write the plan in collaboration with the patient and a licensed clinician should take responsibility for assuring that the plan is correctly implemented.**

**Although information is available at regular staff meetings BOV observed a communication disconnect between the social workers, the chain of command and other staff on the units. Social workers expressed to BOV that they now have more responsibility and sense reduced support within the units with the removal of therapists and other support professionals to the Recovery Center.**

**MEDICATIONS**

**Medication is prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with laws, regulations, and professional guidelines. Medications are delivered to medication areas on the units on an established schedule, and internal controls between the pharmacy and unit medication areas are effective.**

**The psychiatrist/nurse practitioners and nursing staff appear to work well in conjunction with each other which lends itself to good communication and decision making at this level of care. BOV recognizes that some if not many of the patients who are receiving services at MSH have severe illnesses, recidivistic histories, and at times are very refractory to customary treatment approaches. Psychiatrists at MSH treating this acuity are required to make complicated decisions regarding medications. MSH currently uses fairly high doses of anti-psychotic medications with greater potential for medical side effects. BOV observed that MSH uses many first generation antipsychotics that many community-based practitioners have not used in years based on the findings of US Department of Health studies(see: National Institute of Health[10]) .**

**Patients are provided with written and verbal information that is easy to understand about the potential benefits, adverse reactions, and costs related to the use of medications. The pharmacy and nursing staff is available to answer questions pertaining to medications prescribed. "Medication when required" (PRN) is only used as one part of a documented continuum of strategies for safely alleviating a patient's distress. MSH has well established standards in policy and procedure. Documentation regarding the use of PRN was difficult to find in patient charts reviewed, confirming BOV observation that the charting system is cumbersome and not user friendly. Charts reviewed did not always contain documentation regarding the reason for medication changes. The use of 'involuntary' medications is well documented, a clear procedure is in place and employed.**

**Nursing staff actively promotes adherence to medications through negotiation and education, detailed informational handouts and a medication group. Patients who refuse antipsychotic medications are carefully evaluated. Staff interviewed reported to BOV that nursing staff monitors patients for adverse reactions and if a patient is having a difficulty the problem will be brought to the attention of the psychiatrist/nurse practitioner. BOV observed some inconsistency between units regarding adverse medication reactions. Charts on some units provided evidence that abnormal movement disorders are assessed and documented every six months. Other units report conducting the Abnormal Involuntary Movement Scale testing (AIMS) every month, although not all charts contained written evidence of this or documentation of PRN use, monitoring, or treatment of movement disorders.**

**Metabolic clinics are available, A1c[11] testing and baseline fasting glucose levels are measured and monitored. Testing and monitoring occur regularly but it was not apparent through a review of patient charts if medical interventions occur as a result of the data collection and monitoring. For instance AIMS scores and BMI and waist circumference are documented but there was no record of what was done to address the issues that came up as a result of monitoring these issues for patients. When asked, the pharmacy noted that test results are not shared with the pharmacy. It would be helpful to the pharmacy to receive that information.**

[10] NCBI-NIH (National Institute of Health)
http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0040944/

[11] A1c – HbA1c Blood sugar level testing (American Diabetes Association)
http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/a1c/

**There is no quality improvement process in place for decreasing medication errors over time. When asked about this process, a quality assurance staff member reported that this is because there are very few medication errors.**

**Each staff member interviewed discussed the difficulties of working with the electronic records system (EMR) –TIER. Staff reported to BOV that the system is antiquated and is functionally inadequate for current reporting needs, and does not meet current standards for data collection and information sharing. Staff has excess paperwork to document treatment that is time consuming and at times keeps them away from their goals to intervene and assist patients. Ideally, DPHHS will develop an EMR designed to capture treatment information that can follow a patient between state facilities and community-based services and facilitate excellent communication for consistent treatment for patients.**

**Suggestions:**

- **Consider evaluating the offerings at the Recovery Center and the Therapeutic Learning Center for coordination of scheduling, purpose and value to the patients of the offerings, and patient satisfaction with the offerings.**
- **Consider establishing the opportunity for patients to connect with the pharmacy as another safeguard for patients when they may be experiencing an adverse reaction to medication.**

**Recommendations:**

- **Review charting procedures across MSH to assure consistency unit to unit for reporting AIMS testing, PRN use, interventions for adverse medication reactions, and treatment of movement disorders.**
- **Request funding to update or replace the electronic medical record system - TIER system in the budget for the 2015 Legislative session.**
- **Assure that the pharmacy receives copies of laboratory results to avoid confusing or conflicting information regarding patients' medication needs.**
- **Improve the process for creating treatment plans**
    - **Assure consistency across all units at MSH**
    - **Include the social worker, nurse, program manager, psychiatrist and patient in the treatment team**
    - **Assign a licensed clinician to be responsible to review the plan to assure that it is correct and properly implemented**

## *Access and Entry*

**MSH is a state operated acute care psychiatric hospital located in a remote area of Montana. Admission to MSH is established in state law. Decisions regarding admission are made in communities on the local level by community mental health professionals/mental health center staff, district court judges, or county attorneys. Due to the emergency nature of the illnesses most patients are transported by county law enforcement personnel.**

**The services provided at MSH are linked to primary medical care providers and patients have timely access to psychiatric assessment on admission. Psychiatric assessments are dictated within 24 hours of admission and a treatment plan is developed within 10 days. After regular business hours an on-call nurse manager is available to assist patients who enter MSH.**

**Staff interviewed reported that priorities for admission are set based on 1) staffing 2) bed availability and seclusion availability if needed, and 3) an over-the–phone assessment of the patient. The priority is patient safety. Once safety has been established the patient is transported to the unit most appropriate for the individual's diagnosis and treatment.**

**A review of patient charts indicated inconsistent documentation describing patient preferences for release of information and family member communication. It was not clear to BOV which staff members would be the primary contact for family members. Staff interviewed noted that "anyone answering the phone should be expected to assist with family inquiries". Identify one mental health professional responsible for coordinating care and sharing patient information with involved family members.**

**Recommendation:**

- **To assure excellent communication between hospital staff and family members, identify one mental health professional responsible for coordinating care and sharing patient information with involved family members**

## *Continuity of Services through Transitions*

**Continuity of services through transition is a challenge. BOV observed apparent difficulties with some transitions into community services. One observation is the uneasy relationship between MSH and community based mental health centers. Community providers report that in some instances patients being discharged from MSH arrive into their services with incomplete or incorrect information about their treatment needs. Individuals who are placed at MSH under Emergency Detention may leave the hospital on very short notice without significant discharge planning when the Court orders the release. MSH reports significant challenges when placing difficult to serve patients into community based mental health programs.**

**MSH has created a discharge coordination position. This staff member is responsible for coordinating patient discharge activities and with the MSH social worker assures that the community based service provider is involved in the discharge planning. Service providers report that MSH's single point of contact for coordinating the components of a patient's return to the community has been a beneficial change to establish better relationships.**

**BOV observed that the role of MSH social worker in discharge planning was unclear. Reports of poorly coordinated discharges from MSH track back to MSH/community communication, which is the responsibility of the social workers at MSH. When MSH is at or above capacity, discharge planning is challenging. Community mental health center services may also be at capacity. When MSH is full, group home openings on campus and in the community are limited. Communities don't have enough group home beds, and group home beds on campus at MSH are filled with forensic patients so 'step down' or transition services at MSH are not available. Community based mental health centers may not be able to provide immediate access to psychiatrist/nurse practitioners for patients and case management caseloads may be filled.**

**MSH provides patients with medications to last until the patient can be seen by a prescriber in the community. Patients may also be given a prescription to fill in the community.**

**Patients are provided with a hospital satisfaction survey to complete when they are ready to return to the community. According to information provided to BOV the survey results are provided to the Director of Clinical Services who shares the findings with the medical director and physicians at MSH. It is unclear to BOV how MSH's quality assurance/improvement process uses the information collected to improve services.**

**Suggestions:**

- **Consider an additional discharge coordinator position to support patient discharge coordination and communication with community mental health providers.**
- **Review the satisfaction survey data collection process to determine how the information gathered will enhance the quality assurance/improvement process.**

# Recommendations - MSH

1. **Link the guiding principles in the Performance Improvement Plan to specific national guidelines, industry standards, and research-based evidence of "best practices" for the industry.**
2. **Identify specific benchmarks for evaluation of interventions. The document entitled "Vision and Priorities for Montana State Hospital – January 22, 2014" identifies a variety of priorities. However, they are vague and do not include benchmarks for evaluation. For example, "improve staff morale and resilience" is an admirable goal….how will you know what this looks like? How can this be measured?**
3. **Identify individual staff who will take responsibility for the specific benchmarks in the preceding bullet point, with specific timetables for implementation.**
4. **Assure that the grievance process is always thoroughly applied and completed.**
    a. **The grievance committee members should be completely briefed regarding grievances**
    b. **Patients must always receive a response when they have filed a grievance**
5. **Review patient charts to confirm that they contain documentation describing patient preferences for release of information and family member communication.**
6. **Review the patient satisfaction survey instrument.**
    a. **Identify the purpose for the collection of the information**
    b. **Determine the quality assurance/improvement objectives for gathering the data**
    c. **Link the data to measurable quality assurance/improvement activities.**
7. **Provide nursing staff who 'float' with adequate training to address the unique treatment needs of patients on each of the units.**
8. **Through the quality assurance/improvement process examine serious incident reporting to evaluate staff and patient safety on the units, and analyze the need for infrastructure and/or staffing changes to address staff and patient safety.**
9. **Create access for patients who must remain on the units to the supports and groups that are offered at the Recovery Center.**
10. **Address the over-crowding on D Unit and identify options for adding resources and space to the unit to assure patient and staff safety.**
11. **Review charting procedures across MSH to assure consistency unit to unit for reporting AIMS testing, PRN use, interventions for adverse medication reactions and treatment of movement disorders.**
12. **Assure that the pharmacy receives copies of laboratory results to avoid confusing or conflicting information regarding patients' medication needs.**
13. **Improve the process for creating treatment plans**
    a. **Assure consistency across all units at MSH**
    b. **Include the social worker, nurse, program manager, psychiatrist and patient in the treatment team**
    c. **Assign a licensed clinician to be responsible to review the plan to assure that it is correct and properly implemented**
14. **To assure excellent communication between hospital staff and family members, identify one mental health professional responsible for coordinating care and sharing patient information with involved family members.**

# Recommendations - DPHHS

1. **Address the over-crowding on D Unit and identify options for adding resources and space to the unit to assure patient and staff safety.**
2. **Request funding to update or replace the electronic medical record - TIER system in the budget for the 2015 Legislative session.**
3. **Address the shortage of 'step down' services for patients leaving MSH to return to community-based services. Identify options to use other state facilities for those services and/or partner with community providers to expand 'step down' options.**
4. **Review the retention and turnover rates over the last several years for social workers to assess whether the existing market comparison fits the work demands and complexity of the social work duties and responsibilities at Montana State Hospital. To determine possible solutions to the staffing challenges, DPHHS might examine the costs and benefits of creating a two-tiered system for social work at MSH.**
5. **To support quality assurance/quality improvement activities across all four state facilities, including Montana State Hospital, Montana Developmental Center, Montana Mental Health Nursing Care Center and Montana Chemical Dependency Center, consider establishing a Quality Assurance/Quality Improvement technical assistance officer at DPHHS. This staff person would coordinate the quality assurance/quality improvement activities and provide technical support for those facilities to ensure consistency.**

MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services

**Department of Public Health and Human Services**

Addictive and Mental Disorders Division ♦ Montana State Hospital ♦ P.O. Box 300 ♦ Warm Springs, MT 59756 ♦ Voice: 406-693-7000 ♦ Administration Fax: 406-693-7069 ♦ Health Information Fax: 406-693-7160 ♦Admissions Fax: 406-693-7007

**Steve Bullock, Governor**

**Richard H. Opper, Director**

April 18, 2014

Alicia Pichette
Executive Director
Mental Disabilities Board of Visitors
P. O. Box 200804
Helena, MT 59620-0804

Dear Ms. Pichette,

Thank you for the time you, your board members, and consultants took to review our services to those struggling to recover from mental health problems. We appreciate your role in advocating for these individuals and advising us as we work to improve our services.

We received the written report of your January 22-23 visit on March 20, 2014. We carefully reviewed your findings, suggestions, and recommendations. Thank you for the positive feedback, validation, and acknowledgements. Executive leaders with DPHHS, senior leaders at MSH, middle managers, and select direct-care staff considered each of your recommendations. We formulated responses to each recommendation, which are in the enclosed report dated April 18, 2014. As you will see, in most instances we agree with your recommendations. We have offered specific plans to implement these recommendations, which we hope will be acceptable to the Board.

Thank you again for the visit, feedback, and recommendations.

Sincerely,

D. A. Schoening, Ph.D.
Director of Clinical Services
Montana State Hospital

For John W. Glueckert
Hospital Administrator
Montana State Hospital

# Montana State Hospital Response to BOV Site Review Recommendations
April 18, 2014

## Recommendations - MSH

1. **Link the guiding principles in the Performance Improvement Plan to specific national guidelines, industry standards, and research-based evidence of "best practices" for the industry.**

Recommendation 1 Response:

Montana State Hospital will evaluate the Performance Improvement Plan to ensure there is a systematic approach used to evaluate the effectiveness and achievement of identified organizational goals and objectives. This approach will include the identification of lead personnel who will spearhead the performance improvement activities associated with the identified goals and objectives. Montana State Hospital will consult with the Western Psychiatric State Hospital Association with regard to the use of nationally supported benchmarks. Montana State Hospital will adopt applicable benchmarks to compare and measure our outcomes with those of other hospitals. These actions will be completed by the Director of Quality Improvement by July 1, 2014.

The Senior Leadership Team will identify specific staff members who can most effectively develop objective indicators to measure our progress towards our prioritized goals. These individuals will consult with the Quality Improvement Director to develop the quality assurance study. The studies will begin by July 1, 2014 and the Quality Improvement Director will collect information, measure our progress, and provide semiannual summaries of our progress to the Senior Leadership Team. An annual written summary of these studies will be produced by February 1st for the preceding calendar year.

2. **Identify specific benchmarks for evaluation of interventions. The document entitled "Vision and Priorities for Montana State Hospital – January 22, 2014" identifies a variety of priorities. However, they are vague and do not include benchmarks for evaluation. For example, "improve staff morale and resilience" is an admirable goal….how will you know what this looks like? How can this be measured?**

Recommendation 2 Response:

Montana State Hospital will evaluate the Performance Improvement Plan to ensure there is a systematic approach used to evaluate the effectiveness and achievement of identified organizational goals and objectives. This approach will include the identification of lead personnel who will spearhead the performance improvement activities associated with the identified goals and objectives. Montana State Hospital will consult with the Western Psychiatric State Hospital Association with regard to the use of nationally supported benchmarks. Montana State Hospital will adopt applicable benchmarks to compare and measure our outcomes with those of other hospitals. These actions will be completed by the Director of Quality Improvement by July 1, 2014.

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Senior Leadership Team. An annual written summary of these studies will be produced by February 1st for the preceding calendar year.

3. **Identify individual staff who will take responsibility for the specific benchmarks in the preceding bullet point, with specific timetables for implementation.**

Recommendation 3 Response:

Montana State Hospital will evaluate the Performance Improvement Plan to ensure there is a systematic approach used to evaluate the effectiveness and achievement of identified organizational goals and objectives. This approach will include the identification of lead personnel who will spearhead the performance improvement activities associated with the identified goals and objectives. Montana State Hospital will consult with the Western Psychiatric State Hospital Association with regard to the use of nationally supported benchmarks. Montana State Hospital will adopt applicable benchmarks to compare and measure our outcomes with those of other hospitals. These actions will be completed by the Director of Quality Improvement by July 1, 2014.

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4. **Assure that the grievance process is always thoroughly applied and completed.**
    a. **The grievance committee members should be completely briefed regarding grievances**
    b. **Patients must always receive a response when they have filed a grievance**

Recommendation 4 Response:

The Director of Quality Improvement along with the Grievance Committee members will evaluate the current grievance process to evaluate the effectiveness of the process. The evaluation will include the written notification of patients regarding the committee's response to the grievance. The Committee will ensure the process defined in Montana State Hospital Policy is followed for all patient grievances. The tracking log in use by the Grievance Committee will be revised to ensure all patients who file grievance receive a written response from the grievance policy. The tracking log will presented to the grievance committee on a monthly basis. These actions will be completed by the Director of Quality Improvement by July 1, 2014.

5. **Review patient charts to confirm that they contain documentation describing patient preferences for release of information and family member communication.**

Recommendation 5 Response:

Social Workers at Montana State Hospital meet with clients, collect relevant social history, and obtain the names of individuals who the client wants to be involved in their treatment and recovery. Social Workers document the client's authorization for the release of confidential information on a hospital form and file it in the client's chart. If the client has expressed preferences and authorized others to be involved in their care, these forms serve to guide staff in releasing information. Additionally, within seven days of admission social workers complete

a written Initial Social Assessment. By policy, this report is designed to include family and social supports, current living situation, and family history. Additionally, the individualized treatment plan has a category for "treatment preferences" that is used to note what type of treatment patients prefer and who they want involved in their treatment. We believe these policies and procedures support our goal of clarifying who the client wants involved in their treatment and involving those individuals.

6. **Review the patient satisfaction survey instrument.**
    a. **Identify the purpose for the collection of the information**
    b. **Determine the quality assurance/improvement objectives for gathering the data**
    c. **Link the data to measurable quality assurance/improvement activities.**

Recommendation 6 Response:

Montana State Hospital will consult with the Western Psychiatric State Hospital Association members regarding the development and use of an improved patient satisfaction survey. The hospital will determine what the goals and objectives are with regard to conducting satisfaction surveys. The data gathered from the surveys will be used to evaluate identified hospital priorities. These actions will be completed by the Director of Quality Improvement by July 1, 2014.

7. **Provide nursing staff who 'float' with adequate training to address the unique treatment needs of patients on each of the units.**

Recommendation 7 Response:

Montana State Hospital is dedicated to providing the best possible training to all our RN staff. All newly hired RNs expected complete training in a 6 month period:

- 6 days of classroom training;
- Up to one month of preceptorship with a trained RN mentor. The preceptor program can be extended depending on the need;
- All RNs are required to complete training and certification prior to assuming all the duties expected of a RN including CPR, Seclusion and Restraint physical competency, De-escalation Part I and II (both communication and physical MANDT holds), completion of MSH Seclusion and Restraint Competency test and completion of CMHP certification.

Regarding the BOV recommendation, nursing leadership and Staff Development will develop training for "Float" nurses to address the unique treatment needs of patients on each of the units. All RNs including Float nurses at MSH are considered charge nurses and are required to follow the same position description. The list of RN job duties is extensive, and they are primarily responsible for planning, coordinating and evaluating nursing care on the units. When Float nurses are assigned to a specific unit, they are responsible for carrying out the same function as permanent nurses on the unit.

In order to provide clear expectations, Staff Development will ensure that all RNs receive and review a copy of their job description during orientation. Staff Development will also develop a check list and evaluation process for the preceptor program to ensure that training has been successfully completed.

Staff Development and Nursing leadership will develop specific training and direction for Float nurses to include the following:

- The staffing office will be instructed to schedule Float nurses with as much consistency as possible to improve continuity of care;
- Float nurses are expected to review reports and treatment plans on the units as needed;
- Nursing managers, supervisors and permanent RNs will maintain ongoing communication with Float nurses to ensure they are aware of patient needs, changes and updates;
- Float nurses are expected to develop therapeutic relationship with patients on the units and pay particular attention to new admits.

**8. Through the quality assurance/improvement process examine serious incident reporting to evaluate staff and patient safety on the units, and analyze the need for infrastructure and/or staffing changes to address staff and patient safety.**

Recommendation 8 Response:

The Director of Quality Improvement will work collaboratively with the Director of Nursing, Director of Clinical Services, Hospital Administrator, Safety Officer and unit management to evaluate the current data (measures) and review processes associated with staff and patient safety. Serious incident reviews will be included in the evaluation aimed at identifying opportunities to improve patient and staff safety. Data will continue to be monitored to assess the effectiveness of actions. The first review will be completed by the Director of Quality Improvement by July 1, 2014. Actions will be implemented following analysis and tracked for effectiveness. Reassessment will occur on an annual basis.

**9. Create access for patients who must remain on the units to the supports and groups that are offered at the Recovery Center.**

Recommendation 9 Response:

The Senior Leadership Team at Montana State Hospital is committed to providing active treatment to individuals at all levels of recovery. Individuals in early stages of recovery, and thus restricted to the treatment units (red levels or under court order for forensic evaluation), have access to the foundational services that are essential to promote their initial recovery. Once they have recovered their ability to think clearly, remain safe, participate, and learn; they may be referred to mid-level recovery services offered at the Therapeutic Learning Center (TLC) or Recovery Center (RC). We attempt to offer the types of services that are appropriate to the individual's problems and level of recovery. Therefore, we do not believe all of the services offered at the TLC or RC need to be replicated on the units. Nevertheless, we have a system for escorting clients who are on "yellow" levels to allow access to the TLC and RC services. Additionally, we are attempting to develop unit-based activities, groups, and classes that will be co-facilitated by nursing staff and RC or TLC staff. These services will be designed for people in the early stages of recovery (e.g. Illness management, medication management, basic coping skills, basic social skills, mindfulness, physical activities, leisure activities, recreational activities).

**10. Address the over-crowding on D Unit and identify options for adding resources and space to the unit to assure patient and staff safety.**

Recommendation 10 Response:

MSH leadership continues to take patient and staff safety very seriously and is pursuing several short and long term goals for the Forensic Unit:

1. We licensed and opened a new 8-bed group home on campus to increase on-campus placement options for stable forensic patients and reduce overcrowding on D-wing. The McCollom House opened for patients March 25, 2014.
2. In the last month one patient has been recommended for alternate placement off campus.
3. A forensic patient on a civil unit is on a pre-placement visit to MMHNCC as of March 20, 2014.
4. Reviewing increased off unit treatment options for select forensic patients. More stable patients are allowed off unit to RC and TLC.
5. The hospital has been in contact with the licensing and certification bureau to assess whether the existing design, square footage and structure support a higher licensed bed capacity. It appears that the existing space and structure qualify for a licensed capacity of up to 60 beds.
6. All NGMI and GBMI commitments have been re-assessed for possible alternate placements off campus. Seven of 46 GBMI commitments on campus have processes underway where alternate, off-campus placements are being pursued. Four of 12 NGMI commitments have efforts underway for alternate placement off campus.

In addition to these steps, MSH leadership is continuing to work with DPHHS and the Governor's office, the legislature and the Department of Corrections to combine efforts to offer alternative mental health services for forensic patients in the least restrictive and most appropriate therapeutic setting possible.

1. The Monitoring Space and System has been improved on the Forensic Unit by: narrowing the duties of the monitors; increasing their privacy, and; limiting distractions while fulfilling the monitoring function.
2. The Forensic Visitation policy has been revised to better support safety and security on the unit. Some of the changes include that visitors pass through a metal detector prior to visiting and very few items are allowed on the unit with space provided to secure belongings at the front desk during the visit if necessary.
3. All Forensic Observation spaces have been upgraded to allow each space to be used as needed for observation, seclusion and or restraint. Previously there were three observation seclusion rooms and three seclusion and restraint rooms, they can now be used interchangeably as needed.
4. A security fence was installed around the outside yard to decrease overcrowding on the unit and allow a broader range of activities to forensic clients.
5. A comprehensive camera monitoring system was installed, which has the capacity to record.
6. Door security was enhanced (recreational area, medication room, nursing station).
7. Shift change procedures were changed to enhance security.

**11. Review charting procedures across MSH to assure consistency unit to unit for reporting AIMS testing, PRN use, interventions for adverse medication reactions and treatment of movement disorders.**

Recommendation 11 Response:

MSH provides policies and procedures that clearly define reporting and documentation for AIMS testing, PRN use, intervention for adverse medication reactions, and treatment of movement disorders. Montana State Hospital is committed to providing consistent care to our patients. Nursing leadership will determine areas of inconsistencies or deficiencies in documentation and provide correction and training where needed. Our goal is to ensure the requirements of our Policies and Procedures are met. There are situations where individual LIPs may increase the frequency of testing depending on the needs of the patient.

12. **Assure that the pharmacy receives copies of laboratory results to avoid confusing or conflicting information regarding patients' medication needs.**

Recommendation12 Response:

This recommendation has been addressed. Medical Clinic staff now send all lab work to the Pharmacy daily, excluding weekends and Holidays. Our goal is to set-up a fax machine in the Pharmacy. We are waiting for final approval from PAML, our contracted Laboratory service, to implement the faxing system.

13. **Improve the process for creating treatment plans**
    a. **Assure consistency across all units at MSH**
    b. **Include the social worker, nurse, program manager, psychiatrist and patient in the treatment team**
    c. **Assign a licensed clinician to be responsible to review the plan to assure that it is correct and properly implemented**

Recommendation 13 Response:

Montana State Hospital recently completed an eight month-long federal audit of treatment planning. This resulted in significant changes designed to adhere to both state and federal standards. Federal auditors found our treatment planning process and resultant treatment plans acceptable in January 2014. Our policy and procedures require a standard treatment planning process for all clients on all units, involvement of all disciplines, and the client's preferences. The Integrated Summary form reflects the multidisciplinary and client-directed care philosophies as well as the names of individuals involved in the development of the treatment plan. The written plan is approved and signed by the Licensed Independent Practitioner (MD or APRN). The primary practitioner, social worker, and nurse all sign the plan.

14. **To assure excellent communication between hospital staff and family members, identify one mental health professional responsible for coordinating care and sharing patient information with involved family members.**

Recommendation 14 Response:

Montana State Hospital aspires to promote excellent communication with clients, family members, and future providers as authorized by the client. Each new client is assigned a primary social worker, an individual who coordinates care and communicates with others throughout the client's hospitalization. This individual is primarily accountable for authorized communications with families and outside providers. However, at times family members or providers will be referred to other professionals if they have medical, financial, legal, or administrative questions or concerns. Additionally, during certain hours the social worker may not be available. In those situations, nursing staff substitute for the social worker. Nevertheless, the social worker is the primary liaison.

# Recommendations - DPHHS

1. **Address the over-crowding on D Unit and identify options for adding resources and space to the unit to assure patient and staff safety.**

Recommendation 1 Response:

The executive leaders in the Department of Public Health and Human Services (DPHHS) share the Board's concern associated with overcrowding on the forensic unit at Montana State Hospital (MSH). There appears to be a national trend towards increasing numbers of individuals committed to state hospitals under forensic laws, which is what data suggests is also happening at MSH. Unfortunately, DPHHS and MSH have very little control over the flow of people coming to the hospital on forensic commitments. Consequently, we have attempted to identify other strategies for managing this growing population.

In the last five years the Department has sought help from expert consultants and has implemented many of the recommendations to improve safety. Some of the notable safety and security improvements include:

1. The Monitoring Space and System has been improved on the Forensic Unit by: narrowing the duties of the monitors; increasing their privacy, and; limiting distractions while fulfilling the monitoring function.
2. The Forensic Visitation policy has been revised to better support safety and security on the unit. Some of the changes include that visitors pass through a metal detector prior to visiting and very few items are allowed on the unit with space provided to secure belongings at the front desk during the visit if necessary.
3. All Forensic Observation spaces have been upgraded to allow each space to be used as needed for observation, seclusion and or restraint. Previously there were three observation seclusion rooms and three seclusion and restraint rooms, they can now be used interchangeably as needed.
4. A security fence was installed around the outside yard to decrease overcrowding on the unit and allow a broader range of activities to forensic clients.
5. A comprehensive camera monitoring system was installed, which has the capacity to record.
6. Door security was enhanced (recreational area, medication room, nursing station).
7. Shift change procedures were changed to enhance security.

In addition to safety and security enhancements, the Department has attempted to relieve overcrowding on the forensic unit by transitioning individuals in recovery to less restrictive placements as they become available. All but two of the group home placements on campus are filled with individuals on forensic commitments. The Department continues to cooperate with the Board of Pardons and Parole as they consider an individual's readiness for community placements. When individuals appear ready for community placement, the Hospital helps develop aftercare plans and placements to be considered by the Parole Board or Judges considering conditional releases. The Department has pursued pre-release placements for individuals but has only obtained two placements in the last seven years.

In order to relieve overcrowding and offer the least restrictive treatment setting to forensically committed individuals the Department recently renovated, licensed, and opened a new 8-bed group home. The Department acknowledges the challenges of placing these individuals in the

community (stigma, history of offenses, long sentences) but has not given up pursuing community placement options.

The Department recently authorized the hiring of an additional social worker at MSH to assist with community placements for individuals on forensic commitments. This individual will work with the forensic treatment team, forensic review board, and DPHHS legal staff to identify individuals that appear eligible for a review of sentence (GBMI) or conditional release (NGMI). The Department will continue to attempt to secure conditional placements or reviews of sentence through the courts.

2. **Request funding to update or replace the electronic medical record - TIER system in the budget for the 2015 Legislative session.**

Recommendation 2 Response:

Executive leaders with DPHHS understand the importance of an effective electronic health record and even believe it will help facilitate better mental health care at MSH. Therefore, the Information Technology Department within DPHHS has included a proposal for a new electronic health record system in its long range IT plan.

In the interim, the Department has allocated significant financial and human resources to improve the existing electronic records system (TIER). The Hospital recently converted to a new operating system to increase the efficiency of the system, which is being piloted. The IT Department continues to consult with MSH professionals in order to improve the applications within the TIER system.

3. **Address the shortage of 'step down' services for patients leaving MSH to return to community-based services. Identify options to use other state facilities for those services and/or partner with community providers to expand 'step down' options.**

Recommendation 3 Response:

The DPHHS is committed to providing effective mental health care for the people of Montana in the least-restrictive setting possible to ensure safety and treatment effectiveness. This commitment appears to be shared by most of the community mental health centers we work closely with in order to develop funding sources, programs, and community-based resources.

Montana State Hospital will develop a systematic method for collecting discharge planning information to better identify gaps in the community mental health system. In addition, the Department continues to attempt to identify barriers to community placement for individuals ready to leave MSH. The Department has 189 funds available to Community Mental Centers, which are designed to reimburse Centers for a variety of services to recently released individuals. MSH will continue to assist clients with connecting to funding sources prior to discharge. The Hospital will investigate additional health benefits now available to clients through the Affordable Care Act, which could help enable more access to community-based placements.

The Department has expanded the MHSP waiver to cover persons with a diagnosis of major depressive disorder in addition to schizophrenia and bipolar disorder. Further expansion has been proposed to CMS.

4. **Review the retention and turnover rates over the last several years for social workers to assess whether the existing market comparison fits the work demands and complexity of the social work duties and responsibilities at Montana State Hospital. To determine possible solutions to the staffing challenges, DPHHS might examine the costs and benefits of creating a two-tiered system for social work at MSH.**

Recommendation 4 Response:

Executive leaders with DPHHS appreciate the Board's recommendation regarding the availability of social workers at MSH. Social workers are essential members of an effective treatment team and crucial to facilitating aftercare plans that will promote long-term recovery. The Department will consult with the Human Resource Department at MSH and attempt to clarify the recruitment, retention, and turnover rates for social work positions. If significant problems are identified, the Department will consider methods for improvement.

5. **To support quality assurance/quality improvement activities across all four state facilities, including Montana State Hospital, Montana Developmental Center, Montana Mental Health Nursing Care Center and Montana Chemical Dependency Center, consider establishing a Quality Assurance/Quality Improvement technical assistance officer at DPHHS. This staff person would coordinate the quality assurance/quality improvement activities and provide technical support for those facilities to ensure consistency.**

Recommendation 5 Response:

The Department agrees that there is room for improvement in the Quality Improvement processes across the Department but plans to pursue bringing facility administrators together to pursue quality improvements by better coordinating and utilizing existing resources. Pursuing an additional FTE in the current political and fiscal environment holds little promise of success.