Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Center for Mental Health

Helena, Montana

March 18-19, 2010

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Gene Haire

Gene Haire, Executive Director

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Center for Mental Health - Helena
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OVERVIEW

Mental Health Facility reviewed :

Center for Mental Health (CMH-H)
Helena, Montana
Rhonda Champagne, LCSW - Director

Mental Health Center

Authority for review :

Montana Code Annotated, 53-21-104

Purpose of review :

1) To learn about CMH-H services.
2) To assess the degree to which the services provided by CMH-H are humane, consistent with professional standards, and incorporate BOV standards for mental health services.
3) To recognize excellent services.
4) To make recommendations to CMH-H for improvement of services.
5) To report to the Governor regarding the status of services provided by CMH-H .

BOV review team :

Staff:
LuWaana Johnson, Paralegal/Advocate
Craig Fitch, Attorney
Alicia Pichette, Mental Health Ombudsman
Gene Haire, Executive Director

Board:
Brodie Moll
Sandy Mihelish

Consultants:
Bill Docktor, PharmD, BCPP
Pat Frawley, LCSW

Review process :

- Interviews with CMH-H staff
- Observation of treatment activities
- Review of written descriptions of treatment programs
- Informal discussions with clients
- Inspection of physical plant
- Review of treatment records

ASSESSMENT OF SERVICES

Program for Assertive Community Treatment (PACT) / Assertive Community Treatment (ACT)

From CMH-H literature:

PACT:
- *provides intensive services for adults with severely disabling mental illnesses. Consumers reside in their own home settings; staff makes contacts with clients in this natural community environment....*
- *provides medication deliveries and ongoing contacts in the home.....*
- *team clients provide case management in the home environment, coaching for daily living activities and in maintaining housing as well as for success in symptom management.*
- *services are provided by a multidisciplinary team that meets daily, and with a low staff to consumer ratio.*

ACT:
- *provides the same intensive services for adults with severely disabling mental illnesses as the PACT team, but targets clients who are at risk for, or currently involved in, criminal justice systems - including discharging from correctional institutions...*
- *team clients are trained in navigating criminal justice system as well as in substance abuse recovery and relapse prevention to reduce recidivism...*
- *services are provided by a multidisciplinary team that meets daily; with a low staff to consumer ratio…*

Overall impressions about the quality of ACT / PACT services.	Strengths: ▪ The ACT service in Helena is based on the concept of "forensic PACT" teams that have been developed elsewhere in the country; ACT is an important and commendable initiative of CMH-H. ▪ Both PACT and ACT are able to provide rich, evidence-based services; the service paradigm is a defined model with a structured, dedicated staff team, a prescribed treatment philosophy, and a defined limit on the number of clients served based on strict staff:client ratios[1]. Observations: ▪ ACT and PACT team staff indicated to BOV that they feel they need more training about serious mental illnesses.

[1] ACT is capped at 50 clients; PACT is capped at 70 clients.

Adult Case Management

Overall impressions about the quality of Adult Case Management services.	Strengths: ▪ Quality, long-term, dedicated staff. ▪ Long-term, knowledgeable, committed, enthusiastic supervisor. ▪ Case Managers are cross-trained to work with clients on each other's case loads as needed. ▪ The CMH-H case management program works with a number of veterans through a contract with the Veteran's Administration. ▪ CMH-H has set up "on-call case management" to be available Monday through Friday, 10:30 am to 12:00 noon to work with either people who are not yet receiving case management services or current clients who need immediate assistance. ▪ The Case Management team does a good job of structuring communication and providing incidental training via a weekly staff meeting. Observations: ▪ Case managers are on the periphery of, and express some apprehension about, potential changes in their role and mode of working associated with the organization's evolution toward a treatment culture more focused on recovery (the "Village Project" see p. 8), but expressed support for this shift because they feel it will improve the quality of service. ▪ The average caseload for five case managers is 35. CMH-H reports that all case loads are increasing, and that the average caseload could reach 50 by the end of 2010.

Psychiatry / Medication Management / Medication Monitoring

From CMH-H literature:

- *Psychiatric Services teach consumers how to manage medication and symptoms...*
- *psychiatrist and consumer review the consumer's psychiatric history...together they formulate a plan to try to improve the efficacy and decrease the side effects of medication...*
- *psychiatrist or certified professional person is available by beeper 24 hours a day for crises response...*
- *nursing staff operate a medication monitoring system ...that reinforces a graduated self management level system...*

Overall impressions about the quality of Psychiatry / Medication Management / Medication Monitoring services.	Observations: ▪ For a period of at least several months leading to the time of this review, there had been a significant level of turmoil within medical and nursing staff and with medication management. At the time of this review: ➢ At the time of this review, the regional Medical Director was new in her position. ➢ For an indefinite period of time preceding this review, medical leadership in Helena was undefined. ➢ At the time of this review, only one of the four prescribers was present and prescribing (one was on medical leave, one was on extended leave, and one had just resigned). ➢ At the time of the review, there was frustration within the CMH organization (Great Falls and Helena) about the lack of prescriber coverage in Helena and ineffective communication between Helena and Great Falls regarding new prescriber recruitment and coverage. ➢ The ACT psychiatrist who was covering the Care House had expressed his extreme concern about an incident in which he felt his management of a Care House patient had been superseded without his knowledge - to the detriment of the client. ➢ A well-respected locum tenens psychiatrist was about to end his contract as planned. ➢ Information about extensive medication errors dating back to February 2009 had recently surfaced that resulted in the BOV decision to conduct a special review of the situation (see **Addendum 1: Medication Error Review**). These errors were not reported to BOV under statutory requirement to report allegations of neglect[2]. ➢ An LPN had been placed on administrative leave and then resigned over CMH-H concerns about her role in extensive medication errors. ➢ Medical staff reported to BOV that important decisions that directly affect the work of the Medical / Nursing department are made by the CMH regional leadership without solicitation of input from or conversation with Helena medical/nursing professionals or administrators. ➢ The psychiatrist working with Care House and who had an outpatient caseload was on an extended, multi-month leave with an uncertain return date.

[2] §53-21-107, MCA 2009

	6/14/10 CMH-H Update: This psychiatrist did not return and resigned. ➢ The Advance Practice Registered Nurse prescriber had resigned. ➢ The RN who was the supervisor of the Care House and of all CMH-H nursing staff had resigned in the midst of a situation involving medication errors, CMH-H leadership concerns about supervision, and her concerns about how the errors were being handled by CMH-H (see **Addendum 1**). ➢ The ACT psychiatrist who was covering the Care House had told the CMH-H Director that he was not continuing in this role past April 1. ***6/14/10 CMH-H Update:*** ▪ ***The senior LPN has been designated as the supervisor of nurses.*** ▪ ***There is one locum tenens prescriber for all clients not receiving ACT or PACT services.*** ▪ ***CMH-H is actively recruiting for a medical director for Helena, a staff psychiatrist, and a mid-level prescriber.***

Adult Day Treatment (Montana House)

The "Village Project": CMH-H has been working hard for several years to shift to a treatment culture informed by the principles of recovery espoused by Mark Ragins, MD, medical director of The Village[3] in Long Beach, California, and the six recommendations of the New Freedom Commission on Mental Health[4]. This effort has involved many discussions among staff and clients of CMH-H, structural changes in staff teams, and programmatic adjustments - with emphasis on changes to the Montana House "day treatment" program. In 2009, CMH-H received a 'recovery grant'[5] from the Addictive and Mental Disorders Division (AMDD) to fund program service changes within the day treatment program patterned after the Village approach to assisting people with serious mental illnesses become employed. In February 2010, a group of CMH-H staff, clients, and community supporters participated in a three-day immersion training at The Village. The leadership of CMH-H is to be commended for striving to make meaningful changes in the treatment culture of CMH-H, and to emulate such a successful, outcome-oriented, internationally-recognized model for recovery-based services. BOV believes that the recommendations of the New Freedom Commission and the recovery principles of The Village are excellent guides for mental health services in Montana.

Overall impressions of Montana House Day Treatment Center?	Strengths: ▪ Major focus on the "Village Project" (see above) to assist people with serious mental illnesses become employed. CMH-H leaders have begun a weekly forum to address client questions about "Village Project" changes. ▪ A core group of staff have been talking about and planning a shift to a Village-like philosophy and program structure for some time; these efforts have included several trips to the Village by key staff, peer support specialists (client staff), and community representatives. ▪ The CMH-H Director reports that there is a business plan for the café portion of the Village Project, and a written policy/overview of the community recovery center concept that will replace "day treatment on 7/1/10. ▪ Pleasant, clean, safe, welcoming environment. ▪ Good underlying program which encourages clients to participate in meaningful activities and to develop life roles. ▪ Good staff support and positive client/staff interactions throughout the day. ▪ Some staff and clients appear enthusiastic about the "Village Project" change. ▪ Most clients BOV spoke with at Montana House seemed happy about the "Village Project" changes to come and happy about a chance to become employed. Observations: ▪ It appears that the CMH-H leaders and CMH regional leaders are not in agreement about the implementation of the "Village Project" or about this project's philosophical underpinnings; without clear support from the parent organization, the success of this project - and the implementation of the AMDD-funded recovery grant - may be in jeopardy. ▪ CMH-Helena has no written overarching strategic plan for the "Village Project" beyond the Implementation Plan described in the RFP. ▪ It appears that CMH-H leaders overestimate the program's basic readiness for successful implementation of such a complex and comprehensive project as the recovery grant-funded "Village Project". Concerns described throughout this report suggest that there are a number of fundamental

[3] http://www.mhavillage.org/
[4] http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html
[5] Request for Proposals 1010002-GU - Recovery from Mental Illness. Department of Public Health and Human Services, Addictive and Mental Disorders Division. October 1, 2009 through June 30, 2011.

	structural and procedural aspects of the CMH organization - including planning, communication, training, supervision, and relationships with other community providers - that must be addressed before a laudable project like this can hope to be successful. ▪ Several of the Helena business experts, advocates, and other community stakeholders who have been recruited to assist in implementation of the "Village Project" believe that the current deficits in CMH structures and processes (described in this report) may present significant barriers to its success. ▪ There appears to be an incomplete understanding and awareness of the "Village Project" and change process among line staff and clients. ▪ Some staff have expressed concern about the fundamental change in job expectations and types of expertise that will be required of them in the new program paradigm, that needed resources are not being provided to them to make the shift, and that it is not safe to express these concerns. ▪ The target date for implementing the "Village Project" shift overall - and for beginning a number of major programmatic initiatives have been somewhat unclear and are incompletely understood by line staff and clients. ***6/14/10 CMH-H Update: Training is occurring; job descriptions are being updated; 7/1/10 is target implementation date.*** ▪ BOV spoke with a number of clients who are very apprehensive about the "Village Project" changes. These clients expressed concern about whether there would be a place for them in the "new" Montana House. This corresponds with a concern expressed by some BOV team members about how the changes can be made while maintaining necessary supports for clients who are not interested in participating in the new structure, or who may be at a point in their illness where more dynamic activities may be clinically contraindicated. CMH-H leadership seem confident that no one will be "left out", but BOV is unclear how this is being built into the overall program, and how this is being communicated to clients. ***6/14/10 CMH-H Update: Although we are implementing opportunities that include and focus on employment, the individual departments (administration, advertising, skilled labor, culinary dept, snack bar) are a place where the most compromised individuals will have a safe place to be, learn, and be an active member of the program.***

	▪ Despite the intent to move toward increased empowerment of clients consistent with the Village program, Montana House staff still appear to run the program and offer clients choices as opposed to developing an atmosphere in which staff and clients truly work side-by-side making decisions together. Clients appear happy about being asked for their input, but there does not appear to be a structure in place for clients to have genuinely meaningful roles in the program or the decision-making. ***6/14/10 CMH-H Update: Ongoing efforts continue to strive for this type of partnership.*** <u>Recommendation 1:</u> Convene a meeting with key CMH-H and CMH regional leaders, and CMH Board members to establish a consensus regarding the philosophical underpinnings of recovery in general, the "Village Project" in particular, and about the level of support for both in the CMH regional office.

Outpatient Therapy

From CMH-H literature:

- *outpatient therapy is the bio-psycho-social treatment of emotional and psychological problems...*
- *treatment modalities focus on the establishment of a therapeutic relationship to assist in the removal or modification of existing symptoms with the goal of promoting positive personality or family growth and development...*
- *services include individual therapy sessions, family therapy sessions, and skills building groups...*

Overall impressions about the quality of Outpatient services.	**Note**: CMH-H deserves much credit for reorienting its outpatient therapist service – which usually represents a more traditional approach to mental health treatment – decisively in a more progressive, recovery-based direction. BOV believes that getting therapists out of their offices into direct engagement with clients "where they are" is exactly the correct approach. The development of flexible access to therapists is another worthy innovation. <u>Strengths:</u> ▪ Therapists are expected to spend 50% of their time 'in the field'. ▪ An on-call therapist is available to triage emergency issues every week day between 8 am and 5 pm. The on-call therapist schedules time between 10:00 am and 11:00 am and 2:00 pm and 3:00 pm to meet individually with unscheduled people if needed. These slots are available for those persons who may need crisis assistance, but do not otherwise meet criteria for a higher level of care.

Adult Foster Care

From CMH-H literature:

- *consumers are assisted in skill building, including medication and symptom management, community integration and support groups, financial management, hygiene, transportation, social skills, medical / dental appointments, communication skills, sleep hygiene, daily schedules, laundry, nutrition and comparison shopping, cooking and other skills for independent daily living...*
- *consumers live in a family environment with trained providers who coach and teach skills for living successfully in independent settings...*

Overall impressions about the quality of Adult Foster Care services.	Strengths: ▪ The Adult Foster Care (AFC) program operated by CMH-H was the first of its kind in Montana and is the largest (12 AFC providers / 42 beds). ▪ High-energy, motivated, effective AFC manager. ▪ All providers receive thorough training. ▪ CMH-H expectations for knowledge and competence of AFC providers are clear. ▪ The AFC manager has developed a comprehensive handbook/manual for AFC providers. ▪ All AFC providers are required to participate in 20 hours of training per year; training sessions are held bi-monthly; providers are accountable for their attendance and cannot miss more than two trainings in a row. ▪ A case manager from CMH-H meets weekly with each AFC provider to review client services and to support providers. Observations: ▪ AFC clients are expected to be involved in a constructive activity during weekdays; most attend Montana House from 9:00 a.m. to 3:00 p.m., Monday through Friday. It is unclear what AFC clients who do not want to participate in the new "Village project" at Montana House will do on weekdays. CMH-H is working with AFC providers through this transition.

Adult Group Home (Hannaford House)

From CMH-H literature:

- *support for consumers in rapidly navigating and accessing support programs, obtaining housing, and planning for recovery during their transition from an involuntary commitment hospitalization...*
- *wrap-around services are provided to reintegrate the consumer immediately back into their community environment, with assessments and referrals for programs appropriate to client's needs...*
- *staff provide intensive monitoring and coaching 24 hours a day to assess and improve daily living skills in a home-like environment...*
- *consumers typically attend the Montana House Day Treatment program, or another productive activity of their choice, and are referred to other programs based on their personal goals...*
- *short term services for 'unfunded' consumers transitioning from the state hospital...*

Overall impressions about the quality of Hannaford House services.	Strengths: ▪ Well-implemented short-term residential support immersing residents in a program to address the challenges of living independently. ▪ Hannaford House is located in a comfortable residential area of Helena. ▪ Emphasis is placed on recovery, treating clients with dignity and respect, and encouraging trust between clients and staff. ▪ Clients are encouraged to be active in daily operations of the home. ▪ Clients are assisted to develop social skills by looking for and participating in activities in the community. ▪ Planning for discharge starts from the day of admission. ▪ If a resident desires it, staff will help families rebuild relationships; families are encouraged to take part in treatment planning, assessments, and reviews; families are welcome to visit and to participate in activities and outings. Observations: ▪ Line staff appear unclear about the approach to working with clients who struggle with addictions. Line staff appear to believe that the program is too tolerant of substance use by clients. Program leaders are committed to using approaches like 'motivational interviewing' and 'reduction of harm' in working with clients with addictions. This lack of clarity may compromise the consistency of the approach with these clients. ▪ There is only one staff on duty at night. Recommendation 2: a) Review with Hannaford House line staff the approach for working with clients with addictions; provide training as needed. b) Review Hannaford House night staffing levels and address whether there is a need for more than one staff person on duty at night.

Crisis Stabilization Facility (Care House)

Overall impressions about the quality of Care House services.	History: ▪ Care House was developed before the Saint Peter's Hospital Behavioral Health Inpatient Unit existed. Stakeholders in the Helena community had worked with CMH-H to develop an option that could fill this gap in services as an alternative to involuntary commitment to Montana State Hospital. ▪ For a significant period of time, virtually all funding for Care House services was provided by "Goal 189" funds[6]. ▪ An unintended consequence of this scenario was that Care House evolved into attempting to serve people whose illnesses were too acute to safely serve in such a community setting. Therefore, the CMH Medical Director decided to end this practice and to shift the Care House treatment model to a sub-acute model. Strengths: ▪ Energetic staff, dedicated to the success of Care House. Observations: ▪ At the time of this review: ➢ The Care House psychiatrist was on extended leave with no return date known; ACT psychiatrist who was filling in had told CMH-H Director that his last day for filling in was March 31st. ➢ Care House staff reported that there was not a process in place for explaining / training / supervising Care House staff relative to the "new" model of operation. ➢ There was confusion among staff about the mission of Care House and about policies and procedures; there is no written policy/procedure describing operations of Care House following the 3/31/10 model change. ➢ The RN Care House/Nursing supervisor had resigned. Recommendation 3: a) Develop written description of the mission and model of operation for Care House. b) Develop written policies and procedures for Care House operation. c) Provide training for Care House staff in the mission and model of operation. ***6/14/10 CMH-H Update:*** ▪ ***A licensed clinical social worker has been hired as the new manager of Care House.*** ▪ ***There is no designated CMH-H prescriber for Care House; clients must be established in services (CMH-H or otherwise) with a prescriber as a criteria for admission.***

[6] Funds set aside by the Department of Public Health and Human Services to (1) allow mental health centers to provide intensive services in the community for people who would otherwise be committed to Montana State Hospital, and (2) allow Montana State Hospital patients who were ready to be discharged to have community discharge options that were otherwise not available.

Crisis Response Team

From CMH-H literature:

- *provides psychiatric emergency assessments in a coordinated effort with law enforcement and St. Peter's Hospital Emergency Room...*
- *24 hour coverage in the community...*
- *certified professional persons who provide testimony and recommendations for involuntary commitment proceedings...*
- *trained in available community resources and coordinates placements to the least restrictive setting in which the consumer may be safely stabilized...*

Overall impressions about the quality of Crisis Response Team services.	Observations: ▪ At the time of this review, the Crisis Response Team (CRT) supervisor had resigned her position as supervisor (to continue as a CRT therapist) over her concern about how the team overall and individual CRT therapists function. The CRT is now functioning without a direct supervisor ▪ New CRT therapists learn about the job by working with an experienced CRT therapist prior to working an independent shift. ▪ The CRT supervisor reported to BOV that she had received no training in how to supervise when she took the supervisor job; that CRT therapists receive no formal training about the work of the CRT program, program protocol, necessary documentation, or individual responsibilities and expectations; and that the CRT reporting documents were poorly-designed and not used to report and follow up on individuals the team evaluated. ▪ The Cooperative Health Center (CHC) reported to BOV that the CRT has evaluated people who were imminently dangerous to themselves and/or others and who the CRT sent home with the recommendation to see a community provider right away. CHC reported that the CRT does not consistently facilitate connection with community providers and does not communicate with other community resources about the person evaluated. ▪ CMH-H holds ten appointment slots open during each week for emergencies, but one CRT staff interviewed by BOV was not aware of that resource. ▪ Some CRT documentation BOV reviewed was in the form of rough, handwritten notes with no mental status and no indication that a coherent evaluation was done. Recommendation 4: a) Review and revise the policies and procedures for the CMH-H CRT. b) Clearly establish uniform client-response, referral, documentation and follow-up protocols. c) Clearly establish written expectations for the work of CRT staff, and for the CRT supervisor. d) Provide formal training for the CRT staff and supervisor. e) Convene a series of discussions - possibly with an outside facilitator - with CHC; Saint Peter's Hospital Behavior Health Unit; Rocky Mountain Development Council; and the CMH-H CRT staff to review policies, procedures, client response, referral, and follow-up protocol, and inter-organization communication and coordination. ***CMH-H Update 6/14/10:*** ▪ ***CMH-H is actively recruiting for a CRT supervisor. The CMH-H Director reports that individual CRT performance issues are being addressed.***

MENTAL DISABILITIES BOARD of VISITORS STANDARDS

Organizational, Structure, Planning, and Quality Improvement	
Structure:	
Are the lines of authority and accountability in both the organizational chart and in practice: ▪ simple and clear for all staff? ▪ lead to a single point of responsibility and accountability across all sites, programs, professional disciplines and age groups?	Observations: ▪ The CMH-H organizational chart is conventional and appears to graphically depict reasonable lines of authority and accountability. ▪ There are seven reporting "centers" that report directly to the CMH-H director; in addition to these, the CMH-H director is responsible for services in three additional counties and for work of the local CMH foundation. Suggestion: ▪ Consider simplifying the reporting/accountability structure of CMH-H with fewer individuals reporting directly to the Director.
Does CMH-H have a structure that identifies it as a discrete entity within the larger system of mental health services?	Observations: ▪ It appears that the regional office of the Center for Mental Health considers and manages CMH-H program leaders and programs as simply another of a number of "satellite" offices managed by the regional office. This approach appears not to adequately acknowledge the significant number of clients served in by CMH-H (BOV estimates at least 75% of the number served in Great Falls), the broad array or services in Helena (more diverse than in Great Falls) , the resources needed by CMH-H, the need for the CMH-H Director to have authority to establish alliances and agreements with other Helena entities, or the proportion of the regional revenue generated by CMH-H services. ▪ It appears that CMH regional leadership has struggled to develop a service delivery approach that takes into account the unique character and needs of the Helena community. ▪ The CMH Board of Directors established a Center for Mental Health Helena Advisory Committee in February 2010 to make recommendations to "improve the organizational relationship between Helena and Great Falls". BOV understands that CMH executive leadership has not responded fully to this committee's recommendations. Recommendation 5: Implement the nine recommendations made by the Center for Mental Health Helena Advisory Committee.

Does the structure of CMH-H have supports, resources, and infrastructure in place that optimizes efficient planning, decision-making, and service implementation?	No Strengths: ▪ CMH-H leadership are passionate about and have pursued a significant shift in the treatment culture of its services by fully embracing evidence-based practices, and emphasizing recovery, "life roles", and employment as philosophical and practical cornerstones of all services. Observations: ▪ There is apparent incongruence in the understanding of the mission of the Center for Mental Health between CMH regional leadership and CMH-H leadership. ▪ A significant breakdown has developed in communication between CMH regional leadership and CMH-H leadership. ▪ This lack of clarity and agreement about the organizational mission and the breakdown in communication is negatively affecting planning, staff training and supervision, program management, and services to clients. ▪ The resulting absence of a coherent structure and process for planning, for establishing and monitoring implementation of objectives, for conducting continuous quality improvement; and the absence of a coherent chain-of-command for ensuring that such a structure and process is in place and functioning is a core weakness of the Center for Mental Health. ▪ It appears that the CMH regional office does not provide the CMH-H Director adequate information (client demographic data, budget information, etc) in order to make informed decisions critical for CMH-H operations. ▪ CMH operates with what appears to be a computer system that is incapable of supporting the work of center staff: ➢ Clinicians report experiencing long delays in logging on to the system, in accessing information from individual clinical records, and in inputting documentation of services and other information. ➢ Some of the clinical and other documentation is entered directly into the electronic record-keeping system; a significant number of documentation entries are hand-written and later scanned into the record. ➢ CMH-H leaders report that the system is not capable of providing basic data necessary for programmatic decision-making. ➢ The inadequacies of the computer system contribute to the potential for medication errors (see **Addendum 1**). ➢ There is no Information Technology staff resource person readily available to CMH-H programs; CMH has one IT person stationed in Great Falls. Recommendation 6: a) Establish a coherent structure and process for strategic planning and quality improvement, and for monitoring implementation of planning and quality improvement objectives. Consider contracting with an expert who can assist the CMH Board, executive leaders, and program leaders in implementing this recommendation. b) Establish a coherent chain-of-command for ensuring that such a structure and process is in place and functioning.

	Recommendation 7: With the assistance of a professional facilitator, convene a series of structured conversations between the CMH regional leadership and CMH-H leadership. The overarching goals of these conversations should be to: a) establish the optimal organizational model for CMH-H's autonomy, accountability, and authority; b) establish consensus among CMH regional leaders and CMH-H leaders regarding the mission of CMH and potential iterations of that mission that may be uniquely applicable to the community of Helena; c) establish protocol for communication between CMH regional leadership and CMH-H leadership that optimizes planning, staff training and supervision, program management, and service implementation relative to the mission. Recommendation 8: a) With the involvement of clinical and administrative staff from throughout the region and in consultation with experts in electronic medical record keeping systems, evaluate the ability of the current computer system to support the work of CMH staff. If the current system is found to be inadequate, develop a written plan to upgrade the system within a reasonable time frame to one that will support the work of CMH staff and services to clients. b) Put in place immediately temporary computer system solutions that will allow CMH staff to perform essential functions.
Does structure of CMH-H: ▪ promote continuity of care for clients? ▪ reflect / support a multidisciplinary approach to planning and treatment implementation?	Yes - within the limits described above, CMH-H works to achieve a multidisciplinary approach to planning and treatment implementation and continuity of care for clients.
Planning:	
Does CMH-H produce and regularly review a strategic plan?	No Center for Mental Health administrative and clinical leaders had one meeting about one year ago during which strategic planning was discussed. However, the Center has no defined strategic planning process and no written strategic plan. BOV believes that a strategic planning process is essential for driving all other functions in the organization, and that programs should be designed and refined as a means to implement the service-oriented strategies in the strategic plan. ***If strategic planning is not done well or not done at all, services to clients are adversely affected.*** Observations: ▪ CMH-H completed an Implementation Plan for the recovery grant it received from the AMDD.

Does CMH-H have operational plans based on the strategic plan, which establish time frames and responsibilities implementation of objectives?	No Recommendation 9: a) Develop a comprehensive strategic plan with meaningful participation by staff at all levels, clients, family members, and community partners. Even though this recommendation is specific to its review of CMH services in Helena, BOV recommends that CMH develop an overarching strategic plan for its entire organization, with "sub-plans" for each satellite office/program. b) Develop a strategic plan for the recovery grant project with specific objectives, responsibilities, and timelines.
Is the strategic plan of CMH-H developed and reviewed through a process of consultation with staff, clients, family members, other appropriate service providers, and community stakeholders?	No See above.
Quality Improvement:	
Does CMH-H have and use a plan of continuous quality improvement to evaluate and improve all of its activities related to services to clients and families?	No The Center for Mental Health has a section in its Clinical Policy Manual titled "Continuous Quality Improvement". The policy restates licensing requirements for clinical charts, and describes general structures (committees, meeting minutes, etc.) Clinical and administrative leaders report to BOV that there have been discussions about quality improvement. However, the policy does not describe what "continuous quality improvement" is or establish a process for quality improvement. The Center for Mental Health has no quality improvement plan. BOV believes that it is imperative for an organization as large as CMH to develop quality parameters for services provided to its clients, to measure adherence to quality parameters, and – based on these measures - to adjust continually in order to improve the quality of services. ***If quality improvement is not done well or not done at all, services to clients are adversely affected.*** Suggestions: ▪ Consider establishing a regional staff position responsible for organizational quality improvement and who works with all programs in the region. Recommendation 10: Develop a process of continuous quality improvement to evaluate and improve all activities related to provision of services to clients and families**.**
Are designated staff of CMH-H accountable and responsible for the continuous quality improvement process?	No Observations: ▪ With regard to identifying and addressing aspects of CMH-H services that are problematic, CMH-H tends to operate in "crisis mode", reacting to challenges on a daily basis.
Is CMH-H able to demonstrate a process of continuous quality improvement that directly affects health and functional outcomes for individual clients?	No See above.

Rights, Responsibilities, and Safety	
***Rights, Responsibilities*:**	
Does CMH-H define the rights and responsibilities of and provide verbal and written information about rights and responsibilities to clients and family members?	Strengths: ▪ The CMH-H intake/application packet contains a "Patient's Bill of Rights" and treatment information, it was updated in 2009. ▪ Case Managers explain rights and responsibilities to their clients, both verbally and in writing. ▪ Most clients interviewed by BOV reported that they received information about their rights and responsibilities. Observations: ▪ Some clients interviewed by BOV reported that they had not received information about their rights and responsibilities. ▪ A number of staff (including the locum tenens psychiatrist) and clients interviewed by BOV described an atmosphere within CMH-H in which both the physical environment and the casual attitude of staff result in breaches of client confidentiality by staff on a regular basis. Suggestion: ▪ Consider ways to more consistently provide information to clients about rights and responsibilities. Recommendation 11: Assess environmental and attitudinal causes for breeches in confidentiality. Based on this assessment, develop clear written procedures for maintaining confidentiality, and provide training to all staff; correct any physical barriers to maintenance of confidentiality.
Does CMH-H actively promote client access to independent advocacy services by: ▪ providing verbal and written information to clients and clients' family members? ▪ prominently displaying in all of its facilities posters and brochures that promote independent advocacy services including the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana?	Yes Strengths: ▪ The intake/application packet contains a sheet with contact information for the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana. ▪ Information for the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana is nicely displayed in all areas where clients are served. ▪ Brochures provided by BOV and the Mental Health Ombudsman are in the literature rack.

Does CMH-H have an easily accessed, responsive, and fair complaint / grievance procedure for clients and their family members to follow?	Yes Strengths: ▪ Clients interviewed by BOV stated that they are comfortable with their ability to access a staff client and be heard if they have complaints. ▪ There is a formal grievance procedure in place, and all employees are expected to be familiar with the policy. ▪ The grievance form along with an explanation of the grievance procedure is readily available for anyone who wishes to file a complaint. Observations: ▪ The intake/application packet does not contain grievance information. ▪ Clients BOV interviewed did not seem to know about how to file a grievance; most said, "The staff usually solves the problems." Suggestions: ▪ Add grievance information to the Intake/Application packet. ▪ Consider ways to more consistently inform clients about the grievance process.
Does CMH-H provide to clients and their family members at the time of entering services written and verbal information about assistance available from the Mental Disabilities Board of Visitors in filing and resolving grievances?	Yes
Safety:	
Does CMH-H protect clients from abuse, neglect, and exploitation by its staff or agents?	Yes Strengths: ▪ Staff interviewed by BOV were clearly committed to keeping clients safe, and to properly addressing allegations of abuse, neglect, and exploitation of clients. ▪ CMH-H leadership reports that it treats abuse/neglect allegations seriously and addresses them as soon as they receive the complaint. In several instances in which CMH-H has reported allegations to BOV, this has been true.

Has CMH-H fully implemented the requirements of 53-21-107, Montana Code Annotated 2009 for reporting on and investigating allegations of abuse and neglect of clients?	No Strengths: ▪ The PACT team staff interviewed by BOV were aware of the reporting requirements and knew how to complete the steps to file a report. Observations: ▪ Even though CMH has a policy that is consistent with 53-21-107, MCA, few staff seem aware of it or their responsibilities; there is no staff training relative to this statute. ▪ The CMH-H Director has not been given the authority by CMH executive leadership to function as the "professional person in charge of the mental health facility" described in §53-21-107, MCA. BOV believes that this policy is not consistent with the intent of the statute, which is for the program in which allegations of abuse or neglect arise to report and respond immediately based on the judgment of professionals on the scene. ▪ CMH-H reports initial allegations of abuse and neglect to BOV on a form titled: "Abuse and Neglect Investigation Final Summary". This form is not designed and does not facilitate an initial report to BOV. ▪ BOV repeats this 2007 concern and related recommendations below: *"The part of the CMH policy titled "Procedure for dealing with allegations of abuse and neglect" states that "Some of these complaints may be more appropriately conceived as a client grievance and more appropriately and effectively handled through the Center's grievance procedure" and goes on to say that "If the client prefers to address the allegation [of abuse or neglect] informally with the supervisor..." BOV believes that this part of the policy does not adequately frame the requirements when any allegation meets the statutory definition of abuse or neglect. The statute does not allow a provider to exercise discretion when these definitions are met by the circumstances - it must proceed with an investigation and come to a conclusion about whether abuse or neglect did indeed take place, and then to take appropriate corrective action."*

	Recommendation 12: Revise the CMH abuse/neglect policy to remove any indication that discretion may be exercised when an allegation meets the statutory definition of abuse or neglect. Recommendation 13: Revise the forms used for documenting allegations and investigations of allegations of abuse and neglect. Create a form for "initial report" and use the current form for reporting on the results of investigations. Recommendation 14: Change CMH policy so that the CMH-H Director functions as the "professional person in charge of the mental health facility" described in §53-21-107, MCA. Recommendation 15: Provide training for all staff - including supervisors - in the policy and procedure for responding to allegations of abuse and neglect of clients.
In investigations of allegations of abuse, neglect, or exploitation of clients by its staff or agents, does CMH-H thoroughly analyze the events and actions that preceded the alleged event – including actions and/or non-actions of its staff or agents?	See above.
After an allegation of abuse, neglect, or exploitation of a client by its staff or agents is determined to be substantiated, does CMH-H debrief all related circumstances – including all staff and supervisory actions or non-actions that could have contributed to the abuse, neglect, or exploitation – in order to decrease the potential for future recurrence?	See above.
Are staff of CMH-H trained to understand and to skillfully and safely respond to aggressive and other difficult client behaviors?	Yes Strengths: ▪ All staff are trained annually in The Mandt System®[7]. ▪ Clients report feeling safe. ▪ Staff and clients both agree that staff respond quickly and effectively to conflict and aggression at Montana House.
Does CMH-H use procedures that involve behavior control, mechanical restraints, locked and unlocked seclusion or isolation, time out, etc. in a manner that is : ▪ clinically justified? ▪ properly monitored? ▪ implemented only when other less restrictive measures have failed? ▪ implemented only to the least extent necessary to protect the safety and health of the affected individual or others in the immediate environment?	Special treatment procedures are not used.

[7] http://www.mandtsystem.com/

Client / Family Member Participation	
Does CMH-H identify in the service record clients' family members and describe the parameters for communication with them regarding clients' treatment and for their involvement in treatment and support?	Yes Strengths: ▪ With client permission, CMH-H makes every attempt to identify interested family members and record the parameters for communication as described by the client. ▪ CMH-H staff reports that communication with and participation of family members is always welcome - with client permission. If a client does not want staff to initiate communication with family members, staff report that they are proactive about being open to and interested in what family clients report to them. ▪ The PACT team has established a specific goal to increase inclusion of family clients, by inviting family members to treatment plan meetings, and to other treatment conversations (with clients' permission). ▪ CMH-H has created a culture of welcoming families through invitations to a weekly outing/evening and other activities. ▪ Staff report that there is more involvement by families than at any time in the past. Observations: ▪ "Release of information" authorization forms for communicating with family clients are not included in the intake/admission packet; a description of how/when families can participate and how involved they may be is not included in the intake/admission packet. Suggestions: ▪ Consider including more information about family involvement in the intake/admission packet.
Do CMH-H assessments, treatment planning sessions, and treatment reviews proactively include the participation of clients and – with consent – clients' family members?	Yes Strengths: ▪ There appears to be a high level of involvement by clients in treatment planning and review. ▪ CMH-H has developed a culture in which the client is the "driver" of the treatment process and in which treatment plans are made relevant to individual client goals and dreams. ▪ Input and participation from families is encouraged. Observations: ▪ Families are invited to treatment planning, but not actively sought out or included. Suggestions: ▪ Consider ways to be more proactive about including families in treatment planning and review.

When a diagnoses is made, does CMH-H provide the client and – with consent – the client's family members with information on the diagnosis, options for treatment and possible prognoses?	Yes Strengths: ▪ During interviews with BOV, staff spoke about the importance of informing family and clients with all the information they may need/want to understand treatment options/prognoses ▪ Interaction and sharing of information on diagnosis, options for treatment, and prognoses for client and family is encouraged. ▪ Meetings with a nurse are scheduled with each client to discuss diagnosis and prognoses. ▪ Psychiatrists interviewed by BOV described quality interactions with clients about diagnosis, options for treatment and prognosis. Suggestion: ▪ Consider ways to provide clients with more individual and group education on each of the mental illnesses. ▪ Consider ways to more proactively reach out to families to provide information on diagnosis, prognosis, and education about medication and mental illnesses.
Does CMH-H proactively provide clients, and – with consent – clients' family members a copy of the treatment plan?	Observations: ▪ CMH-H provides family members with copies of treatment plans on request - with client permission. Suggestions: ▪ Consider ways to more proactively provide copies of treatment plans to family members - with client permission.
Does CMH-H promote, encourage, and provide opportunities for client and family member participation in the **operation** of its services? Examples: ▪ participation in developing the strategic plan and plan for continuous quality improvement? ▪ advisory groups? ▪ participation in public meetings? ▪ interviews and selection of prospective staff? ▪ peer and staff education and training? ▪ family and client peer support? Does the service have written descriptions of these activities?	Strengths: ▪ family and client peer support? Yes, through Montana House and Hannaford House Observations: ▪ participation in developing the strategic plan and plan for continuous quality improvement? No ▪ advisory groups? No ▪ participation in public meetings? No ▪ interviews and selection of prospective staff? No ▪ peer and staff education and training? No Suggestions: Consider ways to promote, encourage, and provide opportunities for client and family member participation in the **operation** of its services Recommendation 16: Make arrangements for Montana House to host the NAMI Peer-To-Peer program.

Does CMH-H promote, encourage, and provide opportunities for client and family member participation in the **evaluation** of its services? Examples:: ▪ 'customer service' ▪ effectiveness of communication with clients and family members ▪ measurement of health and functional outcomes of clients Does the service has written descriptions of these activities?	Yes <u>Strengths:</u> ▪ The Adult Foster Care program and Hannaford House have developed exit surveys for clients to complete when they leave those programs. <u>Observations:</u> ▪ The most recent client survey report was dated March 2008; it is unclear whether there is a current report. ▪ There does not appear to be active promotion for client and family participation in the evaluation process. <u>Suggestions:</u> ▪ Consider ways for staff to obtain more completed evaluations from clients and families - and to follow through with quality improvements goals.

Staff Competence, Training, Supervision, and Relationships with Clients

Competence and Training:

Does CMH-H define optimum knowledge and competence expectations specific to working with people with mental illnesses and emotional disturbances for each staff position providing services to clients?	No* **** <u>Note</u>: Adult Foster Care does address all areas under <u>Competence and Training</u>. BOV did not see evidence of this in other areas of service.*** <u>Strengths:</u> ▪ The Adult Foster Care coordinator has developed a detailed "manual" for AFC providers that includes definitions of these expectations. <u>Observations:</u> ▪ CMH-H has position descriptions that describe general "skills, knowledge, and abilities" statement related to job title and professional discipline. ▪ Position descriptions appear to be generic and applicable to every office of the Center for Mental Health. Some CMH-H position descriptions provided to BOV appear to have been pulled from programs in Great Falls with Helena staff name inserted; in several instances the names of the Great Falls programs still appeared in Helena position descriptions. ▪ No position descriptions contain descriptions of optimum knowledge and competence expectations specific to working with people with mental illnesses and emotional disturbances. ▪ Supervisors' position descriptions are vague in their descriptions of specific expectations related to supervision.

Does CMH-H have written training curricula for new staff focused on achieving optimum knowledge and competence expectations specific to working with people with mental illnesses and emotional disturbances defined for each position providing services to clients?	No - see * Note above. Strengths: ▪ The Adult Foster Care coordinator has developed a detailed "manual" for AFC providers that includes definitions of these expectations. Observations: ▪ When staff are hired to work at CMH-H, they go to the Great Falls regional office for organizational orientation. ▪ There is no training curriculum for supervisors. Suggestions: ▪ Consider providing new CMH-H staff orientation in Helena instead of in Great Falls.
Does CMH-H train new staff in job-specific knowledge and competence OR require new staff to demonstrate defined optimum knowledge and competence specific to working with people with mental illnesses and emotional disturbances prior to working with clients?	No - see * Note above. Strengths: ▪ Adult Foster Care parents are very well trained ▪ A significant amount of ongoing training on a variety of topics occurs during team meetings. Observations: ▪ CMH-H provided BOV with a notebook containing miscellaneous trainings that have been provided to staff at all levels. ▪ BOV did not see specific information on serious mental illnesses in any documentation of training. From some comments by staff such as "because of their childhood, they behave this way..." BOV is concerned that staff is not getting a good education about serious mental illnesses. ▪ Some ad hoc on-the-job training for new staff occurs by shadowing senior employees. There is no outline, protocol, or check list for tracking knowledge and competence acquisition by staff, or for detailing responsibilities of senior staff for the OJT. ▪ Supervisors receive no training when they become supervisors. Recommendation 17: a) Define optimum knowledge and competency expectations for each staff position providing services to clients including supervisors and peer support specialists.. b) Based on optimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses. c) Develop and implement a training protocol for new staff that follows a written curriculum based on defined optimum knowledge and competence expectations.

Does CMH-H provide staff and clients opportunities for ongoing training including NAMI-MT Provider Training, NAMI Peer-To-Peer Training, NAMI-MT Mental Illness Conference, Mental Health Association trainings, Department of Public Health and Human Services trainings, and professional conferences?	Yes - some of these. Strengths: ▪ CMH-H brings in prominent speakers in the field to present to staff and encourages staff to attend local training such as Post Traumatic Stress Disorder training provided by the Veterans Administration. ▪ All CMH staff meets in Great Falls for an annual training. ▪ A number of staff have been to immersion training at the Village. Observations: ▪ Staff are allotted $200 annually for continuing education. Recommendation 18: Arrange for all CMH-H staff to take the NAMI Provider Education course.
Does CMH-H hire and train people with mental illnesses as peer support specialists?	Strengths: ▪ The PACT and ACT programs each have one FTE Peer Support Specialist (PSS). ▪ CMH-H has hired two people with mental illnesses as several people with mental illnesses to work as PSS under the Recovery from Mental Illness grant. ▪ CMH-H trains PSS staff in a model adopted from a program in Arizona. Observations: ▪ It appears that CMH does not fully empower PSS staff; for example, PSS staff on the PACT and ACT teams are not permitted to deliver medications to clients as are other staff who are not designated as Peer staff, and PACT Peer staff do not receive the same stipend that other staff receive. Suggestions: ▪ Review the policies and procedures that treat Peer staff differently from other staff; revise the policies and procedures so that Peer staff and other staff have the same responsibilities and expectations.
Does CMH-H periodically assess current staff and identify and address knowledge and competence deficiencies?	Strengths: ▪ One round of performance appraisals was conducted in the Spring of 2010. Observations: ▪ It has been reported to BOV that other than recently, CMH staff region-wide had not received performance appraisals “for years”.

Supervision:	
Does CMH-H train supervisors and hold them accountable for appropriately monitoring and overseeing the way clients are treated by line staff?	Strengths: ▪ The appropriate treatment of clients is a high priority of the CMH-H leadership and supervisors. ▪ Informal training for supervisors takes place during weekly scheduled supervisor meetings. Observations: ▪ There is no ***formal*** training for supervisors. (See Recommendation 17)
Does CMH-H train supervisors and hold them accountable for appropriately monitoring, overseeing, and ensuring that treatment and support is provided effectively to clients by line staff according to their responsibilities as defined in treatment plans?	Observations: ▪ There is no ***formal*** training for supervisors. (See Recommendation 17)
Relationships with Clients:	
Do mental health service staff demonstrate respect for clients by incorporating the following qualities into the relationship with clients: ▪ active engagement? ▪ positive demeanor? ▪ empathy? ▪ calmness? ▪ validation of the desires of clients?	Yes
Active Engagement with Clients:	
Do CMH-H direct care staff demonstrate proactive, assertive, supportive, engagement with clients in every applicable treatment environment?	Yes
Are CMH-H professional staff consistently present in all treatment environments interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful interactions?	Yes Strengths: ▪ At Montana House, staff report that professionals and supervisors are regularly out in the milieu interacting with clients and modeling therapeutic interactions. ▪ CMH-H therapists are expected to spend half of their time working out of their offices and in the field so that they can actually see how clients do in the community and in their homes.
Do CMH-H supervisors ensure that direct care staff spend their time with clients engaged in consistently positive, recovery-oriented incidental interactions?	Yes Strengths: ▪ CMH-H has been proactive for several years in developing a treatment culture based on the principles of recovery. The is a primary strength of this program.

Treatment and Support

General:

Is a written treatment plan in place and being implemented for every client receiving services from CMH-H?	Yes Strengths: ▪ In the sample of charts reviewed by BOV, treatment plans were in place and were all clearly written and behaviorally specific.
For all new or returning clients, does CMH-H perform a thorough physical / medical examination or ensure that a thorough physical / medical examination has been performed within one year of the client entering / re-entering the service?	Strengths: ▪ CMH-H ensures that all AFT and group home clients receive initial physical / medical examination; AFC clients receive annual exams thereafter. Observations: ▪ For all other than AFC and group home clients, CMH-H does not ensure current physical/medical exams. ▪ Most clients have a primary care provider who is responsible for medical care. CMH-H staff recommend to clients that they need medical follow up when indicated. The client or case manager then schedules appointments. ▪ Proactively ensuring that clients have current physical / medical examinations does not appear to be a priority - beyond situations that require medical intervention. Recommendation 19: Develop a policy and procedure that prioritizes a proactive role for CMH in ensuring that all consumers have current physical / medical examinations when they enter service, and receive annual physical / medical examinations thereafter.
Does CMH-H link all clients to primary health services and ensure that clients have access to needed health care?	Yes
Does CMH-H proactively rule out medical conditions that may be responsible for presenting psychiatric symptoms?	Diagnostic assessments identify medical conditions. The status of medical issues is included in the psychiatrists' notes. Strengths: ▪ There appears to be a high level of awareness and concern among therapists regarding the relationship between physical and mental illnesses.
Does CMH-H ensure that clients have access to needed dental care?	Every attempt is made to arrange for dental care.

Evidence-Based Services:	
Does CMH-H provide treatment and support to adults that incorporates the following SAMHSA-identified evidence-based practices: Illness Management and Recovery, Assertive Community Treatment, Family Psychoeducation, Supported Employment, Integrated Treatment for Co-occurring psychiatric and substance use disorders.?	Strengths: ▪ CMH-H provides Assertive Community Treatment, has initiated a "Forensic Assertive Community Treatment" service, and is very involved in developing an innovative employment/recovery-focused program based on The Village program that is consistent with core tenets of Supported Employment. ▪ CMH-H is participating in the project led by AMDD to implement Illness Management and Recovery and Integrated Treatment for Co-occurring Psychiatric and Substance Use Disorders - and will be subject to new Administrative Rules in these areas.
Does CMH-H provide treatment and support to adults in a manner that is consistent with the SAMHSA principles for recovery[8]?	Strengths: ▪ CMH-H is in the process of redesigning its day treatment program into a to-be-defined[9] "Community Recovery Center" based on The Village program. Part of this transition is being funded by a 'recovery grant' from AMDD. This project has the potential to move the treatment culture of CMH-H toward a solid recovery-oriented program. ▪ In addition to redesigning the day treatment program, CMH-H has been working for several years to shift the staff/service culture in other areas (outpatient therapy, case management, group home, adult foster care) toward recovery-based services.
Housing:	
Does CMH-H ensure that clients have access to safe, affordable, quality housing in locations that are convenient to community services and amenities?	Yes - within the limits of what is available in Helena. Strengths: ▪ Case Managers work with the Helena Housing Authority (Shelter Plus) and Section 8 Housing. Observations: ▪ The limitation of affordable housing in Helena is a challenge. Staff at Hannaford House work to provide up-to-date information to the clients who are transitioning to independent housing.
Does CMH-H provide support and advocacy to clients in communicating and problem-solving with landlords?	Yes
Does CMH-H work closely with landlords to ensure that clients do not lose their housing during periods of hospitalization or other temporary out-of-community treatment, or other illness-related circumstances?	Yes

[8] http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/

[9] As of the publish date for this report, the Addictive and Mental Disorders Division is in the process of writing Administrative Rules that will define requirements for "Community Recovery Centers" that will essentially replace the services that have traditionally been provided in "Day Treatment" programs.

Does CMH-H provide access to and assistance with options for client home ownership?	No Suggestions: ▪ Contact Montana Home Choice Coalition[10] for information about assistance for home ownership for people with disabilities.
Education:	
Does CMH-H facilitate access to opportunities for continuing education?	Yes
Employment:	
Does CMH-H assist clients to find and keep competitive employment through a supported employment model?	See Adult Day Treatment (Montana House), p. 8. The plan is to develop Montana House into the employment "hub" of CMH-H adult services, and for all CMH-H adult clients to have access to employment assistance through this program. Observations: ▪ Neither ACT nor PACT appear to have viable employment components.
Co-Occurring Psychiatric and Substance Use Disorders:	
Has CMH-H fully implemented the protocols established by AMDD for treatment of people who have co-occurring psychiatric and substance use disorders?	CMH-H is participating in the project led by the AMDD to implement Integrated Treatment for Co-occurring Psychiatric and Substance Use Disorders - and will be subject to new Administrative Rules in this area. Strengths: ▪ CMH-H staff and leaders are aware of the dynamics of co-occurring psychiatric and substance use disorders, and are taking steps toward better integration of mental health and substance us disorder treatment. ▪ The PACT and ACT teams have dedicated Licensed Addiction Counselor positions and have been assessed by AMDD as in compliance with its co-occurring program expectations. ▪ CMH-H utilizes the treatment approaches espoused by the Native American White Bison and Wellbriety[11] programs. ▪ A peer-run AA group meets regularly at Montana House. Observations: ▪ There appears to be heavy reliance on referral to outside addiction treatment resources. ▪ Systemic requirements including separate chemical dependency and mental health funding streams continue to create barriers for truly integrated treatment for people who have co-occurring psychiatric and substance use disorders. Suggestion: ▪ Look for ways to continue moving toward full implementation of the Comprehensive Continuous Integrated System of Care model[12]

[10] http://www3.aware-inc.org/awareinc/montanahomechoice/main.asp
[11] http://www.whitebison.org/about-white-bison/about-white-bison.htm
[12] http://www.kenminkoff.com/ccisc.html ; Minkoff, MD, Kenneth. What Is Integration?. Journal of Dual Diagnosis, Vol. 2(4) 2006. http://www.kenminkoff.com/articles/dualdx2006-4-whatisintegration.pdf :

Crisis Response and Intervention Services:	
Does CMH-H operate a 24 hour / day, 7 day / week crisis telephone line?	Observations: ▪ The CMH-H crisis response system is designed to function with four tracks as follows: 1) crisis telephone line - this is answered by Care House staff 24/7 with CRT back up 2) CRT - licensed mental health professionals responding to callers 3) crisis appointment slots built into therapist and case manager schedules 4) Care House - for clients needing site-based, supervised, sub-acute intervention (See sections on Care House p. 13, and Crisis Response Team p. 14) (See Recommendation 21 below)
Does CMH-H list and advertise its crisis telephone number in a manner designed to achieve maximum visibility and ease of location to people in crisis and their families?	Observations: ▪ The CMH-H crisis telephone number is not advertised in the physical phone book, any of the online phone directories, or on the CMH website. ▪ The crisis telephone number is not displayed on informational bulletin boards at the center entrances or in the waiting areas. Recommendation 20: Revise the manner in which CMH-H crisis resources are advertised so that there is maximum visibility and ease of access to people in crisis and their families.
Does CMH-H respond directly to its own clients, clients of other service providers, and to "unattached" individuals who call its crisis telephone line?	Yes (See Recommendation 21 below)
Is CMH-H's crisis telephone line able to route multiple calls to appropriate responders?	No Observations: ▪ During all hours, crisis telephone calls are taken by Care House staff. If the line is busy, the call rolls over to the answering service. (See Recommendation 21 below)
For crisis line callers who <u>are engaged with another service provider</u>, does CMH-H - after responding appropriately to each caller's immediate need, and after addressing life safety concerns - carefully refer those clients to that provider? For crisis line callers who <u>are ***not*** engaged with any service provider</u>, does CMH-H - after responding appropriately to each caller's immediate need, and after addressing life safety concerns - either open the caller for services or carefully refer those callers to another provider?	BOV is unclear how CMH-H responds to callers who are not its clients. As of the time of finalizing this report, BOV had not been provided with written procedures used by CMH-H for responding to callers to the crisis telephone line or to the CRT. Recommendation 21: Redesign the crisis response telephone system so that it has the following characteristics: a) there is a single telephone number for all "crisis" calls b) a trained CMH-H staff person answers the phone 24/7, evaluates the situation and then makes an affirmative connection for the person who is calling (affirmative = not just

"...integration is distinct from "parallel" services or functions in which mental health and substance components or services are "co-located" within the organization, or provide care in tandem to the client, but without the interwoven fabric between them and the provision of integrated interface within each component."

	giving the caller a name or a number, but directly setting up the contact needed); c) there is a specifically-defined maximum time allowable before the CMH-H staff person answers each incoming call; d) there is no operator or answering service involved; e) CMH-H makes a follow-up telephone call to each caller within 24 hours, to make sure the needs of the person have been or are being properly addressed.
Does CMH-H follow-up on crisis line callers whom it refers out to ensure that the outside provider received the referral?	Observations: ▪ When the CRT supervisor is hired, the plan is for that person will be responsible for following up with every caller and referral.
Medication:	
Is the medication prescription protocol evidence-based and reflect internationally accepted medical standards?	Yes Observations: The charts reviewed all had appropriate medications for the diagnosis and signs and symptoms described.
Is medication prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with laws, regulations, and professional guidelines?	Medications orders are entered into the OnCallData[13] system directly by the prescriber and sent to the pharmacy, OR written medication orders are given by the prescriber to nursing staff who then enter the orders into the OnCallData system. The nurse then sends these orders to the community pharmacy. The pharmacy delivers medications to CMH-H in vials for the outpatient medication monitoring program clients and in 'MediSets' for the PACT program clients. Medications are stored in a locked cabinet in PACT and in a cupboard with padlocked handles in the outpatient program. Observations: ▪ When asked about the process, both nurses with whom the BOV consultant spoke described the process as one in which the system requires them to work around the computer rather than the system facilitating the process. ▪ A padlock across the handles of a cupboard is not a very secure system. Suggestion: ▪ Purchase a more secure locked cabinet for outpatient medication storage.
Are clients and – with consent - family members provided with understandable written and verbal information about the potential benefits, adverse effects, and costs related to the use of medication?	Yes Nurses discuss medications with the client in both the outpatient clinic and in PACT. The prescribers also discuss medication with the client. Observations: ▪ In the outpatient program, clients are given medication information fliers of unknown source and printout information on medications from the OnCallData system. It appears that these sources of information are of questionable value for clients and families.

[13] http://www.oncalldata.com/oncalldata/

	▪ Patient medication education handouts printed out of Epocrates[14] are used in the PACT.
	Suggestion: ▪ Evaluate the quality and appropriateness of the written medication information currently provided to clients and families. If current information is inadequate, replace with higher-quality, client-friendly written information.
Is "medication when required" (PRN) only used as a part of a documented continuum of strategies for safely alleviating the resident's distress and/or risk?	Yes
Does CMH-H ensure access for clients to the safest, most effective, and most appropriate medication and/or other technology?	There are no formulary restrictions placed on the prescribers by CMH-H. Restrictions are imposed by the expenditure cap for medications in the Mental Health Services Plan and by prior authorization requirements for some medications. Assistance programs and samples are used for those who do not have access to needed medications.
Does CMH-H acknowledge and facilitate clients' right to seek opinions and/or treatments from other qualified prescribers and promote continuity of care by working effectively with other prescribers?	There are few options for clients who wish to seek another psychiatrist's opinion. There are psychiatrists in private practice but most CMH-H clients would not be able to afford this option. Although CMH-H prescribers appear open to supporting clients seeking a second opinion, this is unrealistic for most clients.
Where appropriate, does CMH-H actively promote adherence to medication through negotiation and education?	Yes
Wherever possible, does CMH-H not withdraw support or deny access to other treatment and support programs on the basis of clients' decisions not to take medication?	Yes
For new clients, is there timely access to a psychiatrist or mid-level practitioner for initial psychiatric assessment and medication prescription within a time period that does not, by its delay, exacerbate illness or prolong absence of necessary medication treatment?	No Observations: ▪ For new, non-emergency clients, there is a significant waiting period before the first appointment with a psychiatrist.
For current clients, does CMH-H provide regularly scheduled appointments with a psychiatrist or mid-level practitioner to assess the effectiveness of prescribed medications, to adjust prescriptions, and to address clients' questions / concerns?	Yes
When legitimate concerns or problems arise with prescriptions, do clients have immediate access to a psychiatrist or mid-level practitioner?	Yes
Are medication allergies, side effects, adverse medication reactions, and abnormal movement disorders well documented, monitored, and promptly treated?	Yes
Are medication errors documented?	Not consistently. See **Addendum 1: Medication Error Review**
Is there a quality improvement process in place for assessing ways to decrease medication errors?	No See **Addendum 1: Medication Error Review**

[14] http://www.epocrates.com/

Is the rationale for prescribing and changing prescriptions for medications documented in the clinical record?	Yes Strengths: ▪ The notes are quite informative as to what the prescriber was thinking and what the plan was.
Are unused portions of medications and expired medications disposed of appropriately after expiration dates using – when resources are available - the protocols described in SMAR$_X$T DISPOSAL™ [15] or similar protocol?	Yes Expired meds are returned to the pharmacy or placed in the sharps container. In either case, these services would be expected to use proper disposal methods.
Is there a clear procedure for using and documenting emergency medication use, including documentation of rationale, efficacy, and side effects?	Emergency medications are not used by CMH-H.
Is there a clear procedure for using and documenting 'involuntary' medication use, including documentation of rationale, efficacy, and side effects?	Involuntary medication is not used by CMH-H..
Are there procedures in place for obtaining medications for uninsured or underinsured clients?	Yes
When a client who is transitioning to another service provider is taking psychotropic medications, does CMH-H proactively facilitate the seamless continuation of access to those medications by ensuring that: (1) the client has an appointment with the physician who will be taking over psychotropic medication management, (2) the client has enough medications in hand to carry him/her through to the next doctor appointment, and (3) the client's medication funding is established prior to the transition?	Yes

Access and Entry	
Are mental health services convenient to the community and linked to primary medical care providers?	Yes: Strengths: ▪ CMH-H is centrally located with bus service that comes right to the front door. Observations: ▪ It appears that CMH-H tells a significant number of people presenting for services to go to the Cooperative health Center without coordinating or communicating with CHC. ▪ The Cooperative Health Center reports that CMH-H coordinates poorly with it.
Does CMH-H inform the community of its availability, range of services, and process for establishing contact?	Observations: ▪ CMH-H participates in a number of community stakeholder meetings and discussions during which access to CMH-H services is discussed. ▪ BOV could find no advertising in the phone book or otherwise for CMH-H services.
For new clients, is there timely access to psychiatric assessment and service plan development and implementation	No: See above.

[15] http://www.smarxtdisposal.net/

within a time period that does not, by its delay, exacerbate illness or prolong distress?	Strengths: ▪ CMH-H addresses access issues for walk-in clients who need immediate service and have designated hours for clients of the mental health center or the community to be seen the same day by a case manager or therapist. Observations: ▪ The Community Health Center reports that there is not timely access to CMH-H services and that CMH-H sends a significant number of people seeking services to CHC with no/poor referral coordination. ▪ At the time of this review, there was approximately a two-month wait from the time of initial contact seeking services and an appointment for initial clinical assessment.
Is an appropriately qualified and experienced staff person available at all times - including after regular business hours - to assist clients to enter into mental health care?	The Crisis Response Team is the entry point for people in crisis. Outside of crisis situations, people seeking services are given an appointment with a clinician for assessment. At the time of this review, there was approximately a two-month wait from the time of initial contact seeking services and an appointment for initial clinical assessment.
Does CMH-H ensure that clients and their family members are able to, from the time of their first contact with CMH-H, identify and contact a single mental health professional responsible for coordinating their care?	Yes
Does CMH-H have a system for prioritizing referrals according to risk, urgency, distress, dysfunction, and disability, and for commencing initial assessments and services accordingly?	Yes - see above.

Continuity of Services through Transitions	
Does CMH-H provide clients and their family members with information on the range of relevant services and supports available in the community when they exit from the service?	Two scenarios: 1) When a person is working proactively with CMH-H staff to transition to another service or away from services altogether, then - by definition - information is provided in planning for this change. 2) When a person terminates services by discontinuing appointments or other service involvement, CMH-H sends a series of letters encouraging the person to come in for an appointment. If there is no response, a final letter is sent that includes a list of other community resources.
When a client is transitioning to another service provider, does CMH-H proactively facilitate involvement by that service provider in transition planning?	Yes
Does CMH-H ensure that clients referred to other service providers have established contact following exit from CMH-H?	No

If a client ***was*** receiving services from CMH-H prior to an inpatient or residential treatment admission, does the CMH-H assume primary responsibility for continuity of care between inpatient or residential treatment and community-based treatment? Leading up to and at the time of discharge from inpatient / residential treatment, does CMH-H communicate and coordinate in such a way as to ensure continuity of care? Does this coordination include - with consent - involvement of family clients?	These activities have suffered as a result of other issues cited throughout this report.

STATUS of IMPLEMENTATION of 2007 RECOMMENDATIONS

1. AMDD should adopt all of the established national PACT standards and procedures, including the requirement that all of the designated staff team roles be in place.

   2007 Response: *CMH has been collaborating with AMDD and other mental health providers in order to implement peer services within our PACT teams. We plan to have peer support positions within both CMH PACT teams by 5/1/08.*

   2010 Status: *CMH-H has all positions described in the PACT model on both the PACT and ACT teams.*

2. Develop an ongoing quality improvement process; begin to gather information about the effectiveness of the services provided by CMH - Helena, and designate an individual staff person responsible in each service area.

   2007 Response: *The CMH management team is currently developing an ongoing quality improvement process with respect to the effectiveness of the Center for Mental Health's services in Helena. The CMH co-occurring work group developed a new client satisfaction survey that will be implemented during calendar year 2008. We plan to begin gathering more information about the effectiveness of our services, and to ask each program to make a priority of performing such a yearly survey.*

   2010 Status: *CMH executive leadership has not established an overarching quality improvement process; none of its programs - including CMH-H has a quality improvement process.*

3. Incorporate the following into the strategic plan: measurable action steps, names of people responsible for each action step, and the target dates for accomplishment of each action step.

   2007 Response: *The CMH management team is currently working on developing a revised strategic plan with measurable steps, responsible staff, and specific target dates. This new plan should be finalized by 5/1/08.*

   2010 Status:*: CMH executive leadership has not established an overarching strategic plan; none of its programs - including CMH-H - has a strategic plan.*

4. Redesign the strategic planning process so that CMH staff at all levels, consumers, family members, and service providers in the defined community have input.

   2007 Response: *CMH will work on a plan to more fully incorporate the aforementioned partners in our strategic planning process. CMH participates fully in the LAC and SAA processes, which has a great influence on our strategic planning process. In addition, CMH-Helena recently began forming an advisory group (which includes partners from all of the areas mentioned above) to assist us with the implementation of peer support services in the Helena area.*

   2010 Status: *CMH executive leadership has not established an overarching strategic plan; none of its programs - including CMH-H - has a strategic plan.*

5. Redesign the intake process and information provided to consumers and family members so that information about access to independent advocacy services is proactively provided to consumers and family members at the time of entry into services.

   2007 Response: *By 7/1/08, CMH-Helena will proactively provide consumers and families information about how to access to independent advocacy services at the time of entry into services.*

   2010 Status: *Advocacy information is provided in written form in the intake packet.*

6. Display information about outside advocacy services in prominent areas of CMH.

   2007 Response: *CMH will more prominently display information about outside advocacy services by 7/1/08.*

   2010 Status: *Advocacy information displayed in the facility.*

7. *Revise the CMH abuse/neglect policy to remove any indication that discretion may be exercised when an allegation meets the statutory definition of abuse or neglect.*

   2007 Response: CMH will revise our abuse/neglect policy to remove any indication that discretion may be exercised when an allegation meets the statutory definition of abuse or neglect by 7/1/08.

   2010 Status: This policy and procedure has not been revised since the 2007 site review. The concern stated in the 2007 report continues in 2010.

8. Revise the "Abuse Investigation Final Summary" form so that it is titled "Abuse ***and Neglect*** Investigation Final Summary".

   2007 Response: *CMH will revise this form as recommended by 7/1/08.*

   2010 Status: *Form has been revised.*

9. Develop and start to proactively provide a packet to consumers and family members that includes the following:
   a) information about consumer rights and responsibilities including complaint / grievance procedure;
   b) information about independent advocacy services;
   c) information about assistance available from the Mental Disabilities Board of Visitors in filing and resolving grievances;
   d) descriptions of program services;
   e) the mental health center's mission statement;
   f) information about all mental health/substance abuse treatment service options available in the community;
   g) information about psychiatric / substance use disorders and their treatment;
   h) information about medications used to treat psychiatric disorders;
   i) information about opportunities for consumer / family member participation in evaluation of the service;
   j) staff names, job titles, and credentials;
   k) organization chart;
   l) staff code of conduct

   2007 Response: *CMH will work on the development of a packet that includes all of the aforementioned materials. We support the idea of making these materials available to consumers and family members. However, we have increasingly received feedback on the overwhelming amount of paperwork that is required as a part of our application process. Much of this is in the form of data that we are required to collect for AMDD. Some consumers and families have even refused to apply for services upon seeing the amount of paperwork that is already part of our packet. We will work with clients and families to develop a way to proactively provide this information in a way that is not overwhelming to them. We will begin to proactively provide this information to consumers and family members by 7/1/08.*

   2010 Status: *Information provided to clients is adequate.*

10. Develop a role for consumers and family members in the ongoing quality improvement process.

    2007 Response: *Over the next year, as we begin to implement a more thorough QI process with regard to gathering information about the effectiveness of our services, we will develop a role for consumers and family members to assist with this process. Our plan is to utilize the advisory group that will be assisting us with the implementation of peer support services to also help us with addressing QI issues within peer support and other program areas.*

    2010 Status: *CMH executive leadership has not established an overarching quality improvement process; none of its programs - including CMH-H has a quality improvement process.*

11. Develop a more active, dynamic working relationship with the Helena Indian Alliance .

    2007 Response: *During the following year, CMH will develop a more active and dynamic relationship with the Helena Indian Alliance by setting up regular meetings for the purpose of cross-training, consultation, and information sharing.*

    2010 Status: *There is no ongoing working relationship with the Helena Indian Alliance.*

12. Define minimum knowledge and competency expectations for each staff position providing services to consumers.

    2007 Response: *CMH employs licensed mental health professionals whose demonstration of minimum knowledge and competency has been demonstrated by their being granted a Montana license by their respective licensing boards. CMH has recently formed a new training committee. Over the next year we will work on defining minimum knowledge and competency expectations for all direct care staff positions that are unlicensed positions.*

    2010 Status: *Minimum knowledge and competency expectations for each staff position providing services to consumers have not been established.*

13. Based on minimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving minimum knowledge and competency levels. This training should include basic information about all of the major mental illnesses.

    2007 Response: *CMH will develop and implement a more structured training curriculum based upon minimum knowledge and competency expectations that includes basic information about all of the major mental illnesses.*

    2010 Status: *Written training curricula for new staff focused on achieving minimum knowledge and competency levels have not been developed.*

14. Develop position for and hire a staff training specialist for Helena.

    2007 Response: *CMH is currently working to expand and enhance our capacity to provide more thorough training for all staff. At the present time, our operating budget does not allow for recruitment of a staff training specialist for the Helena office. Beginning in the Spring of 2008, we will add a new human resources/administrative assistant position in the Helena office, which will allow supervisors more time to focus on implementation of training processes as developed by the CMH training committee.*

    2010 Status: *No formal training has been developed nor provided to staff; no dedicated staff training positions have been created.*

15. Attach a card to medication boxes with medication names, strengths and frequencies. This card should include a description of each medication by color or imprint so it is identifiable among all the other medications in the box.

    2007 Response: *Beginning in December of 2007, CMH-Helena nursing staff began labeling each medication box at the outpatient clinic with medication names, strengths, and frequencies. With the frequency of medication and brand changes, and the number of clients receiving medication monitoring at this time, our nursing department does not believe that it is desirable or possible to add a description by color or imprint to each medication box at this time.*

    2010 Status: *See* ***Addendum 1: Medication Error Review***

16. Train nurses to do AIMS tests on consumers receiving antipsychotic medications at least every 3 months with prescriber visits. Use a form for documentation and add to the chart.

    2007 Response: *Nurses are currently trained to perform AIMS testing. At this time our nursing department performs these tests when ordered by the prescriber of the antipsychotic medications. Staff without medical training are provided information regarding the importance of noting any evidence of abnormal involuntary movements and of reporting any concerns in this area to medical staff for further assessment, including AIMS*

testing. Consumers are commonly seen several times during a week by some member of their treatment team. When AIMS testing is completed, the results are documented in the medical record. CMH will form a workgroup to determine how we might increase the frequency of AIMS testing.

2010 Status: *Abnormal movement disorders are documented, monitored, and promptly treated.*

17. Redesign the crisis response telephone system so that there is only one crises telephone number and so that it has the following characteristics:
    a) a therapist always answers the single line (24/7), evaluates the situation and then makes an aggressive connection for the person who is calling (aggressive = not just giving the caller a name or a number, but directly setting up the contact needed);
    b) specifically defined maximum time allowable before the therapist answers each incoming call;
    c) no operator involved;
    d) no wait time for returning calls;
    e) no preliminary questions (if someone is a consumer of the center or if the person the caller is concerned about is a consumer of the center);
    f) follow up telephone call to the caller within 24 hours, to make sure the needs of the person were or are being properly addressed.

    2007 Response: *CMH recognizes the limitations of the telephonic crisis response system currently in place. Over the past year in Helena, we have created a system for direct-to-therapist calls during our daytime call rotation. We utilize an answering service on nights and weekends because we believe that there is less chance of missing calls when a service receives the calls as opposed to an individual with a single cell phone. CMH-Helena is interested in working with the community (including AMDD) to form a workgroup that will explore options for a single entity in Helena to operate a crisis line that will meet the criteria listed above. We are optimistic about the funding approved by the last legislature that will be utilized by AMDD for development of a statewide suicide hot line.*

    2010 Status: *6/23/10 – A new supervisor of Care House and the crisis telephone line has been hired. She and her staff are working from a revised crisis telephone line manual.*

18. AMDD should work with all entities in Montana that have "crisis" telephone numbers - including all licensed mental health centers and other mental health providers - and establish uniform, consistent advertisement and aggressive promotion of telephone numbers that are established to respond to people who are suicidal or in other mental health crises.

    2007 Response: *Please refer to the response listed in #17 above.*

    2010 Status: *AMDD has implemented a statewide Strategic Suicide Prevention Plan[16]. There is no uniform, consistent advertisement and promotion of crisis telephone services provided by mental health centers.*

[16] http://www.dphhs.mt.gov/amdd/statesuicideplan.pdf

2010 RECOMMENDATIONS

1. Convene a meeting with key CMH-H and CMH regional leaders, and CMH Board members to establish a consensus regarding the philosophical underpinnings of recovery in general, the "Village Project" in particular, and about the level of support for both in the CMH regional office.
2. a) Review with Hannaford House line staff the approach for working with clients with addictions; provide training as needed.
   b) Review Hannaford House night staffing levels and address whether there is a need for more than one staff person on duty at night.
3. a) Develop written description of the mission and model of operation for Care House.
   b) Develop written policies and procedures for Care House operation.
   c) Provide training for Care House staff in the mission and model of operation.
4. a) Review and revise the policies and procedures for the CMH-H CRT.
   b) Clearly establish uniform client-response, referral, and follow-up protocols.
   c) Clearly establish written expectations for the work of CRT staff, and for the CRT supervisor.
   d) Provide training for the CRT staff and supervisor.
   e) Convene a series of discussions - possibly with an outside facilitator - with CHC; Saint Peter's Hospital Behavior Health Unit; and the CMH-H CRT staff to review policies, procedures, client response, referral, and follow-up protocol, and inter-organization communication and coordination.
5. Implement the nine recommendations made by the Center for Mental Health Helena Advisory Committee.
6. a) Establish a coherent structure and process for strategic planning and quality improvement, and for monitoring implementation of planning and quality improvement objectives. Consider contracting with an expert who can assist the CMH Board, executive leaders, and "satellite" program leaders in implementing this recommendation.
   b) Establish a coherent chain-of-command for ensuring that such a structure and process is in place and functioning.
7. With the assistance of a professional facilitator, convene a series of structured conversations between the CMH regional leadership and CMH-H leadership. The overarching goals of these conversations should be to:
   a) establish the optimal organizational model for CMH-H's autonomy, accountability, and authority relative to the regional CMH organization;
   b) establish consensus among CMH regional leaders and CMH-H leaders regarding the mission of CMH and potential iterations of that mission that may be applicable to the community of Helena;
   c) establish protocol for communication between CMH regional leadership and CMH-H leadership that optimizes planning, staff training and supervision, program management, and service implementation relative to the mission.
8. a) With the involvement of clinical and administrative staff from throughout the region and in consultation with experts in electronic medical record keeping systems, evaluate the ability of the current computer system to support the work of CMH staff. If the current system is found to be inadequate, develop a written plan to upgrade the system within a reasonable time frame to one that will support the work of CMH staff.
   b) Put in place immediately temporary computer system solutions that will allow CMH staff to perform essential functions.
9. a) Develop a comprehensive strategic plan with meaningful participation by staff at all levels, clients, family members, and community partners. Even though this recommendation is specific to its review of CMH services in Helena, BOV recommends that CMH develop an overarching strategic plan for its entire organization, with "sub-plans" for each satellite office/program.
   b) Develop a strategic plan for the recovery grant project with specific objectives, responsibilities, and timelines.
10. Develop a process of continuous quality improvement to evaluate and improve all activities related to provision of services to clients and families**.**
11. Assess environmental and attitudinal causes for breeches in confidentiality. Based on this assessment, develop clear written procedures for maintaining confidentiality, and provide training to all staff; correct any physical barriers to maintenance of confidentiality.
12. Revise the CMH abuse/neglect policy to remove any indication that discretion may be exercised when an allegation meets the statutory definition of abuse or neglect.
13. Revise the forms used for documenting allegations and investigations of allegations of abuse and neglect. Create a form for "initial report" and use the current form for reporting on the results of investigations.
14. Change CMH policy so that the CMH-H Director functions as the "professional person in charge of the mental health facility" described in §53-21-107, MCA.
15. Provide training for all staff - including supervisors - in the policy and procedure for responding to allegations of abuse and neglect of clients.
16. Make arrangements for Montana House to host the NAMI Peer-To-Peer program.

17. a) Define optimum knowledge and competency expectations for each staff position providing services to clients including supervisors and peer support specialists.
    b) Based on optimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses.
    c) Develop and implement a training protocol for new staff that follows a written curriculum based on defined optimum knowledge and competence expectations.
18. Arrange for all CMH-H staff to take the NAMI Provider Education course.
19. Develop a policy and procedure that prioritizes a proactive role for CMH in ensuring that all consumers have current physical / medical examinations when they enter service, and receive annual physical / medical examinations thereafter.
20. Revise the manner in which CMH-H crisis resources are advertised so that there is maximum visibility and ease of access to people in crisis and their families.
21. Redesign the crisis response telephone system so that it has the following characteristics:
    a) there is a single telephone number for all “crisis” calls
    b) a trained CMH-H staff person answers the phone 24/7, evaluates the situation and then makes an affirmative connection for the person who is calling (affirmative = not just giving the caller a name or a number, but directly setting up the contact needed);
    c) there is a specifically-defined maximum time allowable before the CMH-H staff person answers each incoming call;
    d) there is no operator or answering service involved;
    e) CMH-H makes a follow-up telephone call to each caller within 24 hours, to make sure the needs of the person have been or are being properly addressed.

CMH-H RESPONSE to RECOMMENDATIONS 1-21

Center for Mental Health – Helena
Revised Response to March 2010
BOV Site Review Report Recommendations
November 3, 2010

NOTE:
Rhonda Champagne, Director, Center for Mental Health – Helena responded to recommendations 1, 2, 3, 4, 7, 9b, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21.
Sydney Blair, LCSW, Regional Clinical Director / Interim Executive Director responded to recommendations 5, 6, 8, 9a, 12.

Recommendation 1:
Convene a meeting with key CMH-H and CMH regional leaders, and CMH Board members to establish a consensus regarding the philosophical underpinnings of recovery in general, the "Village Project" in particular, and about the level of support for both in the CMH regional office.

CMH held a retreat "clarity" session on October 13th 2010 in the Havre office. This was the first of a series of discussions with CMH staff throughout the CMH region; the next session will be in Helena on November 10, followed by sessions in Great Falls and the rest of the CMH offices. Beginning with the Helena session, CMH Board members will be invited and will be involved. The major focus of these sessions is to discuss and decide the philosophical underpinnings of "Recovery based service", the philosophical approach of each service delivery site, and the level of autonomy and support for the philosophical approach for each area. The following employees are attending: Dr. Eva LaRocque, Medical Director, Dr. Carl Keener, Southern Services Medical Director, Sydney Blair, Clinical Director, Rhonda Champagne, Southern Services Director, Joe Uhl, Northern Services Director, Marlene Mowery, CSCT and Outpatient Director. A written summary of the consensus of this meeting will be presented to all board members for approval and sent to the BOV by October 25th, 2010.

Recommendation 2:
a) Review with Hannaford House line staff the approach for working with clients with addictions; provide training as needed.
b) Review Hannaford House night staffing levels and address whether there is a need for more than one staff person on duty at night.

A. The Hannaford House supervisor has developed a "Hannaford House Group Home Handbook" that includes policy and procedures for working with clients with addictions. A related training schedule has been approved by CMH-H Director. The Hannaford House Supervisor has begun implementation of this schedule to assure the staff will gain the necessary Knowledge and competency. The training schedule started August 2010.

B. The Hannaford House Supervisor and CMH-H Director reviewed the night staffing levels in early October. Based on this review, it was decided that staffing levels are appropriate, but that additional training is needed (see above).

Recommendation 3:

a) Develop written description of the mission and model of operation for Care House.
b) Develop written policies and procedures for Care House operation.
c) Provide training for Care House staff in the mission and model of operation.

CMHA recently entered into a contract with Dr. Carl Keener assigning him as Medical Director for the southern service area of Center for Mental Health. He, along with the new supervisor of Care House, visited the crisis stabilization center in Butte and is in the process of developing a current mission and model of operation along with policies and procedures for the Care House and Crisis line that are congruent with the MOU noted in the response to Recommendation 4 below which addresses continuum of care and community expectations. The Medical Director for Southern Area of CMH and Care House Supervisor will develop the following:

- Written description of mission and model for Care House
- Written policies and procedures for Care House operation
- Written training protocol for Care House staff with regards to the mission and model.
- Completion date is scheduled on or before January 1st, 2011.

Recommendation 4:

a) Review and revise the policies and procedures for the CMH-H CRT.
b) Clearly establish uniform client-response, referral, and follow-up protocols.
c) Clearly establish written expectations for the work of CRT staff, and for the CRT supervisor.
d) Provide training for the CRT staff and supervisor.
e) Convene a series of discussions - possibly with an outside facilitator - with CHC; Saint Peter's Hospital Behavior Health Unit; and the CMH-H CRT staff to review policies, procedures, client response, referral, and follow-up protocol, and inter-organization communication and coordination.

CMH-H Director has met with significant community members and other interested parties in the past two years and together developed a MOU that addresses the mission and mode of operation expectations for the CRT program in the four county areas. The CMH- Director and CRT Supervisor will develop a written policy, procedures, and training outline no later than January 1st, 2011. A draft will be presented January 4th, 2011, at the Mental Health Meeting which includes the following agencies: St. Peter's Hospital Behavioral Health Unit, RMDC, Lewis and Clark County Sheriff's Department, Helena Police Department, County Attorney's Office, CMH, the Cooperative Health Center, and other stake holders.

Recommendation 5:

Implement the nine recommendations made by the Center for Mental Health Helena Advisory Committee.

The CMH Operations Director met with the Mental Health Advisory Committee on three different occasions in the spring of 2010 to address the concerns outlined in the report. In August 2010, the same committee submitted a second letter asking for new leadership. With the retirement of the Executive Director, the Interim Executive Director for the Center for Mental Health (appointed October 2010) will contact the committee members to follow up on any issues unresolved. This will be completed by December 31st.

To address the committee concerns, the center completed an employee survey (conducted by Payne Financial). The survey addressed job satisfaction, communication, company management, training and development, recognition, staffing, and team work/collaboration. A facilitator was then hired to conduct focus groups across the region to gain additional feedback. The goal was to gain insight into what were the things that made the job enjoyable as well as what were the areas that management needed to concentrate on. There were seven areas of priority for the center's management team to focus on for improvement out of the focus groups. The facilitator was then retained to assist the management team with strategic planning not only to understand what needs the employees had but to begin strategic planning for the center. The regional management team met two times identifying five main areas to focus on (management style (level of autonomy), computers, job-descriptions (expectations/training), compensation structure, and clinical approach to services (philosophy) for the areas to focus over the next year. Committees have established goals and timelines to address the issues of concern identified in the recommendations. The intranet and the center's news letter will report progress and committee updates. The Southern Services Director can provide updates to the advisory council based on the reports given to at the regional management team meetings.

#1 Budget: With regard to the recommendation of adding a Helena-based professional fiscal staff to the Helena office, administration does not feel it is warranted. There are currently four program Directors with a similar level of responsibility and job descriptions. The Program Director for Cascade county Community Support Program and has a similar number of open clients and staff members. Services are comparable. This Program Director manages adult programs with 1227 open/active clients and approximately 101 staff members (Not including on-call or less than 20 hours a week staff.) The Southern Services Director (Helena) has the responsibility of four counties with 1138 open/active cases and 89 employees. The Cascade County Program Director works collaboratively with administration in managing her budget and operations. This client to staff ratio comparison and history suggests that a finance staff person dedicated to the Southern Region is not needed. With a national trend of integration of services and cost sharing, adding a fiscal staff person to the Helena area without additional responsibilities to the center as a whole would not be fiscally responsible.

It has always been the Center's practice to meet with the Program Directors to review programs budgets both annually and biannually. In the past, Program Directors were involved in identifying program needs

and educated on the line items expenses and revenue expectations but were not held accountable for these functions. (It is not included in their job descriptions). Administration will continue to define the parameters for the Directors' responsibilities with regard to budgets and expenditures in ongoing regional management meetings. If it is decided that Directors will be given the responsibility and held accountable for budgets respective to their programs, training will be offered to all Program Directors as well as the Southern area director with regard to expenditures as identified. The Helena area director currently referred to as the Southern Region Director will be responsible for asking for the reports as needed pertaining to the budget. If such reports are not produced within a reasonable time period, the Southern area Director will notify her immediate supervisor (the Clinical Director) to assist with acquiring the needed reports. The Clinical Director (Program Directors 'immediate supervisor) will assist Directors with prioritizing services.

For the fiscal year budget 2010-2011, the Financial Director traveled to all the offices to meet with the program supervisors and Directors to gain staff input. It is anticipated that this practice will continue with current administration. At the time of the budget projections, staffs were notified that the expenditures would be reviewed by executive level management and final approval would be through the Executive Director to include input from the executive management team. Because revenues and cash flow vary greatly throughout the year, expenditures must be controlled through a central office. Discussion occurred at a board of directors meeting in spring 2010, with regard to the request for additional autonomy of the Helena region. The board made the decision that the southern county region would not be afforded a different level of autonomy from the current structure.

Presently the board of directors has the authority and responsibility to approve the annual budget. This is another potential area for over sight and feedback with regard to program priorities and growth. It will be strongly encouraged that the Program Directors gain feedback from "stake holders" such as the Helena area advisory committee and their local advisory councils to assist with the prioritizing of program services and needs. Local Advisory Councils will be asked to prioritize services and participate in strategic planning for services.

In regard to having accurate reports of revenues, expenditures, and operating expenses for the Helena based operations our Finance Director with a degree in Business management and major in accounting has been able to provide these reports on a monthly basis at regional management meetings. The reports include current capital expenditures planned as well as a current asset to debt ratio. Additionally the finance director will meet quarterly with each Program Director to review their respective budgets. Capital improvement plans and priorities will be a shared function to include feedback from stake holders. The responsibility is shared between the board of directors, executive management and program directors. Ambassadors of support are the advisory councils, the Foundation, partnering agencies and stake holders.

It should be noted that while there are always services that allow the agency to cover the program costs of salary/benefits, supplies and materials, and operating expenses with some reserves, not all program service reimbursement rates are able to adequately cover these costs. Directors in conjunction with executive management will decide on program staffing needs. A staff to client ratio will be utilized to evaluate its program needs.

#2 Human Resources: Currently Program Directors have the authority to recruit and hire open and approved (budgeted) positions. New positions (not originally anticipated in the budget) under the authority of Program Directors will be approved by the executive management team in a fiscally responsible manner. New hiring procedures have been established (new flow charts will be completed by December 1st) that outline the procedures for hiring and discharging personnel. It is anticipated that the new procedures clarified will assist Program Directors with functioning at an autonomous level. Recent committee discussions include the goal to decrease staff turnover which is a cost that can affect the overall financial outcome and agency morale.

#3 Autonomy within the organization: With regard to level of autonomy for Program Directors: There are two committees identified to assist with defining roles and responsibilities of positions; The job descriptions committee and the management team committee. The Southern Region Director (Helena) is on both of these committees. One management committee goal is to clarify the level of autonomy for each Program Director to function within. The committee's goal was to meet weekly. Because the Executive Director has resigned, the Clinical Director (now the acting-interim Executive Director) will have the responsibility in the interim of clarifying the level of autonomy with regard to development of partnerships. It is the value of the current management team to build consensus and partner whenever possible with outside agencies. Developing partnerships and integrating services will be essential to remain competitive in the era of health care reform. It is the expectation of the regional management team, that Program Directors will be involved in the development of these partnerships. Because these partnerships (MOU's, contracts) affect the center as a whole, the Program Directors will gain the support and approval from the Executive Director who has the responsibility of managing the agencies overall liabilities and contractual agreements.
Job descriptions are presently being updated to include essential job functions for each position. The organizational chart has been updated (October 2010) to reflect current the lines of authority. The management team which comprises of *[sic]* the four Directors and executive management team have made the commitment to continue clarifying authorities and subsequent responsibilities for each location. We believe this process will clarify appropriate levels of responsibilities and lend a greater level of autonomy for the running of each program areas as assigned. It is anticipated that the committees will meet monthly for the next six months to address these issues.

#4 Employee Benefits: Administration has provided employees with the updated leave balances (March 2010). Stipends and pay inequities have been reviewed by the Regional Management Committee (RMT) within the Center. Management has made the commitment to continue to address the issue of establishing a pay scale that reflects the job duties and competencies required for the position. A committee has been established to address the pay inequities to include the Southern Region Director, Operations Director, Financial Director, and the Northern Region Director. The committee meets weekly. It is anticipated that the committee will have a recommendation for the executive management team by January 2010. We anticipate updating job descriptions and performance evaluations within the next year with program supervisors and program directors' input.

#5 Dedicated financial officer: As stated in #1, at this point we do not believe an additional finance officer is needed for the Southern Region. The Operations Director was hired in February of 2010 to assist with the operations across the region. His residence is in Helena and he travels between the two offices to assist with business functions such as; contracts, operations and human resources.

#6 Dedicated Human Resources staff position: The Center for Mental Health has added an additional F.T.E. in human resources to assist with making improvements in our employee practices and benefits. The Operations Director was hired in February. He has a strong background in human resources and was hired to support HR functions and operations. A Human Resources Director was hired in September and has a master in Human Resources. Both positions support the region. The Operations Director currently retains an office in Both Helena and Great falls to assist with timely hiring of staff and to assist with operational decisions (needing executive management decisions). He maintains a current list of open positions relevant to the budget. The Program Directors currently have the authority to make changes with open staff positions to fill program needs. (The client to staff ratio is a reflection of costs and revenues.) Directors will have the ability to make changes in staff positions to best serve program needs using open program employee positions. The Director will notify the Operations Director and HR Director and Clinical Director as well as the Executive Director (once identified) of intended changes and rationale. It is the Clinical Director's intention to support the decision of the Director with regard to these changes. It is believed at this time with the addition of an Operations Director and a Human Resources Director, and improvements in communication of open positions (based on the annual budget plan) that hiring and discharges will be the discretion of the supervisors and Directors. Training with regard to this practice is necessary and available for supervisors to avoid unfair hiring or discharge practices to minimize any potential liability. The processes for the above have been clarified and redefined with flow charts which will be distributed at the next Supervisors' training, November 12th. Although Directors and supervisors have the responsibility of hiring and firing, any subsequent law suits as a result thereof is a shared liability across the Center for Mental Health.

#7 Client loans: The regional management team has discussed the practice of client loans. The process will no longer be offered by the center for several reasons. The past practice of offering client loans for no fee is not consistent with the recovery principles. Client will be assisted in making applications with lending sources or in identifying sources of grants to assist with unanticipated costs such as rent deposits. We cannot provide loans without following the proper accounting guidelines (It's not cost effective). We do not have the resources and do not feel the client would be better served by real life institutes.

#8 Payee ships: In previous years, mental health centers have struggled with finding an independent company to fulfill the role of payee ships. This spring a company (Skill-kin) who provides this service was identified. We anticipate the transfer of client accounts to be completed by October 1st, 2010. The Management involved program supervisors and Program Directors in the decision to proceed with this company.

Recommendation 6:

a) Establish a coherent structure and process for strategic planning and quality improvement, and for monitoring implementation of planning and quality improvement objectives. Consider contracting with a expert who can assist the CMH Board, executive leaders, and "satellite" program leaders in implementing this recommendation.

b) Establish a coherent chain-of-command for ensuring that such a structure and process is in place and functioning.

(A) In response to the findings that The Center for Mental Health lacked adequate strategic plan. A retreat had taken place in January 2010 with the regional management team (Program Directors and executive management team) but the results were never compiled and shared with staff and the process did not include stake holder's feedback. After the BOV's report, the regional management team decided to use an outside consultant to address the shortcomings. There was a two step process that took place prior to the strategic planning session of the regional management team. The first step was that of an employee survey. A on-line survey was designed by a employee of Payne Financial with the goal of gathering feed back with regard to how employees felt about their jobs and management. (A secondary gain was to identify employee needs and priorities.) The second procedure for gaining staff input was to hire an outside consultant to lead focus groups (eight groups in four different agency locations) to expand on the themes identified in the survey. The focus group sessions were held in July 2010. The consultant provided a written report to management and the board of directors. The consultant was then retained to meet with the regional management team to conduct strategic planning based on this feedback. There were two planning sessions held in August and the first week in September. The outcome was five priorities to improve services and agency functioning. The areas of focus are computers, management style, clinical philosophy, job descriptions: expectations & training, and the compensation structure of employees.

One of the five priorities established from the strategic plan was the need to clarify a unified philosophical approach to clinical services. The clinical team (Program Directors, Medical Directors, and the Clinical Director) has the responsibility of the clinical approach to services, quality assurance and program improvement. A retreat was scheduled and completed September 13th by the clinical team to explore the Recovery approach to services. A unified commitment towards the Recovery philosophical approach to services delivery was established at this retreat. A procedure for reflecting this underlying philosophical approach internally and externally was discussed. It was determined that the clinical team would travel to the offices to lead a discussion on the principles of recovery and what each principle meant to them. The goal was to develop with staff input our vision of where we wanted to go with Recovery oriented services and approach. Through these discussions it is anticipated that consensus will be established as well as commitment. A schedule was established for the first four offices (Havre, Helena, Shelby and New Directions). The first office Havre was completed. The other three offices are scheduled in November and December. The clinical team will begin with staff input, and will eventually hold consumer (LAC) meetings for their input. The Board members will be notified of the scheduled times in their respective counties to participate. Additional training and discussion will be provided as identified as a need.

With regard to Helena's vision of services to include the "village model" approach to Recovery oriented services, a strategic planning session was held on September 27th. Originally an outside consultant to assist with the process was hired. When the facilitator canceled that day due to illness, a substitute facilitator was brought in. The Southern services staff and members of the executive management team participated and identified four areas of focus for supporting the village model. A follow up meeting was scheduled to monitor progress and barriers.
Quality improvement: The clinical directors will continue to utilize consumer surveys as a method for measuring quality improvement and gaining consumer feedback with regard to service delivery. The survey is scheduled for November and June. Additionally there will be a quality assurance committee created to develop goals and objectives for service improvement. It is anticipated that the committee's members will meet prior to Dec 31st to serve with the on-going committee. The committee will consist of consumers (minimally one from adult and one from family or a guardian of children services), community partners (a minimum of one) and staff from every direct care service, a member from the foundation will be invited, a psychiatrist and the clinical director. Goals for measuring improvement will be identified. The Clinical Director is responsible for the development of the committee and for guidelines of the committee. The center will investigate the various accreditations to assist with quality improvement processes.

(B) Chain of command: The organizational chart has been updated to reflect the current chain of command. The organizational chart will be sent out to all employees and put on the intranet for viewing. The intranet was a feature added to communicate to employees changes within the center, improve communication with regard to various issues. The intra net will contain minutes from clinical directors meetings, regional management meetings; board minutes meetings, anniversary dates, etc. The Interim Executive Director has the responsibility of clarifying any issues related to the chain of command.

Recommendation 7:
With the assistance of a professional facilitator, convene a series of structured conversations between the CMH regional leadership and CMH-H leadership. The overarching goals of these conversations should be to:
a) establish the optimal organizational model for CMH-H's autonomy, accountability, and authority relative to the regional CMH organization;
b) establish consensus among CMH regional leaders and CMH-H leaders regarding the mission of CMH and potential iterations of that mission that may be applicable to the community of Helena;
c) establish protocol for communication between CMH regional leadership and CMH-H leadership that optimizes planning, staff training and supervision, program management, and service implementation relative to the mission.

(A) Please see the response with regard to autonomy and accountability under 5.
(B) The Executive management team and Clinical team endorses the CMH-H Director, the stakeholders, and the region's intention to integrate the best practice "village" model principles into of Recovery services. The executive management team participated in the strategic planning meeting on September

27th, and will participate in follow up planning sessions to support the Helena area region with this endeavor. The Program Director (Rhonda Champagne) will be responsible for developing with participation from stakeholders, staff and the management team, the strategic plan for integration of these services.
(C) The CMH-H Director (southern services Director has scheduled a follow up meeting with a facilitator for January 10, 2011 to include all of the individuals listed in the response to Recommendation 1 well as other members of the Executive Team - to address optimal organizational model for CMH-H's autonomy, accountability, and authority, relative to the Regional CMH organization.
The focus @ the January 10th will be to review progress on the four areas (identified below), to explore barriers, and to establish a protocol for communication that optimizes training, supervision, program management, and service implementation relative to the mission. Strategic Planning will develop and define a comprehensive plan to include what the following areas: (1)The structures to support the sustainability of the services (job descriptions, training, productivity, measures and markers), (2) The personnel and systems of support (funding sources, hard service needs, reimbursement to workers, etc.) (3) Process (program eligibility, clinical oversight, policy changes to support, peer support roles, eligibility for reimbursements, referral and application processes), and (4)Support services (establish on-going support for sustainability, time lines, priorities, crisis services, group treatment, and development of evidence based approach to treatment. A written summary of this meeting will be sent to BOV no later than January 24, 2010.

Recommendation 8:

a) With the involvement of clinical and administrative staff from throughout the region and in consultation with experts in electronic medical record keeping systems, evaluate the ability of the current computer system to support the work of CMH staff. If the current system is found to be inadequate, develop a written plan to upgrade the system within a reasonable time frame to one that will support the work of CMH staff.

b) Put in place immediately temporary computer system solutions that will allow CMH staff to perform essential functions.

(A) Director of CMH-H will cooperate with CMH Executive Team and other Regional Directors in addressing electronic medical records system and planning of identified problems and solutions.
A committee has been established and is meeting weekly to address the issues associated with the computer system and electronic records. Temporary solutions have been discussed in regional management team to assist with issue preventing clinicians and direct care service providers with keeping current records on clients and with billing procedures.

(B) The issues with regard to our Electronic medical record system and billing system are complex. A software feature was added in May 2010 called "MT scheduler". This software allowed increased flexibility within the clinical record system. To assist staff with keeping current records, the regional management team has discussed options to allow staff to perform essential clinical record keeping functions. Support staff will be trained and utilized to assist staff with logging schedules and

appointments into the system. This will assist direct care staff with reconciling events in a timely manner. With the support of the "executive" board members, additional staff will be added to assist with this issue. Direct care workers who are behind on chart notes can dictate notes or use temp plates in "Word documents" to complete notes efficiently (To be transferred into the Electronic Medical Record (EMR) system). The I.T. staff completed an inventory of current computer equipment for the purpose of establishing priorities for updating equipment and evaluating needs. Priorities will be set by the committee for updating computer as afforded. The Center for Mental Health will continue to seek alternative funding sources to support the goal of updating our computer system. Health Care reform has allocated "meaningful use money" to support EMR systems. Grants have been submitted as well to support updating the computer systems. The committee identified several priorities: Provide staff with access to computers in every location, update the computer system, and increase accessibility to the computers (less people sharing computers). There are some group homes in Great Falls that do not have computers.
The committee on computer issue meets weekly and has reviewed options for increasing speed, improving flexibility within the systems, interfacing with other programs, updating equipment, and improving the internet issues (that affect speed and down time). The committee will present updates and recommendations at the regional management team meetings (RMT meets at a minimum bimonthly). The executive management staff will be responsible for the follow up decisions and expenditures as the budget or grants allow. Outside vendors have evaluated our system issues to provide feedback to the committee. The committee will make recommendations based on these evaluations.

Recommendation 9:

a) Develop a comprehensive strategic plan with meaningful participation by staff at all levels, clients, family members, and community partners. Even though this recommendation is specific to its review of CMH services in Helena, BOV recommends that CMH develop an overarching strategic plan for its entire organization, with "sub-plans" for each satellite office/program.

b) Develop a strategic plan for the recovery grant project with specific objectives, responsibilities, and timelines.

(A) The Center for Mental Health has made a commitment towards a Recovery model for services. Recognizing that individuals' needs are unique from one community to another, we anticipate that each community's vision and approach to Recovery oriented services to be unique as well. The clinical team is traveling to each office within the next six months to facilitate discussion as to what Recovery means to each employee and its stakeholders. The board of directors will be invited to participate in these meetings. Following these sessions, each Director will complete a strategic plan (to include consumer and family input) of how they will incorporate these principles into service deliveries as well as identify the best practice or evidence based approach to services. The strategic plan for Recovery oriented services is to be completed within the next six months by each Program Director. The involvement of stakeholders in the planning will be accomplished at the LAC meetings. Each LAC will provide needs, priorities and time lines if appropriate.

The leaders in the Helena region have made a commitment towards the "village" model approach to Recovery oriented services. It is one of the best practice models of Recovery. The clinical leaders will support Helena in this approach to services. A priority of support will be towards best practice models of Recovery model services.

(B) CMH-H held a strategic planning meeting on September 27th, 2010, which focused on implementation of the basic principles of "Recovery" and specific steps for implementing the "Village Project" in the Opportunities Program and developed a written strategic plan. This process addressed all aspects of CMH-H services. The meeting held on September 27th included the CMH Regional Director of Operations, the Clinical Director, and the Finance Director, all program directors from CMH-H, and three peer support specialists from the Helena office. See attached strategic plan. It is the intention of the Regional management team to support the Helena area with their vision of providing a supported recovery program using the village model approach to services.

Recommendation 10:

Develop a process of continuous quality improvement to evaluate and improve all activities related to provision of services to clients and families.

This recommendation will be addressed in the meeting scheduled for January 10th, 2011. CMH-H will provide a copy of a preferred quality improvement evidence based quality assurance outline as developed by SAMHSA, as well as the Recovery Transformation Progress Report developed by the Medical Director of the Village. CMH-H Director will have these available to all participants by November 1st, 2010.

Recommendation 11:

Assess environmental and attitudinal causes for breeches in confidentiality. Based on this assessment, develop clear written procedures for maintaining confidentiality, and provide training to all staff; correct any physical barriers to maintenance of confidentiality.

Environmental barriers were assessed by both CMH Director and Office Manager during the Month of April. We have implemented a continual quality assurance process for these confidentiality issues. Physical changes were made to ensure confidentiality such as: All client correspondence is now relocated and housed in a secure space behind the receptionist's area. The Office Manager position has assumed responsibility for ongoing assessment and review of HIPAA safe practices. Net Smart training on HIPAA is now required for all staff to be completed within the first 90 days of employment. This current practice was implemented June 2010. The Office Manager is currently researching best practices for better implementation of the HIPAA regulation. A Written procedure and training curriculum will be finalized by January 1, 2011.

Recommendation 12:

Revise the CMH abuse/neglect policy to remove any indication that discretion may be exercised when an allegation meets the statutory definition of abuse or neglect.

An allegation of abuse and neglect form (initial report) has been developed and has been approved by the Clinical Director and the clinical management team (attachment #4). The clinical policy and procedure will be updated by December 31, 2010 to remove the language that allows for staff discretion in reporting. The policy will clarify the procedure for investigations of suspected abuse or neglect. All reports will be kept in a manual and reviewed by the Clinical Director.

Recommendation 13:

Revise the forms used for documenting allegations and investigations of allegations of abuse and neglect. Create a form for "initial report" and use the current form for reporting on the results of investigations.

The 'initial report' form has been revised and submitted to the CMH Clinical Director for review and approval. The CMH-H Director will request formal adoption by CMH Administration on or before November 1st, 2010.

Recommendation 14:

Change CMH policy so that the CMH-H Director functions as the "professional person in charge of the mental health facility" described in §53-21-107, MCA.

CMH will update its policy and procedures for abuse and neglect complaints to clarify that Program Directors are the professional person in charge of the facilities they directly oversee. This will be accomplished by November 1st, 2010.

Recommendation 15:

Provide training for all staff - including supervisors - in the policy and procedure for responding to allegations of abuse and neglect of clients.

CMH-H conducted all staff training on August 24th, 2010 and presented material at subsequent team meetings regarding abuse and neglect statutes.

Recommendation 16:

Make arrangements for Montana House to host the NAMI Peer-To-Peer program.

CMH-H hosted a NAMI peer to peer training in Helena this past August.

Recommendation 17:

a) Define optimum knowledge and competency expectations for each staff position providing services to clients including supervisors and peer support specialists.

b) Based on optimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses.

c) Develop and implement a training protocol for new staff that follows a written curriculum based on defined optimum knowledge and competence expectations.

CMHA has defined an on-going committee to meet weekly to revise job descriptions and identify competency expectations, optimum knowledge requirements and training to support these competencies. Our first meeting is scheduled for September 23rd. After this date there will be an ongoing process with an expected completion date within six months.

Recommendation 18:

Arrange for all CMH-H staff to take the NAMI Provider Education course.

The topic of training all center employees in the NAMI provider course is scheduled to be discussed at the next Clinical Directors meeting on October 13th, 2010. A written summary of the outcome of this recommendation will be sent to BOV by October 15th, 2010.

Recommendation 19:

Develop a policy and procedure that prioritizes a proactive role for CMH in ensuring that all consumers have current physical / medical examinations when they enter service, and receive annual physical / medical examinations thereafter.

A primary task of case management is coordinating and scheduling medical appointments for clients – including ensuring that clients have current physicals whenever possible. In addition, AFC, PACT, ACT, and Group Home programs have procedures that ensure a proactive role in facilitating consumer's annual physical examinations. CMH-H will ensure that all clients with Medicaid or other adequate medical insurance have current physicals - contingent on client willingness. Clients with MHSP or other funding source may have no medical insurance, which will reduce the medical services available to them; with these clients, CMH-H will make every effort to ensure current medical assessment within funding limitations.

Recommendation 20:

Revise the manner in which CMH-H crisis resources are advertised so that there is maximum visibility and ease of access to people in crisis and their families.

CMH-H Director has arranged for the publishing of the crisis line in the Helena area phone book scheduled to be out by October.

Recommendation 21:

Redesign the crisis response telephone system so that it has the following characteristics:

a) there is a single telephone number for all "crisis" calls

b) a trained CMH-H staff person answers the phone 24/7, evaluates the situation and then makes an affirmative connection for the person who is calling (affirmative = not just giving the caller a name or a number, but directly setting up the contact needed);

c) there is a specifically-defined maximum time allowable before the CMH-H staff person answers each incoming call;

d) there is no operator or answering service involved;

e) CMH-H makes a follow-up telephone call to each caller within 24 hours, to make sure the needs of the person have been or are being properly addressed.

(A) There is a single number for all crisis calls- 443-5353

(B) All crisis line calls are now answered by trained CMH-H staff.

(C) All crisis line calls are answered immediately.

(D) CMH-H no longer utilizes an answering service in the operation of the crisis line.

(E) CMH-H has implemented a follow up call procedure and this does occur within 24 hours.

ADDENDUM 1
MEDICATION ERROR REVIEW – CONDUCTED 4/9/10

Background

In early March 2010, the Director of the Center for Mental Health, Helena informed the Executive Director of the Mental Disabilities Board of Visitors (BOV) that a significant number of medication errors had been made in the outpatient office. During a scheduled site review on March 18-19, BOV became aware that the medication errors appeared to be more extensive than first suspected. At this time the BOV Executive Director decided to conduct a special review of the medication errors. On April 9, 2010, two BOV consultants (William Docktor, PharmD, BCPP; Irene Walters, RN; and the BOV Executive Director conducted this review.

Nursing Skills

General observation: Most of the errors identified by Center for Mental Health-Helena (CMH-H) nurses as they were made[17], were made by a single nurse; this suggests that this nurse's skills were deficient. However, overwork, frequent interruptions, absent or inadequate protocol, and poor supervision appear to have contributed to these errors as well.

1. There is a culture in the program in which the "emergency of the moment" takes precedence. This plays out for nurses in frequent, unacceptable interruptions when processing doctors' orders and preparing Medisets.
2. As indicated by the types of errors that have been reported, there appears to have been – at least with one nurse and her inadequate supervision – a failure to follow basic nursing practices including following the "Five Rights"[18].
3. The nurses interviewed reported "borrowing" medication from one patient to use for another when refills had not arrived. This practice is associated with a high incidence of medication errors.
4. The nurses interviewed stated that discontinued medications for some patients have been used for other patients, and that the assistant nursing supervisor was aware of this practice. This is in clear violation of the Center's Medication Management and Monitoring Policy[19].

Supervision

General observation: Supervision appears to have been minimal and inadequate. Medication errors appear not to have been addressed when they were made[20].

1. It was reported to BOV that the nurse who had made multiple errors was told that if she needed help she should call the nursing supervisor, but that when she called, the supervisor did not respond.
2. It was reported to BOV that the nursing supervisor was not helpful in the role as supervisor.
3. The former nursing supervisor functioned as both the nursing supervisor and the supervisor of the crisis stabilization house; the physical location of the nursing supervisor's office was in a different location from the rest of the nursing staff.
4. The former nursing supervisor reported that she did not have regular meetings with the nursing staff.
5. The former nursing supervisor reported that decisions that directly affected nursing functions and staff she supervised were made by her supervisor without her knowledge or input.
6. The new LPN Team Leader reported that the nursing supervisor did not know how to "do meds".
7. Chain of command lines of authority and reporting are unclear.
8. Position descriptions are inadequate and do not appear to be a functional part of defining and ensuring continuity for nurse expectations, training, performance, and supervision.

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[17] The only errors for which information was provided to BOV were those that had been reported via the center's incident report policy. Even though the program director described the errors as "extensive", the center does not have the ability to go back and identify all the errors that actually have been made. Given the problems described above, it seems plausible that medication errors have extend beyond one nurse.

[18] Five Rights Of Medication Administration: 1) Right Patient 2) Right Route 3) Right Dose 4) Right Time 5) Right Medication.

[19] Borrowing medications currently prescribed for one patient for administration to another patient, and using a medication from a discontinued prescription for one patient for administration to another patient are also violations of the Pharmacy Practice Act §37.7, MCA 2009.

[20] It appears that reporting and even awareness of medication errors was inconsistent. Nurses interviewed by BOV reported that there was a general lack of attention to accurate incident reporting due to inconvenience and time constraints, and indicated that it was easier to just fix errors when they were noticed.

Training

General observation: Training (in general and specifically with regard to managing medications) appears to consist entirely of working with another nurse for a few days who shows the new nurse how she/he should do things. Each nurse appears to be left his/her own devices to develop a medication system of his/her own.

1. Nurses reported to BOV that they received minimal or no formal training specific to proper medication procedures or for other nursing duties.
2. The training checklist for nurses addresses primarily generic Center procedures. The sections dealing with nursing procedures are not sufficiently detailed.

Written and Verbal Communication Among Prescribers, Nurses, Supervisors

General observation: Nurses apply a different management protocol with each prescriber.

1. Verbal communication is used to some degree at the center for medication orders; this method is not accepted practice, is often fraught with error, and must be eliminated from the process.
2. Three computer programs are involved in medication management: the eCET system is where a progress note goes, the OnCallData system is where orders are entered, and nurses use a MS Word file for a Medication Administration Record (MAR). These three pieces of software do not communicate with one another requiring nurses to re-enter the same data into each system. Each time data is entered it creates another opportunity for error. In addition, the computers in use do not allow for split screen so that the MAR and OnCallData cannot be viewed simultaneously to double-check information entry.
3. The locum tenens psychiatrist on staff on 4/9/10 reported that OnCallData is often not up to date and not accurate, and that he had to repeatedly recreate the medication documentation history.

Policies and Procedures

General observation: Policies and procedures addressing medication errors are nonexistent, or nearly so. The Medication Management and Monitoring policy in the Center for Mental Health Clinical Policy Manual is vague at best. Specific procedures based on established standards do not exist.

1. There is no requirement for or practice of a "double check system" by the medical professionals. Staff interviewed by BOV reported that they rely on clients to provide this check (this was reported as if it was an adequate process).
2. There is no system for appropriately handling controlled substances. There is a mandate from the former regional medical director prohibiting the storage or distribution of controlled substances by Center staff. However, there are current doctor's orders for a controlled substance for at least one client.
3. The Medication Management and Monitoring policy is riddled with "shoulds"; specific requirements ("musts") do not exist.
4. The Center for Mental Health Clinical Policy Manual, Chapter 12 (Incident Reporting), and Chapter 13 (Continuous Quality Improvement) are vague and do not describe comprehensive guidelines for handling medication errors.

Root Causes of Medication Errors

General observation: Errors in any health care system are usually related to mistakes made at several different levels. This seems to be the case with medication errors made at the Center for Mental Health in Helena[21]. It is likely that there were specific performance problems with the individual nurse who appears to have made most of the medication errors under scrutiny in this review, but this was compounded by systemic issues including inadequate policies and procedures and inadequate supervision.

The following are the root causes for the medication error situation:

1. Inadequate training for new nurses.
2. Lack of / inadequate policies and procedures for managing medication.
3. Lack of a medication error detection and review system.
4. Nurse error - not following basic nursing procedures.
5. Use of three computer systems which do not communicate with each other.
6. Inadequate supervision of nurses.
7. Poorly-designed space in the outpatient clinic for processing medication orders, preparing medication containers, and medication storage.
8. Poorly-designed/managed work-flow/culture with numerous interruptions of nurses when working with doctors' orders and medications.

[21] Given the inadequate corporate policies and procedures, it is plausible that a similar situation exists in other Center for Mental Health offices.

Recommendations

Each of the above root causes needs to be addressed as soon as possible. ***Given the significant potential for client harm inherent in inaccurate processing of doctors' orders and erroneous administration of prescribed medications, the Center for Mental Health should place a high priority on implementation of these recommendations.***

1. Establish clear, specific policies and procedures for medication prescription, documentation, ordering, review, storage, and dispensing along with a system of supervision and communication for these to work properly. These policies and procedures and communication system must be consistent with current standards of practice.
    - An individual with the abilities and experience to develop this system needs to be put in a position and given the power/authority to do so.
    - Implement a system in which a pharmacy prepares Medisets for all CMH-Helena programs. (Medisets for PACT and ACT are filled by the pharmacy.)

2. Establish specific written competence and knowledge expectations and develop and implement a written training process for nurses and nursing supervisors. Ensure that all current and new nurses are trained in this curriculum, and knowledge and competence demonstrated.
    - All nurses must follow established procedures so that the system is consistent.
    - Supervision of the nurses needs to include a review of their performance related to these established policies and procedures.
    - Basic nursing skills should be demonstrated by all nurses and documented.
    - Nursing job descriptions (supervisory and others) need to be revised to reflect the specific duties of each nurse and then should be used to assess their performance.

3. Assess the adequacy of the current computer system; update as needed.
    - A single system for doctors' orders, transcription, progress notes, and medication administration records is the standard of practice.
    - This same system should also be able to serve many/most other needs of the center beyond medication management.

4. Assess the outpatient office space for adequacy of size and physical design. Remodel or relocate to ensure efficient medical/nursing work flow and client confidentiality.
5. Establish an absolute priority for nurses to have uninterrupted time to perform their jobs. The culture of the center needs to change for this to occur.
6. Once appropriate policies and procedures are established, determine and establish optimum nursing staffing levels to ensure that the workload of each nurse is reasonable.
7. Develop and implement a medication error detection and review system - including applicable policies and procedures. This system should be incorporated into a continuous quality improvement process that tracks errors and designs interventions aimed at reducing errors over time.

CMH-H RESPONSE to MEDICATION ERROR RECOMMENDATIONS

Recommendation 1:
Establish clear, specific policies and procedures for medication prescription, documentation, ordering, review, storage, and dispensing along with a system of supervision and communication for these to work properly. These policies and procedures and communication system must be consistent with current standards of practice.

- ***An individual with the abilities and experience to develop this system needs to be put in a position and given the power/authority to do so.***
- ***Implement a system in which a pharmacy prepares Medisets for all CMH-Helena programs. (Medisets for PACT and ACT are filled by the pharmacy.)***

The Center for Mental Health has reviewed our current policies and procedures around medication dispensing to include who dispenses, how and where we store medications, system of supervision, review of medication errors, and ordering of medications. We are in the process of actively rewriting a more detailed and descriptive medication policies. More specifically, a committee comprised of the Chief Medical director, Medical director of Southern Services, and Nursing supervisors and staff involved in medication monitoring will meet as needed at least monthly to review and rewrite these policies and plan to complete the process over the next 6 months.

To address the issue of supervision: The Center for Mental Health replaced the position of supervisor with an experienced LPN who was promoted to the role of administrative supervisor for nursing staff in the Helena area. Her role is to provide clinical and administrative supervision of nursing staff in the Helena office within the scope of her LPN license. For any issues that arise outside the scope of her LPN license, the supervisory responsibility will fall to the site medical director, and in Helena, this would be the Carl Keener, M.D., Medical Director of Southern Services. The Medical Director of Southern Services also provides clinical and administrative supervision to the other psychiatrists as well as the nurse practitioners in the Helena area. Please refer to the attached organizational chart for further details.

In regards to the recommendation that a pharmacy prepares Medisets for all CMH-Helena programs, presently in Helena, South Hills pharmacy is the only pharmacy who has agreed to prepare Medisets for the area clients. South Hills pharmacy does currently prepare Medisets for group home clients as well as PACT and ACT clients free of charge. Our Helena nursing supervisor has explored incorporation of other clients that receive medication set up. We have learned that it would be cost prohibitive as South Hills pharmacy is not willing to provide this service to any additional clients free of charge.

Recommendation 2:
Establish specific written competence and knowledge expectations and develop and implement a written training process for nurses and nursing supervisors. Ensure that all current and new nurses are trained in this curriculum, and knowledge and competence demonstrated.

- ***All nurses must follow established procedures so that the system is consistent.***
- ***Supervision of the nurses needs to include a review of their performance related to these established policies and procedures.***
- ***Basic nursing skills should be demonstrated by all nurses and documented.***
- ***Nursing job descriptions (supervisory and others) need to be revised to reflect the specific duties of each nurse and then should be used to assess their performance.***

The nursing supervisor in collaboration with the site Medical Director will over the next six months review and update established nursing procedures and protocols for Helena nursing staff. This will include written competence and knowledge expectations for all nursing staff as well as a written training program for nurses and nursing supervisors. This will be developed and reviewed in meetings that will occur

monthly (at a minimum) with the site Medical Director until completed. The procedures and protocols will include a list of basic nursing skills that must be demonstrated by nursing staff at the time of hire and documented by the nursing supervisor. The documentation will be forwarded to Human Resources and contained in the staff member's personnel files.

The nursing supervisor will be responsible for performing yearly evaluations of the nursing staff which will include a review of their performance related to these established policies and procedures, and the nursing supervisor will observe and document competency in basic nursing skills as described above. The nursing supervisor at the time of hire and yearly evaluations will identify training needs and assign required training to nursing staff.

With regard the issue of job descriptions, a committee has been established which is comprised of the Clinical Director, Human Resources Director and Operations Director to sequentially review and update all Center job descriptions. The committee will meet at least twice a month. The committee will request input from the nursing supervisor and Medical directors to update the nursing staff job descriptions. The revised job descriptions will include expectations for knowledge, skills/core competencies, and duties specific to their job. This process is expected to be completed specifically for nursing staff positions within three months.

Recommendation 3:
Assess the adequacy of the current computer system; update as needed.

- ***A single system for doctors' orders, transcription, progress notes, and medication administration records is the standard of practice.***
- ***This same system should also be able to serve many/most other needs of the center beyond medication management.***

The Center for Mental Health reviewed the current flaws within the online order entry system, which does not collaborate with the Center's electronic medical record, and MAR system. We have established a Information Technology (IT) committee that has been and will continue to meet at least monthly and will be responsible for developing recommendations to the administrative staff to address the inadequacies of our current system and allow a single system for prescriber orders, transcription, progress notes and medication administration records as well as interface with other areas of Center operations. The committee is comprised of the Center's Information Systems Director, clinical staff (Cascade County CSP Director and Cascade County Adult and Family Director) and the Centers Finance Director. The committee will research and present the information to the Center's executive team for a decision as to whether center will move to an entirely novel computer system versus upgrading and adapting the current system to accomplish the aforementioned goals. The committee at this time has solicited input from outside consultants. The plan is to reach a decision on this matter within the next 6 months.

In the interim, nursing staff have been assigned the duty of checking orders in the OnCallData (online order entry system) against the current MAR and electronic medical record and updating as needed when nursing staff are setting up medication boxes for clients and when there are any changes, additions or discontinuation of medications. The Helena office nursing supervisor Connie Boyer will be responsible to verify with nurses that this procedure is being followed. We have also provided nurses and prescribers with two computer monitors as a temporary solution, to help minimize the potential for error.

Recommendation 4:
Assess the outpatient office space for adequacy of size and physical design. Remodel or relocate to ensure efficient medical/nursing work flow and client confidentiality.

The Nursing Staff Supervisor will meet with nursing staff, and Facilities manager, to discuss space and design solutions for ensuring efficient medical/nursing work flow and client confidentiality. Discussions this far have included purchasing additional storage and or moving offices for increased functionality. The Director of Operations, Medical Director and Southern Director of services will receive this report in one month (11-30-10) and make recommendations to the executive management team to support work needs. The executive team will respond within a month with a decision.

Recommendation 5:
Establish an absolute priority for nurses to have uninterrupted time to perform their jobs. The culture of the center needs to change for this to occur.

The new operation hours for accessing the nurses have been established to minimize interruptions and the potential for error. The hours are as follows: Currently down time (time to allow uninterrupted medication set up) is 8:00 am to 10:00 am, 12:00 pm to 1:00 pm, and 4:00pm to 5:00 pm, Monday through Friday. Client medication monitoring time is Tuesday, Wednesday, Thursday 10:00 am to 12 noon and 1:00 pm to 4:00 pm. A nursing communication form is in place for support staff to relay questions, concerns and requests to nursing staff that occur outside of the newly designated operating hours. Nursing will direct non compliant staff to the communication form. Continued non compliance from support staff will be documented by Nursing Staff Supervisor and communicated to staff's supervisor or site director. Secretarial staff will be directed to leave messages for nursing should they present during nursing down time unless the issue is emergent in nature. These policies will be included in the aforementioned nursing policy and procedures manual.

Recommendation 6:
Once appropriate policies and procedures are established, determine and establish optimum nursing staffing levels to ensure that the workload of each nurse is reasonable.

The current staffing pattern for the nursing department has been reviewed by the Medical Director and Executive team. We will maintain four fulltime nurses to work with three fulltime prescribers. Once the aforementioned nursing policies and procedures are established, after a period of 3 months, the nursing supervisor will review with the site medical director the adequacies of the nursing staffing pattern. If additional staffing is needed, the request will be forwarded by the site medical director to the executive team for review.

Recommendation 7:
Develop and implement medication error detection and review system - including applicable policies and procedures. This system should be incorporated into a continuous quality improvement process that tracks errors and designs interventions aimed at reducing errors over time.

The Center has recently revised documentation and reporting protocol for reporting medication errors. (Forms attached) and will be updating policies to reflect this. The policy with regard to medication errors will be written by the Chief Medical Director with input from the Medical Director for Southern Services and nursing supervisors and will be completed by January 1st

We have instituted a medication error review committee, directed by each site Medical Director and attended by other designated staff including nursing supervisors, foster care and group home supervisors and Clinical Director. The committee will meet at least monthly or not less than 10 times a year. The committee will have the responsibility reviewing each medication error, identifying the basic causal factors underlying the variation in performance, focusing on systems and processes.

The committee will implement a Continuous Quality Improvement plan with regards to medication errors. The committee will gather data, including the rates and types of medication errors in order to assess outcomes of interventions and to set goals and measurable objectives. The committee will review available relevant literature. The committee will review the underlying systems and processes to determine where redesign might reduce risk, and identify risk points and their potential contributions to the error. They will identify potential improvement in processes or systems that would tend to decrease the likelihood of future errors and develop a plan for implementation and monitor performance indicators and progress toward measurable outcomes and goals. This committee will have a written Continuous Quality improvement plan completed by February 1st. The progress towards goals will be reviewed in subsequent quarterly meetings.