MONTANA State Hospital

Making a difference one life at a time

Governing Board Meeting

Meeting Date/Time: August 1, 2023, at 3:30 pm (MT)

Meeting Location: Virtual (ZOOM)

Member Name	Title	Membership Type
Mike Randol	Executive Director, Medicaid and Health Services	Chair, Voting
William Evo	Chief Healthcare Facilities Officer	Voting
David Culberson	Interim Administrator, Montana State Hospital	Voting
Rebecca De Camara	Administrator, Behavioral Health and Developmental Disabilities Division	Voting
Chad Parker	Deputy Chief Legal Counsel	Voting
Kim Aiken	Chief Financial Officer	Non-voting

1. Call to Order – **Called to order @ 3:34pm, all members present except Chad Parker.**
   a. Public Comment Period (*MCA 2-3-201 et seq.)* – **None.**
   b. Board Comment Period – **None.**

2. Old Business
   a. Approval of Previous Meeting Minutes from 4-11-23 - **Approved**

3. New Business
   a. Discussions and Decisions Required (David Culberson)
      1. Discussion
         a) Recent Annual Licensure Surveys of Galen/Group Homes
            Annual Galen/GH's Survey was conducted April/May 2023 – For any and all findings - Action Plan put together, submitted to the State Licensure, and approved.
            Environmental issues found at Galen – issues have since been taken care of.
         b) Unannounced Licensure Visit (from 5/9/23 – 5/11/23)
            3-day visit – 6 PT medical records requested and interview of staff.
            One PT medical record issue found – Five were found no issues.
            Action Plan put together, submitted to the State Licensure, and approved.
         c) Safety Event Investigation & Follow-up
            June 2023 incident – PT ingested a chemical left out by an outside contractor on unit. PT was hospitalized, treated, returned back to MSH and since been discharged.
            MSH has implemented a process where all contractors will continue to sign in at the from desk and now be escorted by MSH staff during the duration of their visit.

d) Spratt
    i. Care Coordination & Planning

        i. House Bill 29 Considerations - **Effective July 1st, 2025**
        ii. Robust Process Improvement Initiative - **Fall program initiated.**

b. Project Updates (Nancy Logel, A&M) – **Nancy provided updates as written in the Appendix.**
    1. Review of New/Updated Policies
    2. CMS Certification Updates
    3. Infection Control Updates
    4. Treatment Plan Focus with Individualized Goals
    5. Environment of Care
    6. Revised Committee Structure (Exhibit 2)

c. Reports – **All were discussed as presented in Appendix.**

    1. Chief Executive Officer Report (David Culberson)
        a) Facilities Upgrades
            i. A&E site visit updates (from 6/27/23)
            A&E working with MSH to identify priority projects. A&E advises that MSH implement a project manager as some of these projects are going to be ongoing.
            ii. Capital Budget Items (Exhibit 3) **– Approved by Legislator**
            Motion to approve capital budget – Motion approved by Governing Board.
        b) Other facility maintenance needs / requests
        Work order process implemented by Facilities Manager.
        c) Med Clinic Spore Testing
        Obtained proper spore testing equipment.
    2. Director of Nursing Report (Jocelyn Peterson, RN)
        a) Medical Equipment
        b) Medical Exam Room Improvements
        c) Fall Improvement Project / John Hopkins Tool
        d) Columbia Suicide Screening
    3. Medical Executive Committee (David Culberson) -
        a) Last Meeting June 29, 2023
        b) Outside Peer Review of Selected Cases
    4. Quality Improvement Committee (Troy Dawes)
        a) New Interim Quality Director Introduction
        b) Quality Metrics Overview
    5. Finance (John Jenkins Jr., A&M)
        a) Monthly statistics
    6. Human Resources (John Jenkins Jr., A&M)
        a) Recruitment, retention, and employee turnover metrics

7. Infection Prevention (Kristin Harris, RN)
    a) Introduction of new Infection Control Practitioner
    b) COVID-19 Updated Plan & Approach
8. Safety Committee (Troy Dawes and Tim Bollig)
    a) Fire Drills & Disaster Planning
    b) Emergency Operations Plan Updates
9. Legal (Nicole Klein)
    a) Improved Communications at Galen

4. Adjournment - **Meeting adjourned at 4:41pm**

Attachments:
A: Project Updates
B: Facilities Upgrades
C: Director of Nursing Report
D: Quality Improvement Committee
E: Finance & HR Report
F: Infection Prevention Report
G: Safety Committee Report
H: Legal Report

Attachment A (Nancy Logel, A&M)
Project Updates

Review of New/Updated Policies

There is a standing agenda item for the Governing Body to review any new or updated policies at MSH.

To date MSH has presented 14 Policies to Med Exec Committee for approval.

A MSH master repository for all policies has been developed with a detailed prioritization process. Share point site has been successfully created with desktop icon that has been added to all MSH computers for easy policy access for staff.

See Exhibit 1 for list of policies and procedures that have been approved by the Med Exec Committee.

CMS Certification

CMS Certification is a 2 + year rigorous journey that will require the following to be woven into the daily operations and MSH culture:

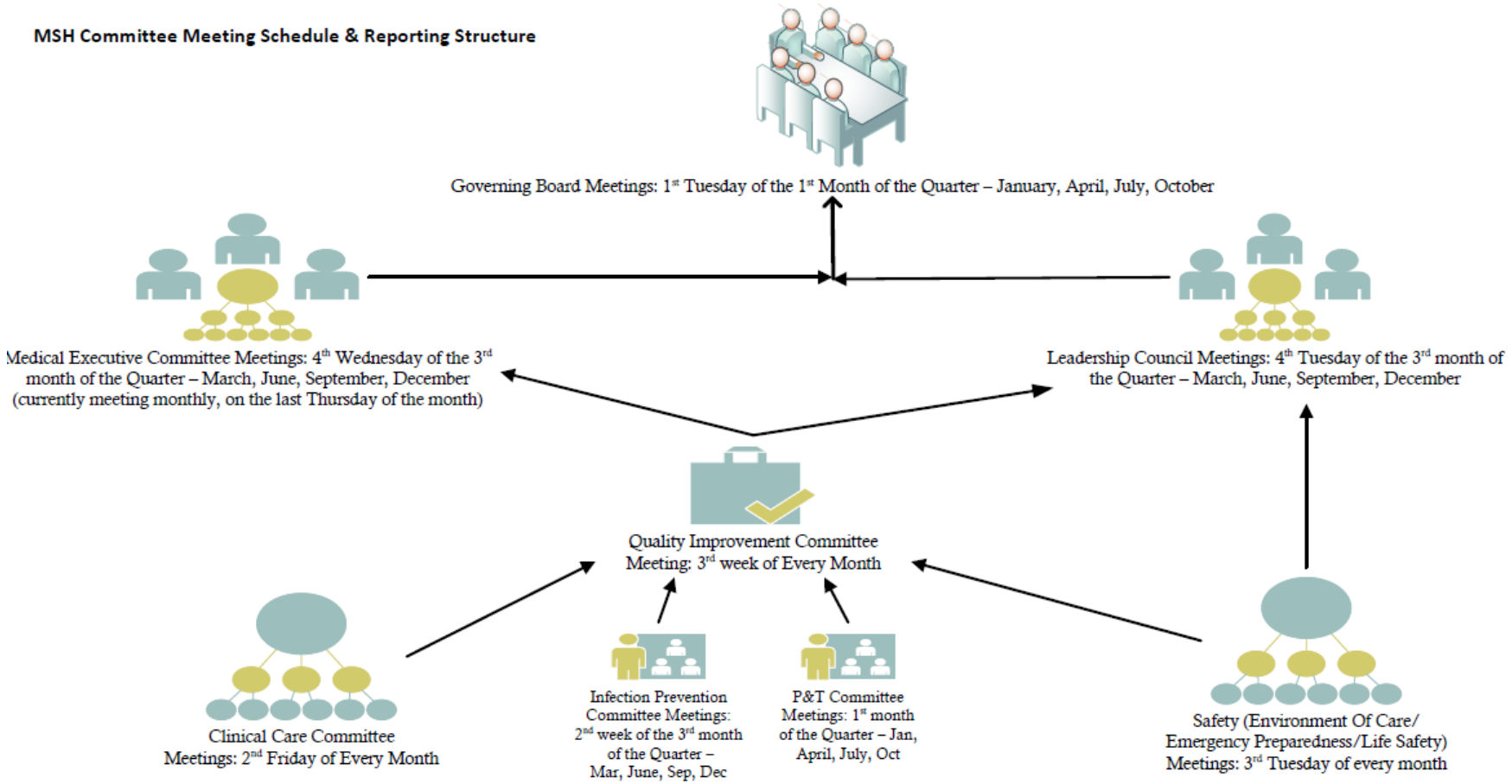
- Key Elements to ensure Sustainable Quality and Safety Care Delivery at MSH:
    - Reinforcement and true adoption of Continuous Process Improvement model (Identify, Plan, Execute, Review)
    - Development of new CMS required policies and revisions of existing policies and procedures that meet federal and state regulations.
    - Reinforcement that policy must match current practice. Polices are a guide that augment clinical judgement and critical problem solving.
    - Continuous Leadership development and mentoring for MSH management staff and fostering critical thinking skills at all levels of the organization.
    - Full provider participation, peer accountability and standard of care that aligns directly with CMS Conditions of Participation.
    - Foster culture of inter disciplinary collaboration and encourage escalation.
    - Organizational wide Infection Control (IC) Model with designated IC clinical resource to ensure full compliance with all CDC and CMS Conditions of Participation.
    - Implementation of newly approved medical staff bylaws, medical staff rules and regulations, a new process for ongoing provider practice evaluation (OPPE), peer review process, and medical executive oversight of the providers.
- Treatment Planning
    - Prioritized and developed a dedicated steering committee to reinvigorate MSH treatment planning with an intra disciplinary approach, inclusive of SMART goals that are individualized for each patient to support ongoing therapeutic interventions with proactive focus on patient recovery and safe discharge.
- Workforce Development
    - Implementation of competency-based job descriptions so that staff are evaluated as safe prior to being placed in patient care areas.
    - Right-sizing staff levels to maintain patient and employee safety.
    - Continuing to support the process of hiring and recruitment efforts to increase the number of state employees versus contract staff to improve quality and reduce costs.
- Physical Plant Improvements

    - $15.9 million was requested through HB5. The hospital building was built in the 1990s. There have been long standing issues with deferred maintenance which has created numerous environmental and Life Safety issues. If not resolved these issues will cause CMS to not recertify the hospital.
    - Projects include: hospital roof replacement, wastewater treatment, restoring the nurse call system, fencing for muster areas for evacuation for fires or disasters, HVAC replacement, medical clinic remediation, repairing sally port doors, replacing smoke and fire doors, addressing ligature risks, automated medication dispensing carts, etc.
- Governance
    - Implementation of a governance structure and governing body to oversee and improve operations.

Exhibit 1: Med Exec Committee Approved Polices & Procedures

1. Consultations and Referrals Policy
2. Orders, Telephone and Verbal Policy
3. Employee Healthcare Services Policy
4. Institutional Review Board Policy
5. Patient Death, Autopsy and Review Policy
6. Fall Risk Assessment, Prevention and Post-Fall Assessment & Care Policy
7. Transfer Agreement Policy
8. Provider Use of Hospital DEA Number Policy
9. Provider Standards of Practice and Supervision Policy
10. Patient Rights and Grievance Procedure
11. Blood Glucose Level Testing Procedure

Exhibit 2: Revised MSH Committee Schedule & Reporting Structure



Attachment B (David Culberson)

Exhibit 3: Pending Capital Improvements

Project	Total Cost
MSH Compliance Upgrades for Recertification and Deferred Maintenance	**$ 15,903,000**
Restore Nurse Call System to Fully Operational Status	$ 800,000
Provide Fencing around Facilities out to Muster Points	$ 180,000
Baseline Statement of Conditions (SOC) by Healthcare A/E	$ 75,000
HVAC Repair/Replacement	$ 1,560,000
Med Clinic Upgrade	$ 250,000
Various Demolition	$ 200,000
Loading Dock Replacement	$ 150,000
Kitchen Upgrade	$ 150,000
Fix Sally Port Relays to Make Operable	$ 3,000
Replace Sliding Sally Port Doors	$ 35,000
Standardize Restraint Bed Type	$ 60,000
Address Ligature Risks and Replace Bumper Guards	$ 1,500,000
Replacement of Fire Doors	$ 120,000
Replacement of Spraying Faucets	$ 10,000
Automated Medication Dispensing Carts (e.g., Pyxis Machines)	$ 372,000
Regular Air Quality/Industrial Hygiene Air Sampling Support	$ 84,000
Replacement of Metal Detectors	$ 10,000
Redundant System for Emergency Supply Water Treatment Backup	$ 200,000
Mobile Water Tank for Fire Protection Back-Up	$ 144,000
Contingency for Unanticipated Repair Projects Impacting Recertification	$ 10,000,000

Attachment C (Jocelyn Peterson, RN)
Director of Nursing Report

Staffing Levels and Traveler Usage

- **CNAs**
  - Total: 128
  - Incoming: 22(July); 5(Aug)
  - Loss: 22 total (July & Aug)
- **MSH Psych Techs**
  - Total: 100
  - Incoming: 8 (Next Orientation)
- **Contract Nurses (RNs & LPNs)**
  - Total: 79(Included covering managers)
  - Exiting: 9 in July & 10 in August
  - Incoming: 12 by 8/8
- **MSH Nurses (RNs & LPNs)**
  - Total: 11(1 pending LPN): 1 new RN Hire; 2 transfers to APRN; 1 LPN Retired; 2 RN moved
- **MSH Nurse Managers**
  - Total: 5; 1 resigned
  - Infection Control Manager (Transfer from Spratt to IP)

Nursing Department

- Implementation of the Interdisciplinary Team Committee:
  - Team Building/Approach
  - Development of a new Treatment Plan Process
  - More to Follow
- Implementation of two new policies:
  - Suicide Precautions-Columbia Suicide Screening
  - Fall Policy-John Hopkins Fall Assessment
- Organizing and Standardizing Medication Rooms
- Continued Organizing Med Clinic Storage Room/Structure
  - Policy Change on Referrals/Consultations
    - Tracking of Referrals & Consultations
  - Supply Carts on Order
    - Wound Cart
    - Oxygen Cart
    - Catheter Cart
    - Phlebotomy Cart
- Medical Supplies:
  - Received Vital Sign Machines for all Units
  - Orders Placed for AEDs to each Unit/Group Homes
- Two Nurse Trainer Positions Posted
  - Development of changes in Orientation, Annual, and Continued Education Training
  - Increase Travel Contract lengths to allow for increased training needs.

- Development of Spratt Team Committee

Clinical Services

- **Staffing**
    - Admission/ Treatment Manager position for FMHF finalized and vacancy filled
    - 2 Peer Support vacancies filled
    - Chaplain resigned suddenly for personal reasons- active recruitment efforts being made
    - Cosmetologist resigned- we are currently unable to provide that service- active efforts being made to explore options to provide this service to MSH patients
- **Programming**
    - Recovery Center – Status: The Recovery Center is active with groups taking place Mon-Fri. This is in addition to groups on the unit.

    - Schedule: At the Recovery Center, groups are scheduled hourly Mon-Fri from 1-4pm. A morning group 'How your Medication Works' hosted by pharmacy staff was added once weekly. Groups are facilitated by Psychologists, Clinical Therapists, LACs, and Peer Support. The Rec Room is scheduled weekly and available for all hospital units. – Groups offered: AA, CBT, Social Skills, Mental Health Skills Group, Mindfulness/Meditation, Anger & Conflict Resolution, Values & Responsibilities, ACT Group, Boundaries, Relapse Prevention, WRAP –

    - Recovery Center Programming Changes: Morning group 'How Your Medication Works' hosted by pharmacy was added once weekly in the morning. Intro to CFT (compassion focused therapy) added to schedule.

    - Therapeutic Learning Center – Status: TLC is active with groups and activity as covid status allows. Schedule: Canteen was reopened consistently in early February 2023 and is available for staff and patients. Gym is open and scheduled for each hospital unit. Library is offering open hours. computer classroom is available and hosting groups and adult education. Boutique is also open and consistently available for patients.

    - Programming updates – Programming delivered by Therapy Team has been evaluated and updated to all evidence-based material. New groups on the units include DBT (dialectical behavior therapy) Skills, ACT (acceptance and commitment therapy) for recovery, and IMR (illness management and recovery).

Attachment D (Troy Dawes)
Quality Improvement Committee – (April – May)

- **Falls**
  - Definition of what is defined as a fall for data collection purposes was reviewed and approved by the Medical Executive Committee. This review was completed for the purpose of accurately recording and reporting.
  - The evidence-based fall tool from Johns Hopkins was implemented in June. The initial pilot has gone well as it appropriately stratifies fall risk with patients, enabling staff to implement necessary interventions to reduce falls. Additionally, monitoring efforts are being developed to assess the effectiveness of the new tool and process.
  - **Main Hospital: Fall Rate** continues to be higher than target rate each month. This is attributable to increased effort to track and report falls with greater accuracy. This is expected to be reduced as falls are more closely tracked and industry standard safety measures are implemented to reduce falls such as the Johns Hopkins Fall Risk Assessment Tool (JHFRAT).
    Spratt: Fall rate continues to be under or near monthly goal by volume. Year to date falls are down on compared to last year by approximately 25%. This is expected to continue to trend downwards as falls are defined and new tool implemented.
  - **Galen:** Falls continue to be low, averaging only 1 per month in 2023.
- **Medication Errors – April & May**
  - Medication errors by volume continue to rise. This is attributed to promotion of reporting and culture of safety to recognize issue areas that can be addressed with training. Errors are most often discovered by the newly implemented daily chart check process. There have been no instances of adverse events associated with medication errors.
  - Electronic Medication Cabinets are expected to reduce the amount of medication errors.
  - Electronic Medication Cabinets were requested as part of the Capitol Improvement Budget that was approved last session.
- **Patient Safety Events – April & May**
  - Top 3 Event types are Violence, Falls, & Hospital Property being damaged.
  - Review of data collection and reporting process will be finalized in QTR 3 of 2023.
- **Restraints & Seclusion – April & May**
  - **Main Hospital:** Most units have been down trending across all utilizations since March. Bravo had an uptick in April in Seclusion utilization but has been reducing its numbers ever since.
  - **Spratt:** Spratt continues to be one of the lowest utilization units for restraint and seclusions at Montana State Hospital.
  - **Galen:** Galen typically maintains low volume of all types. However, there are intermittent spikes in use of Locked seclusion. This is generally the most used of the restraint types for the facility. Mechanical restraints utilization is almost non-existent for 2023.
- **Abuse & Neglect and Patient Grievances - April & May**
  - New CMS Compliance Specialist (Patient Advocate) started on 7/15/23
  - Abuse & Neglect & Patient Grievances

- Working collaboratively with BOV on process of grievances, data collection and reporting to better allocate resources across resolutions and corrective actions. This will assist the Quality Improvement Committee to identify ways to proactively address grievances.
- Current data shows that most grievances come from a small number of patients. Currently RN managers are working to address concerns/complaints at the unit level
- Adopting CMS terminology of “Substantiated” in the findings and data
- A&N allegation investigations are down 38% YOY from 2022 through May 2023. Trending down both for substantiated and unsubstantiated

Exhibit 4: Quality Improvement Dashboard

Montana State Hospital CY 2023	Quality Indicators							
	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	YTD 2023	2023 Monthly Goal	Prior Year
MAIN HOSPITAL (Alpha, Bravo, Delta, & Echo)								
Licensed Beds	114	114	114	114	114	114		114
Average Daily Census	102	102	96	101	109	102		94
Falls	21	7	11	18	22	79	< 13	150
Monthly Fall Rate per 1,000 Patient Days	6.6	2.5	3.7	6.0	6.5	5.1	< 3	4.4
Medication Errors	8	9	4	12	16	49	< 3	27
Patient Safety Events Resulting in Serious Injury Needing Immediate Medical Attention	1	0	2	1	2	6	0	7
Chemical Restraint Occurrence Rate per 1,000 Patient Days	8.54	3.51	11.13	13.59	10.05	8.85	0.00	12.56
Hours Spent in Physical Restraints per 1000 Patient Hours	0.36	0.15	0.46	0.43	0.12	0.26	< 0.39	
Hours Spent in Seclusion per 1000 Patient Hours	16.68	2.41	4.59	11.74	1.81	6.50	< 0.36	
Substantiated Abuse and Neglect Allegations	0	0	1	1	0	2	0	3
Unsubstantiated Abuse and Neglect Allegations	3	1	0	2	2	8	0	20
GERIATRIC-PSYCHIATRY UNIT (Spratt)								
Licensed Beds	60	60	60	60	60	60		60
Average Daily Census	44	43	46	42	40	43		36
Falls	12	16	23	11	16	78	< 18	226
Monthly Fall Rate per 1,000 Patient Days	8.9	13.2	16.2	8.8	13.0	12.1	< 7.6	17.3
Medication Errors	6	3	4	3	7	23	< 2	15
Patient Safety Events Resulting in Serious Injury Needing Immediate Medical Attention	1	0	1	2	0	4	0	7
Chemical Restraint Occurrence Rate per 1,000 Patient Days	2.97	2.48	6.33	0.00	4.05	2.75	0.00	3.37
Hours Spent in Physical Restraints per 1000 Patient Hours	0.04	0.01	0.01	0.01	0.01	0.01	< 0.39	
Hours Spent in Seclusion per 1000 Patient Hours	0.10	0.01	0.05	0.00	0.05	0.05	< 0.36	
Substantiated Abuse and Neglect Allegations	0	0	0	0	0	0	0	6
Unsubstantiated Abuse and Neglect Allegations	2	1	0	2	1	6	0	13
FORENSIC MENTAL HEALTH CENTER (Galen)								
Licensed Beds	54	54	54	54	54	54		54
Average Daily Census	45	45	45	48	46	46		45
Falls	1	0	1	0	0	2	< 2	15
Monthly Fall Rate per 1,000 Patient Days	0.7	0.0	0.7	0.0	0.0	0.3	< 2.9	0.9
Medication Errors	1	0	1	2	0	4	0	4
Patient Safety Events Resulting in Serious Injury Needing Immediate Medical Attention	0	0	0	0	0	0	0	4
Chemical Restraint Occurrence Rate per 1,000 Patient Days	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.45
Hours Spent in Physical Restraints per 1000 Patient Hours	0.0	0.2	0.0	0.0	0.0	0.03	< 0.39	
Hours Spent in Seclusion per 1000 Patient Hours	6.77	4.47	0.05	14.09	24.73	8.51	< 0.36	
Substantiated Abuse and Neglect Allegations	0	0	0	0	0	0	0	0
Unsubstantiated Abuse and Neglect Allegations	0	0	1	0	0	1	0	2
ADDITIONAL METRICS FOR ALL UNITS								
Percent of Patients evaluated for Medicaid eligibility upon admission	100%	100%	100%	100%	96%	99%	95%	
Patient attendance is 100% for group therapy sessions offered	74%	72%	72%	71%	66%	71%	75%	
Completion of Community Reentry form within 10 days of admission	33%	61%	60%	49%	72%	55%	90%	
Percent of the total trainings required by license and job type that are up to date	95%	99%	50%	49%	65%	72%	100%	

MSH Quality Data finalized on the 15th of the following month

Notes:

- Monthly fall rate goals are based literature review for adult and geriatric inpatient psych hospitals. https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000004
- Physical Restraint and Seclusion goals are based on national averages reported by CMS as part of their Inpatient Psychiatric Facility Quality Reporting dataset.
- Training compliance metric methodology was updated for March 2023. Previously, MSH was tracking onboarding training, which includes all required trainings by hospital license type. Now, MSH is tracking annual refresher training, to measure ongoing compliance with required trainings.

Attachment E (John Jenkins Jr., A&M)
Exhibit 5: Finance & HR Report

Performance Indicator	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Goal
Operations Metrics													
Average Daily Census													
Census (Total) - %	74%	73%	74%	84%	84.4%	86.7%	83.3%	82.6%	81.1%	82.2%	84.1%	80.0%	N/A
Census (Total) - Number	200	196	201	227	228	234	225	223	219	222	227	216	N/A
Census (Main Hospital) - Number	120	117	122	146	145	153	149	145	141	141	151	138	N/A
Census (Forensic) - Number	48	46	45	46	49	49	45	45	45	48	46	46	N/A
Census (Group Homes) - Number	32	33	34	35	34	32	31	33	33	33	30	32	N/A
Admissions													
Admissions (Total)	58	50	76	61	75	57	70	57	81	59	66	78	N/A
Admissions (Main Hospital)	51	41	65	53	65	52	61	49	69	49	60	68	N/A
Admissions (Forensic)	7	9	11	8	10	5	9	8	12	10	6	10	N/A
Admissions (Group Homes)	0	0	0	0	0	0	0	0	0	0	0	0	N/A
Discharges													
Discharges (Total)	44	60	50	50	72	66	50	59	74	55	71	87	N/A
Discharges (Main Hospital)	40	49	45	49	66	57	48	51	64	48	63	81	N/A
Discharges (Forensic)	4	10	5	1	5	7	2	4	8	5	6	6	N/A
Discharges (Group Homes)	0	1	0	0	1	2	0	4	2	2	2	0	N/A
Waitlist													
Waitlist for Admission (Total)	44	39	42	42	61	60	61	67	67	67	77	70	**<12**
Waitlist for Admission (Main Hospital)	0	0	0	0	0	0	0	0	0	0	0	0	<1
Waitlist for Admission (Forensic)	44	39	42	42	61	60	61	67	67	67	77	70	<10
Waitlist for Admission (Group Homes)	0	0	0	0	0	0	0	0	0	0	0	0	<1
HR Metrics													
Employee Vacancy Rate	45.0%	45.4%	45.0%	47.1%	45.2%	44.6%	40.9%	40.2%	38.0%	37.0%	38.0%	37.0%	<15%
Employee Turnover Rate	4.1%	2.1%	2.4%	4.4%	1.4%	1.4%	0.6%	1.6%	1.5%	1.5%	3.0%	2.8%	<5.0%
Net Employee Hires	(4)	3	1	2	(1)	5	21	7	11	0	(4)	(5)	>6
Finance Metrics													
Starting Budget - Current SFY	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	$ 48,873,226	N/A
Actuals - Current SFY to Date	$ 1,892,667	$ 9,753,815	$ 17,531,434	$ 25,158,151	$ 30,055,580	$ 34,669,901	$ 44,317,113	$ 49,320,306	$ 57,354,572	$ 58,461,674	$ 64,911,885	$ 75,689,613	N/A
Projected Expenses - Current SFY	N/A	N/A	N/A	N/A	$ 87,172,320	$ 87,434,103	$ 87,434,103	$ 94,284,997	$ 94,886,143	$ 92,681,218	$ 92,606,639	$ 92,671,515	N/A
Variance - Budget to Projected Expenses	N/A	N/A	N/A	N/A	$ (38,299,094)	$ (38,560,877)	$ (38,560,877)	$ (45,411,771)	$ (46,012,917)	$ (43,807,992)	$ (43,733,413)	$ (43,798,289)	>$0
Cost per Bed Day	N/A	N/A	N/A	N/A	$ 1,052	$ 1,004	$ 1,045	$ 1,158	$ 1,187	$ 1,144	$ 1,118	$ 1,175	N/A
Revenue - Current SFY to Date	$ 158,291	$ 349,823	$ 598,321	$ 789,083	$ 999,441	$ 1,526,351	$ 1,729,650	$ 1,886,317	$ 1,948,193	$ 2,078,207	$ 2,034,557	$ 2,208,966	N/A
Traveler Spend	$ 4,286,957	$ 4,609,046	$ 4,352,967	$ 4,408,107	$ 4,759,978	$ 4,795,973	$ 3,968,876	$ 3,321,226	$ 4,126,745	$ 4,124,718	$ 2,849,122	$ 3,898,435	N/A
Monthly Reduction in Traveler Spend	N/A	+8%	-+6%	+1%	+8%	+1%	-17%	-16%	24%	0%	-31%	37%	<-5%

Exhibit 6: Top 10 Positions with Most Vacancies, as of July 11, 2023

Job Title	Total Positions	Vacant Count	Vacancy Rate
Psychiatric Technician	146	77	53%
Registered Nurse 2	46	38	82%
Psychiatric Technician FMHT	48	17	35%
Custodian 1	22	12	54%
Registered Nurse Lead	12	6	50%
Behavioral HC Planner	17	6	36%
Food Preparer 1	15	6	40%
Clinical Therapist 1	6	4	70%
Recreation Therapist 1	6	3	50%
Licensed Practical Nurse 2	7	3	41%

Key Takeaways:

- Average daily census in the Main Hospital is higher compared to last year; census is stable at the forensic mental health center (Galen and Group Homes).
- SFY23 to date actuals increased to $76 million, this is attributable to large number of expenditures being processed against June in anticipation of the fiscal close for SFY23.
- Projected expenses for this fiscal year will exceed the starting budget by approximately $43 million. This is attributable to increased spending on travel nursing staff to cover vacant positions.
- Employee vacancy rate has generally decreased month over month since last year. An emphasis on proactive recruitment has resulted in significant net new hires since the beginning of the calendar. In the past quarter some of the recruiting momentum has dwindled. Hiring and referral incentives will be rolled out soon and will hopefully help to restart recruiting momentum. Additionally, a paid media recruiting campaign is currently being developed to help bolster recruiting efforts.

Attachment F (Kristin Harris)

Infection Prevention Report

- Conducted risk assessments for Main, Spratt and Group Homes. Galen is scheduled for 7/11.
- Created a new IP Plan based on risk assessment findings; plan is in progress at this time pending results from Galen
- Created a new COVID-19 plan based off of the newest guidance from CDC and State
- Selected environmental rounding tools and have scheduled recurring monthly rounds on units with managers; will have PRN rounds as well during outbreaks
- Updated 170 staff on annual IP training with a focus on PPE, disinfecting, precautions (standard and TBP)
- Obtained +150 tuberculosis screening tools and developing a tracking system for maintaining this consistently
- Developed a bi-monthly publication “Bug Bytes”. Have published 2 issues so far
- Developed line listings and unit tracking system
- Met with pharmacy to discuss ABT Stewardship and plan to use McGreers criteria (in progress)
- Developing a better communication method between units, clinic and IP
- Started the OSHA 300 log
- Obtained access to MIDIS and working with Epi team for training
- Reviewing and revising policies (in progress)
- Developing an IC Manual which will be distributed to the units, clinic and admin area
- Developing a plan for respiratory illness in the fall
- Planning vaccine campaigns for influenza and COVID-19
- Planning to develop patient education programs regarding Infection Control
- Moving PPE supplies to IP office to maintain PAR levels and easier access for staff to obtain when management is not here, with a sign out system

Attachment G (Troy Dawes and Tim Bollig)
Safety Committee Report

- Communications Issues
    - Two-Way Radio system upgrade was approved after multiple technology options and vendors were vetted by MSH staff and DPHHS IT department. Currently in the contracting and procurement process.
    - Fax Issues – Faxcomm issues were brought to DPHHS IT on 4/27. No further advancement with implementation efforts has been made/addressed.
- Currently Working on Life Safety/Disaster Preparedness Policy & procedure and related documents
    - Completed Hazard Vulnerability Assessment based off information available for the last 2 years.
    - 13 Hazards were identified will be addressed in the Life Safety/Disaster Preparedness Document. The Kaiser Permanente Hazard Vulnerability Analysis (HVA) tool was used to quantify hazards & emergencies for Montana State Hospital. Those Hazards are:
        - Inclement Weather
        - Pandemic
        - IT System Outage
        - Extreme Temperatures
        - Sewage Failure
        - HVAC Failure
        - Patient Elopement
        - Internal Flood
        - External Fire (Wildfire)
        - Supply Chain Shortage
        - Planned Power Outage
        - Air Quality Issue
        - Drought
    - Document will include components related to:
        - Emergency Evacuation
        - Mutual Aide Agreements
        - Disaster Response/Emergency Preparedness
        - Disaster Drills
    - Fire drills resumed in May of 2023 for Montana State Hospital campus and are up to date with ongoing education. Resolutions for issues are addressed on a case-by-case basis as issues arise or are discovered.
        - Compliance rates are now calculated, and quarterly findings will be available in the future.
        - Currently trying to get contractor (Johnson Controls) out to facilitate memory issues with fire panel in main hospital – Any suggestions or support on this from the governing board?
    - Failure Mode Effects Analysis is scheduled for 7/13/2023.
        - The analysis is a review of a high-risk process/procedure.
        - The process/procedure that will be reviewed is patient visitation.
    - Pro Active Risk Assessment – Is an environmental risk assessment focused on patient safety with an emphasis on ligature risks and their mitigation. On track to be completed Mid-August.
        - Items identified prior to document completion include:
            - Handrails on units are not anti-ligature and are part of capital improvements.
- Survey Readiness – Day One Checklist
    - MSH staff that was working on aggregating the “Day One Checklist” document binders is no longer with MSH and progress on project cannot be located.
    - Open QI analyst positions once filled to assist in getting back on track.
    - New process will utilize SharePoint for security of the documents in one centralized place.
- Recent Root Cause Analysis (RCA) completed.

    - Identified area where policy/procedure was absent, specifically as it relates to vendors or contractors and safe practices while providing service at Montana State Hospital.
- Elopements
    - 3 Patient elopements have occurred in 3 months.
        - 2 were due to doors that are in need of repair and lack of redundant safeguards such as fencing.
            - Fencing of Inpatient unit egress areas is a capital improvement line item.
        - 1 was due to keys not being secured properly by floor staff.
- Quality Reporting Metrics Developed and will be reported out at future Governing Board meetings as well as Hospital level meetings. Safety Committee and Quality Improvement Council.
    - Metrics of safe vendor/contractor practices while on inpatient units.
    - Safety & Security metrics
        - Related to elopements risk.
        - - Emergency communications (Code colors) – Key Knowledge – CMS badge/identification requirements – safe use of established entry points
- Current Reports
    - (De-escalation)
        - Mandt Training upon Hire Year to Date – 100% and has been maintaining that metric in 2023.
        - Mandt Training ongoing compliance Direct care staff (received annual training) – 73% Through June 2023. Training and development has been up trending on this metric steadily since 2022. Training cadence has recently transitioned from bi-weekly trainings to daily trainings to expedite compliance.

Attachment H (Nicole Klein)
Legal Report

- On Forensic side, we are at a bit of a critical inflection point with our waitlist. Currently there are more people on the waitlist than our historical average. There are potentially not enough beds for female forensic patients.
    - We need to find more beds for them (females), and I'm not sure if that should take the form of a pod swap, or if we could start admitting some to a wing or two here at the Main hospital.
- Civil side, recently started using more tools, namely Teams, regarding prospective admissions, which I believe has been helpful.
        i. Essentially, once Lindsey knows someone is headed our way, she posts the medical records she has in a Team chat that consists of Providers, legal, Admissions and Clinical staff to solicit opinions as to which Unit this person should be admitted. This has seemingly worked pretty well, as it seems that someone (typically a Provider) promptly responds with their opinion regarding placement.