MT DPHHS Healthcare Facilities Assessment

December 12, 2022

ALVAREZ & MARSAL
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DRAFT REPORT

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

A&M

Contents

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Executive Summary

Executive Summary | A&M Engagement

DPHHS engaged Alvarez & Marsal to conduct a comprehensive assessment and establish long-term sustainable operation plans for Montana's seven state-run health care facilities.

Assessment

Key Activities

- Assess compliance with regulations, quality standards, workers comp, and patient incidents
- Evaluate climate and culture
- Assess staffing structure, ratios, job descriptions, and scheduling
- Review organizational structure and back-office support functions
- Review key patient data, outcomes, and information on admissions and discharges
- Assess facility finances and rate structure
- Benchmark performance to peers

Strategic Plans for Improvement

- Update facility missions and visions
- Develop strategic plans to optimize utility of facilities and outcomes for patient populations
- Improve quality measures for safe delivery of care

Operational Support

- Report financial status, condition, and operation of facilities
- Support oversight of day-to-day operations
- Support communications and change management
- Support quality initiatives

Executive Summary | Recommendations (1 of 3)

	ID	OBSERVATIONS	RECOMMENDATIONS
Healthcare Facilities Division	1.1	*Significant changes are needed to implement recommendations.*	Stand up Transformation Management Office.
	1.2	*There is a lack of accountability and clinical oversight at the facilities.*	Hire clinical and operational leadership to improve safety and quality, to include: Deputy Chief Healthcare Officer, Chief Medical Officer, Chief Nursing Officer, Chief Clinical Officer, and Quality Managers.
	1.3	*There is an overreliance on certain treatment modalities.*	Implement Medical Staff function for ongoing and focused professional practice evaluation, peer review, credentialing, and privileging.
	1.4	*Paper charting makes data collection difficult and creates patient safety risks.*	Implement a modern electronic health records system to improve patient outcomes and data sharing with providers.
	1.5	*Competency at performing job duties is not evaluated before placing new staff in patient care areas.*	Develop competency-based job descriptions and review processes for direct care staff.
	1.6	*Staff are not receiving adequate professional development opportunities and facilities are not meeting mandatory training requirements.*	Establish a governance system to oversee training programs and implement a learning management system to improve training compliance, career tracking, and professional development.
	1.7	*There are significant vacancies for direct patient care positions, and the applicant pool is further limited due to the geographic location of the facilities.*	Update recruitment strategies and conduct a hiring blitz for nursing and direct service professional positions. Assess the feasibility of staff recruitment and retention strategies, including: hiring, retention, and referral bonuses; apprenticeship programs; high school / college student career pipelines; and academic hospital designations.
	1.8	*Per diem rates and spend on travel nursing has significantly increased.*	Consolidate temporary contracted services spend and recompete staffing contracts to reduce costs and complexity of administration.
	1.9	*Facilities are not actively managing expenses, and the division was overall significantly over budget in FY22.*	Implement active budget, contract, and revenue management processes to control costs.
	1.10	*Facilities are not staffed to benchmark.*	Update staffing plans so that facilities are staffed to acuity and need, as appropriate.
	1.11	*Facilities "feel" institutional and are not home-like.*	Purchase furnishings and other physical assets to improve therapeutic environment.
	1.12	*Recent wage increases are not competitive enough to attract new employees.*	Increase wages to market rates to help recruit and retain employees.

Executive Summary | Recommendations (2 of 3)

	ID	OBSERVATIONS	RECOMMENDATIONS
Montana State Hospital	2.1	*Patients in the Spratt unit are not being prepared for discharge and there are opportunities to improve delivery of care.*	Close Spratt (geriatric psychiatric unit) and transfer patients to Montana Mental Health Nursing Care Center and community providers. Repurpose these beds for hospital use.
	2.2	*Average lengths of stay in units E and Spratt are too long and there is limited active planning for discharge.*	Implement case management model to prepare patients for discharge on admission and based on their projected length of stay and acuity.
	2.3	*High acuity patients are intermixed with lower acuity patients.*	Restructure patient placement by acuity and their individual needs so that highest levels of care are provided in A and Galen, with step down units through B, D, E, Spratt, and group homes to improve care delivery.
	2.4	*There is limited active treatment and treatment areas, gym, etc. are not fully operational.*	Develop appropriate policy for delivery of active treatment. Restart therapeutic programming impacted by the pandemic.
	2.5	*MSH cannot refuse inappropriate forensic admissions due to statutory criteria.*	Change forensic statutory criteria for admission and discharge to mirror civil statutory criteria so that MSH is not required to accept patients that do not meet admission criteria.
	2.6	*MSH has lost revenue with CMS de-certification.*	Seek CMS re-certification and then CARF or Joint Commission accreditation to improve quality oversight.
	2.7	*MSH is a safety net for gaps in the behavioral health continuum of care and there is a significant wait for admission within the jail system.*	Improve Montana's long-term delivery of care by building two new, regional, private behavioral healthcare settings that complement and support MSH and the other state-run facilities in large population areas.
Montana Mental Health Nursing Care Center	3.1	*MMHNCC has licensed beds that cannot be filled because they were repurposed during COVID.*	Build out infirmary as secured memory unit to place patients from Spratt.
	3.2	*There is an overreliance on certain treatment modalities and out-of-date practice guidelines (e.g., psychotropics).*	Update standards of practice and ordering protocols to meet each patient's needs.
	3.3	*Patients were observed without appropriate end-of-life care.*	Contract with licensed hospice organization and develop end-of-life care policies aligned to modern practices.
	3.4	*Facility administrator has 13 direct reports.*	Restructure operations to improve communications and patient outcomes.
	3.5	*There are not clear policies & procedures surrounding admissions and discharges at MMHNCC.*	Develop person-centered admissions and discharge policies based on acuity and need.

Executive Summary | Recommendations (3 of 3)

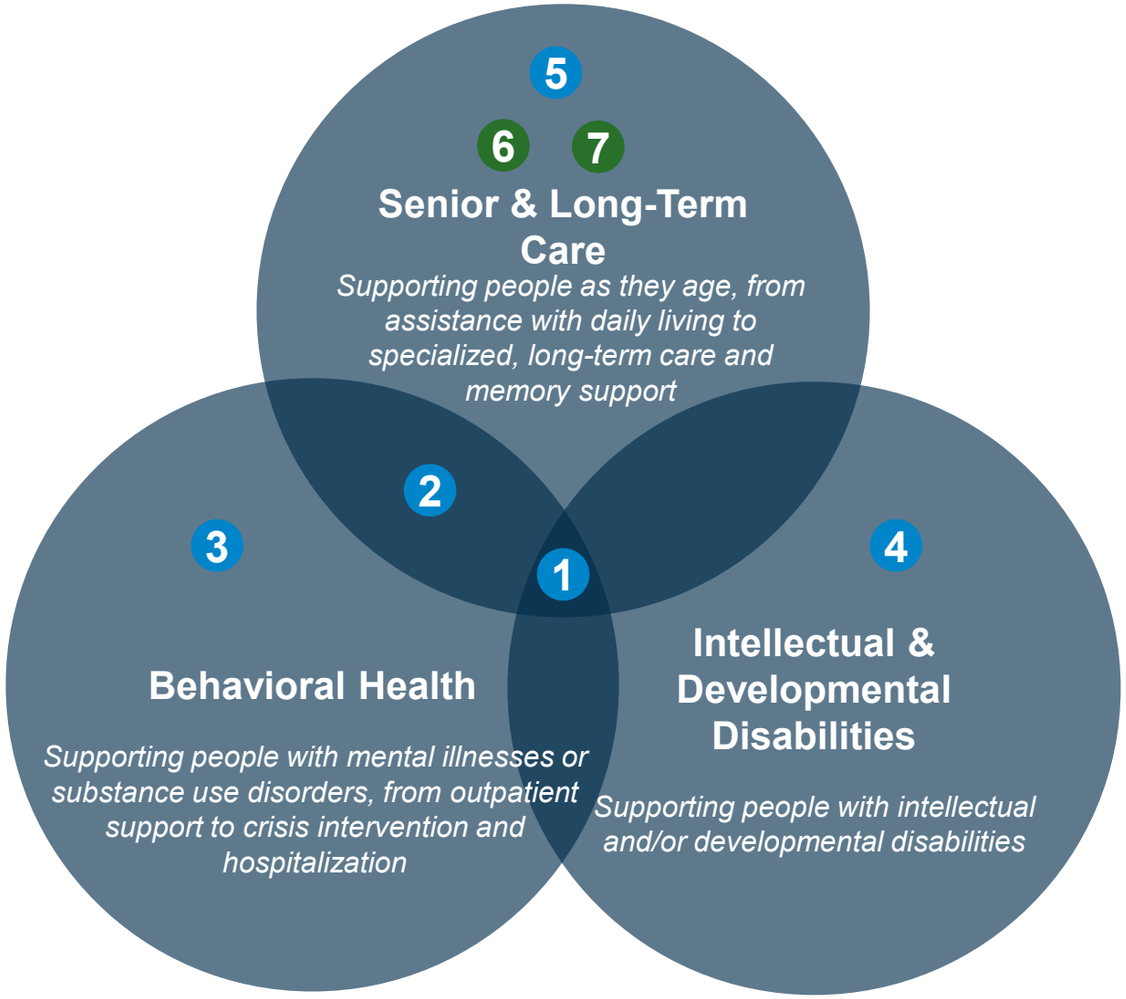
	ID	OBSERVATIONS	RECOMMENDATIONS
Intensive Behavior Center	4.1	*There is limited active treatment and community readiness. The state lacks the ability to implement and manage a short-term intensive treatment facility, licensed as an ICF/IID.*	Take immediate action to improve quality of care and align practices with federal ICF regulations, which may include having a private vendor run the facility. Additional actions to improve quality of care include more active treatment, modernized treatment plans, enhanced treatment areas, and improve integration within the local community. Update policies and procedures based on National Association for the Dually Diagnosed standards.
	4.2	*Individuals are not transitioning back into the community.*	Update the discharge planning process to include person-centered practices (e.g., Charting the LifeCourse) and active transition planning with the provider community.
	4.3	*IBC is not fulfilling intended purpose in continuum of care. The state lacks the infrastructure to provide intensive treatment services to people with intellectual and developmental disabilities at IBC. The existing facility also prevents the state from obtaining certification as an ICF/IID which would allow it to bring in a federal match for services.*	Implement a true short-term, intensive, private treatment facility certified as an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/IID) as an alternative to IBC, to ensure enhanced quality of service and oversight and secure a federal match to operate the new program. This new program would replace the need for the current services provided at IBC, allowing for closure of the facility over the next 2-3 years.
Montana Chemical Dependency Center	5.1	*There is not enough demand based on prior years census. Occupancy rate is below 50% and there is no waiting list.*	Re-evaluate need for state-run acute care substance use disorder (SUD) beds given the broader SUD network capacity and demand trends. Engage with provider and community partners to increase referrals, improve census, and increase revenue.
	5.2	*Barriers to admission deter some patients from seeking treatment.*	Receive patients in facility double rooms and update criteria for admission and discharge to allow for comorbidities and admissions within 48 hours.

[1] Because our observations and ultimate recommendations regarding the three Montana Veterans Homes are covered in the recommendations for the overall Healthcare Facilities Division, we have not included separate recommendations for CFMVH, SWMVH, or EMVH.

Overview of State-Run Health Care Facilities

Overview | Montana's State-run Healthcare Facilities & Continuum of Care

A&M reviewed Montana's behavioral health, aging, and intellectual and developmental disabilities systems to understand the role that the State's facilities play in the broader continuum of care.



STATE-RUN HEALTHCARE FACILITIES

1. Montana State Hospital
2. Montana Mental Health Nursing Care Center
3. Montana Chemical Dependency Center
4. Intensive Behavior Center
5. Montana Veterans Homes – Columbia Falls

CONTRACTOR-RUN HEALTHCARE FACILITIES

6. Eastern Montana Veterans Home
7. Southwestern Montana Veterans Home

Overview | State-run Healthcare Facilities Today

There are seven state-run health care facilities across the behavioral health continuum in Montana. Five are directly run by the state, while two of the veterans' homes (Eastern Montana Veterans Home and Southwestern Montana Veterans Home) are contracted out to state partners.

Facility	Location	License Type	Licensed Beds	Average Daily Census (FY22)	Occupancy Rate	State Operated	Contractor Operated
Montana State Hospital	Warm Springs	Hospital & Mental Health Center	270	206	76%	X	
Montana Mental Health Nursing Care Center	Lewistown	Long Term Care	117	73	62%	X	
Intensive Behavior Center	Boulder	Intermediate Care Facility for the Developmentally Disabled	12	10	82%	X	
Montana Chemical Dependency Center	Butte	Inpatient Chemical Dependency Treatment	48	21	43%	X	
Montana Veterans Home – Columbia Falls	Columbia Falls	Long Term Care	117	72	62%	X	
Eastern Montana Veterans Home	Glendive	Long Term Care	80	53	66%		X
Southwestern Montana Veterans Home	Butte	Long Term Care	36	28	79%		X
		Total	**680**	**463**	**68%**		

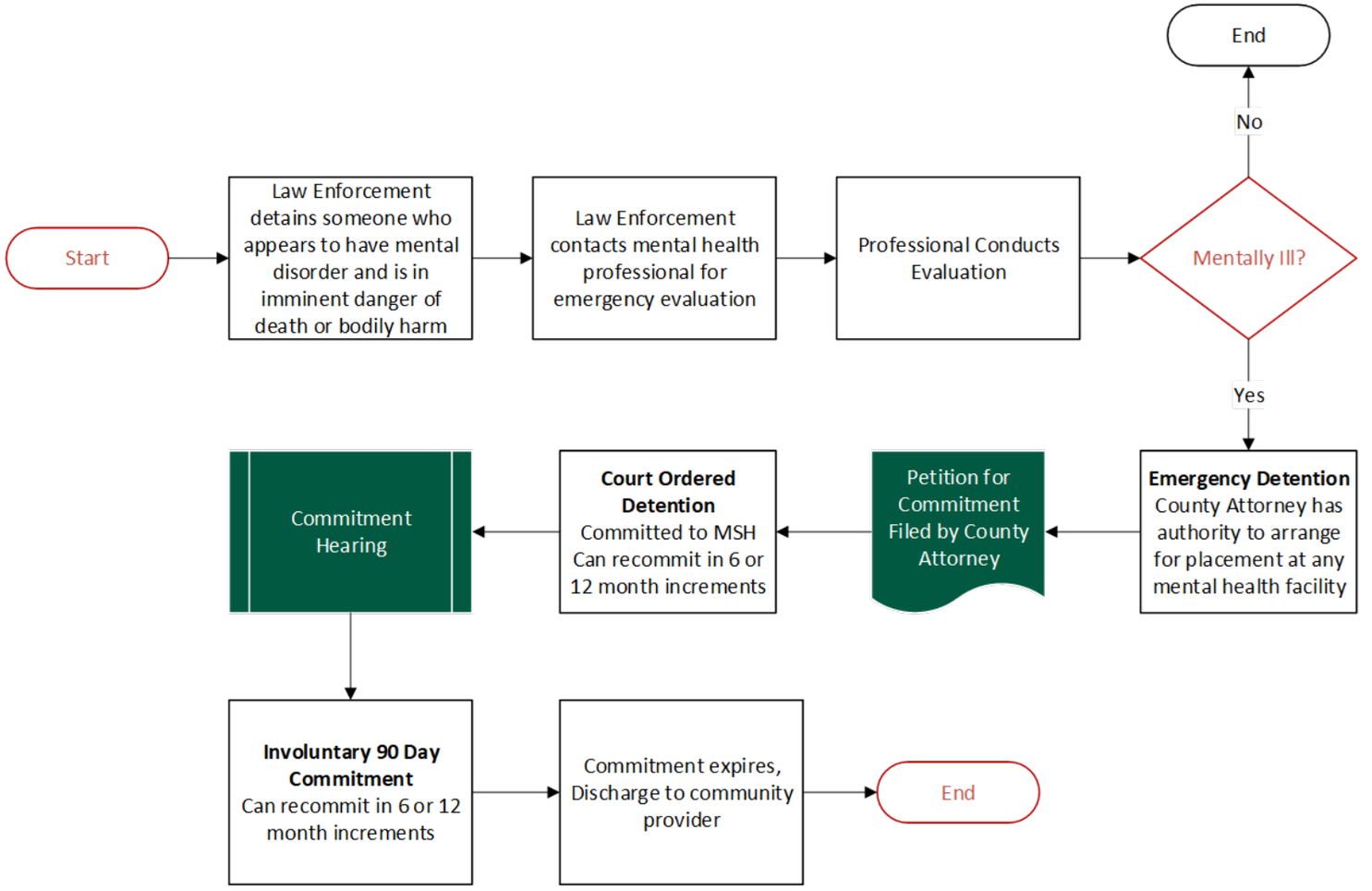
Overview | Montana State Hospital

Montana State Hospital (MSH) provides inpatient psychiatric treatment for adults with serious mental illness on civil or forensic commitment. MSH is codified in MCA 53-21-601.

Unit	Purpose	License Type	Lic. Beds	Avg Census (August 2022)	Setting Description	Patient Population	Length of Stay (Years)	Avg Patient Age
A	Admissions – for stabilization and co-occurring disorders	Hospital	31	13	Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms	Civil commitment	Average: 0.2 Longest: 1.8	45
B	Admissions – for stabilization and co-occurring disorders	Hospital	26	12	Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms	Civil commitment	Average: 0.2 Longest: 1.1	43
D	Management of Legal Issues	Hospital	32	32	Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms	Forensic commitment	Average: 2.6 Longest: 14.5	43
E	Social and Independent Living Skills	Hospital	25	19	Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms	Civil commitment	Average: 2.1 Longest: 11.5	48
Spratt	Adaptive Living for Elderly	Hospital	60	38	Secured, mixed gender, 2 beds per room, with television area and enrichment room	Civil commitment	Average: 1.2 Longest: 6.3	67
Galen – Pod A	Forensic Men's	Mental Health Center	24	20	Jail-like facility, 1 bed per room	Forensic commitment	Average: 0.3 Longest: 1.4	46
Galen – Pod B	Forensic Men's	Mental Health Center	24	21	Jail-like facility, 1 bed per room	Forensic commitment	Average: 1.0 Longest: 18.4	43
Galen – Pod C	Forensic Women's	Mental Health Center	6	4	Jail-like facility, 1 bed per room	Forensic commitment	Average: 0.5 Longest: 1.2	27
Group Homes	Transitional Living	Mental Health Center	42	32	Group home-like setting	Forensic commitment	Average: 5.2 Longest: 24.4	41

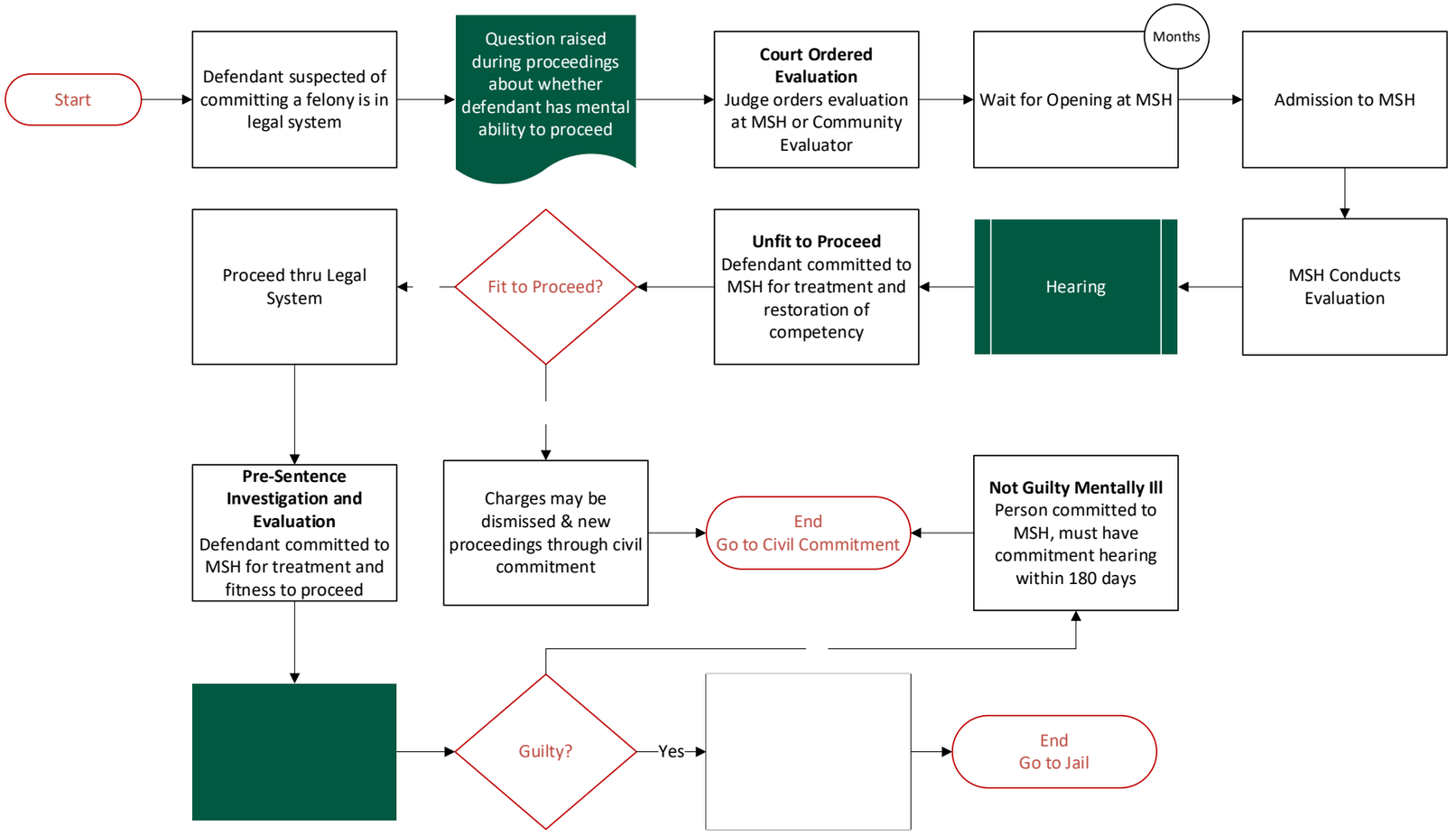
Overview | Montana State Hospital Civil Commitment Process

There are two primary commitment types to MSH: Civil and Forensic. The flow chart below outlines a high-level process for civil commitments, per MCA 53-21, which accounted for 75% of admissions in SFY22 to MSH.



Overview | Montana State Hospital Forensic Commitment Process

There are two primary commitment types to MSH: Civil and Forensic. The flow chart below outlines a high-level process for forensic commitments, per MCA 46-14, which accounted for 14% of admissions in SFY22 to MSH.

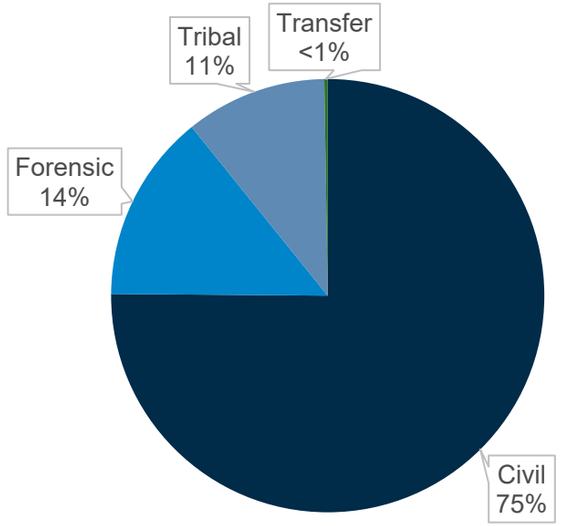


Overview | Montana State Hospital Admissions by Commitment Type, July 2021 to June 2022

Civil commitments made up the vast majority of admissions at MSH from July 2021 to June 2022 (75 percent). The average length of stay across all MSH admissions was 55 days. Forensic commitments, while accounting for only 14 percent of total admissions, had an average stay of 168 days at the facility. Tribal commitments are civil comments that come from tribal lands in the state. For more detailed data, see Appendix A.

Commitment	Commit Type	Admissions	Average Length of Stay (Days)
Court Ordered Detention	Civil	408	33
Involuntary 90 Day	Civil	179	53
Tribal	Tribal	84	21
Unfit to Proceed	Forensic	57	153
Court Ordered Evaluation	Forensic	36	152
Guilty But Mentally Ill	Forensic	12	190
Emergency Detention	Civil	11	31
Pre-Sentence Evaluation	Forensic	6	268
Institutional Transfer	Transfer	1	154
10 Day Inter-Institutional Transfer	Transfer	1	9
Not Guilty Mentally Ill	Forensic	1	289
Subtotals	**Civil**	**598**	**40**
	Forensic	**112**	**168**
	Tribal	**84**	**21**
	Transfer	**2**	**85**
Total	**All**	**796**	**55**[1]

Breakdown of Commitment Types at MSH July 2021 to June 2022



[1] The average length of stay total was calculated as a weighted average based on the proportion of admissions of that commitment type to the total number of admissions at MSH

Overview | Montana Mental Health Nursing Care Center

Montana Mental Health Nursing Care Center (MMHNCC) provides long term care and treatment of persons who have mental disorders and who require a level of care not available in the community, but who cannot benefit from the intensive psychiatric treatment available at Montana State Hospital. MMHNCC is codified in MCA 53-21-401.

Unit	Purpose	License Type	Lic. Beds	Avg Census (August 2022)	Setting Description	Patient Population	Length of Stay (Years)	Avg. Patient Age
A Wing	Independent – Activities of Daily Living	Long Term Care	25	18	Nursing facility with 2 beds per room and with common areas and outdoor yard	Older Adults, behavioral health needs, rejected from other placements, forensic commitments	Average: 3.8 Longest: 10.5	65
D Wing	Infirmary	Not Licensed	0	0	Used to be licensed by Dept of Corrections as Infirmary; secured unit could hold 25 beds.	N/A	N/A	N/A
E Wing	Secured	Long Term Care	34	18	Nursing facility with 2 beds per room and with common areas and outdoor yard	Older Adults, behavioral health needs, rejected from other placements	Average: 1.4 Longest: 5.2	67
F Wing	Memory Care	Long Term Care	28	12	Nursing facility with 2 beds per room and with common areas and outdoor yard	Older Adults, behavioral health needs, rejected from other placements	Average: 2.9 Longest: 17.8	73
G Wing	Heavy Care (Temporary)	Long Term Care	30	21	Nursing facility with 2 beds per room and with common areas and outdoor yard	Older Adults, behavioral health needs, rejected from other placements	Average: 2.1 Longest: 7.7	72

MMHNCC patients are admitted as either **civil or forensic commitments**, and have been denied admissions at least **three times** by other nursing care facilities. As a result, MMHNCC serves a unique, distinct population whose needs differ from other state facilities or privately operated nursing facilities in Montana.

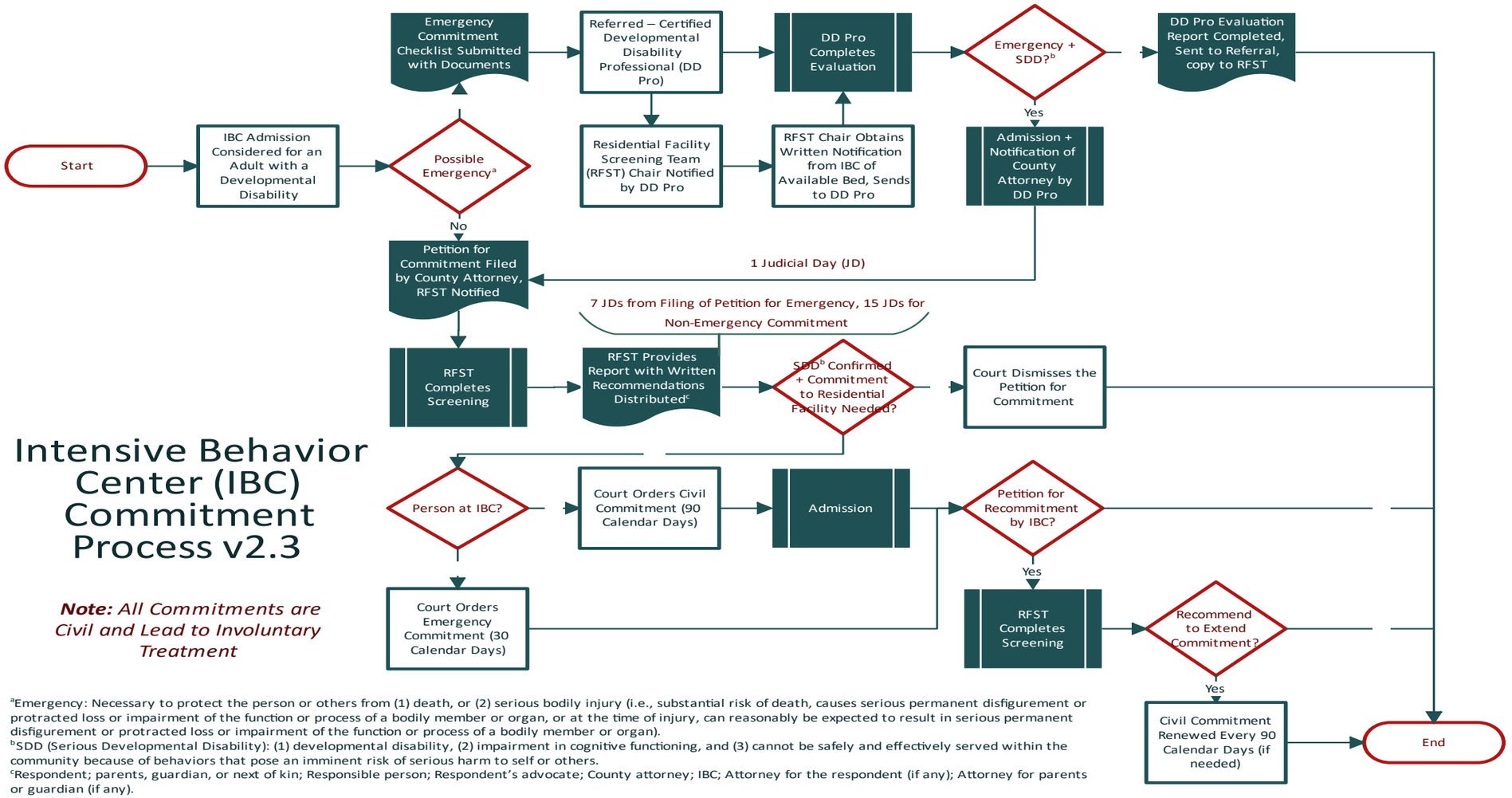
Overview | Intensive Behavior Center

The Intensive Behavior Center (IBC) treats patients with intellectual and developmental disabilities (I/DD) who need intensive treatment due to continuous or repeated behaviors that pose an imminent risk of serious harm to themselves or others. IBC is codified in MCA 53-20-602. Currently, IBC is licensed as an Intermediate Care Facility/Developmentally Disabled (ICF/DD) under ARM 37.106.6, with no federal match for funds.

Cottage	Purpose	License Type	Lic. Beds	Avg Census (August 2022)	Setting Description	Patient Population	Length of Stay (Years)	Avg Patient Age
A, B, and C	Residential	Intermediate Care Facility for the Developmentally Disabled	12	9	Secured, each secure cottage has 4 beds in single rooms, with common area and secure outdoor yard. Kitchens and laundry available in each cottage through locked access.	Civil commitment	Average: 9.0 Longest: 22.8	34

Overview | Intensive Behavior Center Commitment Process

There are two primary commitment types to IBC: Civil and emergency. The flow chart below outlines a high-level process for these two types of commitments to IBC, codified in MCA 53-20-602.



[a]Emergency: Necessary to protect the person or others from (1) death, or (2) serious bodily injury (i.e., substantial risk of death, causes serious permanent disfigurement or protracted loss or impairment of the function or process of a bodily member or organ, or at the time of injury, can reasonably be expected to result in serious permanent disfigurement or protracted loss or impairment of the function or process of a bodily member or organ).
[b]SDD (Serious Developmental Disability): (1) developmental disability, (2) impairment in cognitive functioning, and (3) cannot be safely and effectively served within the community because of behaviors that pose an imminent risk of serious harm to self or others.
[c]Respondent; parents, guardian, or next of kin; Responsible person; Respondent's advocate; County attorney; IBC; Attorney for the respondent (if any); Attorney for parents or guardian (if any).

Overview | Montana Chemical Dependency Center

The Montana Chemical Dependency Center (MCDC) provides detoxification, evaluation, treatment, referral, and rehabilitation services to patients who have substance use disorder. MCDC is codified in MCA 53-21-603.

Unit	Purpose	License Type	Lic. Beds	Avg Census (August 2022)	Setting Description	Patient Population	Length of Stay	Avg Patient Age
A, B, and C	Treatment of individuals with substance use disorder; detoxification, evaluation, treatment, referral, and rehabilitation services	Inpatient Chemical Dependency Treatment	16 each 48 total	11	Building A has 8 detox beds with individual bathrooms and 8 regular treatment beds with four bathrooms. Buildings B&C have 16 beds each with two per room, and eight bathrooms. All buildings have one ADA room and bathroom. All three buildings doors are locked and require a key or fob to enter. Each building has a kitchen, lounge area, laundry room, group room, phone room, and staff offices. There is one nursing station and one med room in each building as well. B&C building each have a fitness room.	Voluntary commitment	19 days	37

Overview | Montana Veterans Home: Columbia Falls, Eastern, and Southwestern

There are three veterans homes in the state of Montana. One, in Columbia Falls, is state-run, while the other two in Eastern and Southwestern Montana are run by contracted state partners. Notably, the waitlist at Columbia Falls is significantly higher than the other two veterans homes.

Unit	Purpose	License Type	Lic. Beds	Avg Census (August 2022)	Setting Description	Patient Population	Length of Stay (Years)	Avg Patient Age	Waitlist (August 2022)
Columbia Falls Montana Veterans Home									
1	Intermediate or skilled nursing home care	Long Term Care	40	16	Montana Veterans Home – Nursing Home/Skilled nursing facility	Honorably discharged veterans or their spouses	4.3	83	191
2	Intermediate or skilled nursing home care	Long Term Care	50	28	Montana Veterans Home – Nursing Home/Skilled nursing facility	Honorably discharged veterans or their spouses	4.3	83	
3	Dementia/Memory care - Intermediate or skilled nursing home care	Long Term Care	15	11	Montana Veterans Home – Nursing Home/Skilled nursing facility	Honorably discharged veterans or their spouses	4.3	83	
4	Domiciliary – independent living	Long Term Care	12	7	Montana Veterans Home – Retirement Home - independent living	Honorably discharged veterans or their spouses	2.8	85	
Eastern Montana Veterans Home									
A/B	Intermediate & Skilled nursing home care; 1 isolation room	Long Term Care	34	30	Other than 1 private room all rooms are double occupancy with 2 rooms sharing 1 bathroom	Male and female veterans and several female spouses of veterans with varied physical needs	1-5 years	70-80	0
C/D	Intermediate & Skilled nursing home care; 1 isolation room	Long Term Care	29	14	Other than 1 private room all rooms are double occupancy with 2 rooms sharing 1 bathroom	All male veterans of varied physical needs	1-5 years	70-80	
SCU	Memory Care	Long Term Care	16	14	Secured unit all double occupancy rooms with 2 rooms sharing a bathroom; day room and enclosed courtyard available	Male and female residents living with advanced dementia and multiple with behaviors	1-5 years	70-80	
Southwestern Montana Veterans Home									
1	Skilled Nursing	Long Term Care	12	12	Each Cottage is set up with 12 single occupancy bedrooms and 12 attached bathrooms. There is also a Spa Room (Tub Room) and Community bathroom in each Cottage.	Voluntary	1 year	80	34
2	Skilled Nursing	Long Term Care	12	11		Voluntary	1 year	84	
3	Skilled Nursing	Long Term Care	12	12		Voluntary	1 year	78	
4	Skilled Nursing – Memory Care Unit	Long Term Care	12	8		Voluntary	1 year	79	
5	Opening later in 2023								

Peer State Analysis

Peer State Analysis | Approach

A&M conducted research into the broader service delivery systems of Montana's peer states. The goal is to identify opportunities and lessons from strengths and weaknesses of these similarly situated states.

Step 1: Develop Selection Model

- Demographics, state expenditures, and mental healthcare need data was pulled from Census Bureau and Health Resources and Services Administration (HRSA) datasets.
- Variables were weighted to create a model that quantified US states' similarity to Montana.

Step 2: Identify Five Peer States

- Our model outputted, in order of similarity to Montana, North Dakota, South Dakota, Alaska, Idaho, and Wyoming as Montana's peer states.
- Input from DPHHS leadership was incorporated before moving forward with the peer states selected by the model.

Step 3: Conduct Peer Analysis

- Quantitative and qualitative data was pulled on peer states' behavioral health and broader healthcare delivery systems.
- Data was categorized into behavioral health background statistics, state hospital statistics, community-based care statistics, crisis response, and legislative comparison.

Peer State Analysis | Background Statistics (1 of 3)

Montana, like all its peer states, has higher suicide rates than the national average. Additionally, Montana has the highest average poor mental health days[3] of its peer states, which is slightly higher than the national average.

	Behavioral Health Outcomes Statistics		
State	**Suicide Rate (per 100k people)[1]**	**Adult Any Mental Illness (AMI) Rate[2]**	**Average Poor Mental Health (MH) days in past 30 days[3]**
North Dakota	18.2	20.5%	3.7
South Dakota	21.0	18.3%	3.7
Alaska	27.5	21.5%	3.9
Idaho	23.2	22.5%	4.4
Wyoming	30.5	22.6%	4.1
Montana	**26.1**	**20.8%**	**4.6**
National Average	**14.0**	**19.9%**	**4.5**

[1] CDC National Center for Health Statistics (2020)
[2] Mental Health America (2022)
[3] County Health Rankings (2022) – average number of self-reported mentally unhealthy days in the past 30 days (age-adjusted)

Peer State Analysis | Background Statistics (2 of 3)

In comparison to peer states, Montana has the fewest residents with mental illness (MI) reporting unmet treatment needs. Additionally, Montana's State Mental Health Authority (SMHA) expenditures are higher than most of its peer states, as well as the national average.

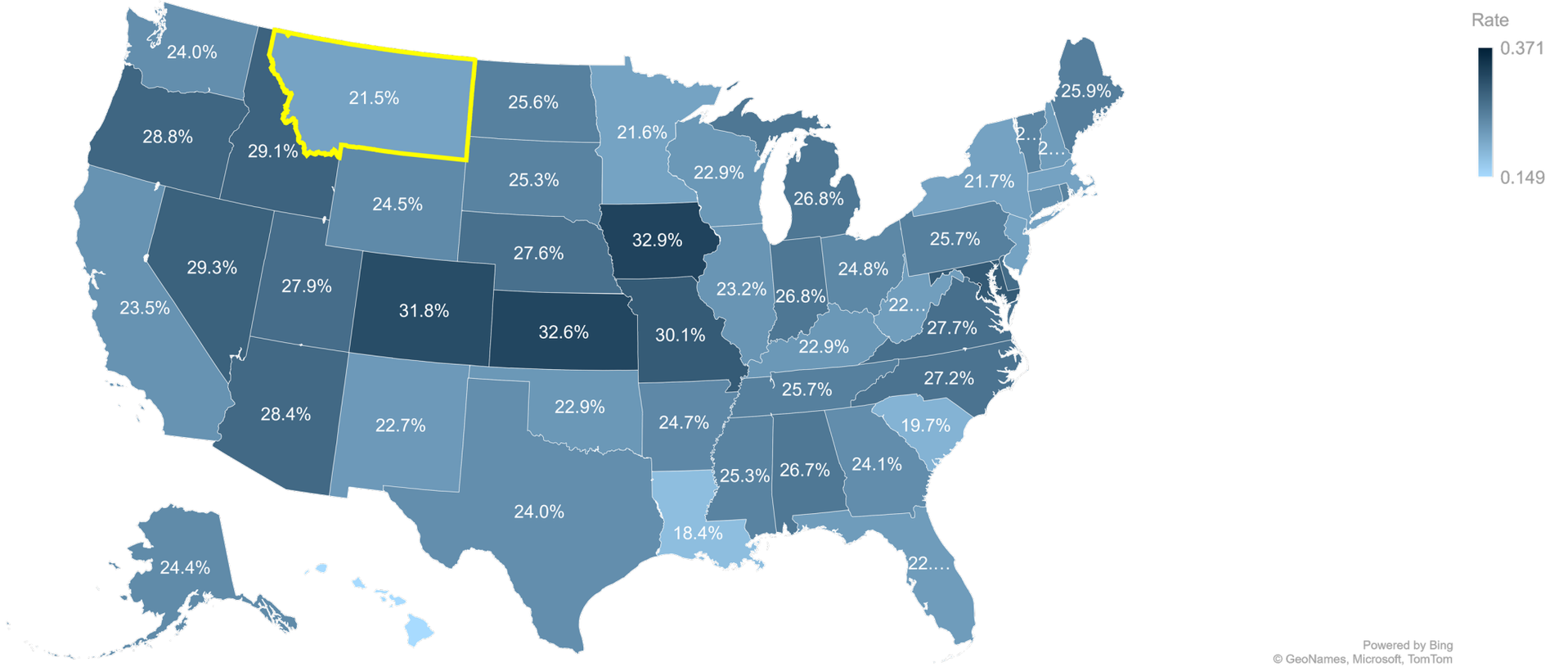
	Behavioral Health Treatment and Spending Statistics				
State	**Adults with MI reporting unmet need for treatment[1]**	**Population to MH providers ratio[2]**	**MH Provider Need Met[3]**	**SMHA Expenditures (per capita)[4]**	**Medicaid Long-term MH Facility Spend (per capita)[5]**
North Dakota	25.6%	470:1	18.8%	$115.82	$25.73
South Dakota	25.3%	500:1	16.8%	$98.52	$3.31
Alaska	24.4%	160:1	18.0%	$283.03	$18.51
Idaho	29.1%	440:1	29.8%	$48.80	$2.08
Wyoming	24.5%	270:1	47.1%	$102.18	$13.49
Montana	**21.5%**	**300:1**	**25.1%**	**$143.52**	**$23.18**
Nationally	**24.7%**	**350:1**	**28.1%**	**$138.49**	**$41.02**

[1] Mental Health America (2022)
[2] County Health Rankings (2022)
[3] Kaiser Family Foundation calculated from the Health Resources and Services Administration's Health Professional Shortage Areas (2021)
[4] SAMSHA Uniform Reporting System (2020)
[5] Kaiser Family Foundation (2020)

Peer State Analysis | Background Statistics (3 of 3)

Of the adults with mental illness in Montana, 21.5 percent report having unmet needs for treatment. This is compares favorably to the national average (24.7%), and higher than each of Montana's peer states. Only three states have lower rates of adults with unmet mental health needs (Hawaii, Louisiana, and South Carolina).

Adults with mental illness reporting unmet needs for treatment



Data pulled from Mental Health America (2022)

Peer State Analysis | State Hospital Statistics

MSH has much longer short-term stays than its peer states. In terms of 180-day readmission rate, Montana's numbers are on the higher end of its peer states.

State	# of State Operated MH Hospitals	Avg. Days of Stay (Discharged)[1]	Avg. Days of Stay (<1 year)[2]	Avg. Days of Stay (>1 year)[3]	Beds	Beds (per 100k people)	180-Day Readmission Rate[4]
North Dakota	1	114	53	3,152	108	14.2	34.2%
South Dakota	1	63	63	1,324	133	15.1	19.4%
Alaska	1	36	98	1,098	61	8.3	24.3%
Idaho	2	56	56	852	165	9.4	16.0%
Wyoming	1	113	89	1,780	122	21.0	11.9%
Montana	**1**	**148**	**117**	**1,485**	**270**	**25.4**	**23.8%**

*As of 7/12/22

[1, 2, 3, 4] SAMSHA Uniform Reporting System (2020)

Peer State Analysis | Community-Based Care Statistics

Montana has more Federally Qualified Health Centers (FQHCs) per 100k people than most of its peer states and is only one of two of its peer states to have any Certified Community Behavioral Health Clinic (CCBHCs). Additionally, while community utilization is high ER BH visits are also high, indicating community services can be improved.

State	# of FQHCs	FQHCs (per 100k people)	CCBHC Status	# of CCBHCs	CCBHCs per 100k People	Community Utilization (per 1,000 people)[1]	ER BH Visits (per 100k people)[2]
North Dakota	5	0.66	None	0	0	18.5	2,111
South Dakota	4	0.45	None	0	0	19.4	1,268
Alaska	29	3.93	Expansion Grants	2	0.27	28.9	No data
Idaho	16	0.91	None	0	0	8.7	No data
Wyoming	8	1.38	None	0	0	28.2	1,505
Montana	**15**	**1.41**	**Expansion Grants**	**3***	**0.28***	**68.80**	**2,048**
Nationally	**27** average FQHCs per state	**0.46**	**N/A**	**10.5** Average CCBHCs per state	**0.14**	**23.9**	**No data**

*All of Montana's CCBHCs are for substance use disorder (SUD) treatment
[1] SAMSHA Uniform Reporting System (2020)
[2] Agency for Healthcare Research and Quality (2019)

Peer State Analysis | Legislative Comparison (1 of 3)

Compared to peer states, Montana has a short duration of custody for emergency evaluation, as well as limitations on who can petition an individual for emergency evaluation, impatient commitment, and outpatient commitment.

	Emergency Evaluation	Access to court for citizens			Forced Medication
State	**Duration of Emergency Custody**	**Who can petition for emergency evaluation?**	**Who can petition for inpatient commitment?**	**Who can petition for outpatient commitment?**	**Can the state provide involuntary medication orders?**
North Dakota	4 business days	Any responsible adult	Any responsible adult	Any responsible adult	Yes
South Dakota	5 days	Any responsible adult	Any responsible adult	Any responsible adult	Yes
Alaska	72 hours	Any responsible adult	Only professionals	Only professionals	Yes
Idaho	5 days	Only professionals	Any responsible adult	Any responsible adult	Yes
Wyoming	72 hours	Any responsible adult	Any responsible adult	Any responsible adult	Yes
Montana	**1 business day**	**Only professionals**	**Only professionals**	**Only professionals**	**Yes**
Best Practice*	**48-72 hours minimum**	**Any responsible adult**	**Any responsible adult**	**Any responsible adult**	**N/A**

Responsible adult: Some states authorize adults with specific relationships, such as parents, siblings, spouses, or guardians, to petition the court. Others authorize any responsible adult with the necessary knowledge of a person's circumstances to do so.

Professional: A physician, psychiatrist, hospital admin, or law enforcement

*According to the Treatment Advocacy Center

Peer State Analysis | Legislative Comparison (2 of 3)

Montana and South Dakota are the only two states within this analysis without a psychiatric deterioration standard for inpatient civil commitment. Additionally, Montana, like almost all its peer states, has a procedural barrier to assisted outpatient treatment (AOT). **The next slide delves into these specific barriers.**

	Inpatient Civil Commitment		Assisted Outpatient Treatment (AOT)	
State	**Barriers to inpatient civil commitment?***	**Has psychiatric deterioration standard?**	**Statutory barriers to AOT?***	**Procedural barriers to AOT?***
North Dakota	No	Yes	No	Yes
South Dakota	No	No	No	Yes
Alaska	No	Yes	Yes	Yes
Idaho	No	Yes	No	Yes
Wyoming	Yes	Yes	Yes	No
Montana	**No**	**No**	**No**	**Yes**

*According to the Treatment Advocacy Center

Peer State Analysis | Legislative Comparison (3 of 3)

Montana and South Dakota are the only two states within this analysis without a psychiatric deterioration standard for inpatient civil commitment. An optimal psychiatric deterioration standard should enable the evaluator to consider the person's treatment history in assessing the likelihood that the current episode of nontreatment will lead to psychiatric deterioration.

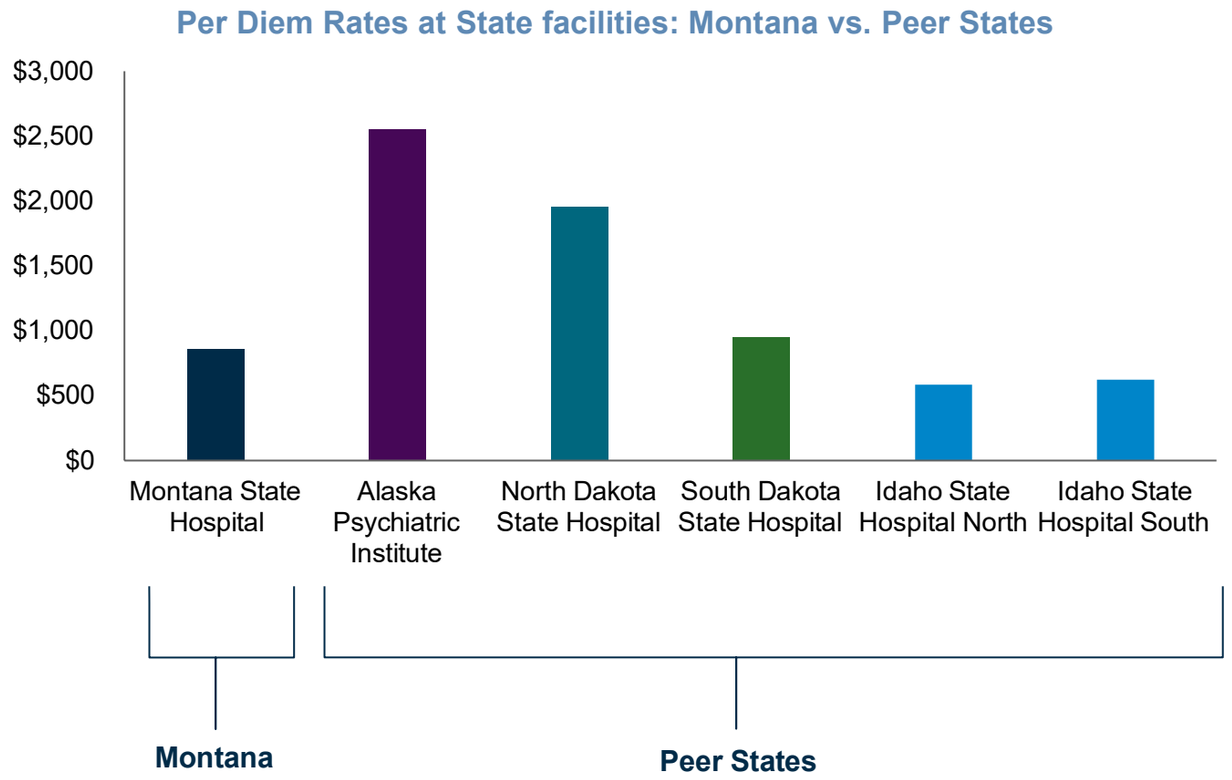
Additionally, Montana only has statutory or procedural barriers for AOT by not requiring a written treatment plan to be shared with courts. Sharing a treatment plan with courts has been shown to increase the success of AOT and prevent re-hospitalization and re-arrest.

North Dakota	South Dakota	Alaska			Montana
Has procedural barriers to AOT: • Written treatment plan not required to be shared with courts	**Doesn't have a psychiatric deterioration standard** **Has procedural barriers to AOT:** • Written treatment plan not required to be shared with courts	**Has statutory barriers to AOT:** • Patient must refuse treatment or affirmatively agree **Has procedural barriers to AOT:** • Written treatment plan not required to be shared with courts • No nonadherence procedure		**Has barriers to inpatient civil commitment:** • Requires imminent harm and endangerment due to grave disability • Requires family/friends to refuse assistance **Has statutory barriers to AOT:** • Must be currently unstable for eligibility	**Doesn't have a psychiatric deterioration standard** **Has procedural barriers to AOT:** • Written treatment plan not required to be shared with courts

Peer State Analysis | Per Diem Charge Benchmarks

Except for Idaho, MSH per diem rates fall below those of Montana's peer states – this is a sign that, compared to other states, Montana is underinvesting financially in its state-run facilities. Note, however, that Montana's Medicaid Long-term MH Facility spend per capita is higher than its peer states, as noted in our previous slides.

Facility	Type	Licensed Beds	Per Diem Rate
Montana State Hospital	**Psychiatric Hospital**	**270**	**$855 (2022)**[1]
Alaska Psychiatric Institute	Psychiatric Hospital	61	$2,556 (2021)
North Dakota State Hospital	Psychiatric Hospital	108	$1,958 (2021)
South Dakota State Hospital	Psychiatric Hospital	133	$953 (2021)
Idaho State Hospital North	Psychiatric Hospital	55	$585 (2019)
Idaho State Hospital South	Psychiatric Hospital	135	$622 (2019)
Wyoming State Hospital	Psychiatric Hospital	122	$1311 (2021)



[1] MSH's per diem rate in 2021 was $628 – the increase in 2022 is largely due to an increase in spend on traveling nurses.

Facility Assessments

Assessment | Facility Census and Waitlist

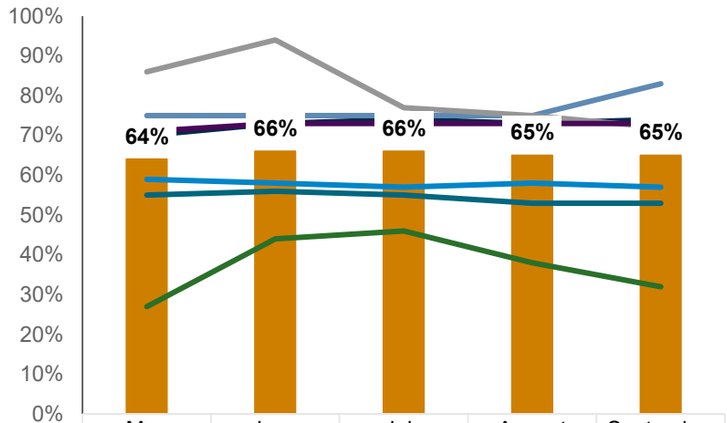
With some facilities having consistently low census and others having high waitlist numbers, there is a clear need to make improvements and adjustments to ensure state-run facilities are providing support to individuals with behavioral health challenges to their full ability. For more detailed data, see Appendix G.

Data Highlights

1. Average daily census across the network of state-run facilities has held steady around 65% over the last five months, with **MCDC consistently having the lowest census of the seven facilities.**

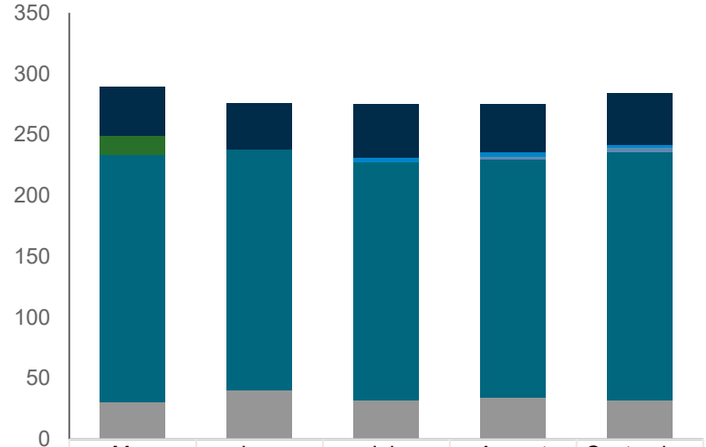
2. Waitlist numbers have remained **high at CFMVH** despite an average daily census of about 55% over the last five months.

Average Daily Census (%)[1,2]



	May	June	July	August	September
Overall	64%	66%	66%	65%	65%
MSH	70%	73%	74%	73%	74%
MMHNCC	59%	58%	57%	58%	57%
IBC	75%	75%	75%	75%	83%
MCDC	27%	44%	46%	38%	32%
CFMVH	55%	56%	55%	53%	53%
SWMVH	86%	94%	77%	75%	72%
EMVH	71%	73%	73%	73%	73%

Waitlist #s at facilities



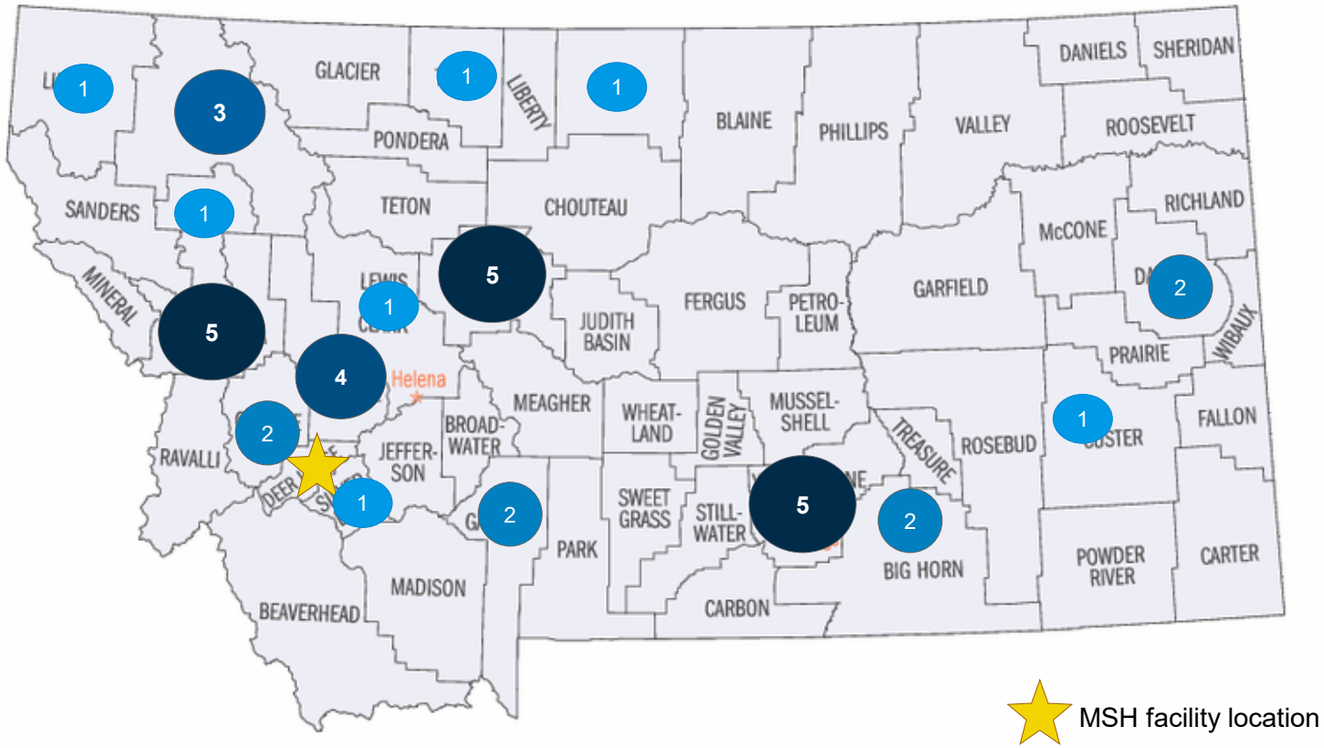
	May	June	July	August	September
MSH	40	38	44	39	42
MMHNCC	0	0	3	4	3
IBC	0	0	0	2	3
MCDC	15	0	0	0	0
CFMVH	203	198	196	196	204
SWMVH	31	40	32	34	32
EMVH	0	0	0	0	0

[1] MSH data includes the Main Hospital, Forensic Unit, and Group Homes
[2] SWMVH added 12 additional beds in July 2022

Assessment | MSH Waitlist by County

As of August 25, 2022, the **forensic unit at MSH** had a 37 person waitlist, with an average wait time of 6 months, where most individuals are waiting in jail. Individuals from Missoula, Yellowstone, and Cascade County represent 41 percent of the waitlist.

MSH Waitlisted Individuals by County (Forensic Unit)



County	# on waitlist	Average wait time (months)
Big Horn	2	19
Cascade	5	6
Custer	1	4
Dawson	2	9
Flathead	3	3
Gallatin	2	4
Granite	2	3
Hill	1	5
Lake	1	3
Lewis & Clark	1	2
Lincoln	1	3
Missoula	5	8
Powell	4	10
Silver Bow	1	3
Toole	1	6
Yellowstone	5	5
Overall	**37**	**6**

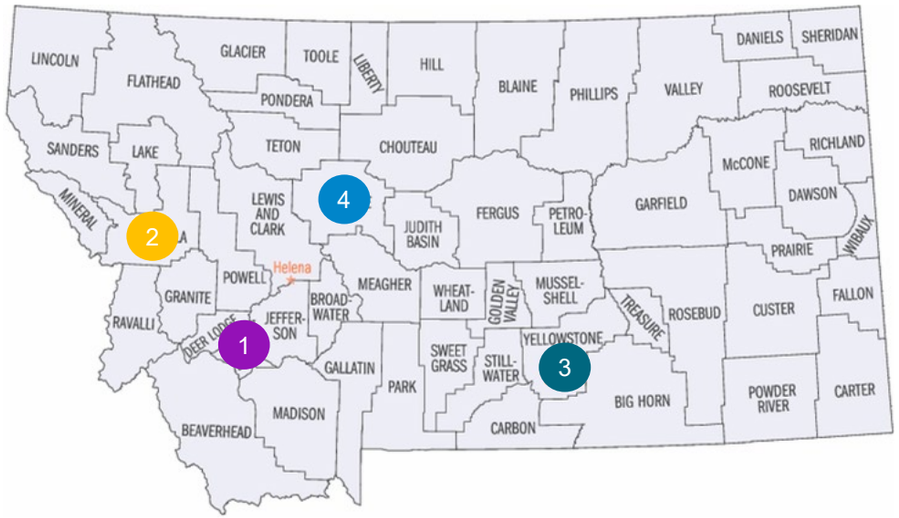
Assessment | MCDC Census and the Montana SUD Facilities Landscape

MCDC is the only state-run Substance Use Disorder (SUD) facility that provides a 3.7 ASAM level of care, and is one of four total 3.7-level facilities across Montana. With 8 dedicated detox beds, MCDC accounts for **17.4 percent** of the 3.7-level beds in the state.

Overall Data: Census and Licensed Beds Data Facilities (All levels of ASAM care)	Montana SUD
Number of Beds: Residential	275
Number of Beds: Inpatient	192
Total average daily census: Residential	121
Total average daily census: Inpatient	13
Average Waitlist (in weeks): Residential	6 – 7 weeks
Average Waitlist (in weeks): Inpatient	2 – 3 weeks
Total number of licensed beds	**467**
Total average daily census across network (#)	**134**
Total average daily occupancy across network (%)	**28.69%**
Average waitlist (in weeks) across network	**5 – 6 weeks**

Benchmark Data: National Average vs. Montana	
SUD beds per 100,000 adults **(national average)**[3]	**42.7**
SUD beds per 100,000 adults **(Montana)**	**69.5**

Geographic spread of 3.7 ASAM level-of-care facilities



There are **four facilities** in the state of Montana that provide a 3.7 ASAM level-of-care, the highest level provided.

3.7-level Facilities: Quick Stats

- **Number of Facilities:** 4
- **Total number of beds**[1]**:** 46
- **Current waitlist times:** 3 – 7 days
- **Estimated census**[2]**:** ~ 55%

Number of 3.7-level beds

1. **Montana Chemical Dependency Center (Building A):** 8 beds
2. **Recovery Center of Missoula:** 16 beds[1]
3. **Rimrock Foundation Detoxification Center:** 16 beds
4. **RMTC, LLC – DBA Rocky Mountain Treatment:** 6 beds

Using the national average number of SUD beds per 100,000 adults as a benchmark, Montana should have a **minimum of 287 SUD beds**. With a total of 467 beds, Montana has **180 beds over the national average**.

Low census numbers indicate that many of these beds remain unoccupied – likely due to a combination of staffing issues, access, awareness, and/or demand.

[1] The number of beds for the Recovery Center is a combination of beds for 3.5 and 3.7 level-of-care patients
[2] The Recovery Center of Missoula did not provide their census information, and thus their census was estimated based on the lack of waitlist times
[3] Source: Psychiatric and Substance Use Disorder Bed Capacity, Need and Shortage Estimates in Sacramento County, California, RAND Corporation (2022)

Assessment | Facility Staffing Levels

A&M assessed facility staffing schedules for patient care areas to establish a baseline and compare to national and regional benchmarks. Facilities have robust staffing levels for their average daily censuses – however, there are high vacancy rates at facilities compared to the number of positions they have budgeted. Additional work is being done to determine what appropriate staffing levels should look like.

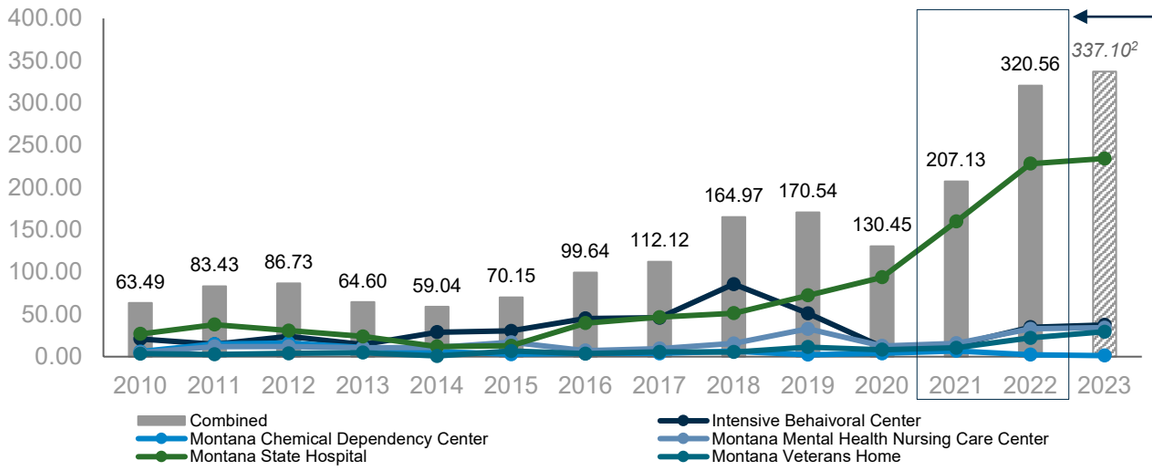
Facility	License Type	Licensed Beds	RN HPPD		RN Skill Mix		Total Nursing Care HPPD	
			Current	*Benchmark*	*Current*	*Benchmark*	*Current*	*Benchmark*
MSH Main Hospital	Hospital	174	2.6	1.9	19%	26%	11.8	7.3
MSH Forensic	Mental Health Center	54	1.1	1.6	10%	25%	8.5	6.4
MSH Group Homes	Mental Health Center	42	0.4	1.6	6%	25%	4.4	6.4
IBC	Intermediate Care Facility for the Developmentally Disabled	12	2.6	1.9	7%	32%	23.1	6.0
MMHNCC	Long Term Care	117	1.2	0.8	24%	21%	5	3.8
MVH	Long Term Care	117	1.8	0.8	33%	21%	5.5	3.8
MCDC	Inpatient Chemical Dependency Treatment	48	2.2	1.0	33%	25%	4.3	3.84

Hours Per Patient Day (HPPD) is an endorsed measure by the National Quality Forum. For example, at MSH Main Hospital, each patient receives an average of 11.8 hours of nursing care in a 24-hour period (i.e., RN, Psych Tech, CNA). HPPD was calculated using average daily census and typical staffing schedules. Long term care benchmarks based on CMS data for 100 bed long term care facilities in Montana. All other benchmarks based on A&M proprietary information of similar behavioral health and forensic facilities. Generally, more acute patient populations require higher staffing levels, for example MMHNCC provides higher levels of care compared to other nursing facilities.

Assessment | Staff Vacancies by Facilities: 10-Year Snapshot

There has been an upward trend in vacancies among the facilities since 2015, with the greatest increase being seen in 2021 when vacancies increased by **58.8%,** partially fueled by the COVID-19 pandemic**.** Concurrently, there has been a **120% increase** in Montana's average home value over the last decade, which poses challenges for recruiting and attracting talent to fill these vacancies.

Vacancies at Montana State-Run Facilities: FY10 – FY23[1,2]



Years	FY11	FY12	FY13	FY14	FY15	FY16	FY17
% change in vacancies over time	+31.4%	+4.0%	-25.5%	-8.6%	+18.8%	+42.0%	+12.5%
	FY18	**FY19**	**FY20**	**FY21**	**FY22**	**FY23[2]**	
	+47.1%	+3.4%	-23.5%	+58.8%	+54.8%	*+5.2%*	

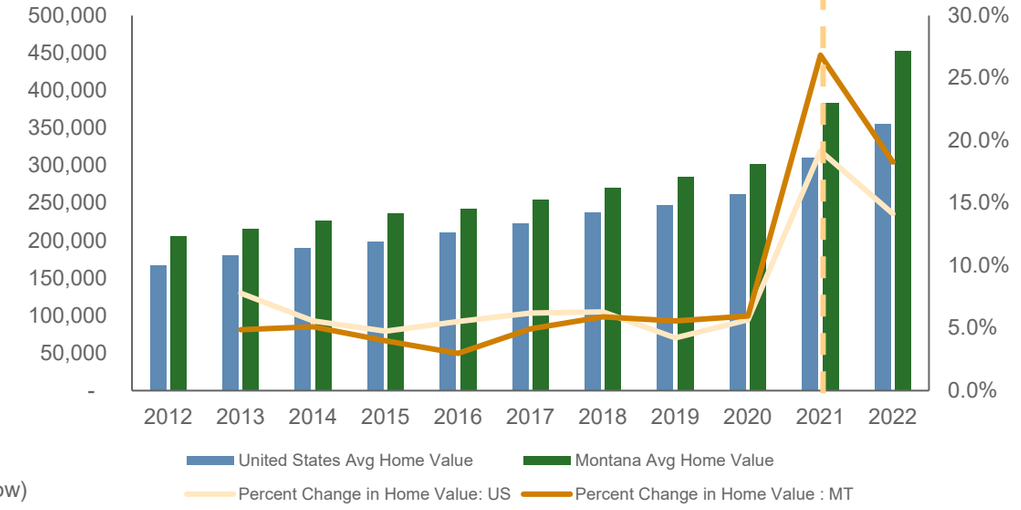
Wage increases went into effect between June 2021 and May 2022.

However, with competing influences of higher cost of living and the ongoing pandemic, alongside competition with private sector wages, there has been no visible positive impact on the level of vacancies.

Top 5 Vacant Positions across Facilities: August 2022

Position	# of Vacancies	% of Total Vacancies
Psychiatric Technician	111	31.1%
Registered Nurse (RN)	47	13.2%
Certified Nurse Aide (CNA)	46	12.9%
Direct Support Professional	32	8.9%
Psychiatric Technician FMHT	22	6.2%

Home Value Trends: US vs. Montana, 2012 – 2022[3,4]

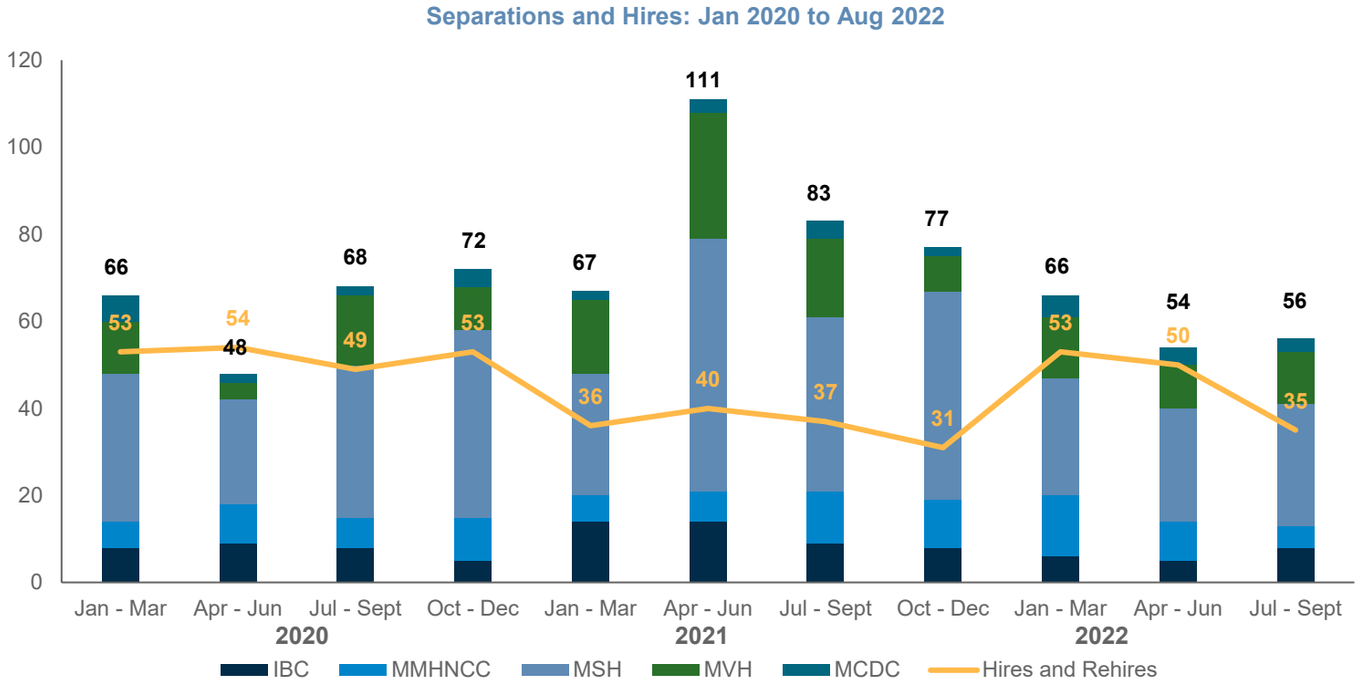


Montana home values increased most significantly in in 2021 (by 26.8%) – **the same year Montana facilities saw the greatest increase in vacancies**.

[1] Vacancies for each fiscal year are a point-in-time count from June of each year, with the exception of FY23 (see note below)
[2] FY23 counts are as of September 8, 2022
[3] Source: Zillow Home Value Index, last retrieved September 9, 2022
[4] Home values are pulled from September of each respective year, with the exception of 2022, where the home value is as of July 31, 2022

Assessment | Staff Turnover and Reasons for Leaving

Since January 2020, there have been 768 separations at Montana state-run facilities, the majority due to employee personal reasons or career choice. However, in that same time period, there have only been 491 new hires or rehires, creating a **net loss of 277 staff** in the last 33 months.



Time Period	2020				2021				2022		
	Jan Mar	Apr Jun	Jul Sept	Oct Dec	Jan Mar	Apr Jun	Jul Sept	Oct Dec	Jan Mar	Apr Jun	Jul Sept
Net Change in Staff[2]	-13	6	-19	-19	-31	-71	-46	-46	-13	-4	-21

Reason[3]	# of Separations
Personal Reasons	**290**
Career Choice	**121**
For Cause	90
Retirement	81
Job Abandonment	64
Probationary Period	47
Relocation	28
End Assignment	12
Work Conditions	10
Family Reasons	7
More Pay	5

54% of separations from January 2020 to August 2022 were due to personal reasons or a career choice[3]

Qualitative Data Insights: Exit Interviews & Pay

Our team received 21 complete exit interviews from two of the five facilities. Of these interviews, **57 percent** said they "strongly disagreed" with the statement that their salary was adequate. **43 percent** listed pay as a reason for leaving their role.

[1] Data for 2022 is through September 30
[2] Net change in staff is calculated by subtracting the number of separations by the number of hires and rehires in that time period
[3] Upon separation, employees are asked to select the most fitting option for their reason for leaving from a list. This list was created and approved by the Montana Department of Administration, and match up with the options available for the HR team to enter into SABHRS. SABHRS does not have the ability to track more than one option.

Assessment | Facilities Recruitment

The shortage of health care workers, including nurses, is not unique to Montana's facilities – health care settings nationwide are grappling with staffing shortages, which have been worsened by the COVID-19 pandemic. However, as a frontier state, this shortage and the challenges associated with recruiting for these positions is acutely felt in Montana.

The COVID-19 pandemic has exacerbated the existing health care worker shortage nationwide. In the last two years of the "Great Resignation," the healthcare field has lost an estimated 20 percent of its workforce, including 30 percent of nurses.[1]

The location of Montana's facilities, cost of living, and housing availability all impact the ability to recruit talent. A study released by WalletHub in June 2022 showed Montana as the state with the second highest resignation rate over the last year, with a resignation rate of 3.69% from June 2021 to June 2022.[2] Alaska had the highest resignation rate, at 4.18%, and Wyoming came in third at 3.69%. All three states face similar recruiting challenges as rural states with a large geographic spread.

Staff turnover is a cause of even more staff turnover. When staff leaves, it puts more stress and strain on the staff remaining. This causes even more burnout, and leads to additional staff turnover, creating a vicious cycle and a recruitment workload that is difficult for HR departments to keep up with.

Tackling the staffing shortage in Montana's facilities

To navigate the unique challenges facing recruitment in Montana and in health care, facilities use a variety of recruitment channels to attract talent.

Recruitment channels across facilities[3]

Facility	State Recruiting System (SOMRS)	Job Sites (Indeed, LinkedIn, etc.)	Social Media	Montana State and Local Media	Word of Mouth	University-level recruitment	Job Fairs	Staffing agencies
MCDC	✓		✓	✓				
MMHNCC	✓			✓		✓	✓	✓
MSH		✓	✓				✓	
MVH-CF	✓	✓		✓		✓		
SWMVH		✓	✓		✓		✓	
IBC				✓				
EMVH		✓		✓			✓	

[1] Source: Health Leaders Media (March 2022)
[2] Source: WalletHub (July 2022)
[3] Information about recruitment initiatives was provided directly by the facilities, and may not be fully comprehensive of all recruitment efforts occurring

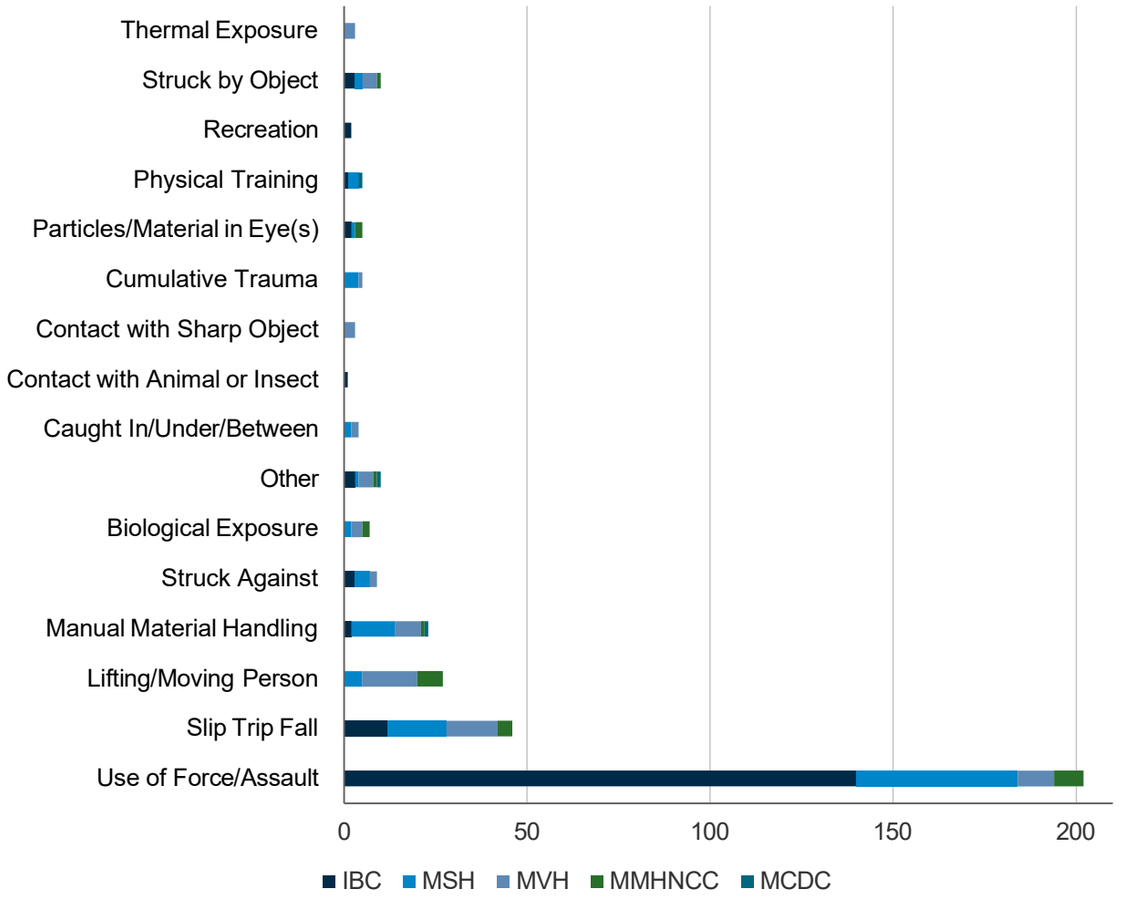
Assessment | Employee Safety: Workers' Compensation Claims

Montana facilities workers' compensations claims are, mostly, underperforming against national benchmarks, with only IBC showing significant improvement between FY21 and FY22. Most workers' compensation claims in the last two fiscal years were for uses of force / assault.

Facility Workers' Comp Claims v. Benchmark

Facility		
IBC	2021	174.2
	2022	81.8
MVH	2021	22.8
	2022	22.8
MMHNCC	2021	7.6
	2022	10.4
MSH	2021	10.3
	2022	7.7
MCDC	2021	0.0
	2022	5.3

Total Workers Comp Claims, FY21-22



Key Considerations for Next Steps and Recommendations

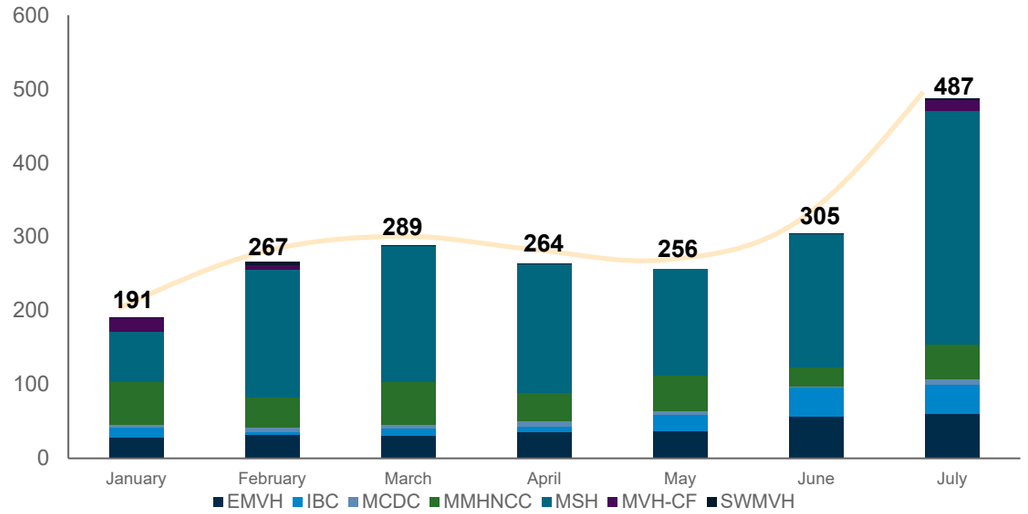
- Target improvements at IBC, with the unique population in mind
- Lower claims MCDC may be due to a low staff to patient ratio at the facility
- Union agreements must be kept in mind as improvements and changes are made

[1] Benchmarks are based on OSHA's 2020 average rate of nonfatal occupational injuries and illnesses for residential care facilities and hospitals, published November 2021. Source: https://www.bls.gov/news/release/osh.t05.htm

Assessment | Patient Safety and Incident Tracking across State-Run Facilities

Incident tracking across facilities is inconsistent and lacks uniformity, with each facility tracking different types of incidents in different ways. Nevertheless, the number of reported incidents at facilities has steadily increased in 2022.

Incidents Across Facilities: 2022



There is a **lack of consistency** between the facilities in which incidents are tracked and how they are being tracked (for more detail, see Appendix E).

The number of incidents have been increasing in 2022, with reported incidents jumping by **60 percent** from June to July this year.

Inpatient Psychiatric Hospital Patient Safety v. National Average

State Hospital	Hours of Physical Restraint Use per Day[1]	Hours of Seclusion Use per Day[1]
Alaska	0.14	0.39
Idaho (South)	0.10	0.39
North Dakota	0.88	2.00
South Dakota	1.25	1.37
Montana (MSH)	**0.26**	**2.13**
National Avg	0.30	0.29

Nursing Home Patient Safety v. National Average

Facility	% of Residents with One or More Falls with Major Injury[2]	% of Residents Who Got an Antipsychotic Medication[2]
MMHNCC	7.7%	69.3%
MVH	8.8%	16.3%
EMVH	5.7%	24.3%
SWMVH	1.6%	15.8%
National Avg	3.4%	14.5%
Montana Avg	5.3%	16.6%

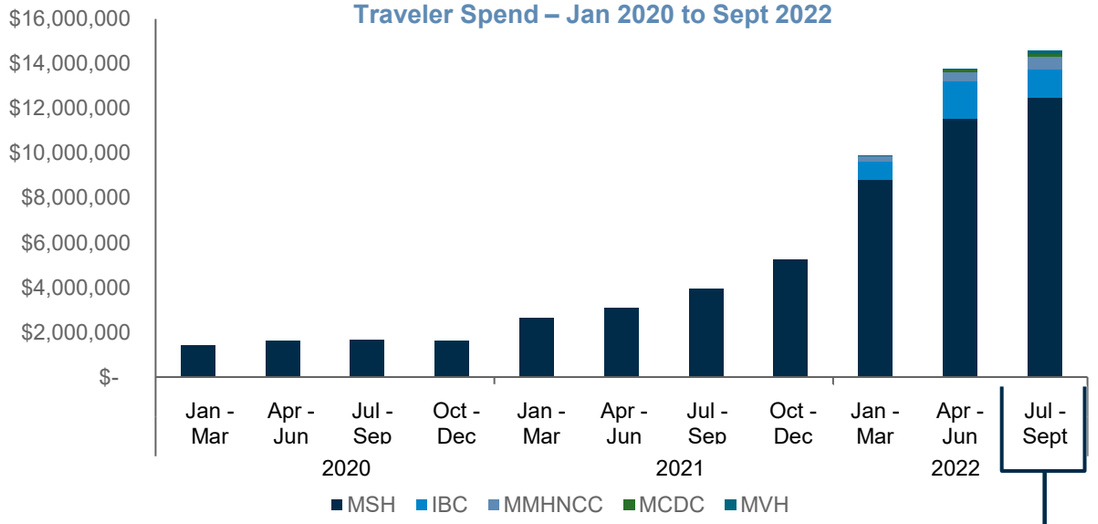
[1] CMS Inpatient Psychiatric Facility Quality Measure Data - by Facility, published July 2022. Source: https://data.cms.gov/provider-data/dataset/q9vs-r7wp
[2] CMS Skilled Nursing Facility Quality Reporting Program - Provider Data, published August 2022. Source: https://data.cms.gov/provider-data/dataset/fykj-qjee

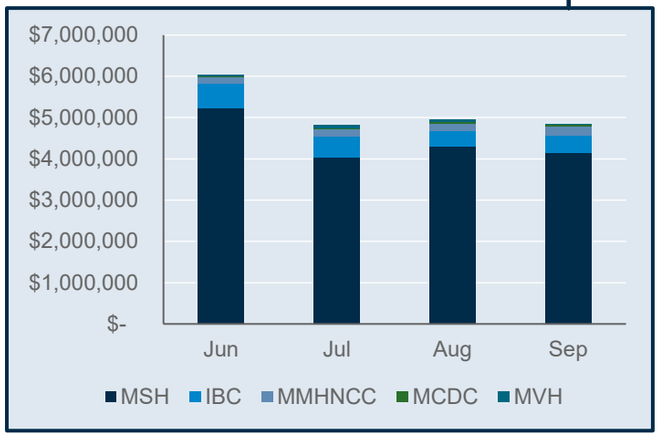
Assessment of Spending on Temporary Contractor Staff, 2023 YTD (Travel Nursing)

A&M has been working with facilities to analyze travel nursing spend and average traveler hourly wages. Overall traveler spend in calendar year 2022 is higher than in 2021. Facilities continue to face high vacancy rates and are using travel nursing to cover gaps in care. DPHHS will release an RFP next month to consolidate traveler contracts, with a goal to reduce administrative burden and obtain better pricing.

	Traveler Hourly Wage[2]			Employee Base Wage + Benefits[3]		
	RN	LPN	CNA	RN	LPN	CNA
MSH	$ 121.14	$ 74.64	$ 72.08	$ 51.10	$ 33.75	$ 27.46
IBC	$ 132.01		$ 81.62	$ 47.91		$ 27.49
MCDC	$ 121.00			$ 47.03		$ 25.68
MMHNCC	$ 79.55	$ 61.60	$ 43.25	$ 46.89		$ 27.27
MVH	$ 91.00	$ 71.04	$ 54.27	$ 47.12	$ 33.58	$ 27.14
Facility Average	**$ 110.05**	**$ 70.65**	**$ 62.27**	**$ 47.92**	**$ 33.66**	**$ 27.20**
Behavioral Health Facility Benchmark[4]				$ 50.74	$ 35.03	$ 20.42
Nursing Home Facility Benchmark[5]				$ 44.41	$ 33.68	$ 21.01
State of Montana 2022 Market Analysis[6]				$ 47.27	$ 33.45	$ 26.69

Wages at MMHNCC and MVH are lower because free housing is provided to travelers.





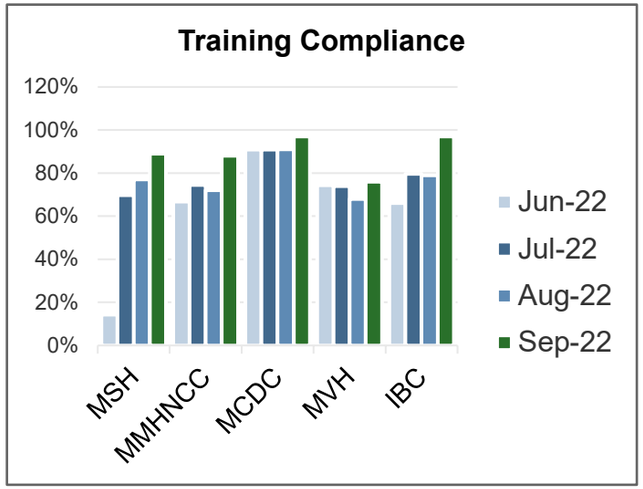
Facility	CY22 Traveler Spend	Vacancy Rate
MSH	$ 32,842,069	45%
IBC	$ 3,799,196	67%
MMHNCC	$ 1,216,045	30%
MCDC	$ 207,608	4%
MVH	$ 205,210	21%

[1] We are working to improve data quality; date is either invoice date or month worked; in the future this will reflect month worked.
[2] Average traveler hourly wage for the time period January 2022 to September 2022
[3] Average state employee base wage based on SABHRS report obtained July 27, 2022, plus benefit packages value.
[4] Hospital & Healthcare Compensation Service, Behavioral Health Salary & Benefits Report, 2022.
[5] Hospital & Healthcare Compensation Service, Nursing Home Salary & Benefits Report, 2022.
[6] State Human Resources (State HR) salary survey data, May 31, 2022.

Legend:
Maturity Rating indicates DPHHS performance compared to best practices.
Green: Aligned with Best Practices
Yellow: Challenges Exist
Red: Significant Gaps

Assessment | Required Training Compliance

In the June 2022 Climate and Culture Survey, employees reported low satisfaction with professional development. An audit of training compliance and course offerings revealed deficiencies at all facilities. Because of improvements to governance & compliance, the maturity rating has improved from red to green. **A&M is working with facilities to enhance practices and improve compliance.**



Montana State Hospital Training Notes:

- MSH's training program was significantly impacted by COVID, and they stopped delivering refresher training.
- Employees hired after October 2021 received onboarding training, but MSH was unable to provide documentation. The increase in training compliance from June to July is primarily because documentation was created.
- Refresher training has now restarted with compliance increasing from 14 to 77% in three months.

Component	Maturity	Findings	Best Practices
People		▪ 1 of 5 facilities has dedicated training staff. ▪ 5 of 5 facilities have staff assigned to deliver training on a part-time basis. ▪ New performance evaluation system (Talent) includes individual goals for each employee.	▪ Facilities have a training program administrator and sufficient instructional resources. ▪ Each employee has an individual learning plan.
Process		*Original State* – 62% Compliance across facilities ▪ Onboarding training processes exist at all facilities. Refresher training processes exist at 3 of 5 facilities. ***Current State* – 76% Compliance across facilities** • **Onboarding and refresher training now occurring at all facilities.**	▪ New employees receive training during onboarding according to job duty. ▪ Employees receive annual training refreshers according to job duty. ▪ Training is delivered using multiple modalities including online, classroom, and on the job.
Tools & Technology		*Original State* ▪ There are no supporting systems to track training compliance outside of spreadsheets. ▪ Training records are inconsistently stored in employee files. ***Current State*** ▪ **DPHHS Learning Management System (Moodle) being piloted at MCDC.**	▪ Learning Management System tracks required trainings by job duty and individual employee compliance.
Governance & Compliance		*Original State* ▪ 2 of 5 facilities did not have training policies. 2 of 5 facilities training policies did not document required trainings by job duty. ▪ There was no evidence that training compliance is being audited regularly. ***Current State*** • ***5 of 5 facilities have updated and comprehensive training policies.*** • ***Facilities now reporting to Division, compliance* is being audited monthly.**	▪ Training policies outline required trainings by job duty, frequency of refresher training

Assessment | Employee Climate and Culture – Methodology

A&M partnered with DPHHS to develop, distribute, and analyze the results of a climate and culture survey. The goal is to identify opportunities that facilities can invest in to improve employee satisfaction, engagement, and retention. **A summary of the complete survey results is available here.**

Step 1: Design Survey

- The survey is based on an evidence-based tool that has been scientifically developed and tested by distinguished research staff at Western Kentucky University.
- Input from DPHHS and facility leadership was incorporated into survey questions.
- The survey was published using the Qualtrics platform.

Step 2: Distribute Survey

- The survey opened on 5/13/22 and closed on 6/10/22 (close date was extended twice).
- Links and QR codes of the survey were distributed to employees via email blasts and posters in breakrooms. Paper forms were also available at facilities as requested.
- Employees provided feedback via smartphone, computer, and paper forms.

Step 3: Analysis

- Steps were taken to anonymize responses: demographic information separated from open-ended responses; open-ended responses summarized by themes; and not analyzing groups with less than 5 responses.
- Quantitative analysis was conducted using Python, and SPSS with various statistical methods.
- Qualitative analysis was conducted using python, manual review, and thematic content analysis.

Key Takeaways

1. Employees reported **dissatisfaction with their salaries** across all facilities, noting they were not competitive with similar jobs
2. Employees reported there were **limited professional development and training opportunities** at the facilities, and also noted dissatisfaction with opportunities for promotion.
3. Employees reported **high senses of accomplishment** across all facilities, noting that they sought this line of work due to their commitment to health care.

Assessment | Employee Climate and Culture – Results Summary

MCDC and SWMVH have the highest overall employee satisfaction levels. MMHNCC and MSH had the lowest overall employee satisfaction levels. Across all facilities, employees reported highest satisfaction with accomplishment and lowest satisfaction with salary. This is particularly the case for CFMVH where the median home cost is over $450,000.

Methodology: Employees responded to survey questions within each dimension using a 1 to 5 scale. A satisfaction level was created for each employee by averaging the scores for each survey question response. This represents each respondent's satisfaction level regarding the corresponding dimension.

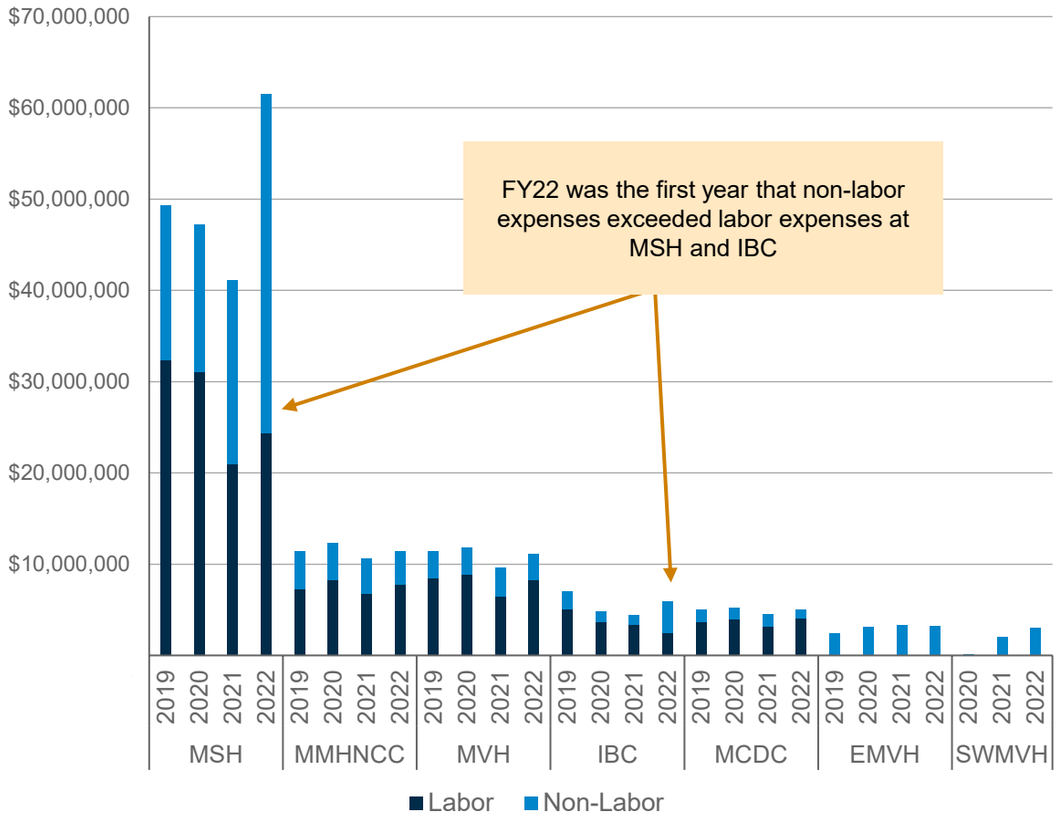
Dimension	Average Satisfaction Level							
	Overall	MSH	MMHNCC	IBC	MCDC	CFMVH	SWMVH*	EMVH*
Accomplishment	**3.7**	3.5	3.4	3.6	4.1	4.0	4.1	3.8
Supervision	**3.5**	3.4	3.2	3.7	3.8	3.6	3.9	3.9
Workload	**3.1**	3.1	2.8	3.1	3.8	2.8	3.7	3.6
Recognition	**3.1**	2.7	2.6	2.9	3.5	3.6	3.8	3.5
Support	**3.0**	2.7	2.5	2.9	3.7	3.2	3.5	3.2
Development	**2.9**	2.7	2.8	2.8	3.1	3.1	3.2	3.3
Salary	**2.5**	2.7	2.4	2.6	2.8	1.9	3.3	3.0
Overall	**3.1**	**3.0**	**2.8**	**3.1**	**3.6**	**3.2**	**3.6**	**3.5**
Count	*410*	*155*	*62*	*17*	*46*	*81*	*22*	*23*

*Southwestern Montana Vets Home (SWMVH) and Eastern Montana Vets Home (EMVH) are run by contractors.

Assessment | Expenses at State Facilities: Four Year Snapshot

In the last four years, total expenses across all state-run facilities has risen – in part due to an increase in non-labor expenses such as traveler nurses at MSH and IBC. This increase in expenses has been coupled with a decrease in revenue for FY22 – more detail on revenue is on the next slide.

Facility Expense, Four Year Snapshot



Summary of Findings

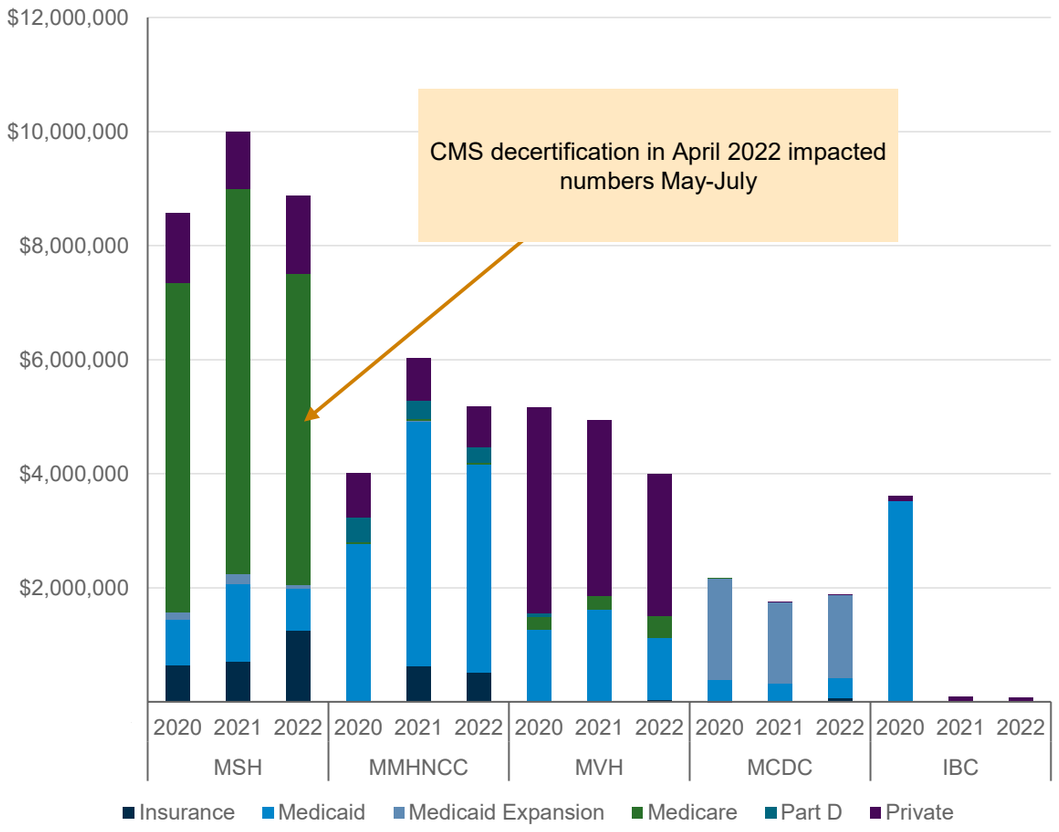
- Expenses have risen since FY19 across facilities, with expenses at MSH accounting for over 50 percent of total facilities spend
- Non-labor expenses include traveler / temporary contracted staff.

Facility	Expense Type	FY19	FY20	FY21	FY22
MSH	Labor	$ 32,390,810	$ 31,095,197	$ 20,991,618	$ 24,353,886
	Non-Labor	$ 16,905,215	$ 16,089,796	$ 20,161,391	$ 37,115,008
	Total	**$ 49,296,025**	**$ 47,184,993**	**$ 41,153,009**	**$ 61,468,894**
MMHNCC	Labor	$ 7,285,758	$ 8,283,679	$ 6,784,532	$ 7,735,836
	Non-Labor	$ 4,170,397	$ 4,048,589	$ 3,812,842	$ 3,666,558
	Total	**$ 11,456,156**	**$ 12,332,268**	**$ 10,597,374**	**$ 11,402,394**
MVH	Labor	$ 8,496,990	$ 8,909,159	$ 6,462,684	$ 8,330,112
	Non-Labor	$ 2,971,657	$ 2,900,827	$ 3,192,131	$ 2,813,495
	Total	**$ 11,468,647**	**$ 11,809,985**	**$ 9,654,815**	**$ 11,143,607**
IBC	Labor	$ 5,023,614	$ 3,729,758	$ 3,351,444	$ 2,403,021
	Non-Labor	$ 1,968,019	$ 1,112,781	$ 1,078,950	$ 3,499,952
	Total	**$ 6,991,632**	**$ 4,842,539**	**$ 4,430,394**	**$ 5,902,973**
MCDC	Labor	$ 3,700,778	$ 3,909,762	$ 3,182,655	$ 4,043,576
	Non-Labor	$ 1,304,630	$ 1,294,883	$ 1,307,663	$ 937,996
	Total	**$ 5,005,408**	**$ 5,204,645**	**$ 4,490,318**	**$ 4,981,572**
EMVH	Labor	$ 71,938	$ 69,664	$ 93,071	$ 58,960
	Non-Labor	$ 2,366,042	$ 3,043,592	$ 3,251,582	$ 3,184,515
	Total	**$ 2,437,981**	**$ 3,113,255**	**$ 3,344,653**	**$ 3,243,475**
SWMVH	Labor	$ -	$ 63,610	$ 101,269	$ 79,479
	Non-Labor	$ -	$ 59,802	$ 2,002,058	$ 2,959,376
	Total	$ -	**$ 123,412**	**$ 2,103,327**	**$ 3,038,855**
Grand Total		**$ 86,655,848**	**$ 84,611,098**	**$ 75,773,890**	**$ 101,181,770**

Assessment | Revenue at State Facilities: Three Year Snapshot

Revenue dropped for all facilities in FY22 – at MSH, this drop in revenue is largely explained by the CMS decertification in April 2022. With expenses, including traveler spend, on the rise, CMS recertification, renegotiating traveler staff contracts, and filling vacant FTE positions are critical pieces to improving the financial health of MSH.

Revenue by Payer Mix



Revenue as a % of Expenses

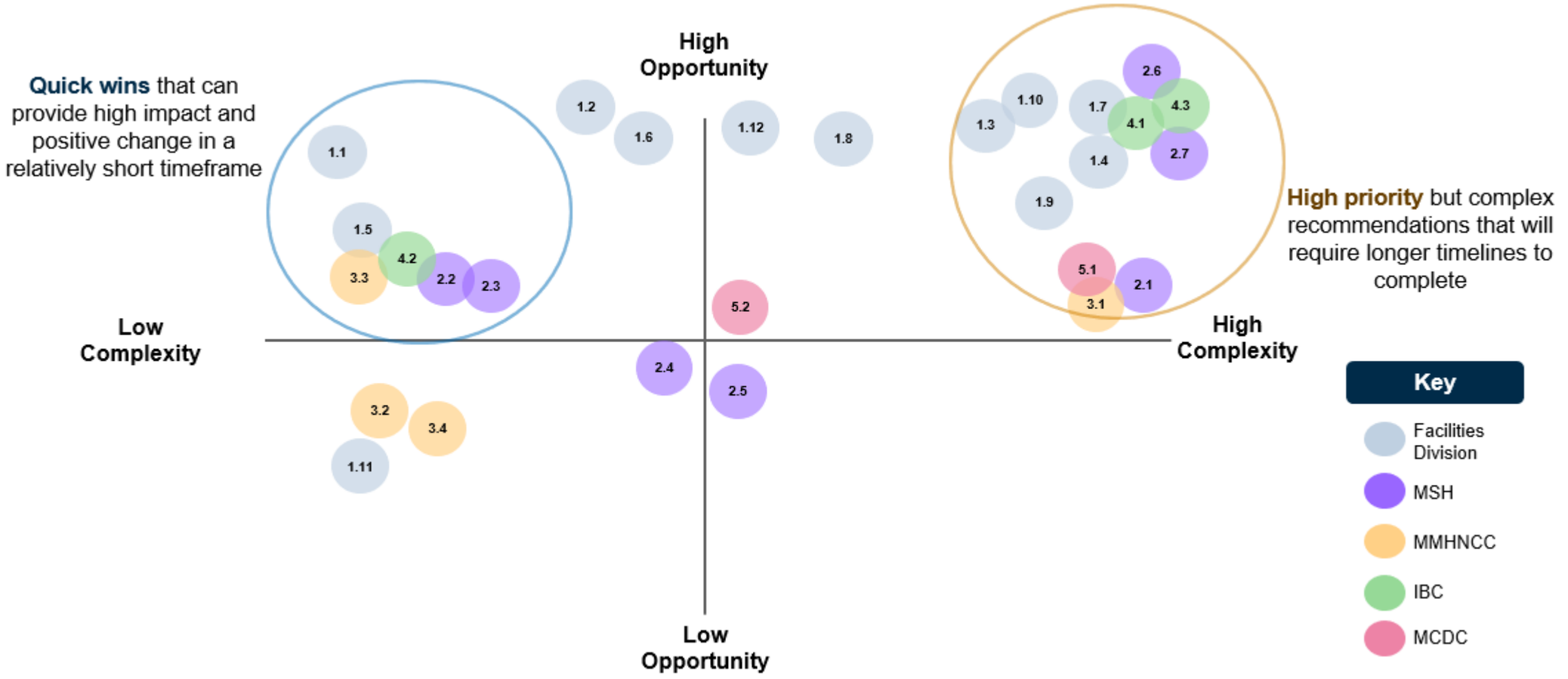
Facility	FY20	FY21	FY22
MSH	18%	24%	11%
MMHNCC	33%	57%	38%
MVH	44%	52%	31%
MCDC	42%	39%	29%
IBC	75%	2%	1%

Facility	FY	Insurance	Medicaid	Medicaid Expansion	Medicare	Part D	Private	Grand Total
MSH	2020	$ 643,048	$ 795,535	$ 135,074	$ 5,782,977	$ -	$ 1,216,111	**$ 8,572,744**
	2021	$ 698,181	$ 1,374,274	$ 175,829	$ 6,745,737	$ -	$ 1,000,526	**$ 9,994,548**
	2022	$ 1,260,733	$ 724,474	$ 66,745	$ 5,446,059	$ -	$ 1,374,494	**$ 8,872,505**
MMHNCC	2020	$ 23,691	$ 2,753,788	$ -	$ 17,976	$ 444,449	$ 769,700	**$ 4,009,603**
	2021	$ 625,063	$ 4,288,825	$ 20,315	$ 26,464	$ 316,377	$ 746,194	**$ 6,023,239**
	2022	$ 524,013	$ 3,634,076	$ -	$ 35,782	$ 275,195	$ 702,938	**$ 5,172,003**
MVH	2020	$ 23,763	$ 1,247,137	$ -	$ 224,548	$ 65,790	$ 3,607,726	**$ 5,168,964**
	2021	$ 13,341	$ 1,605,042	$ -	$ 235,406	$ 12,880	$ 3,081,337	**$ 4,948,006**
	2022	$ 30,396	$ 1,093,818	$ -	$ 375,745	$ 2,360	$ 2,487,275	**$ 3,989,594**
MCDC	2020	$ 22,618	$ 369,768	$ 1,778,936	$ 2,803	$ -	$ (2,310)	**$ 2,171,817**
	2021	$ 23,684	$ 309,509	$ 1,411,483	$ 1,042	$ -	$ 8,521	**$ 1,754,239**
	2022	$ 71,575	$ 341,425	$ 1,466,764	$ 2,396	$ -	$ 9,538	**$ 1,891,698**
IBC	2020	$ -	$ 3,520,415	$ -	$ -	$ -	$ 90,153	**$ 3,610,568**
	2021	$ -	$ -	$ -	$ -	$ -	$ 87,229	**$ 87,229**
	2022	$ -	$ -	$ -	$ -	$ -	$ 74,497	**$ 74,497**

Recommendations for Improvement

Recommendations | Summary of Prioritization

Our recommendations are prioritized based on the opportunity for impact they present and their level of complexity. Level of impact was measured by how significantly implementation of the recommendation would improve quality and delivery of care. Level of complexity was defined by the cost of implementation, length of implementation, stakeholder engagement needed, and obstacles to implementation (including public opinion).



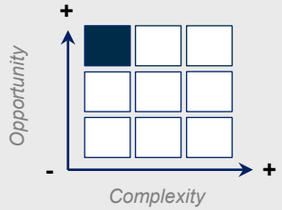
1.1 Healthcare Facilities Division | Stand Up Transformation Office

RECOMMENDATIONS

- Establish Transformation Management Office, which is a central project team that will oversee implementation of A&M's recommendations.
- Establish project governance and steering committee to provide oversight and accountability for results.
- Manage stakeholder engagement and input, including with state agencies, employees and bargaining unions, advocacy groups, provider associations, legislative committees, and patient families and guardians.
- Develop comprehensive communication and change management strategy including education for leaders to introduce / compare new solution and roadmap.

Benefits: Develop an organized, unified approach to the implementation of recommendations without duplicating efforts across projects.

PRIORITY



ESTIMATED IMPACT

	Accountability & Transparency
	$1.7MM
	None

CONSIDERATIONS

Risks	▪ Lack of sponsorship; lack of funding to implement recommendations
Dependencies	▪ N/A
Resources	▪ DPHHS leadership, temporary contract staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Identify team												
2	Stand up governance and steering committees												
3	Develop communications and change management plans												
4	Execute changes and regularly communicate with key stakeholder groups												
5	Develop plan to transition to operations												

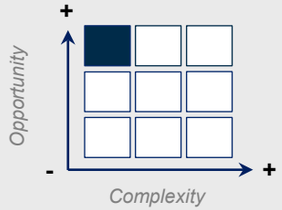
1.2 Healthcare Facilities Division | Hire Clinical and Operational Leadership

RECOMMENDATIONS

- Create new clinical and operational leadership positions, including: Deputy Chief Healthcare Officer, Chief Medical Officer, Chief Nursing Officer, Chief Clinical Officer, and two Quality Managers. Administrative support roles should also be created to support the leadership team.
- Conduct cost-benefit analysis to determine whether to hire as contracted services or as full-time employees.
- Implement matrixed reporting relationships so that physicians, nursing, operations, treatment, and quality programs, across all facilities, are supervised by new divisional leadership positions.
- Set roles and responsibilities and support changes in roles.

Benefits: New leadership will ensure a higher level of accountability, oversight, and transparency at the facilities, thus improving the quality of care provided.

PRIORITY



ESTIMATED IMPACT

Benefits	Accountability, Transparency, & Improved Delivery of Care
One Time Costs	None
Recurring Costs	$1.5MM

CONSIDERATIONS

Risks	▪ Difficulties attracting talent given pay
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or Human Resources

MONTHS

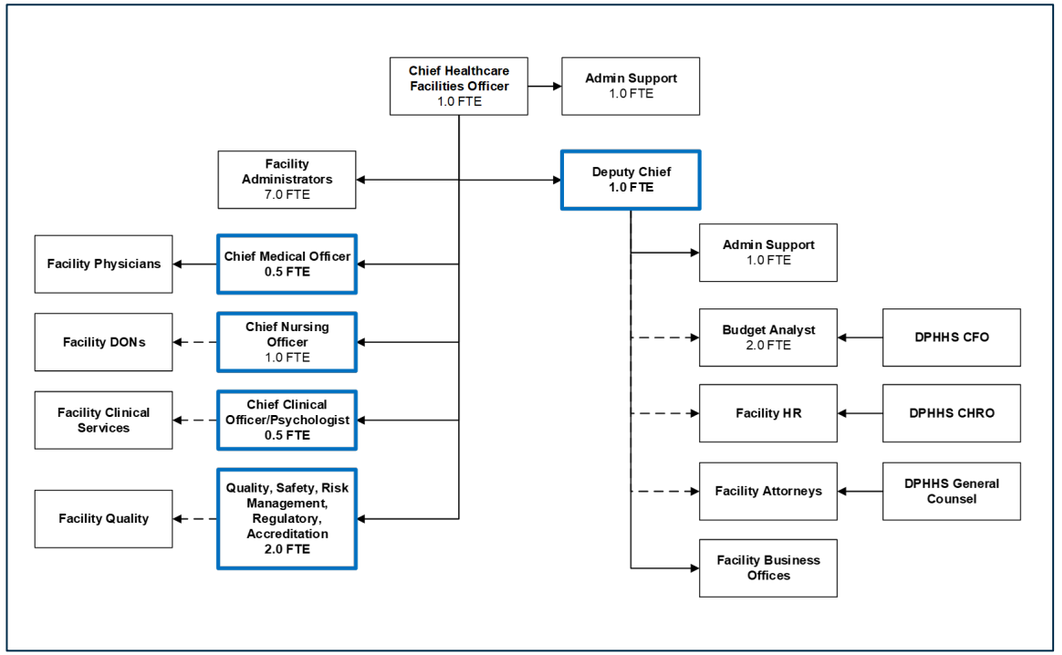
	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct cost-benefit analysis and determine whether to hire positions as contractors or full-time employees												
2	Develop job descriptions and post to the State's job board												
3	Conduct hiring and recruitment processes, or competitive procurement												
4	Realign facility reporting relationships to new clinical leadership positions as applicable												
5	Monitor performance												

1.2 Healthcare Facilities Division | Hire Clinical and Operational Leadership

Below are the recommended clinical leadership roles & responsibilities for the Healthcare Facilities Division.

Position	Roles and Responsibilities	Est. Annual Cost
Chief Medical Officer 0.5 FTE	▪ Oversees development, implementation, maintenance and enhancement of all clinical and medical services and programs, medical policies and procedures, and quality assurance programs and activities ▪ Provides leadership and direction for all for providers ▪ Supports medical staff peer review, credentialing, privileging, reviews of incidents, management of disciplinary actions	$350,000
Chief Nursing Officer 1.0 FTE	▪ Provides leadership to all nursing teams at the facilities ▪ Ensures level of care required by current medical and nursing standards	$136,000
Chief Clinical Officer 0.5 FTE	▪ Provides leadership to all treatment teams at the facilities ▪ Ensures treatment meets quality and safety	$63,000
Quality Program Managers 2.0 FTE	▪ Develops and oversees program quality metrics ▪ Supports risk management activities, including tasks related to regulatory requirements and accreditation	$215,000
Deputy Chief 1.0 FTE	▪ Oversees operations and back-office support improvements across all facilities ▪ Develops financial governance processes and ▪ Ensures compliance with federal and state laws	$136,000

Recommended Future State Division Structure



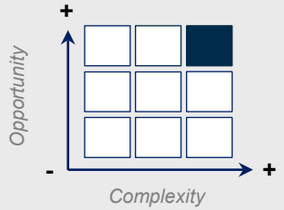
1.3 Healthcare Facilities Division | Optimize Clinical Services

RECOMMENDATIONS

- Develop minimum clinical staffing levels by facility, specialty, and function.
- Implement telemedicine by facility, specialty, and function. Telemedicine should include usage of tele-sitters to reduce costs of 1:1 supervision.
- Restructure clinical services across facilities, mix of in-person and remote.
- Develop bylaws as practice guidelines for psychotropic medication use.
- Build governance processes for: peer review, ongoing and focused professional practice Evaluation, credentialing, and privileging.
- Implement Medical Staff function to oversee governance processes.

Benefits: Improved patient outcomes due to adequate staffing levels with high quality clinical staff, increased oversight, and governance processes.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$250K
Recurring Costs	$750K

CONSIDERATIONS

Risks	▪ Difficulties attracting talent given pay
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or Human Resources

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct staffing analysis for each of the facilities, including recommendations												
2	Implement staffing changes and restructuring												
3	Build governance processes												

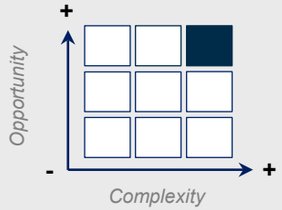
1.4 Healthcare Facilities Division | Implement an Electronic Health Records System

RECOMMENDATIONS

- Assess feasibility of EHRs options and conduct competitive procurement processes.
- Develop change management plan, including training plan, for implementation at facilities.
- Build implementation roadmap for facility rollout.
- Deploy EHRs at facilities.

Benefits: Higher quality and more efficient delivery of care, enable an integrated billing module, improve data quality, and an ability to use data to improve patient outcomes.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Delivery of Care
One Time Costs	$20MM
Recurring Costs	$2.2MM

CONSIDERATIONS

Risks	▪ Difficulties with implementation due to challenges with IT infrastructure at facilities
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or IT

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12+
1	Feasibility assessment												
2	Competitive procurement processes												
3	Deploy EHRs at facilities												24 months

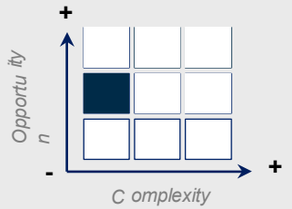
1.5 Healthcare Facilities Division | Implement Competency-Based Job Descriptions

RECOMMENDATIONS

- Update job descriptions so that they include the expected level of performance (knowledge, skills, abilities, and judgment) for clinical roles.
- Require new employees to demonstrate their competency prior to starting their first shift, and require existing employees to re-demonstrate their competency on an annual basis. Competency should be routinely measured and documented.
- Provide additional education and training to employees so that they can become competent in their job.
- Update facility policies and procedures as required to support competency-based job descriptions.

Benefits: Improved patient safety and outcomes due to highly competent employees vetted through defined job competencies.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Safety and Outcomes
One Time Costs	$350K
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Difficulties attracting talent given pay
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or Human Resources

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Review all job descriptions for care delivery across entire system, e.g., CNAs, RNs, etc.												
2	Convert job descriptions to competency-based job descriptions, e.g., demonstrate competency in basic life support, individualized care plans, patient transfers												
3	Revise facility policies and procedures												
4	Support HR process to move employees to updated competency-based job descriptions, socialization with unions												
5	Facilitate job skills day via train-the-trainer model												

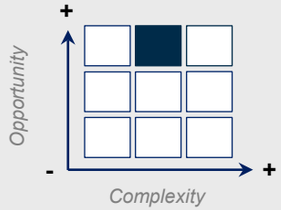
1.6 Healthcare Facilities Division | Improve Training and Learning Management

RECOMMENDATIONS

- Establish a governance system to oversee training programs and implement a learning management system to improve training compliance, career tracking, etc.

Benefits: Higher staff retention due to professional development opportunities, as well as increased staff performance.

PRIORITY



ESTIMATED IMPACT

Benefits	Better Staff Performance and Increased Staff Retention
One Time Costs	$1MM
Recurring Costs	$500K

CONSIDERATIONS

Risks	▪ Difficulties with implementation due to challenges with IT infrastructure at facilities
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or IT

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct competitive procurement process												
2	Develop roadmap for implementation												
3	Deploy LMS at facilities												
4	Establish governance structure for training and learning management												

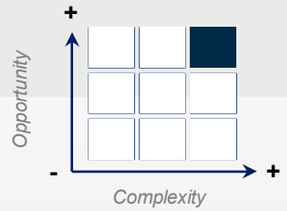
1.7 Healthcare Facilities Division | Conduct Hiring Blitz

RECOMMENDATIONS

- Update recruitment strategies and conduct a hiring blitz for Registered Nurses, Certified Nursing Assistants, Psychiatric Technicians, and Direct Support Professional positions.
- Investigate options for increasing the pool of applicants, including: hiring and referral bonuses; a career pipeline for high school and college students; apprenticeship programs; or teaching hospital designations.
- Contract with recruitment firms to assist with hiring of clinical staff.

Benefits: Improved patient outcomes due to lower vacancies at facilities, adequate staffing levels, and increased number of nurses and direct service professionals.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$512K for Bonuses $250K for Recruiters
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Difficulties attracting talent given pay
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or Human Resources

	HIGH LEVEL ACTIVITIES	MONTHS 1	2	3	4	5	6	7	8	9	10	11	12
1	Assess priority positions for hiring across facilities												
2	Develop recruitment and marketing plans for each facility												
3	Identify high-impact recruitment advertising opportunities												
4	Work with key stakeholders, including external recruiters, facilities HR teams, and internal DPHHS HR team, to develop and implement hiring blitz												
5	Assess feasibility of additional hiring and pipeline opportunities												

1.7 Healthcare Facilities Division | Conduct Hiring Blitz

As part of a hiring blitz, the Healthcare Facilities Division should investigate the feasibility of providing hiring and referral bonuses. Below is a recommended structure for these bonuses along with a conservative cost estimate model.

Hiring Bonuses:
Provided to hires in high-priority vacancies and positions (RNs, CNAs, DSPs, and Psych Techs) **two months** into their position.

Recommended amount: $1,500 one-time bonus
Est. cost: : **$426,000**
- 258 priority vacancies in August 2022 (see table on right)
- $1,500 for each position
- 10% buffer + rounded up

Referral bonuses:
Provided to any employee under DPHHS who refers a candidate that is successfully hired to a high-priority vacancy so long as the new hire remains in the position for at least **two months.**

Recommended amount: $1,000 one-time bonus
Est. cost: $86,000
- Assume 30% of hires to 258 vacancies are successful referrals
- $1,000 for each referral
- 10% buffer + rounded up

Retention bonuses:
The feasibility of retention bonuses should be assessed given potential constraints with union CBAs and performance evaluation criteria at facilities (see recommendation 1.12)

Recommended amount: $500 for employees who remain for 1 year in their role, assuming high performance
Est. cost: TBD, heavily relies on assumptions

Top 5 Vacant Positions across Facilities: August 2022

Position	# of Vacancies	% of Total Vacancies
Psychiatric Technician	111	31.1%
Registered Nurse (RN)	47	13.2%
Certified Nurse Aide (CNA)	46	12.9%
Direct Support Professional	32	8.9%
Psychiatric Technician FMHT	22	6.2%

Est. Total for Hiring and Referral Bonuses:
$512,000

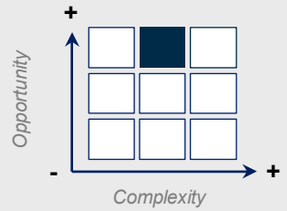
1.8 Healthcare Facilities Division | Consolidate Temporary Staffing Contracts

RECOMMENDATIONS

- Consolidate temporary contracted services spend and recompete staffing contracts to reduce costs and complexity of administration.

Benefits: Facilities cost savings due to consolidated spend and reduced rates for temporary healthcare staffing.

PRIORITY



ESTIMATED IMPACT

Benefits	Increased facilities cost savings
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Complications surrounding prolonged and contentious negotiations
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or Human Resources

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Meet with key stakeholders to discuss goals for staffing contract negotiations												
2	Conduct staffing contract negotiations and recompetes												

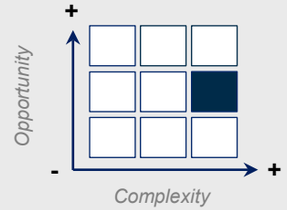
1.9 Healthcare Facilities Division | Establish Financial Accountability and Governance

RECOMMENDATIONS

- Implement active budget, contract, and revenue management processes to control costs.
- Realign reporting structure so that finance and accounting staff report to the agency's CFO.
- Re-baseline facility budgets, especially MSH, so that budgets reflect the actual operational costs.
- Create goals for the next five fiscal years to improve the financial stability of the facilities.

Benefits: Improved financial stability at facilities, risk management, accountability, governance, and transparency.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved financial stability at facilities
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Upfront costs to establish governance along with recommendations to get facilities on track may be high
Dependencies	▪ Success of other fiscal recommendations, including 1.8
Resources	▪ Facilities leaders, Budget team

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Develop budget policies & procedures for each of the facilities												
2	Establish governance structure for facility financial controls, including – budget review processes, reporting cadence, and oversight												
3	Set goals for the next five fiscal years for each of the facilities to move towards financial stability												

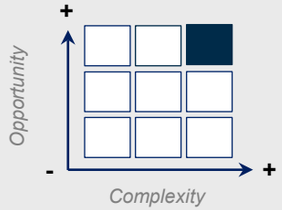
1.10 Healthcare Facilities Division | Staff to Acuity and Need

RECOMMENDATIONS

- Update staffing plans so that facilities are staffed to acuity, census, and need.
- Use benchmarks to inform staffing levels and comparison
- Create staffing model to adjust staffing as demand and needs change in the future.

Benefits: Improved patient outcomes due to adequate staffing levels, where staff can most efficiently provide care.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Difficulties attracting talent given pay
Dependencies	▪ Approval of funding, Union CBAs
Resources	▪ Facilities leaders

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct staffing analysis for each of the facilities, including recommendations on staffing need												
2	Implement staffing changes and restructuring												
3	Develop staffing model to be used if future adjustments are needed to staffing levels												

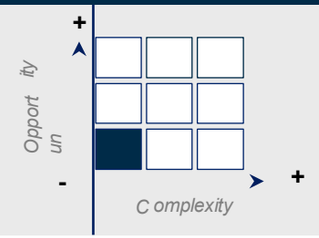
1.11 Healthcare Facilities Division | Improve Therapeutic Environment

RECOMMENDATIONS

- Purchase furnishings and other physical assets for all state-run healthcare facilities to improve therapeutic environment and ensure appropriate infection control efforts are occurring.

Benefits: Improved patient outcomes due to a more comfortable, safe, and welcoming therapeutic environment.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$500K
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Supply chain and budget issues can impact purchasing
Dependencies	▪ Approval of funding
Resources	▪ Facilities leaders, State Procurement

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Assess facility needs regarding physical assets, infrastructure, and furnishings												
2	Conduct procurement processes to order furnishings												

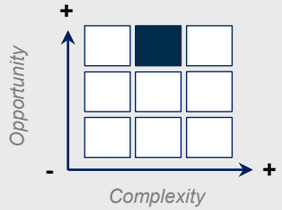
1.12 Healthcare Facilities Division | Increase Wages

RECOMMENDATIONS

- Increase wages to market rates to help recruit and retain employees.
- Work heavily with stakeholders across Montana government to gain approval for and implement wage increases.

Benefits: Improved patient outcomes due to lower staff turnover, higher employee satisfaction, and higher retention rates.

PRIORITY



ESTIMATED IMPACT

Benefits	Higher Employee Satisfaction and Retention
One Time Costs	$9.4M increase in FY24 labor costs
Recurring Costs	$2 – 3M increase for cost of living adjustments annually (COLA)

CONSIDERATIONS

Risks	▪ Need for consensus across various state government entities
Dependencies	▪ Approval of funding, union CBAs, agreement from key stakeholders
Resources	▪ State Procurement and/or Human Resources

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
		MONTHS											
1	Work with key stakeholders, including Human Resources, the legislature, unions, and others to determine feasible increases to wages and bonuses												
2	Develop pay scales for each of the positions												
3	Roll out wage increases and bonuses												

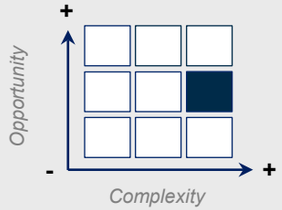
2.1 MSH | Close Spratt

RECOMMENDATIONS

- Make interim life safety improvements at unit to address existing deficiencies.
- Close the geriatric psychiatric unit at MSH (“Spratt Unit”).
- Discharge current patients to Montana Mental Health Nursing Care Center and community providers.
- Conduct assessment to determine whether to repurpose these beds for hospital use.

Benefits: Improved patient outcomes due to better placement based on person-centered planning and needs.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$2.5MM
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Logistical barriers to transitioning patients out of Spratt and closing the facility
Dependencies	▪ Approval of funding
Resources	▪ MSH CEO, social workers

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Stand up a transition team at the facility to manage the transition process												
2	Assess all patients at Spratt, including an assessment of their acuity, programmatic and person-centered needs												
3	Communicate with families to incorporate their input into transition planning												
4	Locate available transition facilities and develop comprehensive transition plans												
5	Transition patients and close down Spratt												

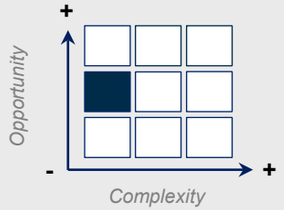
2.2 MSH | Implement Case Management

RECOMMENDATIONS

- Implement case management model to prepare patients for discharge on admission and based on their projected length of stay and acuity.
- Assess alternatives for case management models and select most appropriate model for facility.
- Train staff on case management policies and procedures.

Benefits: Better patient outcomes due to more efficient, person-centered discharge policies that are matched to need and acuity. Recertification will allow the state to receive approximately $8M per year in federal dollars to the general fund.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$300K
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Delays in other improvement initiatives at MSH pushing out implementation
Dependencies	▪ Consensus on appropriate case management model to use
Resources	▪ Facilities leaders and clinical staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Provide training to facilities staff on person-centered planning and case management model best practices												
2	Create case management policies & procedures												

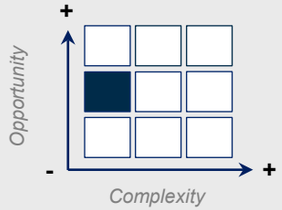
2.3 MSH | Restructure Patient Placement

RECOMMENDATIONS

- Restructure patient placement by acuity and their individual needs so that highest levels of care are provided in A and Galen.
- Develop admission and discharge criteria. Staff to acuity, census, and need within the restructured units.
- Reduce restrictions on units with lower acuity.
- Structure step down units through B, D, E, Spratt, and group homes to improve care delivery.

Benefits: Improved patient outcomes due to better milieu and placement based on person-centered planning and needs.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Logistical barriers to restructuring patient placements
Dependencies	▪ N/A
Resources	▪ Facilities leaders and clinical staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Assess all patients, including assessment of their acuity, programmatic, and person-centered needs												
2	Identify appropriate patient placement settings												
3	Develop comprehensive transition plans												
4	Transition patients												

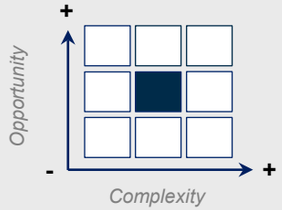
2.4 MSH | Refine Delivery of Active Treatment

RECOMMENDATIONS

- Develop appropriate policy for delivery of active treatment.
- Restart therapeutic programming impacted by the pandemic.
- Identify activities for patients to participate during the day and night as appropriate to their need – including activities within the community.

Benefits: Improved patient outcomes as a result of person-centered treatment and planning, as well as an increased focus on community activities that better prepare patients for community integration.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$300K
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Quality control and treatment oversight
Dependencies	▪ Chief Medical Officer position hire, implementation of medical staff function
Resources	▪ Facilities leaders and clinical staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Assess all patients, including assessment of their acuity, programmatic, and person-centered needs												
2	Develop active treatment policies & procedures and identify appropriate activities for patients, including community activities												
3	Train clinical staff on new policies for delivery of active treatment												
4	Implement active treatment delivery adjustments												

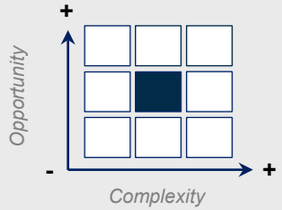
2.5 MSH | Change Forensic Statutory Criteria for Admission

RECOMMENDATIONS

- Change forensic statutory criteria at MCA 46-14 for admission and discharge to mirror civil statutory criteria at MCA 53-21 so that MSH is not required to accept patients that do not meet the new criteria.

Benefits: Better delivery of care at MSH so that the facility can treat patients that are best suited to the facility, ensuring patients are placed in environments most conducive to their needs.

PRIORITY



ESTIMATED IMPACT

Benefits	Increase MSH efficiency in care delivery
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Legislative barriers and need to build consensus
Dependencies	▪ Legislative approval
Resources	▪ Legal team, legislators

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct legislative analysis for changes needed												
2	Work and negotiate with key stakeholders to make legislative rule changes												

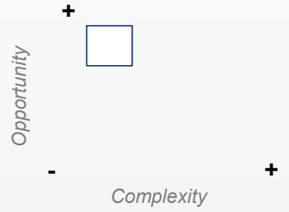
2.6 MSH | Achieve CMS Compliance and Seek Recertification

RECOMMENDATIONS

- Seek CMS re-certification over the next 2 years and then CARF or Joint Commission accreditation to improve quality oversight.
- Develop corrective action plans to respond to CMS survey findings.
- Support MSH with ongoing continued compliance efforts and risk management.

Benefits: Improved patient outcomes and more efficient management of the facility as a result of measures taken to comply with CMS regulations and seek re-certification. Increases the financial sustainability of MSH by bringing back federal funding associated with CMS certification.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes and Facilities Management
One Time Costs	$10MM
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Failure due to lack of preparedness, extending the timeline significantly
Dependencies	▪ N/A
Resources	▪ State Procurement and/or Human Resources

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12+
1	Perform a high-level assessment to determine the required time, resources, and financial support that will be needed to reattain CMS certification												
2	Conduct a high-level assessment to verify that the hospital complies, or does not comply, with the CoPs and the State requirements for the mandatory standards along with the degree, or severity, of any findings and produce a gap analysis												
3	Work with the facility to develop a corrective action plan												
4	Facilitate application process to CMS for recertification												
5	Develop corrective action plans as required to respond to CMS survey findings												

Approximately 24 months

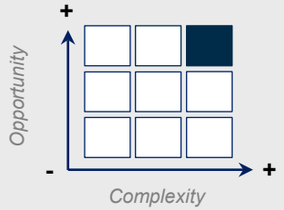
2.7 MSH | Right-size Capacity

RECOMMENDATIONS

- Improve Montana's long-term delivery of care by building two new, regional, private behavioral healthcare settings that complement and support MSH and the other state-run facilities in large population areas.
- Collaborate with relevant government stakeholders to improve mental health and restoration of competency services within jails, providing access to these services quicker and at a lower cost than placement at MSH, which currently has a long waitlist.

Benefits: Increased access to care in underserved, high-population region and improved delivery of care in critical settings. Address the shortage of beds across the state.

PRIORITY



ESTIMATED IMPACT

Benefits	Increased access to behavioral health care
One Time Costs	$84M
Recurring Costs	$37M in operating costs

CONSIDERATIONS

Risks	▪ Long-term process with several key junctures that may cause delays
Dependencies	▪ Approval of funding
Resources	▪ State Procurement, Facilities team, Architecture & Engineering (A&E) team

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct feasibility assessment to determine the most effective location for the new facilities												
2	Conduct competitive procurement activities for any needed contracting services												
3	Roll out plan to construct facilities												

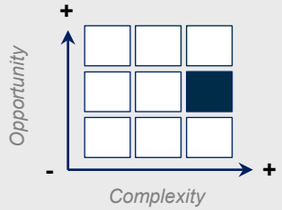
3.1 MMHNCC | Build Out Secured Memory Unit

RECOMMENDATIONS

- Build out infirmary, including purchasing of beds and furniture, as secured memory unit to receive patients from Spratt.
- Obtain updated long term care license to account for increase in beds, including CMS licensure.
- Increase capacity at MMHNCC to support more complex cases.

Benefits: Improve patient outcomes through more appropriate placement of patients and person-centered planning practices.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$500K
Recurring Costs	TBD

CONSIDERATIONS

Risks	▪ Logistical barriers to transitioning patients out of Spratt and closing the facility
Dependencies	▪ Approval of funding
Resources	▪ State Procurement, Facilities leaders

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Stand up a transition team at the facility to manage the transition process												
2	Prepare MMHNCC to receive patients from Spratt, including staff and facility changes needed												
3	Transition patients based on the comprehensive transition plans												

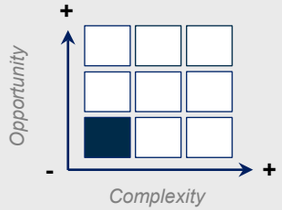
3.2 MMHNCC | Implement Person-Centered Standards of Practice

RECOMMENDATIONS

- Update standards of practice and ordering protocols to meet each patient's programmatic and person-centered needs.
- Train staff in person-centered thinking.
- Develop person-centered plans for current patients and policies for future person-centered plan development.

Benefits: Improved patient outcomes through a focus on person-centered vs. programmatic planning, increasing stability of the facility and policies to ensure appropriate patient placement.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	$200K
Recurring Costs	None

CONSIDERATIONS

Risks	▪ N/A
Dependencies	▪ Appropriate staffing levels and staff skill mix
Resources	▪ Facilities leaders and clinical staff

	HIGH LEVEL ACTIVITIES	MONTHS 1	2	3	4	5	6	7	8	9	10	11	12
1	Assess patients using person-centered thinking methods												
2	Provide training to facilities staff on person-centered planning and best practices												
3	Create person-centered planning policies & procedures												

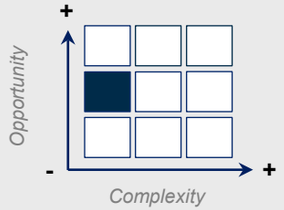
3.3 MMHNCC | Improve End-Of-Life Care Policies

RECOMMENDATIONS

- Contract with licensed hospice organization and develop end-of-life care policies aligned to modern practices.
- Assess patient end-of-life care needs and update care plans to align with best practices and findings.
- Develop policies & procedures aligned with best practices.
- Train staff in appropriate end-of-life care practices.

Benefits: Improved patient outcomes through updating and modernizing care practices to emphasize compassionate, person-centered end-of-life care.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	None
Recurring Costs	$150K

CONSIDERATIONS

Risks	▪ N/A
Dependencies	▪ Timeliness of contracting processes
Resources	▪ Facilities leaders and clinical staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct competitive procurement process to contract with a licensed hospice organization, as needed												
2	Assess patients end-of-life care needs using person-centered planning methods												
3	Provide training to facilities staff on person-centered planning and best practices												
4	Refine and modernize end-of-life care policies & procedures												

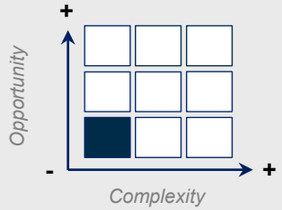
3.4 MMHNCC | Restructure Staffing Hierarchy

RECOMMENDATIONS

- Restructure operations to improve communications and patient outcomes.
- Assess existing staff hierarchy for areas of opportunity and efficiency in organization.
- Seek staff input in restructuring.

Benefits: Improved patient outcomes through updating and modernizing care practices to emphasize compassionate, person-centered end-of-life care.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Staff Outcomes and Facility Management
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Employee turnover if unhappy with changes
Dependencies	▪ Union CBAs, staffing levels and skills mix
Resources	▪ Human Resources

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct staffing assessment, including reviewing exit interviews and staff job descriptions												
2	Develop recommendations for staff restructuring and work with stakeholders to refine												
3	Implement staff restructuring												

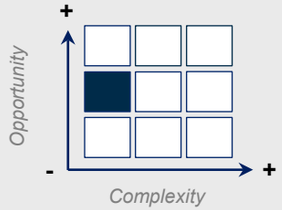
3.5 MMHNCC | Improve Admissions and Discharge Process

RECOMMENDATIONS

- Develop person-centered admissions and discharge policies to prepare patients for discharge on admission and based on their projected length of stay and acuity.
- Train staff on procedures.

Benefits: Better patient outcomes due to more efficient, person-centered discharge policies that are matched to need and acuity.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Patient Outcomes
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Delays in other improvement initiatives at MSH pushing out implementation
Dependencies	▪ Consensus on appropriate model to use
Resources	▪ Facilities leaders and clinical staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Provide training to facilities staff on person-centered planning and best practices												
2	Create policies & procedures												

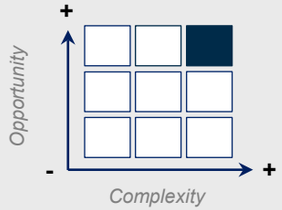
4.1 IBC | Improve Quality of Care

RECOMMENDATIONS

- Bring in an experienced interim facility administrator to generate immediate improvement, aligning practices with federal ICF regulations. Consider hiring an experience private vendor to manage the facility, leading to rapid stabilization and improvement.
- Improve quality of care with more active treatment, modernized treatment plans, enhanced treatment areas, and improve integration within the local community.
- Update policies and procedures based on National Association for the Dually Diagnosed (NADD) standards.

Benefits: Improved client outcomes due to improvement of treatment practices and updated policies and procedures rooted in best practices and nationally-recognized, data-driven policy.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Client Outcomes
One Time Costs	$500K
Recurring Costs	None[1]

CONSIDERATIONS

Risks	▪ Loss of existing staff not interested in making the transition
Dependencies	▪ Locating an experienced contractor/organization
Resources	▪ Facilities leaders and clinical staff, some investment in facility

	HIGH LEVEL ACTIVITIES	MONTHS 1	2	3	4	5	7	8	9	10	11	12
1	Bring in an interim facility administrator											
2	Assess all clients, including an assessment of their acuity, programmatic, and person-centered needs											
3	Develop active treatment policies & procedures, update treatment plans, and introduce new tools to monitor program integrity											
4	Train staff on new policies for delivery of active treatment											
5	Implement active treatment delivery adjustments											
6	Update remaining policies & procedures based on best practices from NADD											
7	Consider a contract to bring in an organization experienced with management and successful operation of a short-term, intensive treatment facility, licensed as an ICF/IID											

[1]Recurring costs offset by funds typically directed to state operation of IBC.

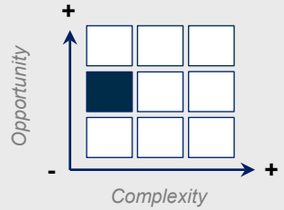
4.2 IBC | Implement Person-Centered Discharge Processes

RECOMMENDATIONS

- Update the discharge planning process to include person-centered practices (e.g., Charting the LifeCourse) and active transition planning with the provider community.

Benefits: Improved client outcomes through a focus on person-centered vs. programmatic planning, increasing stability of the facility and policies to ensure appropriate patient placement.

PRIORITY



ESTIMATED IMPACT

Benefits	Increase Community Integration
One Time Costs	$100K
Recurring Costs	None

CONSIDERATIONS

Risks	▪ N/A
Dependencies	▪ Appropriate staffing levels and staff skill mix
Resources	▪ Facilities leaders and clinical staff

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Assess clients using Charting the LifeCourse tools (e.g., Vision Tool, Life Trajectory)												
2	Update individual plans to include results from person-centered planning assessment built around Charting the LifeCourse												
3	Provide training to facilities staff on person-centered planning and best practices												
4	Create person-centered planning policies & procedures												

4.3 IBC | Transition to New, Private Facility

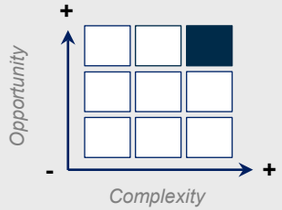
RECOMMENDATIONS

Implement an intensive community alternative to IBC over next 2-3 years, allowing for replacement of the current facility in Boulder with a new facility located within a proximate population center.

- Create a small, effective, alternate and more home-like care setting for individuals with I/DD that need a higher level of support.

Benefits: Moving from a publicly-run ICF/DD to a privately-managed ICF/IID will result in increased accountability, increased quality of services being delivered, decreased cost, and the ability to serve more individuals with complex needs.

PRIORITY



ESTIMATED IMPACT

Benefits	Improved Client Outcomes and Facility Management, Obtain Federal Match
One Time Costs	$10MM[1]
Recurring Costs	$7.5MM (limited net impact to GF if IBC sunsets)

CONSIDERATIONS

Risks	▪ Long-term process with several key junctures that may cause delays
Dependencies	▪ Approval of funding, consensus building with key stakeholders
Resources	▪ State Procurement, Facilities team, Architecture & Engineering (A&E) team

MONTHS

HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12+
1 Conduct feasibility assessment to determine the most effective location for the new facilities												
2 Conduct competitive procurement activities for any needed contracting services												
3 Plan, design, and build alternative location												Over 18 – 30 months

Additional, longer-term activities:

- Assess clients and develop comprehensive transition plans
- Transition clients to new facility
- Operate and certify new location as an ICF/IID

[1] Cost dependent on use of an existing facility vs. a new facility

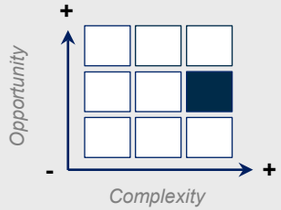
5.1 MCDC | Reevaluate Number of Beds

RECOMMENDATIONS

- Reevaluate need for acute beds within the substance use disorder continuum of care.
- Assess demand across the state network, including by location, to right-size beds at MCDC.

Benefits: More cost-efficient facility management and reduced costs to the state by right-sizing the number of beds based on the demand across the state-wide network.

PRIORITY



ESTIMATED IMPACT

Benefits	Reduce Cost to State
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ Need for consensus among stakeholders
Dependencies	▪ Approval of funding
Resources	▪ State Procurement and/or Human Resources

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct feasibility assessment to determine best option for MCDC facility and patients												
2	Develop comprehensive transition plans												
3	Implement transition plans												

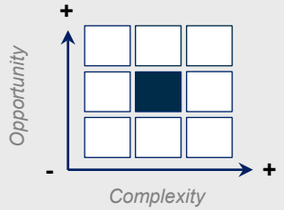
5.2 MCDC | Increase Average Daily Census

RECOMMENDATIONS

- Receive patients in facility double rooms.
- Update criteria for admission and discharge to allow for comorbidities and placement within 48 hours.
- Assess census and demand trends to identify other areas of opportunity, including engaging with providers and community partners.

Benefits: Better quality care and more effective delivery of treatment by taking full advantage of MCDC's capacity to serve.

PRIORITY



ESTIMATED IMPACT

Benefits	Improve Quality and Effectiveness of Care
One Time Costs	None
Recurring Costs	None

CONSIDERATIONS

Risks	▪ N/A
Dependencies	▪ N/A
Resources	▪ Facility leaders

MONTHS

	HIGH LEVEL ACTIVITIES	1	2	3	4	5	6	7	8	9	10	11	12
1	Conduct patient assessments and transition plans to determine which patients should be moved												
2	Assess current waitlist and develop plans to receive patients												
3	Revise facility policies and procedures												

Appendix

Appendix A | Geographic Detail: Montana State Hospital Admissions by Commitment Type, July 2021 to June 2022

Below is a breakdown of the commitment types over a year-long period at MSH, including additional data showing a breakdown of commitments by the top 10 counties in Montana.

Commitment	Commit Type	Admissions	Average Length of Stay (Days)
Court Ordered Detention	Civil	408	33
Involuntary 90 Day	Civil	179	53
Tribal	Tribal	84	21
Unfit to Proceed	Forensic	57	153
Court Ordered Evaluation	Forensic	36	152
Guilty But Mentally Ill	Forensic	12	190
Emergency Detention	Civil	11	31
Pre-Sentence Evaluation	Forensic	6	268
Institutional Transfer	Transfer	1	154
10 Day Inter-Institutional Transfer	Transfer	1	9
Not Guilty Mentally Ill	Forensic	1	289
Subtotals	**Civil**	**598**	**40**
	Forensic	**112**	**168**
	Tribal	**84**	**21**
	Transfer	**2**	**85**
Total	**All**	**796**	**55**[1]

Top 10 Counties	Admissions by Commitment Type				Total Admissions	Population Size (in 1000s)
	Civil	Forensic	Tribal	Transfer		
Missoula	140	28			168	119
Silver Bow	108	7			115	35
Yellowstone	85	11		1	97	160
Glacier	3		60		63	14
Gallatin	61	1			62	111
Lewis & Clark	37	7			44	69
Cascade	20	18			38	82
Flathead	23	3			26	102
Deer Lodge	19	4			23	9
Ravalli	17	5			22	43
Lake	15	6	1		22	30

[1] The average length of stay total was calculated as a weighted average based on the proportion of admissions of that commitment type to the total number of admissions at MSH

Appendix B | Behavioral Health Providers in Montana Today

Name	Address	City	State	Zip	County	Provider Type
3 Rivers Mental Health Solutions	715 Kensington Avenue	Missoula	MT	59801	Missoula	Residential/24-hour residential
AWARE Inc Great Falls	600 6th Street NW	Great Falls	MT	59404	Cascade	Residential/24-hour residential
AWARE Inc Helena	616 Helena Avenue	Helena	MT	59601	Lewis and Clark	Outpatient
AWARE Inc Billings	1050 South 25th Street West	Billings	MT	59102	Yellowstone	Residential/24-hour residential
AWARE Inc	2300 Regent Street	Missoula	MT	59801	Missoula	Residential/24-hour residential
Big Timber Mental Health Center Office	515 Hooper Street	Big Timber	MT	59011	Sweet Grass	Outpatient
Billings Clinic	2950 10th Avenue North	Billings	MT	59101	Yellowstone	Hospital inpatient/24-hour hospital inpatient
Bitterroot Valley Educ Cooperative	300 Park Street	Stevensville	MT	59870	Ravalli	Outpatient
Braided Circle	1500 Colburn Road	Billings	MT	59102	Yellowstone	Residential/24-hour residential
Center for Mental Health Largent Outpatient Services	915 1st Avenue South	Great Falls	MT	59401	Cascade	Outpatient
Center for Mental Health New Directions Center	621 1st Avenue South	Great Falls	MT	59401	Cascade	Partial hospitalization/day treatment
Center for Mental Health	900 Jackson Street	Helena	MT	59602	Lewis and Clark	Outpatient
Center for Mental Health Choteau Center for Mental Health	1 Main Avenue South	Choteau	MT	59422	Teton	Outpatient
Center for Mental Health Conrad Center for Mental Health	514 South Front Street	Conrad	MT	59425	Pondera	Outpatient
Center for Mental Health Havre Center for Mental Health	312 3rd Street	Havre	MT	59501	Hill	Outpatient
Columbus Mental Health Center	2125 8th Avenue North	Billings	MT	59101	Stillwater	Outpatient
Eastern Montana CMHC Forsyth Office	121 North 11th Avenue	Forsyth	MT	59327	Rosebud	Outpatient
Eastern Montana CMHC Glasgow Office	1009 6th Avenue North	Glasgow	MT	59230	Valley	Outpatient
Eastern Montana CMHC Miles City Office	2508 Wilson Street	Miles City	MT	59301	Custer	Residential/24-hour residential
Eastern Montana CMHC Wolf Point Office	124 Custer Street	Wolf Point	MT	59201	Roosevelt	Outpatient
Eastern Montana CMHC	507 North Lincoln Street	Broadus	MT	59317	Powder River	Outpatient
Eastern Montana CMHC Glendive Office	2016 North Merrill Street	Glendive	MT	59330	Dawson	Residential/24-hour residential
Eastern Montana CMHC Substance Abuse	10 West Fallon Avenue	Baker	MT	59313	Fallon	Outpatient
Eastern Montana CMHC Sidney Office	1201 West Holly Street	Sidney	MT	59270	Richland	Outpatient
Eastern Montana CMHC Abuse and Dependency Services	100 West Laurel Street	Plentywood	MT	59254	Sheridan	Outpatient
Gallatin Mental Health Center Hope House	701 Farmhouse Lane	Bozeman	MT	59715	Gallatin	Residential/24-hour residential
Intermountain Community Services	3240 Dredge Drive	Helena	MT	59602	Lewis and Clark	Outpatient
New Day Ranch Inc	5351 King Avenue West	Billings	MT	59101	Yellowstone	Residential/24-hour residential
New Day Ranch Inc Mental Health Center	1724 Lampman Drive	Billings	MT	59101	Yellowstone	Partial hospitalization/day treatment
New Day Ranch Inc	1111 Coburn Road	Billings	MT	59101	Yellowstone	Residential/24-hour residential
Providence Saint Joseph Medical Ctr	6 Thirteenth Avenue East	Polson	MT	59860	Lake	Outpatient
Providence Saint Patrick Hospital	902 North Orange Street	Missoula	MT	59802	Missoula	Hospital inpatient/24-hour hospital inpatient
PureView Health Center	1930 9th Avenue	Helena	MT	59601	Lewis and Clark	Outpatient
Riverfront Mental Health Center West House	1404 Westwood Drive	Hamilton	MT	59840	Ravalli	Residential/24-hour residential
Roundup Satellite Mental Health Ctr	26 West Main Street	Roundup	MT	59072	Musselshell	Outpatient

Appendix B | Behavioral Health Providers in Montana Today

Name	Address	City	State	Zip	County	Provider Type
Safe Haven Home Women and Children	2115 Canyon Drive	Billings	MT	59101	Yellowstone	Residential/24-hour residential
Shodair Childrens Hospital	2755 Colonial Drive	Helena	MT	59601	Lewis and Clark	Hospital inpatient/24-hour hospital inpatient
South Central Montana Reg MH Center Red Lodge MH and Addiction Office	10 Oakes Street South	Red Lodge	MT	59068	Carbon	Outpatient
South Central Montana Regional MHC Lewistown	212 Wendell Street	Lewistown	MT	59457	Fergus	Outpatient
South Central Montana Regional MHC Journey Recovery Program	1245 North 29th Street	Billings	MT	59101	Yellowstone	Outpatient
St Peters Health Behavioral Health Unit	2475 East Broadway Street	Helena	MT	59601	Lewis and Clark	Hospital inpatient/24-hour hospital inpatient
Western Montana Mental Health Center Missoula Adult Services	1315 Wyoming Street	Missoula	MT	59801	Missoula	Partial hospitalization/day treatment
Western Montana Mental Health Center Child and Family Services Network	1305 Wyoming Street	Missoula	MT	59801	Missoula	Outpatient
Western Montana Mental Health Center Lake House Crisis Facility	7 13th Avenue East	Polson	MT	59860	Lake	Residential/24-hour residential
Western Montana Mental Health Center Sanders County Mental Health Center	602 Preston Avenue	Thompson Falls	MT	59873	Sanders	Outpatient
Western Montana Mental Health Ctr Gallatin Mental Health Center	699 Farmhouse Lane	Bozeman	MT	59715	Gallatin	Partial hospitalization/day treatment
Western Montana Mental Health Ctr Hays/Morris House	24 East Copper Street	Butte	MT	59701	Silver Bow	Residential/24-hour residential
Western Montana Mental Health Ctr Butte Childrens Services	81 West Park Street	Butte	MT	59701	Silver Bow	Outpatient
Western Montana Mental Health Ctr Psychiatric Services	81 West Park Street	Butte	MT	59701	Silver Bow	Outpatient
Western Montana Mental Health Ctr Silver House	106 West Broadway Street	Butte	MT	59701	Silver Bow	Partial hospitalization/day treatment
Western Montana Mental Health Ctr Dakota Place	1273 Dakota Street	Missoula	MT	59801	Missoula	Residential/24-hour residential
Western Montana Mental Health Ctr	209 North 10th Street	Hamilton	MT	59840	Ravalli	Partial hospitalization/day treatment
Western Montana Mental Health Ctr Flathead County Adult Mental Health	410 Windward Way	Kalispell	MT	59901	Flathead	Partial hospitalization/day treatment
Western Montana Mental Health Ctr Safe House	412 Windward Way	Kalispell	MT	59901	Flathead	Residential/24-hour residential
Western Montana Mental Health Ctr Fox Creek Adult Group Home	420 Windward Way	Kalispell	MT	59901	Flathead	Residential/24-hour residential
Winds of Change	1120 Cedar Street	Missoula	MT	59802	Missoula	Outpatient
Yellowstone Boys and Girls Ranch Community Based Services	1732 South 72nd Street West	Billings	MT	59106	Yellowstone	Residential/24-hour residential
Yellowstone Boys and Girls Ranch Community Based Services	312 South Pacific Street	Dillon	MT	59725	Beaverhead	Residential/24-hour residential
Youth Dynamics Inc Great Falls Community Office	225 7th Avenue	Great Falls	MT	59405	Cascade	Outpatient
Youth Dynamics Inc Helena Community Office	1005 Partridge Place	Helena	MT	59602	Lewis and Clark	Outpatient
Youth Dynamics Inc	1609 West Babcock Street	Bozeman	MT	59715	Gallatin	Outpatient
Youth Dynamics Inc Butte Community Office	775 West Gold Street	Butte	MT	59701	Silver Bow	Outpatient
Youth Dynamics Inc	220 3rd Avenue	Havre	MT	59501	Hill	Outpatient
Youth Dynamics Inc	1250 15th Street West	Billings	MT	59101	Yellowstone	Outpatient
Youth Dynamics Inc Shelby Community Office	222 Main Street	Shelby	MT	59474	Toole	Outpatient
Youth Dynamics Inc Missoula Community Office	619 SW Higgins Street	Missoula	MT	59803	Missoula	Outpatient
Youth Dynamics Inc Kalispell Community Office	450 Corporate Drive	Kalispell	MT	59901	Flathead	Outpatient
Youth Dynamics Inc Miles City Community Office	1200 Pleasant Street	Miles City	MT	59301	Custer	Outpatient
Youth Dynamics Inc Wolf Point Community Office	112 Main Street	Wolf Point	MT	59201	Roosevelt	Outpatient
Youth Dynamics Inc Glendive Community Office	606 North Merrill Avenue	Glendive	MT	59330	Dawson	Outpatient

Appendix C | List of regulations for each Facility

Facility	License Type	License No.	Authority and Regulations (Links)
Montana State Hospital – Main Hospital	Hospital	12943	37.106.3 (Health Care Facilities) 37.106.4 (Hospitals) MCA 50-5 (Hospitals and Related Facilities)
Montana State Hospital – Forensic (Galen and Group Homes)	Mental Health Center	12910	37.106.3 (Health Care Facilities) 37.106.19 (Mental Health Center) 37.106.20 (Mental Health Center-Foster Care) MCA 50-5 (Hospitals and Related Facilities) MCA 53-21-1 (Treatment of Seriously Mental Ill)
Montana Mental Health Nursing Care Center	Long Term Care	13143	37.106.3 (Health Care Facilities) 37.106.6 (Nursing Facilities)
Intensive Behavior Center	Intermediate Care Facility for Developmentally Disabled	12904	37.106.3 (Health Care Facilities) 37.106.21 (ICF / DD)
Montana Chemical Dependency Center #1	Inpatient Chemical Dependency Facility	13462	37.106.3 (Health Care Facilities) 37.106.14 (Chemical Dependency Facilities)
Montana Chemical Dependency Center #2	Inpatient Chemical Dependency Facility	13461	37.106.3 (Health Care Facilities) 37.106.14 (Chemical Dependency Facilities)
Montana Chemical Dependency Center #3	Inpatient Chemical Dependency Facility	13070	37.106.3 (Health Care Facilities) 37.106.14 (Chemical Dependency Facilities)
Montana Veterans Home Columbia Falls	Long Term Care & Retirement Homes	13517 & 13490	37.106.3 (Health Care Facilities) 37.106.6 (Nursing Facilities) 37.106.25 (Retirement Homes) MCA 52-3-8 (Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act)
Eastern Montana Veterans Home	Long Term Care	13454	37.106.3 (Health Care Facilities) 37.106.6 (Nursing Facilities)
Southwestern Montana Veterans Home	Long Term Care	13594	37.106.3 (Health Care Facilities) 37.106.6 (Nursing Facilities)

Appendix D | Detailed Vacancy and Housing Data, 10-Year Snapshot

There has been an upward trend with both vacancies at state-run facilities and home values in Montana over the last decade. **The greatest increase in both was seen in 2021**, where vacancies at state-run facilities increased by 58.8% and home values increased by 26.8%.

The tables below provide further detail into vacancies over time by facility, as well as the changes in Montana's home values compared to the national average.

Vacancy Rate by Facility	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023[2]
Intensive Behavioral Center	21.00	14.69	23.98	14.25	28.94	30.50	45.13	46.00	85.82	51.31	11.60	13.91	34.91	*37.60*
Montana Chemical Dependency Center	6.00	15.00	16.00	11.00	6.00	3.00	4.00	3.90	6.40	2.40	3.90	6.90	2.40	*1.40*
Montana Mental Health Nursing Care Center	4.89	11.99	12.00	10.55	11.10	17.00	7.20	9.67	15.70	32.93	12.70	15.87	32.90	*34.40*
Montana State Hospital	27.00	37.95	30.85	24.00	12.10	12.90	39.76	46.85	51.45	72.50	93.90	159.85	228.10	*234.20*
Montana Veterans Home	3.60	2.80	3.90	4.80	0.90	6.75	3.55	5.70	5.60	11.40	8.35	10.60	22.25	*29.50*
Grand Total	**63.49**	**83.43**	**86.73**	**64.60**	**59.04**	**70.15**	**99.64**	**112.12**	**164.97**	**170.54**	**130.45**	**207.13**	**320.56**	*337.10*
Percent Change	*n/a*	**31.4%**	**4.0%**	**-25.5%**	**-8.6%**	**18.8%**	**42.0%**	**12.5%**	**47.1%**	**3.4%**	**-23.5%**	**58.8%**	**54.8%**	*5.2%*[2]

Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022[4]
United States Avg Home Value[3,4]	$167K	$180K	$190K	$199K	$210K	$223K	$237K	$247K	$261K	$311K	$355K
Montana Avg Home Value[3,4]	$206K	$216K	$227K	$236K	$243K	$255K	$270K	$285K	$302K	$383K	$453K
Difference in Home Value – MT vs. US *(Change in gap from previous year)*	$39K	$36K *(-3K)*	$37K *(+1K)*	$37K	$33K *(-4K)*	$32K *(-1K)*	$33K *(+1K)*	$38K *(+5K)*	$41K *(+3K)*	$72K *(+31K)*	$98K *(+26K)*
Percent Change in Home Value: US		7.8%	5.6%	4.7%	5.5%	6.2%	6.3%	4.2%	5.7%	19.2%	14.1%
Percent Change in Home Value : MT		4.9%	5.1%	4.0%	3.0%	4.9%	5.9%	5.6%	6.0%	26.8%	18.3%

In addition to the average home value increasing in Montana over the last decade, **the gap between home values in Montana and the national average has increased as well**. In 2021, the gap between the Montana and US average value increased by $31,000, and in 2022, the gap increased again by $26,000.

The increased home value and subsequent increased cost of living in Montana presents challenges to recruitment and talent acquisition efforts.

[1] Vacancies for each fiscal year are a point-in-time count from June of each year, with the exception of FY23 (see note below)
[2] FY23 counts are as of September 8, 2022
[3] Source: Zillow Home Value Index, last retrieved September 9, 2022
[4] Home values are pulled from September of each respective year, with the exception of 2022, where the home value is as of July 31, 2022

Appendix E | Detailed breakdown of incident tracking at facilities (1 of 2)

Below is a breakdown of the method of incident tracking at each facility and which incidents are being tracked – additional incidents are on the next slide.

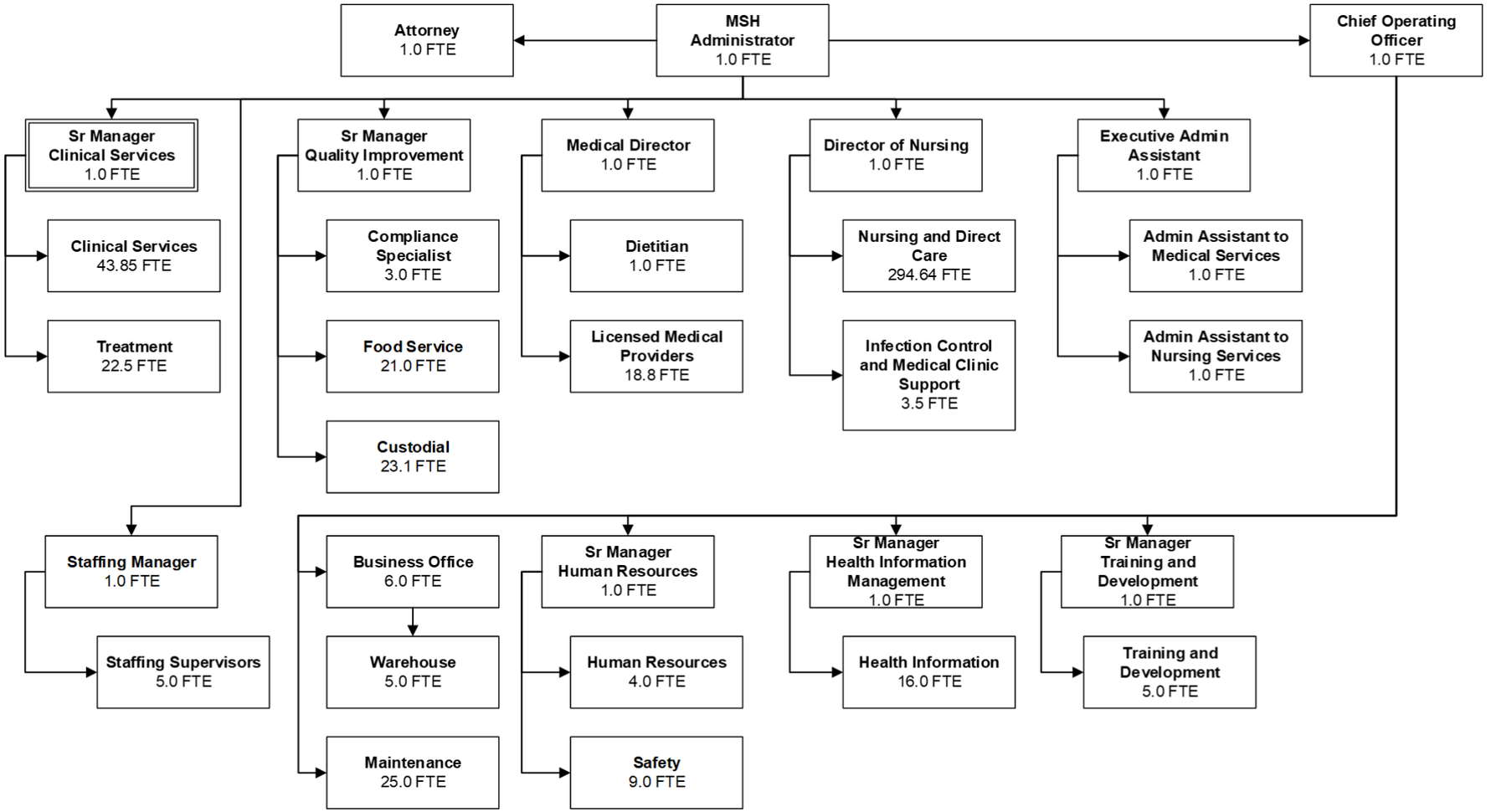
Facility	SWMVH	MMHNCC	MVH-CF	EMVH	MSH	MCDC	IBC	NUMBER OF FACILITIES REPORTING
Software for Tracking	Whiteboard	MS Excel	State Online Portal	Sanders (EHR); RL Solutions; Stat Online Portal	MS Excel, NRI Database	MS Excel	Therap (GERs)	
Falls	x	x	x	x	x			5
Elopement	x		x		x		x	4
Medication Errors		x	x	x		x		4
Alleged Abuse, Neglect, Mistreatment	x	x	x					3
Infections/COVID		x	x	x				3
Injury		x		x		x		3
Property Concerns				x	x	x		3
Accident, Other Misc.			x		x			2
Brief Hold					x		x	2
Care Concerns				x	x			2
Death		x	x					2
IM Injection					x		x	2
Mechanical Restraint (e.g., bed)					x		x	2
Restraint		x	x					2
Self-Inflicted Injury					x		x	2
Sexual Behavior					x		x	2
Violence/Aggression					x		x	2
Assault, Homicide			x					1
Burn	x							1

Appendix E | Detailed breakdown of incident tracking at facilities (2 of 2)

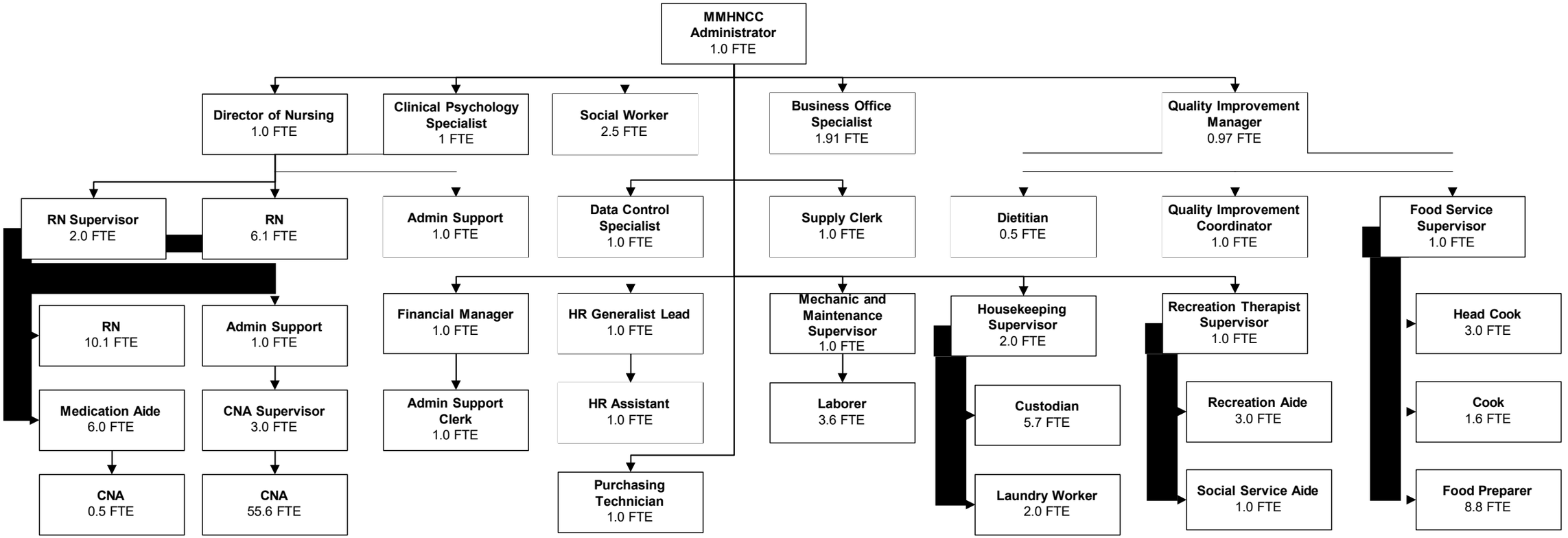
Below is a breakdown of the method of incident tracking at each facility and which incidents are being tracked – continued from the previous slide.

Facility	SWMVH	MMHNCC	MVH-CF	EMVH	MSH	MCDC	IBC	NUMBER OF FACILITIES REPORTING
Software for Tracking	Whiteboard	MS Excel	State Online Portal	Sanders (EHR); RL Solutions; Stat Online Portal	MS Excel, NRI Database	MS Excel	Therap (GERs)	
Clinical Intervention			x					1
Contraband					x			1
Exposure to Blood or Body Fluid					x			1
Fecal Hoarding/Smearing							x	1
Fire or Environmental Emergency					x			1
Hospital Stays		x						1
Lost Resident Items		x						1
Other	x							1
Other Disruptive Behavior							x	1
Pica							x	1
Property Destruction							x	1
Resident to Resident Event	x		x					1
Seclusion					x			1
Skin Tear/Bruise Unknown Origin	x							1
Skin Wound				x				1
Suicidal Ideation		x						1
Suicide, Suicide Attempt			x					1
Suspicion of a Crime			x					1
Transport Blanket					x			1
Unsafe Smoking					x			1
Verbal Aggression							x	1

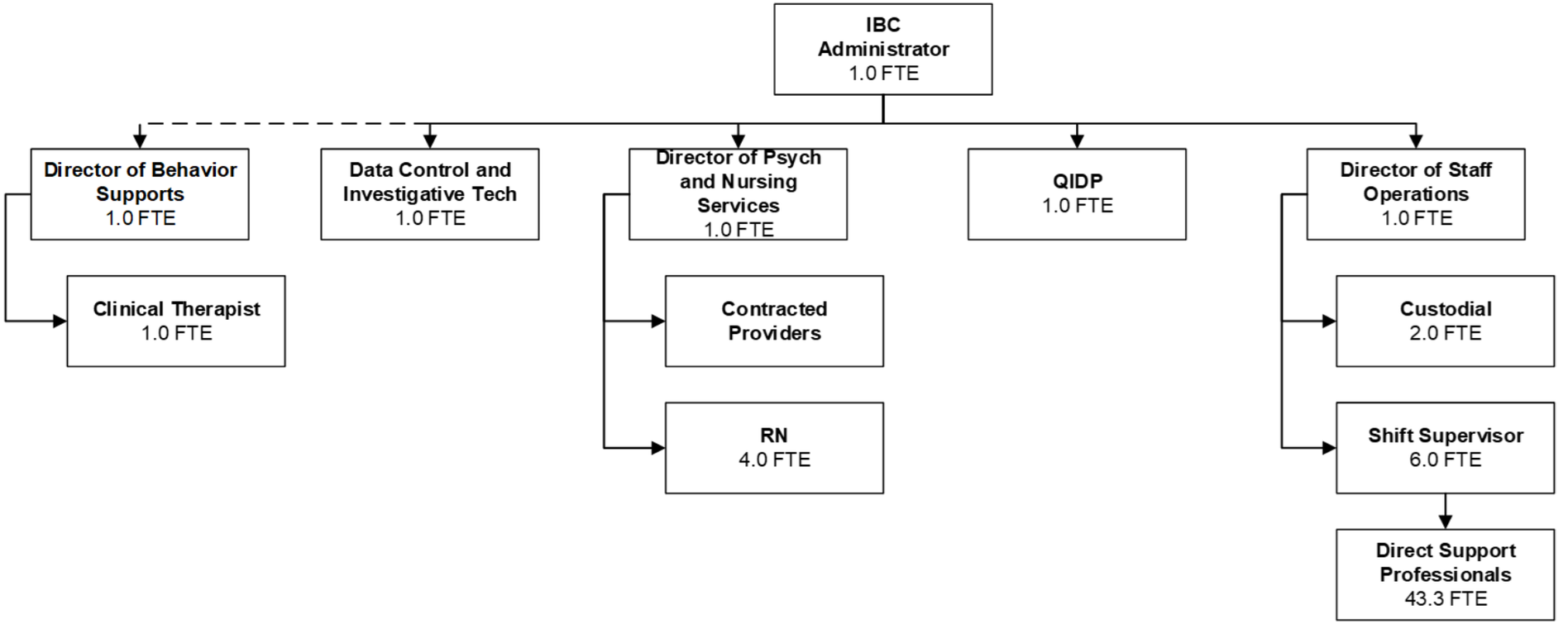
Appendix F | Montana State Hospital: Organizational Structure



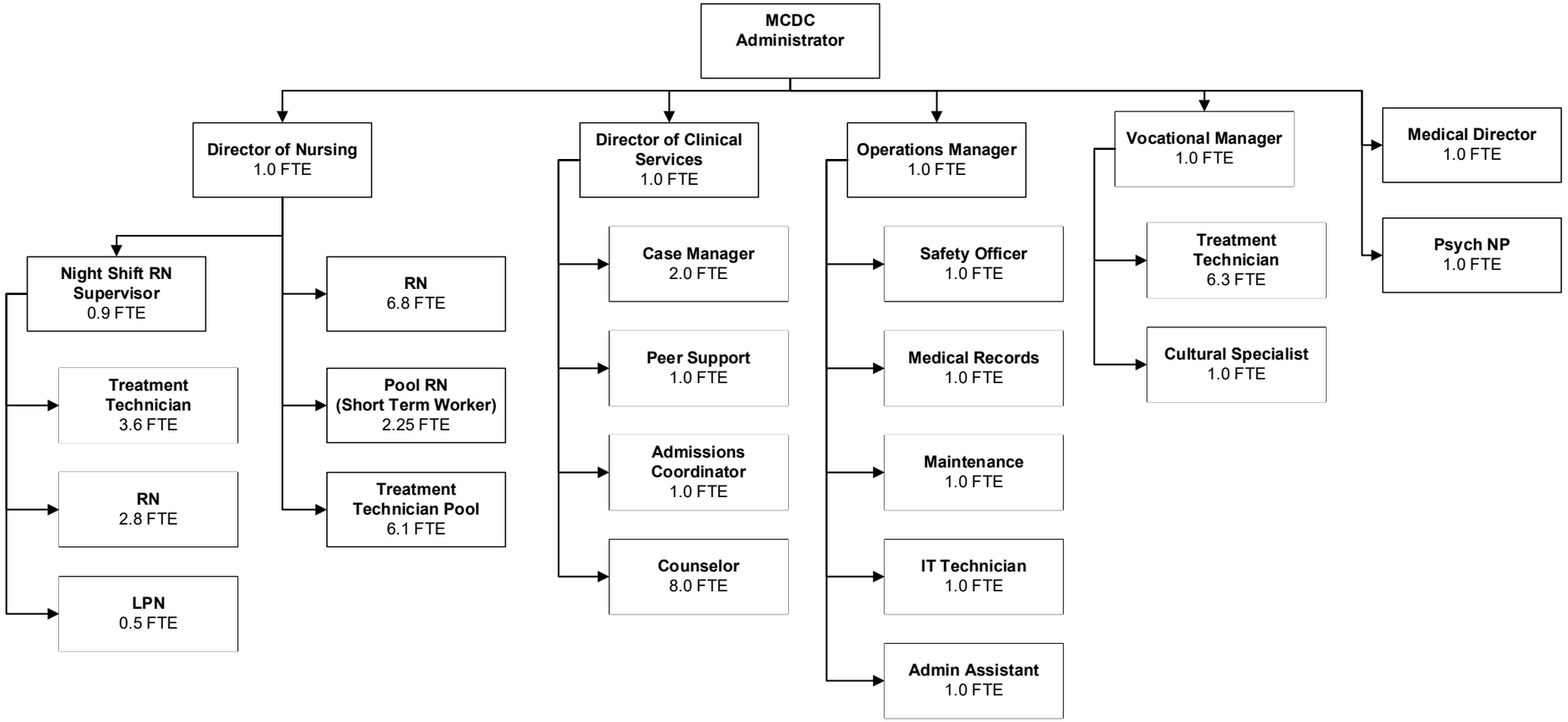
Appendix F | Montana Mental Health Nursing Care Center: Organizational Structure



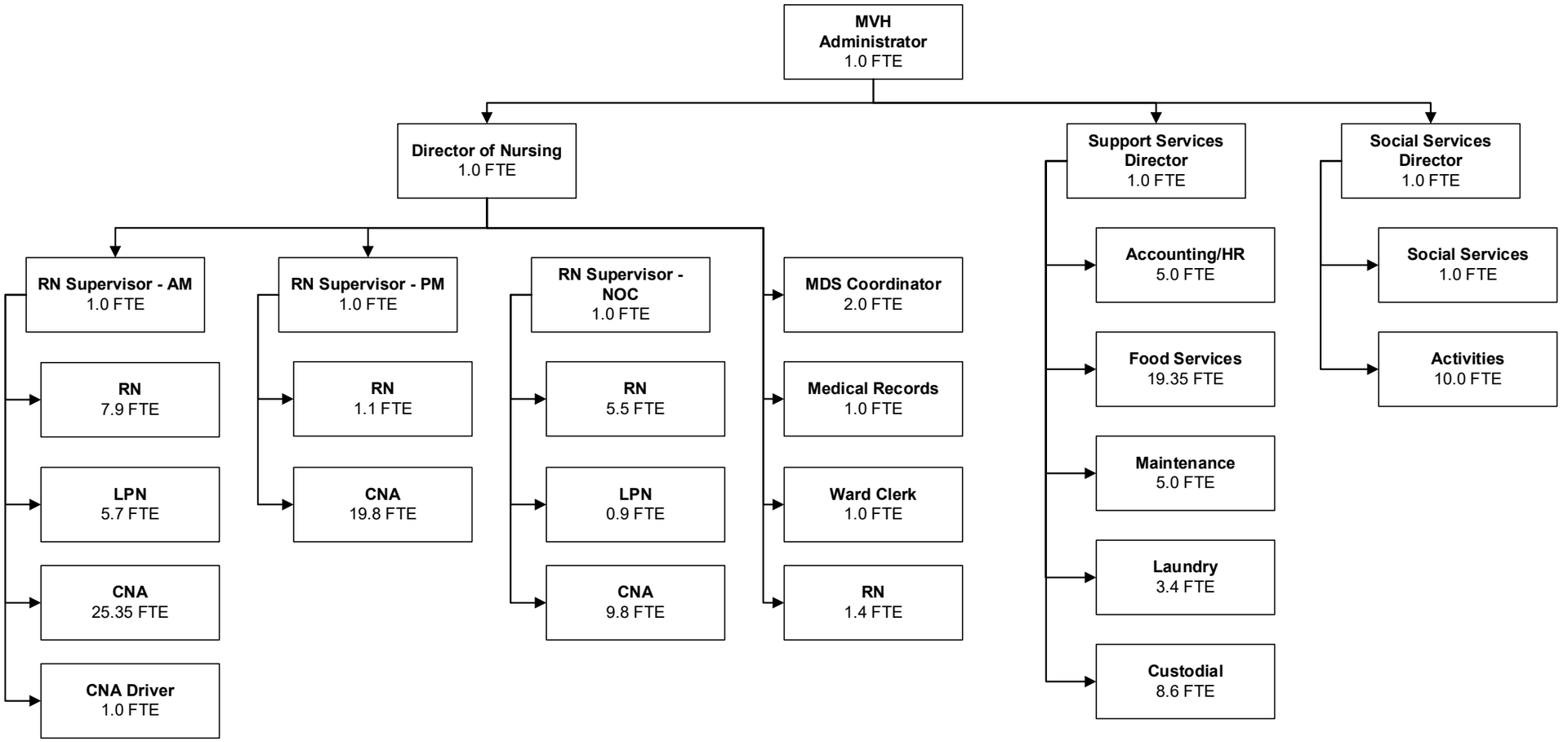
Appendix F | Intensive Behavior Center: Organizational Structure



Appendix F | Montana Chemical Dependency Center: Organizational Structure



Appendix F | Montana Veterans' Home: Organizational Structure



Appendix G | Census, Admissions, Discharges, and Waitlist Numbers

Below is a breakdown of the average daily census (%), and the number of admissions, discharges, and individuals on the waitlist for each of the seven facilities, from May to September 2022.

Month	Facility	Average Daily Census %	Admissions	Discharges	Waitlist
May	MSH	70%	54	59	40
	MMHNCC	59%	2	1	0
	IBC	75%	0	0	0
	MCDC	27%	21	30	15
	CFMVH	55%	0	1	203
	SWMVH	86%	2	3	31
	EMVH	71%	9	3	0
June	MSH	73%	56	48	38
	MMHNCC	58%	1	3	0
	IBC	75%	0	0	0
	MCDC	44%	30	18	0
	CFMVH	56%	3	1	198
	SWMVH	94%	1	1	40
	EMVH	73%	4	3	0
July	MSH	74%	58	44	44
	MMHNCC	57%	3	1	3
	IBC	75%	0	0	0
	MCDC	46%	23	36	0
	CFMVH	55%	0	1	196
	SWMVH	77%	6	3	32
	EMVH	73%	3	2	0
August	MSH	73%	50	60	39
	MMHNCC	58%	0	2	4
	IBC	75%	0	0	2
	MCDC	38%	33	28	0
	CFMVH	53%	0	0	196
	SWMVH	75%	8	4	34
	EMVH	73%	4	3	0
September	MSH	74%	76	50	42
	MMHNCC	57%	2	0	3
	IBC	83%	1	0	3
	MCDC	32%	29	25	0
	CFMVH	53%	2	2	204
	SWMVH	72%	3	1	32
	EMVH	73%	4	6	0