Montana State Hospital
Governing Board

Meeting Minutes by Kristin Finucane

Meeting Date/Time: January 10, 2023, at 1:00 pm (MT)

Meeting Location: Virtual (MS Teams)

1. Call to Order
   Called to order 1:04pm by Cater Anderson

2. Review/Approve Meeting Minutes
   Previous Meeting Minutes approved by board

3. Board Membership

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

   a. Discuss roles/responsibilities and review governing body standards (Attachment A)
      Reviewing By laws with Mountain Pacific
      Get board members a contact list – per Carter Anderson

   b. Decide board chairperson
      Carter nominated Michael Randol – voted as Chairperson

   c. Decide MSH chief executive officer
      Carter Anderson – Interim MSH CEO

   d. Decide Governing Board meeting frequency
      Board decided meetings will be held quarterly.

   e. Decide type and frequency of reports that Governing Board will receive (Attachment B)
      N/A

4. Quality Improvement
   Edward Tu – Presented Attachment C

5. Finance Reports
   Christopher St Jean – Presented Attachment D

6. Human Resource Reports
   No report

7. Treatment/Clinical/Nursing Services
   Jocelyn Peterson – Presented Attachment E

8. Legal
   Nicole Klein – Presented Attachment F

9. Old Business
   N/A – No

10. New Business
    N/A – No

    Meeting adjourned @ 1:40pm.

Attachments:

- *A. Excerpts of §482.12 CMS Condition of Participation: Governing Body*
- *B. Reports to Governing Body required by CMS CoP*
- *C. Quality Improvement Report*
- *D. Finance and HR Report*
- *E. Treatment/Clinical/Nursing Services Report*
- *F. Legal Report*

Attachment A

Excerpts of §482.12 CMS Condition of Participation: Governing Body

§482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital.

§482.12

The hospital must have a governing body which is effective in carrying out its responsibilities for the conduct of the hospital.

The governing body must be functioning effectively and holds the ultimate responsibility for the hospital's compliance not only with the specific standards of the governing body

Each separately-certified hospital in the system must have a QAPI program that is specific to that hospital. This is required not only to demonstrate compliance, but also for the governing body to function effectively

§482.12(a)

The governing body must ensure the medical staff requirements are met. The governing body must determine, in accordance with State law, which categories of practitioners are eligible for appointment to the medical staff.

§482.12(a)(2)

Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.

The governing body determines whether to grant, deny, continue, revise, discontinue, limit, or revoke specified privileges, including medical staff membership, for a specific practitioner after considering the recommendation of the medical staff. In all instances, the governing body's determination must be consistent with established hospital medical staff criteria, as well as with State and Federal law and regulations. Only the hospital's governing body has the authority to grant a practitioner privileges to provide care in the hospital.

§482.12(a)(3)

The governing body must assure that the medical staff has bylaws and that those bylaws comply with State and Federal law and the requirements of the Medicare hospital Conditions of Participation.

§482.12(a)(5)

Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.

The governing body must ensure that the medical staff as a group is accountable to the governing body for the quality of care provided to patients. The governing body is responsible for the conduct of the hospital and this conduct includes the quality of care provided to patients.

§482.12(a)(6)

Ensure the criteria for selection are individual character, competence, training, experience, and judgment

The governing body must assure that the medical staff bylaws describe the privileging process to be used by the hospital. The process articulated in the medical staff bylaws, rules, or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers

§482.12(a)(7)

Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.

In making a judgment on medical staff membership, a hospital may not rely solely on the fact that a MD/DO is, or is not, board-certified. This does not mean that a hospital is prohibited from requiring board certification when considering a MD/DO for medical staff membership, but only that such certification must not be the only factor that the hospital considers. In addition to matters of board certification, a hospital must also consider other criteria such as training, character, competence and judgment. After analysis of all of the criteria, if all criteria are met except for board certification, the hospital has the discretion to decide not to select that individual to the medical staff.

§482.12(a)(10)

Consult directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or his or her designee. At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multi-hospital system governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements of this paragraph (a).

In accordance with §482.22(b)(3), there must be an individual member of the hospital's medical staff who is assigned responsibility for the organization and conduct of the medical staff (for purposes of this

guidance, the “leader” of the medical staff). §482.12(a)(10) requires that the governing body consult with this individual, or with someone the leader of the medical staff has designated.

§482.12(b)

Standard: Chief Executive Officer The governing body must appoint a chief executive officer who is responsible for managing the hospital.

The Governing Body must appoint one chief executive officer who is responsible for managing the entire hospital.

§482.12(c)(1)

Practitioners other than doctors of medicine or osteopathy may join the medical staff if the practitioners are appropriately licensed and medical staff membership is in accordance with State law.

Every Medicare or Medicaid patient must be under the care of a licensed practitioner as defined in this requirement.

§482.12(d)

Standard: Institutional Plan and Budget

The institution must have an overall institutional plan that meets the following conditions:

(1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.

(2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.

(3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph

§482.12(e)

Standard: Contracted Services

The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

The governing body has the responsibility for assuring that hospital services are provided in compliance with the Medicare Conditions of participation and according to acceptable standards of practice,

irrespective of whether the services are provided directly by hospital employees or indirectly by contract.

The governing body must take actions through the hospital's QAPI program to: assess the services furnished directly by hospital staff and those services provided under contract, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities.

§482.12(e)(1)

The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.

Indirect arrangements may take into consideration services provided through formal contracts, joint ventures, informal agreements, shared services, or lease arrangements.

The patient care services, and all other services, provided under contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital.

Attachment B

Reports to Governing Body required by CMS CoP

Report	Requirement	Details
Institutional plan and budget	42 CFR § 482.12(d)	Annual operating budget (revenue and expense) Three-year capital expenditures and financing plans
Contracted services	42 CFR § 482.12(e)	List of all contracted services, including scope and nature of services provided
QAPI program	42 CFR § 482.21	Data-driven quality assessment and performance improvement program that reflects the complexity of the hospital's organization and services, involves all hospital departments and services, and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

Attachment C

Quality Improvement Report

(A). CMS IJs (A-0747 & A-0115), re: Plan of Corrections Implementation Updates

(a) Infection Prevention & Control and Antibiotic Stewardship Program, A-0747.

- Block staff schedule, staff cohorting, for COVID-19 patients.
- Consistent Temperature Monitoring and suspicious case escalating.
- Infection Control Committee reviews and approves annual IC Plan Policy, IC risk assessment findings, Healthcare Acquired Infections (HAIs), and work plan with meeting minutes.
- HAI Surveillance – January to September 2022
    - Covid has become the #1 acquired HAI at Montana State Hospital, accounting for 29% of all.
    - Cellulitis and UTIs remain in the top 3 type of infections, at 16% and 13% respectively. 62% of all UTIs at MSH come from Spratt.
        - Hard to determine whether-or-not these are CAUTIs or general UTIs given the information I have at hand.
        - In March of 2023, CAUTI and UTI prevention will be a major focus during nursing skills training
        - A large number of our cellulitis cases seem to be from self-inflicted wounds; many are lacking context in the orders. A number of those on Spratt seem to be related to skin integrity/skin-tears.
    - There is an increase in athlete's foot cases at Galen.
- 2023 IC plan will have a major focus on Covid, skin care, and UTI prevention.
- Opportunity: regular IC&P Committee Meetings and reports to the Governing Body, §482.42(c)(1)/Tag A-0770 & A-0771.

(b) Patient Rights, A-0115/A-1566: Chemical Restraints/Psychotropic Medications.

- Chemical Restraint policy TX-39 was approved initially as immediate action to remove the immediacy; then the TX-39 consolidated into TX-16 Use of Seclusion and Restraint, 06/24/2022.
- Medical Record audits on standing PRN psychotropic medications and chemical restraint utilization.
- Pharmacy efforts: (1) on monthly medication regimen with providers and (2) Spratt unit specific PRN medication order review.
    - The purpose of those efforts are to shift using PRN medications that work well for the patients to scheduled medications.

(c) Patient Rights, A-0115/A-0145: Alpha Unit Patient Assault.

- Pre-admission Screening
    - Implemented addition patient pre-admission screening procedures include Montana State- and Federal- level sex and criminal registry verifications. Positive findings are shared with care team for safety precautionary measures.

- Staff Education
    - HR-06, Employee Conduct, HR-18 Time and Attendance.
    - New Employee Orientation Education and MANDT Training Curriculum.

(B). CY2022 Hospital Patient Safety Measures Overview, high risk/high volume/problem prone/regulatory requirements, §482.21.

(a) Patient Incidents

- Top Three Patient Incident types: Violence, Falls, and Self-inflicted Injuries.
- Spratt has annual patient fall reduction rate at 7.4% comparing to CY2021.
- MPQH initiated Fall Reduction Taskforce with new patient fall assessment.

(b) Physical Interventions Utilizations

- Monthly Chart Audits on clinical evidence that physical restraints are the last intervention, provider orders, and patient monitoring.
- Surveillance on patient harm due to inappropriate techniques applied.
- MPQH forming ad hoc team for reduction, details TBD.

(c) Medication Variances

- QI proposing performance improvement initiatives addressing medication omissions and incorrect dosing.

(d) Group Home Discharge Patient Satisfaction Survey

- Top Themes
    - My symptoms are not bothering me as much.
    - I deal more effectively with daily problems.
    - Staff were sensitive to my cultural background.
    - The medication I am asking help me control my symptoms that uses to bother me.
- Opportunities
    - My complaints and grievances were addressed.
    - I felt I had enough privacy during my stay.
    - The environment was clean, comfortable and quiet.
- QI team attending weekly Resident Council meetings and working to increase survey response rate

(e) Patient Grievance Analysis

- Current improvement efforts focus on bedside professionalism.

(f) Patient Abuse/Neglect Case Review

- Collaborative Safety met with QI on 1/9/23 to review all abuse and neglect findings to determine learning points.

(g) CY22 Patient Adverse Events

- 1x pt-pt assault, 1x pt-staff assault, 2x pt falls, 1x suicidal attempt, & 3x delayed Tx
- Implemented systematic process improvement measures:
    - Pre-admission screening for sex and criminal registry,

- Piloting new patient fall risk assessment specifically selected for psychiatric populations, and
- Physician order processing.

(C). CY2023 Quality Improvement Council Scopes and Work Plan Overview.

(a) Purpose

- Develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

(b) Quality Improvement Council Scope

- (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and identify and reduce medical errors.
- (2) The program must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital patient care services.

Attachment D

Finance and HR Report

SFY23 Financial Scorecard, as of November 30, 2022

Indicator	*October 2022*	*November 2022*	*Goal*
Starting Budget	$48,873,226	$48,873,226	n/a
Actuals to Date	$25,158,151	$30,055,580	n/a
Projected Expenses	n/a	$87,172,320	n/a
Variance – Budget to Projected Expenses	n/a	- $38,299,094 🔴	**> $0**
Cost per Bed Day	n/a	$1,052	n/a
Revenue to Date	$789,083	$999,441	n/a
Monthly Traveler Spend	$3,950,271	4,124,597	n/a
Percent change in Traveler Spend	+2% 🔴	+4% 🔴	**< -5%**

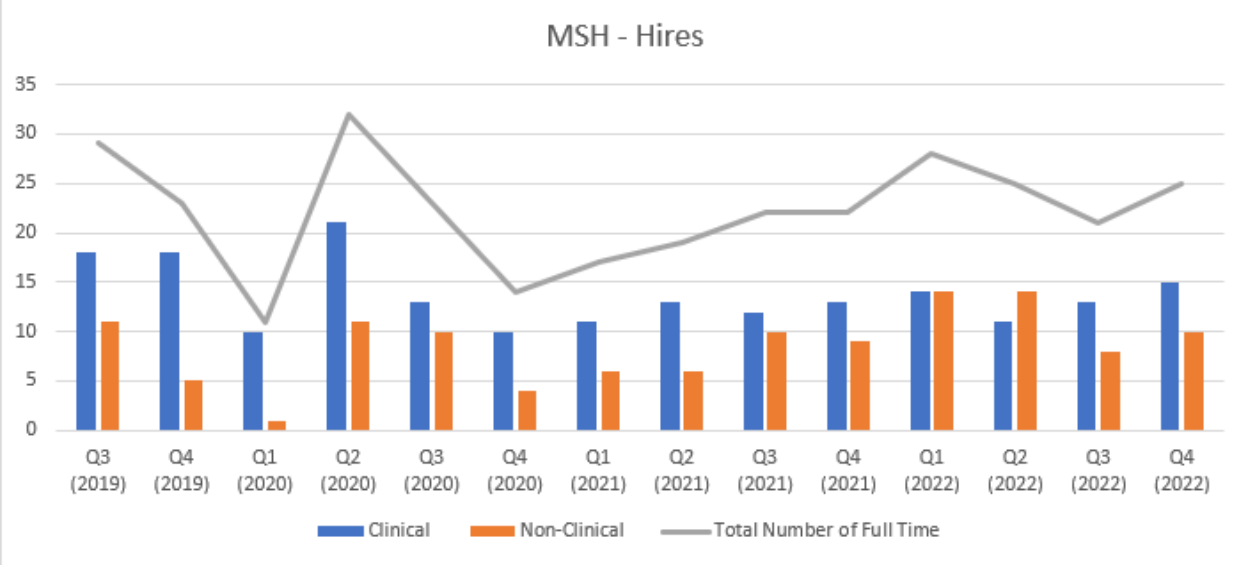
Three-year Capital Expenditures and Financing Plans

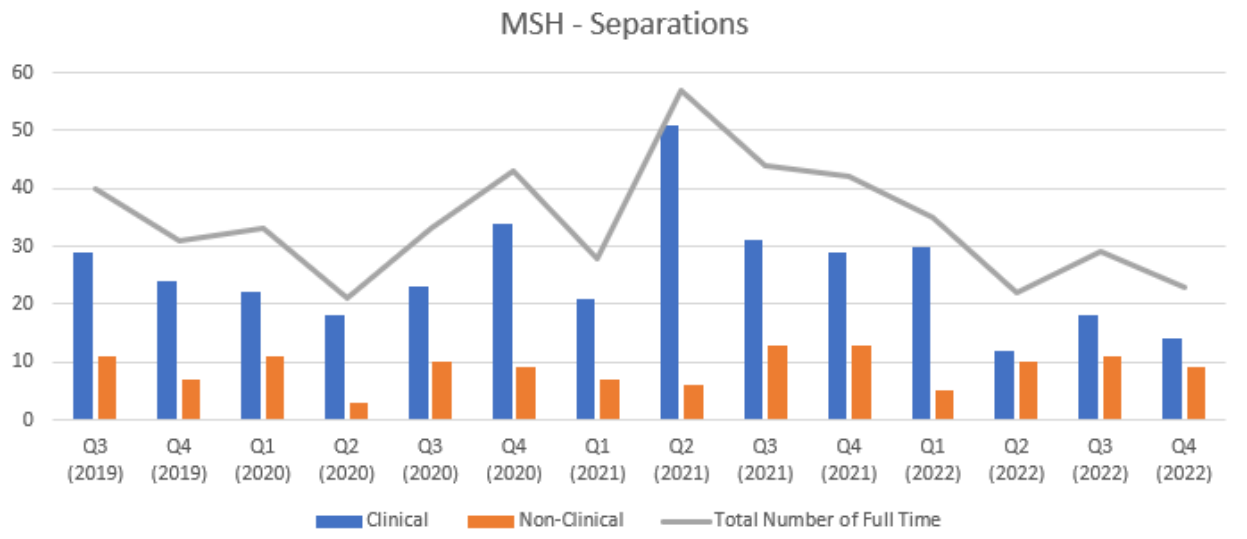
- <u>Existing Project Status</u> (already funded through State appropriation)
  - *Managed by State's Architecture & Engineering team*
    - Greenhouse – Nearly complete, waiting on parts
    - Foundation – $200K, not yet started
    - Roof Replacement – $600K, not yet started
    - Treatment Plant – Nearly complete, winter has slowed final steps
  - *Managed by MSH*
    - Door FOBs – Vendor, Johnson Controls has been slow to respond and is currently set to site-visit in late January.
    - Nurse Call Stations @ Spratt – Vendor, Johnson Controls has been slow to respond and is currently set to site-visit in late January.
    - HVAC – All in process, locally managed and expensed
    - Heating Coils Bravo, $10K
    - Air Handling Units 3-6 and Controls, $$62K
    - Variable Frequency Drive (4), $21K
    - Plumbing – Contractor continues to exceed $25K per month
    - Fire Alarm Modernization – Current system is in failure, $100K
    - Replacement Vehicles due to Fire – potentially ~$130K

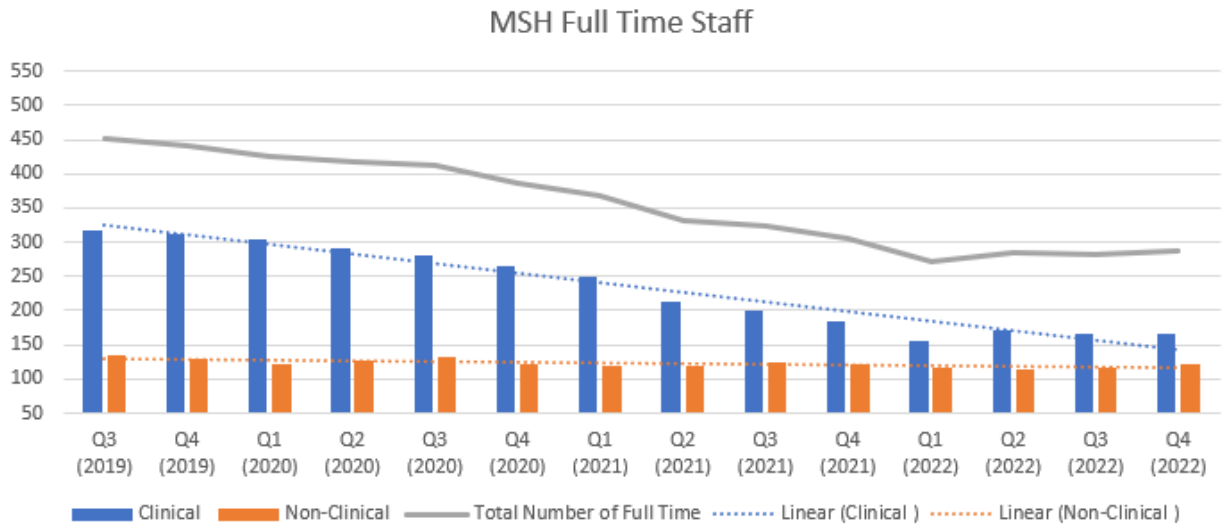
- Three-year Capital Expenditure Plans (Long-range Building Appropriations)
    - House Bill 5 would establish funding for the following capital projects in SFY24/25:

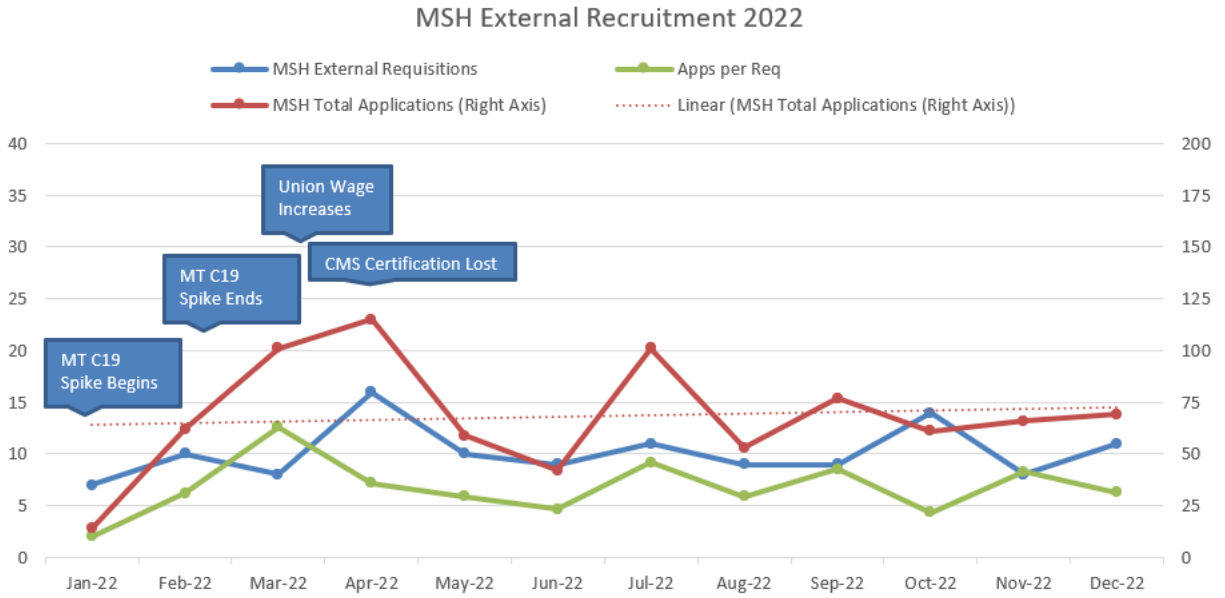
Budget Section	Category	Campus	Effort	Title	Total
Section F - LRBP	Supplemental Repair	MSH	Recertification	Supplemental MSH Wastewater Treatment	$ 1,400,000.00
Section F - LRBP	Supplemental Repair	MSH	Recertification	Supplemental MSH Hospital Roof	$ 800,000.00
Section F - LRBP	New Capital Development	MSH	Recertification	MSH Compliance Upgrades for Recertification	$15,903,000.00
Total					**$18,103,000.00**

Human Resource Reports






MSH Full Time Staff
550
500
450
400
350
300
250
200
150
100
50
Q3 (2019)
Q4 (2019)
Q1 (2020)
Q2 (2020)
Q3 (2020)
Q4 (2020)
Q1 (2021)
Q2 (2021)
Q3 (2021)
Q4 (2021)
Q1 (2022)
Q2 (2022)
Q3 (2022)
Q4 (2022)
Clinical
Non-Clinical
Total Number of Full Time
Linear (Clinical)
Linear (Non-Clinical)


MSH External Recruitment 2022
MSH External Requisitions
Apps per Req
MSH Total Applications (Right Axis)
Linear (MSH Total Applications (Right Axis))
Union Wage Increases
CMS Certification Lost
MT C19 Spike Ends
MT C19 Spike Begins
40
35
30
25
20
15
10
5
0
200
175
150
125
100
75
50
25
0
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22

Attachment E

Treatment/Clinical/Nursing Services Report

COVID Outbreak Status

- 9 Positive Patients (Group Home): All but 1 clearing by Monday (1/9)
- 1 Positive Staff: clears 1/8
- Quarantine: Group Homes

Staffing Levels and Traveler Usage

- **Psych Techs**
  - **State Employees**
    - Total: 80
    - Incoming: 6
  - **Travel CNAs**
    - Total: 133
    - Incoming (Jan): 5
- **Nurses (RNs & LPNs)**
  - **State Employees**
    - Total: 15
  - **Travel RNs and LPNs**
    - Total: 68 (Included covering managers)
    - Exiting: 6-8 in January
    - Incoming: 6
- **Nurse Managers**
  - **State Employees**
    - Total: 8
    - Exiting: 1 in January
- **Clinical Therapists**
  - **State Employees**
    - Incoming: 3 Clinical Therapists
    - Incoming: Treatment Manager
    - Incoming: Eligibility Specialist
    - Incoming: Peer Support Specialist
    - Incoming: Storekeeper

Nursing Department Update

- Implemented Nurse Specific Training for Orientation
- Training for New CNAs/Psych Techs
- Implementation of new Seclusion/Restraint Policy and Paperwork
- Developing New Auditing Tool/Follow Up with Nurses
- Increased Communication amongst the Nurse Manager Team and Direct Reports
  - Huddle Sheets
  - Daily Briefing Meetings/Weekly Manager Meetings
  - Unit Staff Meetings

Active Treatment Update

- **Recovery Center Reopening**
    - Use of Rec Room scheduled weekly for all hospital units
    - Groups offered hourly Mon-Fri from 1-4pm facilitated by Psychologists, Clinical Therapists, LACs, and Peer Support both on the units and at the RC building
        - AA, CBT for Criminal & Addictive Behavior, Social Skills, Mental Health Skills Group, Mindfulness/Meditation, Anger & Conflict Resolution, Values & Responsibilities, ACT Group, Boundaries, Relapse Prevention, WRAP
        - Recovery Team is actively working to add morning groups in the RC for all units
- **Therapeutic Learning Center Reopening**
    - *Schedule active as permitted by COVID restrictions*
    - Use of gym scheduled for all units
    - Library open hours
    - Beauty Shop open hours by appointment
    - Computer classroom
    - Community Survival Group
    - Launch of Adult Education program in collaboration with Butte School District
- **Chaplain**
    - Offers spiritual care on units and in chapel
- **Future Active Treatment Goal**
    - All units are up to 40+ total group offerings with more work being done to incorporate clinical therapists.

Critical Issues

- Continued work on Plan of Correction from Licensure

Attachment F

Legal Report

A. Current Legal Issues

1. We continue to receive medically inappropriate admissions (*EMTALA-esque* etc.);

a) we are limited in terms of medical care we can provide, and as a result, when we get a medically critical patient, we are often unable to address their immediate needs, and have to transport them to local ERs.. (ACH, St. James etc.)..

*As it stands, none of the invol commit statutes have any sort of more medical/EMTALA-type requirements.. for admission.. (so just a finding of a behavioral issue by a social worker..)

i) Ideally, think it would be great if in the ED statute we could weave in EMTALA-like requirements that a sending facility a) appropriately (medically) screened patient, and if relevant, b) that they appropriately stabilized them prior to transport.

a) Is it too late to propose leg for this session?

ii) There is at least one advocate in the state that essentially wants to require that the "professional person" in Invol commit cases have a certain level of medical training. (Right now the statutes leave open the chance for a social worker to be this person..)

2. Lag in entry or administration of med orders

-Had several scenarios lately where a bit of delayed care, at least partly due to a delay in certain meds getting effectively ordered &/or administered

-To the extent we can operationally technologize or streamline med order as much as possible, the better

3. Still have an ongoing *dearth of potential Guardian options* for patients without appropriate family or friends to serve;

B. Summary of Proposed Legislation

1. HB-29; excludes MSH as a civil commitment placement for Alzheimer patients, committed on the basis that they are unable to meet their basic needs.

*Technically, should reduce admissions at MSH/Spratt

-Also there is a stated goal to eventually end Inv. Commitment for all people with Alzheimers/dementia

-Additional piece creating a "transition review committee" within the department that will identify and develop alternative resources for these folks

2. SB-06; seeks to revise/heighten hospital requirements when releasing an adjudicated NGMI patient, but also explicitly implicates certain violations of NGMI CR as a felony

a) Specifically adds absconding from [NGMI] conditional release as a sub-definition of Escape (felony)

b) Additional post-discharge requirements;

i) Provision requiring notice of Conditions or release to their discharge placement, the county attorney on the case, and the County Attorney of the County in which they will be residing

ii) Requires the discharge placement to provide quarterly progress to the County attorneys and Director, and requires that the provider denote any violations of the COR, or "change in person's mental status.."

iii) also seeks to reduce the revocation evidence needed to revoke regarding the imminency of threat of physical injury to self or others (by deleting imminency)

3. SB-04; Bill that would require MSH, regarding AN investigations, to send to DRM; a) "details of the reported Allegation," and b) the final summary report, and would c) preclude us from redacting those at all...

-At present, we're only require to send a notice of suspected AN event, and the final summary to BOV..

4. LC 1368; would require MSH (or DPHHS) to create a "registry" of NGMIs or forensic to civil patients'

a) Crimes they were [merely] charged with, and additional info;

b) This info would be automatically available not only to after-care providers, but seemingly potentially to providers for which a former patient seeks treatment at any point after discharge

-believe that this is broader than what HIPAA permits