Governor's Task Force
On the
Delaware Psychiatric Center

Final Report

December 18, 2007

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Message from the Co-Chairs

The Governor's Task Force on the Delaware Psychiatric Center (DPC) was created by Governor Ruth Ann Minner on August 17, 2007, to examine "opportunities for continued improvement" at the DPC. In announcing the names of the Task Force members, the Governor said, "This is a diverse group and each member will bring a unique set of experiences and knowledge to the table to help make recommendations on ways to improve care and treatment at the Delaware Psychiatric Center." The Task Force membership included community and health advocates, medical professionals, educators and legislators, all with a dedicated interest in the transformation of mental health services.

Over a three-month period, this nine-member volunteer task force reviewed key areas of the DPC and its operations. Through the Governor's Executive Order 100, the members were charged with identifying best medical practices for patient care, program improvement, and community placement options, and providing recommendations on issues, such as hiring procedures, training, professional development opportunities for staff, and the need for a new facility. Please refer to Executive Order 100 contained in this report for a complete review of the charges assigned to the Task Force.

As co-chairs, we would like to thank our fellow Task Force members for the diligence, dedication, and commitment they demonstrated in carrying out the challenging work before us. Several of them engaged in individual research that provided an important framework for discussion and the basis for some of the recommendations presented in this document. Additionally, the insight that each person brought from his or her diverse professional roles served to complement the work of the group as a whole and allowed for thoughtful questioning and debate.

The Task Force offered the public unprecedented access to its proceedings by providing live webcasts of its full member meetings and by maintaining a web page highlighting the work in progress. All meetings of the Task Force and its sub-committees were open to the public and provided a forum for the public to share comments with, and voice concerns to, the members as part of the meeting agenda.

We greatly appreciate the opportunity to interact with the public, the members of the Department of Health and Social Services (DHSS), who presented to us, invited guests, and the community provider network. We are extremely grateful to the individuals who provided staff support to the Task Force. We found their service and support to be exemplary, under an extremely challenging timeframe and environment. We believe that through this exchange, we are able to present a comprehensive plan of recommendations, which are intended to further enhance the quality of mental health services in Delaware.
Sincerely,
Rita M. Landgraf and Pete Ross
Co-Chairs

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Origin of Task Force

The impetus to issue Executive Order 100 through which Governor Ruth Ann Minner gave the Task Force on the Delaware Psychiatric Center its authority, came from a surprise site visit and inspection by the Center for Medicare and Medicaid Services (CMS) during the month of July. As a result of the visit, CMS determined that DPC no longer met Medicare's Conditions of Participation leaving the DPC vulnerable to loss of accreditation. This could have resulted in the subsequent loss of $4 million dollars in funding. The findings in the CMS report were highlighted in a continuing News Journal "Trouble at DPC" series, which revealed deficiencies in Patient Rights and Safety codes.

Due to the serious nature of these reports, coupled with the ongoing media and public attention given to the situation; the Governor's office recruited a group of independent, volunteer citizens, unrelated to the DPC or the Department of Health and Social Services and asked them to bring forth meaningful recommendations to improve the quality of care at the DPC.

This nine member Task Force was not asked to investigate any allegations of misuse or neglect as there were several other bodies already taking that approach. Instead, the Task Force's charge was to review key areas of the DPC and its operations and look for systemic gaps in policy and procedure, which could ultimately result in a breakdown of the quality of care provided to the patients at the DPC. A copy of the Governor's Executive Order is attached as Exhibit A.

The members were also asked to identify ways to enhance and expand community services for those with mental illness and re-occurring substance abuse. Governor Minner asked the Task Force to prepare a report that would be ready to present to her on or before December 15, 2007.

The Purpose of the Task Force

Charge to the Task Force
Per Executive Order No. 100

The Task Force shall examine and make recommendations concerning:

1. **Current hiring procedures, to include recommendations relating to criminal background checks, drug testing, and general interview and orientation processes;**

2. **Best medical practices, to include recommendations specifically relating to restructuring current units to meet the needs of the current patient population, matching staff with the appropriate patient groupings, and policies and protocols relating to care of psychiatric patients;**

3. **Professional development for direct care staff, to include recommendations relating to training practices, needed resources for professional development opportunities, and curricula for direct care staff;**

4. **Additional community placement options for patients at DPC, to include identification of such options and an examination of the existing patient population related to community placement opportunities;**

5. **Adequacy of DPC's buildings and grounds, to include proposed designs for a new facility; and**

6. **Review of the DPS Performance Improvement Unit, to include recommendations regarding changes in both staffing and scope of activities of that unit.**

The Composition of the Task Force

The biographical information of the members of the Task Force is listed in alphabetical order.

Senator Margaret Rose Henry; - Senator Henry is the first African American woman to serve in the Delaware State Senate, when she was elected to finish the term of Herman Holloway, Sr. in 1994. Senator Henry has been re-elected four times since to serve the 2nd Senatorial district. Senator Henry serves as Chair of both the Senate Health and Social Services Committee, and the Public Safety Committee. She is a member of the Joint Finance Committee. She has been active in the Delaware human service community for thirty years, serving as a professional in the field and as a volunteer. Currently, Senator Henry is the Assistant Dean of Students at Delaware Technical and Community College and serves on the Board of the Medical Center of Delaware.

Kevin Ann Huckshorn, RN, MSM, CAP, ICDC – Ms Huckshorn is the Director of the Office of Technical Assistance at the National Association for State Mental Health Program Directors (NASMHPD) and the National Coordinating Center for Seclusion and Restraint Reduction. Ms. Huckshorn is a licensed and certified mental health nurse and substance abuse clinician with practical knowledge from 25 years of professional frontline experience working in a variety of public and private mental health organizations and substance abuse programs. Ms. Huckshorn has extensive experience in both in-patient and outpatient program development including consumer run projects; psychiatric rehabilitation treatment programs for persons with serious mental illness; and recovery-based mental health and substance abuse programs.

Rita M. Landgraf – Since October of 2006, Ms. Landgraf has served as President of AARP Delaware, which is comprised of 160,000 members in the state of Delaware. Ms. Landgraf's focus is on state and national advocacy initiatives geared towards building livable communities for those with disabilities and the aging population. She spent most of her career as Executive Director of The Arc, the state's leading advocate for individuals with intellectual disabilities. Through her tenure at The Arc, she worked with state officials and community leaders for the rights of her agency's clients to live independently. Ms. Landgraf is co-chair of the Commission on Community Based Alternatives for Persons with Disabilities, vice chair of the State Council for Persons with Disabilities, chair of the University of Delaware's Center for Disabilities Studies Advisory Council and vice president of Delaware CarePlan.

Representative Pam Maier – Representative Maier, first elected to the Delaware General Assembly in 1994, is a leading advocate for the health and protection of Delaware's citizens of all ages. As chair of the House of Representatives Health and Human Development Committee, Representative Maier was the lead sponsor of legislation authorizing the Department of Health and Social Services to establish a program for Delaware residents with disabilities to continue living in the community. The program prevents unnecessary institutionalization. Representative Maier serves on

numerous commissions including Commission on Community Based Alternatives for Persons with Disabilities, Delaware Nursing Home Residents Quality Assurance Commission and the Mental Health Association of Delaware Advisory Council. She is an Adjunct English Instructor at Delaware Technical and Community College.

Dennis Rochford – Mr. Rochford is President of the Maritime Exchange for the Delaware River and Bay, non-profit trade association serving port businesses throughout Pennsylvania, New Jersey and Delaware. In addition to managing the association's staff and overseeing the development of port community's automation network. Mr. Rochford represents the regional port community to government officials in Washington, DC; Harrisburg, PA; Trenton, NJ; and Dover, DE concerning a range of key issues critical to the success of the Delaware River regional port complex. He serves as a member of the Delaware Health Care Commission and the Delaware Health Fund Advisory Committee. Mr. Rochford's expertise on issues of governmental and business importance has resulted in weekly Monday evening appearances on WHYY-TV12's news program, *Delaware Tonight,* for the past 12 years.

Harold Rosen, M.D. – Dr. Rosen is a board certified psychiatrist and Chair of the Department of Psychiatry at Christiana Care Health System. Dr. Rosen is a distinguished life fellow of the American Psychiatric Association, Past President of the Delaware Psychiatric Society and serves as Chair of the subcommittee on Mental Health with the Medical Society of Delaware. Dr. Rosen also served as the Senior Vice President of Medical Affairs and as interim Chief Medical Officer for Christiana Care Health System. Dr. Rosen is a Clinical Associate Professor of Psychiatry at Thomas Jefferson Medical College.

Pete M. Ross – Mr. Ross has served as Director of Penn Treaty since December 2003, and as Director of PTNA and ANIC since May 2004. Mr. Ross has over thirty years experience in the development and implementation of public financial policy. He has served as an independent consultant on public policy since November 2004. From 2002 until his retirement in February of 2005, Mr. Ross served as a Senior Policy Scientist with the Institute for Public Administration with the University of Delaware, where he was involved in assisting local government with budget management. Mr. Ross previously served as the State of Delaware Budget Director from 2001 to 2002 and from 1994 to 2000; as Director of Operations, Office of Controller General, State of Delaware; as Senior Legislative Fiscal Management Analyst, Office of Controller General; and as Chief Administrative Officer, New Castle County. Mr. Ross is a member of the Delaware Economic Forecasting Advisory Committee and serves as Co-Chairman of the Delaware Compensation Commission.

Yvonne Stringfield, Ed.D; RN – Since 2006, Dr. Stringfield has assumed the role of Chair of the Department of Nursing at Delaware State University. Prior to that time she was Chairperson of the Undergraduate Nursing Program at Howard University from 2004 to 2006. Dr. Stringfield is a registered nurse in the states of Delaware and Virginia and spent the majority of her career in various supervisory nursing positions at

Riverside Regional Medical Center in Newport News Virginia. She also engaged in international work with Operation Smile in Liberia and Panama.

Gary Wirt, Ed.D – Dr. Wirt's career has largely been in the field of behavioral health services. He gained expertise in community living for persons with mental illness as Director of Bennett House which was a 28 bed transitional living facility, served as State Coordinator for the National Institute of Mental Health Community Support Grant, was Assistant Director of a Community Mental Health Center and Executive Director of the Mental Health Association. Since May of 1973, Dr. Wirt is serving as Adjunct Professor at Goldey Beacom College and instructs behavioral science courses including psychology, sociology, abnormal psychology, social problems and gender in the workplace. He also served as Vice President for Student Affairs and since 1997 Dr. Wirt has served as Vice President of the College. He continue to serve the mental health community as Chair of the Advisory Board of Delaware Psychiatric Center which reports to the Governor's Advisory Council on Substance Abuse and Mental Health where he is also a member.

Guiding Principles

National Goals for U.S. Mental Health Settings

Best practices in mental health treatment settings, both inpatient and outpatient, are rapidly changing. The New Freedom Commission (2003) has found the U.S mental health system of care to be fragmented, that many barriers impede care, and that the system is not oriented to the "single most important goal of the people it serves-the hope of recovery" (p. 3). Recovery is defined by the New Freedom Commission, as:

> **"…the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms." (p. 5).**

Research has noted that 'having hope' and being empowered to 'hope' plays an integral role in helping people to recover. This has clear implications for mental health treatment settings in that they must evaluate their operational processes and systems to assure that these are focused on recovery principles (NF Commission, 2003)

In 2001, the Institute of Medicine (IOM) published landmark work, which focused on the identification of strategies for achieving a substantial improvement in the quality of healthcare delivered to Americans. In 2005, the IOM applied these strategies specifically to the mental and substance abuse treatment fields.

The following guidelines for the Delaware Psychiatric Center (DPC) Task Force are taken from these two documents, as well as the Surgeon General's Report on Mental Health that was released in 1999. All of these nationally respected reports make similar recommendations and these have been adapted herein, for a mental health inpatient setting, such as DPC.

- **Safety must be a system priority. This means that all treatment settings must ensure the safety of the people they serve and the staff who serve them. However, in what may be a conundrum to logic, controlling practices and rigid, institutional rules do not lead to safety but instead lead to rebellion and conflicts. The safest treatment settings in the U.S. have prioritized the values inherent in individualized and compassionate care, an avoidance of coercion, a minimization of the use of violent and restrictive measure such as seclusion and restraint, and have focused staff training on learning how to listen, negotiate, and mediate disputes.**

- **Admission and treatment services must focus on principles that support recovery including self-direction, person-centered, empowerment, non-linear, peer support, respect, responsibility, and hope. These principles should be observed in the environment of care including in the facility's philosophy of care, policies, and procedures; staff hiring processes, job descriptions, training activities, and performance evaluations; treatment planning activities that includes service users; discharge planning processes; and performance improvement measures and the use of data to track key performance indicators.**

- **Admission and treatment services must be customized to individuals, based on their needs, values, and choices. Mental health treatment facilities must make all efforts to create options for service users in treatment planning and daily activities and respect the wishes of services users, even when that is to refuse treatment. *(This needs to be an informed decision, enabling the user to fully comprehend the consequences of such a decision)***

- **Services provided in inpatient settings need to be based on evidence. The implementation of evidence-based practices lags behind current practices by 15-17 years, across this country. All efforts need to focus on the use of evidence-based treatments and promising practices, including assuring the accountability of staff to learn and provide these services.**

- **The patient, or service user, must be the source of control of their services and care. Service users must be given the knowledge, education, motivation, access to information, and opportunity to exercise control over what happens to them, whenever possible. This means that staff must understand both their own and the service users roles and responsibilities and understand how to tailor services to meet patient's goals, as well as how to challenge them to move toward recovery.**

<u>Delaware Psychiatric Center Specific Issues</u>

Recommendations

1. **The Task Force needs to explore DPC's operational response to high risk and problem prone events such as abuse and neglect issues, the use of seclusion and restraint, and patient and staff injuries.**

2. **That the DPC Task Force focus on the specific charges as identified in Executive Order 100 and utilize past reports and/or information from other bodies concerned about the care at DPC, as a means to highlight possible trends in need of immediate attention and correction. All discussions need to begin with a "is this relevant to the present?" question.**

3. **DPC practices and processes should be judged in comparison with the standards of practice in other, like facilities.**

4. **It is important for the Task Force to understand DPC's current compliance with both the federal Centers for Medicare and Medicaid and the Joint Commission on Accreditation of Healthcare Standards of care.**

5. **The Task Force needs to explore whether DPC leaders have the means, resources, guidance, leadership and commitment to moving toward a recovery oriented system of care and what are the barriers that they are struggling with.**

References

Institute of Medicine. (2005). *Quality treatment for people with mental and substance-use disorders.* Rockville, MD: Institute of Medicine Academies Press.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington, DC: National Academy Press.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: DHHS.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2005). *Consensus statement on mental health recovery*. Proceedings from the National Consensus Conference on Mental Health Recovery and Systems Transformation. December 16-17, 2004. Rockville, MD.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: USDHHS, SAMHSA, CMHS, NIH, NIMH.

How The Task Force Went About Its Work

The Task Force held its first meeting on September 14, 2007 for review of the charges and to arrive at a consensus on the Guiding Principles and the process in which to fulfill the Executive Order. It was decided to break down into four teams/subcommittees and each member volunteered to work within at least one of the teams. All meetings of the team would be open to the public, unless legal representation advises otherwise due to patient identification and the need for confidentiality. The teams were broken out into the following categories, which mirror the charges set forth by Executive Order 100:

Team I - Harold Rosen M.D. - Facilitator, Representative Pam Maier, Kevin Ann Huckshorn, R.N., MSN, CAP and Rita Landgraf Co-Chair

Charge: *Review all regulatory, accreditation, monitoring and oversight reports, identifying common themes and trends, which signify areas for improvement. Compile listing of themes, trends and/or concerns and recommended plan of action for improvement and discussion by Task Force. Review best practice in psychiatric centers. Conduct a review of the Delaware Psychiatric Center's performance improvement unit and draft recommendations regarding changes in staffing and scope of activities of that unit.*

Team 2 - Kevin Ann Huckshorn – Facilitator, Yvonne Stringfield, Ed.D., Dennis Rochford, Rita Landgraf

Charge: *Review all hiring procedures, matching of personnel with appropriate patient groupings, policies, procedures and protocols relative to care of psychiatric patients, professional development for direct care staff. Draft recommendations relating to criminal background checks, drug testing, interview and orientation processes, identify best practice in the area of patient/staff matching and configuration of the units. In clued recommendations relating to training practices, needed resources for professional development and curricula for direct care staff.*

Team 3 – Rita Landgraf, - Facilitator, Senator Margaret Rose Henry, Kevin Ann Huckshorn and Gary Wirt, Ed.D

Charge: *Review community options and identify such options in conjunction with the existing patient population. Review best practice in the delivery of community supports and recommend enhancements, which may prevent and lower the need for acute hospitalizations.*

Team 4 - Gary Wirt, Ed.D, Pete Ross Co-Chair, Dennis Rochford and Rita Landgraf

Charge: *Review the adequacy of the Delaware Psychiatric Center's building and grounds, to include proposed designs for a new facility. Coordinate efforts with Team 1, 2 and 3 regarding best practice in facility based care, unit design to ensure effective care, and remaining patient census if community options are increased and enhanced.*

The teams were encouraged to organize their research by inviting members of DHSS to their respective meetings for clarification on current practice and future desires. In addition, correspondence that was forwarded to the Task Force by community organizations, councils and commissions, with an interest in this work, was presented to the appropriate teams for their discussions. The majority of the correspondence was adopted into this report. Therefore, the recommendations are embraced by a larger segment of the Delaware community beyond the nine members of the Task Force. The Task Force and/or respective committees held a total of 14 meetings during this three-month timeframe. In addition, many members did independent research on best practice and current implementation, which is also embraced throughout the report.

The Task Force is providing these recommendations based on the understanding of the information that has been provided to us.

Executive Summary

The Governor's Task Force on the Delaware Psychiatric Center was created in the wake of a series of media articles highlighting allegations of patient abuse, neglect and safety at the State Hospital. Subsequent visits from monitoring bodies such as the Centers for Medicare and Medicaid Services (CMS) revealed additional "significant" issues that unless addressed, left the facility in danger of losing its accreditation and as a result, approximately $4 million dollars in funding.

Governor Ruth Ann Minner issued Executive Order 100 in August 2007, creating the Task Force and charging the nine members with reviewing key areas of the DPC and its operations and making recommendations concerning "continued opportunities for improvement". Specifically, it was asked to make recommendations on hiring processes, best medical practices, professional development and training, additional community placement options, the adequacy of the current DPC facility, and the Performance Improvement (PI) Unit.

The Task Force started meeting in September and quickly decided to break out into four subcommittees (teams) focused on different areas of the charges laid out in the Executive Order. Team 1 reviewed all reports of various monitoring, accreditation and oversight bodies. Team 2 focused on the Performance Improvement Unit, hiring and staff development issues. Team 3 looked into the current state of community provider services. Team 4 reviewed the adequacy of the current DPC structure in preparation for recommendations. Each subcommittee regularly reported the results of their meetings back to the full nine-member body.

All of the Task Force's meetings were open to the public and provided opportunity for public comment. Additionally, several of the Task Force members conducted independent research which assisted in forming the backdrop for some of the recommendations.

The recommendations contained in this report are based on the best information available to it, the results of research on best medical practice from other institutions

nationwide, and the members' interpretation of the information presented to them. The spirit of the recommendations is to make thoughtful and meaningful recommendations which will move the DPC forward in a thoughtful, well planned out manner that will foster an atmosphere of recovery and enhance the quality of care for some of Delaware's most vulnerable citizens.

Additionally, the Task Force would like to extend its appreciation to not only the members of the public, service users, and the network of community service providers who offered thoughtful and compelling comment, but also the leadership of DHSS and the DPC who made themselves available for testimony and questions throughout the three and a half month process.

It should be noted that in the recommendations there were several overlapping themes among the various committees, particularly when it came to how best to improve upon the DPC's managerial and organizational structure. The top recommendations issued by the Task Force, which incidentally often built upon one another were:

- The DPC should create a high level Oversight Committee to monitor the Hospital and support best practice initiatives
- The DPC should immediately contract with an experienced state hospital or organizational expert to spend at least six months on-site to facilitate further organizational and supervisory development with key Division and DPC executive staff
- The DPC administration should hire a well experienced Performance Improvement (PI) Director; enhance the status/staffing for the PI Committee, and update the PI Plan to contain clear expectations
- The DPC should hire a Hospital Director with clinical experience in the behavioral health field
- The DPC should reclassify the position of Unit Director to that of Nurse Manager to provide clear lines of authority over staff on each unit. This would reduce confusion and conflict among staff. It is recommended that the Nurse Manager also have administrative experience.
- The Task Force recommends that a team of DPC leadership should attend national training on how to minimize the use of seclusion and restraint practices

- The DPC should automatically provide notification to the Disabilities Law Project of all allegations of abuse or neglect found on what is commonly known as the PM -46 form. This form should also be updated to specifically prohibit retaliate against those who report such allegations
- The Task Force calls for the rapid expansion and enhancement of community services, specifically by doubling the placement of 50 individuals per year for the next several years in the community
- The DPC should set aside a minimum percentage of its budget each year to support transitioning patients into the community, and provide contractors with appropriate compensation for services that takes inflation into account
- The Task Force recommends for the state to move forward with the construction of a new DPC facility, but only after a detailed actuarial study has been conducted to determine the right number of beds for the hospital, and an independent analysis of cost factors involved is conducted.

Many in the Task Force agreed that significant changes in the organizational and management structure of the DPC are needed if the Hospital is to move forward and truly embrace a patient centered recovery model. However, "changes in structure will be ineffective unless key hospital leadership positions such as the Directors of Performance Improvement and Nursing are filled with skilled professionals. The recruitment and retention of these individuals must become a management priority. Reasons for high turnover must be addressed, including issues of competitive compensation and the use of intimidation as a barrier to change." (team 1 report, page 22).

Even in recommending the construction of a new DPC facility to enhance recovery and promote independent functioning, it is noted: "the Task force emphasizes that a hospital is more than new walls and stresses the need for additional staff training, especially in psychosocial rehabilitation and recovery." Elevating the importance and clarifying the role of the Performance Improvement Unit was another high priority recommendation.

"The DPC requires experienced leaders who understand the continuous performance improvement process that includes the identification of performance benchmarks or key performance indicators." (Team 2 report, page 34) The Task Force did feel it important to commend DPC leadership for its demonstration of performance improvement work in the identification, tracking and timely reporting of seclusion and restraint use. The Task Force would like to see the same methods applied to benchmarks in other areas.

The work and subsequent recommendations of subcommittees 3 and 4, which reviewed options for additional community placement of patients and the need for a new DPC facility also overlapped. Testimony from independent research groups indicates that the nation, as a whole, has shifted away from institutionalizing individuals and toward facilitation of community placements. Yet, Delaware has not kept pace with that national trend. Additionally, testimony by community providers in Delaware mentioned that community placement is less expensive and can leverage additional funding than institutional care.

However, the Task Force believes that its not an either/or choice when it comes to building a new facility versus enhancing community services. According to testimony from DHSS staff, there is a segment of the mental health population who will always need to be served by a state hospital. The Task Force believes those individuals would have better care in a more uplifting, therapeutic environment as opposed to the current facility which is "outdated, costly to maintain, and in need of ongoing, expensive maintenance."

The Task Force in its experience sincerely believes the recommendations that it presents on the following pages, are meaningful steps toward improving the quality of patient care for those afflicted with mental illness and co-occurring substance abuse issues. None of them are intended to assign blame, but to be viewed as opportunities to learn and improve at both the individual, and the system level. The Task Force members worked to keep the tenants of best practice in mind as they formed their

recommendations, which will ultimately provide for a greater level of independent functioning and care for our most vulnerable citizens of our great State.

Team 1 Report – Review of all monitoring and accreditation reports identifying common themes and trends for improvement

(Team 1 – Harold Rosen, M.D., Facilitator; Representative Pam Maier, Kevin Ann Huckshorn, R.N., M.S.N., CAP and Rita Landgraf, Co-Chair)

I. CMS and Joint Commission Concerns

- **The first recommendation is that the DPC Director (or acting director) should immediately re-examine the current DPC Performance Improvement Committee's members. This re-examination's focus is two-fold: 1) to assure that the appropriate staff are assigned to this committee, which should include the DSAMH Director, DPC Hospital Director (CEO), Chief Psychiatrist, Medical Director, Director of Nursing, Director of Clinical Services, Assistant Hospital Administrator, Risk Manager, the HR Liaison responsible for DPC, the Staff Development or Training Director responsible for DPC, whomever supervises adjunct departments such as housekeeping and dietary, and any other key department directors; and 2) to assure that each of these PI committee members understand the priority importance of their assignment to this committee and the work that they will be responsible to perform as a result of their role at DPC.** *Once PIC membership is re-examined and all members are notified they must be oriented to these tasks by the PI Director or a consultant, if a director has not been hired.*

- **The Performance Improvement Committee (PIC), once re-established formally, should be responsible to develop plans to correct and resolve issues identified by the Centers for Medicare & Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and this Governor's Task Force. These plans need to be written, include target dates, and responsible persons for each goal and objective. It is also recommended that this committee meet every week until the majority of these issues are addressed. In addition, key members of the direct care workforce should be included, as should 1-2 external advocates. This Task Force believes that transparency in this process is one way to regain the public trust and assure that accurate information is communicated throughout the organization and to the public. These PIC meetings need to be priority until the corrective action plans are fully constructed and accepted by CMS and the Joint Commission. Only when these plans are being successfully implemented with ongoing monitoring by hospital leadership will the committee meet less often.**

- **The DSAMH Director and DPC Hospital Director (CEO) should review each of the major areas of concern in this *new* Plan of Correction (POC). The work of the PIC should be memorialized in written committee minutes. The priority recommendation for the PIC is to assure immediate implementation of the CMS Plan of Correction (POC) to specifically address the concerns noted by CMS**

that emerged from their recent visits. Items that need to be addressed in these minutes, for each issue include:

1) A clear statement of the concern.
2) A list of corrective action steps/interventions.
3) The Department leader who is responsible to ensure ongoing attention and completion.
4) A list of the necessary changes in processes or systems that will resolve the concern.
5) Specific indicators or measures for accountability.
6) A list of activities that are planned or have ensued.
7) The resolution of the problem noted.

- **Each priority concern (Goal) in the PIC hospital-wide plan and CMS POC should be assigned to an individual member of this team (DPC leaders) and this person should report on their progress each week at the PIC meeting until they are resolved.** As stated previously, minutes should be kept of these meetings. Although DPC has already begun to address these measures, increased structure and monitoring is required, including formal, written plans of action.

II. Hospital Oversight

- **An independent, volunteer board of directors known as the DPC *Oversight Board* should be created to guide current DPC leaders in their work as well as oversee, DPC's Performance Improvement activities to resolve all issues noted by CMS, JCAHO, and this Task Force. The "Board" should be the final oversight group. One way to strengthen and support the leadership of DPC, used by many facilities as a 'check and balance' function, is to identify a variety of stakeholders that includes the DE DHSS, community advocates, community provider leaders, state or nationally recognized consumers, and other state and community experts. This action would assist DPC assure transparency in operations as well as allow an opportunity for DPC staff to draw upon the expertise of skilled community leaders in resolving difficult practice processes, while remaining focused on quality of care enhancements.**

- **This Oversight Board structure should activate and strengthen the current DPC Advisory Committee within the Governors Advisory Council on Substance Abuse and Mental Health. The membership of this Oversight Board should include external mental health experts, external community advocates, including of peer advocates, and representatives from the Disabilities Law Program (DLP) and community provider members. Representatives from the DE Legislature would also be welcome. The Task Force recommends that membership to this Oversight Board be limited to four external experts, two legislative representatives, one DLP representative, one or two community provider leaders. One of these members must be a psychiatrist. In addition, the Task Force recommends that this committee be attended and staffed by**

representatives from DPC's executive management staff including the DSAMH Director, DPC's Director (CEO), the Director of Nursing (DON), the PI Director, and a skilled administrative support person.

- **The Oversight Board should also expect that they would be able to call upon the DHHS Secretary and any other DPC staff determined necessary to provide information to the Oversight Board. The most critical requirement in implementing this Oversight Board is that members need to be able to highlight issues that are of concern, or that are not being resolved, by DPC staff. As such, the Oversight Board needs to have direct access to the DSMAH Directors and the DHHS Secretary to assure that these problems, if they occur, will be resolved. This Oversight Board also would like to have the power to hold ad hoc meetings when necessary and more frequently than the once a month meeting whenever necessary. One way this body can become viable is through appointment, by the Governor, DHSS Secretary or through the Governor's Advisory Council on Substance Abuse and Mental Health.** *The knowledge and experience of the Oversight Board members should become a resource for DPC management and act to assure the community that there is ongoing scrutiny of the quality and safety of patient care, strategic planning, and management performance.*

- **An Oversight Board member should be represented on the DPC PIC Committee, and the Morbidity/Mortality Committee and other committees that may emerge as important.** The Oversight Board's function would be primarily "advisory" as it must be noted that "Governance Boards" are not used in governmental institutions. However, with the representation noted above, it is hoped that Delaware's citizenry will feel some degree of trust in this kind of oversight as DPC works to resolve these issues.

- **The need to restore public confidence in the DPC is critical, and the appointment of a director with demonstrated clinical and administrative experience would be a significant step in demonstrating a commitment to clinical excellence as the institution's first priority.** The search for a new hospital director should be to find the best possible candidate with demonstrated experience in the behavioral health field.

III. Performance Improvement Department

- **The Secretary of DHSS or his designee should chair the DPC Performance Improvement Committee (PIC). The process of change must begin with a change in the governance structure of the DPC. Even the most effective and well-intended leader cannot be successful if the overall organizational structure does not support quality improvement and system learning. This high level committee should be tasked to review any untoward incidents at the facility, community/hospital relational issues, admission and discharge issues, and any grievances or complaints.** *In addition, the Task Force noted that information on*

events were sent to senior management, however, did not see evidence as to the flow of communication and improvement action plans flowing down through the organization in an effective feedback process.

- **DPC needs to prioritize the hiring of an experienced, well-educated Performance Improvement Director.** Due to traditional operational practices, new staff, and current vacancies, DPC's Performance Improvement Department, a critically important department for any hospital, is not functioning in an effective, efficient, comprehensive, or timely manner. The department cannot function effectively within its current configuration, no matter how many staff is added. The basic issue is that this department collects data as its primary focus, without direction from an overall performance improvement plan and attention to analysis, and use of the data to improve hospital functioning. This is partly due to the fact the there are newly hired staff members in the department, and that the department lacks a well-experienced person to direct its function. *The Task Force understands that a Director is being hired and this recommendation is in no way designed to criticize current staff's performance but to emphasize the importance of this unit in promoting quality care measures and protecting the patient population.*

- **DPC needs to provide current PI staff with support and training in order to make the unit as effective and efficient as possible, as well as enabling the individuals who fulfill this responsibility to achieve success.** Changes in structure will be ineffective unless key hospital leadership positions such as the directors of Nursing and Performance Improvement are filled with skilled professionals. The recruitment and retention of these individuals as well as other clinical staff should become a management priority. Reasons for high turnover and lack of consistency in leadership positions must be addressed, including issues of competitive compensation and the use of intimidation as a barrier to change. Bedside staff, no matter how well motivated, cannot succeed without consistent leadership, appropriate training, reasonable resources, and opportunities for new learning. Every adverse event must become an opportunity to learn and improve at both the individual and system level, not an opportunity to assign blame. Each clinical unit must have an identified clinical leader who is empowered to make decisions. Split leadership can be a source of confusion in critical situations where clarity is essential.

- **The role of the Chief Psychiatrist and other physician administrative leaders should include strong leadership of and clear responsibility for the performance of the medical staff at DPC. In addition, these staff members should demonstrate an understanding of the Performance Improvement process and of their roles as "champions" for quality of and safety.** The role of physician leadership in the performance improvement process should be expanded and made more visible. The DPC physicians are ultimately responsible for the care of each patient and must be involved in all reviews, investigations, and critical committees and in substantive roles. The Chief Psychiatrist should be a champion for quality and safety, and this individual must be given sufficient time to perform this function. This is particularly important as testimony provided to this team indicated that these

executive functions have been assigned to a physician who has full time duties as an attending physician and not time to attend to these executive duties. A facility, such as DPC, needs to review physician tasks and productivity hours and assure that physicians who hold administrative positions have time to do this work. Adequate physician to patient ratios, while not a science, are recommended to be 1:15/24 for acute care facilities (5-21 day stays) and 1:24/35 for interim care facilities (21 days to 4 months stays). These ratios should allow physicians to participate in non-direct administrative tasks, including performance improvement processes. Generally, physicians who assume administrative tasks have slightly lower clinical loads than other physicians. These ratios should not be used for nursing long-term care facilities or forensic facilities as these have special needs but, as noted, all DPC clinical staff members' job functions should be reviewed as to direct clinical care hours to help determine adequate and cost effective ratios.

- **The Task Force recommends that there be a re-examination of DPC's Performance Improvement Department within the next year. This will require a thorough review of PI Department functions and tasks; current activities; staff productivity hours including a time study; a review of policy and procedures; a review of data tracking, collection and reporting activities; and a review of current staff member expertise, training, education, and understanding regarding performance improvement processes and outcomes.**

- **The Task Force recommends that processes be implemented to encourage a "culture of reporting and of safety" that is non-punitive. Staff must feel free to report near misses as well as variances, so that opportunities for improvement can be identified as well as addressed.** The PI Committee needs to direct their attention to specific, required performance data that is specific and of issue at DPC. There are literally hundreds of performance indicators that any inpatient facility could spend their time tracking. Most important is that each facility identifies high risk, problem prone or other problematic issues going on in that individual facility. DPC is not an exception. For instance, review of Medication Variances/Errors indicates that these are probably being under reported (as is quite common). Joint Commission is liable to question the low numbers of reported medication variances. But even without that oversight, all healthcare facilities must do everything possible to encourage the accurate reporting of medication errors. The time required to get PM-46 investigations could be another tracked process, as could patient or staff grievance resolution, morbidity and mortality investigations. *The point here is not to over burden a facility with reporting processes but to identify the key high-risk and problem-prone issues that the facility is dealing with and elevate these.*

IV. Investigations of Abuse, Neglect, Morbidity and Mortality

- **The Task Force recommends that specific processes and procedures be developed and implemented to ensure that all allegations of patient abuse are investigated in a timely manner, and that recommendations for action are**

implemented. These procedures need to follow a set pathway, and include mandated expectations for follow-up procedures and report writing as to findings. Abuse and Neglect reports require timely and written responses. CMS and staff members indicate a lack of consistency in the application of the PM46 procedure**.** Delays in these investigations need to be clearly noted and sent to senior hospital leaders to be resolved.

- **The Task Force recommends that a "root cause" analysis be completed on any incidents that were found to be without merit by DPC, but resulted in arrests. Root Cause Analyses provide rigorous examinations of events that have had negative or problematic outcomes, and follow a scripted process designed and published by the JCAHO. All problematic events at any hospital require this level of inquiry and reporting. In many hospitals, the single use of either seclusion or restraint or a medication, a medication error of any kind, a serious injury to a staff member or a patient require this kind of review. Root Cause Analyses are facilitated by a trained staff member and documented as part of the Performance Improvement Process.** The Task Force is possibly not fully aware of DPC's efforts as they relate to "Root Cause Analyses" of recent allegations of abuse or neglect. It is incumbent upon DPC leaders to review these incidents and to examine whether there were any that were found without merit but later were validated. If this is the case, it is crucial that DPC understand and correct the processes that led to these inaccurate decisions. When findings are in doubt, due to patient illness and a lack of ability to report, DPC 'findings' need to state "unresolved due to patient illness and a lack of information" rather than "unfounded" or other kinds of potentially discriminatory verbiage. The DPC investigative team continued to follow-up on at least one incident where findings were inconclusive and this work yielded much more information several weeks later that provided significant findings of staff error. All incidents need to be followed up with this kind of attention. This is a typical performance improvement activity.

- **The Task Force recommends that a section be added to the PM 46 to protect those who allege or report any acts of abuse/neglect and/or crimes under DHSS.** *Language exists currently in the Delaware Ombudsman Law and the anti-retaliation statute to protect reporters of abuse/neglect in long-term care facilities, but the DHSS PM # 46 does not mention it. It is equally important that reports be sensitive to those staff that have been unfairly accused of abuse and ensure that their records are reflective of this.*

- **A true and effective Continuous Performance Improvement Process understands that mistakes will be made in health care settings. To think otherwise is not realistic or fair. The point of a PI Program is to have the ability to identify problems when they occur, do a root cause analysis of the antecedents to the specific problem, and put in place mechanisms that avoid future repeats of the same problem. If the atmosphere is "blame-oriented" this kind of disclosure is unlikely to occur.** Staff and hospital administration need to be encouraged to disclose problems in the spirit of performance improvement and ethics codes, and

those facilities that disclose need to be praised, not blamed. This expectation of no-blame when a facility discloses a mistake or negative event should include the understanding of the community at large and the press, specifically. Facilities who disclose errors are to be praised for their transparency and the courage to so disclose. All facilities encounter 'bad eggs' but these need to be handled over time due to patterns in their behavior and union issues. Also important, when allegations against staff are proved to be false or frivolous this information also needs to be reported and apologies made as to the circumstances that led to these allegations. All recompense to staff needs to be made. Staff morale is very important and staff must feel that they are being treated fairly and be provided clear exoneration when allegations prove to either be without merit or false.

- **The Task Force recommends that all internal policies of the Divisions under DHSS that support PM46 be reviewed for consistency across Divisions and changes made to ensure parity of practice for patients or clients.** *Currently each Division has distinct implementation practices, which should be uniform across the Department, for clearer direction and overall oversight.*

- **The Task Force recommends that a clearer threshold be established to direct personnel when to contact law enforcement when an allegation has been made and define who makes the call.** PM #46 covers more than crimes; it also covers policy matters within DHSS. Any response by law enforcement needs to be documented.

- **The Task Force recommends that patients be debriefed with staff, who are not involved in the incident; this is currently considered best practice and will enable facility leadership to gather the most objective information on antecedents, as well as the actual seclusion/restraint process.** Patients are often debriefed with the same staff members who participate in the restraint and/or an incident. The Disabilities Law Program (DLP) spoke to several patients who believed that they would have felt more comfortable during debriefing with an impartial staff person. Many patients felt they would be able to divulge more information about how they were treated to an impartial staff member. Once the initial debriefing is done with a non-participant, the treatment team would converge to debrief with the patient. A member of the DPC Management Team needs to be informed as soon as possible after a patient has been placed in restraints and again if the order was extended.

- **The Task Force recommends that patients have access to the Patient Advocate during the debriefing due to the stress and trauma involved in revisiting the incident.** Offering patients the opportunity to have a DPC peer advocate (hired as staff) or the DLP Patient Advocate present will help ensure that patients' rights are protected and that there is transparency in the seclusion/restraint practices. The Disabilities Law Program is committed to ensuring that patients are safe while they are hospitalized and will support patients during debriefing, as would a Peer staff member, given adequate support and encouragement to do so.

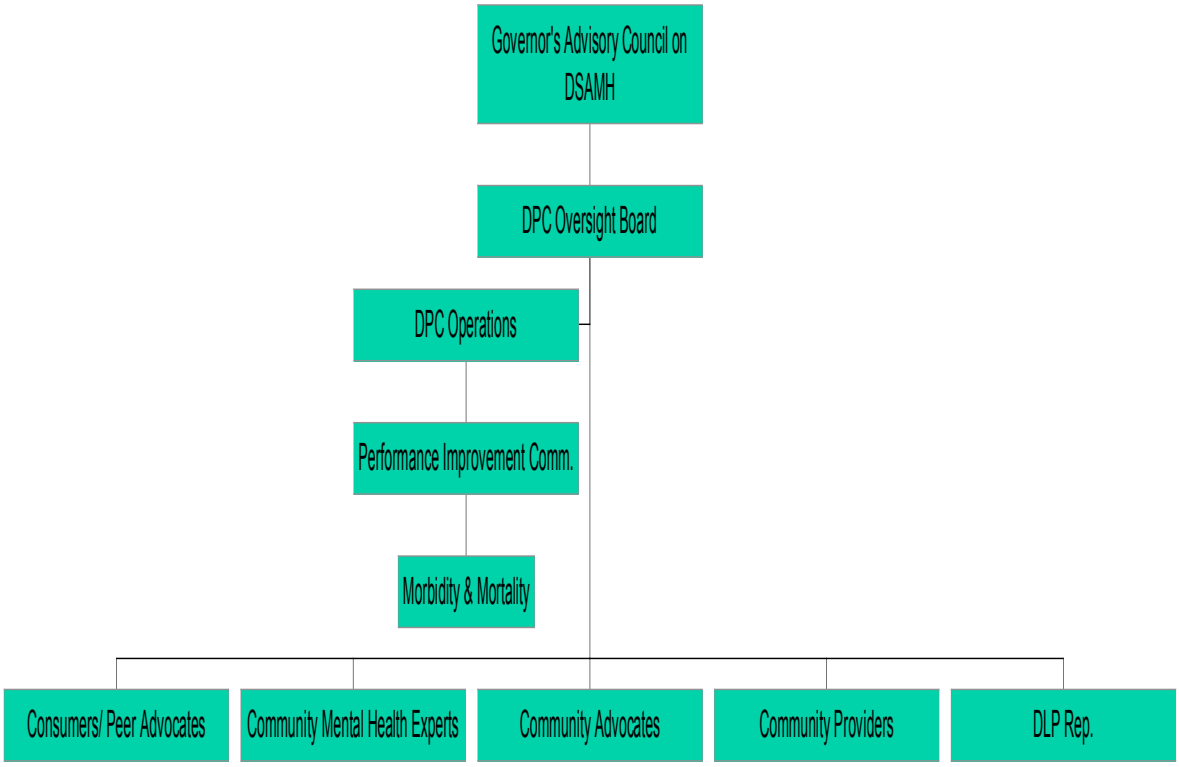
- **The Task Force recommends that DPC report all incidents (whether substantiated or not) to the DLP, which would be an important safety check on the system.** In addition, if the DLP were provided with all redacted PM-46 reports, they would be able to track whether a disproportionate amount of incidents go unsubstantiated and whether patterns of patient mistreatment begin to emerge in specific units or during specific shifts. This independent oversight would strengthen the work of the Performance Improvement Committee and provide for a higher standard in patient care. Many other states including Illinois, Maine, Maryland, North Carolina and Virginia require state facilities to report significant incidents of patient mistreatment, abuse, neglect, death, seclusion and restraints to the state Protection and Advocacy Agency.

- **The Task Force recommends that DHSS re-constitute the Human Rights Committees (HRC) or strengthen the Patient Rights Committee, as a subcommittee of the Oversight Board because this action will promote transparency, accountability and opportunities for system enhancements. External oversight is a larger part of a viable performance improvement process.** *The independent review of abuse/neglect investigations has been diluted over the years. In past years, DHSS required all PM-46 Reports of patient abuse and mistreatment to be reviewed by a Human Rights Committee (HRC) that included community representatives. However, the current policy revised and deleted this approach to monitoring.* The DPC Patient Rights Committee Policy and Procedure Directive entitles the committee to review information on incidents of patient mistreatment including allegations of abuse, neglect, significant injury or misappropriation of patient money/property. *The purpose of this review is to monitor DPC's investigative process. The Patient's Rights Committee (which should combine with the HRC and be a subcommittee of the Oversight Board of Directors), has not received any information regarding incidents of patient mistreatment within the last year. Furthermore the PM 46 coordinator has not attended any meeting within the last year. Although the DPC Policy directive requires all employees to cooperate fully with the PRC, this is not enforced.*

- **The Task Force recommends the establishment of a *Department-wide Morbidity/Mortality Review Committee (MMRC)*.** The Division of Substance Abuse and Mental Health has initiated such a committee, however membership to the committee is internal to the Division and it is unclear as to how often the committee meets. The Division of Developmental Disabilities Services has had a committee in place for several years with some outside representation and meets monthly to review deaths occurring both at Stockley Center and those in community, supported by private providers. The Department of Children, Youth and Their Families is governed by state statute to review all deaths, near deaths, and stillbirths. The Department of Correction also initiated a mortality review committee. Information on all deaths of individuals who participate in state-funded programs must be reported to a committee, which includes individuals outside of the system so that an unvarnished analysis is undertaken. *The MMRC reviews data, reports, and statistics and evaluates the circumstances surrounding each death to determine if there are any*

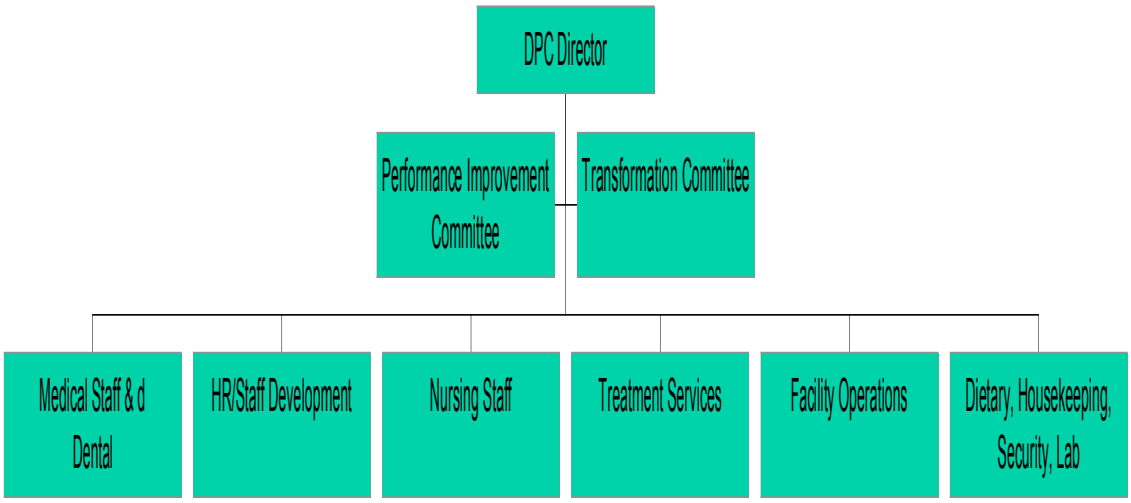
systemic changes that can be made to improve patient care. In addition, other states have statutory mandates for mortality/morbidity review committees such as Maryland, and New Hampshire.

- **The Task Force recommends using vacant staff positions (lapse money) to create DPC Peer Specialist (people in recovery) positions as contracted staff or regular full-time or part-time staff, to interview patients and staff on PM 46 events, all incident reports, seclusion and restraint events, patient satisfaction, staff satisfaction, DPC policy and procedure issues, and any other events that emerge that have to do with treatment, services or care. Peer Specialists, hired as staff, can do more to positive change a facility's culture than any other mechanism, as noted in the New Freedom Commission Report and the Institute of Medicine's reports.**



DPC's Oversight Board – represents an independent volunteer board of directors established to guide DPC leaders in their work and oversee DPC's performance improvement activities to resolve all issues and future issues identified by CMS, JCAHO and the Governor's Task Force. The Board should be the final oversight group. This action would assist DPC in assuring transparency in operations. The Task Force recommends that this Board be attended and staffed by representative from DPC's executive management staff including the DSAMH Director, DPC's Director, the Director of Nursing, the Performance Improvement Director and a skilled administrative support person.

DPC Operations Structure



It is also recommended to recruit volunteers from the DPC Oversight Board to participate as members to the Performance Improvement Committee, the Transformation Committee and to serve as support to the various operational committees that may be established in the future.

Team 2 Report: Personnel and Performance Improvement

(Kevin Huckshorn, RN, MSN, CAP; - Facilitator, Rita Landgraf, Co-Chair Yvonne Stringfield, Ed.D.; Dennis Rochford)

I. Leadership Functions

A. Matrix vs. Direct Line Organizational Structure

- **The priority recommendation of Team Two is for DPC to discontinue the use of an outdated "matrix" organizational (unit operational) structure and move to a more effective and accountable organizational structure.** *This structure generally uses master's level nurses with administrative experience to manage and oversee all unit operations. These lead unit Managers or Directors directly supervise and team with the direct line nursing staff members assigned to their units. As such, all direct nursing staff report to them directly.* This change would require the *Unit Director Position* to be *re-classified* as a *Nurse Director* position, that has direct line authority over all nursing staff, and additional clinical staff on each unit. Another way to implement this structure would be to upgrade the Unit Director position to include a MSN degree or an MS and RN degree as a mandatory qualification of any applicant. Each unit: Kent, Sussex, Mitchell, and Carvel would have a Nurse/Unit Director (as revised) responsible for daily unit functions, to include facility issues and overall treatment activities.

  The *Nurse Director* position would not have daily direct patient care responsibilities but would be available to coach staff, attend treatment team meetings, interface with all other staff on the unit, and assist with patients, who have challenging and complicated behaviors. Some psychiatric settings exempt out certain direct care staff, from this model, that includes social workers, psychologists, and activity therapists from reporting to the Nurse Director. This decision needs to be carefully considered and is generally driven by the functions of these staff and if they work on multiple units or are assigned to only one; due to clinical supervision requirements; hospital operations principles that hold that no supervisor should have more than 6-8 direct reports; and/or operational issues that can be resolved best with one model or another. However, when any type of clinical staff are assigned to work on one unit it is generally most effective to have one supervisor that works on that unit also, who can provide day-to-day supervision. When unit staff are assigned to off-unit supervisors, but are expected to serve as full unit-team members, problems can arise as to loyalties and accountability. This latter issue can be assuaged to some degree if the off-unit, usually non-nurse supervisor(s), of these other staff understand that the priority at DPC is the unit treatment activities and comprehend that all efforts need to be made to assure that unit activities function properly and that staff are not allowed to engage in behaviors that "split" the focus on unit functions or on each staff member's responsibilities.

The rationale for the above recommendation stems from the fact that, on a unit level, key operational responsibilities are unclear at DPC. *When problems arise, such as staff activities, facility management, treatment team attendance, treatment planning processes, performance improvement processes and treatment activities there is difficulty when trying to identify accountable staff or in assuring resolutions to problems.* The key difficulty in the matrix management model lies in direct care staff reporting and accountability. The Senior Unit Nurse and the Unit Director hold lateral positions. The direct care staff report to both, depending on their tasks. The Unit Director is apparently responsible for administrative functions such as facility issues, treatment activities, treatment planning and the like. The Nurse Manager is responsible for all clinical care provided to people admitted to that unit.

The potentially confusing interface of these responsibilities should be clear to any person reviewing this document. The Senior Nurse is a licensed professional, who is legally responsible for the care and well being of all patients in his or her care. *In general the lead RN and any other registered nurses, on any clinical unit, is liable and accountable for all patient care and any non-licensed staff need to report and be supervised by licensed nursing staff only.* The Unit Director, who may or may not be licensed and who does not share that same legal licensing responsibility, currently has equal and formal authority in assuring for services and care. This kind of bifurcated organizational structure can lead to conflict between the nursing staff and the other clinical staff on the unit and does not identify single supervisor accountability. If a staff member who feels more allegiance to the Unit Director does not choose to respond to a nursing directive, the resolution of this conflict can entail days, if not weeks, to resolve and vice versa. This management structure is not efficient, cost effective, patient-care oriented, or user-friendly.

The Unit Director model, as used at DPC, has been replaced in many public mental health facilities across the United States. This is because the matrix model does not facilitate adequate nursing supervision and creates a division between staff on the units, in the worst-case scenario. *Unit staff need to work as a team and under the same philosophy of care; need to share the same values, policies and procedures and work toward the same goals; and need to function together to provide seamless, efficient, effective, quality and accountable care for the person being served. This kind of teamwork can only be reasonably attained with one supervisor, not two.*

The matrix structure does not facilitate timely decision-making, efficient follow-up, effective feedback, or single-points of responsibility and accountability. The current organizational structure will require thoughtful study and an experienced senior leader to make recommendations for change. This reporting structure is possibly the causal factor in many of the issues being experienced by and between staff at DPC. This organizational change will require hands on, high-level leadership involvement. DHSS, DPC leaders and the Delaware legislature may need to work together to resolve this major organizational change. However, this recommendation needs to be implemented, and as soon as possible. The Task Force recognizes and regrets that this organizational change, when made, may negatively affect some staff members

who are performing well. This is very unfortunate, but in times of crisis or change, organizations must move forward. DPC leadership and the leaders who supervise these affected staff should be sensitive to these issues. The laudable effectiveness of one Unit Director cannot derail the effective management of the entire organization. Operational management decisions cannot be based on longevity, individual competence, or personal relationships. These decisions need to be based on management theory, effective processes, and desired outcomes.

B. Revise Position Descriptions to Include Minimum Expectations for Experience and Education

- **The leadership roles and job descriptions of the DPC Hospital Director, Assistant Hospital Director, Physicians, Unit Directors, Nurse Managers, and Nursing Supervisors are unclear in terms of their respective duties and performance improvement responsibilities and need to be revised to include minimum educational standards such as a high school diploma, or a college degree.** Many of these job descriptions also lack specific requirements for experience. Hospitals that serve people with serious mental conditions are generally expected to describe the education and experience expected of staff, especially senior and middle management staff. The traditional pattern of promoting employees with longevity solely, does not work well in our current health care environment, and staff who are hired, that do not have the education or experience to perform their job, are going to be set up for problems.

  The requirement regarding documenting demonstrated experience and educational background is particularly important when hiring clinical leadership positions. It was noted that the Nursing Supervisors are only expected to have an RN license. This requirement can be translated into the lowest level of RN preparation: a non-academic diploma school certification or a two-year ADN technical nurse. These qualifications do not guarantee the kind of education, training, or experience required of these staff who serve as "the eyes and ears" of the hospital executive staff during off-hours, holidays, and weekends. All DPC job descriptions need to include expected preparatory education and work experience requirements and these should only be waived, for good reason, and signed off by the DSAMH Director on a case-by-case basis. When and if these hires occur in the future, the new hires need to be immediately sent to training for specialization or certification in their new area of employment and be afforded access to consultants, who can assist in their orientation and training early on. This issue does not just affect direct care clinical positions but also employees who serve in staff development, performance improvement, risk management, and other critical roles.

  DPC staff report significant overlaps in the functions of Certified Nurse Assistants (CNA), Nursing Assistants (NA), Clinical Support Specialists (CSS), and Active Treatment Facilitators (ATF). Job descriptions are equally unclear and often vague as to key staff's tasks and responsibilities. DPC is to be lauded as to creating a career ladder of sorts for this group of staff but education, experience, and competencies

need to be clear for all in job descriptions, and reflected in pay scales that provide incentives for staff to seek further training.

C. Interim hire of an Experienced Hospital Administrator "Coach" Consultant

- **The re-organization of DPC's organizational structure and Performance Improvement Departmental functions are the single most critical issues that require immediate action, second only to the Joint Commission and CMS corrective action plans. It is recommended that DSAMH immediately contract with an experienced state hospital or organizational expert to spend at least six months, on-site and by phone, to facilitate further organizational and supervisory development with key Division and DPC executive staff. This "coach" is recommended to span the upcoming organizational changes that will occur when the current acting director returns to his regular position and should last through the 2008 election.** This contracted coach / leader would work directly with hospital management staff to implement and monitor new organizational structures, processes, and systems as well as improving existing high risk processes and system operations. This step will require the support of Delaware's Health and Social Services Department at all levels, including DPC leadership, Division leadership and Department leadership. It may be difficult to find such a person but all efforts need to go into this activity.

- **It is recommended that DPC administrators advertise for this position on the NASMHPD website and contact other state commissioners to see if there is an extremely effective state hospital superintendent who could be "loaned" to DPC for six months to eight months.** DSAMH could reimburse the person's current salary and perhaps provide a bonus for coming, as well as, to provide housing provisions and travel expenses for the six – eight month period. There are other ways to find a 'coach' and Team Two members have provided one expert's name to DSAMH already. Again, this may be difficult to orchestrate but is worth trying. Many states may be interested in assisting DPC as many states have been in similar positions in the past.

D. Performance Improvement Department

- **Health care facility Performance Improvement activities are complicated and require staff that have been specifically trained in these functions. DPC is no exception. It is critically important that DPC acquire a highly trained and experienced PI Director as soon as possible. It is understood, at this time, that this activity is in process.** Post the Director hire; all other PI staff members need to be afforded the training and support that will allow them to learn more about the key functions of Performance Improvement as noted in Team One's Report.

- **The second critical recommendation is that the PI Director, post orientation, re-examine the current PI Committee and re-organize the committee into a multi-disciplinary team that should be charged with revising the current PI Plan into a**

comprehensive hospital-wide Performance Improvement Plan. The Plan should identify the roles and responsibilities of *all* hospital staff in the DPC performance improvement activities and includes the identification of performance benchmarks or key performance indicators; the tracking of hospital staff's performance in meeting these indicators; the reporting on a monthly basis on hospital performance on these indicators; and action plans designed to address less than adequate performance against these indicators.

In reviewing this section, it is important to understand the principles of a Performance Improvement Department and its functions. First and most important, effective performance improvement activities only happen in an environment, that understands these key principles:

- 1) That all human managed organizations will experience mistakes, problems, and adverse events (there is no perfect healthcare organization),
- 2) That the second principle of "performance improvement" is to demonstrate absolute transparency when problems do occur,
- 3) The third principle speaks to the organizations expertise and competency in performing "rigorous root cause analyses" when problems, near misses, or adverse events do occur so that the facility can learn from these events and put in place processes to avoid them in the future,
- 4) That these events are identified, tracked, trended and reported to the Performance Improvement Committee, any oversight committees and the Governing Body on an at least quarterly basis, and
- 5) That all healthcare disciplines and departments, individually, identify and monitor issues and problems that they have identified as high risk or problem prone and that each of these department heads report on their work monthly to the PI department with data and quarterly to the PIC. Hospital wide performance improvement *is not the responsibility of one department* but of all hospital leaders, department heads and staff.

Usual hospital indicators would include such benchmarks as: the type and numbers of client and staff injuries on the job; the number of seclusion and restraint events and the hours of use, by client; the number of involuntary medications administrated; the number of adverse medication incidents reported; patient falls; the time it takes to resolve patient grievances; the time involved in resolving abuse and neglect reports; the active treatment hours afforded to each person in care; patient and staff satisfaction; insufficient documentation issues; staff and client attendance at treatment team meetings; external advocacy findings; and any other issues of note for that facility. A facility, such as DPC, will also have several Performance Improvement Projects underway that generally start with the identification of a *system-wide problem* and include the identification of an interdisciplinary committee that meets at least monthly to identify the problematic processes, make recommendations, and implement these *(see later description of the recommended Transformation Committee).*

- **It is recommended that the revised PI Plan should include specific departmental responsibilities and key indicators for each of these departments to track and**

analyze: this includes hospital disciplines such as the medical staff, the nursing staff, the psychology staff, the social work staff, the activity therapists, housekeeping staff, dietary staff, facility management, security staff, laboratory staff, medical and dental staff and any other disciplines/departments that DPC recognizes. Each of these department heads should take the lead on developing at least two performance improvement indicators that are based on current problems or high-risk areas. DPC is not currently tracking discipline-specific performance indicators or getting monthly reports from these departments.

It is important to understand that while DPC is doing an adequate job in tracking some indicators, this "tracking and monitoring" responsibility has fallen, primarily if not completely, on the PI department. A comprehensive Performance Improvement Process *coordinates and oversees* the work of each discipline (administration, physicians, nursing, psychology, social work, activity therapy, security staff, dieticians, housekeepers, et al). As stated above, each discipline will have their own list of improvement goals and processes to track progress. These discipline-specific indicators are generally based on safety/problem prone issues such as the use of seclusion/restraint, medication errors, falls, time used to resolve grievances, suicide attempts, self harm, recidivism, elopements, involuntary medication events, staff and patient injuries, patient refusal of treatment and other issues that have come to the attention of that discipline through incident reports or treatment failures. *For instance, physician improvement goals might include timely physician documentation of admission/discharge summaries, missed physical/medical problems, treatment refusals, discharge-planning failures, lack of active treatment programs, or the overuse of seclusion and restraint. Nursing improvement goals might include monitoring of completion of nursing admission assessments, quality of nursing care plans, medication administration errors, missed medication side effect events, missed behavioral clues that resulted in seclusion or restraint, physical/medical problems that were not caught, or the lack of supervision of unlicensed staff.*

- **Discipline specific benchmarks or indicators should be reported monthly by each department head to the Performance Improvement Committee, which includes the DPC Hospital Director. These findings should also be included in a quarterly hospital-wide PI Report that is sent to the DSAMH Director and the DHSS Secretary by the PI Director.** *Hospital Performance Improvement processes need to be tracked, monitored and result in consistent executive leader follow-up. These DPC PI processes need to be elevated as priorities that inform decision-making at the highest executive levels of DPC and DHSS to work. All of these benchmarks become the responsibility of the Hospital Director to follow-up and he or she needs to be able to obtain support from the DSAMH director and DHSS secretary for high level or complicated issues.* The Performance Improvement Director needs to report directly to the Hospital Director to assure the timely response and resolution of these critical issues, as the PI Director will be the most conversant on the hospital-wide plan and the data that tracks the discipline-specific benchmarks that have been identified in the plan.

DPC is to be commended for its ongoing demonstration of performance improvement in *one targeted area of data application*--- the identification, tracking, and timely reporting of seclusion and restraint use processes and outcomes. This expertise needs to be replicated for other hospital performance indicators. *Currently staff members collect data on numerous indicators, but there are no obvious outcomes or routine reports to other senior leaders. In other words, the majority of data that is being collected at DPC is not being monitored, analyzed, reported, or being used by staff outside of the Performance Improvement Department to create improvements or changes in practices.*

DPC is to be commended for placing an adequate number of staff in the Performance Improvement Unit**.** It is important to note that a fully functioning PI department does not rely on the number of staff but rather the education, training, and expertise of those staff members. For a facility the size of DPC the number of PI staff could total 3-4, given an experienced and competent director and the complete inclusion of other key departments and staff. Again, PI Departments should be mostly concerned with "coordinating" the improvement activities that are occurring in each hospital department. They are not to be held responsible for "doing" that work, per se. *All disciplines in a hospital have significant responsibilities for performance improvement work, again monitored and supervised by Department Directors and the Hospital Director.*

E. Specific Performance Improvement Indicators for DPC to include in a Comprehensive Performance Improvement Plan

- **DPC should develop a *Falls Reduction* program as required by the Joint Commission, and this should be constructed and implemented as soon as possible.** There is a great deal of literature on these issues and the leadership of DPC is encouraged to review this literature. *This is another joint indicator to be shared by physicians and nursing staff* and one-to-one orders are not the answer to this clinical issue, nor are restraint.

- **DPC should develop and track the results of a substance abuse treatment program that is offered to all persons who have these Co-occurring Disorders.** The apparent lack of a treatment program for such an important and experienced co-occurring disorder needs to be rectified and interface with community providers who provide these services.

- **Access to treatment activities and amount (hours per day) of treatment that each person admitted to DPC receives needs to be prioritized. DPC should have a process where admission assessments identify treatment needs, those needs are documented, and these individualized needs are incorporated into a treatment plan that describes that person's priority treatment services. For most individuals, these can be divided into several key areas that should be addressed in all treatment planning meetings and assigned to responsible parties.** The

director of this department was unable to effectively articulate how these services were implemented or how many people were receiving these services**.**

1. The first area is managing the symptoms of mental illness that can be targeted through medication, ordered by the physician, and monitored by nursing staff. This should include medication education, side effect management and monitoring, adverse effects, tracking weight and other lab work, informed consent, discharge support and a plan for supervision for med administration (social workers), and other issues.

2. The next area includes 'functional' issues that may pertain to hygiene skills, communication skills, motivation to get better, denial of illness, illness education, anger management, illness self-management, education including getting a GED or other specific personal goals, job training, the importance of peer support, linking to consumer-run services in the community, and many other issues.

3. The third area generally focuses on any medical or physical problems the person may be experiencing such as weight gain, diabetes, lack of exercise, hypertension, cancer, dental issues and also includes education by physicians and nursing staff. This area may also include the diagnosis of a physical illness or disease that will need specific illness-self management education and support on discharge. People with mental conditions have been identified to die up to 30 years earlier than the general population and most of these illnesses can be prevented or managed to avoid this tragedy.

4. The fourth area includes discharge planning activities that run the gamut from having a choice in where to live, to working with a provider agency to create a discharge placement that will meet the needs of the individual, mediating conflict with the family or caregivers, learning about transportation to and from community providers, financial issues, employment opportunities, etc. This function is the responsibility of the social workers and their supervisor in most cases and many of these issues can be covered in the treatment mall while the person is admitted.

- **It is critical and highly recommended that DPC put into practice performance indicators that track actual 'hours in treatment' for each person served, how these treatment hours address individual needs per the treatment plan, and what the outcomes are. This is just a beginning step but will prepare DPC to begin to identify and develop treatment services that meet the needs of the patients and families whom are Delaware citizens. This PI indicator needs to be the responsibility of the Director that oversees this service and his staff.** A menu of various therapeutic activities, leisure activities, education classes, and socialization opportunities was presented to the team. However, there did not seem to be any organization to this menu and the purpose and expected outcomes of these activities

were equally unclear. It was also not made clear how many patients were actually getting these services. Also unclear was who had access to these services and how these fit into the person's treatment plan.

- **It is recommended that DPC speed the process of hiring consumers of services to be included in their staff or in the treatment services provided to patients**. As noted in the New Freedom Commission and the Institute of Medicine, the inclusion of service users (consumers) is key to developing a recovery-oriented system of care. This step needs to be fast tracked and should be able to utilize vacant staff positions in a re-classification process. A general expectation for hospitals is to start with 2-4 peer specialists to be hired initially. This should be doable considering the vacant positions that DPC is managing currently.

- **DPC's use of One-to-One supervision orders needs to be explored and evaluated as to effectiveness, cost, efficiency, and outcomes. The use of one-to-one supervision is a high level, fairly intrusive intervention that should be used judiciously and only when circumstances merit its use.** This intervention requires at least one staff member to be specifically assigned to observe one patient, at no more than arms length at any time, for an amount of time usually specified in the physician's order. A very specific policy and procedure needs to be developed that specifies when this intervention is to be ordered and the behaviors that warrant its use. These criteria (and the physician's order) need to specify, in objective and measurable language: 1) the behaviors that led to the use of a one-to one, 2) the specific goal of this intervention, 3) what plan is in place to remedy the situation and discontinue the order, 4) who is responsible for initiating and tracking this remedial plan, 5) re-order time limits and the specific requirements required by the physician to re-order, and 6) mandatory oversight by the DPC Director and how that will occur (recommendation is that this should happen every 24 hours).

  One-to-one orders are very costly interventions and should be a time-limited intervention, such as are the use of seclusion and restraint. The constant and on-going use of one-to-one interventions does not teach the patient to do anything differently nor does it generally engage staff in therapeutic interventions. It should be used as a safety measure, on a time-limited basis, and only until a remedy can be found that resolves the issues that led to the person's behaviors that initiated it. Good multi-disciplinary treatment planning is one vehicle that is generally used to resolve these behavioral issues. Staff assigned to one-to-ones need to be trained that this is not a passive assignment but one that requires high level and sometimes sophisticated one-to-one interventions including the continuous documentation of the person's behavior, constant therapeutic communication, a plan, and a recovery-oriented focus and philosophy.

- **Another performance indicator that must be prioritized and tracked by DPC administration is the time it takes to hire new staff, terminate staff, and to track termination reversals that occur by outside legal committees.** It is extremely difficult and an issue that seriously effects staff morale when a staff person is

terminated for cause and then reinstated months or even years later. It sends the message that 'anything goes' and that staff will not be held responsible for their actions. Anything that can be done to correct this current situation needs to be done. The administrative and legislative branch may wish to review the merit system, the multiple levels of due process, and the exempt and non-exempt classifications of staff at DPC.

- **The Task Force recommends that the legislature investigate revising state code to mandate criminal background checks and drug testing for all state employees working in health care settings.** According to JACHO standards, pre-employment drug screening and background checks need to be consistent with state standards; therefore, these types of pre-hire screening processes are aligned with state laws. Most state hospitals and private not-for-profits do these screens as a matter of course. This recommendation is not to say that everyone who has a criminal background screening should not be hired. As in all issues, the individual staff applicant needs to be interviewed and the circumstances of this criminal finding be investigated. DPC needs to at least identify who is applying and their histories so this can be a part of any new hire interview.

- **It is recommended that DPC leadership staff attend training on preventing violence and the use of seclusion, restraint and other traumatizing practices, or similar training, so they come up to speed on current practices that have changed greatly in the last few years. In particular, the focus on prevention conflict before it occurs is paramount in reducing the kinds of events that lead to seclusion and restraint. As noted in this report, DPC is doing a good job in tracking their use of seclusion and restraint. All efforts need to be focused on training staff on how to avoid these events in the first place.** There needs to be a formal and active process in place to reduce the use of these interventions.

- **It is also recommended that DPC consider the use of outside experts to train the DPC leadership and direct care staff on the principles and interventions central to developing a system of care that is trauma-informed. The majority of people served in state mental health facilities have extensive histories of traumatic life experiences and possible PTSD (Post Traumatic Stress Disorder).** This training can prepare DPC staff and community staff to understand this pervasive issue and its effect on the treatment and recovery process.

II. Individualized Treatment Planning and Activities

A. Transformation Committee

- **It is recommended that DPC develop a *Transformation Committee* whose lead reports to the DPC Hospital Director and has representation on the Performance Improvement Committee with attendant performance indicators. The Transformation Committee's charge is to review and revise the hospitals' philosophy, vision, overall goals, and operational objectives. The first priority**

that should be considered is the need to implement 'individualized approaches' in all clinical and adjunctive operations, starting with safety issues, customer services, treatment planning, and treatment activities. This committee also needs to be carefully involved in any planning for the building of a new hospital to assure that individual patient needs are met, living and treatment space is adequate and that the new hospital is able to support the needs of people served well into the future. One of the key goals of the Governor's appointed Task Force was to provide recommendations that lead to changes that would help to *move the DPC hospital's operations toward the development of a recovery-oriented system of care.* At present, this recommendation will require a senior and experienced administrative "coach" to help guide the acting director and other DPC leaders.

- **It is recommended that the onsite leadership consultant (coach) be involved in or guide this work. It is also possible to fulfill this requirement by hiring a separate consultant that can visit DPC frequently, is at a senior level, and is supervised by the DSAMH Director.** As a note, for those who understand the term of use, this Transformation Committee would serve in a similar capacity as a high level *Performance-Improvement Team, as described by JCAHO.*

- **DPC needs to review staffing vacancies and identify where positions can be revised to hire peer consumer specialists, starting with a Director of Consumer Affairs.** *At present, individualized treatment services do not seem to be provided to the majority of DPC patients, and/or individualized services are not provided with any regularity. Patients must receive education on their role in treatment team meetings from day one of their admission and be strongly and sincerely invited to attend their own treatment team meetings. Consumer or Peer Specialists that help to bridge this education gap and help greatly in demonstrating the principles of recovery "in action."* This transition from custodial, homogenized treatment is also occurring nationally in the mental health field and the hire of primary consumers is becoming a national movement that is effective in facilitating this significant culture change.

- **It is recommended that DPC create a permanent/State position for the Director of the Treatment Mall. This would indicate a stronger commitment by DPC to this treatment modality.** It was noted that the Director of the Treatment Mall is currently a temporary, contractual position. If done, this new state position needs to be advertised so that people with significant experience in this model can apply. This is not to infer that the current director is not qualified, the Task Force has no knowledge about this person's qualifications. However, this is a key position, requires a knowledgeable director and the Transformation Committee could play a vital role in developing and/or revising the job description and assisting in the recruitment process.

B. Steps to Develop Processes for Individualization of Treatment

- **The evolving Treatment Mall provides excellent opportunities to begin the process of individualizing recovery-oriented treatment. A first step recommendation should be for all unit staff (by unit) to identify the top ten individual treatment needs of the people they serve and then to summarize these needs on a list of fifteen to twenty priorities. Treatment Mall staff members can be given this list and asked to provide clinical services specific to meet these needs.** While the Hair Salon, Gift Shop, Music Room and other more generic and leisure type activities are very important, these activities do not meet the key mission of the hospital. Instead, treatment activities such as *Conflict Management, Health and Hygiene, Medication Education including Side Effect Management, Illness Education, Substance Abuse Treatment, Illness Self Management, Managing Money, Job Interviews, Getting a GED, Building a Support System, Introduction to Community Self Help, Triggers for Relapse, and What is Recovery*? *are more common to effective, recovery-oriented Treatment Malls.*

- **Once these treatment and recovery groups are developed, with current curriculums and schedules, each treatment team should develop, *with* the person served, their own personal recovery plan and daily schedule that is then provided, in writing, to the person served and to the treatment mall staff.** It was noted that the Department responsible for treatment activities has a list of services available *but it was difficult to understand how these services are implemented and if all patients have access.* Every individual patient should be given a schedule of their own activities, developed in collaboration with the treatment team, to have on his or her person at all times, and mechanisms must be put in place to track attendance at these activities. Patients should have an identified professional staff member (psychology) who encourages and supports them in understanding the benefits of participation in these activities.

C. Access to Recovery/Treatment Mall Activities

- **The Treatment Mall project should be re-evaluated in terms of access to patients admitted to DPC and the schedule of activities seven days a week.** *The optimal treatment mall should be open from morning to lunch and after lunch till dinner, and open on weekends and holidays. To be specific, treatment malls are often open from 9am to noon and from 1pm to 5pm. The treatment mall should be able to serve anyone approved to attend and all persons admitted to DPC should be encouraged to attend.* Patients who need escorts to attend should be provided these. Staff, who usually work on units should be encouraged to provide services in the Mall as, in the best case scenario, the majority of patients will be attending and the need for staff on individual units during the day shift should decrease. The current DPC space constraints that allow no more than forty participants at a time in the Mall area is not a valid reason to deny comprehensive recovery-focused services.

- **It is recommended that DPC compensate for the possible physical space limitations of the Mall by exploring other areas in the hospital that could be made available for treatment mall groups, including empty conference rooms that would expand the ability of DPC to get people off units so they could be actively engaged in treatment designed to facilitate both recovery and discharge.**

- **It is recommended that DPC prioritize a review of their current treatment planning process. In a recovery-oriented system of care, the consumer or patient is asked (and expected) to attend their treatment-planning meeting. Prior to this meeting, the social worker or psychologist should meet with the person and explain what this meeting is about, in a way that can be understood easily by a non-clinical person. Most patients have no working knowledge of their responsibilities in a treatment team meeting nor understand this process unless time is taken to orient, coach, and support each person to attend and participate.** The use of "shared decision making" fact sheets can be helpful here and templates from medical and some psychiatric facilities are available. It is unfair to expect a person who is ill, and who has never been empowered to participate in his or her own planning process to understand what their own responsibilities are here**.** Peer specialists are skilled in this work and clinical staff members need to also gain skills to facilitate consumer participation. In summary, the DPC culture needs to change to expect that all patients attend their treatment team meetings. Staff language needs to change to welcome and accommodate attendance at these treatment plan meetings, patients who cannot or will not attend need to receive additional "engagement" interventions and in general, the DPC staff need to understand that failure of an admitted person to attend their own treatment planning meeting is a treatment failure and needs to be addressed proactively, with respect, compassion and education.

III. Workforce Issues

A. Clarification of Roles

- **DPC should evaluate staffing needs, based on the current patient/client population by unit. This hospital-wide staffing evaluation should not only include all nursing staff positions, but also social workers, activity therapists, psychologists, physicians, and all administrative adjunctive staff such as procurement staff, housekeeping, and dietary positions.** Each clinical staff position should be evaluated against that specific job description and all tasks expectations for that position need to be clearly defined. DPC should look to collapse some of the direct care staff nursing positions that seem to be similar and confusing. Roles that need to be clarified include NA, CNA, CSS, and ATF positions at a minimum, as noted previously. Hospital job descriptions need to be specific, standardized, and developed to hold staff accountable to their responsibilities and tasks. It is expected and hoped that the hospital's union organizations will share in this goal and be invited to assist in this task.

B. Allocation of Staff Time

- **DPC leaders need to determine how staff members are spending their time on a daily basis. The goal is for every clinical staff member to be assigned and monitored in terms of time allocation. Each clinical staff position should be expected to provide a certain number of direct service hours; meaning *face-to-face contact* with clients. The assignment of these hours is based on leaderships' knowledge of the balance between staff administrative tasks, direct service tasks, and personal time. *Administrative tasks* are those that include activities such as treatment team meetings or work that does not include the patient, charting, developing schedules, writing treatment plans, taking off physician orders, phone calls, meetings etc. *Direct service tasks* include activities out on the unit working with clients, one-to-one activities, observations of patients individually or in groups, all group work, treatment planning that include the patient, patient education, escorting, etc. *Personal time* is that time spent on breaks, meals, time off, vacation and sick time. In general, direct care clinical staff, without clearly specified supervisory responsibilities, should be expected to spend five hours of direct service per day when on shift.** This expectation would mean that non-administrative psychology staff, nursing staff, social workers, and rehabilitation/activity staff would be able to document five hours of direct service work per day. This work is generally tracked by each of these staff members' daily schedule, supervision, and medical record documentation.

  It is common in hospitals that, at times, employees are not utilized to their full extent and, as such, precious resources are wasted in either unnecessary positions or a lack of productivity that results in less than optimal outcomes. *Department heads need to develop specific schedules for direct service treatment activities for their staff and these activities need to be integrated into unit specific treatment activity schedules that include the identification of the staff member or members who are responsible for that activity on a day-to-day basis.* All efforts need to be made to assure that treatment also occurs on weekends and holidays and that may mean that new hires in the disciplines of social work, psychology, and activity therapies will need to work weekend hours, if current staff schedules cannot be changed.

C. Competencies

- **DPC should ensure that each staff member assigned to a specific unit for any length of time has been trained and is competent to function within that program**. *Some staff members report that nursing staff are routinely "floated" to programs, such as Forensics, where they are not trained and, if so, they cannot function competently. This situation requires immediate attention. The "floating" of full time and agency staff needs to be minimized to what is absolutely necessary to meet patient safety needs and the need for adequate staff coverage.*

D. Job Training and Ongoing Coaching

- **DPC needs to review their workforce development program, starting with new hire interviews; new hire orientation; the identification of mandatory staff knowledge, skills and attitudes; and specifically clarify population-specific and special-need specific competencies for the special need units.** The purpose here is to implement internal processes to provide effective and documented training, competency evaluations, and ongoing mentoring/coaching activities. For example, DPC's recent requirement of Certification for Nursing Assistants elevates the basic qualification; this basic training prepares individuals to provide physical care. *Additional psychiatric-behavioral training is needed for Certified Nursing Assistants and other entry-level staff.*

- **It is recommended that inpatient-focused education and training be developed and implemented for inpatient DPC staff and that this training be provided at the hospital in a reoccurring manner so as to reach staff on all shifts.** This training curriculum should be mandated, staff required to attend and attendance be monitored by the DPC training staff director (to be developed). Otherwise there is no way to track attendance or hold staff accountable for new learning experiences. The DE Mental Health Summer Training Institute is a very comprehensive and excellent program. However, it is not always easily accessed by staff employed at DPC. All hospitals require onsite training that is specifically directed to the needs of their staff and is very user-friendly, as well as accessible year-round. *Before this inpatient-focused training starts, DPC's leadership needs to issue a policy statement on this training program, outline their expectations for staff, embed these in all job descriptions, and spend face to face time with staff on all shifts to explain the importance of this training.*

E. Functions of Human Resources and Staff Development

- **DPC requires highly effective and immediately accessible human resource and staff development support. It is recommended that DSAMH leadership carefully review the current operations of the centralized DHSS Human Resources Department, of which Staff Development (training) is a component, toward revising this model if necessary. It is strongly recommended that a full-time Staff Development Director be assigned to DPC, even if that person continues to belong to the centralized HR Department. Based on the recent findings of the Centers for Medicaid and Medicare regarding abuse and neglect issues the assignment of a Full-time Staff Development Director and immediate access to experienced and effective HR staff is critical.** If it is necessary to share the State Development DPC Director position than this will require "co-supervision" from both the DPC Director and the centralized HR Department. While this is not the most effective model of supervision it can work when limited to one or two staff. These two functions, HR and SD, are absolutely critical in the successful operations of any state hospital and, even when if centralized, need to provide on-site, direct involvement to the hospital on a day-to-day basis, report to the DPC Director, and be accountable for their activities to DPC leaders. Leadership staff who are managing a

hospital cannot be expected to manage the kinds of day-to-day personnel issues that come up without on-site sophisticated guidance that is available, immediately accessible, and competent regarding union contracts and legal issues.

Team 3 – Expansion of Community Options

(Team 3 – Rita M. Landgraf; Facilitator, Senator Margaret Rose Henry, Kevin Ann Huckshorn, R.N., M.S.N., CAP and Gary Wirt, Ed.D)

I. Patient Population and Community Placement

Respecting the rights of all citizens and upholding the dignity of persons with disabilities, including those with psychiatric conditions, to live work and recreate in the community setting of their choice, our federal government and the Supreme Court have concluded that it is the basic human right not to be warehoused in an institution, but to be able to live in a community with all of the support services necessary to make such community living successful.

The Supreme Court's Olmstead Decision ensures that individuals in "long-term care" facilities and institutions (DPC aggregate length of stay is 2,130 days on average), be assessed in a fair and timely manner to determine how community living would be possible without limiting options solely to what is currently available within community. The court further found that:

> institutional placement of persons who can handle and benefit from community settings perpetuates "unwarranted assumptions" that persons so isolated are incapable or unworthy of participating in community life; and confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment.

Since 1986, there have been several periods of great progress in Delaware, towards the development of a comprehensive community system, which traditionally corresponded with accreditation, certification, overcrowding concerns within the hospital setting. The first period was between 1986 and 1993, with the initiation of community funding and supports. During this timeframe progress was made in the movement of patients from DPC into the community, as well, as the implementation of the Medicaid Plan Amendment. However, between 1993 and 1999 community growth remained stagnant until DPC, was once again, cited by accreditation bodies and vulnerable to loss of funding and operation. As a result of this situation, in the years between 2000 through 2004, over 100 individuals were discharged to community providers and residential options were expanded, which included new supervised apartments and group homes.

The growth spurts in community-based services seem to correspond directly with issues relative to DPC rather then through a comprehensive planning process. Further these growth spurts in community-based services seem to be followed by periods of funding retrenchment, during which DPC censuses and citations rise. Since 1986 and possibly prior to, this activity has been cyclical and will no doubt continue unless a purposeful plan and commitment to expand community services on an ongoing annual basis is made.

It is also important to note that any rise in DPC census may not be as a result of those directly enrolled in the community system. The Task Force was presented with some compelling testimony indicating that this increase may be due to the inadequate capacity in the community system to absorb specialized populations. It is equally interesting to note that after an infusion of resources into the community system in 2000 to create additional community-based residential capacity and to shift acute hospital admissions from DPC to community psychiatric hospitals, the census at DPC has remained fairly consistent. A prominent result of the development of community housing resources has been a 25% decline in the average daily inpatient census from approximately 330 in July 2001 to 247 in July 2007. (DSAMH FY08 Community Mental Health Services Block Grant Plan). This could suggest that expanding and adequately funding community-based service options may decrease the need for more hospital beds.

- **For those reasons cited above, the Task Force recommends the rapid and steady planned expansion and enhancement of new and existing community-based programs for persons currently living at DPC as well as for individuals who might avoid hospitalization if the right combination of adequately funded services existed in the community.** A doubling of the per year community placements for the next three to four years targeting 50 placements per year from both DPC and those in community in need of services should be considered. These placements should be adequately funded based on the individual's needs.

- **The priority recommendation is for DPC to immediately contract for an independent clinical and functional assessment of all patients within the setting.** Assessments should be written and conducted in a fair, objective, unbiased manner by objective, non-state independent consultants. The assessment needs to determine the appropriate housing, health services, social support, transportation, and employment/vocational services, which meet the individual's needs and preferences. Again, independent contractors should conduct the initial and ongoing assessments of the population.

- **The Task Force recommends that the assessment process and practice should provide necessary information to individuals regarding community services and actively engage these individuals in the decision making process.**

- **The Task Force recommends that the assessment process create data that can be used to maintain an accurate database of individual needs and circumstances.** In addition, the cost of providing such services should be estimated and recommended as part of the ongoing budget process.

- **The Task Force recommends that the database be tracked and shared with the community provider network for the development of ongoing placements on an annual basis to prevent unnecessary institutionalization beyond the stabilization of the individual's condition.** This database would enable greater collaboration and coordination of services among all stakeholders.

- **The Task Force recommends that DPC use the database created through the assessment findings to facilitate the transition of individuals to community based living in as expeditious a manner as possible but a no growth in community allocation is not acceptable for future enhancements as has been the history within the behavioral health environment, minus a crisis.**

- The Task Force recommends that the DHSS budget for a yearly percent of individuals to be moved and supported in the community. A minimum percent per year should be set which would determine movement of individuals from DPC to community and the movement of individuals currently residing in the community who may desire and be stabilized to achieve living within a less restrictive environment.

II. Assessments within Community Structure

The Division of Substance Abuse and Mental Health (DSAMH) supports approximately 6,000 individuals living in the community through contracted providers and through state mental health centers. This system of care does face continual challenges, even in light of the fact that Delaware's rate of penetration is less then the national average. At any given time, an additional 6,000 individuals may be in need of these support services if we were to use national penetration and a 2% mental illness prevalency rate and taking in account that not all of this population seek out treatment and support services. The following recommendations attempt to address these issues:

- **The Task Force recommends that an assessment of the current capacity of the community support system be conducted to highlight a balanced and comprehensive system of care.** The findings of this assessment should not be seen in a vacuum but should be applied as cross-reference with the actuarial study for the right sizing of DPC. *Delaware should implement a comprehensive system of care, which minimizes the use of institutions and maximizes community supports, treatment and integration.*

- **The Task Force recommends that the findings of both the actuarial and the community assessment plan should be incorporated into future Olmstead and New Freedom Initiative reports validating the shift from institutional care to community based care. Whenever possible and appropriate, care and treatment should be provided within the most inclusive settings in community.** Delaware's Olmstead Plan issued in 2002, reported a steady decline of DPC's population from 1,530 in 1965 to 248. The pace of this movement to the community has, however slowed in the past several years. The total census is now between 240 and 245, only three shy of the total in 2002**.** If community capacity and resources are enhanced, DPC's role may change over time to become a specialized setting to support those with distinctive needs not being appropriate for community care or treatment such as forensic, medically fragile or acute high end users. However, individuals who could benefit from community should not remain at DPC due to insufficient funding for community placements or lack of comprehensive discharge planning practices.

- **The Task Force recommends that a utilization review (UR) process be initiated that is managed by an independent community contractor not otherwise involved in the DSAMH system of care.** This UR process should mirror the kind of UR performed by other community hospitals and managed care insurers and would provide the state with daily reports regarding people admitted to DPC who no longer meet criteria for this level of care. The above recommendations should alleviate this scenario and would afford the state a comprehensive planning process, which is cost-effective and ensures that the appropriate level of care is provided.

- **For DPC to better reflect their actual length of stay, data needs to be analyzed based by patient population inclusive of Forensic Unit (Mitchell), Long Term Care Unit (Carvel), Acute Care Unit (K-3) and Intermediate Care Units (K-S).** The average aggregate length of stay for resident adult patients at DPC in 2006 was 2,130 days compared to the national average of 869 days. CMHS reports that in 2006 Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%.

III. Funding Considerations

A. National and Historical Perspective

As states steadily shift from a delivery system focused on inpatient services to one of community-based service, this movement has been reflected in their mental health budgets. A national study (NASMHPD Research Institute, 2005) shows dramatic changes in the allocation of total state mental health agency expenditures in the United States between 1993 and 2003. For example:

In 1993
--48% of mental health budget expenditures were allocated to state psychiatric hospital inpatient services
--49% of expenditures were allocated to community-based services

By 2002
--29% of expenditures were allocated to state psychiatric hospital inpatient services
--69% of expenditures were allocated to community-based services

Delaware's allocation of resources today is similar to that of the U.S. in 1993. In 2005, Delaware's spending on community-based services for the same time was 45%. It is difficult to know what Delaware's total community costs are as the state's Medicaid service costs are not included. It may be that with the addition of these Medicaid community mental health expenditures that DE's community funding is higher than 45%, which would change these ratios. Most states include Medicaid expenditures when reporting these costs.

- **The Task Force recommends that an explanation regarding why inpatient service costs are not being shared by Medicaid needs to be provided.** It should also be noted that the 45% of spending on community-based care includes funds to support the involuntary commitments to community psychiatric hospitals such as Rockford Center, Meadowwood and Dover Behavioral Health. The use of state general revenue funding for private psychiatric beds in the community needs to be reviewed. Medicaid generally pays the cost of psychiatric care when that care is provided in a general medical facility.

- **The Task Force recommends that all efforts need to be taken to access these federal dollars to help support these very expensive hospital beds.** Also, the actual per bed day costs need to be described in order to assure that the state is not over-paying for these beds. Costs per bed should reflect the costs paid by managed care providers for these same services for their covered populations.

B. Recent Delaware Budgetary Practices

- **The Task Force recommends that Delaware's budgetary allocations for community support services keep closer pace with the ongoing need, and that the community support service system receive inflationary increases to sustain their current level of services. The Task Force recommends a dedicated % of increase be provided to providers on an annual basis that is reflective of inflationary measures and/or the CPI. Between 2001 and 2007, private providers received less than 4% in contractual increases. During this same timeframe, the consumer price index increased by approximately 30%.** Rates for services, many of them set in 2001, have not be re-evaluated for increases. Providers have indicated this lack of increase has a direct impact on the delivery of service. Many have increased the number of individuals being served assigned to a staff member, resulting in a less intensive service for those with the most significant conditions. DE community mental health providers testified that they have not been able to provide cost of living increases for their employees for many years and that these same employees are still limited to mileage reimbursement that is almost 50% less than the federal rate. *Such erosion of community-based services can lead to increased use of unnecessary hospital care.* The non-state community providers have voiced that since 2001, community-based services have actually eroded. The Legislature last appropriated funds for group homes in the FY01 and FY02 budgets. Funds for supervised apartments were included in FY01, 02, 06, 07 and 08 budgets. As a result, *the Division's inventory of supported housing is limited to fourteen (14) group homes (serving 114 residents) and eight (8) supervised apartment programs. The combined capacity of the entire residential system is only two hundred nine (209) clients statewide.*

- **The Task Force supports the movement of the 35 patients to community-based services and the dedicated funding associated with this movement to adequately support those transitioning from DPC to community. This movement will bring the community residential placements to 244 and hospital census 210, if average**

census remains constant. The justification for this movement has been primarily due to the staffing issues at DPC and not reflective of a planned initiative to adequately fund and support the shift to comprehensive community based services.

- **The Task Force recommends that DSAMH develop a comprehensive plan to support a dedicated number of new community placements on an annual basis including those exiting DPC in need of residential support and those from non-residential community programs in need of this level of support. A previous recommendation is targeting 50 placements per year.**

- **As the primary funding source for both hospitalization and community placement, the Task Force recommends that DSAMH have a team of professionals that support transitions, provide monitoring and follow up services to those in living in the community.** The purpose of follow up is to ensure that the individual's needs are adequately being provided for and if additional supports are needed.

- **The Task Force recommends the development of an evidence-based determination process that assesses reasonable and equitable costs for the provision of services. Ideally individualized budgets should be constructed, as part of the individualized treatment plans and those budgets should be applied to support the provider contracts.** This system seems to be working fairly well in the Division of Developmental Disabilities Services and it is recommended to consult with DDDS for consideration of replication within the mental health system. Mental Health Self Determination projects could be explored to investigate the development of individualized budgets for persons with serious mental illness and re-occurring substance abuse issues. Michigan, Vermont and Florida have been successful in developing individualized budgets for this population.

C. Cost of Community Services and Supports

The Task Force reviewed a chart of costs for selected community-based services from the largest private mental health provider (serving 5,000 individuals), which reflected actual planned expenditures, revenue sources and numbers served. This chart demonstrated that the costs of contractual community-based services range from a low of $400 per person for outpatient treatment to a high of $160,000 for a specialized group home designed to meet the needs of the elderly, and the medically challenged DPC patients re-entering the community after a lengthy hospital stay. The next level of care is a licensed group home that provides supports to former DPC patients at $88,000 per person per year and for individuals requiring supervised care within apartment settings, the cost averages to $50,000 per person per year. Approximately 450 individuals benefit from the Community Continuum of Care Program (CCCP) at a cost of $13,212 per person per year. The most intense care at the highest cost is hospital care at $220,000.

- **The Task Force believes that individuals who require that level of care should be able to access it but also believe that it is beneficial to invest in a community**

continuum of care which will allow individuals to benefit from community life and has proven to be cost effective. An independent actuarial study to determine the right mix of inpatient options, in conjunction with a community assessment would be an investment in building the continuum of care with the premise of establishing services within the least restrictive environments while ensuring individuals are receiving the necessary supports.

- **For those reasons cited above, the Task Force further recommends an expansion and enhancement of new and existing community-based programs. It is also important to recognize that the funding for community-based services does not all come from the general fund budget. The services provided within the community have leverage capability relative to funding mechanisms that DPC cannot access due to federal regulation restrictions.** Therefore, for every fund dollar spent in the community, in many cases, it would be possible to bring in another dollar from other sources, doubling the resources available to expand the system. A well thought out evidence based cost projection should be presented that specifies the amount needed to fortify the community-based system.

- **A possible recommendation is to examine other revenue sources such as the millions of dollars the state now collects in disproportionate share funds that could go back into DSAMH's budget to fund an expansion of community services, where additional Medicaid revenue could be generated.** This would allow for the generation of additional Medicaid funding that could be collected for the same patients once they are out of the hospital.

- **The comprehensive plan which the Task Force has recommended above should also include the NAMI housing program as a vehicle to acquire safe, affordable housing.** NAMI – Delaware's Housing Program has a waiting list of 52 individuals awaiting housing but are in need of the community service component in conjunction with housing. These individuals should receive assessments to determine eligibility for state mental health and other services. If these individuals are not DSAMH eligible, it is important to connect them with the appropriate service agency (ies).

- **The Task Force recommends utilizing the recommendations offered in the Governor's Commission on Community Based Alternatives and the Delaware Interagency Council on Homelessness.** These plans provide a detailed timeline and action steps which if implemented would afford individuals greater access to their community in a holistic manner including access to housing, employment, transportation and health care. In addition to these reports, an update on the status of the HR 93 Report as it relates to enhancing community supports would be beneficial.

- **Based on testimony of family members, it is essential and recommended that DSAMH carefully examine the Performance Improvement Programs within each contracted community service agency.** If deficiencies exist, the provider would be required to institute a plan of correction, requiring approval from the Division and a follow up visit to ensure compliance.

Team 4 Report: Review of Delaware Psychiatric Center's buildings and grounds

(Gary Wirt, Ed.D; Facilitator, Pete Ross, Co-Chair, Dennis Rochford, Rita Landgraf, Co-Chair)

I. Construction of a New Building

- **It is recommended that the State of Delaware should move forward with constructions plans for a new psychiatric center.** *The most recent CMS report (July 2007) cites safety and environmental deficiencies including lack of flame spread ratings, HVAC inadequacies, and sprinkler problems – all of which would have passed review in earlier years. A recent report by Delaware Emergency and Design group reiterates concerns about life-safety systems and code requirements at the Center. The Office of Management and Budget (2007) estimates the cost of loss of accreditation at $4 million, $3 million of which is returned to the General Fund.* The Task Force finds the current Center's buildings to be outdated, costly to maintain, and in need of ongoing expensive maintenance. This concurs with the position repeatedly voiced by consumers, families, staff, NAMI, the Mental Health Association, and the DPC Advisory Committee of the Governor's Advisory Council on Substance Abuse and Mental Health.

  The current structures have serious cracking in perimeter and interior load-bearing walls, cracked slab flooring, and overburdened electrical systems. Emergency power is limited and cannot support HVAC needs in case of an outage. Throughout the facility, there is poor temperature control, lack of water pressure, and deterioration of interior finishes. Air duct systems are not sized for current codes, and sprinkler systems likewise are no longer adequate. For FY 07 deferred maintenance appropriations were over $5.5M and likely to increase in the near term. Accrediting and licensing agencies have "grandfathered" some systems, but have done so only with the expectation that a new facility is forthcoming. A new facility seems essential if Delaware is to maintain its accreditation and certifications. Of equal importance, the Task Force repeatedly heard credible testimony describing the hospital as "dreary, dismal, and depressing." Lack of privacy, lack of appropriate visiting space, and a dark custodial environment were repeatedly cited as leading to an un-therapeutic environment. Testimony also addressed the effects of such a negative environment on staff and visitors who dreaded coming back. *The Task Force finds the May, 2007 Design Report by Array describes a facility that indeed would support better care in a more uplifting environment. The Task Force particularly applauds the "recovery model" approach used in the development and design of the project, a model promoting maximum independent functioning, self-direction, and direct involvement in treatment choices. This treatment approach should not be lost as the project moves forward. Finally, the Task Force emphasizes that a hospital is more than new walls and stresses the need for additional staff training, especially in psychosocial rehabilitation and recovery.*

- **It is recommended that a more detailed independent actuarial analysis be conducted to determine the optimal size of a new DPC. The Task Force was unable to determine how the 205 proposed capacity was determined and thus could draw no conclusions about "right-sizing." DSAMH is urged by the Task Force to conduct a careful independent review of each and every patient at DPC to assess their suitability for inpatient treatment and to determine what levels of support would be needed to relocate them to community-based alternatives.** Testimony stressed that the 205 capacity "allowed for growth," especially among geriatrics and new populations. The current hospital has an operational capacity of 281 (including 42 forensics beds not included in the proposed design.) Average daily census is 245; when removing forensic beds, the current average daily census becomes 203, approximately the size of the proposed new facility. DSAMH staff anticipate an additional 35-patient reduction in FY 08, but also stress that the "ability to downsize further is limited and costly," citing the more complex cases who may require intense supervision outside the hospital. (Testimony, Director Renata Henry). *The Task Force strongly urges a more detailed actuarial analysis of projected need before final determination of a new hospital bed-count. As previously cited in this report, the Task Force strongly urges the expansion of community resources that serve as less costly and more effective alternatives to institutional care. Appropriate community resources clearly reduce the need for inpatient days. The State must not continue to spend disproportionately on institutional care at the expense of community alternatives.*

- **It is recommended that the State develop detailed projections of geriatric psychiatric needs.** DSAMH identifies a need to accommodate a growing geriatric population in need of inpatient psychiatric treatment and has designated 60 of the 205 beds in the proposed new hospital for that population. *The Task Force found no evidence this was a data-driven conclusion, or that the bed count was sufficient or excessive. With the growing national trend of "aging in place," the Task Force anticipates a growing number of alternatives not available to seniors.* More detailed projections of the inpatient needs of this population are appropriate not just to the new hospital, but also to the continuum of care they will need.

- **It is recommended that the State carefully price various options for the construction of the proposed new facility**. **The Task Force recognizes the immense cost of the proposed new facility at $134M, near the size of the State's typical capital budget. It is a long-term investment, expected to serve citizens for decades. Accordingly, every effort should be made to carefully scrutinize costs,**

yet ensure the construction of a quality therapeutic facility. The Task Force found a wide variety of per-bed costs to compare to the current $653,922 per-bed Delaware estimate. The Delaware Veterans Home built a 150-bed facility at approximately $200,000 per bed. Other states projects are wide-ranging, e.g., Florida ($143K per bed), Maine ($300K), Oregon ($402K and $453K), Alaska ($562K), and Massachusetts ($903K).

Clearly such projects are extremely different in scope, often driven by local labor costs, and vary widely in quality. Due to their uniqueness, they are difficult to compare. Nonetheless, the *per-bed costs should be carefully reviewed by obtaining more details on the nature and components of the cited comparison projects. The Task force urges and independent analysis of the cost factors involved for this new facility by a consultant with no vested interest in the eventual construction, similar to the procedure followed with the construction of the new State Courthouse.*

- **It is recommended that the State move forward with construction as rapidly as possible. <u>Only</u> after careful resolution of the issues raised above, the Task Force strongly urges that the project move forward on schedule or, if possible, be accelerated. The cited deferred maintenance costs are an extremely expensive patchwork sewn to keep an outdated facility operational – but at great expense.** The offset of the current maintenance costs would present a significant savings for the new facility's budget. Rapid construction offers direct and indirect savings. *DSAMH has identified over $448K in annual savings afforded by the housing of the hospital in one building, e.g., laundry delivery, food service drivers, pharmacy delivery, and security. Finally, with an original estimate of $117,669,862 (Array), the cost for construction to begin in FY 09 now tops $134,053,000. It is projected that costs will increase by $6 -$7M annually.*

Closing Statement

In closing, the Task Force wishes to recognize the staff at DPC, who continue to strive to create best practice and support to the patients that they provide care to on a day to day basis. It is our hope that these 80 plus recommendations will be seen in the context to promote best practice in the industry and strive to make DPC one of the best psychiatric centers in the United States. The Task Force views this report as a comprehensive performance improvement plan that will be of benefit to this and future administrations if adopted and implemented. We, as members of the Task Force are committed to supporting the administration in this implementation and are available to assist as deemed appropriate.