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Geropsychiatric Care At the Montana State Hospital

Prepared for the
State of Montana
Addictive and Mental Disorders
Division

January 2020

Executive Summary

Background

In November 2019 the State of Montana, Addictive and Mental Disorders Division (the Division), contracted with the Western State Commission for Higher Education Behavioral Health Program (WICHE) to review the Montana State Hospital (MSH) Spratt Unit and provide recommendations to strengthen patient care and unit operation. The 60-bed Spratt Unit provides geropsychiatric and skilled nursing care to patients admitted to the hospital.

Statutory Obligation to Admit

MSH serves as the "safety net" inpatient psychiatric hospital provider in Montana and it is the only state hospital in Montana. The majority of patients are involuntarily committed to MSH or placed at MSH via "emergency detention" as a result of a crisis situation. As a psychiatric hospital, based on federal regulations, MSH should only admit individuals who require hospital level of care due to a serious mental illness (SMI) or a serious and persistent mental illness (SPMI). However, like other Western states, limited behavioral health resources (e.g. crisis stabilization) result in "inappropriate" state hospital admissions. Unfortunately, and also similar to other states in the West, Montana's statutory definition of mental disorder includes "organic" impairment[1]. As a result, a court commitment to MSH of an individual with dementia or another neurocognitive condition (organic to the brain) is allowed under the Montana commitment statute.

Findings and Recommendations

A Treatment Dilemma

As a result of the commitment of individuals with neurocognitive disorders, MSH is forced to attempt to deliver two levels of care (skilled nursing care and inpatient psychiatric care). This raises several significant challenges for the hospital. In addition to being separate levels of care, the evidence-based models of care are quite different for the two subpopulations, including different philosophies of care (custodial care versus active treatment), different staffing requirements/needs, and different requirements in terms of standards and regulations. *There is no clear solution to this dilemma, and it is not a judgement of existing care provided on the Spratt Unit. The report recommendations are crafted to help MSH identify possible actions to strengthen patient care, given the requirement to serve both these populations.*

Patient Care and Documentation

WICHE spent several hours on the Spratt Unit, speaking with patients and staff and observing activities. *MSH and Spratt unit staff have done an outstanding job of caring for individuals on Spratt, given staffing and resource constraints, and having to adjust practices to care for both populations*. *Overall, no significant deficiencies in patient care were found.* The staff all appeared to be engaged and helpful in response to patient requests. Given staffing limitations, the level and nature of staff to patient engagement generally appeared to consist of assisting with activities of daily living. The unit was clean, recently painted, and there were no significant odors present.

WICHE also conducted a review of a sample of medical records. Medical record progress notes during the provider's periods on the units are generally well done and comprehensive. When completed, the templates for psychiatric provider weekly/monthly progress notes appear to be well organized and nicely

[1] Section 53-21-102(9)(a), M.C.A.

completed, but it is observed that these notes are often missing in the chart. There are significant gaps in documentation, apparently during periods of transition between providers. Also, in the sample of charts reviewed there was no active treatment of Alzheimer's-type dementia with evidence-based medication. Dementia treatment also includes treatment for behavioral issues, including medications and behavioral approaches. A neurocognitive disorder should not be considered outside of the realm of mental health disorders and these disorders should not be considered untreatable. Co-occurring diagnoses are the rule rather than the exception and diagnostic clarity should be emphasized. There are appropriate pharmacological approaches for patients with dementia that should be utilized with Spratt patients.

Recommendations:

1. **MSH should strengthen psychiatric provider medical record documentation.**
2. **MSH should ensure that patients with neurocognitive disorders, such as dementia, receive appropriate pharmacological treatment for their neurocognitive illness, within current medical best practice.**
3. **MSH should provide continuing education for the Medical Director and the psychiatric providers who treat geropsychiatric patients.**

Staffing

WICHE also reviewed the unit's allocated (vs. actual) direct care staffing (including licensed nurses and aides/psychiatric technicians) in comparison to a small group of other state psychiatric hospitals, finding that the Spratt Unit is has a significantly higher ratio of beds to staff than the three hospitals included in the comparison. We also compared the ratio of occupational and recreational therapists to 22 other western state psychiatric hospitals and found MSH's FY19 ratio to be approximately only one-third of the average ratio for the other state hospitals. In FY19, MSH had approximately one-third of the occupational and recreational therapy FTE as the other state hospitals. These services are vital with the geropsychiatric population served by Spratt.

WICHE compared the ratio of licensed nursing and direct care staff to beds for MSH and three other WPSHA state psychiatric hospitals – Colorado, Oregon and North Dakota. These ratios reflect "minimum" staffing levels as identified by each state hospital for each shift, averaged to allow for comparison between hospitals. WICHE also compared MSH ratios for occupational therapy and recreational therapy positions. *The MSH Spratt Unit staffing is significantly below the other hospitals.*

Recommendations:

4. ***MSH should increase the direct care FTE allocated to Spratt.***
5. ***MSH should increase the number of occupational and recreational therapy FTE allocated to Spratt.***
6. ***MSH should investigate options to divide the Spratt Unit into two treatment teams, with separate a nurse manager and direct care staff.***

Active Treatment

WICHE staff reviewed the Unit's daily schedule and observed scheduled activities with patients. The Spratt Program Manager indicates the hospital is in the process of addressing active treatment and will be moving forward to strengthen treatment. CMS expects that while patients with neurocognitive disorders may not be appropriate for inpatient psychiatric hospitalization, they must receive active treatment corresponding with a treatment plan. Providing these services to both populations is very challenging from a resource perspective but is required to maintain CMS certification.

Recommendation:

7. ***MSH should continue its efforts to strengthen active behavioral health treatment for Spratt Unit patients, including patients with primary neurocognitive disorders.***

Advanced Directives and End of Life Care

One of the more concerning challenges for geropsychiatric hospitals is the management of end-of-life issues, which is a rapidly growing need for the population served. Because individuals are at the hospital for relatively lengthy stays, they are often at Spratt when their illness enters a pre-terminal or active dying process. Even some new admissions quickly experience a need for end of life planning and care as the medical complexity of the population also intensifies. MSH's use of the Physician's Orders for Life Sustaining Treatment (POLST) form to clarify the patient or designated decision-makers wishes regarding life sustaining treatment is consistent with many other states. WICHE reviewed the MSH "Comfort Measures/End-of-Life Care" policy (dated May 14, 2019). The policy provides appropriate recommendations for treatment in an end-of-life situation; however, it does not define "end of life."

Recommendations:

8. ***The MSH "Advance Directives (Declarations)" policy should be reviewed and revised to integrate the POLST and POLST instructions.***
9. ***The MSH Comfort Measures/End-of-Life Care policy should be revised to define "end of life." The definition should include the signs of active dying and/or a time frame, such as hospice's indication of a 10 day to two weeks expected lifespan.***

Hospice Services

It is not uncommon for state psychiatric hospitals to contract with community hospice providers. Services may either be provided in the state hospital or at a separate hospice facility, depending on the contractual arrangement and community resources. Hospice services are a Medicaid benefit in Montana and are also covered by Medicare. CMS certifies hospice providers, and there are conditions of participation for inpatient hospice that may require review by MSH to determine if MSH, along with the certified local hospice provider, meet the CMS requirements. Use of a hospice provider would allow MSH to obtain assistance with patients near end of life. MSH should not provide hospice services independent of a hospice provider.

Recommendation:

10. ***WICHE recommends that MSH explore a contract with a local hospice provider. The cost to MSH may be minimal if it is determined that MSH meets its share of the CMS hospice certification requirements.***

Barriers to Discharge

It is likely that many Spratt patients could be discharged if there was adequate support in skilled nursing facilities or other appropriate residential settings. Many of the individuals that could be discharged have neurocognitive disorders that, should the providers obtain the training and staffing needed, could be managed by long term care facilities. These patients probably arrived at MSH as a result of an involuntary commitment prompted by allegations of inappropriate behavior in a community placement. Despite significant efforts by MSH staff to obtain discharge, many providers refuse to take these individuals back into community settings.

Recommendation

11. **MSH should develop a formal "discharge barriers" process where Spratt patients who are medically determined ready to discharge, absent an identified placement, are reviewed by an MSH interdisciplinary team and discussed during monthly meetings with the MSH Administrator and Clinical Director.**

About the WICHE Behavioral Health Program

The Western State Commission for Higher Education Behavioral Health Program (WICHE) is a regional governmental entity, created by Congress through an interstate compact in 1953. The Behavioral Health Program was established at the request of the Western governors in 1955. The mission of the program is to support the innovation and improvement of the public mental health system and assist in building a high-quality workforce. WICHE accomplishes this mission though promoting innovation, research, cooperation, resource sharing, and sound public policy. Work traditionally falls into several professional practice areas, including research and evaluation, technical assistance, and education/training.

Team Members

Ken Cole, MPA

Ken has over 25 years of experience in public behavioral health and long-term care. He served as the CEO for the South Dakota Human Services Center (the state's psychiatric hospital). As CEO in South Dakota, Ken oversaw a 69-bed long term care program that faced many of the challenges faced by the Spratt Unit at the Montana State Hospital. Prior to consulting, Ken served as Deputy Director for the Colorado Office of Behavioral Health. His work with the Office of Behavioral Health included leadership and supervision of Colorado's two state psychiatric hospitals and the Colorado public behavioral healthcare system. Ken began his health care career as the Deputy Director for the Colorado Division of State and Veterans Nursing Homes. He has extensive experience in the relationship between psychiatric and medical care at state-operated hospitals and facilities. Ken possesses a strong understanding of the Center for Medicare and Medicaid Services (CMS) certification standards for psychiatric hospitals.

Dr. Charles Dygert, M.D.

Dr. Dygert has served as staff psychiatrist for the Geriatric Treatment Center at the Colorado Mental Health Institute at Pueblo (CMHIP) for the last 25 years. CMHIP is one of two state psychiatric hospitals in Colorado. The Geriatric Treatment Center includes two units (totaling 34 beds) and serves elderly individuals with primary diagnoses of serious mental illness (SMI), along with individuals who have neurocognitive disorders, including dementia. He has also served as a staff psychiatrist to a community mental health center and twice as a medical director in community behavioral health care settings. Dr. Dygert received his medical degree from the University of Indiana and he is board certified in General Psychiatry, with a previous added certification in Geriatric Psychiatry.

Introduction and Background

In August of 2019 the State of Montana, Addictive and Mental Disorders Division, requested proposals to establish a contract with a qualified vendor to review the clinical care being provided to patients on the Montana State Hospital (MSH) Spratt unit and to develop recommendations about strengthening patient care and the operation of the Spratt unit. The Spratt Unit provides geropsychiatric and skilled nursing care to older patients. The unit has a physical capacity of 60 beds and currently has a census of approximately 45 patients. For the purposes of this report, geropsychiatric services refers to behavioral health services provided to individuals with mental health, substance abuse, and/or age-related neurocognitive conditions with behavioral challenges requiring intervention.

Approach and Methodology

This project was completed through a site visit, interviews with staff, review of applicable information (including facilities data and legislative and regulatory requirements), and review of staffing information for geropsychiatric and nursing home services provided by other state hospitals in the Western United States. MSH provided demographic; admission, discharge, and transfer; and diagnostic information from the hospital information system. In addition, WICHE used data from the Western Psychiatric State Hospital Association (WPSHA). WPSHA includes 23 states.

Description of the Spratt Unit's Current Patient Population

Table 1 provides snapshot data about the current Spratt Unit patient population. The majority of patients (19, or 42 percent) have dementia or another neurocognitive disorder, followed by patients with a serious mental illness (17, or 38 percent). The Unit also occasionally treats individuals with a traumatic brain injury and intellectual disabilities. These individuals currently represent about 20 percent of the census.

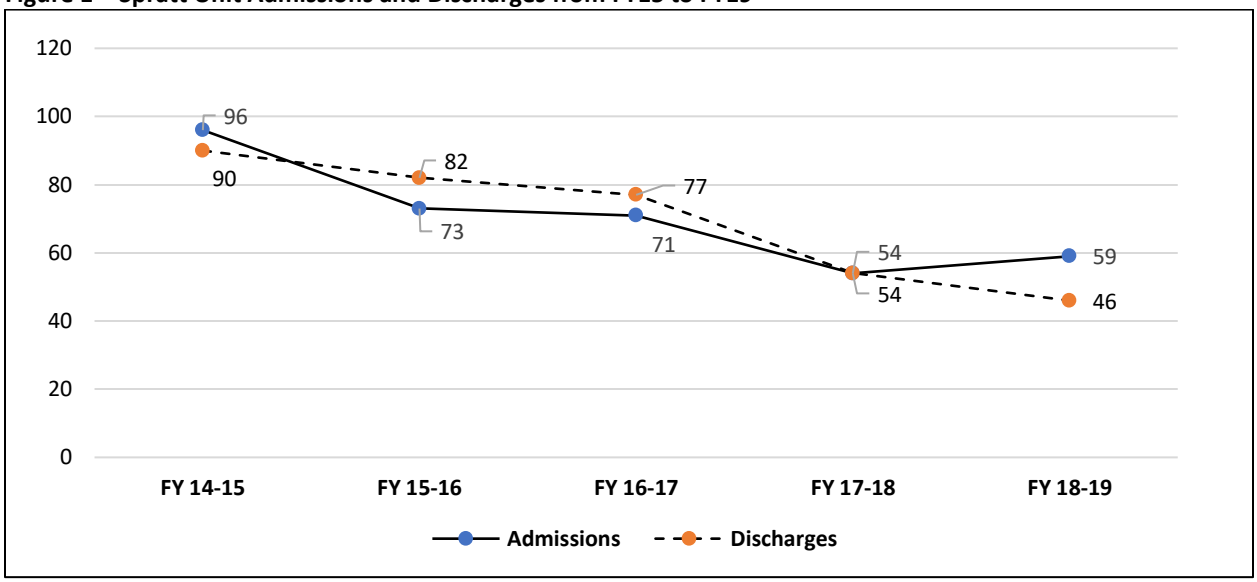
Table 1 – Spratt Unit Patients - Primary Diagnosis as of October 19, 2019

Primary Diagnosis	Number	Percent of Total
Dementia or other neurocognitive disorder	19	42.2%
Serious mental illness	17	37.8%
Traumatic brain injury	5	11.1%
Other medical condition (e.g., stroke)	2	4.4%
Intellectual disability / developmental disability	2	4.4%
TOTAL	**45**	**100.0%**

Source: Montana State Hospital

Figure 1 (next page) details the number of Spratt Unit admissions and discharges for the last five state fiscal years (FY15 to FY19). The number of admissions and discharges declined from FY15 to FY19, by 63 percent and 96 percent, respectively.

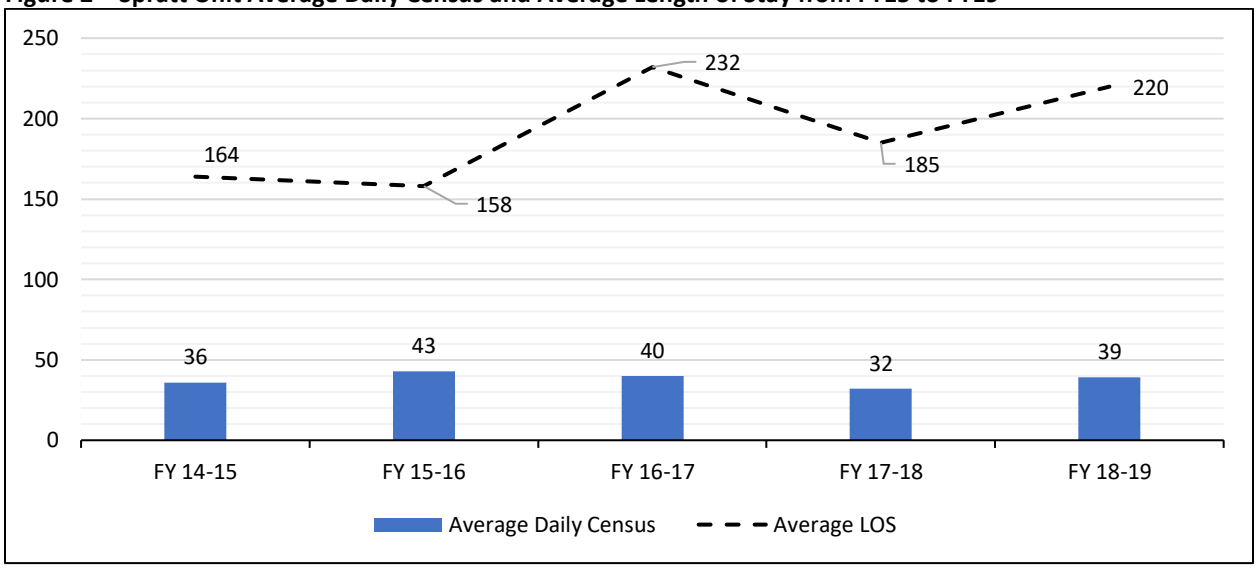
Figure 1 - Spratt Unit Admissions and Discharges from FY15 to FY19



Source: Montana State Hospital

Figure 2 provides the average daily census and the average length of stay for the last five state fiscal years. Over this period, the average daily census remained relatively constant, increasing from 36 patients to 39 patients. The average length of stay (for discharged patients) increased from 164 days to 220 days, an increase of 34 percent during the five-year period. While the average daily census has generally remained constant over the last five years, fewer patients are being admitted and discharged from Spratt and those admitted to Spratt are spending more time in the hospital.

Figure 2 - Spratt Unit Average Daily Census and Average Length of Stay from FY15 to FY19



MSH's Role in Treating Involuntarily Committed Elderly Patients

Statutory Obligation to Admit

MSH serves as the "safety net" inpatient psychiatric hospital provider in Montana and it is the only state hospital in Montana. The majority of patients are involuntarily committed to MSH or placed at MSH via "emergency detention" as a result of a crisis situation. As a psychiatric hospital, MSH would ideally only admit individuals who require hospital level of care due to a SMI or a serious and persistent mental illness (SPMI). However, like other Western states, limited behavioral health resources (e.g. crisis stabilization) result in "inappropriate" state hospital admissions. Unfortunately, and also similar to other states in the West, Montana's statutory definition of mental disorder includes "organic" impairment[2]. As a result, a court commitment to MSH of an individual with dementia or another neurocognitive condition is allowed under the Montana commitment statute.

"Blended" Spratt Populations and Levels of Care

A Treatment Dilemma

The involuntary commitment to MSH of older adults with organic vs. psychiatric illnesses is reflected in the current Spratt Unit population, which includes both individuals who qualify for long-term nursing facility care due to neurocognitive ("organic") conditions with individuals with psychiatric illness.[3] Some of the older adults with neurocognitive conditions, including those with behavioral challenges, could potentially be served in a long-term care facility care rather than at MSH. MSH staff work to find placements for Spratt patients who are appropriate for long term care. However, federal Center for Medicare and Medicaid Services (CMS) rules limit the ability of nursing homes to use antipsychotic medications and behavioral interventions. As a result, individuals with these needs are admitted to Spratt. MSH staff indicate that community providers, including nursing homes, often commit individuals to MSH due to challenging or aggressive behaviors while residing in another setting (i.e., nursing home, assisted living).

As a result of the commitment of individuals with neurocognitive disorders, MSH is forced to attempt to deliver two levels of care (skilled nursing care and inpatient psychiatric care). This raises several significant challenges for the hospital. In addition to being separate levels of care, the evidence-based models of care are quite different for the two subpopulations, including different philosophies of care (custodial care versus active treatment), different staffing requirements/needs, and different requirements in terms of standards and regulations. Beyond the evidence-base, it seems intuitive that these are typically not populations to combine. Most family members would not want their aging loved one with Alzheimer's to live on an inpatient psychiatric unit while most family members watching a loved one experience a psychiatric crisis would not want that care diminished to accommodate others with memory loss.

Due to involuntary commitment standards in Montana, the MSH model of care has been required to attempt to adapt to this blended population. For example, the long-term care model requires more Certified Nursing Assistants (CNAs) to support patient hygiene and basic care, while acute psychiatric units require more trained psychiatric technicians who can provide milieu based psychiatric rehabilitation. Additionally, medical complex populations require additional specialties such as neurology and

[2] Section 53-21-102(9)(a), M.C.A.

[3] It is also important to note that some individuals possess both a SMI as well as neurocognitive disorders, which often appear later in life.

neuropsychology as well as greater numbers of registered nurses who can monitor and treat individuals at risk medically. At the core of long-term care is a philosophy of custodial care, with an emphasis on hands-on assistance with activities of daily living. This is very different in nature, scope and pace from an inpatient psychiatric unit which is highly structured, treatment oriented, and regulated at a much higher standard. They are in fact two distinct levels of care with different licensure.

Best Practice

In best practice models, these populations are not blended, because the level and model of care are so different and because mixing the populations is considered counter therapeutic. Because of these overlapping and often interacting conditions, robust assessment and evaluation are vital to ensure proper treatment decisions and quality care. Professionals caring for older adults should determine the etiology of a person's symptoms (e.g., behavior is secondary to functional psychosis or mood disorder versus complications of dementia or a medical condition) to ensure that the treatment approach is targeting the appropriate underlying cause. Of course, added to this is that individuals do not present in discrete boxes and instead have a mixture of etiology such as medical and neurocognitive or neurocognitive, psychiatric and behavioral and all conditions are interacting and intensifying each other in an additive manner. MSH's current system of care for older adults is challenged in large measure because of a confounding of these factors and populations.

At the base of the challenges for the Spratt Unit is that instead of discrete models of care for specific sub-populations (those with neurocognitive conditions and those with psychiatric conditions), these sub-populations are blended and treated as one singular population. This reduces the efficiency, effectiveness and quality of care. Although, sub-populations can never be fully separated and treated independently because of the overlap of conditions, best practice is to do the best evaluation possible to prioritize treatment need and target specific evidence-based treatment approaches for each condition type. For example, evidence-based care for individuals with dementia is distinct in significant ways from treatment for acute psychiatric conditions.

The Realities at MSH

Like other state hospitals, MSH is forced to live with a foot in each world—offering custodial and long-term care to their stable adults with dementia and serving as an inpatient admission unit with psychiatric care and stabilization for discharge to the community. *MSH and Spratt unit staff have done an outstanding job of caring for individuals on Spratt, given staffing and resource constraints, and having to adjust practices to care for both populations*. Given recent turnover and current vacancies in key Spratt positions (i.e., Nurse Manager, Program Director), the treatment focus is often on memory care (e.g., crafts, reminiscing groups, and social activities for distraction/quality of life), hygiene and daily living activities, and maintenance of ambulatory maintenance (e.g., walking). SMI patients are not able to receive sufficient psychiatric milieu programming. Instead, staff are forced to prioritize and focus on supporting activities of daily living for other patients and managing non-ambulatory populations. Limited staffing also results in difficulties getting the psychiatric patients to the treatment mall or other treatment activities off the unit.

MSH staff are left in a "limbo land" of sorts with regard to documentation standards, treatment model goals, and clear expectations. The individual patient is the one who clearly suffers the most in this blended approach. Acute psychiatric patients are receiving a less therapeutic milieu with specific treatment targets and individuals with dementia are being emotionally impacted and having individual rights restricted because of the presence of angry, sometimes aggressive and unstable psychiatric patients. The mixing of populations on Spratt has led to a cascading effect on other elements of hospital functioning. The

workforce is more stretched and challenged, resulting in more early retirements or premature departures from the career workforce. Resulting workforce shortages in turn increase stress on remaining staff, who work to meet the demand with fewer and fewer resources. The more this happens, the more people leave and then the problem snowballs, becoming incredibly difficult to fix.

Spratt Unit Physical Environment

The layout of the unit poses challenges to providing effective and efficient patient care. There is one nurses' station, located towards the end of one of the two main hallways. In addition, there is a psychiatric technician/Certified Nursing Assistant (CNA) station, located at the other end of the main hallway that includes the nurses' station. The separate staff stations create challenges in monitoring patients and staff and building a culture and team approach to patient treatment.

The unit is clean and has been recently painted. The patient sleeping rooms house up to four patients and there is a bathroom in each patient sleeping room and there appear to be adequate showers and tub facilities for the unit. There is a pleasant visitor's area, outside area, TV room, and exercise room. There are "nooks" or recessed seating areas along the hallway that allow patients to stop and sit while walking the unit.

Spratt Unit Documentation and Patient Care

WICHE spent several hours on the Spratt Unit, speaking with patients and staff, observing activities and reviewing medical records. *Overall, no significant deficiencies in patient care were found.* The staff all appeared to be engaged and helpful in response to patient requests. The level of staff engagement generally appeared to consist of assisting with activities of daily living, similar to a long-term care facility. The unit was clean and there were no significant odors present.

Documentation

WICHE conducted a review of a sample of medical records. This review reflected the recent lack of continuity of the psychiatric providers, physicians and nurse practitioners. According to MSH staff, there have been eight psychiatric providers in the last 12 months. This turnover is obviously incompatible with a stable treatment environment. This lack of continuity is observable in sudden changes in treatment and medications, which can be confusing and disruptive to both hospital staff and to the patient's ongoing course and stabilization, even when the changes are clinically appropriate.

Medical record progress notes during the provider's periods on the units are generally well done and comprehensive. When completed, the templates for psychiatric provider weekly/monthly progress notes appear to be well organized and nicely completed, but it is observed that these notes are often missing in the chart. There are significant gaps in documentation, apparently during periods of transition between providers. It is also observed that diagnoses need to be clarified on a regular basis rather than accepting the admission diagnosis as final.

Pharmacological Treatment for Patients with Neurocognitive Conditions

With the exception of treatment for patients with neurocognitive disorders, chart reviews and interviews with staff indicate identified medical conditions are diagnosed and treated promptly. In the sample of charts reviewed, there was no active treatment of Alzheimer's-type dementia with evidence-based medication. Dementia treatment also includes treatment for behavioral issues, including medications and behavioral approaches. In discussions with several staff, it was noted that a perception exists that for some a neurocognitive disorder is equivalent to "no treatment."

A neurocognitive disorder should not be considered outside of the realm of mental health disorders and these disorders should not be considered untreatable. Co-occurring diagnoses are the rule rather than the exception and diagnostic clarity should be emphasized. There are appropriate pharmacological approaches for patients with dementia. The use of medications for the treatment of behavioral manifestations of neurocognitive disorders needs to be clarified and the reason for use of antipsychotic medication should be clearly documented, including a brief risk versus benefit analysis. Dosages should be limited to the minimum effective dosage and should be reassessed on a regular basis.

Recommendation #1
MSH should strengthen psychiatric provider medical record documentation.

Recommendation #2
MSH should ensure that patients with neurocognitive disorders, such as dementia, receive appropriate pharmacological treatment for their neurocognitive illness, within current medical best practice.

Recommendation #3
MSH should provide continuing education for the Medical Director and the psychiatric providers who treat geropsychiatric patients.

Assessment of Other Treatment Services

MSH staff indicate that the equivalent of 1.0 FTE physician or APRN services are provided to Spratt. This level of staffing is needed to attend to the various medical issues. Staff indicate that transfers to the acute hospital in Anaconda are relatively infrequent, indicating that staff are doing a good job of identifying and treating medical problems before they become serious and require acute care hospitalization.

WICHE provides the following observations about ancillary provider staffing:

- Social work staffing is relatively robust at 3.0 FTE. This staffing level should allow for the development of relationships with discharge programs, including long-term care facilities and other placements. The hospital has implemented a 30-day pre-placement visit PPV program where the patient's bed at Spratt is held for 30 days after discharge, thus providing the community provider with an option for return to MSH if the placement is not successful. The PPV program is an excellent tool to help reduce discharge barriers for Spratt patients. There were seven patients on 30-day visits at the time of our site visit.
- There are currently no physical therapy services available for the Spratt Unit with multiple concerns regarding stability of gait and range-of-motion issues.
- Occupational therapy (OT) is limited or often not available, which results in a major lack of treatment modalities available for restoration of functional capacity and the facilitation of skills and function essential for adaptation to the environment. MSH staff indicate OT services will become available soon.
- The current dietitian does some excellent evaluations with specifics regarding recommendations for certain diets, but care should be taken not to place this clinician outside her scope of practice. Nutrition assessments are excellent.
- Speech therapy is not available, placing the hospital at a significant risk of liability for issues related to aspiration pneumonia and choking episodes.
- Psychology services are available to Spratt patients.

- The rehab staff for this unit is comprised of a recreation therapist and three recreation therapist assistants. Their involvement on the units and with patients is clearly beneficial, but more specific treatment modalities are required from persons with appropriate licensing and certification.
- Dental services appear to be readily available.

Nursing and Direct Care Staffing

Observations

Staffing the Spratt Unit is a significant challenge due to the unit's large size (60 beds) and the physical layout of the building. The management of a unit this large by one treatment team is problematic with an average daily population of 40 to 45 patients, let alone if it was populated near its 60-bed limit. Direct care staff appeared to be knowledgeable about patients and compassionate regarding their care. The acting Nurse Manager is very involved in clarifying procedures and focused on improving patient care.

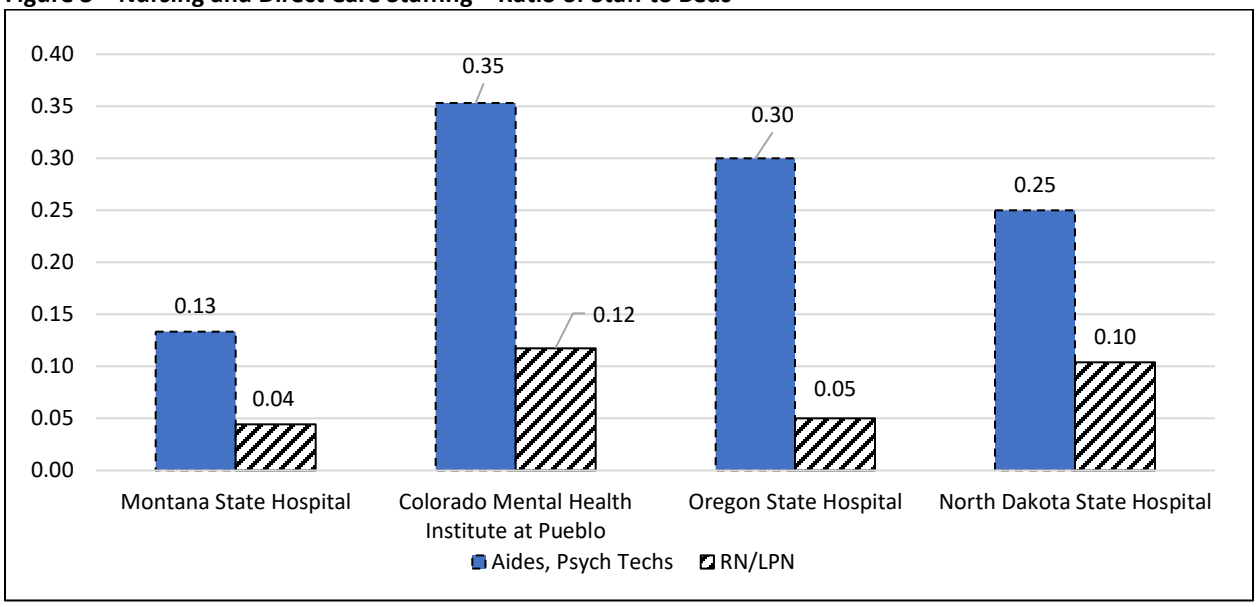
Staff report "turf" issues between psychiatric technicians and Certified Nursing Assistants (CNA's). Perceptions exist that psychiatric technicians who do not have CNA status are doing CNA work and would benefit from training and certification in this area. In addition, although the separate stations on opposite sides of the building may help somewhat with keeping "eyes-on" patients in such a large unit, this appears to exacerbate ongoing issues regarding the coordination of efforts between nurses and psychiatric technicians and CNAs.

The large size of the Spratt Unit creates management and operational challenges. Patients with behavioral challenges could be separated from other patients and comprise the majority of one of the units. While turnover and vacancies have been most to blame for the lack of a cohesive team culture on Spratt, the size of the current unit is problematic. By creating two units within Spratt, team leadership could focus on developing a culture and programming suited for the unit's patients.

Staffing

Nursing and direct care. Figure 3 (next page) details the ratio of licensed nursing and direct care staff to beds for MSH and three other WPSHA state psychiatric hospitals – Colorado, Oregon and North Dakota. These ratios reflect "minimum" staffing levels as identified by each state hospital for each shift, averaged to allow for comparison between hospitals. This average is then divided by the number of beds per hospital staffed unit to obtain the ratio shown in Figure 3. As the graph indicates, the MSH Spratt Unit is significantly below the other hospitals.

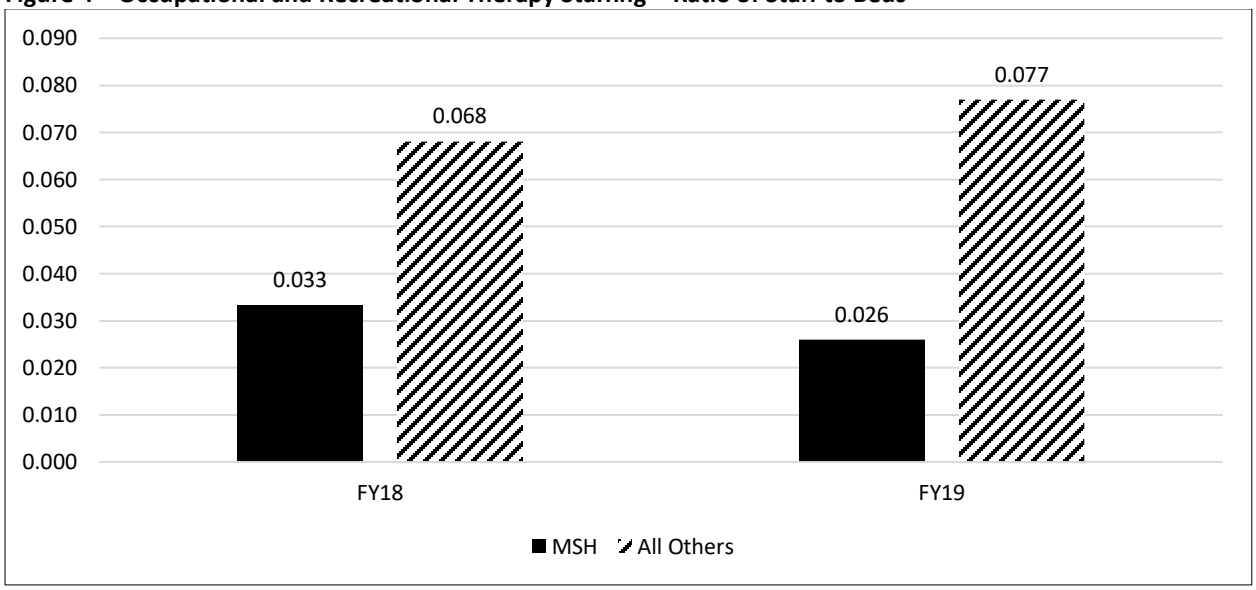
Figure 3 – Nursing and Direct Care Staffing – Ratio of Staff to Beds



Source: Western Psychiatric State Hospital Association

Occupational and Recreational Therapy. Comparative staffing data from 22 other western state psychiatric hospitals (Figure 4) shows that in FY19, MSH (overall) had approximately one-third of the occupational and recreational therapy FTE as the other state hospitals. These services are vital with the geropsychiatric population served by Spratt.

Figure 4 – Occupational and Recreational Therapy Staffing – Ratio of Staff to Beds



Source: Western Psychiatric State Hospital Association

Recommendation #4
MSH should increase the direct care FTE allocated to Spratt.

Recommendation #5
MSH should increase the number of occupational and recreational therapy FTE allocated to Spratt.

Recommendation #6
MSH should investigate options to divide the Spratt Unit into two treatment teams, with separate a nurse manager and direct care staff.

Recruitment and Retention

Recruiting and retaining staff at MSH is a major challenge. Factors impacting workforce recruitment and retention include:

- state hospital location and difficulty recruiting young people to rural parts of the State;
- salary parity with private providers;
- existing shortages in staffing;
- difficulty of the patient population served (especially working with individuals with aggression, high ADL support, etc.)
- stigma of a state facility that models of care are "old fashioned" and out of pace with the rest of the field;
- paper documentation rather than an electronic medical record (especially for new graduates who want to work in state-of-the-art settings); and
- desire for flexible scheduling and other benefits.

At the same time that hospitals are challenged in recruiting a younger and early career workforce, they are experiencing an aging of the experienced and qualified workforce who is retiring from State work. In that process of retirement, the hospitals are literally losing the expertise that is needed to care for their population with no capacity to transfer decades of experience to a new workforce. This then adds to the cycle of shortages as new professionals are quickly overwhelmed and do not have adequate mentoring to learn how to do this important work.

Active Treatment

As the Spratt Unit is a CMS certified inpatient psychiatric hospital unit, MSH is required to provide active treatment to Spratt patients. Active treatment and programming are challenging on the Spratt Unit, given the population mix of the patients and limited staffing. MSH staff indicate there are 1.0 FTE Recreational Therapist (RT) and 3.0 FTE Recreational Therapist Assistant (RTA) assigned to Spratt for the purpose of providing programming. Staff indicate that it is not uncommon for one or more of the RT and RTA staff to be pulled into direct care coverage, such as providing one to one observation when required by a provider's order. Thus, direct care staffing shortages have limited the ability of the RTAs to run groups and activities with the patients. (This report also includes a recommendation (#5) that MSH increase the number of occupational therapy FTE.)

During their visit, WICHE staff observed limited active treatment activities. The Spratt Program Manager indicates the hospital is in the process of addressing active treatment and will be moving forward to strengthen treatment. CMS expects that while patients with neurocognitive disorders may not be appropriate for inpatient psychiatric hospitalization, they must receive active treatment corresponding with a treatment plan. Providing these services to both populations is very challenging from a resource perspective but is required to maintain CMS certification.

Recommendation #7
MSH should continue its efforts to strengthen active behavioral health treatment for Spratt Unit patients, including patients with primary neurocognitive disorders.

Advanced Directives and Physician Orders for Life Sustaining Treatment

MSH's use of the Physician's Orders for Life Sustaining Treatment (POLST) form to clarify the patient or designated decision-makers wishes regarding life sustaining treatment is consistent with many other states. The MSH form is substantively the same as the national template[4] and includes treatment option selections. The hospital has an "Advance Directives" policy. This policy does not speak to the POLST form or POLST process. It is important to keep in mind that a POLST summarizes the patients' wishes in the form of medical orders. An advance directive is a legal document that allows you to share your wishes with your health care team if you can't speak for yourself. Also, a decision for "Do Not Resuscitate" (DNR) is not equivalent to no treatment or comfort care only. These are separate issues, which, when appropriate, may be determined through appropriate hospice services.

Recommendation #8
The MSH "Advance Directives (Declarations)" policy should be reviewed and revised to integrate the POLST an POLST instructions.

End of Life Care

One of the more concerning challenges for geropsychiatric hospitals is the management of end-of-life issues, which is a rapidly growing need for the population served. Because individuals are at the hospital for relatively lengthy stays, they are often at Spratt when their illness enters a pre-terminal or active dying process. Even some new admissions quickly experience a need for end of life planning and care as the medical complexity of the population also intensifies. Because of this trend, geropsychiatric state hospital physicians face increasingly difficult end of life care decisions and supports. MSH does not have formal current palliative care or hospice type services.

End of Life Policy

WICHE reviewed the MSH "Comfort Measures/End-of-Life Care" policy (dated May 14, 2019). The policy provides appropriate recommendations for treatment in an end-of-life situation; however, it does not define "end of life." WICHE provides the following recommendation about this policy:

Recommendation #9
The MSH Comfort Measures/End-of-Life Care policy should be revised to define "end of life." The definition should include the signs of active dying and/or a time frame, such as hospice's indication of a 10 days to two weeks expected lifespan.

- ***These guidelines should be separated from other palliative care considerations, as these should be defined and clarified in another policy.***
- ***Clear separation between palliative care and DNR orders should be clarified.***
- ***The separation between palliative care and hospice care should also be clarified.***

Hospice Services

It is not uncommon for state psychiatric hospitals to contract with community hospice providers. Services may either be provided in the state hospital or at a separate hospice facility, depending on the contractual arrangement and community resources. Hospice services are a Medicaid benefit in Montana and are also

[4] https://polst.org/national-form/

covered by Medicare. CMS certifies hospice providers, and there are conditions of participation for inpatient hospice that may require review by MSH to determine if MSH, along with the certified local hospice provider, meet the CMS requirements. Use of a hospice provider would allow MSH to obtain assistance with patients near end of life. MSH should not provide hospice services independent of a hospice provider.

Recommendation #10
WICHE recommends that MSH explore a contract with a local hospice provider. The cost to MSH may be minimal if it is determined that MSH meets its share of the CMS hospice certification requirements.

Other State Hospitals with Geropsychiatric Care

Table 2 provides a summary of the state hospitals in the WPSHA region that operate geropsychiatric units. Note that no other hospital has a geriatric unit as large as MSH, with most units averaging 20 to 30 beds.

Table 2 – Geropsychiatric Units at WPSHA Hospitals

State Hospital	Licensed Beds	Units
Colorado Mental Health Institute - Pueblo	34	2
Montana State Hospital	60	1
New Mexico State Hospital	20	1
North Dakota State Hospital	24	1
Oregon State Hospital	72	3
Washington - Eastern State Hospital	91	3
Washington - Western State Hospital	143	5

Barriers to Discharge

Some Spratt patients arrived at MSH as a result of an involuntary commitment prompted by allegations of inappropriate behavior in a community placement. Despite significant efforts by MSH staff to obtain discharge, many providers refuse to take these individuals back into community settings. The existing barriers to discharge for many of these individuals can be lengthy and complex, representing a combination of factors. In addition, the availability and type of services provided to geriatric individuals in Montana most likely differs across the state and between community mental health center, including availability of workforce (including specially trained staff), financial resources, and level of community-wide commitment or interest in addressing the needs of the geriatric population. It is likely that some Spratt patients with neurocognitive disorders could be discharged to long term care facilities under certain conditions. These providers would need the appropriate resources (perhaps additional staffing) and training on managing difficult behaviors.

Several factors contribute to discharge barriers:

- Limited residential options in the community, including nursing homes, assisted living facilities or other housing settings.
- Low tolerance among community providers for behavioral challenges, including any aggression secondary to either psychiatric or neurocognitive illness. Staff indicate nursing facilities have a low tolerance for any behaviors; even those behaviors considered by most as normal or expected in community nursing facilities as individuals age with neurocognitive disorders (e.g., resistance to activities of daily living, verbal outburst, wandering, inappropriate singing, etc.).

- CMS implemented significant revisions to the requirements of participation for long-term care facilities. These new regulations, which started in October 2016 and finish implantation this year, limit the use of antipsychotic medications and increase requirements for facilities to report alleged abuse, including verbal abuse, between patients. As many of the patient at Spratt demonstrate challenging behaviors, these CMS rule changes have made community providers even more cautious about admitting patients from state hospitals.

- The stigma associated with a psychiatric admission; especially a state facility admission becomes a reason for denial with community settings refusing to even review discharge materials for an individual. This stigma remains a challenge even for individuals admitted to the state facilities for non-psychiatric reasons (e.g., neurocognitive condition with behavioral concerns).

- Medically comprised individuals are more difficult to place as nursing facilities and other settings are challenged by addressing and meeting the medically complex needs of these individuals.

- Variance of availability of dementia and geropsychiatric services in skilled nursing facilities and the community.

Recommendation #11
MSH should develop a formal "discharge barriers" process where Spratt patients who are medically determined ready to discharge, absent an identified placement, are reviewed by an MSH interdisciplinary team and discussed during monthly meetings with the MSH Administrator and Clinical Director.

Conclusion

Like many state psychiatric hospitals that provide services for older adults, MSH is required to provide two levels of care - skilled nursing care and inpatient psychiatric care – to meet the needs of elderly patients. This dynamic raises several significant challenges for the hospital. MSH is taking steps to address this challenge with the Spratt Unit, and progress is evident. Hopefully, the recommendations included in this report will help provide short- and long-term goals to make the best of a challenging situation. Ideally, patients not in need of inpatient psychiatric treatment would be receive services in a less intensive level of care and perhaps closer to their homes and communities. The Division is examining expansion of its Intensive Community Based Rehabilitation program to potentially serve patients who might otherwise be admitted to MSH and the Spratt Unit. Also, MSH has expressed a willingness to assist long term care providers in developing the skills to better serve individuals with challenging behaviors.