

METROPOLITAN STATE HOSPITAL QUARTERLY REPORT TO THE LEGISLATURE ON KEY MEASURES

Executive Summary

First Quarter Report 2005

Enclosed is the "Metropolitan State Hospital Quarterly Report to the Legislature on Key Measures." The quarterly report is prepared in accordance with Section 33 of the 2004 Budget Trailer Bill. The report is in response to the United States Department of Justice (USDOJ), Civil Rights Division, report that was issued pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C., 1997.

The first components of the report are specific key measures, which are identified within Section 33 of the 2004 Trailer Bill. The specific key measures include data reflecting dates from the January through March 2005 reporting period. An overview of the hospital progress is reflected within the data of the following measures:

Number of Elopements Per Inpatient Day: The number of elopements from the hospital increased from three during the previous quarter to 10 during this reporting period. This increase reflects an increase in elopements of 207%. It should be noted that seven of the 10 elopements occurred during home visits or outside hospitalizations.

Number of Patient Injury Events Per Inpatient Day: The number of client injuries over the reporting period improved. There were 26 client injuries this quarter representing an improvement of 2% over the reporting period.

Medication Error Rate: The number of medication errors during the reporting period has been reduced. The number of medication errors was reduced from 16 during the previous quarter to 4 during this reporting period.

Seclusion Hours/ Percent of Clients Secluded: Seclusion hours over the reporting period has increased since the third quarter of 2004. The current quarter reflects a 31% increase in seclusion hours from the previous quarter. This increase is due to the fact that MSH is attempting to use seclusion as a less-restrictive alternative to restraint. In addition, one individual represents 65% of the total number of seclusion hours. As the hospital utilizes seclusion as the least restrictive measure to restraint, the number of seclusion hours is anticipated to rise. The percentage of clients secluded has also increased over this reporting period representing a 29% increase from the previous reporting period.

Restraint Hours/ Percent of Clients Restrained: The number of hours patients remained in restraint has decreased from the previous quarter reflecting a reduction of 5995 hours to 5023 hours. The current quarter reflects an improvement of 15% in restraint hours from the previous quarter. It should be noted that 75% of the total restraint hours were attributed to only five individuals.

Additionally, the percentage of clients restrained also has improved over this reporting period reflecting a 22% improvement which represents that 91% of the patients at the hospital experienced no seclusion or restraint during the reporting period.

New Generation Antipsychotic Use: The number of patients receiving new generation of antipsychotic medication continues to increase from the previous quarter. This reporting period reflects a .3% improvement in new generation antipsychotic use.

Rate of 30-Day Readmission: The number of 30-day readmissions during this reporting period was two patients. One patient was returned to the hospital from a court hearing and the other readmission was a transfer from an outside medical facility. This is an increase from the previous quarter by one admission.

The second component of the quarterly report includes a document referred to as the "Summary Grid." The Summary Grid reflects the specific USDOJ findings and Metropolitan State Hospital's (MSH) plan and continued progress towards meeting the plan and correcting those findings.

In addition, the trailer bill required that DMH convene two community forums within the fiscal year to address the progress at MSH towards meeting the USDOJ requirements. The two forums consisted of a panel discussion; a slide presentation, and a hospital tour. The first community meeting was held December 3, 2004. The second and final community meeting was conducted May 19, 2005. The public forums addressed the areas of service delivery impacted by federal requirements, the hospital's progress towards meeting those federal requirements, and an overview of DMH's activities in response to the USDOJ investigation.

Finally, Section 33 of the 2004 Budget Trailer Bill requires that quarterly reports include any correspondence between the USDOJ and the Department of Mental Health (DMH) regarding MSH. As of this date, there continues to be no formal correspondence between the USDOJ and DMH to include within this report.

METROPOLITAN STATE HOSPITAL

Quarterly Report to the
Legislature on Key Measures

First Quarter 2005 (January - March)



CALIFORNIA DEPARTMENT OF
Mental Health

METROPOLITAN STATE HOSPITAL QUARTERLY REPORT TO THE LEGISLATURE ON KEY MEASURES

Executive Summary

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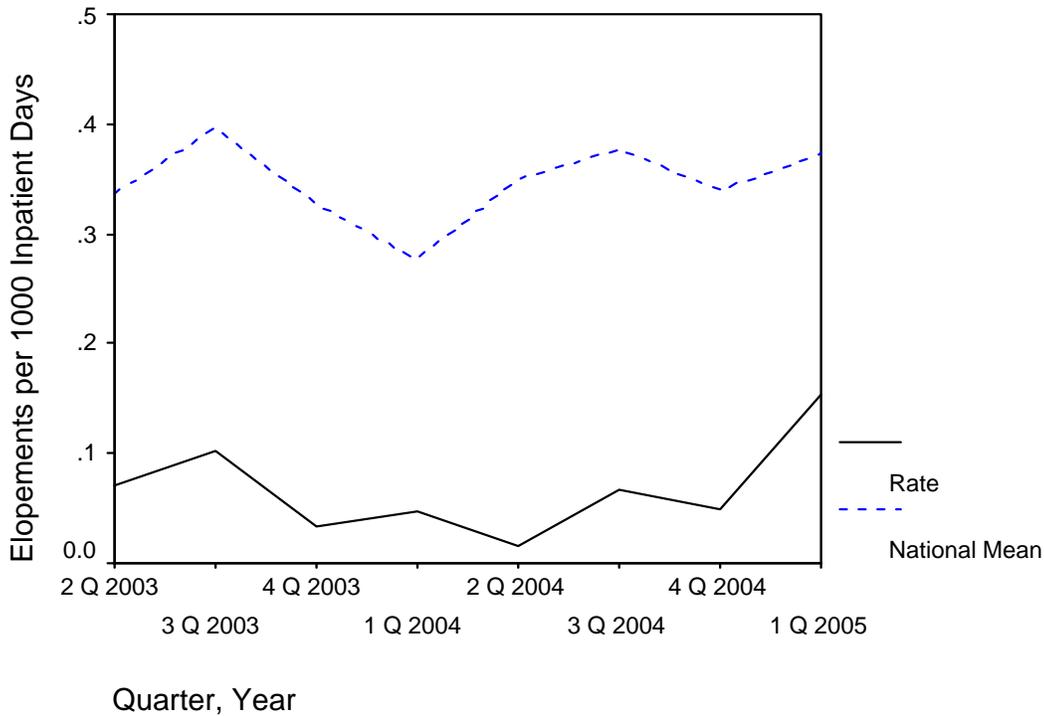
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METROPOLITAN STATE HOSPITAL

QUARTERLY REPORT TO THE LEGISLATURE ON KEY MEASURES

FIRST QUARTER, 2005 (JANUARY – MARCH)

Elopement Rate



Number of elopements that occurred for every 1000 inpatient days. For example, a rate of 0.25 means that 1 elopement occurred for each 4000 inpatient days.

Elopement – Absent from a location defined by the client’s privilege status regardless of leave or legal status. A client is considered to have eloped if the client 1) has not been accounted for when expected to be present or 2) has left the grounds of the facility without permission.

This broad definition includes late returns from home visits and passes, and elopement attempts that were located on hospital grounds and returned to the unit.

NOTE: THERE WERE NO SUCCESSFUL ELOPEMENTS BY FORENSIC (PC) CLIENTS.

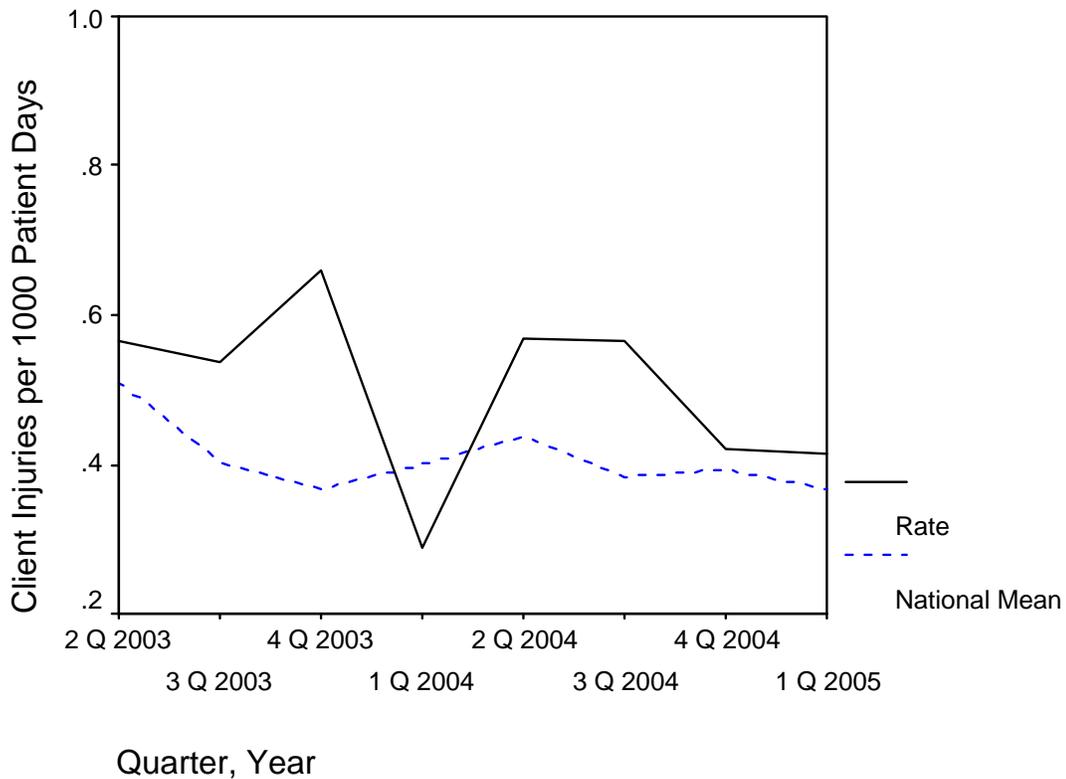
Reporting Period	Eloperments	*Average Rate	Change	National Average
1 Q '04	3	0.0467	40%	0.2767
2 Q '04	1	0.0167	-64%	0.3500
3 Q '04	4	0.0667	300%	0.3767
4 Q '04	3	0.0500	-25%	0.3400
1 Q '05	10	0.1533	207%	0.3733
**Historical Average 2 Q '03 – 1 Q '05	4	0.0675		0.3471

- **Last 8 consecutive quarters were below National Average**
- **During first quarter '05, 5 elopements were from home visits, 2 from supervised outings, and 2 from outside hospitalization. One was an elopement from Camarillo State Hospital that was carried on our census since 1997. All but 2 were returned.**

*Average of Metropolitan’s 3 monthly rates for the quarter

**Analysis begins 7/01 except for those measures that Metropolitan began benchmarking after that date. For those measures, analysis begins with first month of benchmarking.

Client Injury Rate



Number of client injury events that occurred for every 1000 inpatient days. For example, a rate of 0.5 means that 1 injury occurred for each 2000 inpatient days.

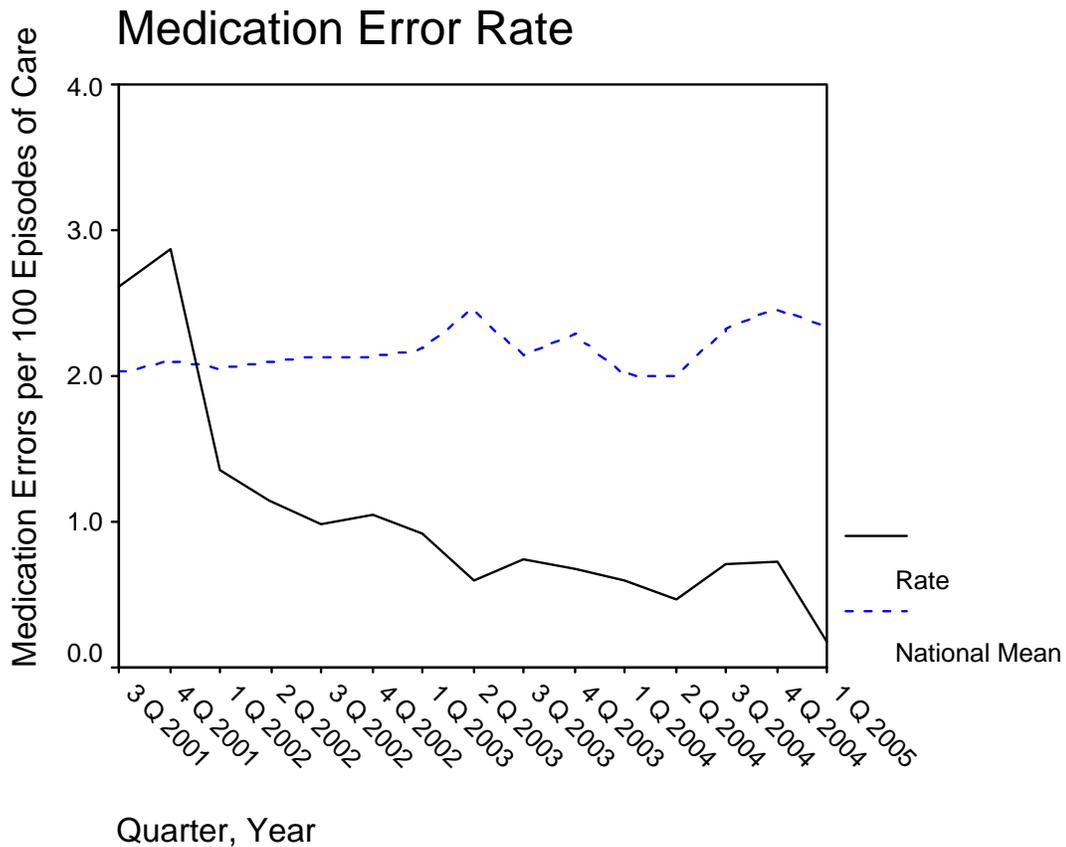
An injury occurs when a client suffers physical harm or damage which requires medical treatment more intensive than minor first aid. Injury types include accidents, assaults and intentional self-injury.

Reporting Period	Client Injuries	*Average Rate	Change	National Average
1 Q '04	18	0.2867	-57%	0.4000
2 Q '04	35	0.5700	99%	0.4367
3 Q '04	35	0.5667	-1%	0.3833
4 Q '04	27	0.4200	-26%	0.3933
1 Q '05	26	0.4133	-2%	0.3667
**Historical Average 2 Q '03 – 1 Q '05	31	0.5023		0.4075

- **Forty-six percent of injuries were self-inflicted (e.g., cutting self with broken piece of plastic or swallowing batteries)**
- **Forty-two percent were from assaults by peers**
- **Three individuals had 26% of incidents**

*Average of Metropolitan's 3 monthly rates for the quarter

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Number of medication error events that occurred for every 100 episodes of care (hospitalizations). For example, a rate of 1.6 means that 2 medication error events occurred for each 125 episodes of care.

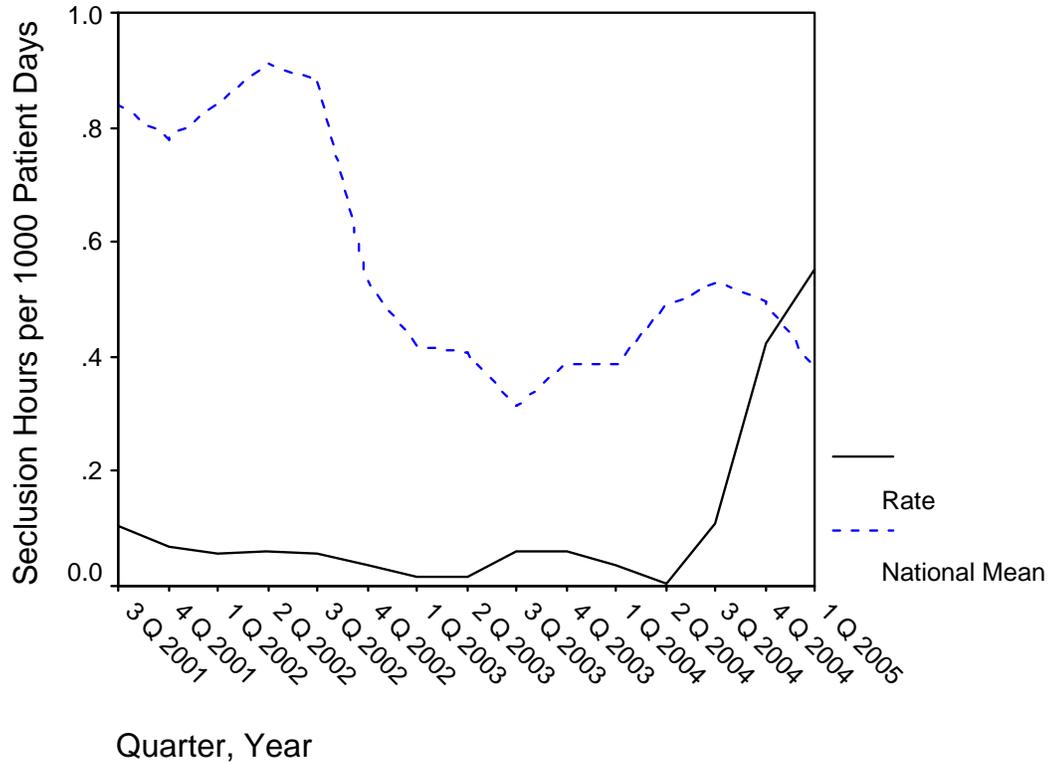
Reporting Period	Medication Errors	*Average Rate	Change	National Average
1 Q '04	13	0.6010	-10%	2.0100
2 Q '04	10	0.4720	-21%	2.0000
3 Q '04	15	0.7023	49%	2.3200
4 Q '04	16	0.7327	4%	2.4567
1 Q '05	4	0.1803	-75%	2.3400
**Historical Average 3 Q '01 – 1 Q '05	26	1.0410		2.1840

- Last 13 consecutive quarters were below US rate

*Average of Metropolitan's 3 monthly rates for the quarter

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Seclusion Hours



Number of hours clients spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours.

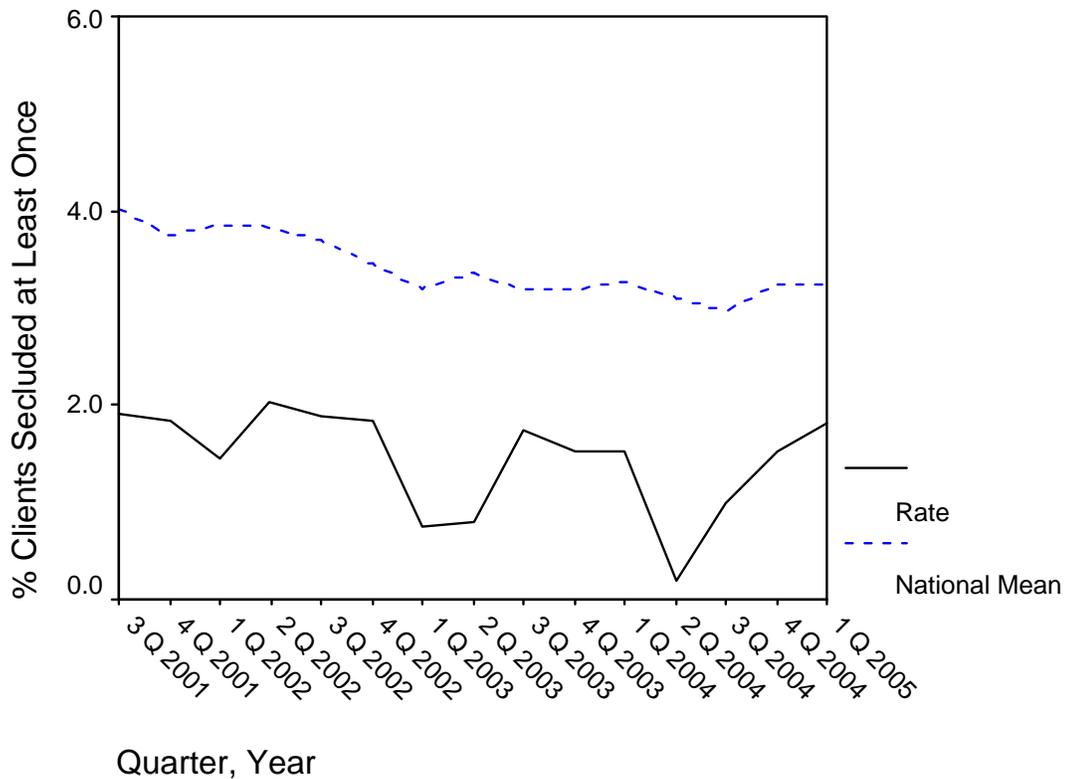
Reporting Period	Seclusion Hours	*Average Rate	Change	National Average
1 Q '04	53	0.0367	-39%	0.3867
2 Q '04	5	0.0033	-91%	0.4867
3 Q '04	161	0.1100	3200%	0.5300
4 Q '04	643	0.4233	285%	0.4967
1 Q '05	821	0.5533	31%	0.3800
**Historical Average 3 Q '01 – 1 Q '05	173	0.1105		0.5729

- **Third quarter '01 through fourth quarter '04, 14 consecutive quarters below US rate**
- **Metropolitan is trying to use more seclusion as a less-restrictive alternative for individuals who have been high users of 5-point bed restraints.**
- **One individual had 65% of the seclusion use during the first quarter of 2005. This individual had a corresponding 41% reduction in restraint use for the first quarter of 2005 compared to the fourth quarter of 2004.**

*Average of Metropolitan's 3 monthly rates for the quarter

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Percent of Clients Secluded



Percent of unique clients who were secluded at least once. For example, a rate of 3.0 means that 3% of the unique clients served were secluded at least once.

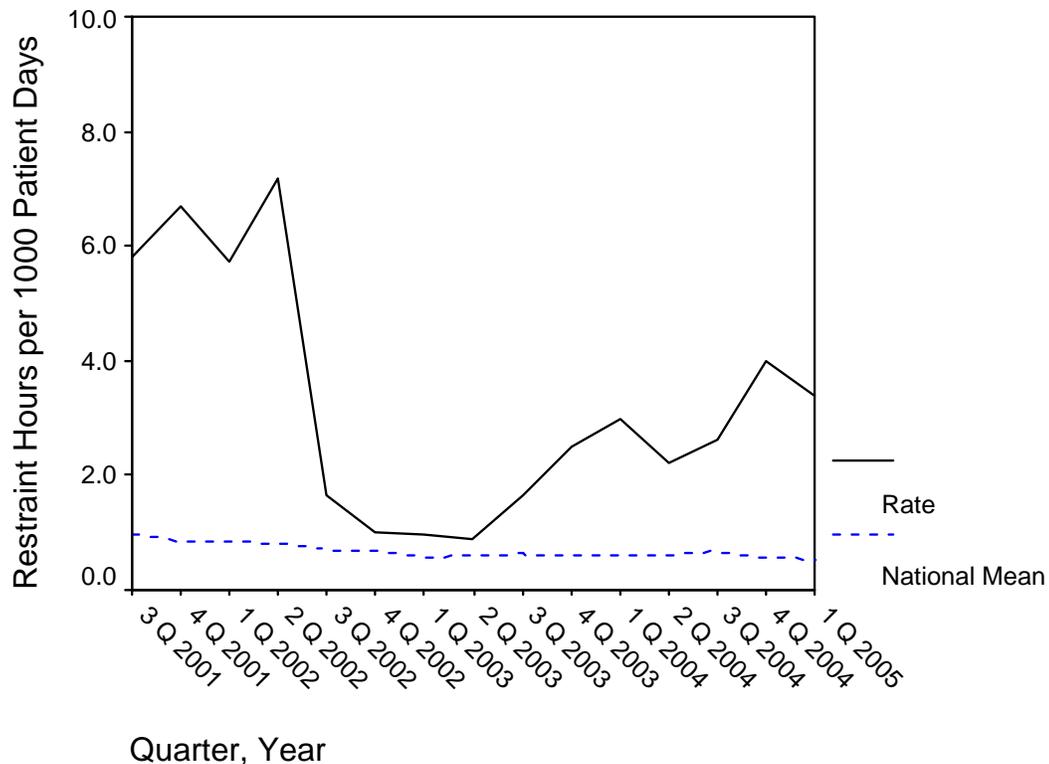
Reporting Period	Seclusion Hours	*Average Rate	Change	National Average
1 Q '04	33	1.5230	152%	3.2667
2 Q '04	4	0.1877	19%	3.1067
3 Q '04	21	0.9847	98%	2.9667
4 Q '04	33	1.5173	152%	3.2500
1 Q '05	40	1.8053	181%	3.2400
**Historical Average 3 Q '01 – 1 Q '05	35	1.4513		3.4240

- Last 15 consecutive quarters were below US rate

*Average of Metropolitan's 3 monthly rates for the quarter

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Restraint Hours



Number of hours clients spent in restraint for every 1000 inpatient hours. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours.

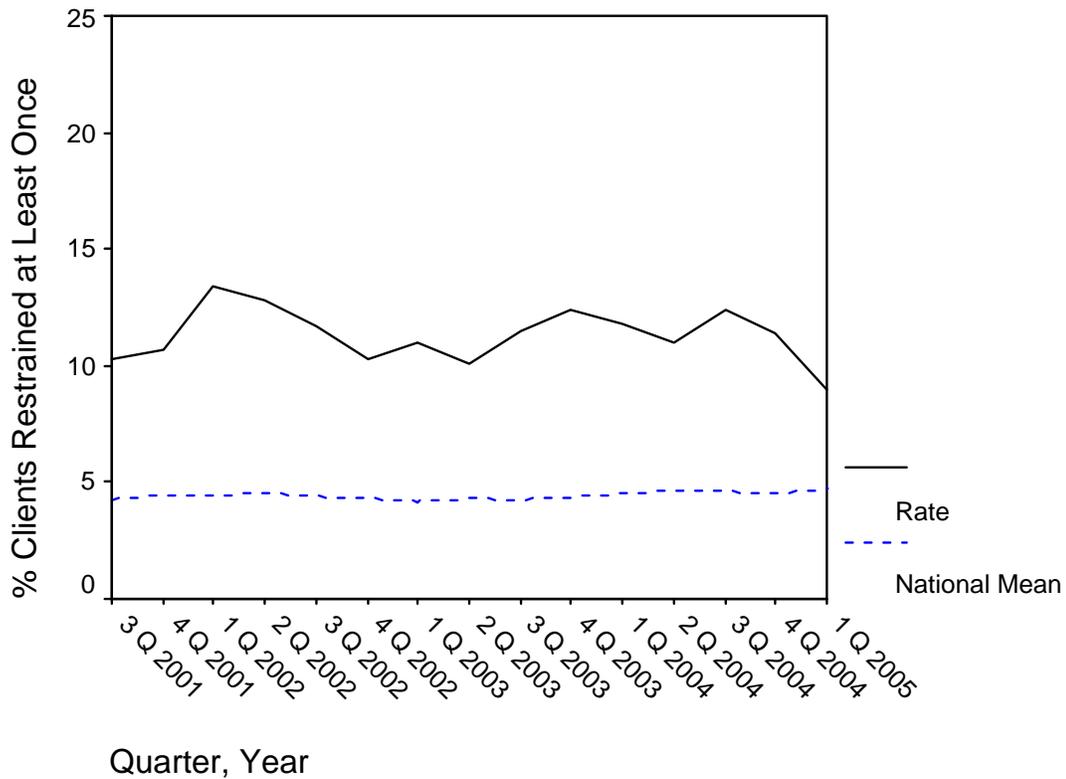
Reporting Period	Restraint Hours	*Average Rate	Change	National Average
1 Q '04	4,452	3.0000	19%	0.6033
2 Q '04	3,190	2.2067	-26%	0.6133
3 Q '04	3,793	2.6367	19%	0.6733
4 Q '04	5,995	4.0033	52%	0.5633
1 Q '05	5,023	3.3933	-15%	0.5333
**Historical Average 3 Q '01 – 1 Q '05	5,458	3.2913		0.6824

- **First quarter '05 - 15% reduction from fourth quarter '04.**
- **During the first quarter of 2005, five individuals (0.4% of those hospitalized at Metropolitan) had over 75% of the total hours.**

*Average of Metropolitan's 3 monthly rates for the quarter

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Percent Clients Restrained



Percent of unique clients who were restrained at least once. For example, a rate of 4.0 means that 4% of the unique clients served were restrained at least once.

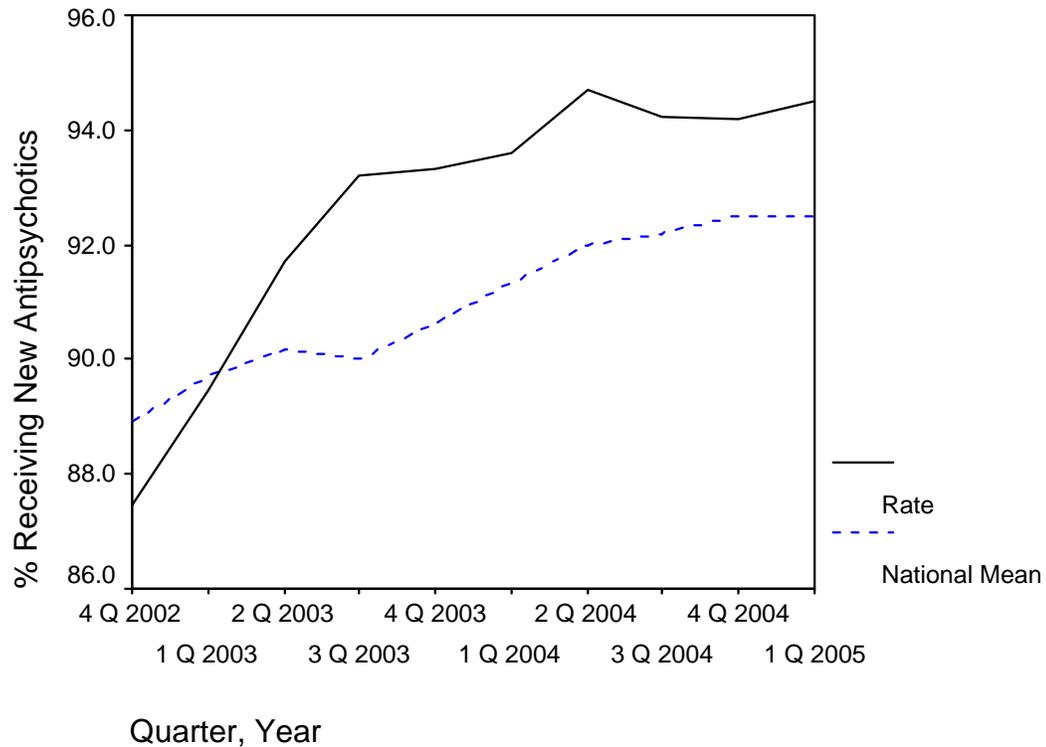
Reporting Period	Clients Restrained	*Average Rate	Change	National Average
1 Q '04	256	11.8380	-4%	4.5000
2 Q '04	234	11.0063	-7%	4.6467
3 Q '04	264	12.3710	12%	4.6033
4 Q '04	247	11.3827	-8%	4.5200
1 Q '05	198	8.9297	-22%	4.7167
**Historical Average 3 Q '01 – 1 Q '05	266	11.2989		4.4344

- **First quarter '05 - 22% reduction from fourth quarter '04.**
- **Highest rates were with the LPS clients. Rates for the forensic (penal code) clients were actually below national average.**
- **During the first quarter of 2005, 91% of the individuals had no seclusion or restraint use at all.**

*Average of Metropolitan's 3 monthly rates for the quarter

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New Generation Antipsychotic Use



Percent of all clients who received any antipsychotic who received new antipsychotics. For example, a rate of 80 means that 80% of all clients receiving antipsychotics received a new generation antipsychotic.

NOTE: FOR THIS MEASURE, HIGHER IS MORE DESIRABLE

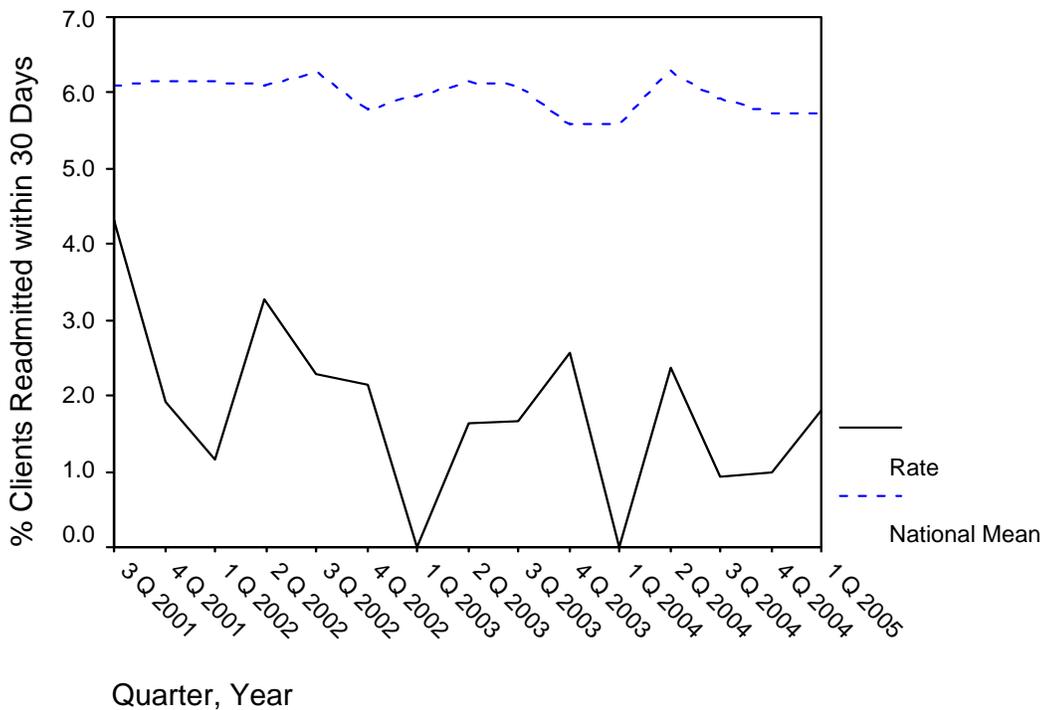
Reporting Period	Clients on New Antipsychotic	*Average Rate	Change	National Average
1 Q '04	1,887	93.6017	0.3%	91.3300
2 Q '04	1,880	94.7107	1.2%	91.9967
3 Q '04	1,807	94.2300	-0.5%	92.1967
4 Q '04	1,931	94.1990	0.0%	92.5133
1 Q '05	1,950	94.5100	0.3%	92.4767
**Historical Average 3 Q '02 – 1 Q '05	1,948	92.6407		90.9943

- Last 8 consecutive quarters were above US rate

*Average of Metropolitan's 3 monthly rates for the quarter

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30 Day Readmission Rate



Percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions.

Reporting Period	30 Day Readmissions	*Average Rate	Change	National Average
1 Q '04	0	0.0000	-100%	5.5967
2 Q '04	3	2.3577	--	6.2900
3 Q '04	1	0.9260	-61%	5.9167
4 Q '04	1	0.9803	6%	5.7400
1 Q '05	2	1.8017	84%	5.7367
**Historical Average 3 Q '01 – 1 Q '05	2	1.8027		5.9751

- **Last 15 consecutive quarters were below US rate**
- **2 Readmissions in Jan '05: one return from jail after court hearing, and one return from transfer to outside medical hospital.**

*Average of Metropolitan's 3 monthly rates for the quarter

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Measure Descriptions

These measures were developed by the National Association of State Mental Health Directors (NASMPD) Research Institute (NRI) and were approved by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). They are used by approximately 240 state psychiatric hospitals and state-contract mental health facilities across the United States. Please note that rates are defined differently—for example, the elopement rate uses inpatient days as a base, while medication error rate uses the duplicated client count (number of hospitalizations) as a base.

1. Elopement Rate

Definition: Number of elopements per inpatient day

Elopement – Absent from a location defined by the client’s privilege status regardless of leave or legal status. A client is considered to have eloped if the client 1) has not been accounted for when expected to be present or 2) has left the grounds of the facility without permission.

Rationale: Psychiatric hospitals, particularly institutions serving severely and persistently ill clients, have a unique responsibility for insuring both client and public safety. Often, the effects of brain disorders that produce mental illness render an individual’s thinking unclear and, at times, irrational. Actions based on such distorted thinking can result in harm to self or others. Harm secondary to distorted thinking can be minor (the development of a minor illness due to insufficient clothing during cold weather) or serious (traffic accident injuring several people). When such consequences are likely, it is desirable for clients to be closely cared for in a safe environment. High rates of elopement from inpatient psychiatric facilities may represent insufficient efforts to insure client and public safety. Alternatively, such high rates may indicate a less than desirable treatment environment from which clients are likely to leave. In either case, opportunities for improvement exist.

2. Client Injury Rate

Definition: Number of client injury events per client day

An injury occurs when a client suffers physical harm or damage which requires medical treatment more intensive than minor first aid. Injury types include accidents, assaults and intentional self-injury

Rationale: If inpatient mental health services are to be maximally effective, clients must feel that they are in a safe environment that is free of unusual physical risks. The rate of physical injury reflects not only the safety of the physical structures of the facility but may also reflect the effectiveness or appropriateness of care. Ineffective care may result in abnormally high instances of harm to clients by self (self-injurious behavior) or others (acts of physical violence). Inappropriate care may be reflected in high rates of injury caused by neglect (e.g. falls) or injuries inflicted by abusive staff.

3. Medication Error Rate

Definition: Ratio of the number of medication errors reported to the duplicated count of clients served during the reporting period (number of hospitalizations)

Rationale: A critical component of the treatment of mentally ill clients, particularly those clients with severe and persistent illness is pharmacotherapy. If appropriately prescribed, distributed, administered and monitored, pharmacotherapy can produce significant improvement in symptoms. However, if inappropriately prescribed, distributed, administered or monitored, medications can be associated with significant harm or death to the client. Given the relatively high incidence of medication use among psychiatric clients and the high potential for adverse outcomes of medication-related errors, tracking of such errors and subsequent identification of causal factors is an essential component of the performance improvement process in organizations providing psychiatric health care.

4. Seclusion and Restraint Use

Definitions:

- Hours of seclusion as a percent of inpatient hours
- Percent of clients secluded at least once during the reporting period

- Hours of restraint as a percent of inpatient hours
- Percent of clients restrained at least once during the reporting period

Rationale: Mental health service providers that are consumer-focused value an individual's autonomy and independence. Therefore, these providers seek to maximize the use of service modalities that are minimally, if at all, restrictive. While restrictive treatments are sometimes necessary, utilization of such treatments must be minimized and closely monitored. Over-utilization of highly restrictive treatments may represent the unavailability of more appropriate, less restrictive therapies or the presence of treatment providers who lack respect for client autonomy and dignity.

5. New Generation Antipsychotic Use

Definition: Proportion of clients receiving scheduled antipsychotic medications that receive new generation agents

Rationale: Organizations that are focused on providing quality services work to insure that clients are receiving treatments that are consistent with defined "best practices." At least two sets of guidelines have been developed for the treatment of psychosis. Both consider new generation ("atypical") antipsychotics to be preferable over older agents. New generation agents have demonstrated advantages in efficacy and, with the exception of clozapine, safety over older agents. Use of these agents may be an indicator of the degree to which clients of the organization are receiving treatments that conform to best practices.

Low utilization of such agents may reflect a lack of understanding by providers of the advantages of new generation agents or, particularly in public sector organizations, a lack of necessary funding to provide these agents to all clients who might benefit from them.

6. 30 Day Readmission Rate

Definition: Rate of readmissions to an inpatient facility that occur within 30 days of a previous discharge from the same facility.

Rationale: The goal of inpatient psychiatric treatment is to provide services that allow individuals to return to the community as soon as possible. Admission to a psychiatric facility following a recent discharge may be an indicator that inpatient treatment was either incomplete or ineffective or that a lack of continuity exists between inpatient providers and community providers. Organizations with inordinately high rates of readmissions within 30 days should further explore factors underlying this finding and may need to implement efforts to improve the effectiveness of its services or strengthen linkages with outpatient mental health providers.

Metropolitan State Hospital SUMMARY GRID

**(CRIPA)
June 2005**

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
A.	Overall Concern				
	MSH does not provide adequate supports and services that result in effective treatment for individuals who are chronically and severely mentally ill	1. MSH is developing and implementing policies and procedures based on a recovery model of mental healthcare that provides individuals with effective treatment consistent with generally accepted professional standards of care.	<p>1.1 The hospital has transitioned to a recovery model of treatment. The clinical staff in the hospital is receiving training in the recovery model.</p> <p>1.2 The mission and vision of the hospital are in the process of revision that includes a change to a recovery model based on individual strengths.</p>	<p>June 2004 MSH is a learning-based organization that will keep up with and incorporate evidence-based rehabilitation and recovery practices in the treatment and care of all individuals ("patients").</p> <p>August 2004 The hospital has drafted a Recovery focused Mission and Core Values. Individual (patient) input took longer than expected.</p>	<p>Completed</p> <p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.3 The vision statement is currently being developed based on the approved mission and core values. The Vision draft has been developed and will be ready for review in December.</p> <p>1.4 Policies and procedures for the hospital are in the process of being re-written or developed which address the new direction of treatment. As policies and procedures come up for regular review every two years they are reviewed for Recovery focus and content.</p> <p>1.5 A Resource Person has been identified to develop a Recovery Resource library.</p> <p>1.6 A room has been designated for the</p>	<p>Therefore, completion date modified (from April 2004).</p> <p>Due to consumer input the process is taking longer than anticipated. December 2004</p> <p>December 2005</p> <p>June 2004</p> <p>On going with new supplies purchased to</p>	<p>Completed</p> <p>In process</p> <p>Completed</p> <p>In process</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
		<p>2. MSH has developed and implemented a person-centered, strength-based, integrated, and recovery-focused assessment and treatment planning system that is based on assessed needs of the individual.</p>	<p>Recovery Resource Library and materials have been purchased which includes books, videos, articles, lesson plans, and other Recovery focused supports.</p> <p>2.1 Process has been developed and begun using a new, recovery-focused, treatment planning process. There is a planned integrated assessment followed by discipline-specific assessments directed by specific clinical questions that arise from the case formulation and treatment outcome reviews.</p> <p>2.2 Instructional Manual is being developed to implement the newly developed Integrated Assessment forms. Due to the need to have consensus about the various disciplines the development of the Integrated Assessment took</p>	<p>meet the needs of the individuals in the recovery program.</p> <p>August 2003</p> <p>December 2004</p> <p>Revised due date February 2005.</p>	<p>Completed</p> <p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>longer than anticipated.</p> <p>2.3 Training has been provided for the new integrated assessment.</p>	<p>Start December 1, 2004 and end January 31, 2005</p>	<p>Completed</p>
		<p>3. MSH treatment teams will review and revise, as appropriate, treatment plans and evidence-based interventions of each individual on a specified schedule based on assessed treatment outcomes.</p>	<p>3.1 The hospital has changed to a recovery-based Treatment Planning Conference (TPC) system that is person-centered and builds on the individual's strengths. The assessments are completed prior to the initial TPC and incorporated into the treatment plan. The treatment plan is centered around the focus of hospitalization vs. the previous problem oriented process. The revised treatment planning process was fully implemented in August, 2003, following training of treatment team members and facilitators.</p> <p>3.2 The TPC process will be automated. The scheduling</p>	<p>August 2003</p> <p>December 2004</p>	<p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>process including course outlines will be automated first with a pilot program to beta test its functioning.</p> <p>Programming difficulties caused a delay in development of the automated program.</p> <p>3.3 The frequency of treatment plan reviews has been increased to reflect the dynamic treatment planning process and the needs of the individual. The new frequency of treatment planning conferences far exceeds Title 22, HCFA and JCAHO standards. Treatment Planning Conferences now occur at 7 days, every 14 days until 60 days after admission and then monthly thereafter.</p> <p>3.4 The timeliness and quality of treatment planning conferences are monitored monthly.</p>	<p>Revised for February 2005</p> <p>August 2003</p> <p>August 2003</p>	<p>Completed</p> <p>Completed</p> <p>Completed Monitoring system in place and</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
					ongoing.
		<p>4. Develop and implement policies and procedures to prohibit the use of seclusion and physical restraints as planned interventions in lieu of active treatment. These interventions are reserved for emergency use for safety of self, peers, and staff.</p>	<p>4.1 The hospital has long recognized that the use of seclusion and restraints (S & R) is not the appropriate means to treat behavior problems, and should only be used in an emergency. There has been a 5-year process in which the hospital has engaged in a systematic approach to the reduction of seclusion and restraint. Since 1998, seclusion and restraint has been reduced by 80%. The reduction plan has included: changing the philosophy of the treatment program to a proactive approach to managing behavior, training all staff in positive approaches, identifying individual preferences during crisis, surveying individuals, intervening early in the escalation phase, removing restraint beds from units and offering</p>	<p>Ongoing This is a long-term effort that will continue and be informed by psychiatric evidenced-based literature. Planned seclusion and restraints will be minimized to the point that seclusion and restraints are used only for medical and behavioral emergencies that pose imminent danger to the individual or others.</p>	<p>Completed System for reduction of S & R in place and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>alternatives to seclusion and restraint. We have added skill-building classes at our new Psycho-Social Rehabilitation Treatment Mall, which assist individuals in learning new skills. Behavior Support Teams have been identified for intervening during Mall Treatment Hours.</p> <p>4.2 The Performance Improvement Committee monitors seclusion and restraint monthly.</p> <p>4.3 A group of staff will receive training on Positive Behavioral Supports.</p>	<p>Ongoing</p> <p>March 2005 Twelve master trainers have been trained as of November 2004.</p> <p>Four more master trainers were trained by April 2005</p> <p>A PBS training plan has been developed and training of hospital staff is</p>	<p>Completed System in place, with ongoing monitoring.</p> <p>Completed</p> <p>Completed</p> <p>In process</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			4.4 Above referenced group will train all clinical staff.	in progress. June 2006	In process
		5. MSH has developed a general physical environment and therapeutic milieu for treating individuals that is consistent with generally accepted professional standards of care.	5.1 Development of Psychosocial Rehabilitation Treatment Malls. 5.2 Upgrading of existing patios adjacent to the living units. 5.3 Upgrading and personalizing the unit living space and dorms.	February 2004 In process. These structures will be upgraded as needed. A pilot patio has been completed (January 2005) and the other patios are in progress. Ongoing. We continuously upgrade unit living space and dorms, and the	Completed Ongoing Ongoing

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
				individuals personalize their own living areas from the time of their admission.	
		6. MSH is developing and implementing plans for enhancing supports and services that will assist individuals to be discharged as soon as their mental health and legal issues, if relevant, have been resolved.	<p>6.1 The treatment planning process includes members of the placing agency to assist/facilitate the discharge process.</p> <p>6.2 Discharge criteria are identified during the Treatment Planning Conferences (TPCs) which describe the improvements in the individual's behavior and the changes that should be evident as a result of the treatment provided in order for the individual to be transitioned to a lesser level of care.</p>	<p>August 2004 Los Angeles County has initiated the process to attend the TPC and CONREP is finalizing their plans to also attend therefore date modified from June 04. CONREP is now being notified of TPC meetings to enable them to attend the conferences.</p> <p>Ongoing For each new admission, the discharge criteria are specified at the 7-day Master Treatment Plan and usually refined as a specific placement is agreed to.</p>	<p>Completed</p> <p>System in place and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>6.3 Individuals are recommended for discharge to alternate level of care when they have met their treatment goals in accordance with their treatment plan.</p> <p>6.4 The Utilization Review department reviews all cases of individuals who have been at MSH more than 6 months.</p>	<p>Ongoing The discharge date is not fixed in advance. It is based on the individual meeting his/her clinical and/or legal discharge criteria before being discharged.</p> <p>Ongoing There is a trigger system that alerts the treatment team that the individual may be “stuck” for one of three reasons: clinical, legal or administrative. This trigger initiates further assessment and additional interventions to move the individuals towards discharge.</p>	<p>System in place and ongoing.</p> <p>System in place, with ongoing reviews.</p>
		<p>7. MSH will train staff to provide effective, positive interventions in a kind, caring, and compassionate manner to all individuals in their care.</p>	<p>7.1 The following training has been and will continue to be provided to the staff:</p> <ul style="list-style-type: none"> a. Mindfulness b. Proactive Team Approach c. Positive Behavior Support 	<p>December 2004 and ongoing. Initial training has been completed in all areas, but not to all staff. Further, competency-based training, is needed to ensure that all staff</p>	<p>Completed and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<ul style="list-style-type: none"> d. Team functioning in a Recovery model program e. PSR Recovery Model f. By Choice Incentive Program g. Cognitive Behavioral Therapy h. Group Process <p>Competency based training is ongoing and continues for all staff.</p> <p>7.2 The following training will be provided or will be repeated:</p> <ul style="list-style-type: none"> a. Dialectical Behavior Therapy (DBT) b. Cognitive therapies c. Mindfulness d. Recovery Model e. Positive Behavior Support f. Proactive Team Approach g. Unit Milieu Therapy 	<p>members receive needed training, and are able to use their skills competently. Additional training will continue to be provided as new evidenced-based literature on psychiatric rehabilitation and recovery becomes available.</p> <p>February 2005</p> <p>December 2004 and ongoing. Initial training has been offered to clinical staff on these topics so that they can be models and trainers for unit staff. Training on all topics, except Dialectical Behavior Therapy has been provided at least once to certain staff members. DBT training will be</p>	<p>Completed and ongoing.</p> <p>Completed and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.3 Established a risk management system to capture major risks related to the provision of medical and psychiatric care.</p> <p>1.4 Developed integrated, interdisciplinary assessments that are strength - based, and include a cultural assessment and case formulation.</p> <p>1.5 MD's are developing defensible diagnostic formulations based on DSM-IV-TR criteria.</p> <p>1.6 Implemented the new Treatment Planning Process that includes review of assessment data, integration psychosocial</p>	<p>January 2005 Forms and system were identified by June 2004. Demonstration project is now in process.</p> <p>August 2004 Draft was developed by June 2004. Date was modified to allow time to develop an instrument that could be used at all State Hospitals.</p> <p>December 2004 and ongoing. Current training will be completed on the DSM-IV-TR, but additional training will be provided as research studies on the DSM-V become available in the literature.</p> <p>August 2003</p>	<p>Completed</p> <p>Completed</p> <p>Completed and ongoing.</p> <p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>and psycho-educational interventions, based on individual strengths, and fully includes the individual in the treatment planning process.</p> <p>1.7 Provide specialized treatments aligned with the needs of subgroups- dementia/low cognitive functioning, substance abuse, and mental retardation.</p> <p>1.8 Develop specialized consulting treatment teams (Positive Behavioral Support; Neuropsychiatric and Dual Diagnosis-Mental Retardation/Mental Illness) for specific sub-populations, including those with behavior problems, neurological disorders and mental retardation.</p>	<p>Continuous: There will be a need to incorporate new treatments as they become available. Continuing medical education will focus on the psychopharmacology review to assess the cognitive affects of medications.</p> <p>January 2005 Established Positive Behavioral Support (PBS) and Mental Retardation/Mental Illness consulting teams. One Neuro-Psychologist has been hired. Date modified due to recruitment problems. Two Psychologists have been selected to lead</p>	<p>Ongoing</p> <p>Completed and in process.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.9 Monitor compliance and provide feedback to physicians through Drug Utilization Evaluations (DUE's).</p>	<p>two PBS Teams along with two RNs. Process has started to recruit two psychiatric technicians and two data entry staff for the two PBS teams.</p> <p>March 2005 two PBS teams have been appointed and the DD Team is partially completed. Due to recruitment problems locating a Ph.D. with appropriate credentials in DD services. Date revised to June 2005.</p> <p>June 2005 DD team has been hired and is in place. Currently recruiting for an Ph.D. for the second PBS team.</p> <p>October 2003</p>	<p>In process</p> <p>Completed System in place, with ongoing monitoring.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
C.	Nursing				
	MSH does not provide adequate nursing services that are consistent with generally accepted professional standards of care.	1. MSH will provide individualized services, supports, and therapeutic nursing interventions that are consistent with generally accepted professional standards of care.	<p>1.1 The Nursing Services Departments of the four DMH hospitals will have a statewide conceptual framework/nursing model that works in concert with standards of practice in psychiatric nursing.</p> <p>1.2 Nursing staff are being trained in the conceptual framework/nursing model.</p> <p>1.3 The Nursing Assessment Tool will be replaced with the newly developed Initial/Integrated instrument which includes or expands upon the Mental Status Exam, risk assessment, BMI and weight management, substance abuse, cultural, linguistic and spiritual needs, ADL screening, fall assessment, education. Nursing staff has received training in the new assessment tool and a monitoring system is being</p>	<p>September 2004 Hospitals have accepted the Johnson Model of patient classification system (PCS) in the Integrated Assessment tool.</p> <p>February 2005</p> <p>December 2004 Second draft has been developed and is in the process of being approved. Date modified since forms are being developed for implementation at all State Hospitals.</p> <p>An automated BMI program has been developed to track BMI.</p> <p>A statewide work group is working with the</p>	<p>Completed</p> <p>Completed</p> <p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>developed.</p> <p>1.4 Standards of psychiatric nursing practice are being integrated into the treatment planning process.</p> <p>1.5 Clinical Nursing Services have been integrated into the PSR Mall.</p> <p>1.6 The process of medication assessment and administration has been revised to include correlation of medication to diagnosis, identification of symptoms, responses and side effects.</p>	<p>various departments to integrate Axis III into the treatment planning process. Implementation date for the Initial/Integrated Reassessment due date February 2005.</p> <p>December 2004 and ongoing. New nursing practices will need to be integrated in treatment planning as they become available in the research literature.</p> <p>February 2004</p> <p>May 2003</p>	<p>Completed</p> <p>Completed and ongoing.</p> <p>Completed</p> <p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.7 Nursing staff has been trained in the medication administration including assessment, diagnosis, symptoms, responses and side effects.</p> <p>1.8 Maintain adequate staffing:</p> <ul style="list-style-type: none"> a. Recruit and retain qualified RN's and PT's. Maintain current staffing levels that are based on patient need via a Patient Classification System. b. Recruit one Psychiatric Nurse Practitioner for the Hospital. c. Recruit one additional Psychiatric Mental Health Nurse Practitioner. <p>1.9 Monitor the competence of nursing staff through Nursing Performance Improvement and</p>	<p>December 2004 and ongoing. New information will be incorporated in the nurses' training as they become available.</p> <p>Ongoing</p> <p>February 2004</p> <p>March 2005</p> <p>June 2005 Since last report, 12 new nursing staff have been added, with another 22 staff in progress in interviews.</p> <p>April 2004 Audit tools have been developed and auditing has begun.</p>	<p>Completed and ongoing.</p> <p>Completed and ongoing</p> <p>Completed</p> <p>In process</p> <p>In process</p> <p>Completed and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			competency evaluation.		
D.	Psychology				
	MSH does not provide psychological supports and services adequate to treat the emotional and behavioral disorders experienced by individuals in its care.	1. MSH psychologists will assess, diagnose, derive treatment needs and provide effective strength-based, recovery-focused psychological interventions to individuals that are integrated with their psychopharmacological, psychosocial and psycho-educational interventions consistent with generally accepted professional standards of care.	1.1 The Psychology department has developed assessment procedures to be completed upon admission. 1.2 Psychology staff has been trained in the use of the new assessment tools.	April 2004 June 2005. Due to the cost of the assessment tools from only one primary source the order is being reviewed to meet budgetary constraints and individual needs.	Completed In process

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.3 The "Decision Tree" concept has been revised to address all clinical disciplines. The "Clinical Trigger" format will now be used. The "Clinical Trigger" format which is now under development will be used to determine the need for further psychological assessment.</p> <p>1.4 Psychology staff has been trained in the use of psychological tests.</p>	<p>February 2005 date was extended due to a delay in the approval of the Integrated Assessment tool.</p> <p>March 2005 Statewide Committee is developing "Clinical Triggers". Will need date extension to May 2005 due to the complexity of the assignment.</p> <p>Current MSH status includes the development of triggers and new monitoring processes. Implementation date is July 2005.</p> <p>June 2005 and ongoing. There is a need for extensive training of psychologists in a range of psychological and psychosocial tests. It will take some time for all psychologists to reach</p>	<p>Ongoing</p> <p>Ongoing</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.5 Develop Behavioral Support Teams.</p> <p>1.6 Develop neuropsychological services at MSH.</p>	<p>competency in some tests.</p> <p>December 2003 2 Positive Behavioral Support team Psychologists and one RN have been appointed. Additional team members to be appointed. Difficulty in recruiting additional staff and RN shortage. Date has been extended to January 2005. Two additional RNs have been hired and four positions for Psychiatric Technicians have been identified and are in the process of being filled.</p> <p>June 2004 Adult Neuropsychologist has been hired. Additional team members need to be appointed once candidates are available. Date has been extended</p>	<p>Completed</p> <p>Completed</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>1.7 Develop services for the assessment and treatment of individuals with developmental disabilities and mental illness.</p> <p>1.8 Establish a Quality Assurance system to evaluate the initial and annual assessments.</p> <p>1.9 Psychology staff will receive continuing training on the theory and practice</p>	<p>to January 2005 due to recruitment problems.</p> <p>March 2005 Two Adult Neuropsychologists were hired and are currently providing services. Additional team members need to be appointed once candidates are available.</p> <p>June 2004. No Psychology candidates with a mental retardation background available. Due to recruitment problems due date is extended to January 2005.</p> <p>April 2004 Audit tools have been developed for auditing psychological assessments.</p> <p>December 2004 and ongoing. Very specific training is</p>	<p>Completed</p> <p>Completed</p> <p>Completed and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
		<p>2. MSH psychologists will assess the need for and provide, as appropriate, behavior therapy based on a positive behavior supports model and cognitive behavior therapy for the emotional and behavioral disorders experienced by the individuals in its care.</p>	<p>of Dialectical Behavior Therapy in a Recovery model, Evidence Based Treatment, Cognitive Behavioral Therapy, and Positive Behavior Supports.</p> <p>2.1 Two Positive Behavior Support Consultation teams will be developed to enhance the capacity of treatment team psychologists to provide strength-based, behavioral treatment programs.</p>	<p>needed in Dialectical Behavior Therapy. The costs are currently prohibitive to hire the specialist trainers needed for this.</p> <p>February 2005 The state hospitals are exploring a statewide training program that will share the costs among several of the hospitals.</p> <p>December 2004 and ongoing. Two behavioral psychologists and two team members have been appointed. Additional teams and members will be added as resources allow. These teams are operational and are now in the process of developing a Positive Behavioral Support policy and procedural</p>	<p>Unable to share cost, will reconsider next fiscal year 2005 - 2006</p> <p>Completed and ongoing.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
				manual in coordination with the statewide committee and related training.	
E.	Pharmacy				
	MSH individuals do not receive pharmacy services that are consistent with generally accepted professional standards of care.	1. MSH will develop and implement policies and procedures that require and enable pharmacists to provide pharmacy services consistent with generally accepted professional standards of care.	<p>1.1 Update "Medication Guidelines" issued by the California Department of Mental Health.</p> <p>1.2 Develop drug regimen review procedures for monitoring compliance and providing feedback to physicians.</p> <p>1.3 Develop guidelines on the use of "as needed" (PRN) medications and monitoring of their use.</p> <p>1.4 Develop tracking system to monitor the use of PRN medications.</p>	<p>Sept 2003</p> <p>November 2003</p> <p>November 2003</p> <p>April 2004</p>	<p>Completed</p> <p>Review completed, with ongoing feedback.</p> <p>Completed with ongoing monitoring.</p> <p>Completed with ongoing monitoring.</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
F.	General Medical Care				
	MSH does not provide adequate preventative, routine, specialized and emergency medical services on a timely basis in accordance with generally accepted professional standards of care.	1. MSH will develop and implement protocols and procedures to ensure timely and effective provision of medical care, including but not limited to vision and dental care, in accordance with generally accepted professional standards of care.	1.1 A second dentist has been hired.	April 2004	Completed
			1.2 Increase specialized emergency medical services.	July 2004 A monitoring plan has been implemented to track missed appointments or multiple refusals by individuals to go to clinics.	Completed and ongoing.
G.	Dietary Services				
	MSH does not provide adequate dietary services particularly for those individuals who experience weight related and/or health	1. MSH will address in a timely manner the needs of those individuals who experience weight problems and/or health related concerns.	1.1 The Dietary Department has developed an Interdisciplinary Team Approach to counter weight related problems.	January 2004	Completed

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
	related problems.		<p>1.2 A 12-week course is presented at the Psychosocial Rehabilitation Mall (PSR) Mall.</p> <p>1.3 All individuals' BMI is being tracked. The "Heart Healthy Menu" for all individuals has been put into place. The menu provides few calories and less fat and higher fiber content.</p> <p>1.4 A "trigger" for action has been initiated for a Body Mass Index (BMI) over 27.</p>	<p>January 2004</p> <p>January 2004</p> <p>January 2004</p>	<p>Course developed, with ongoing training.</p> <p>Program is in place and tracking system is operational and ongoing.</p> <p>Trigger system complete, with ongoing treatments.</p>
H.	Placement in Most Integrated Settings				
	MSH does not actively pursue appropriate discharge	1. MSH will modify discharge-planning practices to ensure that	1.1 The Master Treatment Plan includes the plan for discharge and discharge	August 2003	Completed

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
	<p>of individuals that ensures placement in the most integrated, appropriate setting consistent with their needs.</p>	<p>discharge planning begins at the time of admission and that all individuals have a discharge plan that includes realistic and individualized discharge criteria.</p>	<p>criteria.</p> <p>1.2 The placing agency is expected to attend treatment plan reviews in order to assist in the discharge planning process. Treatment teams actively pursue discharge for individuals who have met their discharge criteria. Placement has frequently been difficult due to a lack of adequate placement resources in the community to meet the complex medical and psychiatric needs of the individual at MSH.</p> <p>1.3 Individuals who have met discharge criteria are placed on alternate level of</p>	<p>January 2005 Currently in place in Program II (I & VI) for the 7 day TPC and with CONREP for the Forensic Units.</p> <p>January 2004 and ongoing.</p>	<p>Completed</p> <p>Completed System in place and</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			<p>care and referred for placement.</p> <p>1.4 Utilization Review monitors all individuals placed on alternate level of care, and these cases are referred to the county interagency committee.</p> <p>1.5 Treatment plans are reviewed monthly to determine if discharge plans are realistic and individualized.</p>	<p>January 2004 and ongoing. A committee composed of UR, Unit PSW and County Caseworkers meet monthly to discuss ongoing individuals awaiting placement.</p> <p>January 2004 and ongoing.</p>	<p>ongoing.</p> <p>Completed System in place, with ongoing monitoring.</p> <p>Completed System in place, with ongoing reviews.</p>
		<p>2. MSH will provide appropriate and effective care and treatment to reduce the length of stay, as well as mitigate the dangers of long-term hospitalization.</p>	<p>2.1 Through transforming our treatment model to a recovery/wellness model, providing adequate assessment, diagnosis, treatment interventions, skill building and discharge planning, it is anticipated that lengths of stay will be decreased.</p>	<p>Ongoing</p>	<p>Ongoing</p>

	DOJ Findings	MSH Response	Enhancement Plan	Anticipated Completion Timeline	Current Status
			2.2. The UR and Performance Improvement Committees monitor length of stay.	January 2004 and ongoing.	System in place, with ongoing monitoring.
I.	Protection From Harm				
	MSH does not provide individuals with a safe and humane environment and does not protect them from harm.	1. MSH will enhance and implement policies and procedures that will ensure individuals are protected from harm, and reside in a safe and humane environment.	1.1 MSH has a comprehensive Risk Management Program, and policies and procedures, which provide oversight and review of monthly data regarding seclusion and restraint, medication use, and other high-risk triggers.	January 2004 and ongoing.	Completed System in place, with on going oversight and reviews