

Mental Disabilities Board of Visitors

SITE REVIEW REPORT

MONTANA DEVELOPMENTAL CENTER

November 8-9, 2010

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Overview

● **Facility Reviewed**

Montana Developmental Center (MDC)
Boulder, Montana

Kathy Zeeck, Superintendent

● **Authority for Review**

Montana Codes Annotated, 53-20-104

● **Purpose of Review**

Assess whether MDC's internal review after the May 2010 sexual assault incident(s) identified and addressed root issues; make recommendations for improvement.

Analyze MDC's organizational culture prior to the May 2010 sexual assault incident(s); make recommendations for improvement.

● **Review Team**

Staff: Leigh Ann Holmes, Advocacy Specialist
Craig Fitch, Attorney
Gene Haire, Executive Director

Board: Lin Olson
Brodie Moll

Consultant: Irene Walters, RN

● **Review Process**

1. Interviews with Montana Developmental Center Staff
2. Interview with contract psychologist
3. Review of treatment records
4. Review of written descriptions of treatment programs

Executive Summary and Key Recommendations

The needs of the clients served by the Montana Developmental Center (MDC) have changed dramatically during the past decade. The complexity of these needs has created a challenge to which MDC has not successfully adapted. This report describes the need for the Montana Developmental Center (MDC) to transform, and makes specific recommendations for that transformation.

Historically, the purpose of MDC was to provide long-term – and in some cases, lifelong - residential care for individuals who were thought of by the general public as “mentally retarded”. That purpose has changed and evolved since the mid-1970s with the continuing development of community-based services to support those individuals.

Today, people who are admitted to MDC present with some of the most complex psychiatric, developmental, and behavioral challenges of all people served by Department of Public Health and Human Services (DPHHS) programs. MDC clients typically have diagnoses of one or more major mental illnesses in addition to developmental disabilities. It is not unusual for MDC clients to also have diagnosed personality disorders, medical and/or neurological disorders, and significant psychosocial and/or environmental stressors. Additionally, a growing percentage of MDC clients has been adjudicated and sent to MDC under court order after committing various crimes including sexual offenses.

At the time of this review, of the 63 MDC clients:

- 89% had a diagnosed serious mental illness in addition to a developmental disability (DD)
- 76% had demonstrated serious aggression toward and/or had caused serious harm to other clients and/or staff at MDC, in community DD service settings, in communities at large, and/or within their families
- 14% were criminally committed/sentenced to MDC
- 29% were admitted to MDC after committing sexual offenses

Despite the shortcomings described in this report, BOV believes that a transformed MDC as a center of treatment excellence and technical assistance will provide an excellent resource for families and clients with developmental disabilities and for providers of developmental disabilities / mental health services. Successful transformation of MDC will require the establishment and careful nurturing of a culture of professional competence, stability, and confidence within the framework of a redefined organizational mission. This transformation will challenge MDC’s leaders to manage complex clinical and behavioral client presentations in a newly-designed environment of evidence-based treatment provided by competent, well-trained clinical professionals and para-professionals working as a coordinated multidisciplinary team. The first priority of transformed leadership is to develop clear and compelling descriptions of MDC’s vision and purpose¹.

Systemic, comprehensive transformation strategies are needed in the following areas:

- Organizational Structure, Planning, and Quality Improvement
- Staff Competence, Training, and Supervision
- Incident Management, Investigation, and Client Protection
- Role of Clinical Professionals
- Leadership and Organizational Culture

MDC and Developmental Disabilities Program (DDP) leaders have strong personal ethics, take their responsibilities seriously, and have devoted their careers to working with people with disabilities. MDC staff care deeply about, want the best for, and strive to work effectively with clients. MDC has an array of professional treatment services not available on-site within any other service for people with developmental disabilities anywhere in Montana.

The new Administrator of the Disability Services Division (DSD) has brought fresh insight, creativity, and motivation to the challenges at MDC. The Director of DPHHS has created a new senior analyst position to focus on quality management within Montana’s state facilities for psychiatric and developmental disabilities services; this person will play a central role in supporting MDC’s transformation. DSD is in the process of recruiting for a new Clinical Director for MDC; this person will bring a critically important level of professional expertise to client services and

to the transformation process. This new emphasis on engaged leadership, quality management, and clinical expertise is critically important and has been long-needed.

An acknowledgement of the changing clientele and the commitment to the vision of MDC as a state-of-the-art treatment center provide the foundation for successful transformation. BOV will work with MDC as it undertakes this transformation, and intends to actively monitor progress over time.

Key Recommendations

The Department of Public Health and Human Services should:

- ❖ Define the vision and mission of MDC.
- ❖ Develop and implement a strategic plan based on this vision and mission.
- ❖ Develop and implement a process of quality improvement.
- ❖ Develop a competent, well-trained, well-supervised staff.
- ❖ Develop the ability to analyze and resolve allegations of client mistreatment that balances fact-finding, corrective action, and clinical oversight.
- ❖ Establish a professional clinical presence and expertise that drives all services and decision-making.
- ❖ Establish clear expectations for effective MDC leadership; support leaders in meeting these expectations; hold leaders accountable for their performance.
- ❖ Transform MDC's culture so that services are provided within an atmosphere of proactively, leadership confidence, staff support, excellence, and continual improvement.

History

Sexual Assault Allegations

On May 24, 2010, a female resident of MDC reported to a staff person that another staff person had “given her candy and had sex with her”². Following the reporting of the May 24 allegation, a number of entities including DPHHS, the Montana Department of Corrections, the Jefferson County Attorney, the Criminal Investigation Division of the Montana Department of Justice, and the Centers for Medicare & Medicaid Services (CMS) began conducting or assisting in investigations and reviews of this situation in the areas of their respective authority. Also during this time, four additional female clients were identified by MDC as having been allegedly sexually assaulted by the same staff person; two of these allegations had been previously investigated by MDC and been determined to be “unsubstantiated”³.

By mid-June, the MDC Client Protection Specialist (CPS) had completed what was described to BOV as the first of a three-phase internal investigation⁴, and was in the process of completing phases 2 and 3.

After becoming aware of the May sexual assault allegations, MDC/DDP/DSD took some reasonable steps to strengthen MDC’s ability to ensure client safety, including revisions of policies and procedures. However, interviews with MDC staff revealed significant frustration and deepening cynicism about problematic aspects of MDC’s organizational culture that have not yet been addressed and which have a direct bearing on whether or not efforts to ensure client safety will succeed.

Staff Morale

There is a palpable climate of fatigue and cynicism at MDC today that wasn’t present during BOV’s last review in 2009. The frustration expressed by staff is focused on disappointment about feeling unable to be effective in their work with clients. Staff do not appear to believe that solutions will be forthcoming. MDC staff and the contract psychologist brought in following the sexual assault incidents describe an atmosphere of fear at MDC: fear of making decisions and taking action, fear of talking with anyone from the outside, fear of being injured by clients, fear of making mistakes, fear of being turned in by co-workers for making mistakes, fear of retaliation by co-workers for reporting legitimate problems, fear of retribution by MDC leadership for expressing opinions about dysfunction they observe. MDC/DDP leadership needs to address the underlying climate of fear and uncertainty felt by staff if the work of ensuring client safety and providing quality treatment is to be effective.

Centers for Medicare and Medicaid Services Surveys

Since March 2002, the Centers for Medicare and Medicaid Services have placed MDC in “Immediate Jeopardy” of losing its certification for Medicaid funding six times because MDC’s “...noncompliance with one or more [CMS] requirements ... has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”⁵.

MDC staff report, and BOV has observed that following each of these “IJs”, corrective plans have been written and CMS has approved the plans - and yet fundamental change in the organizational culture and in MDC’s approach to providing treatment and ensuring client safety that were the root causes of the problems has not occurred. Much of the effort expended on a daily basis at MDC is directed at symptoms of problems rather than root causes - counter-measures taken in reaction to daily crises. These counter measures - while valid and sometimes helpful in the short term - continue to be concerned mostly with only one or another of each problem’s facets without addressing the bigger picture represented by each problem and without ensuring that problem-solving is integrated, comprehensive, and driven by the clinical needs of clients and the purpose of MDC.

Board of Visitors Involvement

BOV conducted thorough analyses of a number of aspects of MDC operations during formal site reviews in 2002 and 2006⁶, including thorough analyses during both reviews of the operation of the “104-R” unit - the precursor of the Assessment and Stabilization Unit (ASU)⁷. In 2009 - after becoming increasingly concerned about the functioning of ASU during 2008, BOV conducted a special site review focusing exclusively on ASU⁸.

Much of the analysis and a number of the recommendations made by BOV in 2002, 2006, and 2009 address client service and operational issues that are at the core of the challenges MDC continues to struggle with – and which continue to create significant risk for both client and staff safety. The root causes of the issues identified as problematic by BOV in 2002, 2006, and 2009 remain largely unaddressed.

As MDC evolves, it will be critical for its leaders to think and perform proactively – to anticipate; to plan strategically; to make consistent, timely decisions; and to follow-through. MDC needs a visionary core of unified leadership to function as a guiding force driving transformation – leadership that can create of a state-of-the-art treatment culture by establishing standards of quality and high expectations for excellence. The staff of MDC need leadership that actively supports them in meeting those expectations, and who ensure that accountability is the norm.

Analysis

Organizational Structure, Planning, and Quality Improvement

Structure:

Are the lines of authority and accountability in both the organizational chart and in practice:

- simple and clear for all staff?
- lead to a single point of responsibility and accountability across all sites, programs, professional disciplines and age groups?

No

Observations:

- BOV was provided with a revised, provisional organizational chart that the MDC Governing Body has developed and which has been approved by the Director of the DPHHS. BOV understands that this organizational chart represents changes that are needed immediately to address the lack of clarity in chain-of-command and supervision responsibilities - and that it is intended to serve as a tool for stabilization. BOV offers the following suggestions for consideration as the organizational structure evolves with transformation activities:
 - (1) Consider adjusting the organizational chart as the MDC mission is clarified.
 - (2) Consider whether artifacts of MDC's historically-evolved staffing and organizational structure continue to be functional. These include:
 - (a) Client Services Director, Unit Coordinator, and Human Services Specialist positions
 - (b) The division of the six ICFMR⁹ units into two organizational 'divisions' - "Intensive Therapeutic Short Term Care" and "Long Term Care Rehabilitation". (Is the mission of MDC - going forward - to provide long-term care?)
 - (3) Examine what appear to be multiple layers of authority in each of the two 'divisions' that have the potential for creating an unwieldy and unnecessarily top-heavy chain-of-command. [Within each 'division' there are five layers of authority above the direct care staff level: a Licensed Psychologist, a Client Services Director, a Qualified Mental Retardation Professional (QMRP), a Unit Coordinator, and a Shift Manager; and there are multiple chains-of-command: 'clinical' under the psychologist, 'administrative' under the CSD/UC, 'treatment' under the QMRP - all creating significant potential for fragmentation of effort and decision-making, and unclear lines of accountability and authority.]
 - (4) Consider consolidating "professional" services (Vocational, Communications, Special Education, Occupational Therapy, Recreation Therapy) under one coherent organizational unit instead of separating between the two 'divisions'.
 - (5) Consider ways to ensure that the organizational chart supports clarity about who runs MDC - who the final decision-maker is. Is it the Superintendent or is it the Clinical Director? Who is the leader of the Facility Management Team?

Planning:

“The strategic leader's vision provides the ultimate sense of purpose, direction, and motivation for everyone in the organization. It is the starting point for developing specific goals and plans, a yardstick for measuring organizational accomplishment, and a check on organizational values. A shared vision throughout the organization is important for attaining commitment to change.

The ability to provide clear vision is vital to the strategic leader, but forming a vision is pointless until the leader shares it with a broad audience, gains widespread support, and uses it as a compass to guide the organization. For the vision to provide purpose, direction, and motivation, the strategic leader must personally commit to it, gain commitment from the organization as a whole, and persistently pursue the goals and objectives that will spread the vision throughout the organization and make it a reality.”¹⁰

Has the leadership of MDC/DDP facilitated a collaborative process to build a shared vision and to define the purpose for MDC by establishing a comprehensive consensus-building process that involves staff, clients, family members, other appropriate service providers, and other stakeholders working together in defining the center's beliefs, mission, and goals?

No

Strengths:

- In 2006, MDC's management team engaged in a facilitated strategic planning process that resulted in a document titled Montana Developmental Center Strategic Plan FY 2006 through 2011 which includes statements describing the vision and the mission/purpose of MDC.

Observations:

- There is a significant level of ambiguity about the mission/purpose of MDC that appears to grow out of the failure to adapt to the significant change - as described above - in the profile of the client population at MDC.
- There is a significant level of ambiguity about the nature of the “DD system”, whether a true continuum of services exists in this system, whether MDC is an integral part of such a continuum – and if so, what role MDC plays in that continuum.
- The vision for MDC described in the strategic plan document provided to BOV includes 16 bulleted statements which list what MDC and its staff “strive to do” – instead of a description of the future state of MDC toward which to aspire¹¹ and around which to organize a plan.
- In the MDC position descriptions for staff who are involved in providing and/or supervising services to clients there are seven different statements of the mission of MDC; the strategic plan document describes an eighth; the MDC website has a ninth.

Does MDC produce and regularly review a strategic plan that translates the vision and purpose into realistic goals?

Strengths:

- The strategic plan document represents a potentially meaningful start toward developing a functional strategic plan. The organizing structure of the strategic plan document is excellent (philosophy --> values --> vision --> mission --> goals --> objectives --> action steps --> measurable outcomes).
- There is a base of dedicated staff who are personally committed to and believe in the work they do. Many of these staff are capable of working together to develop a dynamic strategic plan that could be used as a step-by-step map of the way forward and are willing to do so.

	▪ The strategic plan document addresses in a general way client safety and incident management in its first goal and the first goal's two objectives. ▪ Staff at all levels want to know where MDC is heading and express a desire to be a part of something that is heading in a clear direction. <u>Observations:</u> ▪ MDC staff do not appear to be aware of the strategic plan document - when it was developed, whether it has been implemented, whether it is regularly reviewed or has been revised. ▪ It does not appear that Unit coordinators, Section Leaders, nursing staff, line staff, clients, or clients' families have had a role in developing the strategic plan document. ▪ 89% (56 of 63) of MDC clients have a mental illness diagnosis in addition to a developmental disability diagnosis, however mental illness is not mentioned anywhere in the strategic plan document. ▪ Objective 3,D of the strategic plan, "Improve Internal Communications", addresses a critically important need - while at the same time - it appears that there is a lack of awareness of the plan itself by anyone outside of MDC leadership.
Does MDC have operational objectives based on the strategic plan, with established time frames and responsibilities for implementation of objectives in all treatment and support components of MDC?	No <u>Strengths:</u> ▪ It appears that several of the action steps in the strategic planning document have been taken and some objectives have been achieved. <u>Observations:</u> ▪ There is no process or system to operationalize the strategic plan. ▪ There are no defined individual or team responsibilities or time frames for implementing "action steps". ▪ A number of statements are repeated as both "objectives" and "measurable outcomes", and where stated as "measurable outcomes" are not, in fact, measurable. For example: <i>Action Step: Provide regular professional development and training to all MDC treatment staff. ...</i> <i>Measurable Outcome: Maintenance and improvement of professional skills of all MDC staff.</i> ▪ The strategic planning document does not appear to represent a dynamic process that affects staff actions or daily decision-making.
Does MDC assess the implementation of operational objectives and use the assessment to continually refine and reshape the goals of the strategic plan?	No <u>Observations:</u> ▪ There are no quantifiable parameters for measuring outcomes; some "measurable outcome" statements include more than one discrete thing to be measured; things to be

	measured are not defined. For example: <i>Measurable Outcome: Reduced incidents of confrontations, altercations, and abuse allegations.</i> This statement includes three discrete things to be measured (confrontations, altercations, abuse allegations); "confrontations" and "altercations" are not defined ("abuse" is defined in statute and in MDC policy); a threshold for determining "abuse allegations" to be measured is not defined; there are no defined baseline, time frame, target, or environmental parameters, i.e., the "measurable outcome" statement does not describe the residential unit, the shift, the pre-intervention number of incidents, or the percentage reduction desired. There is no process for refining and reshaping the goals of the strategic plan based on quantified tracking of plan implementation and results.
Does MDC ensure that its vision and purpose guide the treatment process?	No <u>Strengths:</u> - Twenty-four individuals were placed in community services in 2010; 9 were placed in 2009. <u>Observations:</u> - The full implications of the complexity of the diagnostic and behavioral presentations of people being served at MDC - the sheer difficulty of the task; the knowledge, skill, and education requirements for unit staff; the level of psychiatric expertise and experience needed by clinical staff; and organizational leadership needed - have not been fully acknowledged and addressed; the mission and vision statements in the strategic plan document are not informed by these realities. - The emergent¹² status of clients admitted to MDC - and particularly those served on ASU - drives and becomes the default purpose of MDC. - MDC and DDP have struggled since the inception of ASU about whether to pursue ICFMR status for that component of the MDC campus. (ASU is designated as an ICFDD which carries a different standard for treatment than ICFMR.) The thinking among MDC/DDP leaders has been that - eventually - ICFMR status would be sought since this would allow for Medicaid funding. At the same time, it has been clear - at least in its current configuration and mode of operation, and perhaps by definition - that ASU would not qualify for ICFMR status. This situation has created an atmosphere of ambivalence since at least 2007 about what direction to take on ASU from both clinical and management perspectives. This ambivalence has exacerbated the lack of clarity about the purpose of MDC overall, has led to significant confusion when clients move between residential units and ASU, and has intensified the decision-making paralysis discussed elsewhere in this report.

Quality Improvement:

“To be able to put strategic vision, concepts, and plans into reality; strategic leaders must employ reliable feedback systems to monitor progress and adherence to values and purpose. They have to find ways to assess many environmental elements to determine the successfulness of policies, operations, or a transformational vision. ... They must assess themselves; their leadership style, strengths, and weaknesses...They develop performance indicators to signal how well they are communicating to all levels of the organization and how well established systems and processes are balancing the imperatives of the mission, the organizational structure, training, leadership, and personnel.”¹³

Does MDC have and use a plan of continuous quality improvement to evaluate and improve all of its activities related to services to clients and families?

No

Strengths:

- MDC has a Quality Assurance Committee that reports to the Superintendent.
- The Quality Assurance Committee collects raw baseline information about the residential units' treatment environments through in-person spot checks ("Random Visual Checks"), and reviews incident review data.
- Since May 2010, there has been an increased presence of a variety of individuals in the units who are doing Random Visual Checks; this has increased the awareness of staff who appear to be more conscientious of what they are doing, who they are with, and of staff accountability and client safety in general.
- Treatment teams address client safety on a daily basis by reviewing the data from Behavior Data Sheets and Incident Reports; adjustments are made as needed to living units, staffing levels, and programming.

Observations:

- There is no formal Continuous Quality Improvement plan or process at MDC.
- The Quality Assurance Committee does not appear to have authority or direction.
- MDC does not have an operational plan or a process for measuring adherence to defined quality standards related to goals and objectives in the strategic plan document, or for feeding back measures into a process of continual improvement based on these measures.
- The strategic plan document does not address a quality improvement plan or process.
- The activities of the Quality Assurance Committee appear to be perpetually in the process of becoming something as yet undefined.
- The process of collecting and looking at incident report data - appears to be primarily reactive rather than proactive - indicative of a "damage control" mind set.

Are designated staff of MDC accountable and responsible for a continuous quality improvement process?	No <u>Observations:</u> - It appears that Quality Assurance efforts are fragmented in several ways: - divided between two staff positions with no designated leader, - existing as one part of the responsibilities of these two positions, - allocated to staff positions scheduled to work 4pm-12mn shifts and weekends. - The completed Random Visual Inspection forms (hard copy raw data) are put in a basket and then physically filed in a binder. Staff referred to a plan to enter this information into a computerized database at some point so the information can be used, but no one was able to say what the target date for doing this is. - Staff assigned to complete the Random Visual Checks forms receive no training. - The link between Quality Assurance and Incident Management appears weak or non-existent. - There appears to be a method for extrapolating incident data from Therap^{®14} to reveal trends, and to generate trend graphs but data are not used to develop quality improvement interventions.
Is MDC able to demonstrate a process of continuous quality improvement that directly affects health and functional outcomes for individual clients?	No

Bottom Line : Organizational Structure, Planning, and Quality Improvement

Strengths:

- There is ongoing discussion about optimal organizational chart configuration.
- There has been some work done to establish MDC's vision/goals --> mission/purpose --> plan/actions.
- There is a Quality Assurance Committee and the ability to collect and analyze data.

Challenges:

- The development of the strategic plan is incomplete.
- Quality standards are not established.
- There is no quality management/improvement plan.

Recommendations for Organizational Structure, Planning, and Quality Improvement

1. Revisit the strategic planning process:

- Clearly articulate the vision as the desired or intended future state of MDC - develop a written vision stating what MDC will look like when it is fulfilling its purpose.
- Develop a cogent, succinct, written statement of the purpose of MDC.

The goal of this process is to bring absolute clarity and focus to the reason for the existence of MDC that will drive treatment and provide the underpinning for decision-making. This needs to be done before anything else recommended in this report can be accomplished.

2. Following a period of organizational stabilization, revisit the provisional organizational chart and address the following questions:

- Are the Client Services Director, Unit Coordinator, and Human Services Specialist positions relevant to the mission and

support organizational effectiveness?

(b) Is a "Long Term Care Rehabilitation" unit congruent with the mission of MDC?

(c) Are the layers of authority excessive?

(d) Are the multiple chains-of-command necessary?

(e) Are professional services placed in the organization in a way that maximizes their effectiveness and access to all clients?

(f) Does the chart clearly depict who the leader of MDC is?

3. Rework "action step" statements in the strategic planning document so that "who will do what by when" is clearly defined.
4. Rework "measurable outcome" statements in the strategic planning document so that they read like this: *"The number of altercations in Unit Six on the 2pm-10pm shift will be reduced by 20% from the baseline of 10 altercations per shift"*.
5. Develop a system for measuring the "measurable outcomes" in the strategic planning document and for adjusting accordingly.
6. Develop a Quality Improvement Plan and process that is congruent with the vision and purpose of MDC to evaluate and improve all activities related to provision of services to clients.

Suggestions for Implementation of Recommendation 2:

- Start with a blank slate and create the ideal organizational chart - as a graphic representation of ideal organizational structure; ask the question "What would the ideal structure for MDC staff resources look like if we had none of the existing positions, none of the organizational structure history, and no financial constraints?"
- Build the ideal organizational chart with the vision/goal --> mission/purpose --> plan/actions as the foundation; ask the question "How can we design the organizational chart to optimally support the vision/goal --> mission/purpose --> plan/actions?"

Suggestions for Implementation of Recommendation 6:

- Differentiate between *Quality Assurance*¹⁵ and *Quality Improvement*¹⁶.
- Establish at least one dedicated FTE for Quality Management.
- Develop specific operational guidelines for staff responsible for Quality Management.
- Train staff responsible for implementing Quality Management activities.
- Ensure that relevant data is identified, collected, entered into a database, and used by Quality Management staff to make decisions about the design of interventions.
- While developing the quality improvement process, continue to have supervisory and clinical staff conduct "walk-through" visits and document findings; teams should receive copies of the "walk-through" results in a timely fashion to use for decision making.
- Make quality a standing agenda item in all leadership and staff team meetings; quality improvement must become a part of the daily culture.

Staff Competence, Training, and Supervision

"[Employees] work hard ... when they are well-trained and sense that they are part of a first-rate team. Collective confidence comes from succeeding under challenging and stressful conditions, beginning in training."¹⁷

Does MDC define optimum knowledge and competence expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders for each staff position providing services to clients or supervision for these services?

No

Observations:

- Knowledge and competence expectations are described in position descriptions. These descriptions are incomplete, generic, and inconsistent across all position descriptions.
- Since the mission/purpose of MDC is not clearly defined, there is no connection between required competencies and the MDC mission/purpose¹⁸.
- 89% (56 of 63) of MDC clients have a mental illness diagnosis in addition to a developmental disability diagnosis; however position descriptions make no mention of knowledge and competence relative to mental illnesses or working with people with mental illnesses.

Suggestion:

- Rewrite position descriptions to reflect the competence expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders. Ensure that the expectations can be measured by supervisors and are directly linked to performance appraisals.

Does MDC have written training curricula for new staff focused on achieving optimum knowledge and competence expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders defined for each position providing services to clients or supervision for these services?

No

Strengths:

- MDC has a written training outline for new staff.
- There is a system in place to hold staff accountable for completion of required training.
- There is a form that outlines on-the-job training requirements that is to be completed within 2 weeks of pre-service training completion.
- The Psychology department has recently started providing training to new staff on psychiatric disorders and treatment interventions.

Observations:

- Since position descriptions do not describe specific competence and knowledge expectations, there is no context in which to design training that teaches to such definitions.

Does MDC train new staff in job-specific knowledge and competence OR require new staff to demonstrate defined optimum knowledge and competence specific to working with people with multiple developmental, psychiatric, and behavioral disorders defined for each position providing services to clients or supervision for these services??

No

Strengths:

- MDC staff are required to complete specified modules of education in the online College of Direct Support¹⁹; the College of Direct Support is a competency-based training tool.
- The addition of the College Of Direct Support as an

	educational resource for staff has added to both the quality and consistency of the baseline of staff knowledge and competence. <u>Observations:</u> ▪ The lack of written competence and knowledge expectations and directly-related training results in: 1. The possibility that new staff being put into positions that they are not prepared for. 2. Promotions that may not be clearly related to demonstrated knowledge and competence. ▪ Much of the training beyond new employee orientation is informally provided on-the-job by peers; this is likely to be problematic if/when on-the-job training has no defined standards or goals. ▪ Most staff training has no competence demonstration requirements – staff must only complete the training; for the training areas that do define competence standards, it was reported to BOV that “everyone passes”. ▪ Staff report that they have a difficult time completing continuing education online because of staffing patterns and the inability to be off-unit. ▪ The new Training and Development Specialist expressed his impression that training is viewed negatively within the MDC culture – almost as if training is punitive in nature.
Are the education and experience expectations for applicants for line staff positions (Psychiatric Aide) adequate?	No <u>Observations:</u> ▪ MDC/DDP conceptualizes the “direct care” component of the MDC staff as unskilled “aide” positions. ▪ Education and experience requirements for Psychiatric Aides are inadequate for the complexity of the work. ▪ Most new line staff lack a frame of reference for working in an intensive treatment center like MDC and have difficulty fully absorbing much of the information presented in the initial training.
Does MDC regularly and consistently conduct staff performance appraisals, identify and address knowledge and competence deficiencies, and establish annual goals for performance improvement?	No <u>Observations:</u> ▪ Only 55% of MDC staff received performance appraisals in calendar year 2010. ▪ Staff report that performance appraisals are perceived as a punitive process, rather than one of acknowledging strengths and constructively and supportively addressing areas needing improvement. ▪ There appears to be a lack of proactive coaching and mentoring related to the performance appraisal process.
Are MDC supervisors trained and held accountable for appropriately monitoring and overseeing the work of staff at all levels?	No <u>Observations:</u> ▪ The quality and consistency of supervision at MDC is contingent upon the innate skills and initiative of individual supervisors.

	▪ The following basic supervision skills are not consistently displayed at MDC: (1) clearly and consistently articulating performance expectations, (2) providing training, support, and mentoring to enable staff at all levels to perform to expectations, (3) holding staff at all levels accountable for fulfilling performance expectations, (4) continually recognizing staff for good work, and (5) implementing corrective and/or disciplinary action for non-performance, ▪ It does not appear that supervisory staff consistently interact with line staff or clients in the daily milieu where most activities take place. ▪ One Shift Manager reported that she has not seen her supervisor (a Unit Coordinator) in the unit for months. ▪ There is no training for new supervisors.
Do MDC direct care staff demonstrate proactive, assertive, supportive, engagement with clients based on knowledge of working with people with complex multiple developmental, psychiatric, and behavioral disorders and individual treatment plans in every treatment environment?	No <u>Observations:</u> ▪ The quality of staff interactions with clients varies greatly. ▪ Professional clinical oversight appears to be inadequate on all units.

Bottom Line : Staff Competence, Training, and Supervision

Strengths:

- There is a core of dedicated staff who work well with clients on a daily basis.
- There is a foundation of pre-service training curricula.
- The College of Direct Support is a good basic resource.
- In general, staff at MDC are open to new training that is pertinent to their job and that will help them do a job.
- MDC recently hired a new Training and Development Specialist who plans to modify staff training and increase opportunities for staff to receive training in different ways including on-line, video, and webinars.

Challenges:

- Knowledge and competence expectations are either not defined or poorly defined for all staff positions at MDC.
- Staff training is inappropriately rudimentary and not keyed to the mission/purpose of MDC or to attainment of defined Knowledge and competence expectations.
- Expectations and training for supervisors at all levels are inadequate.

Recommendations for Staff Competence, Training, and Supervision

7. Define optimum knowledge and competency expectations specific to working with people with complex multiple developmental, psychiatric, and behavioral disorders for each staff position providing services to clients including supervisors; ensure that knowledge and competency expectations are keyed to the clearly articulated vision/goal --> mission/purpose of MDC.
8. Based on optimum knowledge and competency expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses.
9. Develop and implement a training protocol for new staff that follows a written curriculum based on defined optimum knowledge and competence expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders.
10. Develop a protocol for ensuring that all staff are able to demonstrate defined knowledge and competence specific to working with people with multiple developmental, psychiatric, and behavioral disorders before being assigned to a treatment unit or being assigned to a supervisor position.
11. Reconceptualize the line staff role at MDC as a true "paraprofessional" with a vital, participatory role in providing treatment to clients with complex multiple developmental, psychiatric, and behavioral disorders; transform the Psychiatric Aide position to a well-defined Psychiatric Technician position with enhanced knowledge and competence expectations.

12. Reconceptualize the role of supervision at MDC; look at each level of supervision and ask whether it is necessary or redundant; create a culture in which supervisors are expected to be active teachers and mentors in the milieu; hold supervisors accountable.
13. Develop a comprehensive performance appraisal process for MDC staff at all levels - from line staff to the Superintendent and DDP Director; ensure that performance appraisals are completed consistently and are designed to acknowledge strengths and constructively and supportively address areas needing improvement; hold supervisors at all levels accountable for completing performance appraisals.

Suggestions for Implementation of Recommendations 7 through 13:

- Convene a workgroup to revamp training for new staff.
- Develop a mentoring component within the units in which a veteran staff person who has demonstrated defined knowledge and competence is assigned to each new staff person; give the veteran staff person the responsibility to ensure that the new staff person achieves defined levels of knowledge and competence.
- Define and standardize on-the-job training as a continuation of classroom/online training.
- Establish a periodic knowledge and competence demonstration requirement; provide refresher training to maintain/increase knowledge and competence levels.
- Institute a formal performance improvement project - through 'performance contracts' or some other relational approach to bringing staff into the process - to create increased buy-in and ownership of performance improvement, a collaborative approach to performance expectations and appraisal, and an opportunity for staff at all levels to talk about adjustments in the work environment that would help them perform better. Create explicit written expectations for all MDC staff that are directly related to the healthy functioning of the treatment environment and the purpose of MDC. Ensure that line staff are involved in this process.

Incident Management, Incident Investigation, and Client Protection

Are MDC policies addressing client safety and incident management comprehensive and appropriate?	<u>Strengths:</u> - Following the May sexual assault allegations, the Governing Body initiated a review and revision of policies directly related to client safety and incident management. - The clarity of policies addressing client safety and incident management appears to have improved since the May incident as the older policies were rewritten.
Are staff at MDC trained to understand and properly implement policies addressing client safety and incident management?	No <u>Observations:</u> - Information regarding new policies and changes to current policies are sent via email with a date for staff to review and sign off on. - There is no in-service training provided related to new policies. Staff have the opportunity to ask questions of their immediate supervisors, but it appears that the supervisors are not any more informed than line staff. - Staff report that they are often short-staffed and do not have time to review the policies and ask questions.
Are MDC policies addressing client safety and incident management followed consistently by staff at all levels?	No <u>Strengths:</u> - The insight and persistence of a direct care staff person within hours of the May sexual assault allegation and her rapport with the client are what led directly to the corrective activities that followed. - All staff have access to computers in their work settings to complete the required incident reporting on Therap®. <u>Observations:</u> - There is inadequate training for staff at all levels in the use of Therap®. Some staff have taken it upon themselves to improve their skills in using Therap® and others are waiting for training to be provided. The DDP Director indicated that it would be easy to get the Therap® trainers to MDC, but this has not been done. Until consistent Therap® training is provided, staff will continue to be frustrated. - There is the perception among some staff that policies are only followed "when they're (MDC is) in trouble".
Do MDC policies addressing client safety and incident management address both "reportable incidents" and "critical incidents" by appropriately differentiating between two levels of seriousness? Does MDC/DDP leadership ensure that policies addressing "reportable incidents" and "critical incidents" are implemented with appropriate emphasis on "critical incidents"?	<u>Strengths:</u> MDC devotes a lot of time and attention to "Incident Management"; with the addition of Therap®, there is potential for data analysis, data-driven decision-making, intervention planning and training directed toward increasing the effectiveness of staff interactions with clients, reduction of the number of incidents, and improvement in the outcomes of incidents that do occur.

	<u>Observations:</u> ▪ The Incident Management Committee determines which incidents need further review and/or investigation. ▪ The current policies appear to be overly oriented toward worst-case scenarios. Thus, when following a policy, it can be difficult for staff to use discretion in determining the level of seriousness for reporting. This can create a tendency for all incidents to be considered serious and reported as such. ▪ The differentiation between “reportable incidents” and “critical incidents” appears to have become blurred over time as effort has been made to increase the care taken to acknowledge and review everything that seems to need to be reviewed. ▪ Incidents are routinely reported to a number of agencies, including BOV, County Attorney, DPHHS Quality Assurance Division; routine reports to the County Attorney are considered to be the notification to law enforcement. ▪ It appears that the lengthy time spent processing incident investigations impedes cogent decision-making and impairs an improvement process based on incident investigation findings. ▪ A number of staff interviewed by BOV stated that the quantity of reports required by the current process is “overkill” and takes away from client care, that there are so many incidents that need reporting, that they are “swamped with reporting everything that happens”. ▪ It does not appear that an adequate level of critical thinking is applied to the investigation process or to the administrative review of investigation reports; critical issues and decision points have been missed in a number of Investigation Reports reviewed by BOV.
Does MDC define optimum knowledge and competence expectations for the Client Protection Specialist and the On-Call Investigator positions in these areas? : ➤ conducting investigations of allegations of abuse/neglect/mistreatment of clients ➤ implications of serious, multiple developmental, psychiatric, and behavioral disorders for the process of conducting investigations of allegations of abuse/neglect/mistreatment of clients	No <u>Observations:</u> ▪ Knowledge and competence requirements are defined in the State of Montana Job Profile for the CPS position and are primarily focused on "...knowledge of the concepts and theories of civil and criminal investigation methods; criminal justice jurisdiction, rules of evidence ... civil/criminal procedures; and legal proceedings, case law and regulations pertaining to ICF/MR and ICF/DD facilities." ▪ In the "knowledge, skills, and abilities" section of the CPS Job Profile, there are no descriptions of expectations for knowledge and competence relative to a basic understanding of developmental disabilities or mental illnesses or for working with people who have developmental disabilities and/or mental illnesses. ▪ MDC/DDP does not define conflict of interest with regard to investigations of allegations of abuse/neglect of clients. ▪ The incumbent CPS and On-Call Investigators have career backgrounds in law enforcement. While these backgrounds provide pertinent experience in conducting investigations

	and interviewing in general, there appears to be an excessive emphasis on law enforcement and little emphasis on working with people with multiple, complex developmental and psychiatric disabilities or to soliciting the involvement of clinical staff who can help address root causes of incidents.
Does MDC have a written training curriculum for the Client Protection Specialist and the On-Call Investigator positions?	<u>Observations:</u> BOV was provided with a list of classes the CPS is expected to complete; these classes appear to be the same rudimentary classes that all new MDC staff are required to take during orientation; training specific to the complex duties of the CPS does not appear to exist. <u>Recommendations:</u> see Recommendations 7-10
Does MDC train the Client Protection Specialist and On-Call Investigators in job-specific knowledge and competence prior to working with clients OR require them to demonstrate defined optimum knowledge and competence?	No <u>Observations:</u> - By virtue of having worked at MDC for several years, the incumbent CPS has gained experience working with people with multiple developmental, psychiatric, and behavioral disorders. - The contract On-Call Investigators have other jobs which prevent them from consistently participating in training at MDC and/or other pertinent training.
Did the MDC/DDP internal review adequately review the possibility that there were other potential victims not specifically identified in the initial May sexual assault allegations?	Yes <u>Observations:</u> - MDC/DDP reviewed incident investigations going back to 2003 to determine whether any should be reexamined; five clients were identified in the MDC/DDP review as "high probability" victims. - While the above clients were retrospectively identified as "high probability" victims, it appears that MDC/DDP did not analyze the related Investigation Reports to determine whether there are any lessons to be learned.

Bottom Line : Incident Management and Client Protection

Strengths:

- Policies addressing client safety and incident management have been reviewed by the Governing Body and appear comprehensive and appropriate.

Challenges:

- The process of dissemination of information about new/revised policies is too indirect, and does not have a training component.
- There is an "overload" factor that appears to be caused by inadequate differentiation between incidents that should be handled as treatment and supervision issues and incidents that legitimately should be investigated.
- The incident investigation process does not integrate clinical perspectives with fact-finding.

Recommendations for Incident Management and Client Protection

- Develop a process for annually reviewing and revising policies with a cross-section of MDC staff.
- Develop a process for ensuring that staff can demonstrate working knowledge of new policies and policy changes with specific emphasis on policies addressing client safety/protection and incident reporting and management.
- Provide training in Therap® to all staff that need to use it.
- Reexamine the incident management process and develop an approach that more critically differentiates between incidents that should be handled as treatment and supervision issues and incidents that legitimately should be investigated.

18. In order to give allegations that may constitute criminal offenses the proper emphasis, clarify the policy for reporting incidents to law enforcement; use the language in the mental health code "When the allegation ... may constitute a criminal act, the professional person in charge of the [residential] facility shall immediately report the allegation to the appropriate law enforcement authority."
19. Reexamine the emphasis on a law enforcement focus in the work of the Client Protection Specialist; broaden the perspective in the position description and in policies and procedures to address the implications of serious, multiple developmental, psychiatric, and behavioral disorders in the process of conducting investigations of allegations of abuse/neglect/mistreatment of clients; require clinical professional involvement in all incident investigations.
20. Define conflict of interest and develop contingencies when an investigator has a conflict as defined.
21. Integrate incident management into Quality Management.
22. Require all incident investigation reports to be personally reviewed by the DSD Administrator until there is assurance that the necessary level of critical thinking and decision-making is being applied.

Role of Clinical Professionals

MDC clients typically have primary diagnoses of one or more major psychiatric disorders (Axis I of the DSM-IV²⁰)-in addition to developmental disabilities. It is not unusual for MDC clients to also have diagnosed personality disorders (Axis II of the DSM-IV), medical and/or neurological disorders that may be relevant to primary psychiatric problems (Axis III of the DSM-IV), as well as significant psychosocial and/or environmental stressors (Axis IV of the DSM-IV). This level of clinical complexity requires MDC to reorient its organizational structure and treatment processes so that licensed mental health professionals are in key leadership and service planning and delivery roles. DSD has begun this process by revising the MDC organizational chart accordingly and by creating and recruiting for a "Clinical Director" position.

Is there a clearly-defined and communicated clinical focus of treatment at MDC?

No

Strengths:

- In October 2009, in response to BOV's recommendations, MDC hired a PhD-level psychologist as the ASU Manager; this was a positive step toward expanding the role of clinical professionals at MDC.
- Sections leaders exercise personal initiative in ensuring that their staff provide quality services to individual clients.

Observations:

- A number of the organizational changes related directly to addressing clients' clinical needs that BOV recommended in its 2009 report on ASU have not been implemented; as a result, the new ASU Manager struggled unsuccessfully to implement a functional clinical structure and approach to treatment; the ASU Manager resigned at the end of December 2010.
- The concepts of "professional" and "clinical" appear to have a negative connotation in the residential / treatment units.
- No additional staff have been hired at MDC with the necessary clinical credentials.
- Although the two master's level Psychology Specialists bring a needed level of clinical insight into discussions about client treatment, they are not licensed.
- Supervision and support for the few staff with clinical expertise have been inadequate; coordination of assessment and treatment effort among various professionals has been inconsistent.
- There is no defined protocol for coordination / communication between the contract psychiatrist and the full-time clinical staff.

Is there a well-organized contingent of licensed clinical professionals that is well-integrated into the organizational structure and the practical day-to-day work of MDC?

No

Strengths:

- In addition to registered and licensed practical nursing staff, MDC has several staff who are licensed / certified in their areas of clinical expertise (Occupational Therapist, Recreation Therapist, Speech Pathologist, and Special Education Teacher).
- MDC contracts with one psychiatrist for one day per week, and with a general practice physician for two days per week.

Observations:

- The attitude of MDC/DDP leadership toward a role for clinical professionals in general and mental health professionals in particular has been ambivalent.
- In the past, when MDC did have two licensed mental health professionals, they reported that their role did not appear to be important to MDC/DDP leaders - that their input was not sought and seemed not to be valued.
- The licensed / certified professional staff (excluding nurses) report that their role is marginalized within the organizational culture of MDC by both line staff and leaders.
- The only organizing effort for licensed professionals has been the "Sections Meeting" which appears to have devolved into a meeting that participants can either attend or not without consistency or consequence. This meeting has facilitated constructive communication at times, but flounders because it has not been conceptualized as a central component of an overall treatment culture.
- As of December 31, 2010, MDC did not have any full time licensed mental health professionals on staff.
- None of the MDC nursing staff have experience working in a primary mental health treatment setting or certification such as the Psychiatric & Mental Health Nurse certification available through The American Nurses Credentialing Center²¹.
- The role of the Psychology Specialist position is poorly-defined and poorly-integrated into services structure of MDC.
- The role of the Treatment Program Specialist (TPS) position, while it may have met traditional needs/requirements for client skill training, has not kept pace with the complex treatment needs of the clients served by MDC. The position description for the TPS position does include good language that describes a potentially meaningful role in working with MDC clients²²; however, it does not appear that the expectations of this position are being fully implemented.
- The contract psychiatrist is the only clinician who assesses and diagnoses psychiatric disorders of MDC clients. While the psychiatrist certainly has the expertise to diagnose MDC clients, it may helpful to have additional expertise that would enable a more comprehensive, ongoing differential diagnosis process for these complicated clinical presentations.
- BOV understands that the current plan to hire a Clinical Director to oversee all clinical work and treatment of clients at MDC is necessary due to the need to move assertively to establish clinical expertise within MDC. Given the dysfunction of MDC as

	described throughout this report, BOV reiterates the need to quickly address other organizational components so that the Clinical Director will be fully-supported in implementing necessary change.
Are professional staff consistently present in all treatment areas interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful interactions?	No <u>Strengths:</u> ▪ DSD has recognized the critical importance of creating a clinical presence and structure within MDC, and has advertised for a Clinical Director position (see above). <u>Observations:</u> ▪ There is no requirement for professional staff to be consistently present in all treatment areas interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful interactions. ▪ Historically, MDC staff with clinical responsibilities have been marginalized and have lacked authority. ▪ The attitude toward staff with clinical responsibilities is characterized by mistrust, disrespect, and disregard by rank and file staff - especially if they are "newcomers".
Does MDC/DDP ensure that there is adequate clinical oversight built into the process of investigating critical incidents? Does MDC/DDP ensure that the incident investigation "decision points" that have clinical components are overseen by staff with clinical credentials?	No <u>Observations:</u> ▪ It appears that there is an inadequate level of awareness by MDC/DDP leaders of the need for clinical issues to be integrated into the incident management / investigation process; client protection and clinical issues are considered separate areas of consideration. ▪ There is no protocol for ensuring that clinical oversight is built into the process of investigating critical incidents. ▪ While the CPS reported that, "when necessary", a Psychology Specialist is pulled in to an incident investigation interview; this appears to be an ad hoc and inconsistent process. ▪ In a relatively brief period following the May incidents, DDP contracted with a psychologist to assess and provide clinical support for several client victims, and to assess the need for and offer support to staff. It appears that her expertise and support were not adequately used, and that conflicts developed and remained unresolved between this psychologist and MDC/DDP leaders. ▪ The contract psychologist reported to BOV that she encountered an atmosphere at MDC of fear, a lack of openness to working with her, and a program culture characterized by dysfunctional communication.
Do MDC line staff and supervisors have a working knowledge of clinical issues that are pertinent to their work with MDC clients?	No <u>Observations and Recommendations:</u> ▪ See Staff Competence, Training, and Supervision, p. 15.
Does MDC/DDP ensure that treatment plans and staff training and supervision adequately address client history and clinical/behavioral presentation with regard to sexual	Yes <u>Strengths:</u> ▪ Client histories are well documented in Social Workers'

abuse/assault, sexualization, and sexual reactivity?

reports.

- MDC has a contracted with a Montana Sex Offender Treatment Association therapist for services one day per week.

Observations:

- Psychology Specialists are involved in development of treatment plans, but other staff interviewed by BOV could not articulate clinical/behavioral issues in specific plans; psychology staff roles appear to have little relevance to the treatment provided to clients by non-clinical staff; there is a significant disconnect between direct care staff and psychology staff.
- Treatment plans are deficient in general with regard to addressing psychiatric issues.

Bottom Line : Role of Clinical Professionals

Strengths:

- The Governing Body under the leadership of the DSD Administrator recognizes the critical importance of developing a comprehensive clinical focus and clinical leadership at MDC.
- There is a core of licensed professionals including two Psychology Specialists that represent the building blocks for a clinical infrastructure.

Challenges:

- There is a culture of negativity throughout the MDC organization about professional staff in general and about assertively establishing a central clinical focus for MDC services.
- There is inadequate focus on the clinical components of incident management and investigation.

Recommendations for Role of Clinical Professionals

23. Plan and implement a comprehensive clinical component as part of organizational transformation described in this report.
24. Ensure that all professional staff and staff with clinical mental health credentials have an ongoing, active presence and role in all residential and treatment areas interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful, treatment-based interactions.
25. Following from Recommendation 19, develop specific protocols for ensuring that oversight by clinical professionals is built into the process of managing and investigating critical incidents. Integrate fact-finding and clinical expertise into client protection and abuse/neglect investigations.
26. Ensure that all treatment plans include a clinical assessment of client history and current clinical/behavioral presentation with regard to sexual abuse/assault, sexualization, and sexual reactivity; ensure that all staff are trained to work with clients with these issues and have the opportunity to ask questions and deal with their own feelings and issues in these areas.

Suggestion for Implementation of Recommendation 23:

Consider expanding the contract with the psychiatrist or recruiting a Psychiatric Nurse Practitioner or Advance Practice RN with prescriptive authority.

Leadership and Organizational Culture

Leadership

“A major competency of effective leaders is the skill to see the broad perspective and to transform their long-range view into reality.”²³

“Organizational leaders focus all levels of their organizations on the mission by communicating a clear intent, organizing operational concepts, and applying a systematic approach to execution.

Through words and personal example, leaders communicate purpose, direction, and motivation.

Organizational leaders visualize the larger impact on the organization and mission when making decisions.

Confident and competent organizational leaders do not shy away from asking their close subordinates to give them informal feedback. This includes feedback about their leadership behaviors in critical situations.

Organizational leaders should also invite subordinates to comment on how the leaders could have made things better.”²⁴

Do MDC/DDP leaders guide organizational performance through creation and communication of a compelling vision, mission/purpose, and implementation strategy?	No <u>Strengths:</u> ▪ The newly-formed Governing Body has begun taking an active role in guiding MDC. <u>Observations:</u> ▪ There is genuine confusion throughout MDC about the leadership structure, problem-solving processes, and decision-making. ▪ A number of people BOV interviewed - including professional staff and contract professionals - expressed concern about the absence of direction from MDC/DDP leadership.
Do MDC/DDP leaders ensure that results are achieved by effectively planning work, delegating responsibility, reviewing performance, and improving systems and processes?	No <u>Observations:</u> ▪ There has been inadequate follow-through on the strategic planning activities that took place in 2006 to ensure that they were translated into dynamic, ongoing strategic management. ▪ Quality improvement processes have not been implemented. ▪ Staff perceive that their input into planning and decision-making is requested and then not followed-through with by leaders.
Have MDC/DDP leaders created an environment of collaboration and partnership to ensure effective, integrated working relationships among professional and supervisory staff throughout MDC?	No <u>Observations:</u> ▪ A number of professional and supervisory staff throughout MDC have retreated into pockets of isolation in response to the absence of unity of purpose, collaboration, teamwork, and healthy communication throughout MDC.
Do MDC/DDP leaders create organizational success through creative problem-solving and decision-making?	No <u>Observations:</u> ▪ A significant level of frustration and cynicism has resulted from the difficulty MDC/DDP leadership has had in developing, articulating, and implementing solutions to problems and in ensuring accountability. ▪ Much of the day-to-day decision-making at MDC appears to be ad hoc and reactive; the “crisis of the moment” and a

	sense of chaos appears to drive the decision-making. ▪ Line staff and professionals consistently reported to BOV a lack of trust in MDC/DDP leaders; that staff don't feel they can take their concerns to the people with authority to do something about them, describing a lack of focus, decisiveness, and follow through. ▪ Data do not appear to be used effectively for decision-making.
Organizational Culture <i>“When the activities of a typical day involve spending a great deal of valuable time ‘fighting fires’ and reacting to problems, crisis management can become a habitual replacement to strategic management.”²⁵</i> <i>“Characteristics of a successful organizational climate include a clear, widely known purpose; well-trained and confident employees; disciplined, cohesive teams; and trusted, competent leaders.”²⁶</i> <i>“An organizational culture is an environment in which a group of people have been trained, or who have learned from those around them, how to act in any given situation. ... [One] aspect of organizational culture ... is that it becomes very deeply rooted. It is the identity of an organization, and because of that, it becomes an identity of those who work there, as well. The people end up affecting the culture as much as the culture is affecting them.”²⁷</i> <i>“The bottom line for leaders is that if they do not become conscious of the cultures in which they are embedded, those cultures will manage them.”²⁸</i>	
Are MDC/DDP leaders proactive in nurturing a healthy organizational culture?	No <u>Strengths:</u> ▪ MDC has a foundation of long-term staff who are committed to the work they do, and who care deeply about the clients; these individuals appear ready to step up - if challenged to do so - in an environment of solid leadership, clearly-defined expectations, consistently effective decision-making, and support. ▪ Staff at all levels appear to be primed for change. <u>Observations:</u> ▪ Staff describe the culture at MDC as one of fear and chaos; this was corroborated by the outside psychologist contracted by DDP to support clients and staff following the May incidents. ▪ Staff reported feeling fearful with regard to being open and honest with BOV site review team members when asked about organizational culture and leadership issues. ▪ Staff report that they go to work every day expecting that there will be “a fire to put out” when they get there.
Do MDC/DDP leaders model and facilitate healthy communication as a core value and skill at MDC?	No <u>Observations:</u> ▪ Treatment and Unit teams across MDC do not have regular, consistently structured team meetings. ▪ Several years ago, a contract psychologist facilitated communication sessions between psychology, administration, and line staff for a short period of time. This was reported to BOV as a good process by line staff - but they reported that it was not continued past three or four sessions - and that they wish it would resume.

Do MDC/DDP leaders actively model and demonstrate the desired organizational culture by their reactions to critical incidents and organizational crises?	No <u>Observations:</u> ▪ Direct care staff and middle management report feeling blamed, isolated, angry, and guilty in the wake of MDC/DDP and other agency scrutiny following the sexual assault allegations.
Do MDC/DDP leaders proactively affect the development of a healthy organizational culture through visible acts of role modeling, teaching, and coaching throughout MDC?	No <u>Observations:</u> ▪ MDC leaders do not practice “Managing by walking around”, modeling, teaching, and coaching in the milieu. ▪ The MDC administration reported to BOV that they have issued mandates requiring supervisors to spend time in the units monitoring and mentoring. ▪ A number of staff interviewed by BOV reported feeling “a total disconnect between administrators and direct care staff”.
Do MDC/DDP leaders demonstrate the desired organizational culture through the establishment of criteria for allocation of formal rewards and by continually “catching people doing things right”?	No <u>Observations:</u> ▪ Staff report that they feel unsupported by MDC/DDP leadership - that there is little recognition of good work or constructive feedback and support for improvement when necessary.
Do MDC/DDP leaders demonstrate the desired organizational culture through defined criteria for staff recruitment, selection, promotion, corrective action, and discipline?	No <u>Observations:</u> ▪ Staff report feeling that they cannot admit that they made a mistake without fearing that they will be punished. ▪ Staff report that the policies for abuse and neglect are oriented toward punishment and they cannot provide feedback to coworkers for fear of being turned in themselves for not reporting abuse; on the other hand, staff report that a number of incidents of client mistreatment may be underreported for fear of retaliation by staff peers. ▪ Staff report perceiving that supervisory discipline is not handled consistently or fairly. Some staff reported feeling that “who you are” matters more than “what you did”. ▪ There appears to be a cycle of apathy and supervisory non-accountability that resonates throughout MDC reflected in statements such as: “It’s not my job.” and “We don’t have to (follow basic policies and procedures)”.

Bottom Line : Leadership and Organizational Culture

Strengths:

- The Governing Body has begun taking an active role in addressing the problems at MDC.

Challenges:

- Leadership weaknesses are a root cause for dysfunction at MDC, and exacerbate problematic aspects of the organizational culture.

Recommendations for Leadership and Organizational Culture

27. Establish performance expectations for all MDC staff in leadership positions - including the MDC Superintendent and the DDP Director - that are directly tied to strategic objectives and performance outcomes; develop a process for measuring / quantifying adherence to leadership performance expectations; provide leadership-focused training and coaching to support leaders and to increase leadership success; acknowledge and reward leadership success; consequence non-performance.
28. Use the to-be-developed statement of MDC's purpose as the foundation for decision-making; if the Superintendent or the Management Team is considering doing something that is not consistent with the MDC purpose, it is probably the wrong thing to do. Make every effort to look for alternatives that do not lead down the slippery slope of compromising the purpose of MDC.
29. Start using the data entered into Therap[®] as concrete decision-making and planning tools.
30. Contract with a skilled facilitator with clinical skills to work with staff and MDC/DDP leaders in an atmosphere of safety and support to examine the culture at MDC and to map out the way toward a healthy organizational culture.
31. Ensure that the Superintendent, Client Services Director, professional services staff and supervisors go into all MDC treatment units on a regular basis and "visit" - spend time - talk with and listen to clients and staff - learn the environment - become a part of the milieu - listen to the frustrations - ask for staff ideas - teach.

Suggestion for Implementation of Recommendation 28:

- Implement annual employee satisfaction surveys and "360 degree feedback"²⁹ of leadership personnel in which all employees provide feedback to leaders about their performance.

Suggestion for Implementation of Recommendation 29:

- When a decision that *does* conflict with the purpose of MDC is absolutely unavoidable or is in the best interest of an individual client, process the decision with all team members - including Psychiatric Aides - and do everything possible to mitigate the inconsistencies.

Montana Developmental Center Response

Date: July 5, 2011

TO: Alicia Pichette, Interim Executive Director
Mental Disabilities Board of Visitors

FROM: Gene Haire, Superintendent
Montana Developmental Center

RE: Montana Developmental Center Response to November 2011
BOV Site Review Report Recommendations

Recommendation 1:

Revisit the strategic planning process:

- (a) Clearly articulate the vision as the desired or intended future state of MDC - develop a written vision stating what MDC will look like when it is fulfilling its purpose.
- (b) Develop a cogent, succinct, written statement of the purpose of MDC.

MDC Response:

The MDC Leadership Team is in the process of developing vision and purpose/mission statements as described (with BOV input). We will provide these to BOV when completed.

Target Date for completion:

July 15, 2011

Recommendation 2:

Following a period of organizational stabilization, revisit the provisional organizational chart and address the following questions:

- (a) Are the Client Services Director, Unit Coordinator, and Human Services Specialist positions relevant to the mission and support organizational effectiveness?
- (b) Is a "Long Term Care Rehabilitation" unit congruent with the mission of MDC?
- (c) Are the layers of authority excessive?
- (d) Are the multiple chains-of-command necessary?
- (e) Are professional services placed in the organization in a way that maximizes their effectiveness and access to all clients?
- (f) Does the chart clearly depict who the leader of MDC is?

MDC Response:

The MDC Leadership Team is in the process of redesigning MDC's organizational structure and the depiction of this new structure in an organizational chart. We will provide these to BOV when completed.

Target Date for completion:

July 8, 2011

Recommendation 3:

Rework "action step" statements in the strategic planning document so that "who will do what by when" is clearly defined.

MDC Response:

This recommendation has been rendered moot by plans to develop a new strategic plan.

The new strategic plan will be developed in congruence with the five spheres in the BOV report, and will be rolled out in phases with the highest priority in each sphere initially established as an objective with "who will do what by when" action steps.

Target Date for completion:

The new strategic plan (one objective for each BOV report sphere) will be completed by August 12, 2011.

Recommendation 4:

Rework "measurable outcome" statements in the strategic planning document so that they read like this: *"The number of altercations in Unit Six on the 2pm-10pm shift will be reduced by 20% from the baseline of 10 altercations per shift"*.

MDC Response:

This recommendation has been rendered moot by plans to develop a new strategic plan.

Recommendation 5:

Develop a system for measuring the "measurable outcomes" in the strategic planning document and for adjusting accordingly.

MDC Response:

The new strategic plan will include measurable outcomes and a system for measuring them and for adjusting accordingly.

Recommendation 6:

Develop a Quality Improvement Plan and process that is congruent with the vision and purpose of MDC to evaluate and improve all activities related to provision of services to clients.

MDC Response:

MDC is currently in the process of recruiting a Quality Improvement Specialist. The person hired into this position will be responsible for developing MDC's Quality Management system, which will include a Quality Improvement Plan. This plan will be congruent with the new vision and purpose of MDC and will include evaluation and improvement of all activities related to provision of services to people served.

Prior to developing a Quality Improvement Plan, the new Quality Improvement Specialist will preside over the continuation of the current project to ensure that all MDC policies and procedures are congruent with ICF-MR and ICF-DD regulations. Then the Quality Improvement Specialist will develop a system for continuously monitoring a number of quality indicators reflected in the ICF-MR and ICF-DD regulations and MDC policies. This system will be the Quality Improvement Plan.

Target Date for completion:

Hiring the Quality Improvement Specialist: August 12, 2011.

Development of a Quality Improvement Plan: September 23, 2011

Recommendation 7:

Define optimum knowledge and competency expectations specific to working with people with complex multiple developmental, psychiatric, and behavioral disorders for each staff position providing services to clients including supervisors; ensure that knowledge and competency expectations are keyed to the clearly articulated vision/goal --> mission/purpose of MDC.

MDC Response:

The MDC Leadership Team will develop optimum knowledge and competency expectations specific to working with people with complex multiple developmental, psychiatric, and behavioral disorders for each staff position providing services to clients including supervisors. These expectations will be keyed to the new vision and mission/purpose statements.

The MDC Leadership Team will revise the Pre-Service Training policy and procedure.

Target Date for completion:

Knowledge and competency expectations for Psychiatric Aides, Shift Managers, and Treatment Services Staff: August 29, 2011

Pre-Service Training policy and procedure revision: August 29, 2011

Recommendation 8:

Based on optimum knowledge and competency expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses.

MDC Response:

The MDC Leadership Team will develop training curricula for new staff focused on achieving the newly defined knowledge and competency levels. This training will include basic information about all major mental illnesses.

Target Date for completion:

September 26, 2011

Recommendation 9:

Develop and implement a training protocol for new staff that follows a written curriculum based on defined optimum knowledge and competence expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders.

MDC Response:

The MDC Leadership Team will develop and implement a training protocol for new staff that follows a written curriculum based on defined optimum knowledge and competence expectations specific to working with people with multiple developmental, psychiatric, and behavioral disorders.

Target Date for completion:

October 17, 2011

Recommendation 10:

Develop a protocol for ensuring that all staff are able to demonstrate defined knowledge and competence specific to working with people with multiple developmental, psychiatric, and behavioral disorders before being assigned to a treatment unit or being assigned to a supervisor position.

MDC Response:

The MDC Leadership Team will develop a protocol for ensuring that all staff are able to demonstrate defined knowledge and competence specific to working with people with multiple developmental, psychiatric, and behavioral disorders before being assigned to a treatment unit or being assigned to a supervisor position.

Target Date for completion:

October 31, 2011

Recommendation 11:

Reconceptualize the line staff role at MDC as a true “paraprofessional” with a vital, participatory role in providing treatment to clients with complex multiple developmental, psychiatric, and behavioral disorders; transform the Psychiatric Aide position to a well-defined Psychiatric Technician position with enhanced knowledge and competence expectations.

MDC Response:

MDC leadership has begun and will continue working to reconceptualize the line staff role at MDC as a true “paraprofessional” with a vital, participatory role in providing treatment to clients with complex multiple developmental, psychiatric, and behavioral disorders.

MDC has begun working with Support Development Associates(SDA) on this and other ways to develop the treatment paradigm at MDC. This process will include hands-on training by SDA trainers for line and treatment services staff and generalization of this training into ongoing learning and application within the residential units and in all other treatment areas.

Target Date for completion:

SDA initial training: by August 15, 2011 (tentative - pending training contract completion).

Recommendation 12:

Reconceptualize the role of supervision at MDC; look at each level of supervision and ask whether it is necessary or redundant; create a culture in which supervisors are expected to be active teachers and mentors in the milieu; hold supervisors accountable.

MDC Response:

(See response to Recommendations 1, 2, and 7-10, 13.)

The MDC Leadership Team is in the process of analyzing the role of supervision - in particular Shift Managers and Unit Coordinators, but also the supervisory/teaching role of Treatment Services staff (Licensed clinical staff and Rehabilitation Services staff). The goal is to fully-integrate direct and indirect supervision into the milieu structure and operation.

Target Date for completion:

(See response to Recommendations 1, 2, and 7-10, 13.)

Recommendation 13:

Develop a comprehensive performance appraisal process for MDC staff at all levels - from line staff to the Superintendent and DDP Director; ensure that performance appraisals are completed consistently and are designed to acknowledge strengths and constructively and supportively address areas needing improvement; hold supervisors at all levels accountable for completing performance appraisals.

MDC Response:

The Superintendent, Clinical Director, Residential Services Director, Treatment Services Director, and Human Resources Manager will revise the current performance appraisal process for MDC staff at all levels. This process will ensure that performance appraisals are completed consistently according to established time lines. Performance appraisals will be designed to acknowledge strengths and constructively and supportively address areas needing improvement. Supervisors at all levels will be held accountable for completing performance appraisals.

The DDP Director is no longer in the MDC chain-of-command.

Target Date for completion:

November 7, 2011

Recommendation 14:

Develop a process for annually reviewing and revising policies with a cross-section of MDC staff.

MDC Response:

(See response to Recommendation 6.)

The new Quality Improvement Specialist will be responsible for ensuring that policies and procedures are current and for revising as necessary. This system will be ongoing and will include an annual review at the beginning of each fiscal year.

Target Date for completion:

September 23, 2011

Recommendation 15:

Develop a process for ensuring that staff can demonstrate working knowledge of new policies and policy changes with specific emphasis on policies addressing client safety/protection and incident reporting and management.

MDC Response:

(See response to Recommendation 6.)

The new Quality Improvement Specialist will be develop a system for ensuring that staff can demonstrate working knowledge of new policies and policy changes with specific emphasis on policies addressing client safety/protection and incident reporting and management.

Target Date for completion:

October 17, 2011

Recommendation 16:

Provide training in Therap® to all staff that need to use it.

MDC Response:

MDC participated in two Therap trainings recently, one two-day training in Helena and one two-day, MDC-specific training at MDC. We are in touch with the Therap COO for planning ongoing training - the goal of which is to use Therap to its full potential within six months to one year. We are in the process of establishing a Therap Steering Committee and designating and training MDC staff as Certified Therap Trainers for each applicable organizational unit. The Steering committee will establish the plan for full Therap implementation.

Target Date for completion:

Establishing Therap Steering Committee: July 22, 2011

Having Certified Therap Trainers in place: September 26, 2011

All staff trained: December 2011 - July 2012

Recommendation 17:

Reexamine the incident management process and develop an approach that more critically differentiates between incidents that should be handled as treatment and supervision issues and incidents that legitimately should be investigated.

MDC Response:

The Superintendent has implemented a critical thinking process involving the Clinical Director and Residential and Treatment Services Directors to differentiate between incidents that should be handled as treatment and supervision issues and incidents that legitimately should be investigated.

The Superintendent, Clinical Director, and Client Protection Specialist will develop a new incident management protocol.

Target Date for completion:

Implementation of critical thinking process at the beginning of an “event” report: Established May 30, 2011 and is ongoing.

Development of a new incident management protocol: July 22, 2011.

Recommendation 18:

In order to give allegations that may constitute criminal offenses the proper emphasis, clarify the policy for reporting incidents to law enforcement; use the language in the mental health code “When the allegation ... may constitute a criminal act, the professional person in charge of the [residential] facility shall immediately report the allegation to the appropriate law enforcement authority.”

MDC Response:

This will be included in the development of a new incident management protocol.

Target Date for completion:

Development of a new incident management protocol: July 22, 2011.

Recommendation 19:

Reexamine the emphasis on a law enforcement focus in the work of the Client Protection Specialist; broaden the perspective in the position description and in policies and procedures to address the implications of serious, multiple developmental, psychiatric, and behavioral disorders in the process of conducting investigations of allegations of abuse/neglect/mistreatment of clients; require clinical professional involvement in all incident investigations.

MDC Response:

This will be included in the development of a new incident management protocol.

Target Date for completion:

Development of a new incident management protocol: July 22, 2011.

Revision of the Client Protection Specialist position description: August 26, 2011.

Recommendation 20:

Define conflict of interest and develop contingencies when an investigator has a conflict as defined.

MDC Response:

This will be included in the development of a new incident management protocol.

Target Date for completion:

Development of a new incident management protocol: July 22, 2011.

Recommendation 21:

Integrate incident management into Quality Management.

MDC Response:

This will be included in the development of a new incident management protocol.

Target Date for completion:

Development of a new incident management protocol: July 22, 2011.

Recommendation 22:

Require all incident investigation reports to be personally reviewed by the DSD Administrator until there is assurance that the necessary level of critical thinking and decision-making is being applied.

MDC Response:

This recommendation has been rendered moot by MDC leadership changes.

Recommendation 23:

Plan and implement a comprehensive clinical component as part of organizational transformation described in this report.

MDC Response:

A new Clinical Director started work at MDC on May 23, 2011. Since then, two master's level social workers who will attain licensure as clinical social workers, have started work at MDC. A vacant master's level "Psychology Specialist" position is being re-defined as a Licensed Clinical Social Worker position; recruiting will commence for this position soon. The Clinical Director and Superintendent have established a new "Treatment Services Division" within MDC. This division is divided into a Treatment Services Department and a Residential Services Department. The Treatment Services Team is in the process of developing the treatment paradigm for MDC going forward - which will entail full integration of treatment and residential services. MDC is in the process of finalizing plans to contract for training from Support Development Associates in the areas of clinical assessment, therapeutic team building, and holistic treatment, trauma-informed care, and mental illness and developmental disabilities.

Target Date for completion:

Development of a comprehensive clinical component within MDC: started and ongoing.

Hiring a fourth Licensed/Licensable Clinical Social Worker: August 15, 2011.

Completion of clinical training: October 3, 2011

Recommendation 24:

Ensure that all professional staff and staff with clinical mental health credentials have an ongoing, active presence and role in all residential and treatment areas interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful, treatment-based interactions.

MDC Response:

See response to Recommendation 23.

Recommendation 25:

Following from Recommendation 19, develop specific protocols for ensuring that oversight by clinical professionals is built into the process of managing and investigating critical incidents. Integrate fact-finding and clinical expertise into client protection and abuse/neglect investigations.

MDC Response:

This will be included in the development of a new incident management protocol.

Target Date for completion:

Development of a new incident management protocol: July 22, 2011.

Recommendation 26:

Ensure that all treatment plans include a clinical assessment of client history and current clinical/behavioral presentation with regard to sexual abuse/assault, sexualization, and sexual reactivity; ensure that all staff are trained to work with clients with these issues and have the opportunity to ask questions and deal with their own feelings and issues in these areas.

MDC Response:

The Clinical Director and Treatment Services Team will begin including a clinical assessment of client history and current clinical/behavioral presentation with regard to sexual abuse/assault, sexualization, and sexual reactivity in all treatment plans; and will ensure that all staff are trained to work with clients with these issues and have the opportunity to ask questions and deal with their own feelings and issues in these areas.

Target Date for completion:

Revision of assessments of all current clients to include history and current clinical/behavioral presentation with regard to sexual abuse/assault, sexualization, and sexual reactivity: September 5, 2011.

Assessment of all new admissions for history and current clinical/behavioral presentation with regard to sexual abuse/assault, sexualization, and sexual reactivity: Immediately (June 27, 2011).

Recommendation 27:

Establish performance expectations for all MDC staff in leadership positions - including the MDC Superintendent and the DDP Director - that are directly tied to strategic objectives and performance outcomes; develop a process for measuring / quantifying adherence to leadership performance expectations; provide leadership-focused training and coaching to support leaders and to increase leadership success; acknowledge and reward leadership success; consequence non-performance.

MDC Response:

1) The Superintendent and the Developmental Services Division Administrator will establish performance expectations for the Superintendent that are directly tied to strategic objectives and performance outcomes.

Target Date for completion:

September 5, 2011.

2) The Superintendent, Clinical Director, Residential Services Director, Treatment Services Director, and Human Resources Manager will establish performance expectations for Treatment Services staff that are directly tied to strategic objectives and performance outcomes.

Target Date for completion:

October 3, 2011.

3) (See response to Recommendation 13 for performance appraisal.)

4) The Superintendent, Clinical Director, Residential Services Director, Treatment Services Director, and Human Resources Manager will establish leadership-focused training and coaching to support leaders and to increase leadership success.

Target Date for completion:

November 21, 2011.

Recommendation 28:

Use the to-be-developed statement of MDC's purpose as the foundation for decision-making; if the Superintendent or the Management Team is considering doing something that is not consistent with the MDC purpose, it is probably the wrong thing to do. Make every effort to look for alternatives that do not lead down the slippery slope of compromising the purpose of MDC.

MDC Response:

MDC leadership will use the to-be-developed statement of MDC's purpose as the foundation for decision-making.

Target Date for completion:

Started and ongoing.

Recommendation 29:

Start using the data entered into Therap[®] as concrete decision-making and planning tools.

MDC Response:

See response to Recommendation 16.

Recommendation 30:

Contract with a skilled facilitator with clinical skills to work with staff and MDC/DDP leaders in an atmosphere of safety and support to examine the culture at MDC and to map out the way toward a healthy organizational culture.

MDC Response:

Implementation of the recommendations in the BOV report will - we believe - obviate the need for a facilitated process for shifting the organizational culture toward health. The new leadership is fully aware of the problematic aspects of the MDC organizational culture, and is taking the necessary steps to build a new, transformed organization.

Target Date for completion:

Started and ongoing.

Recommendation 31:

Ensure that the Superintendent, Client Services Director, professional services staff and supervisors go into all MDC treatment units on a regular basis and “visit” - spend time - talk with and listen to clients and staff - learn the environment - become a part of the milieu - listen to the frustrations - ask for staff ideas - teach.

MDC Response:

The Residential Services Director who has worked for 36 years at MDC has always maintained a presence in the residences. The Superintendent, Clinical Director, and Treatment Services Director have begun this practice - prioritizing ASU.

Target Date for completion:

Started and ongoing.

Endnotes

¹ Throughout this report, the terms “purpose” and “mission” are used interchangeably.

² From Montana Developmental Center Critical Incident Investigation Final Report dated 6/8/10.

³ These two allegations were made by the same client and investigated by MDC in 2006 and 2008.

⁴ Phase 1: Investigation based on initial allegation and reported withdrawal of the allegation; Phase 2: Investigation based on the reinstatement of the initial allegation; Phase 3: Investigation of an allegation involving a second client and the same alleged perpetrator.

⁵ **Immediate Jeopardy** - “A situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”. State Operations Manual, Appendix Q - Guidelines for Determining Immediate Jeopardy. Center for Medicare and Medicaid Services. (2004). >> www.cms.gov

⁶ See 2006 report here >> boardofvisitors.mt.gov

⁷ As part of the plan of correction following a 2002 survey by CMS, and with \$2 million appropriated by the 2005 Montana Legislature, DDP created the Assessment and Stabilization Unit opened in December, 2007. It consists of three separate buildings: one four-bed female residential building, two four-bed male residential buildings, and one administrative/treatment building. ASU is separated from the rest of the MDC residential units and is fenced.

⁸ See 2009 ASU report here >> http://boardofvisitors.mt.gov/content/Docs/Site_Review_Report-MDC-ASU_Jan_Feb_2009_FINAL.pdf

⁹ Intermediate Care Facility for the Mentally Retarded (ICFMR); Intermediate Care Facility for the Developmentally Disabled (ICFDD) defined here >> www.dphhs.mt.gov

¹⁰ United States Army. *Field Manual No. 6-2 : Army Leadership*. Washington, D.C. 2006.

¹¹ “Through a vision statement, [an organization] defines its ... image of a desired future.” >> boardsource.org; “Defines the desired or intended future state of an organization.” >> wikipedia.org; “A statement that captures the long-term picture of what the organization wants to become.” >> bestpractices.osi; “The vision should describe what you ultimately envision your ... organization to be. A vision statement is focused five to ten years in the future.” >> montanastateuniversityextension.org

¹² Emergent: occurring unexpectedly and requiring urgent action.

¹³ United States Army. *Field Manual No. 6-2 : Army Leadership*. Washington, D.C. 2006.

¹⁴ <http://www.therapservices.net/>. “Online Documentation and Communication Software System for Providers Supporting People with Developmental Disabilities”

¹⁵ **Quality management** has four components: quality planning, quality control, quality assurance and quality improvement. **Quality Assurance** is the systematic monitoring and evaluation of the various aspects of a service or facility to maximize the probability that minimum standards of quality are being met.

¹⁶ (Continuous) **Quality Improvement** is the systematic creation of an environment in which management and workers strive to create constantly improving quality around defined parameters by (1) identifying target needs/issues/problems for improvement, (2) defining the current situation, (3) analyzing and identifying the root causes of the problem, (4) defining the desired outcome, (5) developing interventions to correct the root causes of the problem and to achieve the desired outcome, (6) observing the results of the interventions - confirming whether the desired outcomes have or have not been achieved, (7) adjusting as necessary.

¹⁷ United States Army. *Field Manual*

¹⁸ Position descriptions collectively describe seven different iterations of MDC’s mission/purpose.

¹⁹ College of Direct Support >> <http://info.collegeofdirectsupport.com/>

²⁰ Diagnostic and Statistical Manual of Mental Disorders wikipedia.org

²¹ <http://www.nursecredentialing.org/NurseSpecialties/PsychiatricMentalHealth.aspx>

²² The MDC position description for Treatment and Programming Specialist (TPS) included the following duties: “Develops behavioral interventions derived from an understanding of the multiple biomedical, neurological, psychiatric and psycho-social conditions that contribute to challenging behavior and that are designed to assist the client in accomplishing their personal goals in a self-enhancing manner”; “Designs interventions to address adaptive skills related to emotional, cognitive and behavioral domains that can be used by the individual to cope with specific problematic situations”; and “Designs crisis prevention protocols...”.

²³ Kirk, Sandra. State of Texas. *STRATEGIC PLANNING: Managing Strategically*. Austin: Texas Workforce Commission, 2005. Online. <http://www.twc.state.tx.us>

²⁴ United States Army. *Field Manual No. 6-2*

²⁵ Kirk

²⁶ United States Army. *Field Manual No. 6-2*

²⁷ “organizationalculture101.com.” *Definition of Organizational Culture*. 2007. Web. 8 Jan 2011.

<<http://www.organizationalculture101.com/definition-of-organizational-culture.html>>.

²⁸ Schein, Edgar. *Organizational Culture and Leadership*. Fort Worth: Harcourt College Publishers, 2001. 375.

²⁹ http://en.wikipedia.org/wiki/360-degree_feedback