

**Colorado Mental Health Institute
at Pueblo
Department of Human Services**

**Performance Audit
November 2009**



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This report contains the results of a performance audit of the Colorado Mental Health Institute at Pueblo. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Human Services and the Colorado Mental Health Institute at Pueblo.

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Glossary of Terms and Abbreviations

Civil Patients - Individuals who have been committed either voluntarily or involuntarily to the Colorado Mental Health Institute at Pueblo or Fort Logan by a court, medical professional, peace officer, social worker, or community mental health center.

CMS - Centers for Medicare and Medicaid Services. The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Department - Department of Human Services. A principal department in Colorado state government that oversees the State's public mental health system, services for people with developmental disabilities, juvenile corrections system, and public assistance programs administered by county departments of human services.

Division - Mental Health Institute Division, Department of Human Services. The Division responsible for administering and overseeing the State's two Mental Health Institutes at Pueblo and Fort Logan.

DPA - Department of Personnel & Administration. A principal department in Colorado state government that oversees the state personnel system, including the State's risk management program.

FCBS - Forensic Community-Based Services. An outpatient program at the Colorado Mental Health Institute at Pueblo that is responsible for facilitating the transition of forensic patients from the Institute campus into the community.

FLSA - Fair Labor Standards Act. Federal law that establishes wage and overtime requirements for covered employees.

Forensic Patients - Individuals who have been accused or convicted of a crime and committed to the Institute by the courts or the Department of Corrections for evaluation and treatment.

FTE - Full-Time Equivalent. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time.

HIPAA - Health Insurance Portability and Accountability Act. Federal law protecting personal health information held by covered entities and patient rights with respect to that information.

Institute - Colorado Mental Health Institute at Pueblo. One of the State's two public psychiatric hospitals that provides inpatient hospitalization for adolescents, adults, and geriatric adults diagnosed with the most serious mental illnesses or emotional disorders.

IOJ Form - Injured-on-the-Job form. The form Department employees are required to file for a workers' compensation claim.

Joint Commission - The Joint Commission on the Accreditation of Healthcare Organizations. An independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.

Nonexempt Employees - Employees subject to federal and state minimum wage and overtime requirements under the federal Fair Labor Standards Act.

PDQ - Position Description Questionnaire. A position summary required under state personnel rules that provides an overall definition of the main functions and responsibilities of a state employee position.

Pinnacol - Pinnacol Assurance. The State's third-party workers' compensation claim administrator, responsible for processing and admitting (approving) or denying all claims filed by state employees.

P.O.S.T. - Peace Officer Standards and Training. A training and certification program for law enforcement officers that requires officers to complete a basic training academy, pass a background check, possess First Aid and CPR certifications, and pass an exam.

University - University of Colorado at Denver Health Sciences Center. The campus within the University of Colorado system that provides physician and other health care professional services to the Colorado Mental Health Institutes at Pueblo and Fort Logan through an interagency agreement.



**Colorado Mental Health Institute at Pueblo
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Purpose and Scope

The purpose of this audit was to review the operations of the Colorado Mental Health Institute at Pueblo and the oversight provided by the Department of Human Services. The audit focused on Institute procedures and controls for ensuring patient, staff, and community safety as well as its systems for managing staff resources. The audit was conducted in response to requests from members of the General Assembly, the Pueblo County District Attorney, and Institute staff.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We acknowledge the assistance and cooperation extended by management and staff at the Department of Human Services, the Mental Health Institute Division, and the Colorado Mental Health Institute at Pueblo.

Overview

The General Assembly established the Colorado Mental Health Institute at Pueblo (Institute) in 1879 to provide inpatient hospitalization for individuals diagnosed with the most serious mental illnesses such that they could not function or be treated in their local community [Section 27-13-101, C.R.S.]. The Pueblo Institute, the larger of the State's two public mental health institutes, is overseen by the Mental Health Institute Division within the Department of Human Services (Department). The Institute is responsible for treating adolescents, adults, and geriatric adults based on referral from a court, community mental health center, other state agency, or professional such as a medical professional. In Fiscal Year 2009 Institute expenditures totaled about \$86 million, of which about \$72.6 million (84 percent) was covered by the State's General Fund.

The Institute provides services 24 hours per day, seven days per week on an extensive 300-acre campus in Pueblo, Colorado. A Superintendent oversees the day-to-day operations of the Institute and over 1,000 staff and contracted medical professionals. In Fiscal Year 2009 the Institute treated or evaluated more than 3,100 inpatients and outpatients. Institute patients fall into two categories: (1) civil patients committed to the Institute either voluntarily or involuntarily because they have been found "gravely disabled" as defined by statute [Section 27-10-102(5)(a), C.R.S.] or pose a danger to themselves or others as a result of mental illness, and (2) forensic patients committed to the Institute

for evaluation and treatment because they have been accused or convicted of a crime. The Institute is the only state facility in Colorado that treats forensic patients and conducts court-related evaluations (e.g., not guilty by reason of insanity, incompetent to proceed in trial, convicted sex offender evaluations, pre-sentence examinations) of individuals to assess their mental condition.

The Institute offers patients a variety of treatment programs, the primary goal of which is to help patients gain the skills needed to transition from the Institute to the community in a residential facility or a home-based community treatment program. According to statute [Section 27-10-101, C.R.S.], the Institute is to treat and rehabilitate patients in the least restrictive setting possible. As patients respond to treatment, the Institute grants them privileges with increased degrees of independence until they are released from Institute custody to live in the community.

Key Findings

Managing Safety Risks

We reviewed the Institute's practices for managing safety risks and found that the Institute lacks controls to adequately protect the safety of patients, staff, and members of the community while ensuring the quality of care received by patients. We found:

Monitoring forensic patient care. Institute quality assurance documentation for a sample of three forensic patients showed the patients had not received appropriate treatment or monitoring from the Institute and a community mental health center prior to escaping from supervision. Two of the three patients' medications were not adequately monitored indicating that they may have been either unmedicated or undermedicated in the months immediately prior to their escapes. Two of the patients did not have an adequate treatment plan.

Patient escapes and elopements. The Institute does not have sufficient procedures for the timely detection of missing forensic patients in the community and notification of the proper authorities. For example, for the three forensic patients in our sample who had escaped during Fiscal Year 2009 the Institute did not notify the media of the escapes until about 5, 10, and 22 hours after the Institute had placed the patients on escape status. In addition, the Institute only notifies one school if a potentially dangerous patient escapes; it does not notify the six other elementary schools located within two miles of the Institute.

Patient complaints. The Institute does not sufficiently track and resolve patient complaints. For 189 of the approximately 1,100 (17 percent) patient complaints received by the Institute during Fiscal Years 2008 and 2009 there was no evidence that the Institute had fully investigated and resolved the complaints. In addition, for almost 270 (25 percent) patient complaints relating to improper staff and treatment issues, the complaint database did not record adequate details of the complaints to identify trends or recurring problems with patient care.

Workers' compensation claims. The Department and Institute do not have sufficient mechanisms in place to reduce workers' compensation claims or control costs related to employee injuries. In Fiscal Years 2006 through 2009 Institute employees filed 721 claims resulting in about \$8.7 million in total costs to the State. For 9 of the 26 (35 percent) claims we reviewed there was no evidence that the Institute investigated and substantiated the employees' injuries as required by the State. Additionally, the Institute does not sufficiently screen current and prospective employees to ensure that they are physically capable of performing their job functions and are thus, less likely to suffer injury in the workplace.

Resource Management

We reviewed the Institute's personnel management practices and found that the following improvements are needed to ensure accountability and efficient and effective use of staffing resources:

Law enforcement. The Institute does not use its Peace Officer Standards and Training certified officers effectively. Instead officers are used to perform administrative functions, such as issuing identification badges and maintaining office supplies and to investigate minor, noncriminal incidents that occur on the Institute campus. Reassigning police officers' administrative functions to administrative staff and ending the practice of requiring officers to investigate minor incidents would save the State about \$67,800 per fiscal year.

Outside employment. The Institute does not adequately monitor employees' outside employment and activities to ensure that the employment and activities do not create a conflict of interest or interfere with the employees' ability to perform their state duties. About 32 percent of Institute employees had employment outside of the Institute during Fiscal Year 2009. Of the 12 employees we sampled, 10 did not appropriately notify the Institute of their outside employment as required by state personnel rules and Department policy. Most of these employees' job duties at the Institute involve working directly with Institute patients. Extensive hours worked in outside employment could impact the quality of care provided to patients.

Contract management. The Department lacks fundamental contract management controls for overseeing its contract with the University of Colorado at Denver Health Sciences Center to provide physician and other health care professional services to the Institute. Specifically: (1) the contract does not clearly define the services to be provided by the contract physicians; (2) the contract does not include sufficient performance measures with which to assess the quality of the services provided by the contract physicians; (3) the contract is monitored by a contract physician; and (4) the Department has not taken an active role in monitoring the performance of the contract physicians.

Our recommendations and the responses from the Department of Human Services and Colorado Mental Health Institute at Pueblo can be found in the Recommendation Locator and in the body of this report.

RECOMMENDATION LOCATOR

Agencies Addressed: Department of Human Services and Colorado Mental Health Institute at Pueblo

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	24	Ensure forensic patients in the community receive appropriate care and monitoring by (a) clearly delineating the roles and responsibilities of the Forensic Community-Based Services program and the community mental health centers in policies and contracts, (b) providing training to Institute and community mental health center staff on health care standards and their roles and responsibilities for monitoring and caring for forensic patients, (c) improving oversight of community mental health centers to ensure that they provide adequate treatment and comply with their contracts, (d) taking appropriate enforcement actions against community mental health centers for contract noncompliance, and (e) implementing a quality assurance process to review forensic patient escapes.	Agree	July 2010
2	32	Strengthen policies and procedures for protecting patients and the public when patients are missing by (a) developing policies and procedures to address the steps Institute and community mental health center staff should take to determine a patient's escape or elopement status and to notify local law enforcement, the media, and area schools, and (b) obtaining an Attorney General's Office opinion on the extent to which federal law allows the Institute to notify outside authorities and provide current threat assessments when forensic and civil patients escape or elope.	Agree	a. July 2010 b. April 2010
3	36	Strengthen the patient complaint system by (a) implementing policies and procedures to ensure that all complaints are investigated and resolved and actions are documented in the database, (b) ensuring that information in the database and the topical categories used to capture data provide sufficient information to facilitate meaningful analysis, and (c) analyzing the information in the complaint database to identify patterns and trends that may affect Institute operations or patient care and taking action as appropriate.	Agree	July 2010

RECOMMENDATION LOCATOR

Agencies Addressed: Department of Human Services and Colorado Mental Health Institute at Pueblo

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
4	41	Strengthen workers' compensation claim policies and procedures by (a) reassessing and revising policies related to investigating and documenting claims to ensure that the claims are valid and should be paid by the State, (b) ensuring that supervisors appropriately investigate all claims and provide all pertinent investigation information to Department human resources staff, and (c) ensuring that Department human resources staff review claims for adequate documentation and complete information before providing the claims to Pinnacol Assurance.	Agree	October 2010
5	44	Consider implementing an injury-reduction program to help reduce the number of workers' compensation claims by Institute employees and the associated costs to the State.	Agree	December 2010
6	49	Ensure the efficient use of law enforcement resources at the Institute by (a) reevaluating the Institute's law enforcement needs and determining the most cost-effective way to meet those needs, (b) reclassifying or eliminating any unnecessary law enforcement positions and ensuring that P.O.S.T.-certified positions are used for law enforcement rather than administrative functions, and (c) clarifying the purpose and jurisdiction of the Institute's police force in statute or Department rule.	Agree	a. October 2010 b. October 2010 c. July 2011
7	53	Ensure that Institute employees appropriately request approval for outside employment and activities by (a) developing a process for routinely notifying employees of their responsibility to submit an outside employment and conflict-of-interest disclosure statement, and (b) developing guidelines for supervisors to use when reviewing outside employment requests to aid in determining whether to approve or deny the request.	Agree	May 2010
8	57	Ensure accountability for physician and other professional medical services provided through the Department's contract with the University of Colorado at Denver Health Sciences Center by (a) clearly defining in the contract the roles, responsibilities, and authority of all individuals included in the contract, performance measures and expectations for contractors, and the services to be provided by the University in exchange for the administrative fee, and (b) actively monitoring the services provided under the contract.	Agree	July 2010

RECOMMENDATION LOCATOR

Agencies Addressed: Department of Human Services and Colorado Mental Health Institute at Pueblo

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
9	62	Improve nonexempt employees' compliance with timekeeping and leave requirements by (a) reviewing and clarifying policies and procedures for monitoring and approving overtime, leave, and time-clock practices, (b) communicating clear policies and providing training to all staff on their responsibilities, and (c) determining how to best allocate read-only timekeeping system licenses to Institute supervisors to enable them to perform timely monitoring of employees' time and leave.	Agree	August 2010
10	65	Evaluate the costs and benefits of implementing an automated staff scheduling system for the Institute and for other 24-hour facilities under the Department's oversight. Implement implementation plans as appropriate.	Agree	September 2010

Overview of the Colorado Mental Health Institute at Pueblo

Chapter 1

The Colorado Mental Health Institute at Pueblo (Institute), one of the State's oldest facilities, was established by the General Assembly in 1879 to treat those individuals diagnosed with the most serious mental illnesses such that they cannot function or be treated in their local community [Section 27-13-101, C.R.S.]. Over the years the Institute has played a critical role in the State's public mental health system. In 1981 the Colorado General Assembly addressed the importance of having a comprehensive public mental health system in Colorado that prioritizes funding and targets services for "the seriously, critically, or chronically mentally ill." Since that time, Colorado's public mental health system has used State-appropriated funds to deliver coordinated statewide services to persons of all ages considered to be "most in need" of mental health treatment. In Fiscal Year 2007 (the most recent data available) Colorado's public mental health system served more than 92,000 individuals diagnosed with serious or persistent mental illnesses or emotional disorders. The system is composed of a number of interlinked agencies and organizations that work in conjunction with the Institute and one another to ensure that the State's mentally ill individuals receive the appropriate treatment. These agencies and organizations are discussed below.

The Division of Behavioral Health within the Department of Human Services provides statutory oversight of the State's public mental health system, as well as administrative and programmatic oversight of the entire community mental health system. The Division of Behavioral Health is the State's mental health authority ensuring compliance with state rules, regulations, and standards for mental health involuntary treatment. The Division of Behavioral Health contracts with community mental health centers and psychiatric specialty clinics throughout the state to provide treatment to persons diagnosed with mental illness. Each of these organizations is discussed further later in this section. The Division also designates residential facilities to provide mental health services at more than 50 locations statewide, including all community mental health centers and both mental health institutes (see below), and it monitors all public and private psychiatric residential treatment facilities that provide mental health services to children.

The Mental Health Institute Division (Division) administers and oversees the State's two mental health institutes in Pueblo and at Fort Logan. The Division directly manages services, operations, finance and budgeting, information

management, quality management, contract management, and regulatory compliance at both institutes.

The Colorado Mental Health Institutes are located in Pueblo and at Fort Logan in Denver. The State's two public mental health institutes function as part of the integrated public mental health system by providing inpatient hospitalization for adolescents, adults, and geriatric adults diagnosed with the most serious mental illnesses or emotional disorders. As mentioned above, the institutes are overseen by the Mental Health Institute Division. The Pueblo Institute is the larger of the two institutes and treats patients on referral from the courts, community mental health centers, specialty clinics, and several other entities.

The Department of Health Care Policy and Financing is responsible for overseeing mental health services for Medicaid-eligible individuals through the Medicaid Mental Health Capitation Program by contracting with the five behavioral health organizations throughout the state. The behavioral health organizations are private non-profit organizations that operate managed care programs in Colorado's 64 counties by coordinating the delivery of mental health services to Medicaid-eligible individuals in an assigned geographic service area. The behavioral health organizations refer patients diagnosed with serious mental illnesses to the mental health institutes and pay for the institutes' costs of treating Medicaid-eligible patients who are under age 21 or over age 64 from the behavioral health organizations' respective geographic regions.

Community Mental Health Centers and Psychiatric Specialty Clinics contract with the Division of Behavioral Health to provide community mental health services throughout the state. Seventeen community mental health centers provide an array of services for the residents of assigned geographic service areas. Six psychiatric specialty clinics serve defined special populations (e.g., members of a specified minority group) and may provide a narrower range of services than the centers. The 23 community mental health centers and specialty clinics refer patients diagnosed with serious mental illnesses to the mental health institutes. The Division of Behavioral Health also contracts with the community mental health centers to provide outpatient treatment and rehabilitation services to patients released from the mental health institutes.

The Judicial and Correctional Systems make referrals to the Pueblo Institute to perform court-ordered sanity and competency evaluations and restorations, convicted sex offender evaluations, pre-sentencing examinations, and re-examinations of patients' continued eligibility for community placement or conditional release. The Department of Corrections refers convicted criminals to the Pueblo Institute for mental health evaluation and treatment.

The Department of Human Services, Division of Youth Corrections makes referrals to the Pueblo Institute for evaluation, stabilization, and treatment of

youth ages 12 to 21 who have serious mental health problems during their commitment to Youth Corrections.

This audit focused on the services provided by the Colorado Mental Health Institute at Pueblo.

Mental Health Institute at Pueblo

As discussed above, the Institute treats the individuals in the state diagnosed with the most serious mental illnesses. The Institute's mission is to work in partnership with patients, families, and their communities to provide quality services that assist patients in achieving their mental health and health care goals within a safe, stimulating, and professionally fulfilling environment.

Regulatory Oversight

In addition to the Department of Human Services, several other organizations share regulatory oversight of the Institute. These organizations include:

The federal Centers for Medicare and Medicaid Services (CMS) administers Medicare, Medicaid, and the State Children's Health Insurance Program, referred to in Colorado as the Children's Basic Health Plan. CMS requires the Institute to be certified and to comply with federal minimum health and safety standards for hospitals and psychiatric hospitals as a condition of receiving Medicare and Medicaid funding for qualifying patients. CMS has given the Joint Commission on Accreditation of Healthcare Organizations the authority to certify whether or not hospitals meet certain Medicare and Medicaid program requirements. CMS also contracts with the Colorado Department of Public Health and Environment to conduct quality assurance hospital surveys and inspections, as discussed below.

The Colorado Department of Health Care Policy and Financing, as discussed previously, is responsible for overseeing and paying the costs of the mental health services provided by the Institute to Medicaid-eligible patients, including those who are under age 21 or over age 64.

The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) is an independent, not-for-profit organization that sets health care quality and accreditation standards for hospitals in the United States. The accreditation standards focus on the health and safety of patients and health care staff. The Joint Commission conducts on-site surveys at least once every three years; its most recent review of the Institute was in July 2009.

The Colorado Department of Public Health and Environment ensures compliance with state and CMS safety standards by performing announced and unannounced inspections of the Institute (most recently in October 2009) and investigating incidents (e.g., patient assaults, deaths, and escapes) and patient complaints.

The Colorado Department of Regulatory Agencies licenses the Institute's health care professionals (e.g., nurses, psychotherapists, psychologists, professional counselors, dentists, and social workers) and conducts inspections and investigates complaints related to dental clinics and pharmacies in Colorado, including those located at the Institute.

Institute Operations

The Institute is a comprehensive residential facility located on a 300-acre campus in Pueblo. The Institute campus includes 450 patient beds on 20 treatment units, a pharmacy, police department, cafeteria and nutrition services, ambulatory care, dental clinic, optometrist, clinical laboratory, radiology center, respiratory therapy clinic, computer labs, legal center, libraries, chapel, recreational center, clothing bank, museum, and custodial and landscaping services. Until August 2009 the Institute campus also had a 20-bed general hospital that served Institute patients and Department of Corrections inmates located on the campus. The Institute closed the general hospital, effective August 1, 2009, because of decreased usage and budget cuts.

A Superintendent oversees Institute operations, including 871 full-time equivalent (FTE) staff (about 1,000 individual staff) and 47 contract physicians as of June 30, 2009. Approximately 650 of the Institute's employees are health care professionals who provide direct care and treatment to patients. These professionals include nurses, psychiatrists, forensic psychologists, and treatment aides. The Institute's remaining employees include management personnel, administrative support personnel, and ancillary staff such as police officers, security guards, pharmacists, dietary aides, food service workers, custodians, and groundskeepers.

In Fiscal Year 2009 the Institute treated or evaluated more than 3,100 inpatients and outpatients, and the average length of stay at the Institute for all discharged inpatients was 119 days. The Institute houses on its campus adolescent, adult, and geriatric inpatients, currently ranging in age from 15 to 89 years. These patients fall into one of two categories, as described below:

- **Civil patients** are adolescent, adult, or geriatric individuals who have been committed either voluntarily or involuntarily by a court, medical professional, peace officer, social worker, or a community mental health

center. To be committed, individuals must be “gravely disabled” as defined by statute [Section 27-10-102(5)(a), C.R.S.] or pose a danger to themselves or others as a result of mental illness. During Fiscal Year 2009 the Institute treated, in total, about 900 civil inpatients.

- **Forensic patients** are individuals who have been accused or convicted of a crime and committed to the Institute for evaluation and treatment. The Institute is the only state facility in Colorado that treats forensic patients. During Fiscal Year 2009 the Institute treated a total of about 1,200 forensic inpatients. These patients included: (1) individuals who had been found by a court of law to be not guilty by reason of insanity or incompetent to stand trial for alleged crimes due to mental illness; (2) inmates from the Department of Corrections or the Division of Youth Corrections who were transferred to the Institute to undergo psychiatric evaluation and treatment; and (3) individuals undergoing court-ordered mental health evaluations. The Institute conducts all of the State’s criminal court-related evaluations of individuals to assess their mental condition (e.g., not guilty by reason of insanity, incompetent to proceed in trial, convicted sex offender evaluations, pre-sentence examinations). During Fiscal Year 2009 the Institute conducted about 850 court-ordered evaluations.

The following table shows the patient census, or average daily attendance, at the Institute for the last five fiscal years broken down by the type of patient.

Patient Census (Average Daily Attendance)					
Fiscal Years 2005 Through 2009					
	2005	2006	2007	2008	2009
Civil Patients	125.7	127.2	126.2	128.7	127.6
Forensic Patients	242.7	241.5	243.0	265.5	267.2
General Hospital¹	8.6	7.7	9.2	10.1	7.1
TOTAL	377.0	376.4	378.4	404.3	401.9
Source: Department of Human Services, Mental Health Institute Division.					
¹ The Institute’s General Hospital served civil and forensic patients and closed in August 2009.					

In addition to serving nearly 2,100 inpatients, during Fiscal Year 2009 the Institute provided outpatient medical services to about 880 Department of Corrections inmates and monitored about 170 forensic outpatients who were residing in the community. Forensic outpatients are patients for whom the courts have issued orders authorizing release to the patients’ homes or residential facilities in the community. Outpatients remain in the custody of the Institute and continue court-ordered treatment at the Institute or in a community mental health

center until granted a conditional or full court-ordered release from their commitment.

Treatment and Rehabilitation Programs

Inpatients typically remain at the Institute 24 hours per day, seven days per week. As mentioned previously, to receive federal funding for qualifying patients, the Institute must comply with federal Centers for Medicare and Medicaid Services regulations. These regulations require that Institute inpatients be engaged in treatment at least eight hours per day, seven days a week. Institute health care professionals work to help both civil and forensic inpatients achieve their individual treatment goals through a variety of inpatient programs and services, depending on the patients' needs. These treatment programs and services include:

- **Individual and Group Therapy.** This program includes one-on-one treatment and therapeutic contact with multiple patients for up to two hours per day. Individual and group therapy includes psychotherapy, cognitive therapy, substance abuse treatment, sex offender treatment, anger management, survivors group therapy, emergency psychiatric treatment, physical and respiratory therapy, recreational therapy, pet therapy, speech therapy, music therapy, and cultural and spiritual activities.
- **Family Therapy.** This program is a therapeutic contact with the patient and one or more family members. Patients' families work with the Institute to prepare patients to return to their homes and communities.
- **Vocational Services.** This service helps patients choose, obtain, and retain paid employment and can include job development, shadowing, coaching, on-the-job training, transitional employment on the Institute campus, and supported employment within the community. The Institute provides occupational therapy, academic and vocational education, and work programs (e.g., landscape maintenance or food service) to help patients develop skills that will enable them to gain employment once they are released from the Institute.
- **Psychological Testing.** This program assesses patients' cognitive, emotional, and psychosocial functioning taking into consideration historical information, strengths, cultural factors, and family issues.
- **Case Management.** This service is intended to ensure that patients receive the services they need, that service delivery is coordinated, and that services are appropriate to the changing needs and stated desires of patients over time. Goals and objectives are developed collaboratively

between case managers and patients. Case management activities occur both at the Institute and in the community and are delivered in the patient's environment.

Community Transition Programs

The primary goal of inpatient treatment is to help patients gain the skills needed to transition from the Institute to the community in a residential facility or a home-based community treatment program. According to Colorado statute [Section 27-10-101, C.R.S.], the Institute is to treat and rehabilitate patients in the least restrictive setting possible. In a settlement agreement to a 2002 lawsuit (*Neiberger v. Schoenmakers*), the Institute agreed to make several changes to its forensic patient treatment program including establishing a program to reduce the number of forensic patients at the Institute and transition them from the institutional setting to community care.

To comply with the settlement agreement and the statutory mandate to treat all patients in the least restrictive setting, the Institute has developed an ongoing assessment process to evaluate the progress of both civil and forensic patients and move them from secured and controlled hospital units to less restrictive settings when they demonstrate mental stability, successfully respond to treatment, and are unlikely to pose a safety risk. The Institute's ongoing assessment process differs for civil and forensic patients. The process for civil patients begins with a clinical risk assessment of the patient to determine where the patient should be housed within the Institute. The assessment considers how the patient is responding to medication and treatment and gauges the patient's risk for violence based on the patient's current diagnosis, psychopathology (e.g., active psychosis, mood instability, impulsivity, or personality disorder), past history of aggressive and antisocial behavior or substance abuse, and likelihood to engage in aggressive behavior in various settings. Overall, as patients' mental status improves and they respond to treatment, the Institute grants them privileges with increased degrees of independence. The final step in the process is to release the patient from Institute custody so that they may then live freely in the community.

The Institute's assessment process for forensic patients is more rigorous than for civil patients because many of the forensic patients have violent criminal histories and can thus pose greater safety risks. Forensic patients who are deemed to pose an imminent risk to themselves or others are placed in maximum security units. To progress to less secure units, forensic patients must undergo several levels of review within the Institute and show progressive response to treatment and a decreased propensity toward violence. Institute clinicians notify the courts once they have made a clinical determination that a forensic patient no longer requires inpatient hospitalization. Upon court approval, the Institute may then transition the patient into the community based on conditions outlined in a court order.

Forensic Community-Based Services Program

The Institute has a Forensic Community-Based Services (FCBS) outpatient program for forensic patients found not guilty by reason of insanity. The FCBS staff facilitate the transition of forensic patients from the Institute campus into the community using three approaches, each of which must be approved by a court: (1) temporary community privileges, such as home passes, where patients remain in the Institute's legal custody; (2) community placement, where forensic patients remain in the Institute's legal custody and both the Institute and community mental health centers continue to treat patients while they live in the community; and (3) conditional release, where patients are no longer in the legal custody of the Institute but continue to be supervised and monitored by the Institute and may receive community-based treatment provided by community mental health centers. The goal of community treatment is to help patients improve to the point where the court may grant their release from Institute custody. At the end of Fiscal Year 2009, of the Institute's approximately 600 forensic patients (inpatients and outpatients), 74 had temporary community privileges and 154 were living in the community in community placement or on conditional release.

Revenue and Expenditures

The Institute receives the majority (84 percent) of its funding from the State's General Fund; the General Fund pays for all Institute expenditures not covered by other revenue sources. In Fiscal Year 2009 Institute expenditures totaled about \$86 million, of which about \$72.6 million (84 percent) was covered by the General Fund. The Institute's non-General Fund revenue was about \$13.4 million, including payments from patients (e.g., cash from disability benefits), Medicare, Medicaid, private-party insurance companies, county departments of human services, school districts for educational services provided to adolescent patients, and other state departments that refer patients to the Institute for care (e.g., the Department of Corrections and the state Judicial Department). The following table shows the Institute's revenue and expenditures for the last five fiscal years.

Revenue and Expenditures						
Fiscal Years 2005 Through 2009						
(In Millions of Dollars)						
	2005	2006	2007	2008	2009	Percent Change 2005 to 2009
Expenditures						
Salaries and Benefits	\$49.2	\$49.7	\$55.0	\$60.1	\$64.1	30%
Personal and Other Services	8.9	9.5	10.1	10.5	10.9	22%
Pharmaceuticals	3.2	2.8	3.3	3.8	3.6	13%
Administration	8.4	7.3	7.4	7.1	7.4	-12%
Total Expenditures	\$69.7	\$69.3	\$75.8	\$81.5	\$86.0	23%
Revenue						
General Fund	\$53.1	\$52.8	\$57.2	\$65.2	\$72.6	37%
Non-General Fund	16.6	16.5	18.6	16.3	13.4	-19%
Total Revenue	\$69.7	\$69.3	\$75.8	\$81.5	\$86.0	23%
Source: Colorado Financial Reporting System.						

Audit Scope and Methodology

This report includes the results of our performance audit of the Colorado Mental Health Institute at Pueblo, which focused on patient and staff safety within the Institute as well as related safety issues in the community. We conducted this performance audit in response to legislative, Pueblo County District Attorney, and Institute staff requests. The audit assessed the Institute's procedures and controls for ensuring safety as well as its systems for managing staff resources. During the audit, we analyzed Institute data and reviewed statutes, rules, and Department and Institute policies and procedures. We also interviewed staff from the Department of Human Services, Mental Health Institute Division, Mental Health Institutes at Pueblo and Fort Logan, Department of Public Health and Environment, Department of Personnel and Administration, Pinnacle Assurance, University of Colorado at Denver Health Sciences Center, CMS, Department of Labor and Employment, Department of Corrections, and community mental health centers. In addition, we obtained information from 10 other states (Arizona, California, Florida, Georgia, Massachusetts, Montana, Nevada, New York, Oregon, and Utah) that have mental health facilities similar to the Institute to gain insight into their operations and identify best practices.

The scope of this audit did not include a review of quality of care, financial controls, or ancillary services except for law enforcement at the Institute. Finally, the audit did not include a review of the Mental Health Institute at Fort Logan.

Managing Safety Risks

Chapter 2

The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) requires hospitals to have procedures in place to protect the safety of patients and hospital workers. Such procedures are paramount for institutes that treat people diagnosed with mental illnesses, as these individuals may not only jeopardize their own safety but may also threaten the safety of other patients and staff as well as members of the community.

The Colorado Mental Health Institute at Pueblo (Institute) treats the State's most severely mentally ill civil and forensic patients, many of whom have, at some point, posed a safety risk to themselves or others. According to statute [Section 27-10-101, C.R.S.], the Institute is to treat and rehabilitate all patients, both civil and forensic, in the least restrictive setting possible. Accordingly, the Institute must strike a balance between maintaining the safety of the patient, Institute staff, and members of the community and treating the patient in a setting that facilitates the patient's progress toward independence. Both civil and forensic patients who pose an immediate danger to themselves or others are held in secured units at the Institute. The Institute is responsible for continuously assessing patients' progress and moving them to less restrictive settings when they demonstrate mental stability, successfully respond to treatment, and are considered unlikely to pose a safety risk. As forensic patients move into less restrictive settings, the Institute and the courts may grant them privileges, such as the freedom to move freely within their Institute units, go outdoors on the Institute's 300-acre campus, travel within the city of Pueblo, or return temporarily to their homes. According to Institute officials, providing patients with incrementally greater degrees of independence is integral to the successful treatment of patients and their potential reintegration into the community.

Although providing greater independence to patients during the course of their treatment can benefit them, it can also expose patients, staff, and community members to safety risks such as assault, injury due to an accident, or death. Events that potentially threaten the safety of or cause injury to patients, staff, or members of the community are classified by the Institute as "critical incidents." The following table shows, by type, the critical incidents that involved Institute patients or staff during Fiscal Years 2007 through 2009.

Critical Incidents, by Type Fiscal Years 2007 Through 2009			
Critical Incident Type	2007	2008	2009
Accident (slip, trip, or fall)	305	345	328
Assault (physical or sexual)	265	238	212
Accident (recreational, horseplay, or other)	162	143	151
Harassment ¹	189	140	134
Other ²	90	89	113
Patient Self-Harm	131	135	96
Contraband ³	72	43	68
Other Medical Incident ⁴	82	82	51
Patient Escape or Elopement ⁵	17	20	23
Other Safety or Security Violation ⁶	24	22	23
Patient Attempted Suicide	24	18	13
Patient Death ⁷	7	9	11
Theft	13	12	11
Patient Attempted Patient Escape or Elopement	12	13	8
Patient Neglect	5	2	7
Total	1,398	1,311	1,249
<p>Source: Office of the State Auditor’s analysis of data from the Colorado Mental Health Institute at Pueblo.</p> <p>¹“Harassment” includes physical and sexual harassment, verbal assault and insults, and indecent exposure.</p> <p>²“Other” includes lost keys, needlesticks, incidents in which the Institute has a duty to warn patients’ victims if patients escape, fires, false fire alarms, missing drugs or dangerous items, lost or damaged property, nonmedical equipment malfunction, and exposure to chemicals.</p> <p>³“Contraband” includes weapons, illegal drugs, or other dangerous items in a patient’s possession.</p> <p>⁴“Other Medical Incident” includes medical emergencies, actual and possible exposure to bodily fluids, medication variance (i.e., taking too much or too little medication), medical equipment malfunction, seizure, choking, unexplained and serious illnesses, and ingestion of an object or substance.</p> <p>⁵“Escape” is used when a forensic patient is missing; “elopement” is used when a civil patient is missing. In Fiscal Year 2009, 14 of the 23 patient escapes and elopements were civil patient elopements and 9 were forensic patient escapes.</p> <p>⁶“Other Safety or Security Violation” includes trespassing, a motor vehicle crash on the Institute campus, staff and patient consensual sexual contact, and other minor security and safety incidents.</p> <p>⁷“Death” includes accidental, unexplained, and natural deaths as well as suicides.</p>			

As the table shows, accidents (slips, trips, falls, recreational incidents, and horseplay), assaults, and harassment have accounted for a majority of the critical incidents occurring over the past three years.

We reviewed the Institute’s practices for managing safety risks such as the critical incidents discussed above and found that the Institute lacks controls to adequately

protect the safety of patients, staff, and members of the community while ensuring the quality of care for patients. Specifically, we found the Institute does not: (1) adequately monitor forensic patients in the community and ensure their quality of care, (2) have adequate procedures for determining when patients are missing or for notifying the public of patient escapes, (3) sufficiently track and resolve patient complaints, or (4) have adequate procedures to reduce workers' compensation claims or control costs related to employee injuries.

Monitoring Forensic Patient Care in the Community

As discussed in Chapter 1, the primary goal of inpatient treatment is to help patients gain the skills needed to transition from the Institute to the community. The successful rehabilitation of forensic patients and the safety of patients and the public are contingent on the Institute's ensuring that patients receive the appropriate treatment and medication while they are in the community. When forensic patients are released into the community, these patients remain under Institute custody and supervision until a court orders their conditional or full release from custody. The Institute's Forensic Community-Based Services (FCBS) program and the community mental health center to which the forensic patient is assigned are jointly responsible for treating and monitoring forensic outpatients and providing periodic reports to the courts. Continued monitoring is essential to ensure that forensic outpatients continue their court-ordered treatment and medication and do not regress to a condition in which they pose a safety risk to themselves or others. An integral component of the monitoring process is ensuring that forensic patients have appropriate treatment plans and medication.

The Joint Commission requires the Institute to develop and maintain for each patient a treatment plan that includes treatment goals and responses to treatment. In addition, the Institute must document in the treatment plan the patient's prescribed medications, rate of medication administration, and any changes made to the plan. Institute policies, which are consistent with Joint Commission requirements, require updated treatment plans and records of all medications that are ordered, prescribed, and administered. In addition, the Department's contracts with the community mental health centers require the centers to follow Institute policies related to treatment plans and medication.

In Fiscal Year 2009 there were nine forensic patient escapes from Institute supervision. We reviewed Institute documentation for three forensic patient escapes to determine if these patients had received the appropriate treatment and monitoring from the Institute and the community mental health centers prior to their escape. Each of the three forensic patients had a violent criminal history and

had been found not guilty by reason of insanity. The three patients had been deemed by physicians and the courts to no longer pose a risk to themselves or others as long as they were undergoing court-ordered treatment and medication and had been allowed access to the community. Each of the three patients escaped from Institute supervision while in the community.

Overall, for the three forensic patients we reviewed we identified significant concerns with respect to the monitoring and treatment the patients' received while they were in the community prior to their escape. According to documentation from the Institute's quality assurance reviews conducted after the patients were apprehended, two of the three patients' medications were not adequately monitored indicating that the patients were either unmedicated or undermedicated in the months prior to the escape. Two of the patients did not have an adequate treatment plan, as described below.

- Forensic Patient No. 1 escaped from Institute custody in September 2008 while on a temporary home pass. According to Institute quality assurance documentation, in the four months prior to escape "neither the patient nor the nursing staff were monitoring the patient's compliance with medication."
- Forensic Patient No. 2 escaped in April 2009 while on conditional release and under supervision and monitoring by Institute FCBS staff and a community mental health center. Institute quality assurance documentation showed that in the three months prior to the patient's escape, blood tests indicated that the patient may not have been taking one of his medications. Additionally, community mental health center documentation showed that the "patient did not consistently take his medication." Further, Institute documentation noted that the community mental health center had not ensured that the patient's treatment plan was measurable, behavioral, and attainable, as required by Institute policy.
- Forensic Patient No. 3 escaped in February 2009 while on community placement and under supervision and monitoring by Institute FCBS staff. According to Institute quality assurance documentation, in the month prior to the patient's escape, the patient's physician had indicated that the treatment plan was incomplete with respect to medications and there was "no prompt [in the treatment plan] to review [the patient's] medication."

The results of our analysis and the Institute's quality assurance reviews for these three patients raise questions about whether forensic patients with community access receive the ongoing care and treatment they need. In recent years the Joint Commission has found similar problems at the Institute. In 2006 the Joint Commission found that the Institute did not adequately monitor medication

effects on inpatients housed on its campus. In addition, in 2006 and again in 2009 the Joint Commission found that the Institute did not adequately update patient treatment plans to reflect changes in treatment. Continuing problems in these areas highlight the need for stronger Institute monitoring procedures and compliance with the procedures already in place.

We identified four areas in which the Department and the Institute need to improve the monitoring of forensic patient care. First, the Department and the Institute should clearly delineate the roles and responsibilities of Institute FCBS staff and community mental health centers related to monitoring forensic patients in the community. Neither the Institute's policies nor the Department's contracts with the community mental health centers clearly outline the Institute's and community mental health centers' respective responsibilities when both organizations are jointly responsible for treating and monitoring a patient. The Department and the Institute should revise policies and procedures, as well as the contracts with the community mental health centers, to more clearly define care, treatment, and monitoring expectations and responsibilities for the Institute and the community mental health centers with respect to patients. The revisions should establish procedures for Institute and community mental health center staff to accurately document medication records and patient treatment plans. Appropriate Institute and community mental health center staff should receive training and guidance on health care standards as well as on their roles and responsibilities for monitoring and caring for forensic patients.

Second, the Department should improve its oversight of community mental health centers to ensure the centers comply with the terms of their contracts and adequately treat forensic patients in their care. Department staff have contract management responsibility for community mental health center contracts and are responsible for ensuring the centers comply with policies and procedures related to treatment plans and medication. However, in one of the cases we found the community mental health center, which was primarily responsible for treating and monitoring the patient, did not ensure that the patient took the prescribed medication and had an adequate treatment plan. This case raises concerns about the adequacy of the Department's monitoring of community mental health centers to ensure their compliance with the contract and monitoring policies and procedures.

Third, the Department should ensure that appropriate enforcement actions are taken against community mental health centers for noncompliance with contract terms. Although the community mental health center contracts allow the Department to fine the centers up to \$300 per day for noncompliance, the Department rarely imposes fines. According to Department and Institute staff, few community mental health centers in Colorado are willing to provide care for the Institute's forensic outpatients. As a result, Department officials are

concerned that fining these centers for noncompliance with contract terms could result in a loss of service altogether. To address this concern, the Department should consider implementing a separate fee schedule that pays higher rates for forensic patients who require more extensive monitoring and who are more likely to violate their court-ordered conditions of release into the community. In addition, the Department should consider implementing more stringent penalties for repeated noncompliance by community mental health centers, such as levying stiffer fines or withholding a portion of the funds paid to the centers. The Department should also investigate alternative means of providing continued care for forensic patients in the community if community mental health centers do not provide adequate care and forensic patient monitoring.

Finally, the Department and the Institute should implement a standard policy to conduct quality assurance reviews when forensic patients escape. The Institute does not typically conduct a quality assurance review of medical records after an escape. The quality assurance reviews for the three patients in our sample occurred only because we requested documentation regarding the patients' care. Escapes should be reviewed after they occur to assess the quality of care that the patients received prior to escaping and to determine if a lack of appropriate care may have contributed to the patients' escape. Corrective actions should also be taken as appropriate. Court orders require forensic patients to be medication compliant to remain in the community. However, according to Institute documentation, the medications of two of the patients we reviewed were not sufficiently monitored by the Institute or a community mental health center, indicating that the patients may have been undermedicated or unmedicated prior to their escapes. If the patients' medication noncompliance had been promptly identified and remedied, the patients may have been less likely to escape.

Recommendation No. 1:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should ensure that forensic patients in the community receive appropriate care and monitoring by:

- a. Implementing policies and procedures and updating contract provisions related to monitoring and treating forensic patients in the community to clearly delineate the respective roles and responsibilities of the Institute's Forensic Community-Based Services (FCBS) program and the community mental health centers.
- b. Providing training and guidance to Institute and community mental health center staff on health care standards, as well as on their roles and responsibilities for monitoring and caring for forensic patients.

- c. Improving oversight of community mental health centers to ensure that they adequately treat forensic patients in their care and comply with the terms of their contracts with the Department.
- d. Ensuring that appropriate enforcement actions are taken against community mental health centers for noncompliance with contract terms. The Department should consider: (1) implementing a separate fee schedule that pays higher rates for forensic patients who require more extensive monitoring, (2) implementing more stringent penalties for repeated noncompliance by community mental health centers, and (3) investigating alternative means of providing continued care for forensic patients in the community if community mental health centers do not provide adequate care and monitoring.
- e. Implementing a standard quality assurance process for reviewing forensic patient records after escapes occur to assess the appropriateness of the patient's care and monitoring prior to escape and to determine if a lack of care and monitoring contributed to the escape. Corrective actions should be taken as appropriate.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: July 2010.

- a. The Department will work with the community mental health centers to revise existing policies, procedures, and contract provisions to clearly delineate the respective roles and responsibilities of the Institute and the community mental health centers for the treatment and monitoring of forensic patients residing in the community.
- b. The Institute and the Division of Behavioral Health currently provide training to community mental health center forensic staff. The Institute and the Division of Behavioral Health will review the frequency and content of current training services to ensure the training includes documentation and review of medication monitoring and preparation and review of treatment plans. Similarly, the Institute will review training in health care standards and documentation provided to FCBS staff.
- c. The Division of Behavioral Health will continue to improve oversight of community mental health centers to ensure their compliance with the terms of the contract and proper execution of the FCBS policies

and procedure handbook incorporated by reference in the contract. The Division of Behavioral Health currently monitors community mental health centers on a quarterly basis by reviewing treatment plans, risk factors, and actions to mitigate risks for community forensic patients. Additionally, the Division recently implemented a change in the collection of patient data provided by the community mental health centers to improve the tracking of forensic patients and their services and treatment outcomes.

- d. The Division of Behavioral Health will continue to monitor the community mental health centers' compliance with their contracts. The Division will follow existing standards for ensuring compliance including proper notice, requiring community mental health centers to establish plans of correction, and providing an opportunity to cure issues, as well as providing needed technical assistance prior to levying liquidated damages and other contract remedies. Should the Division be unsuccessful in achieving results by following the aforementioned process, it then would consider a mix of incentives and sanctions which could include the potential for a higher fee paid for non-Medicaid forensic patients who require more extensive monitoring, increased penalties for repeated noncompliance, and utilization of an alternative group of providers. In order for the Division to pay a higher fee for forensic patients it would be necessary to reduce services to other indigent persons (without an influx of additional resources) and that decision would need to be carefully weighed against other competing demands for services.
 - e. The Mental Health Institute Division will implement a standardized quality assurance process for reviewing escapes by forensic patients. This process will include participation by the Division of Behavioral Health and community mental health center staff as appropriate. The review will include a root cause analysis, assess the appropriateness of the patient's care and monitoring prior to the escape, and identify if the level of the patient's care and monitoring may have contributed to the escape. If the review identifies that Institute staff did not adequately perform treatment or monitoring responsibilities, appropriate supervisory action will be taken. In addition to reviewing patient records following an escape, the Mental Health Institute Division's quality management staff will periodically conduct an audit of a sample of FCBS patient medical records to assess the level of care and monitoring the forensic patients are receiving.
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Patient Escapes and Elopements

When a patient leaves Institute custody without authorization, whether from the Institute campus or from the community, statute [Section 16-8-121, C.R.S.] authorizes the Institute to take all necessary steps to protect the public and secure the missing patient's return. When a forensic patient disappears from custody, the disappearance is considered an "escape" because a criminal court process has referred the patient to the Institute's custody. When a civil patient disappears from custody, the disappearance is called an "elopement" because the patient has either voluntarily committed himself or herself to Institute custody or was committed through a civil commitment process. In Fiscal Year 2009, nine of the Institute's forensic patients escaped from custody, and 14 civil patients eloped. The following table shows patient escapes and elopements over the last five fiscal years.

Patient Escapes and Elopements Fiscal Years 2005 Through 2009						
	2005	2006	2007	2008	2009	Total
Forensic Escapes						
Inpatients ^{1,2}	6	2	7	6	7	28
Outpatients ³	3	2	1	1	2	9
Total Forensic	9	4	8	7	9	37
Civil Elopements⁴	7	17	9	13	14	60
Source: Office of the State Auditor's analysis of Institute data.						
¹ Inpatients living and receiving treatment on the Institute campus.						
² In Fiscal Year 2009, 4 of the 7 forensic inpatients who escaped were temporarily in the community (e.g., on home passes) at the time of their escape.						
³ Forensic outpatients living in the community (on community placement or conditional release) and receiving treatment from the Institute and/or a community mental health center.						
⁴ All civil elopements occur when patients are living and receiving treatment on the Institute campus.						

Prompt apprehension of an escaped or eloped patient is important so that the Institute can quickly reestablish the patient's medication and treatment and reduce the risk of harm to both the patient and the public. Institute procedures for handling missing patients vary, depending on whether the patient is forensic or civil and whether the patient is on the Institute campus or in the community. When either a forensic or a civil patient is discovered missing from the campus, Institute policies require staff to immediately notify the Institute's Department of Public Safety, which includes its police force, security personnel, and communications specialists, as discussed further in Chapter 3. Once notified, the Institute's Department of Public Safety conducts a preliminary investigation and

search for the patient. If the patient is not found, the Institute's attending physician or nurse supervisor must place the patient on escape or elopement status. The Institute's policy for notifying authorities outside of the Institute also differs depending on whether the missing patient is a civil or forensic patient:

- With civil patients missing from the Institute campus, once the patient is placed on elopement status, Institute policy allows the Institute to notify local law enforcement only if that patient poses a threat to public safety. However, due to concerns about confidentiality, it is not Institute policy to notify the media when elopements occur. According to the Institute, under the federal Health Insurance Portability and Accountability Act (HIPAA), the Institute must maintain confidentiality of civil patients' health information.
- With forensic patients missing from either the Institute campus or the community, once the patient has been placed on escape status, policy specifies that the Institute must notify local law enforcement. Institute policy also allows the Institute to notify the media to aid in the forensic patient's return and ensure public awareness and safety.

To evaluate the Institute's procedures for apprehending missing patients and ensuring community safety, we reviewed a sample of 3 of the 9 forensic patient escapes and 3 of the 14 civil patient elopements that occurred during Fiscal Year 2009. Overall, we found that the Institute does not have sufficient procedures in place for the timely detection of missing forensic patients in the community and notification of the proper authorities, as discussed below.

Determination of escape status. According to Institute policy, when the Institute determines that a forensic patient is missing from custody without authorization, the Institute is required to place the patient on "escape status." However, Institute policies do not clearly indicate the conditions that must exist to determine that a patient in the community has escaped. For two of the three forensic patients we reviewed, the Institute's lack of clear policies delayed the placement of the patient on escape status, as described below:

- For the first patient, the Institute did not place the patient on escape status until two days after the patient failed to attend a treatment appointment. This patient was on conditional release and had been living in the community, on and off, for about seven years. The patient missed a court-ordered appointment with a community mental health center that was responsible for giving the patient court-ordered medication. Two days after the missed appointment, the community mental health center staff visited the patient's residence and found that the patient had rented his residence to another tenant at least nine days earlier. At that time, the

community mental health center staff notified Institute staff, who then placed the patient on escape status. In total, over 48 hours elapsed between the patient's missing his appointment and the Institute's placing the patient on escape status.

- For the second patient, the Institute did not place the patient on escape status until about one hour after confirming that the patient was missing. The forensic patient was on community placement and had been living in the community, on and off, for about six years. The patient left a phone message for Institute staff stating that he would miss a court-ordered appointment. According to Institute documentation, Institute staff's attempts to contact the patient by phone were unsuccessful, and therefore one and one-half hours after the missed appointment staff visited the patient's residence. The staff member did not find the patient but did find the patient's discarded ankle monitoring device. In total, four hours elapsed between the patient's leaving a phone message and the Institute's placing the patient on escape status.

The delays in these two cases occurred because Institute policies do not establish a standard protocol, including time frames, for Institute and community mental health center staff to follow in determining whether a patient should be considered "escaped." For example, the Institute's policies do not address whether followup should occur when a patient misses an appointment. In addition, the policies do not require that either Institute or community mental health center staff visit the patient's home in the community when an appointment is missed. In the two cases described above, staff went to the patients' homes only because they were concerned about the patients' whereabouts, and they conducted the visits when time was available.

As discussed above, the Institute must place a forensic patient on escape status before notifying local law enforcement and the media of an escape. Accordingly, any delay in making an escape status determination in turn delays the Institute's ability to seek outside assistance to quickly apprehend the missing patient. Although we are not aware of any harm that occurred as a result of the escapes described above, the longer a patient is missing from custody and away from treatment, the greater the potential threat to the safety of the patient and the public, and the more difficult it may be to locate the patient.

Media notification. According to Institute policy, when a forensic patient escapes the Institute may provide the media with details of the escape after the patient has been placed on escape status. According to Institute officials, in every escape instance since February 2009 the Institute has provided the media with the patient's name, date of birth, physical description, date and county of commitment, and any previous convictions or pending charges. However, the

Institute does not always provide this notification promptly. For example, for the three forensic patients in our sample, the Institute did not notify the media until about 5, 10, and 22 hours after placing the patients on escape status. The delays in media notification occurred because the Institute's media notification policy does not include timelines for notifying the media. Prompt media notification is important to ensure that the public is aware of the potential threat and to inform the public about procedures for notifying law enforcement if the escaped patient is recognized.

Additionally, although the Institute provides the media with the patient's criminal history, the Institute does not provide an assessment of the danger or risk that the patient currently poses. A patient's criminal history is helpful for evaluating the risk that the patient posed prior to treatment, but it does not necessarily reflect the current risk. In contrast, as revealed by our review of other states, the Montana State Hospital provides a current risk assessment to the media when a forensic patient found not guilty by reason of insanity escapes. The assessment is made by the patient's doctor and describes the likely risk to the public that the patient poses when not receiving treatment. Such information can help the public better understand the risk posed by an escaped patient.

Public school notifications for on-campus escapes and elopements. According to Institute policy, in addition to notifying local law enforcement and the media when patients escape or elope from the Institute's campus, the Institute will notify one particular nearby elementary school when a violent or potentially dangerous patient escapes or elopes from the campus and could threaten the safety of children. This school, one of the elementary schools closest to the Institute campus, is to be notified only because the school's principal requested notification. However, we found that the Institute will notify the school only if a patient escapes during school hours (i.e., between 7:30 a.m. and 5:00 p.m.). In addition, although six other elementary schools are located within two miles of the Institute, the Institute does not notify these schools when potentially dangerous patients escape or elope. The Institute should develop a more comprehensive process for notifying these schools, such as notifying local school principals, when missing Institute patients may pose a risk to children near the campus.

The safety of both the missing patient and the community depends on the patient's timely and safe return to Institute custody. Forensic patients are under court-ordered Institute custody and supervision because they can pose a risk to public safety. Some civil patients may also be a danger to themselves or others. For the escapes and elopements during the last five fiscal years, the Institute determined that all of the 37 forensic patients and 15 of the 60 civil patients urgently needed to be returned for the safety and well-being of the patient or the community.

The Institute should have clear procedures in place to quickly recognize when patients are missing and to help return the patient to Institute custody. However, the Institute's current policies and procedures for handling missing patients are disjointed and incomplete. The Institute has six separate policies that contain procedures to be followed when patients disappear from Institute custody. However, none of these policies address important topics, such as what followup should occur when a patient misses an appointment. In April 2009 the Institute began revising and combining three of these policies. The Institute should continue these revisions and develop a comprehensive set of policies and procedures that address the steps that Institute and community mental health center staff should take to determine a patient's escape or elopement status and to notify local law enforcement, the media, and area schools as appropriate. These policies should address the procedures to be followed when a patient misses an appointment, including providing time frames for followup.

When developing its policies and procedures, the Institute should examine those used by other states. We identified two states' policies and procedures that could serve as best practices. For example, Montana has a comprehensive set of policies and procedures that apply to both forensic and civil inpatients. These policies and procedures include written criteria for determining a patient's missing status, staff responsibilities, guidelines for required and optional public notifications, criteria for determining a missing patient's level of threat to the public, steps to take upon locating a missing patient, and a post-incident review process for reassessing the risk that the patient poses and reviewing the events surrounding the escape. As another example, Massachusetts has department-wide missing-patient policies that apply to all facilities that treat individuals diagnosed with mental illnesses. These policies establish clear and consistent standards for all facilities, including standards for classifying patient risk and urgency, immediate steps to take after a patient is determined missing, the search protocol, required and optional public notifications, actions to take upon a patient's return, and a post-incident review. The Department should consider implementing similar policies and procedures at the Institute, as well as for community mental health centers that provide treatment for the Institute's outpatients.

Finally, prior to revising its policies and procedures, the Institute should work with the Department to clarify the types of outside notifications allowed under HIPAA. HIPAA regulations currently permit health care providers to notify law enforcement of patient escapes if the patients are deemed a threat to themselves or the public. The regulations do not distinguish between forensic and civil patients. On the basis of informal discussions with the Attorney General's Office, it is not clear under HIPAA, however, whether: (1) allowed notifications differ for civil and forensic patients, (2) allowed notifications would extend to the media and schools, or (3) a threat assessment can be provided to outside authorities when a dangerous or potentially dangerous patient escapes from Institute custody.

Therefore, the Institute should obtain a formal opinion from the Attorney General's Office to clarify these issues.

Recommendation No. 2:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should strengthen their policies and procedures for protecting patients and the public when patients are missing by:

- a. Developing a comprehensive set of policies and procedures addressing the steps Institute and community mental health center staff should take to determine a patient's escape or elopement status and to notify local law enforcement, the media, and area schools as appropriate. As part of this process, the Department and the Institute should examine other states' missing-patient policies and procedures and incorporate elements from them as appropriate.
- b. Obtaining a formal opinion from the Attorney General's Office to determine the extent to which federal law allows the Institute to: (1) notify outside authorities, including the media and public schools, when forensic and civil patients escape or elope, or (2) provide current threat assessments when forensic and civil patients escape from state custody.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

- a. Agree. Implementation date: July 2010.

The Mental Health Institute Division will review and revise existing escape and elopement policies and create a single policy and procedure that specifies the procedure Institute and community mental health center staff should follow to determine a patient's escape or elopement status and to notify local law enforcement, the media, and area schools. This review will include an examination of other states' missing-patient policies, procedures, and practices as appropriate.

- b. Agree. Implementation date: April 2010.

The Department will request a formal opinion from the Attorney General's Office to determine the extent to which state and federal laws allow the Institute to notify outside authorities, including the media and public schools, when forensic and civil patients escape or

elope. The Department will also request confidential written advice from the Attorney General's Office about providing a threat assessment when civil and forensic patients escape from custody.

Patient Complaints

The federal Centers for Medicare and Medicaid (CMS), HIPAA, Colorado Department of Public Health and Environment, and Department of Human Services' Division of Behavioral Health require hospitals to have processes for resolving complaints brought forward by patients. Hospital complaint systems are meant to protect patients' rights and help ensure effective treatment. In general, effective complaint systems include the following components: (1) a written record or log of the complaint, which is typically entered into a complaint database, (2) categorization of the complaint according to its urgency or importance, (3) investigation and resolution of the complaint within established time frames, (4) followup to ensure that the complaint resolution was implemented, and (5) ongoing analysis of complaint data to identify underlying patterns or trends that need to be addressed or corrected.

To comply with requirements, the Institute has implemented a system for accepting and resolving patient complaints. A complaint is considered resolved when the Institute has taken reasonable and sufficient action to address the patient's concern. Oral complaints are resolved informally, but written complaints are logged, categorized by issue, ranked according to urgency or importance, and entered into the Institute's complaint database. The most urgent level of complaints includes those alleging injury, harm, or violation of patient rights, such as a staff person being verbally or physically abusive. These complaints should be investigated and resolved within 48 hours. The next level of complaints includes those alleging violations of hospital policy, such as the policy prohibiting patients from smoking. These complaints should be resolved within 30 days. The lowest complaint level includes all other complaints (i.e., those that do not involve injury, harm, patient rights, or a violation of hospital policy). These complaints, which may include complaints about the hospital food, the temperature in a room, or other such issues, should also be resolved within 30 days. Typically, complaints are first investigated by the hospital unit in which the incident leading to the complaint occurred. The patient may also request that the complaint be reviewed by the Institute's patient representative or Superintendent, or the Division of Behavioral Health within the Department. All complaint resolutions, regardless of the severity of the complaint, must be provided to the patient in writing.

In Fiscal Year 2009 the Institute recorded 528 patient complaints. Most of these were about Institute staff, treatment, or living conditions, as shown in the following table.

Patient Complaints Fiscal Year 2009	
Complaint Category	Number of Complaints
Institute staff	154
Other treatment issues	115
Living conditions	62
Legal	59
Property	36
Food	26
Peers	25
Contingency Management System ¹	24
Medication	23
Supplies	3
Not categorized	1
Total	528
Source: Colorado Mental Health Institute at Pueblo.	
¹ In this program, patients earn “points” when they demonstrate that they are following basic hospital rules and earn levels of privileges as they accumulate points. Privileges may include phone, outside, or kitchen privileges. Points and privileges can be removed if a patient violates hospital rules.	

We reviewed the Institute’s patient complaint system and database for information about the approximately 1,100 patient complaints received by the Institute during Fiscal Years 2008 and 2009. Overall, we found that the Institute has an effective complaint system and that complaints are generally resolved within the required time frames. However, we identified two areas in which the Institute could strengthen its process for resolving and analyzing complaints:

- **Complaint investigation, resolution, and followup.** CMS regulations require the Institute to investigate and resolve all complaints, including any deeper, systemic problems that may surface during the investigation. We identified two areas where Institute practices for investigating and resolving complaints are inadequate. First, the Institute does not fully investigate and resolve all complaints. Specifically, of the 1,100 complaints we reviewed, 140 (13 percent) were not fully investigated or

resolved because the patient was discharged before a resolution was reached. According to Institute officials, when a patient is discharged, complaint investigation activities cease. By not following through on the investigations for subsequently discharged patients, the Institute may not identify serious, systemic issues that may surface through such investigations. Second, the Institute does not always follow up to ensure that, when a complaint resolution has been identified, the resolution is actually implemented. For 49 of the 1,100 (4 percent) complaints we reviewed, the database contained no evidence of how the complaint was actually resolved. For example, in one case, a patient complained that a staff member had been verbally abusive and the resolution recorded in the database indicated that “the patient is willing to meet with the staff member.” However, the database contained no record of whether the meeting actually occurred or how the complaint was ultimately resolved. By not following up on discharged patients’ complaints or ensuring that resolutions are implemented, the Institute cannot ensure that its complaint system will identify and solve specific or systemic problems as required by CMS regulations.

- **Management and analysis of complaint data.** The Institute’s complaint database does not contain sufficient detail to facilitate analysis and trending of complaint information. Rather, complaint details are maintained in hard copy documents that can be analyzed only through a manual, labor-intensive process. For example, the complaint database does not record the ranking or severity level of the complaint that dictates the amount of time Institute staff have to resolve the complaint. In addition, for the almost 270 complaints relating to improper staff and treatment issues, the complaint database did not record the names of the staff members who were the subjects of the complaints or in some cases the specific concerns about treatment. Without this information, the Institute cannot efficiently analyze data to identify trends or recurring issues that could be contributing to problems with patient care. Also, the topical categories by which complaints are maintained in the database are not as useful as they could be for identifying and analyzing potential patient care problems. Midway through Fiscal Year 2008, the Institute developed the 10 topical categories shown in the previous table to facilitate the identification and analysis of complaint trends and patterns. However, we found that almost a quarter of the complaints recorded during Fiscal Year 2009 (115 of 528 complaints) were entered into a single category: “other treatment issues.” The issues raised in these complaints ranged from a patient’s needing eyeglasses to a patient’s alleging abuse by a staff person. It is difficult to fully identify and analyze trends when almost one-fourth of the complaints are categorized as “other.” Further, many complaints in this category could be categorized in

a more useful manner. For example, 27 complaints in the “other” category related to restrictions placed on patients’ privileges, such as a patient’s not being allowed to transition to a lower security unit; 14 related to concerns from or about a patient’s family; and 12 related to a patient’s medical needs. Each of these three categories could be more useful for analysis than “other.” Minimizing the use of the “other” category and adding categories as needed would make the data more useful for identifying trends in areas of concern.

The Department and the Institute should strengthen the Institute’s complaint process by developing policies and procedures for ensuring that all complaints are investigated and resolved, even after a complainant has been discharged. The complaint process should also include followup to ensure that complaints are addressed and resolutions are documented in the database. Additionally, the Department and the Institute should ensure that data maintained in the complaint database are sufficiently detailed and categorized to facilitate meaningful analysis. Finally, the Department and the Institute should analyze the information contained in the complaint database to identify underlying or recurring trends and take action as appropriate.

Recommendation No. 3:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should strengthen the patient complaint system by:

- a. Implementing policies and procedures to ensure that all complaints, including those submitted by patients who are subsequently discharged, are investigated and resolved. Followup actions taken to address and resolve complaints should be documented in the database.
- b. Ensuring that the information in the complaint database and the topical categories in which the information is captured provide sufficient information to facilitate meaningful analysis.
- c. Analyzing the information in the complaint database to identify patterns and underlying or recurring trends that may affect Institute operations or patient care and taking action as appropriate.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: July 2010.

- a. The Institute will revise patient complaint policies and procedures to ensure that all complaints, including those submitted by patients who are subsequently discharged, are investigated and resolved. It is important to note that the Institute receives patient complaints that may never be resolved given the nature of the complaint (i.e., “I want to be discharged immediately.”). While the resolution of complaints from patients who are discharged may not always occur prior to discharge, the Institute will complete the complaint investigation and document the findings in order to identify any serious or systemic issues that may surface through the complaint. In an effort to increase the number of complaints resolved prior to discharge, the Institute will review and adjust the policy on timelines for addressing grievances. All followup actions taken to address and resolve complaints will be documented in the Institute’s database.
- b. The Institute will ensure the information in the complaint database and the topical categories in which the information is captured provide sufficient information to facilitate meaningful analysis. The Institute database will be revised to separate the “other” category into separate topic categories, based on an analysis of the types of complaints currently included in the “other” category.
- c. Institute management currently reviews patient grievance data, both on a monthly and quarterly basis. The implementation of Recommendation 3(b) will strengthen the Institute’s ability to review and analyze complaint data and take action based on the results of the reviews.

Workers’ Compensation Claims

Under the Colorado Workers’ Compensation Act, an employee who is injured on the job is entitled to compensation for medical expenses associated with the injury, as well as partial wage replacement. Since 1996 the State has been self-insured and pays for all costs associated with state employees’ workers’ compensation claims. Pinnacol Assurance is the State’s third-party workers’ compensation claim administrator and is responsible for processing and admitting

(approving) or denying all claims. If a claim is admitted, the State pays reasonable and necessary medical expenses related to the injury and some wage compensation if the employee misses more than three workdays.

Historically, the Department of Human Services has consistently experienced high rates of claims filed and dollars paid out for workers' compensation claims. In Fiscal Year 2008, 769 Department employees filed 873 workers' compensation claims and were awarded a total of \$5.3 million for medical services and lost wages. During Fiscal Years 2006 through 2009 the Institute consistently paid out more in workers' compensation claims than did any other Department facility. In Fiscal Year 2009, 206 different employees, or about one-fifth of the Institute's workers, filed 254 claims. These claims included injuries from lifting or restraining patients, patient assaults, and ergonomic hazards. As of August 2009 the State had paid a total of about \$525,300 for medical and other expenses related to these claims. However, 23 of these claims were still open as of August 2009, and the State is responsible for paying any remaining costs associated with the injuries. According to data from the Department of Personnel & Administration, only about 5 percent of the Institute's claims are denied by Pinnacle Assurance. The following table shows Institute employees' workers' compensation claims and Institute payments, by injury type, for Fiscal Years 2006 through 2009.

Workers' Compensation Claims by Injury Type Fiscal Years 2006 Through 2009								
Injury Type	2006		2007		2008¹		2009¹	
	No. of Claims Filed	Amount Paid²	No. of Claims Filed	Amount Paid²	No. of Claims Filed	Amount Paid²	No. of Claims Filed	Amount Paid²
Slip, Trip, or Fall	14	\$126,400	31	\$1,095,900	31	\$431,400	35	\$92,000
Assault	29	214,900	28	578,800	58	449,000	92	135,300
Strain	57	2,345,100	38	1,322,400	31	225,100	44	120,200
Struck by object	17	367,500	39	478,700	12	8,000	24	9,900
Other ³	22	67,000	26	94,100	34	405,700	59	167,900
Total	139	\$3,120,900	162	\$3,569,900	166	\$1,519,200	254	\$525,300
Source: Department of Personnel & Administration, Risk Management Section.								
¹ A total of 12 claims filed in Fiscal Year 2008 and 23 claims filed in Fiscal Year 2009 are still pending or have not been fully paid. According to the Department of Personnel & Administration, the average life expectancy of a single workers' compensation claim is seven years, during which the State is responsible for paying any costs associated with the injury.								
² Includes medical and other expenses paid on all claims as of August 2009.								
³ "Other" includes burns, cuts, and injuries due to machinery.								

We reviewed the Department's and the Institute's processes for documenting and investigating workers' compensation claims and found that, overall, the Department and the Institute do not have sufficient mechanisms in place to help

reduce employee injuries and thereby reduce workers' compensation costs. Specifically, neither the Department nor the Institute ensures that workers' compensation claims are appropriately investigated to substantiate that injuries are work-related and to identify the root cause of the injury. Additionally, the Institute does not sufficiently screen current and prospective employees to ensure that they are physically capable of performing their job functions and are thus less likely to suffer injury in the workplace.

Injury Investigations

Risk management guidelines issued by the Colorado Department of Personnel & Administration (DPA) require state agencies to file a written claim with Pinnacol Assurance (Pinnacol) when an employee asserts that he or she was injured on the job. The DPA guidelines also require state agencies to conduct an investigation to determine the root cause of the incident that led to the injury, substantiate that the injury was work-related, and determine how to prevent injuries in the future. When an Institute employee is injured, Department policy requires the employee to complete an Injured-on-the-Job (IOJ) form that includes a description of how the injury occurred. The employee's supervisor is required to investigate the incident to identify the root cause of the injury, document the investigation on the IOJ form, and indicate on the form whether the supervisor's findings concur with the employee's claim. Institute supervisors must then submit the completed IOJ form to Department of Human Services human resources staff. According to Department policy, Department human resources staff are required to review the IOJ forms for completeness, return the forms to the supervisor if not complete, and submit the claim information to Pinnacol for processing. According to Pinnacol, it relies upon Department human resources staff to ensure workers' compensation claims are properly investigated and to provide complete and accurate assessments of whether the injuries occurred on the job.

We reviewed the case files for a sample of 26 workers' compensation claims submitted during Fiscal Years 2008 and 2009. As of August 2009 the State had paid about \$51,500 for these 26 claims. We found the following problems with the claims:

- For 9 of the 26 (35 percent) claims, the file contained no documentation that the employees' injuries had been investigated by the employees' supervisors to determine the root cause of the injuries, as required by DPA and Department policy. For example, in one claim the employee alleged having contracted strep throat from an Institute patient. However, the file contained no documentation that the supervisor verified that an Institute patient with whom the employee had contact had strep throat.

- For 11 of the 26 (42 percent) claims, the employees' injuries had been investigated by Institute police because they occurred during critical incidents, such as assaults. However, for 10 of these 11 claims the Institute did not provide the police investigation reports or any other evidence of investigation to the Department human resources staff responsible for reviewing the claims. The Department submitted the claims to Pinnacol without complete information, even though human resources staff are required by Department policy to return incomplete claims to supervisors.
- For 7 of the 26 (27 percent) claims, the files contained documentation showing that the employees' supervisors had conducted an investigation, as required by DPA and Department policy. However, we found that the investigation conducted for one of these seven claims was not complete. For this claim the Institute supervisor did not interview the injured employee, as required by Department policy.

As discussed above, the Department has historically had one of the highest numbers and associated payment amounts of workers' compensation claims among all state agencies. Ensuring the validity of these claims and determining the root cause of employees' injuries would benefit not only the Department but also the State overall. Therefore, it is important that the Department and the Institute ensure that each workers' compensation claim is investigated and fully documented on the IOJ claim form so that the root cause is identified. Root cause investigations can help the Institute verify that employee injuries are work-related and thus should be paid by the State. For example, as discussed in Chapter 3 about 32 percent of Institute employees have second jobs outside of the Institute, and many of these jobs are at other health care facilities. Accordingly, there is a risk that employees could be injured at their other jobs but claim that the injuries occurred while working at the Institute.

Current Department policies and procedures are inadequate to protect the State from paying inappropriate and unsubstantiated workers' compensation claims. As previously stated, the Department is responsible for ensuring that all claims are fully investigated and documented according to DPA policy. The Department should reassess and strengthen its policies related to investigating workers' compensation claims to ensure that the claims are valid and should be paid by the State. These policies should also address how investigations should be documented in the workers' compensation claim files. Any changes made to the policies should be implemented Department-wide, and the Department should provide training to staff on the policies. In addition, the Department and the Institute should ensure that supervisors appropriately investigate all workers' compensation claims and provide all pertinent investigation information to Department human resources staff. Finally, the Department should ensure that its

human resources staff provide complete information to Pinnacol when claims are submitted. Human resources staff should return IOJ forms to Institute supervisors for completion when relevant information is missing.

Recommendation No. 4:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should strengthen their policies and procedures surrounding workers' compensation claims by:

- a. Reassessing and revising Department policies related to investigating and documenting claims to ensure that the claims are valid and should be paid by the State. Any changes made to the policies should be implemented Department-wide, and the Department should train staff on the policies.
- b. Ensuring that supervisors appropriately investigate all workers' compensation claims and provide all pertinent investigation information to Department human resources staff.
- c. Ensuring that Department human resources staff review claims for adequate documentation and complete information before providing the claims to Pinnacol Assurance.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: October 2010.

- a. The Department will reassess and revise, as necessary, all policies related to investigating and documenting workers' compensation claims. Any changes made to Department policies will be implemented Department-wide and staff will be trained as needed on the policies.
- b. The Department will implement a system to ensure that all departmental supervisors appropriately investigate all workers' compensation claims and provide the information to human resources staff.
- c. The Department will implement internal procedures to ensure that human resources staff review all workers' compensation claims for

adequate documentation and complete information before providing the claims to Pinnacol Assurance.

Injury Reduction Programs

Employee injuries can be costly to the State as well as to the employee. There is a cost for workers' compensation claims that are admitted and paid by the State, a cost for claims that are denied, and ancillary costs, such as those resulting from staffing shortages, inconsistent patient care, and lower employee morale. As of August 2009 the 721 workers' compensation claims received by the Institute during Fiscal Years 2006 through 2009 had cost the State, in total, about \$8.7 million. The average cost per claim was about \$12,600, with costs ranging from \$9 for an ankle injury to about \$569,000 for a hip injury resulting from lifting a patient. Regardless of the nature of the injury, according to DPA Risk Management representatives, agencies must pay for the first doctor visit for all state employees who file a workers' compensation claim, even if the claim is subsequently denied. For Fiscal Year 2009, the average cost per claim of the Institute's denied claims was about \$1,800.

Reducing injuries is the single most effective step an employer can take to reduce workers' compensation costs. To reduce employee injuries, many hospitals have implemented injury reduction programs. Components of strong injury reduction programs typically include: (1) expectations that employees meet physical requirements for performing their jobs, (2) practices for investigating injuries to determine the root cause, (3) methods for tracking injuries to determine trends, and (4) programs for training employees to help prevent future injuries.

In Calendar Year 2007 the Department implemented an initiative called "People-Based Safety," which is meant to reduce staff injuries across the Department. The focus of the initiative is to help employees assume responsibility for their own safety and offer training to change behaviors and reduce risk. In addition, the Institute offers a number of regular training sessions on staff safety designed to deal with violent patients, including verbal judo and techniques for lifting, secluding, and restraining patients.

We reviewed the mechanisms currently used by the Institute to reduce workplace injuries, and thus reduce workers' compensation costs, and identified three areas in which Institute practices could be strengthened. First, the Institute should consider implementing a program to screen employees to make sure they are physically capable of performing their job functions. In Fiscal Year 2009, 53 of the 254 (21 percent) workers' compensation claims made by Institute employees, which totaled about \$125,000, were associated with employees' physical

capabilities. These included repetitive motion injuries and strains from lifting, carrying, pushing, pulling, twisting, and reaching. We also found that some employees had multiple injuries. For example, while the Institute had 254 separate claims in Fiscal Year 2009, 16 of these claims were from just four employees, and payments on these claims totaled about \$9,000. During Calendar Year 2004 the Institute conducted a WorkSTEPS pilot program, which evaluated employees' physical capabilities against job requirements to determine whether staff were in the appropriate job positions to reduce the risk of injuries. The Institute eliminated the program after one year due to budget cuts before any evaluations or cost-savings analysis occurred. The Department and Institute should consider implementing an injury reduction program that assesses employees' physical capabilities, assigns job duties based on capabilities, and provides training to enhance capabilities.

Second, the Institute should consider implementing physical prerequisites for new hires as appropriate. Other states, including Georgia and New York, have physical requirements for new employees at their state mental health hospitals. These requirements include the ability to perform strenuous activities necessary for the job, such as lifting a patient or a heavy object. If the Institute had had similar requirements for its new employees, those requirements might have prevented some of the 44 lifting and straining injuries that occurred at the Institute during Fiscal Year 2009. These 44 injuries cost the State about \$120,000. The Institute should investigate how it can apply the best practice of adopting physical requirements to help ensure that new employees are capable of performing the job for which they are hired.

Third, the Institute should implement procedures to track and analyze information collected from the workers' compensation claim root cause investigations, discussed in Recommendation No. 4, to determine how to prevent injuries. For example, DPA Risk Management representatives said that they have found a correlation between overtime worked by employees and the number of claims filed. As discussed further in Chapter 3, we found that many Institute employees consistently work overtime. The Institute could review whether extended work hours and fatigue are root causes of claims related to employee stress and falls.

To prevent injuries and reduce the resulting workers' compensation costs to the State, the Department and the Institute should develop a more comprehensive approach to minimizing safety risks that can lead to workplace injuries. Based on our preliminary analysis, the long-term benefits of providing an injury reduction program outweigh the costs to the State. The Institute's previous program cost approximately \$140 per employee or, in total, about \$140,000 for the Institute's 1,000 employees. This is significantly lower than the approximately \$8.7 million the Institute paid out in workers' compensation claims during Fiscal Years 2006 through 2009. Therefore, the Department and the Institute should consider

instituting an injury reduction program and evaluate its long-term effect on workers' compensation costs.

Recommendation No. 5:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should consider implementing an injury reduction program to help reduce the number of workers' compensation claims by Institute employees and thereby reduce the associated costs to the State. The Department should consider incorporating in the injury reduction program physical assessments of current employees, physical prerequisites for new direct-care employee hires, and ongoing analysis of information collected from root cause investigations in the injury reduction program. If such a program is implemented, the Department and Institute should evaluate the long-term effects of the program on workers' compensation costs.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: December 2010.

The Department will pursue additional funds to expand its current injury reduction program (People-Based Safety) to continue to help reduce workers' compensation claims and costs for Institute employees. The Department realized significant cost avoidance (\$1.3 million) in state Fiscal Year 2009 in workers' compensation claims. The Department will track and evaluate the long-term effects of the program on workers' compensation costs.

The Department will consider implementing physical assessments for current employees to ensure that they are able to safely carry out assigned job duties. The Department will also consider implementing physical fitness prerequisites for new direct care hires at the Institute to ensure the ability of new hires to meet bona fide job requirements and will collect and evaluate on an ongoing basis the information obtained from root cause investigations in the injury reduction program.

Resource Management

Chapter 3

Operating a mental health care facility, such as the Colorado Mental Health Institute at Pueblo (Institute), 24 hours per day, seven days per week requires a significant investment in staffing resources by the State. As discussed previously, the Institute treats the State's most severely mentally ill civil and forensic patients, many of whom have, at some point, posed a safety risk to themselves or others. The Institute must have a sufficient number of staff with the appropriate training and levels of expertise to effectively treat these patients and ensure the safety of patients, staff, and members of the community.

The Institute employs almost 1,000 staff who are responsible for operating the facility on a day-to-day basis. Approximately 65 percent of these individuals are considered direct care staff because they provide some type of service directly to patients. Direct care staff provide services such as nursing, physical and occupational therapy, social work, pharmacy services, academic and vocational education, nutrition and dietary services, and medical clinical services (e.g., x-ray, respiratory, lab services). The Institute also employs staff to provide management, financial, administrative support, and law enforcement services. In addition, the Institute contracts with 47 physicians through an interagency agreement with the University of Colorado at Denver Health Sciences Center. These individuals primarily provide psychiatric services to Institute patients.

We reviewed the Institute's personnel management practices and found that improvements are needed in several areas to ensure accountability and efficient, effective use of staffing resources. Specifically, we found that the Institute: (1) does not sufficiently utilize its law enforcement personnel for enforcing the law, (2) does not adequately monitor employees' outside employment, (3) lacks fundamental contract management controls for overseeing the interagency agreement with the University of Colorado at Denver Health Sciences Center, (4) does not ensure compliance with timekeeping and leave requirements for employees, and (5) uses an antiquated and inefficient manual process to schedule direct care staff.

Institute Law Enforcement

Statute [Section 24-7-101, C.R.S.] authorizes the Institute to employ security officers to protect institution property and perform other police, security, and administrative functions as may be deemed necessary. The Institute's Department of Public Safety oversees all law enforcement functions on the Pueblo campus and has 88.7 full-time-equivalent (FTE) staff positions, including:

- 67.4 FTE unarmed security guards (80 employees) who primarily maintain patient and staff safety within the hospital buildings, and transport patients, medical supplies, drugs, and correspondence to and from the treatment units. There are no statutorily required training requirements for security guards.
- 16 FTE Colorado Peace Officer Standards and Training-certified (P.O.S.T.-certified) certified armed police officers (18 employees) who: (1) enforce state and local laws on Institute grounds, such as issuing traffic tickets and investigating criminal behavior, in accordance with statute [Section 16-2.5-139, C.R.S.]; (2) enforce Institute policies, such as building security procedures; and (3) issue identification badges and access keys for the Pueblo campus. P.O.S.T.-certified police officers must complete a basic training academy, pass a background check, possess first aid and CPR certifications, and pass an exam to become certified by the Colorado P.O.S.T. Board.
- 5.3 FTE public safety communications specialists (seven employees) who help manage the telephone switchboard for the Institute campus, receive and record 911 emergency and complaint calls, notify the police force of emergencies, and maintain an employee paging and location system.

We reviewed the Institute's use of P.O.S.T.-certified law enforcement personnel on the Pueblo campus and found that the Institute does not sufficiently use these personnel to enforce the laws of the State of Colorado, as required by statute. Specifically, we identified two concerns with how the Institute is using its P.O.S.T.-certified police officers. First, the Institute uses P.O.S.T.-certified police officers to perform some administrative functions that could be performed by administrative staff. According to the police officers' Position Description Questionnaires (PDQs), 3 of the 18 officers are expected to spend, on average, 25 percent or more of their time on administrative work, such as issuing identification badges, maintaining office supplies, and performing background checks. For example, according to the PDQ for one Police Officer II, this individual should spend more than 40 percent of his or her time supervising the mailroom, issuing identification badges to employees and visitors, and

maintaining office supplies. The PDQ for a Police Officer I shows that this individual should spend 22 percent of his or her time creating identification badges for Institute staff and 15 percent of his or her time conducting background checks on Institute job candidates. None of these duties relates to enforcing state laws, as specified in statute [Section 16-2.5-139, C.R.S.]. Further, in its other divisions, the Department uses non-security personnel to issue identification badges and uses Department human resources staff to conduct all of the background checks on prospective Department employees outside of the Institute.

It is an inefficient use of resources to have P.O.S.T.-certified police officers spend a significant portion of their time on administrative functions that could be performed by administrative or human resources staff. The annual salaries for the three police officers identified above range from about \$47,000 to \$53,000. We estimate that it cost the State about \$68,000 for these three officers to perform administrative tasks during Fiscal Year 2009. Based on the average salaries for Administrative Assistant I and II employees, we estimate that administrative staff could have performed these same duties for about \$34,000 annually. Consequently, if administrative staff had performed these functions, the Institute could have saved at least \$34,000 during Fiscal Year 2009.

Second, we found that the Institute uses its P.O.S.T.-certified police officers to investigate minor, noncriminal incidents that occur on the Pueblo campus. As discussed in Chapter 2, the Institute defines a “critical incident” as an event that potentially threatens safety or causes injury. Critical incidents can range from more serious events, such as patient assaults and forensic patient escapes, to less serious events, such as patient falls and needlesticks. In total, the Institute has defined 44 different types of critical incidents. According to the Institute’s critical incident policy, staff are required to report 34 of the 44 different types of critical incidents to the Institute’s Department of Public Safety. The Institute’s P.O.S.T.-certified police officers are then required to investigate all reported critical incidents. In Fiscal Year 2009 Institute staff reported about 93 percent (1,165 of 1,249) of the documented critical incidents occurring on the Pueblo campus to the Institute’s Department of Public Safety.

Of the 34 different types of critical incidents that staff are required to report to Institute police, 14 are minor and do not involve criminal behavior. These types of incidents include lost keys, recreational accidents, needlesticks, body fluid exposures, and burns. Of the 1,165 critical incidents reported to Institute police during Fiscal Year 2009, more than half (606 out of 1,165) were one of these 14 types. For example, 28 percent (328 of 1,165) of the critical incidents involved patient or staff slips, trips, or falls and were not the result of criminal behavior.

According to Institute officials, its police officers do not always investigate minor incidents, such as needlesticks, lost keys, or accidents, even though Institute

policy may require that they do so. The Institute was not able to provide data, however, on the number of minor critical incidents officers investigated during Fiscal Year 2009. Institute officials estimated that when police officers do conduct an investigation, they spend about one to two hours on it. Assuming that police officers investigated most of the approximately 600 minor critical incidents reported during Fiscal Year 2009, we estimate that the officers spent between 600 and 1,200 hours (about 2 to 4 percent of their time) during Fiscal Year 2009 on these investigations. If police officers were no longer to investigate these types of critical incidents, we estimate that it would reduce the Institute's need for up to 0.6 FTE of police officers, which could result in a cost savings of up to \$33,800 per year. Using P.O.S.T.-certified police officers to investigate minor incidents that do not involve criminal behavior is not an efficient use of resources. The Mental Health Institute at Fort Logan, which does not have its own police force, reports only incidents involving criminal behavior to the Denver Police Department.

The cost to the State for the Institute's 16 FTE P.O.S.T.-certified police officers totaled almost \$1 million during Fiscal Year 2009. Although statute allows the Institute to have its own P.O.S.T.-certified police force, the Institute has not demonstrated that it has a need for the 16 FTE. Further, although the Institute has had its own police force since 1962, neither the Department nor the Institute has evaluated the continued need for an Institute police force. The Department and the Institute should reevaluate the Institute's law enforcement needs for the Pueblo campus and determine the most cost-effective way to meet those needs. As part of their evaluation, the Department and the Institute should work with Pueblo City and County law enforcement officials to determine the extent to which local law enforcement could meet the Institute's needs. If the Department and the Institute determine that working with local law enforcement is a feasible alternative, the Department and Institute should develop interagency agreements with Pueblo City and County law enforcement officials to specify each agency's responsibilities. After completing the evaluation, the Department and the Institute should reclassify or eliminate any unnecessary law enforcement positions and ensure that any remaining positions are used for law enforcement, not administrative, functions.

If the Institute decides to maintain a P.O.S.T.-certified police force, the Institute should work with the Department to ensure the roles and responsibilities of the officers are consistent with statute. Current statute [Section 16-2.5-139, C.R.S.] states that police officers employed by the Institute are peace officers whose authority shall include the enforcement of all laws of the State of Colorado and who shall be P.O.S.T.-certified. However, as discussed above, the PDQs for these positions include administrative functions unrelated to law enforcement. Further, neither statute nor the Department's rules clearly establishes the jurisdiction of the Institute's police force. This lack of a clear statement of jurisdiction is of concern

and could cause confusion as the Institute's officers often work with other law enforcement agencies when investigating patient deaths and assaults and when leading investigations into patient escapes, as discussed in Chapter 2. Clarifying the purpose of the police force and how it should operate and interact with other law enforcement agencies in Colorado would ensure that the Institute uses its officers effectively and efficiently to enforce the law and promote safety.

Recommendation No. 6:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should ensure the efficient and effective use of resources for law enforcement at the Institute by:

- a. Reevaluating the Institute's law enforcement needs and determining the most cost-effective way to meet those needs. As part of this evaluation, the Department and the Institute should work with Pueblo City and County law enforcement officials to determine the extent to which local law enforcement could meet the Institute's law enforcement needs. If the Department and the Institute determine that working with local law enforcement is a feasible alternative, the Department and the Institute should develop interagency agreements with local law enforcement officials, as needed.
- b. Reclassifying or eliminating any unnecessary law enforcement positions at the Institute and ensuring that any remaining P.O.S.T.-certified positions are used for law enforcement rather than administrative functions.
- c. Clarifying the purpose and jurisdiction of the Institute's police force in statute or Department rule.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

- a. Agree. Implementation date: October 2010.

The Institute will evaluate law enforcement needs, including the most cost-effective way to meet those needs. This evaluation will include discussions with local law enforcement officials to assess whether it is feasible and cost effective for local law enforcement to assume these duties and responsibilities. An interagency agreement would be developed if this evaluation results in such a partnership with a local law enforcement agency.

- b. Agree. Implementation date: October 2010.

The Institute will review the current duties and responsibilities of each of the P.O.S.T.-certified positions. Following this review, the Department will take appropriate action, which may include reclassifying positions, reassigning duties, or eliminating P.O.S.T.-certified positions. The implementation of Recommendation 6(a) may also result in changes in the P.O.S.T.-certified positions.

- c. Agree. Implementation date: July 2011.

Following the evaluation conducted pursuant to Recommendation 6(a), the Department will review the need to revise statute or create Department rules to clarify the roles and responsibilities of the Institute's police force and P.O.S.T.-certified officers. If the Department and the Governor's Office agree statutory change is required, legislation would be developed for potential sponsorship and introduction during the 2011 Legislative Session.

Outside Employment

When employees within an organization have outside employment, it is important that the organization have sufficient controls in place to reduce the risk that the outside employment will conflict with the employees' primary duties and responsibilities. To address this risk a wide body of laws, state personnel rules, and state policies regulate outside employment for state employees. For example, statute [Section 24-50-117, C.R.S.] prohibits state employees from engaging in outside employment or other activities that create a conflict of interest with their duties as state employees. In addition, state personnel rules provide that state employees may engage in outside employment only with advance written approval from the appointing authority. Further, both the employee and employer are responsible for ensuring that no outside employment arrangement directly conflicts with the duties and responsibilities of the employee's state position.

Having sufficient controls in place with respect to outside employment is particularly important for entities such as the Institute, which provides direct care to people diagnosed with mental illnesses and has a significant portion of its employees involved in other jobs. According to data provided by the Colorado Department of Labor and Employment and the Colorado Secretary of State, 315 of the approximately 1,000 (about 32 percent) Institute employees had employment outside of the Institute during Fiscal Year 2009.

Both the Department and Institute have policies surrounding outside employment. These policies require employees to submit an outside employment and conflict-of-interest disclosure form to their supervisor that describes the nature of the employment, the employee's state work schedule, the proposed outside employment work schedule, and information on the circumstances surrounding the employment for management to use when determining whether to approve or deny the employment. According to Department policy, the supervisor should base his or her approval on whether the outside employment may interfere with an employee's job performance or pose a conflict with the interests of the State, including situations that create the appearance of a conflict. The policy states that a conflict of interest includes outside employment that *may* result in:

- Perceived preferential treatment to any person or company;
- Impedance of governmental efficiency or economy;
- Loss of independence or partiality;
- Disclosure or use of confidential information acquired through state employment;
- Reasonable inference that any of the above may occur or might have occurred;
- Use of state time, equipment, property, supplies, or confidential information for private use or non-state purposes; or
- Adverse effect on public confidence in the integrity of the State.

We reviewed Department of Labor and Employment wage data for all individuals employed at the Institute during Fiscal Year 2009 and Secretary of State data for one employee who owned a private business. As mentioned above we identified 315 employees who received wages outside of the Institute. We selected a sample of 12 of the 315 employees and compared their outside employment wage data between Fiscal Years 2008 and 2009 with Institute documentation. We found that 10 of the employees did not notify the Institute of their outside employment in accordance with Department and Institute policies. Specifically, we found:

- Of the 12 employees in our sample, seven had submitted outside employment and conflict-of-interest disclosure forms and accurately disclosed their outside employment. However, four employees did not submit their forms until more than one year after they had begun their outside employment. In addition, although one employee had submitted a disclosure form, the employee indicated on the form that the outside position should not be considered employment because it was an elected position. However, documentation from the employee's outside employer showed that the individual was an employee and had received a salary.

- The remaining five of the 12 employees in our sample did not disclose their outside employment to the Institute even though Department of Labor and Employment or Secretary of State data indicated that they had received compensation from another employer within the past few years. Three of these employees held outside employment as recently as June 2009; the other two employees held outside jobs in Calendar Year 2008. Institute officials reported to us that they were aware of one of these five employees' outside employment even though the employee did not submit the appropriate disclosure form.

In addition, we found that the outside employment of one employee in our sample would have constituted a conflict of interest according to the Department's policy. This employee had a business that provided catering services to the Institute during the hours the employee was working at his or her state job. Several of the Institute employees we interviewed stated that this individual received preferential treatment by the Institute with respect to this outside business relationship. During our audit the Institute ceased purchasing services from this employee's business. This employee was one of the five employees in our sample who had not disclosed their outside employment to the Institute.

It is important that the Institute review employees' outside employment to ensure that the employment does not create a conflict of interest or interfere with the employees' ability to perform their state duties, as required by statute, state personnel rules, and Department and Institute policies. Institute employees work in a high-stress environment with volatile, high-needs patients. When an employee who works directly with patients has multiple jobs, the result can be long workdays and long work weeks, which in turn can lead to fatigue that diminishes the employee's ability to appropriately care for patients and remain alert for safety risks. Seven of the employees in our sample who had not properly disclosed their outside employment spend a significant amount of their time working directly with Institute patients. Three of these employees are registered nurses, two are psychologists, one is a health care technician, and one is a clinical safety security officer. The nondisclosure of outside employment by these employees raises concerns about the Institute's ability to ensure that its employees are providing the best patient care possible.

The Institute should have sufficient mechanisms in place to identify employees who have outside employment and to determine whether that outside employment is in conflict with the employee's state duties and with the State's interests. According to officials, the Institute asked all employees to submit an outside employment and disclosure form in September and October 2007. Many of the forms we reviewed were from those dates. However, the Institute did not have a process for consistently monitoring employees' outside employment and conflicts of interest prior to or after those dates. In May 2009 the Institute revised its

outside employment and conflict of interest policy when the Institute identified fraudulent activity related to an employee's outside employment. The new policy specifies that employees must disclose conflicts of interest and that a request for outside employment may be denied if the Institute determines that the outside position will interfere with the quality of hospital services. However, the new policy does not establish a standard process for ensuring that employees submit employment disclosure forms, nor does the policy specify how supervisors are to determine when to approve or deny a request.

The Institute should develop a process for routinely notifying employees of their responsibility to submit an outside employment and conflict-of-interest disclosure statement. A best practice implemented by other state agencies is to conduct the disclosure process annually. This statement should require the disclosure of any outside employment or activities that could interfere with the employee's state duties or potentially conflict with the State's interests. The statement should also certify that the employee is aware of and in compliance with applicable statutes, state personnel rules, and Department and the Institute policies related to outside employment and conflicts-of-interest. Finally, the Institute should develop guidelines for supervisors to use when reviewing outside employment requests to aid the supervisors in determining whether to approve the outside employment.

Recommendation No. 7:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should ensure that Institute employees appropriately request approval for outside employment and report activities that could be considered a conflict of interest by:

- a. Developing a process for routinely notifying employees of their responsibility to submit an outside employment and conflict-of-interest disclosure statement. This statement should require employees to request approval for outside employment and disclose activities in order for management to determine if they interfere with employees' state duties or conflict with the State's interests. The statement should also certify that employees are aware of and in compliance with applicable statutes, state personnel rules, and policies.
- b. Developing guidelines for supervisors to use when reviewing outside employment requests to aid in determining whether to approve or deny the outside employment request.

Department of Human Resources and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: May 2010.

- a. The Department will develop a process for routinely notifying all employees of their responsibility to submit an outside employment and conflict of interest disclosure statement. The Department's process will require that employees certify that they are aware of and in compliance with applicable statutes, personnel rules, and policies. The Department already requires that all employees submit outside employment and conflict of interest statements when requesting approval of new or modified outside employment situations.
- b. The Department will develop guidelines for supervisors to use when reviewing outside employment requests to aid in determining whether the outside employment should be approved or denied.

Contract Management

Since 1982 the Department has had an interagency agreement, or contract, with the University of Colorado at Denver Health Sciences Center (University) to provide physician and other health care professional services to the Mental Health Institutes at Pueblo and Fort Logan. This arrangement is authorized by statute [Section 27-13-103, C.R.S.] and, according to the Department, arose when the Institutes were unable to recruit a sufficient number of experienced psychiatric and forensic physicians at competitive salaries through the State's personnel system. Under the contract, the University agrees to provide to the Institutes physicians and other medical professionals who are in non-tenure-track faculty positions with the University. In turn, the Department pays the University for the physicians' salaries, benefits, and malpractice liability insurance, as well as an administrative fee of 8.1 percent. In Fiscal Year 2009 the Department paid the University a total of about \$11.6 million to provide 64 contract physicians (47 at Pueblo and 17 at Fort Logan), as well as on-call physician services, such as forensic evaluations and psychiatric consultations.

We reviewed the Department's procedures for contracting with the University and monitoring the services provided by contract physicians. We identified deficiencies in the contract and in the Department's oversight of the contract that indicate a lack of accountability for state funds and services. Specifically, we

identified two areas where the Department lacks fundamental contract management controls, as described below.

Lack of Clarity in the Contract

According to State Fiscal Rules, all state contracts must include a statement of work. In addition, the Colorado Contract Procedures and Management Manual (Contract Procedures Manual) issued by the State Controller's Office recommends that state agencies establish enforceable contracts that include a precise scope of work and clearly define the way in which compensation will be exchanged for services. However, the scope of work in the Department's contract with the University does not clearly define the services to be provided by the contract physicians and other medical professionals. According to the contract, the contract physicians and other medical professionals shall provide professional services to the State, including team physician duties or other medical duties in accordance with job descriptions that the University shall make available to the Department. We found, however, that the University maintains only one general job description that applies to all 64 contract physicians who are included in the contract. This job description does not define the services to be provided; it merely states that contractors must "work 40 hours per week," "provide patient care services," and "may be on-call."

In addition, although the Department has moved several of the contract physicians into high-level management positions at the Institute, the Department has not amended the contract to address the additional responsibilities associated with these positions. Currently the Institute's Superintendent, Chief of Medicine, Chief of Medical Staff, and Chief Psychiatrist positions are all filled by contract physicians. Some of these contract physicians are responsible for hiring, evaluating, disciplining, and terminating classified state employees within the state personnel system. However, the Department's contract with the University does not address the individuals' responsibilities to perform these management functions. According to the Department, the Institute's Superintendent reports to a classified employee within the Department, which provides for some level of oversight. Nevertheless, without specific contract language that clearly defines contract physicians' authority and responsibilities, the Department lacks fundamental controls to hold these individuals accountable for the work they are to perform.

Finally, the contract does not clearly define the services the University shall provide in return for the annual 8.1 percent administrative fee it charges the Department. In Fiscal Year 2009 the administrative fee totaled \$872,000. According to the contract, the administrative fee is intended to reimburse the University for the administrative costs it incurs in fulfilling its contract

obligations, including recruitment costs and the fee charged by the University's fiscal agent that manages physicians' salary and benefit payments. However, the contract does not include the basis for the 8.1 percent fee, information on the University's administrative costs, or the specific services that the University provides the Department in return for the fee. It is important that contracts specify the services being purchased and justify that the cost of services is fair and reasonable.

Lack of Contract Monitoring and Performance Measures

Statute [Section 24-103.5-101, C.R.S.] and State Fiscal Rules now require all personal services contracts over \$100,000 to include performance measures and monitoring requirements that specify how the governmental body will evaluate the contractor's performance, such as through progress reports, inspections, and reviews of performance data, to ensure that the contract objectives and obligations are met. According to the Contract Procedures Manual, state agencies should assign an individual to monitor the contractor's progress and ensure that the contractor's services are meeting contract requirements and performance standards.

We found that the Department has not taken an active role in monitoring the performance of its contract physicians. Instead, the Department has relied upon the contract physicians to monitor and evaluate each other. The contract requires the Institute Superintendent to monitor the contract physicians' performance. However, since the current Superintendent is included in the agreement as one of the contract physicians, this means that he is responsible for monitoring the performance of his fellow contractors. Additionally, the Department has assigned the contract physician who is currently serving as the Institute's Chief of Medicine to monitor the interagency agreement on the Department's behalf. This individual completes annual performance evaluations for the other contract physicians and makes recommendations to the University for their pay increases. According to Department officials, the Chief of Medicine is responsible for reviewing the performance of other contract physicians because only a physician is qualified to review the performance of another physician. Although this argument may have merit, without independent Departmental monitoring the Department does not know if the evaluations are actually completed, nor is it aware of concerns raised in the evaluations. We reviewed University files for two contract physicians who have worked at the Institute since 1993 and 2000, respectively. We found that neither the University nor the Department could provide performance evaluations for the first individual for Calendar Years 2000 through 2005 or for the second individual for Calendar Years 2005 and 2008.

In addition to the Department's lack of monitoring, we also found that the contract does not include sufficient performance measures with which to assess the quality of the services provided by the contract physicians and other medical professionals. For example, there is no measure to assess whether the physician provides satisfactory services. This could include an assessment of the ways in which the physician interacts with patients, including the assessments, treatments, and procedures they provide; and a review of outcome measures, such as a description of changes in patients' health status. Without written performance measures and expectations for contractors, the Department has no criteria upon which to evaluate contract physician performance or hold contractors accountable for providing quality services in return for the compensation they receive.

The Department should amend its contract with the University to ensure that it complies with state contracting requirements and provides accountability for the services rendered. Specifically, the Department should ensure that the contract clearly defines the roles, responsibilities, and authority of the contract physicians and other medical professionals, especially those functioning in key management positions at the Institute, such as the Superintendent position. The contract should also include sufficient performance measures and expectations for the contract physicians and other medical professionals for the Department to hold these individuals accountable for the quality of services provided. Further, the contract should clearly define the services to be provided by the University in exchange for the administrative fee it charges. Finally, the Department should actively monitor the performance of physicians and other medical professionals included in the contract and ensure that any pay increases are justified and appropriate. The Department's monitoring efforts should include designating a Department employee as contract monitor and having this individual work with the Chief of Medicine during the performance evaluation process for contract physicians and other medical professionals to ensure that evaluations are completed for all contractors.

Recommendation No. 8:

The Department of Human Services should ensure accountability for physician and other professional medical services provided through the Department's contract with the University of Colorado at Denver Health Sciences Center by:

- a. Clearly defining in the contract: (1) the roles, responsibilities, and authority of all individuals included in the contract, especially those functioning in key management positions at the Institute; (2) performance measures and expectations for the contract physicians and other medical

professionals; and (3) the services to be provided by the University in exchange for the administrative fee.

- b. Actively monitoring the services provided under the contract, which should include designating a Department employee as contract monitor and having this individual work with the Chief of Medicine to ensure that performance evaluations are completed for all of the contract physicians and other medical professionals.

Department of Human Services Response:

Agree. Implementation date: July 2010.

- a. The Department will revise its interagency agreement with the University of Colorado at Denver Health Sciences Center to: (1) clearly define the roles, responsibilities, and authority of each provider included in the agreement, including those in management positions; (2) include the basis for periodically evaluating the performance of each provider; and (3) delineate the administrative costs and services incurred by the University in exchange for its administrative fee.
- b. The Mental Health Institute Division will monitor the services provided under the contract. The Division Director will serve as the contract monitor and will work with the Pueblo Mental Health Institute Superintendent and Fort Logan Mental Health Institute Director to ensure that performance evaluations are completed for each provider included in the interagency agreement.

Employee Timekeeping and Leave

As mentioned previously, the Institute has almost 1,000 employees who work in a variety of functional areas, such as health care, law enforcement, and administration. About 770 (77 percent) Institute employees are classified as “nonexempt” under the federal Fair Labor Standards Act (FLSA) and are thus subject to federal and state minimum wage and overtime requirements. The FLSA requires that nonexempt employees be paid overtime pay at a rate of not less than one and one-half times their regular pay after working 40 hours in a workweek. Alternatively, these employees may receive compensatory time, again at a rate of one and one-half times the number of hours worked over 40 hours in a workweek. According to the FLSA, state personnel rules, and Department

policies, the Institute is responsible for managing its employees' time through daily operational controls. These controls include clear timekeeping policies and procedures, supervisory review and approval of time and leave, and employee accountability for time worked.

The Institute tracks the amount of time each nonexempt employee works using an automated card-based time-clock system. Nonexempt employees are required to swipe identification cards at a time-clock at the beginning and end of their work shift. The time-clock system tracks the hours worked and leave accrued and used for each employee. According to Department policy, all overtime must be approved in advance by employees' supervisors, and employees earn compensatory time in lieu of monetary payment for overtime hours worked. Any compensatory time in excess of 60 hours and not taken within 120 days from the month in which it was earned must be paid to the employee in the next regular pay period. Department policy requires supervisors to manage work schedules to minimize the amount of employee overtime and the amount of compensatory time that must be paid. All time records must be approved and certified by both the employee and the supervisor.

We reviewed one to two months of timekeeping and leave records from December 2008 through March 2009 for a sample of 14 nonexempt Institute employees. Overall, we found lax compliance with timekeeping and leave requirements. Specifically, we identified problems with the timekeeping and leave records for 12 (86 percent) of the employees in our sample:

- **Lack of prior approval for overtime.** For six of the nine employees in our sample who earned compensatory time during the months we reviewed, no documentation existed to show that the overtime had been approved in advance by the employees' supervisors. In total, these six employees worked 22 overtime hours during the months reviewed and earned 33 hours of compensatory time.
- **Incomplete leave requests.** The leave request forms for six of the 12 employees in our sample who took leave in the months we reviewed had been approved by the employees' supervisors even though the forms did not clearly specify the type or amount of leave to be taken. Employees are required to submit a complete leave request form to their supervisor for approval prior to taking leave. The form requires employees to specify the type of leave (e.g., vacation, medical, other) they plan to take, as well as the associated number of hours of each type of leave that will be used. Supervisors are to use this information to ensure that employees use compensatory time within 120 days after it was earned and to minimize the amount of compensatory time paid out when employees exceed the 60-hour limit.

- **Questionable time reporting.** We identified instances that demonstrate the potential for employees to abuse overtime and compensatory time policies. For example, the monthly time records for 9 of the 14 employees in our sample showed the employees had repeatedly clocked in or out from 8 to 29 minutes before or after their shift during the months we reviewed. When this happens, employees can earn compensatory time at time and a half if they work more than 40 hours in a workweek. In addition, the records for six employees showed that they did not clock in or out on a total of 19 occasions because they forgot to do so. When an employee does not clock in or out, the employee's work hours are not recorded in the timekeeping system, and the employee must submit a missed card swipe form to their supervisor indicating the amount of hours worked. Two of the six employees reported working additional hours and earned a total of 17.25 compensatory hours on days they did not clock in or out. Without an independent time-clock record of the hours an employee actually worked those days, the supervisors cannot verify the hours reported. According to Department policy, all time worked is recorded in 15-minute increments and rounded to the nearest quarter hour. Thus, if an employee clocks in at least eight minutes early or clocks out at least eight minutes late, he or she receives 15 minutes of overtime if the employee had worked more than 40 hours during the week; at time and a half the employee actually receives 23 minutes of compensatory time. Although we could not determine if the employees' actions in the instances described above were inappropriate, these examples show the potential for abuse of the Department's overtime and compensatory time policies.

The Institute's lack of adequate controls over timekeeping and leave for nonexempt employees has resulted in a significant accrual of compensatory time by a large number of employees. In Fiscal Year 2009 about 600 Institute employees earned a total of almost 17,000 hours of compensatory time. The hours earned per employee ranged from less than one hour to about 164 hours during the year. The Institute could not provide us with the amount of compensatory time that was paid out to employees during the year. The consistent earning and use of a significant amount of compensatory time can negatively affect an organization. As employees use their compensatory time, openings are created in the staffing schedule that must be filled by other employees. Often the other employees must work overtime to cover their own shift plus the opening created by the individual using compensatory time. As a result, these other employees also earn compensatory time. This process can create a never-ending cycle that results in staffing shortages for an organization and can indicate a lack of monitoring of overtime by Institute management, abusive employee timekeeping practices, or both.

Many of the problems we found related to noncompliance with timekeeping, overtime, and leave requirements are due to a lack of controls in two areas. First, Department and Institute policies and procedures are inadequate. For example, although the Department requires overtime to be approved in advance, there is no requirement that the approval be in writing. Without documentation, the Department cannot monitor whether supervisors have actually approved employees' overtime. Further, neither Department nor Institute policies limit the amount of overtime an employee can work. We identified one nurse in our sample who worked 12 double shifts, or 16-hour workdays, as well as three 15-hour workdays between December 1, 2008 and January 2, 2009. In one week alone, the employee worked three consecutive double shifts. This employee worked a total of about 375 hours in the five-week period, almost twice as many hours as would be worked in a 40-hour work week. Although the overtime had been approved in advance, the excessive number of hours worked by this individual almost certainly had a negative effect on the individual's performance and increased the risk of an injury to the employee or a patient. When staff work too many hours, the resulting fatigue not only may impair their ability to actively engage and monitor patients, but also may increase the staff's susceptibility to illness or workplace injury. In addition, Institute policies do not clearly assign responsibility for determining whether annual leave or compensatory time should be charged when an employee takes leave. Several of the employees and supervisors we interviewed had conflicting opinions regarding this leave determination.

Second, the Institute has not implemented sufficient mechanisms for supervisory monitoring of employees' overtime and leave balances. As mentioned previously, supervisors are responsible for reviewing and approving employee time records. However, more than two-thirds (111 of 160) of the Institute's supervisors do not have the necessary license to access employee time records in the automated time-clock system. Instead, about one to two weeks after the end of the pay period, these supervisors receive printed reports to review and approve. As a result, most supervisors cannot actively or timely monitor employees' time records to identify excessive work hours, unapproved overtime, or repeated tardiness. Currently the Department has more than 300 unused system licenses available that the Institute could use at no additional license cost. These licenses would allow supervisors read-only access to the time-clock system for monitoring employee time, leave, and time-clock practices.

Due to the nature of the services provided by the Institute and the population served, it is important that the Institute have sufficient mechanisms in place to adequately monitor and manage employee timekeeping and leave. The Department and the Institute should review and clarify policies and procedures for monitoring and approving nonexempt employees' overtime, leave, and time-clock practices and should communicate these revised policies and procedures to all

staff through training and written guidance. As part of this process, the Department and the Institute should review recent policies and procedures established by the Mental Health Institute at Fort Logan. In response to a 2008 Departmental internal audit, Fort Logan developed a set of timekeeping policies and procedures that include some best practices. For example, Fort Logan policies specify employee responsibilities regarding clocking in and out, providing notice of lateness, and documenting timekeeping. The policies also provide criteria for identifying timekeeping abuses that might warrant disciplinary action, such as patterns of excessive lateness, absenteeism, and missed time-clock punches, and include a procedure for holding supervisors and employees accountable for compliance. Lastly, the Department and the Institute should determine how to best allocate timekeeping system licenses to ensure that supervisors have timely access to the information they need to effectively monitor their staff.

Recommendation No. 9:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should improve nonexempt employees' compliance with timekeeping and leave requirements by:

- a. Reviewing and clarifying, as needed, policies and procedures for monitoring and approving overtime, leave, and time-clock practices. These policies and procedures should address the need for prior approval for overtime, limits on the amount of overtime allowed, clocking in and out, and leave documentation.
- b. Communicating clear policies to all Institute staff and providing training to all staff on their responsibilities. In particular, supervisors' responsibilities should be emphasized.
- c. Determining how to best allocate read-only timekeeping system licenses to Institute supervisors to enable them to perform timely monitoring of employees' time and leave.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: August 2010.

- a. The Department will review and clarify, where needed, policies and procedures for monitoring and approving overtime, leave and time-

clock practices. These policies and practices will address the need for prior approval of overtime, limits on the amount of overtime allowed, where and when employees should clock in and out, and leave documentation.

- b. The Department will communicate clear policies to all Institute staff and provide training to all levels of staff, particularly supervisors, regarding their responsibilities in the areas of leave administration, overtime practices, and timekeeping practices.
- c. The Department will consider the feasibility of allocating read-only timekeeping system licenses to Institute supervisors to enable them to perform real-time monitoring of employees' time and leave.

Staff Scheduling

The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) and the federal Centers for Medicare and Medicaid Services (CMS) require accredited hospitals to maintain appropriate staffing levels at all times. As a residential health care facility, the Institute operates 365 days a year, 24 hours per day. Similar to other 24-hour facilities, the Institute has implemented three staffing shifts to ensure sufficient coverage day and night. The number and type of staff needed in a particular unit varies depending on the type of unit, the number and type of patients in the unit, and the shift. For example, the Institute's minimum staffing requirements call for at least eight staff persons to be on duty in the maximum security forensic units during the day and evening shifts, with no more than 18 patients per unit. The eight staff include five licensed nurses and three unlicensed staff. Comparatively, in a minimum security forensic unit staffing requirements call for a minimum of six staff during the day and evening shifts, including four licensed nurses and two unlicensed staff, with as many as 50 patients. However, the number of staff required for each unit can change depending on patient needs. For example, if a unit has a patient on suicide watch, one staff person per shift must be assigned to watch the patient continuously. Currently the Institute has 20 different units. To meet the Institute's minimum staffing requirements, these units must have a total of 75 to about 120 staff on duty at all times, depending on the shift and patient needs. Accordingly, every day more than 300 of the Institute's approximately 650 direct care employees on staff must be on duty.

The Institute's antiquated and inefficient scheduling system for direct care employees impairs effective management of Institute resources. The Institute's central staffing office, nursing office, and lead nurses on each unit work together

to schedule all direct care employees for the Institute's 20 units. When making staffing decisions, these groups must consider a variety of factors, including the minimum staffing requirements for each unit; the acuity or severity of patients' needs on the unit; the number of employees out on sick, annual, or compensatory leave; the number of employees scheduled for meetings or trainings; and the amount of overtime employees have already worked, as discussed in the previous recommendation. Despite the number and complexity of factors that influence staffing decisions, the Institute uses a manual, paper-based scheduling system. The central staffing office uses paper reports from each patient care unit to calculate the number of staff needed on a shift-by-shift basis and reassign staff as needed. The staffing office also uses a paper schedule to document the staffing mix and changes to work assignments for each shift on each unit daily. Each unit's staffing schedule lists the staff assigned to work each shift for each day of a given week, shows a manual count of the staff who actually worked on each shift, and may include the lead nurses' daily notations regarding staff absences, leave, overtime, reassignments, meetings, and training. The staffing office also monitors whether the Institute is meeting target staffing levels and has an appropriate mix of staff expertise, competence, discipline, and licensure for each shift.

A manual, paper-based scheduling system is an inefficient mechanism for managing approximately 650 direct care staff and does not provide the information that Department and Institute management need to effectively oversee staffing needs. Department and Institute officials informed us that it is difficult to ensure adequate staffing on hospital units and to determine the appropriate staff-to-patient ratio at the Institute using a paper-based scheduling system. As part of our review of timekeeping records, we analyzed the paper staffing schedules for the nonexempt employees in our timekeeping sample. We found that the paper schedules are not always updated when staffing changes occur, thereby limiting supervisors' ability to adequately monitor employee time, as discussed in Recommendation No. 9, and confirm that staff actually worked the hours shown in the timekeeping system. For three of the 14 employees, the paper schedules did not reconcile to the timesheets generated from the time-clock system, so the hours actually worked could not be verified. Also, without accurate, updated paper schedules, the staffing office cannot ensure that the Institute meets target staffing levels and has an appropriate mix of staff on the units.

It is important that the Institute have sufficient mechanisms in place to manage the scheduling process, ensure fiscal responsibility and safety at the Institute, and enable analyses that inform high-level decisions. We surveyed other state agencies and facilities that provide 24-hour care or services (e.g., nursing homes, developmentally disabled facilities, Division of Youth Corrections facilities, and Department of Corrections facilities) as well as other states' mental health hospitals that are comparable to the Institute. We found that some of the State's

youth corrections facilities and one of Florida's forensic mental health hospitals utilize electronic scheduling programs. For example, some youth corrections facilities use a software program to set staffing requirements, schedule employees, and track available personnel and the number of hours scheduled per employee. The retail cost of this scheduling software is about \$500. The Department and the Institute should evaluate the costs and benefits of implementing an automated staff scheduling system that would allow Institute management to create and modify staffing schedules, monitor staffing levels, and identify staffing needs. When conducting this evaluation, the Department should also consider whether an automated scheduling system would benefit the Department's other 24-hour facilities that use paper-based scheduling systems.

Recommendation No. 10:

The Department of Human Services and the Colorado Mental Health Institute at Pueblo should evaluate the costs and benefits of implementing an automated staff scheduling system for the Institute and for other 24-hour facilities under the Department's oversight. The Department should develop implementation plans as appropriate.

Department of Human Services and Colorado Mental Health Institute at Pueblo Response:

Agree. Implementation date: September 2010.

The Department agrees with the recommendation and will convene a workgroup to explore the cost-benefit and feasibility of implementing an automated scheduling system. The Department will develop an implementation plan as appropriate.

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