Governor's Special Master Oregon State Hospital Excellence

Final Report

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Hon. James R. Hargreaves
Governor's Special Master

Governor's Special Master Final Report
Oregon State Hospital Transformation

Dear Governor Kulongoski

I have monitored and overseen the transformation project at the Oregon State Hospital for one year. It has probably been the most interesting and challenging year of my life.

During the past year I have talked with many people, explored many issues that directly or indirectly impact this project, made recommendations as I thought appropriate, and assisted the hospital in solving specific problems. Also, at your request I have drafted suggested legislation to deal with some of the statutory issues that are relevant to the use and operation of the hospital. What follows is my assessment of the current status of various aspects of the transformation project together with my recommendations as to what further actions should be taken. For convenience and ease of understanding I have broken this report down into what I mostly think of as functional categories.

1. In the Beginning

I came to this transformation project approximately a year after it was begun. From extensive conversations with those involved in the beginning and a rather exhaustive review of documents generated early on, I quickly came to the conclusion that the change process within the hospital had gotten started backwards. Apparently feeling the pressure from the inspection by the United States Department of Justice (USDOJ), the hospital started "doing" rather than planning. The failure to plan before doing has continued to plague this project ever sense. It is ironic to me that from what I have been able to determine, that an ongoing problem at the hospital over the years has been planning paralysis; the inability to move from the planning stage to execution. In this case the hospital has gone to the other extreme.

Even as I leave my role as Special Master a year later, and despite my best efforts, within the hospital management there appears to be little understanding of the need for or commitment to planning and structuring this project. The result has been the proliferation of projects being undertaken with no overall goals or objectives and no organization that assures that these projects all work together to move the hospital to its goal of being a first class treatment facility for the mentally ill.

Despite the failure to plan before doing, there are in fact some notable accomplishments that have been achieved. These will be noted in the particular sections set out below.

1. Bricks and Mortar

The planning for the construction of the new Salem facility is on time and is being very well managed. Few people understand or appreciate just how hard many people have worked to meet community expectations, create the design and carry out the programming for this facility. The challenge at this juncture is attempting to finalize the size and configuration of the building to fit the budgeted cost while realizing the goal of having a first class treatment facility. It appears to me that the original cost and size projections were somewhat unrealistic and will have to be modified to some degree to produce a facility that will allow for truly first class treatment delivery.

Many more challenges will be encountered as the project moves into the construction stage; however I have great confidence that this aspect of the transformation will be a success.

The biggest problem with the construction of the new hospital is that there is a substantial possibility that on the day it opens it will be completely filled and will prove to be too small to meet the existing need. If this does in fact occur, it will be driven by the lack of community beds for those who are ready to leave the hospital as well as the lack of treatment available in communities to reduce the need to send people to the hospital.

2. Culture

Every organization develops its own culture; how it sees and responds to its world. The hospital is no different. Successfully changing the culture of this organization is the single most important factor in achieving the goal of establishing the Oregon State Hospital as a first rate hospital for the mentally ill.

For many decades the hospital has been under-funded, under-staffed, over-populated, under-managed, and housed in inadequate facilities. It is no wonder that over time it has become a highly calcified organization lacking in incentive to change and burdened by learned helplessness. It has been clear from working with a variety of people in the hospital that many problems have been well known and have existed for years with little or no attempt to solve them. There appears to never have been a culture in the organization that was supportive of people taking responsibility to do problem solving at the level where the problem is occurring.

Another aspect of the hospital culture that deserves mentioning is what I might call the "ward" view as opposed to a "hospital" view. Largely, I believe, because of the original design of the hospital, staff and patients alike have tended to see each ward as a separate hospital and have tended to operate from that perspective. This has made the management of the hospital as an integrated whole a very difficult task. The centralized model for delivering treatment in the new facility should eliminate the "ward" view and help facilitate the shift to a "hospital" view. This shift should enable the hospital as an organization to become much better managed and operated. This will be an extremely important transition and one that will be quite difficult for many in the hospital to make.

It also appears that the rather pervasive view of the hospital by staff has been to see it as a long term care facility instead of viewing it as an intensive treatment facility. These two different views produce two very different approaches to dealing with patients. The current view seems to be characterized by a general belief that most patients are going to be hospitalized for a long time and that there is no great urgency about moving them through treatment as rapidly as possible. The culture of the hospital needs to be one of viewing itself as an intensive treatment facility that is part of a treatment continuum. There needs to be an attitude by all management and staff and instilled in patients, that the hospital's role is to complete their portion of the treatment of the patient as quickly as possible, consistent with best medical practice, so that the patient can move on to the next stage of recovery and return to the community as rapidly as possible.

These and many more hospital culture issues need to be identified, explored and new cultural norms created as needed to see that the whole atmosphere of the hospital promotes the best possible treatment of patients in the least time necessary. The hospital needs to develop and implement a comprehensive, long term change plan to accomplish this cultural change. This issue of culture is one that will be a large component in a Request for Proposal (RFP) that is currently being drafted to bring professional consulting services to the hospital transformation project.

3. Staffing

There are several challenges in this arena.

It is very unfortunate that hiring a new Chief Medical Officer continues to be a goal, not a reality a year after I assumed this role. Finding someone who wants to be part of a difficult but exciting transformation project is a "must". A key role for this person will be the setting of excellence standards and expectations for medical staff and evaluating performance to see that patients are receiving the best possible care. This is not a position for a person who just wants to do "business as usual." The position will need to be filled by someone who is excited about the prospect of bringing about institutional change.

Some positive steps have been taken to recruit a high quality person into this position. The salary for the position has been established at a competitive level. Options regarding connecting this position to the Oregon Health Sciences University in some adjunct way to perhaps enhance the position are being explored. However, the actual recruiting effort over the last year has been, in my opinion, woefully inadequate. Advertising of the position has been absolutely minimal. Active searching for potential candidates either at medical schools or other mental health treatments facilities across the country has been practically none-existent. Despite the inadequate recruitment efforts, one candidate of high potential was extensively interviewed but eventually declined the position.

At the direction of Dr. Goldberg, Director of DHS, a new, more intensive imitative has recently been undertaken to fill this position. It is too early to know if this will prove adequate or not. This is an issue that needs to be given the highest priority and be vigorously perused…and monitored.

In addition to hiring a new Chief Medical Officer, many hundreds of new staff positions will have to be created and filled over the next two years to ensure that the hospital is fully staffed when it opens. Filling the positions already authorized by the legislature has gone pretty well and has only been slowed by the need to keep hiring in line with budget.

Since it is well known that there are local and nation-wide shortages in a number of job categories a multifaceted, aggressive and creative strategy will have to be developed and carried out to be able to fill the numbers and types of positions necessary with high quality people. Such a strategy does not presently exist and needs to be developed and put into play immediately.

Given the large number of people who will have to be hired over a relatively short period of time it is highly advisable that a comprehensive evaluation of the hiring processes employed by Human Resources be undertaken to see if changes need to be made to accommodate this unusual volume of hiring. Both streamlined hiring processes and adequate staff to carry out the hiring need to be ensured. The streamlining of nurse hiring has recently taken place with a significant reduction in time needed for this process.

There are some serious and related issues regarding unions that have a direct impact on hiring and staff assignments that need to be addressed. The current bargaining agreement gives the unions a substantial role in deciding who fills what position among staff. The wording and terms of the agreement make it difficult for the hospital to hire in an expeditious manner and to see to it that staff serves in positions where their skills and experience are most needed. A letter of understanding has been signed with SEIU to exclude some current hiring from the usual union process. While this is very good, it is only a Band-Aid on a small piece of the problem. There needs to be a long term resolution of this issue.

4. Staff Training

This is going to be another very big issue as the staff grows rapidly. Just the logistics of training many hundreds of new staff will present a large challenge. Most new staff will not have any experience working in a secure psychiatric hospital setting. Existing staff will have challenges in learning to use the new Behavioral Health Integration Project (B-HIP) information system as this will be essentially the only way that records will be kept in the future. There has already been pushback from some who say they will not do their charting and notes on computers. A comprehensive and well directed training plan will be essential. There is currently underway a plan to shorten the usual two-week orientation for new employees to a one-week time frame. Again, this may be good, but will certainly only addresses a small piece of the issue. I believe it would be wise to look at securing the assistance of a professional training company to help develop and execute the training plan. The planning for this cannot begin too soon.

5. Business Process

It has been my observation (strongly supported by the literature in the field) that few if any organizations of any size are capable of successfully carrying out the level of self-analysis necessary to be able to identify, develop and implement business process changes that are necessary to substantially change both the culture of the organization and its essential business processes.

From my earliest time in this position it has seemed ironic to me that millions of dollars were being spent on experts in architecture, engineering and construction to design and build a new physical structure for the hospital but there was no plan to bring in experts to help build a new business structure and culture; the very heart of the operation of the hospital. This vital work of building a new business structure and culture for the organization was apparently expected to be carried out entirely by hospital staff who have no expertise in the disciplines necessary to make this process successful. What is more, the people at the hospital were apparently expected to do this while carrying on their usual daily work assignments. I saw this as a sure recipe for failure.

In my opinion what has been needed from the beginning and what continues to be needed, is the assistance and guidance of a consulting firm specializing in business transformation to do a comprehensive, critical analysis of the business structures and functioning of the organization. From such an analysis an integrated approach to change can be developed and carried out with a reasonable degree of confidence that a stronger, better functioning organization will emerge.

Unfortunately, it is only now, as my tenure in this positions ends that an RFP is being drafted to hire a consulting firm for this purpose. As a part of this professional assistance the hospital will have the benefit of the services of experts in project management, business process change, culture change and change management. All of these disciplines are vital to the success of transformation project.

A strong management structure on both the part of the consulting firm and the hospital will be a critical factor in making the consulting project successful. The hospital will need a strong, experienced project manager and a project governance structure to be able to effectively work with the consultants who are hired. The hospital has neither at this time.

All of the changes contemplated to occur at the hospital over the next couple of years will have a tremendous impact on the way everyone in the organization does business and will need to think about doing business. This magnitude of change must be managed. It is essential to not leave people to flounder through all of this change alone. There are people in

the business world who are expert in managing change and leading organizations through the process. Experts from the consulting firm will work closely with the hospital project manager and hospital management to help manage the impact of changes on hospital staff.

To illustrate the importance of the role of a change manager, it is necessary to understand the magnitude of the change that the staff and patients will be facing.

As mentioned earlier in this report, the hospital operates on a ward structure in which patients eat, sleep and get treatment all within the confines of a single, locked unit. Patients leave the ward for a few reasons but their life is the ward. This is generally the same for the staff. Also as mentioned before, each ward operates much like its own little hospital. This will no longer be the case in the new facility.

In the new hospital the whole ward structure will be gone. Wards will only be for sleeping. Both staff and patients will spend their days in treatment malls where patients will move from place to place for various treatment activities. Everyone's world will be very different. Social relations will be reshaped. Work activities will change. Old power and influence structures will be broken and have to be rebuilt within the new environment. All of both patient and staff time will have to be carefully scheduled and that schedule will need to be strictly followed. The magnitude of this change will have a substantial impact on staff and patients alike. If this whole process of change is not address with staff and patients before it occurs chaos is likely to occur.

One positive step which has been taken is that a Director of Strategic Planning has been hired. A number of new analysts have also been hired to assist the Director. This office has undertaken a number of useful projects and is now being actively sought out by staff to help solve additional problem.

6. Treatment

As indicated above, a whole new way of delivering patient treatment will be employed in the new hospital. The current treatment delivery mode is ward-based. Various treatment providers, such as psychiatrists, psychologists, social workers etc. are assigned to work with patients on a given ward. Most all of the treatment occurs on the ward. If a patient changes wards, virtually his/her whole treatment team changes.

The new treatment delivery mode will focus on delivering treatment off the wards and in various centralized spaces (treatment malls) within the hospital. This approach will allow for greater use of group treatment modalities with various groups moving through classes instead of various classes having to be taken to individual wards. This approach will provide for economies of scale in utilizing treatment providers, easily allow varied treatment approaches to be used with a minimum use of provider time as well as having beneficial impacts on patients through allowing them to mix, mingle and work with a wider range of people to more closely approximate life in the outside world.

The planning for this new approach to treatment has been underway for some time. This approach is currently in use at the hospital in Portland and will soon be utilized on the Salem campus in a limited way as soon as some patients can be moved from their current living units and those units remodeled to accommodate this form or treatment. The remodel of cottages on the hospital grounds is almost complete. These will be used to house patients who will begin treatment in the first treatment mall to open.

In addition to the change in the way that treatment will be delivered, another treatment change is taking place. A much stronger emphasis is being placed on individualizing

treatment to meet each patient's specific needs. This will involve a more rigorous process of evaluation when a patient enters the hospital and the development of a patient-specific treatment plan to ensure that all treatment is clearly directed toward moving the patient back into the community just as quickly as possible. A much stronger emphasis will also be placed on identifying a treatment "team" for each patient. This team will work under the direction of the psychiatrist assigned to the patient and will cooperate and coordinate their work with the patient to see that his/her specific treatment needs are being met.

Work on these treatment changes is under way and progressing, albeit more slowly than would be ideal. The assistance of consultants Drs. Jeffrey Geller and Kris McLoughlin has been critical to the progress made in the area of improved treatment for patients. Their continued participation in this work is essential to its success. I believe that it would be highly beneficial to the project if at least one of them were at the hospital on something approaching a fulltime basis.

7. Technology

It has been only in the last very few years that computers have come to the Oregon State Hospital. While computers have been introduced into the hospital, most recordkeeping and data collection is still done by hand or rather laboriously pulled out of standalone databases and transferred into spreadsheets. The B-HIP automated system will represent a gigantic step forward for the hospital. It would be essentially impossible to run the new hospital without the use of this advanced technology.

The implementation of the electronic hospital management system will allow access to information at all campuses of OSH, as well as Blue Mountain Recovery Center and the Junction City facility when it opens in 2013. The system will improve care for people receiving psychiatric treatment by:

- Tracking services, medications, lab results, dietary requirements, staffing resources and other data;
- Scheduling hundreds of patients and staff for daily activities within the proposed treatment mall milieu;
- Facilitating the successful transfer of patients to lower levels of care in the community by providing electronic records and discharge plans to the community providers;
- Facilitating clinical decisions in the placement of patients in lower levels of care by tracking the availability of treatment resources (e.g., availability of residential setting or other options);
- Giving patients improved access to their health records, to which all patients are entitled under the Health Insurance Portability and Accountability Act;

This aspect of the project is well managed and appears to be on track to meet its timelines for being up and running. Nevertheless, it will be a major challenge to select a commercial system, get it configured, do all of the staff training and get it in use in the current hospital facility within the stated time frame goal of one year prior to the opening of the new facility. Since the operation of this system will be key to the functioning of the new hospital this project needs to be watched closely and given what ever assistance may be necessary to make it successful.

8. Hospital Front Door

In reality, the hospital has two front doors; the civil commitment door and the criminal court door. In my role as Special Master I was asked to focus on the forensic, or criminal commitment population.

There are two situations within the criminal justice system that bring defendants to the hospital. One group comes because of issues around their ability understand the criminal proceeding and aid and assist in their own defense prior to or during trial. The other group comes because they have been found to have committed a crime but in addition were found not to be criminally responsible for their acts because they were acting under the influence of a mental disease of defect so either did not know that what they were doing was wrong or were not able to conform their conduct to the law. The hospital has no control over the number or timing of the arrival at the hospital of either group. That is solely within the control of the courts.

I chose to focus my attention first on the cohort of defendants who come to the hospital because they are unable to aid and assist because I saw this as the most fertile ground for making some important changes. Some changes have been put in place that should save the hospital considerable staff time. With the cooperation of judges, the hospital is receiving more information from the courts regarding the crimes defendants are charged with, computation of the maximum length of stay for defendants, and what governmental agency is to pay for certain evaluations. These issues have consumed a great deal of hospital staff time in the past that should have and now will be put to much better use.

In regard to the length of stay for defendants who come to the hospital to be treated so that they are competent to stand trial, I have written an analysis of the law pertaining to this issue and circulated it to judges, prosecutors and defense attorneys. This has sparked a serious discussion in the legal community that may considerably shorten the length of the commitment for many defendants coming to the hospital. This matter will most likely be the subject of one or more appeals to the Court of Appeals before the legal issues are finally determined. This will need to be monitored in the future to see if the desired impact is being achieved.

An ongoing effort is underway to obtain a ruling on the legality of municipal courts sending defendants to the hospital on fitness to proceed issues on minor municipal offenses. The volume of these cases is significant and the discontinuance of such admissions would have a beneficial impact on the shortage of beds at the hospital. It would also help reduce the "street sweeping" of mentally ill people whose conduct is more bothersome than criminal. Using the hospital to clean the streets of these people for a short period of time provides little if any benefit to the defendant and just postpones the day when municipalities have to come to grips with this as a community issue.

The problem with municipal courts is only one aspect of the whole larger issue of the appropriate use of the hospital facility. I was astounded when I came to this position and first sat down to review the hospital population and the underlying crimes that brought them to the hospital. The number of defendants in the hospital for minor felonies and misdemeanors was truly amazing to me. That so many judges had found so many minor criminals so dangerous that they had to be treated in such a high security facility raised all kinds of questions about the both the law and the decision making process at the trial court level. While I suspect there are a number of reasons in play that drive these kinds of decisions, time was not sufficient to explore this issue and see if some changes could be made.

One important consideration that I am sure is a driver for use of the hospital is the lack of other treatment facilities or treatment providers in the community. I have no doubt that if reasonable alternatives to the hospital were available judges and attorneys could be convinced to look to these local resources for many of these more minor cases. This belief

is supported by conversations I have had with judges, prosecutors and defense counsel in several counties.

9. Hospital Back Door

This is a very complex and wide ranging area for discussion, involving both patients at the hospital through civil commitment proceedings as well as those from the forensics side. While there are far more issues surrounding the release of forensic patients, there is one commonality between the two groups; lack of appropriate placements in the community for those determined to be ready for discharge from the hospital.

Since my direction was to focus on the forensic side of the hospital, I will limit my observations to that group. In addition, since the challenges relating to moving the patients who have come to the hospital on fitness to proceed issues out of the hospital are generally few, I will start there.

The main issue with this cohort is not so much getting them out of the hospital as keeping them out. The problem is that a significant number of defendants who reach the stage where they are capable of understanding and aiding in their defense, when returned to the jail in the county where they are pending trial decompensate while awaiting a court hearing. When the hearing is held, the defendant is once again not fit to proceed and has to be returned to the hospital. Courts and the hospital need to work together more closely to better coordinate the return of these defendants so that they can be moved quickly to court for further proceedings.

The challenges in moving patients who have been found guilty but insane out of the hospital and on to further treatment are several and multifaceted. Within the hospital there has been little or no use of individualized treatment plans focused on what a patient needs to achieve to be ready for discharge. Likewise, there has been no standardized testing to measure progress. The hospital has recently adopted a standard testing process to determine current dangerousness which is a major achievement. They have also been working on developing individualized treatment plans for all patients which is another big step forward.

Another issue internal to the hospital is not having a common understanding of when a patient has met all of the necessary conditions to be ready to move out of the hospital and into the next phase of treatment. This is a much larger issue than just success in treatment. Depending on the patient there may be a need for a birth certificate, social security card, a driver's license or ID card, food stamps, medical card, medication prescription, etc. The list is endless. There are also a myriad of different approvals to get and processes to go through within the hospital.

Recently the people in the strategic planning group worked with the hospital staff to draw up a comprehensive checklist of all of the steps that a patient must go through to truly be ready to leave the hospital. The list itself should be of great assistance. Using the list as a starting point for examining the release process and streamlining it as much as possible will be even more important.

Another issue that has an impact on the release of patients is the need to find appropriate housing in treatment facilities or other living accommodations in the community. Not only is there a serious lack of such facilities, the ones that do exist have to be matched with the needs of the patient. An open bed in a sex offender treatment facility does nothing to help an arsonist move out of the hospital.

Yet another factor in the placement process has been the willingness of the hospital to try to meet the desires of the patent when looking for a placement. Some patients don't want to be in one or another city. Some balk at using their social security or other funds to pay part of the cost of being in a particular facility. There may be any number of reasons expressed by the patient in opposition to a particular placement. While on the one hand it may be true that if the hospital can put a patient in a placement with which they feel comfortable the chance of success may be greater; but on the other hand this means that some patients stay in the hospital longer than necessary and not unlikely, a treatment bed remains empty longer. This issue needs to be explored further.

The other side of the placement coin is the willingness of the hospital to allow placement providers to decide if a particular patient is someone they wish to take into their program. There is a rather time consuming process for providers to interview patients to determine if they wish to work with that individual. Again, focusing on how this placement system can be streamlined would serve the hospital and patients well.

DHS has recently reconstituted a group dedicated to helping the hospital find placements for patients ready to leave the hospital. This additional assistance is already having a positive impact in speeding up the releases. This work needs to be continued as a critical part of the release process.

I want to expand a bit on the problem of lack of community beds for patients.

Of course, the one overarching issue in the release process is the action of the PSRB (Psychiatric Security Review Board). They determine which patients get out of the hospital, when these patients get out of the hospital and where they go when they do get out.

By statute the PSRB and the hospital apply essentially the same (and vague) criteria in determining whether a patient is appropriate for some form of release. Again by statute the overriding concern in making a release decision is the safety of the community. While both the hospital and the PSRB are applying the same test, the test is so vague that it is not unusual that the two entities find themselves at odds regarding whether or not someone is ready for conditional release. It remains unclear to me how many patients get rejected for release by the PSRB who have been proposed for release by the hospital. That is something that needs to be explored. No matter what the answer, there needs to be a much closer interaction between the hospital and the PSRB with the goal of establishing a common set of criteria with common definitions or measurements for both the hospital and the PSRB to use in selecting people for release.

Finally in dealing with the release issue, I also want to expand a bit on the problem of lack of community beds for patients. It has generally been the case that at any given time there are approximately 30-40 people under the jurisdiction of the PSRB who have been accepted by the Board for conditional release but who remain in the hospital because no appropriate bed is available in the community.

A, if not *the,* major contributing factor in the lack of community bed space for people ready for conditional release by the PSRB is the inability to site new facilities in communities due to strong resistance from local residents and some law enforcement. There is currently available money to build new beds but this is stalled due to community resistance. There currently exists no mechanism to overcome such resistance short of litigation in individual instances and such litigation will likely drag on for several years and then may or may not be successful in solving the problem.

It is my belief that the inability to move patients out into community facilities in a reasonable time makes the State potentially vulnerable to legal action. I also believe that the State's vulnerability is further enhanced by the fact that money is available to help alleviate the bed space problem and yet the state, through the legislature or the Attorney General, has taken no action to date to attempt to overcome the facility siting problem.

In April of 2008, the Governor convened the Psychiatric Security Review Board Siting Group. Quoting from the executive summary from the report of the Group,

> "Over the course of nine months, the Psychiatric Security Review Board (PSRB) Siting Workgroup held seven meetings. The membership of the group was appointed by the Governor's Office and included a balanced representation of public safety and victim interests, mental health consumers and advocates, local government officials, state legislators and other stakeholders relevant to the topic. The leadership of respective associations, such as the National Alliance on Mental Illness, the Oregon State Sheriff's Association etc., was asked to nominate a representative to sit on the panel.
>
> The workgroup was convened by the Governor's Public Safety and Human Services advisors, who charged the workgroup with identifying ways to enhance the understanding of Oregon's system for managing individuals placed within the jurisdiction of the PSRB and to reach consensus on ways to strengthen the process for siting residential treatment facilities that serve these individuals. The Governor's Office identified the following four touchstones to guide the workgroup's ultimate recommendations:
> • Protect the Public Safety;
> • Protect the Safety and Individual Rights of Individuals with Mental Illness;
> • Support Effective Treatment of Persons with Mental Illness; and
> • Recognize the Realities of State and Partner Budget Considerations."
>
> "The workgroup adopted individual recommendations across seven major topic areas. This final report sets forth the Workgroup's recommendations within those categories:
> 1. Communication and Collaboration
> 2. Victims' Rights
> 3. Standards, Operations and Quality
> 4. Distribution of Facilities and Siting
> 5. Education
> 6. Licensing Requirements
> 7. Notification"

One other likely consequence of failure to immediately deal with the issue of community beds for both forensic and civil commitment patients is that when the new hospital comes on line in 2010 it will be completely full from day one and there will be no mechanism available to deal with the fact there will be no room to take in new patients. In reality, it may already be too late to avoid this problem. Even if sites could be immediately found and planning begun for new facilities to bring the already funded beds on line, it seems doubtful these beds would be ready by the time the new hospital opens.

A final potential challenge that would affect the "back door" is if the legislature should adopt a requirement of minimum time limit in the hospital as a result of a conviction or plea of "guilty except for insanity." If, as rumored, the change is sought to have people spend at least the same amount of time in the hospital as they would if they had been sentenced to prison, there appear to be many implications, the impact of which would need to be explored through statistically analysis. For instance, would the hospital population increase because

more people would be staying longer? Would the opposite occur given the prison times mandated by the sentencing matrix? Would there be a great disparity in impact depending upon the crime severity level on which the sentencing is based? Would *more* "guilty except for insanity" pleas occur because the time of commitment and the sentencing time would be the same so defendants would be more interested in getting treatment at the hospital rather than go to the corrections division? These unknowns could have a very large impact on the hospital population and must receive careful scrutiny before any legislative action is taken.

10. A Sense of Urgency

The longer I have worked on this project and the more people I have talked to, the clearer it has become to me that there is little sense of urgency surrounding this transformation. There appears to be a pervasive sense that there is lots of time to accomplish what needs to be accomplished to transform the hospital into a first-class operation. From my experience working on large transformation projects this is an entirely inaccurate perception. If we use the date for the opening of the new hospital as the "drop dead" date for all of the transformation work that needs to be done, that leaves less than two years to accomplish the work. It is my sense that most people have no concept of how quickly that time will evaporate. I also don't believe that most people have a realistic sense of how long and difficult the journey through this transformation process will be. It is up to hospital leadership to understand and convey this sense of urgency to all. To date, that has not happened.

11. Constitutional Rights of Institutionalized Persons Act (CRIPA)

Having participated in the negotiations with the USDOJ on the issues raised by them about the hospital it appears to me that this matter *should* end up being resolved through some sort of agreed settlement. We are in agreement with the USDOJ on essentially all of the substantive issues regarding patient care and hospital conditions. In addition to being in agreement with USDOJ on patient care and hospital conditions, the hospital has been and continues to be actively involved in making the changes necessary to resolve these issues.

There are three unresolved issues that have nothing to do with patient care or hospital conditions have stalled the reaching of a settlement agreement. The three issues are: 1) the USDOJ desire to have the agreement be incorporated into a court order; 2) their desire to try to extend their oversight into community placements; and 3) their desire to have any settlement last long enough that the new hospital would be open and running so that they could be sure that changes made at the current location carry over into the new facility.

The whole process of dealing with the USDOJ has been handled very well by the attorneys in the office of the Attorney General and the negotiating team. If, how or when this matter will get resolved is unknown. As I indicated above, this matter *should* settle, however, during my judicial career I have seen many cases go to trial where it made no sense at all.

12. A Wild Card

The impact of the recent passage of the legislature's version of a sentencing bill related to certain property and drug crimes on the hospital is still an unknown. The last projections I saw from the Corrections Division indicated that they would have around 1,500 new prisoners as a result of this enactment. Given the significant number of defendants committed to the Corrections Division who have significant mental illness issues, it is reasonable to assume that there may be some impact on the hospital as well as prison population as the cases sort themselves out at the trial court level. At this time it is

impossible to predict the impact on the hospital. This is an issue that bears watching over the next couple of years.

13. Legislation

As I worked on various aspects of the admission to the hospital of forensic patients, I drafted and presented to the Governor's staff for consideration a number of proposed statutory changes to deal with what I felt were significant shortcomings of the existing statutory scheme.

One proposed change deals with defendants who are sent to the hospital on multiple occasions in the course of the same criminal prosecution because they lose the fitness to proceed from time to time as the case progresses. Some courts have taken the position that this process can continue indefinitely, no matter how many days, weeks, months or years the defendant may accumulate in time spent in the hospital. The statutory change would make clear that a defendant cannot spend more time in the hospital on multiple commitments on the same case than he or she could spend on a maximum single commitment.

A second proposed change deals with the introduction of a statutory process for dealing with fitness to proceed defendants who require medication to regain competency but who refuse. Constitutional law provides that hospitals, if they meet certain requirements may involuntarily medicate these defendants even if they are competent enough to knowingly refuse. The proposed change would put into the statutes a process consistent with constitutional requirements.

A third proposed law change deals with the length of time someone committed to the hospital as unfit to proceed could remain in the hospital for treatment. This proposal would also bar the use of the hospital for the most minor misdemeanors.

Presently, someone sent to the hospital as unfit to proceed can be kept for treatment for the length of the statutory maximum sentence for the crime or three years, which ever is least on felony charges and for one year or the statutory maximum for a misdemeanor, which ever is less. For felonies, the proposed change would limit the time in the hospital for all but the most serious crimes to the maximum sentence the defendant could receive under the statutory sentencing matrix or eighteen months, which ever is less. For misdemeanors, the time would be four month as a maximum.

The fourth proposed statutory change would establish criteria to be followed by judges, prosecutors and attorneys in cases where a determination of whether a defendant meets the statutory criteria for being found guilty but insane is to be made without a jury trial. There is currently no such criteria in the statute.

I believe that a number of opportunities for both statutory and administrative rule changes remain that could improve both the legal framework around the forensic admissions to the hospital and the rules by which some of the hospital is directed to perform its work.

14. Project Oversight

I believe that I would be remiss in my duty to you and to the public we all serve if I did not comment on this issue.

It did not take me long to realize just what a smart move it was on your part to create this role. Putting someone in a position to "helicopter" over the entire project and drop in as seemed appropriate to suggest, comment, critique, cheerlead, educate, problem solve or play

what ever other role was needed at the time has proven to be very beneficial to the project. I also believe that having someone as an outside and independent observer who could report to you and Dr. Goldberg also proved to be most useful in allowing you to become aware of both progress and problems and to deal with problems in an expeditious manner.

It is my belief that there continues to be a very strong need for someone in this position to continue to help move this vital transformation project toward a successful conclusion.

Conclusion

Throughout the course of the last year some important gains have been made in this transformation project. Having overcome a number of difficult challenges the facility planning and construction project has managed to move forward on time. Barring any unforeseen difficulties over the next year the hospital should open on schedule and be a highly functional facility allowing for the delivery of excellent treatment for patients.
The B-HIP project which will supply the core technology for the operation of the hospital also continues to proceed on time. Since the technology of B-HIP will be essential to the ability to operate the hospital it is important that this part of the overall project be given whatever support is needed to allow it to continue its work at the same rapid pace that it has been. Bringing the system up in a timely fashion and at the same time having staff trained in its use will be a tall order. I believe that the B-HIP team has shown that it is up to the task, if it receives that appropriate support.

Changes in the approach to and type of treatment for patients are progressing, albeit not as rapidly as would be ideal. Our two consultants are doing an excellent job assisting the hospital in this area. The problem is that they are not here on a fulltime basis. Even though at the end of each consulting visit hospital staff are left with work to accomplish before the next consultation, there is no doubt in my mind that more would be accomplished more quickly if one or both of the consultants were on site full time.

While a number of good changes have been or are being made, much is left to do.

There are people at the hospital who are eager for change and will fully embrace it. There are those who are not and will not. No matter which group someone falls into, change is going to occur. The only question is how much change will occur and how difficult the transition will be.

Without question the move to the new facility with the concomitant shift to delivering treatment in a central mall arrangement will force a great deal of change. However, unless carefully planned for and managed it will also create a great deal of disruption and dysfunction that will have long lasting effects.

The changes that will be brought about by the move to the new facility and the change in the method of delivering treatment to patients will not be sufficient to bring the hospital to the place of functioning as a first class operation. To accomplish this goal much additional work will need to be done in relation to the way the hospital is managed and carries out its daily activities. A substantial change in some of the cultural aspects of the hospital must occur as well.

It is my hope that adequate professional help will be engaged in time to help ensure that all needed changes occur so that all aspects of the hospital can be brought up to the standard of excellence that will be need to make this a truly first class operation.

Time has drawn short for the hospital to achieve all that it needs to before moving to the new facility. It is going to take the adoption of a new sense of urgency and a greatly increased commitment on the part of management to drive all of the changes that need to occur throughout the organization if the goal of having a first class hospital in a first class building is to be achieved by the time the new facility is occupied.

Respectfully submitted

James R. Hargreaves
Governor's Special Master for
Oregon State Hospital Excellence