State Hospitals Staffing Model

November 22, 2016
Today’s Discussion

The Project

Methodology

Recommendations
Earlier this year, ESSB 6656 directed the Washington Department of Social & Health Services to address ward-level staffing concerns at the two State Hospitals. OTB Solutions was contracted to recommend a staffing model to meet evolving patient care demands, with a focus on:

- Barriers to recruitment and retention of staff
- Creating a sustainable culture of wellness and recovery
- Increasing responsiveness to patient needs
- Reducing wards to an appropriate size
- The use of interdisciplinary health care teams
- The appropriate staffing model and staffing mix to achieve optimal treatment outcomes considering patient acuity
Methodology

Baseline data
Stakeholder interviews
Site visits
Tour
SWOT Exercise
A “day in the life”
Benchmarks/Research/Acuity Tools
Ward-level staffing model
Methodology – Site Visit Stats

DSHS Clinical Staffing Model Project

<table>
<thead>
<tr>
<th>Participants</th>
<th>Interactions</th>
<th>Consultant Hours</th>
<th>Stakeholder Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>336</td>
<td>52</td>
<td>260</td>
<td>26</td>
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</table>

Engagement Mix:
- Senior Leadership: 30%
- Non-clinicians & Social Workers: 30%
- Clinicians: 40%

Themes:
- Leadership
- EMR
- Comm
- Retention
- Space
- Care Planning
- Safety
- Staffing
- Training
- Discharge
- Recruiting
- Pay

Key Activities:
- SWOT (Strength Weakness Opportunity Threat Analysis)
- “Day in the Life”

Facility Tours & Listening Sessions

Prepared for WA State Department of Social and Health Services (DSHS)

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Ward level staffing - Assumptions

- Staff function at the full scope of their licensure
- Increase active treatment hours
- Ward-level baseline staffing by shift for a weekday with no 1:1 patients.
- Augment staff using acuity tool
- The current 28-30 beds (plus emergency beds) model will continue.
- Includes Systems Improvement Agreement (SIA) requirements for any ward-level staff
- There are few, if any meaningful national benchmarks for staffing psychiatric hospitals
Ward-level staffing - Assumptions

This model does not account for:

• Weekend staffing, seasonality patterns, non-productive time
• Variation in duties across wards
• A ward by ward detailed analysis
• Permanent versus temporary positions
• Levels within a job description role (e.g. MHT1, MHT2, MHT3)
• Variation in shift length (e.g. 8, 10 or 12 hours) and shift start and end times.
• The length of shift overlap, current vacancy levels and on-call coverage
# Proposed Ward-Level Staffing

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Forensic</th>
<th>Adult Psych</th>
<th>Gero Psych</th>
<th>Habilitative (HMH)</th>
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<tbody>
<tr>
<td>Typical Ward Size</td>
<td>28-30</td>
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<tr>
<td><strong>Type</strong></td>
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<td>Admission</td>
<td>Higher Acuity Long Term</td>
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<td><strong>Shift</strong></td>
<td>Day</td>
<td>Eve</td>
<td>Night</td>
<td>Day</td>
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<td>RN3 (Shift Nursing Supr)</td>
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<td>LPN2/LPN4/PSN</td>
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<td>3.00</td>
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<td>MHT3/MHT2/MHT3/PSA</td>
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<td>OD</td>
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Per Geller Model - Extra MHT on admission wards & geropsych wards 1/5 to 1/6 ratio overall of staff to pts 1 psychiatrist/15 pts (2 per ward).
1 per 2 wards for most, 1 dedicated for admission & geropsych ones
1 per ward only, 2 wards on days, 1 per ward on days only, 1 per ward on days only, 1 per 2 wards on days
1 per Center/Unit in gero-psych & .5 in HMH
1 per Center/Unit in geropsych & .5 in HMH
5 per ward in gero-psych & .5 for HMH
1 per ward on days, cover 2 wards on days
1 per ward on days, cover 2 wards on days
Recommendations

In the next six months:
- Hire ward administrators that have 24/7 accountability
- Implement center/unit-based float pools
- Select and adopt an acuity tool
- Use ARNP, P-ARNP and PA-C to ease constraints created by lack of psychiatrists in the workforce, physician unavailability and recruitment delays.
- Develop a standardized discharge planning process
- Adopt “Lean” methods to accelerate change

In the next twelve to eighteen months:
- Deploy the Electronic Health Record and other technologies to enable better care and the integration of physical and behavioral health
- Standardize care planning across the two hospitals
- Introduce transition programs for patients re-entering the community
- Strengthen linkages with academic institutions
Final thoughts.....

The adoption of the model “as is” will take some time and may not be achievable in the short-term. The evolution to a new staffing model will likely require an iterative approach and may ultimately look different from the recommendations made here. Progress toward the model should be measured with the following in mind:

- Healthcare is local
- A new clinical staffing model will require large-scale cultural transformation
- Lasting change does not happen overnight
- Large numbers of staff were and are being hired at both state hospitals regardless of this staffing model
What questions do you have?