



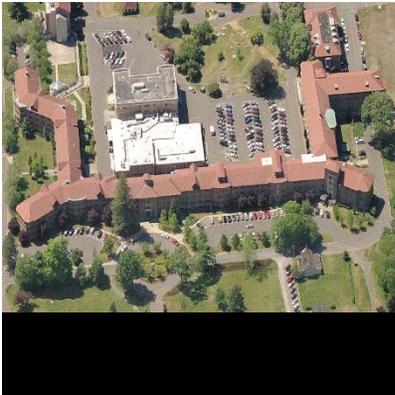
State Hospitals Staffing Model

November 22, 2016

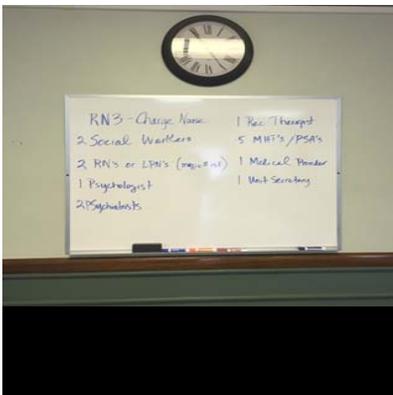
Today's Discussion



The Project



Methodology



Recommendations

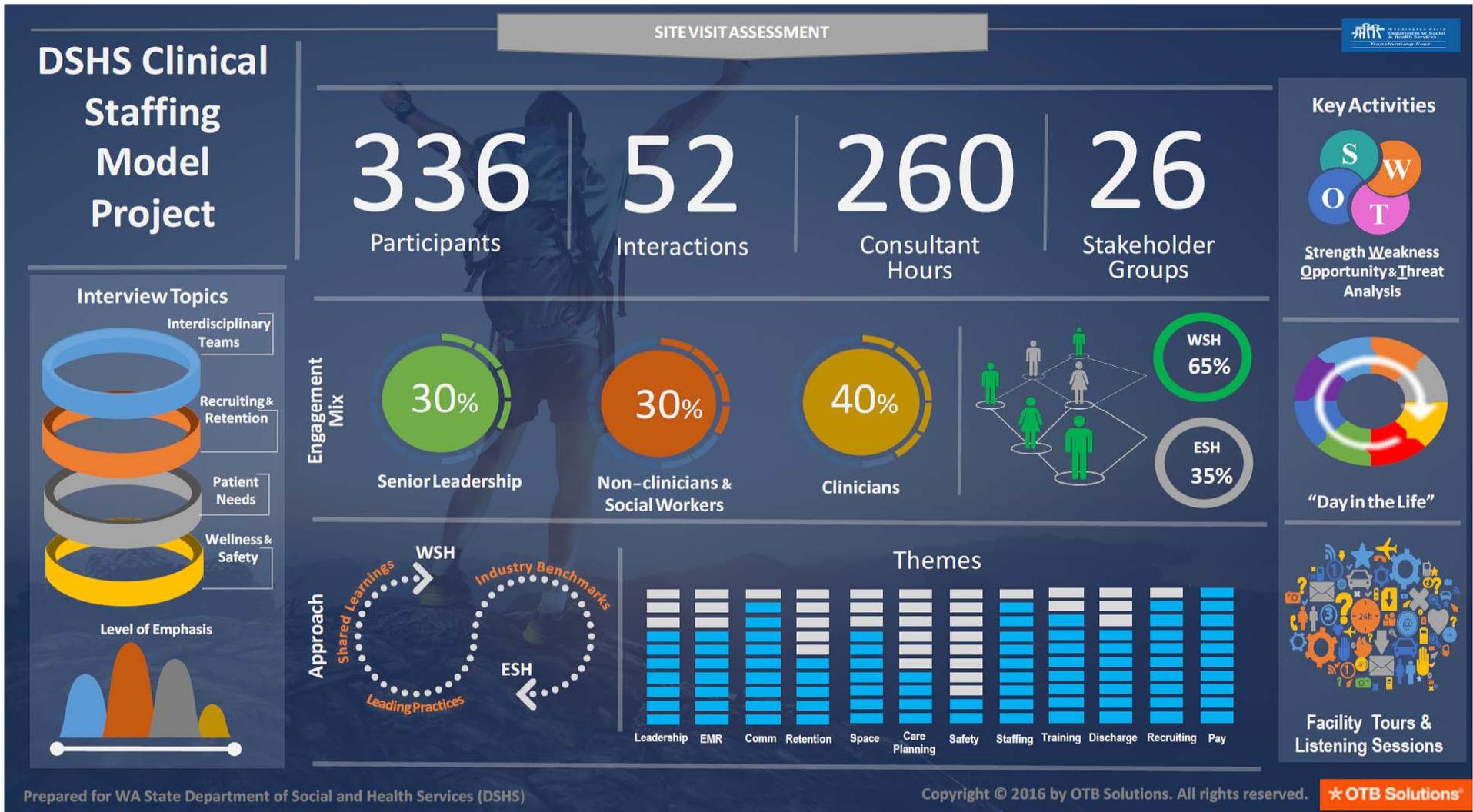
A little history.....



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 – Site Visit Stats



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

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Ward level staffing - Assumptions

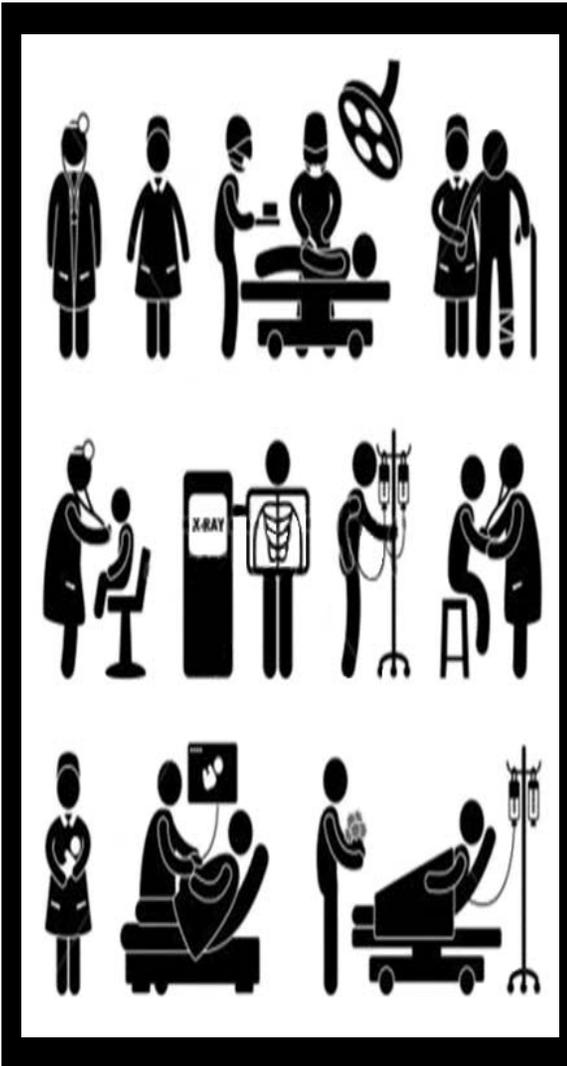
- Staff function at the full scope of their licensure
- Increase active treatment hours
- Ward-level baseline staffing by shift for a weekday with no 1:1 patients.
- Augment staff using acuity tool
- The current 28-30 beds (plus emergency beds) model will continue.
- Includes Systems Improvement Agreement (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



Practice Type Typical Ward Size Type Shift	Forensic				Adult Psych				Gero Psych				Habilitative (HMH)				
	28-30				28-30				28-30				30				
	NGRI				Admission				Higher Acuity Long Term				Developmental Disabilities				
	Day	Eve	Night	Total	Day	Eve	Night	Total	Day	Eve	Night	Total	Day	Eve	Night	Total	
Ward Program Administrator	1.00			1.00	1.00			1.00	1.00			1.00	1.00			1.00	1 per ward, onsite day shift but has 24/7 responsibility
Office Assistant	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1 per ward on days, cover 2 wards on eves
Med Rec/Quality Asst	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1 per ward on days only
Management and Support Totals	3.00	0.50	0.00	3.50	3.00	0.50	0.00	3.50	3.00	0.50	0.00	3.50	3.00	0.50	0.00	3.50	
RN3 (shift nursing supr)	1.00	0.50	0.50	2.00	1.00	0.50	0.50	2.00	1.00	0.50	0.50	2.00	1.00	0.50	0.50	2.00	
RN2	3.00	3.00	1.00	7.00	3.00	3.00	1.00	7.00	3.00	3.00	1.00	7.00	3.00	3.00	1.00	7.00	
LPN2/LPN4/PSN	1.00	1.00	1.00	3.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	3.00	1.00	1.00	1.00	3.00	
MHT1/MHT2/MHT3/PSA	4.00	4.00	4.00	12.00	6.00	6.00	5.00	17.00	6.00	6.00	5.00	17.00	4.00	4.00	4.00	12.00	Per Geller Model - Extra MHT on admission wards & geropsych wards
Nursing Totals	9.00	8.50	6.50	24.00	11.00	10.50	7.50	29.00	11.00	10.50	7.50	29.00	9.00	8.50	6.50	24.00	1/5 to 1/6 ratio overall of staff to pts
Psychiatrist/Psych ARNP	2.00	OD		2.00	2.00	OD		2.00	2.00	OD		2.00	2.00	OD		2.00	1 psychiatrist/15 pts (2 per ward).
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	0.50	OD		0.50	1.00	OD		1.00	1.00	OD		1.00	0.50	OD		0.50	1 per 2 wards for most, 1 dedicated for admission & geropsych ones
Medical Totals	2.50	0.00	0.00	2.50	3.00	0.00	0.00	3.00	3.00	0.00	0.00	3.00	2.50	0.00	0.00	2.50	
Psychologist	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	Pair 1 Psych and 1 PA per ward baseline (others TBD per ward type)
Psych Associate	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	
Social Worker	2.00	0.00	0.00	2.00	2.00	0.00	0.00	2.00	2.00	0.00	0.00	2.00	2.00	0.00	0.00	2.00	2 per ward
Social Work Assistant	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1 per ward
Institution Counselor	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00	1 per ward baseline, but additional ones TBD depending upon ward service
Recreation Therapist	1.00	2.00	0.00	3.00	1.00	2.00	0.00	3.00	1.00	2.00	0.00	3.00	1.00	2.00	0.00	3.00	1 per ward on days, supplement on eves after Tx Mall closed
Occupational Therapist				0.00				0.00	0.25	0.00	0.00	0.25	0.50	0.00	0.00	0.50	1 per Center/Unit in gero-psych & .5 in HMH
Physical Therapist				0.00				0.00	0.25	0.00	0.00	0.25	0.50	0.00	0.00	0.50	1 per Center/Unit in gero-psych & .5 in HMH
Therapy Assistants (PTA, COTA, other)				0.00				0.00	0.50	0.00	0.00	0.50	0.50	0.00	0.00	0.50	.5 per ward in gero-psych & .5 for HMH
Treatment Totals	7.00	2.00	0.00	9.00	7.00	2.00	0.00	9.00	8.00	2.00	0.00	10.00	8.50	2.00	0.00	10.50	
Dietary Aide	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1 per ward on days, cover 2 wards on eves
Env Services	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50	1 per ward on days, cover 2 wards on eves
Non-Clinical Totals	2.00	1.00	0.00	3.00	2.00	1.00	0.00	3.00	2.00	1.00	0.00	3.00	2.00	1.00	0.00	3.00	
Ward Totals	23.50	12.00	6.50	42.00	26.00	14.00	7.50	47.50	27.00	14.00	7.50	48.50	25.00	12.00	6.50	43.50	

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?

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