STATE HOSPITALS
CLINICAL MODEL ANALYSIS PROJECT

Clinical Staffing Model
Analysis & Recommendations

OTB Solutions
October 31, 2016

Clinical Staffing Model Analysis & Recommendations

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VERSION HISTORY

Date	Version	Author	Description of Changes
08/24/2016	0.01	Larry Holden	Outline template for draft recommendations report
09/07/2016	1.00	OTB Solutions	First Draft Report
09/28/2016	2.00	OTB Solutions	Second Draft Report
10/05/2016	3.00	OTB Solutions	Final Report
10/31/2016	4.00	OTB Solutions	Final Report (after Executive review)

INTRODUCTION

In July 2016, OTB Solutions was tasked with providing a Clinical Model Analysis for the two state psychiatric hospitals based on legislation from earlier in the year. The analysis was to include a study of the use of interdisciplinary health care teams, the barriers to recruitment and retention, responsiveness to patient needs and a culture of safety and wellness. The Department commissioned similar studies in the past and those are referenced throughout the document and informed this Clinical Staffing Model.

It bears calling out at the beginning of this report that 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 very different from the recommendations made here. Progress toward the model should be measured with the following in mind:

- Healthcare is local. While it may be optimal to standardize the model across the two hospitals, it is understood it may not be suitable in every situation. Western State Hospital is significantly larger and is just starting to see results from recent leadership changes. Eastern State Hospital's turn-around is three years in the making. Both hospitals are led by excellent and experienced individuals. Both are providing the best care possible and within the safety and security constraints of their physical plants. Standardization should be attempted, where appropriate.
- A new clinical staffing model will require a large-scale cultural transformation. With near constant legislative, media and public pressure on these facilities, the budget cuts of 2008 (most remarkable at Western State Hospital) and recent threats of federal de-certification, there is unease and uncertainty among the staff. Because of this, a very deliberate implementation approach, based on change management principles, should be non-negotiable. A new staffing model is dependent on the commitment of time, funding and effort to achieve.
- Lasting change does not happen overnight. There are areas of improvement that can take place immediately, others will take time to plan and implement. Everyone with an interest in the adoption of a new clinical model should acknowledge the time constraints and move forward with purpose rather than speed.
- Large numbers of staff were and are being hired at both state hospitals regardless of this staffing model commissioned by DSHS. Filling these positions is critical; however, these roles may not align perfectly with the developed model and it will take time for things to shake out.

This model takes the facilities about 80% toward their goal of defining staffing requirements. Some additional fine tuning will be necessary by each facility to arrive at final baseline numbers for particular wards. In addition, certain positions discussed in this report need further role clarity to finalize optimal staffing numbers. The Clinical Staffing Model developed for the two state hospitals was itself completed under time constraints and does not address a level of detail expected with a lengthier study. In addition, this report is being written nearly simultaneously with other groups making staffing recommendations. Every attempt was made to align with previous and current recommendations.

Please contact Shelley McDermott at shelley.mcdermott@otbsolutions.com with questions regarding the content of this report.

EXECUTIVE SUMMARY

The Washington Department of Social & Health Services (DSHS) is addressing staffing model concerns at Eastern and Western State Hospitals. While both facilities face staffing issues, Western State Hospital is also facing federal de-certification, and is under both public and political pressure to address these challenges. OTB Solutions was contracted by DSHS to recommend a clinical staffing model which will meet evolving patient care demands, while keeping a focus on:

- Barriers to recruitment and retention
- Use of interdisciplinary health care teams
- Responsiveness to patient needs
- Culture of wellness and safety

In order to accomplish this, OTB Solutions conducted interviews with numerous stakeholders in the state hospitals (including hospital and other DSHS leadership, hospital staff, Labor leadership, among others); has collected and is reviewing current hospital staffing data (baseline data); has conducted site visits at both hospitals; and will apply national benchmarking standards to develop an achievable clinical staffing model.

Because the hospitals are a rich source of knowledge to inform the recommendations, much of the required data has been collected from time spent on site. Site visit activities included:

- Group exercises to address staffing issues in these domains:
  - Clinical
  - Ancillary
  - Support
- Stakeholder interviews, including leadership, management, clinical and ancillary staff
- Facility tours to observe limitations of the physical plant and understand security and safety concerns across the facilities

Deliverables

After the site visits, stakeholder interviews, data analysis and benchmarking activities are complete, OTB Solutions will provide a set of deliverables that include:

- Near term opportunities
- Recommended staffing model
- Strategic opportunities to maximize support for the staffing model
- Risk management plan

The project will conclude with a report delivered to senior leadership, hospital management, CQIP and the Select Committee. The project timeline is July 1 – September 30, 2016.

PROJECT OVERVIEW

INTRODUCTION

The growing demand for state hospital beds has strained the state's capacity to meet that need while providing for a sufficient workforce to operate the state hospitals safely. The state legislature enacted ESSB 6656 in March, 2016 to address concerns around state hospital audit findings, appropriate staffing levels and practices. In response to the bill, the Department of Social & Health Services contracted OTB Solutions to complete a Clinical Staffing Model Analysis at the two state hospitals.

The analysis and recommendations contained in this report take into account the clinical models of care, current staffing models, and use of interdisciplinary health care teams, ward size, appropriate staffing models and the staffing mix to achieve optimal treatment outcomes. The study includes a review of the barriers to recruitment and retention of staff and considers related issues such as steps to achieving a sustainable culture of wellness and recovery, improved responsiveness to patient needs, limitations of the physical plant and recommended practices to increase safety for staff and patients.

PROJECT OBJECTIVES

The project objectives stated below are based on the contractual requirements between DSHS and OTB Solutions, application of domain knowledge of OTB Solutions, and meeting the needs of the legislation:

- Validate types and numbers of staff needed to optimally support patient treatment outcomes at Eastern State Hospital (ESH) and Western State Hospital (WSH)
- Increase awareness of and best practices for safety and security
- Define staff roles to allow function at the full scope of licensure or job classification
- Understand clinical care team variances between WSH and ESH
- Review national benchmarks, best practices and industry standards to inform the staffing model analysis
- Compare the Washington state hospitals to others of similar size and patient mix
- Provide staffing model recommendations that take into account and support patient acuity and admission type
- Examine recruitment and retention practices, workforce market shortages and other factors impacting implementation of a new staffing model at the state hospitals

SCOPE

OTB Solutions, along with leadership from the State Hospitals and DSHS headquarters developed a scope of work to achieve the project objectives as stated above.

In Scope

At a high level, items in scope for the Clinical Model Analysis project include:

- Collection and analysis of baseline data for each of the hospitals, including
  - Number of and type of wards
  - Number, position, type, level and role of clinical, ancillary and support staff
- Inspection of the physical plant at each hospital, with particular attention paid to facility constraints to safety and quality of care
- Gathering of feedback from stakeholders regarding the current and future state at the hospitals
- Evaluation of current issues in four focus areas:
  - Barriers to recruitment and retention
  - Responsiveness to patient needs
  - Culture of wellness and safety
  - Use of interdisciplinary health care teams
- Research and comparison of the Washington State hospitals to available benchmarks and best practices relating to available staffing models

The scope items above informed the methodologies and approach used to achieve the project objectives. The approach is outlined in a later section of this document.

Out of Scope

Certain items are out of scope due to time and budget constraints. Out of scope items help to further define the project and result in deliverables that reflect actual versus perceived needs. Items out of scope for the Clinical Model Analysis project include:

- The Child Study and Treatment Center
- Documentation of activities, processes and workflow at the hospitals with the exception of the "Day in the Life" exercise
- Validation of clinical responsibilities related to licensure/credentials (Note: there are recommendations associated with general tasks/assignments based on roles rather than a point-by-point analysis)
- Detailed implementation plan

ASSUMPTIONS

Findings and recommendations reported in this document are based on the following assumptions:

- OTB is developing a clinical staffing model for ward-level staff, ancillary staff and relevant support staff that directly impact clinical bandwidth.
- OTB Solutions will have timely access to DSHS stakeholders, and leadership and staff at both facilities.
- The clinical staffing model will be developed based on immediate and mid-range needs for the state hospitals. Other consulting groups are looking at the mental health system as a whole. Findings from all groups will be shared and synchronized, where appropriate.
- DSHS and state hospital staff is able to provide agreed-upon data and other information as outlined in the timeline.
- Data and other information provided by DSHS and the state hospitals is accurate.
- Review and feedback of draft deliverables is timely.
- The project must be completed prior to October 4, 2016. DSHS and the state hospitals understand the time constraints for reviewing data and completion of the staffing model. All findings and recommendations are provided with the understanding that a more detailed study is possible with additional time.

APPROACH

Summary

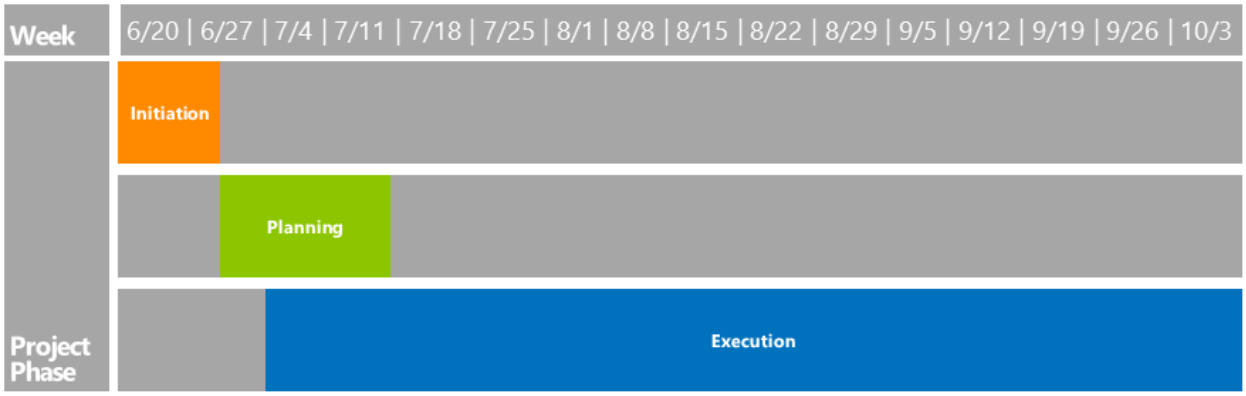
OTB Solutions used a comprehensive approach to gathering, analyzing and reporting on information for the project, and was divided into phases of project initiation, project planning and project execution.

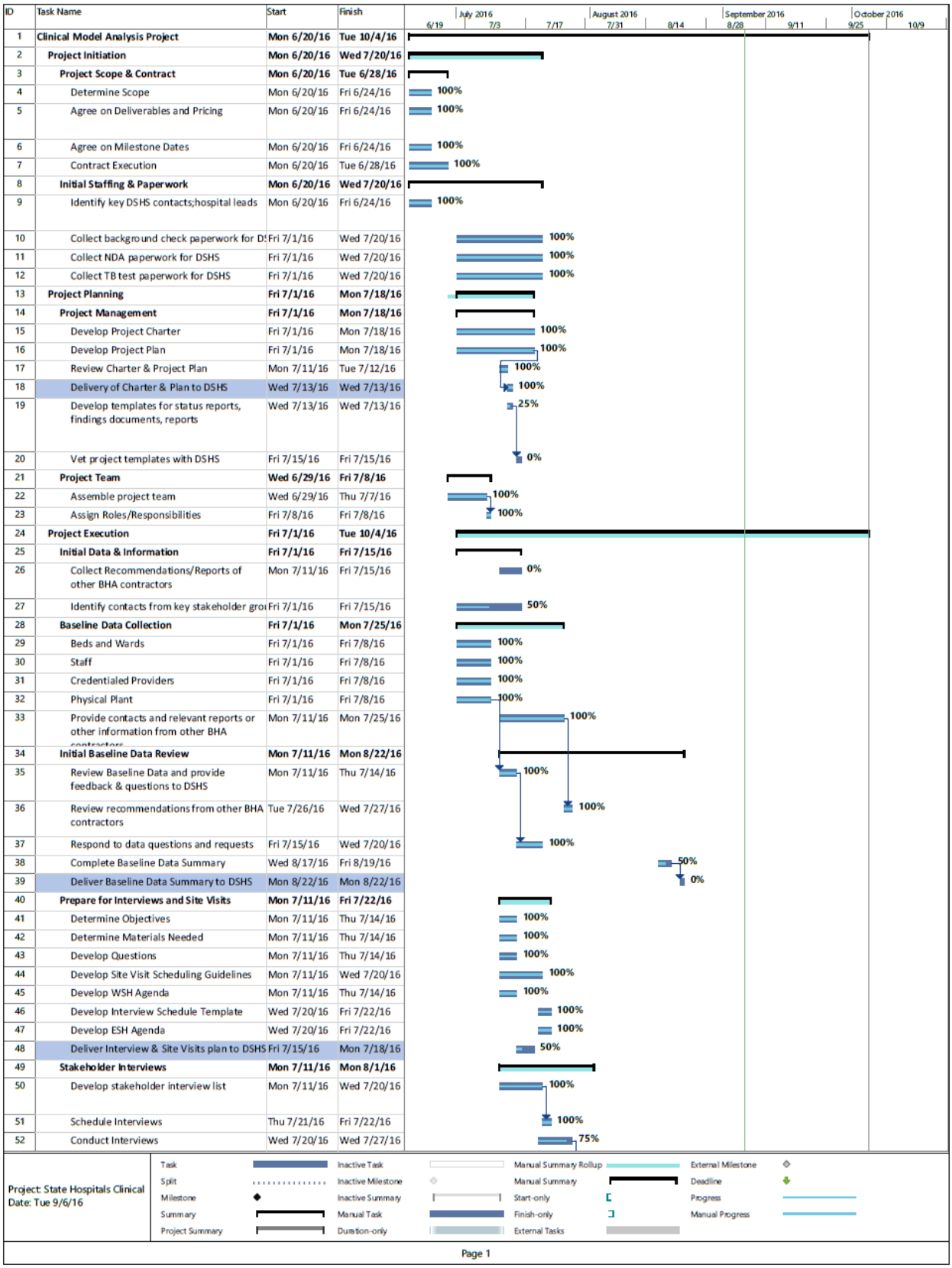
The initiation phase included identification of key project personnel for both DSHS and OTB Solutions, scope determination, agreement on deliverables, project pricing and contract execution. The planning phase included development of a charter and high-level project plan, determination of reporting formats for various deliverables, and final definition of project roles.

The bulk of activity for the Clinical Model Analysis project occurred during the execution phase, which included a number of activities, but primarily featured hospital site visits as well as stakeholder interviews, which comprised much of the work informing the overall analysis and recommendations. There is more specific information below regarding our methodology for the site visits and stakeholder interviews.

Project Timeline & Project Plan Gantt Chart

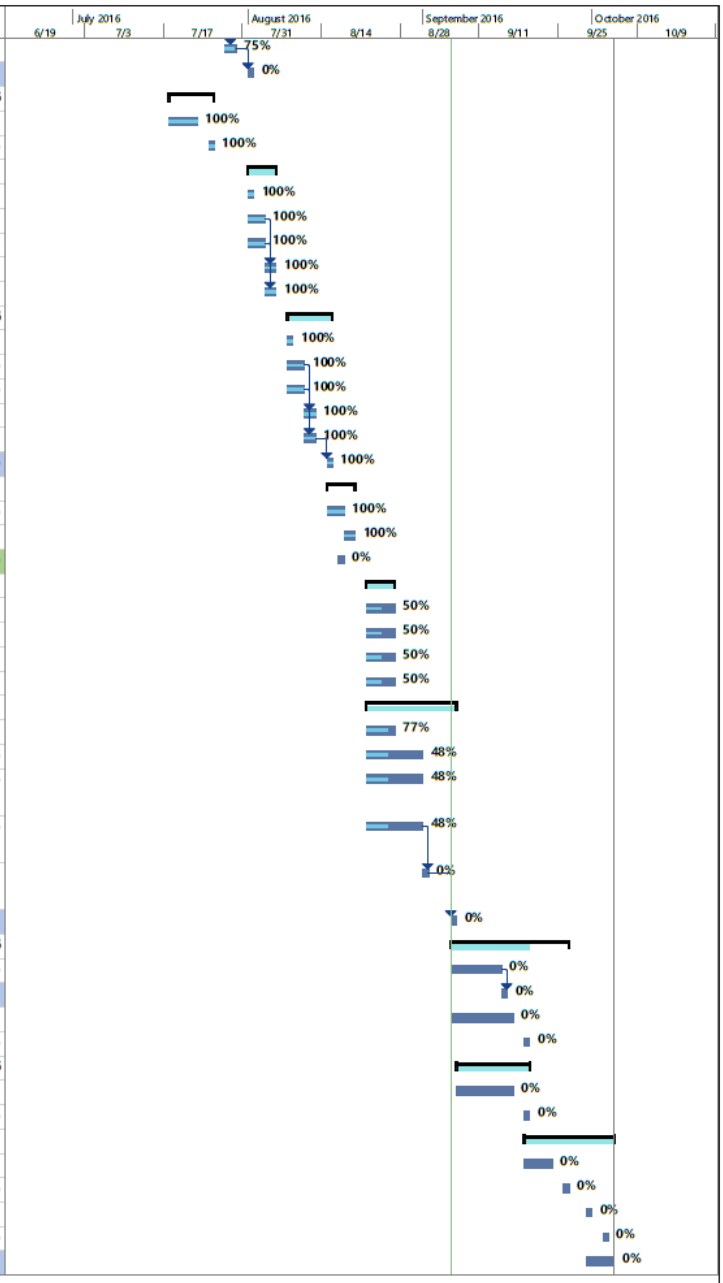
The project phases took place over approximately 15 weeks beginning around June 20, 2016 with project initiation activities. After project initiation and planning, the project execution phase began July 1, 2016, and is scheduled to wrap up by October 4, 2016. Below is a graphic depicting the high-level timeline, with a more detailed view of the project plan shown in Gantt Chart format on the following pages:





ID	Task Name	Start	Finish
1	**Clinical Model Analysis Project**	**Mon 6/20/16**	**Tue 10/4/16**
2	**Project Initiation**	**Mon 6/20/16**	**Wed 7/20/16**
3	**Project Scope & Contract**	**Mon 6/20/16**	**Tue 6/28/16**
4	Determine Scope	Mon 6/20/16	Fri 6/24/16
5	Agree on Deliverables and Pricing	Mon 6/20/16	Fri 6/24/16
6	Agree on Milestone Dates	Mon 6/20/16	Fri 6/24/16
7	Contract Execution	Mon 6/20/16	Tue 6/28/16
8	**Initial Staffing & Paperwork**	**Mon 6/20/16**	**Wed 7/20/16**
9	Identify key DSHS contacts;hospital leads	Mon 6/20/16	Fri 6/24/16
10	Collect background check paperwork for DS	Fri 7/1/16	Wed 7/20/16
11	Collect NDA paperwork for DSHS	Fri 7/1/16	Wed 7/20/16
12	Collect TB test paperwork for DSHS	Fri 7/1/16	Wed 7/20/16
13	**Project Planning**	**Fri 7/1/16**	**Mon 7/18/16**
14	**Project Management**	**Fri 7/1/16**	**Mon 7/18/16**
15	Develop Project Charter	Fri 7/1/16	Mon 7/18/16
16	Develop Project Plan	Fri 7/1/16	Mon 7/18/16
17	Review Charter & Project Plan	Mon 7/11/16	Tue 7/12/16
18	Delivery of Charter & Plan to DSHS	Wed 7/13/16	Wed 7/13/16
19	Develop templates for status reports, findings documents, reports	Wed 7/13/16	Wed 7/13/16
20	Vet project templates with DSHS	Fri 7/15/16	Fri 7/15/16
21	**Project Team**	**Wed 6/29/16**	**Fri 7/8/16**
22	Assemble project team	Wed 6/29/16	Thu 7/7/16
23	Assign Roles/Responsibilities	Fri 7/8/16	Fri 7/8/16
24	**Project Execution**	**Fri 7/1/16**	**Tue 10/4/16**
25	**Initial Data & Information**	**Fri 7/1/16**	**Fri 7/15/16**
26	Collect Recommendations/Reports of other BHA contractors	Mon 7/11/16	Fri 7/15/16
27	Identify contacts from key stakeholder gro	Fri 7/1/16	Fri 7/15/16
28	**Baseline Data Collection**	**Fri 7/1/16**	**Mon 7/25/16**
29	Beds and Wards	Fri 7/1/16	Fri 7/8/16
30	Staff	Fri 7/1/16	Fri 7/8/16
31	Credentialed Providers	Fri 7/1/16	Fri 7/8/16
32	Physical Plant	Fri 7/1/16	Fri 7/8/16
33	Provide contacts and relevant reports or other information from other BHA contractors	Mon 7/11/16	Mon 7/25/16
34	**Initial Baseline Data Review**	**Mon 7/11/16**	**Mon 8/22/16**
35	Review Baseline Data and provide feedback & questions to DSHS	Mon 7/11/16	Thu 7/14/16
36	Review recommendations from other BHA contractors	Tue 7/26/16	Wed 7/27/16
37	Respond to data questions and requests	Fri 7/15/16	Wed 7/20/16
38	Complete Baseline Data Summary	Wed 8/17/16	Fri 8/19/16
39	Deliver Baseline Data Summary to DSHS	Mon 8/22/16	Mon 8/22/16
40	**Prepare for Interviews and Site Visits**	**Mon 7/11/16**	**Fri 7/22/16**
41	Determine Objectives	Mon 7/11/16	Thu 7/14/16
42	Determine Materials Needed	Mon 7/11/16	Thu 7/14/16
43	Develop Questions	Mon 7/11/16	Thu 7/14/16
44	Develop Site Visit Scheduling Guidelines	Mon 7/11/16	Wed 7/20/16
45	Develop WSH Agenda	Mon 7/11/16	Thu 7/14/16
46	Develop Interview Schedule Template	Wed 7/20/16	Fri 7/22/16
47	Develop ESH Agenda	Wed 7/20/16	Fri 7/22/16
48	Deliver Interview & Site Visits plan to DSHS	Fri 7/15/16	Mon 7/18/16
49	**Stakeholder Interviews**	**Mon 7/11/16**	**Mon 8/1/16**
50	Develop stakeholder interview list	Mon 7/11/16	Wed 7/20/16
51	Schedule Interviews	Thu 7/21/16	Fri 7/22/16
52	Conduct Interviews	Wed 7/20/16	Wed 7/27/16

ID	Task Name	Start	Finish
53	Interview Write-Up	Thu 7/28/16	Fri 7/29/16
54	Deliver Interview Write Up to DSHS	Mon 8/1/16	Mon 8/1/16
55	**Plan Site Visits**	**Mon 7/18/16**	**Mon 7/25/16**
56	Develop Site Visit Plan	Mon 7/18/16	Fri 7/22/16
57	Deliver Site Visit Plan to DSHS	Mon 7/25/16	Mon 7/25/16
58	**Site Visit Western State Hospital**	**Mon 8/1/16**	**Fri 8/5/16**
59	Facility Tour	Mon 8/1/16	Mon 8/1/16
60	Interviews	Mon 8/1/16	Wed 8/3/16
61	Facilitated Sessions	Mon 8/1/16	Wed 8/3/16
62	Map key workflows/processes	Thu 8/4/16	Fri 8/5/16
63	Write up Findings	Thu 8/4/16	Fri 8/5/16
64	**Site Visit Eastern State Hospital**	**Mon 8/8/16**	**Mon 8/15/16**
65	Facility Tour	Mon 8/8/16	Mon 8/8/16
66	Interviews	Mon 8/8/16	Wed 8/10/16
67	Facilitated Sessions	Mon 8/8/16	Wed 8/10/16
68	Map key workflows/processes	Thu 8/11/16	Fri 8/12/16
69	Write up Findings	Thu 8/11/16	Fri 8/12/16
70	Deliver Site Visit Findings	Mon 8/15/16	Mon 8/15/16
71	**Site Visit Analysis**	**Mon 8/15/16**	**Fri 8/19/16**
72	WSH Site Visit Analysis	Mon 8/15/16	Wed 8/17/16
73	ESH Site Visit Analysis	Thu 8/18/16	Fri 8/19/16
74	**Mid-Project Internal Review**	Wed 8/17/16	Wed 8/17/16
75	**Baseline Data Analysis**	**Mon 8/22/16**	**Fri 8/26/16**
76	Beds	Mon 8/22/16	Fri 8/26/16
77	Staff	Mon 8/22/16	Fri 8/26/16
78	Physical Plant	Mon 8/22/16	Fri 8/26/16
79	Credentialed Providers	Mon 8/22/16	Fri 8/26/16
80	**Develop Findings and Recommendations**	**Mon 8/22/16**	**Tue 9/6/16**
81	Compile Current State Documents	Mon 8/22/16	Fri 8/26/16
82	Research national benchmarks	Mon 8/22/16	Wed 8/31/16
83	Develop Preliminary Analysis and National Benchmark Research Report	Mon 8/22/16	Wed 8/31/16
84	Develop draft staffing model based on current state, benchmarks	Mon 8/22/16	Wed 8/31/16
85	Review Preliminary Findings and Recommendations	Thu 9/1/16	Thu 9/1/16
86	Deliver Preliminary Findings & Recommenc	Tue 9/6/16	Tue 9/6/16
87	**Develop Presentation for Stakeholders**	**Tue 9/6/16**	**Mon 9/26/16**
88	Refine Preliminary Findings & Recommend	Tue 9/6/16	Wed 9/14/16
89	Deliver Revised Analysis and Recommenda	Thu 9/15/16	Thu 9/15/16
90	Draft Presentation for Stakeholders	Tue 9/6/16	Fri 9/16/16
91	DSHS Sign Off on Presentation	Mon 9/19/16	Mon 9/19/16
92	**Implementation Plan**	**Wed 9/7/16**	**Mon 9/19/16**
93	Develop High Level Transition/Implementic	Wed 9/7/16	Fri 9/16/16
94	DSHS Sign Off on Implementation Plan	Mon 9/19/16	Mon 9/19/16
95	**Project Close-Out**	**Mon 9/19/16**	**Tue 10/4/16**
96	Refine/Revise Final Report	Mon 9/19/16	Fri 9/23/16
97	Review Final report with Stakeholders	Mon 9/26/16	Mon 9/26/16
98	Final Report/Staffing Model	Fri 9/30/16	Fri 9/30/16
99	Present Findings to Stakeholders	Mon 10/3/16	Mon 10/3/16
100	Final Deliverables Sign Off	Fri 9/30/16	Tue 10/4/16



Project: State Hospitals Clinical
Date: Tue 9/6/16

Task | Split | Milestone | Summary | Project Summary
Inactive Task | Inactive Milestone | Inactive Summary | Manual Task | Duration-only
Manual Summary Rollup | Manual Summary | Start-only | Finish-only | External Tasks
External Milestone | Deadline | Progress | Manual Progress

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Site Visit Methodology

OTB Solutions followed the same methodology for each of the hospital site visits. There were multiple activities spanning three days. The general approach over the span of the visit was to meet initially with executive and senior leadership, tour the facilities with representatives from hospital management as well as safety & security personnel (including an in-depth discussion of safety and security issues), and slowly funnel into more specific and granular information with individuals and smaller groups representing multiple disciplines as the days progressed.

Meetings with the senior leadership groups at both sites included a SWOT exercise to facilitate the identification of **S**trengths, **W**eaknesses, **O**pportunities and **T**hreats in two focus areas. A large assembly of representatives from various clinical and non-clinical disciplines participated in another group exercise, "A Day in the Life", which was used to illustrate the timelines, activities, interdependencies and roadblocks occurring during a typical 24-hour day at the hospitals.

Interviews were held with both individuals (e.g., CEO, CNO, CMO, etc.) and groups (e.g., psychiatrists, medical doctors, nurses, psychologists, social workers, therapists, etc.). Both clinical and non-clinical disciplines were covered.

Stakeholder Interview Methodology

OTB Solutions used a standard interview template with a few pre-determined questions designed to encourage discussion around current state, issues and opportunities for near-term change, within the structure of the project focus (barriers to recruitment and retention, use of interdisciplinary care teams, responsiveness to patient needs, and culture of wellness and safety).

Interview Questions

What is your perception of the current state of the following areas?

- *Barriers to recruitment and retention*
- *The use of interdisciplinary care teams*
- *A culture of wellness and safety*
- *Responsiveness to patient needs*

What are the primary impacts of maintaining the status quo?

What suggestions do you have for helping DSHS achieve an improved clinical care model?

What are the main challenges for transitioning to a new clinical care model?

Other topic areas we did not cover?

Interviews were held with both individuals and groups and included leadership from the hospitals, DSHS headquarters, the Behavioral Health Administration and hospital labor representatives from SEIU 1199, UPW and WFSE.

While some respondents answered all of the questions, others were engaged in the discussion as a whole and did not answer every question on the list above. Our methodology focused on capturing the salient points rather than maintaining strict adherence to the question/answer format.

KEY ANALYSIS FINDINGS

SITE VISITS

OTB Solutions conducted multi-day site visits at both state hospitals as part of the fact finding and data collection activities during the project, visiting Western State Hospital on August 1 through August 3, and Eastern State Hospital from August 8 through August 10. The findings described below are a compilation of facts and data uncovered through the various activities and interviews performed at the hospital sites.

Eastern State Hospital

- Compensation disparity among job classes is a concern. Staff receiving recent pay increases are very pleased, but are feeling the effects of salary compression from their peers because of the differences in pay among job classes. Related to this issue is the "assignment pay" nature of the wage increases and the threat that previous pay levels will resume next year.
- Clinical documentation and moving paper around are taking time away from treatment. Clinicians and social workers are spending a disproportionate amount of time on paper processes, thereby spending less time with patients.
- The nurse recruiting and onboarding sprint yielded positive results – approximately 30-45 days for a nursing recruit to be ready to work on the ward. Staff appreciate the increased focus on recruiting.
- Staff is used to a minimalistic way of working, and their can-do attitude, though serving well in getting the work done, may be causing a natural resistance to change. Workarounds have been created when a more efficient process might be established, or staff may be spending time doing things "the way we've always done them".
- A tour of the facility revealed a number of significant issues with the physical plant, including problems such as poor line of sight, insufficient safety for staff and patients, end of life flooring/carpeting and the location of the Treatment Mall, whose distance and pathway from most wards require great effort and attention when transporting patients back and forth. Though outdated, the facility has been retro-fitted in some areas to meet both staff and patient safety needs. Other issues with the physical plant include the lack of a sally port and appropriate security for entry into Forensics.
- The shortage of qualified psychiatrists in the workforce continues to cause difficulty finding and providing adequate and appropriate coverage and care for wards on the campus.
- Eastern State Hospital is using a staffing model that is generally working there, and has implemented unit-based float pools to fill gaps created by vacancies, sick and annual leave, FMLA and time off due to injury (L&I).

Western State Hospital

- The recession of 2008, resulting budget cuts in the millions of dollars, and staff reductions have crippled Western State Hospital. Overcoming the length of time and breadth of damage caused by operating at sub-standard staffing levels will take intense focus and commitment.
- Near constant pressure from CMS, the media and the threat of de-certification have fostered a culture of negativity and blame at WSH. The infusion of new leadership has sparked enthusiasm among the management team and staff across the hospital.
- The Western State Hospital staffing model is loosely based on the Johnson Acuity Model and is updated daily in the scheduling application. On-call Nurses, Mental Health Technicians and others are used daily to fill vacancies and absences. The on-call staff may or may not be fully trained in the operations of the wards they are assigned to, often creating difficulty for existing staff.
- There are a number of successful former programs to be considered for re-instatement, including the CNA (Certified Nursing Assistant) School. Patients have important medical needs at Western State Hospital and providing CNA training to floor staff will allow nurses and physicians more time to focus on patient needs. Other programs include PALS (Program for Adaptive Living Skills), residency programs and fellowships.
- A clinical staffing model that supports ward-level excellence starts with hiring a well-qualified workforce for all disciplines. At present, there is no ward-level accountability through the existing chain of command.

Leadership and staff at both hospitals expressed concerns with the pace of the Electronic Health Record (EHR) project. Staff are especially curious about the go-live date, and an absence of communication about the shifts in the implementation schedule.

Both facilities are clearly outdated and lack modern fittings such as badge entry. One physician at Eastern State reports that he is required to unlock 7 doors to get to his office and 4 doors to get to the men's room. Western State Hospital does not have an employee cafeteria or other on site dining options outside of vending machines.

A national shortage of psychiatrists and those graduating from medical school with this specialty is affecting both hospitals, with numerous vacant psychiatrist positions between the hospitals, and few perceived options for filling these critical roles.

Both hospitals report that communication is an area of concern, and expressed ideas about improving internal and external communication. As an example, staff feel in the dark about the status and schedule of the Electronic Health Record and other projects. There is an immediate opportunity to better educate and inform staff using approaches ranging from daily updates to strategic communications.

Finally, both hospitals are hungry for training resources and are making progress with the frequency and content of New Employee Orientation (NEO). Former training programs were cut with the budget shortfalls during the recession and have not been restored. Like many things at the state hospitals, staff are doing the best they can with what they have.

STAKEHOLDER INTERVIEWS

Collection and review of stakeholder input was a vital component of the work performed and the data collected during the project. Interviews were held with both individuals and groups of key stakeholders representing multiple categories including DSHS and BHS leadership, ESH and WSH leadership and staff, and Labor leadership.

OTB Solutions used a standard interview template with a few pre-determined questions designed to encourage discussion around current state, issues and opportunities for near-term and strategic change, within the structure of the project focus: use of interdisciplinary health care teams, barriers to recruitment and retention, culture of wellness and safety, and responsiveness to patient needs.

The findings described below are a compilation of facts and data uncovered through these interviews, which too, place in person, on the phone, and during the site visits.

Use of Interdisciplinary Care Teams

- Adverse conditions challenge the care teams on a daily basis and most have suffered from a lack of role clarity, standardized processes and little time to meet, develop and manage care plans.
- One stakeholder commented that, "healthcare is a team sport, especially mental health. We are struggling with collaboration because individually, people are in survival mode." This was a common thread among participants and speaks to a need for team leadership and a workforce that wants to be led.
- Most respondents felt that the lack of an Electronic Health Record (EHR) is a significant barrier to improved patient care and safety, communication among the disciplines, a streamlined discharge process and the ability to collect, use and analyze data.

Barriers to Recruitment and Retention

- While the recruiting sprints are generally viewed as positive, there are a number of complaints regarding recent hires, e.g. re-hiring previously terminated employees. Most agree that a stable, well-qualified, better prepared staff is favorable over hiring "just more staff".
- There is consensus around the shortage of psychiatrists and a number of ideas to fill the vacancy gaps, including hiring Psych ARNP's, increased focus on better methods for recruiting physicians and process improvements that increase the ability for other clinicians to work at the top of their licensure. One respondent commented that, "the State does not know how to recruit doctors."
- Another common theme is the cannibalization of the workforce and the competition in various markets for psychiatrists, social workers, RNs, etc. There is a static number of workers whose skill set is interchangeable among employers, making them more unstable as a whole. Retention becomes a problem due to a plug & play skill set that allows for movement within the mental health community when conditions at the current employer change, pay increases occur or new facilities open up.

- There are too many barriers to recruiting, including the absence of more contemporary recruiting methods such as social media. While some techniques have improved and been modernized, recruiting practices remain outdated and out of touch with current and future generations of workers.
- Other barriers to effective staffing are related to the collective bargaining agreements and the relationship between labor and management. While patient care and safety should be top of mind for all parties, adherence to ineffective work rules and individual needs seem to be taking precedence over a team-based approach.

Culture of Wellness and Safety

- The physical plant at both locations, and the limitations of the environment are significant barriers to quality care. The lack of capital funding to improve conditions for patients and staff is a concern and is contributing to low morale and potential threats to safety.
- The deployment of staff for 1:1 monitoring is a major staffing concern and was articulated by a number of respondents. While necessary, the practice of absorbing 1:1's on the wards to a certain threshold and using on-call staff to supplement is causing safety issues for employees and patients. On-call staff are not familiar with work rules, patients or their peers and often times create more work and safety concerns for others.
- With regard to training, New Employee Orientation (NEO) improvements, ongoing CEU's and CME's, and annual refresher courses and basic mental health education for floor staff and nurses are needed, and just beginning at WSH.
- PERT (Psychiatric Emergency Response Team) roll-outs have had mixed results, with Eastern State Hospital experiencing success, while Western State has been challenged with its implementation, and has redesigned its program, which appears to be much improved. Conservative estimates for the ESH PERT speak to a roughly 50% decrease in seclusions since the go-live in late 2015.

Responsiveness to Patient Needs

- Quality care is an overarching theme and was discussed with nearly every stakeholder group. Most, if not all expressed concerns over the lack of patient focus, insufficient and/or poorly trained staff, lack of a staffing model, poor approach to treatment, variances in the use of interdisciplinary care teams, and a belief that some staff don't know what "a good job" looks like.
- There is too much variation in the treatment planning process and around who is leading treatment teams. The process from start to finish is inconsistent, including how to evaluate and measure the treatment plan for success.
- The use of de-certified beds for the aging patient population is drawing staff away from higher acuity patients at Western State Hospital. These patients are not benefiting from the hospital and should be transferred to long-term care, skilled nursing facilities or other appropriate community settings. Many respondents are curious about the organization's mission as an "active treatment facility versus a residence" for patients not able to function independently.

BENCHMARKING/BEST PRACTICE FINDINGS

Introduction

A recent Staffing Plan Assessment commissioned by the Oregon State Hospital concludes that due to the uniqueness of each psychiatric hospital and perhaps other factors, there are no meaningful national staffing benchmarks and/or comparable resources for inpatient psychiatric hospital models. Furthermore, each hospital has treatment methodologies and outcome goals that influence staffing. Consistent feedback, including input from the Director of Quality for the National Association of Psychiatric Health Systems and The Joint Commission, Inpatient Psychiatric Hospital Standards Division, supports this conclusion.

There are few psychiatric hospitals to use as benchmarks because, in part, most are struggling to acquire, train and retain enough high performing staff, are operating in poorly designed and maintained physical environments, and lack strong leadership to make system changes. That said, there are practices emerging in a few states where hospitals, like ESH and WSH, have been charged with making significant improvements in quality of care. Those practices are beginning to be collected and shared among states in the Western Psychiatric State Hospital Association (WPSHA). This report contains examples of some of those practices and tools with potential applicability to the unique needs of ESH and WSH.

WPSHA also annually collects data from 24 state psychiatric hospitals covering 15 states in the western region of the United States. The aggregated self-reported data is then provided to the hospitals for benchmarking purposes. This data reflects the median and average in the categories of Direct Care FTE per Staffed Bed (Median 1.59, Average 1.63) and Average Daily Cost per Bed (Median $582, Average $621). Because each hospital varies in size, scope and intensity in the services provided, the types of patients they treat, and the care model they use, it is difficult to draw any meaningful conclusions or insights from the data. This is why the sharing of emerging promising practices is proving more useful since it provides for the sharing of new ideas, some of which can be deployed to different environments with appropriate adjustments made by the professionals in each hospital.

The following example practices are from Oregon State Hospital. There are undoubtedly similarities between Washington's experience and where Oregon was approximately six years ago. Oregon continues to make investments in improved practices that ultimately affect its staffing. Although significant financial investments were made to build a new facility, the practice examples provided have little to do with a new hospital physical campus, but describe work done in continuing to transform the culture and improve quality of care. Following a recent joint commission review, it was suggested that OSH apply for a Baldrige Award. Staffing plans are reviewed and adjusted each biennium based upon the effects of and needs related to these practices.

Oregon State Hospital Staffing Model Framework

The specific factors affecting staffing are:

- Patient Acuity
- Call-Outs/Absenteeism
- Staff Competencies and Experience
- Precautions (1:1, 2:1, 3:1)
- Admissions and Transfers
- Physical Environment
- Care Delivery Model

The Outcome Measures in the OSH Performance Management System are:

Patient Outcomes

- Adverse Events
- Seclusion and Restraint
- Assaults
- Falls
- Hospital Outcomes

Hospital Outcomes

- Financial Costs
- Throughput
- Wait Time for Admission

Staff Outcomes

- Retention
- Satisfaction
- Injuries Turnover

Oregon's current staffing model uses a ratio model combined with acuity-based staffing. A set mix of clinical staff is allocated to each program each day. As patient acuity increases, additional staff can be added. Patient acuity is routinely reevaluated throughout the shift to ensure staffing is appropriate to meet the needs of the patient population.

The criteria used to make daily staffing decisions are based on unit census and on a Supervising Nurse's assessment of patient acuity (i.e., Patients on 1-to-1 precautions, or close supervision due to a patient's behavior). This is done on every shift, on every unit. OSH developed "staffing ratios" for each unit and shift last year, based on six months' worth of aggregated data that led them to identify "usual" staffing levels (e.g., a unit's ratio may be 1 to 3, so if that unit has 21 patients who are not on precautions, they would not be questioned if they worked with seven MHT staff). Thus, the Supervisor's decision each day is a determination of whether a unit can work above or below the number of staff that the ratio provides. Every unit on day and swing shift gets two RNs. Night shift gets one RN per unit. The Supervising Nurse, if and when necessary, can contact their supervisor (called the Assistant Director of Nurses) for help.

Absenteeism/call-outs/vacancies are covered with a mix of voluntary (98.4%) and mandatory (1.6%) overtime. Additional FTE are being requested to reduce the amount of overtime.

Precautions are by physician order and these 1:1, 2:1, or 3:1 staff ratios have a significant impact on the number of staff needed each day. Only a doctor can order precautions, but the MD's decision is based on input from the unit RN. Precautions are tracked and monitored for accountability, continuous improvement and best practice information each day. OSH is considering building some number of projected precautions staffing into the daily model, but will be mindful that this may drive behavior toward assigning when not necessary or may result in additional staff call outs.

A significant part of OSH's treatment model entails the use of treatment malls. In order for patients to travel to treatment malls and off-site activities while others remain on program floors, additional staff is required.

OSH is requesting an additional 203 FTE broken down as follows:

- Mental Health Technician (MHT): 166
- Registered Nurse (RN): 23
- Licensed Practical Nurse (LPN): 14

Although additional staff sometimes exceeds the cost of overtime with existing staff numbers, there are other costs to consider, arguably more significant, such as fatigue, burnout, medications errors and other safety risks related to excessive overtime.

Float Pool

OSH aims to have about 100 staff in their float pool, which, right now, includes only MHTs. There have been RNs in the float pool in the past, but this is not currently necessary because the hospital is able to fill enough full-time RN positions. MHTs are only required to be CNAs if working on the neuro-geriatric units.

Float pool MHTs can be assigned anywhere. Early on in their employment, they are deliberately floated to every area, so they have some familiarity with the different populations, and with the rules that can vary by unit.

The float pool has been a critical strategy for ensuring adequate staffing and in reducing mandated overtime for the hospital.

Psychiatrist Staffing (OHSU Partnership)

Oregon State Hospital, like most psychiatric hospitals, has struggled to recruit psychiatrists in the past. A partnership with the Oregon Health & Science University (OHSU) has alleviated that problem. When a doctor is hired, each has a choice to be employed either by OSH or by OHSU. Currently, about half of the doctors are OHSU employees. This arrangement ensures adequate staffing and helps to create a future workforce pipeline.

Other Staffing Needs

The OSH Cabinet (executive leaders) at the beginning of each biennium, develop a "staffing plan" that lists the number of every type of staff they need and can afford. The staffing plan guides all hiring, and is adjusted periodically when circumstances change (e.g., they decided to hire more Collaborative Problem Solving (CPS) coaches, so had to decrease what had originally been planned in other areas).

OSH doesn't have specific standards for transporting patients to the treatment mall because they are all inside a secure perimeter. If the malls were in a separate building, they would require at least three MHTs to transport them. Normally two staff (a Security staffer and a MHT) transport patients off grounds. More can be assigned if they have concerns about the patient's behavior, or if he/she poses an escape risk.

Hiring/Selection Process

All applicants are interviewed by a panel of staff from the department in which they'll be working, after having been screened in or out by HR (which reviews applications to determine if a person meets the qualifications). Sometimes, there are two levels of interviews (i.e., two separate panels). OSH has low turnover of newly-hired staff in most areas which is a positive indicator.

Current low turnover in nursing is attributed to a much-improved orientation process.

HR resources are adequate, but the hospital points out it can always use more.

Constraints

Barriers to more effective use of staff at OSH include limitations imposed by union contract language and the volume of patients coming in to hospital for Aid and Assist to determine competency for court trial.

OSH leadership will need to collaborate with the union to revise contract language to better serve patient needs. Agency and state-level leadership support may be required.

Staff call-outs/absenteeism continues to be an issue. Provisions of union contracts and FMLA/OFLA protect most, if not all, of these absences. OSH will seek to collaborate with the union on an approach to address accountability for calling out.

According to WPSHA, the median and average number of court orders for per-100,000 population by state are 4.79 and 6.04 respectively. Oregon is at 17.73, the highest in the western states. The legislature, state policy makers, and local jurisdictions must work together to stop this growth trend as it is unsustainable for OSH.

Overtime Tracking, Monitoring, Reporting

Perhaps the most significant practice affecting staffing and overtime is daily tracking and monitoring to the staffing plan. If a manager deviates from the plan, they must provide appropriate justification. This has improved manager performance and ensured proper actions are taken, and not just those of least resistance.

Use of Interdisciplinary Teams

The structure for Interdisciplinary Teams (IDTs) at OSH begins with Cabinet-level oversight. At the top of the organizational structure reporting to the Cabinet is a Clinical/Administrative Team (CAT). This team includes a CMO, Deputy CMO, Discipline Chiefs, Program Directors and a Treatment Mall Director.

At the next level are the Program Executive Teams (PETs), each of which includes a Program Director, Associate Chiefs and a Treatment Mall Manager.

Representing the last layer are the IDTs, each of which includes an MD, a Ward Program Administrator and a Social Worker as core staff. As needed, a Treatment Mall Manager, a Psychologist, and Rehabilitation therapists (OTs/RTs) are added.

It is important to note that although this structure provides for accountability with daily, weekly, monthly and quarterly metrics, it isn't designed to be top down. The CAT serves the PETs and the PETs serve the IDTs.

On the Treatment Mall, there are "terms", like a community college, for example. Offerings are designed based on needs by program. Hours and progress are tracked and regularly assessed by the IDTs.

A Clinical Rounds Model entails the core IDT meeting with patients two hours each morning, making clinical decisions, and problem solving unit issues.

Collaborative Problem Solving Treatment Model

The Collaborative Problem Solving (CPS) treatment model focuses on including the patient as an equal partner in their recovery journey. Patients and CPS treatment providers work together to develop and strengthen the skills required to transition back into the community and avoid re-admission. The CPS model provides cutting-edge mental health treatment to patients, and it has proven to reduce violence, injuries to both staff and patients, and episodes of patient seclusion and restraint. This model has the potential to increase patient-to-staff ratios, reducing the number of direct-care staff needed for patient care.

OSH has been using the CPS model on the four units with the highest acuity for more than a year, and the results are very promising. During the first year of using the CPS model, patient restraints dropped by 41%, patient seclusions dropped by 34%, staff injuries dropped by 12% and patient injuries dropped by 24%. The expected results from expansion of the CPS model would be similar for the remaining 26 units of the hospital. More than 800 staff have completed CPS training so far.

Currently, the CPS team consists of one Program Executive Manager, and 17 CPS coaches (14 in Salem and 3 in Junction City). OSH is seeking to expand by adding 13 additional staff – 10 CPS coaches (9 in Salem and one in Junction City), one Program Executive Manager, one Clinical Psychologist II, and one Administrative Specialist I. With expansion, each campus would have a dedicated CPS coach and support from a Psychologist. The Manager will serve as an associate manager, and the Clinical Psychologist II will serve as a CPS content expert and provide clinical coaching in CPS methodology. CPS coaches are a mix of MHTs, psychologists, rehabilitation staff and staff with other clinical backgrounds.

Expansion of CPS throughout the hospital means OSH will consistently and fully meet the active treatment requirements for CMS certification.

Discharge Planning

Discharge planning is the responsibility of the treatment team on the unit. As with many other functions and processes at OSH, there are performance metrics around time to discharge as part of Lean management and the OSH Performance Management System. Additional support staff were hired in order to alleviate Social Workers from administrative tasks preventing them from fully working to the level of their licensure. For example, support staff handle much of the paperwork and conduct basic outreach to locate placement opportunities for patient discharge. Keeping this function with the treatment teams supports a patient-centered approach rather than a function-centered approach. The treatment team is most motivated to achieve outcomes for the patient.

Reimbursable Services

OSH recently received CMS certification for 115 beds and is well-positioned to certify an additional 454 hospital beds, bringing the total to 569, which would be all hospital-level-of-care beds. CMS certification means the hospital can bill insurance plans for patients covered under Medicare, Medicaid, and third party (commercial) insurances. If OSH can certify the additional beds, the conservative estimate is a $33.5 million increase in other fund revenues for 2017-2019 and $40-$75 million or more in subsequent biennia. To achieve and sustain CMS certification, the hospital needs to invest $23.1 million of this new revenue in utilization management, safety improvements that address treatment and staffing levels, and compliance with CMS regulations. The benefit of this effort accomplishes the following:

- Reduces the financial burden on patients
- Reduces uncompensated care
- Frees up General Fund dollars to be reinvested in the community behavioral health system
- Improves care and treatment for patients
- Improves safety for both patients and staff

Staffing implications include expanding the Collaborative Problem Solving model and hiring more CPS coaches; potentially adding a limited duration Nursing Float Pool; establishing higher staff-to-patient ratios to maintain a safe treatment environment when high acuity is present; and additional staff for Precautions as ordered by doctors.

Communications

A key component of the transformation work to date is an emphasis on communications, especially internal communications. A small communications staff of three people perform a long list of services designed to support the culture of continuous improvement and staff engagement, coordinate well with external stakeholders, and assist with recruitment efforts by bringing professional-level communications and marketing strategies to a partnership with HR. A formal communications plan is in place, is flexible as needed, and is reviewed and updated annually.

CURRENT STAFFING MODEL

While two previous staffing model studies have been commissioned over the past 7-8 years (referenced as the "Geller" report and the "Nash" report), neither set of recommendations was ever fully implemented at either state hospital. The general consensus at both hospitals, however, is that both models could have been effective if employed.

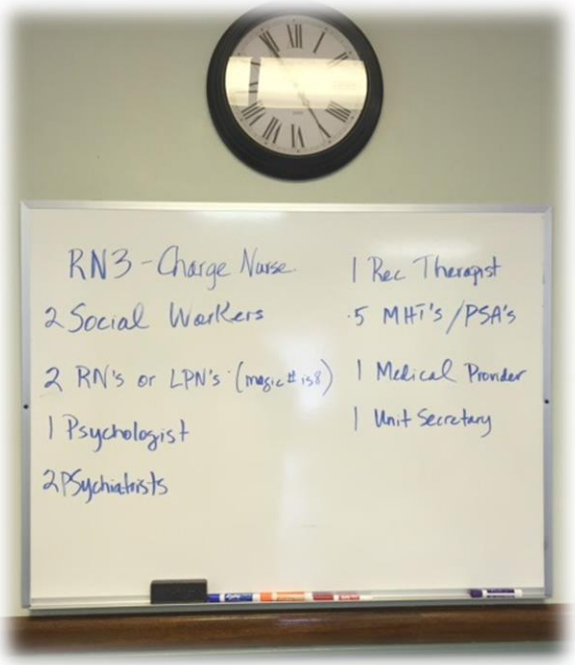
At this time, neither state hospital uses an official staffing model as the basis for staffing patient wards, nor is a standard method of staffing used between the hospitals, with each hospital addressing their unique staffing needs through their own process or set of processes.

At the inception of the project, the hospitals provided a set of baseline data which included staffing levels by ward, divided into centers/units and type of ward. Below is a summary of the staffing process at each hospital.

Eastern State Hospital

ESH has a certain base staffing level at each ward which is based on considerations such as number of beds, average census, and type of ward (e.g., forensic admissions, civil habilitative mental health, or HMH, civil geropsych, etc.). Current open job positions (vacancies) in each ward also play into a ward's base staffing.

To staff wards daily, the base staff is taken into account, and adjusted situationally based on current census, current level of acuity, physician-assigned 1:1 or 2:1 monitoring. Additionally, staff vacations, leaves and call-outs are considered.



Once the current staffing situation is gauged, staff schedulers at ESH use a target number to figure how many, if any, additional staff must be brought in for the day (or longer period) to meet this number, which is in essence a combination of nursing workers including RNs, LPNs and MHTs (or PSNs and PSAs, in the case of forensic wards). To meet these daily staffing needs, ESH uses pools of ward-level floaters or on-call workers.

The tables on the following two pages illustrate the current staffing levels by unit and type of ward at Eastern State Hospital.

Eastern State Hospital
Total Number of Staff Positions Assigned per Ward

	Ward Info	Forensic - FSU					Civil - HMH	
	Ward/Unit	2N3	1S1	2S1	3S1	Total	HMH	Total
	Type of Ward	& Cond. Rel	CR	& Cond. Rel.	CR		DD	
	Admissions Unit		X					
	Census	31	25	34	27	86	8	8
	Beds	30	28	40	27	95	10	10
Day	RN3	1.00	1.00	1.00	1.00		1.00	
	RN2	3.30	4.00	3.00	3.00		2.00	
	LPN2/LPN4/PSN	2.00	1.00	2.00	1.00		1.00	
	MHT1/MHT2/MHT3/PSA	6.80	9.00	6.00	8.00		8.00	
	Psychiatrist	1.00		1.00	1.00		0.50	
	Physician		1.00				1.00	
	Psychologist	1.00						
	PA/ARNP	1.00			1.00			
	Psychology Associate		0.50		0.50			
	Social Worker	2.00	2.00	1.00	1.00		1.00	
	Office Assistant	1.00	1.00	1.00	1.00		1.00	
Eve	RN3	1.00	1.00	1.00	1.00		1.00	
	RN2	1.60	2.00	3.10	3.00		2.00	
	LPN2/LPN4/PSN	2.00	1.00	1.00	2.00			
	MHT1/MHT2/MHT3/PSA	5.10	8.00	8.00	7.00		11.00	
	Psychiatrist							
	Physician							
	Psychologist							
	Psychology Associate							
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Night	RN3	1.00	1.00	1.00	1.00		1.00	
	RN2	3.30	2.00	2.00	2.00		2.00	
	LPN2/LPN4/PSN	2.00	1.00	1.00	1.00		1.00	
	MHT1/MHT2/MHT3/PSA	6.80	4.00	5.00	5.00		8.00	
	Psychiatrist							
	Physician							
	Psychologist							
	Psychology Associate	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00

FLOAT staff:	RN	PSA	MHT
DAY SHIFT	2.60	3.60	1.80
EVENING SHIFT	1.00	3.20	0.60
NIGHT	3.20	4.50	2.50

PERT TEAM	RN	IC 3
DAY	2	2
EVE	1	4
NIGHT	0	0

NGRI: Not Guilty By Reason Of Insanity
CR: Competency Restoration
Cond Rel: Pre-conditional and Conditional Release
DD: Developmentally Disabled
Older Adult: 50+ years old
Rehab: Rehabilitation; long-term

Eastern State Hospital
Total Number of Staff Positions Assigned per Ward

	Ward Info	Civil - APU				Civil - GPU			
	Ward/Unit	1N1	2N1	3N1	Total	B_WARD	D_WARD	E_WARD	Total
	Type of Ward								
	Admissions Unit	X					X		
	Census	31	29	30	90	16	15	30	61
	Beds	31	30	30	91	30	31	30	91
Day	RN3	1.00	1.00	1.00		1.00	1.00	1.00	
	RN2	4.00	2.00	2.00		3.00	4.20	3.00	
	LPN2/LPN4/PSN	3.00	3.00	2.00		2.00	1.00	2.00	
	MHT1/MHT2/MHT3/PSA	7.00	7.00	7.00		9.00	6.00	6.00	
	Psychiatrist	2.00	1.00	1.00		1.00	2.00	1.00	
	Physician	1.00							
	Psychologist		4.00				2.00		
	PA/ARNP			1.00		1.00		1.00	
	Psychology Associate								
	Social Worker	3.00	2.00	1.00		1.00	3.00	1.00	
	Office Assistant	1.00	1.00	1.00		1.00	1.00	1.00	
Eve	RN3	1.00	1.00	1.00		1.00	1.00	1.00	
	RN2	5.00	2.50	3.00		3.00	3.50	2.00	
	LPN2/LPN4/PSN	2.00	1.00	1.00		1.00	1.00	2.00	
	MHT1/MHT2/MHT3/PSA	14.00	7.00	8.00		7.00	7.00	5.50	
	Psychiatrist								
	Physician								
	Psychologist								
	Psychology Associate								
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0
Night	RN3	1.00	1.00	1.00		1.00	1.00	1.00	
	RN2	3.00	2.00	3.00		2.00	2.00	2.00	
	LPN2/LPN4/PSN	2.00	1.00	1.00		1.00	1.00	1.00	
	MHT1/MHT2/MHT3/PSA	5.00	4.00	3.00		5.00	3.00	3.00	
	Psychiatrist								
	Physician								
	Psychologist								
	Psychology Associate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0

FLOAT Staff:	RN	PSA	MHT
DAY	2.60	3.60	1.80
EVE	1.00	3.20	0.60
NIGHT	3.20	4.50	2.50

PERT TEAM	RN	IC 3
DAY	2	2
EVE	1	4
NIGHT	0	0

NGRI: Not Guilty By Reason Of Insanity
CR: Competency Restoration
Cond Rel: Pre-conditional and Conditional Release
DD: Developmentally Disabled
Older Adult: 50+ years old
Rehab: Rehabilitation; long-term

Western State Hospital

Wards at WSH have a certain base staffing complement which has been heavily impacted in recent years by staff leaving the hospital for various reasons outlined in this report, and the numerous barriers to recruitment and retention that have made it difficult to fully staff each ward with full-time employees. While there is a base staffing level for each ward which takes into account the same types of considerations that are used at Eastern State Hospital, there is high likelihood that any given ward is understaffed when compared to its authorized complement of employees.

As such, WSH depends heavily on prior daily staffing and loosely uses the Johnson acuity tool to make adjustments based on the shifting needs of the ward and its patients. Nurses in each ward report daily on the acuity levels they are experiencing, and based on this information, the centralized scheduling function determines the level of staffing necessary each day for each shift in each ward. It should be noted that this is largely a paper-based process.

Western State Hospital does not have ward or center-based float pools, but rather a small number of float staff and on-call workers from whom they draw to fill necessary roles in the wards.

The centralized scheduling office is largely responsible for daily staffing levels and manages a spreadsheet-based application to ensure a minimum number of nursing staff, MHT's and PSA's are on the wards. If there are large numbers of call-outs or 1:1's that day, on-call staff are deployed to fill staffing gaps. A common objection to this approach was voiced by numerous staff, largely based on lack of safety and other training necessary to keep both patients and staff safe and wards operating efficiently. WSH has implemented some new training programs recently to address some of these concerns.

The tables on the following three pages illustrate the current staffing levels by unit and type of ward at Western State Hospital.

Western State Hospital
Total Number of Staff Positions Assigned per Ward

	Ward Info	Center for Forensic Services (CFS)										
	Ward/Unit	E1	F1	F2	F3	F4	F5	F6	F7	F8	S4	Total
	Type of Ward	NGRI	CR	CR	CR	NGRI & CR	NGRI	CR	NGRI	NGRI	Cond Rel	
	Admissions Unit		X	X	X							
	Average Daily Census	31	27	25	27	30	29	24	31	31	14	269
	Beds	30	29	29	29	31	31	29	31	31	15	285
Day 6:45 a.m. - 3:00 p.m.	RN3	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	10
	RN2	2.00	4.00	4.00	3.00	3.00	3.00	4.00	3.00	3.00	2.00	31
	LPN2/LPN4/PSN	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	29
	MHT1/MHT2/MHT3/PSA	5.00	7.00	6.00	4.00	5.00	5.00	6.00	5.00	5.00	3.00	51
	Institution Counselor 2				1.00			1.00				2
	Institution Counselor 3											-
	Psychiatrist	1.00	2.00	2.00	1.50	1.00	1.00	1.50	1.50	1.00	1.00	14
	Physician	0.50	0.50	0.50	0.33	0.33	0.50	0.50	0.75	0.33	0.25	4
	Psychologist	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	10
	Social Worker		3.00	3.00	2.00	2.00	2.00	3.00	2.00	2.00		19
	Office Assistant	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	10
Eve 2:45 p.m. - 11:00 p.m.	RN3	0.50	1.00	1.00	1.00	1.00	0.50	1.00	0.50	1.00	0.50	8
	RN2	2.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	28
	LPN2/LPN4/PSN	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	2.00	28
	MHT1/MHT2/MHT3/PSA	5.00	6.00	6.00	6.00	4.00	5.00	6.00	5.00	5.00	2.00	50
	Institution Counselor 2											-
	Institution Counselor 3											-
	Psychiatrist											
	Physician											
	Psychologist											
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Office Assistant											
Night 10:45 p.m. - 7:00 a.m.	RN3	0.50	1.00	1.00	0.50	0.50	0.50	0.50	0.50	0.50	0.50	6.00
	RN2	3.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	1.00	0.00	18.00
	LPN2/LPN4/PSN	3.00	3.00	3.00	3.00	2.00	2.00	2.00	2.00	2.00	1.00	23.00
	MHT1/MHT2/MHT3/PSA	3.00	3.00	3.00	3.00	3.00	3.00	4.00	3.00	3.00	1.00	29.00
	Institution Counselor 2	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Psychiatrist											
	Physician											
	Psychologist											
	Social Worker											
	Office Assistant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Psychiatrist coverage for evening, night, and weekends is handled by 1 FTE.
Physician coverage for evening, night, and weekends is handled by 1 FTE.
These positions work only day shift; there is no coverage for evening, nights and weekends.

NGRI: Not Guilty By Reason Of Insanity
CR: Competency Restoration
Cond Rel: Pre-conditional and Conditional Release
DD: Developmentally Disabled
Older Adult: 50+ years old
Rehab: Rehabilitation; long-term

Nurse Managers: Each Center has at least one Nurse Manager
CFS - 3
Central - 1
East - 1
South/HMH - 1

Western State Hospital
Total Number of Staff Positions Assigned per Ward

	Ward Info	HMH*			Central						
	Ward/Unit	W1N	W1S	Total	C2	C3	C5	C6	C7	C8	Total
	Type of Ward	DD	DD		Older Adult Rehab	Acute	Acute	Acute	Rehab	Acute	
	Admissions Unit					X	X	X		X	
	Average Daily Census	14	14	28	30	29	29	29	30	30	177
	Beds	15	15	30	30	30	30	30	30	30	180
Day 6:45 a.m. - 3:00 p.m.	RN3	0.50	0.50	1	1.00	1.00	1.00	1.00	1.00	1.00	6
	RN2	1.00	1.00	2	3.00	3.00	3.00	3.00	3.00	3.00	18
	LPN2/LPN4/PSN	1.00	2.00	3	3.00	3.00	3.00	3.00	3.00	4.00	19
	MHT1/MHT2/MHT3/PSA	0.00	0.00	-	5.00	4.00	4.00	4.00	4.00	3.00	24
	Institution Counselor 2	6.00	6.00	12		1.00		1.00	1.00	1.00	4
	Institution Counselor 3	2.00	2.00	4			1.00				1
	Psychiatrist	0.50	0.50	1	1.00	1.00	1.00	1.00	1.00	1.00	6
	Physician	0.33	0.33	1	0.50	0.50	0.50	0.50	0.33	0.50	3
	Psychologist			-	1.00	1.00	1.00	1.00	1.00	1.00	6
	Social Worker	0.50	0.50	1							-
	Office Assistant	1.00	1.00	2	1.00	1.00	1.00	1.00	1.00	1.00	6
Eve 2:45 p.m. - 11:00 p.m.	RN3	0.50	0.50	1	0.50	0.50	0.50	0.50	0.50	0.50	3
	RN2	0.50	0.50	1	3.00	3.00	3.00	3.00	3.00	3.00	18
	LPN2/LPN4/PSN	1.00	1.00	2	3.00	3.00	2.00	3.00	3.00	3.00	17
	MHT1/MHT2/MHT3/PSA	1.00	2.00	3	5.00	5.00	5.00	3.00	3.00	6.00	27
	Institution Counselor 2	7.00	7.00	14				1.00	1.00		2
	Institution Counselor 3	1.00	1.00	2			1.00				1
	Psychiatrist										
	Physician										
	Psychologist										
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Office Assistant										
Night 10:45 p.m. - 7:00 a.m.	RN3	0.50	0.50	1.00	0.50	0.50	0.50	0.50	0.50	0.50	3.00
	RN2	1.00	1.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	12.00
	LPN2/LPN4/PSN	1.00	2.00	3.00	2.00	2.00	3.00	3.00	3.00	3.00	16.00
	MHT1/MHT2/MHT3/PSA	1.00		1.00	4.00	3.00	3.00	3.00	3.00	3.00	19.00
	Institution Counselor 2	3.50	3.50	7.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Psychiatrist										
	Physician										
	Psychologist										
	Social Worker										
	Office Assistant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

*HMH: Habilitative Mental Health

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These positions work only day shift; there is no coverage for evening, nights and we

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CFS - 3
Central - 1
East - 1
South/HMH - 1

Western State Hospital
Total Number of Staff Positions Assigned per Ward

	Ward Info	East								South					
	Ward/Unit	E2	E3	E4	E5	E6	E7	E8	Total	S3	S7	S8	S9	S10	Total
	Type of Ward	Rehab	Older Adult Rehab	Rehab	Older Adult	Older Adult Rehab	Older Adult Rehab	Older Adult Rehab		Older Adult Rehab	Rehab	Rehab	Rehab	Rehab	
	Admissions Unit				X										
	Average Daily Census	26	30	27	27	26	28	27	191	30	32	29	30	30	151
	Beds	27	30	27	30	26	28	27	195	30	32	30	30	30	152
Day 6:45 a.m. - 3:00 p.m.	RN3	1.00	1.00	1.00	1.00	1.00	1.00	1.00	7	1.00	1.00	1.00	1.00	1.00	5
	RN2	3.00	3.00	3.00	3.00	3.00	3.00	3.00	21	2.00	2.00	2.00	2.00	3.00	11
	LPN2/LPN4/PSN	3.00	4.00	3.00	3.00	3.00	3.00	4.00	23	3.00	3.00	3.00	3.00	3.00	15
	MHT1/MHT2/MHT3/PSA	6.00	5.00	6.00	6.00	6.00	5.00	5.00	39	4.00	4.00	5.00	5.00	5.00	23
	Institution Counselor 2			2.00					2	1.00	1.00	1.00	1.00		4
	Institution Counselor 3								-						-
	Psychiatrist	1.00	1.00	1.00	2.00	1.00	1.00	1.00	8	1.00	1.00	1.00	1.00	1.00	5
	Physician	0.83	0.50	0.33	1.00	0.50	0.50	1.33	5	1.33	0.33	0.33	0.33	0.50	3
	Psychologist	1.00	1.00	1.00	1.00	1.00	1.00	1.00	7	1.00	1.00	1.00	1.00	1.00	5
	Social Worker	2.00	1.50	1.00	2.00	1.50	1.50	1.50	11	1.50	1.50	1.50	1.00	1.50	7
	Office Assistant	1.00	1.00	1.00	1.00	1.00	1.00	1.00	7	1.00	1.00	1.00	1.00	1.00	5
Eve 2:45 p.m. - 11:00 p.m.	RN3	1.00	0.50	1.00	1.00	0.50	0.50	0.50	5	0.50	0.50	1.00	0.50	0.50	3
	RN2	3.00	3.00	3.00	3.00	3.00	3.00	3.00	21	2.00	2.00	2.00	2.00	2.00	10
	LPN2/LPN4/PSN	3.00	3.00	3.00	3.00	3.00	3.00	3.00	21	3.00	3.00	3.00	3.00	3.00	15
	MHT1/MHT2/MHT3/PSA	4.00	5.00	4.00	5.00	5.00	4.00	5.00	32	3.00	5.00	4.00	5.00	5.00	22
	Institution Counselor 2			2.00					2	1.00		1.00	1.00		3
	Institution Counselor 3								-						-
	Psychiatrist														
	Physician														
	Psychologist														
	Social Worker	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Office Assistant														
Night 10:45 p.m. - 7:00 a.m.	RN3	1.00	0.50	0.50	0.50	0.50	0.50	0.50	4.00	1.00	0.50	0.50	0.50	0.50	3.00
	RN2	2.00	2.00	2.00	2.00	2.00	2.00	2.00	14.00	2.00	2.00	2.00	2.00	2.00	10.00
	LPN2/LPN4/PSN	3.00	2.00	3.00	3.00	3.00	3.00	2.00	19.00	2.00	3.00	2.00	3.00	3.00	13.00
	MHT1/MHT2/MHT3/PSA	2.00	4.00	3.00	3.00	3.00	3.00	4.00	22.00	4.00	3.00	4.00	3.00	3.00	17.00
	Institution Counselor 2	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Psychiatrist														
	Physician														
	Psychologist														
	Social Worker														
	Office Assistant	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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STAFFING MODEL RECOMMENDATIONS

INTRODUCTION

As a result of the analysis described above and with consideration of benchmarking information and best practices, a proposed Clinical Staffing Model has been developed. Please refer to Appendix A for full details.

The analysis and recommendations contained in this report take into account current staffing models, the use of interdisciplinary health care teams, ward size, and what staffing models and staffing mix would achieve optimal treatment outcomes. The study included a review of the barriers to adequate recruitment and staff retention and considered related issues such as steps to achieving a sustainable culture of wellness and recovery, improved responsiveness to patient needs, and recommended practices to increase safety for staff and patients. Finally, workforce market shortages and other limiting factors to realizing a new staffing model at the state hospitals were considered.

This model should be considered as core foundational ward staffing to provide safe and high quality care. This core staffing can then be adjusted utilizing a relevant acuity model which takes into account ward characteristics (census, admissions, discharges, escorts, whether the ward is solely for admissions, unique physical layout), psychiatric/behavioral considerations (1:1, close observation) and medical considerations (medical close observation, treatments and procedures). A framework for developing that acuity tool is discussed in a later section.

The model includes ward-level patient care staff as well as staff that provide important services but report through centralized departments (e.g. Pharmacy), those who work on specialized teams (e.g. PERT) and/or those who directly impact the ability of the ward staff to care for the patient (e.g. dietary aides). General administrative or support departments such as Food Services, Facilities, Information Technology, Security and others not directly providing patient care are not included.

Ideally, both hospitals would transition to the proposed Clinical Staffing Model in the short-term; however, there are a number of factors that may prevent an immediate implementation, especially at WSH. Adoption of a new Clinical Staffing Model takes time under the best of circumstances. The WSH and ESH transitions should be thoughtfully and deliberately planned, with significant emphasis placed on the coaching and training of executive staff, application of proven Change Management principles and development of and adherence to performance measures to monitor progress. *This cannot be overstated.*

Given the difficult history with staffing shortages and related challenges, efforts will need to be ramped up further to address team building, fostering trust, clarification of roles and responsibilities for each discipline and rapid process improvements. This work is *not* the same as the equally important organizational development work related to recruiting, hiring, providing technical skills training and general onboarding/preceptorship/new hire mentoring. This work is about an *organizational culture shift*. Staffing level adjustments are only part of the solution and even positive change can be stressful in and of itself.

It should be noted that many of the proposed changes contained in this document are well underway and we applaud and support the efforts of hospital leadership to work through and resolve issues.

Major work is also in progress to address the stipulations of the Systems Improvement Agreement (SIA) and the related hiring plan is consistent with this model. A significant organizational turnaround such as that currently happening at WSH is an evolutionary process as these new hires come on board and are integrated into the workforce.

ASSUMPTIONS

This proposed Clinical Staffing Model which outlines the staff needed by shift by ward or by Center/Unit was based upon the following assumptions:

- The model positions staff roles to function at the full scope of their licensure or certification, education and job classification.
- The model positions staff to be able to increase active treatment hours.
- Staffing needs change constantly because patients' psychiatric and physical needs change unpredictably, as is the case with any hospital. In addition, evidence-based practices that are identified at a later date would need to be staffed for.
- This model is for ward-level baseline staffing by shift for a weekday with no 1:1 patients.
- The numbers on the staffing model spreadsheet are per ward, not per Center/Unit.
- The acuity tool would be completed each shift for each patient, and per those scores additional staffing could augment these baseline numbers (including any additional staff needed for 1:1 patients).
- This is ward-level staffing only. Staffing for centralized departments (such as the central PT department), the Treatment Mall and special teams (e.g. PERT Team) would be additional.
- These numbers do not reflect a net gain in staffing from current levels.
- This model takes the facilities about 80% to defining baseline staffing requirements. Certain positions have incomplete staffing numbers in the model due to the need for further role clarity. These include Psychologists, Psych Associates and Institution Counselors. Additional analysis is needed for these roles.
- Beyond the clarifications noted above, some additional fine tuning will be necessary by each facility to arrive at their final baseline staffing numbers.
- Although 24-bed wards are optimal, this model assumes the current 28-30 beds (plus emergency beds) model will continue.
- Each Center/Unit will continue to have dedicated admission wards.
- Any additional supervisory layers would be in addition to the numbers in this staffing model; the numbers reflect direct-care staff and overall ward management.
- Systems Improvement Agreement (SIA) requirements for any ward-level staff are included (e.g. MHT, IC staff).
- Habilitative Mental Health (HMH) mandated staffing requirements for any ward-level staff are included.
- There are duties that should be reallocated to other staff and would no longer be the responsibility of the ward-level Nursing staff, such as:
    - Camera monitoring (this is a security function)
    - Dietary Aide duties (e.g. passing trays, cleaning up the dining area)
    - Environmental service duties (e.g. janitorial, housekeeping, laundry, general cleaning)
- Environmental Services duties (as described above) are *not* the same as environmental *safety* checks performed on the wards.

- Staff should be hired for positions and perform duties that are consistent with their education/training and job description (e.g. Institution Counselors that are Bachelor's or higher prepared in psychology, sociology or other social sciences that bring valuable treatment skills should not be functioning as MHTs performing personal care on the wards. Their job description describes a treatment role so the model appropriately places them in that category).
- The electronic medical record deployment is still at least one year away, so certain staff roles will not significantly change before then (e.g. medical records).
- This model does not account for:
    - Weekend staffing
    - Seasonality patterns
    - Relief coverage to cover non-productive time for training, vacations, etc.
    - The exact duties performed by certain staff which may vary across wards – for example, the role and types of evaluations performed by Psychologists varies by ward since patient populations vary
    - A ward by ward detailed discussion due to time constraints
    - 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)
    - Variation in shift start and end times
    - The length of shift overlap
    - Current vacancy levels
    - On-call coverage (other than general comments)
- Finally, although meaningful national benchmarks for staffing psychiatric hospitals do not exist, this staffing model and overall report contains examples of some specific practices and tools with probable applicability to the needs of ESH and WSH.

Concurrent organizational change management work will be critical to the success of any new staffing model so staff will have the support they need to transition to new work responsibilities, accountability expectations and reporting structures.

Overall, the Nursing staff levels in this model were based on the March 2009 Geller report, *State Hospital Ward Sizes, Discharge Practices, and Community Placement Issues*. The guiding assumptions included the following:

- There will be at least two licensed nurses on each ward at all times, with at least one being a Registered Nurse. If the LPN is being used in direct care staff (versus managing medications and treatments), then two RN's would be needed that shift.
- The required Hours per Patient Day (HPPD) for WA state hospitals should be 6.0 for adult wards. (*Note: HPPD = (Total Nursing Staff x 8 hours)/Ward Census)*
- The required percentage of staff that must be Registered Nurses on adult wards should be 35%.
- The required minimum ratio of direct care nursing staff (*non-RN staff such as MHT, PSA, LPN, PSN)* on adult wards should be:
    - 1:5 for all shifts on acute care wards
    - 1:5 for days and evenings and a 1.6 ratio for nights on intermediate and long term wards
- When a 1:1 situation arises, the ward can absorb the first one *only if* the required overall skill mix ratios are as defined above; if not, additional staff should be provided via the float pool, on call staff or another approach.

Of note, Oregon was utilizing a direct nursing care ratio if 1:3 when they opened their new hospital and were ramping up for the electronic medical record (EMR) deployment. They have since lowered those ratios as they have reached more of a steady state, so the recommendation here is to follow the Geller guidelines for these staffing numbers.

While this Staffing Model presents a shift-by-shift view of staff needed for a snapshot in time on a ward, it does not account for the total number of people needed to fill an FTE position 24/7/365 to account for days off, training, leave and other reasons. Per the 2009 Geller report, a conversion factor of 1.8 would be needed to cover the non-productive time for each FTE. Currently, the Behavioral Health Administration (BHA) uses a ratio of 1.7. Other staffing levels addressed in the March 2009 Geller report included those for Psychiatrists, Social Workers, Medical Physicians, Rehabilitation staff, and the levels depend upon calculations that factor in admissions, transfers and specific characteristics of the patient population (e.g. geropsychiatric patients). Accounting for these would require a great deal more drill-down analysis and data collection per Center/Unit; therefore, only general Geller recommendations were employed, along with WSH and ESH staff recommendations, considerations for the Center/Unit involved, and some benchmarking in order to address staffing those disciplines in the model.

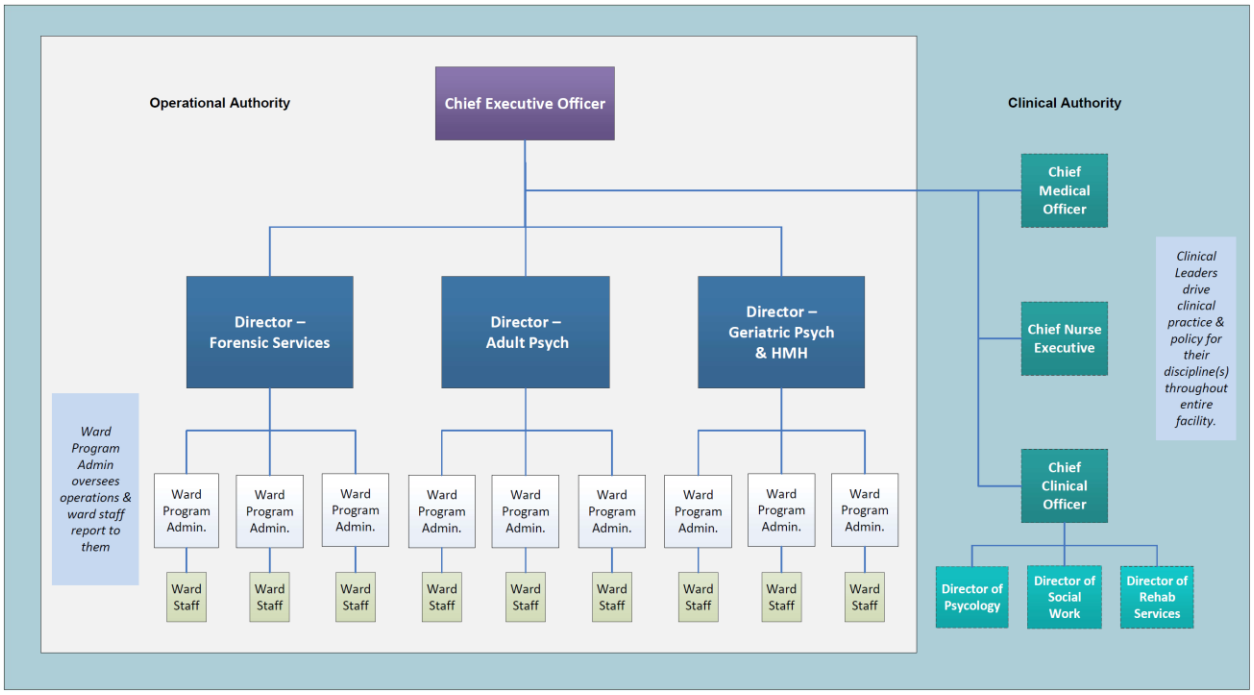
The model assumes that some staff will be going to the treatment mall daily with patients (probably MHT). However, a dedicated core number of mall staff should be in place, along with a dedicated escort/transport staff discussed in this report to minimize the number of staff leaving the ward. This optimizes safety and allows staff remaining on the wards to attend to the more acute patients and work on treatment planning. A deeper dive into the staffing of the Treatment Mall and the staffing required for escorting patients is needed to determine expectations for ward staff involvement in those activities.

ACCOUNTABILITY OVERVIEW

Organization Chart and Lines of Authority

As discussed previously, one of the key issues with the existing clinical staffing model was a result of unclear lines of reporting, management roles and lines of authority to adequately support the clinical and operational organization as a whole. The following organization chart illustrates the proposed structure to address these issues, although it may not be implemented exactly in this way initially. Some additional clinical authority may be needed to assist with staff oversight as the new model evolves.

These changes are currently underway at both hospitals.



Overall, the structure is progressing to be more service-line oriented. Currently, the Center/Unit Directors oversee their areas but have no line authority. At WSH, the directors also have additional responsibilities as clinical practice directors for Rehabilitation Services, Psychology and Social Work which presents challenges in regard to decision making and bandwidth.

In the proposed Clinical Staffing Model, the Center/Unit Directors would act as true service line directors for their respective areas. Each of the wards in their Center/Unit would have a Ward Program Administrator (WPA) who would then report to the Center/Unit Director. In turn, all ward staff from all disciplines would report to their respective Ward Program Administrator. There would be additional supervisors within some wards for certain disciplines depending upon their patient populations. This would provide clear lines of decision making and authority, with the Center/Unit Directors having ultimate administrative responsibility for their area.

Of note, the exception to this would be all physicians and mid-level providers who would report directly though their line of authority to the Chief Medical Officer for their facility and not through the WPA. There is further elaboration on this in the medical section of the staffing model discussion.

Clinical Chiefs at the hospitals drive overall clinical practice, oversight and policy decisions, and set the strategic direction. The Chief Medical Officer, the Chief Nurse Executive and the Chief Clinical Officer would provide this executive guidance for the facility and cultivate key partnerships and affiliations. They would collaborate with Ward Program Administrators and Center/Unit Directors to identify opportunities for improvement and driving clinical quality improvement within their disciplines.

The Center/Unit Directors collaborate with the Clinical Chiefs, with a focus on their respective disciplines. One notable observation during this analysis was that clinicians within the same discipline seemed very silo'd and very focused within their Center. The Clinical Chiefs would play a critical role in teambuilding and conducting regular all-staff meetings within their teams to foster communication as well as to introduce and reinforce best practices. They would also serve as valuable resources for Ward Program Administrators and other staff and provide a higher level perspective during process improvement initiatives. They would identify training opportunities, guidance and assist with performance evaluations so that clinicians could work to the fullest extent of their licensure or certification.

STAFFING MODEL

Ward-Level Staffing Model Components

Two objectives of this analysis were to identify where there may be overlap or lack of clarity for certain roles and to identify where staff could be working to a higher level. While it is understood that all staff are part of the treatment team and are accountable to help execute the treatment plan for a patient (e.g. reinforce certain behaviors, encourage steps to achieve goals, foster certain life skills), their exact role in that process varies. Some staff are more medical and/or personal care focused, some are more therapy focused and some have other duties as they work together to help the patient. The Clinical Staffing Model attempts to better sort out/clarify some of those roles, while acknowledging the overall collaborative nature of the work.

The Clinical Staffing Model is comprised of two portions – ward-level and non-ward-level. Although the scope in this analysis was to define clinical staffing, certain non-clinical positions were also considered since they support the clinicians and their absence contributes to significant additional workload for the direct patient care staff. Professional staff are also drawn away from their essential duties and are not working to the fullest extent of their licensure and training.

Of note, for some of the staff positions additional information is needed such as volumes of transports or present floating needs on Forensics units. Also, there is currently a considerable amount of blending of the Treatment staff roles (e.g. running groups, 1:1 therapy, various evaluations). Therefore, it is difficult to determine to which position staff should be allocated since their optimal duties need to be sorted out further. The summary below and the staffing model spreadsheet serve as discussion points to examine these questions further as the model is implemented.

Many of the changes described below are already underway at one or both hospitals, and consistent with the proposed model.

The major components of the ward-level sections of the Clinical Staffing Model are described below:

Management and Office Support Staff

Each ward would have a **Ward Program Administrator** (WPA) who would have line authority for all staff on that ward (all disciplines) and would have 24/7 responsibility for operations. This position would oversee hiring, conduct performance evaluations for staff, address performance or attendance issues (in collaboration with respective Clinical Directors), disseminate information to staff, troubleshoot issues, encourage team building, address quality issues on the ward, oversee the ward schedule development, manage the budget and perform other management responsibilities. One critical function would be to oversee the interdisciplinary care planning process on the ward to ensure that plans are completed and staff is actively engaged. The Ward Program Administrator would not be included in patient care staffing numbers and would not be included in the bargaining unit.

Individual Ward Program Administrators would have 24/7 responsibility for ward

Various persons could fill the Ward Program Administrator role. However, they should be at least a Masters prepared Registered Nurse, Social Worker, Psychologist or professional in a related field and have 3-5 years of management and leadership experience. Other state hospitals researched for this analysis solely utilize Nurses in this role and the 2009 Geller report supports this approach as well. Regardless of the background of the Ward Program Administrator, they should have previous management experience, with mental health and psychiatric hospital experience strongly preferred. As staff phrased it, they "need leaders, not just highly educated people with no leadership skills and no experience."

The Ward Program Administrator positions previously existed at WSH (then known as Program Managers), but were eliminated during the economic downturn. When they were in place, one issue was lack of leadership experience in general and another was a perception that the Program Managers were making clinical decisions without the credentials to do so. There would need to be clarity regarding the general operational/administrative oversight responsibilities of the WPA and that they do not drive clinical decision-making.

Ward-level office support staff would assist the Ward Program Administrator and others and needed

Ward-level office support staff would include an **Office Assistant** who would assist the Ward Program Administrator as well as perform other duties such as updating forms, placing court orders in the chart, managing other paperwork and providing data entry for treatment plans. This person would act in more of a support role for staff versus a record management person. Those currently in Ward Clerk positions would likely transition to this role.

A second office support staff role could be a **Medical Record/Quality Management Assistant** to maintain charts from arrival through departure and who could take over some of the chart maintenance and quality audits. They could also assist with Lean and other process improvement activities on the wards. Their role could be further defined by the Chief Quality Officer, in collaboration with the Center/Unit Directors. Administrative staff duties would likely change somewhat with electronic medical record deployment in 2017.

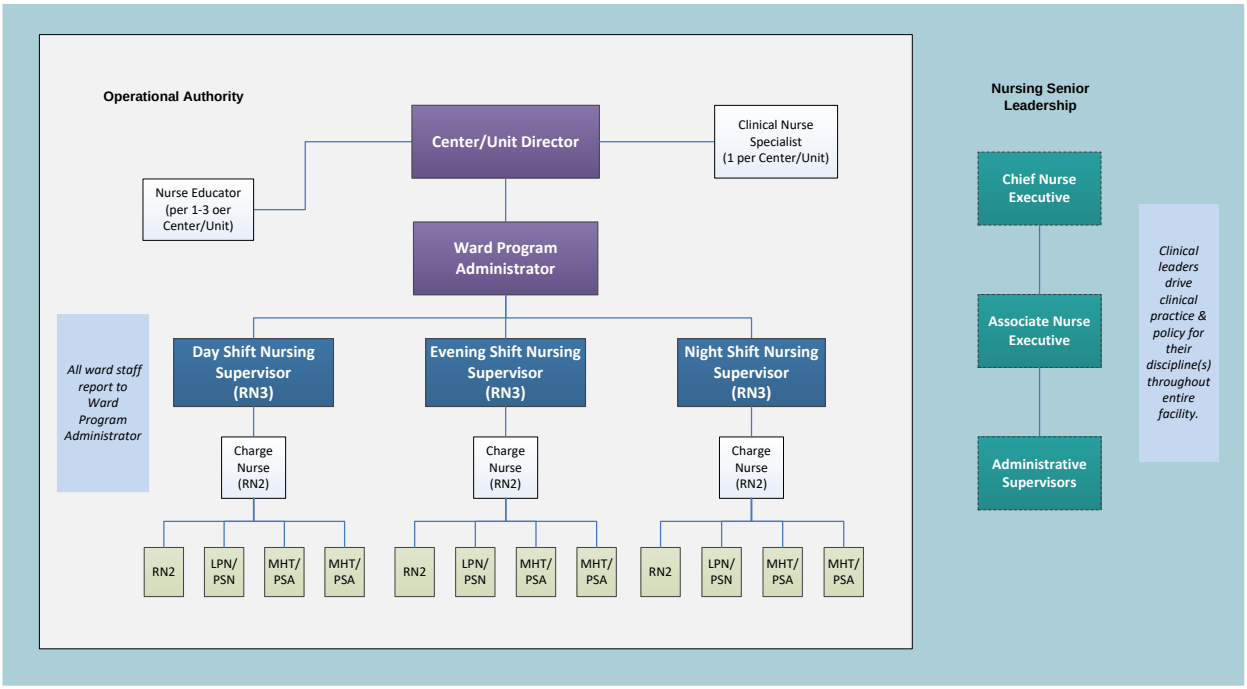
Nursing Staff

Two licensed nurses would be assigned to each ward at all times, and at least one must be a Registered Nurse (usually an RN2). It was clear from the analysis that in addition to their mental health diagnosis, many patients also have a significant number of physical health issues and medication side effects which must be carefully monitored. This is particularly true in the geriatric psychiatric wards. In some cases, non-medical staff and managers downplayed the severity or frequency of significant physical health issues. The nursing role is critical to address both the patient's physical needs and treatment plan goals.

At least two nurses would be assigned to a ward at all times

Currently, at WSH there is a great deal of role confusion and overlap in duties between the RN3, RN4 and the Staffing Office. The RN4 activities include acting as troubleshooter and "referee" for nursing issues, addressing urgent needs, supervising other RN's, signing overtime slips, auditing and overseeing audits, and helping resolve staff-to-staff conflicts. Duties are more clear at ESH, but there is still some sorting out of roles needed between shifts.

The following diagram illustrates the proposed reporting structure for Nursing staff:



The **RN3** staff should function as the ward nursing shift supervisors, with 50% of their time allocated to the office and 50% on the ward (assisting staff, mentoring, serving as charge nurse if needed and other duties such as some auditing). They would complete performance evaluations for the staff on their shift, in collaboration with that person's clinical discipline director (e.g. to clarify policy and expected professional practices) and the Ward Program Administrator. This would increase accountability and enable performance issues to be dealt

with in a more timely manner. Day shift would have one ward-level RN3 each, with evenings and nights having a half positions (or possible one per Center/Unit). That decision could vary by Center/Unit.

RN2 staff would generally serve in the Charge Nurse position on the wards, oversee all nursing staff on the unit and would participate in the Interdisciplinary Care Team meetings. They could also teach groups and oversee other therapeutic interventions on the ward. Currently, these staff are being diverted to perform laundry, housekeeping and other lower level tasks versus working to their licensure.

The nurses should also participate in some sort of shift handoff report for continuity and to build a sense of teamwork. Currently, in many cases the treatment team perspective is that of day shift and other shifts do not feel that they are included. Having more robust reporting and possible scheduling care teams during shift overlap could help incorporate other valuable perspectives as well.

Licensed Practical Nurses (LPN) and Psychiatric Security Nurses (PSN - in forensics units) would function primarily as a medication nurse, document medication compliance and patient response, transcribe the orders, check blood sugar levels and complete treatments. They would assist the RN and other nursing staff as needed and function as a leader when working on the floor with patients and MHT/PSA staff.

Of note, in many, if not most, hospitals the ward clerk/office assistant staff would transcribe orders, with licensed staff simply double checking them. However, given the nature of orders in this setting it is safer to have clinical staff transcribing the orders. Also, with the electronic medical record deployment anticipated within the next year it would be disruptive to transfer this role to office staff and then deploy computerized provider order entry (CPOE) in the near future, thereby changing the process yet again.

The LPN role is heavily relied upon by the state hospitals. Teaching programs are not available on the east side of the state to address this resource, so ESH faces particular challenges recruiting and utilizing these staff.

Mental Health Technicians (MHT) and Psychiatric Security Attendants (PSA – in forensics units) are primarily entry level staff that provide for patient comfort (personal care such as grooming, rest, activity and nourishment), take vital signs, provide for safe milieu (coverage for 1:1 needs, conduct environmental checks), perform general duties around the ward and assist the licensed staff as needed. They could also assist with other duties as needed such as picking up any environmental services or dietary aide duties when the ward is busy or those staff are absent for all or part of a shift. These support tasks should not be expectations of the licensed staff who should be working to the full extent of their licensure and training. A consistent theme during this analysis was that MHT and PSA staff should all have Certified Nursing Assistant (CNA) credentials to provide the most flexibility as they may be needed on the ward. Of note, most, if not all, the MHTs and PSA are high school graduates who come to the facility without any hospital or mental health experience, and as such would need significant training. Recruitment strategies are being revised to better attract those with some health related background.

MHT/PSA staff should be Certified Nursing Assistants (CNA)

Finally, each Center/Unit would have 1-3 **Nurse Educators** to assist with onboarding and serve as a preceptor for new staff. Some may be assigned to a specific ward as needs are identified for staff in those areas. In some cases, the Nurse Educator may be able to cover 2-3 units but most wards could use a dedicated person. Their role would be the more "nuts and bolts" duties related to new employee onboarding, precepting and mentoring; they would also conduct annual review activities, brief targeted training based on identified needs and work with staff who need refresher/remediation training when performance challenges are identified. A separate group of more advanced Clinical Nurse Specialist (CNS) staff, discussed below, would provide additional support for complex patient care and foster adoption of evidence-based clinical practices.

Medical Staff

In addition to their mental health diagnoses, numerous patients also have physical health issues. In many cases these issues can be significant, including seizures, pneumonia, fever, aspiration, Hepatitis C, liver disease, COPD, hypertension, obesity, Diabetes and mobility issues. There are also many patients with substance use disorder challenges, and both hospitals have a population of frail elderly. Patients are often admitted with little to no history from outside and it is difficult to complete a medical workup from scratch. In addition, patients don't communicate, so the providers need to rely much more heavily on skill, laboratory results and x-rays. It can take 6 months to a year on these types of wards to develop a relationship and trust with patients so they are able and willing to communicate more freely and be more involved in their own care.

WSH has an onsite clinic with laboratory and radiology services included. On the other hand, ESH provides medical care on the wards. ESH radiology services are contracted out and are only onsite as needed. Lab services are performed either onsite in the CAP certified laboratory for routine tests, or contracted out if necessary. For major emergencies, there is an onsite response process and 911 is called to transport the patient to the hospital.

Medical physicians, psychiatrists and midlevel staff face various other challenges as well. Lower pay, the lack of time and reimbursement for continuing medical education (CME), chronic shortages with heavy workloads, a churn of locum tenens staff (due to their increased cost and lower continuity with patients) and other issues continue to be taxing. Many of these staff are at or approaching retirement age which will increase the shortage of qualified workforce over the next few years. Medical providers are less involved in treatment teams and planning and sometimes feel that the medical perspective is secondary to mental health even when the patient has significant physical health issues. They should be selectively included in care conferences as indicated for those patients.

Recruiting is a major issue due to the negative attention the hospitals have received as well as a shortage of psychiatrists in particular. In the past, there were medical and psychiatric clinical rotations and a psychiatric residency program which provided a good source of new hires. However, the residency program was eliminated around the time of the 2008 economic downturn. On the other hand, salary levels have recently increased significantly and the physicians are now saying that they're almost comparable with the private sector so that barrier has been reduced.

One unique consideration for the medical providers is that while they will be ward-level in the sense of their duty assignments, they would *not* report to the Ward Program Administrators up to the Center/Unit Directors. They would report through their own line authority (likely the newly hired Center Medical Directors at WSH) up to the Chief Medical Officer (at both facilities). However, since they are assigned to specific wards, their numbers are included in the staffing model spreadsheet.

Neither hospital requires physicians to be on call during evenings, nights, weekends and holidays. Off-hour coverage is provided by a designated Officer of the Day (OD) position, with two shifts from 4:00pm to 12:00am and 12:00am to 8:00am. MDs fill this role, work hours after the day shift and on weekends and are compensated with extra duty pay. The designated medical OD at WSH is onsite for physical health issues. At ESH, there is no medical OD onsite during off hours. An onsite psychiatrist OD performs the initial medical assessment and if the situation warrants, the patient is then taken to a local hospital for urgent or emergent care.

Medical Physicians should have a staffing ratio of one physician covering no more than two wards, with the admission and geropsychiatric areas requiring one per ward (due to the full medication review & full physical examination required every month for the latter). Other wards with long-term or chronic treatment could also utilize one physician per ward. Physician coverage would optimally be not more than 40-50 patients per MD.

Medical Physician-to-Patient coverage of 1 to 45 or Physician-to-Ward coverage 1 to 2 depending on acuity

Currently, WSH does not utilize either **Advanced Registered Nurse Practitioner (ARNP)** staff or **Certified Physician Assistant (PA-C)** staff as medical providers. In previous years, WSH utilized some PA-C staff that were not yet certified and were not functioning to their full capacity. They were primarily performing physical exams. Any Physician Assistants hired in the future would need to be certified by the state.

Utilize ARNPs and PA-Cs on the medical staff

ESH employs 4 PA-C and 2 medical ARNPs (not Psych ARNPs) and the staff there feel the mid-level provider model works quite well, as long as their scope of practice is understood. They carry full patient caseloads. Staff is not sure why the state and/or the hospitals are reluctant to consider expanding this model at ESH and instituting it at WSH.

There were concerns raised by physicians regarding this changeover. Their perception was that mid-levels are trained to deal with more common & everyday patient issues (not including mental health issues), and are not trained in more complicated and/or multiple issues affecting many of the hospital patients. Another concern was that physicians would need to manage the workflow to both provide care and also oversee the mid-levels (both ARNP and PA-C), adding to their own workload. While there are some highly complex patients that perhaps would not be appropriate, most patients could be well served by mid-levels, though the transition and orientation process would need to be managed carefully. Finally, a concern was raised about call and night coverage and there is an assumption that mid-levels cannot support call.

ARNPs are independent practitioners and work quite competently in other peer facilities. Per WAC 246-840-300 (ARNP Scope of Practice), the following would guide ARNP practice:

- The ARNP is prepared and qualified to *assume primary responsibility and accountability* for the care of patients.
- ARNP practice is grounded in nursing process and incorporates the use of independent judgment. Practice includes collaborative interaction with other health care professionals in the *assessment and management of wellness and health conditions*.
- An ARNP shall obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or practices.
- Performing within the scope of the ARNP's knowledge, experience and practice, the licensed ARNP may perform the following:
  - Examine patients and establish diagnoses by patient history, physical examination, and other methods of assessment;
  - Admit, manage, and discharge patients to and from health care facilities;
  - Order, collect, perform, and interpret diagnostic tests;
  - Manage health care by identifying, developing, implementing, and evaluating a plan of care and treatment for patients;
  - Prescribe therapies and medical equipment;
  - Prescribe medications when granted prescriptive authority under this chapter;
  - Refer patients to other health care practitioners, services, or facilities; and
  - Perform procedures or provide care services that are within the ARNP's scope of practice according to the commission approved certifying body as defined in WAC 246-840-302.

Certified Physician Assistants (PA-C) on the other hand can be somewhat more limited in their practice and do require supervision. PA-C practice would be guided by RCW 18.71A.020, which specifies:

- That the practice of a physician assistant shall be limited to the performance of those services for which he or she is trained; and
- That each physician assistant shall practice *medicine only under the supervision and control of a physician licensed in this state*, but such supervision and control shall not be construed to necessarily require the personal presence of the supervising physician or physicians at the place where services are rendered.

Per RCW 18.71A.030 Limitations on practice—Scope of practice, the following would also guide PA-C practice:

- Physician assistants may provide services that they are competent to perform based on their education, training, and experience and that are consistent with their commission-approved delegation agreement. *The supervising physician and the physician assistant shall determine which procedures may be performed and the degree of supervision under which the procedure is performed.*

- Physician assistants *may practice in any area of medicine* or surgery as long as the practice is not beyond the supervising physician's own scope of expertise and practice.

Therefore, mid-level providers could work on the wards as they currently do at ESH or in the WSH clinic. The ARNP could assume the same independent patient loads as the medical providers and the PA-C would assume a patient load as determined with their supervising physician, which might vary by patient population. Currently, PA-C at ESH carry their own patient loads and their oversight consists of the following:

- An administrative physician supervisor who signs leave slips, etc.
- A supervising physician with whom they have a written PA practice plan. When the supervising MD is out, the plan names an alternate. The plan details what they are allowed to do at the facility, which is essentially the same as physicians with few exceptions. The supervising MD may supervise more than one PA.
- The medical provider team (the CMO and all the MD and mid-level providers) meets every morning (gero-psych holds a separate meeting). The team reviews consults, complex medical patients, admits and other pressing medical issues.
- The PA consults with their supervising physician as needed for questions and to develop a medical treatment plan for a patient.

Integration of PA-C and ARNP into clinical practice at WSH will require careful planning and trust building with the physician team. Suggested strategies to assist with this integration include the following:

Careful planning and good strategy will help with integration of ARNP and PA-C

- Have WSH physicians conduct site visits and shadow staff at ESH (and/or have ESH providers visit WSH to share best practices)
- Develop a tiered practice plan – start as detailed and restricted as needed, with specific criteria to loosen oversight to what ESH currently has in place as the PA demonstrates competency
- Start with lower caseloads and/or more established patients for the PA as the supervising physicians and the PA build their rapport
- Consider hiring MDs that have worked with mid-levels in other settings
- Use WSH as a PA-C student site (MEDEX students from UW currently work at ESH)
- Hire only NCPPA certified PA who have been board certified via a national exam

With careful implementation planning and hiring criteria, these professionals would bring valuable skills to the facilities as well as help ease the staffing shortages.

Psychiatrists face many of the same challenges as the medical physicians with regard to shortages, difficulty recruiting and pending retirements. Fortunately, there are locums tenens companies who focus just on Psychiatry, but regular use of locums physicians does contribute to unfamiliarity on the part of the patients with those physicians. One suggestion by staff was to rethink the role of the psychiatrist in the Interdisciplinary Care Team (ICT), which could relieve some of their workload in that regard.

Psychiatrist-to-Patient ratio of 1 to 15

A suggested ratio by the providers for their staffing would be a minimum of 1.5 psychiatrists per typical ward and another source suggested 1 per 15 patients or 2.0 psychiatrists per ward. The recommendation here is 2 per ward.

As stated above, neither hospital requires physicians to be on call during evenings, nights, weekends and holidays. Off-hour coverage is provided by a designated Officer of the Day (OD) position, with two shifts from 4:00pm to 12:00am and 12:00am to 8:00am. At both hospitals, an onsite psychiatrist OD covers addresses acute mental health needs.

Utilize Psychiatric ARNPs & expedite residency program implementation

Neither ESH nor WSH currently utilizes **Psychiatric Advanced Registered Nurse Practitioners (P-ARNP)**. However, in July of 2016, a Memorandum of Understanding (MOU) was signed between the State of Washington and the Union of Physicians of Washington (UPW) to create a pilot residency program for one Psychiatric ARNP at WSH and one Psychiatric ARNP at ESH. Additional discussions are underway at this time regarding the details of launching this program. However, given the pressing need for medical providers, the residency program implementation should be expedited and expanded.

Typical duties for Psychiatric ARNPs to work to their full licensure could include:

- Function as a primary psychiatric care provider on a ward just as a Psychiatrist functions
- Attend and lead Interdisciplinary Care Team (ICT) meetings for assigned patients
- Consult with Psychiatrist or medical MD as needed
- Admit and discharge patients
- Other duties as outlined above in the ARNP Scope of Practice

One subject brought up during the analysis was the need for the hospitals to help the Psychiatrists and ARNP with the admission assessment and paperwork, which can be quite time consuming. Some settings do not require the Psychiatrist to complete all the admission work. They perform the examination and documentation and an MSW or Psych Associate would then finish the rest of the admission. ESH might consider utilizing Psych Associates as WSH does, or have Social Workers assist with that function.

Despite the concerns expressed, there was acknowledgment that the use of mid-levels should expand to increase medical provider staffing at the hospitals. Both ESH and peer hospitals in other states are utilizing them, as well as most other non-psychiatric hospitals in the state of Washington. The residency program outlined in the July 2016 MOU will allow for this integration of Psych ARNP into the clinical practice and will provide valuable information on their optimal role. Perhaps as Psychiatric ARNP are integrated into the workforce, psychiatric provider coverage could be one Psychiatrist and one ARNP per ward.

Reinstitute Psychiatric residency program

Specific recommendations would include reinstituting the Psychiatric residency program, initiating other clinical rotations at the facility and rehiring a Continuing Medical Education (CME Coordinator) or incorporating that into a related existing position to facilitate this valuable benefit for the provider staff.

Investigate use of Telepsychiatry

One final recommendation would be to investigate the use of telepsychiatry. Someone who graduated from the residency program at ESH has been doing outpatient work utilizing this technology.

Treatment Staff

Treatment staff can be ward-level, or practice primarily in the Treatment Mall.

Of note, while there are some distinct duties, there also appears to be a great deal of overlap and lack of clarity regarding the various roles. Staff discussed that although involved with active engagement or therapeutic engagement, many were hard pressed to define their role in that process. For example, several different kinds of staff ran groups, although the criteria for starting or sunsetting a group seemed more related to the interest and experience of the staff person rather than an assessment of patient needs. Staff also questioned who led which groups or activities. For example, nurses are teaching anxiety management classes versus others appropriate for their skill set and training, like Diabetes and medication management, and having the various therapists address these other issues.

In particular, the role of the **Psychologist** relative to the other treatment staff could be clarified. Some felt that they were the natural Ward Program Administrators if that role is created, some were very involved in evaluations and preferred to do other more active engagement and 1:1 therapy similar to what others are now doing, some wanted to lead groups that other staff now lead, some felt they should be the lead for the Interdisciplinary Care team meetings (versus the Psychiatrist), some saw themselves in a joint management/clinical role, some felt they should spend more time in the Treatment Mall and some felt they should be conducting training on de-escalation techniques and psychological principles (especially for Nursing staff). Many of these duties would overlap with what other clinical disciplines are doing.

However, there is little benchmarking information that could be found, and as well, the roles could vary significantly across Center/Unit. For this reason, additional discussion with the Center/Unit Directors will be needed to really be able to complete that piece of the model. The analysis thus far has only been able to discuss staffing to a certain degree, not at the ward level. The respective roles could be clarified further to aid those staffing decisions. Nuances in Treatment staffing requirements are still TBD, although at least one per ward would be baseline staffing.

Organize Lean initiative to clarify Treatment team role expectations

A Lean initiative should be organized to clarify expectations between the Treatment disciplines regarding roles as well as to develop better criteria to match group content and format to patient needs.

Utilize Psychology Associates to bolster Psychology team

Currently there are 14 **Psychology Associates** at WSH and none at ESH. Their primary function is support of the Psychologist and they could assist the psychiatrists with admissions. They are Masters-prepared professional staff. ESH should consider adding these clinicians, and they have been noted in the model. In some settings they are paired with Psychologists so their numbers per ward would be similar.

Social Workers employed at the hospitals are all Masters prepared (MSW). They perform a variety of roles, mostly around discharge planning and working with the patient and the family. There is a great deal of administrative paperwork, logistics planning, supply ordering and other duties that they must contend with as well. Many stated that they would like to teach more groups (e.g. anger management, symptom awareness, medication, behavior skills, community reentry, other topics) and had several other ideas. They would also like to participate in more 1:1 therapy with patients. As stated above, this overlaps with roles described by other staff such as Psychologists, Psych Associates, Institutional Counselors, Nurses and others. Social Workers are frustrated in that they consider themselves clinicians, but feel they are not seen that way. These respective roles should be clarified to better set expectations and enhance the ability to provide high quality care. Some Social Workers also work in the Treatment Mall. They are members of the care team, but on many units can be disproportionately expected to carry the load of documentation for those meetings.

Most of the Social Workers are ward-level, but some at WSH work on a centralized Discharge Team. Despite the fact that overall discharge criteria may be similar, the process is handled differently on different wards with different staff. Forensics and civil discharges have different statutes that need to be followed and inconsistent policies at the facilities were also noted. Ward-level MSWs do not really speak to the placement facility, which is the discharge liaison's role at WSH. This is a wall for the MSWs and creates confusion regarding the status of the placement or what is causing any delays. Additionally, the method of employing these liaisons and their process differs from county to county. Other issues include the discharge team members (including escorts) being non-permanent staff so once they are trained and become really effective they are often gone.

Centralizing that function more could enable more efficiency in that process. See the discussion later in this report regarding the Discharge Team and Escort/Transport services.

Two social workers per ward would be ideal. If the discharge function is centralized further (or completely), those staffing needs could change. Currently, WSH has Center-based MSW float pools. ESH uses retirees who already know the facility and processes and this has been a successful strategy to augment staff where needed.

Utilize Social Worker Assistants to ease the paperwork burden

The proposed **Social Work Assistant** would assist the Social Workers in their discharge planning activities specifically. In the absence of an electronic medical record, there is a great deal of faxing of materials to community placements and outside agencies which can be very time consuming. The assistant could manage the paperwork and logistics responsibilities to allow the MSW to spend more time with the patient, family and care team members.

The **Institution Counselor (IC)** role is included in the Treatment team staffing and not in Nursing. They are usually Bachelors-prepared in areas such as sociology or psychology. Upon review of their job description, as well as their typical duties with regard to conducting groups and discharge planning, their role is more therapeutic in nature, versus personal care. Some IC are required to have CNA credentials and some do not. Some are utilized for Activity of Daily Living (ADL) training with patients, which are usually consistent with an Occupational Therapist or their aide. There seems to be significant blending of roles with these staff and they should be freed of personal care expectations so they can function to their highest level with the above duties and performing certain types of evaluations in some specific programs that can utilize their skills. The ICs have previously been involved in discharge planning and conducting groups in the Treatment Mall. ESH utilizes IC staff on the PERT Team and in other ways on the wards and the Treatment Mall. They also previously ran the community reintegration PALS program at WSH. Their numbers on the staffing model beyond the baseline of one per ward are TBD pending further discussion about their role.

Of note, the Habilitative Mental Health (HMH) wards at WSH utilize Institution Counselors as patient coordinators and do not have MHT staff. The recommendation here is to continue to utilize IC staff on HMH wards as patient coordinators, but free them from personal care responsibilities by hiring MHT to take on those duties.

Wards would benefit from more Recreational Therapy staff

The wards would benefit from more **Recreational Therapy** staff who are actively engaged with patients between day and swing shift, evenings and weekends. Their shifts could be adjusted or they could have flexible staffing to extend into the evening. These activities could include 1:1 or group activities or off-ward activities. The staffing model includes two therapists for evening shift, although the hours may actually be noon to 8 pm for example, not a traditional evening shift.

Recreational Therapists generally hold undergraduate degrees and should be state registered and nationally certified. Occupational Therapists are generally Masters or Bachelor's prepared and are certified by a different governing body than Recreational Therapists. However, while they have distinct education pathways, their responsibilities overlap and they could benefit from additional clarification of duties.

Occupational Therapists, Physical Therapists, Recreational Therapists and **Aides (PTA, COTA, Recreational Specialists)** tend to work off the ward, either in a centralized department or in the Treatment Mall. However, some may be ward-level.

PT and OT are included in the ward-level model for the gero-psychiatric and HMH areas which could benefit from one each per Center/Unit. The aides should be staffed one for approximately every two wards in gero-psych, and HMH as well. Other wards in the facility could also be evaluated for this support depending upon their patient population.

Each ward also has assigned Recreational Therapists extending into evening shift due to the noted increase in patient escalation potential at the end of the day after all the Treatment Mall activities have concluded.

Non-Clinical Staff

Non-clinical staff (such as Environmental Services Workers and Dietary Aides) are included in the recommended model

In addition to ward-level clinical staff, certain other non-clinical staff are included in the model because their absence significantly adds to the workload of the clinicians. The main areas are with regard to environmental service and dietary duties. For those reasons, an **Environmental Services Worker** and **Dietary Aide** will be added to each ward, with the exact numbers varying by shift. During off hours, they could cover more than one ward and may have some additional duties such as supply management. The Environmental Services staff person would be responsible for janitorial work, laundry and general cleaning of the area and they would cover more than one ward (perhaps even a Center/Unit) on evenings and night shifts. This worker would *not* be doing the environmental safety checks.

Non Ward-Level Staffing Model Components

In addition to the ward-level staff, many important services are provided by clinicians that work in centralized departments (e.g. Pharmacy), who work on specialized teams or who directly impact the ability of the ward staff to care for the patient. The following describes the general staffing for those functions:

Administrative Supervisor

Administrative Supervisors would ensure management coverage during off hours

Although the Ward Program Administrators would have 24/7 responsibility for their wards, there is also a need for onsite operational support during off hours (evening and night shifts), holidays and weekends. Management staff are present during normal business hours, but at other times one Administrative Supervisor would be present at each facility to manage urgent staffing issues, incidents, safety issues or other concerns, and troubleshooting. WSH could possibly utilize two given its average daily census and campus size. They would report to the Associate Nurse Executive.

Of note, coverage provided by this Administrative Supervisor is *not* the same as medical provider or psychiatric provider off-hours coverage. This is an *operational* role to oversee the facility and staff, not to provide direct medical care.

Patient Care Staff Reporting to Centralized Departments

The following staff provide critical patient care and support, but are not ward-level. Their staffing could be gauged overall based on benchmarks for the number needed per patients in a facility. Some initial benchmarking information and general comments are included below, although more information is needed. Specifically, some additional volume data from the hospitals regarding the number or patients seen per day would help determine these staffing needs.

There are no national benchmarks with regard to staffing these disciplines in a psychiatric hospital. The discussion below reflects staff best practice suggestions, input from other state facilities and levels utilized in other facilities of similar size and/or type.

Pharmacists (RPh) are not ward-level at either hospital. At both facilities there are multiple pharmacies on the campus. At WSH, there are 19 clinical pharmacists, 11 technicians and support staff (10 pharmacists staff 3 pharmacies). The staffing also includes a Diabetes Educator pharmacist and a Safety pharmacist. An on-call pharmacist is always available. Duties include participation on multiple committees, training of nursing staff and New Employee Orientation (NEO). In the past they provided patient education, but the Treatment Mall schedule currently precludes that. Pharmacists do assist with discharge medication teaching. Approximately 25% of their day is impacted when new nurses and doctors join (due to the knowledge gap) and medication review decision changes also cause delays.

Hospitals need more pharmacists – the recommended ratio is one pharmacist per 60 patients

Both facilities report that more pharmacist positions are needed to meet the needs of the patients and support of ward staff. They also report their compensation lags behind other pharmacists in like settings. At WSH staff reports many of the pharmacists are board certified and not compensated appropriately. Both pharmacies report that the managers are due to retire in the near future. WSH also has one FTE dedicated to the Cerner project, and the pharmacist position is backfilled with a temporary person. At ESH, 90-100 patients per pharmacy is higher than the 60 patients per pharmacy at WSH. One pharmacist per every 60 patients is the recommended number.

The recommended staffing for **Pharmacy Technicians** was 2 techs for every RPh. A 2011 WA State Department of Corrections Staffing Analysis recommended this ratio as well.

There was a high degree of satisfaction expressed with the staff and the services of the WSH Pharmacy, while there were some challenges identified at ESH. To address some of the challenges at ESH, best practices can be adopted from WSH and an onsite visit from WSH could be considered.

Dentists, Dental Assistants and Hygienists also work in the main dental clinics at their facilities. ESH currently has one dentist, although he will be leaving soon. The dentist works half time and there is a six week wait list to be seen, with a throughput of about 10 patients/day. No benchmarks were found for this staff, although it would seem that 1.5 dental FTE would be needed at ESH to significantly shorten the wait time. WSH currently has 2 dentists, but is a significantly larger facility.

A 2011 WA State Department of Corrections Staffing Analysis recommended this level of dental staffing for the major facilities approximately the size of WSH. General benchmarks were:

- Outpatient dentist ratio of 1:1000 patients to average daily census
- Intake dentist ratio is 1: 300 admits
- Outpatient dental assistant ratio of 2 per dentist
- Outpatient dental hygienist ratio of 1:2000 average daily census

Registered Dieticians at the facilities are currently staffed at four for ESH and five for WSH. No widely accepted benchmarking information was found regarding staffing this position in a psychiatric facility or larger hospitals, although one source mentioned a ratio of one dietician for every 65-75 patients in acute care medical hospitals. Salary levels were mentioned as the main issue with this group of clinicians.

Infection Control at WSH is staffed with three regular staff and one temporary staff. They cover patients and staff and reportedly are able to perform "only the basics". ESH has one RN3, an RN2 and a temporary light-duty data analysis person. They generate several reports including a quarterly report to internal committees and their respective local/regional health departments. One more RN and a permanent data person would be needed, along with a Certified Director in Infection Control. A Lead (including a pharmacist) to work in the Antibiotics Stewardship program would also be desired.

Chemical Dependency Professionals (CDP)

The Systems Improvement Agreement (SIA) with CMS recommends that WSH have a robust substance use disorder (SUD) treatment program for the majority of WSH patients that have a dual diagnosis. Staff indicated that significant percentage of patients have some issues with substance abuse which can be a complicating factor with their inpatient care and with their discharge planning. To address this, WSH is in the process of hiring a Therapy Supervisor and eight **Chemical Dependency Professionals (CDP)**. There would be four CDP on each of 2 specialized chemical dependency treatment wards, the exact locations still to be determined. Since they are only associated with two wards, they were not included in the overall staffing model for WSH.

Currently ESH utilizes an outside contractor for SUD assessments only, but not for active treatment. A high percentage of their patients also have both mental health and SUD issues. There is an identified need to add staff to provide active SUD treatment and for additional training for all staff in supporting recovery for their patients with these challenges.

Peer Support Specialists

Whenever possible, involvement of others that support the patient's recovery is encouraged. This may include family, friends, **Peer Support Specialists**, and/or volunteers, residential providers or others. The treatment and support provided at the hospitals is designed to help patients live outside of the hospital and continue their recovery. In 2016, WSH hired their first Peer Support Specialist and hope to expand that role. These individuals have had their own experience with mental health issues and can help guide the patient through their recovery and re-integration into the community. They are not unit based, but are a new support available for the patients.

Clinic and Ancillary (Laboratory and Radiology)

ESH has Medical Doctors who are assigned wards and are based out of the wards. Most of these are Internists. They optimally are assigned no more than two wards each. WSH has an onsite clinic that provides essential services. The WSH Clinic has three staff including an RN3 and two LPN's. Specialty clinic physicians are contracted (Orthopedics, Ob/Gyn, Neurology, Podiatry, Ophthalmologists, Optometry). They perform routine exams, EKGs and assist providers with various procedures. The main need articulated was for 4 more escorts.

Center/Unit-Based Nursing Float Pool

A recurring theme throughout this analysis was the consistency of on-call staff used in the wards, and the challenges presented by on-call staff being ill-prepared for their duties. This continual churn of on-call staff has created issues for the regular staff, including the extra duty of watching out for the on-call personnel on their wards. On-call staff could include RN, LPN/PSN and MHT/PSA. Staff who were expected to float to another Center/Unit were very uncomfortable due to the difference in patient populations; this has been particularly true of staff floating onto Forensics Units. In addition, staff floating to Forensics were required to have two years of experience, with the result that the other units were often left with less experienced staff to handle their own complex patients. Additional data would be needed to understand the exact numbers of floats to staff float pools dedicated to the individual Centers/Units.

Both hospitals have initiated a Nursing float pool, which is intended to provide both consistent and better trained staff. Float pool staff are regular employees of the hospitals, but not assigned to any one ward. They float to the wards within their Center/Unit and are assigned by the central Staffing office at the beginning of each shift. They would report to one of the Associate Nurse Executives or their Center/Unit Director. MHT/PSA could cover regular duties and 1:1 assignments. This flexibility could prevent the ward from having to absorb the first 1:1 which can sometimes affect their ability to complete other duties.

There are no national benchmarks for psychiatric facility nursing float pool staffing. As stated earlier in this report, Oregon State Hospital (OSH), which has just over 600 beds in their main facility, aims to have about 100 staff in their nursing float pool, although currently the pool includes only MHTs. It should ultimately include RN, LPN/PSN and MHT/PSA staff. Further analysis of WSH and ESH call-ins and wards where 1:1 support is most needed would help guide these discussions. Typically, medical hospitals of comparable size tend to have 50+ float pool staff.

WSH also currently has a Center-based Social Worker float pool, and that should continue.

Psychiatric Emergency Response Team (PERT)

One successful approach at Eastern State Hospital was to reinstitute the Psychiatric Emergency Response Team (PERT) to assist with behavioral incidents and to de-escalate situations where staff could be assaulted. The PERT team also tries to spend time on some of the high acuity wards engaging patients, providing a presence in the milieu and developing rapport with staff and patients. Their focus could be adjusted as acuity and other circumstances change across certain wards. One model to consider would be Center-based PERT teams at WSH, given the size of the facility.

The ESH Director of Security/PERT reported they had "soft" statistics indicating that PERT was able to decrease the number of restrictive events about 50% overall since the start of the program. Though there is never complete certainty that seclusion was prevented by PERT intervention (due to not knowing how the patient would react with vs. without PERT interaction), Quality Management data from the month prior to PERT implementation indicate that the hospital-wide seclusion hours for that month were 467 compared to 185 hours post-implementation. This is a 61.4% decrease in seclusion utilization, and the data strongly indicates a correlation in this decrease with the implementation of PERT. Incident response volumes range from approximately 130 to 230 per month. ESH is planning to expand this team.

The members of PERT are available on day and evening shifts, but not at night. The team consists of the Director and Institution Counselors, as well as three Registered Nurses. The team Director reports directly to the hospital CEO. PERT's main role is to provide well-trained staff to respond to a psychiatric emergency anywhere in the hospital. They step into volatile situations to relieve regular staff during an incident, and use therapeutic interactions to diffuse and de-escalate potentially dangerous circumstances. If unable to do so, the PERT team may secure a patient in either seclusion or seclusion and restraints (S&R). Their assistance could also ultimately result in alternate ways to manage 1:1 patient situations.

An attempt to institute this team failed at Western due to perceived heavy handedness. Of note, this team at the time did not utilize RN staff, which is thought to be a key success factor at ESH. With a well-conceived and appropriately staffed PERT model, WSH is already activating a new PERT roll-out. They are incorporating best practices from ESH and receiving hands-on training from the ESH PERT lead.

Discharge Team

One of the major challenges with both hospitals, especially for WSH, is the backlog of admissions and discharges. The discharge challenges are to a large degree precipitated by a shortage of community placements for patients. Some of the challenges are also due to staffing considerations, escort capacity and the discharge process itself.

Discussions with the staff illustrated that the discharge process could be more coordinated. Currently, ward-level social workers and in some cases, Institution Counselors will be working with the patient on discharge planning and handling all the logistics and paperwork necessary.

WSH also has a centralized discharge planning team that works on many of the same tasks, but can be unaware of what the ward-level staff has done. For example, the social workers will call

the WA State Department of Licensing to obtain identification cards, the Social Security Administration, Immigration and Naturalization Service and other agencies to obtain documentation for a single patient. If the discharge process were centralized with the discharge team, it would be easy for them to call for a dozen patients versus 1-2, and they have already developed the relationships and knowledge needed to navigate those agencies more efficiently. On occasion, a placement may suddenly become available for a limited period of time, and if the ward-level social worker is out of the office or otherwise unavailable, it is very hard for someone else to pick up the work to take advantage of the community bed.

The staff at WSH across disciplines suggested that their discharge process be centralized. Their recommended staffing for the WSH Discharge Team (which could as well be considered for ESH) would be:

- 2 Community Nurse Specialists
- 3 Social Worker
- 2 Institution Counselors
- 2 Mental Health Technicians
- Dedicated transport staff (permanent staff)

ESH has a more ward-level approach. Social workers at ESH work with the patient from admission to build rapport with them, and can be more actively engaged as a member of the interdisciplinary care team. Oregon State Hospital has also used this ward-level approach with good success. Perhaps certain functions such as interfacing with agencies could be centralized with a discharge team, while the majority remain decentralized to the ward.

Regardless of the centralized or decentralized model, it is critical that all discharges be tracked centrally in a readily accessible location and that the status of the discharge process and responsible persons are noted. There should also be regular check-ins with all the ward-level Social Workers and the central discharge team so cross coverage can happen and troubleshooting can occur. Currently it is silo'd at WSH.

Lack of community placements was repeatedly mentioned as a barrier for discharge. Work is underway to address the discharge challenges; however, a top priority broader-based Lean team should be formed, including facility staff, Behavioral Health Organization (BHO) liaisons and even some current community placement owners. They would examine the discharge process and develop new approaches to develop community placements, including less restrictive placements in the community.

Prioritize a Lean initiative to rapidly streamline the discharge process, optimize the team and develop community placements

Ultimately, centralized, decentralized or hybrid approaches for discharge planning can all work, but this rapid process improvement team can determine what the best model is for WSH.

In addition, certain members of the Discharge Team could be allocated solely for the purpose of outside placement development. They would nurture relationships and educate the community regarding the process of working with the hospitals and to solicit feedback for process improvements. A dashboard could be kept to track progress of this initiative. The team could be fully staffed and operating very efficiently, but ultimately there needs to be a destination for the patient after discharge.

Transport/Escort Teams

Lack of escorts or their unpredictable availability was mentioned repeatedly as contributing to the overall staffing challenges. There are essentially three types of escort/transport services needed for the hospitals:

- Internal (to the medical clinic, the Treatment Mall or other on-campus locations such as court)
- External (for appointments such as other legal proceedings, medical visits or other off-campus appointments)
- External (for discharges)

Currently, at WSH the Clinic has a dedicated transport team that seems to be working well. ESH does not have an onsite Clinic so this is not an issue there.

Escort to and from the Treatment Mall or other onsite locations continues to be problematic as it pulls nursing and other staff from the wards resulting in wards that are short staffed for varying periods of time. In some cases, staff may remain with the patient, but most times this is not required. ESH has additional risk in transporting large groups to the mall, which is located outside of a secure perimeter.

Consider facility-wide or Center/Unit-based dedicated transport teams

A dedicated transport team (either Center/Unit-based or facility wide) should be available to be engaged for routine patient movements. These transporters would have standard training and could help out with some other general duties (e.g. supply management) during any down time outside of typical mall session hours. By making transport teams Center/Unit-based, transporters would be escorting the same patients multiple times and could engage and build rapport with patients more easily.

In addition to the internal escort function, there is a need for a transport team to provide escort services as well as transportation services to off-campus locations. In some cases, security and other professional staff would also be accompanying the patient based on the nature of the patient's behaviors, his/her level of privileges, as well as the destination. Staff felt the need for additional security for the offsite transports.

Some of the escorts from the internal escort team could be cross-trained to fill in with the off-site transports. Discharge transports would have priority. Currently, WSH has a transport team to assist with discharges, but these are temporary staff and often get pulled for other duties.

Having the Escort/Transport team accompany patients to their appointments would free up ward staff to allow them to conduct care conferences, complete other duties and attend to the remaining patients who did not attend Treatment Mall activities. The remaining patients would be the higher acuity individuals who could benefit from extra engagement and are often the most time consuming to care for.

Transport volume and discharge data would need to be examined in more detail by Centers/Units and by shift to determine optimal staffing for this team.

Treatment Mall

The Treatment Mall should have dedicated staff (Recreational Therapists, Institution Counselors, Nurses and others) to develop curriculum, facilitate groups and activities with professional rigor and oversee other staff who teach classes there. The MHT role should not be expected or asked to develop and conduct sessions; other ward-level staff might be, but only if provided with training and materials ahead of time. If MHT's are in attendance during treatment mall hours, their role should be that of support for the patient. Only patients that are deemed stable are allowed in the mall.

A more robust treatment mall model should also include the use of Psychologists, MSW's and RN's to lead groups and teach classes. These classes could include Symptom Management, Anger Management, Medication Management, to name a few. Assigning permanent staff to the Treatment Mall, to develop programs and provide active service, increases active treatment hours and reduces the number of ward-level staff pulled off the unit for periods of time. Eastern State is currently evaluating Institution Counselors for these dedicated positions.

Involve Psychologists, MSW's and RN's in teaching classes at the Treatment Mall

More information on this area is needed such as hours of operation, structure, who conducts groups, what sessions are held, the escort process and criteria for when staff remain with the patient. Also, additional analysis is needed to determine how many ward staff would remain in the Treatment mall with their patients.

A common complaint from staff was the difficulty in having access to the patient for required evaluations, physical assessments, nursing care and other activities during the day due to the Treatment Mall schedule. The vast majority of the activities occur between 8 am and 5 pm, with a dramatic drop off after that. Further analysis is needed to determine which activities can possibly be done into the evening shift or adapt the daytime Mall schedule for certain patient populations to optimize access to the patient for all disciplines.

Clinical Nurse Specialists

Patients at both hospitals have significant medical needs. Staff reported that 5-10 medical diagnoses for a single patient was not uncommon, that 18% of WSH patients have diabetes and they are on potent medications with significant side effects that need to be monitored. The need for close medical monitoring and medical/surgical nursing care was clear.

At WSH, the Clinical Nurse Specialist functions include teaching, audits, reviewing difficult cases to problem solve with the treatment team, serving on planning committees for emergency psychiatric evaluation, serving on the safety committee, mentoring some of the RN3 staff, developing action plans for CMS surveys due by April, chairing committee for patient-to-patient assault evaluation and other non-clinical duties. Time spent on committees can range from 50-70%, although they would like to spend more time in patient related activities. One of the CNS has supervisory responsibilities while the other two are individual contributors. At ESH, they have 3 Clinical Nurse Specialists who perform a variety of functions from patient education, to managing high risk medications, to providing consultation to the Nursing staff.

One CNS per Center/Unit to participate on care teams and help manage complex patients

Suggestions to improve the staffing would be to have at least one *certified* Clinical Nurse Specialist per Center/Unit to allow them to participate more on the care teams and to help manage complex patients. Currently, some nurses in those positions are not certified clinicians, but could possibly continue in those roles if skills and experience are deemed appropriate. Certification could be sought at a later date, within a required time frame. Certification would be required for new hires.

Evolve to DNP degree for newly hired CNS

A preferred option would be for new hires to bring a Doctor of Nursing Practice (DNP) degree, which has a more clinical care focus versus a research focus. As this is a newer pathway for clinical advancement, and since the number of potential candidates is limited, it would likely take some time to transition to this preferred credential and skill set for new hires. Currently, neither facility has DNP staff.

These advanced practice nurses bring valuable skills to the facilities and should be utilized to their highest level. Committees, administrative duties, auditing and other non-clinical responsibilities should be limited so they are able to focus on management of complex patients, mentoring staff and fostering evidence-based best practices across their facility.

Of note, WSH also has an 8-member Medical/Surgical Nurse Team that provides support for patients with more complex care and treatment needs. While this is valuable, some of the nurses were frustrated in that they felt they were losing some of their medical surgical skills due to this team performing wound care, IV therapies and other clinical care. As staffing levels and training opportunities improve and Clinical Nurse Specialists are working to their highest level, the hospitals should evaluate whether some of these duties could be given back to the staff nurses on the wards enabling them to better retain their skills. The Med/Surg Nurse team could possibly be disbanded and the nurses transitioned to other roles. However, an IV Therapy Nurse (possibly even infusion certified) would be a valuable resource for each facility.

Chaplain

Currently, WSH has two chaplains for the entire campus and ESH has one. There was an expressed need for additional help, although community resources could possibly assist as well. The other identified need was for office support assistance. No benchmarking information was found for staffing this position in a psychiatric facility.

Quality Management

Positions in the WSH Quality Management Department include functions related to accreditation, compliance and standards, data analysis, risk management, Performance Improvement teams and others. The department interfaces with the clinical disciplines and there is overlap in duties in some cases – primarily related to audits and validation of previous audits. The staffing model does include a ward-level Medical Records/Quality Assistant to perform these functions in consultation with their RN3. In the short term while under threat of

decertification, these staff would likely have more to do with auditing but it would decline as staffing improved and the immediate remediation workload declined.

Of note, additional staff have recently been hired which should provide significant support for compliance and overall risk management efforts. These include a Certification and Compliance analyst, Policy Project Manager, Research & Data Analyst, Long Term Care Surveyor and further administrative support.

Currently, ESH has fairly complete Quality-related staffing in place; however, there is limited support for monitoring, regulatory compliance and overall risk management efforts. Staff includes a Quality Management Director, a data compiler, an administrative assistant, an Infection Control office, a Patient Rights office and Clinical Risk management staff. They oversee a quality committee and provide dashboard reporting. Needs include support staff who are cross-trained, one additional Clinical Risk Management (CRM) person, more Investigators/Auditors and someone for the Patient's Rights Office.

Health Information Management (Medical Records)

Medical Records responsibilities can pull a lot of time away from other clinical duties for both medical and licensed nursing staff. As outlined in the Quality Management section, the staffing model accounts for a ward-level Medical Records/Quality Assistant who could help with these tasks as well as helping with data collection for process improvement initiatives and mandated audits. When the electronic medical record is deployed in 2017, this role will likely change as will many of the other centralized Medical Records functions. Finally, additional Medical Records staff have been recently hired, which is an additional step forward.

Outside of the wards themselves, the Registered Health Information Technicians (RHIT) and other medical records staff perform concurrent chart review and retrospective chart review, chart audit, Medicare enrollment, coding and release of information activities.

Program for Adapted Living Skills (PALS) Program

The Program for Adapted Living Skills (PALS) was housed in a stand-alone "dorm-like" 30-bed residence on the grounds of Western State Hospital. It was closed in 2011, but had operated for more than two decades, and housed more than two dozen former patients at any one time whom no one else would take because of behavioral problems, complex medical needs, or histories such as arson. This community reintegration program was seen as a successful approach to assisting challenging patients in moving toward discharge.

Reinstate the PALS program

Staff felt that this program should be reinstituted. Staffing for this program would need to be determined at a later date. Institution Counselors had run the PALS program before, so they could likely take on that role again if re-opened.

ESH has an NGRI ward which houses higher functioning patients. These patients are low-risk for elopements and ready or nearly ready to be released to the community.

Psychiatric Intensive Care Unit (PICU)

Statistics from WSH and ESH track assaults and injuries resulting from patient-to-patient aggression or patient-to-staff aggression, and indicate that there are usually a limited number of specific patients who are responsible for the majority of these incidents. A PICU has been built at ESH to serve up to eight patients that are demonstrating very aggressive behavior. It is intended to treat the patient in a more secure environment with the safety of the patient, staff and others in mind. It has not yet been populated with patients due to difficulty staffing the unit with qualified staff (not the least of which is a psychiatrist), and lack of budgeting, but the target date for admission of the first two patients is January 2017. Western State is looking to build out a similar ward and is in the process of hiring a Director. They hope to open a 12-bed PICU ward.

Psychiatric Intensive Care Units reduce acuity on the other wards and allow time for staff and patients to focus on active treatment, as well as providing a safe environment for supporting and treating high-risk patients. It is likely that a cultural shift will ensure, when staff and others see the commitment the hospitals are making toward safer models of care.

More information is needed to understand the staffing model needed for the PICUs.

CLINICAL PROCESS RECOMMENDATIONS

Changing staffing numbers alone will be only part of the overall staffing solution. To ensure the likelihood of success as a new staffing models are introduced, clinical processes and technology must support the staff so they are able to work to their highest and best level, and overall productivity can be optimized. The following are critical elements that address ways to best optimize the new clinical staffing model.

Acuity Tool

Currently, any discussion of acuity is primarily in relation to how many 1:1 or 2:1 patients are in-house. However, acuity determination should take into account several other factors. Using such a tool allows for the unique characteristics of each facility to be considered as well.

As described above, the central scheduling office would roll up the ward submissions to develop the master facility ward-level schedule. This core staffing can then be adjusted shift by shift for each ward utilizing a relevant acuity model which takes into account:

- Ward characteristics (census, admissions, discharges, whether the ward is an admission ward)
- Psychiatric/behavioral considerations (1:1, close observation)
- Medical/nursing considerations (medical close observation, total care, treatments and procedures)
- Specific attributes or criteria weighting based on the ward's predominate patient population

Nurses would complete it each shift for each patient and the Charge Nurse would ensure that the information is submitted to the Scheduling Office no later than two hours before the beginning of the next shift. The Scheduler could then utilize that data along with call-in data to fill any gaps and ensure that the overall minimum staffing levels *and required skill mix* are maintained.

One unique situation is that of 1:1 and 2:1 patients. Using the acuity process described above, the ward would be staffed at the beginning of each shift for all known 1:1 patients. As new situations present during the shift, the ward would evaluate absorbing that situation with current staffing if the overall staffing ratios can be maintained. If not, the Scheduling Office (or Administrative Supervisor during off hours) should fill the extra need with floats, on-call or other staff.

ESH has had encouraging results since the PERT team has been implemented, so the availability of that resource should decrease the number of 1:1 or seclusion and restraint situations that require this extra staffing. If implementation of PERT results in reduced 1:1's the "new normal" will be to maintain the baseline numbers in the recommended staffing model. The baseline numbers in the model assume no 1:1 are present on the ward, but the model includes a mechanism (via the acuity tool) to selectively add to ward staffing as needed.

Nurses should be trained in use of the acuity tool during new employee orientation and at the annual or periodic training updates scheduled after that.

Prioritize a Lean initiative to adapt an acuity tool for WSH/ESH

An interdisciplinary Lean team should be formed to adapt existing tools for use at the state hospitals. Most tools are for nursing acuity, but can provide a valuable framework to extend to other disciplines.

Please see Appendix B for sample acuity tools from the following organizations:

- Arizona State Hospital (ASH)
- Vanderbilt Psychiatric Hospital (VPH)
- Vermont Psychiatric Care Hospital (VPCH)

Interdisciplinary Care Team (ICT)

Currently, there are many issues with the Interdisciplinary Care Team (ICT) meeting and overall process. Roles are unclear, documentation may not capture the progress of the patient, meetings are not held regularly, often due to short staffing. Follow through can be inconsistent.

Specific recommendations to rectify this situation include:

- Schedule the team meetings for a consistent day and time each week, although that may vary from ward to ward; utilizing shift overlap time in the morning or afternoon could help free up some staff.
- The Ward Program Administrator oversees the process and ensures that staff engage and complete their responsibilities related to treatment planning.
- Engage a Lean team to evaluate the treatment planning form to ensure that it meets all mandated requirements and captures patient needs. This work is already underway.
- Post the ICT conference schedule where staff can access it and plan their schedule to attend.

The ICT meets on a regular basis to develop a treatment plan for a particular patient that includes describing problem behaviors, interventions and goals. These are fine-tuned at subsequent meetings based on patient progress or lack of progress.

Schedule ICT meetings at predictable times so that all members can attend

The ICT includes a Psychiatrist or a Psychiatric ARNP. One of these positions must be present to hold a meeting. These positions have the same scope of practice in this role which is to lead the meeting and ensure all disciplines in attendance provide clinical data to develop the *Interdisciplinary Evaluation and Treatment* form, which is tailored specifically to a particular patient and not just a generic template of interventions and goals.

The Ward Program Administrator should be present at ICT meetings whenever possible. They ensure that all necessary disciplines are present and that the meeting is timely and complete. The manager may choose to enter the data during the meeting or assign it to the office assistant or other willing attendee. After the development of the plan, the manager ensures the plan is complete, all disciplines have signed the plan and that the changes are communicated to all staff involved with the patient.

An RN must be present in order to hold an ICT meeting. An RN who is familiar with the patient provides information including behaviors, interventions and outcomes, medication teaching and compliance, PRN ("as needed") medications given and any restrictive or emergency measures. The RN may be a staff nurse or a shift supervisor RN.

An MHT, PSA or IC who is familiar with the patient should be present at the ICT meeting to provide more detailed description of patient behavior in the milieu and off the ward. They report on the effectiveness of care plan interventions and may suggest new interventions.

The Psychologist (or possibly a Psych Associate) attends the ICT meeting to provide insight into patient behavior, help develop meaningful interventions and goals and assist in measuring the outcomes. The Psychologist may provide testing as appropriate, meet with patient 1:1 or in groups and teach classes in the Treatment Mall. When a patient presents dangerous or disruptive behaviors the Psychologist may develop a behavioral support plan designed to address the behavior specifically with interventions, goals, outcomes and perhaps rewards. This is to be developed with the input of other team members.

The Social Worker discusses patient's social issues and begins developing a plan for discharge. As the patient progresses toward discharge the MSW will explore and contact placement options with the patient and/or with the family. The Social Worker should meet with patients regularly to discuss the plan for discharge and also be available for 1:1 therapy and/or family therapy.

Rehabilitation staff from the Treatment Mall would be present to describe patient behavior, attendance and progress while at the mall. This could be staff ranging from Occupational Therapists, Certified OT Assistants (COTA) or licensed Recreational Therapists.

Finally, medical providers (MD or mid-level) and Clinical Pharmacists should be included in the team conferences as indicated for those with very complex medical or polypharmacy needs.

ICT meetings should have the patient present. The plan is written so that the patient can understand it and participate in it to the best of the patient's ability. The patient is asked to sign the form if they agree with the plan.

Scheduling

Staffing is an ongoing challenge. Patient's psychiatric and physical needs change often and sometimes drastically. This changing acuity demands ongoing flexibility in staffing as it often creates staff shortages.

Currently, the WSH Scheduling Office generates a master schedule that reflects a very top-down approach. They utilize a fairly rigid software system that is based upon the Dorothy Johnson assessment tool. This focuses on seven subsystems (Affiliation, Dependency, Sexuality, Aggression, Elimination, Ingestion, Achievement) plus a subsystem labeled as restorative which focused on activities of daily living. One notable limitation is that an assessment based on a behavioral model does not easily permit the nurse to gather detailed information about the biological systems, while patients at the state hospitals certainly have significant physical health needs. Nurses report they complete the Johnson tool every shift, but do not feel that it is utilized for staffing. ESH does not use the Johnson acuity tool.

Introduce staff self-scheduling onto the wards after the WPA is hired

The hospitals should consider a ground-up approach, and more actively engage staff in the process. Once the scheduling is completed at the ward level, it would be submitted to the central scheduling office. After the roll-up schedule is produced in the scheduling office, any gaps can be filled by the Center/Unit-based Nursing float pool, the Social Worker float pool and by on-call staff if all other options have been exhausted. The master schedule can then be refined using a more sophisticated acuity tool that takes into account various circumstances related to both the ward and the patients.

In addition, the following strategies could be utilized to address the current challenges. The 51 nursing positions being hired at WSH should definitely help to achieve some of these recommendations:

- To safely staff the hospital, consider designing and implementing flexible shifts for Nursing and Treatment staff. These could include ten or twelve hour shifts, weekend shifts, part-time shifts and possibly weekend-only shifts.
- With or without extended shift lengths, evaluate the usefulness of shift overlap. The extra staff on hand could free up others to attend care conferences or assist with morning care for those with heavier personal care needs on the geropsychiatric wards (e.g. the night shift could work until 0900 to assist with breakfast and morning care).
- Shift lengths should allow for a 30-minute handoff time for outgoing Nursing staff to provide a complete report to oncoming Nursing staff. This can significantly improve continuity of care. Currently there is a 15-minute overlap for nurses on most floors.
- Investigate self-staffing *once Ward Program Administrators are hired*. Establish guidelines based on contract requirements, ward requirements and other considerations. Staff would negotiate amongst themselves and complete the staffing self-management tool, with the Ward Program Administrator making final decisions as needed. This approach has worked well within unionized settings.
- The hospital may use a pool of Center/Unit-based float pool staff, temporary staff, agency/locums staff to fill remaining staffing gaps. Staff may also choose to volunteer for extra shifts in compliance with regulations and collective bargaining agreements.
- Float staff (and those who work on a specific ward who may float on occasion to another ward) should be kept within their specific Center/Unit. This optimizes continuity of care, enhances safety (especially on the Forensic units), decreases staff stress and leverages their familiarity of patients and routines.
- Management and labor should address issue of staff absences when abuse of sick time seems apparent (such as patterning sick days, etc.).

Update staffing software

Staffing software should be updated to provide a single tool for streamlining the staffing process, reflecting acuity tool scores, allow staff to self-schedule when vacancies exist or make themselves available for shift vacancies, allow staff to sign in and out of their shifts, allow staff to request time off, and make staff leave balances available for review.

The Scheduling Office would continue to play an important role in the management of facility needs, providing an enterprise view, data to support changes in staffing requirements and

troubleshooting issues. After Ward Program Administrators are in place, staff could begin self-scheduling and rely on the Ward Program Administrator to make decision on how best to cover gaps. The Scheduling Office would receive schedules from the wards to develop the master plan for the facility and then manage the day-to-day flexing that may be needed due to changes in acuity, call-ins or other circumstances.

Training

Training was a significant topic of discussion. There was some concern among staff that any training to address a specific citation issue or corrective action was due to their errors. This is an example of a needed cultural shift that will take time to turn around. In the meantime, training continues to be a significant need and both hospitals are taking major steps to address the many training needs in their facilities.

All new employees attend New Employee Orientation (NEO) before they are assigned to wards. Much of this is learning physical plant layout, policy and procedure, and therapeutic communication. After classroom orientation, staff receive informal training on the wards. A much-repeated theme suggested that the orientation period is inadequate as many new hires are not able to function independently when taken off orientation. The hospitals might consider developing a mentorship program where new employees are teamed with experienced staff members who can continue teaching and role modeling interactions with patients. Assign the staff and mentor to the same ward and shift for a period of time until the mentor releases the new staff member to function safely and independently, when that staff member will be an asset to the team and patients. Both employees would count in the staffing for the day.

Implement a staff mentoring program teaming new employees with experienced staff

Staff reported that training outside of NEO has been cut back significantly since 2008 when the state experienced significant budget shortfalls. Creative ways to provide training to all staff could include the following:

- Keep training short and focused to minimize time away from the wards or daily responsibilities.
- Utilize computer-based training in work areas, including on the ward. Use communication tools such as Skype (instant messaging) to enhance interaction, get questions answered quickly and provide a method to determine the availability of staff and managers.
- Provide training of nursing staff during overlap between shifts which effectively doubles the target group.
- Provide training during all shifts to prevent changing staff work schedules. Many nursing staff work evenings or night shift. It would be more efficient to have some trainers flex schedules to accommodate other shifts rather than to have other shifts accommodate a few trainers who only work dayshift.
- Increase training budget to allow staff to attend classes, conferences or bring in experts from outside the hospitals to teach or train staff in specialty areas.

One of the most frequently mentioned challenges during this analysis was the number of new staff coming on without adequate training which contributes to turnover and staff frustration. Some investment in that training now can reap big rewards in terms of lower turnover, higher morale and safer care.

Recruitment and Retention

Both WSH and ESH have had chronic staff vacancies, and have been operating at sub-standard staffing levels for years. Both hospitals are feeling the effects of a national psychiatrist shortage and an aging cadre of physicians, media pressure and negative public image. A number of barriers to recruitment were articulated during the site visit and stakeholder interviews, including:

- An encumbered hiring process, that does not take into account the specialized training needed to recruit physicians. One psychiatrist reported that during the hiring process at a local hospital, he was contacted by a recruiter who let him know what to expect throughout the process and spoke with him about compensation, benefits and schedule, and this process gave him a sense belonging.
- Though there have been recent (and welcome) pay increases, those working at the state hospitals have historically been paid lower wages than their private sector peers. This includes those working on military bases and at the VA.
- Psychiatrists working in the state hospitals often carry higher patient loads than the national standard would indicate, thereby not establishing an attractive or optimal view of work/life balance.
- Negative and near-constant media pressure and attention from the legislature have stigmatized the hospitals and affected the ability to recruit top talent. One psychiatrist stated, “Nobody wants to work here”.
- Both campuses suffer from outdated physical plants with aged technology. The buildings are difficult to retrofit and do not encourage a safe and pleasant work environment for potential new hires.
- Technology is inadequate, with most work processes still paper-based. It is nearly impossible to recruit and retain qualified staff that want to work in a paper-based environment, when Electronic Health Records, Enterprise Resource Planning systems and scheduling software are the norms in the private sector.
- The Eastern State Hospital campus is relatively isolated and does pose some threat due to winter driving and long commute times.
- Western State Hospital has few, if any staff amenities including ample accessible parking and office space for staff, and there are no cafeterias or break rooms. Staff have no way to access food during breaks or lunch and cannot easily leave campus due to parking constraints.
- Though this is no longer true under current leadership, there is a recent history of clinical decisions being usurped by administrators.
- The risk of violence and injury in this environment is relatively high.

Offer more mental health training during New Employee Orientation and provide periodic refresher training

A primary concern for nurses and floor staff is the practice of hiring new employees with little or no mental health care experience. Additional mental health training should be included in new employee orientation, with refresher courses offered throughout the year. Retention suffers when new staff are not prepared to function safely and therapeutically in the milieu, and is compounded when new hires are being floated throughout different treatment centers. This includes RN's, LPN's, PSN's, MHT's and PSA's.

Recruitment and retention strategies for consideration include:

- Given the current bleak outlook for recruiting Psychiatrists, the hospitals should explore the use of "tele-psychiatrists" and the expansion of mid-level roles, including Psychiatric ARNP's.
- Consider extending orientation time when a new employee is not expected to function independently in the work place.
- Develop a mentorship program for new or struggling employees to give them a resource and provide role modeling in therapeutic interactions. Assign the mentor and new employee to the same shift during this time and include them in the shift head count.
- Re-instate tuition reimbursement programs for staff completing their degrees.
- Implement student loan debt forgiveness policies.
- Fund ongoing certification training for all clinicians (CME's, CNE, CEU's for example).
- Fund educational opportunities including conferences, travel expenses and tuition for employees.
- Continue to streamline the hiring process, leverage social media tools and learn how to recruit physicians. Physician recruitment is very different in the private sector and it would serve the state well to understand the process and how best to attract and retain clinicians.
- Include ward staff, together with managers and supervisors, in the hiring process. The recent hiring sprints are yielding results but suffer from mixed reviews.
- Consider the National Health Service Corps (NHSC), which offers tax-free loan repayment assistance to support qualified health care providers who choose to take their skills where they're most needed. Primary care medical, dental and mental/behavioral health clinicians can get up to $50,000 to repay their health profession student loans in exchange for a two-year commitment to work at an approved NHSC site in a high-need, underserved area. Approved sites are located across the U.S., in both urban and rural areas.
- Consider targeted outreach to military contacts to hire veterans. Many have medical background of some type and are accustomed to public service. Given the increased emphasis on mental health in general, and PTSD and traumatic brain injuries in particular, working at the hospitals may be of interest to them.
- Bring the HR function back to the hospitals. The headquarters model is likely not the most effective way to recruit hospital staff, since these staff are unlike most other office-based state employees.

Partnerships and affiliations

WSH should explore reestablishing relationships with the colleges and universities in the state. The use of clinical rotations, preceptorships and research would benefit all stakeholders involved in mental health care. It would also expose potential employees of multiple disciplines to the state hospitals and provide additional opportunities to regain its stature as a center of excellence in certain areas of study (e.g. dementia care).

Reestablish relationships with the colleges and universities in the state at WSH

ESH currently has affiliations with the University of Washington (UW), Washington State University (WSU) and Gonzaga University (GU). Nursing students from the latter two schools and UW MEDEX program PA students complete clinical rotations at the facility. Further discussions are underway with WSU about additional opportunities. The Psychiatry residency program at ESH was particularly valuable with recruiting at one time and would be good to re-establish.

Consider reestablishing onsite CNA training program

WSH and ESH should also explore re-establishing an onsite Certified Nursing Assistant (CNA) training program with a focus on mental health to increase qualified hires and increase exposure to the field.

Technology Optimization

The hospitals are woefully behind from a technical perspective and lack most, if not all of the modern technical advantages of today's medicine. The hospitals do not currently even have WiFi capability. Important factors to enable successful clinical process change would be efficient access to patient clinical data and the ability to optimize staff time so they can function at their highest and best level. The adoption of priority technology would greatly assist in that endeavor.

Investments should be made in the following:

- Fast-track the implementation of the Electronic Health Record (EHR). Ready the facilities immediately, and deploy a project team that has experience/expertise in this type of work.
- Deploy medical staff software to optimize recruitment of physicians and manage the medical staff.
- Deploy staffing software which would enable the units to develop their schedules and the central staffing office could use to manage daily changes.
- Consider the use of Tele-psychiatry to supplement treatment time. Dr. Floura, the Chief Medical Officer at ESH has seen the technology and supports the use of tele-psych as a viable option.
- Install Skype or a similar application to help with discharge planning sessions and community placements. Most, if not all, modern businesses (including hospitals) use Skype for Business or other applications for group meetings, instant messaging and video conferencing. Installing this type of application will increase productivity, especially for MSW's and others working with the community.

- Take advantage of the Health Care Authority's Clinical Data Repository (CDR) when it goes live in 2017. The CDR will contain valuable claims and clinical data for Medicaid patients and will prove to be an invaluable tool for clinicians in need of medical histories for psychiatric patients.

Fast-track the EHR implementation

The advantages of the EHR implementation alone cannot be overstated. Increases in staff productivity, in addition to other benefits, such as a scheduling module, Computerized Physician Order Entry (CPOE) and workflow management, will be realized almost immediately. Adjustments to the Staffing Model would need to be considered in anticipation of the deployment as roles would change somewhat.

Build out an enterprise data warehouse and business intelligence/data visualization tools

The EHR implementation should be followed by a project to build out an enterprise data warehouse, business intelligence and data visualization tools. These tools will be enormously helpful for the hospitals to understand their patient population, articulate and visualize trends, and provide a rich data set for research and analytics.

CHANGE MANAGEMENT

Numerous factors, including the immediate CMS system improvement requirements at WSH, are driving the need for leadership development at the hospitals. Research and evaluation studies are resulting in new methods and tools for facilitating change and for recovery of mental health patients. Payers (CMS), service beneficiaries (patients), their families, and the general public are seeking increased accountability for and effectiveness of services rendered. States and the Federal Government are implementing contracts and grants that require treatment facilities to demonstrate specified levels of patient outcomes rather than just delivery of services. Licensing and credentialing bodies are raising their standards and expecting higher qualifications from applicants for certification or licensure. In this maturing environment, complex treatment issues call for more sophisticated and competent treatment and management skills.

Adding to these external pressures, many internal pressures at the hospitals have resulted in what might be called a cultural "hangover". These pressures include chronic low staffing for the past few years resulting in inefficient workarounds, conflation of professional duties across disciplines and suboptimal work habits. In addition, media exposure is frequent and primarily negative. Many staff and leadership have "lived in a bubble", for decades in some cases, without experience at other facilities and work settings for exposure to other best practices or work cultures. These factors all make it very difficult to "turn the ship around", so ***immediate and concurrent change management work will be needed*** to ensure success as the proposed Clinical Staffing Model is being deployed.

The 2016 senior management change at WSH has already started to shift the sense of discouragement amongst the staff. Many noted the positive changes that have occurred over the past few months, but continued work with the staff and managers is needed to sustain the progress to date.

A competency-centric model of leadership development provides a framework for understanding, learning, and implementing the multiple functions and tasks of clinical supervision. Becoming a more effective and competent clinical leader is a developmental process. As knowledge and skills accumulate and are applied over time, the person's proficiency incrementally increases, regardless of their position or level held in the organization. Service improvement is found to be strongly correlated to investment in managerial training. Employees are found to more productive and efficient when they have the freedom to practice new skills in an environment of support and mentoring than through critical judgment.

Staff Leadership Development

Leadership development at the hospitals comprises two main components which are described below.

Executive Coaching and Change Management

Adoption of a new Clinical Staffing Model takes time under the best of circumstances, much less under the threat of decertification. The WSH and ESH transitions should be thoughtfully and deliberately planned, with significant emphasis placed on the coaching and support of executive

staff, application of proven Change Management principles and development of and adherence to performance measures to monitor progress. *This cannot be overstated.*

In addition to the executive-level coaching, significant work will need to *immediately* commence across the organization to address *team building, fostering trust, clarification of roles and responsibilities for each discipline and rapid process improvements*. This work is *not* the same as organizational development work related to recruiting, hiring, providing technical skills training and general onboarding/preceptorship/new hire mentoring. This work is about an ***organizational culture shift***.

A significant organizational turnaround such as that underway at WSH is an evolutionary process as these new hires come onboard and are integrated into the workforce. Although there have been significant changes already, it will be important to accomplish some quick wins as the turnaround continues to build, sustain momentum and demonstrate results.

Ward Program Administrator (WPA) and Supervisor Development

One critical success factor in the deployment of a new staffing model is the effectiveness of the Ward Program Administrators. There is some history at WSH to overcome with this role, which makes their integration into the workforce more challenging. Roles and responsibilities need to be very clear, and individuals in these roles are *not* responsible for clinical decision-making. However, they *will* be responsible to ensure that the ward runs well operationally, that high quality patient treatment plans are completed and that the overall level of staff accountability on their ward is elevated.

While candidates for this role will be required to be experienced managers and be Masters prepared, WSH in particular is an organization undergoing significant cultural change, and these employees will likely be new to the facility and possibly even to a state hospital setting. It is also probable that some existing staff with varying degrees of management experience could be hired or grandfathered into these roles. Training and coaching for this management group will be essential to:

- Reinforce leadership attributes and core competencies
- Reduce the likelihood of interdisciplinary conflicts
- Build effective work teams and implement supportive management strategies for staff working in a stressful environment
- Develop comradery, cohesiveness and buy-in amongst this cohort of new managers very early on
- Facilitate retention and job satisfaction
- Enhance the collective functioning of the hospital management team

Specific focus areas could include personal effectiveness, team building and management, Lean principles, communication skills, coaching skills and others identified by senior leadership. Financial management practices and human resources management in a state environment are also needed.

In addition to WPA training, support will be needed for supervisors as well. It was apparent that supervisory time is limited on most wards and related activities are frequently more

administrative than clinical in nature. Supervisors usually carry a clinical caseload and have a variety of program management responsibilities that limit direct clinical supervision of staff (including performance observation, feedback, and mentoring), and are rarely a part of staff development plan. New supervisors who receive little or no training in clinical supervision could create enormous inconsistency in the quality of supervision, thereby contributing to uncertainty and chaos.

It is increasingly important for State Hospitals to invest in leadership programs that train both experienced and new supervisors on how to monitor, evaluate, and promote clinical competence directly and objectively. Such a program must ensure fidelity with evidence-based practices and target Increase in treatment efficacy and cost-effectiveness as primary objectives.

Staff Support and Communication

Another critical success factor is that staff feel supported and know what is happening as they deal with a challenging work environment and continue to work on correcting some existing problems. The following strategies have been successfully employed elsewhere and should be considered to support WA state hospitals in these efforts:

- Both WSH and ESH have Employee Assistance Programs in place. This program is utilized when staff have experienced traumatic situations at work or have personal issues affecting work performance. These are confidential and short term. Also, continue use of the critical incident stress management (CISM) services after violent or upsetting events. This allows staff to debrief and recover.
- Provide coffee shop/espresso stand capabilities. Given the size of the campuses, there would likely need to be more than one staff dining area.
- Contract for food trucks to come onsite and solicit staff feedback on which types of food the staff would enjoy.
- Introduce art into the ward milieu and other areas of the campus as appropriate. Include staff and patient works and inspirational items and staff created murals.
- Convene a short-term rapid process improvement team to address staff communication. This might include staff representation from all areas of the facility to solicit ideas on how/when/why they prefer communication, especially given that many staff do not regularly read e-mail.
- Focus on visible data for the staff – this provides motivation for them and provides concrete data for outside stakeholders to demonstrate improvement. Have each ward or group identify 1-2 “pain points” that if they could be improved would make a significant difference and then set up a simple tracking board. Examples topics might include time from admission to evaluation, number of assaults, etc. This was implemented at Oregon State Hospital with resounding success.
- Brighten/paint the facility with a particular focus on some of the older buildings.
- Streamline hiring and transfer processes to maximize likelihood of keeping positions filled. Covering vacancies usually means others are not at optimal performance, increasing the risk of burnout.
- Invest in well-trained staff on an ongoing basis. Provide relevant trainings and support staff seeking to further education or those training others, such as a mentor program.

Staff ideas for other "quick wins" should continue to be solicited. It was noted that many processes are top down versus bottom up and staff had many good ideas on how to streamline and improve those. This includes scheduling and various clinical activities. There are probably many "low hanging fruit" that would bear rapid results and increase staff confidence and buy-in if they were more actively engaged in the solution. Even little things matter.

Prioritize a Lean initiative to optimize staff communications & identify "quick wins"

Finally, management accessibility is key to building relationships and to foster communication. As much as possible, managers should attempt to make daily rounds and participate in "management by walking around". This sends a powerful message to staff that they are valued. In addition to the rounds, staff forums would also be an effective strategy. These practices have already begun at both ESH and WSH and will be critical to continue.

Lean Adoption

Lean methodologies to examine current state and desired future state clinical and business processes should be utilized. The Lean methodology reviews processes by mapping all steps and identifying those that add value to the customer. In Lean, all other steps that do not add value are considered waste. Examples of waste in a service industry include over-processing (duplicate data entry), searching for information, batch processing and prolonged wait periods, to name a few. The Lean process uses people closest to the work to help identify ways to minimize waste and focus on customer value and hospital staff had many excellent ideas. Not surprisingly, in the context of this analysis, workflow issues were uncovered. Rather than "baking" existing business processes into the staffing and competency recommendations, this approach using Lean will help integrate a more streamlined process into the new vision for the hospitals.

Lean relies on a philosophy of continuous process improvement, to drive out waste by following a Plan-Do-Check-Adjust cycle. Given the severity of the situation at WSH in particular, a focus should be on increasing the ability to get "quick wins," which would in turn increase stakeholder participation and confidence in outcomes. Understanding that parties representing differing interests must view the facilitator as impartial, these techniques provide a valuable framework to ensure that stakeholders feel heard and difficult topics can be discussed in a non-threatening way.

Finally, in order to improve productivity and alter long-standing ways of working, barriers (and the natural resistance) to change that will likely emerge from those most directly impacted by the stated goals should be addressed. The organizational development plan should be designed to link the identified culture gaps to the strategic plan and business challenges.

Priorities for Lean analysis would include the following:

- Sort out/clarify professional responsibilities for Treatment team members: Psychologist, Psych Associate, Institution Counselor, Social Worker and Chemical Dependency Professional
- Adapt an acuity tool based on some best practices from peer hospitals
- Refine the interdisciplinary treatment plan tool
- Streamline the discharge process (this is already underway at WSH)
- Refine/improve internal communications process with staff (this is already underway at WSH, with a regular newsletter being distributed to staff)

RISK SUMMARY

The risks described below should be reviewed from the perspective of clinical staffing consistent with the project's outlined scope and the recommendations made within this document. This summary assessment is not an exhaustive risk evaluation of the staffing models for the Washington State psychiatric hospitals.

<table>
<tr><th>Risk Description</th><th>Impact</th><td>High</td></tr>
<tr><td rowspan="2">Safety Risk and Workflow Inefficiencies</td><th>Probability</th><td>High</td></tr>
<tr><th colspan="2">Suggested Mitigation</th></tr>
<tr><th colspan="2">Contributing Issues</th><td rowspan="2">Market assessments should be conducted regularly to assess and address any gaps in salary levels.
Salary compression situations should be avoided to prevent certain clinical groups from feeling disenfranchised.
Incentive programs and non-monetary perks such as flexible schedules could be explored.
Reintroduce mandatory competency training as a requirement. Staffing plans and forecasts should be adjusted to accommodate for training. Training should be in-person if possible and require demonstrated competency in de-escalation before staff is released to the floor.
Develop incentive programs for hard to recruit positions such as Clinical Nurse Specialists (CNS). CNS have advanced practice preparation and influence the quality of nursing care.</td></tr>
<tr><td colspan="2">Challenges with recruitment and retention of qualified talent across clinical disciplines contributes to increased strain on existing staff resulting in workflow inefficiencies, safety issues and high turnover.
In some disciplines, salaries and benefits are not competitive with private sector facilities in an employment market that is already short of resources.
The temporary nature of some salary increases, while providing short term relief, is not a long term mitigation.
High nurse workloads increase the risk and number of reported on-the-job injuries, potentially resulting in high levels of nurse burnout and increased staff turnover.
Limited availability of appropriate competency training poses safety risk. This is a particular issue for those disciplines that require continuing education to meet licensure requirements. Exacerbating this challenge is low staffing that makes it difficult for existing staff to attend whatever training is offered.
Current staffing model does not permit adequate mentorship ("preceptor" program) and supervision of new staff, resulting in inadequately supervised floor staff. There is frequent need to use more senior staff for direct clinical care while also being responsible for overall quality of care in their ward.</td></tr>
</table>

Risk Description	Impact	Medium
Weakened Staff Morale	**Probability**	High
	Suggested Mitigation	
Contributing Issues		
• Recent press and publicity have been distracting to staff causing uncertainty and ambiguity in their professional and personal lives. • Perception of limited career progression within certain job classifications - especially true for rehabilitation services where unlicensed staff members quickly reach the highest job classification available to them.	• Engage a Public Relations (PR) firm to share success stories about State Psychiatric facilities. • Ensure timely and effective communication from leadership, with talking points and tools on how to deal and respond to adverse events. • Leaders should periodically "round" with the staff and put in place an effective process for examining staffing concerns. • Invest in developing career ladder opportunities that allow assumption of additional responsibilities and employee professional growth and mobility without necessarily requiring placement into supervisory or managerial positions. • Once educational support and reimbursement programs are in place, provide HR assistance to communicate and raise awareness of additional training and career advancement opportunities available at the hospitals.	

Risk Description	Impact	High
Limited Implementation of Staffing Model	**Probability**	Medium
	Suggested Mitigation	
Contributing Issues	• Re-align recruiting strategy with staffing model recommendations. • Impact of post-EHR implementation may require a "refresh" of the staffing model. • Explore flexible staffing options - create more part-time positions that cover evening and night shifts and/or rely on permanent float pool shift which include both full-time and part-time positions. • Increase pool of mid-levels.	
• Recruiting activity preceding the rollout of the recommended staffing model may not be aligned with model recommendations. • Staffing model recommendations assume the status quo, and not the staffing environment post-EHR implementation. • Mandated overtime undermines staff morale; that could lead to productivity and safety challenges. • Continued shortage of non-clinical personnel such as housekeeping and dietary staff distracts nursing staff from patient care.		

Risk Description	Impact	Medium
Restrictions in Spurring Innovation	Probability	High
	Suggested Mitigation	

Contributing Issues

- Market dynamics point to an aging workforce and limited interest in mental health among next generation healthcare professionals in comparison with other medical specialties.
- Extended delays in rolling out the Electronic Health Records (EHR) system compels continued dependency on paper records and manual processes restricting workflow automation.
  - Puts WA State psychiatric facilities at the "lagging edge" of Health Information Technology (HIT) that continues to experience high growth with capabilities such as telemedicine
  - Contributes to lack of interest among next generation workforce that wants to be part of an innovation-friendly culture

Suggested Mitigation

- Launch PR campaigns among target audience (colleges, universities etc.) to promote mental health as a critical area of focus by healthcare leaders and legislation.
  - Outreach to new generation professionals should focus on intrinsic motivators - privilege of offering compassion, inspiring hope, and teaching others the necessary skills required to overcome their current circumstances.
- Leadership should aggressively pursue expedient EHR implementation and have a robust communication plan for sharing its value with facilities.
- Partner with private organizations to launch pilot programs that target demonstrable improvement and outcomes in patient care.

RECOMMENDATIONS SUMMARY

There are numerous recommendations distributed throughout this document. The recommendations outlined below are intended to be a representative sampling of these. This is not an exhaustive list.

Recommendation	Timing Priority
Reorganize the management model on the wards to include a Ward Program Administrator (WPA) responsible for 24/7 ward operations. This would clarify the chain of command and provide a continuity of authority and communication relevant to the wards.	**0-6 months**
Use Center/Unit-based permanent float pools that include full time and part time positions. This would increase the *quality and continuity* of care for patients, and improve overall safety in the workplace.	**0-6 months**
Use ARNP, P-ARNP and PA-C to ease constraints created by lack of qualified psychiatrists in the workforce, physician unavailability and recruitment delays.	**0-6 months**
Invest in leadership programs that train both experienced and new supervisors on how to monitor, evaluate, and promote clinical competence directly and objectively.	**0-6 months**
Create an organizational work structure that supports both administrative and clinical functions, encouraging appropriate time and focus on patient care and active treatment by clinical staff, with non-clinical activities carried out by administrative and other support services.	**0-6 months**
Address staffing shortages in non-clinical disciplines such as housekeeping, transportation, dietary and food services, which distract nursing staff from their core responsibility of patient care.	**0-6 months**
Conduct thorough facility assessments at both hospitals to evaluate the functional facility design from the perspective of safety, security, privacy and staff working conditions and remediate issues found. This will go a long a way in creating environments in which patients and staff are safe and trauma-informed.	**0-6 months**
Adopt and enforce the use of industry accepted assessment tools and criteria for treatment planning. Treatment standards, process measures, and clinical outcomes that are specific and individualized to the complex populations of patients will drive faster throughput and recovery times.	**0-6 months**
Engage a Public Relations firm to help share what is good about the state hospitals, and share success stories. Appropriate HIPAA authorizations and other releases can also be obtained to share patient stories, as appropriate.	**0-6 months**

Develop a uniform discharge planning process across both state hospitals with responsibility falling to social workers. Elements of a successful discharge planning protocol should include the following: – Cultivate a culture of discharge planning beginning at admission. – Adopt a proven and predictable discharge planning screening tool so that information is not solely drawn from chart notes. – Formulate standardized screening tools around prediction rules; for example, a symptom checklist. – Train social workers and discharge planners related to the special needs of the homeless. – Co-develop a discharge readiness assessment tool with the Behavioral Health Organizations (BHO's). Such a tool would be used to evaluate patients for re-entry in the community, including level and type of placement.	**0-6 months**
Invest in "Lean" efficiency work flow exercises to specifically identify areas of opportunity to maximize nursing/clinical staff time on direct patient care and reduce bottlenecks. This would empower the leadership to take definitive actions and decisions to optimize productivity and staffing levels. Several ideas for Lean exercises are suggested earlier in the document.	**0-6 months (and ongoing)**
Develop management reporting metrics. Examples would be a monthly scorecard depicting fill rates and annualized turnover rates for clinical staff positions reported to hospital leadership (this report would demonstrate the effect of actions being taken to enhance recruitment and retention). Supporting this, develop another report used to monitor number of contractors including locum tenens deployed to cover for staffing inadequacies.	**0-6 months (and ongoing)**
When adverse or unusual occurrence events take place, consistently enforce a thorough analysis of these events. There should be rigorous debriefing to form a comprehensive analysis of circumstances, and how the event can be prevented or avoided in the future. Included in the debrief should be questions covering: what happened, what was missed, what led up to this event, what could have been done differently, what practices precipitated this event, and what can be changed.	**0-6 months (and ongoing)**
Establish and reinforce a philosophy of a recovery-centric culture, and extend to the community the hospitals' consultative expertise, access, and training related to the diagnosis and treatment of people with complex conditions who may be at risk of harm to self or others. Provisioning this expertise will help legislators, courts, community providers, families, and others understand the role of the state psychiatric hospitals in the context of recovery and the public health care system. Such actions also provide opportunities to strengthen linkages with the community, develop staff skills, and recruit and retain high quality staff.	**0-6 months (and ongoing)**
Reinstitute a formal mentoring program for clinical staff before these staff are assigned to direct patient care. The current "preceptor" program may be insufficient in training nurses and other caregivers on practical everyday challenges in the wards. Avoid assigning staff to float pools until they have fully completed the mentor program and are signed off by the Center/Unit leader.	**6-12 months**

Re-introduce programs (e.g., PALS) to support community engagement and reintegration for patients who have experienced long state psychiatric hospital lengths of stay. Transition services would include skills training to manage patients' illness, health, daily activities, and living environment as well as care coordination, peer support services, and community consultation and liaison.	**6-12 months**
Reestablish strong linkages with medical schools and other academic institutions for education, training, and research to enhance recruitment and retention of workforce.	**6-12 months**
Implement a floating pool of instructional aides within rehab to permit licensed rehabilitation therapists to use their skills more effectively and be more actively involved in treatment.	**6-12 months**
Encourage and enable staff to pursue continuing education within or outside of the workplace, with particular emphasis on evidence-based practices, cultural competence and services designed to manage special sub-populations of patients.	**6-12 months**
Embrace and promote the use of modern health information technologies in daily operations. Hospital leadership should *strongly advocate expedient deployment* of a fully functioning Electronic Health Record system, and explore the use of telemedicine for specialty consultation.	**6-12 months (and ongoing)**
Standardize care planning teams across all hospitals; identify best practice and/or evidence-based practices to include collaboration with peer support specialists. Inclusion in treatment planning wherever practical and feasible is a key component of staff satisfaction, and will go a long way in instilling a sense of belonging and work fulfilment for staff.	**12+ months**
Launch a formal employee referral program with bonuses tied to hiring and retention. Accelerate recruiting by providing a forum for on-call nurses/staff who may be interested in exploring full time or predictable part time opportunities.	**12+ months**

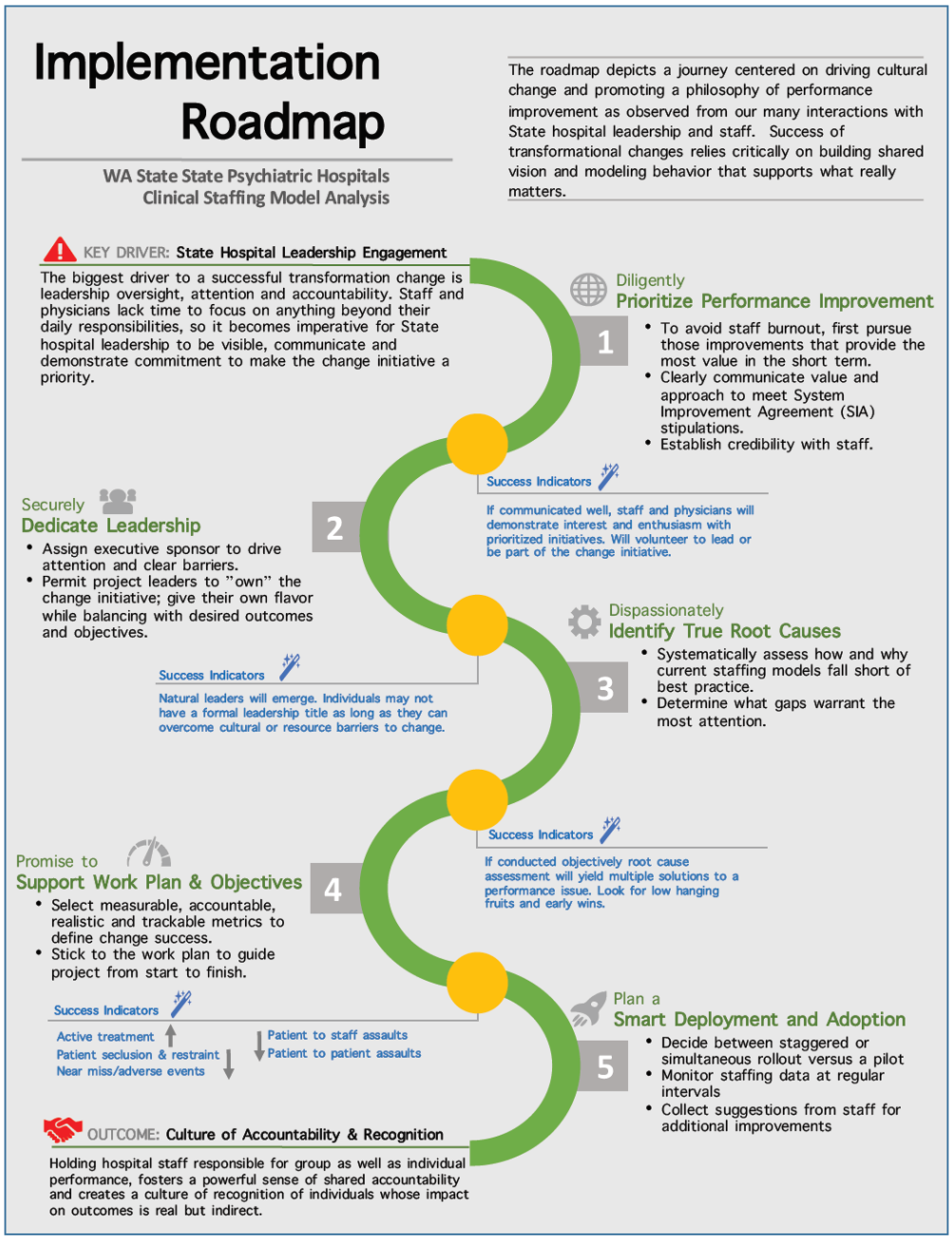
Summary

The transition to a new Clinical Staffing Model will take some time to accomplish and should be thoughtfully and deliberately planned. There may be factors that limit the hospitals' ability to fully implement the documented model, but significant efforts should be made to incorporate the recommendations to the fullest extent possible. Organizational Change Management (OCM) principles and practices can significantly reduce risk during adoption and should be strongly considered as a starting point for the transition.

Finally, a staffing model is much more than numbers on a spreadsheet. The culture of the organization, the accountability of management and staff and the willingness to change are key factors in the success of any system or institution. An understanding and celebration of the good work being done at these places will be paramount to the success of the new model. It will take time, money, commitment and effort to restore them to the world-class institutions that patients, staff and our communities deserve.

NEXT STEPS

The graphic shown below presents a high-level framework for leadership focus as efforts to incorporate the staffing model and other recommended changes begins. The state hospitals should consider development of a detailed implementation plan as a priority next step, and the impact of using local hospital leadership and staff resources to select, prioritize and implement changes outlined in this report should be contemplated.



APPENDIX A: CLINICAL STAFFING MODEL

The Clinical Staffing Model for this project is provided separately as an Excel Workbook file with one tab each for Eastern State Hospital and Western State Hospital. The workbook file is provided separately to facilitate the ability of both hospitals to have access to overall staffing numbers and calculations, should there be a desire or need to tweak the model for a particular purpose.

The tables on the following pages are provided from the Model for purposes of viewing within this document by the reader.

Each table has 3 sets of nearly identical notes which apply to the Model. The first set are general notes:

General notes:

- *The Assumptions section of the main Staffing Model Analysis project report provides additional context for these numbers.*
- *This reflects ward-level baseline staffing by shift. Staffing for centralized depts (e.g. the central PT dept), the Treatment Mall and special teams (e.g. PERT Team) would be additional.*
- *This defines typical weekday baseline staffing without 1:1 patients. Some adjustment would be needed for the weekend. Additional staff would be needed to cover any 1:1 patients.*
- *For each subgrouping with more than one ward indicated (e.g. multiple Forensic admission wards), the staff counts listed here apply to each ward in that subgroup.*
- *The yellow shaded line items have incomplete ward-level staffing. Additional analysis is needed to determine full baseline staffing for these roles.*
- *The acuity tool would be completed each shift for each patient and per those scores additional staffing could augment these baseline numbers, if needed.*
- *These numbers do not reflect total FTE per ward. A conversion factor of 1.8 would be needed to determine 24/7/365 coverage for each staff position noted here.*
- *These numbers do not reflect a net gain in staffing from current levels.*
- *SIA requirements for any ward-level staff are assumed to be included here (e.g. MHT, RN, IC staff).*
- *HMH mandated staffing requirements for any ward-level staff are assumed to be included here.*
- *Center level staff (in addition to the ward-level staffing) includes:*
  - *Clinical Nurse Specialists*
  - *Nurse Educators*
  - *Nursing Float pool*
  - *Social Work float pool*
  - *Peer Support Specialists*
  - *PERT Team*
  - *Transport/Escort team*

In addition, each table also has a set of notes which apply to specific staff roles:

Notes on specific staff roles:

- *Evening and night shifts - ESH has one Administrative Supervisor for the entire facility on each shift. WSH would have two.*
- *RN3 are shift nursing supervisors that are 50% office and 50% on the ward (can act as Charge Nurse if needed).*
- *Medical providers and psychiatrists do not have call. There are designated staff to cover off hours - the Officer of the Day (the OD).*
- *Physicians and mid-level providers (ARNP and PA-C) are considered interchangeable.*
- *On HMH wards, the Institution Counselors function as patient coordinators. This assumes IC would also not perform personal care MHT duties.*
- *Environmental service duties (e.g. janitorial, housekeeping, laundry, general cleaning) are not the same as environmental safety checks. The gero-psych wards could possibly use some additional Environmental Services staff, but TBD.*
- *Ward-level janitorial services would be available during days and evenings, but would be managed facility-wide during the night.*
- *Gero-psych would have one Physical Therapist and one Occupational Therapist assigned per Center. HMH wards would also have some PT/OT ward-level support.*
- *Gero-psych would have one Aide (COTA or PTA) assigned for every two wards. HMH wards would also have some PT/OT assistant ward-level support.*
- *Each Center would have 1-3 Clinical Nurse Specialists, varying by the patient population.*
- *Each Center would have 1-3 Nurse Educators who would assist with onboarding and related duties.*

Finally, for each staff position noted in the spreadsheet, there are staffing ratios and comments to the right side of the table:

Position	Notes
Ward Program Administrator	*1 per ward, onsite day shift but has 24/7 responsibility*
Office Assistant	*1 per ward on days, cover 2 wards on eves*
Med Rec/Quality Asst	*1 per ward on days only*
Management and Support ↑	
RN3 (shift nursing supr)	
RN2	
LPN2/LPN4/PSN	
MHT1/MHT2/MHT3/PSA	*Per Geller Model - Extra MHT on admission wards & geropsych wards*
Nursing ↑	***1/5 to 1/6 ratio overall of staff to pts***
Psychiatrist/Psych ARNP	*1 psychiatrist/15 pts (2 per ward).*
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	*1 per 2 wards for most, 1 dedicated for admission & geropsych ones*
Medical ↑	
Psychologist	*Pair 1 Psych and 1 PA per ward baseline (others TBD per ward type)*
Psych Associate	
Social Worker	*2 per ward*
Social Work Assistant	*1 per ward*
Institution Counselor	*1 per ward baseline, but additional ones TBD depending upon ward services*
Recreation Therapist	*1 per ward on days, supplement on eves after Tx Mall closed*
Occupational Therapist	*1 per Center/Unit in gero-psych & .5 in HMH*
Physical Therapist	*1 per Center/Unit in gero-psych & .5 in HMH*
Therapy Assistants (PTA, COTA, other)	*.5 per ward in gero-psych & .5 for HMH*
Treatment ↑	
Dietary Aide	*1 per ward on days, cover 2 wards on eves*
Env Services	*1 per ward on days, cover 2 wards on eves*
Non-Clinical ↑	

The tables on the following pages illustrate the detailed staffing per Center/Unit, per hospital.

Eastern State Hospital (ESH) Target Staffing Model (Ward-Level)

Unit	Forensic Services Unit (FSU)											
Wards	1S1				2S1 3S1				2N3			
Total Beds	28				67				30			
Type	Admission				NGRI				Conditional Release			
Shift	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
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
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
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**
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
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
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
MHT1/MHT2/MHT3/PSA	6.00	6.00	5.00	17.00	4.00	4.00	4.00	12.00	4.00	4.00	4.00	12.00
Nursing Totals	**11.00**	**10.50**	**7.50**	**29.00**	**9.00**	**8.50**	**6.50**	**24.00**	**9.00**	**8.50**	**6.50**	**24.00**
Psychiatrist/Psych ARNP	2.00	*OD*		2.00	2.00	*OD*		2.00	2.00	*OD*		2.00
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	1.00	*OD*		1.00	0.50	*OD*		0.50	0.50	*OD*		0.50
Medical Totals	**3.00**	**0.00**	**0.00**	**3.00**	**2.50**	**0.00**	**0.00**	**2.50**	**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
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
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
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
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
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
Occupational Therapist				0.00				0.00				0.00
Physical Therapist				0.00				0.00				0.00
Therapy Assistants (PTA, COTA, other)				0.00				0.00				0.00
Treatment Totals	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**
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
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
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**
Ward Totals	**26.00**	**14.00**	**7.50**	**47.50**	**23.50**	**12.00**	**6.50**	**42.00**	**23.50**	**12.00**	**6.50**	**42.00**

Figure 1 – ESH Staffing Model – Forensic Services Unit (FSU)

Eastern State Hospital (ESH) Target Staffing Model (Ward-Level)

Unit	Adult Psychiatric Unit (APU)											
Wards	1N1				2N1				3N1			
Total Beds	31				30				30			
Type	Admission				Higher Acuity Long Term				Highest Acuity Long Term			
Shift	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
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
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
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**
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
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
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
MHT1/MHT2/MHT3/PSA	6.00	6.00	5.00	17.00	4.00	4.00	4.00	12.00	4.00	4.00	4.00	12.00
Nursing Totals	**11.00**	**10.50**	**7.50**	**29.00**	**9.00**	**8.50**	**6.50**	**24.00**	**9.00**	**8.50**	**6.50**	**24.00**
Psychiatrist/Psych ARNP	2.00	*OD*		2.00	2.00	*OD*		2.00	2.00	*OD*		2.00
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	1.00	*OD*		1.00	0.50	*OD*		0.50	0.50	*OD*		0.50
Medical Totals	**3.00**	**0.00**	**0.00**	**3.00**	**2.50**	**0.00**	**0.00**	**2.50**	**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
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
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
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
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
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
Occupational Therapist				0.00				0.00				0.00
Physical Therapist				0.00				0.00				0.00
Therapy Assistants (PTA, COTA, other)				0.00				0.00				0.00
Treatment Totals	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**
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
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
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**
Ward Totals	**26.00**	**14.00**	**7.50**	**47.50**	**23.50**	**12.00**	**6.50**	**42.00**	**23.50**	**12.00**	**6.50**	**42.00**

Figure 2 – ESH Staffing Model – Adult Psychiatric Unit (APU)

Eastern State Hospital (ESH) Target Staffing Model (Ward-Level)

Unit	Geropsychiatric Unit (GPU)															
Wards	D				E				B				Closed			
Total Beds	31				30				30				0			
Type	Admission				Lower Acuity Long Term				Higher Acuity Long Term				Highest Acuity Long Term			
Shift	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				
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				
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				
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**				
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				
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				
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				
MHT1/MHT2/MHT3/PSA	6.00	6.00	5.00	17.00	6.00	6.00	5.00	17.00	6.00	6.00	5.00	17.00				
Nursing Totals	**11.00**	**10.50**	**7.50**	**29.00**	**11.00**	**10.50**	**7.50**	**29.00**	**11.00**	**10.50**	**7.50**	**29.00**				
Psychiatrist/Psych ARNP	2.00	*OD*		2.00	2.00	*OD*		2.00	2.00	*OD*		2.00				
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	1.00	*OD*		1.00	1.00	*OD*		1.00	1.00	*OD*		1.00				
Medical Totals	**3.00**	**0.00**	**0.00**	**3.00**	**3.00**	**0.00**	**0.00**	**3.00**	**3.00**	**0.00**	**0.00**	**3.00**				
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				
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				
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				
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				
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				
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				
Occupational Therapist	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25				
Physical Therapist	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25				
Therapy Assistants (PTA, COTA, other)	0.50	0.00	0.00	0.50	0.50	0.00	0.00	0.50	0.50	0.00	0.00	0.50				
Treatment Totals	**8.00**	**2.00**	**0.00**	**10.00**	**8.00**	**2.00**	**0.00**	**10.00**	**8.00**	**2.00**	**0.00**	**10.00**				
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				
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				
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**	**0.00**	**0.00**	**0.00**	**0.00**
Ward Totals	**27.00**	**14.00**	**7.50**	**48.50**	**27.00**	**14.00**	**7.50**	**48.50**	**27.00**	**14.00**	**7.50**	**48.50**	**0.00**	**0.00**	**0.00**	**0.00**

Figure 3 – ESH Staffing Model – Geropsychiatric Unit (GPU)

Eastern State Hospital (ESH) Target Staffing Model (Ward-Level)

Unit	Habilitative (HMH)			
Wards	Ward A			
Total Beds	10			
Type	Developmental Disabilities			
Shift	Day	Eve	Night	Total
Ward Program Administrator		1.00		1.00
Office Assistant	1.00	0.50	0.00	1.50
Med Rec/Quality Asst	1.00	0.00	0.00	1.00
Management and Support Totals	**3.00**	**0.50**	**0.00**	**3.50**
RN3 (shift nursing supr)	1.00	0.50	0.50	2.00
RN2	3.00	3.00	1.00	7.00
LPN2/LPN4/PSN	1.00	1.00	1.00	3.00
MHT1/MHT2/MHT3/PSA	4.00	4.00	4.00	12.00
Nursing Totals	**9.00**	**8.50**	**6.50**	**24.00**
Psychiatrist/Psych ARNP	2.00	*OD*		2.00
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	0.50	*OD*		0.50
Medical Totals	**2.50**	**0.00**	**0.00**	**2.50**
Psychologist	1.00	0.00	0.00	1.00
Psych Associate	1.00	0.00	0.00	1.00
Social Worker	2.00	0.00	0.00	2.00
Social Work Assistant	1.00	0.00	0.00	1.00
Institution Counselor	1.00	0.00	0.00	1.00
Recreation Therapist	1.00	2.00	0.00	3.00
Occupational Therapist	0.50	0.00	0.00	0.50
Physical Therapist	0.50	0.00	0.00	0.50
Therapy Assistants (PTA, COTA, other)	0.50	0.00	0.00	0.50
Treatment Totals	**8.50**	**2.00**	**0.00**	**10.50**
Dietary Aide	1.00	0.50	0.00	1.50
Env Services	1.00	0.50	0.00	1.50
Non-Clinical Totals	**2.00**	**1.00**	**0.00**	**3.00**
Ward Totals	**25.00**	**12.00**	**6.50**	**43.50**

Figure 4 – ESH Staffing Model – Habilitative Mental Health (HMH)

Western State Hospital (WSH) Target Staffing Model (Ward-Level)

Center	Center For Forensic Services (CFS)															
Wards	F1 F2 F3 F6				F4 F5 F7 F8				E1				S4			
Total Beds	118				124				31				15			
Type	Admission				NGRI				Conditional Release				Transitional/Extended			
Shift	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
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	0.50	0.50	0.00	1.00
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	0.50	0.00	0.00	0.50
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**	**2.00**	**0.50**	**0.00**	**2.50**
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	1.00	1.00	1.00	3.00
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	6.00	6.00	5.00	17.00	4.00	4.00	4.00	12.00	4.00	4.00	4.00	12.00	2.00	2.00	2.00	6.00
Nursing Totals	**11.00**	**10.50**	**7.50**	**29.00**	**9.00**	**8.50**	**6.50**	**24.00**	**9.00**	**8.50**	**6.50**	**24.00**	**5.00**	**4.50**	**4.50**	**14.00**
Psychiatrist/Psych ARNP	2.00	*OD*		2.00	2.00	*OD*		2.00	2.00	*OD*		2.00	1.00	*OD*		1.00
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	1.00	*OD*		1.00	0.50	*OD*		0.50	0.50	*OD*		0.50	0.50	*OD*		0.50
Medical Totals	**3.00**	**0.00**	**0.00**	**3.00**	**2.50**	**0.00**	**0.00**	**2.50**	**2.50**	**0.00**	**0.00**	**2.50**	**1.50**	**0.00**	**0.00**	**1.50**
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
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	1.00	0.00	0.00	1.00
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	0.50	0.00	0.00	0.50
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
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	0.50	1.00	0.00	1.50
Occupational Therapist				0.00				0.00				0.00				0.00
Physical Therapist				0.00				0.00				0.00				0.00
Therapy Assistants (PTA, COTA, other)				0.00				0.00				0.00				0.00
Treatment Totals	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**	**5.00**	**1.00**	**0.00**	**6.00**
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	0.50	0.50	0.00	1.00
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	0.50	0.50	0.00	1.00
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**	**1.00**	**1.00**	**0.00**	**2.00**
Ward Totals	**26.00**	**14.00**	**7.50**	**47.50**	**23.50**	**12.00**	**6.50**	**42.00**	**23.50**	**12.00**	**6.50**	**42.00**	**14.50**	**7.00**	**4.50**	**26.00**

Figure 5 – WSH Staffing Model – Center for Forensic Services (CFS)

Western State Hospital (WSH) Target Staffing Model (Ward-Level)

Center	Psychiatric Treatment & Recovery Center (PTRC) - Adult Psych											
Wards	C3 C5 C6 C8				C2 C7 S3 S7 S8 S9 S10				Closed (was C4)			
Total Beds	122				212				0			
Type	Admission				Higher Acuity Long Term				Highest Acuity Long Term			
Shift	Day	Eve	Night	Total	Day	Eve	Night	Total	Day	Eve	Night	Total
Ward Program Administrator	1.00			1.00	1.00			1.00				
Office Assistant	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50				
Med Rec/Quality Asst	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00				
Management and Support Totals	**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				
RN2	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				
MHT1/MHT2/MHT3/PSA	6.00	6.00	5.00	17.00	4.00	4.00	4.00	12.00				
Nursing Totals	**11.00**	**10.50**	**7.50**	**29.00**	**9.00**	**8.50**	**6.50**	**24.00**				
Psychiatrist/Psych ARNP	2.00	*OD*		2.00	2.00	*OD*		2.00				
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	1.00	*OD*		1.00	0.50	*OD*		0.50				
Medical Totals	**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				
Psych Associate	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				
Social Work Assistant	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00				
Institution Counselor	1.00	0.00	0.00	1.00	1.00	0.00	0.00	1.00				
Recreation Therapist	1.00	2.00	0.00	3.00	1.00	2.00	0.00	3.00				
Occupational Therapist				0.00				0.00				
Physical Therapist				0.00				0.00				
Therapy Assistants (PTA, COTA, other)				0.00				0.00				
Treatment Totals	**7.00**	**2.00**	**0.00**	**9.00**	**7.00**	**2.00**	**0.00**	**9.00**				
Dietary Aide	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50				
Env Services	1.00	0.50	0.00	1.50	1.00	0.50	0.00	1.50				
Non-Clinical Totals	**2.00**	**1.00**	**0.00**	**3.00**	**2.00**	**1.00**	**0.00**	**3.00**	**0.00**	**0.00**	**0.00**	**0.00**
Ward Totals	**26.00**	**14.00**	**7.50**	**47.50**	**23.50**	**12.00**	**6.50**	**42.00**	**0.00**	**0.00**	**0.00**	**0.00**

Figure 6 – WSH Staffing Model – Psychiatric Treatment & Recovery Center (PTRC) – Adult Psychiatry

Western State Hospital (WSH) Target Staffing Model (Ward-Level)

Center	Psychiatric Treatment & Recovery Center (PTRC) - Geriatric Psych															
Wards	E5				E7				E3 E6 E8				E2 E4			
Total Beds	30				28				83				54			
Type	Admission				Lower Acuity Long Term				Higher Acuity Long Term				Highest Acuity Long Term			
Shift	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
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
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
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	6.00	6.00	5.00	17.00	6.00	6.00	5.00	17.00	6.00	6.00	5.00	17.00	6.00	6.00	5.00	17.00
Nursing Totals	**11.00**	**10.50**	**7.50**	**29.00**	**11.00**	**10.50**	**7.50**	**29.00**	**11.00**	**10.50**	**7.50**	**29.00**	**11.00**	**10.50**	**7.50**	**29.00**
Psychiatrist/Psych ARNP	2.00	*OD*		2.00	2.00	*OD*		2.00	2.00	*OD*		2.00	2.00	*OD*		2.00
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	1.00	*OD*		1.00	1.00	*OD*		1.00	1.00	*OD*		1.00	1.00	*OD*		1.00
Medical Totals	**3.00**	**0.00**	**0.00**	**3.00**	**3.00**	**0.00**	**0.00**	**3.00**	**3.00**	**0.00**	**0.00**	**3.00**	**3.00**	**0.00**	**0.00**	**3.00**
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
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
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
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
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
Occupational Therapist	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25
Physical Therapist	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25	0.25	0.00	0.00	0.25
Therapy Assistants (PTA, COTA, other)	0.50	0.00	0.00	0.50	0.50	0.00	0.00	0.50	0.50	0.00	0.00	0.50	0.50	0.00	0.00	0.50
Treatment Totals	**8.00**	**2.00**	**0.00**	**10.00**	**8.00**	**2.00**	**0.00**	**10.00**	**8.00**	**2.00**	**0.00**	**10.00**	**8.00**	**2.00**	**0.00**	**10.00**
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
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
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	**27.00**	**14.00**	**7.50**	**48.50**	**27.00**	**14.00**	**7.50**	**48.50**	**27.00**	**14.00**	**7.50**	**48.50**	**27.00**	**14.00**	**7.50**	**48.50**

Figure 7 – WSH Staffing Model – Psychiatric Treatment & Recovery Center (PTRC) - Geriatric Psychiatry

Western State Hospital (WSH) Target Staffing Model (Ward-Level)

Center	Habilitative (HMH)			
Wards	W1N W1S			
Total Beds	30			
Type	Developmental Disabilities			
Shift	Day	Eve	Night	Total
Ward Program Administrator	1.00			1.00
Office Assistant	1.00	0.50	0.00	1.50
Med Rec/Quality Asst	1.00	0.00	0.00	1.00
Management and Support Totals	**3.00**	**0.50**	**0.00**	**3.50**
RN3 (shift nursing supr)	1.00	0.50	0.50	2.00
RN2	3.00	3.00	1.00	7.00
LPN2/LPN4/PSN	1.00	1.00	1.00	3.00
MHT1/MHT2/MHT3/PSA	4.00	4.00	4.00	12.00
Nursing Totals	**9.00**	**8.50**	**6.50**	**24.00**
Psychiatrist/Psych ARNP	2.00	*OD*		2.00
Med. Physician/Med-Surg ARNP/Physician Assistant (PA-C)	0.50	*OD*		0.50
Medical Totals	**2.50**	**0.00**	**0.00**	**2.50**
Psychologist	1.00	0.00	0.00	1.00
Psych Associate	1.00	0.00	0.00	1.00
Social Worker	2.00	0.00	0.00	2.00
Social Work Assistant	1.00	0.00	0.00	1.00
Institution Counselor	1.00	0.00	0.00	1.00
Recreation Therapist	1.00	2.00	0.00	3.00
Occupational Therapist	0.50	0.00	0.00	0.50
Physical Therapist	0.50	0.00	0.00	0.50
Therapy Assistants (PTA, COTA, other)	0.50	0.00	0.00	0.50
Treatment Totals	**8.50**	**2.00**	**0.00**	**10.50**
Dietary Aide	1.00	0.50	0.00	1.50
Env Services	1.00	0.50	0.00	1.50
Non-Clinical Totals	**2.00**	**1.00**	**0.00**	**3.00**
Ward Totals	**25.00**	**12.00**	**6.50**	**43.50**

Figure 8 – WSH Staffing Model – Habilitative Mental Health (HMH)

APPENDIX B: ACUITY MODELS

ARIZONA STATE HOSPITAL (ASH)

260 Beds

Contact Information

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DATE: SHIFT:

FORENSIC ACUITY TOOL			Pt. Name	Nurse Assigned	MHPS Assigned	Complex Procedures	New Admit	Scheduled Staffings	Appts.	S & R	Discharge	Transfer	COS LOS HR	COS 2:1	Off Site Transport Appts.	ADL Total Care
Recommended Staffing																
RN	0.00															
LPN / Med Nurse	1															
MHPS	1.00															
MHPS Acuity																
Unit Capacity																
Empty Beds																
Routine Patients																
COS / LOS / HR (With Dr. Order)	0															
COS 2:1 (With Dr. Order)	0															
Census and COS Q15 check	1															
Off Site Transports / Appts.	0															
ADL Total Care	0															
Nurse Acuity																
Complex Procedures	0															
New Admit	0															
Scheduled Staffings	0															
Appointments	0															
S and R	0															
Discharge	0															
Transfer	0															
Medication Nurse / LPN	1															

KEY	
	Required Field
	Input error

Version Date 11-1-15

Figure 1 – Arizona State Hospital Forensic Acuity Tool

VANDERBILT PSYCHIATRIC HOSPITAL

100 Beds

Website

http://www.mc.vanderbilt.edu/documents/evidencebasedpractice/files/Quantifying%20Psychiatric%20Acuity.pdf

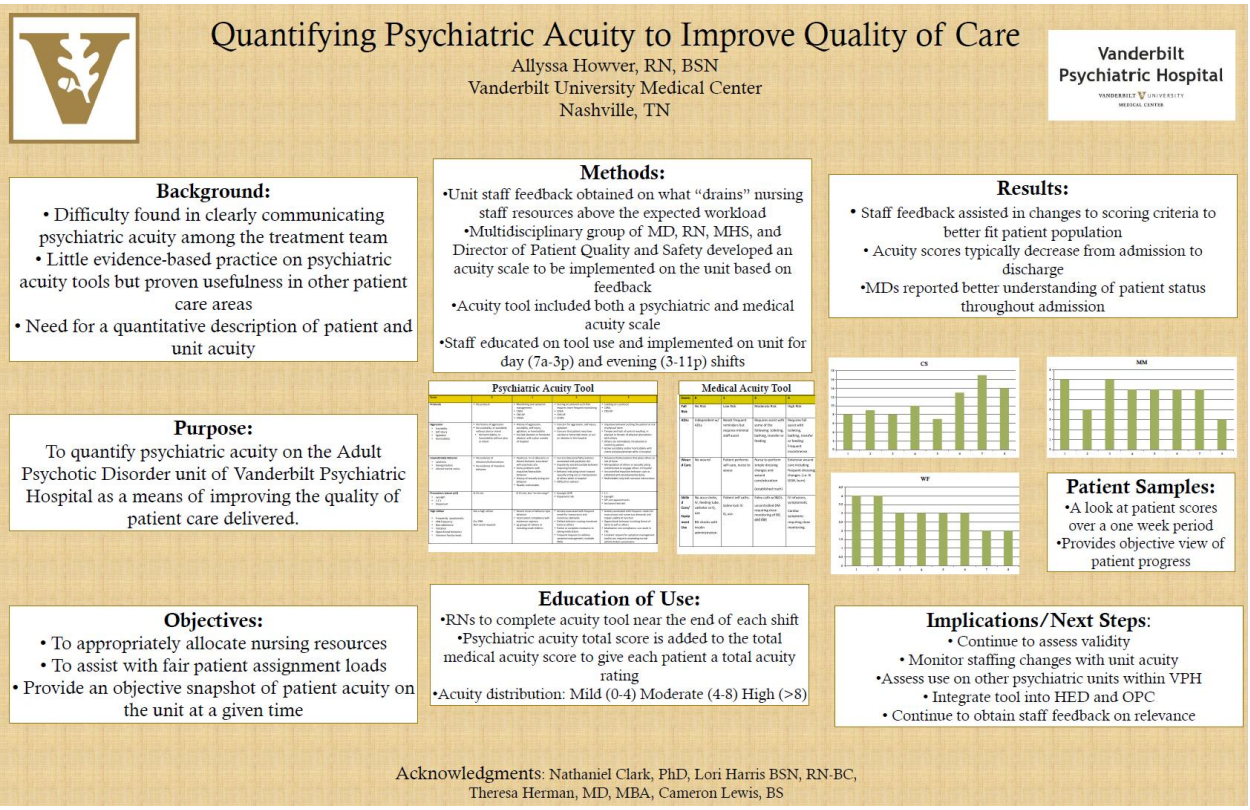

Figure 2 – Vanderbilt Psychiatric Hospital Quantifying Acuity Overview

Psychiatric Acuity Tool

Score:	0	1	2	3
Protocols	• No protocol	• Monitoring and symptom management • CIWA • CNS-DP • COWS	• Scoring on protocol such that requires more frequent monitoring • CIWA • CNS-DP • COWS	• Loading on a protocol • CIWA • CNS-DP
Aggression • Suicidality • Self-injury • Agitation • Homicidality	• No history of aggression • No suicidality, or suicidality without plan or intent • No homicidality, or homicidality without plan or intent	• History of aggression, suicidality, self-injury, agitation, or homicidality • Suicidal ideation or homicidal ideation with a plan outside of hospital	• Concern for aggression, self-injury, agitation • Concern that patient may have suicidal or homicidal intent, or act on ideation in the hospital	• Impulsive behavior putting the patient at risk of physical harm • Temper and lack of control resulting in physical or threats of physical altercations with others • Others are intimidated, threatened or incited by patient • Active suicidality and/or homicidality with intent and plan/attempt while in hospital
Unpredictable Behavior • catatonia • disorganization • altered mental status	• No evidence of delusions/hallucinations • No evidence of impulsive behavior	• Psychosis- hx of delusions or bizarre behavior associated with psychotic d/o • Some problems with impulsive/distractible behavior • History of sexually acting out behavior • Readily redirectable	• Current delusions/hallucinations associated with psychotic d/o • Impulsivity and distractible behavior impairing function • Behavior indicating intent toward sexually acting out or manipulation of others while in hospital • Difficult to redirect	• Delusions/hallucinations that place others at risk of harm • Manipulation of others or sexually acting out/attempts to engage others in hospital • Uncontrolled impulsive behavior such as exhibited with developmental delay • Redirectable only with constant intervention
Precautions (above q15) • eyesight • 1:1's • Elopement	Q 15 min	Q 15 min, but "on the verge"	• Eyesight OOR • Elopement risk	• 1:1 • Eyesight • Off-unit appointments • Seclusion/restraint
High Utilizer • Frequently symptomatic • PRN frequency • Non-adherence • Visitation • Oppositional behaviors • Intensive Family needs	Not a high utilizer Occ PRN Non-acute requests	• Recent onset of defiance type behavior • Inconsistent compliance with treatment regimen • Lg groups of visitors or including small children	• Anxiety associated with frequent needs for reassurance and numerous demands • Defiant behavior causing emotional harm to others • Partial or complete resistance to taking medications. • Frequent requests to address symptom management, multiple PRNs	• Anxiety associated with frequent needs for reassurance and numerous demands and impairs ability to function • Oppositional behavior involving threat of harm to self or others • Medication non-compliance, can result in TRC • Constant request for symptom management and/or prn requests exceeding normal administration parameters

Figure 3 – Psychiatric portion of acuity tool

Medical Acuity Tool				
Score:	**0**	**1**	**2**	**3**
Fall Risk	No Risk	Low Risk	Moderate Risk	High Risk
ADLs	Independent w/ ADLs	Needs frequent reminders but requires minimal staff assist	Requires assist with some of the following: toileting, bathing, transfer or feeding	Requires full assist with toileting, bathing, transfer or feeding. Frequent incontinence.
Wound Care	No wound	Patient performs self-care, nurse to assess	Nurse to perform simple dressing changes and wound care/education (established trach)	Extensive wound care including frequent dressing changes. (i.e. SI GSW, burn)
Skilled Care/ Equipment Use	No accu-cheks, IV, feeding tube, catheter or 0_2 use BG checks with insulin administration.	Patient self caths. Saline lock IV. O_2 use. .	Foley cath w/I&Os. uncontrolled DM requiring close monitoring of BG and diet	IV infusions, symptomatic Cardiac symptoms requiring close monitoring

Figure 4 – Medical portion of acuity tool

VERMONT PSYCHIATRIC CARE HOSPITAL (VPCH)

25 Beds

Internet Resources

Memorandum re: Staffing Plan for the Vermont Psychiatric Care Hospital dated July 18, 2014

Vermont Psychiatric Care Hospital – Review of Nurse Staffing Report dated January 3, 2016

VPCH Patient Acuity Rating Scale

Level	Applies to Patient
1	Ready for discharge or transfer No longer meets criteria for hospitalization
2	Independent with ADLs Cooperative with program
3	Assessment/documentation/engagement requiring < 20 min. on a shift Assistance with ADLs/physical care < 20 min. on a shift Treatment Plan Meeting Phlebotomy Fingersticks for blood glucose 30 min. checks Transport by social worker
4	Refusing Medication 15 minute checks Assessment/documentation/engagement requiring > 20 min. on a shift Supervised visits and/or phone calls Behavioral Plan in place Assistance with ADLs/physical care > 20 min. on a shift Requiring frequent redirection Behavioral Plan in place
5	Manual restraint Mechanical restraint or seclusion < 15 min. New admission during this 24 hrs. Transport by Nursing staff High Risk for Falls (by Falls Risk) Non-Emergency Involuntary Medication Frequent vital signs, neuro checks, etc.
6	Constant Observation (during any part of the 24 hrs.) Transport by Sheriffs or ambulance Mechanical restraint or seclusion > 15 min. Emergency Involuntary Medication Medical emergency Need for staff response from other units

Figure 5 – VPCH Patient Acuity Rating Scale (Pilot July 2014)

APPENDIX C: SITE VISIT EXECUTIVE INFOGRAPHIC

This graphic was originally provided as part of the OTB Solutions Site Visit Report that was delivered to the hospitals on August 22, 2016.