STATE OF KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

OSAWATOMIE STATE HOSPITAL OPERATIONS ASSESSMENT

EXECUTIVE SUMMARY

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OVERVIEW

The Osawatomie State Hospital (OSH) in Osawatomie (Miami County) is a psychiatric hospital operated by the State of Kansas Department for Aging and Disability Services (KDADS). OSH has a licensed bed capacity of 176 beds but can accommodate as many as 190 patients. Its budgeted census for fiscal year (FY) 2013 was 175 patients. OSH is certified by the Centers for Medicare and Medicaid Services (CMS) and accredited by The Joint Commission.

Between FY 2008 and FY 2012, OSH had an average of 2,191 discharges per year, with an average length of stay (ALOS) ranging from around ten days for patients admitted for crisis stabilization to more than six months for patients needing longer term treatment. The majority of OSH's patients are admitted involuntarily, and many have had a significant degree of involvement with law enforcement and the courts. Many of the patients are admitted for competency evaluations.

The cost of operating OSH is paid primarily by Medicaid and the State General Fund. In FY 2013, approximately 71% of OSH's $29 million budget was attributed to the State General Fund and Medicaid. An additional 28.5% was covered by the Fee Fund.

Because of on-going concerns about state government expenditures, KDADS engaged The Buckley Group, L.L.C. (TBG) to conduct an assessment of OSH's clinical services. The purpose of the assessment was to find opportunities for improving efficiency/productivity and reducing costs without compromising the quality and effectiveness of OSH's services.

TBG initiated this assessment in February, 2013. As part of this assessment, we obtained and reviewed a wide range of data and descriptive information related to OSH's program content, organizational structure and staffing levels. We then made a site visit to OSH during which we met with executive and medical staff, toured each of the inpatient programs and interviewed the direct care, therapy and social service staff. In addition, we reviewed a total of approximately 50 open and closed medical records during and after the site visit. The following is a summary of our observations, findings and recommendations.

At the outset, we would like to emphasize that we found OSH staff to be dedicated and intent on providing quality services and helping their patients recover and be enabled to lead productive and purposeful lives. Throughout the assessment process, staff were extremely helpful and eager to provide information related to programming and patient care at the facility.

However, we found that there are significant opportunities to streamline the organization, improve the efficiency with which patient care is provided and reduce costs at OSH. Using our model of organization and staffing, there is a potential for OSH to reduce its annual salary and benefit costs by more than $3.0 million.

The basis for this conclusion is presented in the following sections of this report.

OSH PROGRAMS

OSH operates five separate programs on its campus, each with a different clinical focus. These include the following.

1. Crisis Stabilization Program (CSP): The majority of OSH's patients are admitted for stabilization of a severe and acute behavioral crisis. Between FY 2008 and FY 2012, CSP patients represented around 51% of OSH's total discharges. The ALOS for the CSP patients averaged approximately ten days during this timeframe.

2. Managing and Preventing Symptoms (MAPS): This program focuses on patients who are experiencing moderate to severe psychoses. MAPS discharges represented around 23% of

OSH's total discharges between FY 2008 and FY 2012. Its ALOS ranged between 37 and 58 days.

3. Continuing Care Program (CCP): The CCP is designed for patients who have committed crimes and have complicated behavioral health problems. An adjunct to the CCP is the Pathways to Success Program (PSP), which focuses on patients who were admitted to OSH after committing a crime and then determined by a court to be not guilty by reason of insanity (NGRI). ALOS on the CCP unit has ranged between five and nine months over the past five fiscal years; discharges from the CCP represented around 3% of OSH's total discharges.

4. Healthy Options, Plans and Experiences (HOPE): The HOPE program treats patients experiencing mood and substance abuse disorders. Discharges from HOPE comprised 17% of OSH's total discharges between FY 2008 and FY 2012. Its ALOS was around 29 days.

5. Successful Living Program (SLP): The SLP treats males who have histories of aggression and/or inappropriate sexual behavior. SLP patients represented around 3% of OSH's total discharges between FY 2008 and FY 2012. ALOS on SLP ranged between four and six months.

ISSUES AND FINDINGS

Acuity Level

OSH treats a range of patients at various stages of illness. These include those who need short-term hospitalization to resolve an acute crisis, as well as patients who need longer term psychiatric care. A key finding is that many of the longer-term patients could be cared for in a residential or outpatient setting.

As an acute psychiatric hospital, OSH may only admit and retain patients whose behavior poses a threat to themselves or others. According to CMS, the need for services must require a level of intensity and frequency exceeding what may be rendered in an outpatient setting, including psychiatric partial hospitalization. Patients who do not meet acute care criteria should be placed and cared for in less restrictive settings, such as residential facilities and outpatient clinics.

OSH staff have recognized that many of its patients could be discharged to a lower level of care and attributed the continued hospitalization of these patients to a number of factors.

One factor is the relationship between OSH and the community mental health centers (CMHCs) in the State. Nearly all of OSH's admissions are screened through one of the CMHCs. OSH also coordinates with the CMHCs in its planning for discharge.

According to OSH staff, the CMHCs are sometimes reluctant or unwilling to accept the discharge from OSH because they believe the patient needs continued inpatient care and/or sufficient resources are not available to permit a safe and successful transition to the outpatient setting. Some patients are considered "bridge burners" because of repeated problems they have caused caregivers, resulting in a lack of willingness among providers to accept the patients back into their care.

An additional factor cited by OSH is the lack of appropriate residential and community-based resources for chronically mentally ill patients. Delays in discharge may occur because of the absence of these resources and/or an assessment by OSH and the CMHC staff that discharge to one of these options may not be safe or effective and will soon result in a readmission.

Another reason for unnecessary hospitalization cited by staff is the lack of a sufficient number of psychiatrists who can attend to the patients in a timely way. Insufficient attention from psychiatrists may lead to prolonged lengths of stay beyond the point at which discharge is warranted. However, as discussed below, our analysis indicates that OSH has a sufficient number of psychiatrists given its mix of acute care and residential level patients.

We found that these circumstances may contribute to longer than necessary stays, but they do not fully explain the problem of keeping non-acute patients in the hospital. Instead, we found that there are several processes in the delivery of care that could be improved to facilitate more timely discharge. These include patient assessment, treatment planning, the provision of therapy and discharge planning.

Therapy

OSH uses several teams of therapists for each inpatient unit to oversee the provision of therapy and to ensure that treatment plans are developed and followed. OSH's therapy services are overseen by an interdisciplinary team (IDT) made up of physicians, psychologists, therapists and nurses. However, the IDT does not include the patient's primary therapist. The Interdisciplinary Team monitors the patient's progress towards their goals.

In addition to the IDT is the Psychological and Therapy Services (PTS) team, whose role includes the coordination of treatment services. On average, each team has eight members, including psychologists, social workers, music and art therapists and leisure and fitness specialists. The Psychological and Therapy Services Team also utilizes Peer Specialists, who are former patients.

The structure of OSH's Therapy Department differs from that used in many psychiatric hospitals today. First, because of the way in which the Therapy Department is organized, OSH's psychologists (Ph.D.) and clinical therapists (Master's level) must devote a significant portion of their days in team meetings rather than in providing individual and group therapy.

In addition, OSH's ratio of patients to therapists, including psychologists, social workers and other therapists and activity personnel, is higher than the ratio of patients to direct care staff. However, documented involvement of therapists with their patients is infrequent. It appears that therapists visit patients regularly but not always on a weekly basis.

OSH offers a full schedule of appropriate individual and group therapy sessions as well as leisure activities. Despite the range of therapeutic programs, the actual level of involvement in these activities is around 53% (based on activity logs in March and April of this year). We would expect a participation level of 80%.

Nursing Department

OSH's nursing staff-to-patient ratios are appropriate for its residential level patients but low for its acute care patients. Under our staffing model, OSH would add 1.0 full-time equivalent (FTE) licensed nursing staff to its day and evening shifts on its CSP.

Even with the recommended staff additions, it appears that OSH has an insufficient number of direct care staff, as evidenced by a high rate of overtime and mandatory callbacks. OSH has a need to hire additional direct care staff to reduce overtime and mandatory callbacks.

The frequency of nursing documentation is consistent with residential services but not with acute care. Additionally, some of the required elements in the nursing assessments are missing. Further, there is no documentation of patient education by nurses in the patient charts.

The Nursing Department includes a Director of Nursing (DON), an Assistant Director of Nursing (ADON) and a Nurse Program Director, as well as several Nurse Managers (RN Specialists), who oversee each of the inpatient programs. There is an opportunity to consolidate some of the positions in the Nursing Department as well as to decentralize some of the department functions to the patient care units, including patient education and crisis intervention and prevention training.

Social Services

OSH's Social Service staff are involved in case management and discharge planning. In addition to the Director of Social Services, there is a Program Consultant and a Social Work Supervisor, as well as 10.0 FTE social workers. These positions are in addition to the licensed clinical social workers who are assigned to the Psychological and Therapy Services Teams. The number of social work staff is higher than what we would employ.

In our chart review, we found that discharge planning efforts could be initiated on a more timely basis. The lack of timely discharge planning may unnecessarily increase the patient's length of stay and contribute to the low acuity levels among patients.

Medical Staff

OSH's medical staff include a Medical Director and seven FTE psychiatrists. Two of these psychiatrists cover evenings and nights. The number of medical staff is low for acute care but high for residential care.

Most patients do not routinely receive individual visits from their attending physician; some may be seen every two weeks. We would expect that patients in an acute setting to be seen daily. In addition, the frequency of physician documentation and involvement in patient assessment and care planning are not sufficient for acute care patients. However, the fact that a high number of OSH's inpatients need only residential care lessens the total need for psychiatrists and the frequency of patient visits.

OSH has indicated that it has a shortage of psychiatrists. However, as noted previously, medical staff coverage should be sufficient given the mix of acute care and residential level patients. The demands on the medical staff may be mitigated if OSH were to differentiate the patient's need to be seen by a psychiatrist according to the patient's acuity. Typically, patients in a residential setting need to be seen only once per week, while those in acute care beds should be seen daily.

CONCLUSIONS AND RECOMMENDATIONS

In our review, we found significant opportunities to streamline OSH's organizational model, improve the efficiency of its clinical operations and reduce staffing and benefit costs. Our conclusions and recommendations are as follows.

- OSH serves a mix of patients at both acute and residential levels but staffing is the same in all units. Staffing should be based on the acuity levels of the patients, as well as the goals of treatment and discharge. Under our staffing model, the CSP (the unit with the highest acuity levels) would have one additional licensed nurse on the day and evening shifts.

- The structure of OSH's Therapy Department requires therapists to spend a sizable portion of each day in team meetings, rather than in patient care. Further, some therapists do not carry any caseload. We would restructure the Therapy Department to ensure that all therapists are directly involved with the patients, including providing individual, group and family therapy.

- There is currently 1.0 FTE therapy staff for every nine OSH patients. In an acute psychiatric hospital, we would recommend one Master's prepared therapist for every eight patients. For residential level patients, we recommend one therapist for every 12 patients.

- The supply of Activity Therapy personnel, including music and art therapists, peer specialists and leisure and fitness specialists, also exceeds our recommended levels. For the mix of patients at OSH, we would provide 1.0 FTE Activity Therapist for every 30 patients. There is currently 1.0 FTE for every nine patients.

- There is an opportunity to decentralize some of the functions in the Nursing Department. Patient education could be provided by nurses assigned to each specific unit, rather than by full-time nurse educators. The responsibility for crisis intervention training could also be moved to unit staff.

- Currently, OSH's inpatient units are overseen by Nurse Managers. We recommend eliminating the Nurse Manager positions and creating Program Managers, who would include mental health professionals with other backgrounds, such as social work and psychology as well as mental health nurses.

- As noted above, OSH's Social Services Department employs 13.0 FTE social workers, a ratio of approximately 1.0 FTE social worker to approximately 14 patients. Our staffing model uses a ratio of 1:30 and the Director carries a caseload.

- We recommend a ratio of 1.0 FTE psychiatrists for every 15 acute patients (1:15) and a ratio of 1:60 for residential level patients. OSH currently has 8.0 FTE psychiatrists. It appears that OSH has an adequate number of psychiatrists, and potentially a surplus, based on our assumptions related to the mix of acute care and residential level patients it serves.

These recommendations are based on our model of staffing and operations in a private psychiatric hospital, both not-for-profit and for-profit. Using this model would result in substantial changes in the way in which OSH operates as well as significant staff reductions. If KDADS were to pursue these changes, we recommend establishing a transition plan that would achieve improved efficiencies over a specified period of time in order to avoid disruptions.