Report to the Legislature

State Psychiatric Hospital Budget and Staffing Plans

Substitute House Bill 1105, 2015 Regular Session, Section 5(7)

December 21, 2015

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Substitute House Bill 1105, Section 5(7), passed by the 2015 Legislature, states:

> *$5,524,000 of the appropriation is provided for covering increased costs of operations at the state hospitals. By April 1, 2015, the department shall prepare and submit to the office of financial management and the fiscal committees of the legislature a staffing plan for the state institutions of the mental health division that will maintain expenditures within appropriated levels*.

A staffing plan that will maintain expenditures within appropriated levels is not possible without reducing the number of staff and the number of available psychiatric hospital beds. Operating the existing number of psychiatric hospital beds specified in ESSB 6052 without sufficient staffing or other funding should be expected to cause some or all of the following: excessive assaults, falling treatment hours, loss of federal Centers for Medicare and Medicaid Services-authorized funding and/or loss of accreditation from The Joint Commission (TJC). TJC accredits and certifies health care organizations and programs in the United States. Because court orders such as Trueblood, the Single Bed Certification ruling, and multiple show cause hearings require an increase in the number of State hospital beds, it is assumed for the purposes of this report that reducing the number of state psychiatric hospital beds is not a viable option (it is certainly not a DSHS recommended option). Based on the above the DSHS Behavioral Health and Service Integration Administration (BHSIA) cannot provide appropriate therapeutic care to people with severe mental illness and maintain the safety of the staff and patients of the state's psychiatric hospitals within current appropriated levels. It is not feasible to staff current beds within our existing budget without reducing the number of beds.

Because the object of the above-referenced budget proviso is not possible the remainder of this report provides background for policymakers on issues related to budget and staffing, in particular, current FTE and funding allocation, staff to bed ratios, current and recommended staffing models and current efforts to control hospital expenditures.

CURRENT FTE AND FUNDING ALLOCATION

During FY15, the Legislature appropriated $224 million[1] for the operation of Western State Hospital (WSH) and Eastern State Hospital (ESH). The tables below show the allotment and actual expenditures for WSH and ESH in terms of FTEs, Beds and Cost per bed. Strictly as illustration, and not as a recommendation, the data demonstrated that in order to operate the hospital within appropriated levels as requested by the proviso, it is estimated that the number of beds at WSH would need to be reduced by 34 and the number of beds at ESH would need to be reduced by 12. Importantly, because DSHS BHSIA is not under the impression that reducing state psychiatric hospital beds is a short term option these numbers are simply intended as rough illustrations, not actual projections. Additionally, it is important to understand that although the staffing levels and ratios set for ESH in this report appear to be sufficient to retain TJC certification, recent surveys by CMS of WSH make clear that increased staffing even beyond these levels will be required if WSH is to retain federal funding.

Western State Hospital – FY15 Allotments vs. Expenditures

	FY15 Allotments	FY15 Expenditures	Difference
Average FTEs	1871.3	1933.6	(62.3)
Assumed Beds	827	827	
FTE per Bed	2.26	2.34	(0.08)
Cost per Bed	532.28	554.94	(22.66)
Funding	160,672,474	167,511,380	(6,838,006)
***Funding allotment backs out early supplemental items that were not carried forward into the 15-17 biennium or were not spent due to timing to better reflect continued base staffing shortfall.**			
****Funding and FTEs include Consolidated Institution Business Services and Consolidated Maintenance Operations to show complete picture of hospital costs.**			

[1] This is the appropriation less early action supplemental items that were either not carried forward or not spent to better show the on-going issue.

Eastern State Hospital – FY15 Allotments vs. Expenditures			
	FY15 Allotments	**FY15 Expenditures**	**Difference**
Average FTEs	753.3	772.1	(18.8)
Assumed Beds	287	287	
FTE per Bed	2.62	2.69	(0.07)
Cost per Bed	605.28	632.22	(26.94)
Funding	63,406,366	66,228,615	(2,822,249)
*** Funding allotment backs out early supplemental items that were not carried forward into the 15-17 biennium or were not spent due to timing to better reflect continued base staffing shortfall.**			
****Funding and FTEs included Consolidated Support Services to show complete picture of hospital costs.**			

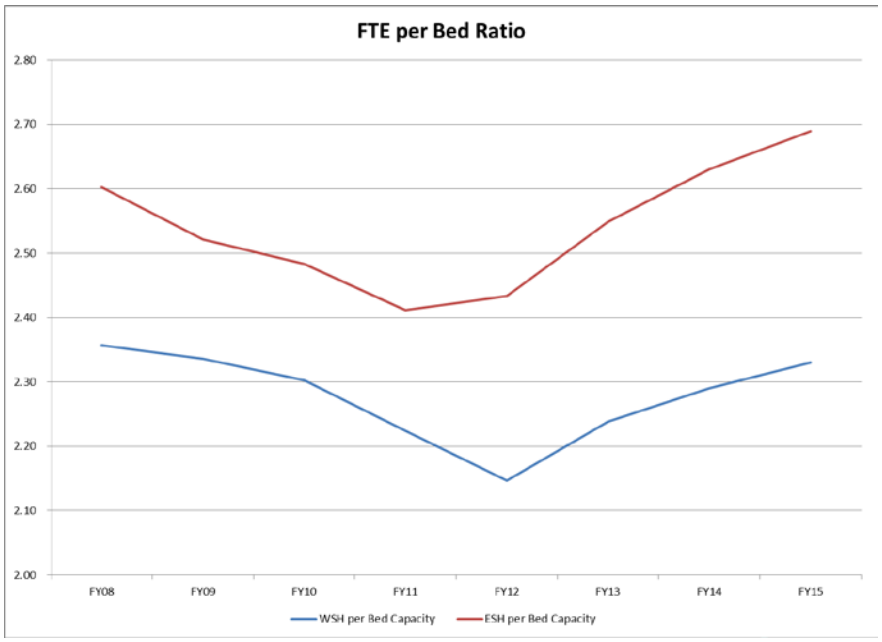
Based on these numbers, for the FY 2015 budget period the two adult psychiatric hospitals operated at approximately 81 FTEs higher than budgeted. The increased FTEs are necessary to provide more staff on the wards and to support the wards. This increased staff time on the ward was covered by new positions, on-call positions and overtime. Importantly, in response to recent surveys by CMS WSH is now implementing plans that materially increase staffing to a level more equivalent to the ESH levels. And again, as emphasized above, this is necessary in order to maintain accreditation by TJC, decrease patient-to-patient and patient-to-staff assaults, comply with Washington State Department of Labor & Industries (L&I) safety requirements and provide appropriate treatment hours.

Staff to Bed Ratio

Like most hospitals, WSH and ESH expenditures are driven first and foremost by staffing levels. The most insightful analysis of budget and service levels can be found in the ratio of the number of staff per patient served (also known as FTEs per Bed).

If we compare the staffing levels at WSH on a FTE per Bed basis to staffing levels in previous years, the data shows even at our current increased staffing levels we are below historic levels at WSH. More precisely, actual FTEs per Bed ratios at WSH were 2.36 FTE per Bed in FY 2008 versus our current level of 2.34 per Bed for FY 2015. Again, it is important to note that these projections pre-date the increased staffing steps required by the Immediate Jeopardy Abatement Plans committed to in response to the most recent CMS survey.

ESH operates on a much smaller scale at one-third the size, and as a short-term evaluation and treatment facility. ESH FTEs per Bed Ratio is much higher. The actual FTEs per Bed ratios at ESH are 2.60 FTE per Bed in FY 2008 versus 2.69 in FY2015. Following full implementation of the staffing increases at WSH driven by the Immediate Jeopardy Abatement Plans WSH staff ratios will trend up towards that of ESH, but is not anticipated to exceed the ESH ratio.



Adequate staffing is essential to provide appropriate therapeutic care and safely operate our state hospitals.

CURRENT AND PROPOSED STAFFING MODEL

Attachment A provides a Target Staffing Model for each hospital by Ward Type prior to implementation of the Immediate Jeopardy Abatement Plans at WSH. Implementation of these plans will impact the staff model.

Close to half of the total FTEs at each of the state hospitals are Registered Nurses (RN), Licensed Practical Nurses (LPN), Psychiatric Security Nurses (PSN), Mental Health Technicians (MHT) and Psychiatric Security Attendants (PSA) that work on the wards. The level of staffing for each of these positions varies by ward and by shift. The attached chart reflects the targeted staffing for each of the positions by type of ward and by shift for a typical day of a week. Please note that these are the

targeted levels before acuity adjustments, which are typically covered by a doctor's order for 1:1 staffing, which would be above the levels reflected in the chart. Further, the chart does not reflect FTEs, as the level of staffing is for 24 hours, 7 days a week and an FTE is the equivalent of a 40 hour work week. In addition, an FTE cost includes paid leave, which is not reflected here. In order to reach the targeted staffing level, on-call and float positions are needed to cover for scheduled and unscheduled leave. Due to all the factors mentioned, the number of people scheduled to work on the wards on any given day will vary.

It is critically important to understand the role physician-ordered 1:1 staffing plays at the psychiatric hospitals. Physician-ordered 1:1 staffing is not included in the base staffing shown in the attachment due to the fact that the 1:1 levels vary by day and ward. Additional 1:1 staffing on the wards is typically completed by Mental Health Technicians or Psychiatric Security Attendants. One to one staffing is as it sounds, a single staff person is assigned to track, monitor and engage a specific patient. This 1:1 staffing occurs over all three shifts. Because the hospitals are 24/7 facilities a single 1:1 staffing assignment drives approximately 4.2 FTEs. At WSH, for example, for the most recently reported week (12/6/2015 – 12/12/2015) there was an average of 40 assigned 1:1s during any shift. It is also important to understand that long-term doctors, nurses and other staff at the psychiatric hospitals frequently comment that the acuity levels of patients are trending up significantly over the years and this is driving significant increases in 1:1. BHSIA is making efforts to better track and project this factor which is extremely important because no adjustment is made in the state hospital budgets to account for this trend.

The other half of the FTEs at the state hospitals includes psychiatrists, psychologists, physicians, pharmacy staff, social workers, food workers, custodians, security guards, and many other dedicated staff needed to operate a large hospital. Further work needs to be undertaken on targeted staffing levels for these positions, not least of all because hiring shortages of psychiatrists and psychologist will need to drive more efficient use of these professionals and greater delegation of tasks that can be safely delegated. BHSIA is seeking to engage an external consultant to assist in the development of innovative staffing to address this issue and to provide recommendations for staffing levels for the wide variety of other staffing categories at the hospitals.

Finally, where the hospitals have been unable to hire psychiatrists each of the hospitals have contracted with *Locum Tenens* in order to maintain operations, and these services are purchased at a substantially higher cost not reflected in the hospital budget appropriations.

CURRENT EFFORTS TO MANAGE HOSPITAL EXPENDITURES

Efforts to Recruit and Retain Staff

BHSIA has placed great emphasis on hiring to fill critical vacancies because this impacts both client care and operating cost. A temporary recruiter position was established to focus efforts on recruitment for the state hospitals. Job announcements were posted to Careers.wa.gov and WorkSource and advertising efforts included national outreach in locations such as LinkedIn – which included a Psychiatry and Nursing campaign; Indeed; CareerBuilder; Journal of American Medical Association; American Psychiatric Association (APA); Washington Healthcare News; American College of Healthcare Executives (ACHE); WA State Nurses Association (WSNA); Washington State Hospital Association (WSHA); Western Psychiatric State Hospital Association (WPSHA); and the WA Community Mental Health Council. The department partnered with the Employment Security Department to promote hiring events in Tacoma and Spokane focused on medical professionals: Registered Nurses; Psychiatric Security Nurses; Psychiatric Security Attendants; and Psychiatrists. In addition, Recruitment Recognition Awards were offered to DSHS employees who referred candidates that were hired and successfully completed New Employee Orientation and their probationary periods of employment.

Despite significant efforts to fill vacancies in the hospitals, critical staffing shortages continue. In 2015, WSH filled over 350 positions., Over 325 employees completed new employee orientation during 2015, but 125 of those employees separated from employment during the year. Vacancies in the nursing department averaged just over ten percent for permanent positions and over 26 percent for non-permanent and on call positions.

Managing the use of Overtime

The two primary drivers of overtime are staff vacancies and unscheduled leave. Overtime costs are a substantial burden on the allotment provided for staffing. Due to the shortage of filled FTE's, there is increased reliance on overtime, float staff and on call staff to safely operate the facilities. The state hospitals are engaged in major initiatives to reduce the use of overtime. However, while hourly overtime pay is typically 1.5 times straight time pay, the costs associated with paying staff for straight time most often include benefits, which, when added to hourly pay, approach the amount paid for an overtime hour. In other words, reducing the use of overtime hours does not necessarily generate dramatic savings. However, the hospitals are committed to obtaining all savings available,

but overtime is often required to ensure staffing levels are sufficient to meet the needs of patients and provide a safe workplace.

Schedule Managers have been hired at each hospital to begin to take control of the staffing schedule institution-wide. This centralization will allow for better management of overtime and ensure that business needs and work requirements are met, while honoring vacations, scheduled trainings and on-call resources.

In order to address unscheduled leave, a new attendance policy went into effect January 1, 2015. All call-in's are reported to the Schedule Manager who began issuing attendance reports February 1, 2015.

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FUTURE IMPACTS TO HOSPITAL EXPENDITURES

As reference above, in October and November 2015, WSH had two visits from the federal Centers for Medicare and Medicaid Services (CMS). The visits resulted in the issuance of six notices of immediate jeopardy. An immediate jeopardy is a condition that must be cured immediately or federal funding (and some related local funding) is lost. In the case of WSH approximately $64million annually was at risk. Key findings constituting immediate jeopardies included insufficient staffing levels, inadequate staff training, lack of appropriate application and monitoring of seclusion and restraints, and inadequate infection controls.

In order to successfully abate the immediate jeopardies and address the deficiencies cited by CMS, DSHS committed to take a number of actions which do impact staffing. Addressing these issues will result in better quality of care, safer patients and safer staff. Importantly, CMS found these commitments sufficient to lift the immediate jeopardies. However, future CMS surveys early in 2016 will be required to verify implementation. Naturally, these changes lead to expenditures that further exceed the current allocations.

Forensic		**Day**					**Eve**					**Night**				
Admission	# of wards	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**
ESH	1	1	2	1	6	**10.0**	1	1	1	6	**9.0**	0.5	1	1	3	**5.5**
WSH	4	1	2	1	4	**8.0**	0.5	2	1	4	**7.5**	0.5	1	1	3	**5.5**
NGRI																
ESH	2	1	1	1	5	**8.0**	1	1	1	5	**8.0**	0.5	1	1	4	**6.5**
WSH	4	1	1	1	4	**7.0**	0.5	1	1	4	**6.5**	0.5	1	1	2	**4.5**
Conditional Release																
WSH	1	0.5	1	1	4	**6.5**	0.5	1	1	4	**6.5**	0.5	1	1	2	**4.5**
Forensic Total																
ESH	3	3	4	3	16	**26.0**	3	3	3	16	**25.0**	1.5	3	3	11	**18.5**
WSH	9	8.5	13	9	36	**66.5**	4.5	13	9	36	**62.5**	4.5	9	9	22	**44.5**
Adult Psych		**Day**					**Eve**					**Night**				
Admission	# of wards	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**
ESH	1	1	2	1	5	**9.0**	1	2	1	5	**9.0**	0.5	1	1	3	**5.5**
WSH	4	1	2	1	3	**7.0**	0.5	2	1	3	**6.5**	0.5	1	1	2	**4.5**
Higher Acuity long-term																
ESH	2	1	1	1	5	**8.0**	1	1	1	4	**7.0**	0.5	1	1	2	**4.5**
WSH	7	1	1	1	4	**7.0**	0.5	1	1	4	**6.5**	0.5	1	1	2	**4.5**
Highest Acuity long-term																
WSH	1	1	1	1	6	**9.0**	0.5	1	1	6	**8.5**	0.5	1	1	2	**4.5**
Adult Psych Total																
ESH	3	3	4	3	15	**25.0**	3	4	3	13	**23.0**	1.5	3	3	7	**14.5**
WSH	12	12	16	12	46	**86.0**	6	16	12	46	**80.0**	6	12	12	24	**54.0**
Geriatric Psych		**Day**					**Eve**					**Night**				
Admission	# of wards	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**	RN3 (5 d/wk	RN2	LPN/PSN	MHT/PSA	**Total**
ESH	1	1	2	1	4	**8.0**	1	1	1	5	**8.0**	0.5	1	1	3	**5.5**
WSH	1	1	2	1	3	**7.0**	0.5	2	1	3	**6.5**	0.5	1	1	3	**5.5**
Lower Acuity long-term																
ESH	1	1	1	1	5	**8.0**	1	1	1	5	**8.0**	0.5	1	1	2	**4.5**
WSH	2	1	1	1	4	**7.0**	0.5	1	1	4	**6.5**	0.5	1	1	3	**5.5**
Higher Acuity long-term																
ESH	1	1	2	1	6	**10.0**	1	1	1	5	**8.0**	0.5	1	1	3	**5.5**
WSH	2	1	1	2	5	**9.0**	0.5	1	2	5	**8.5**	0.5	1	1	4	**6.5**
Highest Acuity long-term																
WSH	1	1	1	1	7	**10.0**	0.5	1	1	7	**9.5**	0.5	1	1	3	**5.5**
Geriatric Psych Total																
ESH	4	3	5	3	15	**26.0**	3	3	3	15	**24.0**	1.5	3	3	8	**15.5**
WSH	6	6	7	8	28	**49.0**	3	7	8	28	**46.0**	3	6	6	20	**35.0**