STATE OF KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

LARNED STATE HOSPITAL OPERATIONS ASSESSMENT
EXECUTIVE SUMMARY

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October, 2013
EXECUTIVE SUMMARY

Overview

The Larned State Hospital (LSH) in Larned (Pawnee County) is an acute psychiatric hospital operated by the State of Kansas Department for Aging and Disability Services (KDADS). LSH has a budgeted capacity of 525 beds. These beds are located in three programs, each with a separate focus, as follows.

- **Psychiatric Services Program (PSP):** This includes 90 budgeted beds, of which 30 are designated as a crisis stabilization unit (CSU) and 60 beds are used for patients in need of long-term, residential treatment.

- **State Security Program (SSP):** The SSP operates 220 budgeted beds, of which 200 are for a mentally ill forensic population. The other 20 beds are located in the Security Behavior Unit (SBU) and serve a civilly committed population who pose a security risk or are extremely dangerous towards others. Two SSP units with a total of 60 beds are designated as residential care.

- **Sexual Predator Treatment Program (SPTP):** This program has 225 budgeted beds; 218 beds are located on the LSH campus and seven "reintegration" beds are located at the Osawatomie State Hospital (OSH) in Osawatomie ("MiCo" House).

All of LSH programs are accredited by The Joint Commission (TJC). The PSP is the only LSH program that is certified by the Centers for Medicare and Medicaid Services (CMS).

In Fiscal Year (FY) 2013, LSH had an average daily census (ADC) of 494 patients (excluding the beds at MiCo House, which currently houses seven patients). In FY 2012, LSH maintained an ADC of 497 patients and expended a total of $58,018,740 to operate; this is equivalent to almost $320 per day. In contrast, the costs of operating the Osawatomie State Hospital (OSH) in FY 2012 were $387 per day.

Because of the costs of operation and the increasing strain on the State's finances, KDADS contracted with The Buckley Group to conduct an assessment of clinical and residential care services at LSH and OSH in order to find potential opportunities to improve efficiencies in residential and clinical services without compromising patient care. The following Executive Summary contains the results of the operational assessment conducted at LSH.

As part of this assessment, we obtained and reviewed a wide range of data and descriptive information related to LSH's program content, organizational structure and staffing levels. We then made a site visit to LSH in March, 2013, during which we met with executive staff and interviewed the direct care, therapy and social service staff. In addition, we reviewed 30 open medical records during and after the site visit. The following is a summary of our analysis, findings and recommendations.

In summary, we found that LSH management is focused on improving the quality and cost-effectiveness of their services and intent on helping their patients recover and be enabled to lead productive and purposeful lives. We also found, that in general, direct care staffing levels are appropriate; however, there is a need to expand the pool of direct care staff to reduce overtime. Social Services, Psychological Therapy (Therapy) and Activity Therapy are overstaffed in relation to the industry benchmarks we use. In contrast, LSH is underserved in Psychiatry and there is a need to recruit additional Psychiatrists.

ISSUES AND FINDINGS

Direct Care Staffing

Direct patient care is provided by registered nurses (RNs), licensed practical nurses (LPNs) and mental health and developmental disability technicians (MHDDTs). Overall, we found that PSP’s direct care
staffing levels are consistent with the standards we recommend. Variances from standards are reasonable given the nature of the population served at LSH.

We did find two significant issues with direct care staffing. One is that the direct care staff have higher than expected rates of overtime and compensatory time earned (CTE). Related to and perhaps causing the high rate of overtime and CTE's that LSH staff have a high rate of unscheduled/unplanned absences (call-ins). Both issues apparently stem from a high vacancy rate in these positions, especially the MHDDTs.

LSH uses a Call Center to fill staff vacancies resulting from call-ins (unplanned absences). There are currently 6.0 FTEs in the Call Center. According to LSH, there is an average of 12 to 13 call-ins per day across all three shifts, a rate of around 5%. We would expect a much lower rate (1% to 2%).

We believe it may be possible to reduce the frequency of unplanned absences through tighter standards of employee accountability and by expanding the pool of direct care staff. Increasing the pool of MHDDTs and other direct staff should also reduce the high rate of overtime.

**Therapy Staffing**

In contrast to the direct care staffing ratios, we found that staff to patient ratios in Social Services, Therapy and Activity Therapy are higher than what we would recommend.

- There are currently 9.0 FTE Social Service staff, including a Director, assigned to the PSP; there is also one vacant position. The ratio of Social Services Staff to patients (excluding the vacant position), is 1:10. We would use a ratio of one Social Services Staff to every 30 patients (1:30).

- There is a total of 11.0 FTE Therapy Staff assigned to the PSP, a ratio approximately 1:8. Given the mix of residential and acute patients, we would recommend a staffing ratio of 1:10.

- The PSP has a total of 9.0 Activity Therapists, a ratio of 1:10. We recommend a ratio of 1:30 for Activity Therapy staff.

- There are 8.0 FTE Social Workers assigned to the SSP, a ratio of 1:23. As with the PSP, we recommend a ratio of 1:30.

- The SSP has a total of 17.0 FTE Therapy Staff. This is a ratio of 1:11. We would recommend a ratio of 1:12.

- There are 19.0 FTE Activity Therapists on the SSP (with one vacant position), a ratio of roughly 1:10; again, we would recommend a ratio of 1:30.

- There are 2.0 FTE Social Workers and 13.0 FTE Therapists assigned to the SPTP. Given the limited number of discharges, the long average length of stay (ALOS) and the long-term nature of treatment, we believe that current staffing for Social Workers and Therapists is appropriate.

- In contrast, there are 16.0 FTE Activity Therapists in the SPTP, a ratio of approximately 1:10, versus our recommended ratio of 1:30.

It should also be noted that while LSH has a higher than expected number of Activity Therapists, the aggregate participation rates by patients in Activity Therapy are estimated at around 50%; LSH does not currently track participation rates for each individual patient. We would expect a participation rate
of 80%. The participation rate in psychological therapy, both on the aggregate and individual levels, is not currently being tracked.

Tracking the number of individual and group activity and psychological therapy sessions is necessary in order to monitor patients' compliance with treatment plan goals as well as measure therapist productivity levels and staffing needs. LSH is currently planning to implement a system that would enable it to monitor participation on both an individual and group level for both Therapy and Activity Therapy and to measure staff productivity.

**Psychiatric Coverage**

Psychiatric coverage at LSH is insufficient. Based on our benchmarks and assessment, LSH would need 13.9 FTE Psychiatrists. It currently has approximately 6.0 FTEs Psychiatrists (including part-time and locum tenens physicians) and is actively recruiting additional permanent and temporary staff. If all of its current efforts are successful, LSH will still have a need for approximately 3.5 FTE Psychiatrists.

**Chart Audit**

As part of this operations assessment, we conducted an audit of 30 open patient charts. In general, there is a high level of compliance with CMS requirements for documentation. In part, compliance levels are high because LSH's electronic medical record system prompts caregivers to enter data related to care processes and clinical indicators. The primary reason for a lack of compliance is the absence of system prompts in specific areas.

We found that a number of elements were often missing from several sections of the charts, including psychiatric evaluations, histories and physicals, psychosocial histories, nursing assessments and treatment plans. Additional prompts in the medical record system should correct these deficiencies.

In addition, there is a lack of documented involvement by Psychiatrists in treatment planning and the frequency of visits with patients is not in compliance with current guidelines. The lack of involvement may reflect the need for additional Psychiatrists and/or psychiatric Advanced Practice Registered Nurses (APRNs).

As with OSH, LSH has a number of patients in its Medicare-certified beds (PSP) who are at a residential level and do not meet acute care criteria. As an acute psychiatric hospital, LSH may only admit and retain patients whose behavior poses a threat to themselves or others. Related to inpatient psychiatric treatment, CMS states:

“The patient must require intensive, comprehensive, multimodal treatment including 24 hours per day of medical supervision and coordination because of a mental disorder. The need for 24 hours of supervision may be due to the need for patient safety, psychiatric diagnostic evaluation, potential severe side effects of psychotropic medications associated with medical or psychiatric comorbidities, or evaluation of behaviors consistent with acute psychiatric disorders for which a medical cause had not been ruled out.”

In summary, 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.

As at OSH, we found that a high proportion of current PSP patients has low acuity needs and could be served in a residential or community setting, rather than in an acute psychiatric hospital. There are two key reasons for the high number of residential patients in the PSP.
One reason is that there is a lack of residential or community-based resources that will or can accept these patients. A second reason is the need to improve the level of psychiatric coverage and the frequency of visits with patients.

SUMMARY

Key issues in the operations assessment include the following.

- Direct care staffing levels are appropriate, but Social Services, Therapy and Activity Therapy staffing levels in the PSP and SSP are higher than recommended.
- The SPTP has an appropriate Social Services and Psychological Therapy staffing levels, but a high Activity Therapy to patient ratio.
- There may be an opportunity to reduce the length of stay among PSP patients by increasing psychiatric coverage and expanding the number of community-based residential care providers to which LSH could discharge its patients.
- LSH's medical records show a high level of compliance with CMS requirements; however, there are several areas in which LSH is out of compliance.

CONCLUSIONS

Our analysis suggests there is an opportunity to reduce personnel at LSH by 50.0 FTEs, including Administrative, Social Services, Therapy and Activity Therapy staff. These reductions would achieve an estimated corresponding reduction of nearly $2,700,000 in salary and benefit costs, based on representative compensation data provided by LSH.

This estimate does not factor in the reduction in overtime pay that may result by increasing the pool of direct care staff. It also does not include the incremental costs that would be incurred with the addition of Psychiatrists; however, it is possible that some of the costs of adding Psychiatrists may be offset to a degree by a shorter length of stay for both acute care and residential patients.