

**MINUTES
HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP**

ADAMS BLDG, ROOM 264

Tuesday, March 4, 2008

ATTENDANCE:

Dr. David Rubinow, Mike Pedneau, Dr. Stephen Oxley, Cliff Hood, Peter Mumma, Iris Rubin, Rickye Collie, Mike Hennike, Laura White, Dr. Jack St. Clair, Deby Dihoff, Dr. John Esse, Dr. Donald Baucom, Pamela Graham, Dr. Ranata Hall, Dr. Patsy Christian, Barbara Whitaker, Kathryn Davis, Walker Wilson, Laura Thomas, Carmen Vincent, Lena Klumper

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
Approval of February 19, 2008 Minutes	Mike Pednaun opened the meeting and asked for any changes to the minutes. There were no changes and staff asked for approval.	Minutes approved
Staffing Ratios and Model	<p>Dr. Oxley presented a PowerPoint presentation of other state hospital staffing models across the nation. The Memphis Mental Health Institute and Austin State Hospital were compared to DDH and JUH admissions. Austin is the only one that is remotely close to NC but there are still some major differences. Staff ratios were also compared. Dr. Oxley said admissions dictate the workload for staffing and that is why the ratios are smaller for CRH. No numbers were provided for Austin for psychology. Memphis does not use LPNs much so those numbers were not provided. HCT ratios are close, but when there is such a small multiplier it can have a large impact. Dr. St. Clair asked about the social work staff ratios because there do not seem to be enough social workers for the patient load. Dr. Oxley replied that the same model was used by comparing admissions rather than beds. The first set of columns of the document show the original proposal, and the last set of columns represent the revised model based on the researched models. These are by all shifts. The replacement factor is to cover holidays and leave. If the total numbers do not add up (they may be off by 1) it is due to rounding. Dr. Christian looked at Memphis and Austin for the nurse staff ratios and used an average for the revised figures.</p> <p>There are 2 lines for the AAU and CTU because 20 beds will be taken from both of these units to create a high management subunit. There are some patients who are violent and aggressive who need more intensive management.</p> <p>24 additional RNs are being suggested for the adult units per this revised model. It is not as richly staffed as Memphis but better staffed than Austin. Peter Mumma asked about RNs running groups and other activities and Carmen Vincent asked if acuity was built into the figures. Dr. Christian said that one-to-ones is not accounted for in the RN Staffing Part 3 Revised section. Dr. Osberg asked if staffing needed to be flexed to account for acuity, but Dr. Christian said that this model is staffed for the current type of patient, which are higher acuity. So this model is significantly better than what is currently being staffed. Additional RNs are being requested for the treatment malls and screening. An Education Coordinator has been added as well.</p> <p>No changes are asked for in child and adolescent because it is felt these areas are adequately staffed for LPNs and HCTs. The major areas needing additional staffing are in the adult units.</p> <p>LPNs have been added to the Forensic unit for medication management, etc.</p>	<p>Although the workgroup agreed there is only a certain amount of funds, it was also agreed that the committee ask for what is actually needed for adequate staffing. Therefore, more staffing is needed to meet the needs at this time. SOS to rework the staffing plan.</p> <p>Recommendation to address the acute problem (hospital staffing) but also the long-term problem of not enough outpatient services that meet the needs of patients discharged from the hospitals (Crisis Services Workgroup to address).</p> <p>Rapid clinical follow up post discharge must be addressed for the hospitals to be successful.</p> <p>Recommendation to split out clinical social work functions to social workers doing discharge planning. Or, to add staff who can do more outreach with the community.</p> <p>Recommendation made to incentivize</p>

HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
	<p>HCTs have been significantly changed, going from 6.4 patients per tech to 5 patients per tech. High Management was also split out to 2.5 patients per tech given the acuity levels. A 6 position “hiring class” has been added to allow for new hires to complete all required training without using a position that is needed for direct care. 15 HCT positions per shift have been added to provide one-to-one coverage for precautions. Questions were asked about differences in shifts, but the group agreed that this ratio is needed for all shifts.</p> <p>Discussion ensued about ratcheting back or actually requesting what is felt is needed for safety, even if the numbers seem high. The M&O Executive Team had requested the decrease, but the workgroup is asking for the higher staffing model. Peter stated that the community hospitals will not take the higher acuity patients, so the state hospitals should be staffed higher. Dr. Hall emphasized that to keep training and education optimal, then the staffing should be richer. Dr. Esse agreed with this approach. Laura Thomas discussed that it is difficult for RNs to keep up with discharge planning and appropriate practices, so more RNs are needed. Dr. Christian said it is difficult to get actual staffing numbers from community hospitals and that this group is being relied upon to indicate where there are gaps in staffing. Recruiting was brought up as a possible issue and the state has limited funds for advertising. Some local hospitals have staff dedicated to only doing recruitment.</p> <p>Turnover of staff is also an element in the formula to keep quality staff, so enough staff can prevent burnout and is more cost effective when it comes to training resources.</p> <p>Community services were addressed regarding not having adequate intensity of outpatient services, such as ACT Teams and Community Support Teams, and how this contributes to the high admissions and recidivism rates. Dr. Rubinow discussed how state paid psychiatrists have assisted with appropriate care of people being discharged from hospitals. Quality of outpatient providers is crucial to the success of lowering admissions and recidivism rates.</p> <p>Mike Pedneau suggested empowering the discharge teams to not discharge patients too soon or to inappropriate environments, such as homeless shelters. Dr. St. Clair addressed this as an issue and discharging too soon contributes to recidivism. State hospitals do not have a differentiation between clinical social workers and discharge planners. Dr. Osberg stated that hospital staff never wants to send patients to inappropriate settings, but there is a very limited amount of options for placements. Housing is also an issue for our patients.</p> <p>Dr. Oxley stated that decisions about “who to serve” is a daily issue to determine whether to take acute admissions or to discharge a patient who is somewhat stable, but probably not stable enough. He also indicated how hospital social workers have difficulty with LMEs and providers being involved in assisting with appointments. Dr. Rubinow discussed recapturing dollars that are being wasted on community services and that as the community services are at this point, the level of staffing being recommended is necessary. Dr. Rubinow asked if there was a way to model what it would cost the system, community and hospitals, 5 years from now. Mike Hennike said this could be done.</p>	<p>LMEs to be involved in discharge planning and to be accountable for their consumers.</p> <p>Recommend that discharge assessments and recommendations for treatment from the hospitals not be duplicated or changed in the community as is occurring now (for Crisis Workgroup to address).</p> <p>Recommendation was made to have a statewide medical record, or at least a web portal so that electronic records can be shared.</p>

HOSPITAL MANAGEMENT AND OPERATIONS WORKGROUP

ITEM	RECOMMENDATIONS/CONCLUSIONS/ACTION	FOLLOW-UP
<p>Data Related to Staffing</p>	<p>The discharge destination data were reviewed.</p> <p>In community hospitals there was a decrease of 1838 to 1650 licensed beds from 2001 to 2006. The group discussed financial incentives required for community hospitals to increase the number of operational beds.</p> <p>Comparative Stats: Med error rates (NC above the national mean). Qualifier about types of patients and the national rates pertain more to long term patients. 4.8 per 100 is too high. Reflective of RNs and LPNs being overworked with too high patient ratios. Dr. Oxley said that about 50% of med errors are transcription errors and someone misread something. NC's system is archaic compared to the nation. NC's scripts are handwritten and we are just now in the process of electronic MARs, bar code administration (piloted at JUH right now) so that CRH will be ready. The same package will be available for the other state hospitals. This methodology has shown to reduce errors by about 88%. Implemented at JUH 2 months ago. Carmen mentioned that those med errors are only those that were reported. JUH has a national consultant to do a process analysis to address poor practices before implementing the technology.</p> <p>Seclusion and Restraint Data: Although NC looks relatively good compared to other states, NC could do better. Need to continue to reduce the use of seclusion and restraint practices. Need to discuss investigation of patient abuse process.</p>	<p>Recommendation to increase use of video cameras and use of outside law enforcement (SBI) in investigating abuse allegations and deaths in the hospitals rather than relying solely on local hospital law enforcement.</p> <p>Committee to review the rest of the data that was provided at the last meeting for further discussion.</p>
<p>Hiring Practices</p>	<p>Additional data documents were passed out on temporary nursing staff and overtime expenditures. A proposal for facility recruitment and retention incentives on sign-on bonus program was handed out by Mr. Collie.</p> <p>Carmen asked for minutes from the Crisis Services Workgroup to be given to the M&O Workgroup.</p>	<p>Mike Hennike to arrange for minutes from the Crisis Services Workgroup to be shared with the M&O Workgroup.</p>
<p>Next Meeting</p>	<p>March 18, 2008.</p>	

There being no further business, the meeting was adjourned at 3:10 p.m.

Respectfully submitted,

Lena Klumper
State Operated Services