MENTAL HEALTH SERVICE CHANGE PROJECT PROFILE

Stanley Street Treatment and Resources (SSTAR)

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Stanley Street Treatment and Resources (SSTAR) is a non-profit health care and social service agency, providing a wide range of mental health and substance abuse treatment services to people throughout the communities of Southeastern Massachusetts and Rhode Island.

PROJECT TITLE

EXECUTIVE SPONSOR:	Nancy Paull, CEO
CHANGE LEADER:	Pat Emsellem, COO
TEAM MEMBERS:	Maggie Cook, Clinical Nurse Specialist, Program Director of Dual Diagnosis Unit Linda Coutinho, Operations Manager Sandy Degaetano, CADAC, Clinical Director of Inpatient Services Shelly Medeiros, Front Office Receptionist Gerry Jacobs, R.N., Dual Diagnosis Unit Liz Roberts, Admissions Assistant, Dual Diagnosis Unit Sue St. Amour, N.P., Director of Nursing Inpatient Services Lou Cooper, R.N., Utilization Review Nurse, Inpatient Services Louise Keane, Executive Assistant
LOCATION:	Dual Diagnosis Unit, Inpatient Services
LEVEL OF CARE:	Dual Diagnosis Enhanced, Level III Detox
POPULATION:	Adult men and women with a dual diagnosis
AIM ADDRESSED:	Increase admissions; reduce wait time
START DATE:	8/26/2005
PROJECT STATUS:	Exceeded expectations; goal sustained

GOALS AND MEASURES

The SSTAR DDASS and Dual Diagnosis Detoxification Service programs are co-ed, staff-secure inpatient treatment programs for dually-diagnosed clients. The highly structured program

aims to stabilize behavior of people who have substance abuse and mental health issues. The length of stay is expected to be less than 10 days. The multidisciplinary staff of psychiatrists, social workers, psychiatric nurses and milieu therapists offers a highly-structured program of group education, individual and group therapy, 12-step commitments and recreational activities. Aftercare planning is an essential part of this program.

The dual diagnosis unit was losing money at an alarming rate. We realized that we needed to increase census or close down the entire department. Our Change Team identified the customer as the psychiatric hospitals that were making referrals. Our goal was to improve the daily census by testing changes to the referral process. We also realized that we needed to address our chronic nursing shortage.

	Dual Diagnosis Unit	Inpatient Department
FY 2004	($117,422)	($239,766)
FY 2005	($12,327)	($226,457)

PROJECT AIM

Increase Average Daily Census on DDS by One Bed Day.

- One bed day = $116,000 per year revenue
- ADC in year before project: 13.77
- Goal: 14.77

CHANGES IMPLEMENTED

PDSA Cycle 1: Fill Admission Nurse Slot

We first assumed that we would not be able to improve the census until we had filled the position for an admissions nurse. We had not been able to keep this budgeted position filled due to a nursing shortage. Before we could fill the admissions slot, we had to divert our attention to the larger issue of the recruiting and retaining good nurses.

We had some success in recruiting good nurses, but they were leaving after having completed a 12- to 16-week paid orientation program. Our first Change Project recruited one of the nurses who left after completing the orientation to be part of the Change Team. We asked her about her experience at SSTAR and discovered that her experience was similar what we identified when we completed a walk-through of the admissions process for our substance abuse treatment programs. She did not feel welcomed to our organization; did not feel engaged with SSTAR or that her concerns about working with a challenging population were adequately addressed. As a result, we decided to revamp the orientation program for new nurses.

Another issue that we knew was a source of stress for our existing nursing staff was forced overtime, a result of our staffing shortage. Our nurses had no idea how long their shifts would be on any given day.

We sent a survey to the nurses' homes informing them of our proposed Change Project to reduce forced overtime. We enclosed a self-addressed stamped envelope for them to mail in a report on how many times they had completed forced overtime in the previous three months.

This became our baseline data, and we considered the nurses our informal Change Team. We also asked the nurses for their suggestions on how to reduce or eliminate forced overtime.

As a result for the change we implemented, the forced overtime problem corrected itself: every 24 hours, one of the existing nurses would be on call if another nurse called in sick. Response to this change was very positive. Our nurses told us that it was important for them to know that we were paying attention and that we valued their ideas in finding a solution. The secure knowledge that their shifts would end at a predictable hour was a valuable exchange for having to be on call.

We then filled the admission nurse's slot, and while we saw improvements in other areas, an examination of the admissions pattern and the average daily census showed no increase in admissions. That confirmed that filling the admissions slot was not the solution to increase census

PDSA Cycle 2: Offer transportation to incoming referrals

A member of the Change Team had previously worked as a nurse at one of our major referral hospitals suggested we make it easier for referral hospitals to get patients to us by offering transportation. SSTAR would pick up the patient at the referring hospital. We expected this to make an improvement and added admissions slot hours just make sure we could accommodate the extra admissions. However, the hospitals did not avail themselves of this service.

PDSA Cycle 3: Streamline admission approval process

A regular complaint from the referral hospitals was that it took to long to get an answer from SSTAR on whether or not we could admit a patient. The standard procedure was that the admissions clerk would have to consult with the admissions nurse on bed availability; and this could take some time. The hospital needed to know that if we could not admit a patient, they would have to find another provider.

Most of our referrals come from five psychiatric hospitals, and they know what SSTAR DDASS and Dual Diagnosis Detoxification Service is like. By the time they call us, they know that the patient is appropriate for our service and the insurance company as already approved it. We decided to consider these five psychiatric hospitals our "preferred providers," and that we would always be able to give them an immediate "yes" if a bed was available. We also faxed bed availability daily to these hospitals days.

PDSA Cycle 4: Dedicated admission phone line for select psychiatric hospitals

We looked at our phone system and realized that our preferred referrals sometimes were greeted with an auto-attendant or a busy signal when they called. We decided to give our preferred referrals their own phone number, which would always be answered immediately, 24 hours a day, seven days a week. When they call, the phone is answered by a live person—the admissions nurse—and they get an answer right away. This change yielded immediate results and the census rose higher than it had ever been.

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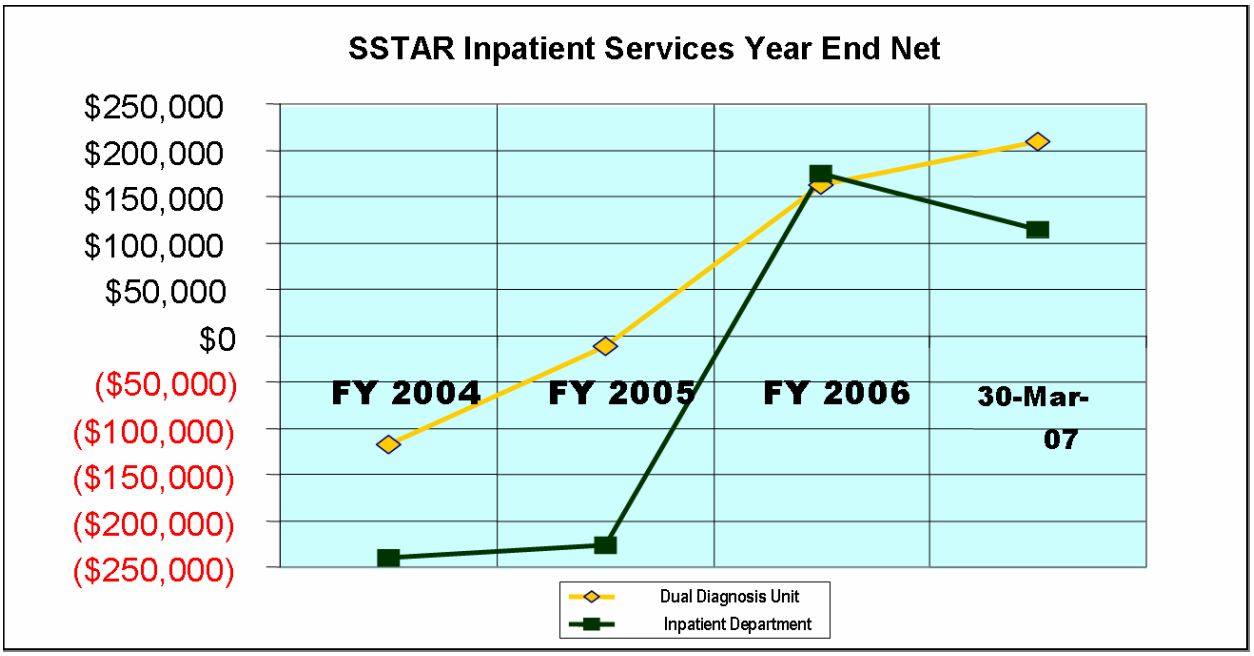
BUSINESS CASE IMPACT



LESSONS LEARNED

- The NIATx model can have a major impact on the financial position of the agency.
- What we assume to be true often isn't true—filling the admissions nurse slot did not have an impact on the daily census. While this was not adding staff but filling a vacant position, the data we collected supports the NIATx guideline that the last possible change you test is adding staff.

SUSTAINABILITY PLANS

- Referral sources—we are now the first choice for those five hospitals and we are their first choice; ensuring sustainability of the changes we tested.
- As our agency has become more stable—we no longer work in crisis mode and we have a stable nursing staff who know that they have employment security

CHANGE PROJECT DATA

Add a graph or chart that plots the progress of this change project. Submit the data on which the chart is based, either as a table in this document or in a separate file.

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