Stanley Street Treatment and Resources (SSTAR)
Inpatient Change Team Celebrates Success

By Pat Emsellem, SSTAR Chief Operating Officer and Change Leader

March 2006

This case describes the approaches Stanley Street Treatment and Resources (SSTAR) used to increase its average daily census in its Dual Diagnosis Services (DDS) unit. SSTAR used rapid cycle testing to identify effective ways to increase admissions. By increasing its average daily census from 13.77 to 15.03, SSTAR's DDS unit has made a significant contribution to the organization's financial viability.

Aim: Increase admissions

Paths: scheduling, intake and assessment, outreach

Key words: admissions, aim, business case, Change Leader, Change Team, dual diagnosis, inpatient services, referrals

SSTAR's Increase Dual Diagnosis Admissions Change Team,
September 2005

Background

SSTAR was originally known for its addiction treatment services based in Fall River, Mass., but since its incorporation in 1977, the agency has offered multiple services organized around a "one-stop shopping" model. SSTAR offers primary health care including office-based buprenorphine treatment, domestic violence services, a range of HIV/AIDS services, outpatient and intensive outpatient mental health and addiction counseling, babysitting and parenting programs, and is a member of the northern New England node of the NIDA clinical trials network. We have a 15-bed detoxification unit, a 15-bed dual diagnosis unit, an 8-bed locked unit for women civilly committed into addiction treatment, and a 17-bed post-detox "step-down" unit. Through its affiliate, SSTAR of Rhode Island, SSTAR also operates Rhode Island's public detoxification service, as well as a residence for pregnant women suffering from addiction and their children (SSTARBIRTH).

In September 2005, SSTAR of Fall River, Mass., formed a Change Team to increase admissions and the census on its Dual Diagnosis Services (DDS) Unit. This change project was one of five undertaken at SSTAR since becoming a NIATx member site. SSTAR was awarded a grant from the Robert Wood Johnson Foundation in 2004 to improve addiction treatment using "rapid change" process improvement techniques.

The Change Team designated to increase DDS admissions was comprised of managers and front line staff.

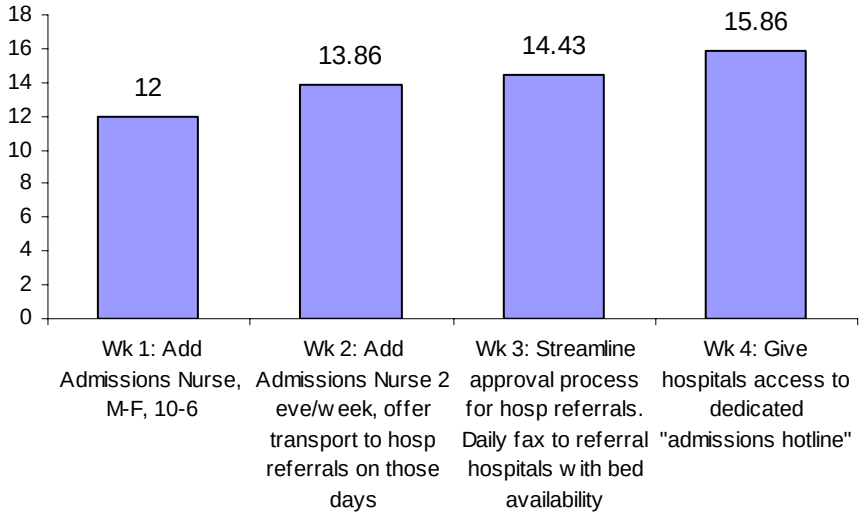
Increase DDS Admissions—Change Team

- Nancy Paull, Executive Sponsor
- Pat Emsellem, Change Team Leader
- Louise Keane, Executive Assistant
- Genie Bailey, Medical Director, DDS
- Gerry Jacobs, DDS Charge Nurse
- Katie Boyle, Admissions Assistant
- Shelly Pildade, Inpatient Front Office
- Linda Coutinho, Operations Manager
- Lou Cooper, Inpatient UR Nurse
- Maggie Cook, DDS Program Director
- Paul Lasiewski, DDS Counseling Coordinator
- Sandy Degaetano, Clinical Director, ATS, SOAP
- Sue St. Amour, Inpatient Director of Nursing

Results

The average daily census (ADC) for the fiscal year ending June 30, 2005 was **13.77**. Our goal was to increase it by one admission to 14.77. Since initiating our fourth change cycle the last week in September 2005, the ADC has been **15.03**.

DDS Change Project: Average Daily Census (ADC)
September 2005



Business case for the Increase Admissions Change Project

Increasing the average daily census by one bed per day on the DDS unit translates into a revenue increase of $116,000 per year. This is of major financial significance to the agency and for Inpatient Services, which has operated at a loss for a number of years. The improved census on DDS, combined with the successful financial operation of the Structured Outpatient Addiction Program (SOAP), has led to a positive “bottom line” for Inpatient Services for the first time in many years.

The four change cycles

Cycle 1

The team initially felt that the main obstacle to increasing admissions was the lack of an admissions nurse. We had budgeted for an inpatient admissions nurse, Monday through Friday from 10 AM to 6 PM, but had not been able to fill these time slots due to a nursing shortage. For the previous several months, two other Change Teams had worked on improving the nursing staffing issues—a second team to reduce the percentage of nurses who stayed for less than six months following orientation, and a team that aimed to reduce "forced overtime"—believed to be a significant factor in nursing staff turnover as well as contributing to difficulties in recruiting new nurses. By August 2005, the nursing staffing situation had significantly improved.

For week one—the first week in September—we focused on having the Monday through Friday admissions nurse slot filled. This did not lead to improved average daily census or increased admissions. Census was **12** for the first week, and we had only **8** admissions. Although the change week included a holiday weekend that was probably a factor in the unusually low census and number of admissions, the team felt that the availability of admission nurse during the weekdays would not have a significant impact on the census. This was borne out by an analysis of the previous year's data on number of admission nursing slots filled each week versus number of admissions. The data showed no positive correlation between these two factors.

Cycle 2

Since the first change didn't produce the desired increase in admissions or census, the team brainstormed other solutions. The DDS unit gets the bulk of their admissions through referrals from psychiatric hospitals. One of the team members previously worked for one of the referring hospitals and pointed out that if the hospital doesn't succeed in finding placement for the patient before 1:00 PM, it's too late to arrange for their driver to transport the patient to a DDS program—whether ours or a competing facility—and the patient will take up another expensive bed day at the psychiatric hospital for which they may not get reimbursed. We decided to offer to pick up the patients in the afternoons on two days that week. In order to manage a possible increase in late-day admissions on those days, we added evening admissions nurse hours. Though the census and number of admissions increased from the previous week, it didn't seem that the transporting and additional nursing hours contributed to the increase. There were no requests from the referring hospital for transport. The census increased to **13.86**.

Cycle 3

The team sought to come up with another strategy that would make our facility more attractive than our competition to the psychiatric hospital staff making the referrals. One complaint we hear from referring hospitals is that it takes too long to get an answer when they ask to refer someone to SSTAR DDS. We reviewed the process:

1. The referring hospital calls the Inpatient Admissions Office, usually in the morning, and they are instructed to fax over the patient records.

2. The admission clerk then takes the records up to the DDS charge nurse to review for appropriateness. Sometimes the admissions clerk is busy and doesn't get to the faxed information right away or is delayed in getting the documents to the nurse.

3. The charge nurse is often very busy and may not review the information for hours. As a result, sometimes the referring hospital will have found a bed in another facility before we get back to them.

The Team debated the necessity of having the nurse review the records prior to accepting the referral. Ninety percent of the hospital referrals come from five hospitals. These hospitals are very familiar with SSTAR's DDS Unit, their staff has determined that the patient is appropriate for SSTAR DDS, and the insurance company has already given authorization before the hospital places the call to SSTAR admissions. There had been not one instance that the Team could remember in which the nurse had deemed a referral from one of these five hospitals to be inappropriate for DDS. So why go through that review process? We designated these five hospitals "priority referents" and offered them a streamlined process for admission. Though they needed to fax the records to allow for coordination of care, a records review would not be required for an admissions decision. If a bed was available, the patient would be accepted. We began faxing these five priority hospitals daily with notice of bed availability, and the census increased to **14.43**.

Cycle 4

Since we seemed to be on the right track, the Team decided to make the process even easier for these priority referent hospitals. We established a special admissions "hotline" telephone number that was directed to a portable phone the admissions clerk kept with her even when she was walking around the building. If she was not on duty, the phone would be kept with the DDS charge nurse. The number was given out only to the referring staff from those five priority hospitals. The goal was that when these priority hospitals called the admission hotline it would be answered by someone who could immediately give them an answer regarding the admissions request. This hotline number was listed on the daily faxes we sent to the five hospitals. The average daily census during that week was **15.86**—the highest census of any week in the DDS Unit's history. From that week through the end of January 2006, the average daily census has been **15.03**—comfortably above the initial aim of an ADC of 14.77.