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Optimizing the Implementation and Dissemination of the Recovery Model Approach

Lani Schofield

University of San Francisco

July 31, 2019

Abstract

For a period of nine months spanning 2018 and 2019, monthly patient satisfaction survey scores in a 22-bed sub-acute inpatient psychiatry unit at a safety-net hospital in California decreased significantly, which revealed that patients felt they were not receiving satisfactory care and which warranted calls for innovative approaches to improve care delivery. The patient experience of care affects recovery and length of stay. Because prolonged hospital stays result in increased costs and increased use of healthcare resources in hospital units, including sub-acute psychiatric microsystems, it benefits hospitals to improve the quality of patient care. In an effort to improve quality of care, the hospital's sub-acute inpatient psychiatry unit integrated the Substance Abuse and Mental Health Services Administration's Recovery Model Approach with the traditional Medical Model Approach. The clinical nurse leader (CNL) led a practice-change project to educate a patient population whose mental illnesses included, but were not limited to, depression, psychosis, schizophrenia, paranoia, eating disorders, substance/alcohol abuse disorders, borderline personality disorder, bipolar disorder, and mania. The education was intended to help patients develop skills and knowledge to guide them through the treatment process. A daily patient education program, which lasted one hour, was administered for a year. Patient satisfaction surveys were collected and analyzed monthly for a year to correlate with the discharge rate and to determine if there was a significant benefit. The survey results over the past six months indicate that the approach enhances the patient's quality of life and improves the patient experience at the facility.

Introduction

With assistance from nursing students from a college in San Francisco, the San Francisco Hospital (SFH) conducted monthly patient satisfaction surveys in an inpatient psychiatry unit. The survey results reflected the grievances that the patients routinely voiced during their stays at the hospital.

The key to wellness in sub-acute psychiatric microsystems is a recovery approach that addresses patients' unique needs, that "meets them where they are." The approach is based on the Substance Abuse and Mental Health Services Administration's four dimensions of recovery: health, purpose, community, and home (Substance Abuse and Health Services Administration, 2019). Several inpatient psychiatric hospitals around the Bay Area have implemented this approach successfully. This six-month program was piloted on the unit a year ago, but the project champion dropped out due to personal reasons. The program was re-introduced on March 17, 2019.

Problem Description

The patient population in the inpatient psychiatric sub-acute unit at SFH is diverse in terms of culture, race, gender, and sexual orientation, though the patients are predominantly homeless and/or economically disadvantaged. Patients range in age, but no patient is younger than 18 years. The unit, which has a maximum census of 22 patients at any given time, is staffed by physicians, psychiatrists, residents (i.e., medical students), psychologists, pharmacists, social workers, nurses, medical assistants, certified nursing assistants, and occupational therapists.

The patient-to-RN ratio is a maximum of six to one, although it can be lower at any given time, depending on patient care needs. One charge nurse is assigned to the unit each shift; that charge nurse does not take patients. One certified nursing assistant or licensed psychiatric

technician helps manage the milieu each shift. Two pharmacists visit the unit for two hours each shift for medication reviews. The occupational therapist runs the group for about six hours each day, while social workers address placement options, discharges, and some legal matters pertaining to conservatorship.

The SFH Psychiatry Department has four units: Psychiatric Emergency Services (PES), the site of initial patient presentation; 7B, the acute inpatient unit where patients stay for stabilization; 7L, the forensic unit; and 7C, the sub-acute unit for patients who need further stabilization and who are awaiting placement. PES doctors determine where a patient will transfer after 72 hours. A patient can either be transferred to 7B or 7L (note: 7L is reserved for patients who were involved in a recent significant assault incident that included filed charges).

The length of the stay for patients in 7C ranges from one month to one year, depending on placement options and the patient's support system. Daily scheduled groups start at 9:00 AM and run until 6:00 PM, and patients discuss such topics as medication, coping with stress, dealing with symptoms, grooming, and hygiene. Patients also watch movies at scheduled times. The interdisciplinary treatment team collaborates to help patients reach their goals for improving their ability to engage in day-to-day activities and for maximizing quality of life.

SFH is dedicated to improving the lives of patients in unit 7C and to maintaining a safe environment. During monthly Assault and Battery Prevention meetings, the staff members review Seclusion and Restraint forms to assess their decisions and actions after incidents. Through this project, students from a college in San Francisco conducted patient satisfaction surveys once a month to gauge patient sentiments about their hospital stays. In order to improve the 7C patient experience, the Quality Improvement Specialist collected the data, then

coordinated meetings with the interdisciplinary team, which is comprised of psychiatrists, nurses, occupational therapists, and unit managers.

Available Knowledge

PICOT Question

The program developed the following population, intervention, comparison, outcome, and timeframe (PICOT) question: Would at least 90% (outcome) of patients at an inpatient psychiatry sub-acute unit (population) mark “yes” on patient satisfaction surveys if the unit’s staff implemented daily one-hour educational sessions for one year (timeframe) to help patients develop the skills and acquire the knowledge they needed to guide them through the treatment process (intervention)? In the June 2018 patient satisfaction survey, 84% of the patients marked “yes.”

Rationale

According to Roy’s model, a person is a bio-psycho-social being in constant interaction with a changing environment. He or she uses innate, acquired mechanisms to adapt. The model applies to people as individuals and to groups such as families, organizations, and communities (Petiprin, 2016).

Changes to a system are usually challenging because they force people out of their comfort zones, and learning new information can be stressful. Resistance to change is often caused by fear of the loss of something of value, and that resistance can interfere with a person’s ability to adjust to something new.

Specific Project Aim

The project’s aim was to develop and reintroduce a sustainable Recovery Model for a daily group-based or mentor-based program, administered every morning before breakfast. This

program supplements the existing Medical Model Approach to treatment. The goal of the project was to increase, over a period of six months, satisfaction survey scores (from 84% to 90%) of patients in the inpatient sub-acute psychiatric unit.

Methods

Context

The assessment of the inpatient sub-acute unit at SFH, which has a maximum census of 22 patients, was completed using the Dartmouth Microsystem Assessment Tool. The unit caters to patients with diagnoses such as schizophrenia, psychosis, depression, mania, eating disorders, and traumatic brain injuries. The patient-to-staff ratio can be no greater than six patients to one licensed nurse (registered nurse or licensed psychiatric technician). At a minimum, three registered nurses and one licensed psychiatric technician are required for a full census.

Providing safe and effective treatment is a collaborative effort among healthcare providers. Occupational therapists and social workers staffed the unit seven days a week. They ran the groups that helped the patients on their journey to recovery. The nurse-run recovery group encouraged empowerment and independence through the development of decision-making skills because, as research shows, patients are empowered by education that enhances their autonomy and encourages them to become full healthcare partners, and such patients fare better than patients who are treated as objects whose values or attitudes need to be shaped and changed through education or clinical intervention (Jotterand et al., 2016).

Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

A SWOT analysis was conducted to determine the microsystem's internal strengths and weaknesses and its external opportunities and threats (see Appendix D for SWOT analysis).

The analysis revealed several strengths, the most notable of which was the unit's approach to staff morale and communication. The inpatient sub-acute unit is known for its promotion of teamwork among registered nurses, licensed psychiatric technicians, and patient care assistants. They create an environment that is largely stress free so that staff can focus on being productive. From 9:30 AM to 11:00 AM, Monday through Friday, the licensed nurses, psychiatrists, psychologists, pharmacists, social workers, occupational therapists meet to pool their knowledge about patients and to collaborate on treatment. The staff meets with quality improvement specialists and nurse educators twice a week for two hours to discuss further developments and/or to address deficiencies. The unit employs effective communication techniques, including the communication boards that inform staff daily of transfers, admissions, scheduled discharges, and placement statuses. These boards are an essential tool for keeping the night-shift staff apprised of important information.

Weaknesses include staffing inadequacies, and nurses on the regular schedule in their home units are often floated in other units. The situation can be frustrating because it diminishes routine familiarity, which affects productivity and workflow efficiency. Weaknesses also include the small size of the patients' rooms, an inadequate number of seclusion rooms (there is only one in the unit), and patient overflow. Sometimes there are not enough male or female rooms, and the result of this patient overflow is that patient beds are sometimes placed in hallways or dayrooms.

There are opportunities for additional staff education and training. The unit is also working to increase staff satisfaction by recognizing staff members with minimal absences from work. There are also opportunities for lateral transfers for those seeking to upgrade their skill sets. The administration recently created a behavioral emergency response team to help maintain order and increase safety during patient-related crises.

There are numerous threats, which must not be underestimated. Threats include longer length of stay (LOS), high readmission rates, patient noncompliance with treatment, and poor hygiene. The homeless patients often lack a support system, which can make placements challenging. The low patient satisfaction survey scores are also a threat to the unit.

Intervention

The patients had a one-hour recovery group daily, which was managed by the clinical nurse leader (CNL), from 6:30 AM to 7:30 AM, while waiting for breakfast. Drinks such as coffee, cocoa, and tea were served to encourage the patients to stay for the entire session. Patients were asked to choose from a variety of activities meant to promote hope and recovery during their hospital stays. Staff identified activity leaders, who received an orientation about the objectives and the operation of the activities.

Study of Intervention

The Medical Model Approach, which is supported by evidence-based science, is the traditional approach to psychiatric treatment. Providers who use this approach make medication the focus of mental healthcare. This model is often used in conjunction with the Recovery Model Approach to enhance the quality of care and improve patient outcomes. The Recovery Model Approach emphasizes principles such as hope, empowerment, peer support, and self-management (Duckworth, 2015).

Measures

To measure the effectiveness of the program, patients completed satisfaction surveys every 30 days for 12 months. Students from a college in the San Francisco conducted the survey. The survey contained 15 questions related to patient-care experiences. Patients could choose from among three responses: “yes,” “no,” and “sometimes.” The Quality Improvement Specialist

collected and reviewed the surveys to assess the value and strength of the implementation of the program. A report was generated at the end of a six-month period and presented to a multidisciplinary team.

Ethical Considerations

When attempting to reform systems, providers must take heed of ethical considerations like autonomy. Allowing patients to preserve their autonomy means respecting their wishes, even when the provider does not believe that the patients' wishes serve their best interests. Patients enter treatment facilities with a variety of different perspectives, and what may seem inconsequential to a provider may seem monumental for a patient. The best way for a provider to approach a patient whose perspective is radically from the provider's perspective is to acknowledge the patient's right to hold that perspective. Respecting patients' autonomy was a key consideration in this project.

This project also considered patients' totality and integrity, which meant taking into account the entire person when deciding which therapies, medications, or procedures to provide to a patient. The project offered a variety of activities designed to accommodate patients' various mental and physical abilities. For example, activities that were easy to understand were explained in simple language so that patients with organic brain syndrome could participate.

Outcome Measure Results

The initial baseline data was established in June 2018. A comparison of the results of patient surveys from June 2018 to February 2019 showed an overall decrease in patient satisfaction from 84% to 75%. Patient comfort in talking to staff about concerns decreased from 80% to 58%. Knowledge about living situations/community resources post discharge decreased from 80% to 63%. Belief that the staff talked to the patient about the patient's goals decreased

from 80% to 63%. Belief that the staff gave the patient suggestions when the patient was upset decreased from 100% to 67%. These dramatic decreases in patient satisfaction warranted a reintroduction of the Recovery Model Approach, which was brought back to the unit on March 17, 2019. The six-month patient surveys will be summarized in August of 2019.

Discussion

Summary

After comparing the results from the February 2019 patient surveys to the results of the June 2018 surveys, which served as the baseline data, it was clear that patient satisfaction declined significantly. Staff did not use the Recovery Model Approach from June 2018 until February 2019, and as a result, the majority of patients in the sub-acute unit experienced uncertain discharge dispositions, which contributed to low patient satisfaction. Many patients responded "sometimes" to the survey questions, which might indicate that the staff lacked knowledge of Recovery-based practices.

Conclusions

The key to wellness and recovery in sub-acute psychiatric microsystems is a recovery approach that addresses patients' unique needs. Having seen firsthand the benefits of the Recovery Model Approach, SFH's Department of Psychiatry has adopted a clinical framework that incorporates the Recovery Model Approach with the traditional Medical Model Approach. This change created an opportunity to develop and implement Recovery-based care, which should improve the quality of life for patients living in the inpatient sub-acute facility. That improvement in patient satisfaction should be reflected in increases in patient satisfaction survey scores.

References

Duckworth, K. (2015). Science meets the human experience: Integrating the medical and recovery models. Retrieved from https://www.nami.org/blogs/nami- blog/april-2015/science-meets-the-human-experience-integrating-th

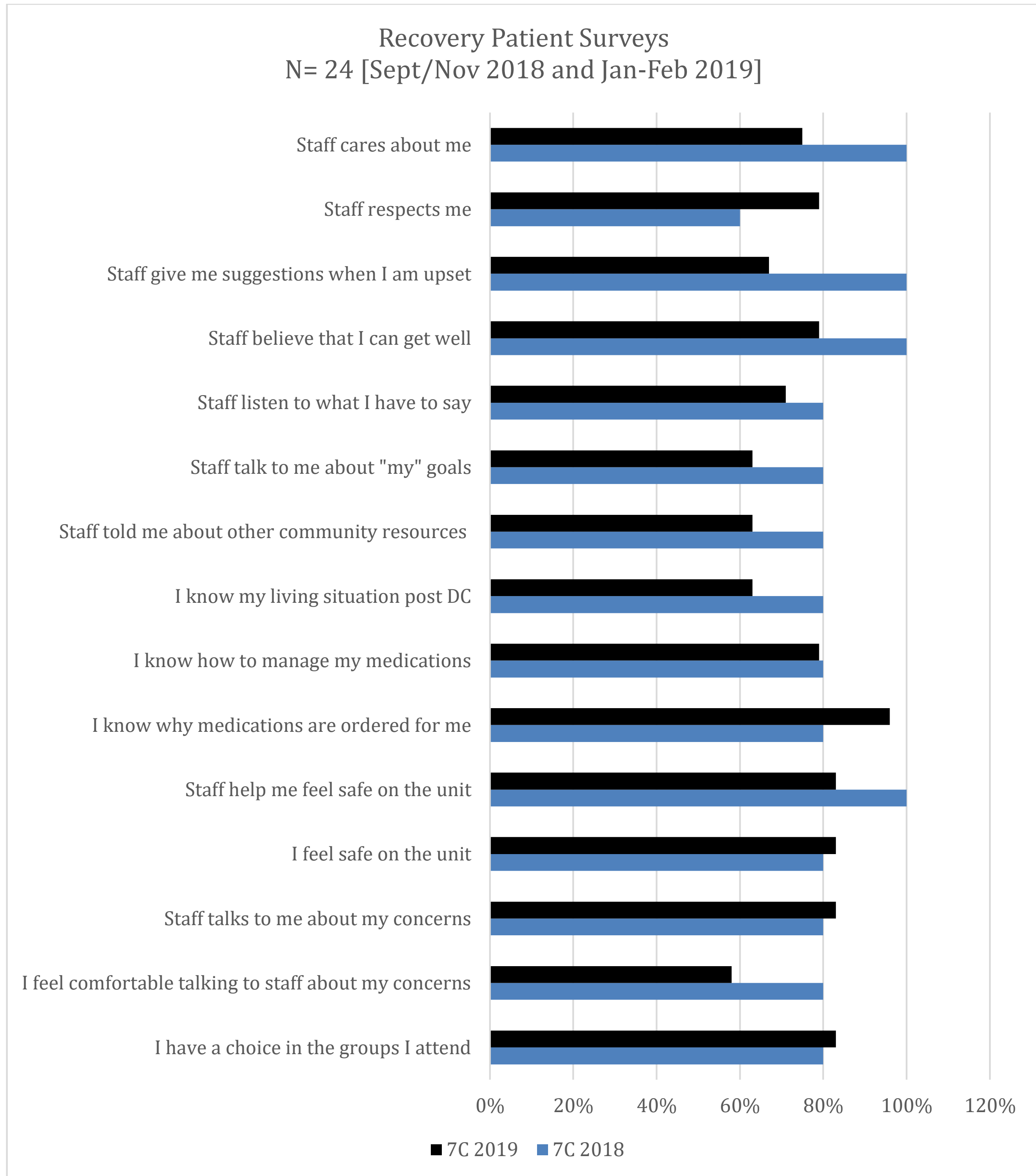
Jacob K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/

Jotterand, F., Amondio, A., Elger, B.S. (2016). Patient education as empowerment and self-rebiasing. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/27179973

Petiprin, A. (2016). Roy adaptation model. Retrieved from http://www.nursing-theory.org/theories-and-models/roy-adaptation-model.php

Substance Abuse and Mental Health Services Administration (2019). Recovery and Recovery Support. Retrieved from https://www.samhsa.gov/find-help/recovery

Appendix A



Appendix B

Patient Surveys Comparison

	7C 2018	7C 2019
I have a choice in the groups I attend	80%	83%
I feel comfortable talking to staff about my concerns	80%	**58%**
Staff talks to me about my concerns	80%	83%
I feel safe on the unit	80%	83%
Staff help me feel safe on the unit	100%	**83%**
I know why medications are ordered for me	80%	96%
I know how to manage my medications	80%	**79%**
I know my living situation post DC	80%	**63%**
Staff told me about other community resources	80%	**63%**
Staff talk to me about "my" goals	80%	**63%**
Staff listen to what I have to say	80%	**71%**
Staff believe that I can get well	100%	**79%**
Staff give me suggestions when I am upset	100%	**67%**
Staff respects me	60%	79%
Staff cares about me	100%	**75%**
Number of 7C Patients in Survey = 24		

Appendix C

Gantt Chart for the Recovery Model-Based Care

Part A

	January 2019	February 2019	March 2019	April 2019	May 2019	June 2019	July 2019	August 2019
Research Review & Presentation	Intro-duced the literature and program with the IDT							
Program Creation and Presentation		Program designed						
Program Roll Out			Program launched	Program ongoing	Program ongoing	Program ongoing	Program ongoing	Program ongoing
Program Evaluation & Improvement				Patient Survey	Patient Survey	Patient Survey	Patient Survey	Summary and Review of comments and feedback

Gantt Chart for the Recovery Model-Based Care

Part B

	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
Research Review & Presentation							
Program Creation and Presentation							
Program Roll Out	Program ongoing	Program ongoing	Program ongoing	Program ongoing	Program ongoing	Program ongoing	Program ongoing
Program Evaluation & Improvement	Patient Survey	Patient Survey	Patient Survey	Patient Survey	Patient Survey	Summary and Review of comments and feedback	Summary and recom-mendation

Appendix D

Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis

INTERNAL FACTORS

STRENGTHS	WEAKNESSES
• Teamwork among registered nurses, licensed psychiatric technicians, and patient care assistants. • Collaboration among the licensed nurses, psychiatrists, psychologists, pharmacists, social workers, occupational therapists, quality improvement specialists and nurse educators • Good communication tools • Supportive nurse and department managers	• Frequent floating of licensed nurses • Weak WiFi signal in most areas • Staffing inadequacies • Patient overflow • Inadequate seclusion room • Inadequate medical equipment (e.g., bladder scanner) • Small patient rooms

EXTERNAL FACTORS

OPPORTUNITIES	THREATS
• Staff education and training • Staff recognition and celebration • Lateral transfers • Tuition assistance/reimbursement for education • Behavioral emergency response team • Increasing staff satisfaction	• Longer length of stay • Increase in readmission rate • Patient noncompliance with treatment • Poor hygiene among patients • Age of staff (i.e., nurses close to retirement) • Uncertain discharge disposition • Lack of support system • Decreased patient satisfaction

Appendix E

CNL Project: Statement of Non-Research Determination Form

<u>Student Name</u>: Lani Schofield

<u>Title of Project:</u>

The clinical nurse leader is the educator: Optimizing the implementation and dissemination of the Recovery Model Approach for patients in inpatient sub-acute psychiatric unit

<u>Brief Description of Project:</u>

Nature of the Project:

The clinical nurse leader (CNL) takes the lead in educating patients to develop skills and impart knowledge that will support patients through the treatment process.

Data That Shows the Need for the Project:

For the past several years, patient satisfaction surveys have revealed that patients are dissatisfied with the care and treatment they have been receiving as inpatients in the sub-acute unit of the San Francisco Hospital Psychiatry Department. A patient's experience affects recovery and length of stay, and prolonged hospital stays mean increased healthcare costs and decreased hospital resources. In an effort to improve the quality of life of the sub-acute unit's patients and to reduce the duration of hospital stays, the staff proposes using the Recovery Model Approach to educate and develop the skills of the patients and the healthcare team treating the patients.

Earlier studies show evidence that suggests that self-management strategies based on the Recovery Model have better results than models that are focused strictly on improving physical health. An analysis of recovery-based research suggests that the dominant themes from the stakeholder perspectives were identity, the service provision agenda, the social domain, power and control, hope and optimism, risk and responsibility. There is clear consensus around the belief that good quality care should be made available to service users to promote recovery, both in inpatient units and in the community. The language of recovery is being increasingly employed in service delivery, mental health policy, and psychiatric research (Jacob, 2015).

Goal of the Project:

The goal of this project was to improve the patient experience and increase patient satisfaction up to 90% as measured by a satisfaction survey in an inpatient sub-acute psychiatric unit.

Evidence to Support the Project:

A) Aim Statement:

The aim of this project was to implement a daily group-based or mentor-based program—every morning before breakfast—that provided different activities meant to promote positive behaviors that enhance recovery for patients in the sub-acute psychiatric unit.

B) Description of Intervention:

Patients were invited a one-hour recovery group daily, which was managed by the CNL, from 6:30 AM to 7:30 AM, while waiting for breakfast. Coffee, cocoa, and tea were served to encourage the patients to stay for the entire session. Patients were asked to choose from a variety of activities meant to promote hope and recovery during their hospital stays.

C) How Will This Intervention Change Practice?:

The Medical Model Approach, which is supported by evidence-based science, is the traditional approach to psychiatric treatment. Providers who use this approach make medication the focus of mental healthcare. This model is often used in conjunction with the Recovery Model Approach to enhance the quality of care and improve patient outcomes. The Recovery Model Approach emphasizes principles such as hope, empowerment, peer support, and self-management (Duckworth, 2015).

D) Outcome Measurements:

In order to measure the effectiveness of the program, patients completed (and continue to complete) a recovery patient survey every 30 days for 12 months, beginning on the date of the project's implementation (03/17/2019). Results are reviewed and summarized after 6 months and to be presented to the treatment team.

References:

Duckworth, K. (2015). Science meets the human experience: Integrating the medical and recovery models. Retrieved from https://www.nami.org/blogs/nami-blog/april-2015/science-meets-the-human-experience-integrating-thhtt

Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418239/

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

x This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	**X**	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves	**X**	

staff who are working at an agency that has an agreement with USF SONHP.		
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print):

____

Signature of Student:

____**DATE**____________

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

____

Signature of Supervising Faculty Member (Chair):

____**DATE**____________