# Section 1: Summary of Major Findings

**Key problems**

- ✓ At the start of the project, the executive office identified the budget deficit and violence as the two major problems facing the hospitals. The acting director also noted lack of good IT support.
- ✓ The LTCS deputy director summarized the major problems facing the hospitals as staffing, safety and security, old infrastructure, and the increasingly forensic nature of the population being served.
- ✓ The administrative deputy director summarized the major problems facing the hospitals as "culture" and "under-resourced for their [administrative] mission."
- ✓ During hospital interviews, the hospital executive directors summarized their challenges as complying with the Enhancement Plan; developing aggression reduction strategies; recruitment difficulties; heavy overtime usage; problems with IT systems; aging infrastructure and poor space utilization; poor vendor relations due to prior deficits; service and communication issues with headquarters; for the psychiatric programs, feeling like step-children; and for one hospital (Metropolitan SH) concern about its declining population and long-term mission.
- ✓ Hospital administrative staff interviewed by the team identified the following problems: the inability to fill positions (recruitment, exam blockage, hiring freeze); long contract review processes; undocumented procedures and instructions; exclusion by headquarters in decision-making; patient violence; a lack of respect from headquarters for hospitals' skills; and in general a lack of headquarters support.
- ✓ Medical staff interviewed by the team noted a lack of medical leadership; unintended mission impacts of the Enhancement Plan including less time for interaction with patients and loss of focus on the forensic mission; exclusion from decision-making; lack of electronic health records and other shortfalls in medical data management; the need for a safe, harassment-free workplace; and misalignment of medical work with classifications.
- ✓ The project team concurred with the problems above and identified additional issues: lack of management support for cost-consciousness and fiscal accountability; overall inadequate planning for and implementation of the department's information technology program; lack of detailed base budgets and other fiscal systems necessary for budget control; lack of training for budget control; and rudimentary implementation of the accounting system resulting in the inability to collect necessary cost data.

**Management Assessment (Section 2)**

- ✓ Headquarters has not provided effective leadership, teamwork and communications, particularly as it relates to fiscal control. The division charged with hospital oversight was preoccupied with complying with the federal Civil Rights of Institutionalized Persons Act (CRIPA) court order, placing it before budget considerations. The administrative division lacked the knowledge and leadership to address and resolve the emerging deficit.
- ✓ Hospitals have performed better than headquarters, but they lack robust, shared fiscal management systems and training.
- ✓ Headquarters' executive structure should be revised to replace the existing LTCS division with an operations division and a clinical division. The operations deputy director should have the specific mandate of balancing mission requirements with budget realities. The clinical deputy director should be a forensic psychiatrist who can provide the medical leadership which the department currently lacks.

**Organizational Assessment (Section 3)**

- ✓ Headquarters is thinly staffed with a limited capacity for analysis. Given budget constraints, a federated model (flat organization) in which hospitals and headquarters team together to develop plans, policies and procedures might allow limited headquarters staff to be used in the most effective fashion.
- ✓ Hospital administrative structures are also thinly staffed, especially in fiscal oversight functions.
- ✓ A strong budget office is essential to fiscal control, but at the time of this report the budget office was rebuilding staff and for the period of review was only marginally functional.
- ✓ Hospital budget staff need training and in some cases additional personnel. The report recommends a specific approach for the hospitals to team together to improve their fiscal mastery.
- ✓ The program division senior management failed in its fiscal oversight role when it required hospitals to comply with the Enhancement Plan without addressing the budget impact satisfactorily.
- ✓ The administration division management, as well as senior managers in the budget office and the accounting office at headquarters, failed in a primary fiscal responsibility when they participated in moving expenditures without necessary authorizations in order to facilitate year-end closing.
- ✓ There was no compelling evidence observed, either from a cost or a performance point of view, for centralizing hospital administrative functions at headquarters. In general, more delegation of responsibility to hospitals appears merited.

**Weak Administrative Processes (Section 4)**

- ✓ The department's overall system of appropriation control is deficient. Detailed base budgets are missing in headquarters and the hospitals. A formal plan needs to be prepared to regain fiscal control.
- ✓ The department has implemented CALSTARS at a minimal level and lacks an overall cost center plan for tracking expenditures in order to meet management information needs and sound fiscal control.
- ✓ Key fiscal processes are not documented and perform weakly: expenditure forecasts, salary savings management, position change authorization, reconciliation of staffing standards to the Schedule 7A and to hospital allocations, and reconciliation of hospital allocations to the State Controller's Office records.
- ✓ Budget resource acquisition does not address several important mandatory staffing requirements, such as enhanced observations and the patient intake process. Operating expense budgets have not received cost adjustments for years.
- ✓ The timely filling of positions is hampered by recruitment difficulties, exam slowdowns, and the hiring freeze. For positions involved in direct patient care, this results in hospitals using overtime for necessary coverage at a higher cost.
- ✓ Contract processing takes an unreasonably long time—9 to 12 months—causing operational problems in hospitals.
- ✓ DMH incorrectly reported compliance with the findings of the 2008 internal controls audit prepared by the Office of State Audits and Evaluations. Many of the findings, such as the need to create base budgets, are as current now as they were three years ago.

**Information Technology (Section 5)**

- ✓ IT resources are inadequate for a hospital system that serves approximately 6,350 patients and 11,700 employees.
- ✓ IT security is minimal; there are thousands of vulnerabilities.
- ✓ IT architecture (network, hardware, and software) is unsustainable unless remediated. Applications currently in use lack system support and stabilization.
- ✓ The IT organization structure was actually six separate organizations, inefficient, and not well coordinated.
- ✓ Communication channels are minimal between IT staff and between IT and its customers.
- ✓ There are no procedural structures for system maintenance or projects that provide direction for staff with repeatable processes and reduce risk of errors.
- ✓ There is no IT planning and no IT budget. There is minimal asset management. Assets are aging out without plans or resources to replace them.
- ✓ There is minimal documentation of existing systems; the organization relies on existing staff knowledge and there is no succession planning.
- ✓ There is no disaster recovery.
- ✓ There is minimal compliance with statewide policies and procedures.

**Medical Issues (Section 6)**

- ✓ Over the past 20 years the hospital system has moved away from its community origins. The percentage of forensic patients has increased, bringing an increasing risk of violence, involvement with the penal system, sometimes different treatment objectives, and an aging, more medically fragile patient population.
- ✓ There is no shared culture of cost containment in the department as a whole, much less for patient care. System-wide goals, leadership and coordination are needed.
- ✓ The hospitals' management models and tools have not kept pace with those of the broader medical community.
    - The department should examine managed care models for guidance in cost containment for areas such as formulary programs, utilization review, and provider networks.
    - Medical data management needs upgrading and modernization, beginning with electronic health records.
- ✓ The cost pressures in the medical area are the Enhancement Plan, the use of contracted professionals, the use of proprietary drugs over generics, patient demographics which drive a need for more physical medicine services, and the use of outside medical care over on-site medical care.
- ✓ The performance pressures in the medical area are concern over safety in the work environment, compliance with the Enhancement Plan, lack of central medical leadership and program planning, lack of decisional teamwork with headquarters, difficulty of recruitment in some areas, lack of system-wide automated tools (particularly electronic health records), and lack of networking between hospitals.
- ✓ Establishing a clinical deputy director at headquarters who is a forensic psychiatrist will help to provide the program direction, oversight, and improved teamwork among disciplines that the hospital clinicians need.
- ✓ The Enhancement Plan needs to be reassessed with the intent of focusing on 1) more clinician interaction with patients and 2) the forensic mission.

**The Hospital Deficit (Section 7)**

- ✓ The department experienced deficits in 2009-10 and 2010-11. The operational shortfall is chronic, with an additional deficit expected in 2011-12. The 2011-12 deficit is projected to be $133.6 million if census reserves are not available and $68.9 million if they are available. Assumptions behind this estimate are documented in the report. Absent additional funding or major, immediate savings, if funds are set aside to meet payroll the department is likely to experience a cash shortage for vendor payments in early winter, 2011-12.
- ✓ The hospital deficit is the result of reductions to the appropriation coupled with expenditure increases, one of which was for an expansion of the Enhancement Plan that was not authorized by the Legislature. The department contributed to the deficiency through a lax approach to fiscal management.

- ✓ In the team's view, balancing DMH's budget through savings will require significant operational changes as opposed to minor adjustments at the margin. The Enhancement Plan which resulted from federal court order constrains major budget reductions and will require negotiation with the court monitor if the goal is to maintain compliance. Other savings opportunities exist but may take time to implement, and the possibility of closing the gap without addressing activities undertaken for the Enhancement Plan appears limited.
- ✓ The department needs to identify how it will judge cost performance for each hospital and for the system as a whole. All managers need to be held accountable.
- ✓ There are a number of organizational and process changes the department can make to improve fiscal management and help avoid deficits in the future. Recommendations are made throughout the report.

**Other Issues (Section 8)**

- ✓ The department's strategic plan needs to be updated to address the serious issues facing provision of mental health care to the department's patient population: balancing resources with mission expectations, concerns about a safe working environment, medical leadership, and unintended impacts of the Enhancement Plan.
- ✓ Metropolitan SH is at a crossroads. The hospital faces declining population, aging facilities and community restrictions on the type of patients it can serve. On the other hand, its location offers the opportunity to expand the range of services it currently provides for the hospital system.
- ✓ The department has a backlog of $22.7 million in special repairs and aging facilities that need to be reviewed as part of an organized facilities management program. With the exception of Coalinga SH and the psychiatric programs, state hospital facilities were not built for a forensic population.