Section 2: Management Assessment

Background: In the opening interview, the acting director and acting chief deputy director identified two major problems facing the hospitals: the budget deficit and violence.

The hospitals have a chronic budget deficit that DMH could neither quantify reliably nor explain when requesting financial assistance in the spring of 2011. The problem first appeared as a $27 million year-end shortfall in 2009-10 which was carried over for payment to 2010-11 through Board of Control claims.[1] In 2010-11 the deficit reappeared and had grown. The official estimate of the deficit in the spring of 2011 was $50 million, but by June it was clear the deficit was significantly greater although still not quantified. Towards the end of July the deficit for 2010-11 was finally sized at about $120 million.[2] The 2011-12 budget was expected to have a deficit near the same range.

The executive office offered these possible causes for the deficit and difficulty in quantifying it:

- In the past the hospitals had excess salary savings due to chronic recruitment lags, so they could absorb budget cuts for several years without immediate adverse consequences.[3] However, they eventually reached a point where this excess was eliminated through budget reductions, so they could not stay within their allocations;
- The hiring freeze and furloughs led to the payment of unbudgeted overtime to stay in compliance with licensing and court-ordered staffing standards;
- There was no overall control of expenses; and
- Decentralized financial and IT operations cause poor flow of management and fiscal information to headquarters. The Executive Office anticipated the need to centralize a number of administrative functions—such as accounting— in a new state hospital department.

The second major problem facing hospitals is violence, i.e., patient assaults on staff and other patients. At the time of the opening interview, no connection was drawn between violence and the budget deficit, although it later became clear that violence does influence costs (see Section 7).

The Executive Office asked the team to identify administrative organizational changes appropriate for the proposed new department as well as processes and systems that might be hampering fiscal accountability. The office later expanded this request to include collecting information on the deficit.

[1] The shortfall was later revised to $28.9 million, and by September 2011 revised again to $34.2 million. See Section 7 on the hospital deficit.
[2] See Section 7 for a description of the problem in sizing the 2011-12 deficit.
[3] See Section 4 for a discussion of recruitment difficulties.

The Long Term Care Services (LTCS) Division: The LTCS division oversees the hospitals and manages related programs (see Appendix 2.A). As noted earlier, there are five free-standing hospitals and two smaller hospitals called psychiatric programs located on CDCR prison grounds. As of July 2011, the seven hospitals together have a budget of $1.2 billion and 11,700 employees, and house approximately 6,350 patients.

The division's activities include hospital oversight (primarily monitoring of compliance with the court-ordered Enhancement Plan), fiscal and administrative support to the hospitals, forensic services,[4] and a liaison unit with CDCR and the courts. At the time of this review, the seven hospital executive directors reported to the division deputy director.

For a number of years the LTCS division has operated as an intermediary between the hospitals and the administrative division. According to the LTCS deputy director, the division was forced to set up separate administrative oversight of the hospitals because the administrative division was focused almost entirely on the Community Services Program which oversees mental health programs.[5] As a consequence of this focus (and reportedly also due to understaffing), the administrative division provided little service to the LTCS division and the hospitals. The deputy director reported that the LTCS division was not staffed for this administrative oversight and asked many times—unsuccessfully—for additional administrative staff for both itself and the hospitals.

The deputy director noted that the hospitals have been funding themselves out of salary savings for years and that the LTCS division "knew the [budget] train wreck was coming" as this capacity dried up. The division reported the impending 2010-11 hospital deficit early in the fiscal year to the executive office, prepared a supplemental funding request, asked the hospitals to save where they could, and with those actions appeared to have felt it had discharged its fiscal duty.

The LTCS deputy director summarized the major problems facing the hospitals as staffing, safety and security, old infrastructure, and the change in the type of patient being served (i.e., increasingly forensic). She saw the major challenge facing a new hospital department as lack of programmatic understanding at headquarters and a weak IT structure.

Headquarters Administration: The administrative division consists of two branches: the accounting office and the budget office under a fiscal assistant deputy director, and the human

[4] The forensic services unit consists of the conditional release program which is a statewide system of community-based, involuntary outpatient treatment and supervision; the mentally disordered offender program which assesses CDCR inmates prior to release to determine whether they fit mentally disordered offender criteria and should be placed in the state mental health system; and the sexual offender commitment program which assesses whether inmates committed for a sexually violent predatory offense have a diagnosed mental disorder that, prior to release, justifies placement of the inmate in the state mental health system.

[5] This program is part of the 2011-12 realignment of county mental health funding and is not a component of a new state mental hospital department.

resources and business services offices under a separate assistant deputy director. At the time of our interview, the administrative deputy director was a retired annuitant who had previously served both as the chief deputy director and as the administrative deputy director.

The administrative deputy director agreed with the LTCS deputy director that poor administrative staffing levels at headquarters had impeded service to the hospitals. However, in his view the prior director was more focused on community health programs, leaving oversight of the hospitals to the LTCS division. The deputy director believed that the LTCS division had blocked any attempts the administrative division had made to engage directly with the hospitals. He painted a picture where contact with the hospitals—even contact between the executive office and the hospitals—was controlled through the LTCS division. Instructions the administrative division prepared for hospitals were rewritten by the LTCS division and issued as LTCS special orders.[6] Even conference calls between the administrative division and the hospitals were led by the LTCS division.

The administrative deputy director summarized the major problems facing the hospitals as "culture" and "under-resourced for their [administrative] mission." He described hospitals as operating autonomously, taking direction from the executive directors (chief administrators) who run the hospitals as "fiefdoms" and do not view themselves as part of DMH.

Regarding under-resourcing, the administrative deputy director stated he suspected but could not prove that the hospitals were underfunded in their administrative functions, largely because the hospitals were unable to say specifically what they needed. He described hospitals as having no real budget experience, and the department's budget office as being more technical than policy in nature.

In summary, neither the LTCS deputy director nor the administrative deputy director listed the hospital deficit as among the primary problems they thought hospitals faced. Both agreed that the hospitals had received little administrative service, but each blamed the other division for that problem. Both agreed that hospitals needed more administrative staff, although the LTCS deputy director's assessment of staffing needs was broader, including hospital program delivery.

Interviews with other senior program managers in headquarters reinforced a picture of difficult access to the hospitals; some reported that working with the LTCS management could be challenging.

The hospitals: The team had heard the "out of control" assessment about hospitals several times, so it was expecting to see disorder when it began its hospital visits. What the team observed instead were complex operations run in a business-like manner. There were soft spots, primarily in terms of sophistication of fiscal systems, but the overall impression was one of competence. Nor were there signs of internal management fracture, as with headquarters.

[6] Special orders are management directives that cover diverse topics.

The chain of command between the hospitals and the LTCS division appeared to be fairly tight, allaying team concerns about "fiefdoms." Granted, the team observed differences between hospitals.[7] However, the overall system presentation was cohesive rather than fragmented, so on this issue the team agreed with the LTCS division.

The team asked the executive directors why they had not maintained budget control. To a person they gave the same answer: the hospitals were directed by the LTCS division to comply with the requirements of the court-ordered Enhancement Plan regardless of budget impact. This was the first the team had heard of a major, unauthorized expenditure of funds on the Enhancement Plan.

Enhancement Plan: The federal Department of Justice sued four of the five free-standing hospitals for alleged violations of the CRIPA.[8] The department negotiated a settlement in May 2006, committing to development of higher standards of hospital care. As part of the settlement, a court monitor was appointed to represent the court's requirements for treatment improvement. The department hired a consultant team to represent it with the monitor, and a plan for increased services was developed that eventually came to include detailed audit requirements to prove that compliance was occurring. This higher level of treatment services, coupled with auditing, became known as the Enhancement Plan.

DMH's initial request for Enhancement Plan funding was based on extrapolating the compliance activities required for Metropolitan SH to the remaining hospitals. This funding proved inadequate because DMH failed to anticipate that the plan would be an evolving target that would increase both in breadth and in detail over the years.

As new compliance activities were mandated that were not included in the initial funding request, the LTCS division told hospitals to redirect patient care positions (called LOC or level-of-care positions) immediately to meet the need.[9] The team has been advised that the division submitted a request for additional funding several years ago to backfill that redirection, but reportedly the request was denied before it reached the Department of Finance. According to the hospitals, the LTCS division required them to comply anyway.

An important point is that redirecting an LOC position does not mean that the primary function goes uncovered. Instead, the hospital fills behind the position with overtime, temporary help, or a personal services contract in order to meet patient care requirements. Thus, much of the

[7] Where differences are most striking was in data information technology, although there are organizational differences as well and varying degrees of cost consciousness.

[8] Coalinga SH was not sued because it had just become operational. The two psychiatric programs within prison grounds also were not included in the suit, since inmates are not subject to CRIPA.

[9] DMH classifies its positions as either level-of-care or non-level-of-care. The former is a position in direct performance of patient care and includes classifications such as psychiatrists, psychologists, nurses and psychiatric technicians. The latter is any position that does not meet the definition of level-of care and includes positions such as hospital police, janitors, plant operators, and administrative staff.

redirection of LOC positions to fulfill additional compliance activities was not a redirection of funding—it was an added expense.

The fiscal effect of performing additional, unfunded compliance activities was masked initially. The new Enhancement Plan positions approved by the Legislature took time to fill. In addition, during this time period the department experienced recruitment problems due to salary disparities with similar positions at CDCR. Moreover, DMH has chronic recruitment problems with certain classes.[10] The result of recruitment delays was excess salary savings that temporarily offset the cost of unfunded Enhancement Plan activities.

Salary disparities with CDCR were resolved at approximately the same time as the State started reducing departments' funding to balance its budget.[11] Eventually as DMH's vacancy rates dropped—and therefore its excess salary savings—the combination of budget cut-backs and the unfunded portion of the Enhancement Plan tipped the hospitals into deficit.[12]

Some of the hospitals confirmed that the LTCS division did direct them to eliminate administrative travel and reduce other operating costs. However, according to one hospital it did not get directions in 2010-11 from headquarters to cut costs until June 15. Another hospital reported that it had not received any instruction to stay within budget.[13]

Moreover, the team understands that the division did not share with the Department of Finance the existence of the unfunded portion of the Enhancement Plan when it reported deficits in 2009-10 and 2010-11. At that time, the deficit was described as driven primarily by overtime, without mention of compliance activities that the department undertook on its own authority.

Observations

- ✓ The prior director, according to several senior staff, was focused on the Community Services program and left management of the hospitals to the LTCS division.
- ✓ The LTCS division may have initially acted as administrative intermediary for the hospitals out of necessity, but it appears the division's executive management preferred that arrangement and reinforced this position through restrictive communication protocols.
- ✓ The LTCS senior executive team adopted a management approach to the Enhancement Plan which resulted in a budget deficit but at no time (that the team observed) assumed any portion of the responsibility for that deficit.
- ✓ The LTCS team placed mission before fiscal accountability instead of balancing the two.

[10] See Section 4 for a discussion of DMH's difficulties in filling positions.
[11] Most salaries for *Coleman*-, *Plata*-, and *Perez*-related positions were brought near parity with CDCR in 2007, helping recruitment but reducing excess salary savings.
[12] An additional factor is the extent to which normal operations, such as enhanced observations, acuity staffing, and certain admissions activities are not recognized at all in the budget acquisition process. See Section 7.
[13] LTCS fiscal unit reported that hospitals were asked to prepare 5-10-15% reduction plans several years ago, but that nothing came of these plans.

- ✓ On the other hand, the division and the hospitals believed that failing to comply with the plan would have resulted in court action against the department, with the potential for federal receivership as happened with CDCR.
- ✓ The LTCS senior executives appeared to feel that their fiscal responsibilities vis-à-vis the hospitals deficit were discharged by reporting an impending deficit, requesting funds, and asking the hospitals to reduce expenditures. According to the hospitals, the division did not conduct any formal reduction planning in the last two years or offer alternatives for major program changes to bring resources and mission requirements into alignment.
- ✓ The LTCS senior executives did not divulge knowledge of a major deficit factor (i.e. the Enhancement Plan redirection) from the interim executive office and possibly from the administrative division. That information was also not divulged to the Department of Finance.
- ✓ Poor relationships between the LTCS division and the administrative division had a polarizing influence on senior staff at headquarters.
- ✓ The strain between the LTCS division and the administrative division—and the excessively bureaucratic communication channels—was a factor in the poor relationship between the hospitals and the administrative division.
- ✓ The administrative division did not display adequate knowledge of hospital operations or budgets.
- ✓ The fiscal side of the administrative division failed standards of personal professional accountability. Division senior management failed to report headquarters' category over-expenditures during the year-end closing process. In the team's view, the executives and senior managers in the division had the opportunity to report the extent of these erroneous transactions to the executive office but did not.
- ✓ Hospital executive directors appeared generally competent. The team did not observe evidence of "fiefdoms" or hospitals "out of control."
    - Most administrative systems appeared adequate. However, the team observed unsophisticated fiscal systems in hospitals that are described in other sections.[14]
    - IT systems tend to be "homegrown" in the absence of department-wide systems. See Section 5.
- ✓ Hospitals' connectedness with headquarters appears low.
    - Hospitals lack sufficient presence on the department's senior management team.
    - The hospitals have massive amounts of data, but it has not been organized into a systematic reporting system so that the executive team has relevant information about hospitals on a timely basis. A key factor in this is fragmented IT systems. See Section 5.
    - Written communications are inadequate or poorly organized.
        - The administrative division does not have control of written administrative guidelines to the hospitals and hence relies on oral instructions which are easily misunderstood.
        - The LTCS division has a "special orders" process that several hospitals reported as difficult for information retrieval.

[14] The team did not verify hospitals' compliance with the Office of State Audits and Evaluations' 2008 internal control audit.

- Hospital input on administrative policies and procedures is not routinely solicited. The medical staff reports a similar problem relative to special orders.

✓ Hospitals see the administrative division as uninformed about hospital operations, complicit in poor processes and systems, and disrespectful of hospital administrative skills.[15] The team directly observed interactions and analyzed processes which supported the hospitals' views. (See Section 4 on weak administrative processes.)

✓ Hospitals felt they had no option but to conform to management direction that resulted in deficits. Some reported raising the issue repeatedly to the LTCS division to no avail.

Conclusions

✓ Headquarters has lacked effective leadership, teamwork and communications, particularly as it relates to fiscal control. Changes in senior executives and managers are starting to break this cycle, but attitudes that act against transparency and teamwork may take time to change.

✓ The management team lost perspective: the director was focused on the community services program; the LTCS division management was preoccupied with one facet of its mission (Enhancement Plan), placing it before other considerations (the budget); the administrative division placed control above service, and operating with little knowledge of hospitals and without direct lines of communication, succeeded with neither.

✓ The divisions did not share information fully. LTCS division management did not disclose to the new executive office the massive redirection of positions into the Enhancement Plan; the administrative division concealed headquarters' category overexpenditures.

✓ The hospitals have been sequestered from full participation in the management of the department.

✓ Hospitals do not have the benefit of functional guidance from headquarters in multiple areas, administratively and programmatically.

✓ Hospitals do not have the benefit of shared systems. The responsibility for this lies with headquarters which failed to provide those systems and in some cases blocked the hospitals from sharing theirs with each other.

✓ Lack of regular, structured management reporting to the executive office leaves that office feeling disconnected with its hospitals and programs. The hospitals experience that problem in reverse.

Recommendations

➢ The executive leadership must articulate and continually reinforce performance standards of personal responsibility and openness.

➢ Modify senior management duty statements to add specific responsibilities for fiscal and internal controls.

➢ Increase the hospitals' presence on the senior management team.

➢ Revise the deputy director structure by adding a deputy director of operations to whom the executive directors report. This deputy director should have the specific mandate of raising

[15] It is important to note that every hospital identified individual headquarters staff members who were helpful. However, the assessment in the aggregate was that headquarters was *not* helpful.

to the executive office any conflicts between hospitals' mission requirements and budget realities, and devising plans to resolve such conflicts. Appendices 2.A and 2.B show the existing and proposed deputy director structure with possible functional responsibilities for the deputy director of operations. Appendix 2.B also includes a proposed clinical deputy director that is discussed in Section 3 (Organizational Assessment) and Section 6 (Medical Issues).

- Remove communication barriers between headquarters' divisions and between headquarters and the hospitals.
    - Address poor service orientation at headquarters.
    - Develop a cohesive body of policies and procedures, ensuring hospital input.
    - Develop a plan for structured sharing of management information between levels of the organization. Although IT is key to that goal, lack of department-wide information systems should not prevent instituting regular management reporting.
    - As the budget permits, reinstitute meetings between organizational levels of the department. Hold these meetings at hospitals whenever practical so that headquarters managers and staff members have the opportunity to learn the hospital mission.