Section 8: Other Issues

This section addresses headquarters' category over-expenditures, strategic planning, mission observations about Metropolitan SH, and hospitals' special repairs needs.

Headquarters' Category Over-expenditures

In meetings with the accounting and budgeting offices in July, the team learned that those offices, with the knowledge of (prior) division leadership, had moved expenses between categories of Item 440-001-0001 to facilitate the 2010-11 year-end closing. Reportedly similar adjustments had been made in previous years. At that time the 2010-11 year-end statements for the headquarters' appropriation had already been submitted to the State Controller's Office. At the direction of the executive office, one of the team's accountants undertook an analysis of the expenditure transfers with the aim of resubmitting the year-end statements manually, reversing incorrect transactions. The following summarizes actual appropriation status:

Observations

- ✓ 4440-001-001 ended the year with category over-expenditures that totaled $9.4 million in programs 20 (Long Term Care) and 35 (Administration). In contrast, program 10 (Community Services) had a surplus of $14.2 million. See Appendix 8.A for summary.
- ✓ Other federal funds and special funds were over-expended by $576,870.
- ✓ To correct the problem and close properly, the department sought permission from the Finance to do the following:
    - Reverse a prior budget revision which unscheduled budgeted reimbursements, and reschedule those funds for expenditure. Reimbursement authority was raised by $4 million to reflect all Medi-Cal reimbursements received from the Department of Health Care Services. (The other half of the adjustment was to program 10). The authority for this revision is Control Section 28.50 of the Budget Act of 2010. Background: The reimbursement schedule was reduced in April 2011 by $4 million to reflect estimated reimbursement revenue and generate cash for payroll. Actual revenue (determined by rates and number of claims) came in higher than their estimates. Total unscheduled reimbursements were $4,326,259.
    - Move $8 million in expenditure authority from program 10 to program 20. The authority for this change is in Item 4440-001-0001, provision 2, of the 2010 Budget Act. Background: Program 20 expenses exceeded authority due to increased Sex Offender Commitment Program evaluation workload generated by CDCR. Claims are still coming in.
    - Move $2.5 million in expenditure authority from program 10 to program 34 in Item 441-001-0001 (with a corresponding change to distributed administration.

The authority for this change is Control Section 26.00 of the 2010 Budget Act. It is the team's understanding the problem has been resolved with Finance.

- In addition, these reports to Finance were made:
    - Expenditures for two federal grants (Projects for Assistance in Transition from Homelessness and Substance Abuse and Mental Health Services Administration grants) exceeded authority by $97,167 in Item 4441-001-0891 and were charged to Item 4440-001-0001, program 10 (General Fund).
    - Expenditures in the Licensing and Certification Fund, Item 4440-001-3099 exceeded authority by $479,703 and were moved to Item 4440-001-0001, program 10. Fund 3099 collects fee revenue for state-mandated licensing functions in Mental Health Rehab Centers and Psychiatric Health Facilities.
- The team did not analyze program impacts in 2010-11 or review possible implications for headquarters' 2011-12 appropriation.
- The team commented on the original transfers in Section 3 of the report, noting that the accounting office management, budget office management, and division leadership failed in a primary fiscal responsibility by moving expenses at year-end without correct authorization. In some cases there was no point in these actions since notification to Finance would have sufficed to authorize the movement of expenditure authority.

Conclusions

- ✓ The method of resolving over-expenditures for programs 20 and 35 depended in part on excess funds from program 10, which is moving out of DMH this year.
- ✓ Ultimate responsibility for incorrect resolution of category over-expenditures appears to reside with division executive managers, although accounting and budget office senior management failed their fiscal responsibility as well.
- ✓ Reluctance to bring problems forward obstructs fiscal accountability in a department.
- ✓ The executive office is responsible for setting the right management tone in the department for accountability.

Recommendations

- ➢ New division leadership must require the accounting and budget offices to demonstrate appropriate fiscal management, including the reporting of problems for correct resolution.
- ➢ The executive office needs to encourage the reporting of problems and error throughout the department.

Strategic and Business Planning

Observations

- ✓ **Problems that might be addressed through strategic and business planning**. This project identified key issues that can serve as the basis for a strategic planning process.
    - The executive office identified the budget deficit and violence as the two major problems facing the hospitals. The 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.
    - 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, perceiving some disconnection from other facilities; and for one hospital (Metropolitan SH), worry about its declining population and long-term mission (see the discussion on Metropolitan SH later in this section.)
    - 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; inattention from headquarters; 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 the lack 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 workplace; and misalignment of medical work with classifications.
    - The team concurred with the problems above and identified additional issues: lack of management support for cost-consciousness and fiscal accountability; poor 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 simplistic implementation of the accounting system resulting in the inability to collect necessary cost data.

- ✓ **Current status of strategic and business planning**.
  - The department currently does not have a business plan for addressing inputs to mission performance.
  - The department has a LTCS strategic plan that can be located on its webpage. This plan provides statements on the hospital mission, vision and core values. It lists 12 key processes summarized below:
    - **Ethics, rights and responsibilities**: The goal is to respect patients' civil rights. The objectives tie to process identification.
    - **Provision of care, treatment and services**: The goal is to provide patient services using a recovery model based on assessed needs. The objectives tie to development of reports, policies, processes, and guidelines.
    - **Medication management**: The goal is improve outcomes through medication and treatment that is evidence based. Objectives are manuals and updates of special orders.
    - **Improving organizational performance**: The goal is system-wide approach to processes and performance measurement. The objectives tie to reports, training, manual revisions, trend analysis on specific issues, clarification of specified roles, and establishment of procedures.
    - **Leadership**: The goal is to be recognized as among state and national leaders in mental health. A secondary goal relates to a specific risk assessment tool for sex offenders. Objectives tie to updating documents, providing training, and standardizing hospital bylaws.
    - **Management of the environment of care**: The goal is to provide safe infrastructure for the hospital system. A secondary goal relates to providing smoking cessation support. Objectives tie to updating or developing reports and analyzing space needs for medical records.
    - **Management of human resources**: The goal is to have competent staff in place, properly organized, and following the program's stated values. A secondary goal is to bring psychosocial rehabilitation training to the hospitals. Objectives tie to sharing hospital hiring lists and creating an equal employment opportunity manual.
    - **Management of information**: The goal is to use information technology to support the hospital mission. The objectives tie to processes, charter development and other documentation, reorganization to match control agency requirements, and development of a feasibility report for electronic health records.
    - **Surveillance, prevention and control of infection**: The goal is to decrease the risk for the spread of infectious diseases in the hospitals. The objective is to develop a statewide policy with procedures.
    - **Security**: The goal is to improve internal and perimeter security to protect patients, staff, and communities. The objectives relate to

updating special orders, identifying necessary equipment and purchasing it, analyzing training requirements, and annually auditing safety equipment.
    - **Investigations**: The goal is timely, solid investigations. The objective ties to updating policies and manuals.
    - **Management of fiscal resources**: The goal is to provide continuous improvement of fiscal systems, processes and reporting requirements. The objectives tie to a contracting manual and draft legislation for rate caps for outside medical providers.

✓ **Discussion of LTCS strategic plan versus identified problems**.

- Although some of the goal titles would appear to address the problems identified through team interviews, in substance there is a significant mismatch in level of focus. The strategic plan does not clearly address (or in some cases at all) the main problems reported: the divergence between mission expectations and the budget; concerns about a safe work environment; the unintended consequences of the Enhancement Plan such as the loss of interaction with patients and the loss of focus on the forensic mission; the extent of recruitment problems and other workforce management issues; and the communication and leadership gap between headquarters and the hospitals.
- The format of the objectives is more suited to an action plan than a strategic plan. Moreover it is not possible to tell why the objectives listed are the most important in meeting the goal, or why the goals listed are the most important for meeting the mission statement.
- The State has a Performance Management Council and online training resources through the Department of Personnel Administration to guide effective development of strategic plans. These sources suggest:
    - Core values should describe ideal characteristics that are critical to achieving the department's vision. Keeping the description of key values clear and concise helps in conveying meaning to the audience.
    - Goals should be specific, measureable, attainable, relevant, and time-bound. Goals should represent the department's long-term priorities.
    - The plan should provide a basis for budgetary priorities. It should be a guide to future budget requests and allocation of resources.
    - A department should choose relevant performance measures from exiting data to evaluate progress on strategic planning and operational integration activities.
    - The department should regularly review strategic planning progress and make changes as needed (objective dates in the current DMH report are from 2010).
    - There must be strong executive leadership in order for the plan to be successful.

Conclusions

- ✓ Now would be a good time to review and update the strategic plan, as DMH prepares to transition to a state hospital department.
- ✓ The strategic plan is the department's public statement about its direction. The department's current strategic plan does not adequately frame or address the range of problems facing the department or provide a rationale for what the best goals and objectives should be in addressing those problems.
- ✓ Some of the problems identified might be best addressed in a business plan.
- ✓ The strategic plan would benefit from following guidelines promulgated by the Performance Management Council.

Recommendations

- ➢ Update the strategic plan and consider developing a business plan that focuses on mission inputs.
- ➢ Ensure that the department's primary challenges are the focus of the plans. Consider reassigning some of the current objectives in the strategic plan to an action plan.
- ➢ Use the strategic and business plans as primary sources of communication with not only the mental health community, but also with patient families, the Administration, the Legislature, the DMH workforce, and other stakeholders such as the department's provider and vendor network. Make sure the plans are readable for the average citizen.

Metropolitan SH's Future

In the team's visits to the hospitals, Metropolitan SH stood out because of declining population, aging facilities, and community restrictions that made addressing its use challenging. The report includes the following comments about Metropolitan SH because it appears to be at a crossroads.

Observations:

- ✓ Metropolitan SH continues to experience a downward trend in population associated with the reduction in Lanterman-Petris-Short (LPS) admissions.[1] In October 2006, the census was 710. By August 2011 the census had dropped to 609, representing a 14 percent reduction over the six-year period.
- ✓ The LPS population is also declining system-wide, while the number of forensic commitments is increasing.
- ✓ An exclusionary criteria agreement between Metropolitan SH and community agencies limits the types of individuals eligible for admission to the facility to low and medium security risks. Specifically, individuals may not be admitted to the hospital who are

[1] LPS patients are committed through the courts to DMH county beds through civil proceedings.

convicted of, or having charges pending for, murder, mayhem, and certain sexual crimes, or who are considered at risk of escaping. Currently, the agreement does not limit the number of penal code individuals admitted to the hospitals SNF.

- ✓ Metropolitan SH currently has the highest average cost per patient in the hospital system (see Section 7). The hospital believes its average costs stem in part from a smaller patient caseload over which to spread its fixed costs.
- ✓ Metropolitan SH facilities are underutilized, leaving room for new admissions.
- ✓ The hospital is optimally located near many universities, medical facilities, and other partners and resources.
- ✓ Metropolitan SH and Napa SH are the only DMH facilities licensed for SNFs. Individuals meeting SNF acuity criteria in other state hospitals are currently being treated in outside medical facilities. Their medical needs increase outside medical care costs for hospitals without SNF units.
- ✓ Metropolitan SH currently utilizes telepsychiatry with a local university.

Conclusions

- ✓ Increasing the hospital's caseload should reduce its average cost per patient.
- ✓ Overall, by developing key local partnerships Metropolitan SH may have the capacity to provide services to DMH facilities statewide. These services may result in both short- and long-term cost savings.
- ✓ The current budget situation provides the State with the opportunity to develop the hospitals' role, especially given its location and unused capacity.
- ✓ There may be benefits to the surrounding community from allowing the hospital to expand its mission while still serving a low- to medium-risk population.

Recommendations

- ➢ Address Metropolitan SH's underutilization.
- ➢ Explore the option of using Metropolitan SH as the single DMH SNF site providing services for individuals who qualify for SNF services. The team understands the hospital has developed a proposal with these goals and considerations:
  - DMH would work with the community to ensure that Metropolitan SH continues to serve the lower and medium risk patients treated in the state hospitals. The exclusionary criteria would need to be discussed with local, county and state officials in order to ensure that the hospital's plans meet the community's interests.
  - Provide economic benefits for the surrounding areas in the form of jobs and increased business for local vendors.
  - Require capital outlay to meet current federal fire, life and safety requirements, such as renovation of the sprinkler system.
  - Result in cost savings. For example, 1) Napa SH would no longer need facility funding for improvements required for its SNF; 2) more in-system SNF care would reduce outside medical costs; and 3) concentrating SNF patients at Metropolitan SH would improve overall census and bed utilization management. At the time of this report, the hospital was verifying fiscal impacts.

- Explore the possibility of creating a telemedicine hub at Metropolitan SH. The hospitals' location near large metropolitan areas with multiple universities and hospitals increases the number of clinical specialists available.
  - In addition to using civil service and outside provider consultants, the hospital can use interns and residents to increase the pool of expertise made available to the other hospitals via telemedicine.
  - This strategy could also benefit the local community by providing jobs and increased demand for local vendors' services.
- Expand the Residency and Medical Forensic Fellowship Programs at the hospital and require a work commitment at a DMH hospital where recruitment has been difficult.
- Metropolitan SH also has the space to serve as a central training center for the other hospitals (e.g., forensic training, continuing education, or hospital police officer training).

Special Repairs

The team did not have the opportunity to address a significant need in the department: capital outlay planning and an assessment of infrastructure needs. Therefore, this section is limited to presenting a listing of the backlogged special repair needs by hospital and recommending that a facilities needs assessment be conducted. Many of the department's facilities are quite old and need constant upkeep. For several years the State has been unable to provide funding except for critical fire/life/safety projects. The backlog of projects is summarized below. A complete project listing is in Appendix 8.B.

Table 8.1: Unfunded Special Repairs Summary

Hospital	Cost Estimate
Atascadero SH	$ 4,628,512
Coalinga SH	$ 284,005
Metropolitan SH	$ 9,229,477
Napa SH	$ 4,656,000
Patton SH	$ 3,947,706
TOTAL	$ 22,745,700