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Improved Budgeting For the Department of State Hospitals

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Senate Budget Subcommittee No. 5 on Public Safety
Hon. Loni Hancock, Chair

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Overview of the Department of State Hospitals (DSH)

☑ ***Facilities.*** The Department of State Hospitals (DSH) provides inpatient behavioral health services at five state hospitals and three prison-based psychiatric programs.

☑ ***Patient Classifications.*** Patients at DSH are either civil commitments or forensic commitments. Civil commitments are referred by counties. Forensic commitments are typically referred by the courts and include state prison inmates, as well as individuals classified as incompetent to stand trial, not guilty by reason of insanity, mentally disordered offenders, or sexually violent predators. Currently, about 92 percent of the DSH patient population are forensic commitments.

☑ ***Proposed Budget.*** The Governor's budget for 2015-16 proposes about $1.7 billion for DSH, including about $1.6 billion from the General Fund. The budget assumes that the department will maintain about 7,200 beds at an average cost of almost $230,000.

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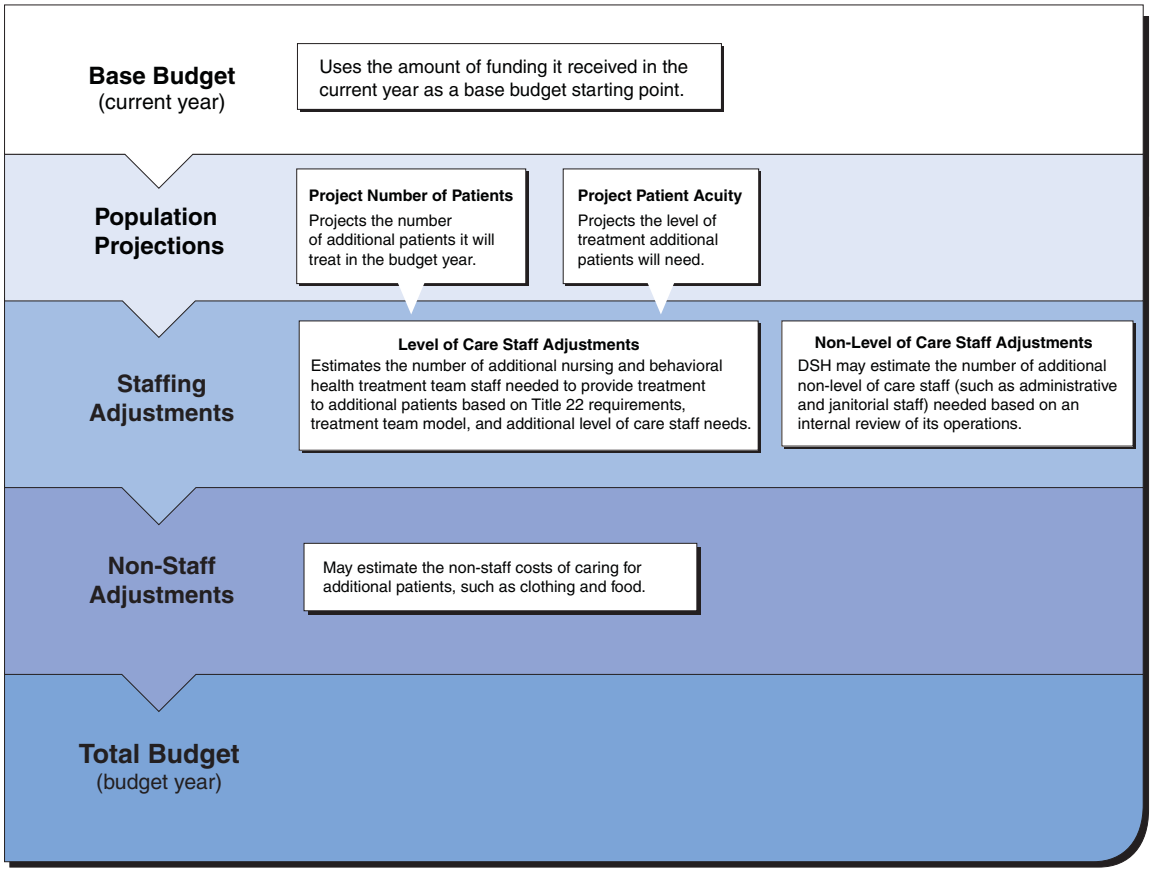
How DSH Develops Its Annual Budget Request

How the Department of State Hospitals Builds Its Budget Request



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How DSH Develops Its Annual Budget Request *(Continued)*

☑ Base Budget

- In developing its budget-year request, the department uses the amount of funding it received in the current year as a base budget or starting point. This includes total funding to treat DSH patients, including staff and non-staff costs.

☑ Population Projections

- The DSH projects the number of patients it will treat in the upcoming fiscal year. Based on the expected change from the current year, DSH estimates how many beds it needs to request.
- The department classifies patients as needing one of three levels of care (called acuity levels). Because acuity levels affect costs and staffing, DSH must estimate the acuity levels of any additional patients in the budget year.

☑ Staffing Adjustments

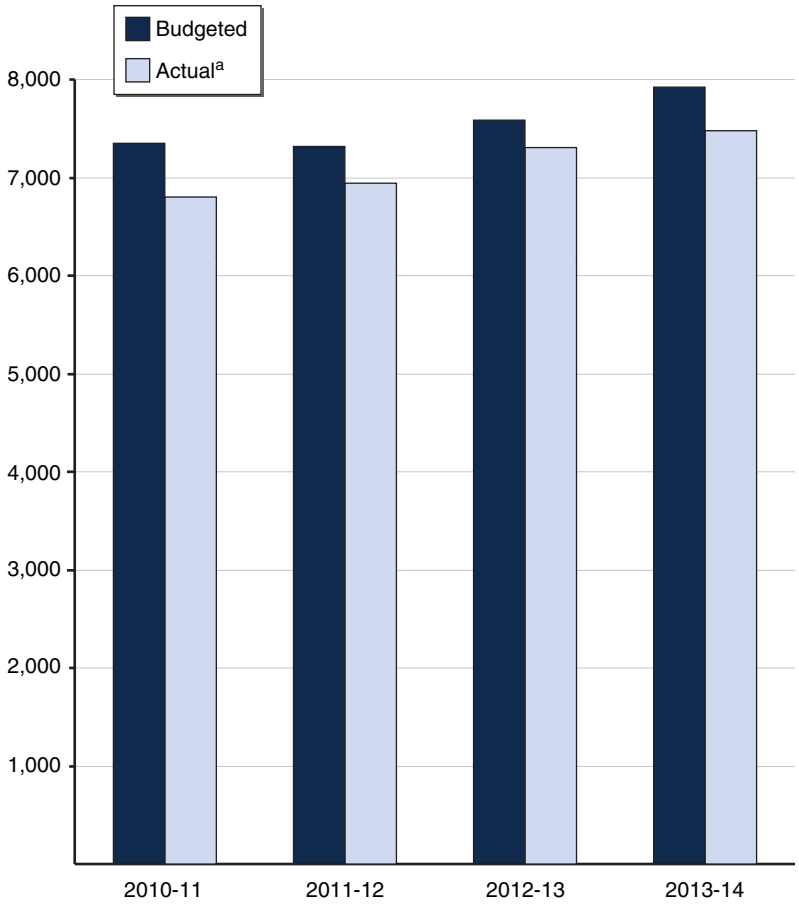
- Level of care staff provide treatment services to DSH patients. When DSH requests adjustments to these staff, it generally considers (1) Title 22 of the California Code of Regulations (minimum number of nursing staff based on patient acuity) and (2) the DSH treatment team model (number of patients a group of clinicians can treat). The department also sometimes requests additional staff for certain services.
- The DSH also sometimes requests adjustments for a variety of other staff (referred to as non-level of care staff), including nonbehavioral health clinicians and administrative staff.

☑ Non-Staff Adjustments

- While DSH's annual budget requests are typically limited to the staffing related adjustments, the department sometimes also requests adjustments for non-staff costs such as clothing, food, and facility costs.

Bed Vacancy Rate Has Been High in Recent Years

DSH Budgeted Population Exceeds Actual Population



[a] Population reflects the annual average daily population, excluding patients on temporary leave.

DSH = Department of State Hospitals.

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Bed Vacancy Rate Has Been High in Recent Years *(Continued)*

- The number of patients that DSH actually treats relative to the number of patients it is funded to treat is known as the bed vacancy rate. The DSH has consistently maintained several hundred vacant beds in recent years. In December 2014, DSH had nearly 600 vacant beds.

- About one-third of the department's vacant beds are reserved for patients who are expected to return to the facility, such as those patients out to court. Currently, it is difficult to determine what factors account for the remaining two-thirds of the bed vacancies, but certain flaws in the department's budgeting process could be a factor.

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Department Staffing Needs Unclear

☑ **Level of Care Staffing Model Does Not Account for Certain Workload**

- The department's level of care staffing model has not been updated to account for all of the services the department provides.
- As a result, it is possible that the department is redirecting staff from beds for which it is funded in order to provide services that it is not funded for.

☑ **Actual Staffing Exceeds Title 22 Requirements and Treatment Team Staffing Model**

- We found that the department employed about 2,200 more staff than required under Title 22 and DSH's own staffing model. This suggests that the department's level of care staffing ratios are no longer useful.

☑ **Independent Audits Identified Concerns With Level of Care Staffing**

- In May 2014, an audit found that care was widely inconsistent, often nontherapeutic, and did not include certain types of treatment, even when patients clearly required such treatment.
- In 2008, an audit cited concerns that clinical staff were performing administrative functions. It noted that shifting this workload to nonclinical staff could reduce costs. It also found that DSH was redirecting savings from its staffing budget to cover deficiencies in its operations budget.

☑ **Staffing Needs Have Not Been Independently Reviewed**

- Despite the above concerns, the department's staffing needs have not been independently reviewed to assess whether the current staffing levels are appropriate.

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Budgeting Methodology Creates Poor Incentive Structure

☑ Budget Process Creates Fiscal Disincentive for DSH to Fill Vacant Beds

- The department's budget is not typically adjusted to reflect its actual patient population, including the number of vacant beds. As a result, most of the funding tied to the unutilized capacity (such as for staff, clothing, and food costs) is generally not reverted to the General Fund.
- Because the department's budget is not typically adjusted based on the actual population, it has no fiscal incentive to ensure that all its beds are filled.
- This incentive to maintain vacant beds is further compounded by the workload that the department is not funded for, since it can redirect staff associated with the vacant beds to support this workload.

☑ Facilities Have Incentive to Overestimate Patient Acuity

- According to DSH, facilities receive additional funding and staff if they expect to have an increase in high acuity patients.
- Since the additional funding is not adjusted for actual patient acuity, there is an incentive for facilities to overestimate the needs of their patients, which can result in the department spending more than is necessary to treat its patients.

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Other State Departments Have More Effective Budgeting Practices

☑ ***Independent Staffing Analysis.*** The federal Receiver overseeing inmate medical care, recently contracted for an independent review of the prison medical care staffing model. This included a review of staff responsibilities, patient acuity, the volume and variety of services provided, facility–specific factors (such as proximity to community hospitals), and other factors.

☑ ***Ratio-Driven Level of Care Staffing.*** Based on the above analyses, the Receiver now uses a ratio–driven staffing model. Under the model, the Receiver estimates inmates' medical acuity based on the projected inmate population and uses staffing ratios to determine staffing levels.

☑ ***Non-Level of Care Staffing.*** The state's Division of Juvenile Justice (DJJ) also contracted with an independent consultant to develop a new staffing model, including a model for non-level of care staff. The DJJ now adjusts non-level of care staff annually based on changes to the population or facilities.

☑ ***Adjustment for Actual Population and Acuity.*** The Receiver's office biannually reviews its population for differences between the estimated and actual inmate population and estimated and actual inmate acuity. Based on that review, the Receiver's budget and staffing levels are adjusted biannually.

☑ ***Validation of Acuity Designations.*** The Receiver uses a quality control process to ensure that inmates are appropriately assigned to an acuity level. This ensures that the process by which inmates are assigned to acuity levels is accurate and consistent.

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LAO Recommendations: Redesigning DSH's Budget Process

☑ **Validate Patient Acuity Model**

- Recommend DSH contract for an analysis of its patient acuity model to ensure the model is up-to-date and reflects patients' treatment needs.
- Recommend DSH establish an ongoing process to control for the quality of how it designates patient acuity

☑ **Update Staffing Methodology and Establish a Standardized Non-Staff Cost**

- Recommend DSH contract for independent analyses of its level of care and non-level of staffing to establish a ratio-driven staffing process that provides the appropriate number and type of staff needed to deliver care efficiently and effectively.
- Recommend DSH also establish a standardized per patient, non-staff cost estimate.

☑ **Make Adjustments Based on Actual Population and Acuity**

- Recommend DSH biannually provide updated information comparing its current-year actual patient population by acuity level to the levels assumed in the budget so that the budget can be adjusted based on the updated information.

☑ **Require Additional Information in Short Run**

- Recommend that in the interim DSH provide additional information to justify any population-driven budget requests, such as the size and acuity of the patient population and the staffing ratios used for patients of each acuity level. The department should also provide justification when any of the proposed staffing exceeds its staffing ratios.