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June 8, 2012

To: Supervisor Zev Yaroslavsky Chairman
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From: William T Fujioka
Chief Executive Officer

PSYCHIATRIC EMERGENCY SERVICES DECOMPRESSION PLAN (BUDGET DELIBERATIONS, AGENDA OF JUNE 25, 2012)

On April 17, 2012, the Board instructed the Chief Executive Officer to: provide a report back with a financing plan for a prioritized psychiatric emergency services decompression plan to be considered as part of the Board's adoption of the Fiscal Year (FY) 2012-13 budget; include Harbor-UCLA Medical Center in the report to know what this medical center is doing to ease adolescent overcrowding at that facility; and include the anticipated capital and operating costs of any replacement plan for the psychiatric urgent care facility.

BACKGROUND

Psychiatric Emergency Services (PES) are designed to quickly assess emergencies and produce one of three outcomes: 1) resolve mental health issues; 2) stabilize and refer for outpatient follow-up; or 3) admit to acute inpatient psychiatric care. Patient census at each of the three County hospitals offering PES, Harbor-UCLA Medical Center (Harbor), LAC+USC Medical Center (LAC+USC), and Olive View Medical Center (OVMC), regularly exceeds 20 per hospital and in peak periods can reach or exceed 30 for a total of 60 - 90. These numbers reflect overcrowding at the PES as the total current licensed bed capacity at the three County hospitals is 39 (15 at Harbor, 12 at LAC+USC, and 12 at OVMC).

To help address this overcrowding issue in recent years, Department of Mental Health (DMH) was provided with $9.3 million earmarked for PES decompression, which DMH focused and invested in eight programs/areas, including: Psychiatric Urgent Care Centers; Psychiatric Diversion Program; Institutions for Mental Disease (IMD) programs and services, and an array of crisis residential and emergency shelter beds. DMH currently contracts for a total of 220 State Hospital Beds, 775 IMD beds, 417 IMD Step-Down beds, 105 Short-Doyle beds, 13 Psychiatric Diversion Program beds, and 34 Crisis residential beds at any given time.

Despite these efforts, the unmet needs for psychiatric emergency services contribute to PES overcrowding.

FINDINGS

The Department of Health Services (DHS) and DMH conducted an extensive assessment of their existing operations, and identified several strategies to address the problem. As a result of such efforts, the departments developed a report entitled, Addressing Overcrowding of Psychiatric Emergency Services in Los Angeles County [(PES Plan), refer to Attachment I for Executive Summary Recommendations]. The report focuses on reducing the inflow of patients into the PES, accelerating the discharge of patients from the PES, and ensuring that current PES facilities are adequate.

The departments are commended for their critical review and innovative approach in addressing this issue. The recommendations do not simply request additional funding for new inpatient beds. Instead, DHS and DMH reviewed their existing service delivery models and determined that: 1) substantial progress can be made by improving existing processes and addressing operational inefficiencies; and 2) the most effective use of additional funds would be to add capacity in lower levels of care, either on the front-end in the form of Urgent Care Centers (UCCs) or on the back-end in the form of acute diversion units, crisis residential facilities, or IMD Beds/IMD-Step Down Beds.

A total of 28 recommendations were identified in the following three categories.

Category	Process Improvement	System Capacity
Reduce the inflow of patients into the PES	8	6
Accelerate the discharge of patients from the PES	8	2
Ensure adequacy of existing PES facilities	0	4
TOTAL	16	12

OVERVIEW OF PES PLAN

DMH and DHS will continue implementing process improvement efforts to alleviate PES overcrowding. These include various operational initiatives and policy changes, Phase I, require no cost or minimal expense to implement.

Twelve recommendations of the PES Plan that are primarily intended to enhance the capacity of the system, or Phase II, require identification and commitment of new funding and the departments were asked to develop a set of priorities and estimated costs. Phase II will focus on the most urgent system capacity needs and will enhance capacity building at: OVMC-ER and Urgent Care, MLK-Augustus Hawkins, inpatient beds, and IMD/IMD step down beds (Attachment II). In addition to the program components with estimated costs, Attachment II also lists the Departments' recommended priorities. In some cases, components were inextricably linked so that one component could not be implemented without the simultaneous implementation of another program component. In those circumstances, the same priority was assigned, item 4.1 and 4.2.

Phase III will focus on the remaining capacity building components of the PES Plan. As one example, Harbor and LAC+USC would benefit from dedicated space to serve pediatric and adolescent psychiatric patients. Harbor plans to renovate a portion of its current Emergency Department, once vacated, to create this space; funding for this proposal will be submitted with the larger backfill budget at a later date. LAC+USC is currently evaluating a set of options for creating this space and, once the optimal solution and budget is determined, a funding proposal will be submitted through the regular budget process.

Given the County fiscal constraints, the Departments were also asked to make every effort to identify funding resources. In conducting the requested analysis, DMH identified several PES Plan components that are consistent with the Department's approved Mental Health Services Act (MHSA) Community Services and Supports (CSS) plan and are potentially eligible for this funding (Attachment II). As all current ongoing CSS funds are fully allocated, DMH has proposed to use a portion of the MHSA Prudent Reserve over a two-year period beginning in FY 2012-13 in order to initiate implementation of Phase II as soon as possible. Based on projections of future MHSA funding it is anticipated that revenues will increase over the next two years allowing the initial investment of one-time reserve funding to be fully sustainable by FY 2014-15. However, several PES Plan-Phase II components, OVMC-ER Renovation, inpatient beds, IMD beds, and certain positions are not eligible for MHSA funding (Attachment II).

RECOMMENDATIONS

As previously noted, the Departments are strongly commended for their critical review and thorough assessment of the current processes. As a result, process improvements have been identified and they are moving forward with these changes – Phase I of the PES Plan which require no cost or minimal expense to implement. Under Phase II, 12 capacity-building investment items requiring funding have been identified, along with the top eight priorities and associated cost estimates have been provided. Phase III will include the four remaining capacity-building investment items and costs estimates have not yet been determined. Furthermore, DMH has identified MHSA funding that can be utilized to mitigate some of the estimated costs for Phase II over the next two years:

Item	FY 2012-13	FY 2013-14
Phase II Costs	$ 13,300,000	$ 13,200,000
MHSA Funding – Prudent Reserve	3,900,000	$ 7,800,000
Balance – Net County Cost (NCC) Request	**9,400,000**	**5,400,000**

Although Board action is not require at this time to proceed, we recommend the following:

1. Support DHS and DMH's PES Plan, specifically the continued implementation of Phase I – which involves 16 process improvements that require no cost or minimal expense to implement;

2. Support Phase II of the PES Plan at an estimated cost of $13.3 million, partially offset by the use of MHSA Prudent Reserve monies, estimated at $3.9 million. Based on projections of future MHSA funding it is anticipated that revenues will increase over the next two years allowing the initial investment of funding to be fully sustainable by FY 2014-15; and

3. Defer the request to utilize NCC funding, estimated at $9.4 million for FY 2012-13 and $5.4 million for FY 2013-14, until the Supplemental Budget, at which time the full impact of the State's budget actions will be known.

If you have any questions regarding this matter, please contact Sheila Shima at (213) 974-1160.

WTF:SAS:MLM
VLA:hd

Attachments

c: Executive Officer, Board of Supervisors
County Counsel
Health Services
Mental Health

060812_HMHS_MBS_PES Decompression Plan

ATTACHMENT I

PSYCHIATRICT EMERGENCY SERVICES

SUMMARY RECOMMENDATIONS

DEPARTMENT OF HEALTH SERVICES
and
DEPARTMENT OF MENTAL HEALTH

June, 2012

EXECUTIVE SUMMARY

The Psychiatric Emergency Services (PES) census in Los Angeles County frequently exceeds the intended capacity. This is due to both the overall high volume of patients who come to the PES for evaluation and management as well as the challenges LA County faces in efficiently moving patients through inpatient and outpatient systems of care. Overcrowded conditions contribute to security and privacy concerns, but also importantly detract from the therapeutic milieu that is needed to de-escalate distressed or agitated patients in the PES.

To address PES overcrowding and privacy concerns, the Department of Health Services (DHS) and the Department of Mental Health (DMH) have developed the following summary recommendations detailed below. Notably absent from these recommendations is a request for substantial additional funding for new inpatient beds. It is DHS' and DMH's strong belief that: 1) substantial progress can be made by improving existing processes and addressing operational inefficiencies; and 2) the most effective use of additional funds would be to add bed capacity in lower levels of care, either on the front-end in the form of Urgent Care Centers (UCCs) or on the back-end in the form of acute diversion units, crisis residential facilities, or IMD/IMD-step down beds.

SUMARY RECOMMENDATIONS TO ADDRESS PES OVERCROWDING

A. Reduce the inflow of patients into the PES

Process improvements

1. *Engage with LPS-designated individuals, including peace officers, as a means of encouraging appropriate utilization of 5150 holds and promoting understanding of the range of potential destinations to which patients on holds may be transferred.*
2. *As resources permit, expand the Psychiatric Diversion Program to more frequently allow carefully selected patients direct admission to inpatient acute psychiatric beds.*
3. *Continue efforts to establish a Unique Patient Identifier within DHS and a County Master Patient Index that will facilitate information- and data-sharing efforts within DHS and between DMH and DHS.*
4. *Explore opportunities to further invest in intensive case management programs for individuals that frequently utilize the PES.*
5. *Work with DPH to streamline access for PES patients into substance abuse rehabilitation programs.*
6. *Continue to investigate supportive housing opportunities.*

7. *Further investigate financial, operational, and clinical implications of creating a 23-hour holding unit for DCFS children within the integrated pediatric service network at LAC+USC – the Children's Village.*

8. *Continue to monitor trends in PES utilization by AB109 releasees and, in collaboration with CDRC, develop strategies to divert inappropriate visits as needed.*

Facility/programmatic investments

9. *Maximize use of Olive View Urgent Community Services Program by obtaining LPS designation.*

10. *Investigate feasibility of expanding operating hours of the Olive View Urgent Community Services Program to 24/7.*

11. *Consider expansion of Urgent Care Center model to DHS hospital campuses as master plans for MLK and Harbor permit.*

12. *Evaluate optimal use of vacant 5-bed unit at Augustus Hawkins, including option of staffing unit to hold Probation adolescents.*

13. *Consider programmatic changes to further meet the needs of incarcerated youth with developmental delays and/or serious behavioral issues.*

14. *Continue to investigate financial and operational implications of creating a 24-hr acute stabilization unit and a "Step-down" intensive day-treatment program at a Probation or post-adjudication facility.*

B. Accelerate the discharge of patients from the PES

Process improvements

15. *Increase DMH liaison activities in the PES; as resources permit, assign additional dedicated liaison staff.*

16. *Expand DMH DCFS mental health liaison presence to LAC+USC.*

17. *Work with DCFS to investigate means of better coordinating care for children/ adolescents requiring psychiatric treatment (e.g., single DCFS liaison as point of contact for children/adolescents in the PES).*

18. *Increase education of mental health inpatient and PES staff to more rapidly discharge patients to open community-based facilities.*

19. *Expand use of selected tools and processes that may reduce interfacility variation in clinical practice patterns within the PES and inpatient units.*

20. *Address operational issues that delay timely throughput of patients through the PES and inpatient units.*

21. *Develop Post-hospitalization Placement Problem Committee to expedite placement of inpatients no longer requiring acute inpatient hospitalization for whom a disposition is not easily forthcoming.*

22. *Monitor progress on placing "difficult to place" patients through systematic data collection efforts.*

Facility/programmatic investments

23. *Continue to pursue Request for Information regarding development of a joint DHS/DMH SNF contract.*

24. *Based on the availability of funds, consider additional investment into community-based residential facilities such as crisis residential beds and acute diversion units.*

C. Adequacy of existing PES facilities

25. *Amend plans to backfill current Harbor ED to include a dedicated pediatrics/adolescent psychiatric unit adjacent to the existing PES.*

26. *Continue to investigate options to decrease overflow of adult psychiatric patients from the PES into the medical ED [at LAC+USC].*

27. *Complete financial analysis of creating pediatric crisis stabilization unit in LAC+USC PES.*

28. *Weigh priority for Olive View PES replacement/renovation project in relation to other proposed capital plans within DHS.*

ATTACHMENT II

COUNTY OF LOS ANGELES
PSYCHIATRIC EMERGENCY DECOMPRESSION PLAN - ESTIMATED COSTS
FISCAL YEARS 2012-13 AND 2013-14
JUNE 6, 2012

($ in Millions)

Phase II Components	2012-13 DHS	2012-13 DMH	2013-14 DHS	2013-14 DMH
1. ** Olive View-UCLA Emergency Room Renovation	$ 4.0	$ -	$ -	$ -
2. * Expansion of Olive View Urgent Care Center (a)	-	0.5	-	1.1
3. * Implement Martin Luther King -Augustus F. Hawkins Urgent Care Center (a)	-	2.7	-	5.5
4.1 * 1.0 Psychiatric Social Worker II position (a)	-	0.1	-	0.1
4.2 ** Additional contracted acute inpatient beds	-	2.1	-	2.1
5. ** 2.0 Deputy Public Conservator positions (b)	-	0.2	-	0.2
6. ** 40 Additional Institutions for Mental Disease (IMD) beds	-	2.8	-	2.8
7. * 11 Additional IMD step-down beds (a)	-	0.6	-	1.1
8. ** 1.0 Child Psychiatrist at Harbor-UCLA	0.3	-	0.3	-
Total (c)	**$ 4.3**	**$ 9.0**	**$ 0.3**	**$ 12.9**
* MHSA-Eligible	$ -	$ 3.9	$ -	$ 7.8
** NCC Required	$ 4.3	$ 5.1	$ 0.3	$ 5.1

Notes:

a) * Eligible for Mental Health Services Act (MHSA) funding. DMH estimates that $13.0M in one-time MHSA funding is available. Any one-time MHSA funding not expended in the first year would be available in out-years until the $13M one-time funding is exhausted.

b) Staff to handle conservatees' affairs; only applicable upon additional inpatient bed capacity.

c) Staffing costs, by their nature, are less flexible than costs utilized to purchase services from contract providers (e.g. 4.2, 6, and 7 above), which can more easily vary with need.