CONTRA COSTA REGIONAL MEDICAL CENTER
PSYCHIATRIC EMERGENCY SERVICES (PES)
REMODEL PROJECT

OBJECTIVE: The objectives of this project include 1) separation of children (ages 7 through 12 years) and adolescents (ages 13 through 17 years) from adult patients; 2) provision of a larger dedicated space more conducive to a therapeutic environment to better support youth and their families; 3) addition of a confidential triage space at the entrance to PES, and 4) expansion of treatment space for adults.

BACKGROUND:

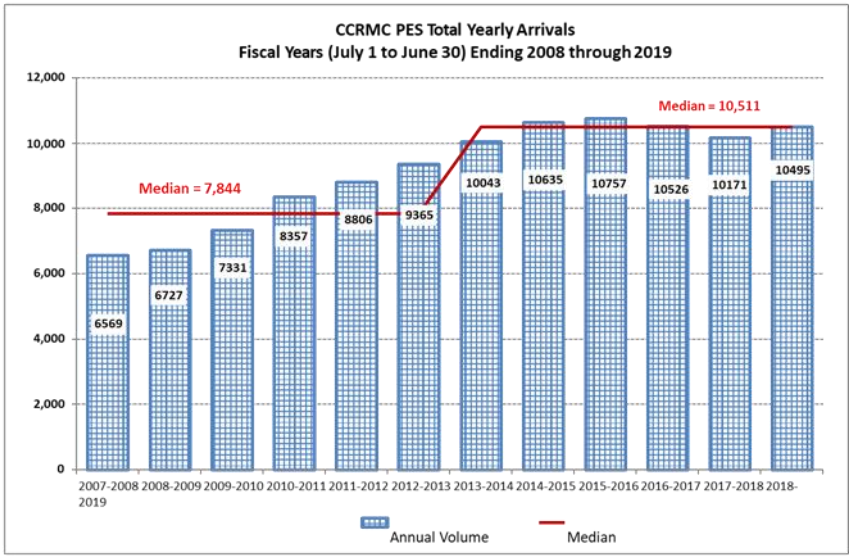
Psychiatric Emergency Service (PES) is the only Crisis Stabilization Unit (CSU) in Contra Costa County. It is located at the Contra Costa Regional Medical Center (CCRMC) in Martinez, California. It is the only CSU in Contra Costa County certified by the State Department of Health Care Services to receive persons on involuntary treatment holds pursuant to Article 1, Section 5150 of the California Welfare and Institutions Code.

Treatment functions include assessment of mental health conditions, triage for appropriate level of care, stabilization of a crisis, and referral to appropriate outpatient services or, when indicated, psychiatric hospitalization. The basis for initiating and sustaining involuntary treatment include imminent danger to self, danger to others or grave disability due to a mental health condition. While the majority of clients come to PES on a 5150 hold, a significant number seek these services on a voluntary basis.

The Crisis stabilization unit, a covered Medi-Cal benefit, is open to the community and provides services regardless of insurance type or coverage. It is important to emphasize that crisis stabilization is intended to have a duration of no longer than 23 hours and 59 minutes. PES is not an inpatient unit and instead is a Specialty Mental Health outpatient program. It is noteworthy that some commercial insurance plans do not reimburse for crisis stabilization services, others partially reimburse, and Medi-Cal reimburses only up to 20 hours of the 24-hour maximum stay. It is a common misunderstanding in the community that services are to be provided for the full 72-hour duration of a 5150 WIC hold.

Utilization of PES increased significantly each year from FY 2008-2009 to FY 2014-15 then plateaued with annual visits of about 10,000+. Reasons contributing to the increases include the closure of inpatient psychiatric units in the greater Bay Area (which also has resulted in longer lengths of stay in PES while an inpatient bed is sought), county population growth, changes in social determinants of health such as poverty and homelessness, significant prevalence of methamphetamine use with induced psychosis, and, very significant absence of adequate outpatient resources for persons with commercial insurance.

CCRMC Psychiatric Emergency Services
Select Key Performance Indicators (KPIs) through December 2019



Yearly Patients

Options:

Discussion

To address the assorted needs, several options were examined using input from clinicians, family community advocates, and current best practices.

Initial consideration was given to a) creating a separate stand-alone CSU for youth off campus, b) located within the George and Cynthia Miller Wellness Center (MWC), or c) in the inpatient unit within CCRMC. Off campus locations would require proximity to a medical facility, capacity to receive ambulances 24 hours/7 days a week, and community support for siting a high intensity treatment center and therefore ruled out.

Utilization of an inpatient unit would require significant and costly retrofitting in order to meet more recent building requirements and significant uncertainty about approval by DHCS to convert an inpatient unit to an outpatient clinic. Even for temporary use of this type, DHCS declined to consider approval prior to completion of physical plant modifications. But even if eventually approved for outpatient services, using an interior inpatient unit would require delivery of individuals in acute distress, often highly disorganized, dis-regulated, and agitated and restrained on a gurney through the corridors of the hospital. This would provide far less privacy to clients and potentially disrupt other patient care areas.

However, apart from the above considerations, utilization data did not support a free-standing CSU for youth. It became evident that utilization of PES by youth was very seasonal (particularly low census during summer months) and that throughout the year there were significant periods of time when no youth were present on the unit. Given the 24/7 hours of

operation required of PES, the costs of staffing and operating a unit that was not consistently used would be prohibitive.

Moving the entire PES , serving both youth and adults, to a new and separate location introduced the same barriers as when considering one just for youth: locating an acceptable property, establishing an intensive treatment program with 24/7 ambulance traffic, and being in close physical proximity of a health facility. Additionally, costs of a new building would be significant.

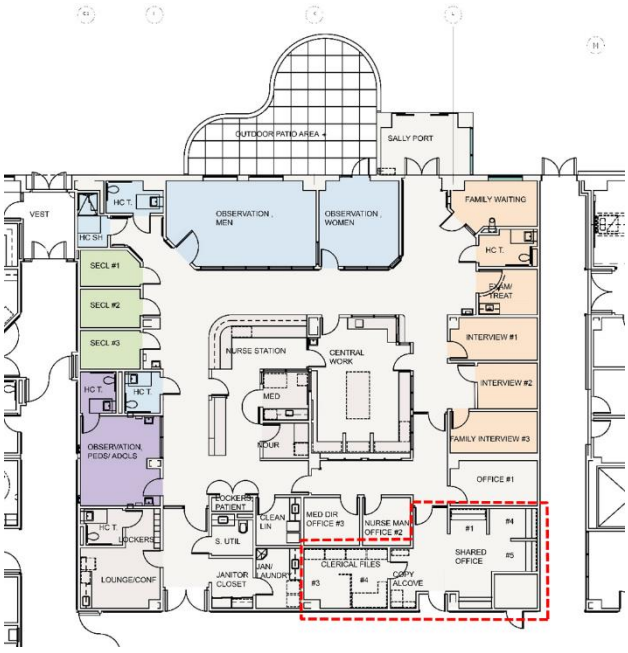
Redesign of the existing PES is considered more feasible than other of the options. Three conceptual models for redesign evolved over a several year period and recently were presented at different community forums. Each of these options would create a separate and distinct treatment center for youth, result a greater square footage of PES with expanded capacity for both youth and adults, and accomplish other stated objectives.

Whichever option might be selected will require some period of disruption in PES operations due to noise, worker traffic, presence of tools, etc. Alternatives would need to be considered to maintain a safe and secure area for clients while construction is in progress.

Below are conceptual, not to scale, floor plans showing the current state and the three options which were examined. Further details will be addressed when a selection is made and during the preparation and review of architectural drawings.

In each option presented, additional security may be needed within the PES during construction.

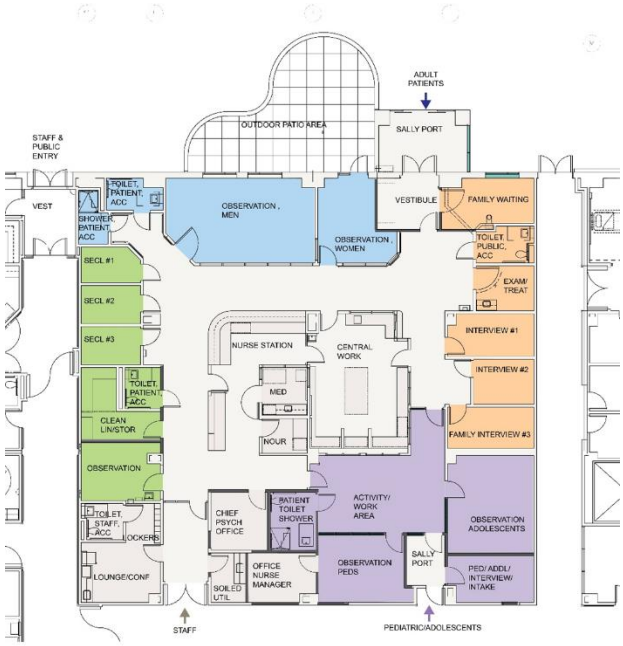
Current Floor Plan



Current Floor Plan

The PES is “land-locked” with limited expansion opportunities. On the right in this picture is the Intensive Care Unit (ICU) and Critical Care Unit (CCU). On the left is the Emergency Department; neither of which can be feasibly relocated. The only practical solution for expansion within this space is to relocate non direct-care administrative space, identified within the red dotted line, to another location,

Option 1



Option 1 moves the youth into the relocated administrative space, creating a dedicated unit, with locked doors, away from the adult patients. This option also creates a dedicated entry and uses the hallway between the PES and ICU/CCU with a dedicated exterior door. Option 1 also creates a vestibule inside the PES where the handoff can occur for a patient on a gurney from EMS to the CCRMC staff. Currently this handoff is done directly inside the PES, in potential earshot of other patients. Once the youth space is constructed, the current youth observation area will be renovated into an additional adult observation area.

Some operational problems exist with this option, as well as Options 2 and 3. While not ideal, these can be addressed by phasing construction.

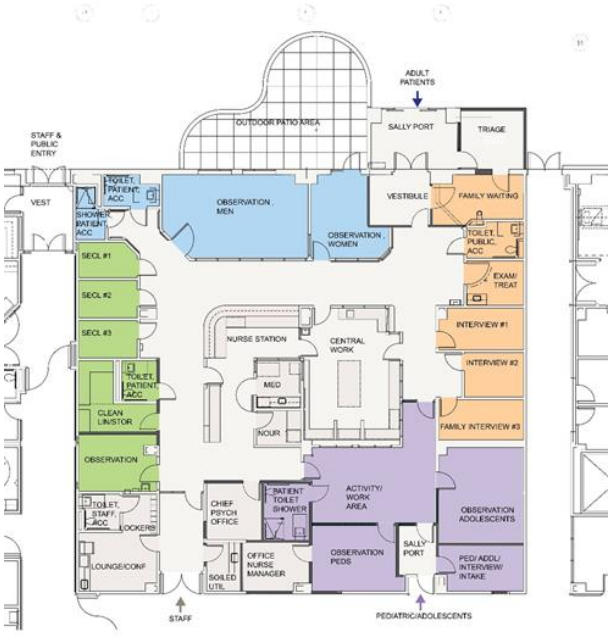
Phase I. Creating the vestibule will present an operational impact on patients entering through the sally port. If phasing construction and changing workflows are not feasible, we will need to close the unit for a period of time or go on diversion. Once the vestibule is competed normal entry can resume.

Phase II would build out the youth space and once complete the youth would be relocated with a dedicated, separate entrance.

Phase III would be the renovation of the current youth observation space into an additional adult observation area.

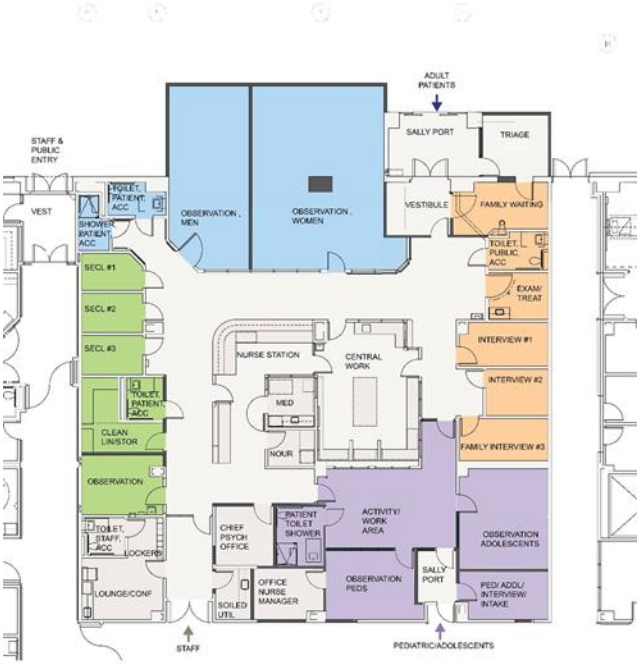
This is the cheapest option but does not address the need for additional pre-entrance triage space, nor for a meaningfully larger adult space.

Option 2



This option builds on Option 1 and creates a private triage space outside the PES. Today, patients presenting must stand in the covered vestibule outside the entrance to PES. Often, ambulatory patients are arriving there with other patients awaiting triage along with arriving ambulances and vehicle exhaust, thus creating a space that is not private, unwelcoming, and unhealthful. The triage area creates a private, confidential, space for ambulatory patients coming to the PES to be triaged and evaluated. If this option were selected, the triage area could be built while the vestibule is closed.

Option 3



This option presents the same operational issues outlined above in addition to enlarging the men and women observation space into the current, and little used, outdoor patio. If this option were selected the construction phasing addressed earlier would be the same.

To keep the PES operational, a wall would be constructed inside the observation area to allow for exterior construction. The entire dorm would not be usable for a short period when the expansion is attached to the existing building. During this time, current adult patients will need to be transferred to another facility and arriving adult patients will need to be diverted to other facilities. This will require BHS to ensure options are available in the community.

TIMELINE

Below is an estimated timeline for each option, which has been prepared by a professional construction estimating company in San Francisco. The exact timeline will be developed in coordination with the selected architect. The timeline may vary depending on the construction activity in the Bay Area. Incentives may be built into the construction contract for a sooner completion.

	Option 1	Option 2	Option 3
Design	3-4 months	4-5 months	4-5 months
OSHPD and Permitting	6-8 months	7-9 months	7-9 months
Construction	10-12 months	12-15 months	14-16 months
Total Months	19-24 months	23-29 months	25-30 months

PROJECT COST

Below are cost estimates developed in December 2019. Actual costs may be different depending on Bay Are costs of labor and materials.

	Current Sq Ft	Added Sq Ft	Total Sq Ft	Construction Cost	Project Mgt Cost[1]	Security Cost[2]	Total Cost	$/Sq Ft
	5,370							
Option 1		2,101	7,471	$2,296,783	$1,148,392	$282,560	$3,727,735	$1,774
Option 2		2,265	7,635	$3,092,272	$1,546,136	$282,560	$4,920,968	$2,173
Option 3		3,499	8,869	$5,366,607	$2,683,304	$282,560	$8,332,471	$2,381
Notes:	1. All options use 50% of construction cost for project management cost							
	2. All options add Security (1 Deputy 10 hours/day, M-F, during 16 months of construction)							

FUNDING

The project will be financed with a ten to twenty-year bond issuance (review pending). Debt service will likely be a combination of grant and/or Mental Health Services Act (MHSA) funds (validation pending).

RECOMMENDATION:

The recommended solution is Option 2, with the provision there is additional inpatient availability for youth and/or adult patients within the County or neighboring counties.

In the absence of additional inpatient beds option 3 would be the recommendation to move forward with.

Whichever option is selected, there will be several significant challenges which will need to be addressed

- Patient volume must be closely managed. There is a high possibility of needing to close or minimize the number of adult and/or youth patients in PES during this time
- Due to noise and construction activities, which may negatively affect our patients, there is a distinct possibility that we may need to go on diversion, or to close completely for a period
    - Creating a vestibule will present an operational impact on patients entering through the sally port. If phasing construction and changing workflows are not feasible, we will need to close the unit for a period or go on diversion.
    - In Option 3, enlarging the observation rooms and constructing a temporary interior wall present significant challenges when the wall is taken down and the enlarged rooms are connected to the building. At that time current adult patients will need to be transferred and new adult patients will need to be diverted to other facilities. This will require BHS to ensure options are available in the community.
- The contractor must closely monitor tools and equipment within the PES
- CCRMC and Behavioral Health Division (BHS) will work closely together to ensure minimal disruption to services. BHS needs to ensure there is mutual regional cooperation agreement
- There will be a need for increased administrative, clinical, and security staff during this time
- Last minute changes may need to be made to operational processes, construction phasing, labor availability, construction cost, timelines, and security requirements, which will need to be immediately addressed
- Construction will present issues which are not planned for that will require immediate decisions regarding construction and operational issues
- Staff will need to be flexible and accommodate short notice changes
- There will be inconveniences to departments outside the PES