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PATIENT CHARACTERISTICS AND AVERAGE LENGTH OF
STAY AT COUNTY INPATIENT FACILITIES

By

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Patient Characteristics and Average Length Of Stay at County Inpatient Facilities

Abstract

This brief research note attempts to offer some clues about why the mean lengths of stay at three County acute psychiatric units at general hospitals are different. Adult inpatients from Los Angeles County/USC Medical Center, Olive View Medical Center and Harbor/UCLA Medical Center were compared on diagnosis, Global Assessment Scale scores and legal status. These three measures of severity of illness did not account for differences in length of stay. Comparisons on referral out recommendations, however, suggested that inpatient lengths of stay may be a function of administrative strategies that are carried out differentially in the context of a larger system of treatment services. It is suggested that future research on this topic develop more comprehensive measures of the severity of clients' illnesses and also that a systematic study be made of length of treatment as a function of hospital administrative practices and the relationship of these practices to the total continuum of pre-hospital, in-hospital and post-hospital care including the availability of other health and social services.

The utilization of inpatient resources has been the subject of ongoing concern to the County Department of Mental Health since it implemented a strategy of decreased reliance on hospitals with a concurrent but not equivalent increase in the use of community-based alternatives to hospitalization. Consistent with this strategy, some hospitals have exhibited shorter lengths of stay and/or a higher turnover of patients while others have not. This brief research note will attempt to offer some clues as to why this is the case by exploring figures routinely reported by the Department of Mental Health along with comments received from hospital administrators. 1/

Differences Among County Hospitals

Table 1 shows that during Fiscal Years 1979 and 1980 the mean lengths of stay at Los Angeles County USC Medical Center (19.2 and 23.2 days) and at Los Angeles County Harbor/UCLA Medical Center (21.3 and 20.6 days), were considerably higher than the mean lengths of stay at Olive View Medical Center (8.7 and 8.8 days.) Furthermore, the mean length of stay for discharged adult patients at LAC/USC increased 21 percent from 19.2 to 23.2 between fiscal years 1979 and 1980, while the averages at Olive View and Harbor remained virtually unchanged. A distribution of the number of days spent in each hospital during the two fiscal years (see Table 2) shows that the percentage of patients staying 33 days or longer is considerably higher in both years for LAC/USC and Harbor than for Olive View.

Why are LAC/USC's and Harbor/UCLA's lengths of stay higher than Olive View's? Do they receive different types of patients? Do they provide different types of services? While each of the three psychiatric facilities is located in a general hospital under County aegis and each has teaching programs, each facility also has a separate administrative structure, which may imply different admission and discharge policies. In addition, they may receive different types of cases because of differences in size and capabilities. Using available information, a series of comparisons was created to address these questions

1/ This paper benefitted from the inputs of Joseph Blanton, M.D. of Olive View Medical Center, R. Bruce Sloane, M.D. of the Los Angeles County/USC Medical Center and Keh-Ming Lin, M.D. of the Harbor/UCLA Medical Center. The substance of this paper, however, does not necessarily reflect their points of view.

in an exploratory way and to attempt to provide some clues regarding their answers.

Patient Characteristics And Length Of Stay

Table 3, which focuses upon the final primary diagnosis for inpatients during fiscal year 1980, seems to offer a clue as to why Olive View's length of stay is substantially lower than those of the other hospitals. The percentage of persons diagnosed as neurotic at Olive view (31.2 percent) is dramatically higher than the corresponding percentge at LAC/USC (6.4 percent) or Harbor/UCLA (2.7 percent). The possibility that Olive View's shorter length of stay is a result of receiving a more "treatable" or "containable" type of illness, however, is called into question by the fact that its mean length of stay is lower than the other two hospitals' for all diagnostic categories, regrdless of their severity (see Table 3). Diagnosis is not related to length of stay for the three hospitals under study.

Client impairment, as measured by the Global assessment Scale, does not account for the shorter length of stay at Olive View. As can be seen in Table 4, the impairment levels of most admissions fell within a range of 11 to 50 and exhibited a high degree of similarity between Olive View and Harbor/UCLA. LAC/USC's admissions did, however, exhibit a tendency toward greater impairment: 65 percent of its clients received GAS ratings of 30 or lower, compared with 52 percent at Olive View and 54 percent at Harbor/UCLA.

The relatively high percentage of involuntary commitments shown in Table 5 for LAC/USC seems to present evidence that its higher lengths of stay are due to the fact that it is receiving more seriously ill clients. Over 90 percent of LAC/USC's inpatient admissions during FY 80 were admitted involuntary while at Olive View and Harbor UCLA the percentages of involuntry admissions were 56.5 percent and 55.7 percent, respectively. Again, however, Olive View's mean length of stay is dramatically lower than LAC/USC's, and Harbor/UCLA's is about as high in both voluntary and involuntary admissions. Legal status does not provide an explanation of the differences in length of stay among the hospitals because Olive View shows fewer units of service per client discharged regardless of whether a given client was voluntary or involuntary at the time of admission.

While the three measures of severity of illness -- Global Assessment Scale, involuntary hospitalization, and diagnosis -- did not account for difference in lengths of stay, it should be mentioned that they are not definitive measures of severity. It is possible that other measures would detect differences in the three hospitals' patient populations (the number of complicating conditions^{1/} or the chronicity of illness, for example) which could explain differences in length of stay.

Administrative Differences And Length Of Stay

Another way to look at differences among hospitals is in terms of policy and administrative procedures, especially as they affect admission and discharge practices. Hospitals may have different admissions criteria and different explicit or implicit criteria for judging when hospital treatment is complete. One administrative strategy which could account for differences in length of stay would be a policy of referring the more difficult psychiatric emergency room clients to other hospitals. Such a policy would imply differences in severity in the different hospitals' inpatient populations, differences indicated by the patient characteristics already described above.

Table 6 shows, for each emergency room's referrals for inpatient treatment, the percentages referred to the emergency unit's parent hospital ("own inpatient unit") and to state and other inpatient facilities. These figures show similar figures for Olive View and LAC/USC but a completely different pattern for Harbor: While LAC/USC and Olive View themselves admit 65.1 percent and 58.7 percent, respectively, of their emergency room clients needing inpatient care, Harbor/UCLA admits only 19.3 percent. Harbor's emergency unit sends 43.1 percent of those needing inpatient care to state hospitals, while LAC/USC and Olive View refer 22.4 percent and 28.0 percent, respectively, to state hospitals. These data, with the close correspondence between the Olive View and LAC/USC figures, obviously do not account for the shorter length of stay at Olive View. They simply confirm what is already known, that Harbor's inpatient capacity is so small that most of its emergency room clients needing inpatient treatment

^{1/} Unfortunately, Axis III (i.e., medical) diagnosis at two of the three hospitals was not fully reported during the time period of this study. For this reason, the contribution of complicating nonpsychiatric medical conditions to an explanation of length of stay cannot be presently assessed.

must be referred elsewhere. Harbor's small size, in addition, does allow it a greater selection of patients than the other hospitals. However, the criteria for the selection, if any, are unknown.

The existence of administrative variations among the hospitals is also evident in figures showing the disposition of all cases from emergency rooms. Figures indicate that Olive View is less selective than the other two hospitals in its decision to admit emergency room patients as inpatients. At Olive View, 29.4 percent of its 5,930 emergency room patients discharged during fiscal year 1980 were referred for admission to its own inpatient wards. The figures for LAC/USC (which reported 18,244 emergency room discharges) and Harbor/UCLA (which reported 4,301 such discharges) were much lower at 10.2 and 6.7 percent, respectively. That LAC/USC and Harbor/UCLA kept their inpatients longer during fiscal year 1980, may be a result of selecting more seriously ill patients from their emergency room populations.

Our measures of diagnosis, legal status and impairment did indicate that LAC/USC admitted more seriously ill patients than the other two hospitals. That our indicators of illness severity in turn were not strongly related to length of stay is not conclusive. It could mean that alternative measures of severity (to be discussed later) might explain LAC/USC's apparent selectivity and longer length of stay. The dramatically lower average length of stay at Olive View during the same year may reflect an inpatient screening policy that allowed for a wider range of symptom severity with the result that many less severely ill clients were treated in a short amount of time.

Table 7 was constructed to investigate the possibility that Olive View's lower length of stay might be due to a policy of discharging patients needing long term treatment and transferring them to state hospitals or some alternative treatment modality. Both Olive View (5.1 percent) and Harbor/UCLA (5.7 percent) referred higher percentages of discharged patients to state hospitals than LAC/USC (1.9 percent). These differences are not large enough to provide a single factor explanation of length of stay differences, but they suggest that proportionately fewer transfers to state hospitals might have contributed to LAC/USC's longer length of stay.

It is of further interest to note that 71.5 per cent of Olive View's referrals at discharge and 65.4 per cent of Harbor/UCLA's were to outpatient or day treatment programs. Only 21.2 per cent of LAC/USC's discharges were so referred. In addition, a high (51.4) percent of "no need" for further treatment was reported by LAC/USC. The number of referrals for continuing care at LAC/USC is too low and the number with "no need" too high to ignore the possibility of reporting errors. Indeed, data compiled by the Continuing Care Office of the of the Central Region shows that 47.1 per cent of patients discharged from LAC/USC were discharged with continuing care plans for referral and only 2.4 per cent were discharged without need for such a plan. However, even allowing for the possibility of some reporting error, these figures indicate that LAC/USC is more likely to keep its inpatients until there is no further need for the services that it offers, while the other two hospitals are more likely to utilize community services as a more integral part of the treatment they have begun. Such differences in administrative procedure could account, at least in part, for LAC/USC's longer lengths of stay, though not for Harbor's.

The significance of administrative strategy as a variable for further research consideration is illustrated by recent figures from LAC/USC ^{1/}, which were calculated for its own, in-house administrative purposes. While the figures reported in the present paper are based on a definition of length of stay that uses the mean number of days spent in the hospital by persons discharged during a given year, administrators at LAC/USC have devised a different measure for use in identifying wards that have longer lengths of stay and in identifying clients with very long lengths of stay. The measure is based upon the number of days patients currently in the hospital have spent in the hospital as of a particular date. LAC/USC's measures of time in the hospital by ward reveal two striking patterns. First, average time in the hospital varies considerably among LAC/USC's six psychiatric wards: e.g., from 18.2 to 49.6 during November 1980; from 12.6 to 52.9 during January 1981; and from 13.6 to 28.0 during March, 1981. There is no known selection criteria for the wards and these variational extremes may mean that differences in administrative strategy

^{1/} These figures are contained in an LAC/USC memo titled "Psychiatric Hospital Adult Inpatient Stay" dated April 3, 1981.

exist not only between hospitals, but may also exist among wards within certain hospitals. The measures also show a dramatic drop over time for average time in the hospital as a whole. In six month period from November, 1980 to April, 1981 the overall average days spent in the hospital declined in the following sequence: 30.9, 30.2, 21.8, 19.8, 19.3, 16.5.^{1/} It is doubtful that this trend is a function of changing client characteristics. It seems probable that it is a direct reflection of changing administrative practices that affected all six wards.

Recent changes in the program structure and administrative strategy as reported by Olive View's administrators will also likely change the lengths of stay of its psychiatric inpatients. A major change involves the addition of a 10-bed Crisis Utilization unit to its Psychiatric Emergency Services. This new unit will serve persons experiencing crises who formerly were admitted as inpatients, and the average length of stay for Olive View's inpatient facility can be expected to rise. Another change involves the legal status of patients admitted. Fewer voluntary patients are admitted and most persons now admitted are involuntary patients with serious levels of illness. Furthermore, Olive View has been receiving a significant number of severely disturbed patients with medical problems such as diabetes, epilepsy, and malnutrition. Since such patients require intensive medical consultation in addition to psychiatric treatment, they can also be expected to contribute to a higher average length of stay. Figures for the first half of calendar year 1981 show an average length of stay at Olive View of 10.9 with the highest mean (13.1) occurring for June. This increase over the fiscal year 1980 average of 8.8 suggests that these changes have had an effect. The increase also indicates that the relationship between administrative policy and length of stay is not necessarily direct. Changes in administrative strategy involving available resources may change the characteristics of the client population which, in turn, may effect length of stay. Furthermore, the changes at Olive View -- e.g., higher percentages of involuntary patients (including conservatees) and patients with

^{1/} During the same approximate time period (November, 1980 through June, 1981) Los Angeles County Department of Mental Health statistics showed a drop at LAC/USC from the fiscal year 1980 average length of stay of 23.2 to an average of 21.7, (with a low of 18.2 for March, 1981.)

complicating medical problems -- can be expected to result in an administrative structure and inpatient population that is increasingly similar to what already exist at LAC/USC. If these programatic changes and client characteristics are correlated with length of stay, then the two hospitals' lengths of stay should be less disparate in the future.

Because of Harbor/UCLA's smaller size, many of its administrative concerns will probably remain different from the other two hospitals. While its service area is more populated than that of the other two hospitals (i.e., Coastal Region's population is 2,086,101 vs. 1,371,246 for Central Region and 1,584,470 for the San Fernando/Antelope Valley Region ^{1/}) its facility is about one half the size of Olive View and one sixth the size of LAC/USC. Because of this, it necessarily refers a relatively higher percentage of emergency room patients to the state hospital and other inpatient facilities. Therefore, persons admitted to Harbor/ UCLA as inpatients are likely to be carefully selected. According to a Harbor/UCLA administrator, there are other reasons for its high lengths of stay. Because of its proximity to International Airport, the hospital may attract more than its share of transients from other states and foreigners who become psychotic. The staff tries to retain such persons as inpatients to prevent them from becoming lost in the state hospital system. Another reason is that Harbor/UCLA's policy of trying to keep involuntary patients in treatment (as evidenced by the relatively high percentage of 14-day holds shown in Table 5) contributes to higher lengths of stay.

Relationship to Other Systems and Length of Stay

Length of stay variations are also likely related to each hospital's relationship with other service delivery systems and organizations. Los Angeles County contains a complex interconnection of social systems, and the service statistics of no single service delivery facility can be adequately understood in isolation

^{1/} Source: 1980 U.S. Census.

from its societal context. Olive View, for example, has reported that the administrative practices of the Public Guardian's office can soon be expected to impact its average length of stay. The number of conservatees in its inpatient wards has recently increased and the Public Guardian's office has been very slow to process them. During fiscal year 1980, LAC/USC and Harbor/UCLA reported that 6.4 and 5.4 per cent of their inpatients were discharged as conservatees, compared to 2.7 per cent at Olive View. Increased numbers of conservatees at Olive View will undoubtedly raise its overall average length of stay because the average stay of its conservatees during FY 1980 was over twice the amount of its general average (20.9 days vs. 8.8 days). Although the average length of stay for Olive View's conservatees was much lower than LAC/USC's and Harbor/UCLA's which were 41.5 and 35.9 days), its growing Conservatorship problem should contribute to a greater similarity of population characteristics between the two hospitals. A recent task force report on the length of stay at LAC/USC^{1/} has reported similar problems with the Public Guardian's office and recommended the funding of an alternative facility for conservatees close to Department 95 (the court where conservatorship cases are heard) and a meeting with the Public Guardian and other appropriate county departments to discuss the inappropriate use of acute beds for conservatorship cases.

The hospitals under study have varying degrees of connection with universities, and variations in their function as a teaching environment for interns and residents could also affect their decision-making policies and the average length of stay of their patients. Other systems -- for example the State Department of Mental Health, the courts, law enforcement, DPSS, corrections, the polity, the economy -- undoubtedly also directly or indirectly affect the services delivered by county inpatient facilities. Family resources and the nature of patients' connection with resources in their respective communities would also be expected to have an effect. Further attempts at explaining variations in service delivery statistics might be enhanced if administrative

^{1/} L.A. County/USC Medical Center Psychiatric Hospital Length of Stay Review. June 25, 1981 (unpublished report).

differences are considered in a systems context. Length of stay in a hospital is most appropriately viewed as a part of a full continuum or system of care with the involvement and influence of many other service providers. Available data, however, do not permit a systematic exploration of this.

Conclusions and Implications

Difference in the lengths of stay for adult inpatients at LAC/USC Medical Center, Olive View Hospital and Harbor/UCLA Medical Center do not seem to be a function of patient characteristics as measured by diagnosis, Global Assessment Scale rating, or legal status at admission. While other measures (i.e., measures not available to this study) might explain differences in the hospitals' length of stay, the strategy of this study was to search for clues among available data and information that might suggest avenues for further research as well as tentative explanations of hospital differences.

Figures showing the referral-out recommendations of the three hospitals suggested that variations in mean length of stay might be a function of differing administrative strategies and differing utilization of existing psychiatric and social service resources. Length of stay figures at LAC/USC might be relatively high because it is more selective than the other two hospitals in its decision to admit emergency room patients as inpatients and because it is more likely to keep its inpatients until there is no further need for the services it offers. Furthermore, since both Olive View and Harbor/UCLA are compelled to routinely use State Hospital acute beds because they have fewer beds than LAC/USC, LAC/USC's apparent selectivity maybe partially due to the fact that its use of state beds is not a routinized occurrence.

LAC/USC's own ward by ward data imply that it is possible to change the average length of stay without necessarily changing the client population. Although reporting errors seems to be present in our data, the administrative strategies at Olive View and Harbor seem to have resulted in a higher percentage of discharged inpatients being referred to outpatient and day treatment programs. Olive View and Harbor thus seem to have made greater use than LAC/USC of treatment alternatives as a means of providing ongoing treatment. This suggests that shorter lengths of stay should be viewed in the context of administrative

strategies that consider a full continuum of care. However, recent changes in program structure and administrative strategy at Olive View are likely to change the characteristics of its client population and increase its average length of stay in the near future. The administrative structure and inpatient population at Olive View may become increasingly similar to what already exists at LAC/USC Harbor/UCLA, on the other hand, because of its smaller size and larger service area population will likely continue to have many administrative concerns that differ from the other two hospitals.

The figures reported in this study were limited to variables routinely collected by the Mental Health Department's data reporting system. If future studies are designed to explain length of stay variations among hospitals it is suggested that systematic information be gathered on such factors as patients' lack of family and community resources, chronicity of illness, multiple illnesses and more specific types of behavior (such as dangerousness) that may be more directly related to length of stay. The reliability of diagnosis and measures of impairment across the three hospitals should also be assessed. Different diagnostic practices may lead to spurious differences among the hospitals and make comparative attempts at explanation difficult. Although the use of a given diagnostic practice may be consistent and valid within a given hospital, methods with proven reliability are needed if meaningful inter-hospital comparisons are to be made. Variations in the administrative practices of hospitals should also be systematically assessed. Hospitals should also be viewed as a component of a much larger system of care delivery and the relationship of each hospital with other programs should be carefully scrutinized. Future studies should also be designed for multiple factor explanations of length of stay. The present study seems to indicate that single factors -- such as measures of client severity or measures of referral practices -- are not of great explanatory value when considered alone. A multivariate model that combines the contributions of several sets of independent variables -- including patient characteristics, administrative differences and relationships to other systems -- and their interactive effects seems called for in future studies of this topic.

Finally, the unquestioned assumption of this paper is that lower length of stay are better or more desirable. Previous research on this topic has

provided contradictory findings, some of which support this assumption and some of which do not. ^{1/} Further research is needed on whether or not this assumption is generally true for Los Angeles County hospitals and whether it applies to all inpatients or only those with certain types of illnesses. Furthermore, the mental health system might benefit from a more general study that attempts to explain the effectiveness and efficiency of its hospitals by assessing the relationship of their lengths of stay and patients' participation in the available continuum of pre and post hospital care to the frequency and duration of rehospitalizations.

^{1/} Harold Altman, Ivan Sletten and Marvin E. Nebel, "Length of Stay and Readmission Rates in Missouri State Hospitals", Hospital and Community Psychiatry, Vol. 24, no. 11, November, 1973, pp. 773-776, and P.W. Burvill and M. Mittelman, "A Follow-up Study of Chronic Mental Hospital Patients", Social Psychiatry, vol.6, no. 4, 1971, pp.167-171.

Table 1. Mean Length Of Stay For All Adult Inpatients Discharged From Los Angeles County Hospitals During Fiscal Years 1978-79 and 1979-80.

	Mean Length Of Stay		
	FY 1979	FY 1980	Change
Los Angeles County/ USC Medical Center	19.2	23.2	+21%
Olive View Hospital	8.7	8.8	+ 1%
Los Angeles County Harbor/UCLA Medical Center	21.3	20.6	- 3%

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Table 2: Number of Days in Hospital for All Adult Inpatients Discharged from Los Angeles County Hospitals During Fiscal Years 1980 and 1979

Number of Days in Hospital	Los Angeles County/ USC Medical Center				Olive View Hospital				Los Angeles County Harbor/UCLA Medical Center			
	FY 78-79		FY 79-80		FY 78-79		FY 79-80		FY 78-79		FY 79-80	
	f	%	f	%	f	%	f	%	f	%	f	%
1	167	6.8	108	5.8	212	10.4	153	8.9	16	5.1	8	2.7
2 - 4	242	9.9	86	4.6	461	22.6	419	24.3	41	13.1	36	12.2
5 - 16	795	32.5	536	28.9	965	47.4	809	47.0	102	32.6	102	34.7
17 - 32	807	33.0	678	36.6	356	17.5	309	18.0	67	21.4	79	26.9
33 - 60	401	16.4	411	22.2	44	2.2	30	1.7	84	26.8	66	22.4
61 - 99	36	1.5	33	1.8	0	0.0	1	.1	3	1.0	3	1.0
TOTAL*	2448	100.1	1852	99.9	2038	100.1	1721	99.9	313	100.0	294	99.9

*Totals may vary somewhat from table to table because of incomplete reporting on some variables.

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Table 3: Final Primary Diagnosis For All Adult Inpatients Discharged From Los Angeles County Hospitals Between July 1, 1979 And June 30, 1980

Final Primary Diagnosis	Los Angeles County/USC Med. Center			Olive View Hospital			Los Angeles County Harbor/UCLA Med. Center		
	f	%	\bar{X}_{us} *	f	%	\bar{X}_{us}	f	%	f
Sen. Psych.	5	.3%	16.2	10	.6%	12.7	1	.3%	64.0
Alc. Psych.	15	.8	20.3	61	3.5	5.7	1	.3	10.0
Psych. Org.	113	6.1	15.3	57	3.3	6.9	1	.3	32.0
Schizoph.	385	20.8	23.1	791	46.0	10.8	94	32.0	27.0
Aff. Dis.	284	15.3	27.1	100	5.8	11.1	38	12.9	20.4
Paranoid	2	.1	14.5	23	1.3	8.6	13	4.4	13.1
Other Psych.	69	3.7	28.3	14	.8	7.9	69	23.5	16.7
Unsp. Psych.	9	.5	28.7	0	0	-	1	.3	3.0
Neurosis	118	6.4	26.5	537	31.2	6.9	8	2.7	28.4
Per Dis.	81	4.4	15.3	45	2.6	6.4	25	8.5	13.6
Sex. Dev.	2	.1	4.5	1	.1	1.0	0	0	-
Alcohol	18	1.0	23.8	0	0	-	3	1.0	4.0
Drug Dep.	11	.6	23.8	2	.1	6.5	0	0	-
Psychosom.	1	.1	40.0	0	0	-	0	0	-
*Special Symp.	83	4.5	21.9	0	0	-	28	9.5	19.1
Sit. Dist.	9	.5	9.2	62	3.6	2.5	6	2.0	2.8
Ch./Adol.	2	.1	40.0	0	0	-	1	.3	24.0
Organic	72	3.9	27.6	12	.7	11.5	4	1.4	27.0
Maladjust	1	.1	1.0	1	.1	3.0	1	.3	3.0
Oth. Prob.	569	30.7	20.9	3	.2	5.3	0	0	-
Unknown	3	.2	3.7	2	.1	11.0	0	0	-
Total**	1,852	100.2%	23.2	1,721	100.0%	8.8%	294	99.7%	20.6

* \bar{X}_{us} = mean length of stay.

**This category refers to special symptoms not classified elsewhere.

***Totals may vary from table to table because of incomplete reporting on some variables.

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Table 4. Impairment Rating (Global Assessment Scale) At Admission For All Adult Inpatients Discharged From Los Angeles County Hospitals Between July 1, 1979 and June 30, 1980

Impairment Rating	Los Angeles County/USC Med. Center, Adult		Olive View Hospital		Los Angeles County, Harbor/ UCLA Med. Center	
	f	%	f	%	f	%
1-10	82	6.7	73	4.2	22	7.7
11-20	209	17.0	313	18.0	50	17.4
21-30	501	40.9	522	29.9	84	29.3
31-40	276	22.5	473	27.1	82	28.6
41-50	110	9.0	321	18.4	42	14.6
51-60	32	2.6	30	1.7	6	2.1
61-70	12	1.0	10	.6	1	.3
71-80	4	.3	0	0	0	0
81-90	0	0	1	.1	0	0
91-99	0	0	0	0	0	0
Totals*	1,226	100.0	1,743	100.0	256	100.0

*Totals may vary from table to table because of incomplete reporting on some variables.

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Table 5. Legal Status At Admission For All Adult Inpatients Discharged From Los Angeles County Hospitals Between July 1, 1979 and June 30, 1980

Legal Status At Entry	Los Angeles County/USC Med. Center			Olive View Hospital			Los Angeles County Harbor/ UCLA Med. Center		
	f	%	\bar{X}_{us} *	f	%	\bar{X}_{us}	f	%	\bar{X}_{us}
Voluntary	150	8.0%	24.6	748	42.9%	8.8	98	34.1%	21.2
72 Hour Hold	1,684	90.3	22.9	986	56.5	8.7	160	54.7	21.0
14 Day Cert.	30	1.6	32.7	7	.4	9.7	27	9.4	16.6
Conservatorship	0	-	-	3	.2	14.5	2	.7	8.0
Total**	1,864	99.9%	23.2	1,744	100.0	8.8	287	99.9%	20.6

* \bar{X}_{us} = Mean length of stay.

**Totals may vary from table to table because of incomplete reporting on some variables.

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Table 6: Referral-out recommendations* for clients discharged from Los Angeles County hospital psychiatric emergency rooms and referred for adult inpatient treatment between July 1, 1979 and June 30, 1980.

Referral-out recommendation	Emergency room at LAC/USC Medical Center		Emergency Room at Olive View Hospital		Emergency Room at Harbor/UCLA Medical Center	
	f	%	f	%	f	%
State inpatient	642	22.4	833	28.0	640	43.1
Own inpatient unit	1865	65.1	1745	58.7	287	19.3
Other "county inpatient"	124	4.3	182	6.1	291	19.6
Other psychiatric inpatient	236	8.2	211	7.1	267	18.0
TOTAL	2867	100.0	2971	99.9	1485	100.0

*Referrals labeled as to "own inpatient unit" are the actual number of admissions to those units. For LAC/USC and Olive View these numbers will not appear in emergency room discharge data because it is their practice to complete admission/discharge forms only on those emergency room clients not admitted to their own inpatient units.

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Table 7: Referral Out Recommendations For All Adult Inpatients
Discharged From Los Angeles County Hospitals
Between July 1, 1979 And June 30, 1980

Referral Out Recommendation	Los Angeles County/USC Med. Center		Olive View Hospital		Los Angeles County Harbor/ UCLA Med. Center	
	f	%	f	%	f	%
State Inpatient	34	1.9%	85	5.1%	16	5.7%
County Inpatient	11	.6	10	.6	0	-
State Outpatient	24	1.3	16	1.0	11	4.0
County Outpatient	220	12.0	1,068	63.6	126	45.3
County Part. Day Care	21	1.1	48	2.9	29	10.4
Other Inpatient (Psy)	28	1.5	8	.5	4	1.4
Other Outpatient (Psy)	100	5.5	57	3.4	14	5.0
Other Day Treatment	24	1.3	10	.6	2	.7
Board And Care	140	7.6	60	3.5	7	2.5
Med. Inpatient	54	2.9	22	1.3	1	.4
Med. Outpatient	13	.7	26	1.5	35	12.6
Drug/Alc.	2	.1	1	.1	3	1.1
Probation Dept.	0	-	1	.1	0	-
Courts	3	.2	0	-	0	-
Jail/Corrections	0	-	0	-	0	-
Police/Sher.	2	.1	1	.1	0	-
Other Legal	0	-	0	-	0	-
Other Soc. Ag.	2	.1	5	.3	0	-
Religious Org.	0	-	1	.1	0	-
No Need	941	51.4	1	.1	0	-
Client Withdrew	207	11.3	228	13.6	10	3.6
Client Died	4	.2	3	.2	0	-
Client Moved	0	-	24	1.4	6	2.2
Not Available	1	.1	0	-	0	-
Other	1	.1	4	.2	14	5.0
Total	1,831	100.0%	1,679	100.2%	278	99.9%

*Totals may vary from table to table because of incomplete reporting on some variables.

SL:shg