AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, FEBRUARY 27, 2017

2:30 P.M. - STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

ITEM	DESCRIPTION	
4120	**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHPD)**	**1**
ISSUE 1	OSHPD OVERVIEW AND BUDGET	1
ISSUE 2	2016 HEALTH CARE WORKFORCE FUNDING	4
ISSUE 3	ELECTIVE PERCUTANEOUS CORONARY INTERVENTIONS REPORTING BUDGET CHANGE PROPOSAL	8
ISSUE 4	HEALTH CARE WORKFORCE RECRUITMENT LEGISLATION (AB 2024 AND AB 2048) BUDGET CHANGE PROPOSAL	10
ISSUE 5	RELOCATION RENT ADJUSTMENT BUDGET CHANGE PROPOSAL	12
4440	**DEPARTMENT OF STATE HOSPITALS**	**14**
ISSUE 6	DEPARTMENT OF STATE HOSPITALS OVERVIEW AND BUDGET	14
ISSUE 7	INCOMPETENT TO STAND TRIAL PROPOSAL AND TRAILER BILL FOR AN ADMISSION, EVALUATION, AND STABILIZATION CENTER	22
ISSUE 8	CONDITIONAL RELEASE PROGRAM (CONREP) PROPOSALS	26
ISSUE 9	ENHANCED TREATMENT UNITS STAFFING PROPOSAL	28
ISSUE 10	ENHANCED TREATMENT UNITS CAPITAL OUTLAY BUDGET CHANGE PROPOSAL	30
ISSUE 11	METROPOLITAN FIRE ALARM SYSTEM CAPITAL OUTLAY BUDGET CHANGE PROPOSAL	32
ISSUE 12	PATTON FIRE ALARM SYSTEM CAPITAL OUTLAY BUDGET CHANGE PROPOSAL	34
ISSUE 13	NAPA COURTYARD CAPITAL OUTLAY BUDGET CHANGE PROPOSAL	36
ISSUE 14	COALINGA COURTYARD CAPITAL OUTLAY BUDGET CHANGE PROPOSAL	38
ISSUE 15	METROPOLITAN CONSOLIDATION OF POLICE OPERATIONS CAPITAL OUTLAY BUDGET CHANGE PROPOSAL	40
ISSUE 16	DSH-NAPA EARTHQUAKE REPAIRS PROPOSAL	42

ITEMS TO BE HEARD

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 1: OSHPD OVERVIEW AND BUDGET

PANELISTS

- **Robert P. David**, Director, Office of Statewide Health Planning and Development
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

The Office of Statewide Health Planning and Development (OSHPD) develops policies, plans and programs to meet current and future health needs of the people of California. Its programs provide health care quality and cost information, ensure safe health care facility construction, improve financing opportunities for health care facilities, and promote access to a culturally competent health care workforce.

The Facilities Development Division (FDD):

1. Reviews and inspects health facility construction projects.
2. Has projects, currently under plan review or construction, valued in excess of $20 billion.
3. Enforces building standards, per the California Building Standards Code, as they relate to health facilities construction.
4. Is one of the largest building departments in the State of California.

The Healthcare Information Division (HID) collects and disseminates healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products. The Division collects and publicly discloses facility level data from more than 5,000 CDPH-licensed healthcare facilities - hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. The Division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality (outcome) ratings for heart surgery and other procedures are also published. The Division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

For example, this Division recently produced a report showing the increase in emergency room care resulting from heroin overdoses from 2012 to 2016 by age group. For 20-29 year olds, the number of ER visits increased from approximately 210 in 2012 to 412 in 2016. For 30-39 year olds, the number of visits increased from approximately 100 in 2012 to 209 in 2016.

The Healthcare Workforce Development Division (HWDD) supports healthcare accessibility through the promotion of a diverse and competent workforce while providing analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. The division's programs, services and resources address, aid and define healthcare workforce issues throughout the state by:

1. Encouraging demographically underrepresented groups to pursue healthcare careers.

2. Identifying geographic areas of unmet need.

3. Encouraging primary care physicians and non-physician practitioners to provide healthcare in health professional shortage areas in California.

HWDD staff collect, analyze and publish data about California's healthcare workforce and health professional training, identify areas of the state in which there are shortages of health professionals and service capacity, and coordinate with other state departments in addressing the unique medical care issues facing California's rural areas.

PROPOSED BUDGET

For 2017-18, the Governor’s Budget proposes $131.5 million for the support of OSHPD. Of this amount, approximately $110.8 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects a 33 percent ($44 million) decrease from the current year budget, primarily reflecting major grants that are nearing their end, including a $52 million healthcare workforce grant from The California Endowment and the Mental Health Services Act (Proposition 63) Workforce, Education and Training ("WET") program.

The budget display below does not reflect the January proposal to eliminate $33.3 million in General Fund appropriated in the 2016 Budget Act to increase the capacity of various healthcare workforce programs, including the Song Brown program that supports medical residency slots. The administration chose not to include this General Fund appropriation in their budget displays.

OSHPD Budget *(Dollars in Thousands)*					
Fund Source	**2015-16 Actual**	**2016-17 Projected**	**2017-18 Proposed**	**CY to BY $ Change**	**% Change**
Hospital Building Fund	$53,298	$60,501	$61,726	$1,225	2.0%
Health Data & Planning Fund	$31,203	$35,930	$30,447	-$5,483	-15.3%
Registered Nurse Education Fund	$2,081	$2,180	$2,172	-$8	-0.37%
Health Facility Construction Loan Insurance Fund	$5,891	$4,882	$4,807	-$75	-$1.5%
Health Professions Education Fund	$9,536	$10,855	$1,070	-9,785	-90.1%
Federal Trust Fund	$1,444	$1,554	$1,447	-$107	-6.9%
Reimbursements	$5,096	$7,120	$863	-$6,257	-87.9%
Mental Health Practitioner Education Fund	$391	$397	$394	-$3	-0.76%
Vocational Nurse Education Fund	$218	$229	$224	-$5	-2.2%
Mental Health Services Fund	$31,473	$49,482	$26,023	-$23,459	-47.4%
Medically Underserved Account For Physicians, Health Professions Education Fund	$2,255	$2,302	$2,302	$0	0%
TOTAL EXPENDITURES	**142,886**	**$175,432**	**$131,475**	**-$43,957**	**-25.1%**
Positions	443.7	449.0	447.0	-2	-0.45%

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an overview of the department and its proposed budget, and to provide any significant program updates within OSHPD.

Staff Recommendation: No action is recommended at this time.

ISSUE 2: 2016 HEALTH CARE WORKFORCE FUNDING

PANELISTS

- **Robert P. David**, Director, Office of Statewide Health Planning and Development
- **Stacie Walker**, Deputy Director, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Governor's January budget proposes to eliminate $100 million General Fund that was included in the 2016 Budget Act, to be allocated over three fiscal years: 2016-17, 2017-18, and 2018-19. Therefore, $33.3 million would be eliminated from the 2017-18 budget. No funds have been expended yet in the 2016-17 fiscal year.

This funding was appropriated for the support and expansion of healthcare workforce programs, primarily the Song Brown Program. Per the 2016 Budget Act, the funding is to be used as follows:

- Up to $18.7 million to fund grant awards at existing primary care residency slots;
- Up to $5.7 million to fund primary care residency slots at existing Teaching Health Centers;
- Up to $3.3 million to fund new primary care residency slots at existing programs;
- Up to $3.3 million to fund newly accredited primary care residency programs;
- Up to $2.0 million to administer the program at OSHPD; and
- Up to $333,000 for the State Loan Repayment Program.

BACKGROUND

Song-Brown provides grants to support health professions training institutions that provide clinical training for Primary Care residents, Family Nurse Practitioners, Primary Care Physician Assistants, and Registered Nurse students. Residents and trainees are required to complete training in medically underserved areas, underserved communities, lower socio-economic neighborhoods, and/or rural communities (Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, Primary Care Shortage Areas, and Registered Nurse Shortage Areas).

According to OSHPD, Song-Brown-funded programs have led practitioners to be at the forefront of curricula development and clinical care for many contemporary challenges facing California's healthcare system such as homeless, refugee, and immigrant health. Various studies indicate that residents exposed to underserved areas during clinical training are more likely to remain in those areas after completing their training.

Funding is provided to family practice residency programs via capitation funding. Each training program funded by Song-Brown must meet the accreditation standards set forth by their specific discipline. Song-Brown funds do not replace existing resources but are used to support and augment primary care training. Family practice residency programs are funded in increments of $51,615 per capitation cycle ($17,205 per year for three years). Funding included in the 2014 Budget Act provided a higher level of support for *new* residency slots.

The intent of the 2016 proposal was to not only support traditional primary care residency programs operated by hospitals, but also to expand on relatively new but successful Teaching Health Center (THC) programs. California currently has six THCs that are community-based primary care training programs committed to preparing physicians to serve the needs of the community. According to stakeholders, by moving primary care training into the community, THCs are on the leading edge of innovative educational programming dedicated to ensuring a relevant and sufficient supply of health workforce professionals.

In 2016, stakeholders provided the following data:

1. Primary care training programs are facing a $43 million fiscal cliff as significant federal and private foundation grants have recently expired or are set to expire this year.
   - $21 million California Endowment grant to the Song-Brown Program
   - $4 million California Health Data and Planning Fund appropriation to the Song-Brown Program
   - $18 million Health Resources and Services Administration (HRSA) funding for the Primary Care Residency Expansion to California

2. In addition, the federal THC program, which has already distributed more than $15 million to California primary care training programs, has cut grants by 40 percent and is set to expire in 2017.

Stakeholders argued that several areas of the state with the most critical primary care shortages could greatly benefit from a new residency program in their specific region (e.g., Humboldt, Tulare and Imperial counties), but current funding levels are inadequate to support that kind of investment. The amount of money needed to create a residency program can vary significantly depending on preexisting infrastructure. Consultants who work with hospitals and communities to build residency programs estimate the start-up costs to be $500,000 to $1 million before capital expenditures.

Horizon 2030: Meeting California's Primary Care Workforce Needs (2016), a recently released report commissioned by the California Primary Care Association (CPCA),

offers an analysis of California's primary care workforce today while detailing key opportunities to meet the workforce needs of tomorrow. With six out of nine California regions experiencing a primary care provider shortage, and a ratio of primary care physicians in Medicaid that is half the federal recommendation, California ranks 32nd in physician access. The report estimates that California will need 8,243 additional primary care physicians by 2030 and provides a stark reminder that the primary care workforce shortage has reached a critical point and will continue to devolve if California does not take immediate action. To remedy current primary care shortages and avoid future shortfalls, it is estimated that the U.S. needs to add another 1,700 to 3,000 primary care residency slots.

The 2014 budget included the following augmentations related to the Song-Brown Program:

1. ***Song-Brown Program – New Residency Slots***. As proposed by stakeholders, the 2014 Budget Act augmented OSHPD's budget by $4 million (California Health Data and Planning Fund) to fund new residency slots in the Song-Brown Health Care Workforce Training Program over three years. Priority was given to support new primary care physician slots and to physicians who have graduated from a California-based medical school.

2. ***Song-Brown Residency Support Program***. As proposed by the Governor, the 2014 Budget Act included $2.84 million (California Health Data Planning Fund) per year for three years to expand the Song-Brown program. Eligibility for Song-Brown funding was expanded to THCs and increased the number of primary care residents specializing in internal medicine, pediatrics, and obstetrics and gynecology. The 2014 Budget Act also included resources for one three-year limited-term position to develop and implement this program expansion.

CMS Approval of an Extension to the Hospital Quality Assurance Fee (QAF)
This OSHPD appropriation in the 2016 Budget Act ($100 million General Fund) was made contingent upon the state receiving federal (CMS) approval of an extension to the hospital QAF. Through 2016 budget trailer bill, the QAF was extended for one year, and subsequently extended indefinitely through Proposition 52 on the November 2016 ballot. DOF explains that when legislation extends a QAF, the administration must then develop an implementation model which is what is actually submitted to CMS for approval. The administration has been working on the development of this new QAF model for the past several months, and it has been significantly complicated by the issuance of new, complex managed care rules by the federal government. They expect to submit the model to CMS for approval next month (March, 2017). The QAF itself will become operational as soon as they submit the model for approval (next month), however the OSHPD funding is contingent on actual receipt of federal approval, which could take up to a year.

STAFF COMMENTS/QUESTIONS

The inclusion of this one-time $100 million General Fund investment in California's healthcare workforce in the final 2016 Budget Act was a significant achievement for stakeholders and advocates of healthcare access, as well as a high priority for the Legislature. while the economy may have changed, and perhaps 2016 revenue estimates have proven to be overly optimistic, it is unclear how recouping one-time funding will help address on-going state costs.

The Subcommittee requests OSHPD to provide an explanation for the proposal to remove this funding from the budget, and respond to the following:

- Please describe the overall funding picture for the Song Brown program given the end of various grants and funding streams, as described above.

Staff Recommendation: Staff recommends the Subcommittee deny the proposal to eliminate $100 million ($33.3 million in 2017-18) General Fund for three years of support for healthcare workforce funding.

ISSUE 3: ELECTIVE PERCUTANEOUS CORONARY INTERVENTIONS REPORTING BUDGET CHANGE PROPOSAL

PANELISTS

- **Chris Krawczyk**, Acting Deputy Director, Healthcare Information Division, Office of Statewide Health Planning and Development
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

OSHPD requests $358,000 (special funds) on-going and the conversion of 2.0 limited-term positions to permanent, and contracts authority to support the on-going workload for the Percutaneous Coronary Intervention (PCI) Program, originally authorized by SB 906 (Correa, Chapter 368, Statutes of 2014). These resources are proposed to be supported by the Health Care Data Planning Fund (which contains revenue from fees on hospitals and nursing homes).

BACKGROUND

SB 906 established the Elective PCI Program which allows certified hospitals without onsite surgical backup to perform elective PCIs. In Fiscal Year (FY) 2015-16, the Legislature approved 2.0 limited-term positions and contract funding for data acquisition and clinical expertise to analyze PCI procedures and outcomes at certified hospitals. The Legislature requested that the ongoing workload be evaluated after the startup of the program.

The statute requires the California Department of Public Health (CDPH) to certify hospitals that would like to perform elective PCIs without surgical backup. These hospitals must submit their data to the National Cardiovascular Data Registry (NCDR) and allow OSHPD use of that data. OSHPD is tasked with obtaining the data from NCDR and creating an annual risk-adjusted outcomes report on mortality, post-op stroke, and post-op Coronary Artery Bypass Graft (CABG) for certified hospitals. The PCI program authorizes CDPH to certify an unlimited number of general acute care hospitals that are licensed to provide urgent and emergent cardiac catheterization laboratory services in California to perform elective PCIs without onsite surgical backup. This statute also authorizes CDPH to establish an advisory oversight committee to analyze the public outcomes report produced by OSHPD and make recommendations for changing the data analysis or risk-adjustment methods and possible outcomes to add in future reports.

OSHPD states that the 2.0 positions are needed on an ongoing basis to annually acquire, validate, reformat, manage, and analyze complex NCDR data and perform all related tasks:

- RPS I: Liaison with all stakeholders (including certified hospitals, CDPH, and NCDR), acquire the PCI data from NCDR, develop, organize and manage relational databases, monitor information and periodic database changes, and assist with producing the annual outcome reports.

- RS III: Validate the methodology for reporting risk-adjusted measures, analyze the NCDR data received by OSHPD, develop and refine risk-adjustment models for hospital performance measures, write analytic code, complete statistical analysis, interpret data output, and create required annual outcome reports.

OSHPD also states that continued contract resources are needed to ensure accurate clinical input to contribute to the development of the risk-adjustment methodologies. As cardiac procedures are constantly being changed, the need for ongoing clinical support is necessary. OSHPD is required to maintain and manage a contract with American College of Cardiology Foundation to acquire the necessary data to produce the mandated report.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD present this proposal and describe the evaluation history of this program.

When is the annual outcome report expected to be completed?

Staff Recommendation: Staff recommends no action at this time.

ISSUE 4: HEALTH CARE WORKFORCE RECRUITMENT LEGISLATION (AB 2024 & AB 2048) BUDGET CHANGE PROPOSAL

PANELISTS

- **Stacie Walker**, Deputy Director, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

OSHPD requests limited-term resources (equivalent to 3.5 staff) and expenditure authority of $400,000 in 2017-18, $250,000 (equivalent to 2.5 staff) in 2018-19 and 2019-20, and $70,000 (equivalent to 0.5 staff) in 2020-21 through 2023-24 to implement AB 2024 (Wood, Chapter 496, Statutes of 2016) that requires OSHPD to collect data on Critical Access Hospitals, and AB 2048 (Gray, Chapter 454, Statutes of 2016) that modifies the California State Loan Repayment Program (SLRP).

BACKGROUND

AB 2024 (Wood, Chapter 496, Statutes of 2016)

AB 2024, until January 1, 2024, authorizes federally certified Critical Access Hospitals (CAHs) to employ medical professionals (physicians and surgeons, or doctors of podiatric medicine) and charge for professional services rendered by these professionals when certain conditions are met. This bill requires OSHPD to provide a report to the Legislature, on or before July 1, 2023, containing data on the impact of this authorization on CAHs and their ability to recruit and retain physicians and surgeons. OSHPD requests an increase in budget authority of $200,000 from the California Health Planning and Data Fund in FY 2017-18 and $70,000 in FY 2018-19 through FY 2023-24 to meet AB 2024 reporting requirements. The limited-term resources will support development of research methods and protocol, systems development, CAH site coordination, responding to technical questions regarding research requirements, data collection and data analysis, and legislative report preparation.

Specifically, OSHPD requests limited-term resources (equivalent to 1.5 staff) and expenditure authority of $200,000 in FY 2017-18 and $70,000 (equivalent to 0.5 staff) annually until 2023-24 to engage in data collection (formatting and reporting instructions for CAHs and systems development), data analysis, legislative report preparation, and program management and oversight. The following is a description of the responsibilities that will be performed:

- The limited-term staff would be responsible for developing the research methods and protocol including data collection and reporting instructions which are one-time functions in FY 2017-18. From FY 2018-19 until completion of the report, the RPS II would be responsible for coordination with the 34 CAHs and other internal/external offices, responding to technical questions regarding research requirements, data compilation and data analysis, detailing findings from submitted data, and developing the legislative report.

- The limited-term staff would be responsible for development of a web-based data collection process and tools that would be compatible with OSHPD's existing environment, provision of programming resources and network/server support, serving as database administrator, and performing system maintenance. All responsibilities associated with these resources are one-time in nature and will occur in FY 2017-18.

AB 2048 (Gray, Chapter 454, Statutes of 2016)

AB 2048 requires OSHPD to include all federally qualified health centers located in California in the SLRP eligible cite list. OSHPD requests a limited-term increase in budget authority of $200,000 from the California Health Planning and Data Fund for SLRP in FY 2017-18 and $180,000 each in FYs 2018-19 and 2019-20 to process additional SLRP applications and provide technical assistance to the additional applicants.

OSHPD requests limited-term resources (equivalent to 2.0 staff) and expenditure authority of $200,000 in FY 2017-18 and $180,000 each in FYs 2018-19 and 2019-20 to support increased SLRP applications and technical assistance as a result of AB 2048.

Currently, there are 415 healthcare facilities on the SLRP eligible cite list. To comply with AB 2048, SLRP must update its practice site list to include approximately 2,500 additional FQHC sites. This is six times the number of facilities on the current list. This increase in the number of practice sites on the list would increase both the number of practice sites and providers who can participate in SLRP. SLRP currently receives an average of 3,500 technical assistance inquires per year. The addition of 2,500 practice sites on the list would increase the number of technical assistance calls exponentially. An increased number of applicants would also lead to an increase in technical assistance provided by OSHPD. All applications must be scored and analyzed. Increased applications and increased technical assistance result in increased workload. The staff would also assist in the one-time input of the additional 2,500 FQHC sites into the automated system used to link facilities and providers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to present this proposal.

Staff Recommendation: Staff recommends no action at this time.

ISSUE 5: RELOCATION RENT ADJUSTMENT BUDGET CHANGE PROPOSAL

PANELISTS

- **Monica Flowers**, Deputy Director, Administrative Services Division, Office of Statewide Health Planning and Development
- **Guadalupe Manriquez**, Principal Program Budget Analyst, Department of Finance
- **Sergio Aguilar**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

OSHPD requests increased expenditure authority in the amount of $1.2 million (special funds, existing resources) to support increased rent costs for the new Sacramento headquarters and Los Angeles office locations.

BACKGROUND

The California Public Employees' Retirement System (CalPERS) provided OSHPD and the Department of General Services (DGS), serving as OSHPD's real estate agent, notification that it would not renew the lease for its Sacramento downtown headquarters location once the soft term has ended on November 30, 2020. OSHPD plans to relocate its headquarters to the new location in Natomas in the Spring of 2017. OSHPD's headquarters' relocation is a large project requiring approximately 125,000 square feet for multiple programs and more than 400 employees. Given the limited real estate options in downtown Sacramento and surrounding areas for a project this size, OSHPD worked quickly with DGS to secure available office space in a tight market. OSHPD explains that moving before the current lease expires ensures sufficient time for a well-planned and efficient move, and protects the department from incurring increased rent costs under the existing soft term lease agreement.

The Metropolitan Water District (MWD), lessor of OSHPD's current LA location, provided OSHPD and DGS notification that it would not renew the lease once the soft term has ended on May 31, 2017. MWD is conducting seismic retrofitting of the current building and needs the OSHPD space to relocate its staff. OSHPD is currently working with DGS to secure a new location and expects to complete the move for the LA relocation in late 2017.

The new leases result in increased rent costs estimated at $1.2 million ongoing beginning in FY 2017-18. Approximately $1 million is attributable to the Sacramento headquarters relocation and $200,000 is attributable to the LA relocation.

All relocation costs for both OSHPD facilities are being absorbed within existing resources. OSHPD has established an Architectural Revolving Fund (ARF) for both relocations. OSHPD has deposited $8 million over FY 2014-15 and FY 2015-16 into the ARF for the headquarters relocation and is still responsible to fund an estimated additional $1 million in ARF-ineligible costs. OSHPD has deposited $2 million from FY 2015-16 into the ARF for the LA relocation and is still responsible to fund an estimated additional $800,000 in ARF-ineligible costs. The majority of these additional costs will be absorbed in FY 2017-18. However, the amounts deposited in the ARF did not include increased rent.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to present this proposal and respond to the following:

1. Please explain why it is necessary for OSHPD to pay $1 million per year more in rent in Sacramento?

2. Given this significant increased cost, please explain the rationale for moving earlier than necessary.

3. Where did the $8 million in the Architectural Revolving Fund come from?

Staff Recommendation: Staff recommends no action at this time.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 6: DEPARTMENT OF STATE HOSPITALS OVERVIEW AND BUDGET

PANELISTS

- **Pam Ahlin**, Director, Department of State Hospitals
- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

BACKGROUND

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals.

State Hospitals. California has five state hospitals and three prison-based psychiatric programs that treat people with mental illness. Approximately 90 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital by the criminal justice system. The state hospitals are as follows:

- ***Atascadero (ASH).*** ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons referred by the court related to criminal violations). Population: 1,258.
- ***Coalinga (CSH).*** Located in the City of Coalinga, CSH is the newest state hospital, opened in 2005, and treats forensically committed and sexually violent predators. Population: 1,293.
- ***Metropolitan (MSH).*** Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court-ordered penal code commitments. Population: 807.
- ***Napa (NSH).*** Located in the City of Napa, NSH is a low-to-moderate security state hospital. Population: 1,269.
- ***Patton (PSH).*** PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals. Population: 1,527.

Prison-Based Psychiatric Programs. The prison-based psychiatric facilities treat approximately 1,107 inmates. They include: 1) Vacaville Psychiatric Program; 2) Salinas Valley Psychiatric Program; and 3) Stockton Psychiatric Program. The January budget includes a proposal to transfer the authority and resources for psychiatric care from DSH to the California Department of Corrections and Rehabilitation (CDCR). This proposal will be discussed at a joint hearing of Subcommittees #1 and #5 on April 3, 2017 at 2:30 pm.

DEPARTMENT BUDGET

The Governor's proposed 2017-18 Department of State Hospitals (DSH) budget includes total funds of $1.6 billion dollars, of which $1.4 billion is General Fund. The difference is primarily in the form of "reimbursements" from counties that pay the state hospitals for civil commitments. The proposed 2017-18 budget is a 17.5 percent ($278.2 million) decrease from current year funding, primarily reflecting the Governor's proposal to shift responsibility for mental health treatment for state prison inmates from DSH to CDCR.

DEPARTMENT OF STATE HOSPITALS
(Dollars in Thousands)

Fund Source	2015-16 Actual	2016-17 Estimate	2017-18 Proposed	CY to BY $ Change	% Change
General Fund	**$1,606,390**	**$1,727,968**	**$1,443,593**	**-$284,375**	**-16.5%**
CA State Lottery Education Fund	$24	$21	$21	$0	0%
Reimbursements	$136,714	$140,284	$146,490	$6,206	4.4%
Total Expenditures	**$1,743,128**	**$1,868,273**	**$1,590,104**	**-$278,169**	**-14.9%**
Positions	10,973.7	10,481.8	8,549.9	-1,931.9	-22.6%

The following are the key State Hospitals estimate adjustments included in the Governor's January 2016 budget:

1. ***Transfer authority and resources from DSH to CDCR:***
   DSH and CDCR propose transferring $250.4 million and 1,977.6 positions from DSH to CDCR in order to transition the psychiatric care for prison inmates from DSH to CDCR. This proposal will be discussed in detail at a joint hearing of Subcommittees #1 and #5 on Monday, April 3rd, 2017 at 2:30 pm.

2. ***IST Admission, Evaluation, and Stabilization Center:***
   DSH is requesting $1.8 million General Fund for 2017-18 to create a new, first-of-its-kind program to receive all ISTs, provide stabilization treatment and evaluation, and referrals for some to other treatment locations such as State Hospitals.

3. ***Enhanced Treatment Units:***
   DSH requests a reappropriation of $11,467,000 General Fund to renovate the existing state hospitals at Atascadero and Patton to provide Enhanced Treatment Units (ETU).

4. ***Conditional Release (CON-REP) Program:***
   DSH is requesting $1 million General Fund on-going to cover increased costs of the CON-REP program and $2.4 million General Fund to cover the costs of increased caseload of sexually violent predators, including many who are "transient" and require full-time protection from the public.

STATE HOSPITALS CASELOAD

The State Hospitals provide treatment to approximately 6,121 patients, who fall into one of two categories: 1) civil commitments (referrals from counties); or 2) forensic commitments (committed by the courts). Civil commitments comprise approximately 10 percent of the total population while forensic commitments approximately 90 percent. The DSH also operates a Conditional Release Program in which patients reside in community settings.

The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment by the courts:

Committed Directly From Superior Courts:

- *Not Guilty by Reason of Insanity* – Determination by court that the defendant committed a crime and was insane at the time the crime was committed.

- *Incompetent to Stand Trial (IST)* – Determination by court that defendant cannot participate in trial because defendant is not able to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. This includes individuals whose incompetence is due to developmental disabilities.

Referred From The California Department of Corrections and Rehabilitation (CDCR):

- *Sexually Violent Predators (SVP)* – Hold established on inmate by court when it is believed probable cause exists that the inmate may be a SVP. Includes 45-day hold on inmates by the Board of Prison Terms.

- *Mentally Disordered Offenders (MDO)* – Certain CDCR inmates for required treatment as a condition of parole, and beyond parole under specified circumstances.

- *Prisoner Regular/Urgent Inmate-Patients* – Inmates who are found to be mentally ill while in prison, including some in need of urgent treatment.

State Hospitals & Psychiatric Programs Caseload Projections			
	2016-17 Estimate	**2017-18 Projected**	**CY to BY Change**
Population by Commitment Type			
IST – PC 1370	1,552	1,530	-22
NGI – PC 1026	1,421	1,404	-17
MDO	1,322	1,325	3
SVP	920	920	0
LPS/PC 2974	625	628	3
PC 2684 (Coleman)	306	306	0
WIC 1756 (DJJ)	8	8	0
Subtotal	**6,154**	**6,121**	**-33**
Population by Psych Program			
Vacaville	392	0	-392
Salinas	235	0	-235
Stockton	480	0	-480
Subtotal	**1,107**	**0**	**-1,107**
Population Grand Total	**7,261**	**6,121**	**-1,140**

Violence & Aggression in State Hospitals

Over the past approximately fifteen years, the state hospitals' population has changed dramatically, becoming an increasingly "forensic" population with the percentage of civil commitment in decline. Now, approximately 90 percent of the state hospital population is forensic, largely a result of key laws being passed, including: 1) legislation in 1995 (AB 888 [Rogan] and SB 1143 [Mountjoy]), which established a new category of commitment for sexually violent predators (SVPs), which requires certain SVP criminal offenders, upon release from prison, to be placed in state hospitals for treatment; and, 2) Proposition 83 ("Jessica's Law"), passed by voters in 2006, increased criminal penalties for sex offenses and eased the way for more SVPs to be placed in hospitals. As a result of these laws, as well as changes to the population, violence in the hospitals increased substantially. In October of 2010, a patient assault resulted in the death of an employee.

Cal/OSHA has had significant and ongoing involvement with State Hospitals as a result of insufficient protections for staff. The LA Times reported on March 2, 2012 that Cal/OSHA has issued nearly $100,000 in fines against Patton and Atascadero, alleging that they have failed to protect staff and have deficient alarm systems. These citations are similar to citations levied in 2011 against NSH and MSH. Cal/OSHA found an average of 20 patient-caused staff injuries per month at Patton (2006-2011) and eight per month at Atascadero (2007-2011), including severe head trauma, fractures, contusions, lacerations, and bites. The former-DMH explained that they were working closely with Cal/OSHA to resolve the issues and to take all necessary corrective measures to protect staff at all of the State Hospitals.

Sacramento Bee Editorial

On February 8, 2015, the *Sacramento Bee* published an editorial written by Dr. Stephen Seager, a staff psychiatrist at Napa State Hospital that calls attention to the violence in State Hospitals and the resulting danger level for staff in the hospitals. Dr. Seager states that Napa State Hospital has roughly 3,000 assaults per year, and that patients are most often the victims. Seager states that both staff and patients have been murdered. Seager asserts that the response from the administration is woefully inadequate and suggests the following solutions: 1) Move staff offices away from inpatient units: 2) Supply guards to escort staff; 3) Supply hall monitors and guards; 4) Create segregation for the worst offenders; and 5) Mandate that every forensic patient sent to a State Hospital come with a court order for the administration of anti-psychotic medications.

On February 22, 2015, the *Sacramento Bee* published a response to this editorial from DSH, which states, "By the end of 2013, our hospital system recorded reductions in aggressive incidents that translated into 180 fewer patient assaults and 30 fewer staff assaults per month from the peak of violence in 2010." The response describes some of the violence-prevention/reduction strategies already implemented in the state hospitals (listed in detail below), and identifies the following bills that were signed into law in 2014 that they expected would help:

- AB 1960 (Perea, Chapter 730) allows department clinicians to access the criminal history of all patients;

- AB 1340 (Achadjian, Chapter 718) allows for building enhanced treatment units where the most aggressive patients will receive specialized treatment in a restricted setting;

- AB 2186 (Lowenthal, Chapter 733) and AB 2625 (Achadjian, Chapter 742) streamline involuntary medication orders and court procedures to help staff treat those who are incompetent to stand trial.

DSH provided to the Legislature the following listing of the violence reduction strategies implemented so far in the State Hospitals:

"Assessment. In this domain, our goal is to train clinicians to understand the cause of, and improve our ability to predict, violent behavior. To accomplish this goal, we have:

- Implemented Violence Risk Assessments statewide; all patients receive some type of assessment depending on their commitment type and hospital.
- Completed statewide training in state-of-the-art violence risk assessment tools. Trainings will continue on a regular cycle.
- Begun working to leverage technology to ensure data from these assessments are incorporated into the treatment planning process.

Treatment. As our goal, we will optimize the treatment of violence. We have:

- Researched, created, published and disseminated to DSH clinicians the California Violence Assessment and Treatment Guidelines (Cal-VAT) last year, which is unique in the literature. Cal-VAT is based on University of California, Davis research demonstrating that psychiatric inpatient aggression can be categorized as psychotic, predatory or impulsive. DSH is currently developing guidelines targeting violence due to cognitive issues.
- Implemented the Psychopharmacology Resource Network led by national expert Stephen Stahl MD, PhD. This group of experts provides training and consultation to our doctors statewide on the pharmacological treatment of violence.
- Implemented a statewide Continuing Medical Education (CME) program that includes intensive focus on forensic training and training on the Cal-VAT guidelines. We have provided more than 100 hours of group CME training to DSH psychiatrists since January 2013.
- Implemented an internal Data Analytics, Treatment and Assessment team who aid in identifying, piloting and implementing best non-pharmacological practices such as Dialectical Behavioral Therapy. Based on the team's recent data analysis related to DSH's chronic assaulter analysis, they are now working to implement statewide cognitive rehabilitation programs.
- Established an online Education Connection for level-of-care staff; thus far, 970 users have received more than 25,000 hours of education in the last year to enhance their clinical skills.
- Creating a model called Forensic Focused Treatment Planning and recently had an article accepted for publication on this topic. This model identifies and focuses on salient forensic issues such as inpatient aggression.
- Working with other states to define and publish a forensic standard of care.

Environment. For this domain, our goal is to establish appropriate treatment environments. We have:

- Implemented the Personal Duress Alarm System at three of five hospitals and implementation is in process at the other two freestanding facilities.
- Implemented Specialty Unit Pilots: an Enhanced Treatment Unit at Atascadero State Hospital that treats patients whose severe violence is primarily driven by severe psychiatric symptoms; a Specialized Services Unit at Coalinga State Hospital that treats patients whose criminogenic behavior is primarily driven by characterological traits; a Substance Abuse Treatment Unit at Napa State Hospital that treats patients who are actively abusing substances, which is a major risk factor for violence.
- In process of evaluating an ecological approach to environmental violence reduction at Patton State Hospital.
- Begun developing the Enhanced Treatment Program, described in AB 1340. This legislation enabled the creation of specialized, safety-oriented settings for the treatment of violence that is likely to cause severe physical harm and is not containable in a regular treatment setting. The Department has launched a multi-

focal plan for the design, construction and programmatic aspects of these units. The Enhanced Treatment Program will allow the Department to begin stratifying our hospitals beds based on level of therapeutic security as well as treatment needs.

- Analyzed worker's compensation data and found that DSH staff are injured as often during containment as they are by assault. As a result, the Department is currently exploring best practices related to de-escalation training, as well as approaches in other countries.

Data. Our goal is to improve the integrity, architecture and analysis of violence-related data to achieve ongoing performance improvement related to violence. We have:

- Established a unit tasked with accomplishing this goal.
- Begun expanding the University of California, Davis research program to all hospitals.
- Completed a violence data analysis project to determine trends in violence in the State Hospital System.
- Initiated a chronic aggressors project. The results of the violence data analysis indicated that 2 to 3 percent of the patient population was responsible for 30 to 40 percent of the hospital violence each year. DSH developed a coding process for reviewing these cases to find common risk factors in the hopes of developing targeted interventions for this portion of the patient population.
- Initiated a worker's compensation data analysis project. The violence data analysis indicated that patient-to-staff violence has not decreased as much as patient-to-patient violence. DSH developed this project to analyze data from the worker's compensation databases to better understand patient-to-staff violence and find areas to mitigate the risk of staff injury.
- Created a process for reporting to the DSH Governing Body on discipline specific outcomes and best practices on a statewide basis, some of which impacts violence reduction.
- Begun leading an effort to establish national forensic benchmarking data with partners in other states."

In April 2014, DSH published a report on violence in the State Hospitals that includes a substantial amount of data and other information, focusing on years 2010-2013. The full report can be accessed at:

http://www.dsh.ca.gov/Publications/docs/Docs/Final_Violence_Report_April_18.pdf

DSH publishes an annual report on violence and aggression in the State Hospitals. The most recent (2016) report can be accessed at:

http://www.dsh.ca.gov/Publications/docs/2016_Violence_Report.pdf

DSH indicates that violence and aggression rates have been decreasing since 2010, and that they cannot be sure exactly which of their interventions have had the greatest impact.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to provide an overview of the department, the state hospitals system, and the Governor's proposed 2017-18 budget for this department.

Please also provide an update on progress towards decreasing violence in the State Hospitals.

Staff Recommendation: No action is recommended at this point in time.

ISSUE 7: INCOMPETENT TO STAND TRIAL PROPOSAL AND TRAILER BILL FOR AN ADMISSION, EVALUATION, AND STABILIZATION CENTER

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Mathew Garber**, Deputy Director, Forensics, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office
- **Margaret Johnson**, Advocacy Director, Disability Rights California

Public Comment

PROPOSAL

DSH is requesting $10.8 million General Fund, 1.0 position, and trailer bill to create an Admission, Evaluation, and Stabilization (AES) Center to help address the waiting list of individuals deemed Incompetent to Stand Trial (IST).

BACKGROUND

When a judge deems a defendant to be incompetent to stand trial (IST), the defendant is referred to the state hospitals system to undergo treatment for the purpose of restoring competency. Once the individual's competency has been restored, the county is required to take the individual back into the criminal justice system to stand trial, and counties are required to do this within ten days of competency being restored.

For a portion of this population, the state hospital system finds that restoring competency is not possible. For these individuals, the responsibility for their care returns to counties which are required to retrieve the patients from the state hospitals within ten days of the medical team deeming the individual's competency to be unlikely to be restored. AB 2625 (Achadjian, Chapter 742, Statutes of 2014) changed this deadline for counties from three years to ten days. Prior to this bill, many individuals in this category would linger in state hospitals for years.

Over the past several years, the state hospitals have seen a growing waiting list of forensic patients, with a ten percent annual increase in IST referrals from courts to DSH. Currently, there are 525 ISTs on the waiting list. DSH has undertaken several efforts to address the growing IST waitlist including: 1) increasing budgeted bed capacity by activating new units and converting other units; 2) establishing a statewide patient

management unit; 3) promoting expansion of jail-based IST programs; 4) standardizing competency treatment programs; 5) seeking community placements; 6) improving referral tracking systems; and 7) participating in an IST workgroup that includes county sheriffs, the Judicial Council, public defenders, district attorneys, patients' rights advocates, and the administration. DSH acknowledges that, despite these efforts, IST referrals have continued to increase. When queried about the potential causes of the growing number of referrals from judges and CDCR, the administration describes a very complex puzzle of criminal, social, cultural, and health variables that together are leading to increasing criminal and violent behavior by individuals with mental illness.

Restoration of Competency (ROC) In County Jails Program

The 2007 Budget Act included $4.3 million for a pilot program to test a more efficient and less costly process to restore competency for IST defendants by providing competency restoration services in county jails, in lieu of providing them within state hospitals. This pilot operated in San Bernardino County, via a contract between the former Department of Mental Health, San Bernardino County, and Liberty Healthcare Corporation. Liberty provides intensive psychiatric treatment, acute stabilization services, and other court-mandated services. The State pays Liberty $278, well below the approximately $450 cost of a state hospital bed. The county covers the costs of food, housing, medications, and security through its county jail. The results of the pilot were very positive, including: 1) treatment begins more quickly than in state hospitals; 2) treatment gets completed more quickly; 3) treatment has been effective as measured by the number of patients restored to competency but then returned to IST status; and, 4) the county has seen a reduction in the number of IST referrals. San Bernardino County reports that it has been able to achieve savings of more than $5,000 per IST defendant, and therefore total savings of about $200,000. The LAO estimated that the state achieved approximately $1.2 million in savings from the San Bernardino County pilot project.

The LAO produced a report titled*, An Alternative Approach: Treating the Incompetent to Stand Trial*, in January 2012 on this issue. Given the savings realized for both the state and the county, as well as the other indicators of success in the form of shortened treatment times and a deterrent effect reducing the number of defendants seeking IST commitments, the LAO recommends that the pilot program be expanded.

In 2012, budget trailer bill authorized the state to continue the pilot on an ongoing basis, and the DSH is in the process of actively encouraging expansion to other counties. DSH recently signed contracts with Sacramento and with San Bernardino to expand to cover Los Angeles County. The 2015 Budget included $10.1 million in additional funding to expand the ROC program, and the 2016 Budget Act includes up to $1.7 million to expand and support this program even further. The program is now operating in Sonoma and San Diego.

Current Proposal

The current proposal is to create a jail-based program, similar to ROC, however different from ROC in that all ISTs (in Southern California) will be referred to the AES and evaluated there, rather than being evaluated prior to a referral to ROC or a State

Hospital. Once at the AES, an individual IST will be evaluated and either determined to be appropriate for being treated at the AES or not appropriate and therefore referred to a State Hospital. Regardless of the outcome of this referral, all ISTs will receive stabilization services at the AES. The proposal states that the AES will have 60 beds, however given the turnover in patients, DSH expects to be able to serve over 200 patients per year through the AES.

Proposed Trailer Bill
The DSH-proposed trailer bill provides authority to the court to refer ISTs to the AES, as an option for referrals in addition to State Hospitals and Jail Based Competency (ROC) programs. The proposed language also gives DSH emergency regulations authority to establish additional AES Centers in other parts of the state as quickly as possible should the opportunity to do so arise.

LAO Assessment and Recommendations
The LAO states that the proposed AES Center is virtually identical to a JBCT program. Like a JBCT program, the AES center would screen IST patients and treat those it finds clinically appropriate in a jail setting, at a lower cost than a state hospital. LAO notes that, DSH indicates that the AES Center beds would cost more than average JBCT beds because the contract with Kern County would allow DSH to send some higher-security inmates to the center. However, there is no reason similar agreements could not be reached with existing or future JBCT programs.

LAO argues that the only meaningful difference is the proposed budget trailer legislation that would generally allow DSH to determine who would be admitted to the center. However, the language does not expand DSH's authority to refer patients to existing JBCT programs.

In light of the IST waitlist and the lower cost of providing treatment through the contract with Kern County, LAO recommends that the Legislature approve the funding and positions requested by the department and revise the proposed budget trailer legislation to give DSH the authority to determine who is admitted to JBCT programs as well. Such a change would help achieve the intended goals of the proposed AES Center, but in a much broader way that maximizes the number of patients that receive treatment without waiting for a bed in a state hospital and reduces future state costs.

Disability Rights California (DRC) Concerns
DRC Submitted concerns and recommendations to the Subcommittee with regards to the IST population and the administration's proposal. DRC is concerned that the Administration's recommendations generally speak only to increasing capacity in institutional settings. DRC states that, consistent with competency restoration programs in other states, it is important to increase community capacity to provide competency programs. DRC states that other states have robust outpatient competency programs. DRC believes that the proposal does not appear to address non-institutional services for individuals when it is determined that an individual's competency cannot be restored. DRC makes the following recommendations:

1) Increase Community-Based Competency Programs

2) Increase Community Based Options for Individuals Whose Competency Can Not Be Restored

3) Increase Overall State Hospital Capacity by Expanding the Use of the ConRep Program for Individuals No Longer Needing State Hospital Services

4) Implement the Remaining Judicial Council Recommendations to Increase Judicial Discretion for Competency Restoration Programs

5) Require Better Coordination between Agencies to Avoid Placement of Regional Center Consumers in State Hospital Competency Programs

STAFF COMMENTS/QUESTIONS

The growing waiting list of ISTs continues to plague DSH, as the growth rate continues to exceed the increasing resources that have been provided to DSH over the past few years. This situation is untenable and calls on the state to be creative and think outside of the box. The current proposal is novel and, if successful, would address a significant portion of the waiting list. If it proves to be successful, and therefore is expanded to more than one AES, perhaps eventually this solution could address a significant portion of the waiting list.

The Subcommittee requests DSH to present this proposal and to respond to the concerns raised by the LAO and Disability Rights California.

What is DSH doing in order to expedite the implementation timeline on this project, given its urgency?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 8: CONDITIONAL RELEASE PROGRAM (CONREP) PROPOSALS

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Mathew Garber**, Deputy Director, Forensics, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CONREP Transitional Housing Cost Increase ($976,000 GF)

For the continuation of the Statewide Transitional Residential Program (STRP) for CONREP patients, DSH is requesting $976,000 in General Fund authority. STRP beds provide temporary housing to CONREP patients unable to live in the community without direct supervision. DSH activated 16 beds in FY 2016-17 and this request provides the ongoing funding for the continued operation of these beds.

CONREP Sexually Violent Predator (SVP) Program Cost Increase ($2.4 million GF)

Based on anticipated court-ordered release dates, DSH estimates the cost of releasing two additional SVP patients (with housing available) and two additional transient SVP patients in FY 2017-18 to be $2.4 million. This funding will increase the current caseload for conditionally released SVPs from 19 in FY 2016-17 to 23 in FY 2017-18. Given the security requirements for this population, DSH is unable to absorb the cost increase with existing resources.

BACKGROUND

The California Forensic Conditional Release Program (CONREP) oversees patients who have been conditionally released from DSH by a judge. DSH's medical directors recommend patients for release when their symptoms have been stabilized and they no longer present a danger to society. Only the courts have the authority to order a release. SVPs in CONREP receive an intensive regimen of treatment and supervision that includes at least weekly individual contact by supervision staff, specialized sex offender treatment, weekly drug screening, surveillance, polygraph examinations, and active Global Positioning System tracking.

CONREP was mandated as a state responsibility in 1984, and began operating in 1986. Its patients have typically experienced lengthy hospital stays and in some cases served full prison sentences. The goal of CONREP is to ensure public protection in California communities while providing an effective and standardized outpatient treatment system.

Most patients in the CONREP program have gotten there after a lengthy stay in a state hospital. Once psychiatric symptoms have been stabilized and the patients are considered no longer to be a danger, the state hospital medical director recommends eligible inpatients to the courts for outpatient treatment under CONREP.

Individuals must agree to follow a treatment plan designed by the outpatient supervisor and approved by the committing court. The court-approved treatment plan includes provisions for involuntary outpatient services. In order to protect the public, individuals who do not comply with treatment may be returned to a state hospital.

CONREP patients receive an intensive regimen of treatment and supervision that includes individual and group contact with clinical staff, random drug screenings, home visits, substance abuse screenings and psychological assessments. The Department has performance standards for these services which set minimum treatment and supervision levels for patients in the program. Each patient is evaluated and assessed while they are in the state hospital, upon entry into the community, and throughout their CONREP treatment.

The state budget provides 100 percent of the funding for CONREP's intensive level of assessment, treatment and supervision. The Department contracts with county mental health programs and private agencies to provide services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this budget change proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 9: ENHANCED TREATMENT UNITS STAFFING PROPOSAL

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Sophie Cabrera**, ETP project Director, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Consistent with Assembly Bill (AB) 1340, DSH is requesting staff and resources to begin implementation of the Enhanced Treatment Program (ETP). The ETP will provide treatment for patients who are at the highest risk of violence and who cannot be safely treated in a standard treatment environment. DSH plans to establish three 13-bed ETP units at DSH-Atascadero and one 10-bed ETP unit at DSH-Patton. DSH is requesting $2.3 million in one-time funding and $5.6 million ongoing to support the activation of the first two ETP units at DSH-Atascadero, as well as 44.7 positions in FY 2017-18 and 115.1 positions in FY 2018-19. Resources for DSH-Atascadero's third unit and DSH-Patton's unit will be requested in the FY 2018-19 Governor's Budget Estimate.

BACKGROUND

DSH is proposing, in accordance with AB 1340, (Achadjian, Chapter 718, Statutes of 2014), to construct enhanced treatment units that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. Patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed ETUs are intended to create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

LAO Assessment and Recommendations

"Permanent Positions and Funding Not Necessary Given Pilot Is Only for Four Years. The administration is requesting ongoing funding and positions to operate ETP units. However, Chapter 718 only authorizes each ETP unit to operate for four years. To the extent that the required evaluation of each ETP unit finds that the program is

effective, the Legislature could consider providing ongoing funding to operate the units as part of its budget deliberations in future years. Thus, we find that it is premature at this time to provide the department permanent funding and positions for ETP units.

Required Evaluations Will Allow Legislature to Assess Whether Pilot Units Should Continue After Four Years. The statutorily required evaluations should allow the Legislature to assess the effectiveness of the ETP pilot units and the extent to which such units should continue and be expanded on an ongoing basis. While DSH is required to provide various data in the evaluation reports (such as the length of time patients spend in the program), the department is not specifically required to provide some of the key outcomes that are necessary to measure whether ETP units are effective at reducing violence in state hospitals. These key outcomes are (1) whether ETP patients are able to return to the general population without additional violent incidents, (2) the effect of ETP units on overall rates of patient violence, and (3) whether the ETP pilot units could be modified in order to improve these outcomes.

Approve Funding and Positions on Limited-Term Basis. In view of the above, we recommend the Legislature approve the funding and associated positions for each of the first two ETP units on a limited-term basis as envisioned in Chapter 718, rather than on an ongoing basis as proposed by the Governor.

Adopt Budget Trailer Legislation to Provide Additional Detail on Required Evaluations. We recommend that the Legislature adopt budget trailer legislation to require DSH, as part of its annual evaluation reports on ETP units, to provide information on the following key outcomes: (1) whether ETP patients are able to return to the general population without additional violent incidents, (2) the effect of ETP units on overall rates of patient violence, and (3) whether ETP units could be modified to improve these outcomes."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this budget change proposal and respond to the concerns and recommendations of the LAO.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 10: ENHANCED TREATMENT UNITS CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Sophie Cabrera**, ETP project Director, Department of State Hospitals
- **Sydney Tanimoto**, Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests a reappropriation of $11,467,000 General Fund to renovate the existing state hospitals at Atascadero and Patton to provide Enhanced Treatment Units (ETU). DSH-Atascadero will have 39 rooms and DSH-Patton will have 10 rooms for a total of 49 ETU rooms. The proposed renovation will provide enhanced security and treatment for patients.

During the preliminary plans phase, it was necessary to modify the design in order to meet clinical treatment requirements. The scope includes the conversion of existing patient dorm rooms to individual rooms, individual and group treatment space, the installation of lockable doors, toilets and sinks in patient rooms, and the conversion of existing day/dining rooms into laundry day/dining rooms and other related program space.

Due to this modified design and subsequent scope change, the completion of preliminary plans was delayed and resulted in modifications to the construction estimates. Preliminary plans were approved on December 15, 2016; the project has recently begun the working drawings phase. The result of this delay is that construction is not expected to be started until after June 30, 2017, necessitating the re-appropriation for construction funds.

BACKGROUND

DSH is proposing, in accordance with AB 1340, (Achadjian, Chapter 718, Statutes of 2014), to construct enhanced treatment units that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. Patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed ETUs are intended to create secure

locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

Reappropriation Rational
The Budget Act of 2014, Senate Bill 852 (SB 852), Chapter 25, Statutes of 2014, authorized $2,102,650 to be made available for encumbrance until June 30, 2016 for the development of preliminary plans and working drawings for the ETU project. The project's schedule at that time had estimated that preliminary plans would be completed in March of 2016 and working drawings in April of 2016. Construction was scheduled to begin in July 2016, with completion in September 2017. The Budget Act of 2015, Assembly Bill 93 (AB 93), Chapter 10, Statutes of 2015, then authorized $11,467,000 for construction of the units.

The Department of General Services (DGS) was unable to execute a contract for an architect to begin preliminary plans until October 2015, due to issues with contracting a single project at multiple locations statewide. While DSH and DGS are working very closely to expedite the project, this delay has required DSH to seek the reappropriation of both working drawings and construction funds.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 11: METROPOLITAN FIRE ALARM SYSTEM CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administration, Department of State Hospitals
- **Sydney Tanimoto**, Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests $3,916,000 General Fund to upgrade the existing fire alarm systems for the Chronic Treatment East (CTE) building at DSH-Metropolitan. The upgraded fire alarm system will be fully automatic and addressable which specifies location of incident and/or alarm activation and connected to the new central monitoring system located at Hospital Police Dispatch (HPD). The existing system is not code compliant per National Fire Protection Association (NFPA) 101 Life Safety 2012 which is a requirement of Centers for Medicare and Medicaid Services (CMS) and cannot be serviced or expandability due to the age of the existing system.

BACKGROUND

All buildings that house patients have security measures limiting freedom of movement, including the ability to freely exit buildings. As such, the State Fire Marshal (SFM) has established minimum building and maintenance standards for fire alarm systems for these facilities. Failure to maintain these mandatory systems can and will result in enforcement actions form the SFM.

The current Fire Alarm System (FAS) is 25 years old. It is challenging to obtain necessary parts for regular maintenance and fixes because there is a lack of consistent and trained personnel to maintain the system. To address this, DSH-Metropolitan has hired a specialized 0-16 fire protection contractor on grounds to conduct repairs, when necessary, on a continuous basis. This has cost DSH-Metropolitan a total of $15,000-$20,000 per year to maintain the FAS.

There are numerous devices that fail on a frequent basis causing the panel to show a red flag, requiring a response. DSH-Metropolitan is reporting failures five to six times a week due to hot weather conditions. These incidents have caused shut downs of the air handling units in CTE and Central Treatment West buildings, which are patient occupied

24/7. It should be noted, outages reported are difficult to quantify due to the varying degrees of loss of power. In some cases, only minor losses of power were reported, whereas in other cases, full scale facility outages were documented.

The local fire department does not respond to DSH-Metropolitan alarm activations. Hospital Police Officers (HPO) are the first responders in the event of a fire alarm activation, if a fire alarm activation is determined to be creditable, HPD contacts the local fire department and/or calls 911. Due to false alarms, this response is the preferred approach.

In the event of a fire alarm system malfunction, a fire watch is implemented to ensure minimal Fire/Life/Safety measures are met. Fire watches are conducted by HPO.

The existing fire alarm system does not currently meet NFPA codes and UL standard for fire alarm control panels and field devices. These systems do not meet the SFM requirements for Institution Class two (1-2) or Institution Class three (1-3) occupancies. The current codes and UL standard are:

- 2007 California Fire Code
- 2007 NFPA 72-National Fire Code
- 2006 NFPA 101 Life Safety Code

Currently, during an active fire alarm, the entire building must exit because fire alarms do not specify location of fire. With the proposed system, it will be possible to exit into adjoining fire smoke compartments. This allows the hospital flexibility in evacuating patients from the building which is useful from an operational treatment and security perspective.

This CTE building was previously included in the Metropolitan: Fire Alarm System Update Project upgrading the Fire Alarm Systems in four psychiatric patient housing units and installing a new central monitoring system. Due to an increased project cost estimate after the completion of working drawings, the Legislature was notified on May 19, 2016 and a scope change was approved by the State Public Works Board on June 13, 2016 to remove the CTE building from the project to remain on schedule and provide for a small overall savings of $747,000. This COBCP would provide funding and authority for this last building and allow the original timeline to be resumed.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH or DOF to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 12: PATTON FIRE ALARM SYSTEM CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administration, Department of State Hospitals
- **Sydney Tanimoto**, Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests $6,140,000 General Fund to remove and replace deficient SimplexGrinnell Fire Alarm Control Panels (FACP) and associated components in four patient occupied buildings at Patton State Hospital (PSH) which have reached the end of their usable life and are no longer serviceable.

BACKGROUND

The fire alarm systems in the four secured patient housing buildings and treatment areas (30, 70, U & EB) are severely compromised and not in compliance with regulatory requirements and customary industry standards.

A study provided by DGS concluded that the current fire alarm systems at PSH do not meet standards set by the State Fire Marshall (SFM), National Fire Protection Association (NFPA) codes, and Underwriters Laboratory (UL) standards for FACPs, nor do they meet requirements for 1-2 and or 1-3 occupancies. The systems are deficient as described in:

- California Code of Regulations, Title 19 (Flame Retardants) and Title 24 (Fire Code).
- NFPA Codes: 2007 NFPA 72 (National Fire Code) and 2006 NFPA 101 (Life Safety Code).
- 2003 UL 864 9th Ed. Standard for Control Units and Accessories for Fire Alarm Systems.

The project will remove and replace four FACPs at the aforementioned buildings, with existing initiating and signaling devices being reused where possible. This is a scope reduction from the last authorized COBCP to begin preliminary plans on 7/1/2015. The original project scope encompassed five buildings instead of the current proposal of

four. Upon completion, all of the buildings will have addressable devices which will provide hospital police with exact locations and room numbers of the initiating device, thereby allowing for a quicker emergency response to the exact area of need.

This project will enable PSH to bring the existing fire alarm systems into compliance with regulatory requirements. The existing fire alarm systems are a safety hazard. The four buildings, 30, 70, U, and EB, included in this project house the majority of PSH's patients. These buildings also contain kitchens, dining rooms, medical and dental clinics, therapeutic areas, offices, and nursing stations for staff. Failure to address the fire alarm systems at PSH puts both patients and staff at risk should a fire occur and the notification alarm to evacuate fails.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 13: NAPA COURTYARD CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administration, Department of State Hospitals
- **Sydney Tanimoto**, Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests a reversion of $2,029,000 in existing General Fund for the construction phase and a new appropriation of $1,846,000 General Fund for working drawings and construction (based on bidding in August 2016) to improve security in the courtyards at the patient housing buildings which include: replacement of gates and fabricating and installing extensions to raise the height of security fencing in Buildings 168, 195, 196, 197, 198, and 199.

BACKGROUND

The Budget Act of 2015, Assembly Bill (AB) 93 (Chapters 10 and 11, Statutes of 2016) authorized $2,029,000 for construction. As of June 30, 2016, the balances specified below, of the appropriations provided in the following citations shall revert to the balances in the funds from which the appropriations were made. The project was bid for construction in August 2016, and the project was $1,846,000 over-budget due to increasing construction costs at DSH-N's 44 courtyards due to custom fencing, existing courtyard conditions, requirement for galvanizing fencing, existing construction market conditions, and working within secure treatment environment.

The project consists of the design, fabrication and installation of extensions to raise the height of the 44 existing courtyard security fences and selective demolition and replacement of existing courtyard gates at DSH-N patient housing buildings. This includes Building 168 (9 courtyards). Building 199-0 Units (9 courtyards), and Buildings 198,197,196, 195-T Units (a total of 26 courtyards for T Units) for a campus total of 44 courtyards.

The purpose of this project is to eliminate existing security vulnerabilities in the courtyard fencing and gates that have allowed forensic and civilly-committed patients to climb over the fence and escape from their home unit courtyards. This vulnerability resulted in the escape of a forensically-committed patient from DSH-N Secured Treatment Area (STA). DSH-N has modified the STA security fence, but the courtyard fencing needs are beyond the existing hospital resources.

The same security vulnerabilities exists in the building that houses Lanterman Petris Short (LPS) civilly- committed patients; this has resulted in patients escaping from hospital grounds.

These deficiencies create a significant safety risk to DSH-N and the surrounding community. Many DSH-N patients have committed violent crimes including rape and murder. Once outside courtyard walls, DSH-N grounds allow patients to find areas to hide making staff vulnerable to attack. On October 23, 2010, a DSH-N employee was attacked and murdered by a hospital patient while walking to the building where she worked.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 14: COALINGA COURTYARD CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administration, Department of State Hospitals
- **Sydney Tanimoto**, Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests $5,738,000 General Fund to design and construct a secure treatment courtyard at Coalinga State Hospital (CSH). The current main courtyard is undersized and cannot serve as an area of refuge in the event of a fire. Additionally, the current courtyard does not provide sufficient space for group exercise, social interactions, and other outdoor activities. This project will erect a new courtyard that will have enough open-air space to accommodate the full capacity of the facility in the event of a fire and for outdoor activities.

BACKGROUND

As presently configured, the current main courtyard is far too small for its intended usage, with a practical-use capacity of approximately 60 patients. With a current census of approximately 1,150 patients, the current main courtyard cannot serve as an area of refuge in the event of a fire. This creates a significant concern since the patients of CSH are entirely forensic and must be able to be evacuated to a secured location at least 50 feet away from the facility.

Additionally, the main courtyard and the smaller courtyards attached to the residential units are proving inadequate for exercise and treatment purposes. Because use of each residential courtyard requires staff to monitor patient usage, utilizing them is staff intensive and difficult for the hospital. Additionally, the current courtyards are too small for aerobic activities. With diabetes and chronic excess weight problems for patients, the need for exercise opportunities and programs are critical to maintain physical and psychological health.

The patients at CSH have threatened litigation against the state regarding limited outdoor space, which violates their patient rights. With the construction of the new courtyard, CSH patients will have the required area of refuge and will be able to have appropriate outdoor recreation time, without taxing hospital staff resources.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH or DOF to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 15: METROPOLITAN CONSOLIDATION OF POLICE OPERATIONS CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administration, Department of State Hospitals
- **Sydney Tanimoto**, Finance Budget Analyst, Department of Finance
- **Koreen van Ravenhorst**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

DSH requests $1,327,000 General Fund to construct a new building to consolidate (house) the DSH-Metropolitan Department of Police Services (DPS), Office of Special Investigation (OSI), and the Emergency Dispatch Center. The new building will allow for the consolidation of hospital police services into a single location and include the demolition of seismically deficient buildings.

BACKGROUND

DSH-Metropolitan's DPS, OSI, and the Emergency Dispatch Center are located in buildings that have significant health and safety issues. These issues include asbestos in floor tiles and a Seismic Risk Assessment of Level V, which means it is unacceptable for hospitals and essential facilities. Additionally, the configuration of these existing buildings were not originally designed as police facilities, which impacts quality, efficiency, and security of police operations.

The current buildings do not qualify as Essential Services Buildings. California Administrative Code (2013, Title 24, Part 1, Chapter 4, Article 1, Section 4-207) defines an Essential Services Building as "any building...used or designed to be used as a fire station, police station, emergency operations center, California Highway Patrol office, sheriffs office or emergency communication dispatch center." That same section further defines police station as meaning "any building that contains the operational facilities and the alarm and communications equipment necessary to respond to police emergencies." The code dictates that such buildings must be "capable of providing essential services to the public after a disaster," and "be designed and constructed to minimize fire hazards and to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds."

DSH buildings housing the aforementioned police functions must qualify as Essential Services Buildings. At DSH-Metropolitan, the Administration Building and the 206/208 building house its police functions. As the buildings currently housing the police operations functions do not qualify as Essential Services Buildings, the hospital must relocate these operations to buildings that meet regulatory requirements so that the hospital can ensure responsiveness after a disaster.

DSH-Metropolitan hospital police are currently located in two buildings separated by a distance of 1,700 feet from one another. The main hospital police and investigation building 206/208 is far removed from the patient population and administration, lengthening response time. Buildings 206/208 have a lengthy list of deficiencies including being seismically deficient. Consolidation of all hospital police functions into one location will provide greater efficiency of police operations. Relocating the hospital police to Bloomfield and 6th will put the HPDs in proximity with the Secured Treatment Area and near the Administration building.

A study completed by the Intelligence Building Infrastructure (IBI) Group in September 2014 evaluated how best to accomplish consolidating police operations into an Essential Services Building. Due to the limited number of buildings large enough to accommodate police operations staff and the amount of work needed to renovate an existing building to qualify as an Essential Services Building, the study concluded that new construction would be the most cost effective way to meet the project objectives.

During the design phase, the potential to demolish additional buildings at DSH-Metropolitan will be reviewed. In addition to the five buildings that will be demolished to build the new project, 23 buildings have been identified for future potential demolition. Given the possibility of an economy of scale savings for demolishing 28 buildings and conducting a single Environmental Impact Report, this is a potential avenue to explore.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH or DOF to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 16: DSH-NAPA EARTHQUAKE REPAIRS PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administration, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

DSH requests a $6.2 million General Fund loan that would be repaid with federal reimbursements as phases of the project are constructed. Accordingly, the Governor's budget also includes $6.2 million in federal reimbursement authority. The administration anticipates this funding will be sufficient to complete the first two phases of the project.

BACKGROUND

DSH-Napa suffered damage as part of the 2014 South Napa Earthquake. After the earthquake, DSH requested federal funding to make repairs to buildings damaged in the earthquake. In 2015, DSH secured a grant from the Federal Emergency Management Agency (FEMA) to cover up to 75 percent of project costs once portions of the project are completed. In adopting the *2015-16 Budget Act*, the Legislature approved one-time funding of $5.7 million from the General Fund to cover the state's 25 percent share of the estimated $22.9 million project, as well as $17.2 million in reimbursement authority to allow the department to use the federal funding it expects to receive for the project. After DSH submitted a description of the project to the federal government in 2015, FEMA decided that the project could not be approved without more detailed drawings and specifications on how project repairs of historical buildings would be completed. In order to complete this additional design work, DSH spent $1 million of the $5.7 million provided in 2015-16, with the remaining $4.7 million going unspent in 2015-16. This design work is scheduled to be completed by July 2017.

DSH has divided the project into three phases. The first phase will repair three buildings identified as historically significant. The department estimates the cost of the first phase will be $6 million and be completed by July 2019. The second phase of the project will be to repair 21 buildings located outside the Secure Treatment Area (STA), which is the area where patients accused of crimes are housed. The department estimates the cost of the second phase will be $2.3 million and also be completed by July 2019. The third phase of the project will be to repair 15 buildings located within the STA. At this time, the department has not provided the cost estimate or project schedule for the third phase.

LAO Assessment and Recommendations

"Necessary Information About Third Phase of Project Not Included. While DSH provides cost estimates and project schedules for the first two phases of the project, this same information has not been submitted for the third phase of the project. It is important for the Legislature to know how much the entire project is expected to cost and when it is scheduled to be completed before allocating funds for the construction of the first two phases.

Assumes Funding Provided in 2015-16 Remains Available for Project. As previously indicated, the Legislature appropriated $5.7 million on a one-time basis for the DSH-Napa project. However, the Governor's budget assumes that $2.1 million from this one-time appropriation remains available to fund the state's share of the cost for the first two phases of the project. Based on our conversations with the administration, it appears that when the 2015-16 budget was adopted, DOF erroneously entered the funding as an ongoing appropriation in its fiscal data system.

Withhold Action Until New Funding Plan and Complete Cost Estimates and Project Schedule Are Available. Given that DSH has not submitted complete information on the third phase of the project, we recommend that the Legislature withhold action until the department submits a complete cost estimate and project schedule for all three phases of the project.

Direct DOF to Report How It Plans to Fix Error. We also recommend that the Legislature direct DOF to report at spring budget hearings on how it plans to correct the error that it acknowledges was made in reflecting the $5.7 million that was appropriated in 2015-16 as an ongoing adjustment to DSH's base budget (rather than as a one-time appropriation as approved by the Legislature)."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this proposal and to please respond to the concerns and recommendations raised by the LAO.

Staff Recommendation: Staff recommends holding this item open.