AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER SHIRLEY N. WEBER, PH.D., CHAIR

MONDAY, MARCH 24, 2014

4:00 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

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4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: COMMISSION OVERVIEW

The Mental Health Services Oversight & Accountability Commission (MHSOAC) was established to provide oversight and accountability for the Mental Health Services Act (MHSA, Proposition 63).

BACKGROUND

The MHSOAC's primary roles include: 1) oversight, review, accountability, and evaluation of projects and programs supported with MHSA funds; 2) ensure that services provided pursuant to the MHSA are cost-effective and in accordance with recommended best practices; 3) provide oversight and accountability for the public community mental health system; 4) review county innovation Program and Expenditure Plans, and 5) provide counties technical assistance in MHSA program plan development and to accomplish the purposes of the MHSA. The MHSOAC also advises the Governor and the Legislature regarding state actions to improve care and services for people with mental illness.

The MHSOAC was established in 2005 and is composed of 16 voting members who meet criteria contained in the MHSA. Among other functions, the MHSOAC seeks to:

1. Ensure that services provided, pursuant to the MHSA, are cost effective and provided in accordance with best practices;

2. Ensure that the perspective and participation of members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations; and

3. Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the MHSA.

The purpose of the MHSA is to expand mental health services to children, youth, adults and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources). The MHSA imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a “cash basis” (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

With the exception of a maximum of 5 percent for state administration, the Act's funding is expended by counties for mental health services consistent with their local 3-year plans as well as with the required five components of the MHSA, which are:

- ***Community Services and Supports for Adult and Children's Systems of Care*.** This component funds the adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through a stakeholder process, a listing of programs for which these funds would be used.

- ***Prevention and Early Intervention*.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.

- ***Innovation*.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration.

- ***Workforce Education and Training*.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. Counties have 10 years to spend these funds.

- ***Capital Facilities and Technological Needs*.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

Evaluation. Evaluation is a core activity by which the MHSOAC fulfills its oversight and accountability role. The primary audience for this aspect of MHSOAC evaluation activity is state policy makers (Governor, Legislature, and state agencies) and the general public. Its oversight and accountability responsibilities entail ensuring that the expenditure of MHSA funds is in accord with the requirements of the MHSA and that the funds lead to improvements for the consumers of the public mental health system. The evaluation function is one of the ways in which MHSOAC meets those responsibilities.

The MHSOAC evaluation activity also serves as a valuable quality improvement tool. The results of evaluations are used to improve policy and practice to ensure that clients and families receive the most effective services possible. The audiences for MHSOAC activities are those at the local level who receive services, provide services, and pay for services.

MHSOAC Budget

The MHSOAC's funding is a component of the MHSA state administration funds, capped at 5 percent of MHSA revenue. The remaining state administration funds are appropriated to many different state departments for a variety of MHSA functions, the details of which are provided to the Legislature in a report by the Department of Health Care Services. Total state administration funding for 2014-15 is proposed to be $79.4 million, based on total MHSA revenue projected to be $1.587 billion. The proposed MHSOAC 2014-15 budget is a modest increase over the current year budget, and the significant increase in funding between 2012-13 and 2013-14 reflects the MHSOAC's new responsibilities created through the President Pro Tem's 2013 Investment in Mental Health Wellness Initiative which provided $54 million ($32 million MHSA funds and $22 million federal Medi-Cal) to fund 600 triage personnel in select rural, suburban and urban regions.

MHSOAC
(Dollars In Thousands)

	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change	% Change
Total Funds (Proposition 63)	**$6,850**	**$62,310**	**$62,948**	**$638**	**1%**
Positions	19	28.2	27	(1.2)	(4.2%)

STAFF COMMENTS/QUESTIONS

No issues or concerns have been brought to the Subcommittee's attention with regard to the proposed MHSOAC budget. The Subcommittee requests the MHSOAC to provide an overview of the Commission, its proposed budget, and any other issues it deems appropriate to discuss with the Subcommittee.

Staff Recommendation: This is an informational item at this point in time and no action is necessary.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: DEPARTMENT OF STATE HOSPITALS OVERVIEW

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals. The DSH seeks to ensure the availability and accessibility of effective, efficient, and culturally competent services. DSH activities and functions include advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

BACKGROUND

The Governor's 2011 May Revision first proposed the elimination of the former Department of Mental Health (DMH), the creation of the new DSH, and the transfer of Medi-Cal and other community mental health programs to the DHCS. The 2011 Budget Act approved of just the transfer of Medi-Cal mental health programs from the DMH to the DHCS. In 2012, the Governor proposed, and the budget adopted the full elimination of the DMH and the creation of the DSH. All of the community mental health programs remaining at the DMH were transferred to other state departments as part of the 2012 budget package. The budget package also created the new DSH which has the singular focus of providing improved oversight, safety, and accountability to the state's mental hospitals and other psychiatric facilities.

State Hospitals. California has five state hospitals and three prison-based psychiatric programs that treat people with mental illness. Approximately 92 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).

- ***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.

- ***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.

- ***Napa (NSH).*** Located in the City of Napa, NSH is a low-to-moderate security state hospital.

- ***Patton (PSH).*** PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals.

- ***Vacaville & Salinas Valley Psychiatric Programs.*** These programs are located within state prisons.

- ***Stockton Psychiatric Program.*** This is the newest facility that began operation in July of 2013, serving 432 High Custody/Level IV inmates/patients at the intermediate level of care, within the California Health Care Facility in Stockton.

Cost Over-Runs. Over the past several years, state hospital costs had been rising at an alarming rate, and substantial current year deficiencies had become the norm and even expected from year to year. For example, in the 2010-11 FY, the deficiency rose from $50 million to $120 million and the then-DMH staff could not explain why. In general, the department lacked any clear understanding of what the major cost drivers were and how to curb or stabilize costs in the system. In 2011, DMH leadership facilitated and oversaw an in-depth exploration and analysis of state hospital costs, resulting in a lengthy report that is available on the department's website. The research team identified the following system-wide problems/cost drivers: increased patient aggression and violence; increased operational costs and significant overspending; inadequate data tracking and reporting systems; inflexible treatment models; and redundant staff work.

Based on the report described above, in 2012 the Administration proposed a comprehensive list of reforms, to reverse the rising cost trend, which addressed three stated goals: 1) improve mental health outcomes; 2) increase worker and patient safety; and, 3) increase fiscal transparency and accountability. Perhaps the most significant of these proposed reforms was the reduction of 600 positions from throughout the state hospital system. Of these 600 positions, 230 were vacant while 270 were filled. In addition to the reduction in positions, the 2012 budget package included key changes in the following areas:

1. Modified mall services, streamlined documentation, and reduced layers of management;

2. Flexible staffing ratios, focusing on front-line staff, and redirecting staff to direct patient care;

3. New models for contracting, purchasing, and reducing operational expenses; and,

4. Elimination of adult education. The Legislature strongly objected to the elimination of adult education in the state hospitals, but was unsuccessful in protecting it.

DSH Budget

The Governor's proposed 2014-15 budget includes total funds of $1.6 billion dollars, of which nearly $1.5 billion is General Fund. The proposed 2014-15 budget is a modest 1.4 percent increase over current year funding.

DEPARTMENT OF STATE HOSPITALS *(Dollars in Thousands)*					
Fund Source	**2012-13 Actual**	**2013-14 Projected**	**2014-15 Proposed**	**BY to CY Change**	**% Change**
General Fund	**$1,274,968**	**$1,475,926**	**$1,497,970**	**$22,044**	**1.5%**
CA State Lottery Education Fund	74	91	91	0	0
Reimbursements	117,910	127,560	127,560	0	0
Total Expenditures	**$1,392,952**	**$1,603,577**	**$1,625,621**	**$22,044**	**1.4%**
Positions	9,715.2	10,871.7	11,234.0	362.3	3.3

State Hospitals Caseload

The State Hospitals provide treatment to approximately 5,400 patients, who fall into one of two categories: 1) civil commitments (referrals from counties); or 2) forensic commitments (committed by the courts).

The psychiatric facilities are located within state prisons, and currently treat approximately 1,000 inmates. They include: 1) Vacaville Psychiatric Program; 2) Salinas Valley Psychiatric Program; and 3) Stockton Psychiatric Program. Approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital by the criminal justice system. The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment:

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				
	2013-14 Estimate	2014-15 Projected	CY to BY $ Change	CY to BY % Change
Population by Hospital				
Atascadero	1,052	1,091	39	3.7%
Coalinga	1,151	1,206	55	4.8%
Metropolitan	814	930	116	14.3%
Napa	1,287	1,407	120	9.3%
Patton	1,513	1,503	(10)	(0.7%)
Subtotal	**5,817**	**6,137**	**320**	**5.5%**
Population by Psych Program				
Vacaville	386	386	0	0.0%
Salinas	177	177	0	0.0%
Stockton	514	514	0	0.0%
Subtotal	**1,077**	**1,077**	**0**	**0.0%**
Population Grand Total	**6,894**	**7,214**	**320**	**4.6%**
Population by Commitment Type				
IST – PC 1370	1,583	1,912	329	20.8%
NGI – PC 1026	1,375	1,398	23	1.7%
MDO	1,126	1,067	(59)	(5.2%)
SVP	909	936	27	3.0%
LPS/PC 2974	556	556	0	0.0%
PC 2684 (Coleman) – Hospitals	258	258	0	0.0%
PC 2684 (Coleman) – Psych Prog.	1,077	1,077	0	0.0%
WIC 1756 (DJJ)	10	10	0	0.0%

The DSH projects a 5.5 percent increase in the overall population, and this increase is primarily in the IST population. The increase in the IST population and resulting IST waiting list is discussed in more detail below under Issue 2.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the department to provide an overview of the department and the state hospitals system, provide a brief history of significant changes in the department and in the state hospitals system with a focus on the state's recent fiscal crisis, and present the Governor's proposed 2014-15 budget for this department.

Staff Recommendation: This is an informational item at this point in time and no action is necessary.

ISSUE 2: EXPANSION TO ADDRESS INCOMPETENT TO STAND TRIAL WAITLIST

The budget proposes $7.87 million General Fund for the current year (2013-14) and $27.8 million General Fund for 2014-15 to increase bed capacity by 105 beds to address the waitlist specific to "Incompetent to Stand Trial (IST)" patients.

Specifically, the DSH is proposing three new units with 35 beds each, anticipating activation of the first unit in March 2014, the second in May 2014, and the third in July 2014. The DSH proposes to use savings realized from delays in the activation of the Stockton facility for the current year costs.

BACKGROUND

When a judge deems a defendant to be incompetent to stand trial, 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. There is no statutory deadline for the county to retrieve these individuals, and therefore they often linger in the state hospitals for years. The counties have a disincentive to re-acquiring this population in that the state is covering the costs of their care while in the state hospitals, whereas their costs become the counties' responsibility once they take them out of the state hospitals. The DSH indicates that there is a policy bill currently in the Legislature to create a ten day deadline for this population.

Over the past several years, the state hospitals have seen a growing a waiting list of forensic patients. The largest waiting lists are for IST and Coleman commitments. The current waitlist contains approximately 500 patients. 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.

The DSH is required to admit patients within certain timeframes and can be (and has been) required to appear in court or be held in contempt of court when it fails to meet these timeframes. This type of legal action can become quite costly for the department.

The budget proposes to activate the proposed 105 new beds a DSH-Coaling, by filling these beds with current MDO patients transferred from the other four state hospitals. The beds made available from this transfer would then be made available to IST patients currently on the waiting list.

Legislative Analyst (LAO) Concerns & Recommendations

The LAO raises several concerns with regard to this proposal, and the next issue (proposal) in this agenda, as follows:

Excess Bed Space. The LAO states that the DSH is currently budgeted for 616 more beds than it has patients. There are several reasons that the DSH either intentionally or unintentionally has unfilled bed space including staffing challenges, restrictions on the types of beds in locations with different commitment needs, and the need to maintain a percentage of vacant beds for new admissions. The DSH believes that the quantity of unfilled beds is primarily intentional in order to maintain space and flexibility for new admissions. The DSH lacks flexibility to address the additional unfilled beds due to the fact that they are within units that are licensed for specific purposes (i.e., commitment types), and it is very difficult to move staff from one location to another.

Decreasing IST Population? Based on a point-in-time comparison, the LAO highlights the fact that DSH data shows a decrease in the IST population in January 2014 as compared to June 2013. Based on this decrease, LAO questions the justification for requesting additional bed space and resources for this population. They also point out that the 2013 Budget Act includes resources for an additional 155 beds. Nevertheless, the DSH expects that the 155 beds provided in 2013 will be filled by June of this year, and disagrees with LAO's approach to the data; the DSH instead points to a consistent increase in the IST population and waitlist over several years. The following table shows the numbers of IST "pending placements" by month from July 2012 to February 2014:

Month	Number of IST Pending Placements
July 2012	153
August 2012	152
September 2012	162
October 2012	172
November 2012	151
December 2012	168
January 2013	157
February 2013	192
March 2013	199
April 2013	225
May 2013	272
June 2013	287
July 2013	262
August 2013	291
September 2013	311
October 2013	314
November 2013	339
December 2013	383
January 2014	393
February 2014	359

The DSH also provided the data in the following table on the system-wide average daily census which appears to show a trending increase in the population overall, and particularly in the IST population:

State Hospitals System-Wide Average Daily Census					
Commitment Type	**08/09**	**09/10**	**10/11**	**11/12**	**12/13**
PC 1370 (IST)	1,076	1,105	1,135	1,089	1,196
PC 2962/2964a (MDO)	522	530	538	528	443
PC 2972 (MD0)	683	620	712	712	738
MDSO	26	26	27	27	24
PC 1026 (NGI)	1,269	1,282	1,318	1,315	1,334
W&I 6602 (SVP)	279	283	299	316	333
W&I 6604 (SVP)	473	467	518	527	535
PC 2684 (Coleman)	624	737	809	883	975
LPS	523	501	494	522	538
TOTAL	**5,475**	**5,552**	**5,850**	**5,920**	**6,116**

Staffing Ratios & Difficulty Filling Positions. LAO points out, and the DSH acknowledges, that it has been very challenging for state hospitals to fill positions. The LAO provides the following staff vacancy rate information in their analysis:

Department of State Hospitals Staff Vacancy Rates			
Location	**Budgeted Positions**	**Vacant Positions**	**Percent Vacant**
Atascadero	1,827.8	254.4	14%
Coalinga	1,750.0	303.5	17%
Metropolitan	1,218.0	178.4	15%
Napa	1,965.0	160.5	8%
Patton	2,032.9	181.6	9%
Salinas Valley	315.7	103.5	33%
Vacaville	472.7	159.6	34%
Totals	**9,582.1**	**1,332.5**	**14%**

The DSH and LAO cite several causes for the difficulty in hiring staff, including:

- Undesirable locations;
- Lower pay than CDCR for very similar work;
- Insufficient number of qualified mental health professionals, in the state and nationally; and
- Increasing competition from the private health care market in response to the move towards mental health parity.

The DSH has undertaken a substantial array of varied strategies to increase hiring and decrease staff vacancies, most notably a substantial outreach effort and an increase in pay for psychiatrists. The DSH is also exploring re-establishing psychiatric medical fellowships (or residency placements) within the state hospitals, in partnership with medical residency programs.

Staffing Ratios. The LAO points out that until 2013 (beginning in 2006), the DSH was under a consent decree pursuant to the federal Civil Rights for Institutionalized Persons Act. The terms of the consent decree had dictated DSH staffing ratios, among many other provisions and requirements. Now that the DSH is no longer under court oversight, it has the ability to assess and reassess its staffing ratios based on best practices, evidenced-based treatment models, and any other expertise that is relevant to ensuring the highest quality of care in a fiscally-responsible way. Therefore, the LAO recommends that the Legislature direct DSH to develop a proposal to contract for an independent staffing analysis to determine appropriate staffing levels for each facility.

In response, the DSH explained that they have been collecting information from mental health professionals working throughout the state hospitals system to determine staffing ratios. The DSH has learned that staffing ratios should be based on commitment type, rather than a one-size-fits-all approach. The DSH believes that the best expertise available on this are the mental health professionals working within the state hospitals, and they are working to utilize that expertise to develop more effective and sophisticated staffing ratios.

LAO Alternatives

In light of the concerns raised above, the LAO recommends that the Legislature reject the Governor's proposals to provide additional funding for increased bed capacity in Vacaville and Salinas Valley (the next issue in the agenda), and at the various facilities due to receive additional IST bed capacity. As potential alternatives to reduce the IST waitlist, the LAO suggests the Legislature consider the following:

Subcommittee Reports. The LAO recommends that the Legislature direct the DSH to report all of the following at Budget Subcommittee hearings: 1) why the patient population remains stable despite growing waitlists; 2) why there is a mismatch between their budget capacity and their patient population; 3) what steps the department is taking to address its high vacancy rate; 4) the department's progress on expanding Restoration of Competency services in county jails; and 5) the findings of the IST working group (discussed in more detail below).

Restoration of Competency In County Jails. LAO encourages the Legislature and the DSH to pursue an expansion of the Restoration of Competence (ROC) in county jails pilot 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 have been 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. The DSH reports that they have had significant discussions with 14 counties and that draft agreements have been developed and are being processed for Los Angeles, Alameda, and Sacramento Counties.

Administration Workgroup. The administration has convened a workgroup involving many of the major stakeholders in the state's criminal justice system, including the DSH, to discuss and collaborate on system-wide issues. The LAO suggests that one of the purposes of this workgroup is to identify reasons for the increase in IST patient commitments and possible solutions for managing the resulting increase in this population. The DSH reports that the workgroup has discussed this issue, however formal analysis or outcomes are not necessarily forthcoming.

STAFF COMMENTS/QUESTIONS

It would be most helpful to have a better understanding of the causes of the increasing numbers of referrals to the state hospitals of IST patients for budgeting and other planning purposes. Nevertheless, in the absence of such analysis, the DSH has documented the growing waiting list and steadily increasing patient population. Moreover, it appears that the DSH is aggressively pursuing expansion of the Restoration of Competency in county jails pilot program, which, if implemented in other large counties such as Los Angeles, can be expected to have a substantial impact on decreasing the waiting list. Therefore, staff recommends approval of this proposal.

Staff Recommendation: Staff recommends approval of this request for $7.8 million (current year savings) in 2013-14 and $27.8 million General Fund in 2014-15 to expand bed capacity for IST patients.

ISSUE 3: SALINAS VALLEY & VACAVILLE PSYCHIATRIC PROGRAMS

The DSH is requesting authority to continue operating an additional 137 beds at Salinas Valley and Vacaville (beyond the bed migration plan), at a cost of $13.3 Million in the current year (to be funded with savings from the delayed activation of beds at the Stockton program) and $26.3 million General Fund in 2014-15 (and on-going). The DSH requests these resources to maintain 204.3 existing positions at Salinas Valley and Vacaville.

BACKGROUND

In April 2012, the state released a "blueprint" titled, "The Future of California Corrections," which contains a series of improvements to the state's correctional system intended to satisfy the Supreme Court's ruling regarding prison overcrowding, cost savings, and system-wide improvements. The blueprint includes a proposal to transfer 450 beds from the Salinas Valley and Vacaville Psychiatric programs to the new Stockton program at the new California Health Care Facility (CHCF). The DSH is in the process of transferring these beds and was scheduled to complete the transfer by December 2013; however, completion of the transfer has been delayed, primarily due to staff recruitment challenges.

This proposal reflects the following:

1. The DSH expected to complete the migration of patients to Stockton by the end of 2013, however this has not been completed as a result of great difficulty filling the psychiatry staff classifications;

2. There was a steady increase in the rate of Coleman referrals through 2013; and

3. The DSH indicated in 2013 that a higher level of staffing should be provided at Salinas and Vacaville than what has been there in the past.

The DSH has thus far been unable to explain the increase in Coleman referrals from the California Department of Corrections and Rehabilitation (CDCR), but states that they are working with CDCR to gain this understanding. They also indicate that the referrals have decreased in 2014, and therefore are not necessarily seeing an ongoing increase.

Legislative Analyst Concerns and Recommendations

The LAO raises several concerns that are relevant to both this proposal as well as the prior proposal (increasing bed capacity for IST patients). Therefore, their concerns are described in detail under Issue #2 in this agenda.

STAFF COMMENTS/QUESTIONS

The DSH indicates that it is still analyzing these population numbers and trends, and is working on a revised proposal to reflect new evidence of a decrease in Coleman referrals. Therefore, this proposal will be updated later in the spring, and likely modified to reflect fewer beds to remain at Salinas Valley and Vacaville than what is proposed here. Therefore, it would be appropriate to hold this issue open at least until the administration provides an updated proposal later this year.

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

1) Please provide an update on staffing and bed migration to the Stockton facility.

2) Please explain the excess unfilled beds already within the hospital system (as highlighted by the LAO) and the remaining justification for requesting additional bed capacity and resources given this situation.

3) Please explain how staffing ratios are determined, and please provide a response to the LAO's recommendation for an independent staffing analysis.

Staff Recommendation: Staff recommends holding this item open pending updated information and a revised proposal due later this spring.

ISSUE 4: STATEWIDE ENHANCED TREATMENT UNITS CAPITAL OUTLAY

The budget proposes $1.5 million General Fund to prepare an analysis, estimate, and infrastructure design for the development of approximately 44 enhanced treatment units (ETUs) at the state hospitals.

BACKGROUND

The state hospitals were designed and constructed for a patient population that was quite different than the population currently in the state hospitals. Now, 92 percent of the population is forensic, having been referred to the state hospitals by either courts or prisons. Substantial evidence demonstrates an increasing rate of aggression and violent incidents at state hospitals.

The proposal explains that, in spite of this significant change in the state hospitals' patient population, there is currently no legal, regulatory, or physical infrastructure in place for the DSH to effectively and safely treat patients who have demonstrated severe psychiatric instability or extremely aggressive behavior. As a result, often the only option available to a state hospital dealing with an extremely violent patient is the use of emergency seclusion and restraints, which is short term only and a more extreme response. Subsequent to the use of seclusion and restraint, a violent patient must be placed in "one-on-one or two-on-one observation," which the DSH states is labor intensive and does not necessarily improve safety.

The DSH states that the proposed ETUs will provide a more secure environment to address patients that become psychiatrically unstable resulting in highly aggressive and violent behavior towards themselves, other patients, or staff. Candidates for an ETU would exhibit a level of physical violence that is not containable using other interventions or protocols currently available in the state hospitals. The DSH also points out that the existing physical facilities are so old, and designed for a different population, that it is not possible to provide more security within existing facilities.

The proposal contains the following three examples of the types of patients who would be appropriate candidates for the proposed ETUs:

1. "The case of psychotic aggression in a patient who has a history of strangling people to death in the night in response to certain delusions and hallucinations: He reports to DSH staff he is experiencing the same delusions and hallucinations that previously caused him to kill people in the middle of the night. He is currently housed in a hospital with dormitory style rooms with no locks on the doors or other physical plant control to mitigate the risk of strangling other patients. Under current legal and regulatory authority, the only option for containment of risk is seclusion or restraint, and it's questionable as to whether he would meet the existing criteria for seclusion and restraint.

2. A case of chronic predatory aggression in a patient who had previously murdered a peer: In this case, the patient tells DSH staff he does not like a particular peer and states: "You know what I do when I don't like someone." Given his history, this indirect verbal threat indicates a high risk of severe violence (murder). However, current legal and regulatory authority does not allow for restraint and seclusion to contain this threat despite the high risk this patient presents.

3. A case of a chronically assaultive patient who assaults so frequently that he required constant restraint in a hospital: He describes the assaults as impulsive, and explains that he just gets the urge to attack people and he cannot control himself. Upon being interviewed, he states unequivocally that he prefers being treated in the lower stimulation and external controls offered by a locked room in the higher safety environment of a state prison."

Licensing & Statutory Changes

The proposal states that the establishment of the proposed statewide ETU may require statutory and regulatory changes, licensing changes, development of a specialized treatment program with appropriate staffing, patient parameters, an admissions/discharge system, and an analysis of physical plant space. It states further that the proposed ETU can be accomplished through statutory language added under the licensing for Acute Psychiatric Hospitals. Such language could allow for individual rooms with bathroom facilities and doors to lock externally.

The DSH proposes to create a Forensic Needs Assessment Panel (FNAP), consisting of the DSH Medical Director, the referring hospital Medical Director, and the ETU hospital Medical Director, to discuss patient placement issues. The DSH also proposes to create and utilize a system-wide team, Forensic Needs Assessment Team (FNAT), consisting of a panel of psychologists with expertise in forensic assessment and violence risk assessment.

The DSH currently lacks the statutory authority to use locked units within state hospitals. A policy bill has been introduced to provide the DSH the authority to create and utilize ETUs, including with external locking doors.

ETU Admissions & Evaluation Procedures

The proposal includes a detailed 8-step process that will be required for a patient to be admitted to an ETU. Generally, the proposed admissions criteria includes time frames for clinical evaluation, placement, reconsideration of ETU placement, standards for treatment and case management time frames, and increases in clinical oversight and treatment. For example, the process would require that within 3 business days of placement in an ETU, a dedicated forensic evaluator, who is not on the patient's treatment team, must complete a full clinical evaluation of the patient. Further, within 7 business days of placement in the ETU, with 72-hours notice to the patient and patient advocate, the FNAP would be required to conduct a placement evaluation meeting with the referring clinician, the patient and his/her patient advocate, and the dedicated forensic evaluator who performed the full clinical evaluation.

Legislative Analyst (LAO) Concerns and Recommendations
The LAO questions the viability of an analysis being developed by the Department of General Services (DGS) given the lack of substantial specificity and detail in this proposal. For example, the proposal lacks information on lengths of stay, types of locked facilities, or other design specifications. In general, the LAO does not make a policy argument against the use of ETUs, or even locked facilities specifically. However, the LAO recommends the Legislature reject this proposal due to concerns that planning the ETUS without more specificity could result in unnecessary costs.

Disability Rights California (DRC) Opposition
DRC is opposed to this proposal due to the fact that the ETUs would be locked facilities. DRC understands that the proposal is to "exempt these rooms from licensing requirements related to seclusion and restraint and place patients in them without adequate due process, such as a hearing before a judge or hearing officer." DRC argues that the programs must comply with current federal and state licensing requirements, including those related to seclusion and restraint, and includes adequate due process before patients are placed in them. DRC states that secluding patients in locked rooms deprives patients of their personal liberties, thereby violating numerous federal and state laws, including the United States Constitution.

STAFF COMMENTS/QUESTIONS

The DSH indicates that this proposal is being developed further, and that a revised version of it will be included in the Governor's May Revision. Given that revisions are being developed, coupled with the lack of statutory authority to operate the proposed ETUs with locked doors, and finally the significant concerns of DRC, staff recommends holding this issue open at this time.

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

1. How can DGS develop an analysis, cost estimate, and construction plans in the absence of more specificity?

2. Please respond to DRC's position that ETUs must include due process, such as a hearing before a judge or hearing officer.

3. Does the DSH plan to formalize the proposed admission and evaluation process that is outlined in the proposal, such as through either statute or regulations?

Staff Recommendation: Staff recommends holding this issue open until the expected revised proposal has been received and reviewed by the Legislature.

ISSUE 5: PATIENT MANAGEMENT UNIT

The budget includes $1.1 million General Fund and 10.0 2-year limited-term positions to establish a Patient Management Unit to centralize admissions and transfers of patients throughout the state hospitals system.

BACKGROUND

Generally, the DSH is in the process of implementing various policy reforms aimed at transforming the state hospitals into a coordinated, singular system of hospitals, from the way it has operated historically as a collection of hospitals that operate independently from one other. One of the consequences of this lack of coordination has been an inefficient system of patient placement that leads to delays and often inappropriate placements. Judges often interpret state statute as giving them the authority to refer an individual to one specific hospital, rather than to DSH generally (i.e., to the state hospitals system). The result can be excess patients at one hospital, with substantial excess bed space at another hospital. It also results in certain patients being placed at hospitals that are not best suited to treat them or otherwise meet their needs.

Therefore, the DSH proposes to create this unit to ensure: 1) timely access to in-patient care; 2) placement in the most appropriate clinical settings based on treatment and security needs; 3) timely resolution to placement issues; and 4) cost-effective utilization of hospital beds and staffing resources.

Legislative Analyst (LAO) Concerns and Recommendations

The LAO is generally supportive of the concept of creating a centralized patient placement unit, and therefore expresses concerns regarding the lack of full cooperation by judges in the absence of a statutory change (or clarification). In response to the LAO's analysis on this, the administration has indicated that they are in agreement and will propose trailer bill language to clarify that referrals from judges shall be to the DSH, rather than to any particular hospital.

STAFF COMMENTS/QUESTIONS

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

1. Please describe any forthcoming trailer bill language necessary for successful implementation.

2. Please describe how the criteria for placement will be established and whether it will be proposed for statute or regulations. Specifically, please describe the role that proximity to family or other community ties will play in determining placement.

Staff Recommendation: Staff recommends holding this item open pending receipt of proposed trailer bill language.

ISSUE 6: THIRD PARTY BILLING BCP

The DSH is requesting 15.0 2-year limited-term positions and $1,893,000 General Fund (in the form of reimbursements that result from successful third-party payer collections, and therefore not a new General Fund appropriation) to consolidate functions related to billing and collection of third party resources that are not performed by the Department of Developmental Services (DDS).

BACKGROUND

DDS and DSH entered into a Memorandum of Understanding (MOU) when the two departments split responsibility for their respective patient populations approximately 20 years ago. At that time, the DDS population was larger than the DSH population, thereby justifying DDS retaining the entire billing and collections function. Since then, the DDS population has become increasingly community-based (migrating away from institutions), whereas the state hospitals population continues to grow. The DSH states that their billing, collection, technical assistance, claims resolution and rate development services have become increasingly complex.

The DSH plans to implement a more rigorous collection process, claims resolution process, and technical training for state hospital billing staff. The DSH also plans to consolidate functions related to billing and collection of third party resources not performed by DDS, which they expect will increase Medicare revenue collected and remitted to the General Fund for mental health and medical services provided to DSH patients. The DSH is requesting to begin assuming gradually increasing responsibility for the billing functions currently performed by DDS with full implementation in 2017-18.

STAFF COMMENTS/QUESTIONS

No concerns have been brought to the Subcommittee's attention with regard to this proposal. The Subcommittee requests the DSH to present and explain this proposal.

Staff Recommendation: Staff recommends approval of this BCP for approximately $1.9 million General Fund and 15.0 2-year limited-term positions to consolidate billing and collections of third party resources.

ISSUE 7: CAL-OSHA STANDARDS BCP

The DSH requests $502,000 (General Fund) and 5.0 2-year limited-term positions to establish statewide support for compliance with Department of Occupational Safety and Health (Cal-OSHA) standards.

BACKGROUND

In response to the murder of a psychiatric technician in one of the state hospitals in 2010, Cal-OSHA conducted numerous reviews of the state hospitals over a 3-year period, resulting in 38 citations totaling $316,000. The reviews also found several violations and deficiencies related to state safety regulations. For example, the findings included: ineffective procedures for correcting hazards, ineffective policies to mitigate patient assault hazards, ineffective escort policies that put staff safety at risk, ineffective procedures for investigating injuries, ineffective hazardous materials exposure reaction plans, blocked electrical panels, and blocked fire extinguishers.

In October 2013, the Cal-OSHA appeals board approved a settlement of outstanding citations that requires the implementation of a new safety framework. This order is being monitored for one year by Cal-OSHA and the presiding administrative law judge. The DSH has created a completely revised safety framework which must be customized and implemented at each state hospital in order to comply with the settlement with Cal-OSHA. Therefore, the DSH proposes to put one position in each of the five state hospitals to implement the required improvements in order to increase safety at the state hospitals and comply with the Cal-OSHA settlement.

STAFF COMMENTS/QUESTIONS

No concerns have been brought to the Subcommittee's attention with regard to this proposal. The Subcommittee requests the DSH to present and explain this proposal.

Staff Recommendation: Staff recommends approval of this BCP for $502,000 General Fund and 5.0 2-year limited-term positions to support compliance with Cal-OSHA standards.

ISSUE 8: MEDICAL GRADE NETWORK BCP

The DSH is requesting 2.0 permanent positions and $7.4 million General Fund in 2014-15, and $2.3 million General Fund ($726,000 one-time and $1.5 million on-going) for 2015-16 to implement the Medical Grade Network (MGN) project to add foundational infrastructure to the DSH inter-hospital network.

BACKGROUND

The DSH network infrastructure is required for clinical programs to communicate in support of critical patient care and clinical operations at each hospital. Infrastructure Services secure and protect medical data and support 24/7 network connectivity to critical systems for over 6,350 patients and 12,530 enterprise (serving all hospitals) users. The DSH states that the current network lacks the complete infrastructure necessary to sustain hospital operations.

Currently, the DSH network is a "single Wide Area Network (WAN)." The DSH states that a single WAN does not have redundant network connections between points, introducing many single points of failure, and is therefore substantially less reliable than a "redundant WAN," which has a network with multiple connections between locations. The DSH states that a single WAN cannot adequately support the connection of critical clinical applications needed to provide more cost efficient and effective patient care.

Existing infrastructure has experienced significant network disruptions that have had a negative impact on medical care operations. For example, Metropolitan State Hospital experienced a technology failure in March 2012, resulting in two days when staff was unable to communicate with other facilities and had no access to clinical applications needed for patient treatment. In another example, all DSH facilities experienced a technology failure in June 2013, resulting in an interruption in access for all users to any applications deployed in an enterprise manner.

The DSH states that the health and safety of state hospital patients is at risk when medication records and treatment plans are not fully accessible. Currently, there are times when clinicians are unable to make well-informed or appropriate treatment decisions critical to the patient's well-being as a result of network-caused data errors, incorrect or missing patient information, or unavailable systems. The inadequate capacity of the current network also prohibits the DSH from maintaining offsite data backups.

According to the DSH, this project will add redundant network connectivity paths across the enterprise network, thereby eliminating single points of network connectivity failure. The MGN helps form an essential foundation for implementation of shared enterprise clinical systems such as electronic health records. The DSH states that without the MGN upgrade, the DSH will not be able to deploy any enterprise applications that are critical to life and safety because they cannot guarantee reliable 24/7 access to these systems.

STAFF COMMENTS/QUESTIONS

No concerns have been brought to the Subcommittee's attention with regard to this proposal. The Subcommittee requests the DSH to present and explain this proposal.

Staff Recommendation: Staff recommends approval of this BCP for $7.4 million General Fund and 2.0 permanent positions in 2014-15, and $2.3 million General Fund in 2015-16, to implement the Medical Grade Network project.

ISSUE 9: ADULT EDUCATION IN STATE HOSPITALS

The 2012 Budget Act eliminated $3.6 million General Fund and 46.8 positions by eliminating the Adult Education Program in state hospitals. The Legislature was not supportive of the elimination at that time and continues to be interested in the possibility of restoring this program.

BACKGROUND

During discussions in 2012 on the proposed elimination of adult education within state hospitals, the former Department of Mental Health provided the chart below that details the adult education that existed at that time.

Hospital	Level of Participation	Alternatives Available
Atascadero	• 404 patients enrolled in the program. • Teachers average 20 hours/week educating patients.	Academic Education (reading, writing, math) will be consolidated into one class. Will focus on those who are 22 or younger, have been in special education, or have not earned a HS diploma or GED. Will continue to offer 20 hours a week.
Coalinga	• 17% of the patient population (167 patients) enrolled in the program. • Average daily attendance total is 28 (4 students per teacher per class, average). • Teachers average 20 hours/week educating patients.	Academic Education (i.e., reading, writing, math) is being consolidated. At this time there are no patients requiring mandated education service (i.e., under 22 or GED). Computer lab courses will continue by utilizing other resources. In the event of an admitted patient requiring mandated services, Chief of CPS has a teaching credential and will provide services as needed.
Metropolitan	• 16.8% of the patient population enrolled in the program. • Teachers average 20 hours/week educating patients.	MSH will continue to provide Special Education to patients 18-22 years old; therefore, one Special Education teacher and one General Education teacher will remain and will be available to facilitate educational classes.
Napa	• 81 patients enrolled in the program. • Teachers average 11.5 hours/week educating patients.	Two current teachers will retire prior to June 2012. The four remaining LH/MD (Learning Handicapped/ Mentally Disabled) teachers will facilitate required educational programs.
Patton	• 47 patients enrolled in the program. • Teachers average 6 hours/week educating patients.	PSH has an extensive Vocational Services Program and Distance Learning Program available to all adult learners. Community college courses are available to adult learning students who do not have GED or HS Diploma. The facility also has peer tutors available to help prepare students for the GED.

STAFF COMMENTS/QUESTIONS

In 2012, there was considerable opposition to the proposal to eliminate adult education in the state hospitals. At that time, the Subcommittee struggled to understand the value of adult education as a component of mental health treatment, and as a component of a process of rehabilitation intended to help patients regain the ability to successfully live in the community, outside of an institution. Today, in light of the improved economic situation in the state, the Subcommittee has the same concerns.

The Subcommittee requests the DSH to provide a brief history of adult education in state hospitals and respond to the following:

1. What is known about the therapeutic value of adult education in this type of setting?

2. What is known about the impact of adult education on criminal recidivism?

3. Is restoring adult education in one or more hospitals a priority for the DSH? Please explain why or why not.

Staff Recommendation: Staff recommends holding this issue open.

ISSUE 10: CAPITAL OUTLAY PROJECTS

The DSH proposes the following capital outlay projects: 1) $14.5 million to upgrade security fencing at Patton; 2) $325,000 for seismic upgrades at Atascadero; 3) $191,000 for security fencing at Napa; and 4) $712,000 for a fire alarm upgrade at Metropolitan.

BACKGROUND

This issue covers the four following proposed capital outlay projects:

Security Fencing at Patton ($14.5 million). This project proposes to demolish ground guard posts, existing fencing, lighting, paving and selected trees and shrubs. Construction will be a Level II design, double perimeter fence with barbed tape, fence detection system, 13 ground guard posts, two vehicle and pedestrian sally ports, perimeter patrol roadway improvements, modification to portions of the internal roads, new security lighting and closed circuit television cameras. This project will support the re-evaluation of existing working drawings, and fund the construction phase. The total project cost is estimated to be $16.4 million, and CDCR expects savings of $4.8 million in annual savings due to reduction in security staff.

Seismic Upgrades at Atascadero ($325,000). This project requests a one-time augmentation to perform a seismic retrofit at the main East-West corridor at Atascadero State Hospital. The retrofit will include construction of steel framed lateral frames in the upper third portion of the corridor. Construction also will include a security sally port and temporary access doors. It is anticipated that this project will reduce the Risk Level of the corridor from the current Level V to a Level III.

Security Fencing at Napa ($191,000). This project is to improve security in the courtyards in the patient housing buildings, including: replacement of gates and fabricating and installing extensions to raise the height of security fencing in specified buildings. The cost to develop working drawings is $191,000.

Fire Alarm Upgrade at Metropolitan ($712,000). This proposal is to completely upgrade the existing Notifier Fire Alarm Systems in patient housing and to provide a new central monitoring system located at Hospital Police Dispatch. The total project cost is estimated to be approximately $9 million. According to the proposal, the existing system is not code compliant and does not provide serviceability and/or expandability. The requested $712,000 is for the working drawings phase of the project. Development of preliminary plans was funded in the current fiscal year at $633,000, and construction will be funded in 2015-16 for $7,634,000.

STAFF COMMENTS/QUESTIONS

No concerns have been brought to the Subcommittee's attention with regard to these proposals. The Subcommittee requests the DSH to present these proposals and explain in which phase of the full project each proposal falls.

Staff Recommendation: Staff recommends approval of all four of these capital outlay proposals.