AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 16, 2018

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

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: SUBSTANCE USE DISORDER SERVICES OVERVIEW

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Tom Renfree**, County Behavioral Health Directors Association
- **Helyne Meshar**, Advocate, California Association of Alcohol and Drug Program Executives, Inc.
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance

Public Comment

ISSUE 2: MEMBERS AND STAKEHOLDER PROPOSAL FOR DRUG/ALCOHOL COUNSELORS IN EMERGENCY DEPARTMENTS

PANELISTS

- **Assemblymember Miguel Santiago**
- **Aimee Moulin, MD,** Emergency Physician, President, California Chapter of the American College of Emergency Physicians

Public Comment

ISSUE 3: MEMBER PROPOSAL TO INCREASE MEDI-CAL RATES FOR MEDICATION-ASSISTED TREATMENT PROVIDERS

PANELISTS

- **Assemblymember Marie Waldron**

Public Comment

ISSUE 4: STAKEHOLDER PROPOSAL ON HOSPITAL DETOXIFICATION SERVICES

PANELISTS

- **Helyne Meshar**, Advocate, California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)

Public Comment

ISSUE 5: STAKEHOLDER PROPOSAL ON AB 395 IMPLEMENTATION

PANELISTS

- **April Grant**, Director, Government Affairs and Policy, Alkermes, Inc.

Public Comment

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 6: NALOXONE FUNDING UPDATE

PANELISTS

- **Karen Smith, MD, MPH**, Director and State Public Health Officer, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 7: STAKEHOLDER PROPOSAL ON OPIOID TREATMENT NAVIGATION

PANELISTS

- **Laura Thomas**, Acting State Director, Drug Policy Alliance

Public Comment

ISSUE 8: STAKEHOLDER PROPOSAL ON SYRINGE EXCHANGE AUTHORIZATION

PANELISTS

- **Laura Thomas**, Acting State Director, Drug Policy Alliance

Public Comment

ISSUE 9: STAKEHOLDER PROPOSAL ON NALOXONE EDUCATION AND DISTRIBUTION IN PRISONS

PANELISTS

- **Lynn Wu,** Staff Attorney, Youth Justice Policy and Projects Manager, Prison Law Office

Public Comment

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 10: 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
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 11: INCOMPETENT TO STAND TRIAL PROPOSALS

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Matt Garber**, Deputy Director, Forensics, Department of State Hospitals
- **Kate Warburton**, Medical Director, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 12: ELECTRONIC HEALTH RECORDS PLANNING BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 13: INFORMATION SECURITY PROGRAM EXPANSION BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 14: ONGOING COSTS FOR PERSONAL DURESS ALARM SYSTEM BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 15: UNIFIED HOSPITAL COMMUNICATIONS PUBLIC ADDRESS SYSTEM – PHASE 2 BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 16: CAPITAL OUTLAY BUDGET CHANGE PROPOSALS AND SPRING FINANCE LETTER

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

Public Comment

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 1: SUBSTANCE USE DISORDER SERVICES OVERVIEW

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Tom Renfree**, County Behavioral Health Directors Association
- **Helyne Meshar**, Advocate, California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)
- **Elena Humphreys**, Finance Budget Analyst, Department of Finance
- **Ben Johnson**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

The budget includes $706.7 million ($84.5 million General Fund, $509.5 million federal funds, and $112.7 million county funds) in 2017-18 and $1.5 billion ($22.7 million General Fund, $1.1 billion federal funds, and $224.9 million county funds) in 2018-19 for Drug Medi-Cal.

2017-18 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2017-18**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$220,546	$5,966	$166,313	$48,267	49,067
Outpatient Drug Free Treatment Services	$29,548	$841	$24,501	$4,206	35,976
Intensive Outpatient Treatment Services	$9,847	$1,404	$8,293	$150	6,252
Residential Treatment Services	$1,830	$39	$1,277	$514	361
Organized Delivery System Waiver	$426,342	$76,172	$296,693	$53,477	-
Drug Medi-Cal Cost Settlement	$3,000	$100	$2,900	$-	-
Drug Medi-Cal County Administration	$6,496	$-	$3,248	$3,248	-
County Util. Review/Quality Assurance	$9,131	$-	$6,278	$2,853	-
TOTAL	**$706,740**	**$84,522**	**$509,503**	**$112,715**	**91,656**
Regular Total	$678,509	$84,272	$490,884	$103,353	90,313
Perinatal Total	$9,604	$150	$6,193	$3,261	1,343
Other Total	$18,627	$100	$12,426	$6,101	-

2018-19 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2018-19**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$230,979	$8,216	$173,261	$49,502	50,133
Outpatient Drug Free Treatment Services	$31,207	$1,162	$25,686	$4,359	36,784
Intensive Outpatient Treatment Services	$10,029	$1,503	$8,373	$153	6,323
Residential Treatment Services	$1,924	$53	$1,344	$527	370
Organized Delivery System Waiver	$1,199,462	$209,808	$829,760	$159,894	-
Drug Medi-Cal Cost Settlement	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$6,496	$-	$3,248	$3,248	-
County Util. Review/Quality Assurance	$23,177	$-	$15,934	$7,243	-
TOTAL	**$1,503,274**	**$220,742**	**$1,057,606**	**$224,926**	**93,610**
Regular Total	$1,452,843	$220,405	$1,025,562	$206,876	92,238
Perinatal Total	$20,758	$337	$12,862	$7,559	1,372
Other Total	$29,673	$-	$19,182	$10,491	-

BACKGROUND

In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state's role in administering programs and functions related to substance use disorders (SUD). Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in 2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform). Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement.

Health Care Reform Expansion of SUD Benefits

The federal Affordable Care Act (ACA) requires states electing to enact the Act's Medicaid expansion to provide all components of the "essential health benefits" (EHB) as defined within the state's chosen alternative benefit package to the Medicaid expansion population. The ACA included mental health and substance use disorder

services as part of the EHB standard, and because California adopted the alternative benefit package it was required to cover such services for the expansion population.

SB 1 X1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, required Medi-Cal to provide the same mental health and substance use disorder services for its enrollees that they could receive if they bought a particular Kaiser small group health plan product designated in state law as the EHB benchmark plan for individual and small group health plan products. SB 1X 1 required this benefit expansion for both the expansion population and the pre-ACA Medi-Cal population. Consequently, those individuals previously and newly-eligible for Medi-Cal have access to the same set of services.

For SUD-related services, SB 1 X1:

- Expanded residential substance use services to all populations (previously these benefits were only available to pregnant and postpartum women);

- Expanded intensive outpatient services to all populations (previously these benefits were only available to pregnant women and postpartum women and children and youth under 21); and

- Provided medically necessary voluntary inpatient detoxification (previously this benefit was covered only when medically necessary for physical health reasons).

DHCS received approval from CMS to expand intensive outpatient services to all populations and to provide medically necessary voluntary inpatient detoxification in general acute hospital settings. However, CMS asked the state to remove the expansion of residential substance use services to all populations and the provision of inpatient voluntary detoxification in other settings in its state plan amendment (SPA) because of the Institutions for Mental Disease (IMD) payment exclusion.

Medi-Cal Substance Use Disorder Services

Substance use disorder services are provided through both the Drug Medi-Cal program and also through Medi-Cal managed care and fee-for-service.

Drug Medi-Cal program services include:

- **Narcotic Treatment Services** – An outpatient service that utilizes methadone to help persons with opioid dependency and substance use disorder diagnoses detoxify and stabilize. This service includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

- **Residential Treatment Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.) Prior to SB 1 X1, this benefit was only available to pregnant and postpartum women.

- **Outpatient Drug Free Treatment Services** – These outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Services include individual and group counseling, crisis intervention, and treatment planning.

- **Intensive Outpatient Treatment Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week. Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women and children and youth under 21.

Other Medi-Cal SUD benefits, that are not included in DMC, include:

- **Medication-Assisted Treatment** – This service includes medications (e.g., buprenorphine and Vivitrol) that are intended for use in medication-assisted treatment of substance use disorders in outpatient settings. These medications are provided via Medi-Cal managed care or Medi-Cal FFS, depending on the medication.

- **Medically Necessary Voluntary Inpatient Detoxification** – This service includes medically necessary voluntary inpatient detoxification and is available to the general population. This service is provided via Medi-Cal FFS.

- **Screening and Brief Intervention** – This service is available to the Medi-Cal adult population for alcohol misuse, and if threshold levels indicate, a brief intervention is covered. This service is provided in primary care settings. This service is provided via Medi-Cal managed care or Medi-Cal FFS, depending on which delivery system the patient is enrolled.

Drug Medi-Cal Waiver

DHCS has received CMS approval for a DMC Organized Delivery System Waiver. DHCS states that this waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key elements of the new waiver include:

- **Continuum of Care:** Participating counties will be required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.

- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.

- **Case Management and Residency:** Case management services to ensure that the client is moving through the continuum of care, and requiring counties to coordinate care for those residing within the county.

- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.

- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the State. State appeals will focus solely on ensuring network adequacy.

- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.

- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.

- **Coordination:** Supporting coordination and integration across systems, such as requiring counties enter into memoranda of understanding (MOUs) with Medi-Cal managed care health plans for referrals and coordination and that county substance use programs collaborate with criminal justice partners.

- **Authorization and Utilization Management:** Providing that counties authorize services and ensuring Utilization Management.

- **Workforce:** Expanding the pool of Medi-Cal eligible service providers to include licensed practitioners of the healing arts for the assessment of beneficiaries, and other services within their scope of practice.

- **Program Improvement:** Promoting consumer-focused evidence-based practices including medication-assisted treatment services and increasing system capacity for youth services.

This waiver will only be operational in counties that elect to opt into this organized delivery system. DHCS states that the early phases are considered demonstration projects but the goal is for the model to eventually be implemented statewide. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

DMC-ODS Waiver Implementation Schedule
November 2017 Estimate with Updates

Number	N17 Assumed Implementation Date	County	Known Changes
1	February-17	San Mateo	no change
2	February-17	Riverside	no change
3	April-17	Marin	no change
4	June-17	Santa Clara	6/15/2017
5	June-17	Contra Costa	6/30/2017
6	July-17	San Francisco	no change
7	July-17	Los Angeles	no change
8	December-17	Sonoma	Unknown
9	December-17	San Luis Obispo	1/1/2018
10	December-17	Napa	12/15/2017
11	January-18	Santa Cruz	no change
12	February-18	Monterey	
13	February-18	Imperial	
14	February-18	San Diego	
15	April-18	Santa Barbara	
16	April-18	Orange	
17	April-18	San Bernardino	
18	May-18	Ventura	
19	May-18	Stanislaus	
20	June-18	Yolo	
21	July-18	Alameda	
22	July-18	Sacramento	
23	July-18	San Joaquin	
24	August-18	Merced	
25	August-18	Fresno	
26	August-18	Placer	
27	August-18	San Benito	
28	August-18	Solano	
29	August-18	Humboldt	
30	August-18	Lassen	
31	August-18	Mendocino	
32	August-18	Modoc	
33	August-18	Shasta	
34	August-18	Siskiyou	
35	August-18	Trinity	
36	August-18	Kings	
37	August-18	Kern	

38	August-18	El Dorado
39	August-18	Nevada
40	August-18	Tulare
41	did not opt-in	Calaveras
42	did not opt-in	Yuba/Sutter
43	did not opt-in	Tuolumne
44	did not opt-in	Mono
45	did not opt-in	Tehama
46	did not opt-in	Madera
47	did not opt-in	Inyo
48	did not opt-in	Butte
49	did not opt-in	Colusa
50	did not opt-in	Del Norte
51	did not opt-in	Glenn
52	did not opt-in	Lake
53	did not opt-in	Plumas
54	did not opt-in	Alpine
55	did not opt-in	Amador
56	did not opt-in	Mariposa
57	did not opt-in	Sierra

Proposition 64

Proposition 64 legalizes non-medical uses of Cannabis and taxes it. According to the Legislative Analyst's Office (LAO), the estimated revenue is subject to significant uncertainty. The LAO provided the following overview of how the proposition specifies the distribution and mandates uses of the revenue:

- The figure below summarizes the specific allocations made after regulatory and administrative cost are addressed.

Proposition 64 Makes Specific Allocations for Various Purposes

Primary Administrator	Purpose	Annual Funding	Duration
Governor's Office of Business and Economic Development	Implement a community reinvestment grant program that would fund certain services (such as job placement assistance and substance use disorder treatment) in communities most affected by past drug policies.	$10 million to $50 million[a]	2018-19 and ongoing
Public University or Universities in California	Evaluate the effects of the measure.	$10 million	2018-19 through 2028-29
California Highway Patrol	Create and adopt methods to determine whether someone is driving while impaired, including by cannabis.	$3 million	2018-19 through 2022-23
University of California San Diego Center for Medical Cannabis Research	Study the risks and benefits of medical cannabis.	$2 million	2017-18 and ongoing

[a] $10 million in 2018-19, increasing by $10 million annually until 2022-23, and $50 million each year thereafter.

Allocation of Remaining Revenues

☑ **60 Percent—Youth Education, Prevention, Early Intervention and Treatment Account**

- Funds would be allocated to the Department of Health Care Services to support youth programs including substance use disorder education, prevention, and treatment program.

☑ **20 Percent—Environmental Restoration and Protection Account**

- Funds would be allocated to the Department of Fish and Wildlife and the Department of Parks and Recreation to clean up and prevent environmental damage resulting from the illegal growing of cannabis.

☑ **20 Percent—State and Local Government Law Enforcement Account**

- Funds would be allocated to the California Highway Patrol to support programs designed to reduce driving while impaired, including by cannabis.
- Funds would also be allocated to the Board of State and Community Corrections to support programs designed to reduce any potential negative impacts on public health or safety resulting from the measure.

Stakeholders have raised concerns with regard to the programs and issues below:

Screening, Brief Intervention, Referral, and Treatment (SBIRT)
The SBIRT program provides screening, brief intervention, referral, and treatment (SBIRT) focused on alcohol misuse and has been shown to reduce hazardous drinking across diverse populations when implemented according to established best practices.

Workforce Capacity Building
The DMC-ODS waiver has expanded both the quantity and the type of reporting of services. Providers must be trained on the new Audit Compliance and Reporting requirements covering cost reporting, treatment records, and data and evaluations reporting. CAADPE recommends that the state fund training of all licensed and certified SUD providers in Audit Compliance and Reporting Requirements.

County of Residence (COR)/County of Service (COS)
Since realignment, only SUD services provided to individuals within their county of residence are reimbursed through Medi-Cal. Counties have been encouraged to enter into contracts with other counties and with providers in nearby counties, however counties assert that the state should find a solution to this problem. Stakeholders state that this unresolved problem and dispute between counties and the state impedes access to care. CAADPE recommends the state:

a) Withhold funds from counties and conduct a settlement/settle up at the end of each fiscal year; and
b) Require counties to recognize and pay for out of county services.

Medi-Cal Eligibility of Individual Residing in Community Treatment Facilities
CAACPE states that DHCS has labeled/misidentified three Community Treatment Program facilities as public institutions. The three Community Treatment Programs are: Custody to Community Transitional Reentry Program/Enhanced Alternative Custody Program (CCTRP/EACP), Female Offender Treatment and Employment Program (FOTEP) and Male Community Reentry Program (MCRP). Facilities that contract with CDCR to operate Community Treatment Programs are free-standing non-profit entities under IRS codes. Residents in the facilities are both individuals on parole and their children. Neither the parolees nor their children are defined as "inmate". While some residents are pre-release residents, others residing or participating in the CCTRP/EACP, FOTEP, and MCRP programs are non-inmates. DHCS mis-identification of Community Treatment Programs has had the consequence of DHCS determining that all individuals residing in Community Treatment Programs are ineligible for Medi-Cal benefits, when, in fact, parolees and their children meet the federal and state eligibility criteria for Medi-Cal. CAADPE recommends that DHCS modify their Information Letter No. I 17-23 to specify that:

1. The CCTRP/EACP, FOTEP, and MCRP programs are not state public institutions; and

2. Not all individuals residing or participating in Community Treatment Programs are considered to be incarcerated inmates; and

3. Med-Cal applications with listed addresses matching these programs may not be denied based on the address alone.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of substance use disorder services and the budget for those services and respond to the following:

1. Please explain DHCS's process for measuring and monitoring access to these services.

2. Please describe DHCS's thinking and planning with regard to Proposition 64 revenue that DHCS will receive and respond to the following:

   a) When will the state begin receiving Proposition 64 revenue?

   b) Is there a revenue estimate, overall, and specifically for DHCS, for 2018-19?

   c) How does the administration plan to develop spending priorities for these funds?

3. Please describe the SBIRT program and respond to the following:

   a) For what reason are SBIRT services only reimbursable in primary care settings?

   b) Are SBIRT services reimbursable when provided by a certified drug and alcohol counselor?

The Subcommittee requests County Behavioral Health Directors Association describe their overall sense of the quality of, and access to, substance use disorder services and to respond to the stakeholder concerns raised as a part of this Issue.

The Subcommittee requests CAADPE explain the concerns that they have raised as detailed above.

Finally, the Subcommittee requests DHCS respond to the concerns raised by CHBDA and CAADPE.

Staff Recommendation: No action is recommended at this time.

ISSUE 2: MEMBERS AND STAKEHOLDER PROPOSAL FOR DRUG/ALCOHOL COUNSELORS IN EMERGENCY DEPARTMENTS

PANELISTS

- **Assemblymember Miguel Santiago**
- **Aimee Moulin, MD,** Emergency Physician, President, California Chapter of the American College of Emergency Physicians

Public Comment

PROPOSAL

Assemblymember Santiago, with the support of many other Members, and the California Chapter of the American College of Emergency Physicians (CalACEP) request $20 million one-time for the creation of a statewide pilot program that places a certified drug and alcohol counselor in each of the roughly 400 emergency departments (EDs) throughout California, at an estimated cost of $50,000 per counselor. The pilot would include data collection to measure the efficacy of treatment and the cost savings to the Medi-Cal program and to other payers.

BACKGROUND

Assemblymember Santiago and CalACEP provided the following background information:

There is compelling evidence in published research that brief intervention for substance use disorders works. This is particularly true when performed by drug and alcohol counselors on individuals at-risk of, and with, substance-use disorders and when patients can be transported into specialist treatment settings.

An ED visit is an opportunity for intervention. Brief interventions are successful in a variety of settings, but there is a unique opportunity to provide this intervention in the ED. Patients presenting to the ED are more likely to have alcohol-related problems than those presenting to primary care. In addition, the ED visit offers the opportunity for a "teachable moment" due to the crisis that precipitated the ED visit. The drunk driving accident or the opioid overdose may be the catalyst needed for the patient to seek treatment.

A variety of studies have shown direct referrals to treatment have enrollment rates as high as 50%. In New Jersey, the newly established Opioid Overdose Recovery Program provides ED intervention for patients who experience an opioid overdose. In the first 6 months of implementation, over 80% accepted bedside intervention, over 40% of those patients accepted recovery support services, and 45% accepted detox, substance use disorder treatment and/or recovery. Over 60% of the overdose patients were Medicaid patients. A study in Washington found that chemical dependency treatment cut monthly ED costs almost in half.

Reduced ED utilization has been shown to achieve Medi-Cal savings. Patients with substance use disorders are more likely to have high ED utilization, as well as hospitalization rates. The UC Davis Medical Center ED applied for a grant through the UC Office of the President over a year ago to employ a certified drug and alcohol counselor to provide interventions in their ED and has also shown impressive results. Over a 12 month period, the Medi-Cal insured patients who received a brief intervention and referral to treatment experienced a 60% decline in ED utilization after the intervention. Based on an average cost to Medi-Cal of $861.50 per visit, this one program resulted in savings to the Medi-Cal program of more than $350,000. This is only the savings from reduced ED visits. There are also savings associated with reduced hospital admissions. While that data has not yet been compiled at UC Davis, studies have shown persons who needed substance abuse treatment and didn't get it were 81% more likely to be admitted to the hospital during their current ED visit and 46% more likely to have reported making at least 1 ED visit in the previous 12 months.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Santiago and CalACEP present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 3: MEMBER PROPOSAL TO INCREASE MEDI-CAL RATES FOR MEDICATION-ASSISTED TREATMENT PROVIDERS

PANELISTS

- **Assemblymember Marie Waldron**

Public Comment

PROPOSAL

Assemblymember Waldron requests $20 million for the Department of Health Care Services to increase the Medi-Cal reimbursement rate for medication-assisted treatment (M.A.T.) for opioid addiction.

BACKGROUND

Assemblymember Waldron provided the following background:

In recent years, opioid dependence has become a major epidemic in the United States. Despite the increasing success of M.A.T. for opioid abuse, less than 2 percent of California medical providers are certified to prescribe this treatment protocol, which severely limits access for patients in rural areas.

Studies show that outpatient medication treatment is effective and offers greater flexibility to treatments done at home or once a month, helping rural communities with limited access to care. A major reason physicians are not offering medication-assisted treatment is that some require certification and registration within DEA guidelines. Rural areas are impacted with some of the highest addiction rates in the state and are underserved in treatment options due to lack of accessibility. Incentivizing providers to utilize this treatment would uniquely benefit individuals that have limited access to an authorized clinic or certified provider.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Waldron present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 4: STAKEHOLDER PROPOSAL ON HOSPITAL DETOXIFICATION SERVICES

PANELISTS

- **Helyne Meshar**, Advocate, California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)

Public Comment

PROPOSAL

CAADPE requests $25 million for the hospital detoxification services benefit under DMC-ODS for free standing acute psychiatric and chemical dependency hospitals as outlined in the 1115 waiver terms and conditions.

BACKGROUND

CAADPE provided the following background information:

The 1115 waiver, waived the IMD exclusion for residential and hospital detoxification services as an allowable and reimbursable benefit under the 1115 waivers' terms and conditions. For detoxification it permits the use of Free Standing Acute Psychiatric and Chemical Dependency Hospitals. The Department of Health Care Services has issued a bulletin clarifying only state general acute hospitals or psychiatric hospitals within general acute hospitals can claim reimbursement directly through the state Medi-Cal fee-for-service system. All other detox services, free standing acute psychiatric and chemical dependency facilities are to seek funding for detoxification services through their county DMC-ODS.

However, counties and stakeholders assert that the DMC-ODS waiver did not fund hospital detoxification services through DMC-ODS as the state did for the expansion of residential service. Since these free-standing facilities are not eligible for state reimbursement, this badly needed hospital level of care is essentially nonexistent creating a true barrier to care.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CAADPE present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 5: STAKEHOLDER PROPOSAL ON AB 395 IMPLEMENTATION

PANELISTS

- **April Grant**, Director, Government Affairs and Policy, Alkermes, Inc.

Public Comment

PROPOSAL

Alkermes, Inc. respectfully requests that the legislature direct funding in support of patient-centered care at NTPs, made possible through AB 395.

BACKGROUND

Alkermes, Inc. provided the following background information:

AB 395 (Bocanegra, Chapter 223, Statutes of 2017) enhances the medication-assisted treatment (MAT) offerings within Narcotic Treatment Programs (NTPs). Before its passage, the Health and Safety Code (Sec. 11839.1, et al.) permitted licensed NTPs to only provide Narcotic Replacement Therapy (NRT) to patients suffering from an opioid use disorder (OUD). NRT involves the use of U.S. Food and Drug Administration (FDA)-approved controlled substance medications as part of treatment. However, there are also a number of FDA-approved medications for the treatment of substance use disorders (SUDs) that are not controlled substances, including long-acting injectable naltrexone (VIVITROL®). VIVITROL is approved for the prevention of relapse to opioid dependence following opioid detoxification, as well as the treatment of alcohol dependence in patients who can abstain in an out-patient setting. AB 395 revised the Health and Safety Code to expand patient access to MAT by allowing all forms of MAT to be provided in NTP settings for the treatment of SUDs.

AB 395, however, was not passed with any corresponding funding mechanism to enable practical implementation of the legislative changes within the NTP treatment system. Both the Assembly and Senate Appropriations analyses of the law indicated that costs were expected to be minimal, and therefore the bill was not designated as fiscal legislation. This is in part because AB 395 did not change how the initially-allowed medications were to be paid for by the state. However, new costs are associated with the delivery of the newly-added medication treatments. As a consequence of the lack of funding, patients are not gaining access to VIVITROL treatment in the NTP system and the intent of AB 395 that patients have access to all forms of SUD treatments not being realized.

DHCS recognized this need for funding in its “MHSUDS INFORMATION NOTICE NO.: 18-004,” released on January 10th of this year. It notes that AB 395 amended the Health and Safety Code to allow NTPs to “provide all non-controlled medications

approved by the FDA for providing MAT to patients with a SUD (Expanded MAT), in addition to the previously allowable FDA approved NRT medications. However, AB 395 does not add funding for Expanded MAT services [emphasis added]."

Without adequate funding, patients at NTPs do not have equal access to all available FDA-approved options for MAT as intended by AB 395.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Alkermes, Inc. present this proposal.

Staff Recommendation: No action is recommended at this time.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 6: NALOXONE FUNDING UPDATE

PANELISTS

- **Karen Smith, MD, MPH**, Director and State Public Health Officer, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

OVERSIGHT ISSUE

The 2016 Budget Act included $3 million one-time General Fund for the Department of Public Health to purchase and distribute Naloxone to counties and community-based organizations in order to prevent opioid overdose deaths.

The following statutory language was approved as part of the budget package to direct the use of the funds:

> *PART 6.2. Naloxone Grant Program [1179.80- 1179.80.] (Part 6.2 added by Stats. 2016, Ch. 30, Sec. 2.) 1179.80.*
>
> *(a) In order to reduce the rate of fatal overdose from opioid drugs including heroin and prescription opioids, the State Department of Public Health shall, subject to an appropriation for this purpose in the Budget Act of 2016, award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations, regional opioid prevention coalitions, or both, to support or establish programs that provide Naloxone to first responders and to at-risk opioid users through programs that serve at-risk drug users, including, but not limited to, syringe exchange and disposal programs, homeless programs, and substance use disorder treatment providers.*
>
> *(b) The department may award grants itself or enter into contracts to carry out the provisions of subdivision (a). The award of contracts and grants is exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and is exempt from approval by the Department of General Services prior to their execution.*
>
> *(c) Not more than 10 percent of the funds appropriated shall be available to the department for its administrative costs in implementing this section. If deemed necessary by the department, the department may allocate funds to other state departments to assist in the implementation of subdivision (a).*

(Added by Stats. 2016, Ch. 30, Sec. 2. (SB 833) Effective June 27, 2016.)

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to describe the status of these funds and provide detail on how the Naloxone was purchased and distributed, and respond to the following:

1) Have law enforcement agencies been the recipients of these resources?

2) What form (nasal spray or injection) of Naloxone was purchased and for what reasons?

Staff Recommendation: No action is recommended at this time.

ISSUE 7: STAKEHOLDER PROPOSAL ON OPIOID TREATMENT NAVIGATION

PANELISTS

- **Laura Thomas**, Acting State Director, Drug Policy Alliance

Public Comment

PROPOSAL

The Drug Policy Alliance requests $11 million one-time General Fund for opioid treatment and response, specifically to be used as follows:

1) $7,700,000 for grants to 30-35 harm reduction programs to establish treatment navigation to address drug-related harms and connection to services;

2) $1,500,000 for staff training, technical assistance, and capacity building to harm reduction programs to support expansion; and

3) $1,760,000 to State Office of AIDS to support administration and oversight of contract activities and evaluation projects.

BACKGROUND

The Drug Policy Alliance provided the following background:

The national opioid crisis has demonstrated our communities' vulnerability to overdose and infectious disease. Syringe access programs that provide harm reduction services have been on the frontlines of this crisis in California and nationwide, training people who use drugs to recognize and respond to overdose, linking people to opioid use disorder treatment, and addressing a broad range of social and health needs for individuals not otherwise connected to services or care. The alarming rise in new hepatitis C infections nationally, the rapid spread in California of hepatitis A among unvaccinated people who use drugs, and the looming threat of HIV outbreaks among people who inject drugs collectively signal an urgent need to scale up and sustain harm reduction services in California. Syringe access programs play a unique public health role as the specialists in outreach and engagement for people who use drugs, and require additional investments to fulfill their potential in protecting and promoting community health and safety.

Opioids and Overdose: Accidental drug overdose is the leading cause of death for Americans under 50. It is the leading cause of accidental death in California, which has the highest number of deaths from drug overdose in the U.S. More than 4,600 people perished in 2015. Each of those people left behind families devastated by grief.

According to testimony by the Director of California Department of Public Health Dr. Karen Smith, heroin overdose deaths increased by 57% between 2012 and 2015. The

state mortality numbers for heroin were already tragically high, and increased by 57% in just three years. Dr. Smith also testified that heroin-related emergency rooms visits increased by 140% between 2010 and 2015.

California can greatly reduce the number of deaths by recruiting persons who inject heroin, opioids, cocaine and methamphetamine into substance disorder treatment programs. Of the existing structures in the state, the syringe exchange programs are the only ones that have daily or weekly contact with the people injecting drugs, have the trust of the population, and a proven track record of effective case management and system navigation for injecting drug users.

Hub and Spoke System: The 21st Century Cures Act created funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) – State Targeted Response (STR) Opioid Grant Program. California is receiving $90 million over the next two years and is using it to expand medication assisted treatment for opioid misuse and dependence. The California "hub and spoke" system (H&SS) includes access to methadone or buprenorphine, as well as ensuring that individuals are enrolled in health insurance and connected to primary medical care. Methadone and buprenorphine reduce mortality among people who use drugs by over half and are an important component of ending the opioid crisis. California is prioritizing rural areas, tribal communities, and other areas with limited access. Increased federal funding for drug treatment provides an excellent opportunity to reduce the burden of suffering related to problematic drug use. However, this federal funding will not address the urgent issue of recruiting persons into treatment who lack insurance, lack housing, lack a medical home, a case manager or advocate.

Syringe access programs: These programs are effective in engaging and connecting people who use drugs to life-saving services, from HIV and hepatitis C testing to naloxone to prevent overdose to drug treatment to healthcare. California's 43 programs offer a variety of low-threshold, community-based services to people who use drugs (PWUD), people engaged in sex work, and other communities affected by drug use. These services acknowledge the risk of drug use and aim to minimize the harm while providing supportive, empowering, and trauma-informed services to connect people to a broad range of social and health services.

Syringe access and disposal providers are uniquely positioned to address several converging epidemics: HIV, viral hepatitis, and opioid overdose. These programs serve as the point of contact when an individual is at highest risk for overdose and transmission of infectious disease. Providers engage and support people who use drugs at every stage of their process towards health, recovery, and stability through referrals and linkages, education and supplies, and counseling and case management.

Syringe exchange programs are serving the most at-risk, high-need drug users in the state. Studies have consistently shown that most people coming to syringe exchange programs have no medical care except for what they get at the exchange and that syringe exchange program participants express a high level of trust in the staff and volunteers of the programs. For decades in California, syringe exchange programs have provided HIV case management through Ryan White Care grants. Staff often help

clients access and navigate care for hepatitis C, navigate medical appointments for other conditions, advocate for them to enter stable or temporary housing, and enter substance use disorder programs.

In 2015, the Legislature and Administration budgeted $3 million on-going for the California Department of Public Health to provide material support to the authorized syringe access and disposal programs. This support includes safer injection supplies, disposal equipment, and biohazard waste pick-up service. At this time, the State does not provide funding for program staff.

In September 2017, syringe access providers from across the state met to identify strategies to increase access to harm reduction services and connect PWUD to social and health services – including housing placement, SUD treatment, primary care, and mental health – and identified support for increasing staff capacity as the top priority.

Proposal Outline and Objectives:

- Duration: 4-years. OA will receive funding in 2018-19 fiscal year, and finish providing grants by the end of fiscal year 2021-22. The proposed budget assumes six months start-up for OA, and 3.5 years of funding for programs
- Grants to 30 to 35 programs to add one or two FTE each for substance use disorder treatment and health navigation. Grants may also cover cost of program materials and transportation of staff and program participants. Indirects will cover supervision, data collection and reporting.
- To apply, programs shall describe the need in their community, including overdose rates, HIV and viral hepatitis risk, and other relevant measures; experience working with people who use drugs; and demonstrate that increased staffing will increase service linkage and program capacity.
- Program activities supported by the grant may include: outreach to people who use drugs; health education including overdose awareness and naloxone distribution; education about reducing health risks related to injection drug use including HIV and viral hepatitis; syringe access and disposal; linkage to SUD treatment, HIV and hepatitis C testing and treatment, primary health care, mental health care, housing, and other services; care coordination, including in-person advocacy and transportation; building partnerships with treatment providers; and providing peer support at navigating systems and achieving health goals.
- Funding for training and technical assistance will be used to develop a training curriculum and train the new staff as well as provide technical assistance and capacity building assistance to all of the funded programs.
- Annually programs will report to the State Office of AIDS how many persons were linked to treatment and health insurance.
- The State Office of AIDS may assign other deliverables to the program to measure success, but if in doing so, OA will ensure that the grants are also adequate to pay for staff to do data entry and evaluation work, as needed.

On or before December 31, 2021, the State Office of AIDS will provide an interim report to the chairs of Assembly and Senate Budget Committees and the Department of Finance on changes in treatment enrollment, if any, demonstrated by the programs that received navigator grants. The primary measurement of success will be increased enrollment in substance abuse disorder treatment with an emphasis on medication assisted treatment.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Drug Policy Alliance to present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 8: STAKEHOLDER PROPOSAL ON SYRINGE EXCHANGE AUTHORIZATION

PANELISTS

- **Laura Thomas**, Acting State Director, Drug Policy Alliance

Public Comment

PROPOSED TRAILER BILL

The Drug Policy Alliance (DPA) proposes trailer bill language to reauthorize and modify DPH authority over syringe exchange programs as follows:

1) Delete the sunset;

2) Reduce the public comment period to 45 days, which is common in state and federal law. According to DPA, 90 days results in unnecessarily high costs and delays for program and for state staff. These delays make it difficult for programs to receive funding from private sources, due to long periods of uncertainty.

3) Amend Health & Safety Code 11364.7 (a) to allow state and local governments to purchase materials deemed by the state or local health department to be necessary to prevent the spread of communicable diseases, and to prevent drug overdose, injury or disability. Current law only provides that syringes are exempt from state paraphernalia laws, therefore CDPH and local health departments are legally prevented from adapting to emerging crises, such as the current rise of fentanyl in not only heroin, but in crack cocaine, powder cocaine, methamphetamine and other drugs.

BACKGROUND

Drug Policy Alliance provided the following background:

AB 604 (Skinner, Chapter 744, Statutes of 2011) resulted in the authorization of two new programs to prevent the transmission of deadly diseases and fatal drug overdoses, and there are several more that will be established in the coming 12-months pursuant to the legislation. The chaptered bill included a sunset for the end of 2018, and therefore legislation is needed in the coming year to lift the sunset. Other amendments should be considered to provide CDPH appropriate flexibility to use their budget to prevent drug overdose and the spread of HIV, viral hepatitis and other communicable disease. This will provide for flexibility, but no new funding.

Impact of AB 604 and other changes since 2011

Prior to AB 604, only local governments had the authority to establish syringe exchange programs. AB 604 provided that CDPH could also authorize syringe exchange programs to combat the spread of HIV and bloodborne hepatitis infection among injection drug users. The bill provided that local law enforcement and public health

leaders would be specifically informed when State DPH was considering an application, provided for a 90-day public comment period before the state could authorize a program, and that the programs may be reauthorized every two years.

Further, AB 604 provided that program participants would not be subject to criminal prosecution for possession of needles or syringes acquired from an authorized needle and syringe exchange project entity. Prior syringe exchange legislation did not protect individuals from arrest for the very same syringes provided by a program.

Since passage of AB 604, the Legislature and Governor supported these important changes:

- In the 2014-15 budget, CDPH received on-going funding of $3 million annually to provide material support to legally authorized syringe exchange programs, in the form of syringes, disposal containers, sterile water, and other materials needed to prevent disease transmission.

- AB 1743 (Ting, Chapter 331, Statutes of 2014) provides for legal possession of syringes from authorized sources including physician, pharmacists and syringe exchanges statewide. Sunsets January 1, 2021.

- In the 2016-17 budget, CDPH received funding for a staff position to provide technical assistance to programs seeking legal authorization to provide syringe exchange services. A highly qualified person was hired in early 2017.

Programs authorized by CDPH pursuant to AB 604:
- Kings County
- City of Santa Ana, Orange County

Programs that are likely to be authorized by CDPH in 2017 and 2018, pursuant to AB 604:
- City of Merced, Merced County
- Plumas County
- Others are likely to be considered very soon, but have not been posted yet for public comment

Finally, CDPH is providing technical assistance to tribal governments in the counties of San Diego, Tulare, Tuolumne, as they consider establishing syringe exchange programs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPA to present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 9: STAKEHOLDER PROPOSAL ON NALOXONE EDUCATION AND DISTRIBUTION IN PRISONS

PANELISTS

- **Lynn Wu,** Staff Attorney, Youth Justice Policy and Projects Manager, Prison Law Office

Public Comment

PROPOSAL

The Prison Law Office is requesting that $2.5 million on-going for the Department of Public Health, Office of AIDS to administer a program similar to the The DOPE (drug overdose prevention education) Project, a Harm Reduction Coalition program since 2005, that has been educating people in jails, shelters, SROs, syringe access programs, and treatment programs about overdose since 2001 and coordinating the distribution of naloxone in San Francisco since 2003 and in the San Francisco jail since 2013.

BACKGROUND

The Prison Law Office provided the following background:

People recently released from prison are at an especially high risk of overdose because incarceration often results in lower tolerance to the types of drugs available to people when they are released. This is likely due to a reduction in drug use while incarcerated; any continued drug use in prison may be with drugs of lower purity and strength.

The risk of overdose related death is particularly high in the first two weeks after release (three to eight times higher than in subsequent weeks). One study of people released from Washington's state prisons found that their risk of death was 12.7 times higher than the general population in the first two weeks after release and the leading cause (nearly 25%) of death was drug overdose. A Norwegian study found that up to 85 percent of deaths in the two weeks following release were from drug overdose. An examination of NYC jail releases found that 37.3% of deaths in the first 42 days after release were from opioid overdoses.

California's Prison Overdose Problem

People incarcerated in CA state prisons are at a higher risk of overdose compared to incarcerated people in other state and federal prisons and also compared to the general California population. In 2014, people in CA state prisons represented 8.7% of people incarcerated in state and federal prisons, but 32.2% of all drug and alcohol intoxication related deaths in state and federal prisons from 2001 to 2014. In 2016, the drug overdose death rate in CDCR (22.5/100,000) was 50 percent higher than in California (11.2/100,000).

Vaccine Model

Research supports distributing naloxone based on a vaccine model where the goal is saturation of a community as opposed to providing naloxone only to individuals with a history of opioid use. A study of 19 communities in Massachusetts (accounting for 30 percent of the state population) with overdose education and nasal naloxone distribution (OEND) conducted over eight years indicated that "the higher the cumulative rate of OEND implementation, the greater reduction in death rates." A biostatistics analysis from Scotland, the first country to fund naloxone for people leaving prison as a public health policy, suggests that annual naloxone distribution should be nine to 20 times the annual number of opioid deaths in a community.

Outcomes

Research suggest that providing naloxone to people leaving prison reduces mortality rates in the first weeks after release, giving them time to connect with community-based services to help them recover from their substance abuse in the long term. Scotland's National Naloxone Program was associated with a 36 percent reduction in overdose related deaths. Opioid overdose prevention and response is associated with a 27-46 percent reduction in opioid overdose mortality in community settings.

San Francisco Jail Program

San Francisco has been distributing naloxone to people leaving the jail since 2013. Naloxone distribution in San Francisco is done through an on-demand model so anyone who uses drugs or is likely to witness an overdose can access naloxone. Particularly in a correctional setting, this is done to avoid the stigma of and barriers associated with self-identifying or being identified as someone who has an addiction problem. Approximately 67% of people who watch the education video opt to get naloxone when they leave. Linkage to community is an integral part of improving health outcomes for people leaving jail beyond just reducing overdose deaths immediately after release.

Cost of Naloxone

The cost of naloxone varies by formulation. Common formulations include vials, auto injectors, and nasal spray. The budget trailer bill should not specify which formulation of naloxone to use. The Department of Public Health should have the authority to exercise their discretion to determine the appropriate, most cost-effective formulation to be used in various circumstances.

This proposal's estimate is based on the price of Narcan nasal spray, which is the formulation most commonly used by law enforcement agencies. It costs $75 for a kit that contains 2 doses of naloxone in a nasal spray.

Approximately 35,000 people are released from CDCR custody each year. Based on the naloxone distribution program in the San Francisco jail, we estimate that approximately 67% of these 35,000 people (23,450) will opt to get a Narcan kit. The estimated cost for the Narcan is 23,450*$75 = 1.76M.

The remaining funds would be awarded to local syringe exchanges and/or community-based organizations to develop educational materials to be used inside CDCR prisons, provide technical assistance to CDCR staff, and support or establish harm reduction navigation programs that connect people being released from CDCR to programs in

their communities that include, but are not limited to syringe exchange and disposal programs, homeless programs, and substance use disorder treatment providers.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Prison Law Office present this proposal.

Staff Recommendation: No action is recommended at this time.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 10: 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
- **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: 1,175.

- ***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: 1,393.

- ***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: 1,043.

- ***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: 1,492.

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 2017 Budget transferred the authority and resources for psychiatric care in these facilities from DSH to the California Department of Corrections and Rehabilitation.

DEPARTMENT BUDGET

The Governor's proposed 2018-19 DSH budget includes total funds of $1.9 billion dollars, of which $1.7 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 2018-19 budget is a 13.3 percent ($225.6 million) increase from current year funding, primarily reflecting the Governor's proposals on diversion efforts to reduce the waiting list of Incompetent to Stand Trial (IST) referrals, discussed in more detail in the next Issue in this agenda.

DEPARTMENT OF STATE HOSPITALS
(Dollars in Thousands)

Fund Source	2016-17 Actual	2017-18 Estimate	2018-19 Proposed	CY to BY $ Change	% Change
General Fund	**$1,744,870**	**$1,526,982**	**$1,752,590**	**$225,608**	**14.8%**
CA State Lottery Education Fund	106	32	32	$0	0%
Reimbursements	$140,537	$167,263	$167,263	$0	0%
Total Expenditures	**$1,885,513**	**$1,694,277**	**$1,919,885**	**$225,608**	**13.3%**
Positions	11,079.7	9,809.5	10,344.1	534.6	5.4%

STATE HOSPITALS CASELOAD

The State Hospitals provide treatment to approximately 6,372 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.

	2017-18	2018-19
Population by Hospital		
Atascadero	1,247	1,175
Coalinga	1,318	1,393
Metropolitan	807	1,043
Napa	1,269	1,269
Patton	1,509	1,492
Population Total	**6,150**	**6,372**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,523	1,774
Not Guilty by Reason of Insanity (NGI)	1,407	1,404
Mentally Disordered Offender (MDO)	1,328	1,296
Sexually Violent Predator (SVP)	920	920
Lanterman-Petris-Short Civil Commitments (LPS)	628	634
Coleman Referrals	336	336
Dept. of Juvenile Justice (DJJ)	8	8
Jail-Based Competency Treatment (JBCT) Programs		
Riverside JBCT	25	25
San Bernardino JBCT	126	146
Sacramento JBCT (Male and Female)	44	44
San Diego JBCT	30	30
Sonoma JBCT	10	10
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Mendocino JBCT	TBD	TBD
Stansislaus JBCT	12	12
Proposed Expansion of JBCT	--	54
Total JBCT Programs	**307**	**381**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2018-19 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2018*

Key DSH Budget Adjustments

Metropolitan State Hospital Secured Bed Capacity Increase ($53.1 million GF)
To provide additional capacity to address ongoing system-wide forensic waitlist with a particular focus on the continuing IST waitlist, this expansion at DSH-Metropolitan is the final phase of the project. DSH is requesting 346.1 positions and $53.1 million in FY 2018-19 and 473.4 positions and $68.9 million in FY 2019-20. This phase follows the first phase which provided for the 100s Building to be prepared for LPS patient transfer from the Chronic Treatment West (CTW). Once the patients are transferred from the (CTW) to the 100s building, the vacated units in CTW will be converted to forensic beds with the construction of security fencing around the building, and reactivated in FY 2018-19 for a net gain of approximately 236 forensic beds. Additional resources for reactivating CTW for treatment of ISTs is necessary since staff previously assigned to these units transferred with their LPS patients to the 100s Building.

Metropolitan State Hospital per Patient OE&E (3.7 million GF)
Over the last five years, DSH patient population increased significantly as a result of newly activated beds within the five state hospitals. With these activations, DSH did not receive funding for patient related operating and equipment expenses (OE&E). DSH requests $3.671 million General Fund in FY 2018-19 and ongoing to support the OE&E cost per patient for the 236 newly activated beds resulting from the DSH-Metropolitan Increased Secured Bed Capacity project. This total is based on a per patient OE&E cost of $15,555 at DSH-Metropolitan State Hospital.

ETP Staffing (-$5.0 million in FY 17-18 and $2.8 million GF)
The Budget Act of 2017 provided DSH $8.0 million for 2017-18 and $15.2 million in 2018-19 and ongoing for the staff and operating expenses and equipment needed for the first two 13-bed unit activations, Units 29 and 33 of the Enhanced Treatment Units (ETP) at DSH-Atascadero. The 2018-19 Governor's Budget includes plans to establish one more 13-bed ETP unit at DSH-Atascadero and one 10-bed ETP unit at DSH-Patton, Units 34 and U-06, respectively. Construction and activation of the ETP units has been unavoidably delayed due to the emergency fire situation in several California counties. DSH is pending final approval of the ETP working plans from the State Fire Marshal and due to the activation delays, DSH anticipates a savings of $5 million in FY 2017-18 associated with the first two ETP units and requests $2.8 million in 2018-19 and $8.35 million in FY 19-20 for resources for the third and fourth ETP units.

DSH- Coalinga Increased Capacity ($11.5 million GF)
To offset forensic bed capacity impacts due to the Enhanced Treatment Program (ETP) constructions and activations, DSH requests approval to increase Mentally Disordered Offender (MDO) capacity at Coalinga State Hospital by an additional 80 beds. The capacity increase would occur across eight units; increasing each unit by ten beds to reach the maximum licensed capacity. The increased capacity will allow for the transfer of 80 PC 2972 patients from other hospitals and the backfilling of the vacated beds with forensic patients, primarily PC 1370 Incompetent to Stand Trial patients. DSH requests 81.2 positions and $11.5 million in FY 2018-19 and 96.9 positions and $13.7 million in FY 2019-20 to accommodate the additional 80 beds.

Napa State Hospital Earthquake Repair Funding ($2.4 million GF in 2017-18)
The Budget Act of 2017 provided total expenditure authority of $8,954,000 for construction funding which consisted of $2,075,000 GF and $6,879,000 in reimbursement authority for receipt of the 75% FEMA funding. After the 2017 Budget Act, DSH and DGS updated the project costs and timelines for all three projects increasing estimated construction costs in the current year by $2.362 million. Rather than request increased expenditure authority to cover these cost increases, DSH proposes to cover the total current year project costs by utilizing savings of $2.362 million from the delayed activation of the Enhanced Treatment Program (ETP) project.

LPS Pop & Personal Services ($20.1 million GF)
The Department of State Hospitals (DSH) admits Lanterman-Petris-Short (LPS) patients through civil commitment processes. LPS beds are funded through reimbursements from counties that use the DSH system. Due to the increasing LPS population, DSH's reimbursement authority is not sufficient for the services provided to counties. Based on LPS bed usage, the Department projects it will collect approximately $20,118,813 more in FY 2017-18 than its current reimbursement authority. DSH requests an additional $20,118,813 reimbursement authority for LPS in FY 2018-19.

CONREP Transitional Housing Cost Increase ($976,000 GF)
The Budget Act of 2017 included a one-time appropriation of $976,000 to expand the Statewide Residential Treatment Program (STRP) to serve up to an additional 16 clients at an annual rate of $61,000 per bed. The funding authorized in 2017-18 was used to operate a 16-bed STRP in Fresno County. However, as of November 2017, DSH ended its contract with the provider and is working to establish a new contract for this important resource to CONREP providers and clients. DSH requests ongoing funding to maintain a 16-bed STRP, contingent upon securing a new contract provider. Because the Budget Act of 2017 only authorized a one-time appropriation to support the STRP, DSH requests an appropriation of $976,000 in FY 18-19 to continue operating this program on an ongoing basis and ensure the availability of the 16 new STRP beds in future years.

Contracted Patient Services Estimate ($130.9 million GF)

Jail-Based Competency Treatment (JBCT) Program Update to Existing Programs
($8.1 million GF) DSH requests a total increase in state GF of $8.054 million in FY 2018-19 and $8.273 in FY 2019-20 and ongoing to support existing DSH Jail Based Competency Treatment (JBCT) programs. Additional funding is required to support the additional 5-beds at the Riverside JBCT and the additional 50 beds at the San Bernardino JBCT program.

Jail-Based Competency Treatment (JBCT) Program Expansion to Establish New Programs ($8.0 million GF)
DSH requests an additional $8.043 million in FY 2018-19 and $9.279 in FY 19-20 to expand the JBCT program. Of this, $1.840 million is requested to establish a 6-12 bed program in a northern California county and $2.680 million to establish two 5-10 bed programs in two additional northern California counties. Further, DSH is requesting $1.147 million for a new southern California program, which would add 5-10 beds and

$1.376 million for a new central California county, which would add 6-12 beds for IST patients. Additionally, DSH requests $1 million to establish JBCT programs in two small northern California counties that are flexible in size and scope to serve their limited number of IST referrals. These programs would serve 20 to 25 IST patients annually.

LA County IST Restoration – Community Mental Health Treatment ($14.8 million GF)

DSH proposes to contract with Los Angeles (LA) County to treat LA County felony IST patients in community mental health treatment settings. The intent is to expand IST treatment options in LA County providing a continuum of care in three different spectrums of placements for felony ISTs and creating additional capacity of 150 beds to serve LA County's ISTs. A total cost of $12.3 million ongoing is proposed for the 150 beds. Additionally, the proposal requests $2.5 million ongoing for LA County staffing resources to fund approximately 10-12 positions to provide patient support consisting of a clinical team and navigation team. The total DSH request for IST placement, treatment and staff is $14.8 million in FY 2018-19 and ongoing.

IST Diversion Program ($100.0 million GF)

DSH proposes to contract with counties to develop new or expand existing diversion programs for individuals with serious mental illness who are primarily diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with potential to be found IST on felony charges. Counties will be required to provide outcomes data to DSH and must contribute matching funds of 20% to receive 80% state funding up to specified amounts. A total of $99.5 million is proposed for counties and will be primarily targeted to the 15 counties with the highest referrals of felony ISTs to DSH with funding also available for other counties. DSH is also requesting $501,000 to fund 2.0 positions for program support and oversight and to augment an existing research contract that will support the diversion program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to provide an overview of the department, the state hospitals system, and the Governor's proposed 2018-19 budget for this department.

Please also present any and all program updates and proposals not otherwise contained in another Issue in this agenda.

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

ISSUE 11: INCOMPETENT TO STAND TRIAL PROPOSALS

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Matt Garber**, Deputy Director, Forensics, Department of State Hospitals
- **Kate Warburton**, Medical Director, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

DSH requests two positions and expenditure authority of $117.3 million ($114.8 million General Fund and $2.5 million Mental Health Services Fund) in 2018-19 to contract with counties to develop new or expand existing diversion programs for individuals with serious mental illness with potential to be found incompetent to stand trial (IST) on felony charges.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$114,800,000	$376,000
3085 – Mental Health Services Fund*	$2,500,000	$2,500,000
Total Funding Request:	**$117,300,000**	**$2,876,000**
Total Positions Requested:**	**2.0**	**2.0**

* Mental Health Services Fund is also separately reflected in the MHSOAC budget request.
** Positions are limited-term and would be authorized through 2020-21.

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. 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, consistent with national trends.

Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 840 as of December 2017. In 1972, the United States Supreme Court found in Jackson v. Indiana that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

Administration Proposals to Increase IST Capacity in State Hospitals.
In addition to a $117.5 million package to promote community-based diversion of those at risk for being referred as IST, the budget includes several proposals that implement previously approved capacity expansions at State Hospitals, as follows:

Metropolitan State Hospital Secured Bed Capacity Increase.
DSH requests 346.1 positions and General Fund expenditure authority of $53.1 million in 2018-19 and 473.4 positions and General Fund expenditure authority of $69 million in 2019-20 and annually thereafter to activate newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that currently house civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment. This request activates and provides staff for approximately 236 forensic beds over the course of 2018-19 to treat IST patients.

Metropolitan State Hospital Per Patient Operating Equipment and Expenses
DSH requests General Fund expenditure authority of $3.7 million annually to fund the operating equipment and expenses associated with the activation of the additional 236 beds for the treatment of IST patients at Metropolitan State Hospital.

Jail-Based Competency Treatment Program Activation
DSH requests General Fund expenditure authority of $516,000 in 2017-18, $8.1 million in 2018-19, and $8.3 million in 2019-20 and annually thereafter to activate jail-based competency treatment (JBCT) beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. The current system-wide census of IST patients receiving JBCT services is 173 as of June 30, 2017. This request nets savings from delayed implementation of existing JBCT contracts in Mendocino, Sacramento, and Stanislaus counties with additional costs for the activation of five JBCT beds in Riverside and 50 beds in San Bernardino.

Coalinga State Hospital MDO Bed Activation
DSH requests 81.2 positions and General Fund expenditure authority of $11.5 million in 2018-19 and 96.9 positions and General Fund expenditure authority of $13.7 million in 2019-20 to increase capacity for the treatment of mentally disordered offenders (MDOs) at Coalinga State Hospital. This increased capacity is intended to allow transfer of MDOs from other State Hospitals to create additional capacity in those State Hospitals for the treatment of IST patients. Coalinga has already increased its MDO capacity by 25 beds. This request will allow for a two-phase activation of an additional 80 beds during 2018-19.

Kern Admission, Evaluation, and Stabilization Center
DSH reports a reduction in General Fund expenditures in 2017-18 of $1.7 million related to delays in negotiation and execution of a contact with Kern County to establish an Admission, Evaluation, and Stabilization (AES) Center at the Lerdo PreTrial Facility located in Bakersfield. The Kern AES Center is expected to receive and treat IST patients committed to State Hospitals directly from nearby catchment counties.

State-County Partnerships for Diversion of Potential IST Offenders
DSH requests trailer bill language and General Fund expenditure authority of $100 million to contract with counties to develop new or expand existing diversion programs for individuals with severe mental illnesses. These programs would be primarily focused on individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges. Programs components would include:

- Evidence-based community mental health treatment and wrap around services, such as forensic assertive community treatment teams, crisis intervention teams, forensic alternative centers, intensive case management, criminal justice coordination, peer support, supportive housing, and vocational support.

- Targeting of individuals with serious mental illnesses where a nexus exists between the illness and the alleged criminal activity, there is significant evidence of mental illness at the time of the alleged crime, the crime is driven by conditions of homelessness, and the individual does not pose a significant safety risk if treated in the community.

Counties would be required to contribute matching funds of 20 percent of the program costs and provide outcomes data on the success of the program towards the goal of reducing IST referrals by 30 percent. In addition to funding for county diversion contracts, DSH requests one Chief Psychologist and one Health Program Specialist I position on a three-year, limited-term basis to provide diversion and risk assessment expertise and to review and provide technical assistance for county diversion proposals.

Los Angeles County Community Mental Health Treatment of IST Offenders

DSH requests General Fund expenditure authority of $14.8 million to contract with Los Angeles County for 150 beds to treat IST patients in community settings, based on the county's experience in treating misdemeanor IST patients in similar settings. The contract, currently under negotiation to begin July 2018, would provide a coordinated continuum of mental health placements including five beds in a locked acute psychiatric hospital, 45 beds in a locked Institute for Mental Disease or mental health rehabilitation center, and 100 beds in residential facilities with clinical and supportive services. Los Angeles County has approximately 185 IST offenders awaiting state hospital placement. The contract will also include $2.5 million of funding for Los Angeles County staffing resources for 10-12 positions, including a clinical team of six to eight staff members, which would provide patient support by stabilizing patients on medications and preparing them for community placement, and a navigation team of two to three staff members to support connections to social services and other needs.

	Locked Inpatient	Locked IMD type IMD Type	Unlocked, secured, Clinically Enhanced Type
Proposed # of Beds	5	45	100
Facility Type	General Acute Care Hospital or Acute Psychiatric Hosptial -- likely Olive View Medical Center	Low acuity hospital, and/or Nursing facility; licenses as an Institute for Mental Disease facility or a Mental Health Rehabilitation Center	Residential site with clinical and supportive services on-site
Facility Bed Capacity	18 total beds with 5 set aside for this project	2 different facilities: 1st up to 15 beds in San Fernando Valley part of LA County; 2nd with up to 35 beds in southern LAC or San Diego County	3-5 sites across LA County with 20-40 beds each
Security	Locked unit	Locked facilities	Open, but gated and with staff and security cameras monitoring entrance/exit
Staffing	24/7 nursing and MD staff, full-time clinical SW and support staff	24/7 nursing staff, M-F and on call MD staff, full-time clinical SW and support staff	24/7 case management and security staff, full-time clinical social work and nursing staff; potentially nurse practitioner on call
Treatment	Stabilization of Acute Mental Health or Medical symptoms	Sub-acute stablization of patients who do not require acute care, but who are not clinically ready for outpatient care and restoration of competency treatment.	Outpatient treatment, maintenance of stabilization, on-site psychiatric care, medication support and monitoring, group and individual therapy and restoration of competency treatment.

Figure 1: Los Angeles County IST Restoration in Community Mental Health Treatment Placements
Source: *2018-19 Department of State Hospitals Governor's Budget Proposals and Estimate*

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present these proposals and respond to the following:

1) The community-based diversion proposal provides $100 million for three years for these state-county partnerships. Are county programs expected to utilize these funds for one-time expenditures, or for an ongoing program? How would counties be expected to sustain programs without ongoing funding?

2) Counties would be expected to provide outcomes data for funded diversion programs. How would DSH hold counties accountable for meeting the objectives of these programs, particularly the goal of diverting 30 percent of current IST referrals for treatment in the community?

3) Does DSH or the Administration generally expect these community mental health diversion programs for individuals at risk of justice involvement to have the additional benefit of diverting individuals from incarceration in county jails or state prisons, as well as reducing felony IST referrals to State Hospitals?

Staff Recommendation: No action is recommended at this time.

ISSUE 12: ELECTRONIC HEALTH RECORDS PLANNING BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests four positions and General Fund expenditure authority of $1.3 million in 2018-19 and $713,000 in 2019-20. If approved, these positions and resources would allow DSH to complete Stages 3 and 4 of the Project Approval Lifecycle process for implementation of an integrated electronic health record for State Hospital inpatients.

BACKGROUND

DSH manages the nation's largest inpatient forensic mental health hospital system. The five State Hospitals managed by DSH employ nearly 11,000 staff and served 13,403 patients with an average daily census of 7,087 in 2016-17. The department's jail-based competency programs served a total of 729 patients with a capacity of 178 and its conditional release program (CONREP) maintains an average daily census of approximately 636.

According to DSH, the size of the State Hospital system and its affiliated programs result in complex problems maintaining continuity of patient care and the accurate flow of information and patient data within and among hospitals and external care providers. Intra-hospital patient transfers occur frequently to accommodate changes in levels of care, commitment codes, safety, proximity to family and social supports, and other individualized needs. DSH reports it uses approximately 27 separate systems related to admissions, registration, pharmacy, billing, and primary medical care functions.

DSH reports that it is out of compliance with the federal Health Information Technology for Economic and Clinical Health (HITECH) Act, which provides assistance and support for organizations to become meaningful users of electronic health records (EHR). DSH also reports it is out of compliance with federal and state recommendations that it adopt an inventory system to safeguard pharmaceutical drugs. As a result, DSH is seeking to implement an EHR system, and is collaborating with Cerner, a supplier of Health Information Technology solutions, as one possible alternative solution.

DSH seeks to replace certain key functions currently managed by other systems with implementation of an EHR system. Specifically, DSH seeks to replace admissions registration, pharmacy services, billing, and certain primary care business functions currently managed through other processes or through no process at all. DSH is seeking to achieve improvement in the following metrics:

1) Admission Registration
   a) Decrease the number of returning DSH patients incorrectly matched with previous records.
   b) Assign 100 percent of patients a single patient identifier across all electronic systems.

2) Pharmacy Services
   a) Provide access to active medication list for patients (Goal: 80 percent of patients within the first 90 days).
   b) Provide data exchange between pharmacy and billing systems, which does not currently exist.

3) Billing
   a) Reduce the number of Medicare claims returned with errors to less than 25 percent.
   b) Provide accurate patient cost of care accounts to reduce reconciliation time and labor.
   c) Eliminate instances of double billing.

4) Primary Care
   a) Provide exchange of data between primary care and other systems, which does not currently exist.
   b) Provide functionality to complete 100 percent of documents electronically.

DSH intends its proposed EHR system to meet confidentiality, security, and privacy requirements for protected health information (PHI) and personally identifiable information (PII) and other state and federal requirements. DSH also indicates it intends the EHR to be interoperable with external EHR systems to allow for continuity of care and data exchange for State Hospital patients discharged into the community.

Resources Requested to Complete Project Approval Lifecycle
DSH has begun the Project Approval Lifecycle process required by the California Department of Technology. The Stage 1 Business Analysis is complete and DSH is finalizing its Stage 2 Alternatives Analysis. According to DSH, the Stage 2 Alternatives Analysis is evaluating lower cost options to implement an EHR system, as its initial special project report indicates the cost is over $386 million.

DSH requests the following positions and resources to complete Stages 3 and 4 of the Project Approval Lifecycle:

1) One Data Processing Manager IV to serve as project manager to track and manage all EHR project readiness and governance efforts.

2) One Data Processing Manager II to serve as contract manager to coordinate among control agencies, DSH legal EHR experts, and project planning team members to ensure the solicitation development, selection, and award is properly planned and executed.

3) One Health Program Specialist I to implement organizational readiness activities to ensure the billing functions are integrated effectively with the clinical goals of the project.

4) One Attorney III to serve as a legal expert to ensure all HIPAA, privacy, and contractual considerations and requirements are addressed.

5) Contract Resources of $500,000 one-time to hire EHR implementation consultants. These consultants will focus on organizational readiness, provide guidance based on market research and contract preparation, and serve as subject matter experts, soliciting and incorporating input from DSH clinicians.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this Budget Change Proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 13: INFORMATION SECURITY PROGRAM EXPANSION BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests two positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. If approved, these positions and resources would allow DSH to provide adequate staffing to protect information assets and remediate findings identified in a recent security assessment by the California Military Department.

BACKGROUND

AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department.

Because DSH systems contain confidential and sensitive information, including Social Security Numbers and protected health information, DSH underwent a CND security assessment in October 2017. In January 2018, DSH also initiated a security review pursuant to the requirements of State Administrative Manual Section 5300 and HIPAA Security Rules. Both of these assessments identified similar findings:

1) Existing asset tracking practices do not include a comprehensive inventory of all information system components, nor permit full life cycle management of information assets.
2) Continuous monitoring of systems and alerting on security incidents has not been possible due to lack of personnel in security operations positions.
3) Detection of rogue devices connected to the DSH network is not possible using existing tools and personnel.
4) Insufficient funds exist for training of staff on modern, industry-standard secure coding techniques.

5) Scanning of systems for vulnerabilities is completed by security staff, but system hardening and remediation of vulnerabilities is difficult or impossible with existing tools.

DSH Requests Resources to Remediate Findings of the Security Assessment
In order to remediate the findings of the CND and internal security assessments, DSH requests two permanent positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. Specifically, DSH requests:

1. One Systems Software Specialist II to lead technical staff managing and maintaining the system which inventories all assets and tracks them through their lifecycle.

2. One Systems Software Specialist II to serve as lead technical staff managing and maintaining the system which monitors the threats to the Department's information technology resources from external and internal sources.

3. Security System Solutions including inventory and asset management, security information and event management, patching solutions for non-Microsoft applications, secure code review solutions and training, and on-premise rogue device detection paired with mobile and cloud security solutions.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this Budget Change Proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 14: ONGOING COSTS FOR PERSONAL DURESS ALARM SYSTEM BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests ongoing General Fund expenditure authority of $2.7 million to support ongoing maintenance and service for its Personal Duress Alarm System Project.

BACKGROUND

The 2013 Budget Act approved resources to implement a Personal Duress Alarm System (PDAS) within the State Hospital system. PDAS units are used to alert hospital police and other nearby employees when a duress incident occurs. The system was approved in response to significant numbers of violent incidents within State Hospitals. According to 2013 data, patients committed 2,586 physically aggressive acts against staff and 3,344 physically aggressive acts against other patients.

According to DSH, when the PDAS project was initially approved and funded, the budget did not include sufficient funding to cover upgrades to new models or versions of equipment necessary for ongoing maintenance of the system. Vendors frequently introduce new models and versions of equipment and phase-out support of older models and versions. DSH requests General Fund resources of $2.7 million annually to refresh hardware components of the PDAS system as they reach the end of their useful life and are no longer supported by the manufacturer.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this Budget Change Proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 15: UNIFIED HOSPITAL COMMUNICATIONS PUBLIC ADDRESS SYSTEM – PHASE 2 BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears**, Chief Information Officer, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DSH requests two positions and General Fund expenditure authority of $359,000 in 2018-19, $4.6 million in 2019-20, $7.7 million in 2020-21, and $3.7 million in 2021-22 and annually thereafter. If approved, these positions and resources would allow DSH to support an increase in maintenance costs for Phase 1, and implementation of Phase 2, of its Unified Hospital Communications Public Address System Project.

BACKGROUND

The 2015 Budget Act approved resources to fund Phase 1 of the implementation of a new public address system for the State Hospitals. The new Unified Hospital Communications Public Address (UHCPA) System is intended to improve communication and dissemination of information quickly and intelligibly throughout each hospital campus. According to DSH, once it is implemented, the UHCPA system will allow for two-way communications between public speakers in key areas and dispatch, allow for targeted announcements to specific hospital areas to prevent disruption in non-affected areas, provide clear and intelligible announcements, and allow message prioritization to prevent concurrent message delivery.

Phase 1 of implementation provided for the installation of the PA systems and associated local area networks (LAN) at Coalinga and Patton State Hospitals. Network-based PA systems can be integrated with a hospital's emergency system through a single interface, which can then broadcast appropriate warnings over the speakers on every floor in the event of an emergency or natural disaster. The UHCPA systems also provide complementary alert capability to the Personal Duress Alarm Systems (PDAS) implemented in recent years to provide alerts to nearby hospital police and other staff regarding incidents of physical aggression. According to DSH, the PDAS cannot inform staff when a response to an alert is no longer necessary. The UHCPA system can provide situational details to staff to respond appropriately to incidents of aggression and other emergencies.

Phase 2 of the UHCPA system project would provide for the installation of the system at Metropolitan, Atascadero, and Napa State Hospitals. DSH requests two Senior Information Systems Analysts, to be shared among the three hospital locations, to provide support for management of vendor contracts and performance, and to assist in

integrating the new systems related to the PA system at the three hospitals. Implementation of Phase 2 would begin in October 2018 and proceed in three waves, concluding in January 2024. The DSH request includes contract resources of $1.7 million in 2019-20, $5.3 million in 2020-21, and $1.3 million in 2021-22 and annually thereafter for maintenance and operations of the system, as well as non-capital asset equipment purchases of $2.6 million in 2019-20, $2.1 million in 2020-21 and 2021-22, and $2 million in 2022-23 and annually thereafter.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this Budget Change Proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 16: CAPITAL OUTLAY BUDGET CHANGE PROPOSALS AND SPRING FINANCE LETTER

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

Public Comment

PROPOSALS

Coaling: New Activity Courtyard Reappropriation
DSH requests $5.7 million in FY 2018-19 to design and construct a new secure outdoor activity and treatment courtyard at the DSH-Coalinga. 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 activity courtyard that will have enough open-air space to accommodate the full capacity of the facility in the event of a fire and allow for outdoor activities.

Metropolitan: Consolidation of Police Operations
DSH requests $1.5 million in Fiscal Year (FY) 2018-19, to construct a new building to accommodate Department of State Hospitals-Metropolitan (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. Per California Code of Regulations, Title 24, Part 1, Chapter 4, Article 1, this new building will be designated an Essential Services Building, which will be the only building on the DSH-Metropolitan campus meeting the regulatory requirements for Hospital Police buildings. Site work consists of demolition of five existing buildings and associated improvements to include site clearing and grading, paving for roads and parking, retaining walls as required, and site utilities.

Metropolitan: CTE Fire Alarm System Upgrade Reappropriation
DSH requests $3.4 million in FY 2018-19 to upgrade the existing fire alarm systems for the Chronic Treatment East (CTE) building at Department of State Hospitals - Metropolitan. The upgraded fire alarm system will be connected to the new central monitoring system located at Hospital Police Dispatch (HPD) and fully addressable which specifies the location of the alarm activation. The existing system is not code compliant per National Fire Protection Association (NFPA) 101 Life Safety 2012 (which regulates Centers for Medicare and Medicaid Services) nor provides for serviceability due to the age of the existing system.

Patton: Fire Alarm System Upgrade

DSH requests $9.4 million in Fiscal Year (FY) 2018-19 to remove and replace deficient SimplexGrinnell Fire Alarm Control Panels (FACP) and associated components in four patient-occupied buildings at the Department of State Hospitals - Patton (DSH-Patton). The existing fire alarm systems are not serviceable and have reached the end of their usable life. The four buildings (30, 70, U and the Ed Bernath (EB) building house most DSH-Patton's patients and contain satellite kitchens, dining rooms, medical and dental clinics, therapeutic areas, offices, and nursing stations for staff. This project will enable DSH-Patton to bring the existing fire alarm systems into compliance with regulatory requirements.

Patton: Construct New Main Kitchen Reappropriation

DSH requests $33,086,000 in Fiscal Year (FY) 2018-19 to reappropriate the construction phase funding. The project includes building and fully equipping a new main kitchen of approximately 32,000 square feet, which will accommodate a modern cook/chill food preparation system and all dietary support facilities.

The project is currently in construction and scheduled to be completed in March of 2019. This project has been delayed during construction for various reasons, including inclement weather and design errors and omissions. DSH and DGS are working closely to prevent future delays and keep the project on the current schedule. On March 23, 2018, the Department of Finance notified the Legislature of its intent to recognize the scope change for the addition of a drainage channel and approval of an augmentation driven by the construction delays. A reappropriation is needed to complete the project.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Administration present these proposals.

Staff Recommendation: No action is recommended at this time.