AGENDA

PART 2

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR

WEDNESDAY, APRIL 3, 2013

1:30 P.M. - STATE CAPITOL ROOM 444

Please note that public comment may be limited or consolidated based on time and the number of speakers, at the discretion of the Subcommittee Chair.

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ITEMS TO BE HEARD

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: DEPARTMENT OVERVIEW

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals. DSH seeks to ensure the availability and accessibility of effective, efficient, and culturally competent services. DSH activities and functions include advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services. This section of the agenda covers the Governor's proposed 2013-14 budget for this department, background information on state hospitals, and major recent fiscal and policy developments within the state hospitals.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

New Department

DSH is a new department, created as part of the 2012 Budget Act. The Governor's 2011 May Revision first proposed the elimination of the former Department of Mental Health (DMH), the creation of the new DSH, and the transfer of Medi-Cal and other community mental health programs to other departments, primarily the Department of Health Care Services (DHCS). The 2011 Budget Act approved of just the transfer of Medi-Cal mental health programs from DMH to DHCS. In 2012, the budget included the full elimination of DMH, the creation of DSH, and the transfer of the remaining community mental health programs to other state departments. DSH now has the singular focus of providing improved oversight, safety, and accountability to the state's mental hospitals and prison-based psychiatric facilities.

State Hospitals Overview

California has five state hospitals and three psychiatric programs that treat people with mental illness. The state hospitals' population has changed dramatically over time, and now, unlike many years ago, approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital by the criminal justice system. The state hospitals are as follows:

1. Atascadero (ASH). ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons appointed by the court for criminal violations).

2. 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.

3. Metropolitan (MSH). Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court penal code commitments.

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

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

CA State Hospitals 2013-14					
	ASH	CSH	MSH	NSH	PSH
Employees	2,173	1,889	1,431	2,307	2,480
Licensed Beds	1,275	1,500	1,074	1,362	1,287
Caseload	1,112	1,053	751	1,174	1,530
Buildings	59	49	127	143	74
Acres	290	320	320	138	257
Year Opened	1954	2005	1915	1875	1893
Budget	$220 million	$181.2 million	$169.5 million	$256 million	$306.5 million

The psychiatric facilities are located within state prisons, and currently treat under 700 inmates. They are as follows:

1. Vacaville Psychiatric Program (VPP)

2. Salinas Valley Psychiatric Program (SVPP)

3. Stockton Psychiatric Program (SPP). This is the newest facility that will begin operation in July of 2013, serving 514 High Custody/Level IV inmates/patients at the intermediate level of care, within the California Health Care Facility in Stockton.

As stated above, 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital by the criminal justice system. The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment:

Committed Directly From Superior Courts:

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

- *Incompetent to Stand Trial* – 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* – 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* – 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.

Proposed 2013-14 Budget

The Governor's proposed 2013-14 budget includes total funds of nearly $1.6 billion, almost all of which is State General Fund. The proposed 2013-14 budget includes a 10 percent General Fund increase of $136 million, which primarily reflects the cost ($100.9 million) of fully staffing the new California Health Care Facility in Stockton, thereby activating 514 new beds. In the chart below, several funding sources can be seen to have been discontinued, which reflects the following changes:

- General Fund/Prop 98 – This $14.8 million was specifically for the Early Mental Health Initiative (EMHI), a mental health prevention program in schools. In the 2012 budget, the Legislature relocated the program, and funding, from DMH to the Department of Education, and the Governor subsequently vetoed all of the funds.

- Federal Trust Fund – Federal funding was the federal financial participation in Medi-Cal mental health programs, which have been moved to DHCS, and therefore these funds are no longer part of the DSH budget.

- Mental Health Services Fund – All Mental Health Services Act programs were moved to other departments as part of the reorganization done in 2011 and 2012.

- Facility Licensing Fund – Licensing of community mental health facilities was also moved from DMH to the Department of Social Services (DSS) in 2012. In this year's budget, the Governor is now proposing moving licensing from DSS to DHCS instead, a proposal that was discussed at this Subcommittee's hearing on March 18, 2013.

DEPARTMENT OF STATE HOSPITALS					
Fund Source	**2011-12 Actual**	**2012-13 Projected**	**2013-14 Proposed**	**CY to BY Change**	**% Change**
General Fund	$1,313,572,000	$1,320,859,000	$1,457,306,000	$136,447,000	10%
General Fund, Prop 98	14,878,000	-	-	-	-
CA State Lottery Education Fund	48,000	90,000	90,000	-	-
Federal Trust Fund	62,318,000	-	-	-	-
Reimbursements	793,316,000	119,036,000	121,491,000	2,455,000	2%
Mental Health Services Fund	1,824,585,000	-	-	-	-
Facility Licensing Fund	391,000	-	-	-	-
Total Expenditures	**$4,009,108,000**	**$1,439,985,000**	**$1,578,887,000**	**$138,902,000**	**9.6%**
Positions (at DSH)	309	303.1	313.4	10.3	3.4%
Positions (at hospitals)	9,507.7	9,650.2	10,474	823.8	8.5%
Caseload	6,320	6,521	6,560	39	0.6%

The primary adjustments to the budget include the following:

"Net technical (population driven) adjustments ($133.6 million):

1. One-time funding reductions for PDAS and Stockton IT data/equipment and partial year funding received for Stockton -- $10.8 million General Fund (GF)
2. Health benefits and retirement increases -- $18.2 million GF
3. Miscellaneous (OTECH, lease revenue, lottery funds) decrease -- $323,000
4. County reimbursement increase -- $20.1 million

Program adjustments ($84.9 million):

1. Stockton Facility Activation (Issue #3 of this agenda) -- $67.5 million GF
2. Vacaville Psychiatrist-on-Duty (Issue #4 of this agenda) -- $782,000 GF
3. Personal Duress Alarm System (Issue #5 of this agenda) -- $16.6 million GF

- *Support Budget*. The proposed 2013-14 budget for operating expenses and equipment (OE&E) for the state hospitals is $356.5 million, approximately $5 million more than the current year estimate, attributable to an increase in external consulting and professional services. OE&E for just DSH (headquarters) is budgeted at $56.6 million, approximately $6 million over the current year, also attributable to an increase in external consulting and professional services.

- *Caseload Growth*. The Administration projects almost no caseload growth throughout the state hospitals system. The 2013-14 caseload estimate is 6,560 as compared to the current year estimate of 6,521. This projection assumes that approximately 450 patients will transfer from the psych programs in Vacaville and Salinas to the new facility in Stockton. The transfer will be updated in the May Revise. The caseload increase is modest; however, the Administration explains that the increase is in higher acuity patients, requiring a higher level of staffing and therefore increased costs.

- *Civil Commitments*. DSH is requesting an increase of $20.1 million (in reimbursements by counties) in reimbursement authority reflecting the increase in the rate paid by counties for civil commitments that was adopted within the 2012 budget.

- *Overtime Costs*. DSH requests $8.2 million to cover overtime costs in the current year (2012-13), which is to be covered by savings generated from delays in the Vacaville Psychiatric Program L-Wing activation.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DSH to provide an overview of the department, the state hospitals system, and the proposed 2013-14 budget. As with all of the departments that fall within the jurisdiction of this Subcommittee, DSH has been asked to provide an overview of how state hospitals and their patients have been affected by the state's recent fiscal crisis.

Please explain the unanticipated overtime costs in the current year, as well as the delay in the VPP L-Wing activation.

Staff Recommendation: Oversight issue; no action recommended

ISSUE 2: HISTORY OF FISCAL CHALLENGES

Prior to the creation of DSH in 2012, the former DMH was the oversight agency managing the state hospitals along with community mental health services. Over the past several years, under the authority of DMH, the state hospitals' budget could be characterized as a series of unanticipated and unexplained deficits, growing, yet not understood, costs, and substantial fiscal mismanagement. This situation resulted in various audits and exploratory efforts by the Administration to gain a better understanding of the primary causes of these problems, and the potential solutions, as described below.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

OSAE Audit. In 2007, the Office of State Audits and Evaluation (OSAE), within the Department of Finance (DOF), conducted an audit of the DMH budget, which included a couple of key findings that arguably foreshadowed this string of deficits: 1) the staffing model did not adequately reflect hospital workload; and, 2) funding was insufficient for annual operating expenditures. The OSAE also identified the seeds of a fiscal problem that would eventually become a major contributor to the deficits: the DMH used salary savings to offset operating expenditures and equipment (OE&E). Over the following few years, salary savings would decrease as the number of vacancies decreased, and OE&E costs would rise, leading to unavoidable deficits. Per the 2012 Budget Act, the OSAE has just completed a follow-up audit, which is discussed below.

DMH Audit. In 2011, in order to gain a clearer understanding of the causes of these deficits, DMH assembled a team of DMH staff and retired annuitants, with extensive state management experience, to investigate and analyze the state hospitals' budget. The original purpose of the project was to collect information necessary to develop recommendations for the new administrative structure for the newly proposed DSH. However, ultimately the scope of the project was widened to address the growing deficits and related fiscal challenges. Building on the 2007 OSAE audit, the 2011 report provided a similar, but clearer picture of the unsustainable fiscal management of the state hospitals, which they explained as a combination of increasing costs coupled with decreasing resources. The decreasing resources occurred through a combination of actual budget reductions, such as s $75 million reduction between 2008-09 and 2009-10, and the decreasing availability of salary savings mentioned above. The increasing costs are a more complex story, involving the following key issues, described in more detail below: 1) the federal Civil Rights of Institutionalized Persons Act (CRIPA); 2) violence-related costs; 3) unfunded overtime; and 4) lack of budget transparency.

1. Civil Rights of Institutionalized Persons Act (CRIPA)

In 2006, four out of five state hospitals were found to be in violation of the federal CRIPA. The federal court found that the hospitals failed to provide safe environments for their patients or complete psychiatric assessments, and neglected to regularly review patients' needs before prescribing medications. As a result, a Consent Judgment was issued requiring the hospitals to change the way they care for patients by implementing an array of reforms contained in an Enhancement Plan. The Enhancement Plan required the hospitals to implement a new treatment model and to substantially increase documentation, both of which increased workload, and therefore costs, at the hospitals. The former DMH reported that, overall, the Enhancement Plan has helped reform the way patients are treated in state hospitals and that the new treatment model has improved care by reducing the use of drugs, seclusion and restraint as primary treatment tools. Nevertheless, DMH explained last year that since the Enhancement Plan had been in effect for some time, it had become clear that some aspects of the Plan have been helpful while others have not. Based on this analysis, to reduce costs, last year's budget eliminated certain Enhancement Plan strategies that have proven to be unhelpful or even inappropriate. DMH stated last year that the CRIPA court monitor was aware of the changes being proposed and did not expressed any concerns or objections.

On September 24, 2012 the court tentatively ruled to terminate all provisions with the exception of Section 1.H regarding prone restraints as they apply to NSH. The Court Monitor will continue to evaluate NSH for an additional 12 months; all other state hospitals affected by the CRIPA Consent Judgment have been released from U.S.D.O.J. oversight.

2. Violence-Related Costs

Over the past approximately fifteen years, the state hospitals' population has changed dramatically, becoming an increasingly "forensic" population with civil commitment in decline. Now, approximately 92 percent of the state hospital population is forensic, a result of key laws being passed, including: 1) legislation in 1995 (AB 888 Rogan and SB 1143 Mountjoy), which established a new category of civil commitment for sexually violent predators (SVPs), which requires certain SVP criminal offenders, upon release from prison, to be placed in state hospitals for treatment; and, 2) Proposition 83 ("Jessica's Law"), passed by voters in 2006, increased criminal penalties for sex offenses and eased the way for more SVPs to be placed in hospitals. As a result of these laws, and consequential changes to the population, violence in the hospitals has increased substantially. In October of 2010, a patient assault resulted in the death of an employee. The number of aggressive acts during calendar years 2009, 2010, and 2011 is outlined in the table below:

State Hospital	Aggressive Acts Against Patients			Aggressive Acts Against Staff		
	2009	2010	2011	2009	2010	2011
NSH	1,212	2,688	2,085	141	928	436
PSH	2,231	2,894	1,795	854	1,208	646
MSH	2,318	2,438	2,598	684	1,324	1,802
ASH	636	647	573	349	415	505
CSH	477	707	565	277	719	676
TOTAL	**6,874**	**9,374**	**7,616**	**2,305**	**4,594**	**4,065**

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

There are several increased costs that result from the population being almost entirely criminal in nature:

- Jessica's Law more than doubled the workload related to screening and evaluating sex offenders for SVP commitments;

- Outside hospitalization costs have risen substantially, largely due to patients harming themselves or others. Hospitalization costs rose an average of ten percent per year between 2008-09 and 2010-11, from $9.5 million to $41.4 million; and,

- Increased security measures, such as alarm systems (as discussed under issue #6), have become necessary to protect both patients and staff; the alarm systems are quite sophisticated and costly. Other types of safety upgrades are also necessary and costly given that the hospitals were not constructed for a violent, forensic population. The 2011-12 budget included $5.4 million and new positions to implement Grounds Presence Teams and Grounds Safety Teams:

    - *Grounds Presence Teams (GPTs).* GPTs are utilized at Napa and Metropolitan State Hospitals. GPTs are comprised of psychiatric technicians responsible for direct supervision of patients throughout the "secure treatment areas." They supplement hospital police officers during emergencies and patrol the campus grounds. They provide crisis intervention, detection of safety and security issues, redirect inappropriate activities or behavior, monitor all individuals entering and exiting the facility, perform periodic searches throughout the grounds, and implement and oversee health and safety procedures.

- *Grounds Safety Teams (GSTs).* GSTs are comprised of hospital police officers (HPOs) who report directly to the Chief of Police. GSTs respond to safety issues, including reports of suspected contraband. The 2011 budget included funding and positions for GSTs at NSH, MSH, and PSH.

3. Unfunded Overtime

Overtime costs nearly doubled between 2005-06 and 2010-11, increasing from $58.6 million to $110 million, an average annual increase of 17.5 percent per year. Since 2005-06, DMH spent over $500 million on overtime costs. Increasing violence has resulted in increased worker's compensation claims, and worker's compensation claims drive overtime costs as state hospitals must meet federal and state patient-to-staff ratios. There are several other conditions and circumstances within DSH and state hospitals that lead to overuse of overtime.

4. Lack of Transparency in Budgeting

Last year, DMH explained that while the deficits were attributed to costs rising simultaneously with resources diminishing, they also reflected a budgeting process that failed to account for the true and full costs of the state hospitals. Overall, their exploration, analysis and report, did not unearth evidence of waste or abuse of public resources as the explanation for years of increasing expenditures. Rather, the evidence pointed to increasing costs and a budget process that did not accurately reflect these rising costs. DMH also pointed out that the division responsible for hospital oversight had been preoccupied with complying with the CRIPA court order, at the expense of more accurate and responsible budget work. DMH stated that this division "lacked the knowledge and leadership to address and resolve the emerging deficit." In response to years of inadequate and inaccurate budgeting, DMH (and now DSH) has sought to build a more accurate "workload budget" in order to reveal and convey the actual costs of the hospitals continuing to do what they already do.

2012 Savings Proposals

Based on the DMH audit described above, in 2012 the Administration proposed a comprehensive list of reforms, to reverse the rising cost trend, which addressed three stated goals: 1) improve mental health outcomes; 2) increase worker and patient safety; and, 3) increase fiscal transparency and accountability. Perhaps the most significant of these proposed reforms was the reduction of 600 positions from throughout the state hospital system. Of these 600 positions, 230 were vacant while 270 were filled. The department's goal with the 270 filled positions was to offer as many of these people as possible positions elsewhere in the system, in order to minimize layoffs.

In addition to the reduction in positions, the 2012 budget package included key changes in the following areas:

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

2. Flexible staffing ratios, focusing on front-line staff, and redirecting staff to direct patient care, and streamlined mental health and medical assessments;

3. New models for contracting, purchasing, and reducing operational expenses, including negotiation of registry contract hourly rates that are in alignment with civil service staff rates, and rate caps on outside hospital services negotiated with outside medical providers;

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

5. Reduction in pharmacy costs by increasing the use of generics.

6. Increase in the county bed rate – the amount counties pay the state per patient per day for civil commitments to state hospitals.

According to DSH, approximately $200 million will have been saved by the end of FY 12-13 from this effort.

Management and Leadership

The 2011 DMH audit found weaknesses in management both at the state level and within the hospitals, which have contributed to inaccurate and incomplete budgets that fail to reflect the true operational costs of the hospitals. Therefore, the quality of management should be addressed at the same time that additional resource reductions are being made to the hospitals. The DMH report includes the following observations:

- "Headquarters is thinly staffed with a limited capacity for analysis; hospital administrative structures are also thinly staffed, especially in fiscal oversight functions;

- The division charged with hospital oversight was preoccupied with complying with the federal CRIPA court order;

- Hospitals have performed better than headquarters, but they lack robust, shared fiscal management systems and training;

- Headquarters' executive structure should be revised to replace the existing Long-Term Care Supports division with an operations division and a clinical division; and,

- There are a number of organizational and process changes the department can make to improve fiscal management and help avoid deficits in the future."

2012 Budget Act Actions

In response to the budgetary challenges related to state hospitals, the Legislature took the following actions during last year's budget process:

1. Approved trailer bill language establishing the Legislature's intent that:

   a) Any changes in staffing ratios at the state's mental hospitals address adequate staff and patient safety standards;

   b) Staffing ratios may vary based on patient acuity; and,

   c) Adult education in the state hospitals is not to be eliminated or substantially reduced.

2. Approved of budget bill language to reflect the Legislature's intent that adult education continue to be offered in the State Hospitals, targeting $3.6 million for adult education purposes.

3. Directed DSH to reduce the operating expenses of the State Hospitals' budget by $3.6 million, to cover the costs of adult education.

4. Restored authority for 37.6 positions for adult education for DSH.

5. Adopted the following budget bill language (4440-011-0001):

   13. Of the amount appropriated in Schedule (2), up to $3,600,000 is for the Adult Education program.

   14. The State Department of State Hospitals (DSH) shall reimburse the Office of State Audits and Evaluations (OSAE) within the Department of Finance to review its prior audit report of the State Department of Mental Health and determine which of its recommendations related to state hospitals have not been implemented by the State Department of Mental Health, or its successor, the State Department of State Hospitals and the status of implementation. The OSAE shall also assist the DSH to determine the priorities of outstanding audit findings based on fiscal and programmatic risk and cost efficiency. Prior to contracting with the OSAE, the DSH shall further define the scope of the audit in consultation with the Legislature. The DSH shall provide information to the OSAE as necessary for it to complete its analysis and provide recommendations. It is the Legislature's intent for the DSH to notify the OSAE to proceed with this analysis during the fall of 2012. The OSAE's report should be submitted to the Legislature by April 1, 2013, to ensure hospitals are making progress and to enable the Legislature to consider what further actions may need to be taken for the following fiscal year.

   (This follow-up OSAE audit has been received by the Legislature, as required. The audit found that, overall, DSH implemented 22 recommendations, implementation of 9 is in progress, 46 recommendations have not been implemented, and 8 are no longer applicable).

15. The Director of the State Department of State Hospitals shall submit three reports to the Director of Finance and the chairpersons and vice chairpersons of the committees in both houses of the Legislature that consider the State Budget, comparing each institution's expenditures to its approved allotments for the fiscal year beginning July 1, 2012. The first report shall be submitted with the 2013–14 Governor's Budget, the second report shall be submitted by April 1, 2013, and the third report, containing a yearend summary, shall be submitted by October 15, 2013. If any institution's expenditures are trending above the allotments provided to it, the Director of the State Department of State Hospitals shall detail the reasons why the institution is spending at a level above its allotments and list the actions the department is undertaking in order to align expenditures with approved allotments.

The Director of the State Department of State Hospitals shall submit to the chairpersons and vice chairpersons of the committees in both houses of the Legislature that consider the State Budget, the Director of Finance, and to the Legislative Analyst's Office by October 15, 2012, an operating budget for each of the facilities under the control of the State Department of State Hospitals. Specifically, the report shall include:

a) The yearend expenditures by line item detail for each institution in the 2011-12 fiscal year.

b) The allotments and projected expenditures for each institution in the 2012–13 fiscal year.

c) The number of authorized and vacant positions, estimated overtime budget, estimated benefits budget, and operating expense and equipment budget for each institution.

d) The clinical and ancillary physician/surgeon staffing ratios being implemented in the 2012–13 fiscal year.

e) *A list of all capital outlay projects occurring or projected to occur during the 2012–13 fiscal year.*

The reports required through 2012 budget bill language have been submitted to the Legislature as required. In general, the reports show that state hospitals' expenditures have not exceeded budget act allotments. The following table shows budget act appropriations, actual expenditures for the first six months of the current fiscal year, and projected expenditures for the second half of the fiscal year:

	2012 Budget Act Appropriation	Actual Expenditures (July – Dec.)	Projected Expenditures (Jan. – June)	TOTAL Projected Expenditures
ASH	$224,376,963	$97,644,992	$126,598,420	$224,243,412
CSH	198,665,287	84,531,773	114,112,929	198,644,702
MSH	167,879,602	73,405,952	94,254,088	167,660,040
NSH	254,312,897	114,729,940	139,171,079	253,901,019
PSH	296,469,348	126,905,049	169,136,023	296,041,072
SVPP	63,460,262	28,882,057	34,134,432	63,016,489
VPP	69,118,574	31,441,960	37,332,382	68,774,342
SPP	8,845,454	1,461,748	7,041,760	8,503,508
Total of All Hospitals	$1,328,122,773	$562,114,377	$763,646,646	$1,325,761,023

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DSH to provide an update on the overall fiscal condition and stability of the state hospitals, and to address the following:

1. Please describe how DSH has met the requirements included in budget and trailer bill language as part of the 2012 budget package.

2. Please describe how DSH has addressed the deficiencies in management and leadership that were identified in the DMH audit in 2011.

3. How many state hospitals staff were laid off as a result of the elimination of positions over the past year?

4. Please summarize the OSAE report issued in February of 2013 and respond to the identified deficiencies in terms of failure to implement recommendations made in the 2007 OSAE report.

5. Please summarize the DSH report to the Legislature (due by April 1, 2013), comparing each institution’s expenditures to its approved allotments for the fiscal year beginning July 1, 2012.

6. What is the reason that for all of the hospitals, the projected expenditures for the second half of the fiscal year are all substantially greater than the actual expenditures for the first half of the fiscal year?

7. Does DSH intend to reinstate adult education in the state hospitals when sufficient resources are available to do so? Please comment on DSH's assessment of the value of adult education in the hospitals.

Staff Recommendation: Oversight issue; no action recommended.

ISSUE 3: STOCKTON FACILITY AUGMENTATION

The budget proposes $100.9 million (General Fund) for the new California Health Care Facility (CHCF) in Stockton to begin operations, activating 514 beds. This funding covers facility staffing, including $33.4 million for full year costs of existing positions (appropriated in 2012-13) and $67.5 million for new staff.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The Coleman Federal Court is the result of a lawsuit brought against CDCR asserting that they were not providing adequate mental health care to inmates. As a result, when inmates require in-patient mental health care, they are referred to DSH, which refers them to either Salinas Valley Psychiatric Program (SVPP) or the Vacaville Psychiatric Program (VPP). Significant waiting lists have developed at these two facilities, resulting in the court directing California to address the waiting lists on a faster time-line. DSH (and the former DMH) and CDCR have worked closely with the "special master" of the Coleman Federal Court to develop a plan to reduce or eliminate the waiting lists at the SVPP and VPP. The former-DMH and CDCR jointly submitted a proposed three-pronged approach to the court, which approved of the plan. Specifically, to reduce the waiting lists, the DMH and CDCR began: 1) moving patients who have been stabilized to ASH; 2) moving other patients who are deemed very stable to CSH; and, 3) converting the "L Wing" of the California Medical Facility (which houses the VPP) to an Intermediate Care Facility Level of Care to accommodate over 100 temporary patients.

DSH indicates that there has been a sudden, still-unexplained, spike in the waiting list to approximately 315. DSH does not know the cause of the increase but currently is attempting to analyze the cause(s). In the meantime, DSH is increasing bed capacity beyond the new Stockton facility, by adding a total of 70 new beds at CSH and ASH.

The Federal Court also directed the State to construct and activate a 64-bed Intermediate Care Facility (ICF) for Level IV/high custody inmate/patients, no later than September 2011. The CDCR and DMH chose to meet this requirement by expanding the VPP within the California Medical Facility.

In October of 2009, the CDCR signed a Resolution of Approval with the Federal Receiver to construct 1,722 medical and mental health beds. In the Coleman case, the court ordered the CHCF in Stockton to be activated, begin patient admissions by July 2013, and be completed to full occupancy by December 2013. The CHCF will be operated as a fully integrated correctional medical facility by DSH, CDCR, and the Federal Receiver. DSH will be responsible for 514 beds for High Custody/Level IV inmates/patients, to be referred to as the Stockton Psychiatric Program (SPP).

The SPP will begin accepting patients in July of 2013, through both direct admission and by transferring patients from VPP and SVPP. A total reduction of 450 beds will occur at VPP and SVPP.

The SPP will employ a total of 931 clinical and administrative staff. DSH states that it has undertaken outreach and education efforts to affected staff at Vacaville and Salinas, thereby providing information about employment opportunities at SPP. The hiring plan has been phased in over a two-year period to accommodate building activations, licensing and patient movement plans. DSH expects to fill all positions by December 2013. The January 2013-14 budget does not include the savings from staff reductions at VPP and SVPP, however this savings is expected to be reflected in the May Revision.

The chart below reflects the timelines in which positions and dollars are authorized for DSH-Stockton. DSH-Stockton activation totals $114.9 million and 931.0 positions

Department of State Hospitals Stockton Psychiatric Program Funding and Position Authority to Date

Fiscal Year	Process	Activation	Personal Services	OE&E	Total	Positions	PYs*	Comments
2011-12	Governor's Budget Estimates	-			-	-	-	
2011-12	May Revisions Estimates	Stockton Healthcare Facility	$1,228,000	$136,000	$1,364,000	8.0	7.6	(8.0 full year equivalent)
2012-13	Governor's Budget Estimates	Stockton Healthcare Facility	$6,774,000	$1,215,000	$7,989,000	75.9	72.1	(359.4 full year equivalent)
		Stockton Healthcare Facility IT	$721,000	$2,641,000	$3,362,000	7.0	6.7	(7.0 full year equivalent)
2012-13	May Revisions Estimates	-			-	-		
2013-14	Full Year Adjustment				$33,395,000	283.5	283.5	Full year adjustment
2013-14	Governor's Budget Estimates	Stockton Activation - Positions Required for Continued Activation	$56,886,000	$8,356,000	$65,242,000	522.3	522.3	(538.6 full year equivalent)
		Stockton Activation - Psychiatrist-On-Duty	$782,000	-	$782,000	-	-	No additional staff, will use hourly staff and extend shifts
		Stockton Activation - Employee Relocation Costs	-	$759,000	$759,000	-	-	One-time expenditure
		Stockton Activation - Stockton Housekeeping Staff	$719,000	-	$719,000	18.0	18.0	
2014-15	Full Year Adjustment				$1,320,000	16.3	16.3	Estimated Full year adjustment
Total					$114,932,000	931.0		

*Costing based on prior year positions.

The major 2013-14 costs associated with this request include the following:

1. Required positions for Stockton activation -- $65,242,000
2. Psychiatrist-on-Duty 24-hours per day -- $782,000
3. Relocation costs for promotional staff -- $759,000
4. 18.0 additional housekeeping staff -- $719,000

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DSH to describe this request and provide an overview of the Coleman Court and the new Stockton facility.

Staff Recommendation: Approve as budgeted.

ISSUE 4: VACAVILLE PSYCHIATRIST-ON-DUTY

DSH is requesting $782,000 in both 2012-13 and 2013-14 to establish 24-hour on-site psychiatric coverage at Vacaville in order to better meet the needs of patients and to reduce overtime costs.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

Currently, Vacaville utilizes a Psychiatrist-on-Call (POC) program, which DSH deems insufficient to meet patient needs. Therefore, DSH is proposing to establish a Psychiatrist-on-Duty (POD) program that ensures 24 hour per day on-site coverage by a psychiatrist. According to DSH, POD coverage is necessary to meet Joint Commission Accreditation Standards.

DSH explains that savings will be realized with a POD, as psychiatrists-on-call get paid an hourly rate, including one hour for travel time; a psychiatrist-on-duty would not be paid for travel time, and there would be reduced overtime pay for staff who are waiting for a psychiatrist-on-call to arrive.

DSH states that the absence of a POD program will threaten compliance with the Coleman Court. CDCR provided funding for POD coverage until July 1, 2012 and will no longer support the program financially. POD coverage is also included in the proposed funding for the Stockton facility.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DSH to explain this proposal in full, and also to explain CDCR's prior role and responsibilities with regard to POD coverage. For what reasons did CDCR cease funding for POD coverage?

Staff Recommendation: Approve as budgeted.

ISSUE 5: PERSONAL DURESS ALARM SYSTEM BUDGET CHANGE PROPOSAL

For the 2013-14 budget, the DSH is requesting 4.0 positions and $16.6 million General Fund to install and support the Personal Duress Alarm System (PDAS) at ASH and CSH, and to complete the PDAS project at MSH and PSH. The DSH also requests 3.0 positions at NSH to produce triple break-away lanyards that are part of the PDAS.

The budget proposes a reduction of $5.6 million General Fund for the PDAS at MSH and PSH, reflecting an updated project schedule. The total cost of the PDAS project is $47.9 million.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As described above under issue #2, the state hospitals have experienced a substantial increase in violence as a result of the population becoming almost entirely a forensic population. The PDAS is one of the major safety initiatives being implemented at the state hospitals, involving each staff person wearing a personal alarm. The PDAS has been fully implemented at NSH and, based on its success, will be implemented at the other four hospitals. Implementation is underway at MSH and PSH, and this BCP proposes resources to begin implementation at CSH and ASH. The 4.0 positions requested will be divided equally between CSH and ASH, resulting in two positions each at all five hospitals. The three additional positions at NSH are for the purpose of producing triple break-away lanyards, which NSH staff developed in order to eliminate all strangulation risk. According to DSH, this type of lanyard is not produced by any manufacturers in the private sector, and that lanyard manufacturers generally are uninterested in producing them for the state hospitals due to liability concerns. The DSH estimates that approximately one-third of the lanyards will need replacement annually.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DSH to describe this proposal, and to give an update and overview of the full project.

1. What is the timeline for full implementation of the PDAS at the remaining four hospitals?

Staff Recommendation: Approve as budgeted.

ISSUE 6: ACTIVE DIRECTORY RESTRUCTURING BUDGET CHANGE PROPOSAL

The DSH is requesting $1.1 million General Fund ($994,000 one-time and $140,000 ongoing) for 2013-14 to support the development and maintenance of a new single Active Directory (AD) domain, to centralize and consolidate eight existing independent ADs.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

In general, the State Hospital system is extremely deficient in terms of information technology (IT). In fact, it is so lacking in up-to-date IT that arguably it cannot operate as a system at all. Instead, it operates as eight independent hospitals and facilities. One of the goals of DSH is to operate, manage, and oversee the hospitals as a single hospital system. According to DSH, a central AD is the essential foundation to implementing shared enterprise clinical systems, such as electronic health records (EHRs). DSH states that consistent patient services and effective management systems require sharing information and application capabilities, and a centralized AD is one of the foundational components to enabling an enterprise approach to EHR, patient treatment plan management, and other critical clinical applications. Within the current environment of eight independent domains, it is virtually impossible for DSH and hospitals to share clinical technologies and other information and to conduct any type of electronic communications.

Within this new centralized AD, DSH will consolidate these eight ADs into one centrally managed employee directory and into a single logical network as part of the California Government Enterprise Network. One of the major purposes of the centralized AD will be to assist with staff scheduling, which, according to DSH, is currently highly inefficient.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked DSH to describe this proposal and explain the uses and value of this type of technology.

Staff Recommendation: Approve as budgeted.

ISSUE 7: AUTOMATED STAFF SCHEDULING AND INFORMATION SUPPORT TOOL BUDGET CHANGE PROPOSAL

Through the Governor's January budget for 2013-14, the DSH is requesting 4.0 positions and $5.4 million General Fund in 2013-14, and $1.2 million in 2014-15 and on-going, to implement an Automated Staff Scheduling and Information Support Tool (ASSIST). The DSH anticipates that ASSIST will eventually save approximately 5 percent of overtime costs, or at least $4.8 million.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The state hospital system manages the schedules of an average of 1,000 "Level of Care" (LOC, direct patient care) staff and hundreds of Contract Registry staff at each facility on a 24-hour per day, seven-days per week basis. Currently, each facility spends an average of 23.1 positions on staffing and scheduling efforts. The estimated current annual cost of scheduling is over $10.5 million.

Each facility must schedule LOC staff in such a way as to meet court mandated staffing levels and classifications as well as state statutory requirements while considering the clinical and security needs of the patient population and an individual's specific clinical case, acuity level, necessary level of care and emergent conditions or situations that require enhanced observations. Moreover, the staffing office must take into account bargaining unit agreements, overtime rules, vacation bidding rules and immunization and certification requirements when generating schedules. The staffing office must manually create and maintain this schedule while covering an average of 50 unscheduled absences per day.

An ASSIST tool is used to create an efficient staff scheduling system. DSH states that the tool will help each facility responsible for generating schedules, relief pool lists, and reports on staffing and overtime costs in order to better manage their operations. The tool allows management to improve management of staffing levels, overtime usage, and tracking training and certification requirements throughout the hospital system. The effective management of schedules and overtime should ensure proper staffing ratios and ultimately a reduction in overtime costs.

Centralized staffing data also will allow DSH to respond to information requests regarding overtime costs and other aspects of scheduling. DSH expects this tool to ultimately reduce redundancies and inefficiencies in scheduling, thereby reducing overtime, and overtime costs. DSH states that hospital staff have repeatedly requested the acquisition of this tool, and that CDCR uses an ASSIST-type tool.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has asked DSH to describe this proposal and the ASSIST tool.

1. How will the ASSIST tool differ from the Active Directory, with regard to staff scheduling?

Staff Recommendation: Approve as budgeted.

ISSUE 8: METROPOLITAN STATE HOSPITAL FIRE ALARM UPGRADE CAPITAL OUTLAY

The 2013-14 budget proposes $633,000 General Fund to upgrade the Notifier Fire Alarm System at MSH, in psychiatric patient housing and to provide a new central monitoring system, as part of a project with a total cost of $8.9 million.

PANELISTS

- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

According to the Administration, the fire alarms in all of the State Hospitals are in need of upgrades; they proposed starting the upgrades with Napa because it has experienced the greatest number of problems and failures. Therefore, the 2011 Budget Act included $2.2 million General Fund for the preliminary plans and working drawing phase of the project. In 2012, the budget act included $15.5 million to replace the fire alarm systems in several buildings at Napa State Hospital.

According to the Administration, the existing Fire Alarm Control Panels and Field devices are out-dated and no longer meet the National Fire Protection Association (NFPA) codes and 2007 California Fire Code (listed in Title 24, Part 9 Section 202, Occupancy Classification, [B] Institutional Groups I-1.1, I-2 and I-3). The existing Fire Alarm Control Panels and Field devices are not compatible with the current manufacturer's Fire Alarm Control Panels built to 2003 UL 864 9th Edition-Standard for Control Units and Accessories for Fire Alarm Systems. The existing Fire Alarm Control Panels and field devices are no longer listed by the State Fire Marshall's Office. The Administration states that there are numerous devices that fail on a continuous basis, which necessitates constant repair. MSH has a specialized C-16 fire protection contractor on grounds conducting repairs nearly continuously. Overall, the systems lack serviceability and/or expandability and the technology is very outdated.

Given the deficiencies in the fire alarm system at MSH, when the fire alarm system malfunctions, Fire Watch is utilized to ensure all fire/life/safety measures are met. Fire Watch is an expensive process that is conducted by MSH Hospital Police working on overtime status. Since January 2012 the DSH-Metropolitan fire alarm system has failed 584 times. The fire alarms fail so regularly that the fire department considers them not credible, and therefore does not respond unless hospital staff call 911 directly. For these reasons, the DMH asserts that the Fire Alarm Systems require replacement to protect the patients, staff, and visitors.

STAFF COMMENTS/QUESTIONS

"Capital Outlay" projects, such as the three included for State Hospitals and described in this agenda, are contained in a section of the budget specific to capital outlay, and separate from the various departments throughout state government that are related to the projects. Specifically, this, and the next two capital outlay projects on State Hospitals, are proposals outside of the DSH budget.

The Subcommittee has asked the Administration to describe this proposal and the justification for it, as well as how the budget is organized with regard to capital outlay in general.

Staff Recommendation: Approve as budgeted.

ISSUE 9: PATTON STATE HOSPITAL SECURITY PERIMETER FENCING CAPITAL OUTLAY

The 2013-14 budget proposes $560,000 General Fund for the re-evaluation of existing working drawings, and for the construction phase of increased security fencing and other related physical improvements for security purposes. The total estimated project cost is $16.4 million. The California Department of Corrections and Rehabilitation (CDCR) anticipates annual savings of $4.8 million due to the reduction in security staff that will be possible as a result of this project.

PANELISTS

- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

In response to a request by then-Assemblymember Leonard, the former DMH toured the PSH security system in January 1998 to identify potential ways to enhance perimeter security. In March 1998, the Joint Legislative Audit Committee requested the Bureau of State Audits (BSA) to study security at the facility. The BSA audit recommended installation of a double fence, each 14 feet high with razor ribbon, closed-circuit TV and anti-climb mesh, electronic detection system devices, vehicle patrol outside, and bicycle patrol inside. In response to the BSA audit, DMH hired private consultants to study the problem in December 1999. Farbstein and Associates called for complete full double fencing, thereby shifting hospital security from CDCR to hospital-based police, and replacement of kiosk staff with mobile perimeter patrols.

The preliminary plans and working drawing phases of this project were completed, however due to funding restrictions and other higher priorities; the project was officially placed in suspension in 2005. Currently, the CDCR Correctional Officers provide security at PSH and because of current CDCR budget constraints; they state that they are no longer able to provide the level of security needed to meet the needs of the facility and the concerns of the nearby community.

The proposed funding will cover: 1) the demolition of ground guard posts, existing fencing, lighting, paving and selected trees and shrubs; and, 2) construction of a Level II design, double perimeter fence with barbed tape, fence detection system, 13 ground guard posts, two vehicle and pedestrian sally ports, perimeter patrol roadway improvements, modification to portions of the internal roads, new security lighting and closed-circuit television cameras.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked the Administration to describe this proposal and the justification for it.

Staff Recommendation: Approve as budgeted.

ISSUE 10: NAPA STATE HOSPITAL SECURITY GATES AND FENCING CAPITAL OUTLAY

The 2013-14 budget proposes $863,000 General Fund to fund security improvements in the patient housing courtyards at Napa State Hospital (NSH).

PANELISTS

- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As described in other parts of this agenda, many violent criminals now reside in state hospitals. Given this fact, coupled with the reality that the state hospitals facilities were not built to be prisons, significant security vulnerabilities persist at the hospitals putting patients, staff, and the community at risk of violence. According to the Administration, the purpose of this project is to eliminate such vulnerabilities in the courtyard fencing and gates at NSH that have allowed forensic and civilly committed patients to climb over the fence and escape from the courtyards. A forensically committed patient escaped from the Secured Treatment Area (STA), resulting in improvements to the STA fence, however, according to DSH, NSH lacks the resources to make similar improvements to the courtyard fencing.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked the Administration to describe this proposal and the justification for it.

Staff Recommendation: Approve as budgeted.