AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 5
PUBLIC SAFETY

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

and

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, APRIL 3, 2017

2:30 P.M. – CALIFORNIA STATE CAPITOL ROOM 437

ITEMS TO BE HEARD

ITEM	DESCRIPTION	
5225 4440	**CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION AND DEPARTMENT OF STATE HOSPITALS**	
ISSUE 1	TRANSFER OF INTERMEDIATE AND ACUTE LEVELS OF CARE	1

ITEMS TO BE HEARD

5225 CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: TRANSFER OF INTERMEDIATE AND ACUTE LEVELS OF CARE

The Department of State Hospitals (DSH) and California Department of Corrections and Rehabilitation (CDCR) will present this proposal to transfer responsibility for psychiatric inpatient care of CDCR inmates from DSH to CDCR and California Correctional Health Care Services (CCHCS) at three CDCR institutions.

PANELISTS

- Department of State Hospitals
- California Department of Corrections and Rehabilitation
- California Correctional Health Care Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

GOVERNOR'S PROPOSAL

The CDCR, CCHCS and DSH request the transfer of $250,407,000 General Fund (GF) and 1,977.6 positions from DSH to CDCR and CCHCS effective July 1, 2017 and ongoing. This transfer represents the mutual agreement of the agencies to transfer responsibility for psychiatric inpatient care of CDCR inmates from DSH to CDCR and CCHCS at three CDCR institutions, along with the associated resources.

Specifically, this request would transfer responsibility for the following psychiatric inpatient programs:

Institution	Intermediate Care Facility (ICF) Beds (Low Custody)	ICF Beds (High Custody)	Acute Psychiatric Program (APP) Beds	Total Beds
California Health Care Facility	0	360	154	514
California Medical Facility	84	94	218	396
Salinas Valley State Prison	0	246	0	246
Total	**84**	**700**	**372**	**1,156**

The proposed transfer of the DSH inpatient programs is proposed to occur on July 1, 2017. At that time, CDCR and CCHCS will take operational control over the existing DSH programs at the three institutions. Initially CDCR intends to implement, operate and staff these programs exactly as they are operated and staffed by DSH. In the long term, if CDCR decides to make changes, it will take time to implement changes in staffing structure as CDCR and CCHCS will need to work closely with the California Department of Human Resources and the affected employees, as well as employee bargaining units on any staffing changes to reduce the overall impact. The goal is to implement changes while considering the overall continuum of care and ensuring no disruption in care for the seriously mentally ill patients served by these programs.

BACKGROUND

Inpatient Psychiatric Programs. Inpatient psychiatric programs are operated in both state prisons and state hospitals including a total of 1,547 inpatient psychiatric beds. There are two levels of inpatient psychiatric programs:

1. Intermediate Care Facilities (ICFs). ICFs provide longer-term treatment for inmates who require treatment beyond what is provided in CDCR outpatient programs. Inmates with lower-security concerns are placed in low-custody ICFs, which are in dorms, while inmates with higher-security concerns are placed in high-custody ICFs, which are in cells. There are 784 ICF beds, 700 of which are high-custody ICF beds, in state prisons. In addition, there are 306 low-custody ICF beds in state hospitals.

2. Acute Psychiatric Programs (APPs). APPs provide shorter-term, intensive treatment for inmates who show signs of a major mental illness or higher-level symptoms of a chronic mental illness. Currently, there are 372 APP beds, all of which are in state prisons.

In addition to these beds, there are 85 beds for women and condemned inmates in state prisons that can be operated as either ICF or APP beds, as we discuss below. As of January 2017, there was a waitlist of over 120 inmates for ICF and APP beds.

DSH Inpatient Psychiatric Programs. Almost all inpatient psychiatric programs are operated by DSH. Specifically, DSH operates a total of 1,462 beds in both state prisons and state hospitals—all but the 85 beds for women and condemned inmates. The first inpatient psychiatric program in a state prison opened at the California Medical Facility (CMF) in Vacaville in 1988. At the time, the state hospitals, rather than CDCR, were given the greater responsibility to provide treatment services to inmates because of their experience operating inpatient psychiatric hospitals. DSH currently operates inpatient psychiatric programs at three state prisons - CMF, California Health Care Facility (CHCF) in Stockton, and Salinas Valley State Prison in Soledad. In these prisons, DSH operates 1,156 ICF and APP beds at an annual cost of around $216,000 per bed. In state hospitals, DSH operates 306 ICF beds for low-custody patients (256 beds at DSH-Atascadero and 50 beds at DSH-Coalinga). We estimate that the annual cost to operate a low-custody ICF bed in a state hospital to be about $218,000.

CDCR Inpatient Psychiatric Programs. In 2012, CDCR began providing inpatient psychiatric programs for certain inmates with the operation of a 45-bed facility for women at the California Institution for Women in Corona. In 2014, CDCR began operating a 40-bed inpatient program for condemned inmates at San Quentin State Prison in Marin County. These programs provide both ICF and APP treatment to inmates housed in cells. In addition to being operated by CDCR instead of DSH, these programs are also different in that they serve specific inmate groups (women and condemned inmates), which could significantly affect program operations and costs. The annual cost for a bed in a CDCR-operated, inpatient psychiatric program is around $301,000.

Inpatient Psychiatric Program Referral Process. When CDCR seeks to place an inmate in a DSH inpatient psychiatric bed, DSH staff must agree with CDCR's assessment that the inmate needs inpatient care. In addition, both CDCR and DSH also must agree on the location in which the inmate should be served. Once both departments agree on the placement, the inmate is required to be transferred within 72 hours. Under the current referral process, ICF referrals take 15 business days to complete while APP referrals take 6 business days to complete. However, if there are disagreements between the departments, the placement can take even longer.

DSH Background

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

- ***Atascadero (ASH).*** ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons referred by the court related to criminal violations). Population: 1,258.

- ***Coalinga (CSH).*** Located in the City of Coalinga, CSH is the newest state hospital, opened in 2005, and treats forensically committed and sexually violent predators. Population: 1,293.

- ***Metropolitan (MSH).*** Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court-ordered penal code commitments. Population: 807.

- ***Napa (NSH).*** Located in the City of Napa, NSH is a low-to-moderate security state hospital. Population: 1,269.

- ***Patton (PSH).*** PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals. Population: 1,527.

Prison-Based Psychiatric Programs. The prison-based psychiatric facilities treat approximately 1,107 inmates. They include: 1) Vacaville Psychiatric Program; 2) Salinas Valley Psychiatric Program; and 3) Stockton Psychiatric Program.

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

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.

DSH's role in providing psychiatric care to prison inmates in prisons began in 1991 in response to the Coleman class action lawsuit which found that inmates were not receiving psychiatric care which amounted to cruel and unusual punishment. At that time, CDCR had no experience or expertise on providing psychiatric care and therefore DSH was brought in to do this work until such time that CDCR developed the capacity to provide it. Initially DSH was brought in to provide acute care within the Vacaville prison. Subsequently, in the mid-2000s, DSH established an acute care program within the Salinas Valley prison. Finally and most recently, the California Health Care Facility was established in Stockton, and was designed to include acute psychiatric care also provided by DSH.

CDCR Background

Under current practice, CDCR inmates requiring mental health services are cared for by each of the three agencies, depending upon the level of services needed. CDCR is responsible for providing mental health services to the inmate population through the Mental Health Services Delivery System (MHSDS), and CCHCS is responsible for providing medical care to the inmate population. However, CDCR had not in the past established an effective, psychiatric inpatient program. Therefore, inmates requiring an inpatient level of mental health care meeting CDCR and DSH agreed-upon or In-Patient Intermediate Care Facility (ICF) and Acute admission criteria, are discharged from the CDCR mental health program and admitted to the appropriate level of care at a DSH program in accordance with a Memorandum of Understanding (MOU) between the agencies. DSH oversees the inpatient level of care for these inmates through their delivery care model. DSH is responsible for managing California's forensic mental health state hospital system, including inpatient mental health services.

In 2012, in response to the Coleman Court's requirement to establish a psychiatric inpatient program for female inmates, CDCR, CCHCS and DSH (then referred to as the Department of Mental Health) collaborated on the construction and activation of the 45-bed Psychiatric Inpatient Program (PIP) at the California Institution for Women (CIW). The new CIW facility was activated July 3, 2012, received initial Joint Commission accreditation on July 9, 2012, and has successfully maintained full accreditation since February 14, 2013. Additionally, on October 1, 2014, CDCR activated the San Quentin

Condemned PIP program, a 40-bed psychiatric inpatient program for condemned male inmates which has also achieved Joint Commission accreditation.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION MENTAL HEALTH INPATIENT CARE MILESTONES

1988 The California Department of Corrections (CDC) enters into an interagency agreement with the Department of Mental Health to operate 210 licensed and unlicensed beds at the California Medical Facility (CMF) for mentally ill inmates.

1991 A class action lawsuit is filed in federal court arguing that inmates are denied mental health treatment in violation of the eighth amendment against cruel and unusual punishment, to be known as the Coleman lawsuit.

1994 CDC creates and implements the Mental Health Delivery System (MHDS) to address inadequacies in mental health services through the establishment of policies and procedures that address issues such as identification of inmates needing services, multiple levels of care, programming, and staffing.

1995 Federal Court Judge Karlton finds under the Coleman lawsuit that CDCR's treatment of mentally ill inmates is in violation of the eighth amendment.

1997 In 1997, CDC and the Coleman plaintiffs reach agreement on the Mental Health Services Delivery System and the Program Guide that provides the policies and procedures that govern delivery of these mental health services.

1998 In 1998, in response to the Coleman Special Master's concerns regarding bed availability for inmates requiring and Intermediate Care Facility (ICF) level of care, CDC and DMH increase the number of Intermediate Care Facility (ICF) beds for CDC inmates by licensing 84 ICF beds at CMF and proposing to establish 64 ICF beds at Salinas Valley State Prison (SVSP), the newest prison opened by CDC in 1996. These beds would be operated by DMH. This plan ultimately resulted in the design and construction of an ICF treatment center at SVSP.

2003 DMH opens the 64-bed ICF at SVSP, designed to provide intermediate mental health services to inmates with higher security needs.

2006 The court orders several expansion projects, including building a second 74-bed ICF unit at SVSP, activation of 36 ICF beds at CMF in unit P-2, temporary establishment of 116 ICF beds in D-5/D-6 units at SVSP and 30 beds in P-3 unit at CMF. DMH was added to the Coleman case as a Defendant.

2010 The court orders activation of 116 high-custody ICF beds at SVSP on C5/C6 units. In addition, DMH and CDCR activate a 32-bed acute unit in P-1 at CMF to address the increased demand for acute beds.

2011/2012 Expansion projects are identified that include construction and activation of the 64-bed ICF high-custody treatment center at CMF and the court-ordered activation of 113 temporary ICF beds on L-Wing at CMF. The L-Wing beds were temporary pending the opening of the DSH program at the California Health Care Facility (CHCF), where construction is underway with a planned activation of July 2013.

2012 The California Department of Corrections and Rehabilitation (CDCR) (formerly known as CDC) opens a 45-bed inpatient facility (Psychiatric Inpatient Program, or PIP) for female inmates with mental health needs at the California Institution for Women. In that same year, the program receives accreditation by the Joint Commission.

2013 CDCR opens CHCF at Stockton. Included within the facility is a 514-bed program that provides inpatient mental health services for male inmates operated by the Department of State Hospitals (formerly known as DMH).

2014 CDCR opens a 40-bed PIP at San Quentin designed to provide inpatient mental health services for the condemned population. In that same year, the program receives accreditation by the Joint Commission.

2015 CDCR and DMH enter into an updated Memorandum of Understanding regarding the provision of inpatient psychiatric care of CDCR inmate-patients. Revised policies and procedures include streamlining the referral, acceptance, transfer, and admission of seriously mentally ill CDCR patients to inpatient care at DSH programs.

2016 In his monitoring report of inpatient mental health care programs operated by both DSH and CDCR, Special Master Matthew Lopes voices his support for the transfer of inpatient programs at CMF, SVSP, and CHCF currently operated by DSH to CDCR.

Given these initiatives, CDCR believes that it has demonstrated that the Department is now positioned to assume responsibility for the inpatient programs DSH runs at the three existing facilities, while ensuring continuity of care to the patients. The three agencies therefore propose to shift management and responsibility of the inpatient programs housed at California Health Care Facility (CHCF), California Medical Facility (CMF), and Salinas Valley State Prison (SVSP) to CDCR. Low custody programs managed by DSH at Coalinga and Atascadero State Hospitals will continue to be managed by DSH as they are located within DSH facilities.

Transfer from DSH to CDCR and CCHCS

This proposal is part of the final stage of a long-term plan to establish and maintain the complete mental health care program for inmates within CDCR. The Administration explains that, now that CDCR has demonstrated the ability to operate both outpatient and inpatient mental health programs, continuing to have one component of the mental health program run by a separate agency proves less efficient. This is demonstrated through the process of referring a patient from the CDCR MHSDS level of care and admitting the patient into a DSH program, which requires several essential procedural layers to ensure the best placement of the patient at the appropriate level of care. DSH manages the nation's largest inpatient forensic mental health hospital system. Its

mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings, and is responsible for the daily care and provision of mental health treatment of its patients. Designing and maintaining programs for both CDCR inmates within CDCR institutions and citizens in DSH mental hospitals requires a significant effort for DSH.

Impacts on the Patient Referral Process

In determining whether a transfer of responsibility for the in-prison programs to CDCR was appropriate, the agencies reviewed the current referral process for a CDCR inmate who requires inpatient mental health care services. According to the proposal, transferring full responsibility of the inpatient programs to CDCR, the following improvements and efficiencies could be achieved:

- Acute Psychiatric Program: The referral process timeframe is reduced by 50% (from six to three business days). This is achieved by CDCR's ability to manage the referral process in its entirety. CDCR Inpatient Coordinators will be directly responsible for utilization management of these beds, including making local referrals, determination of appropriate level of care, and accountability for timeliness and quality of the referral. The CDCR Inpatient Coordinators will be provided the least restrictive housing much sooner in the process. This level of accountability eliminates the time required for a CDCR Headquarters clinician to perform an independent review for appropriateness, as well as the time required for a DSH Coordinator to review. This can only be accomplished by creating a unified program structure under the control of one agency.

- Intermediate Care Program: The referral process timeframe is reduced by 40% (from 15 to nine business days) for high custody bed programs. This is achieved just as the acute process above, allowing CDCR to manage the referral process in its entirety. CDCR Inpatient Coordinators will be provided the least restrictive housing much sooner in the process.

The Administration states that with CDCR and CCHCS managing the complete continuum of mental health care within the prisons, the ability to provide a standardized, quality continuum of care model, while immediately affecting a dramatic reduction in referral processing times, will allow CDCR and CCHCS to better manage the utilization of these beds..

This transfer is expected to provide a more efficient access to care process for CDCR inmates requiring an inpatient level of mental health care. CDCR/CCHCS will have direct control of the majority of the mental health population, ensuring uniform bed management, standardized training, policies and procedures, and uniform application of diagnostic and treatment approaches to patient care. It also provides some important cost avoidances to both CCHCS and DSH operations.

Additionally, the Receiver is responsible for ensuring that a constitutional level of health care is provided to CDCR inmates (Plata), including inmates that are placed into programs or facilities other than CDCR institutions (e.g. out of state prisons, community correctional facilities, etc.). A unit is dedicated to monitoring and providing periodic assessments of the medical care provided, but they do not currently provide monitoring to CDCR inmates that are placed in a DSH program. CCHCS has not previously requested resources to establish monitoring of the health care provided in these programs. If this proposal is not approved, CCHCS anticipates potentially requesting resources to support the ongoing oversight of the medical care DSH provides at SVSP and CMF.

LAO ASSESSMENT AND RECOMMENDATION

Proposed Shift Could Achieve Notable Outcomes . . . Shifting the inpatient psychiatric programs from DSH to CDCR could reduce wait times and, as a result, allow inmates to be admitted to appropriate treatment programs sooner than otherwise. This could help improve the quality of care these inmates receive. In addition, the shift could generate state savings by reducing the number of days that inmates spend in MHCBs, which are more costly than inpatient psychiatric beds. The proposal could also achieve economies of scale by having only one department oversee inmate mental health beds. For example, it would reduce the need to maintain two administrative and supervisory structures and eliminate the need for staff involved in transferring inmates between CDCR and DSH.

. . . But Uncertain if Notable Outcomes Will Actually Be Achieved. While the Governor's proposed shift in responsibility is well intended, there is significant uncertainty regarding the extent to which the shift will actually achieve the desired outcomes. Specifically, it is uncertain:

What Will Happen to Program Costs? While the initial costs of operating inpatient psychiatric programs would not change once they are transferred to CDCR, it is uncertain how such costs might change in the long run. On the one hand, as discussed above, the proposal could reduce operational costs. On the other hand, there are reasons why it could increase costs. For example, DSH uses Medical Technical Assistants (MTAs) that combine nursing and custody responsibilities, which prevent the need for hiring two separate staff members for these functions. According to CDCR, it does not plan to use MTA positions in the long run, which would increase costs. Moreover, the cost per bed of the units currently operated by CDCR is $301,000 per year—well above the $216,000 cost per bed for the in-prison programs operated by DSH. This difference could be driven by various factors including (1) the populations served by CDCR are very different from those served by DSH and (2) there could be economies of scale achieved by DSH by operating larger programs. Despite these notable differences, the much greater cost per bed raises concern.

How Will Quality of Care Be Affected? Given that the Administration has not provided information regarding how these programs will be operated in the long term, it is unclear whether the programs will be as effective as the current programs operated by DSH. The department has indicated that it plans to operate the programs differently after two years, such as by no longer using MTA positions, but it is uncertain what other changes might occur and how those changes would affect the level of service provided.

LAO Recommendation

Reject Complete Shift and Instead Pilot Proposed Shift. Given the significant uncertainty on whether the proposed shift in responsibility would result in more cost-effective care being delivered, the LAO recommends that the Legislature reject the Governor's proposal and instead shift a limited number of beds over a three-year period. Specifically, the LAO recommends that the Legislature implement a pilot program in which CDCR would provide inpatient psychiatric care to a portion of inmates who would otherwise get their care from DSH. Such a pilot could allow the Legislature to determine (1) whether wait times for these programs decrease as expected, (2) what particular staffing changes need to be made and the cost of making those changes, and (3) the effectiveness of the treatment provided. The LAO recommends that the pilot include both ICF and APP units and be operated at more than one facility. For example, CDCR could have responsibility for an APP unit at CHCF and an ICF unit at CMF. This would ensure that the pilot can test CDCR's ability to operate multiple levels of care at multiple facilities. In addition, the LAO recommends that the pilot include one unit that is currently being operated by DSH, and one new unit that would be operated by CDCR.

The LAO recommends that the Legislature require CDCR to contract with independent research experts, such as a university, to measure key outcomes and provide an evaluation of the pilot to the Legislature by January 10, 2019. This evaluation would ensure that the Legislature has adequate information after the completion of the pilot to determine the extent to which inpatient psychiatric program responsibilities should be shifted to CDCR. These key outcomes would include how successfully CDCR was able to return inmates to the general population without additional MHCB or inpatient psychiatric program admissions, whether wait times decreased, and the cost of the care provided. The LAO estimates the cost of this evaluation to be around a few hundred thousand dollars.

Stakeholder Concerns

AFSCME is opposed to this proposal to transfer authority for psychiatric care of inmates from DSH to CDCR. AFSCME states that "DSH specializes in providing psychiatric stabilization for those inmates whom CDCR has deemed to mentally ill to be managed in a prison setting." They argue that the mission of DSH is to provide effective psychiatric treatment while CDCR has a custodial mission. They believe that DSH's mission enhanced safety and focuses on treatment which would be lost with this proposed transfer.

Disability Rights California (DRC) does not oppose the transfer, but has two concerns which they shared with the Subcommittees: 1) Access and quality of care; and 2) abuse and neglect reporting.

Access and Quality of Care. DRC states that there is a long history of inadequate access to care provided to inmate-patients. DRC wants to ensure inmate-patient care focuses on essential principles of timely access, adequate individualized treatment, and least restrictive settings. DRC believes that, regardless of which governmental entity is providing psychiatric care to CDCR prisoners, the care must meet the community standard of care; there is no "prisoner" standard of care. DRC states that:

> "The care must meet all legal and constitutional requirements, including compliance with any relevant court orders aimed at ensuring adequate access and treatment. All inpatient psychiatric care should be provided in therapeutic inpatient settings, with adequate staffing and treatment space. Access to care must be timely and individualized to meet the clinical needs of each patient. Treatment must be delivered in the least restrictive setting appropriate to current individual needs and circumstances of the patient. No patient should be placed in a higher-security or more-restrictive-than-necessary setting in order to receive clinically indicated psychiatric treatment. Custody classifications must not serve as a barrier to patients receiving timely access to appropriate care. A patient's clinical needs cannot be sacrificed based on blanket custody-related classifications or restrictions."

Abuse and Neglect Reporting. Currently, state psychiatric hospitals are statutorily required to report to DRC incidents suggestive of abuse or neglect, including unexpected or suspicious deaths of state hospital residents, allegations of sexual abuse where the alleged perpetrator is a staff member, and allegations of physical abuse reported to local enforcement in which a staff member is implicated. This reporting facilitates DRC's mandate as a protection and advocacy agency under state and federal law, to monitor the safety of individuals and investigate incidents of abuse.

To date, incidents involving inmates at the psychiatric programs operated by DSH inside prison facilities, in the California Medical Facility (Vacaville), Salinas Valley State Prison, and California Health Care Facility (Stockton), are included in their reporting requirement. DRC states that:

> "In mandating that certain incidents suggestive of abuse or neglect get reported to DRC, the Legislature recognized the important independent oversight and investigative function of protection and advocacy agencies and their expertise in addressing abuse and neglect of people with disabilities. The Legislature also recognized conflicts of interest exist within these facilities where internal investigators respond and investigate allegations of abuse and neglect."

With the transfer of these programs to CDCR, this reporting and external oversight would cease. As the CDCR-operated inpatient programs would serve individuals with mental health disabilities indistinguishable to those served in state hospitals, DRC seeks to continue the current reporting of the incidents listed above suggestive of abuse and neglect. That is, treatment of the inpatient population in these programs should not be shielded from DRC's oversight role as a result of this transfer of agency control.

STAFF COMMENTS

The Subcommittees request CDCR, DSH, and CHCS to present this proposal and respond to the following:

1. Please provide evidence of CDCR's ability and capacity to provide psychiatric care in an effective, high quality manner.

2. Please describe any staffing changes CDCR intends to make within the psychiatric programs after this transfer.

3. Please describe how CDCR will handle salary differences between CDCR and DSH.

4. Does CDCR intend to seek Joint Commission accreditation for these three programs?

5. Please provide reactions to the stakeholder concerns described above.

Staff Recommendation: Subcommittee staff recommends no action on this proposal at this time.