AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER TONY THURMOND, CHAIR

MONDAY, APRIL 4, 2016

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

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ITEMS TO BE HEARD

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: DEPARTMENT OF STATE HOSPITALS OVERVIEW

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
- **Carla Castañeda**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

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

BACKGROUND

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: 1,252.
- ***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: 803.
- ***Napa (NSH).*** Located in the City of Napa, NSH is a low-to-moderate security state hospital. Population: 1,177.
- ***Patton (PSH).*** PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals. Population: 1,533.

Prison-Based Psychiatric Programs. There are three prison-based psychiatric programs, located in Vacaville, Salinas and Stockton (within the California Health Care Facility in Stockton). Total Population: 1,107.

Cost Over-Runs

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

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

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

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

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

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

DEPARTMENT BUDGET

The Governor's proposed 2016-17 DSH budget includes total funds of $1.7 billion dollars, of which $1.6 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 2016-17 budget is a 0.4 percent decrease from current year funding.

DEPARTMENT OF STATE HOSPITALS *(Dollars in Thousands)*					
Fund Source	**2014-15 Actual**	**2015-16 Estimate**	**2016-17 Proposed**	**CY to BY $ Change**	**% Change**
General Fund	**$1,525,443**	**$1,620,485**	**$1,631,202**	**$10,717**	**0.7%**
CA State Lottery Education Fund	$141	$24	$24	$0	0%
Reimbursements	$124,237	$155,265	$138,022	($17,243)	-11.1%
Total Expenditures	**$1,649,821**	**$1,775,774**	**$1,769,248**	**($6,526)**	**-0.4%**
Positions	10,843.7	10,306.3	10,301.3	(5)	-0.05%

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

1. ***Jail Based Competency Program ("Restoration of Competency" or "ROC"):*** DSH is requesting $1.4 million General Fund for 2016-17 to expand the program by ten additional beds and $336,000 (2016-17) and $334,000 on-going for IST Evaluators for Los Angeles County.

2. ***Conditional Release (CON-REP) Program:*** DSH is requesting $680,000 General Fund on-going to cover increased costs of the CON-REP program and $2.97 million General Fund to cover the costs of increased caseload of sexually violent predators, including many who are "transient" and require full-time protection from the public.

STATE HOSPITALS CASELOAD

The State Hospitals provide treatment to approximately 6,058 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; this program currently has a caseload of 668.

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:

Committed Directly From Superior Courts:

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

- *Incompetent to Stand Trial (IST)* – Determination by court that defendant cannot participate in trial because defendant is not able to understand the nature of the

criminal proceedings or assist counsel in the conduct of a defense. This includes individuals whose incompetence is due to developmental disabilities.

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

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

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

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

State Hospitals & Psychiatric Programs
Caseload Projections

	2015-16 Estimate	2016-17 Projected	CY to BY Change
Population by Commitment Type			
IST – PC 1370	1,477	1,477	0
NGI – PC 1026	1,411	1,411	0
MDO	1,385	1,385	0
SVP	907	907	0
LPS/PC 2974	614	614	0
PC 2684 (Coleman)	256	256	0
WIC 1756 (DJJ)	8	8	0
Subtotal	**6,058**	**6,058**	**0**
Population by Psych Program			
Vacaville	392	392	0
Salinas	235	235	0
Stockton	480	480	0
Subtotal	**1,107**	**1,107**	**0**
Population Grand Total	**7,165**	**7,165**	**0**

DSH projects no change in the overall population.

STAFFING ISSUES

It has been very challenging for State Hospitals to fill positions and maintain reasonably-low staff vacancy rates. The DSH cites several causes for the difficulty in hiring staff, including:

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

The following chart shows the staff vacancy rates for the State Hospitals and for the prison-based psychiatric programs:

DSH Position Data as of January 1, 2015						
Classification	**Filled**	**Vacant**	**FTE**	**Civil Service Vacancy Rate**	**Contractor FTE**	**Vacancy Rate With Contractors**
State Hospitals						
Clinical Social Worker*	228.35	25.55	253.90	10%	4.31	8%
Hospital Police Officer	465.00	118.30	583.30	20%	0.00	20%
Medical Technical Assistant	0.00	0.00	0.00	N/A	0.00	N/A
Psychiatric Technician (Safety)*	2274.30	284.90	2559.20	11%	0.00	11%
Psychologist*	203.30	37.80	241.10	16%	7.17	13%
Registered Nurse (Safety)*	1232.70	177.60	1410.30	13%	0.07	13%
Rehabilitation Therapist	225.25	39.75	265.00	15%	0.00	15%
Staff Psychiatrist*	172.80	49.30	222.10	22%	25.21	11%
Prison-Based Psych Programs						
Clinical Social Worker*	61.00	10.40	71.40	15%	0.97	13%
Hospital Police Officer	0.00	0.00	0.00	N/A	0.00	N/A
Medical Technical Assistant	337.00	10.50	347.50	3%	0.00	3%
Psychiatric Technician (Safety)*	405.00	80.20	485.20	17%	2.40	16%
Psychologist*	53.00	13.40	66.40	20%	0.00	20%
Registered Nurse (Safety)*	266.00	28.00	294.00	10%	1.29	9%
Rehabilitation Therapist	57.00	13.40	70.40	19%	0.00	19%
Staff Psychiatrist*	51.00	21.40	72.40	13%	3.35	25%

*Civil Service vacancy rate offset by contract staff.

The DSH has undertaken a substantial array of varied strategies to increase hiring and decrease staff vacancies, most notably a substantial outreach effort and an increase in pay for psychiatrists. Over the past few years, the California Association of Psychiatric Technicians (CAPT) has shared information and concerns about State Hospitals staffing with the Subcommittee. In short, CAPT cites evidence of significant staff shortages, leading to mandated overtime at some of the hospitals. CAPT also points out that regularly there is a substantial number of staff not working because of "Industrial Disability, Enhanced Industrial Disability, or worker's comp." DSH states that it is aware

of CAPT's concerns with mandated overtime and is working with them to resolve these issues. DSH also acknowledges that the staffing needs can be addressed by filling vacancies rather than by pursuing additional resources. DSH has undertaken a staffing study which is expected to be completed sometime this year.

VIOLENCE & LAW ENFORCEMENT

Over the past approximately fifteen years, the state hospitals' population has changed dramatically, becoming an increasingly "forensic" population with the percentage of civil commitment in decline. Now, approximately 90 percent of the state hospital population is forensic, largely a result of key laws being passed, including: 1) legislation in 1995 (AB 888 [Rogan] and SB 1143 [Mountjoy]), which established a new category of commitment for sexually violent predators (SVPs), which requires certain SVP criminal offenders, upon release from prison, to be placed in state hospitals for treatment; and, 2) Proposition 83 ("Jessica's Law"), passed by voters in 2006, increased criminal penalties for sex offenses and eased the way for more SVPs to be placed in hospitals. As a result of these laws, as well as changes to the population, violence in the hospitals increased substantially. In October of 2010, a patient assault resulted in the death of an employee. The numbers of aggressive acts during calendar years 2009, 2010, and 2011 are outlined in the table below. Since 2010, violence and aggression rates have decreased.

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

Sacramento Bee Editorial

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

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

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

- AB 1340 (Achadjian, Chapter 718) allows for building enhanced treatment facilities where the most aggressive patients will receive specialized treatment;

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

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

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

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

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

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

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

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

The Enhanced Treatment Program will allow the Department to begin stratifying our hospitals beds based on level of therapeutic security as well as treatment needs.

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

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

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

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

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

Office of Law Enforcement Support (OLES)

OLES was established in 2014 to change the Office of Protective Services (OPS) culture and provide oversight, and be directly involved in all OPS operations. The OLES is organized as follows:

Organizational Development Section

- Training and Policy Development Unit
- Selections and Standards Unit

Professional Standards Section

- Serious Misconduct Review Team
- Use-of-Force Monitoring

The creation of the OLES in the 2014 budget came about in response to underperformance by the OPS within each Developmental Center and State Hospital. CHHS conducted an in-depth analysis of OPS operations within DSH which revealed the following critical deficiencies:

- Inability to recruit, hire, and retain qualified personnel
- Inconsistent and outdated policies and procedures
- Inadequate supervision and management oversight
- Inconsistent and inadequate training
- Inconsistent and deficient disciplinary processes
- Lack of independent oversight, review, and analysis of investigations
- Inadequate headquarters-level infrastructure
- Lack of experienced law enforcement oversight

In early March 2015, the California Health and Human Services Agency (CHHS) provided a report to the Legislature, as required in 2014 budget trailer bill, on the creation of the OLES, also approved through 2014 budget trailer bill. The report, *Office of Law Enforcement Support Plan To Improve Law Enforcement In California's State Hospitals and Developmental Centers*, is required to contain specific and detailed recommendations on improving law enforcement functions in a meaningful and sustainable way that assures safety and accountability in the State Hospitals and Developmental Center systems. The report contains a review and evaluation of best practices and strategies, including an independent oversight, for effectively and sustainably addressing the employee discipline process, criminal and major incident investigations, and the use of force within state hospitals and psychiatric programs.

The report states that inefficiencies in hiring practices and pay disparity led to fewer and less qualified employees, which resulted in more than 270,000 hours of overtime at a cost of $10.1 million in 2013. The report includes the following recommendations for next steps:

1. Establish a Professional Standards Section's Special Investigations Unit to monitor critical incidents, such as those involving sexual assault or other major assaults, and assist with complex investigations involving employee misconduct at state hospitals and developmental centers.

2. Establish a Professional Standards Section's Investigations Analysis Unit to provide quality control and analyses of administrative cases.

3. Hire Vertical Advocates who will ensure that investigations into allegations of employee misconduct are conducted with the thoroughness required for prosecution.

4. Conduct independent, comprehensive staffing studies of law enforcement duties and needs at the state hospitals and developmental centers.

INCOMPETENT TO STAND TRIAL WAITING LIST

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. The largest waiting lists are for IST and Coleman commitments. Currently, there are 439 individuals determined to be ISTs on the waiting list. DSH has undertaken several efforts to address the growing IST waitlist including: 1) increasing budgeted bed capacity by activating new units and converting other units; 2) establishing a statewide patient management unit; 3) promoting expansion of jail-based IST programs; 4) standardizing competency treatment programs; 5) seeking community placements; 6) improving referral tracking systems; and 7) participating in an IST workgroup that includes county sheriffs, the Judicial Council, public defenders, district attorneys, patients' rights advocates, and the administration. DSH acknowledges that, despite these efforts, IST referrals have continued to increase. When queried about the potential causes of the growing number of referrals from judges and CDCR, the administration describes a very complex puzzle of criminal, social, cultural, and health variables that together are leading to increasing criminal and violent behavior by individuals with mental illness.

Restoration of Competency (ROC) In County Jails Program

The 2007 Budget Act included $4.3 million for a pilot program to test a more efficient and less costly process to restore competency for IST defendants by providing competency restoration services in county jails, in lieu of providing them within state hospitals. This pilot operated in San Bernardino County, via a contract between the former Department of Mental Health, San Bernardino County, and Liberty Healthcare Corporation. Liberty provides intensive psychiatric treatment, acute stabilization services, and other court-mandated services. The State pays Liberty $278, well below the approximately $450 cost of a state hospital bed. The county covers the costs of food, housing, medications, and security through its county jail. The results of the pilot were very positive, including: 1) treatment begins more quickly than in state hospitals; 2) treatment gets completed more quickly; 3) treatment has been effective as measured by

the number of patients restored to competency but then returned to IST status; and, 4) the county has seen a reduction in the number of IST referrals. San Bernardino County reports that it has been able to achieve savings of more than $5,000 per IST defendant, and therefore total savings of about $200,000. The LAO estimated that the state achieved approximately $1.2 million in savings from the San Bernardino County pilot project.

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

In 2012, budget trailer bill authorized the state to continue the pilot on an ongoing basis, and the DSH is in the process of actively encouraging expansion to other counties. DSH recently signed contracts with Sacramento and with San Bernardino to expand to cover Los Angeles County. The 2015 Budget included $10.1 million in additional funding to expand the ROC program, and the 2016-17 proposed budget includes approximately $1.7 million to expand and support this program even further.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to provide an overview of the department and the state hospitals system, and the Governor's proposed 2016-17 budget for this department. Please also respond to the following:

1. Please provide an overview of the trends in violence and injury rates at the State Hospitals, and describe what factors have had the greatest impact on reducing violence rates since 2010. What evidence is there, if any, of improvement in this area?

2. What impact has the new OLES (within the Health & Human Services Agency) had on State Hospitals?

3. Please provide an update on the IST waitlist and what is known about increasing IST referrals.

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

ISSUE 2: INJURY & ILLNESS PREVENTION PLANS BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administrative Services, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSAL

DSH requests authority to transition 5.0 existing two-year limited-term Associate Governmental Program Analysts (AGPA) positions into 5.0 permanent positions and an ongoing General Fund augmentation of $522,000 to implement new Hospital Injury and Illness Prevention Plans (IIPP) required under a settlement agreement with the Department of Industrial Relation's Division of Occupational Safety and Health (Cal/OSHA). One AGPA will be dedicated to the implementation of one new IIPPs at each of the five State Hospitals.

BACKGROUND

Since 1991, IIPPs have been a requirement for every California employer with more than 10 employees. The legal and regulatory purpose of Injury and Illness Prevention Plans are established in California Code of Regulations (Title 8, Section 3203), Welfare and Institutions Code (4141), and the Labor Code Section (6401.7).

Each State Hospital has an IIPP specific to their site infrastructure, patient populations, management structure, and employee roles and responsibilities. The five hospital IIPPs are tailored to address program safety issues or previous enforcement actions taken by regulatory authorities such as Cal/OSHA, California Department of Public Health (CDPH) Licensing Program, and/or the Joint Commission (JC). These plans are the responsibility of Hospital Executive Management, and the IIPP administrator is the site Hospital Health and Safety Officer. The IIPPs are updated at least annually, training is provided year-round, instruction/consultation is available on site, and plans are made available to all DSH employees through technology services and hard copy/binders.

Between 2009 and 2012, Cal/OSHA conducted 11 separate inspections of DSH hospitals and cited DSH 46 times. Of the 46 citations, 29 were related to workplace violence (per Title 8, Sections 3203, 3220, and 6184) with accompanying penalties of $289,215. DSH and Cal/OSHA developed a global settlement combining all the workplace violence citations into a Special Order.

In January 2014, the Cal/OSHA Occupational Safety and Health Appeals Board (Appeals Board) approved a Special Order that created a legal global "Safety Framework" agreement with DSH. This "Safety Framework" requires that new lIPPs be developed and implemented by the DSH.

The Special Order is being monitored by the Appeals Board and the presiding administrative law judge. DSH consults with Cal/OSHA and provides Quarterly Reports on its progress. If the DSH successfully fulfills the development of new IIPPs, as described in the Special Order, the Appeals Board may dismiss the 29 citations and the associated penalties of $289,215 currently held in abeyance against DSH.

To address the on-going workload associated with the review and implementation of the DSH IIPPs at each hospital, the Administration was authorized in Fiscal Year (FY) 2014-15 one two-year limited-term Associate Governmental Program Analyst for each of the five hospitals.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this budget change proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 3: UNIFIED HOSPITAL COMMUNICATIONS PUBLIC ADDRESS SYSTEM BUDGET CHANGE PROPOSAL

PANELISTS

- **Rogene Sears,** Chief Information Officer (A), Department of State Hospitals
- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSAL

DSH requests $6.5 million General Fund and 2 full-time permanent positions in 2016-17 ($1.6 million in out-years) for the first phase in the development of a Unified Hospital Communications (UHC) system to provide continuity and standardization throughout the state hospitals. Specifically, this request addresses the Public Address (PA) systems and related Local Area Network (LAN) systems at DSH-Coalinga and DSH-Patton.

BACKGROUND

DSH staff throughout the hospital system require regular, accurate and up-to-date hospital communications. PA systems are believed to be a critical component to the overall safety of staff and patients. While every DSH hospital has some form of a PA system, DSH states that these PA systems lack sufficient campus coverage, are outdated, in constant need of repair, and no longer under warranty. For example, the PA system at DSH-Coalinga is ten years old and DSH-Patton is over 30 years old. The DSH proposes the integration of, and where necessary replacement of, existing PA systems into a more comprehensive and reliable network based PA system with wider campus coverage at the Coalinga and Patton State Hospital facilities. DSH-Coalinga and DSH-Patton are the focus of the proposal because both locations have the least amount of coverage and are most prone to errors. DSH hopes to update additional hospitals at a later date.

DSH explains that the new PA system will allow for many health and safety improvements in the communication and dissemination of information quickly and intelligibly throughout the hospital campuses. New technology will allow for 2-way communications between public speakers in key areas and dispatch, targeted announcements to specific hospital areas to prevent disruption in non-affected areas, clear and intelligible announcements, and message prioritization to prevent concurrent message delivery. Additionally, improvements and upgrades will help minimize the number of failures and unplanned down time thereby reducing potential health and safety implications for staff and patients.

As a part of this project, DSH will also need to upgrade its existing LAN system wherever necessary to support the new PA technology. These upgrades will be made in accordance with DSH architecture and adhere to the DSH medical grade standard.

For many of the aging PA systems, the sound produced is either too quiet to be audible in a busy hospital environment or produces sound that has low intelligibility. Intelligibility is defined as the capability of being understood or comprehended (distinguishable and understandable). Voice alarms that are intelligible ensure that vital emergency messages transmitted through a building's PA system are clearly heard and understood.

DSH states that in a life-threatening situation, the right staff must get to the right place as quickly as possible. Whether it is a doctor page, an assault incident, a security incident or a fire, the PA system must reliably broadcast clear messages that everyone understands.

DSH argues that without the ability to intelligibly broadcast emergencies or security incidents throughout the facility, DSH puts its staff and patients at substantial risk. The DSH has the opportunity to ensure that all staff and patients can be reached in emergency situations to reduce the likelihood of patient and staff injury by installing network based PA systems with full campus coverage.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this budget change proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 4: PATIENT MANAGEMENT UNIT BUDGET CHANGE PROPOSAL

PANELISTS

- **George Maynard**, Deputy Director, Strategic Planning, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSAL

DSH requests $1.1 million in ongoing General Fund authority to transition 10.0 two-year limited-term positions to permanent full-time positions for the ongoing operation of the Patient Management Unit (PMU) to provide oversight and centralized management of patient admissions and collection of data and reporting on patient population trends as required by Section 7234 of the Welfare & Institutions Code.

BACKGROUND

DSH established a PMU in 2014 to provide oversight and centralized management of patient admissions and collection of data and reporting on patient population trends as authorized by Section 7234 of the Welfare & Institutions Code. Accordingly, the DSH was approved 10.0 limited-term positions to establish the PMU.

The PMU has benefitted the Department by providing hospital staff and executives with comprehensive data that allows them to efficiently place patients in the most appropriate clinical setting based on their safety and medical needs, diagnoses, and commitment type.

The goals of the PMU are to improve patient treatment outcomes by providing patients timely access to inpatient mental health care, in the most appropriate clinical settings, based on treatment and security needs; provide timely resolutions to patient placement issues; and ensure cost-effective utilization of DSH beds and staffing resources. Bed stratification across the DSH enterprise is a central component of DSH's strategic planning goals. The ability to manage patient placements across the continuum of care within the state hospitals, psychiatric programs, Conditional Release Program (ConRep) and Jail Based Competency Treatment programs is necessary to operate as a unified system and maximize utilization of available treatment options.

Prior to the establishment of the PMU, the waitlist for DSH admissions fluctuated with the increasing demand for beds consistent. In July 2012, the waitlists averaged around 200 and had grown to just over 500 by December 2013. The waitlist reached its highest of nearly 600 in October 2014.

While hospital staff have implemented measures to address the waitlist, such as improving treatment measures and implementing efficiencies to shorten the average length of stay for ISTs in order to serve a higher volume of patients, the waitlist continues to grow. As the demand for state hospital beds increases, risks resulting from delays to timely access of treatment include:

- Increased wait times for DSH beds leading to: a) decompensation of patients' mental health; b) increased length of stay upon admission; and c) more costly treatment.

- Orders to Show Cause, which is a court order requiring one or more parties of a case to justify the delay; and,

- Negative impact to counties, including extended stays in local jails awaiting treatment.

Decentralized Patient Management

Historically, the DSH's management of patient referrals and placements was decentralized. The following key factors contributed to the DSH's decentralized function:

Courts Committing to Specific Hospitals. A single hospital focus and management was initially developed to allow each hospital to serve its surrounding communities/counties. This decentralized approach historically resulted in overutilization of beds at some hospitals and under-utilization at others thus creating longer admission wait times. The DSH shifted patients to utilize existing capacity as waitlists increased on an ad hoc basis; however, additional resources were required to proactively plan and project for population growth before waitlists significantly increased.

Treatment Settings and Licensing Types Differ Among Each State Hospital. Further complicating the process of placing and admitting patients was the operational capacity of the hospitals which considers staffing levels, licensing requirements, patient acuity level and violence risk, admission unit capacity, and unit design.

Specialty Services Vary By Location. Over the years, each state hospital defined specific medical and/or mental health needs of its patients and either clinically developed special needs units within the hospital setting and/or contracted for such services. Depending on the state hospital, medical care can cover a wide range of preventative, acute, subacute, medical care, general primary care, and Americans with Disabilities Act (ADA) needs. For example, Atascadero State Hospital (ASH) has an infirmary unit for medically-intensive needs, Patton State Hospital (PSH) has a unit for individuals with significant chronic medical problems (e.g. serious congestive heart failure, emphysema, renal disease), and Metropolitan State Hospital (MSH) has a Skilled Nursing Facility.

Patient Referral Process is Complex. The patient referral process is quite complex, and factors to be considered when determining placement include: a) the patient's legal commitment and security risk; b) statutory requirements that vary among DSH facilities;

c) court-imposed requirements; d) agreements with the CDCR and local government agencies; and e) Departmental policy.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this budget change proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 5: THIRD PARTY PATIENT COST RECOVERY BUDGET CHANGE PROPOSAL

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administrative Services, Department of State Hospitals
- **Han Wang**, Finance Budget Analyst, Department of Finance
- **Carla Castañeda**, Finance Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSAL

DSH requests $3.2 million ($2.8 million ongoing and $400,000 one-time) in General Fund authority to transition 15.0 limited-term positions to permanent full-time positions to continue improvements to the patient cost recovery system, including accounts management, billing and collection, litigation and court appearances, assets determination, policies and procedures, compliance and auditing as well as oversight functions.

BACKGROUND

To offset pressures to the General Fund, the DSH researches and coordinates avenues to support third party reimbursement including from: Medicare Parts A, B and D; private insurance; private pay; private trust accounts; and legal settlements. In recent years, the state hospitals have seen a significant growth in population levels, thereby increasing potential cost recovery. The DSH served 12,936 patients in FY 2014-15, over 14 percent higher than FY 2012-13. Further, the rate of admissions has grown with approximately 6,281 new patients admitted in FY 2014-15, 26 percent higher than FY 2012-13.

Transition from the DDS to the DSH

The Department of Developmental Services (DDS) was traditionally responsible for administering DSH's third party billing system. In the 1980s, the DDS and the then-Department of Mental Health (DMH) entered into a Memorandum of Understanding (MOU) agreement to identify its respective roles. The DMH would provide administrative services regarding State Hospital Cost Reporting, Patient Trust, Patient Billing for Third Party Payers, Conservatorship and Collection Services and the DDS would be responsible for developing hospital billing rates, compliance services, claims resolutions and risk management. The DMH would be responsible for the accuracy of data submitted to the DDS for Medicare billing and rate development, respond timely to audit inquiries, perform quarterly internal audits and quality control reviews of state hospital records.

When the DDS stopped performing the services outlined in the MOU, and as the population served by the DSH increased, the DSH did not have sufficient staff to perform the functions formally performed by the DDS. As such, quality control reviews, audits, claim corrections, trust functions and private pay collections were not being performed which resulted in the decline of revenue.

With the approved 15.0 two-year LT positions, the DSH began the process of assuming the third party billing responsibilities from the DDS with the goal of maximizing revenue from Medicare, private pay and insurance collections by providing technical assistance to the state hospitals regarding: billing; Medicare compliance reviews; managing patient trust accounts; performing patient benefit and insurance enrollment; provider enrollment; hospital certification; asset determination; and pursuing legal efforts in private payer collections.

The FY 2014-15 Budget Act authorized the DSH to create a Patient Cost Recovery Section (PCRS) that included 15.0 full-time limited-term (LT) positions to develop and implement a standardized and streamlined third party billing system that would include accounts management, billing and collection, assets determination, policies and procedures, compliance and auditing as well as oversight functions. The intent was for the DSH to assume the responsibility for all billing and collections functions previously performed by DDS for the DSH.

The PCRS is responsible for securing and maintaining inpatient and outpatient Medicare certification which determines the Department's ability to seek reimbursement for Medicare Part A and B services. The California Department of Public Health (CDPH) licenses facilities to ensure facilities comply with state laws and regulations. CDPH has a cooperative agreement with CMS to ensure that facilities accepting Medicare payments meet federal requirements. Once certified, the DSH staff monitors the services provided at the five state hospitals to maintain compliance with federal regulations and CMS certification. Because each hospital may render varying services, each hospital has a unique formula for certification. For each hospital certification application, the CMS survey process may take up to a year to complete.

California Welfare and Institution Code Sections 7275-7295 define the DSH's responsibility for the collection of third-party payments to support a patient's costs for care and treatment services received in a state hospital. The DSH is required to assess, upon patient admission, the availability of money, property, or interest in property, and collect payment for a patient's cost of care from public and private health insurance as well as private pay. Collection for cost of care is complicated as it includes evaluating patients' health insurance and/or eligibility based on their commitment type, enrolling them if eligible into a public insurance program, and evaluating personal assets for billing and collection purposes.

The PCRS will be responsible for creating a compliance program that will standardize policies and procedures and manage risks. Responsibilities will include serving as a liaison to the DSH legal department, developing business process re-engineering initiatives, developing standards of operation as well as policies and procedures, training, auditing programs and services, and creating internal controls.

The implementation of DSH cost recovery effort has taken longer than expected due to:

- Positions not being filled until December 2014 as a result of difficulty finding qualified candidates;
- More Medicare training was required than originally anticipated. The DDS training of Medicare Part A, B and D occurred in March 2015 with additional Part B training in May 2015 and Trust training in April 2015;
- Transition time to access the DDS Medicare billing system and its associated training;
- Delays in beginning corrections of claim errors;
- PCRS identified a significant number of systemic issues resulting in prioritization of workload;
- Extended site visits confirming lack of business process uniformity system-wide;
- Greater than expected complexity of Medicare billing process, lack of standardized systems, and varying degrees of compliance; and
- Longer than anticipated process to correct Medicare Part D billing.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this budget change proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 6: INCREASED SECURE BED CAPACITY AT METROPOLITAN CAPITAL OUTLAY

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Matt Lea**, Finance Budget Analyst, Department of Finance
- **Koreen Hansen**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSAL

The proposed budget includes $31,182,000 in capital outlay funding for this project which is to increase the secured bed capacity at Metropolitan State Hospital (MSH). This project will increase capacity to house forensic inmates by securing 505 beds by constructing a secured fence for two buildings at the hospital. The proposed project will construct two perimeter security fences, one fence around the Continuing Treatment West (CTW) building and adjacent park, and a second perimeter fence around the Skilled Nursing Facility (SNF). The scope includes 16-foot high fences with electronic security features including sensor cable, closed circuit TV, card access, floodlights, and alarms, six new kiosks, interior security enhancements in unit and patios, the addition of perimeter roads, replacement parking, and the construction of a bathroom facility in the park. The total project cost is estimated to be $35,530,000, and the 2015 Budget Act included $1.9 million for the development of preliminary plans.

BACKGROUND

The purpose of this project is to enclose two buildings with secure fencing to help address the projected shortage of secured state hospital beds. The number of forensic patients committed to DSH as Incompetent to Stand Trial (IST), Not Guilty by Reason of Insanity (NGI), and Mentally Disordered Offender (MDO) has increased significantly. At present, DSH is experiencing a waitlist for these forensic commitment categories, which is expected to compound by the anticipated ongoing increase in patients in each category.

DSH explains that, currently, the CTW and SNF buildings are underutilized as only Lanterman/Petris/Short (LPS) patients can reside in these two buildings. There is a surplus of beds for LPS patients and a shortage of forensic/secure beds in the Los Angeles Metropolitan area. Additionally, DSH states that it is over-bedded in some of its facilities with forensic patients, and the expansion of the number of secured beds at MSH would enable DSH to help relieve the over-bedding.

By securing both the CTW and SNF buildings, DSH will increase its capacity for forensic patients without having to construct new patient treatment buildings that would

themselves be fenced, saving both time and money. In order to fence the CTW and SNF buildings, DSH would also need to fence the park adjacent to CTW to serve as an area of refuge for patients in the event of a fire or other damage to the secured buildings. Since fencing the park will have the added benefit of allowing it to be used for treatment purposes for patients, the project includes the construction of a small bathroom to prevent staff from having to escort patients back and forth into the secured buildings, which would be a drain on staffing resources, according to DSH.

Additionally, the current visitor center is undersized for the hospital's current use and will be inadequate for an increase in forensic patients. Accordingly, the project will expand the visitor's center by adding approximately 3,500 sq. ft. Lastly, the project will include necessary, but ancillary, modifications to the areas surrounding the buildings, such as the replacement of parking displaced by the fence and relocation of utility lines.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.

ISSUE 7: ENHANCED TREATMENT UNITS CAPITAL OUTLAY

PANELISTS

- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Sophie Cabrera**, ETP Project Manager, Department of State Hospitals
- **Matt Lea**, Finance Budget Analyst, Department of Finance
- **Koreen Hansen**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSAL

For $12,336,000 capital outlay, this project is for renovations to provide Statewide Enhanced Treatment Units (ETU) at two state hospitals. DSH is proposing a retrofit of existing facilities in order to provide Statewide ETU rooms system-wide.

BACKGROUND

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

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

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

STAFF COMMENTS/QUESTIONS

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

1. Please describe what the process will be for transferring patients from the various hospitals to one of the two hospitals that will have an ETU.

2. When do you expect the ETUs to be operational?

3. How have the costs changed to reflect the scope change to this project?

4. Will the ETUs be staffed with state civil servants?

Staff Recommendation: Staff recommends holding this item open.

ISSUE 8: OTHER CAPITAL OUTLAY PROPOSALS

PANELISTS

- **Lupe Alonzo-Diaz**, Deputy Director, Administrative Services, Department of State Hospitals
- **Stephanie Clendenin**, Chief Deputy Director, Department of State Hospitals
- **Matt Lea**, Finance Budget Analyst, Department of Finance
- **Koreen Hansen**, Principal Program Budget Analyst, Department of Finance
- **Jonathan Peterson**, Fiscal & Policy Analyst, Legislative Analyst's Office

PROPOSALS

Atascadero: For $5,288,000 capital outlay, this seismic project will correct the structural deficiencies in the main East-West corridor at Atascadero State Hospital (ASH). This corridor is a major thoroughfare for the hospital and is integrated with multiple ward buildings. Hundreds of staff and patients travel along this corridor daily. Because this section of the hospital is designated a Risk Level V on the Division of the State Architect's (DSA) Seismic Risk Assessment scale, DSH is proposing to seismically retrofit it to lower the risk of injury or death in the event of an earthquake.

Coalinga: For $603,000 capital outlay, this project will design and construct a secure treatment courtyard at Coalinga State Hospital (CSH). The current main courtyard is undersized and cannot serve as an area of refuge in the event of a fire. Additionally, the current courtyard does not provide sufficient space for group exercise, social interactions, and other outdoor activities. This project will erect a new courtyard that will have enough open-air space to accommodate the full capacity of the facility in the event of a fire and for outdoor activities.

Patton: For $554,000 capital outlay, this fire/life/safety project is to remove and replace deficient SimplexGrinnell Fire Alarm Control Panels (FACP) and associated components in four patient occupied buildings at Patton State Hospital (PSH) which have reached the end of their usable life and are no longer serviceable. This project will enable PSH to bring the existing fire alarm systems into compliance with regulatory requirements. The existing fire alarm systems are a safety hazard. The four buildings, 30, 70, U, and EB, included in this project house the majority of PSH's patients. These buildings also contain kitchens, dining rooms, medical and dental clinics, therapeutic areas, offices, and nursing stations for staff. Failure to address the fire alarm systems at PSH puts both patients and staff at risk should a fire occur and the notification alarm to evacuate fails.

BACKGROUND

Atascadero

The East-West Corridor was evaluated for seismic safety in January 1998 and was assigned a Risk Level V on the DSA' s Seismic Risk Assessment scale. Structures with a Risk Level of V are designated as having a "substantial" risk to life in the event of an earthquake.

This corridor, which is over 800 feet long, is part of the main thoroughfare for ASH. The hospital is shaped like an "L," and is composed of two corridors ("East-West" and "North-South"). The two corridors are long, open hallways, and treatment rooms, patient housing, courtyards, etc. all connect to these corridors. Should the corridor collapse in an earthquake, patients and staff in the corridor at the time of collapse could suffer injury or death, and those patients and staff in adjoining areas could be cut off from rescue.

Coalinga

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

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

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

Patton

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

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

- California Code of Regulations, Title 19 (Flame Retardants) and Title 24 (Fire Code).

- NFPA Codes: 2007 NFPA 72 (National Fire Code) and 2006 NFPA 101 (Life Safety Code).

- 2003 UL 864 9'^ Ed. Standard for Control Units and Accessories for Fire Alarm Systems.

The project will remove and replace four FACPs at the aforementioned buildings, with existing initiating and signaling devices being reused where possible. This is a scope reduction from the last authorized COBCP to begin preliminary plans on 7/1/2015. The original project scope encompassed five buildings instead of the current proposal of four. Upon completion, all of the buildings will have addressable devices which will provide hospital police with exact locations and room numbers of the initiating device, thereby allowing for a quicker emergency response to the exact area of need.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH to present this capital outlay proposal.

Staff Recommendation: Staff recommends holding this item open.