

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark DeSaulnier**

**Senator Elaine K. Alquist  
Senator Bill Emmerson**



**April 12, 2012**

**10:30 AM or  
Upon Adjournment of Session**

**Room 4203  
(John L. Burton Hearing Room)  
Part 2 Health Agenda**

(Joe Stephenshaw)

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## **Department of Alcohol and Drug Programs (4200)**

**Departmental Overview.** The Department of Alcohol and Drug Programs (DADP) provides leadership, policy, coordination, and investments in the planning, development, implementation, and evaluation of a comprehensive statewide system of alcohol and other drug prevention, treatment, and recovery services, as well as problem gambling prevention and treatment services. As the state's alcohol and drug authority, the Department is responsible for inviting the collaboration of other departments, local public and private agencies, providers, advocacy groups, and individuals in establishing standards for the statewide service delivery system.

California's system for the provision of substance use disorder (SUD) services is primarily run at the county level, overseen by the DADP. DADP administers the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, nearly \$260 million in 2011-12 with a Maintenance of Effort requirement, and other discretionary grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Parolee Services Network Program, Narcotic Treatment Program, Driving Under the Influence Program, Office of Problem Gambling, and Drug Court Programs. DADP also certifies and licenses SUD providers in the community and, until the transfer approved as part of the 2011 Realignment, administered the Drug Medi-Cal Treatment Program (DMC), which accounted for about a quarter of the functions at the Department.

DADP contracts with counties and direct service providers for the provision of DMC. County participation in DMC is optional, and counties may elect to provide services directly or subcontract with providers for these services. All but approximately 15 California counties currently maintain a program. If a county chooses to not participate in DMC and a certified provider within that county indicates a desire to provide these services, DADP currently executes a service contract directly with the provider.

In 2000, California voters approved the Substance Abuse and Crime Prevention Act, or Proposition 36, which changed state law so that certain adult offenders who use or possess illegal drugs are sentenced to participate in drug treatment and supervision in the community rather than being sentenced to prison or jail, supervised on probation, or going without treatment. From 2001-02 until 2005-06, Prop. 36 provided annual appropriations of \$120 million General Fund for related substance abuse treatment programs. The Offender Treatment Program was an adjacent program, and the two programs were funded fully, then partially over the course of the next several years. The 2009-10 Budget included minimal federal funding and no General Fund for the programs. The two programs have remained with no funding since that time.

Drug court programs combine judicial monitoring with intensive treatment services over a period of about 18 months typically for nonviolent drug offenders. In general, these are county-administered programs through which the state provides funding and oversight. There are two main programs – the Drug Court Partnership Act program created in 1998 that supports adult drug courts in 32 counties and the Comprehensive Drug Court Implementation Act program created in 1999 that supports adult, juvenile, family, and some Dependency Drug Courts in 53 counties.

**2011 Realignment.** California’s statewide treatment, recovery and prevention network consists of public and private community-based providers serving approximately 230,000 people annually. The 2011 budget plan realigns several substance abuse treatment programs that were previously funded through the General Fund. The following are the major substance abuse treatment programs realigned:

- Regular and Perinatal Drug Medi-Cal. The Drug Medi-Cal program provides drug and alcohol-related treatment services to Medi-Cal beneficiaries. These services include outpatient drug free services, narcotic replacement therapy, day care rehabilitative services, and residential services for pregnant and parenting women.
- Regular and Perinatal Non Drug Medi-Cal. The Non Drug Medi-Cal program provides drug and alcohol-related treatment services generally to individuals, including women’s and children’s residential treatment services, who do not qualify for Medi-Cal.
- Drug courts. Drug courts link supervision and treatment of drug users with ongoing judicial monitoring and oversight. There are several different types of drug courts including: (1) dependency drug courts, which focus on cases involving parental rights; (2) adult drug courts, which focus on convicted felons or misdemeanants; and (3) juvenile drug courts, which focus on delinquency matters that involve substance-using juveniles.

As part of the 2011-12 budget plan, funding for specific alcohol and other drug programs was shifted from the state to local governments. A total of about \$184 million of DADP programs (Regular and Perinatal Drug Medi-Cal, Regular and Perinatal Non Drug-Medi-Cal, and Drug Courts) were shifted to the counties.

In addition to the fund shifts in 2011 Realignment, administrative functions for the DMC Program that were previously performed by DADP were transferred to DHCS. DHCS, in collaboration with DADP, was required to develop an administrative and programmatic transition plan that includes specified components to guide the transfer of the DMC Program to DHCS.

## **Issue 1: DADP Governor’s Budget Proposals**

**Governor’s Budget.** The Governor’s budget for 2012-13 proposes to:

1. Provide a permanent funding structure for the programs that were part of the 2011 Realignment, specifically Drug Medi-Cal Treatment Program (DMC Program), Non Drug Medi-Cal, and Drug Courts.

Trailer bill language on a superstructure for realignment has yet to be received from the administration.

2. Propose trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for the DMC Program from DADP to DHCS.

The administration has released its proposed trailer bill language. Stakeholders are reviewing it and reacting with issues and questions around governance, rates, contracts, and regulatory control.

3. Eliminate DADP:

The Governor's budget proposes to eliminate DADP entirely effective July 1, 2012 and redirect funding and positions for certain SUD services to other departments. This proposal would transfer the remaining non-Medi-Cal SUD programs, including 231.5 positions and budget authority of \$322.103 million (\$32.166 million state operations, \$289.937 million local assistance) (\$34.069 million General Fund) from the DADP to three departments as described in the chart below. A description of programs affected follows the chart.

The Administration states that the proposal follows the actions taken previously for DADP in the 2011-12 Budget and that the transfer of remaining departmental responsibilities to other state departments will integrate activities within those new placements.

**Administration's Proposal: Department of Alcohol and Drug Program Functions**

Function or Program	Recipient Department Positions/Total Funding
Administration of SAPT Block Grant and other SAMHSA Discretionary Grants, Data Collection Function, Reporting and Analysis, Statewide Needs Assessment and Planning, Program Certification, Technical Assistance and Training, Substance Abuse Prevention Activities, Resource Center, Parolee Services Network	<b>Department of Health Care Services</b> \$305.572 million (\$285.937 local assistance, \$19.635 state operations) 161.5 Positions
Counselor Certification, Narcotic Treatment Programs, Driving Under the Influence Programs, Office of Problem Gambling	<b>Department of Public Health</b> \$12.002 million (\$4.0 local assistance, \$8.002 state operations) 34.0 Positions
Program Licensing	<b>Department of Social Services</b> \$4.529 million (all state operations) 36.0 Positions

**Current Proposal Lacks Detail.** The current elimination proposal lacks detail on (1) real program outcomes that are goals for the reorganization, (2) the readiness and appropriateness of receiving departments to take on the DADP positions, functions, and oversight, (3) accountability and transparency in the implementation of this elimination and transfer, and (4) assurances that the elimination and shifting will not disrupt services for consumers, patients, and providers dependent on current DADP functions. Policy and oversight considerations require time and attention, and are further challenged without a detailed proposal.

**Fiscal Assessment.** The proposal from the Administration contains no cost savings as a result of the DADP elimination and attendant transfer of all functions to three departments. Without a thoughtful, thorough transition plan to understand how this transfer would occur over a phased-in period and under what principles and terms, it is difficult for the Legislature to evaluate the Administration's proposal.

**Provider Concerns.** Stakeholder's have raised concerns regarding the Administration's DADP proposals, including; 1) sustainability of substance use programs and funding, 2) the maintenance of a statewide approach to the DMC programs, and 3) the logic of transferring certain DADP functions to separate departments.

**Recommendation.** Hold open.

## **Department of Mental Health (4440)**

The Department of Mental Health (DMH) operates five state mental hospitals and two psychiatric programs within state prisons (California Medical Facility and Salinas Valley State Prison), which provide inpatient mental health treatment. Four of the mental health hospitals – Napa, Metropolitan (Norwalk), Atascadero, and Patton (San Bernardino) – were constructed more than 50 years ago. In 2005, DMH opened the Coalinga Mental Hospital to provide treatment for sexually violent predators. DMH also oversees a variety of state and local public mental health programs. In 2011, funding for some local mental health services was realigned to counties.

The majority of the state hospital population, approximately 92 percent, is forensic or penal code related. Major categories of state hospital patients include:

- Judicial commitments directly from superior courts - Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST)
- Civil commitments as Sexually Violent Predators (SVPs)
- Referrals/transfers from California Department of Corrections and Rehabilitation (CDCR) including Mentally Disordered Offenders (MDOs) and Parolees
- Civil commitments from counties under the Laterman-Petris-Short Act

On May 2, 2006, the United States Department of Justice (USDOJ) and the State reached a settlement concerning civil rights violations at four state mental hospitals. The judgment called for Metropolitan State Hospital, Napa State Hospital, Patton State Hospital, and Atascadero State Hospital to implement an “Enhancement Plan” to improve conditions. Coalinga was not covered by the agreement because it had just opened, but it has similar reforms in place now. The extensive reforms required by the five-year Consent Judgment were to ensure that individuals in the hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health.

The USDOJ conducted its investigation pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA). This statute allows the federal government to identify and root out systemic irregularities such as those identified in this case, rather than focus on individual civil rights violations.

In November of 2011, the USDOJ released Patton State Hospital and the Atascadero State Hospital from oversight, deeming them in compliance with the bulk of the consent judgment's demands. However, DOJ officials asked a judge to extend federal oversight of Napa State Hospital and Metropolitan State Hospital, saying the facilities have failed to comply with critical provisions of the consent judgment.

In July of 2011, DMH commissioned a report to assist in the proposal for a state mental hospital department to be included in the 2012-13 Governor's Budget. The scope of the project was to recommend the administrative structure for a state mental hospital department, to identify processes that might be organized differently for better performance and accountability, and to collect information on the department's budget deficit. The report was released in December 2011.

The Governor’s budget proposes to eliminate DMH, proposes to create the Department of State Hospitals (DSH), and transfer responsibility for community mental health programs to other state departments. The budget includes \$1.4 billion from all fund sources and 9,861.3 positions to support 6,439 patients in 2012-13.

(dollars in millions)

<b>Program</b>	<b>Positions</b>	<b>Funding</b>
In-Patient Services Program	9,594.7	\$1,411.6
Evaluations and Forensic Services	75.1	\$21.4
Legal Services	24.7	\$5.6
Administration	166.8	\$16.7
Distributed Administration	-	-\$16.7
<b>Total</b>	<b>9861.3</b>	<b>\$1,438.6</b>

The budget proposes to transfer the majority of community mental health programs for DMH to the Department of Health Care Services (DHCS). In total, the budget transfers \$104.7 million from DMH to other state departments or entities, as follows:

(dollars in millions)

<b>Department</b>	<b>Function/Program</b>	<b>Positions</b>	<b>State Ops.</b>	<b>Local Assist.</b>	<b>Total</b>
Health Care Services (DHCS)	Financial Oversight, Certification Compliance, Quality Improvement, Mental Health Services Act (MHSA) State Functions, County Data Collection and Reporting, Suicide Prevention, Co-Occurring Disorders, Veterans Mental Health, Substance Abuse and Mental Health Services Administration Block Grant, Projects for Assistance in Transition from Homelessness, Training Contracts, CA Institute for Mental Health, CA Health Interview Survey, Policy Management, Admin Staff, CA Mental Health Planning Council	41	\$11.1	\$61.2	\$72.3
Social Services (DSS)	Licensing/Quality Improvement (Mental Health Rehabilitation Centers, Psychiatric Health Facilities)	12	\$1.1	\$-	\$1.1
Mental Health Services	Training Contracts – Consumer Groups, MHSA Program Evaluation	-	\$1.7	\$-	\$1.7

Oversight and Accountability Commission					
Public Health	Office of Multicultural Services, Disaster Services and Response	4	\$2.3	\$-	\$2.3
Education (CDE)	Early Mental Health Initiative	0	\$-	\$15.0	\$15.0
Office of Statewide Health Planning and Development	Mental Health Services Act Workforce Education and Training	1	\$.1	\$12.2	\$12.3
<b>Totals</b>		<b>58</b>	<b>\$16.3</b>	<b>\$88.4</b>	<b>\$104.7</b>

**Violence Related Costs.** Over the past approximately fifteen years, the state hospitals' population has changed dramatically, becoming an increasingly "forensic" population with civil commitment in decline. Now, approximately 92 percent of the state hospital population is forensic, a result of key laws being passed, including: 1) legislation in 1995 (AB 888 Rogan and SB 1143 Mountjoy), which established a new category of civil commitment for sexually violent predators (SVPs), which requires certain SVP criminal offenders, upon release from prison, to be placed in state hospitals for treatment; and, 2) Proposition 83 ("Jessica's Law"), passed by voters in 2006, increased criminal penalties for sex offenses and eased the way for more SVPs to be placed in hospitals. As a result of these laws, and consequential changes to the population, violence in the hospitals has increased substantially. In 2010, there was an average of 23 incidents of violence per day toward patients or workers, and almost three staff injuries per day. In 2009, an employee at Napa State Hospital was killed by a patient.

Safety issues are discussed in more detail below, however it is important to note here that there are several increased costs that result from the population being almost entirely criminal in nature:

- Jessica's Law more than doubled the workload related to screening and evaluating sex offenders for SVP commitments;
- Outside hospitalization costs have risen substantially, largely due to patients harming themselves or others. Hospitalization costs rose an average of ten percent per year between 2008-09 and 2010-11, from \$9.5 million to \$41.4 million; and,
- Increased security measures, such as alarm systems, have become necessary to protect both patients and staff. The alarm systems are quite sophisticated and costly. Other types of

safety upgrades are also necessary and costly given that the hospitals were not constructed for a violent, forensic population.

***Unfunded Overtime***

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

**Lack of Budget Transparency.** The DMH explains that while the deficits can be attributed to costs rising simultaneously with resources diminishing, they also describe a budgeting process, which failed to reflect the true and full costs of the state hospitals. According to the DMH, the division responsible for hospital oversight has been preoccupied with complying with the CRIPA court order, at the expense of more accurate and responsible budget work. The DMH states that this division "lacked the knowledge and leadership to address and resolve the emerging deficit." In response to years of inadequate and inaccurate budgeting, the DMH has tried to build a more accurate "workload budget" in order to reveal and convey the actual costs of the hospitals continuing to do what they already do. This workload budget revealed a \$180 million shortfall from the existing appropriation. The DMH discovered the following core functions at State Hospitals that have been unfunded activities, and therefore funding is being proposed for these purposes, though estimates will be updated in May Revision:

*Enhanced Observations.* The DMH is requesting \$30,684,039 GF in 2011-12 and 2012-13 to address unfunded operating enhanced observation expenses resulting from the redirection of core unit staff that is backfilled by additional staff who are needed to maintain basic licensing ratios. Enhanced observation of a patient is required when: 1) a patient's behavior is determined to cause a danger to either the patient or other people; 2) a medical condition dictates increased observation; or, 3) a patient is transported outside the hospital for medical care. As discussed previously in this agenda, as the state hospitals population has become almost entirely a forensic population, aggressive behavior and violence have increased substantially, thereby increasing the need for enhanced observation.

*Admission Assessments.* The DMH is requesting \$6,340,175 GF in 2011-12 and 2012-13 to cover unfunded operating expenses resulting from the required admission assessment. The CRIPA Consent Judgment requires assessments to be performed on all patients admitted to a state hospital in the following disciplines: psychiatry, psychology, rehabilitation therapy, nursing, social work, and nutrition. A complete medical history and physical are also required. Each hospital maintains an "admission suite" to process the assessments for new patients. The DMH is requesting this augmentation to offset the costs of temporary help and overtime incurred by the redirection of both core admission suite staff and staff that perform the assessments.

*Operating Expenses & Equipment.* The DMH is requesting \$45,069,000 GF in 2011-12 and 2012-13 for increased OE&E costs. According to the DMH, OE&E costs have increased significantly since 2006-07, primarily as a result of the following:

1. The opening of CSH;
2. Backfilling up to 500 beds with patients committed as Mentally Disordered Offenders and Incompetent to Stand Trial, two very unstable populations;
3. Flat OE&E funding for SVPP and VPP; and,
4. OE&E base reductions leading to insufficient annual price increases.

The amount of the funding request was determined by averaging actual expenditures for 2005-06 and 2006-07 to establish base expenditures. The annual expenditure amount was determined by averaging annual expenditures for 2007-08 through 2011-12.

**Savings Proposals.** Given the recent deficits and current shortfall, either resources have to be increased or expenditures reduced, and, in light of the state's overall fiscal condition, the DMH is therefore proposing the following state hospitals' savings strategies:

Elimination of 619 Positions. According to the DMH, 80-90 percent of all state hospital costs are salaries and other staff benefits and costs. Therefore, the majority of savings (\$122.6 million in 2011-12 and \$193.1 million 2012-13) would come from a proposed reduction of 619.5 positions within the state hospital system, of which 230 are filled and 370 vacant.

Reduction to patient staff ratio for ICF Treatment Teams. The majority of positions being eliminated (for GF savings of \$21.2 million Current Year and \$68.1 million Budget Year) are a result of a proposed reduction in the required staff to patient ratio specific to Treatment Teams, which are made up of a group of medical professionals who, together as a team, act as case managers for patients. These professionals are not the "front line" staff who supervise and interact with patients, one on one, on a daily basis. The ratio for the teams used to be one team per 35 patients, and was reduced to 1 team per 25 patients per the CRIPA court ordered Enhancement Plan. The DMH explains that this lower ratio was necessary in order for the team members to be able to complete increased documentation requirements, also included in the CRIPA Enhancement Plan, which also can be reduced at this point in time, according to the DMH. The DMH explains that the level of documentation required by CRIPA has not proven necessary, and therefore can be reduced, thereby allowing Treatment Teams sufficient time to handle a larger patient caseload. Related to staffing ratios, AB 2397 (Allen) would require a minimum ancillary clinical staff-to-patient ratio of 1 to 25 for each applicable staff classification.

The SEIU has raised concerns regarding the staff reductions and changes being implemented by the DMH. In general, SEIU states that the DMH is moving forward very rapidly without regard for the impacts of the staffing changes and without sufficient communication efforts with SEIU. They also state that staff have been moved into new positions for which they are unqualified and for which they are receiving no training.

Pharmacy Costs. The proposed State Hospitals budget assumes savings of \$2 million Current Year and \$13 million Budget Year by requiring the use of generic drugs as much as possible. The DMH is also exploring the use of a third party receiver, mirroring the practice utilized by the CDCR.

Increase to County Bed Rate. Counties pay the State approximately \$500 per patient per day for civil commitments to state hospitals and, according to the DMH, the amount counties pay is below the cost of care for the hospitals, and below private sector and Medi-Cal rates. The difference is made up with state GF and therefore the DMH proposes to bridge this gap by increasing the county bed rate, for GF savings of \$20 million in 2012-13. This savings estimate is preliminary in that the DMH states that they, in consultation with counties and hospitals, will be developing a methodology to accurately calculate the per-patient cost over the next two months, and will present a revised proposal and savings estimate at May Revise.

Adult Education Program Elimination. The proposed State Hospitals budget assumes savings of \$3.6 million and a reduction of 46.8 positions in 2012-13 by eliminating the Adult Education Program, an optional program for hospitals. Subcommittee staff has asked the DMH to provide detail on the specifics of this program at each hospital, including what subjects are taught and how many patients participate in the program.

Other Savings. The proposed State Hospitals budget includes many other changes to the operations of state hospitals; please refer to the attached chart (Attachment B) provided by the DMH that details all of the changes and related savings and positions reductions. The total savings from all of the proposals is \$122.6 million in 2011-12 and \$193.1 million in 2012-13.

## **Issue 1: Department Administration**

As described above, the state hospitals have fallen victim to a combination of rising costs, largely attributable to a more aggressive and violent hospital population, and decreasing resources, thereby leading to increasing and regular budget deficits. Nevertheless, the DMH, in its 2011 audit of the hospitals, also found weaknesses in management both at the state level and within the hospitals, which also have contributed to inaccurate and incomplete budgets that fail to reflect the true operational costs of the hospitals. Therefore, the quality of management should be addressed at the same time that additional resource reductions are being made to the hospitals. The Department's current leadership is new, yet temporary. The DMH report includes the following observations:

- "Headquarters is thinly staffed with a limited capacity for analysis; hospital administrative structures are also thinly staffed, especially in fiscal oversight functions;
- The division charged with hospital oversight was preoccupied with complying with the federal CRIPA court order;
- Hospitals have performed better than headquarters, but they lack robust, shared fiscal management systems and training;
- Headquarters' executive structure should be revised to replace the existing Long-Term Care Supports division with an operations division and a clinical division; and,

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

**LAO Recommendation**

The LAO highlights the fact that many of the problems identified by the OSAE audit in 2008-09 still have not been addressed and were identified again by the DMH's own investigation in 2011. Therefore, the LAO is recommending additional oversight in the form of another OSAE audit of the department beginning in January 2013. The LAO suggests that the audit should cover:

1. What measures are being taken to ensure proper fiscal controls and whether those measures are effective;
2. A detailed look at vacancies and their impact on the state budget and hospital performance;
3. A detailed review of the personnel needs by hospital; and,
4. An analysis of patient aggression and the impact of the new security measures.

Staff notes that the Department of Finance would like to work to further define the scope of the audit.

**Recommendation.** Adopt placeholder TBL for an OSAE follow-up audit of the state hospitals, as recommended by the LAO.

**Issue 2: Hospital Safety**

**Background.** A substantial source of increased costs in the state hospital system is the increased violence that is occurring as a result of the population becoming almost entirely a forensic population. The DMH reports that at NSH in 2010-11, patients committed 75 physically aggressive acts against staff, and there were nearly four times as many patient-on-staff assaults, and twice as many patient-on-patient aggressive incidents, than in the prior year. In October of 2010, a patient assault resulted in the death of an employee. The number of aggressive acts for just calendar year 2010 is outlined in the table below.

<b>Aggressive Acts in State Hospitals in 2010</b>		
Hospital	Aggressive Acts Against Staff	Aggressive Acts Against Others
NSH	928	2,688
PSH	1,208	2,894
MSH	1,324	2,438
ASH	415	647
CSH	719	707
<b>TOTAL</b>	<b>4,594</b>	<b>9,374</b>

Cal/OSHA has had significant and ongoing involvement with the State Hospitals as a result of insufficient protections for staff. The LA Times reported on March 2, 2012 that Cal/OSHA has issued nearly \$100,000 in fines against Patton and Atascadero State Hospitals, alleging that they have failed to protect staff and have deficient alarm systems. These citations are similar to citations levied in 2011 against Napa and Metropolitan State Hospitals. 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 DMH explains that they are 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.

The State has both a legal and moral obligation to take necessary measures to protect both patients and staff in the hospitals. The DMH explains that in all of the proposed changes and position eliminations to achieve cost savings, there are no proposed reductions to "front-line" staff and no reductions to hospital police officers. Moreover, the 2011-12 budget includes \$5.4 million and added positions to implement Grounds Presence Teams and Grounds Safety Teams. Specifically:

1. **Grounds Presence Teams (GPTs).** GPTs are utilized at Napa and Metropolitan State Hospitals. GPTs are comprised of psychiatric technicians responsible for direct supervision of patients throughout the "secure treatment areas." They supplement hospital police officers during emergencies and patrol the campus grounds. They provide crisis intervention, detection of safety and security issues, redirect inappropriate activities or behavior, monitor all individuals entering and exiting the facility, perform periodic searches throughout the grounds, and implement and oversee health and safety procedures. The cost for the GPTs is \$2.2 million and 28 new positions were requested to create the GPTs.
2. **Grounds Safety Teams (GSTs).** GSTs are comprised of hospital police officers (HPOs) who report directly to the Chief of Police. GSTs respond to safety issues, including reports of suspected contraband. The 2011 May Revise requested \$3.2 million and 50 new positions for GSTs at Napa, Metropolitan and Patton State Hospitals.

Per the current proposal, the state is also in the process of implementing new, far more sophisticated alarm systems at the State Hospitals, as described below.

<b>PDAS Implementation Time-Line</b>		
<b>Completion of:</b>	<b>MSH &amp; PSH</b>	<b>CSH &amp; ASH</b>
Service Contract	July 2012	July 2013
Hardware contract	July 2012	July 2013
Site survey & design	Sept. 2012	Sept. 2013
Network build out	March 2013	March 2014
Training	April 2013	April 2014
Deployment	May 2013	May 2014

**Governor’s Proposal.** The Governor’s budget contains the following requests:

***Napa State Hospital (NSH)***

The DMH is requesting \$446,000 GF ongoing, and 2.5 positions for maintenance of the Personal Duress Alarm System (PDAS) pilot that is being installed at NSH. The PDAS system at NSH is expected to be complete by the end of June 2012.

NSH is serving as the pilot program for upgraded PDAS, and therefore implementation is underway at NSH. \$4 million was approved in the 2011-12 budget, which did not include resources for maintenance and operation for the wireless network infrastructure, management of the wireless intrusion detection and prevention system, management of the alarm system, around-the-clock monitoring of the PDAS, or the annual license renewal, all of which would be covered by this request.

***Metropolitan State Hospital (MSH) & Patton State Hospital (PSH)***

The DMH is requesting \$22.76 million GF (\$22.2 million one-time and \$566,000 on-going) and 5 permanent positions to install and support PDAS for MSH and PSH.

***Atascadero State Hospital (ASH) & Coaling State Hospital (CSH)***

The DMH is anticipating costs of approximately \$22.4 million GF (\$20.6 million one-time and \$1.8 million on-going) and the need for 4 permanent positions to install and support PDAS at ASH and CSH in 2013-14.

**Recommendation.** Approve as budgeted.

**Issue 3: *Coleman* Class Action Lawsuit**

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

The *Coleman* also directed the CDCR and the DMH to construct and activate a 64-bed Intermediate Care Facility (ICF) for Level IV/high custody inmate/patients, no later than September 2011. The CDCR and DMH chose to meet this requirement by expanding the VPP within the California Medical Facility. The DMH states that the management and operational infrastructure are in place to support this expansion at the VPP, and that these positions are necessary to provide the appropriate groups and activities, maintain acceptable regulatory standards of nursing care and security, and provide for 24-hour support services.

In October of 2009, the CDCR signed a Resolution of Approval with the Federal Receiver for the *Plata* Court, which oversees inmate medical care, to construct 1,722 medical and mental health beds.

The California Health Care Facility (CHCF) is scheduled to begin patient admissions by July 2013, and be completed to full occupancy by December 2013. The CHCF in Stockton will be operated as a fully integrated correctional medical facility by the DMH, CDCR, and the Federal Receiver. The DMH will be responsible for 475 beds for High Custody/Level IV inmates/patients, to be referred to as the Stockton Psychiatric Program (SPP), which are part of the *Coleman* bed-plan. The SPP will begin accepting patients in July of 2013.

**Governor's Proposal.** *Coleman* Waitlist. The Governor's Budget proposes \$13.9 million GF and 139.7 positions (132.7 PYs) in 2011-12 and \$27.3 million and 289.2 positions (274.7 PYs) in 2012-13 to reduce the *Coleman* waitlist, as outlined above.

64-Bed Expansion. The Governor's Budget proposes \$2.5 million GF and 23.7 positions for the last phase of staffing for the court ordered 64-bed high custody ICF. This policy was initially approved as part of the 2011 Budget Act.

Stockton Psychiatric Program. The Governor's Budget proposes \$7.99 million GF and 75.9 positions (72.1 PYs) to phase in the remainder of staff for activation from January 1 through June 1, 2013. This is a partial year request for 2012-13 and grows to \$90.6 million and 783 positions (743.8 PY) in 2013-14.

**Staff Comment.** Although significant General Fund expenses, these proposals represent costs of court mandates, including previously approved court mandated projects.

**Recommendation.** Approve, as budgeted, 1) the proposal to reduce the *Coleman* waitlist, 2) staffing for the 64-bed Intermediate Care Facility in Vacaville, and 3) staffing to operate the mental health beds at the California Health Care Facility in Stockton.

#### **Issue 4: Incompetent to Stand Trial Pilot Expansion**

**Background.** As established by a 1960 Supreme Court decision, all individuals facing criminal charges must be mentally competent to help in their defense, meaning that the defendant both understands the charges against him and has sufficient mental ability to help in his or her own defense. A subsequent US Supreme Court decision in 1972 ruled that Incompetent to Stand Trial (IST) patients may not be held for more than a reasonable period of time necessary to determine the probability that the patient will attain competence in the near future. Generally, when a defendant is found incompetent to stand trial, he or she will be ordered to undergo treatment at a state hospital to restore competency. However, if no hospital space is available, defendants are placed on a statewide waitlist and held in county jail until space becomes available.

In order to protect a defendant's right to due process, state law requires state hospitals to admit, examine, and report to the court on the likelihood of competency restoration within 90 days of the defendant's commitment. In a 2010 case called *Freddy Mille v. Los Angeles County*, the Second District Court of Appeal ruled that persons determined to be IST must be transferred to a state hospital within a "reasonable amount of time" in order to comply with this 90-day statutory requirement. Further, the courts have recommended that the transfer of IST defendants be

completed in no more than 35 days. Nevertheless, significant shortages of space and staff at the state hospitals have resulted in substantial delays and waiting lists for the transfer of IST defendants. In 2008-09, defendants waited an average of 68 days and some transfers are taking as long as 162 days, despite the court orders and recommendations of 35 days. Waiting lists average 200-300 IST defendants at any given time.

Insufficient hospital space is largely a reflection of staffing shortages in the hospitals. Despite aggressive recruitment and retention efforts, the DMH has been unable to fill key personnel classifications such as psychiatrists. Some hospitals report vacancy rates as high as 40 percent in these categories. The hospitals have had to resort to using overtime by existing hospital staff and private contractors to fill the gap, which has contributed to overall increasing hospital costs.

*Pilot Project.* 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 was implemented in San Bernardino County, via a contract between the DMH, San Bernardino County, and Liberty Healthcare Corporation. Liberty provides intensive psychiatric treatment, acute stabilization services, and other court-mandated services. The State pays Liberty \$278, well below the approximately \$450 cost of a state hospital bed. The county covers the costs of food, housing, medications, and security through its county jail. The results of the pilot have been very positive, including: 1) treatment begins more quickly than in state hospitals; 2) treatment gets completed more quickly; 3) treatment has been effective as measured by the number of patients restored to competency but then returned to IST status; and, 4) the county has seen a reduction in the number of IST referrals. San Bernardino County reports that it has been able to achieve savings of more than \$5,000 per IST defendant, and therefore total savings of about \$200,000. The LAO estimates that the state achieved approximately \$1.2 million in savings from the San Bernardino County pilot project.

**Governor's Proposal.** The Governor's Budget assumes a \$3 million GF savings expected to result from treating IST patients in county jails rather than in state hospitals, per the success of a pilot program in San Bernardino County. Therefore, the DMH is proposing trailer bill language to expand the San Bernardino pilot project, which is expected to result in the \$3 million in savings.

***LAO Report and Recommendation.*** The Legislative Analyst's Office produced a thorough report, *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, specifically by expanding the existing contract with Liberty into Los Angeles, Kern, and San Diego Counties, all of which commit a high number of IST defendants to ASH and PSH. While recommending the expansion of the pilot, the LAO nevertheless questions the soundness of the \$3 million savings estimate put forth by the DMH.

A policy bill, AB 1693 (Hagman), has been introduced to implement the LAO's recommendation to expand the San Bernardino County pilot program by mandating participation by Los Angeles and Kern Counties. The Assembly Appropriations Committee estimates that start-up costs would be approximately \$1 million, which would be offset within one year by savings of approximately \$4 million

GF. As stated above, the DMH also has proposed trailer bill language to expand the pilot statewide, but on a voluntary basis.

**Staff Comment.** Although there appear to be questions with the assumptions used by the department to reach the savings estimate of \$3 million, there is sufficient evidence to suggest that an appropriate expansion of this program should allow the DMH to realize their savings target.

**Recommendation.** Adopt placeholder trailer bill language to expand the IST pilot program.

### **Issue 5: Division of Juvenile Justice Closure**

**Background.** The DMH has been providing mental health services to wards of the former California Youth Authority since the 1980s. Funding was provided in 2002-03 for operation of a 24-bed Correctional Treatment Center for wards (under the age of 21) requiring an intermediate level of inpatient mental health care at the Division of Juvenile Justice's Southern Reception Center and Clinic (SRCC). In 2011, the CDCR announced that the SRCC facility would close by November 2011 due to the ward population decreasing as a result of legislative changes and CDCR restructuring changes. The Correctional Treatment Center was also closed in light of the closing of the SRCC.

**Governor's Proposal.** The Governor's Budget proposes a reduction of \$2.7 million in reimbursements in 2011-12 and \$3.6 million in 2012-13 and ongoing, and elimination of 37.4 positions (35.5 PYs) in 2011-12 and 49.9 positions (47.9 PYs) in 2012-13, due to the closing of the SRCC.

**Recommendation.** Approve as budgeted.

### **Issue 6; Network Capacity Augmentation**

**Background.** The DMH is experiencing frequent network failures resulting in the loss of patient data. Any losses of patient data can negatively impact medication and treatment plans. The DMH intends for this capacity increase to occur concurrently with a change in the site-to-site communications service provider, as required by the Office of Technology Services. The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires data contained in this network to be secure and accessible. The DMH explains that the current network capacity is inadequate causing the system to experience frequent failures. The inadequate capacity also results in the inability to maintain offsite backups of data, and therefore the DMH cannot recover data during a system failure and the loss of data can occur. State law requires state agencies to migrate from existing site-to-site communications network services to CGEN as part of the CTA, IT consolidation effort. The new vendor is CGEN, and the cost will increase by \$422,244, for a total cost of \$778,020 annually.

**Governor's Proposal.** The Governor's Budget proposes a one-time 2012-13 augmentation of \$10,500 and \$422,244 ongoing to increase network capacity in order to protect patient data.

**Recommendation.** Approve as budgeted.

### **Issue 7: HIPAA Compliance**

**Background.** In 2001-02, the DMH established the Health Insurance Portability and Accountability Act (HIPAA) Project office (HPO) with five staff members. At that time, the HIPAA requirements did not require staff with technical expertise in Information Technology, which is now needed to address information security activities associated with protecting electronic patient health data. The DMH no longer has a designated HPO, but maintains the five HIPAA positions. The resources requested will be used to perform IT security activities, which require knowledge of applying technical safeguards to protect electronic patient medical information. The DMH states that failure to implement and stay current with HIPAA requirements will put the state at risk of privacy breaches resulting in identity theft and federal fines of \$50,000 per incident, up to a maximum of \$1,500,000 per year.

**Governor's Proposal.** The Governor's Budget proposes to establish 3 positions to achieve compliance with HIPAA requirements. The DMH states that it will establish the 3 positions administratively effective April 1, 2012, using existing HIPAA funds (unspent HIPAA funding from prior years) with a total Budget Year cost of \$332,000.

**Recommendation.** Approve as budgeted.

### **Issue 8: Staff Counsel Position Request**

**Background.** As described earlier in this agenda, IST defendants are committed to state hospitals, and some of these individuals need medication in order to reduce the risk of violence. According to the DMH, approximately 60 percent of IST patients who are admitted to a state hospital without a court order to administer involuntary medication will commit aggressive acts upon themselves, other patients, or hospital staff. Previously the law did not provide an avenue for hospitals to medicate these individuals unless it was considered an emergency. AB 366 (Allen), Chapter 654, Statutes of 2011 allows treating psychiatrists at the state hospitals to certify and provide antipsychotic medication, and authorizes continuing administration of the drugs for 21 days if the administrative law judge agrees with the certification. This allows the hospitals to administer antipsychotic medications while the hospitals await involuntary medication orders from the Superior Court. AB 366 requires the DMH to implement the hearing process by either hiring administrative law judges or by contracting with an agency like the Office of Administrative Hearings to conduct these hearings for the DMH. AB 366 also requires that the patients be represented at the administrative hearing, hence creating the need for these attorneys.

**Governor's Proposal.** The Governor's Budget proposes a 2012-13 one-time GF augmentation of \$1.2 million for 2 Staff Counsel I positions (1.9 PY) to represent the DMH in administrative hearings involving the state hospitals for involuntary medication of individuals who are Incompetent to Stand Trial (IST) as mandated by AB 366. The DMH anticipates that this proposal may generate savings that could be used to fund costs in the future.

**LAO Recommendation.** The Legislative Analyst’s Office recommends that the requested positions be approved on a limited-term basis as the department explores ways to streamline the process.

**Recommendation.** Approve as budgeted.

### **Issue 9: Staff Counsel Positions for SVP, IST & Involuntary Treatment Hearings**

**Background.** In 2009, the Office of the Attorney General (AG) determined that the DMH Legal Office must provide the DMH with legal representation in “non-complex” matters, including hearings related to Sexually Violent Predator (SVP) release, IST defendants release, involuntary treatment and subpoenas. The AG has restricted the number of lawsuits for which it will provide legal services to the DMH.

Historically, the AG has provided legal representation to the DMH, and other State Departments, for litigation and court appearances. In September of 2009, the AG informed DMH of policy changes that would substantially reduce the amount of legal services provided by the AG to DMH as a result of reduced resources within the AG. In the spring of 2010, the Administration requested 6 new legal positions at a cost of \$3,076,000 GF to respond to the reduction in representation by the AG. The Legislature instead approved of \$1.2 million in funding and budget bill language requiring the AG to provide all necessary legal representation to DMH. In 2011, the DMH requested \$2.1 million for legal services to be performed by the AG.

The Administration states that the AG has informed DMH that it does not have sufficient resources to handle all of the health and human services workload and tort costs. DMH states that if sufficient funding is not provided, the DMH will be subject to serious and significant legal consequences, such as default judgments up to millions of dollars; court findings that carry fines and expose the DMH Director to contempt findings; and DMH hospitals being unable to obtain court authority for involuntary medication or medical treatment that psychiatrists or physicians have found necessary for the patients.

The Administration explains that there are several state departments that used to benefit from legal representation from the AG, for which the AG has reduced or eliminated legal services.

As a result, the DMH has requested additional Staff Counsel positions for the past two years, requests that have been denied or reduced by the Legislature. Therefore, the DMH has entered into costly contracts with private attorneys. According to the DMH, without sufficient legal counsel to file petitions and make court appearances, the DMH, State and Governor are at risk of significant and damaging legal consequences.

**Governor’s Proposal.** The Governor’s Budget proposes \$604,000 GF and 6.0 positions (4.0 Staff Counsel 1 positions and 2 Legal Secretary positions) to represent the DMH in SVP court matters, IST hearings, involuntary treatment hearings, and hearings related to subpoenas.

**Recommendation.** Approve as budgeted.

### **Issue 10: Staff Counsel Positions for Personnel Actions**

**Background.** Currently, the Department of Personnel Administration (DPA) represents the DMH in personnel appeals to the State Personnel Board. The DMH referred 156 personnel appeals in 2010-11 and as of October 2011, the DMH referred 99 new appeals. Over the previous three years, there has been an average of 128 personnel appeals per year. Currently there are 114 personnel files open. The DMH spends approximately \$75,000 per month on DPA attorney services. According to the DMH, many other state agencies handle their own legal representation in these matters, including the CDCR. Therefore, primarily for purposes of cost savings, the DMH is proposing to hire two entry-level attorney positions that will substantially reduce the cost of this legal work.

**Governor's Proposal.** The Governor's Budget proposes \$251,000 GF and 2.0 Staff Counsel I positions to represent the Department in personnel actions involving DMH employees who are represented currently by the DPA. The Administration estimates this proposal will result in average annual savings of \$649,000; the amount the DMH historically has paid the DPA for representation in these matters.

**Recommendation.** Approve as budgeted.

### **Issue 11: Mentally Disordered Offender Program Positions**

**Background.** The Mentally Disordered Offender (MDO) Act was enacted in 1986 and created a mandatory mental health forensic evaluation and treatment program for inmates who have severe mental disorders that are not in remission at the time of their parole. The MDO program receives referrals from the CDCR institutions of inmates to be forensically evaluated to determine if they meet MDO criteria. Inmates who are found to meet MDO criteria are sent to a state hospital for treatment as a condition of parole. The DMH has contracted for most of these evaluation services since the start of the program. Civil service evaluators have been utilized primarily for emergency referrals when time is short, as they have greater availability. CDCR policies and court decisions continually increase the number of referrals to the DMH of inmates who are scheduled to parole in less than two weeks. This increase in the number of emergency referrals has prompted the need for additional civil service positions in order to ensure prompt completion of the evaluations.

**Governor's Proposal.** The Governor's Budget includes position authority for 2.0 positions (1.9 PYs) for the MDO Program evaluation services. Funding for these positions will be redirected from approved external contract funds (by reducing the number of contracted positions). The 2 positions will be administratively established in the Current Year.

**LAO Recommendation.** The Legislative Analyst's Office recommends that the requested positions be approved on a limited-term basis and that DMH and CDCR should work together to improve the referral process.

**Recommendation.** Approve as budgeted.

<b>Issue 12: Sexually Violent Predator Evaluator Services</b>
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**Background.** The Sexually Violent Predator Act (SVPA), AB 888 (Rogan), Chapter 763, Statutes of 1995, requires the DMH to perform forensic evaluations of Sexually Violent Predators (SVP) referred by the CDCR to determine if the offenders meet statutory criteria as a SVP. The Sex Offender Commitment Program (SOCP) administers the SVPA and, since the inception of the program in 1996, has contracted for evaluation services. In March of 2008, the State Personnel Board issued an administrative ruling that the DMH was not in compliance with Government Code Section 19130(b)(3), because it had failed to make a reasonable, good faith effort to hire qualified civil service employees to perform the evaluations. Since then, the DMH has experienced difficulty in attracting and recruiting qualified civil service employees. SOCP referrals increased dramatically after the implementation of Jessica's Law in 2006. Nevertheless, the DMH states that it is not yet known whether referrals will increase or decrease and expects that the SOCP will know more in time for the May Revision. The following chart contains the most recent data as provided by the CDCR.

<b>Sex Offender Referrals Received by DMH from CDCR</b> (as of 3/12/2012)							
<b>Month/Year</b>	<b>2005-06</b>	<b>2006-07</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>	<b>2011-12</b>
<b>July</b>	42	43	760	540	540	896	716
<b>August</b>	63	40	696	544	437	785	1,084
<b>September</b>	48	69	601	801	718	941	856
<b>October</b>	60	236	562	590	532	706	639
<b>November</b>	29	593	474	363	459	599	200
<b>December</b>	44	571	461	624	696	837	233
<b>January</b>	41	708	510	603	772	655	208
<b>February</b>	37	733	786	514	791	681	291
<b>March</b>	44	695	663	527	814	773	108
<b>April</b>	57	842	694	530	612	1,593	
<b>May</b>	50	1,270	596	405	575	1,466	
<b>June</b>	68	1,068	628	807	494	601	
<b>Total</b>	<b>583</b>	<b>6,868</b>	<b>7,431</b>	<b>6,848</b>	<b>7,440</b>	<b>10,533</b>	<b>4,335</b>

**Governor's Proposal.** The Governor's Budget proposes authority for 16.0 positions in 2012-13 and an additional 20.0 positions in 2013-14 to support SVP evaluator services. Funding of \$3.4 million in 2012-13 and \$8.4 million in 2013-14 is to be redirected from external contract funds (by reducing the number of contract positions) and no additional funding is being requested. Ten of the positions will be administratively established in 2011-12, but would be temporary until legislative approval is granted.

**LAO Recommendation.** The Legislative Analyst’s Office notes that SOCP referrals are trending down in the current year. As such, they are recommending that the requested positions be approved on a limited-term basis to allow for future trend analysis.

**Recommendation.** Approve as budgeted.

### **Issue 13: Job Analysis Unit Positions**

**Background.** A Job Analyses (JA) is required to be performed prior to administration of exams, per an array of state and federal laws, regulations, and case law, including: the Civil Rights Act of 1964, American with Disabilities Act, Uniform Guidelines on Employee Selection Procedures Requirements, State Personnel Board (SPB) Rule 50, and more. The SPB states that a new JA is required every five years and a new JA must be completed prior to exam administration.

The DMH has not conducted full or complete JAs on any of its more than 300 classifications, bringing it to the attention and scrutiny of the SPB which states that the “mini” JA used by the DMH is substandard and fails to adequately meet standards. The SPB states that none of DMH’s exams may stand up to scrutiny under appeal, which has severely hampered the Department’s ability to conduct exams and hire for critical positions. Moreover, the DMH’s inability to conduct JAs, conduct examinations, test and hire qualified staff jeopardizes the ability to meet the mandates of both the *Coleman* Case and the CRIPA Consent Judgment. The DMH may face substantial fines, further litigation, and Federal receivership.

The DMH states that it is far from having sufficient resources to conduct the exams that support the recruitment and hiring of staff for the 12,000 employee state hospital system in conformance with required civil service procedures governed by the SPB. In September 2011, the state hospitals and psychiatric programs were surveyed and identified 314.8 positions system-wide that were unable to be filled due to the lack of recruitment due to exam issues. The DMH’s exam backlog has had a severe adverse impact on the hospital system’s ability to fill positions. This has led the hospitals to rely on high cost overtime and medical registries to fill level of care positions, thereby subjecting the DMH to union unfair labor practice charges of employment being given to non-civil servants for functions that should be performed by state employees.

**Governor’s Proposal.** The Governor’s Budget proposes \$375,000 and 4.0 positions (3.8 PYs) to establish a Job Analysis unit to meet the ongoing testing and hiring needs of the State Hospitals.

**Recommendation.** Approve as budgeted.

### **Issue 14: Napa State Hospital Fire Alarm**

**Background.** According to the DMH, the existing Fire Alarm Control Panels and Field devices at Napa are outdated and no longer meet the National Fire Protection Association (NFPA) codes and 2007 California Fire Code (listed in Title 24, Part 9 Section 202, Occupancy Classification, [B]

Institutional Groups I-1.1, I-2 and I-3). The existing Fire Alarm Control Panels and Field devices are not compatible with the current manufacturer's Fire Alarm Control Panels built to 2003 UL 864 9<sup>th</sup> Edition-Standard for Control Units and Accessories for Fire Alarm Systems. The existing Fire Alarm Control Panels and field devices are no longer listed by the State Fire Marshall's Office. For these reasons, the DMH asserts, the Fire Alarm Systems require replacement to protect the patients, staff, and visitors. According to the Administration, the fire alarms in all of the State Hospitals are in need of upgrades; they are proposing to start with Napa because it has experienced the greatest number of problems and failures. The 2011 Budget Act includes \$2.2 million GF for the preliminary plans and working drawing phase of this project.

**Governor's Proposal.** The Governor's Budget proposes \$15.6 million to replace the fire alarm systems in several buildings at Napa that do not meet NFPA codes, UL standards or the State Fire Marshall requirements.

**Recommendation.** Approve as budgeted.

### **Issue 15: Napa & Metropolitan SNFs Fire Sprinklers**

**Background.** The federal Centers for Medicare and Medicaid Services issued new regulations that require all long-term care facilities to be equipped with sprinkler systems by August 13, 2013. According to the DMH, this new requirement is based on evidence of an 82 percent reduction in the chance of death, when a fire occurs and sprinklers are present. Fire sprinkler installations will require review and approval by the Office of Statewide Health Planning. The DMH requested \$2.1 million GF for this purpose in 2011.

**Governor's Proposal.** The Governor's Budget includes \$14.1 million to install fire sprinklers in Skilled Nursing Facility buildings at Metropolitan and Napa state hospitals.

**Recommendation.** Approve as budgeted.

### **Issue 16: Napa & Patton New Main Kitchens**

**Background.** These capital outlay projects are in progress, and the funding has already been appropriated in prior years, however the DMH is in need of authority to continue the appropriation in order to continue to use the funds and finish the projects.

**Governor's Proposal.** The Governor's Budget re-appropriates \$62.1 million in bond funds to build and fully equip new main kitchens at Napa and Patton to accommodate modern cook/chill food preparation systems and all dietary support facilities.

**Recommendation.** Approve as budgeted.