*Senate Budget and Fiscal Review—Nancy Skinner, Chair*

# SUBCOMMITTEE NO. 3 Agenda

**Senator Susan Talamantes Eggman, Ph.D., Chair**
**Senator Melissa Melendez**
**Senator Richard Pan, M.D.**

**Thursday, February 10, 2022**
**9:30 a.m., or upon adjournment of session**
**State Capitol - Room 4203**

Consultant: Scott Ogus



**PUBLIC COMMENT**

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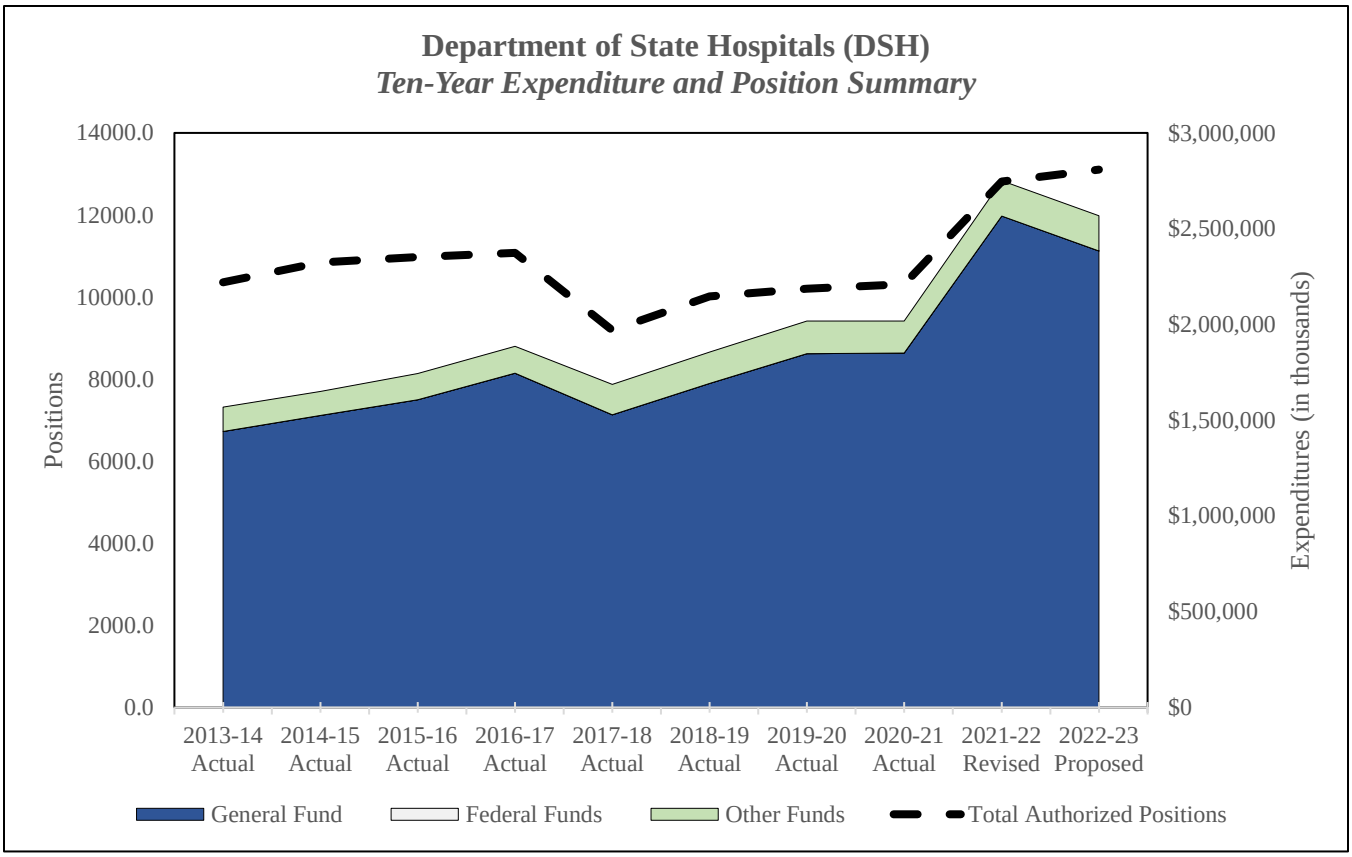
## 4440 DEPARTMENT OF STATE HOSPITALS

### Issue 1: Overview




| Department of State Hospitals - *Department Funding Summary* *(dollars in thousands)* | | | | |
|---|---|---|---|---|
| **Fund Source** | **2020-21 Actual** | ***2021-22 Budget Act*** | ***2021-22 Revised*** | ***2022-23 Proposed*** |
| **General Fund** | $1,851,098 | $2,301,880 | $2,566,522 | $2,384,336 |
| **Federal Funds** | $0 | $0 | $0 | $0 |
| **Other Funds** | $167,059 | $183,711 | $183,684 | $183,703 |
| **Total Department Funding:** | **$2,018,157** | **$2,485,591** | **$2,750,206** | **$2,568,039** |
| **Total Authorized Positions:** | **10312.0** | **11158.2** | **12819.3** | **13105.5** |
| **Other Funds Detail:** | | | | |
| ***CA State Lottery Education Fund (0814)*** | *$80* | *$27* | *$19* | *$19* |
| ***Reimbursements (0995)*** | *$166,979* | *$183,684* | *$183,684* | *$183,684* |

**Background.** DSH oversees five state hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 86 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others. The categories of individuals admitted to state hospitals for treatment are:

- **Incompetent to Stand Trial (IST) –** IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. Most IST patients are charged with felonies, with some misdemeanors.

- **Not Guilty by Reason of Insanity (NGI) –** NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have been imposed, though may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

- **Offenders with a Mental Health Disorder (OMD) –** OMD patients are parolees who meet the following six criteria for OMD classification: (1) presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury, (6) the prisoner continues to be dangerous due to the severe mental disorder. OMD commitments under Section 2962 of the Penal Code span the length of the parole term, but may be extended for up to one year if the patient represents a danger of physical harm to others.

- **Sexually Violent Predators (SVP) –** SVP commitments are civil commitments of prisoners released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

- **Lanterman-Petris-Short (LPS) –** LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

- ***Coleman* Class Patients (Mentally Ill Prisoners) –** *Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill while in prison. *Coleman* patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as an OMD.

- **Conditional Release Program (CONREP)** – CONREP provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

| | 2021-22 | 2022-23 |
|---|---|---|
| **Population by Hospital** | | |
| Atascadero | 1,000 | 1,000 |
| Coalinga | 1,311 | 1,311 |
| Metropolitan | 808 | 948 |
| Napa | 1,122 | 1,122 |
| Patton | 1,349 | 1,359 |
| **State Hospitals Population Total** | **5,590** | **5,740** |
| **Population by Commitment Type** | | |
| Incomptent to Stand Trial (IST) | 1,197 | 1,341 |
| Not Guilty by Reason of Insanity (NGI) | 1,343 | 1,343 |
| Offender with a Mental Health Disorder (OMD) | 1,149 | 1,155 |
| Sexually Violent Predator (SVP) | 931 | 931 |
| Lanterman-Petris-Short Civil Commitments (LPS) | 801 | 801 |
| *Coleman* Referrals | 169 | 169 |
| **Contracted Programs** | | |
| Kern Admission, Evaluation, and Stabilization (AES) Center | 60 | 90 |
| Statewide Regional JBCT | 277 | 280 |
| Single County JBCT | 235 | 294 |
| Small County Model JBCT (Mariposa) | N/A | N/A |
| Los Angeles Community Based Restoration | 515 | 515 |
| Other Counties Community Based Restoration | 54 | 222 |
| **Total Contracted Programs** | **1,141** | **1,401** |
| **Total State Hospitals and Contracted Programs Population** | **6,731** | **7,141** |

**Figure 1: State Hospital Projected Census by Hospital, Commitment Type and Contracted Programs**
**Source:** *2022-23 Governor's Budget Estimate, Department of State Hospitals, January 2022*


**Figure 2: State Hospital Demographic Snapshot: All Commitment Types**
**Source:** *2022-23 Governor's Budget Estimate, Department of State Hospitals, January 2022*

The five state hospitals operated by DSH are:

- **Atascadero State Hospital –** Located on the Central Coast in San Luis Obispo County, Atascadero is a self-contained psychiatric hospital with an all-male population primarily composed of OMD, *Coleman,* IST, and NGI patients. Atascadero has a licensed bed capacity of 1,275 beds.

- **Coalinga State Hospital** – Located in the Central Valley in Fresno County, Coalinga is a self-contained psychiatric hospital with an all-male population primarily composed of LPS, OMD, *Coleman*, NGI, and SVP patients. Coalinga has a licensed bed capacity of 1,500 beds.

- **Metropolitan State Hospital** – Located in Norwalk in Los Angeles County, Metropolitan is an "open" style campus within a security perimeter. Due to community concerns, a formal agreement with the City of Norwalk and the county sheriff prohibits Metropolitan from accepting patients charged with murder or a sex crime, or at high risk for escape. Metropolitan primarily serves LPS, IST, OMD, and NGI patients and has a licensed bed capacity of 1,106 beds.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, LPS, OMD, and NGI patients and has a licensed bed capacity of 1,418 beds, but is currently able to operate only 1,374 beds.

- **Patton State Hospital** – Located in the town of Highland in San Bernardino County, Patton is an "open" style campus within a security perimeter operated by correctional officers from CDCR due to concerns from the surrounding community. Patton primarily serves LPS, IST, OMD, *Coleman* and NGI patients and has a licensed bed capacity of 1,287 beds.

## 2021 BUDGET ACT INVESTMENTS – IMPLEMENTATION UPDATES

The 2021 Budget Act included several important investments in the DSH budget. The subcommittee is monitoring implementation of the following investments:

**IST Solutions Workgroup.** The 2021 Budget Act included trailer bill language to require DSH to convene an IST Solutions Workgroup to identify short-term, medium-term, and long-term solutions for alternatives to placement of defendants determined to be IST in a state hospital. The workgroup was required to submit a report to CalHHS and the Department of Finance on short-term solutions by November 30, 2021, and medium- and long-term solutions by April 1, 2022.

The establishment of the workgroup was in response to continuous backlogs of admission of IST patients to state hospitals due to insufficient capacity. Individuals determined to be IST often wait months in county jails before they are admitted to a state hospital for competency restoration treatment. In 2015, the American Civil Liberties Union (ACLU) sued DSH, alleging the length of time an individual typically spends in a county jail awaiting admission to a state hospital is a violation of the individual's due process rights. The ruling of the Alameda Superior Court in *Stiavetti v. Clendenin*, ultimately affirmed by the California Court of Appeal, requires DSH to commence substantive treatment services within 28 days for felony IST patients.

The IST Solutions Workgroup met five times between August 2021 and November 2021 to develop solutions to the backlog of IST patients awaiting admission to state hospitals. The workgroup focused on three primary areas: 1) early access to treatment and stabilization for individuals determined to be IST on felony charges; 2) diversion and community-based restoration for individuals determined to be IST on felony charges; and 3) improving the quality of initial county competency evaluations. The workgroup released its findings in a report in November 2021 that included short-, medium-, and long-term recommendations. More information about these recommendations can be found in "*Issue 2: Incompetent to Stand Trial Solutions Package*" in the subcommittee agenda.

**IMD and Sub-Acute Bed Capacity Funding Program.** The 2021 Budget Act included 22 positions and General Fund expenditure authority of $267.1 million, and the Legislature approved trailer bill language,

to authorize DSH to contract for subacute bed capacity to address the increasing number of IST patient referrals to state hospitals.

DSH reports it began engagement with multiple private providers in Summer 2021 and continues to work with those providers to develop bed capacity throughout the state. DSH is attempting to partner with providers that can provide a blend of acute and sub-acute bed capacity, which DSH believes will allow more individuals to transition from jail to community settings and promote a broader continuum of care. DSH is engaging counties that currently lack capacity to stabilize IST patients to provide funding to expand the reach of diversion programs. In addition, DSH is engaging with counties that have not been able to fully participate in diversion and community-based restoration programs due to lack of availability of sub-acute beds in their communities. DSH is also attempting to align funding for this program with the proposals contained within its IST Solutions Package.

The subcommittee has requested the department to discuss implementation of both of these 2021 Budget Act investments in "*Issue 2: Incompetent to Stand Trial Solutions Package*". Additional background on these two investments may also be found in that portion of the subcommittee agenda.

**Subcommittee Staff Comment.** This is an informational item.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

## Issue 2: Incompetent to Stand Trial Solutions Package

**Incompetent to Stand Trial Solutions and Trailer Bill Language Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $93 million in 2021-22 and $571 million annually thereafter to support implementation of solutions to provide timely treatment for patients determined incompetent to stand trial (IST) on felony charges and to support ongoing efforts to decriminalize mental illness in California. Included in this request is General Fund expenditure authority of $75 million in 2021-22 and $175 million annually thereafter for IST solutions, and $18 million in 2021-22 and $46 million annually thereafter for IST diversion and community-based restoration (CBR), approved in the 2021 Budget Act. The total additional ongoing funding requested in the Governor's January budget is $350 million beginning in 2022-23.

The Administration proposes the following solutions:

- Stabilization and Early Access to Treatment ($24.9 million in 2021-22; $66.8 million in 2022-23)
- Care Coordination and Waitlist Management ($1.7 million in 2021-22; $4.9 million in 2022-23)
- Housing Augmentation for Current Diversion Contracts ($60 million in 2021-22)
- Housing Infrastructure - CBR or Diversion Beds ($6.4 million in 2021-22; $233 million in 2022-23)
- Community Program Funding for CBR or Diversion Clients ($266.5 million in 2022-23)
- Increased Conditional Release Program (CONREP) Placements ($433,000 in 2022-23)

DSH also requests trailer bill language to cap the total number of felony IST referrals by each county based on the current fiscal year (2021-22) and require counties to assume a share of the cost of care for IST patients referred above the cap.

| **Program Funding Request Summary** | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| **2021 Budget Act Authority – IST Solutions:** | | |
| 0001 – General Fund | $75,000,000 | $175,000,000 |
| | | |
| **2021 Budget Act Authority – Diversion and CBR:** | | |
| 0001 – General Fund | $18,000,000 | $46,000,000 |
| | | |
| **2022 Governor's January Budget Request:** | | |
| 0001 – General Fund | $- | $350,000,000 |
| **Total Funding Request:** | **$93,000,000** | **$571,000,000** |
| **Total Requested Positions:** | **0.0** | **0.0** |

* Resources ongoing after 2022-23.

**Background.** The State Hospitals system admits individuals determined to be incompetent to stand trial (IST) under Section 1370 of the Penal Code, typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, as of December 2021, 1,706 individuals in the IST population are housed in county jails awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown significantly in the last two years due to the COVID-19 pandemic, places operational and fiscal

stress on county jails and, according to recent court rulings, violates the due process rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency.

**Incompetent to Stand Trial Referrals.** Under California law "[a] person cannot be tried or adjudged to punishment or have his or her probation, mandatory supervision, post-release community supervision, or parole revoked while that person is mentally incompetent." IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. If a defendant's attorney raises concerns about his or her competency to stand trial, the judge in the case may order a mental health evaluation by a psychiatrist or clinical psychologist. If the evaluation finds substantial evidence the defendant is incompetent, a competency hearing is scheduled with additional expert testimony and an opportunity for the defendant to respond to or refute the findings of the evaluation. If the court finds a defendant incompetent to stand trial, the local community health director determines whether the defendant is best treated in a local facility, an outpatient facility, or at a state hospital. Misdemeanants are typically treated in an outpatient setting or released, while felonies are typically referred for treatment at a state hospital. If a bed is not available in a state hospital, the defendant remains in the custody of the county until a bed becomes available. Capacity constraints in the state hospital system have resulted in ongoing backlogs of defendants deemed IST in county jails for extended periods awaiting treatment.

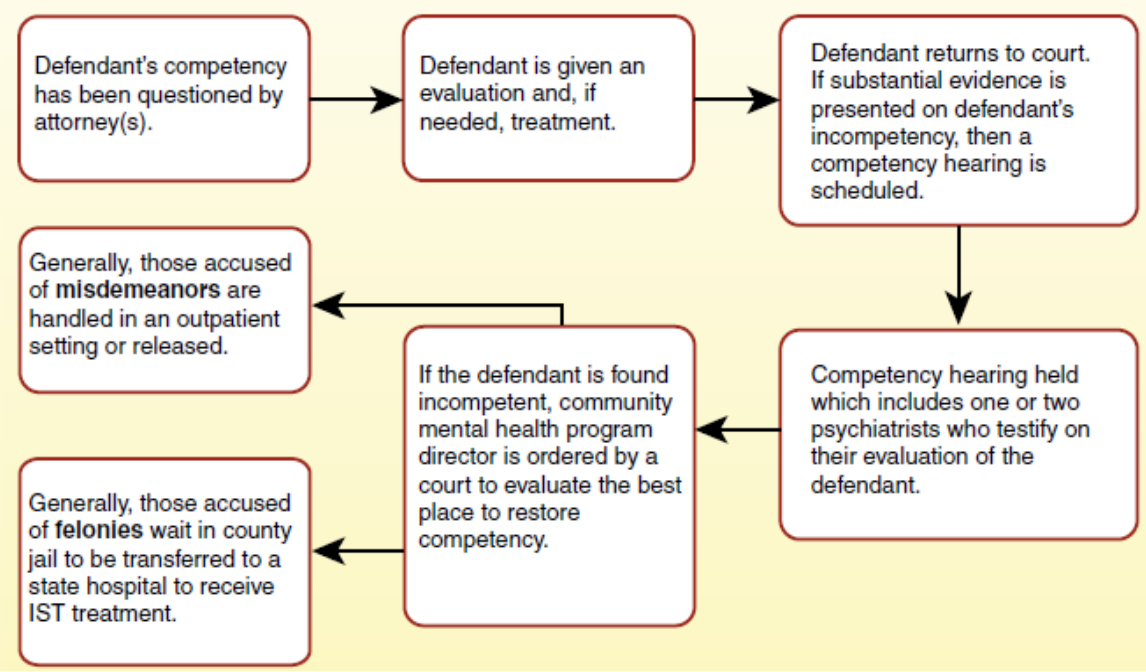



**Figure 1: Incompetent to Stand Trial Commitment Process**
**Source:** *"An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

**Long-Standing Issues with IST Backlog.** Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 1,706 as of December 2021. In 1972, the United States Supreme Court found in *Jackson v. Indiana* that a person committed on account

of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

***Stiavetti v. Clendenin* Requires Commencement of Treatment for IST Patients Within 28 Days.** In 2015, five family members of IST patients committed to DSH and the Department of Developmental Services (DDS) filed suit against the state challenging statewide delays in transfer of IST patients from county jails to DSH or DDS to begin substantive treatment services as a violation of the patients' due process rights. On April 19, 2019, the Alameda County Superior Court concluded that IST patients have a constitutional right to substantive services within a reasonable period of time and that DSH and DDS had violated the due process rights of IST patients referred to a state hospital or to DDS. The court found that constitutional due process requires that DSH and DDS must commence substantive services to restore an IST patient to competency within 28 days of the transfer of responsibility for an IST patient to DSH. On August 25, 2021, the California Supreme Court denied final review of the court's decision and, upon remand, the Alameda County Superior Court issued the following amended compliance timelines for DSH and DDS:

- No later than August 27, 2022: DSH and DDS must commence substantive services for all IST patients within 60 days from the transfer of responsibility date.
- No later than February 27, 2023: DSH and DDS must commence substantive services for all IST patients within 45 days from the transfer of responsibility date.
- No later than August 27, 2023: DSH and DDS must commence substantive services for all IST patients within 33 days from the transfer of responsibility date.
- No later than February 27, 2024: DSH and DDS must commence substantive services for IST patients within 28 days from the transfer of responsibility date.

**Administration Proposals to Increase IST Capacity in State Hospitals.** Over recent years, the Administration has proposed a series of projects to expand capacity in State Hospitals for the treatment of IST patients. These proposals were in response to the growing backlog of IST patients in county jails over the last ten years and the potential for court mandates resulting from the *Stiavetti* case. These proposals include: 1) expansion of secured bed capacity at Metropolitan State Hospital to treat IST patients; 2) expansion of existing jail-based competency treatment programs and implementation of new programs; and 3) activation of OMD bed capacity at Coalinga State Hospital to allow transfer from other secured units to provide treatment space for IST patients in other hospitals.

**2018 Budget Act - IST Community-Based Diversion Program.** The 2018 Budget Act included General Fund expenditure authority of $100 million to establish an IST Diversion Program, which contracts with counties to serve individuals with serious mental illnesses with potential to be determined to be incompetent to stand trial (IST) on felony charges. The program prioritized $91 million of funding for these programs in the 15 counties with the highest referrals of ISTs to DSH in 2016-17, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego,

San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. These counties were not required to submit a competitive application. In May 2020, Stanislaus County chose not to participate due to COVID-19 related economic issues and lack of other county resources to establish the program.

Of the remaining funding, $8.5 million was made available to other counties under a competitive funding process. In June 2019, DSH awarded funding to the following counties: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo. In November 2019, DSH awarded a second round of funding to Humboldt, San Mateo, Siskiyou, and Ventura counties.

**IST Workgroup Established to Recommend Solutions to Reduce Backlog.** In response to the court's ruling in *Stiavetti*, the 2021 Budget Act included trailer bill language to require DSH to convene an IST Solutions Workgroup to identify short-term, medium-term, and long-term solutions for alternatives to placement of defendants determined to be IST in a state hospital. The IST Solutions Workgroup met five times between August 2021 and November 2021 to develop solutions to the backlog of IST patients awaiting admission to state hospitals. The workgroup focused on three primary areas: 1) early access to treatment and stabilization for individuals determined to be IST on felony charges; 2) diversion and community-based restoration for individuals determined to be IST on felony charges; and 3) improving the quality of initial county competency evaluations. The workgroup released its findings in a report in November 2021 that included short-, medium-, and long-term recommendations.

The workgroup's recommendations were as follows:

Short-Term Recommendations

1. Support for increased access to psychiatric care, including stabilizing medications, in jail for IST patients while pending placement or when returning from IST treatment to jail pending court proceedings. Care would include long-acting injectable psychiatric medications, use of telehealth for medication and treatment determinations, connect competency evaluator opinions on patient medication needs to jail providers for consideration in the treatment plan, and training for jail clinicians.
2. Improve coordination between the state, criminal justice partners, county behavioral health departments, and county public guardians. This coordination should include transition and treatment planning to ensure continuity of care between systems, provision of a 90 day medication supply upon discharge, use of common drug formularies, data sharing, and identifying community based and diversion alternatives.
3. Provide training and technical assistance and develop best practice guides for jail clinical staff, criminal justice partners, and county staff for understanding and implementing effective treatment engagement strategies. This training and technical assistance would include seeking treatment and medication histories from family members, incentives or other strategies to engage treatment, use of best practices for developing patient-clinician rapport and continuity, securing voluntary consent to medication whenever possible, and obtaining involuntary medication orders whenever necessary.
4. Re-assess current DSH wait list to identify individuals who may be eligible for release into community treatment programs.
5. Expand technical assistance for diversion and community-based restoration including developing best practice guides, assisting newly developing programs, and assisting with options to assess and mitigate public safety risks.

6. Provide training and technical assistance for court-appointed evaluators to improve the quality of reports used to determine if a defendant is IST including checklists for items to be considered, template evaluation reports, increasing knowledge and skills for court-appointed evaluators such as principles of community based mental healthcare, and inclusion of information on discrepancies and biases in evaluations.
7. Prioritize community-based restoration and diversion by allowing individuals in diversion to retain their place on the IST waitlist if they are unsuccessful, improve communication between DSH and courts to ensure an individual is not removed from consideration for diversion when a DSH bed becomes available.
8. Prioritize diversion funding to support diverting eligible individuals from the DSH IST waitlist.
9. Include justice-involved individuals with serious mental illness as priorities in state-level homelessness, housing, behavioral health, and community care infrastructure expansion funding opportunities.
10. Augment DSH diversion contracts with counties to provide for interim housing to support increased diversion placements.
11. Implement local planning efforts for homelessness housing, behavioral health continuum, and community care expansion that includes behavioral health and criminal-justice partners.

Medium-Term Recommendations

1. Statutorily prioritize community outpatient treatment and diversion for IST patients with less severe behavioral health needs and criminogenic risk, reserving jail-based competency treatment and state hospital treatment beds for individuals with the highest need.
2. Provide increased opportunities and dedicated funding for intensive community treatment models for IST patients including assisted outpatient treatment (AOT), forensic assertive community treatment (FACT), full service partnerships (FSPs), regional community-based treatment and diversion programs, crisis residential, substance abuse residential treatment, psychiatric health facilities, mental health rehabilitation centers, transitional residential treatment.
3. Establish a new category of forensic AOT commitment that includes housing, long-acting injectable psychiatric medication, involuntary medication orders when necessary, FACT team, and intensive case management.
4. Establish a statewide pool of court-appointed evaluators and increase the number of qualified evaluators including those with cultural and linguistic competency.
5. Improve statutory process leading to finding of incompetence or restoration to competence including time frames for appointments of evaluators and receipt of reports, statewide standards for evaluations and reports, and expansion of individuals who can recommend the need for re-evaluation.
6. Revise items court-appointed evaluators must consider when assessing competence including eligibility for diversion, likelihood of restoration, medical needs, capacity to consent to medication, consideration of malingering.
7. Revise and improve involuntary medication order statutory process including having involuntary medication orders follow the person rather than being placement-specific, allowing court-appointed psychologists to opine on consent capacity and need for involuntary medications, and revise rules for provision of involuntary medications by jails.
8. Provide access to community-based inpatient treatment, when needed, for stabilization of acute mental health symptoms prior to placement in diversion programs.

9. Provide funding to expand support services to increase utilization of diversion and CBR and enhance services for existing jail-based competency treatment programs including technical assistance and support from psychiatrists and criminal justice experts 24 hours a day, utilization of forensic peer support specialists, and explore opportunities for probation partnerships to provide diversion supervision for higher risk individuals.
10. Support individuals with serious mental illness remaining stable in the community by implementing psychiatric advance directives, and enhance funding for public guardians to ensure appropriate placement in the continuum of care.
11. Explore alternative jail-based competency treatment and CBR contract models to maximize utilization of community facilities rather than jail facilities.
12. Expedite assessment and treatment immediately upon booking of defendants with serious mental illness including completing behavioral health and suicide risk assessments and screenings, performing a housing and service needs assessment, considering family perspective and documentation of the individual's mental health history and treatment, determining a course of treatment that may begin in jail with discharge planning beginning at the time of booking, reviewing cases at booking or as soon as possible to determine cases that will not be filed or opportunities for pre-trial release into treatment and services.
13. Establish requirements or provide incentives to support increased community-based treatment and housing for justice-involved individuals with serious mental illness including increasing community providers, facilities, and landlords willing to provide housing and treatment for these individuals, as well as increasing access to acute inpatient services.
14. Provide flexibilities and expedited licensing of psychiatric health facilities, mental health rehabilitation centers, and adult residential facilities.
15. Revise DSH CONREP to facilitate increased felony IST placement in CONREP, diversion, and CBR, and increase transitions from state hospitals for patients Not Guilty by Reason of Insanity (NGI), or Offenders with Mental Health Disorders (OMD).
16. Allow access to and regularly assess eligibility for transition to DSH funded diversion opportunities for individuals who are treated at state hospitals and jail-based competency treatment programs.
17. Provide increased and ongoing funding to support expansion of DSH diversion and CBR programs.

<u>Long-Term Recommendations</u>

1. Partner with the California Interagency Council on Homelessness to advocate for federal eligibility of individuals at-risk of homelessness for housing resources, leverage federal allocations to local continuums of care, consider flexibilities around housing first approaches and inclusion of individuals at-risk of homelessness, provide training and technical assistance to continuums of care and other partners on providing effective housing services for justice-involved individuals with serious mental illness, support data exchange between behavioral health/criminal justice and continuums of care to ensure connection to the homeless crisis response system, encourage local hosing system leaders to participate in interdisciplinary meetings focused on justice-involved populations, and support inclusion of justice-involved individuals with serious mental illness in housing priorities and preferences for housing funding.
2. Support effective implementation of the proposed California Advancing and Innovating Medi-Cal (CalAIM) components including enrollment in Medi-Cal prior to release from custody, 90 day in-reach of services prior to release, intensive community-based care and coordination, access to

community supports, capacity building, and application for waiver of the federal exclusion on matching funds for Institutes for Mental Disease (IMD) services.

3. Develop quality improvement oversight and peer review of court-appointed evaluators and their reports including developing a certification program, implementing pay for performance tied to quality, requiring standardized training, and implementing a peer review process to improve quality.
4. Increase opportunities for alternatives to arrest and pre-booking diversion including mobile non-police crisis response teams, sobering or triage centers, diversion centers.
5. Expand community treatment and hosing options for justice-involved individuals with serious mental illness including dedicated funding for diversion and CBR programs, funding to incentivize development and expansion of CBR programs statewide, incentives or flexible housing pool models for additional housing resources for justice-involved individuals with serious mental illness, include justice-involved individuals with serious mental illness as priorities in homelessness and behavioral health, provide landlord incentives, expand social rehabilitation facilities, develop unlocked residential housing with treatment and supports, support regional programs and approaches for behavioral health and housing strategies, increase permanent supportive housing opportunities for justice-involved individuals with serious mental illness, and funding support for accessory dwelling units to allow families to provide independent housing for family members with serious mental illness on their properties.
6. Develop a new licensing category for enriched and intensive community treatment options for individuals living with serious mental illness including mental health, health care, and intensive support services in a home-like setting. These models could be similar to Short-Term Residential Therapeutic Programs that serve foster youth and facilities that support adults with developmental disabilities.
7. Facilitate appropriate information sharing and support cross-system data initiatives including state health information guidance on sharing health and housing information, support for counties to analyze their criminal justice populations to understand trends and identify strategies to reduce IST referrals, and funding to develop a state approach to monitor key data at the intersection of criminal justice, behavioral health, and homelessness.
8. Support development and expansion of a culturally and linguistically competent workforce to meet an individuals' forensic and behavioral health needs including forensic fellowships, utilizing psychiatry residents and psychology students for court-appointed evaluations, increased psychologist and psychiatrist training including rotation requirements to serve justice-involved individuals, expansion of mental health and other professionals to serve justice-involved individuals, expand use of peer support specialists and family members, support care team models, provide recruitment and retention incentives, identify funding to address workforce shortages, educate workforce on serving in the role of housing advocate, collaborative justice principles, motivational interviewing assessing and mitigating dangerousness, implicit bias, and other culturally relevant competencies.
9. Phase out reliance on jail-based competency treatment programs as CBR and diversion program options are expanded.
10. Explore and, if needed, implement improvements to the Mental Health Services Act and the Lanterman-Petris-Short Act to facilitate access to care and treatment for individuals who are experiencing severe and disabling mental health crisis.
11. Provide funding support to counties to expand access to mental health diversion, pursuant to AB 1810, including for misdemeanors.
12. Provide increased access to permanent supportive housing for justice-involved individuals with serious mental illness.

13. Revise IST statutes to require the prosecution to establish competency, rather than requiring the defense to establish incompetency.

**IMD and Sub-Acute Bed Capacity Funding Program.** In addition to establishment of the IST Workgroup, the 2021 Budget Act included 22 positions and General Fund expenditure authority of $267.1 million to authorize DSH to contract for subacute bed capacity to address the increasing number of IST patient referrals to state hospitals. DSH reports it began engagement with multiple private providers in Summer 2021 and continues to work with those providers to develop bed capacity throughout the state. DSH is attempting to partner with providers that can provide a blend of acute and sub-acute bed capacity, which DSH believes will allow more individuals to transition from jail to community settings and promote a broader continuum of care. DSH is engaging counties that currently lack capacity to stabilize IST patients to provide funding to expand the reach of diversion programs. In addition, DSH is engaging with counties that have not been able to fully participate in diversion and community-based restoration programs due to lack of availability of sub-acute beds in their communities. DSH is also attempting to align funding for this program with the proposals contained within its IST Solutions Package.

**Governor's January Budget Proposes Package of IST Solutions.** DSH requests General Fund expenditure authority of $93 million in 2021-22 and $571 million annually thereafter to support implementation of solutions to provide timely treatment for patients determined incompetent to stand trial (IST) on felony charges and to support ongoing efforts to decriminalize mental illness in California. Included in this request is General Fund expenditure authority of $75 million in 2021-22 and $175 million annually thereafter for IST solutions, and $18 million in 2021-22 and $46 million annually thereafter for IST diversion and community-based restoration (CBR), approved in the 2021 Budget Act. The total additional ongoing funding requested in the Governor's January budget is $350 million beginning in 2022-23.

The Administration proposes the following solutions:

- *Stabilization and Early Access to Treatment.* $24.9 million in 2021-22 and $66.8 million in 2022-23 and annually thereafter would provide access to treatment services for individuals on the IST waitlist. Treatment would be facilitated in partnership with county jail mental health providers and would include administration of medications such as long-acting injectable (LAI) medications, increased clinical engagement, and competency education. DSH indicates it would leverage its existing jail-based competency treatment infrastructure to provide these services.
- *Care Coordination and Waitlist Management*. $1.7 million in 2021-22 and $4.9 million in 2022-23 and annually thereafter would support teams to screen all IST patients to determine eligibility for community-based programs, provide enhanced monitoring of the waitlist, and provide commitment-to-admission case management to coordinate appropriate placements and maximize bed usage.
- *Housing Augmentation for Current Diversion Contracts*. $60 million in 2021-22 would support one-time interim housing investments for IST patients participating in a DSH diversion program. $75,000 per patient would support the cost of appropriate housing to facilitate increased diversion placements of patients determined IST on felony charges. Counties would use this funding to provide housing to diversion clients in the most appropriate level-of-care such as IMDs, mental health rehabilitation centers, residential housing with clinically enhanced services, board and care homes, and other appropriate residential facilities.

- *Housing Infrastructure - CBR or Diversion Beds.* $6.4 million in 2021-22 and $233 million in 2022-23 and annually thereafter would support development of residential housing settings for IST patients participating in CBR or diversion programs. $350,000 in start-up funds would be provided for approximately 700 housing units to cover down payment, retrofitting, and furnishings to provide approximately 5,000 beds.
- *Community Program Funding for CBR or Diversion Clients*. $266.5 million in 2022-23 and annually thereafter would support creation or expansion of permanent community-based treatment programs for IST patients. These resources would support a robust per-patient rate, non-treatment costs of managing community-based programs, transitional housing support for IST patients released from custody, and technical assistance resources for participating counties.
- *Increased Conditional Release Program (CONREP) Placements*. $433,000 in 2022-23 and annually thereafter would support a pilot for a new independent placement determination panel to increase the number of individuals served in the community through the Conditional Release Program (CONREP). The panel would revise the role of the Community Program Director and improve the assessment process for individuals committed to DSH as Not Guilty by Reason of Insanity (NGI) and Offenders with a Mental Health Disorder (OMD). Increasing utilization of CONREP would increase bed capacity in the state hospitals available for inpatient treatment of IST patients.

In addition to these investments, DSH requests trailer bill language to cap the total number of felony IST referrals by each county based on the current fiscal year (2021-22) and require counties to assume a share of the cost of care for IST patients referred above the cap. According to DSH, the county's share of the cost of care would be based on the treatment location, including inpatient or community-based programs.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide an update on the activities of the IST Solutions Workgroup and the recommendations published in its November 2021 report.

2. Please provide an update on the department's efforts to implement the IMD and Sub-Acute Bed Capacity Funding Program authorized in the 2021 Budget Act.

3. Please provide a brief overview of the individual components of the IST Solutions Proposal.

4. How do these solutions align with the short-, medium-, and long-term recommendations of the IST Solutions Workgroup?

5. What additional recommendations from the IST Solutions Workgroup report is DSH considering for future action?

6. Has DSH performed an analysis of what increases in capacity for community-based programs or reductions in IST referrals from counties would be required to meet the timelines established by the court in *Stiavetti*? Are the individual components of the IST Solutions Proposal sufficient to achieve the required increases in community-based program capacity or reduction in IST referrals?

**Panel Discussion.** The subcommittee has requested several stakeholders to share their perspectives on the Administration's IST Solutions Proposals, as well as the landscape of treatment and services for justice-involved individuals with serious mental illness.

**Dr. Veronica Kelley**, Chief-Mental Health and Recovery Services, Orange County Health Care Agency
**Kim Pederson**, Senior Attorney - Mental Health Practice Group, Disability Rights California
**Stephanie Regular**, Assistant Public Defender, Contra Costa County
**Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH)
**Michael T. Risher**, Of Counsel, American Civil Liberties Union Foundation of Northern California
**Sandra Siedenburg**, Family Member of an IST Patient.

The subcommittee has requested these stakeholders to respond to the following:

Behavioral Health Directors

1. Please provide your organization's perspective on the Administration's IST Solutions Proposals.

2. Please describe the challenges county behavioral health departments face in appropriately treating and stabilizing justice-involved individuals with serious mental illness.

3. How will the recent investments in infrastructure, including the Behavioral Health Continuum Infrastructure Program and Community Care Expansion, as well as the current IST Solutions Proposal, support county efforts to expand treatment and services capacity for this population?

4. Will these resources allow options to be available in enough time to help DSH meet its court-mandated treatment guidelines, as well as its goals for increased IST diversion and community-based treatment?

5. What types of programs and other initiatives have counties implemented to try to intercept justice-involved individuals with serious mental illness before they commit a felony that results in an IST referral?

Disability Rights California

1. Please provide your organization's perspective on the Administration's IST Solutions Proposals.

2. What other reforms would your organization like to see implemented, either from the IST Solutions Workgroup recommendations or elsewhere, to ensure appropriate treatment options for justice-involved individuals with serious mental illness?

Public Defenders

1. Please provide your organization's perspective on the Administration's IST Solutions Proposals.

2. What other reforms do you believe are necessary to intercept individuals with serious mental illness early enough to receive appropriate treatment and services, and prevent justice-involvement?

3. What additional reforms to court proceedings or other legal procedures are necessary to maximize opportunities to divert individuals with serious mental illness into treatment and services?

Council on Criminal Justice and Behavioral Health

1. Please provide your organization's perspective on the Administration's IST Solutions Proposals.

2. How do these proposals align with previous recommendations your organization has made regarding the issue of justice-involved individuals with serious mental illness?

3. Are there additional reforms or investments that you believe are necessary to appropriately treat and stabilize these individuals prior to justice-involvement?

ACLU

1. Please provide some brief background on the constitutional due process violations affirmed by the court in *Stiavetti*.

2. Please provide your organization's perspective on the Administration's IST Solutions Proposal.

3. What additional reforms or investments, or other changes to IST treatment options, may be necessary to ensure IST patients' rights are not violated?

Family Member of IST Patient

1. Please describe your and your family member's experience with the current process for referral, admissions, and treatment for individuals deemed IST.

2. What reforms do you think would help your family member and others in similar situations access the treatment they need, avoid involvement with the justice system, and maintain stable housing, employment, and connections with family and the community?

## Issue 3: COVID-19 Direct Response Expenditures

**Budget Change Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $64.6 million in 2022-23. If approved, these resources would support response activities to the COVID-19 pandemic, primarily for staffing, supplies, testing, and logistics.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $64,600,000 | $- |
| **Total Funding Request:** | **$64,600,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The state's response to the COVID-19 pandemic has required rapid deployment of state and federal resources to support a wide variety of activities designed to mitigate the spread of the virus, while maintaining vital services and protecting the most vulnerable Californians. The 2021 Budget Act included General Fund expenditure authority of $52 million in 2021-22 to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation, commodity purchases, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions.

For 2022-23, DSH reports the following updates on COVID-19 response in the state hospitals:

- *COVID-19 Cases and Hospital Updates.* As of November 2021, DSH performed 98,645 tests on 9,116 patients in its five state hospitals. 2,102 patients tested positive. In addition, DSH performed 186,977 PCR tests and 1,165,113 antigen tests on state hospital staff statewide with a total of 2.686 staff testing positive.
- *Quarantine, Isolation, and Surge Capacity.* Each hospital has continued to maintain quarantine and isolation plans, including COVID-19 emergency plans and supplemental procedures for managing isolation units and infection control methods. DSH is also utilizing space in Metropolitan State Hospital as an Admission Observation Unit.
- *Isolation and Testing.* Patients displaying COVID-19 symptoms are immediately isolated in a private room and laboratory samples taken for testing. Positive patients are transferred to the COVID-19 isolation unit for care for a minimum of 14 days.
- *Support for Employees and Patients.* DSH is supporting employees and patients through a variety of efforts including establishment of an Employee Support Line, making the California Chaplain Corps available, collaborating with the state's Employee Assistance Program, and educating and providing updates on COVID-19, personal protective equipment and safety practices, sanitizing equipment, and the importance of testing.

**Resource Request.** DSH requests General Fund expenditure authority of $64.6 million in 2022-23 to support response activities to the COVID-19 pandemic, primarily for staffing and testing. Specifically, DSH requests resources in the following three categories:

- Personal Services – DSH requests General Fund expenditure authority of $50.6 million in 2022-23 for staff time directly related to COVID-19 including cleaning, sanitization, staffing coverages, environmental projects, performing custody tasks, screening staff, isolation staff and testing staff.
- Testing – DSH requests General Fund expenditure authority of $14 million for costs of testing patients and employees of the state hospitals.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 4: Program and Caseload Updates

**Program and Caseload Updates – Governor's Budget.** DSH requests resources to support the following program and caseload updates in its 2022-23 Governor's Budget Estimate.

**Program Update – Metropolitan: Increased Secure Bed Capacity.** DSH estimates General Fund savings of $21.8 million in 2021-22 due to delays in the activation of newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that previously housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment.

According to DSH, of the five units under construction, Unit 1 was activated September 23, 2019 and Unit 2 was activated on January 29, 2020. Units 3, 4, and 5 were scheduled to be activated in September 2021. The activation of these units has been delayed until July 2022. The delays are due to the following: 1) impacts from the COVID-19 pandemic, 2) use of these units to relocate skilled nursing facility patients due to water damage to the facility, and 3) use of these units as swing space as Metropolitan upgrades its fire alarm system in other housing units in the hospital.

**Program Update – Enhanced Treatment Program (ETP) Staffing.** DSH estimates a reduction of 56.5 positions and General Fund savings of $9.6 million in 2021-22 and $8.9 million in 2022-23 and annually thereafter due to delayed completion of Enhanced Treatment Program (ETP) units at Atascadero and Patton State Hospitals, as well as indefinite suspension of two units at Atascadero. AB 1340 (Achadjian), Chapter 718, Statutes of 2014, authorized DSH to establish an ETP pilot project to expand the range of clinical treatment options for patients determined to be at the highest risk of dangerous behavior or violence against other patients or hospital staff and cannot be safely treated in a standard treatment environment. According to DSH, the risk of violence against other patients or hospital staff imposes both a threat to health and safety, as well as a barrier to the effective treatment of other patients who may fear for their physical safety in a standard treatment environment with a potentially violent patient. The pilot project period extends approximately five years from the first patient admitted to the ETP and imposes certain requirements on admission and treatment within an ETP.

Patients are evaluated for admission to an ETP based on requirements contained in AB 1340. A patient referred to an ETP by state hospital clinical staff is assessed by a dedicated forensic psychologist within three business days to make an initial determination regarding the appropriateness of the referral. If the referral is appropriate, the patient is further assessed by a panel comprised of a state hospital medical director, psychiatrist, and psychologist to certify admission to the ETP within seven days of the original referral. Upon admission, a forensic needs assessment team psychologist conducts a violence risk assessment and develops a treatment plan in writing and, if possible, with the collaboration of the patient. The treatment plan, which must be reviewed and updated every ten days, must include information about the patient's mental health status and diagnoses, prescribed medications, goals of treatment, planned interventions and methods, documentation of success in meeting objectives, evaluation of the factors contributing to or detracting from the patient's progress, an activity plan, plans for other services needed

by the patient, discharge criteria, goals for an aftercare plan in a standard treatment environment upon discharge, and a plan for post-discharge follow up.

In addition to the admission and treatment criteria, each ETP has specified staff-to-patient ratios, housing and facility requirements, and accessibility requirements. Each ETP is also required to maintain an independent patients' rights advocate to provide advocacy services to patients admitted to an ETP.

According to DSH, the construction of Unit 29 at Atascadero was completed in July 2021. The state Fire Marshal has issued a Certificate of Occupancy, the Department of Public Health issued a license in August 2021, and the first patients were admitted in September 2021. The four-year pilot project for this unit will continue until September 2025.

DSH expected to resume fire sprinkler installation on Patton Unit U-06, which was in progress when construction was suspended, in July 2021. However, unforeseen fire sprinkler installation design changes, the need to survey for potential asbestos containing materials, and discovery of gaps in the existing smoke barrier have extended the length of the project until October 2022.

Construction on Atascadero Units 33 and 34 was suspended due to COVID-19, with an expected resumption date of October and November 2021. However, because both units comprising 92 beds would need to be taken offline to continue construction, DSH is recommending suspending construction of these two units until current IST bed pressures are resolved. The expected construction timelines are as follows:

| Units/Hospital | Construction Initiated (Actual or Scheduled) | Construction Completion (Actual or Scheduled) |
|---|---|---|
| DSH-Atascadero Unit 29 | September 24, 2018 | July 2021 |
| DSH-Atascadero Unit 33 | Suspended | Suspended |
| DSH-Atascadero Unit 34 | Suspended | Suspended |
| DSH-Patton Unit U-06 | April 2022 | October 2022 |

**Program Update – Vocational Services and Patient Minimum Wage Caseload.** DSH estimates General Fund savings of $279,000 in 2021-22 due to lower than expected referrals to its Vocational Rehabilitation Program related to restrictions on patient activities and movement due to the COVID-19 pandemic. This program serves as a therapeutic program to provide a range of vocational skills and therapeutic interventions for patients, including the development of social, occupational, life, and career skills, and confidence. Patients are paid an hourly wage for the work performed in the following jobs: custodial, kitchen worker, product assembler, laundry attendant, landscaper, painter, plumbing, barber, horticulture, multimedia production, peer mentor, office clerk, and repair technician.

**Program Update – Mission-Based Review: Court Evaluations and Reports.** DSH estimates General Fund savings of $1.5 million in 2021-22 related to delays in filling positions to support court evaluation and report workload. The 2019 Budget Act included 94.6 positions and General Fund expenditure authority of $40.2 million over three years to support forensic services workload associated with court-directed patient treatment. Due to the COVID-19 pandemic, the 2020 Budget Act shifted some of these resources and positions to be phased in across a four-year period. According to DSH, the categories of positions for which savings are expected are as follows:

- Evaluations, Court Reports and Testimony – 37.7 positions have been established out of a total of 53.1 proposed to be phased in for evaluations of patients, court reports, and testimony. 30.9 positions have been filled, resulting in General Fund savings of $705,000 in 2021-22.
- Forensic Case Management and Data Tracking – All 16.3 proposed positions have been established for forensic case management and data tracking. 10.3 positions have been filled, resulting in General Fund savings of $425,000 in 2021-22.
- Neuropsychological Service – All 25.2 proposed positions have been established for conducting neuropsychological assessments and implementing a cognitive remediation pilot program. 21.5 positions have been filled, resulting in a General Fund savings of $392,000 in 2021-22.

**Program Update – Mission Based Review: Direct Care Nursing.** DSH estimates General Fund savings of $4.6 million in 2021-22 and requests 32 positions and General Fund expenditure authority of $735,000 in 2022-23 and annually thereafter for staffing changes to implement methodologies to provide appropriate 24-hour nursing care, administration of medication, and an afterhours nursing supervisory structure. The 2019 Budget Act included a total of 379.5 positions and General Fund expenditure authority of $46 million, phased in over three years, to implement the direct care nursing staffing methodology changes. Due to the pandemic-induced recession, and resulting General Fund deficit, the 2020 Budget Act shifted these resources to be phased in across a longer time frame. DSH reports the following updates to the phase in of positions:

- Medication Pass Psychiatric Technicians – The 2019 Budget Act included 335 positions for medication pass staffing. The 2020 Budget Act adjusted the positions to be phased-in over five years. 152.5 positions have been established and 104 positions have been filled, resulting in a General Fund savings of $3 million in 2021-22.
- Afterhours Supervising Registered Nurses – The 2019 Budget Act included 44.5 positions for afterhours nursing supervision. The 2020 Budget Act adjusted these positions to be phased-in over two years. All 44.5 positions have been established and 26.9 positions have been filled, resulting in a General Fund savings of $1.6 million in 2021-22.

In addition to phasing in positions, the 2019 Budget Act reallocated position authority between hospitals to provide the appropriate level of staffing needs for each hospital. The proposed hospital position shifts are as follows:

- Atascadero – Shift 132.0 positions
- Coalinga – Shift 76.1 positions
- Patton – Shift 27.4 positions
- Metropolitan – Gain of 142.5 positions once shifts are complete
- Napa – Gain of 93.0 positions once shifts are complete

According to DSH, a total of 217.5 positions have been shifted and recruitment and hiring efforts continue at Metropolitan and Napa to fill all the received positions. DSH reports some of the vacant positions originally identified are no longer vacant and no longer can be shifted to a different location.

DSH also has recognized an oversight in the phase-in process of positions that has led to inadequate funding for annual increases in employee compensation and retirement costs for positions added in out-

years. As a result, DSH requests General Fund expenditure authority of $735,000 in 2022-23 and annually thereafter to support these additional costs.

**Program Update – Workforce Development for Psychiatric Residency Programs and Psychiatric Technicians.** DSH estimates General Fund savings of $415,000 in 2021-22 related to delays in workforce development programs for psychiatry residents, nursing staff, and psychiatric technicians. The 2019 Budget Act included eight positions and General Fund expenditure authority of $1.8 million in 2019-20, $2.2 million in 2020-21, $2.4 million in 2021-22 and 2022-23, and $2.6 million annually thereafter to implement a Psychiatric Residency Program and expand resources for nursing recruitment. DSH expected four residents would have been recruited in July 2020. However, the implementation of the program was delayed until July 2021. When the program commenced in July 2021, instead of four residents the program enrolled seven, using savings from the prior year delay to support the additional residents. DSH is anticipating savings of $363,000 remaining from the delay in beginning the residency program. In addition, a planned expansion of nursing and psychiatric technician programs is no longer moving forward and a related reclassification of a position will result in one-time General Fund savings of $52,000.

**Program Update – Mission Based Review: Protective Services.** DSH estimates General Fund savings of $1.6 million in 2021-22 and requests 10 positions and $2.3 million in 2022-23 and $2 million annually thereafter to support hospital police officers to provide protective services in the State Hospitals. In 2020-21, DSH proposed a new staffing standard to support protective services functions including 46.3 positions and General Fund expenditure authority of $7.9 million in 2020-21, and 47.8 positions and General Fund expenditure authority of $13.4 million annually thereafter. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act included no positions or expenditure authority for this purpose. The 2021 Budget Act included 94.1 positions and $11.4 million, phased in over two years to support full implementation of the staffing standard. DSH reports the following updates to the phase in of positions:

- Support and Operations Division – The 2021 Budget Act included 88.1 positions to support the Support and Operations Division to be phased in over two years. 24 positions have been established and none of the positions have been filled, resulting in a General Fund savings of $1.4 million in 2021-22.
- Executive Leadership Structure – The 2021 Budget Act included six positions to support the Executive Leadership Structure. All six positions have been established, but none of the positions have been filled, resulting in a General Fund savings of $671,000 in 2021-22.
- Field Training Overtime Funding – Once Hospital Police Officer cadets complete academy coursework and graduate, they must perform four months of field training with another officer. This assignment to the same post with another officer results in overtime costs. Due to delays in hiring, DSH estimates a shift of General Fund expenditures from 2021-22 to 2022-23 for this purpose.

DSH also has recognized an oversight in the phase-in process of positions that has led to inadequate funding for annual increases in employee compensation and retirement costs for positions added in out-years. As a result, DSH requests General Fund expenditure authority of $660,000 in 2022-23 and annually thereafter to support these additional costs.

**Program Update – Mission Based Review: Treatment Team and Primary Care.** DSH estimates General Fund savings of $9.2 million in 2021-22 and requests a reduction of one position and General Fund expenditure authority of $1.2 million in 2022-23 and annually thereafter to support .In 2020-21, DSH proposed changes to its staffing methodologies for its treatment and primary care teams, including a total of 250.2 positions and General Fund expenditure authority of $64.2 million over a five year period. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act only included 12.5 positions and General Fund expenditure authority of $5 million in 2020-21 and 30 positions and General Fund expenditure authority of $10 million annually thereafter to support implementation of these staffing changes. The 2021 Budget Act included 213.3 positions and $54.1 million, phased in over five years, to support full implementation of the new staffing methodology. DSH reports the following updates to the phase-in of positions:

- Interdisciplinary Treatment Team – Over the last two budgets, a total of 180.4 positions were allocated to support the Interdisciplinary Treatment Team, which is responsible for the planning and delivery of treatment, discipline-specific other workload, administrative and professional responsibilities, crisis prevention, unit milieu work, and crisis and incident management. 16.2 of the 180.4 positions have been established and none of the positions have been filled, resulting in a General Fund savings of $1.9 million in 2021-22.
- Primary Medical Care – Over the last two budgets, a total of 31.9 positions were allocated to support primary medical care including routine preventative care and the treatment of non-life-threatening medical illness. 19.6 of the 31.9 positions have been established and 3.2 positions have been filled including one Chief Physician/Surgeon and 2.2 physician/surgeons, resulting in a General Fund savings of $3.2 million in 2021-22.
- Trauma-Informed Care – Over the last two budgets, a total of six positions were allocated to support trauma-informed care, a comprehensive approach that includes workforce training, trauma-informed policies and standards, and the provision of evidence-based, trauma-specific screening, assessment, referral, and treatment. All six of the positions have been established and one position has been filled (one Senior Psychologist Specialist), resulting in a General Fund savings of $480,000 in 2021-22.
- Clinical Executive Structure: Administrative Support – Over the last two budgets, a total of six positions were allocated for administrative support positions for personnel management. All six of the positions have been established and none of the positions have been filled, resulting in a General Fund savings of $379,000 in 2021-22.
- Clinical Executive Structure: Executive Leadership – Over the last two budgets, a total of 12 positions were allocated for clinical executive leadership including six Medical Directors, one Assistant Medical Director, and five Chiefs of Primary Care Services for the five state hospitals. All 12 positions have been established, but none of the positions have been filled, resulting in a General Fund savings of $3.3 million in 2021-22.
- Discharge Strike Team – Over the last two budgets, a total of six positions were allocated to support the Discharge Strike Team, which focuses on establishing and strengthening relationships with placement communities to improve knowledge of community resources, address barriers to placement and improve communication in efforts to expedite placement. All six positions have been established, but none of the positions have been filled, resulting in a General Fund savings of $452,000 in 2021-22.
- Clinical Operations Advisory Council – Over the last two budgets, a total of ten positions were allocated to support the Clinical Operations Advisory Council (COAC), which facilitates the

development, evaluation, and maintenance of clinical standards for the department. All ten positions have been established in Sacramento. Because the original request was for positions only, there is no General Fund impact.

DSH also has recognized an oversight in the phase-in process of positions that has led to inadequate funding for annual increases in employee compensation and retirement costs for positions added in out-years. As a result, DSH requests General Fund expenditure authority of $718,000 in 2022-23 and annually thereafter to support these additional costs.

**Program Update – Telepsychiatry Resources.** DSH estimates no changes to positions or General Fund expenditures in its Telepsychiatry Resources program. The 2019 Budget Act included eleven positions and General Fund expenditure authority of $2.2 million in 2019-20 and 21 positions and General Fund expenditure authority of $3.7 million annually thereafter for an expansion of telepsychiatry, which allows DSH to overcome geographic barriers in providing psychiatric services to its patients. According to DSH, the seven positions allocated to Atascadero were never filled due to more recent success in hiring on-site psychiatrists. As a result, these positions were shifted to Coalinga, for a total of 13 allocated positions. DSH reports the following updates to the phase-in of positions:

- Oversight – One position was allocated to provide oversight and guidance of staff psychiatrists and the overall program. The position has been established and filled.
- Staff Psychiatrists – 18 positions were allocated to support telepsychiatry services. All 18 positions have been established and 12 positions have been filled.
- Coordinators – 18 positions were allocated to support the staff psychiatrists in coordinating telepsychiatry services. All 18 positions have been established and ten have been filled.

**Program Update – Patient-Driven Operating Expenses and Equipment.** DSH requests General Fund expenditure authority of $1.9 million in 2022-23 and $2.1 million annually thereafter to support operating expenses and equipment (OE&E) related to the care and treatment of DSH patients. These expenses include funding for outside medical care, pharmaceuticals, patient clothing, food, and costs for patient advocacy. DSH estimates OE&E costs of $21,085 per patient based on 2018-19 data, as data from later fiscal years is complicated from significant additional medical care costs related to the COVID-19 pandemic. The request for additional ongoing General Fund resources is based on this estimated cost per patient and projections for growth in patient census.

**Caseload Update: Forensic Conditional Release Program (CONREP) – General/Non-Sexually Violent Predator (Non-SVP) Program.** The Forensic Conditional Release Program (CONREP) was established in 1986 and provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. The CONREP population includes patients committed to state hospitals as Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and felony Incompetent to Stand Trial (IST). After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

According to DSH, when a patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if the patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional

Residential Program (STRP), a resource used by CONREP to provide patients the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hour supervision.

DSH estimates General Fund savings of $7.4 million in 2021-22 and requests General Fund expenditure authority of $4.6 million in 2022-23 and annually thereafter to fund its contracted CONREP caseload of 938 clients in 2021-22 and 1,018 clients in 2022-23. DSH reports activation delays of facilities for CONREP treatment including:

- Southern CA IMD Facility – DSH reports delayed activation of a 78 bed Institute for Mental Disease (IMD) facility in southern California. Delays are due to pending external approvals including from the federal Centers for Medicare and Medicaid Services (CMS) and the state Department of Public Health. These delays resulted in a one-time General Fund savings of $7.3 million in 2021-22.
- Northern CA IMD Facility – DSH established a ten bed IMD facility in northern California, which was activated in July 2020. In July 2021, DSH extended the contract term and expanded the program by an additional ten beds. DSH reports as of late November 2021, 13 of the beds are filled or reserved for patients ready for placement. Delays in opening the expanded bed space resulted in a one-time General Fund savings of $570,000 in 2021-22.
- Northern CA MHRC – DSH reports contract discussions to establish a five bed mental health rehabilitation center (MHRC) in northern California have come to a halt and DSH has declined to move forward with the program activation. This suspension of program activation resulted in ongoing General Fund savings of $913,000 in 2021-22. DSH proposes to redirect these savings to support activation of a 30 bed adult residential facility in northern California.
- Northern CA ARF – DSH is negotiating with a provider to establish a 30 bed adult residential facility (ARF) in northern California for IST patients ordered to CONREP. DSH expects contract execution and program activation to occur by April 2022. DSH requests General Fund expenditure authority of $1.4 million in 2021-22 and $5.5 million in 2022-23 and annually thereafter to support the new facility.
- Forensic Assertive Community Treatment – DSH reports it is working with a provider to establish 180 dedicated beds and staff resources for the new CONREP Mobile Forensic Assertive Community Treatment (FACT) program, which increases placement options for CONREP patients by using this model of care where a community-based restoration program is not available. DSH expects 60 beds in northern California to activate in early Winter 2022, 60 beds in southern California to activate in early Spring 2022, and 60 beds in the Bay Area to activate in early Fall 2022.

**Caseload Update – Forensic CONREP: Sexually Violent Predator (SVP) Program.** Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH estimates a total caseload of 25 SVPs could be conditionally released into the community by June 30, 2022. Currently, there are 16 current participants in the CONREP-SVP program and 15 individuals with court-approved petitions for release into the program who are awaiting placement. In addition, 11 more individuals have filed petitions for conditional release and are proceeding through the court process. DSH requests one position and General Fund expenditure authority of $245,000 in 2022-23 and annually thereafter to support an Attorney III position to provide legal coverage for an increasing number of court hearings related to CONREP-SVP clients.

**Program Update – Jail-Based Competency Treatment (JBCT) Programs and Admission, Evaluation, and Stabilization (AES) Center.** DSH contracts with county jail facilities to provide restoration of competency services in jail-based competency treatment (JBCT) programs, treating IST patients with lower acuity and that are likely to be quickly restored to competency. DSH estimates total JBCT bed capacity of 572 in 2021-22 and 664 in 2022-23. DSH reports net General Fund savings of $7 million in 2021-22 composed of one-time cost savings of $2.6 million for recruitment and renovation related delays in activation of additional beds at the Kern Admission, Evaluation, and Stabilization (AES) Center, and $4.4 million for delayed activation of eight JBCT programs offset by expanded capacity in five programs and a five percent rate increase for ten programs. DSH also requests General Fund expenditure authority of $11.6 million in 2022-23 and $11.8 million annually thereafter to support expansion of existing JBCT programs and establishment of new programs. The components of this request are as follows:

- Existing Program Bed Capacity and Expenditures – DSH requests General Fund expenditure authority of $3.5 million in 2022-23 and $3.7 million annually thereafter to support existing bed capacity and expenditures. According to DSH, eight currently funded JBCT programs are experiencing delays in activation and some bed capacity levels are being adjusted due to a change in the program location within the jail. In addition, four JBCT programs (Humboldt, Kings, Monterey, and Sonoma) will expand capacity and one program pending activation (Northern CA County H) will increase its capacity by an additional 20 beds and serve as a statewide program. In addition, DSH expects a five percent rate increase for Humboldt, Kings, Sonoma, Sacramento, San Luis Obispo, Shasta, Stanislaus, Ventura, Northern CA County H, and Northern CA County N.
- Service Expansion for Early Access to IST Treatment – DSH requests General Fund expenditure authority of $2.6 million in 2022-23 and annually thereafter to perform early access to treatment services to support IST patients while pending placement in a DSH program and housed near a county jail that hosts a JBCT program. This expansion is included in the Administration's IST Solutions Proposal. Services would include psychiatry, one-to-one clinical engagement, competency restoration services, and medications. DSH proposes to repurpose anticipated General Fund savings in 2021-22 to support this expansion.
- New JBCT Program Activations – DSH requests General Fund expenditure authority of $5.4 million in 2022-23 and annually thereafter to support two new JBCT programs (Central CA County L and Southern CA County M), that will increase bed capacity by 35 beds.
- Patients' Rights Advocacy Funding – DSH requests General Fund expenditure authority of $49,000 in 2022-23 and annually thereafter to support contracted patients' rights advocacy services to support the new JBCT activations. AB 103 (Committee on Budget), Chapter 17, Statutes of 2017, requires all DSH patients to have equal access to patients' rights advocacy resources.
- Public Records Act Requests Travel Costs – DSH requests General Fund expenditure authority of $40,000 in 2022-23 and annually thereafter to support previously unanticipated travel costs associated with Public Records Act requests.

**Program Update – Community-Based Restoration Program.** The 2018 Budget Act included General Fund expenditure authority of $13.1 million to contract with Los Angeles County for 150 beds to treat IST patients in community settings, known as community-based restoration (CBR). The 2021 Budget Act included 4.5 positions and General Fund expenditure authority of $4.9 million in 2020-21, $32.8 million in 2021-22, and $59.8 million annually thereafter to expand the Los Angeles CBR program and expand it

to other counties. DSH requests General Fund expenditure authority of $3 million in 2022-23 and $3.2 million annually thereafter to correct a calculation error and fund increased daily bed rates in the Los Angeles County CBR program. DSH reports it executed an amended contract with Los Angeles County for an additional 200 beds that were activated in Summer 2021, and an additional 100 beds activated in November 2021, for a total bed capacity of 515 beds. In addition, DSH began direct outreach to multiple counties to expand CBR programs beyond Los Angeles County, and will provide an update on these efforts at May Revision. According to DSH, its budget request is due to a calculation error that undercounted the total number of beds, and increased daily bed rates in the Los Angeles County CBR program as a result of the amended contracts.

**Program Update – Statewide IST Off-Ramp (SISTOR) Program.** DSH reports it is electing to dissolve the Statewide IST Off-Ramp (SISTOR) program, resulting in General Fund savings of $1 million in 2021-22 and annually thereafter. As DSH began to implement its Re-Evaluation Services for Felony ISTs program authorized in the 2021 Budget Act, DSH identified a need for a standardized assessment process and evaluation report. The SISTOR contract was inconsistent with that approach, with the provider using an independent assessment process. To avoid creating discrepancies in re-evaluation referrals and reporting standards, DSH elected to cancel the SISTOR contract and dissolve the program.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of each of the program updates referenced in this item.

## Issue 5: State Hospitals Cost of Care and Treatment/Financial Assistance Policy

**Trailer Bill Language Proposal – Governor's Budget.** DSH proposes trailer bill language to update or remove outdated statutory language and provide patient financial relief for billing the cost of care and treatment in a state hospital that does not jeopardize the ability to seek reimbursement from the federal Medicare Program.

**Background.** DSH is required by state law to seek and collect payments for the cost of care from liable patients and their legal representatives. The 2014 Budget Act authorized the creation of the DSH Patient Cost Recovery Section (PCRS) to develop and implement a standardized and streamlined third-party billing program. In particular, PCRS is tasked with maximizing reimbursement of patient treatment costs from the federal Medicare program.

The issue of DSH billing and other financial practices first came to the subcommittee's attention during discussion of a 2019 Budget Act proposal to increase the patient minimum wage for vocational services and sheltered workshop programs. The wages earned by patients in these programs are deposited into the patient's personal deposit fund. Previously, DSH would retain any patient earnings above $500 in the patient's account to support the cost of care and treatment in a state hospital. The Legislature adopted trailer bill language as part of the 2019 Budget Act to prohibit that practice, but the subcommittee identified several other areas of state law that permit DSH to confiscate other funds received by patients, as well as collect for the cost of care and treatment from a patient's or former patient's estate or from family members or other responsible parties.

**Prohibition of Family Billing and Supplemental Reporting Language.** During evaluation of the 2021 Budget Act, advocacy organizations reported clients that received bills for more than $1 million for care and treatment of family members that had been discharged from the state hospital system. According to DSH, as a condition of participation in the federal Medicare program, patients must be required to repay the cost of medical services they receive while in a state hospital program, and the state must enforce this requirement in the same way it enforces the collection of all other debts. However, Medicare does not require billing of family members for these services and the Legislature adopted trailer bill language in the 2021 Budget Act prohibiting that practice, as well. The Legislature also adopted supplemental reporting language to require DSH to prepare a report assessing existing law and guidance pertaining to patient and family member financial liability for the care and treatment at a state hospital facility, necessity of those laws in obtaining Medicare reimbursement, and recommendations regarding patient relief from the financial impact of these requirements.

According to DSH, it receives reimbursement for the treatment and care of its patients from the following sources (includes Lanterman-Petris-Short reimbursements from counties):

| Source | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|
| Medicare Parts A/B | $838,397 | $516,104 | $471,776 | $510,144 |
| Medicare Part D | $1,091,620 | $1,130,527 | $1,045,330 | $989,063 |
| Private Pay | $2,574,851 | $2,538,219 | $1,741,601 | $2,044,477 |
| Other | $109,204 | $117,971 | $47,609 | $125,167 |
| Lanterman-Petris-Short | $156,030,990 | $160,656,436 | $168,617,208 | $166,076,215 |
| Uninsured COVID-19 Reimb | N/A | N/A | N/A | $8,989,126 |

| | | | | |
|---|---|---|---|---|
| CARES Act | N/A | N/A | $491,882 | $458,201 |
| **TOTAL** | **$160,645,082** | **$164,959,257** | **$172,415,406** | **$179,192,393** |

**Existing Welfare and Institutions Code (WIC) Provisions Related to Financial Liability.** In its report released with the Governor's January budget, DSH identified the following statutes related to patient financial liability for the cost of care and treatment at a state hospital:

- Welfare and Institutions Code (WIC) Section 4025 – This section requires DSH to only charge patients for the actual cost of care, which may include treatment, support, maintenance, and other services, and may include costs for capital outlay. DSH reports it complies with these requirements.
- WIC Section 7275 – This section provides generally for financial liability for the cost of care and treatment of a patient or their estate if referred under Penal Code sections. This does not include referrals of sexually violent predators and civil commitments under the Lanterman-Petris-Short Act. However, DSH reports it collects from all patients or their estate to meet federal Medicare regulations.
- WIC Section 7276 – This section authorizes DSH to reduce, cancel or remit the amount to be paid by a patient's estate for the cost of care and treatment in a state hospital, if the estate is unable to pay or the amount is uncollectible.
- WIC Section 7277 – This section requires DSH to collect the charges for the cost of care and treatments for patients in a community health clinic. However, DSH indicates it does not operate public community mental health clinics, nor does it collect for the cost of care and treatment for individuals in the CONREP program for whom it does contract with community mental health clinics. However, DSH does offset housing, food, clothing, and incidental expenses for CONREP clients with any income or benefits available to the patients, such as Supplemental Security Income (SSI) or Social Security Disability Income.
- WIC Section 7277.1 – This section allows DSH to seek reimbursement for liable patients after they are deceased, but within specified time frames.
- WIC Section 7278 – This section requires DSH to conduct an asset determination for all patients liable for the cost of care and treatment in a state hospital.
- WIC Section 7279 – This section allows DSH to file a petition with the courts to require conservators to make payments towards a patient's cost of care and treatment from the patient's estate. DSH reports this is not its existing practice.
- WIC Section 7281 – This section establishes a patient's personal deposit fund and allows DSH to divert any amounts over $500 to the cost of care, support, maintenance, and medical attention. According to DSH, in 2020-21 $121,081 was collected from this practice.
- WIC Section 7281.1 – This section prohibits the diversion of wages from a patient's personal deposit fund received in a vocational rehabilitation or sheltered workshop program.
- WIC Section 7282 – This section authorizes DSH to bring a court action to enforce payments for transportation to a state hospital or for the cost of care and treatment from liable parties.
- WIC Section 7353 – This section requires DSH to pay premiums for third-party health coverage of Medicare beneficiaries who are state hospital patients. This allows DSH to bill Medicare for covered services for eligible patients.

**Proposed Trailer Bill Would Establish Financial Assistance and Delete Obsolete Provisions.** DSH proposes trailer bill language to update or remove outdated statutory language and provide patient financial relief for billing the cost of care and treatment in a state hospital that does not jeopardize the

ability to seek reimbursement from the federal Medicare Program. Specifically, DSH is proposing the following changes to statute.

- Financial Assistance Program (WIC Section 7276) – DSH is proposing to amend WIC Section 7276 to require development and implementation of a financial assistance program to reduce or cancel the amount a patient owes for the cost of care and treatment. Criteria for eligibility for the program would include the following factors: 1) income level, 2) essential living expenses and financial liabilities, 3) and public benefit program participation (e.g. Medi-Cal and Social Security). The program would also allow DSH to develop reasonable payment plans suited to the patient's ability to pay.
- Repeal Authority Requiring Sales of Estate Property (WIC Section 7279) – DSH is proposing to repeal statutory authority to order a guardian or conservator over a patient's estate to sell the estate's property to pay for the cost of care and treatment. DSH indicates this practice is not a necessary collection effort and is not in alignment with its mission or goals.
- Repeal Removal of Funds from Patient Personal Deposit Fund (WIC Section 7281) – DSH is proposing to repeal its authority to remove funds in excess of $500 from a patient's personal deposit fund. DSH indicates allowing patients to accumulate income in excess of $500 would ease their transition into the community upon discharge.
- Repeal Ability of DSH to Apply to be Patient Guardian or Conservator (WIC Sections 7284 and 7287) – DSH proposes to repeal its authority to apply to the court to be appointed as guardian or conservator of a person's estate. DSH believes engaging in this practice would be a conflict of interest.
- Repeal Ability of DSH to Invest Estate Funds (WIC Sections 7285, 7286, and 7290) – DSH proposes to repeal its authority to invest funds held as executor, administrator, guardian, or conservator of estates. DSH believes engaging in these practices would be a conflict of interest.
- Repeal Obsolete Provisions for County Payments for Patients (WIC Sections 7291 and 7292) – DSH proposes to repeal requirements that counties pay for the cost of care and treatment for individuals referred to state hospitals under obsolete commitment categories.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of the changes to state hospitals financial procedures contained in the proposed trailer bill language.

## Issue 6: Administrative Services Workload

**Budget Change Proposal – Governor's Budget.** DSH requests 12 positions and General Fund expenditure authority of $1.7 million annually. If approved, these positions and resources would allow DSH to address additional administrative workload resulting from increases in staff in recent years and to address complex policy issues.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $1,699,000 | $1,699,000 |
| **Total Funding Request:** | **$1,699,000** | **$1,699,000** |
| **Total Requested Positions:** | **12.0** | **12.0** |

* Positions and resources ongoing after 2023-24.

**Background.** Over the past several fiscal years, the Legislature has approved DSH proposals that have significantly increased the number of staff positions throughout the state hospital system. The DSH Mission-Based Review proposals, covering the areas of protective services, treatment teams, direct care nursing, workforce development, and court evaluations and reports, will add a total of 829.5 positions to DSH once fully implemented. In addition, expansions of capacity at Metropolitan and Coalinga State Hospitals will add 475.7 positions and 81.2 positions, respectively, when fully implemented. Several other proposals, including implementation of an electronic health records system and development of telepsychiatry resources, have also increased staff positions at DSH.

DSH reports its administrative services workload has increased significantly along with the increase in staff. DSH human resources staff are experiencing increases in personnel workload such as recruitment and hiring, onboarding and training, grievances and employee discipline, increased management consultation and special projects, and monthly payroll and benefits transaction processing. DSH's Office of Human Rights, which is responsible for implementing non-discrimination policies and the Equal Employment Opportunity (EEO) program, has also experienced an increase in workload related to additional staff. DSH budget staff are also experiencing increased workload related to fiscal oversight, accountability, and analysis.

In addition to administrative services workload related to increased staff, DSH research, evaluation, and data staff have experienced increased workload related to the need for evaluation of data related to implementation of new programs and initiatives.

**Staffing and Resource Request.** DSH requests 12 positions and General Fund expenditure authority of $1.7 million annually to address additional administrative workload resulting from increases in staff in recent years and to address complex policy issues. Specifically, DSH requests the following positions and resources:

Human Resources Branch – Nine positions

- **One Staff Services Manager (SSM) I** position and **eight Associate Governmental Program Analysts (AGPA)** would provide sufficient resources to support the personnel management needs of the department. The SSM I position would be located in Sacramento, while one AGPA would be

located at each of the five state hospitals, with one additional AGPA at Napa, Patton, and Coalinga. These staff would support recruitment and hiring of newly established positions, completing compliance workload and processing personnel transactions.

Office of Human Rights – One position

- **One SSM I** position would provide direct supervision of existing EEO investigators and provide oversight of the complaints and investigations workload. The SSM I would train new investigators, provide ongoing education and training on new EEO laws, policies, and investigative tools, and review all EEO investigative reports and external responses. The SSM I would also be responsible for conducting more complex investigations and external responses.

Budget Management Branch – One position

- **One SSM I** position would develop all Mission-Based Review project-related documents including meeting materials, action plans, risk or issue logs, as-is and to-be workflows, and communication plans.

Research, Evaluation, and Data Branch – One position

- **One Research Data Specialist I** position would conduct an annual population review of the four primary staffing groups included in the Mission-Based Review project: forensic, nursing, treatment team/primary care, and protective services. The position would also collect and update data points that drive staffing workload for each group, assess changes to hospital units, update the Unit Categorization Matrix, collect and update data points that drive patient-driven or task-driven methodologies, and assess potential changes to hospital layouts to evaluate impacts to fixed or layout-based methodologies.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 7: Data Governance and De-identification Compliance

**Budget Change Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $1.5 million in 2022-23 and 2023-24. If approved, these resources would allow DSH to establish the leadership for its Research, Evaluation, and Data Insights (REDI) Program, which would implement a comprehensive data strategy, stablish a data governance structure, and comply with state data de-identification guidelines.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $1,457,000 | $1,457,000 |
| **Total Funding Request:** | **$1,457,000** | **$1,457,000** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** According to DSH, the state hospital system and related programs manage a significant amount of health information data including patient pre-admission and discharge data, clinical data, law enforcement data, and administrative and operational data for its programs. In addition, DSH collects health information data in the categories of psychiatric treatment planning and delivery, medical treatment delivery, forensic evaluation and court reporting, pharmacy, law enforcement and criminal offense data, billing and utilization, licensing, health and safety, administration, and community re-entry.

DSH reports much of its current data analytics work requires manual data collection, merging, reconciliations, adjustments, and data cleanup. DSH provides several regular reports on a daily, weekly, and monthly basis for internal and external stakeholders. According to DSH, automation and standardization of these efforts would allow for more rapid analytics. DSH plans to establish a Research, Evaluation, and Data Insights (REDI) program to implement a comprehensive data strategy, and establish a data governance structure. The REDI data team would guide business teams to standardize best practice governance and quality processes that reduce the time to get to analysis and insights while balancing the operational needs of the business teams to reduce burdens.

**Data De-identification Guidelines.** Federal and state privacy laws require data de-identification when disclosing personally protected health information or personally identifiable information without the authorization of the individual. The California Health and Human Services Agency (CalHHS) is developing a data de-identification guidelines (DDG) policy directive to provide guidance to departments to implement DDG and ensure compliance with federal and state privacy laws. DSH reports it needs additional resources to fully adhere to the CalHHS policy direction, including in the expert determination process and governance.

**Resource Request.** DSH requests General Fund expenditure authority of $1.5 million in 2022-23 and 2023-24 to establish the leadership for its Research, Evaluation, and Data Insights (REDI) Program, which would implement a comprehensive data strategy, stablish a data governance structure, and comply with state data de-identification guidelines. According to DSH, the REDI Program would include research, data, and technology expertise to enable continuous advancement in health data analytics, governance and privacy compliance, data automation and transparency, and research and evaluation of services and operations. Specifically, DSH requests the following resources:

- Resources equivalent to **one Career Executive Appointment Range C** position would serve as the Chief Data Officer, leading and overseeing the establishment of the REDI program, operating as the senior executive responsible for creating the strategy and vision for achieving a comprehensive data program that provides data solutions across all programmatic, clinical, and operational needs.
- Resources equivalent to **one Staff Services Manager III** position would serve as a Research Data Officer to establish, oversee, and directly lead the DSH Data Governance Program. The program would include a Data Governance Advisory Council and a Data Governance Team to address four primary data functions: 1) data quality and utility, 2) data literacy, 3) expert determination and privacy compliance, and 4) data escalation and acquisition.
- Resources equivalent to **one Staff Services Manager III** position would serve as Research Manager and would function as the primary expert supervisor over Expert Determination Program. The position would provide direct supervision of DDG practices, applying expert determination scoring, and certifying all scoring and recommendations prior to external release of data.
- Resources equivalent to **one Staff Services Manager II Specialist** position would function as lead across strategic planning activities, coordinate with executives and teams and guide the selection of key performance indicators for monitoring the performance of all goals, objectives, and projects.
- Resources equivalent to **one Information Technology Specialist (ITS) III** position would serve as a Data Engineer and would lead collaboration across business and IT units in building, managing, and operationalizing data pipelines in support of key data and analytics use cases.
- Resources equivalent to **one ITS III** position would serve as a Data and Information Architect and would lead the strategy for technology and business teams in the design, implementation, and health management of enterprise-wide data technologies and processes.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 8: DSH-Napa Camille Creek Implementation, Monitoring, Adaptive Management Plan

**Budget Change Proposal – Governor's Budget.** DSH requests six positions and General Fund expenditure authority of $1.1 million in 2022-23 and $1 million annually thereafter. If approved, these positions and resources would allow DSH to implement and maintain operations of water storage facilities at Napa State Hospital in compliance with the California Fish and Game Code.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $1,141,000 | $1,016,000 |
| **Total Funding Request:** | **$1,141,000** | **$1,016,000** |
| **Total Requested Positions:** | **6.0** | **6.0** |

* Positions and resources ongoing after 2023-24.

**Background.** Napa State Hospital manages five water storage facilities that historically had been used to meet domestic and agricultural water needs of the hospital. These facilities continue to operate as water impoundments but are no longer used for domestic or agricultural water consumption. The operation of these facilities affect the timing and flow of water passing through the structures and may impact downstream fish populations in Camille Creek. State fish and wildlife laws require sufficient water to pass through a dam to keep any fish below the dam in good condition.

In 2018, Water Audit California filed a lawsuit alleging violations of state fish and game laws governing water impoundment at the Lake Marie and Lake Camille dams operated by DSH at Napa. Under a proposed settlement to address the claims in the lawsuit, DSH would need to complete ongoing stream assessments and modify the operations of the Lake Marie dam. DSH would also have to coordinate with, and receive approval from, the California Department of Fish and Wildlife. DSH reports it retained a consultant to develop an Implementation, Monitoring, and Adaptive Management Plan (IMAMP) for compliance with the relevant fish and wildlife laws. The IMAMP document would summarize existing baseline conditions (e.g. hydrology, fish habitat, fish species distribution), identify the facilities that can be used to augment flow, and describe the proposed flow release regime. The IMAMP would include the following components:

- Implementation procedures including: 1) valve testing and calibration of flows to ensure flow release amounts; 2) development of a flow release schedule including timing, metrics, triggering flow releases, and duration; 3) procedures for initiating and curtailing flow releases, including determining flow release amounts; 4) identification of DSH personnel authorized to make flow releases; 5) communication protocol for flow releases; and 6) safety procedures to be followed during all aspects of the flow release program.
- Monitoring procedures including: 1) flow monitoring below the Lake Marie outlet with installation of a stream gauging station, discharge measurements during flow releases, and development of a state-discharge rating curve; 2) reservoir elevation monitoring with installation of a water level recorder and barometric pressure transducer near low lake elevation valve; 3) water temperature monitoring with installation of a longitudinal array of temperature recorders; and 4) wet-dry habitat mapping.

- Biological monitoring procedures including: 1) fish surveys in areas wetted by flow releases; 2) annual fish surveys in the inlet tributary; and 3) qualitative invertebrate sampling within areas wetted by flow releases.

**Staffing and Resource Request.** DSH requests six positions and General Fund expenditure authority of $1.1 million in 2022-23 and $1 million annually thereafter to implement and maintain operations of water storage facilities at Napa State Hospital in compliance with the California Fish and Game Code. Specifically, DSH requests the following:

- **One Chief of Plant Operations II** position would oversee and direct all activities and have oversight of the compliance efforts.
- **Two Stationary Engineers** would collect and analyze data and adjust and repair mechanical equipment associated with the dams.
- **One Chief Engineer** would supervise staff and oversee the overall operation and maintenance of the onsite equipment.
- **One Maintenance Mechanic** would maintain daily work order logs, inspect and repair equipment, and complete miscellaneous minor dam construction and repair work.
- **One Research Data Analyst** would compile the acquired data and prepare draft reporting documentation.

In addition to these positions, DSH requests General Fund expenditure authority of $300,000 in 2022-23 and $175,000 annually thereafter to support contracted subject matter experts to assist in implementing the recommended flow release program by installing flow measurement and recording devices, calibrating the gate valve to establish the flow release, initiating the data collection protocol, assessing the program impact on fish habitat and populations, and training DSH staff until knowledge and expertise is gained to conduct these activities on an ongoing basis.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 9: Electronic Health Records Phase 3 – Wireless Network Upgrades

**Budget Change Proposal – Governor's Budget.** DSH requests six positions and General Fund expenditure authority of $2.4 million in 2022-23, two additional positions and General Fund expenditure authority of $19.8 million in 2023-24, two additional positions and General Fund expenditure authority of $20.8 million in 2024-25, and $8.2 million annually thereafter. If approved, these positions and resources would allow DSH to prepare for and support operation of the enterprise Continuum Electronic Health Records (EHR) Project.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $2,366,000 | $19,802,000 |
| **Total Funding Request:** | **$2,366,000** | **$19,802,000** |
| **Total Requested Positions:** | **6.0** | **8.0** |

* Additional fiscal year resources requested – 2024-25: 10 positions and $20,769,000; 2025-26 and ongoing: $8,236,000.

**Background.** In 2017, DSH began a project to implement an integrated electronic health record (EHR) for state hospital patients, submitting a Stage 1 Business Analysis and Stage 2 Alternatives Analysis to the California Department of Technology (CDT) as part of its Project Approval Lifecycle (PAL) process. The 2018 Budget Act included four positions and General Fund expenditure authority of $1.3 million in 2018-19 and $713,000 in 2019-20 for DSH to complete Stages 3 and 4 of the PAL process for implementation of the EHR system. Due to the COVID-19 pandemic, DSH received approval in the 2020 Budget Act to extend the timeline of the project for two years, with a go-live date of 2026.

DSH reports that when the EHR system is implemented, it will employ its current wireless network to support wireless medical devices, such as tablets, blood pressure cuffs, and glucometers. According to reports from other healthcare providers, EHR implementation has the potential to increase wireless traffic by as much as three-fold. DSH is planning to enhance its networks and implement a technology that would allow its wireless access points to automatically re-calibrate to maintain network accuracy and integrity. The EHR solution would support patient triage, care management functions, administrative functions, document management, email, web browsing, real-time image transfer, bi-directional data exchange, telemedicine, remote system monitoring, and administration.

**Staffing and Resource Request.** DSH requests six positions and General Fund expenditure authority of $2.4 million in 2022-23, two additional positions and General Fund expenditure authority of $19.8 million in 2023-24, two additional positions and General Fund expenditure authority of $20.8 million in 2024-25, and $8.2 million annually thereafter to prepare for and support operation of the EHR project. Specifically, DSH requests the following positions and resources:

- Wireless Local Area Network (WLAN) Upgrade – DSH requests resources to begin upgrading its wireless local area networks (WLAN). DSH plans to begin the upgrade in 2022-23 with one hospital. Two additional hospitals would receive upgrades in 2023-24, and the final two hospitals would receive upgrades in 2024-25.
- WLAN Network Staff – **Five Information Technology (IT) Specialist I** positions would serve as wireless network analysts at each of the five state hospitals. One position would be added in 2022-23,

two positions would be added in 2023-24, and two more positions would be added in 2024-25 as the upgrades occur in each of the state hospitals.

- Senior IT Personnel – **Four IT Specialist III** positions and **one IT Specialist II** position would support expansion of IT security, network, application development, and technical integration staff.
- Project Team Equipment – DSH is requesting resources for equipment (laptops, monitors, and software) for each member of the project team, estimated to be 75 individuals (49 DSH staff plus 26 contract employees).
- Project Oversight – Oversight of the PAL process would be provided by the CDT Office of Statewide Project Delivery and Statewide Technology Procurement Division. DSH is billed monthly for these oversight costs.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 10: Increasing Regulations Resources to Improve Operations and Mitigate Risk

**Budget Change Proposal – Governor's Budget.** DSH requests three positions and General Fund expenditure authority of $510,000 annually. If approved, these positions and resources would allow DSH to meet demand for DSH to promulgate regulations, resulting in standardization of practices, transparency, and accountability across the DSH integrated behavioral health system.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $510,000 | $510,000 |
| **Total Funding Request:** | **$510,000** | **$510,000** |
| **Total Requested Positions:** | **3.0** | **3.0** |

* Positions and resources ongoing after 2023-24.

**Background.** According to DSH, the Regulations and Policy Unit (RPU) was initially staffed to coordinate a minimal number of regulations. However, as DSH has moved towards operating as an integrated behavioral health system, the need for promulgation of new regulations to support operation of new programs has increased. The RPU currently has four positions, one manager and three analyst positions, responsible for reviewing all hospital administrative directives and policies for regulatory language.

DSH reports that, as a result of insufficient staffing to promulgate regulations, it received 16 underground regulation challenges in 2018-19 and an additional four challenges in 2020-21. In addition, insufficient staffing has led to delays in regulations, such as those for the enhanced treatment program to treat patients at high risk of dangerous behavior.

**Staffing and Resource Request.** DSH requests three positions and General Fund expenditure authority of $510,000 annually to meet demand for DSH to promulgate regulations, resulting in standardization of practices, transparency, and accountability across the DSH integrated behavioral health system. Specifically, DSH requests the following positions and resources:

- Research and Policy Unit – **Two Associate Governmental Program Analysts** would enable DSH to process additional regulatory packages and complete the necessary analysis of existing policies and regulations. Addition of these staff are expected to result in a three-fold increase in the amount of regulations processed annually.
- Legal Division – **One Attorney III** position would assist the RPU with review of rulemaking packages to ensure compliance with the Administrative Procedures Act and other statutes or mandates that affect the state hospitals and their operations.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 11: Statewide Plant Operations Workload

**Budget Change Proposal – Governor's Budget.** DSH requests 26 positions and General Fund expenditure authority of $2.6 million annually. If approved, these positions and resources would allow DSH to expand plant operations capacity at the five state hospitals to address deferred maintenance backlogs, regulatory compliance projects, and preventative maintenance programs.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $2,629,000 | $2,629,000 |
| **Total Funding Request:** | **$2,629,000** | **$2,629,000** |
| **Total Requested Positions:** | **26.0** | **26.0** |

* Positions and resources ongoing after 2023-24.

**Background.** According to DSH, its five state hospitals are comprised of 474 buildings, more than 6.6 million square feet of space on 2,600 acres of land. The oldest state hospital campus is 145 years old. DSH reports that several factors have hindered its ability to sustain the environmental and physical requirements of its hospital campuses and mitigate system-wide infrastructure deficiencies. Some of these factors include: older buildings originally designed for civilly committed patients, increased referrals to DSH, aging interior building infrastructure (plumbing, mechanical, electrical, elevators), aging campus infrastructure (roads, parking lots, utilities, water, fire water lines, sewage/wastewater, storm drainage), seismically deficient buildings, and regulatory compliance (e.g. Americans with Disabilities Act, historical buildings, building codes). In addition, surveys and inspections by the State Fire Marshall, the Joint Commission, and the Department of Public Health have identified the need for plumbing repairs, replacement of rusty vents, additional signage, equipment testing improvements, extension of smoke barriers, repair of negative pressure in isolation rooms, repair of chipped or peeling paint, and replacement of broken patient beds.

The 2020 Budget Act included General Fund expenditure authority of $15 million and the 2021 Budget Act included General Fund expenditure authority of $100 million to address the most essential deferred maintenance and repair projects including roof replacement, replacing chillers and water tanks, and emergency access road repairs.

**Staffing and Resource Request.** DSH requests 26 positions and General Fund expenditure authority of $2.6 million annually to expand plant operations capacity at the five state hospitals to address deferred maintenance backlogs, regulatory compliance projects, and preventative maintenance programs. This request would allow DSH to develop and maintain a proper maintenance program with continuous inspections, data collection, and an analysis of operations. Specifically, DSH requests positions and resources for the following purposes:

<u>Emergency Repairs, Deferred Maintenance, and Preventative Maintenance</u> – 10 positions

- **Five Maintenance Mechanics** and **five Electrician I** positions, one at each of the five state hospitals, would oversee work on 22 essential deferred maintenance and repair projects. These positions would be responsible for: maintaining and repairing electrical equipment, testing and inspecting electrical motors and controls, prepping and maintaining work orders, testing of emergency generators,

performing preventative maintenance tests on electrical equipment, inspecting and troubleshooting plumbing systems, performing risk assessments on plumbing apparatus, removing ligature risks, maintaining and repairing fixtures and equipment, tool control, maintaining and requisitioning materials, and assessing emergency repairs and appropriate courses of actions for timely remediation.

Regulatory Compliance Projects – 10 positions

- **Five Stationary Engineers** and **five Plumber I** positions, one at each of the five state hospitals, would focus on projects relative to implementation of federal Centers for Medicare and Medicaid Services (CMS), Joint Commission, and other unplanned regulatory mandates. These positions would prioritize compliance projects for mandates that take effect in January 2022, including standards for Water Management Plans. These positions would be responsible for maintaining sewage treatment plants; repairing clarifiers, bio-filters, digesters, related equipment, pumps, lines, and motors; taking water samples and recording results daily; performing weekly cooling tower chemical testing and analysis; adjusting chemical feed rates; documenting temperature and activity readings; calibrating equipment sensors; and installing, maintaining, inspecting, and repairing plumbing equipment and systems.

Project Management and Oversight Team – Six positions

- **One Project Director III** position and **five Associate Construction Analysts** would establish a Project Management and Oversight Team, which would work directly with hospital Plant Operations, Executive Management, and state control agencies in all phases of DSH projects. The team would provide guidance and technical expertise in the following areas of architectural and engineering design and construction management: budget package development; preliminary plan development, review, and critique; working drawing development, review, and critique, construction primary point of contact, periodic observation of construction; problem solving for unforeseen conditions; and information gathering for decision making.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 12: Quality Improvement and Internal Auditing, Monitoring, Risk Management

**Budget Change Proposal – Governor's Budget.** DSH requests 11 positions and General Fund expenditure authority of $1.6 million annually. If approved, these positions and resources would allow DSH to support standards compliance and quality improvement operations, and provide resources to conduct independent financial, operational, compliance, and performance audits.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $1,593,000 | $1,593,000 |
| **Total Funding Request:** | **$1,593,000** | **$1,593,000** |
| **Total Requested Positions:** | **11.0** | **11.0** |

* Positions and resources ongoing after 2023-24.

**Background.** The DSH Statewide Quality Improvement Division (SQID) guides and monitors policy formulation and implementation of an integrated quality improvement program at the five state hospitals. The SQID includes four unites: the Statewide Quality Improvement Program (SQIP), the Standards Compliance/Quality Improvement (SC/QI) unit, the Office of Audits (OOA), and Enterprise Health and Safety (EHS). These four units are responsible for the following:

*Statewide Quality Improvement Program (SQIP) Unit.* The Statewide Quality Improvement Program (SQIP) Unit provides overall guidance and direction for the SQID, and provides technical support for the DSH Governing Body, including facilitating statewide communication of meetings, reports, and decisions. The DSH Governing Body is the entity that is legally responsible for the conduct of the hospital, pursuant to federal and state regulations.

*Standards Compliance/Quality Improvement (SC/QI) Unit.* The Standards Compliance and Quality Improvement (SC/QI) Unit is responsible for centralized coordination of monitoring, oversight, and compliance with federal and state laws, regulations, policies, and procedures. These include compliance with Department of Public Health (DPH) licensing regulations, Joint Commission hospital accreditation standards, and federal Centers for Medicare and Medicaid Services (CMS) regulations. The SC/QI Unit also develops and maintains oversight of the statewide quality improvement program, which includes the following focus areas:

1. Performance Improvement – a data driven methodology approach to continuous study and improvement of processes, systems, and structures within a healthcare facility that directly impact the safety and quality of care, treatment, and services provided to patients and others.
2. Quality Assurance – a systemic process that monitors and evaluates various aspects of patient care to ensure that established standards of quality are maintained and met.
3. Incident Management – activities within a system that identify and analyze hazards to patient safety, security, and treatment and hospital operation and property to correct them and prevent recurrence.
4. Clinical Risk Management – an approach to improving the quality and safety of healthcare services by identifying the circumstances and chances that put patients at risk of harm and then acting to prevent or manage those risks.
5. Clinical Outcomes – endpoints chosen that reflect the efficacy of interventions on patient care at a particular point in time.

6. Regulatory Compliance – a process for compliance with relevant laws, standards, policies, regulations, and guidelines.

In addition, DSH reports the SC/QI unit assumed additional roles and responsibilities to support, assess, implement, and evaluate the department's COVID-19 pandemic response.

*Office of Audits (OOA).* The Office of Audits (OOA) mitigates risks and enhances the effectiveness of DSH operations by conducting independent and objective audits of the department's program, administrative, and accounting controls.

*Enterprise Health and Safety (EHS) Unit.* The Enterprise Health and Safety (EHS) Unit is responsible for statewide systems coordination and oversight of occupational employee safety and health programs including serving as liaison with Cal/OSHA, emergency planning and preparedness coordination for the state hospital system, conducting ergonomic equipment assessments for employees, and providing specialized project management services.

According to DSH, due to lack of centralized oversight and monitoring with sufficient clinical and analyst staff, DSH has been unable to develop standardized clinical compliance auditing tools, conduct analysis of statewide quality assurance audit data, or establish an integrated systems approach to reviewing survey and investigation findings and implementing corrective measures. The current SQID resources enable development of the infrastructure for an integrated QI program, but do not enable DSH to use the data for statewide QI initiatives, planning purposes, or adequately monitor and identify deviations in practice or compliance measures. In addition, an external peer review of OOA recommended it conduct more performance, operational, and compliance audits to determine if controls are in place and working as intended to help ensure DSH meets its goals and objectives.

**Staffing and Resource Request.** DSH requests 11 positions and General Fund expenditure authority of $1.6 million annually to support standards compliance and quality improvement operations, and provide resources to conduct independent financial, operational, compliance, and performance audits. Specifically, DSH requests the following positions and resources:

SC/QI Unit – Seven positions

- **Two Nurse Consultant I** positions would support statewide clinical QI and risk management; train hospital staff in root cause analysis, incident investigation, serious incident debriefing, and incident data analysis; and conduct semi-annual hospital QI consultation visits.
- **One Staff Services Manager II** position would serve as statewide liaison with the hospital Standards Compliance directors; oversee quality assurance auditing and monitoring functions; prepare statewide quality assurance and QI reports; analyze legislative and regulatory changes related to compliance and oversight by other state entities; and supervise designated employees.
- **Three Associate Governmental Program Analysts** would support statewide Joint Commission and DPH licensing activities; monitor and inform hospitals of changes in licensing and accreditation standards; share licensing and accreditation survey findings across the department; manage the Joint Commission contract; support data collection and analysis related to auditing and monitoring, incident management, and QI projects; and provide technical assistance for policy development.

- **One Office Technician** would provide clerical support; manage travel arrangements and timesheets; coordinate meetings and take minutes; and facilitate intra-departmental communication.

Office of Audits (OOA) – Four positions

- **Four Associate Management Auditor** positions would perform financial, operational, compliance, and performance audits to effectively evaluate, assess, and strengthen internal controls, program compliance, operations, and mitigate risks.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 13: Workplace Violence Prevention in Healthcare Reporting Compliance

**Budget Change Proposal – Governor's Budget.** DSH requests six positions and General Fund expenditure authority of $1.6 million in 2022-23 and $1.1 million annually thereafter. If approved, these positions and resources would allow DSH to support compliance with reporting requirements for prevention of workplace violence in the five state hospitals.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24*** |
| 0001 – General Fund | $1,610,000 | $1,110,000 |
| **Total Funding Request:** | **$1,610,000** | **$1,110,000** |
| **Total Requested Positions:** | **6.0** | **6.0** |

* Positions and resources ongoing after 2023-24.

**Background.** SB 1299 (Padilla), Chapter 842, Statutes of 2014, requires specified healthcare settings to develop and implement a Workplace Violence Prevention Plan and other reforms to improve employee safety. SB 1299 contained language that exempted certain state departments from these requirements, including DSH, the Department of Developmental Services (DDS), and the California Department of Corrections and Rehabilitation (CDCR). However, SB 1299 also authorized the Occupational Safety and Health Standards Board (OSHSB) to require any of these exempt departments to adopt Workplace Violence Prevention Plans.

In October 2016, OSHSB adopted new regulations that continued to exempt CDCR and DDS, but did not exempt DSH. These regulations included the following requirements for DSH:

- Development and implementation of a Workplace Violence Prevention Plan at each hospital
- Utilization of a new statewide violent incident reporting system with data elements defined by Cal/OSHA
- 80 specific procedures for oversight, monitoring, and improvements, where necessary
- Development, implementation, and maintenance of a Violent Incident Log and Violent Incident Report
- Development and delivery of comprehensive violence prevention training to all staff, with refresher training annually for patient contact staff
- Establishment of a system to review and evaluate the effectiveness of the Plan with criteria for staffing, security systems, job design, high risk areas, and conducted with employees and their representatives.

Due to lack of sufficient staff resources, DSH applied for and received from the Department of Industrial Relations (DIR) a temporary experimental variance for the reporting requirements. The variance required that DSH produce and transmit the Violent Incident Report to Cal/OSHA each quarter and include specific data elements including assaults requiring medical attention or hospitalization, weapons, and sexual assaults. The variance also relieved DSH from reporting within 24 hours the use of physical force with a high likelihood of resulting in injury, psychological trauma or stress, and other less severe or potentially violent incidents within 72 hours. DSH received two variance extension approvals in June 2018 and November 2018. DSH applied to OSHSB for a permanent variance in January 2019, but the variance expired while the application was pending review. OSHSB ultimately denied DSH's application for

permanent variance, but DIR approved an extension of the experimental variance until October 1, 2022, to allow DSH sufficient time to secure the necessary resources to address the additional workload associated with the expanded reporting requirements expected when the variance expires.

According to DSH, compliance with SB 1299 requirements will require the following current and new activities:

- Redesign of the Workplace Violence Prevention Plans at each state hospital to reflect the expedited timelines and reporting requirements.
- Redesign training curriculum and retrain all employees on the expedited timelines and reporting requirements.
- Improve data collection and reporting capability to meet the expanded violent incident reporting timelines.

**Staffing and Resource Request.** DSH requests six positions and General Fund expenditure authority of $1.6 million in 2022-23 and $1.1 million annually thereafter to support compliance with reporting requirements for prevention of workplace violence in the five state hospitals, pursuant to SB 1299 and OSHSB regulations. Specifically, DSH requests the following positions and resources:

- **Five Associate Governmental Program Analysts**, one for each hospital, would administer increased workload to meet the expanded 24 hour and 72 hour violent incident reporting requirements that will be implemented when the DIR variance expires.
- **One Information Technology (IT) Specialist I** position would provide necessary data infrastructure, support, and data integration licenses.

DSH also requests one-time consultant services for improving data collection and reporting capabilities through its Wellness and Recovery Model Support System (WaRMSS).

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 14: Atascadero – Sewer and Wastewater Treatment Plant

**Capital Outlay Budget Change Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $4.1 million in 2022-23. If approved, these resources would support preliminary plans for Atascadero State Hospital to provide upgrades to the sewer collection system, installation of a screening system, and connection to the City of Atascadero's wastewater treatment system.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $4,069,000 | $- |
| **Total Funding Request:** | **$4,069,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** According to DSH, Atascadero State Hospital has not made significant improvements to its sewer collection and wastewater treatment plant since it was commissioned in the early 1950s. An assessment by the Central Coast Regional Water Quality Control Board determined the plant's treatment processes will not comply with requirements of a new general order for Waste Discharge Requirements (WDR). The assessment also identified a variety of other deficiencies including improper flow rates complicated by inadequate treatment capabilities and various corroded components. To avoid potential shut down of the plant by the State Water Resources Control Board, DSH proposes to upgrade the sewer collection system and connect to the wastewater treatment plant operated by the City of Atascadero, rather than upgrade the existing plant, due to the significant number of deficiencies identified in the assessment.

**Capital Outlay Request – Preliminary Plans.** DSH requests General Fund expenditure authority of $4.1 million in 2022-23 to support preliminary plans for Atascadero State Hospital to provide upgrades to the sewer collection system, installation of a screening system, and connection to the City of Atascadero's wastewater treatment system. The upgrades to the sewer collection system would include spot repairs, replacement of sections of pipes, and installation of new manholes to provide maintenance access. The screening system would be used to remove certain solids from the sanitary sewer collection system prior to conveying to the city wastewater treatment plant. Connection to the city's plant results in DSH becoming a new city sewer customer, with screened wastewater flowing by gravity to the plant. This connection would result in a one-time Sewer Connection Fee and monthly Sewer Service Charges that would be subject to negotiation and agreement between DSH and the City of Atascadero. These charges would be a function of the average daily wastewater discharge volume and wastewater strength composition.

According to DSH, total project costs are estimated to be $14.2 million, including:

- Preliminary Plans - $4.1 million
- Working Drawings - $1 million
- Construction - $9.1 million

The construction phase costs would include $7.1 million for the construction contract, $495,000 for contingency, $772,000 for architectural and engineering services, and $729,000 for other project costs.

According to DSH, the preliminary plans phase would begin in July 2022 and be completed in July 2023.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 15: Metropolitan – Central Utility Plant Replacement

**Capital Outlay Budget Change Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $1.8 million in 2022-23. If approved, these resources would support preliminary plans for Metropolitan State Hospital to replace its existing Central Utility Plant, which supplies steam for hot water and central heating and chilled water for air conditioning to 32 patient housing and administrative buildings.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $1,835,000 | $- |
| **Total Funding Request:** | **$1,835,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The Central Utility Plant at Metropolitan State Hospital was completed in 1988 and provided a net electrical output of 27,800 kilowatts. Originally built and operated by Wheelabrator Norwalk Energy Corporation, Metropolitan assumed control of plant operations after termination of the contract with Wheelabrator. According to DSH, the plant operates the central steam boiler system and chiller plants, underground mechanical, electrical, and steam distribution infrastructure, energy management systems, and provides connection to the site's natural gas, water, and sanitary sewer lines. DSH reports that the old, inefficient design of the plant and the age of the equipment, along with the lack of modern environmental controls, makes future repair and maintenance difficult and extremely costly. In addition, DSH reports the original steam and underground piping distribution system was installed in 1915 and up to 20 percent of steam is lost through leaks. Major repairs to the infrastructure and full replacement of the older heating and cooling systems are necessary to achieve current operating standards for reliability, efficiency, and cost-effectiveness.

**Capital Outlay Request – Preliminary Plans.** DSH requests General Fund expenditure authority of $1.8 million in 2022-23 to support preliminary plans for Metropolitan State Hospital to replace its existing Central Utility Plant, which supplies steam for hot water and central heating and chilled water for air conditioning to 32 patient housing and administrative buildings. DSH expects the project to: 1) replace the chillers, boilers, and pumps and replace all steam and condensate piping with hot water piping; 2) remove the steam and condensate piping campus-wide; 3) install hot water lines in the tunnels, crawl spaces, and open trenches with removable steel open grating locations; 4) install temporary steam boilers at several locations; and 5) install new boiler plant in the existing gas compressor room, consisting of three hot water boilers and pumps with room for a fourth boiler and pump if needed in the future. According to DSH, the new boilers would be comprised of commercial duty, low emissions equipment certified by the Southern California Air Quality Management District. The hot water pumps would also utilize variable speed operation to maximize plant efficiency.

According to DSH, total project costs are estimated to be $38.7 million, including:

- Preliminary Plans - $1.8 million
- Working Drawings - $1.7 million
- Construction - $35.2 million

The construction phase costs would include $28.5 million for the construction contract, $2 million for contingency, $2.5 million for architectural and engineering services, and $2.2 million for other project costs.

According to DSH, the preliminary plans phase would begin in July 2022 and be completed in November 2022.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 16: Metropolitan – Fire Water Line Connection to Water Supply

**Capital Outlay Budget Change Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $548,000 in 2022-23. If approved, these resources would support preliminary plans for Metropolitan State Hospital to provide the capacity of water required for its fire sprinkler system to comply with current fire code requirements.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $548,000 | $- |
| **Total Funding Request:** | **$548,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** According to DSH, marginal pressure and fire flows serving the new fire sprinkler system in the Central Kitchen at Metropolitan State Hospital resulted in a new fire water line project in 2011. The project included laying approximately 2,760 feet of dedicated fire main pipe from the existing storage tank site to the Central Kitchen. In addition, a 16-inch water line was designed to connect from the outlets of both existing 750,000 gallon steel water tanks. However, before completion of the project the State Fire Marshall inspector discovered the outlets on both water tanks did not possess an anti-vortex plate. As a result the project was not completed and there is no dedicated fire suppression line throughout the hospital as required by the National Fire Protection Association (NFPA).

**Capital Outlay Request – Preliminary Plans.** DSH requests General Fund expenditure authority of $548,000 in 2022-23 to support preliminary plans for Metropolitan State Hospital to provide the capacity of water required for its fire sprinkler system to comply with current fire code requirements. DSH proposes to demolish one of the existing 750,000 gallon steel tanks and replace it with a new 1 million gallon dedicated fire water storage tank that would be able to meet current and future NFPA fire water flow requirements. The project would provide adequate fire flows and pressures to the fire suppression sprinkler systems for the hospital's Central Kitchen, skilled nursing facility, and Administration building. In addition, the project would allow for future expansion of the system to cover the entire hospital campus, including sizing the pump house for a future additional set of fire water pumps.

According to DSH, total project costs are estimated to be $8.8 million, including:

- Preliminary Plans - $548,000
- Working Drawings - $486,000
- Construction - $7.8 million

The construction phase costs would include $6.5 million for the construction contract, $454,000 for contingency, $603,000 for architectural and engineering services, and $245,000 for other project costs.

According to DSH, the preliminary plans phase would begin in July 2022 and be completed in November 2022.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 17: Atascadero – Potable Water Booster System

**Capital Outlay Budget Change Proposal – Governor's Budget.** DSH requests General Fund expenditure authority of $1.9 million in 2022-23. If approved, these resources would the construction phase of the continuing project to install a potable water booster pump system to improve the performance of the main water system at Atascadero State Hospital.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $1,906,000 | $- |
| **Total Funding Request:** | **$1,906,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** According to DSH, Atascadero State Hospital's water supply is generated from five underground wells located on the northeast part of the campus. Each well station has a pump that sends water from the wells to an adjacent underground reservoir, from which it is pumped to a one million gallon storage tank on top of a hill. The storage tank then supplies water to the hospital by gravity feed. This gravity line supports the hospital's fire sprinkler system, as well as patient showers, kitchens, and bathrooms.

DSH reports when multiple users draw water, the hospital's main water pressure drops considerably. Water pressure during normal operations averages between 40 and 50 pounds per square inch (psi), which is below the necessary 60 psi required for normal facility operations. According to DSH, the reduced pressure could compromise the hospital's fire sprinkler system in the event of a fire.

**Capital Outlay Request – Construction.** DSH requests General Fund expenditure authority of $1.9 million in 2022-23 for the construction phase of the continuing project to install a potable water booster pump system to improve the performance of the main water system at Atascadero State Hospital. According to DSH, the project would include installation of a booster pump station parallel to the existing main line. The pump station would consist of five pumps that would turn on when the inlet pressure drops. When the pressure rises to an acceptable level, the booster pump station would shut off and the existing gravity system would provide the required pressure to the buildings. A second in-line booster pump would also be installed parallel to the distribution line at the central plant feeding the water system to handle peak demand.

According to DSH, total project costs are estimated to be $2.3 million, including:

- Preliminary Plans - $133,000
- Working Drawings - $229,000
- Construction - $1.9 million

The construction phase costs would include $1.5 million for the construction contract, $103,000 for contingency, $180,000 for architectural and engineering services, and $156,000 for other project costs.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.

## Issue 18: Patton – Fire Alarm System Upgrade - Reappropriation

**Capital Outlay Budget Change Proposal – Governor's Budget.** DSH requests reappropriation of General Fund expenditure authority of $9.4 million originally approved in the 2018 Budget Act. If approved, these resources would support the construction phase of a project to remove and replace fire alarm systems in four secured patient housing buildings and treatment areas at Patton State Hospital.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2022-23** | **2023-24** |
| 0001 – General Fund | $9,428,000 | $- |
| **Total Funding Request:** | **$9,428,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** According to DSH, the existing alarm systems at Patton State Hospital are not serviceable and have reached the end of their usable life. In addition, the Department of General Services reports the systems are not in compliance with regulatory requirements and industry standards including occupancy requirements (I-2 and I-3) set by the State Fire Marshal, National Fire Protection Association (NFPA) codes, and Underwriters Laboratory (UL) standards. The project would remove and replace alarm systems in four buildings at Patton that house the majority of patients and contain satellite kitchens, dining rooms, medical clinics, and dental clinics. The 2015 Budget Act authorized General Fund expenditure authority of $731,000 for preliminary plans and the 2016 Budget Act authorized General Fund expenditure authority of $554,000 for working drawings. The 2018 Budget Act included General Fund expenditure authority of $9.4 million in 2018-19 to continue to the construction phase of the fire alarm replacement project at Patton. At the time of approval, DSH expected the project to proceed to bid in October 2018, the contract to be awarded in January 2019, and the project to be completed in December 2020. However, due to delays in the regulatory review process and impacts of the COVID-19 pandemic, DSH requests reappropriation of this funding to complete the construction phase of the project.

**Capital Outlay Request – Construction.** DSH requests reappropriation of General Fund expenditure authority of $9.4 million originally approved in the 2018 Budget Act to support the construction phase of a project to remove and replace fire alarm systems in four secured patient housing buildings and treatment areas at Patton State Hospital.

According to DSH, total project costs are estimated to be $10.7 million, including:

- Preliminary Plans - $731,000
- Working Drawings - $554,000
- Construction - $9.4 million

The construction phase costs would include $6.6 million for the construction contract, $463,000 for contingency, $843,000 for architectural and engineering services, and $1.5 million for other project costs.

According to DSH, construction would begin in March 2022 and be completed in August 2024.

**Subcommittee Staff Comment and Recommendation—Hold Open.** Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

**Questions.** The subcommittee has requested DSH to respond to the following:

1. Please provide a brief overview of this proposal.