*Senate Budget and Fiscal Review—Holly J. Mitchell, Chair*

# SUBCOMMITTEE NO. 3 Agenda

**Senator Richard Pan, M.D., Chair**
**Senator Melissa Hurtado**
**Senator Jeff Stone**

**Tuesday, May 14, 2019**
**10:00 a.m.**
**State Capitol - Room 4203**

**PART A**

Consultant: Scott Ogus

## PUBLIC COMMENT

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# ISSUES FOR DISCUSSION

## 0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
## 4260 DEPARTMENT OF HEALTH CARE SERVICES
## 5180 DEPARTMENT OF SOCIAL SERVICES

### Issue 1: State Verification Hub Planning Activities (Issue 405-MR)

**May Revision.** The Administration requests that the following items be modified to begin planning activities for a State Verification Hub to enhance eligibility verifications in public assistance programs. The requested adjustments are as follows:

- Health and Human Services Agency - The Administration requests that Item 0530-001-9745 be increased by $747,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Health Care Services – The Administration requests that Item 4260-001-0001 be increased by $78,000 and Item 4260-001-0890 be increased by $77,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Social Services – The Administration requests that Item 5180-001-0001 be increased by $149,000 and one position and Item 5180-001-0890 be increased by $144,000 and one position on a two-year limited-term basis to support two positions.

**Staff Comment and Recommendation – Hold Open**.

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

1. Please provide a brief overview of this proposal.

## 4265 DEPARTMENT OF PUBLIC HEALTH

### Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

**DOF Issue#:** 4265-003-ECP-2019-GB
4265-036-BBA-2019-GB
4265-401-ECP-2019-MR

**ADAP Local Assistance Estimate May Revision Update.** The May 2019 ADAP Local Assistance Estimate reflects revised 2018-19 expenditures of $407.5 million, which is a decrease of $362,000 or less than 0.1 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced medication expenditures for medication-only clients. For 2019-20, DPH estimates ADAP expenditures of $449.5 million, a decrease of $320,000 or less than 0.1 percent, compared to the Governor's January Budget, and an increase of $42 million or 10.3 percent, compared to the revised 2018-19 estimate. DPH also reports this decrease is primarily due to reduced medication expenditures for medication-only clients.

| **ADAP Local Assistance Funding 2018-19 May Revision Comparison to January Budget** | | |
|---|---|---|
| **Fund Source** | ***January Budget*** | ***May Revision*** |
| 0890 – Federal Trust Fund | $129,143,000 | $129,143,000 |
| 3080 – AIDS Drug Assistance Program Rebate Fund | $278,735,000 | $278,373,000 |
| **Total ADAP Local Assistance Funding – All Funds** | **$407,878,000** | **$407,516,000** |

| **ADAP Local Assistance Funding 2019-20 May Revision Comparison to January Budget** | | |
|---|---|---|
| **Fund Source** | ***January Budget*** | ***May Revision*** |
| 0890 – Federal Trust Fund | $135,138,000 | $135,138,000 |
| 3080 – AIDS Drug Assistance Program Rebate Fund | $314,650,000 | $314,330,000 |
| **Total ADAP Local Assistance Funding – All Funds** | **$449,789,000** | **$449,468,000** |

ADAP tracks caseload and expenditures by client group. After May Revision updates, DPH estimates ADAP caseload and expenditures for 2018-19 and 2019-20 will be as follows:

| **Caseload by Client Group** | **2018-19** | **2019-20** |
|---|---|---|
| **Medication-Only** | 12,809 | 12,580 |
| **Medi-Cal Share of Cost** | 118 | 136 |
| **Private Insurance** | 9,883 | 10,687 |
| **Medicare Part D** | 7,683 | 7,683 |
| **Pre-Exposure Prophylaxis (PrEP) Assistance Program** | 1,490 | 3,542 |

| Expenditures by Client Group | 2018-19 | 2019-20 |
|---|---|---|
| **Medication-Only** | $304,807,079 | $315,972,368 |
| **Medi-Cal Share of Cost** | $1,071,494 | $1,477,505 |
| **Private Insurance** | $65,031,384 | $87,982,784 |
| **Medicare Part D** | $23,838,377 | $27,631,337 |
| **PrEP Assistance Program** | $3,865,266 | $7,309,358 |

**Enrollment and Case Management Reimbursement Update.** In addition to expenditures for services to clients, the ADAP Local Assistance Estimate also includes funds for a variety of enrollment, case management, and quality improvement efforts to support the program. Previously, enrollment sites received a fixed reimbursement for these activities. Beginning in 2017-18, a new reimbursement methodology includes a payment floor and total payment dependent on volume of the following services:

1. New Medication Enrollment
2. Bi-Annual Self-Verification
3. ADAP Annual Re-Enrollment
4. New Insurance Assistance Enrollment
5. Insurance Assistance Annual Re-Enrollment
6. New PrEP Enrollment
7. PrEP Re-Enrollment
8. Paid PrEP Related Out-of-Pocket Claims
9. Paid Insurance Assistance Medical Out-of-Pocket Claims.

According to DPH, enrollment sites will receive $7.1 million in 2018-19 and $7.7 million in 2019-20 under the new reimbursement methodology.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of the changes to caseload and expenditures in the ADAP May Revision Estimate.

## Issue 2: HIV Care Program Financial Eligibility – Trailer Bill Language Proposal

**DOF Issue#:** Trailer Bill Language Proposal

**Trailer Bill Language Proposal.** DPH requests trailer bill language to adopt the financial eligibility requirement used by the AIDS Drug Assistance Program for the HIV Care Program. Adoption of this language would allow the HIV Care Program to address a finding from the federal Health Resources and Services Administration (HRSA) that the program does not have consistent, statewide financial eligibility standards, as required by the federal Ryan White HIV/AIDS program.

**Background.** DPH contracts with 43 local health departments and community-based organizations to provide services under the HIV Care Program in all 58 counties. Contractors may fund any combination of 21 allowable service categories including medical case management, outpatient or ambulatory health services, food bank or home-delivered meals, and medical transportation services. DPH receives funding for the program from the federal Ryan White HIV/AIDS Program of $33 million, consisting of $27 million in base award and $6 million in supplemental funds. According to DPH, the program served about 12,790 clients in 2018.

Individuals are eligible for programs funded through the Ryan White HIV/AIDS Program if the individual has a medical diagnosis of HIV/AIDS and is low-income as defined by the state. In March 2016, HRSA issued a finding that the HIV Care Program had no established statewide financial eligibility requirement, with eligibility requirements varying from county to county. HRSA findings stated that DPH did not "consistently define 'low-income' in Part B eligibility criteria throughout the state."

DPH requests trailer bill language to adopt the financial eligibility requirements used by the AIDS Drug Assistance Program (ADAP) for the HIV Care Program. ADAP is also funded by the Ryan White HIV/AIDS Program and shares many of the same clients as the HIV Care Program. Individuals are eligible for ADAP if the individual's modified adjusted gross income does not exceed 500 percent of the federal poverty level. According to DPH, approximately 91 existing clients, representing one percent of all clients served, would no longer be eligible for services under the proposed adoption of statewide eligibility requirements consistent with ADAP.

In addition to defining the financial eligibility for the program, the proposed trailer bill language would rename the CARE Services Program to the HIV Care Program, as it is currently known. These changes would become operative on April 1, 2020 to coincide with the start of the Ryan White HIV/AIDS Program fiscal year, coincide with the conclusion of the next open enrollment period for Covered California, and provide sufficient time for all current clients to complete their biannual recertification.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these proposed statutory changes.

## Issue 3: Infectious Disease Prevention and Control

**DOF Issue#:** 4265-404-BCP-2019-MR

**May Revision Issue.** DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023. If approved, these positions and resources would allow DPH to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2019-20*** | **2020-21** |
| 0001 – General Fund | | |
| State Operations | $8,000,000 | **$-** |
| Local Assistance | $32,000,000 | $- |
| **Total Funding Request:** | **$40,000,000** | **$-** |
| **Total Positions Requested:** | **4.0** | |

* Resources available until June 30, 2023.

**Background.** DPH and 61 local health jurisdictions across the state work to monitor, prevent, and control more than 90 different infectious diseases. DPH estimates there were between 7.6 million and 10.8 million cases and between 1,760 and 7,160 deaths due to infectious disease in 2016. In recent years, DPH and local health jurisdictions have experienced significant increases in the incidence and risk of infectious diseases, including sexually transmitted diseases (STDs), foodborne diseases, vaccine-preventable diseases, and new emerging infectious diseases.

DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023 to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

The $32 million for local health jurisdictions would be allocated after engaging with stakeholders to determine metrics and appropriate weighting for each metric. According to DPH, the short-term outcomes expected from this funding would be: 1) infectious disease prevention, 2) increased partnerships between DPH and local health jurisdictions and providers and payers that serve communities at risk, 3) enhanced integration between public health and health care data systems to monitor delivery of preventive services, and 4) increased training, consultation, and quality improvement activities related to infectious disease prevention. Long term, DPH expects these resources would help reduce incidence of tuberculosis, STDs, vaccine preventable diseases and outbreaks, severe pertussis cases in infants, disparities in the burden of these diseases among disproportionately affected populations, and prevention of illness, death, disability, and further spread of infectious diseases.

The $8 million of state administration funding would support the following positions:

- **One Staff Services Manager II** position would supervise a contract monitoring unit which would oversee the grant allocations, contract execution, and monitoring and evaluation of tasks associated with the grants.
- **Two Associate Governmental Program Analysts** would provide coordination between a disease investigation team and grant recipients, and provide technical assistance to grant recipients regarding data requirements. These positions would also manage and monitor the administrative requirements of grant recipients and coordinate the collection of work plans and progress reports from grant recipients for review.
- **One Senior Accounting Officer** would support administrative functions including payment processing and accounting record oversight.

DPH would also enter into an interagency agreement to perform activities including, but not limited to, epidemiology and disease surveillance, communication, data management, and disease investigation for outbreak response. This request allocates $5.2 million of the state administration funding for this purpose.

**May Revision Proposal Similar to Funding Request from Local Health Departments.** The subcommittee previously heard a similar request from the County Health Executives Association of California (CHEAC) and the Health Officers Association of California (HOAC) for annual General Fund expenditure authority of $50 million to improve infrastructure to prevent and control the spread of infectious disease in California using strategies that best meet the needs of local jurisdictions. According to CHEAC and HOAC, local health departments do not have adequate funding to fulfill their unique mandate to prevent and control infectious diseases within their jurisdictions. State and federal funding for communicable disease control activities have considerably declined over time and are primarily siloed based on disease. This has led to significant challenges in addressing the rising rates of ever-present diseases such as sexually transmitted diseases and tuberculosis, and addressing outbreaks experienced in California such as Hepatitis A, influenza, Zika and measles, posing a health and safety risk to residents throughout the state.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of this proposal.

2. What entities would be part of the planned interagency agreement for surveillance, communication, data management, and outbreak response? What are each of the parties' responsibilities under the agreement?

## Issue 4: Genetic Disease Screening Program – May Revision Estimate and Adjustments

**DOF Issue#:** 4265-002-ECP-2019-GB
4265-402-ECP-2019-MR

**Genetic Disease Screening Program Estimate - May Revision Update.** The May 2019 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $133.8 million ($30.6 million state operations and $103.2 million local assistance) in 2018-19, a decrease of $273,000 or 0.3 percent compared to the January budget. According to DPH, the decreased costs are primarily attributable to reduced estimates of live births in California. The estimate also includes $143 million ($31.4 million state operations and $111.6 million local assistance) in 2019-20, an increase of $1.8 million or 1.6 percent compared to the January budget, and an increase of $9.2 million or 6.8 percent compared to the revised 2018-19 estimate. According to DPH, the increase in costs is due to increased laboratory supply and equipment costs and an increasing need for case management and coordination services for newborn screening.

| **Genetic Disease Screening Program 2018-19 May Revision Comparison to January Budget** | | |
|---|---|---|
| **Fund Source** | ***January Budget*** | ***May Revision*** |
| 0203 – Genetic Disease Testing Fund | | |
| State Operations: | $29,451,000 | $30,593,000 |
| Local Assistance: | $103,501,000 | $103,228,000 |
| **Total GDSP Funding** | **$132,952,000** | **$133,821,000** |

| **Genetic Disease Screening Program 2019-20 May Revision Comparison to January Budget** | | |
|---|---|---|
| **Fund Source** | ***January Budget*** | ***May Revision*** |
| 0203 – Genetic Disease Testing Fund | | |
| State Operations: | $31,351,000 | $31,351,000 |
| Local Assistance: | $109,825,000 | $111,624,000 |
| **Total GDSP Funding** | **$141,176,000** | **$142,975,000** |

**Background.** According to DPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

- Screens newborns and pregnant women for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.

- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening program and the Prenatal Screening program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

**Newborn Screening (NBS) Program.** Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to DPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2017, 18,920,529 babies were screened resulting in early identification of 18,015 cases for the following disorders:

| Disorder | Cases |
|---|---|
| Phenylketonuria (PKU) and hyperphenylalaninemia | 1,264 |
| Primary congenital hypothyroidism | 7,857 |
| Galactosemia | 1,018 |
| Sickle cell disease and other clinically significant hemoglobinopathies[1/] | 5,006 |
| Biotinidase deficiency (BD) | 209 |
| Cystic fibrosis (CF) | 636 |
| Congenital adrenal hyperplasia (CAH) | 376 |
| Metabolic fatty acid oxidation disorders | 741 |
| Metabolic amino acid disorders other than PKU | 203 |
| Metabolic organic acid disorders | 518 |
| Other metabolic disorders | 62 |
| Severe combined immunodeficiencies | 75 |
| X-linked adrenoleukodystrophy (ALD) and other peroxisomal disorders | 50 |
| **TOTAL** | **18,015** |

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be

added to the NBS program screening panel within two years. In July, 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP, which must be added to the NBS screening panel within two years. The fee for screening in the NBS program is currently $142.25.

Caseload Estimate: The budget estimates NBS program caseload of 461,083 in 2018-19, a decrease of 8,067 or 1.7 percent, compared to the January budget estimate. The budget estimates NBS program caseload of 460,153 in 2019-20, a decrease of 930 or 0.2 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in live births. DPH assumes 100 percent of births will participate in the NBS program annually.

**Prenatal Screening (PNS) Program.** The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect:

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).
- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

The PNS program provides pregnant women with a risk assessment for open neural tube defects (NTD), Down syndrome (trisomy 21), trisomy 18 and Smith-Lemli-Opitz Syndrome (SLOS) through one or two blood tests. The screening test indicates risk, but does not diagnose fetal birth defects.

For women with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $221.60.

Caseload Estimate: The budget estimates PNS program caseload of 329,081 in 2018-19, a decrease of 5,349 or 1.6 percent, compared to the January budget estimate. The budget estimates PNS program caseload of 326,472 in 2019-20, a decrease of 2,609 or 0.8 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in live births.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

## Issue 5: Women, Infants, and Children Program – May Revision Estimate

**DOF Issue#:** 4265-001-ECP-2019-GB
4265-403-ECP-2019-MR

**Women, Infants, and Children Program Estimate – May Revision Update.** The May 2019 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($902.2 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19, an increase of $7.2 million ($10.1 million federal funds offset by a decrease of $2.9 million WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2019 WIC Program Estimate includes $1.1 billion ($880.7 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20, an increase of $1.3 million ($2.6 million federal funds offset by a decrease of $1.3 million WIC manufacturer rebate funds) compared to the Governor's January budget, and a decrease of $34 million ($21.4 million federal funds and $12.5 million WIC manufacturer rebate funds) compared to the revised 2018-19 estimate. The federal fund amounts include state operations costs of $63.7 million in 2018-19 and $62.3 million in 2019-20.

| **WIC Funding Summary 2018-19 May Revision Comparison to January Budget** | | | |
|---|---|---|---|
| | **2018-19** | | **Jan to May** |
| **Fund Source** | ***January Budget*** | ***May Revision*** | ***Change*** |
| 0890 – Federal Trust Fund | | | |
| State Operations: | $63,684,000 | $63,684,000 | $- |
| Local Assistance: | $828,388,000 | $838,489,000 | $10,101,000 |
| 3023 – WIC Manufacturer Rebate Fund | | | |
| Local Assistance: | $229,080,000 | $226,211,000 | ($2,869,000) |
| **Total WIC Expenditures** | **$1,121,152,000** | **$1,128,384,000** | **$7,232,000** |

| **WIC Funding Summary 2019-20 May Revision Comparison to January Budget** | | | |
|---|---|---|---|
| | **2019-20** | | **Jan to May** |
| **Fund Source** | ***January Budget*** | ***May Revision*** | ***Change*** |
| 0890 – Federal Trust Fund | | | |
| State Operations: | $62,270,000 | $62,270,000 | $- |
| Local Assistance: | $815,905,000 | $818,462,000 | $2,557,000 |
| 3023 – WIC Manufacturer Rebate Fund | | | |
| Local Assistance: | $214,929,000 | $213,678,000 | ($1,251,000) |
| **Total WIC Expenditures** | **$1,093,104,000** | **$1,094,410,000** | **$1,306,000** |

The May Revision assumes a monthly average of 959,513 WIC participants in 2018-19, a decrease of 12,466 or 1.3 percent compared to the Governor's January budget. The May Revision assumes a monthly average of 905,182 WIC participants in 2019-20, a decrease of 11,875 or 1.3 percent compared to the Governor's January budget, and a decrease of 54,331 or 5.7 compared to the revised 2018-19 caseload estimate.

**Food Expenditures Estimate.** The May Revision includes $745.3 million ($519.1 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19 for WIC program food expenditures, a decrease of $11.3 million ($8.4 million federal funds and $2.9 million WIC manufacturer rebate funds) or 1.5 percent, compared to the January budget. The May Revision includes $717.3 million ($503.6 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20 for WIC program food expenditures, a decrease of $12.7 million ($11.4 million federal funds and $1.2 million WIC manufacturer rebate funds) or 1.7 percent compared to the January budget, and a decrease of $28 million ($15.5 million federal funds and $12.5 million WIC manufacturer rebate funds) or 3.8 percent compared to the revised 2018-19 food expenditures estimate. According to DPH, the decreases in both years are due to lower than projected participation levels and a significantly lower inflation rate.

**Nutrition Services and Administration (NSA) Estimate.** The May Revision includes $319.4 million for other local assistance expenditures for the NSA budget in 2018-19, an increase of $18.5 million or 6.1 percent compared to the January budget. The May Revision includes $314.8 million for the NSA budget in 2019-20, an increase of $13.9 million or 4.6 percent compared to the January budget, and a decrease of $4.6 million or 1.4 percent compared to the revised estimate for 2018-19. According to DPH, the increases in NSA funding are for grants provided to the Office of Systems Integration to fund the transition to the California WIC Card, an electronic benefit card system that will replace paper checks for WIC recipients.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of the major changes to caseload and expenditure in the WIC May Revision Estimate.

## Issue 6: California Home Visiting and Black Infant Health Programs – Federal Matching Funds

**DOF Issue#:** 4265-017-BCP-2019-GB
4265-018-BCP-2019-GB
4265-402-BCP-2019-MR
4265-403-BCP-2019-MR

**May Revision Issue.** DPH requests reimbursement expenditure authority of $34.8 million annually. If approved, these resources would allow DPH to draw down federal Medicaid funds for services provided by the California Home Visiting Program (CHVP) and the Black Infant Health (BIH) Program to Medi-Cal beneficiaries. For CHVP, DPH is requesting increased reimbursement expenditure authority of $2 million for state operations and $20.9 million for local assistance. For the BIH Program, DPH is requesting increased reimbursement authority of $1.3 million for state operations and $10.7 million for local assistance.

In the January budget, DPH requested 13 positions and General Fund expenditure authority of $23 million annually to expand participation in current and new sites for the California Home Visiting Program (CHVP), and to include new evidence-based home visiting models, with a focus on low-income, young mothers. DPH also requested four positions and General Fund expenditure authority of $7.5 million annually to expand the Black Infant Health Program to improve African-American infant and maternal health.

| **Combined Program Funding Request Summary – California Home Visiting Program** | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | | |
| State Operations | $2,000,000 | $2,000,000 |
| Local Assistance | $21,000,000 | $21,000,000 |
| 0995 – Reimbursements | | |
| State Operations | $2,000,000 | $2,000,000 |
| Local Assistance | $20,869,000 | $20,869,000 |
| **Total Combined Funding Request:** | **$45,869,000** | **$45,869,000** |
| **Total Positions Requested*:** | **13.0** | |

* Positions and resources ongoing after 2020-21.

| **Combined Program Funding Request Summary – Black Infant Health Program** | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | | |
| State Operations | $500,000 | $500,000 |
| Local Assistance | $7,000,000 | $7,000,000 |
| 0995 – Reimbursements | | |
| State Operations | $1,300,000 | $1,300,000 |
| Local Assistance | $10,650,000 | $10,650,000 |
| **Total Combined Funding Request:** | **$19,450,000** | **$19,450,000** |
| **Total Positions Requested*:** | **4.0** | |

* Positions and resources ongoing after 2020-21.

The California Home Visiting Program (CHVP), established in 2010 by authority contained in the federal Affordable Care Act, provides voluntary, evidence-based home visiting services to pregnant and newly parenting families who have one or more of the following risk factors: domestic violence, inadequate income, unstable housing, education less than 12 years, substance abuse, depression, or mental illness. Services are provided by a public health nurse or paraprofessional in the family's home and may begin prenatally or right after the birth of a baby up to age three.

The Black Infant Health Program, administered by DPH, provides empowerment-focused group support services and case management to improve the health and social conditions for African-American women and their families. Created in 1989 to address a disproportionately high infant mortality rate for black infants, the program seeks to address the complex factors related to infant mortality and preterm births for the population at greatest risk. Black Infant Health providers offer participants health education, social support, individualized case management, home visitation and referrals to other services.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these proposed changes.

## Issue 7: Proposition 99 Adjustments – Health Education, Research, and Unallocated Accounts

**DOF Issue#:** 4265-031-BBA-2019-GB
4265-402-BBA-2019-MR

**Proposition 99 Tobacco Tax Allocations.** DPH requests the following technical corrections reflecting changes in Proposition 99 revenues:

Health Education Account
- Item 4265-001-0231 be increased by $950,000
- Item 4265-111-0231 be increased by $500,000

Research Account
- Item 4265-001-0234 be increased by $521,000

Unallocated Account
- Item 4265-001-0236 be increased by $29,000

According to DPH, these adjustments would support state administrative activities and competitive grants.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of these proposed technical changes.

## Issue 8: Adult Use of Marijuana Act: Cannabis Surveillance and Education

**DOF Issue#:** 4265-404-BBA-2019-MR

**May Revision Issue.** The May Revision includes 15 positions and reimbursement expenditure authority of $12 million in 2019-20, transferred by DHCS from the California Cannabis Tax Fund, pursuant to the Adult Use of Marijuana Act approved by voters in 2016. The expenditure authority supporting these positions and resources is continuously appropriated to DHCS from cannabis tax revenue, and will be transferred to DPH under an interagency agreement to conduct cannabis surveillance and education activities.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21** |
| 0995 – Reimbursements | $12,000,000 | $- |
| **Total Funding Request:** | **$12,000,000** | **$-** |
| **Total Positions Requested:** | **15.0** | |

**Background.** The Adult Use of Marijuana Act (Proposition 64) imposes a 15 percent excise tax on the sale of recreational cannabis products sold in the state of California to be deposited in the California Cannabis Tax Fund. Proposition 64 requires tax proceeds deposited in the fund to be distributed as follows:

1) Costs incurred by state agencies for requirements of Proposition 64.
2) $10 million dollars to universities annually for ten years to research the effect of Proposition 64.
3) $3 million dollars annually for five years to the California Highway Patrol to adopt protocols to determine whether a driver is operating a vehicle while impaired by the use of cannabis or cannabis products.
4) $10 million dollars annually in 2018-19, increasing to $50 million dollars in 2022-23 and annually thereafter for the Governor's Office of Business and Economic Development to administer a community reinvestments grants program.
5) $2 million dollars annually to the University of California San Diego Center for Medicinal Cannabis Research.

After disbursing funds for these purposes, 60 percent of the remaining funds are deposited into the Youth Education, Prevention, Early Intervention and Treatment Account and continuously appropriated to DHCS to enter into interagency agreements with DPH and the California Department of Education (CDE) to implement and administer programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance use. Proposition 64 requires the programs to emphasize accurate education, effective prevention, early intervention, school retention, and timely treatment services for youth, their families and caregivers.

The May Revision reflects a total Proposition 64 allocation of $119.3 million to DHCS for these programs. According to the Administration, $80.5 million will be transferred to CDE to subsidize up to 9,600 child care slots for school-age children up to 13 years old from income-eligible families. $21.5 million will be retained by DHCS for stakeholder engagement, program oversight, and staffing for local programs emphasizing prevention-oriented care that promotes health and well-being for youth. $5.3

million will be transferred to the California Natural Resources Agency to support youth community access grants to support youth access to natural or cultural resources, with a focus on low-income and disadvantaged communities, for positive programming to discourage substance use.

The May Revision also reflects $12 million transferred to DPH to conduct cannabis surveillance and education activities. According to DPH, these resources would be allocated as follows:

1) Data Analysis ($3 million) – DPH staff will gather, analyze, and interpret data from multiple sources to produce surveillance reports, develop targeted educational materials informed by surveillance data, and help provide relevant, actionable information to state and local regulators and stakeholders.

2) Survey Data Purchase and Development ($1 million) – DPH will determine the data questions among multiple survey tools, including the Behavioral Risk Factor Surveillance System, the California Health Interview Survey, and development of a DPH-specific survey tool.

3) Data Interface Development ($6 million) – DPH will integrate various data systems interfaces to create an interoperable system and identify gaps in data. The data systems may include emergency department data, poison control, and emergency medical services data. DPH proposes to integrate four data sets in the first year. Larger investments may be needed at the outset and reduced amounts may be sufficient for ongoing maintenance and operation.

4) Educational Activities ($2 million) – DPH staff will update and enhance its Let's Talk Cannabis website. The updates include development of targeted materials such as fact sheets, frequently asked questions, social media, user friendly data report, references to new research. The enhancements include development of a data dashboard.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of this proposed allocation of cannabis tax revenue.

## 4440 DEPARTMENT OF STATE HOSPITALS

### Issue 1: 2019-20 Program Updates – May Revision Adjustments

**DOF Issue#:** 4440-043-ECP-2019-GB
4440-044-ECP-2019-GB
4440-045-ECP-2019-GB
4440-047-ECP-2019-GB
4440-049-ECP-2019-GB
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4440-058-ECP-2019-GB
4440-089-ECP-2019-MR
4440-090-ECP-2019-MR
4440-091-ECP-2019-MR
4440-092-ECP-2019-MR
4440-093-ECP-2019-MR
4440-094-ECP-2019-MR
4440-095-ECP-2019-MR
4440-096-ECP-2019-MR
4440-097-ECP-2019-MR
4440-100-ECP-2019-MR

**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 91 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 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 MDO, *Coleman*, IST, and NGI patients. Atascadero has an operational bed capacity of 1,184.

- **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 MDO, *Coleman*, and SVP patients. Coalinga has an operational bed capacity of 1,286.

- **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, MDO, and NGI patients and has an operational bed capacity of 826.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, NGI and LPS patients and has an operational bed capacity of 1,255.

- **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, MDO, and NGI patients and has an operational bed capacity of 1,527.

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.

- **Mentally Disordered Offenders (MDO)** – MDO patients are parolees who meet the following six criteria for MDO 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. MDO 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 MDO.

- **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.

| | 2018-19 | 2019-20 |
|---|---|---|
| **Population by Hospital** | | |
| Atascadero | 1,143 | 1,106 |
| Coalinga | 1,403 | 1,403 |
| Metropolitan | 858 | 1,046 |
| Napa | 1,278 | 1,278 |
| Patton | 1,509 | 1,484 |
| **Population Total** | **6,191** | **6,317** |
| **Population by Commitment Type** | | |
| Incomptent to Stand Trial (IST) | 1,491 | 1,617 |
| Not Guilty by Reason of Insanity (NGI) | 1,396 | 1,396 |
| Mentally Disordered Offender (MDO) | 1,425 | 1,416 |
| Sexually Violent Predator (SVP) | 953 | 953 |
| Lanterman-Petris-Short Civil Commitments (LPS) | 694 | 703 |
| *Coleman* Referrals | 230 | 230 |
| Dept. of Juvenile Justice (DJJ) | 2 | 2 |
| **Jail-Based Competency Treatment (JBCT) and Contracted Programs** | | |
| Kern Admission, Evaluation, and Stabilization (AES) Center | 60 | 60 |
| Riverside JBCT | 25 | 25 |
| Sacramento JBCT (Male and Female) | 44 | 44 |
| San Bernardino JBCT | 126 | 146 |
| San Diego JBCT | 30 | 30 |
| Sonoma JBCT | 10 | 10 |
| Stansislaus JBCT | 12 | 18 |
| Monterey JBCT | 10 | 10 |
| San Joaquin JBCT | -- | 10 |
| Solano JBCT | 12 | 12 |
| Mendocino JBCT | TBD | TBD |
| Mariposa JBCT | TBD | TBD |
| Butte JBCT | 5 | 5 |
| Proposed New JBCT (Northern, Central, and Southern CA) | 5 | 74 |
| **Total JBCT Programs** | **339** | **444** |

**Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs**
**Source:** *2019-20 May Revision Estimates, Department of State Hospitals,May 2019*

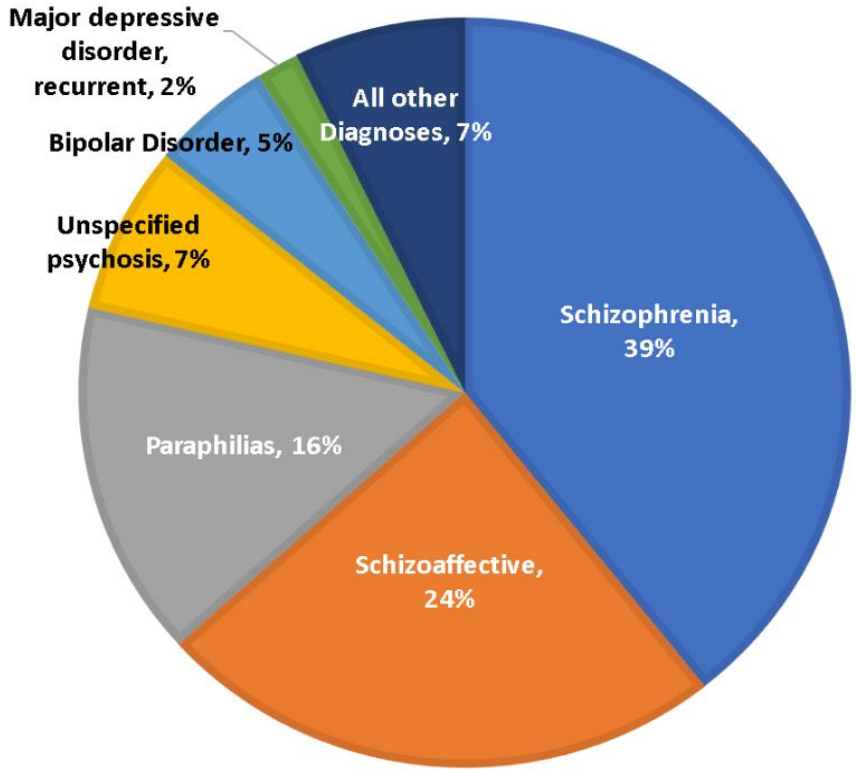


**Figure 2: State Hospital Population By Major Diagnosis**
**Source:** *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

**Program Update: Patient Driven Operating Expenses and Equipment.** In a 2015 report, the Legislative Analyst's Office made recommendations for improvement in the DSH budgeting methodology, including the establishment of a standardized per patient operating expenses and equipment cost estimate and an annual budget adjustment based on patient census. According to DSH, the average operating cost per patient is $19,534 across all five state hospitals, which represents an increase of 18 percent over the last six years. This increase is primarily driven by the costs of pharmaceuticals and outside hospitalization.

Over the past five years, DSH reports its patient population has increased by 547 beds, including expansions of 236 secured beds at Metropolitan State Hospital. However, DSH did not budget for operating expenses and equipment for much of these new beds. The 2018 Budget Act included $3.7 million for the operating expenses and equipment for the 236 secured beds at Metropolitan. Due to delays in unit activations, DSH reports 140 of those beds will not be activated as expected, resulting in $2.2 million General Fund savings in 2018-19.

In the January budget, DSH requested General Fund expenditure authority of $10.5 million annually to support the full cost of operating expenses and equipment for the 547 beds activated since 2012-13 in the five state hospitals.

In the May Revision, DSH requests additional General Fund expenditure authority of $547,000, for a total of $11 million annually, based on updated projected census figures.

**Program Update: Lanterman-Petris-Short (LPS) Population and Personal Services Adjustment.** 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. Counties reimburse state hospitals for the costs of treatment for LPS patients.

According to DSH, the focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. In 2017-18, DSH had a budgeted LPS capacity of 628. As of July 2018, DSH reported a total LPS census of 690. The 2018 Budget Act included a $20.1 million adjustment in reimbursement authority to account for actual expenditures for LPS patients.

In the January budget, DSH requested additional reimbursement expenditure authority of $606,000 in 2019-20 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS caseload from county commitments. The amount of this additional authority was calculated based on 2018-19 projected expenditures of $157.4 million, which is $606,000 less than its 2018-19 authority of $156.7 million.

In the May Revision, DSH requests additional reimbursement expenditure authority of $2.7 million in 2019-20 and annually thereafter, for a total increase in reimbursement expenditure authority of $3.3 million. According to DSH, these adjustments are due to updated collection figures.

**Program Update: 2014 South Napa Earthquake Repairs.** The 2014 South Napa Earthquake caused damage to buildings at Napa State Hospital with historical significance, within the hospital's secure treatment area, and in non-secured areas of the hospital. DSH received expenditure authority in previous budgets to make repairs associated with the South Napa Earthquake. As of the 2018 Budget Act, the timeline of construction and expenditures on these repairs is as follows:

| | **DGS PROJECT 1** Three Historical Buildings | **DGS PROJECT 2** Buildings Outside the STA | **DSH PROJECT 3** Buildings Inside the STA |
|---|---|---|---|
| Design Completion | July 6, 2017 | May 2018 | N/A |
| Begin Construction | November 2, 2018 | September 21, 2018 | October 1, 2017 |
| Complete Construction | July 5, 2019 | September 21, 2019 | December 31, 2019 |

| **Project** | **2015-16** | **2016-17** | **2017-18** | **2018-19** | **2019-20** | **Grand Total** |
|---|---|---|---|---|---|---|
| 1. Three Historical Buildings | $989,900 | $0 | $7,129,000 | $0 | $0 | $8,118,900 |
| 2. Buildings Outside the STA | $0 | $326,200 | $3,675,000 | $0 | $0 | $4,001,200 |
| 3. Buildings Inside the STA | $0 | $0 | $1,624,958 | $1,216,958 | $608,479 | $3,450,395 |
| **Totals** | **$989,900** | **$326,200** | **$12,428,958** | **$1,216,958** | **$608,479** | **$15,570,495** |

In the May Revision, DSH requests reduction of General Fund expenditure authority of $1.1 million in 2018-19 and $608,479 in 2019-20 as the department will not be proceeding with the completion of the remaining Project 3 repairs, which are comprised of minor cosmetic repairs. DSH reports ongoing challenges and delays in the availability and hiring of labor for this project, leading to no significant efforts towards completing the repairs. In addition, DSH reports these repairs are within patient-occupied areas and would require swing space to complete the project that is currently unavailable.

**Program Update: Enhanced Treatment Program (ETP) Staffing.** 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.

The 2017 Budget Act authorized 44.7 positions and $8 million in 2017-18 and 115.1 positions and $15.2 million annually thereafter to activate the first two ETP units at Atascadero State Hospital. According to DSH, construction for the first unit began in September 2018 and was completed February 2019, while construction for the second unit was expected to begin February 2019 and be completed June 2019.

The 2018 Budget Act included reversion of General Fund savings of $4.9 million General Fund in 2017-18 and $4.6 million in 2018-19 related to construction delays of the ETP units. For 2019-20, the 2018 Budget Act included 60.3 positions and General Fund expenditure authority of $8.3 million annually thereafter to fund an additional ETP unit at Atascadero, as well as one unit at Patton. According to DSH, construction for the third unit at Atascadero is expected to begin June 2019 and be completed in September 2019, while construction for the unit at Patton is expected to begin September 2019 and be completed in January 2020.

In the January budget, DSH estimated General Fund savings in 2019-20 of $1.8 million due to a five-month delay for the ETP unit at Patton.

In the May Revision, DSH estimates additional General Fund savings of $2.6 million and a reduction of 7.1 positions in 2018-19 and $716,000 and 2.3 positions in 2019-20, for a total reduction in 2019-20 of $2.5 million. These savings are the result of implementation delays due to unforeseen electrical and ducting work. DSH also proposes to redirect $139,000 of savings in 2019-20 to critical needs identified by the Patton ETP unit.

**Program Update: Metropolitan State Hospital Bed Expansion.** The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings at Metropolitan State Hospital that housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients 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. The 2017 Budget Act included 22.2 positions in 2017-18, and 38.5 positions and $12.4 million in 2018-19 to prepare for the expansion by relocating LPS patients and hiring hospital police officers. The 2018 Budget Act included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in activations. The 2018 Budget Act also included 162.8 positions and $24.8 million in 2018-19 and 342.2 positions and $50.6 million in 2019-20 for patient movement and activation of four new forensic units. The current budget request activates and provides staff for approximately 236 forensic beds between March and November 2019 to treat IST patients.

In the January budget, DSH requested 119.3 positions and General Fund expenditure authority of $18.6 million in 2019-20 and 130 positions and General Fund expenditure authority of $20.1 million in 2020-21 and annually thereafter to activate the newly secured units at Metropolitan to provide increased capacity for the treatment of IST patients.

In the May Revision, DSH requests reduction of 22.5 positions and General Fund expenditure authority of $3.4 million in 2018-19 and reduction of 20.1 positions and General Fund expenditure authority of $3.1 million in 2019-20. These reductions result in a net request of 96.8 positions and General Fund expenditure authority of $15.2 million in 2018-19 and 109.9 positions and General Fund expenditure authority of $17 million in 2019-20. According to DSH, the reduction in requested expenditure authority is due to minor delays in the award of the contract, and a new State Fire Marshall requirement for fire sprinkler pipe fitter companies to have certified workers.

**Program Update: Telepsychiatry Resources.** In the May Revision, DSH requests 11 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. If approved, these resources would allow DSH to expand its use of telepsychiatry as an alternative to providing in-person psychiatric treatment to patients and ensure appropriate delivery of care. Specifically, these resources would add clinical oversight and supervision, telepsychiatry coordinators, as well as information technology equipment and resources.

**Program Update: Forensic Conditional Release Program (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 reports there are currently 14 patients residing in a house and two in a motel throughout California within the county of commitment. DSH has established two rate structures for CONREP-SVPs: 1) $310,000 per SVP where a permanent residence has been established, and 2) $653,000 per CONREP-SVP when ordered as a transient release.

In the January budget, DSH requested General Fund expenditure authority of $768,000 in 2018-19 and $2.1 million annually thereafter. If approved, these resources would support an expected caseload increase of four SVPs in 2018-19, including two transient releases, for a total of 21 SVPs conditionally released to the community by June 2019, and an additional two SVPs released by June 2020 for a total caseload of 23.

In the May Revision, DSH requests a decrease in General Fund expenditure authority of $1 million in 2018-19 and $994,000 in 2019-20, for a net decrease in expenditure authority of $245,000 in 2018-19 and a net increase in expenditure authority of $1.1 million. DSH indicates these downward adjustments are based on a net decrease of two SVP commitments compared to the January budget.

**Program Update: Forensic Conditional Release Program (CONREP) – Step-Down Transition Program.** In the May Revision, DSH requests General Fund expenditure authority of $5.7 million in 2019-20 and $11.6 million annually thereafter. If approved, these resources would allow DSH to expand its continuum of care for CONREP patients by establishing a step-down program. DSH would contract for a 78-bed vendor operated community step-down program for MDO and NGI patients preparing for conditional release from state hospitals within 18 and 24 months. The requested resources would also allow DSH to expand its existing contract with Sylmar Health and Rehabilitation Center by four beds for a total of 24 beds.

**Program Update: Jail-Based Competency Treatment Program Expansions.** In the January budget, DSH reported net General Fund savings of $253,000 in 2018-19 composed of one-time cost savings of $1.9 million at San Bernardino and San Joaquin JBCT programs, offset by $1.6 million in increased costs at Sacramento, Sonoma, Mariposa, Solano, Mendocino, and Butte JBCT programs. In the January budget, DSH also requested General Fund expenditure authority of $1.1 million in 2019-20, and $1.7 million in 2020-21 and annually thereafter to activate jail-based competency treatment beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. DSH expects these programs to increase bed capacity by 254 in 2018-19 and 274 in 2019-20.

In the May Revision, DSH requests a reduction in General Fund expenditure authority of $725,000 in 2018-19 and $5.9 million annually thereafter for existing JBCT programs due to activation delays and changes to program capacity.

In the January budget, DSH requested General Fund expenditure authority of $191,000 in 2018-19, $11 million in 2019-20, and $11.4 million in 2020-21 and annually thereafter for the proposed activation of new JBCT programs. DSH proposed: 1) an April 2019 activation of a five-bed JBCT program in a

Southern California county; 2) a July 2019 activation of a five-bed JBCT program in a Central California county, a six-bed JBCT program in a Northern California county, and a 48-bed JBCT program in a Northern California county; and 3) an October 2019 activation of a 10-bed JBCT program in a Southern California County. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

In the May Revision, DSH requests additional General Fund expenditure authority of $2,000 in 2018-19, $5.7 million in 2019-20, and $9,000 annually thereafter. According to DSH, the increase in requested resources are due to updated assumptions regarding the timing of contract execution and program activation for new programs identified in the January budget.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**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 2: Technical Adjustment – Interagency Agreement with Health and Human Services Agency

**DOF Issue#:** 4440-103-BCP-2019-MR

**May Revision Issue.** DSH requests reduction of General Fund expenditure authority of $222,000 annually to reflect an adjustment to the interagency agreement between DSH and the California Health and Human Services Agency. This adjustment is related to a commensurate increase in positions and General Fund expenditure authority requested by CHHSA to replace the historical funding for one position provided by DSH.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | ($220,000) | ($220,000) |
| **Total Funding Request:** | **($220,000)** | **($220,000)** |

* Resource reduction ongoing after 2020-21.

**Background.** According to DSH, the department has historically funded one Assistant Secretary position at the Health and Human Services Agency (CHHSA). CHHSA has a companion request that establishes the position authority and funding for the Assistant Secretary position within the CHHSA budget. As a result, this request for a reduction of General Fund expenditure authority of $222,000 annually is consistent with the proposed transfer of funding for the Assistant Secretary position from DSH to CHHSA.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of this proposal.

## Issue 3: Technical Adjustment – California State Lottery Fund

**DOF Issue#:** 4440-098-BBA-2019-MR

**May Revision Issue.** DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually. These resources reflect updated funding derived from the sale of lottery tickets to fund DSH programs.

**Background.** The California State Lottery was established in 1985 after approval of a voter initiative. In general, the state distributes approximately 50 percent of lottery sales revenue back to the public in the form of prizes. The state distributes the remaining revenues to public schools, the California State University, the University of California, and various other state entities including DSH. The allocation to DSH is designated for clients with developmental or mental disabilities who are enrolled in state hospital education programs.

According to DSH, the California State Lottery has updated the funding allocations from the California State Lottery Education Fund. DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually to reflect this updated funding allocation for DSH education programs for state hospital patients.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of this proposal.

## Issue 4: Enhanced Treatment Units - Statewide

**DOF Issue#:** 4440-304-COBCP-2019-MR

**May Revision Capital Outlay Issue.** DSH requests General Fund expenditure authority of $2.4 million in 2019-20. If approved, these resources would allow DSH to complete construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21** |
| 0001 – General Fund | $2,387,000 | $- |
| **Total Funding Request:** | **$2,387,000** | **$-** |

**Background.** AB 1340, Chapter 718, Statutes of 2014, authorized the construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. According to DSH, patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed units will create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

Once completed, the Enhanced Treatment Program will provide 39 secured beds at Atascadero State Hospital and 10 beds (female only) at Patton State Hospital. The Atascadero project is currently under construction, and is approximately 25 percent complete. However, DSH reports bids recently received for construction of the Patton project were significantly higher than the state's estimate due to an underestimation of the cost of installing fire sprinklers in an existing facility and for procurement of detention doors, coordination of construction activities of a phased project within a secured environment, and current conditions in the construction services market in San Bernardino. According to DSH, these issues have resulted in the need to provide additional funding to complete construction of the project at Patton.

DSH requests General Fund expenditure authority of $2.4 million in 2019-20 to allow DSH to complete construction of the Enhanced Treatment Units at Atascadero and Patton State Hospitals. DSH expects the total project will cost $16 million, including $1.2 million for preliminary plans, $869,000 for working drawings, and $13.9 million for construction. The preliminary plans and working drawings components of the project have been completed. If approved, this request would only support completion of construction for the Enhanced Treatment Units.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of this proposal.

## 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES
## 4440 DEPARTMENT OF STATE HOSPITALS

### Issue 1: Relocation to the Clifford L. Allenby Building

**DOF Issue#:** 4300-410-BCP-2019-MR
4440-077-BCP-2019-MR

**May Revision Finance Letter.** The California Health and Human Services Agency (CHHSA), in collaboration with the Department of Developmental Services (DDS) and DSH request positions and resources to support the services and equipment necessary to relocate these entities to the new Clifford L. Allenby Building in January 2021. The components of this request are as follows:

DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter.

DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. The subcommittee will hear the DDS portion of this request during consideration of the DDS May Revision adjustments.

| **Program Funding Request Summary - DDS** | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | $3,401,000 | $1,814,000 |
| **Total Funding Request:** | **$3,401,000** | **$1,814,000** |
| **Total Positions Requested**:** | **1.0** | |

* Additional fiscal year resources requested: 2021-22 to 2022-23: $1,185,000; 2023-24 and ongoing: $1,429,000
** Positions are ongoing.

| **Program Funding Request Summary - DSH** | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | $4,891,000 | $1,760,000 |
| **Total Funding Request:** | **$4,891,000** | **$1,760,000** |
| **Total Positions Requested**:** | **2.0** | |

* Additional fiscal year resources requested: 2021-22 and ongoing: $2,760,000;
** Positions are limited-term and expire at the end of 2020-21.

**Background.** A 2015 study of Sacramento state office infrastructure identified serious deficiencies with existing state building including the Bateson Building, occupied by CHHSA, DDS, and DSH. The 2016 Budget Act included a $1.3 billion transfer over two years from the General Fund to a new State Project Infrastructure Fund to be used specifically for the renovation or replacement of state office buildings in the Sacramento area. One of the initial projects that received funding was the construction of a new building at 1215 O Street in Sacramento to replace the vacant Department of Food and Agriculture Annex. Since that time, CHHSA, DDS and DSH were chosen as the new building's future tenants and the building has been named the "Clifford L. Allenby Building (Allenby Building)." Construction of the

Allenby Building is currently underway, and all three departments expect to occupy the building beginning in January of 2021.

According to the DDS and DSH, to physically move to, occupy and conduct business in the new Allenby Building, the departments must move some of the current office contents to the Allenby Building and decommission the Bateson Building, outfit the new building with necessary items and equipment not included in the project's scope of work, and reduce the current Bateson Building document storage footprint to fit into the new storage space. The three departments are currently pursuing a shared contract for moving services to relocate each department's office contents and equipment from the Bateson Building to the Allenby Building. This contract would also include the disposal of surplus assets and equipment. The Bateson Building decommission would include the removal of the data cables from all workstations and the disconnection of all hard-wired connections to existing furniture.

DDS and DSH report that if the three departments are to physically fit their documents into the new building, the current document storage footprint will have to be reduced significantly. Part of the expectation of tenancy in the Allenby Building is a 50 to 70 percent reduction in storage needs. Each department is currently reviewing their respective document retention schedules and plan to update them before the end of 2018-19. This will be followed by the destruction of documents as permitted by the retention schedule and organization of the remaining documents into a system conducive for digitalization. Despite this effort, the departments anticipate a need to further reduce storage needs by January of 2021 to meet the Allenby Building's requirements.

According to DDS and DSH, the requested resources would fund the following activities:

Move to the New Allenby Building – Moving to the new building includes physical relocation of the contents of the Bateson building and required removal of surplus items and certain electronic and telecommunication connections. The Department of General Services (DGS) will be contracting with a professional moving consultant to conduct a comprehensive review of the established acquisition and relocation strategies developed by the tenant agencies.

New Equipment Required for the Allenby Building – The DGS capital outlay project does not include all the equipment that will be necessary for the three departments to function in the new building. Certain items must be purchased by the individual departments and installed in the Allenby Building prior to occupancy. The operation and management of an energy efficient and robust shared enterprise IT environment in the new building entails the following composite hardware, software, network resources and services:

- Migration of on premise business applications and server infrastructure to the cloud
- Cloud performance monitoring tools
- Network infrastructure which includes the Local Area Network, Wide Area Network, Wireless LAN
- Personal computer deployments
- Print and Fax management
- Telecommunications
- Project management

Short and Long-Term Document Solution – The three departments must reduce the current document storage space to physically fit into the Allenby Building. To do this, the departments propose to contract with an outside vendor which would scan and store the existing 38 million documents housed in the Bateson Building. The three departments report that, due to need to scan all these documents by January 2021, an outside contract would contract with the departments to scan, electronically store, and then destroy all the existing documents by the proposed move date. The cost for this service would be approximately $4 million and would require about a $1,000 per month in user fees for as long as the departments use the system.

Positions and Funding Requested – DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter. According to the departments, the DDS funding would support **one Staff Services Manager I** position that would provide IT support.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

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

1. Please provide a brief overview of this proposal.

# 4120 EMERGENCY MEDICAL SERVICES AUTHORITY
# 4265 DEPARTMENT OF PUBLIC HEALTH
# 4440 DEPARTMENT OF STATE HOSPITALS
# 5180 DEPARTMENT OF SOCIAL SERVICES

## Issue 1: Disaster Preparedness, Response, and Recovery

**DOF Issue#:** 4120-401-BCP-2019-MR
4265-401-BCP-2019-MR
4440-087-BCP-2019-MR
5180-407-BCP-2019-MR

**May Revision Issue.** The Administration proposes new positions and additional General Fund and special fund expenditure authority for various departments, including EMSA, DPH, DSH, and DSS, to enhance the state's disaster preparedness, response, and recovery capabilities.

| Program Funding Request Summary - EMSA | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | $979,000 | $303,000 |
| **Total Funding Request:** | **$979,000** | **$303,000** |
| **Total Positions Requested*:** | **2.0** | |

* Positions and resources ongoing after 2020-21.

| Program Funding Request Summary - DPH | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | $569,000 | $569,000 |
| 3098 – Licensing and Certification Program Fund | $390,000 | $390,000 |
| **Total Funding Request:** | **$959,000** | **$959,000** |
| **Total Positions Requested*:** | **6.0** | |

* Positions and resources ongoing after 2020-21.

| Program Funding Request Summary - DSH | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | $996,000 | $826,000 |
| **Total Funding Request:** | **$996,000** | **$826,000** |
| **Total Positions Requested*:** | **6..0** | |

* Positions and resources ongoing after 2020-21.

| Program Funding Request Summary - DSS | | |
|---|---|---|
| **Fund Source** | **2019-20** | **2020-21*** |
| 0001 – General Fund | $2,943,000 | $2,739,000 |
| **Total Funding Request:** | **$2,943,000** | **$2,739,000** |
| **Total Positions Requested*:** | **20.0** | |

* Positions and resources ongoing after 2020-21.

**Statewide Disaster Preparedness, Response, Recovery.** According to the Administration, California is experiencing unprecedented wildfire activity with increases in the number and severity of wildfires. 15 of the 20 most destructive wildfires in the state's history have occurred since 2000 and ten of the most destructive fires have occurred since 2015. The fire season is getting longer each year with many parts of the state experiencing nearly year-round fire danger. Climate change has led to historic periods of drought, which has created critically dangerous fuel conditions and resulted in over 147 million dead or dying trees. Additionally, growth in the wildland urban interface has put more Californians at risk than ever before. More than 25 million acres of the state's wildlands are classified as under very high or extreme fire threat. The catastrophic wildfire activity in 2018, including the Camp, Woolsey, and Hill fires, underscores the serious dangers that current conditions pose to individuals and communities in high-risk areas of the state.

Based on lessons learned and because of the increased magnitude, frequency, and complexity of recent disasters, the Administration proposes $39.9 million ($38.6 million General Fund) and 159.5 positions for various departments to enhance the state's disaster preparedness, response, and recovery capabilities; support the continuity of state government during disasters, and increase technical proficiency to best position the state to maximize appropriate federal reimbursements of billions of dollars. This includes resources to enhance disaster contingency planning and preparedness for the following departments:

- Office of Emergency Services (Cal OES)—$5.9 million in ongoing funds ($5.1 million General Fund) and 76 positions to enhance Cal OES disaster preparedness and response capacity for future state disasters. Without the appropriate tracking and coordination of disaster costs, California would be at risk of losing federal funding.

- Department of Housing and Community Development—$2 million General Fund (with $740,000 in ongoing resources) and four positions to create a permanent Disaster Response and Recovery Unit that will provide housing expertise in coordination with statewide disaster recovery efforts and to hire a consultant that will conduct local needs assessments related to the 2018 Camp and Woolsey fires as well as create local long-term recovery plan frameworks.

- State Water Resources Control Board—$1 million ongoing General Fund and six positions to improve emergency response capabilities between the State Water Board, regional boards, and other state entities during emergencies. These resources will enable the Water Board to lessen the impacts of disasters on vulnerable populations by addressing a wide range of issues in the periods following and between emergencies, including addressing engineering and operation issues facing drinking water systems and waste water utilities, and preventing or minimizing impacts to water quality, water supply security, and safety.

- Department of Resources Recycling and Recovery—$2.8 million ongoing General Fund and 21.5 positions for the Department to continue its significant role in emergency response mission tasking responsibilities. These resources will establish a dedicated team to help facilitate timely, safe, and effective debris removal operations as well as to assist local governments in the preparation of debris removal plans for future incidents.

- Emergency Medical Services Authority—$979,000 ongoing General Fund and two positions to increase disaster medical services capacity, including coordination of medical assets during

emergency response efforts and one-time purchases of medical treatment and communications equipment.

- Department of Public Health—$959,000 in ongoing funds ($569,000 General Fund) and six positions to support health care facilities and mass care shelters during emergencies as well as disaster preparedness, response, and recovery efforts. Activities will include deployment of infection control teams and continuous updates to an existing health facility mapping application used during disasters.

- Department of State Hospitals—$996,000 ongoing General Fund and six positions to improve emergency coordination and preparedness, and business continuity planning at five state hospitals and the Department of State Hospitals headquarters. The additional resources will enhance the Department's ability and capacity to more effectively care for patients and coordinate staff in the event of a disaster.

- Department of Social Services—$2.9 million ongoing General Fund and 20 positions to support the Department of Social Services' mandated disaster planning, coordination, and training activities. The Department is responsible for statewide mass care and shelter responsibilities, as designated by Cal OES.

**Emergency Medical Services Authority.** According to EMSA, the rapidity of its ability to provide emergency medical care to disaster victims is critical in any disaster or major event. While EMSA plans and stands ready for California's threat of a major earthquake, tsunami, flooding or volcano; recent wildfire response activities have identified gaps in response capabilities. EMSA is requesting General Fund expenditure authority of $979,000 to support the following:

Medical Treatment Site Deployment – $256,000 and 2 positions
These resources would support **two Emergency Medical Services Coordinators** to support preparedness, response, and recovery medical services operations.

Bio-Medical/ Medical Supply – $169,000
According to EMSA, some of its bio-medical equipment, such as portable ventilators, AEDs, intravenous fluid pumps, is beyond the average lifespan. The requested bio-medical/medical supply items are generally more compact, durable and efficient, providing increased field reliability and capability.

Medical Treatment Site Deployment Equipment – $103,000
This funding would supply lighting for safety and security at the EMSA base of operations, to allow 24 hour operation, rather than having to wait for rented light towers to arrive. This funding would also be used to purchase basic fire safety equipment for deploying personnel into active fire areas, such as fire shelter packs and helmets.

Fleet/ Station – $189,000
This funding would allow EMSA to purchase a stake bed truck with a four-wheel drive rough terrain forklift attachment, and three UTV-style vehicles that allow for movement of supplies, equipment and personnel, due to the size of base of operations or shelters\close quarters of other structures in which regular vehicles would not be allowed and rough roadway conditions. This funding would also support

the replacement of the generator on EMSA's command and control vehicle due to poor performance operating communications equipment.

Communications/Information Technology – $262,000
This funding would replace the rack radios, communications rack, upgrade telex radio dispatch panel and update the V-Sat system on the command and control vehicle. The radio stacks in the three Mission Support Team vehicles would also be replaced. According to EMSA, these dated systems and legacy devices are slow, unreliable and often incompatible with the EMSA's response partner's communication infrastructure.

**Department of Public Health.** Public Health requests six positions and annual expenditure authority of $959,000 ($569,000 General Fund and $390,000 Licensing and Certification Program Fund), to address California's continuing efforts to better prepare for public health emergencies, response, and recovery efforts. Of the six positions, 2.5 positions would directly serve health facilities and may be funded through licensing fees. These resources would support **three Staff Services Manager I Specialists, two Nurse Consultants,** and **one Information Technology Specialist I** position, based out of the department's Emergency Preparedness and Disaster Response Unit, which would support the recovery of the health care delivery system by collectively exploring and pursuing opportunities for rebuilding after an emergency event and options that allow health care facilities to return to operations quickly. These opportunities and options may include submitting waiver requests, reviewing and approving regulatory flex requests, and applying for various reimbursement mechanisms.

**Department of State Hospitals.** According to DSH, during a disaster, state hospitals are responsible for the lives, safety, care, and treatment of medically fragile, severely mentally ill, and forensic patients. Each of the five state hospitals have over 1,000 patients and employ thousands of staff who are responsible for the patients' care. Hospital emergency preparedness, staff training, plan exercises, and mitigation to protect this fragile and high-risk population is critical to ensure healthcare personnel are ready to respond effectively to a crisis and keep patients safe from harm. While DSH has demonstrated the ability to care for the patient population and communicate with staff and emergency management partners during a disaster, the October 2017 Atlas/Tubbs fire experiences have identified gaps in response capabilities. DSH request six positions and annual General Fund expenditure authority of $996,000 to support the following:

Expanded Emergency Notification System – $50,000
DSH seeks to utilize the current partnership with DDS to expand the existing emergency notification system used for Sacramento employees into a statewide network. This system expansion would increase the number of employees who are able to receive emergency notifications from 515 in Sacramento to over 11,000 statewide. This system could also be used to notify and communicate critical information during an emergency event with the families and guardians of nearly 7,000 patients.

Emergency Satellite Phone Network Expansion for Hospitals – $30,000 annually, $20,000 in 2019-20.
According to DSH, each state hospital sits upon a large parcel of land, includes dozens of buildings, uses secure treatment areas with significant security and access restrictions, and services a variety of critical safety, treatment and infrastructure operations. Each hospital has four satellite phones currently, and this proposal would raise that number to nine satellite phones per site. The Sacramento headquarters has four satellite phones.

Emergency Intermediate Operations Facility for Business Continuity – $30,000
During the October 2017 Atlas-Tubbs fires impacting Napa State Hospital, the facility's power, cellular communications, access to the internet, DSH email, and patient data systems were disabled. Napa staff convened in the executive director's conference room and communicated with emergency responders and DSH headquarters via a land-line "red phone" emergency communications system. DSH proposes to contract services for mobile emergency operations facilities that would be delivered to a designated site and activated with office space, satellite links for technology and communications, power generators and experienced personnel to support activation and decommissioning of the facility. These facilities would service 20 Emergency Operations Center management and staff to administer life and safety decisions and business continuity administration.

Business Continuity Plan Statewide Consolidation Consultant – $150,000 in 2019-20
DSH currently conducts the emergency preparedness, response, and recovery activities with a 2016-2021 Business Continuity Plan and five hospital Emergency Operational Plans (EOP). This proposal would use expert consultant guidance to create, consolidate and coordinate existing plans into one statewide "Business Continuity, Response and Recovery Plan" for all six sites. The consultant would evaluate current plan connectivity, propose consolidation designs, draft the approved consolidation plan for review, and upon approvals would conduct training and hospital exercises at each site. Following the plan approval, training, and exercises, the consultant would provide an evaluation for future improvements to be addressed by DSH.

Emergency Management Coordinators – $716,000
DSH proposes to recruit an Emergency Management Services Coordinator for each hospital, and one Senior Emergency Management Coordinator in Sacramento to organize and coordinate efforts statewide. These coordinators would be responsible for emergency preparedness coordination at each hospital and would work with headquarters to establish a standardized, consistent, and coordinated statewide emergency preparedness program. The coordinators would be responsible for integrating the needs and program deliverables of Fire/Police, Medical/Clinical, Administration/Health and Safety, Infrastructure/Plant Operations into the "Emergency Operation/Business Continuity Plan," and conduct training, exercises, and performance evaluations. The coordinators would work with subject matter experts to ensure compliance with regulatory/oversight agency requirements, including The Joint Commission. The coordinators would work with the senior management coordinator to improve existing systems, test those systems, and develop recommendations for improvements to meet DSH emergency response and management needs.

**Department of Social Services.** The Administration requests that Item 5180-001-0001 be increased by $2.9 million and 20 positions to support mandated disaster preparedness, response, and recovery operations related to the Department of Social Services' mass care and shelter responsibilities. This proposal is part of the Administration's larger Disaster Preparedness, Response, and Recovery May Revision package. Based on lessons learned and due to the increased magnitude, frequency, and complexity of recent disasters and those likely to come, the May Revision includes resources for various departments to enhance the state's disaster response preparedness and support the continuity of state government during disasters.

DSS is assigned by the California Governor's Office of Emergency Services (Cal OES) in the State Emergency Plan as the lead for Mass Care and Shelter, and in the California Disaster Recovery Framework as the lead for Social Services Recovery for the state. Prior to 2015, incidents requiring state

Mass Care & Shelter leadership and support were infrequent, but disasters, specifically fires, in California are increasing in frequency and destructiveness. The October 2017 Wildfires forced tens of thousands to evacuate and destroyed over 5,000 homes. Mass Care and Shelter operations included over 50 shelters being supported and incurred an estimated 15,000 hours of staff time for response and recovery. This figure does not capture additional workload associated with training, demobilization, and administrative work associated with a disaster response.

Even with staff members working long hours (nearly 300 hours of overtime a month in some cases). Disaster Services Bureau programs are experiencing delays in service delivery during fire response. Inadequate bandwidth to mobilize and deploy mass care and shelter support workforce has resulted in a lack of adequate staffing at shelters in every major fire over the past two years. Grant processing can be delayed, causing citizens to wait for critical financial assistance.

According to the department, approval of the requested staff resources will allow DSS to increase mass care capabilities and strengthen relationships with community non-profit, tribal, local, state, and federal partners. Additionally, these staff will allow the department to build critical capacity necessary to carry out its disaster-related responsibilities. Utilizing the requested resources, the department intends to complete the following annual tasks:

- Develop and/or revise 24 local, state, and federal mass care and social services recovery plans.
- Conduct 48 training courses and exercises to internal and external stakeholders.
- Deploy 25 additional specialized staff to local, state, and federal emergency operations centers to coordinate mass care response and social services recovery operations.
- Complete 120 critical shelter facility assessments.
- Coordinate and facilitate 12 Regional Mass Care and Shelter Workshops.
- Develop and/or revise 12 departmental disaster program response/recovery plans.

**Subcommittee Staff Comment and Recommendation—Hold Open.**

**Questions.** The subcommittee has requested EMSA, DPH, DSH, and DSS to respond to the following:

1. Please provide a brief overview of these proposals.