Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Ellen Corbett, Chair
Senator William Monning
Senator Mimi Walters

Thursday, April 3, 2014
9:30 a.m. or Upon Adjournment of Session
State Capitol Room 4203

Agenda Part A

Consultant: Julie Salley-Gray

Items Proposed for Vote-Only

Items Proposed for Discussion

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

PROPOSED FOR VOTE ONLY

4440 Department of State Hospitals (DSH)

1. **Third Party Billing BCP.** DSH is requesting 15 two-year limited-term positions and $1,893,000 General Fund (in the form of reimbursements that result from successful third-party payer collections, and therefore not a new General Fund appropriation) to consolidate functions related to billing and collection of third party resources that are not performed by the Department of Developmental Services (DDS).

2. **Cal-OSHA Standards BCP.** DSH requests $502,000 (General Fund) and five two-year limited-term positions to establish statewide support for compliance with Department of Occupational Safety and Health (Cal-OSHA) standards.

3. **Seismic Upgrades at Atascadero.** This project requests $325,000 in General Fund for the preliminary plans necessary to perform a seismic retrofit at the main East-West corridor at Atascadero State Hospital. The retrofit will include construction of steel framed lateral frames in the upper third portion of the corridor. Construction also will include a security sally port and temporary access doors. It is anticipated that this project will reduce the risk level of the corridor from the current Level V to a Level III. Project construction costs are estimated to be $6.2 million.

4. **Security Fencing at Napa.** This project is to improve security in the courtyards in the patient housing buildings, including: replacement of gates and fabricating and installing extensions to raise the height of security fencing in specified buildings. The cost to develop working drawings is $191,000. Total costs for the fencing are estimated to be approximately $900,000.

5. **Fire Alarm Upgrade at Metropolitan.** This proposal is to completely upgrade the existing Notifier Fire Alarm Systems in patient housing and to provide a new central monitoring system located at Hospital Police Dispatch. The total project cost is estimated to be approximately $9 million. According to the proposal, the existing system is not code compliant and does not provide serviceability and/or expandability. The requested $712,000 is for the working drawings phase of the project. Development of preliminary plans was funded in the current fiscal year at $633,000.

Recommendation: APPROVE Items 1-5

ITEMS TO BE HEARD

4440 Department of State Hospitals

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals. The DSH seeks to ensure the availability and accessibility of effective, efficient, and culturally competent services. DSH activities and functions include advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

The Governor's 2011 May Revision first proposed the elimination of the former Department of Mental Health (DMH), the creation of the new DSH, and the transfer of Medi-Cal and other community mental health programs to the Department of Health Care Services (DHCS). The 2011 Budget Act approved of just the transfer of Medi-Cal mental health programs from the DMH to the DHCS. In 2012, the Governor proposed, and the Legislature adopted, the full elimination of the DMH and the creation of the DSH. All of the community mental health programs remaining at the DMH were transferred to other state departments as part of the 2012 budget package. The budget package also created the new DSH which has the singular focus of providing improved oversight, safety, and accountability to the state's mental hospitals and other psychiatric facilities.

California has five state hospitals and three prison-based psychiatric programs that treat people with mental illness. Approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital through the criminal justice system. The state hospitals are as follows:

- Atascadero (ASH). ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons referred by the court due to criminal violations).
- Coalinga (CSH). Located in the City of Coalinga, CSH is the newest state hospital, opened in 2005, and treats forensically committed and sexually violent predators.
- Metropolitan (MSH). Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court-ordered penal code commitments.
- Napa (NSH). Located in the City of Napa, NSH is a low-to-moderate security state hospital.
- Patton (PSH). PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals.
- Vacaville & Salinas Valley Psychiatric Programs. These programs are located within state prisons.
- Stockton Psychiatric Program. This is the newest facility that began operation in July of 2013, serving 432 High Custody/Level IV inmates/patients at the intermediate level of care, within the California Department of Corrections and Rehabilitation’s (CDCR) California Health Care Facility in Stockton.

Cost Over-Runs. Over the past several years, state hospital costs had been rising at an alarming rate, and substantial current year deficiencies had become the norm and even expected from year to year. For example, in the 2010-11 fiscal year, the deficiency rose from $50 million to $120 million and the then-DMH staff could not explain why. In general, the

department lacked any clear understanding of what the major cost drivers were and how to curb or stabilize costs in the system. In 2011, DMH leadership facilitated and oversaw an in-depth exploration and analysis of state hospital costs, resulting in a lengthy report that is available on the department's website. The research team identified the following system-wide problems/cost drivers: increased patient aggression and violence; increased operational treatment models; and redundant staff work.

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

1. Reduced layers of management and streamlined documentation.

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

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

4. Elimination of adult education.

State Hospitals Caseload

The five state hospitals provide treatment to approximately 6,000 patients, who fall into one of two categories:

1. Civil commitments (referrals from counties).

2. Forensic commitments (committed by the courts).

The psychiatric facilities are located within state prisons, and currently treat approximately 1,000 inmates. They include:

1. Vacaville Psychiatric Program.

2. Salinas Valley Psychiatric Program.

3. Stockton Psychiatric Program.

Approximately 92 percent of the state hospitals' population is considered forensic, in that they have been committed to a hospital by the criminal justice system. The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment:

Committed Directly From Superior Courts:

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

- *Incompetent to Stand Trial (IST*) – Determination by court that the defendant cannot participate in trial because the defendant is not able to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. This includes individuals whose incompetence is due to developmental disabilities.

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

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

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

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

State Hospitals & Psychiatric Programs
Caseload Projections

	2013-14	2014-15
Population by Hospital		
Atascadero	1,052	1,091
Coalinga	1,151	1,206
Metropolitan	814	930
Napa	1,287	1,407
Patton	1,513	1,503
Subtotal	**5,817**	**6,137**
Population by Psych Program		
Vacaville	386	386
Salinas	177	177
Stockton	514	514
Subtotal	**1,077**	**1,077**
Population Total	**6,894**	**7,214**

Population by Commitment Type		
Incompetent to Stand Trial (IST)	1,583	1,912
Not Guilty By Reason of Insanity (NGI)	1,375	1,398
Mentally Disordered Offender (MDO)	1,126	1,067
Sexually Violent Predator (SVP)	909	936
Lanterman-Petris-Short Act/PC 2974	556	556
Coleman Referral – Hospitals	258	258
Coleman Referral – Psych Programs	1,077	1,077
Department of Juvenile Justice	10	10

State Hospitals Budget.

The Governor's proposed budget includes $1.6 billion for DSH in 2014-15 ($1.5 billion General Fund). This represents a 1.4 percent increase over 2013-14 funding. The proposed budget year position authority for DSH is 11,234 positions, an increase of 363 positions (3.3 percent) from the current year. The department's budget includes increased funding for several proposals, including plans to operate 242 more beds than were budgeted in 2013-14, initiate a program to manage bed space on a statewide level, and develop a cost estimate for enhanced security units.

(dollars in thousands)

Funding	2012-13 Actual	2013-14 Projected	2014-15 Proposed
General Fund (GF)	$1,274,968	$1,475,926	$1,497,970
Reimbursements	117,910	127,560	127,560
CA Lottery Education Fund	74	91	91
Total	$1,392,952	$1,603,577	$1,625,621
Positions	9,715.2	10,871.7	11,234

Issue 1: Medical Grade Network (MGN)

Background. DSH network infrastructure is required for clinical programs to communicate in support of critical patient care and clinical operations at each hospital. Infrastructure Services in medical settings are required to secure and protect medical data and support 24/7 network connectivity throughout the state hospital system. DSH states that the current network lacks the complete infrastructure necessary to sustain hospital operations.

Currently, the DSH network is a single Wide Area Network (WAN). The DSH states that a single WAN does not have redundant network connections between points, introducing many single points of failure, and is therefore substantially less reliable than a redundant WAN, which has a network with multiple connections between locations. The DSH states that a single WAN cannot adequately support the connection of critical clinical applications needed to provide more cost efficient and effective patient care.

Existing infrastructure has experienced significant network disruptions that have had a negative impact on medical care operations. For example, Metropolitan State Hospital experienced a technology failure in March 2012, resulting in two days when staff was unable to communicate with other facilities and had no access to clinical applications needed for patient treatment. In another example, all DSH facilities experienced a technology failure in June 2013, resulting in an interruption in access for all users to any applications deployed in an enterprise manner.

The DSH states that the health and safety of state hospital patients is at risk when medication records and treatment plans are not fully accessible. Currently, there are times when clinicians are unable to make well-informed or appropriate treatment decisions critical to the patient's well-being as a result of network-caused data errors, incorrect or missing patient information, or unavailable systems. The inadequate capacity of the current network also prohibits the DSH from maintaining offsite data backups.

According to the DSH, this project will add redundant network connectivity paths across the enterprise network, thereby eliminating single points of network connectivity failure. The Medical Grade Network (MGN) helps form an essential foundation for implementation of shared enterprise clinical systems such as electronic health records. The DSH states that without the MGN upgrade, the DSH will not be able to deploy any enterprise applications that are critical to life and safety because they cannot guarantee reliable 24/7 access to these systems.

Governor's Budget. DSH is requesting two permanent positions and $7.4 million General Fund in 2014-15, and $2.3 million General Fund ($726,000 one-time and $1.5 million on-going) for 2015-16 to implement the MGN project to add foundational infrastructure to the DSH inter-hospital network.

Staff Comments. No concerns have been brought to the subcommittee's attention regarding this proposal.

Staff Recommendation: Approve as budgeted.

Issue 2: Statewide Enhanced Treatment Units Capital Outlay

Background. The state hospitals were designed and constructed for a patient population that was quite different than the population currently in the state hospitals. Now, 92 percent of the population is forensic, having been referred to the state hospitals by either courts or prisons. Substantial evidence demonstrates an increasing rate of aggression and violent incidents at state hospitals.

The Administration argues that, in spite of this significant change in the state hospitals' patient population, there is currently no legal, regulatory, or physical infrastructure in place for DSH to effectively and safely treat patients who have demonstrated severe psychiatric instability or extremely aggressive behavior. As a result, often the only option available to a state hospital dealing with an extremely violent patient is the use of emergency seclusion and restraints, which is short term only and a more extreme response. Subsequent to the use of seclusion and restraint, a violent patient must be placed in one-on-one or two-on-one observation, which DSH states is labor intensive and does not necessarily improve safety.

DSH requests funding to develop and plan enhanced treatment units (ETUs) to provide a secure environment to more effectively treat patients that become psychiatrically unstable resulting in highly aggressive and violent behavior towards themselves, other patients, or staff. Candidates for an ETU would exhibit a level of physical violence that is not containable using other interventions or protocols currently available in the state hospitals. DSH argues that the existing physical facilities are old and designed for a different population, therefore it is not possible to provide more security within existing facilities.

Licensing & Statutory Changes. The proposal states that the establishment of the proposed statewide ETU may require statutory and regulatory changes, licensing changes, development of a specialized treatment program with appropriate staffing, patient parameters, an admissions/discharge system, and an analysis of physical plant space. It states further that the proposed ETU can be accomplished through statutory language added under the licensing for acute psychiatric hospitals. DSH assumes that such statutory changes would include allowing for individual rooms with bathroom facilities and doors that lock externally. None of the necessary policy is currently in place to develop the type of ETUs outlined in the budget proposal.

AB 1340 (Achadjian). This proposed legislation would require, beginning on July 1, 2015, and subject to available funding, each of the five state mental hospitals to establish and maintain an enhanced treatment unit for the placement of aggressive patients and requires any case of assault by a patient be immediately referred to the local district attorney. This legislation is currently awaiting hearing in the Senate Health Committee and, if approved and signed into law, could provide the necessary policy guidance for the development and running of potentially locked ETUs in the state hospitals. Absent this legislation, DSH currently has the authority to establish ETUs that do not involve individual, externally locked rooms, as they have done at Atascadero State Hospital.

Governor's Budget. The Governor's budget requests $1.5 million in General Fund for DHS and the Department of General Services (DGS) to prepare an analysis, estimate, and infrastructure design for the development of 44 locked ETUs in the five state hospitals.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Please describe how the current ETUs in the state operate and whether or not they are an effective treatment model.

2. How does the Administration intend to ensure that the locked rooms are used only for treatment and not as punishment for patients?

Legislative Analyst's Office (LAO). The Administration has not provided language that would give DSH the authority it seeks. As such, the details of the project remain uncertain. For example, there is no information about the approved lengths of stay or types of locked facilities that would be permitted under statute. Without that clarity, DGS may not be able to create an accurate budget package or determine the most appropriate infrastructure design for these units. The LAO is also concerned that the lack of specificity about the ETUs creates uncertainty about DSH's ability to build the units. Under the Administration's proposal, it is unclear whether each hospital will be permitted to maintain ETUs or whether units will be required at each location. Additionally, it is unclear what design specifications may be required, such as room size, bathroom facilities, or type of door lock. Without such information, it is unclear how DGS will be able to conduct the proposed analysis. Because each hospital has a different physical plant design, some hospitals may not meet those specifications, or it may be prohibitively expensive to build the units.

LAO Recommendation. In light of these concerns, the LAO recommends that the Legislature reject the Governor's proposed $1.5 million to obtain a DGS study of ETUs. While the LAO does not have major concerns with the proposal to consider the development of ETUs in DSH hospitals, they are concerned that planning the units without having specific guidelines could result in unnecessary costs.

Staff Comments. Given the complexity of the policy required for the ETUs and the fact that none of those policy decisions have been made, this proposal appears to be premature. The Legislature should ensure that the appropriate statutory language is in place to adequately protect both patients and staff and to restrict the use of ETUs for treatment, rather than for the inappropriate incarceration of patients, prior to approving $1.5 million in funding for the planning and infrastructure design of 44 ETUs.

Staff Recommendation: Hold open.

Issue 3: Patient Management Unit

Background. DSH is in the process of implementing various policy reforms aimed at transforming the state hospitals into a coordinated, singular system of hospitals. Historically, state hospitals have operated as independent entities. One of the consequences of this lack of coordination has been an inefficient system of patient placement that leads to delays and often inappropriate placements. Current law states that judges may refer individuals to "a state hospital." Judges often interpret this statute as giving them the authority to refer an individual to one specific hospital, rather than to DSH generally (i.e., to the state hospitals system). The result can be excess patients at one hospital, with substantial excess bed space at another hospital. It also results in certain patients being placed at hospitals that are not best suited to treat them or otherwise meet their needs.

Therefore, DSH proposes creating a patient management unit to help improve:

1. Timely access to in-patient care.

2. Placement in the most appropriate clinical settings based on treatment and security needs.

3. Timely resolution to placement issues.

4. More cost-effective utilization of hospital beds and staffing resources.

Governor's Budget. The budget includes $1.1 million General Fund and 10 two-year limited-term positions to establish a patient management unit to centralize admissions and transfers of patients throughout the state hospital system.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. How many vacant beds does DHS have throughout the state hospital system, and where are they located?

2. How will DSH ensure that the new system will allow for judicial discretion when appropriate?

3. How does DSH plan to ensure that the needs of the patients and proximity to their families and communities are protected, rather than simply placing patients where it is easiest and most convenient for the hospital system?

Legislative Analyst's Office (LAO).

Proposal Has Merit. The current disconnected system of patient placement has numerous drawbacks. The Governor's proposal has the potential to address many of the issues. For example, the proposal might allow DSH to find placements for patients more quickly, which could reduce court orders requiring DSH to accept specific patients from waitlists. It could

also improve the department's ability to budget for each institution, because it would allow DSH to place patients in available bed space rather than having some facilities have empty space while others have patients waiting for entry. It could also reduce lengths of stay by placing patients in the most clinically appropriate setting.

The LAO notes, however, that there could be some additional costs associated with the patient management unit. For example, patients assigned to locations far from their county of commitment might incur additional travel costs for court visits. In addition, evaluating patients before placement could also slow the placement and transfer processes, resulting in longer lengths of stay. Despite this, the potential operational benefits of the proposal would likely outweigh such drawbacks.

But Department Lacks Authority to Fully Realize Benefits of Management Unit. The DSH currently does not have the statutory authority to implement patient placement programs, and the Governor's proposal does not include trailer bill language to provide the department with that authority. Although some courts and counties permit DSH to manage patient placement, the discretion to allow this remains with those entities, not the department. Even if DSH were to establish a patient management and bed utilization unit, it would be unable to fully realize the benefits of such a program because, without statutory changes, referring entities would remain the arbiters of patient placement.

LAO Recommendation. Although the Administration's proposal could result in increased efficiency and potential cost savings, until statutory language exists permitting DSH to fully control the placement of the patients committed to its care, the benefits of the patient management unit cannot be fully realized. Therefore, the LAO recommends the Legislature support the Administration's proposal to create a patient management and bed utilization unit and adopt trailer bill language clarifying that DSH has the authority to fully control patient placements.

Staff Comments. Current law gives the courts the discretion to place an individual in a state hospital, rather than placing them into the state hospital system and allowing DSH to determine the appropriate placement of the individuals. At a minimum, DSH would need trailer bill language to clarify what discretion, if any, the courts will have in determining where an individual would be hospitalized. In addition, trailer bill language may be needed to protect the best interests of the patients in order to ensure that patients are placed in hospitals close to their communities and families whenever possible.

The Administration has not proposed any trailer bill language to accompany this budget item.

Staff Recommendation. Hold open pending the receipt of necessary trailer bill language.

Issue 4: Incompetent to Stand Trial Waiting List

Background. When a judge deems a defendant to be incompetent to stand trial, the defendant is referred to the state hospital system to undergo treatment for the purpose of restoring competency. Once the individual's competency has been restored, the county is required to take the individual back into the criminal justice system to stand trial, and counties are required to do this within ten days of competency being restored.

For a portion of this population, the state hospital system finds that restoring competency is not possible. There is no statutory deadline for the county to retrieve these individuals, and therefore they often linger in the state hospitals for years. The state pays the costs of their care while in the state hospitals; whereas their costs become the counties' responsibility once they take them out of the state hospitals. This funding model creates a disincentive for counties to retrieve patients once it is determined that competency restoration is not possible.

Over the past several years, state hospitals have maintained a waiting list of forensic patients. The largest waiting lists are for incompetent to stand trial (IST) and *Coleman* referrals (inmates in state prison who have been deemed too mentally ill to remain in a prison setting). As of January 2014, there were 393 IST and 63 *Coleman* patients awaiting placement in DSH facilities. When queried about the potential causes of the growing number of referrals from judges and CDCR, the Administration describes a complex puzzle of criminal, social, cultural, and health variables that together are leading to increasing criminal and violent behavior by individuals with mental illness.

DSH is required to admit patients within certain timeframes and can be (and has been) required to appear in court, or be held in contempt of court, when it fails to meet these timeframes.

The budget proposes to activate 105 new beds at DSH-Coalinga. Those beds would be occupied by current MDO patients transferred from the other four state hospitals. The beds made available from this transfer would then be utilized to treat IST patients currently on the waiting list.

Governor's Budget. The budget proposes $7.87 million General Fund for the current year (2013-14) and $27.8 million General Fund for 2014-15, to increase bed capacity by 105 beds to address the waiting list specific to IST patients.

Specifically, the DSH is proposing three new units with 35 beds each, anticipating activation of the first unit in March 2014, the second in May 2014, and the third in July 2014. The DSH proposes to use savings realized from delays in the activation of the Stockton facility for the current year costs.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Does the length of the waiting list vary from month-to-month? If so, please provide the subcommittee with data on the last 12 to 24 months.

2. How many ISTs are left by counties at state hospitals after their competency is restored and what is the average length of stay for this population that is left lingering in the hospitals?

3. Is this only a problem with certain counties? If so, which ones?

4. Has the Administration considered charging a per-day rate for those patients who should have been retrieved by the county responsible for their commitment?

5. Has the Administration done an inventory and analysis to determine whether the state has the appropriate mix of types of treatment beds throughout the system to meet the needs of its current population?

6. How flexible are the bed types within the system? For example, can vacant SVP beds be used to serve MDOs or IST patients?

Legislative Analyst's Office (LAO). DSH has seen an increase in waiting lists for forensic patients. The largest waitlists are for IST and *Coleman* commitments. As noted above, as of January 2014, there were 393 IST and 63 *Coleman* patients awaiting placement in DSH facilities. Such long waitlists are problematic because they could result in increased court costs and higher risk of DSH being found in contempt of court orders to admit patients. This is because DSH is required to admit patients within certain time frames and can be required to appear in court, or be held in contempt, when it fails to do so. In light of these concerns, the 2013-14 budget provided $22.1 million to increase treatment capacity for IST and MDOs by 155 beds.

DSH Over-Budgeted. In recent years, there has been a significant mismatch between the size of the population DSH is funded to serve and the number of patients actually in the hospitals. This is because while DSH has received funding increases in recent years to support additional beds, the department has not been able to activate the planned beds at the rate expected—resulting in much lower-than-expected growth in the patient population. DSH has consistently maintained a smaller population than beds for which it is budgeted to support. In total, DSH is currently budgeted for 616 more beds than it has patients. Specifically, the department is over-budgeted by 365 beds in state hospitals and 251 beds in the psychiatric programs. Despite this, the department has not reverted unused funds to the General Fund at the end of the year.

There are several reasons that may explain why there is a gap between the population DSH is budgeted to serve and the population it actually serves. First, DSH is not always able to utilize beds for which it has received funding. For example, DSH often has difficulty hiring clinical staff to support available bed space, and, therefore, cannot utilize available beds. Also, patients are committed to specific locations by referring agencies (such as courts), so some available beds may not be filled because patients are not being referred to those locations.

Second, according to DSH, it must receive funding to staff beds that will remain vacant for a portion of the year. For example, the department indicates that some beds are budgeted for certain commitment types—such as for IST patients—and those beds must be open for only

those commitment types. Also, a certain percentage of beds must remain vacant for patients who are attending court hearings or transferring locations. While the LAO acknowledges that it is necessary to maintain some number of vacant beds for this purpose, it is unclear from the information provided by DSH that the current number of vacant beds is appropriate. The LAO notes, for example, that the number of vacant beds—both at various DSH facilities and by commitment type—changes frequently with little evidence of corresponding changes in care. This suggests that DSH has been able to operate with fewer vacant beds than they currently have.

The gap between the budgeted and actual population is problematic for two reasons. First, it suggests that the department is over-budgeted to serve its current population. Second, it suggests that approving additional funds for the department will not necessarily result in an increase in population or a reduction in waitlists. Instead, additional funding may only result in funding for positions that DSH is unable to fill, not an increase in hospital capacity. For example, despite the Legislature approving funding to support 155 additional beds in the 2013-14 budget for IST and MDO populations, these populations have actually declined by 30 patients statewide.

LAO Recommendation. The LAO recommends rejecting the increased funding for additional IST beds. In addition, they recommend that the Legislature direct DSH to report at budget subcommittee hearings this spring on:

1. Why the patient population remains stable despite growing waitlists.

2. Why there is a mismatch between their budgeted capacity and their patient population.

3. What steps the department is taking to address its high vacancy rate.

4. The department's progress on expanding restoration of competency (ROC) services in county jails and the findings of the IST working group.

Such information could assist the Legislature in making a determination about the appropriate level of budget and staffing increases necessary to treat the DSH patient population. The LAO further recommends that the Legislature direct DSH to develop a proposal to contract for an independent staffing analysis to determine appropriate staffing levels for each facility. These staffing ratios should be based on licensing requirements, clinical need, necessary bed vacancies, and other factors; as deemed appropriate by the independent assessor.

Staff Comment. DSH's proposal to develop a patient management unit may address many of the problems associated with the current waiting lists as the department is able to better manage its existing beds and fill some of the 600 vacant beds in its current budget. In addition, the Legislature may wish to consider adopting the LAO proposal to require an independent staffing analysis prior to approving any additional funding for DSH.

Staff Recommendation. Hold open pending updated population data in the May Revision.

Issue 5: Salinas Valley and Vacaville Psychiatric Programs

Background. In April 2012, CDCR released a report entitled *The Future of California Corrections* detailing the Administration's long-range plan to reorganize various aspects of CDCR operations, facilities, and budgets in response to the effects of the 2011 realignment of adult offenders, as well as to meet federal court requirements. The plan was intended to build upon realignment, create a comprehensive plan for CDCR to significantly reduce the state's investment in prisons, satisfy the Supreme Court's ruling to reduce overcrowding in the prisons, and get the department out from under federal court oversight.

The plan included a proposal to transfer 450 beds from the Salinas Valley and Vacaville Psychiatric programs to the new Stockton program at the new California Health Care Facility (CHCF). DSH is in the process of transferring these beds and was scheduled to complete the transfer by December 2013; however, completion of the transfer has been delayed, primarily due to staff recruitment challenges.

This proposal reflects the following:

1. DSH originally expected to complete the migration of patients to Stockton by the end of 2013, however this has not been completed as a result of difficulty filling the psychiatry staff classifications.

2. An increase in the rate of *Coleman* referrals through 2013.

3. DSH indicated in 2013 that a higher level of staffing should be provided at Salinas and Vacaville than what has been there in the past.

Governor's Budget. DSH is requesting authority to permanently continue operating an additional 137 beds at Salinas Valley and Vacaville (beyond the bed migration plan), at a cost of $13.3 million in the current year (to be funded with savings from the delayed activation of beds at the Stockton program) and $26.3 million General Fund in 2014-15 (and on-going). DSH requests these resources to permanently maintain 204.3 existing positions at Salinas Valley and Vacaville.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Please provide an update on the staffing and activation of DSH – Stockton.

2. What caused the *Coleman* referrals to increase steadily in recent years and why does the Administration believe those referrals are leveling off?

3. Why is the Administration backing off from the commitment made in the CDCR plan to significantly reduce the programs at Vacaville and Salinas Valley by requesting this permanent expansion of program beds?

Legislative Analyst's Office (LAO). As noted in the previous section, in recent years, there has been a significant mismatch between the size of the population DSH is funded to serve and the number of patients actually in the hospitals. This is because, while DSH has received funding increases in recent years to support additional beds, the department has not been able to activate the planned beds at the rate expected—resulting in much lower-than-expected growth in the patient population. DSH has consistently maintained a smaller population than beds for which it is budgeted to support. *In total, DSH is currently budgeted for 616 more beds than it has patients. Specifically, the department is over-budgeted by 365 beds in state hospitals and 251 beds in the psychiatric programs.* Despite this, the department has not reverted unused funds to the General Fund at the end of the year.

The gap between the budgeted and actual population is problematic for two reasons. First, it suggests that the department is over-budgeted to serve its current population. Second, it suggests that approving additional funds for the department will not necessarily result in an increase in population or a reduction in waitlists. Instead, additional funding may only result in funding for positions that DSH is unable to fill, not an increase in hospital capacity. For example, despite the Legislature approving funding to support 155 additional beds in the 2013-14 budget for IST and MDO populations, these populations have actually declined by 30 patients statewide.

LAO Recommendation. In view of their current over-budgeting, the LAO recommends that the Legislature reject the Governor's proposal to provide additional funding for increased bed capacity at DSH–Vacaville and DSH–Salinas Valley.

Staff Comment. Similar to the previous issue, prior to providing any additional funding, the Legislature may wish to require the department to better manage its existing beds and fill some of the 600 vacant beds in its current budget, including 251 beds in the prison psychiatric programs. In addition, the Legislature may wish to consider adopting the LAO proposal to require an independent staffing analysis prior to approving any additional funding for DSH.

Staff Recommendation: Hold open pending updated population data in the May Revision.

Issue 6: Security Fencing at Patton

Governor's Budget. This project proposes to demolish ground guard posts, existing fencing, lighting, paving, and selected trees and shrubs. Construction will be a Level II design, double perimeter fence with barbed tape, fence detection system, 13 ground guard posts, two vehicle and pedestrian sally ports, perimeter patrol roadway improvements, modification to portions of the internal roads, new security lighting, and closed circuit television cameras. This project will support the re-evaluation of existing working drawings, and fund the construction phase. The total project cost is estimated to be $16.4 million, and CDCR expects savings of $4.8 million in annual savings due to a reduction in security staff.

Staff Comments. No concerns have been brought to the subcommittee's attention concerning this proposal.

Staff Recommendation. Approve as budgeted.