Department of State Hospitals
2021-22 Governor's Budget Estimates
TABLE OF CONTENTS

SECTION	Current Year Update		Budget Year Request		Tab
	Dollars (in thousands)	Positions	Dollars (in thousands)	Positions	
A. EXECUTIVE SUMMARY					A
1. Program Overview					
2. Funding and Position Summary					
3. Population Data					
B. BUDGET CHANGE PROPOSALS					B
1. Protected Health Information (PHI) Implementation	$ -	0.0	$ 986	8.0	
2. Increased Court Appearances and Public Records Act Requests	$ -	0.0	$ 777	5.5	
3. Patient Education	$ -	0.0	$ 352	3.0	
4. Medical and Pharmaceutical Billing System	$ -	0.0	$ 794	1.0	
5. Skilled Nursing Facility Infection Preventionists	$ -	0.0	$ 350	2.0	
6. Community Care Demonstration Project (CCDP) for Felony IST	$ -	0.0	$ 233,187	4.0	
7. Deferred Maintenance Allocation	$ -	0.0	$ 15,000	0.0	
8. COVID-19 Direct Response Expenditures	$ -	0.0	$ 51,982	0.0	
C. ENROLLMENT, CASELOAD, AND POPULATION					C
STATE HOSPITALS					
1. Lanterman-Petris-Short (LPS) Population and Personal Services Adjustment	$ -	0.0	$ 8,102	0.0	
2. Metropolitan State Hospital Increased Secure Bed Capacity	$ (18,617)	-120.6	$ -	0.0	
3. Enhanced Treatment Program (ETP)	$ (4,711)	-30.1	$ (1,776)	-11.6	
4. Vocational Services and Patient Wages Caseload	$ (100)	0.0	$ -	0.0	
5. Mission Base Review (MBR) Staffing Studies	$ (739)	0.0	$ -	22.0	
6. COVID-19 Informational Only	$ -	0.0	$ -	0.0	
7. Telepsychiatry Resources	$ (911)	-6.5	$ -	0.0	
CONDITIONAL RELEASE PROGRAM (CONREP)					
8. CONREP Non-SVP Caseload Update	$ -	0.0	$ 1,200	0.0	
9. CONREP SVP Caseload Update	$ -	0.0	$ -	0.0	
10. CONREP Continuum of Care	$ (6,590)	0.3	$ 7,340	0.5	
11. CONREP Mobile Forensic Assertive Community Treatment (FACT) Team	$ -	0.0	$ 5,577	2.0	
CONTRACTED PATIENT SERVICES					
12. Jail-Based Competency Treatment (JBCT) Programs	$ (2,378)	0.0	$ 6,337	0.0	
13. Incompetent to Stand Trial (IST) Diversion Program	$ -	0.0	$ 47,584	3.0	
14. LA Community-Based Restoration (CBR) Program	$ 9,758	0.0	$ 4,503	1.0	
EVALUATION AND FORENSIC SERVICES					
15. SOCP and OMD Caseload Update	$ -	0.0	$ -	0.0	
D. INFORMATIONAL ONLY UPDATES					D
E. DSH TECHNICAL ADJUSTMENT					E
F. REFERENCES					F
1. Population Profiles					
2. Hospital Profiles					
G. FINANCIAL ACTIVITY REPORT					G

CALIFORNIA DEPARTMENT OF STATE HOSPITALS
PROGRAM OVERVIEW

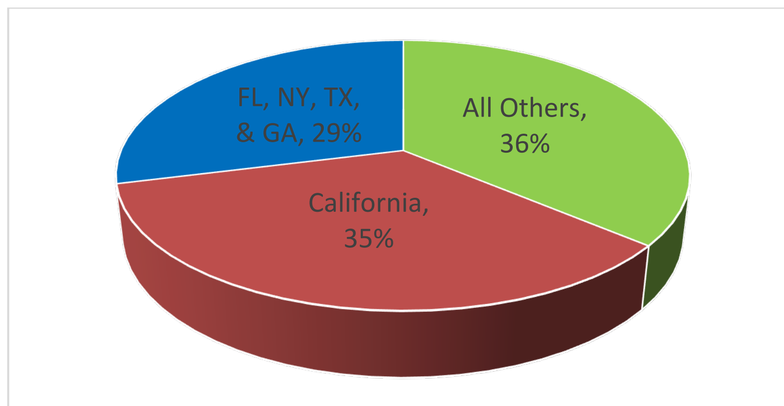
DSH Program Background

The mission of the California Department of State Hospitals (DSH) is to provide evaluation and treatment to patients in a safe and responsible manner, while seeking innovation and excellence in hospital operations across a continuum of care and settings. DSH was established on July 1, 2012 in accordance with Assembly Bill (AB) 1470, Statutes of 2012. AB 1470 reorganized the Department of Mental Health (DMH), which formerly was responsible for managing the state hospital system and community mental health services. DSH was created to manage and operate the state hospital system and is governed by Welfare and Institutions Code Sections 4000-4027. The community mental health services functions under the former DMH were transferred to other state departments.

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In Fiscal Year (FY) 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily census of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

According to the National Association of State Mental Health Program Directors (NASMHD), California comprises 35 percent of all forensic mental health patients served in the United States. By comparison, the next four largest states – Florida, New York, Texas and Georgia – collectively comprise less than a third (29 percent) of the population. The following graph illustrates the distribution of the United States' forensic mental health population per the 2015 National Association of State Mental Health Program Directors, State Profiles.

Figure 1: Percentage of Forensic Mental Health Population Served in the United States



Over the past 25 years, the Department's population demographic has shifted from primarily civil court commitments to a forensic population referred through the criminal court system. For the forensic patients it serves, DSH treats patients and the courts decide when they can be discharged. DSH cannot admit or discharge patients without a court's consent order nor refuse to treat patients. More than 90 percent of the patient population is forensic, including *Coleman* patients referred from CDCR. The remaining 10 percent of the population are patients admitted per the *Lanterman-Petris-Short* (LPS) Act.

With nearly 13,000 employees located in headquarters and five facilities throughout the state, every staff member's efforts at DSH focuses on the provision of mental health treatment in a secure setting while maintaining the safety of patients and staff. Approximately half of the Department's employees are in nursing classifications, including psychiatric technicians and registered nurses.

DSH is funded through the General Fund and reimbursements from counties for the care of LPS patients. All DSH facilities are licensed through the California Department of Public Health and four of the five facilities (Atascadero, Metropolitan, Napa, and Patton) are accredited by The Joint Commission an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States.

DSH State Hospitals

DSH-Atascadero: Opened in 1954, DSH-Atascadero is located on the Central Coast of California in Atascadero (San Luis Obispo County). The hospital is a forensic mental health hospital and is a self-contained psychiatric hospital constructed within a security perimeter. The majority of the all-male patient population is remanded for treatment by county superior courts or by CDCR pursuant to various sections of the California Penal Code (PC) and the Welfare and Institutions Code (WIC).

DSH-Atascadero primarily serves the following four patient types: Offender with a Mental Health Disorder (OMD), *Coleman* patients from CDCR, Incompetent to Stand Trial (IST), and Not Guilty by Reason of Insanity (NGI).

DSH-Coalinga: Opened in 2005, DSH-Coalinga is located on the western edge of Fresno County. The hospital is California's newest forensic mental health hospital and was created to primarily treat Sexually Violent Predators (SVP). It is a self-contained psychiatric hospital constructed with a security perimeter. CDCR provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The majority of the all-male patient population is remanded for treatment by county superior courts or CDCR pursuant to various sections of the California Penal Code and the Welfare and Institutions Code.

DSH-Coalinga primarily serves the following three patient types: OMD, *Coleman* patients from CDCR, and SVP.

DSH-Metropolitan: Opened in 1916, DSH-Metropolitan is located in Norwalk (Los Angeles County). The hospital is an "open" style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. This agreement has limited the total number of patients that DSH-Metropolitan can treat below the licensed bed capacity.

DSH-Metropolitan's operational bed capacity is restricted due to multiple units within two areas of the hospital that are located outside of the secured treatment area (STA). The units outside of the STA are unable to house PC forensically committed patients. In order to properly house the PC patients and provide additional capacity, a secured fence surrounding the remaining non-STA area is required and would increase the operational capacity to 1,062. To provide additional capacity to address the ongoing system-wide forensic waitlist, the 2016 Budget Act included capital outlay construction funding for the Increased Secure Bed Capacity project. This project added security fencing and infrastructure for existing patient buildings and allowed for the treatment of forensic patients.

DSH-Metropolitan primarily serves the following four patient types: LPS, IST, OMD and NGI.

DSH-Napa: Opened in 1875, DSH-Napa is located in Napa County. Most of the hospital is a forensic mental health hospital, and the first State Hospital. This hospital opened due to overcrowded conditions at the Stockton Asylum. DSH-Napa is the oldest California state hospital still in operation and has an "open" style campus with a security perimeter.

DSH-Napa primarily serves the following four patient types: LPS, IST, OMD and NGI.

DSH-Patton: Opened in 1893, DSH-Patton is located in the town of Highland in San Bernardino County. Most of the hospital is a forensic mental health hospital and has an "open" style campus with a security perimeter. Due to concerns from the community about the risk of a patient escape, CDCR correctional officers provide perimeter security and transportation at DSH-Patton.

DSH-Patton primarily serves the following four patient types: LPS, IST, OMD and NGI.

For additional information on the specific state hospitals, please reference the DSH Hospital Profiles located within Section F2.

Fund	Reference	Program	Current Service Level	2021-22 Governor's Budget: Baseline Budget Adjustments								
				Allocation for Employee Compensation	Allocation for Other Post-Employment Benefits	Allocation for Staff Benefits	Lease Revenue Debt Service Adjustment	Lottery Fund Adjustment per GOV 8880.5(h)	Miscellaneous Baseline Adjustment	Section 3.60 Pension Contribution Adjustment	Section 3.90 Employee Compensation Reduction	BBA Total
0001-General Fund	**RF 003**	4410010-Atascadero	$3,672,000				$1,000					$1,000
		4410020-Coalinga	$31,538,000				$13,000					$13,000
		4410030-Metropolitan	$2,198,000				$1,000					$1,000
		4410040-Napa	$2,239,000				$1,000					$1,000
		4410050-Patton	$968,000				$0					$0
	RF 003 Total		**$40,615,000**				**$16,000**					**$16,000**
	RF 011	4400010-Headquarters Administration	$65,024,000	$784,000	$143,000	$50,000			$2,455,000	-$393,000	$0	$3,039,000
		4400020-Hospital Administration	$102,395,000	$1,547,000	$220,000	$335,000			$390,000	-$394,000	$0	$2,098,000
		4410010-Atascadero	$299,713,000	$3,652,000	$706,000	$744,000			-$1,513,000	-$5,918,000	$0	-$2,329,000
		4410020-Coalinga	$319,330,000	$3,492,000	$672,000	$1,016,000			$195,000	-$6,778,000	$0	-$1,403,000
		4410030-Metropolitan	$247,060,000	$4,129,000	$755,000	$738,000			-$365,000	-$5,847,000	$0	-$590,000
		4410040-Napa	$307,637,000	$5,395,000	$1,037,000	$798,000			-$15,000	-$6,375,000	$0	$840,000
		4410050-Patton	$369,094,000	$4,316,000	$864,000	$526,000			-$999,000	-$6,226,000	$0	-$1,519,000
		4410060-State Hospital Police Academy	$6,447,000									
		4420010-Conditional Release Program	$16,877,000	$17,000	$3,000	$0			$252,000	-$21,000	$0	$251,000
		4420020-Conditional Release Program - Sexually Violent Predators	$34,461,000	$9,000	$2,000	$0				-$11,000	$0	$0
		4430010-Admission, Evaluation, Stabilization Center	$16,063,000	$2,000						-$2,000	$0	$0
		4430020-Jail Based Competency Treatment	$59,942,000	$4,000	$1,000				-$103,000	-$2,000	$0	-$100,000
		4430030-Other Contracted Services	$17,202,000	$2,000					$20,000	-$2,000	$0	$20,000
		4440-Evaluation and Forensic Services	$23,415,000	$66,000	$15,000	-$4,000			-$317,000	-$148,000	$0	-$388,000
	RF 011 Total		**$1,884,660,000**	**$23,415,000**	**$4,418,000**	**$4,203,000**			**$0**	**-$32,117,000**	**$0**	**-$81,000**
	RF 017	4400010-Headquarters Administration	$428,000	$7,000	$1,000					-$4,000	$0	$4,000
		4400020-Hospital Administration	$894,000	$44,000	$6,000	$10,000				-$9,000	$0	$51,000
	RF 017 Total		**$1,322,000**	**$51,000**	**$7,000**	**$10,000**				**-$13,000**	**$0**	**$55,000**
	RF 021	4400010-Headquarters Administration										
		4400020-Hospital Administration										
		4410010-Atascadero										
		4410020-Coalinga										
		4410030-Metropolitan										
		4410040-Napa										
		4410050-Patton										
		4410060-State Hospital Police Academy										
		4430020-Jail Based Competency Treatment										
	RF 021 Total											
	RF 502	4410010-Atascadero	$46,000									
		4410020-Coalinga	$101,000									
		4410030-Metropolitan	$150,000									
		4410040-Napa	$480,000									
		4410050-Patton	$323,000									
	RF 502 Total		**$1,100,000**									
0001-General Fund Total			**$1,927,697,000**	**$23,466,000**	**$4,425,000**	**$4,213,000**	**$16,000**		**$0**	**-$32,130,000**	**$0**	**-$10,000**
0814-California State Lottery Education Fund	**RF 511**	4410010-Atascadero	$8,000					-$1,000				-$1,000
		4410030-Metropolitan	$8,000					-$1,000				-$1,000
		4410040-Napa	$8,000					-$1,000				-$1,000
		4410050-Patton	$8,000					-$2,000				-$2,000
	RF 511 Total		**$32,000**					**-$5,000**				**-$5,000**
0814-California State Lottery Education Fund Total			**$32,000**					**-$5,000**				**-$5,000**
0995-Reimbursements	**RF 511**	4400010-Headquarters Administration	$0									
		4400020-Hospital Administration	$3,412,000						-$3,160,000			-$3,160,000
		4410010-Atascadero	$2,629,000						$3,160,000			$3,160,000
		4410020-Coalinga	$32,000									
		4410030-Metropolitan	$83,617,000									
		4410040-Napa	$59,399,000									
		4410050-Patton	$26,493,000									
	RF 511 Total		**$175,582,000**						**$0**			**$0**
0995-Reimbursements Total			**$175,582,000**						**$0**			**$0**
Grand Total			**$2,103,311,000**	**$23,466,000**	**$4,425,000**	**$4,213,000**	**$16,000**	**-$5,000**	**$0**	**-$32,130,000**	**$0**	**-$15,000**

Detailed Funding Summary - All Programs
2021-22 Governor's Budget Detail of Adjustments

			2021-22 Governor's Budget: Budget Change Proposals								
Fund	Reference	Program	Community Care Demonstration Project for Felony ISTs	COVID-19 Direct Response Expenditures	Increased Court Appearances and Public Records Act Requests	Medical and Pharmaceutical Billing System	One-Time Deferred Maintenance Allocation	Patient Education	Protected Health Information Permanent Implementation	Skilled Nursing Facility Infection Preventionists (AB 2644)	BCP Total
0001-General Fund	**RF 003**	4410010-Atascadero									
		4410020-Coalinga									
		4410030-Metropolitan									
		4410040-Napa									
		4410050-Patton									
	RF 003 Total										
	RF 011	4400010-Headquarters Administration	$644,000		$720,000	$4,000			$978,000		$2,346,000
		4400020-Hospital Administration	$4,000		$6,000	$790,000		$3,000	$8,000	$2,000	$813,000
		4410010-Atascadero					$2,063,000				$2,063,000
		4410020-Coalinga			$51,000		$6,000,000	$349,000			$6,400,000
		4410030-Metropolitan					$1,886,000			$174,000	$2,060,000
		4410040-Napa					$2,500,000			$174,000	$2,674,000
		4410050-Patton					$2,551,000				$2,551,000
		4410060-State Hospital Police Academy									
		4420010-Conditional Release Program									
		4420020-Conditional Release Program - Sexually Violent Predators									
		4430010-Admission, Evaluation, Stabilization Center									
		4430020-Jail Based Competency Treatment									
		4430030-Other Contracted Services	$232,539,000								$232,539,000
		4440-Evaluation and Forensic Services									
	RF 011 Total		**$233,187,000**		**$777,000**	**$794,000**	**$15,000,000**	**$352,000**	**$986,000**	**$350,000**	**$251,446,000**
	RF 017	4400010-Headquarters Administration									
		4400020-Hospital Administration									
	RF 017 Total										
	RF 021	4400010-Headquarters Administration		$2,977,000							$2,977,000
		4400020-Hospital Administration		$1,171,000							$1,171,000
		4410010-Atascadero		$7,663,000							$7,663,000
		4410020-Coalinga		$8,141,000							$8,141,000
		4410030-Metropolitan		$14,224,000							$14,224,000
		4410040-Napa		$4,144,000							$4,144,000
		4410050-Patton		$13,461,000							$13,461,000
		4410060-State Hospital Police Academy		$1,000							$1,000
		4430020-Jail Based Competency Treatment		$200,000							$200,000
	RF 021 Total			**$51,982,000**							**$51,982,000**
	RF 502	4410010-Atascadero									
		4410020-Coalinga									
		4410030-Metropolitan									
		4410040-Napa									
		4410050-Patton									
	RF 502 Total										
0001-General Fund Total			**$233,187,000**	**$51,982,000**	**$777,000**	**$794,000**	**$15,000,000**	**$352,000**	**$986,000**	**$350,000**	**$303,428,000**
0814-California State Lottery Education Fund	**RF 511**	4410010-Atascadero									
		4410030-Metropolitan									
		4410040-Napa									
		4410050-Patton									
	RF 511 Total										
0814-California State Lottery Education Fund Total											
0995-Reimbursements	**RF 511**	4400010-Headquarters Administration									
		4400020-Hospital Administration									
		4410010-Atascadero									
		4410020-Coalinga									
		4410030-Metropolitan									
		4410040-Napa									
		4410050-Patton									
	RF 511 Total										
0995-Reimbursements Total											
Grand Total			**$233,187,000**	**$51,982,000**	**$777,000**	**$794,000**	**$15,000,000**	**$352,000**	**$986,000**	**$350,000**	**$303,428,000**

Detailed Funding Summary - All Programs
2021-22 Governor's Budget Detail of Adjustments

Department of State Hospitals
2021-22 Governor's Budget Estimates

Fund	Reference	Program	2021-22 Governor's Budget: Enrollment, Caseload and Population Adjustments							
			Admission, Evaluation and Stabilization Center: Existing Activation Delay	Community-Based Restoration Program Expansion	CONREP Continuum of Care: Existing	CONREP Continuum of Care: New	CONREP Non-SVP Caseload Update	CONREP Non-SVP Mobile FACT Team	Enhanced Treatment Program	IST Diversion Program Augmentation
0001-General Fund	RF 003	4410010-Atascadero								
		4410020-Coalinga								
		4410030-Metropolitan								
		4410040-Napa								
		4410050-Patton								
	RF 003 Total									
	RF 011	4400010-Headquarters Administration		$4,000		$2,000		$8,000		$14,000
		4400020-Hospital Administration		$1,000		$1,000		$2,000	-$12,000	$3,000
		4410010-Atascadero							-$1,477,000	
		4410020-Coalinga								
		4410030-Metropolitan								
		4410040-Napa								
		4410050-Patton							-$287,000	
		4410060-State Hospital Police Academy								
		4420010-Conditional Release Program			$0	$7,337,000	$1,200,000	$5,567,000		
		4420020-Conditional Release Program - Sexually Violent Predators								
		4430010-Admission, Evaluation, Stabilization Center	$0							
		4430020-Jail Based Competency Treatment								
		4430030-Other Contracted Services		$4,498,000						$47,567,000
		4440-Evaluation and Forensic Services								
	RF 011 Total		$0	$4,503,000	$0	$7,340,000	$1,200,000	$5,577,000	-$1,776,000	$47,584,000
	RF 017	4400010-Headquarters Administration								
		4400020-Hospital Administration								
	RF 017 Total									
	RF 021	4400010-Headquarters Administration								
		4400020-Hospital Administration								
		4410010-Atascadero								
		4410020-Coalinga								
		4410030-Metropolitan								
		4410040-Napa								
		4410050-Patton								
		4410060-State Hospital Police Academy								
		4430020-Jail Based Competency Treatment								
	RF 021 Total									
	RF 502	4410010-Atascadero								
		4410020-Coalinga								
		4410030-Metropolitan								
		4410040-Napa								
		4410050-Patton								
	RF 502 Total									
0001-General Fund Total			$0	$4,503,000	$0	$7,340,000	$1,200,000	$5,577,000	-$1,776,000	$47,584,000
0814-California State Lottery Education Fund	RF 511	4410010-Atascadero								
		4410030-Metropolitan								
		4410040-Napa								
		4410050-Patton								
	RF 511 Total									
0814-California State Lottery Education Fund Total										
0995-Reimbursements	RF 511	4400010-Headquarters Administration								
		4400020-Hospital Administration								
		4410010-Atascadero								
		4410020-Coalinga								
		4410030-Metropolitan								
		4410040-Napa								
		4410050-Patton								
	RF 511 Total									
0995-Reimbursements Total										
Grand Total			$0	$4,503,000	$0	$7,340,000	$1,200,000	$5,577,000	-$1,776,000	$47,584,000

Detailed Funding Summary - All Programs
2021-22 Governor's Budget Detail of Adjustments

Department of State Hospitals
2021-22 Governor's Budget Estimates

Fund	Reference	Program	2021-22 Governor's Budget: Enrollment, Caseload and Population Adjustments												
Fund	Reference	Program	Jail-Based Competency Treatment Program: Existing	Jail-Based Competency Treatment Program: New	Lanternman-Petris-Short Population and Personal Services Adjustment	Metropolitan State Hospital Increased Secure Bed Capacity Adjustment	Mission Based Review: Court Evaluations and Reports	Mission Based Review: Protective Services	Mission Based Review: Treatment Team	Psychiatric Workforce Development	Telepsychiatry Resources	Vocational Services and Patient Minimum Wage Caseload	ECP Total	GB Total	Grand Total
0001-General Fund	RF 003	4410010-Atascadero												$1,000	$3,673,000
		4410020-Coalinga												$13,000	$31,551,000
		4410030-Metropolitan												$1,000	$2,199,000
		4410040-Napa												$1,000	$2,240,000
		4410050-Patton												$0	$968,000
	RF 003 Total													**$16,000**	**$40,631,000**
	RF 011	4400010-Headquarters Administration					$0		$354,000	$0	$0		$382,000	$5,767,000	$70,791,000
		4400020-Hospital Administration				$0		$12,000	$30,000		$0		$37,000	$2,948,000	$105,343,000
		4410010-Atascadero						-$1,000	$186,000		-$791,000	$0	-$2,083,000	-$2,349,000	$297,364,000
		4410020-Coalinga							$1,210,000	$0	$791,000	$0	$2,001,000	$6,998,000	$326,328,000
		4410030-Metropolitan				$0	$0	-$4,000	-$1,080,000			$0	-$1,084,000	$386,000	$247,446,000
		4410040-Napa					$0	-$7,000	-$350,000	$0	$0	$0	-$357,000	$3,157,000	$310,794,000
		4410050-Patton					$0		-$350,000			$0	-$637,000	$395,000	$369,489,000
		4410060-State Hospital Police Academy													$6,447,000
		4420010-Conditional Release Program											$14,104,000	$14,355,000	$31,232,000
		4420020-Conditional Release Program - Sexually Violent Predators												$0	$34,461,000
		4430010-Admission, Evaluation, Stabilization Center											$0	$0	$16,063,000
		4430020-Jail Based Competency Treatment	$62,000	$6,275,000									$6,337,000	$6,237,000	$66,179,000
		4430030-Other Contracted Services											$52,065,000	$284,624,000	$301,826,000
		4440-Evaluation and Forensic Services												-$388,000	$23,027,000
	RF 011 Total		**$62,000**	**$6,275,000**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$70,765,000**	**$322,130,000**	**$2,206,790,000**
	RF 017	4400010-Headquarters Administration												$4,000	$432,000
		4400020-Hospital Administration												$51,000	$945,000
	RF 017 Total													**$55,000**	**$1,377,000**
	RF 021	4400010-Headquarters Administration												$2,977,000	$2,977,000
		4400020-Hospital Administration												$1,171,000	$1,171,000
		4410010-Atascadero												$7,663,000	$7,663,000
		4410020-Coalinga												$8,141,000	$8,141,000
		4410030-Metropolitan												$14,224,000	$14,224,000
		4410040-Napa												$4,144,000	$4,144,000
		4410050-Patton												$13,461,000	$13,461,000
		4410060-State Hospital Police Academy												$1,000	$1,000
		4430020-Jail Based Competency Treatment												$200,000	$200,000
	RF 021 Total													**$51,982,000**	**$51,982,000**
	RF 502	4410010-Atascadero													$46,000
		4410020-Coalinga													$101,000
		4410030-Metropolitan													$150,000
		4410040-Napa													$480,000
		4410050-Patton													$323,000
	RF 502 Total														**$1,100,000**
0001-General Fund Total			**$62,000**	**$6,275,000**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$70,765,000**	**$374,183,000**	**$2,301,880,000**
0814-California State Lottery Education Fund	RF 511	4410010-Atascadero												-$1,000	$7,000
		4410030-Metropolitan												-$1,000	$7,000
		4410040-Napa												-$1,000	$7,000
		4410050-Patton												-$2,000	$6,000
	RF 511 Total													**-$5,000**	**$27,000**
0814-California State Lottery Education Fund Total														**-$5,000**	**$27,000**
0995-Reimbursements	RF 511	4400010-Headquarters Administration													$0
		4400020-Hospital Administration												-$3,160,000	$252,000
		4410010-Atascadero			$162,000								$162,000	$3,322,000	$5,951,000
		4410020-Coalinga													$32,000
		4410030-Metropolitan			$3,727,000								$3,727,000	$3,727,000	$87,344,000
		4410040-Napa			$2,269,000								$2,269,000	$2,269,000	$61,668,000
		4410050-Patton			$1,944,000								$1,944,000	$1,944,000	$28,437,000
	RF 511 Total				**$8,102,000**								**$8,102,000**	**$8,102,000**	**$183,684,000**
0995-Reimbursements Total					**$8,102,000**								**$8,102,000**	**$8,102,000**	**$183,684,000**
Grand Total			**$62,000**	**$6,275,000**	**$8,102,000**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$78,867,000**	**$382,280,000**	**$2,485,591,000**

POSITION SUMMARY
CURRENT YEAR 2020-21

	Authorized Positions Budget Act 2020	Authorized Blanket Positions 2020	Protected Health Information (PHI) Permanent Implementation	Medical and Pharmaceutical Billing System	Patient Education	Increased Court Appearances and Public Records Act Requests	Skilled Nursing Facility Infection Preventionists	IST Diversion	DSH - Metro ISBC	Enhanced Treatment Program	Telepsychiatry Resources	Mission Based Review - Protecive Services	Mission Based Review - Treatment Team	Community-Based Restoration (CBR) Program Expansion	CONREP Continuum of Care - New	CONREP Non-SVP Mobile Fact Team	Community Care Demonstration Project for Felony ISTs	Total November Estimate Adjustments	Total Positions CY 2020-21	Total CY Adjustments
Headquarters Admin	**252.2**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.5	0.0	-0.6	0.0	0.3	0.0	0.0	**-0.8**	**251.4**	**-0.8**
Hospital Admin	**246.0**	**2.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**248.0**	**0.0**
DSH-Atascadero	**2167.5**	**30.1**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-28.0	-3.5	0.0	-1.0	0.0	0.0	0.0	0.0	**-32.5**	**2,165.1**	**-32.5**
DSH-Coalinga	**2354.7**	**28.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.5	0.0	0.5	0.0	0.0	0.0	0.0	**-1.0**	**2,381.7**	**-1.0**
DSH-Metropolitan	**2165.0**	**67.2**	0.0	0.0	0.0	0.0	0.0	0.0	-120.6	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	**-120.3**	**2,111.9**	**-120.3**
DSH-Napa	**2487.3**	**47.5**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.0	0.0	0.4	0.0	0.0	0.0	0.0	**-0.6**	**2,534.2**	**-0.6**
DSH-Patton	**2415.0**	**81.2**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-2.1	0.0	0.0	0.4	0.0	0.0	0.0	0.0	**-1.7**	**2,494.5**	**-1.7**
State Hospital Police Academy	**10.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**10.0**	**0.0**
CONREP	**13.2**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**13.2**	**0.0**
CONREP SVP	**5.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**5.0**	**0.0**
AES	**1.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**1.0**	**0.0**
JBCT	**5.1**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**5.1**	**0.0**
Other Contracted Services	**1.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**1.0**	**0.0**
Evaluation and Forensic Services	**66.3**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**66.3**	**0.0**
2020-21 Established Position Totals	12,189.2	256.0	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**-120.6**	**-30.1**	**-6.5**	**0.0**	**0.0**	**0.0**	**0.3**	**0.0**	**0.0**	**-156.9**	**12,288.3**	**-156.9**

POSITION SUMMARY
BUDGET YEAR 2021-22

	Authorized Positions Budget Act 2020	Authorized Blanket Positions 2020	Protected Health Information (PHI) Permanent Implementation	Medical and Pharmaceutical Billing System	Patient Education	Increased Court Appearances and Public Records Act Requests	Skilled Nursing Facility Infection Preventionists	IST Diversion	DSH - Metro ISBC	Enhanced Treatment Program	Telepsychiatry Resources	Mission Based Review - Protecive Services	Mission Based Review - Treatment Team	Community-Based Restoration (CBR) Program Expansion	CONREP Continuum of Care - New	CONREP Non-SVP Mobile Fact Team	Community Care Demonstration Project for Felony ISTs	Total November Estimate Adjustments	Total Positions BY 2021-22	Total BY Adjustments
Headquarters Admin	**246.8**	**0.0**	8.0	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	0.0	0.5	0.0	4.0	**24.5**	**271.3**	**24.5**
Hospital Admin	**246.0**	**2.0**	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**1.0**	**249.0**	**1.0**
DSH-Atascadero	**2,217.4**	**30.1**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-9.9	-7.0	1.0	-2.0	0.0	0.0	0.0	0.0	**-17.9**	**2,229.6**	**-17.9**
DSH-Coalinga	**2,380.0**	**28.0**	0.0	0.0	3.0	0.5	0.0	0.0	0.0	0.0	7.0	0.0	3.0	0.0	0.0	0.0	0.0	**13.5**	**2,421.5**	**13.5**
DSH-Metropolitan	**2,206.7**	**67.2**	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	4.0	0.0	0.0	0.0	0.0	0.0	**5.0**	**2,278.9**	**5.0**
DSH-Napa	**2,515.5**	**47.5**	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	7.0	1.0	0.0	0.0	0.0	0.0	**9.0**	**2,572.0**	**9.0**
DSH-Patton	**2,470.0**	**81.2**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.7	0.0	0.0	1.0	0.0	0.0	0.0	0.0	**-0.7**	**2,550.5**	**-0.7**
State Hospital Police Academy	**10.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**10.0**	**0.0**
CONREP	**13.2**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	**2.0**	**15.2**	**2.0**
CONREP SVP	**5.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**5.0**	**0.0**
AES	**1.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**1.0**	**0.0**
JBCT	**5.1**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**5.1**	**0.0**
Other Contracted Services	**1.0**	**0.0**	0.0	0.0	0.0	0.0	0.0	3.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	0.0	**4.0**	**5.0**	**4.0**
Evaluation and Forensic Services	**66.3**	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**	**66.3**	**0.0**
2021-22 Established Position Totals	12,383.9	256.0	**8.0**	**1.0**	**3.0**	**5.5**	**2.0**	**3.0**	**0.0**	**-11.6**	**0.0**	**12.0**	**10.0**	**1.0**	**0.5**	**2.0**	**4.0**	**40.4**	**12,680.3**	**40.4**

STATE HOSPITALS POPULATION

	2020-21 May Revise Projection	CURRENT YEAR 2020-21				
	June 30, 2020 Projected Census	**July 1, 2020 Actual Census**	**Previously Approved Adjustments CY 2020-21**	**2020-21 November Adjustment CY 2020-21**	**2020-21 May Revision Adjustment CY 2020-21**	**June 30, 2021 Projected Census**
POPULATION BY HOSPITAL						
ATASCADERO	*1,069*	1,027	13	0	0	1,040
COALINGA	*1,392*	1,365	0	0	0	1,365
METROPOLITAN	*891*	797	0	0	0	797
NAPA	*1,255*	1,090	0	0	0	1,090
PATTON	*1,487*	1,445	0	0	0	1,445
TOTAL BY HOSPITAL	***6,094***	**5,724**	**13**	**0**	**0**	**5,737**
POPULATION BY COMMITMENT						
Coleman - PC 2684[1]	*187*	280	0	0	0	280
IST - PC 1370	*1,506*	1,025	4	0	0	1,029
LPS & PC 2974	*736*	775	3	0	0	778
OMD[2] - PC 2962	*541*	546	3	0	0	549
OMD[2] - PC 2972	*776*	749	0	0	0	749
NGI - PC 1026	*1,387*	1,407	3	0	0	1,410
SVP - WIC 6602/6604	*961*	942	0	0	0	942
TOTAL BY COMMITMENT	***6,094***	**5,724**	**13**	**0**	**0**	**5,737**
CONTRACTED PROGRAMS						
AES KERN CENTER	*90*	55	5	0	0	60
REGIONAL JBCT	*218*	176	61	0	0	237
SINGLE COUNTY JBCT	*105*	111	9	13	0	133
SMALL COUNTY MODEL JBCT: MENDOCINO, MARIPOSA[3]	*N/A*	N/A	N/A	N/A	N/A	N/A
TOTAL - CONTRACTED PROGRAMS	***413***	**342**	**75**	**13**	**0**	**430**
CY POPULATION AND CONTRACTED TOTAL	***6,507***	**6,066**	**88**	**13**	**0**	**6,167**

Note: DSH contracts with community based programs to provide IST restoration and conditional release services. These services are provided through the Los Angeles IST Restoration Program, which operates 150 beds and through the Conditional Release Program, which operates an average of 646 beds.

DJJ census is not displayed in accordance with data de-identification guidelines

[1] *Coleman* - Reflects current census; pursuant to *Coleman v. Brown* 336 beds are available to *Coleman* patients.

[2] Effective January 1, 2020 the term referring to the patient population Mentally Disordered Offender (MDO) is changed to Offender with a Mental Health Disorder (OMD) per SB 591 (Statutes of 2019).

[3] Mendocino and Mariposa JBCT do not have a set number of beds and instead focus on the number of patients served. As such, the annual population change total does not include these additional beds.

STATE HOSPITALS POPULATION

	2020-21 May Revise Projection	BUDGET YEAR 2021-22				
	June 30, 2021 Projected Census	July 1, 2021 Projected Census	Previously Approved Adjustments BY 2021-22	2020-21 November Adjustment BY 2021-22	2020-21 May Revision Adjustment BY 2021-22	June 30, 2022 Projected Census
POPULATION BY HOSPITAL						
ATASCADERO	*1,095*	1,040	-40	0	0	1,000
COALINGA	*1,392*	1,365	0	0	0	1,365
METROPOLITAN	*1,031*	797	140	0	0	937
NAPA	*1,255*	1,090	0	0	0	1,090
PATTON	*1,497*	1,445	10	0	0	1,455
TOTAL BY HOSPITAL	***6,270***	**5,737**	**110**	**0**	**0**	**5,847**
POPULATION BY COMMITMENT						
Coleman - PC 2684[1]	*187*	280	0	0	0	280
IST - PC 1370	*1,658*	1,029	86	0	0	1,115
LPS & PC 2974	*742*	778	6	0	0	784
OMD[2] - PC 2962	*550*	549	9	0	0	558
OMD[2] - PC 2972	*776*	749	0	0	0	749
NGI - PC 1026	*1,396*	1,410	9	0	0	1,419
SVP - WIC 6602/6604	*961*	942	0	0	0	942
TOTAL BY COMMITMENT	***6,270***	**5,737**	**110**	**0**	**0**	**5,847**
CONTRACTED PROGRAMS						
AES KERN CENTER	*90*	60	30	16	0	106
REGIONAL JBCT	*264*	237	0	0	0	237
SINGLE COUNTY JBCT	*135*	133	10	28	0	171
SMALL COUNTY MODEL JBCT: MENDOCINO, MARIPOSA[3]	*N/A*	N/A	N/A	N/A	N/A	N/A
TOTAL - CONTRACTED PROGRAMS	***489***	**430**	**40**	**44**	**0**	**514**
BY POPULATION AND CONTRACTED TOTAL	***6,759***	**6,167**	**150**	**44**	**0**	**6,361**

Note: DSH contracts with community based programs to provide IST restoration and conditional release services. These services are provided through the Los Angeles IST Restoration Program, which operates 150 beds and through the Conditional Release Program, which operates an average of 646 beds.

DJJ census is not displayed in accordance with data de-identification guidelines

[1] *Coleman* - Reflects current census; pursuant to *Coleman v. Brown* 336 beds are available to *Coleman* patients.

[2] Effective January 1, 2020 the term referring to the patient population Mentally Disordered Offender (MDO) is changed to Offender with a Mental Health Disorder (OMD) per SB 591 (Statutes of 2019).

[3] Mendocino and Mariposa JBCT do not have a set number of beds and instead focus on the number of patients served. As such, the annual population change total does not include these additional beds.

POPULATION DATA
STATE HOSPITALS
POPULATION AND PERSONAL SERVICES ADJUSTMENTS
(Informational Only)

COVID-19 IMPACT ON CENSUS AND REFERRALS

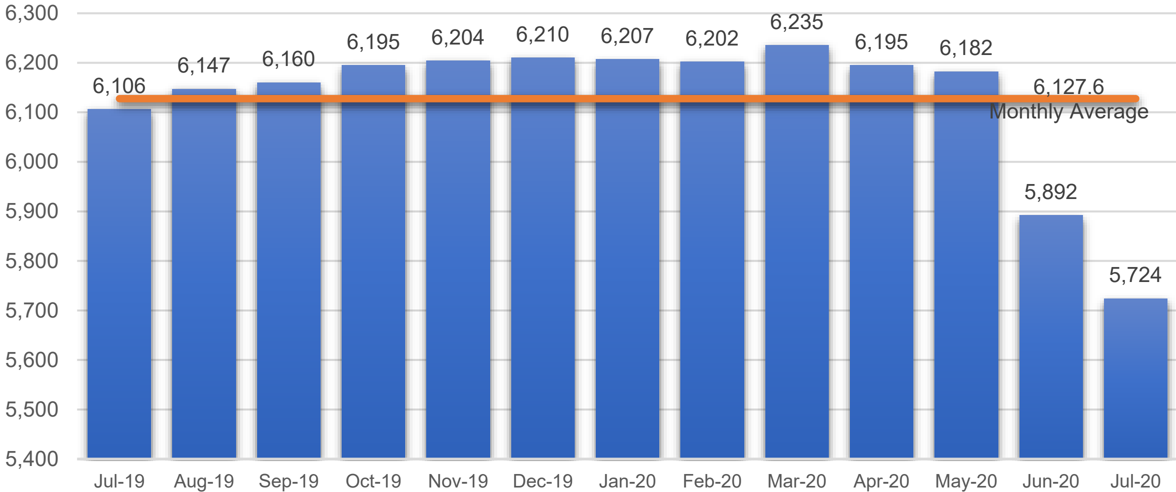
Temporary Census Reduction due to COVID-19

On March 2, 2020 Governor Gavin Newsom issued a Proclamation of a State of Emergency, followed by a shelter-in-place (SIP) order that went into effect on March 19, 2020. On March 21, 2020 the Department of State Hospitals (DSH) temporarily suspended patient admissions into its hospitals for all patient commitment types, excluding Offenders with a Mental Health Disorder (OMD) under authority of Executive Order N-35-20.

As DSH resumed admissions at the end of May 2020, inpatient census was temporarily decreased due to the need to create Admission Observation Units (AOUs) and isolation units to mitigate the impacts of COVID-19 and prioritize the safety of patients and staff. To establish AOUs and isolation units, hospitals needed to empty units which impacted DSH's inpatient census and the ability to maintain admission rates. As a result of the need to keep newly admitted patients separate, units that normally housed multiple patients in dorm rooms were only able to house one patient per room, thus limiting the census on AOUs to the number of rooms within the unit. As admissions resumed DSH also needed to isolate patients in AOUs for at least 14 days while testing the cohort for COVID-19. Further testing and quarantine procedures were observed when positive COVID-19 cases were identified in an admission cohort or when hospitals experienced an outbreak.

Due to the need to create AOUs and isolation units, DSH's census reduced by approximately nine percent from 6,235 on March 1, 2020 to 5,724 on July 1, 2020. This census decrease caused DSH's occupancy rates to temporarily come down to 91 percent from the pre-COVID-19 occupancy rate of 96 percent. DSH anticipates this decrease to be temporary until AOUs and isolation units are no longer needed for COVID-19 response.

Chart 1: State Hospitals Monthly Census Trend: July 2019 - July 2020



Staffing Needs

While the DSH census has temporarily decreased as a result of COVID-19, staffing needs and responsibilities at all hospitals have increased. Maintaining appropriate staffing levels in a hospital is essential to providing a safe work environment for health care personnel as well as to preserving safe patient care. With the onset and progression of the COVID-19 pandemic, hospitals are experiencing impacts to staffing in both staff isolating or quarantining as well as an increase in responsibilities in continuing to mitigate the spread of COVID-19 within the hospital.

Below is an overview of the additional protocols that have been established throughout the hospitals as well as additional responsibilities that healthcare personnel are needing to perform as a result of COVID-19. Hospitals have had to implement the following protocols and procedures to ensure the safety of patients and staff during this pandemic:

- Staff a full COVID-19 screening line across three shifts to perform primary and secondary screening and evaluation for all staff entering the hospitals, with the secondary screening being provided by a health care personnel
- Set up AOUs to house newly admitted patients for a quarantine period
- Establish Isolation Units to separate COVID-19 positive patients from patients that are not sick
- Set up Patient Under Investigation (PUI) Rooms or Units for patients that have symptoms consistent with COVID-19 but are not confirmed to be infected
- Quarantine units as needed to safeguard against spread of COVID-19
- Provide increase cleaning and sanitation protocols on the units
- Limit movement of staff between quarantined units and non-quarantine units and dedicate staffing to isolation units to prevent cross-contamination between units.
- Observe and audit staff compliance with personal protective equipment (PPE) protocols and social distancing protocols.
- Increase resources for the DSH Public Health teams to perform COVID-19 related functions such as contact tracing, testing, reporting and coordination with county Public Health Department
- Coordinate and manage all off-unit patient movement to avoid cross-contamination between units by requiring staff to escort patients
- Coordinate return to work functions for staff returning from COVID-19 related leave
- Provide all meals on unit for high risk populations and quarantined units, impacting both nutrition services and staff on unit
- Suspend all in-person patient visits and switch to a virtual visitation experience

With the additional protocols and procedures being implemented at the hospitals staff are having to assume additional responsibilities which include the following:

- Increased tracking and documentation requirements related to COVID-19
- Admit patients in cohorts, which involves bringing in larger groups of patients over a short period of time, increasing the treatment team workload as documentation requirements are needing to be completed quicker for a larger group of patients
- Perform screening protocols for patients and staff arriving into the hospital
- Provide continuous education to patients and other staff regarding safety protocols, droplet/contact precautions, and medical isolation process and expectations to mitigate COVID-19 risk and exposure
- Continuously clean and disinfect units, equipment, and high touch surface areas in both patient and staff occupied areas
- Perform high-risk procedures such as administering COVID-19 tests on patients, made more complex by DSH's patient population
- Follow specific testing protocols for quarantined units including baseline testing for all patients and staff and subsequent testing until two sequential rounds of testing show negative results for all employees and patients
- Perform surveillance testing for Skilled Nursing Facility (SNF) patients and health care personnel.
- Perform assessments of patients displaying symptoms of COVID-19
- Continuously assess vital signs and respiratory status for patients in quarantined units, isolation units and PUI rooms
- Coordinate all on unit meal services for high risk populations and quarantined units
- Provide all treatment, including religious service options and group treatment, on unit, creating the need to rewrite/restructure treatment plans and groups to accommodate the new delivery formats
- Coordinate virtual visits for patients

Referral and Census Trends

Since the inception of COVID-19 and the implementation of the SIP order, followed by the implementation of a safe admission process into AOUs, the Incompetent to Stand Trial (IST) waitlist has increased by 50 percent to 1,306 as of November 30, 2020. Although DSH observed a 56 percent decrease in weekly IST referral rates associated with county court closures following the SIP order, the IST waitlist increased following DSH's temporary suspension of admissions. Similar referral trends were observed with the Lanterman–Petris–Short (LPS), Not Guilty by Reason of Insanity (NGI), OMD 2972, Sexually Violent Predator (SVP), and *Coleman* legal classes following the SIP order. Weekly referral rates decreased by the following rates: 23 percent for LPS population, 43 percent for the NGI population, 57 percent for the OMD 2972 population, 51 percent for the SVP population and 77 percent for the *Coleman* population. As county courts have begun resuming court proceedings, DSH's referral rates have steadily increased.

Table 1: Pre and Post SIP Order Waitlist and Weekly Referral Averages*

CA Statewide Shelter-in-Place Order: **March 19, 2020**							
	IST	LPS	OMD 2962	OMD 2972	NGI	SVP	*Coleman*
Pre-SIP Waitlist: 3/16/2020	869	241	54	<11	24	0	<11
Post-SIP Waitlist: 5/25/2020	1144	196	97	11	38	<11	<11
Current Waitlist: 11/30/2020	1306	259	28	<11	31	***	23
Pre-SIP Average Weekly Referrals (7/1/19 – 3/21/20)	78.5	<11	<11	<11	<11	<11	12.8
Post-SIP Average Weekly Referrals (3/22/20 – 5/30/20)	34.9	<11	11.7	<11	<11	<11	<11
% Change (Referrals):	*-56%*	*-23%*	*23%*	*-57%*	*-43%*	*-51%*	*-77%*
Current Average Weekly Referrals[1]	79.9	<11	<11	<11	<11	<11	<11

*Referral data excludes JBCT Transfers, SH Transfers and Court Returns.
[1]Current average weekly referrals reflect most recent referral data from October 2020 through November 2020.

Prior to the onset of COVID-19 in March 2020, DSH's average monthly IST referrals were trending close to fiscal year (FY) 2018-19 averages and overall DSH referrals were almost one percent higher. Due to COVID-19, average monthly referrals have generally declined with an overall 11.4 percent decrease from FY 2018-19 to FY 2019-20, with *Coleman* being the only population to have an increase in average monthly referrals (+30.8%).

Table 2: Average Monthly Referrals*

	FY 2018-19	**FY 2019-20** (Pre-COVID-19) [1]	**FY 2019-20** (Post-COVID-19) [2]	**FY 2019-20**	**% Change** FY 2018-19 to FY 2019-20
IST *(with JBCT/AES)*	350.0	345.5	209.8	300.3	-14.2%
LPS	15.8	<11	<11	<11	-48.8%
OMD2962	46.4	40.6	46.5	42.6	-8.2%
OMD2972	<11	<11	<11	<11	-11.3%
NGI	11.3	11.8	<11	<11	-7.8%
SVP	<11	<11	<11	<11	-40.8%
CDCR	35.3	56.1	26.3	46.2	30.8%
	465.7	**468.3**	**301.3**	**412.8**	**-11.4%**

[1]FY 2019-20 pre-COVID-19 referral data reflects averages from July 2019 through February 2020.
[2]FY 2019-20 post-COVID-19 referral data reflects averages from March 2020 through June 2020.
DJJ census and referral data is not displayed in accordance with data de-identification guidelines.

* Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

Table 3: Patient Census

	June 30, 2019	February 29, 2020 (Pre-COVID-19)	June 30, 2020	% Change 6/30/2019 to 6/30/2020
IST *(with JBCT/AES)*	1,811	1,894	1,324	-26.9%
LPS	736	747	776	5.4%
OMD2962	559	508	533	-4.7%
OMD2972	778	760	748	-3.9%
NGI	1,416	1,415	1,407	-0.6%
SVP	962	943	942	-2.1%
CDCR	185	296	281	51.9%
	6,447	**6,563**	**6,011**	**-6.8%**

DJJ census and referral data is not displayed in accordance with data de-identification guidelines.

POPULATION PROJECTIONS

Census and Pending Placement List Projections

DSH utilizes the actual census as the baseline census for both current year (CY) and budget year (BY). For the Governor's Budget and May Revision, the methodologies to project future census figures are applied as described below.

Methodology

In the 2016 Governor's Budget DSH implemented a methodology to project the pending placement list. Through collaborative efforts with the University of California, Irvine's (UCI) Department of Criminology, Law, and Society research team this methodology has been enhanced and expanded to include additional commitments. Moving forward this methodology will be used as the standard forecasting tool to project the pending placement list for the IST, LPS, OMD, NGI and Sexually Violent Predator (SVP) populations. This methodology does not project for the *Coleman* or the Division of Juvenile Justice (DJJ) patients. Department of Corrections and Rehabilitation (CDCR) determines the bed need and produces projections for the *Coleman* population and contracts with DSH for a specific number of beds to serve the DJJ population.

This methodology utilizes four main measures, as well as expected systemwide capacity expansions, to forecast the pending placement list. These measures include pending admissions, average referrals, average admissions and average length of stay (ALOS). A projected pending placement list is generated by adding a point-in-time pending placement list value to an average of monthly new patient referrals. This value is then reduced by the correlating average of monthly admissions, which are offset to incorporate any bed decreases. Expected systemwide capacity increases, augmented by the appropriate ALOS, are then subtracted from the projected pending placement list to yield a modified pending placement list projection for future months.

The projected pending placement list for CY and BY is based on the modified pending placement list value calculated for June 30, 2021 and June 30, 2022. Variables are specific to patient legal class and are typically calculated using actual data for the most recent 12-month period. Variables had to be adjusted for the FY 2021-22 Governor's Budget Estimate to incorporate COVID-19-related circumstances for admissions and referrals.

To ensure that admission and referral variables reflect current conditions, pending placement projections are calculated based on the trends observed in September 2020 for the IST, NGI, LPS and SVP populations. OMD variables continue to be based on the most recent 12-month period ending September 30, 2020 as OMD admissions were not suspended. As such. referral rates for this patient type were not impacted by court closures.

The table below presents the DSH pending placement list projections for the IST, LPS, OMD, NGI and SVP populations. The table also presents the actual census for July 1, 2020 as well as the projected census for CY and BY for all DSH populations. The actual census reflects the systemwide total number of patients at DSH on July 1, 2020. The projected census for June 30, 2021 (for CY) and June 30, 2022 (for BY) reflects the actual census as well as the approved and proposed census adjustments.

Table 4: Census and Pending Placement List Projections

CURRENT YEAR			
Legal Class	July 1, 2020 Actual Census	June 30, 2021 Projected Census	June 30, 2021 Projected Pending Placement List
IST *(with JBCT/AES)*	1,367	1,459	1,268
LPS	775	778	257
OMD2962	546	549	34
OMD2972	749	749	7
NGI	1,407	1,410	80
SVP	942	942	6
Subtotal	5,786	5,887	1,652
Coleman[1]	280	280	
Total	6,066	6,167	1,652
BUDGET YEAR			
Legal Class	July 1, 2021 Projected Census	June 30, 2022 Projected Census	June 30, 2022 Projected Pending Placement List
IST *(with JBCT/AES)*	1,459	1,629	769
LPS	778	784	311
OMD2962	549	558	30
OMD2972	749	749	7
NGI	1,410	1,419	131
SVP	942	942	0
Subtotal	5,887	6,081	1,248
Coleman[1]	280	280	
Total	6,167	6,361	1,248

[1] The projected pending place list is not calculated for the Coleman and DJJ populations within the DSH forecasting model. Projections for the Coleman population is developed by CDCR; the DJJ population is based on contracted beds agreed to between CDCR and DSH. DJJ census is not displayed in accordance with data de-identification guidelines.

COMMITMENT CODES

Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI*	RONGI, RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
IST	IST PC1370	PC 1370 or TITLE 18 USC 4244	Incompetent to Stand Trial
Other IST	MIST	PC 1370.01	Misdemeanant Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST, RO1370	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1370 (IST)
Other IST*	DDIST	PC 1370.1	Commitment as Incompetent to Stand Trial because of Developmental Disability (up to 6 months) and Mental Disorder
OMD	PC2962	PC 2962	Parolee Referred from the Department of Corrections
OMD	PC2964a	PC 2964(a)	Parolee Rehospitalized from CONREP after DSH hearing
OMD	PC2972	PC 2972	Former Parolee Referred from Superior Court
OMD*	RO2972	PC 1610	Temporary admission while waiting for court revocation of PC 2972
MDSO*	MDSO	WIC 6316	Mentally Disordered Sex Offender--Observation
MDSO*	MDSOI	WIC 6316	1. MDSO Observation Indeterminate; 2. MDSO Return by Court
MDSO*	ROMDSO	PC 1610	Temporary Admission while waiting for Court Revocation of MDSO
Other SVP	SVPH	WIC 6601.3	Sexually Violent Predator BPH Hold
Other SVP	SVPE	WIC 6600	Sexually Violent Predator Court Hold
SVP	SVP	WIC 6604	Sexually Violent Predator
SVP	SVPP	WIC 6602	Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Prisoner from the Department of Corrections
PC 2685	PC2684A	PC 2684A	Prisoner from the Department of Corrections
DJJ W&I 1756	YAC	WIC 1756	Office
LPS	T.CONS	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship for Gravely Disabled Persons
LPS	VOL	WIC 6000	Voluntary
LPS	DET	WIC 5150	72-Hour Detention
LPS	CERT	WIC 5250	14-Day Certification
LPS	SUIC	WIC 5260	Additional 14-Day Certification for Suicidal Persons
LPS	POST	WIC 5304(a)	180-Day Post Certification--ONLY (until 6/91 used for pending cases also, see 37)
LPS	ADD	WIC 5304(b)	Additional 180-Day Post Certification
LPS	A-CERT	WIC 5270.15	30-Day Certification
LPS	PCD	WIC 5303	Pending Court Decision on 180-Day Post Certification
LPS	MURCONS	WIC 5008(h)(1)(B)	Murphy's Conservatorship
LPS	DMR	WIC 6500, 6509	Persons with Intellectual Disabilities Committed by Court
LPS	CAMR	WIC 4825, 6000(a)	Voluntary Adult Developmentally Disabled Under Own Signature by Regional Center
LPS	VJCW	WIC 6552	Voluntary Juvenile Court Ward
LPS	DMRH	WIC 6506	Hold Pending Hearing on W&I 6509 Petition
LPS*	PC 2974	PC 2974	Recommitment after expiration of prison term (must have concurrent W&I commitment)

* Items marked with an asterisk were previously captured in the "Other PC" category

Department of State Hospitals

Demographic Snapshot: All Commitment Types
July 1, 2020; Census: 5,724

Basic Demographics

Gender

M 86%
F 14%

Age

18-64: 84%
65+: 16%

Ethnicity

Asian 5%
Black 25%
Hispanic 25%
Other/Unknown 3%
White 42%

Resident County

South Coast Region 42%
Bay Area 19%
Central Region 15%
North Central Region 11%
Inland Deserts Region 11%
Northern Region 3%

Language Spoken at Home

English 66.6%
Spanish 3.8%
Tagalog 0.2%
Vietnamese 0.3%
Other / Unknown 29.2%

While at a State Hospital

Level of Care

ACUTE PSY 23%
SNF 2%
ICF - SUBACUTE 69%
RESIDENTIAL 6%

Prevelance of Diagnoses

Schizophrenia 38%
Schizoaffective disorders 24%
Paraphilias 16%
Unspecified psychosis not due to a substance or known physiological condition 8%
Bipolar Disorder 5%
Other Disorders 9%

Summary

The DSH population is composed of 86% males and 14% females; a majority of this population is between the ages of 18 and 64. Approximately 42% identify as White, 25% Black, and 25% Hispanic with mostly English spoken at home. The majority of the DSH population are residents of South Coast and Bay Area counties. DSH patients are being treated at an Intermediate level of care 69% of the time, followed by 23% at an Acute level of care, 6% at an RRU level of care, and 2% at an SNF level of care. Schizophrenia, Schizoaffective, and Paraphilia-type disorders are the three most common diagnoses for the DSH population, accounting for 78% of the population.

Note: US Citizenship field is not required in ADT. Therefore, data may not reflect true values.

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	Business Unit	Department	Priority No.
2021-22	4440	Department of State Hospitals	04

Budget Request Name	Program	Subprogram
4440-002-BCP-2021-GB	4400 – Administration	4400010 – Headquarters Administration

Budget Request Description
Protected Health Information (PHI) Permanent Implementation

Budget Request Summary
The Department of State Hospitals (DSH) requests $986,000 General Fund in Fiscal Year (FY) 2021-22 and FY 2022-23 to extend 8.0 limited- term positions for an additional two years to continue processing of invoices and payments from external medical providers containing Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and consolidating DSH's financial operations into a single budget unit.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed
☐ Yes ☒ No	Click or tap here to enter text.

Does this BCP contain information technology (IT) components? ☐ Yes ☒ No	Department CIO	Date
If yes, departmental Chief Information Officer must sign.	Click or tap here to enter text.	Click or tap to enter a date.

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. Click or tap here to enter text. **Project Approval Document:** Click or tap here to enter text.

Approval Date: Click or tap to enter a date.

If proposal affects another department, does other department concur with proposal? ☐ Yes ☒ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Vu T. Tran, Chief of Accounting	7/23/2020	Marcelo Acob, Chief Financial Officer	Click or tap to enter a date.
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	Click or tap to enter a date.	Mark Ghaly, MD, MPH	Click or tap to enter a date.

Department of Finance Use Only

Additional Review: ☐ Capital Outlay ☐ ITCU ☐ FSCU ☐ OSAE ☐ CALSTARS ☐ Dept. of Technology

PPBA	Date submitted to the Legislature
Click or tap here to enter text.	Click or tap to enter a date.

A. Budget Request Summary

The Department of State Hospitals (DSH) requests $986,000 General Fund in Fiscal Year (FY) 2021-22 and FY 2022-23 to extend 8.0 limited-term positions for an additional two years. DSH has a need to continue the processing of invoices and payments from external medical providers containing Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the consolidation of DSH's financial operations into a single budget unit. This request will help DSH to more effectively process payments for outside medical services without jeopardizing access to PHI and quality patient care as well as standardizing the process for capturing medical invoice data and minimizing redundant key data entry.

B. Background/History

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 12,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily censuses of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

In FY 2019-20, DSH processed over 63,000 outside medical invoices and more than 80 percent of these (51,000) contained PHI. DSH patients have unique and acute medical and clinical needs that oftentimes require visits to specific external providers (i.e. specialists, emergency services, etc.). These medical providers' invoices in turn contain a combination of patient information (i.e. patient's name, patient identification number, diagnosis, medical service received, date of service, etc.) to document services rendered to DSH patients. Invoices that contain PHI are governed by mandated HIPAA requirements. Each state hospital receives direct invoices from outside medical providers for services rendered to its patients. Every invoice is adjudicated by the appropriate DSH accounting and program staff.

New electronic systems introduce the need to develop protection measures to prevent exposure of PHI, including auditing and incident response to safeguard internal controls. As noted previously, a significant portion of DSH's invoices contain confidential and sensitive information, including patient data that falls under mandated HIPAA compliance. Security experts estimate data breach costs ranging from $150 to $350 per record. These costs include required fines that the state would pay and services for the individuals impacted that include phone service to answer questions, advertising to publicize the breach, and credit monitoring services if social security numbers (SSN) are involved. A data breach would be detrimental to those whose data is compromised and costly to the State.

In July 2018, a new statewide Accounting system called Financial Information System for California (FI$Cal) was implemented at DSH to replace the legacy system, California State Accounting and Reporting System (CalSTARS). To increase transparency of the state's financial reporting and information, the FI$Cal and State Controller's Office (SCO) implementation brought in additional processes and requirements to statewide accounting practices. The PHI solution to FI$Cal required the development of operating policies such as workflow, records retention and SCO audit procedures. During the first year of implementation SCO performed a review of each of the state hospitals outside medical invoice payment processes and determined that DSH had followed the proper program rules and guidelines for issuing payment.

However, one area of vulnerability for a security breach is processing payments for external medical providers. FI$Cal was not configured to accept PHI and given DSH's approximate annual volume of 36,000 PHI invoices, the risk of information security breaches is high. Prior to FI$Cal

implementation, California Office of Health Information Integrity (CalOHII) was a key advocate on behalf California Health and Human Services (CHHS) and DSH requesting that we be granted an extension to implement FI$Cal since system was not HIPAA compliant. We updated CalOHII while developing MedCP so they were aware of home grown system that allowed for HIPAA compliancy and still used FI$Cal to create voucher payments. As such, DSH developed a HIPAA compliant process for procurement, claim adjudication, and claim payments of invoices to external providers. The Medical Claims Processing (MedCP) data base system, developed by DSH, standardized the process of capturing medical invoice data. MedCP de-identifies PHI so payments can still occur timely, but will not include any PHI, consequently reducing DSH's risk of an information security breach. DSH includes the minimum information necessary for vendors to reconcile their invoice to the voucher and reduce the number of vendor inquiries regarding vouchers.

In addition to implementing FI$Cal (PeopleSoft Platform), DSH consolidated its organization structure shifting from six Organization Codes or Business Units (BU) to one. Historically, all DSH locations have done their own accounting and SCO reconciliation. Reports used for reconciliation purposes contained only transactions which pertained to the individual BUs. With the shift to one BU, those reconciliation tools now contain data for all six locations, which makes the accounting reconciliations much more complex and requiring more resources. Additionally, accounting data for all five facilities resides under a single program because all facilities now fall under one program In 2018-19 DSH was authorized 8.0 three-year limited-term positions to address the increased workload associated with payment of invoices containing PHI and the increased workload associated with reconciliations.

Resource History

(Dollars in thousands)

Program Budget	**PY – 3**	**PY – 2**	**PY-1**	**PY[1]**	**CY[1]**
Authorized Expenditures	$410	$410	$853[2]	$858	$858[2]
Actual Expenditures	$410	$410	$853[2]	$858	$858[2]
Revenues	N/A	N/A	N/A	N/A	N/A
Authorized Positions	3.8	3.8	6.8	6.8	6.8
Filled Positions	3.8	3.8	6.8[3]	6.8[3]	6.8[3]
Vacancies	0.0	0.0	0.0	0.0	0.0

[1]2020-2021 Numbers are projections based on prior years.

[2]Includes expenditures due to new funds from limited term PHI BCP.

[3]Includes filled positions due to new positions from limited term PHI BCP.

WORKLOAD HISTORY

WORKLOAD MEASURE	**PY – 4**	**PY – 3**	**PY – 2**	**PY-1**	**PY**	**CY**
Number of PHI Invoices	36,109	35,459	33,758	40,550	51,352	51,149[1]

[1] This a projection based on YTD actuals but numbers are expected to increase in Jan-Jun. It is difficult to project as COVID-19 cases fluctuate from month to month and there is a typical lag in provider billings

C. State Level Consideration

This proposal is consistent with statewide and departmental priorities such as:

- DSH's goal for a safe environment and excellence in treatment. Providing timely payment to contracted medical providers helps DSH patients receive quality and timely treatment
- DSH Technology Services Division Management Plan Goal #4 - Safeguard sensitive and confidential data
- State of California's Information Technology Strategic Plan Goal 4 - Secured Information, Objective 4.1 - Protect sensitive data through robust security and privacy programs
- California State Auditor report 2015-611 recommendations that state entities work with the California Department of Technology to reach full compliance with security standards

Additionally, this proposal is in alignment with California Health and Human Services strategic priorities focused on integrating health and human services, specifically integrating clinical, financial, and system structures to facilitate seamless care delivery for DSH's patients.

D. Justification

If DSH is not able to retain the 8.0 positions to continue processing HIPAA compliant invoices through Medical Claims Processing (MedCP) database system, it would be difficult to continue making timely payments and DSH would run the risk that current medical vendors may discontinue providing services to DSH patients. Also providing prompt payment to medical service vendors promotes continued access to quality, affordable patient care. Furthermore, retention of the 8.0 limited-term positions will continue to reduce the risk of a breach of HIPAA data, which would result in fines and potential legal action.

DSH has an entirely paper-based process for processing its 63,000 outside vendor invoices annually. The business processes and associated workloads are identified below.

5.0 Accounting Officer Specialists are requested for an additional two years to continue to address the continued increased workload associated with the transaction of PHI invoices in both MedCP and PeopleSoft (PS). Because PHI data cannot be entered into PS, detailed information related to the supplier payment is entered in MedCP upon adjudication and approval of services performed. The de-identified data from each invoice will then be uploaded into PS. If there are upload errors, staff must research which system that causes the failure and take necessary steps to resolve the issue. PS will generate vouchers then submit to SCO for approval. SCO will issue warrants to medical providers and interface payment information to PS. DSH Accounting must manually key in the voucher IDs and warrant information into MedCP. A reconciliation has to be performed so that both MedCP and PS have the same records. DSH Accounting must maintain original invoices for SCO post audit as outlined in the MOU signed in October 2018. SCO requires payment information from PS for 1099 reporting purpose.

The outside medical invoice workload consists of 63,000 invoices annually or 12,600 invoices per hospital. Processing time is estimated 15 minutes per invoice, 30 invoices daily which equate to eight additional hours per day. 250 business days is equivalent to 1.0 FTE and there are 5 hospitals; therefore, 5.0 FTEs continue to be needed on an ongoing basis.

DSH is also requesting the 3.0 Associate Accounting Analysts be extended for an additional two years to support general reconciliation activities. Due to PS implementation and consolidation of six BUs to one, all reports are now under one BU but DSH still has a need to segregate by location for budget projection purposes and transparency. As there is no unique identifier on the data to indicate what transactions belong to which facility, and therefore not able to be broken out, DSH-Sacramento perform the SCO monthly reconciliation for the entire department. Sacramento currently represents only eight percent of total transactions captured on the SCO Tab Run, and reconciliation takes one staff member 40 hours to complete. Reconciling the remaining 92 percent of transactions results in an increase of 460 hours, or 500 hours total. With each reconciliation taking 500 staff hours to complete, multiplied by 12 months, there is a total workload increase of 6,000 hours annually = 3.0 (2.88) FTEs.

E. Outcomes and Accountability

Approval of this proposal will support the continued processes, procedures and protocols for payment to outside medical providers while maintaining the accountability and integrity of the accounting system and reporting and compliance with HIPAA rules and regulations. The requested extension of existing limited-term positions will be proportionate with oversight and timelines to enforce adherence of the State Administrative Manual (SAM) and SCO policies and procedures. The positions will allow DSH to successfully continue its operation in achieving its mission and goal by providing the best care to our patients. The administration of proper control will minimize risk of overspending during the fiscal year and prevent breach of PHI/HIPAA data which may result in fines and potential legal action.

Projected Outcomes

Workload Measure	CY	BY	BY+1	BY+2	BY+3	BY+4
Number of PHI Invoices	51,149	51,149	51,149	51,149	51,149	51,149

F. Analysis of All Feasible Alternatives

Alternative 1 – Approve the request for $986,000 General Fund FY 2021-22 and in FY 2022-23 to extend the 8.0 limited-term positions for an additional two years. This will allow for improved coverage of the workload increase.

Pros:
- Provides Accounting with the staff resources needed to continue processing invoices and payments from external medical providers containing PHI in compliance with HIPAA;
- Supports DSH's processing of payments for outside medical services without jeopardizing access to PHI and quality patient care as well as standardizing the process for capturing medical invoice data and minimizing redundant key data entry.
- Does not increase number of positions.

Cons:
- Requires ongoing general fund resources.

Alternative 2 – Approve 8.0 limited-term positions for one additional year.

Pros:
- No disruption in current operations and allows DSH to continue timely payments to medical vendors.
- Does not increase number of positions.

Cons:
- Requires general fund resources.

Alternative 3 – Do not approve the request to extend the resources.

Pros:
- Does not incur any additional funding requirements beyond the 2020-21 Fiscal Year.

Cons:
- Will cause payment delays which may result in late payment penalties in accordance with California Prompt Payment Act.
- Medical vendors may discontinue providing services to patients.
- Increased vulnerability for a security breach in processing payments for external medical providers.
- Could risk legal action for not providing timely medical care to facility patients.
- Potential additional recruitment and retention obstacles.

G. Implementation Plan

DSH has already hired Accounting and support staff to fill the limited term positions. If these positions are extended for an additional two years, DSH will be able to continue the quality, timely provision of processing invoices.

H. Supplemental Information

Attachment A: BCP Fiscal Details Sheets

I. Recommendation

DSH recommends approval of Alternative 1, with two-year limited-term funding to support the extension of the 8.0 positions. Adoption of this request will allow DSH to continue to timely process payments for outside medical services without jeopardizing access to PHI and quality patient care.

BCP Fiscal Detail Sheet

BCP Title: Protected Health Information (PHI) Permanent Implementation **BR Name: 4440-002-BCP-2021-GB**

Budget Request Summary

			FY21			
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Temporary	0.0	8.0	8.0	0.0	0.0	0.0
Total Positions	**0.0**	**8.0**	**8.0**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Temporary Help	0	523	523	0	0	0
Total Salaries and Wages	**$0**	**$523**	**$523**	**$0**	**$0**	**$0**
Total Staff Benefits	0	335	335	0	0	0
Total Personal Services	**$0**	**$858**	**$858**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	0	64	64	0	0	0
5304 - Communications	0	8	8	0	0	0
5320 - Travel: In-State	0	8	8	0	0	0
5324 - Facilities Operation	0	40	40	0	0	0
5346 - Information Technology	0	8	8	0	0	0
Total Operating Expenses and Equipment	**$0**	**$128**	**$128**	**$0**	**$0**	**$0**
Total Budget Request	**$0**	**$986**	**$986**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	986	986	0	0	0
Total State Operations Expenditures	**$0**	**$986**	**$986**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$986**	**$986**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	978	978	0	0	0
4400020 - Hospital Administration	0	8	8	0	0	0
Total All Programs	**$0**	**$986**	**$986**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4546 - Accounting Officer (Spec)				0.0	5.0	5.0	0.0	0.0	0.0
4588 - Assoc Accounting Analyst				0.0	3.0	3.0	0.0	0.0	0.0
Total Positions				**0.0**	**8.0**	**8.0**	**0.0**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4546 - Accounting Officer (Spec)	0	304	304	0	0	0
4588 - Assoc Accounting Analyst	0	219	219	0	0	0
Total Salaries and Wages	**$0**	**$523**	**$523**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	7	7	0	0	0
5150210 - Disability Leave - Nonindustrial	0	2	2	0	0	0
5150350 - Health Insurance	0	24	24	0	0	0
5150450 - Medicare Taxation	0	8	8	0	0	0
5150500 - OASDI	0	32	32	0	0	0
5150600 - Retirement - General	0	154	154	0	0	0
5150700 - Unemployment Insurance	0	1	1	0	0	0
5150800 - Workers' Compensation	0	24	24	0	0	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	14	14	0	0	0
5150900 - Staff Benefits - Other	0	69	69	0	0	0
Total Staff Benefits	**$0**	**$335**	**$335**	**$0**	**$0**	**$0**
Total Personal Services	**$0**	**$858**	**$858**	**$0**	**$0**	**$0**

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	Business Unit	Department	Priority No.
2021-22	4440	Department of State Hospitals	03

Budget Request Name	Program	Subprogram
4440-005-BCP-2020-GB	4400 – Administration	4400010 – Headquarters Administration

Budget Request Description
Increased Court Appearances and Public Records Act Requests

Budget Request Summary
The Department of State Hospitals (DSH) requests $777,000 General Fund in Fiscal Year (FY) 2021-22 and in FY 2022-23 to support 5.5 two-year limited term (LT) positions for the Legal Division (LD) to address the sustained increase in workload of court hearings at which DSH attorneys are required to appear throughout the state and the sustained increase in workload of Public Records Act (PRA) requests to which DSH must respond.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed	
☐ Yes ☒ No	Click or tap here to enter text.	
Does this BCP contain information technology (IT) components? ☐ Yes ☒ No *If yes, departmental Chief Information Officer must sign.*	**Department CIO** Click or tap here to enter text.	**Date** Click or tap to enter a date.

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. Click or tap here to enter text. **Project Approval Document:** Click or tap here to enter text.

Approval Date: Click or tap to enter a date.

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Christine Ciccotti Chief Counsel/Deputy Director	Click or tap to enter a date.	George Maynard	Click or tap to enter a date.
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	Click or tap to enter a date.	Mark Ghaly, MD, MPH	Click or tap to enter a date.

Department of Finance Use Only

Additional Review: ☐ **Capital Outlay** ☐ **ITCU** ☐ **FSCU** ☐ **OSAE** ☐ **CALSTARS** ☐ **Dept. of Technology**

PPBA	Date submitted to the Legislature
Click or tap here to enter text.	Click or tap to enter a date.

Analysis of Problem

A. Budget Request Summary

The Department of State Hospitals (DSH) requests $777,000 General Fund in Fiscal Year (FY) 2021-22 and in FY 2022-23 to support 5.5 two-year limited term (LT) positions for the Legal Division (LD) to address the sustained increase in workload of court hearings at which DSH attorneys are required to appear throughout the state and the sustained increase in workload of Public Records Act (PRA) requests to which DSH must respond.

B. Background/History

The Department of State Hospitals (DSH) manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 12,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily censuses of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

Starting in 2014, the number of persons found incompetent to stand trial (IST) under Penal Code section 1370 and committed by the courts throughout the State to be admitted to DSH or its contracted Jail Based Competency Treatment (JBCT) programs to receive competency treatment began to increase. Since 2014, the number of IST referrals exceedingly outpaces the number of DSH, JBCT or other contracted beds available for these patients, generating a waitlist for admission.

Figure 1: IST Waitlist

YEAR	# OF PATIENTS WAITING FOR ADMISSION TO DSH HOSPITALS OR JBCT	YEARLY WAITLIST INCREASE
2014	371 – as of 7/7/14	N/A
2015	340 – as of 7/6/15	- 8%
2016	463 – as of 7/4/16	36%
2017	528 – as of 7/3/17	14%
2018	836 – as of 7/2/18	58%
2019	854 – as of 7/1/19	2%
2020	1204 -as of 7/6/20*	41%
TOTAL INCREASE FROM 2014 TO 2020	**833**	**225%**

This increase in referrals is a result of DSH's 60-day suspension of admissions of IST patients due to COVID-19 as described below.

As a result of the increasing IST waitlist, DSH began experiencing a shortage of beds. DSH statutorily must provide reports to the committing criminal court within 90 days of a patient's commitment order, advising the court whether it is likely or not that a patient will regain competency, so they can be returned to court and stand trial, or if the court should order continued competency treatment. As the IST waitlist has continued to grow, the timelines for admission to DSH have significantly increased, with many patients not being admitted for competency treatment until shortly before the statutorily-required 90-day report, or later. Consequently, the superior courts have questioned the amount of time ISTs wait in county jail before they are admitted to DSH to receive competency restoration treatment and returned to trial.

On March 4, 2020, the Governor issued a proclamation of a State of Emergency due to the outbreak of COVID-19. On March 21, 2020, the Governor issued Executive Order N-35-20 authorizing the Director of DSH to waive statutes that affected the execution of laws related to the

care, custody, and treatment of persons with mental illness committed to DSH. On March 23, 2020, the DSH Director suspended admissions and discharges of almost all patients, including ISTs to its facilities to prevent the introduction of COVID-19 in to DSH's 5 hospitals. During the first 30-day suspension, DSH implemented CDC and California Department of Public Health (CDPH) recommended infection control measures across its system to help reduce the risks of COVID-19 for patients and employees. DSH extended this suspension of admissions and discharges of IST patients for another 30 days until allowing it to expire on May 22, 2020. During this next 30 day period, DSH consulted the CDPH Healthcare Acquired Infections group, to develop an admissions process that would help reduce introduction of COVID-19 during the process of admitting patients to its hospitals. DSH now only admits smaller groupings of patients in a cohort fashion to an observation unit, where they are serially tested before being released to a housing unit, so as to limit the possibility of a newly admitted patient being COVID positive and spreading the infection to others throughout the hospital. This cohorting process has increased the number of days defendants wait in jail before being admitted to a hospital which in turn has and will continue to result in an increase in the number of Orders to Show Cause (OSC) set by the courts.

As a result of the ongoing and growing waitlist of IST patients, DSH has experienced a significant amount of litigation including:

- The county public defenders filing motions seeking OSCs why DSH should not be held in contempt for not timely admitting the IST patients, and seeking sanctions against DSH;
- The county public defenders filing motions under Code of Civil Procedure section 177.5 seeking sanctions against DSH for not complying with the superior court orders to admit these patients by a date specified;
- Superior courts issuing OSCs seeking to sanction DSH for not timely admitting IST patients or violating court orders to admit patients;
- The courts setting status conferences, with mandatory appearances by DSH, to explain why the patients have not been transported, or admitted to its hospitals, or considering whether to hold DSH in contempt;
- County public defenders filing motions seeking standing orders requiring that DSH admit Defendants by a specified time-frame (for example, order requiring patients be admitted within 60 days of commitment in Contra Costa County under *In Re Loveton* (2016), 244 Cal.App.4th 1025);
- County public defenders filing writs of habeas corpus, writs seeking release of Defendants held in jail awaiting admission to DSH, and writs of mandate requiring DSH to comply with various specified time-frames for patient admissions; and
- The ACLU and private law-firms filing state and federal civil-rights cases seeking injunctive relief and damages for alleged violations of IST defendants' constitutional rights.

DSH attorneys must respond, object, appear, or serve as staff counsel to represent DSH in each of these types of motions, status conferences, OSCs, standing-order requests, writs, and civil-rights litigation. The courts oftentimes provide DSH less than one-week notice that they must appear to defend DSH against an OSC, and it is not uncommon for DSH to be provided only 24 or 48-hour notice of a contempt hearing. DSH attorneys are required to constantly be ready to travel on short notice anywhere from two to four hours away to appear on DSH's behalf in county superior courts, to advocate against findings of contempt or sanctions.

Initially, the Health, Education, and Welfare (HEW) Section of the Attorney Generals' Office (AGO) represented DSH in all OSCs. In 2009, HEW advised DSH that it could no longer appear at all OSCs, due to the increasing number of hearings. DSH and AGO agreed that for OSCs and status conferences, DSH attorneys would make the appearances, and that for more complex or

contentious appearances, including OSC evidentiary hearings, AGO would appear on DSH's behalf with LD staff counsel assistance.

DSH attorneys have worked on dozens of such OSC evidentiary hearings with the AGO related to IST admissions or the on-going complex litigation previously described, in addition to appearing in the other OSC appearances identified. The legal landscape of IST-related litigation is fast-paced, complex, and spans almost every county superior court, several district courts of appeal, and federal court, under a variety of different causes of action and legal theories.

Prior to the increase in hearings, LD already represented DSH in due process hearings before Administrative Law Judges and in superior courts for patients needing the administration of involuntary medications or treatment, besides its routine in-house counsel work. In 2014, LD also began petitioning and appearing in proceedings for patients found unlikely to be restored to competency needing conservatorship. With the additional assumption of court appearances on IST OSCs, the attorneys' workload steadily increased, without any increased positions dedicated to performing this work.

Prior to receiving position authority in FY19-20 for 3 two-year limited term attorney positions, DSH's staff of 25 staff attorneys were unable to manage the accelerating number of court appearances. However, Superior Court judges continue to order DSH's attorneys to appear to show cause as to why DSH should not be held in contempt due to the waitlist of patients needing admission to the hospitals for competency treatment. This work is unique to DSH as few, if any , departments require its attorneys to appear in superior court in 58 counties throughout the state to defend its interests. Without any increase in positions dedicated to this work until the 2019 Budget Act, DSH attorneys were required to appear in a steadily increasing number of court matters as detailed below in Figure 2:

Figure 2: Number of Matters Appeared in Per Year

YEAR	# OF MATTERS APPEARED IN
2014	1,730
2015	1,871
2016	3,117
2017	3,614
2018	3,972
2019	2,112

The 2018 appearance rate more than doubled 2015's monthly average. The data demonstrates that each of LD's attorneys appeared, on average, in 74 matters per year in 2016, in 172 matters per year in 2017, and in 158 matters per year in 2018.

Beginning in 2019, the Los Angeles County Superior Court Mental Health Court discontinued its practice of ordering DSH to appear in court to show cause as to why it should not be held in contempt due to the waitlist of patients needing admission to the hospitals for competency treatment. At that time, the Court had previously issued four rulings imposing monetary sanctions against DSH for delayed admissions of IST patients. DSH appealed all four rulings. Due to the pending legal question before the Second District Court of Appeals, the Los Angeles County Superior Court chose to forgo further OSCs while this issue was under appellate review in late 2018 throughout 2019. On March 4, 2020, the Second District Court of Appeals issued its ruling upholding all the lower court's rulings sanctioning DSH.

As a result of this temporary reduction in OSCs by Los Angeles County while the underlying legal questions were on appeal, DSH saw its OSC workload momentarily decrease. In the six-month timeframe from October 1, 2017 to March 31, 2018, DSH appeared in 758 OSC matters in Los Angeles County as compared to appearing in only 161 OSC matters in Los Angeles County in the corresponding six-month timeframe from October 1, 2018 to March 31, 2019. However, as a result

of the March 4, 2020 Appellate Court ruling upholding the Los Angeles County Superior Court's sanctions orders, the resumption of DSHs admission of IST patients at the end of May 2020 following a 60-day suspension due to COVID-19, as well as the resumption of trial court proceedings in criminal matters after a temporary suspension due to COVID-19, LD anticipates a return to the sustained high workload requirements for its attorneys to appear in OSC hearings in Los Angeles County Superior Courts.

In September 2016, the Contra Costa County Superior Court began issuing OSCs at the request of the Contra Costa County Public Defender's Office, seeking sanctions against DSH, pursuant to Code of Civil Procedure (CCP) section 177.5, for violation of the 60-day admission from commitment standing order following the decision in *In re Loveton*. Specifically, the Public Defender's Office sought sanctions for each day DSH was in the violation of the *Loveton* order when IST defendants were not admitted to a DSH facility within 60 days from an IST defendant's date of commitment, with a statutory limit of a $1,500 sanction per defendant.

As a result of the OSCs, DSH appeared numerous times to contest the imposition of sanctions pursuant to CCP 177.5, arguing that DSH was not a party to the criminal proceeding. The Court denied DSH's request for an evidentiary hearing and imposed sanctions for 12 defendants, totaling $16,500.

DSH appealed the sanctions orders to the California Court of Appeal, First Appellate District regarding the lack of due process to DSH resulting from the Court's denial of an evidentiary hearing and the applicability of using CCP 177.5 to sanction DSH, a non-party to the criminal proceedings.

After briefing and oral argument on September 30, 2019, the Court of Appeal affirmed the lower Court's imposition of sanctions as to all but one defendant, thereby reducing the total sanctions to $15,000 for 10 defendants. The Court upheld the use of CCP 177.5 to impose sanctions on DSH, a non-party. As a result of this additional recent ruling, LD anticipates a continuation of the sustained workload requirements related to OSCs.

Since this resumption of IST patient admissions in late May 2020 following the 60-day suspension due to COVID-19, courts and Public Defenders across the state have increased their inquiries to DSH as to when IST defendants are going to be admitted, either through email inquiries or by Public Defender's requesting courts issue OSCs. As the wait time for admission for IST defendants to a DSH facility lengthens to support safe admission protocols, Public Defenders and courts are already, and will likely increasingly issue OSCs to pressure faster admissions, despite the public health risks of doing so. For example, upon the Yolo County Public Defender's request the court issued OSCs seeking to hold DSH's Director personally in contempt for not admitting IST defendants within 60-days of commitment. Similarly, DSH is currently responding to six OSCs in Santa Barbara County regarding wait times for admission of IST defendants to DSH. DSH LD sees the total number of OSCs, and the number of counties issuing OSCs, continuing to grow as the COVID-19 pandemic has no clear end in sight.

Recently, a handful of courts throughout the state have also issued OSCs against DSH in regard to wait times for Sexually Violent Predators. Public Defenders have also filed writs of habeas corpus seeking release of Defendants found Not Guilty by Reason of Insanity (NGI) for wait times related to their delayed admissions. As the COVID-19 pandemic continues to require DSH cohort patient admissions in a limited fashion to keep patients and staff safe, the number of OSCs and writs regarding wait times for these additional commitments will likely increase across the state, necessitating DSH LD respond and appear for these court appearances.

As such, LD anticipates that in the coming year, the average number of attorney appearances will likely resume or sustain at the prior high workload levels of 2018. If LD is not able to retain the 5.5 positions authorized to perform this work, it will force DSH attorneys to forgo their other work in order to appear when ordered.

Figure 3 below summarizes total annual matters by appearance type for each year:

Figure 3: Number of Matters Appeared in By Type of Matter Per Year

Matter Type	2015	2016	2017	2018	2019
ALJ	112	111	100	122	104
1370	249	248	237	200	250
4210 PROCESSES	356	445	388	394	360
OSC	819	1,975	2,344	2,810	1,028
OFR	NA	NA	NA	NA	42[1]
B1/C1	128	62	140	80	18
CLARIFICATION	36	35	45	77	42
3200	15	34	40	54	19
ECT	NA	NA	NA	NA	31[2]
SPB/CalHR	124	111	121	110	104
Other	32	96	199	115	156
TOTALS	1,871	3,117	3,614	3,972	2,112
Average Hearings/month	156	283	301	331	176

[1] OFR/Status Reports had previously been included in OSC Hearings until LD began separate tracking in August 2019.

[2] ECT hearings had previously been included in 3200 Hearings until LD began separate tracking in 2019.

Amplifying the workload of attorney appearances in OSCs is the fact that many of the superior courts require in-person appearances, usually at long distances from LD's office in Sacramento. Until 2018, all LD attorneys were based in Sacramento. In December 2018, LD established an office at DSH-Metropolitan in Norwalk, and over time, moved three Attorney positions and one Assistant Chief Counsel (ACC) position from Sacramento to reduce the time spent traveling to Southern California for court appearances. By successfully opening the Southern California office, this effectively mitigated LD's travel costs and reduced the time attorneys spend traveling

Figure 4 below shows the trend in LD travel costs. LD intends to continue to place the appropriate level of resources in Southern California to ease the burden and costs of travel for court appearances.

Figure 4: LD Travel Costs

FISCAL YEAR	ANNUAL TOTAL TRAVEL COSTS
2014/2015	$333,716
2015/2016	$408,463
2016/2017	$448,125
2017/2018	$477,697
2018/2019	$190,686

To more accurately reflect the time attorneys spend traveling to hearings, LD implemented a system to track such time beginning in January 2019. This tracking does not account for the time spent by attorneys and support staff reviewing the OSCs, researching the facts relevant to each patient to draft a response, preparing responses and declarations to OSCs, corresponding with our clients, or filing the responses. Nor does it include the time spent serving as staff counsel assisting the Attorney General's Office in preparing for those OSCs that go to an evidentiary hearing, for an appeal, civil litigation cases involving the IST waitlist, or the travel associated with attending proceedings alongside the Attorney General's Office as staff counsel. The number of hours attorneys have spent traveling per month specifically to represent DSH is reflected below in Figure 5.

Figure 5: Number of Hours Spent Traveling To Hearings Per Month

MONTH – 2019	# HOURS SPENT TRAVELING TO OSCs	# HOURS SPENT TRAVELING TO ALL APPEARANCES	AVG. # OF TRAVEL HOURS PER ATTORNEY PER MONTH
Jan	61.25	287.75	18
Feb	83.25	282	19
Mar	142.75	367.25	20
Apr	112.75	315.50	20
May	96.5	292.25	18
Jun	116.25	296.25	18
Jul	107.75	312.5	17
Aug	55.75	265	17
Sep	52	270	19
Oct	96.25	268	18
Nov	63.25	250.50	16
Dec	152.25	348	14
TOTAL	**1,140**	**3,555**	**18**

The burden placed on LD attorneys of spending almost three working days per month traveling has also created a retention issue, with several knowledgeable and experienced attorneys seeking positions with other departments that require less travel. During COVID-19 many courts allowed for the use of video appearances by DSH attorneys which helped ease the travel burden. However, now that many courts have resumed regular court proceedings, we anticipate resumption of the requirements that DSH attorneys appear in-person.

DSH has made great efforts to address the IST waitlist, including adding more than 1,000 beds to its hospitals, and contracted programs since 2012-2013, as well as receiving $120 million in additional funding in the Governor's 2018-2019 budget to develop and implement programs targeted at addressing the IST patient population, including IST diversion and community-based IST restoration. However, to date, these undertakings have only been able to partially offset the increase in IST referrals and a doubling of the waitlist. As such, LD must continue to defend DSH in superior courts throughout the state and advocate that DSH is committed to the timely treatment of all patients, and should not be held in contempt, nor sanctioned for its waitlist.

Similarly, without any increase in positions dedicated to this workload until the 2018-2019 limited term positions, the workload associated with responding to PRA requests remains at levels significantly above the that of 2012 as demonstrated by Figure 6 below:

Figure 6: Number of PRA Requests Received Per Year

YEAR	# OF PRA REQUESTS	YEARLY INCREASE
2012	171	N/A
2013	191	12%
2014	239	25%
2015	226	-5%
2016	239	5%
2017	255	7%
2018	503	97%
2019	319	-36%
2020	220 as of 5/31/2020 528 - PROJECTED	65%

The highest percentage of PRA requests (28% of requests received in 2019 and 30% of requests received for the first five months of 2020) were seeking more complex series of documents such as e-mails, costing and budgeting data, trainings, meeting minutes, facility memos, plans, studies, protocols, audits, grants, log books, programs, and catalogs. The second highest percentage of PRA request were for more simple information such as DSH's staff information such as staff e-mail

addresses, phone numbers, positions, titles, license numbers and internet use (approximately 24% of 2019's requests) or policies and procedures (27% of 2020's requests received so far). A smaller percentage request readily available information such as DSH's contracts (approximately 19% of 2019's requests), or statistical information such as bed counts, patient counts, census, or specific data points such as the number of patients or employees found with contraband (approximately 16% of 2019's requests).

The other way PRA requests have evolved is that DSH patients, especially those from DSH-Coalinga, continue to file voluminous requests seeking a variety of records including various hospital records, meeting minutes, e-mails, logs, policies, procedures, work orders, etc. DSH-Coalinga patients constitute the overwhelming majority of patient-generated PRA requests. Of the 320 PRA requests received for 2019, 43% of them requested records from DSH-Coalinga, compared to less than 15% of the requests requiring records from each of the other 4 hospitals, with that number increasing to 55% seeking DSH-Coalinga records for the first five months of 2020 as compared to less than 6% requiring records from each of the other four hospitals.

The LD AGPA who handles these requests used to have anywhere between 5 to 15 requests open at one time and could closely monitor each one. Now, LD has 52 open requests, and without extending these resources, will be unable to continue to meet all deadlines or maintain contact with each requestor, due to the increased volume.

PRAs also continue to consume significant staff resources across the divisions, including DSH's Technology Services Division (TSD). DSH LD must provide legal advice and assistance to TSD as they search for and compile documents responsive to PRA requests. In the last 12 months, TSDs units have spent over 1,450 hours in conducting electronic searches in response to PRA and electronic discovery request as detailed below:

- TSD'S INFORMATION SECURITY OFFICE - OVER 200 HOURS
- IT OPERATIONS OFFICE – APPROX. 480 HOURS
- DATA MANAGEMENT OFFICE – APPROX. 670 HOURS
- ADMINISTRATIVE SUPPORT UNIT – APPROX. 56 HOURS
- VENDOR MANAGEMENT UNIT – APPROX. 46 HOURS

These searches require frequent collaboration and consultation between TSD and LDs analysts and attorneys.

Resource History

(Dollars in thousands)

Program Budget	**2016-17**	**2017-18**	**2018-19**	**2019-20[3]**	**2020-21[3]**
AUTHORIZED EXPENDITURES	$11,032	$11,637	$13,271	$14,739	$17,152
ACTUAL EXPENDITURES	$10,517	$11,711	$13,200	$14,730	$14,730
REVENUES	N/A	N/A	N/A	N/A	N/A
AUTHORIZED POSITIONS[1]	44.5	43.5	44.5	55.0	54.0
FILLED POSITIONS[2]	38.5	38.5	30.5	53.5	52.0
VACANCIES[2]	6.0	5.0	2.0	14.0	2.0

[1] The "Authorized Positions" data is sourced from a point-in-time from the Schedule 7A report generated on July 1 each year and includes attorney and non-attorney positions.

[2] The "Vacancies" data is sourced from the DSH Monthly Vacancy Reports as of July 1 of each year and includes attorney and non-attorney positions.
[3]2019-20 is a combination of actual expenditure data as of Period 11 (May 2020) and expenditure projections for Period 12 (June 2020). 2020-21 numbers are projections based on prior years.

Workload History

Workload Measure	PY – 4	PY – 3	PY – 2	PY-1	PY	CY
Attorney Appearances in Court on behalf of DSH	1,871	3,117	3,614	3,972	2,112[1]	1483[2]
Public Record Act Requests Received	226	239	255	503	319	480[3]

[1]In 2019 the Department appealed sanctions orders from LA and Contra Costa. During the appeals process both counties substantially slowed down issuing OSC's. The Department lost both appeals and, as a result of that, we anticipate those counties will resume significant numbers of OSC's.
[2] YTD - DSH attorneys have appeared in 1,483 appearances and submitted another 211 court-ordered status responses that they were not required to appear on. This is a historic low due to COVID. These numbers are not reflective of the workload from 2014-19.
[3] Reflects YTD data.

C. State Level Consideration

This proposal is consistent with DSH's mission, values, and goals. The Department's mission is to provide evaluation and treatment in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. This mission is jeopardized when LD attorneys are unable to provide in-depth, well-researched, real-time legal advice to the five hospitals and DSH-Sacramento including its Forensics Division and CONREP which affect public safety. LD supports DSH's full compliance with local, state, and federal statutory, regulatory, and constitutional requirements to focus on providing responsible treatment. LD attorneys are unable to attend to this legal work when they must travel almost three working days per month, every month, to appear in county superior courts to defend DSH against OSCs.

LD must uphold DSH's stature in courts throughout the state by appearing on its behalf, in a timely, efficient, and informative manner. It is both legally unadvisable and unprofessional for DSH to risk contempt by failing to send an attorney to defend its interests.

This proposal is also consistent with California Health and Human Services Agency's Guiding Principle of focusing on outcomes and generating value. LD's representation of DSH throughout the superior courts helps build strong partnerships with those systems that commit patients to us and demonstrates our dedication to patient care. LD's attorneys are often the ones bringing all county and state stakeholders to the table to figure out how best to care for IST patients on our waitlist in a way that decriminalizes mental illness, as well as promotes public safety. These attorney-driven stakeholder meetings are oftentimes the building blocks upon which county collaboration with DSH begins and they help lead to the delivery of DSH's programs and services in a way that remains centered on the patients we serve.

D. Justification

LD must retain these positions so that it can continue to appear in court as required. LD's monthly average appearance rates demonstrate that the hearings at which DSH attorneys must appear has experienced sustained increases with the exception of a short period of reduced litigation activity in 2019 while the legal question of the Court's authority to sanction DSH was under review

by the Appellate court. The number of appearances per year will only continue to increase as DSH attorneys must forgo their other work so that they appear when ordered in OSCs. These appearance rates are unsustainable for LD's attorneys without extending the limited term resources approved in FY 2019-20.

Despite the opening of the Southern California office, the travel burden placed on DSH attorneys created a retention issue, with several knowledgeable and experienced attorneys seeking positions with other departments that require less travel. Many of the Superior Courts to which the Sacramento-based LD attorneys must travel are often at significant distances, including Fresno, Tulare, and San Luis Obispo counties. Travel this far often necessitates attorney being out of the office one to two days.

LD does not anticipate that its workload or need to continue to defend DSH against sanctions will lessen, until the waitlist abates. Although there has been increased funding allocated to DSH to address the IST waitlist, the IST waitlist continues to increase, especially during COVID-19. Until the IST waitlist is addressed, DSH will require additional attorneys who are knowledgeable about DSH's efforts to address the IST waitlist, available to appear in superior courts to defend DSH, and seek to reduce or eliminate the courts' continual threat of sanctions.

The nature of PRA requestors is also increasingly changing to plaintiffs' attorneys who may be seeking to utilize publicly available information to bring litigation against DSH, which necessitates attorney involvement in the response. PRA responses now involve more complex legal issues such as those requiring the assertion of the deliberative process or official information exemptions to protect the agency's internal decision-making, peer-review records wherein doctors evaluate whether fellow physicians met the required standard of patient care, and private patient records. PRA requests such as this require far more involvement by LD attorneys and increase the workload. DSH also maintains records throughout the five DSH hospitals which can also increase the PRA workload. The requirement to engage in thorough searches of multiple electronic databases throughout DSH also tasks DSH's TSD staff, with whom LD staff must consult so that searches are thorough and appropriate.

Most PRA requests are also seeking a more complex series of documents such as costing and budgeting data, trainings, meeting minutes, and facility memos, plans, studies, protocols, audits, grants, logbooks, programs, and catalogs.

Another significant way PRA requests have changed is that DSH patients, especially those from DSH-Coalinga, have begun filing multiple requests seeking a variety of records including various hospital records, meeting minutes, logs, policies, procedures, work orders, etc. DSH-Coalinga patients constitute the overwhelming majority of patient-generated PRA requests.

While the existing LD staff resources were previously sufficient to meet the PRA response deadlines, or to keep in contact with all requestors when extensions to the PRA deadlines were necessary, that is no longer the case. Without extending the limited term resources, LD will be unable to meet all deadlines or maintain contact with each requestor, due to the increased volume.

For PRAs, the Legal Analyst position's duties include handling the administrative work of cataloguing the increasing number of PRA requests and responses in the GovQA tracking system. The Legal Analyst is also responsible for gathering the input for PRA responses from hospital management including advising DSH staff on PRA issues, reviewing and redacting responsive documents, preparing the draft PRA responses on legal issues, tracking data and preparing monthly reports for DSH management, and attending PRA-related meetings with hospital staff, DSH-Sacramento, and California Health and Human Services (CHHS) personnel.

DSH-Coalinga's Executive AGPA previously spent a minority of time responding to PRA requests. Due to the increased demand, this position had begun to spend 80 percent of scheduled time gathering documents and responding until the limited term Staff Services Analyst (SSA) position was authorized. As a result, DSH-Coalinga requests two-year extension of the part-time SSA to help

address the significant PRA request, that represents approximately 60 percent of all PRA requests received. This half-time SSA position supports DSH-Coalinga's workload in responding to an ever-increasing volume of PRA requests from patients and their attorneys. Fulfilling PRA requests for patients can be extremely time consuming as they request many records and data and often do not have the resources to pay for many copies. As a result, in addition to pulling and coordinating many records, DSH-Coalinga staff must sit with a patient while they review all the documents satisfying the request and determine which specific pages they may want to copy to reduce costs, in accordance with the PRA's requirements to allow for inspection and copying.

Based upon the sustained hearing and PRA workload, LD also requests the three Attorney I positions and Legal Secretary be extended for an additional two years.

The three Attorney Is have been able to effectively address the volume of OSC appearances and other hearing-related work. OSC work includes reviewing the hospital and patient documentation; reviewing the alienist reports and commitment packets; working with the DSH Patient Management Unit and hospital forensic staff to ascertain the patient's status on the waitlist; communicating with courts and public defenders to seek to have OSCs vacated or taken off calendar in the event the patient has been, or will shortly be, admitted to DSH or a JBCT program; drafting and filing OSC responses and supporting declarations; and appearing in court to defend DSH at hearings on the Court's orders to transport the patient, OSCs to hold DSH in contempt, and any follow-up status conferences.

LD also requests the limited term Legal Secretary position be be extended for an additional two years to support the three attorneys in performing the administrative portion of those tasks.

In total, the three attorney positions, with the support of the two support staff positions in LD (one Legal Secretary and one Legal Analyst) and one part-time position at DSH-Coalinga, will allow DSH to continue to effectively address the rising number of court appearances and PRA requests while also providing thorough and quality legal advice and representation to DSH.

Impact of No Approval:

If this request is not approved, LD will be unable to appear to defend DSH's interests in escalating numbers of administrative and court hearings. As attorneys increasingly spend their time out of the office, on the road, or in airports, traveling to court appearances, LD will be continually hampered in its ability to provide legal advice to DSH on matters such as:

- serving as staff counsel to assist the AGO in civil litigation cases DSH is involved in, including tort and civil rights lawsuits seeking millions of dollars in damages, and the *Coleman v. Newsom* federal class action case involving monitoring of the care provided to DSH patients sent by the CDCR;
- involuntary medication hearings, involuntary treatment petitions, and other due process hearings;
- challenges to policy directives and proposed regulations, and the impact of proposed legislation;
- providing advice and support to CONREP for patients including Sexually Violent Predators and Mentally Disordered Offenders that are released into the community;
- bio-ethical legal concerns including transgender issues;
- CalOSHA complaints and investigations;
- enforceability of proposed contracts and memoranda of understanding;
- contract disputes including Union challenges to personal services contracts;
- forensic legal issues related to the Sexually Violent Predator population;
- subpoena and PRA requests;

- hospital bylaws, Joint Commission standards, and Department of Public Health licensing requirements;
- patient trust account issues;
- patient cost recovery actions;
- personnel and employment law matters including State Personnel Board hearings;
- compliance with Office of Law Enforcement Support requirements related to its monitoring and investigation of employee disciplinary matters;
- California Office of Health Information Integrity monitoring and investigation, and supporting compliance with state and federal privacy law;
- conflict of interest issues;
- social media and copyright infringement;
- environmental regulatory agency citations;
- internal audits resulting in client questions to LD; and
- state bond matters.

DSH provides care to six different types of patients committed to its five hospitals and oversees patients released to the community (CONREP), with corresponding laws governing the legal framework for each commitment type. LD is an integral part of supporting the nation's largest inpatient forensic hospital system in abiding by the complex web of statutes, regulations, licensing and other administrative provisions that govern patient care and treatment.

LD's inability to appear at and defend DSH's interest at all hearings, inability to conduct the thorough legal analyses necessitated by complex PRA requests, and inability to devote the time necessary to provide legal advice to DSH will result in increasing legal risk and liability for DSH with potentially significant costs and adverse consequences. Further, DSH will be hampered in its ability to proactively recover funds for the State through its patient cost recovery program as LD must continue to divert attorney resources to cover the increased number of hearings. The IST waitlist, and the litigation from it, have only increased over the last four years. Many years of sustained high workloads without any increase in resources has overtaxed its existing attorneys – existing LT positions in LD will need to be extended so that LD can focus its attention on the myriad of legal issues DSH faces, rather than subsuming all attorneys' time solely with IST litigation.

E. Outcomes and Accountability

DSH expects that the primary outcome of this budget request is that LD attorneys will continue to be able to appear in all OSCs, while still providing expert legal support to all other areas of DSH, and timely responses to all PRA requests, both simple and complex. DSH also expects to see the rate of hearings each LD attorney must appear in annually reduce to manageable levels, and to see the number of hours each attorney must travel reduced.

The requested resources will be monitored by tracking the number of matters appeared in per attorney and the number of hours of travel per attorney per month.

Projected Outcomes

Workload Measure	CY	BY	BY+1	BY+2	BY+3	BY+4
Attorney Appearances in Court on behalf of DSH	2,202	2,316	3,003	3,003	3,003	3,003
Public Record Act Requests Received	528	450	450	450	450	450

F. Analysis of All Feasible Alternatives

ALTERNATIVE 1 – Approve $777,000 General Fund to support the two-year extension of the existing 5.5 limited-term positions which will allow for improved coverage of the workload increase.

Pros:

- Provides LD with the staff resources needed to respond to the increased IST-waitlist related litigation and PRA requests.
- LD would have improved resources to address the complex legal issues facing DSH, be better positioned to provide proactive legal advice, and help avoid litigation or liability at the outset of a problem.
- This alternative will utilize staffing resources most efficiently.

Cons:

- This option expends resources that could be utilized in other areas such as level of care staff.
- This option requires general fund resources.

ALTERNATIVE 2 – Contract with the Attorney General's Office for additional Deputy Attorneys General to appear on DSH's behalf in all superior court OSCs and appearances per year.

Pros:

- Would support consistent, effective representation by attorneys well-qualified to represent DSH in OSC matters.
- No additional staffing would need to be directed to DSH.

Cons:

- AGO bills DSH at a rate of $170 per hour, which far exceeds the annual salary of an Attorney I. The AGO would bill DSH $301,920 for 1,776 hours of work, whereas an Attorney I's salary would only cost DSH $88,632.
- AGO would likely need additional resources to carry out these mandates imposed by the superior court.
- DSH must reimburse AGO the costs of defense, which would far exceed the costs of DSH adding its own attorney positions.

ALTERNATIVE 3 – Do not approve any resources.

Pros:

- Does not incur any additional funding requirements.

Cons:

- Inhibits DSH LD's ability to defend the Department.
- Causes LD attorneys to forgo other work to continue to appear at a significant number of court appearances than it has been resourced for.
- Likely to lead to additional recruitment and retention obstacles.

G. Implementation Plan

DSH has already hired attorneys and support staff to fill the limited term positions. If these positions are extended for an additional two years, DSH will be able to continue the quality, timely provision of legal advice.

H. Supplemental Information

Attachment A: BCP Fiscal Details Sheets

I. Recommendation

DSH recommends approval of Alternative 1, which will allow DSH to satisfy its legal obligations and allow LD to continue to support DSH's mission of treating patients safely and responsibly, through legal compliance. Additionally, Alternative 1 upholds DSH's values including respect and communication with all our county stakeholders and courts who are grappling with the IST waitlist alongside DSH. These resources are essential to DSH's legal defense in this crisis.

BCP Fiscal Detail Sheet

BCP Title: Increased Court Appearances and Public Records Act Requests **BR Name: 4440-005-BCP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Temporary	0.0	5.5	5.5	0.0	0.0	0.0
Total Positions	**0.0**	**5.5**	**5.5**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	0	26	26	0	0	0
Earnings - Temporary Help	0	394	394	0	0	0
Total Salaries and Wages	**$0**	**$420**	**$420**	**$0**	**$0**	**$0**
Total Staff Benefits	0	267	267	0	0	0
Total Personal Services	**$0**	**$687**	**$687**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	0	44	44	0	0	0
5304 - Communications	0	6	6	0	0	0
5320 - Travel: In-State	0	6	6	0	0	0
5324 - Facilities Operation	0	28	28	0	0	0
5346 - Information Technology	0	6	6	0	0	0
Total Operating Expenses and Equipment	**$0**	**$90**	**$90**	**$0**	**$0**	**$0**
Total Budget Request	**$0**	**$777**	**$777**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	777	777	0	0	0
Total State Operations Expenditures	**$0**	**$777**	**$777**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$777**	**$777**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	720	720	0	0	0
4400020 - Hospital Administration	0	6	6	0	0	0
4410020 - Coalinga	0	51	51	0	0	0
Total All Programs	**$0**	**$777**	**$777**	**$0**	**$0**	**$0**

Personal Services Details

Positions			Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1282	-	Legal Secty				0.0	1.0	1.0	0.0	0.0	0.0
5157	-	Staff Svcs Analyst (Gen)				0.0	0.5	0.5	0.0	0.0	0.0
5237	-	Legal Analyst				0.0	1.0	1.0	0.0	0.0	0.0
5778	-	Atty				0.0	3.0	3.0	0.0	0.0	0.0
Total Positions						**0.0**	**5.5**	**5.5**	**0.0**	**0.0**	**0.0**

Salaries and Wages			CY	BY	BY+1	BY+2	BY+3	BY+4
1282	-	Legal Secty	0	49	49	0	0	0
5157	-	Staff Svcs Analyst (Gen)	0	26	26	0	0	0
5237	-	Legal Analyst	0	61	61	0	0	0
5778	-	Atty	0	284	284	0	0	0
Total Salaries and Wages			**$0**	**$420**	**$420**	**$0**	**$0**	**$0**

Staff Benefits			CY	BY	BY+1	BY+2	BY+3	BY+4
5150200	-	Disability Leave - Industrial	0	5	5	0	0	0
5150210	-	Disability Leave - Nonindustrial	0	2	2	0	0	0
5150350	-	Health Insurance	0	19	19	0	0	0
5150450	-	Medicare Taxation	0	6	6	0	0	0
5150500	-	OASDI	0	26	26	0	0	0
5150600	-	Retirement - General	0	124	124	0	0	0
5150800	-	Workers' Compensation	0	19	19	0	0	0
5150820	-	Other Post-Employment Benefits (OPEB) Employer Contributions	0	11	11	0	0	0
5150900	-	Staff Benefits - Other	0	55	55	0	0	0
Total Staff Benefits			**$0**	**$267**	**$267**	**$0**	**$0**	**$0**
Total Personal Services			**$0**	**$687**	**$687**	**$0**	**$0**	**$0**

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	Business Unit	Department	Priority No.
2021-22	4440	Department of State Hospitals	01

Budget Request Name	Program	Subprogram
4440-004-BCP-2020-GB	4410 – State Hospitals	4410020 - Coalinga

Budget Request Description
Patient Education

Budget Request Summary

Department of State Hospitals (DSH) requests 3.0 permanent positions and $352,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing to expand patient education services at DSH-Coalinga. DSH's goal is to offer comparable education services for DSH-Coalinga patients as it does at its other hospitals and improve patient outcomes. Education and related services are a critical component of in-patient treatment and help patients successfully re-establish life in their community upon hospital discharge.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed	
☐ Yes ☒ No	Click or tap here to enter text.	
Does this BCP contain information technology (IT) components? ☐ Yes ☐ No *If yes, departmental Chief Information Officer must sign.*	**Department CIO** Click or tap here to enter text.	**Date** Click or tap to enter a date.

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. Click or tap here to enter text. **Project Approval Document:** Click or tap here to enter text.

Approval Date: Click or tap to enter a date.

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Jenna Herford	7/17/2020	Catherine Hendon	Click or tap to enter a date.
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	Click or tap to enter a date.	Mark Ghaly, MD, MPH	Click or tap to enter a date.

Department of Finance Use Only

Additional Review: ☐ **Capital Outlay** ☐ **ITCU** ☐ **FSCU** ☐ **OSAE** ☐ **CALSTARS** ☐ **Dept. of Technology**

PPBA	Date submitted to the Legislature
Click or tap here to enter text.	Click or tap to enter a date.

Analysis of Problem

A. Budget Request Summary

Department of State Hospitals (DSH) requests 3.0 permanent positions and $352,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing to expand patient education services at DSH-Coalinga. DSH's goal is to offer comparable education services for DSH-Coalinga patients as it does at its other hospitals and improve patient outcomes. Education and related services are a critical component of in-patient treatment and help patients successfully re-establish life in their community upon hospital discharge.

B. Background/History

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 12,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily censuses of 6,143and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

DSH-Coalinga served 1,547 patients in 2018-19 and had an average daily census of 1,366 patients. This hospital serves individuals committed as Sexually Violent Predators and Offenders with Mental Health Disorders. Sexually Violent Predators (SVP) and Sexually Violent Predator Probable (SVPP) patients are committed to DSH-Coalinga after serving prison terms in California Department of Corrections and Rehabilitation. SVPs and SVPPs have an average length of stay in the state hospitals of nine years. Offenders with Mental Health Disorders treated at DSH-Coalinga have been committed to another DSH hospital following the completion of their prison term. If after their initial commitment in the state hospital and the individual's parole term is ending, if they are determined by a court to continue to require continued treatment, they may remain at the original state hospital for treatment or be transferred to DSH-Coalinga for treatment. Offenders with Mental Health Disorders have an average length of stay of four years. The average age of the patients at Coalinga is 47, however, the Coleman Unit treats patients 20 years and older.

DSH facilities, including DSH-Coalinga, provide treatment for individuals with serious mental health issues. The state hospitals serve individuals with a civil or forensic commitment and diagnosis of major mental, emotional, physical, psychological limitations or illness. Patients in state hospitals present widely varied skills and functional cognitive abilities. Patients at DSH-Coalinga have varying educational backgrounds, such as not being able to read up to a college education. Of the 1,366 patients at DSH-Coalinga, 305 of them have some form of college level education, 279 completed up to grade 12, and 204 patients have obtained a GED. There are 578 patients that have an education that ranges between grades two thru eleven.

To help patients overcome these limitations, DSH provides educational services at their hospitals which includes the administration of Special Education, Adult Basic Education (ABE), Vocational Education (Voc Ed), and High School Equivalency (HSE) programs and courses. Section 504 of the Rehabilitation Act of 1973 requires all students admitted to a state hospital under age 22 to have a free appropriate public education offered to them if they have previously received past special education services. To remain compliant with this requirement, all newly admitted patients 22 years of age or younger are interviewed by the DSH education departments at each hospital upon admission. If students self-report that they received past special education services or it is determined by some other means (i.e., transcript confirmation) that they have received special education, DSH enrolls students in education services.

Education services for patients 22 years and older are provided in the ABE and Vocational Services programs. ABE includes educational services that teach basic literacy or to work towards their HSE. ABE also includes academic skill building and developing life skills. DSH offers the Arts in Mental Health (AIMH) program to develop their arts education through art fundamentals, theater arts,

poetry/creative writing, design and illustration, and Taiko drumming. They also offer Vocational Services in a pre-vocational class or Industrial Therapy assignment. Other services offered within these programs include computer skills, occupational skills, treatment program courses, and substance recovery programs, to name a few.

DSH-Napa, DSH-Patton, DSH-Atascadero, and DSH-Metropolitan state hospitals offer the full complement of the adult education, vocational programs, High School Equivalency (HiSET), and diploma programs to their patients. Specific requirements for many of these programs are set forth in the following legislation: 1) the Federal Individuals with Disabilities Education Act (IDEA, Part B, 2) Workforce Innovation and Opportunity Act (WIOA), 3) Proposition 98 General Fund allocations per California Education Code, and 4) Code of Federal Regulation, Title 34, Section 300.32. More specifically, DSH received notice of their regular grant approval for the 2020-23 Workforce Innovation and Opportunity Act (WIOA), Title II: Adult Education and Family Literacy Act (AEFLA) to provide adult Basic Education (ABE), Vocational Adult Basic Education (learning job skills), ESL, Vocational ESL, and HiSET. This grant provides supplemental funding to participating schools. It provides funding for educational supplies, equipment and some training. It also provides the data collection software and testing materials and training through the California Adult Student Assessment System (CASAS), some professional development and technical assistance for curriculum development. Once DSH establishes the education programs at DSH-Coalinga, they will contact the California Department of Education and request to add DSH-Coalinga to the California State School Directory at the beginning of a school year. Individual state hospital funding is based on payments points that are generated by progress made by students on the CASAS testing. Points are earned when students move up a level in testing and when they attain a high school equivalency certificate. Funding per payment point varies from year to year as it is dependent on the amount of funding Congress allocates for adult education. Generally funding per payment point is around $250- $300 for each level attained and $500 for earning a high school equivalency certificate.

DSH-Coalinga, due to limited resources, does not offer the same level of educational services to its patients as the other four hospitals. They provide hooked on phonics and college distance learning through Coastline College, but do not offer additional ABE programs similar to the other hospitals, high school equivalency programs, nor Special Education programs. With DSH planning to include DSH-Coalinga in the WIOA grant in the future, they need support and resources to match the education programs provided at the other four locations to meet requirements for funding. Most importantly, DSH-Coalinga strives to reduce recidivism rates through educational services that help patients achieve success in their communities upon discharge. Attachment A illustrates the current disparity of educational offerings at DSH-Coalinga compared to the other hospitals, and the workload history below shows the number of patients that DSH-Coalinga served over the last five years.

Analysis of Problem

FY 19-20 Resource History
(Dollars in thousands)

Program Budget	DSH-A	DSH-C	DSH-M	DSH-N	DSH-P
Authorized Expenditures[1]	$1,053	$541	$1,225	$1,010	$1,291
Actual Expenditures (Personnel Services)[2]	$705	$411	$1,026	$612	$818
Actual Expenditures (OE&E)[2]	$8	$1	$62	$6	$9
Authorized Positions	10	4	10	9	10
Filled Positions	7	3	9	8	9

[1] Although DSH does not budget to the level of what educational services are provided in the hospitals this is the total cost of fully staffed positions and OE&E.

[2] 2019-20 is a combination of actual expenditure data as of Period 11 (May 2020) and expenditure projections for Period 12 (June 2020).

Workload History (DSH-C only)

Workload Measure	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Patients Served in Post-Secondary Education Program – Coastline College	10	5	4	7	3
Vocational Rehabilitation	795	683	610	605	605
Vocational Education Courses	106	94	159	151	51

C. State Level Consideration

Individuals served in state hospitals who are age 22 and younger are entitled to a free and appropriate public education in the least restrictive environment, pursuant to the provisions of the Individuals with Disabilities Education Act (IDEA) and the California Education Code (CEC), Part 30, Chapter 8. Adults age 18 and older are to receive education and training consistent with the provisions of the Rehabilitation Act of 1973 and the Americans with Disabilities Act and that will prepare them for re-entry into the community.

Part of DSH's mission is to provide evaluation and treatment in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings. Providing education services educational services to effectively rehabilitate its patients supports this mission as well as to

help individuals safely transition back to living and working in the community. DSH's focus is to improve patient outcomes through innovative programs and explore new ideas for services, capacity and treatment, as well as monitor data and trends through research and education. DSH maintains high standards of treatment and educational practices to help patients re-integrate into their communities successfully and reduce the rate of re-incarceration.

DSH also aligns with the California Health and Human Services Agency Strategic goals and guiding principles. The educational offerings of DSH focus on delivering programs that center on the patients. By providing these services, they help the patients become successful in their communities, thus keeping the communities safe. Providing educational services to our most vulnerable populations helps to reduce chances of patients returning to institutional settings.

D. Justification

Education services are a critical component of patient treatment as they help patients develop basic literacy, social, and job skills for reintegration into the community. They also allow patients possible attainment of a high school equivalency certificate which can significantly impact the patient's future and enhance their self-esteem. Education is a known strategy for also reducing patient recidivism rates. Having a solid educational foundation increases the patient's ability to live and work in their community successfully upon hospital discharge.

Education impacts patient care and treatment specifically related to preventing the patient's return to the institutional setting, commonly known as recidivism for forensic commitments. While research specifically regarding the impacts of education for individuals committed to state hospitals is not available, several reports and research exist on the impacts of education for prisoners. DSH-Coalinga's patients are all former inmates who have been committed at the end of their prison term to continue treatment in the DSH system, therefore looking at impacts of education on inmates is an appropriate comparison. A 2008 LAO report, From Cell Blocks to Classrooms: Reforming Inmate Education to Improve Public Safety, noted "A recent study found that educational programs ranked among the most successful strategies for reducing inmate recidivism. Education programs were also found in the study to have direct fiscal benefit which included reduced state court and incarceration costs, as well as a reduction in local costs for criminal investigations and jail operations." A subsequent 2016 study by the RAND Corporation also found that individuals who participate in any type of educational program while in an institution were 43 percent less likely to return. These findings support the need for education programs in institutional settings for qualified patients.

The long-term effects of patient education increase the likelihood they will not reoffend. The Prison Studies Project says that enhancing educational services and offerings within the prison system reduces recidivism, and a study conducted by the Correctional Education Association from 1997-1998 shows that re-arrest, re-conviction, and re-incarceration rates of Continuing Education (CE) participants are significantly lower than those of non-participants. In fact, the CE participants versus non-participants rates illustrated the following results: re-arrest 48% versus 57%, re-conviction 27% versus 35%, and re-incarceration 21% versus 31%.

DSH-Coalinga does not have a credentialed educator onsite to expand its educational offerings. DSH is committed to enhancing DSH-Coalinga's educational offerings to patients so that patients who transfer to DSH-Coalinga from CDCR prisons or other state hospitals can continue their education. DSH-Coalinga has enough staff to only offer the courses listed below. Should DSH-Coalinga receive new position authority, they will be able to expand offerings to more eligible patients and the number of enrolled patients should increase.

- Hooked on Phonics
- Distance Learning through Coastline College
- Computer Skills
- Hope and Spirituality
- Treatment Program Courses

- Substance Recovery Courses
- Vocational Education
- Patient Library
- Patient to Patient Mentoring
- One on one tutoring with a Behavioral Health Specialist

The education programs that DSH-Coalinga will offer, should they receive approval of this proposal, include:

Adult Basic Education (ABE)

DSH-Coalinga's ABE programs will allow patients access to courses that include mathematics, literacy, reading and writing, English and a second language, Vocational English as a Second Language, and job skills. This program also teaches life skills, academic skill building, and includes learning lab opportunities. The ABE program provides patients with reputable skills and abilities which increases their chances of employment upon discharge. These courses also help improve self-confidence while re-entering their communities and workforce.

Once the adult basic education program begins operation, Coalinga will be added to the department's WIOA Grant. This grant provides supplemental funds for programs based on adult learner progress made on pre-and post- tests. Learners who advance levels on the tests and/or attain a High School Equivalency Certificate earn payment points that will generate funds to supplement the state program. In addition to the supplemental funding that reimburses agencies for the items they purchase pursuant to grant requirements, the grant provides all testing materials, software required for reporting, training, and online testing (optional), technical assistance, curriculum development online, and professional development for staff who work with adult learners. This is a federal grant that is administered by the California Department of Education, Office of Adult Education.

High School Equivalency (HSE)

The DSH-Coalinga HSE courses will provide intermediate and advanced high school equivalency exam preparation. DSH-Coalinga will offer the HiSET exam to their patients as well and prepare the patients to take this exam through courses such as reading, writing, mathematics, science, and social studies. Obtaining a HiSET certificate verifies that patient's academic knowledge and skills are equivalent to a high school graduate. The HiSET improves self-confidence and can help with a patient who wants to continue their education.

Special Education

DSH-Coalinga will also offer transitional services planning, which is part of a special education student's IEP. These services mandate the development of post-secondary skills that will carry students into adulthood and prepare them for community living. The ability to provide special education services to vulnerable patients increases the likelihood these patients will be successful in school.

DSH-Coalinga lacks dedicated positions that strictly work on educational activities within the hospital. Currently, DSH-Coalinga utilizes Psychiatric Technicians and Behavioral Health Specialists from their regular duties covering other capacities of patient care to help the patients with academic opportunities. DSH proposes 1.0 full-time Special Education Teacher, and 2.0 Psychiatric Technicians to manage and expand the education programs throughout the hospital. Currently, DSH-Coalinga has the capacity to offer the following programs to patients, which totals 85 hours per week of academic instruction.

The requested positions will allow DSH-Coalinga to develop curriculum to expand beyond its current capacity at this facility and be in alignment with the other DSH facilities. DSH-Coalinga will expand course offerings to include basic literacy such as mathematics, reading, writing, and basic life skills. English as a second language, Vocational English as a Second Language, and job skill training will also be included. With additional positions, the hospital can offer more programs and opportunities, thus increasing enrollment. The following describe roles and responsibilities of the requested resources.

1.0 Full-Time Special Education Teacher

Analysis of Problem

The credentialed Special Education Teacher's responsibilities center around planning, assigning, and supervising the work of the Adult Basic Education Program, High School Equivalency, and the Adult Special Education program within DSH-Coalinga. The teacher will design curriculum, administer daily lessons to the students, and manage the educational programs. The teacher oversees the curriculum so that it meets the needs of the programs and the state and federal standards for high school equivalency programs. The teacher also develops IEPs for patients, helps classrooms remain on task, and maintains discipline among students. The teacher must also work to maintain the programs after implementation of new services.

The Teacher is crucial to the success of DSH-Coalinga's Education programs. Without the teacher, DSH-Coalinga does not have staff that can readily provide the full range of these services, and the patients are at a disadvantage by not having access to all possible programs. The teacher provides educational structure, administers curriculum, and gives patients an opportunity to learn skills to help patients re-enter into their communities. DSH-Coalinga cannot successfully administer its additional educational programs without this position.

2.0 Full-Time Psychiatric Technicians

The Psychiatric Technicians play an integral role to the success of the education programs and to the patients. They assist the teacher through assessment of patients and development of their IEPs and provide support to the students. This support helps patients complete assignments, prepare for exams, and get the best out of their educational opportunity. They will also lead training in their area of expertise and assist the teacher with maintaining educational records, ordering supplies, etc.

The Psychiatric Technicians are crucial to the success of the education program at DSH-Coalinga. If these positions are not approved, the patient experience will be limited with the diminished quality of educational offerings. These positions are also crucial to the Teacher being able to focus their attention on the patient instead of administrative duties to make the educational experience more client centric.

Should this proposal not get approved, DSH-Coalinga risks compromising the continuity of care when patients arrive from or return to a jail or prison. The impact of DSH-Coalinga being unable to enhance the educational programs may be seen for years with a potential increase of re-offenders and longer waitlists for qualified patients who need inpatient mental health treatment. With the approval of this proposal DSH-Coalinga could participate in the process to obtain federal reimbursements through WIOA for patients who complete the offered education programs. Without an experienced education program leader and staff, the beneficial education programs will not exist. DSH strives to offer comparable services to all patients and to maintain readiness to provide services to patients who are legally eligible to receive them.

E. Outcomes and Accountability

There are two specific objectives that must be met for this program to be successful. First, DSH-Coalinga must enhance the education programs and serve all eligible students upon arrival at Coalinga. To increase services, DSH-Coalinga will identify the standards and courses required, develop curriculum, hire the staff, and draft lesson plans. The new education team will report progress on a weekly and monthly basis to the Executive Director until the programs go live. Serving eligible student includes the following tasks: 1) Evaluate patients for eligibility into the program, 2) Develop IEPs, 3) Maintain order throughout the classrooms, and 4) Compile reports to meet State and Federal reporting requirements. DSH anticipates DSH-Coalinga would like to have the minimum program requirements in place to effectively administer the expanded education Program. DSH-Coalinga's goal is to also increase enrollment by 50% in its first year and continue to increase the percentage in following years.

Projected Outcomes

Workload Measure	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Enhance Current and Implement new Education Programs	**N/A**	**100%**				
Serve eligible students	**N/A**	**100%**	**100%**	**100%**	**100%**	**100%**
Increase Enrollment in educational programs	**N/A**	**50%**	**75%**	**100%**		

F. Analysis of All Feasible Alternatives

Alternative 1: Approve DSH's request for $352,000 and 3.0 permanent positions, 1.0 Special Education Teacher and 2.0 Psychiatric Technicians, to implement new and enhanced DSH-Coalinga Adult Education Programs.

Pros:

1. Provides enough resources to support expanded education services to DSH-Coalinga patients.
2. Reduces recidivism rates by educating patients and helping them find practical ways to re-integrate back into their communities.
3. Results in improvements at DSH-Coalinga in educational opportunities for patients.

Cons:

1. This proposal results in increased General Fund costs.

Alternative 2: Approve the request for $238,000 for 1.0 full-time Special Education Teacher and 1.0 full-time, permanent Psychiatric Technician to develop and implement the DSH-Coalinga Adult Education Programs.

Pros:

1. Reduces recidivism rates by educating patients and helping them find practical ways to re-integrate back into their communities.
2. Some improvements at DSH-Coalinga in educational opportunities for patients.

Cons:

1. Increase in General Fund spending
2. Would have to delay some program enhancements due to insufficient resources

Alternative 3: Remain the status quo and delay implementation of a more robust program of Special Education services at DSH-Coalinga until a later date.

Pros:

1. No increase in General Fund Spending

Cons:

1. Continue to risk an inability to timely provide education services for eligible patients

2. Continue to provide minimal educational services to special needs patients
3. Does nothing to reduce recidivism rates through educational services which in turn has a negative impact on the General Fund with the potential increase of reoffenders and longer waitlists for qualified patients who need inpatient mental health treatment.

G. Implementation Plan

Month/Year	Task
June 2021	Develop duty statements
July 2021	Advertise and hire teacher position
September 2021	Onboard Teacher
September 2021	Advertise Psychiatric Technician Positions
November 2021	Onboard Psychiatric Technicians
Dec 2021	Begin tasks to enhance the Adult Basic Education Programs

H. Supplemental Information

Attachment A: BCP Fiscal Detail Sheets

Attachment B: Workload Analysis

Attachment C: Current DSH Educational Programs

I. Recommendation

DSH recommends approval of the full request for $352,000 in General Fund and 1.0 full time Special Education Teacher and 2.0 Psychiatric Technician positions. These positions will help to provide consistent resources for DSH-Coalinga to provide ABE, HSE, and special education services to eligible patients. This proposal also improves the safety and well-being of the patients and their communities by providing them with specialized skills to help them successfully re-integrate into society after hospital discharge.

Should this proposal not get approved, DSH-Coalinga risks compromising the continuity of care when patients arrive from or return to a jail or prison. The effects of not being able to maintain the educational programs may be seen for years with a potential increase of reoffenders and longer waitlists for qualified patients who need inpatient mental health treatment. With the approval of this budget request DSH-Coalinga could participate in the process to obtain federal reimbursements through the WIOA grant for patients who complete the offered education programs. Without an experienced education program leader and staff, reimbursements and the beneficial education programs will not exist. DSH strives to offer comparable services to all patients and to maintain readiness to provide services to patients that are legally eligible to receive them.

BCP Fiscal Detail Sheet

BCP Title: Patient Education **BR Name: 4440-004-BCP-2021-GB**

Budget Request Summary

			FY21			
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	3.0	3.0	3.0	3.0	3.0
Total Positions	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
Salaries and Wages						
Earnings - Permanent	0	205	205	205	205	205
Total Salaries and Wages	**$0**	**$205**	**$205**	**$205**	**$205**	**$205**
Total Staff Benefits	0	99	99	99	99	99
Total Personal Services	**$0**	**$304**	**$304**	**$304**	**$304**	**$304**
Operating Expenses and Equipment						
5301 - General Expense	0	24	24	24	24	24
5304 - Communications	0	3	3	3	3	3
5320 - Travel: In-State	0	3	3	3	3	3
5324 - Facilities Operation	0	15	15	15	15	15
5346 - Information Technology	0	3	3	3	3	3
Total Operating Expenses and Equipment	**$0**	**$48**	**$48**	**$48**	**$48**	**$48**
Total Budget Request	**$0**	**$352**	**$352**	**$352**	**$352**	**$352**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	352	352	352	352	352
Total State Operations Expenditures	**$0**	**$352**	**$352**	**$352**	**$352**	**$352**
Total All Funds	**$0**	**$352**	**$352**	**$352**	**$352**	**$352**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	0	3	3	3	3	3
4410020 - Coalinga	0	349	349	349	349	349
Total All Programs	**$0**	**$352**	**$352**	**$352**	**$352**	**$352**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
2273 - Teacher				0.0	1.0	1.0	1.0	1.0	1.0
8253 - Psych Techn (Safety)				0.0	2.0	2.0	2.0	2.0	2.0
Total Positions				**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2273 - Teacher	0	74	74	74	74	74
8253 - Psych Techn (Safety)	0	131	131	131	131	131
Total Salaries and Wages	**$0**	**$205**	**$205**	**$205**	**$205**	**$205**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	3	3	3	3	3
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	9	9	9	9	9
5150450 - Medicare Taxation	0	3	3	3	3	3
5150600 - Retirement - General	0	41	41	41	41	41
5150800 - Workers' Compensation	0	9	9	9	9	9
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	6	6	6	6	6
5150900 - Staff Benefits - Other	0	27	27	27	27	27
Total Staff Benefits	**$0**	**$99**	**$99**	**$99**	**$99**	**$99**
Total Personal Services	**$0**	**$304**	**$304**	**$304**	**$304**	**$304**

Department of State Hospitals
Patient Education

WORKLOAD ANALYSIS FOR:

Special Education Teacher (1.0)				
Classes	***Hours Required To Accomplish***	***Frequency of Task (Monthly)***	**Months**	***Total Hours Projected (Annually)***
Current Events	0.7	Weekly	12	32
Hooked on Phonics	0.7	Weekly	12	32
Introduction to Hand Tools	3.3	Weekly	12	160
Mill and Cabinetry, Introduction	3.3	Weekly	12	160
Mill and Cabinetry, Advanced	3.3	Weekly	12	160
Understanding Hand Tools – Beginning	3.3	Weekly	12	160
Understanding Hand Tools – Advanced	3.3	Weekly	12	160
Printing Skills Maintenance	3.3	Weekly	12	160
Graphic Arts Introduction	3.3	Weekly	12	160
Introduction to Computer	0.3	Weekly	12	16
Mill and Cabinetry, Introduction	3.3	Weekly	12	160
Administrative Functions	8.7	Weekly	12	416
TOTAL HOURS PROJECTED ANNUALLY				**1,776**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**1.0**

Department of State Hospitals
Patient Education

WORKLOAD ANALYSIS FOR:				
Psych Tech (2.0)				
Classes	***Hours Required To Accomplish***	***Frequency of Task (Monthly)***	**Months**	***Total Hours Projected (Annually)***
Current Events	1.3	Weekly	12	64
Hooked on Phonics	1.3	Weekly	12	64
Introduction to Hand Tools	6.7	Weekly	12	320
Mill and Cabinetry, Introduction	6.7	Weekly	12	320
Mill and Cabinetry, Advanced	6.7	Weekly	12	320
Understanding Hand Tools – Beginning	6.7	Weekly	12	320
Understanding Hand Tools – Advanced	6.7	Weekly	12	320
Printing Skills Maintenance	6.7	Weekly	12	320
Graphic Arts Introduction	6.7	Weekly	12	320
Introduction to Computer	0.7	Weekly	12	32
Mill and Cabinetry, Introduction	6.7	Weekly	12	320
Administrative Functions	17.3	Weekly	12	832
TOTAL HOURS PROJECTED ANNUALLY				**3,552**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**2.0**

Attachment C

Current Education Programs Available at Department of State Hospitals						
	Pre-General Education Development (GED)	GED / High School Equivalency Test (HiSET) / Treatment Accountability for Safer Communities (TASC)	Adult Basic Education	Special Education	Advanced Education	Other
DSH - Atascadero	**No**	**Yes** • HiSET	**Yes** DSH A has the Aztec School which offers: • Math 1, 2, 3 • Literacy • Reading and Writing 2, 3 • ESL • American Sign Language	**Yes** • 1 Retired Annuitant - Part time • 20% support from AGPA	**No**	• Computer Skills • Hope & Spirituality • Legal • Treatment Program Courses • Substance Recovery Programs • Vocational Education • Patient Library • Reach Program
DSH - Coalinga	**No**	**No**	**Yes** • Hooked on Phonics	**No**	**Yes** • College Distance Learning - Coastline College	• Computer Skills • Hope & Spirituality • Treatment Program Courses • Substance Recovery Programs • Vocational Education • Patient Library • Patient to Patient Mentoring • Behaviorial Specialists offer one on one tutoring to patients
DSH - Metropolitan	**Yes** • Educational Software for the most foundational skills up through preparation for the high school equivalency exam	**Yes** • TASC • HS Diploma program is available for eligible Special Ed students and minors in partnership with Whittier Union High School District (WUHSD)	**Yes** • The 'School' at DSH-M consists of three school classrooms run by two special educators • Academic Skill Building • Developing Life Skills	**Yes** • 2 Special Education Teachers	**No**	• Computer Skills • Hope & Spirituality • Legal • Treatment Program Courses • Substance Recovery Programs • Occupational Skills • Patient Library
DSH - Napa	**No**	**Yes** • In process of becoming a HiSET brand testing center but currently Napa Valley Adult School proctors the HiSET for patients monthly	**Yes** DSN-Ns Educational Services Center is known as the Phoenix Adult School (PAS) and offers: • Life Skills / CHOICES • ESL • ABE / Literacy and Basic Math • Rosetta Stone/Ind. Study (improved grasp of English)	**Yes** • 4 Full-Time Special Education Teachers • 1 Part-Time Special Education Teacher	**No**	• Computer Skills • Hope & Spirituality • Legal • Treatment Program Courses • Substance Recovery Programs • Vocational Education
DSH - Patton	**Yes** • Intermediate / Advanced high School Equivalancy Preparation • Minors are served through a High School Diploma program in partnership with the San Bernardino County Superintendent of Schools (SBCSS)	**Yes** • TASC	**Yes** • ESL • Academic Skills Building • Learning Lab	**Yes** • 1 Full-Time Special Education Teacher • 1.5 Retired Annuitant - Part time	**Yes** • Distance Learning Program is open to all patients w ho have obtained a GED / TASC or HS Diploma.	• Computer Skills • Hope & Spirituality • Legal • Treatment Program Courses • Substance Recovery Programs • Vocational Education

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	Business Unit	Department	Priority No.
2021-22	4440	Department of State Hospitals	02

Budget Request Name	Program	Subprogram
4440-003-BCP-2020-GB	4400 – Administration	4400020 – Hospital Administration

Budget Request Description
Medical and Pharmaceutical Billing System

Budget Request Summary
Department of State Hospitals (DSH) requests 1.0 permanent position and $794,000 General Fund in Fiscal Year (FY) 2021-22 and $774,000 annually in FYs 2022-23, 2023-24 and 2024-25 to enhance system functionality for the Cost Recovery System to capture, bill and recover eligible patient cost of care reimbursements until DSH has successfully implemented an Electronic Health Record.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed
☐ Yes ☒ No	Click or tap here to enter text.

Does this BCP contain information technology (IT) components? ☒ Yes ☐ No	Department CIO	Date
If yes, departmental Chief Information Officer must sign.	Andrew Hinkle	Click or tap to enter a date.

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. TBD **Project Approval Document:** S1BA

Approval Date: TBD

If proposal affects another department, does other department concur with proposal? ☒ Yes ☐ No
Department of Developmental Services

Prepared By	Date	Reviewed By	Date
Angela Griffith	9/9/2020	George Maynard	Click or tap to enter a date.
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	Click or tap to enter a date.	Mark Ghaly, MD, MPH	Click or tap to enter a date.

Department of Finance Use Only

Additional Review: ☐ **Capital Outlay** ☐ **ITCU** ☐ **FSCU** ☐ **OSAE** ☐ **CALSTARS** ☐ **Dept. of Technology**

PPBA	Date submitted to the Legislature
Click or tap here to enter text.	Click or tap to enter a date.

Analysis of Problem

A. Budget Request Summary

Department of State Hospitals (DSH) requests $794,000 General Fund in Fiscal Year (FY) 2021-22 and $774,000 annually in FYs 2022-23, 2023-24 and 2024-25 to support 1.0 permanent position and contract resources equivalent to 2.0 consultants. The resources will be used to enhance system functionality for the Cost Recovery System (CRS) to capture, bill and recover eligible patient cost of care reimbursements until DSH has successfully implemented an Electronic Health Record (EHR).

CRS is housed within the Department of Developmental Services (DDS) and is the electronic billing system for DDS and DSH that is utilized for tracking, documenting, billing, and recovering funds for patient cost of care. This request will provide the necessary technical resources to allow DSH to improve the CRS functionality to increase revenue, comply with Federal and State mandates, and reduce the risk of inaccurate billing. The enhancement of the CRS system will allow DSH to bridge the gap between the current CRS limitations and the implementation of a full EHR solution scheduled for implementation in 2025, while allowing for increased revenue collection during this interim period. The proposed programming of CRS does not directly impact EHR or Pharmacy Modernization. Upon implementation, CRS will be replaced by the standard cost recovery functionality that is incorporated into the EHR System.

B. Background/History

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily census of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

<u>Transition from DDS to DSH</u>

DDS was traditionally responsible for administering DSH's third-party billing system. In the 1980s, DDS and the then-Department of Mental Health (DMH) entered into a Memorandum of Understanding (MOU) agreement to identify its respective roles. DMH would provide administrative services regarding state hospital cost reporting, patient trust, patient billing for third party payers, conservatorship, and collection services and DDS would be responsible for developing hospital billing rates, compliance services, claims resolutions, and risk management. DMH would be responsible for the accuracy of data submitted to DDS for Medicare billing and rate development, respond timely to audit inquiries, and perform quarterly internal audits and quality control reviews of state hospital records.

Due to resource constraints, it was challenging for DDS to perform the services outlined in the MOU, and as the population served by DSH increased, DSH did not have sufficient staff to perform the functions formally performed by DDS. The MOU has since been replaced with an Inter-Agency Agreement (IAA). The IAA stipulates that DSH will reimburse DDS for California Department of Technology (CDT) data storage and Experian Health claim processing fee

Analysis of Problem

Table 1: Reimbursement Revenue, FY 2016-17 to FY 2019-20

Reimbursement Type	*FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Medicare Part A and B	$753,688	$838,397	$516,104	$471,776
Medicare Part D	$921,048	$1,091,620	$1,130,527	$1,045,330
Private Pay	$3,480,176	$2,574,851	$2,538,219	$1,741,061
**Other	$4,992	$109,204	$117,971	$47,609
Totals	**$5,159,904**	**$4,614,072**	**$4,302,821**	**$3,305,776**

* DDS received and processed DSH's reimbursement revenue for the first three months of the FY. DDS charged DSH $55,584 for this service.
** Other Reimbursement Types include reimbursements from Supplemental Medicare Insurance and excess fund payments from patient trust accounts (Welfare and Institutions Code (WIC) § 7281).

DSH Established the Patient Cost Recovery Section (PCRS)

The 2014 Budget Act authorized DSH to create PCRS, which included 15.0 full-time limited term positions, to develop and implement a standardized and streamlined third-party billing system that would include accounts management, billing and collection, assets determination, policies and procedures, compliance and auditing. A third-party billing system refers to an entity performing billing services as an intermediary between two parties. PCRS acts as an intermediary to recuperate charges related to a patient's cost of care from any applicable insurance or private pay parties. All moneys collected from the established third-party billing system are remitted to the State General Fund. The intent of establishing PCRS was for DSH to assume the responsibility for all billing and collections functions previously performed by DDS through the MOE.

The 2015 Budget Act authorized the limited term positions to become permanent as of July 1, 2016. DSH continues the process of assuming the third-party billing responsibilities from DDS with the goal of maximizing revenue from Medicare, private pay, and insurance collections by providing technical assistance to the state hospitals regarding billing, Medicare compliance reviews, managing patient trust accounts, performing patient benefit and insurance enrollment, provider enrollment, asset determination, and pursuing legal efforts in private payer collections.

Due to CRS system limitations, DSH continues to see a decline in revenue. With the addition of the system programmers, DSH will be able to prioritize DSH system change requests more timely which will enable DSH to have the ability to bill for services that are not being captured or billed such as Medicare Part A, Skilled Nursing Facilities (SNF), durable medical equipment (DME), and telemedicine.

The enhancement of the CRS system will allow DSH to bridge the gap between the current CRS limitations and the implementation of a full EHR solution. The EHR project is in the planning phase and is expected to receive final approval of the Stage 2 Alternatives Analysis by the California Department of Technology (CDT) in early January2021. The current timeline anticipates submitting a draft Request for Proposal to CDT in December 2021, awarding an implementation contract in the spring of 2023, and beginning installation at all five hospitals in mid-2025. One of the critical requirements of the EHR solution – and a feature that is standard in all major EHR software products – is a comprehensive billing and cost recovery module that will replace the need for the CRS application. The new billing solution would become effective immediately upon EHR Go Live in 2025. Through the interim, the Common Business Oriented Language (COBOL) programming solution will allow for increased revenue collection while working towards addressing the CRS limitations listed below.

Current CRS System limitations for Medicare Part A and Part B include:

Analysis of Problem

- Inability to generate Medicare Part A claims for SNF units.
- Does not capture the correct bed placement resulting in inaccurate bed charges.
- Unable to accept the transfer of diagnosis codes from the Admissions Data Transfer (ADT) System for Medicare Part A claims.
- Does not transfer all Medicare covered services to Experian/ Data System Group (DSG) on Medicare Part A and B claim forms.
- Erroneously creates and sometimes bills Medicare Part A and B claims for services never performed.

CRS System limitations for Medicare Part D include:

- Caps medication dispensing at a 30-day cycle, however, DSH uses a 45-day dispensing cycle. This creates under billing for medications.
- Adjusts medication pricing profile which causes losses discrepancies with the amount billed.

General system limitations include:

- CRS is unable to create Medicare Part A, B and D billing files which requires DDS and DSH to contract for an outside source (Experian) to generate Medicare claims.
- CRS cannot electronically bill private insurances to meet current industry billing standards for eligible services.
- CRS is unable to cross reference duplicate claims or services.
- CRS does not always accept electronic payments from Medicare resulting in inaccurate tracking of cost of care and incoming reimbursement.
- CRS does not automatically apply all payments and reimbursements to patient cost of care account balances. This causes monthly statement of account bills sent to patients to be inaccurate, reducing payments from private payors.
- CRS does not track historical changes made to a patient account resulting in inaccurate account information.
- DSH is dependent upon DDS programmers to update and maintain the Charge Description Master (CDM). The CDM applies a charge for every service provided. DDS staff have not had capacity to update DSH's CDM, and as a result, it has not been updated since 2009. Thus, DSH may be underbilling for services provided to patients.
- DDS staff do not have capacity provide written CRS billing logic for DSH to reference to determine what is being billed.
- Currently, only DDS staff have the capability to make modifications to DSH patient account information.
- Currently, CRS does not automatically apply credits, payments, or reimbursements; a DSH employee manually adjust a patient's cost of care account.

DSH's patient population has an added layer of complexity due to the changing legal classifications and corresponding Medicare eligibility for billing those classifications. DSH patients are more complex than typical community hospital patients due to the number of admissions, transfers, and discharges; length of stay; complicated legal requirements and forensic dispositions; and the severity of their mental disorders. CRS is currently not customized for the complex DSH patient population. Workarounds and custom programming are necessary to navigate the changing environment that DSH is faced with considering the different types of health insurances and patient eligibility. DDS' patient population varies significantly from DSH; however, the same billing system is utilized for both departments.

Inaccuracies of submitted claims may be construed as false claims. This is of significant concern as there is a large volume of claims that need to be corrected for a variety of technical errors. Claims may contain multiple errors and as of FY 2019-20 there are approximately 16,314 claims with errors.

Analysis of Problem

Table 2 below reflects the magnitude of claims and claims with errors in FY 2018-19 and FY 2019-20. (See Table 4: FY 2019-20 Summary of Error Codes Tied to CRS).

Table 2: Medicare Claims Error Rate

Medicare Program	Number of Claims Submitted		Number of Claims with Errors[1]		Error Rate (CMS Standard = 7.25%)	
	2018-19	2019-20	2018-19	2019-20	2018-19	2019-20
Medicare Part A and Part B	9,240	8,837	2,866	2,355	31%	27%
Medicare Part D	29,294	26,178	13,444	13,959	46%	53%
Totals	**38,534**	**35,015**	**16,310**	**16,314**	**42%**	**47%**

[1] One claim may contain multiple errors.

DSH's current business environment with CRS presents challenges in developing and implementing more rigorous processes, claims resolution, and technical training for state hospital staff. PCRS staff have minimal control over CRS functionality due to no dedicated resources from DSH collaborating with DDS on CRS. Also, DDS is reducing its resident population and potential need for CRS, while DSH's patient population remains steady and dependent on CRS. DDS does not have the current resources to address all DSH requests related to CRS. The increasing DSH requests places added pressure on DDS' limited resources and hinders DSH from improving current processes. Utilizing CRS and depending on DDS (given their resource challenges) for billing impacts PCRS' ability to achieve its mission of increasing revenue in order to offset pressures to the state GF.

Resource History

(Dollars in thousands)

Program Budget	**PY – 4[1]**	**PY – 3**	**PY – 2**	**PY-1**	**PY**	**CY**
Authorized Expenditures	0	$2,670	$2,426	$2,827	$3,180	$2,670
Actual Expenditures	0	$1,556	$1,891	$2,454	$2,932	$1,556
Revenues	0	0	0	0	0	0
Authorized Positions	0	17.0	17.0	18.0	18.0	17.0
Filled Positions	0	15.0	13.0	15.0	17.0	15.0
Vacancies	0	2.0	4.0	3.0	1.0	2.0

[1] PCRS did not exist at this time. No unit data available.

Analysis of Problem

Workload History

Workload Measure	PY – 4	PY – 3	PY – 2	PY-1	PY	CY
Medicare Part A and B Claims						
Number of claim errors corrected in DSG	68,183	104,297	48,445	57,519	54,357	N/A
Number of claims corrected	3,199	6,074	7,523	4,871	5,433	N/A
Number of claims transmitted to CMS	7,179	10,528	13,992	9,240	8,837	N/A
Dollar value of claims transmitted to CMS (billed but not reimbursed)	$7,789,945	$17,728,763	$18,140,340	$8,273,808	$7,349,754	N/A
Medicare Part D Claims						
Number of claims rejected by Prescription Drug Plans (PDP)	16,941	10,539	14,857	13,444	13,959	N/A
Number of resubmitted claims approved by PDPs	4,432	4,481	5,318	5,064	5,236	N/A
Trust Office*						
Number of account reviews	N/A	N/A	N/A	N/A	10,492	N/A
Number of patient or third-party asset searches	N/A	N/A	N/A	N/A	2,155	N/A
Number of account r6reconciliation requested by DSH-Legal Division	N/A	N/A	N/A	N/A	15	N/A
Number of statement of accounts mailed	N/A	N/A	N/A	N/A	17,632	N/A
Number of itemized statements requested	N/A	N/A	N/A	N/A	44	N/A
*Fields labeled with N/A are not available because this information was not tracked prior to FY 19-20.						

C. State Level Consideration

This proposal addresses the requirements of the WIC §§ 7275-72937292 to seek out and collect payments for cost of care. Approval of this proposal will increase collections from federal Medicare and other third-party payment sources and offset the state General Fund for treatment services provided at the state hospitals.

The need for statewide mental health services, both community-based and institutional care, continues to grow. DSH expects the population to increase over time in response to the need for inpatient mental health services. In addition, DSH's population is aging. The resulting increase in patients eligible for federally reimbursable services is creating expanded opportunities for revenue collection.

Adding DSH resources to improve the functionality of CRS will also align with California Health and Human Services Agency (CHHS) Guiding Principles, specifically:

- Adopt a Culture of Collaboration and innovation: DSH will work with DDS for all training within CRS, as well as with all change requests from beginning to implementation for the issues identified and those yet to be discovered. The collaborative effort will seek to solve longstanding problems that may benefit both departments.
- Focus on Outcomes and Value Generation: Updating CRS will better serve DSH patients by pursuing all reimbursement opportunities, particularly those with Medicare, and lowering their cost of care account balance.
- Using Data to Drive Action: CRS improvements will increase its reporting capabilities as the data being pulled and reported will be more accurate and have more data to pull from. The data generated from the reports will allow DSH the opportunity to see where services provided to our patients may be improved. In addition, with CRS improvements DSH will be able to perform quality control functions and report information to third party efficiently and timely.

In addition, this request supports all of the department's goals of organizational and operational excellence and an integrated behavioral health system.

DSH has four Goals as part of its Strategic Plan:

- A safe environment for patients and employees-The current IT systems provide many layers of complexity in storing patient data that causes inaccuracies and inefficiencies. Addressing challenges associated with the antiquated IT infrastructure will result in increased data integrity of patient's health information.
- Organizational and operational excellence-This proposal is grounded in responsible stewardship so that PCRS is able to recover patient cost of care and provide accurate account balances. The outdated programming prevents PCRS from fully reaching its potential to recover costs and relieve pressure from the General Fund.
- Innovative treatment and forensic evaluation-PCRS is responsible for managing patient cost of care regardless of patient commitment type. This proposal aims to analyze the medical and pharmaceutical billing policies and procedures of all commitment types including forensic. Through an analysis of enterprise-wide billing and collection practices, of which forensic business practices are included, PCRS may better understand the requirements and potentially standardize and streamline processes related to patient cost of care. These improvements support DSH preparations for the move to Electronic Health Records thus enabling forensic staff to better focus on treatment and evaluation rather than administrative functions related to billing.
- Integrated behavioral health system-This proposal supports integration between the state hospital system and other health systems, such as Medicare, private insurance, and county health systems.to improve system performance through innovation and increase alignment with standardization system operations, policies and processes

Extending the existing functionality of the CRS for medical and pharmaceutical billing will maximize efficiencies and effectiveness within the system and improve system performance through innovation.

D. Justification

There are critical needs at the CRS systems level to continue to advance PCRS' goals of revenue generation and risk management, in conjunction with addressing identified workflow and compliance challenges. CRS was built in the 1980s and was designed with the intent of a patient population that is not in alignment with the current environment. CRS is an antiquated billing system that can no longer account for the complexity of DSH's patient population and rapidly changing needs. As PCRS staff conducts further analysis and identifies trends related to CRS, PCRS staff can then determine a CRS solution to ensure compliance with applicable medical billing laws. Currently, DDS is only staffed with two Senior Programmer Analysts to address the needs of both departments.

Analysis of Problem

Furthermore, DDS' patient population is decreasing as they move towards closing their Developmental centers, while DSH's patient population is growing. The amount of billing transactions per month processing through CRS come predominantly from DSH rather than DDS, with DSH accounting for approximately 90-95 percent of the billing transactions produced out of CRS.

Addressing Critical Technical Business Needs

As noted in the background information section, PCRS has prioritized key program areas and opportunities moving forward. However, for each of those program areas, there exists a critical technical component with the commonality of utilizing CRS as the repository of all billing information. The following paragraphs describe the specific technical components that must be addressed to better ensure compliance with State and Federal laws and regulations.
The following table demonstrates a summary of key claim errors. These errors result in inaccurate account balances, increased workload to manually correct these errors, inaccurate Medicare claim information, not meeting current medical billing industry standards, and a heightened risk of negative audit findings.

Table 3: FY 2019-20 Summary of Error Codes Tied to CRS

Type Error	Description of Error	Number of Errors
Diagnosis codes not transmitted properly to CRS.	Ancillary transactions being transmitted to CRS are being flagged as diagnosis codes not recognized by CRS. The diagnosis codes appear to be entered correctly and are supported by both ADT and CRS.	5,671
Transactions not accepted because they have been entered past the service code expiration date.	Services not entered in CRS because the service code is listed as expired in CRS. CRS is unable to set an expiration date for a service code so the ability to access the codes are "turned off" in CRS. Transactions with dates of service preceding the expiration date are not accepted.	3,693
Transactions not entered in CRS because accounts are not established.	Data Integrity: CRS does not always accept ADT patient profiles and designates the patient as "Pre-Admit". When services are transmitted to CRS for this account the transactions are not billed and not applied to the patient's cost of care account.	3,375
Transactions not entered in CRS for services involving providers not recognized by CRS.	Data Integrity: Provider profiles are established in ADT but are not always accepted by CRS. All services entered will not be billed or captured in the cost of care until the provider account is established correctly in CRS.	2,211
Transactions not entered because service codes are not recognized or defined.	Services not entered in CRS because the service code is not recognized. CRS has limited capacity on the number of procedure codes it can hold at a given time. As such, not all procedure codes are entered in CRS. If a code is used at the hospital (supported by ADT) but is not supported/set up in CRS at the time of entry, the service will not make it in to CRS.	2,081
Room and bed movements are not reflected in CRS.	Data Integrity: CRS does not accept all room and bed movements from ADT resulting in missed and inaccurate per diem bed rates applied to patient accounts and inaccurate Medicare claim information.	2,046

Pharmacy transactions not entered in CRS due to prescription national drug code number not recognized or accepted.	CRS does not accept certain over the counter (OTC) medications which triggers a system error. CRS is also set up to put an end date on medications the manufacturer is no longer producing which also triggers an error as the system deems the medication obsolete when the end date is beyond two years.	1,410

PCRS notes that the technical component is only one phase of approaching the errors identified in Table 3. Other factors that may contribute to errors consist of inaccurate data entry or a lack of understanding of what data may be needed. For example, one of the errors identified above is that data essential to the processing of Medicare part A claims is not appearing on claim forms. PCRS has pursued an investigation to determine the source of the problem. Staff have discussed the issue with DDS and have conducted teleconferences with the hospitals to verify what information is available. PCRS also worked with DSH internal audits team to conduct a thorough review of current billing practices from the medical provider to submitting an accurate claim. However, PCRS learned that the patient management data system and CRS currently do not have a mechanism in place to transmit all the necessary data needed on the claim form. PCRS has taken measures to document the problem and has begun addressing the missing data at the front-end, however, addressing the technical piece is critical because the data must flow seamlessly. PCRS must simultaneously work with staff to address workflow inefficiencies or training issues.

While the occurrence of errors in new claims is unavoidable, it can be reduced significantly with proper policies, procedures, training, and technology solutions. PCRS is working to provide consistent oversight, standardization of policies and procedures, and technical assistance to reduce the number of errors generated from new claims, particularly during this period of procedure development. The errors listed above have led to research efforts by PCRS staff to identify what, if anything, can be done to address the issues. DSH has worked with DDS to modify CRS to meet its needs, however, absent the dedicated resources needed, the modifications have not been viable. Some of those reasons include but are not limited to: DDS IT staff do not have capacity to make the proposed modification; CRS is incapable of making the modification; the proposed modification will put other areas of the CRS at risk for non-compliance. The following table describes some of the specific CRS issues.

Table 4: Backlog of CRS Challenges Requested by DSH to be Addressed

CRS Challenges	Business Need Addressed (if corrected)
Inability to bill Medicare Part A claims for SNF.	*Revenue generation and risk management*—By billing for all eligible services DSH can ensure compliance with WIC §§ 7275-7293, which mandates DSH to collect on third-party payments to support a patient's cost of care and treatment.
DDS has access and the ability to make modifications to DSH patient account information.	*Risk management*—DSH will mitigate the risk of patient account corruption and ensure the Health Insurance Portability and Accountability Act (HIPAA) requirements to allow only DSH users to have access to confidential patient information.
Inability to bill commercial insurance.	*Revenue generation and risk management* — By billing for all eligible services DSH can ensure compliance with WIC § 7275-7293, which mandates DSH to collect on third-party

Analysis of Problem

	payments to support a patient's cost of care and treatment.
Inability to bill all medical component types (global, technical and professional).	*Revenue generation and risk management*—By billing for all eligible services DSH can ensure compliance with WIC § 7275-7293, which mandates DSH to collect on third-party payments to support a patient's cost of care and treatment.
Inability to bill for all medical services including, but not limited to DME, telehealth and telemedicine services.	*Revenue generation and risk management*—By billing for all eligible services DSH can ensure compliance with WIC § 7275-7293, which mandates DSH to collect on third-party payments to support a patient's cost of care and treatment.
CRS is unable to accept industrial standard of Electronic Remittance Advice (ERA)/835 files. These files are used to automatically post claim reimbursements in billing systems.	*Risk management and cost saving*—DSH's ability to download 835 files automatically, reducing the number of errors in a patient's cost of care account.
Diagnosis codes do not transmit directly and error out; system cannot support coding modifiers.	*Revenue generation and risk management*—DSH will be able to meet current industry standards and manage patient accounts accurately.
Inability to track changes made in a patient account.	*Risk management*—This will allow DSH the ability manage patient accounts with ease and develop training materials.
Manual account reconciliation process.	*Risk management and risk management—Time spent completing account reconciliations manually will be redirected to other critical areas of need.*
Inaccurate account balances creating inaccurate billing statements and Medicare claims.	*Revenue generation*—Time spent processing expired claims can be redirected to workable/payable claims.
Customized filter to prevent services over one year old from being submitted as a claim.	*Revenue generation*—Time spent processing expired claims can be redirected to other critical areas of need.
Update to billing rates for services provided at the hospitals.	*Revenue generation*—DSH rates have not been updated since 2009, therefore updating the rates in CRS to match usual and customary standards may yield additional revenue (currently working on updating rates).
Certain eligible procedures performed at the hospitals are being flagged by CRS as "not billable to Medicare" and a claim is not generated.	*Revenue generation and risk management* —DSH could potentially bill for additional services that are not programmed in CRS, which would increase reimbursement and decrease risk because of equitable billing practices.
Understanding and customizing business rules to identify "non-covered" Medicare services to prevent claims from being produced.	*Revenue generation—T*ime spent processing unworkable claims can be redirected to other critical areas of need.
Increases to size of data fields to allow staff to enter full and accurate data on patient account balances.	*Risk management*—Improves the accuracy of patient account balances which are the record of what patients owe to the State of California.

Analysis of Problem

Generation and customization of DSH tailored routine and ad hoc reports (ex. Telenet).	*Risk management and Revenue Generation*—DSH relies on data to make informed decisions based on trends and analysis. However, resources to generate and program CRS are not always available.
Correction of issue where diagnosis codes are not being included for all UB (institutional) claims.	*Risk management*—All claims submitted to CMS should include accurate and appropriate information needed to determine if a claim is payable. Diagnosis is a critical field in making that determination.
CRS automatically "closes" patient beds. This error prevents patients from being fully admitted and allowing documentation of charges for services rendered.	*Risk management and Revenue Generation*—If a patient is not considered fully admitted in CRS then the patient will not accumulate all appropriate charges and claims will not be produced.
Managing user access for DSH employees and assigning appropriate functionality.	*Risk management and Revenue Generation*—Appropriate DSH staff must be able to access CRS to input patient eligibility information, correct claim errors, and conduct quality control and assurance issues.

PCRS has endeavored to address many of the CRS challenges to minimize the risk to DSH but cannot progress further without addressing the technical issues in the CRS system through programing changes to provide permanent solutions to the problems regarding compliance, cost recovery, or claims submission.

If not approved, DDS will continue to provide limited claims processing services and DSH will not be able to address the necessary business and legal functions related to proper coding, billing, and collections of third-party resources. Within DSH facilities, DSH will be unable to collect claims revenue due to unresolved corrections of rejected claims currently submitted by DSH through CRS. Without this proposal, Medicare claims, collections, and reporting processes will not be established. DSH state hospital staff will not be provided proper training on claims coding and Medicare billing processes and CMS compliance, and DSH will be in violation of WIC §§ 7275-7279 related to patient liability and federal regulations governing Medicare.

In conclusion, if this proposal is not funded, state revenue from Medicare and private pay claims will continue to diminish, and the state will be at high risk for severe economic penalties and the loss of Medicare certification at DSH state hospitals. DSH is continuing to investigate and correct any and all deficiencies related to Medicare Parts A, B, and D billing to avoid any inappropriate billing that could lead to potential fines imposed by the False Claims Acts (FCA) of up to $11,000 per claim. Additionally, the Civil Monetary Penalties Law, § 1128A of the Social Security Act, authorizes OIG to impose civil penalties for healthcare billing violations. Penalties range from $10,000 to $50,000 per violation.

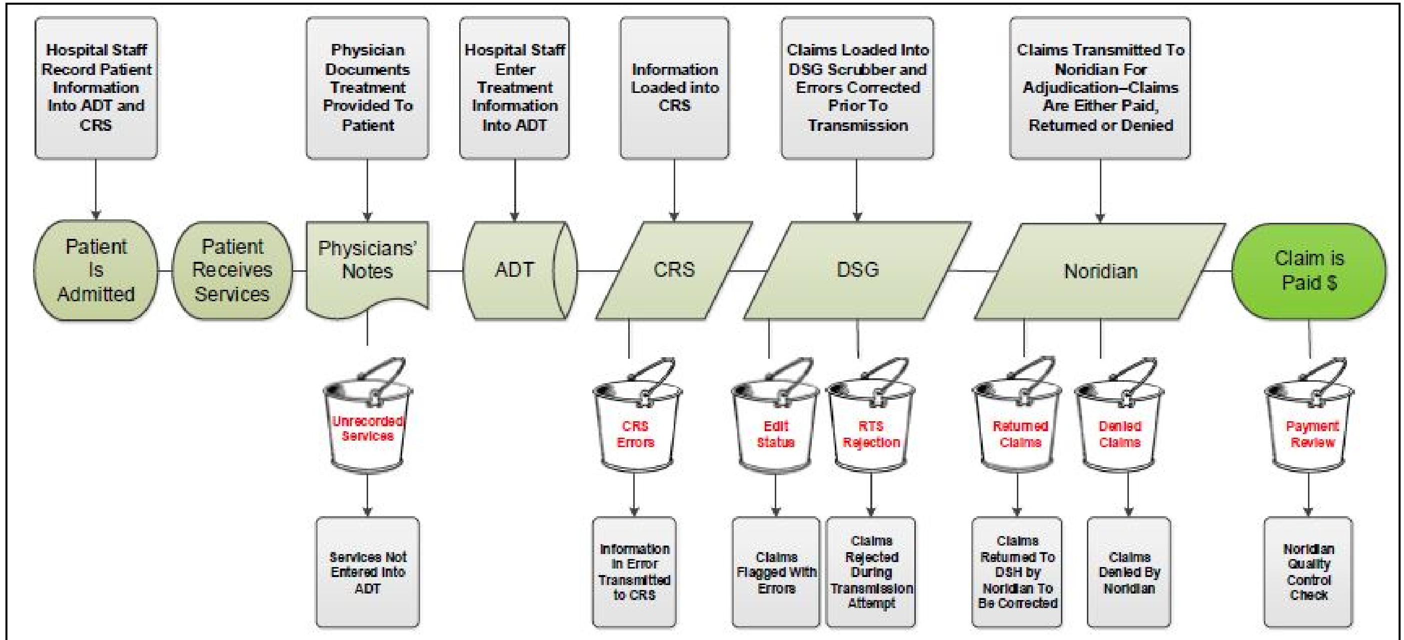
DSH is requesting 1.0 permanent position and contract funding for COBOL Consultant programmers. The state position is required to oversee and act as a liaison between DSH PCRS and DDS. DSH does not have IT resources available to fulfill this role given the current IT efforts underway at DSH. The availability of COBOL programmers among state staff is limited as COBOL was a coding system popular in the 1980s. Thirty-five plus years later, most state employees with this skill set have retired. DSH does not currently have staff available with COBOL background. When DSH has requested assistance from DDS to meet the programming needs, DDS is unable to accommodate the programming needs due to their own backlog. The DDS Programming backlog does not include the programming needs of DSH.

Analysis of Problem

System Integration/Liaison Responsibilities

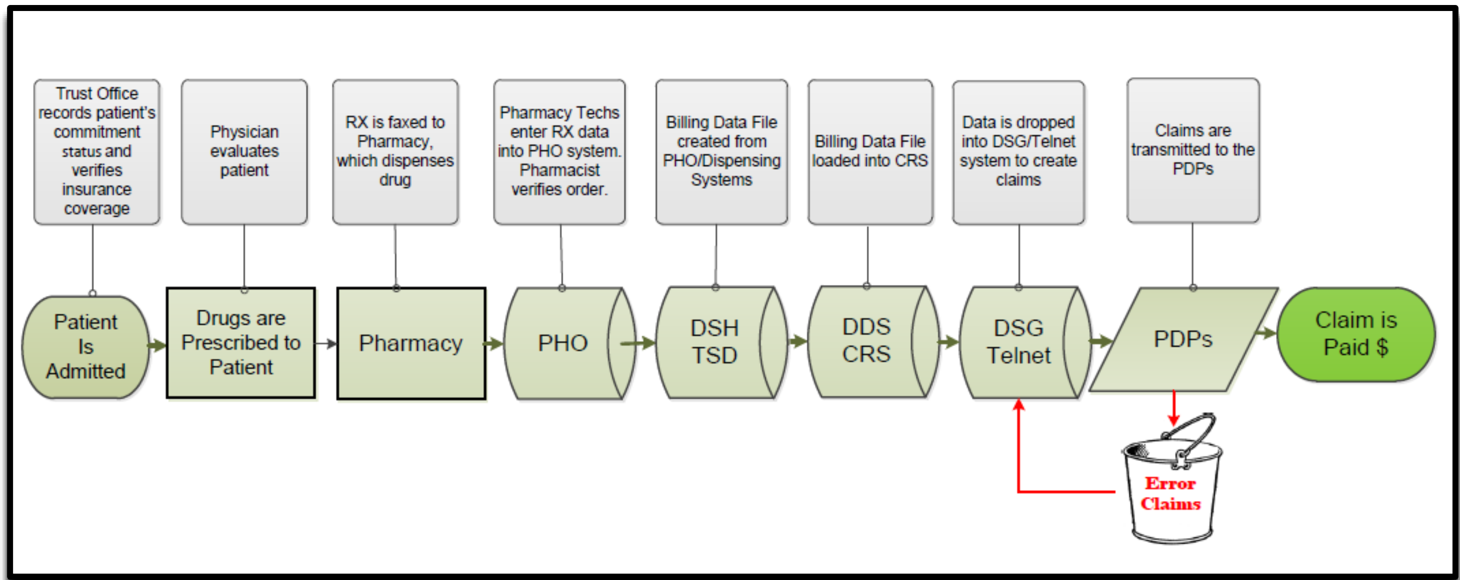
There are multiple IT systems that patient data must flow through for a Medicare claim to successfully be paid. CRS is the primary driver for billing information; however, CRS relies on data input to apply charges and then outputs data into a tertiary system (DSG) which makes DSH claims HIPAA compliant for electronic transmission. A flowchart outlining the claims reimbursement process for Medicare Part A and B is shown below in Table 6.

Table 5: Medicare Part A and B Claims Reimbursement Process



Analysis of Problem

Table 6: Medicare Part D Claims Reimbursement Process



PCRS has documented the many steps in the Medicare claims reimbursement process as identified above. An ideal IT solution would consist of patient management data and billing data to be one cohesive system, however, that is not the current business environment. If approved, the investment to extend the existing functionality of the CRS billing system will be offset by additional revenues collected and will ensure compliance with various state and federal laws regarding medical billing and patient information.

Impact of No Approval

If the technical staff and funding to bolster the CRS medical and pharmaceutical billing system are not approved, DSH will continue under collect on billings, be at risk for noncompliance with state and federal laws and continue reliance on DDS for system change requests to the aging CRS system. Some specific issues are:

- CRS prevents Medicare Part A claims from being generated for Medicare eligible patients that receive treatment in the SNF and non-certified acute units (ANC) which results in a substantial loss of revenue collections.
- With these updates to CRS, DSH anticipates increased revenue as we will be able to collect for Medicare Part A SNF, DME, and Telehealth.
- CRS does not have the ability to track the number of Inpatient Psychiatric Facility (IPF) admission days. Patients have a lifetime allowance of 190 days. Extending the functionality of the existing billing system will be required to have the capability to track the remaining patient days and suppress the generation of Medicare Part A claims once that limit has been reached.
- Potential federal penalties associated with the False Claims Act (FCA), United States Code (USC) §§ 3719-3733. Each violation of a false claim could potentially carry civil penalties that can include fine of $5,000-$10,000 plus three times the amount of damages which the government sustains because of the act.
- DDS has proprietary ownership of CRS and is maintaining CRS as a legacy system as it continues to meet the requirements of their patient commitments for Medi-Cal billing, of which DSH patients are not eligible for. Should this legacy system fail, DSH and DDS would be without a functional billing system. Code review and documentation may help extend the life of CRS until implementation of the billing system within the new DSH EHR system, which will replace CRS.

Analysis of Problem

- DDS manages DSH medication pricing – unaware of medication mark up, final cost billed out to PDP, and methodology for dispensing fees resulting in potential over or underbilling medications. With adequate resources to update and maintain medication pricing on an ongoing basis, accurate reimbursements may be secured.
- By not billing for eligible services, DSH is at risk of violating WIC § 7275-7293 which mandates DSH collect on third-party payments to support patient's cost of care and treatment.

E. Outcomes and Accountability

DSH anticipates extending the existing functionality of the CRS system will have a significant impact to its medical and pharmaceutical billing as well as its cost of care collection efforts. Functionality improvements to the billing system will reduce the number of claims generated with errors while producing more accurate claims for adjudication. A reduced error rate will result in an increase to Medicare reimbursement revenue as well as avoid inappropriate billing that could lead to potential fines imposed by the FCA. Extending the functionality of the CRS will improve DSH's ability to accurately bill patients and liable third-party relatives. Currently, CRS does not automatically apply credits, payments, or reimbursements; a DSH employee manually posts these to a patient's cost of care account. By accurately billing Medicare, the department expects to increase annual revenue by approximately $16 - $20 million from Medicare reimbursements alone. The department expects to increase its Medicare reimbursement revenue, as well as all other reimbursement revenue sources, after implementation of functionality improvements to the existing billing system. In addition, by obtaining its own programming team, DSH will no longer be a burden on DDS IT staff for DSH system upgrades and modifications.

Extending the existing CRS with enterprise wide medical and pharmaceutical billing functionality, will provide sustainable benefits in the following areas:

Projected Outcomes

Workload Measure	**CY**	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Medicare Part A, B, and D claim error rate	45%	45%	40%	35%	25%	7%
Medicare Part A, B, and D reimbursement revenue	$1,500,000	$1,500,000	One-time approximately $53,000,000-$112,000,000	Up to approximately $16,000,000 - $20,000,000	Up to approximately $21,000,000	Up to approximately $22,050,000

The above outcomes will be achieved as DSH will prioritize creating compliant Medicare claims for SNF, DME, telemedicine, telehealth and Medicare covered services. With autogenerated claims being produced for Medicare covered services, PCRS will be able to process Medicare claims efficiently therefore increase Medicare reimbursement. In addition, claim error rates will decrease as DSH will be able to focus on work on outcomes that best suits the needs of DSH.

F. Analysis of All Feasible Alternatives

Alternative 1: Approve as requested to support 1.0 permanent position and contract funding equivalent to 2.0 consultants to extend existing functionality of the software programming for CRS, provide software solutions in response to government mandates, and serve as a liaison for systems integration.

Pros:

- Supports a more robust DSH billing, collections and claims resolution process for third party billing.
- Facilitates the generation of additional revenue and relieves pressure from the GF.
- Reduces the risk of an adverse OIG and/or CMS audit.
- Maintains and extends the current baseline of billing, collections, and claims resolution.
- Supports the development of standardized enterprise third party billing policies and procedures.
- Aligns resources with current workload and department goals.
- Promotes interdepartmental collaboration to address current and future business needs.
- Provides technical expertise to plan and adjust for the current and future medical billing environment (e.g. International Classification of Diseases-10 (ICD-10) and EHR).
- Builds on existing research and analysis by PCRS staff to address the IT systems component of challenges.

Cons:

- Inability to generate HIPAA compliant claims. This will still require the use of Experian Health/DSG or another contracted vendor to provide this service.
- DDS has proprietary ownership of CRS and is maintaining a legacy system. Should this system fail, DSH and DDS would be without a functional billing system.
- Inaccurate medication pricing – CRS adjusts medication pricing profile which causes discrepancies with the amount billed.

Alternative 2: Utilize a Revenue Cycle Management (RCM) system. Alternative 2 would require a Project Manager resource of 1.0 position as well as $3.1 million in state GF augmentation in FY 2021-22 and $329,000 in FY 2022-23, FY 2023-24 and FY 2024-25.

Pros:

- Will be a stand-alone centralized RCM system.
- Ability to process claims and reimbursements without waiting for a new EHR system.
- Reimbursement growth: Ability to generate Medicare Part A claims for SNF and operational, medical, and pharmacy opportunities.
- Meet compliance requirements for WIC §§ 7275-7295 and the FCA.
- Standardization, enabling efficiency in Medical and pharmacy billing.
- DSH has released a Request for Information (RFI) and has received positive responses from potential vendors.

Cons:

- Separate vendors for billing and EHR will create integration challenges and integration costs.
- Extracting RCM disrupts end to end process from a workflow perspective. It may also change part of the EHR solution.
- May cause duplicated functions and compatibility restrictions.
- Coding and associated functionality may be found to be just as complex as EHR.
- Conflicting information. The RCM data will be separate from the EHR.
- Syncing challenges and data integrity between RCM and EHR may be jeopardized.
- The RCM must be able to integrate with antiquated ADT, PHO, and CRS legacy systems.

- Prematurely making the decision on the EHR solution by selecting an EHR based on the back-office needs.
- Investment from the funding and resource perspective equates to what would have been done for an EHR solution.
- Redundant training (train for one solution then again for the new system billing procedures) will create user adoption challenges.
- Tier 2 vendors may require signing 5-year contracts.
- Timeline conflicts. We may have design challenges due to RCM being in UAT while EHR is being created. This can cause scheduling issues.
- System implementation could take up to two years.
- Without EHR, there is a five percent HITECH/Meaningful use penalty for being out of compliance.

Alternative 3: Deny the request for 1.0 position and 2.0 COBOL Programmers.

Pros:

- Saves General Fund expenditures

Cons:

- Hinders the ability of the DSH to develop and implement a more robust DSH billing, collections and claims resolution process
- Increases the risk of an adverse OIG and/or CMS audit
- Limits DSH's ability to increase opportunities for revenue generation and relieving pressure from the General Fund
- Requires DDS Senior Programmer Analysts to potentially work overtime to address DSH business needs
- Denies DSH technical resources to appropriately adjust to current and future needs of the medical billing environment
- Denies resources to address documented CRS billing challenges

G. Implementation Plan

The estimated implementation plan for the recommended option assumes a July 1, 2021 start date as follows:

<u>FY 2021-22</u>

- Hire employee and contractor(s).
- Update Inter-Agency Agreement (IAA) to address Governance and Change Control of the CRS between DDS and DSH.
- Participate in training from DDS and DSH on third party billing, CRS, and appropriate subject materials.
- Employee and contractor familiarization and exposure to current PCRS business needs and identified challenges.
- Address backlog of DSH CRS issue requests to improve the processing of Medicare, private insurance, and private payer billing.
- Provide user training, education, and technical assistance to DSH business staff and DSH-Technical Services Division (TSD) staff as required.
- Document business rules and progress towards the completion of CRS related requests.
- Perform compliance reviews related to CRS data integrity.
- Coordinate IT related efforts across DDS and DSH.
- Address systems component of government mandated medical billing rule changes as needed.

FY 2022-23 forward

- Ongoing training.
- Participate in development of system for processing Medicare, private insurance, and private payer billing.
- System improvements for accurate cost of care account balances which directly impacts third party collection efforts.
- Secure an extension with Experian Health/DSG or another contracted vendor to generate HIPAA compliant claims from CRS.
- Consider other possible options for pharmacy billing in the event Experian Health changes their pharmacy platform.
- Site visits.
- Address backlog of DSH CRS issue requests to improve the processing of Medicare, private insurance, and private payer billing.
- Provide technical assistance to PCRS and hospital staff on the business rules and capabilities of CRS.
- Perform compliance reviews related to CRS data integrity.
- Joint coordination of IT related efforts across DDS and DSH.
- Develop software solutions for DSH-requested changes in CRS, which includes (but not limited to), ad-hoc data requests, report requests, and custom programming to update Medicare billing rates, billing for all Medicare eligible services, and billing modifiers specific to DSH hospital practices.
- Provide expert analysis, design, development, testing, system and user documentation, and implementation of CRS software for DSH requested changes, using the industry standard Software Development Life Cycle methodologies and best practices.
- Provide user training, education and technical assistance to DSH business staff and TSD staff as required.
- Address systems component of government mandated medical billing rule changes as needed.
- Serve as subject matter experts for requirements and transition to her

H. Supplemental Information

Attachment A: BCP Fiscal Details Sheet

Attachment B: Workload Analysis

I. Recommendation

DSH recommends the approval of Alternative 1 to extend and improve billing, collections, and claims resolution process for third party billing with an emphasis on the IT systems. Alternative 1 provides resources to address current deficiencies and improve billing system related policies and procedures. Approval of Alternative 1 will allow DSH to bridge the gap between the current legacy system limitations and the implementation of a full EHR solution in 2025.

BCP Fiscal Detail Sheet

BCP Title: Medical and Pharmaceutical Billing System | **BR Name: 4440-003-BCP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Temporary	0.0	1.0	1.0	1.0	1.0	0.0
Total Positions	**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.0**
Salaries and Wages						
Earnings - Temporary Help	0	85	85	85	85	0
Total Salaries and Wages	**$0**	**$85**	**$85**	**$85**	**$85**	**$0**
Total Staff Benefits	0	53	53	53	53	0
Total Personal Services	**$0**	**$138**	**$138**	**$138**	**$138**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	0	8	8	8	8	0
5304 - Communications	0	1	1	1	1	0
5320 - Travel: In-State	0	1	1	1	1	0
5324 - Facilities Operation	0	5	5	5	5	0
5340 - Consulting and Professional Services - External	0	640	620	620	620	0
5346 - Information Technology	0	1	1	1	1	0
Total Operating Expenses and Equipment	**$0**	**$656**	**$636**	**$636**	**$636**	**$0**
Total Budget Request	**$0**	**$794**	**$774**	**$774**	**$774**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	794	774	774	774	0
Total State Operations Expenditures	**$0**	**$794**	**$774**	**$774**	**$774**	**$0**
Total All Funds	**$0**	**$794**	**$774**	**$774**	**$774**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	4	4	4	4	0
4400020 - Hospital Administration	0	790	770	770	770	0
Total All Programs	**$0**	**$794**	**$774**	**$774**	**$774**	**$0**

Personal Services Details

Positions	Salary Information: Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1402 - Info Tech Spec I				0.0	1.0	1.0	1.0	1.0	0.0
Total Positions				**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1402 - Info Tech Spec I	0	85	85	85	85	0
Total Salaries and Wages	**$0**	**$85**	**$85**	**$85**	**$85**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	1	1	1	1	0
5150350 - Health Insurance	0	4	4	4	4	0
5150450 - Medicare Taxation	0	1	1	1	1	0
5150500 - OASDI	0	5	5	5	5	0
5150600 - Retirement - General	0	25	25	25	25	0
5150800 - Workers' Compensation	0	4	4	4	4	0
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	2	2	2	2	0
5150900 - Staff Benefits - Other	0	11	11	11	11	0
Total Staff Benefits	**$0**	**$53**	**$53**	**$53**	**$53**	**$0**
Total Personal Services	**$0**	**$138**	**$138**	**$138**	**$138**	**$0**

Department of State Hospitals
Medical and Pharmaceutical Billing System

WORKLOAD ANALYSIS FOR: IT Specialist 1- Project Manager (1.0)				
	Hours Required To Accomplish	***Frequency of Task (Monthly)***	**Months**	***Total Hours Projected (Annually)***
Plans and manages the extension of existing software programming functionality for the Cost Recovery System (CRS). Responsible to ensure standardized planning, implementation, and documentation adheres to CRS guidelines. Liaison between the DSH and DDS Sr programming team; responsible for CRS communications and serves as a single point of contact. Responsibilities include: project schedule, managing the change request approval processes, distribution of status reports, ensuring issues are resolved in a timely manner and risk identification and mitigation.	2	Daily	12	500
Ensures deliverables and functionality are achieved as defined in the PCRS Requirements documentation and subsequent project plans. Works with project and program teams to conduct process walk-throughs in preparation for 'to-be' business process flow documentation.	1	Daily	12	376
Plans, guides, and oversees the day-to-day internal activities of the technical team that support the PCRS planning for CRS. Effectively manages technical staff activities, time and resources within the development best practices methodology with specific attention to testing to ensure the necessary changes do not disrupt ongoing functionality. Ensures that resources and timelines are being met and reported to department leadership.	1	Daily	12	250
Develops or assists in the development of the master project schedule and all other project work plans. Schedules technical team activities based on department prioritizations and availability of resources. Projects hours, timelines, training and staffing needs.	1	Daily	12	250
Accountable for the development, maintenance, and adherence of the technical requirements to the Project Office infrastructure and supporting methodologies (e.g., processes, procedures, standards, and templates) that follow with CA-PMF and Best Practices.	1	Daily	12	100
Ensures follow up on all outstanding or unresolved technical issues. Utilizes and adheres to proper change control policies and procedures. Identifies potential areas where policies/procedures require development or change. Analyzes and provides clarification for all technical enhancement/change requests.	1	Daily	12	300
TOTAL HOURS PROJECTED ANNUALLY				**1,776**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**1.0**

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	**Business Unit**	**Department**	**Priority No.**
2021/2022	4440	Department of State Hospitals	005

Budget Request Name	**Program**	**Subprogram**
444-006-BCP-2021-GB	4410 – State Hospitals	4410030 – Metropolitan 4410040 - Napa

Budget Request Description
Skilled Nursing Facility Infection Preventionists

Budget Request Summary
The Department of State Hospitals (DSH) requests $350,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing for 2.0 permanent positions to establish Infection Preventionists at DSH-Metropolitan and DSH-Napa in accordance with requirements set forth in AB 2644 (Chapter 287, Statutes of 2020) and section 1255.9 of the Health and Safety Code.

Requires Legislation	**Code Section(s) to be Added/Amended/Repealed**	
☐ Yes ☒ No	Click or tap here to enter text.	
Does this BCP contain information technology (IT) components? ☐ Yes ☒ No *If yes, departmental Chief Information Officer must sign.*	**Department CIO** Click or tap here to enter text.	**Date** Click or tap to enter a date.

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. Click or tap here to enter text. **Project Approval Document:** Click or tap here to enter text.

Approval Date: Click or tap to enter a date.

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	**Date**	**Reviewed By**	**Date**
Ellen Bachman, Deputy Director, SQIP	10/8/2020	George Maynard, Deputy Director, ASD	10/8/2020
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin, Director	Click or tap to enter a date.	Mark Ghaly, CHHS Secretary	Click or tap to enter a date.

Department of Finance Use Only

Additional Review: ☐ **Capital Outlay** ☐ **ITCU** ☐ **FSCU** ☐ **OSAE** ☐ **CALSTARS** ☐ **Dept. of Technology**

PPBA	**Date submitted to the Legislature**
Click or tap here to enter text.	Click or tap to enter a date.

Analysis of Problem

A. Budget Request Summary

The Department of State Hospitals (DSH) requests $350,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing for 2.0 permanent positions to establish Infection Preventionists at DSH-Metropolitan and DSH-Napa in accordance with requirements set forth in Assembly Bill 2644 (Chapter 287, Statutes of 2020) and section 1255.9 of the Health and Safety Code.

B. Background/History

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily census of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

The five state hospitals are fully licensed by the California Department of Public Health (CDPH). Two of the hospitals, DSH-Metropolitan and DSH-Napa, operate licensed Skilled Nursing Facility (SNF) programs. DSH-Metropolitan has 102 SNF beds. DSH-Napa has 36 SNF beds. These programs meet CDPH SNF licensing requirements and Federal Centers for Medicare and Medicaid Services (CMS) certification. These programs provide continuous nursing treatment and care for both Penal Code and civilly committed state hospital patients whose primary need is availability of skilled nursing care on an extended basis.

In response to the Coronavirus Disease 2019 (COVID-19) pandemic in 2020, CDPH issued numerous All Facilities Letters (AFL), providing specific guidance and regulatory updates to health care facilities to address infection control and mitigation expectations. Due to the higher risk of severe illness and death from COVID-19 among elderly persons and those with chronic medical conditions, CDPH issued specific requirements for SNFs to expand their existing infection control policies. AFL 20-52, issued May 11, 2020, advised SNFs of the requirement to submit a facility specific COVID-19 mitigation plan with specific elements to the CDPH within 21 calendar days and provided updated infection control guidance for healthcare providers. The mitigation plan required that the SNF have a full-time, dedicated Infection Preventionist (IP). The IP role could be shared by more than one staff member, but a plan had to be in place for infection prevention quality control.

As demonstrated by the COVID-19 pandemic, a strong infection prevention and control program is critical to protect both SNF residents and healthcare personnel. Per the Centers for Disease Control and Prevention (CDC) guidance updated June 25, 2020, nursing homes/SNFs should assign at least one individual with training in infection prevention and control practices to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an infection prevention and control program is responsible, including developing infection prevention and control policies and procedures, performing infection surveillance, providing competency-based training of healthcare personnel, and auditing adherence to recommended infection prevention and control practices.

The CDC guidance was reorganized according to core infection prevention and control practices that should remain in place even as SNFs resume normal practices, plus additional strategies to promote the use of everyday preventative actions to limit the spread of infection. These core practices include:

- assigning one or more individuals with training in infection control to provide on-site management of the infection prevention and control program;

- reporting COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly;
- educating residents healthcare personnel, and visitors about COVID-19, current precautions being taken in the facility, and actions they should take to protect themselves;
- implementing source control measures, e.g. facemasks; having a plan for visitor restrictions;
- having a plan for testing residents and healthcare personnel for SARS-CoV-2;
- evaluating and managing healthcare personnel, utilizing symptom screening measures, and having systems in place to mitigate staffing shortages;
- providing supplies necessary to adhere to recommended infection prevention and control practices, including personal protective equipment (PPE) and hand hygiene supplies;
- identifying space in the facility that could be dedicated to monitor and care for residents with COVID-19;
- creating a plan for managing new admissions and readmissions whose COVID-19 status is unknown; and
- evaluating and managing residents with symptoms of COVID-19.

Additional measures may include implementing social distancing precautions and visitor restrictions.

CMS issued Nursing Home Reopening Recommendations for State and Local Officials (QSO-20-30-NH, revised 09/28/2020), which outlines infection control and prevention precautions that should remain in place as a part of the ongoing response to the COVID-19 pandemic. SNFs must remain vigilant for COVID-19 among residents and healthcare personnel in order to prevent spread and protect residents and healthcare personnel from severe infections, hospitalizations, and death.

DSH-Metropolitan and DSH-Napa submitted COVID-19 mitigation plans to CDPH as required by AFL 20-52 and those plans became effective June 1, 2020. Due to the urgency of meeting this new requirement, DSH-Metropolitan and DSH-Napa temporarily redirected existing nursing staff resources (Registered Nurse Health Services Specialists) to cover the IP position and address focused infection control needs in their SNFs. The requirements outlined in AFL 20-52 would remain in effect until discontinued by CDPH or adopted into law through legislative action.

Assembly Bill 2644 (Chapter 287, Statutes of 2020) made permanent the IP requirement that was established under AFL 20-52 and was signed by the Governor on September 29, 2020. This bill added Sections 1255.9 and 1275.41 to the Health and Safety Code, relating to SNFs. Section 1255.9 states:

1255.9.

(a) (1) A skilled nursing facility shall have a full-time, dedicated Infection Preventionist (IP).

(2) The IP role may be filled either by one full-time IP staff member or by two staff members sharing the IP responsibilities, as long as the total time dedicated to the IP role equals at least the time of one full-time staff member.

(3) The IP shall be a registered nurse or licensed vocational nurse and shall not be included in the calculation of three and one-half hours of direct patient care per day provided to skilled nursing facility residents.

(b) A skilled nursing facility shall have a plan in place for infection prevention quality control.

(c) A skilled nursing facility shall ensure all health care personnel receive infection prevention and control training on an annual basis.

Resource History
(Dollars in thousands)

Program Budget	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Authorized Expenditures	N/A	N/A	N/A	N/A	N/A	N/A
Actual Expenditures	N/A	N/A	N/A	N/A	N/A	N/A
Revenues	N/A	N/A	N/A	N/A	N/A	N/A
Authorized Positions	N/A	N/A	N/A	N/A	N/A	N/A
Filled Positions	N/A	N/A	N/A	N/A	N/A	N/A
Vacancies	N/A	N/A	N/A	N/A	N/A	N/A

Workload History

Workload Measure	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Implement SNF Infection Prevention & Control Program, including adherence to written infection control policies and procedures.	N/A	N/A	N/A	N/A	44 hours x 2 = 88 hours	267 hours x 2 = 534 hours
Implement infection prevention education programs; train staff on infection prevention strategies.	N/A	N/A	N/A	N/A	22 hours x 2 = 44 hours	133 hours x 2 = 266 hours
Conduct adherence monitoring rounds and promote completion of audits regarding implementation and compliance with infection prevention and control policies.	N/A	N/A	N/A	N/A	37 hours x 2 = 74 hours	222 hours x 2 = 444 hours
Conduct surveillance of infections (COVID-19, C-Difficile, Pneumonia, scabies, etc.) to include tracking and tracing efforts for all departments identified; and conduct outbreak investigations.	N/A	N/A	N/A	N/A	22 hours x 2 = 44 hours	133 hours x 2 = 266 hours
Conduct quality assessments of nursing interventions for the biophysical, psychosocial, environmental, self-care, and educational needs of the patients; provide data to authorized individuals or committees as assigned; serve on hospital-wide committees; provide quality improvement data and information in program/unit meetings.	N/A	N/A	N/A	N/A	22 hours x 2 = 44 hours	133 hours x 2 = 266 hours

C. State Level Consideration

The California Health and Human Services Agency (CHHS) is responsible for state level policy, program and administration of public health programs. In support of compliance with AB 2644 (Chapter 287, Statutes of 2020), this proposal aligns with CHHS Guiding Principles to focus on outcomes and value generation that centers on the needs of DSH patients served and employees who deliver those critical care services in the two DSH SNF programs. These positions and program deliverables also support CHHS guiding principle for actionable data. As the battle against COVID-19 and other infectious diseases has required an emphasis on quality health care and data to evaluate progress and hot spots that need interventions, the IPs will be responsible for data quality and reporting that will help to demonstrate the value of training, education, and monitoring of infection control in a skilled nursing environment of care. CHHS Strategic Priorities call for addressing the needs of persons with disabilities with quality care, support and housing of vulnerable populations. DSH patients are some of the most vulnerable and fragile Californians served by our State's healthcare system. The DSH Strategic Plan 2018-2023 calls for operational excellence focused on improving the quality of services through ongoing assessment, change management, and accountability. This proposal supports the quality of care delivered by DSH particularly for infection control and program monitoring to support a better healthcare system and outcomes for the patients and State of California.

D. Justification

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), SNFs are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms.

In June 2020, DSH-Metropolitan and DSH-Napa temporarily reassigned Health Services Specialist (HSS) registered nurses to fulfill the IP responsibilities in their SNFs, to comply with the requirements outlined in CDPH AFL 20-52. Due to this staff redirection, the reassigned Health Services Specialists' duties have been covered through overtime and by managers. These duties include

- assisting unit staff in the implementation of policies and procedures, licensing and Joint Commission requirements;
- mentoring/teaching nursing staff, often in the form of on-the-job training on medical and behavioral healthcare procedures;
- responding to life threatening emergency situations, overseeing safe and effective utilization of medical equipment, and providing oversight of coordination, monitoring and evaluation of medical emergency responses such as Cardiopulmonary Resuscitation;
- auditing key high risk processes such as application of behavioral restraints;
- providing oversight of instruction, education, and preparation regarding treatment/medical procedures required in advance of medical appointments and post-appointment care;
- supporting appropriate assessment, intervention, evaluation and reporting, of
    - seclusion and/or restraints,
    - medication administration,
    - change of physical condition and reassessments,
    - outside hospital transfers/emergency room visits and upon patient return from outside medical stays,
    - medical emergencies,
    - admission assessments to support compliance with policies and procedures;

- collaborating with the Public Health Department regarding prevention, monitoring and reporting of infectious diseases.

As the duties are critical functions that must be performed, reassigning the HSS to perform the IP role is not a permanent solution. DSH would still require overtime or coverage of these duties by management.

The HSS is responsible for ongoing monitoring, assessing, and making recommendations for the maintenance of quality nursing services, with primary emphasis on the physical care needs of patients in a program on an assigned shift. They assure education and training in nursing care is provided to unit personnel and perform other duties as needed to support and monitor provision of nursing care. They have a primary role in consistently monitoring compliance with title 22 licensing standards through daily rounds on each shift. HSSs are key personnel in each hospital program, not just in the SNFS. Particularly in this time of COVID-19 related illness and deaths, the redirection of HSSs to the SNF IP assignment has caused significant additional workload beyond the baseline for the other HSSs. All routine work of the HSSs plus the additional COVID-related work is being covered by other staff through overtime and by the manager.

E. Outcomes and Accountability

The proposed IP positions will support necessary activities at the SNF programs at DSH-Metropolitan and DSH-Napa aimed at preventing healthcare associated infections by isolating sources of infections to limit the spread of infectious organisms. The IPs will collaborate with the hospital Public Health Nurse and the Infection Control Committee to promote safe practices in the SNF. The IPs will conduct educational and training activities for healthcare personnel through instruction and dissemination of evidence-based information on healthcare practices. The IPs will implement the SNF Infection Prevention and Control Program in collaboration with program management, nursing, physicians, housekeeping, dietary, standards and compliance, and other departments.

Projected Outcomes

Workload Measure	CY	BY	BY+1	BY+2	BY+3	BY+4
Implement SNF Infection Prevention & Control Program, including adherence to written infection control policies and procedures.	533 hours x 2 = 1066 hours	533 hours x 2 = 1066 hours	533 hours x 2 = 1066 hours	533 hours x 2 = 1066 hours	533 hours x 2 = 1066 hours	533 hours x 2 = 1066 hours
Implement infection prevention education programs; train staff on infection prevention strategies.	267 hours x 2 = 534 hours	267 hours x 2 = 534 hours	267 hours x 2 = 534 hours	267 hours x 2 = 534 hours	267 hours x 2 = 534 hours	267 hours x 2 = 534 hours
Conduct adherence monitoring rounds and promote completion of audits regarding implementation and compliance with infection prevention and control policies.	444 hours x 2 = 888 hours	444 hours x 2 = 888 hours	444 hours x 2 = 888 hours	444 hours x 2 = 888 hours	444 hours x 2 = 888 hours	444 hours x 2 = 888 hours
Conduct surveillance of infections (COVID-19, C-Difficile, Pneumonia, scabies, etc.) to include tracking and tracing efforts for all departments identified; and conduct outbreak investigations.	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours
Conduct quality assessments of nursing interventions for the biophysical, psychosocial, environmental, self-care, and educational needs of the patients; provide data to authorized individuals or committees as assigned; serve on hospital-wide committees; provide quality improvement data and information in program/unit meetings.	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours	266 hours x 2 = 532 hours

F. Analysis of All Feasible Alternatives

Alternative 1: Approve the proposal for $350,000 General Fund in 2021-22 and ongoing for 2.0 permanent positions to establish Infection Preventionists at DSH-Metropolitan and DSH-Napa in accordance with requirements set forth in AB 2644 (Chapter 287, Statutes of 2020) and section 1255.9 of the Health and Safety Code.

Pros:

- DSH will comply with AB 2644, CDPH AFL 20-52, CDC guidance for management of COVID-19 in SNFs, and CMS Nursing Home Reopening Recommendations for State and Local Officials.
- DSH will maintain infection prevention, surveillance, and control measures in its SNF programs to protect vulnerable elderly and chronically ill patients and healthcare providers from the spread of COVID-19 and other serious infectious diseases.

Cons:

- This option requires new State General Fund resources.

Alternative 2: Do not approve the proposal and maintain coverage of the IP positions through redirection of existing hospital resources.

Pros:

- This option would not require General Fund dollars.

Cons:

- Risk of noncompliance with Health and Safety Code 1255.9, CDPH and CMS regulations, which could result in fines, deficiencies, citations, loss of State licensure or Federal CMS certification.
- Inability for the hospitals to cover the workload that the redirected employees were responsible for prior to assuming the IP assignment.

G. Implementation Plan

Once approved, the hiring process for the requested positions will begin. Recruitment, screening, interviews, and candidate selection will be conducted in July and August 2021 with anticipated start dates soon thereafter and appropriate training to commence upon hire.

H. Supplemental Information

Attachment A: BCP Fiscal Details Sheets

Attachment B: workload Analysis

I. Recommendation

DSH recommends approval of Alternative 1 for $350,000 General Fund in 2021-22 and ongoing for 2.0 permanent positions to establish IPs at the DSH-Metropolitan and DSH-Napa SNF Programs.

BCP Fiscal Detail Sheet

BCP Title: Skilled Nursing Facility Infection Preventionists **BR Name: 4440-017-BCP-2021-GB**

Budget Request Summary

			FY21			
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	2.0	2.0	2.0	2.0	2.0
Total Positions	**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Salaries and Wages						
Earnings - Permanent	0	214	214	214	214	214
Total Salaries and Wages	**$0**	**$214**	**$214**	**$214**	**$214**	**$214**
Total Staff Benefits	0	104	104	104	104	104
Total Personal Services	**$0**	**$318**	**$318**	**$318**	**$318**	**$318**
Operating Expenses and Equipment						
5301 - General Expense	0	16	16	16	16	16
5304 - Communications	0	2	2	2	2	2
5320 - Travel: In-State	0	2	2	2	2	2
5324 - Facilities Operation	0	10	10	10	10	10
5346 - Information Technology	0	2	2	2	2	2
Total Operating Expenses and Equipment	**$0**	**$32**	**$32**	**$32**	**$32**	**$32**
Total Budget Request	**$0**	**$350**	**$350**	**$350**	**$350**	**$350**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	350	350	350	350	350
Total State Operations Expenditures	**$0**	**$350**	**$350**	**$350**	**$350**	**$350**
Total All Funds	**$0**	**$350**	**$350**	**$350**	**$350**	**$350**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	0	2	2	2	2	2
4410030 - Metropolitan	0	174	174	174	174	174
4410040 - Napa	0	174	174	174	174	174
Total All Programs	**$0**	**$350**	**$350**	**$350**	**$350**	**$350**

Personal Services Details

Positions	Salary Information: Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
9699 - Hlth Svcs Spec (Safety)				0.0	2.0	2.0	2.0	2.0	2.0
Total Positions				**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
9699 - Hlth Svcs Spec (Safety)	0	214	214	214	214	214
Total Salaries and Wages	**$0**	**$214**	**$214**	**$214**	**$214**	**$214**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	4	4	4	4	4
5150350 - Health Insurance	0	10	10	10	10	10
5150450 - Medicare Taxation	0	4	4	4	4	4
5150600 - Retirement - General	0	42	42	42	42	42
5150800 - Workers' Compensation	0	10	10	10	10	10
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	6	6	6	6	6
5150900 - Staff Benefits - Other	0	28	28	28	28	28
Total Staff Benefits	**$0**	**$104**	**$104**	**$104**	**$104**	**$104**
Total Personal Services	**$0**	**$318**	**$318**	**$318**	**$318**	**$318**

Department of State Hospitals

Skilled Nursing Facility Infection Preventionists

WORKLOAD ANALYSIS FOR: Health Services Specialist (2.0)				
	Hours Required To Accomplish	***Frequency of Task (Monthly)***	**Months**	***Total Hours Projected (Annually)***
Planning and Directing Infection Control Program Activities. The IP collaborates with the hospital Public Health Nurse and the Infection Control Committee to promote safe practices in the Skilled Nursing Facility (SNF). The IP implements the SNF infection control prevention and control program in collaboration with Program Management, physicians, nursing, housekeeping, dietary, standards compliance and other hospital departments.	4.0	Daily	12	1066
Adherence Monitoring. Conducts rounds, discusses and monitors infection prevention strategies with staff, monitors compliance with hand hygiene and precaution policies; monitors infectious disease screening and vaccination programs for residents and staff; monitors compliance with respirator fit testing; oversees post exposure management; uses CDPH/CDC recommended screening tools for adherence monitoring.	3.4	Daily	12	888
Surveillance and Data Management. Conducts surveillance of infections (COVID-19, C-Difficile, Pneumonia, Scabies, etc.) to include tracking and tracing efforts for all departments identified; conducts outbreak investigations; reviews healthcare acquired infection data for SNF and develops goals for the reduction of respiratory infections, urinary tract infections, CLABSI and MDROs; collects infection data, tracks and trends the data, and maintains records of each case of healthcare acquired infection.	2.0	Daily	12	532
Continuous Quality Improvement. Conducts quality assessments of nursing interventions for the biophysical, psychosocial, environmental, self-care, and educational needs of the patients; provides data to authorized individuals or committees as assigned; serves on hospital-wide committees; provides quality improvement data and information in program/unit meetings.	2.0	Daily	12	532
Training. Conducts educational and training activities for healthcare personnel through instruction and dissemination of evidence-based information on healthcare practices.	11.1	Weekly	12	534
TOTAL HOURS PROJECTED ANNUALLY				**3,552**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**2.0**

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	Business Unit	Department		Priority No.
2021-22	4440	Department of State Hospitals		06
Budget Request Name		**Program**	**Subprogram**	
4440-062-BCP-2021-GB		4430-Contracted Patient Services	4430030-Other Contracted Services	

Budget Request Description
Community Care Demonstration Project for Felony IST

Budget Request Summary
The Department of State Hospitals (DSH) requests 4.0 positions and $233.2 million General Fund in fiscal year (FY) 2021-22 and 4.0 positions and $136.4 million General Fund in FY 2022-23 and ongoing to establish the Community Care Demonstration Project for Felony Incompetent to Stand Trial (IST), for the department to contract with counties to provide a continuum of services to felony ISTs in the county as opposed to state hospitals. This proposal includes corresponding statutory changes and provisional language.

Requires Legislation	Code Section(s) to be Added/Amended/Repealed	
☒ Yes ☐ No	Penal Code sections 1370, 1372, 1600 and 1615; Welfare and Institutions Code section 4335.1	
Does this BCP contain information technology (IT) components? ☐ Yes ☒ No *If yes, departmental Chief Information Officer must sign.*	**Department CIO**	**Date**

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. **Project Approval Document:**

Approval Date:

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	Date	Reviewed By	Date
Ashley Breth, Forensic Services, Program Manager	Click or tap to enter a date.	Chris Edens, Forensic Services Division Deputy Director	Click or tap to enter a date.
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	Click or tap to enter a date.	Mark Ghaly, MD, MPH	Click or tap to enter a date.

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Additional Review: ☐ **Capital Outlay** ☐ **ITCU** ☐ **FSCU** ☐ **OSAE** ☐ **CALSTARS** ☐ **Dept. of Technology**

PPBA	Date submitted to the Legislature

A. Budget Request Summary

DSH requests 4.0 positions and $233.2 million General Fund in FY 2021-22 and 4.0 positions and $136.4 million General Fund in FY 2022-23 and ongoing to establish the Community Care Demonstration Project for Felony Incompetent to Stand Trial (IST) (CCPD-IST), for the department to contract with counties to provide a continuum of services to felony ISTs in the county as opposed to state hospitals. This proposal includes corresponding statutory changes (see the Department of Finance website for a copy of the language at https://esd.dof.ca.gov/trailer-bill/trailerBill.html) and provisional language (see Supplemental Information section below for the language).

The counties will assume responsibility for the treatment and restoration of felony IST defendants as soon as July 1, 2021. The goal of this proposal is to promote a community-based continuum of care for felony IST defendants in the state. It seeks to demonstrate the effectiveness of streamlining responsibility to drive improved outcomes (reduced incarceration, recidivism and homelessness) for individuals with serious mental illness.

This proposal requests funding to support contracts with several counties of various sizes to participate in CCDP-IST. DSH will provide an update at May Revision of the counties identified to participate in CCDP-IST. Additionally, DSH may need to shift a portion of funding from this proposal to provide for the continued operation and administrative support of new Community-Based Restoration (CBR) program beds in 2021-22 and ongoing. See the CBR Program Expansion proposal for additional information.

B. Background/History

DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily census of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

Beginning in FY 2012-13, DSH began to experience an increase in the number of IST patients referred to the department. In the following years, the number of ISTs referred to the department has continued to increase, leading to a pending placement list as demonstrated in Attachment C. As of November 30, 2020, the number of IST individuals pending placement into a DSH facility or JBCT program was 1,306 patients. While the high number of individuals pending placement can be partially attributed to protective measures implemented by DSH in response to COVID-19, the number of ISTs pending placement to a DSH program prior to COVID-19 was over 800. This was primarily because the volume of new IST referrals to DSH continues to outpace the beds available within the DSH system.

To address the increasing referrals to its system, DSH has expanded capacity within its system of care by over 900 beds over the past eight years ending FY 2019-20 (refer to Attachment D). This expansion includes activating additional state hospital beds, implementing jail-based treatment, and implementing multiple efficiencies within its hospitals to restore ISTs to competency as expeditiously as possible. The department has activated multiple beds throughout the state hospitals over the years to respond to the increasing number of referrals. Most recently, DSH completed the Increased Secure Bed Capacity project at DSH-Metropolitan, to add security infrastructure to an existing patient building to make over 200 additional beds available for IST treatment. In Fiscal Year 2019-20, 92 beds from this project were activated for IST treatment. The remaining beds have been temporarily placed on hold due to the department's response to COVID-19 pandemic. Throughout the years, the department has also been partnering with County Sheriff Offices and to date, established over twenty JBCT programs across the state that provide competency restoration treatment in a jail setting.

Analysis of Problem

The 2018 Budget Act included funding for DSH to contract with counties to develop new or expand existing programs to provide diversion opportunities for individuals who have been or are likely to be found incompetent to stand trial on felony charges. Currently DSH is working with 25 counties to establish the Incompetent to Stand Trial Diversion Program (Diversion) which places defendants in community treatment with the goal of preventing future interactions with the justice system, dismissing charges when specific criteria are in place, and linking them into ongoing community care.

The 2018 Budget Act also included funding for DSH to establish its first Community-Based Restoration Program (CBR) in partnership with the Los Angeles County Office of Diversion and Reentry. In this program, ISTs that would otherwise be referred to DSH or a JBCT are restored to competency in the community in the least restrictive setting possible. ISTs who successfully complete treatment in CBR and after criminal proceedings, are eligible for continued community placement through the permanent supportive housing program. This model of care bridges a significant gap often experienced by individuals, especially those with mental health conditions, re-entering the community after incarceration, and offers both hope for the individuals and a decreased likelihood of recidivating.

Even with these interventions over the years, the number of ISTs pending placement to DSH has remained unsustainably high. As a result of a continued high waitlist, DSH faces ongoing pressure from the courts to admit additional individuals into its system of care. Recently, new timelines for admission were ordered by the Superior Court. DSH continues to seek alternative solutions to increase current capacity in order to meet this ongoing pressure to the state hospital system.

In California, counties are responsible for almost all mental health treatment for low-income Californians with serious mental illness, except for felony forensic commitments which includes the felony IST population. Counties are currently responsible for providing treatment to individuals deemed IST on misdemeanor charges. Given that competency restoration treatment for misdemeanor ISTs is generally the same for felony ISTs, the counties are well positioned to assume responsibility. In addition, counties are well positioned to braid multiple funding sources to support the felony IST population. For example, local MHSA funding may be used to support the adult forensic mental health population through Full-Service Partnerships (FSPs) designed to serve this higher need population, incorporating intensive case management and a "whatever it takes" approach to mental health service delivery. Counties also demonstrated promising outcomes through the Whole Person Care (WPC) Pilot Programs, which are set to conclude December 31, 2021. WPC Pilots were developed in various communities to provide comprehensive and coordinated care for high-utilizing Medi-Cal recipients, including those reentering from correctional settings. Almost half of approved WPC Pilot plans focus on individuals released from institutions including correctional settings (Council of Criminal Justice and Behavioral Health). The WPC Pilots are helping to build a foundation for an integrated approach to coordinating medical care, behavioral health treatment and social services to improve health outcomes, that are proposed to be continued with the California Advancing and Innovating Medi-Cal (CalAIM) proposal, included in the 2021-22 Governor's Budget. CalAIM proposes to provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges. Both FSPs and the programming developed for WPC Pilots, that will continue through CalAim, are examples of the types of treatment that participating counties may implement or build upon to successfully transition felony ISTs to community care.

Analysis of Problem

Resource History[1]
(Dollars in thousands)

Program Budget	PY – 3	PY – 2	PY-1	PY	CY
Authorized Expenditures	$21,974	$38,398	$61,517[2]	$76,030	$89,223
Actual Expenditures	$21,925	$34,955	$59,993	$74,734	$84,699[3]
Revenues	$0	$0	$0	$0	$0
Authorized Positions	3.6	3.6	3.6	5.6	7.1
Filled Positions	3.6	2.6	2.6	4.6	6.1
Vacancies	0	1.0	1.0	1.0	1.0

[1]Reflects staffing and contract costs associated with programs that address felony ISTs.
[2]Does not include $100 million in special funds that were used to develop Diversion contracts with 15 counties.
[3]Projected expenditures based on contracts established in CY and PY expenditure trends.

Workload History

Workload Measure	PY – 4	PY – 3	PY – 2	PY-1	PY	CY
Total IST Referrals from Proposed Counties	1,210	1,178	1,457	1,238	1,062	TBD

C. State Level Consideration

The proposed CCDP-IST program addresses multiple state-level priorities including IST treatment needs and waitlist, criminal justice reform, and homelessness.

Since 2013, DSH has treated a growing number of felony IST patients. Over time, the rate of growth in this population has continued to increase, and the waitlist for those seeking treatment at DSH hospitals has grown in spite of the numerous interventions DSH has instituted. The quickly increasing demand has led to waitlists that at times have exceed 1,000 ISTs and wait times for admission that currently exceed 100 days or more on average (current wait times have been increased due to new admission protocols put in place in response to the COVID-19 pandemic). In 2019, the Superior Court of California ruled in *Stiavetti v. Ahlin* that the Department must admit IST defendants within 28 days. The Department was given until October 2020 to come into compliance with this order, and the State could be subject to substantial fines for non-compliance of court ordered timelines (for context, Washington State has paid over $80.0 million in fines for non-compliance with a similar court order) and could potentially be placed under federal receivership or be appointed a federal monitor to oversee the department's efforts to comply if the State's ongoing appeal is unsuccessful.

Beyond the pressure the State faces from the courts related to the IST waitlist, this issue is also a necessary criminal justice reform. In the Department's decade long analysis of its IST population, DSH has found that the majority of ISTs that are admitted to the state hospitals have not received sufficient mental health care prior to their admission and are cycling in and out of the criminal justice system. Approximately 50% have not accessed community mental health treatment resources in the 6 months prior to their arrest and 45% have had 15 or more prior arrests. Because these individuals' mental illness is not under control, their symptoms may be causing them to behave in ways that lead to their arrest. Once they are in jail those symptoms can become worse.

The additional wait to get into a state hospital bed after being declared IST considerably increases the time that individual may be held compared to what someone without a mental illness would be. Implementation of the CCDP-IST program will allow counties to build up capacity at the local level to move these individuals more quickly out of jail and into treatment and allow their cases to be resolved as expeditiously as possible. In addition, the CCDP-IST funding can be used to create and expand on other types of programming, such as pre-arrest and pre-trial diversion, that can reduce the overall number of IST defendants in the community by creating alternatives to arrest and trial for these individuals and connect individuals with mental health treatment.

Additionally, DSH's IST research found the almost 50 percent of the ISTs admitted into its system of care were unsheltered homeless at the time of their arrest. California has experienced a surge in its homeless population in recent years. A portion of individuals who are homeless struggle with serious mental illness and co-occurring substance use disorders. The funding from the CCDP-IST program can help counties expand the availability of permanent supportive housing options. The program will also support the development of increased treatment resources in the community and the warm hand-off of recent ISTs from county jails into ongoing treatment programs to prevent a large percentage of them from falling out of treatment and cycling back into the criminal justice system.

Finally, this proposal is in alignment with California Health and Human Services Agency Strategic Priorities and specifically the priority to" Improve the Lives of California's Most Vulnerable". This proposal addresses two aspects of this priority; it addresses the needs of persons with disabilities including issues such as care, support, and housing for one of California's most vulnerable populations. It also includes components that encompass the sup-priority "to expand diversion and re-entry services so that anyone released from an incarcerated setting has a service access plan and the main behavioral health treatment setting for those with serious mental illness stops being our jails by default". As part of the continuum of care from the local to the State level, implementing this program would allow the State hospital system to partner with counties to augment available care in the community for this population and thus focus DSH hospital resources towards those who truly cannot be served in the community and reduce their wait times for treatment. This demonstration project aligns with DSH's Strategic Plan goal to provide "Innovative Treatment and Forensic Evaluation". This goal focuses on expanding the available treatment and evaluation options to improve patient outcomes by exploring new ideas for services, capacity and treatment, monitoring data and trends.

D. Justification

Under this demonstration project, DSH proposes to contract with counties in 2021-22 who will assume responsibility for the treatment and restoration of felony IST defendants, to provide a continuum of services to felony ISTs in the county as opposed to state hospitals. On this date, any felony IST defendant pending placement to DSH for treatment and any newly committed felony ISTs, thereafter, are directed to the selected counties for treatment and competency restoration in the counties' continuums of care. Counties will continue to have access to DSH beds for individuals who cannot be safely treated in the counties' continuum. Any felony IST defendant admitted to DSH and receiving treatment in a state hospital or JBCT program prior to July 1, 2021 will continue to be the responsibility of DSH until discharged and/or final dispositions are determined.

To estimate the number of IST referrals the counties will be responsible for beginning in FY 2021-22, DSH used a three-year average (FY 2017-18 through FY 2019-20) of the total actual number of ISTs referred to DSH inpatient programs (hospital and JBCT) from a sample of counties. DSH applied an average of three prior years to control for the impact of COVID-19 on referral rates to DSH in FY 2019-20. DSH assumes an annual total of 1,252 ISTs will be committed by the participating counties for treatment which is the basis of this proposal's cost estimate. The actual referral rates from these counties for the last five fiscal years are displayed below, along with the average for the last three years:

Analysis of Problem

CCDP-IST Proposed Counties	
IST Referrals to DSH	**TOTALS**
2015-16	1210
2016-17	1178
2017-18	1457
2018-19	1238
2019-20	1062
Avg # of Referrals[1]	**1252**

[1]Averaged using the last 3 years

While the rate of referrals appears comparatively high in FY 2017-18, the Legislature authorized investments in FY 2018-19 to address the rate of referrals to DSH, including the CBR and IST Diversion programs. With these investments, coupled with the rate of referrals in four of the five years reflected above, DSH believes the estimated annual total of ISTs used as the basis for projected funding is reasonable. Over the initial three years of the felony IST transfer, DSH proposes to evaluate the need for an annual adjustment process to account for natural growth factors in the population of the participating counties.

Population Distribution by Treatment Setting

DSH assumes that a continuum of treatment settings will be required to serve the felony IST population and counties will need some time to develop the capacity necessary to treat felony ISTs in the community. Treatment settings include but are not limited to:

- County operated jail treatment program
- Acute inpatient psychiatric beds
- Institution for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) beds
- Unlocked residential beds with onsite treatment services; outpatient clinics
- Access to state hospital beds for individuals who need the highest level of care

To determine the proportion of the population eligible for treatment in the community, DSH utilized the percentages presented by the RAND Corporation in their research report "Estimating the Size of the Los Angeles County Jail Mental Health Population Appropriate for Release into Community Services" (2020). Based on these findings, DSH estimates a minimum of 32% of county ISTs will require a level of care comparable to DSH (either in a state hospital bed or a county-run jail restoration program) and up to 68% of ISTs can be treated in a less restrictive setting in the community.

Utilizing actual admission rates from the selected counties to state hospitals and JBCT transfers to a state hospital bed in FY 2019-20, DSH estimates that of the minimum number of ISTs (32%) that would need care comparable to state hospital services, 70% would require a state hospital bed and 30% would require care in jail-based restoration programming. DSH used the average number of admissions per month for June 2019 through February 2020 to control for the impact of COVID-19 on admissions beginning in March 2020. Using the data points addressed herein, DSH assumes the following distribution of the population by treatment setting:

Analysis of Problem

IST Population- % Distribution by Treatment Setting (12 Months)		
Treatment Setting	**Percentage**	**Annual # of ISTs Served**
Community Care Continuum*	78%	971
Community Care Treatment	*(68%)*	*851*
Jail-Based Treatment	*(10%)*	*120*
State Hospital	22%	281
TOTAL	**100%**	1,252

**Community Care Continuum includes county-run jail programs, acute in-patient, IMD and unlocked residential settings. DSH estimates 55 individuals will be transferred to a state hospital from a jail-based or community program.*

Baseline Funding and Cost Assumptions

To support the community care treatment for ISTs, DSH proposes to provide ongoing baseline funding to counties at $108,345 per estimated felony IST. This is equivalent to the cost of care at DSH for an IST ($699 daily bed rate at an average length of stay of 155 days). Funding counties at the cost for IST treatment and restoration in the state hospitals may help promote the development of a full continuum of treatment options that can be made available to ISTs in the community including but not limited to acute, intermediate and unlocked residential beds. While the cost of care in the community is potentially lower than the cost of care at DSH, the average length of stay (ALOS) in community treatment may be substantially longer. The current ALOS in a DSH facility is approximately 155 days; depending on the type of programming used by the county, the ALOS for defendants can be 12 months (using a CBR model) to 24 months (using a Diversion model). The difference in these lengths of stay reflect the different goals of the treatment models: at DSH the goal is to restore competency as quickly as possible so that criminal proceedings can continue; in most community treatment models the goal is to treat each individual to address their mental health condition and help them remain connected to the appropriate long-term treatment resources in the community for continuity of care after their criminal cases are resolved. The goals of community treatment programs require a longer ALOS than DSH treatment, but ultimately will have longer-lasting positive outcomes for the individual and the community.

The table below outlines the total funding required for IST treatment in year one of the transfer, including the costs for the estimated ISTs on the pending placement list as of July 1, 2021:

YEAR ONE COST			**RATE**		**TOTALS**
Baseline County Treatment*	1252	individuals	$108,345	$	135,684,055
One-Time Waitlist Treatment Cost	460	individuals	$108,345	$	49,838,700
One-Time Program Implementation**				$	35,000,000
One-Time County Program Expansion Transfer				$	11,911,000
DSH Support Functions				$	753,000
YEAR ONE - FUNDING REQUEST				**$**	**233,186,755**

**Number of individuals and rates as displayed are rounded to nearest whole number/dollar.*

***Up to $35 million one-time will be made available in BY for start up costs including capacity infrastructure*

In addition to the baseline funding, DSH proposes allocating:

Analysis of Problem

- $49.8 million one-time in FY 2021-22 for costs of care for an estimated 460 ISTs who were pending placement to DSH as of July 1, 2020 and for which the county assumes responsibility.
- $35.0 million one-time in FY 2021-22 to the counties to support initial implementation activities including building capacity infrastructure. Some examples of what these implementation funds will be used for are securing or creating additional housing and beds across the county continuum of care, hiring and training staff in county behavioral health and other county departments with a role in programming, and contracting with necessary Community-Based Organizations for services.
- $11.9 million one-time in FY 2021-22 for costs of care for defendants already receiving treatment through an expansion of the CBR program prior to activation of the CCDP. This funding will support patients already admitted to these programs prior to July 1, 2021.

The table below outlines the ongoing funding requested to support this program after the first year:

ONGOING COSTS						
Baseline County Treatment*	1252	individuals	$	108,345	$	135,684,055
DSH Support Functions					$	753,000
ONGOING - FUNDING REQUEST					**$**	**136,437,055**

**Number of individuals and rates as displayed are rounded to nearest whole number/dollar.*

Growth - Population and Inflation Adjustments

Starting in FY 2024-25, DSH will evaluate the need to reassess the baseline funding amount for counties based on the estimated felony IST population on an annual basis to account for changes to overall growth in county population and/or cost of care factors that may drive increases outside of the county's control. Information collected over the next few years will inform the effectiveness of the existing methodology or the development of a revised methodology that takes changes in county demographics and cost of care into account and can be applied to all counties should this program go statewide. This proposal does not include resources associated with the reassessment of baseline funding for counties.

Excess Use of State Hospital Beds

In the population and cost assumptions used to develop the proposed rate and baseline funding for this program, DSH estimates a total of 32% of the felony IST population will require a level of care comparable to DSH. Of that total, approximately 22% will require a state hospital bed and 10% will require treatment comparable to a DSH JBCT bed operated by the county. Additionally, approximately half of the IST patients treated in a JBCT are ultimately transferred to a state hospital for continued treatment. To further promote development of a full and appropriate continuum of community care, and to reduce the counties' reliance on state hospital beds, DSH proposes to establish a tiered reimbursement structure for the counties' use of state hospital beds. DSH will establish an annual allocation of bed days for the selected counties and will charge 150 percent of DSH's current daily bed rate for each day used by the counties for the treatment of ISTs at a state hospital. For any number of state hospital bed days used in excess of the maximum number assumed in the counties' annual allocation, a tiered rate structure will be utilized, and the cost of those bed days will incrementally increase in accordance to the number of excess bed days used. The county allocation of bed days is for purposes of applying a tiered rate structure only and does not guarantee bed availability at the time of referral. Referrals to DSH from counties participating in CCDP-IST will be processed and admitted based on IST commitment date along with all other ISTs committed to DSH in accordance with existing regulations.

County Program Savings and Reinvestment Opportunities

Analysis of Problem

Through this program, DSH seeks to encourage use of Diversion programs and other upstream efforts to further reduce the number of individuals declared IST, their involvement with the criminal justice system, and discourage inappropriate use of the IST commitment. However, DSH does not propose to reduce funding levels commensurate with a decline in the annual number of IST referrals that falls below the baseline number assumed in the initial year of transfer. Like public safety realignment, DSH proposes counties be required to reallocate any savings achieved to support continued growth in innovative strategies and programs that are designed to serve individuals most at-risk of becoming an IST. Counties will be required, as included in the trailer bill to establish this program, to submit plans for their use of available savings to DSH for review and approval The counties will be required to target a defined population with this funding, including individuals with a serious mental illness who are not accessing other community mental health treatment, who are homeless, or who are restored to competency and are being released back into the community (or any combination of these).

County Funding Mechanism

DSH, via contract with the counties, proposes to directly allocate baseline funds on a monthly basis. Ten percent of each county's total allocation will be held and dispersed on a quarterly basis in arrears upon the county's submission of the data reports required for program evaluation. All one-time funds and other transfers will be disbursed at the beginning of the respective FY. The table below displays the annual allocation schedule for disbursement of baseline county funding:

Annual Baseline Funding Disbursement Schedule			
	90% Base Funds	10% Withhold (Est. Distribution)	Totals
July	$ 10,176,304		$ 10,176,304
August	$ 10,176,304		$ 10,176,304
September	$ 10,176,304		$ 10,176,304
October	$ 10,176,304		$ 10,176,304
November	$ 10,176,304	$ 3,392,101	$ 13,568,406
December	$ 10,176,304		$ 10,176,304
January	$ 10,176,304		$ 10,176,304
February	$ 10,176,304	$ 3,392,101	$ 13,568,406
March	$ 10,176,304		$ 10,176,304
April	$ 10,176,304		$ 10,176,304
May	$ 10,176,304	$ 3,392,101	$ 13,568,406
June	$ 10,176,304		$ 10,176,304
August*		$ 3,392,101	$ 3,392,101
Total	**$ 122,115,650**	**$ 13,568,406**	**$ 135,684,055**

**Final payment for data submission*

DSH Support Functions

DSH requests 4.0 positions and $753,000 General Fund in FY 2021-22 and ongoing to support implementation, monitoring, and evaluation activities of the demonstration project. DSH requests 1.0 Consulting Psychologist (CP), 1.0 Health Program Manager III (HPM III), 1.0 Research Data Analyst II, and 1.0 Staff Services Analyst (SSA) position totaling $648,000. Based on the high rate of travel experienced with planning and implementation of the Diversion program, an additional $45,000 is needed for the HPM III and CP to support travel costs to counties for outreach, program planning, program activation and program evaluation.

Additionally, $60,000 is needed to contract with national experts to provide consultation and training to DSH and the counties under consideration. The experts selected will consult with DSH on

the implementation of this demonstration project and strategies for a potential statewide roll-out. They will also be made available to assist the selected counties as needed with the development of the necessary countywide programming.

Workload related to this request will be comparable to Diversion, JBCT and current CBR programs and the staffing request is based on lessons learned from all three regarding necessary program activities. The incumbents assigned to this program will be responsible for acting with the highest level of independence in order to engage directly with executive, criminal justice and treatment staff from the counties. The department requires these additional staff positions to effectively oversee these programs, communicate with stakeholders, complete billing and administrative tasks, and provide the data and reports necessary to run the program and inform future DSH policy decisions. Attachment B provides the workload analysis for these positions.

E. Outcomes and Accountability

Goals of Felony IST Demonstration Project

- To support the principles of deinstitutionalization for individuals who can best be cared for in the least restrictive setting in the community.
- To promote a community-based continuum of care for felony IST defendants in the selected counties so that counties can successfully assume responsibility for the treatment and restoration of felony IST defendants best served in the community.
- To demonstrate the effectiveness of community-based programs for felony IST defendants and to achieve better overall outcomes for individuals with serious mental illness who are justice-involved and lay the groundwork for expanding this program statewide.
- Timely restoration of competency of IST defendants which will allow DSH to avoid legal fines and contempt findings by the courts.
    - If unsuccessful on appeal, DSH will be required to admit ISTs within a maximum of 28 days from commitment. Under the original order this was to be implemented by October 2020. Current average timelines exceed this and have been exacerbated by COVID-19.
- To promote increased flexibility within existing county funding streams to reduce siloed approaches to the delivery of treatment and services to this population.
- To align increased mental health treatment services at the local county level.

Oversight and Program Evaluation

In order to assess the effectiveness of this demonstration program and evaluate feasibility for statewide implementation in the future, DSH proposes statutory changes to provide DSHP authority to require the submission of program plans and data from participating counties. DSH's experience in implementing the Diversion Program is informing this request. Citing privacy concerns, some counties have delayed completing program agreements and data sharing between the department and counties while working to address these issues. DSH released a Department Letter in October 2019 to clarify the department's authority under federal law to collect data on program participants. Similar authority for the demonstration project would support DSH's ability to collect program participant data.

Participating counties will be required to submit a full-scope community treatment program plan to DSH on an annual basis including, but not limited to:

- Identification of key contacts in county program
- Description of stakeholder groups and planning and oversight entities
- Description of the full scope of evidence-based programs and strategies employed by the county
- Annual spending plan
- Data collection plan

Counties will also be required to report demographic and treatment data to DSH on a quarterly basis and fiscal data on an annual basis so that DSH can effectively perform program review and evaluation. DSH will develop a master program plan template, data reporting template, data dictionary and fiscal reporting template to support consistency in reporting across counties. Counties will be required to report data elements to DSH including but not limited to:

- Total number of felony IST evaluations ordered
- Total number of felony IST assessments resulting in an IST commitment
- Total number of felony ISTs treated at each level of care in the community continuum described in county plan and the length of stay
- Recidivism rates of restored ISTs over a specified time period
- Expenditures by funding source at each level of care

Projected Outcomes

Workload Measure	CY	BY
Estimated IST Waitlist/Fiscal Year End	1,298.0	112.3

F. Analysis of All Feasible Alternatives

ALTERNATIVE 1 – Approve the request for 4.0 positions and $233.2 million General Fund in FY 2021-22 and 4.0 positions and $136.4 million General Fund in FY 2022-23 and ongoing to support counties in assuming responsibility for the treatment and restoration of felony IST defendants beginning July 1, 2021. Also, approve corresponding statutory change and provisional language.

Pros:

- Potential to significantly decrease wait times in jails for ISTs ordered into competency treatment and may help to meet timelines ordered by the courts. This may accelerate treatment for pending IST patients and allow DSH to reduce mounting legal fines and contempt findings by the courts.
- Increase the number of individuals best served in the community receiving treatment in the community.
- By establishing demonstration projects in multiple counties of various sizes across the state, the CCDP-IST will provide data to the state to shape future policy and explore statewide rollout of this program.
- The program is designed to encourage counties to invest in preventive and pre-trial diversion programming to reduce the number of individuals with serious mental illness (SMI) cycling in and out of the criminal justice system. Counties will have an ongoing funding stream that can be used to patch the gaps in their current funding streams for people with SMI and criminal justice involvement.

- CCDP-IST program may disincentivize overuse of DSH beds for ISTs by the counties and delays in treatment and may encourage a quick discharge process once an IST has been restored.

Cons:

- Requires a significant General Fund commitment. However, DSH will likely be unable to comply with Court orders that it admit all IST Defendants within 28 days of commitment unless this proposal is approved. Inability to meet these benchmarks for admission could result in legal fines or further findings of contempt.

ALTERNATIVE 2 – Approve 4.0 positions for $214.0 million General Fund in FY 2021-22 and 4.0 positions and $122.3 million General Fund in FY 2022-23 and ongoing to support one county in assuming the responsibility for the treatment and restoration of felony IST defendants beginning July 1, 2021. Approve corresponding statutory change and provisional language.

Pros:

- Funding for this program is decreased by $19.2 million General Fund in FY 2021-22 and $14.1 million General Fund in FY 2022-23 and ongoing.
- May significantly decrease wait times in jails for ISTs ordered into competency treatment and may increase the number of individuals best served in the community receiving treatment in the community.
- The program is designed to encourage counties to invest in preventive and pre-trial diversion programming to reduce the number of individuals with SMI cycling in and out of the criminal justice system. The selected county will have an ongoing funding stream that can be used to patch the gaps in their current funding streams for people with SMI and criminal justice involvement.
- CCDP-IST program may disincentivize overuse of DSH beds for ISTs by the counties and delays in treatment and may encourage a quick discharge process once an IST has been restored.

Cons:

- DSH may not be able to meet court-mandated admission times as quickly as needed to help avoid legal fines or contempt.
- By limiting this demonstration project to one county, the state will not have to opportunity to evaluate how this program is effective in counties of various sizes in different parts of the state. This will potentially lengthen the time needed to create a statewide program.
- Fewer counties will receive funding to allow them to expand their existing continuums of care to serve individuals with SMI.

ALTERNATIVE 3 – Status quo.

Pros:

- Does not incur any additional funding requirements.

Cons:

- Large numbers of IST defendants will continue to suffer from long wait times in jail for competency treatment. Many jails do not provide adequate mental health services to inmates, further exacerbating the symptoms of their illness.
- If DSH is unable to meet admission timelines set by the courts, the state could face significant legal fines for non-compliance like other states. The State of Washington, for example, had

fines of approximately $80 million imposed as a result of similar litigation. Additionally, DSH could be placed under federal receivership or be appointed a court monitor.

- IST waitlist at DSH will continue to grow.

G. Implementation Plan

After the release of the Governor's Budget in January 2021, DSH will immediately begin outreach to the counties it is considering for this program to discuss details and develop implementation timelines with the counties if the program is approved. DSH will begin the recruitment process for the proposed positions in Spring 2021 so that hiring can be completed immediately in the new fiscal year if this program is approved in the Budget Act. DSH will also engage with national experts and expedite the completion of any contracts so consultant work on the project can begin as quickly as possible.

Using lessons learned and resources from other community-based projects like the LACBR and the Felony Mental Health Diversion program, DSH will begin work with the counties to develop their countywide program plans and negotiate all contract terms. DSH has a library of existing contract templates and program planning resources that can easily be modified for use in this program. DSH will begin this work, particularly contract negotiations, prior to the start of FY 2021-22 so that all contracts can be fully executed, and the activation of programming can commence in FY 2021-22.

H. Supplemental Information

Attachment A: BCP Fiscal Details Sheets

Attachment B: Workload Analysis

Attachment C: DSH and JBCT IST Pending Placement List

Attachment D: IST Increased Capacity, FY 2012-13 – December 2020

<u>Provisional Language</u>

This proposal includes provisional language authorizing General Fund costs to be offset by reimbursements from the counties participating in the Community Care Demonstration Projection for Felony ISTs, subject to notification to the Chairperson of the Joint Legislative Budget Committee.

See proposed 2021 Budget Act, Item 4440-011-0001, Provision 13 below:
"13. Notwithstanding any other law, upon order of the Department of Finance, the amounts in Schedules (4) and (8) shall be adjusted to accommodate reimbursements received to support the Community Care Demonstration Project for Felony ISTs. Not more than 30 days after the adjustments are made, the Director of Finance shall notify in writing the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee of this action."

I. Recommendation

DSH recommends approval of alternative 1 for 4.0 positions and $233.2 million General Fund in FY 2021-22 and 4.0 positions and $136.4 million General Fund in FY 2022-23 and ongoing to support a contract with counties for the treatment and restoration of felony IST defendants in the community. This includes the approval of corresponding statutory changes and provisional language. This will promote a community-based continuum of care for felony IST defendants in the state and will demonstrate the effectiveness of streamlining responsibility to drive improved outcomes (reduced incarceration, recidivism and homelessness) for individuals with serious mental illness. Additionally, this will assist the state in ensuring IST Defendants have timely access to competency restoration and avoid legal fines or contempt findings by committing courts.

BCP Fiscal Detail Sheet

BCP Title: Community Care Demonstration Project for Felony IST | **BR Name: 4440-062-BCP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	4.0	4.0	4.0	4.0	4.0
Total Positions	**0.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**
Salaries and Wages						
Earnings - Permanent	0	357	357	357	357	357
Total Salaries and Wages	**$0**	**$357**	**$357**	**$357**	**$357**	**$357**
Total Staff Benefits	0	227	227	227	227	227
Total Personal Services	**$0**	**$584**	**$584**	**$584**	**$584**	**$584**
Operating Expenses and Equipment						
5301 - General Expense	0	32	32	32	32	32
5304 - Communications	0	4	4	4	4	4
5320 - Travel: In-State	0	49	49	49	49	49
5324 - Facilities Operation	0	20	20	20	20	20
5340 - Consulting and Professional Services - External	0	232,494	135,744	135,744	135,744	135,744
5346 - Information Technology	0	4	4	4	4	4
Total Operating Expenses and Equipment	**$0**	**$232,603**	**$135,853**	**$135,853**	**$135,853**	**$135,853**
Total Budget Request	**$0**	**$233,187**	**$136,437**	**$136,437**	**$136,437**	**$136,437**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	233,187	136,437	136,437	136,437	136,437
Total State Operations Expenditures	**$0**	**$233,187**	**$136,437**	**$136,437**	**$136,437**	**$136,437**
Total All Funds	**$0**	**$233,187**	**$136,437**	**$136,437**	**$136,437**	**$136,437**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	644	644	644	644	644
4400020 - Hospital Administration	0	4	4	4	4	4
4430030 - Other Contracted Services	0	232,539	135,789	135,789	135,789	135,789
Total All Programs	**$0**	**$233,187**	**$136,437**	**$136,437**	**$136,437**	**$136,437**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
5157 - Staff Svcs Analyst (Gen)				0.0	1.0	1.0	1.0	1.0	1.0
5731 - Research Data Analyst II				0.0	1.0	1.0	1.0	1.0	1.0
7620 - Consulting Psychologist				0.0	1.0	1.0	1.0	1.0	1.0
8429 - Hlth Program Mgr III				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5157 - Staff Svcs Analyst (Gen)	0	52	52	52	52	52
5731 - Research Data Analyst II	0	73	73	73	73	73
7620 - Consulting Psychologist	0	127	127	127	127	127
8429 - Hlth Program Mgr III	0	105	105	105	105	105
Total Salaries and Wages	**$0**	**$357**	**$357**	**$357**	**$357**	**$357**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	0	5	5	5	5	5
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	16	16	16	16	16
5150450 - Medicare Taxation	0	5	5	5	5	5
5150500 - OASDI	0	22	22	22	22	22
5150600 - Retirement - General	0	105	105	105	105	105
5150800 - Workers' Compensation	0	16	16	16	16	16
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	10	10	10	10	10
5150900 - Staff Benefits - Other	0	47	47	47	47	47
Total Staff Benefits	**$0**	**$227**	**$227**	**$227**	**$227**	**$227**
Total Personal Services	**$0**	**$584**	**$584**	**$584**	**$584**	**$584**

Department of State Hospitals
Contracted Patient Services
Community Care Demonstration Project for Felony IST

WORKLOAD ANALYSIS FOR: Consulting Psychologist (CP)

	Hours Required To Accomplish	*Frequency of Task (Monthly)*	Months	*Total Hours Projected (Annually)*
Consultation to the development and review of new program and related policies	8	4	12	384
Training & technical assistance to the counties (development and delivery of formalized training): -County evaluator education/training -Forensic focused treatment plans -Forensic court report writing -Competency Restoration Education/Training	24	1	12	288
Provide consultation and clinical assistance in the assessment, competency treatment, admission and discharge of patients to individual programs\	1	9	12	108
Review and provide feedback to initial and annual update county plans to evaluate proposed clinical treatment program, staffing and funding levels. Collaborate with county stakeholders for regular adjustments.	40	1	3	120
Data collection, outcomes tracking and reporting. Analyze reportable data from each program to develop strategies to increase program effectiveness.	24	1	4	96
Formal Program Review and evaluation - to review county programs, strategies used and evaluation of effectiveness for potential future adjustments and program expansion. Includes preparation/planning for review, travel to county, conduct review, identify any areas of concern/recommended action; develop written report;	100	1	3	300
Regular/ongoing site visits and monitoring (includes travel to/from location); and participation in in-state conferences as subject matter expert	24	1	12	288
Other program administration tasks: - Internal coordination meetings - management briefings - Development and management of internal and external status reports	5	4	12	240
Other duties: - GC 19995.4 (c)-(e) mandated training - Department mandated trainings	24	1	1	24
TOTAL HOURS PROJECTED ANNUALLY				**1,848**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**1.0**

Department of State Hospitals
Contracted Patient Services
Community Care Demonstration Project for Felony IST

WORKLOAD ANALYSIS FOR: Health Program Manager III (HPM III)

	Hours Required To Accomplish	*Frequency of Task (Monthly)*	**Months**	*Total Hours Projected (Annually)*
Development of new program and related policies	12	4	12	576
Population/Local Assistance Estimate development	8	21	2	336
Development and management of performance-based contracts/MOUs with the counties	48	1	3	144
Coordinate data collection, outcomes tracking and reporting	8	1	4	32
Program Review and evaluation - to review county programs, strategies used and evaluation of effectiveness for potential future adjustments and program expansion	60	3	1	180
Rate setting, cost evaluation, and fiscal monitoring of programs	8	3	2	48
Billing and county reimbursement reconciliation	3	1	12	36
Training, technical assistance and consultation to the counties: -County evaluator education/training -Forensic focused treatment plans -Forensic court report writing -Competency Restoration Education/Training	16	1	12	192
Travel: - Participating county site visits - In-state conferences/meetings	24	1	12	288
Other program administration tasks: - Internal coordination meetings - Coordination with program consultants/management of consultant contracts - Development and management of internal and external status reports	5	4	12	240
Other duties: - GC 19995.4 (c)-(e) mandated training - Department mandated trainings	24	1	1	24
TOTAL HOURS PROJECTED ANNUALLY				**2,096**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**1.2**

Department of State Hospitals
Contracted Patient Services
Community Care Demonstration Project for Felony IST

WORKLOAD ANALYSIS FOR: Research Data Analyst II

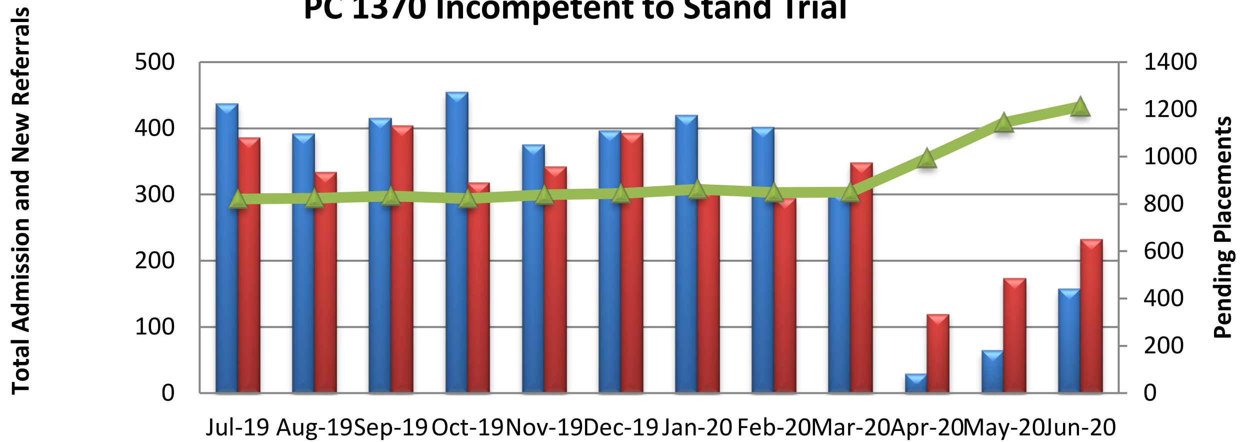
	Hours Required To Accomplish	*Frequency of Task (Monthly)*	Months	*Total Hours Projected (Annually)*
Design/develop/maintain data collection tool for counties	40	1	1	40
Receive/collate/analyze data submitted by counties; run statistical analysis and develop comprehensive report on rate of referrals, admissions, discharges, length of stay; bed utilization and other outcomes as compared to other county data (Non-CCDP) tracked by DSH.	135	1	4	540
Provide technical asisstance/consulation to counties on reporting requirements; consult with the counties to validate data submitted.	24	1	4	96
Produce statistical reports/analysis to be used by program staff for county program review and evaluation preparation. Following program review, collate/analyze new data collected during review; produced charts, graphs, data anlaysis for use by program staff in written report.	80	1	3	240
Develop/produce statistical reports/analysis for use by program staff in development/presentation of bi-annual Population/Local Assistance Estimate	4	21	2	168
Development of new research/data policies and procedures; and consultation to program policies/procedures	6	4	12	288
Run data reports for program facilitation of billing and county reimbursement reconciliation; and for rate setting, cost evaluation, and fiscal monitoring of programs; rate setting; cost evaluation and fiscal monitoring	12	1	12	144
Other program administration tasks: - participate in internal coordination meetings - produce ad-hoc data reports as requested by management	5	4	12	240
Training	24	1	1	24
TOTAL HOURS PROJECTED ANNUALLY				**1,780**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**1.0**

Department of State Hospitals
Contracted Patient Services
Community Care Demonstration Project for Felony IST

WORKLOAD ANALYSIS FOR: Staff Services Analyst (SSA)

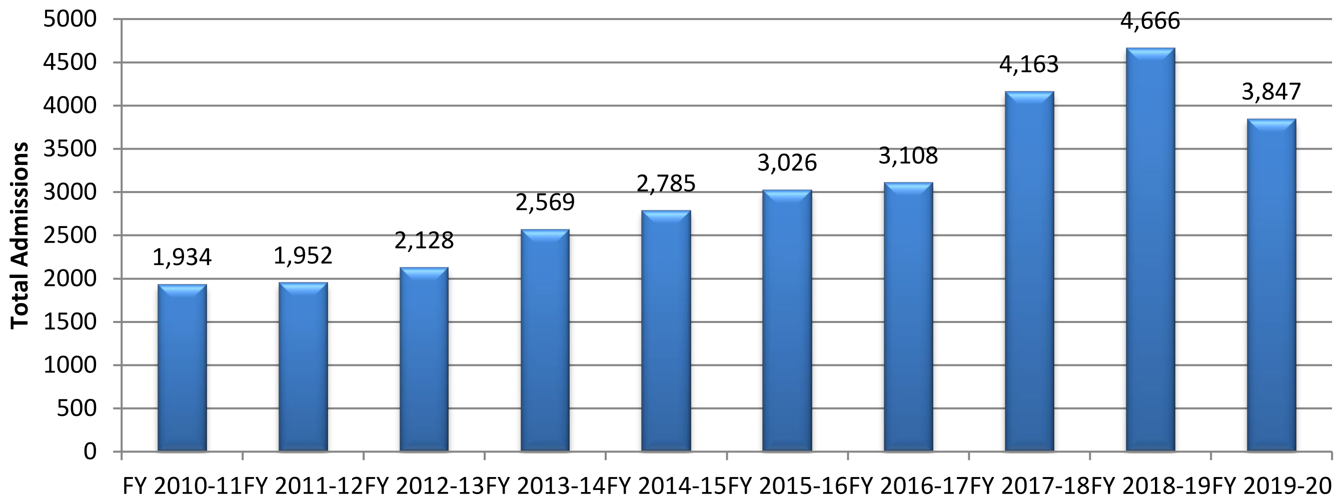
	Hours Required To Accomplish	*Frequency of Task (Monthly)*	**Months**	*Total Hours Projected (Annually)*
Preparing monthly county allocation payments	40	1	12	480
Billing and county reimbursement reconciliation: - Tracking monthly county bed usage - Preparing county invoices - Reconciling county costs to monthly allocation payments	60	1	12	720
Reconcile annual county fiscal reports	40	1	1	40
Maintain monthly fiscal trackers and reports	16	1	12	192
Program Administration: - Schedule meetings, develop meeting agendas, track action items - Assist with travel arrangements - Maintain contract and program implementation trackers - Maintain county contact lists	8	4	12	384
Training	24	1	1	24
TOTAL HOURS PROJECTED ANNUALLY				**1,840**
TOTAL HOURS PROJECTED ANNUALLY: 1,776 (hours/1,776 = PYs)				
TOTAL POSITIONS NEEDED				**1.0**

Department of State Hospitals & Jail Based Competency Treatment
FY 2019-20 Referrals
PC 1370 Incompetent to Stand Trial



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Admissions	437	392	415	455	375	396	420	402	305	29	64	157
New Referrals	386	334	404	318	342	393	312	294	348	119	173	232
Pending Placements	821	824	834	823	839	844	862	848	850	993	1144	1212

Department of State Hospitals & Jail Based Competency Treatment
PC 1370 Incompetent to Stand Trial
Actual Admissions
FY 2010-11 to FY 2019-20



Note: *FY 2010-11 to FY 2016-17 admission data includes only state hospital admissions. The 2017-18 to 2019-20 admission data includes both state hospital and JBCT admission data. All admission data includes transfers.*

Attachment 2
IST Increased Capacity, FY 2012-13 - December 2020

State Hospitals

FY	Hospital	Date of Activation	Net Capacity Increase
FY2012-13	DSH-Atascadero	January 2013	35
	DSH-Atascadero	February 2013	35
		2012-13 Net Increase	**70**
FY2013-14	DSH-Metropolitan	March 2014	30
	DSH-Napa	April 2014	26
	DSH-Coalinga	June 2014	70
		2013-14 Net Increase	**126**
FY2014-15	DSH-Coalinga	March 2015	35
		2014-15 Net Increase	**35**
FY2015-16	DSH-Coalinga	August 2015	50
	DSH-Atascadero	August 2015	55
		2015-16 Net Increase	**105**
FY2016-17	DSH-Patton	October 2016	25
	DSH-Napa	January 2017	50
		2016-17 Net Increase	**75**
FY2017-18	DSH-Coalinga	May 2018	25
		2017-18 Net Increase	**25**
FY2018-19		**2018-19 Net Increase**	**0**
FY2019-20	DSH-Metropolitan	September 2019	46
	DSH-Metropolitan	January 2020	46
		2019-20 Net Increase	**92**
FY2020-21		**2020-21 Net Increase**	**0**
		TOTAL Net Increase	**528**

AES/JBCT

FY	Hospital	Date of Activation	Net Capacity Increase
FY2012-13	JBCT- San Bernardino[1]	2011	20
	JBCT-Riverside[2]	2013	20
		2012-13 Net Increase	**40**
FY2012-13		**2013-14 Net Increase**	**0**
FY2014-15		**2014-15 Net Increase**	**0**
FY2015-16	JBCT- San Bernardino	July 2015	76
	JBCT- Sacramento	October 2015	16
	JBCT- Sacramento	March 2016	16
		2015-16 Net Increase	**108**
FY2016-17	JBCT- San Diego	March 2017	30
		2016-17 Net Increase	**30**
FY2017-18	JBCT- Sonoma	July 2017	10
	JBCT-Sacramento	November 2017	12
	JBCT-Riverside	January 2018	5
	JBCT-Stanislaus	February 2018	12
	AES - Kern	April 2018	60
	JBCT-San Bernardino	June 2018	30
		2017-18 Net Increase	**129**
FY2018-19	JBCT-Mariposa	December 2018	N/A
	JBCT-Butte	January 2019	5
	JBCT-Solano	February 2019	12
		2018-19 Net Increase	**17**
FY2019-20	JBCT-Mendocino	July 2019	N/A
	JBCT-San Luis Obispo	July 2019	5
	JBCT-San Bernardino	August 2019	20
	JBCT-San Joaquin	January 2020	10
	JBCT-Stanislaus	January 2020	6
	JBCT-Monterey	May 2020	10
		2019-20 Net Increase	**51**
FY2020-21	JBCT-Sonoma	July 2020	2
	JBCT-Kings	July 2020	5
	JBCT-Humboldt	August 2020	6
	JBCT-Shasta	September 2020	6
	JBCT-Placer	September 2020	15
	JBCT-Santa Barbara	November 2020	10
	JBCT-Ventura	December 2020	8
		2020-21 Net Increase	**52**
		TOTAL Net Increase	**427**

State Hospitals & AES/JBCT Total

FY	Hospital	Date of Activation	Net Capacity Increase
FY2012-13	JBCT- San Bernardino[1]	2011	20
	JBCT-Riverside[2]	2013	20
	DSH-Atascadero	January 2013	35
	DSH-Atascadero	February 2013	35
		2012-13 Net Increase	**110**
FY2013-14	DSH-Metropolitan	March 2014	30
	DSH-Napa	April 2014	26
	DSH-Coalinga	June 2014	70
		2013-14 Net Increase	**126**
FY2014-15	DSH-Coalinga	March 2015	35
		2014-15 Net Increase	**35**
FY2015-16	DSH-Coalinga	August 2015	50
	DSH-Atascadero	August 2015	55
	JBCT- San Bernardino	July 2015	76
	JBCT- Sacramento	October 2015	16
	JBCT- Sacramento	March 2016	16
		2015-16 Net Increase	**213**
FY2016-17	DSH-Patton	October 2016	25
	DSH-Napa	January 2017	50
	JBCT- San Diego	March 2017	30
		2016-17 Net Increase	**105**
FY2017-18	JBCT- Sonoma	July 2017	10
	JBCT-Sacramento	November 2017	12
	JBCT-Riverside	January 2018	5
	JBCT-Stanislaus	February 2018	12
	AES - Kern	April 2018	60
	DSH-Coalinga	May 2018	25
	JBCT-San Bernardino	June 2018	30
		2017-18 Net Increase	**154**
FY2018-19	JBCT-Mariposa	December 2018	N/A
	JBCT-Butte	January 2019	5
	JBCT-Solano	February 2019	12
		2018-19 Net Increase	**17**
FY2019-20	JBCT-Mendocino	July 2019	N/A
	JBCT-San Luis Obispo	July 2019	5
	JBCT-San Bernardino	August 2019	20
	DSH-Metropolitan	September 2019	46
	DSH-Metropolitan	January 2020	46
	JBCT-San Joaquin	January 2020	10
	JBCT-Stanislaus	January 2020	6
	JBCT-Monterey	May 2020	10
		2019-20 Net Increase	**143**
FY2020-21	JBCT-Sonoma	July 2020	2
	JBCT-Kings	July 2020	5
	JBCT-Humboldt	August 2020	6
	JBCT-Shasta	September 2020	6
	JBCT-Placer	September 2020	15
	JBCT-Santa Barbara	November 2020	10
	JBCT-Ventura	December 2020	8
		2020-21 Net Increase	**52**
		TOTAL Net Increase	**955**

[1] JBCT-San Bernardino includes 20 beds of capacity previously under the San Bernardino ROC Program activated prior to FY 2012-13.

[2] JBCT-Riverside includes 20 beds of capacity previously under the Riverside ROC Program.

*Note: JBCT-Mariposa and JBCT-Mendocino were established as small county models in which there are not a designated number of beds but an expectation for patients served within the year.

STATE OF CALIFORNIA
Budget Change Proposal - Cover Sheet
DF-46 (REV 02/20)

Fiscal Year	**Business Unit**	**Department**	**Priority No.**
2021-22	4440	Department of State Hospitals	07

Budget Request Name	**Program**	**Subprogram**
4440-060-BCP-2021-GB	4410-State Hospitals	4410010-Atascadero; 4410020-Coalinga; 4410030-Metropoliatin; 4410040-Napa; 4410050-Patton

Budget Request Description

One-Time Deferred Maintenance Allocation

Budget Request Summary

The Department of State Hospitals (DSH) requests one-time $15 million General Fund, available over three years, to address critical deferred maintenance, special repairs/replacement, and regulatory compliance projects at DSH's five hospitals. The planned projects include those related to fire and life safety, critical infrastructure, and any facilities modernization required to complete major repairs and systems replacements.

Requires Legislation	**Code Section(s) to be Added/Amended/Repealed**
☐ Yes ☒ No	Click or tap here to enter text.

Does this BCP contain information technology (IT) components? ☐ Yes ☒ No	**Department CIO**	**Date**
If yes, departmental Chief Information Officer must sign.	Click or tap here to enter text.	Click or tap to enter a date.

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No. Click or tap here to enter text. **Project Approval Document:** Click or tap here to enter text.

Approval Date: Click or tap to enter a date.

If proposal affects another department, does other department concur with proposal? ☐ Yes ☐ No
Attach comments of affected department, signed and dated by the department director or designee.

Prepared By	**Date**	**Reviewed By**	**Date**
Nicole Hicks, Chief Operating Officer	Click or tap to enter a date.	George Maynard, Admin Deputy Director	Click or tap to enter a date.
Department Director	**Date**	**Agency Secretary**	**Date**
Stephanie Clendenin	Click or tap to enter a date.	Mark Ghaly, MD, MPH	Click or tap to enter a date.

Department of Finance Use Only

Additional Review: ☐ **Capital Outlay** ☐ **ITCU** ☐ **FSCU** ☐ **OSAE** ☐ **CALSTARS** ☐ **Dept. of Technology**

PPBA	**Date submitted to the Legislature**
Click or tap here to enter text.	Click or tap to enter a date.

Analysis of Problem

A. Budget Request Summary

DSH requests one-time $15 million General Fund, available over three years (until June 30 2024), to address critical deferred maintenance, special repairs/replacement, and regulatory compliance projects at DSH's five hospitals. The planned projects include those related to fire and life safety, critical infrastructure, and any facilities modernization required to complete major repairs and systems replacements.

B. Background/History

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily census of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

DSH entered into an Architecture and Engineering Retainer contract with the firm J.C. Chang to develop a comprehensive plan to address and prioritize the Department's deferred maintenance projects.

DSH has conducted a current needs identification and prioritization of all special repair (deferred maintenance) projects required to address major building repairs and site-wide infrastructure needs. Accordingly, DSH conducted an analysis of deferred maintenance projects and created a matrix of pending repair projects by category (roof repairs, duct maintenance, painting, landscaping, utility infrastructure repairs, road repairs, etc.). Each project was then assigned a criticality score based upon the hospital's assessment of the need for repair and prioritized based upon the potential impact to the hospital operations. Of this list, DSH has identified 19 critical infrastructure projects submitted for consideration herein. The projects are listed on Attachment B.

For reference, the 2019 Budget Act, Control Section 6.10 included $15 million General Fund, available over three years, to support deferred maintenance projects as follows:

Hospital	**Allocation**
DSH-Atascadero	$ 9,00,000
DSH-Coalinga	$ 200,000
DSH-Napa	$ 7,600,000
DSH-Patton	$ 6,300,000
Total	**$15,000,000**

C. State Level Consideration

DSH provides quality mental health evaluation and treatment for its patients in a safe and responsible manner, seeking innovation and excellence in its operations, across a continuum of care settings. This proposal aligns with DSH Strategic Plan Goal "A safe environment fosters a therapeutic environment free from emotional and physical harm for all patients and employees. This proposal also aligns with California Health and Human Service Agency Strategic Priorities and

Guiding Principles, specifically the strategic principal "Create a system in which every Californian, regardless of origin or income has access to high quality, affordable health care coverage". Ensuring DSH hospital buildings are in good repair helps ensure DSH can provide safe and quality care for its patients.

These projects will allow DSH to continue to utilize these buildings, protect the buildings from further deterioration, increase energy efficiency of the building's envelope and allow DSH to maintain licensing requirements. It is essential to protect the significant investment already funded by the State and to provide adequate safety and security of our state hospital patients, staff, and local communities by ensuring the hospitals are maintained in optimal operating condition.

D. Justification

DSH must be able to address these critical infrastructure risks in a timely manner. Additionally, due to the system-wide unavailability of swing space for temporary patient housing, the hospitals face significant challenges relocating patients from buildings in the event that they experience a major or catastrophic failure and could result in a loss of capacity. Further, failure to provide funding for these special repairs may result in violation of regulatory agencies' requirements. For example, the California Code of Regulations, Title 22, Section 71641(a) states that each "hospital shall be clean, sanitary and in good repair at all times."

Outside of resources from periodic statewide special repairs (deferred maintenance) proposals—DSH is only able to dedicate around $1.9 million annually for these projects. In the event of unplanned emergency repairs, DSH may divert the entirety of the $1.9 million to one hospital, delaying required deferred maintenance and preventative maintenance even further.

Approval of this appropriation will enable DSH to effectively address a portion of its most critical deferred maintenance priorities. Should the Department not receive funding to undertake these projects in full, these buildings will continue to be pose a challenge to patient and staff health and safety, risk regulatory noncompliance, suffer from continued structural compromise related to aging infrastructure and likely result in more costly repair/renovation projects in the future. See Attachment B for additional details on the proposed special repairs.

E. Outcomes and Accountability

DSH's infrastructure that spans 474 buildings and 2,600 acres of land is aging and many of the critical building systems have exceeded their useful life and continue to fail. Addressing minor problems before they escalate is especially crucial as to prevent significant health and safety risks to patients and staff occupying buildings. While the hospitals have relied on existing resources to maintain the existing systems, these repairs are considered temporary fixes as the older systems are undersized and deteriorated beyond ability to achieve lasting repair. Rather than continue incurring ongoing maintenance costs for ineffective cycles of systems failing and temporary repairs, DSH is recommending the following allocation per hospital to address 19 critical infrastructure projects:

Hospital	Allocation
DSH-Atascadero	$ 2,063,113
DSH-Coalinga	$ 6,000,000
DSH-Metropolitan	$ 1,885,998
DSH-Napa	$ 2,500,000
DSH-Patton	$ 2,550,889
Total	**$15,000,000**

Analysis of Problem

F. Analysis to All Feasible Alternatives

ALTERNATIVE 1 – Approve $15 million General fund in FY 2021-22, available over three years, to complete 19 critical infrastructure projects.

Pros:

- Upgrades existing infrastructure and failing systems
- Addresses a portion of DSH's deferred maintenance projects
- Installing equipment/systems necessary to keep patients and employees safe
- Advances patient and staff health and safety
- Reduces likelihood of costly litigation by patients or their families

Cons:

- The State will expend $15 million from General fund appropriation
- May require some disruption to operations during construction

ALTERNATIVE 2 – Status quo.

Pros:

- Does not incur any additional funding requirements

Cons:

- Continued growth of deferred maintenance projects
- Increase future costs and capital expenditures
- Asset/infrastructure deterioration or impairment
- Ongoing Health and safety implications
- Citations from regulatory agencies for failing systems

G. Implementation Plan

As with any Special Repair project under the jurisdiction of the Department of General Services (DGS), upon receipt of funding, DSH will transfer funds to DGS via the Architectural Revolving Fund. Once received, DGS will contract for an architectural firm to develop specifications and designs (Working Drawings). Upon completion of the designs and approval by regulatory entities (the State Fire Marshal, Division of the State Architect, etc.), DGS would then issue a solicitation to a firm for the construction phase. All projects that fall under DSH authority will be grouped together to the extent possible to reduce design and construction costs (economy of scale). Current estimates are that the design period for each project will last approximately 4-6 months. Upon successful solicitation and award, construction durations are estimated to be 12-16 months.

H. Supplemental Information

In order to provide additional time for DSH to encumber or expend the one-time $15 million General Fund, the below provisional language is proposed under the 2021 Budget Act, Item 4440-011-0001, Provision 12.

12. Of the funds appropriated in Schedule (2), $15,000,000 shall be expended to address deferred maintenance projects that represent critical infrastructure deficiencies. The amount allocated shall be available for encumbrance or expenditure until June 30, 2024.

Attachment A: BCP Fiscal Detail Sheets
Attachment B: Project Listing

13. Recommendation

DSH recommends approval of alternative 1, approve deferred maintenance appropriation to fund 19 critical infrastructure projects. This proposal ensures that these patient housing, treatment, and support buildings are in regulatory compliance, do not suffer from continued wear and tear associated with the aging infrastructure. Correcting these issues now prevents more costly projects in the future and is critical to maintaining a safe and healthy treatment environment for staff and patients. Additionally, approval of this appropriation will enable DSH to effectively address a portion of its deferred maintenance priorities.

BCP Fiscal Detail Sheet

BCP Title: One-Time Deferred Maintenance Allocation **BR Name: 4440-060-BCP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5324 - Facilities Operation	0	15,000	0	0	0	0
Total Operating Expenses and Equipment	**$0**	**$15,000**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$0**	**$15,000**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	15,000	0	0	0	0
Total State Operations Expenditures	**$0**	**$15,000**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$0**	**$15,000**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4410010 - Atascadero	0	2,063	0	0	0	0
4410020 - Coalinga	0	6,000	0	0	0	0
4410030 - Metropolitan	0	1,886	0	0	0	0
4410040 - Napa	0	2,500	0	0	0	0
4410050 - Patton	0	2,551	0	0	0	0
Total All Programs	**$0**	**$15,000**	**$0**	**$0**	**$0**	**$0**

	Department Name:	Department of State Hospitals	
CODE	**FACILITY LOCATION (click on filter in lower right hand corner of this cell to capture information by hospital)**	**PROJECT TITLE AND DESCRIPTION**	**ESTIMATED COST**
CRI	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	***Bldg. 30 plumbing repairs (EOC)*** *- Major plumbing repairs to preparation sink in Building 30 which poses sanitation risk.* ***Sink in café on 1st floor, pipes located under floor.***	$ 57,502
CRI	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	***HVAC Replacement in Patient Cafeterias-West STA*** *- 30 and 70 satellite kitchen insufficient cooling, requires recalculation of heat load and additional exhaust and cooling.*	$ 328,282
CRI	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93425*	***Replace pumps for chilled water system -*** *(8 pumps)*	$ 100,000
FLS	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	***Repair Parking Lot (EOC) Resolve Staff Safety Issue*** *- Repair sink hole in the asphalt to avoid trip and fall risk in Main Canteen northeast parking lot.*	$ 333,000
FLS	*DSH-Metropolitan 11401 Bloomfield Avenue Norwalk, CA 90650*	***Domestic Water Tank #1 Roof Replacement and Foundation Repair*** *- Remove the wooden roof and structural members from Water Tank #1 and replace with new welded steel roof, support columns and rafters/purlins. Repair the damage to the foundation of Water Tank #1*	$ 1,493,196
FLS	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93423*	***Door Repairs*** *- Test, recertify and label for fire ratings (EOC) - Numerous doors were identified during TJC as not being labeled for fire rating, an independent contractor will need to test and re-certify fire doors*	$ 627,290
CRI	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93423*	***Pharmacy Clean Room*** *- Accrediting Standard MM.05.01.07 requires that a pharmacist admixes all compound sterile preparation.*	$ 156,823
FLS	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	***Repair Accessible Path of Travel, staff safety (EOC)*** *- Repair uneven walkway between Admin and Central Staffing Office, concrete pad*	$ 15,683
FLS	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93423*	***Replace 30-year old underground tank with new 10,000 gallon above ground diesel tank*** *- Serves two main emergency generators with above tank and to tie-in and cross-connect with two existing above ground 8,000 gallon tanks. Hospitals are required to provide 72 hours of emergency back-up power, so fuel is licensing and accreditation requirement.*	$ 333,000
CRI	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93424*	***Replace Existing Refridgerant Systems -*** *(15 coolers and freezers)*	$ 333,000
CRI	*DSH-Coalinga 24511 West Jayne Avenue Coalinga, CA 93210*	***Re-routing of Fire Suppression Water & Domestic Water Lines -*** *The remaining support buildings that have Fire Suppression water lines and Domestic water lines that feed up under the building foundation need to be intercepted close to the building where the piping transitions from plastic to steel and replaced with new piping and re-routed into the mechanical riser rooms as done in Bldgs. 1, 2, 3, 4, 5, 6, 7, 8 & 20.*	$ 6,000,000
CRI	*DSH-Napa 2100 Napa Vallejo Highway Napa, CA 94558*	***Replace Boiler #2 -*** *Replace existing Boiler #2 at Central Plant. Boiler is past is life expectancy and is failing.*	$ 2,500,000
FLS	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	***Repair Entry Threshold at O Bldg. (EOC)*** *- Replacing threshold at north entrance due to potential fall risk in the O Building Library near Central Compound*	$ 20,910
FLS	*DSH-Metropolitan 11401 Bloomfield Avenue Norwalk, CA 90650*	***Custodian's Eye Wash installation, staff safety (EOC)*** *- Installation of American National Standards Institute approve eye wash stations on the units' (should be located in custodian's closet) deficiency*	$ 59,802
CRI	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	***Roof - Administration Bldg. -*** *Roof tear off and replacement.*	$ 1,100,000
FLS	*DSH-Patton 3102 E. Highland Avenue Patton, CA 92369*	**All Courtyards -** Remove/repour all courtyards due to root damage and deterioration.	$ 695,512
FLS	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93423*	***Reline Domestic Hot Water Storage Tanks*** *- Interior of the existing three tanks need to be relined in order to prevent corrosion of the metal shell.*	$ 180,000
CRI	*DSH-Metropolitan 11401 Bloomfield Avenue Norwalk, CA 90650*	***Refacing Medicine Room, Nurses Station and Laundry Room Cabinets*** *- Replace cabinets. Current cabinets are made with Melamine, which is a form of particle board, and used for light weight duty and falling apart with the heavy duty use. The cabinets are currently having constant maintenance as cabinets are used 24/7 for storing files, medicines and supplies.*	$ 333,000
FLS	*DSH-Atascadero 10333 El Camino Real Atascadero, CA 93423*	***Door Repairs - Repair electromagnetic hold open devices, which automatically close when fire alarm actuated (EOC)*** *- Mitigation of safety risks in the units due to inoperable fire doors, bad magnets, and the need to address frequent repairs*	$ 333,000
		Total	**$15,000,000**

Total:	**$**	**15,000,000**
Atascadero:	$	2,063,113
Coalinga:	$	6,000,000
Metropolitan:	$	1,885,998
Napa:	$	2,500,000
Patton:	$	2,550,889

This Budget Change Proposal (BCP) is part of the "STATEWIDE COVID-19 BCP" and can be found at the Department of Finance Website.

https://esd.dof.ca.gov/dofpublic/viewBcp.html

STATE HOSPITALS

STATE HOSPITALS
LANTERMAN-PETRIS-SHORT (LPS)
POPULATION AND PERSONAL SERVICES ADJUSTMENT

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$8,102**	**$8,102**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Reimbursement Authority	*0.0*	*0.0*	*0.0*	*$0*	*$8,102*	*$8,102*

BACKGROUND:

The Lanterman-Petris-Short (LPS) collections methodology is a combination of actual bed collections received in Fiscal Year (FY) 2018-19 and a projection of anticipated collections for the remaining months. The Department of State Hospitals (DSH) utilized a weighted average of current year collections and applied it to the remaining months of the fiscal year. The trend from FY 2017-18 displayed a continued general increase in actual bed use, which justified the request for increased reimbursement authority for FY 2018-19. These collections included patients admitted under Penal Code Section 1370.01 Misdemeanor Incompetent to Stand Trial (MIST). MIST patients were identified within the current LPS Memorandum of Understanding (MOU) as patients who could receive inpatient psychiatric care and treatment services.

MIST reimbursements are realized through the same mechanism as reimbursements for patients admitted under the LPS Act; via monthly reductions of each county's respective Health and Welfare Realignment fund appropriation. These monthly reductions reflect each county's total patient bed use but are not separated by commitment type.

Due to the increasing LPS population, DSH's reimbursement authority has become insufficient for the services provided to counties. The LPS and MIST patient populations for FY 2019-20 was 741. In the Budget Act of 2020, DSH adjusted the reimbursement authority to be an additional $5.8 million ongoing, bringing the ongoing LPS reimbursement authority to $160,092,754.

DESCRIPTION OF CHANGE:

DSH contracted with the Public Consulting Group (PCG) to review and update DSH's bed rates. The contract began on June 1, 2018 and ended December 30, 2019. The contractor evaluated DSH's bed rates and provided DSH with the methodology so DSH may independently update the bed rates annually going forward. PCG reviewed numerous reports containing DSH service use costs and frequencies from prior fiscal years. DSH is currently reviewing and finalizing the draft rates received from the contractor. Upon final approval of the new bed rates, notice will be provided to the counties in accordance with WIC requirements and implementation of the new bed rates is planned to begin on July 1, 2021.

DSH is projecting LPS collections of $177,431,362[1] in FY 2020-21; a difference of $8,102,362 from the current reimbursement authority. DSH is currently analyzing the LPS population at each hospital and will provide an update to the methodology.

[1] FY 2020-21 is a projected figure based on available data from collections through 9/24/2020.

Additionally, DSH will explore an additional current year (CY) component for future LPS Reimbursement Authority requests. DSH will provide the updated methodology and new bed rates in the FY 2021-22 May Revision.

The table below displays the LPS Reimbursement Authority, LPS collections, and the difference between the two from FY 2012-2021.

FY	LPS Reimbursement Authority	LPS Collections	Difference
2020-21	$169,329,000	$177,431,362	+$8,102,362
2019-20	$160,092,754	$167,105,483[2]	+$7,012,729
2018-19	$156,746,470	$161,567,304	+$4,820,834
2017-18	$136,627,657	$155,826,584	+19,198,927
2016-17	$137,539,100	$147,447,785	+$9,908,685
2015-16	$135,072,112	$141,964,866	+$6,892,754
2014-15	$123,419,000	$124,580,524	+$1,161,524
2013-14	$123,635,294	$123,635,294	0
2012-13	$115,991,452	$118,858,565	+$2,867,113
PPYs	-	-	+$8,477,440

[2] Updated FY 2019-20 collection amount based on actual reimbursement received.

BCP Fiscal Detail Sheet

BCP Title: Laternman-Petris-Short Population and Personal Services Adjustment | **BR Name: 4440-032-ECP-2021-GB**

Budget Request Summary

FY21

	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
539X - Other	0	8,102	8,102	8,102	8,102	8,102
Total Operating Expenses and Equipment	**$0**	**$8,102**	**$8,102**	**$8,102**	**$8,102**	**$8,102**
Total Budget Request	**$0**	**$8,102**	**$8,102**	**$8,102**	**$8,102**	**$8,102**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0995 - Reimbursements	0	8,102	8,102	8,102	8,102	8,102
Total State Operations Expenditures	**$0**	**$8,102**	**$8,102**	**$8,102**	**$8,102**	**$8,102**
Total All Funds	**$0**	**$8,102**	**$8,102**	**$8,102**	**$8,102**	**$8,102**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4410010 - Atascadero	0	162	162	162	162	162
4410030 - Metropolitan	0	3,727	3,727	3,727	3,727	3,727
4410040 - Napa	0	2,269	2,269	2,269	2,269	2,269
4410050 - Patton	0	1,944	1,944	1,944	1,944	1,944
Total All Programs	**$0**	**$8,102**	**$8,102**	**$8,102**	**$8,102**	**$8,102**

STATE HOSPITALS
DSH-METROPOLITAN INCREASED SECURE BED CAPACITY
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**-120.6**	**0.0**	**0.0**	**-$18,617**	**$0**	**$0**
One-time	*-120.6*	*0.0*	*0.0*	*-$18,617*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

To provide additional capacity to address the ongoing system-wide forensic waitlist, particularly focusing on the Incompetent to Stand Trial (IST) patient waitlist, the 2016 Budget Act included capital outlay construction funding for the Increased Secure Bed Capacity (ISBC) project at Department of State Hospital (DSH) Metropolitan. This project added security fencing and infrastructure for existing patient buildings at the hospital, which had primarily been used to house civilly committed Lanterman-Petris-Short (LPS) patients. These patients were transferred from the Continuing Treatment West (CTW) to the non-secured 100s Building in October 2018. With the new security infrastructure, these buildings can now be used for the treatment of forensic patients. Specifically, this project included:

- Enclosing the CTW Building with fencing to secure 376 beds
- Enclosing the Skilled Nursing Facility (SNF) Building with fencing to secure 129 beds
- Enclosing the adjacent park next to the CTW Building for recreation activities
- Creating a new, larger visitor center as well as expand parking facilities
- Installing required sally-ports, security kiosks, security alarms, security cameras, security lighting, and perimeter roads to ensure surveillance and access for emergency response vehicles around newly secured areas

In the 2020 Budget Act, DSH had a one-time savings of 41.7 positions and $6.5 million due to activation delays and received ongoing position authority and funding for 2.0 positions: 1.0 Pharmacist I and 1.0 Pharmacy Technician. Due to an increase of patient census, the 2.0 positions were needed to operate the reopened Satellite Pharmacy to support the five IST units.

<u>Unit Activations:</u>

Unit 1 was activated on September 23, 2019, as reported in the FY 2020-21 Governor's Budget, and Unit 2 was activated on January 29, 2020. In addition, as reported in the FY 2020-21 May Revision, DSH experienced a one-time savings of $26.5 million and 171.3 positions in FY 2019-20 and $6.8 million and 43.7 positions in FY 2020-21. These savings resulted from further unforeseen construction delays and State Fire Marshal code compliance requirements.

In the FY 2020-21 May Revision, DSH assumed delayed activation of Units 3, 4 and 5. One of the inactivated units was converted to a COVID-19 isolation unit. The other two were proposed to be used as swing space for the Continuing Treatment East (CTE) Fire Alarm project.

DESCRIPTION OF CHANGE:

As of the FY 2021-22 Governor's Budget, DSH continues to experience delays in the activation of the three remaining units. Due to COVID-19, the CTE Fire Alarm Upgrade Project and all Unit construction has been placed on hold. With these delays DSH will yield a one-time current year (CY) savings of $18.617 million and 120.6 positions. DSH-Metropolitan prioritized using the three inactive units for its COVID-19 response. One unit is utilized for isolation of patients testing positive for COVID-19 and the other two units were used so DSH-Metropolitan could create Admission Observation Units (AOUs). These AOUs are used to cohort, test and observe newly admitted patients for COVID-19 prior to being moved to a housing unit.

Prior to COVID-19, and in anticipation of the activation of Unit 3, DSH-Metropolitan hired a total of 37.0 positions as of April 2020:

- 1.0 Supervision Registered Nurse
- 10.0 Registered Nurses
- 16.0 Psychiatric Technicians
- 6.0 Psychiatric Technician Assistants
- 2.0 Psychologists
- 2.0 Clinical Social Workers

However, with the onset of COVID-19 and further construction delays, Unit 3 was not able to activate as previously scheduled. Since then, these positions have been shifted to support DSH-Metropolitan's COVID-19 response.

Activation Timeline Adjustment

Unit Activation	Number of Beds	Scheduled Activation as of 2020-21 May Revision	Scheduled Activation as of 2021-22 Governor's Budget	Change from May Revision
Unit 1	48	September 23, 2019	September 23, 2019	No change
Unit 2	48	January 29, 2020	January 29,2020	No change
Unit 3	48	November 2020	July 2021	8-month delay
Unit 4	46	November 2020	July 2021	8-month delay
Unit 5	46	January 2021	July 2021	6-month delay

The table below displays a position and funding summary of the project by fiscal year, showing the adjustments made throughout the life of the project. DSH will provide further updates in the FY 2021-22 May Revision.

DSH-Metropolitan Increased Secure Bed Capacity				
	FY 18-19	**FY 19-20**	**FY 20-21**	**FY 21-22**
FY 2018-19 Governor's Budget				
Positions	346.1	473.4	473.4	473.4
Funding	$53,085	$68,953	$68,953	$68,953
FY 2018-19 May Revision				
Positions	-183.3	-131.2	-1.2	0.0
Funding	-$28,304	-$18,374	$17	$0
FY 2019-20 Governor's Budget				
Positions	0.0	119.3	130.0	130.0
Funding	$0	$18,589	$20,117	$20,117
FY 2019-20 May Revision				
Positions	-22.5	-20.1	-128.5	-128.5
Funding	-$3,476	-$3,055	-$19,850	-$19,850
FY 2020-21 Governor's Budget				
Positions	0.0	-51.1	2.0	2.0
Funding	$0	-$7,928	$294	$294
FY 2020-21 May Revision				
Positions	0.0	-171.3	-43.7	0.0
Funding	$0	-$26,455	-$6,758	$0
FY 2021-22 Governor's Budget				
Positions	0.0	0.0	-120.6	0.0
Funding	$0	$0	-$18,617	$0
Total Request by Year Ongoing				
Positions	140.3	219.0	311.4	476.9
Funding	$21,305	$31,730	$44,156	$69,514

BCP Fiscal Detail Sheet

BCP Title: DSH - Metro ISBC | **BR Name: 4440-028-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	-120.6	0.0	0.0	0.0	0.0	0.0
Total Positions	**-120.6**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	-11,197	0	0	0	0	0
Total Salaries and Wages	**$-11,197**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-5,490	0	0	0	0	0
Total Personal Services	**$-16,687**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-964	0	0	0	0	0
5304 - Communications	-121	0	0	0	0	0
5320 - Travel: In-State	-121	0	0	0	0	0
5324 - Facilities Operation	-603	0	0	0	0	0
5346 - Information Technology	-121	0	0	0	0	0
Total Operating Expenses and Equipment	**$-1,930**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-18,617**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-18,617	0	0	0	0	0
Total State Operations Expenditures	**$-18,617**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-18,617**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	-121	0	0	0	0	0
4410030 - Metropolitan	-18,496	0	0	0	0	0
Total All Programs	**$-18,617**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I				-3.7	0.0	0.0	0.0	0.0	0.0
7552 - Physician & Surgeon (Safety)				-1.6	0.0	0.0	0.0	0.0	0.0
7619 - Staff Psychiatrist (Safety)				-6.9	0.0	0.0	0.0	0.0	0.0
8094 - Registered Nurse (Safety)				-27.9	0.0	0.0	0.0	0.0	0.0
8104 - Unit Supvr (Safety)				-1.8	0.0	0.0	0.0	0.0	0.0
8252 - Sr Psych Techn (Safety)				-9.7	0.0	0.0	0.0	0.0	0.0
8253 - Psych Techn (Safety)				-48.3	0.0	0.0	0.0	0.0	0.0
8324 - Rehab Therapist (Recr-Safety)				-6.9	0.0	0.0	0.0	0.0	0.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety				-6.9	0.0	0.0	0.0	0.0	0.0
9873 - Psychologist (Hlth Facility-Clinical-Safety)				-6.9	0.0	0.0	0.0	0.0	0.0
Total Positions				**-120.**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2011 - Custodian I	-122	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-363	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	-1,871	0	0	0	0	0
8094 - Registered Nurse (Safety)	-2,879	0	0	0	0	0
8104 - Unit Supvr (Safety)	-168	0	0	0	0	0
8252 - Sr Psych Techn (Safety)	-738	0	0	0	0	0
8253 - Psych Techn (Safety)	-3,182	0	0	0	0	0
8324 - Rehab Therapist (Recr-Safety)	-552	0	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	-586	0	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-736	0	0	0	0	0
Total Salaries and Wages	**$-11,197**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-153	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-55	0	0	0	0	0
5150350 - Health Insurance	-773	0	0	0	0	0
5150450 - Medicare Taxation	-162	0	0	0	0	0

5150500	-	OASDI	-8	0	0	0	0	0
5150620	-	Retirement - Public Employees - Safety	-2,385	0	0	0	0	0
5150630	-	Retirement - Public Employees - Miscellaneous	-36	0	0	0	0	0
5150700	-	Unemployment Insurance	-11	0	0	0	0	0
5150800	-	Workers' Compensation	-505	0	0	0	0	0
5150900	-	Staff Benefits - Other	-1,402	0	0	0	0	0
Total Staff Benefits			**$-5,490**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services			**$-16,687**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
ENHANCED TREATMENT PROGRAM (ETP) STAFFING
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**-30.1**	**-11.6**	**0.0**	**-$4,711**	**-$1,776**	**$0**
One-time	*-30.1*	*-11.6*	*0.0*	*-$4,711*	*-$1,776*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

The Enhanced Treatment Program (ETP) will accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment. The ETP will provide treatment intended to return patients to a standard treatment environment, with supports that prevent future aggression while increasing safety in the facility and protecting patients and staff from harm. As such, the ETP will provide enhanced treatment, staffing, security and implement an admissions and treatment planning processes that identify and address patients' violence risk factors.

Assembly Bill (AB) 1340, Statutes of 2014, established the admissions process in statute. It is designed to identify patients at the highest risk of violence and address their risk factors. Admission into the ETP will be initiated by the referring state hospital Psychiatrist or Psychologist. The patient will then be assessed by a dedicated Forensic Psychologist who makes an initial assessment of the appropriateness of the referral. If the referral is determined to be appropriate, the patient will be evaluated by a Forensic Needs Assessment Panel (FNAP) comprised of a State Hospital Medical Director, Psychiatrist, and Psychologist. If the FNAP certifies the patient for admission into the ETP, the patient will be referred to a Forensic Needs Assessment Team (FNAT) Psychologist. The FNAT will then conduct an in-depth violence risk assessment and develop a treatment plan in coordination with the multi-disciplinary team assigned to the unit. The FNAT Psychologists are dedicated to the ongoing management and treatment of ETP patients.

Per AB 1340, treatment is the ETP's focus, and every patient will receive treatment from a multi-disciplinary team comprised of 1.0 Psychiatrist, 2.0 Psychologists, 1.0 Registered Nurse, 1.0 Clinical Social Worker, 2.0 Rehabilitation Therapists, and 1.0 Psychiatric Technician. A treatment team will be assigned to each unit. Due to the acuity of the patient population, the ETP will be staffed at a higher level than the Department's standard state hospital units. A nursing ratio of 1:1.5 was established for AM and PM shifts to allow for focused treatment, constant assessment of violence risk, and response in cases of an incident. A staff-to-patient ratio of 1:3 was established for the NOC shift. The direct care staff are a combination of Registered Nurses and Psychiatric Technicians. Enhanced security will also be provided by Hospital Police Officers (HPO). There will be 2.0 to 3.0 HPOs on each unit across all shifts and will be available to provide additional support and assistance in cases of emergency.

The staffing ratios were established by an interdisciplinary workgroup which included participation from Medical Directors, Clinical and Nursing Administrators, Psychiatrists, Psychologists, Rehabilitation Therapists, Psychiatric Technicians, Clinical Social Workers, Hospital Protective Services, Clinical Operations and fiscal and program staff. To establish the staffing for the ETPs, the workgroup reviewed the nursing activities performed on the Enhanced Treatment Unit at DSH-Atascadero and developed staffing scenarios based on the program and treatment schedule.

DSH is authorized to construct 4 ETP units, three 13-bed units at DSH Atascadero to serve male patients, and one 10-bed unit at DSH-Patton to serve female patients. The 2020 Budget Act included a one-time reduction of $994,000 and 9.9 positions due to delays in ETP unit construction. The reasons for the delays were various, including existing site conditions, code issues, and resulting changes required by the State Fire Marshal. In addition, DSH-Patton ETP construction at Unit U-06 was delayed due to an extended regulatory review process and an unsuccessful initial bid process.

DESCRIPTION OF CHANGE:

ETP Activation Timeline

Units/Hospital	Construction Scheduled Initiation	Construction Scheduled Completion	Delay from 2020-21 May Revision
DSH-Atascadero Unit 29	September 24, 2018 (Actual)	December 2020	7-month delay
DSH-Atascadero Unit 33	July 2021	February 2022	15-month delay
DSH-Atascadero Unit 34	July 2021	February 2022	15-month delay
DSH-Patton Unit U-06	July 2021	December 2021	5-month delay

DSH-Atascadero ETP construction at Unit 29 experienced continued delays due to existing site conditions, code issues and resulting changes required by the State Fire Marshal. Unforeseen conditions such as unknown regular and low voltage electrical conduits, materials damage and unexpected ductwork also contributed to delays. The contractor had challenges with the availability of labor, material deliveries, and subcontractor scheduling, all of which exacerbated the already existing construction delays. In addition, one subcontractor had to be rescheduled as some employees tested positive for COVID-19 prior to working on-site. State Fire Marshal approval of the fire alarm system was delayed until November 15, 2020 due to the California wildfires. As a result of the delayed approval and other delays referenced above, construction will extend into December 2020.

Technology services subcontractors are anticipated to install video surveillance cameras and intercom systems in Unit 29 in December 2020. Once all construction work is completed, the unit will be cleaned, furnished, and prepared for occupancy. The California Department of Public Health licensing survey will then be scheduled. DSH estimates completion and licensure to be in January 2021. ETP staff training was scheduled in November and December 2020 with for a planned mid-January 2021 unit activation. However, due to a COVID-19 outbreak at DSH-Atascadero, this training was delayed, thus delaying the planned activation. DSH currently estimates activation may occur in Spring 2021, however, the activation date could be further delayed by COVID-19 conditions at DSH-Atascadero. DSH will provide updates in the May Revision.

In August 2020, construction of Unit 33 and Unit 34 at DSH-Atascadero was suspended temporarily due to the ongoing uncertainties related to COVID-19. The suspension continues, however DSH is targeting July 2021 to resume construction on Units 33 and 34, with an anticipated activation date of February 2022.

In February 2020, the DSH-Patton U-06 Building fire sprinkler installation project commenced. This project must be completed prior to beginning ETP construction at unit U-06. However, in June 2020, shortly after installation began, construction was suspended temporarily due to COVID-19 and the need to utilize this Unit for COVID-19 response in the interim.. Currently DSH is targeting resumption of the fire sprinkler project in July 2021, with subsequent Unit U-06 ETP construction anticipated to begin in January 2022. Unit activation is projected to be completed by May 2022. DSH will provide

updates in the May Revision.

ETP Funding and Position Authority

The 2019 Budget Act included $640,000 in one-time funds for a service contract proposed for the completion of cabling installation in Units 33, 34 and U-06. Due to construction delays, DSH anticipated cabling installation would not be completed in Units 33, 34 or Unit 06 until after August 2020 and recognized a one-time savings of $581,037, which was re-appropriated along with additional unforeseen increase in cost.

Due to the delays identified above, DSH anticipates a one-time savings in Information Technology Equipment and Services of $254,000 and $4,457,000 in positions, resulting in a total savings in FY 2020-21 of $4,711,000 and 30.1 positions and a BY one-time savings in FY 2021-22 of $1,776,000 and a reduction of 11.6 positions.

Please see the chart below for a breakdown of ETP funding and position authority as of the 2021-22 Governor Budget

ETP Cost Breakdown
Dollars in Thousands

Timeframe	2017-18	2018-19	2019-20	2020-21	2021-22
2017 Budget Act	*$7,990*	*$15,228*	*$15,249*	*$15,249*	*$15,249*
2018-19 Governor's Budget	($4,953)	$2,835	$8,350	$8,350	$8,350
2018-19 May Revision	($4,883)	($4,571)	$8,300	$8,782	$8,782
Total as of 2018 Budget Act	*$3,107*	*$10,657*	*$23,549*	*$24,031*	*$24,031*
2019-20 Governor's Budget	$0	$0	($1,765)	$0	$0
2019-20 May Revision	$0	($2,616)	($716)	$0	$0
Total as of 2019 Budget Act	*$3,107*	*$8,041*	*$21,068*	*$24,031*	*$24,031*
2020-21 Governor's Budget	$0	$0	($5,330)	$385	$0
2020-21 May Revision	$0	$0	($3,085)	($1,385)	$0
Total as of 2020 Budget Act	*$3,107*	*$8,041*	*$12,653*	*$23,031*	*$24,031*
2021-22 Governor's Budget	$0	$0	$0	($4,711)	($1,776)
Total:	**$3,107**	**$8,041**	**$12,653**	**$18,320**	**$22,255**

ETP Position Authority Breakdown

DSH-Atascadero Units 29 & 33	2017-18	2018-19	2019-20	2020-21	2021-22
FY 2017-18 Governor's Budget	44.7	115.1	115.1	115.1	115.1
FY 2018-19 Governor's Budget	-35.8	0.0	0.0	0.0	0.0
FY 2018-19 May Revision	0.0	-57.9	0.0	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	0.0	0.0	0.0
FY 2019-20 May Revision	0.0	-7.1	-3.4	0.0	0.0
FY 2020-21 Governor's Budget	0.0	0.0	-26.7	0.0	0.0
FY 2020-21 May Revision	0.0	0.0	-21.1	-6.0	0.0
FY 2021-22 Governor's Budget	0.0	0.0	0.0	-21.1	-5.0
Total Authority Ongoing	**8.9**	**50.1**	**63.9**	**88.0**	**110.1**
DSH-Atascadero Unit 34 & DSH-Patton Unit U-06	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**
FY 2017-18 Governor's Budget	0.0	0.0	0.0	0.0	0.0
FY 2018-19 Governor's Budget	0.0	23.2	65.7	65.7	65.7
FY 2018-19 May Revision	0.0	-22.2	-5.4	0.0	0.0
FY 2019-20 Governor's Budget	0.0	0.0	-12.7	0.0	0.0
FY 2019-20 May Revision	0.0	0.0	5.7	0.0	0.0
FY 2020-21 Governor's Budget	0.0	0.0	-5.6	-1.5	0.0
FY 2020-21 May Revision	0.0	0.0	0.0	-2.4	0.0
FY 2021-22 Governor's Budget	0.0	0.0	0.0	-9.0	-6.6
Total Authority Ongoing	**0.0**	**1.0**	**47.7**	**52.8**	**59.1**

While this aspect of the proposal still yields an increase in savings, DSH is taking a more systematic approach to adjusting staffing when activation timelines change. In previous updates, when savings were scored DSH would delay every position associated with the proposal. However, the Department has already filled certain positions with the emphasis on those necessary in developing the infrastructure for the ETP. The positions DSH does not anticipate scoring savings on are related to management, supervisors, information technology, human resources, and protective services. DSH does not propose adjusting the management and supervisory positions because those positions are primarily responsible for establishing the ETP units, developing policies and procedures, and setting-up program objectives and goals. In addition, management and supervisors are responsible for staffing the units, security coordination, and assisting with preparing the units and licensing efforts once construction is complete. DSH's staffing and associated scored funding relate directly to the treatment team and other unit-based staffing, which will be filled upon unit activations.

BCP Fiscal Detail Sheet

BCP Title: Enhanced Treatment Program | **BR Name: 4440-030-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	-30.1	-11.6	0.0	0.0	0.0	0.0
Total Positions	**-30.1**	**-11.6**	**0.0**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	-2,657	-1,062	0	0	0	0
Total Salaries and Wages	**$-2,657**	**$-1,062**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-1,320	-528	0	0	0	0
Total Personal Services	**$-3,977**	**$-1,590**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-239	-91	0	0	0	0
5304 - Communications	-30	-12	0	0	0	0
5320 - Travel: In-State	-30	-12	0	0	0	0
5324 - Facilities Operation	-151	-59	0	0	0	0
5346 - Information Technology	-284	-12	0	0	0	0
Total Operating Expenses and Equipment	**$-734**	**$-186**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-4,711**	**$-1,776**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-4,711	-1,776	0	0	0	0
Total State Operations Expenditures	**$-4,711**	**$-1,776**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-4,711**	**$-1,776**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	-30	-12	0	0	0	0
4410010 - Atascadero	-4,198	-1,477	0	0	0	0
4410050 - Patton	-483	-287	0	0	0	0
Total All Programs	**$-4,711**	**$-1,776**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)				-0.8	-0.3	0.0	0.0	0.0	0.0
4588 - Assoc Accounting Analyst				-0.4	-0.2	0.0	0.0	0.0	0.0
5393 - Assoc Govtl Program Analyst				-1.2	-0.5	0.0	0.0	0.0	0.0
7619 - Staff Psychiatrist (Safety)				0.5	0.5	0.0	0.0	0.0	0.0
8094 - Registered Nurse (Safety)				-17.2	-9.2	0.0	0.0	0.0	0.0
8252 - Sr Psych Techn (Safety)				-1.6	-0.1	0.0	0.0	0.0	0.0
8253 - Psych Techn (Safety)				-4.9	0.2	0.0	0.0	0.0	0.0
8324 - Rehab Therapist (Recr-Safety)				-2.1	-1.1	0.0	0.0	0.0	0.0
9699 - Hlth Svcs Spec (Safety)				-0.8	-0.3	0.0	0.0	0.0	0.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety				0.5	0.5	0.0	0.0	0.0	0.0
9873 - Psychologist (Hlth Facility-Clinical-Safety)				-2.1	-1.1	0.0	0.0	0.0	0.0
Total Positions				**-30.1**	**-11.6**	**0.0**	**0.0**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1138 - Office Techn (Gen)	-32	-12	0	0	0	0
4588 - Assoc Accounting Analyst	-28	-14	0	0	0	0
5393 - Assoc Govtl Program Analyst	-81	-34	0	0	0	0
7619 - Staff Psychiatrist (Safety)	136	136	0	0	0	0
8094 - Registered Nurse (Safety)	-1,775	-949	0	0	0	0
8252 - Sr Psych Techn (Safety)	-122	-8	0	0	0	0
8253 - Psych Techn (Safety)	-323	13	0	0	0	0
8324 - Rehab Therapist (Recr-Safety)	-168	-88	0	0	0	0
9699 - Hlth Svcs Spec (Safety)	-82	-31	0	0	0	0
9872 - Clinical Soc Worker (Hlth/CF)-Safety	42	42	0	0	0	0
9873 - Psychologist (Hlth Facility-Clinical-Safety)	-224	-117	0	0	0	0
Total Salaries and Wages	**$-2,657**	**$-1,062**	**$0**	**$0**	**$0**	**$0**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	-37	-14	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-13	-5	0	0	0	0

Account		Description						
5150350	-	Health Insurance	-183	-74	0	0	0	0
5150450	-	Medicare Taxation	-39	-15	0	0	0	0
5150500	-	OASDI	-9	-4	0	0	0	0
5150600	-	Retirement - General	-42	-18	0	0	0	0
5150620	-	Retirement - Public Employees - Safety	-542	-216	0	0	0	0
5150700	-	Unemployment Insurance	-2	-1	0	0	0	0
5150800	-	Workers' Compensation	-120	-48	0	0	0	0
5150900	-	Staff Benefits - Other	-333	-133	0	0	0	0
Total Staff Benefits			**$-1,320**	**$-528**	**$0**	**$0**	**$0**	**$0**
Total Personal Services			**$-3,977**	**$-1,590**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
VOCATIONAL SERVICES AND PATIENT MINIMUM WAGE CASELOAD
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$100**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*-$100*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

As part of the patient treatment plan and rehabilitation process, the Department of State Hospitals (DSH) offers its patients access to the Vocational Rehabilitation Program, which serves as a therapeutic program to provide a range of vocational skills and therapeutic interventions for patients. DSH clinicians work closely with DSH Vocational Rehabilitation Program managers to incorporate a treatment plan to assist patients in developing social, occupational, life, and career skills, and confidence. This assists patients in preparing for discharge and/or transition to next level of care, successful community integration when released, obtaining future employment and reducing criminal recidivism.

The program consists of clinicians evaluating the patient's current health to determine if the patient meets the preliminary criteria to participate in the program, including medical clearance and approval, determining the patient is not a danger to themselves or others and the program will be beneficial for the patient's treatment and care. The program allows patients to be paid an hourly wage for the work performed. Patients' work consists of the following type of jobs: custodial, kitchen worker, product assembler, laundry attendant, landscaper, painter, plumbing, barber, horticulture, multimedia production, peer mentor, office clerk, and repair technician. The Vocational Rehabilitation Program strives to build and enhance patient skills through direct physical experiences patients can effectively use while in the hospital or community for employment stabilization and reduction of recidivism.

The 2019 Budget Act included $3.2 million in ongoing funding beginning in fiscal year (FY) 2019-20 for DSH to implement a new and uniform wage structure for DSH's Vocational Rehabilitation Program. This allows DSH to pay a standardized wage rate of federal minimum wage for its patients, who are not California Department of Corrections and Rehabilitation (CDCR) inmates, participating in vocational rehabilitation programs across the five state hospitals. The $3.2 million in ongoing funding included $470,000 for payroll taxes associated with payments to patient workers. DSH has since determined that the department is not required to pay these payroll taxes as DSH patient workers are not performing work as employees, but instead are participants of the rehabilitative or therapeutic programs of the hospitals. As part of the FY 2020-21 May Revision, DSH reallocated the payroll tax funds to supplement the costs of increased patient wage funding at DSH-Atascadero and to continue the implementation of a single department wide patient payroll system.

DESCRIPTION OF CHANGE:

In the FY 2021-22 Governor's Budget, DSH is reflecting a one-time estimated current year (CY) savings of $100,000. Due to COVID-19, the vocational referrals were impacted due to the restrictions on patient work and the many job sites and activities that cannot host patient workers at this time. DSH will provide an update in the FY 2021-22 May Revision.

Below is a table that reflects FY 2019-20 actual data including expenditures, average hours worked and average number of patient workers.

FY 2019-20 Actual Data

State Hospitals	Expenditures	Avg Hours Worked	Avg Number of Patient Workers
Atascadero	$671,182	57	150
Coalinga	$1,815,488	37	547
Metropolitan	$132,350	17	89
Napa	$181,694	12	167
Patton	$269,820	17	180
Sacramento	$334,000	N/A	N/A
Total:	**$3,404,535**	**140**	**1,133**

Funding

Current Year Projections
The table below displays the projected FY 2020-21 monthly average number of patient workers, monthly average hours worked per patient and total expenditures. Due to COVID-19, DSH has adjusted the projection methodology. The below projections were calculated by creating a pre-COVID-19 rate and a COVID-19 rate. DSH is projecting six months at the pre-COVID-19 rate and six months at the COVID-19 rate, with an estimation that normal patient work hours and wages will resume in early 2021. Expenditures are calculated by multiplying the average hours worked per patient, by the average number of workers, by the Federal Minimum Wage of $7.25 by 12 months per year. Totals have been rounded to the nearest thousand.

State Hospitals	Avg Hours Worked per Patient	Avg Number of Patient Workers	Expenditures
Atascadero	56	128	$624,000
Coalinga	38	490	$1,607,000
Metropolitan	17	89	$133,000
Napa	12	157	$167,000
Patton	18	147	$228,000
Sacramento	N/A	N/A	$334,000
Total:	**141**	**1,011**	**$3,093,000**

Allocation Adjustment
Comparing the base allocation from FY 2019-20 to the FY 2020-21 projections, DSH is showing a one-time estimated savings of $100,000 in CY.

State Hospitals	FY 2019-20 Allocation	FY 2020-21 Projected Expenditures	FY 2020-21 Adjustment
Atascadero	$197,000	$624,000	$427,000
Coalinga	$1,706,000	$1,607,000	-$99,000
Metropolitan	$39,000	$133,000	$94,000
Napa	$758,000	$167,000	-$591,000
Patton	$159,000	$228,000	$69,000
Sacramento	$334,000	$334,000	$0
Total:	**$3,193,000**	**$3,093,000**	**-$100,000**

Initial allocations in FY 2019-20 were determined based on a survey at each hospital to identify the number of patient workers at each location, in addition to the average number of hours worked. As DSH activated this new program and actual expenditures began to post, it was observed that some of the hospital allocations needed to be adjusted. This information was utilized to alter the allocations for FY 2020-21 to be more aligned with each hospital's need.

Fusion II Payroll System

The FY 2020-2021 May Revision permanently reallocated $200,000 of the payroll tax funds to support the patient payroll system. It was determined that the existing patient payroll system used by the DSH-Atascadero trust office could be expanded to accommodate the tracking of patient wages for DSH-Atascadero and all state hospitals. Fusion II was acquired in June 2020 and is scheduled to be fully implemented at all hospitals by June 2021. This will replace the antiquated TACS II system and provide a single, uniform patient payroll and trust accounting system at all state hospitals.

Implementation at DSH-Atascadero is scheduled to be completed by March 2021 and all other hospitals are scheduled to be implemented by June 2021. Fusion II is a cloud-based solution to payroll and patient trust accounting. It has very little management overhead, all of which will be assumed at the administrative level of each hospital. The interface providing patient data to Fusion II will be automated, updating throughout the day at regular intervals (every 10 minutes), in addition to a nightly sync, which will update all current patient data in Fusion II.

The trust office business processes will remain essentially the same in the new system. Staff will continue to do their day to day business operations (i.e. Deposits, disbursements, patient admitting and discharging, cost of care, and reporting). Patient data is retrieved from DSH systems using a DSH developed interface based on the data required by Fusion II. Accounts Receivable and Payables transactions will be recorded individually for each patient. DSH will also use Fusion II for their commissary software. Charges will be updated in the patient data in Fusion II via the automated interface.

Furthermore, in the 2019 Budget Act, DSH received 1.0 positions to support the Fusion II payroll software. The Sr. Accounting Officer (Spec) position has been filled in DSH-Sacramento and is responsible for performing oversight and maintenance of the Fusion II implementation, processing of monthly reports from Fusion II and compiling data for 1099 reporting of patient earnings.

BCP Fiscal Detail Sheet

BCP Title: Vocational Services and Patient Minimum Wage Caseload **BR Name: 4440-020-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
539X - Other	-100	0	0	0	0	0
Total Operating Expenses and Equipment	**$-100**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-100**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-100	0	0	0	0	0
Total State Operations Expenditures	**$-100**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-100**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4410010 - Atascadero	427	0	0	0	0	0
4410020 - Coalinga	-99	0	0	0	0	0
4410030 - Metropolitan	94	0	0	0	0	0
4410040 - Napa	-591	0	0	0	0	0
4410050 - Patton	69	0	0	0	0	0
Total All Programs	**$-100**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION BASED REVIEW - DIRECT CARE NURSING
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$0**	**$0**
Medication Pass Psychiatric Technicians	0.0	0.0	0.0	$0	$0	$0
Afterhours Supervising Registered Nurses	0.0	0.0	0.0	$0	$0	$0

BACKGROUND:

In 2013, the Department of State Hospitals (DSH) initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to ensure past practices and staffing methodologies continue to be adequate and appropriate for the department's growing and evolving populations, as well as, consistent amongst all DSH facilities. DSH's population served has grown by 25 percent since FY 2007-08. In addition to this growth, the composition of the population has changed, becoming increasingly more forensic and geriatric. These dynamics along with the application of new treatment modalities over time necessitate the review and analysis of current staffing models.

The Clinical Staffing Study is comprised of four components: Hospital Forensic Departments, 24-Hour Care Nursing Services, Protective Services, and Treatment Planning and Delivery. Each of these components involve a comprehensive examination into current staffing practices and development of staffing methodologies. These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, safety to patients and treatment providers, and delivery of psychiatric treatment. As part of each component's assessment, the Clinical Staffing Study will review current staffing standards and practices, propose new data-driven staffing methodologies to adequately support the current populations served, assess relief factor coverage needs and review current staffing levels within core clinical and safety functions.

The staffing standard was developed through research conducted within DSH's Clinical Staffing Study and in collaboration with the Department of Finance Research and Analysis Unit through a Mission-Based Review. The proposal examined nurse-to-patient ratios for providing 24-hour nursing care and the components available to achieve these ratios including internal registries, overtime, and position movements among facilities. The proposal additionally presented staffing methodologies for the administration of medication and the afterhours nursing supervisory structure. All methodologies will be re-assessed annually with updates provided within the annual DSH Caseload Estimate.

The 2019 Budget Act included a total of 379.5 positions and $46 million, phased in over three years, to support the workload of providing 24-hour care nursing services within DSH.

The 2020 Budget Act shifted resources in response to the economic impacts of the COVID-19 pandemic. The positions were shifted based on need and updated to be phased-in across a four-year period. Below is a table displaying the shift in phase-in.

Fiscal Year 2019-2020	7/1/2019 Positions	10/1/2019 Positions	1/1/2020 Positions	4/1/2020 Positions	Total	Filled	Position Savings
Psychiatric Technician	0.0	19.7	12.6	0.0	**32.3**	**32.3**	**0.0**
Supervising Registered Nurse	0.0	0.0	1.5	0.0	**1.5**	**1.5**	**0.0**
TOTAL	**0.0**	**19.7**	**14.1**	**0.0**	**33.8**	**33.8**	**0.0**

Fiscal Year 2020-2021	7/1/2020 Positions	10/1/2020 Positions	1/1/2021 Positions	4/1/2021 Positions	Total	Filled	Position Savings
Psychiatric Technician	19.2	27.7	16.0	8.0	**70.9**	**19.2**	**0.0**
Supervising Registered Nurse	7.5	0.0	0.0	0.0	**7.5**	**7.5**	**0.0**
TOTAL	**26.7**	**27.7**	**29.1**	**8.0**	**78.4**	**26.7**	**0.0**

Fiscal Year 2021-2022	7/1/2021 Positions	10/1/2021 Positions	1/1/2022 Positions	4/1/2022 Positions	Total	Filled	Position Savings
Psychiatric Technician	45.3	25.5	17.0	8.5	**96.3**	**0.0**	**0.0**
Supervising Registered Nurse	35.5	0.0	0.0	0.0	**35.5**	**0.0**	**0.0**
TOTAL	**80.8**	**25.5**	**17.0**	**8.5**	**131.8**	**0.0**	**0.0**

Fiscal Year 2022-2023	7/1/2022 Positions	10/1/2022 Positions	1/1/2023 Positions	4/1/2023 Positions	Total	Filled	Position Savings
Psychiatric Technician	51.0	25.5	13.3	6.0	**95.8**	**0.0**	**0.0**
Supervising Registered Nurse	0.0	0.0	0.0	0.0	**0.0**	**0.0**	**0.0**
TOTAL	**51.0**	**25.5**	**13.3**	**6.0**	**95.8**	**0.0**	**0.0**

Fiscal Year 2023-2024	7/1/2023 Positions	10/1/2023 Positions	1/1/2024 Positions	4/1/2024 Positions	Total	Filled	Position Savings
Psychiatric Technician	39.8	0.0	0.0	0.0	**39.8**	**0.0**	**0.0**
Supervising Registered Nurse	0.0	0.0	0.0	0.0	**0.0**	**0.0**	**0.0**
TOTAL	**39.8**	**0.0**	**0.0**	**0.0**	**39.8**	**0.0**	**0.0**

DESCRIPTION OF CHANGE:

Medication Pass Psychiatric Technicians

In the FY 2019-20 Governor’s Budget, a total of 335.0 positions were allocated to support the Medication Pass rooms to be phased-in over three years. In the FY 2020-21 May Revision, all recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing exposure. DSH adjusted the 335.0 positions to be phased-in over five years. The phase-in resumed in July of 2020. As of November 1, 2020, 51.5 positions have been established and 51.5 have been filled.

Afterhours Supervising Registered Nurses (SRNs)

In the FY 2019-20 Governor’s Budget, a total of 44.5 positions were allocated to provide nursing supervision afterhours to be phased-in over one year. In the FY 2020-21 May Revision, all recruitment efforts were paused, and resources shifted to focus on managing the COVID-19 priorities and minimizing exposure. DSH adjusted the 44.5 positions to be phased-in over two years. As of November 1, 2020, 9.0 positions have been established and 13.0 have been filled. DSH-Napa had the opportunity to hire an additional 4.0 SRNs into the blanket. The 4.0 blanket positions are currently being funded through DSH-Napa’s existing funding authority. Once funding and position authority become available through the phase-in implementation in FY 2021-22, the 4.0 positions will be made permanent.

Alignment of Position Authority

The proposal reallocated position authority between the hospitals to provide DSH-Metropolitan and DSH-Napa authorized positions to meet the need identified by the BCP. The redistribution allows all hospitals to staff between 88 and 93 percent of need. This effort redistributes position authority only and does not reallocate funding.

As of November 1, 2020, the hospital position shifts are in the following status:

- DSH-Atascadero had shifted 112.0 positions out of 132.0
- DSH-Coalinga had shifted 55.0 positions out of 76.1
- DSH-Patton had shifted 27.4 positions out of 27.4
- Once all position shifts are complete, this will equate to a total gain of 142.5 positions for DSH-Metropolitan and 93.0 positions for DSH-Napa

Due to current filled positions and recruitment efforts in process, some of the vacant positions originally identified in the BCP to move between hospitals are no longer vacant, and therefore unavailable to be shifted to a different location. DSH will continue to work with the hospitals to identify remaining positions to be shifted as vacancies are identified. As of November 1, 2020, 68.0 of the shifted positions have been filled and recruitment and hiring efforts continue at DSH-Napa and DSH-Metropolitan to fill the remaining positions. In addition, as the positions are filled, DSH-Napa has experienced a 4.7 percent decrease in overtime use. An update on the total number of shifted positions and the status of the backfill will be provided in the FY 2021-22 May Revision.

DSH continuously recruits and hires for all nursing positions and will increase efforts as needed to fill new and vacated positions. To serve as a point of reference, from July 2020 to September 2020 DSH hired over 238.0 nursing personnel. The table below displays the total number hired by hospital and classification.

Total Nursing Personnel Hired
July 2020 – September 2020

Classification	DSH-Atascadero	DSH-Coalinga	DSH-Metropolitan	DSH-Napa	DSH-Patton	Total
Registered Nurse/SF	9.0	6.0	19.0	19.0	22.0	**75.0**
Psych Tech A/S	2.0	1.0	0.0	9.0	0.0	**12.0**
Psych Tech/S	31.0	26.0	22.0	13.0	52.0	**144.0**
License Voc Nurse/SF	0.0	2.0	3.0	1.0	1.0	**7.0**
TOTAL:	**42.0**	**35.0**	**44.0**	**42.0**	**75.0**	**238.0**

Temporary Help and Contracted Help Hours

Temporary help position authority is used to meet intermittent nursing staffing needs. The Direct Care Nursing Budget Change Proposal (BCP) added 254.0 temporary help position authority to better align budgeted levels with the levels used during FY 2017-18.

The alignment of position authority shifted positions from DSH-Atascadero, DSH-Coalinga, and DSH-Patton. As a result, these hospitals had less position authority (90% for DSH-Atascadero and DSH-Coalinga, and 93% for DSH-Patton) and couldn't meet 100% of their staffing needs. In addition, the alignment of position authority will bring DSH-Metropolitan and DSH-Napa to 88% of their staffing needs once all the position shifts are complete. In order for the hospitals to meet 100% of their staffing needs, the BCP provided temporary help authority (30.1 for DSH-Atascadero, 28.0 for DSH-Coalinga, 67.2 for DSH-Metropolitan, 47.5 for DSH-Napa, and 81.2 for DSH-Patton) that are funded by using current Operating Expenses funds. The combination of permanent positions, temporary help, and overtime will allow all hospitals to meet 100% of their staffing needs.

The table below summarizes how the hospitals will meet 100 percent of their staffing needs

	DSH-Atascadero		DSH-Coalinga		DSH-Metropolitan		DSH-Napa		DSH-Patton	
	Positions	% of Need	Positions	% of Need	Positions	% of Need	Positions	% of Need	Positions	% of Need
Positions Needed	1,003.6	-	989.5	-	803.4	-	1,204.6	-	1,164.7	-
Current Positions	1,032.6	103%	964.1	97%	563.2	70%	964.9	80%	1,110.9	95%
Position Authority Shift	-132.0	-	-76.1	-	142.5	-	93.0	-	-27.4	-
Revised Position Authority	900.6	90%	888.0	90%	705.7	88%	1,057.9	88%	1,083.5	93%
Added Temporary Help	30.1	3%	28.0	3%	67.2	8%	47.5	4%	81.2	7%
Added Overtime (Position Equivalent)	-72.9	7%	-73.5	7%	-30.5	4%	-99.2	8%	0.0	0%
Revised Staffing Total:	**1,003.6**	**100%**	**989.5**	**100%**	**803.4**	**100%**	**1,204.6**	**100%**	**1,164.7**	**100%**

In FY 2019-20, DSH has had 350.6 temporary help positions related to the Direct Care Nursing proposal; an increase of 14.8 percent from the FY 2018-19 level of 305.27 temporary help positions. As stipulated in the original BCP, future requests will include increasing the temporary help authority to better align with hospital staffing needs and reduce overtime usage.

Redirected Off-Unit Positions

DSH identified 50.0 nursing classification positions to be redirected from administrative functions back to providing nursing services on the units. As part of this redirection of off-unit nursing staff, DSH established 50.0 administrative positions, primarily Staff Services Analysts, in order to redirect 50.0 nursing positions back to the units.

As of November 1, 2020, all 50.0 positions have been shifted back to the units or are in the process of doing so. The hospitals are currently recruiting for the administrative positions to backfill the duties for the positions redirected to the units. The FY 2021-22 May Revision will include an update in reporting on the redirected off-unit positions and will evaluate additional opportunities to redirect nursing positions back to the units.

STATE HOSPITALS
WORKFORCE DEVELOPMENT FOR PSYCHIATRIC RESIDENCY PROGRAMS AND PSYCHIATRIC TECHNICIANS
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$425**	**$0**	**$0**
Psychiatric Residency Program	0.0	0.0	0.0	-$239	$0	$0
Psychiatric Technician Program	0.0	0.0	0.0	-$186	$0	$0

BACKGROUND:

The provision of mental health care requires attracting and retaining a sufficient workforce of trained medical professionals, psychologists, social workers, rehabilitative therapists and nursing staff. This BCP focused on psychiatrists and nursing level of care staff due to the high vacancy rates in these classifications. In California, a medical doctor specializing in the diagnosis, treatment, and prevention of mental health illness must complete a four-year residency program in psychiatry in addition to specialized fellowship training to become a licensed psychiatrist.

While DSH employs a large number of psychiatrists, many positions remain vacant. DSH and other state employers of psychiatrists, such as California Department of Corrections and Rehabilitation (CDCR) are experiencing difficulties in filling these positions largely due to the nationwide shortage of psychiatrists. In addition, successful recruitment is also challenged by the high-risk work environment. While nursing level of care classifications vary at DSH, this BCP focused primarily on recruitment for registered nurses (RNs) and psychiatric technicians (PTs). These two nursing classifications reflect most of the authorized nursing positions at DSH.

The 2019 Budget Act included a total of 8.0 permanent full-time positions and $1.8 in FY 2019-20, $2.2 in FY 2020-21, $2.4 million in FY 2021-22 and 2022-23 and $2.6 million in FY 2023-24 and ongoing to support the development and implementation of a Psychiatric Residency Program and expand resources for Nursing Recruitment to meet the mission of providing mental health services to patients and reduce vacancy rates for mental health providers.

Position	Program	Authority	Filled	Savings
Program Director	Residency	1.0	1.0	$0
Assistant Program Director	Residency	1.0	0.0	$66,000
Nurse Instructor	Psych Tech Program	5.0	3.0	$138,000
Associate Governmental Program Analyst	Psych Tech Program	1.0	0.0	$48,000
TOTAL		**8.0**	**4.0**	**$252,000**

DESCRIPTION OF CHANGE:

The Psychiatric Residency Program

General psychiatry residency programs provide medical school graduates an opportunity to specialize in psychiatry and thereby be exposed to mental health and forensic mental health. Through the establishment of a new residency program, residents will experience clinical rotations at DSH-Napa. As such, DSH will benefit from creating its own workforce supply to meet its increasing patient population. Overall, residents will spend a third of their time providing direct patient care to DSH patients.

DSH proposed to partner with Touro University to develop an employer consortium comprised of DSH, Touro University, as well as two additional county mental health departments to create a new Psychiatric Residency Program. DSH requested a Program Director and Assistant Program Director to establish the residency program and develop the curriculum with Touro University. The residency program will open to its first cohort of four residents and continue to add an additional four residents on-going for each year of the program, for an eventual total of 16 residents participating in the program.

As of October 1, 2020, DSH has completed the Master Affiliation agreements with St. Joseph Medical Center (SJMC) to create the new Residency Program. DSH has hired an Associate Psychiatry Program Director for Psychiatry Residency program at DSH-Napa. DSH's Associate Program Director will work closely with the new Program Director at SJMC. With the filling of these critical roles, the residents' rotation schedules have been developed and the final application to the Accreditation Council for Graduate Medical Education (ACGME) has been submitted. DSH-Napa has had its first site visit with the ACGME in October 2020 and will schedule more visits prior to receiving certification. Suitable candidates for DSH's Assistant Program Director for the residency program have not yet been found. In order to increase the candidate pool, DSH is recruiting for other position classifications that may be appropriate for this role. In July 2020, DSH anticipated 4.0 residents to have been recruited, however, this has been delayed to July 2021. Due to delays in program activation, DSH expects a one-time savings of $173,000. The Assistant Program Director position is expected to be filled by November 30, 2020. This delay will cause a one-time savings of $66,000 in FY 2020-21.

Psychiatric Technician Program

California Welfare and Institutions Code - WIC § 4320 requires DSH to establish an education and training program to provide an adequate supply of psychiatric technicians for state hospitals and states that DSH "shall establish in state hospitals a course of study and training equivalent, as determined by the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to the minimum requirements of an accredited program for psychiatric technicians in the state". "This section shall not be construed to reduce the effort presently expended by the community college system or private colleges in training psychiatric technicians".

DSH's long-term solution to fill vacancies for nursing level of care staff is to continue and/or expand partnerships with local community colleges to increase class sizes and/or number of available cohorts. This will immediately result in more RN and PT candidates available to work at DSH hospitals. With the approved BCP, DSH would hire five Nurse Instructors to provide additional instructional resources to increase the number of RN and PT candidates within the local community colleges. Strengthening this partnership between DSH and local community colleges will allow colleges to tailor their curriculum and recruitment efforts to better serve the DSH patient population.

The Nurse Instructors will not be limited to only curriculum-based workload and will also serve as local hospital outreach coordinators. The Nurse Instructors will work collaboratively with the Sacramento Recruitment Unit to assist in the participation of candidate outreach, career fairs, and be ambassadors for DSH to partner with educational industries. The Nurse Instructors will serve as subject matter experts, guidance counselors for potential candidates going through the hiring process, and mentors for the new workforce joining DSH. To effectively coordinate these recruitment efforts, DSH proposed to expand the current Sacramento Recruitment Unit by providing one Associate Governmental Program Analyst (AGPA) in Sacramento to focus only on RN and PT recruitments statewide.

DSH-Atascadero was approved by the Board of Vocational Nursing & Psychiatric Technicians in March 2020 and supported by Cuesta College to increase the program class size to 45 from the current 30. However, COVID-19 safety concerns have caused clinical sites to close and the expanded class size of 45 students will start in May 2021. The 3.0 Nursing Instructor positions allotted have been filled and over 300 potential students registered to attend the virtual career fair at the hospital.

DSH-Coalinga was to finalize a contract agreement for the Psychiatric Technician Program at West Hills College (WHC), however, WHC does not have the need to use DSH's Nurse Instructors with class sizes below 30 as WHC can accommodate 30 students with current faculty. WHC will only use DSH Nurse Instructors for class sizes of 45 students per the contract agreement. However, due to COVID-19 safety protocols and security issues that do not allow for class sizes over 30 students for on-site visits at DSH-Coalinga, the partnership between WHC and DSH-Coalinga has been delayed. DSH-Coalinga will not fill the 1.0 Nurse Instructor position until the classes resume a size of 45 students. This delay will cause a one-time savings of $69,000 in FY 2020-21.

DSH-Napa executed the contractual agreement with Napa Valley College and is now advertising the 1.0 Nurse Instructor position. The position is expected to be filled by November 30, 2020. The delay has caused a one-time savings of $69,000 in FY 2020-21.

DSH-Sacramento will be expanding their efforts for RN and PT recruitments statewide. The DSH Recruitment Unit continues with cold calls and emails to 144 Nursing schools and 14 Psychiatric Technician Schools in California, offering to provide career counseling and outreach opportunities to students who might be interested in enrolling in the Psychiatric Technician Program. The approved AGPA position to expand recruitment efforts has been delayed. The position was filled by in October 31, 2020. Due to the delay in hiring DSH yields a one-time savings of $48,000 in FY 2020-21.

BCP Fiscal Detail Sheet

BCP Title: Workforce Development **BR Name: 4440-029-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Salaries and Wages						
Earnings - Permanent	-145	0	0	0	0	0
Total Salaries and Wages	**$-145**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-80	0	0	0	0	0
Total Personal Services	**$-225**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-12	0	0	0	0	0
5304 - Communications	-1	0	0	0	0	0
5320 - Travel: In-State	-1	0	0	0	0	0
5324 - Facilities Operation	-8	0	0	0	0	0
5340 - Consulting and Professional Services - External	-173	0	0	0	0	0
5346 - Information Technology	-5	0	0	0	0	0
Total Operating Expenses and Equipment	**$-200**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-425**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-425	0	0	0	0	0
Total State Operations Expenditures	**$-425**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-425**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	-53	0	0	0	0	0
4410020 - Coalinga	-67	0	0	0	0	0
4410040 - Napa	-305	0	0	0	0	0
Total All Programs	**$-425**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5393 - Assoc Govtl Program Analyst	-26	0	0	0	0	0
8102 - Program Asst	-37	0	0	0	0	0
8154 - Nurse Instructor	-82	0	0	0	0	0
Total Salaries and Wages	**$-145**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-1	0	0	0	0	0
5150350 - Health Insurance	-10	0	0	0	0	0
5150450 - Medicare Taxation	-2	0	0	0	0	0
5150500 - OASDI	-4	0	0	0	0	0
5150620 - Retirement - Public Employees - Safety	-20	0	0	0	0	0
5150630 - Retirement - Public Employees - Miscellaneous	-17	0	0	0	0	0
5150800 - Workers' Compensation	-8	0	0	0	0	0
5150900 - Staff Benefits - Other	-18	0	0	0	0	0
Total Staff Benefits	**$-80**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-225**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION BASED REVIEW-COURT EVALUATIONS AND REPORTS
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$314**	**$0**	**$0**
Evaluations, Court Reports and Testimony	*0.0*	*0.0*	*0.0*	*-$76*	*$0*	*$0*
Forensic Case Management and Tracking	*0.0*	*0.0*	*0.0*	*-$39*	*$0*	*$0*
Neuropsychological Services	*0.0*	*0.0*	*0.0*	*-$199*	*$0*	*$0*

BACKGROUND:

In 2013, the Department of State Hospitals (DSH) initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to ensure past practices and staffing methodologies continue to be adequate and appropriate for the department's growing and evolving populations, as well as, consistent amongst all DSH facilities. DSH's population served has grown by 25 percent since FY 2007-08. In addition to this growth, the composition of the population has changed, becoming increasingly more forensic and geriatric. These dynamics along with the application of new treatment modalities over time necessitate the review and analysis of current staffing models.

The Clinical Staffing Study is comprised of four components: Hospital Forensic Departments, 24-Hour Care Nursing Services, Protective Services, and Treatment Planning and Delivery. Each of these components involve a comprehensive examination into current staffing practices and development of staffing methodologies. These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, safety to patients and treatment providers, and delivery of psychiatric treatment. As part of each component's assessment, the Clinical Staffing Study was designed to review current staffing standards and practices, propose new data-driven staffing methodologies to adequately support the current populations served, assess relief factor coverage needs and review current staffing levels within core clinical and safety functions.

As part of DSH's staffing study efforts and in collaboration with the Department of Finance Research and Analysis Unit through a Mission-Based Review, the process for completing all forensic services workload within each hospital's Forensic Services Department was examined. This examination involved review of all statutory language directing the commitment and treatment of patients, depiction of the forensic process (i.e., flow charts) from commitment to discharge for each commitment type, review of datasets available to document the throughput of the process and convening a multitude of subject matter expert interviews to document current practices and challenges. This in-depth review lead to the proposed methodologies for staffing each component of Forensic Services.

The 2019 Budget Act included 94.6 permanent full-time positions and $40,227,000, phased-in over three years, to implement a staffing standard to support the forensic services workload associated with court-directed patient treatment. The standard establishes population-driven methods for calculating staffing needs for the following forensic functions: Evaluations, Court Reports and Testimony, Forensic Case Management and Data Tracking and Neuropsychological Services (Neuropsychological Assessments and Cognitive Remediation Pilot Program).

The 2020 Budget Act shifted some of the resources approved in the 2019 Budget Act into the out years in response to the economic impact of the COVID-19 pandemic. The positions were shifted based on need and phased-in across a four-year period. The following tables display the shift in phase-in.

Evaluations, Court Reports and Testimony	7/1/2019	1/1/2021	7/1/2021	1/1/2022	7/1/2022	Total	Filled	Position Savings
Senior Psychiatrist Supervisor	0.0	1.0	1.0	0.0	0.0	**2.0**	**0.0**	**0.0**
Senior Psychiatrist Specialist	0.0	0.8	0.8	1.8	1.8	**5.1**	**0.0**	**0.0**
Staff Psychiatrist	-0.5	0.0	0.0	0.0	0.0	**-0.5**	**-0.5**	**0.0**
Senior Psychologist Supervisor	2.0	1.6	1.6	0.4	0.4	**5.9**	**2.0**	**0.0**
Senior Psychologist Specialist	26.8	4.2	4.2	5.1	5.1	**45.2**	**25.8**	**1.0**
Psychologist - Clinical	-10.5	0.0	0.0	0.0	0.0	**-10.5**	**-10.5**	**0.0**
Consulting Psychologist	2.0	1.0	1.0	0.5	0.5	**4.9**	**2.0**	**0.0**
Research Data Specialist II	1.0	0.0	0.0	0.0	0.0	**1.0**	**1.0**	**0.0**
TOTAL	**20.8**	**8.5**	**8.5**	**7.7**	**7.7**	**53.1**	**19.8**	**1.0**

Case Management and Data Tracking	7/1/2019	1/1/2021	7/1/2021	1/1/2022	7/1/2022	Total	Filled	Position Savings
Staff Services Manager I	1.0	0.0	0.0	0.0	0.0	**1.0**	**1.0**	**0.0**
Correctional Case Records Supervisor	-1.0	0.0	0.0	0.0	0.0	**-1.0**	**-1.0**	**0.0**
Psychiatric Technician	-6.0	0.0	0.0	0.0	0.0	**-6.0**	**-6.0**	**0.0**
Associate Governmental Program Analyst	15.0	2.1	2.1	0.0	0.0	**19.1**	**15.0**	**0.0**
Correctional Case Records Analyst	-14.5	0.0	0.0	0.0	0.0	**-14.5**	**-14.5**	**0.0**
Staff Services Analyst	12.0	2.9	2.9	0.0	0.0	**17.7**	**11.0**	**1.0**
TOTAL	**6.5**	**4.9**	**4.9**	**0.0**	**0.0**	**16.3**	**5.5**	**1.0**

Neuropsycho-logical Services	7/1/2019	1/1/2021	7/1/2021	1/1/2022	7/1/2022	Total	Filled	Position Savings
NEUROPSYCHOLOGICAL ASSESSMENTS AND TREATMENT								
Senior Psychologist Supervisor	2.0	0.8	0.8	0.0	0.0	**3.5**	**2.0**	**0.0**
Senior Psychologist Specialist	4.0	1.8	1.9	0.0	0.0	**7.7**	**4.0**	**0.0**
COGNITIVE REMEDIATION PILOT PROGRAM								
Senior Psychologist Specialist	3.0	0.5	0.5	0.0	0.0	**4.0**	**1.0**	**2.0**
Psychiatric Technician	4.0	3.0	3.0	0.0	0.0	**10.0**	**3.0**	**1.0**
TOTAL	**13.0**	**6.1**	**6.2**	**0.0**	**0.0**	**25.2**	**10.0**	**3.0**

DECRIPTION OF CHANGE:

Evaluations, Court Reports and Testimony

In the FY 2020-21 Governor's Budget, a total of 53.1 positions were allocated to support forensic evaluations, court reports and testimony to be phased-in over three years. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing staff and patient exposure. DSH adjusted the 53.1 positions to be phased-in over four years. The next phase-in is set to begin in January 2021. As of November 1, 2020, 20.8 positions have been established and 19.8 have been filled. A one-time current year (CY) savings of $76,000 will be recognized in the FY 2021-22 Governor's Budget.

It is important to note that implementation plans are developed to estimate the number of positions which could be recruited and filled each year. The implementation phase-in plan factors in recruitment efforts and challenges but is ultimately to be used as a guide with clear hiring targets each year. Implementation plans are not intended to be limiting or prohibiting for prompt recruitment success.

Future updates will include population data (average daily census, admissions, etc.) which will be used to refine Forensic Evaluator workload methodology calculations. The hospital resources and staff currently addressing the COVID-19 pandemic have been repurposed for emergency responses. Hence, any caseload data would be skewed and wouldn't reflect normal hospital operations. In order to avoid the dangers of extrapolation, it would be prudent to gather and analyze data once the pandemic has subsided.

Forensic Case Management and Data Tracking

In the FY 2020-21 Governor's Budget, a total of 16.3 positions were allocated to support forensic case management and data tracking, phased-in over two years. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing exposure. DSH adjusted the 16.3 positions to be phased-in over three years. The next phase-in is set to begin in January 2021. As of November 1, 2020, 6.5 positions have been established and 5.5 have been filled. A one-time CY savings of $39,000 will be recognized in the FY 2021-22 Governor's Budget.

The Forensic Case Management and Data Tracking workload is driven based on the number of patients admitted and the average census (by commitment type) maintained within each hospital annually. The hospitals are currently addressing the COVID-19 pandemic and resources have been redirected for emergency responses. As such, any caseload data would be skewed by these efforts and wouldn’t reflect normal operations. In order to avoid the dangers of extrapolation, it would be prudent to gather and analyze data once the pandemic has subsided. The workload methodology calculations and accompanying population data will be incorporated within the biannual Caseload Estimate. Metrics associated with the methodologies and the development performance measures will be incorporated.

Neuropsychological Service

In the FY 2020-21 Governor’s Budget, a total of 25.2 positions were allocated to support neuropsychological services, phased-in over two years. This included 11.2 positions for conducting Neuropsychological Assessments and 14.0 positions in a Cognitive Remediation Pilot Program at DSH-Metropolitan and DSH-Napa. In the FY 2020-21 May Revision, recruitment efforts were paused, and resources shifted to focus on managing COVID-19 priorities and minimizing exposure. DSH adjusted the 25.2 positions to be phased-in over three years. The next phase-in is set to begin in January 2021. As of November 1, 2020, 13.0 positions have been established and 10.0 have been filled. A one-time CY savings of $199,000 will be recognized in the FY 2021-22 Governor’s Budget.

The Neuropsychological Assessments portion of the proposal conservatively assumed that 25 percent of patients would require second level cognitive assessments. Current research identifies that approximately 50 percent of all new admissions will require secondary neuropsychological testing. DSH is working to track and document all secondary Neuropsychological Assessment referrals. Future updates will include continuing assessment of available data to determine the necessary staffing levels based on the actual percentage of patients requiring a second level assessment and referral to enhanced neuropsychological services.

The Cognitive Remediation Pilot Programs are progressing at both DSH-Metropolitan and DSH-Napa. These programs focus on treatment for patients identified during second level screening as having severe neurocognitive disorders. At both DSH-Metropolitan and DSH-Napa, patients have been selected for the remediation programs and baseline assessments are occurring. Treatment space with computers has been set up and both hospitals started the first cohort group as of March 2020. As of November 1, 2020, less than 11 patients are in the program and that number is expected to increase in February 2021. Patients have been provided the use of the Brain HQ software program, which provides tools and exercises that focuses on cognitive function, attention, brain speed, memory, people skills, intelligence, and navigation.

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review - Court Evaluations and Reports | **BR Name: 4440-035-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Salaries and Wages						
Earnings - Permanent	-188	0	0	0	0	0
Total Salaries and Wages	**$-188**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-95	0	0	0	0	0
Total Personal Services	**$-283**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-16	0	0	0	0	0
5304 - Communications	-5	0	0	0	0	0
5320 - Travel: In-State	-1	0	0	0	0	0
5324 - Facilities Operation	-6	0	0	0	0	0
5346 - Information Technology	-3	0	0	0	0	0
Total Operating Expenses and Equipment	**$-31**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-314**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-314	0	0	0	0	0
Total State Operations Expenditures	**$-314**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-314**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	-3	0	0	0	0	0
4410030 - Metropolitan	-198	0	0	0	0	0
4410040 - Napa	-75	0	0	0	0	0
4410050 - Patton	-38	0	0	0	0	0
Total All Programs	**$-314**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
5157 - Staff Svcs Analyst (Gen)	-20	0	0	0	0	0
8253 - Psych Techn (Safety)	-26	0	0	0	0	0
9839 - Sr Psychologist (Hlth Facility) (Spec)	-142	0	0	0	0	0
Total Salaries and Wages	**$-188**	**$0**	**$0**	**$0**	**$0**	**$0**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	-4	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-1	0	0	0	0	0
5150350 - Health Insurance	-12	0	0	0	0	0
5150450 - Medicare Taxation	-3	0	0	0	0	0
5150500 - OASDI	-1	0	0	0	0	0
5150620 - Retirement - Public Employees - Safety	-36	0	0	0	0	0
5150630 - Retirement - Public Employees - Miscellaneous	-6	0	0	0	0	0
5150800 - Workers' Compensation	-8	0	0	0	0	0
5150900 - Staff Benefits - Other	-24	0	0	0	0	0
Total Staff Benefits	**$-95**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-283**	**$0**	**$0**	**$0**	**$0**	**$0**

STATE HOSPITALS
MISSION BASED REVIEW-TREATMENT TEAM AND PRIMARY CARE
New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**10.0**	**10.0**	**$0**	**$0**	**$0**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*10.0*	*10.0*	*$0*	*$0*	*$0*

BACKGROUND:

In 2013, the Department of State Hospitals (DSH) initiated a comprehensive effort to evaluate staffing practices among the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was conducted to ensure past practices and staffing methodologies continue to be both adequate and appropriate for the department's growing and evolving populations, and consistent among all DSH hospitals. DSH's population served has grown by 34 percent since fiscal year (FY) 2007-08, including Jail Based Competency Programs (JBCT). In addition to this growth, the structure of the population has become increasingly forensic and more geriatric. These dynamics, along with the application of new treatment methods, over time necessitate the review and analysis of current staffing models.

The Clinical Staffing Study is comprised of four components: Hospital Forensic Departments, 24-Hour Care Nursing Services, Protective Services, and Treatment Planning and Delivery. Each of these involved a comprehensive examination into current staffing practices and development of staffing methodologies. These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, safety to patients and treatment providers and delivery of psychiatric and medical treatment. As part of each component's assessment, the Clinical Staffing Study reviewed current staffing standards and practices, reviewed current staffing levels and assessed available workload data, assessed relief factor coverage needs and developed data-driven staffing methodologies to adequately support workload functions and the current populations served.

As part of DSH's staffing study efforts and in collaboration with the Department of Finance Research and Analysis Unit through a Mission-Based Review, the four core areas of Treatment Planning and Delivery were examined:

- Interdisciplinary treatment team caseload ratios and categorization of treatment and treatment units
- Primary care delivery and physician caseload
- Clinical leadership structure
- Clinical programs and best practices

The Budget Change Proposal (BCP) included in the 2020-21 Governor's Budget included a total request of 250.2 positions and $64.2 million, phased in across a five-year period, to support the workload of providing psychiatric and medical care treatment to patients committed to DSH. The phase-in requested 80.9 permanent full-time positions and $32.0 million in FY 2020-21, an additional 69.0 permanent full-time positions and $37.7 million in FY 2021-22, 48.7 permanent full-time positions and $49.7 million in FY 2022-23, 30.0 permanent full-time positions and $57.5 million in FY 2023-24 and the remaining 21.6 permanent full-time positions and $64.2 million in FY 2024-25.

Due to COVID-19, the Legislature ultimately approved the methodologies contained in the BCP but were only able to provide funding and resources for the most critical portions of the proposal, approving $5 million and 12.5 positions in FY 2020-21 and $10 million and 30.0 positions in FY 2021-22 and ongoing. This item will be reporting on the progress bi-annually, through the Enrollment, Caseload and Population (ECP) process in lieu of continuing to request the funding and positions for the remainder of the proposal.

The tables below summarize the total staffing needs as identified in the BCP and staffing study as well as the total positions received.

Total Staffing Needs:

Classification	Total Need	Current Resources	Remaining Need
Assistant Director of Dietetics	1.0	0.0	1.0
Assistant Medical Director	1.0	0.0	1.0
Associate Personnel Analyst	6.0	0.0	6.0
Chief of Primary Care Services	5.0	0.0	5.0
Chief Physician & Surgeon	11.0	5.0	6.0
Chief Psychologist	1.0	0.0	1.0
Clinical Social Worker	291.3	259.3	32.0
Medical Director	6.0	0.0	6.0
Physician & Surgeon	148.4	121.5	26.9
Program Director	1.0	0.0	1.0
Psychiatrist	287.3	224.7	62.6
Psychologist	287.3	227.6	59.7
Rehabilitation Therapist	287.3	256.3	31.0
Senior Psychiatrist Specialist	2.0	0.0	2.0
Senior Psychologist Specialist	5.0	0.0	5.0
Senior Psychologist Supervisor	1.0	0.0	1.0
Supervising Registered Nurse	1.0	0.0	1.0
Supervising Rehab Therapist	1.0	0.0	1.0
Unit Supervisor	1.0	0.0	1.0
TOTAL	**1,344.6**	**1,094.4**	**250.2**

Total Staffing Received:

Classification	Request	Received	Remaining Need
Assistant Director of Dietetics	1.0	0.0	1.0
Assistant Medical Director	1.0	0.0	1.0
Associate Personnel Analyst	6.0	0.0	6.0
Chief of Primary Care Services	5.0	5.0	0.0
Chief Physician & Surgeon	5.0	5.0	0.0
Clinical Social Worker	33.0	1.0	32.0
Medical Director	6.0	6.0	0.0
Pharmacist II	1.0	0.0	1.0
Physician & Surgeon	25.9	9.0	16.9
Physician and Surgeon	1.0	0.0	1.0
Program Director	1.0	0.0	1.0
Psychiatrist	62.6	1.0	61.6
Psychologist	59.7	1.0	58.7
Rehabilitation Therapist	31.0	1.0	30.0
Senior Psychiatrist Supervisor	1.0	0.0	1.0
Senior Psychologist Specialist	5.0	0.0	5.0
Senior Psychologist Supervisor	2.0	1.0	1.0
Supervising Registered Nurse	1.0	0.0	1.0
Supervising Rehab Therapist	1.0	0.0	1.0
Unit Supervisor	1.0	0.0	1.0
TOTAL	**250.2**	**30.0**	**220.2**

DESCRIPTION OF CHANGE:

With the augmentation of funding and resources, DSH prioritized the Clinical Executive Structure and the partial implementation of Primary Medical Care in FY 2020-21. Implementation of other components of this proposal - including the remaining primary care positions, treatment team positions, trauma-informed care, and discharge planning resources - are delayed pending further resources. DSH is implementing the following within the approved resources.:

- 4.0 Treatment Team positions at DSH-Atascadero for Coleman patients
- 5.0 Chief Physician and Surgeons
    - 1.0 additional per hospital, for a total of two per hospital, to serve as the mid-level primary care supervisors.
- 9.0 Physician and Surgeon positions allocated based on census need
- 1.0 Senior Psychologist Supervisor in Sacramento for Trauma Informed Care (TIC)
- 6.0 exempt Medical Directors; 1.0 for each hospital, including Sacramento, which will allow the Chief Psychiatrist position classification to return to serve as the Chief of Psychiatric Services for each hospital
- 5.0 exempt Chief of Primary Care Services
    - The 1.0 for each hospital, which was approved after the 2020-21 May Revision, will allow the Chief Physician and Surgeon position classification to be used as a mid-level primary care supervisor, similar to other clinical disciplines.
    - In the BCP, the Chief of Primary Care Services is known as the Chief of Medicine. The title was changed to Chief of Primary Care Services to better suit the job functions of this classification and will be referred to as such in this narrative.

- Blanket Authority for 10.0 Clinical positions to backfill resources at the hospitals that were redirected to Sacramento as part of the Clinical Operations Advisory Council (COAC)
- Exempt entitlement status for an Assistant Medical Director in Sacramento

Interdisciplinary Treatment Team

The Treatment Team is responsible for the planning and delivery of treatment, discipline-specific other workload, administrative and professional responsibilities, crisis prevention, unit milieu work and crisis and incident management. Treatment planning involves tasks required to collect information, document findings and ultimately develop, adjust and review the patient treatment plans. Treatment delivery involves various means of providing treatment to patients. This includes structured and unstructured individual and group therapy. Discipline-specific other workload varies based on each discipline's scope of practice and consists of responsibilities that do not clearly fall within other categories, including case management for clinical social workers and involuntary medication orders for psychiatrists. Administrative and professional responsibilities consist of committees and meetings clinicians are required to participate in. Crisis and incident prevention and unit milieu work regards tasks required to keep patients calm. Crisis and incident management comprises of responding to incidents and crisis situations as they occur, completing post-incident debriefs, as well as documentation and follow-up. These incidents range from verbal assault to physical incidents resulting in patients being placed on enhanced observation orders or seclusion and restraint.

Interdisciplinary Treatment Team Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for the Interdisciplinary Treatment Team.

Classification	Total Need	Current Resources	Remaining Need
Psychiatrist	286.3	224.7	61.6
Psychologist	287.3	227.6	59.7
Clinical Social Worker	286.3	259.3	27.0
Rehabilitation Therapist	287.3	256.3	31.0
TOTAL	**1,147.2**	**967.9**	**179.3**

Interdisciplinary Treatment Team Staffing Received:

The table below summarizes the total positions received for the Interdisciplinary Treatment Team.

Classification	Request	Received	Remaining Need
Psychiatrist	61.6	1.0	60.6
Psychologist	59.7	1.0	58.7
Clinical Social Worker	27.0	1.0	26.0
Rehabilitation Therapist	31.0	1.0	30.0
TOTAL	**179.3**	**4.0**	**175.3**

The revised COVID-adjusted phase-ins will establish new position authority for 4.0 positions at DSH-Atascadero specifically related to the treatment of Coleman patients. The positions to be received are: 1.0 Staff Psychiatrist, 1.0 Psychologist, 1.0 Clinical Social Worker, and 1.0 Rehab Therapist. All positions will be phased in beginning on July 1, 2021.

DSH has received 4.0 of the needed Treatment Team positions. The remaining 175.3 positions will be requested in the future as additional resources become available. New methodologies cannot be

put in place until adequate staffing levels are achieved at each hospital. These staffing levels will assist DSH in ensuring quality patient care in addition to reaching desired caseload ratios.

Primary Medical Care

Primary care positions consist of Chief Physician & Surgeons and Physician & Surgeons. The Chief Physician & Surgeon directly supervises primary care providers, and is responsible for all medical services which includes, but is not limited to, patient caseload medical services, on-site clinics, and the coordination of off-site medical services and hospitalizations. Physician & Surgeons are responsible for planning, directing, and performing all phases of the medical services provided and for making professional decisions regarding surgery and general medical work.

Primary Medical Care Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for the Primary Medical Care.

Classification	Total Need	Current Resources	Remaining Need
Chief Physician & Surgeon	11.0	5.0	6.0
Physician & Surgeon	147.4	121.5	25.9
TOTAL	**158.4**	**126.5**	**31.9**

Primary Medical Care Staffing Received:

The table below summarizes the total positions received for the Primary Medical Care.

Classification	Request	Received	Remaining Need
Chief Physician & Surgeon	6.0	5.0	1.0
Physician & Surgeon	25.9	9.0	16.9
TOTAL	**31.9**	**14.0**	**17.9**

The revised COVID-adjusted phase-ins will begin in January 1, 2021 and consist of 5.0 Chief Physician & Surgeon positions and 9.0 Physician & Surgeon positions at the hospitals. The 9.0 Physician and Surgeon positions are allocated based on staff-to-patient ratios, in which DSH-Coalinga will receive 5.0 positions, DSH-Napa 2.0 and DSH-Patton 2.0.

DSH has received 14.0 of the needed Primary Care positions. The remaining 17.9 positions will be requested in the future as additional resources become available. New methodologies cannot be put in place until adequate staffing levels are achieved at each hospital. These staffing levels will assist DSH in ensuring quality patient care in addition to reaching desired caseload ratios.

Trauma-Informed Care

The objective of the TIC team is to provide patient screening, assessments, crisis interventions, treatment programming, risk management and primary medical care. When fully implemented through the DSH system, the shift to trauma-informed care can be expected to improve diagnostic accuracy and treatment outcomes, reduce the number of aggressive incidents, and assist with targeted interventions for some of DSH's most challenging patients. Trauma-informed approaches also improve staff morale, reduce burnout and enhance performance by improving the overall treatment environment, as well as increasing safety through a reduction in violence and aggression.

Lastly, a shift to trauma-informed care will bring DSH in line with widely accepted national practices in behavioral health care and promote DSH Strategic Goals.

Trauma-Informed Care Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for Trauma-Informed Care.

Classification	Total Need	Current Resources	Remaining Need
Senior Psychologist Supervisor	1.0	0.0	1.0
Senior Psychologist Specialist	5.0	0.0	5.0
TOTAL	**6.0**	**0.0**	**6.0**

Trauma-Informed Care Staffing Received:

The table below summarizes the total positions received for Trauma-Informed Care

Classification	Request	Received	Remaining Need
Senior Psychologist Supervisor	1.0	1.0	0.0
Senior Psychologist Specialist	5.0	0.0	5.0
TOTAL	**6.0**	**1.0**	**5.0**

The revised COVID-adjusted phase-in will begin on October 1, 2020 and will consist of 1.0 Senior Psychologist Supervisor in DSH-Sacramento.

DSH has received 1.0 of the needed TIC positions. The remaining 5.0 Senior Psychologist Specialists will be requested in the future as additional resources become available. New methodologies cannot be put in place until adequate staffing levels are achieved at each hospital. These staffing levels will assist DSH in ensuring quality patient care in addition to reaching desired caseload ratios.

Discharge Strike Team

DSH patients have unique discharge planning needs based on their commitment types, with some presenting significant obstacles in finding placement due to their physical disabilities, medical conditions, history of violent behavior, pending or open criminal charges and/or the nature of their crimes. To better address discharge barriers and find placement for discharge-ready patients, DSH has identified a need to develop a statewide Discharge Strike Team to create a comprehensive discharge program.

The Discharge Strike Team will focus on establishing and strengthening relationships with placement communities to improve knowledge of various community resources, address barriers to placement and improve communication in efforts to expedite placement. These efforts will allow DSH to increase the rate of discharge and placement into a lower level of care for eligible patients.

The team will be comprised of a clinical social worker at each hospital and a program director at DSH-Sacramento, who will collaborate with hospitals to establish best practices in discharge planning and to create a comprehensive discharge planning program. Their efforts will focus on identifying community resources, local barriers and identifying needs related to discharge. The team will also engage in stakeholder education and partnership-building with behavioral health organizations and other local resources. Additionally, the team will develop curriculum and programming, establish standards of performance necessary to achieve program objectives and continuously train and

develop hospital staff to maximize discharge outcomes. The efforts of the Discharge Strike Team will allow DSH to establish a more coherent referral process for community placement and address challenges related to preparing individuals for the transition to a lower level of care at the community level, increasing DSH's discharge rates for eligible patients.
Discharge Strike Team Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for the Discharge Strike Team.

Classification	Total Need	Current Resources	Remaining Need
Program Director	1.0	0.0	1.0
Clinical Social Worker	5.0	0.0	5.0
TOTAL	**6.0**	**0.0**	**6.0**

Discharge Strike Team Staffing Received:

The table below summarizes the total positions received for the Discharge Strike Team.

Classification	Request	Received	Remaining Need
Program Director	1.0	0.0	1.0
Clinical Social Worker	5.0	0.0	5.0
TOTAL	**6.0**	**0.0**	**6.0**

The revised COVID-adjusted phase-ins did not provide any Discharge Strike Team positions. The 1.0 Program Director and 5.0 Clinical Social Workers will be requested in the future as additional resources become available. New methodologies cannot be put in place until adequate staffing levels are achieved at each hospital. These staffing levels will assist DSH in ensuring quality patient care in addition to reaching desired caseload ratios.

Clinical Executive Structure

The Clinical Executive Structure is needed to establish standard practices and procedures, provide leadership to staff and supervisors, and engage in administrative tasks such as recruitment and retention. Positions in this group do not provide direct patient care but support the staff that do.

Administrative Support Positions

The increase of staff within this proposal, as well as the complexities associated with filling these classifications, creates a need for an adjustment of personnel staff. Personnel management is a vital part of the Clinical Executive Structure. Personnel resources perform work related to personnel management for classification and pay, recruitment, selection, retention, training, benefits, position control and organizational development. This proposal establishes an additional Associate Personnel Analyst (APA) at each of the five hospitals and DSH-Sacramento for implementation efforts and to provide ongoing support for increased staffing levels.

Administrative Support Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for the Administrative Support.

Classification	Total Need	Current Resources	Remaining Need
Associate Personnel Analyst	6.0	0.0	6.0
TOTAL	**6.0**	**0.0**	**6.0**

Administrative Support Staffing Received:

The table below summarizes the total positions received for the Administrative Support.

Classification	Request	Received	Remaining Need
Associate Personnel Analyst	6.0	0.0	6.0
TOTAL	**6.0**	**0.0**	**6.0**

The revised COVID-adjusted phase-ins did not provide any Administrative Support positions. The 6.0 APA positions will be requested in the future as additional resources become available. New methodologies cannot be put in place until adequate staffing levels are achieved at each hospital. These staffing levels will assist DSH in ensuring quality patient care in addition to reaching desired caseload ratios.

Clinical Executive Leadership

The Clinical Executive Leadership positions provide leadership for various departments and disciplines. They are required to meet the legal requirements for the practice of medicine in California as determined by the Medical Board of California or the California Board of Osteopathic Examiners and must meet all legal requirements to practice psychiatry in California. The Medical Directors have comprehensive management responsibility for psychiatry, medical, allied health, psychology, pharmacy, dental and forensic evaluation services within DSH hospitals. Direct reports include the Chiefs of each of these respective areas. They are responsible for developing and maintaining an ongoing program to deliver, monitor, evaluate, and improve the quality and appropriateness of all mental health, medical, dental, pharmacy and medication management, specialized care and clinical services and allied health. The Chief of Primary Care Services will oversee the Chief Physician and Surgeon and the Chief of Psychiatric Services will provide direct supervision to Senior Psychiatrist Supervisors.

Clinical Executive Leadership Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for the Clinical Executive Leadership.

Classification	Total Need	Current Resources	Remaining Need
Medical Director	6.0	0.0	6.0
Assistant Medical Director	1.0	0.0	1.0
Chief of Primary Care Services	5.0	0.0	5.0
TOTAL	**12.0**	**0.0**	**12.0**

Clinical Executive Leadership Staffing Received:

The table below summarizes the total positions received for the Clinical Executive Leadership.

Classification	Request	Received	Remaining Need
Medical Director	6.0	6.0	0.0
Assistant Medical Director	1.0	0.0	1.0
Chief of Primary Care Services	5.0	5.0	0.0
TOTAL	**12.0**	**11.0**	**1.0**

The revised COVID-adjusted phase-ins began October 1, 2020 and consist of 6.0 Medical Directors. Medical Directors will be established at each hospital and Sacramento using new Exempt Entitlements. With the addition of the Medical Director positions, the existing 5.0 Chief of Psychiatry positions (one per hospital) will become the Chief of Psychiatric Services. An Assistant Medical Director will be established at DSH-Sacramento by reclassing an existing Staff Psychiatrist and applying the new class code assigned from CalHR through the Exempt Entitlement process.

On February 1, 2021, 5.0 Chief of Primary Care Services positions, one per hospital, will be established using new position authority and existing Exempt Entitlements.

DSH has received 11.0 of the needed Clinical Executive Leadership positions. The remaining 1.0 Assistant Medical Director position will be requested in the future as additional resources become available. New methodologies cannot be put in place until adequate staffing levels are achieved at each hospital. These staffing levels will assist DSH in ensuring quality patient care in addition to reaching desired caseload ratios.

Clinical Operations Advisory Council Positions (COAC)

The Clinical Operations Division facilitates the development, evaluation and maintenance of clinical standards for DSH. Included as part of this division is COAC, an interdisciplinary leadership team of clinicians from across the system, which is responsible for developing interdisciplinary best practices that can be standardized and deployed systemwide. COAC serves a critical need as it provides leadership for the provision of quality clinical care and therapeutic services to DSH patients.

When DSH was created, the need for such an advisory council was not originally contemplated. Therefore, this critical need has historically been supported through the redirection of resources. This proposal provides position authority only for nine positions that have been established administratively to meet the needs of DSH, which will formalize the COAC within the Clinical Operations Division.

The Clinical Operations division supports a "ground up" change model where executive level decision making is based on input from unit staff at each facility. This model provides clinical staff with a voice for communicating their critical needs, which can then be incorporated into the decision making, priority identification and planning process at headquarters in Sacramento. Conversely, the Clinical Operations Division provides a conduit of clear, effective and timely communication from headquarters to clinical leadership and staff.

COAC works closely with clinical leaders to identify best practices within DSH facilities, as well as facilities outside of California and in the current academic literature. While conducting onsite reviews of clinical services, COAC gathers information to assist in improving data collection methodologies. These methodologies are used to better understand DSH patients, identify patterns and trends and create tools for mentoring clinical staff.

Clinical Operations Advisory Council Staffing Needs:

The table below summarizes the total staffing needs as identified in the BCP for the Clinical Operations Advisory Council.

Classification	Total Need	Current Resources	Remaining Need
Chief Psychologist	1.0	0.0	1.0
Supervising Rehab Therapist	1.0	0.0	1.0
Physician & Surgeon	1.0	0.0	1.0
Assistant Director of Dietetics	1.0	0.0	1.0
Supervising Registered Nurse	1.0	0.0	1.0
Unit Supervisor	1.0	0.0	1.0
Psychiatrist	1.0	0.0	1.0
Senior Psychiatrist Specialist	2.0	0.0	2.0
TOTAL	**9.0**	**0.0**	**9.0**

Clinical Operations Advisory Council Staffing Received:

The table below summarizes the total positions received for the Clinical Operations Advisory Council.

Classification	Request	Received	Remaining Need
Chief Psychologist	1.0	0.0	1.0
Supervising Rehab Therapist	1.0	0.0	1.0
Physician & Surgeon	1.0	0.0	1.0
Assistant Director of Dietetics	1.0	0.0	1.0
Supervising Registered Nurse	1.0	0.0	1.0
Unit Supervisor	1.0	0.0	1.0
Psychiatrist	1.0	0.0	1.0
Senior Psychiatrist Specialist	2.0	0.0	2.0
TOTAL	**9.0**	**0.0**	**9.0**

Clinical Operations Advisory Council Staffing Request

The COAC team consists of 11.0 positions and has been moved to DSH-Sacramento as a permanent program. A total of 10.0 positions and funding were moved from the hospitals to DSH-Sacramento to establish this program. Historically the hospitals have backfilled behind positions being redirected for COAC in the blanket.

In the FY 2021-22 Governor's Budget, DSH requests 10.0 permanent position authority only to permanently backfill behind the positions redirected from the hospitals to create COAC in the Clinical Operations Division in Sacramento. DSH has identified the below classifications that better suit the COAC needs.

The table below summarizes the total positions requested for replenishing the positions redirected from the hospitals for COAC.

Classification	Request
Senior Psychiatrist Supervisor	1.0
Clinical Social Worker	1.0
Psychiatrist	1.0
Supervising Rehab Therapist	1.0
Physician and Surgeon	1.0
Assistant Director of Dietetics	1.0
Pharmacist II	1.0
Unit Supervisor	1.0
Senior Psychologist Supervisor	1.0
Supervising Registered Nurse	1.0
TOTAL	**10.0**

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review - Treatment Team **BR Name: 4440-036-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	10.0	10.0	10.0	10.0	10.0
Total Positions	**0.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**
Salaries and Wages						
Earnings - Permanent	541	50	50	50	50	50
Total Salaries and Wages	**$541**	**$50**	**$50**	**$50**	**$50**	**$50**
Total Staff Benefits	76	-250	-250	-250	-250	-250
Total Personal Services	**$617**	**$-200**	**$-200**	**$-200**	**$-200**	**$-200**
Operating Expenses and Equipment						
5301 - General Expense	-794	83	83	83	83	83
5304 - Communications	11	26	26	26	26	26
5320 - Travel: In-State	11	26	26	26	26	26
5324 - Facilities Operation	57	130	130	130	130	130
5346 - Information Technology	11	30	30	30	30	30
539X - Other	87	-95	-95	-95	-95	-95
Total Operating Expenses and Equipment	**$-617**	**$200**	**$200**	**$200**	**$200**	**$200**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
Total State Operations Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	281	354	354	354	354	354
4400020 - Hospital Administration	11	30	30	30	30	30
4410010 - Atascadero	-99	186	186	186	186	186
4410020 - Coalinga	733	1,210	1,210	1,210	1,210	1,210
4410030 - Metropolitan	-554	-1,080	-1,080	-1,080	-1,080	-1,080
4410040 - Napa	-186	-350	-350	-350	-350	-350
4410050 - Patton	-186	-350	-350	-350	-350	-350
Total All Programs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
2155 - Assistant Director of Dietetics				0.0	1.0	1.0	1.0	1.0	1.0
7552 - Physician & Surgeon (Safety)				-2.7	-3.0	-3.0	-3.0	-3.0	-3.0
7561 - Chief Physician & Surgeon				0.4	0.0	0.0	0.0	0.0	0.0
7609 - Sr Psychiatrist (Supvr)				0.0	1.0	1.0	1.0	1.0	1.0
7619 - Staff Psychiatrist (Safety)				0.0	2.0	2.0	2.0	2.0	2.0
7981 - Pharmacist II				0.0	1.0	1.0	1.0	1.0	1.0
8096 - Supvng Registered Nurse (Safety)				0.0	1.0	1.0	1.0	1.0	1.0
8104 - Unit Supvr (Safety)				0.0	1.0	1.0	1.0	1.0	1.0
8316 - Supvng Rehab Therapist				0.0	1.0	1.0	1.0	1.0	1.0
8323 - Rehab Therapist (Occ-Safety)				0.0	1.0	1.0	1.0	1.0	1.0
9831 - Sr Psychologist (Hlth Facility) (Supvr)				0.5	2.0	2.0	2.0	2.0	2.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety				0.0	2.0	2.0	2.0	2.0	2.0
9873 - Psychologist (Hlth Facility-Clinical-Safety)				0.0	1.0	1.0	1.0	1.0	1.0
VR00 - Various				1.8	-1.0	-1.0	-1.0	-1.0	-1.0
Total Positions				**0.0**	**10.0**	**10.0**	**10.0**	**10.0**	**10.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
2155 - Assistant Director of Dietetics	0	0	0	0	0	0
7552 - Physician & Surgeon (Safety)	-165	-816	-816	-816	-816	-816
7561 - Chief Physician & Surgeon	103	1	1	1	1	1
7609 - Sr Psychiatrist (Supvr)	0	0	0	0	0	0
7619 - Staff Psychiatrist (Safety)	0	277	277	277	277	277
7981 - Pharmacist II	0	0	0	0	0	0
8096 - Supvng Registered Nurse (Safety)	0	0	0	0	0	0
8104 - Unit Supvr (Safety)	0	0	0	0	0	0
8316 - Supvng Rehab Therapist	0	0	0	0	0	0
8323 - Rehab Therapist (Occ-Safety)	0	82	82	82	82	82
9831 - Sr Psychologist (Hlth Facility) (Supvr)	103	128	128	128	128	128
9872 - Clinical Soc Worker (Hlth/CF)-Safety	0	87	87	87	87	87
9873 - Psychologist (Hlth Facility-Clinical-Safety)	0	109	109	109	109	109

VR00 - Various	500	182	182	182	182	182
Total Salaries and Wages	**$541**	**$50**	**$50**	**$50**	**$50**	**$50**
Staff Benefits						
5150200 - Disability Leave - Industrial	38	78	78	78	78	78
5150210 - Disability Leave - Nonindustrial	12	25	25	25	25	25
5150350 - Health Insurance	133	280	280	280	280	280
5150450 - Medicare Taxation	43	91	91	91	91	91
5150600 - Retirement - General	656	1,384	1,384	1,384	1,384	1,384
5150700 - Unemployment Insurance	3	6	6	6	6	6
5150800 - Workers' Compensation	133	280	280	280	280	280
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	82	172	172	172	172	172
5150900 - Staff Benefits - Other	-1,024	-2,566	-2,566	-2,566	-2,566	-2,566
Total Staff Benefits	**$76**	**$-250**	**$-250**	**$-250**	**$-250**	**$-250**
Total Personal Services	**$617**	**$-200**	**$-200**	**$-200**	**$-200**	**$-200**

STATE HOSPITALS
MISSION BASED REVIEW - PROTECTIVE SERVICES
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**12.0**	**12.0**	**0.0**	**$0**	**$0**
One-time	0.0	0.0	0.0	$0	$0	$0
Ongoing	0.0	12.0	12.0	$0	$0	$0

BACKGROUND:

In 2013, the Department of State Hospitals (DSH) initiated a comprehensive effort to evaluate staffing practices amongst the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to ensure past practices and staffing methodologies continue to be adequate and appropriate for the department's growing populations, as well as, consistent amongst all DSH facilities. DSH's population served has grown by 34 percent since fiscal year (FY) 2007-08 (including Jail-Based Competency Treatment (JBCT) programs). In addition to this growth, the composition of the population has changed, becoming increasingly more forensic and geriatric. Forensic patients are those referred to DSH through the state's criminal court system. These dynamics along with the application of new treatment modalities over time necessitate the review and analysis of current staffing models.

The Clinical Staffing Study is comprised of four components: Hospital Forensic Departments, 24-Hour Care Nursing Services, Protective Services and Treatment Planning and Delivery. Each of these components involve a comprehensive examination into current staffing practices and development of staffing methodologies. These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, safety to patients and treatment providers and delivery of psychiatric treatment. As part of each component's assessment, the Clinical Staffing Study reviews current staffing standards and practices, proposes new data-driven staffing methodologies to adequately support the current populations served, assesses relief factor coverage needs and reviews current staffing levels within core clinical and safety functions.

DSH Protective Services encompasses all operations necessary for providing a secure and safe treatment environment for patients and a safe work environment for DSH employees. This service extends to operating a safe facility within the residing communities and ensuring safety to all individuals entering the hospital grounds. As a law enforcement agency, DSH Protective Services provide 24-hour police services responsible for the safety of all hospital operations, including:

- Ensuring safety and security for the patients and staff during daily living activities and therapeutic treatments
- Securing all hospital housing and buildings occupied by patients and staff
- Securely managing and overseeing the inflow and outflow of patients, staff and visitors
- Safely transporting forensic patients to medical appointments, procedures and court appearances
- Providing 24-hour safety and security custodial presence to patients hospitalized in outside hospitals
- Securing all hospital grounds both inside and outside the secured treatment areas (STA)

The Protective Services component focuses entirely on three key elements:

- Identification of staffing standards across all protective services operations
- Developing standardized methodologies for calculating staffing needs
- Identification of the appropriate relief factors to ensure sufficient coverage across all posts

In the 2020 Governor's Budget, DSH requested 46.3 permanent full-time positions and $7.9 million in fiscal year (FY) 2020-21, an additional 47.8 permanent full-time positions and $13.4 million in FY 2021-22 and on-going, in addition to $12.0 million in FY 2022-23 to implement the staffing standard to support protective services functions at DSH. As part of DSH's staffing study efforts and in collaboration with the Department of Finance (DOF) Research and Analysis Unit through a Mission-Based Review (MBR), the process for completing all protective services workload within DSH-Napa's Support Services and Operations Divisions was examined. The proposed standard identifies protective service posts and establishes workload-driven staffing methodologies to allocate adequate resources for essential police functions and reduce overtime usage. DSH is continuing to enhance data collection efforts and will provide updates on data findings impacting the presented standards.

Subsequent to the release of FY 2020-21 Governor's Budget, California, our nation, and the world were impacted by the COVID-19 pandemic. In response to the COVID-19 economic impacts, the Legislature ultimately approved the methodologies that were presented in the Budget Change Proposal (BCP), however no dollars or positions were authorized. Going forward, DSH plans to report on the progress bi-annually of the implementation, through the Enrollment, Caseload and Population (ECP) process in lieu of continuing to request the funding and positions for the remainder of this proposal.

The tables below summarize the total staffing needs as identified in the BCP and staffing study.

Total Staffing Needs:

Classification	Total Need	Current Resources	Remaining Need
OPS: Chief of Law Enforcement	1.0	1.0	0.0
OPS: Assistant Chief of Law Enforcement	1.0	0.0	1.0
Chief of Police	5.0	0.0	5.0
Assistant Chief of Police	5.0	5.0	0.0
Hospital Police Lieutenant	6.0	3.0	3.0
Hospital Sergeant	18.6	14.3	4.3
Hospital Police Officer	212.2	131.4	80.8
TOTAL	**248.8**	**154.7**	**94.1**

DESCRIPTION OF CHANGE:

Support and Operations Division

Support and Operations division personnel are responsible for the security of main sally-ports, visiting centers, package centers, transportation, admission units, off-grounds custody, perimeter kiosks, hospital patrol (i.e. corridor and building patrol, grounds and patient services patrol, perimeter patrol), investigations and the communication and dispatch centers at the hospitals. Personnel in this division include Hospital Police Lieutenant, Hospital Police Sergeant, and Hospital Police Officers.

The FY 2020-21 Governor's Budget proposed 88.1 positions and $5.9 million in FY 2020-21 and ongoing for the support and operations division. However, in the FY 2020-21 May Revision this proposal was Deferred Without Prejudice (DWOP). Subsequently DOF approved DSH to utilize DSH's overtime budget for off-grounds custody to administratively establish (AE) additional Hospital Police Officer (HPO) positions in FY 2020-21. In FY 2019-20, the hospitals spent $1.5 million on overtime costs for off-ground custody. With the annual cost of a Hospital Police Officer being $117,000, the $1.5 million in funding will be able to support 12.0 positions. Starting in January 1, 2021, DSH-Atascadero, DSH-Napa, and DSH-Metropolitan will AE HPO's as follows:

- DSH-Atascadero: 1.0 position
- DSH-Napa: 7.0 positions
- DSH-Metropolitan: 4.0 positions

The permanent position authority and funding for this proposal is requested in for budget year (BY) and ongoing.

The following table displays the Support Services Division Staffing needs:

Classification	Total Need	Current Resources	Remaining Need
Hospital Police Lieutenant	6.0	3.0	3.0
Hospital Sergeant	18.6	14.3	4.3
Hospital Police Officer	212.2	131.4	80.8
TOTAL	**236.8**	**148.7**	**88.1**

The following table displays the Support Services Division Staffing received:

Classification	Request	Administratively Established	Remaining Need
Hospital Police Lieutenant	3.0	0.0	3.0
Hospital Sergeant	4.3	0.0	4.3
Hospital Police Officer	80.8	12.0	68.8
TOTAL	**88.1**	**12.0**	**76.1**

Executive Leadership Structure

Leadership positions within Office of Protective Services (OPS) and Department of Police Services (DPS) are part of the DSH executive leadership team. The executive team provides strategic and operational leadership to the department by setting goals, developing strategies and ensuring those strategies are executed effectively and are aligned with the department's mission and vision. OPS and DPS leadership strive to streamline processes and procedures on an enterprise level and to provide ongoing training, supervision and guidance to law enforcement personnel.

The FY 2020-21 Governor's Budget proposed 6.0 positions and $2 million in FY 2020-21 and ongoing to support the executive leadership structure. These positions will be requested at a later date as funding is available.

The following table displays the Executive Leadership Structure Staffing needs:

Classification	Total Need	Current Resources	Remaining Need
OPS: Chief of Law Enforcement	1.0	1.0	0.0
OPS: Assistant Chief of Law Enforcement	1.0	0.0	1.0
Chief of Police	5.0	0.0	5.0
Assistant Chief of Police	5.0	5.0	0.0
TOTAL	**12.0**	**6.0**	**6.0**

The following table displays the Executive Leadership Structure Staffing received:

Classification	Request	Received	Remaining Need
OPS: Chief of Law Enforcement	0.0	0.0	0.0
OPS: Assistant Chief of Law Enforcement	1.0	0.0	1.0
Chief of Police	5.0	0.0	5.0
Assistant Chief of Police	0.0	0.0	0.0
TOTAL	**6.0**	**0.0**	**6.0**

Total Staffing Requested:

Classification	Request	Administratively Established	Remaining Need
OPS: Chief of Law Enforcement	0.0	0.0	0.0
OPS: Assistant Chief of Law Enforcement	1.0	0.0	1.0
Chief of Police	5.0	0.0	5.0
Assistant Chief of Police	0.0	0.0	0.0
Hospital Police Lieutenant	3.0	0.0	3.0
Hospital Sergeant	4.3	0.0	4.3
Hospital Police Officer	80.8	12.0	68.8
TOTAL	**94.1**	**12.0**	**82.1**

BCP Fiscal Detail Sheet

BCP Title: Mission Based Review - Protective Services **BR Name: 4440-033-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	12.0	12.0	12.0	12.0	12.0
Total Positions	**0.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
Salaries and Wages						
Earnings - Permanent	363	727	727	727	727	727
Overtime/Other	-698	-1,396	-1,396	-1,396	-1,396	-1,396
Total Salaries and Wages	**$-335**	**$-669**	**$-669**	**$-669**	**$-669**	**$-669**
Total Staff Benefits	239	477	477	477	477	477
Total Personal Services	**$-96**	**$-192**	**$-192**	**$-192**	**$-192**	**$-192**
Operating Expenses and Equipment						
5301 - General Expense	48	96	96	96	96	96
5304 - Communications	6	12	12	12	12	12
5320 - Travel: In-State	6	12	12	12	12	12
5324 - Facilities Operation	30	60	60	60	60	60
5346 - Information Technology	6	12	12	12	12	12
Total Operating Expenses and Equipment	**$96**	**$192**	**$192**	**$192**	**$192**	**$192**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
Total State Operations Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400020 - Hospital Administration	6	12	12	12	12	12
4410010 - Atascadero	0	-1	-1	-1	-1	-1
4410030 - Metropolitan	-2	-4	-4	-4	-4	-4
4410040 - Napa	-4	-7	-7	-7	-7	-7
Total All Programs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
1937 - Hosp Police Officer				0.0	12.0	12.0	12.0	12.0	12.0
Total Positions				**0.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
1937 - Hosp Police Officer	-335	-669	-669	-669	-669	-669
Total Salaries and Wages	**$-335**	**$-669**	**$-669**	**$-669**	**$-669**	**$-669**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	5	9	9	9	9	9
5150210 - Disability Leave - Nonindustrial	1	3	3	3	3	3
5150350 - Health Insurance	17	33	33	33	33	33
5150450 - Medicare Taxation	5	11	11	11	11	11
5150600 - Retirement - General	131	262	262	262	262	262
5150800 - Workers' Compensation	17	34	34	34	34	34
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	14	29	29	29	29	29
5150900 - Staff Benefits - Other	49	96	96	96	96	96
Total Staff Benefits	**$239**	**$477**	**$477**	**$477**	**$477**	**$477**
Total Personal Services	**$-96**	**$-192**	**$-192**	**$-192**	**$-192**	**$-192**

STATE HOSPITALS
COVID-19 RESPONSE
Informational Only

BACKGROUND:
The Department of State Hospital (DSH) executed a COVID-19 response plan across its system that followed guidance from the California Department of Public Health (CDPH), the Centers for Disease Control and Prevention (CDC) and other state and local partners. Under these circumstances, DSH took the following steps:

- In mid-March, DSH activated its Emergency Operation Center. DSH hospitals activated their Incident Command Centers and developed incident action plans to better communicate and coordinate DSH's pandemic response efforts, including infection control and respiratory protection.
- Implemented policies and procedures for infection control, respiratory protection, COVID-19 testing and personal protective equipment at its hospitals.
- Pursuant to Executive Order N-35-20, DSH issued directives temporarily suspending admissions and discharges of its patients to provide DSH time to implement significant infection control measures across its system.
- Resumed admissions for specified patient types in April 2020 and for all remaining patient types in May 2020.
- Implemented policies to reduce the risk of patients with COVID-19 entering DSH facilities by requiring updated health information related to COVID-19 from sending facilities; not accepting individuals currently positive for COVID-19, under investigation for COVID-19 or currently quarantined due to an exposure; and admitting patients in cohorts each week to screen, observe and isolate cohorts as needed.

<u>COVID-19 Cases and Hospital Updates</u>
Beginning in May 2020 and through the summer, DSH experienced larger COVID-19 outbreaks among patients, employees and other workers at three of the five DSH hospitals. When a positive employee or patient is identified, the hospitals perform widespread PCR testing on-site for both patients and employees. DSH also performs regular ongoing surveillance testing for employees working in specified units. Beginning in December 2020, due to the widespread community transmission of COVID-19 throughout California, DSH increased surveillance testing for its hospital employees to daily antigen testing for all employees working on patient units or in-patient care areas and to weekly PCR testing of employees working in non-patient care areas. Patient testing is still performed via PCR; however, antigen testing is being used for those patients who are symptomatic.

As of December 1, 2020, DSH has performed 31,543 tests on a cumulative total of 6,217 patients across all five hospitals, with a total of 583 patients testing positive. DSH has performed 17,363 staff tests statewide and 663 have tested positive. DSH experienced the early outbreaks at a time when national testing turnaround times were severely prolonged; DSH test results took between 10-14 days to be returned. This contributed to difficulties in containing outbreaks over the summer. DSH now is experiencing test results in 48 hours or less, which significantly assists DSH in reducing transmission.

<u>Quarantine/Isolation/Surge Capacity</u>
As part of preparation efforts, each hospital developed quarantine and isolation plans, including COVID-19 pandemic emergency plans and supplemental procedures addressing management of isolation units and infection control methods. Hospital isolation units are activated as needed as patients become symptomatic and test positive for COVID-19. Additional areas of the hospitals have also been identified to provide some surge capacity, as needed.

As an additional safeguard, and to provide for additional increased surge capacity, DSH entered into an Interagency Agreement with California Department of Corrections and Rehabilitation to utilize a portion of the Southern Youth Correctional Reception Center and Clinic in Norwalk, CA through September 30, 2021 as an Alternate Care Site (ACS). The ACS is being operated as a satellite facility to Metropolitan State Hospital, and features two housing units, one 50-bed and one 48, plus a separate building for treatment and office space.

Due to the increase in patient cases that began to rise significantly in November, the first ACS unit was activated, and 43 patients who tested negative for COVID-19 were transferred to the ACS the week of December 2nd to provide for additional isolation space at DSH-Patton.

Isolation and Testing

When a patient is actively displaying symptoms of COVID-19, nursing staff immediately isolate the patient in a private room and instruct the patient to wear a surgical face mask when in the presence of others. Nursing staff utilize additional PPE, perform nursing assessments in a private room, and contact the physician for further evaluation and instruction. Any area the patient accessed as well as the assessment location must be cleaned and disinfected if the patient is ordered to be isolated by the physician. Laboratory samples for COVID-19 are taken in the isolation room where the patient is housed, and the patient remains in isolation until the results are received.

When a patient is designated as under investigation (PUI) or is awaiting COVID-19 test results, the unit where the patient is/was housed is placed under quarantine until released by a physician. The room assignment is single occupancy for the affected patient and contact with unaffected patients is not permitted. Each PUI is placed in a separate isolation room. Once the test confirms that the patient has tested positive for COVID-19, the patient is transferred to the COVID-19 isolation unit for disease care and will be isolated for a minimum of 14 days. The unit where the patient was housed when they tested positive remains in quarantine and all patients undergo response testing serially at Baseline (Day 1), Day 7 and Day 14. If all three tests are negative for all patients and patients are asymptomatic, the unit is released from quarantine.

Vaccination Planning

As the state and the country prepare for approved COVID vaccinations, DSH is also taking a number of preparatory steps to ensure the effective delivery of vaccines to health care workers and patients, including appropriately registering the Department and each state hospital in the state system to order vaccines as they become available; implementing logistical plans at each hospital to accept, store and maintain appropriate volumes of vaccines; training civil service or contracted staff to administer vaccinations; and readying the technology systems developed for COVID testing tracking to accept necessary vaccination data.

Support

Employee Support

DSH has made a number of support resources available for employees that may be struggling during this global pandemic and the significant impact it has had on their work and personal life, including establishing an Employee Support line, making the California Chaplain Corps available, and collaborating with the state's Employee Assistance Program (EAP) to allow employees to access EAP providers through message therapy, telehealth, and tele-EAP coaching platforms.

Patient Support

DSH continues to educate and provide updates on COVID-19, PPE and safety practices, sanitizing equipment, and the importance of testing to patients. DSH also implemented changes to treatment protocols to allow hospitals to continue treating patients, including providing tele-visits for specialty

medical providers; reducing group sizes and establishing social-distancing practices; and offering tele-video visits with loved ones

COVID-19 Budget Year Fiscal Impacts

Fiscal impacts for FY 2021-22 are included in the statewide COVID-19 Direct Response Expenditures proposal (there is no funding associated with COVID-19 response in the DSH estimate). The following summary is provided for informational purposes only.

The table below assumes the public health emergency will continue through December 31, 2021 and summarizes projected COVID-19 expenditures through this date. Projections may be updated in the FY 2021-22 May Revision as additional details are known regarding COVID-19.

BY 2021-22	
	BY 2021-22
Personal Services: Regular Time	$2,517,000
Personal Services: Overtime	$7,666,000
OE&E: Commodity Purchase	$12,525,000
OE&E: Service Contracts	$300,000
OE&E: Other Operating Costs	$22,349,000
Testing: Employees	$5,201,000
Testing: Patients	$1,424,000
Total:	**$51,982,000**

Personnel Services

Personnel services captures staff whose regular time is directly related to COVID-19 and overtime hours for additional cleaning/sanitization, staffing coverages, environmental projects, performing custody tasks, screening staff and isolation staff. Projections in this category are based on estimated FY 2020-21 totals and reduced by half to reflect 6 months of costs.

Operating Expense and Equipment

OE&E captures commodity purchases that are both tangible and non-tangible in nature. Items that are tangible and generally consumable in nature require continuous replenishment. This includes personal protective equipment (PPE), sanitation supplies and food and food supplies that are above and beyond normal expenditures due to the change in food service. Non-tangible items are non-consumables in nature, this includes items related to modifying existing space and the setup up temporary space for COVID-19 response. This also includes equipment, heating/air, filters and IT solutions. Projections in this category are based on estimated FY 2020-21 totals and reduced by half to reflect 6 months of costs. Additionally, any one-time contract costs are also included in the projections for FY 2021-22.

Testing

Testing captures costs for the collection and coordination of staff and patient tests. Projections in this category do not assume costs associated with test collection kits, testing at the laboratory, transportation of the swab, and the software test reporting system. Projections in this category utilize weekly average testing data from FY 2020-21 and multiply the weekly average by 26 weeks.

STATE HOSPITALS
TELEPYSCHIATRY RESOURCES
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**-6.5**	**0.0**	**0.0**	**-$911**	**$0**	**$0**
One-time	*-6.5*	*0.0*	*0.0*	*-$911*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*

BACKGROUND:

The Department of State Hospitals (DSH) has increased its use of telepsychiatry to provide psychiatric treatment remotely to patients at hospitals where it is historically difficult to hire psychiatrics due to its geographical location. Telepsychiatry uses electronic communications and information technologies to provide clinical psychiatric care services to all patients, regardless if the patient is a penal code or civil commitment. In a conference room equipped with interactive videoconferencing equipment, treatment team staff and telepsychiatry coordinators at the hospital can present patients and their treatment plans to a Staff Psychiatrist at a remote location also equipped with videoconferencing capability. This allows the provider to observe patient behavior and speak with them about their care.

Although physically in another location, the remote telepsychiatrist maintains the same responsibilities as a psychiatrist physically located at the treating hospital. The telepsychiatrist actively participates in treatment conferences, serves as a member of the patient's treatment team and performs the same duties as an onsite Staff Psychiatrist, with the exception of ordering seclusion and restraint in emergency situations.

In the 2019 Budget Act, DSH added clinical oversight and supervision, telepsychiatry coordinators, as well as information technology (IT) equipment and resources to support the program. To accommodate this expansion, the 2019 Budget Act included 11.0 positions and $2.2 million in fiscal fear (FY) 2019-20 and an additional 10.0 positions and $1.5 million in FY 2020-21, for a total of 21.0 positions and $3.7 million ongoing.

DESCRIPTION OF CHANGE:

Telepsychiatry Staffing

Staff Psychiatrist
DSH proposed to recruit and fill 18.0 existing vacant Staff Psychiatrist positions as telepsychiatrists in a two-phase process beginning in FY 2019-20. Figure 1 below outlines the phased-in plan by which telepsychiatry slots will be filled at each hospital.

Figure 1: Telepsychiatry Phase-In Plan		
	FY 2019-20[1]	FY 2020-21[2]
DSH-Atascadero	3.0	4.0
DSH-Coalinga	3.0	3.0
DSH-Napa	2.0	3.0
TOTAL	**8.0**	**10.0**

[1]These positions are physically located at DSH-Metropolitan but will provide service remotely.
[2]These positions will be physically located at DSH-Sacramento but will provide service remotely.

DSH-Atascadero experienced obstacles in hiring civil service Staff Psychiatrists as well as contracted Staff Psychiatrists. However, the increased salary rate for contractors in recent years has increased the recruitment success of contracted Staff Psychiatrists. As a result, DSH-Atascadero at this time continues to focus on recruitment of on-site providers and has not filled the seven positions originally identified for telepsychiatry services. Due to a continued interest and need in telepsychiatry, these resources will alternatively be utilized by DSH-Coalinga. DSH will continue to monitor DSH-Atascadero's psychiatry needs and may need to pursue telepsychiatry in the future.

DSH-Coalinga filled all 3.0 of the positions in phase one and plans to fill the 3.0 positions in phase two. With DSH-Atascadero opting out, DSH-Coalinga will identify 7.0 additional existing Staff Psychiatrists to participate in the telepsychiatry program. DSH-Coalinga plans to fill 10.0 positions in FY 2020-21.

DSH-Napa has hired 1.0 full-time telepsychiatrists and 1.0 part-time telepsychiatrist of the 2.0 positions authorized in phase one and has hired 2.0 of the 3.0 positions authorized in phase two. The remaining 2.5 positions will be filled in FY 2021-21.

The table below illustrates the updated position authority, the actual number of telepsychiatry positions filled per hospital in FY 2019-20, and the projections for FY 2020-21.

Figure 2: Updated Telepsychiatry Phase-In Plan[1]

	FY 2019-20 Updated Authority	FY 2020-21 Updated Authority	FY 2019-20 Actuals	FY 2020-21 Projections
DSH-Atascadero	0.0	0.0	0.0	0.0
DSH-Coalinga	3.0	10.0	3.0	10.0
DSH-Napa	2.0	3.0	1.5	3.5
TOTAL	**5.0**	**13.0**	**4.5**	**13.5**

[1]These positions will be physically located at various hospitals but will provide service remotely.

Eighteen offices were identified to house the telepsychiatry Staff Psychiatrists who will provide services to DSH-Coalinga and DSH-Napa. Eight of these offices are at DSH-Metropolitan and ten of these offices are designated in the new Clifford L. Allenby building currently under construction at DSH-Sacramento. The office space remains available at DSH-Metropolitan and updates have been made of adding minor furnishings and telepsychiatry IT equipment. The office space at DSH-Sacramento is expected to be available April 1, 2021, once construction is complete and DSH has moved. An update of the DSH Sacramento Hub will be provided in the 2021-22 May Revision. By expanding the existing telepsychiatry program to offer both a Northern and Southern California hub, DSH hopes to incentivize candidates within major metropolitan areas with greater candidate pools to apply. DSH anticipates that current recruitment success rates will increase, and historically high vacancy rates will be reduced.

Coordinators

Coordinators were needed to support the telepsychiatrists and act as an extension of the treatment team. These staff escort patients from their units to the telepsychiatry conference room, set up the equipment, establish the connection between the patient and doctor, coordinate meetings with the psychiatrist, patient and treatment teams, and maintain the overall caseload and scheduling.

DSH received authority for Psychiatric Technicians based on a 1:1 ratio to Staff Psychiatrist for telepsychiatry services. The table below illustrates the updated position authority, the actual number of Psychiatric Technicians filled per hospital in FY 2019-20 and the projections for FY 2020-21.

Figure 3: Updated Coordinators Phase-In Plan				
	FY 2019-20 Updated Authority	FY 2020-21 Updated Authority	FY 2019-20 Actuals	FY 2020-21 Projections
DSH-Atascadero	3.0	4.0	0.0	0.0
DSH-Coalinga	3.0	3.0	3.0	10.0
DSH-Napa	2.0	3.0	1.0	4.0
TOTAL	**8.0**	**10.0**	**4.0**	**14.0**

DSH-Atascadero received authority for 7.0 positions. Of these positions, 0.0 have been filled. As of October 1, 2020, these positions have not been established and will be shifted to DSH-Coalinga.

DSH-Coalinga received authority for 6.0 positions and transferred 7.0 from DSH-Atascadero. Of these positions, 3.0 have been filled. As of October 1, 2020, 10.0 are vacant and plan to be filled January 2021. This will result in a one-time CY savings of $570,000.

DSH-Napa received authority for 5.0 positions. Of these positions, 3.0 have been filled. As of October 1, 2020, 2.0 are vacant and plan to be filled January 2021. This will result in a one-time CY savings of $114,000.

Oversight

To accommodate the expansion of telepsychiatry, a Senior Psychiatrist Supervisor position was authorized to provide oversight and guidance of the Staff Psychiatrists and telepsychiatry program overall. This position is located within the Clinical Operations Division of DSH-Sacramento. As of October 1, 2020, this position is vacant and the division plans to fill by January 2021. This will result in a one-time CY savings of $445,000.

IT Staff Support

To accommodate the expansion of telepsychiatry, IT support staff were authorized to provide hands-on support to trouble-shoot any issues with the telepsychiatry equipment and ensure that the connection is maintained between the remote Staff Psychiatrist and the receiving hospital. One position was authorized to be located at DSH-Atascadero and the other at DSH-Coalinga. IT support for DSH-Napa will be provided remotely by existing staff, therefore no additional IT positions were requested for this location. As of October 1, 2020, 2.0 positions are filled, and 0.0 positions are vacant. The DSH-Atascadero position provides technical support remotely to DSH-Coalinga given the shift in resources to DSH-Coalinga.

Telepsychiatry Equipment

IT Equipment
In order to support the expansion of telepsychiatry, DSH requested one-time funds of $584,312 in FY 2019-20 and one-time funds of $626,824 and $331,225 in FY 2020-21 and ongoing to fund the necessary IT equipment, infrastructure, licensing and IT support services. The specific equipment consists of headsets, cameras, Voice Over Internet Protocol (VOIP) phones, pagers, cabling, computers and monitors. Additionally, WebEx licenses are needed for the telepsychiatrists, coordinators and Staff Psychiatrist Supervisor. As of December 1, 2020, all equipment for FY 2019-20 has been procured and distributed, funds allocated for FY 2020-21 funds are expected to be fully expended by June 30, 2020.

Office Furnishings
DSH requested one-time funding to provide minimal office furnishings, such as desks, office chairs and conference room tables at the DSH-Metropolitan location. As of December 1, 2020, all furnishings have been procured. The DSH-Sacramento telepsychiatry hub will contain modular furniture. No additional furnishings are needed for this location.

BCP Fiscal Detail Sheet

BCP Title: Telepsychiatry Resources | **BR Name: 4440-031-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	-6.5	0.0	0.0	0.0	0.0	0.0
Total Positions	**-6.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Salaries and Wages						
Earnings - Permanent	-541	0	0	0	0	0
Total Salaries and Wages	**$-541**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Staff Benefits	-262	0	0	0	0	0
Total Personal Services	**$-803**	**$0**	**$0**	**$0**	**$0**	**$0**
Operating Expenses and Equipment						
5301 - General Expense	-50	0	0	0	0	0
5304 - Communications	-8	0	0	0	0	0
5320 - Travel: In-State	-8	0	0	0	0	0
5324 - Facilities Operation	-34	0	0	0	0	0
5346 - Information Technology	-8	0	0	0	0	0
Total Operating Expenses and Equipment	**$-108**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-911**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-911	0	0	0	0	0
Total State Operations Expenditures	**$-911**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-911**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	-225	0	0	0	0	0
4400020 - Hospital Administration	-8	0	0	0	0	0
4410010 - Atascadero	-396	-791	-791	-791	-791	-791
4410020 - Coalinga	-169	791	791	791	791	791
4410040 - Napa	-113	0	0	0	0	0
Total All Programs	**$-911**	**$0**	**$0**	**$0**	**$0**	**$0**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
7609 - Sr Psychiatrist (Supvr)				-0.5	0.0	0.0	0.0	0.0	0.0
8253 - Psych Techn (Safety)				-6.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**-6.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
7609 - Sr Psychiatrist (Supvr)	-145	0	0	0	0	0
8253 - Psych Techn (Safety)	-396	0	0	0	0	0
Total Salaries and Wages	**$-541**	**$0**	**$0**	**$0**	**$0**	**$0**
Staff Benefits						
5150200 - Disability Leave - Industrial	-7	0	0	0	0	0
5150210 - Disability Leave - Nonindustrial	-2	0	0	0	0	0
5150350 - Health Insurance	-38	0	0	0	0	0
5150450 - Medicare Taxation	-7	0	0	0	0	0
5150620 - Retirement - Public Employees - Safety	-116	0	0	0	0	0
5150800 - Workers' Compensation	-24	0	0	0	0	0
5150900 - Staff Benefits - Other	-68	0	0	0	0	0
Total Staff Benefits	**$-262**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Personal Services	**$-803**	**$0**	**$0**	**$0**	**$0**	**$0**

CONDITIONAL RELEASE PROGRAM (CONREP)

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
GENERAL/NON-SEXUALLY VIOLENT PREDATOR (NON-SVP) PROGRAM
Caseload Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$0**	**$1,200**	**$1,200**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$1,200*	*$1,200*

BACKGROUND:

The Forensic Conditional Release Program (CONREP) is the Department of State Hospital's (DSH) statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system.

The CONREP population includes:

- Not Guilty by Reason of Insanity (NGI) (Penal Code (PC) 1026)
- Offender with a Mental Health Disorder (OMD) (both PC 2964 parolees who have served a prison sentence and PC 2972 parolees who are civilly committed for at least one year after their parole period ends)
- Felony Incompetent to Stand Trial (IST) (PC 1370 patients who have been court-approved for outpatient placement in lieu of state hospital placement)
- OMD (WIC 6316)

CONREP services are also offered to Sexually Violent Predators (SVP) (WIC 6604). Individuals suitable for CONREP may be recommended by the state hospital Medical Director to the courts for outpatient treatment. Currently, DSH contracts with seven county-operated and eight private organizations to provide outpatient treatment services to clients in all 58 counties in the state with non-SVP commitments.

As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director, with the Court's approval (or in the case of OMDs, the Board of Parole Hearings' approval), assesses and makes the recommendation for individuals' placement in CONREP.

CONREP delivers an array of mental health services to individuals during their period of outpatient treatment. In conjunction with the court-approved treatment plan, contractors coordinate and provide a wide array of services needed to support community reintegration, including forensic mental health treatment through individual and group therapy settings, life skills training, residential placement, collateral contacts (e.g., other individuals/agencies), home visits, substance abuse screenings, psychiatric services, case management, court reports, and psychological assessments. DSH has developed standards for these services which set minimum treatment and supervision levels for individuals court ordered to CONREP. Regular evaluations and assessments on treatment progress are completed by contractors during the period of state hospitalization and while receiving treatment in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if a CONREP-eligible patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP). The STRPs are a cost-effective resource used by CONREP to provide patients with the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hours per day, seven days per week (24/7) supervision while they transition from a state hospital to a community site. The STRP is limited to a 90- to 120-day stay as residential treatment. Once the patient has made the necessary adjustments and is ready to live in the community without structured 24/7 services provided by the STRP, the patient is able to live in a Board & Care, Room & Board, or other independent living arrangements without direct staff supervision.

Continuum of Care

The 2019 Budget Act included $5.1 million in fiscal year (FY) 2019-20 and $11.0 million in FY 2020-21 and ongoing to establish a 78-bed step-down program. The program was designed for state hospital patients ready for CONREP in 18-24 months through a contract with an Institute for Mental Disease (IMD) facility in Southern California. This setting allows for patients to step down into a lower restrictive environment and provide the skills necessary for a more independent living setting when transitioning to CONREP. These patients are individuals who have been institutionalized for a number of years and include OMD and NGI patients.

The contract with the community IMD provider has been executed and program implementation was originally anticipated to occur during spring 2020. The original activation timeline was predicated on the assumption that all necessary approvals required for physical plant modifications would be received and construction activities would have been completed January or February 2020. As of this update, final approval of retrofit plans and construction activities are still pending and the new timeline for program activation is April 2021.

State hospital admission rates and bed capacity have reduced as a result of operational adjustments implemented to ensure the health and safety of its patients amid the COVID-19 pandemic. However, the rate of referrals has not reduced to the same level and is significantly outpacing DSH's ability to admit new patients. Expanding the availability of beds to treat DSH patients in other facilities is critical to providing timely access to those requiring treatment. To address the shortage of available beds within the DSH system of care and expand treatment options available to its patients, DSH recently executed an emergency contract with another IMD facility in Northern California for 10-beds.

Activation of the 10-bed step-down program began in July 2020 which included the development of policies and procedures, training staff and phased admissions. The provider is currently interviewing patients for admission and requesting minute orders from the courts. Additionally, the IMD has expressed interest in expanding to a 20-bed program in FY 2021-22.

Additionally, DSH initiated contract negotiations with a new Mental Health Rehabilitation Center (MHRC) in Northern California for 20 beds to provide competency restoration and mental health treatment services to IST patients ordered for placement to CONREP. DSH expects contract execution and program activation to occur by February 2021. Please see Continuum of Care: Step-Down Transitional Program update for more details on these three programs.

Community Program Director (NGI and IST Evaluations)

In the 2020 Budget Act, DSH received $2.2 million in contract funding to support the increase in placement evaluations. DSH has increased its CONREP provider contract funding to support the increased workload associated with placement recommendations for IST and NGI defendants charged with a felony crime. Providers have increased staffing as necessary in order to meet the increased workload.

DESCRIPTION OF CHANGE:

Increased Salary and Operating Expense Costs

Pursuant to WIC 4360 (a) and (b) and PC 1615, the DSH-CONREP program pays 100 percent of the costs incurred by providers that deliver treatment and supervision services to CONREP clients. DSH has experienced an increase in costs associated with salary and operating expenses for the contracted vendors that provide services to the CONREP programs.

As part of the budgeting process, CONREP providers request the standard cost of living and operational cost increases. CONREP county providers are obligated to provide salary increases imposed by the respective union collective bargaining contracts. DSH is requesting funding to support the salary and operating expense increases for contracted providers to avoid the contractors experiencing a funding shortfall in order to meet their contractual obligations with operating a CONREP program. The impact of insufficient funding to support contractual staffing levels could result in a reduction in the number of CONREP providers willing to serve patients. DSH is requesting $1.2 million in FY 2021-22 and ongoing to support the increased salary and operating expenses costs of the CONREP providers.

Funding Methodology

Current contracts are based on FY 2018-19 budgeted compensation and operating expense costs provided by the vendors in early 2018. Based on projected average salary percentage increases and the average inflation rates for 2020, 4.5 percent was applied to the total salaries and 2.5 percent was applied to totaled operating expenses. The total cost to support increased salaries and operating costs for contracted providers is projected $1.2 million annually.

Caseload Update

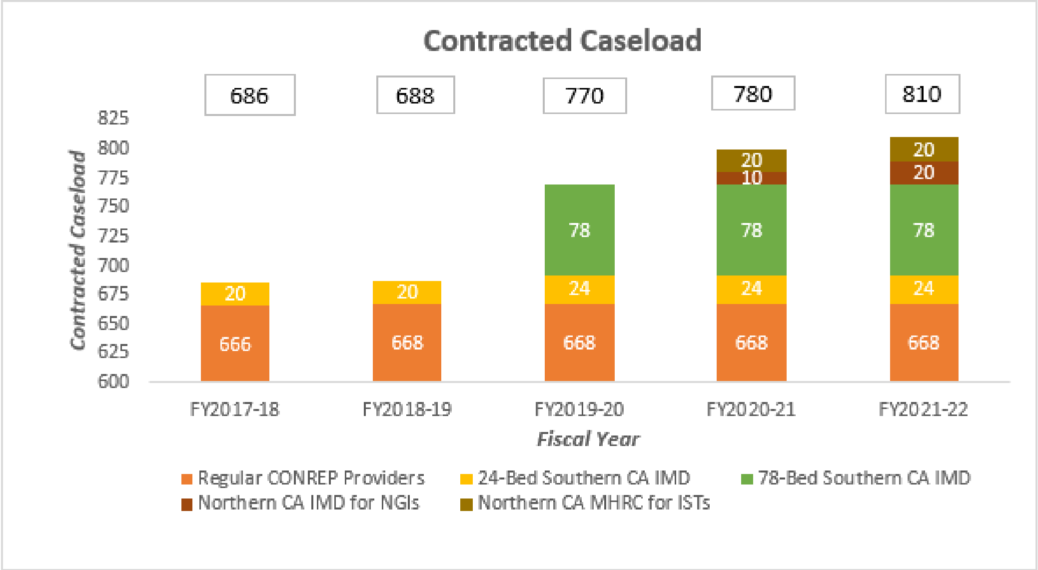
DSH anticipates a contracted caseload of 810 CONREP clients for FY 2021-22. This contracted caseload includes 668 regular CONREP clients and 142 IMD clients (24-bed Southern CA IMD, 78-bed Southern CA IMD, a 20-bed Northern CA IMD and a 20-bed Northern CA MHRC).

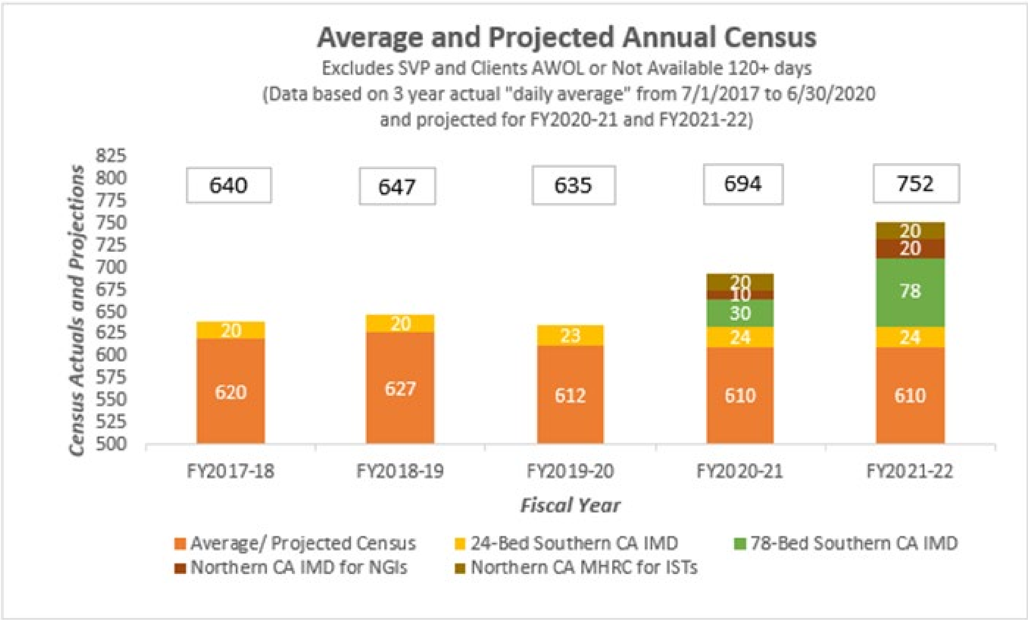
Due to unexpected circumstances resulting from COVID-19, CONREP census dropped slightly from the prior year to an average of 635 clients for FY 2019-20. During the early stages of the pandemic and in order to reduce the risk of transmission of COVID-19 throughout its hospitals, DSH suspended admissions and discharges from its hospitals. Additionally, community housing providers were generally not accepting new admissions during Shelter-in-Place orders in effect at the time. These actions impacted the movement of patients to and sometimes from CONREP.

It should be noted that the current caseload level does not translate into cost savings because current resources have been redirected to increased salary and operating costs of the existing contracts. CONREP providers have absorbed increasing salary and operating cost for several years within the existing program allocation and contracts. As such this has resulted in reduced funding for census in CONREP. Additionally, CONREP providers had not received any funding adjustments over past years to accommodate the increased housing costs for community placement of CONREP clients. As a step towards addressing this funding gap, in FY 2019-20, DSH requested and received authorization of $1 million to support increased housing costs to support contracted census levels. Similarly, DSH must also address the funding shortfall in CONREP provider salaries and related operating expenses in order to have sufficient funding to serve the contracted census levels. Currently, there is a waitlist of more than 150 patients with court or Board of Parole Hearings (BPH) orders or who have received a referral by the state hospitals for placement to CONREP. If the proposed $1.2 million to support contract cost increases is denied, DSH would be unable to increase its caseload.

Further impacting CONREP census growth, the timeline for activation of the 78-bed step-down program originally estimated patient admissions to begin in spring 2020, however, due to external approval and construction delays, admissions are now anticipated to occur in April 2021. These limitations resulted in CONREP census starting at a lower level at the start of FY 2020-21 than originally projected.

The following charts illustrated DSH's projected contracted caseload and anticipated census, respectively.





DSH is expeditiously increasing efforts to increase patient census in the CONREP program in 2020-21. Based on current funding levels, DSH has a contracted caseload of 780 CONREP clients in FY 2020-21 and a projected contracted caseload of 810 in FY 2021-22. The projected annual caseloads for FY 2020-21 and FY 2021-22 are 694 and 752, respectively. A caseload update for the CONREP Non-SVP clients will be presented in the 2021-22 May Revision.

BCP Fiscal Detail Sheet

BCP Title: CONREP Non-SVP Caseload Update **BR Name: 4440-021-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	0	1,200	1,200	1,200	1,200	1,200
Total Operating Expenses and Equipment	**$0**	**$1,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**
Total Budget Request	**$0**	**$1,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	1,200	1,200	1,200	1,200	1,200
Total State Operations Expenditures	**$0**	**$1,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**
Total All Funds	**$0**	**$1,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4420010 - Conditional Release Program	0	1,200	1,200	1,200	1,200	1,200
Total All Programs	**$0**	**$1,200**	**$1,200**	**$1,200**	**$1,200**	**$1,200**

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
SEXUALLY VIOLENT PREDATOR (SVP) PROGRAM
Caseload Update

BACKGROUND:

Effective January 1, 1996, Sexually Violent Predators (SVP) were added to the Forensic Conditional Release Program (CONREP) population (WIC 6604). Prior to the conditional release of the first SVP in 2003, existing CONREP providers did not have treatment services to accept SVPs as patients, requiring the Department of State Hospitals (DSH) to enter into an annual contract with a single private provider serving all 58 counties. Current statute requires that SVPs be conditionally released to their county of domicile and sufficient funding be available to provide treatment and supervision services when an SVP is conditionally released into the community by court order.

Similar to the general non-SVP program, the CONREP-SVP program offers clients with direct access to an array of mental health services with a forensic focus. Additionally, required services for SVPs in CONREP include regularly scheduled sex offender risk assessments, polygraph testing, and the review of Global Position System (GPS) data and surveillance.

In recent years, DSH has experienced significant challenges that have impacted the cost of operating the CONREP-SVP program. The most notable issues include locating appropriate housing and public resistance of the placement of SVPs within their communities. Once the court has ordered an SVP be released from a DSH hospital into the community via CONREP, it takes an average of 12 months to secure court-approved housing, resulting in increased preplacement services and costs. There are three types of accommodations that CONREP-SVPs typically reside in: a house, recreational vehicle (RV), and motel.

In response to public resistance to SVP placement and ensuring both patient and public safety, the need for heightened 24/7 security and monitoring has also resulted in significant cost increases. As the courts approve additional petitions for release, the lack of housing options has resulted in some SVPs being ordered released into their communities as transients, further increasing costs.

The number of SVPs in CONREP is limited and movement in and out of the program cannot be reliably projected utilizing historical census data. Caseload changes for the CONREP-SVP program are based on the most up-to-date information for each client including, but not limited to, court information regarding the status of those petitioning for conditional release from DSH-Coalinga, current CONREP clients petitions for unconditional release, status of clinical evaluations, clients progress in the program, housing status, and historical experience with placement in the county of commitment. After accounting for these factors, current year and budget year caseload are adjusted in accordance with the month projected for admission to or discharge from CONREP. Similarly, funding associated with projected caseload changes are prorated to reflect the partial-year value of phasing new clients in and out of the program.

<u>Funding Methodology</u>

This program is funded from the General Fund (GF) for the provision of CONREP outpatient services. The CONREP program element budget item contains all personal services and operating expenses and equipment (OE&E) costs associated with CONREP.

Pursuant to WIC 4360 (a) and (b) and Penal Code (PC) Section 1615, DSH CONREP pays 100 percent of the costs incurred by providers that deliver treatment and supervision services to CONREP clients. Historically, DSH has established annual contracts with providers and paid a fixed monthly rate, regardless of services provided.

To improve the program's fiscal accountability and transparency, the CONREP-SVP program is incorporating fundamentally different methodology of establishing budgets for CONREP-SVP services. Specifically, CONREP-SVP has moved away from an allocation-based methodology with providers/contractors to a service-based methodology that provides funding based on the actual number of patients in CONREP programs and services provided to these patients. Under this new methodology, the contractor works with DSH to establish monthly cost per client rates for all services based on prior actual expenditures. As the census increases, the cost per client rate decreases. Monthly cost per client rates range from 8 to 22 clients. The contractor's reimbursement is calculated using the daily average client census for the month times the applicable established rate. The implementation of this methodology began with the renewal of contracts effective July 1, 2018. Funding for other program expenses must either be approved in advance by DSH or are billed and paid in arrears for the actual cost. These expenses include pre-placement client costs, enhanced supervision client costs and life support costs. At the end of each fiscal year, DSH will analyze the actual level of services provided by the contractor.

CONREP-SVP Program Cost Increase

Prior to Fiscal Year (FY) 2019-20, the CONREP-SVP program funded SVP commitments at an average cost of $310,000 per client. This subset of the CONREP population is significantly more expensive to treat than the rest of CONREP. Major cost drivers (see table below) include a greater number of required services during outpatient treatment, costs associated with placement case management (once an SVP petitions for release into CONREP, the CONREP contractor handles all activities related to placing that individual in the community including locating and paying for housing and attending court), costs associated with providing enhanced supervision, and increased housing costs.

DSH realized an increase in direct service costs of $34,000 per client, for a total average cost of $344,000 per client. After prior year cost analysis, DSH has concluded that non transient and transient SVP costs are comparable, with the exception of enhanced supervision and security costs. While transient SVPs typically have increased costs for enhanced supervision and security, these costs can also be imposed by a non-transient SVP due to clinical or community safety needs. Due to unpredictable fluctuations in census and a reduction in the initial anticipated transient costs, DSH expects to be able to absorb this increase of cost per client within its current funding.

Sexually Violent Predator (SVP) Program Costs	
Service Costs:	**FY 2021-22**
1) Caseload Costs*	$5,200,000
2) Pre-Placement Client Costs	$110,000
3) Enhanced Supervision Costs	$400,000
4) Life Support Costs	$1,000,000
5) Outside Security Costs	$500,000
Total SVP Cost	**$7,210,000**
Average Cost per Patient:	**$344,000**

* The caseload costs include personnel compensation, operating expenses, travel costs, staff training, hospital liaison visits, administrative overhead as well as provider costs such as treatment services, polygraph, toxicology screening, GPS, etc.

DESCRIPTION OF CHANGE:

Caseload Adjustment

As of the 2021 Budget Act, DSH assumes that a total caseload of 21 SVPs will be conditionally released into the community by June 30, 2022. There are 16 court-ordered clients who are currently participating in the CONREP-SVP program and less than 11[1] individuals with court-approved petitions for release into the program who are awaiting placement in the community. Additionally, 16 individuals have filed petitions for Conditional Release and are proceeding through the court process. Finally, there are less than 11[1] individuals who are anticipated to petition for the CONREP-SVP program and are expected to be placed within FY 2021-22.

It is estimated from the above numbers and a review of DSH's patient population with the contractor that up to 28 individuals could be placed into the CONREP-SVP program in budget year, however DSH will conservatively assume a total caseload of 21 SVPs. This caseload projection accounts for admissions as well as any potential discharges. As such, no adjustment is needed, DSH is still assuming a total caseload of 21 SVPs. A caseload update will be provided in the FY 2021-22 May Revision.

	Current Status of Clients for Placement[1]	Projected CONREP Placement in FY 2021-22[1]
Currently in CONREP:	16	12
Approved for CONREP:	<11	<11
Petitioned for CONREP:	16	<11
Expected to Petition:	***	<11
TOTAL	**57**	**28**

Note: Accounts for admissions and discharges

[1] Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines. Counts between 1-10 are masked with "<11" within tables or "less than 11" within the narrative. Complimentary masking is applied using "***" where further de-identification is needed to prevent the ability of calculating the de-identified number.

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
CONTINUUM OF CARE: STEP-DOWN TRANSITIONAL PROGRAM
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$6,590**	**$7,340**	**$7,340**
One-time	*0.0*	*0.0*	*0.0*	*-$9,792*	*$0*	*$0*
Ongoing	*0.3*	*0.5*	*0.5*	*$3,202*	*$7,340*	*$7,340*

BACKGROUND:

The 2019 Budget Act included $5.1 million in fiscal year (FY) 2019-20 and $11.0 million in FY 2020-21 and ongoing to establish a 78-bed step-down program for state hospital patients ready for the Forensic Conditional Release Program (CONREP) in 18-24 months. The Department of State Hospitals (DSH) identified an Institute for Mental Disease (IMD) facility in Southern California in the community that will allow for patients to step down into a lower restrictive environment and focus on the skills necessary for independent living when transitioning to CONREP. These beds are essential to preparing Offenders with a Mental Health Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) patients who have been institutionalized for a number of years. This type of setting allows patients to step down into a lower restrictive environment and focus on developing the skills necessary for transition to a more independent living environment in CONREP.

The IMD program will be operated by a private contractor who owns the facility, has experience in working with the CONREP population and has a strong interest in increasing capacity to serve more clients who have behavioral health challenges.

The existing space is currently licensed as a skilled nursing facility (SNF) and the provider has received programmatic approval from Department of Health Care Services (DHCS), Mental Health and Substance Use Division (MHSUD) to establish a Special Treatment Program (STP) designation. The physical space requires modifications to assure safety and security of the patients. This includes increasing the height of the perimeter fencing on patient courtyards, performing safety modifications such as break-away curtain hooks in shower stalls and mitigating ligature risks in patient rooms and common areas. In addition to these modifications, the space will need to be updated with new paint and patient rooms will be furnished with equipment appropriate for the population to be served.

The timeline for activation of the 78-bed step-down program was originally estimated to take approximately seven to nine months, with initial patient admissions projected to start April 2020. Activation activities include:

- STP certification
- Retrofitting/Safety Modifications (Requires approval by the Office of Statewide Health Planning and Development (OSHPD))
- Development of policies and procedures
- Recruitment, hiring and training staff
- Phased-in admissions of patients

DESCRIPTION OF CHANGE:

78-Bed Southern CA IMD Facility

In the FY 2020-21 May Revision, DSH anticipated that activation would begin with recruitment and training activities in July 2020 and patient admissions would begin in August 2020. The timing of activation was predicated on physical space modifications required to assure safety and security of the patients. Currently, the architectural changes proposed are pending regulatory approval. This along with the COVID 19 pandemic has delayed the projected completion of the retrofit. The provider also received programmatic approval from DHCS to work towards an STP designation, which cannot be received until a physical certification is obtained. The official STP certification will be provided upon completion of the remodel.

The 78-bed IMD contract was executed in July 2020, with a start date of January 1, 2020. Architectural plans have been finalized and a construction timeline has been provided. It is anticipated that construction will be complete and program activation will occur by April 2021, however this trimline is preliminary and dependent upon regulatory approvals. As a result of this delay, DSH estimates a one-time cost savings of $9.8 million in the current year (CY), specific to this program. Currently, DSH does not anticipate an impact to budget year (BY). An update on program activation activities will be provided in the FY 2021-22 May Revision.

10-Bed to a 20-Bed Northern CA Step-Down Facility (Northern CA IMD for NGIs)

State hospital admissions have slowed as a result of operational adjustments implemented to ensure the health and safety of its patients amid the COVID-19 pandemic. However, the rate of referrals has not reduced and are significantly outpacing DSH's ability to admit new patients. Expanding the availability of beds to treat DSH patients in other facilities is critical to providing timely access to those requiring treatment. To address the shortage of available beds within the DSH system of care and expand treatment options available to patients, DSH executed an emergency contract with an IMD facility in Northern California for 10 beds for treatment of state hospital patients ready for step-down into a CONREP program in 18 to 24 months.

Activation of the 10-bed step-down program began in July 2020, which included development of policies and procedures, training staff, and phased admissions. The provider is currently interviewing and evaluating patients for admission and requesting minute orders from the courts. Additionally, the IMD has expressed interest in expanding to a 20-bed program in FY 2021-22. The current contract totals $1.7 million with a per diem rate of $404.77, plus additional supplemental services to be billed in arrears for actual costs. Supplemental services include client transportation costs, life support and enhanced supervision.

DSH utilized one-time savings from the delay of the 78-bed Southern CA IMD program activation in FY 2020-21, totaling $1.7 million, to support this emergency contract. DSH proposes to continue this contract in BY and requests ongoing funding to support the 10-bed contract while also increasing the contract by an additional 10-beds, totaling $3.6 million in BY and ongoing.

20-Bed Northern CA Step-Down Facility (Northern CA MHRC for ISTs)

DSH is continuing its efforts to expand the availability of beds to treat DSH patients in order to provide timely access to Incompetent to Stand Trial (IST) evaluation and treatment. To address the shortage of available beds within the DSH system of care and expand treatment options available to patients, DSH is in active discussions with a second Northern California facility, licensed as a Mental Health Rehabilitation Center (MHRC), which operates several 24-hour residential care facilities for seriously mentally ill individuals. The facility's goal is to reduce inpatient hospitalizations and expedite client transition to lower levels of care to promote community re-entry.

DSH is in negotiations with the Northern California MHRC facility to establish a 20-bed program in the CY, that will serve ISTs who have been ordered to CONREP. DSH expects contract execution and program activation to occur by February 2021, at an estimated CY cost of $1.5 million. DSH plans to utilize one-time savings from the delayed activation of the 78-bed Southern CA IMD program activation in FY 2020-21. To support this new 20-bed IST program in the BY and ongoing, DSH requests additional funding of $3.7 million.

To support these program expansions, DSH requests a half-time Staff Services Manager I, Specialist position to serve as a project manager for these programs. DSH did not receive any position authority for support of the 78-bed program when funding was initially approved and received in the 2019 Budget Act. Duties will include managing and ensuring compliance with the contracts; reviewing invoices and processing payments; monitoring census of the program beds, developing data and reporting trends; and acting as an administrative and operational liaison between the programs and assigned DSH CONREP Consulting Psychologist. This position will be established January 1, 2021, with a CY cost of $44,000 and a CY position authority ask of .3, DSH will offset this cost using one-time savings from the delayed activation of the 78-bed Southern CA IMD program activation. DSH additionally requests position authority of 0.5 and funding of $78,000 in FY 2021-22 and ongoing.

DSH requests additional funding of $7,250,000 for all 40 beds and 0.5 position authority at $78,000, for a total of $7.3 million BY and ongoing.

Continuum of Care
Change for 2020 Budget Act and Projection for FY2021-22

	Bed Capacity	Total Budget
2020 Budget Act:	**78**	**$ 10,961,000**
FY2020-21 Projected Costs*	30	$ 1,168,813
FY2020-21 Northern CA IMD for NGIs	10	$ 1,658,408
FY2020-21 Northern CA MHRC for ISTs	20	$ 1,500,000
Position (.5 FTE)		$ 44,000
2020 Budget Act Reduction		**$ (6,589,779)**
2021 Budget Act:		
Southern CA Facility (IMD)	78	$ 10,961,000
FY2020-21 Northern CA IMD for NGIs	20	$ 3,611,825
FY2020-21 Northern CA MHRC for ISTs	20	$ 3,650,000
Position (.5 FTE)		$ 78,000
2021 Budget Act for Continuum of Care	**118**	**$ 18,300,825**

*Calculated 3 months of costs for April-June 2021 for 78-Bed Southern CA Facility

Funding

Pursuant to WIC 4360 (a) and (b) and Penal Code (PC) section 1615, DSH CONREP pays 100 percent of the costs incurred by providers who deliver treatment and supervision services to CONREP patients. Under the funding methodology, contractors work with DSH to establish a per diem rate for all required services based on prior actual expenditures. The rate is then multiplied by the number of days in a month the client receives services. Funding for other program expenses must either be approved in advance by DSH (supplemental services) or will be billed and paid in arrears. At the end of each fiscal year, DSH will analyze the actual level of required services provided by the contractor.

The overall contract budget for the programs are calculated by multiplying the established per diem rate by the total bed capacity and the number of contract days in the fiscal year. Supplemental service costs are added in and revenue offsets, such as Supplemental Security Income (SSI), are subtracted to provide a total contract budget.

BCP Fiscal Detail Sheet

BCP Title: CONREP Continuum of Care - Existing **BR Name: 4440-022-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-9,792	0	0	0	0	0
Total Operating Expenses and Equipment	**$-9,792**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-9,792**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-9,792	0	0	0	0	0
Total State Operations Expenditures	**$-9,792**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-9,792**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4420010 - Conditional Release Program	-9,792	0	0	0	0	0
Total All Programs	**$-9,792**	**$0**	**$0**	**$0**	**$0**	**$0**

BCP Fiscal Detail Sheet

BCP Title: CONREP Continuum of Care - New | **BR Name: 4440-056-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.3	0.5	0.5	0.5	0.5	0.5
Total Positions	**0.3**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**
Salaries and Wages						
Earnings - Permanent	25	41	41	41	41	41
Total Salaries and Wages	**$25**	**$41**	**$41**	**$41**	**$41**	**$41**
Total Staff Benefits	15	27	27	27	27	27
Total Personal Services	**$40**	**$68**	**$68**	**$68**	**$68**	**$68**
Operating Expenses and Equipment						
5301 - General Expense	2	4	4	4	4	4
5304 - Communications	0	1	1	1	1	1
5320 - Travel: In-State	0	1	1	1	1	1
5324 - Facilities Operation	2	3	3	3	3	3
5340 - Consulting and Professional Services - External	3,158	7,262	7,262	7,262	7,262	7,262
5346 - Information Technology	0	1	1	1	1	1
Total Operating Expenses and Equipment	**$3,162**	**$7,272**	**$7,272**	**$7,272**	**$7,272**	**$7,272**
Total Budget Request	**$3,202**	**$7,340**	**$7,340**	**$7,340**	**$7,340**	**$7,340**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	3,202	7,340	7,340	7,340	7,340	7,340
Total State Operations Expenditures	**$3,202**	**$7,340**	**$7,340**	**$7,340**	**$7,340**	**$7,340**
Total All Funds	**$3,202**	**$7,340**	**$7,340**	**$7,340**	**$7,340**	**$7,340**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	1	2	2	2	2	2
4400020 - Hospital Administration	0	1	1	1	1	1
4420010 - Conditional Release Program	3,201	7,337	7,337	7,337	7,337	7,337
Total All Programs	**$3,202**	**$7,340**	**$7,340**	**$7,340**	**$7,340**	**$7,340**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4800 - Staff Svcs Mgr I (Eff. 01-01-2021)				0.3	0.5	0.5	0.5	0.5	0.5
Total Positions				**0.3**	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4800 - Staff Svcs Mgr I (Eff. 01-01-2021)	25	41	41	41	41	41
Total Salaries and Wages	**$25**	**$41**	**$41**	**$41**	**$41**	**$41**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	1	1	1	1	1
5150350 - Health Insurance	1	2	2	2	2	2
5150450 - Medicare Taxation	0	1	1	1	1	1
5150500 - OASDI	2	3	3	3	3	3
5150600 - Retirement - General	7	12	12	12	12	12
5150800 - Workers' Compensation	1	2	2	2	2	2
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	1	1	1	1	1	1
5150900 - Staff Benefits - Other	3	5	5	5	5	5
Total Staff Benefits	**$15**	**$27**	**$27**	**$27**	**$27**	**$27**
Total Personal Services	**$40**	**$68**	**$68**	**$68**	**$68**	**$68**

FORENSIC CONDITIONAL RELEASE PROGRAM (CONREP)
GENERAL/NON-SEXUALLY VIOLENT PREDATOR (NON-SVP) PROGRAM
MOBILE FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT) TEAM

New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**2.0**	**2.0**	**$0**	**$5,577**	**$7,977**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*2.0*	*2.0*	*$0*	*$5,577*	*$7,977*

BACKGROUND:

The Forensic Conditional Release Program (CONREP) is the Department of State Hospital's (DSH) statewide system of community-based services for specified court-ordered forensic individuals. Mandated as a State responsibility by the Governor's Mental Health Initiative of 1984, the program began operations on January 1, 1986 and operates pursuant to statutes in Welfare and Institutions Code (WIC) 4360 (a) and (b). The goal of CONREP is to promote greater public protection in California's communities via an effective and standardized community outpatient treatment system.

The CONREP population includes:

- Not Guilty by Reason of Insanity (NGI) patients Penal Code (PC) 1026
- Offender with a Mental Health Disorder (OMD) patients (both PC 2964 parolees who have served a prison sentence and PC 2972 parolees who are civilly committed for at least one year after their parole period ends)
- Felony Incompetent to Stand Trial (IST) patients (PC 1370) who have been court-approved for outpatient placement in lieu of state hospital placement), and Offender with a Mental Health Disorder (WIC 6316)

CONREP services are also offered to Sexually Violent Predator (SVP) patients (WIC 6604).

Individuals suitable for CONREP may be recommended by the state hospital Medical Director to the courts for outpatient treatment. Currently, DSH contracts with seven county-operated and three private organizations to provide outpatient treatment services to clients in all 58 counties in the state with non-SVP commitments. As specified in PC 1600-1615 and 2960-2972, the CONREP Community Program Director, with the Court's approval (or in the case of an OMD, the Board of Parole Hearings' approval), assesses and makes the recommendation for individuals' placement in CONREP.

CONREP delivers an array of mental health services to individuals during their period of outpatient treatment. In conjunction with the court-approved treatment plan, contractors coordinate and provide a wide array of services needed to support community reintegration, including forensic mental health treatment through individual and group therapy settings, life skills training, residential placement, collateral contacts (e.g., other individuals/agencies), home visits, substance abuse screenings, psychiatric services, case management, court reports, and psychological assessments. DSH has developed standards for these services which set minimum treatment and supervision levels for individuals court ordered to CONREP. Regular evaluations and assessments on treatment progress are completed by contractors during the period of state hospitalization and while receiving treatment in CONREP.

When a DSH patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if a CONREP-eligible patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP). The STRPs are a cost-effective resource used by CONREP to provide patients with the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hours per day, seven days per week (24/7) supervision while they transition from a state hospital to a community site. The STRP is limited to a 90- to 120-day stay as residential treatment. Once the patient has made the necessary adjustments and is ready to live in the community without structured 24/7 services provided by the STRP, the patient is able to live in a Board & Care, Room & Board, or other independent living arrangement without direct staff supervision.

The current structure of CONREP is based around a centralized outpatient clinic that supports an assigned county or region, With the exception of the few clients (less than 30) residing in a STRP bed and home visits, the majority of treatment services are provided in the clinic whereby clients must seek transportation or walk to access services. Living in a residence within close proximity to the clinic or along a major bus route is essential to accessing treatment timely and on a regular basis. This type of service model limits the inventory of housing secured for placement of CONREP clients since it isn't practical to place individuals in areas that would require a client to navigate multiple bus routes or result in a costly taxi ride to access the outpatient clinic.

DESCRIPTION OF CHANGE:

DSH is partnering with CONREP providers to plan an expansion of CONREP services by implementing a mobile treatment team that is based on the forensic assertive community treatment (FACT) model of care to expand the continuum of treatment options for clients served through CONREP. This level of care can be leveraged to expand community treatment options for individuals committed as an IST, OMD or NGI. Expansion of CONREP capacity and placement of OMD and NGI patients will allow DSH to backfill some of the vacated state hospital beds with ISTs pending placement to DSH and not eligible for outpatient treatment. Additionally, a FACT model of care can be used to place ISTs who may be suitable for outpatient treatment where a community-based restoration program is not available.

FACT Description

Assertive community treatment was developed to help persons with severe mental illness who are at risk of homelessness and hospitalization to become integrated into their communities. This treatment modality engages high-risk individuals in care by using mobile services that are available around the clock and by performing active outreach.[1] FACT builds upon the assertive community treatment model by addressing criminogenic risks in addition to behavioral health needs for individuals involved in the criminal justice system.

Increased Housing and Service Footprint

Implementing a FACT model of care within CONREP would allow providers to seek housing in a broader radius than currently used. This would allow CONREP to access a larger inventory of available housing at potentially lower rates. In prior year budget estimates, the department discussed the challenges with securing new housing and the competition among different community service providers seeking to place their clients in the limited number of board and care facilities and room and board residences. DSH plans to address this challenge through securing master-lease contracts with housing providers to establish dedicated CONREP to deliver treatment services.

[1] https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.55.11.1285

In addition to increased CONREP housing, the FACT model of care will expand the number of IST and state hospital patients who can be eligible for CONREP placement because, unlike the centralized clinic model, services will be primarily delivered at the client's residence and assigned teams are available to respond 24/7. Establishing a flexible model of care that will be responsive to the needs of higher need, higher risk patients will allow DSH to provide a supportive transition for individuals releasing from jail or who have been institutionalized for long periods.

Contracted FACT Staffing, Operating and Housing Resources

To implement the FACT model of care, DSH proposes to augment existing contracts with current CONREP providers and/or partner with new contract providers. Resources required to operate a FACT program include:

- Clinical treatment and client support staff
- Staff travel costs (vehicle and maintenance for staff traveling to/from different housing sites)
- Administrative support and other operational expenses
- Client life support costs (i.e. clothing, food, incentives, toiletries)
- Client housing costs (i.e. rent, utilities)

To support staffing, operational and client-specific costs, DSH assumes an annual cost per bed at $75,000. This cost is based on experience with DSH's contract with the Los Angeles County Office of Diversion and Re-Entry to operate the felony IST community based restoration program, in addition to increased costs associated with procurement and maintenance of staff vehicles required to travel to and from client housing and to transport clients to medical and court appointments.

A fully staffed FACT team can serve up to 100 clients at any given time. This estimate assumes a budget to support a total of 100 beds as new clients may transition in and out of the program during the course of a year. The length of stay of clients will vary depending on the legal commitment and purpose for placement in the FACT level of care and the transition to/from other levels of care based in response to client needs and readiness. The annual cost to operate 100 beds at a cost per bed of $75,000 is $7.5 million with a three percent rate increase beginning in year three of the program.

FACT Staffing

Staffed with clinical and client support positions, FACT teams are mobile and provide 24/7 support to clients as needed to support the client's success and reduce the likelihood of rehospitalization through de-escalation and crisis intervention practices.

In-home services and client visits can range from a typical caseload where five to six clients residing in different residences can be seen each day. DSH anticipates greater efficiency by also employing the use of residences dedicated to housing CONREP clients. Contracted FACT team staffing classifications, functions and proposed staff to client ratios are referenced below:

Job Title	Job Description	Staff to Client Ratio
Psychiatrist, MD	• Meet with clients as needed for psychiatric appointments and to discuss medication needs • Available full time to clients and team for case consultation	1:25 plus relief

Case Manager	• Manage and attend client's appointments • Practice skills with client • Meet with client as needed based on treatment plan • Be available to client for phone calls or visits as needed • Coordinate and collaborate with criminal justice partners and client housing partners • Perform rotations for 24/7 on call coverage • Coordinate crisis intervention as needed • Work with team to stabilize clients	1:10 plus relief
Clinician/Therapist, PhD/PsyD	• Individual therapy with client • Group therapy and socialization activities with clients • Coordination with treatment team and case management on skill work with clients	1:10 plus relief
Nurse, RN/LVN	• Administration of medications • Coordination with Psychiatrist on tele-medical appointments • Monitoring of client's health in relation to medications and overall health	1:25 plus relief
Administrator	• Coordinate and schedule appointments for clinicians, psychiatry, nurses and case managers • Record keeper of client files • Main phone line coverage for public inquiry • Manage team meetings and take notes	1:50
Peer Support	• Meet with client to practice skills • Advocate for client as a peer who has similar lived experience with the criminal justice system and mental health challenges • Training with substance abuse mentorship to aid as a support person and dual attendee for NA/AA	1:10

Housing Start-Up/Program Implementation Costs

In addition to the ongoing costs of $75,000 per bed, per year, DSH anticipates the need to support start-up costs and activation of new programs and housing sites. Costs include housing search activities, procurement of housing, potential minor retrofit/modifications and safety enhancements, patient furnishings, and staff recruitment activities.

Assuming five to eight beds per residence, approximately 15 housing sites would be needed to support a 100-bed program. DSH estimates approximately $100,000 per housing site will be needed to fund program implementation and start up activities for a total of $1.5 million one-time and $10,000 per housing site to support periodic furniture replacement and/or repair for a total of $150,000 ongoing.

DSH Program Oversight and Support Resources

In addition to contract provider resources, DSH requests $287,000 and 2.0 positions in budget year (BY) and ongoing to finalize program planning. These positions will also begin implementation activities such as facilitating contract negotiations, identifying immediate housing options, developing admission and discharge protocols, and working with hospital and CONREP teams to identify and

assess patients ready for discharge into the community. To begin the program planning process and to secure housing and provider contracts by January 2022, DSH requests to establish positions at the start of the budget year. The positions and associated duties are outlined below.

1.0 Clinical Social Worker - Program Oversight
The incumbent will be forensically trained with knowledge and expertise in discharge planning, forensic inpatient and community-based programs. Functions performed will include, but not be limited to, the following:

- Coordinate development of program operations including, but not limited to, developing protocols for referral and placement to the FACT level of care within CONREP
- Coordinate development of policies and procedures for admissions and discharges to and from FACT
- Coordinate with hospital, CONREP, DSH patient management and FACT provider liaisons to facilitate and review process and placement of clients
- Work with program support to develop and maintain a pending placement list
- Identify and implement methods of coding and tracking barriers to discharge
- Engage in stakeholder education and partnership-building (i.e. county behavioral health, law enforcement, corrections, judges, district attorneys, etc.)
- Monitor programs and perform onsite visits to ensure identified best practices in discharge planning are implemented
- Work collaboratively with the program support incumbent to utilize collected data for ongoing program improvement
- Identify and coordinate statewide training, technical assistance and consultation
- Serve in a statewide advisory capacity
- Develop a statewide communication plan and coordinate development of educational materials for staff

1.0 Health Program Specialist (HPS) I – Program Support, Housing Coordination and Data Analytics
The HPS I will serve in a highly skilled specialized role to support the FACT level of care within CONREP. Functions will include, but not be limited to, the following:

- Identify and collaborate with housing providers and prospective landlords and act as a liaison to CONREP providers to coordinate contract negotiations for increased housing
- Negotiate, develop and maintain all other required program contracts
- Monitor established housing contracts to ensure programmatic compliance with contract scope of work
- Perform research and data analysis to support program monitoring including policy and fiscal impacts
- Participate in the development and maintenance of FACT program policies, procedures, training and technical assistance
- Provide administrative and programmatic support to the Clinical Social Worker assigned to FACT administration

<u>Travel, Training and Technical Assistance Resources</u>

Building off of lessons learned with planning and implementation of the DSH Diversion Program, DSH requests an additional $10,000 in BY and ongoing for each proposed position ($20,000 annually) to support the high level of travel to proposed program sites and meeting with stakeholders for program planning, activation and ongoing monitoring and evaluation.

Additionally, DSH requests $20,000 in BY and ongoing to contract with experts to provide technical assistance and training to service providers implementing felony FACT programs ensure that providers are kept up to date on the latest in forensic treatment modalities and best practices. The typical community-based treatment provider does not have a lot of experience in providing forensically focused treatment to patients in the community. Ongoing training and support are essential to the success of the FACT program.

Total Funding Request

Budget Category	CY	BY	BY+1	BY+2	BY+3 (3% rate inc)	BY+4 (3% rate inc)
FACT Program						
Start-Up/Program Implementation Costs	$ -	$ 1,500,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000
FACT Housing/Treatment	$ -	$ 3,750,000	$7,500,000	$7,500,000	$7,725,000	$7,725,000
Subtotal FACT Program	$ -	$ 5,250,000	$7,650,000	$7,650,000	$7,875,000	$7,875,000
Program Support Costs						
DSH Staff Salaries, Benefits, & Operating Expenses	$ -	$ 287,000	$ 287,000	$ 287,000	$ 287,000	$ 287,000
DSH Staff- Additional Travel	$ -	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000
Ongoing Provider Training & Technical Assistance	$ -	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000
Subtotal DSH Support	$ -	$ 327,000	$ 327,000	$ 327,000	$ 327,000	$ 327,000
GRAND TOTAL BUDGET	**$ -**	**$ 5,577,000**	**$7,977,000**	**$7,977,000**	**$8,202,000**	**$8,202,000**

BCP Fiscal Detail Sheet

BCP Title: CONREP Non-SVP Mobile Fact Team **BR Name: 4440-057-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	2.0	2.0	2.0	2.0	2.0
Total Positions	**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**
Salaries and Wages						
Earnings - Permanent	0	163	163	163	163	163
Total Salaries and Wages	**$0**	**$163**	**$163**	**$163**	**$163**	**$163**
Total Staff Benefits	0	92	92	92	92	92
Total Personal Services	**$0**	**$255**	**$255**	**$255**	**$255**	**$255**
Operating Expenses and Equipment						
5301 - General Expense	0	16	16	16	16	16
5304 - Communications	0	2	2	2	2	2
5320 - Travel: In-State	0	22	22	22	22	22
5324 - Facilities Operation	0	10	10	10	10	10
5340 - Consulting and Professional Services - External	0	5,270	7,670	7,670	7,895	7,895
5346 - Information Technology	0	2	2	2	2	2
Total Operating Expenses and Equipment	**$0**	**$5,322**	**$7,722**	**$7,722**	**$7,947**	**$7,947**
Total Budget Request	**$0**	**$5,577**	**$7,977**	**$7,977**	**$8,202**	**$8,202**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	5,577	7,977	7,977	8,202	8,202
Total State Operations Expenditures	**$0**	**$5,577**	**$7,977**	**$7,977**	**$8,202**	**$8,202**
Total All Funds	**$0**	**$5,577**	**$7,977**	**$7,977**	**$8,202**	**$8,202**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	8	8	8	8	8
4400020 - Hospital Administration	0	2	2	2	2	2
4420010 - Conditional Release Program	0	5,567	7,967	7,967	8,192	8,192
Total All Programs	**$0**	**$5,577**	**$7,977**	**$7,977**	**$8,202**	**$8,202**

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
8338 - Hlth Program Spec I (Eff. 07-01-2021)				0.0	1.0	1.0	1.0	1.0	1.0
9872 - Clinical Soc Worker (Hlth/CF)-Safety (Eff. 07-01-2021)				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
8338 - Hlth Program Spec I (Eff. 07-01-2021)	0	76	76	76	76	76
9872 - Clinical Soc Worker (Hlth/CF)-Safety (Eff. 07-01-2021)	0	87	87	87	87	87
Total Salaries and Wages	**$0**	**$163**	**$163**	**$163**	**$163**	**$163**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	2	2	2	2	2
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	8	8	8	8	8
5150450 - Medicare Taxation	0	2	2	2	2	2
5150500 - OASDI	0	5	5	5	5	5
5150600 - Retirement - General	0	40	40	40	40	40
5150800 - Workers' Compensation	0	8	8	8	8	8
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	4	4	4	4	4
5150900 - Staff Benefits - Other	0	22	22	22	22	22
Total Staff Benefits	**$0**	**$92**	**$92**	**$92**	**$92**	**$92**
Total Personal Services	**$0**	**$255**	**$255**	**$255**	**$255**	**$255**

CONTRACTED PATIENT SERVICES

CONTRACTED PATIENT SERVICES
JAIL-BASED COMPETENCY TREATMENT PROGRAMS AND ADMISSION, EVALUATION, AND STABILIZATION CENTER (JBCT/AES)
EXISTING PROGRAMS AND ACTIVATION UPDATES
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**-$3,163**	**$62**	**$62**
One-time	*0.0*	*0.0*	*0.0*	*-$3,163*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$0*	*$62*	*$62*

BACKGROUND:

The Department of State Hospitals (DSH) admits Incompetent to Stand Trial (IST) patients under Penal Code (PC) 1370, which are trial defendants determined by the court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense. DSH contracts with a number of California counties to provide restoration of competency services while the IST patient is housed in county jail facilities. Jail-Based Competency Treatment (JBCT) programs are designed to treat IST patients with lower acuity and to quickly restore them to trial competency, generally within 90 days. If a JBCT program is unable to restore an IST patient to trial competency quickly, the patient is referred to a state hospital for longer-term IST treatment. In the 2020 Budget Act, DSH's JBCT Program received an augmentation of $6.1 million to expand the JBCT program in new locations. This funding provided DSH the ability to provide restoration of competency services to a wider geographic range of patients.

The information below reflects an update on current programs and planned activations in the current year (CY) and the budget year (BY) as well as the ongoing impact of the proposed changes.

DESCRIPTION OF CHANGE FOR EXISTING PROGRAMS AND ACTIVATION UPDATES:

<u>Existing JBCT Program Updates - Cost Increase</u>

Kern Admission, Evaluation, and Stabilization (AES) Center: 60-Beds (-$2.2 million One-time CY Savings)

The 2020 Budget Act included $5.3 million in FY 2020-21 and ongoing to support an additional 30 male AES beds. DSH continues to experience a waitlist of felony ISTs referred to DSH for treatment, which has been further impacted by COVID-19. To help meet this demand for IST treatment, DSH has identified the opportunity to increase the AES Center's capacity by an additional 16 beds to accommodate female IST referrals. A subsequent request will be included in the FY 2021-22 May Revision.

Presently, the Kern AES cannot activate the additional 30 male beds for expansion due to the facility's need to reserve space for COVID-19 isolation. As a result, the expansion has been delayed to July 2021. DSH therefore has a one-time savings of $2.2 million in CY and proposes to realign this funding to use for CY cost increases for existing JBCT programs as well as the CY activation for a Southern California County 8-bed program. (Please refer to the New JBCT Programs Update.) An expansion update will be presented in the FY 2021-22 May Revision.

Calaveras JBCT Program: 10-Beds (-$960,000 One-time CY Savings)

DSH estimated a new 10-bed JBCT program would be activated in Calaveras County at a daily bed rate of $420. This program will serve IST patients from multiple counties in California. DSH originally estimated that startup activities for program activation would begin in July 2020. However, due to significant delays in finalizing the contract and in startup activities, DSH now projects that patient admissions will begin in March 2021. This delay in activation has resulted in a one-time CY savings of $960,100.

JBCT Related Travel Reimbursement ($62,000 BY and Ongoing)

DSH requests funding in contract dollars to support increased operational expenses required to employ a mobile psychologist who will travel to multiple JBCT locations to deliver services. The use of a traveling psychologist will also mediate the recruitment challenges counties experience due to their rural locations. The psychologist will travel between various locations to provide a periodic onsite presence while also using telehealth to supplement service delivery.

DSH worked with impacted programs to develop a cost estimate of approximately $62,000 annually. While this cost appears low, DSH is unable to absorb this amount in its existing JBCT program budget. DSH proposes to redirect a portion of the savings from delayed program activations to fund this expense.

Existing JBCT Program Updates – Informational Only

The following is a list of the JBCT programs that have recently activated or are in process of activating. No change is requested at this time.

San Bernardino JBCT Program: 146-Beds (Future Fiscal Issue)

This program's 146-bed contract expires on December 31, 2020. Due to increases in operational expenditures, San Bernardino County is anticipating a rate increase that DSH will require additional funding to cover. DSH is actively working with the county to understand all JBCT cost drivers to finalize the renewed contract by January 2021. DSH plans to offset the CY cost by utilizing savings from the delayed expansion of the Kern AES program and will submit a request for ongoing BY funding in the FY 2021-22 May Revision.

Riverside JBCT Program: 25-Beds (Future Fiscal Issue)

This program's 25-bed contract expires on December 31, 2020. Similar to the San Bernardino JBCT, Riverside County is also anticipating a rate increase that is estimated to drive up the overall funding need. DSH is actively working with the county to understand all JBCT cost drivers to finalize the renewed contract. DSH plans to offset the CY cost by utilizing savings from the delayed expansion of the Kern AES program and will submit a request for ongoing BY funding in the FY 2021-22 May Revision.

Sacramento JBCT Program: 44-Beds (Future Fiscal Issue)

The program's female 12-bed contract expired on June 30, 2020 and was merged with the 32-male bed contract to reflect a total 44-bed contract beginning July 1, 2020. This new contract merger was negotiated with a new daily bed rate of $452 for all 44 beds. The 2020 Budget Act included funding to increase the daily bed rate for the 32 male beds from $440 to $452. This rate increase reflects cost increases in each contracted staff's salary commensurate with contract salary increases, each county health staff's salary commensurate with bargained salary increases, and an increase in the jail facility's daily rate. This deficit in funding equates to approximately $149,000 in CY and ongoing.

In addition, DSH was unable to commit to securing a contract with Sacramento County beyond the current extension to June 30, 2021 and cannot maintain future contract costs within the program's maximum budget of $452 per bed, per day beginning in FY 2021-22. The county has indicated that overall jail and JBCT clinical costs are expected to increase. DSH is exploring options to accommodate the increase to the contract cost. DSH plans to offset the CY cost by utilizing savings from the delayed expansion of the Kern AES program and will submit a request for ongoing BY funding in the FY 2021-22 May Revision.

Mendocino JBCT Program: Small County Model (Future Fiscal Issue)

This program's small county model contract will expire on April 30, 2021. Due to increases in IST commitments to DSH from Mendocino County, the program will transition from a small county model to a dedicated 4-bed JBCT program to support the increasing rate of IST referrals. DSH, the county, and subcontract clinical provider are currently negotiating contract terms and costs. DSH will provide an update and may present a request for additional resources in the FY 2021-22 May Revision.

Contra Costa JBCT Program (Informational Only)

DSH estimated this 10-bed program would activate in April 2021 and is currently working with the county on finalizing the contract. Anticipated construction and renovations needed in the area of the jail designated for the JBCT may require an adjustment to the timeline for activation. Additional updates will be provided in the FY 2021-22 May Revision.

Stanislaus JBCT Program: 6-Bed Expansion (Informational Only)

DSH estimated the Stanislaus JBCT program would increase its capacity by an additional six beds in January 2020, increasing the program's total capacity to 18 beds to serve IST patients from that county. This expansion occurred as planned in January 2020 and is fully activated.

San Joaquin County JBCT Program: 10-Bed (Informational Only)

DSH estimated that a new 10-bed JBCT program would be activated in San Joaquin County with patient admissions beginning in October 2019. Patient admissions were slightly delayed and began in January 2020.

Monterey JBCT Program: 10-Bed (Informational Only)

DSH estimated that a new 10-bed JBCT program would be activated in Monterey County at a daily bed rate of $420, which will serve male IST patients from multiple neighboring counties. Startup activities began in June 2019 to renovate the treatment space. Due to delays in completing these necessary renovations and recruiting their clinical staff, DSH estimated that patient admissions would

begin in January 2020. As a result of delays in recruitment and completing the necessary renovations, patient admissions were slightly delayed and began in May 2020.

Kings JBCT Program: 5-Bed (Informational Only)

DSH estimated that a new 5-bed JBCT program would be activated in Kings County at a daily bed rate of $420 in December 2019, which would serve IST patients from that county. Patient admissions began in July 2020.

Humboldt JBCT Program: 6-Bed (Informational Only)

DSH estimated that a new 6-bed JBCT program would be activated in Humboldt county at a daily bed rate of $420 in January 2020, which will serve male IST patients from neighboring counties. Due to significant delays in finalizing the contract and in startup activities, patient admissions began in August 2020.

Shasta JBCT Program: 6-Bed (Informational Only)

DSH estimated that a new 6-bed JBCT program would be activated in Shasta County at a daily bed rate of $420 in January 2020, which will serve IST patients from multiple counties across Northern California. Startup activities began in July 2019 to begin renovating the treatment space. Due to significant delays in finalizing the contract and in startup activities, patient admissions began in September 2020.

Placer JBCT Program: 15-Bed (Informational Only)

DSH estimated that a new 15-bed JBCT program would be activated in Placer County at a daily bed rate of $420 in June 2020, which would serve IST patients from multiple counties across Northern California. Due to the COVID-19 pandemic, the JBCT designated programming area in the jail is being used to book and house female inmates from another Placer County jail. As a result of the delay in identifying an alternate programming area, patient admissions began in September 2020.

Santa Barbara JBCT Program: 10-Bed (Informational Only)

DSH estimated that a new 10-bed JBCT program would be activated in Santa Barbara County at a daily bed rate of $420 and will serve IST patients specifically from this county. Startup activities for program activation were estimated to begin in April 2020. Due to significant delays in finalizing the contract and completing their startup activities, patient admissions began in November 2020.

Solano JBCT Program: 10-Bed (Informational Only)

This 10-bed JBCT program was activated in Solano County in February 2019. Due to the plant's physical layout and lack of a therapeutic and milieu environment, the JBCT was moved from the Justice Center Detention to the Stanton Correctional Facility in Solano County. The layout of the new facility warranted a need for additional correctional officers; this increase of staffing augmented the daily bed rate negotiated with Solano County that DSH was able to accommodate within the budget authorized for this program.

Existing JBCT Program Summary Table

Existing JBCT Program Bed Capacity and Proposed Funding						
	Bed Capacity in FY 2020-21	Bed Capacity in FY 2021-22	Per Diem Rate	2020-21	2021-22	2022-23
JBCT-Related Travel Reimbursement	N/A	N/A	N/A	$0	$62,000	$62,000
Calaveras JBCT	10	10	$420	($960,000)	$0	$0
Kern AES	60	106	$480	($2,203,000)	$0	$0
Riverside JBCT	25	25	$360.64	-	-	-
Sacramento JBCT	44	44	$452	-	-	-
San Bernardino JBCT	146	146	$390	-	-	-
Contra Costa JBCT	0	10	$420	-	-	-
Butte JBCT	5	5	$420	-	-	-
Solano JBCT	10	10	$417.75	-	-	-
San Luis Obispo JBCT	5	5	$424.28	-	-	-
San Joaquin JBCT	10	10	$417.42	-	-	-
San Diego JBCT	30	30	$391	-	-	-
Sonoma JBCT	12	12	$431	-	-	-
Stanislaus JBCT	18	18	$375	-	-	-
Monterey JBCT	10	10	$419.25	-	-	-
Kings JBCT	5	5	$409.69	-	-	-
Humboldt JBCT	6	6	$418.64	-	-	-
Shasta JBCT	6	6	$373.73	-	-	-
Placer JBCT	15	15	$374.44	-	-	-
Santa Barbara JBCT	10	10	$418.46	-	-	-
Mariposa JBCT[1]	N/A	N/A	N/A	-	-	-
Mendocino JBCT[1]	N/A	N/A	N/A	-	-	-
TOTAL:	**427**	**483**		**($3,163,000)**	**$62,000**	**$62,000**

[1]Specific to the small county models, due to the payment model with both fixed and variable costs, a per diem rate is not applicable for these programs. Additionally, each small county model will serve up to 15 IST patients annually.

BCP Fiscal Detail Sheet

BCP Title: Jail-Based Competency Treatment (JBCT) Program - Existing **BR Name: 4440-024-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-960	62	62	62	62	62
Total Operating Expenses and Equipment	**$-960**	**$62**	**$62**	**$62**	**$62**	**$62**
Total Budget Request	**$-960**	**$62**	**$62**	**$62**	**$62**	**$62**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-960	62	62	62	62	62
Total State Operations Expenditures	**$-960**	**$62**	**$62**	**$62**	**$62**	**$62**
Total All Funds	**$-960**	**$62**	**$62**	**$62**	**$62**	**$62**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4430020 - Jail Based Competency Treatment	-960	62	62	62	62	62
Total All Programs	**$-960**	**$62**	**$62**	**$62**	**$62**	**$62**

BCP Fiscal Detail Sheet

BCP Title: Admission, Evaluation and Stabilization (AES) Center - Existing **BR Name: 4440-023-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	BY	BY+1	BY+2	BY+3	BY+4
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	-2,203	0	0	0	0	0
Total Operating Expenses and Equipment	**$-2,203**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Budget Request	**$-2,203**	**$0**	**$0**	**$0**	**$0**	**$0**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	-2,203	0	0	0	0	0
Total State Operations Expenditures	**$-2,203**	**$0**	**$0**	**$0**	**$0**	**$0**
Total All Funds	**$-2,203**	**$0**	**$0**	**$0**	**$0**	**$0**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4430010 - Admission, Evaluation, Stabilization Center	-2,203	0	0	0	0	0
Total All Programs	**$-2,203**	**$0**	**$0**	**$0**	**$0**	**$0**

CONTRACTED PATIENT SERVICES
JAIL-BASED COMPETENCY TREATMENT (JBCT) PROGRAMS
NEW PROGRAM UPDATES
New Item

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**0.0**	**0.0**	**$785**	**$6,275**	**$6,275**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$0*	*$0*
Ongoing	*0.0*	*0.0*	*0.0*	*$785*	*$6,275*	*$6,275*

BACKGROUND:

The Department of State Hospitals (DSH) continues to build out its continuum of care to support Incompetent to Stand Trial (IST) patients by working with a number of counties to develop new Jail-Based Competency Treatment (JBCT) programs in their local jails and secure contracts to activate these programs in the budget year (BY). The target range of beds for each county is based on an analysis of the county's monthly trend of felony IST referrals. Negotiations and contract development are at various stages for each location and the proposals below reflect the programs furthest along in the process. DSH requests authority to establish funding to allow contract and program development to continue moving forward. DSH assumes an estimated daily bed rate of $420, which is consistent with the rates established for past JBCT program activations but, based on the size, physical layout of the jail, geographical location, and other factors, the final per diem rate may vary by program.

DESCRIPTION OF CHANGE:

New JBCT Programs with Dedicated JBCT Beds/Treatment Milieu

DSH is actively working with several counties to establish dedicated JBCT beds. The target range of beds for each county is based on an analysis of the monthly trend of felony IST referrals tracked by DSH and the county's interest in establishing a local or regional program. DSH assumes an estimated daily bed rate of $420, which is consistent with the rates established for past JBCT program activations.

December 2020 Proposed Activation:

- *Southern California County A: Request to Establish 8-Bed Program ($782,000 Current Year (CY); $1.2 Million BY and Ongoing)*

  DSH proposes to establish a JBCT program in a Southern California county that will provide eight beds for IST patients from that county. Assuming program activation will occur in December 2020 at a daily bed rate of $420, the estimated cost to support all eight beds in the CY is approximately $781,555. As such, DSH proposes to utilize $781,555 of the CY savings from the delayed expansion of the Kern Admission, Evaluation and Stabilization Center (AES) program to offset this need. The annual ongoing cost is approximately $1.2 million.

July 2021 Proposed Activations:

- *Central California B: Request to Establish 6-Bed Program ($920,000 BY and Ongoing)*

  DSH proposes to establish a JBCT program in a Central California county that will provide six beds for IST patients from that county. At a daily bed rate of $420, the estimated cost to support all six beds in the BY and ongoing is $919,800.

- *Central California C: Request to Establish 12-Bed Program ($1.8 million BY and Ongoing)*

  DSH proposes to establish a JBCT program in a Central California county that will provide 12 beds for IST patients from that county. At a daily bed rate of $420, the estimated cost to support all 12 beds in the BY and ongoing is approximately $1,840,000.

- *Northern California County G: Request to Establish 5-Bed Program ($767,000 BY and Ongoing)*

  DSH proposes to establish a JBCT program in a Northern California county that will provide five beds for IST patients from that county. At a daily bed rate of $420, the estimated cost to support all five beds in the BY and ongoing is approximately $767,000.

New Small County JBCT Models

DSH is also working with three Northern California counties to establish JBCT programs that are flexible in size and scope to serve their limited number of felony IST referrals. The payment model assumes a fixed cost for county administrative and medical costs, and variable costs to compensate for the daily jail rate and competency services delivered when IST patients are ordered into the program. Because these programs will serve a small annual total of patients, the program costs will be reduced in comparison to the JBCT programs that designate a specific number of beds. DSH proposes to activate three new small county JBCT programs, all in Northern California counties with an estimated annual cost of approximately $500,000 for each program in the BY and ongoing.

July 2021 Proposed Activations:

- *California County D: Small County ($500,000 BY and Ongoing)*
- *California County E: Small County ($500,000 BY and Ongoing)*
- *California County F: Small County ($500,000 BY and Ongoing)*

Patients' Rights Advocates Funding

DSH requests $22,000 in FY 2021-22 and ongoing to fund contracted patients' rights advocacy services to support the proposed new JBCT programs in order to comply with Assembly Bill (AB) 103 (Statutes of 2017). AB 103 requires that all DSH patients have equal access to patients' rights advocacy resources, including IST patients who are admitted to JBCT programs. DSH will utilize CY savings from the delayed Kern AES expansion, to offset the CY cost of $3,000.

JBCT	Caseload	PRA Position	Annual Cost
FY 2021-22 Proposed Program with Dedicated Beds	31	0.5	$20,000
FY 2021-22 Proposed Small County Models	3	0.1	$2,000
TOTAL	**34**	**0.6**	**$22,000**

New JBCT Program Summary Table:

New JBCT Program Bed Capacity and Proposed Funding						
	Bed Capacity in FY 2020-21	**Bed Capacity in FY 2021-22**	**Per Diem Rate**	**2020-21**	**2021-22**	**2022-23**
Southern California County A JBCT	8	8	$420	$782,000	$1,226,000	$1,226,000
Central California County B JBCT	0	6	$420	$0	$920,000	$920,000
Central California County C JBCT	0	12	$420	$0	$1,840,000	$1,840,000
Northern California Small County D JBCT	N/A	N/A	N/A	$0	$500,000	$500,000
Northern California Small County E JBCT	N/A	N/A	N/A	$0	$500,000	$500,000
Northern California Small County F JBCT	N/A	N/A	N/A	$0	$500,000	$500,000
Northern California County G JBCT	0	5	$420	$0	$767,000	$767,000
Patients' Rights Advocate Funding	N/A	N/A	N/A	$3,000	$22,000	$22,000
TOTAL:[1]	**8**	**31**		**$785,000**	**$6,275,000**	**$6,275,000**

[1]The savings from the delayed Kern AES expansion will be used to fund new programs in the CY. Please refer to the Existing Programs narrative.

BCP Fiscal Detail Sheet

BCP Title: Jail-Based Competency Treatment (JBCT) Program - New | **BR Name: 4440-025-ECP-2021-GB**

Budget Request Summary

	FY21					
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Operating Expenses and Equipment						
5340 - Consulting and Professional Services - External	785	6,275	6,275	6,275	6,275	6,275
Total Operating Expenses and Equipment	**$785**	**$6,275**	**$6,275**	**$6,275**	**$6,275**	**$6,275**
Total Budget Request	**$785**	**$6,275**	**$6,275**	**$6,275**	**$6,275**	**$6,275**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	785	6,275	6,275	6,275	6,275	6,275
Total State Operations Expenditures	**$785**	**$6,275**	**$6,275**	**$6,275**	**$6,275**	**$6,275**
Total All Funds	**$785**	**$6,275**	**$6,275**	**$6,275**	**$6,275**	**$6,275**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4430020 - Jail Based Competency Treatment	785	6,275	6,275	6,275	6,275	6,275
Total All Programs	**$785**	**$6,275**	**$6,275**	**$6,275**	**$6,275**	**$6,275**

CONTRACTED PATIENT SERVICES

JAIL-BASED COMPETENCY TREATMENT PROGRAMS AND ADMISSION, EVALUATION, AND STABILIZATION CENTER (JBCT/AES)

Total Bed Capacity and Projected Funding

Redirection of Current Year (CY) Savings

Due to the delays in the Kern Admission, Evaluation, and Stabilization (AES) expansion and Calaveras Jail-Based Competency Treatment (JBCT) activations funded in the 2020 Budget Act, the Department of State Hospitals (DSH) proposes to utilize $785,000 of the anticipated current year (CY) savings to fund the following fiscal fear (FY) 2020-21 cost pressures:

- Patients' Rights Advocates contract: $3,000
- New Program Southern CA County A activation: $782,000

DSH is currently in negotiations for both existing and new JBCT contracts and will provide additional updates on CY savings utilization in the 2021-22 May Revision.

Total JBCT Capacity and Projected Funding						
	Bed Capacity in FY 2020-21	Bed Capacity in FY 2021-22	Per Diem Rate	2020-21	2021-22	2022-23
JBCT-Related Travel Reimbursement	N/A	N/A	N/A	$0	$62,000	$62,000
Calaveras JBCT	10	10	$420	($960,000)	$0	$0
Kern AES [1]	60	106	$480	($2,203,000)	$0	$0
Riverside JBCT	25	25	$360.64	-	-	-
Sacramento JBCT	44	44	$452	-	-	-
San Bernardino JBCT	146	146	$390	-	-	-
Contra Costa JBCT	0	10	$420	-	-	-
Butte JBCT	5	5	$420	-	-	-
Solano JBCT	10	10	$417.75	-	-	-
San Luis Obispo JBCT	5	5	$424.28	-	-	-
San Joaquin JBCT	10	10	$417.42	-	-	-
San Diego JBCT	30	30	$391.00	-	-	-
Sonoma JBCT	12	12	$431	-	-	-
Stanislaus JBCT	18	18	$375	-	-	-
Monterey JBCT	10	10	$419.25	-	-	-
Kings JBCT	5	5	$409.69	-	-	-
Humboldt JBCT	6	6	$418.64	-	-	-
Shasta JBCT	6	6	$373.73	-	-	-
Placer JBCT	15	15	$374.44	-	-	-
Santa Barbara JBCT	10	10	$418.46	-	-	-
Mariposa JBCT [1]	N/A	N/A	N/A	-	-	-
Mendocino JBCT [1]	N/A	N/A	N/A	-	-	-
Southern California County A JBCT	8	8	$420	$782,000	$1,226,000	$1,226,000

Central California County B JBCT	0	6	$420	$0	$920,000	$920,000
Central California County C JBCT	0	12	$420	$0	$1,840,000	$1,840,000
Northern California Small County D JBCT	N/A	N/A	N/A	$0	$500,000	$500,000
Northern California Small County E JBCT	N/A	N/A	N/A	$0	$500,000	$500,000
Northern California Small County F JBCT	N/A	N/A	N/A	$0	$500,000	$500,000
Northern California County G JBCT	0	5	$420	$0	$767,000	$767,000
Patients' Rights Advocate Funding	N/A	N/A	N/A	$3,000	$22,000	$22,000
Total	**435**	**514**		**($2,378,000)[2]**	**$6,337,000**	**$6,337,000**

[1]Specific to the small county models, due to the payment model with both fixed and variable costs, a per diem rate is not applicable for these programs. Additionally, each small county model will serve up to 15 IST patients annually.
[2]DSH proposes to utilize $785,000 of CY savings to offset the CY program activations and cost increases.

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL (IST) DIVERSION PROGRAM
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**3.0**	**3.0**	**0.0**	**$47,584**	**$1,230**
One-time	*0.0*	*0.0*	*0.0*	*$0*	*$47,584*	*$1,230*
Ongoing	*0.0*	*3.0*	*3.0*	*$0*	*$0*	*$0*

BACKGROUND:

The 2018 Budget Act included $100 million one-time General Fund, available for expenditure between fiscal years (FY) 2018-19 through FY 2022-23, to establish the IST Diversion Program. The Program authorizes the Department of State Hospitals (DSH) to contract with counties to develop new, or expand existing, Diversion programs. These county programs serve individuals with serious mental illnesses who are diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with potential to be found IST on felony charges.

<u>County Program Funding</u>

Of the $100 million, $99.5 million was available to fund counties. Of the $99.5 million, $91 million was earmarked for the 15 counties with the highest referrals of felony ISTs to DSH in FY 2016-17: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. Funding was specifically earmarked for these top fifteen counties; therefore, they did not have to submit a competitive application to participate in the program (Round 1).

Of the $99.5 million, $8.5 million was made available to other counties. In December 2018, DSH released a Request for Application (RFA) to all other counties in the state to apply for a portion of the $8.5 million available in a competitive funding process (Round 2). In June 2019, DSH awarded the "Round 2" funding to the following counties: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo.

In November 2019, DSH released a second competitive RFA (Round 3) to counties not included in Round 1 or awarded funds in Round 2. A total of $4.4 million in program savings from the original 15 counties has been awarded to a third round of counties: Humboldt, San Mateo, Siskiyou and Ventura counties.

<u>Program Administration</u>

Of the $100 million, $500,000 was dedicated for 2.0 staff, operating expenses and research contract funding. With a fully staffed IST Diversion team, DSH has been able to work closely with the Council of State Governments Justice Center (CSG) and the Council on Criminal Justice and Behavioral Health (CCJBH). Both DSH and CCJBH have contracts with CSG to develop technical assistance trainings, learning materials and program templates for county use, and to connect DSH and CCJBH with experts in other states who have prior experience implementing Diversion programs. The DSH team also recently joined the CSG California Stepping Up Initiative Partners group which brings together stakeholders in criminal justice and behavioral health to discuss potential solutions to the issue of the seriously mentally ill in the criminal justice system.

County Program Implementation Status

As of December 2020, the following has occurred:

- Thirteen counties have activated their felony Diversion programs
- An additional seven counties have fully executed contracts with DSH and planned activation dates for winter 2021
- One county has a contract pending county approval
- Four counties are currently in contract negotiation with DSH

In total, current participating counties anticipate diverting 841 felony ISTs over the course of their programs. The following table displays county status, funding, target population total and program activation dates:

	County Program Status			
	Activated Programs			
County	**Funding Round**	**Funding**	**Population**	**Program Start Date**
Del Norte	2	$426,000	9	6/1/2020
Humboldt	3	$979,800	23	7/1/2020
Kern	1	$7,891,400	56	1/13/2020
Los Angeles	1	$25,864,100	200	3/1/2019
Marin	2	$531,476	12	6/12/2020
San Bernardino	1	$7,464,800	53	1/1/2020
San Diego	1	$3,328,000	30	10/27/2020
San Francisco	2	$2,300,400	30	7/1/2020
San Luis Obispo	2	$1,278,000	9	8/20/2019
Santa Barbara	1	$2,644,500	18	9/22/2020
Santa Clara	1	$2,840,000	20	7/1/2020
Santa Cruz	2	$1,362,536	45	10/1/2020
Sonoma	1	$3,839,100	27	1/1/2020
Subtotal		**$60,750,112**	**532**	
	Executed Contracts			
County	**Funding Round**	**Funding**	**Population**	**Estimated Start Date**
Alameda	1	$3,114,100	22	Winter 2021
Contra Costa	1	$3,114,100	22	Winter 2021
Fresno	1	$5,843,700	42	Winter 2021
Placer	2	$1,065,000	21	Winter 2021
Sacramento	1	$4,478,900	32	Winter 2021
Ventura	3	$2,428,200	18	Winter 2021
Yolo	2	$1,100,000	8	Winter 2021
Subtotal		**$21,144,000**	**165**	

	Contracts Pending County Approval			
County	**Funding Round**	**Funding**	**Population**	**Estimated Start Date**
San Mateo	3	$835,757	12	TBD
Subtotal		**$835,757**	**12**	
	Contracts in Negotiation			
County	**Funding Round**	**Funding**	**Population**	**Estimated Start Date**
Riverside	1	$6,910,100	48	TBD
San Joaquin	1	$2,986,000	21	TBD
Siskiyou	3	$194,000	40	TBD
Solano	1	$3,242,300	23	TBD
Subtotal		**$13,332,400**	**132**	
Grand Total		**$96,062,269**	**841**	

In late May 2020, DSH was informed that Stanislaus County, one of the original "Top 15" counties guaranteed funding under this program, chose not to participate. According to the county, their withdrawal was due to COVID-19 economic issues and a lack of other county resources to establish the program. Please see the section *Request Extension of FY 2018-19 Funding for Counties* for the associated savings and DSH's request to utilize those funds for other counties.

Program Administration Update

DSH continues to provide all counties participating in the felony IST Diversion program with technical assistance and training opportunities. As of September 30, DSH has provided 67 hours of in-person and web-based training to counties. In FY 2018-19 and 2019-20, DSH technical assistance focused primarily on topics to support county planning and initial implementation efforts. Topics for FY 2020-21 focus on supporting counties as their programs are activated and becoming established. Current topics include a series on the following:

- Appropriate medications and psychopharmacology considerations for prescribers in Diversion programs
- How to use risk assessments to inform client treatment plans
- Case plan review sessions with DSH psychiatrists, external experts and other county staff to assist counties in evaluating more difficult cases

Additionally, DSH partnered with the Department of Health Care Services and the California Institute for Behavioral Health Solutions to provide additional trainings to counties across the state. Through a contract with the University of Cincinnati's Corrections Institute (UCCI), the partnership has created two online e-learning modules that launched on June 30, 2020. In August and September of 2020, UCCI successfully led four virtual training sessions for cohorts of 15 county participants. This training focused on Core Correctional Practices - risk mitigation strategies - that county-based mental health treatment providers can utilize when working with clients involved in the criminal justice system.

Finally, the Competency to Stand Trial group applied for and was awarded membership in the Substance Abuse and Mental Health Services Administration (SAMHSA) Gather, Assess, Integrate, Network, and Stimulate (GAINS) Center Communities of Practice in FY 2019-20. Through this Communities of Practice program, the Diversion team and our county participated in a national learning collaborative with other states developing solutions to the competency to stand trial crisis. As part of this group, DSH and counties shared experiences with and learned from the experiences of other states. The Diversion program also received complimentary technical assistance from national experts coordinated through the SAMHSA GAINS Center. In July 2019, Drs. Lisa Callahan and Deb Pinals, two national experts in mental health and criminal justice diversion, provided a two-day in person training to counties participating in the DSH Diversion program. The training focused on helping counties finalize their program plans, brought various county stakeholders together, and helped the counties continue to network as a program cohort.

SAMHSA GAINS extended its Communities of Practice program into 2020. The DSH Diversion team and counties were invited to attend a series of virtual seminars led by national experts on topics related to competency restoration and community treatment. The seminar series provided stakeholders with 30 hours of free training in May, June and July; similar to Summer 2019. SAMHSA also provided additional direct technical assistance to the DSH program from Dr. Deb Pinals. Dr. Pinals who, in partnership with DSH psychiatrists, provided three case consultation sessions to DSH counties in August 2020.

Diversion Program Data Collection Efforts and Research

DSH is actively collecting the data required in Welfare and Institutions Code (WIC) 4361 from every county with an activated Diversion program. Data is collected quarterly in arrears on all county IST Diversion Program participants. As of June 30, 2020, 144 individuals have been diverted to a county-run program. DSH is continuing to work one-on-one with all other counties as they prepare to activate programs to ensure data collection is as seamless as possible for the county and the department.

In September 2019, DSH was awarded an incubation grant of $39,600 from the Abdul Lateef Jameel Poverty Action Lab (J-PAL) North America of the Massachusetts's Institute of Technology. J-PAL North America supports the development and implementation of randomized control trials (RCTs) in public health and welfare programs. DSH Diversion was awarded the use of J-PAL academicians and funding to determine if an RTC of the Diversion program is feasible. Regular meetings with the J-PAL team began in October 2019 but have been on hold due to COVID-19 since spring 2020. J-PAL has approved a no-cost extension on this grant to DSH through June 30, 2022.

DESCRIPTION OF CHANGE:

Request to Expand Felony IST Diversion Program Statewide

DSH requests $46.4 million one-time General Fund to expand the current IST Diversion program in both current and new counties. Consistent with the current IST Diversion program authorized in FY 2018-19, DSH proposes a one-time appropriation in BY that can be obligated over a three-year period with an additional two years to fully expend funding.

New County Expansion

DSH proposes to expand the Diversion program to new counties and will apply the same assumptions used to fund current participating counties:

- Assume 20-30% of the felony IST population for each county may be eligible for diversion. The average annual felony IST referral rates over the last three FYs is used as the base to calculate the 20-30% range. The range established will serve as the target population for program planning and to identify funding levels.

- Apply the three-year allocation rate of $142,000 ($47,333/annually) per diversion client to the projected target population range.

- The target population number at 30% of the total annual felony IST referrals multiplied by the allocation rate = maximum funding available for the county.

- Counties will be required to submit a program implementation plan detailing diversion program housing and services, establish a contract with DSH and report required data on a quarterly basis to DSH for fund distribution.

Existing County Expansion

DSH proposes to expand the number of individuals served by counties where funding has been provided to implement Diversion programs for DSH's target population. These counties have an established population target along with program implementation plans developed and approved by DSH. Additional funding for these counties would support a 10-20% increase in the number of diversion clients served, above the counties' established population target established in their approved program implementation plan and corresponding contract.

The table below displays the maximum funding requested to support expansion of Diversion programs to new and existing counties. DSH estimates completing the majority of county contracts (for both new programs and the expansion of existing programs) by June 2022, with most new programs activated between December 2022 and July 2023.

DSH Diversion Expansion - Funding Request			
Program Type	**Number of Counties**	**Estimated Annual Pop. (High Range)**	**Maximum Funding (3-Year Total)**
New County Programs	33	204	$ 28,968,000
Existing County Programs	25	123	$ 17,409,200
TOTAL	**58**	**327**	**$ 46,377,200**

Request Extension of FY 2018-19 Funding for Original Counties

DSH requests to extend the availability of funding for the IST Diversion Program pilot project by 12 months. At this time, DSH estimates that up to $8.0 million General Fund will not be encumbered by the existing deadline of June 30, 2021 as determined from the following:

- $4.0 million from one county who declined to participate in the current program and two counties that have contracted for less than the maximum funding available to them
- $3.0 million from one county at risk of not participating
- $1.0 million in potential savings from counties not yet contracted with DSH who may elect to take less than their full allotment.

This request will allow DSH to encumber any remaining contract funding through June 30, 2022 and to liquidate all funding to counties ($99.5 million) through June 30, 2024. Multiple impacts from the COVID-19 pandemic, detailed below, delayed or derailed county programs through the spring and summer of 2020. Some counties also experienced program implementation delays due to the need for additional time to develop program infrastructure and execute contracts. The additional 12 months requested will grant DSH and participating counties enough time to complete the full pilot program. Additionally, DSH will be able to fully utilize the $100 million appropriation by allocating the remaining unallocated program funding to counties with capacity to serve more individuals through this program. See the proposed 2021 Budget Act, Item 4440-490 for the reappropriation authority.

Beginning in March 2020, Governor Newsom placed the State of California under a shelter-in-place in response to the COVID-19 crisis. DSH continues to work closely with our county partners to track the impacts of the pandemic on their felony mental health Diversion programs. The majority of DSH Diversion county programs have been delayed because of this crisis. Changes in the counties' Board of Supervisors' schedules and updates to their hiring plans due to budget-driven hiring freezes, have delayed counties in getting contracts. Identifying potential Diversion candidates across the state has become more difficult because of COVID-19 outbreaks in local jails, mass-releases of inmates, and policies adopted by Sheriff's Offices to limit outside visitors without an option to interview prisoners. Additionally, the temporary closure of a number of courts during the first few months of the Pandemic also further impacted delays in activations and diversion of individuals. With the uncertainties of the course of the COVID-19 pandemic additional program delays may result.

The development of Diversion programs in some counties has also been delayed by other factors in addition to the challenges of COVID-19. A number of counties did not have existing programs for felony offenders that they could expand for this program. In these counties, additional time was needed to develop a program plan, policies and procedures for all of the stakeholders involved, and build the capacity in their system of care to provide services for this population. Many counties have also had to contract out for service providers for this project and have had to work through lengthy RFP processes which have contributed to activation delays.

Request for Resources for Program Administration and Data Collection Activities

The original funding proposal approved for this program included funding for three years to support the equivalent of 2.0 positions at DSH as well as $100,000 one-time for research and data collection efforts. To support the expansion, implementation and management of both new and existing programs, DSH requests 3.0 permanent, ongoing positions and $560,000 in five-year limited-term funding beginning in BY to support the 2.0 positions currently assigned to this project and the addition of 1.0 additional staff position through the end of the pilot program. Additionally, DSH assumes increased travel of $75,000 ($25,000 each) annually to support in person site visits to evaluate all programs and to conduct in person trainings.

DSH is requesting permanent position authority and five-year limited-term funding for the 3.0 staff positions. The original support resources for the pilot program included three years of limited-term funding and no position authority; DSH was instructed to redirect and fill current vacant positions in a limited-term capacity. Per Government Code (GC) 19080.3, state departments can only use limited-term positions with the same incumbents and duty statement for 12 months. DSH has designated

authority to extend limited-term positions for up to 24 months but will not be able to extend the current Diversion positions for an additional four years in a limited-term capacity and cannot establish the newly requested position in a limited-term capacity for five years. At the end of this project the Department will reassess the need for the requested positions to support this or other department priorities and initiatives and, if necessary, will request ongoing funding at that time.

In the original proposal, DSH requested funding equivalent to 1.0 Chief Psychologist and 1.0 Health Program Specialist. However, in implementing the program, DSH found utilizing 1.0 Senior Psychologist (Supervisory) and 1.0 Staff Services Manager II (Specialist) was more appropriate for managing the roll-out and ongoing operation of this program. In addition, to support the workload of expanding this program statewide, DSH requests 1.0 Associate Governmental Program Analyst:

1.0 Senior Psychologist (Supervisory) – Program Support and Oversight ($238,000 SGF)
DSH requests $238,000 BY ongoing to support 1.0 Senior Psychologist (Supervisory). The current incumbent is forensically trained with expertise in diversion, risk assessment and risk mitigation, and data collection and research. The incumbent's clinical expertise is necessary to:

- Review initial county program proposals and any changes to pilot program treatment protocols
- Provide ongoing technical assistance and support to counties and stakeholder education (county behavioral health, law enforcement, judges, district attorneys, etc.)
- Consult on measuring program effectiveness
- Monitor programs and perform onsite visits to ensure identified best practices in diversion are implemented
- Monitor programmatic compliance with the contract scope of work
- Work collaboratively with the contracted research analyst to utilize collected data for ongoing program improvement
- Serve in a statewide advisory capacity

1.0 Staff Services Manager II (Specialist) – Program Support and Oversight ($179,000 SGF)
DSH requests $179,000 BY ongoing to support 1.0 Staff Services Manager II (Specialist). The current incumbent has expertise in diversion programming, program implementation and project management, and all department administrative functions. The incumbent's administrative and policy expertise is necessary to:

- Review initial county program proposals and any changes to pilot program treatment protocols
- Provide ongoing technical assistance to counties and stakeholder education (county behavioral health, law enforcement, judges, district attorneys, etc.) and support
- Monitor programs and perform onsite visits to ensure identified best practices in diversion are implemented
- Monitor programmatic compliance with the contract scope of work
- Manage all administrative aspects of the program including but not limited to contract negotiations with county stakeholders and development of fiscal reporting requirements and processes
- Act as a policy expert and advisor to the department on diversion-related matters
- Serve as a liaison for the department with county leadership and other state and national workgroups
- Perform research and analysis of program, policy and fiscal impacts of Diversion programs for the State

1.0 Associate Governmental Program Analyst – Program Support and Oversight ($142,000 SGF)
DSH requests $142,000 BY ongoing to support 1.0 Associate Governmental Program Analyst. The incumbent will be responsible for the following duties:

- Manage all internal contract processing and tracking for program
- Reconcile client diversion data for payment authorization and process/track allocation payments to counties; work with county contacts to reconcile discrepancies
- Collect and consolidate all county fiscal reports; work with county contacts to reconcile discrepancies
- Track current status of all county programs including but not limited to program plan development, contract language review, and program activation status
- Manage logistics for all department sponsored technical assistance and training provided to counties, including maintenance and development of program webpage resources for counties and management of DSH Diversion email inbox
- Maintain all status reports for internal and external stakeholders

DSH also requests five-year limited term funding in support of the research and data collection efforts for this program. In the original request for this program, DSH assumed an online portal could be developed which counties would use to directly input their data reports. However, because of the limited timeframe for this project, development of such a portal was unfeasible and DSH is instead collecting and consolidating county data manually.

DSH is using its ongoing research relationship with the University of California, Davis (UC Davis) to consolidate and analyze all data received from the counties. The current workload associated with collecting, reconciling, analyzing and finalizing all data reports from 25 participating counties requires 1.5 Research Assistants and 0.3 Research Director. In addition to the collection and reconciliation of data during the pilot project, DSH is tasked with tracking recidivism data after participants complete their Diversion programming. To support the statewide expansion of this pilot program, DSH requests 3.0 Research Assistants and a 0.5 Research Director.

DSH requests a total of five years limited-term funding to adequately track recidivism data after all pilot programs are completed—including the yearly salary increases reflected in the current contract with UC Davis:

UC - Davis Research Team Funding						
Staffing	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**	**FY 2024-25**	**FY 2025-26**	**Total Requested**
3.5 FTE	$ 472,499	$ 496,332	$ 509,148	$ 522,474	$ 536,334	$ 2,536,787

Additionally, DSH requests five-year limited-term funding of $100,000 to contract with national experts to provide technical assistance and training to counties implementing felony pre-trial mental health diversion programs. As with current experience in implementing the IST Diversion program, many county behavioral health systems require the support to educate existing and new treatment providers on best practices and latest treatment modalities. The typical community treatment provider does not have a lot of experience in providing forensically focused competency restoration treatment to felony IST patients in the community. Ongoing training and support are essential to the success of the Diversion programs.

Funding Request for Resources for Diversion Program Support

The total funding request is limited term from FY 2021- 22 to FY 2025-26. The total request per year is the 3.0 position funding of $560,000 in addition to the cost of UC Davis Research team, which increases annually. The table below illustrates the total breakdown of the IST Diversion limited term funding request:

Support Resources for DSH Diversion Expansion					
	BY	BY+1	BY+2	BY+3	BY+4
Staff Svcs Mgr II	$ 179,000	$ 179,000	$ 179,000	$ 179,000	$ 179,000
Sr. Psych (Supvr)	$ 238,000	$ 238,000	$ 238,000	$ 238,000	$ 238,000
Assoc Govtl Prog Analyst	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000
Travel	$ 75,000	$ 75,000	$ 75,000	$ 75,000	$ 75,000
UC Davis Research	$ 472,499	$ 496,332	$ 509,148	$ 522,474	$ 536,334
Consulting	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
TOTAL	**$ 1,206,499**	**$ 1,230,332**	**$ 1,243,148**	**$ 1,256,474**	**$ 1,270,334**

BCP Fiscal Detail Sheet

BCP Title: IST Diversion Program Augmentation | **BR Name: 4440-026-ECP-2021-GB**

Budget Request Summary

			FY21			
	CY	**BY**	**BY+1**	**BY+2**	**BY+3**	**BY+4**
Personal Services						
Positions - Permanent	0.0	3.0	3.0	3.0	3.0	3.0
Total Positions	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
Salaries and Wages						
Earnings - Temporary Help	0	313	313	313	313	313
Total Salaries and Wages	**$0**	**$313**	**$313**	**$313**	**$313**	**$313**
Total Staff Benefits	0	198	198	198	198	198
Total Personal Services	**$0**	**$511**	**$511**	**$511**	**$511**	**$511**
Operating Expenses and Equipment						
5301 - General Expense	0	24	24	24	24	24
5304 - Communications	0	3	3	3	3	3
5320 - Travel: In-State	0	78	78	78	78	78
5324 - Facilities Operation	0	15	15	15	15	15
5340 - Consulting and Professional Services - Interdepartmental	0	100	100	100	100	100
5340 - Consulting and Professional Services - External	0	46,850	496	509	522	536
5346 - Information Technology	0	3	3	3	3	3
Total Operating Expenses and Equipment	**$0**	**$47,073**	**$719**	**$732**	**$745**	**$759**
Total Budget Request	**$0**	**$47,584**	**$1,230**	**$1,243**	**$1,256**	**$1,270**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	0	47,584	1,230	1,243	1,256	1,270
Total State Operations Expenditures	**$0**	**$47,584**	**$1,230**	**$1,243**	**$1,256**	**$1,270**
Total All Funds	**$0**	**$47,584**	**$1,230**	**$1,243**	**$1,256**	**$1,270**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	14	14	14	14	14
4400020 - Hospital Administration	0	3	3	3	3	3
4430030 - Other Contracted Services	0	47,567	1,213	1,226	1,239	1,253

Total All Programs	$0	$47,584	$1,230	$1,243	$1,256	$1,270

Personal Services Details

Positions	Salary Information Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4801 - Staff Svcs Mgr II (Supvry)				0.0	1.0	1.0	1.0	1.0	1.0
5393 - Assoc Govtl Program Analyst				0.0	1.0	1.0	1.0	1.0	1.0
9831 - Sr Psychologist (Hlth Facility) (Supvr)				0.0	1.0	1.0	1.0	1.0	1.0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2026)				0.0	0.0	0.0	0.0	0.0	0.0
Total Positions				**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4801 - Staff Svcs Mgr II (Supvry)	0	0	0	0	0	0
5393 - Assoc Govtl Program Analyst	0	0	0	0	0	0
9831 - Sr Psychologist (Hlth Facility) (Supvr)	0	0	0	0	0	0
TH00 - Temporary Help (Eff. 07-01-2021)(LT 06-30-2026)	0	313	313	313	313	313
Total Salaries and Wages	**$0**	**$313**	**$313**	**$313**	**$313**	**$313**

Staff Benefits	CY	BY	BY+1	BY+2	BY+3	BY+4
5150200 - Disability Leave - Industrial	0	4	4	4	4	4
5150210 - Disability Leave - Nonindustrial	0	1	1	1	1	1
5150350 - Health Insurance	0	14	14	14	14	14
5150450 - Medicare Taxation	0	5	5	5	5	5
5150500 - OASDI	0	19	19	19	19	19
5150600 - Retirement - General	0	92	92	92	92	92
5150800 - Workers' Compensation	0	14	14	14	14	14
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	8	8	8	8	8
5150900 - Staff Benefits - Other	0	41	41	41	41	41
Total Staff Benefits	**$0**	**$198**	**$198**	**$198**	**$198**	**$198**
Total Personal Services	**$0**	**$511**	**$511**	**$511**	**$511**	**$511**

CONTRACTED PATIENT SERVICES
INCOMPETENT TO STAND TRIAL (IST) DIVERSION PROGRAM
SUPPLEMENTAL REPORTING LANGUAGE
Informational Only

BACKGROUND:

The Budget Act of 2019 added the following Provisional Language: *Item 4440-011-0001—Department of State Hospitals 1. Incompetent to Stand Trial Diversion Program. Trial courts shall work with the Judicial Council to provide data pursuant to mental health diversion programs set forth in Penal Code section 1001.36 including the number of petitions that were granted. When possible, the courts shall also report the (1) number of petitions that were denied (2) number of petitions denied because the defendant did not meet the statutory requirements for eligibility, (3) number of individuals who successfully completed the diversion program, and (4) number of individuals that were terminated from the program. The Judicial Council will make this data available to the Legislature and the Department of State Hospitals on an annual basis commencing July 1, 2020. The Department of State Hospitals shall include this report in the data elements it receives from counties that have contracted with the department for mental health diversion programs funded pursuant to Chapter 6.5 (commencing with Section 4361) of the Welfare and Institutions Code.*

In response to the Provisional Language request, the Department of State Hospitals (DSH) and the Judicial Council worked to ensure the Superior Courts of California data related to Penal Code (PC) section 1001.36 is transmitted and incorporated into the county data sets collected from the pre-trial diversion program (per Welfare and Institutions Code (WIC) 4361). This report describes the methodologies employed by both departments to collect the data required by WIC 4361 and the Provisional Language, as well as challenges encountered. Additionally, a high-level summary of the data collected as of June 30, 2020 is provided.

2021-22 GOVERNOR'S BUDGET REPORT:

I. Judicial Council Data Collection Methodology

Pursuant to the Supplemental Report of the 2019 Budget Act by the Legislative Analyst's Office regarding Assembly Bill 1810 (Stats. 2018, ch. 34), trial courts are required to work with the Judicial Council of California to provide data pursuant to mental health diversion programs set forth in PC 1001.36 and the Judicial Council is to make this data available to the Legislature and DSH on an annual basis, beginning January 1, 2020. In response to those requirements, the Judicial Council amended its quarterly superior court data surveys to include items asking superior courts to report totals of petitions for mental health diversion, petition outcomes, and program outcomes. These items were further amended to distinguish between petitions and diversions for cases including at least one felony charge and total petitions and diversions.

Below is the language of the survey items that the Judicial Council uses to collect mental health diversion data:

- Number of petitions received for pretrial mental health diversion pursuant to PC 1001.36
- Number of petitions received for pretrial mental health diversion pursuant to PC 1001.36 for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions granted
- Number of pretrial mental health diversion petitions granted for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions denied

- Number of pretrial mental health diversion petitions denied for individuals charged with at least one felony
- Number of petitions for mental health diversion denied because defendant does not meet the statutory requirements for eligibility under PC 1001.36(b)
- Number of petitions for mental health diversion denied because defendant does not meet the statutory requirements for eligibility under PC 1001.36(b) for individuals charged with at least one felony
- Number of pretrial mental health diversion petitions in which the individual successfully completed diversion
- Number of pretrial mental health diversion petitions in which the individual successfully completed diversion for individuals charged with at least one felony

Data Collection Challenges

The end of the first quarter of 2020 and the usual reporting period for data reflecting activity during that quarter (one month following the end of the quarter) corresponded with the initial weeks of the COVID-19 shelter-in-place (SIP) order in California. This, in addition to subsequent orders and the closure of many court buildings, meant superior court staff across much of the state may not have the opportunity to access the data systems or set up the queries required to report these data to the Judicial Council. The data for these petitions and programs reported therefore should not be interpreted as a comprehensive count of statewide totals but rather a subset of them. The data that has been reported, moreover, may not have been as thoroughly vetted as it would have been in usual circumstances and as such may be subject to future changes.

II. <u>DSH Data Collection Methodology</u>

Pursuant to WIC 4361, counties funded by DSH for a felony mental health diversion program are required to submit quarterly data reports that capture the following information:

- The number of individuals that the court ordered to post-booking diversion and the length of time for which the defendant has been ordered to diversion
- The number of individuals originally declared incompetent to stand trial on felony charges that the court ultimately ordered to diversion
- The number of individuals participating in diversion
- The name, social security number, date of birth, and demographics of each individual participating in the program[1]
- The length of time in diversion for each participating individual. This information shall be confidential and shall not be open to public inspection [1]
- The types of services and supports provided to each individual participating in diversion[1]
- The number of days each individual was in jail prior to placement in diversion[1]
- The number of days that each individual spent in each level of care facility[1]
- The diagnoses of each individual participating in diversion[1]
- The nature of the charges for each individual participating in diversion[1]
- The number of individuals who completed diversion
- The name, social security number, and birthdate of each individual who did not complete diversion and the reasons for not completing

DSH operationalized the collection of these data points via a master data dictionary and workbook. As counties complete the contracting process with DSH, the DSH data team collaborates with the

[1] This information shall be confidential and shall not be open to public inspection.

county data teams to individualize the master data dictionary and workbook for each county. Typically, adjustments to the data dictionary occur in the section capturing services provided as each program has a different combination of available treatment opportunities.

Once counties begin diverting, they have 90 days after the end of each quarter to submit data reports to DSH. DSH provides each county with access to a secure online file transfer system to upload reports. DSH established reporting quarters in alignment with the state fiscal year (FY):

- Quarter 1 – July 1 through September 30
- Quarter 2 – October 1 through December 31
- Quarter 3 – January 1 through March 31
- Quarter 4 – April 1 through June 30

Data Collection Challenges

DSH has encountered two main issues related to the collection of data for this project to date. The first issue is challenges to DSH's authority to collect patient-level data from certain County Counsels and county information security departments. DSH released a Department Letter (DL 19-001) in October 2019 establishing its authority to collect this information as a "health oversight agency" as defined by the Health Insurance Portability and Accountability Act of 1996 (42 C.F.R. part 164.501) and as a program evaluator and auditor per 42 C.F.R. part 2.53. Clarifying this authority to the counties allows DSH to require the submission of patient-level mental health and substance use disorder treatment for the purposes of evaluating these programs.

The second challenge to the collection of data in FY 2019-20 has been the COVID-19 pandemic. Numerous counties that had planned to activate programs and begin diverting individuals before June 30, 2020 were delayed due to the numerous impacts of the pandemic, including court closures, budget cuts and hiring freezes in the county, mass releases of inmates at the local jails and virus outbreaks at the jails. These delays have reduced the number of counties reporting to DSH in FY 2019-20. DSH anticipates most, if not all, remaining counties will activate their programs in FY 2020-2021and the department will be able to report a more robust data set to the legislature in the next report.

III. Summary of Data Reported to Judicial Council and DSH

The following tables are a high-level summary of the data reported to DSH and the Judicial Council per the requirements of the Provisional Language.

FY 2018-19

DSH began collecting county data in FY 2018-19 as the first two county programs activated. The Judicial Council, however, was not required to collect data from counties until the first quarter of FY 2019-20.

FY 2018-19 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	N/A
PC 1001.36 Petitions Received (Felony)	N/A
PC 1001.36 Petitions Granted	N/A
PC 1001.36 Petitions Granted (Felony)	N/A
PC 1001.36 Petitions Denied	N/A
PC 1001.36 Petitions Denied (Felony)	N/A
PC 1001.36 Petitions Denied due to Statute	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A
PC 1001.36 Successful Completions	N/A
PC 1001.36 Successful Completions (Felony)	N/A
PC 1001.36 Unsuccessful Terminations	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	34
WIC 4361 Diversion Started	29
WIC 4361 Unsuccessful Terminations	0
WIC 4361 Successful Completions	0

FY 2019-20

DSH collected data throughout the FY and activated three additional county programs. The Judicial Council officially began collecting data in the third quarter of the FY, however the courts could voluntarily submit data prior to the third quarter.

FY 2019-20 Totals	
Judicial Council Data	**Statewide Total**
PC 1001.36 Petitions Received	1915
PC 1001.36 Petitions Received (Felony)	555
PC 1001.36 Petitions Granted	674
PC 1001.36 Petitions Granted (Felony)	216
PC 1001.36 Petitions Denied	245
PC 1001.36 Petitions Denied (Felony)	98
PC 1001.36 Petitions Denied due to Statute	93
PC 1001.36 Petitions Denied due to Statute (Felony)	48
PC 1001.36 Successful Completions	77
PC 1001.36 Successful Completions (Felony)	30
PC 1001.36 Unsuccessful Terminations	60
PC 1001.36 Unsuccessful Terminations (Felony)	< 11
DSH Data	**Statewide Total**
WIC 4361 Diversion Orders	114
WIC 4361 Diversion Started	115
WIC 4361 Unsuccessful Terminations	< 11
WIC 4361 Successful Completions	0

Number of Counties Reporting by Quarter

The following tables display the total number of counties reporting on each data element by FY quarter from 2018-19 through 2019-20.

Fiscal Year 2018-19				
January - March 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0
April - June 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	2	0	0	0
WIC 4361 Diversion Started	2	0	0	0
WIC 4361 Unsuccessful Terminations	2	0	0	0
WIC 4361 Successful Completions	2	0	0	0

Fiscal Year 2019-20				
July - September 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	15	2
PC 1001.36 Petitions Received (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Granted	25	16	15	2
PC 1001.36 Petitions Granted (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied	23	17	16	2
PC 1001.36 Petitions Denied (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Petitions Denied due to Statute	19	21	16	2
PC 1001.36 Petitions Denied due to Statute (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Successful Completions	22	18	16	2
PC 1001.36 Successful Completions (Felony)	N/A	N/A	N/A	N/A
PC 1001.36 Unsuccessful Terminations	22	18	16	2
PC 1001.36 Unsuccessful Terminations (Felony)	N/A	N/A	N/A	N/A
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0
October - December 2019				
Judicial Council Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
PC 1001.36 Petitions Received	25	16	16	1
PC 1001.36 Petitions Received (Felony)	25	16	16	1
PC 1001.36 Petitions Granted	24	16	17	1
PC 1001.36 Petitions Granted (Felony)	24	16	17	1
PC 1001.36 Petitions Denied	23	17	17	1
PC 1001.36 Petitions Denied (Felony)	23	17	17	1
PC 1001.36 Petitions Denied due to Statute	21	19	17	1
PC 1001.36 Petitions Denied due to Statute (Felony)	20	20	17	1
PC 1001.36 Successful Completions	24	16	17	1
PC 1001.36 Successful Completions (Felony)	24	16	17	1
PC 1001.36 Unsuccessful Terminations	22	18	17	1
PC 1001.36 Unsuccessful Terminations (Felony)	22	18	17	1
DSH Data	**Total Counties Reporting**	**Data Unavailable**	**Item Left Blank**	**No Data Received**
WIC 4361 Diversion Orders	3	0	0	0
WIC 4361 Diversion Started	3	0	0	0
WIC 4361 Unsuccessful Terminations	3	0	0	0
WIC 4361 Successful Completions	3	0	0	0

Fiscal Year 2019-20				
January - March 2020				
Judicial Council Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
PC 1001.36 Petitions Received	40	11	5	2
PC 1001.36 Petitions Received (Felony)	39	12	5	2
PC 1001.36 Petitions Granted	40	10	6	2
PC 1001.36 Petitions Granted (Felony)	39	11	6	2
PC 1001.36 Petitions Denied	38	13	5	2
PC 1001.36 Petitions Denied (Felony)	37	13	6	2
PC 1001.36 Petitions Denied due to Statute	31	17	8	2
PC 1001.36 Petitions Denied due to Statute (Felony)	31	19	6	2
PC 1001.36 Successful Completions	39	11	6	2
PC 1001.36 Successful Completions (Felony)	39	11	6	2
PC 1001.36 Unsuccessful Terminations	38	12	6	2
PC 1001.36 Unsuccessful Terminations (Felony)	37	13	6	2
DSH Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
WIC 4361 Diversion Orders	4	0	0	0
WIC 4361 Diversion Started	4	0	0	0
WIC 4361 Unsuccessful Terminations	4	0	0	0
WIC 4361 Successful Completions	4	0	0	0
April - June 2020				
Judicial Council Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
PC 1001.36 Petitions Received	37	7	5	9
PC 1001.36 Petitions Received (Felony)	36	8	5	9
PC 1001.36 Petitions Granted	37	7	5	9
PC 1001.36 Petitions Granted (Felony)	36	7	6	9
PC 1001.36 Petitions Denied	36	8	5	9
PC 1001.36 Petitions Denied (Felony)	35	9	5	9
PC 1001.36 Petitions Denied due to Statute	31	13	5	9
PC 1001.36 Petitions Denied due to Statute (Felony)	30	14	5	9
PC 1001.36 Successful Completions	36	7	6	9
PC 1001.36 Successful Completions (Felony)	36	7	6	9
PC 1001.36 Unsuccessful Terminations	36	8	5	9
PC 1001.36 Unsuccessful Terminations (Felony)	36	8	5	9
DSH Data	Total Counties Reporting	Data Unavailable	Item Left Blank	No Data Received
WIC 4361 Diversion Orders	5	0	0	0
WIC 4361 Diversion Started	5	0	0	0
WIC 4361 Unsuccessful Terminations	5	0	0	0
WIC 4361 Successful Completions	5	0	0	0

CONTRACTED PATIENT SERVICES
LOS ANGELES COMMUNITY-BASED RESTORATION (CBR) PROGRAM
Program Update

	Positions			Dollars in Thousands		
	CY	BY	BY+1	CY	BY	BY+1
Governor's Budget	**0.0**	**1.0**	**1.0**	**$9,758**	**$4,503**	**$4,978**
One-time	*0.0*	*0.0*	*0.0*	*$9,758*	*$248*	*$0*
Ongoing	*0.0*	*1.0*	*1.0*	*$0*	*$4,255*	*$4,978*

BACKGROUND:

The 2018 Budget Act included $15.6 million General Fund in 2018-19 and ongoing to support the Department's partnership with Los Angeles (LA) County to treat LA County Felony Incompetent to Stand Trial (IST) patients in community mental health treatment settings who would otherwise be treated in a state hospital or Jail Based Competency Treatment (JBCT) program. This community-based restoration (CBR) program has expanded IST treatment options in LA County by providing a continuum of care comprised of 150 beds in three different spectrums of placements. These include a locked acute psychiatric hospital, a locked Institute of Mental Disease (IMD) or mental health rehabilitation center, and residential facilities with clinical and supportive services onsite, with established daily bed rates for each level of care. The average length of stay for a patient in a CBR program is approximately 12 months.

This program includes a Clinical/Navigation Team to stabilize patients on medications and prepare them for community placement. To support their transition out of custody, the team provides support for social and other services as needed (i.e. Supplemental Security Income and other benefits). They also connect patients to other critical services in the county with an emphasis on Substance Use Disorder (SUD) services, primary medical care, care management, and specialty mental health services.

As of November 30, 2020, the number of ISTs pending placement into a DSH facility or jail-based treatment programs was 1,306 patients. While the high number of individuals pending placement to a DSH program can be partially attributed to protective measures implemented by DSH in response to reducing the impact of COVID-19, ISTs pending placement to a DSH program prior to COVID-19 impact was consistently in the high 800's. The volume of new IST referrals to DSH continues to outpace the beds available within the DSH system to serve this population.

As a result of maintaining high wait lists, DSH faces ongoing pressure from the courts to admit additional patients into its system of care. Recently, new timelines for admission were ordered by the Superior Court. These court-ordered timelines are currently under appeal and DSH is involved in ongoing, exhaustive litigation across the state related to wait times for admission. DSH continues to seek alternative solutions to increase current capacity in order to meet this ongoing pressure to the state hospital system. Providing services in the community for a significant number of LA County Felony IST patients will assist DSH with addressing the continued growth in its IST caseload.

DESCRIPTION OF CHANGE:

DSH requests $9.8 million one-time General Fund in 2020-21, 1.0 position and $4.5 million General Fund in 2021-22, and 1.0 position and $5.0 million General Fund in 2022-23 and annually thereafter to expand the current Los Angeles County CBR program beginning in 2020-21 and establish new CBR programs in additional counties beginning 2021-22. This proposal is projected to increase capacity by up to 200 beds in 2021-22 in Los Angeles County and by up to 50 beds in 2021-22 in the additional counties.

The 2020-21 costs to expand the Los Angeles County CBR program are included in this proposal. However, the 2021-22 and ongoing costs to expand the Los Angeles County CBR program are not currently included pending final determination of which counties will participate in the Community Care Demonstration Project for ISTs (CCDP-IST). DSH will provide an update at May Revision and depending upon the outcome of the CCDP-IST budget change proposal and counties identified to participate, DSH may need to shift its funding request from the CCDP-IST proposal to provide for the continued operation of these beds in 2021-22 and ongoing. See the CCDP-IST budget change proposal for additional information.

Expanding the LA community-based treatment program and establishing new programs in other parts of the state will support the development of a comprehensive continuum of care for felony ISTs. In conjunction with established Felony Mental Health Diversion Program (Diversion) and JBCT programs, this initiative will expand the capacity to treat ISTs in the community by reducing the number of patients pending placement to DSH facilities and support the overall goal of reducing admission times for treatment. DSH plans to establish up to 200 new beds in Los Angeles County in 2020-21 and provide time-limited transitional resources to support the off-ramp of IST defendants to the community who may restore to competency while waiting in jail. DSH anticipates activating all 200 beds on a rolling basis in the current year beginning January 1, 2021 for an estimated cost of $9.8 million dollars.

The 2021-22 and ongoing costs in this proposal reflect the costs to expand the CBR program in additional counties outside Los Angeles County. DSH is re-engaging with multiple counties post COVID who have previously expressed a strong interest in establishing new community-based programs. DSH will continue to work with the counties to provide more specific details and an updated bed estimate in the May Revision.

DSH's goal is for these new programs to work in conjunction with established Diversion programs, JBCT programs, and Conditional Release Programs (CONREP) to create a continuum of care in the community for felony ISTs and to create additional capacity to serve DSH's IST waitlist. These new programs will be customized by county, depending on the current inventory of available housing resources, and is assumed to include a mix of acute inpatient, locked Institute for Mental Disease (IMD), and unlocked adult residential care facilities or other supportive residential beds. The number of IST patients served by each county program will vary according to each county's rate of IST referrals, as well as available bed capacity and resources. DSH estimates adding up to 50 CBR beds in other areas of the state in two phases, with 20 beds activating July 1, 2021 and an additional 30 beds activating by October 1, 2021.

To estimate a budget for the new community-based programs, DSH is using cost information garnered from actual expenses from LA County in operating both the CBR program and the pre-trial felony mental health diversion programs. Annual cost assumptions for the county-operated programs are reflected in the table below:

Felony IST Community Based Restoration - County Program Costs				
Budget Categories	**Cost Assumptions**	**CY- LA County 200 Beds Only***	**BY- New Counties 50 Beds Only***	**BY+1 & Ongoing - New Counties 50 Beds Only***
Start-Up / Program Implementation Costs	Average cost of $7500 per bed for new site start-up costs for 133 unlocked residential beds in CY and 33 unlocked residential beds in BY. Minor retrofitting/modifications include conversion of space for group treatment rooms and office space for on-site staffing. Other costs include the purchase of patient and office furniture, security cameras, appliances, etc. This is a one-time budget category assumed for the first year of the programs.	$ 1,013,000	$ 248,000	$ -
Clinical Program Management and Navigation Services	Centralized program operation staff are needed to identify and assess prospective clients for program participation. Functions include but are not limited to clinical assessment; criminal justice partner coordination (working with Public Defender, District Attorney, Superior Court, Jail Mental Health staff); facilitate navigation services for placement in appropriate housing/treatment bed; coordinate pre-trial probation services when appropriate; forensic report writing; court testimony; facilitate transition plan for clients post-CBR; and program adminstration support. Also includes assessing ISTs in jail or those who may have restored to competency prior to placement in a DSH program; and can be "off-ramped" from the IST waitlist.	$ 726,000	$ 232,000	$ 272,000
Community Based Restoration Services - All Bed Types	Estimted costs assume various levels of care for felonty ISTs patients: 133 unlocked residential beds in CY and 33 beds in BY ongoing at $175 per bed, per day; 60 locked IMD beds in CY and 16 beds in BY ongoing at $340 per bed, per day; 7 acute psychiatric beds in the community in CY and 1 bed in BY ongoing at $600 per bed, per day.	$ 6,708,000	$ 3,690,000	$ 4,312,000
Pre-Trial Probation Services	Best practice identified as part of the DSH Diversion program: pre-trial probation services for the contingent of individuals who may need a higher level of supervision while out in the community. This service provides the additional layer of public safety support that allows programs to broaden the pool of prospective program participants for the courts to consider. Approximately $4500 annually per client + 15% administrative overhead. Budget estimate assumes 133 clients in CY and 33 clients in BY ongoing.	$ 261,000	$ 110,000	$ 171,000
Off-Ramp IST Transition Services	For ISTs who restore in jail prior to placement in a DSH program and can be off-ramped from the IST waitlist, funding supports the contingent of indiviudals who are eligible for release back to the community. The funding will provide the ability for the program to facilitate a "warm hand off" by providing transitional housing and services upon release from jail for a period of up to 90 days while a permanent supportive living situation is coordinated by the team. Costs assume placement in an unlocked residential bed and provision of intensive case management, clinical and psychiatric services. The budget estimate is based on the ulocked residential bed rate of $175 per day x 90 days x 150 clients.	$ 1,050,000	$ -	$ -
	TOTALS	$ 9,758,000	$ 4,280,000	$ 4,755,000
*Start-Up/Program Implemenation Costs are one-time only in the first year.				

Resources for Ongoing Program Support

To support the implementation and ongoing management of these programs and the existing LA CBR program, DSH requests 1.0 Staff Services Manager II (SSM II) who will operate in a specialist capacity. If the CCPD-IST budget change proposal is not approved, additional resources of $390,000 in 2021-22 and ongoing will be needed to support this proposal. Workload related to this request will be comparable to the Diversion, JBCT and current CBR programs. The staffing request is based on lessons learned from all three regarding necessary program activities, including the importance of taking a hands-on approach with communities and providers to ensure programs are operating effectively and efficiently. The incumbent assigned to this program will be responsible for acting with the highest level of independence in order to engage directly with executive, criminal justice and treatment staff from the counties in establishing the new programs. The incumbent will be required to effectively oversee these programs, communicate with stakeholders, manage contracts and billing, and provide the data and reports necessary to run the program and inform DSH policy decisions.

Based on the high rate of travel experienced with planning and implementation of the Diversion program, DSH requests an additional $20,000 in BY and ongoing to support the SSMII's travel costs to counties for outreach, program planning, program activation and program evaluation.

Additionally, DSH requests $40,000 in BY and ongoing to contract with national experts to provide technical assistance and training to counties implementing felony CBR programs. Based on experience from prior implementations of the DSH Diversion program, many county behavioral health systems require the support to educate existing and new treatment providers on best practices and latest treatment modalities. The typical community treatment provider does not have much experience in providing forensically focused competency restoration treatment to felony IST patients in the community. Ongoing training and support are essential to the success of the CBR programs.

The following chart displays the breakdown of the total request:

Felony IST - Community Based Restoration Program Expansion (250 Beds)
Summary of Costs

Budget Category	CY- LA County 200 Beds Only*	BY- New Counties 50 Beds Only*	BY+1 & Ongoing - New Counties 50 Beds Only*
County CBR Program			
Start-Up/Program Implementation Costs	$ 1,013,000	$ 248,000	$ -
Clinical Program Management/Navigation	$ 726,000	$ 232,000	$ 272,000
CBR Housing/Treatment	$ 6,708,000	$ 3,690,000	$ 4,312,000
Pre-Trial Probation	$ 261,000	$ 110,000	$ 171,000
Off-Ramp Transition Services	$ 1,050,000	$ -	$ -
Subtotal CBR Program	*$ 9,758,000*	*$ 4,280,000*	*$ 4,755,000*
County Support Costs			
Training & Technical Assistance	$ -	$ 40,000	$ 40,000
DSH Support Costs			
Salaries, Benefits & Operating Expenses	$ -	$ 163,000	$ 163,000
Additional Travel	$ -	$ 20,000	$ 20,000
Subtotal DSH Support	*$ -*	*$ 183,000*	*$ 183,000*
GRAND TOTAL BUDGET	**$ 9,758,000**	**$ 4,503,000**	**$ 4,978,000**

BCP Fiscal Detail Sheet

BCP Title: Community-Based Restoration (CBR) Program Expansion **BR Name: 4440-054-ECP-2021-GB**

Budget Request Summary

			FY21			
	CY	BY	BY+1	BY+2	BY+3	BY+4
Personal Services						
Positions - Permanent	0.0	1.0	1.0	1.0	1.0	1.0
Total Positions	**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**
Salaries and Wages						
Earnings - Permanent	0	90	90	90	90	90
Total Salaries and Wages	**$0**	**$90**	**$90**	**$90**	**$90**	**$90**
Total Staff Benefits	0	57	57	57	57	57
Total Personal Services	**$0**	**$147**	**$147**	**$147**	**$147**	**$147**
Operating Expenses and Equipment						
5301 - General Expense	0	8	8	8	8	8
5304 - Communications	0	1	1	1	1	1
5320 - Travel: In-State	0	21	21	21	21	21
5324 - Facilities Operation	0	5	5	5	5	5
5340 - Consulting and Professional Services - External	9,758	4,320	4,795	4,795	4,795	4,795
5346 - Information Technology	0	1	1	1	1	1
Total Operating Expenses and Equipment	**$9,758**	**$4,356**	**$4,831**	**$4,831**	**$4,831**	**$4,831**
Total Budget Request	**$9,758**	**$4,503**	**$4,978**	**$4,978**	**$4,978**	**$4,978**

Fund Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Fund Source - State Operations						
0001 - General Fund	9,758	4,503	4,978	4,978	4,978	4,978
Total State Operations Expenditures	**$9,758**	**$4,503**	**$4,978**	**$4,978**	**$4,978**	**$4,978**
Total All Funds	**$9,758**	**$4,503**	**$4,978**	**$4,978**	**$4,978**	**$4,978**

Program Summary

	CY	BY	BY+1	BY+2	BY+3	BY+4
Program Funding						
4400010 - Headquarters Administration	0	4	4	4	4	4
4400020 - Hospital Administration	0	1	1	1	1	1
4430030 - Other Contracted Services	9,758	4,498	4,973	4,973	4,973	4,973
Total All Programs	**$9,758**	**$4,503**	**$4,978**	**$4,978**	**$4,978**	**$4,978**

Personal Services Details

Positions	Salary Information: Min	Mid	Max	CY	BY	BY+1	BY+2	BY+3	BY+4
4801 - Staff Svcs Mgr II (Supvry) (Eff. 07-01-2020)				0.0	1.0	1.0	1.0	1.0	1.0
Total Positions				**0.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**

Salaries and Wages	CY	BY	BY+1	BY+2	BY+3	BY+4
4801 - Staff Svcs Mgr II (Supvry) (Eff. 07-01-2020)	0	90	90	90	90	90
Total Salaries and Wages	**$0**	**$90**	**$90**	**$90**	**$90**	**$90**
Staff Benefits						
5150200 - Disability Leave - Industrial	0	1	1	1	1	1
5150350 - Health Insurance	0	4	4	4	4	4
5150450 - Medicare Taxation	0	1	1	1	1	1
5150500 - OASDI	0	6	6	6	6	6
5150600 - Retirement - General	0	27	27	27	27	27
5150800 - Workers' Compensation	0	4	4	4	4	4
5150820 - Other Post-Employment Benefits (OPEB) Employer Contributions	0	2	2	2	2	2
5150900 - Staff Benefits - Other	0	12	12	12	12	12
Total Staff Benefits	**$0**	**$57**	**$57**	**$57**	**$57**	**$57**
Total Personal Services	**$0**	**$147**	**$147**	**$147**	**$147**	**$147**

EVALUATION AND FORENSIC SERVICES

EVALUATION AND FORENSIC SERVICES
SEX OFFENDER COMMITMENT PROGRAM AND OFFENDER WITH A MENTAL HEALTH DISORDER (SOCP/OMD) PRE-COMMITMENT PROGRAM

Caseload Update

BACKGROUND:

The Department of State Hospitals (DSH) is required to provide forensic evaluation services to determine if an inmate within the California Department of Corrections and Rehabilitation (CDCR), prior to parole, requires continued treatment in a state hospital as an Offender with a Mental Health Disorder (OMD) as a condition of parole or as a Sexually Violent Predator (SVP). DSH administers these services through the OMD Program and the Sex Offender Commitment Program (SOCP). DSH currently employs 3.0 Chief Psychologists, 25.0 Consulting Psychologists (CP), and 19.0 SVP Evaluators (SVP-E) in addition to contracted psychologists to perform psychological evaluations, develop forensic evaluation reports, provide expert witness court testimony and consultation related to these evaluation services, as well as maintain up-to-date training associated with these programs. These services must be performed at a variety of locations throughout California, including state prisons, state hospitals, jails, and courts. The forensic evaluations are time-sensitive and must be completed and referred to the District Attorney's Office no less than 20 days prior to the inmate's release from prison for those individuals determined to meet the criteria as an SVP to comply with a statutory requirement.

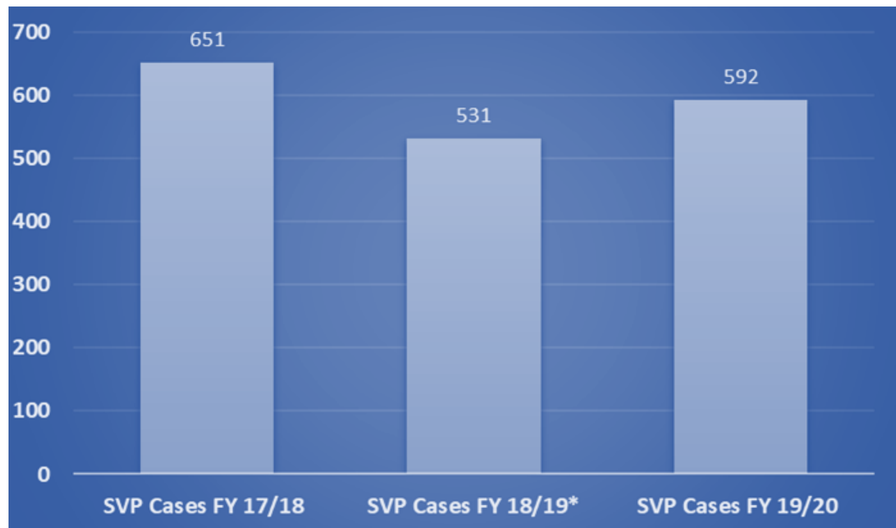
The above forensic evaluator staffing reflects the required level to support the volume of interviews, evaluations, forensic report development, and expert witness and court testimony services driven by the number of CDCR referrals for potential SVP and OMD commitments to the state hospitals. Additional workload may include, but is not limited to: completing SVP update evaluations required in preparation for court; developing and maintaining a robust quality assurance program, including data analytics to target training and/or support needs to evaluators and CDCR stakeholders; participating in a mentorship program that pairs highly experienced evaluators with less experienced evaluators; developing and implementing standardized assessment protocols; and maintaining licensure requirements. Failure to perform these forensic services accurately and timely could result in the inappropriate release of an OMD or SVP into the community, compromising public safety.

<u>Sex Offender Commitment Program (SOCP)</u>

The SOCP was established in 1996 pursuant to the Sexually Violent Predator Act, Welfare and Institutions Code (WIC) 6600, et seq. In accordance with WIC 6601(b), the Board of Parole Hearings (BPH) performs the clinical aspects of screening CDCR inmates to determine whether the individual is likely to be an SVP and warrants two forensic psychological evaluations by DSH.

Per WIC 6601(b), CDCR and BPH are responsible for performing a two-part screening process of CDCR inmates. This consists of: (1) identifying whether the individual committed qualifying offenses for commitment as an SVP; and, if so, (2) BPH conducting a clinical review of the individual's qualifying offense(s) and social, criminal, and institutional history to determine whether the individual is likely to be an SVP. If CDCR and BPH determine an individual is likely to be an SVP, CDCR refers the individual to DSH for a full evaluation of whether the person meets the criteria.

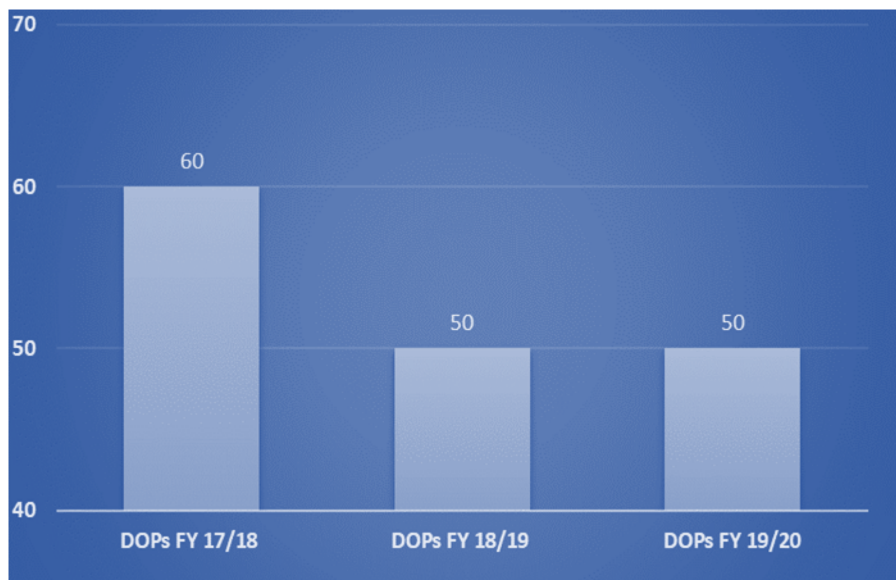
For the period between July 2019 and June 2020, approximately 592 cases were referred to DSH for full evaluations. The chart below illustrates the trends seen in the past three years:



*Decrease due to screens going to BPH

For each referral, DSH is required to complete two forensic psychological evaluations to determine if the individual meets the statutory criteria for civil commitment as an SVP. When there is a difference of opinion (DOP) by the two forensic civil service evaluators initially assigned by DSH to perform full evaluations, DSH is statutorily required to assign two additional independent evaluators who are not state government employees to assess the individuals.

For the period between July 2019 and June 2020, approximately 50 DOPs were completed by DSH. As shown below, the number of DOPs has stayed largely consistent in the past three years.



Forensic evaluations are required to travel to the inmate's location to administer an in-person interview, perform case records reviews including criminal and medical history, develop a written evaluation report and provide expert witness testimony once the case goes to trial. Updated forensic evaluations may be required as part of the preparation for court. Due to the COVID-19 pandemic, beginning March 2020, the cost of travel significantly declined. DSH utilized telepsychology to conduct most inmate interviews

Per WIC 6600 statute, initial evaluations should be performed by civil servants. In certain incidences, such as impending release dates, a contracted evaluator will need to evaluate the inmate when a civil service evaluator isn't available. When a contractor is used, the Department incurs additional costs to pay the contracted rates. In the past three years, the use of contractors used for initial SVP evaluations has declined and rush referrals continue to make up only a small portion of the total referrals.

DSH is coordinating with CDCR/BPH to determine if there will be a workload impact to the SOCP due to referral increases as a result of programming calculations and the Governor's Executive Order to reduce the number of inmates due to COVID-19. DSH continues to monitor these referral trends, especially as they may result in a request for additional resources to meet the demand and comply timely with statute. An update will be provided in the 2021-22 May Revision.

Offender with a Mental Health Disorder (OMD) Program

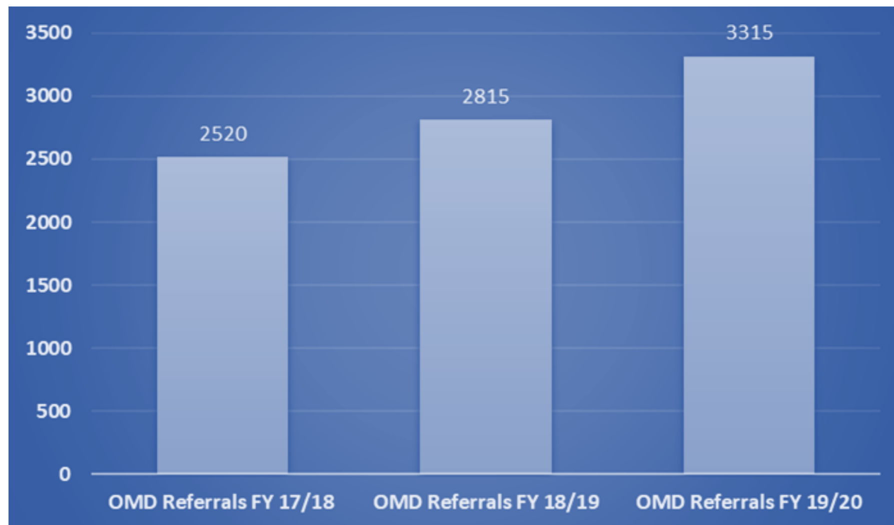
The OMD commitment was created to provide a mechanism to detain and treat severely mentally ill prisoners who have reached the end of their determinate prison terms and are dangerous to others as a result of a severe mental disorder. The law became effective July 1, 1986 and is codified in Penal Code (PC) 2960 – 2981.

The OMD commitment is a two-phase process:

First Phase

The first phase requires a certification by CDCR's Chief Psychiatrist that an inmate meets the OMD criteria. The certification process consists of CDCR conducting the initial file review and performing one clinical evaluation prior to referring to DSH. DSH then receives the OMD referral from the applicable CDCR institution and sends a clinician to the appropriate CDCR facility to conduct the second forensic psychological evaluation and determine if the inmate meets the OMD statutory criteria prior to release from prison. Due to the COVID-19 pandemic, beginning in March 2020, the cost of travel significantly declined. DSH utilized telepsychology to conduct most inmate interviews.

For the period between July 2019 and June 2020, DSH received approximately 3,315 referrals from CDCR to perform an OMD evaluation for potential commitment to a state hospital. Of these, 322 DSH evaluations were positive and 2,993 DSH evaluations were negative. A positive evaluation means the individual was deemed a potential commitment to a state hospital. If CDCR and DSH evaluators determine that the individual should be committed to DSH as an OMD, certification paperwork is submitted to the BPH hearing officer for review. If approved, the individual is sent to DSH to serve their parole. The chart below illustrates a trend of increasing referrals in the past three fiscal years.



Of the referral total, 458 were admitted to a state hospital based on DSH evaluations and DOP evaluations conducted by BPH.

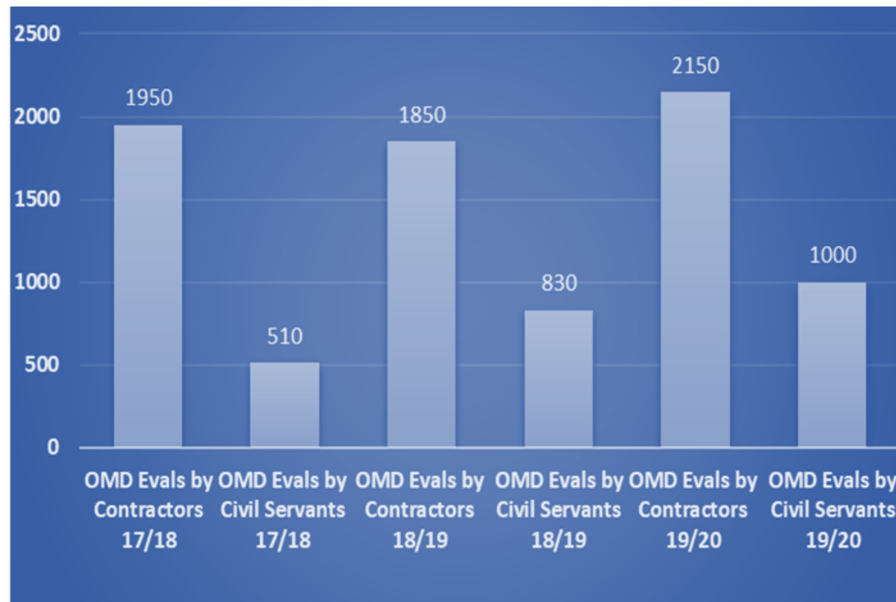
When there is a DOP between the CDCR and DSH forensic evaluators based on criteria outlined in PC 2962, BPH is responsible for conducting two additional, independent evaluations. BPH conducts approximately 300 DOPs annually.

DSH has received an increase in OMD referral dates in part due to the Governor's Executive Order to initiate early release dates due to COVID-19. Shorter sentencing and early releases led to more referrals with lower acuity and shorter due dates requiring DSH to perform parallel evaluations without waiting for the CDCR score. However, despite these changes, the hospital admission rate has remained steady in comparison to non-pandemic impacted years.

Second Phase

The second phase is a statutory mandate requiring BPH to commit inmates who are found to meet OMD criteria to a state hospital for treatment as a special condition of parole. After a parolee is discharged from CDCR to DSH, the individual is civilly committed as an OMD for involuntary treatment.

As stated above, FY 2019-2020 saw an increase in OMD evaluations from years prior. However, due to the increase use of telepsychology and the decrease in travel costs due to COVID-19, DSH is currently able to absorb this increase in workload costs. DSH's reliance on contractors remains high and COVID-19 related rushes increased the use of contractors in FY 19-2020. However, the overall rate of evaluations completed by civil servants is increasing.



DSH is coordinating with CDCR/BPH to determine if there will be a workload impact to the OMD program due to referral increases as a result of programming calculations and the Governor's Executive Order to reduce the number of inmates due to COVID-19. DSH continues to monitor these referral trends, especially as they may result in a request for additional resources to meet the demand and comply timely with statute. An update will be provided in the 2021-22 May Revision.

Evaluator Workload Adjustment

DSH conducted three separate time studies to review and analyze the increase in complexity of the SVP evaluations and the number of hours worked by the evaluators, as well as compare the ratio of civil servant to contracted employees that perform OMD evaluations.

The first study was performed in 2016 by Cooperative Personnel Services (CPS) Consulting and the second two were in-house time studies conducted in 2019 by the DSH-Forensic Services Division's Data and Research Unit. All three studies concluded that CPs and SVP-Es are working an average of more than 50 hours per week. This conflicted with the current Bargaining Unit 19 contract, which specifies evaluators' workload should average 40 hours per week over the course of the year. However, CPs and SVP-Es are exempt classifications and are not authorized to receive overtime.

In addition to the number of average hours evaluators worked, the CPS time study conducted in 2016 identified areas for efficiencies and workload adjustments that were implemented in late 2016 and early 2017 to reduce the average weekly hours.

The implemented efficiencies included:

- Obtaining access to the CDCR electronic health record database that minimized evaluators' wait time for medical records needed to conduct evaluations;
- Coordinating with CDCR institutions to implement telepsychology where possible. At the time, the majority of CDCR institutions did not have the capability of providing telepsychology, however most institutions have recently made telepsychology available due to COVID-19 impacts;
- Addressing connectivity issues by issuing new laptops with updated software.

The subsequent internal time studies conducted two years after the initial time study determined that the implemented efficiencies and workload adjustment did not reduce the average weekly hours. Based on the workload study data and in response to current operations, all evaluator caseloads were adjusted beginning January 1, 2020. The adjustment aligned the current workload for all evaluators to an average 40-hour work week as indicated by the current union contract.

As part of the workload adjustment implementation, the impact to the caseload adjustment were to be monitored to provide potential recommendations based on:

- Number of evaluations completed by civil service evaluators compared to what is projected with the newly proposed work capacities;
- Fiscal impact of contractors used to verify projections of increased contractor use and determine if there is a need to request additional resources through the Estimates process; and
- Number of weekly hours worked by civil servant and contractor evaluators;

Although the data for the above is being collected, the subsequent review has been delayed due to COVID-19 impacts and likely to be conducted after CDCR/BPH data is available to determine if there will be a long-term impact with increased number of referrals and to estimate the potential workload impact.

<u>Caseload Update</u>

On July 10, 2020, by authority of Governor Newsom, CDCR announced it would reduce its population by 10,000 in order to reduce the risk of transmission of COVID-19 within its facilities. As a result, CDCR is pursuing a series of expedited release efforts and estimates that, in addition to the 10,000 released inmates, an additional 8,000 inmates will be eligible for early release. One cohort, associated with release and credit-earning actions requires that inmates have 180 days or less to serve on their sentence, are not sentenced for domestic or a violent crime, are not sentenced with a crime that requires that they register as a sex offender under PC 290, and do not have an assessment score that indicates a high risk for violence. Under the other cohort, referred to as a "one-year release", CDCR is reviewing inmates with 365 days or less remaining on their sentence and who reside within identified institutions that house large populations of high-risk patients. This cohort must meet the same criteria as those within the 180-day timeframe. CDCR is also considering expedited release based on age and medical risk.

DSH is working closely with CDCR/BPH to determine the number of OMD referrals to DSH as a result of the expedited releases, which is difficult to project at this point. DSH continues to monitor the OMD and SVP referral trends and will provide a caseload update in the 2021-22 May Revision.

PROGRAM UPDATE

Informational Only

2014 South Napa Earthquake Repairs

Napa Earthquake Repairs (Projects 1 & 2)

The Department of State Hospitals (DSH) collaborated with the Department of General Services (DGS), the California Office of Emergency Services (OES), and the Federal Emergency Management Agency (FEMA) to determine the estimated project costs for the repairs associated with the damage at DSH-Napa resulting from the South Napa earthquake in August 2014. DSH prioritized the repairs to DSH-Napa's buildings into the following three projects:

- *Project 1*: Repair the three buildings that have been identified as historically significant (Electric Shop Building 147, Manor House Building 181, and Central Nursing Building 183)
- *Project 2*: Repair the 23 buildings located outside the Secure Treatment Area (STA)
- *Project 3*: Cancelled

Due to ongoing challenges and delays in the availability and hiring of casual labor, DSH was not able to make significant efforts toward completing Project 3, which was comprised of minor cosmetic repairs, including plaster repairs and painting. Further complicating the issue, those repairs are within patient occupied areas. This would involve moving furniture within patient rooms to allow for proper ventilation so that plaster and paint can dry in addition to requiring swing space DSH-Napa does not have available. As such, DSH cancelled the Project 3 deliverables to allow for further analysis through its system-wide Infrastructure Master Plan, which will consider the prioritization and appropriateness of all repairs at DSH-Napa, not just those specific to the damage related to the 2014 South Napa Earthquake. The 2019-20 May Revise reported a savings of $1,138,958 in FY 2018-19 and $608,479 in FY 2019-20 due to the cancellation of the Project 3 repairs.

Projects Update:

- *Project 1*: Repairs to three historical buildings: Electric Shop Building 147, Manor House Building 181, and Central Nursing Building 183. The project was put out for bid January 9, 2020. The lowest bid was $4,439,000 and new contract amount with Change Orders resulted in a $4,568,693 estimate. The construction contract was awarded to CWS Construction Group Inc. while the Notice to Proceed was issued on March 31, 2020. The DGS project estimate has been revised based on the low bid and includes DGS soft costs. Currently, the project is approximately 45% complete and is scheduled to finalize construction in January of 2021. The project experienced initial delays due to steel fabrication shop drawing errors, however DSH is currently anticipating the construction to be completed as scheduled.
- *Project 2*: Repairs to the 23 buildings located outside the STA. Construction work was completed with final inspection on December 16, 2019. The total amount of reimbursement authority received for this project was $1,842,432.
- *Project 3*: Cancelled

Patient-Driven Operating Expenses

Between fiscal year (FY) 2012-13 and FY 2018-19, the DSH patient population increased significantly due to newly activated beds within the five state hospitals. For the bed activations, DSH received funding for positions and associated staff operating expenses and equipment (OE&E) but did not receive funding for patient related OE&E. Included in this category are items such as funding for outside medical care, pharmaceuticals, patient clothing, etc. DSH previously managed to absorb the increased costs due to savings in other areas, however, this model is no longer sustainable in the long-term to adequately support ongoing OE&E costs driven by patient care.

The 2019 Budget Act included a standardized patient OE&E cost estimate methodology based on updated census estimates for FY 2019-20 and estimated costs per patient, derived from past year actual expenditures for outside medical care contracts. As a result, the 2019 Budget Act included funding for a projected FY 2019-20 census of 6,317 and a per patient cost of $19,534 for a total patient-driven OE&E cost of $123.4 million in FY 2019-20.

In the 2020-21 Governor's Budget, DSH requested an additional $3.5 million in ongoing authority beginning in FY 2020-21. This estimate was based on projected cost increases in two budget categories; Outside Hospitalization and Pharmaceuticals, in addition to a projected census increase. However, due to General Fund deficits California faced as a result of the COVID-19 global pandemic in spring of 2020, DSH's request was denied.

Due to COVID-19 impacts on DSH's operations, at this time it is difficult to project future patient driven costs. DSH will continue to monitor and manage these expenditures closely through the budget year, for possible inclusion in the FY 2022-21 Governor's Budget.

Statewide Incompetent to Stand Trial Off Ramp (SISTOR) Program

The 2019 Budget Act included funding for an "Incompetent to Stand Trial (IST) Off-Ramp" team in Los Angeles (LA) County to assess felony ISTs (FIST) committed by LA County in the jail for restoration of competency prior to placement in a DSH program. FIST commitments are distinguished from misdemeanor IST (MIST) commitments as MIST commitments are by law required to be treated by counties and are only referred to DSH under very specific circumstances. Under this program, if a FIST is assessed and found to be competent, the team psychiatrically stabilizes the defendant to ensure competency is maintained. They subsequently submit a restoration of competency report to the court to allow the defendant to proceed with their case rather than having to be transferred to a DSH program. This effort has proven successful and, as of November 9, 2020, 308 IST defendants have been off-ramped.

The 2020 Budget Act included $1.0 million to implement four additional IST "Off-Ramp" programs in the following four regions: the Bay Area, northern California, central California, and southern California. It also included an ongoing budget of $2.0 million, starting in FY 2021-22, to sustain the program.

Implementing IST "Off-Ramp" services in more counties prevent additional IST defendants from being transferred unnecessarily to a DSH treatment program and instead allows local communities to restore competency. These programs deploy forensically trained psychologists in contracted positions to each region to monitor FIST defendants for restoration of competency, while the defendant is incarcerated pending placement to a DSH IST treatment program. The contracted psychologists coordinate medication and treatment protocols with existing jail mental health staff, perform evaluations, write court reports, and provide court testimony.

The funding would support contracted psychologist services that are centralized at existing Jail Based Competency Treatment (JBCT) program counties (the “hubs”) and deployed to neighboring counties (the “spokes”) to assess and provide services to ISTs within the jails located in their assigned region. This is known as a “Hub and Spoke” program model. The estimated annual cost would reimburse contracted psychologist services including salaries, benefits, basic operating expenses and increased travel costs associated with traveling to each county jail within their assigned region. This service is now referred to as the Statewide Incompetent to Stand Trial Off-Ramp (SISTOR) Program.

The contractor will have the latitude to implement the SISTOR program through a Hub and Spoke program model. The contractor will incorporate contracted positions and “off-ramp” workload into an existing JBCT program as an extension of competency restoration services. If the existing JBCT program uses its own resources, then DSH will reimburse the JBCT through the SISTOR program. Alternatively, the contractor can submit a different statewide plan that describes how to most effectively identify and reassess IST defendants on the IST waitlist.

DSH has completed the drafting of the Scope of Work as well as the Request for Proposal in order to secure a provider to implement the SISTOR program within the current year. DSH anticipates securing a vendor in the fall 2020 to ensure program activation in early 2021. An update will be provided in the FY 2021-22 May Revision.

Hospital Police Officer (HPO) Academy

The 2019 Budget Act created a new sub-program for the Hospital Police Officer (HPO) Academy, which allows for better transparency and overall management of Academy resources. This transferred all budget and position authority redirected from DSH-Atascadero to its own program – the State Hospital Police Officer Academy. Having the HPO Academy separate from other facilities allows DSH to track this budget independently and report on academy-specific funding, costs, and outcomes. Additionally, the 2019 Budget Act approved the conversion of 3.0 positions from full-time limited term to permanent in order to support DSH’s Academy and graduate up to 150 HPO cadets annually. This expanded the Academy resources to 7.0 permanent positions.

The 2019 Budget Act added Provisional language stating:

“The State Department of State Hospitals shall provide a status update on the recruitment and retention of hospital police officers, to be included in the department’s 2020-21 Governor’s Budget estimate and subsequent May Revision estimate. The update shall include the number of authorized and vacant positions for each hospital, the actual attrition rate for the 2019-20 fiscal year, the projected attrition rate for the 2020-21 fiscal year, and the rate of success pertaining to the number of hospital police officer cadet graduates of the OPS Police Academy.”

Hospital Police Officer Positions

As of October 1, 2020, the following is the status of HPO authorized positions:

HPO Authorized Positions[1]				
State Hospital	Filled	Vacant	FTE[2]	Vacancy Rate
Atascadero	119.0	6.5	125.5	5.18%
Coalinga	202.0	13.5	215.5	6.26%
Metropolitan	104.0	35.0	139.0	25.18%
Napa	101.0	5.0	106.0	4.72%
Patton	62.5	0.5	63.0	0.79%
Total:	**588.5**	**60.5**	**649.0**	**8.43%**

[1] Only Includes classification 1937 - Hospital Police Officer
[2] Authorized Positions as of DSH Budget Management Branch Hospital Position Report FY 2020-21 August, Rev A.xlsx

Please note, DSH-Metropolitan shows a higher vacancy rate due to the approval of the Increased Secure Bed Capacity (ISBC), which resulted in a significant increase in HPO positions which were phased-in the beginning of FY 2019-20. DSH continues to actively recruit for these positions as units activate.

Hospital Police Office Attrition Rate

As of October 1, 2020, the projected attrition rate based on actual attrition rates and trends for FYs 2017-2018, 2018-19 and 2019-20:

HPO Attrition Rate					
State Hospitals	FY 2020-21 FTE[1]	FY 2020-21 Attrition Rate[2]	Avg Estimated Monthly Pos.	FY 2021-22 Attrition Rate[3]	Avg Estimated Monthly Pos.
Atascadero	126.8	0.89%	1.1	0.81%	1.0
Coalinga	215.7	0.73%	1.6	0.83%	1.8
Metropolitan	139.0	1.71%	2.4	1.53%	2.1
Napa	106.0	0.73%	0.8	0.62%	0.7
Patton	63.0	1.11%	0.7	1.08%	0.7
Total:	**650.5**	**1.03%**	**6.6**	**0.98%**	**6.3**

[1] Authorized Positions as of DSH Budget Management Branch (BMB) Hospital Position Report FY 2020-21 August, Rev A.xlxs
[2] Projected attrition rate based on FY 2017-18, 2018-19, and 2019-20 data
[3] Projected attrition rate based on FY 2018-19, 2019-20, and 2020-21 data

Cadet Graduation Rate

Below are the actual graduation rates as of FY 2018-19 to current cadet Academy cohorts:

Cadet Graduate Rates			
Academy	**Number of Cadets Attended**	**Number of Cadets Graduated**	**Graduate Rate**
Academy 27 February 12, 2018 – May 18, 2018	50	44	88.00%
Academy 28 August 13, 2018 - November 16, 2018	49	42	85.71%
Academy 29 October 1, 2019 – January 10, 2019	38	32	84.21%
Academy 30 February 11, 2019 – May 31, 2019	33	31	93.94%
Academy 31 August 12, 2019 – November 22, 2019	43	34	79.07%
Academy 32 December 2, 2019 – March 20, 2020	19	17	89.47%
Academy 33 February 10, 2020 – May 22, 2020	20	16	80.00%
Academy 34 August 24, 2020 – December 10, 2020	25	TBD	TBD
Academy 35 December 28, 2020 – April 22, 2021	15	TBD	TBD
TOTAL:	**292**	**216**	**85.71%**

Academy cohorts 32, 33, 34 and 35 had lower than anticipated cadet attendance. Attendance was impacted due to continued delays in medical screenings and physical fitness ability tests (PATs) at DSH-Metropolitan, issues identified with the background investigations contract, and delays caused by the COVID-19 pandemic. Due to the delays caused by COVID-19, it is inconclusive whether the delays in medical/PAT screenings have been resolved.

COVID-19 Impacts

Academy 32

Academy 32 received a modified graduation ceremony, on March 20, 2020. Graduations are typically in person and with family, friends, Chiefs, Chief of Law Enforcement, and various other DSH attendees. With the COVID-19 pandemic this graduation was streamed online to allow for virtual attendance.

Academy 33

The cohort which began in February was sent back to their facilities on March 19, 2020 during the statewide Stay-in-Place orders issued by Governor Newsom. Cadets were moved to an online training platform to allow them to continue training while the San Luis Obispo Academy (Camp SLO) was closed. The cadets resumed in person trainings on June 1, 2020 and received training in areas unable to be provided in the online learning platform. The cohort completed the Academy and graduated on July 16, 2020; two months after their original graduation date.

Academy 34

COVID-19 impacted the background and pre-employment components for completing hires for this Academy. Many applicants were unable to obtain required original documents to provide for their background or employment references due to statewide closures. Conducting interviews or traveling to interview or review files was severely impacted due to the statewide closures and social distancing guidelines. The pre-employment impacts on Academy 34 is one conclusive reason for the low cadet attendance.

However, the Office of Protective Services (OPS) has utilized various alternatives to help continue pre-employment processes for the HPO Academy. OPS conducted Background Intake Interviews via online or telephone as an alternative solution. In addition, OPS requested that the HPO exam be given online utilizing the latest online proctoring through CPS. The request was approved, and the contract is in the final process of being executed.

FY 2021-22
TECHNICAL ADJUSTMENT

BACKGROUND:

Each year, the Department of State Hospitals (DSH) programs are provided funding for state operations in the Budget Act. Due to changes in business practices, DSH has identified necessary technical adjustments within various programs. These adjustments will accurately align budget authority with anticipated expenditures.

DESCRIPTION OF CHANGE:

DSH requests to permanently realign existing resources in fiscal year (FY) 2021-22 and ongoing to properly align budget and position authority with existing expenditures. This is a net-zero proposal and does not include additional funding or positions.

Below is a report out of the net-zero adjustments requested in this adjustment:

1. <u>Transfer of Accountant Trainee from Metropolitan State Hospital (DSH-M) to DSH-Sacramento (DSH-Sac)</u>

Transfer of Accountant Trainee			
Program	**4400**	**4410**	**Net Change**
Related Funding	$97,000	-$97,000	$0

This move will permanently transfer 1.0 position authority and $97,000 in funding to DSH-Sac (4440-011-0001) from DSH-M (4410-011-0001) in order to address workload needs in the Accounting Branch. This is a permanent realignment of funding and position authority.

2. <u>Transfer of Clinical Operations Advisory Council (COAC) Position Funding from Hospitals to DSH-Sac</u>

Transfer COAC Position Funding			
Program	**4400**	**4410**	**Net Change**
Related Funding	$2,557,000	-$2,557,000	$0

This move will permanently transfer funding for 10.0 positions from DSH-Atascadero (DSH-A), DSH-Napa (DSH-N), DSH-M and DSH-Patton (DSH-P) (4410-011-0001) to DSH-Sac (4400-011-0001). The Mission Based Review Treatment Team BCP was approved in Budget Act 2020 and the Estimate, Caseload, Population (ECP) narrative is providing the position authority for these positions beginning in FY 2021-22, however the funding is internal within DSH.

3. <u>Transfer of Assistant Medical Director Position from DSH-A to DSH-Sac</u>

Transfer of Assistant Medical Director			
Program	**4400**	**4410**	**Net Change**
Related Funding	$426,000	-$426,000	$0

This move will permanently transfer 1.0 position authority and $426,000 in funding from DSH-A (4410-011-0001) to DSH-Sac (4400-011-0001) to align with the intent of the Treatment Team

BCP which was approved in Budget Act 2020. This position is currently being used to upgrade the Assistant Medical Director per the BCP, however the baseline position and funding need to be shifted in order for the upgrade to occur.

4. Transfer of Funding from DSH-M to DSH-Sac

Transfer of Funding for Retirement Payout			
Program	**4400**	**4410**	**Net Change**
Related Funding	-$193,000	$193,000	$0

This is a transfer of funding from DSH-Sac to DSH-M to that was erroneously captured in Governor's Budget development. This error will be addressed during the May Revise process.

5. Realignment of Increased Court Appearances and Public Record Act Requests BCP

Realignment of Increased Court Appearances and Public Record Act Requests BCP			
Program	**4400**	**4410**	**Net Change**
Related Funding	-$48,000	$48,000	$0

This move will permanently transfer 0.5 position authority and $48,000 in funding from DSH-Sac (4400-011-0001) to DSH-Coalinga (DSH-C) (4410-011-0001) in order to more adequately meet the intent of the BCP. This BCP was approved in Budget Act 2019 and these resources were shifted in a Budget Revision in FY 2019-20, however the shift was never made permanent. This request is to shift resources ongoing.

6. Realignment of Post-Incident Debriefing and Support BCP

Realignment of Post-Incident Debriefing and Support BCP			
Program	**4400**	**4410**	**Net Change**
Related Funding	-$735,000	$735,000	$0

This move will permanently transfer 5.0 position authority and $735,000 funding for the Post-Incident Debriefing and Support BCP from DSH-Sac (4440-011-0001) to State Hospitals (4410-011-0001) in order to more adequately meet the intent of the BCP which was approved in Budget Act 2020. Position authority and funding was originally positioned in DSH-Sac as a placeholder and is now being realigned to fulfill the objectives of the BCP.

7. Realignment of Reimbursement Funding

Realignment of Reimbursement Funding			
Program	**4400**	**4410**	**Net Change**
Related Funding	-$3,160,000	$3,160,000	$0

This move will permanently realign reimbursement authority from DSH-Sac (4440-011-0001) to State Hospitals (4410-011-0001) where the expenses will be occurring. This is a cleanup item from DSH's budget restructure in fiscal year (FY) 2018-19.

8. Transfer of Senior Psychologist Specialist from DSH-A to DSH-Sac

Transfer Senior Psychologist Specialist			
Program	**4400**	**4410**	**Net Change**
Related Funding	$203,000	-$203,000	$0

This move will permanently transfer 1.0 position authority and $203,000 from DSH-A (4440-011-0001) to DSH-Sac (4440-011-0001) as part of the Clinical Operations Division in order to better meet the needs of the Department. This position was shifted in a Budget Revision in FY 2019-20, which is why it was excluded from the COAC part of the Treatment Team BCP. However, the shift was never made permanent. This request is to shift resources ongoing.

9. Transfer of Staff Services Manager I from Forensic Services Division (FSD) to DSH-Sac

Transfer Staff Services Manager I			
Program	**4400**	**4440**	**Net Change**
Related Funding	$148,000	-$148,000	$0

This move will permanently transfer 1.0 position authority and $148,000 from Evaluation & Forensic Services (4440-011-0001) to DSH-Sac (4400-011-0001). This move is associated with the increased workload in processing FSD contracts.

10. Realignment of Information Technology Funding from DSH-A to DSH-Sac

Realignment of Information Technology Funding			
Program	**4400**	**4410**	**Net Change**
Related Funding	$390,00	-$390,000	$0

This move will permanently transfer funding from State Hospitals (4410-011-0001) to DSH-Sac (4400-011-0001) for information technology costs. These costs have been centralized within DSH-Sac and when BCPs are approved a portion of the standard compliment for each newly established position related to information technology needs to be moved.

11. Transfer of Associate Governmental Program Analyst from FSD to Conditional Release Program (CONREP)

Transfer of Associate Governmental Program Analyst			
Program	**4420**	**4440**	**Net Change**
Related Funding	$126,000	-$126,000	$0

This move will permanently transfer 1.0 position authority and $126,000 from FSD (4440-011-0001) to CONREP (4420-011-0001). This move was made to address the expanding workload related to renewing or establishing contracts with counties and evaluators.

12. Transfer of Associate Governmental Program Analyst from Contracted Patient Services (CPS) to CONREP

Transfer of Associate Governmental Program Analyst			
Program	**4420**	**4430**	**Net Change**
Related Funding	$126,000	-$126,000	$0

This move will permanently transfer 1.0 position authority and $126,000 from CPS (4430-011-0001) to CONREP (4420-011-0001). This move was made to address the expanding workload related to establishing and renewing contracts with counties and evaluators.

13. Transfer of funding for a Student Assistants from FSD to CPS

Transfer of funding for Student Assistants			
Program	**4430**	**4440**	**Net Change**
Related Funding	$43,000	-$43,000	$0

This move will permanently move funding from FSD (4440-011-0001) to CPS (4430-011-0001) to fund student assistants in two subprograms. The Student Assistants will help with administrative support functions. The funding will be allocated as follows:

- $20,000 for Diversion under subprogram 4430030
- $23,000 for Jail-Based Competency Treatment (JBCT) program under subprogram 4430020

POPULATION PROFILE

Penal Code 2684 (*Coleman*) Patients

Description of Legal Class:

The Department of State Hospitals (DSH) admits *Coleman* patients pursuant to Penal Code (PC) 2684, which stipulates that mentally ill patients confined in a state prison may be transferred to a DSH hospital in order to expedite their rehabilitation. The *Coleman* patients are California Department of Corrections and Rehabilitation (CDCR) patients, who are transferred from CDCR for inpatient mental health care with the expectation that they will return to CDCR (pursuant to PC 2685) when they have reached maximum benefit from treatment. If they are still mentally ill at the end of their prison term, they may receive further state hospital treatment as an Offender with a Mental Health Disorder if they meet the criteria under PC 2962. Additionally, patients who do not meet the criteria pursuant to PC 2962 may be treated at DSH either as a parolee with a mental health disorder pursuant to PC 2974, or as a Lanterman-Petris-Short civil commitment.

The following are the various *Coleman* commitments, and their corresponding citation in statute:

PC 2684	Prisoner from CDCR, under approval by the Board of Parole Hearings, that is referred to a state hospital for mental health treatment.

Legal Requirements/Legal Statute for Discharge:

The goal of DSH is to provide each *Coleman* patient with the appropriate treatment to stabilize their mental health symptoms and gain the necessary skills to safely transition and reintegrate into the appropriate environment within CDCR. A patient may be eligible for discharge from DSH when the Interdisciplinary Treatment Team determines that the patient has met the requested treatment outcome expectations, the current treatment goals and objectives, and the appropriate continued care has been arranged. A patient may be discharged directly into the community when they are institutionally released from CDCR.

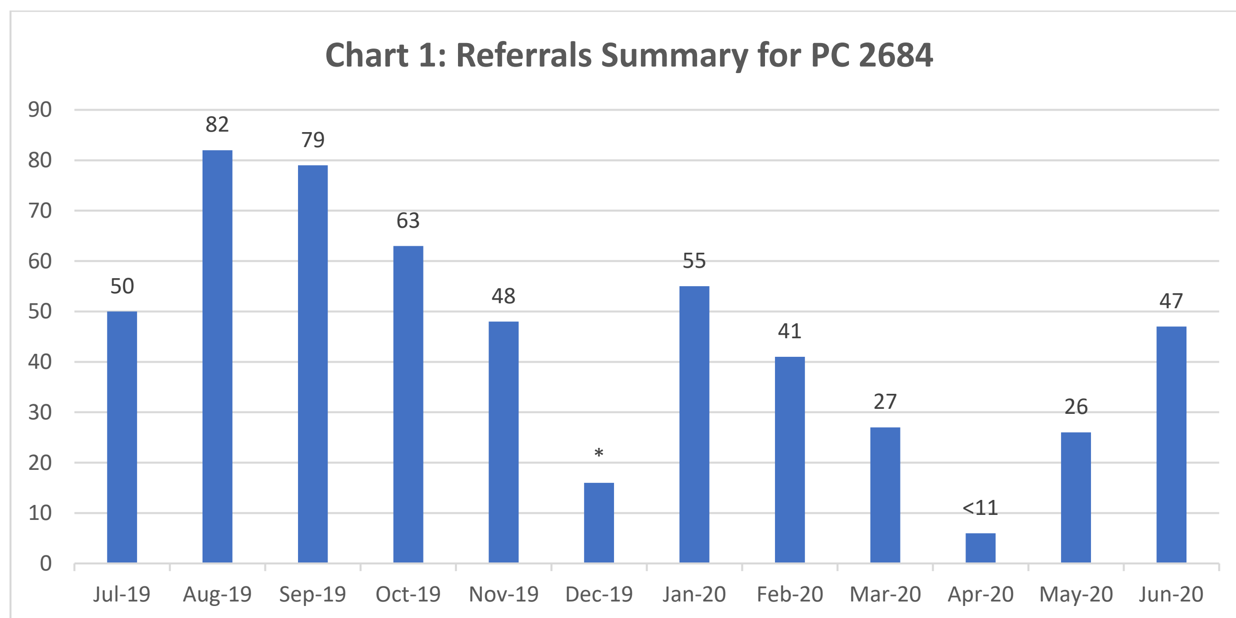
Treatment:

The focus of treatment for the *Coleman* population is on psychiatric stabilization. A number of *Coleman* patients are sent to DSH because of complicated presentations, such as complex medical diagnoses, cognitive issues, or developmental disabilities along with mental illness. In addition to psychiatric and medical services, psychosocial treatments are provided with a focus on helping the patient manage their mental illness symptoms and reintegrate back into a prison environment when discharged from the state hospital.

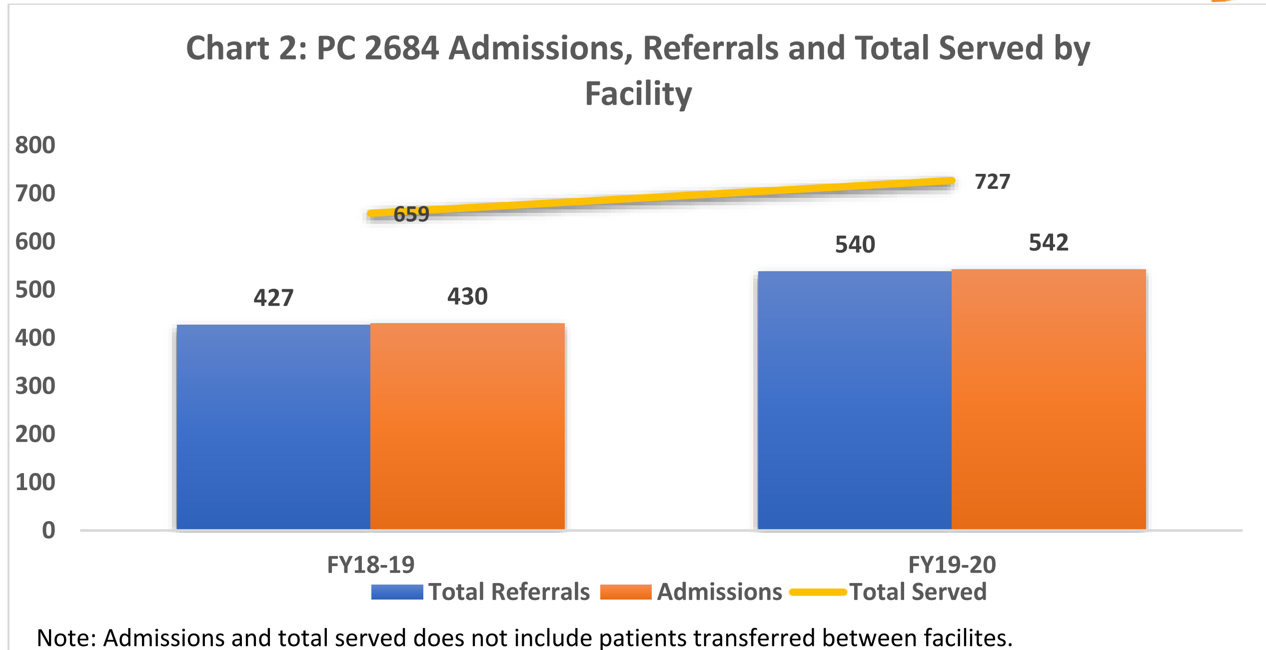
Population Data:

In FY 2019-20, 540 *Coleman* patients were referred and accepted for admission to the state hospitals, a 26 percent increase from FY 2018-19.

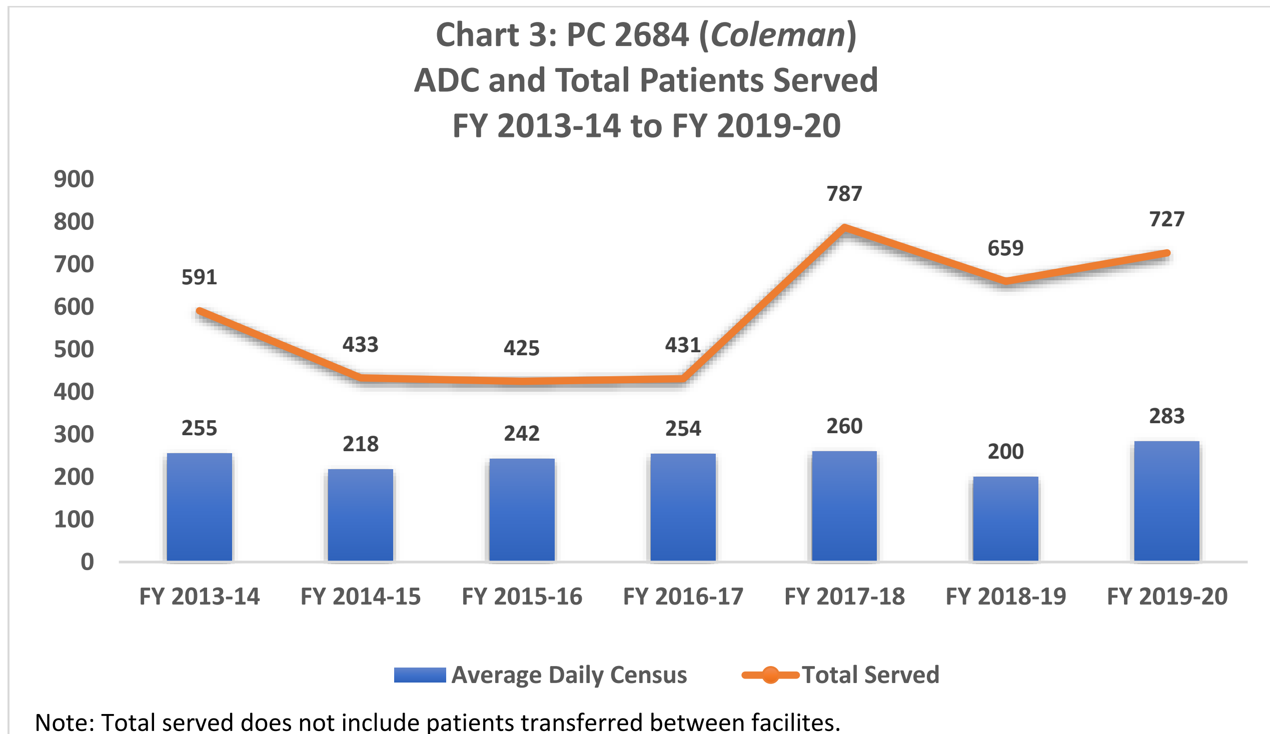
Of the 540 patients referred in FY 2019-20, 434 of the patients were referred to state hospitals between July 2019 and February 2020, a 48 percent increase from referrals received during the same months in FY 2018-19 - July 2018 through February 2019. At the start of the FY 2019-20, the July 1 census was 185 and on February 28, 2020, the census had increased to 298, a 61 percent increase. With the exception of a lull in December 2019, DSH continued to operate under the increased flow of referrals that remained steady prior to the COVID-19 pandemic. During the period of March 2020 through June 2020, 106 patients were referred to DSH, a 21 percent decrease from the number of referrals received during the same time period in FY 2018-19.



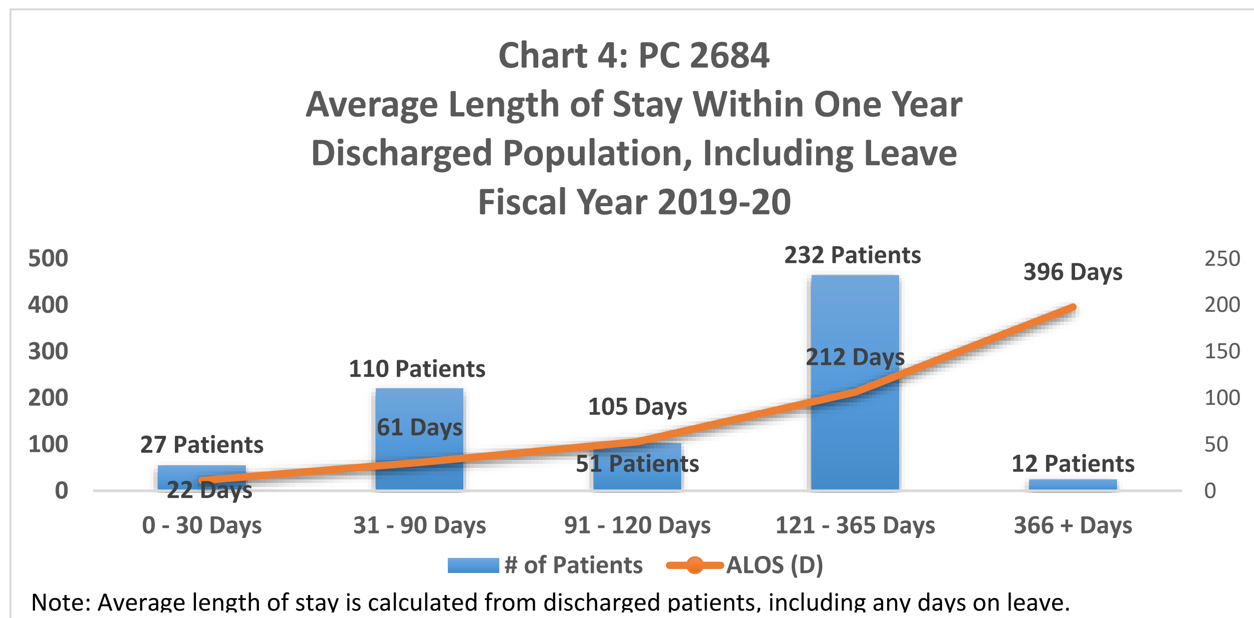
Over the course of FY 2019-20, 542 *Coleman* patients were admitted into a state hospital. Chart 2 displays the admission, referrals, and total patients served systemwide for the *Coleman* population in FY 2018-19. The number of admissions increased by 26 percent even with the admission suspension that occurred from March 16, 2020 through April 16, 2020.



On average, 283 *Coleman* patients are treated daily in the state hospitals, representing 5 percent of the overall patient population in FY 2019-20. Chart 3 displays the average daily census (ADC) and total number of patients served for the *Coleman* population during FY 2013-14 to FY 2019-20. As of June 30, 2020, the system-wide *Coleman* census was 281 patients.



Because the focus of treatment is acute stabilization, the length of hospitalization for *Coleman* patients tends to be shorter than the other commitment types. In FY 2019-20, 432 *Coleman* patients were discharged with an average length of stay of 154 days, a little less than half a year. Chart 4 displays the distribution of lengths of stay for all discharged *Coleman* patients.



POPULATION PROFILE
Incompetent to Stand Trial Patients

DESCRIPTION OF LEGAL CLASS:

The Department of State Hospitals (DSH) admits Incompetent to Stand Trial (IST) patients under Penal Code (PC) 1370: Inquiry into the Competence of the Defendant Before Trial or After Conviction. IST patients are referred to DSH after a court has determined that they are unable to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. These defendants are then committed by the court to DSH for treatment specifically designed to enable the defendant to proceed with trial, conducted as clinically appropriate at either a state hospital or a jail-based competency treatment program. Patients receive competency-based treatment and return to court once they have regained competency and can effectively assist in their trial proceedings. IST patients committed to DSH mostly include felony criminal charges, and occasionally include misdemeanor charges.

The following are the various IST commitments, and their corresponding citation in code:

PC 1370	Incompetent to Stand Trial
PC 1370.01	Misdemeanor charges, Incompetent to Stand Trial
PC 1370.1	IST commitment for a defendant whose incompetence is due to developmental disability
PC 1372(e)	Continued hospitalization for an IST defendant who is no longer incompetent to stand trial, but who requires continued, involuntary treatment in a state hospital to maintain competency while awaiting trial and during the course of trial
PC 1370(b)(1)	Unlikely to regain competency; may apply to PC 1370, PC 1370.01, or PC 1370.1. The treating facility may recommend to the court that an individual is unlikely to regain competency regardless of length of treatment or resources available at the state hospital level of care, and if the court agrees with that recommendation, the committing county must pick up the individual within 10 days of notification by DSH.
PC 1370(c)(1)	IST that remains at DSH within 90 days of their maximum term commitment; may apply to PC 1370, PC 1370.01, or PC 1370.1. These patients are required to be picked up by their committing county 90 days prior to the expiration of their IST commitment.
PC 1610	Temporary admission while waiting for court revocation of PC 1370 (IST)

LEGAL REQUIREMENTS/LEGAL STATUE FOR DISCHARGE:

An IST patient cannot be confined for longer than is reasonably necessary for restoration of competency or determination that competency cannot be restored. The maximum IST commitment time is two years[1] for felony offenses, or up to the maximum term of imprisonment for the alleged crime, whichever is shorter (PC 1370, subdivision (c)(1)). An IST commitment may end when either: (1) the maximum time for confinement runs out; (2) the defendant obtains certification that he or she has regained competency pursuant to PC section 1372; or (3) DSH determines there is no substantial likelihood a patient will regain competency in the foreseeable future. If a patient/defendant has not regained competency to stand trial by the end of their IST commitment term or is determined there is no substantial likelihood they will regain competency in

[1] Effective January 1, 2019, the maximum term for ISTs was reduced from three years to two years, pursuant to SB 1187.

the foreseeable future, the patient/defendant must be returned to the committing county or if meets specified criteria, can be hospitalized further under a civil commitment.

As defined in PC 1370(b)(1), a patient may be deemed by the treatment team as unlikely to regain competency, and upon notification of the county of commitment, the patient must be picked up within 10 days. Often, the county will pursue other means to ensure the patient is receiving treatment and care, which may include securing a conservatorship and referring the individual back to the state hospital. In the event a patient is nearing their maximum term of commitment, the state hospital, pursuant to PC 1370(c)(1) must notify the county, who must pick up the patient at least 90 days prior to the expiration of the commitment term. On occasion, a county does not retrieve their committed patients in a timely manner or pursues conservatorship without discharging the individual in question, and the patient remains in the state hospital and in the census. In FY 2018-19, when applying the average length of stay for an IST patient, this practice resulted in a loss of 132.3 IST patients served between PC 1370(b)(1) and PC 1370(c)(1) individuals.

Misdemeanor IST commitments are only committed to DSH if there are no less restrictive placements for competency treatment and the county enters into a contract with DSH for cost of competency treatment.

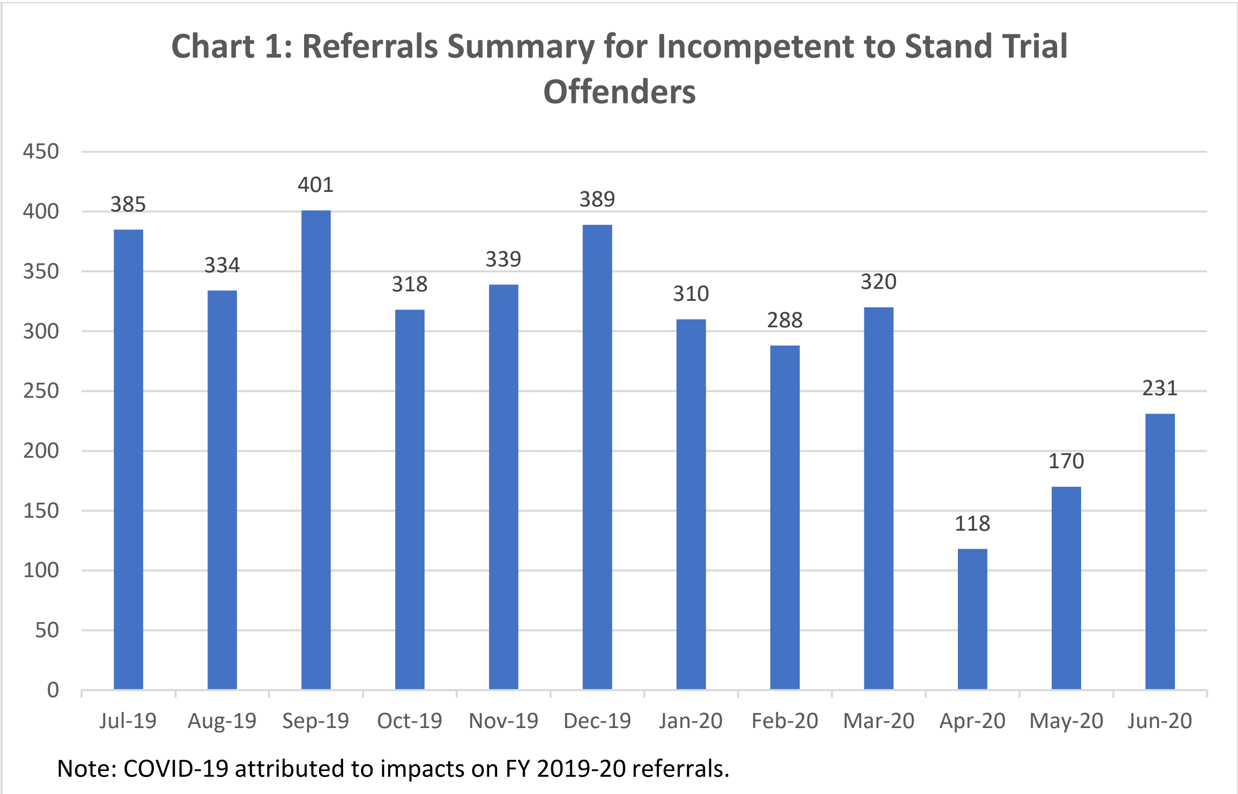
TREATMENT:

The focus of treatment for the IST population is on restoration of trial competency in the most expeditious manner. To this end, IST patients are treated in one treatment program so the training of criminal procedures can be constantly present in the treatment milieu. Once specific mental health issues and medication needs are addressed, patients are immersed in groups that train them in the various aspects of court.

Throughout treatment, patients are regularly evaluated and, if there is concurrence that a patient is competent, a forensic report is sent to the court, identifying that the patient is competent and ready to be discharged to the county of commitment where they can stand trial.

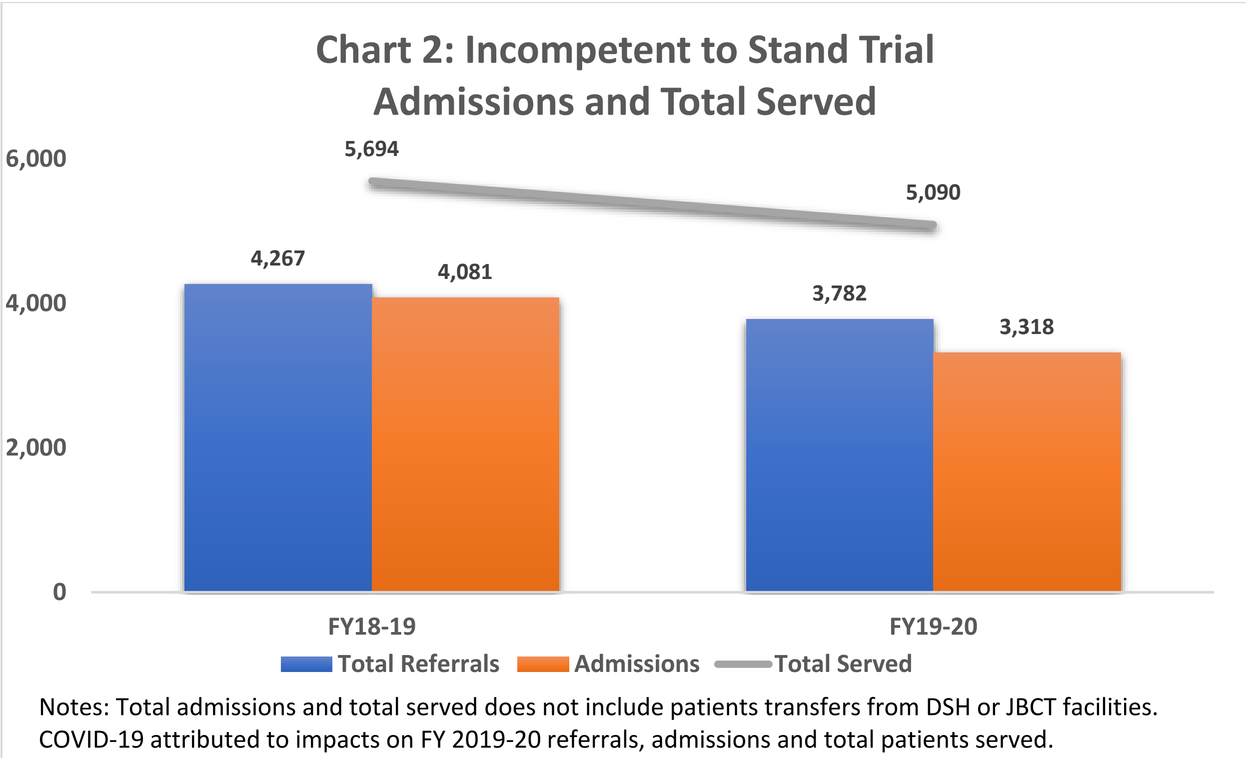
POPULATION DATA:

In FY 2019-20, 3,603 IST patients were committed to DSH, a 14 percent decrease from FY 2018-19. The COVID-19 pandemic directly impacted IST referral rates. Following Governor Gavin Newsom's Proclamation of a State of Emergency dated March 2, 2020 a shelter-in-place order went into effect on March 19, 2020. The decrease in IST referral rates is associated with county court closures following the shelter-in-place order. With the exception of a lull from April through June 2020 as a result of court closures, DSH continued to operate under the steady flow of referrals that remained consistent with prior year.

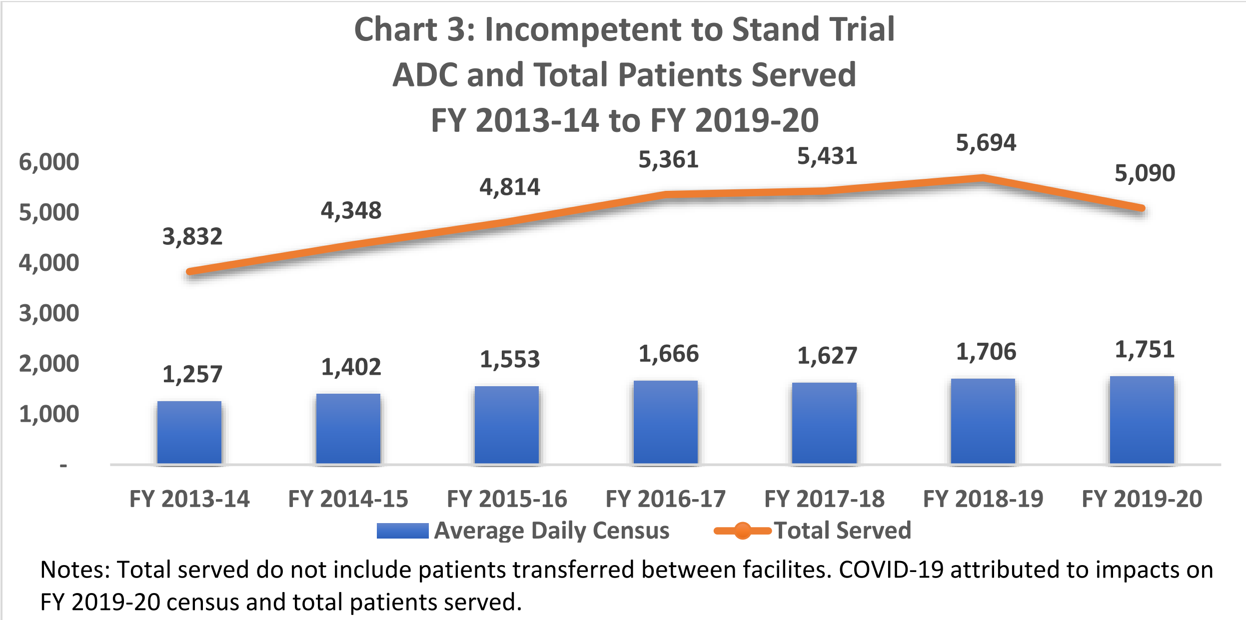


Incompetent to Stand Trial Data

Over the course of FY 2019-20, 3,318 IST patients were admitted into a state hospital and jail-based programs which is a decrease of 19 percent from the prior year. This decrease is attributed to the temporary suspension of IST admissions into DSH hospitals to mitigate the impacts of COVID-19 throughout its hospitals. As DSH resumed admissions at the end of May 2020, admission rates were impacted due to the need to cohort patients in an admission observation unit for at least 14 days while the cohort is tested for COVID-19. Admission rates were further impacted when positive COVID-19 cases were identified in an admission cohort causing the need to further test, observe and quarantine the unit, or when a hospital had a COVID-19 outbreak. Availability of single patient rooms was also a compounding factor on admission rates. Due to the need to keep newly admitted patients separate, units that normally housed multiple patients in dorm rooms were only able to house one patient per room, thus limiting the census on an observation unit to the number of rooms the unit has. DSH continuously monitored and adjusted its admissions to prioritize the safety of its patient and staff. As admissions directly correlate to patients served, DSH served 11 percent less patients in FY 2019-20 than in the prior year. Chart 2 displays referrals, admissions, and total patients served systemwide for the IST population in FY 2018-19 and FY 2019-20.

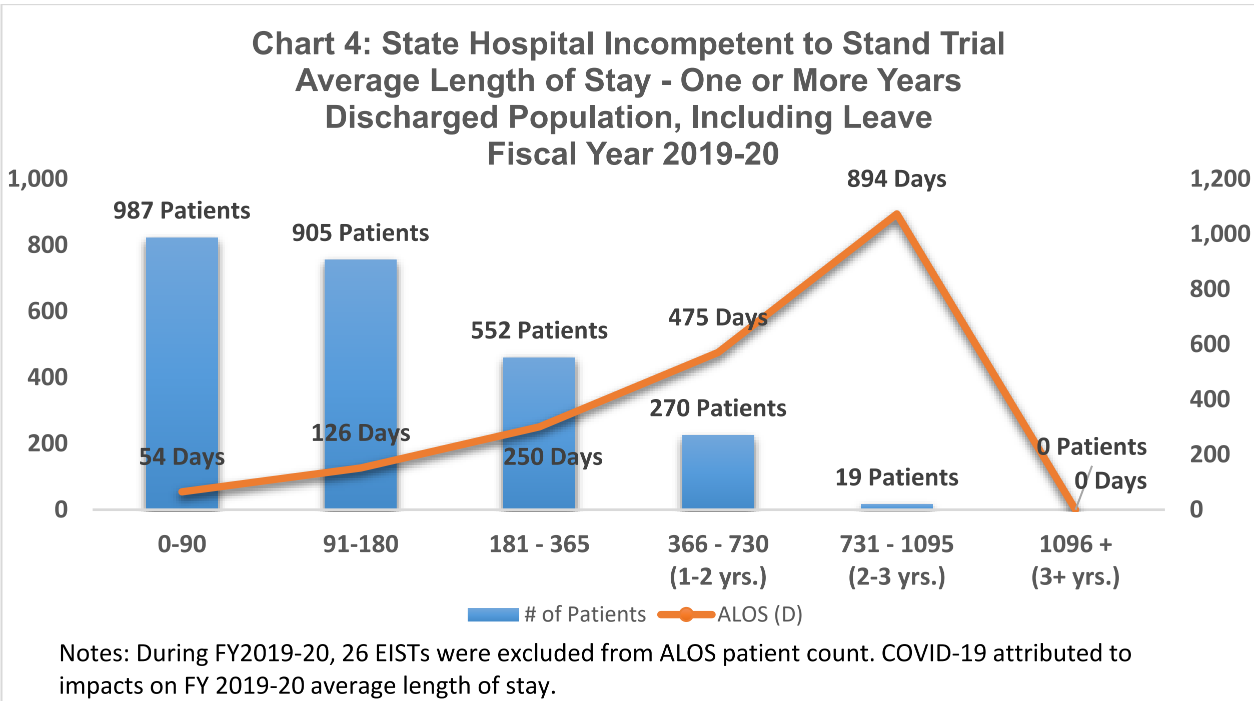


On average, 1,751 IST patients are treated daily in the state hospitals and jail-based programs, representing 27 percent of the overall patient population in FY 2019-20. Chart 3 displays the average daily census (ADC) and total number of patients served in state hospital facilities and jail-based programs for the IST population from FY 2013-14 to FY 2019-20. As of June 30, 2020, the system-wide IST census is 1,347 patients.



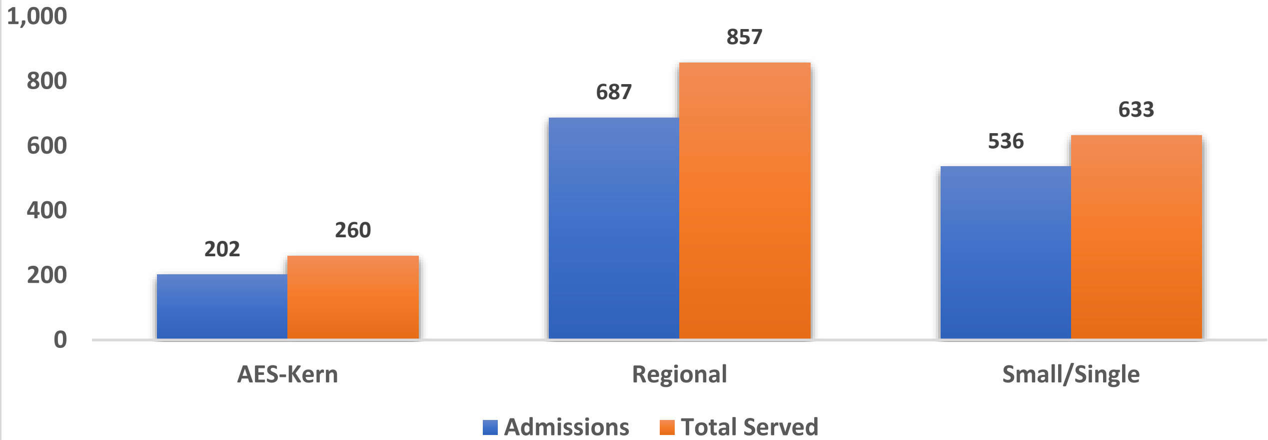
In FY 2019-20, 2,733 IST patients were discharged from state hospitals with an average length of stay of 165 days, 0.5 years. The State Hospital length of stay increased by 11 percent (or approximately 16 days) as compared to the prior year. This increase in the length of stay can be

attributed to COVID-19 as DSH had to temporarily suspend IST admissions and discharges to mitigate the impacts of COVID-19 throughout its hospitals. Chart 4 displays the distribution of lengths of stay for all discharged IST patients.



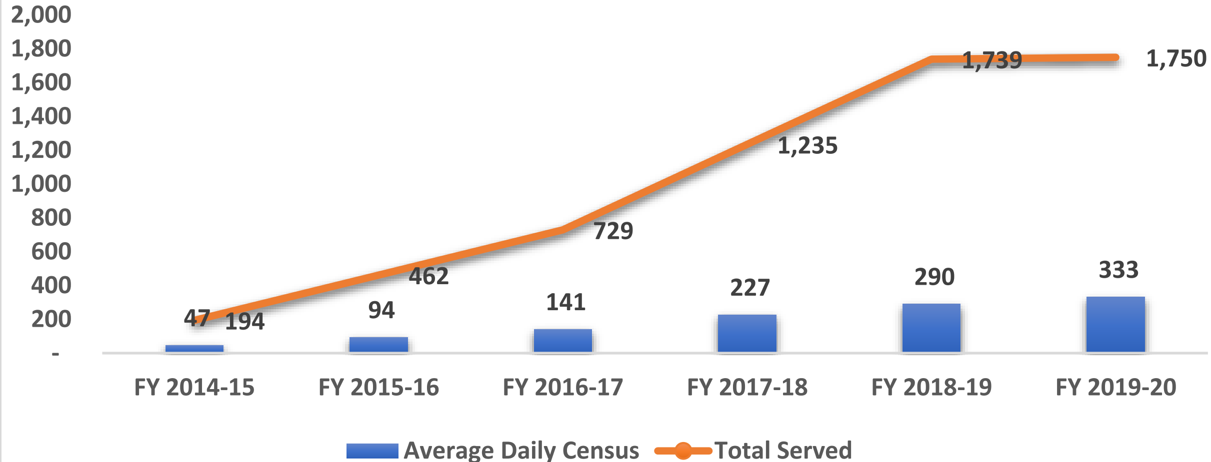
Jail-Based Competency Treatment Program Data

Over the course of FY 2019-20, 1,425 IST patients were admitted into a JBCT facility or the Admission, Evaluation, and Stabilization (AES) Center which is a decrease of three percent from the prior year. This decrease is attributed to reduced admission rates following the SIP order to mitigate the impacts of COVID-19 throughout facilities. JBCT facilities and the AES Center experienced significantly lower admissions from April through June 2020 as a result of COVID-19. Chart 5 displays the admission and total patients served distribution by AES/JBCT facility categories for the IST population in FY 2019-20.

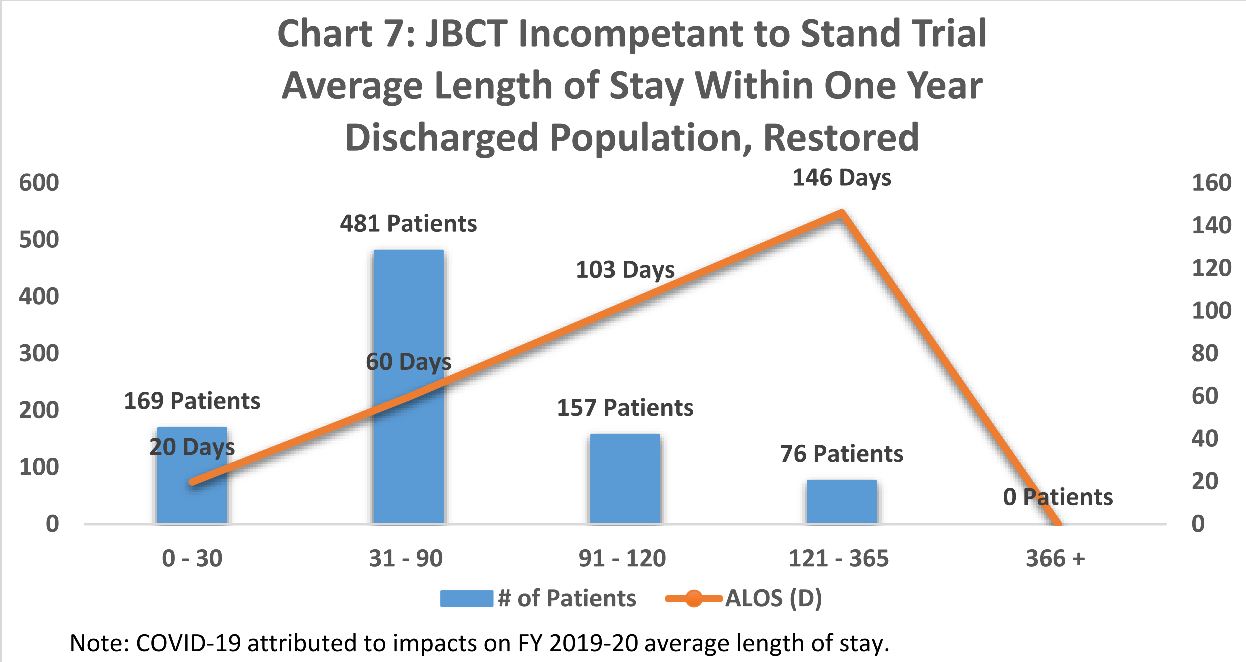


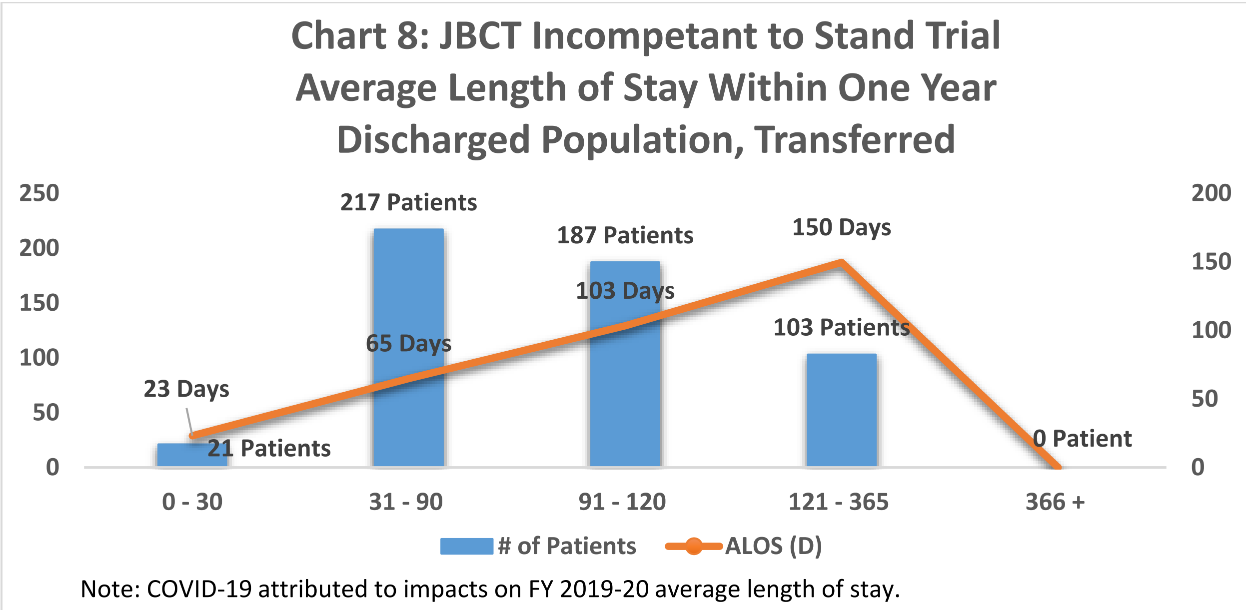
On average, 333 IST patients are treated daily in the AES/JBCTs, a 15 percent increase from FY 2018-19. Chart 6 displays the ADC and total number of patients served year over year in the AES/JBCTs for the IST population. As of June 30, 2020, the AES/JBCT system-wide IST census is 301 patients.

The IST population at the jail-based programs in both ADC and total number of patients served has increased, only recently plateauing in FY 2019-20. Due to the increasing availability of jail-based programs, the Department's IST census has balanced between state hospitals and jail-based facilities, though overall the impact of ISTs continues to rise.



The JBCT and AES programs were designed to treat patients who had a stronger likelihood of quick restoration of competency, generally under 90 days from admission. If, during the course of treatment, the patient demonstrates a need for a higher level of care, or restoration is of slower progress than anticipated, the individual can be transferred to a state hospital for continuation of restoration care. In FY 2019-20, 883 IST patients were restored and discharged with an average length of stay of 67 days. During that same period, 528 IST patients were discharged from the AES/JBCT program and transferred to a state hospital, with an average length of stay of 93 days. Chart 7 displays the distribution of lengths of stay for all discharged IST patients that were restored. Chart 8 displays the distribution of lengths of stay for all discharged IST patients that transferred to state hospital facilities.





Community-Based Restoration Program Data

On July 1, 2018, DSH, in collaboration with Los Angeles County, activated the Community-Based Restoration (CBR) Program for Felony IST commitments. Managed by the Los Angeles County-Office of Diversion and Re-entry, CBR aims to regularly assess committed IST patients while they wait for a bed at DSH to 1) re-evaluate competency and the need for competency treatment (“off-ramp”) and 2) identify suitability for a community-based treatment option in a network of 200+ beds.

As part of this two-prong approach, the off-ramp team monitors Felony ISTs in the jail for restoration of competency prior to placement in a state hospital or into the community restoration program. If competence is suspected, the team prepares court documentation and petitions the court to approve the determination of restored competence. Over the course of FY 2019-20, CBR successfully off-ramped 99 patients. Chart 9 displays the number of patients found competent monthly in CBR’s off-ramp assessment.

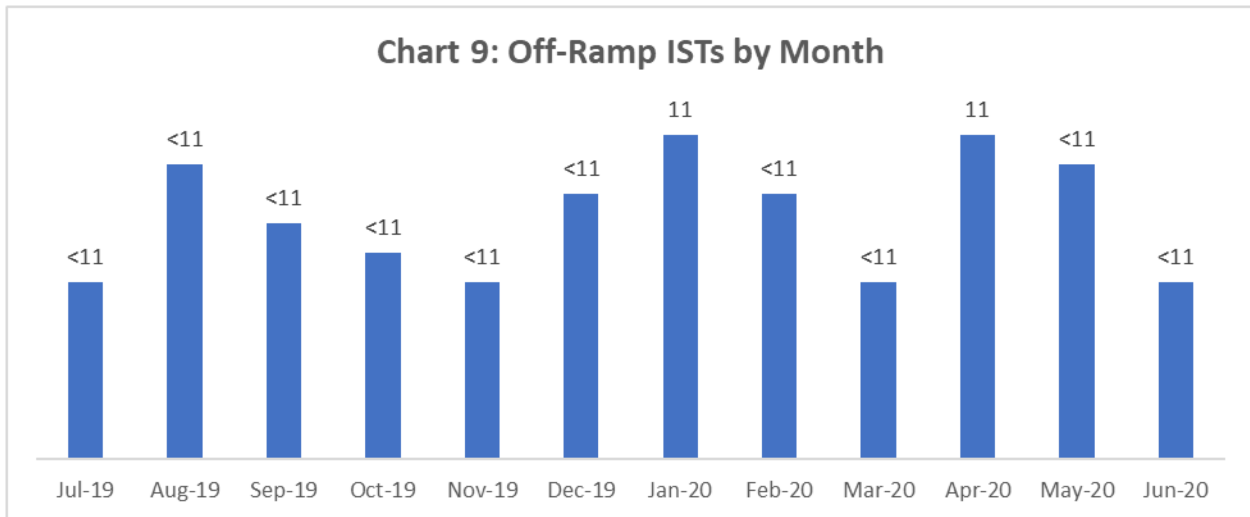


Chart 9. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

Upon assessment of Los Angeles County IST referrals, a patient may still present in need of competency restoration services, and staff may consider a patient appropriate for the CBR program and petition the court for this conditional release and placement. If conditional release is approved by the court, the matched provider arranges pickup of the patient and admits into their community facility to begin treatment. In FY 2019-20, 152 patients were conditionally released to CBR, and were subsequently admitted into community beds at an acute level of care, subacute level of care, or in an unsecured residential facility. Chart 10 displays the Average Daily Census by month in the various levels of care.

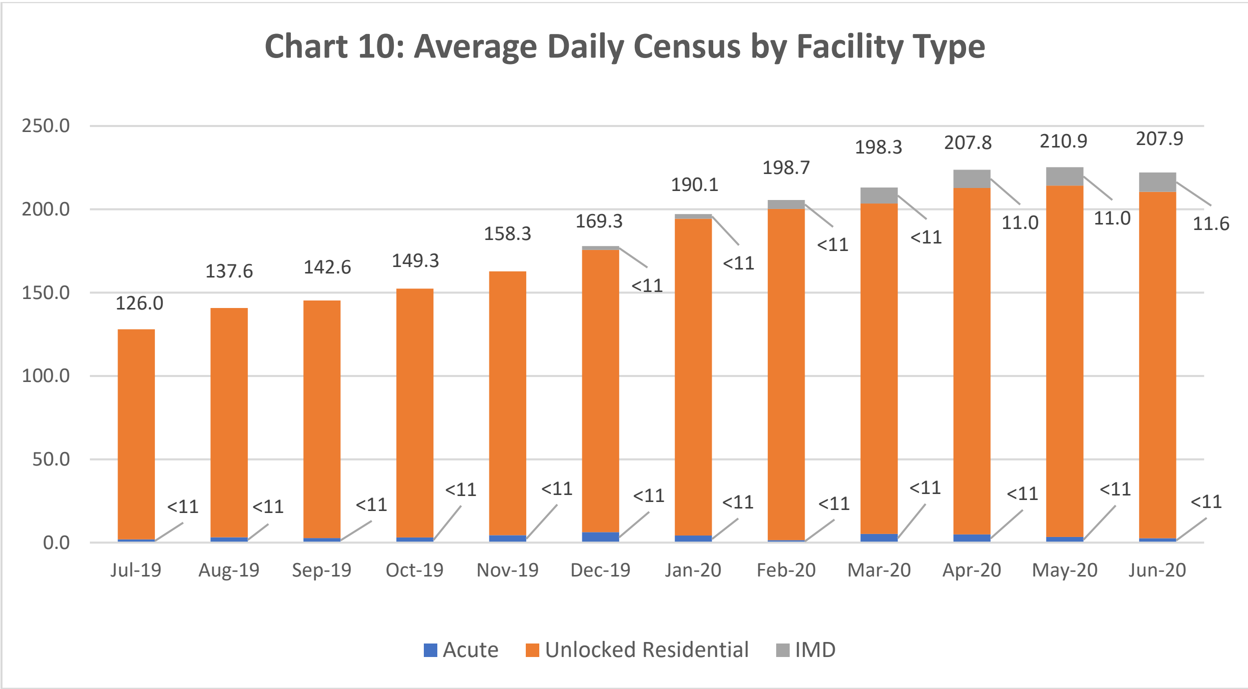


Chart 15. Data has been de-identified in accordance with the California Health and Human Services Agency Data De-Identification Guidelines.

In FY 2019-20, less than 11 patients were restored to competency with an Average Length of Treatment of 243 days.

In the absence of this program, the Los Angeles County patients who have been served by CBR either through competency assessment and off-ramp petition (n = 99), or conditional release and admission to a community facility (n = 152), would have continued as referrals to DSH and awaited an available bed in in a state hospital or JBCT.

POPULATION PROFILE
Lanterman-Petris-Short Patients

Description of Legal Class:

The Lanterman-Petris Short (LPS) population includes multiple civil commitment types of patients who have been admitted under the LPS Act. These patients require physically secure 24-hour care and are committed through civil court proceedings if legal criteria concerning a danger to themselves or others, or grave disability, are met. Certain current parolees or former parolees may also be conserved under LPS commitments. It is also possible for other forensic commitments to convert to LPS commitments, such as if an Incompetent to Stand Trial (IST) patient is found substantially unlikely to regain competence in the foreseeable future but requires ongoing mental health inpatient treatment and the respective county pursues legal conservatorship.

Over the past five years, 86 percent of all LPS patients served in state hospitals were committed under WIC 5353 or 5358 as conservatees. During the same period, approximately 1 percent was committed under Penal Code (PC) 2974, and 12 percent were conserved under WIC 5008(h)(1)(B) (Murphy Conservatorship). The remaining LPS population within DSH was comprised of the other 4 legal statutes under the LPS Act.

The following are the various LPS commitments, and their corresponding citation in code:

WIC 5358	Conservatorship (CONS), in which the appointed conservator places the conservatee in an appropriate facility, such as a state hospital, and can require treatment to remedy or prevent the recurrence of the conservatee's mental illness.
WIC 5353	Temporary conservatorship (T.Cons), in which an appointed temporary conservator may make arrangements, sometimes at a state hospital, to provide the individual with food, shelter, and care pending a conservatorship determination.
WIC 5270.15[1]	30-day certification (A-Cert) upon completion of a 14-day certification pursuant to WIC 5250 in the event that the individual remains gravely disabled or is unwilling or unable to voluntarily accept treatment. A certification review hearing is conducted to determine suitability of commitment.
WIC 5303[1]	Pending court decision on 180-day post certification (PCD), the conservatee remains at the treatment facility until released by court or in the event the petition is withdrawn.
WIC 5304(a)	Post certification treatment authorized for 180 days in the event the individual attempted, inflicted, or made a serious threat of physical harm upon another after having been taken into custody, or within seven days of being taken into custody, or as part of the reason for being taken into custody.
WIC 5304(b)	Additional 180-day post certification (ADD) in the event that the individual has attempted, inflicted, or a made a serious threat of physical harm upon another during post certification treatment.

WIC 4825, 6000(a)[1]	Admission to a state hospital of a developmentally disabled individual by their conservator; if competent, the individual may apply for and receive services at a regional center instead.
WIC 5250[1]	14-day certification (CERT) following detainment pursuant to WIC 5150 (72-hour detention), WIC 5200 (court ordered for evaluation, Article 2), or WIC 5225 (court ordered for evaluation, Article 3). The individual must be offered treatment on a voluntary basis, but has been unwilling or unable to accept the recommended treatment, and no family, friend, or other individual has submitted in writing their willingness to provide for the person's basic personal needs.
WIC 5150[1]	72-hour detention (DET) for assessment, evaluation, and crisis intervention with probable cause that a person is a danger to themselves or others, as a result of a mental health disorder.
WIC 6500, 6509[1]	A person with a developmental disability committed to a state hospital if found to be a danger to themselves or others; this commitment expires after one year pursuant to WIC 6500(b)(1)(A).
WIC 6506[1]	A temporary hold for an individual with a developmental disability while awaiting a hearing pursuant to WIC 6503.
WIC 5260[1]	Additional 14-day certification for suicidal persons who demonstrated this behavior via threats or attempts during the previous 14-day period or 72-hour evaluation period (SUIC)
WIC 6552[1]	Voluntary application as Juvenile court ward to be treated for a mental disorder at a state hospital (VJCW)
WIC 6000	Voluntary application to a state hospital for treatment and care made by a competent adult; they may leave at any time after notifying, or their conservator notifying in the case of conservatorships, hospital staff and following hospital discharge procedures (VOL)
PC 2974: Parolee from CDCR	Initiation of a LPS commitment to a state hospital for CDCR parolees. Such inmates must meet LPS criteria of being found to be dangerous to themselves or others, or gravely disabled. Because these patients are parolees, the cost is borne by CDCR and reimbursed to DSH on the same basis as the treatment cost of prison inmates under PC 2684.
WIC 5008(h)(1)(B): Murphy Conservatee	An IST defendant who is deemed gravely disabled and ordered to be held in a state hospital under a Murphy Conservatorship.

[1]During Fiscal Year (FY) 2019-20, this population was not served in the state hospitals.

Legal Requirements/Legal Statute for Discharge:

LPS conservatorships have not been charged with a crime, but are instead referred by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act. Those whose psychiatric conditions require a higher level of care and cannot be treated in locked facilities or board and care homes are sent to DSH for treatment. A patient's LPS conservatorship lasts for one year and can be renewed by the court on an annual basis. A new petition for renewal is filed with the court prior to the current conservatorship's expiration. LPS patients are discharged from DSH when (1) their county of residence places them in a different facility, (2) their county of residence places them in independent living or with family, or

(3) they have successfully petitioned the court to remove the conservatorship.

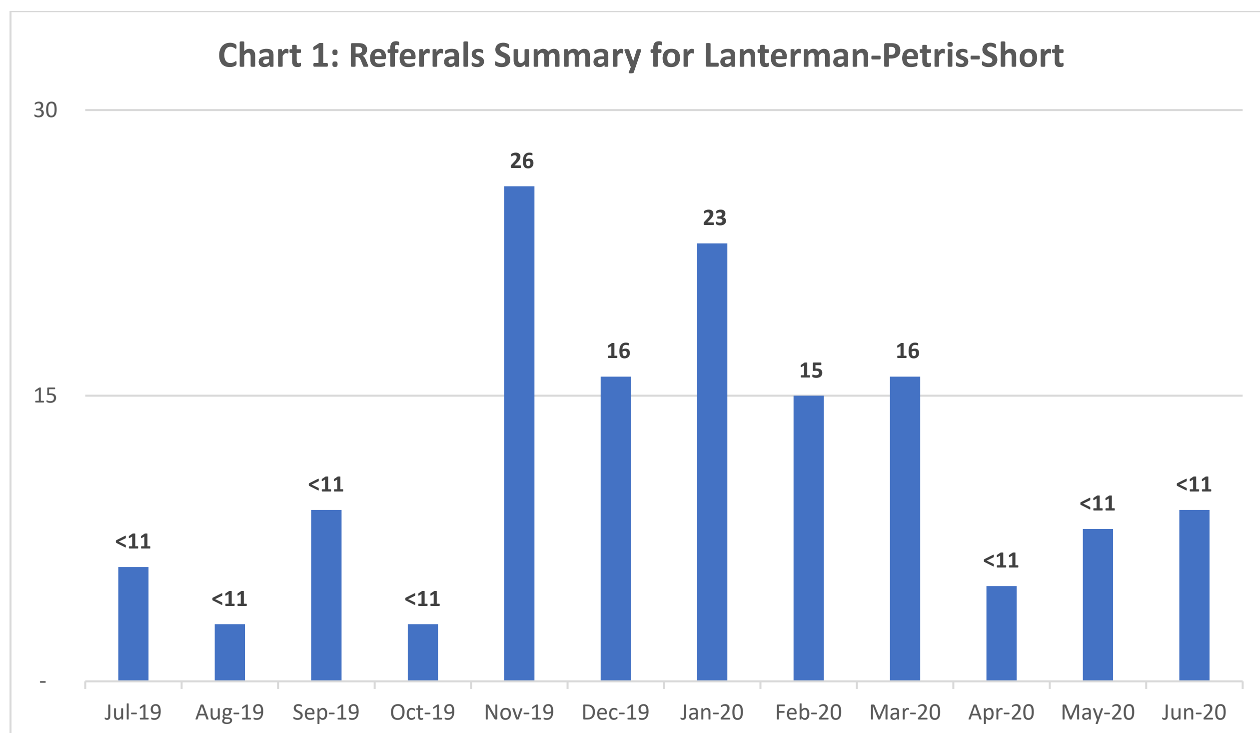
Treatment:

Under WIC 5150, an individual, on probable cause, can be taken into custody for mental health treatment for 72 hours. The individual can then be evaluated for an additional 14-day period of treatment pursuant to WIC 5250. After further evaluation and judicial review, the individual can then be placed on hold or temporarily conserved (T.Cons) for up to 30 days pending a full commitment hearing under WIC 5353 or WIC 5270. If the individual is gravely disabled, they can be placed under conservatorship pursuant to WIC 5350 for one year.

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. Because of the wide diversity of patients under the LPS commitment, discharge criteria differ for each legal statute. Most LPS patients can be treated in the community once the DSH treatment team believes the patient is no longer a danger to themselves or others.

Population Data:

LPS Population data in Charts 1 through 5 displays DSH LPS population including Murphy Conservatorship. A subset of Murphy Conservatorship data can be found on page 6. In Fiscal Year (FY) 2019-20, 139 LPS patients were committed to the state hospitals, a 32 percent decrease from FY 2018-19.



Over the course of FY 2019-20, 31 LPS patients were admitted into a state hospital. Chart 2 displays the referrals, admissions, and total patients served for the LPS population in FY 2019-20.

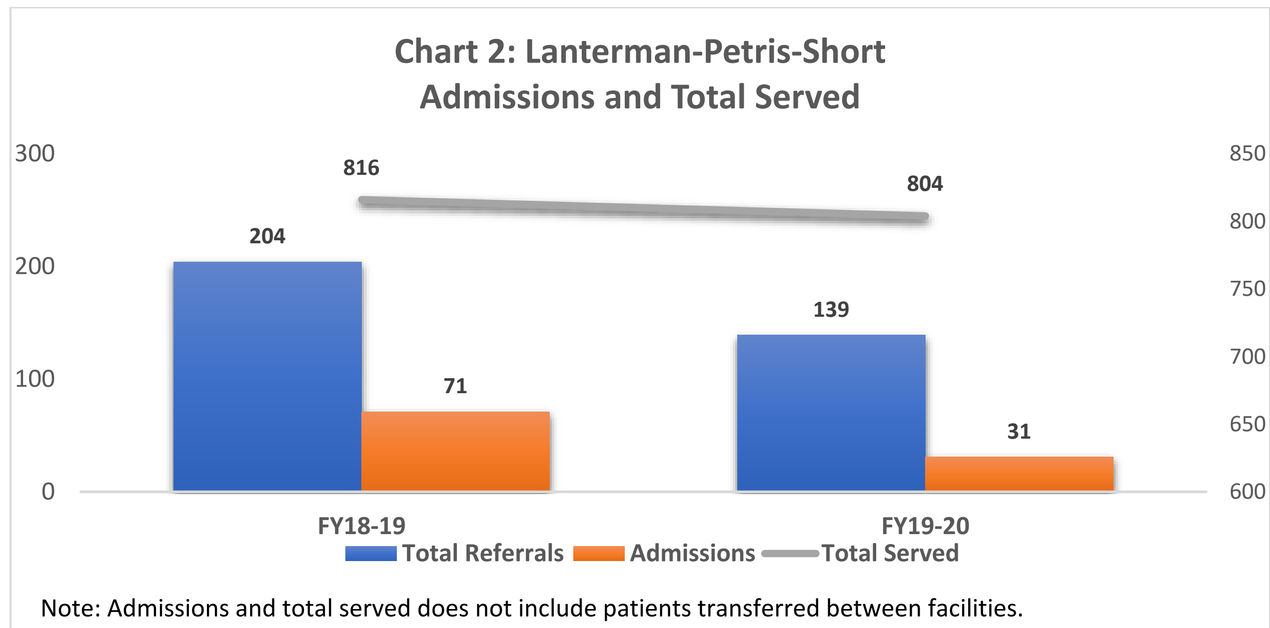
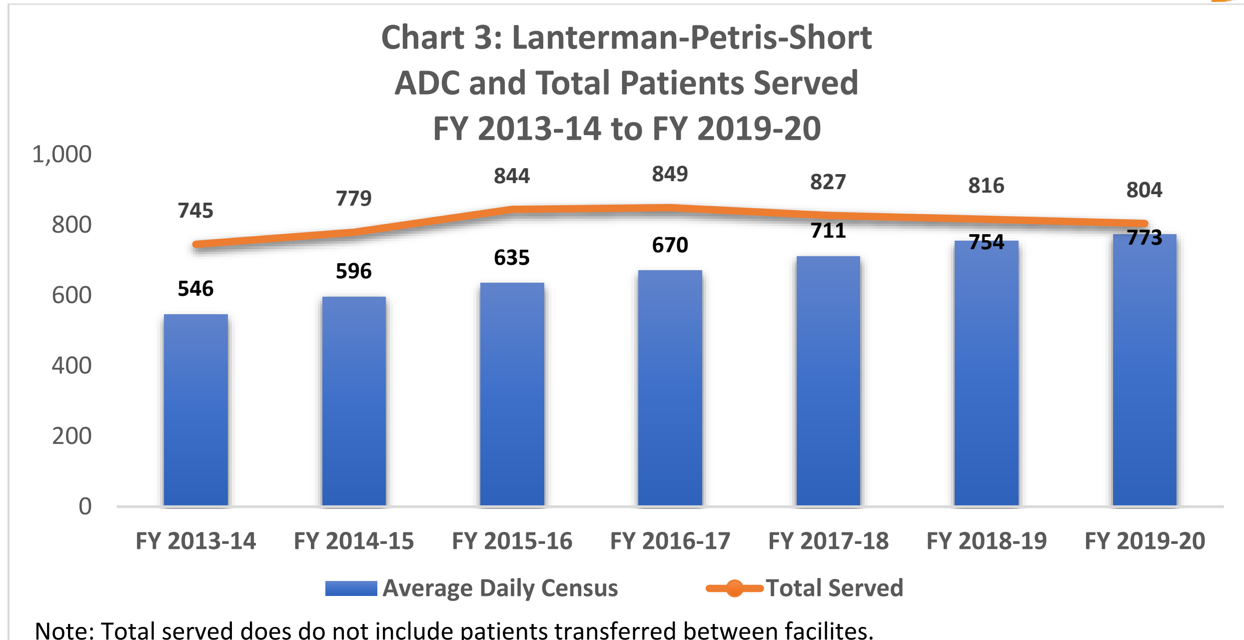
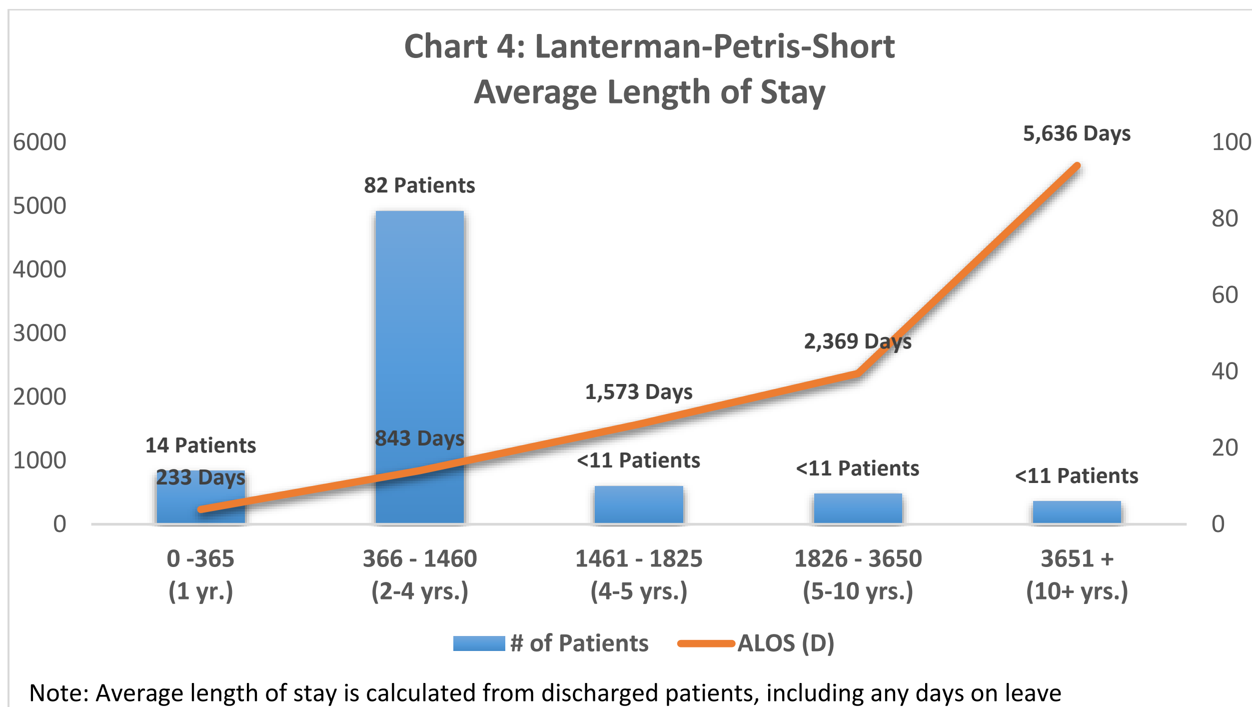
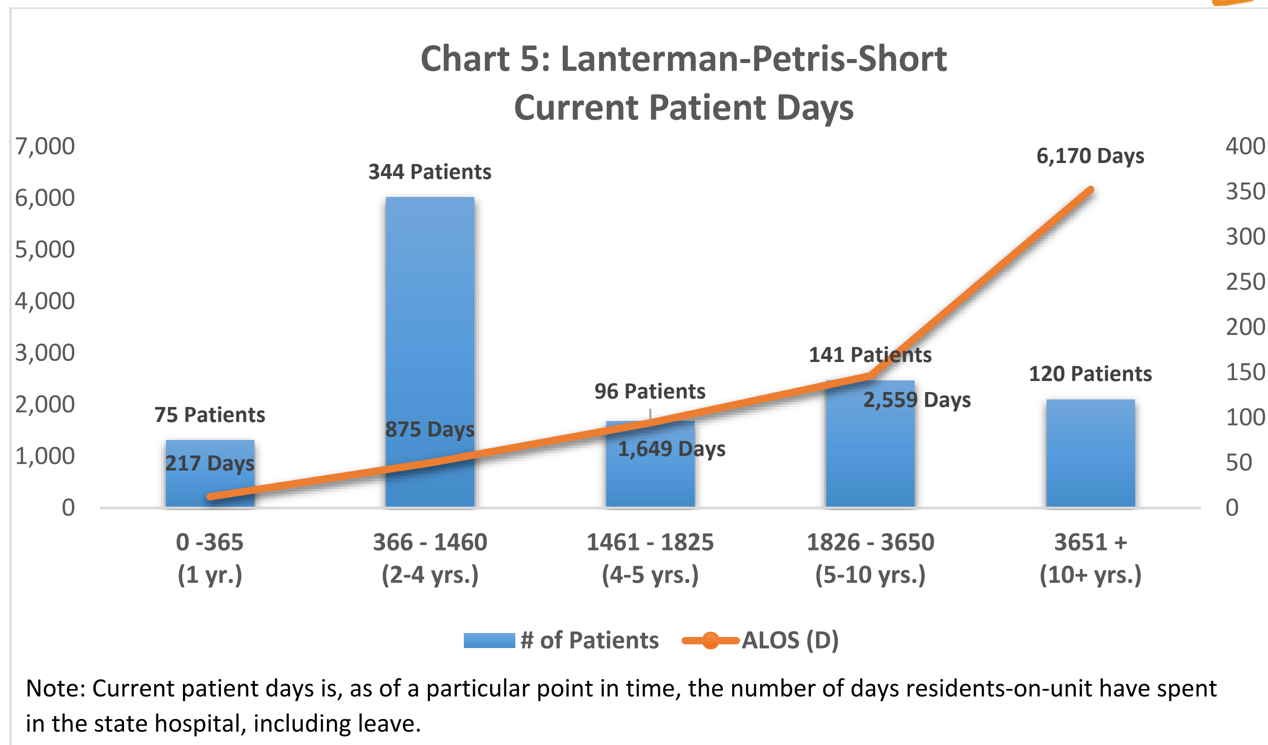


Chart 3 displays the average daily census (ADC) and total number of patients served for the LPS population during FY 2013-14 to FY 2019-20. On average, 773 LPS patients are treated daily in the state hospitals, representing 12 percent of the overall patient population. As of June 30, 2020, the system-wide LPS census was 776.



In FY 2019-20, 120 LPS patients were discharged with an average length of stay of 3.2 years. Chart 4 displays the distribution of lengths of stay for all discharged LPS patients, and Chart 5 displays the distribution of patient days for those LPS patients who remain residents on unit as of June 30, 2020.





Murphy Conservatorships

Murphy conservatorships (MURCON) are patients that have been previously found to be IST, and at the end of the IST commitment period the patient has been retained for further treatment because (1) the patient is subject to a pending indictment or information charging the individual with a felony involving death, great bodily harm, or threat to the physical well-being of another; (2) as a result of a mental disorder, the patient continues to be unable to understand or meaningfully participate in the pending criminal proceedings; (3) the patient has been found incompetent pursuant to PC section 1370; and (4) the patient is currently dangerous as the result of a mental disorder, defect or disorder. The conservatorship lasts for one year, just like any other LPS conservatorship, and can be extended indefinitely if a new conservatorship is obtained each year. MURCON patients also have the right to a yearly court review and/or jury trial to petition the court to remove the conservatorship.

Over the course of FY 2019-20, less than 11 Murphy Conservatorship patients were admitted into a state hospital. Chart 6 displays the admissions and total served distribution by state hospital for the LPS Murphy Conservatorship population in FY 2019-20.

DSH

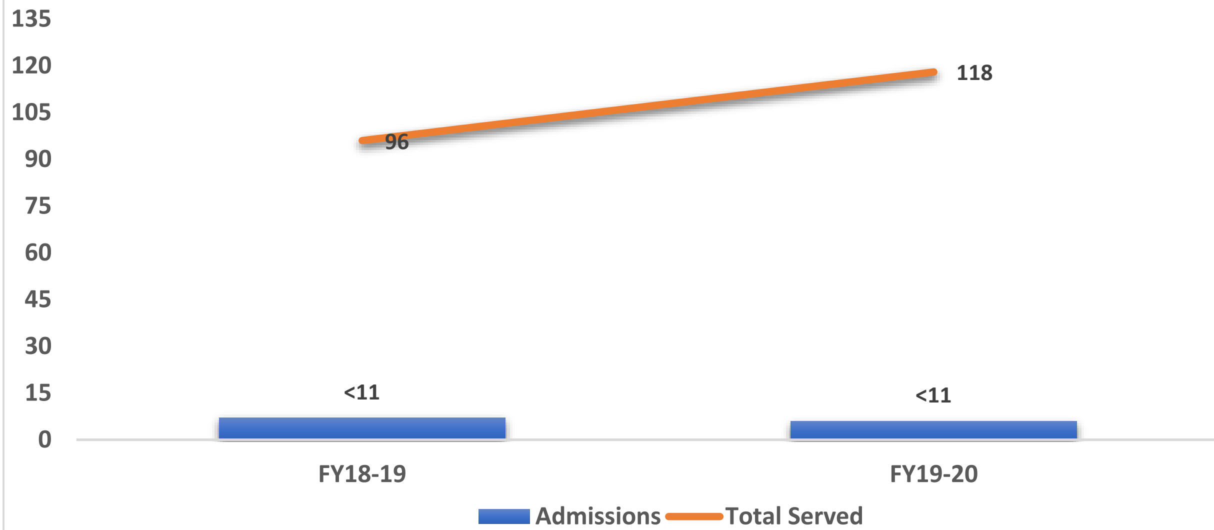
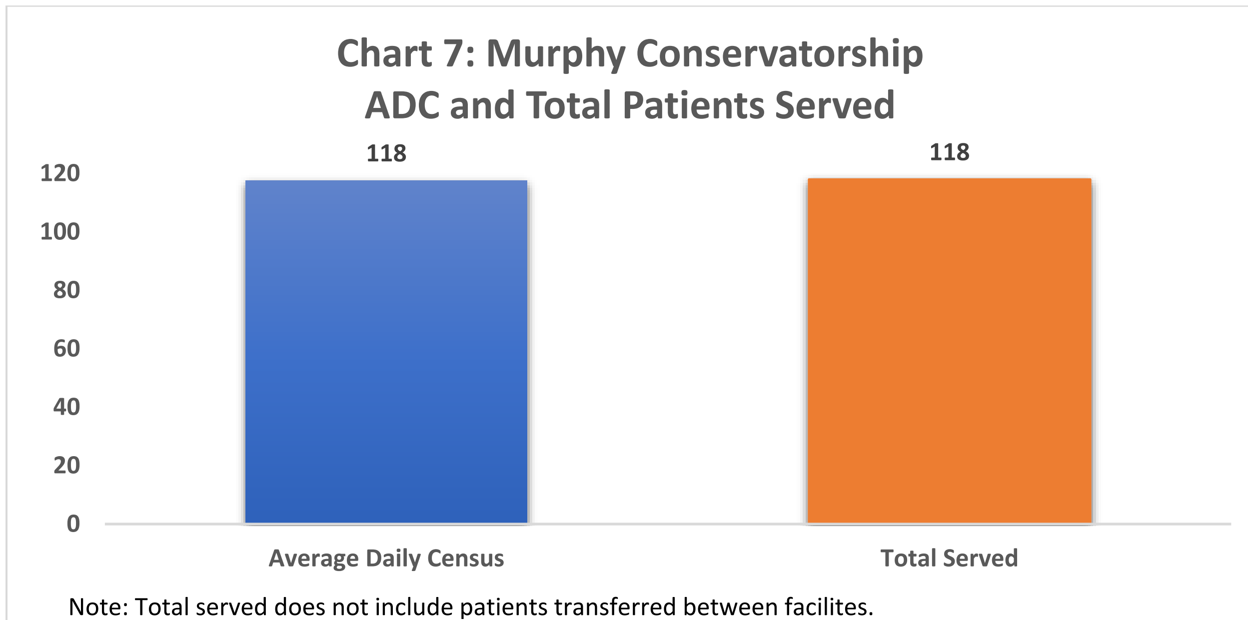
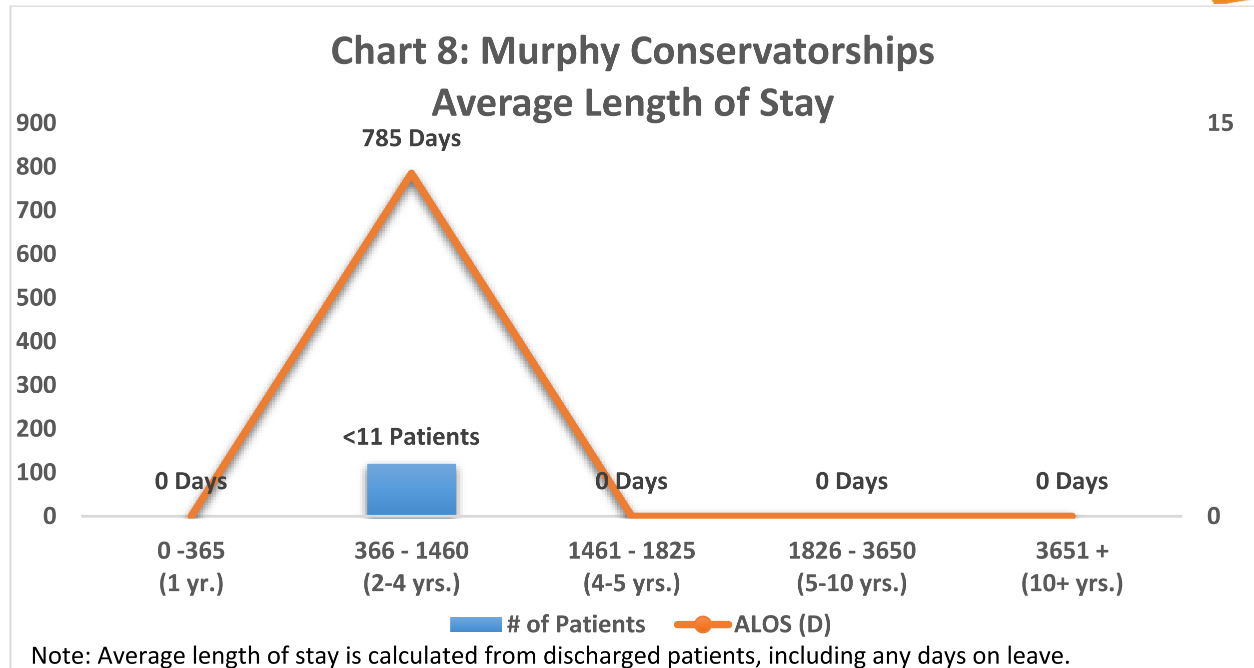


Chart 6: Murphy Conservatorship
Admissions and Total Served by Facility
135
120
105
90
75
60
45
30
15
0
118
96
<11
<11
FY18-19
FY19-20
Admissions
Total Served
Note: Admissions and total served does not include patients transferred between facilites.

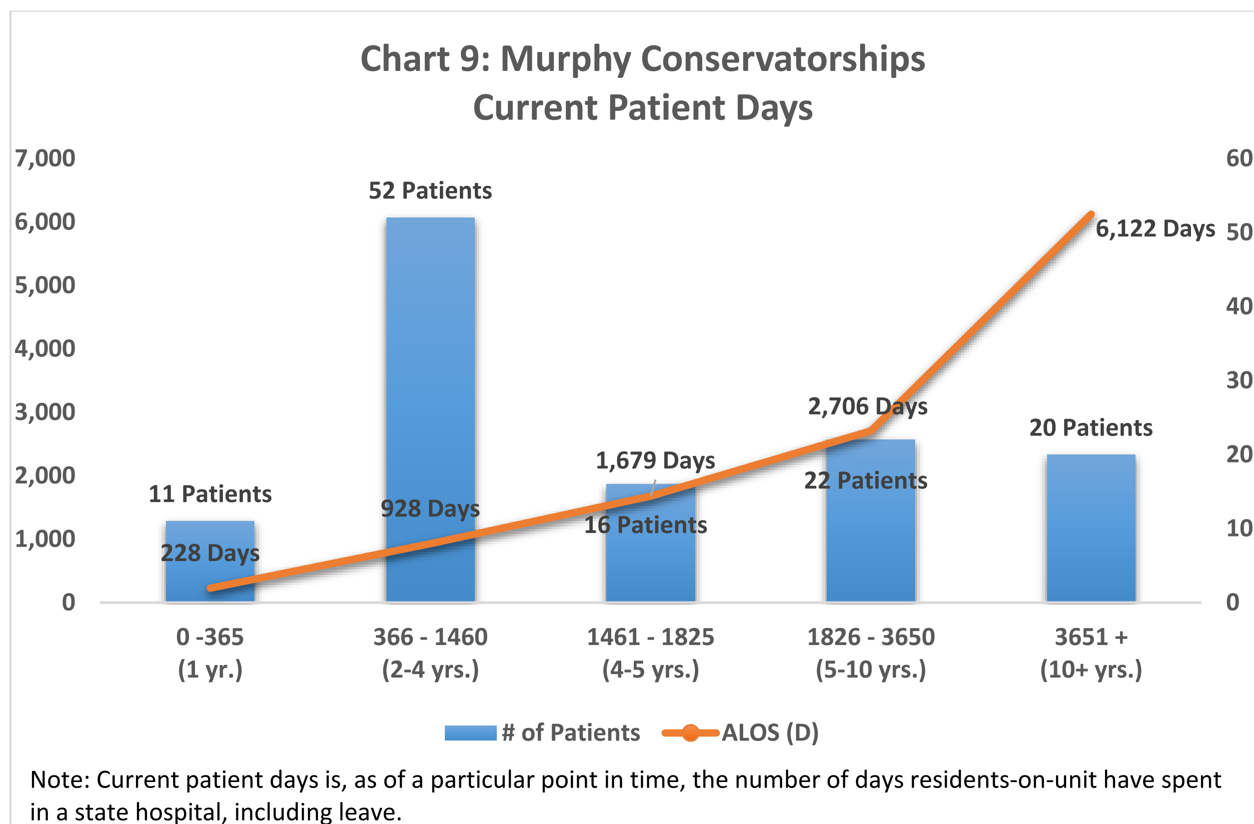
On average, 118 Murphy Conservatorship patients are treated daily in the state hospitals, representing 2 percent of the overall patient population in FY 2019-20. Chart 7 displays the average daily census (ADC) and total number of patients served for the MURCON population in FY 2019-20. As of June 30, 2020, the system-wide MURCON census was 121.



In FY 2019-20, less than 11 MURCON patients were discharged with an average length of stay of 2.2 years. Chart 8 displays the distribution of lengths of stay for all discharged MURCON patients, and Chart 9 displays the distribution of patient days for those MURCON patients who remain residents on unit as of June 30, 2020.



Note: Average length of stay is calculated from discharged patients, including any days on leave.



Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in a state hospital, including leave.

POPULATION PROFILE
Not Guilty by Reason of Insanity Patients

Description of Legal Class:

Not Guilty by Reason of Insanity (NGI) patients are admitted to the Department of State Hospitals (DSH) once a court determines that the individual (defendant) is found guilty but was insane at the time the crime was committed. The court commits these defendants to DSH for a maximum term of commitment equal to the longest sentence which could have been imposed for the crime. Based on the criminal conviction, the patient is found not guilty by reason of insanity. A patient may be placed immediately in outpatient treatment in the community under supervision rather than going directly to a state hospital. The court can recommit the patient to DSH beyond the maximum term of the original commitment if the patient is found, based on his or her mental illness, to represent a substantial danger of physical harm to others. A recommitment lasts for two years from the date of the recommitment order.

The following are the various NGI commitments, and their corresponding citation in code:

PC 1026	Not Guilty by Reason of Insanity
PC 1026.5 (extension)	Prior to the expiration of the current maximum term of commitment, PC 1026.5 allows the medical director to recommend to the prosecuting attorney an extension of the maximum term for a patient under Not Guilty by Reason of Insanity. This extension is valid for an additional two years; additional extensions subsequent to the initial extension may be requested in the same manner pursuant to PC 1026.5.
PC 1610	Temporary admission while waiting for court revocation of a PC 1026 (RONGI)
WIC 702.3	Minor Not Guilty by Reason of Insanity (MNGI)

Legal Requirements/Legal Statute for Discharge:

Restoration of sanity is a two-step process in which evidence is presented and reviewed that would determine a patient is a danger to the health and safety of others, due to his or her mental illness, if released under supervision and treatment in the community. The two-step process requires (1) an outpatient placement hearing and (2) a restoration hearing following a year in outpatient care. During the first step of the process the court must find that the patient is no longer a danger to the health and safety of others, due to his or her illness, if released under supervision and treatment in the community. During the second step of the process, the court must determine whether the patient has been fully restored to sanity. The court's finding of restoration will result in the patient's unconditional release from supervision. A patient may bypass the mandatory one-year of outpatient commitment and have an early restoration hearing in the event the conditional release program director recommends an early release.

Treatment:

Because NGI patients tend to be severely mentally ill and their crimes involve severe violence, treatment requires substantial time resources. The treatment team must demonstrate to the court that the NGI patient has achieved long-term stabilization and no longer poses a danger due to their mental illness. Thus, the patient needs to demonstrate long-term symptom stability, long-term adherence to psychiatric

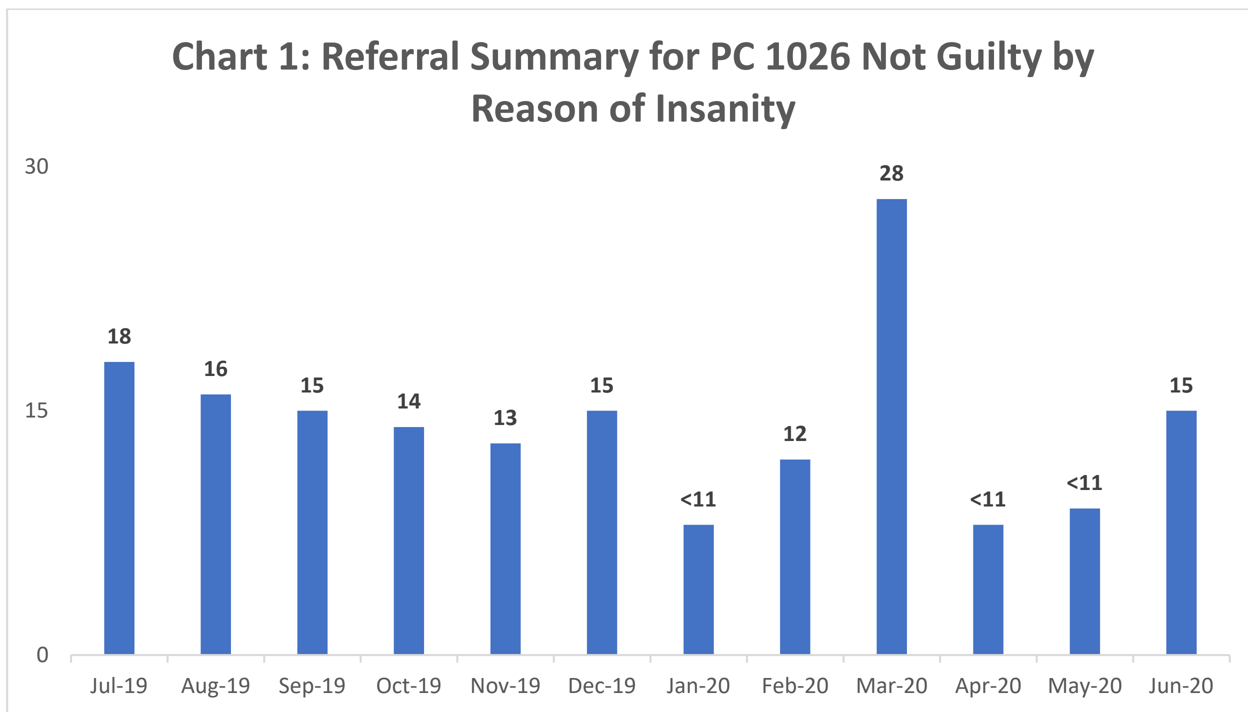
treatments, and an understanding of the factors that exacerbate their mental illness. Each NGI patient's progress in treatment is evaluated and submitted to the court via an annual report completed by the DSH treatment team and medical director of the state hospital. In the event that the maximum term approaches and the treatment team does not feel discharge would be appropriate, the hospital can pursue an extension of the NGI sentence to extend the stay of the individual, pursuant to Penal Code (PC) 1026.5. In Fiscal Year (FY) 2019-20, 444 patients were served at the state hospitals under this extension option.

To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted. Based on the individual NGI patient's mental illness factors and violence risk, individualized treatments must be developed. Additionally, scenarios that could realistically provoke similar violent responses must be evaluated and worked through with the patient. Furthermore, the patient must understand their violence risk factors and be able to demonstrate that they would take preventive actions to mitigate any factors that would heighten their violence risk.

Although NGI patients are admitted to DSH because of severe mental illness and dangerousness, NGI patients have the right to refuse treatment unless that right is removed by case law or regulation, as guided by the *Greenshields* involuntary medication order process. This can effectively lengthen the patient stay at the state hospital if they choose not to fully participate in the treatments recommended by their treatment team.

Population Data:

In FY 2019-20, 171 NGI patients were committed to the state hospitals, a 4 percent increase from FY 2018-19. Chart 1 depicts the monthly referrals of NGI patients to DSH.



Over the course of FY 2019-20, 118 NGI patients were admitted into a state hospital. Chart 2 displays the referrals, admissions and total patients served for the NGI population which is a decrease of 24 percent from the prior year. This decrease is attributed to the temporary suspension of NGI admissions into DSH hospitals to mitigate the impacts of COVID-19 throughout its hospitals.

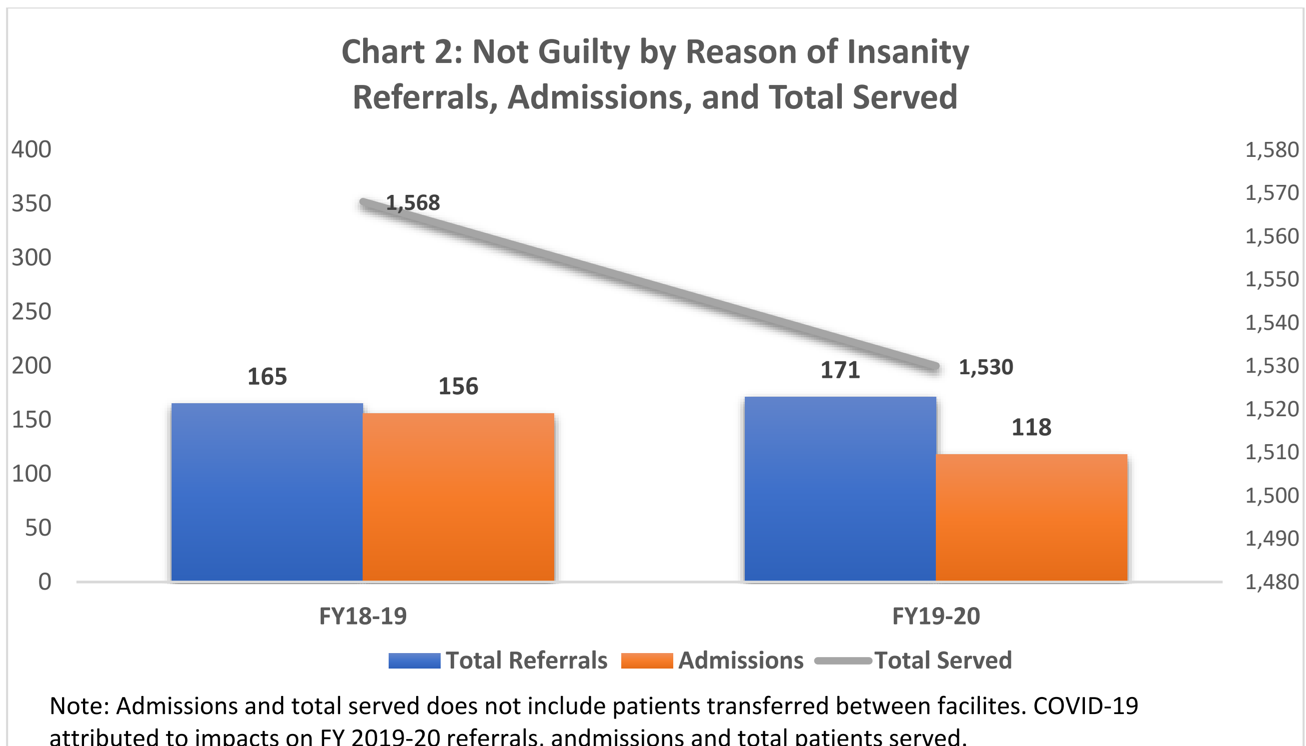
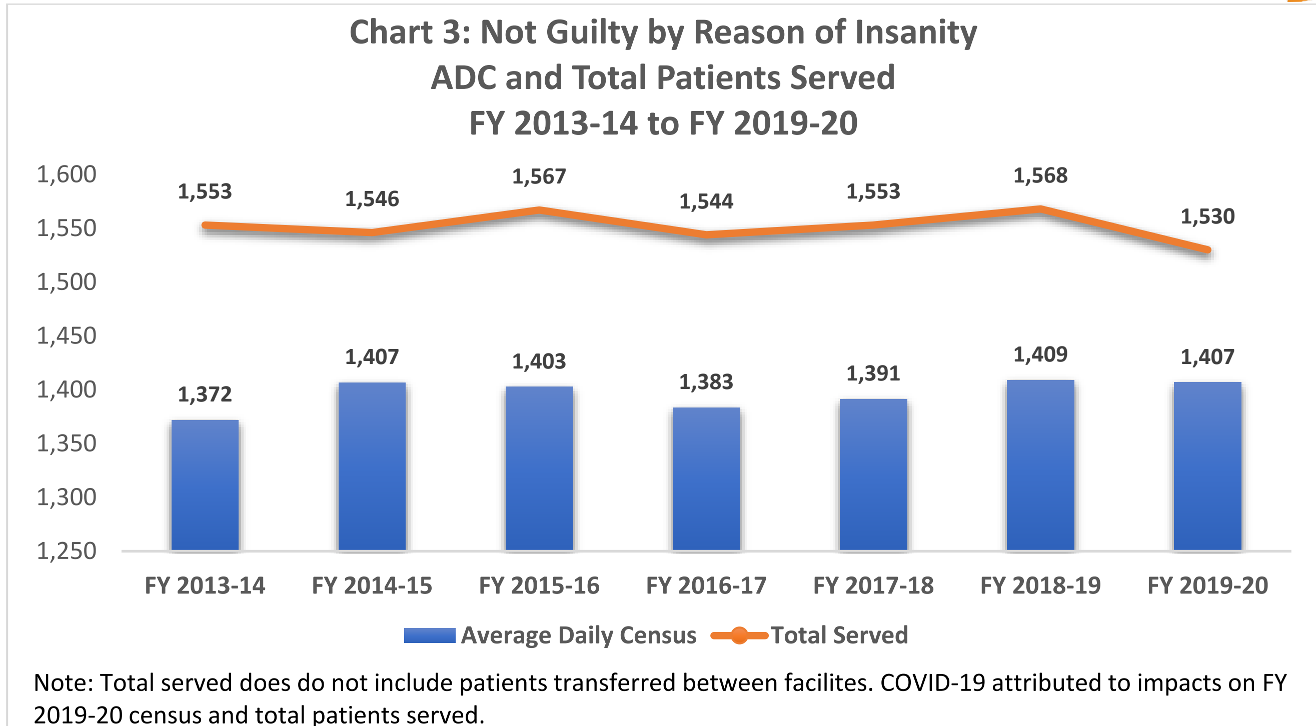
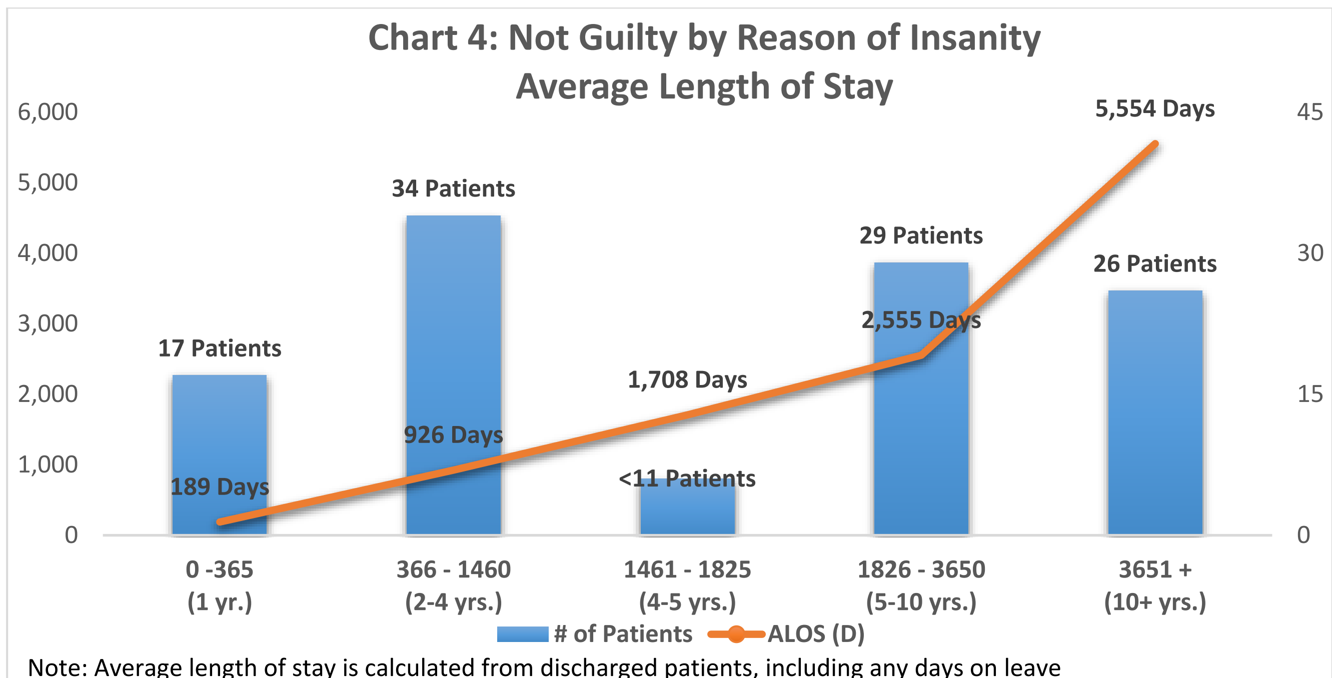


Chart 3 displays the average daily census (ADC) and total number of patients served for the NGI population during FY 2013-14 to FY 2019-20. On average, 1,407 NGI patients are treated daily in the state hospitals, representing 22 percent of the overall patient population. As admissions directly correlate to patients served, DSH served 2 percent less patients in FY 2019-20 than in the prior year. As of June 30, 2020, the system-wide NGI census was 1,407 patients.

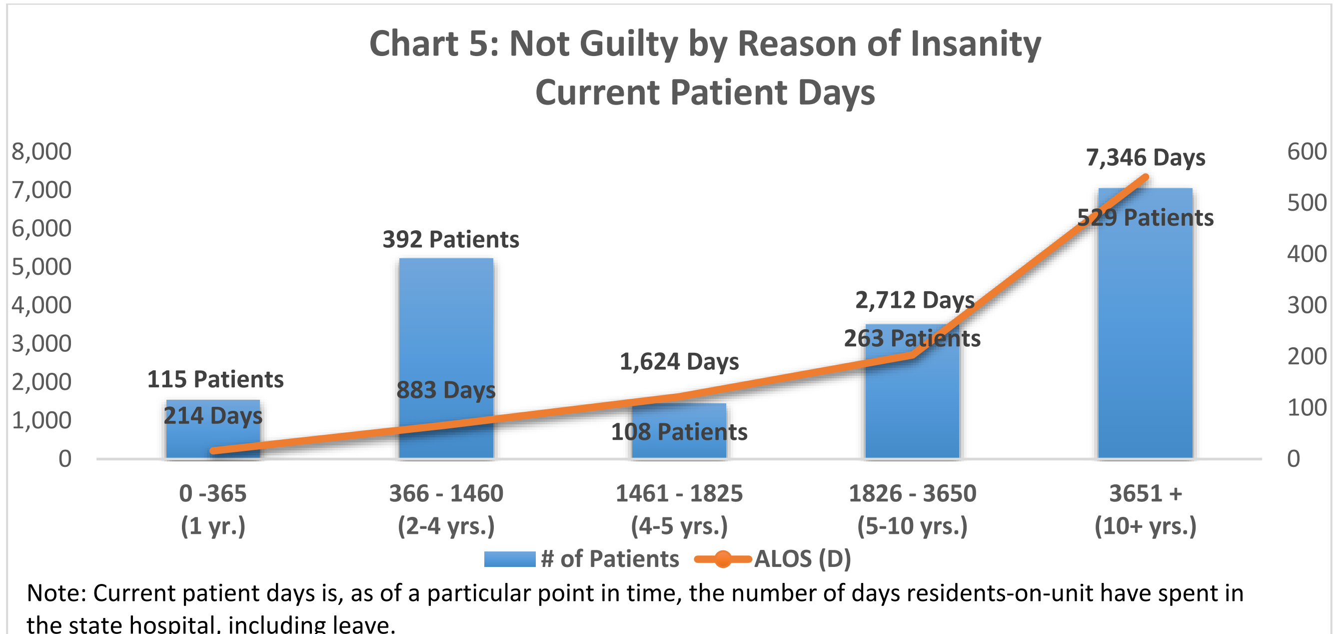


In FY 2019-20, 112 NGI patients were discharged with an average length of stay of 6.4 years. Chart 4 displays the distribution of lengths of stay for all discharged NGI patients.



A number of NGI patients remain with DSH for lengthy periods as a result of the various maximum sentences that could have been imposed, and the seriousness of their mental illness and

dangerousness. On average, the 1,407 NGI patients who continue to reside at DSH as of June 30, 2020 have been there for 3,657 days, or 10 years. These days will continue to accrue until the individual NGI patients have been discharged. Chart 5 displays the distribution of patient days for all NGI residents on unit as of June 30, 2020.



Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

POPULATION PROFILE
Offenders with a Mental Health Disorder

DESCRIPTION OF LEGAL CLASS:

The Department of State Hospitals (DSH) admits Offenders with a Mental Health Disorder (OMD) patients under Penal Code (PC) 2962: Disposition of Mentally Disordered Prisoners upon Discharge. OMD commitments are patients who are parolees (or former parolees), referred by the California Department of Corrections and Rehabilitation (CDCR), who meet the six criteria for OMD classification. The criteria include (1) the 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 for at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury and (6) the prisoner continues to be dangerous due to the severe mental disorder. The individual is evaluated by both the treating CDCR psychologist/psychiatrist and a DSH psychologist/psychiatrist. If the evaluators agree the individual meets all the conditions above, the Board of Prison Terms can commit that individual to a state hospital as a condition of parole. The individual then receives treatment at DSH unless they can be certified for outpatient treatment or the individual challenges the commitment.

Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term; these patients are committed under PC 2962. If the person still requires treatment at the end of their parole term, they can be committed under PC 2972 if it is determined that the patient has a severe mental disorder, that the patient's severe mental disorder is not in remission or cannot be kept in remission without treatment, and that by reason of their severe mental disorder, the patient represents a substantial danger of physical harm to others. A person committed under PC 2972 is committed for one year.

The following are the various OMD commitments, and their corresponding citation in code:

PC 2962	Parolee referred from the California Department of Corrections and Rehabilitation.
PC 2964(a): OMD admission from outpatient	Outpatient OMD placed in secure mental health facility (usually a state hospital) following determination by community program director that the individual can no longer be safely or effectively treated as an outpatient. DSH is then required to conduct a hearing within 15 days. This usually results in return to inpatient OMD status.
PC 2972	If an OMD still requires treatment at the end of the parole term, the patient can be civilly committed under PC 2972. This commitment must be filed by the district attorney (DA) and must show that the individual has a severe mental disorder that is not in remission and that, due to this mental disorder, the individual is a substantial danger to others. Civil OMD commitments last for one year, upon which they must be renewed by the DA. After an individual is committed, they are treated by DSH until they are either able to be placed in outpatient treatment, conserved, or successful in petitioning for their release.
PC 1610	RO 2972: Temporary admission while waiting for court revocation of PC 2972. ROMDSO: Temporary admission while waiting for court revocation of MDSO.

WIC 6316: MDSO	Former statute, now repealed, under which a person convicted of a sex offense could be ordered by the court to receive mental health treatment. The treatment and extension processes are similar for PC 1026. A few MDSO patients remain in the state hospitals.

LEGAL REQUIREMENTS/LEGAL STATUTE FOR DISCHARGE:

After one year, a parolee is entitled to an annual review hearing conducted by the Board of Parole Hearings (BPH) to determine if (1) the parolee still meets the six criteria for OMD classification and (2) whether the parolee can be treated on an outpatient basis. The length of a parole period is determined by statute and depends on the type of sentence imposed. Parole terms can extend beyond the maximum parole period due to revocation or escape attempts. A parole period can be waived at the discretion of BPT. Most parolees have a maximum parole period of three years, with a four-year maximum if parole was suspended due to revocation. The parole period may exceed four years for more serious offenses.

An OMD patient (or parolee) may be placed into outpatient treatment in the Conditional Release Program (CONREP) if the Court believes that the OMD patient can be safely and effectively treated on an outpatient basis. Outpatient status may not exceed one year, after which time the Court must either discharge the patient, order the patient confined to a facility, or renew the outpatient status.

TREATMENT:

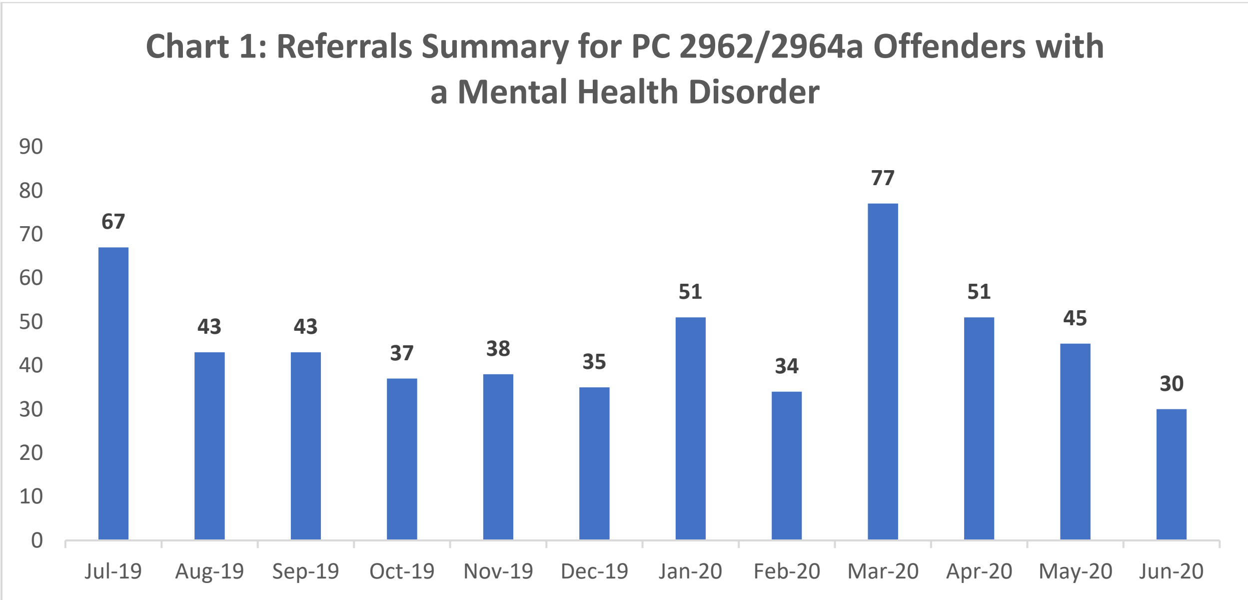
OMD patients have unique needs and challenges. Because their crimes involve violence, many have spent years in prison and need specialized psychosocial treatments to aid in their reintegration back into society. Due to the seriousness and long-term nature of their mental illness, as well as a history of violent crime, these patients require extra assessments and treatment to guide their mental illness treatments and treatment of violence risk.

The focus of treatment for the OMD population involves helping patients increase their ability to safely and effectively manage symptoms associated with their mental illness and prepare them for eventual transfer to the Conditional Release Program (CONREP). Another area of focus is substance abuse treatment since a history of substance abuse is prevalent in most OMD patients. Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of self-discipline and Activities of Daily Living (ADL) skills. Examples of ADL skills include practicing good hygiene, grooming, and feeding.

POPULATION DATA:

PC 2962/2964a Offenders with a Mental Health Disorder (OMD)

In Fiscal Year (FY) 2019-20, 551 PC 2962/2964a OMD patients were committed to the state hospitals, a 6 percent decrease from FY 2018-19.



Over the course of FY 2019-20, 456 PC 2962/2964a OMD patients were admitted into a state hospital. Chart 2 displays the referrals, admissions and total patients served for the PC 2962/2964a OMD population in FY 2019-20.

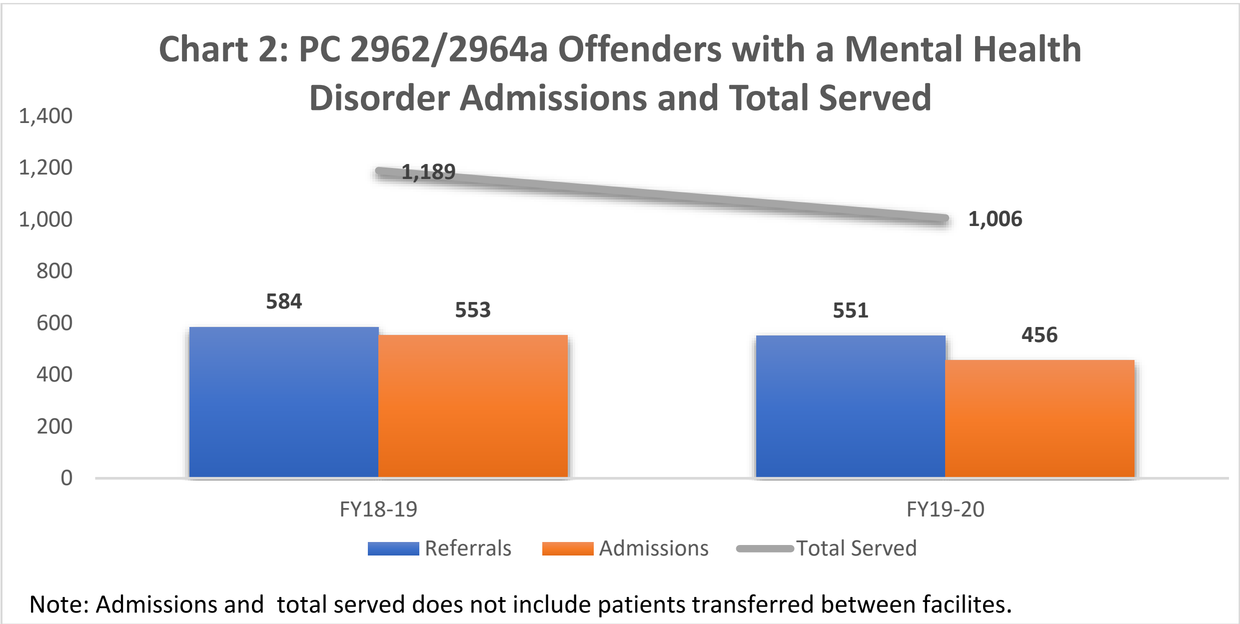


Chart 3 displays the average daily census (ADC) and total number of patients served for the PC 2962/2964a OMD population during FY 2013-14 to FY 2019-20. On average, 521 PC 2962/2964a OMD patients are treated daily in the state hospitals, representing 8 percent of the overall patient population. As of June 30, 2020, the system-wide PC 2962/2964a OMD census was 533 patients.

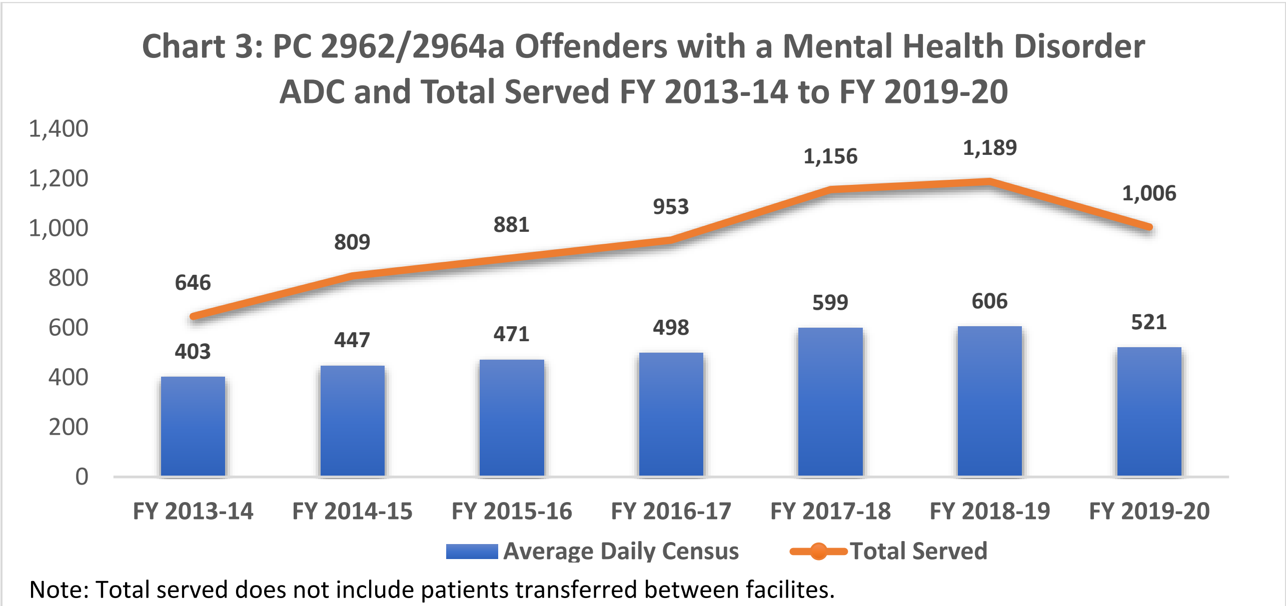
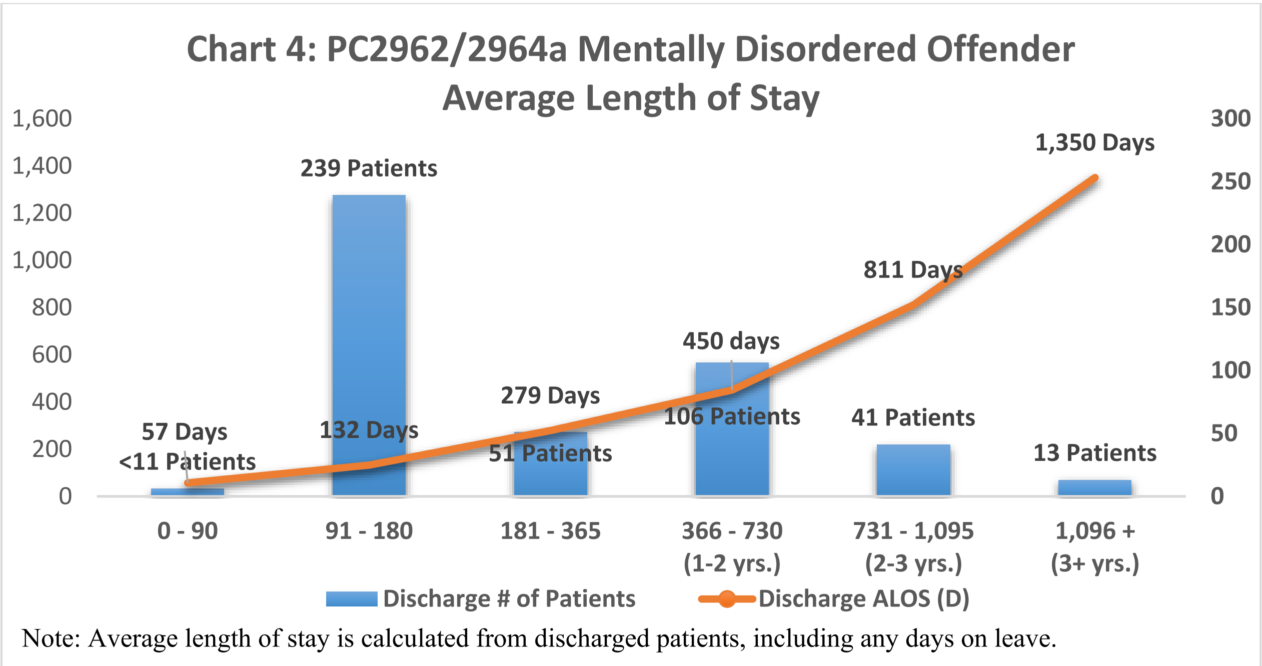
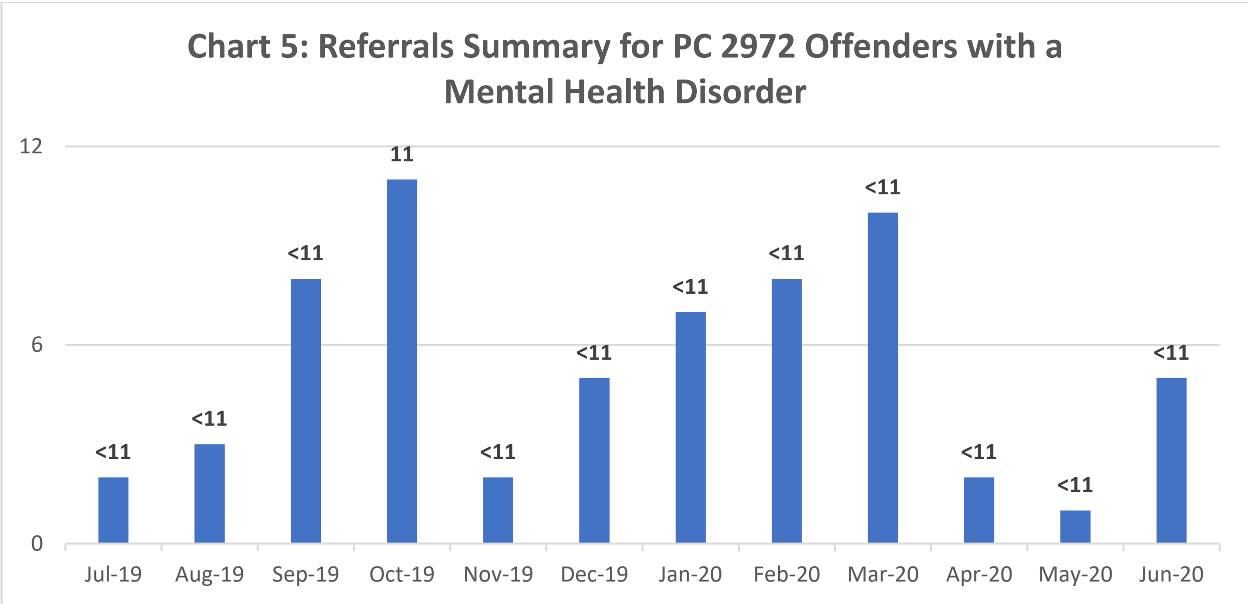


Chart 4 displays the distribution of lengths of stay for all discharged PC 2962/2964a OMD patients. In FY 2019-20, 456 PC 2962/2964a OMD patients were discharged with an average length of stay of 317 days, a little less than 1 year.



PC 2972 Offenders with a Mental Health Disorder (OMD)

In Fiscal Year (FY) 2019-20, 64 PC 2972 OMD patients were committed to the state hospital, a 57 percent decrease from FY 2018-19.



Over the course of FY 2019-20, 37 PC 2972 OMD patients were admitted (including transfer admissions) to a state hospital. Chart 6 displays the referrals, admissions and total patient served for the PC 2972 OMD population in FY 2019-20.

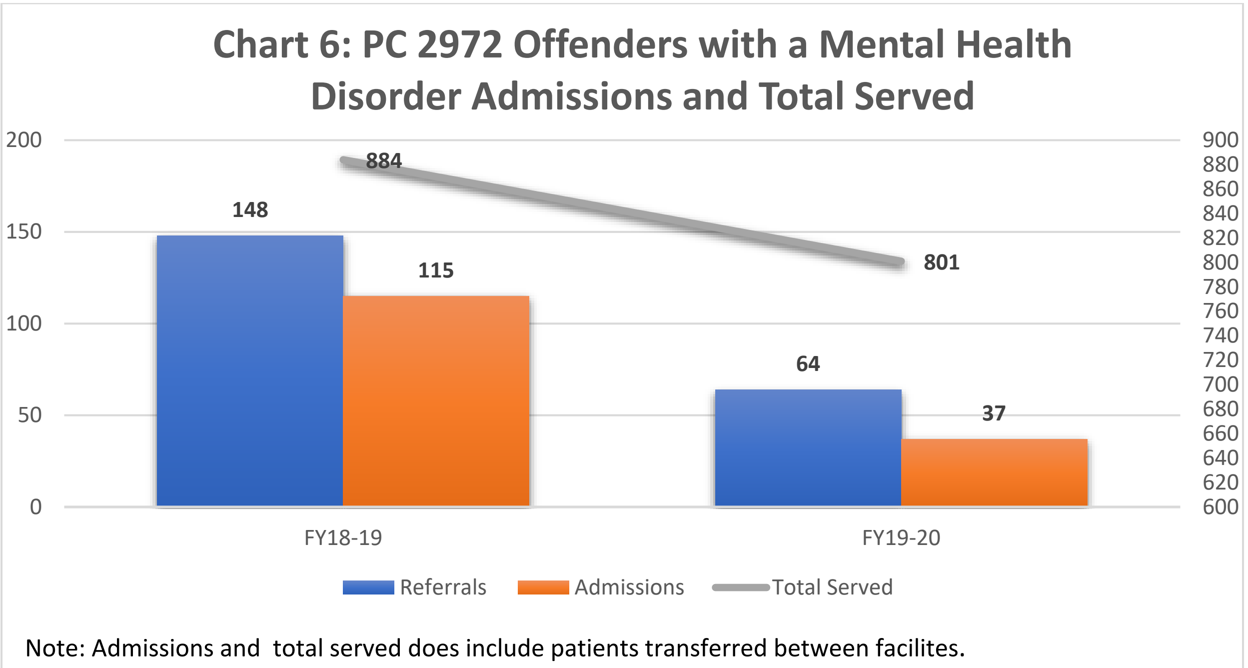
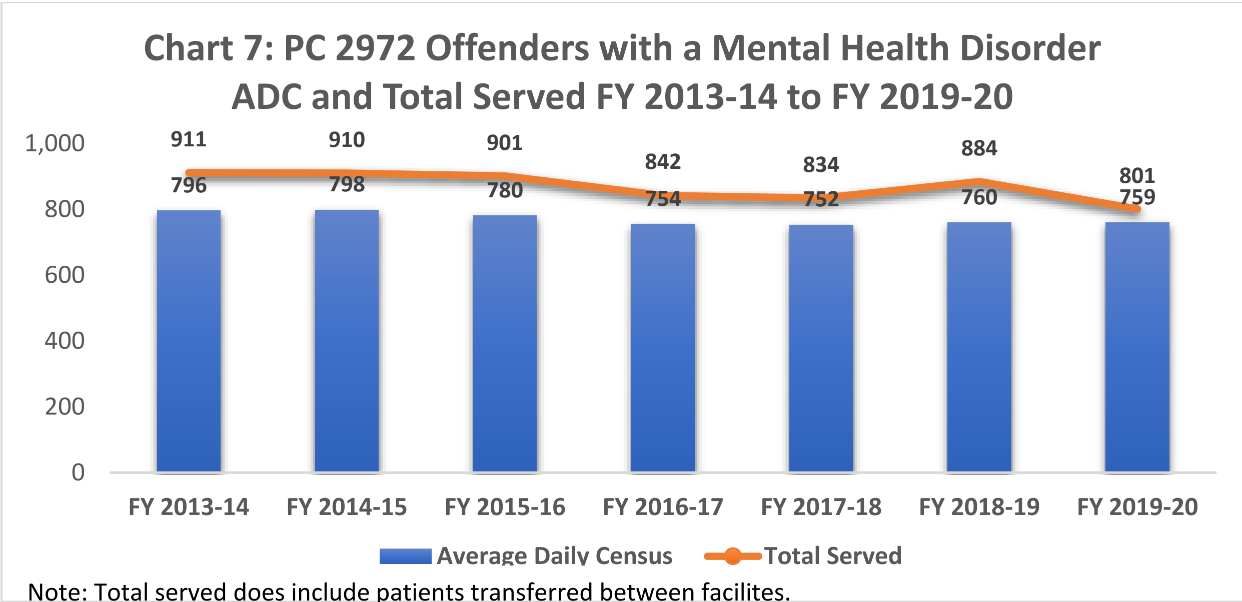


Chart 7 displays the average daily census (ADC) and total number of patients served for the PC 2972 OMD population during FY 2013-14 to FY 2019-20. On average, 759 PC 2972 OMD patients are treated daily in the state hospitals, representing 12 percent of the overall patient population. As of June 30, 2020, the system-wide PC 2972 OMD census was 748 patients.



In FY 2019-20, 67 PC 2972 OMD patients were discharged with an average length of stay of 6 years. Chart 8 displays the distribution of lengths of stay for all discharged PC 2972 OMD patients.

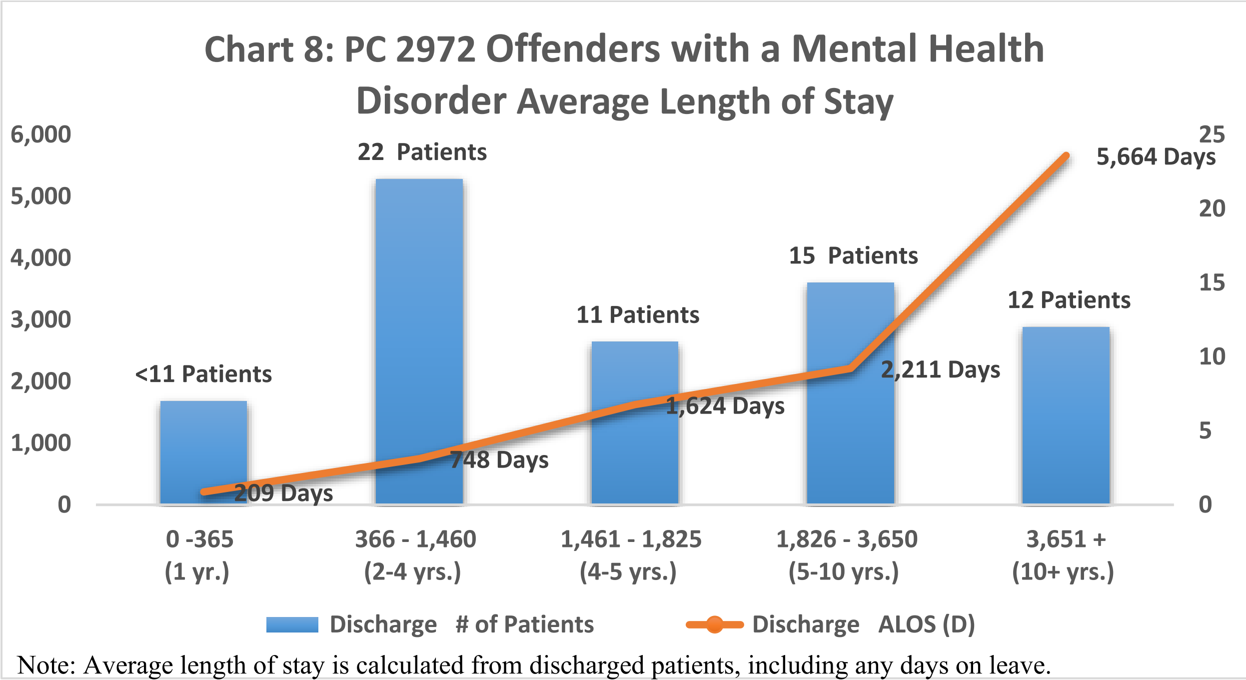
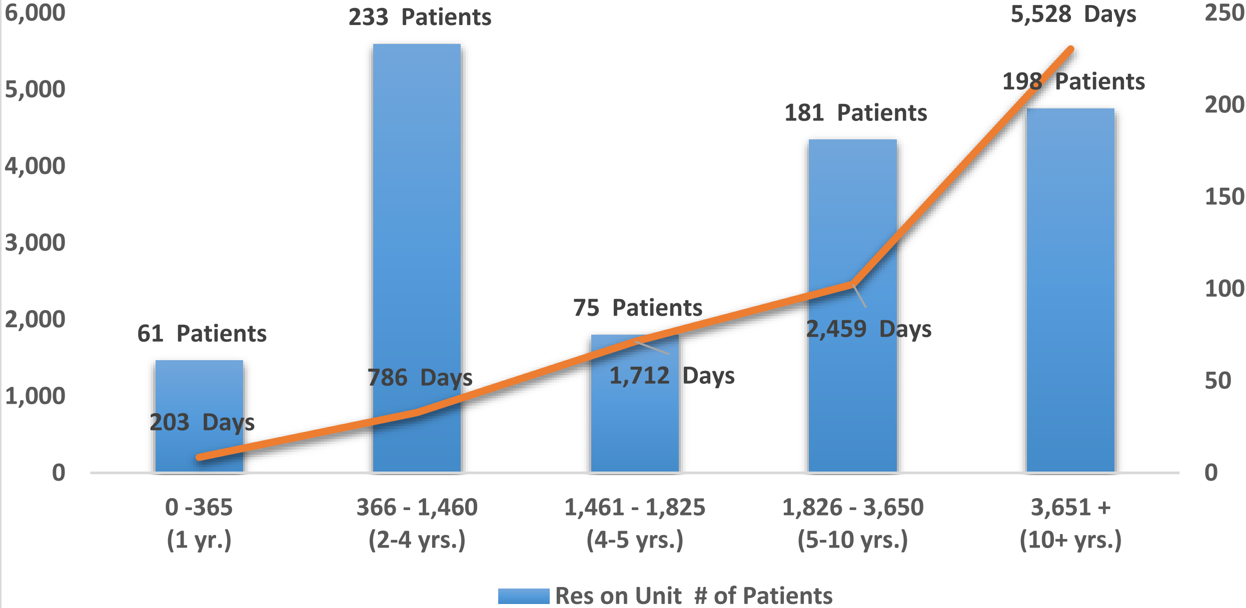


Chart 9 displays the distribution of patient days for all PC 2972 OMD residents on unit as of June 30, 2020. On average, the 748 PC 2972 OMD patients who continue to reside at DSH as of June 30, 2020 have been there for 2,491 days or 7 years; these days will continue to accrue until the individual PC 2972 OMD patients have been discharged.

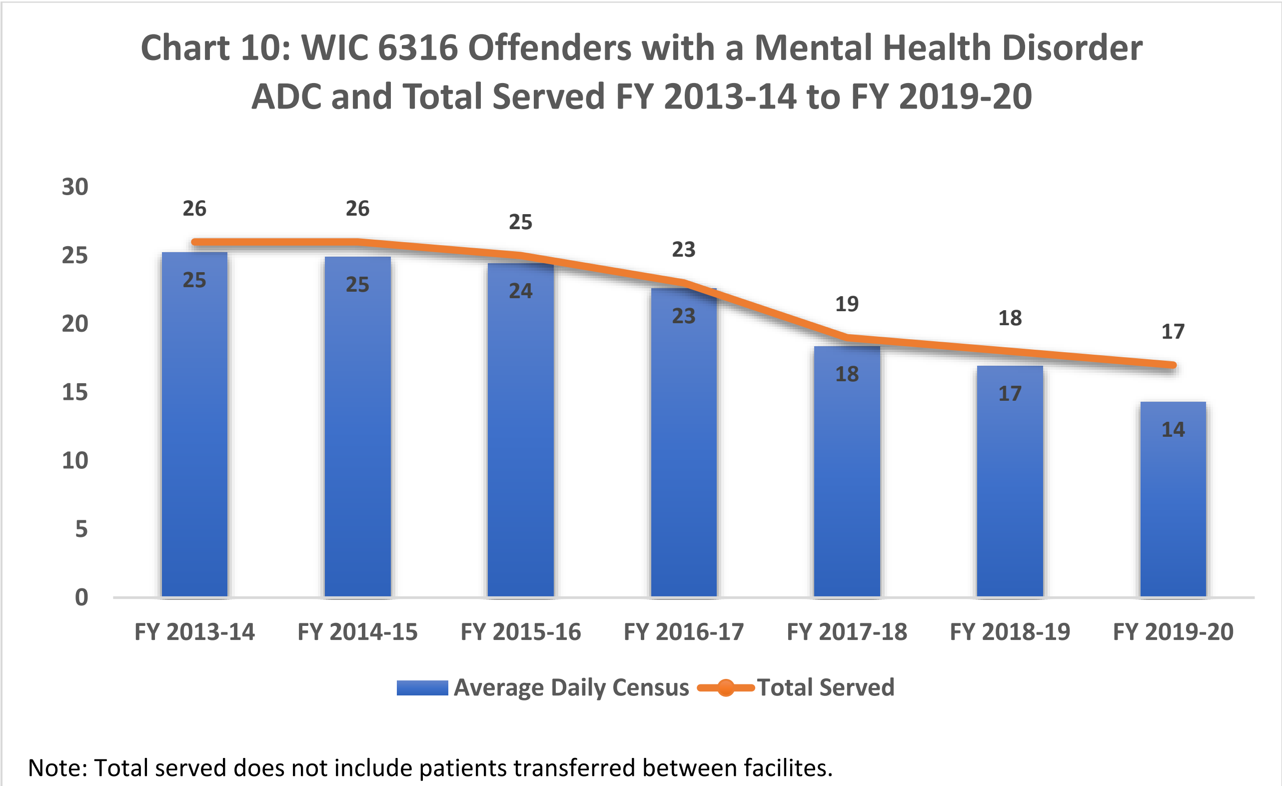


Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in the state hospital, including leave.

WIC 6316 Mentally Disordered Sex Offender (MDSO) Patients

The entirety of WIC 6300, and therefore the accompanying legal class WIC 6316, was repealed by the Statutes and Amendments to the Codes 1981 (c. 928, p. 3485, § 2). Subsequently, there have since been no new commitments under this legal classification at DSH.

Chart 10 displays the average daily census (ADC) and total number of patients served for the WIC 6316 MDSO population during FY 2013-14 to FY 2019-20. On average, 14 WIC 6316 MDSO patients are treated daily in the state hospitals, representing 0.2 percent of the overall patient population. As of June 30, 2020, the system-wide WIC 6316 MDSO census was 14 patients.



In FY 2019-20, WIC 6316 MDSO patients that discharged had an average length of stay of sixteen years. For the 14 WIC 6316 MDSO patients who continue to reside at DSH, they have been there for 2,331 days, or 6 years. These days will continue to accrue until the individual WIC 6316 MDSO patients have been discharged.

POPULATION PROFILE
Sexually Violent Predator Patients

Description of Legal Class:

The Department of State Hospitals (DSH) admits Sexually Violent Predator (SVP) patients under Welfare and Institutions Codes (WIC) 6602 and 6604: Sexually Violent Predator. SVP commitments are civil commitments of prisoners released from prison who meet criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses against one or more victims, and who have a diagnosed mental disorder that makes the person a danger to the health and safety of others in that it is likely that they will engage in sexually violent criminal behavior.

SVP patients are evaluated by DSH and the California Department of Corrections and Rehabilitation (CDCR) as to whether an individual meets the criteria of an SVP after completion of their prison term. Before leaving CDCR, SVPs are committed to DSH pending further hearings for probable cause (WIC 6602). A commitment trial is held and, if adjudged to be an SVP, the individual is committed to a state hospital for an indeterminate period of time (WIC 6604).

The following are the various SVP commitments, and their corresponding citation in code:

WIC 6602	An individual who has been identified as likely to engage in sexually violent predatory criminal behavior upon release and will remain in custody until the completion of the probable cause hearing at which point a determination of WIC 6604 will be made.
WIC 6604	An individual who has been deemed a Sexually Violent Predator by a court or jury pursuant to proceedings as defined by WIC 6602, and committed to the Department of State Hospitals for treatment and confinement of an indeterminate term.
WIC 6601.3[1]	Authorizes the Board of Prison Terms to impose a temporary 45-day hold on CDCR inmates where there is probable cause that the inmate may be a SVP
PC 1610	Temporary admission while waiting for court revocation of Sexually Violent Predator commitment

[1]During Fiscal Year (FY) 2019-20, this population was not served in the state hospitals.

Legal Requirements/Legal Statute for Discharge:

Once a court determines a patient meets the criteria for an SVP commitment, these patients undergo an annual review process where the patient's SVP status is evaluated. At that point, DSH may decide that the patient is ready to be released into the community on a conditional release basis. A patient may have a hearing to determine whether they should be released from the hospital under conditional release to the community or unconditional release to the community without supervision.

If the court agrees that the patient no longer meets the SVP criteria and will not pose a public safety threat if conditionally released into a supervised program, it will order the patient be

conditionally released. If the patient is conditionally released, DSH's Forensic Conditional Release Program (CONREP) takes over the monitoring and supervision of the patient. Alternatively, the court may decide that the patient is ready for unconditional release; if a patient is placed on unconditional release a CDCR parole agent takes over the monitoring and supervision of that individual.

Treatment:

Because their crimes typically involve severe sexual violence and many have mental disorders that are not amenable to standard medication treatments, treatment for SVP patients typically requires substantial time resources. Because of the risk to the community, if an SVP patient was not treated effectively, psychosocial treatments, relapse prevention/wellness, and recovery action planning are emphasized and reinforced across all clinical disciplines and treatment modalities.

To assess dangerousness and develop effective treatments to reduce violence risk, specialized violence risk assessments must be conducted to both guide treatment and measure progress in treatment.

DSH must submit an annual report to the court of the SVP patient's mental condition, a review of whether they still meet the SVP criteria, whether conditional release to a less restrictive environment or unrestricted discharge would be in the best interest of the individual, and whether conditions could be imposed upon release that would adequately protect the community. If the state hospital provides the court with the opinion that the individual no longer meets SVP criteria, or that the individual can be treated in a less restrictive setting, a court hearing is held. SVP patients can also petition for a hearing.

Before being recommended for release, the SVP patient must demonstrate long-term stability and adherence to treatments, as well as demonstrate an understanding of their sexual violence risk factors and patterns of thinking that relates to their criminal activity patterns. Furthermore, the SVP patient must be able to demonstrate that they would take preventive actions to avoid or mitigate any factors that would increase their sexual violence risk.

Although SVP patients are admitted to DSH because of severe mental illness and dangerousness, all patients (including SVPs) have the right to refuse treatment, unless individually directed by a court to comply. This can effectively lengthen the patient stay at the state hospital if a patient chooses not to actively engage or fully participate in the treatments recommended by their treatment team.

Population Data:

In Fiscal Year (FY) 2019-20, 36 SVP patients were committed, of which 25 SVP patients were admitted into a state hospital. Chart 1 displays the referrals, admissions, and total patients served for the SVP population in FY 2019-20.

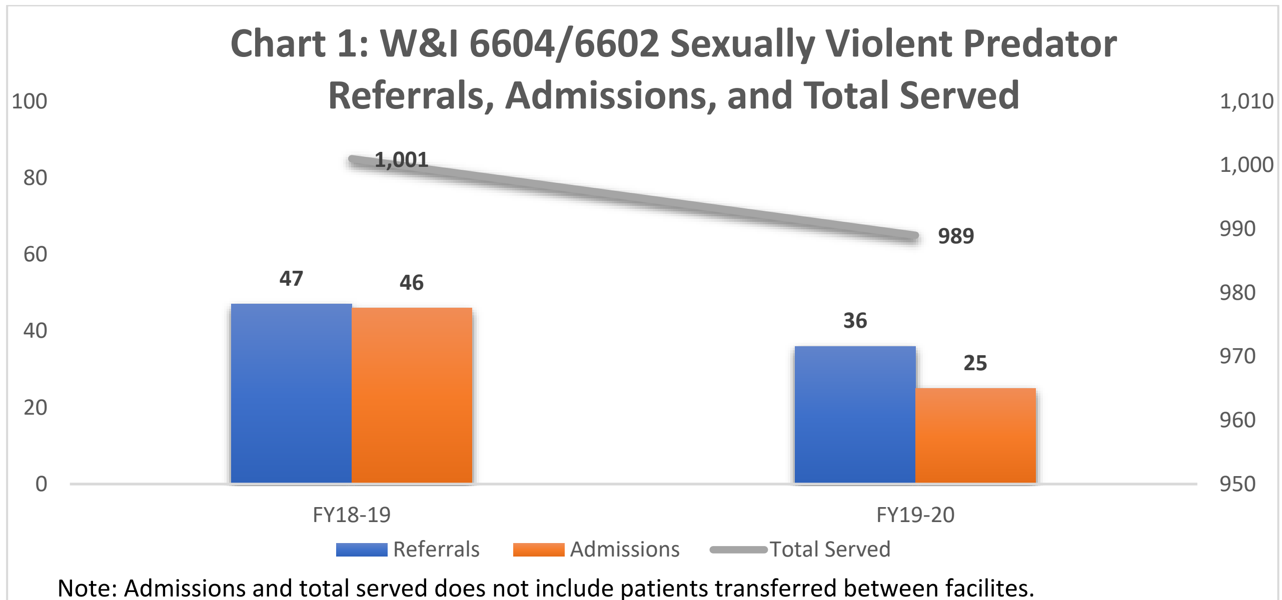
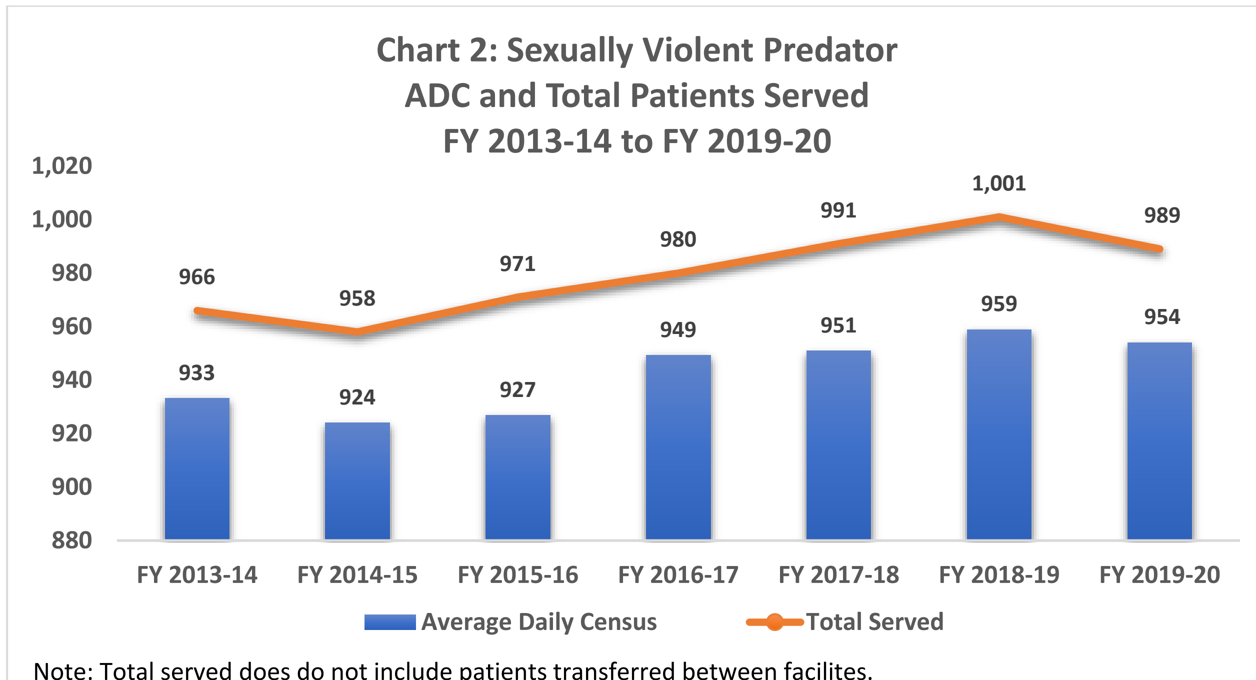


Chart 2 displays the average daily census (ADC) and total number of patients served for the SVP population during FY 2013-14 to FY 2019-20. On average, 954 SVP patients are treated daily in the state hospitals, representing 15 percent of the overall patient population. As of June 30, 2020, the system-wide SVP census was 942 patients.



In FY 2019-20, 44 SVP patients were discharged with an average length of stay of 10 years. Chart 3 displays the distribution of lengths of stay for all discharged SVP patients.

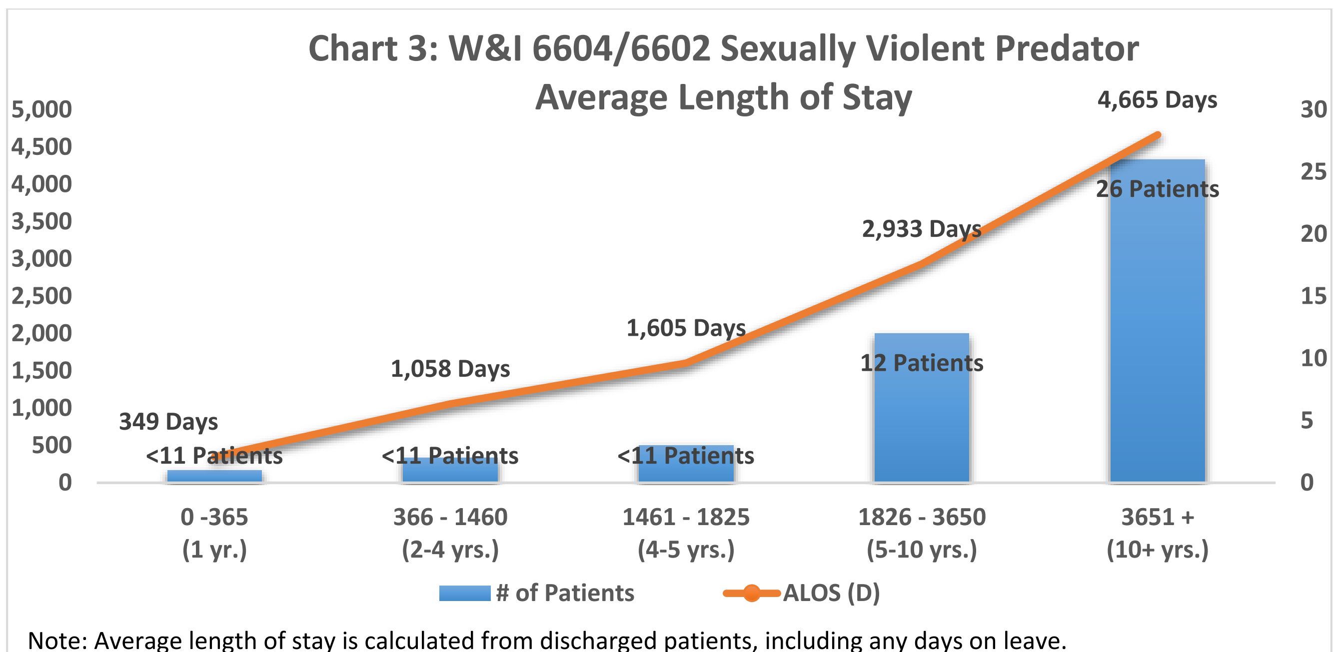
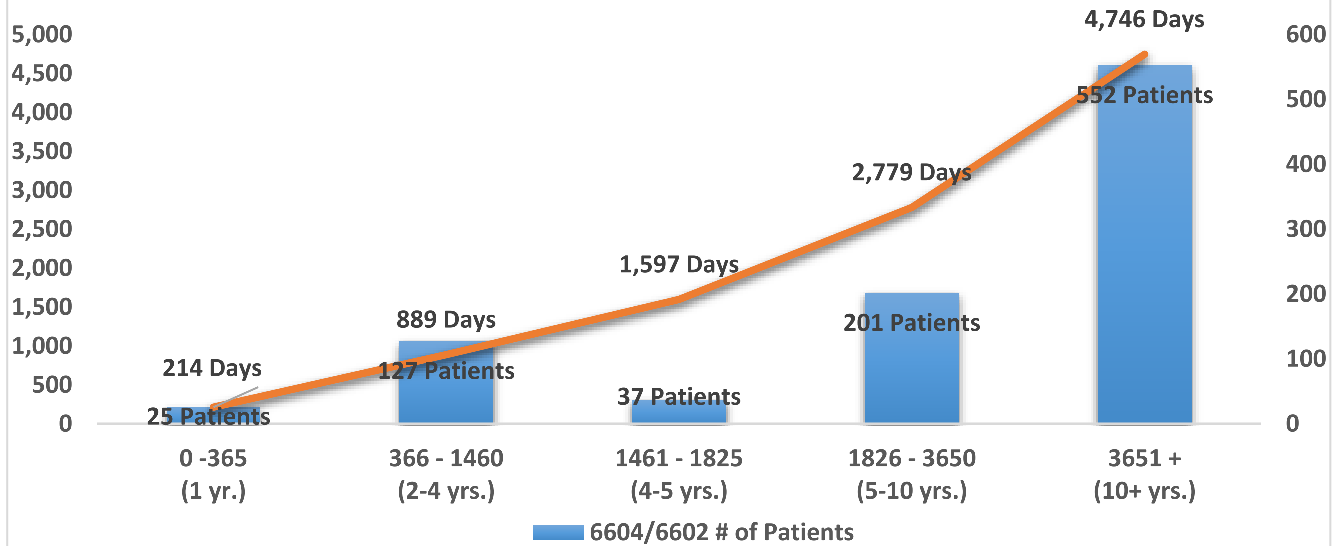


Chart 4 displays the patient days for all SVP patients that remained on census as of June 30, 2020. On average, the 942 SVP patients who continue to reside at DSH as of June 30, 2020 have been there for an average of 3,563 days, or 10 years.



Note: Current patient days is, as of a particular point in time, the number of days residents-on-unit have spent in a state hospital, including leave.

Department of State Hospitals – Atascadero

HISTORY

The Department of State Hospitals-Atascadero is a secure forensic hospital located on the Central Coast of California, in San Luis Obispo County. It opened in 1954 and is a psychiatric hospital constructed within a secure perimeter. DSH-Atascadero treats only male patients, the majority of which are remanded for treatment by county superior courts or by the California Department of Corrections and Rehabilitation (CDCR). The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,275 beds. In Fiscal Year (FY) 2019-20, DSH-Atascadero served 1,040 patients. The commitment categories of patients treated at DSH-Atascadero are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris Short	-
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,208 employees work at DSH-Atascadero providing round-the-clock care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The residential treatment programs, in conjunction with Recovery and Mall Services (defined below), provide a variety of patient, group, and unit-wide skills training, rehabilitative and enrichment activities. These activities are prescribed by the treatment team according to the patient's identified interests and assessed needs. Included in these activities is a vocational rehabilitation program which provides the patients with the opportunity to learn an increasing number of vocational and work skills under the direction of trained vocational counselors and a variety of school-based classes where patients can improve academic achievement, receive a GED, or pursue advanced independent studies.

Program management is responsible to ensure a safe and therapeutic environment through the appropriate management of resources and the delivery of group psychotherapy, psychoeducational and rehabilitation treatment specific to the patients' needs.

When indicated, individual patient psychotherapy, vocational training, and educational training are also provided.

Treatment Plan

Treatment planning is directed toward the goal of helping patients to recover from psychiatric disability, which includes the reduction of symptoms, acquisition of skills for coping with the effects of mental illness, successful fulfillment of constructive adult roles, and the development of supports, which in combination, will permit maximum independence and quality of life. The planning process offers the patient, family members, relatives, significant others, and authorized representatives the full opportunity to participate meaningfully in the recovery and discharge process.

Each patient will have a comprehensive, individualized treatment plan based on the integrated assessments of mental health professionals. Therapeutic and rehabilitation services are designed to address each patient's needs and to assist the patient in meeting his specific treatment goals, consistent with generally accepted professional standards of care. Such plans are developed and reviewed on a regular basis in collaboration with the patient.

Treatment Team

The treatment team consists of an interdisciplinary core of members, including at least the patient, treating psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, and psychiatric technician, and may include the patient's family, guardian, advocates, and attorneys as appropriate. Based on the patient's needs, other members may also include, but are not limited to: registered dietitian, pharmacist, teacher, physical therapist, speech-language pathologist, occupational therapist, vocational services staff, and psychiatric nurse practitioner.

Families and officials (i.e. Conservators) may be included as active participants with the team and may be of considerable assistance in assessment, planning, treatment, and post-hospital care of the patients. At the time of admission, families shall be notified so that they may meet with the team, provided the patient gives consent for notification.

Provision of Treatment, Rehabilitation, and Supplemental Activities

DSH’s goal is to provide individualized active recovery services that focus on maximizing the functioning of persons with psychiatric disabilities. DSH endeavors to identify, support, and build upon each recovering patient’s strengths to achieve maximum potential towards his or her hopes, dreams, and life goals.

Recovery and Mall Services (RMS)

Recovery Mall Services (RMS) is a clinical treatment program that utilizes Recovery oriented Psychosocial Rehabilitation philosophy to provide quality, evidence based, recovery focused, therapeutic and rehabilitation services, as well as supplemental leisure activities designed to facilitate the psychiatric rehabilitation of patients at DSH-A. All services provided through RMS promote increased wellness and independent functioning. RMS Provides centralized campus locations for treatment where facilitators from throughout the hospital may provide approved, scheduled treatment groups. These areas include the Phoenix Campus, Gymnasium, Community Center, Music Center, Main Courtyard and Art Center.

The RMS department offers Interfaith Services, Volunteer Services, Library Services— through the Logan Library – Patient and Professional Libraries, Aztec Adult School, Graphic Arts Services, Barbershop Services, and Substance Use Recovery Services. In addition, RMS also offers Vocational Training Programs that include Printing/Graphic Arts and Landscape Gardening. Furthermore, RMS offers scheduled hospital wide supplemental activities, events and meetings including but not limited to: Phoenix Club, Incentive Bingo and Community Center, Evening Open Gym, Monthly Birthday Party and the Hospital Advisory Council meetings.

Central Medical Services (CMS)

CMS provides definitive medical care and evaluation to all residents in the hospital. These services include radiology, public health, laboratory, physical therapy, dentistry, pharmacy, medical clinics, unit sick call, contractual services inside and outside the hospital, and review of community-based consultations. Services are available to residents on referral from general physicians and psychiatrists who have primary responsibility for the care of patients on residential treatment units.

ACCREDITATION AND LICENSURE

This facility is accredited by The Joint Commission (TJC). TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and whether or not certain conditions or reporting requirements should be implemented to maintain accreditation status. TJC standards deal with subject matter such as organization quality, patient safety, provision of care, treatment and services, as well as the environment in which care is provided.

DSH-Atascadero is licensed by the California Department of Public Health. DSH-Atascadero has eight units licensed as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following

basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Atascadero also has 26 units licensed as Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND INTERNSHIPS

DSH-Atascadero offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Atascadero's training programs.

DSH-Atascadero Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon [2]	• Accepts Contracted Students
Psychiatric Technicians [3]	• Psychiatric Technician Trainee • Pre-Licensed Psychiatric Technician • 20/20 Psychiatric Technician Training Program
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	• Accredited Dietetic Internship • Contracted Cal-Poly San Luis Obispo Dietetic Internship
Rehabilitation Therapy	• Recreation Therapy (Student Assistants) • Music Therapy (Student Assistants)
Social Work	• Unpaid Master of Social Work Internships

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are: University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Physician and Surgeon:** Accepts Family Nurse Practitioner students who need clinical hours. They can execute contracts with the school to formalize these rotations.

[3] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

Department of State Hospitals – Coalinga

HISTORY

The Department of State Hospitals-Coalinga is California's newest state mental health hospital located at the edge of the Coastal Mountain Range on the western side of Fresno County. Coalinga is halfway between Los Angeles and San Francisco and 60 miles southwest of Fresno.

DSH-Coalinga opened in 2005 and began treating forensically committed patients, most of which are sexually violent predators (SVPs). It is a self-contained psychiatric hospital constructed with a security perimeter. California Department of Corrections and Rehabilitation (CDCR) provides perimeter security as well as transportation of patients to outside medical services and court proceedings. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,500 beds. In Fiscal Year (FY) 2019-2020 DSH-Coalinga served 1,365 patients, a significant change from the previous year due to the COVID-19 pandemic. The commitment categories of patients treated at DSH-Coalinga are as follows:

Patient Commitments	Penal Code
Lanterman-Petris Short	5358 (WIC)
Offender with a Mental Health Disorder	2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026
Sexually Violent Predators	6602/6604

HOSPITAL STAFF

Approximately 2,382 employees work at DSH-Coalinga providing round-the-clock care, including psychologists, psychiatrists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse

workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The fundamental goal of the DSH-Coalinga Sex Offenders Treatment Program is for the patient to acquire pro-social skills and to prevent recurrence of sexual offending. The program combines components of the Self-Regulation/Better Life models with the principles of Risk-Need-Responsivity (RNR). This combined approach strengthens the patient's self-regulation skills to prepare him for a life free of sexual offending. The three principals of the RNR model are explained here in more detail.

The risk principle involves matching the intensity of treatment to the patient's risk level of reoffending, with high-risk offenders receiving more intensive and extensive treatment than low-risk offenders. Offense risk is determined by the combination of static and dynamic risk factors.

The need principle focuses on assessing dynamic risk factors and targeting them in treatment. Dynamic Risk Factors are defined as enduring but changeable features of an offender; they are amenable to interventions, and when successfully addressed, result in a decrease in recidivism risk.

The responsivity principle states that services should be delivered in a manner that is engaging and consistent with the learning style of the individual. Examples include fostering strengths; establishing meaningful relationships; and attending to relevant characteristics such as age, cognitive skills, cultural factors, and emotional regulation issues. It also states that the primary treatment components should use social learning and cognitive-behavioral approaches.

Empirical studies indicate that adhering to RNR principles can maximize treatment effects and reduce recidivism.

The Self-Regulation/Better Life model also provides some educational opportunities, vocational services, and recreational activities. Individuals with intellectual disabilities or severe psychiatric disorders participate in programs adapted for their treatment needs.

LICENSURE

DSH-Coalinga is licensed by the California Department of Public Health. DSH-Coalinga has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. In addition, DSH-Coalinga has 23 units licensed as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. DSH-Coalinga also has seven unlicensed Residential Recovery Units (RRU), which provides inpatient care to patients who are required to reside at DSH but have a lesser need for supervision.

TRAINING AND INTERNSHIPS

DSH-Coalinga offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Coalinga's training programs.

DSH-Coalinga Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation • Nursing Students Preceptorship
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	• Psychiatric Technician Trainee • Pre-Licensed Psychiatric Technicians • 20/20 Psychiatric Technician Training Program
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Rehabilitation Therapy [3]	• Recreation Therapy (Student Assistants) • Recreation Therapy Internship Program • Music Therapy (coming soon)
Social Work [4]	• Masters of Social Work Internships (Graduate Student Assistants)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are: University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Trainees are currently enrolled in a Psychiatric Technician School and work part time inside DSH hospitals (up to 20 hours/week). 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities. 3. 20/20 Psychiatric Technician training programs are open to current employees that have been accepted into a Psychiatric Technician School.

The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

[3] **Recreational Therapy Internship:** Recreational Therapy Internship Candidates are in their final semester of their degree and are required to complete a minimum of a 14-week 560-hour internship. Partners can be made with any accredited school in the country with a Recreational Therapy or Therapeutic Recreation program. The specific DSH-C Recreation Therapy Internship Program lasts for a minimum of 17-weeks due to New Employee Orientation. Once completed, students are eligible for national certification with National Council for Therapeutic Recreation Certification (NCTRC). To ensure the safety and well-being of students, patients, and staff, the Internship is designed to follow the guidelines outlined in the American Therapeutic Recreation Association (ATRA) Code of Ethics.

Music Therapy Internship: DSH-C is able to provide current opportunities for skill growth and professional development in accordance with American Music Therapy Association (AMATA) guidelines.

[4] **Social Work:** The Master of Social Work Internship program accepts four Graduate Student Assistants per academic program year. Graduate students are currently enrolled in a Master of Social Work program at an accredited university and complete at least 20 internship hours at DSH-C each week. The Field Instructor and Preceptor for each student will communicate with one another throughout the internship to assess progress and determine appropriate rotation throughout the hospital. The Social Work Department is currently contracted with nine Master of Social Work universities. The contracted schools include: University of California (USC), California State University Fresno (CSUF), California State University Bakersfield (CSUB), California State University Monterey Bay (CSUMB), San Jose State University (SJSU), Arizona State University (ASU), Campbellsville University (CU), Brandman University, and Simmons University.

Department of State Hospitals – Metropolitan

HISTORY

The Department of State Hospitals Metropolitan opened in 1916 as a self-sufficient facility with its own dairy cows, pigs, chickens and farmland. Located in Norwalk in Los Angeles County, today it serves as a modern-day psychiatric facility providing state of the art psychiatric care. The hospital is an open style campus within a security perimeter. Due to concerns raised by the community, DSH-Metropolitan maintains a formal agreement with the City of Norwalk and the Los Angeles County Sheriff not to accept patients charged with murder or a sex crime, or at high risk for escape. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,106 beds. In Fiscal Year (FY) 2019-20, DSH-Metropolitan served 797 patients. The commitment categories of patients treated at DSH-Metropolitan are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris Short	-
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,232 employees work at DSH-Metropolitan providing around-the-clock care, including psychiatrists, psychologists, social workers, rehabilitation therapists, registered nurses, psychiatric technicians, and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers,

groundskeepers, information technology staff, plant operations staff, spiritual leaders, teachers and other administrative staff.

TREATMENT AND PROGRAMS

DSH-Metropolitan is the first state hospital in California to have a specialized unit dedicated to Dialectical Behavior Therapy (DBT). DBT is a systematic cognitive-behavioral approach founded in the late 1970s by psychologist Marsha Linehan. It balances principles of acceptance (mindfulness) and change (behaviorism) and is effective for treating complex, difficult-to-treat mental disorders.

Research indicates DBT to be effective in reducing:

- Suicidal and self-injurious behaviors
- Treatment resistant depression
- Intense anger or difficulty with controlling emotions
- Impulsive behaviors that are potentially self-damaging (e.g., substance abuse, eating disorders)
- Treatment dropout
- Psychiatric hospitalizations

DSH-Metropolitan has a specialized unit dedicated to DBT as a treatment modality for patients who are diagnosed with a serious mental illness and who typically have a complex response to trauma that directly influenced their attachment styles, coping mechanisms, and interpersonal relationships.

Each patient in the DBT Program participates in the following activities:

- DBT Skills Groups which include four modules: Mindfulness, Emotional Regulation, Distress Tolerance, and Interpersonal Relationships
- Homework and Review Group
- Weekly Individual Therapy
- Bi-Weekly Outings
- Groups focused on practicing and applying skills

Other treatment programs include:

Trial Competency Program:

The Trial Competency Program is for patients admitted to the hospital pursuant to Penal Code (PC) 1370, Incompetent to Stand Trial (IST). The IST patients are trial defendants determined by the court to be unable to participate in their trial because they are not able to understand the nature of the criminal proceedings or assist counsel in the conduct of their defense due to psychiatric symptoms associated with a mental illness. These patients receive a specialized program of treatment which is specifically designed to help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense. Treating the defendant as IST and returning him/her to court for trial is sometimes followed by a court determination that the defendant is Not Guilty by Reason of Insanity (NGI) and requires further treatment under PC 1026.

Offender with a Mental Health Disorder (OMD) Program:

The OMD Program is for patients paroled to the hospital by authority of the Board of Paroles under provisions of PC 2962. Patients may be released to parole, placed in a Conditional Release Program (CONREP), or become civilly committed.

Lanterman-Petris-Short (LPS) Program:

The LPS Program provides treatment for civilly committed patients who suffer from severe symptoms of mental illness, who engage in the behaviors that are dangerous to themselves or others, or who are gravely disabled by their mental illness and thereby unable to formulate a viable plan for self-care. The program provides a highly structured treatment environment for re-socialization in preparation for community placement.

Skilled Nursing Facility (SNF):

The fully licensed SNF provides continuous nursing treatment and care for both Penal Code (PC) and civilly committed patients whose primary need is availability of skilled nursing care on an extended basis. Program objectives include the provision of interventions that are person-appropriate, foster hope and caring, and honor the resident's individual rights, cultural differences, spirituality and dignity.

ACCREDITATION AND LICENSURE

DSH-Metropolitan is accredited by The Joint Commission (TJC) an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. TJC standards evaluate organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Metropolitan is licensed by the California Department of Public Health and has 23 units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Metropolitan also has three units designated as a Skilled Nursing Facility (SNF). A SNF means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

TRAINING AND PARTNERSHIPS

DSH-Metropolitan offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of those training programs.

DSH-Metropolitan Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing [1]	• Registered Nursing Clinical Rotation Programs • Nursing Students Preceptorship
Pharmacy [2]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Physician and Surgeon	• Student Volunteer Opportunities
Psychiatric Technicians [3]	• 20/20 Psychiatric Technician Training Programs
Psychiatry	• Pacific Northwest University – Psychiatry Clerkship • Western University of Health Sciences – Psychiatry Clerkship
Psychology	• Association of Psychology Postdoctoral and Internship Center – Affiliated Internship Program
Registered Dietitians	• Accredited Dietetic Internship
Rehabilitation Therapy	• Art Therapy (Loyola Marymount University/ Practicum Students) • Music Therapy (American Music Therapy Association National Roster Internship Program /Volunteer Positions) • Recreation Therapy (Volunteer Positions)
Social Work	• Masters of Social Work Internships (Volunteer Positions)

[1] **Nursing:** Preceptorship for Bachelor of Science in Nursing (BSN) and Masters of Science in Nursing (MSN) programs available on an individual basis.

[2] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are: University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[3] **Psychiatric Technicians:** DSH-M offers 20/20 Psychiatric Technician training program for only Psychiatric Technician Assistants to become a Psychiatric Technician. The modified work hours shall be a maximum of twelve (12) months in length and the amount of the 20/20 time utilized by each selected employee will depend on the type of education/training programs available.

Department of State Hospitals – Napa

HISTORY

In 1872, a site was selected, and work began for the erection of the 500-bed, four-story, Gothic Style Hospital building. The Hospital originated in response to overcrowding at Stockton Asylum, the first State Hospital. The Department of State Hospitals-Napa opened on Monday, November 15, 1875 and is the oldest State Hospital still in operation. DSH-Napa was once self-sufficient, with its own dairy and poultry ranches, vegetable gardens, orchards and other farming operations. Treatment programs for developmentally disabled residents were available from October 1968 to August 1987 and from October 1995 to March 2001. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,418 beds. In Fiscal Year (FY) 2019-2020, DSH-Napa served 1,090 patients. The commitment categories of patients treated at DSH-Napa are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris Short	-
Offender with a Mental Health Disorder	2972
Not Guilty by Reason of Insanity	1026
Recommitment After Expiration of Prison Term (Must have concurrent W&I commitment)	2974

HOSPITAL STAFF

Approximately 2,535 employees work at DSH-Napa, providing round-the-clock care, including psychologists, psychiatrists, physicians, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, and other clinical staff. In addition, there are various non-level of care job classifications at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT PROGRAMS

Patients are screened prior to being scheduled for admission to ensure that DSH-Napa is the appropriate treatment setting. One treatment program is located outside the Secure Treatment Area (STA) for primarily civil commitments and four programs are located inside the STA for forensic commitments. Within these treatment programs there are residential units, each having a focus on a particular population and treatment. Staff orients the patient to the unit on arrival. Members of the Treatment Team meet with patients and continue the assessment process and develop treatment plans. Once developed, the plan is reviewed regularly by the Treatment Team and updated as the patient progresses and treatment objectives change. Family, significant others, conservators, California Forensic Conditional Release Program (CONREP), and the courts may play a role as the patient moves through the continuum of care from admission to discharge.

In addition to the living units there are other service sites. For instance, Mall Services provides a variety of off unit services for patients. Mall Services is a centralized approach to delivering services where the patients and staff from throughout the hospital come together to participate in services. Mall Services represents more of a centralized system of programming rather than a reference to a specific building or certain location. The services are provided, as much as possible, in the context of real-life functioning and in the rhythm of life of the patient. Thus, Mall Services extends beyond the context of a “building or place," and its services are based on the needs of the patient, not the needs of the program, the staff members, or the institution. Vocational Services provides opportunities for patients to develop job skills and habits, as well as earn funds. Educational Services enables patients to continue their education, high school or college, and provide skills groups for anger management and development of interpersonal skills. Rehabilitation Therapy Services, facilitated by music, dance, art, occupational and recreation therapists, provide treatment groups to engage the patient in wellness and improved quality of life. Department of Medicine (Medical Ancillary Services) provides clinics that deliver various medical services, including, but not limited to physical, occupational and speech therapies as well as dental, podiatry, neurology, cardiac and obstetrics and gynecology clinics.

The goal of treatment services is to assist patients to recognize and manage psychiatric symptoms. Patients also work on developing socially responsible behaviors, independent living skills, and coping skills to address their mental illness and forensic issues.
Specialty units include:

- Admission units- focused on completion of initial assessments and initiation of behavioral stabilization.
- Incompetent to Stand Trial (Penal Code (PC) 1370) treatment, focuses on trial competency treatment, attainment of competency and return them to court for adjudication of pending charges. Patients participate in a wide range of mental health groups and therapeutic activities to assist in addressing symptoms and behaviors that may interfere with their ability

to understand the court proceedings and to cooperate with their attorney in preparing a defense.

- Other commitments proceed from admission units through the continuum of care from stabilization to discharge. During a patient's stay some patients may receive specialized treatment.
  - Dialectic Behavior Therapy (DBT) involves individualized treatment and unit milieu management that focuses on supporting patient's use of DBT skills to minimize harm to self and others.
  - Treatment for polydipsia (intoxication resulting from excessive consumption of fluids).
  - Sex offender treatment
  - Intensive Substance Abuse Recovery
  - Geropsychiatric
- Discharge units focus on skills development for community living and on relapse prevention. Each patient prepares a personalized relapse prevention plan. The Treatment Teams work closely with CONREP towards returning patients to the community under CONREP supervision.

ACCREDITATION AND LICENSURE

This facility is accredited by The Joint Commission (TJC). TJC conducts unannounced surveys of this hospital at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. TJC standards deal with organization quality, safety of care issued, and the safety of the environment in which care is provided.

DSH-Napa is licensed by the California Department of Public Health. DSH-Napa has two units designated as acute psychiatric. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Napa has one unit designated as a (Skilled Nursing Facility (SNF). A SNF means a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. Additionally, DSH-Napa has 33 units designated as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

TRAINING AND PARTNERSHIPS

DSH-Napa offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Napa's training programs.

DSH-Napa Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatric Technicians [2]	• Psychiatric Technician Apprentice • Pre-Licensed Psychiatric Technicians
Psychiatry	• UC Davis, Psychiatry and Law • CA North State University • Touro University • Clinical Clerkships for Medical School Graduates
Psychology	• American Psychological Association Approved Pre-Doctoral Internship
Registered Dietitians	• Accredited Dietetic Internship
Rehabilitation Therapy	• Recreation Therapy (Volunteer Positions) • Occupational Therapy (Volunteer Positions) • Music Therapy (Volunteer Positions) • Dance Movement Therapy (Volunteer Positions) • Art Therapy (Volunteer Positions)
Social Work	• Masters of Social Work Internships (Graduate Student Assistants)

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are: University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University.

[2] **Psychiatric Technicians:** 1. Psychiatric Technician Apprentice - This class is limited term and designed for entrance and performance in an apprentice program leading to status as a licensed Psychiatric Technician. Persons in this class receive training under the provisions of apprenticeship standards and written apprentice agreements under Chapter 4, Division 3, California Labor Code. 2. Pre-Licensed Psychiatric Technicians are graduates from Psychiatric Technician School but have not yet passed the state licensing exam. They are limited to 9 months in that role (test must be passed within the 9 months) and work full time with some limitations on their job responsibilities.

Department of State Hospitals – Patton

HISTORY

The Department of State Hospitals-Patton is a secure forensic psychiatric hospital located in Patton, CA, in San Bernardino County. DSH-Patton was established in 1890 and opened in 1893. DSH-Patton provides treatment to forensically and civilly committed patients within a secure treatment area. The hospital does not accept voluntary admissions.

PATIENT POPULATION

The hospital is licensed to operate up to approximately 1,287 beds. In Fiscal Year (FY) 2019-20, DSH-Patton served 1145 patients. The commitment categories of patients treated at DSH-Patton are as follows:

Patient Commitments	Penal Code
Incompetent to Stand Trial	1370
Lanterman-Petris Short	-
Offender with a Mental Health Disorder	2962 / 2972
Coleman/CDCR	2684
Not Guilty by Reason of Insanity	1026

HOSPITAL STAFF

Approximately 2,496 employees work at DSH-Patton providing around-the-clock care, including psychiatrists, psychologists, social workers, rehabilitation therapists, psychiatric technicians, registered nurses, registered dieticians and other clinical staff. In addition, there are various non-level of care staff at the facility, including hospital police, kitchen staff, custodial staff, warehouse workers, groundskeepers, information technology staff, plant operations staff, spiritual leaders, and other administrative staff.

TREATMENT AND PROGRAMS

The Trial Competency Program is for patients admitted to the hospital under Penal Code (PC) 1370 as Incompetent to Stand Trial. These patients receive a specialized program of treatment

which is designed to specifically help the patient gain the knowledge and skills necessary to return to court. The goal is for the patient to understand court proceedings and effectively participate in their defense.

The focus of treatment for our Offenders with a Mental Disorder (OMD) and Not Guilty by Reason of Insanity (NGI) population emphasizes the potential for each patient to learn new skills and adaptive coping mechanisms to enhance the quality of the patient's life at the hospital and prepare them for eventual transfer to Community Outpatient Treatment (COT). Other goals are to motivate patients for treatment, develop greater self-autonomy and independence, and the mastery of Activities of Daily Living (ADL) skills and self-discipline.

All treatment programs at DSH-Patton utilize the recovery philosophy offering a broad spectrum of treatment, while fully endorsing the hospital's mission to provide comprehensive clinical services within the context of a biopsychosocial rehabilitation model within an environment of safety and security for all patients, staff and the community in an atmosphere of dignity and respect.

ACCREDITATION AND LICENSURE

This facility is accredited by The Joint Commission (TJC). TJC conducts unannounced surveys at least every three years. The purpose of the survey is to evaluate the hospital's compliance with nationally established TJC standards. The survey results are used to determine whether accreditation should be awarded and under what conditions that happens. TJC standards deal with organization quality, safety of care issues and the safety of the environment in which care is provided.

DSH-Patton has 12 units designated as acute. An acute psychiatric facility means having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care for persons with mental health disorders or other patients referred to in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code , including the following basic services: medical, nursing, rehabilitative, pharmacy, and dietary services. DSH-Patton also has 21 units designated as an Intermediate Care Facility (ICF). An ICF means a health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

DSH-PATTON MUSEUM

The DSH-Patton Museum examines the history of psychiatry and treatment of mental illness in California state-run facilities. The museum offers a glimpse of the evolution of the treatment of mental illness during the last 127 years.

Patton accepted its first patients on August 1, 1893. The museum, only the second of its kind west of the Mississippi River, features more than 140 items. Among the artifacts found in the museum are original medical and surgical equipment, firefighting equipment from the early part of the last century and nursing uniforms from the 1950s.

The museum itself is located on the grounds of the hospital in a 1920s cottage home that once was inhabited by hospital staff and their families.

TRAINING AND PARTNERSHIPS

DSH-Patton offers various training and internship opportunities across many clinical disciplines. Please see the table below for a brief description of DSH-Patton's training programs.

DSH-Patton Training Programs

DISCIPLINE	PROGRAM TYPE
Nursing	• Registered Nursing Programs Clinical Rotation
Pharmacy [1]	• Systemwide, DSH's pharmacy discipline is currently contracted with 11 pharmacy schools.
Psychiatry	• Loma Linda • UC Riverside • Kaiser Permanente
Psychology	• Practicum • American Psychological Association Approved Pre-Doctoral Internship • Post-Doctoral Fellowship
Registered Dietitians	• Accredited Dietetic Internship
Rehabilitation Therapy	• Recreation Therapy (Student Assistants)
Social Work	• Masters of Social Work and Bachelors of Social Work Internships

[1] **Pharmacy:** Systemwide, DSH's pharmacy discipline is currently contracted with 12 pharmacy schools. The preceptor at each of the hospitals will communicate with the schools to determine when to send students for their clinical rotations. The contracted schools are: University of Southern California (USC), University of California-San Francisco (UCSF), Touro University California College of Pharmacy, California North State University, California Health Sciences University, Loma Linda University (LLU), St Louis College of Pharmacy, University of Montana, University of the Pacific (UOP), Western University of Health Science, Chapman University, and Marshal B Ketchum College of Pharmacy.

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CALIFORNIA DEPARTMENT OF STATE HOSPITALS

REPORT ON STATE HOSPITAL FINANCIAL ACTIVITY

California Department of State Hospitals

FISCAL YEAR 2020-21

January 10, 2021

DIRECTOR
Stephanie Clendenin

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

EXECUTIVE SUMMARY

Pursuant to the Fiscal Year (FY) 2020-21 Budget, the Department of State Hospitals (DSH) submits this report to the California State Legislature on the financial activity of the state hospitals. This report is prepared in accordance with Item 4440-011-0001, Provision 9 of the 2020 Budget Act which requires DSH to provide a year-end summary and an operating budget for each state hospital with the FY 2021-22 Governor's Budget and May Revision estimate. Specifically, this report includes the following information for each state hospital:

- The number of authorized and vacant positions for each institution;
- The number of authorized and vacant positions for each institution, broken out by key classifications;
- The number of authorized positions utilized in the temporary help blanket for each institution;
- The 2019-20 year-end budget and expenditures by line-item detail for each institution;
- The budgeted allocations for each institution for current and budget year;
- The projected expenditures for current and budget years

THE DEPARTMENT OF STATE HOSPITALS OVERVIEW

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 13,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily censuses of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

SUMMARY OF AUTHORIZED AND VACANT POSITIONS

The following table provides a summary of the authorized and vacant positions for the state hospital system as of November 1, 2020.

State Hospital	Authorized Positions[1/2]	Vacant as of 11/1/20	Percent Vacant
Atascadero	2,207.6	303.5	13.7%
Coalinga	2,382.7	232.0	9.7%
Metropolitan	2,232.2	510.5	22.9%
Napa	2,534.8	302.0	11.9%
Patton	2,496.2	239.9	9.6%
Totals	**11,853.5**	**1,587.9**	**13.4%**

[1]Includes authorized Temporary Help per the Schedule 7A.
[2]Includes positions approved for Estimate Items Enhanced Treatment Program (28.0 in Atascadero and 2.1 in Patton) and Metropolitan State Hospital Increased Secure Bed Capacity (120.6 in Metropolitan) that will not be filled due to COVID-19 impacts to these projects as described in the 2021-22 Governor's Budget Estimate.

AUTHORIZED VERSUS VACANT POSITIONS BY CLASSIFICATION

As of November 1, 2020, DSH's vacancy rate is 13.4 percent. Item 4440-011-0001, Provision 9 requires DSH to provide the number of authorized and vacant classifications, including psychiatric technicians, nurses, physicians, psychiatrists, social workers, and rehabilitation therapists. The following table provides a summary of the authorized and vacant positions for those classifications.

		Atascadero		Coalinga		Metropolitan		Napa		Patton	
Class Title	**Class Code**	**Authorized**	**Vacant**	**Authorized**	**Vacant**	**Authorized**	**Vacant**	**Authorized**	**Vacant**	**Authorized**	**Vacant**
Staff Psychiatrist	7619	44.3	35.3	39.6	24.6	70.3	41.3	53.4	8.4	66.5	34.0
Psychologist	9873	44.7	3.7	37.5	10.5	42.0	6.0	47.4	0.9	59.2	5.6
Senior Psychiatric Technician	8252	103.2	23.2	88.0	4.0	80.3	31.3	83.0	11.0	81.0	0.0
Rehabilitation Therapist	Various	55.0	7.0	46.5	5.5	55.0	6.5	59.1	4.1	69.1	3.1
Registered Nurse	8094	245.8	33.8	232.0	10.0	294.5	95.1	451.2	33.2	362.1	22.1
Clinical Social Worker	9872	45.1	5.1	45.1	5.1	56.3	10.3	52.2	1.2	69.0	1.0
Psychiatric Technician	8253	604.8	69.8	706.7	44.7	473.9	135.9	449.0	72.2	682.6	39.6
Physician/Surgeon	7552	16.0	3.0	12.4	3.4	24.5	1.5	22.5	1.0	26.0	3.0

TEMPORARY HELP BLANKET POSITIONS

Temporary help blanket positions are temporary help positions utilized to offset vacancies and overtime. The following table provides a summary of authorized temporary help blanket positions for the state hospitals as of November 1, 2020. The Department is continuing to evaluate the use of internal registry positions to determine the appropriate temporary help position authority.

Authorized Blanket Positions	
Atascadero	30.1
Coalinga	28.0
Metropolitan	67.2
Napa	47.5
Patton	81.2
Total	**254.0**

STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

Exhibit I (attached) provides detail on the budget and expenditures for all five state hospitals and each facility individually, listed by FI$Cal account code for FY 2019-20. For FY 2020-21 and FY 2021-22, Exhibit II (attached) displays the projected budget and expenditures for all five hospitals and each facility individually. Any anticipated savings due to delayed projects or unit activations have been reflected in these allocations and projected expenditures.

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit I—All Hospitals[1]

		2019-20 Budget	2019-20 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$810,855,000	$685,522,000
	5100150-Earnings - Temporary Civil Service Employees	$38,320,000	$32,397,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$121,907,000	$103,064,000
Salaries and Wages Total		**$971,082,000**	**$820,983,000**
Staff Benefits	5150150-Dental Insurance	$968,000	$1,051,000
	5150200-Disability Leave - Industrial	$8,128,000	$8,831,000
	5150210-Disability Leave - Nonindustrial	$3,824,000	$4,155,000
	5150350-Health Insurance	$18,086,000	$19,650,000
	5150400-Life Insurance	$52,000	$57,000
	5150450-Medicare Taxation	$11,097,000	$12,057,000
	5150500-OASDI	$6,772,000	$7,358,000
	5150600-Retirement - General	$169,487,000	$184,149,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$399,000	$433,000
	5150750-Vision Care	$182,000	$198,000
	5150800-Workers' Compensation	$35,773,000	$38,868,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$151,263,000	$164,348,000
Staff Benefits Total		**$406,031,000**	**$441,155,000**
Operating Expenses and Equipment	5301400-Goods - Other	$4,998,000	$8,684,000
	5302900-Printing - Other	$446,000	$776,000
	5304800-Communications - Other	$1,905,000	$3,311,000
	5306700-Postage - Other	$121,000	$211,000
	5308900-Insurance - Other	$209,000	$364,000
	5320490-Travel - In State - Other	$644,000	$1,120,000
	5320890-Travel - Out of State - Other	$1,000	$2,000
	5322400-Training - Tuition and Registration	$396,000	$689,000
	5324350-Rents and Leases	$9,145,000	$15,894,000
	5324550-Special Repairs and Deferred Maintenance	$0	$0
	5326900-Utilities - Other	$11,848,000	$20,592,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$2,503,000	$4,350,000
	5340580-Consulting and Professional Services - External - Other	$46,778,000	$81,303,000
	5342600-Departmental Services - Other	$28,000	$49,000
	5344000-Consolidated Data Centers	$21,000	$37,000
	5346900-Information Technology - Other	$161,000	$279,000
	5368115-Office Equipment	$15,972,000	$27,760,000
	5390900-Other Items of Expense - Miscellaneous	$45,616,000	$79,284,000
	5395000-Unallocated Operating Expense and Equipment	$0	$0
	5415000-Claims Against the State	$5,000	$8,000
	5490000-Other Special Items of Expense	$1,557,000	$2,707,000
Operating Expenses and Equipment Total		**$142,354,000**	**$247,420,000**
Grand Total		**$1,519,467,000**	**$1,509,558,000**

[1]*Budget and Expenditure do not include reimbursements.*

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit I—Atascadero State Hospital[1]

		2019-20 Budget	2019-20 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$154,328,000	$132,042,000
	5100150-Earnings - Temporary Civil Service Employees	$11,810,000	$10,105,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$17,396,000	$14,884,000
Salaries and Wages Total		**$183,534,000**	**$157,031,000**
Staff Benefits	5150150-Dental Insurance	$147,000	$165,000
	5150200-Disability Leave - Industrial	$1,765,000	$1,981,000
	5150210-Disability Leave - Nonindustrial	$1,240,000	$1,392,000
	5150350-Health Insurance	$3,194,000	$3,584,000
	5150400-Life Insurance	$11,000	$12,000
	5150450-Medicare Taxation	$2,025,000	$2,272,000
	5150500-OASDI	$1,271,000	$1,426,000
	5150600-Retirement - General	$32,439,000	$36,404,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$138,000	$155,000
	5150750-Vision Care	$34,000	$38,000
	5150800-Workers' Compensation	$8,767,000	$9,839,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$25,062,000	$28,125,000
Staff Benefits Total		**$76,093,000**	**$85,393,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,114,000	$1,502,000
	5302900-Printing - Other	$84,000	$113,000
	5304800-Communications - Other	$328,000	$442,000
	5306700-Postage - Other	$36,000	$49,000
	5308900-Insurance - Other	$8,000	$11,000
	5320490-Travel - In State - Other	$275,000	$370,000
	5322400-Training - Tuition and Registration	$124,000	$167,000
	5324350-Rents and Leases	$1,732,000	$2,334,000
	5324550-Special Repairs and Deferred Maintenance	$0	$0
	5326900-Utilities - Other	$2,280,000	$3,073,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$589,000	$794,000
	5340580-Consulting and Professional Services - External - Other	$17,924,000	$24,158,000
	5342600-Departmental Services - Other	$0	$0
	5344000-Consolidated Data Centers	$11,000	$15,000
	5346900-Information Technology - Other	$16,000	$22,000
	5368115-Office Equipment	$4,400,000	$5,930,000
	5390900-Other Items of Expense - Miscellaneous	$9,531,000	$12,846,000
	5395000-Unallocated Operating Expense and Equipment	$0	$0
	5415000-Claims Against the State	$1,000	$1,000
	5490000-Other Special Items of Expense	$0	$0
Operating Expenses and Equipment Total		**$38,453,000**	**$51,827,000**
Grand Total		**$298,080,000**	**$294,251,000**

[2]*Budget and Expenditure do not include reimbursements.*

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit I—Coalinga State Hospital[1]

		2019-20 Budget	2019-20 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$163,937,000	$155,767,000
	5100150-Earnings - Temporary Civil Service Employees	$886,000	$842,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$24,335,000	$23,122,000
Salaries and Wages Total		**$189,158,000**	**$179,731,000**
Staff Benefits	5150150-Dental Insurance	$185,000	$221,000
	5150200-Disability Leave - Industrial	$1,185,000	$1,419,000
	5150210-Disability Leave - Nonindustrial	$831,000	$995,000
	5150350-Health Insurance	$3,408,000	$4,079,000
	5150400-Life Insurance	$12,000	$14,000
	5150450-Medicare Taxation	$2,160,000	$2,586,000
	5150500-OASDI	$1,518,000	$1,817,000
	5150600-Retirement - General	$35,482,000	$42,475,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$119,000	$142,000
	5150750-Vision Care	$35,000	$42,000
	5150800-Workers' Compensation	$4,603,000	$5,510,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$28,475,000	$34,086,000
Staff Benefits Total		**$78,013,000**	**$93,386,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,076,000	$1,412,000
	5302900-Printing - Other	$106,000	$139,000
	5304800-Communications - Other	$446,000	$585,000
	5306700-Postage - Other	$47,000	$62,000
	5308900-Insurance - Other	$72,000	$94,000
	5320490-Travel - In State - Other	$338,000	$443,000
	5320890-Travel - Out of State - Other	$2,000	$2,000
	5322400-Training - Tuition and Registration	$66,000	$86,000
	5324350-Rents and Leases	$1,242,000	$1,629,000
	5324550-Special Repairs and Deferred Maintenance	$0	$0
	5326900-Utilities - Other	$3,008,000	$3,944,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$622,000	$816,000
	5340580-Consulting and Professional Services - External - Other	$21,961,000	$28,798,000
	5342600-Departmental Services - Other	$26,000	$34,000
	5344000-Consolidated Data Centers	$1,000	$1,000
	5346900-Information Technology - Other	$111,000	$145,000
	5368115-Office Equipment	$2,855,000	$3,744,000
	5390900-Other Items of Expense - Miscellaneous	$14,243,000	$18,677,000
	5415000-Claims Against the State	$1,000	$1,000
Operating Expenses and Equipment Total		**$46,223,000**	**$60,612,000**
Grand Total		**$313,394,000**	**$333,729,000**

[3]*Budget and Expenditure do not include reimbursements.*

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit I—Metropolitan State Hospital[1]

		2019-20 Budget	2019-20 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$144,551,000	$87,379,000
	5100150-Earnings - Temporary Civil Service Employees	$7,004,000	$4,234,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$10,177,000	$6,152,000
Salaries and Wages Total		**$161,732,000**	**$97,765,000**
Staff Benefits	5150150-Dental Insurance	$213,000	$171,000
	5150200-Disability Leave - Industrial	$982,000	$787,000
	5150210-Disability Leave - Nonindustrial	$406,000	$325,000
	5150350-Health Insurance	$3,630,000	$2,909,000
	5150400-Life Insurance	$10,000	$8,000
	5150450-Medicare Taxation	$1,856,000	$1,487,000
	5150500-OASDI	$1,328,000	$1,064,000
	5150600-Retirement - General	$29,405,000	$23,564,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$31,000	$25,000
	5150750-Vision Care	$36,000	$29,000
	5150800-Workers' Compensation	$6,956,000	$5,574,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$30,495,000	$24,437,000
Staff Benefits Total		**$75,348,000**	**$60,380,000**
Operating Expenses and Equipment	5301400-Goods - Other	$661,000	$1,876,000
	5302900-Printing - Other	$35,000	$99,000
	5304800-Communications - Other	$14,000	$41,000
	5306700-Postage - Other	$5,000	$13,000
	5308900-Insurance - Other	$66,000	$188,000
	5320490-Travel - In State - Other	$20,000	$57,000
	5322400-Training - Tuition and Registration	$26,000	$73,000
	5324350-Rents and Leases	$845,000	$2,398,000
	5324550-Special Repairs and Deferred Maintenance	$0	$0
	5326900-Utilities - Other	$716,000	$2,032,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$171,000	$485,000
	5340580-Consulting and Professional Services - External - Other	$1,193,000	$3,384,000
	5342600-Departmental Services - Other	$1,000	$2,000
	5344000-Consolidated Data Centers	$2,000	$6,000
	5346900-Information Technology - Other	$0	$0
	5368115-Office Equipment	$470,000	$1,333,000
	5390900-Other Items of Expense - Miscellaneous	$3,212,000	$9,111,000
	5395000-Unallocated Operating Expense and Equipment	$0	$0
	5415000-Claims Against the State	$1,000	$2,000
	5490000-Other Special Items of Expense	$2,000	$5,000
Operating Expenses and Equipment Total		**$7,440,000**	**$21,105,000**
Grand Total		**$244,520,000**	**$179,250,000**

[4]*Budget and Expenditure do not include reimbursements.*

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit I—Napa State Hospital[1]

		2019-20 Budget	2019-20 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$170,254,000	$151,262,000
	5100150-Earnings - Temporary Civil Service Employees	$5,851,000	$5,198,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$30,152,000	$26,788,000
Salaries and Wages Total		**$206,257,000**	**$183,248,000**
Staff Benefits	5150150-Dental Insurance	$224,000	$278,000
	5150200-Disability Leave - Industrial	$2,196,000	$2,743,000
	5150210-Disability Leave - Nonindustrial	$520,000	$650,000
	5150350-Health Insurance	$3,990,000	$4,984,000
	5150400-Life Insurance	$9,000	$11,000
	5150450-Medicare Taxation	$2,190,000	$2,736,000
	5150500-OASDI	$1,234,000	$1,542,000
	5150600-Retirement - General	$32,084,000	$40,079,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150700-Unemployment Insurance	$26,000	$33,000
	5150750-Vision Care	$37,000	$46,000
	5150800-Workers' Compensation	$7,596,000	$9,489,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$30,889,000	$38,586,000
Staff Benefits Total		**$80,995,000**	**$101,177,000**
Operating Expenses and Equipment	5301400-Goods - Other	$422,000	$1,578,000
	5302900-Printing - Other	$43,000	$162,000
	5304800-Communications - Other	$477,000	$1,784,000
	5306700-Postage - Other	$13,000	$50,000
	5308900-Insurance - Other	$3,000	$13,000
	5320490-Travel - In State - Other	$31,000	$117,000
	5322400-Training - Tuition and Registration	$60,000	$226,000
	5324350-Rents and Leases	$938,000	$3,507,000
	5324550-Special Repairs and Deferred Maintenance	$0	$0
	5326900-Utilities - Other	$2,290,000	$8,558,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$393,000	$1,469,000
	5340580-Consulting and Professional Services - External - Other	$3,352,000	$12,511,000
	5342600-Departmental Services - Other	$3,000	$13,000
	5344000-Consolidated Data Centers	$1,000	$5,000
	5346900-Information Technology - Other	$29,000	$107,000
	5368115-Office Equipment	$2,674,000	$9,993,000
	5390900-Other Items of Expense - Miscellaneous	$4,977,000	$18,598,000
	5415000-Claims Against the State	$0	$1,000
	5490000-Other Special Items of Expense	$0	$0
Operating Expenses and Equipment Total		**$15,706,000**	**$58,692,000**
Grand Total		**$302,958,000**	**$343,117,000**

[5]*Budget and Expenditure do not include reimbursements.*

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit I—Patton State Hospital[1]

		2019-20 Budget	2019-20 Expenditure
Salaries and Wages	5100000-Earnings - Permanent Civil Service Employees	$180,359,000	$159,072,000
	5100150-Earnings - Temporary Civil Service Employees	$13,626,000	$12,018,000
	5108000-Overtime Earnings (Other than to Temporary Help)	$36,416,000	$32,118,000
Salaries and Wages Total		**$230,401,000**	**$203,208,000**
Staff Benefits	5150150-Dental Insurance	$205,000	$216,000
	5150200-Disability Leave - Industrial	$1,802,000	$1,901,000
	5150210-Disability Leave - Nonindustrial	$752,000	$793,000
	5150350-Health Insurance	$3,881,000	$4,094,000
	5150400-Life Insurance	$11,000	$12,000
	5150450-Medicare Taxation	$2,821,000	$2,976,000
	5150500-OASDI	$1,431,000	$1,509,000
	5150600-Retirement - General	$39,465,000	$41,627,000
	5150620-Retirement - Public Employees - Safety	$0	$0
	5150630-Retirement - Public Employees - Miscellaneous	$0	$0
	5150700-Unemployment Insurance	$74,000	$78,000
	5150750-Vision Care	$41,000	$43,000
	5150800-Workers' Compensation	$8,017,000	$8,456,000
	5150820-Other Post-Employment Benefits (OPEB) Employer Contributions	$0	$0
	5150900-Staff Benefits - Other	$37,082,000	$39,114,000
Staff Benefits Total		**$95,582,000**	**$100,819,000**
Operating Expenses and Equipment	5301400-Goods - Other	$1,449,000	$2,316,000
	5302900-Printing - Other	$165,000	$263,000
	5304800-Communications - Other	$287,000	$459,000
	5306700-Postage - Other	$23,000	$37,000
	5308900-Insurance - Other	$36,000	$58,000
	5320490-Travel - In State - Other	$83,000	$133,000
	5322400-Training - Tuition and Registration	$86,000	$137,000
	5324350-Rents and Leases	$3,771,000	$6,026,000
	5324550-Special Repairs and Deferred Maintenance	$0	$0
	5326900-Utilities - Other	$1,868,000	$2,985,000
	5340330-Consulting and Professional Services - Interdepartmental - Other	$492,000	$786,000
	5340580-Consulting and Professional Services - External - Other	$7,792,000	$12,452,000
	5344000-Consolidated Data Centers	$6,000	$10,000
	5346900-Information Technology - Other	$3,000	$5,000
	5368115-Office Equipment	$4,230,000	$6,760,000
	5390900-Other Items of Expense - Miscellaneous	$12,548,000	$20,052,000
	5395000-Unallocated Operating Expense and Equipment	$0	$0
	5415000-Claims Against the State	$2,000	$3,000
	5490000-Other Special Items of Expense	$1,691,000	$2,702,000
Operating Expenses and Equipment Total		**$34,532,000**	**$55,184,000**
Grand Total		**$360,515,000**	**$359,211,000**

[6]*Budget and Expenditure do not include reimbursements.*

Department of State Hospitals

Report on State Hospital Financial Activity: FY 2020-21

Exhibit II—All Hospitals[1]

	2020-21 Budget	2020-21 Projected Expenditure	2021-22 Budget	2021-22 Projected Expenditure
4410010-Atascadero	$271,278,000	$268,565,220	$303,811,000	$300,772,890
4410020-Coalinga	$289,155,000	$286,263,450	$326,328,000	$323,064,720
4410030-Metropolitan	$195,352,000	$193,398,480	$247,446,000	$244,971,540
4410040-Napa	$280,063,000	$277,262,370	$310,794,000	$307,686,060
4410050-Patton	$334,021,000	$330,680,790	$369,489,000	$365,794,110
Grand Total	**$1,369,869,000**	**$1,356,170,310**	**$1,557,868,000**	**$1,542,289,320**

[7]*Budget and Expenditure do not include reimbursements.*