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Appendix O.A: Project Team

The project team altogether has 225 years of state service.

Irene **Briggs** has worked 16 years for the State, 8 years of which have been managing both budget and policy at the Department of Mental Health and Department of Transportation. The majority of her work experience is in managing departmental budget development and revenue forecasting functions.

Gloria **Deroo** worked 34 years for the State, 33 years of which were with the Department of Forestry and Fire Protection in various administrative program areas. The majority of her work experience is in personnel, budgeting, business services and program administration.

Roger **Desrosiers** worked 31 years for the State, 28 years of which were in managing accounting operations for Department of Forestry and Fire Protection, Department of General Services, California Department of Corrections & Rehabilitation, and Department of Motor Vehicles. The majority of work experience is in accounts receivable, accounts payable, cash receipts, cost accounting, fiscal systems analysis and year-end financial statement preparation.

Christina **Edens** has worked 13 years for the State, 12 of which were as an analyst and manager at the Department of Mental Health. Her work experience includes program administration, contracts, budgets, accounting and operations.

Catherine **Hendon** has a master's degree in counseling psychology and a Project Management Professional certification. She has worked 3 years for the State as an analyst and manager at the Department of Mental Health. The majority of her work experience is in strategic planning and project management.

Carla **Lenerd** has 30 years of service with the State, 15 years as an executive with the State Controller's Office and EdFund. The majority of her work experience is in accounting, budgeting, debt service management, and general administration.

Manny **Mateo** worked 42 years for the State, 34 years of which were as an executive in the Department of Finance, the Attorney General's Office, the State Treasurer's Office, the State Controller's Office, and the former Department of Health. The majority of his work experience is fiscal policy analysis, accounting, budgeting, state bond negotiation and trust management, and general administration.

Shelley **Mateo** worked 26 years for the State, 18 years of which were as an executive in the Department of Finance and the Department of Forestry and Fire Protection. The majority of her work experience is in fiscal policy analysis, budgeting and general administration.

Valerie **Varzos** is a Certified Public Accountant with a Masters in Business Administration. Her career includes 30 years in State service, with 10 years of experience auditing state and local governments as well as the health care industry prior to her career in information technology. During her career with the State, Ms. Varzos specialized in the development of government financial and administrative systems. She both developed systems and provided independent oversight to some of the largest and most complex state projects. Her career includes working at several State agencies including the State Controller's Office, the Department of Finance, the California Technology Agency, the Department of Health Care Services, and the Department of Motor Vehicles.

Appendix 0.B: Compilation of Recommendations

Recommendations	Reference	Item #
<p>1. Management Assessment: General Management</p> <ul style="list-style-type: none"> ➤ Standards of personal responsibility: The executive leadership must articulate and continually reinforce performance standards of personal responsibility and openness. ➤ Update duty statements for fiscal responsibility. Modify senior management duty statements to add specific responsibilities for fiscal and internal controls. ➤ Add EDs to senior management team. Increase the hospitals' presence on the senior management team. ➤ Deputy director structure: Revise the deputy director structure by adding a deputy director of operations to whom the executive directors report. This deputy should have the specific mandate of raising to the executive office any conflicts between hospitals' mission requirements and budget realities, and devising plans to resolve such conflicts. Appendices 2.A and 2.B show the existing and proposed deputy structure with possible functional responsibilities for the deputy director of operations. Appendix 2.B also includes a proposed clinical deputy that is discussed in Section 3 (Organizational Assessment) and Section 6 (Medical Issues). ➤ Communication: Remove communication barriers between headquarters' divisions and between headquarters and the hospitals. <ul style="list-style-type: none"> • Address poor service orientation at headquarters. • Develop a cohesive body of policies and procedures, ensuring hospital input. • Develop a plan for structured sharing of management information between levels of the organization. Although information technology is key to that goal, lack of department-wide information systems should not prevent instituting regular management reporting. • As the budget permits, reinstitute meetings between organizational levels of the department. Hold these meetings at hospitals whenever practical so that headquarters managers and staff members have the opportunity to learn the hospital mission. 	<p>Section 2, p. 18</p>	<p>1.1</p> <p>1.2</p> <p>1.3</p> <p>1.4</p> <p>1.5</p> <p>1.5a</p> <p>1.5b</p> <p>1.5c</p> <p>1.5d</p>

Recommendations	Reference	Item #
<p>2. Management Assessment: Analytic Staffing</p> <ul style="list-style-type: none"> ➤ Add budget policy staff: Size the budget office to 1) review budget change proposals for policy coherence and completeness of cost/benefit considerations, 2) review hospitals' expenditure projections to form an independent assessment of accuracy, and 3) advise the executive directors, the deputies, and the executive office of likely impacts of external and internal budget pressures. ➤ Add bed utilization planning function: Create a bed utilization unit that addresses capacity planning and patient movement by commitment type and operational needs (e.g., violence, geriatrics, skilled nursing needs). The unit would recommend strategies for matching facility design and usage to population acuity characteristics, and would be a major source of input to capital outlay planning. The team sees this function placed under the deputy director of operations. ➤ Add cost containment analysis: Create a cost containment unit that systematically collects cost savings concepts, developing them into full proposals with feasibility assessments and cost/benefit analysis. Vest this function with the deputy director of operations since that division has the most in-depth knowledge of hospital operations. 	<p>Section 3, p. 22</p>	<p>2.1</p> <p>2.2</p> <p>2.3</p>
<p>3. Organizational Assessment: Budgeting</p> <p>Budget office/divisions</p> <ul style="list-style-type: none"> ➤ Fill budget office vacancies. To ensure timely submission of budget documents to Finance, the budget office must immediately fill all vacancies. It also needs additional temporary help to meet training and workload demands this fall. ➤ Instill correct ethic. The administrative division must espouse and practice a strong ethic for correct budget management and reporting of problems. ➤ Provide staff for hospital oversight. Staff the headquarters budget office correctly for working with hospitals and providing budget policy assistance. This is work that previously was not performed. ➤ Establish headquarters unit budgets. Prepare and distribute unit allocations as quickly as possible after fall budget preparation is completed and training requirements are met. Begin with budgeting at the division level to ease the transition. (The draft unit allotments previously prepared by the budget office but never distributed, are too detailed.) ➤ Train headquarters units to manage allocations. Train the headquarters divisions in budget 	<p>Section 3, p. 27</p>	<p>3.1</p> <p>3.2</p> <p>3.3</p> <p>3.4</p> <p>3.5</p>

Recommendations	Reference	Item #
<p>management. Ensure that each division has an administrative assistant to assist with transaction reconciliation and expenditure control. This same assistant could assist the division with other administrative processes.</p> <p>LTCS fiscal unit</p> <ul style="list-style-type: none"> ➤ Refocus fiscal unit. Reorganize the duties of the fiscal unit so that it no longer performs budget office functions and focuses instead on program cost analysis and cost containment. Move that revised function from the LTCS division to the deputy director of operations or to the administrative division. <p>Hospitals' fiscal offices</p> <ul style="list-style-type: none"> ➤ Improve hospitals' budget management. Develop a plan to gradually increase the sophistication of hospital budget management. <ul style="list-style-type: none"> • Create a hospital accounting self-governance group. Establish a hospital-based fiscal advisory position by expanding the duties of one of the fiscal officers. Task the fiscal officers as a group to develop a plan for increasing hospital budgeting strength, under the leadership of the fiscal advisory position. • Give the group necessary tools. Provide the hospitals with appropriate budget management tools. Share hospitals' best desktop budget systems. Share headquarters tools (such as the Excel version of the Schedule 8) with the hospitals. ➤ Staff hospital budgeting correctly. As hospital budget systems evolve in complexity, staff them correctly. <ul style="list-style-type: none"> • Begin by returning the fiscal positions that headquarters has borrowed from the hospitals. • Perform a workload analysis at each step of system expansion and solicit resources as needed. 		<p>3.6</p> <p>3.7</p> <p>3.7a</p> <p>3.7b</p> <p>3.8</p>
<p>4. Organizational Assessment: Accounting</p> <p>Headquarters accounting office</p> <ul style="list-style-type: none"> ➤ Instill correct FISMA ethic. The administrative division must instill in the accounting office, from the top down, a strong ethic for fiscal management and reporting of problems (Fiscal Integrity and State Manager's Accountability Act of 1983—FISMA). 	<p>Section 3, p. 30</p>	<p>4.1</p>

Recommendations	Reference	Item #
➤ Improve knowledge of hospital operations. Prior to the accounting office expanding its oversight of hospitals, skills and knowledge of hospital fiscal operations and a better service ethic must firmly be in place.		4.2
➤ Keep historical fiscal records. In addition to CALSTARS on-line information, the accounting office should retain copies of year-end financial statements for analysis and future research purposes.		4.3
➤ Rewrite duty statements for accountability. In order to perform an oversight role, duty statements must be rewritten to include hospital oversight responsibility.		4.4
➤ Assess office workload. Evaluate headquarters' accounting office staffing based on workload justification. If not justified, return borrowed fiscal positions to the hospitals.		4.5
Hospital accounting offices		
➤ Leave hospital accounting decentralized. The team recommends leaving the current accounting structure in place as long as the department uses CALSTARS as its accounting system. Future accounting systems such as FI\$Cal may drive a re-examination of this issue.		4.6
➤ Create a hospital accounting self-governance group to improve implementation of CALSTARS. The hospital fiscal advisory position (recommended under the budgeting assessment above) should work with the hospital fiscal officers to gradually improve the implementation of CALSTARS at the hospitals. The operational benefit will be improved information on program costs.		4.7
<ul style="list-style-type: none"> • Consider contracting with Finance or hiring a retired annuitant with CALSTARS systems analysis skills to assist the fiscal officers with system design issues. 		4.7a
<ul style="list-style-type: none"> • Ensure hospitals know how to access the Uniform Codes Manual, State Administrative Manual, Leg Info Website, etc. 		4.7b
<ul style="list-style-type: none"> • In addition to the assistance provided by the hospital fiscal advisory office, each hospital should have an assigned accountant liaison in the accounting office. The liaison should be able to answer accounting questions and share information. 		4.7c
➤ Improve headquarters' understanding of hospital accounting through field visits. Accounting managers should visit hospitals to gain an understanding of operational needs and issues. Train the office to a "service with control" standard.		4.8
➤ Training. Provide on-site training on state fund accounting at headquarters and in the hospitals.		4.9

Recommendations	Reference	Item #
<p>5. Organizational Assessment: Personnel</p> <ul style="list-style-type: none"> ➤ More decentralization. Where allowable, decentralize processing tasks more completely, reshaping headquarters into a “service with control” role. ➤ Resolve exam blockage. Negotiate a solution with SPB that leaves the workload for job analysis within practical reach of the department. The problem is impeding hospital operations. ➤ Reduce headquarters processing times. Evaluate turn-around times in the classification and pay unit. 	Section 3, p. 33	<p>5.1</p> <p>5.2</p> <p>5.3</p>
<p>6. Organizational Assessment: Contracting</p> <ul style="list-style-type: none"> ➤ Delegate more completely. ➤ Shorten the contract approval process. Reduce the contract approval time to no more than three months. ➤ Provide more assistance. Assist the hospitals in addressing contract needs. ➤ Accountability through better policies and procedures. Rely on written policies and procedures for accountability, created collaboratively, rather than time-consuming review loops at headquarters with shifting standards. ➤ Formalize the business services officers group. Assign a permanent legal liaison to the group for continuity in the provision of contracting legal advice. ➤ Reassign contract signature responsibilities. Decrease bottlenecking by placing headquarters’ contract signature responsibilities with the business services office, not with the administrative deputy director. ➤ Update the signature cards for contracts so that hospitals can take advantage of the \$250,000 contract threshold. ➤ Conduct audits: Charge headquarters with conducting periodic audits of hospitals’ contracting practices. ➤ Help hospitals track contract status. Create a system to communicate contract location and status. This function will be automated in the new Fi\$Cal system, but implementation of that system in DMH may be at least five years away. ➤ More centralized contracting. Consider broader use of centralized contracting in certain areas (such as for lab services) for cost savings, but do so collaboratively with the hospitals and avoid 	Section 3, p. 35	<p>6.1</p> <p>6.2/25.2</p> <p>6.3</p> <p>6.4</p> <p>6.5</p> <p>6.6/26.1</p> <p>6.7</p> <p>6.8</p> <p>6.9/25.3</p> <p>6.10</p>

Recommendations	Reference	Item #
time delays that hamper hospital operations.		6.11/50
<p>7. Weak Administrative Processes: Appropriation Control</p> <ul style="list-style-type: none"> ➤ Prepare a formal plan to regain appropriation control. Comprehensively review all fiscal control systems and redesign those that are deficient. Prepare a formal plan for regaining appropriation control. Triage necessary process changes, assign responsibility and timeframes for resolution, and monitor progress. ➤ Clearly establish accountability. Evaluate duty statements and make changes to clearly assign responsibility for process management and for fiscal accountability. Then hold management accountable. ➤ Document procedures and processes—the failure to do so is the number one problem that hospitals report. ➤ Share fiscal control tools. Until the department has the information technology resources to focus on appropriation control systems, it should ensure that hospitals share their “best of breed” IT desktop systems. Share appropriate headquarters tools, as well. 	Section 4.1 p. 39	7.1 7.2 7.3 7.4
<p>8. Weak Administrative Processes: Base Budgets</p> <ul style="list-style-type: none"> ➤ By March 2012, implement hospital and headquarters division base budgets by line-item for 2011-12. ➤ Set up cross-organizational systems and processes that support line item control of the hospitals’ and headquarters’ allocations. This may require hiring or contracting for assistance. ➤ Provide necessary training to the budget office, headquarters’ managers, the LTCS fiscal unit, and the hospitals in base budget maintenance. 	Section 4.2, p. 40	8.1 8.2 8.3
<p>9. Weak Administrative Processes: Cost Centers</p> <ul style="list-style-type: none"> ➤ Establish cost centers that support fiscal control. Develop a plan that identifies management and operational uses for hospital cost data. The plan should set an achievable starting point for each of the headquarters divisions’ and hospitals’ respective charts of accounts, considering workload impact and experience. Develop a vision of where information collection, and therefore cost 	Section 4.3, p. 41	9.1

Recommendations	Reference	Item #
<p>centers, should be in three years.</p> <ul style="list-style-type: none"> ➤ Ensure a well-designed cost center plan through training. Provide necessary training and assistance so that 1) the plan is well-informed on costs (workload) and benefits (improved program information, fiscal control) and 2) implementation has a good prognosis for success. ➤ Phase in the plan as necessary. ➤ Prepare for pending changes to statewide accounting systems. Become familiar with FI\$Cal, the state’s new comprehensive fiscal management system. If implementation of FI\$Cal proceeds according to schedule, the state hospital department should be transitioned to it within 5 to 7 years. The goal is to have a well-developed structure of cost centers and sound data collection in place in advance of that time. 		<p>9.2</p> <p>9.3</p> <p>9.4</p>
<p>10. Weak Administrative Processes: Expenditure Projections/Year-end Closing/Cash Management</p> <ul style="list-style-type: none"> ➤ Establish systems for expenditure projections and cash management at both hospitals and headquarters. Assign and document responsibilities, develop and document procedures, and train as necessary in how to read CALSTARS reports and to prepare estimates and analyses. ➤ Implement management reporting for expenditure and cash status. Develop standardized management expenditure reports distributed on a regular basis that identify significant issues. This recommendation applies both to hospitals and headquarters. ➤ Reduce the use of clearing accounts for timely expenditure reporting. Minimize the use of the clearing account to reflect costs more accurately and timely. Additional CALSTARS training might eliminate this problem. ➤ Standardize hospital expense reporting. Charge the hospitals with collaboratively standardizing their hospital expenditure reporting and projection methodologies. <ul style="list-style-type: none"> • Have the fiscal officers develop a plan for standardization and documentation of processes with timelines. • It would be appropriate for headquarters to participate but not to lead, given current lack of experience with hospital budgets. ➤ Assess staffing needs for fiscal projections. Address staffing requirements of expenditure analysis as resources permit (both headquarters and the hospitals). ➤ Revise external registry encumbrances to improve expenditure forecasting accuracy (See “External Registry Contracting” below). 	<p>Section 4.4, p. 44</p>	<p>10.1</p> <p>10.2</p> <p>10.3</p> <p>10.4</p> <p>10.4a</p> <p>10.4b</p> <p>10.5</p> <p>10.6</p>

Recommendations	Reference	Item #
<p>11. Weak Administrative Processes: Preventing the Unintentional Loss of Level-of-Care Position (LOC) Authority</p> <ul style="list-style-type: none"> ➤ Verify whether the Schedule 7A understates LOC positions. The department needs to detail the reported discrepancy between staffing standards and LOC authorized positions, and verify the cause so that correct system solutions are implemented. ➤ If a loss has occurred, negotiate solutions with control agencies. If there is a shortage, the department will need to negotiate a solution to the problem with Finance. ➤ Document correct processes to prevent future problems. Whichever process alternative the department and Finance agree to, the conclusion and related procedures should be documented and communicated to the hospitals, the budget office, and the LTCS fiscal unit. ➤ Reconcile standards-driven and fixed LOC positions each year. The budget office, LTCS fiscal unit, and the hospital human resources directors should jointly reconcile standards-driven and fixed LOC each year. 	<p>Section 4.5, p. 46</p>	<p>11.1</p> <p>11.2</p> <p>11.3</p> <p>11.4</p>
<p>12. Weak Administrative Processes: Reconciling Allocations to Hospitals' Authorized Positions; Salary Savings</p> <ul style="list-style-type: none"> ➤ Reconcile allocations to the Schedule 7A quarterly. Require hospitals to reconcile their allocations and the Schedule 7A as part of the quarterly allocation process. Develop and document reconciliation processes. ➤ Redistribute census positions when allocation changes are made. Require the LTCS fiscal unit to redistribute positions between hospitals based on census changes. Use the Form 607 process to implement this, and do it when allocation adjustments are made. Notify hospitals in advance of these changes. ➤ Bank unused census-driven positions. Bank positions that exceed system-wide census until the census justifies their redeployment. Report movement in and out of this bank to Finance. ➤ Evaluate the fiscal impact of position changes. Require funding certification for position reclassifications. ➤ Clean up blanket positions. Remove permanent positions from the blanket where that placement is not justified by temporary needs such as disability leave. ➤ Develop corrective plans based on a global reconciliation of positions to the allocations each 	<p>Section 4.6 p. 47</p>	<p>12.1</p> <p>12.2</p> <p>12.4</p> <p>12.4</p> <p>12.5</p> <p>12.6</p>

Recommendations	Reference	Item #
<p>year. Require that the hospitals, budget office, and LTCS fiscal unit reconcile the staffing standards to the Schedule 7A, and the Schedule 7A to available funding for each hospital at the beginning of each year. Discrepancies between staffing standards, position authority, and funding, beyond normal salary savings, should be identified to the hospitals and the senior management team and a corrective plan developed.</p> <p>➤ Train hospitals on correct management of salary savings. The current approach focuses on the listing of authorized positions rather than actual funding availability.</p>		12.7
<p>13. Weak Administrative Processes: Reconciliation of Hospitals’ Allocations, the Hospital Appropriation, and State Controller Accounts</p> <p>➤ Regain control over reconciliation: Assign responsibilities and document the process of reconciling the LTCS fiscal unit’s allocation data with the budget offices’ appropriation records and with the State Controller’s sub-appropriations for the hospitals.</p> <p>➤ Keep involved parties informed. When funds are moved between sub-appropriations at year-end to ensure payment of payrolls, make sure the LTCS fiscal unit and hospitals are informed.</p> <p>➤ Provide reasons for changes. Release allocation changes with detailed instructions for the correct way to load the adjustment and the reason for the change. Document this process.</p>	Section 4.7, p. 48	13.1 13.2 13.3
<p>14. Weak Administrative Processes: Staffing standards used for the population BCP</p> <p>✓ Update staffing standards to better reflect actual operations. Update the methodology for the population BCP to include a more complete range of staffing requirements for the department (admission suite staffing, enhanced observations, acuity staffing). This issue connects with the deficit. See also staffing recommendations for the pharmacy and physical medicine programs below under “medical issues.”</p> <p>✓ Make corresponding changes to allocations. The allocation process should parallel any changes made to the population BCP.</p>	Section 4.8. p. 50	14.1 14.2
<p>15. Weak Administrative Processes: Planning and resource acquisition for operating expenses</p> <p>➤ Require each hospital to prepare an annual analysis of its operating expenses versus budget, and to submit a copy to the LTCS fiscal unit and the budget office. Use a standard format developed collaboratively by headquarters and the hospitals. Present this analysis to Finance with the annual</p>	Section 4.9 p. 50	15

Recommendations	Reference	Item #
population BCP, regardless of funding policy to establish a history of program need.		
<p>16. Weak Administrative Processes: Resource Acquisition for NLOC positions</p> <ul style="list-style-type: none"> ➤ Analyze NLOC staffing needs and be prepared to request funding adjustments when budget policy permits. Use the “build it and they will come” approach for resource acquisition. Prepare workload standards for programs such as hospital police in anticipation of the time when funding may be available. Workload standards can also assist with program management. ➤ Pilot this effort. Charge the hospital administrators with selecting one or two areas to pilot this effort so that workload impact is manageable. 	Section 4.10, p. 51	16.1 16.2
<p>17. Weak Administrative Processes: Deficit Management</p> <ul style="list-style-type: none"> ➤ Prepare a program of deficit management. Using guidelines provided in the report, assign the hospital administrators, the accounting office, and LTCS fiscal unit, and the budget office the task of identifying how the department can best manage a deficit situation. Establish a due date of December 15th, 2011, since cash shortages may occur this winter. 	Section 4.11, p. 52	17
<p>18. Weak Administrative Processes: Internal Controls Auditing/Response to Audits</p> <ul style="list-style-type: none"> ➤ Use limited resources wisely. Make best use of limited resources by providing coordination assistance for the auditor and reshaping her duties to follow up on major audit findings in order to assess whether compliance was achieved. ➤ Use a team approach. Consider a team approach to reviewing compliance with major audit finding. These teams might be drawn from the hospitals. ➤ Document a plan. Draft a plan and procedures to implement better enforcement of compliance with audit findings. 	Section 4.12, p. 53	18.1 18.2 18.3
<p>19. Weak Administrative Processes: Incorrect Application of Benefit Rates</p> <ul style="list-style-type: none"> ➤ Document and train staff in benefit costing. Document processes and train hospital and all budget office staff on correct calculation and application of benefit rates. ➤ Plan a technical review of the budget. Conduct a technical analysis of the base budget in the spring of 2010 (see recommendations under “Hospital Deficit” below.) 	Section 4.13, p. 54	19.2 19.3

Recommendations	Reference	Item #
<p>20. Weak Administrative Processes: Reimbursement of County Beds through Fund 872</p> <ul style="list-style-type: none"> ➤ Correct under-budgeting. Increase annual reimbursable expenditure authority from Fund 872 to reflect actual expenses under the county contracts. ➤ Plan for use of fund balance. Develop a plan of use for the Fund 872 balance and submit that plan to Finance. 	Section 4.14, p. 55	20.1 20.2
<p>21. Weak Administrative Processes: Unused Balances in Fund 942 (Audit Exceptions)</p> <ul style="list-style-type: none"> ➤ Revolve excess fund balance. Justify retention or work with Finance to revert the balance. ➤ Document procedures related to the audit exceptions fund. Develop written procedures that ensure this type of transfer has justification and balances are reviewed periodically. 	Section 4.15, p. 55	21.1 21.2
<p>22. Weak Administrative Processes: Overtime Payments</p> <ul style="list-style-type: none"> ➤ Periodic payroll audits. Establish and enforce a policy for periodic payroll audits. ➤ Train hospitals in the correct audit procedure. ➤ Review compliance with the audit program. Headquarters should periodically assess whether hospitals are conducting required audits. 	Section 4.16 p. 56	22.1 22.2 22.3
<p>23. Weak Administrative Processes: Out-of-class Assignments</p> <ul style="list-style-type: none"> ➤ Verify procedures, audit use, do not suspend use casually. Ensure that proper guidelines are in place for out-of-class assignments, conduct periodic review to make sure assignments are made correctly, but do not suspend the hospitals' ability to make these assignments without carefully considering operational impacts. 	Section 4.17, p. 56	23
<p>24. Weak Administrative Processes: Recruitment</p> <ul style="list-style-type: none"> ➤ Resolve exam blockage. Pursue a possible compromise with the State Personnel Board that allows the department greater flexibility in dealing with the exam blockage, given overall funding constraints and the operational problems the hospitals are experiencing. ➤ Improve management of hiring freeze exemption process: <ul style="list-style-type: none"> • Allow hospitals to determine which of their positions need priority in the exemption request 	Section 4.18, p. 57	24.1 24.2a

Recommendations	Reference	Item #
<p>process.</p> <ul style="list-style-type: none"> • Ensure prompt processing of hiring freeze exemptions within the department. <p>➤ Reduce use of in-lieu personal service contracts where feasible</p> <ul style="list-style-type: none"> • Develop in-house registries wherever practical. • Examine telepsychiatry and telemedicine as an alternative to physician contract registries. • Consider internship and residency programs that require placement for a specified time period in remote hospital locations. 		<p>24.2b</p> <p>24.3a</p> <p>23.3b</p> <p>23.3c</p>
<p>25. Weak Administrative Processes: Contract Time Frames</p> <p>➤ Document processes and responsibilities: Ensure that procedures are fully documented and that roles and responsibilities are assigned in the hospitals and at headquarters.</p> <p>➤ Reduce contract processing times to three months. Reduce the number of times the contract needs to go through the review loop to once for most types of contracts.</p> <p>➤ Create a tracking system that allows hospitals to know where their contracts are in the review process. This same system would allow auditing of the three-month review timeframe.</p>	<p>Section 4.19, p. 60</p>	<p>25.1</p> <p>25.2/6.2</p> <p>25.3/6.9</p>
<p>26. Weak Administrative Processes: Contract delegation and signature levels</p> <p>➤ Place the PCO function with the business services manager.</p> <p>➤ Ensure that the hospitals have current policy and procedural references.</p> <p>➤ Delegate to the maximum extent practical, subject to periodic performance checks.</p>	<p>Section 4.20, p. 61</p>	<p>26.1/6.6</p> <p>26.2</p> <p>26.3</p>
<p>27. Weak Administrative Processes: Encumbering External Registry Contracts</p> <p>➤ Select one or more of several strategies to reduce or eliminate the need for over-encumbering external registry contracts:</p> <ul style="list-style-type: none"> • Reduce reliance on contracts by addressing underlying problems that make filling authorized positions difficult. • Reduce contracting timeframes so that the contract amendment process is workable. • Consider master contracting as described above. 	<p>Section 4.21, p. 62</p>	<p>27</p>

Recommendations	Reference	Item #
<p>28. Information Technology: Organizing Solutions</p> <ul style="list-style-type: none"> ➤ The department should organize solutions in the following categories: <ul style="list-style-type: none"> • Quick wins – no funding required • Longer term improvements – no funding required • Allocation of existing resources to highest priority efforts, including cost saving proposals. Recognize that redirecting existing resources will require the elimination of corresponding existing workload or providing additional temporary help until the savings is realized. • Identification of high priority efforts, including cost saving proposals that require additional funding 	Section 5, p. 84	28
<p>29. Information Technology: Organization</p> <ul style="list-style-type: none"> ➤ Comply with GC 11545; all IT resources are the responsibility of the CIO including telecom. ➤ Manage the IT organization as a single division but recognize the benefits of statewide location with IT staff co-located with the primary customer, the hospital staff. ➤ Standardize existing software. Leverage existing resources by standardizing existing software and selecting “best of breed” for each function. Share solution successes between the organizations. ➤ Regionalize IT to provide local leadership, support, synergy, and provide day to day IT operational services to the psychiatric programs. ➤ Reevaluate IT classifications statewide to ensure position duties are aligned with the position classification. ➤ Reevaluate workload and staffing in response to the demands of the hospitals; recognize 24/7 hospital operations in the evaluation 	Section 5, p. 84	29.1 29.2 29.3 29.4 29.5 29.6
<p>30. Information Technology: IT Budget</p> <ul style="list-style-type: none"> ➤ Budget development timeframes. The IT budget should be developed 18 to 24 months in advance of the budget year. ➤ Follow approval and funding cycles. IT project budgets must follow the project approval cycle and the Legislative funding cycle. ➤ Add necessary IT administrative staff. IT Administration should include an IT budget and IT project 	Section 5, p. 84	30.1 30.2 30.3

Recommendations	Reference	Item #
<p>budget expert.</p> <p>➤ Administer budget centrally. IT must track and manage its operating and project budgets centrally.</p>		30.4
<p>31. Information Technology: Planning</p> <p>➤ Support IT Governance Steering Committee. IT Administration should include staff to support the IT Governance Steering Committee and the Hospital Automation Committee; these two groups are responsible for IT planning activities.</p> <p>➤ Make planning a top priority. Planning must be a first priority for IT; the following must be developed as a plan of action to remediate the organization:</p> <ul style="list-style-type: none"> • Corrective Action Plan (short term) • Capital Plan (longer term) • Strategic Plan (long term) • IT Governance Charter (leadership and direction, service levels, service model, establish workload and project priorities, resolve and leverage relationship with CDCR) 	Section 5, p. 85	<p>31.1</p> <p>31.2</p> <p>31.2a</p> <p>31.2b</p> <p>31.2c</p> <p>31.2d</p>
<p>32. Information Technology: Project Management Office (PMO)</p> <p>➤ Develop a PMO to provide the following project support functions: Initiation and planning, Budget development and tracking, schedule creation and maintenance, project status reporting, project portfolio management</p>	Section 5, p. 85	32
<p>33. Information Technology: Communication</p> <p>➤ Establish IT governance (see #35 below).</p> <p>➤ Create IT library of documents on the intranet for IT Division and other interested department staff; library should include:</p> <ul style="list-style-type: none"> • IT policies and procedures • IT project information (project documents, schedule, status reports, etc.) • IT calendar of planning events • IT organization chart • Roles and responsibilities with a directory of staff 	Section 5, p. 85	<p>33.1/35.1</p> <p>33.2</p> <p>33.2a</p> <p>33.2b</p> <p>33.2c</p> <p>33.2d</p> <p>33.2e</p>

Recommendations	Reference	Item #
<ul style="list-style-type: none"> ➤ Conduct weekly IT managers meetings. ➤ Regular staff meetings. Require IT managers to have weekly staff meetings to keep all staff informed 		<p style="text-align: right;">33.3</p> <p style="text-align: right;">33.4</p>
<p>34. Information Technology: Procurement</p> <ul style="list-style-type: none"> ➤ Streamline the procurement process <ul style="list-style-type: none"> • Establish a central IT procurement unit with appropriate training and procedures; • Leverage procurement when savings can be achieved 	Section 5, p. 85	<p style="text-align: right;">34.1</p> <p style="text-align: right;">34.2</p>
<p>35. Information Technology: Policy, Process, and Procedures</p> <ul style="list-style-type: none"> ➤ Establish IT Governance; IT is a shared resource. Establish an IT governance steering committee composed of the Chief Information Officer, the Deputy Directors, and the Hospital Directors. The IT governance steering committee is responsible for: <ul style="list-style-type: none"> • Providing vision and leadership. • Prioritizing IT efforts using available resources. • IT business needs will exceed IT resources; the governance steering committee will either recommend delaying new efforts or support additional funding either through a budget change proposal, through savings created by automation or with redirection if an existing function can be discontinued. ➤ IT Managers Committee. Establish a committee of the IT managers (hospital automation committee) to: <ul style="list-style-type: none"> • Identify and standardize effective IT policies and processes to ensure: <ul style="list-style-type: none"> ▪ Compliance with statewide requirements ▪ Efficient and transparent operations ▪ Avoid bottlenecks and no-value-added functions. • Leverage IT resources to avoid duplication of effort. • Provide customer service and service agreements. • Provide concept analysis on proposed projects for presentation to Governance Steering Committee. 	Section 5, p. 86	<p style="text-align: right;">35.1/33.1</p> <p style="text-align: right;">35.2</p> <p style="text-align: right;">35.2a</p> <p style="text-align: right;">35.2b</p> <p style="text-align: right;">35.2c</p> <p style="text-align: right;">35/2d</p>

Recommendations	Reference	Item #
<p>36. Application Systems Support and Stabilization</p> <ul style="list-style-type: none"> ➤ Develop documentation for systems in production now. ➤ Develop a plan that stabilizes the existing clinical application systems, improves performance and work with customers to identify areas of functionality that could be streamlined. ➤ Ensure that the existing staff are trained or fill with qualified staff that maintain the 14 statewide systems. ➤ Develop a current and executable disaster recovery plan for the existing clinical applications. ➤ Identify an application architect to develop software development standards including coding, documentation, and development processes. 	Section 5, p. 86	36.1 36.2 36.3 36.4 36.5
<p>37. Information Technology: Infrastructure</p> <ul style="list-style-type: none"> ➤ Develop enterprise architecture. Identify an enterprise architect to develop DMH enterprise architecture. ➤ Follow statewide enterprise architecture standards. ➤ Operations and service requests. Adopt a standard methodology for operations and service requests such as IT Infrastructure Library. ➤ Develop a schedule to replace aging infrastructure. ➤ Strategies for system reliability and availability. Recognize the need for 99.9% reliability and system availability and develop a strategy that will meet that need at a reduced risk. ➤ Standardize systems and applications and centrally host them at a Tier 3 data center once the communication reliability is resolved. (Tier 3 data center provides the conditions for 99.982% availability and reliability by providing plant and system infrastructure features such as dual-power sources, cooling, ventilation, redundant independent distribution paths, physical security, and more.) 	Section 5, p. 86	37.1 37.2 37.3 37.4 37.5 37.6
<p>38. Information Technology: Security</p> <ul style="list-style-type: none"> ➤ Plan and resource a security program and infrastructure. Develop a multi-year plan to resource and implement a security program and security infrastructure. 	Section 5, p. 87	38
<p>39. Information Technology: Disaster Recovery</p> <ul style="list-style-type: none"> ➤ Corrective plan for disaster recovery. The IT division must review the disaster recovery report 	Section 5, p. 87	39.1

Recommendations	Reference	Item #
<p>critique provided by the Technology Agency and develop a corrective action plan.</p> <ul style="list-style-type: none"> ➤ Develop a disaster recovery infrastructure. ➤ Periodic disaster recovery testing. Schedule periodic disaster recovering testing (drills) to ensure recovery procedures are in place and staff is trained. 		<p>39.2</p> <p>39.3</p>
<p>40. Information Technology: Asset Management</p> <ul style="list-style-type: none"> ➤ Select asset management tools. Examine asset management tools used by other agencies; determine which tool may be used or shared by the department. ➤ Dedicate staff to asset management maintenance. 	Section 5, p. 87	<p>40.1</p> <p>40.2</p>
<p>41. Information Technology: Staffing Workload</p> <ul style="list-style-type: none"> ➤ Complete a workload study for existing services; workload for IT must be determined based on the type of work and the rate of changes required (i.e. changes to software or to equipment). ➤ Fund new work correctly. All new products and services must be properly resourced going forward. 	Section 5, p. 87	<p>41.1</p> <p>41.2</p>
<p>42. Information Technology: Succession Planning</p> <ul style="list-style-type: none"> ➤ Individual development plans. Require managers to provide individual development plans for staff. ➤ Fund training. Provide for a reasonable training complement for staff that reflects their duties. ➤ Train in state policy and procedures. Provide all IT staff relevant training in state policies and administrative processes; ➤ Rotate staff to provide cross training. 	Section 5, p. 87	<p>42.1</p> <p>42.2</p> <p>42.3</p> <p>42.4</p>
<p>43. Information Technology: Recommended Projects</p> <ul style="list-style-type: none"> ➤ The following projects were proposed for safety and efficiency by both program and IT managers interviewed: <ul style="list-style-type: none"> • Electronic medical records (federal mandate to be implemented by FY 2014-15) • Standard reports (and reporting) department wide • Ability to measure program outcomes 	Section 5, p. 87	<p>43.1</p> <p>43.2</p> <p>43.3</p>

Recommendations	Reference	Item #
<ul style="list-style-type: none"> • Scheduling tool for staffing hospital shifts • IT tools for patient treatment (schools and cognitive disorders) • Computer training rooms for employee training of internal applications • Develop billing system to recover funds from public and private medical insurance. • Repair infrastructure and security for system reliability and integrity. • Implement Voice over Internet protocol (VOIP) for communication between hospitals; pilot at Napa SH was successful. Telecommunication costs will only be reduced if communication between hospitals is via VOIP. • Develop personal duress alarm system for employee safety at all campus; prioritize campuses with the highest risk. • Replace metal keys with electronic keys to reduce lock-downs, overtime, and locksmith costs. 		<p>43.4</p> <p>43.5</p> <p>43.6</p> <p>43.7</p> <p>43.8</p> <p>43.9</p> <p>43.10</p> <p>43.11</p>
<p>44. Medical and Other Patient Care Issues: Deputy Director Structure</p> <p>➤ Establish a clinical deputy director at headquarters who is a forensic psychiatrist. Provide the program direction, oversight, and teamwork environment that the medical staff has reported it needs.</p>	<p>Section 6, p. 122</p>	<p>44.1/1.4</p>
<p>45. Medical and Other Patient Care Issues: Cost Consciousness</p> <p>➤ Medical cost consciousness is needed. Promote the management position that cost-consciousness is necessary for the medical community. State hospitals, just as private hospitals, have a bottom line for the budget.</p>	<p>Section 6, p. 122</p>	<p>45</p>
<p>46. Medical and Other Patient Care Issues: Enhancement Plan</p> <p>➤ Reassess the Enhancement Plan with the intent of refocusing on 1) more physician interaction with patients in lieu of paperwork involvement and 2) the forensic mission.</p>	<p>Section 6, p. 122</p>	<p>46</p>
<p>47. Medical and Other Patient Care Issues: Pharmacy and Physical Health Program Assessments</p> <p>➤ Assess pharmacy and physical health programs for robustness. Recognize that the patient population is increasingly at risk medically, and evaluate the physical health and pharmacy programs for robustness. Consider more staffing in general, more on-staff specialties, and more on-site clinics.</p>	<p>Section 6, p. 122</p>	<p>47</p>

Recommendations	Reference	Item #
<p>48. Medical and Other Patient Care Issues: Pharmacy Cost Containment Objectives</p> <ul style="list-style-type: none"> ➤ Establish pharmacy cost containment objectives. <ul style="list-style-type: none"> ● Preserve the savings that will materialize as proprietary drugs go generic. ● Ensure the use of generics whenever clinically appropriate. ● Improve review processes: <ul style="list-style-type: none"> ○ For non-formulary drugs ensure that the review process is robust, performed by qualified clinicians, and data is collected on rates of denial/approval. The non-formulary review process should be uniform across facilities. ○ For formulary drugs, consider implementing the preauthorization review process under development by senior medical staff for selected expensive formulary medications or high liability formulary medications. ● Use committee platforms effectively for the statewide pharmacy program. The current contract language makes it difficult for departments to choose to use generics over proprietary drugs. Strong committee participation is needed to change this situation. 	Section 6, p. 122	<p>47.1</p> <p>47.2</p> <p>47.3</p> <p>47.3a</p> <p>47.3b</p> <p>47.4</p>
<p>49. Medical and Other Patient Care Issues: Contracted Health Care Provider Network</p> <ul style="list-style-type: none"> ➤ Consider a contracted health care provider network for outside medical services (like Health Net provides for CDCR) to enhance access to services, reduce contracting workload, and potentially have access to utilization management for outside medical services. 	Section 6, p. 122	
<p>50. Medical and Other Patient Care Issues: Statewide Contracting for Medical Support</p> <ul style="list-style-type: none"> ➤ Use statewide contracting more often to reduce workload and improve contract rates. This could be done as a stand-alone contract or be bundled with a larger healthcare network provider contract. Laboratory services, x-ray imaging and contract registries are reasonable places to start, but hospitals should be included in the planning process. 	Section 6, p. 123	50/6.11
<p>51. Medical and Other Patient Care Issues: Conflict of Interest</p> <ul style="list-style-type: none"> ➤ Policy revisions to address conflict of interest. Ensure that vendor contact with physicians has neither the substance nor the appearance of conflict of interest. The team recommends an overall review of the conflict of interest policies for the medical staff. 	Section 6, p. 123	51

Recommendations	Reference	Item #
<p>52. Medical and Other Patient Care Issues: Electronic Health Records.</p> <ul style="list-style-type: none"> ➤ Develop electronic health records to help medical staff manage patient care and to serve as input to a cost management system. Electronic health records should also save medical staff time. 	Section 6, p. 123	52
<p>53. Medical and Other Patient Care Issues: Manuals</p> <ul style="list-style-type: none"> ➤ Automate manual. Explore the option of an automated manual in place of multiple special orders; some special orders are outdated and need review. 	Section 6, p. 123	53
<p>54. Medical and Other Patient Care Issues: Medicare Billings</p> <ul style="list-style-type: none"> ➤ Re-establish a medical billing unit. Request resources for a replacement Medicare and private insurance billing unit, offsetting that cost either through revenue collection or through the scheduling of reimbursements. ➤ Create incentives to reduce physician billing errors. To create the incentive needed to curb physician errors in billing claims, schedule some portion of the recovery either against the current hospital budget, or set up an incentive-based fund (such as for medical equipment) that can be accessed only when cost recovery exceeds anticipated General Fund revenue from billings. 	Section 6, p. 123	54.1 54.2
<p>55. Medical and Other Patient Care Issues: Data Analysis for Cost Control</p> <ul style="list-style-type: none"> ➤ Plan medical cost containment data needs. Identify the key data needed to evaluate and control costs trends in patient care. Develop methods to identify medical costs by patient commitment type, level of care, age, and chronic condition. Plan for IT system and account system changes to meet at least that minimum information threshold. 	Section 6, p. 123	55
<p>56. The Hospital Deficit, Short-Term Recommendations: Plan for Managing the Deficit Situation</p> <ul style="list-style-type: none"> ➤ Recognize that it might not be possible to avert a deficiency in the current year through savings alone. Plan appropriately for a deficiency situation. Section 4 of this report (#11) suggests ways to improve the department’s deficit management. 	Section 7, p. 141	56

Recommendations	Reference	Item #
<p>57. The Hospital Deficit, Short-Term Recommendations: Technical Review of the Budget</p> <p>➤ Since the team did not conduct a technical review of the budget, it recommends that the department do so to ensure that technical budgeting processes are sound and do not contribute to the deficit.</p>	Section 7, p. 141	57
<p>58. The Hospital Deficit, Short-Term Recommendations: Assess Managers' Fiscal Performance</p> <p>➤ Periodically assess the department's management team on fiscal performance. For hospitals, establish review criteria, such as cost per patient. Hold managers accountable.</p>	Section 7, p. 142	58
<p>59. The Hospital Deficit, Short-Term Recommendations: Transparency Principles</p> <p>➤ Adopt transparency principals with other stakeholders who will be influenced by the department's budget situation.</p> <ul style="list-style-type: none"> • Keep employees apprised of the budget and cash situation and whether it might affect them. • Prepare a vendor payment plan in cooperation with the hospitals, including methods to advise the vendor community of status. 	Section 7, p. 142	59
<p>60. The Hospital Deficit, Long-Term Recommendations: Organizational Issues</p> <p>➤ Improve organizational issues that impair fiscal control following the recommendations set out in Section 3. Key among these are 1) to put in place a deputy director structure that will provide the leadership for recommended changes, and 2) strengthen the budget offices at headquarters and in the hospitals.</p>	Section 7, p. 142	See above.
<p>61. The Hospital Deficit, Long-Term Recommendations: Process Issues</p> <p>➤ Improve process issues that impair fiscal control following the recommendations set out in Section 4. A key process goal is the establishment of base budgets at both the hospitals and headquarters.</p>	Section 7, p. 142	See above
<p>62. The Hospital Deficit, Long-Term Recommendations: Medical Cost Consciousness</p> <p>➤ Improve medical cost consciousness as recommended in Section 6.</p>	Section 7, p. 142	See above.

Recommendations	Reference	Item #
<p>63. The Hospital Deficit, Long-Term Recommendations: Enhancement Plan</p> <ul style="list-style-type: none"> ➤ Simplify and refocus the Enhancement Plan both for savings and for better attention on the forensic mission and clinician/patient interaction, as noted in Section 6. 	Section 7, p. 142	See above.
<p>64. The Hospital Deficit, Long-Term Recommendations: Reliable Data for Cost Control</p> <ul style="list-style-type: none"> ➤ IT needed to support cost control. Modernize the data management environment in the department so that change—including issues of fiscal control—can be based on reliable data. See Section 5. 	Section 7, p. 142	See above.
<p>65. Other Issues: Headquarters' Category Over-expenditures</p> <ul style="list-style-type: none"> ➤ Reporting of problems by the fiscal division: New division leadership must instill in the accounting and budget offices a strong ethic for appropriate fiscal management, including the reporting of problems for correct resolution. ➤ Executive offices role in supporting reporting of problems. The executive office needs to encourage the reporting of problems and error throughout the department. 	Section 8, p. 144	65.1/3.2/4.1 65.2
<p>66. Other Issues: Strategic and Business Planning</p> <ul style="list-style-type: none"> ➤ Mission outputs for the strategic plan, mission inputs for the business plan. Update the strategic plan and consider developing a business plan that focuses on mission inputs. ➤ Give the plans the right focus. Ensure that the department's primary challenges are the focus of the plans. Consider reassigning some of the current objectives in the strategic plan to an action plan. ➤ Communicate through the plans. Use the strategic and business plans as primary sources of communication with not only the mental health community, but also with patient families, the Administrations, the Legislature, the DMH workforce, and other stakeholders such as the department's provider and vendor network. Make sure the plans are jargon-free and readable for the average citizen. 	Section 8, p. 148	66.1 66.2 66.3

Recommendations	Reference	Item #
<p>67: Other Issues: Metropolitan State Hospital's (SH) Future</p> <p>➤ Address Metropolitan SH's underutilization. Consider these possibilities:</p> <ul style="list-style-type: none"> ● Metropolitan SH as single SNF site. Explore the option of using Metropolitan SH as the single DMH SNF site providing services for individuals who qualify for SNF services. (See the report for the hospital's proposal.) ● Metropolitan SH as the telemedicine hub. Explore the possibility of creating a telemedicine hub at Metropolitan SH. ● Metropolitan SH as a recruitment base. Consider expanding programs at the hospital that might assist with recruitment at other state hospitals. 	<p>Section 8, p. 149</p>	<p>67.1 67.2 67.3 67.4</p>
<p>68. Other Issues: Special Repairs</p> <p>➤ Conduct a facilities needs assessment.</p>	<p>Section 8, p. 150</p>	<p>68</p>

Appendix 2.A

DEPARTMENT OF MENTAL HEALTH

As of 06/01/11

DMH HQ TOTAL	
Total Positions:	512
MHSA Funded Positions:	147
Vacant Positions:	96

Office of External Affairs
Vacant
(Kincaid)

Office of Multicultural Services
Vacant
(Guerrero)

California Mental Health Planning Council
Ann Arneill-Py

DIRECTOR
(Acting)
Cliff Allenby¹⁸
Chief Deputy Director
(Acting)
Kathy Gaither

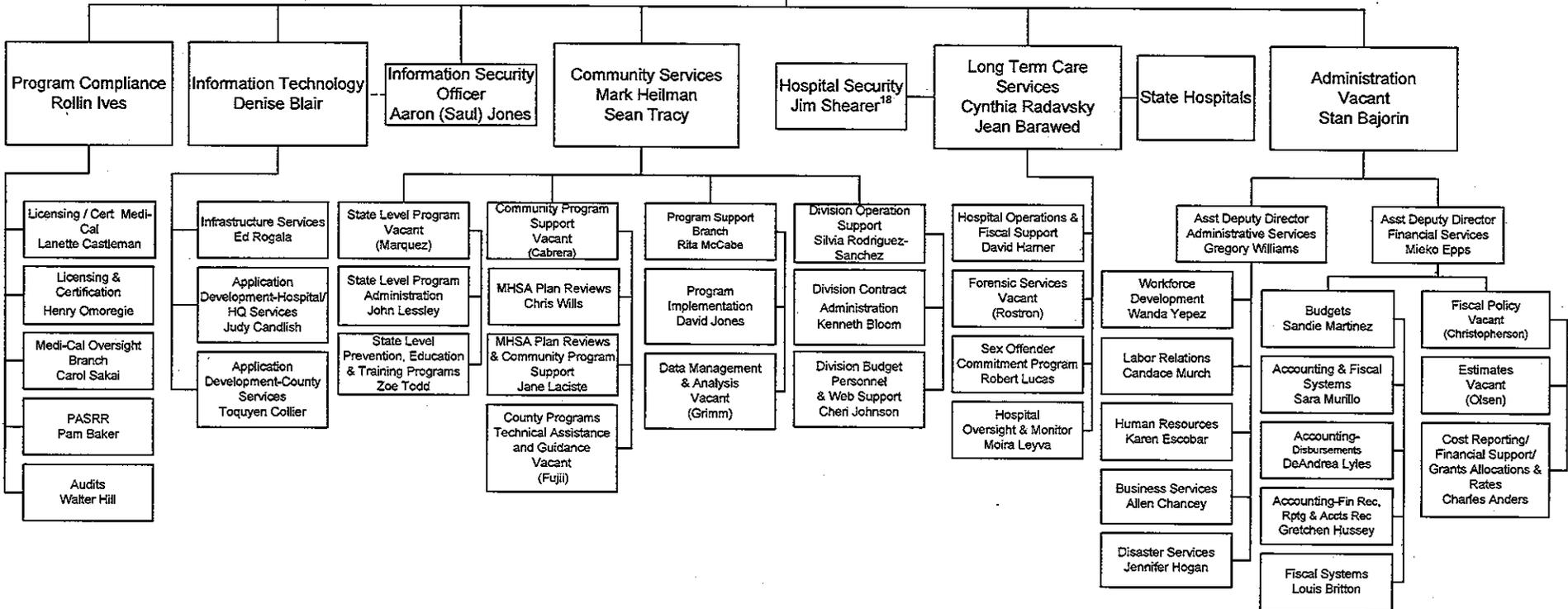
Legal Services
Cynthia Rodriguez

Legislation
Carolyn Baker

Office of Human Rights
Glenna Wheeler

Internal Audits
Valley Walker

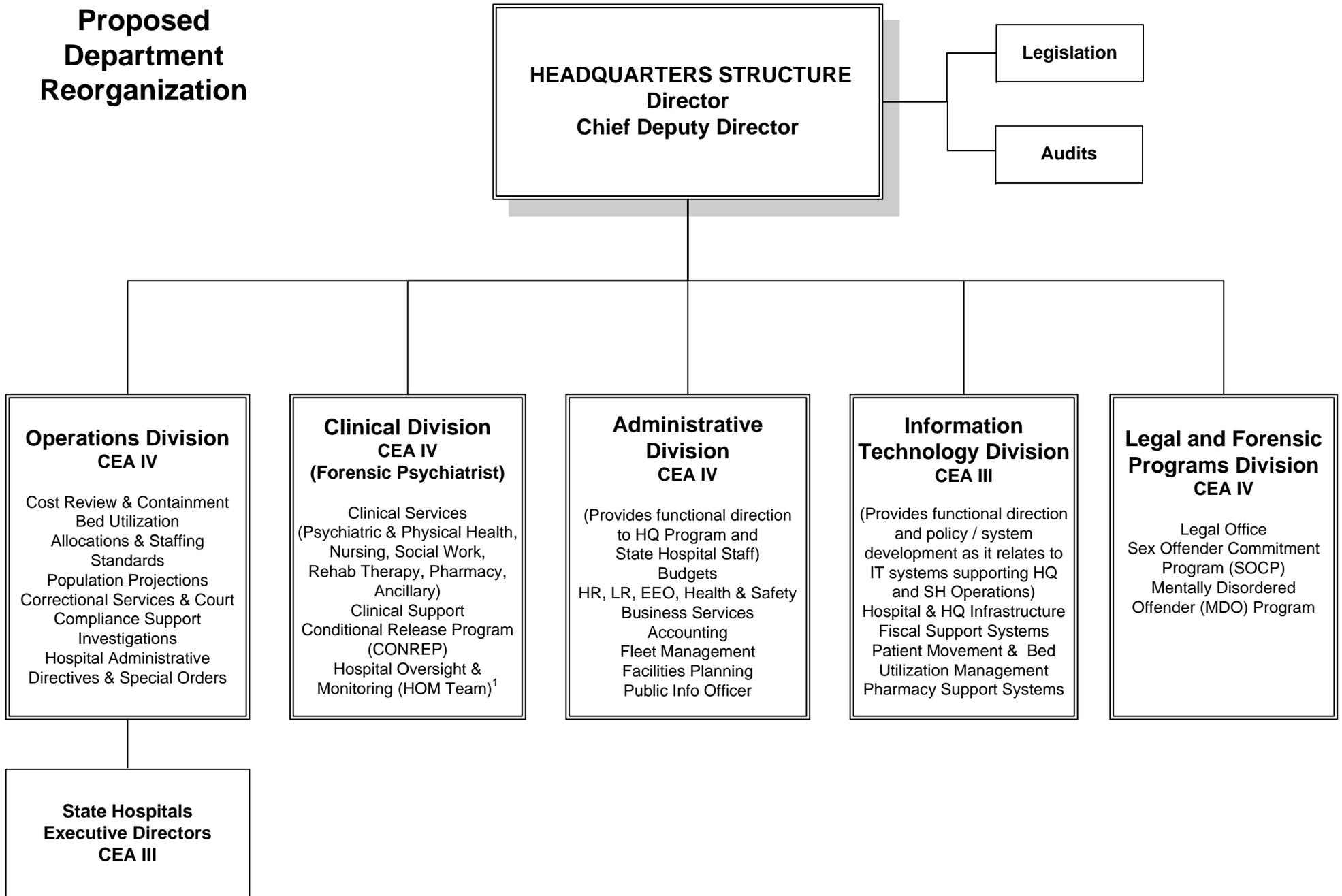
Strategic Management
J.P. Fish



¹⁸ Retired annuitant

**DRAFT
Proposed
Department
Reorganization**

Appendix 2.B



¹ Includes most functions performed by HOM team, including oversight and monitoring of clinical/treatment services, risk management and incident management. Operational functions currently performed by HOM such as administration of special orders and hospital directives will be under the Operations Division.

Appendix 3.A: State Hospital and LTCS Loaned/Redirected Positions As of July 15, 2011

	Loaned From	Loaned To	Original Position #	Original Class	Current Reclass #	Current Class	Mid Range Yearly Salary	
1.0	ASH	HOM	455-500-8329-001	Associate MH Spec	455-500-8329-001	Associate MH Specialist	58,488	
1.0	ASH	?	455-500-8558-003	Supv Spec Invest	461-800-8548-001		73,032	
			455-518-1312-007;				102,960	
1.0	ASH	HQ	455-541-4707-001		455-518-5795-001	Staff Counsel III		
1.0	ASH	HQ	455-050-1139-004		455-050-1139-001	Off Tech		
							35,700	
								Sub-Total
								270,180
1.0	CSH	HOM	437-603-7609-003	Sr. Psychiatrist Supv	437-603-7609-001	Sr. Psychologist (Sup)	250,866	
1.0	CSH	HOM	437-702-8253-095	Psych Tech		Medical Record Consultant	60,750	
1.0	CSH	Legal	437-427-7659-008	Pharmacist I	437-500-5795-002	Staff Counsel III	102,960	
1.0	CSH	Legal	437-427-7659-007	Pharmacist I	437-500-5778-001	Staff Counsel	75,012	
1.0	CSH	HOFS	437-341-9699-010	Health Services Spec	437-543-5393-801	Associate Personnel Analyst	58,488	
1.0	CSH	HOFS	437-500-6749-001	Chief of Plant Ops III	437-500-3961-001	Sr. Architect	107,952	
1.0	CSH	Personnel	437-341-9699-019	Health Services Spec	437-543-5157-800	Staff Services Analyst	43,578	
1.0	CSH	HQ	437-xxx-8325-xxx	Staff MH Specialist (position to be located and		reclassified to SMHS)	64,242	
1.0	CSH	HQ	437-500-1247-005		437-500-1728-001	Executive Assistant	43,704	
1.0	CSH	HQ	437-518-1470-701		437-518-1579-001	Associate Prog Analyst	63,096	
								Sub-Total
								870,648
1.0	MSH	HOM	487-230-5758-001	Office Tech	487-230-5758-001	RPS II	70,560	
1.0	MSH	HOM	487-231-8101-002	Psych Tech	487-231-8101-002	Nursing Coordinator	73,092	
			487-230-1148-803;				67,236	
1.0	MSH	HQ	487-230-1148-806		487-230-4800-001	SSM I		
								Sub-Total
								210,888
1.0	NSH	HOM	480-012-8236-062	Psych Tech Asst	480-201-8316-001	Rehab Therapist	41,676	
1.0	NSH	HOM	480-500-7594-001	Medical Director	480-500-7594-001	Psychiatrist (Medical Director)	265,524	
1.0	NSH	HOM	480-548-2193-002	Food Service Tech II	480-548-5731-001	RA II	61,410	
1.0	NSH	WaRMSS			480-518-1337-002	Sr. ISA (Spec.)	76,080	
1.0	NSH	WaRMSS			480-518-1337-003	Sr. ISA (Spec.)	76,080	
1.0	NSH	CSSU	??	??		Program Director (safety)	86,814	
1.0	NSH	HQ	480-518-1312-005		480-518-5778-001	Staff Counsel	75,012	
1.0	NSH	HQ	480-541-4549-001		480-541-4549-001	Accountg Admin I Sup	67,236	
1.0	NSH	HQ	480-521-5157-701		480-521-5304-001	Assoc Admin Analyst (A/S)	61,410	
								Sub-Total
								811,242
1.0	PSH	HOM	502-062-8236-007	Psych Tech Asst	502-201-9831-025	Sr. Psychologist (Sup)	107,820	
1.0	PSH	HQ	502-541-5157-702		502-541-5157-701	SSA	43,578	
1.0	PSH	HQ	502-544-5393-001		502-544-5393-001	Assoc Bud Analyst	58,488	
1.0	PSH	HOM	502-548-2194-009	Food Svc Tech I	502-500-4800-002	SSM I	67,236	
								Sub-Total
								277,122
1.0	SVPP	HQ				Accounting Officer	51,066	
								Sub-Total
								51,066

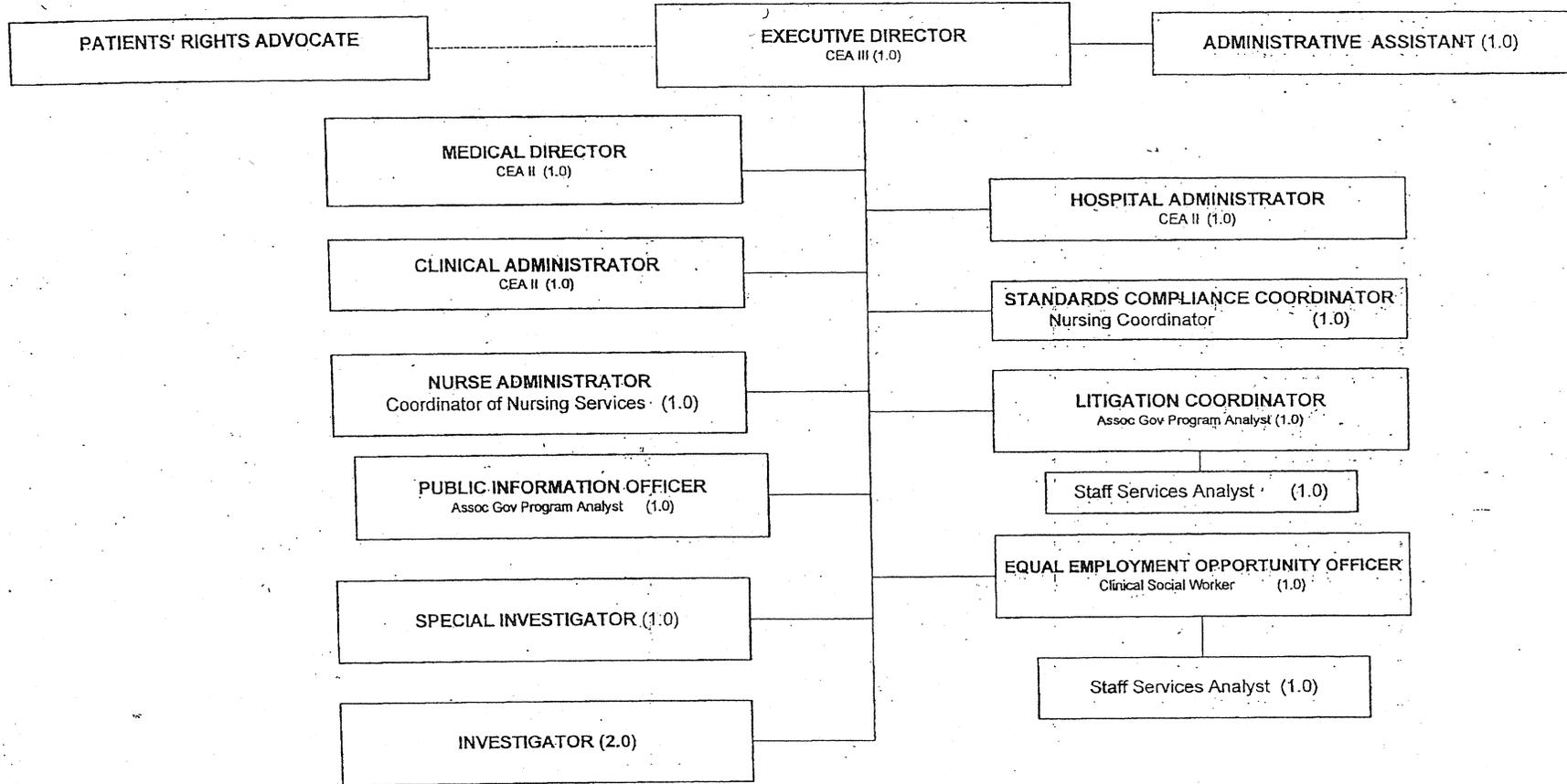
\$2,491,146

\$3,363,047

Appendix 3.B: State Hospital and Psychiatric Programs
Executive Offices and Fiscal Branches

DEPARTMENT OF MENTAL HEALTH
ATASCADERO STATE HOSPITAL

EXECUTIVE OFFICE



TOTAL POSITIONS: 15
01/20/2011

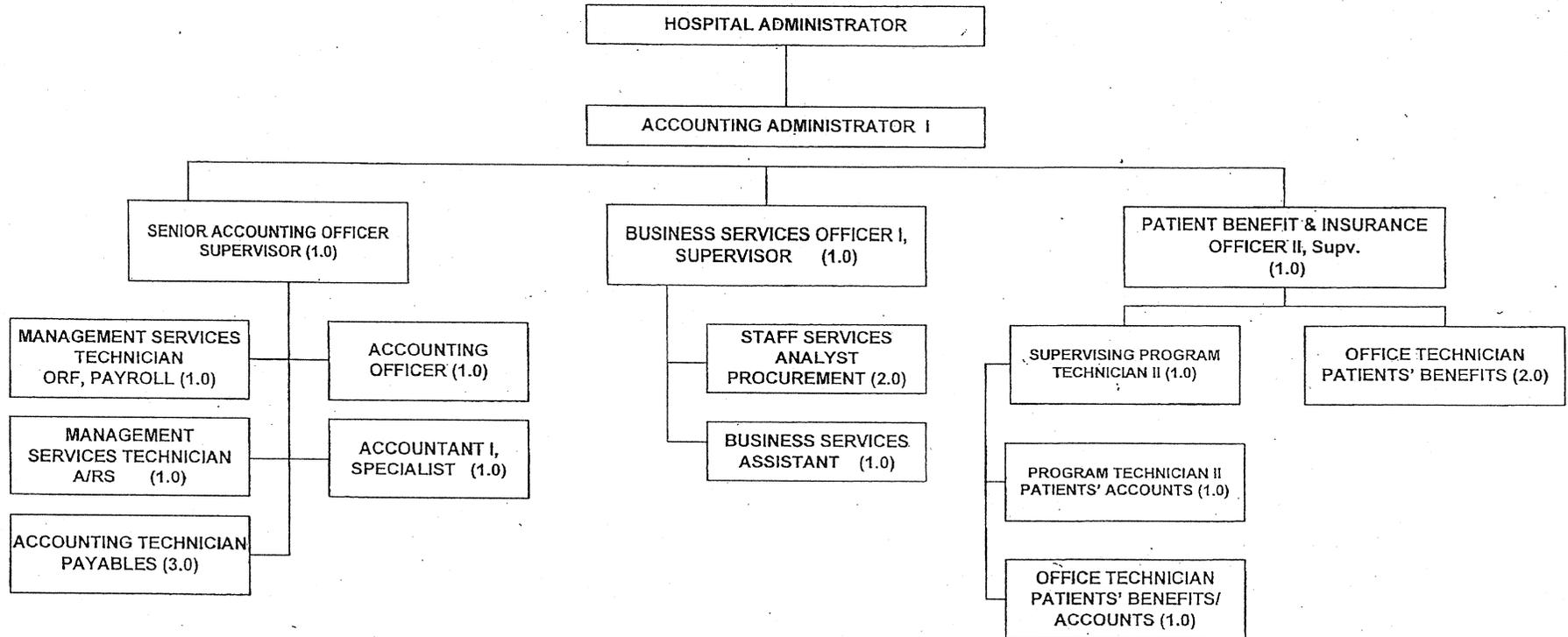
Jon De Morales
Jon De Morales
Executive Director

Date

4/25/2011

DEPARTMENT OF MENTAL HEALTH
ATASCADERO STATE HOSPITAL

FISCAL SYSTEMS



TOTAL POSITIONS: 18

Robert Hushing-Kline 6/24/10
 Robert Hushing-Kline Date
 Accounting Administrator I

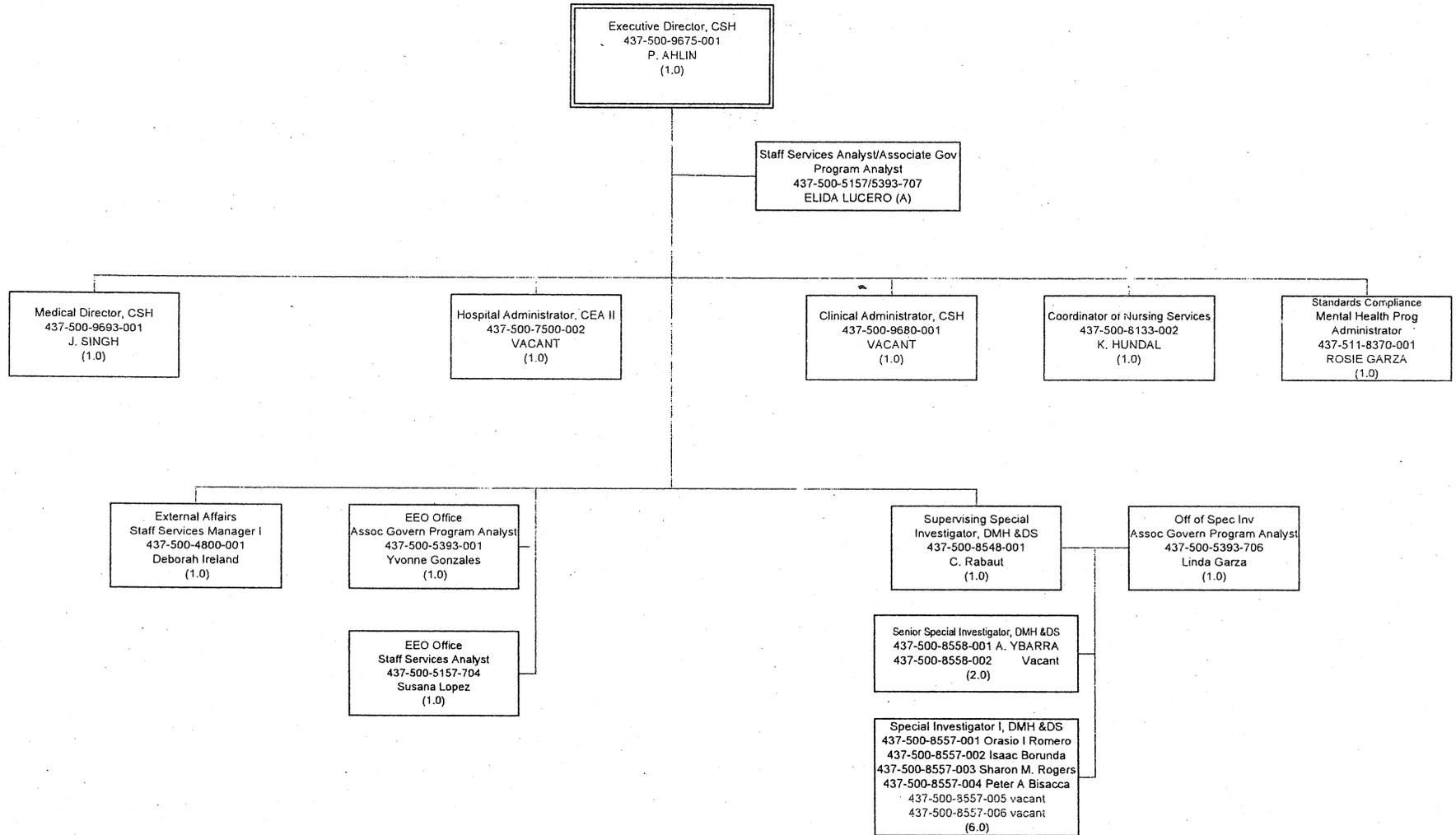
Linda S. Persons 06/24/2010
 Linda S. Persons Date
 Hospital Administrator

Org Chart #1

Approved

DEPARTMENT OF MENTAL HEALTH COALINGA STATE HOSPITAL

EXECUTIVE OFFICE



Pam Ahlin
Executive Director, CSH

DATE

DEPARTMENT OF MENTAL HEALTH
COALINGA STATE HOSPITAL
ADMINISTRATIVE SERVICES DEPARTMENT

Org Chart #14

CURRENT

FISCAL SERVICES

Hospital Administrator, CEA II
437-500-7500-002
Vacant
(1.0)

Staff Services Manager II
437-541-4801-001
Gary Martinez
(1.0)

Office Technician (T)
437-541-1139/1379-801
Stephanie Trujillo
(1.0)

ACCOUNTING SERVICES

TRUST SERVICES

PROCUREMENT SERVICES

Accounting Officer (Specialist)
437-541-4546-001
Elena Misch
(1.0)

Accounting Officer (Specialist)
437-541-4546-002
Clement Osunde
(1.0)

Accountant I (Specialist)
437-541-4177-001
Lennie Bantay
(1.0)

Accountant I (Specialist)
437-541-4177-002
Vacant
(1.0)

Accounting Administrator I (Sup)
437-541-4549-001
Susan Davey
(1.0)

Senior Accounting Officer (Sup)
Claims/Paymt
437-541-4569-001
Vacant
(1.0)

Accounting Officer (Sup)
437-541-4563-001
Carol Russ
(1.0)

Office Assistant (CASHIER)
437-541-1379-001
Donna Ball
(1.0)

Accountant I (Specialist) (1.0)
437-541-4177-003 Barbara Moyle

Accounting Technician (2.0)
437-541-1741-008 Kassim Migadde
437-541-1741-005 Lisa Reckas

Patient Benefit & Ins Officer II (Sup)
437-544-8660-001
Yvonne Beuster
(1.0)

Office Technician (T)
437-544-1139/1379-801
Alysha Sanchez
(1.0)

Patient Benefit & Ins Officer I
437-544-8662-002
Debra Phillips
(1.0)

Patient Benefit & Ins Officer I
437-544-8662-001
Vacant
(1.0)

Accounting Technician
437-544-1741-001 Melissa Del Rosario
437-544-1741-002 Vacant
437-544-1741-003 Deborah Jacinto
(3.0)

Staff Services Manager I
437-541-4800-001
Elizabeth Moreno
(1.0)

Associate Governmental Program Analyst
437-545-5393-702
Elizabeth Stevenson
(1.0)

Staff Service Analyst (G)
437-545-5157-001 Jasmine Giddrick
437-545-5157-701 John Pacheco
(2.0)

Office Technician (T)
437-545-1139-801
Behind
Jacqueline Radebaugh
(1.0)

GARY MARTINEZ
Staff Services Manager II

DATE

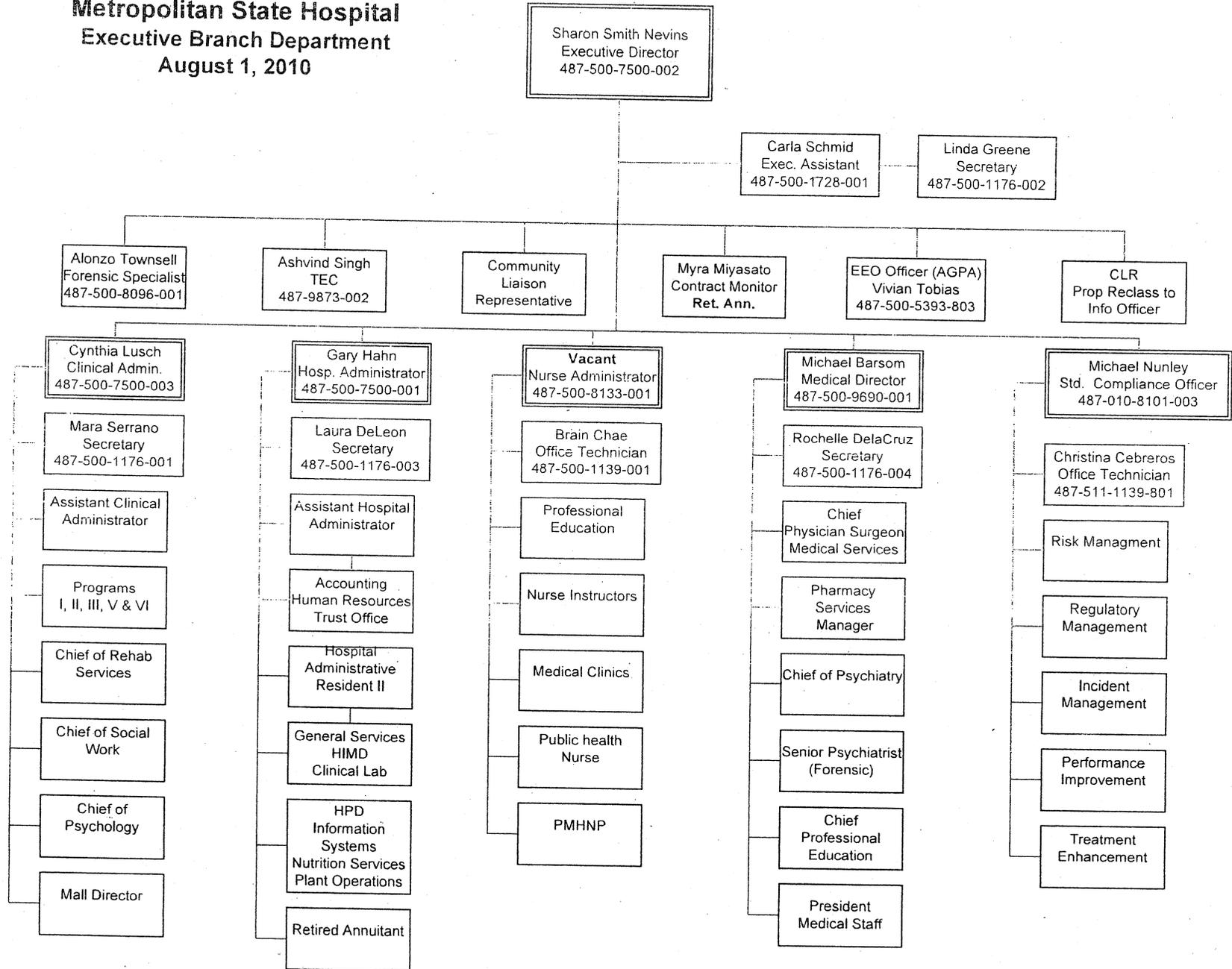
Rev. June 10, 2010

Total Positions 25.0

VACANT
Hospital Administrator

DATE

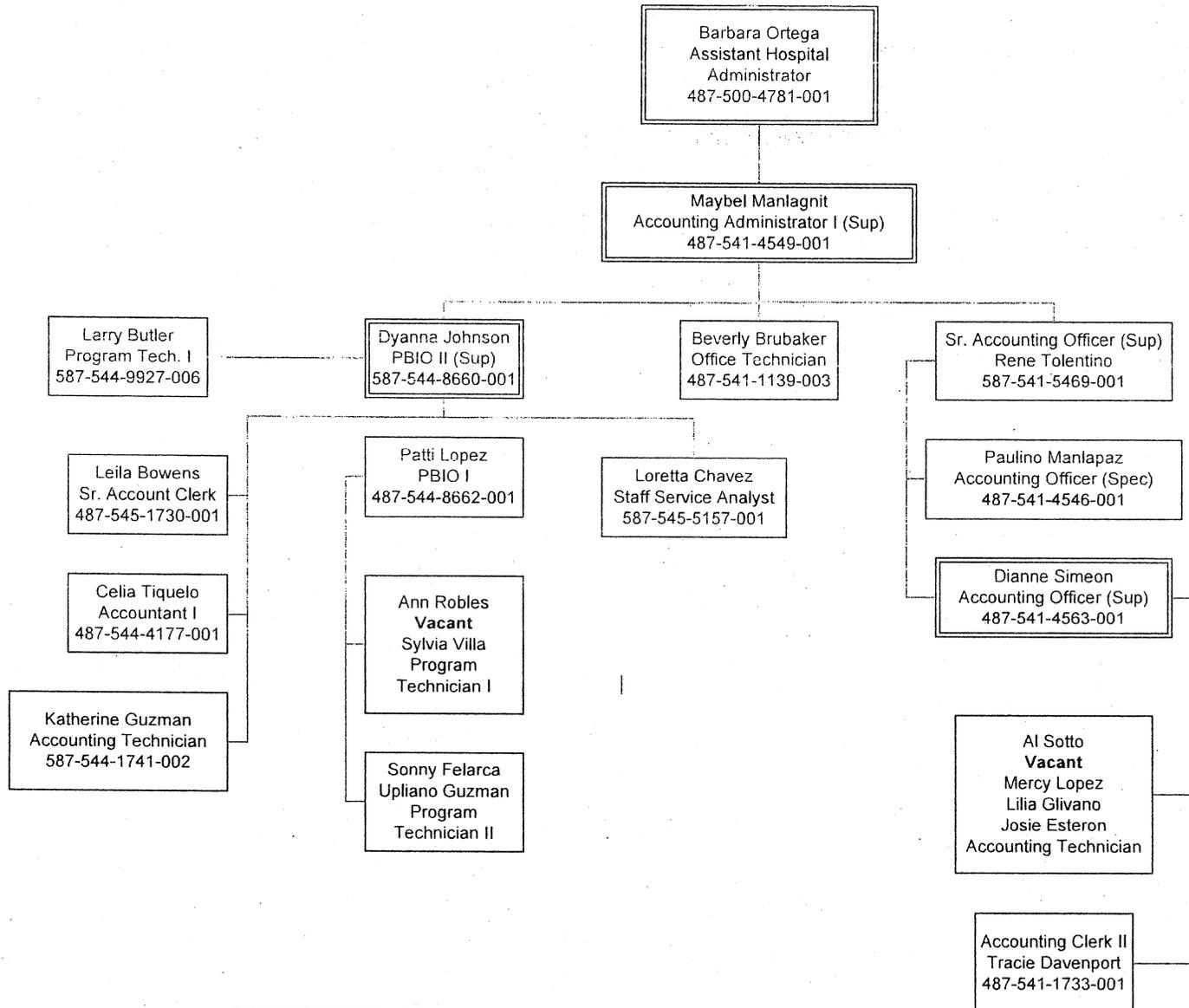
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Executive Branch Department
August 1, 2010



Metropolitan State Hospital

Accounting Department

August 1, 2010

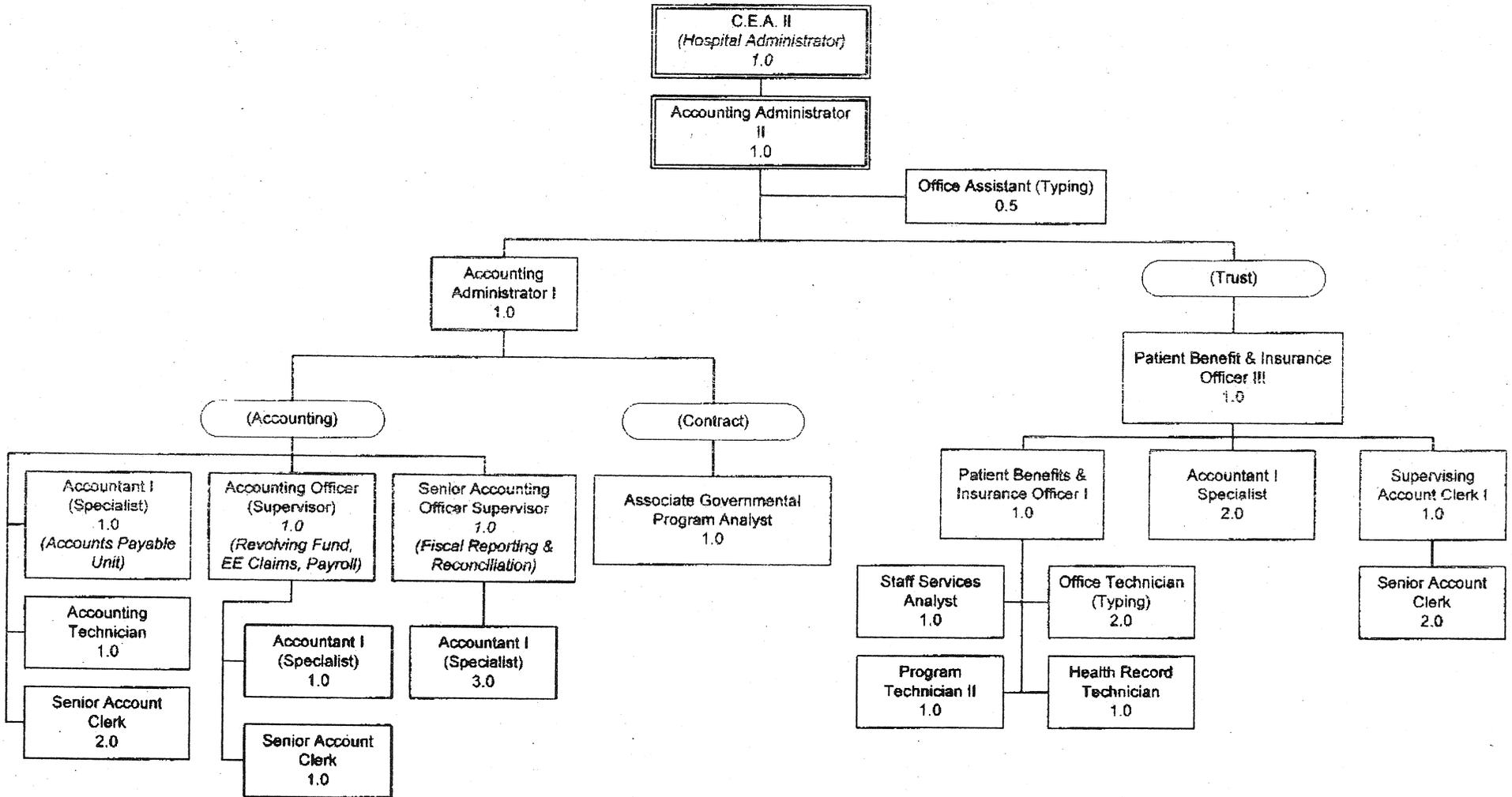


Maybel Manlagnit, Accounting Administrator I (Sup) Date

DEPARTMENT OF MENTAL HEALTH

NAPA STATE HOSPITAL

FINANCIAL SERVICES DEPARTMENT



VACANT
Accounting Administrator #71


MICHAEL W. MCQUEENEY
 Acting Hospital Administrator

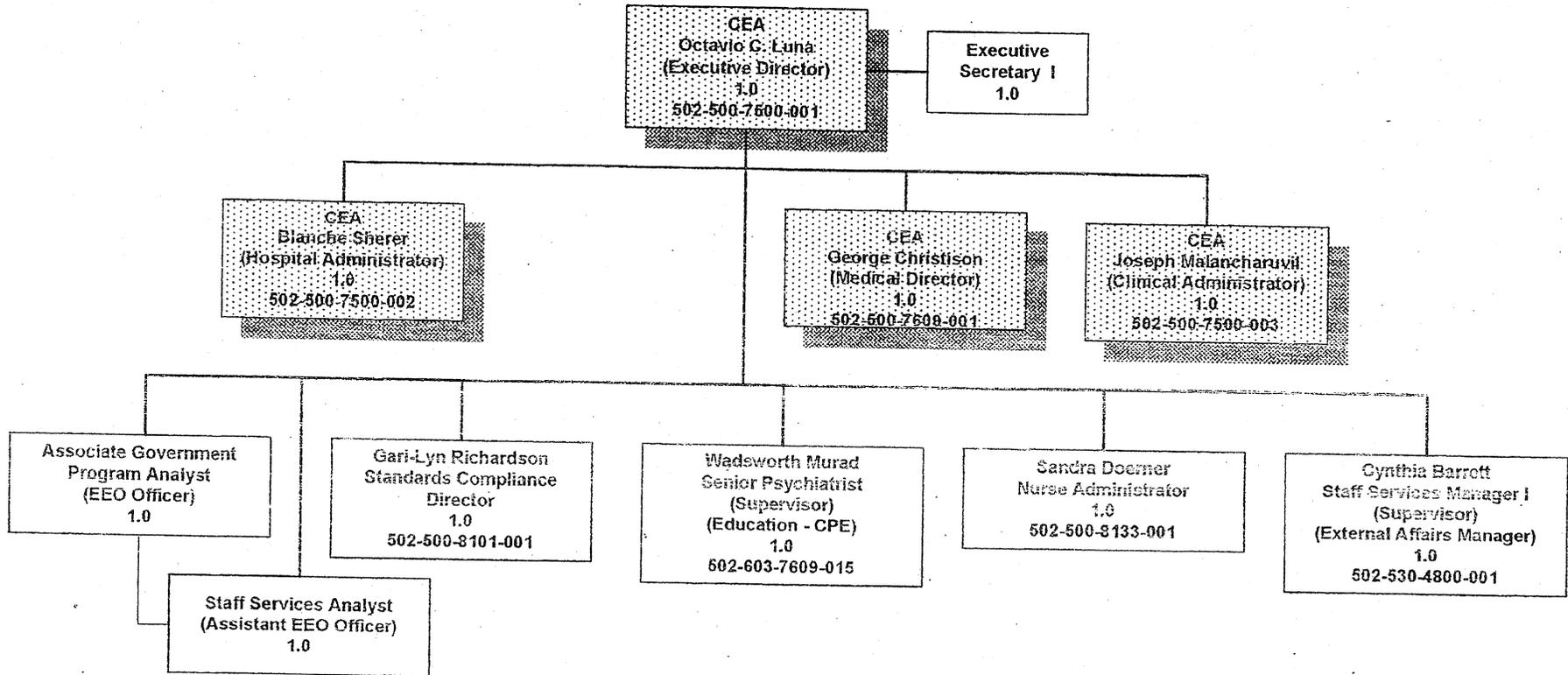
Legend:

CEA Career Executive Assignment
EEO Equal Employment Opportunity

PATTON STATE HOSPITAL

2010 / 2011

EXECUTIVE DIRECTOR



Octavio C. Luna
Executive Director

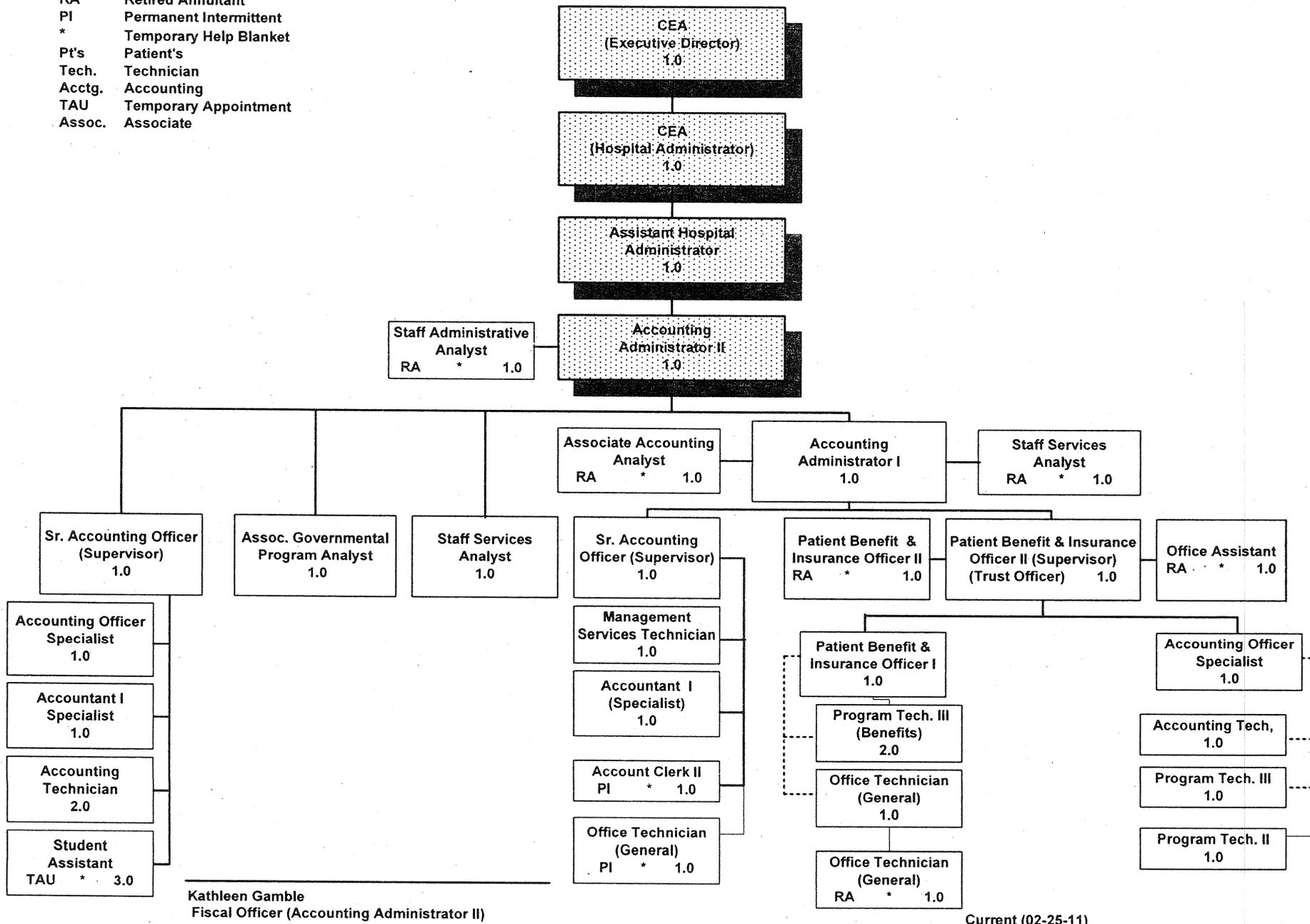
New, 10/02/10

PATTON STATE HOSPITAL

2010 / 2011 ACCOUNTING

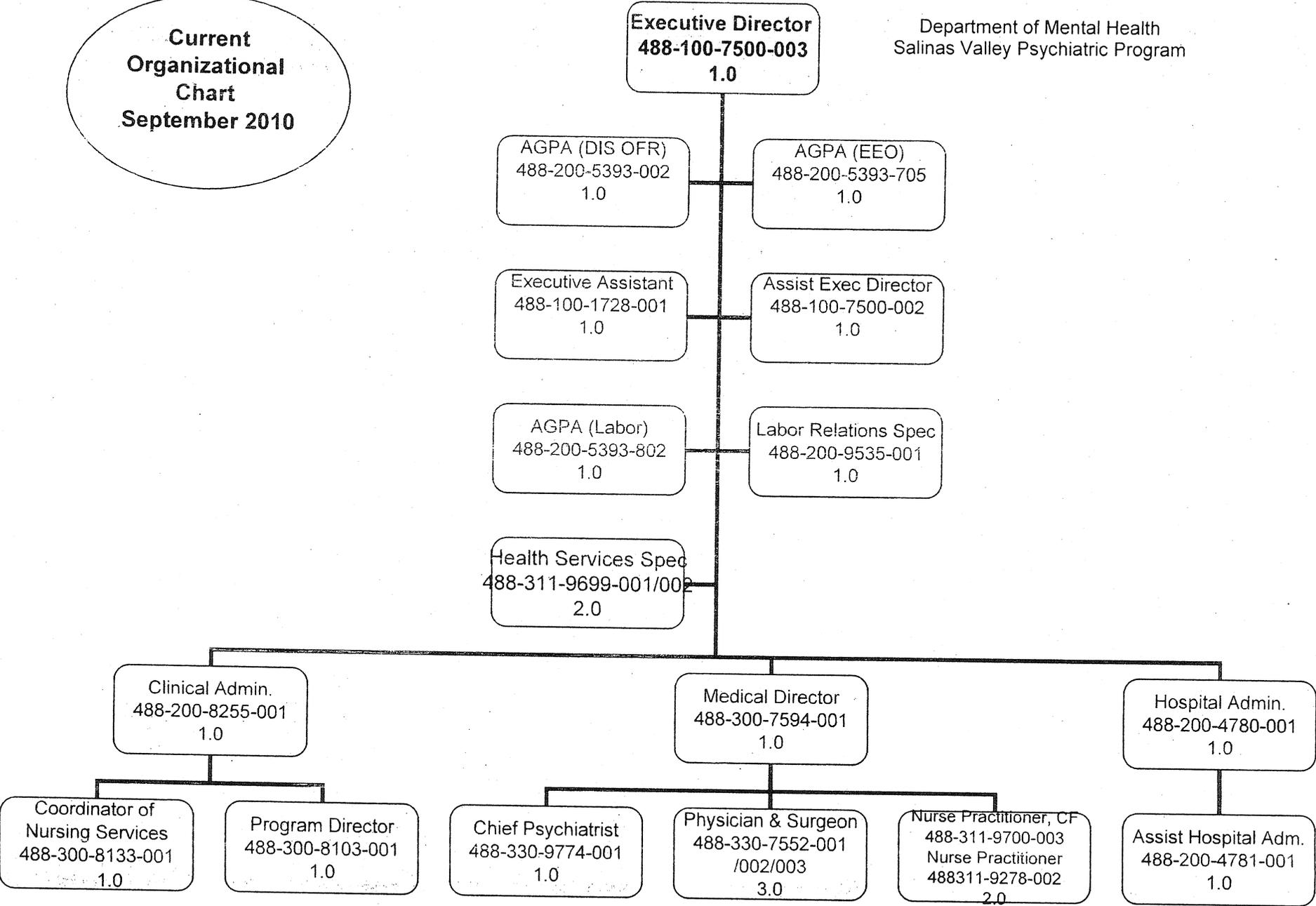
Legend

- CEA Career Executive Assignment
- SR Senior
- RA Retired Annuitant
- PI Permanent Intermittent
- * Temporary Help Blanket
- Pt's Patient's
- Tech. Technician
- Acctg. Accounting
- TAU Temporary Appointment
- Assoc. Associate

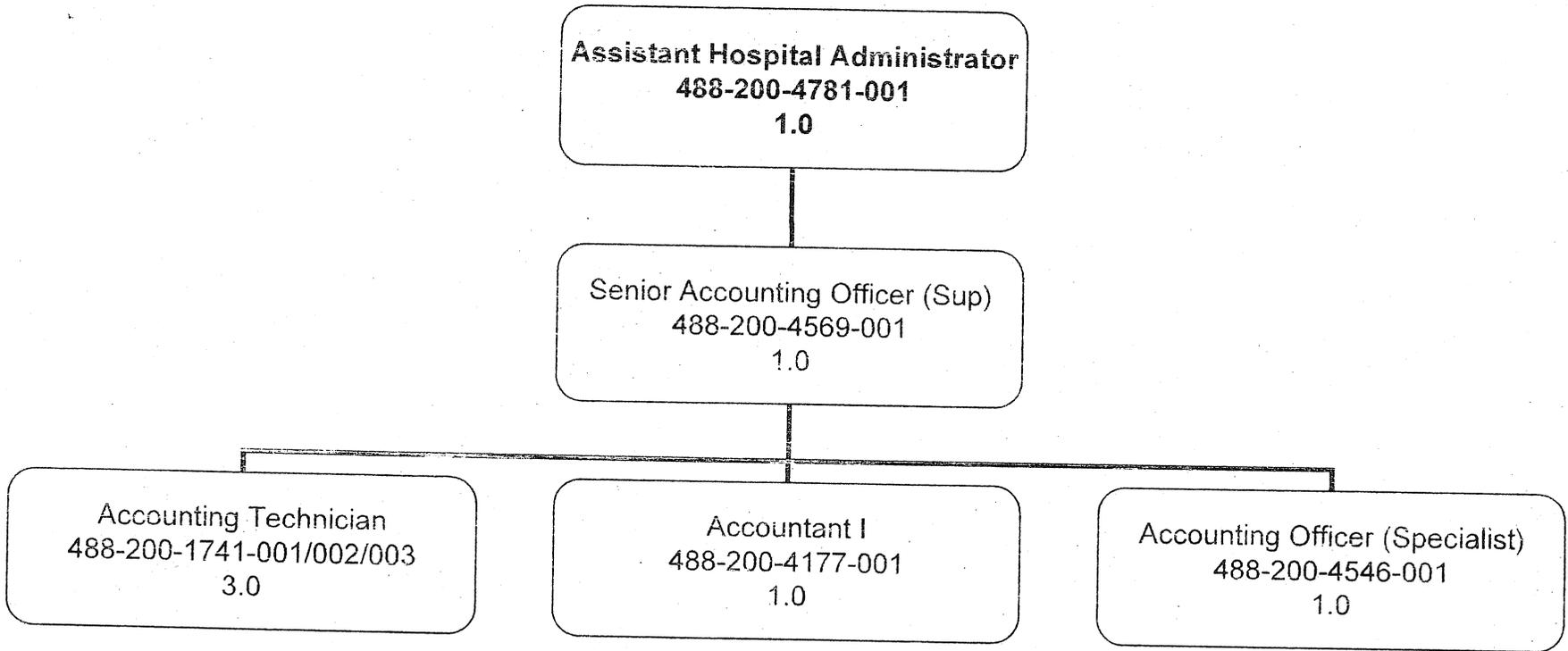


**Current
Organizational
Chart
September 2010**

Department of Mental Health
Salinas Valley Psychiatric Program

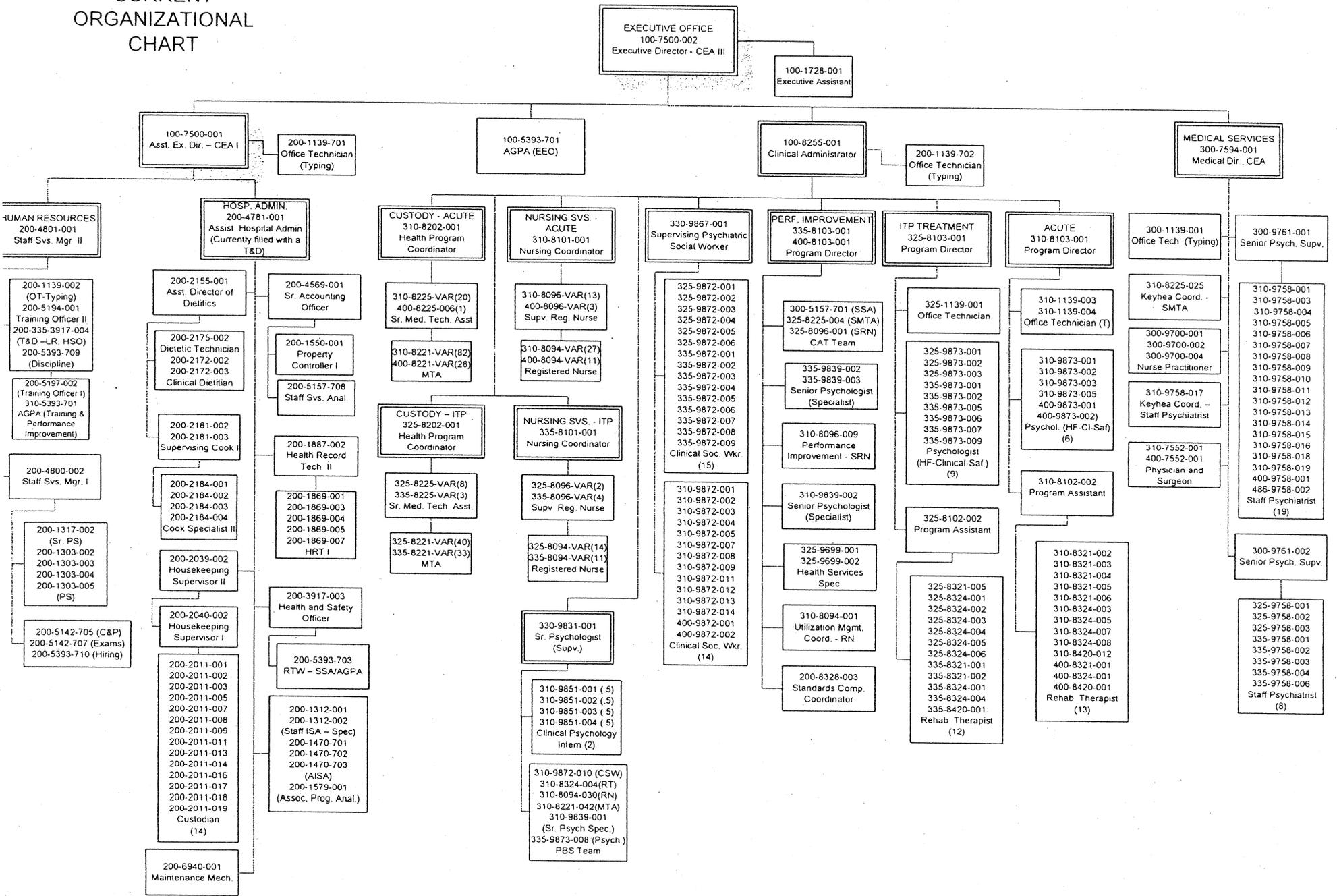


**Current
Organizational
Chart
September 2010**



DEPARTMENT OF MENTAL HEALTH
 VACAVILLE PSYCHIATRIC PROGRAM (AGENCY 486)

CURRENT
 ORGANIZATIONAL
 CHART



AN INTERNAL CONTROL REVIEW

California Department of Mental Health

Prepared By:
Office of State Audits and Evaluations
Department of Finance

084450016

December 2007

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EXECUTIVE SUMMARY

The Department of Finance, Office of State Audits and Evaluations (Finance), was requested to review and determine the adequacy of the California Department of Mental Health's (DMH) design and operation of internal accounting and administrative controls. This report meets DMH's requirement to comply with the reporting provisions of the Financial Integrity and State Manager's Accountability Act of 1983, Government Code Section 13400, et. seq.

Our review includes DMH headquarters as well as the five state hospitals and two acute psychiatric programs (hospitals) administered by DMH. Finance identified areas where controls are not in place or working as intended. Overall, we determined the controls to be weak.

HEADQUARTERS ISSUES

Fiscal Integrity At Risk

Our review identified weak budgetary controls, lack of communication and coordination, and weak fiscal oversight among units.

The following budgetary controls are lacking or weak: organizational and programmatic budgets; a cost allocation plan; a review and approval process of the hospitals' budgets; written procedures over the hospitals' budget development process; and hospital operating expense and equipment budget projections and allocations.

Communication and coordination among administrative, program, and hospital units need improvement. For example, standardized policies and procedures for the hospitals' administrative and fiscal operations have not been issued, hampering the hospitals' ability to operate efficiently and comply with state and DMH management directives.

Due to weak fiscal oversight, DMH has not effectively or timely prevented or detected budgeting and accounting errors which have resulted in lost opportunities to fund critical needs.

To ensure a high degree of fiscal integrity, DMH needs to institute organizational and programmatic budgets, proper accounting structures and allocation methods, document and communicate fiscal processes and control activities, and monitor mechanisms at all levels within the department.

Inadequate Cash Flow Management

Significant control weaknesses in the accounts receivable function negatively impact cash flow and DMH's ability to meet its obligations as they become due. Control deficiencies include: lack of knowledgeable staff; lack of policies and procedures for billing, collecting, and writing-off receivables; inadequate cost recovery techniques; lack of review and reconciliations; and lack of collection efforts. At June 30, 2007, receivable balances totaling \$156.7 million remained outstanding for over 120 days. DMH should provide proper training to staff, and develop policies and procedures to ensure timely billing, collecting, and writing-off of receivables.

Other Headquarters issues

The Information Security Officer (ISO) does not report directly to the DMH Director. The lack of direct access prevents the ISO from discharging its authority, and fulfilling its responsibilities effectively. Specifically, the ISO has not certified the Information Technology (IT) Risk Management Plan, designed an adequate Operational Recovery Plan, classified sensitive data, and adequately controlled computer access and programming rights. To ensure the effectiveness of the ISO, DMH should revise the reporting structure of the ISO to provide direct access to the DMH Director.

System development and IT project management procedures are outdated. DMH's IT project management does not meet the state minimum requirements for planning, tracking, risk management, and communication. DMH should develop and communicate IT policies and procedures, and adhere to the minimum requirements to ensure successful projects.

HOSPITAL ISSUES

Inadequate Personnel Practices

Personnel practices at the hospitals do not provide assurance that attendance records are correct and accurate, and that payroll is proper, especially regarding overtime. Hospitals are highly susceptible to payroll fraud and abuse. DMH should institute adequate timekeeping procedures, including overtime pre-approvals and random audits.

Acquisition Controls Need Improvement

Contract executions are not timely, contract language provisions are vague, and state contracting procedures are circumvented. DMH needs to strengthen acquisition controls to ensure the legality of acquisitions and that the best interest of DMH is served.

Ineffective Accounting and Oversight of Accounts Receivable

Accounts receivable are not correctly recorded, costs are not always recovered, billings are late, and collection efforts are weak. As of June 30, 2007, receivables totaling \$763,874 may be uncollectible. DMH should strengthen accounting and oversight of accounts receivable to ensure the timely collection of amounts due.

Other Hospital Issues

Other control weaknesses identified at the hospitals include: inadequate safeguarding of assets, incomplete or outdated employee housing rental agreements, weak controls over accounting and trust, and financial statement preparation need improvement.

Finance met with DMH management and staff to discuss opportunities for enhancements to activities designed to achieve DMH's mission and goals. This report is intended to assist DMH management in focusing attention on strengthening internal controls, preventing and mitigating risks, and improving operations. To strength controls, DMH should develop a plan to address the observations and recommendations noted in this report.

BACKGROUND, OBJECTIVES, SCOPE AND METHODOLOGY

Background

The California Department of Mental Health (DMH) leads the state's mental health system, ensuring the availability and accessibility of effective, efficient, and culturally competent mental health services. To administer its programs, DMH has oversight of a \$5 billion budget. DMH has experienced tremendous growth in both its Community Services (CS) and Long-Term Care Services programs (LTCS). This growth has been driven primarily by new laws, regulations, and regulatory agency reviews, and has proved to be a challenge to the administrative infrastructure, directly impacting DMH's ability to efficiently manage its programs. In recent years, the programs have experienced deficiencies and have become the subject of multiple reviews by both state and other regulatory agencies.

Community Services Program

The CS program coordinates delivery of mental health treatment and support services. It also sets overall policy for the delivery of mental health services statewide; develops and oversees performance contracts with county mental health departments; monitors compliance with state and federal statutes; and administers various state-funded programs and projects. Funding assists counties in providing a broad array of mental health treatment and rehabilitative services in a local setting that promotes recovery and integration into the community for patients with mental illness and children and youth with serious emotional disturbance. The CS program has experienced growth due to the Early and Periodic Screening Diagnosis and Treatment program and the Proposition 63 Mental Health Initiative.

Long-Term Care Services Program

The LTCS program administers the California state hospital system which includes five state hospitals (state hospitals) and two acute psychiatric programs. For purposes of this report, the term hospitals is used when referring to the five state hospitals and two acute psychiatric programs. The acronyms below are used when referring to each individual entity:

- Atascadero State Hospital (ASH)
- Coalinga State Hospital (CSH)
- Metropolitan State Hospital (MSH)
- Napa State Hospital (NSH)
- Patton State Hospital (PSH)
- Salinas Valley Psychiatric Program at Salinas Valley State Prison (SVPP)
- California Medical Facility in Vacaville (VPP)

Forensic patients are generally committed by the courts to hospitals under one of four categories: incompetent to stand trial, mentally disordered offender, not guilty by reason of insanity, and sexually violent predator (SVP). Some patients of the California Department of Corrections and Rehabilitation (CDCR) receive care on the prison grounds while others are transferred to the state hospitals for mental health treatment. Counties also contract with the state hospitals to purchase beds for adults and children committed for mental health treatment under the Lanterman-Petris-Short Act (LPS).

About 90 percent of occupied beds are for forensic patients and 10 percent are purchased by the counties for patients committed under the LPS. The cost of care for forensic patients is supported by the state's General Fund. The LTCS program faces major challenges including the Civil Rights Institutionalized Person's Act Consent Order, the Proposition 83 Initiative (Jessica's law), and two lawsuits—*Ralph Coleman, et al., vs. Arnold Schwarzenegger et al.*, and *Marciano Plata et al., vs. Arnold Schwarzenegger, et al.*—which ordered salary increases for CDCR staff triggering a mass exodus of DMH staff.

Objectives and Scope

The Legislature enacted the Financial Integrity and State Manager's Accountability Act of 1983 (FISMA), Government Code Section 13400, et. seq. which charged each state agency with the responsibility of maintaining effective systems of internal accounting and administrative program control as an integral part of its management practices. The Legislature also mandated that the systems of internal accounting and administrative program control be evaluated on an ongoing basis.

To assist DMH in complying with the reporting provisions of FISMA, the Department of Finance, Office of State Audits and Evaluations (Finance), performed this internal control review at headquarters, the five hospitals, and the two acute psychiatric programs. Our objectives were to determine whether:

- Assets are safeguarded from unauthorized use or disposition.
- Financial transactions are executed in accordance with management's authorizations and recorded properly to permit the preparation of reliable financial statements.
- Financial operations are conducted in accordance with State Administrative Manual guidelines.
- Information technology security and risk management controls are functioning as prescribed.

This review did not include an assessment of the efficiency or effectiveness of DMH's program operations, or the accomplishment of program goals and objectives. In addition, this review did not include an assessment of the efficiency or effectiveness of information technology project management as this responsibility lies with DMH; the Health and Human Services Agency; and the Department of Finance, Office of Technology Review, Oversight, and Security.

Methodology

An understanding of DMH's environment, including mission-critical program objectives and business functions, was gained and was followed by a risk assessment to discover where the greatest vulnerabilities lie. Our risk assessment included a review of industry-specific risk factors; prior audit findings reported by Finance, the Bureau of State Audits, and the Department of General Services; court orders; interviews with executive and key staff; and identification of accounting and administrative controls critical to DMH's mission. Based on that information, our strategy was to (1) identify any mitigating controls or lack thereof, (2) evaluate whether mitigating controls are functioning as intended, and (3) identify and recommend controls that need to be in place to mitigate risks.

In order to document current fiscal processes, we observed operations, reviewed policies and procedures, and conducted interviews with DMH headquarters and hospital staff, including management and consultants. To test controls, we inspected, on a sample basis, accounting and personnel records, and contract files. Organization charts, laws, regulations, and internal policies and procedures were also reviewed.

During the course of our review, we identified best practices at the hospitals (Appendix III). However, this compilation of best practices was not tested or evaluated and is provided for informational purposes only. Additional analysis is required to validate the effectiveness and efficiency of these practices.

Our recommendations were developed based on the State Administrative Manual, State Contracting Manual, State Information Management Manual, best business practices, and DMH's policies and directives. For reference, criteria used to develop our issues are cited in Appendix I. This review was conducted during the period July 2007 through December 2007.

Appendix 4.B: Cash Flow Form

Hospital System Summary 2011-12 Operating Expenditure Cash Projections

Object Code	BUDGET CATEGORIES / LINE ITEMS	FY	July Actual	August Actual	Sept Projection	October Projection	November Projection	December Projection	January Projection	February Projection	March Projection	April Projection	May Projection	June Projection	FM 13 Projection & OEE Deferral	Total Operating Expenditures
	BEGINNING CASH		1,167,600,000	1,098,247,431	1,001,996,911	896,909,117	789,267,143	685,776,065	591,337,625	496,347,661	404,173,953	312,364,357	221,260,020	130,035,660	28,394,784	(97,884,795)
	PERSONAL SERVICES															
003	Salaries & Wages	11/12	48,270,047	54,730,302	55,799,606	55,783,892	58,413,737	58,688,220	59,498,951	59,490,079	58,992,263	59,228,828	59,140,875	59,563,317	13,915,475	701,515,591
	salary adjustment BU agreement									(2,500,000)	(2,500,000)	(2,500,000)	(2,500,000)		(10,000,000)	
033	Temp Help	11/12	525,003	1,664,563	1,788,400	1,790,994	1,804,155	1,778,893	1,759,879	1,730,739	1,767,472	1,771,393	1,714,632	1,711,530	926,402	20,734,055
083	Overtime	11/12	1,266,011	9,979,774	9,526,928	9,527,074	10,483,992	9,831,788	10,059,432	9,733,575	9,549,033	9,703,187	10,282,747	10,057,866	7,969,817	117,971,225
	FY 11/12 Subtotal - Salaries	11/12	50,061,062	66,374,639	67,114,933	67,101,960	70,701,884	70,298,901	71,318,261	68,454,392	67,808,768	68,203,409	68,638,254	71,332,713	22,811,694	830,220,871
	FY 11/12 Staff Benefits	11/12	18,367,087	21,245,461	22,882,241	24,019,704	24,173,524	23,675,806	23,405,020	23,647,174	23,591,931	23,747,822	23,543,229	23,817,226	5,583,090	281,699,315
	FY 11/12 Subtotal Personal Services	11/12	68,428,148	87,620,100	89,997,175	91,121,664	94,875,409	93,974,707	94,723,281	92,101,566	91,400,699	91,951,230	92,181,483	95,149,939	28,394,784	1,111,920,186
	OPERATING EXPENSES & EQUIPMENT															
413	C&PS-External-Hlth & Med.	11/12	166,470	995,307	3,842,264	5,154,538	4,104,180	3,973,147	3,942,662	3,823,613	3,833,386	3,141,477	3,430,739	3,542,677	7,643,733	47,594,192
	deferral							(2,000,000)	(2,000,000)	(2,000,000)	(2,000,000)	(2,000,000)	(2,000,000)	(2,000,000)	14,000,000	0
326	C&PS-External	11/12	27,620	148,296	1,543,776	1,550,226	1,558,776	1,543,776	1,562,738	1,543,776	1,558,776	1,543,776	1,543,776	19,713,415	831,433	34,670,158
	deferral							(500,000)	(500,000)	(500,000)	(500,000)	(500,000)	(1,000,000)	(10,000,000)	13,500,000	0
506	Foodstuffs	11/12	123,719	1,306,589	1,199,868	1,298,933	1,261,933	1,370,293	1,233,418	1,310,591	1,368,617	1,139,404	1,223,312	1,128,697	732,371	14,697,745
516	Chemicals, Drugs & Lab Supplies	11/12	63,151	872,389	457,346	534,820	540,985	479,446	514,948	551,470	597,259	458,849	520,677	455,052	216,623	6,263,014
516 01	Pharmaceuticals	11/12	2,785,757	2,967,161	4,371,608	3,602,620	3,625,427	3,638,029	3,511,464	3,449,474	3,662,344	3,476,799	3,635,004	3,332,000	1,637,796	43,695,483
	deferral							(1,000,000)	(1,000,000)	(1,000,000)	(1,000,000)	(1,000,000)	(1,000,000)	(1,000,000)	7,000,000	0
VARIOUS	Other	11/12	798,692	4,883,830	6,217,166	10,587,248	4,924,444	7,025,452	6,501,529	5,493,294	8,388,591	6,292,876	5,389,445	6,519,170	10,036,867	83,058,604
	deferral							(6,566,335)	(6,000,000)	(5,000,000)	(8,000,000)	(6,000,000)	(5,000,000)	(6,500,000)	43,066,335	0
	FY 11/12 Critical OE&E for CF Purposes		3,965,409	11,173,572	17,632,028	22,728,385	16,015,745	7,963,808	7,766,759	7,672,217	7,908,972	6,553,181	6,742,953	15,191,011	98,665,157	229,979,196
	FY 11/12 TOTAL ALL OE&E from original		3,965,409	11,173,572	17,632,028	22,728,385	16,015,745	18,030,143	17,266,759	16,172,217	19,408,972	16,053,181	15,742,953	34,691,011	21,098,822	229,979,196
	FY 11/12 Total PS & OE&E		72,393,557	98,793,672	107,629,202	113,850,049	110,891,154	101,938,515	102,490,040	99,773,783	99,309,671	98,504,412	98,924,436	110,340,951	127,059,941	1,341,899,381
	Add: Reimbursements		3,040,988	2,543,152	2,541,409	2,541,409	3,733,409	3,833,409	3,833,409	3,933,409	3,833,409	3,733,409	4,033,409	5,033,409	780,362	43,414,586
	Add: Reimbursements (spread)					3,666,667	3,666,667	3,666,667	3,666,667	3,666,667	3,666,667	3,666,667	3,666,667	3,666,667	0	33,000,000
	Ending Cash Balance		1,098,247,431	1,001,996,911	896,909,117	789,267,143	685,776,065	591,337,625	496,347,661	404,173,953	312,364,357	221,260,020	130,035,660	28,394,784	(97,884,795)	(1,363,369,590)
	Assumptions															
\$1	Personal Services costs are paid															
#2	Life and safety OE&E 413 326 506 516 506.01 are paid to the extent possible															
\$3	Reimbursements will be mostly collected by June 30															

Appendix 4.C: Comparison of 7A to Staffing Standards

Placeholder

**Appendix 4.D: HOSPITAL ALLOCATION ROLLUP
FISCAL YEAR 2011-12**

**Attachment "A"
Initial Allocation
Date: August 22, 2011**

Unit	LOC Staffing	Non-LOC Staffing	Salary Savings	Subtotal	OE&E	Initial Allocation 2011-12
Atascadero	123,426,298	53,166,876	(6,380,208)	170,212,967	\$34,155,587	\$204,368,553
Coalinga	84,234,720	65,156,536	(5,397,418)	143,993,838	\$30,242,182	\$174,236,020
Metropolitan	80,454,712	54,236,142	(4,867,740)	129,823,114	\$20,575,719	\$150,398,833
Napa	133,029,903	63,747,064	(7,110,875)	189,666,092	\$38,093,080	\$227,759,172
Patton	179,036,368	51,234,060	(8,320,880)	221,949,547	\$49,813,635	\$271,763,182
Subtotal	600,182,002	287,540,678	(32,077,121)	855,645,559	\$172,880,203	\$1,028,525,761
Vacaville	53,089,302	6,521,540	(2,158,742)	57,452,100	\$743,000	\$58,195,100
Salinas Valley	67,477,024	6,733,558	(2,681,185)	71,529,397	\$277,000	\$71,806,397
Headquarters				\$0	\$17,999,391	\$17,999,391
Special Repairs (held in Reserve until distributed)				\$0	\$1,372,787	\$1,372,787
TOTALS	\$720,748,328	\$300,795,776	(\$36,917,048)	\$984,627,056	\$193,272,381	\$1,177,899,437
Total State Hospital Budget FY 2011-12						\$1,249,125,000
Total Initial State Hospital Allocation						(\$1,177,899,437)
Reserve Balance						\$71,225,563
To be distributed in future allocations:						
Lottery Funds						\$145,000
Medicare (Part B)						\$500,000
Psych Tech 20/20 Training Program						\$250,000
					BALANCE OF RESERVE	\$72,120,563

Assumptions:

- 1) LOC and NLOC staffing captures reductions for a) misc. reductions per BL 10-33 Employee Comp, b) 5% PLP for five months (July-Nov), c) 7% WorkForce Cap, d) 5% salary savings.
- 2) LOC and NLOC staffing captures 62.3 positions established as approved for the VPP 64 Bed Expansion.
- 3) Includes Personal Services for HPO, Grounds Safety Teams and PC 7301 transfers.

Appendix 4.E: Sample Allocation Sheet

INITIAL ALLOCATION - August 22, 2011

ATASCADERO STATE HOSPITAL

FY 2011-12

LOC staffing allocated per budgeted methodology

LEVEL-OF-CARE

STAFFING - RATIOS & POSITIONS

1,031 LOC TREATMENT - BASE STAFFING	ACTUAL CENSUS		DMH MD Ph.D. PSW REHAB EDUC					Nursing Staff		LOC STAFFING
	#	%						RNs	PTs	
Patients Less than 90 days (1:15) Formula Staffing	299	29%	0.0850 <i>25.4</i>	0.0850 <i>25.4</i>	0.0850 <i>25.4</i>	0.0850 <i>25.4</i>	0.000 <i>0.0</i>	0.9290 <i>91.7</i>	0.9290 <i>186.1</i>	379.4
Patients Over 90 days (1:25) Formula Staffing	732	71%	0.052 <i>38.1</i>	0.052 <i>38.1</i>	0.052 <i>38.1</i>	0.052 <i>38.1</i>	0.053 <i>38.8</i>	0.900 <i>217.4</i>	0.900 <i>441.4</i>	850.0
	0	0%	0.000 <i>0.0</i>	0.000 <i>0.0</i>	0.000 <i>0.0</i>	0.000 <i>0.0</i>	0.000 <i>0.0</i>	0.000 <i>0.0</i>	0.000 <i>0.0</i>	0.0
(A) SUBTOTAL - LOC Treatment Staff	1,031	100%	63.5	63.5	63.5	63.5	38.8	309.1	627.5	1,229.4

FORENSIC TRIAL DUTIES

ADDITIONAL STAFFING

FORENSIC TRIAL DUTIES - ADDITIONAL STAFFING	#	%	DMH MD Ph.D. PSW REHAB EDUC					Nursing Staff		FORENSIC STAFFING
								RNs	PTs	
6604 SVP	6	1%	0.0		0.0					0.0
2962 MDO	630	61%	5.7							5.7
2972 PC	182	18%	0.5	0.7	0.5					1.7
1026 NGI	121	12%	0.4	0.4	0.4					1.2
1370 IST	88	9%	0.4							0.4
(B) SUBTOTAL - Forensic Duties	1,027	100%	7.0	1.1	0.9	0.0	0.0	0.0	0.0	9.0

(C) Physicians/Surgeons Per 7A

12.0

12.0

TOTAL STAFFING REQUIRED PER ACTUAL CENSUS

TOTAL LOC STAFF NEEDED (A + B + C)	#	%	DMH MD Ph.D. PSW REHAB EDUC					Nursing Staff		TOTAL STAFFING
								RNs	PTs	
	1,031	100%	82.5	64.6	64.4	63.5	38.8	309.1	627.5	1250.4

ACTUAL CENSUS BY PATIENT CATEGORY

	7-1-11			7-1-10	
	#	%		# difference	% difference
SVP	6	1%	7	-1	0.00%
MDO	630	61%	567	63	11.11%
PC 2684	182	18%	249	-67	-26.91%
NGI	121	12%	116	5	4.31%
IST	88	9%	187	-99	-52.94%
LPS	3	0%	2	1	50.00%
OTHER PC	1	0%	2	-1	-50.00%
CYA	0	0%	0	0	0.00%
TOTAL CENSUS	1,031	100%	1130	-99	-8.76%

Appendix 4.F: Funds 872 and 942 Data

State Hospital Account Fund 0872 History

	As of 7/1/05	As of 7/1/06	As of 7/1/07	As of 7/1/08	As of 7/1/09	As of 7/1/10	As of 7/1/11
Balance	11,441,406.37	21,589,670.79	34,690,630.55	51,242,514.10	46,125,171.36	39,790,155.33	33,365,233.53
Receipts	78,128,453.55	79,901,254.23	77,073,871.04	81,449,243.55	82,810,451.34	84,725,999.16	27,457,199.43
Interest	1,187,305.78	1,886,123.08	1,734,012.51	1,082,032.88	374,008.29	210,736.83	86,439.34
Disbursements	69,167,494.91	68,686,417.55	62,256,000.00	79,548,619.17	89,819,475.66	90,961,657.79	15,010,892.74
GF Loans	-			8,100,000.00	7,800,000.00	8,200,000.00	7,000,000.00
GF Repayment					8,100,000.00	7,800,000.00	8,200,000.00
Balance	21,589,670.79	34,690,630.55	51,242,514.10	46,125,171.36	39,790,155.33	33,365,233.53	47,097,979.56
	As of 6/30/06	As of 6/30/07	As of 6/30/08	As of 6/30/09	As of 6/30/10	As of 6/30/11	As of 10/31/11

Special Deposit Account 09420001 1945 603

Funds Due from DHCS to Remit to Counties

As of	38,899.00	39,264.00	39,630.00	39,995.00	40,360.00	40,725.00
Cash in State Tre:	16,118,863.43	29,120,670.63	26,824,229.30	49,825,385.30	27,447,668.03	68,863,000.42

JE0057370 dated 6/27/07 transferred \$23,288,969.74 from 0001 4450 2004 101 90 to the 09420001 1945 603 account and

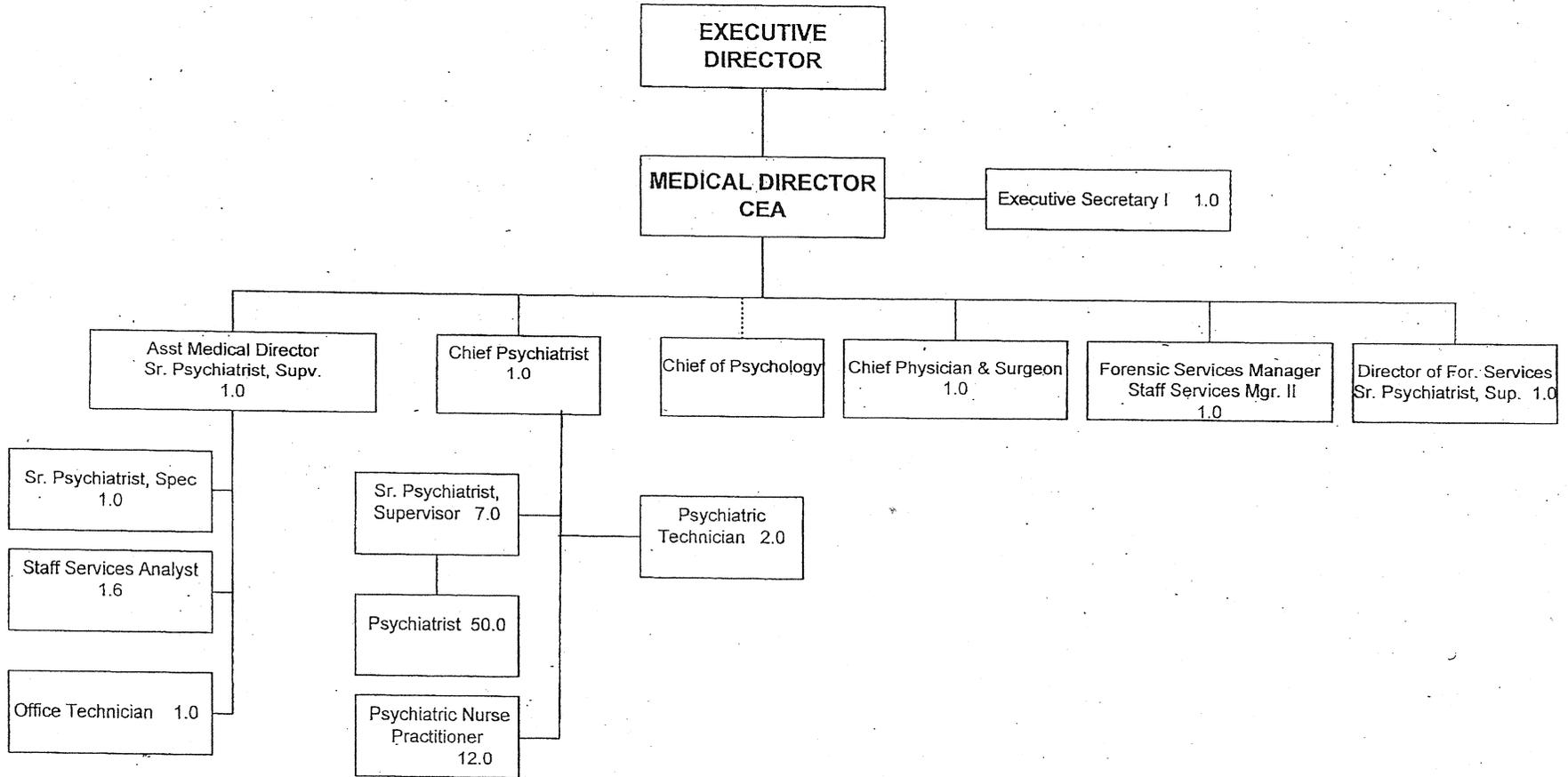
JE0057792 dated 6/27/07 transferred \$1,139,090.02 from 0001 4450 2004 101 90 to the 09420001 1945 603 account.

It appears neither transfer should have been made since the cash is still in the 0942 Account.

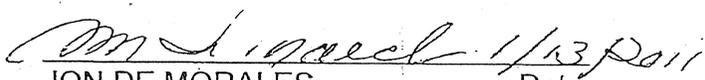
Appendix 6.A: State Hospital and Psychiatric Programs
 Medical Organization Charts

DEPARTMENT OF MENTAL HEALTH - ATASCADERO STATE HOSPITAL

MEDICAL DIRECTOR




 THOMAS CAHILL, M.D.
 Acting Medical Director
 Date 1/13/2011


 JON DE MORALES
 Executive Director
 Date 1/13/2011

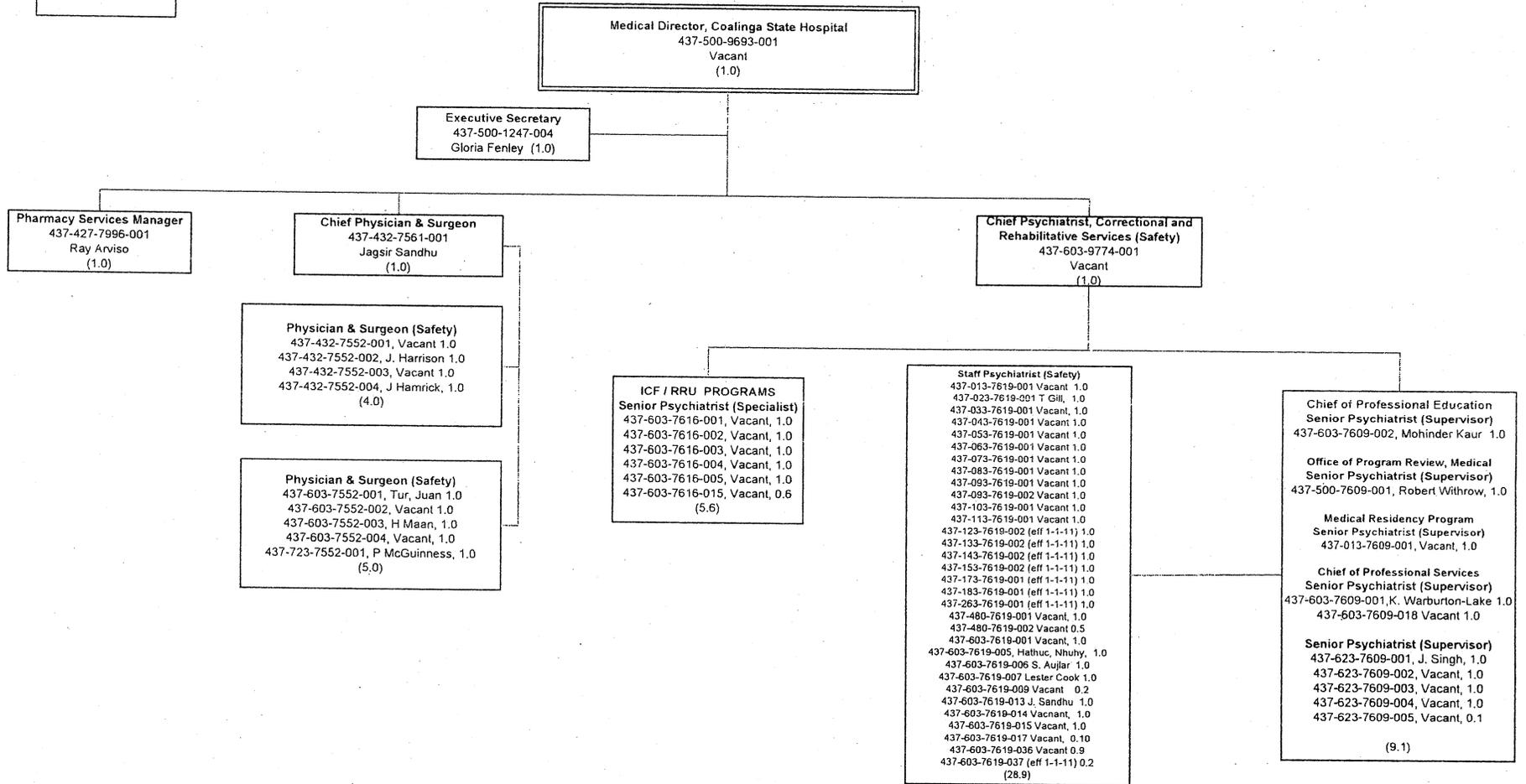
TOTAL POSITIONS: 80.6

--- denotes Clinical Supervision 207 of 271
 --- denotes Administrative Supervision

Org Chart #4

Approved

DEPARTMENT OF MENTAL HEALTH COALINGA STATE HOSPITAL



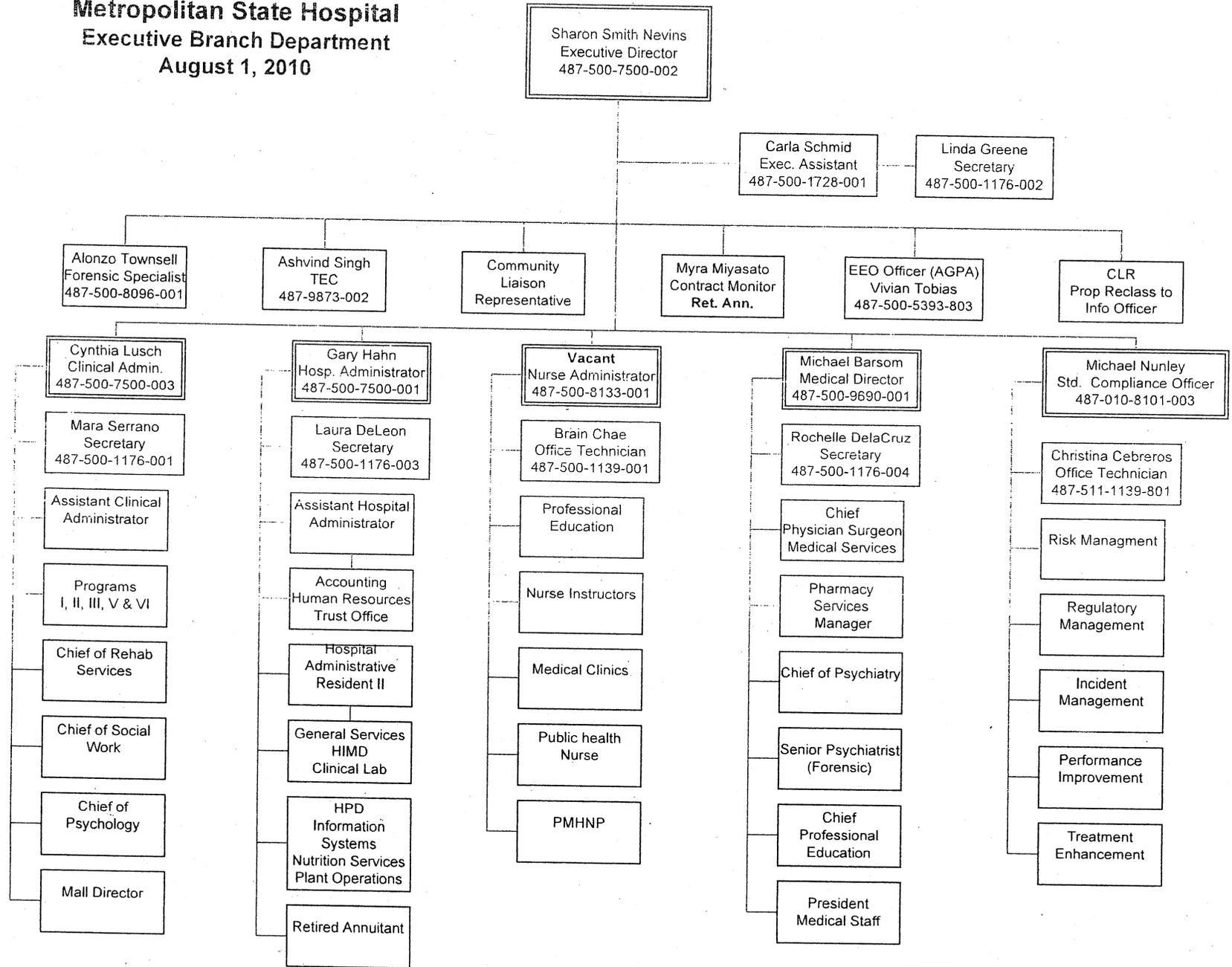
Vacant
Medical Director, Coalinga State Hospital

Date

Pam Ahlin
Executive Director, Coalinga State Hospital

Date

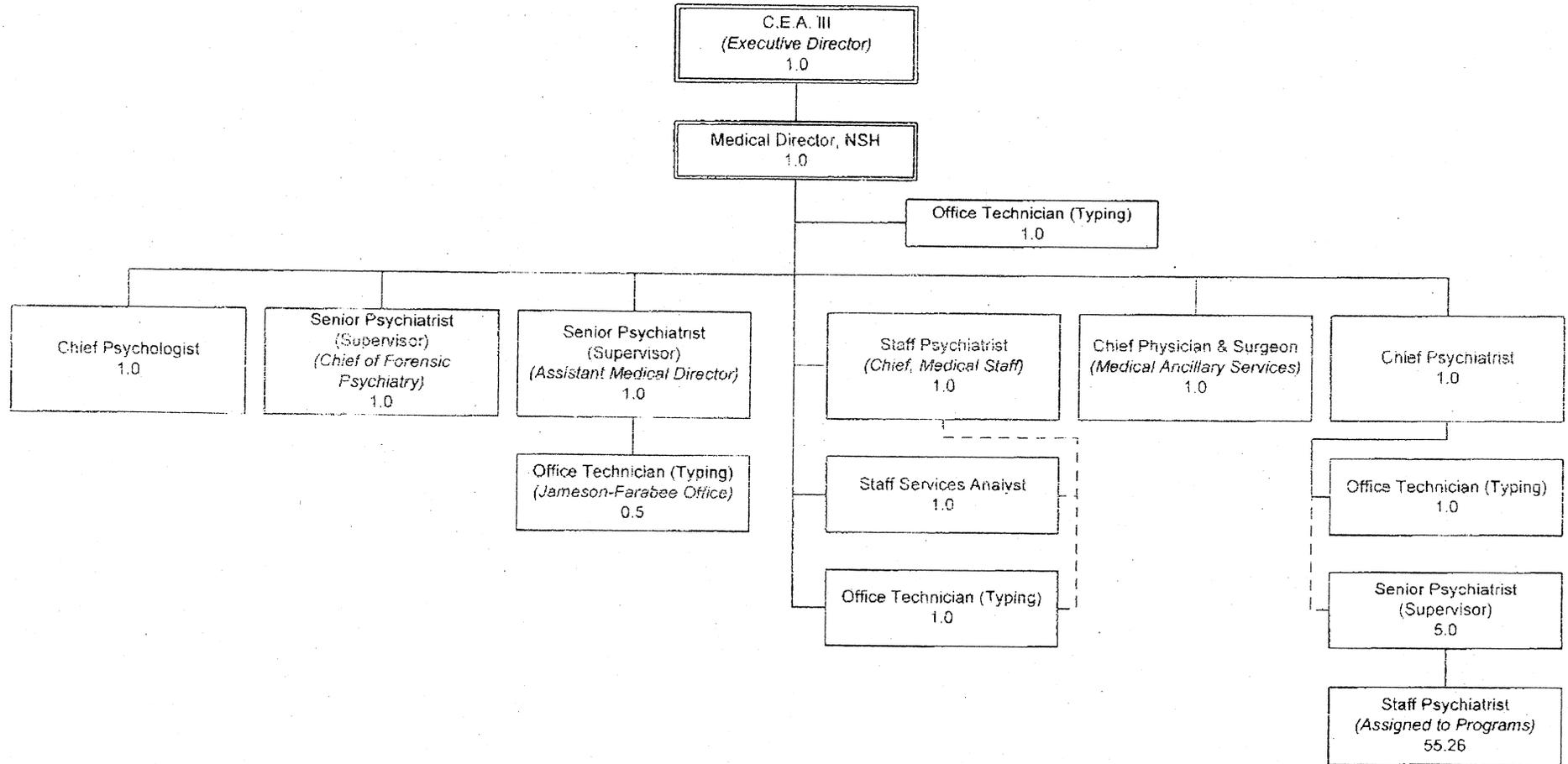
**Metropolitan State Hospital
Executive Branch Department
August 1, 2010**

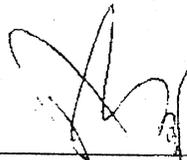


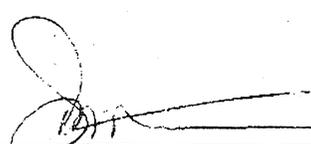
August 2010

DEPARTMENT OF MENTAL HEALTH

NAPA STATE HOSPITAL MEDICAL SERVICES




ANISH S. SHAH, M.D.
Acting Medical Director

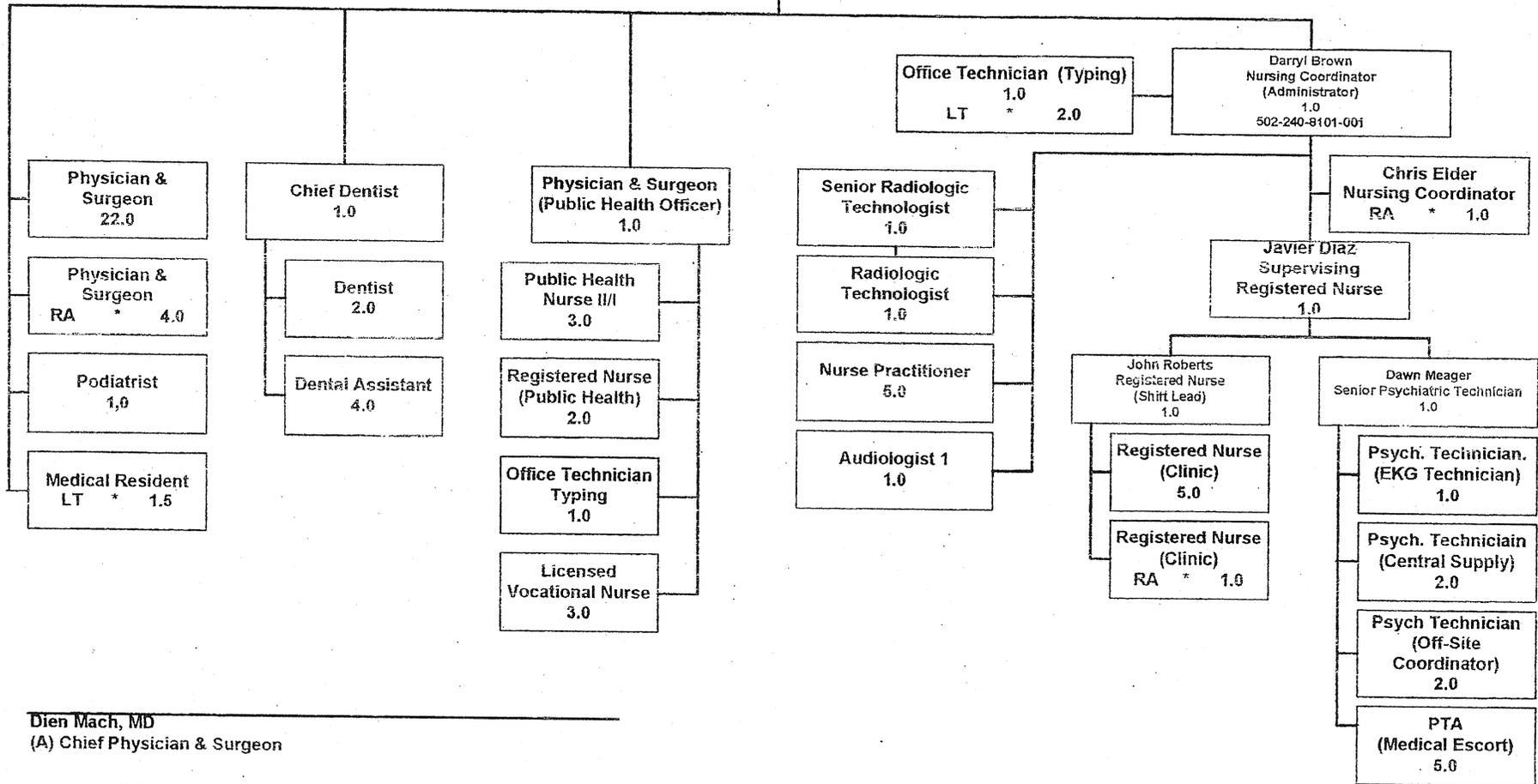
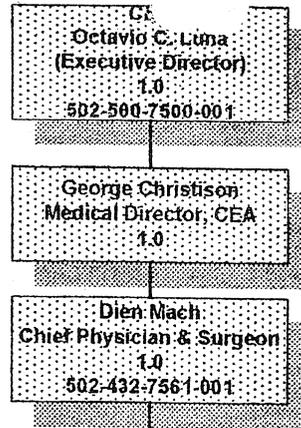

DOLORES F. MATTEUCCI
Interim Executive Director

PATTON STATE HOSPITAL

2010 / 2011 MEDICAL SERVICES

Legend:

- CEA Career Executive Assignment
- RA Retired Annuitant
- LT Limited Term
- *
- Sr. Temporary Help Blanket
- Senior
- PTA Psychiatric Technician Assistant
- Psych. Tech. Psychiatric Technician

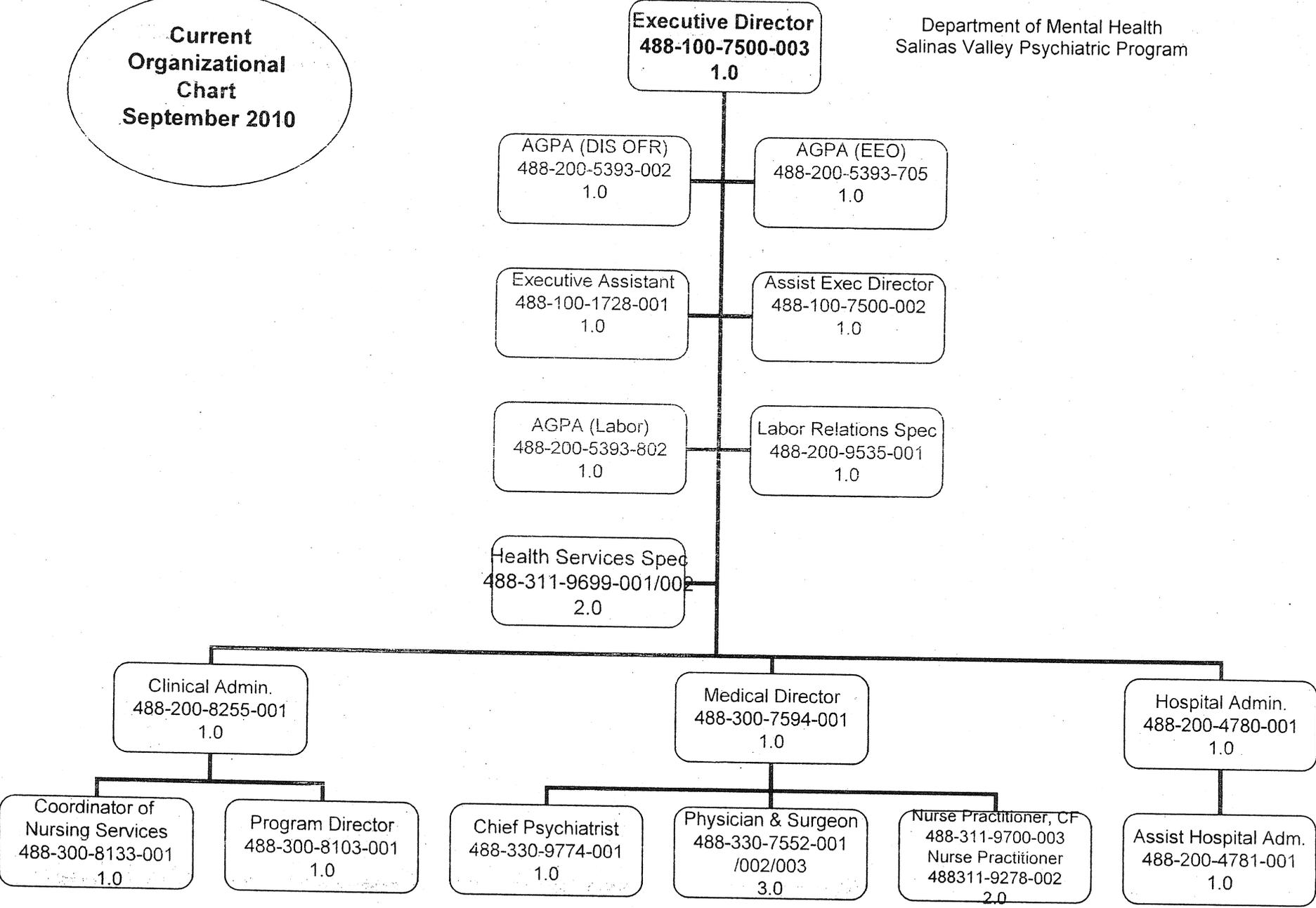


Dien Mach, MD
(A) Chief Physician & Surgeon

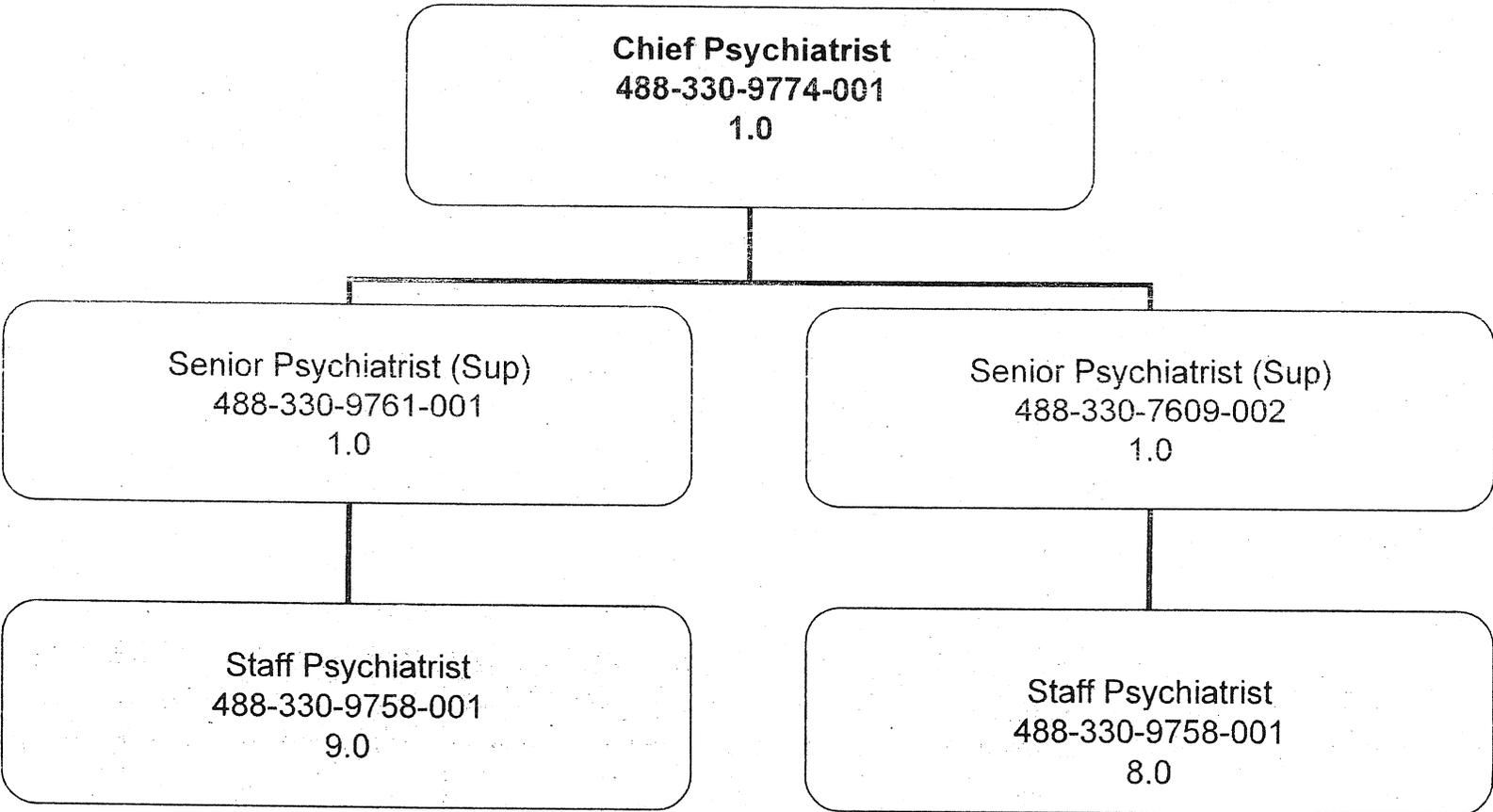
New, 10/2/10

**Current
Organizational
Chart
September 2010**

Department of Mental Health
Salinas Valley Psychiatric Program

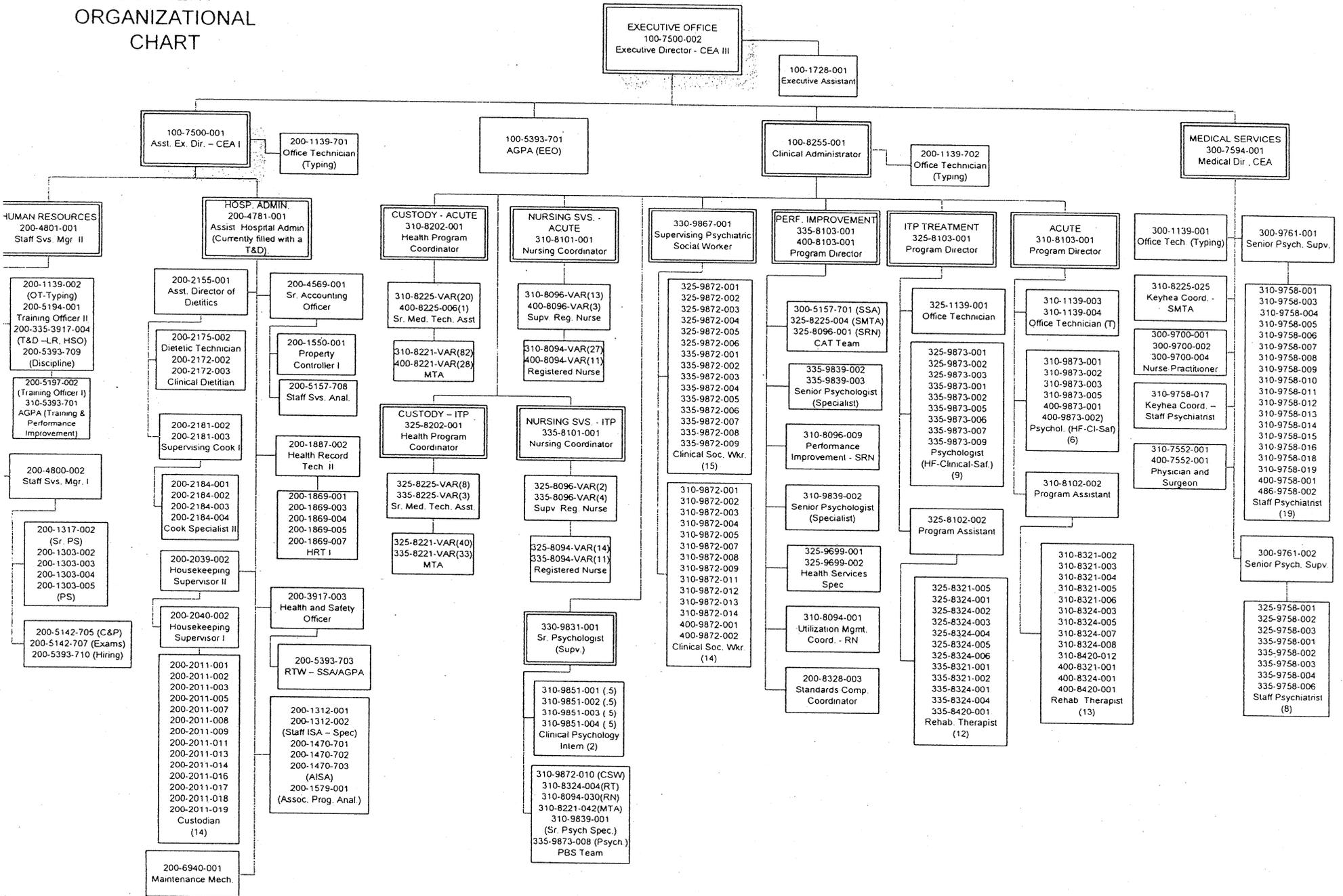


**Current
Organizational
Chart
September 2010**



DEPARTMENT OF MENTAL HEALTH
 VACAVILLE PSYCHIATRIC PROGRAM (AGENCY 486)

CURRENT
 ORGANIZATIONAL
 CHART



Appendix 6.B: Filling Behind Cost Comparison

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		Regular		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
Psy Tech																
Hourly Cost	\$26	\$28	\$34	\$36	\$39	\$42	\$24	\$35	\$39	\$42	\$31	\$34	\$26	\$28	\$26	\$28
Daily Cost			\$270	\$291	\$312	\$336	\$192	\$280	\$312	\$336	\$250	\$269	\$208	\$224	\$208	\$224
Position Cost (monthly)																
Vacant	\$4,476	\$4,915														
Filled with			\$5,819	\$6,390	\$6,864	\$7,392	\$4,224	\$6,160	\$6,864	\$7,392	\$5,491	\$5,914	\$4,576	\$4,928	\$4,576	\$4,928
Filled Position (monthly)																
Cover with					\$12,683	\$13,782	\$10,043	\$12,550	\$12,683	\$13,782	\$11,310	\$12,303	\$10,395	\$11,318	\$10,395	\$11,318
1. Minimum of Range S to max of Range U.																
2. Second shift based on time and half																
3. Rates based on 8 hour day and 176 hour month for Temp Help and Ret Annt (total different for 168 hour month).																
4. Second position based on straight time rate																
5. Monthly Salary based on salary plus 30% for benefits for full-time																
6. Monthly salary based on salary plus 20% for Temp Help																
7. Contract hires Coalinga only.																

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		Regular		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
RN																
Hourly Cost	\$40	\$46	\$52	\$60	\$60	\$69	\$39	\$50	\$60	\$69	\$48	\$55	\$40	\$46	\$40	\$46
Daily Cost			\$416	\$478	\$480	\$552	\$312	\$400	\$480	\$552	\$384	\$442	\$320	\$368	\$320	\$368
Position Cost (monthly)																
Vacant	\$6,938	\$8,030														
Filled with			\$9,019	\$10,439	\$10,560	\$12,144	\$6,864	\$8,800	\$10,560	\$12,144	\$8,448	\$9,715	\$7,040	\$8,096	\$7,040	\$8,096
Filled Position (monthly)																
Cover with					\$19,579	\$22,583	\$15,883	\$19,239	\$19,579	\$22,583	\$17,467	\$20,154	\$16,059	\$18,535	\$16,059	\$18,535
1. Minimum of Range T to max of Range T (For Salinas Valley check Rg U).																
2. Second shift based on time and half																
3. Rates based on 8 hour day and 176 hour month (total different for 168 hour month).																
4. Second position based on straight time rate																
5. Monthly Salary based on salary plus 30% for benefits for full-time																
6. Monthly salary based on salary plus 20% for Temp Help																
7. Contract hires Coalinga only.																

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		Regular		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
S Psychiatrist																
Hourly Cost	\$88	\$123	\$114	\$160			\$200	\$200			\$106	\$148	\$88	\$123	\$88	\$123
Daily Cost			\$915	\$1,279			\$1,600	\$1,600			\$845	\$1,181	\$704	\$984	\$704	\$984
Position Cost																
Vacant	\$15,214	\$21,311														
Filled with			\$19,778	\$27,704			\$35,200	\$35,200			\$18,586	\$25,978	\$15,488	\$21,648	\$15,488	\$21,648
Filled Position																
Cover with							\$54,978	\$62,904			\$38,364	\$53,682	\$35,266	\$49,352	\$35,266	\$49,352
1. Minimum of Range S to max of Range T																
2. Rates based on 8 hour day and 176 hour month for Temp Help and Ret Annt (total different for 168 hour month).																
3. Second position based on straight time rate.																
4. Monthly Salary based on salary plus 30% for benefits for full-time																
5. Monthly salary based on salary plus 20% for Temp Help																
6. Contract based on WIC rate of \$200.00.																

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		Regular		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
Hosp Police																
Hourly Cost	\$20	\$25	\$26	\$33	\$30	\$38					\$24	\$30	\$20	\$25		
Daily Cost			\$208	\$260	\$240	\$300					\$192	\$240	\$160	\$200		
Position Cost (monthly)																
Vacant	\$3,455	\$4,360														
Filled with			\$4,492	\$5,668	\$5,280	\$6,600					\$4,224	\$5,280	\$3,520	\$4,400		
Filled Position (monthly)																
Cover with					\$9,772	\$12,268					\$8,716	\$10,948	\$8,012	\$10,068		
1. Rates based on 8 hour day and 176 hour month for Temp Help and Ret Annt (total different for 168 hour month).																
2. Monthly Salary based on salary plus 30% for benefits for full-time																
3. Monthly salary based on salary plus 20% for Temp Help																

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		Regular		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
MTA																
Hourly Cost	\$25	\$35	\$33	\$46	\$38	\$53			\$38	\$53	\$30	\$42	\$25	\$35	\$25	\$35
Daily Cost			\$260	\$364	\$300	\$420			\$300	\$420	\$240	\$336	\$200	\$280	\$200	\$280
Position Cost (monthly)																
Vacant	\$4,416	\$6,144														
Filled with			\$5,741	\$7,987	\$6,600	\$9,240			\$6,600	\$9,240	\$5,280	\$7,392	\$4,400	\$6,160	\$4,400	\$6,160
Filled Position (monthly)																
Cover with					\$12,341	\$17,227			\$12,341	\$17,227	\$11,021	\$15,379	\$10,141	\$14,147	\$10,141	\$14,147
1. Minimum of Range J to max of Range K																
2. Second shift based on time and half																
3. Rates based on 8 hour day and 176 hour month (total different for 168 hour month).																
4. Second position based on straight time rate																
5. Monthly Salary based on salary plus 30% for benefits for full-time																
6. Monthly salary based on salary plus 20% for Temp Help																

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		MOD Shift		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
MOD (Medical Officer - Physician and Surgeon)																
Hourly Cost	\$72	\$90	\$72	\$90			\$200				\$86	\$108	\$72	\$90	\$72	\$90
16 hr shift	\$1,152	\$1,440	\$1,152	\$1,440			\$3,200				\$1,382	\$1,728	\$1,152	\$1,440	\$1,152	\$1,440
24 hr shift	\$1,728	\$2,160	\$1,728	\$2,160			\$4,800				\$2,074	\$2,592	\$1,728	\$2,160	\$1,728	\$2,160
1. Minimum of Range S to max of Range T																
2. Second position based on straight time rate																
3. Monthly salary based on salary plus 20% for Temp Help																
4. Based on 16 hr shift during week, 24 hr shift on weekend																

Department of Mental Health																
Comparison of Filling Behind Strategies																
Class	Salary Rate		POD Shift		Overtime		Contract		2nd Shift		Temp Help		Ret Annt		Second Pos	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
POD (S Psychiatrist)																
Hourly Cost	\$88	\$123	\$88	\$123			\$200				\$106	\$148	\$88	\$123	\$88	\$123
16 hr shift	\$1,408	\$1,968	\$1,408	\$1,968			\$3,200				\$1,690	\$2,362	\$1,408	\$1,968	\$1,408	\$1,968
24 hr shift	\$2,112	\$2,952	\$2,112	\$2,952			\$4,800				\$2,534	\$3,542	\$2,112	\$2,952	\$2,112	\$2,952
1. Minimum of Range S to max of Range T																
2. Second position based on straight time rate																
3. Monthly salary based on salary plus 20% for Temp Help																
4. Based on 16 hr shift during week, 24 hr shift on weekend																

Appendix 6.C: Average Daily Census by Level of Care^{1,2}

All Hospitals and Psychiatric Programs

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	1273.9	1266.4	1346.3	1536.7	1704.2	1739.8
SNF	80.4	86.1	84.9	80.1	73.3	73.6
ICF - SUBACUTE	3581.5	3616.7	3543.4	3465.8	3468.7	3557.1
ACUTE CHILD	31.3	24.2	5.7	0.0	0.0	0.0
RESIDENTIAL	73.0	276.9	449.3	442.2	443.1	436.6
Systemwide Total	5040.8	5271.3	5430.5	5525.6	5690.2	5808.1

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	20.6	22.2	19.2	17.0	18.2	25.0
SNF	25.5	27.1	25.7	23.7	20.4	22.3
ICF - SUBACUTE	1114.6	1117.6	1111.5	1098.1	1097.7	1101.3
Napa SH Total	1160.8	1167.0	1156.5	1138.8	1136.4	1148.6

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	438.7	375.7	381.2	513.0	580.9	545.6
SNF	54.9	59.0	59.1	56.3	52.9	51.3
ICF - SUBACUTE	148.3	214.1	210.7	65.9	13.6	9.2
ACUTE CHILD	31.3	24.2	5.7	0.0	0.0	0.0
Metro SH Total	673.2	672.9	656.7	635.3	647.3	606.1

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	480.2	476.4	483.4	482.7	483.0	469.7
ICF - SUBACUTE	1020.6	1016.4	1016.1	1021.8	1021.0	1020.3
Patton SH Total	1500.8	1492.8	1499.5	1504.5	1504.0	1490.0

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	145.0	139.4	148.3	201.0	215.9	263.6
ICF - SUBACUTE	1136.2	1016.0	866.0	817.4	813.6	877.5
scadero SH Total	1281.1	1155.4	1014.3	1018.4	1029.5	1141.1

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	4.0	19.6	20.6	19.5	18.1	18.5
ICF - SUBACUTE	61.1	144.2	204.5	327.2	428.6	449.3
RESIDENTIAL	73.0	276.9	449.3	442.2	443.1	436.6
Coalinga SH Total	138.1	440.7	674.4	788.8	889.9	904.4

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	133.3	136.7	137.1	133.6	156.6	186.3
ICF - SUBACUTE	99.8	107.4	133.6	134.4	93.3	98.4
vacaville PP Total	233.7	245.0	271.7	268.7	250.7	285.7

Level of Care	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
ACUTE PSY	52.1	96.5	156.9	169.9	231.4	231.1
ICF - SUBACUTE	1.0	1.0	1.0	1.0	1.0	1.0
is Valley PP Total	53.1	97.5	157.9	170.9	232.4	232.1

¹Average Daily Census (Source: Admission, Discharge, and Transfers System) is calculated by taking the total patient days for each level of care, and dividing this total by the number of days in each year (e.g., SVPPP's ICF-subacute average daily census for FY 2005-06 = 365 ÷ 365 = 1.0).

²There are 366 days for FY 2007-08.

Appendix 6.D: AVERAGE LENGTH OF STAY* (ALOS) BY COMMITMENT TYPE AND HOSPITAL

Commitment Type	HOSP	ALOS FY 2001	ALOS FY 2011	Percent Change	Commitment Type	HOSP	ALL HOSP ALOS FY 2001	ALL HOSP ALOS FY 2011	Percent Change
CDCR	ASH	249.9	199.5	-20.18%	CDCR	ALL	157.6	173.0	9.82%
CDCR	PSH	107.3	168.5	57.11%					
CDCR	SVPP	0.0	241.0	N/A					
CDCR	VPP	115.5	83.2	-27.98%					
DJJ	MSH	0.0	222.5	N/A	DJJ	ALL	N/A	180.8	N/A
DJJ	NSH	0.0	271.5	N/A					
DJJ	PSH	0.0	48.5	N/A					
IST	ASH	108.2	133.7	23.53%	IST	ALL	204.9	199.5	-2.67%
IST	MSH	319.8	249.3	-22.05%					
IST	NSH	235.5	248.5	5.51%					
IST	PSH	156.2	186.4	19.30%					
IST	SVPP	0.0	179.5	N/A					
LPS	ASH	480.4	1602.0	233.47%	LPS	ALL	860.0	1023.9	19.07%
LPS	MSH	365.2	811.4	122.16%					
LPS	NSH	1340.8	490.1	-63.45%					
LPS	PSH	1253.4	1192.3	-4.87%					
MDO	ASH	525.0	441.3	-15.95%	MDO	ALL	392.1	1180.2	201.02%
MDO	CSH	0.0	384.2	N/A					
MDO	MSH	211.0	1749.9	729.33%					
MDO	NSH	316.2	1907.0	503.16%					
MDO	PSH	516.1	1418.7	174.90%					
NGI	ASH	313.1	951.0	203.70%	NGI	ALL	914.6	1689.9	84.76%
NGI	MSH	616.0	1399.6	127.21%					
NGI	NSH	1301.9	2257.7	73.41%					
NGI	PSH	1427.4	2151.2	50.71%					
Other PC	ASH	1039.5	177.0	-82.97%	OTHER PC	ALL	487.1	349.6	-28.23%
Other PC	MSH	92.6	266.6	187.90%					
Other PC	NSH	106.9	293.6	174.63%					
Other PC	PSH	709.4	661.2	-6.79%					
SVP	ASH	695.1	0.0	N/A	SVP	ALL	695.1	1096.7	57.78%
SVP	CSH	0.0	1096.7	N/A					

*These figures only include days where patients were physically present in the state hospitals/psychiatric programs, not days where patients were out on leave:

([Discharge Date] - [Admission Date] - [Out on Leave Days] = Length of Stay).

Data Source: HCO/ODS ("Patient History" table) - Yumie Park

Run Date: 10/25/2011

**Appendix 6.E
TEAMS AND GROUPS USED BY HOSPITALS**

ASH CSH MSH NSH PSH SVP VVP

Interdisciplinary Team:

1. Individual	X	X	X	X	X	X	X
2. Treating Psychiatrist	X	X	X	X	X	X	X
3. Treating Psychologist	X	X	X	X	X	X	X
4. Treating Rehab Therapist	X	X	X	X	X	X	X
5. Treating Social Worker	X	X	X	X	X	X	X
6. Registered Nurse	X	X	X	X	X	X	X
7. Psychiatric Technician	X	X	X	X	X		
8. Family, Guardian, Advocate, Attorney			X				
9. Pharmacist and staff	(see #2)	(see #2)		X			
10. Team Recorders	X			X			
11. Dietician			X	X		X (if app)	
12. Registered Dietician				X			X
13. Medical Technical Assistant						X	X
14. Program Medical Consultant			X (SNF)				

Forensic Review Panel

1. Director of Forensic Psychiatry	X	Not under order	X	X	X		
2. Facility Director or designee	X		X	X	X		
3. Medical Director or designee	X		X	X	X		
4. Chief of Psychology or designee	X		X	X	X		
5. Chief of Social Services or designee	X		X	X	X		
6. Chief of Nursing Services or designee	X		X	X	X		
7. Chief of Rehab Services or designee	X		X	X	X		

Postive Behavior Support Team

3 teams

3 teams

1. Clinical Psychologist	1,1,1	X	X	X	X		X
2. Registered Nurse	1,2,1	X	X	X	X		
3. Two Psychiatric Technicians (1 of whom may be a behavior specialist)	3,3,3	X	X	X	X		
4. Medical Technical Assistant							X
5. Sr Psychologist							X
6. Social Worker							X
7. Data Analyst (who may be a behavior specialist)	existing member	X		X	X		

**Appendix 6.E
TEAMS AND GROUPS USED BY HOSPITALS**

	ASH	CSH	MSH	NSH	PSH	SVP	VVP
9.. Research Specialist			x	x			

Developmental and Cognitive Abilities Team

1. Clinical Psychologist	x	x		x	x		
2. Registered Nurse	x	x		x	x		
3. Social worker	x	x		x	x		
4. Psychiatric Technician	x (2)	x		x	x		
5. Data analyst (who may be a behavior spec)	existing team member	x		x	x		

Behavioral and Consultation Committee

1. Chief of Psychology	x	Not Established	x		Replaced with PSSC below		
2. Chief of Psychiatry	x		x				
3. Sr Psychologist			x				
4. Psychology Specialized Services Coordinator	x						

Program Review Committee (PRC)

1. Program Director	x	x		x	x		
2. Senior Psychiatrist	x	x		x	x		
3. Senior Psychologist	no or sporadic	x		x	x		
4. Senior Social Worker	no or sporadic	x		x	x		
5. Senior Rehab Therapist	no or sporadic	x		x	x		
6. Health Services Specialist	x	x		x	x		
7. Nursing Coordinator	x	x		x	x		
8. Risk Manager SC liaison	x	x		x	x		
9. US's	x	x		x			

Enhanced Trigger Review Committee (ETRC)

1. Chief of Psychiatry	x	x		x	x		
2. Clinical Administrator	x	x		x	x		

**Appendix 6.E
TEAMS AND GROUPS USED BY HOSPITALS**

	ASH	CSH	MSH	NSH	PSH	SVP	VVP
3. Discipline Chiefs	x	x		x	x		
4. Coordinator of Psychology Specialist Services	x	x			x		
5. Standards Compliance Director	x	x		x	x		
6. Risk Manager SC Lead	x	x		x	x		
7. PBS Team Leader or designee	x	x		x			
8. The following should attend if an individual from their program is being discussed: Senior Psychiatrist, Senior Psychologist, and Program Director	x	x		x	x		
9. The following should attend if an individual from their unit is being discussed: Unit Supervisor, WRPT Psychiatrist and Psychologist	x	x		x	x		

Psychology Specialist Services Committee (PSSC)

1. Coordinator to Psychology specialist Services	x	x		x	x		
2. Chief of Psychology	x	x		x	x		
3. Chief of Psychiatry	x	x		x	x		
4. Clinical Administrator	x	x		x	x		
5. Risk Manager SC Lead	x	x		x	x		
individual from their program is being discussed: Senior Psychiatrist, Senior	x	x		x	x		
7. The following should attend if an individual from their unit is being discussed: Unit Supervisor, WRPT Psychiatrist and Psychologist	x (Unit Sup no or sporadic)	x		x	x		
8. The following should attend if an individual is receiving or will receive psychology specialist services: PBS Team Leader	x	x		x	x		

Medical Risk Management Committee (MRMC)

Chief Physician and Surgeon	x	x		x	x		
Nurse Administrator	x	x		x	x		
Medical Director	x	x		x	x		
Risk Manager SC Behavior Specialist	x	x		x	x		
CNS HSS	x	x		x			

**Appendix 6.E
TEAMS AND GROUPS USED BY HOSPITALS**

ASH CSH MSH NSH PSH SVP VVP

Facility Review Committee (FRC)

Medical Director	X	X		X	X		
Clinical Administrator	X	X		X	X		
Discipline Chiefs (Psychiatry, Psychology, RT, SW)	X	X		X	X		
Nurse Administrator	X	X		X	X		
Standards Compliance Director	X	X		X	X		
Risk Manager SC Lead	X	X		X	X		
PSSC and PBS lead	X	X		X			
The following should attend if an individual from their program is being discussed: Senior Psychiatrist, Senior Psychologist, and Program Director	X	X		X	X		
The following should attend if an individual from their unit is being discussed: Unit Supervisor, WRPT Psychiatrist and Psychologist	X	X		X	X		

Risk Management Committee

Medical Director Chair	X	Not Established		X			
Committee Chairs from ETRC, MRMC, PSSC	X			X			
Chief of Psychiatry	X			X			
SC Director	X			X			
Data analyst	X						
Data Manager	X						
OT	X			X			

Quality Council (expanded to incl Prog Directors and Dept Heads)

Executive Team (ED, CA, HA, MD, and NA)	X	X		X	X		
AHA and Dept Heads	X						
Standards Compliance Director	X	X		X	X		
Risk Manager	X	X		X	X		
PD Representative	X						
Anyone who is interested in attending. We are open to all, the minutes are distributed to members, PD's and US's.	X	X					

Appendix 6.E
TEAMS AND GROUPS USED BY HOSPITALS

	ASH	CSH	MSH	NSH	PSH	SVP	VVP
Individual Representative (2 at PSH)(5 at ASH,one from each program)	x	x		x	x		

Appendix 6.F



**THE DEPARTMENT OF GENERAL SERVICES
PHARMACY ADVISORY BOARD**

CHARTER

2011

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A. Introduction

Recognizing that State governmental entities need to control the costs relating to the purchase and use of pharmaceuticals and medical supplies, the Department of General Services (DGS), by virtue of this Charter and under the authority of Government Code (GC) 14982(a) et seq., does hereby establish the Pharmacy Advisory Board (PAB).

The Directors of the DGS, Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Health Care Services (DHCS), California Department of Public Health (CDPH), the Secretaries of the California Department of Corrections and Rehabilitation (CDCR), California Department of Veterans Affairs (CDVA), the Receiver of the California Correctional Health Care Services, the Chief Executive Officer of the California Public Employees Retirement System (CalPERS), and the President of the University of California (UC), are the Executive Sponsors, and hereby direct the PAB to meet, discuss, make decisions, and act on critical issues relevant to authorities granted and legislative expectations of Government Code (GC) Sections 14977 through 14982.

The PAB drives operational decisions to lower levels in the organizations when appropriate, and gives clear direction.

B. Background

The DGS Pharmaceutical Acquisitions Section (Rx Section) has procured pharmaceuticals for State Agencies for many years. Beginning in 2000 the California Legislature recognized the increasing costs of pharmaceuticals and introduced legislation establishing the Statewide Pharmaceutical Program and requiring the DGS and State Agencies to work together to control drug costs.

C. PAB Mission

Coordinate the efforts of various State and local governmental entities, as appropriate, to identify and implement opportunities for cost savings and quality improvement regarding pharmaceuticals and medical supplies.

D. PAB Values

- Integrity – We do the right things for the right reasons.
- Accountability – We hold ourselves and each other responsible for all we do.
- Communication – We listen and share information openly and honestly with the goal of mutual understanding and transparency.
- Excellence – We strive for the best for each other and our customers.
- Innovation – We cultivate ideas and implement improvements throughout our organizations.
- Teamwork – We value our organizational diversity and work together to achieve great results.

E. PAB Goals

1. Rational Drug Use - Establish systems that ensure the most cost effective medication therapy within State and local governmental entities.
2. Strategic Procurement Initiatives - Leverage departmental efficiencies to obtain the best value on pharmaceutical and medical supply procurements.
3. Program Quality – Establish and monitor performance standards for protocols, guidelines and contracts established for State and local governmental entities supporting the Statewide Pharmaceutical Program.
4. Cost Management Strategies – Develop short term and long term plans integrating private, government, and industry resources for managing drug and medical supply costs within State and local governmental entities.

F. PAB Membership

Membership is appointed by the Executive Sponsors. Additional State and local governmental entities eligible to participate in the Statewide Pharmaceutical Program pursuant to GC Section 14978 may participate in the PAB as appropriate.

G. Conflict of Interest

PAB members shall be free from interests that could compromise the objectivity necessary to make independent assessments.

H. PAB Process

The PAB shall be organized in a manner consistent with improving communications and processes. The PAB Members shall form standing and *ad Hoc* committees to align with the goals of the PAB. The PAB shall appoint and dedicate appropriate resources to committees it forms. The DGS shall administer the PAB under the authority of GC Sections 14977 through 14982.

I. PAB Roles and Responsibilities.

PAB Member

- Implement the goals of the PAB charter.
- Provide leadership and oversight on issues that cross Agency or Departmental lines, and advise the PAB.
- Receive review, recommend, and reports on high priority and sensitive issues.
- Serves as the point of contact between the PAB and their Executive Sponsor, and appropriate resources within their agencies.
 - Provides briefings on current issues.
 - Receives and gives feedback to the PAB.

- Coordinates and appoints appropriate resources to subcommittees and workgroups established by the PAB.

DGS Pharmaceutical Program Manager (Facilitator)

- Manages meeting logistics
- Tracks PAB action items through resolution.

J. Charter Amendments and Revisions

This Charter may be revised or amended as and when necessary. The PAB shall review any proposed changes, revisions, or amendments and submit to their various Executive Sponsors for approval.

K. PAB Charter Approvals

**Department of General Services
Fred Klass, Director**

**California Correctional Health Care Services
J. Clark Kelso, Receiver**

**Department of Mental Health
Cliff Allenby, Acting Director**

**Department of Developmental Services
Terri Delgadillo, Director**

**CalPERS
Anne Stausboll, Chief Executive Officer**

**University of California
Dr. Mark G. Yudof, President**

**California Department of Corrections and
Rehabilitations
Matthew Cate, Secretary**

**Department of Health Care Services
Toby Douglas, Director**

**California Department of Public Health
Dr. Ron Chapman, Director**

**California Department of Veterans Affairs
Peter James Gravett, Secretary**

Appendix 6.G



**THE DEPARTMENT OF GENERAL SERVICES
COMMON DRUG FORMULARY COMMITTEE**

CHARTER

2011

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A. Introduction

Recognizing State governmental need to leverage resources improving efficiencies to establish quality standards and control the costs relating to the purchase and use of pharmaceuticals and medical supplies, the Pharmacy Advisory Board (PAB), by virtue of this Charter, does hereby establish the Common Drug Formulary (CDF) Committee.

Committee membership is appointed by the PAB. The CDF Committee functions to:

- Promote Rational Drug use to ensure the most cost effective medication therapy is used within State and local governmental agencies.
- Develop information on the relative effectiveness and safety of prescription drugs.
- Promote program quality by establishing and monitoring performance standards for protocols, guidelines and contracts supporting the SPP.
- Investigate and implement options and strategies to achieve the greatest savings on prescription drugs.

B. Background

Beginning in 2000 the California Legislature recognized the increasing costs of pharmaceuticals and introduced legislation (Government Code Sections 14977 through 14982) establishing the Statewide Pharmaceutical Program (SPP) and requiring the Department of General Services (DGS) and State Agencies to work together to control drug costs. In order to meet the statutory requirements established by Government Code (GC) Sections 14978 and 14982(3), the DGS established the Common Drug Formulary (CDF) Committee as a subcommittee of the Pharmacy Advisory Board (PAB).

C. Mission

The CDF Committee will implement a Common Drug Formulary System.

D. Values

1. **Integrity** – We do the right things for the right reasons.
2. **Accountability** – We hold ourselves and each other responsible for all we do.
3. **Communication** – We listen and share information openly and honestly with the goal of mutual understanding and transparency.
4. **Excellence** – We strive for the best for each other and our customers.
5. **Innovation** – We cultivate ideas and implement improvements throughout our organizations.
6. **Teamwork** – We value our organizational diversity and work together to achieve great results.

E. Goals

The following are goals of the CDF Committee:

1. Rational Drug Use - Establish systems that ensure medically appropriate and cost effective medication therapy within State and local governmental entities.
2. Program Quality – Establish and monitor performance standards for protocols, guidelines and contracts established for State and local governmental entities supporting the Statewide Pharmaceutical Program.
3. Cost Management Strategies – Control costs on prescription drugs.

F. Responsibilities

The responsibilities of the CDF Committee are as follows:

1. Maintain a regular meeting schedule.
2. Maintain a CDF that ensures access to medically appropriate, cost-effective drugs while promoting and/or assuring the continuity and standardization of medical care.
3. Develop or adopt Clinical Practice Guidelines when appropriate. Clinical Practice Guidelines are defined as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances”¹
4. Develop or adopt Clinical Protocols when appropriate. Clinical Protocols are defined as an agreed upon series of treatment steps which should or must be taken to assure optimal care

G. Procedural Objectives

The following are procedural objectives of the CDF Committee:

1. Determining the composition of the CDF.
2. Develop and maintain the clinical rationale for criteria used to select pharmaceuticals for the CDF.
3. Serve as clinical experts as needed for implementing GC Sections 14977-14982.
4. Work with the DGS to maintain a list of definitions of terms pertinent to the CDF Committee in carrying out its mission.
5. Maintain a current CDF membership list.
6. Provide the PAB at their April meeting with the CDF Strategic Plan that would be in effect for the next fiscal year.
7. Prepare and maintain CDF Meeting Agendas.
8. Prepare and maintain CDF Meeting Minutes.

¹ The National Guideline Clearinghouse™ (NGC) employs the definition of clinical practice guideline developed by the Institute of Medicine (IOM).

9. Prepare and maintain a formulary list of drugs.
10. Develop policies for the operation of the CDF System.
11. Develop guidelines for the Implementation and Administration of the CDF System.
12. Develop procedures for the operation of the CDF System.
13. Work with the DGS to establish cost effective pharmaceutical contracts.
14. Coordinate with involved agencies to implement and administer the CDF System.

H. Membership

The CDF Committee shall be composed of representatives appointed by the PAB, or the Directors of the entities participating in the pharmacy program established by GC Sections 14977 through 14982. The CDF Committee members shall be physicians, pharmacists, or other health care professionals a majority of whom are actively practicing.

I. Conflict of Interest

Committee members shall be free from interests that could compromise the objectivity necessary to make independent assessments concerning formulary status of individual drugs, prescribing guidelines, coverage criteria, or clinical program issues brought before the CDF Committee.

J. Confidentiality

The CDF Committee will develop procedures relevant to confidentiality.

K. Decisions

Decisions of the CDF Committee regarding formulary status of individual drugs, use of specified prescribing guidelines and protocols, implementation of individual programs designed to affect drug utilization, and requests for approval by the Common Drug Formulary Committee of any other clinical program or intervention must be made by unanimous consensus.

Consensus is a process for group decision-making. It is a method by which an entire group of people can come to an agreement. The input and ideas of all participants are gathered and synthesized to arrive at a final decision supportable by all.

Consensus does not mean that everyone thinks that the decision made is necessarily the best one possible, or even that they are sure it will work. What it does mean is that in coming to that decision, everyone feels that their position on the matter was understood and given a proper hearing. Consensus means that all members of the Common Drug Formulary Committee agreed to the decision made.

1. Absent CDF members shall be briefed on a consensus issue by the DGS and/or the CDF Chairperson. If all absent members agree to support an issue, unanimous consensus is declared for that issue.
2. If all absent CDF members cannot agree to support an issue after being briefed, the issue may be reintroduced at a subsequent meeting.
3. A vacancy in CDF membership shall not preclude the remaining members of the CDF Committee from reaching unanimous consensus.

L. Subcommittees

The CDF Committee may designate subcommittees of one or more members to act for the CDF Committee with respect to specified issues.

M. Support

The PAB and the DGS will ensure the CDF Committee receives the following support:

1. The PAB shall ensure the personnel resources needed for effective operation of the CDF System.
2. The DGS Pharmaceutical Consultant II, or alternate shall provide leadership and liaison to the CDF Committee, the DGS, and the PAB to coordinate and accomplish the objectives of GC Sections 14977 through 14982.
3. The CDF Committee members will develop and implement procedures for managing the CDF Committee.
4. The DGS will support the CDF Committee by:
 - i. Scheduling meetings.
 - ii. Providing meeting accommodations.
 - iii. Working with the Chairperson in establishing the agenda for each meeting.
 - iv. Distributing the agenda and other meeting materials in advance of each meeting.
 - v. Compiling and storing the minutes from the CDF Committee meetings.
5. The DGS will periodically report to the CDF on the following issues:
 - i. Contract development and negotiations status.
 - ii. Development of work products to implement the CDF System.
 - iii. Assessment of progress to implement Government Code Sections 14977-14982 goals and other mission critical objectives.
 - iv. Identification of constraints to achieve Government code Sections 14977-14982 objectives.
 - v. Recommendations to address program risk and program quality assurance activities.
 - vi. Compliance reports for the CDF.
 - vii. Report on cost effectiveness of CDF System.

N. Charter Amendments and Revisions

1. This Charter may be revised or amended as and when necessary. The PAB shall review and approve any proposed changes, revisions or amendments to this Charter.
2. The CDF Committee shall review this Charter annually and provide the PAB with any proposed changes, revisions or amendments to the Charter at their October meeting.

O. Charter Approvals

POLICY DIRECTIVE

MH 359 (Rev. 1/99)

<p>No.: 805</p> <p>Effective Date: February 11, 2009</p> <p>Supersedes: July 19, 2004</p> <p><i>(Original signed by the Director)</i></p> <p>Approved: STEPHEN W. MAYBERG, Ph.D. Director</p>	<p>Subject: PSYCHOPHARMACOLOGY ADVISORY COMMITTEE (PAC)</p> <p style="text-align: right;">Page 1 of 3</p>
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Reference: Government Code Section 11152; and DMH Special Order 105

Purpose: To define the function of the Department of Mental Health (DMH) Psychopharmacology Advisory Committee (PAC) as well as the appointments and terms for its membership.

Definition: The Psychopharmacology Advisory Committee is established by the Director to advise DMH on issues pertaining to psychopharmacology and to develop and maintain the Department's Psychotropic Medication Policy.

Method: **Composition**

PAC membership is composed of:

- One representative from the Medical Directors Council;
- One pharmacist from each State Hospital and Psychiatric Program;
- One psychiatrist from each State Hospital and Psychiatric Program;
- One pharmacist or psychiatrist from the Department of Juvenile Justice;
- One pharmacist or psychiatrist from the Department of Veterans Affairs;
- One pharmacist or psychiatrist from California Department of Corrections and Rehabilitation;
- One pharmacist or psychiatrist from Department of Developmental Services;
- Two county medical directors representing the California Mental Health Directors Association (CMHDA);
- Medical Director(s) from DMH headquarters; and
- One pharmacist from DMH Headquarters.

Nomination and Appointment Process

When a vacancy occurs, the Director will request a nomination from the respective state hospital, psychiatric program Medical Director, designated department director, or CMHDA for consideration for appointment to the committee. The Director will review and make official appointments to the committee, and a letter will be sent to each member appointed to the committee.

Terms

The Director appoints each member to the committee for a period of three (3) years. At the discretion of the Director, members may be reappointed for subsequent terms. Members may be removed at the discretion of the Director.

PAC Chair

The committee's members will nominate two (2) of its members for appointment by the Director to serve as committee chair. Of those two nominations, the Director may appoint one or two individuals to chair/co-chair the committee, respectively. The committee Chair(s) will serve in that capacity for three (3) years. The Chair(s) may be reappointed for subsequent terms at the discretion of the Director or may be removed at the discretion of the Director.

Voting Members

The DMH PAC voting membership is comprised of all DMH Director-appointed individuals from the Medical Directors Council, each state hospital and psychiatric program, and other state departments, with the exception of DMH Headquarters Medical Director(s) and pharmacy representative(s) who shall be ex officio and non-voting. The PAC generally operates by consensus; however, specific motions can be approved by simple majority. For PAC meetings, a quorum shall be defined as at least one (1) Chair and at least three (3) voting members.

PAC Responsibilities

- The committee shall develop policies and related materials for the use of psychotropic medications, as described in Special Order 105: DMH Psychotropic Medication Policy, in DMH hospitals and psychiatric programs to include, but not limited to, pre-treatment evaluation, dosage, length of treatment, protocols/algorithms, monitoring, and management of side effects.

Medical Directors Council Review: Proposed PAC revisions to the Psychotropic Medication Policy shall be reviewed and commented on by the Medical Directors Council in a timely manner. The Medical Directors Council may endorse, reject, revise, or remand for revision to PAC all proposed draft policy changes. The actions of Medical Directors Council shall be communicated to the Chair(s) of PAC by the Chair of the Medical Directors Council. Any relevant questions or proposals for policy revision shall be submitted by the Chair of the Medical Directors Council to PAC.

Approval and Implementation: Following approval by the PAC and the Medical Directors Council, revisions to the Psychotropic Medication Policy shall be presented at least annually to the Director for approval in consultation with the DMH Medical Director(s) and Pharmacist(s). The approved DMH Psychotropic Medication Policy shall be appended to Special Order 105 and shall be adopted for implementation by each hospital and psychiatric program. Any systematic exceptions or deviations from the policies, as opposed to isolated errors or departures, shall be presented by the respective Chief of Staff to the governing body at its semi-annual meeting.

- The PAC serves as an intra-departmental centralized forum for discussion of information, ideas, approaches, and new research data regarding the therapeutic decision process, medication terminology, dosage guidelines, and medication management.
- DMH state hospital or psychiatric program clinical staff may submit proposals or questions to the PAC via its Chair(s) or via appointed PAC members. The committee will invite other agencies, departments and experts in the field as necessary to participate and discuss current issues, approaches and drug research findings.
- Committee members may also serve as appointees on statewide medication and drug formulary related work groups as determined by the Director.

Frequency of Meetings

The committee meets at least every four months and as often as is necessary to meet its responsibilities, using audio or video conferencing as much as possible to reduce travel expenses. Between meetings, the Chair(s) may act on behalf of the PAC with respect to facilitating moving policy recommendations forward or making non-substantive revisions to proposed policy language.

Appendix 6.I: Outside Med./ Registry/Pharmaceutical expenses

Category	FY	ASH	CSH	MSH	PSH	NSH	SVPP	VPP	TOTAL
Outside Medical Contracts (Personal Svcs & Other) 413/418									
	5/6	3,546,233	839,368	1,889,496	8,691,676	3,549,111	223,948	9,888	18,749,720
	6/7	3,241,022	4,173,672	2,246,789	11,937,141	5,040,978	2,410,909	20,104	29,070,615
	7/8	26,327,217	12,698,697	1,540,997	13,299,609	10,925,027	1,880,805	1,101,681	67,774,033
	8/9	22,220,633	14,283,978	1,008,390	15,707,050	9,326,526	724,570	113,040	63,384,187
	9/10	20,719,113	21,438,580	1,287,513	11,731,742	7,714,891	5,856,116	461,024	69,208,979
	10/11	20,427,736	23,583,912	1,267,738	18,518,542	11,331,127	9,552,801	1,551,473	86,233,329
	11/12	16,707,439	9,279,484	1,745,775	16,277,062	7,525,403	10,942,849	2,273,746	64,751,758
TOTAL Outside Medical		113,189,393	86,297,691	10,986,698	96,162,822	55,413,063	31,591,998	5,530,956	399,172,621
Personal Svcs/Registry									
	5/6	1,316,339	413,465	488,042	188,115	0	0	0	2,405,961
	6/7	1,289,014	0	587,341	158,879	243,567	0	0	2,278,801
	7/8	23,257,558	7,692,693	708,257	969,441	6,190,722	0	0	38,818,671
	8/9	19,921,527	4,784,099	551,463	957,192	2,825,117	0	0	29,039,398
	9/10	17,576,980	14,097,497	385,366	158,465	434,727	0	0	32,653,035
	10/11	16,064,998	16,642,247	517,252	367,946	1,879,207	0	0	35,471,650
	11/12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub-total		79,426,416	43,630,001	3,237,721	2,800,038	11,573,340	0	0	140,667,516
Other									
	5/6	2,229,894	425,903	1,401,454	8,503,561	3,549,111	223,948	9,888	16,343,759
	6/7	1,952,008	4,173,672	1,659,448	11,778,262	4,797,411	2,410,909	20,104	26,791,814
	7/8	3,069,659	5,006,004	832,740	12,330,168	4,734,305	1,880,805	1,101,681	28,955,362
	8/9	2,299,106	9,499,879	456,927	14,749,858	6,501,409	724,570	113,040	34,344,789
	9/10	3,142,133	7,341,083	902,147	11,573,277	7,280,164	5,856,116	461,024	36,555,944
	10/11	4,362,738	6,941,665	750,486	18,150,596	9,451,920	9,552,801	1,551,473	50,761,679
	11/12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sub-total		33,762,977	42,667,690	7,748,977	93,362,784	43,839,723	31,591,998	5,530,956	258,505,105

Appendix 6.I: Outside Med./ Registry/Pharmaceutical expenses

516 Pharmaceuticals

5/6	7,146,485	932,922	5,645,588	11,904,432	9,903,555	58,878	23,516	35,615,376
6/7	8,265,152	2,306,410	5,944,402	12,368,071	8,524,334	84,147	61,512	37,554,028
7/8	9,693,779	3,176,134	8,796,696	14,975,574	10,069,322	17,001	20,129	46,748,635
8/9	9,461,141	3,148,311	6,584,024	13,121,868	10,396,083	20,120	24,532	42,756,079
9/10	9,061,594	3,781,061	6,348,921	15,321,232	9,657,610	113,228	81,923	44,365,569
11/10	11,069,924	4,198,353	6,241,695	14,357,837	11,670,283	8,343	8,253	47,554,688
11/12	11,579,387	3,874,126	7,566,241	15,465,160	11,100,367	10,043	10,000	49,605,324
TOTAL Pharmaceuticals	66,277,462	21,417,317	47,127,567	97,514,174	71,321,554	311,760	229,865	304,199,699

Appendix 6.J: State Hospital Outside Medical Costs

	2007-08			2008-09			2009-10 (Amount Includes Board of Control Claims)				2010-11			
ASH	07/08 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	07/08 Outside Medical Services in \$	08/09 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	08/09 Outside Medical Services in \$	09/10 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to	09/10 Outside Medical Services in \$	10/11 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to	10/11 Outside Medical Services in \$
	\$1,926,238.20	5 totaling \$953,574.12	\$2,553,704.86	\$828,817.76	1 totaling \$359,019.67	\$2,018,787.66	\$1,584,898.48	0	\$2,995.12	\$1,488,980.13	\$2,171,249.66	0	\$63,746.96	\$2,186,244.40
CSH	07/08 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	07/08 Outside Medical Services in \$	08/09 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	08/09 Outside Medical Services in \$	09/10 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	09/10 Outside Medical Services in \$	10/11 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	10/11 Outside Medical Services in \$
	\$1,468,652.86	0	\$3,705,493.93	\$4,981,094.46	1 totaling \$266,859.05	\$4,272,630.34	\$8,063,275.94 (includes BOC)	0	3 incidents totaling: \$18,196.66	\$2,541,074.10 (includes BOC)	\$5,279,786.73	1 totaling \$356,134.42	7 incidents totaling: \$41,586.57	\$3,438,157.96
MSH	07/08 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	07/08 Outside Medical Services in \$	08/09 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	08/09 Outside Medical Services in \$	09/10 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	09/10 Outside Medical Services in \$	10/11 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	10/11 Outside Medical Services in \$
	\$ 7,597.59	0	\$ 22,478.98	\$ 71,767.34	0	\$ 36,739.22	\$ 341,877.68	0	totalling: \$3,410.22	\$ 50,148.99	\$ 152,877.95	0	totalling: \$12,609.59	\$ 76,284.11
NSH	07/08 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	07/08 Outside Medical Services in \$	08/09 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	08/09 Outside Medical Services in \$	09/10 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	09/10 Outside Medical Services in \$	10/11 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	10/11 Outside Medical Services in \$
	\$ 1,444,722.34	3	\$ 1,375,810.72	\$ 4,336,301.56	3	\$ 2,230,331.05	\$6,577,133.59 (inc	8	totalling: \$ 251,948.08	\$2,821,504.97 (includes BOC)	\$ 7,576,256.63	6	totalling: \$804,742.45	\$ 2,661,722.37
PSH	07/08 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	07/08 Outside Medical Services in \$	08/09 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	08/09 Outside Medical Services in \$	09/10 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	09/10 Outside Medical Services in \$	10/11 Outside Hospitalization in \$	# of Hospitalizations over \$100,000	\$ Amount of Hospitalizations due to violence (harm to self, harm to others)*	10/11 Outside Medical Services in \$
	\$15,346,445.66	15	\$4,015,217.12	\$11,377,413.22	24	\$5,270,767.48	\$10,401,909.26	25	356,411.55	\$3,150,591.42	\$11,194,420.56	14	366,966.31	\$6,653,789.59

Appendix 7.A
SUMMARY OF STATE HOSPITAL DEFICIENCY
FISCAL YEAR 2010/2011

	GF SCO Allocation*	GF Actual Exp Thru June	FM 13 Accruals	2010 Total**	Deficit	\$50 Mil Allocation***	New Deficit	FY 2009	FY 2008
PERSONNEL SERVICES									
Salaries & Wages	697,197,947	674,534,115	10,188,896	684,723,011	12,474,935	6,450,973	18,925,908	575,994,390	611,406,877
Temporary Help	14,487,233	20,140,725	739,480	20,880,205	(6,392,972)	46,900	(6,346,072)	20,567,567	18,983,834
Overtime	86,517,866	99,157,249	6,469,861	105,627,110	(19,109,244)	1,783,277	(17,325,967)	93,455,910	75,725,534
Net Salaries	798,203,046	793,832,089	17,398,237	811,230,326	(13,027,281)	8,281,150	(4,746,131)	690,017,868	706,116,244
Workers' Compensation	17,637,496	23,066,680	3,806,529	26,873,209	(9,235,713)	471,000	(8,764,713)	17,094,428	20,254,952
Retirement	110,372,076	113,644,116	933,459	114,577,575	(4,205,499)	164,577	(4,040,922)	103,404,396	108,740,755
Other Benefits	124,264,426	114,560,573	1,868,659	116,429,232	7,835,194	1,228,206	9,063,400	107,183,774	104,787,175
Subtotal Staff Benefits	252,273,999	251,271,369	6,608,647	257,880,016	(5,606,018)	1,863,783	(3,742,235)	227,682,598	233,782,881
TOTAL, PERSONAL SERVICES	1,050,477,044	1,045,103,458	24,006,884	1,069,110,343	(18,633,298)	10,144,933	(8,488,366)	917,700,466	939,899,125
OPERATING EXPENSES & EQUIPMENT									
OE & E Other	71,619,509	68,916,880	7,983,826	76,900,706	(5,281,197)	2,554,165	(2,727,032)	50,313,694	57,255,307
C&PS-External-Health & Medical	35,805,425	29,688,120	14,950,344	44,638,464	(8,833,039)	3,668,024	(5,165,015)	53,115,876	38,667,475
LOC Outside Contracts	18,879,744	21,256,154	1,612,860	22,869,014	(3,989,270)	4,102,701	113,431	19,468,027	22,646,498
Foodstuffs	12,210,424	9,743,643	1,310,876	11,054,520	1,155,905	295,000	1,450,905	11,706,280	12,994,355
Pharmaceuticals	44,922,633	42,651,529	4,595,212	47,246,741	(2,324,108)	850,000	(1,474,108)	40,420,055	41,079,742
Gov't Claims (HQ Only)	0	17,685,870	3,120,859	20,806,729	(20,806,729)	0	(20,806,729)	0	0
Penalties	214,172	2,494,620	15,000	2,509,620	(2,295,448)	5,000	(2,290,448)	56,614	151,356
TOTAL, OE & E	183,651,907	192,436,815	33,588,978	226,025,794	(42,373,887)	11,474,890	(30,898,997)	175,080,546	172,794,734
RECEIPTS	(82,639,516)	(80,260,924)	(1,292,677)	(81,553,601)	(1,085,915)	0	(1,085,915)	(34,270,786)	(33,780,800)
TOTAL, GF EXPENDITURES	1,151,489,435	1,157,279,350	56,303,186	1,213,582,536	(62,093,101)	21,619,822	(40,473,278)	1,058,510,226	1,078,913,059

*Totals Must tie to FM 12 General Fund (GF) B06 (No Lottery or Medicare Premium). Allocation must also tie to SCO tab allocation 6/30/2011

**Total Must tie to PY GF B06 (without \$50 Million Alloc share)

***Allocations received from the \$50 Million, 7/1/11 through 7/28/11

Reconciliation to Appropriation (in thousands)

SCO GF Allocations thru 6/30/11	1,151,489
Add'l Allocations 7/1 thru 7/29	21,620
Balance of \$50 mil to be allocated	28,380
011 GF Appropriation Total	1,201,489

Net Deficit after alloc of \$50 mil balance (12,093)

**Appendix 7.B: Hospital System Summary
2011-12 Operating Expenditure Projections**

Object Code	BUDGET CATEGORIES / LINE ITEMS	FY	Allocation	July Actual	August Actual	Sept Projection	October Projection	November Projection	December Projection	January Projection	February Projection	March Projection	April Projection	May Projection	June Projection	FM 13 Projection	Total Operating Expenditures	Surplus/(Deficit)
	PERSONAL SERVICES																	
003	Salaries & Wages	09/10	563,994,868	43,381,305	50,098,478	50,256,886	49,879,094	49,503,397	50,199,182	51,283,141	50,417,171	49,194,566	50,566,489	50,359,733	54,933,131	9,769,885	609,842,460	(45,847,592)
	(includes 088 Holiday Pay)	10/11	634,309,218	49,870,456	53,193,643	53,007,872	52,829,332	54,290,303	55,330,515	55,661,900	55,389,066	54,154,781	56,559,710	53,180,977	55,372,624	13,564,616	662,405,793	(28,096,575)
	Avg. Jun & Aug- 5% inc in Nov.	11/12	642,524,923	48,270,047	54,727,669	55,956,068	55,407,542	57,609,918	57,748,871	58,414,692	58,385,523	57,915,204	58,174,443	58,106,786	58,581,160	11,527,067	690,824,990	(48,300,067)
033	Temp Help	09/10	13,568,279	596,534	1,710,225	1,705,489	1,750,533	1,733,567	1,807,679	1,739,530	1,773,183	1,478,127	1,597,844	1,469,297	1,525,268	638,703	19,525,980	(5,957,701)
		10/11	17,840,326	570,795	1,607,112	1,686,247	1,723,000	1,782,072	1,720,532	1,873,750	1,815,745	1,699,512	1,789,351	1,678,486	1,972,603	567,966	20,487,173	(2,646,847)
	August actual for entire year	11/12	2,439,278	525,003	1,712,952	1,720,199	1,801,021	1,784,749	1,759,486	1,740,472	1,711,332	1,748,066	1,751,986	1,695,226	1,692,127	745,822	20,388,441	(17,949,162)
083	Overtime	09/10	84,523,733	935,899	7,430,484	8,341,945	7,935,951	9,449,445	8,595,533	8,585,582	9,294,254	8,030,461	8,301,230	9,053,231	9,719,890	4,723,379	100,397,286	(15,873,552)
		10/11	111,336,028	1,425,232	9,600,592	8,868,027	8,615,050	10,035,062	8,701,185	9,766,232	9,399,327	8,803,621	9,438,628	10,464,864	9,910,924	4,964,743	109,993,489	1,342,539
	Aug X 9, Oct and Nov PY OT for Court Monitors	11/12	63,166,496	1,266,011	9,847,551	8,971,350	8,935,136	9,685,512	9,278,941	9,506,585	9,180,728	8,996,186	9,150,340	9,729,900	9,505,019	6,589,032	110,642,292	(47,475,795)
	FY 09/10 Subtotal - Salaries	09/10	662,086,880	44,913,738	59,239,187	60,304,321	59,565,579	60,696,409	60,602,395	61,608,253	61,484,609	58,703,154	60,465,564	60,882,261	66,178,289	15,131,967	729,765,726	(67,678,845)
	FY 10/11 Subtotal - Salaries	10/11	763,485,572	51,866,483	64,401,347	63,562,147	63,167,382	66,107,437	65,752,233	67,301,883	66,604,138	64,657,914	67,787,690	65,324,326	67,256,151	19,097,325	792,866,455	(29,400,883)
	FY 11/12 Subtotal - Salaries	11/12	708,130,698	50,061,062	66,288,172	66,647,616	66,143,700	69,080,178	68,787,298	69,661,749	69,277,583	68,659,456	69,076,770	69,531,912	69,778,306	18,861,921	821,855,722	(113,725,025)
	Staff Benefits:																	
103	OASDI	09/10	24,164,746	1,763,167	1,806,091	1,747,961	1,727,429	1,782,598	1,871,446	1,874,728	1,865,655	1,881,066	1,816,969	1,837,370	1,838,162	51,092	21,863,735	2,301,011
	104 Dental Ins & 105 Health/Welfare included in	10/11	25,601,912	1,845,941	1,803,901	1,823,304	1,828,092	1,840,505	2,032,444	2,008,143	2,052,332	2,030,513	2,039,017	2,017,221	2,051,817	48,233	23,421,463	2,180,449
	August actual for entire year	11/12	24,814,495	1,961,316	1,988,698	2,007,766	1,990,813	2,040,623	2,114,889	2,154,361	2,186,911	2,222,741	2,241,085	2,286,165	2,354,680	187,489	25,737,539	(923,044)
106	Retirement	09/10	121,238,687	7,989,331	9,022,754	9,134,207	9,130,722	9,066,994	9,160,808	9,283,964	9,102,977	8,987,080	9,235,759	9,093,194	9,394,120	373,953	108,975,862	12,262,825
		10/11	126,528,162	9,135,893	9,572,320	9,656,856	14,408,524	11,274,854	11,504,761	9,146,464	9,220,112	9,039,752	9,437,335	8,944,394	9,258,501	540,086	121,139,851	5,388,310
	August actual for entire year	11/12	116,591,082	8,453,002	9,541,755	9,881,612	10,698,566	10,456,748	10,534,170	10,300,982	10,300,784	10,273,429	10,273,311	10,271,011	10,328,289	1,471,793	122,785,452	(6,194,370)
125	Workers' Compensation	09/10	20,670,145	0	0	4,581,120	1,928,755	1,646,923	1,878,835	2,082,416	1,870,215	1,774,200	2,283,931	2,437,189	(4,431,574)	(3,108,134)	12,943,877	7,726,267
		10/11	21,955,039	0	0	0	1,322,876	7,151,647	3,945,107	2,103,000	2,612,860	2,005,056	2,683,760	1,295,492	0	4,224,486	27,344,285	(5,389,246)
	Average May - August	11/12	26,581,322	539,233	1,858,557	3,283,071	2,296,142	2,671,839	2,331,491	2,160,003	2,411,567	2,224,303	2,349,786	2,197,231	2,128,182	1,177,891	27,629,296	(1,047,973)
127	Industrial Disability Leave	09/10	7,030,937	327,494	496,769	555,970	569,005	539,537	560,918	670,069	604,971	757,872	712,415	600,149	641,990	344,843	7,382,000	(351,064)
		10/11	8,774,076	372,860	527,220	537,839	554,814	687,671	816,971	707,690	733,578	839,307	1,033,172	768,348	834,746	279,756	8,693,971	80,105
	August actual for entire year	11/12	8,437,200	472,799	666,274	793,259	681,941	772,527	833,332	726,841	744,776	794,686	782,197	726,789	738,114	208,876	8,942,411	(505,211)
132	Nonindustrial Disability Leave	09/10	2,644,703	33,486	126,838	117,784	221,270	173,289	234,549	182,486	229,856	343,839	311,720	264,435	231,753	58,526	2,529,829	114,873
		10/11	3,086,708	48,363	115,520	183,654	289,362	171,533	241,423	181,166	277,940	204,789	287,541	352,460	381,268	101,294	2,836,314	250,394
	August actual for entire year	11/12	3,000,096	32,847	216,533	240,849	321,821	241,163	220,632	233,426	315,865	275,508	322,881	320,523	302,623	155,957	3,200,627	(200,531)
133	Unemployment Insurance	09/10	1,641,563	0	0	0	0	357,263	165,462	144,720	0	498,505	0	223,580	208,538	249,000	1,847,068	(205,505)
		10/11	1,689,160	0	0	0	127,641	186,274	213,683	0	(15,515)	232,017	(21,125)	164,611	337,919	261,500	1,487,005	202,154
	Same as last year (SALY)	11/12	1,477,882	2,132	18,553	19,103	163,478	246,444	39,391	164,686	39,760	134,630	164,537	121,428	231,427	285,342	1,630,911	(153,029)
134	Other	09/10	78,783,368	5,988,569	6,319,893	5,486,544	5,463,637	6,383,547	6,525,394	6,549,858	6,567,730	6,620,995	6,567,989	6,543,238	6,673,774	419,846	76,111,015	2,672,354
	(includes 135 Life Insur, 136 Vision, 137 Medicare)	10/11	88,501,132	6,187,251	6,463,557	6,580,613	6,838,058	6,799,644	7,355,003	7,316,513	7,256,603	7,354,856	7,417,505	7,281,624	7,250,611	836,773	84,938,613	3,562,520
	August actual for entire year	11/12	81,170,130	6,905,758	7,232,769	7,269,613	7,165,072	7,362,271	7,415,230	7,455,554	7,416,667	7,445,694	7,404,919	7,414,641	7,466,028	826,278	88,780,495	(7,610,366)
	FY 09/10 Subtotal - Staff Benefits	09/10	256,174,149	16,102,047	17,772,345	21,623,586	19,040,817	19,950,150	20,397,412	20,788,242	20,241,404	20,863,557	20,928,784	20,999,153	14,556,763	(1,610,873)	231,653,386	24,520,762
	FY 10/11 Subtotal - Staff Benefits	10/11	276,136,190	17,590,308	18,482,518	18,782,266	25,369,367	28,112,127	26,109,392	21,462,977	22,137,910	21,706,290	22,877,207	20,824,150	20,114,862	6,292,127	269,861,502	6,274,688
	FY 11/12 Subtotal - Staff Benefits	11/12	262,072,206	18,367,087	21,523,138	23,495,272	23,317,833	23,791,617	23,489,135	23,195,852	23,416,331	23,370,990	23,538,715	23,337,790	23,549,345	4,313,625	278,706,731	(16,634,525)

**Appendix 7.B: Hospital System Summary
2011-12 Operating Expenditure Projections**

Object Code	BUDGET CATEGORIES / LINE ITEMS	FY	Allocation	July Actual	August Actual	Sept Projection	October Projection	November Projection	December Projection	January Projection	February Projection	March Projection	April Projection	May Projection	June Projection	FM 13 Projection	Total Operating Expenditures	Surplus/(Deficit)
OPERATING EXPENSES & EQUIPMENT																		
311	General Expense	09/10	6,257,469	17,474	61,014	253,036	342,647	268,312	268,807	271,534	712,144	679,745	494,518	510,455	213,711	259,323	4,352,721	1,904,748
		10/11	4,714,222	(417)	(379)	26,645	528,427	651,119	435,139	334,091	217,585	378,299	270,802	165,161	364,682	1,749,747	5,120,900	(406,678)
	SALY	11/12	5,136,619	91,397	370,097	526,621	602,298	414,912	414,912	410,912	415,912	415,912	415,912	415,912	440,908	501,675	5,437,384	(300,765)
312	Printing	09/10	1,582,240	(274)	16,836	112,606	136,845	111,971	82,167	167,068	123,297	119,795	107,916	171,162	53,806	205,725	1,408,920	173,320
		10/11	1,472,783	(1,020)	(937)	33,482	83,011	173,320	172,051	99,378	179,548	222,763	77,217	61,642	140,321	59,683	1,300,460	172,323
	SALY	11/12	1,363,721	9,085	101,585	103,839	139,954	94,565	138,565	111,565	113,565	128,565	103,565	113,565	103,565	132,583	1,394,568	(30,848)
313	Communications	09/10	3,264,538	(99)	217,208	259,760	255,334	244,028	310,131	235,551	356,186	307,699	316,418	341,963	137,335	101,109	3,082,626	181,912
		10/11	3,147,946	(245)	(300)	46,670	579,640	402,125	369,826	212,089	135,407	305,261	321,482	173,973	359,520	77,425	2,982,873	165,072
	SALY	11/12	2,861,370	60,893	198,780	173,828	319,899	243,248	243,248	243,248	243,248	243,248	243,248	243,248	243,252	252,930	2,952,321	(90,951)
314	Postage	09/10	369,105	(1,076)	7,622	21,146	16,567	12,688	31,279	9,555	51,420	28,835	8,411	47,234	20,299	1,234	255,214	113,891
		10/11	352,775	(1,150)	(1,332)	(1,499)	22,508	24,250	51,676	6,011	25,439	14,701	57,635	128	57,415	10,186	265,967	86,808
	SALY	11/12	285,594	25,063	9,291	13,680	74,131	18,875	18,875	28,875	28,875	28,875	18,875	63,875	18,871	(93)	348,068	(62,474)
315	Insurance	09/10	706,482	(49)	28,542	124,557	154,737	57,292	43,365	202,202	60,665	(119,163)	126,034	34,783	56,609	43,339	812,913	(106,432)
	(includes Insurance & Pt Medicare Insurance)	10/11	700,261	(10)	(2,188)	105,648	15,757	144,213	192,036	162,833	12,677	74,758	(1,331)	82,277	155,914	(22,728)	919,855	(219,594)
	SALY	11/12	464,713	953	59,493	75,295	135,845	108,669	66,669	101,669	91,669	66,669	101,669	91,669	68,672	(102,515)	866,427	(401,714)
317	Travel-In-State	09/10	726,295	(1,151)	(304)	62,991	64,184	36,928	41,868	77,640	114,865	19,317	92,030	70,631	37,092	25,592	641,481	84,814
	Added OT Meal Tickets	10/11	888,989	(5,805)	(4,529)	(4,662)	52,591	103,718	91,311	65,564	17,545	76,477	76,043	65,000	191,766	168,297	893,316	(4,326)
	SALY	11/12	861,090	8,031	61,490	65,064	78,273	71,308	68,308	71,308	71,308	71,308	71,308	71,308	71,303	58,930	839,246	21,844
318	Travel-Out-of-State	09/10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		10/11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		11/12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
321	Training	09/10	615,448	36,430	(23,489)	6,938	30,803	22,315	46,581	136,719	29,800	44,556	42,689	53,487	26,758	13,933	467,520	147,928
		10/11	414,632	0	0	3,413	64,550	24,331	79,780	25,316	(10,624)	42,548	33,065	38,451	45,177	24,199	370,204	44,428
	SALY	11/12	392,198	5,583	6,219	29,374	44,316	39,455	26,955	36,455	36,455	31,455	31,455	31,455	31,455	54,649	405,283	(13,085)
323	Facilities Operation	09/10	8,079,153	11,448	162,491	282,343	561,912	508,475	565,669	469,980	671,152	665,753	813,631	610,032	356,343	525,642	6,204,871	1,874,282
		10/11	6,978,978	(1,506)	(317)	51,172	1,135,116	650,864	392,056	830,089	(111,356)	1,011,842	601,884	717,308	1,389,919	(5,803)	6,661,267	317,710
	SALY	11/12	6,179,740	237,791	404,041	448,070	542,763	655,670	555,670	510,670	460,670	485,670	635,670	485,670	620,668	1,271,958	7,314,985	(1,135,244)
352	Special Repairs & Deferred Maint.	09/10	1,686,777	0	251	2,795	(1,275)	4,384	(10,529)	152,834	17,112	14,580	102,160	3,645	6,763	391,613	684,332	1,002,444
		10/11	694,785	0	0	0	42,109	0	230,680	21,473	768	(40,682)	42,143	1,454	198,600	0	496,544	1,982,241
	Full allocation	11/12	1,995,495	0	45,365	46,216	44,248	44,248	44,248	44,248	44,248	44,248	44,248	44,248	1,417,038	268,577	2,131,183	(135,688)
324	Utilities	09/10	15,288,393	53,116	776,361	1,350,870	1,612,754	663,486	965,746	953,263	1,319,210	679,394	1,174,929	988,590	1,130,531	468,152	12,136,401	3,151,992
		10/11	14,324,750	(50)	(5,550)	338,271	1,867,838	3,091,718	915,736	1,112,599	545,689	1,419,956	1,118,864	695,492	1,784,463	929,757	13,814,783	509,967
	SALY plus historical increase of 12%	11/12	14,016,274	184,213	670,480	1,724,313	1,474,175	1,358,034	1,336,034	1,338,034	1,133,034	1,108,034	1,283,034	1,058,034	1,286,037	1,088,361	15,041,822	(1,025,548)
325	C&PS-Interdepartmental	09/10	1,748,990	(604)	8,749	228,991	137,844	44,211	337,512	111,155	95,689	318,825	150,505	113,909	124,942	55,757	1,727,483	21,507
		10/11	1,293,265	(510)	(561)	112,568	73,699	501,230	506,455	92,754	294,891	135,043	48,940	194,828	290,487	(131,987)	2,117,835	(824,570)
	SALY	11/12	1,812,122	288	35,669	265,121	142,594	139,210	139,210	146,210	139,210	141,210	161,210	161,210	159,917	184,754	1,795,810	16,311
326	C&PS-External	09/10	24,128,925	17,140	156,725	99,633	90,514	176,283	36,354	136,154	120,096	127,371	115,572	85,767	15,581,397	59,735	16,802,742	7,326,184
	(See 418 for Personnel Contracts)	10/11	11,799,694	0	0	525,831	1,499,560	3,449,316	2,175,441	1,037,170	765,748	2,090,142	1,911,592	1,090,527	2,255,359	49,841	16,850,526	(5,050,832)
	SALY	11/12	32,212,407	27,620	105,662	1,469,162	1,448,758	1,443,770	1,428,770	1,443,770	1,428,770	1,443,770	1,428,770	1,428,770	19,428,161	1,031,433	33,557,186	(1,344,779)
328	Consolidated Data Centers	09/10	384,248	0	792	1,912	16,518	904	3,024	37,424	3,828	22,868	75,505	19,403	64,214	11,595	257,986	126,262
		10/11	394,533	0	0	0	13,987	31,183	41,620	21,719	14,107	31,953	109,008	19,078	9,904	60,174	352,734	41,799
	SALY	11/12	370,277	1,250	12,368	14,627	26,747	23,801	23,801	23,801	23,801	23,801	23,801	23,801	23,801	48,122	293,519	76,758
329	Data Processing	09/10	4,712,876	0	806,627	204,562	103,618	156,292	271,389	576,523	254,215	781,702	310,983	682,078	105,006	371,058	4,624,053	88,823
		10/11	5,646,435	0	0	16,608	1,301,921	289,596	946,972	359,393	26,353	337,850	443,482	67,568	210,938	75,760	4,076,441	1,569,994
	SALY	11/12	5,719,954	50,091	315,718	268,376	525,241	656,806	1,256,806	326,806	356,806	456,806	356,806	356,806	356,810	233,660	5,517,441	202,512
332	Equipment	09/10	934,347	0	0	60,049	34,500	166,422	208,386	92,599	51,869	20,997	227,233	86,578	22,987	2,715	974,337	(39,990)
		10/11	1,640,468	0	0	2,355	117,426	1,983	12,335	66,443	141	159,843	42,561	59,842	139,810	152,769	755,509	884,960
	SALY	11/12	1,563,996	2,667	18,636	36,925	22,926	121,714	121,714	121,714	121,714	121,714	121,714	121,714	51,714	413,627	1,398,490	165,506
413	C&PS-External-Hlth & Med.	09/10	35,222,440	4,030	1,132,471	1,438,719	1,682,253	1,638,413	2,467,780	4,537,630	2,519,319	3,726,746	2,440,144	2,379,851	922,830	6,973,263	31,863,449	3,358,991
		10/11	46,562,064	0	0	193,602	6,745,971	4,583,578	6,832,603	2,046,018	2,661,451	5,428,894	3,641,688	4,533,039	3,820,366	9,369,742	49,856,952	(3,294,889)
	SALY	11/12	45,954,337	166,470	981,960	3,316,191	4,650,275	3,869,547	3,869,547	3,869,547	3,869,547	3,269,548	3,069,548	3,269,548	3,369,548	8,431,160	45,502,434	451,903
418	Outside Services	09/10	32,242,601	0	1,720,973	2,555,709	3,945,720	2,254,597	3,177,125	2,803,994	3,949,199	4,187,724						

**Appendix 7.B: Hospital System Summary
2011-12 Operating Expenditure Projections**

Object Code	BUDGET CATEGORIES / LINE ITEMS	FY	Allocation	July Actual	August Actual	Sept Projection	October Projection	November Projection	December Projection	January Projection	February Projection	March Projection	April Projection	May Projection	June Projection	FM 13 Projection	Total Operating Expenditures	Surplus/(Deficit)
	FY11/12 Total OE & E		207,696,532	3,965,409	11,508,315	18,013,827	17,500,333	16,550,737	16,999,370	16,148,863	15,373,863	15,552,364	15,492,364	15,302,364	34,898,251	21,770,316	219,076,376	(11,379,844)
	FY11/12 GRAND TOTAL PS and OE&E		1,177,899,436	72,393,557	99,319,625	108,156,716	106,961,866	109,422,533	109,275,804	109,006,464	108,067,777	107,582,810	108,107,849	108,172,065	128,225,902	44,945,862	1,319,638,829	(141,739,393)
	Less: Reimbursement		(76,241,826)	(3,040,988)	(2,543,152)	(2,541,409)	(2,541,409)	(3,733,409)	(3,833,409)	(3,833,409)	(3,933,409)	(3,833,409)	(3,733,409)	(4,033,409)	(5,033,409)	(33,780,362)	(76,414,586)	172,760
	FY11/12 Total General Fund PS and OE&E		1,101,657,610	69,352,569	96,776,473	105,615,308	104,420,457	105,689,125	105,442,396	105,173,056	104,134,369	103,749,401	104,374,440	104,138,656	123,192,493	11,165,500	1,243,224,243	(141,566,632)

Appendix 7.C

SUMMARY OF STATE HOSPITAL ALLOCATIONS AND EXPENDITURES
2009/2010
(IN THOUSANDS)

	Population	Allocation	Estimated Expenditures	Deficiency	Cost Per Patient
ASH	1,022	210,585	221,503	(10,918)	216.7
CSH	829	141,918	150,393	(8,475)	181.4
MSH	668	149,469	151,934	(2,465)	227.4
NSH	1,160	230,599	236,496	(5,897)	203.9
PSH	1,525	286,220	289,397	(3,177)	189.8
SVPP		44,892	44,279	613	
VPP		48,235	46,848	1,387	
HQ		15,552	15,552		
TOTALS	5,204	1,127,470	1,156,402	(28,932)	

Cost Per Patient – 5 Hospitals

5,204	1,049,723	201.7
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11/08/11

SUMMARY OF STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

2010/2011

(IN THOUSANDS)

	<u>Population</u>	<u>Allocation</u>	<u>Estimated Expenditures</u>	<u>Deficiency</u>	<u>Cost Per Patient</u>	<u>Percentage Growth Over Prior Year</u>
ASH	1,141	215,520	237,682	(22,162)	208.3	-3.8%
CSH	905	174,707	174,230	477	192.5	6.1%
MSH	635	149,935	167,118	(17,183)	263.2	15.7%
NSH	1,163	222,272	253,683	(31,411)	218.2	7.0%
PSH	1,515	262,264	312,338	(50,074)	206.2	8.6%
SVPP		68,751	59,655	9,096		
VPP		50,659	54,968	(4,309)		
HQ		30,145	34,189	(4,044)		
TOTALS	5,359	1,174,253	1,293,863	(119,610)		

Cost per patient –5 hospitals

5,359	1,145,051	213.7	5.9%
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11/10/11

SUMMARY OF STATE HOSPITAL ALLOCATIONS AND EXPENDITURES

2011/2012
(IN THOUSANDS)

	<u>Population</u>	<u>Allocation</u>	<u>Estimated Expenditures</u>	<u>Deficiency</u>	<u>Cost Per Patient</u>	<u>Percentage Growth Over Prior Year</u>
ASH	1,031	204,369	226,395	(22,026)	219.6	5.4%
CSH	920	174,236	179,730	(5,494)	195.4	1.5%
MSH	617	150,399	172,118	(21,719)	279.0	6.0%
NSH	1,159	227,759	261,140	(33,381)	225.3	3.0%
PSH	1,507	271,763	324,904	(53,141)	215.6	4.5%
SVPP	*	71,806	73,889	(2,083)	*	
VPP	*	58,195	61,421	(3,226)	*	
HQ		17,999	17,999	0		
Sub-total				(141,070)		
Special Repairs		1,373	1,373	0		
Colman Reserve		29,520		29,520		
Census Reserve		41,706		41,706		
Other Sp. Fds		895	895	0		
TOTALS	5,234	1,250,020	1,319,864	(69,844)		

* Cost per Patient not computed since the psychiatric programs are not funded like the other hospitals.

Total Expenditures	1,319,864	
Net Deficit		(69,844)
Less Special Funds	895	895
Net Expenditures (deficit)	1,318,969	(68,949)

Cost per Patient – 5 Hospitals

5,234	1,164,287	222.4	4.1%
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11/12/11

Appendix 7.D

2010-11 Personal Leave Program (PLP)

Total PLP Hours Charged 2010-11	494,619
Number of hours charged to overtime (44.7%)	221,095
Mid range Psych Tech (Safety) Salary	\$4,633
Hourly Rate	\$27
Overtime Hourly Rate	\$40
Total cost of PLP overtime hours for 2010-11	\$8,864,407

Assumptions:

Psychiatric Technician most frequently utilized class for overtime shift coverage

Utilizes average safety salary, multiplied by 1.5 for overtime

Hourly rate determined by dividing average monthly salary by 173.33 hours

Data Source:

MIRS

DPA Salary Scale

Appendix 7.E

**Summary of FY 2009-10 Deficit Carried into 2010-11 via
Board of Control Claims**

Hospital	Total Claims	Penalties	Total Payment
Coalinga	\$7,904,235	\$779,258	\$8,683,493
Metro	2,211,129	199,867	2,410,996
Napa	6,994,261	242,567	7,236,828
Patton	6,676,036	62,201	6,738,237
Salinas	1,035,682	87,578	1,123,260
Vacaville	<u>241,485</u>	<u>1,528</u>	<u>243,013</u>
TOTAL	\$25,062,828	\$1,372,999	\$26,435,827

Appendix 7.F
Position Information from Enhancement Plan BCP

ENHANCEMENT PLAN FY 06-07 BUDGET CHANGE PROPOSAL (BCP) POSITIONS									
CATEGORY	CLASSIFICATION	POSITIONS							AMOUNT
		HQ	ASH	CSH	MSH	NSH	PSH	TOTAL	
By Choice	Psychiatric Technician	0.0	2.0	2.0	2.0	2.0	2.0	10.0	\$ 454,269
Clerical Support	Office Technician	0.0	17.0	1.5	13.5	0.0	16.0	48.0	\$ 1,681,344
Compliance Monitoring	Psychiatric Social Worker	0.0	4.1	1.0	2.0	3.4	3.8	14.3	\$ 868,366
Compliance Monitoring	Registered Nurse	0.0	4.1	1.0	2.0	3.4	3.8	14.3	\$ 1,012,780
Compliance Monitoring	Rehabilitation Therapist	0.0	4.1	1.0	2.0	3.4	3.8	14.3	\$ 659,123
Compliance Monitoring	Senior Psychiatrist	0.0	8.1	1.0	4.0	6.8	7.6	27.5	\$ 4,391,290
Compliance Monitoring	Senior Psychologist	0.0	5.7	1.0	2.8	4.8	5.3	19.6	\$ 1,410,265
Core Clinical and Level of Care Staffing	Psychiatric Social Worker	0.0	-3.7	2.7	-6.9	0.3	-8.4	-16.0	\$ (971,599)
Core Clinical and Level of Care Staffing	Psychiatric Technician	0.0	10.3	-0.6	3.7	-2.7	2.3	13.0	\$ 590,550
Core Clinical and Level of Care Staffing	Registered Nurse	0.0	5.1	-3.6	11.0	3.9	1.1	17.5	\$ 1,239,416
Core Clinical and Level of Care Staffing	Rehabilitation Therapist	0.0	0.0	-2.4	5.0	-4.8	18.3	16.1	\$ 742,090
Core Clinical and Level of Care Staffing	Senior Psychiatrist	0.0	-5.4	6.8	2.9	7.5	7.4	19.2	\$ 3,065,918
Core Clinical and Level of Care Staffing	Senior Psychologist	0.0	46.1	0.5	22.9	20.8	45.0	135.3	\$ 9,735,146
Dietary Services	Clinical Dietician	0.0	2.9	0.0	0.0	1.7	0.9	5.5	\$ 256,009
HQ Support	Associate Mental Health Specialist	1.0	0.0	0.0	0.0	0.0	0.0	1.0	\$ 57,380
HQ Support	Consulting Psychologist	1.0	0.0	0.0	0.0	0.0	0.0	1.0	\$ 65,533
Investigations	Special Investigator	0.0	1.8	0.0	2.1	2.9	1.8	8.6	\$ 472,821
Neuropsychologists	Senior Psychologist	0.0	1.0	1.0	1.0	1.0	1.0	5.0	\$ 359,761
PBS Teams	Health Records Technician I	0.0	4.7	1.0	2.4	4.0	4.4	16.5	\$ 567,879
PBS Teams	Psychiatric Social Worker	0.0	1.0	1.0	1.0	1.0	1.0	5.0	\$ 303,625
PBS Teams	Psychiatric Technician	0.0	8.4	1.0	3.8	7.0	7.8	28.0	\$ 1,271,953
PBS Teams	Registered Nurse	0.0	4.7	1.0	2.4	4.0	4.4	16.5	\$ 1,168,593
PBS Teams	Senior Psychologist	0.0	4.7	1.0	2.4	4.0	4.4	16.5	\$ 1,187,213
Trigger System	Health Records Technician I	0.0	1.0	1.0	1.0	1.0	1.0	5.0	\$ 172,085
Trigger System	Psychiatric Social Worker	0.0	3.0	2.0	2.0	3.0	3.0	13.0	\$ 789,424
GRAND TOTAL		2.0	130.7	20.9	85.0	78.4	137.7	454.7	\$ 31,551,234

Appendix 7.G
List of Enhancement Plan Redirected Positions

Classification	ASH	Coalinga	Metro	Napa	Patton	Salinas	Vacaville	Total	Annual Cost	EP Cost*
Sr Psychiatrist	4	0	4	8	11	0	0	27	\$9,632,654	\$7,017,182
Sr Psychologist	22	7	8	16	15	0	4	72	\$10,292,624	\$7,497,956
Psychiatric Social Worker	8	2	4	0	26	0	1	41	\$4,154,065	\$3,026,147
Rehab Therapist	8	2	7	0	12	0	1	29	\$2,841,422	\$2,069,915
Registered Nurse	32	23	12	30	34	1	3	134	\$16,947,761	\$12,346,080
Psychiatric Technician	107	18	23	18	107	0	0	273	\$21,598,509	\$15,734,050
Health Record Technician	0	3	0	0	1	0	0	4	\$248,802	\$181,247
Clinical Dietitian	0	11	1	4	6	0	0	21	\$1,580,088	\$1,151,060
Special Investigator	0	4	1	3	5	0	0	13	\$1,105,712	\$805,487
Office Technician	4	3	0	10	1	0	0	18	\$902,275	\$657,288
Stock Clerk	0	0	0	0	1	0	0	1	\$45,173	\$32,907
Custodian	0	0	0	0	9	0	0	9	\$356,334	\$259,581
Asst Dir Nutr Service	0	0	0	0	1	0	0	1	\$86,116	\$62,734
Psych Tech Asst	4	0	0	0	13	0	0	17	\$753,523	\$548,925
Health Service Specialist	0	0	0	0	1	0	0	1	\$126,099	\$91,861
Licensed Vocational Nurse	0	0	1	0	3	3	0	7	\$404,320	\$294,538
Unit Supervisor	5	1	5	0	1	0	0	12	\$1,355,687	\$987,589
Office Assistant	0	0	16	0	27	0	0	43	\$1,779,486	\$1,296,317
Nursing Coordinator	2	0	1	0	1	1	0	5	\$664,195	\$483,852
Student Assistant	0	0	0	0	5	0	0	5	\$114,339	\$83,293
Pharmacist I	0	0	0	1	1	0	0	2	\$304,162	\$221,575
Pharm Tech	0	0	0	0	3	0	0	3	\$159,629	\$116,287
Physical Therapist II	0	0	0	1	1	0	0	2	\$158,922	\$115,771
Physical Therapist	1	0	0	3	3	0	0	7	\$504,543	\$367,548
Physical Therapy Asst.	0	0	0	2	1	0	0	3	\$142,367	\$103,712
Occupational Therapist	2	0	0	1	3	0	0	6	\$579,882	\$422,432
Sr. Occup Therapist	0	0	0	1	0	0	0	1	\$106,318	\$77,451
Behavioral Specialist	2	24	0	0	0	0	0	26	\$2,326,858	\$1,695,066
Nurse Practitioner	13	0	0	0	0	0	0	13	\$1,982,965	\$1,444,548
Sr Psych Tech	11	4	2	0	4	0	0	21	\$1,768,635	\$1,288,413
Chief Psych	0	0	0	1	0	0	0	1	\$365,080	\$265,953
Research Prog Spec II	0	0	0	1	0	0	0	1	\$99,073	\$72,173
Program Director	0	0	0	1	0	0	0	1	\$121,896	\$88,798

Appendix 7.G

List of Enhancement Plan Redirected Positions

Staff Serv Analyst	0	1	0	1	0	0	1	3	\$183,564	\$133,722
Medical Transcriber	0	0	0	1	0	0	0	1	\$48,332	\$35,209
Speech Path	1	0	0	2	0	0	0	3	\$231,963	\$168,980
Asst Tech Spec	0	0	0	1	0	0	0	1	\$62,249	\$45,347
Asst Tech Supvr	0	0	0	1	0	0	0	1	\$71,921	\$52,393
Senior Special Investigator	0	0	6	0	0	0	0	6	\$513,488	\$374,065
Psychologist	9	0	3	0	15	0	1	28	\$3,617,727	\$2,635,437
Supervisor Rec Therapist	5	3	4	6	7	0	0	25	\$2,537,068	\$1,848,200
Psychiatrist	1	0	1	0	13	0	0	15	\$4,886,419	\$3,559,651
Research Analyst	0	0	1	0	0	0	0	1	\$65,510	\$47,722
Senior CSW	5	3	3	5	8	0	0	24	\$2,799,933	\$2,039,691
Nurse Instructor	9	0	0	0	0	0	0	9	\$1,081,820	\$788,082
Senior Vocational Counselor	1	0	0	0	0	0	0	1	\$64,078	\$46,679
Program Assistant	0	1	0	0	0	0	0	1	\$106,285	\$77,426
Medical Tech Asst	0	0	0	0	0	7	3	10	\$847,178	\$617,151
Sr Medical Tech Asst	0	0	0	0	0	4	8	12	\$1,302,329	\$948,718
Supv Registered Nurse	0	0	1	0	0	0	8	9	\$981,331	\$714,879
Totals	255	110	103	118	338	16	30	969	\$103,010,707	\$75,041,088
Diverted for EP	162	98	99	118	230	0	0	706		
Percent (%) Diverted for EP	64%	89%	96%	100%	68%	0%	0%	73%		

* Weighted average percentage based on all hospitals.

**Appendix 7.H
Temporary Help, Overtime, Worker's Comp, and Registry**

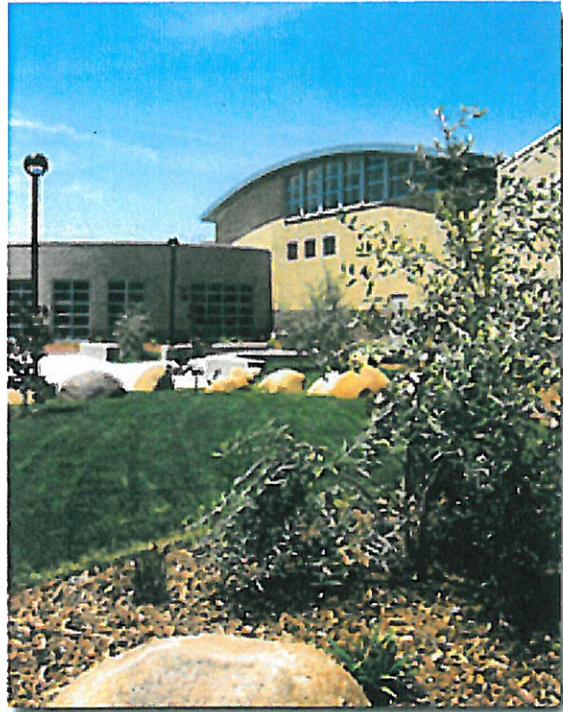
Category	FY	ASH	CSH	MSH	PSH	NSH	SVPP	VPP	TOTAL
(033) Temp. Help									
	5/6	1,773,774	0	2,844,754	8,003,877	306,605	0	0	12,929,010
	6/7	2,177,705	0	2,818,593	13,449,274	545,809	0	0	18,991,381
	7/8	3,281,299	0	3,483,377	9,892,719	222,599	0	0	16,879,994
	8/9	3,703,998	0	3,771,370	11,066,612	479,115	0	0	19,021,095
	9/10	4,740,460	0	4,259,810	10,397,149	245,790	0	0	19,643,209
	10/11	3,971,184		6,133,146	9,053,979	310,892	0	0	19,469,201
	11/12	3,722,371	966,715	6,383,171	9,322,488	339,310	0	0	20,734,055
<i>Sub-total Temp. Help</i>		23,370,791	966,715	29,694,221	71,186,098	2,450,120	0	0	127,667,945
(083) Overtime									
	5/6	12,456,224	942,137	10,125,129	14,813,834	15,687,106	882,351	3,742,342	58,649,123
	6/7	12,580,119	2,405,155	14,310,578	17,704,240	18,166,722	2,554,285	4,731,912	72,453,011
	7/8	9,900,775	4,964,453	14,568,193	23,470,140	19,803,669	3,989,276	6,482,580	83,179,086
	8/9	9,671,820	6,756,435	11,639,340	24,589,615	18,855,936	3,571,979	5,988,037	81,073,162
	9/10	10,810,278	10,415,434	14,194,073	30,912,430	24,838,304	4,369,895	5,817,835	101,358,249
	10/11	15,234,363	10,490,986	13,552,032	31,800,954	26,156,170	5,879,132	6,387,904	109,501,541
	11/12	13,902,492	10,785,101	18,323,120	31,915,621	28,613,993	7,501,572	6,929,325	117,971,224
<i>Sub-total Overtime</i>		84,556,071	46,759,701	96,712,465	175,206,834	152,121,900	28,748,490	40,079,935	624,185,396
(125) Worker's Comp.									
	5/6	4,736,946	67,224	5,261,617	4,494,820	4,842,092	76,475	677,236	20,156,410
	6/7	5,311,765	315,292	5,657,734	4,631,334	4,407,046	83,234	585,189	20,991,594
	7/8	4,513,640	551,385	6,115,818	4,440,415	4,170,717	99,515	669,506	20,560,996
	8/9	5,147,556	502,754	4,687,882	4,454,913	5,102,279	235,624	497,260	20,628,268
	9/10	5,509,674	65,266	435,077	1,658,924	4,782,802	333,113	158,721	12,943,577
	10/11	6,767,291	2,002,452	6,358,383	5,928,479	5,202,781	623,058	461,841	27,344,285
	11/12	6,764,960	2,062,526	6,673,039	6,161,589	4,942,721	149,966	488,954	27,243,755
<i>Sub-total Worker's Comp.</i>		38,751,832	5,566,899	35,189,550	31,770,474	33,450,438	1,600,985	3,538,707	149,868,885

Appendix 7.H
Temporary Help, Overtime, Worker's Comp, and Registry

Personal Svcs/Registry									
	5/6	1,316,339	413,465	488,042	188,115	0	0	0	2,405,961
	6/7	1,289,014	0	587,341	158,879	243,567	0	0	2,278,801
	7/8	23,257,558	7,692,693	708,257	969,441	6,190,722	0	0	38,818,671
	8/9	19,921,527	4,784,099	551,463	957,192	2,825,117	0	0	29,039,398
	9/10	17,576,980	14,097,497	385,366	158,465	434,727	0	0	32,653,035
	10/11	16,064,998	16,642,247	517,252	367,946	1,879,207	0	0	35,471,650
	11/12	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<i>Sub-total Registry</i>		79,426,416	43,630,001	3,237,721	2,800,038	11,573,340	0	0	140,667,516

BUDGET ESTIMATES AUDIT

California Department of Mental Health State Hospital Budget Estimate Review



Source: California Department of Mental Health, "Coalinga State Hospital Main Courtyard"

Prepared By:
Office of State Audits and Evaluations
Department of Finance

094440007DIR

November 2008

EXECUTIVE SUMMARY

The California Department of Mental Health (DMH) operates five state hospitals throughout California. Each state hospital provides inpatient treatment services for Californians with serious mental illnesses. Pursuant to the 2008-09 Budget Act and an Interagency Agreement with the DMH, the Department of Finance, Office of State Audits and Evaluations (Finance), conducted an audit of DMH's state hospital budget estimation process.

The DMH uses a regression analysis formula of patient census and historical costs to project anticipated patient caseloads and expenditures. The projected patient caseloads and expenditures are used to prepare the Governor's Budget and May Revision. The following observations were noted:

- The methodology for estimating patient case load and level-of-care personal services appears to be reasonable and adequately supported.
- The methodology for estimating operating expenditures appears to be reasonable and adequately supported.
- Coalinga State Hospital operating expenditures were not included in the 2008-09 budget year projection.
- Hospital expenditures are adequately monitored.

Other matters outside the scope of this audit came to our attention that significantly impact hospital quality of care, employee morale, and cost of care. These issues should be considered to improve hospital operations:

- The current staffing model may not adequately reflect hospital work load.
- The equity pay increases resulting from the Coleman, Plata and Perez lawsuits have not been incorporated into the budgeted overtime allocations.
- Funding is insufficient for annual operating expenditures.

Additionally, the development and implementation of corrective actions for the hospital budget process audit findings identified in Finance's December 2007 report should continue.

BACKGROUND, SCOPE, AND METHODOLOGY

BACKGROUND

The California Department of Mental Health (DMH) leads the state's mental health system, ensuring the availability and accessibility of effective, efficient, and culturally competent mental health services. DMH's Long Term Care Services (LTCS) Program has a \$1.3 billion budget that includes the five state hospitals: Atascadero (ASH), Coalinga (CSH), Metropolitan (MSH), Napa (NSH), and Patton (PSH). Each hospital is staffed by professionally trained clinicians and administrative support teams who provide full-time inpatient care to the most serious mentally ill and those incapable of living in the community. These referrals come from county mental health departments, the courts, and the Department of Corrections and Rehabilitation (CDCR).

The patients served are often classified on the basis of the legal class or type of commitment proceeding that resulted in their placement in a state hospital. There are two basic types of commitments to state hospitals: patients may be committed as a danger to self or others, or gravely disabled, under civil statutes commonly referred to as Lanterman-Petris-Short (LPS) commitments; or they may receive a Judicially Committed/Penal Code commitment from the courts, Board of Prison Terms, or CDCR, these patients are known as forensic patients.

The cost of caring for various categories of forensic patients is generally supported from the State General Fund. Counties reimburse the state hospitals using funds that they receive from the state under the 1991 state-local realignment of tax revenues and mental health program responsibilities. Approximately 90 percent of occupied beds are now utilized for forensic patients while about 10 percent are purchased by the counties.

- The DMH's LTCS Program has experienced a tremendous growth in the patient population (20 percent increase in 5 years) and patient level of care treatment. This growth has significantly impacted DMH's operating costs. DMH's average total cost per patient (including personal services and operating expenditures) in 2003-04 was \$144,798 and increased to \$194,732 in fiscal year 2007-08 (Table 1). The growth has been driven primarily by new laws, regulations, and equity pay adjustments as well as recent reviews by regulatory agencies¹. Over five years, the average cost per patient has increased approximately 34 percent. Two thirds of the patient care cost increases occurred in personal services. The average personal services cost per patient increased \$33,260, from \$123,468 (2003-04) to \$156,728 (2007-08). Increases in personal services costs were primarily due to the equity pay increases resulting from the Coleman, Plata, and Perez lawsuits and the Civil Rights of Institutionalized Persons Act (CRIPA Enhancement Plan). The other drivers for DMH's operating costs were primarily outpatient medical care, medical consultants, food, and pharmaceuticals (Table 8).

¹ See Appendix A for details relating to the DMH's legal challenges resulting in increased costs to the state hospitals.

Table 1: 2003-04 to 2007-08 Cost Per Patient					
	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08
Total Expenditures	\$640,439,838	\$697,561,964	\$793,878,175	\$898,723,843	\$1,035,389,324
Census at June 30th	4,423	4,907	5,002	5,183	5,317
Cost per patient	\$144,798	\$142,157	\$158,712	\$173,398	\$194,732

Source: DMH Patient Census Data and Expenditure Reports

SCOPE

The Department of Finance, Office of State Audits and Evaluations (Finance) was directed to perform a review of DMH's state hospital budget estimate system, including the projection of patient caseload categories and operating expenditures. Additionally, the objectives of this review included a review of marginal costing information used for this population. Inquiries were also made to state hospital systems outside of California to identify other budgeting methodologies. This review is limited to the five state hospitals; ASH, CSH, MSH, NSH, and PSH. The two acute psychiatric programs at the California Medical Facility and the Salinas Valley State Prison were not included in our review.

While observations 6 and 7 are outside the scope of this audit, they were included in this report because of their significant impact on personal services and operating expenditures.

For informational purposes an update of DMH's corrective action plan as it relates to the hospital budget process findings from the 2007 Internal Control Review was obtained.

METHODOLOGY

To evaluate DMH's state hospital budget estimates, interviews were conducted with the following entities: DMH's LTCS Division, ASH, CSH, MSH, NSH, PSH, California Department of Developmental Services, the Pennsylvania Department of Public Welfare, Bureau of Community and Hospital Operations, and the Texas Department of State Health Services, Mental Health and Substance Abuse Division. Topics discussed included:

- Budget methodology and allocation
- Patient census data
- Operating expenditures
- Level of care (LOC) and non-LOC personal services
- Implementation of state hospital changes per the CRIPA Enhancement Plan

Additional steps performed to meet the audit objectives:

- Review the budget methodology and allocation
- Review patient census data calculations used to prepare the Governor's Budget and the May Revision
- Compare budgeted appropriations to actual expenditures
- Perform analytical reviews of personal services and operating expenditures
- Compare other state hospitals budget methodology to DMH

In order to meet our objectives we relied upon interviews and inquiry of DMH staff. We did not evaluate documents and reports received from the DMH for validity. However, nothing came to

our attention that led us to believe the information provided was unreliable or misstated. Our review and analysis of personal services data was primarily limited to LOC as it is directly related to the patient caseload projections.

Recommendations were developed based on our review of documentation made available to us, our observations, and interviews with the management and key staff directly responsible for developing budget estimates. This review was conducted during the period July 2008 through October 2008.

The review was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. In connection with this review, there are certain disclosures required by *Government Auditing Standards*. Finance is not independent of the DMH, as both are part of the State of California's Executive Branch. As required by various statutes within the California Government Code, Finance performs certain management and accounting functions. These activities impair independence. However, sufficient safeguards exist for readers of this report to rely on the information contained herein.

Appendix 8.A: 2010-11 Deficiency in State Operations

4440-001-0001 is in deficit by a total of \$9.4 million in 2010-11 in programs 20 (Long Term Care) and 35 (Admin) combined. In contrast, program 10 has a surplus of \$14.2 million. Other federal and special funds also are in deficit by a total of \$576,870. In order to cure and close properly, we need:

1. Permission from DOF to either cancel BR #4 or process a new BR to increase reimbursement authority in 4440-001-0001 by \$4,000,000 to more fully reflect all Medi-Cal reimbursements received from DHCS. (The other half of the adjustment would be to program 10.)

Authority: Control Section 28.50

The reimbursement schedule was reduced in April 2011 by \$4 million to “generate cash for payroll” and also reflect estimated reimbursement revenue. Actual revenue (determined by rates and number of claims) came in higher than their estimates. Total unscheduled reimbursements was \$4,326,259

2. Permission from DOF to move \$8,000,000 million in expenditure authority from program 10 to program 20.

Authority: 4440-001-0001 provision 2

Program 20 expenses exceeded authority due to increased SOCP (Sex Offender Commitment Program) evaluation workload generated by CDCR. Claims are still coming in.

3. Permission from DOF to move \$2,500,000 in expenditure authority from program 10 to program 35 in Item 4440-001-0001. (Corresponding change to distributed Admin)

Authority: C.S. 26.00

Program 35 expenses exceeded authority. When a 2008-09 BCP was backed out of the change book system, there was a \$1.9 million error in the Admin schedule that DMH was told by DOF to live with but DMH did not.

4. Report to DOF that expenditures for 2 federal grants exceeded authority by \$97,167 in 4441-001-0890 and were charged to 4440-001-0001 program 10.

PATH and SAMSHA are the federal grants (the grants did not exceed budget authority)

5. Report to DOF that expenditures in the L&C Fund 4440-001-3099 exceeded authority by \$479,703, and were moved to 4440-001-0001 program 10.

Fund 3099 collects fee revenue for state mandated licensing functions in Mental Health Rehab Centers and Psychiatric Health Facilities.

In summary, if DOF approves the above, DMH would

- Ensure BR #4 is cancelled or write and process new BR to Increase program 10 and reimbursement authority by \$4,000,000
- Correct BR #2 – only one leg was posted by SCO
- Reverse the \$5.7 million in charges to the MHSA Fund
- Move \$16,475 in additional expenditures from fund 3099 to program 10
- Reverse the \$8.3 million in expenditures charged to program 10 and move them back to program 20 where they
- Move \$8.0 million in expenditure authority from program 10 to program 20
- Reverse the \$2.35 million in expenditures charged to program 10 and move them back to program 35 where they belong.
- Prepare a Section 26.00 request to move \$2.5 million in authority from program 10 to program 35. Distribute Admin at a higher level

DMH STATE HOSPITALS UNFUNDED SPECIAL REPAIRS			
HOSP	PROJECT TITLE	YEAR SUBMITTED	ESTIMATE
ASH	BOILER #1 REACTIVATION	2004	\$350,000
ASH	PERIMETER PROPERTY FENCE	2006	\$72,450
ASH	WASTEWATER TREATMENT CONNECTION	2007	\$256,556
ASH	GYM HVAC SYSTEM	2007	\$133,750
ASH	INTERIOR PAINT, Units 12,13,14,15,21,22,23,25, and NTA	2007	\$212,118
ASH	MUSIC CENTER VISUAL ALARM SYSTEM	2007	\$13,482
ASH	POTABLE WATER MAIN BOOSTER PUMP SYSTEM	2008	\$304,950
ASH	EXTERIOR PAINT, Main Ct. Yd., Parking Lot Markings,	2008	\$196,799
ASH	APARTMENT STAIRS	2008	\$142,310
ASH	HVAC CONTROL UPGRADE - PHASE 2	2008	\$149,800
ASH	ANALYZE SECURITY ALARM SYSTEM	2008	\$37,450
ASH	REPAIRS OF DINING ROOMS AND SCULLERIES	2009	\$396,700
ASH	258 ALARM UPGRADE	2009	\$281,410
ASH	ROOF COATING (PHASE 1)	2009	\$557,074
ASH	10,000 GALLON ABOVE GROUND DIESEL TANK	2010	\$192,521
ASH	BOILER CATALYTIC CONVERTOS	2010	\$306,000
ASH	SALT PIT EXPANSION	2011	\$47,285
ASH	ELECTRIC BACKBONE HV UPGRADE (PHASE 1)	2011	\$229,900
ASH	ELECTRIC BACKBONE HV UPGRADE (PHASE 2)	2011	\$225,500
ASH	PLANT OPS FIRE PREVENTION SPRINKLER REPLACE	2011	\$52,800
ASH	FIRE ALARM UPGRADE PHASE V	2012	\$160,500
ASH	SANITARY SEWER LIN CLEANING	2012	\$21,400
ASH	RELINE DOMESTIC HOT WATER STORAGE TANK	2012	\$17,617
ASH	FIRE ALARM UPGRADE PHASE VI	2013	\$107,500
ASH	FIRE ALARM UPGRADE PHASE VII	2013	\$162,640
ASH SUBTOTAL			\$4,628,512
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #1	2007	\$24,261
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #2 & #3	2008	\$57,593
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #4	2010	\$29,965
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #5 EXPLORATORY	2010	\$7,352
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #6	2010/2011	\$96,217
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #7	2011	\$42,456
CSH	UNDERGROUND HYDRONIC LEAK REPAIR #8	2011	\$26,162
CSH SUBTOTAL¹			\$284,005
MSH	CTE BLDG AIR HANDLER PIPING REPLACEMENT	2007	\$392,000
MSH	CTW BLDG AIR HANDLER PIPING REPLACEMENT	2007	\$392,000
MSH	HOSPITALWIDE DUCT CLEANING	2007	\$364,000
MSH	HOSPITALWIDE RESTROOM PARTITION/TOILET PAPER DISPENSERS	2006	\$267,000
MSH	HVAC SYSTEM REPAIRS	2005	\$395,000
MSH	REPAIR AIR HANDLERS	2002	\$237,000
MSH	REPLACE ROOF PLANT OPS	2002	\$886,000
MSH	SNF BLDG AIR HANDLER PIPING REPLACEMENT	2007	\$93,000
MSH	HOSPITAL SOFTENER EQUIPMENT REPAIR	2008	\$259,000
MSH	CTE FENCE ALARM & VIDEO SURVEILLANCE SYS UPGRADE	2011	\$268,000
MSH	ASBESTOS ABATEMENT & MODIFICATIONS IN BLDG 301	2011	\$286,000
MSH	REPAIR CTE PASSENGER ELEVATOR #3	2011	\$169,000
MSH	301 EMERGENCY BACKUP GENERATOR SYSTEM	2011	\$259,000
MSH	NORWALK PERIMETER FENCE	2011	\$288,000
MSH	ADMINISTRATION BLDG DUCT CLEANING	2009	\$114,000
MSH	UNITS READING LIGHTS UPGRADE	2006	\$255,000
MSH	UPGRADE NEW ADMIN BLDG EMERGENCY CIRCUIT	2006	\$176,000
MSH	4TH STREET STEAMCONDENSATE PIPE REPLACEMENT	2008	\$368,000
MSH	CTW REHAB ROOF REPLACEMENT	2005	\$82,000
MSH	DEMOLISH OLD COMMUNITOR	2001	\$209,000

HOSP	PROJECT TITLE	YEAR SUBMITTED	ESTIMATE
MSH	REPLACEMENT OF ASBESTOS COATED AWNING COVERS	2009	\$66,000
MSH	NORTH CIRCLE DOMESTIC WATER LOOP INSTALLATION	2008	\$129,000
MSH	PLACE ADEQUATE TREES ON PATIOS	2007	\$360,000
MSH	REFACING MED ROOM, NURSES STATION & LAUNDRY ROOM CABINETS	2005	\$208,000
MSH	REPAIR HOSPITAL CAMPUS ROADS	2007	\$116,000
MSH	ROAD REPAIRS -CIRCLE/ADMIN LOT	1998	\$60,443
MSH	TREE TRIMMING	2006	\$44,000
MSH	REFURBISH CTW UNIT 402	2011	\$259,000
MSH	ROAD IMPROVEMENT (NORTH CIRCLE TO SOUTH CIRCLE)	2009	\$71,000
MSH	SIDEWALK REPLACEMENT & RENOVATION (HOSPITALWIDE)	2009	\$61,000
MSH	300 BUILDINGS HVAC REPAIRS	2006	\$310,000
MSH	PLANT OPERATIONS COMPOUND & NINTH STREET REPR	2003	\$384,000
MSH	REPAIR RESIDENCE #20 EXTERIOR	2007	\$92,000
MSH	SLURRY SEAL ROADS	1999	\$223,182
MSH	BARBER/BEAUTY BUILDING TILE ABATEMENT	2001	\$39,000
MSH	EMPLOYEE BLDG. #2 REPAIRS	2000	\$201,000
MSH	NORWALK PLANTER RENOVATION	2003	\$48,000
MSH	REPAIR DETERIORATED CTE/CTW BRICK FAÇADE	2005	\$292,000
MSH	REPAIR PLANT OPERATIONS COMPOUND	1999	\$51,852
MSH	REPAIR HOSPITAL RESIDENCES ROOFS	2008	\$83,000
MSH	TREE TRIMMING	2009	\$58,000
MSH	REPAIR & LANDSCAPE BLOOMFIELD SECTION	2007	\$186,000
MSH	200 BUILDING ASBESTOS ABATEMENT & FLOOR REPAIR	2008	\$128,000
MSH SUBTOTAL			\$9,229,477
NSH	REPLACE SEWER MAIN LATERALS	2004	\$73,000
NSH	REPAIR ROADS	2004	\$56,000
NSH	REPLACE FLOOR COVERINGS	2004	\$59,000
NSH	REPLACE LAWN IRRIGATION SYSTEMS	2004	\$71,000
NSH	REPLACE SEWER MAIN LATERALS	2005	\$27,000
NSH	REPAIR ROADS	2005	\$18,000
NSH	REPAVE COURTYARDS	2005	\$34,000
NSH	REPLACE FLOOR COVERINGS	2005	\$44,000
NSH	REPLACE ROOF	2003	\$116,000
NSH	REPLACE EXTERIOR WINDOWS	2006	\$163,000
NSH	REPAIR SEWER LINE LATERALS	2006	\$67,000
NSH	REPLACE MAIN WATER VALVES	2006	\$69,000
NSH	REPLACE T-2 COURTYARDS	2006	\$30,000
NSH	REPLACE SINK COUNTERTOPS	2007	\$68,000
NSH	REPLACE BED LIGHTS	2007	\$58,000
NSH	REPLACE LOCKS AND CABINETS	2007	\$339,000
NSH	REPLACE SEWER MAIN LATERALS	2007	\$68,000
NSH	REPLACE SIDEWALKS AND CURBS	2007	\$69,000
NSH	REPAIR ROADS	2007	\$71,000
NSH	REPAIR REFRIGERATION SYSTEMS	2007	\$53,000
NSH	REPLACE FIBER OPTIC CABLE	2007	\$137,000
NSH	REPLACE BED LIGHTS	2008	\$47,000
NSH	REPLACE SWITCHGEAR BREAKERS	2008	\$79,000
NSH	REPLACE HEATING COILS	2008	\$120,000
NSH	REPAIR SEWER MAINS	2008	\$30,000
NSH	REPLACE LOCKS	2008	\$55,000
NSH	REPLACE IRRIGATION SYSTEM	2008	\$25,000
NSH	REPLACE STORM DRAINS	2008	\$89,000
NSH	REPLACE MAIN TRANSFORMERS	2009	\$89,000
NSH	REPLACE MAIN WATER VALVES	2009	\$66,000
NSH	REPLACE FLOOR COVERING	2009	\$54,000
NSH	REPLACE SINK COUNTERTOPS	2009	\$74,000
NSH	EXTERIOR PAINTING	2009	\$99,000

HOSP	PROJECT TITLE	YEAR SUBMITTED	ESTIMATE
NSH	REPLACE ROOFS	2009	\$208,000
NSH	REPLACE EXTERIOR WINDOWS	2009	\$206,000
NSH	REPLACE SWITCHGEAR BREAKERS	2009	\$84,000
NSH	REPLACE LOCKS	2009	\$68,000
NSH	REPAIR ROADS	2009	\$68,000
NSH	REPAIR COURTYARD PAVING	2009	\$33,000
NSH	REPLACE EVAPORATIVE COOLERS	2009	\$216,000
NSH	REPLACE EVAPORATIVE COOLERS	2007	\$145,000
NSH	REPLACE ROOFS-BLDG 164	2010	\$190,000
NSH	REPLACE MAIN WATER VALVES	2010	\$66,000
NSH	REPLACE EXTERIOR WINDOWS	2010	\$37,000
NSH	REPLACE ROADS	2010	\$77,000
NSH	REPLACE SINK COUNTERTOPS	2010	\$79,000
NSH	RECONDITION ELEVATORS	2010	\$128,000
NSH	REPLACE COOLING COILS	2010	\$94,000
NSH	REPAIR SIDEWALKS AND CURBS	2010	\$84,000
NSH	REPLACE LOCKS	2010	\$84,000
NSH	REPAIR SEWER MAIN LATERALS	2010	\$73,000
NSH	REPLACE REFRIGERATION SYSTEMS	2010	\$64,000
NSH	REPAIR ELEVATOR - BLDG 199	2008	\$135,000
NSH SUBTOTAL			\$4,656,000
PSH	REPLACE HVAC - AUDITORIUM	2000	\$118,860
PSH	REINSULATE 12 STRUCTURES	2004	\$63,672
PSH	ABATEMENT & EXTERIOR PAINTING - U/O/P BUILDINGS	2007	\$250,237
PSH	ABATEMENT AND EXTERIOR PAINT - 70 BUILDING	2008	\$345,052
PSH	ABATEMENT AND EXTERIOR PAINT - 30 BUILDING	2008	\$345,052
PSH	REPLACE COURTYARD AWNINGS - 70 BUILDING	2007	\$345,218
PSH	EXTERIOR PAINTING - 7 RESIDENCES	2006	\$102,594
PSH	EXTERIOR PAINT-RESIDENCES 1 & 2, PLANT	2004	\$139,202
PSH	EXTERIOR PAINT-UPHOL/AUDITORIUM	2001	\$44,952
PSH	REPLACE PULL BOXES	1997	\$233,863
PSH	INTERIOR PAINT - MAIN KITCHEN	2000	\$66,552
PSH	ABATEMENT & EXTERIOR PAINTING - R/M BUILDINGS	2007	\$379,535
PSH	RESURFACE/REPAIR ROADS- PLANT OPS/MOTOR POOL	2008	\$800,856
PSH	DUCTING CLEANING - 8 STRUCTURES	2010	\$86,523
PSH	RESURFACE ROADS - N BLDG.	2010	\$275,538
PSH	O & P HVAC	2010	\$350,000
PSH SUBTOTAL			\$3,947,706
ALL HOSPITALS -- GRAND TOTAL			\$22,745,700

¹ CSH Repairs are the result of faulty underground pipe installation during facility construction. These costs are repair costs to date. This is not a scheduled project, but repairs that become necessary as leaks are discovered. This system provides heating and hot water to all occupied areas of the facility.