5000 Medical Bed Project Initiative Appendices

5000 Medical Bed Project Initiative Appendix 1 - September 2007 ABT Associates Final Report

5000 Medical Bed Project Initiative Appendix 2 – August 2007 Navigant Report

5000 Medical Bed Project Initiative Appendix 3 – November 13, 2007 Order to Show Cause

APPENDIX 2

DIVISION OF CORRECTIONAL HEALTH CARE SERVICES
P. O. Box 942883
Sacramento, CA 94283-0001

AUG 17 2007

J. Michael Keating, Jr.
Office of the Special Master
2351 Sussex Lane
Fernandina Beach, FL 32034

via: Lisa Tillman
Deputy Attorney General
Department of Justice
1300 I Street, Suite 125
P. O. Box 944255
Sacramento, CA 94244-2550

RE: SUPPLEMENTAL BED PLAN REPORT – AUGUST 2007

Dear Mr. Keating:

In compliance with the *Coleman* court order of June 28, 2007, please find enclosed the *Supplemental Bed Plan Report – August 2007*, which outlines the California Department of Corrections and Rehabilitation's (CDCR) actions to address two issues raised in regards to the *Mental Health Bed Plan – December 2006* (previously submitted to the Court on December 19, 2006). These two issues are: CDCR's relationship with the Department of Mental Health (DMH) concerning the delivery of inpatient acute and intermediate care; and the consolidation of the more intensive mental health treatment programs[1].

If you need clarification on any aspect of this plan, please contact me at (916) 323-0229, or Doug McKeever, Director, Mental Health Program, Division of Correctional Health Care Services (DCHCS), at (916) 928-2530.

Sincerely,

ROBIN DEZEMBER
Director
Division of Correctional Health Care Services

Enclosure

[1] More intensive mental health treatment programs are defined as: Enhanced Outpatient Program, Mental Health Crisis Beds, inpatient non-acute/Intermediate Care Facility (including the Day Treatment Program), and inpatient Acute.

cc: James Tilton, Secretary, CDCR
Kingston Prunty, Undersecretary, Operations, CDCR
Stephen W. Kessler, Undersecretary, Program Support, CDCR
Bruce Slavin, General Counsel, Office of Legal Affairs, CDCR
Kathleen Keeshen, Chief Deputy General Counsel, Office of Legal Affairs, CDCR
Scott Kernan, Chief Deputy Secretary, Adult Operations, CDCR
Lea Ann Chrones, Director (A), Division of Adult Institutions, CDCR
Karen Wong, Deputy Director of Administration (A), DCHCS, CDCR
Yulanda Mynhier, Deputy Director (A), Health Care Administrative Operations Branch, DCHCS, CDCR
Deborah Hysen, Chief Deputy Secretary of Facilities, Planning, and Construction, CDCR
Doug McKeever, Director (A), Mental Health Program, DCHCS, CDCR
Frank Furtek, Chief Counsel, California Health and Human Services Agency
Cindy Radavsky, Deputy Director, Long Term Care Services, DMH
Jean Barawed, Assistant Deputy Director Long Term Care Services, DMH
Cynthia Rodriquez, Chief Legal Counsel, Legal Services, DMH
Judy Burleson, Special Assistant to the Director, DCHCS, CDCR
Kim A. Garcia, Chief of Facilities, DCHCS, CDCR
Michael Stone, Staff Counsel, Office of Legal Affairs, CDCR
Jay Sturges, Principal Program Budget Analyst, Department of Finance
Margie Imai, Personnel Program Manager, Department of Personnel Administration

SUPPLEMENTAL BED PLAN REPORT
AUGUST 2007

A. Purpose:

This report responds to the April 17, 2007, *Coleman* court order, requiring the California Department of Corrections and Rehabilitation (CDCR) to "file a supplemental report, by June 15, 2007, which addresses two issues: CDCR's relationship with [Department of Mental Health] DMH and CDCR's consolidation plan. This supplemental report supersedes the report required in the Court's March 27, 2007 order." On June 13, 2007, the CDCR requested an extension to the June 15, 2007 submission date, and on June 28, 2007 the Court ordered that "not later than August 17, 2007, defendants [CDCR] shall file the supplemental report required by this court's April 17, 2007 order."

B. Background:

On December 19, 2006, the CDCR submitted to the *Coleman* Court the *Mental Health Bed Plan - December 2006* (hereafter referred to as the December 2006 Bed Plan). This plan outlines several strategies and projects that when implemented will meet the CDCR's projected need for acute and intermediate inpatient beds, Mental Health Crisis Beds (MHCBs), as well as Enhanced Outpatient Program (EOP) beds, for all seriously mentally ill male and female patients clinically determined to be in need of those levels of care.

On February 7, 2007, the *Coleman* Special Master submitted his report regarding the sufficiency of the December 2006 Bed Plan. In this report the Special Master noted that the plan introduced two major changes in CDCR's handling of mental health services. Specifically the Special Master stated that:

> "The first underlying concept for which the defendants seek approval envisions CDCR assuming responsibility for the delivery of inpatient acute and intermediate care and ending its reliance on DMH for the provision of inpatient care. The second calls for a significant restructuring and consolidation of CDCR's delivery of all of its more intensive mental health treatment programs."[1]

The Special Master's report continues by stating:

> "Defendants' Plan does not provide enough information to justify the Court's approval of the two major proposed underlying changes, namely CDCR's assumption of responsibility for all inpatient mental health from DMH and the consolidation of all intensive mental health programs, with

[1] Source: *Special Master's Report and Recommendations on Defendants' December 2006 Mental Health Bed Plan.* February 7, 2007. Page 15.

the exception of 72 Mental Health Crisis Beds, in just eight CDCR institutions."[2]

The goal of this supplemental report is to provide sufficient detail to allow an evaluation of the aforementioned two concepts initially presented in the December 2006 Bed Plan.

C. December 2006 Bed Plan and Consolidation – Overview:

The December 2006 Bed Plan indicates that beds designated only for *male* mental health patients would be located at seven prisons. At these seven prisons existing mental health beds are to be used and, if needed, additional beds would be constructed. These seven prisons were comprised of the California Medical Facility (CMF), and Salinas Valley State Prison (SVSP) plus five prisons called Consolidated Care Centers (CCCs). The CCC prisons are: California State Prison – Sacramento (SAC), Richard J. Donovan Correctional Facility (RJD), California State Prison – Los Angeles County (LAC), California Institution for Men (CIM), and California Men's Colony (CMC).

The CCCs are to be hub institutions across the State that specialize in the delivery of mental health services. The CCCs will provide a continuum of mental health care such as; intake, mental health assessments, outpatient care (e.g. EOP), and licensed inpatient care (e.g. MHCB, ICF[3], and at one location Acute), which are important to managing the higher risk patients that drive the majority of health care costs. The proposed CCCs are located near urban centers, allowing the institutions to draw from a large recruitment pool of qualified staff. The CCCs also feature multiple bed types (i.e. unlicensed and licensed) at the institution, supporting the movement of patients across multiple levels of care without requiring transfers to other institutions. The CCCs bring the most complex patients to the most qualified providers, and will be equipped to offer comprehensive chronic care and case management services. It is anticipated that the establishment of CCCs will result in economies of scale, reductions in unnecessary or avoidable hospitalizations, and a more efficient use of internal bed resources.

SVSP, which is located in a more rural area, and shall be retained due to the number of both existing and planned licensed mental health beds at this location. In addition, the DMH has a successful history of operating its mental health program at SVSP, and will continue to operate this program as discussed below in Section D.1.3 of this report.

[2] Source: *Special Master's Report and Recommendations on Defendants' December 2006 Mental Health Bed Plan.* February 7, 2007. Page 18.
[3] The acronym "ICF" stands for "non-acute/Intermediate Care Facility".

As originally proposed in the December 2006 Bed Plan, consolidation of the mental health program into the aforementioned seven prisons will result in either the removal or reduction of existing EOP and MHCBs at prisons such as California State Prison – Corcoran (COR), and Mule Creek State Prison (MCSP). Moreover, once sufficient capacity is available and consolidation complete, the December 2006 Bed Plan proposed that CDCR operate all the mental health beds at each of the seven prisons.

D. Summary of Actions:

This report focuses on two goals:

1. The CDCR's assumption of the delivery of inpatient non-acute/Intermediate Care Facility (hereafter referred to as ICF), and inpatient Acute levels of care for *male* patients at the proposed CCCs (with the exception of such programs operated by DMH at SVSP and CMF), and for *female* patients at the California Institution for Women (CIW); *and*
2. The consolidation of CDCR's more intensive mental health programs[4].

Accomplishment of these goals requires the dedication of a project team (hereafter referred to as the CCC Project Team) of experienced staff to create and manage the operation of the CCCs and to oversee the consolidation of the mental health program. The following provides a summary of the actions to be accomplished in achieving the aforementioned goals:

Actions:
CCC Project Team
CCC Project Team Composition
Responsibilities
DMH – CDCR Relationship
Acute Care Hospital Location
Planning, Design, and Construction, of the CCCs
Activation and On-going Operations of the CCCs
Mental Health Consolidation
Receiver Coordination

[4]More intensive mental health programs are defined as the following levels of care: EOP, MHCB, ICF (including Day Treatment Program), and Acute.

D.1 CCC Project Team

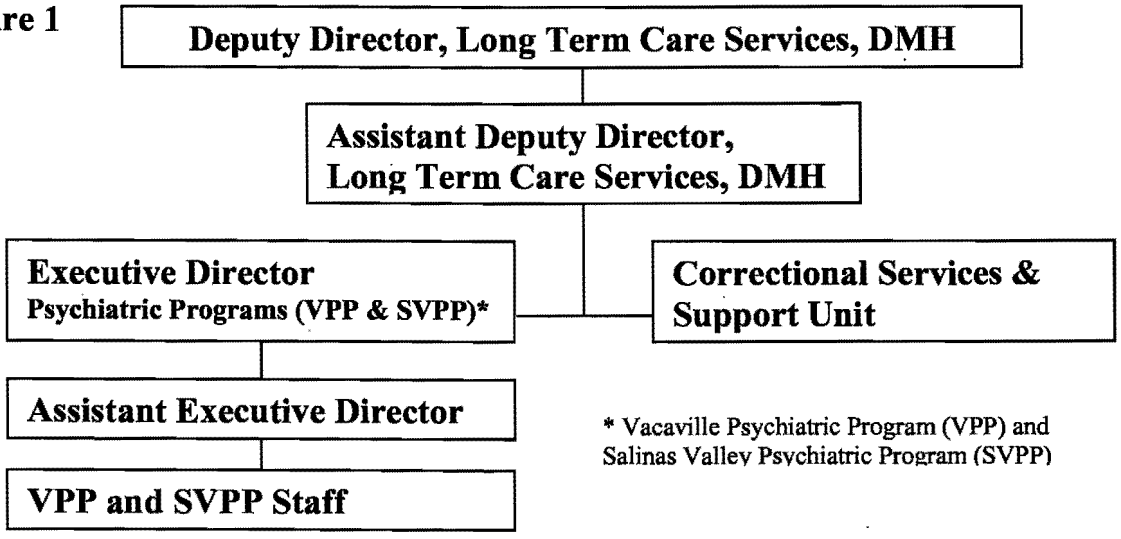
D.1.1 CCC Project Team Composition:

CCC Project Team staff shall include executive personnel and staff from CDCR and DMH with expertise necessary to plan, direct, and manage large-scale and complex projects similar in nature to the CCCs. This section outlines the proposed composition of the CCC Project Team and ensuing management structure. However, the actual composition may need to be adjusted in the future, after actual practice provides information as to the most appropriate makeup of the teams and the most efficient management reporting structure. It is currently anticipated that a portion of the CCC Project Team staff will be designated from existing resources, with remaining staff positions to be requested through the annual State budget process.

Staff dedicated to the CCC Project Team and this project from CDCR shall include representatives from: mental health (executive, clinical, and support staff), nursing, licensing, adult institutions (custody), budgets, human resources, labor relations, training, classification services unit, health care placement unit, transportation unit, facilities management, and information technology.

Staff designated to the CCC Project Team to assist with this project from DMH shall include the following, or similar classifications: an executive director, an assistant executive director, a standards and compliance coordinator, a clinical coordinator, and an office support position. The following figure (Figure 1) is a graphical representation of DMH's organizational structure for the staff designated to assist with this project[5].

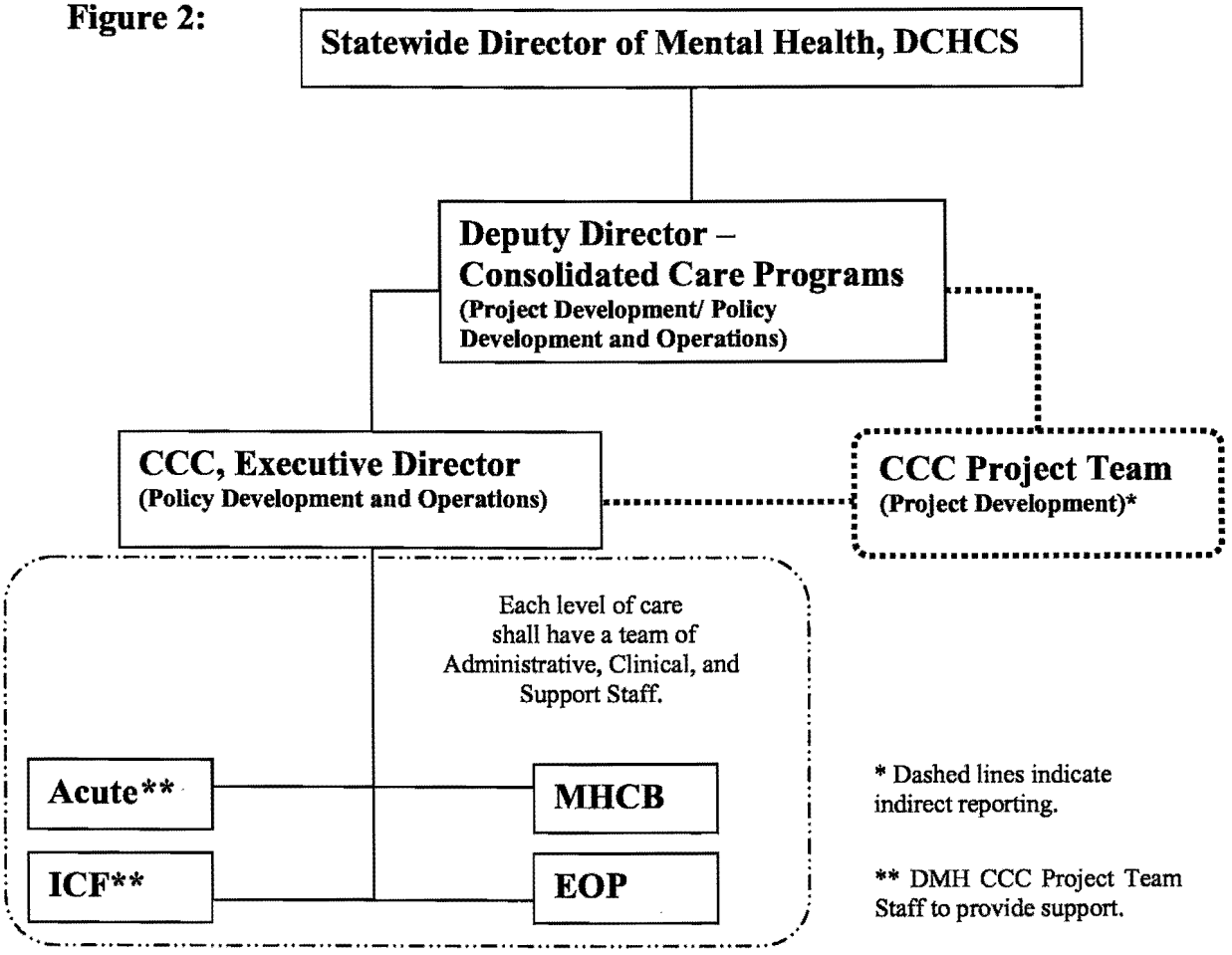
Figure 1



[5] Note: These positions are illustrated in the CCC Project Team in the subsequent Figure 2.

The CCC Project team will indirectly report up through the Division of Health Care Services (DCHCS) Mental Health Program. The following figure (Figure 2) illustrates this reporting structure:

Figure 2:



The CCC Executive Director and support staff teams, as illustrated in Figure 2, shall be responsible for the ongoing operation of a CCC, however, these staff shall be acquired and trained in accordance with a scheduled operational plan to also assist the CCC Project Team in activating the CCCs as they are completed. Although not illustrated in Figure 2, there shall be five CCC Executive Directors with support staff that shall be responsible for the ongoing operation of each CCC once constructed, with each CCC Executive Director reporting to the Deputy Director, Consolidated Care Programs[6].

[6] Adjustments to the illustrated staffing structure in Figure 2 may be required based on final facility design.

D.1.2 Project Team Responsibility:
The CCC Project Team shall exercise oversight of the planning, design, construction, activation, and transition to the CCCs, and the 45 Acute/ICF beds at CIW, along with ensuring there is an adequate infrastructure to support ongoing operation of these facilities. These efforts shall be coordinated with the Assembly Bill (AB) 900 Facilities Strike Team and other applicable Departmental initiatives.

As a one-time special project, the CCC Project Team shall also oversee the transition of mental health programs from other prisons to the CCCs (otherwise termed the consolidation of the mental health program). However, the CCC Project Team shall not be responsible for the ongoing operation of the mental health programs, as this will be the role of the CCC Executive Directors, (Figure 2).

It is anticipated that DMH and CDCR will collaboratively oversee the remaining non-CCC projects described in the December 2006 Bed Plan, with some of the projects' activities overlapping with the CCC Project Team efforts[7].

D.1.3 DMH – CDCR Relationship:
The DMH provides Acute, ICF, and Day Treatment Program (DTP)[8] levels of care to CDCR patients within DMH State Hospitals and at two CDCR prisons, CMF and SVSP. The December 2006 Bed Plan proposed to change that relationship by having the CDCR provide these levels of care within its prisons, therefore, gradually eliminating its use of DMH services. This report modifies that original concept to maintain DMH's operation of the existing Acute, ICF, and DTP programs at CMF and SVSP, inclusive of the additional ICF beds to be built at each of these sites, (i.e. the 64 bed ICF project at CMF and the 64 bed ICF project at SVSP), and assisting CDCR in "bringing up" the new Acute and ICF programs.

The Acute and ICF programs to be implemented at the CCCs and CIW shall be modeled on DMH's program structure and established milieu. Paramount to successful implementation is a mentorship relationship that will be organized between DMH and CDCR. Elements of this relationship include DMH participation in: the planning and design of program space; the training and mentoring of the

[7] These projects are (with the Project # as indicated in the December 2006 Bed Plan, Table III.B.1 listed in parentheses): SAC – EOP office and treatment space (#2); CMC – 50 bed MHCB unit (#5); LAC – EOP office and treatment space (#8); CIW – EOP and EOP-Administrative Segregation Unit (ASU) bed project (#'s 13 and 13A); SVSP – 64 bed ICF (#9); SVSP – EOP and EOP-ASU project (#10); CMF – 50 bed MHCB unit (#11); and CMF – 64 bed ICF (#12).
[8] Note: The DTP is located only at CMF.

CDCR members of the project team and staff at CDCR headquarters that are directly responsible for the administration of these new mental health beds; ensuring sufficient CDCR resources exist for program implementation and on-going operations; and monitoring CDCR's assumption of the delivery of Acute and ICF levels of care.

The following describes the actions to be taken to foster that relationship and ensure that CDCR's delivery of Acute and ICF levels of care at the CCCs and CIW meets constitutional standards:

- **Transitional Plan:** Development of a detailed transitional plan that includes hiring and embedding CDCR staff in DMH programs prior to CDCR Acute or ICF program activation, (See Enclosure I for further details, and an example of the training and mentoring aspects of this plan).

- **SAC ICF Program:** The DMH, in collaboration with CDCR, will implement the proposed new ICF program at SAC. The process of hiring staff and developing program protocols will take at least one year. Obtaining security clearances and required advanced training for Medical Technical Assistants (MTAs)[9] will take a minimum of 18 months. The DMH will share responsibility with the CDCR project staff in implementing the ICF program, with DMH continuing the training process and having the primary responsibility of managing the program, and supporting the CDCR's goal of assumption of full operational control of this program.

  As outlined in Training Plan (See Enclosure I), the goal of the second phase, the transition phase of training is to ensure qualified CDCR administrative, clerical, and support staff is available to work directly with DMH in developing and implementing the ICF program at SAC. During the transitional phase, staff will be hired and tasks will be completed to allow for the successful activation of the new program, with DMH providing on-going assessment of staff performance and

[9] As of May 31, 2007 all MTAs (including Senior MTAs and Health Program Coordinators) within CDCR were converted to Licensed Vocational Nurses (LVNs). Source: Receiver's Fifth Quarterly Report. Section II.G.4. Page 23. It is important to note, however, that DMH continues to use the MTA classification as a component in its treatment model for Acute and ICF care. In implementing DMH's treatment model at the CCCs and CIW this report assumes that MTAs will be utilized, however, the CCC Project Team shall consider the use of MTAs, or other appropriate classifications, working under the direction of the DCHCS-Mental Health Program, to achieve successful implementation of the Acute and ICF programs at each facility.

overall program progress, (feedback will be shared with individual CDCR team members and the designated supervisor at CDCR headquarters). A core team of this staff may be used for activation of subsequent programs at the CCCs.

The CDCR will exercise control of the ICF program once it has demonstrated the ability to achieve an operation that meets established operational criteria. The DMH shall collaborate with CDCR in developing the operational criteria, and shall assume responsibility for evaluating and determining that CDCR meets the operational criteria, before turning over the operation fully to the CDCR. During the third phase of training (See Enclosure I), the activation of the program, the CDCR will continue in a training modality with DMH providing on-going assessment of staff performance and overall program feedback. Once CDCR fully assumes operational control, the DMH shall perform evaluations on a quarterly basis for a one-year period. The feedback from these evaluations will be shared with the SAC staff and the designated staff at CDCR headquarters.

If during one of the follow up evaluations the CDCR fails to meet the operational criteria, the DMH will assist the CDCR in correcting any identified deficiencies. Full operational control will be restored to the CDCR once the DMH determines that CDCR again meets the operational criteria. The DMH, based on the circumstances and upon its own discretion, may extend this one-year follow-up period to ensure that the CDCR is consistently meeting the criteria.

- **All Other CCCs and CIW:** The CDCR will initiate primary responsibility for implementing the ICF programs at all other CCC sites[10] and CIW, in concert with DMH's provision of consultative on-site assistance. However, DMH, as with the SAC ICF program, will initiate primary responsibility for implementing the Acute program at CIM. The DMH shall be responsible for evaluating and determining that CDCR meets the operational criteria both initially and on a follow-up basis as previously outlined for SAC. The feedback will be shared with the institutional staff and the designated staff at CDCR headquarters.

[10] These CCC sites are: RJD, CMC, CIM, and LAC.

- **Acute and ICF Programs at CMF and SVSP:** The DMH will continue to operate the existing Acute, ICF, and DTP programs at CMF and SVSP, inclusive of the additional ICF beds to be built at each prison site, (i.e. the 64 bed ICF project at CMF and the 64 bed ICF project at SVSP).

The CDCR and DMH shall work collaboratively in assuming their respective roles, with any issues that arise being resolved at the department level between the Statewide Director of Mental Health, DCHCS, CDCR, and the Deputy Director, Long Term Care Services, DMH.

D.1.4 Acute Care Hospital Location:

The December 2006 Bed Plan proposed to build additional Acute beds at multiple CCC sites. However, the CDCR and DMH have re-evaluated the allocation of these beds in an effort to model the Acute program on DHM's program structure and milieu. Based on this evaluation, all the 90 additional Acute beds proposed, under the December 2006 Bed Plan, will be planned for CIM. The following table (Table 1) indicates those changes:

TABLE 1: Acute Care Beds

	NUMBER OF ACUTE BEDS		
Institution*	December 2006 Bed Plan	Supplemental Bed Plan Report – August 2007 (Proposed Re-Allocation)	Change
RJD	30	0	-30
CMC	30	0	-30
CIM	30	90	+60
Total:	**90**	**90**	**0**

* Richard J. Donovan Correctional Facility (RJD), California Men's Colony (CMC), and California Institution for Men (CIM).

These changes shall be incorporated into the current capital outlay requests and facility planning. No other location changes for Acute beds are contemplated, however, a site review for CIM needs to be completed in order to establish it as the permanent site.

These changes capitalize on the economy of scale and operational efficiencies that may be realized through this consolidation. As an example, constructing one hospital of larger scale eliminates tasks that must be repeated in the design and construction of three separate facilities, and produces cost efficiencies. In addition, operational efficiencies are realized by having the administration of the program at one location, thereby eliminating the need for administrative staff at multiple sites, and reducing the overall total number of staff required.

D.2 Planning, Design, and Construction, of the CCCs:

The CCCs shall be planned and designed as secure mental health treatment facilities, with the focus of providing a continuum of quality care in a humane manner. The design approach will not be based upon structures designed as prisons that are then modified for use in mental health treatment. Rather DMH and CDCR management and clinicians from the CCC Project Team shall be involved from the beginning and throughout the planning and designing of these facilities, in order to maintain the facilities' design focus as a mental health treatment center secure enough to accommodate high security inmates. To ensure security measures are met, representatives from the CDCR's Division of Adult Institutions (DAI) along with security consultants (individuals outside CDCR with demonstrated security design knowledge and experience) also will be engaged in the planning and design of the facilities. Where competing needs exist, the DMH and CDCR clinicians from the CCC Project Team shall ensure that the facilities' design does not compromise it as a secure mental health treatment center.

Attached to this report, as Enclosure II, is a list of preliminary physical plant issues and assumptions that must be considered in the planning and designing of these facilities, (See Enclosure II).

A generic schedule for the planning, design, and construction of the CCC at RJD has been established and is provided below for illustrative purposes. This schedule assumes use of a design build project delivery method, which requires legislative approval, and is contingent upon the Legislature approving the necessary funding in keeping with the proposed schedule[11].

CCC at RJD:
11 months - Architectural Programming
14 months - Schematic Design
20 months - California Environmental Quality Act (CEQA)
21 months - Preliminary Plans and Bridging Documents
26 months - Award Design Build contract and Start Construction
59 months - Construction Completed

Per the above schedule, the estimated project duration to construct the medium-sized CCC at RJD is four (4) years and 11 months from initial funding. For comparative purposes, approximately six (6) to 12 months should be added or subtracted to this project duration for the larger and smaller CCCs respectively. It is important to note that each CCC would be staggered a minimum of 6 months

[11] It is important to note that at the time of writing this report, there is no Legislative authority to construct any of the five CCC's.

due to available staff resources to move teams onto the next project, and front end processes. Staggering these projects in time may be required also due to the limited number of qualified design and construction professionals available to complete them, given the numerous major capital construction projects underway in California during this time frame.

D.3 Activation and Operation of the CCCs:

The CDCR plans to conduct activation activities at the CCCs as construction of each facility is completed, and based on the staggered timing of the construction, the CDCR anticipates activating these facilities on a rollout schedule. In order to accomplish this, the CCC Project Team shall begin the development of a detailed operational plan during the design phase of each CCC project that can be "rolled into" a master plan for the entire building program.

Assuming nearly 60-months of planning, design and construction as the basis for CDCR's operational plan, and understanding also that it may be shortened, requires the CDCR to consider alternatives for establishing operational capability earlier. The only alternative that is sensible under this circumstance is to begin earlier than the CDCR might otherwise have done. Therefore, the CDCR expects to hire in 2007 the Deputy Director Consolidated Care Programs (See Figure 2, Section D.1.1 above) and utilize this person's expertise and attention to assist in the development of the full operational plan. The hiring of this position will be accomplished within existing DCHCS resources.

The operational plan shall be developed using the project plans for the activation of two recent DMH programs, (i.e. SVPP and Coalinga State Hospital) as guides, (See Enclosure III, SVPP plan as an example). Examples of summary tasks[12] that may be included in the operational plan are listed below in Table 2. For illustrative purposes, timeframes based on the generic construction schedule have been applied to these summary tasks. In addition, these summary tasks have been divided into two phases with Phase I providing resources necessary to accomplish Phase II.

Table 2: SAMPLE Consolidated Care Center Operational Plan

	Summary Task	Timeframe (Fiscal Years):
PHASE I:		
I.A	**Administrative** Note: Includes hiring of Senior Management Team (including the Deputy Director Consolidated Care Programs and staff – Figure 2); temporary office space; and activation manual and operational plan development.	**2007/2008; 2008/2009**

[12] A summary task consists of a logical group of tasks, called subtasks.

Table 2: SAMPLE Consolidated Care Center Operational Plan		
	Summary Task	**Timeframe (Fiscal Years):**
I.B	**Staff Recruitment** Note: Includes training and developing CDCR staff at DMH facilities (or otherwise referred to as the core team).	**2009/2010 (core team)** **(ongoing through) 2011/2012**
PHASE II:		
II.A	**Operational Manual Development and Approval**	**2011/2012**
II.B	**Policy and Procedures Development and Approval** Note: The CCC Project Team shall use DMH's policies and procedures and operations manual, along with other pertinent documents, from the Vacaville Psychiatric Program and Salinas Valley Psychiatric Programs to assist in the development of similar documents for the CCCs. These documents will also be reviewed with experts for potential revision.	**2011/2012**
II.C	**Construction**** Note: Includes Information Technology, facility walk through, punch list development and completion.	**(ongoing through) 2012/2013**
II.D	**Operational Drills**	**2012/2013**
II.E	**Administration Activation**	**2012/2013**
II.F	**Facility Activation** Note: Includes licensing preparation, Fire Marshal survey, Department of Health Services survey, and patient admissions.	**2012/2013***
Facility activation is estimated to take six (6) months after construction completion (Summary Task II.C). ** It is important to note that at the time of writing this report, there is no Legislative authority to construct any of the five CCC's, which may impact this timeframe.		

It is important to note that operational plan development will include the identification of staff required, in incremental numbers and classifications, along with the necessary request for budget authority beginning with the 2009/2010 budget cycle and following years, to bring up management and staff sufficient to operate the facilities once they are completed.

Attached to this report, as Enclosure IV, is a list of preliminary staffing and recruitment issues and assumptions that must be considered in developing the operation plan for these facilities, (See Enclosure IV).

D.4 Consolidation of the Mental Health Program:

The December 2006 Bed Plan proposes to transfer the male mental health programs from currently staffed programs in institutions such as COR, MCSP, and Pelican Bay State Prison (PBSP) to the CCCs, CMF, and SVSP. This report modifies the December 2006 Bed Plan to retain the mental health program at PBSP as it currently exists. This modification is requested due to PBSP's unique

mission, its history of successful mental health program operation, and its remote location. Therefore, if adopted this change would result in the existing 64 bed EOP, 128 bed Psychiatric Services Unit (PSU), and 10 MHCBs remaining at PBSP.

The CCC Project Team shall be responsible for developing, implementing, and managing a detailed transition plan to accomplish the consolidation of the mental health program, and ensure that the mental health needs of the inmate-patients are met throughout the consolidation process. The transition plan will have several subsidiary plans that address, at a minimum: staffing, transportation, and return of beds to alternate use. Examples of major actions to be included in these plans follows.

Staffing: A staffing plan for the reduction of staff through attrition at institutions with either a removal or reduction in mental health beds shall include:

- When staff leave positions that are to remain vacant, ensure registry staff is hired to cover vacancies.
- Actions to be taken to address staff remaining in positions that are to be reduced.

Transportation: For MHCB care, a limited number of beds were reduced in the December 2006 Bed Plan[13], leaving institutions with the ability to treat crisis patients locally as opposed to transporting a patient throughout the State to an available bed. This allows for greater availability of MHCBs closer to patients. However, if transportation is required, the greater distribution of larger MHCB units at the CCCs and CMF allows for a decrease in transport distance to care, thereby increasing access to mental health services. A transportation support plan shall include:

- Actions required to ensure appropriate inmate-patient care. security, escorting, and timely transport of mental health patients from institutions with either a removal or reduction in mental health beds, (with transportation not initiating until sufficient capacity exists at the CCCs).
- Actions required to ensure appropriate inmate-patient care, security, escorting, and on-going transport from the affected institutions to the CCCs, CMF, SVSP and PBSP.

[13] Mental Health Bed Plan, December 2006. Enclosure II. Table #1. It is anticipated that at San Quentin there will be a total of 32 MHCBs comprised of: 12 MHCBs in the Condemned Complex and 20 MHCBs in Building 22.

Mental Health Bed Return: A plan for the mental health beds (both permanent and temporary) returned to other uses shall include:

- Coordination with custody and the Receiver's office for the return of 92 Correctional Treatment Center (CTC) or General Acute Care Hospital (GACH) beds.
- Coordination with custody and the Receiver's office for the return of the remaining 1,644 mental health beds[14].

It is anticipated that transitional planning will begin approximately two years prior to the activation of the first CCC. This timeline allows the project team time to begin longer-range activities such as the reduction of existing institutional staff through attrition, and the reallocation of existing staff to other institutions. Throughout the consolidation process, the CCC Project Team shall coordinate with the DAI and DCHCS to ensure the inmate-patients' safety and security along with their health care needs are met.

D.4 Coordination with the Receiver:

D.4.1 Coordination of Planning, Design and Construction:

A complicating factor in determining a schedule for the completion of the CCCs is the need to coordinate with the Plata Receiver's plans for constructing medical facilities. The Receiver's plans are not yet completed, however the prisons at which he intends to build likely will include the five (5) identified sites for the CCCs. Both the Receiver's plans and the CDCR plans for the CCCs include the requirement that the facilities be built outside the existing secure perimeter of the prisons selected as the sites for this construction. The use of this space, and the relationship of mental health beds in the CCCs with the Receiver's plans for long-term medical care and disability housing, call for a coordinated approach for these two building programs.

While the basic timeline expressed in this report results from experience with typical construction projects, the CDCR will be evaluating options for expediting the construction process. Since the Receiver will establish his plan sometime in mid to late August 2007, and determinations governing how it will proceed will be made thereafter, the CDCR cannot assure at this time that its present understanding of the timeline is accurate. For the sake of operational planning, however, the CDCR needs to adopt a timeline and work back from the anticipated completion date to the present to establish an order of tasks that

[14] Mental Health Bed Plan, December 2006. Table III.D.1. Page 15. (Total beds [1,933] – MHCBs [92] – 197 beds at PBSP = 1,644).

need to be accomplished. The CDCR chose a 60-month timeline for this purpose, (See Table 2, Section D.3 above).

The CDCR expects to be able to bring more certainty to this picture once the Receiver's plan is known and initial planning has been accomplished.

D.4.2 Coordination of Ongoing Operations:
The CDCR recognizes that collaboration with the Receiver is paramount to the successful creation and ongoing delivery of a continuum of health care services at the CCCs. Inmate-patients in the CCCs, as well as throughout CDCR, must have timely access to both medical and mental health services. Therefore, details regarding areas such as inmate-patients' access to care, shared services (e.g. pharmacy, nursing, and medical records), and staff roles and responsibilities shall be developed in a coordinated effort with the Receiver, and shall be included in the CCCs operational plan. The CDCR anticipates that this effort shall be undertaken during the initial planning stages of the CCCs and carried on through the operation of these facilities. Included shall be a coordinated effort to provide systematic and ongoing monitoring and evaluation of the access, quality and continuity of health care services to ensure these services meet, and continue to meet, constitutional standards. This system shall include elements to: diminish risk by preventive measures, produce quality outcomes, identify opportunities to improve the quality of services provided, evaluate and suggest improvement of systems, and to resolve problems that are identified in a timely, effective, and efficient manner.

E. Conclusion/Summary of Changes to the December 2006 Bed Plan:

This report plans the following modifications to the December 2006 Bed Plan:

- The DMH will continue to operate the Acute, ICF, and DTP programs at CMF and SVSP, inclusive of the new ICF beds to be built at each prison.
- The DMH will in collaboration with CDCR implement the ICF program at SAC.
- The DMH will initially operate the ICF program at SAC with CDCR continuing in a training modality. The responsibility of operating SAC will eventually transfer to CDCR.
- The DMH will assume an oversight role in the implementation of the ICF beds at the other CCCs[15] and CIW, however, at CIM the DMH, as with SAC, shall initially operate the Acute beds with eventual transfer to CDCR.

[15] These CCC sites are: RJD, CMC, CIM, and LAC.

- The planned Acute beds shall be consolidation to CIM.
- The existing mental health mission at PBSP shall be maintained.

Enclosure V to this report indicates the above changes to the original December 2006 Bed Plan – Enclosures II and III. In the case of male inmate-patients these modifications are actually amendments to original Enclosure II, and for female inmate-patients the modifications are corrections of typographical errors. Furthermore, Enclosure V compares Navigant's current mental health bed forecast based upon Spring 2007 general population projections to the planned beds, (See Enclosure VI for full Navigant Bed Forecast)[16]. This comparison illustrates that the mental health beds, as currently planned, continue to sufficiently meet the projected need for such resources through June 2012, with the exception of EOP and EOP-ASU beds for female inmate-patients. The deficiency in female inmate-patient mental health beds shall be addressed in future planning efforts.

F. Documents Reviewed:

1. *Special Master's Report and Recommendations on Defendants' December 2006 Mental Health Bed Plan.* February 7, 2007.
2. *California Prison Health Care Receivership Corporation (CPR, Inc.) Prison Medical Care System Reform Plan of Action.* May 2007.
3. *Receiver's Fifth Quarterly Report.* June 20, 2007.
4. *Mental Health Bed Need Study – Based on Spring 2007 Population Projections.* July 2007. Navigant Consulting.

[16] Notes:

1) The July 2007 forecast recommends the use of the prior March 2007 forecast for male acute psychiatric bed need, therefore, all projected male acute bed needs are taken from the March 2007 forecast, (see *Mental Health Bed Need Study – Based on Spring 2007 Population Projections.* July 2007. Navigant Consulting. page 9).
2) There is a typographical error on page 41 of the July 2007 forecast that was corrected. In the table, under the "Program" column, in the row labeled "MHCB – Female Supply/Planned" the number of beds was changed, with the original text noted in strikeout format and the corrected text placed to the left of the original text. This change also affected the row directly below labeled "Bed Surplus/<Deficit>", with changes highlighted in the same manner.

G. Acronyms:

LIST OF ACRONYMS for Report and Enclosures (Arranged in Alphabetical Order)	
AB	Assembly Bill
AGPA	Associate Governmental Program Analyst
ASH	Atascadero State Hospital – DMH (Male)
ASU	Administrative Segregation Unit
APP	Acute Psychiatric Program
CCC	Consolidated Care Center
CDCR	California Department of Corrections and Rehabilitation
CEQA	California Environmental Quality Act
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
CO	Correctional Officer
COR	California State Prison – Corcoran
CSH	Coalinga State Hospital – DMH (Male)
CTC	Correctional Treatment Center
DAI	Division of Adult Institutions
DCHCS	Division of Correctional Health Care Services
DHS	Department of Health Services
DMH	Department of Mental Health
DTP	Day Treatment Program
EOP	Enhanced Outpatient Program
GACH	General Acute Care Hospital Bed
ICF	Intermediate Care Facility
LAC	California State Prison – Los Angeles County
LOC	Level of Care
LVN	Licensed Vocational Nurse
MCSP	Mule Creek State Prison

SUPPLEMENTAL BED PLAN REPORT
AUGUST 2007

LIST OF ACRONYMS for Report and Enclosures (Arranged in Alphabetical Order)	
MHCB	Mental Health Crisis Bed
MTA	Medical Technical Assistant
PBSP	Pelican Bay State Prison
PSH	Patton State Hospital – DMH (Female)
PSU	Psychiatric Services Unit
PSW	Psychiatric Social Worker
RJD	Richard J. Donovan Correctional Facility
RN	Registered Nurse
RT	Rehabilitation Therapist
SAC	California State Prison – Sacramento
SMTA	Senior Medical Technical Assistant
SQ	California State Prison - San Quentin
SVSP	Salinas Valley State Prison
SVPP	Salinas Valley Psychiatric Program
VPP	Vacaville Psychiatric Program

SUPPLEMENTAL BED PLAN REPORT
AUGUST 2007

TRAINING PLAN FOR CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (CDCR) PROJECT STAFF

Goal: To train CDCR executive and clerical staff to independently operate acute, intermediate and mental health crisis beds within designated CDCR institutions.

The training process will include CDCR members of the project team and headquarters staff being embedded into Department of Mental Health (DMH) facilities for possibly up to two years prior to the activation of a CDCR mental health program. Clinically privileged psychologists and psychiatrists will provide direct patient care in their assigned facility, and although the CDCR staff are hired by CDCR, DMH has full supervisory responsibilities until such time that CDCR and DMH jointly determine that the project staff are competent to work independently.

The following provides more detail and may need to be modified based on project need.

Phase 1. Pre-Activation of the CDCR Mental Health Programs (1-2 years)

Training/Objectives:

A. The CDCR headquarters staff and project team members will participate in training classes that include a general orientation to the DMH psychiatric programs, multidisciplinary team process, training in mental illness diagnoses (if not already shown competency), assessment expectation.

   The CDCR project team members will participate in the DMH/Vacaville Psychiatric Program (VPP) orientation program with a goal of 100% attendance and at least 90% participation as indicated by the orientation trainers.

   The CDCR headquarters and project team members will participate in available trainings that include the working processes of a multidisciplinary team which would also include role expectations of various staff within the team, the role of assessment in the treatment planning process and other related topics. Criteria for success is based on attendance and completion of all and any assignments.

B. The project team members will rotate between units on a monthly or bi-monthly basis with the opportunity to work on acute and intermediate level. It is expected that they will integrate into the team at a level compatible with each person's training. Staff will have direct patient involvement.

   The CDCR project team members will spend one to two months working on a specific patient unit and will rotate to another patient unit when that timeframe has elapsed. The project team member will be expected to work a schedule that is similar to other team members on that unit and is designated by the unit supervisor with the DMH administrative approval. The project staff member will meet with the designated supervisor every two weeks to discuss progress and any concerns. A written evaluation will be provided at the mid-term and final week of the training on that specific unit. The goal is for staff to be rated as having met the objectives for at

least 80% of the skills listed and if there is an area for needing improvement, a plan will be developed to help that staff member develop the specific skills.

This process will occur for each unit the project staff member is assigned to for training. It is expected that training on the units will take at least six-twelve months.

The designated CDCR headquarters staff will also participate in training at the DMH psychiatric programs. However they will participate for less time on the units and in the administrative offices.

C. The project team staff having satisfactorily met the objectives for working on the patient units will begin to work with middle management and the executive staff. It is expected that they will learn the roles and duties of each of these positions with the intent of developing specific skills in the area that they will ultimately be assigned (executive, nursing, budgets, human resources, training, classification services, etc).

The CDCR project team members will spend two to three months working with the administrative and executive staff of the DMH facility. The project team member will be expected to work a schedule that is similar to others working in similar positions with the DMH administrative approval. The project staff member will meet with the designated supervisor every two weeks to discuss progress and any concerns. A written evaluation will be provided at the mid-term and final week of the training on that specific unit. The goal is for staff to be rated as having met the objectives for at least 80% of the skills listed and if there is an area for needing improvement, a plan will be developed to help that staff member develop the specific skills.

Phase II. During the Transition-Activation Phase (1 year)

Training/Objectives:
The project team members will continue to function in a training capacity.

The CDCR headquarters staff and project team members will develop skills in staff hiring, plant operations, program development, licensing requirements, managerial skills, and other skills needed to effectively oversee the implementation and activation of a psychiatric program.

Phase III. Activation Phase (1 year)

Training/Objectives:
The CDCR headquarters staff and project team members will demonstrate their skills by taking a more active role in staff hiring, plant operations, program development, licensing requirements, managerial skills, and other skills needed to effectively oversee the implementation and activation of a psychiatric program.

SUPPLEMENTAL BED PLAN REPORT
AUGUST 2007

PRELIMINARY PHYSICAL PLANT ISSUES AND ASSUMPTIONS FOR CONSIDERATION IN THE PLANNING AND PROGRAMMING PHASES OF THE CONSOLIDATED CARE CENTER (CCC) BUILDING PROGRAM

I. Physical Plant Issues:

A. There will be numerous programmatic difficulties trying to operate Level III and Level IV (high-custody)[1] Intermediate Care Facility (ICF) programs contained within a single floor (RJD, SAC, CMC, LAC)[2] i.e., sharing group rooms and staff, differing program rules for each custody level, differing treatment foci for staff. Historically this has resulted in the custody level defaulting to the highest custody level, severely limiting the Level III ICF programming. This issue shall be considered when planning and designing the CCCs.

B. There will be numerous programmatic difficulties at California Institution for Men (CIM) trying to operate an Acute level of care, Level III ICF and Level IV ICF in the same building and would be compounded if located on the same floor. This issue shall be considered when planning and designing CIM.

II. Programming:

Maximizing the program's ability to provide the indoor and outdoor therapeutic modalities expected at the Acute and ICF levels of care shall be considered in the facilities' configurations.

III. Assumptions:

A. *Therapeutic Containment Modules:* Assuming the Department of Mental Health (DMH) treatment model and therapeutic milieu is utilized, there would be no cages or "therapeutic containment modules" permitted.

B. *Single Cell Construction:* The DMH assumption is that to maximize access to Level III ICF programs, all new construction is to be single-cell only. The Vacaville Psychiatric Program (VPP) single cells for Level III and IV can serve as feeders to the existing dormitories, which have been chronically underutilized (Salinas Valley Psychiatric Program Level IV ICF and VPP Level III ICF), thereby maximizing bed utilization.

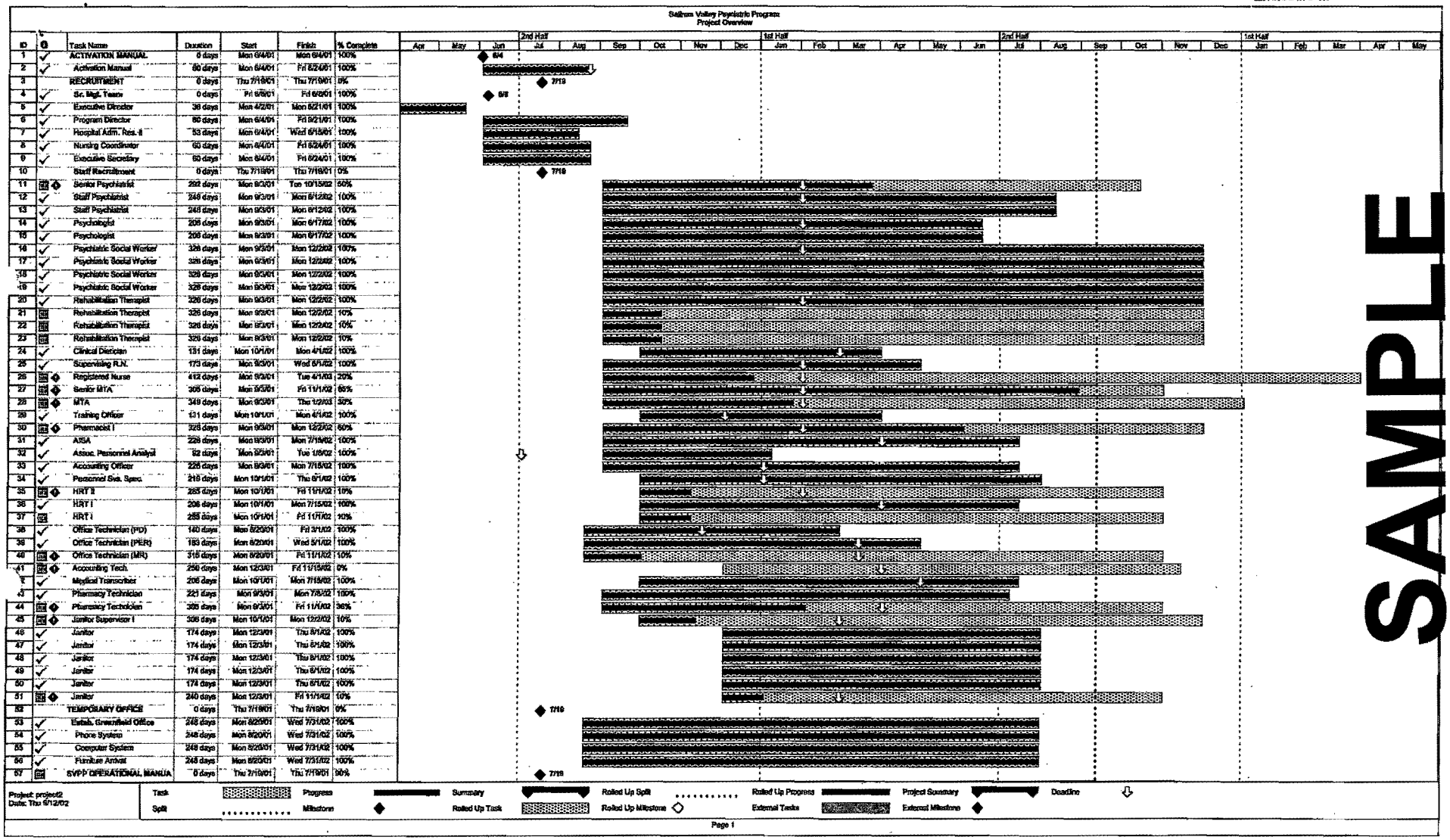
C. *Penal Code 1370s:* These inmate-patients are exclusively Level IV because Level III 1370s are assessed and treated at Atascadero State Hospital. At this time, it is assumed for the purposes of planning the CCCs that all 1370s will be housed in the same program.

---

[1] Throughout this document, Level IV (high-custody) refers to inmate-patients requiring celled housing.

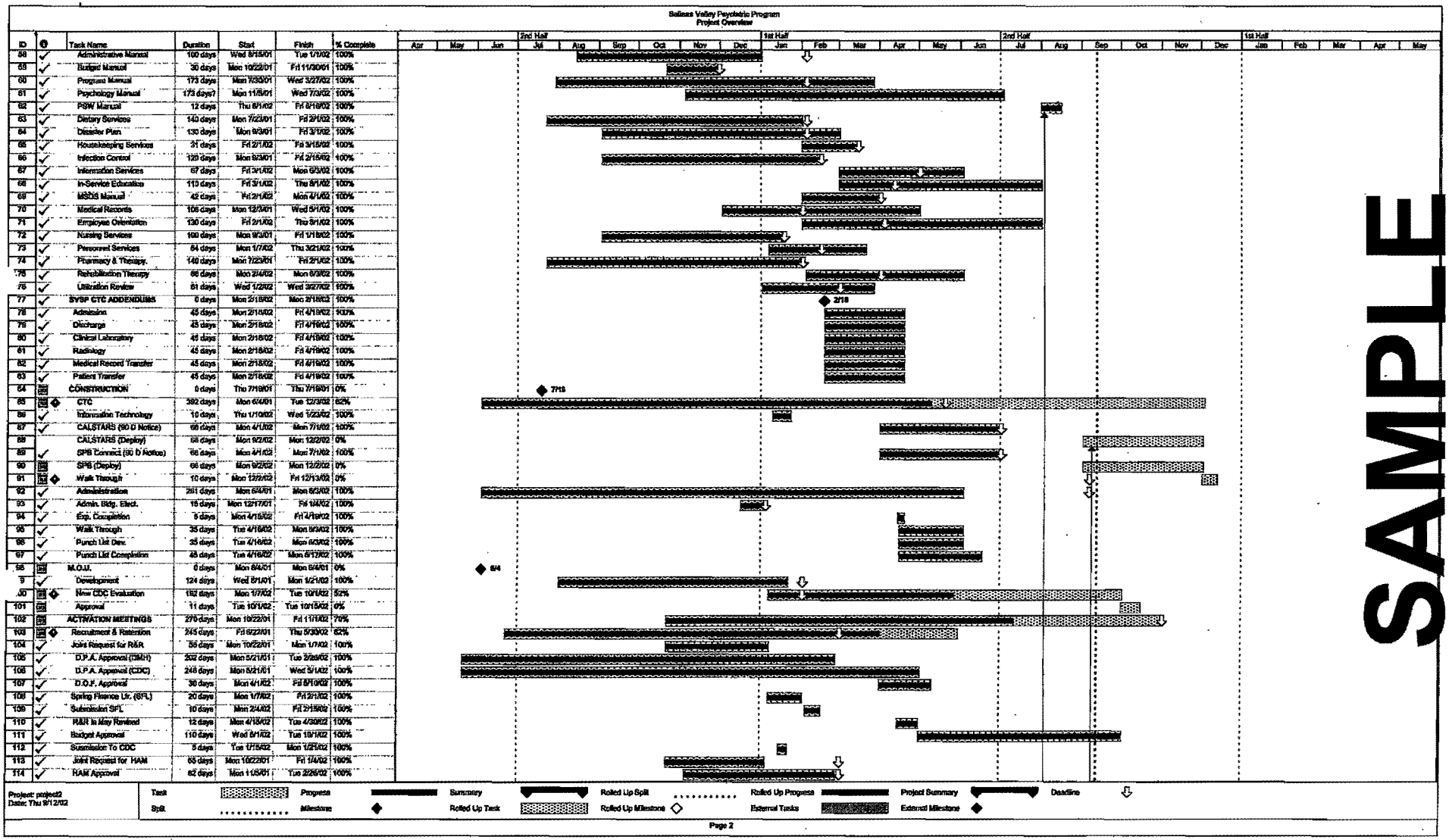
[2] Richard J. Donovan Correctional Facility (RJD), California State Prison – Sacramento (SAC), California Men's Colony (CMC), and California State Prison – Los Angeles County (LAC).

Enclosure III

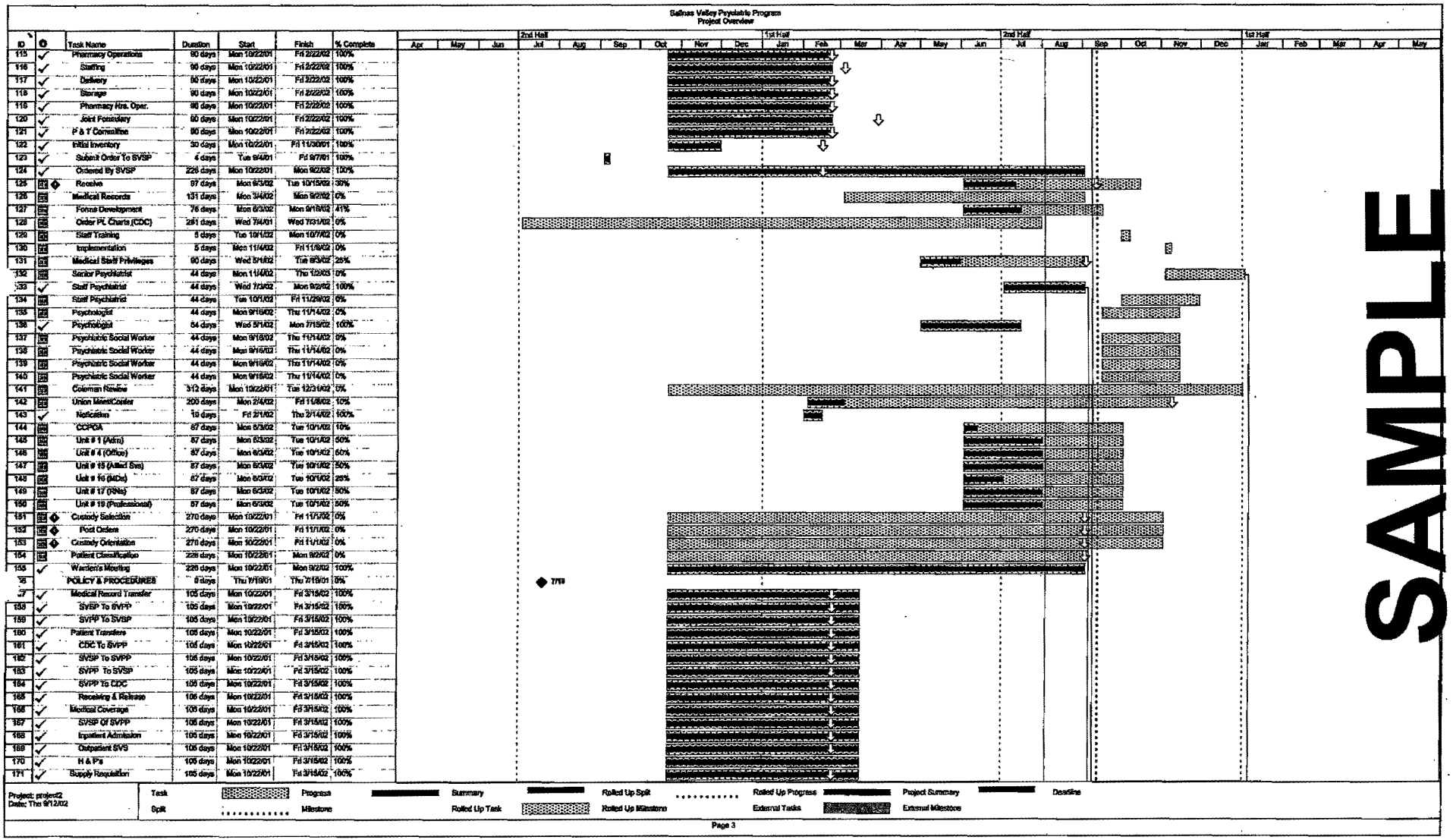


ID	Task Name	Duration	Start	Finish	% Complete
1	ACTIVATION MANUAL	0 days	Mon 6/4/01	Mon 6/4/01	100%
2	Activation Manual	80 days	Mon 6/4/01	Fri 8/24/01	100%
3	RECRUITMENT	0 days	Thu 7/19/01	Thu 7/19/01	0%
4	Sr. Mgt. Team	0 days	Fri 6/8/01	Fri 6/8/01	100%
5	Executive Director	38 days	Mon 4/2/01	Mon 5/21/01	100%
6	Program Director	60 days	Mon 6/4/01	Fri 8/21/01	100%
7	Hospital Adm. Res. II	53 days	Mon 6/4/01	Wed 8/15/01	100%
8	Nursing Coordinator	60 days	Mon 6/4/01	Fri 8/24/01	100%
9	Executive Secretary	60 days	Mon 6/4/01	Fri 8/24/01	100%
10	Staff Recruitment	0 days	Thu 7/19/01	Thu 7/19/01	0%
11	Senior Psychiatrist	292 days	Mon 8/3/01	Tue 10/15/02	60%
12	Staff Psychiatrist	246 days	Mon 9/3/01	Mon 8/12/02	100%
13	Staff Psychiatrist	246 days	Mon 9/3/01	Mon 8/12/02	100%
14	Psychologist	206 days	Mon 9/3/01	Mon 6/17/02	100%
15	Psychologist	206 days	Mon 9/3/01	Mon 6/17/02	100%
16	Psychiatric Social Worker	328 days	Mon 9/3/01	Mon 12/2/02	100%
17	Psychiatric Social Worker	328 days	Mon 9/3/01	Mon 12/2/02	100%
18	Psychiatric Social Worker	328 days	Mon 9/3/01	Mon 12/2/02	100%
19	Psychiatric Social Worker	328 days	Mon 9/3/01	Mon 12/2/02	100%
20	Rehabilitation Therapist	326 days	Mon 9/3/01	Mon 12/2/02	100%
21	Rehabilitation Therapist	326 days	Mon 9/3/01	Mon 12/2/02	10%
22	Rehabilitation Therapist	326 days	Mon 9/3/01	Mon 12/2/02	10%
23	Rehabilitation Therapist	326 days	Mon 9/3/01	Mon 12/2/02	10%
24	Clinical Dietician	131 days	Mon 10/1/01	Mon 4/1/02	100%
25	Supervising R.N.	173 days	Mon 9/3/01	Wed 5/1/02	100%
26	Registered Nurse	412 days	Mon 9/3/01	Tue 4/1/03	20%
27	Senior MTA	305 days	Mon 9/3/01	Fri 11/1/02	65%
28	MTA	349 days	Mon 9/3/01	Thu 1/2/03	30%
29	Training Officer	131 days	Mon 10/1/01	Mon 4/1/02	100%
30	Pharmacist I	326 days	Mon 9/3/01	Mon 12/2/02	60%
31	AISA	228 days	Mon 9/3/01	Mon 7/15/02	100%
32	Assoc. Personnel Analyst	82 days	Mon 9/3/01	Tue 1/8/02	100%
33	Accounting Officer	226 days	Mon 9/3/01	Mon 7/15/02	100%
34	Personnel Svs. Spec.	215 days	Mon 10/1/01	Thu 8/1/02	100%
35	HRT II	285 days	Mon 10/1/01	Fri 11/1/02	10%
36	HRT I	206 days	Mon 10/1/01	Mon 7/15/02	100%
37	HRT I	285 days	Mon 10/1/01	Fri 11/1/02	10%
38	Office Technician (PD)	140 days	Mon 8/20/01	Fri 3/1/02	100%
39	Office Technician (PER)	193 days	Mon 8/20/01	Wed 5/1/02	100%
40	Office Technician (MR)	315 days	Mon 8/20/01	Fri 11/1/02	10%
41	Accounting Tech.	250 days	Mon 12/3/01	Fri 11/15/02	0%
42	Medical Transcriber	206 days	Mon 10/1/01	Mon 7/15/02	100%
43	Pharmacy Technician	221 days	Mon 9/3/01	Mon 7/8/02	100%
44	Pharmacy Technician	285 days	Mon 9/3/01	Fri 11/1/02	30%
45	Janitor Supervisor I	306 days	Mon 10/1/01	Mon 12/2/02	10%
46	Janitor	174 days	Mon 12/3/01	Thu 8/1/02	100%
47	Janitor	174 days	Mon 12/3/01	Thu 8/1/02	100%
48	Janitor	174 days	Mon 12/3/01	Thu 8/1/02	100%
49	Janitor	174 days	Mon 12/3/01	Thu 8/1/02	100%
50	Janitor	174 days	Mon 12/3/01	Thu 8/1/02	100%
51	Janitor	240 days	Mon 12/3/01	Fri 11/1/02	10%
52	TEMPORARY OFFICE	0 days	Thu 7/19/01	Thu 7/19/01	0%
53	Establ. Greenfield Office	248 days	Mon 8/20/01	Wed 7/31/02	100%
54	Phone System	248 days	Mon 8/20/01	Wed 7/31/02	100%
55	Computer System	248 days	Mon 8/20/01	Wed 7/31/02	100%
56	Furniture Arrival	248 days	Mon 8/20/01	Wed 7/31/02	100%
57	SVPP OPERATIONAL MANUA	0 days	Thu 7/19/01	Thu 7/19/01	0%

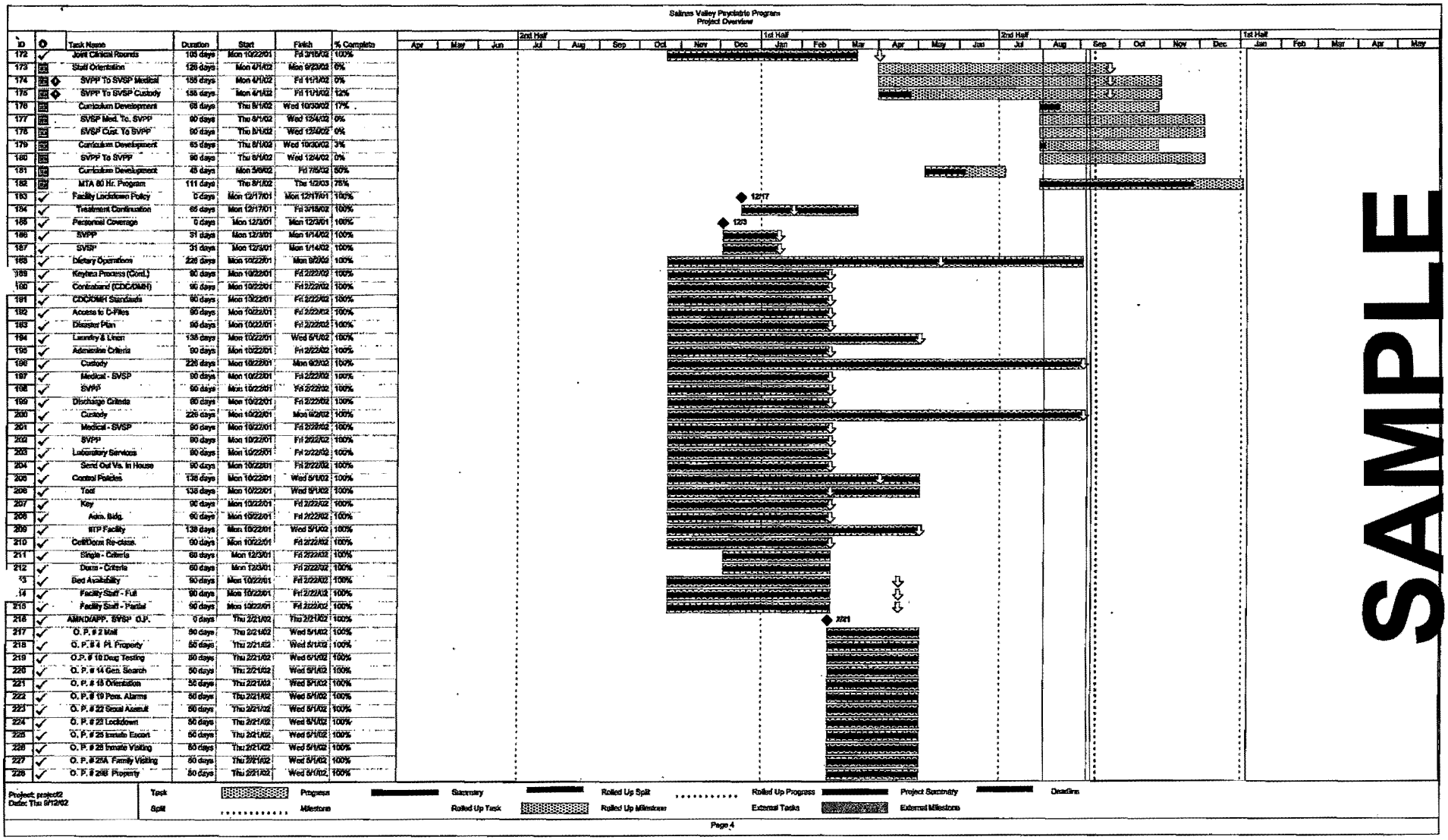
SAMPLE

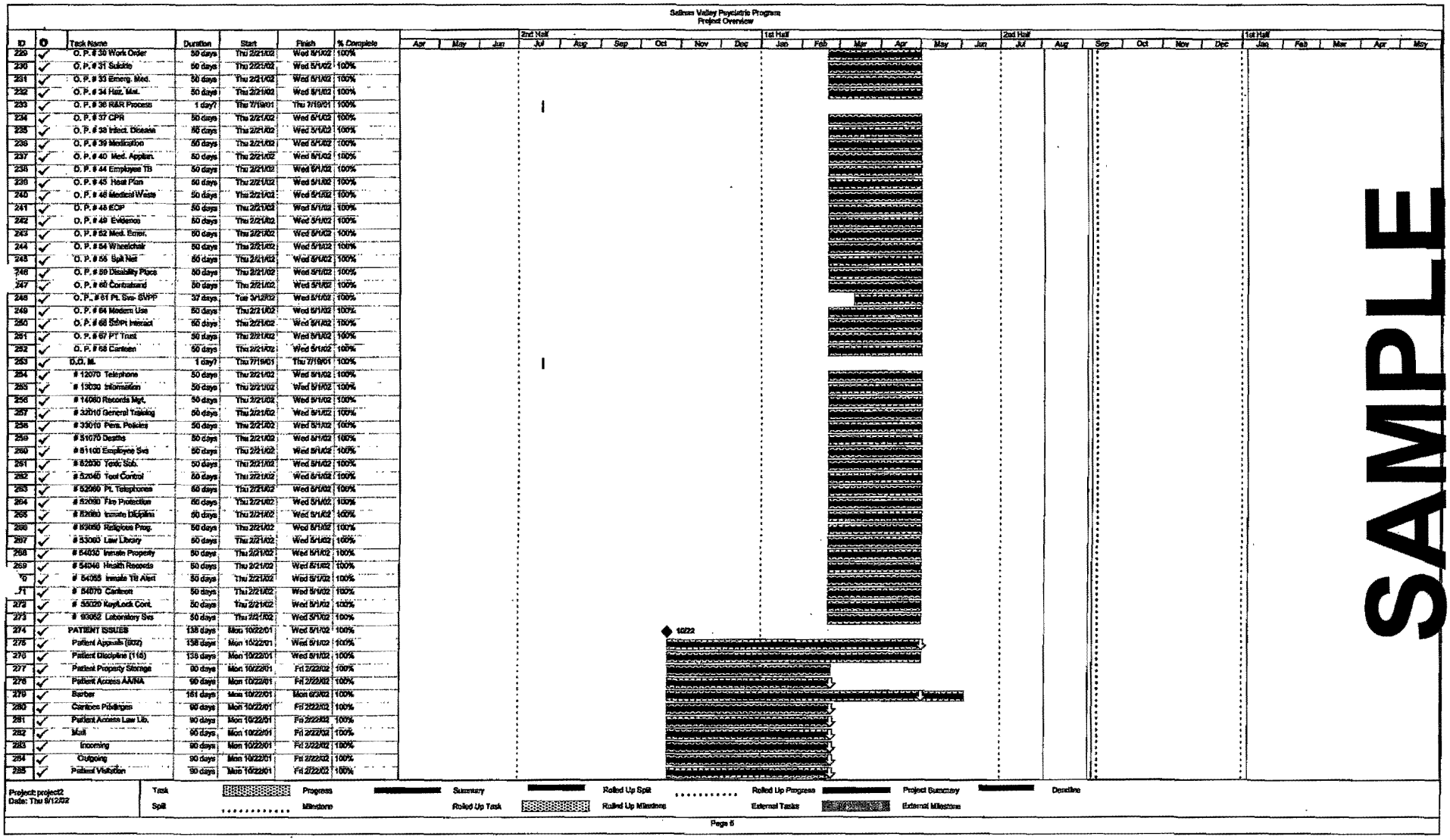


ID	Task Name	Duration	Start	Finish	% Complete
58	Administrative Manual	100 days	Wed 8/15/01	Tue 1/1/02	100%
59	Budget Manual	30 days	Mon 10/22/01	Fri 11/30/01	100%
60	Program Manual	173 days	Mon 7/30/01	Wed 3/27/02	100%
61	Psychology Manual	173 days?	Mon 11/5/01	Wed 7/3/02	100%
62	PSW Manual	12 days	Thu 8/1/02	Fri 8/16/02	100%
63	Dietary Services	140 days	Mon 7/23/01	Fri 2/1/02	100%
64	Disaster Plan	130 days	Mon 8/3/01	Fri 3/1/02	100%
65	Housekeeping Services	31 days	Fri 2/1/02	Fri 3/15/02	100%
66	Infection Control	128 days	Mon 8/3/01	Fri 2/15/02	100%
67	Information Services	67 days	Fri 3/1/02	Mon 6/3/02	100%
68	In-Service Education	110 days	Fri 3/1/02	Thu 8/1/02	100%
69	MSDS Manual	42 days	Fri 2/1/02	Mon 4/1/02	100%
70	Medical Records	106 days	Mon 12/3/01	Wed 5/1/02	100%
71	Employee Orientation	130 days	Fri 2/1/02	Thu 8/1/02	100%
72	Nursing Services	100 days	Mon 9/3/01	Fri 1/18/02	100%
73	Personnel Services	64 days	Mon 1/7/02	Thu 3/21/02	100%
74	Pharmacy & Therapy.	140 days	Mon 7/23/01	Fri 2/1/02	100%
75	Rehabilitation Therapy	66 days	Mon 2/4/02	Mon 5/6/02	100%
76	Utilization Review	81 days	Wed 1/2/02	Wed 3/27/02	100%
77	SVSP CTC ADDENDUMS	0 days	Mon 2/18/02	Mon 2/18/02	100%
78	Admission	45 days	Mon 2/18/02	Fri 4/19/02	100%
79	Discharge	45 days	Mon 2/18/02	Fri 4/19/02	100%
80	Clinical Laboratory	45 days	Mon 2/18/02	Fri 4/19/02	100%
81	Radiology	45 days	Mon 2/18/02	Fri 4/19/02	100%
82	Medical Record Transfer	45 days	Mon 2/18/02	Fri 4/19/02	100%
83	Patient Transfer	45 days	Mon 2/18/02	Fri 4/19/02	100%
84	CONSTRUCTION	0 days	Thu 7/19/01	Thu 7/19/01	0%
85	CTC	392 days	Mon 6/4/01	Tue 12/3/02	82%
86	Information Technology	10 days	Thu 1/10/02	Wed 1/23/02	100%
87	CALSTARS (90 D Notice)	66 days	Mon 4/1/02	Mon 7/1/02	100%
88	CALSTARS (Deploy)	66 days	Mon 9/2/02	Mon 12/2/02	0%
89	SPB Connect (90 D Notice)	66 days	Mon 4/1/02	Mon 7/1/02	100%
90	SPB (Deploy)	66 days	Mon 9/2/02	Mon 12/2/02	0%
91	Walk Through	10 days	Mon 12/2/02	Fri 12/13/02	0%
92	Administration	261 days	Mon 6/4/01	Mon 6/3/02	100%
93	Admin. Bldg. Elect.	15 days	Mon 12/17/01	Fri 1/4/02	100%
94	Eqp. Completion	5 days	Mon 4/15/02	Fri 4/19/02	100%
95	Walk Through	35 days	Tue 4/16/02	Mon 6/3/02	100%
96	Punch List Dev.	35 days	Tue 4/16/02	Mon 6/3/02	100%
97	Punch List Completion	45 days	Tue 4/16/02	Mon 6/17/02	100%
98	M.O.U.	0 days	Mon 6/4/01	Mon 6/4/01	0%
9	Development	124 days	Wed 8/1/01	Mon 1/21/02	100%
30	New CDC Evaluation	182 days	Mon 1/7/02	Tue 10/1/02	52%
101	Approval	11 days	Tue 10/1/02	Tue 10/15/02	0%
102	ACTIVATION MEETINGS	276 days	Mon 10/22/01	Fri 11/1/02	70%
103	Recruitment & Retention	245 days	Fri 8/22/01	Thu 5/30/02	82%
104	Joint Request for R&R	55 days	Mon 10/22/01	Mon 1/7/02	100%
105	D.P.A. Approval (DMH)	202 days	Mon 5/21/01	Tue 2/26/02	100%
106	D.P.A. Approval (CDC)	248 days	Mon 5/21/01	Wed 5/1/02	100%
107	D.O.F. Approval	30 days	Mon 4/1/02	Fri 5/10/02	100%
108	Spring Finance Ltr. (SFL)	20 days	Mon 1/7/02	Fri 2/1/02	100%
109	Submission SFL	10 days	Mon 2/4/02	Fri 2/15/02	100%
110	R&R is May Revised	12 days	Mon 4/15/02	Tue 4/30/02	100%
111	Budget Approval	110 days	Wed 8/1/02	Tue 10/1/02	100%
112	Submission To CDC	5 days	Tue 1/15/02	Mon 1/21/02	100%
113	Joint Request for HAM	55 days	Mon 10/22/01	Fri 1/4/02	100%
114	HAM Approval	62 days	Mon 11/5/01	Tue 2/26/02	100%

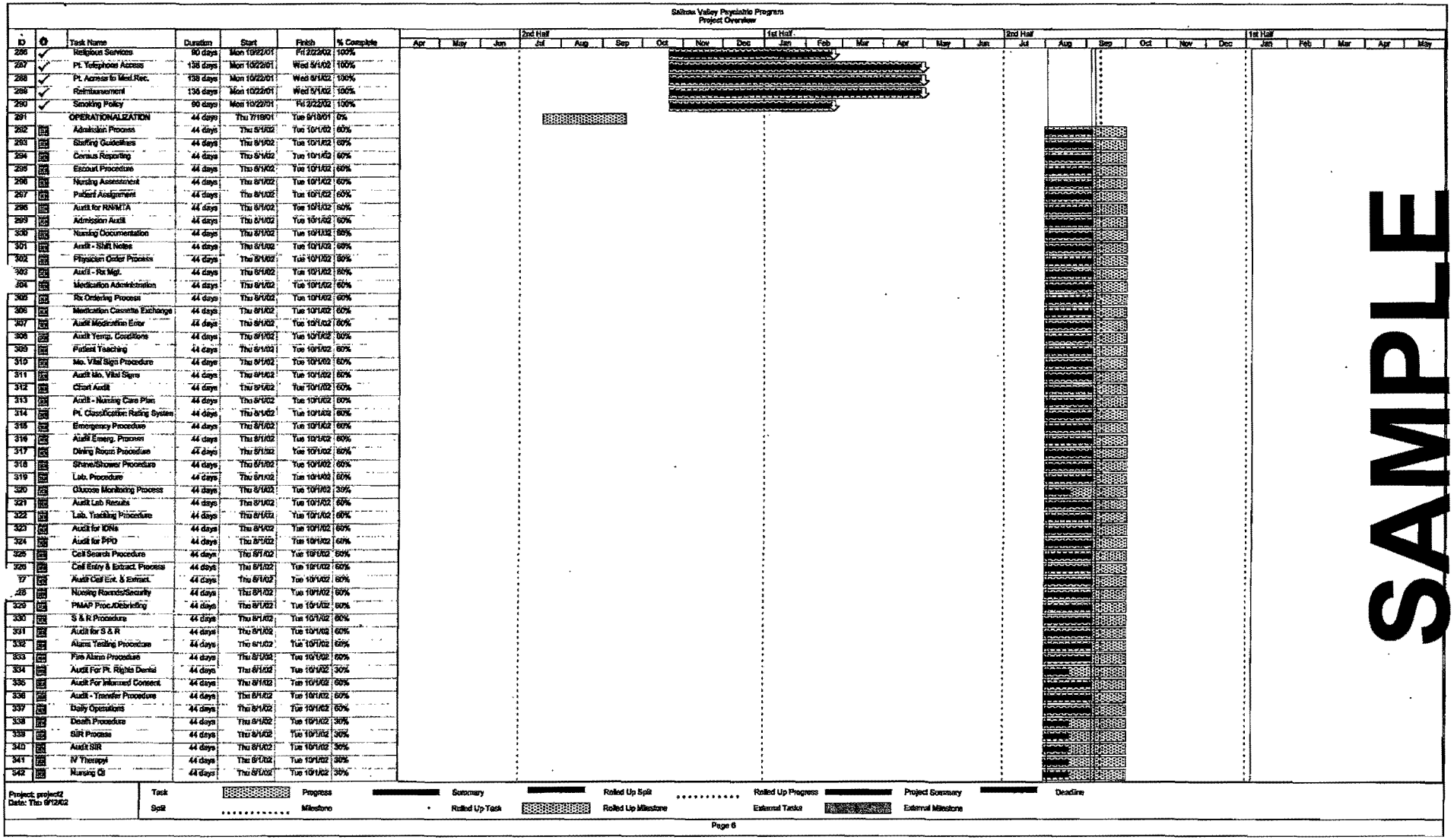

Salinas Valley Psychiatric Program
Project Overview
ID
Task Name
Duration
Start
Finish
% Complete
115 Pharmacy Operations 90 days Mon 10/22/01 Fri 2/22/02 100%
116 Staffing 90 days Mon 10/22/01 Fri 2/22/02 100%
117 Delivery 90 days Mon 10/22/01 Fri 2/22/02 100%
118 Storage 90 days Mon 10/22/01 Fri 2/22/02 100%
119 Pharmacy Hrs. Oper. 90 days Mon 10/22/01 Fri 2/22/02 100%
120 Joint Formulary 90 days Mon 10/22/01 Fri 2/22/02 100%
121 P & T Committee 90 days Mon 10/22/01 Fri 2/22/02 100%
122 Initial Inventory 30 days Mon 10/22/01 Fri 11/30/01 100%
123 Submit Order To SVSP 4 days Tue 9/4/01 Fri 9/7/01 100%
124 Ordered By SVSP 226 days Mon 10/22/01 Mon 9/2/02 100%
125 Receive 97 days Mon 6/3/02 Tue 10/15/02 30%
126 Medical Records 131 days Mon 3/4/02 Mon 9/2/02 0%
127 Forms Development 76 days Mon 6/3/02 Mon 9/16/02 41%
128 Order Pt. Charts (CDC) 261 days Wed 7/4/01 Wed 7/31/02 0%
129 Staff Training 5 days Tue 10/1/02 Mon 10/7/02 0%
130 Implementation 5 days Mon 11/4/02 Fri 11/8/02 0%
131 Medical Staff Privileges 90 days Wed 5/1/02 Tue 9/3/02 25%
132 Senior Psychiatrist 44 days Mon 11/4/02 Thu 1/2/03 0%
133 Staff Psychiatrist 44 days Wed 7/1/02 Mon 9/2/02 100%
134 Staff Psychiatrist 44 days Tue 10/1/02 Fri 11/29/02 0%
135 Psychologist 44 days Mon 9/16/02 Thu 11/14/02 0%
136 Psychologist 64 days Wed 5/1/02 Mon 7/15/02 100%
137 Psychiatric Social Worker 44 days Mon 9/16/02 Thu 11/14/02 0%
138 Psychiatric Social Worker 44 days Mon 9/16/02 Thu 11/14/02 0%
139 Psychiatric Social Worker 44 days Mon 9/16/02 Thu 11/14/02 0%
140 Psychiatric Social Worker 44 days Mon 9/16/02 Thu 11/14/02 0%
141 Coleman Review 312 days Mon 10/22/01 Tue 12/31/02 0%
142 Union Meet/Confer 200 days Mon 2/4/02 Fri 11/8/02 10%
143 Notifiers 10 days Fri 2/1/02 Thu 2/14/02 100%
144 CCPOA 87 days Mon 6/3/02 Tue 10/1/02 10%
145 Unit # 1 (Adm) 87 days Mon 6/3/02 Tue 10/1/02 50%
146 Unit # 4 (Office) 87 days Mon 6/3/02 Tue 10/1/02 50%
147 Unit # 15 (Allied Svs) 87 days Mon 6/3/02 Tue 10/1/02 50%
148 Unit # 16 (MDs) 87 days Mon 6/3/02 Tue 10/1/02 25%
149 Unit # 17 (RNs) 87 days Mon 6/3/02 Tue 10/1/02 50%
150 Unit # 19 (Professional) 87 days Mon 6/3/02 Tue 10/1/02 50%
151 Custody Selection 270 days Mon 10/22/01 Fri 11/1/02 0%
152 Post Orders 270 days Mon 10/22/01 Fri 11/1/02 0%
153 Custody Orientation 270 days Mon 10/22/01 Fri 11/1/02 0%
154 Patient Classification 226 days Mon 10/22/01 Mon 9/2/02 0%
155 Warden's Meeting 226 days Mon 10/22/01 Mon 9/2/02 100%
POLICY & PROCEDURES 0 days Thu 7/19/01 Thu 7/19/01 0%
7/19
157 Medical Record Transfer 105 days Mon 10/22/01 Fri 3/15/02 100%
158 SVSP To SVPP 105 days Mon 10/22/01 Fri 3/15/02 100%
159 SVPP To SVSP 105 days Mon 10/22/01 Fri 3/15/02 100%
160 Patient Transfers 105 days Mon 10/22/01 Fri 3/15/02 100%
161 CDC To SVPP 105 days Mon 10/22/01 Fri 3/15/02 100%
162 SVSP To SVPP 105 days Mon 10/22/01 Fri 3/15/02 100%
163 SVPP To SVSP 105 days Mon 10/22/01 Fri 3/15/02 100%
164 SVPP To CDC 105 days Mon 10/22/01 Fri 3/15/02 100%
165 Receiving & Release 105 days Mon 10/22/01 Fri 3/15/02 100%
166 Medical Coverage 105 days Mon 10/22/01 Fri 3/15/02 100%
167 SVSP Of SVPP 105 days Mon 10/22/01 Fri 3/15/02 100%
168 Inpatient Admission 105 days Mon 10/22/01 Fri 3/15/02 100%
169 Outpatient SVS 105 days Mon 10/22/01 Fri 3/15/02 100%
170 H & Ps 105 days Mon 10/22/01 Fri 3/15/02 100%
171 Supply Requisition 105 days Mon 10/22/01 Fri 3/15/02 100%
Apr May Jun 2nd Half Jul Aug Sep Oct 1st Half Nov Dec Jan Feb Mar Apr May Jun 2nd Half Jul Aug Sep Oct Nov Dec 1st Half Jan Feb Mar Apr May
Project: project2
Date: Thu 9/12/02
Task
Split
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Split
Rolled Up Milestone
Rolled Up Progress
External Tasks
Project Summary
External Milestone
Deadline
Page 3

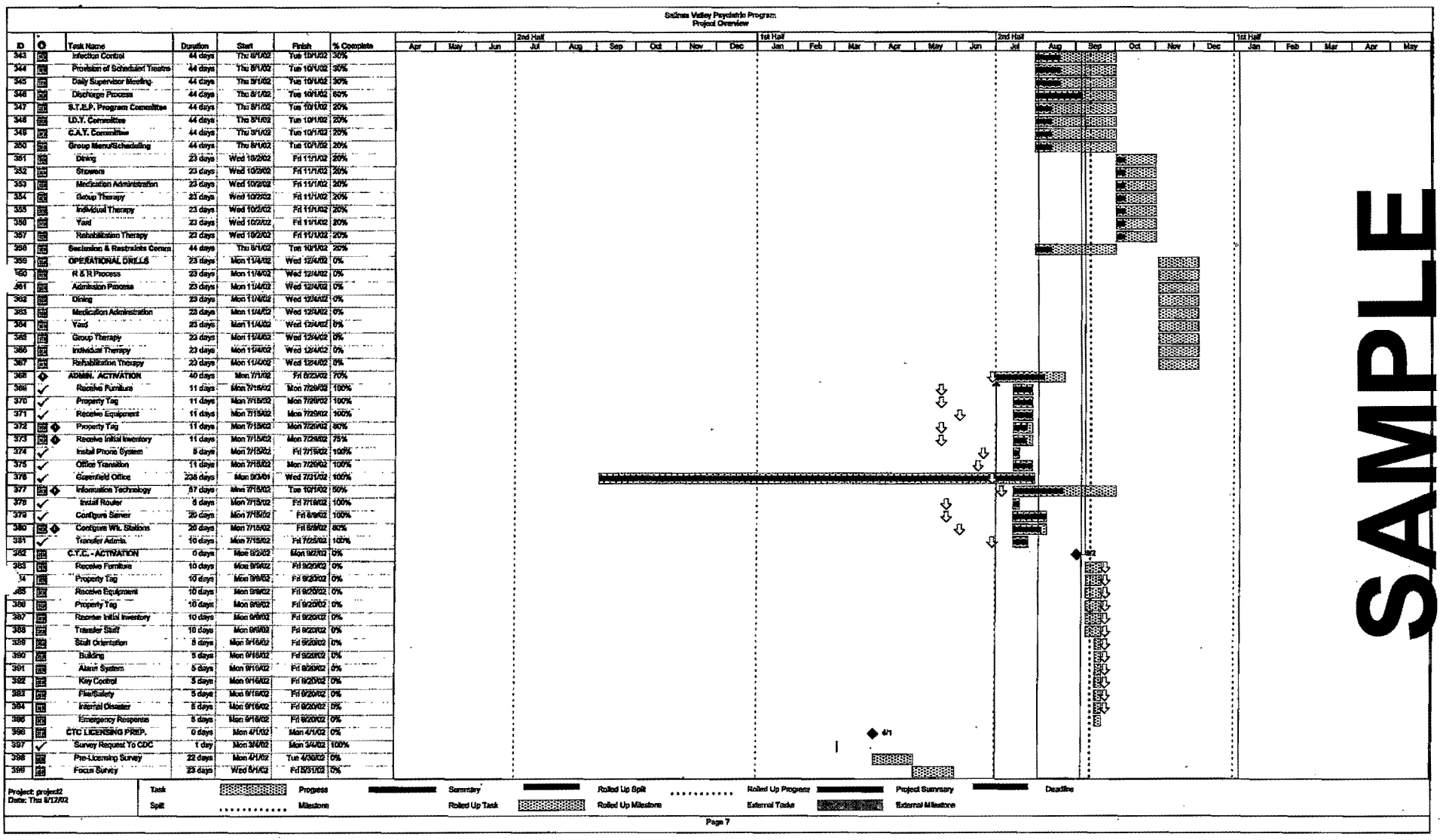
SAMPLE


Salinas Valley Psychiatric Program
Project Overview
SAMPLE
Project: project2
Date: Tue 9/12/02
Page 4


Salinas Valley Psychiatric Program
Project Overview
ID
Task Name
Duration
Start
Finish
% Complete
2nd Half
1st Half
2nd Half
1st Half
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May
229 O. P. # 36 Work Order 50 days Thu 2/21/02 Wed 5/1/02 100%
230 O. P. # 37 Suicide 50 days Thu 2/21/02 Wed 5/1/02 100%
231 O. P. # 33 Emerg. Med. 50 days Thu 2/21/02 Wed 5/1/02 100%
232 O. P. # 34 Haz. Mat. 50 days Thu 2/21/02 Wed 5/1/02 100%
233 O. P. # 36 R&R Process 1 day? Thu 7/19/01 Thu 7/19/01 100%
234 O. P. # 37 CPR 50 days Thu 2/21/02 Wed 5/1/02 100%
235 O. P. # 38 Infect. Disease 50 days Thu 2/21/02 Wed 5/1/02 100%
236 O. P. # 39 Medication 50 days Thu 2/21/02 Wed 5/1/02 100%
237 O. P. # 40 Med. Applian. 50 days Thu 2/21/02 Wed 5/1/02 100%
238 O. P. # 44 Employee TB 50 days Thu 2/21/02 Wed 5/1/02 100%
239 O. P. # 45 Heat Plan 50 days Thu 2/21/02 Wed 5/1/02 100%
240 O. P. # 46 Medical Waste 50 days Thu 2/21/02 Wed 5/1/02 100%
241 O. P. # 48 EOP 50 days Thu 2/21/02 Wed 5/1/02 100%
242 O. P. # 49 Evidence 50 days Thu 2/21/02 Wed 5/1/02 100%
243 O. P. # 52 Med. Emer. 50 days Thu 2/21/02 Wed 5/1/02 100%
244 O. P. # 54 Wheelchair 50 days Thu 2/21/02 Wed 5/1/02 100%
245 O. P. # 55 Spill Net 50 days Thu 2/21/02 Wed 5/1/02 100%
246 O. P. # 59 Disability Place 50 days Thu 2/21/02 Wed 5/1/02 100%
247 O. P. # 60 Contraband 50 days Thu 2/21/02 Wed 5/1/02 100%
248 O. P. # 61 Pt. Svs. SVPP 37 days Tue 3/12/02 Wed 5/1/02 100%
249 O. P. # 64 Modem Use 50 days Thu 2/21/02 Wed 5/1/02 100%
250 O. P. # 66 SVPI Interact 50 days Thu 2/21/02 Wed 5/1/02 100%
251 O. P. # 67 PT Trust 50 days Thu 2/21/02 Wed 5/1/02 100%
252 O. P. # 68 Canteen 50 days Thu 2/21/02 Wed 5/1/02 100%
253 D.O. M. 1 day? Thu 7/19/01 Thu 7/19/01 100%
254 # 12070 Telephone 50 days Thu 2/21/02 Wed 5/1/02 100%
255 # 13030 Information 50 days Thu 2/21/02 Wed 5/1/02 100%
256 # 14060 Records Mgt. 50 days Thu 2/21/02 Wed 5/1/02 100%
257 # 32010 General Training 50 days Thu 2/21/02 Wed 5/1/02 100%
258 # 33010 Pers. Policies 50 days Thu 2/21/02 Wed 5/1/02 100%
259 # 51070 Deaths 50 days Thu 2/21/02 Wed 5/1/02 100%
260 # 51100 Employee Svc 50 days Thu 2/21/02 Wed 5/1/02 100%
261 # 52030 Toxic Sub. 50 days Thu 2/21/02 Wed 5/1/02 100%
262 # 52040 Tool Control 50 days Thu 2/21/02 Wed 5/1/02 100%
263 # 52060 Pt. Telephones 50 days Thu 2/21/02 Wed 5/1/02 100%
264 # 52080 Fire Protection 50 days Thu 2/21/02 Wed 5/1/02 100%
265 # 52090 Inmate Displins 50 days Thu 2/21/02 Wed 5/1/02 100%
266 # 53050 Religious Prog. 50 days Thu 2/21/02 Wed 5/1/02 100%
267 # 53060 Law Library 50 days Thu 2/21/02 Wed 5/1/02 100%
268 # 54030 Inmate Property 50 days Thu 2/21/02 Wed 5/1/02 100%
269 # 54040 Health Records 50 days Thu 2/21/02 Wed 5/1/02 100%
70 # 54055 Inmate Tb Alert 50 days Thu 2/21/02 Wed 5/1/02 100%
71 # 54070 Canteen 50 days Thu 2/21/02 Wed 5/1/02 100%
272 # 55020 Key/Lock Cont. 50 days Thu 2/21/02 Wed 5/1/02 100%
273 # 93052 Laboratory Svs 50 days Thu 2/21/02 Wed 5/1/02 100%
274 PATIENT ISSUES 138 days Mon 10/22/01 Wed 5/1/02 100%
275 Patient Appeals (602) 138 days Mon 10/22/01 Wed 5/1/02 100%
276 Patient Discipline (115) 138 days Mon 10/22/01 Wed 5/1/02 100%
277 Patient Property Storage 90 days Mon 10/22/01 Fri 2/22/02 100%
278 Patient Access AA/NA 90 days Mon 10/22/01 Fri 2/22/02 100%
279 Barber 161 days Mon 10/22/01 Mon 6/3/02 100%
280 Canteen Privileges 90 days Mon 10/22/01 Fri 2/22/02 100%
281 Patient Access Law Lib. 90 days Mon 10/22/01 Fri 2/22/02 100%
282 Mail 90 days Mon 10/22/01 Fri 2/22/02 100%
283 Incoming 90 days Mon 10/22/01 Fri 2/22/02 100%
284 Outgoing 90 days Mon 10/22/01 Fri 2/22/02 100%
285 Patient Visitation 90 days Mon 10/22/01 Fri 2/22/02 100%
10/22
Project: project2
Date: Thu 5/12/02
Task
Split
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Split
Rolled Up Milestone
Rolled Up Progress
External Tasks
Project Summary
External Milestone
Deadline
Page 6

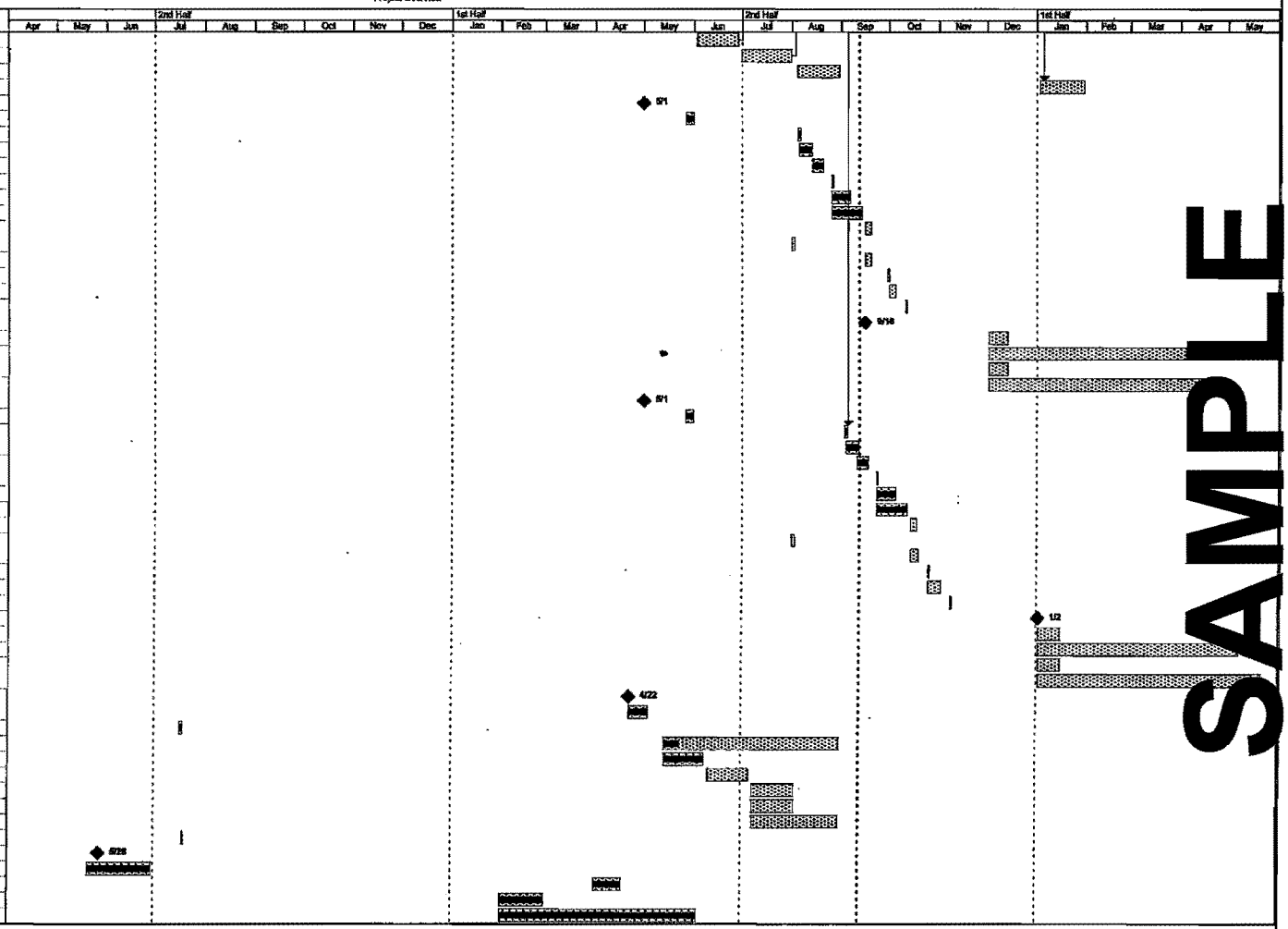
SAMPLE


Salinas Valley Psychiatric Program
Project Overview
ID
Task Name
Duration
Start
Finish
% Complete
286 Religious Services 90 days Mon 10/22/01 Fri 2/22/02 100%
287 Pt. Telephone Access 136 days Mon 10/22/01 Wed 5/1/02 100%
288 Pt. Access to Med.Rec. 136 days Mon 10/22/01 Wed 5/1/02 100%
289 Reinstatement 136 days Mon 10/22/01 Wed 5/1/02 100%
290 Smoking Policy 90 days Mon 10/22/01 Fri 2/22/02 100%
291 OPERATIONALIZATION 44 days Thu 7/19/01 Tue 9/18/01 0%
292 Admission Process 44 days Thu 8/1/02 Tue 10/1/02 60%
293 Staffing Guidelines 44 days Thu 8/1/02 Tue 10/1/02 60%
294 Census Reporting 44 days Thu 8/1/02 Tue 10/1/02 60%
295 Escort Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
296 Nursing Assessment 44 days Thu 8/1/02 Tue 10/1/02 60%
297 Patient Assignment 44 days Thu 8/1/02 Tue 10/1/02 60%
298 Audit for RN/MTA 44 days Thu 8/1/02 Tue 10/1/02 60%
299 Admission Audit 44 days Thu 8/1/02 Tue 10/1/02 60%
300 Nursing Documentation 44 days Thu 8/1/02 Tue 10/1/02 60%
301 Audit - Shift Notes 44 days Thu 8/1/02 Tue 10/1/02 60%
302 Physician Order Process 44 days Thu 8/1/02 Tue 10/1/02 60%
303 Audit - Rx Mgt. 44 days Thu 8/1/02 Tue 10/1/02 60%
304 Medication Administration 44 days Thu 8/1/02 Tue 10/1/02 60%
305 Rx Ordering Process 44 days Thu 8/1/02 Tue 10/1/02 60%
306 Medication Cassette Exchange 44 days Thu 8/1/02 Tue 10/1/02 60%
307 Audit Medication Error 44 days Thu 8/1/02 Tue 10/1/02 60%
308 Audit Temp. Conditions 44 days Thu 8/1/02 Tue 10/1/02 60%
309 Patient Teaching 44 days Thu 8/1/02 Tue 10/1/02 60%
310 Mo. Vital Sign Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
311 Audit Mo. Vital Signs 44 days Thu 8/1/02 Tue 10/1/02 60%
312 Chart Audit 44 days Thu 8/1/02 Tue 10/1/02 60%
313 Audit - Nursing Care Plan 44 days Thu 8/1/02 Tue 10/1/02 60%
314 Pt. Classification Rating System 44 days Thu 8/1/02 Tue 10/1/02 60%
315 Emergency Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
316 Audit Emerg. Process 44 days Thu 8/1/02 Tue 10/1/02 60%
317 Dining Room Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
318 Shave/Shower Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
319 Lab. Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
320 Glucose Monitoring Process 44 days Thu 8/1/02 Tue 10/1/02 30%
321 Audit Lab Results 44 days Thu 8/1/02 Tue 10/1/02 60%
322 Lab. Tracking Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
323 Audit for IDRs 44 days Thu 8/1/02 Tue 10/1/02 60%
324 Audit for PPD 44 days Thu 8/1/02 Tue 10/1/02 60%
325 Cell Search Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
326 Cell Entry & Extract. Process 44 days Thu 8/1/02 Tue 10/1/02 60%
327 Audit Cell Ent. & Extract. 44 days Thu 8/1/02 Tue 10/1/02 60%
328 Nursing Rounds/Security 44 days Thu 8/1/02 Tue 10/1/02 60%
329 PMAP Proc./Debriefing 44 days Thu 8/1/02 Tue 10/1/02 60%
330 S & R Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
331 Audit for S & R 44 days Thu 8/1/02 Tue 10/1/02 60%
332 Alarm Testing Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
333 Fire Alarm Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
334 Audit For Pt. Rights Denial 44 days Thu 8/1/02 Tue 10/1/02 30%
335 Audit For Informed Consent 44 days Thu 8/1/02 Tue 10/1/02 60%
336 Audit - Transfer Procedure 44 days Thu 8/1/02 Tue 10/1/02 60%
337 Daily Operations 44 days Thu 8/1/02 Tue 10/1/02 60%
338 Death Procedure 44 days Thu 8/1/02 Tue 10/1/02 30%
339 SIR Process 44 days Thu 8/1/02 Tue 10/1/02 30%
340 Audit SIR 44 days Thu 8/1/02 Tue 10/1/02 30%
341 IV Therapy 44 days Thu 8/1/02 Tue 10/1/02 30%
342 Nursing QI 44 days Thu 8/1/02 Tue 10/1/02 30%
Apr May Jun 2nd Half Jul Aug Sep Oct Nov Dec 1st Half Jan Feb Mar Apr May Jun 2nd Half Jul Aug Sep Oct Nov Dec 1st Half Jan Feb Mar Apr May
Project: project2
Date: Thu 9/12/02
Task
Split
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Split
Rolled Up Milestone
Rolled Up Progress
External Tasks
Project Summary
External Milestone
Deadline
Page 6


Salinas Valley Psychiatric Program
Project Overview
ID
Task Name
Duration
Start
Finish
% Complete
343 Infection Control 44 days Thu 8/1/02 Tue 10/1/02 20%
344 Provision of Scheduled Treatm 44 days Thu 8/1/02 Tue 10/1/02 20%
345 Daily Supervisor Meeting 44 days Thu 8/1/02 Tue 10/1/02 20%
346 Discharge Process 44 days Thu 8/1/02 Tue 10/1/02 60%
347 S.T.E.P. Program Committee 44 days Thu 8/1/02 Tue 10/1/02 20%
348 U.D.Y. Committee 44 days Thu 8/1/02 Tue 10/1/02 20%
349 C.A.Y. Committee 44 days Thu 8/1/02 Tue 10/1/02 20%
350 Group Menu/Scheduling 44 days Thu 8/1/02 Tue 10/1/02 20%
351 Dining 23 days Wed 10/2/02 Fri 11/1/02 20%
352 Showers 23 days Wed 10/2/02 Fri 11/1/02 20%
353 Medication Administration 23 days Wed 10/2/02 Fri 11/1/02 20%
354 Group Therapy 23 days Wed 10/2/02 Fri 11/1/02 20%
355 Individual Therapy 23 days Wed 10/2/02 Fri 11/1/02 20%
356 Yard 23 days Wed 10/2/02 Fri 11/1/02 20%
357 Rehabilitation Therapy 23 days Wed 10/2/02 Fri 11/1/02 20%
358 Seclusion & Restraints Comm 44 days Thu 8/1/02 Tue 10/1/02 20%
359 OPERATIONAL DRILLS 23 days Mon 11/4/02 Wed 12/4/02 0%
360 R & R Process 23 days Mon 11/4/02 Wed 12/4/02 0%
361 Admission Process 23 days Mon 11/4/02 Wed 12/4/02 0%
362 Dining 23 days Mon 11/4/02 Wed 12/4/02 0%
363 Medication Administration 23 days Mon 11/4/02 Wed 12/4/02 0%
364 Yard 23 days Mon 11/4/02 Wed 12/4/02 0%
365 Group Therapy 23 days Mon 11/4/02 Wed 12/4/02 0%
366 Individual Therapy 23 days Mon 11/4/02 Wed 12/4/02 0%
367 Rehabilitation Therapy 23 days Mon 11/4/02 Wed 12/4/02 0%
368 ADMIN. ACTIVATION 40 days Mon 7/1/02 Fri 8/23/02 70%
369 Receive Furniture 11 days Mon 7/15/02 Mon 7/29/02 100%
370 Property Tag 11 days Mon 7/15/02 Mon 7/29/02 100%
371 Receive Equipment 11 days Mon 7/15/02 Mon 7/29/02 100%
372 Property Tag 11 days Mon 7/15/02 Mon 7/29/02 80%
373 Receive Initial Inventory 11 days Mon 7/15/02 Mon 7/29/02 75%
374 Install Phone System 5 days Mon 7/15/02 Fri 7/19/02 100%
375 Office Transition 11 days Mon 7/15/02 Mon 7/29/02 100%
376 Greenfield Office 236 days Mon 9/3/01 Wed 7/31/02 100%
377 Information Technology 57 days Mon 7/15/02 Tue 10/1/02 50%
378 Install Router 5 days Mon 7/15/02 Fri 7/19/02 100%
379 Configure Server 20 days Mon 7/15/02 Fri 8/9/02 100%
380 Configure Wk. Stations 20 days Mon 7/15/02 Fri 8/9/02 80%
381 Transfer Admin. 10 days Mon 7/15/02 Fri 7/26/02 100%
382 C.T.C. - ACTIVATION 0 days Mon 9/2/02 Mon 9/2/02 0%
383 Receive Furniture 10 days Mon 9/9/02 Fri 9/20/02 0%
14 Property Tag 10 days Mon 9/9/02 Fri 9/20/02 0%
385 Receive Equipment 10 days Mon 9/9/02 Fri 9/20/02 0%
386 Property Tag 10 days Mon 9/9/02 Fri 9/20/02 0%
387 Receive Initial Inventory 10 days Mon 9/9/02 Fri 9/20/02 0%
388 Transfer Staff 10 days Mon 9/9/02 Fri 9/20/02 0%
389 Staff Orientation 5 days Mon 9/16/02 Fri 9/20/02 0%
390 Building 5 days Mon 9/16/02 Fri 9/20/02 0%
391 Alarm System 5 days Mon 9/16/02 Fri 9/20/02 0%
392 Key Control 5 days Mon 9/16/02 Fri 9/20/02 0%
393 Fire/Safety 5 days Mon 9/16/02 Fri 9/20/02 0%
394 Internal Disaster 5 days Mon 9/16/02 Fri 9/20/02 0%
395 Emergency Response 5 days Mon 9/16/02 Fri 9/20/02 0%
396 CTC LICENSING PREP. 0 days Mon 4/1/02 Mon 4/1/02 0%
397 Survey Request To CDC 1 day Mon 3/4/02 Mon 3/4/02 100%
398 Pre-Licensing Survey 22 days Mon 4/1/02 Tue 4/30/02 0%
399 Focus Survey 23 days Wed 5/1/02 Fri 5/31/02 0%
2nd Half
1st Half
2nd Half
1st Half
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May
4/1
9/2
Project: project2
Date: Thu 8/1/02
Task
Split
Progress
Milestone
Summary
Rolled Up Task
Rolled Up Split
Rolled Up Milestone
Rolled Up Progress
External Tasks
Project Summary
External Milestone
Deadline

Salinas Valley Psychiatric Program
Project Overview

ID	Task Name	Duration	Start	Finish	% Complete
400	Focus Survey	20 days	Mon 6/3/02	Fri 6/28/02	0%
401	Focus Survey	25 days	Mon 7/1/02	Wed 7/31/02	0%
402	Focus Survey	20 days	Mon 8/5/02	Fri 8/30/02	0%
403	Focus Survey	20 days	Fri 1/3/03	Thu 1/30/03	0%
404	FIRE MARSHALL SUR.	0 days	Wed 8/1/02	Wed 8/1/02	0%
405	Administration Bldg.	5 days	Mon 6/27/02	Fri 8/31/02	100%
406	CTC Inspection	2 days	Mon 8/5/02	Tue 8/6/02	100%
407	Statement of Def.	5 days	Tue 8/6/02	Tue 8/13/02	100%
408	Plan of Correction	5 days	Wed 8/14/02	Tue 8/20/02	100%
409	Re-Inspection	1 day	Mon 8/26/02	Mon 8/26/02	100%
410	CTC Occup. Approval	10 days	Mon 8/26/02	Fri 9/6/02	100%
411	Facility Preparation	15 days	Mon 8/26/02	Fri 9/13/02	100%
412	DHS LICENSING	4 days	Mon 9/16/02	Thu 9/19/02	0%
413	Submission of Application	2 days	Thu 8/1/02	Fri 8/2/02	0%
414	DHS Licensing Survey	4 days	Mon 9/16/02	Thu 9/19/02	0%
415	Statement of Deficiencies	1 day	Mon 9/30/02	Mon 9/30/02	0%
416	Plan of Correction	4 days	Tue 10/1/02	Fri 10/4/02	0%
417	DHS Acceptance	1 day	Fri 10/11/02	Fri 10/11/02	0%
418	PATIENT ADMISSIONS	0 days	Mon 9/16/02	Mon 9/16/02	0%
419	Admit Rate Full Staff	10 days	Mon 12/2/02	Fri 12/13/02	0%
420	3 Pts/Week 90 days	90 days	Mon 12/2/02	Fri 4/4/03	0%
421	Admit Rate Partial Staff	10 days	Mon 12/2/02	Fri 12/13/02	0%
422	2 Pt/Week 40 days	100 days	Mon 12/2/02	Fri 4/18/03	0%
423	FIRE MARSHALL SUR.	0 days	Wed 5/1/02	Wed 5/1/02	0%
424	Administration Bldg.	5 days	Mon 5/27/02	Fri 5/31/02	100%
425	CTC Inspection	2 days	Tue 9/3/02	Wed 9/4/02	100%
426	Statement of Def.	5 days	Wed 9/4/02	Wed 9/11/02	100%
427	Plan of Correction	5 days	Wed 9/11/02	Tue 9/17/02	100%
428	Re-Inspection	1 day	Mon 9/23/02	Mon 9/23/02	100%
429	CTC Occup. Approval	10 days	Mon 9/23/02	Fri 10/4/02	100%
430	Facility Preparation	15 days	Mon 9/23/02	Fri 10/11/02	100%
431	DHS LICENSING	4 days	Mon 10/14/02	Thu 10/17/02	0%
432	Submission of Application	2 days	Thu 8/1/02	Fri 8/2/02	0%
433	DHS Licensing Survey	5 days	Mon 10/14/02	Fri 10/18/02	0%
434	Statement of Deficiencies	1 day	Fri 10/25/02	Fri 10/25/02	0%
435	Plan of Correction	6 days	Fri 10/25/02	Fri 11/1/02	0%
436	DHS Acceptance	1 day	Fri 11/8/02	Fri 11/8/02	0%
437	PATIENT ADMISSIONS	0 days	Thu 1/2/03	Thu 1/2/03	0%
438	Admit Rate Full Staff	10 days	Thu 1/2/03	Wed 1/15/03	0%
439	3 Pts/Week 90 days	90 days	Thu 1/2/03	Wed 5/7/03	0%
440	Admit Rate Partial Staff	10 days	Thu 1/2/03	Wed 1/15/03	0%
11	2 Pt/Week 40 days	100 days	Thu 1/2/03	Wed 5/21/03	0%
42	PATIENT ASSESSEMENT	0 days	Mon 4/22/02	Mon 4/22/02	0%
443	Develop Tool	10 days	Mon 4/22/02	Fri 5/3/02	100%
444	Request For Information	2 days	Tue 7/17/01	Wed 7/18/01	100%
445	Commence Assessment	79 days	Tue 5/14/02	Fri 8/30/02	10%
446	SVSP (Doc Rev)	19 days	Tue 5/14/02	Fri 6/7/02	100%
447	PBSP (Doc Rev)	20 days	Mon 6/10/02	Fri 7/5/02	0%
448	CSP-Sac. (Doc Rev)	20 days	Mon 7/8/02	Fri 8/2/02	0%
449	CSP-Corcoran (Doc Rev)	20 days	Mon 7/8/02	Fri 8/2/02	0%
450	HDSP (Doc Rev)	40 days	Mon 7/8/02	Fri 8/30/02	0%
451	SVPP OPERATIONS	1 day?	Thu 7/19/01	Thu 7/19/01	0%
452	Business Sve.	0 days	Mon 5/28/01	Mon 5/28/01	0%
453	Financial Reporting	30 days	Mon 5/21/01	Fri 6/29/01	100%
454	Statistical Reporting	13 days	Mon 4/1/02	Wed 4/17/02	100%
455	Procurement (via ASH)	20 days	Fri 2/1/02	Thu 2/28/02	100%
456	Procurement (via ASH)	87 days	Fri 2/1/02	Mon 6/3/02	100%

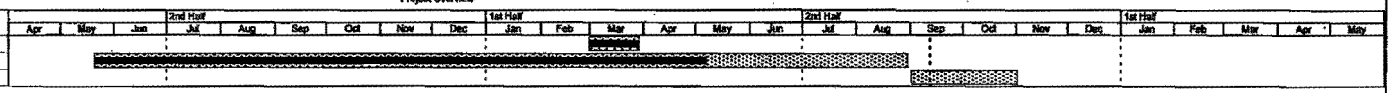


Project: project2
Date: Thu 9/12/02

Task | Split | Progress | Milestone | Summary | Rolled Up Task | Rolled Up Split | Rolled Up Milestone | Rolled Up Progress | External Tasks | Project Summary | External Milestone | Deadline

Salinas Valley Psychiatric Program
Project Overview

ID	Task Name	Duration	Start	Finish	% Complete
457	Interpal Rev. Svs Rpt.	21 days	Fri 3/1/02	Fri 3/29/02	100%
458	Payroll (Via HO)	335 days	Mon 5/21/01	Fri 8/30/02	75%
459	Payroll (Via SVPP)	45 days	Mon 9/2/02	Fri 11/1/02	0%



SAMPLE

Project: project2
Date: Thu 9/12/02

Task | Progress | Summary | Rolled Up Split | Rolled Up Progress | Project Summary | Deadline
Split | Milestone | Rolled Up Task | Rolled Up Milestone | External Tasks | External Milestone

SUPPLEMENTAL BED PLAN REPORT
AUGUST 2007

PRELIMINARY STAFFING AND RECRUITMENT ISSUES AND ASSUMPTIONS THAT ARE ASSOCIATED WITH CONSOLIDATED CARE CENTERS (CCCs)

I. Staffing:

The clinical staffing package (physicians, psychologists, Psychiatric Social Worker [PSWs], and Rehabilitation Therapists [RTs]) is based on Salinas Valley Psychiatric Program (SVPP) and Vacaville Psychiatric Program (VPP) actual operations. Registered Nurse (RN), and Licensed Vocational Nurse (LVN)/ Medical Technical Assistant (MTA)[1] staffing for Level IV[2] is based on SVPP actual operations and Level III is based on VPP actual operations. Differences in building configurations may require adjustments to the staffing package.

- The Department of Mental Health (DMH) will utilize the MTA and Senior Medical Technical Assistant (SMTA) classifications. This is necessary to allow management to effectively gain access to patients. Therefore, DMH/California Department of Corrections and Rehabilitation (CDCR) will need to recruit MTAs and SMTAs which, with no pool to draw from, may take 2-4 years.

- The DMH uses the MTA and SMTA classifications to not only provide nursing and custodial services but also immediate access to patients. Otherwise, DMH would have to rely solely on Correctional Officers (COs) to access patients; thereby impacting groups, activities, feeding, basic nursing care, and response times to certain inmate-patient emergencies, by the need to wait for COs to assist with access. In addition, it would be a significant recruiting challenge for the CDCR to provide the necessary contingent of COs if MTAs were not used.

- Plan on requiring additional COs to perform MTA custody functions until sufficient MTA staff can be hired to replace registry (declining scale). MTAs provide nursing care, escorts, medications, vital signs, emergency medical response, cell searches, pat downs, fifteen minute health and safety round observations and documentation, observation during patient movement, group observation, and group and activity co-facilitation.

[1] As of May 31, 2007 all MTAs (including Senior MTAs and Health Program Coordinators) within CDCR were converted to Licensed Vocational Nurses (LVNs). Source: Receiver's Fifth Quarterly Report. Section II.G.4. Page 23. It is important to note, however, that DMH continues to use the MTA classification as a component in its treatment model for Acute and ICF care. In implementing DMH's treatment model at the CCCs and CIW this report assumes that MTAs will be utilized, however, the CCC Project Team shall consider the use of MTAs, or other appropriate classifications, working under the direction of the DCHCS-Mental Health Program, to achieve successful implementation of the Acute and ICF programs at each facility.

[2] Throughout this document, Level IV (high-custody) refers to inmate-patients requiring celled housing.

SUPPLEMENTAL BED PLAN REPORT
AUGUST 2007

II. Executive/Administrative Needs:

The CDCR does not currently have the managerial and executive staff classifications that have similar training and responsibilities to DMH. DMH executive staff have hospital administration/health care administration training to run these programs. If CDCR is unable to recruit individuals into these positions, then alternative strategies will be required to attract and retain qualified individuals.

III. Recruitment:

A. To allow sufficient time to recruit, hire and train required MTAs, it is projected that hiring authority is needed two years prior to opening.

B. Once employed and prior to the programs' opening, the MTAs will work at existing DMH programs (VPP & SVPP) for training and education. The following are MTA training options:

   1. CDCR hires and trains MTA staff, **or**

   2. MTAs work for not less than three months or more prior to activation to understand treatment methods and treatment milieu.

C. The programs may need to supplement the available MTA staff with registry LVNs and RTs until MTAs can be recruited. Registry contracts should ensure continuity of care with consistent staff that know the patients as opposed to staff that turns over almost daily.

D. The programs may utilize additional COs to compensate for lack of MTA staffing, (i.e., access to patients at additional cost).

E. The program will undertake efforts to hire non-MTA staff (e.g. professional, clinical and support staff) 12 months prior to program openings.

IV. Assumption:

The programs are independent organizations; separate entities, not under the auspices of the prison and prison management. If this assumption is implemented, departments such as Medical Records, Personnel, and Fiscal Services are contained within the program's staffing packages and are not under the prison authority. This assumption limits the potential for maximizing cost efficiencies through the sharing of resources, however, it helps in maintaining the program's resources for duties for which they were authorized, by protecting them from being re-directed for other non-program related duties.

California Department of Corrections and Rehabilitation

Mental Health Bed Plan, December 2006 - Enclosure II (Amended#)

MALES

Introduction: As a general rule, the following proposal uses existing beds at five (5) Consolidated Care Center (CCC) sites*(the CCC sites are SAC, RJD, CMC, CIM, and LAC), plus at SVSP and CMF, and proposes to build additional capacity to meet and exceed Navigant's projected mental health bed need for June 2011, (based upon Spring 2006 population projections).

PROPOSAL - Assumes that the CDCR will operate the Acute and ICF programs and that there is no bed capacity at DMH hospitals (i.e. no beds at ASH, CSH, Napa, or Metro).

INITIAL
Expected Permanent Bed Capacity, June 2011
NO NEW BEDS
(Status Quo)

Table #1: Number of **permanent** mental health beds anticipated in June 2011** with **no** construction of additional beds, (except where noted).

	Level of Care							
Institution	EOP	ASU	PSU	MHCB	Acute	ICF	ICF-High Custody	Total
SAC	384	124	192	24				724
RJD	330	63		14				407
CMC[1]	580	54		50				684
CIM				18				18
LAC[2]	450	54		12				516
SVSP[3]	192	45		10			128	375
CMF[4]	600	58		50	150	84	64	1,006
PBSP[5]	64		128	10				202
Sub-Total:	2,600	398	320	188	150	84	192	3,932
COR	150	54		23				227
MCSP	510	36		8				554
SQ		36		32				68
HDSP				10				10
ISP				5				5
KVSP				12				12
NKSP				10				10
PVSP				5				5
SATF				16				16
SOL[6]				9				9
WSP				6				6
Sub-Total:	660	126	0	136				922
Grand Total:	3,260	524	320	324	150	84	192	4,854
							Navigant Bed Need, June 2011[A]	6,306
							Beds Deficient (Bed Need - Grand Total Beds Table #1):	1,452

* Note: will not use existing EOP, ASU, or MCHBs at CMC and CIM.

** Data sources for number of beds: Health Care Placement Unit, Licensing Unit, and Office of Facilities Management.

[1] Assumption: CMC - The 50 bed MHCB project proposed in the Interim ICF and MHCB Plan, June 2006 will be constructed.

[2] Assumption: LAC - The 150 bed EOP project as proposed in the April 2006 plan will be constructed.

[3] Assumptions: SVSP - 1. The 64 bed ICF project will be constructed.
2. All 128 ICF beds are counted as High Custody.

[4] Assumptions: CMF - 1. ICF: The 64 bed ICF facility as proposed in the April 2006 plan will be constructed.
2. EOP: The 30 temporary ICF beds at P-3 will be returned to 87 EOP beds.
3. MHCB: The 50 bed MHCB unit is constructed.

[5] PBSP: 4 of the 10 MHCBs are not covered under budgeted/staffed positions. Covered under registry or overtime.

[6] SOL: CTC can treat only 9 MHCB patients because of physical plant issues.

PROPOSAL
New Beds to be Constructed
+ Reduction of Existing Beds

Table #2: Estimated number of **new permanent** beds to be constructed by June 2011, and reduction of existing **permanent** beds to meet the bed deficiency in Table #1.

		Level of Care							
	Institution	EOP	ASU	PSU	MHCB	Acute	ICF	ICF-High Custody	Total
NEW BEDS	SAC	336			26		46	24	432
	RJD	390	62	128	16	0	46	24	666
	CMC[7]	720	125	128		0	46	24	1,043
	CIM[8]	720	125		30	90	46	24	1,035
	LAC	270	71		38		46	24	449
	SVSP[9]	96	70						166
	CMF								0
	PBSP								0
	Sub-Total:	2,532	453	256	110	90	230	120	3,791
REDUCTION OF EXISTING BEDS	COR	-150	-54		-23				-227
	MCSP	-510	-36		-3				-549
	SQ		-36						-36
	HDSP				-5				-5
	ISP								
	KVSP				-12				-12
	NKSP				-5				-5
	PVSP								
	SATF				-11				-11
	SOL				-9				-9
	WSP				-1				-1
	CMC	-580	-54						-634
	CIM				-18				-18
	SVSP[10]		-45						-45
	Sub-Total :[11]	-1,240	-225	0	-87				-1,552
	Grand Total (net):	1,292	228	256	23	90	230	120	2,239

Bed Deficiency Table #1:	1,452
Adjustment - Add Reserve^^ from Table #3:	787
Bed Deficiency Adjusted for Reserve:	2,239

[7] Assumption: CMC not using existing EOP and ASU population facilities, and the 50 bed MHCB unit is constructed see Table #1, footnote #1.

[8] Assumption: CIM not using the existing 18 GACH acute psych. beds as MHCBs. Total equals all new beds.

[9] Assumption: SVSP - The 128 bed ICF facility as proposed in the Statewide Mental Health Bed Plan, April 2006 will be re-scoped to construct a 70 bed EOP-ASU, and will convert existing space at SVSP to accommodate an additional 96 EOP beds.

[10] Assumption: SVSP - The current 45 ASU beds will be included in the proposed new 70 bed EOP-ASU construction project.

[11] Note: Does not include the return of temporary beds, (i.e., 36 MHCBs at CMC, 112 ICF Beds at SVSP, and 38 ICF beds at CMF P-2).

FINAL
Expected Permanent Bed Capacity
WITH CONSTRUCTION OF NEW BEDS
Post Implementation of Mental Health Bed Plan, December 2006
(Proposal)

Table #3: Number of **permanent** mental health beds anticipated through construction of new beds.

	Level of Care								
Institution	EOP	ASU	PSU	MHCB	Acute	ICF	ICF-High Custody	ICF Sub-Total	Total
SAC	720	124	192	50		46	24	70	1,156
RJD	720	125	128	30	0	46	24	70	1,073
CMC	720	125	128	50	0	46	24	70	1,093
CIM	720	125		30	90	46	24	70	1,035
LAC	720	125		50		46	24	70	965
SVSP	288	70		10			128	128	496
CMF	600	58		50	150	84	64	148	1,006
PBSP	64		128	10					202
Sub-Total:	4,552	752	576	280	240	314	312	626	7,026
COR									0
MCSP				5					5
SQ				32					32
HDSP				5					5
ISP				5					5
KVSP									0
NKSP				5					5
PVSP				5					5
SATF				5					5
SOL									0
WSP				5					5
Sub-Total:				67					67
Grand Total:	4,552	752	576	347	240	314	312	626	7,093
Navigant:[A]	4,175	675	401	268	224	299	264	563	6,306
Reserve:[AA]	377	77	175	79	16	15	48	63	787
% Reserve:	9.0%	11.4%	43.6%	29.5%	7.1%	5.0%	18.2%	11.2%	

[A] Source: Mental Health Bed Need Study - 2006 Update. Navigant Consulting. June 2006.

[AA] The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.

SPRING 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:

	EOP	ASU	PSU	MHCB	Acute	ICF	ICF-HC	ICF-ST	Total
Navigant:[AAA]	3,684	639	409	330	222	304	307	611	5,895
Reserve:	868	113	167	17	18	10	6	15	1,198
% Reserve:	23.6%	17.7%	40.8%	5.2%	8.1%	3.3%	1.6%	2.5%	

HC = High Custody; ST = Sub-Total

[AAA] Forecasted need - Planned Beds = Reserve.

Source: Mental Health Bed Need Study - Based on Spring 2007 Population Projections, Navigant Consulting, July 2007. Note: Per this study the Acute projected need was taken from the Mental Health Bed Need Study - Based on Fall 2006 Population Projections, Navigant Consulting, March 2007.

The Supplemental Bed Plan Report - August 2007 amends the December Bed Plan - 2006. Modifications to the original December Bed Plan - 2006 Enclosure II are underlined and shaded.

KEY: Modified Text

California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 - Enclosure II (Amended#)

MALES

Table #4: Actual vs. Target Reserve: The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed.
Table 4.A: Indicates how the target reserve was calculated using the percent increase in projected populations for the years indicated in the Spring 2006 Navigant Study as minimums and maximums and calculating a target reserve based on the midpoint of the two.*
Table 4.B: Indicates actual reserve for the proposal along with the difference between the actual and the target reserve.*

Table 4.A:	Minimum			Maximum			Midpoint		Table 4.B:		
	Navigant Spring 2006: Projected Population By Year and Percent Increase								Actual Reserve for Proposal		
	2010	2011	%	2007	2011	%	Target % Reserve	Target Reserve	Actual % Reserve	Actual Reserve	Difference Between Actual and Target Reserve
EOP	4,123	4175	1%	3,672	4175	14%	7.5%	312	9.0%	377	65
ASU	666	675	1%	572	675	18%	9.7%	65	11.4%	77	12
PSU	390	401	3%	332	401	21%	11.8%	47	43.6%	175	128
MHCB	266	268	1%	252	268	6%	3.6%	10	29.5%	79	69
Acute	222	224	1%	203	224	10%	5.6%	13	7.1%	16	3
ICF	294	299	2%	267	299	12%	6.8%	20	5.0%	15	-5
ICF (High Custody)	261	264	1%	197	264	34%	17.6%	46	18.2%	48	2
							Total:	513	Total:	787	274

* Differences in the reserve numbers in Table 4.A. and Table 4.B are due to rounding.

California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 - Enclosure II (Amended#)

MALES

LIST OF ACRONYMS (Arranged in Alphabetical Order)	
ASH	Atascadero State Hospital - DMH (Male)
ASU	Administrative Segregation Unit
CCC	Consolidated Care Center
CDCR	California Department of Corrections and Rehabilitation
CIM	California Institution for Men
CIW	California Institution for Women
CMC	California Men's Colony
CMF	California Medical Facility
COR	California State Prison - Corcoran
CSH	Coalinga State Hospital - DMH (Male)
CTC	Correctional Treatment Center
DHS	Department of Health Services
DMH	Department of Mental Health
DOF	Department of Finance
DPA	Department of Personnel Administration
DTP	Day Treatment Program
DVI	Deuel Vocational Institution
EOP	Enhanced Outpatient Program
GACH	General Acute Care Hospital Bed
HDSP	High Desert State Prison
ICF	Intermediate Care Facility
ISP	Ironwood State Prison
KVSP	Kern Valley State Prison
LAC	California State Prison - Los Angeles County
MCSP	Mule Creek State Prison
MHCB	Mental Health Crisis Bed
NKSP	North Kern State Prison
PBSP	Pelican Bay State Prison
PSH	Patton State Hospital - DMH (Female)
PSU	Psychiatric Services Unit
PVSP	Pleasant Valley State Prison
RJD	Richard J. Donovan Correctional Facility
SAC	California State Prison - Sacramento
SATF	Substance Abuse Treatment Facility at Corcoran
SOL	California State Prison - Solano
SQ	California State Prison San Quentin
SVSP	Salinas Valley State Prison
WSP	Wasco State Prison

California Department of Corrections and Rehabilitation
Mental Health Bed Plan, December 2006 Enclosure III (Corrected#)

FEMALES

Introduction: The following proposal uses existing beds at female institutions, and proposes to build additional capacity to meet and exceed the mental health bed need for June 2011 as projected by Navigant, (based upon Spring 2006 population projections).

PROPOSAL - Assumes that the CDCR will operate the Acute and ICF programs and that there will be no bed capacity at DMH hospitals, (i.e. no beds at PSH).

INITIAL
Expected Permanent Bed Capacity, June 2011
NO NEW BEDS
(Status Quo)

Table #1: Number of **permanent** mental health beds anticipated in June 2011** with no construction of additional beds, (except where noted).

	Level of Care					
Institution	EOP	ASU	PSU	MHCB	Acute/ ICF	Total
CCWF	54			12		66
CIW[1]	75		20	10	25	130
VSPW		9				9
Total:	129	9	20	22	25	205

Navigant Bed Need, June 2011:^	345
Beds Deficient (Bed Need - Total Beds Table #1):	140
Adjustment - PSU beds not projected and added back in:	20
Total Bed Deficiency with Adjustment, (20 PSU Beds + Beds Deficient):	160

** Data sources for number of beds: Health Care Placement Unit, Licensing Unit, and Office of Facilities Management.

[1] Assumptions: CIW - 1. The 25 bed Acute/ICF facility proposed in the April 2006 plan will be constructed. Note if this proposal is approved, this project will require a scope change to include the MHCB and Acute/ICF beds in Table #2.
2. The 20 bed PSU project is completed.

PROPOSAL
New Beds to be Constructed

Table #2: Estimated number of new **permanent** beds to be constructed by June 2011 to meet the bed deficiency in Table #1.

	Level of Care					
Institution	EOP	ASU	PSU	MHCB	Acute/ ICF	Total
CCWF						0
CIW*	168	15		3	17	203
VSPW						0
Total:	168	15	0	3	17	203

Bed Deficiency Table #1:	160
Adjustment - Add Reserve ^^ from Table #3:	43
Bed Deficiency Adjusted for PSU beds and Reserve:	203

* Assumptions: CIW - 1. EOP and ASU - New beds through conversion of existing space.
2. Acute/ICF and MHCB - 20 new beds will be added to the 25 bed Acute/ICF project proposed in the April 2006 plan.

FINAL
Expected Permanent Bed Capacity, June 2011
WITH CONSTRUCTION OF NEW BEDS
Post Implementation Mental Health Bed Plan, December 2006
(Proposal)

Table #3: Number of **permanent** mental health beds anticipated through construction of new beds.

	Level of Care					
Institution	EOP	ASU	PSU	MHCB	Acute/ICF	Total
CCWF	54			12		66
CIW	243	15	20	13	42	333
VSPW		9				9
Total:	297	24	20	25	42	408
Navigant:^	262	22	N/A	22	39	345
Reserve:^^	35	2		3	3	43
% Reserve:	13.4%	9.1%		13.6%	7.7%	

^ Source: Mental Health Bed Need Study - 2006 Update. Navigant Consulting. June 2006.

^^ The reserve is the number of beds above the forecasted mental health bed need in the Navigant study. The reserve is included in the Mental Health Bed Plan, December 2006, to allow additional program flexibility in an effort to ensure sufficient bed capacity exists once the facilities are constructed. See Table #4 below on Page 2 of 3 for further detail.

SPRING 2007 FORECASTED BED NEED FOR FISCAL YEAR 2011/2012:						
	EOP	ASU	PSU	MHCB	Acute/ICF	Total
Navigant:^^^	336	27	N/A	16	33	412
Reserve:	-39	-3		9	9	-24
% Reserve:	-11.6%	-11.1%		56.3%	27.3%	

^^^ Forecasted need - Planned Beds = Reserve. Source: Mental Health Bed Need Study - Based on Spring 2007 Population Projections, Navigant Consulting, July 2007.

This document corrects a typographical error noted in the original Mental Health Bed Plan - December 2006 Enclosure III and provides an updated forecasted bed need. Corrections are limited to the PSU Table #3 with all changes underlined and shaded.

KEY: Modified Text