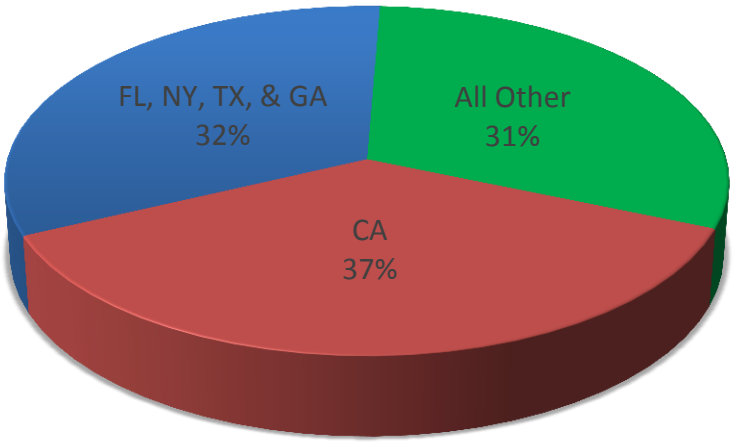
Little Hoover Commission
Mandated Staff Overtime Hearing
Department of State Hospitals
Testimony
August 27, 2015

Thank you for the opportunity to speak to you today about this very important topic. My name is Lupe Alonzo-Diaz, and I am the Deputy Director of Administrative Services for the Department of State Hospitals. Before I touch on the subject of mandated overtime, I'd like to provide an overview of our department, our patient population and how we serve them. This will provide important background information to then better understand our use of mandated overtime. As you will see from the data we will provide, the Department's use of mandated overtime is necessary and yet limited. My testimony is presented in a manner that addresses all the main points included in your July 20, 2015 invitation to present.

Introduction

The Department of State Hospitals (DSH) manages the nation's largest state forensic mental health hospital system. In FY 2014-15, DSH served 12,936 patients and on any given day the hospitals' census is approximately 6,700 in a 24 hours per day, 7 days per week hospital system. According to the National Association of State Mental Health Program Directors (NASMHD), California comprises 37% of all forensic mental health patients served in the United States. By comparison, the next four largest states – Florida, New York, Texas and Georgia – collectively comprise less than a third (32%) of the population. The following graph illustrates the distribution of the United States' forensic mental health population per the 2013 National Association of State Mental Health Program Directors, State Profiles.

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



DSH oversees five state hospitals and three psychiatric programs located in state prisons. Our five state hospitals are Atascadero, Coalinga, Metropolitan – Los Angeles, Napa and Patton. Through an interagency agreement with the California Department of Corrections and Rehabilitation (CDCR), DSH also treats inmate-patients within an inpatient setting at prisons in Vacaville, Salinas Valley and Stockton.

DSH's mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings.

With more than 12,000 employees located in headquarters and eight facilities throughout the state, every staff member's efforts at DSH focuses on the provision of mental health treatment in a secure setting while maintaining the safety of patients and staff. Approximately half of DSH's employees are in nursing classifications, including psychiatric technicians and registered nurses.[1]

The state hospital population is currently comprised of 91% forensic patients, committed via the criminal court system and convicted or accused of a felony crime linked to their mental illness. DSH treats patients and the courts decide when they can be discharged. DSH cannot admit or discharge patients without a court's consent order nor refuse to treat patients. As such, DSH must be staffed appropriately at all levels and at all times. The following table summarizes the DSH patient census for FY 2014-15.

Table 1: DSH Census by Commitment Type,[2] FY 2014-15

Commitment Type	Percent
Not Guilty By Reason of Insanity (NGI)	21%
Incompetent to Stand Trial (IST)	20%
Mentally Disordered Offender (MDO)	19%
Coleman/CDCR (PC 2684)	18%
Sexually Violent Predator (SVP)	13%
Lanterman-Petris Short (LPS)	9%

The state hospitals have seen a significant growth in population levels as noted in Table 2. DSH served 12,936 patients in FY 2014-15, over 14% higher than FY 2012-13. Further, the rate of admissions has grown with approximately 6,281 new patients admitted in FY 2014-15, about 26% higher than FY 2012-13.

	FY 2012-13	FY 2013-14	FY 2014-15
Patients Served	11,304	12,295	12,936
Patients Admitted	4,990	5,971	6,281

The patient population at DSH includes both short and long-term commitments. ISTs and CDCR inmates oftentimes receive short-term psychiatric treatment and return to their committing court to continue their due process or to CDCR to serve the remainder of their term. For example, the majority of ISTs are served in less than one year and more than 30% of ISTs are in and out of the hospital within 60 days. Patients being provided longer-term care include LPS, MDOs and SVPs and they can remain in the state hospitals for years, even decades.

The preponderance of forensic patients and complex nature of the patients served results in more aggressive acts. A study conducted by the DSH found that 25% of all violent incidents that took place between 2011 and 2014 occurred within the first 90 days of admission. Patients commit approximately 300 patient-on-patient and patient-on-staff assaults in state hospitals each month. Unlike the custody environment of the prisons, the state hospitals cannot lock

[1] As of June 2015, the top five position classifications employed by DSH are: Psychiatric Technicians (31%), Registered Nurses (15%), Hospital Police Officers (5%), Medical Technical Assistants (3%), and Custodians (3%). Psychiatric Technician, Registered Nurse, and Medical Technical Assistant percentages are based on all positions within the classification series including trainees, assistants, seniors, and supervisors. Percentages based on a total of 12,278.4 positions for FY 2014-15.
[2] Percentages are based on the average daily census for FY 2014-15.

patients within their rooms. DSH patients are free to move about their unit and to off-unit treatment locations.

The majority of aggressive behavioral issues are addressed by placing patients on an "enhanced observation" also knows as a one to one (1:1) which requires one nursing staff to monitor one patient. Approximately 50% of enhanced observation shifts are covered through overtime. Hospitals also utilize internal and external staff registries and some of the enhanced observations are absorbed within the existing unit staff available during the shift. Due to the type of patients DSH serves, it is difficult to predict when overtime will be required to cover an enhanced observation. In the FY 2012-13 budget, DSH received $30.7 million in funding to cover the costs of overtime and temporary help resulting from enhanced observations.

The following information is provided in response to the multiple items of interest noted in the July 20, 2015 invitation to present to the Commission.

1. Mandatory and Voluntary Overtime Data and Costs

Table 3 provides summary information on overtime for DSH psychiatric technicians and nurses whereas Table 4 illustrates the number of overtime hours per nursing position. As is noted in both tables, mandatory overtime is a small component of total overtime hours worked by nursing staff. In fact, mandatory overtime was less than 10% of total overtime (9.4%) over this three-year period and equated to three to six shifts per year per nursing employee.

Table 3: DSH Overtime Hours for Nursing Staff, FY 2013-13 to FY 2014-15

Overtime	2012-13	%	2013-14	%	2014-15	%
Psychiatric Technicians						
Voluntary	867,458	90.8	983,254	91.4	1,131,740	88.3
Mandatory OT	87,763	9.2	92,122	8.6	149,878	11.7
Registered Nurses						
Voluntary	327,448	87.2	376,221	91.2	429,084	91.7
Mandatory OT	48,046	12.8	36,207	8.8	38,689	8.3
Licensed Vocational Nurses						
Voluntary	68,922	90.4	66,291	91.6	66,928	93.0
Mandatory OT	7,352	9.6	6,030	8.4	5,000	7.0
Total	1,406,989		1,560,125		1,821,319	

Table 4: Overtime Hours per Nursing Position, FY 2012-13 to FY 2014-15[3]

	2012-13	2013-14	2014-15
Psych Tech - Positions[4]	2,814	3,235	3,348
Mandatory	31	28	45
Voluntary	308	304	338
Percentage Mandatory	9.19%	8.57%	11.69%
Total	339	332	383
Registered Nurses - Positions[5]	1,412	1,591	1,581
Mandatory	34	23	24
Voluntary	232	236	271
Percentage Mandatory	12.80%	8.78%	8.27%
Total	266	259	296
Licensed Vocational Nurses - Positions	136	125	113
Mandatory	54	48	44
Voluntary	507	530	593
Percentage Mandatory	9.64%	8.34%	6.95%
Total	561	579	638

2. Department's Policies on Mandatory and Voluntary Overtime including Measures to Protect Patients and Staff when Working Extended Hours

The Department's policies on mandatory and voluntary overtime are governed by the existing collective bargaining agreements (CBA). CBAs for Bargaining Units 17 (Registered Nurses), 18 (Psychiatric Technicians) and 20 (Licensed Vocational Nurses) contain similar provisions allowing for and limiting mandatory overtime under specific conditions. CBAs provide employee protections regarding when management can require level of care employees to work overtime. Attachment 1 contains Article 19.15 of the Bargaining Unit 17 agreement titled "Overtime Scheduling".

In May of 2006, the former Department of Mental Health (DMH) reached an agreement with Bargaining Unit 18 on a pilot project at DSH-Metro on allocating voluntary and mandatory overtime. The purpose of the MOU was to resolve excessive mandatory overtime requirements by allowing level of care staff to sign up for either the pre-hire (pre-posted vacant shifts) overtime and/or the voluntary overtime process, as a way to allow employees to have some control over when they would work overtime.

In September of 2011, the DMH issued a best practices guide to address staffing, scheduling staff overtime, and working effectively with State and Federal laws and Department policy. This document (Attachment 2) describes DSH processes for the allocation of overtime. Central Staffing Offices go through a variety of options to fill shifts left vacant due to vacation, sick leave, injury or other absences including the use of retired annuitants and permanent intermittent employees. With respect to overtime, hospitals pre-post vacant shifts that employees voluntarily select in advance and then consider voluntary overtime before mandatory overtime is employed.

[3] Positions filled as of June 1 of each year.
[4] Psychiatric technicians include psychiatric technicians, senior psychiatric technicians, and psychiatric technician assistants.
[5] Registered nurses include registered nurses and supervising registered nurses.

Further, the DSH is engaging in multiple approaches to reduce 1:1s and identifying site-specific best practices to consider for statewide implementation. DSH-Metropolitan will conduct a rigorous review when 1:1s exceed 72 hours. DSH-Napa uses an approach that provides extra unit staffing but does not allow 1:1s. DSH-Metro has adopted this approach as a pilot and it appears that the numbers of incidents are reducing the number of 1:1 staffing coverage.

3. Workplace Accidents Affecting Patient Care or Workplace Health and Safety Associated with Overtime

In FY 2013-14, DSH had 651 psych techs out on Industrial Disability Leave – losing 320,456 work hours to injuries – the equivalent of 180 full time employees. The following table provides detailed information regarding lost hours due to injuries. DSH's data systems do not readily provide for breaking this data down by injuries that occur during a regular or overtime shift. It is important to note, however, that lost hours due to workplace injuries contribute to the need for DSH's nursing staff to work overtime.

Table 5: FY 2013-14 – 2014-15 Nursing Staff Work Hours Lost to Injury

Fiscal Year	Psych Techs			RNs			LVNs		
	Staff	Hours	FTEs	Staff	Hours	FTEs	Staff	Hours	FTEs
2013-14	651	320,456	180	152	66,031	37	15	6,905	4
2014-15	666	354,901	200	147	81,701	46	17	10,860	6

4. Evaluations on Costs of Overtime vs. Costs of Increasing Permanent Staff

Reducing overtime including mandated overtime is of importance to the DSH. As noted in Table 6, filling vacant positions could offset as much as 1.14 million hours of overtime. Determining staffing needs to offset remaining overtime is complex and would be determined through a detailed staffing study.

Table 6: Overtime Hours Offset by Filling Vacancies

Classifications	Overtime Hours 2014-15	Vacant Positions	OT Hours Offset by Filling Vacancies
Psychiatric Technician	1,281,618	410.3	728,693
Registered Nurse	467,773	225.9	401,198
Licensed Vocational Nurse	71,928	7.6	13,498
Totals	1,821,319	643.8	1,143,389

DSH is in the process of conducting a study to evaluate staffing levels, including patient to staff ratio and relief factors for 24-hour care nursing classifications to determine appropriate level of staffing for its current patient population and hospital operations.

If the staffing study determines that the Department needs additional positions, most of the expense associated with these new positions would be self-funded through a reduction in overtime costs. Nevertheless, there is a gap between the cost savings from reducing overtime and the cost of salary and benefits for these positions as detailed in Table 7 below. Each additional psychiatric technician position would cost an additional $7,100 to cover the costs of salary and benefits not offset by a reduction in overtime.

Table 7: Cost per Position vs. Offset Overtime Costs

Classifications	Cost Per Position[6]	OT Costs Offset[7]	Cost Gap
Psychiatric Technician	$81,158	$74,058	$7,100
Registered Nurse	$135,224	$123,394	$11,829
Licensed Vocational Nurse	$57,140	$52,141	$4,999

5. Number of Positions and Vacancies in Classifications Affected by Mandatory Overtime

The following table notes the DSH positions filled and vacant totals for FY 2014-15.

Table 8: DSH Vacancies for Positions Affected by Mandatory Overtime, FY 2014-15

Classifications	Filled	Vacant	Total
Psychiatric Technician	3,379.7	410.3	3,790.0
Registered Nurse	1,587.2	225.9	1,813.1
Licensed Vocational Nurse	119.6	7.6	127.2

6. Nursing and Psychiatric Technician Staffing Issues Unique to DSH Including Recruitment and Retention

The following are issues that are unique to DSH regarding nursing staffing issues:

- DSH operates 24 hours per day, 7 days per week hospital facilities that require legally-prescribed minimum staffing levels to maintain hospital licenses and accreditation. This requires shifts to be covered, even if positions are vacant, most frequently through voluntary and some mandatory overtime.

- DSH has historically experienced high staff vacancy rates. The department employs more than 12,000 employees in approximately 332 classifications represented by 18 bargaining units. Department vacancy rates have ranged from 12-14%, or approximately 1,200 to 1,400 vacant positions, over the past three years.

- DSH's work environment is high-risk due to the high acuity of its patients, rate of assaults and its mentally and physically demanding requirements. The potential to be assaulted is a daily threat for nursing staff.

- The geographic location of some hospitals makes it difficult to recruit and retain key staff. DSH-Atascadero and DSH-Coalinga have a particularly difficult time recruiting and retaining staff. Both locations are more remote, away from major metropolitan cities that would provide a pool of staff that could commute to these hospitals. Moreover, the more rural location of these facilities often compete for limited staff resources with multiple correctional institutions situated in the same area.

- DSH salaries are not comparable and are generally lower than other entities. Below is a table comparing DSH salaries of its Registered Nurses and Psychiatric Technicians to comparable position classifications at Kaiser Permanente, and the University of California

[6] Positions are costed at the mid-step of the salary range plus 40.358 percent for benefits.
[7] A full-time employee is able to offset approximately 1,776 hours of overtime multiplied by the overtime hourly rate.

(UC) Medical System. In both classifications as noted in Table 9, DSH had the lowest salaries.

Table 9: Comparison of Salaries for Nursing Classifications

	Registered Nurse			Psychiatric Technician		
	Min	Max	Mid	Min	Max	Mid
DSH	$ 83,256	$ 109,428	$ 96,342	$ 53,712	$ 65,028	$ 59,370
Kaiser Permanente	$ 82,470	$ 144,120	$ 113,295	$ 64,597	$ 74,488	$ 69,543
UC Medical System	$ 78,718	$ 173,596	$ 126,157	$ 44,558	$ 80,346	$ 62,452

7. Lessons Learned from Private Sector or other States

Due to the complexity and volume of patients served, it is difficult to find private sector or other state hospitals that can be reasonably compared to California. In a survey sent to the Western Psychiatric State Hospital Association, Oregon, Idaho, Nevada and Arizona reported that they do not have specific rules that prohibit mandatory overtime. Similar to California, these states employ specific protocols before overtime is authorized. Unlike California, these states have relatively small patient populations and do not drive the level of overtime experienced by DSH.

As noted above, the DSH is the largest state forensic mental health hospital system in the nation. DSH staff treat 37% of the forensic mental health patients in the United States. Our patients have both a high level of criminality and mental health acuity. As such, DSH is not comparable to any other hospital system. The issues that drive our staffing are unique to DSH.

There are serious consequences if the DSH is unable to staff state hospitals if there were prohibitions and/or limitations to mandated overtime including patient safety and death: loss of certification and accreditation; potential Receivership oversight; litigation by advocacy groups; court sanctions; and penalties and fines.

8. Solutions

DSH is employing the following strategies to address overtime, including mandatory overtime.

ASSIST

ASSIST is a staff scheduling application that will automate the scheduling of thousands of DSH level-of-care (LOC) staff in a 24/7 environment while meeting all the appropriate rules and regulations that promote safety and continuity of care. Prior to ASSIST, this difficult and detailed task was managed with little or no technology support. ASSIST is now deployed at DSH-Atascadero, DSH-Coalinga, and DSH-Napa. Implementation at the other DSH hospitals will occur in the near future. This application is expected to help reduce mandatory overtime thereby improving morale, reducing fatigue, and increasing job satisfaction among DSH staff.

Recruitment Unit

In July of 2014, DSH established a pilot program focused on recruitment of psychiatrists, DSH's most difficult to fill classification. In addition to managing contracts with recruitment firms, DSH staff coordinate a number of efforts to hire new staff including attending professional conferences and career fairs; presenting career opportunities with residency programs and local colleges, military bases, regional occupation programs; and developing professional advertising and marketing materials for hard to recruit classifications. Over the course of last year, efforts from the DSH team have yielded a 36% higher rate of new hires than professional recruitment

firms contracting with DSH. In the near future, DSH plans to document its best practices and explore a focus on nursing staff.

Staffing Study
DSH is in the process of conducting a clinical staffing study to assess staffing methodologies and staff to patient ratios within core clinical functions. Currently, the staffing study is focused on 24-Hour Care Nursing Services for both core staffing and relief factors. Historically, new nursing positions budgeted to support caseload growth have reflected the lowest level of staffing required by statue (Title 22) and court orders (Sapunor Decision).

Bed Stratification Project
DSH facilities provide not only acute and intermediate care to forensic and civil patients, but our facilities must also provide numerous types of specialty services to population sub-groups. Some of the specialized services provided are for polydipsia patients, patients requiring treatment in enhanced treatment units (ETU), patients with increased medical needs in addition to their psychiatric conditions, geriatric patients, psychologically fragile patients, deaf/hard of hearing patients, etc. These specialty services require enhanced staffing due to the high acuity and medical needs of the population. DSH is currently working with a contractor to provide a detailed accounting of all of DSH's beds, specifically the beds within units that provide these specialized services. Once identified and defined, DSH as a whole can compare each hospital's specialized services to one another and identify best practices in operations and staffing of these units.

Clinical Interventions and other interventions to Reduce Violence
In addition to these administrative strategies, DSH has also focused on clinical and other interventions to reduce violence as 1:1s are the primary reason for increased overtime, including mandatory overtime. Attachment 3 provides more detailed information.

Attachment 1
Bargaining Unit 17 Article Regarding Overtime

Article 19.15 of the Bargaining Unit 17 agreement titled, “Overtime Scheduling”, states in part:

A. The Departments recognize and understand the importance of reducing overtime to Unit 17 employees. To this end, the departments will make every effort to schedule staff in a manner that will reduce the need for mandatory overtime. Both parties agree that mandatory overtime is an undesirable method of providing staff coverage.

B. There shall be no mandatory overtime on an employee’s RDO (Regular Day Off) (an employee’s RDO begins at the end of the employee’s last scheduled shift in the workweek) or pre-approved day off, except:

1. In an emergency situation such as a natural disaster; or
2. During a state of emergency declared by the State or Federal authorities; or
3. During an emergency situation declared by a Superintendent, Executive Director or designee; or
4. During a severe internal emergency (e.g., an incident which necessitates assistance from an outside agency or a health care crisis); or 5. When the employee’s shift relief does not report for work or gave less than two (2) hours notice of intent not to report for work, an employee may be mandated if no volunteer is available.
6. When all other options have been exhausted.

C. Except in cases of emergency or planned program activity employees shall not be required to:

1. Work more than five (5) mandatory overtime shifts per month of at least two (2) hours of duration; or
2. Work in excess of sixteen (16) hours continuously in a forty-eight (48) hour period; or
3. Work in excess of two (2) mandatory overtime shifts in an employee’s scheduled work week; or,
4. When an employee is required to work twelve (12) to sixteen (16) hours that employee shall not be mandated to work overtime the next calendar day.

Attachment 2
Best Practices Guide

CALIFORNIA DEPARTMENT OF
Mental Health

Memorandum

To: Jon De Morales
Deputy Director, Operations

Date: September 15, 2011

From: Greg Williams
Assistant Deputy Director
Administrative Services

Telephone: (916) 657-4959

Subject: STAFFING MINIMUMS

At the request of the Deputy Director of Long Term Care Services, Administrative Services/Labor Relations convened conference calls with the Department's hospitals and psychiatric programs to discuss problems and possible solutions related to meeting staffing minimums.

Following several meetings from March to May 2011, the group studied business practices at each facility as they related to staffing, scheduling staff overtime, and working effectively with State and Federal laws and Department policy.

As a result, the group developed a series of best practices and recommendations for processes to minimize the obstacles associated with meeting staffing minimums at the hospitals and psychiatric programs.

Those practices included:

1. Overtime based on essential function
2. Central Staffing Office (CSO) and processes
3. Process for unscheduled absences
4. Prescheduled (pre-hire) overtime
5. Family and Medical Care Leave Act (FMLA)

Should you have any questions regarding this information, or wish to make policy changes based on these recommendations, please let me know.

GREG WILLIAMS
Assistant Deputy Director
Administrative Services

cc: Kathy Gaither
Ellen Venturino
Cindy Radavsky
Candace Murch
Steven Lederer

Staffing Minimums

Recommended Best Practices of the

Department of Mental Health
State Hospitals & Psychiatric Programs
Study Group

September 2011

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Overtime Based on Essential Function

- Affirm the finding of the DMH workgroup implemented via the memo (Attachment A) dated July 28, 2003, from John Rodriguez that states in pertinent part, "...Overtime will be considered a "*qualification standard*," not an "essential function." This was affirmed by SPB precedential decision in Beverly Kelly vs. DDS. As a qualification standard, an individual may be expected to work overtime hours, but management has discretion to approve exceptions based on health or other valid rationale."

- Change the standard language in all level of care staff duty statements (Attachment B) to include overtime as a qualification standard, and refer it to the bargaining unit language re: the mandatory overtime requirement that employees may be mandated 6 overtime shifts a month (specifically CBA 17, 18 and 20).

- Pre-employment employees must go through the Reasonable Accommodation process if they are unable to meet this qualification standard.

Central Staffing Office (CSO) and Processes

1. Recommend facilities implement a centralized staffing office and processes to ensure consistency of practices and procedures are applied to all Level of Care (LOC) employees.

2. The following staffing sequence should be followed to ensure classifications are hired/staffed appropriately to fill shifts left vacant by full time employees due to sick leave, call off, injury (i.e., do not violate Collective Bargaining Agreements (CBA), policies, procedures; for example, appropriate license for job):
   A. Retired Annuitant
   B. Permanent Intermittent (PI) includes in-house registries, etc.
   C. Overtime
      1) Pre-Hire (2 weeks in advance)
      2) VOT (voluntary)
      3) MOT (mandatory)

3. Each facility needs to implement a pre-determined, step-by-step emergency staffing process. Refer to sample in Attachment C.

4. CSO should be staffed with appropriate administrative staff; i.e., Office Technician, Staff Services Analyst, Associate Governmental Program Analyst (not LOC staff; i.e., Registered Nurse/Psychiatric Technician). Note: Minimal use of LOC staff so they can be out on the units; emphasis on use of administrative classes as appropriate in CSO.

5. Establish centralized call-in number. See Coalinga State Hospital's example (Attachment D) for LOC staff to utilize when calling in sick/off:

6. Conduct weekly projected staffing needs. [These numbers include "Required Staff, Close/Constant Observation (1 on 1) and Approved Rovers/Floats.]

7. Implement a standardized automated staffing system to track sick leave, FMLA, exchange of days off (Swaps), etc., and pre-hire for staffing needs two weeks in advance.

8. Hire appropriate classifications for the job. Have separate Psychiatric Technician (PT)/Registered Nurse (RN) list to reduce staffing/overtime.

Process for Unscheduled Absences

This is a CSO process broken down into two sections; short term and long term. Before the long term process is implemented, staffing issues and consistency standards throughout the hospitals have to be determined and decided upon.

Short Term

All unscheduled absences for special events or holidays go through the Nursing Coordinator (NC) or the Program Officer of the Day (POD).

Long Term

1. CSO posts/updates priority staffing grid for the unit/program/hospital to ensure hospital-wide standardization and to limit controllable overtime expenditures.
   - Floats
   - PI employees (In-House Registry)
   - Overtime (OT):
     - Pre-Hired
     - VOT (voluntary)
     - MOT (mandatory)
   - Emergency Staffing Plan

2. All LOC must call CSO at least 2 hours prior to start of shift for unscheduled absences. CSO adjusts the facility staffing numbers, adjusts for overtime or floating, and notifies the appropriate shift lead.

3. A supervisor (i.e. Unit Supervisor (US), NC, POD, etc.) may require medical substantiation during the absence or deny the request.
   Note: If medical verification is requested and not provided by an employee, an Absence Without Leave (AWOL)/Dock notice may be issued.

4. If an employee is a "no show, no call," they are marked as AWOL, will be counseled and docked the time, and appropriate disciplinary action may be taken, including dismissal from State service.

5. Unscheduled absence reports are generated quarterly for each employee and reviewed/signed by the employee, shift lead, US and NC. Approved vacation shall be reviewed (including Post and Bid vacations) and may be cancelled on a case-by-case basis if the employee has insufficent leave credits.

Prescheduled (Pre-Hire) Overtime (POT/VOT/MOT)

Develop clear language of expectations for supervisors (US, NC, POD, CSO and staff committing to pre-hire overtime (POT), with consequences of cancelling:

Expectations

1. A pre-hire list is created for the unit(s) by classification needed.

2. CSO or Program Director posts vacant shifts for employees to pre-hire.

3. The CSO is provided with a pre-hire vacancy list by Friday morning for two weeks prior.

4. Employees are given priority to pre-hire in their assigned program.

5. Once an employee works overtime, they are dropped to the bottom of the MOT list.

6. Hire appropriate classifications for the job. Have separate Psychiatric Technician (PT)/Registered Nurse (RN) list to reduce staffing/overtime.

Consequences for Cancellation

1. Pre-hire (POT) and voluntary overtime (VOT) is a commitment to work; grounds for disciplinary action without 2 hour prior notice of change.

2. CSO requests from the employee, supervisor and/or NC the reason for cancellation. The employee's supervisor shall determine if a pattern exists (case-by-case), and an opportunity is given to improve.

3. Employees may be denied the right to POT & VOT for up to 90 days if they cancel three or more times in a quarter, on a case-by-case basis.

Mandatory Overtime (MOT)

Ensure all LOC employee positions are part of MOT list regardless of duty work assignment. Hire appropriate classifications needed. Have separate PT/RN list.

Family and Medical Leave Act

- Implement terms and conditions outlined in DMH FMLA Policy Directive 509
- Designate a facility FMLA coordinator to communicate with US/NC/POD/CSO

1. When an employee is mandated and chooses FMLA in lieu of other leave, he/she is referred to the appropriate US/NC/POD.

2. The after hours POD, or designee, is notified to verify and approve "not working overtime" due to FMLA. The FMLA coordinator should be consulted to ensure appropriate use of FMLA - qualifying, number of days used.

3. Once the supervisor (US/NC/POD) authorizes the FMLA usage, personnel and staffing generates an e-mail to the US, NC, staffing officer, and the FMLA coordinator responsible for tracking.

4. CSO will give them mandatory overtime credit which drops them to the bottom of the MOT list. This FMLA exemption counts as part of their 6 MOT/month.

5. FMLA usage is tracked on a spreadsheet each month and the certification list provided by the FMLA Coordinator is attached to verify FMLA on the spot when called in.

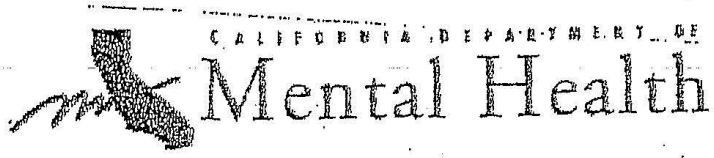
6. The supervisor gets an absence report the following day of any call-ins.
   Note: If an FMLA doesn't match the certification, a conversation is needed with the employee to determine appropriate leave or dock. If claiming FMLA, confirmation is requested from the FMLA Coordinator. It's noted as sick, but it may not be approved after the fact.

7. The US ensures all FMLA hours are charged on the timesheet (overtime or regular), and the FMLA coordinator (or personnel) provides the check and balance to ensure accuracy.

8. FMLA is done at the unit level; reviewed by the supervisor in conjunction with human resources for overseeing the FMLA process.

9. CSO electronically gathers the data (employees names, classification, cycles, and if they are scheduled to work, etc.) from the monthly LOC schedules (Unit Supervisors are responsible for maintaining accurate information), transfers the information to the electronic staffing sheets CSO uses to staff the facility.
   Note: The goal for generating these reports is to provide FMLA information to the NC's who share the information with program timekeepers. The timekeepers then rectify any FMLA discrepancies reported to CSO prior to submitting their 672's to Personnel. This process works towards a better tracking.

Attachment A



Memorandum

To: Executive Directors Date: 07/28/2003

From: Long Term Care Services Telephone: (916) 654-2413

Subject: DECISIONS RELATED TO ESSENTIAL FUNCTIONS

It has come to my attention that each hospital and psychiatric facility is progressing well in beginning to determine the Essential Functions for vacant positions and those positions held by individuals who cannot or that the supervisors observe may not be able to perform identified duties. It is my understanding that hospital/facility staff members may not be aware of the following decisions made by the Executive Directors' Council:

1. Overtime will be considered a "qualification standard," not an "essential function." As a qualification standard, an individual may be expected to work overtime hours, but management has discretion to approve exceptions based on health or other valid rationale.

2. Prevention and Management of Assaultive Behavior (PMAB), including all aspects, will be an Essential Function for the Psychiatric Technician, Registered Nurse, Medical Technical Assistant, and Hospital Police Officer (through Sergeant) classification series and Teaching Assistant positions. PMAB will (generally) be considered a Marginal Function for the remaining direct care and direct patient/individual contact positions. Individual positions may include PMAB as an Essential Function, if the determination analysis supports this conclusion. It is important to establish and maintain consistency between similarly situated positions in the Department when assigning Essential Functions.

3. Each identified Essential Function will be indicated on the duty statement by bolding the function wherever it falls in the text of the duty statement. Listing the Essential Functions separately within the duty statement is not required.

Do Your Part To Help California Save Energy
For energy saving tips, visit the DMH website at
www.dmh.cahwnet.gov

4. Each hospital/facility will develop a local Resource Library when determining Essential Functions for positions. The Resource Library should contain the completed duty statement, with the Essential Functions in bold type, as well as copies of the "Determining Essential Job Functions" (MH1762A) and the "Documenting Essential Job Functions" (MH 1762B) for each function that was subject to the analysis process and one "Essential Job Functions Review" (MH 1762C) form for the complete package of information. Hospitals/facilities will share information upon request and provide an electronic copy of each analysis to the DMH Information Security Officer (Vonnie Behm) for inclusion in the Department Resource Library.

Hospital/facility staff should already be aware that Special Order 423 (identifying Essential Functions) requires the establishment of Essential Functions Oversight Committees and quarterly implementation progress reports to the Office of Human Rights. Please share this with your staff.

JOHN RODRIGUEZ
Deputy Director

cc: Cindy Radavsky
Angela Lazarow
Vonnie Behm

DUTY STATEMENT
DEPARTMENT OF MENTAL HEALTH
ATASCADERO STATE HOSPITAL

JOB CLASSIFICATION: PSYCHIATRIC TECHNICIAN (SAFETY)

1. MAJOR TASKS, DUTIES, AND RESPONSIBILITIES

Psychiatric Technicians work under general supervision and, in addition to their custody responsibilities, provide a basic level of general behavioral and psychiatric nursing care and are expected, through their attitude, knowledge, and performance, to facilitate the rehabilitation of clients/patients.

Psychiatric Technicians work to maintain order and supervise the conduct of clients/patients, to protect and maintain the safety of persons and property; to provide a basic level of general behavioral psychiatric nursing care to clients/patients who are mentally disordered; and to participate in the overall psychiatric treatment program.

The employee is required to work any shift and scheduled in a variety of settings throughout the hospital and required to work overtime and float, in accordance with their collective bargaining agreement, to other work locations as determined by the operational needs of the hospital.

25% **Helps to create a clean, safe and therapeutic environment for patients or inmates; apply mental health principles and relationship security with patients or inmates;** develop, encourage participation in, and **supervise patient activities,** such as on-the-unit group and individual program activities for patients or inmates; assist rehabilitation therapists in occupational, recreational, vocational, and educational therapy programs for patients or inmates; motivate and assist patients or inmates with activities of daily living; follow safe work practices; protect patients, inmates and others from personal injury; order supplies as needed; keep records; and participate in in-service training programs.

25% **Performs custody tasks including supervision of patient activities** escorting patients or inmates in the facility and in the community; distributing and inspecting patients' or inmates' mail for hazardous contraband; **Shakedown; i.e., searching for drugs, contraband, weapons and inspecting facilities to identify security breaches that could lead to the escape of a patient or inmate; observing and intervening in patient behavior that may injure people, damage property or signal impending escape attempts. Applies and demonstrates knowledge of correct methods in the prevention and management of assaultive behavior (PMAB) that includes patient containment, heavy lifting (over 50 pounds), applying restraints, and responding to emergency situations throughout the hospital.**

25% **Performs nursing procedures such as administering medications including oral medications and hypodermic injections, observing patients or inmates physical condition and behavior and reporting significant changes to a shift supervisor, unit supervisor or physician and recording nursing notes: in the patients or inmate record;** preparing and caring for patients or inmates during treatment; giving first aid and **CPR, and following infection control procedures** as needed.

10% Works with other disciplines as part of the treatment team to provide an overall treatment program for the patient.

10% Other duties as assigned including but not limited to: assist in courtyard supervision, tasks that require repetitive motion, carrying items that weigh up to 30 pounds, trash removal, general housekeeping duties.

5% May assist in the training or supervision of Psychiatric Technician Training Candidates, Psychiatric Technician Trainees, Psychiatric Technician Assistants, Pre-licensed Psychiatric Technicians, Pre-licensed Registered Nurses, Licensed Vocational Nurses and other ancillary staff.

2. SUPERVISION RECEIVED

Unit Supervisor, RN Shift Lead, Senior Psych. Tech., Health Services Specialist.

3. SUPERVISION EXERCISED - N/A

4. KNOWLEDGE AND ABILITIES

KNOWLEDGE OF:

Under direct supervision of shift supervisor; knowledge of custody procedures, public and property protection policies; fundamentals of nursing care; general behavioral and psychiatric procedures involved in the care and treatment of individuals or groups of mentally disordered clients/patients; current first aid methods; medical terminology; pharmacology; cardiopulmonary resuscitation; management of assaultive behavior techniques; hospital procedures.

ABILITY TO:

Under direct supervision of shift supervisor; ability to learn and apply sound judgment for situations including the protection of persons and property; apply basic nursing knowledge, skills and attitudes; establish effective therapeutic relationships with mentally disordered clients/patients; recognize symptoms requiring medical or psychiatric attention; think and act quickly in emergencies; work with a treatment team to provide occupational, recreational, vocational, and educational therapy programs for clients/patients; follow directions; keep appropriate records; develop clear and concise reports of incidents; analyze situations accurately and take effective action.

5. REQUIRED COMPETENCIES

INFECTION CONTROL
Applies knowledge of correct methods for controlling the spread of pathogens appropriate to job class and assignment.

SAFETY
Actively supports a safe and hazard free workplace through practice of personal safety and vigilance in the identification of safety or security hazards.

CPR
Maintains current certification.

AGE SPECIFIC
Provides services commensurate with age of patients / clients being served. Demonstrates knowledge of growth and development of the following age categories:

Adult Geriatric

MANAGEMENT OF ASSAULTIVE BEHAVIOR
Applies and demonstrates knowledge of correct methods in the management of assaultive behavior (MAB).

RESTRAINT/SECLUSION
Demonstrates knowledge of criteria and appropriate uses: applies, and removes restraint and/or seclusion.

CULTURAL AWARENESS
Demonstrates awareness to multicultural issues in the workplace which enable the employee to work effectively.

SITE SPECIFIC COMPETENCIES
Applies and demonstrates knowledge of the following:

Hospital Emergency Preparedness and Program Area Specific Plan

Follow the hospital policies on Sexual Harassment, Patient Interaction.

Observe patients on continuous monitoring documenting changes when appropriate.

Participates as a member of the interdisciplinary team providing nursing input into the treatment planning of individual patients.

Participates in sponsor groups, functioning as a sponsor / co-sponsor. Identifies and confiscates and disposes of contraband per policy.

Relationship Security demonstrates professional interactions with the patients and maintains therapeutic boundaries.

TECHNICAL PROFICIENCY (SITE SPECIFIC)
Applies and demonstrates knowledge of :
I-vac, blood glucose monitor, O2 Delivery/suction, Gurney & Backboard.
Pain Management
Patients Rights
Medication Administration
Shakedown process.

6. **LICENSE OR CERTIFICATION**
It is the employee's responsibility to maintain a license, credential or required registration pertinent to their classification on a current basis. Any failure to do so may result in termination from Civil Service. Employees in this classification must: maintain an active Psychiatric Technician License issued by the California Board of Psychiatric Technicians and Vocational Nurse Examiners.

7. **TRAINING** - Training Category = **1**
The employee is required to keep current with the completion of all required training.

8. **WORKING CONDITIONS**
All employees are required to have an annual health review and repeat health reviews whenever necessary to ascertain that they are free from symptoms indicating the presence of infection and are able to safely perform their essential job duties.

Employee Signature	Print Name	Date
Supervisor Signature	Print Name	Date
Reviewing Supervisor Signature	Print Name	Date

EMERGENCY STAFFING PLAN

(Rev. December 21, 2010)

The Central Staffing Office has been instructed by the Clinical Administrator to staff to acuity on all shifts (see chart below) until further notice.

Examples of staffing to acuity

Number of Staff per Acuity	Number of staff Delivered
5.2	5
5.49	5
5.5	5.5
5.7	5.7
5.8	5.8
5.9	6
6	6

Units reporting their anticipated staffing needs to the Central Staffing Office are to specify:

1. Current acuity
2. # staff required by acuity
3. # regular staff and license composition scheduled to come in
4. # of staff still needed
5. # of patients currently on 1:1

(Each unit is to call the Central Staffing Office with changes as they occur.)

The Central Staffing Office has been authorized to implement the following Emergency Staffing Plan on a step by step basis and discontinue the plan when staffing needs are met:

The Executive Officer of the Day will be notified by 10:00 AM the following day that the Emergency Staffing Plan was implemented.

When the Central Staffing Office has exhausted all of the affected program's resources (Voluntary OT, Mandatory OT, and intermittent employees as appropriate), the Central Staffing Office is authorized to initiate the Emergency Staffing plan as outlined below:

STEP 1 –The Central Staffing Office will contact the Shift Leads of each unit in the affected Program to review all acuities on their units including 1:1's. Any appropriate reduction in acuity requirements will be communicated to the Central Staffing Office.

STEP 2 – The Central Staffing Office will utilize the volunteer list compiled of Managers, Supervisors, and Rehabilitation Therapists (RTs) who have volunteered and are confirmed to come in to assist with staffing the shift.

STEP 3 – The Central Staffing Office will reduce staffing in the affected program to hospital minimums. [Exception: All NOC shifts and any unit with a minimum of four additional staff (above minimum) will be required for patients that remain on 1:1s.] (see charts below). Additional staffing for 1:1 coverage will be determined by Program Director or designee based on safety and security needs.

Examples of staffing to hospital minimums on ICF units

Patient Population	AM Shift	PM shift	NOC Shift *Never Below 3
27-35	4	4	3
36-39	5	5	3
40-43	5	5	3
44-51	6	6	3
52-55	7	7	3
56-59	7	7	4

Examples of staffing to hospital minimums on ACUTE units

Patient Population	AM Shift (1:6)	PM shift (1:6)	NOC Shift (1:12) *Never Below 3
28-35	5	5	3
36-39	6	6	3
40-43	6	6	3
44-51	7	7	3
52-55	8	8	4
56-59	9	9	4

STEP 4 – If the program still fails to meet minimums, the Central Staffing Office will then float any staff from programs that are staffed over their acuity.

STEP 5 – If the Program still fails to meet minimums, the Central Staffing Office will use lists of Intermittent staff (retired annuitants and other intermittent staff) from other programs.

STEP 6 – If the Program still fails to meet minimums, staff that have volunteered for overtime on other programs will be called and offered Voluntary Overtime on the affected program.

STEP 7 – If the program still fails to meet minimums, the Central Staffing Office will begin mandating staff from other programs to make available sufficient staff for the affected program to meet minimums.

STEP 8 – The Central Staffing Office will contact the shift leads on units of other programs to review acuities of their units under criteria outlined in Steps 1 and 2. The Central Staffing Office will then float staff made available from other programs.

STEP 9 – If the program still fails to meet minimums, the Central Staffing Office is authorized to reduce staff in other programs to licensed minimums as outlined in Step 3. The Central Staffing Office will then float staff made available from other programs.

STEP 10 – If the Program fails to meet minimums, the Central Staffing Office is to notify the Program Officer of the Day (POD) of the affected program to call in Managers and Supervisors from their program **on a rotation-basis as set-up by each Program until the minimums are met.**

The POD will notify the Central Staffing Office regarding which Supervisor/Manager will be coming in (as soon as the decision is made.)

STEP 11 – If the program still fails to meet minimums, the Central Staffing Office will notify the Program Officer of the Day (POD) of other programs to call in Managers and Supervisors from their program **on a rotation-basis as set-up by each Program until the minimums are met on the affected program.**

Only in emergencies, and with the Executive Director's approval, go to Step 12.

STEP 12 – The POD's will call in RT's and level-of-care from home.

CHARLIE JOSLIN
Clinical Administrator

CALIFORNIA DEPARTMENT OF
Mental Health

General Services
ATTENDANCE LINE
559-935-6978

Please speak clearly and give the following information:

Your Name
Your Title
Your Direct Supervisor
Why you are Calling

What Kind of Time you want to use.
Is this related to FMLA?
How Long you Expect to be out.
A telephone number where you can be reached.

POLICY DIRECTIVE

MH 359 (Rev. 10/2008)

No.: 509	
Title: Family & Medical Leave Act (FMLA) California Family Rights Act (CFRA) Pregnancy Disability Leave (PDL)	**Signature:** *Original signed by the Director* **Approved:** Cliff Allenby, Acting Director
Effective Date: June 16, 2011	

Policy Statement: The Department of Mental Health (DMH) is committed to provide employees self and family care by administering medical, pregnancy and disability leaves to eligible DMH employees free from discrimination and harassment.

Purpose: Ensure that DMH managers, supervisors, and employees are fully informed of their rights and responsibilities under the federal Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and the Pregnancy Disability Law (PDL).

Responsibility:

Executive Sponsor:	Chief Deputy Director
Operational Managers:	Deputy Directors and Office Chiefs

Owner: Assistant Deputy Director
Administrative Services

Reference: Government Code Section 12926, 12940, 12945, 12945.2
29 CFR 825.100, et seq. & CCR, Title 2, 7297.0, et seq.

Attachment(s):
Procedures related to "FMLA/CRFA/PDL" policy
FMLA/CFRA Leave Request MH 3206
Notice of Eligibility and Rights and Responsibilities MH 3207
Certification of Health Care Provider for employee's Serious Health Condition MH 3208E
Certification of Health Care Provider for Family Member's Serious Health Condition MH 3208F
Certification of Qualifying Exigency for Military Family Leave (Family and Medical Leave Act) MH 3210
Certification for Serious Injury or Illness of Covered Service Member for Military Family Caregiver Leave MH 3211
FMLA/CFRA Leave Designation Notice MH 3212

Appendix A
Procedures Related to "FMLA" Policy

Procedure Number	Procedure Title
509P1	FMLA Policy

Department of Mental Health

Policy Directive Procedure # 001P1

Title: FMLA, CFRA and PDL	Effective Date: June 16, 2011

Purpose: Ensure that DMH managers, supervisors, and employees are fully informed of their eligibility and rights and responsibilities under the federal Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and the Pregnancy Disability Law (PDL).

Definitions:

Family Medical Leave Act (FMLA) is a federal law requiring employers to provide job protected leave for their employees due to a serious health condition.

California Family Rights Act (CFRA) was established to ensure employee leave rights related to family care.

Pregnancy Disability Law (PDL) permits a female employee up to four months of leave for the period during which she is disabled due to pregnancy, childbirth, or a related medical condition.

Background:

Eligibility

An employee is eligible if employed with the State of California for a total of twelve months, even with a break in service, *and* also worked 1,250 hours (actual time worked) in the past year immediately preceding the commencement of FMLA/CFRA leave.

Employees, who are in a classification in Work Week Group E or SE, are exempt from the Fair Labor Standards Act (FLSA), and are presumed to have worked 1,250 hours if employed for 12 months.

These eligibility requirements do not apply to PDL.

FMLA/CRFA Leave and Entitlement

FMLA/CFRA may be taken for one or more of the following reasons:

1. The birth and/or care of newborn child
2. The placement of a newly adopted child or care of a child newly placed in foster care
3. The care of spouse, child, or parent with a serious health condition, and/or

4. For an employee's own serious health condition that makes the employee unable to perform the functions of his or her job, and

5. For qualifying exigency arising out of the fact that an employee's spouse, child, or parent who is on call to active military duty status or deployed to a foreign country

6. To take military caregiver leave to care for a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness

FMLA/CFRA leave authorizes an employee to take up to a total of twelve (12) workweeks of paid or unpaid, job-protected leave during a 12-month period. Employees may substitute some or all of the unpaid leave with appropriate existing leave accruals; i.e., sick, vacation, etc. In addition, employees are not required to exhaust all paid leave before choosing unpaid leave, unless otherwise required by their applicable Collective Bargaining Agreement (CBA).

A leave of 12 weeks is provided to either spouse for birth, adoption, or foster care placement of a child. Parents may be on leave simultaneously. However, in the event both parents are married State employees, the Department may limit FMLA/CFRA leave to a combined total of 12 weeks. The 12 workweek leave must be completed within one year of the birth, adoption, or foster care placement of the child. Additionally, the basic minimum duration of such leave is two (2) weeks. However, the supervisor shall grant a request for CFRA leave for less than two (2) weeks duration on any two (2) occasions. Leave may also be taken on an intermittent basis or on a reduced work schedule. The plan for leave taken on an intermittent or reduced work schedule must be submitted in writing and approved in advance by the employee's supervisor.

When medically necessary, FMLA/CFRA leave may be taken in a single continuous twelve (12) workweek period or, on an intermittent or reduced leave schedule not to exceed the employee's 12 workweek period; i.e. 480 hours.

Pregnancy Disability Leave

In addition to leave taken under the provisions of FMLA/CFRA, a female employee is entitled to pregnancy disability leave (PDL). PDL is available for up to four (4) months (88 days) for the period of actual disability which may take place during pregnancy, at birth, or post-partum. This includes prenatal care, severe morning sickness, or doctor-ordered bed rest. An employee need not meet the eligibility requirements for FMLA/CFRA to be eligible for PDL.

Relationship of FMLA, CFRA and PDL

- FMLA and CFRA run concurrent except during PDL. Qualifying Exigency Leave, and Military Caregiver Leave if family member is not covered under CFRA.
- Where the FMLA laws and the CFRA law differ, the most generous/less restrictive leave provision must be applied.
- Registered Domestic Partners are covered under CFRA just like spouses (Family Code 297.5). However, this may give the requesting employee more family leave because FMLA leave does not run concurrent with the CFRA leave to care for a domestic partner.

Military Family Leave

- **Qualifying Exigency Leave**: Employees are entitled to take up to 12 weeks of "qualifying exigency leave" in a 12-month period when a spouse, child, or parent in the Armed Forces are called to active duty in support of a contingency operation or deployed to a foreign country. This may include short notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, post-deployment activities, etc. A Certification of Qualifying Exigency for Military Family Leave MH 3210 should be completed to qualify for military family leave.
- **Military Caregiver Leave**: Employees are entitled to take up to 26 weeks of "military caregiver leave" during a single 12-month period to care for a spouse, child, parent, or "**next-of-kin**" (service member's nearest blood relative, other than the covered service member's spouse, parent, son, or daughter) who is a current member of the Armed Forces, who has a serious injury or illness. It also provides the employee the ability to take time off to care for a veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. The veteran must be a member of the Armed Forces (including National Guard or Reserves) at any time within five (5) years preceding treatment of the serious injury or illness. A Certification for Serious Injury or Illness of Covered Service Member MH 3211 should be completed to qualify for military family leave.

Family Member

Leave may be taken to care for an employee's family member under CFRA with a serious health condition. Family members include:

- A spouse is a husband or a wife as defined or recognized under State law.

- Son or daughter means a biological, adopted, or foster child, stepchild, legal ward, or a child of a person standing "**in loco parentis**" (in the place of a parent, or of a parent's authority) and, regardless of age, who has a serious health condition and is incapable of self-care.

- Parent is a biological parent or an individual who stands or stood "in loco parentis" to an employee, when the employee was a son or daughter. The term does not include parent-in-law.

- Persons who are "**in loco parentis**" include those with day-to-day responsibilities to care for and financially support a child, or in the case of an employee, who had such responsibility for the employee when the employee was a child. A biological or legal relationship is not necessary.

Serious Health Condition

A serious health condition means an illness, injury, impairment, or physical or mental condition and involves:

1. **Hospital Care** - Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity, i.e. inability to work, attend school, or perform other regular daily activities, or any subsequent treatment in connection with such inpatient care.

2. **Absence Plus Treatment** - A period of incapacity of more than three (3) consecutive, full calendar days, and any subsequent treatment or period of incapacity related to the same condition that also includes:

   a) Treatment two (2) or more times by or under the supervision of a health care provider, i.e., in-person visit, the first within 7 days and both within 30 days of the first day of incapacity

   b) One treatment by a health care provider, i.e., in-person visit within 7 days of the first day of incapacity, with a continuing treatment of prescription medication, physical therapy, etc.

3. **Pregnancy** - Any period of incapacity due to pregnancy, or for prenatal care. A visit to the health care provider is not necessary for each absence. An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.

4. **Chronic Conditions Requiring Treatment** - Any period of incapacity or treatment by or under the supervision of a health care provider due to a chronic serious health condition, which extends over a period of time, requires periodic visits (at least twice a year) and involve occasional episodes of incapacity.

5. **Permanent/Long Term Conditions Requiring Supervision** - A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include: Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (non-Chronic Conditions)** - Any period of absence to receive multiple treatments, including any period of recovery after the treatment(s), either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment; such as, cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis), etc.

Allergies, stress, substance abuse, or minor illnesses, such as the common cold, flu, earaches, upset stomach, or routine dental problems, orthodontic treatments, or periodontal disease could convert into a more serious health condition if complications occur; i.e., the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider.

Voluntary or cosmetic treatments which are not medically necessary are not "serious health conditions" unless inpatient hospital care is required. Routine preventative physical examinations are excluded.

Health Care Provider

The Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a doctor of medicine or osteopathy who is authorized to practice medicine or surgery by the secretary of labor to be capable of providing health care services.

Others who can provide health care services include properly licensed podiatrist, dentist, clinical psychologist, optometrist and chiropractors. (A chiropractor is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.) Nurse practitioners, nurse-

midwives, clinical social workers and physicians assistants are included, as are Christian Science practitioners or any health care provider from whom an employer (State of California, Department of Mental Health) or the employer's group health plan benefits manager will accept certification of the existence of a serious health condition to substantiate a claim for benefits. Licensed health care providers in foreign countries also are included.

12-Month Period

Employees are entitled to up to full twelve (12) weeks of FMLA/CFRA leave during a calendar year, January to December, and each year after.

The exception is for those employees in the collective bargaining units (BU) listed below:

- BU 6 (Medical Technical Assistant);
- BU 9 (Senior Mechanical Engineer/Architect);
- BU16 (Staff Psychiatrist, Physician and Surgeon, Dentist, etc.)

These employees are entitled to up to twelve (12) full weeks of leave within a "rolling" 12-month period. Leave will be measured backward from the date an employee uses any FMLA/CFRA leave. Each time an employee takes a FMLA/CFRA leave, the remaining leave entitlement is any balance of the 12 workweeks that has not been used during the applicable 12 month period.

Intermittent Leave

FMLA/CFRA/PDL leave does not need to be taken in one continuous period of time.

When FMLA/CFRA/PDL leave is taken for a serious health condition of the employee, or the serious health condition of the employee's spouse, parent, or child, it may be taken intermittently or on a reduced work schedule when the family member's health care provider indicates that it is medically necessary.

If an employee needs intermittent leave or leave on a reduced work schedule that is foreseeable based on planned medical treatment for the employee or the employee's family member, DMH may temporarily assign an employee to an available alternative position with equivalent pay and benefits that better accommodates the employee's intermittent or reduced leave schedule.

Roles and Responsibilities: Employee

- If an employee's need for a FMLA/CFRA/PDL leave is foreseeable based on an expected birth, placement for adoption for foster care, or planned medical treatment, an employee must give at least 30 days notice prior to the need for the leave begins by completing a FMLA/CFRA/PDL Leave Request (MH 3206).

- If 30 days notice is not possible, an employee is required to provide notice as soon as practicable under the facts and circumstances of the particular situation. This is usually within the time prescribed by the employee's usual and customary requirement for requesting leave.

- If the need for an FMLA/CFRA/PDL leave is foreseeable, such as the unexpected birth of a child or a planned medical treatment for the employee or family member, employees must provide 30 calendar days notice in advance, preferably by competing an FMLA/CRFA/PDL Leave Request (MH 3206) before the need for the leave begins.

- Employees must make a reasonable effort to schedule leave for medical or other FMLA/CFRA related appointments at a time that minimizes disruption to the Department's operations.

- Employees seeking leave due to a FMLA/CFRA qualifying reason, for which the Department has previously provided FMLA/CFRA protected leave, must either reference specifically the qualifying reason for leave or the need for FMLA leave.

- Employees must notify the Department as soon as practicable if the dates for the schedule leave changes, are extended or were initially unknown.

Designated Manager, Supervisor or FMLA Coordinator

- Must inform employees about information regarding their FMLA/CFRA/PDL eligibility and benefits. This may be done upon an employee's request for FMLA/CFRA/PDL leave or upon an employee's knowledge that an employee's absence or leave, current or future, may be FMLA/CFRA/PDL qualifying. This information may be provided by completing a FMLA/CFRA Notice of Eligibility and Rights and Responsibilities MH 3207.

- Employees must be provided information regarding their eligibility (MH 3207) within five (5) working days after DMH receives a request for leave or becomes aware that an

employee's leave may qualify for FMLA/CFRA. If the employee is not eligible, the employee must be notified of the reason for the ineligibility.

- Must inform employees if leave will be designated as FMLA/CFRA/PDL protected and the amount of leave counted against the employee's leave entitlement. Employees must also be notified if the leave will not be designated as FMLA/CFRA protected.

- Must advise an employee or an employee's spokesperson in the event of an FMLA/CFRA/PDL management designation. Management designations shall be done when sufficient knowledge has been obtained that an employee's absence is FMLA/CFRA/PDL qualifying. Management designations may be done absent an employee's request and employees must be advised of the amount of leave counted against their FMLA/CFRA/PDL leave benefit entitlement.

Medical Certification

If instructed, employees must provide sufficient and complete information for the Department to determine if the FMLA/CFRA/PDL leave request qualifies for protection under the provisions of the respective laws and, if so, the anticipated timing and duration of the leave. Sufficient information; i.e. Certification of Health Care Provider for Employee's Serious Health Condition MH 3208E, Certification of Health Care Provider for Family Member's Serious Health Condition MH3208F, etc. may be required before an employee's leave is designated as FMLA/CFRA/PDL.

If the medical certification is incomplete or insufficient, DMH must state in writing what additional information is necessary. If the validity of the employee's medical certification is in question (i.e. if you do not believe the leave request is valid or medically necessary), DMH may require a second opinion. If an employee fails to submit a timely properly requested medical certification (absent sufficient explanation of the delay), FMLA protection for the leave may be delayed or denied. If an employee never provides a medical certification, then the leave is not protected under the FMLA/CFRA statutes.

DMH may require the employee to provide a recertification upon the expiration of the time period that the health care provider estimated the employee needed to care for his or her own serious condition or take care of the employee's child, parent or spouse if additional leave is requested. An employee is required to provide

DMH with sufficient information if the circumstances of the previous certification have changed significantly, or the employer has information that questions the validity of an employee's reason for the leave.

DMH will give the employee a written notice of a requirement for medical certification each time a certification is required.

Use of Leave Credits

An employee may choose to use sick leave, vacation, annual, CTO, or personal leave credits while on FMLA/CFRA/PDL, provided the employee meets the requirements for use of such leave as defined by the applicable CBA or DMH policy.

Health Benefit Coverage

During a FMLA/CFRA/PDL unpaid leave, the Department will continue to pay its share of employee health, dental, and vision benefits under the same conditions as if an employee were working. Upon returning to work, employees are required to pay for their share of the health premiums.

Employees may be required to reimburse DMH the cost of health insurance premiums paid on the employee's behalf while on FMLA/CFRA leave, except if the employee does not return to work following their FMLA/CFRA leave for the following reasons:

1) the continuation, recurrence, or onset of a serious health condition of the employee, or the employee's family member which would otherwise entitle the employee to FMLA/CFRA/PDL leave;

2) the continuation, recurrence, or onset of a covered service member's serious injury or illness, which would entitle the employee to FMLA/CFRA leave; or

3) other circumstances beyond the control of the employee.

DMH will provide an employee with advance written notice of the terms and conditions under which these payments must be made.

An employee who currently receives the "cash option" (in lieu of health benefits) under the Flex-Elect program will not receive the "cash option" during an FMLA/CFRA/PDL leave.

Restoration to Employment Following Leave

An employee taking FMLA/CFRA for his/her own serious health condition or PDL will be required to present a medical release to "return to work" prior to being restored to employment. The employee's return to work may be delayed until the medical release is provided.

An employee returning from a FMLA/CFRA/PDL leave will be returned to the same position the employee held when the leave commenced, or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment.

An employee is entitled to such reinstatement even if the employee has been replaced, or his or her position has been restructured to accommodate the employee's absence. If the employee is permanently unable to perform an essential function of the job, the Americans with Disabilities Act may govern DMH obligations.

Enforcement

An employee may file an internal complaint with the Department's Office of Human Rights, hospital/psychiatric program Equal Employment Office, or file an external complaint with the Department of Fair Employment and Housing; U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer if they feel their FMLA/CFRA/PDL rights have been violated.

CFRA and the PDL are State laws administered and enforced by the Department of Fair Employment and Housing.

FMLA/CFRA/PDL does not supersede any MOU that provides greater family or medical leave rights.

FMLA/CFRA/PDL Coordinators

The Department's FMLA/CFRA Coordinator is a staff person in the Labor Relations Office. Additionally, each State hospital will appoint a FMLA/CFRA Coordinator to provide immediate technical support to supervisors/managers. Employees may contact the Personnel Services Specialist responsible for the employee's payroll unit with questions regarding the FMLA/CFRA/PDL.

Training

The Labor Relations Office is responsible for providing FMLA/CFRA/PDL training to managers and supervisors, as well as their roles and responsibilities related to those laws.

Attachment 3
Reducing Violence in State Hospitals

The California Department of State Hospitals (DSH) has adopted a strategic approach to reducing violence in our hospitals and meeting the changing needs of our patient population. We continue to pursue solutions to eliminate serious inpatient violence in the state hospitals.

As a relatively new department, DSH has reworked its mission, vision, values and goals to reflect its mission and emphasis on safety and forensic issues. The Department has a four-pronged effort to obtaining knowledge to hone its approach to mitigate violence in the state hospitals:

1. Outreach to other states. The Department is an active participant in the Western Psychiatric State Hospital Association (WPSHA) and the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

2. Understanding the medical literature. All clinical initiatives are heavily researched and supported by the existing evidence. We are also now contributing to the literature.

3. Forming academic partnerships. The Department has built close partnerships with national academic leaders in the areas of psychopharmacology, forensics, violence risk assessment and forensic research.

4. Leveraging internal expertise. Best practices and internal leaders are identified and engaged in the development of clinical interventions to address violence.

DSH is the largest forensic hospital system in the nation—three times larger than the next largest system. Increasing forensic populations, and increasing violence, are national trends. California experiences these issues most acutely because of its size.

No one yet has an adequate understanding of—or approach to—how to prevent forensic inpatient violence. There is compelling evidence that, nationally, state hospitals are now treating a new type of patient in addition to their traditional patient population.

In 2011, the Department launched new efforts to address violence in our hospitals. They fell into eight domains: Medical Leadership, Administrative Leadership, Legislation, Clinical Leadership, Statewide Performance Improvement, Violence Risk Assessment, Specialty Units and System Leadership. Subsequently, those eight domains were streamlined into four: Assessment, Treatment, Environment and Data.

Assessment. In this domain, our goal is to train clinicians to understand the cause of, and improve our ability to predict, violent behavior. To accomplish this goal, we have:

- Implemented Violence Risk Assessments statewide; all patients receive some type of assessment depending on their commitment type and hospital.
- Completed statewide training in state-of-the-art violence risk assessment tools. Trainings will continue on a regular cycle.
- Begun working to leverage technology to ensure data from these assessments are incorporated into the treatment planning process.

Treatment. As our goal, we will optimize the treatment of violence. We have:

- Researched, created, published and disseminated to DSH clinicians the California Violence Assessment and Treatment Guidelines (Cal-VAT) last year, which is unique in the literature. Cal-VAT is based on University of California, Davis research demonstrating that psychiatric inpatient aggression can be categorized as psychotic, predatory or impulsive. DSH is currently developing guidelines targeting violence due to cognitive issues.
- Implemented the Psychopharmacology Resource Network led by national expert Stephen Stahl MD, PhD. This group of experts provides training and consultation to our doctors statewide on the pharmacological treatment of violence.
- Implemented a statewide Continuing Medical Education (CME) program that includes intensive focus on forensic training and training on the Cal-VAT guidelines. We have provided more than 100 hours of group CME training to DSH psychiatrists since January of 2013.
- Implemented an internal Data Analytics, Treatment and Assessment team who aid in identifying, piloting and implementing best non-pharmacological practices such as Dialectical Behavioral Therapy. Based on the team's recent data analysis related to DSH's chronic assaulter analysis, they are now working to implement statewide cognitive rehabilitation programs.
- Established an online Education Connection for level-of-care staff; thus far, 970 users have received more than 25,000 hours of education in the last year to enhance their clinical skills.
- Creating a model called Forensic Focused Treatment Planning and recently had an article accepted for publication on this topic. This model identifies and focuses on salient forensic issues such as inpatient aggression.
- Working with other states to define and publish a forensic standard of care.

Environment. For this domain, our goal is to establish appropriate treatment environments. We have:

- Implemented the Personal Duress Alarm System at three of five hospitals and implementation is in process at the other two freestanding facilities.
- Implemented Specialty Unit Pilots: an Enhanced Treatment Unit at Atascadero State Hospital that treats patients whose severe violence is primarily driven by severe psychiatric symptoms; a Specialized Services Unit at Coalinga State Hospital that treats patients whose criminogenic behavior is primarily driven by characterological traits; a Substance Abuse Treatment Unit at Napa State Hospital that treats patients who are actively abusing substances, which is a major risk factor for violence.
- In process of evaluating an ecological approach to environmental violence reduction at Patton State Hospital.
- Begun developing the Enhanced Treatment Program, described in AB 1340. This legislation enabled the creation of specialized, safety-oriented settings for the treatment of violence that is likely to cause severe physical harm and is not containable in a regular treatment setting. The Department has launched a multi-focal plan for the design, construction and programmatic aspects of these units. The Enhanced Treatment Program will allow the Department to begin stratifying our hospitals beds based on level of therapeutic security as well as treatment needs.
- Analyzed worker's compensation data and found that DSH staff are injured as often during containment as they are by assault. As a result, the Department is currently exploring best practices related to de-escalation training, as well as approaches in other countries.

Data. Our goal is to improve the integrity, architecture and analysis of violence-related data to achieve ongoing performance improvement related to violence. We have:

- Established a unit tasked with accomplishing this goal.
- Begun expanding the University of California, Davis research program to all hospitals.
- Completed a violence data analysis project to determine trends in violence in the State Hospital System.
- Initiated a chronic aggressors project. The results of the violence data analysis indicated that 2 to 3 percent of the patient population was responsible for 30 to 40 percent of the hospital violence each year. DSH developed a coding process for reviewing these cases to find common risk factors in the hopes of developing targeted interventions for this portion of the patient population.
- Initiated a worker's compensation data analysis project. The violence data analysis indicated that patient-to-staff violence has not decreased as much as patient-to-patient violence. DSH developed this project to analyze data from the worker's compensation databases to better understand patient-to-staff violence and find areas to mitigate the risk of staff injury.
- Created a process for reporting to the DSH Governing Body on discipline specific outcomes and best practices on a statewide basis, some of which impacts violence reduction.
- Begun leading an effort to establish national forensic benchmarking data with partners in other states.