Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 5 Agenda

Senator Loni Hancock, Chair
Senator Joel Anderson
Senator Holly Mitchell

Thursday, May 1, 2014
9:30 a.m. or Upon Adjournment of Session
State Capitol - Room 113

Consultant: Julie Salley-Gray

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PROPOSED FOR VOTE ONLY

Department of Corrections and Rehabilitation

1. **Parole Revocation and Compliance Workload.** The Spring Finance Letter requests the continuation of $5.191 million (General Fund) and the conversion of 36 parole agent 1 positions from limited-term to permanent positions in order to manage the ongoing workload associated with parole revocations and court compliance.

2. **Office of Attorney General Litigation Services.** The Governor's budget requests $1.36 million for five additional full-time deputy Attorney General positions in order to provide ongoing representation for CDCR in the class action cases of *Coleman v. Brown, Plata v. Brown*, the Three Judge Panel, and other class action litigation.

ITEMS TO BE HEARD

0552 Office of the Inspector General

The Office of the Inspector General (OIG) protects public safety by safeguarding the integrity of California's correctional system. The OIG is responsible for contemporaneous oversight of the California Department of Corrections and Rehabilitation's (CDCR) internal affairs investigations, use of force, and the employee disciplinary process. When requested by the Governor, the Senate Committee on Rules, or the Speaker of the Assembly, the Inspector General reviews the policies, practices, and procedures of the CDCR. The Inspector General reviews the Governor's candidates for appointment to serve as warden for the state's adult correctional institutions and as superintendents for the state's juvenile facilities; conducts metric-oriented inspection programs to periodically review delivery of medical care at each state prison and the delivery of reforms identified in the department's document, released in April 2012, entitled "The Future of California Corrections: A blueprint to save billions of dollars, end federal court oversight, and improve the prison system." The OIG receives communications from individuals alleging improper governmental activity and maintains a toll-free public telephone number to receive allegations of wrongdoing by employees of the CDCR; conducts formal reviews of complaints of retaliation from CDCR employees against upper management where a legally cognizable cause of action is present; and reviews the mishandling of sexual abuse incidents within correctional institutions. The OIG provides critical public transparency for the state correctional system by publicly reporting its findings.

In addition, the Public Safety and Offender Rehabilitation Services Act of 2007, Chapter 7, Statutes of 2007, created the California Rehabilitation Oversight Board (Board) within the OIG. The Board's mandate is to examine the CDCR's various mental health, substance abuse, educational, and employment programs for inmates and parolees. The Board meets quarterly to recommend modifications, additions, and eliminations of offender rehabilitation and treatment programs. The Board also submits biannual reports to the Governor, the Legislature, and the public to convey its findings on the effectiveness of treatment efforts, rehabilitation needs of offenders, gaps in offender rehabilitation services, and levels of offender participation and success.

Following is the total funding and positions for the OIG, as proposed in the Governor’s Budget. The OIG is funded exclusively from the General Fund.

(dollars in thousands)

Funding	2012-13	2013-14	2014-15
General Fund	$13,507	$15,762	$17,031
Total	$13,507	$16,366	$17,031
Positions	87.2	93.4	95.4

Issue 1: Semi-annual Report (SAR) Update

Background. The OIG's Discipline Monitoring Unit (DMU) is responsible for monitoring the California Department of Corrections and Rehabilitation's (CDCR) employee disciplinary process. The OIG monitors and assesses CDCR's internal affairs investigations of alleged employee misconduct, as well as the disciplinary decisions related to sustained employee misconduct and any subsequent appeal. They monitor both administrative and criminal investigations conducted by CDCR. In addition, the OIG monitors and assess CDCR's response to critical incidents, contraband surveillance watch and, in 2013, they included the Use-of-Force report as part of the SAR publication. They publish their assessment of monitored cases and the department's response bi-annually, covering a six-month reporting period in each publication. The most recent report was released in March 2014.

In volume one of the most recent report, the OIG provides an assessment of 308 employee disciplinary cases that were closed between July 1 and December 31, 2013. 55 out of the 308 cases included a use-of-force component. Out of the 308 cases assessed, the OIG found deficiencies in the handling of over 130 of the cases.

Volume two of the report provides an assessment of critical incident responses. CDCR is required to notify the OIG of any critical incident immediately following the event. Critical incidents include serious events that require an immediate response by the department, such as riots, homicides, escapes, uses of deadly force, and unexpected inmate deaths. Between July 1 and December 31, 2013, the OIG completed assessments of 133 critical incidents. The OIG found that CDCR failed to report critical incidents to the OIG within the required time frame in 20 percent of the incidents. 39 of the 133 incidents assessed during the six month period involved the use of deadly force and 31 of the incidents involved the death of an inmate in custody. Out of the 133 cases assessed, the OIG found deficiencies in the handling of approximately 40 cases.

Among the on-going concerns raised by the OIG in the most recent report are the following:

1. The amount of time it takes to begin and complete investigations and the disciplinary process within CDCR continues to take too long. Sometimes individuals wait years for allegations to be resolved, which affects the morale of the department and prohibits them from removing subpar employees expediently.

2. The OIG has identified potential conflicts by the Office of Legal Affairs, specifically within the Employment Advocacy Integration Team (EAPT) Vertical Advocates.

Questions for the Inspector General. The Inspector General should be prepared to present the findings from the report and address the following question:

1. Are you noticing any trends or patterns over the years in terms of the types of critical incidences or the number of critical incidences? In addition, have you found that certain institutions have a larger number of incidents than other institutions? If so, please provide the subcommittee with the institutions that have the largest number of incidents.

2. Similarly, have you noticed any trends or patterns in terms of the types or number of employee disciplinary cases? Are there any institutions that appear to have more or less cases than the other institutions? Please provide a list of those institutions.

3. Have you found CDCR to be responsive to your office's recommendations or do you find that the same problems seem to arise year after year?

Issue 2: Medical Inspections BCP

Budget Proposal. The Governor's budget proposes a $1.262 million (General Fund) augmentation to establish four permanent positions in the Medical Inspections Unit of the OIG to evaluate medical care provided to inmates in state prison. In addition, the budget proposes reducing the California Correctional Health Care Services (CCHCS) budget by $645,000 (General Fund) and two positions. The net cost of the proposal is $617,000.

The four positions consist of three physicians and one nurse who will provide medical expertise for the OIG to add clinical case reviews to the existing compliance-based monitoring system that is in place.

Background. In 2007, the federal receiver appointed to oversee medical care in California's state prisons, approached the Inspector General about developing an inspection and monitoring function for prison medical care. The receiver's goal was to have the OIG's inspection process provide a systematic approach to evaluating medical care. Using a court-approved medical inspection compliance-based tool, the OIG's Medical Inspection Unit (MIU) was established and conducted three cycles of medical inspections at CDCR's 33 adult institutions and issued periodic reports of their findings from 2008 through 2013.

In 2013, court appointed medical experts began conducting follow-up evaluations of prisons scoring 85 percent or higher in the OIG's third cycle of medical inspections. (Those evaluations are discussed in more detail in a later item.) The expert panel found that six of the ten institutions evaluated had an inadequate level of medical care, despite scoring relatively high overall ratings in the OIG's evaluations. The difference between the two types of evaluations resulted in very different findings. The OIG's evaluations focused on the institutions' compliance with CDCR's written policies and procedures for medical care. The court experts, however, focused on an in-depth analysis of individual patients' medical treatment to determine the quality of care at each prison. After meeting with the receiver's office and the court medical experts, the Inspector General decided that his inspections should be modified to include the methodologies used by the medical experts in order to determine the quality of care being provided.

5225 Department of Corrections and Rehabilitation

Effective July 1, 2005, the California Department of Corrections and Rehabilitation (CDCR) was created, pursuant to the Governor's Reorganization Plan No. 1 of 2005 and SB 737 (Romero), Chapter 10, Statutes of 2005. All departments that previously reported to the Youth and Adult Correctional Agency (YACA) were consolidated into CDCR and include the California Department of Corrections, Youth Authority (now the Division of Juvenile Justice), Board of Corrections (now the Board of State and Community Corrections (BSCC)), Board of Prison Terms, and the Commission on Correctional Peace Officers' Standards and Training (CPOST).

The mission of CDCR is to enhance public safety through safe and secure incarceration of offenders, effective parole supervision, and rehabilitative strategies to successfully reintegrate offenders into our communities.

The CDCR is organized into the following programs:

- Corrections and Rehabilitation Administration
- Juvenile: Operations and Offender Programs, Academic and Vocational Education, Health Care Services
- Adult Corrections and Rehabilitation Operations: Security, Inmate Support, Contracted Facilities, Institution Administration
- Parole Operations: Adult Supervision, Adult Community-Based Programs, Administration
- Board of Parole Hearings: Adult Hearings, Administration
- Adult: Education, Vocational, and Offender Programs, Education, Substance Abuse Programs, Inmate Activities, Administration
- Adult Health Care Services

The 2013 Budget Act projected an adult inmate average daily population of 128,885 in the current year. However, the current year adult inmate population is now projected to exceed budget act projections by 6,101 inmates, a 4.7 percent increase, for a total population of 134,986. The budget year adult inmate population is projected to be 137,788, a 6.9 percent increase of 8,903 inmates over the revised current year. Current projections also reflect an increase in the parolee population of 3,439 in the current year compared to budget act projections, for a total average daily population of 45,934. The parolee population is projected to be 36,652 in 2014−15, a decrease of 5,843.

The Governor's budget proposes $9.8 billion ($9.5 billion General Fund and $320 million other funds) and 60,598.7 positions for CDCR in 2014-15. The following table shows CDCR's total operational expenditures and positions for 2012-13 through 2014-15.

(dollars in thousands)

Funding	2012-13	2013-14	2014-15
General Fund	$8,534,272	$9,263,117	$9,494,977
General Fund, Prop 98	16,824	17,910	17,698
Other Funds	53,534	62,690	63,053
Reimbursements	138,275	179,647	185,043
Recidivism Reduction Fund	-	-81,109	72,811
SCC Performance Incentive Fund	-615	-1,000	-1,001
Total	$8,742,290	$9,441,255	$9,932,581
Positions	50,728.7	60,790.1	60,598.7

California Correctional Health Care Services (CCHCS)

The CCHCS receivership was established as a result of a class action lawsuit (*Plata v. Brown*) brought against the State of California over the quality of medical care in the state's 33 adult prisons. In its ruling, the Federal Court found that the care was in violation of the Eighth Amendment of the U.S. Constitution which forbids cruel and unusual punishment. The State settled the lawsuit and entered into a stipulated settlement in 2002, agreeing to a range of remedies that would bring prison medical care in line with constitutional standards. The State failed to comply with the stipulated settlement and on February 14, 2006, the Federal Court appointed a receiver to manage medical care operations in the prison system. The current receiver was appointed in January of 2008, and currently remains in place. The receivership continues to be unprecedented in size and scope nationwide.

The receiver is tasked with the responsibility of bringing the level of medical care in California's prisons to a standard which no longer violates the U.S. Constitution. The receiver oversees approximately 10,000 prison health care employees, including doctors, nurses, pharmacists, and administrative staff. Over the last ten years, healthcare costs have risen significantly. The estimated per inmate health care cost for 2014-15 is almost two and a half times the cost for 2005-06. The state spent $1.2 billion in 2005-06 to provide health care to 162,408 inmates. The state estimates that it will be spending over $2.2 billion in 2014-15 for 120,660 inmates.

CDCR Historical Health Care Costs Per Inmate

Type of Care	2005-6	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Medical	$5,803	$7,183	$9,721	$12,170	$10,957	$10,439	$12,525	$12,280	$13,585	$13,845
Mental Health	$1,463	$1,976	$2,802	$2,839	$2,420	$3,168	$2,621	$2,596	$3,214	$3,304
Dental	$313	$398	$916	$1,049	$1,066	$1,088	$1,127	$1,163	$1,248	$1,266
Total	**$7,580**	**$9,558**	**$13,349**	**$16,058**	**$14,443**	**$14,695**	**$16,273**	**$16,039**	**$18,048**	**$18,415**

Issue 3: Update on Inmate Medical Care and the Receivership

Background. On June 30, 2005, the United States District Court ruled in the case of *Marciano Plata, et al v. Arnold Schwarzenegger, et al,* that it would establish a receivership and take control of the delivery of medical services to all California prisoners confined by CDCR. In a follow-up written ruling dated October 30, 2005, the court noted:

> *By all accounts, the California prison medical care system is broken beyond repair. The harm already done in this case to California's prison inmate population could not be more grave, and the threat of future injury and death is virtually guaranteed in the absence of drastic action. The Court has given defendants every reasonable opportunity to bring its prison medical system up to constitutional standards, and it is beyond reasonable dispute that the State has failed. Indeed, it is an uncontested fact that, on average, an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the CDCR's medical delivery system. This statistic, awful as it is, barely provides a window into the waste of human life occurring behind California's prison walls due to the gross failures of the medical delivery system.*

As noted earlier, since the appointment of the receivership, spending on inmate health care has almost tripled. A new prison hospital has been built, new systems are being created for maintaining medical records and scheduling appointments, and new procedures are being created that are intended to improve health outcomes for inmates. According to the CCHCS, over 400,000 inmates per month have medical appointments and the rate of preventable deaths has dropped 46 percent since 2006.

It remains unclear, however, if or when the receivership will end and responsibility for medical care will be returned to the state.

Chief Executive Officers for Health Care. Each of California's 33 prisons has a chief executive officer (CEO) for health care who reports to the receiver. The CEO is the highest-ranking health care authority within a CDCR adult institution. A CEO is responsible for all aspects of delivering health care at their respective institution(s) and reports directly to the receiver's office.

The CEO is also responsible for planning, organizing, and coordinating health care programs at one or two institutions and delivering a health care system that features a range of medical, dental, mental health, specialized care, pharmacy and medication management, and clinic services.

Serving as the receiver's advisor for institution-specific health care policies and procedures, the CEO manages the institution's health care needs by ensuring that appropriate resources are requested to support health care functions, including

adequate clinical staff, administrative support, procurement, staffing, and information systems support.

Regional CEOs. As part of transition activities, the receivership has been in discussions with CDCR regarding what would be the appropriate organizational model for oversight of institutional health care. Under CDCR, both dental and mental health had previously adopted, and had in place, a geographical, "regional" model for organizational oversight of their activities. As part of the movement toward transitioning medical care back to the state, the receiver felt that creation of cohesive, interdisciplinary regions that included medical leadership would lead to a more sustainable model for the future. As a result, the receiver took steps to hire four regional CEOs and worked with CDCR to align each region geographically so that medical, mental health, and dental consistently oversee the same institutions on a regional basis. The four regions are as follows:

1. Region I: Pelican Bay State Prison, High Desert State Prison, California Correctional Center, Folsom State Prison, California State Prison Sacramento, Mule Creek State Prison, California State Prison San Quentin, California Medical Facility, and California State Prison Solano.

2. Region II: California Health Care Facility, Stockton, Sierra Conservation Center, Deuel Vocational Institution, Central California Women's Facility, Valley State Prison, Correctional Training Facility, Salinas Valley State Prison, and California Men's Colony.

3. Region III: Pleasant Valley State Prison, Avenal State Prison, California State Prison Corcoran, Substance Abuse Treatment Facility, Kern Valley State Prison, North Kern State Prison, Wasco State Prison, California Correctional Institution, California State Prison Los Angeles County, and California City Prison.

4. Region IV: California Institution for Men, California Institution for Women, California Rehabilitation Center, Ironwood State Prison, Chuckawalla Valley State Prison, Calipatria State Prison, Centinela State Prison, and RJ Donovan Correctional Facility.

Each region consists of a regional health care executive, one staff services analyst/associate governmental program analyst, one office technician, and one health program specialist I. The cost for each of the regional offices is $565,000 per year, with a total budget for regional CEOs of almost $2.25 million per year. The funding and positions were created within CCHCS using existing resources and the receiver did not ask the Legislature to approve the creation of the regional CEO offices.

Health Care Evaluations. In September 2012, the Federal Court requested that the court's medical experts conduct evaluations at each CDCR prison to determine whether an institution is in substantial compliance. The order defined substantial compliance and constitutional adequacy as receiving an overall OIG score of at least 75 percent and an

evaluation from at least two of the three court experts that the institution is providing adequate care.

In conducting the reviews, the medical experts evaluated essential components to an adequate health care system. These include organizational structure, health care infrastructure (e.g., clinical space, equipment, etc.), health care processes, and the quality of care.

To date, the medical experts have evaluated ten institutions. Of those ten, six were found to be providing inadequate medical care and the remaining four had specific procedural problems that needed to be addressed in order for their care to be deemed adequate. A few examples of the findings for those institutions providing inadequate care are:

- *California Institution for Men (CIM)* – The medical experts found that CIM, in August of 2013, was either approaching or at its maximum capacity to manage inmates with high medical needs. In addition, they found significant problems related to the management of patients with chronic diseases and that primary care physicians did not adequately address patients' chronic diseases or abnormal laboratory findings in a timely or appropriate manner. Further, the experts found that nurses did not perform medical screenings in a clinical setting, but instead used a "confessional booth," which the medical experts had noted initially in a 2006 visit.

- *Corcoran State Prison* – At Corcoran, the medical experts found serious problems related to access, timeliness, and quality of care. During their visit, the experts found in the General Acute Care Hospital that patient monitoring was not performed in accordance with physician orders. In addition, they found a high number of intravenous catheter and other infections that, in some cases, led to sepsis. They noted that the potentially life-threatening infections are indicative of a lack of adequate hygiene, sanitation, and infection control activities in the unit. A hand washing study conducted in April and May of 2013 showed that none of the observed staff washed their hands before engaging in patient care.

- *California State Prison at Sacramento (CSP-SAC)* – A key finding during the medical experts' visit in October of 2013 was that in many cases nurses and providers did not perform an adequate history of the patients' complaints or perform adequate physical examinations, even when patients presented with symptoms of serious medical conditions. The experts believe that a contributing factor was that providers and nurses did not consistently evaluate patients in an examination room with adequate privacy. The standard practice at CSP-SAC was for patients to be handcuffed, placed in a cage, and for correctional officers to remain in the room during examinations.

- *California Central Women's Facility (CCWF)* – The experts found that many of the medical problems at CCWF appeared to be related to the overcrowded

conditions and an inadequate number of medical staff. The evaluation noted that between July 2012 and July 2013, the population had increased by 30 percent (830 inmates) since Valley State Prison had been converted from a women's institution to a male institution. Despite the increase in the number of prisoners, CCWF had a 21 percent reduction in medical provider staffing. The experts found that there were an inadequate number of skilled nursing beds to accommodate patients which sometimes resulted in patients being sent back to the housing units or discharged prematurely from the skilled nursing facility. In addition, they found that there was no medical provider assigned to the skilled nursing facility which resulted in care being episodic and providers that did not address all of the patients' medical conditions.

Medical Treatment for Female Inmates. As noted above, one of the three women's institutions was included in the ten medical evaluations conducted by the federal court's medical experts. In general, the experts found that the institution was not providing adequate medical care, primarily due to overcrowding and insufficient staffing.

In addition to inadequate medical care for female inmates at one of the women's institutions, CDCR adopted a policy in 1999 for female prisoners that included sterilization/tubal ligation in obstetrical care for postpartum women. According to statistics provided to the State Auditor by Justice Now, between 1997 and 2005, 136 female inmates housed in CDCR institutions were sterilized by tubal ligation during labor and delivery. Between 2006 and 2010, over 115 more women were sterilized.

Many of the tubal ligations can be traced back to one doctor and his staff at Valley State Prison. According to news reports, in addition to the tubal ligations, the same doctor arranged other types of procedures that resulted in the sterilization of women 378 times between 2006 and 2012, all while the prisons were under the care of the federal receivership. The procedures included hysterectomies, removal of ovaries and endometrial ablation. It is unclear whether these procedures were conducted for sterilization purposes.

According to the receiver's office, the situation was brought to their attention in 2010. The receiver's office states that only one tubal ligation has been performed since that time. However, a 2008 memo from the receiver's office regarding the procedure, confirms that the receiver's office knew that sterilization was being offered and performed on pregnant/birthing women in the women's institutions well before 2010.

Transition Planning. On September 9, 2012, the federal court entered an order entitled *Receivership Transition Plan and Expert Evaluations*. As part of the transition from the receivership, the court required the receiver to provide CDCR with an opportunity to demonstrate their ability to maintain a constitutionally adequate system of inmate medical care. The receiver was instructed to work with CDCR to determine a timeline for when CDCR would assume the responsibility for particular tasks.

As a result of the court's order, the receiver and CDCR began discussions in order to identify, negotiate, and implement the transition of specific areas of authority for specific operational aspects of the receiver's current responsibility—a practice that had already been used in the past (construction had previously been delegated to the state in September 2009). On October 26, 2012, the receiver and the state reached agreement and signed the first two revocable delegations of authority:

> ***Health Care Access Units*** are dedicated, institution-based units, comprised of correctional officers, which have responsibility for insuring that inmates are transported to medical appointments and treatment, both on prison grounds and off prison grounds. Each institution's success at insuring that inmates are transported to their medical appointments/treatment is tracked and published in monthly reports.
>
> ***The Activation Unit*** is responsible for all of the activities related to activating new facilities, such as the California Health Care Facility at Stockton and the DeWitt Annex. Activation staff act as the managers for CDCR and coordinate activities such as the hiring of staff for the facility, insuring that the facility is ready for licensure, overseeing the ordering, delivery, and installation of all equipment necessary for the new facility, as well as a myriad of other activities. Activation activities, again, are tracked on monthly reports provided to the receiver's office.

In addition to the two delegations that have been executed and signed by the receiver and CDCR, the receiver has produced draft delegations of authority for other operational aspects of its responsibility which have been provided to the state. These operational aspects include:

- Quality Management
- Medical Services
- Healthcare Invoice, Data, and Provider Services
- Information Technology Services
- Legal Services
- Allied Health Services
- Nursing Services
- Fiscal Management
- Policy and Risk Management
- Medical Contracts
- Business Services
- Human Resources

Questions for the Receiver's Office. The receiver should be prepared to address the following questions:

1. What types of training and written policies were provided to CDCR employees prior to the transfer of the health care access units and the activation unit in order to increase the chances of a successful transition?

2. How are you training both the medical and custodial staff to ensure the provision of adequate medical care and that the staff understand what adequate care entails?

3. What procedures have you put in place throughout the system to ensure that adequate care continues once the receivership ends?

4. In 2010, you anticipated that once your information technology projects and constructions projects were completed, the receivership would no longer be required. At the time, you assumed that would take approximately 24 months. Please provide an update on both the IT projects and the Healthcare Facility Improvement Program (HCFIP)?

5. What is the current timeline for transitioning medical care out of the receivership and back to CDCR?

6. With large numbers of sterilizations being done at one prison, what types of safeguards have you put in place to ensure that unnecessary procedures are not being done at institutions? Is there a regular process for comparing the numbers of procedures across institutions to recognize outliers, such as Valley State Prison that had six times the number of sterilizations as CCWF?

7. Recent reports, such as the incidents at Mule Creek and Pleasant Valley State Prison last fall, suggest that there is a problem between the custody staff and the medical staff in terms of proper procedures that should be followed when someone is in medical danger. In both cases, the custody staff's concerns appear to have outweighed the medical staff's. What has the receiver's office done to develop a formal procedure for each institution that clarifies what should happen in such emergencies when the medical staff requires that someone be removed from a cell and the custody staff refuses? What type of training has been provided to both the custody staff and the medical staff in this area?

8. Given that the CCWF medical evaluation found the overcrowding and understaffing is contributing to the failure to provide adequate medical care, what steps is the receiver's office taking to ensure that both of those situations are corrected?

Questions for CDCR. The Administration should be prepared to address the following questions:

1. Please respond to the receiver's assessment of the current medical situation in the adult institutions.

2. What type of specialized training is provided to custody staff who will be working with patients in the medical facilities at the institutions?

3. What led to CDCR adopting a policy of providing tubal ligation as a part of postpartum obstetrical care? Is there a new policy in place? If so, please describe it.

4. What steps does CDCR plan to take to address the problems raised in both the CIM and CSP-SAC medical evaluations that suggest that prisoners and medical personal are not provided with adequate privacy to conduct appropriate medical examinations? In particular, what procedural changes are being developed so that patients are not handcuffed and placed in cages for medical examinations and evaluations?

Issue 4: California Health Care Facility Intake

Background. The California Health Care Facility (CHCF) was designed and constructed to be a state-of-the-art medical facility that would provide care to inmates with high medical and mental health care needs. The construction of CHCF was completed in July 2013 and the receiver and CDCR began shifting inmates to the new hospital facility. The facility provides about 1,800 total beds including about 1,000 beds for inpatient medical treatment, about 600 beds for inpatient mental health treatment, and 100 general population beds. The CHCF cost close to $1 billion to construct and has an annual operating budget of almost $300 million.

Almost immediately after activation began, serious problems started to emerge. Reports suggested that there was a shortage of latex gloves, catheters, soap, clothing, and shoes for the prisoners. In addition, over a six-month period, CHCF went through nearly 40,000 towels and washcloths for a prison that was housing approximately 1,300 men. Investigations by officials at the facility found that the linens were being thrown away, rather than laundered and sanitized. In addition, the prison kitchen did not pass the initial health inspections, resulting in the requirement that prepared meals be shipped in from outside the institution. The problems were further compounded by staffing shortages and a lack of training. For example, a lack of training for nurses on the prison's bedside call system may have contributed to the death of an inmate in January. In addition, early this year, the prison suffered from an outbreak of scabies which the receiver's office attributes to the unsanitary conditions at the hospital.

Despite being aware of serious problems at the facility as early as last September, it was not until February that the receiver closed down intake at the facility and stopped admitting new prisoners. In addition, the receiver delayed the activation of the neighboring DeWitt-Nelson facility, which is designed to house inmate labor for CHCF, mentally ill prisoners, and prisoners with chronic medical conditions who need on-going care.

Questions for the Receiver's Office. The receiver should be prepared to provide an update on the activation of CHCF, and the DeWitt-Nelson facility, and address the following questions:

1. Why did you wait until February to close down intake, despite being aware of serious problems as early as last September?

2. Have you resolved the supply problems that led to the lack of adequate basic medical supplies such as catheters, latex gloves, and properly fitting adult incontinence products? Please explain how that problem occurred in the first place.

3. When do you plan on reopening intake? When do you anticipate that both CHCF and DeWitt-Nelson will be fully activated?

4. Many staff members were in place before the first inmates were admitted. What types of training were done for both medical and custody staff in advance of the facility opening?

5. What types of written procedures were in place prior to the facility's opening in July 2013?

6. In your opinion, is there adequate staffing of both medical staff and custody staff at the institution?

7. What type of planning was done in advance to determine the level of care required for the patients, their mobility, adequate visitation, their custody level, and that appropriate programming and outdoor space would be available for both the inmate workers and the patients?

8. It is our understanding that your office has conducted a root cause analysis to determine the deficiencies in the system and a patient safety survey. Can you please share the results of both of those studies?

9. Originally, the plan was for the state to build five or six of these state-of-the-art health care facilities throughout the state. Is that plan still being considered?

10. What policies and procedures are in place for communication between CDCR and the medical staff when problems arise?

Questions for the Administration. The Administration should be prepared to address the following questions:

1. What type of specialized training is provided to the custody staff working in this unique medical setting?

2. In the event of an incident, such as the one at Mule Creek noted earlier, what written policies and procedures are in place to ensure that the medical needs of the patient take priority in this hospital setting?

3. The chief executive medical officer is currently rebooting each unit to determine whether it is adequately staffed and the appropriate policies are in place to care for the patients. What is the role of the warden and the custody staff in that reboot?

4. In a recent visit to CHCF, corrections staff expressed concern about the lack of custody staff in each unit. What is CDCR doing to address that problem and determine whether or not there is adequate custody staffing throughout the facility?

Issue 5: Valley Fever Incidents and Protocol Update

Background. Between 2008 and 2013, almost 2,700 inmates housed in the state's prisons were diagnosed with Valley Fever (also known as cocci). Of that number, almost 50 died as a result. Valley Fever is considered hyperendemic at eight of the 33 adult institutions:

- Avenal State Prison
- Pleasant Valley State Prison
- Corcoran State Prison
- Substance Abuse Treatment Facility
- California Correctional Institution
- Wasco State Prison
- Kern Valley State Prison
- Northern Kern State Prison

The highest rates of Valley Fever are at Avenal State Prison and Pleasant Valley State Prison. However, all eight institutions make up the CDCR Valley Fever Exclusion Area.

CDCR first identified significant increases in the number of inmates contracting valley fever at Avenal and Pleasant Valley in 2005. At the receiver's request, the California Department of Public Health (CDPH) conducted an investigation at Pleasant Valley. In January of 2007, CDPH made final recommendations that included inmate and staff education, environmental controls and the relocation of the highest risk groups to other prisons. CDPH further noted that the exclusion of high-risk inmates would be the most effective method of decreasing the risk. While CDCR provided additional educational materials and transferred inmates with a high risk due to pulmonary conditions, they did not transfer inmates with diabetes, or African American and Filipino inmates out of the institutions. In addition, they also failed to implement any of the recommendations concerning ground cover and soil sealant. In the years between the 2007 report and the June 2013 court order, it appears that not much progress had been made toward mitigating the impact of valley fever on inmates in the hyperendemic area, especially at the two most affected institutions, Avenal and Pleasant Valley.

What is Valley Fever? Coccidioidomycosis, more commonly referred to as cocci or valley fever, is an infection caused by the coccidioides fungus spores, which are prevalent in the dry soil of the West and Southwest. These spores are found in the soil in certain areas (called endemic), and get into the air when the soil is disturbed. This can happen with construction, gardening, farming, windy weather, dirt biking, or driving all-terrain vehicles (ATV's) in these areas. Coccidioidomycosis cannot be passed from person-to-person. The most common states for people to be infected with coccidioidomycosis are Arizona and California, followed by Nevada, New Mexico, Texas, and Utah.

Symptoms include fever, chills or in more severe cases chronic pneumonia or meningitis. Generally, patients develop symptoms within one to three weeks after exposure. The flu-like symptoms beyond those mentioned above can include headaches, rash, muscle aches, extreme tiredness, and weakness. The symptoms typically last a few weeks to months.

According to the Centers for Disease Control and Prevention, approximately 40 percent of those infected require hospitalization, and the disease can be fatal.

Court Order. In June of 2013, the federal judge overseeing the *Plata* decision ordered CDCR to transfer all inmates who are classified as high-risk for valley fever under the American Thoracic Society definition from Avenal State Prison and Pleasant Valley State Prison within 90 days of the court order. The American Thoracic Society criteria for increased risk includes patients with impaired cellular immunity, such as those with organ transplants, those with HIV infection, and those with chronic obstructive pulmonary disease, chronic renal failure, congestive heart failure, diabetes; patients receiving certain inhibitors (medications used in the treatment of arthritis); Filipino and African-American men; and pregnant women in the second or third trimester.

Questions for the Receiver's Office. The receiver should be prepared to address the following questions:

1. What types of mitigation efforts have been put in place to reduce the incidents of valley fever? Have all eight institutions in the target area implemented some type of mitigation plan?

2. Have you seen an overall reduction in the number of valley fever cases? Please provide us with the most recent data since the court ordered changes have been in place.

3. Were you able to determine why the incidents of valley fever were higher at Avenal and Pleasant Valley than in their surrounding communities?

4. How many inmates were relocated as a result of the court order?

5. Please describe the court required training your office provided to all CDCR medical and nursing staff on the recognition, diagnosis, and treatment of cocci. Has everyone received the training? How was the training delivered?

Questions for CDCR. CDCR should be prepared to address the following questions:

1. Why did it take so many years and ultimately require a court order to take serious steps to reduce the risk of valley fever in the affected institutions? Why the reluctance to move beyond providing surgical masks for those who asked for them, installing equipment to keep out dust, installing new air filters, and posting laminated signs outlining the symptoms of valley fever?

2. Why did CDCR largely ignore the recommendations presented by the Department of Public Health in its January 2007 report?

3. Initially, CDCR refused to exclude inmates with diabetes, African-American and Filipino inmates from the valley fever exclusion area. What was the reason for that refusal?

4. Among other concerns, the Administration expressed some concern about moving African American and Filipino men out of the exclusion area because it might result in an ethnic imbalance at some of the institutions. Have any problems arisen in this area to validate the initial concerns?

5. Has the appropriate ground cover or high-grade soil sealant been utilized at either Avenal or Pleasant Valley State Prisons? If not, why not?

Issue 6: CalPIA Janitorial Services BCP

Budget Proposal. The Governor's budget proposes to expand the California Medical Facility (CMF) pilot project regarding the cleaning of health care facilities on a statewide basis. Specifically, the budget proposes a $14.5 million General Fund augmentation for 2014-15, which would increase to $19.5 million in 2015-16, for the receiver to enter into a statewide health care facility janitorial contract with the California Prison Industry Authority (CalPIA). By contrast, without this proposal the receiver's office would likely spend around $8 million to keep health care spaces in the prisons clean. The Governor's budget also proposes the elimination of 83 receiver staff positions in 2014-15, as the CalPIA contract will replace existing receiver janitorial resources. The budget proposes to transfer these janitorial positions to CalPIA. In addition, the proposal includes one full-time staff position for program oversight, and anticipates employing 628 trained inmate laborers. The statewide contract cost will be approximately $28 million in 2015-16 (upon full implementation), which translates to a cost of $1.38 per square foot serviced.

Background. As part of the 2002 settlement agreement in *Plata v. Brown*, CDCR agreed to ensure clean and sanitary health care environments in its prisons. Most of the cleaning is performed by inmates supervised by custody staff. Although the sanitation of health care facilities is held to a higher standard than the cleaning of non-health care facilities, the inmates do not receive training in health care facility cleaning and disinfection. The provision of these janitorial services varies widely by institution. While some institutions have fixed schedules to clean some or all of the health care areas at the institution, other institutions have no set cleaning schedules for any of their health care areas. In their analysis, the Legislative Analyst's Office notes that at some institutions, additional cleaning is done by contracted janitors.

In 2012, the *Plata* court ordered medical inspections of institutions that had reached a certain level of compliance with the 2002 settlement agreement. These inspections are performed by court experts and included an evaluation of health care cleanliness and sanitation (discussed in detail elsewhere in this agenda). Several of the audits identified deficiencies in facility cleanliness, which could delay the transfer of responsibility for the management and provision of inmate medical services back to the state. We also note that in 2012, the chief executive officer of the CMF in Vacaville approached CalPIA about developing a health care facilities cleaning service pilot project. The contract included the training of inmate laborers, staff oversight of inmate laborers, the maintenance of cleanliness in clinical areas, and the provision of cleaning materials. This pilot project has been extended through 2014 and now employs 46 inmate workers.

Questions for the Receiver's Office. The receiver should be prepared to present the proposal and address the following questions:

1. The BCP creates a vocational training program designed to train inmates in state prison to provide specialized cleaning in a health care setting upon their release.

Have you done any surveys or studies to determine whether or not there are jobs available in the health care field for this type of custodial work? Further, have you determined whether or not employers would be willing to hire individuals with serious and violent felony records to fill those positions?

2. How many former inmates who participated in the pilot program have been able to obtain these specialized health care custodial jobs upon their release?

3. Please provide detail on how the $28 million dollars annually will be spent. How much will be for custodial supervisors and other staff who will be working directly in the prison training inmates? How much will be spent on supplies and equipment? How much will be spent on CalPIA administration of the program?

Legislative Analyst's Office (LAO) Recommendation. While the LAO acknowledges the need for improved janitorial services, they recommend that the Legislature withhold action on this proposal until the receiver's office can justify the significant cost of the contract with CalPIA. They also recommend the Legislature require the receiver's office to report at budget subcommittee hearings this spring on why these janitorial services cannot be provided at a lower cost by CalPIA or an outside contractor.

Issue 7: Pharmaceuticals Augmentation BCP

Budget Proposal. The Governor's budget proposes adjustments to the inmate pharmaceutical budget for both the current and budget years. For 2013-14, the budget proposes to reduce the current-year pharmaceutical budget to $168 million. For 2014-15 and ongoing, the budget proposes $161 million for inmate pharmaceuticals. This $161 million budget would become the new baseline for the receiver's pharmaceutical spending, establishing an ongoing budget based on current purchasing and prescribing practices.

Background. The receiver's office is currently responsible for providing medical pharmaceuticals prescribed by physicians under his management, as well as psychiatric and dental medications prescribed by psychiatrists and dentists managed by CDCR. From 2004-05 through 2010-11, the inmate pharmaceutical budget increased from $136 million to $216 million. (The pharmaceutical budget reflects only the cost of pharmaceuticals and not the cost of medication distribution or management.)

Increases in the inmate pharmaceutical budget can occur for several reasons, such as additional inmates needing prescription drugs and increases in the rate at which inmates are prescribed drugs. Moreover, we note that pharmaceutical costs generally rise at a faster pace than inflation. For example, in 2012, average drug costs increased approximately 3.8 percent and average prices for brand name drugs increased 25.4 percent, compared to an overall 1.7 percent increase in consumer prices. Brand name drugs are often prescribed when generic alternatives are unavailable due to patent protections. In addition, while cost savings can be achieved by using a formulary (a list of preferred medicines that cost less), drugs that have few alternatives are less likely to have formulary options, which can also contribute to cost growth. This is particularly an issue for CDCR because the inmate population is disproportionately likely to have health issues for which there are no generic prescription therapies available. For example, about 26 percent of the inmate patient population has a serious mental health diagnosis and many mental health medications are patent-protected, which results in high mental health pharmaceutical costs.

Recognizing the uncertainty associated with pharmaceutical cost growth, the size and acuity of the patient population, and the potential cost savings of various programmatic changes initiated by the receiver, the Legislature increased the inmate pharmaceutical budget on a limited (rather than permanent) basis in recent years. Specifically, since 2007-08, the Legislature has provided only limited-term augmentations (typically for one to three years) to support inmate pharmaceutical costs. Spending on such costs has declined in the past couple of years compared to previous highs. The enacted 2013-14 budget includes a total of $178 million for inmate pharmaceuticals. Of this amount, $51 million was provided on a limited-term basis.

Legislative Analyst's Office (LAO) Recommendation. The Governor's budget proposes to increase the base budget for inmate pharmaceuticals. However, the LAO is concerned that increasing the ongoing base budget for a system that has not yet fully

realized recommended efficiency improvements could remove any incentive for further improvement and result in excess cost. Thus, while they recommend that the Legislature approve the Administration's proposed pharmaceutical budget, the LAO recommends that it be for only two years (2014-15 and 2015-16), so that it can reevaluate the need for ongoing funding in two years. In addition, the LAO recommends that the Legislature require the receiver's office to perform an analysis of the potential savings that could be achieved by addressing the issues identified by the Office of the Inspector General and Health Management Associates and report to the Legislature by January 2016. This information will allow the Legislature to better assess what the ongoing size of the receiver's pharmaceutical budget should be when the limited-term funding expires.

Questions for the Receiver's Office. The receiver's office should be prepared to present the proposal and answer the following question:

1. While it is understood that this particular budget proposal only relates to the cost of pharmaceuticals, and not the cost of distribution or management, please provide the subcommittee with an update on the central fill pharmacy and the savings that were anticipated as a result of shifting the filling of prescriptions from individual institutions to the central fill pharmacy.

    a. What is the status of the central fill pharmacy?
    b. How much did the pharmacy cost to build and operate?
    c. How much has the state saved as a result?
    d. How many individual institutional pharmacies were closed as a result of the creation of the central fill pharmacy?

Issue 8: Medical Classification Staffing Model BCP

Budget Proposal. The Governor's budget requests the reduction of 148 positions and the approval of the implementation of a new population methodology that will be used to adjust medical staffing based upon patient-inmate acuity and each institution's medical mission. There is no salary savings associated with the reduction in positions. The savings were already captured through the reduction in the prison population due to realignment.

Background. In 2012, the receiver's office informed the Legislature that it was developing a new staffing methodology for inmate medical services. According to the receiver, the new methodology was intended to allocate staff among prisons based on the amount and types of medical services provided at each location. As such, prisons with more inmates with medical needs and higher medical acuity levels would be allocated more medical staff than other prisons. The receiver expected the methodology to significantly reduce the overall number of prison medical staff and result in significant savings.

In order to monitor the receiver's progress in implementing the new staffing methodology, the 2012-13 Budget Act required the receiver to report on the methodology not later than 30 days following its approval by the Department of Finance (DOF). Specifically, the receiver was required to submit to the Legislature a report that includes:

1. Data on the overall number of staff allocated to each of the state prisons, both prior to, and following the implementation of the revised methodology.

2. A detailed description of the methodology used to develop the revised staffing packages.

3. The estimated savings or costs resulting from the revised methodology.

Last Year's Budget Discussions. During the 2013-14 budget subcommittee hearings last spring, the receiver informed the Legislature that he was in the process of implementing the new staffing methodology and that over 800 positions would be eliminated as part of this effort. Beyond that, the receiver has not provided any additional details on the methodology. The receiver also informed the LAO that he did not intend to report to the Legislature (as required by the 2012-13 Budget Act) on the staffing methodology prior to its implementation because it had not been formally submitted to, nor approved by DOF. According to the receiver, the effect of the staffing changes on inmate medical care would be monitored over the next year and if there are no significant negative impacts, a formal budget request would be submitted to DOF in 2014-15.

Legislative Analyst's Office (LAO) Concerns. The receiver's approach of seeking legislative approval of the staffing methodology after implementing it is contrary to the normal state process and circumvents the Legislature's authority to review and approve the proposed changes. The normal state process requires departments to submit major proposed staffing and budgetary changes for legislative review and approval prior to implementation so that the Legislature can ensure the changes are consistent with its priorities and will result in an appropriate expenditure of state funds. If the receiver does not report on the new staffing plan until after it is fully implemented, it will be too late for the Legislature to take different actions if it determines that elements of the new staffing methodology are inconsistent with its priorities or will not achieve a level of savings necessary for the receiver to meet his current- and budget-year reductions.

LAO 2013-14 Budget Recommendation. The LAO recommended that the receiver report at budget hearings on the implementation of the new methodology, including the specific items required in the 2012-13 Budget Act. This would have provided the Legislature with the opportunity to review the receiver's changes and ensure that those changes meet legislative and budgetary priorities.

Questions for the Receiver's Office. The receiver's office should be prepared to present the medical classification staffing model and answer the following question:

1. Please explain your refusal to comply with the reporting requirements adopted by the 2012-13 Budget Act within the specified time frame.

Issue 9: Armstrong Compliance BCP and Spring Finance Letter

Budget Proposal. The Governor's budget requests 42 full-time, permanent positions and $4 million (General Fund) in order to assist in complying with the *Armstrong* Remedial Plan and the requirements of the Americans with Disabilities Act (ADA).

Spring Finance Letter. The Administration submitted a Spring Finance Letter requesting a one-time augmentation of $17.5 million (General Fund) to begin construction of ADA improvements at four prisons and to begin the design phase for improvements at 15 additional institutions.

Background. The federal Americans with Disabilities Act (ADA) provides civil rights protections and equal access to public and private services and facilities for individuals with disabilities. In 1994 a lawsuit, *Armstrong v. Brown*, was filed alleging CDCR was not in compliance with the ADA. In 1999, CDCR negotiated a settlement in the lawsuit and developed the *Armstrong* Remedial Plan (ARP) to address the areas of noncompliance. In 2007, the court issued an injunction because it found CDCR to be in continued violation of the ADA and ARP. In 2012, the court clarified the 2007 injunction, and specified that the receiver's office is also subject to the ARP. In August 2012, the receiver signed a memorandum of understanding (MOU) with the plaintiffs, requiring all medical staff to comply with ARP and all orders from the *Armstrong* court. Based on the outcomes of compliance reviews conducted by CDCR's Office of Audits and Court Compliance, the receiver's office currently has an *Armstrong* compliance percentage of 84 percent, with the goal of obtaining 100 percent compliance.

Currently, the workload associated with the MOU at each prison is being handled by administrative support staff in the inmate medical services program overseen by the receiver. This workload is in addition to their normal responsibilities. The Legislative Analyst's Office notes that three analysts at CDCR headquarters are responsible for reviewing compliance documents and monitoring reports, as well as for developing corrective action plans and ensuring institution compliance with ARP. According to the receiver's office, there have been challenges in carrying out the above activities with existing staff. As a result, some institutions have experienced delays in submitting the required documents or, in some cases, have submitted incomplete documents. In addition, there have also been delays in the reviews conducted by staff at CDCR headquarters.

Legislative Analyst's Office (LAO) Recommendation. The LAO finds that the two sign language interpreter positions proposed by the Governor are justified and recommend the Legislature approve them. However, while they acknowledge that the *Armstrong* MOU has resulted in increased workload for the receiver's office, the LAO is concerned that the other 40 additional positions proposed by the Governor on a permanent basis do not take into account the volume of workload either at a statewide level or at each institution. The LAO is concerned that workload will decline in future years and that approving permanent staff is unnecessary.

Given these concerns, the LAO recommends that the Legislature approve 14 one-year, limited-term positions statewide for the receiver to achieve ARP and ADA compliance. This would provide the receiver with the same compliance staff to total staff ratio that CDCR uses to achieve compliance. They also recommend that the Legislature require the receiver to report this spring at budget hearings on specific workload and performance metrics by institution and statewide. The measures the receiver reports on should include, but not be limited to: performance on the *Armstrong* audit tool, performance on internal audits, volume of staff noncompliance allegations, volume of inquiries and cases closed, progress on corrective action plans, and number of staff training events. This information would allow the Legislature to reassess the appropriate level of staffing as part of its spring budget deliberations. Should the receiver present information that suggests that additional positions are necessary, or that positions should be provided on a permanent basis, the Legislature could modify the level of staffing at that time.