Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 5 Agenda

Senator Loni Hancock, Chair
Senator Joel Anderson
Senator Jim Beall

Thursday, March 12, 2015
9:30 a.m. or Upon Adjournment of Session
State Capitol - Room 113

Consultant: Julie Salley-Gray

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ITEMS TO BE HEARD

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 2014 budget act projected an adult inmate average daily population of 136,530 in the current year. The current year adult inmate population is now projected to decrease by 633 inmates, a 0.5 percent decrease, for a total population of 135,897. The budget year adult inmate population is projected to be 137,002, a 0.8 percent increase of 1,105 inmates over the current year. The current projections also reflect an increase in the parolee population of 1,360 in the current year compared to budget act projections, for a total average daily population of 43,226. The parolee population is projected to be

40,467 in 2015-16, a decrease of 2,759 over the current year. These projections do not include the impact of the passage of Proposition 47, which reduced various felonies to misdemeanors.

As of February 18, 2015, the total in-custody adult population was 131,469. The institution population was 116,556 which constitutes 136.3 percent of prison capacity. The most overcrowded prison is the Central California Women's Facility in Chowchilla which is currently at 167.3 percent of its capacity. For male inmates, Mule Creek State Prison is currently the most overcrowded at 165.9 percent of its capacity.

The Governor's budget proposes total funding of $10.2 billion ($9.9 billion General Fund and $300 million other funds) in 2015-16. This is an increase of approximately $1 billion ($833 million General Fund) over 2013-14 expenditures. The following table shows CDCR's total operational expenditures and positions for 2013-14 through 2015-16.

(dollars in thousands)

Funding	2013-14	2014-15	2015-16
General Fund	$9,156,505	$9,827,940	$9,989,790
General Fund, Prop 98	16,530	18,385	18,635
Other Funds	56,080	67,250	62,329
Reimbursements	167,644	185,074	185,064
Recidivism Reduction Fund	-103,199	25,968	28,227
SCC Performance Incentive Fund	-1000	-1,000	-1,000
Total	$9,292,560	$10,123,617	$10,283,0451
Positions	52,260	60,812	61,579

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. 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 over 11,000 prison health care employees, including doctors, nurses,

pharmacists, psychiatric technicians and administrative staff. Over the last ten years, healthcare costs have risen significantly. The estimated per inmate health care cost for 2015-16 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 $2.4 billion in 2015-16 for 117,217 inmates.

CDCR Historical Health Care Costs Per Inmate

Type of Care	2005-6	2007-08	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Medical	$5,803	$9,721	$10,957	$10,439	$12,525	$12,280	$13,585	$13,845	$14,288
Mental Health	$1,463	$2,802	$2,420	$3,168	$2,621	$2,596	$3,214	$3,304	$3,190
Dental	$313	$916	$1,066	$1,088	$1,127	$1,163	$1,248	$1,266	$1,229
Total	**$7,580**	**$13,349**	**$14,443**	**$14,695**	**$16,273**	**$16,039**	**$18,048**	**$18,415**	**$18,707**

Issue 1: Update on Inmate Medical Care and the Transition Plan

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 discussed 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.

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.

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.

Office of Inspector General (OIG) – Enhanced Medical Inspections. In 2007, the federal receiver, 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.

In the 2014 Budget Act, the OIG received 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 reduced the California Correctional Health Care Services (CCHCS) budget by $645,000 (General Fund) and two positions. The net cost of the proposal was $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. The Inspector General will be providing a detailed update of his medical inspections at a subcommittee hearing later in the spring.

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.
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> ***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

***March 10, 2015 Order Modifying Receivership Transition Plan*.** Earlier this week, the federal court issued an order describing a process for ending the federal receivership.

The order employs the OIG medication inspection reports to determine which institutions are providing a constitutional level of care. Once it is determined by the OIG and the receiver that an inspection shows that an institution is suitable for return to CDCR control, the authority for the healthcare at that institution will be delegated back to the state. Once the institution is returned to the state, the receiver will monitor the state's oversight for one year and at that time, if the quality of care is maintained, the institution will be removed from receivership. Finally, once healthcare in all 34 institutions has been returned to the state and the final year of monitoring is completed, the plaintiffs will have 120 days to file a motion with the court if they do not believe a constitutional level of care is being provided. In the absence of such a motion, the parties are ordered to promptly file a stipulation and proposed order terminating the receivership and the *Plata v. Brown* lawsuit.

It remains unknown, however, how long it will take to transition the responsibility for healthcare for all 34 prisons to the state.

Special Report from the Receiver. Along with the court order issued on March 10, the receiver issued a special report detailing the improvements that have been made over the last decade in the quality of healthcare provided to inmates. In the report, the receiver notes that significant improvement has been made in the quality and delivery of medical care. However, there also remains significant variation in the quality of care at the institution level.

The report found that competent and experienced leadership and staff are now in place at headquarters, in four regional offices, and in all of the institutions. The organizational structure that has been created provides a direct line of authority from headquarters to the individual Chief Executive Officers for Healthcare at the institutions.

The report further found that the state consistently meets, or is within five percent of meeting, statewide process implementation goals such as access to care, population health management, and medication management. The report also notes that there have been significant improvements in recruiting board-certified and appropriately credentialed medical providers.

However, despite progress, the report notes that there is remaining work to be done in for system-wide areas:

- Implementation of an electronic healthcare record that allows for information transferability and access to a patients complete medical history.
- Improvements in scheduling so that primary care physicians' are not overloaded, creating backlogs and delays.
- Addressing remaining shortcomings in chronic care, infection control, information management, and continuity of care.
- Continuing the facility improvements required under the Health Care Facility Improvement Plan (HCFIP).

In addition to system-wide improvements, the report notes that there are roughly three levels of institutions: early adopters that have made substantial improvements and maintain a higher quality of care, institutions that are following behind the early adopters and learning from their implementation and adopting best practices, and a third group that is lagging significantly behind in medical care improvements. The greatest remaining challenge will be improving the care at those lagging institutions.

The report speaks generally of these three categories of institutions but does not specify the number of institutions or which institutions fall into each category. The primary reason the report does not provide specific details is that it lays out a general framework for the transition and does not presume to predetermine what the Inspector General's inspections will find concerning the quality of care provided at each of the 34 state prisons. The Inspector General has scheduled the first 12 inspections:

1. Folsom State Prison (12/8/15)
2. Correctional Training Facility (1/5/15)
3. California Rehabilitation Center (1/26/15
4. California Correctional Center (2/16/15)
5. North Kern State Prison (3/9/15)
6. Chuckawalla Valley State Prison (3/30/15)
7. California State Prison - Solano (4/13/15)
8. Kern Valley State Prison (6/29/15)
9. California Correctional Institution (7/13/15)
10. Pelican Bay State Prison (8/3/15)
11. Valley State Prison (8/24/15)
12. Centinela State Prison (9/7/15)

These prisons were chosen by the receiver's office because their indicators suggest that they are among those institutions that will likely be determined to be early adopters and provide the highest level of care. This does not mean, however, that the receiver has presupposed what the Inspector General's medical inspections will find in terms of the constitutional level of care.

Questions for the Healthcare Receiver. The receiver should be prepared to address the following questions:

1. Please provide a detailed overview of the recent court order and your special report.

2. Please provide an update on the delegation of any additional responsibility from the receiver to CDCR since last spring.

3. 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?

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

5. It has been an on-going concern of the Legislature that there is a problem between the custody staff and medical staff in terms of proper procedures that should be followed when someone is in medical danger. In several incidents, 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?

6. Please provide an update on improvements that have been made as a result of the court-appointed medical experts' inspections. In that update, please provide information on the specific improvements that have been made at the Central California Women's Facility.

7. Given that the CCWF medical evaluation found that 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 the Department. 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 types of specialized training and written policies are provided to CDCR custody staff prior to allowing them to work in a medical unit or with inmate-patients?

Issue 2: California Health Care Facility Staffing

Governor's Proposal. The Governor's budget proposes a General Fund augmentation of $76.4 million, and 714.7 additional clinical positions in 2015-16, to ensure adequate staffing upon full activation of the California Health Care Facility (CHCF) in Stockton, including primary care, nursing, and support staff. (The receiver is also seeking a supplemental appropriation to cover the partial-year cost of the proposed staffing increase in 2014-15.) If the proposed augmentation to CHCF staffing is approved, total clinical staffing costs would increase from about $82 million annually to about $158 million, annually, and staffing levels would increase from 810 positions to 1,525 positions.

Background. 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. It was reported 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. 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 September of 2013, it was not until February of 2014, 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. The CHCF resumed admissions in July 2014, and currently houses about 1,900 inmates.

Legislative Analyst's Office. Given the deficiencies in care identified at CHCF, the LAO recommends the Legislature approve the additional clinical staffing and funding requested. However, they recommend that only a portion of the staff be approved on an ongoing basis and the remainder on a limited–term basis. Specifically, the LAO recommends that the Legislature approve the staffing recommended by the CPS HR

staffing analysis—excluding those staff the receiver found to be unnecessary—on an ongoing basis. This amounts to about $52 million and 515 permanent positions. For the remaining positions not recommended by CPS HR Consulting, they recommend that the Legislature approve them on a one-year, limited-term basis because it is unclear whether all of these positions are necessary. This amounts to about $24 million and 200 limited-term positions.

In order to assess whether the above limited-term positions are necessary on an ongoing basis and whether care can be delivered in a more efficient manner than proposed by the receiver, the LAO recommends that the Legislature require the receiver to contract for an updated staffing analysis for CHCF. This staffing analysis, which would likely cost less than $100,000, should include (1) a review of all positions not recommended by the CPS HR analysis, and (2) whether adequate care can be delivered with fewer positions. As this analysis would be carried out after CHCF is fully activated, it would provide better information on what the ongoing staffing needs of CHCF are than the other reviews conducted to-date. The results of the analysis should be provided to the Legislature in time for its consideration of the 2016-17 budget.

Questions for the Healthcare Receiver. The receiver should be prepared to address the following questions:

1. The budget proposal requests approximately 150 more positions than the CPS staffing analysis calls for (583 in the analysis and 714.7 in the budget proposal). Please explain the reason for the disparity and why the scope of the analysis did not include a comprehensive assessment of staffing needs for CHCF.

Issue 3: Workforce Development – Clinician Recruitment and Retention

Governor's Proposal. The Governor's budget proposes $872,000 from the General Fund, and 8 positions, to build an internal recruitment and retention program designed to recruit and retain clinicians and other medical personnel.

Background. In 2007, the Plata Workforce Development Unit was created in response to a court order requiring the receiver to develop a detailed plan designed to improve prison medical care. The unit consisted of 40 positions dedicated to the recruitment and retention of positions within the medical program deemed critical to providing a constitutional level of medical care. The goal was met in 2010 and the positions were shifted to other healthcare improvement priorities.

A subsequent federal court order on March 27, 2014, requires CHCS to report on recruitment and retention in their tri-annual reports in order to ensure that healthcare facilities do not dip below a 10 percent vacancy rate. The latest recruitment and retention report submitted in January 2015, show that 18 prisons currently have a vacancy rate of less than 10 percent, including remote prisons such as Pelican Bay in Crescent City and Ironwood and Chuckawalla Valley prisons in Blythe. Another 13 prisons have a vacancy rate for physicians between 10 and 30 percent. Finally, two prisons, North Kern Valley and Salinas Valley, have a physician vacancy rate in excess of 30 percent. Given the vacancy patterns and the fact that in several instances, there is a disparity in the ability to recruit and retain adequate staff between prisons that are in very close proximity. For example, North Kern State Prison has at least a 30 percent vacancy rate for physicians, while neighboring Wasco State Prison has a physician vacancy rate of less than 10 percent. Similar examples can be seen throughout the report. This would suggest that geography or remoteness of institutions is not the reason for high turnover or high vacancies, rather something in the working conditions, culture or the running of the institution itself may be causing the difficulties in recruiting or retaining clinicians.

Legislative Analyst's Office. The LAO does not have a recommendation pertaining to this budget proposal.

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

1. What can you tell us about the disparity in vacancy rates and retention, given that the patterns would suggest that the problem is not geographical remoteness?

2. Do conditions in some prison lead to a high rate of turnover or medical personnel being unwilling to work in certain institutions? How do you envision your recruitment and retention staff solving this problem?

3. What authority will they have to improve working conditions in institutions?

4. What is your proposed timeline for showing improvements in recruitment and retention, especially at those facilities with vacancy rates higher than 30 percent?

5. The Legislature hears regularly from psychiatric technicians who appear to be understaffed and are being required to work a significant amount of mandatory overtime. Can you please address the concerns raised by psychiatric technicians and update the committee on efforts that have been put in place to investigate these concerns and ensure that there is adequate psychiatric technician staffing in all facilities?

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

1. Committee staff have been told that in December of last year five psychiatric technicians were hired to work in the administrative segregation unit at Avenal State Prison. Less than 60 days later, the unit staff received a notice that the segregation unit would be shut down in 45 days. Can you please explain why positions were filled in a unit that was scheduled to be shut down and what procedures you and the receiver have in place to make sure you are not working at cross purposes in filling vacancies?

Issue 4: Quality Management Proposal

Governor's Proposal. The Governor's budget proposes $4.9 million from the General Fund, and 30 positions, to expand the receiver's quality management efforts in 2015-16. Of the additional staff being requested, 20 positions are to develop quality management programs in the receiver's new regional offices. Regional staff would be responsible for overseeing prisons located within their geographic area of responsibility. Similar to existing quality management staff, these requested staff would be responsible for tracking prison performance, identifying areas where medical care is deficient, developing performance improvement plans, and sharing best practices across prisons.

Background. In June 2008, the federal court approved the receiver's "Turnaround Plan of Action" to achieve a sustainable constitutional level of medical care. The plan identified six major goals for the state's inmate medical care program, including specific objectives and actions for each goal. One of the identified goals was to implement a quality assurance and continuous improvement program to (1) track prison performance on a variety of measures (such as access to care), (2) provide some training and remedial planning (for example, developing a plan to improve access to care at a prison that is struggling to meet that goal), and (3) share best practices across prisons, among other tasks.

Currently, the quality management section within the receiver's office has 32 positions and a budget of $3.9 million. In addition, there are also 170 staff statewide (5 positions at each prison) who are involved in quality management activities. These staff include psychologists, managers, and program specialists who perform quality management functions as well as other responsibilities. According to CHCS, about 90 percent of their time is devoted to quality management activities.

Legislative Analyst's Office. In 2012, the receiver contracted with Health Management Associates (HMA) for a review of the structure of the receiver's office. In February 2013, HMA released its analysis and recommendations. The analysis recommended several changes to the receiver's quality management section, including reassigning many of the staff to other activities. According to HMA, the size of the quality management section in the receiver's office far exceeded that in any other prison or health care system of a similar scale. At the time HMA found the quality management section to be overstaffed, it had 24 staff. Under the Governor's proposal, the section would have 62 staff. This does not include the 170 additional staff that spend a majority of their time on quality management activities at the state's 34 prisons.

Private health insurance plans generally spend about 0.7 percent of their budget on quality management activities. Currently, the receiver's office spends about 0.25 percent of their budget on the headquarters quality management section. However, including the prison–level quality management staff, the receiver's office currently spends about 1.3 percent of their budget on quality management—more than double the spending of private health plans. If the Governor's proposal was approved, the receiver's office would spend about 1.6 percent of its budget on quality management.

Given that the receiver's quality management section was found to be unnecessarily large in an independent assessment and is already larger than the community standard, the LAO finds no compelling reason at this time to expand the receiver's quality management staff. Thus, they recommend the Legislature reject the Governor's proposal.

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

1. Please respond to the LAO's concerns about the size of your quality management staff in light of the findings of your own HMA-contracted study released in 2013.

Issue 5: Valley Fever Testing

Governor's Proposal. The Receiver spent $5.4 million on sufficient supplies to test 90,000 inmates for Valley Fever. On January 12, 2015, the tests were administered to roughly 30,000 consenting inmates. The Receiver is seeking a supplemental appropriation in the current year to cover the costs of the medical supplies already purchased. In the future, the Receiver will administer Valley Fever skin tests to all new inmates entering the prison system who are eligible for placement at ASP and PVSP. The Receiver anticipates that savings from not treating Valley Fever in the future would offset future testing costs.

Background. Between 2008 and the early months of 2015, ,734 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 appeared 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.

Valley Fever is a disease caused by inhaling fungal spores found in the soil in many areas of California. Most people who get Valley Fever have few or no symptoms, but some individuals can experience severe symptoms similar to flu or pneumonia or even die. Once an individual has Valley Fever he or she cannot get it again. The fungal spores that can cause Valley Fever are particularly common in the areas surrounding Pleasant Valley State Prison (PVSP) in Coalinga and Avenal State Prison (ASP). During the 2013-14 fiscal year, 942 inmates were diagnosed with Valley Fever.

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.

In April 2013, the Receiver requested assistance from the federal Centers for Disease Control and Prevention (CDC) in reducing the number of Valley Fever cases. In July 2014, the CDC recommended several options for the Receiver to consider. For example, the CDC recommended excluding from placement at ASP and PVSP inmates who do not have Valley Fever. Under this policy, inmates who test negative for Valley Fever would be excluded from placement at ASP or PVSP, while inmates who test positive would be eligible to be housed at ASP or PVSP. The rationale is that excluding inmates who test negative from placement at ASP or PVSP could eventually reduce Valley Fever cases by about 60 percent, as such exclusion would reduce their likelihood of obtaining Valley Fever. The testing protocol will replace the current protocol that excludes inmates with certain respiratory conditions, inmates of African American and Filipino descent, and inmates with diabetes from being housed at both ASP and PVSP.

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.

Legislative Analyst's Office. According to the receiver, the potential reduction in the number of inmates with Valley Fever will likely generate some medical care–related savings in 2015–16 and thereafter. However, the Governor's budget does not reflect any potential savings. Given that the receiver spends $23 million on Valley Fever treatment each year and the CDC estimates that its recommendations could decrease Valley Fever cases by 60 percent, the receiver could eventually see a reduction in treatment costs of around $14 million annually within a few years. Though the proposal indicates that savings could be used to fund ongoing testing, such testing is only estimated to cost a couple million dollars annually. In addition, the receiver used only about one–third of testing supplies it purchased. According to the receiver's office, they will use those tests for their ongoing testing, which would reduce the ongoing costs associated with Valley Fever in the budget year. Despite these considerations, the administration has not provided information on how any additional savings would be used.

We do not have concerns with the receiver having tested inmates for Valley Fever in January of this year. However, the LAO is concerned that the Governor's proposal does not account for all the savings associated with implementing an ongoing Valley Fever testing process. Accordingly, they recommend that the Legislature request that the receiver report at budget hearings this spring on (1) the amount of annual savings from reductions in the number of inmates with Valley Fever and (2) how he plans to account for these savings in the budget year and on an ongoing basis. This would ensure the Legislature has sufficient oversight of the receiver's budget, and that any savings as a result of Valley Fever testing are spent in a way that is consistent with the Legislature's priorities.

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

1. Please provide an update on the testing process including the number of inmates tested, the results of those tests, and the accuracy of the test.

2. The subcommittee had extension conversations with your office last year on Valley Fever. At no point was broader testing mentioned. When did you decide to take this step to test every prisoner and why did you wait until January to inform the administration and the Legislature?

3. Please address the concerns raised by the LAO analysis, particularly, why your proposed budget does not assume any reduced health care costs as a result of the widespread testing.

4. 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.

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

6. Will this testing change the number of inmates who are being redirected to prisons outside of the exclusion area?

7. The exclusion area encompasses eight prisons. However, the deficiency request only mentions two of the eight prisons. Have you changed the exclusion area to only include Avenal State Prison and Pleasant Valley State Prison?