Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 5 Agenda

Senator Loni Hancock, Chair
Senator Joel Anderson
Senator Jim Beall

Thursday, March 17, 2016
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 CALIFORNIA CORRECTIONAL HEALTHCARE 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 34 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 ($21,815) is almost three times the cost for 2005-06 ($7,668). 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 approximately $2.8 billion in 2016-17 for 128,834 inmates. Of that amount, $1.9 billion is dedicated to prison medical care under the oversight of the receivership.

CDCR Historical Health Care Costs Per Inmate

Program	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Medical	$10,841	$12,917	$12,591	$13,661	$15,496	$16,843
Dental	$1,094	$1,128	$1,165	$1,247	$1,311	$1,378
Mental Health	$2,806	$2,236	$2,279	$2,587	$2,990	$3,594
Total Health Care	**$14,740**	**$16,281**	**$16,035**	**$17,496**	**$19,796**	**$21,815**

Issue 1: Update on Healthcare Transition

Governor's Budget. The budget includes $1.9 billion General Fund for prison medical care. At the request of the receiver, this amount includes $26.8 million for increased pharmaceutical costs, $12.1 million to expand janitorial services at the California Health Care Facility in Stockton, and $11.9 million to establish executive healthcare management teams at prisons that currently share management oversite and create supervisory ratios for certain healthcare classifications. The Administration notes that these augmentations support the transition of medical care back to the state.

Background. On June 30, 2005, the United States District Court ruled in the case of *Marciano Plata, et al v. Arnold Schwarzenegger* 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.*

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 450,000 inmates per month have medical appointments and the rate of preventable deaths has dropped 54 percent since 2006 (from 38.5 per 100,000 inmates in 2006 to 17.7 per 100,000 inmates in 2014).

Chief Executive Officers for Health Care. Each of California's 34 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 executives consistently oversee the same institutions on a regional basis. The four regions are as follows:

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.

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.

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.

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.

Office of Inspector General (OIG) – 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.

Previous Budget Action. The 2015-16 budget provided $3.9 million and 19 additional positions to allow the Office of the Inspector General (OIG) to annually evaluate the quality of medical care provided to inmates in all of the California Department of Corrections and Rehabilitation (CDCR) adult institutions. The medical inspections staff increase included:

- Three Analysts
- Three Nursing Consultants
- Three Physicians
- Nine Registered Nurses
- One Nursing Supervisor

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

Process for Delegating Responsibility to State. In March 2015, the Plata court issued an order outlining the process for transitioning responsibility for inmate medical care back to the state. Under the order, responsibility for each institution, as well as overall statewide management of inmate medical care, must be delegated back to the state. The court indicates that, once these separate delegations have occurred and CDCR has been able to maintain the quality of care for one year, the receivership would end.

The federal court order outlines a specific process for delegating care at each institution back to the state. Specifically, each institution must first be inspected by the Office of the Inspector General (OIG) to determine whether the institution is delivering an adequate level of care. The receiver then uses the results of the OIG inspection—regardless of whether the OIG declared the institution adequate or inadequate—along with other health care indicators, including those published on each institution's Health Care Services Dashboard, to determine whether the level of care is sufficient to be delegated back to CDCR. To date, the OIG has completed inspections for 13 institutions and has found nine to be adequate and four to be inadequate.

As of March 11, 2016, the receiver has delegated care at Folsom State Prison and the Correctional Training Facility at Soledad back to CDCR. The receiver is currently in the process of determining whether to delegate care at the other institutions that have been found adequate by the OIG. In addition, the receiver could also delegate care at the four prisons deemed inadequate by the OIG if care has been found to have improved. The OIG plans to complete medical inspections for the remaining institutions by the end of 2016. The process for delegating the responsibility for headquarters functions related to medical care does not require an OIG inspection. Under the court order, the receiver only has to determine that CDCR can adequately carry out these functions.

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

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

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. It has been a concern of the Legislature that there is on-going tension 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 in recent years, 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? Have you seen a change in the way that medical staff and custody staff are interacting?

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

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?

3. The Department of State Hospitals uses medical technical assistants (MTA) instead of correctional officers to provide custody in their psychiatric inpatient programs. Does CDCR use MTAs to provide custody for inmates with significant medical or mental health needs? If not, why not?

Issue 2: California Health Care Facility – Stockton Janitorial Services

Governor's Budget. The budget proposes five positions and $6.4 million General Fund in the current year, and $12 million General Fund in the budget year, to contract with PRIDE Industries to provide janitorial services for the California Healthcare Facility (CHCF) in Stockton.

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, prisoners with mental illnesses, and prisoners with chronic medical conditions who need on-going care. The CHCF resumed admissions in July 2014, and currently houses about 2,200 inmates.

PRIDE Industries. PRIDE is a non-profit organization operating in 14 states that employs and serves over 5,300 people, including more than 2,900 people with disabilities.

Previous Budget Actions. The 2015-16 budget included a General Fund augmentation of $76.4 million, and 714.7 additional clinical positions to increase staffing at CHCF, including primary care, nursing, and support staff. The receiver is also received a supplemental appropriation to cover the partial-year cost of the proposed staffing increase in 2014-15. With the augmentation to CHCF, total clinical staffing costs increased from about $82 million annually to about $158 million, annually, and staffing levels increased from 810 positions to 1,525 positions.

The 2014-15 budget included a General Fund augmentation of $12.5 million General Fund to increase staffing at CHCF to address problems raised by the federal healthcare receiver around plant operations, food services, and custody staffing.

Legislative Analyst's Office (LAO). The LAO did not raise any concerns with this proposal.

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

1. Please describe the various alternatives you considered prior to entering into the contract with PRIDE Industries, including using state employees or the current CalPIA training program.

2. Concerns have been expressed about bringing potentially vulnerable individuals into a work environment that will require them to interact with individuals who perhaps have a history of manipulating, victimizing and preying on people. Please describe the steps PRIDE Industries, CDCR and the receiver's office are taking to ensure that CHCF will be a safe place to work for PRIDE employees.

Issue 3: Healthcare Supervisory Positions

Governor's Budget. The Governor's budget proposes a $12 million General Fund augmentation and 68.6 additional positions to increase health care executive and supervisory staffing levels throughout the prison system.

Background. In 2014-15, the receiver adopted a medical classification staffing model (MCM) which is a new population methodology that is now used to adjust medical staffing based upon patient-inmate acuity and each institution's medical mission. That staffing model, however, did not include any adjustments in the supervisory classifications that are necessary to carry out the administrative functions of the healthcare facility.

In an effort to control costs, the first healthcare receiver implemented a sister institution structure for several prisons. While most institutions have their own health care executive management teams, there are 16 sister institutions—eight pairs of prisons that are very near to one another—that share health care executive management teams. The following are the current institution pairings:

- High Desert State Prison and the California Correctional Center
- Central California Women's Facility and Valley State Prison
- California Institution for Women and California Rehabilitation Center
- Avenal State Prison and Pleasant Valley State Prison
- Calipatria State Prison and Centinela State Prison
- California Correctional Institution and California City Correctional Facility
- Chuckawalla Valley State Prison and Ironwood State Prison
- Deuel Vocational Institution and Sierra Conservation Center

Previous Budget Actions. As noted above, in the 2014-15 budget, the Legislature approved a new healthcare staffing model which included the reduction of 148 positions and the approval of the implementation of the MCM.

Legislative Analyst's Office. The LAO recommends that the Legislature reject the Governor's proposal to provide a $6 million augmentation in 2016-17 to provide for a separate executive management team at each institution, as such separate teams do not appear to be necessary in order to deliver a constitutional level of care.

While the LAO recognizes the need to transition control of inmate medical care back to the state in a timely manner, their analysis indicates that the need for each of the 16 sister institutions to have its own executive management team has not been justified.

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

1. Please address the LAO's findings that institutions that are sharing an executive team have been found to be providing a constitutional level of care. Why do you believe it is necessary at this time to require each institution to have its own, separate team?

Issue 4: Increased Pharmaceutical Costs

Governor's Budget. The proposed budget includes $20 million General Fund in 2015-16 and $27 million General Fund in 2016-17 and on-going to address shortfalls in pharmaceutical funding caused by increasing drug costs, the implementation of the Electronic Health Record System (EHRS) and the implementation of the Women's Health Care Initiative (WHCI). The specific components driving the increase are as follows:

- Pharmaceutical cost increases — $27.6 million in 2015-16 and $35.5 million in 2016-17.
- Implementation of the pharmacy program in EHRS — $7.5 million in 2015-16 and $5.5 million in 2016-17.
- Women's Health Care Initiative — $632,000 beginning in 2016-17.
- Hepatitis C Treatment Savings — $15 million in 2015-16 and 2016-17.

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 2014-15, the inmate pharmaceutical budget increased from $136 million to $236 million. (The pharmaceutical budget reflects only the cost of pharmaceuticals and not the cost of medication distribution or management.) According to information provided by the LAO, the level of spending on pharmaceuticals per inmate has also increased over this time period, increasing from $860 in 2004-05 to $2,000 by 2014-15, an increase of over 130 percent.

Women's Health Care Initiative. Recently, CCHCS established a Women's Health Care Initiative that is responsible for insuring that the health care of incarcerated female patients meets community standards. Among other findings, it was determined that family planning services at the California Institution for Women, the Central California Women's Facility and the newly established Folsom Women's Facility needed enhancements. As a result, part of the pharmaceutical budget will now include funding for birth control/contraception services for female patients who would benefit from their use. Effective use of family planning services will reduce the risks of unwanted pregnancies as a result of conjugal visits, as well as providing services for women nearing parole who are seeking assistance.

Previous Budget Actions. Last year's budget included a one-time General Fund augmentation of $18.4 million in 2014-15 for unanticipated increases in the pharmaceutical budget. In addition, the budget included a General Fund increase of $51.8 million in 2014-15, and $60.6 million in 2015-16, for the cost of providing inmates with new Hepatitis C treatments.

Legislative Analyst's Office. An independently verified source to determine how pharmaceutical prices have changed, or are likely to change in the future, is an appropriate method to use when determining whether adjustments in the pharmaceutical budget are necessary. Accordingly, using the pharmaceutical consumer price index (CPI) for estimating future increases in pharmaceutical costs seems reasonable. However, the receiver proposes using past-year changes in the pharmaceutical CPI to estimate future-year changes, rather than relying on available projections of how the pharmaceutical CPI is actually expected to change. Using pharmaceutical CPI projections is preferable as it may account for changes in the market that are not reflected in the past–year values of the index. For example, pharmaceutical CPI projections for 2015-16 and 2016-17 are lower than the 4.9 percent

growth assumed by the receiver. Specifically, projections of the pharmaceutical CPI suggest that prices will only increase by 3.8 percent in 2015–16 and by 3.3 percent in 2016–17. Accordingly, these projections suggest that the pharmaceutical budget requires $1.7 million less than proposed by the Governor in 2015–16 and $4.3 million less in 2016–17.

In view of the above, LAO recommends that the Legislature approve increases to the inmate pharmaceutical budget based on projections for the pharmaceutical CPI in 2015–16 and 2016–17. However, in order to determine the appropriate adjustments, they recommend the Legislature hold off on taking such action until the receiver provides additional information. Specifically, the receiver should provide by April 1 (1) an updated estimate of current–year monthly pharmaceutical expenditures, and (2) an updated estimate of the pharmaceutical CPI for the remainder of the current–year and the budget–year based on the most recent projections available.

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

1. Please respond to the LAO recommendation and explain why the current methodology does not rely on available CPI projections for pharmaceutical costs and instead relies on past changes.

Issue 5: Recruitment and Retention/Student Loan Repayment Program

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.

Availability of Student Loan Repayment Programs to Assist in Attracting Medical Staff. The receiver's workforce development unit has relied on tools such as the Federal Loan Repayment Program (FLRP) which provides physicians with federal funding to pay student loan debts in exchange for working in a federal-designated health professional shortage area. The state's prisons are often included in those designated areas. However, since 2012 FLRP funding has been reduced and fewer programs meet the requirements as a designated health professional shortage area. CCHCS notes that the number of employees receiving funding through FLRP (mostly psychiatrists) has decreased from 231 participants in 2012 to 36 participants in 2015, an 84 percent decrease.

Previous Budget Actions. The 2015 budget act included $872,000 from the General Fund, and eight positions, to build an internal recruitment and retention program designed to recruit and retain clinicians and other medical personnel.

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

1. The 2015-16 budget included funding to allow the receiver to increase clinician recruitment activities. Please provide an update on that effort.

2. The subcommittee held a joint hearing with the Senate Committee on Public Safety on March 15, 2016, to explore ways in which CDCR can better train and support staff working in the state's prisons. Specifically, the both committees would like to ensure that custody staff and others working in highly stressful and often volatile environment are provided with the tools they need to successfully navigate often complicated and difficult interactions with inmates. Similarly, the

medical staff in the institutions must often deal with difficult and stressful situations. Has your office considered ways in which training and other supports may need to be expanded to ensure the best environment for both the medial employees and the patients in their care?

5225 CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

Issue 1: Physician and Licensed Vocational Nurse Coverage

Governor's Budget. The budget proposes $2 million General Fund beginning in 2016-17 to provide additional medical coverage at the in-state contract facilities, as required by the federal receiver's office.

Background. The *Plata v. Brown* lawsuit requires that the state provide a constitutional level of care for all inmates in the state's prison system. While the receivership has been primarily focused on improving care at the 34 state-run institutions, the receiver has required that inmates housed in the in state contract facilities must receive a level of care that is consistent with the medical care provided to all patients housed within CDCR.

Legislative Analyst's Office. The LAO has not raised any concerns with this budget request.

Issue 2: Access to Healthcare

Governor's Budget. The Governor's budget requests$9.4 million General Fund and 78.4 positions in 2016-17, $11.8 million General Fund and 98.7 positions in 2017-18, and $12.2 million General Fund and 102 positions in 2018-19 and ongoing, for increased staffing needs related to the Health Care Facility Improvement Program (HCFIP), triage and treatment areas/correctional treatment centers, and the heating, ventilation, and air conditioning system replacement at Ironwood State Prison.

All but five of the positions requested are for additional correctional officers. Sixty one of the new positions will be providing security for new or expanded primary care clinics at 23 institutions. The 36 remaining correctional officer positions will provide security at the triage and treatment areas or correctional treatment centers at 18 institutions. The standardized staffing model used by CDCR to determine staffing needs is based upon changes to the physical layout of a prison or changes in activities, rather than being based on the number of inmates housed in an institution. Therefore, despite a declining inmate population, the need for security staff is increasing.

The remaining five positions are for the stationary engineers due to the increased workload resulting from the construction of a new chilled water plant at Ironwood State Prison.

Background

Health Care Facility Improvement Program (HCFIP). As discussed in previous agenda items, the healthcare receivership was established by U.S. District Court Judge Thelton E. Henderson as the result of a 2001 class-action lawsuit (*Plata v. Brown*) against the State of California over the quality of medical care in the State's then 33 prisons. The court found that the medical care was a violation of the Eighth Amendment of the U.S. Constitution, which forbids cruel and unusual punishment. The state settled the suit in 2002, and in June 2005, Judge Henderson established a receivership for prison medical care. A major component of the receiver's "Turnaround Plan of Action" includes HCFIP.

The goal of HCFIP is to provide a facilities infrastructure within the CDCR institutions. This allows timely, competent, and effective health care delivery system with appropriate health care diagnostics, treatment, medication distribution, and access to care for individuals incarcerated within the CDCR. The existing health facilities, constructed between 1852 and the 1990s, were deficient and did not meet current health care standards, public health requirements and current building codes. The facilities also served a population that was greater in number than when it was originally built. These conditions were one of the conditions leading to the *Plata v. Brown* lawsuit.

Healthcare Access Unit (HCAU). Health Care Access Units (HCAU) 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.

On October 26, 2012, delegation of the HCAUs was turned over to the secretary of CDCR. Upon the effective date of the delegation, the secretary assumed control of the HCAU. Because standardized staffing was implemented prior to the delegation of HCAU positions being turned over to the CDCR's direct control, the CDCR did not include HCAU posts in the reviews and standardization of custody

health care positions. The Division of Adult Institutions, working collaboratively with the California Correctional Health Care Services, has identified 18 institutions with custody staffing deficiencies within the triage and treatment areas and correctional treatment centers.

Standardized Staffing. In the 2012 Blueprint, CDCR established a standardized staffing model at the adult institutions to achieve budgetary savings and improve efficiency in operations. Prior to standardized staffing, the department's budget was adjusted on a 6:1 inmate-to-staff ratio based on changes in the inmate population—for every six inmates, the department received or reduced the equivalent of one position. These staffing adjustments occurred even with minor fluctuations in population and resulted in staffing inconsistencies among adult institutions. The prior staffing model allowed local institutions to have more autonomy in how budgeted staffing changes were made. The standardized staffing model provides consistent staffing across institutions with similar physical plant/design and inmate populations. The model also clearly delineates correctional staff that provide access to other important activities, such as rehabilitative programs and inmate health care. The concept that an institution could reduce correctional staff for marginal changes in the inmate population was not valid without further detriment to an institution's operations. Therefore, the standardized staffing model was established to maintain the staff needed for a functional prison system.

According to the Administration, given the significant population reductions expected as a result of realignment, using the CDCR's ratio-based adjustment would have resulted in a shortage of staff and prison operations would have been disrupted. The Administration argues that a standardized methodology for budgeting and staffing the prison system was necessary to provide a staffing model that could respond to fluctuations in the population and allow for the safe and secure operation of housing units at each prison regardless of minor population changes.

Legislative Analyst's Office. The LAO recommends that the Legislature reduce the Governor's proposal to provide $524,000 for maintenance of the new central chiller system at Ironwood State Prison (ISP) by $275,000 to reflect savings available from eliminating maintenance on the pre-existing cooling system.

Issue 3: Segregated Housing Unit Conversion

Governor's Budget. The Governor's budget proposes to reduce General Fund support for CDCR by $16 million in 2015–16 and by $28 million in 2016–17 to account for savings from a reduction in the number of inmates housed in segregated housing units. According to the department, the policy changes it is implementing pursuant to the *Ashker v. Brown* settlement will reduce the number of inmates held in ASUs and SHUs, allowing it to convert several of these units to less expensive general population housing units. For example, CDCR estimates that the number of inmates held in SHUs could decline by around 1,000, or about one–third of the current population.

In addition, the Administration requests $3.4 million General fund for 2015-16 and $5.8 million General Fund for 2016-17 to increase the number of staff in the Investigative Services Unit (ISU), which would offset the above 2016–17 savings. The redirected funding would support the addition of 48 correctional officers to the ISU, an increase of 18 percent. According to the Administration, these positions are needed to handle workload from an anticipated increase in gang activity related to the new segregated housing policies. Specifically, the department plans to use the additional positions to monitor the activities of gang members released to the general population. The department is requesting 22 of the proposed positions be approved on a two-year, limited-term basis because it has not yet determined the exact amount of ongoing workload associated with the segregated housing policy changes.

Background. CDCR currently operates different types of celled segregated housing units that are used to hold inmates separate from the general prison population. These segregated housing units include:

> ***Administrative Segregation Units (ASUs).*** ASUs are intended to be temporary placements for inmates who, for a variety of reasons, constitute a threat to the security of the institution or the safety of staff and inmates. Typically, ASUs house inmates who participate in prison violence or commit other offenses in prison.
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> ***Security Housing Units (SHUs).*** SHUs are used to house for an extended period inmates who CDCR considers to be the greatest threat to the safety and security of the institution. Historically, department regulations have allowed two types of inmates to be housed in SHUs: (1) inmates sentenced to determinate SHU terms for committing serious offenses in prison (such as assault or possession of a weapon) and (2) inmates sentenced to indeterminate SHU terms because they have been identified as prison gang members. (As discussed below, changes were recently made to CDCR's regulations as a result of a legal settlement.)

Segregated housing units are typically more expensive to operate than general population housing units. This is because, unlike the general population, inmates in segregated housing units receive their meals and medication in their cells, which requires additional staff. In addition, custody staff are required to escort inmates in segregated housing when they are temporarily removed from their cells, such as for a medical appointment.

Ashker v. Brown. In 2015, CDCR settled a class action lawsuit, known as *Ashker v. Brown*, related to the department's use of segregated housing. The terms of the settlement include significant changes to many aspects of CDCR's segregated housing unit policies. For example, inmates can no longer be

placed in the SHU simply because they are gang members. Instead, inmates can only be placed in the SHU if they are convicted of one of the specified SHU-eligible offenses following a disciplinary due process hearing. In addition, the department will no longer impose indeterminate SHU sentences. The department has also made changes in its step-down program to allow inmates to transition from segregated housing (including SHUs and ASUs) to the general population more quickly than before.

Investigative Services Unit (ISU). CDCR currently operates an ISU consisting of 263 correctional officer positions located across the 35 state–operated prisons. Correctional officers who are assigned to the ISU receive specialized training in investigation practices. These staff are responsible for various investigative functions such as monitoring the activities of prison gangs and investigating assaults on inmates and staff.

Legislative Analyst's Office (LAO)

Proposed ISU Staffing Increase Lacks Detailed Workload Analysis. While the LAO acknowledges that the new segregated housing policies may drive some increased workload for the ISU, the department has not established a clear nexus between the policy changes and the increased workload. In particular, the department has been unable to provide a detailed analysis which indicates the specific workload increases that will result from the policy changes and how it was determined that 48 is the correct number of staff to handle this increased workload. Without this information it is difficult for the Legislature to assess the need for the requested positions.

Other Factors Have Impacted ISU Workload in Recent Years. There are a variety of factors that drive workload for the ISU, such as the number of violent incidences occurring in the prisons. It appears that a couple of these key factors have declined in recent years. First, the number of inmates in CDCR-operated prisons has decreased from about 124,000 in 2012-13 to a projected level of about 117,000 in 2015-16. Second, the number of assaults on inmates and staff has decreased from about 8,500 in 2012-13 to about 1,200 in 2014-15. Accordingly, the ISU now has fewer inmates to monitor and fewer assaults to investigate. Despite these developments, correctional officer staffing for the ISU has actually increased slightly from 253 officers in 2012-13 to 263 officers in 2014-15. This raises the question of whether any increased workload for the ISU resulting from segregated housing policy is offset by other workload decreases in recent years, meaning that potential workload increases could be accommodated with existing resources.

LAO Recommendation. The LAO recommends that the Legislature reject the Administration's proposal for $5.8 million to fund increased staffing for the ISU because the proposal lacks sufficient workload justification, particularly in light of recent declines in other ISU workload.

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

1. Please provide an update on the SHU conversion. Have all inmates with indeterminate SHU terms been released?

2. Is CDCR providing any specialized programming to assist inmates who have served long SHU terms as the reintegrate back into the general prison population?

3. Please provide information on any problems that have arisen as a result of inmates being reintegrated back into the general population.

Issue 4: Alternative Housing for Inmates

Governor's Budget

Conservation Camps. The budget does not propose any changes or expansions to the budget for the 44 conservation camps, and the budget proposes a combined CDCR/CalFIRE annual camp budget of approximately $200 million General Fund.

Male Community Reentry Program (MCRP). The Governor's budget proposes $32 million (General Fund) in 2016–17 and $34 million in 2017–18 to expand the MCRP. The 2016–17 appropriation includes $20 million to support existing contracts and $12 million to expand the program. The proposed augmentation would allow CDCR to contract with four additional facilities—three in Los Angeles County and one in San Diego County—to provide an additional 460 beds. In addition, CDCR proposes to increase the amount of time participants can spend in the program from 120 days to 180 days.

Custody to Community Transitional Re-Entry Programs (CCTRP) for Women. The proposed budget includes an increase of $390,000 General Fund on-going to expand both their San Diego CCTRP and Santa Fe Springs CCTRP by an additional 36 beds each.

Alternative Custody Program. The proposed budget includes an increase of $3.3 million General Fund and 20 positions in 2015-16 and $6 million General Fund and 40 positions in 2016-17 and on-going for the workload associated with implementing a 12-month Alternative Custody Program for male inmates as is required by the *Sassman v. Brown* judgement.

Background. For decades, the state's prison system has included alternative types of housing for certain low-risk inmates. Among these programs are the following:

> ***Conservation (Fire) Camps —*** The Conservation Camp Program was initiated by CDCR to provide able-bodied inmates the opportunity to work on meaningful projects throughout the state. The CDCR road camps were established in 1915. During World War II much of the work force that was used by the Division of Forestry (now known as CalFIRE), was depleted. The CDCR provided the needed work force by having inmates occupy "temporary camps" to augment the regular firefighting forces. There were 41 "interim camps" during WWII, which were the foundation for the network of camps in operation today. In 1946, the Rainbow Conservation Camp was opened as the first permanent male conservation camp. Rainbow made history again when it converted to a female camp in 1983. The Los Angeles County Fire Department (LAC), in contract with the CDCR, opened five camps in Los Angeles County in the 1980's.
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> There are 43 conservation camps for adult offenders and one camp for juvenile offenders. Three of the adult offender camps house female fire fighters. Thirty-nine adult camps and the juvenile offender camp are jointly managed by CDCR and CalFIRE. Five of the camps are jointly managed with the Los Angeles County Fire Department.

The conservation camps, which are located in 29 counties, can house up to 4,522 adult inmates and 80 juveniles, which make up approximately 219 fire-fighting crews. A typical camp houses five 17-member fire-fighting crews as well as inmates who provide support services. As of March 9, 2016, there were 3,554 inmates living and working in the camps.

The Male Community Reentry Program (MCRP) — MCRP is designed to provide or arrange linkage to a range of community-based, rehabilitative services that assist with substance use disorders, mental health care, medical care, employment, education, housing, family reunification, and social support. The MCRP is designed to help participants successfully reenter the community from prison and reduce recidivism.

The MCRP is a voluntary program for male inmates who have approximately 120 days left to serve. The MCRP allow eligible inmates committed to state prison to serve the end of their sentences in the community in lieu of confinement in state prison.

The MCRP is a Department of Health Care Services-licensed alcohol or other drug treatment facility with on-site, 24-hour supervision. Participants are supervised by on-site correctional staff in combination with facility contracted staff.

As of March 9, 2016, there were 137 male inmates in the MCRP.

The Custody to Community Transitional Reentry Program (CCTRP) — CCTRP allows eligible inmates with serious and violent crimes committed to state prison to serve their sentence in the community in the CCTRP, as designated by the department, in lieu of confinement in state prison and at the discretion of the secretary. CCTRP provides a range of rehabilitative services that assist with alcohol and drug recovery, employment, education, housing, family reunification, and social support.

CCTRP participants remain under the jurisdiction of the CDCR and will be supervised by the on-site correctional staff while in the community. Under CCTRP, one day of participation counts as one day of incarceration in state prison, and participants in the program are also eligible to receive any sentence reductions that they would have received had they served their sentence in state prison. Participants may be returned to an institution to serve the remainder of their term at any time.

As of March 9, 2016, there were 235 female inmates in the CCTRP.

Alternative Custody Program (ACP) — In 2010, Senate Bill 1266 (Liu), Chapter 644, Statutes of 2010, established the ACP program within the CDCR. The program was subsequently expanded in 2012 by SB 1021 (Committee on Budget and Fiscal Review), Chapter 41, Statutes of 2012. Under this program, eligible female inmates, including pregnant inmates or inmates who were the primary caregivers of dependent children, are allowed to participate in lieu of their confinement in state prison. Through this program, female inmates may be placed in a residential home, a nonprofit residential drug-treatment program, or a transitional-care facility that offers individualized services based on an inmate's needs. The program focuses on reuniting low-level inmates with their families and reintegrating them back into their community.

All inmates continue to serve their sentences under the jurisdiction of the CDCR and may be returned to state prison for any reason. An inmate selected for ACP is under the supervision of a parole agent and is required to be electronically monitored at all times.

To be eligible for the program, a woman must, meet the eligibility criteria, and cannot have a current conviction for a violent or serious felony or have any convictions for sex-related crimes.

Services for ACP participants can include: education/vocational training, anger management, family- and marital-relationship assistance, substance-abuse counseling and treatment, life-skills training, narcotics/alcoholics anonymous, faith-based and volunteer community service opportunities.

On September 9, 2015, the federal court found in *Sassman v. Brown* that the state was unlawfully discriminating against male inmates by excluding them from the ACP and ordered CDCR to make male inmates eligible for the program. The ruling now requires the state to expand the existing female Alternative Custody Program to males.

As of March 9, 2016, there were 38 inmates participating in ACP.

None of the inmates in these alternative housing program count toward the state's 137.5 percent prison population cap established by the federal court. Therefore, these programs and their expansion create an important tool for the state's prison population management.

Legislative Analyst's Office (LAO)

MCRP. The LAO recommends that the Legislature reject the Governor's proposed $32 million General Fund augmentation for the Male Community Reentry Program (MCRP), as it is unlikely to be the most cost–effective recidivism reduction strategy given that it (1) does not target higher–risk offenders and (2) it is very costly. To the extent that the Legislature wants to expand rehabilitative programming, the LAO recommends directing the department to come back with a proposal that focuses on meeting the rehabilitative needs of higher–risk offenders.

CCTRP and ACP. The Governor's proposals to expand CCTRP and allow male inmates to participate in the ACP appear to be aligned with recent court orders. However, unlike the current ACP which takes inmates for up to 24 months, the budget proposes reducing that time to the last 12 months of an inmate's sentence. However, the LAO notes that the Administration has not provided information to justify that change. Therefore, they recommend that the Legislature withhold action on the Governor's proposal to reduce the length of the alternative custody programs pending additional information to determine whether the proposed change is warranted.

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

1. Several months ago, CDCR staff and the contractor for the Bakersfield MCRP mentioned that there was difficulty finding male inmates to fill all 50 of the beds in that program. Based on the recent population reports, it would appear that continues to be a problem? What is CDCR doing to promote the MCRP's among inmates and what is your plan for ensuring that all MCRP beds are continuously filled?

2. Please explain how CDCR determines an inmates eligibility for a conversation camp and how many years an inmate can be housed and work in a camp.

3. Last year, CDCR proposed expanding eligibility for the conservation camps but has since backed off on that expansion. Please explain why you decided not to expand eligibility. In addition, please provide an update on the population of the camps and your ability to safely and effectively keep those camps filled.

4. Does the training and experience received by an inmate in a fire camp allow them to gain employment as a CalFIRE firefighter upon their release? If not, has CDCR considered working with CalFIRE and the State Personnel Board to ensure that those individuals are eligible to compete for those positions?