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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	2:90-cv-00520 KJM-DB (PC) **DEFENDANTS' RESPONSE TO JULY 2, 2020 ORDER**

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INTRODUCTION

Over the past four months, the California Department of Corrections and Rehabilitation (CDCR) and the Department of State Hospitals (DSH) have tirelessly worked to protect inmates from the coronavirus (COVID-19) pandemic, in close collaboration with the federal *Plata* Receiver, while simultaneously ensuring that inmate-patients' mental health needs are met. Among a number of proactive measures, Defendants implemented substantial reductions in the size of the inmate population, which has both reduced the population of *Coleman* class members and made more space and resources available for those in the Mental Health Services Delivery System (MHSDS) who do not qualify for release. Building on these reductions, Defendants have now initiated a new set of measures to reduce the population even further. Despite these efforts, the Court suggests that still further releases are necessary, whether because of COVID-19 or otherwise.[1] But Court-ordered releases are not necessary, especially given the extensive population reductions that have already occurred (approximately 10,000 inmates since March, when the pandemic hit the State's institutions) and those that are imminently expected (approximately 8,000 planned by the end of August, with additional rolling releases anticipated), which have had and will continue to benefit the *Coleman* class.

There is no dispute that COVID-19 has affected Defendants' progress towards the many Court-ordered tasks and Special Master-led projects that were under way before the pandemic. Even though Defendants have been forced to shift their daily focus and resources to address

[1] *See, e.g.*, *Plata/Three-Judge Panel* Order, Apr. 4, 2020, ECF No. 3261 at 14-15 (J. Mueller concurring and observing that "[e]ven though the prison population for some time has remained below the cap this [Three-Judge Panel] previously set, Defendants have not achieved the durability of remedy required" and that "current circumstances appear to expose, in stark terms, the potential need to revisit the current population cap" and stating that "[g]iven the availability of expedited proceedings before [the *Plata* and *Coleman*] district courts to immediately exhaust the possibility of inmate transfers and relocations to secure facilities to achieve constitutionally acceptable conditions for the Plaintiff classes, those proceedings must be invoked first"); ECF No. 6643 at at 1-2 (inviting any party or intervenor on April 27 to file "[a]ny motion concerning the initial crisis management phase of planning for the impact of the COVID-19 on defendants' obligations to class members in this action . . . within the next thirty days"); May 15, 2020 Status Conf. Tr. at 24-25 (inviting "plaintiffs in particular" to "proceed by way of focused motion practice, and it can be on an expedited basis," to raise *Coleman*-specific issues related to CDCR's COVID-19 response). The Court has reminded the parties that it "is remaining open for consideration of motions and respectively 24/7." (ECF No. 6557 at 32.)

COVID-19, and take specific responsive action to protect the lives of inmates and staff, the Court has expressed a desire to get this case "back on track," with "plans to resume proceedings to oversee defendants' compliance with those aspects of the Program Guide in this case with which compliance has not yet been achieved." (ECF No. 6643 at 2.) Defendants are doing the best they can to confront a deadly disease that is rapidly infecting communities across the nation, and this Court, the Special Master, and Plaintiffs have acknowledged that inmate safety is paramount and should take precedence over strict compliance with some Program Guide requirements. (ECF No. 6679.)

In response to the Court's first question in its July 2 order, Defendants oppose further clustering of mental health patients. Further clustering on top of the significant clustering that has already occurred is not a feasible option and will not improve Program Guide compliance by limiting class member transfers. Rather, further clustering will increase transfers and compound pressures on clinical and custodial staff tasked with providing care to large numbers of high acuity patients, and burn staff out. In addition, clustering will not remedy the current Program Guide modifications due to COVID-19, such as reduced group programming and unmet transfer timelines, as those modifications are a direct reflection of the new steps that must be taken to protect patients and staff alike during this pandemic. Addressing the Court's second question in its July 2 order, while Defendants are in the midst of additional inmate releases that will include *Coleman* class members, these releases are targeted to protect inmates from contracting COVID-19, not to improve compliance with the Program Guide and other remedial measures. Lastly, in response to the Court's third inquiry, the Court cannot sua sponte convene a new three-judge court because such a court has already been empaneled for the purpose of considering Plaintiffs' initial request for a prisoner release order. Rather, if the PLRA's requirements are met, Plaintiffs could seek modification of the prior population reduction order to limit the size of the *Coleman* class specifically.

Defendants have shown that they are prepared to address the ever-changing demands presented by COVID-19 to save inmate lives and also provide mental health care. Rather than

subject Defendants to even more orders, the Court should recognize the flexibility and authority Defendants need under these extraordinary conditions.

ANALYSIS OF THE COURT'S QUESTIONS

I. QUESTION NO. 1: FURTHER CLUSTERING OF EOP PATIENTS AND PATIENTS AT HIGHER LEVELS OF CARE WILL NOT LIMIT CLASS MEMBER TRANSFERS NOR IMPROVE COMPLIANCE WITH THE PROGRAM GUIDE.

CDCR has expended significant resources and time over the past several years to analyze options for clustering EOP and high acuity mental health patients in fewer institutions. Even before the COVID-19 pandemic, Defendants made clear that they could not further cluster the mental health population without interfering with Defendants' ability to meet patients' needs and staffing requirements. COVID-19 has not changed that position. In short, further clustering is not the panacea to achieve compliance with staffing and bed transfer requirements, and clustering will not limit class member transfers. Significant clinical, custodial, and public health concerns outweigh any possible benefit of further clustering of the mental health population.

A. CDCR Already Clusters Class Members.

CDCR already clusters higher acuity MHSDS patients, limiting options for further clustering. Currently, CDCR houses 6,572 EOP inmates at just fifteen of its thirty-five institutions. Two institutions house only female EOP inmates. (Powell Decl., Ex. A (Summary of Mental Health Population by Institution and Level of Care (H1) as of July 15, 2020).)[2] At the institutions housing male EOP inmates, the percent of the inmate population in the MHSDS already ranges from 31 percent to as high as almost 63 percent.[3] (*Id.*) And at almost half of these institutions, the EOP population alone accounts for approximately 16 percent or more of the total

[2] CDCR houses EOP inmates at the following institutions: Central California Women's Facility (CCWF), California Health Care Facility (CHCF), California Institution for Women (CIW), California Men's Colony (CMC), California Medical Facility (CMF), California State Prison-Corcoran (COR), Kern Valley State Prison (KVSP), California State Prison- Los Angeles County (LAC), Mule Creek State Prison (MCSP), Richard J. Donovan Correctional Facility (RJD), California State Prison- Sacramento (SAC), California Substance Abuse Treatment Facility (SATF), San Quentin State Prison (SQ), Salinas Valley State Prison (SVSP), and Valley State Prison (VSP). (*Id.*)

[3] Comparing the EOP population with the total CDCR population. *See* https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/07/Tpop1d200708.pdf (retrieved July 15, 2020)

population. (*Id.*) In addition, CDCR clusters the MHSDS population at five Psychiatric Inpatient Programs (PIPs) at five institutions (CHCF, SVSP, CMF, SQ, and CIW), and at three DSH facilities (DSH Atascadero, DSH-Coalinga, and DSH-Patton). (*Id.*) Patients needing MHCB level of care may be transferred to one of twenty-one MHCB units across the state (nineteen for males and two for females). (*Id.*) In addition to clustering based on patients' assigned levels of care, Defendants also cluster patients by excluding the MHSDS population from being housed and treated at certain institutions. Under the agreement approved by the Court, CDCR does not provide mental health programming at six desert institutions.[4] And with very limited exceptions, CDCR does not house any MHSDS patients in the desert institutions. (ECF No. 6279.) Options for further clustering are also limited by inmates' case factors—such as restrictions due to Valley Fever, other medical needs, physical disabilities, enemy concerns, staff separations, and custody level. (ECF No. 5591-5 at 2 and ECF No. 5922 at 32-36.)

Further clustering inmates in the MHSDS will have an ancillary impact on other class actions, such as *Clark* and *Armstrong*, as many inmates are cross-class members. (*Id.*) For example, a *Coleman* class member who is also an *Armstrong* class member may only be housed at institutions that are able to accommodate the patient's disability, further limiting the options for that class member's housing. Consequently, CDCR may not be able to house any given EOP inmate in one of the 15 institutions with EOP housing and programming. Defendants have previously explained how patients' custody factors limit the number of institutions where they may be housed:

> For example, a male EOP inmate with Level II custody points who is high risk medical can only be housed at CHCF, CMF, MCSP, or SATF. See Attachment H- Case Factors at Institutions. A male EOP inmate with Level III custody points and a disability that impacts placement can only be housed at three institutions: MCSP, RJD, or SVSP. *Id.* A male EOP inmate with Level IV custody points who is on Clozapine can only be housed at COR, MCSP, or SAC. *Id.* Adding one additional case factor to the examples above, such as a Cocci restriction, enemy concerns, or a lower bunk/lower tier requirement would further limit the alternative institutions in which the inmate could be appropriately housed. There are a sizeable number of *Coleman* class members who are in situations

[4] The desert institutions are Calipatria State Prison, California City Correctional Facility, the California Correctional Center, Centinela State Prison, Chuckawalla Valley State Prison, and Ironwood State Prison.

> similar to those described above. Of the 7,551 EOP inmates, 2,496 are high risk medical, which means that one-third of the EOP population can be housed within 11 of the 15 EOP institutions, two of which house only female inmates. *See* Attachment G- MHSDS Pop by Case Factor. Restricting EOP placement at even one of these institutions would further limit the options for inmate placement, causing delays in regular transfers between institutions, transfers out of segregation, and transfers out of reception centers.

(*Id*. at 19-20.)

CDCR has already concentrated its EOP and PIP patients to a limited number of institutions. Further narrowing the options for safe patient housing for mental health treatment will place unnecessary burdens on staff and resources without evidence that additional clustering will reduce patient transfers or improve the provision of mental health care to the *Coleman* class.

B. CDCR Has Previously Analyzed and Reported Problems Inherent in Clustering the Highest Acuity Patients.

The Special Master in his Twenty-Sixth Round Monitoring Report originally recommended clustering to meet CDCR's 2009 staffing plan and address staffing at hard-to-recruit institutions. (ECF No. 5439 at 131.) In response, the Court adopted the Special Master's clustering recommendation and ordered Defendants and the Special Master to meet and confer monthly to discuss and consider strategies and initiatives, including but not limited to potential clustering of higher-acuity mentally ill inmates at those institutions where it has been shown that mental health staff can be more readily attracted and retained. (ECF No. 5477 at 5.) On October 10, 2017, after reviewing the parties' positions on clustering and rejecting Defendants' objections, the Court adopted the Special Master's further recommendation and "advised" Defendants to work with the Special Master to develop a more robust clustering plan. (ECF No. 5711 at 26.) The work that followed the Court's order confirmed CDCR's position that further clustering of the *Coleman* class is not a viable solution to CDCR's staffing challenges and would raise myriad clinical and custody concerns. Defendants' position has not changed, and Defendants are not aware of any factual basis to support the conclusion that further clustering EOP patients at even fewer institutions will result in a durable increase in staff or compliance with the Program Guide or other remedial orders.

On December 18, 2018, this Court ordered the parties to participate in a settlement conference focused "on whether mentally ill inmates can be located in fewer total institutions to address persistent impediments to Program Guide compliance in the areas of staffing, bed transfers and cultural compliance training." (ECF No. 6050.) The settlement judge then ordered the parties to present options for clustering that included a discussion of how clustering could help eliminate "the persistent obstacles to full achievement of a constitutional remedy in this case," including the ways in which compliance with staffing and bed transfers could be achieved. (ECF No. 6075 at 2.) CDCR again analyzed the options for further clustering and presented them to the Court and Plaintiffs in the context of settlement discussions and in reporting options for compliance with staffing proposals. (ECF No. 5922 at 17-36.) Part of the analysis included identification of the reasons why further clustering of class members is not clinically or custodially sound. The analysis concluded that further clustering of the EOP population will not improve compliance with programming and staffing requirements. (ECF No. 5922 at 18.) EOP patients require more time and attention from all staff, including mental health, custody, nursing, and medical. (*Id.*) EOP patients are more challenging to communicate with and often have difficulty following staff direction. (*Id.*) There is a limit to how many high acuity patients one facility can reasonably handle—if one facility has too many high acuity patients, "care processes begin to break down and staff experience burnout and become dissatisfied." (*Id.* at 19.)

CDCR's current approach to clustering the CCCMS and EOP population, while beneficial, affects staff morale and satisfaction. (*Id.* at 18-19.) Similarly, the *Plata* court experts opined following an April 13, 2017 inspection at Salinas Valley State Prison that "[a] higher acuity mental health population is more a difficult population to manage clinically and is likely to make recruitment of staff even more challenging." (Thorn Decl., Exh. E (*Plata* Court Experts' Salinas Valley State Prison Report, dated Apr. 13, 2017, at 6).) In other words, grouping high acuity inmates in geographically desirable locations does not mean that CDCR will be able to hire sufficient staff to provide care to such a large, higher acuity population. (*Id.*) To the contrary, populating an institution with mostly EOP patients will increase incidences of burnout and job dissatisfaction, and, in turn, lead to a higher rate of staff turn-over, making it more difficult to

comply with the 90 percent fill rate required by the Court's 2002 order. (ECF No. 5591, at 16-17, ECF No. 5591-2 at 5, and ECF No. 5591-5 at 2.) Clustering the EOP population also adversely impacts population management, including CDCR's ability to transfer inmates in a timely manner, as *Coleman* class members have additional case factors which make them difficult to place. (ECF No. 5591-5 at 2.) Clustering limits the flexibility CDCR needs to address these case factors when making housing decisions, particularly if safety concerns arise at any given institution. (*Id.*) In that regard, more clustering undercuts CDCR's ability to make safe and appropriate housing decisions for individual Coleman class members. (*Id.*)

C. More Clustering Will Not Limit Class Member Transfers.

The high volume and frequency of the EOP population's transfers between different levels of care make further clustering of that population unsound and, in light of the current pandemic, unsafe. CDCR's mental health population, including its EOP population, frequently change levels of care. Clustering the EOP population is not a ready or permanent fix to address the dynamic nature of this population. Even if the Court were to order further clustering of all EOP patients to a handful of institutions, CDCR would still be required to transfer *Coleman* class members to higher or lower levels of care.

In 2018, 5,635 EOP patients transferred to a MHCB, and in 2019, 4,768 EOP patients transferred to a MHCB. (*See* Powell Decl., ¶ 5; Exh. C.) In 2018, 449 EOP patients transferred to PIP beds, and in 2019, 507 EOP patients transferred to PIP beds. (*Id.*) These numbers do not include the additional transfers that may have been necessary upon the patient's discharge from the MHCB or PIP programs. And every year thousands more patients change level of care between EOP and CCCMS, necessitating transfers in many cases.

An order requiring that CDCR house patients at a specific level of care at a handful of institutions will necessarily increase the need for inter-institution transfers, when those patients are referred to a level of care not available at their home institution. Increases in transfers bring added pressures to custodial, medical, and mental health staff, notwithstanding additional serious concerns due to the spread of COVID-19 from transfers. For example, transfers to crisis beds require mental health staff to complete referral packages and perform appropriate discharge

reviews and documentation before a patient may transfer. (ECF No. 5680, at 6-7; ECF No. 5680-7, at 1-21; and ECF No. 5680-10, at 3-5.) Transfers also require CDCR classification and parole representatives at the referring institution to perform multiple tasks, including planning for transportation of the inmate; clearing issues that could halt patient movement; contacting the receiving institution to confirm the patient is medically cleared for transport; contacting the sending and receiving institutions to provide the details of the transportation arrangements, including the coordination of all records, pharmacy needs and other items as necessary for each individual patient; completing the non-committee endorsement upon receipt of the transfer chrono (order) from mental health; contacting the receiving institution to ensure they were notified and can physically accept the inmate; and determining whether the receiving institution has any inmates who should be returned to the receiving institution. (*Id.*)

The EOP population's needs are best addressed when CDCR has the flexibility to transfer these patients to facilities with appropriate treatment space and programming opportunities. Clustering those patients at fewer institutions takes away that flexibility and will result in reduced programming, educational, and vocational opportunities available to *Coleman* class members.

D. More Clustering Will Require Construction of New Prison Facilities in Violation of the PLRA.

Federal courts cannot order a government entity that represents the public to spend money to build new prisons facilities. *See Padgett v. Stein*, 406 F. Supp. 287, 303 (M.D. Pa. 1975); *Jones v. Wittenberg*, 29 Ohio Misc. 35 (N.D. Ohio 1971), *aff'd sub nom. Jones v. Metzger*, 456 F.2d 854 (6th Cir. 1972). The PLRA provides, "[n]othing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts." 18 U.S.C. § 3626(a)(1)(C). Thus, even for those institutions with sufficient space to add EOP beds, the Court does not have the authority to order additional clustering of the population if such clustering would require construction of office and treatment space to accommodate the patient population.

E. The 2013 *Plata v. Brown* Decision Does Not Support Further Clustering.

The Court's proposed clustering order fails to meet the PLRA's requirement that the order be narrowly drawn, extend no further than necessary to correct the federal violation, and be the least intrusive means to achieve full and durable compliance. 18 U.S.C. § 3626(a)(1)(A).

In its July 2 order, the Court asks whether the *Plata* court's decision at *Plata v. Brown*, 427 F.Supp.3d 1211 (N.D. Cal. 2013) gives it authority to order Defendants to submit a clustering plan and to order implementation of that plan. (ECF No. 6750 at 2.) It does not. The Court's proposed clustering order lacks the foundation that supported the exclusion order in *Plata*. The exclusion order in *Plata* was issued in response to the plaintiffs' motion to compel CDCR to implement the *Plata* Receiver's exclusion policy to reduce risks associated with infectious disease (Coccidioidomycosis (Cocci)) at two prisons that reported high rates of Cocci cases. The *Plata* Receiver and the California Department of Public Health performed investigations and issued recommendations that patients with certain factors should be excluded from those two institutions. *Id.* at 1215-20. Defendants argued that Plaintiffs' motion seeking an exclusion order was, in effect, an improper request for a prisoner release order under the PLRA. Both the *Plata* court and the Ninth Circuit held that the court could order inmates excluded from two prisons without running afoul of the PLRA because it would merely require the intra-system transfer, and not release, of inmates.

The *Plata v. Brown* decision is inapposite here. Whereas in *Plata*, both the Receiver and the California Department of Public Health recommended the exclusion of certain inmates from two institutions, no comparable recommendations exist here. No prior reports or expert evidence suggest that clustering would reduce the frequency of inter-institutional transfers and thus reduce the risk of some harm to *Coleman* class members. To the contrary, the record suggests that less intrusive means of ensuring compliance exist. The EOP population and class members requiring treatment at higher levels of care make up only a small percentage of the *Coleman* class, but that segment of the mental health population require the most resources. (*See* CDCR's 2009 Staffing Plan, ECF No. 3693; MHSDS Program Guide, 2018 Revision, ECF No. 5864-1 at 53-56, 57-65, and 65-66.) Housing and treating the most challenging group of class members together in fewer

institutions will not reduce their need for inpatient and crisis bed transfers and group treatment. And clustering will not avoid the public health concerns Defendants face daily in efforts to provide the requisite level of mental health treatment to the *Coleman* class.

Defendants have shown that clustering will further delay Program Guide compliance and present an even greater challenge to CDCR's ability to operate its mental health program, negatively impacting on staffing (both medical and mental health) and exacerbating the lack of programming and other resources available at institutions that may not be appropriate locations to cluster high acuity patients. In *Plata*, the defendants were given the discretion as to where affected inmates could transfer and thus retained flexibility in the administration of their system. But a clustering order here would have the opposite effect by further limiting the already-limited number of institutions where certain patients could be housed. And as explained above, those limited number of institutions do not have the infrastructure and staff to support the influx of mentally acute patients. Nor does the State—facing deep deficits due to the pandemic—have the budget to implement changes to those institutions to accommodate this influx of high acuity patients, and the PLRA prohibits this Court from ordering the State to construct such facilities.

II. QUESTION NO. 2: DEFENDANTS' PLANS FOR ADDITIONAL VOLUNTARY RELEASES ARE INTENDED TO PROTECT INMATES FROM COVID-19, AND DEFENDANTS CONTINUE TO SUBSTANTIALLY COMPLY WITH PROGRAM GUIDE REQUIREMENTS WHERE FEASIBLE.

A. This Court's Premise That Additional Population Reductions Are Necessary to Achieve "Full and Durable" Program Guide Compliance Is Flawed.

The Three-Judge Court already determined that to achieve the constitutional delivery of adequate mental health care, the population must be capped at 137.5 percent of design bed capacity. No court has issued any subsequent order holding that additional population reductions are necessary "to reduce the size of the plaintiff class in sufficient numbers to achieve full and durable compliance with the Program Guide and other remedial requirements of this action." (ECF No. 6675 at 2.) It is unclear if targeted release of *Coleman* class members would affect Defendants' ability to address the COVID-19 pandemic. It is also unclear whether it would meaningfully affect their ability to meet "full and durable" compliance with the Program Guide

and this Court's orders regarding the provision of mental health care. Significantly, twenty-five years into the remedial phase of this litigation, neither the Court nor the Special Master have established benchmarks for "full and durable" constitutional compliance at any population level.

Beyond the immediate COVID-19 crisis, reductions in CDCR's overall inmate population will not necessarily translate into improved Program Guide compliance, due to the continuing need to transfer the MHSDS population. Even at this point in time, CDCR currently has sufficient available bed space at each level of care to provide the requisite mental health treatment to the *Coleman* class. (Powell Decl., Exh. A (Summary of Mental Health Population by Institution and Level of Care (H1) as of July 15, 2020).) As current capacity and population data indicate, as of July 15, 2020, CDCR had 4,507 empty CCCMS general population beds at twenty-four institutions; 728 empty EOP beds at eleven institutions; 320 empty crisis beds at twenty institutions; 14 empty acute inpatient beds at four psychiatric inpatient programs; and 13 empty Intermediate Care Facility beds at four PIPs and three DSH hospitals. (*Id.*) There is no evidence to suggest that the number of available beds is somehow insufficient, or that *Coleman*-specific patient reductions are necessary.[5]

Defendants do not dispute that efforts to protect inmates from COVID-19 exposure present challenges to Program Guide compliance. Indeed, the COVID-19 pandemic has made nearly every aspect of incarceration more challenging. CDCR has had to change the manner in which it offers treatment, and its ability to freely transfer patients between facilities is hampered by the need for pre-transfer COVID-19 testing. As discussed above, clustering would only exacerbate those issues.

[5] Staffing continues to be an urgent priority. Defendants have a set of proposals related to staffing that they would like to discuss with the Special Master and Plaintiffs. Discussion of these proposals has been delayed in part because of the current COVID-19 pandemic.

B. *Coleman* Class Members Have and Will Continue to Benefit from CDCR's Plans to Voluntarily Release Inmates.

Since mid-March, CDCR has reduced its inmate population by at least 10,000 inmates "as part of its previous pandemic emergency decompression efforts to reduce the risk of COVID-19 transmission within its facilities," along with regularly scheduled releases.[6]

In addition, CDCR is in the process of implementing a new set of release and credit-earning actions designed to mitigate the impact of COVID-19 in its institutions and to safeguard inmates, including *Coleman* class members. Those plans are described in detail on its website at https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/, a print-out of which is attached as Exhibit A, and has four primary elements.

First, CDCR will initially release approximately 4,800 inmates who have 180 days or less to serve on their sentences. Those inmates are currently being screened and CDCR estimates they will be released by the end of this month. On a rolling basis going forward, CDCR will also review all eligible inmates with 180 days or less to serve. Inmates serving time for domestic violence or a violent crime, or with a current or prior sentence that requires registration as a sex offender under Penal Code 290, and an assessment score that indicates a high risk for violence, are not eligible for early release.

Second, CDCR will screen for release a second cohort of incarcerated persons with one year or less to serve on their sentence, and who reside at the following institutions, which were selected based on several factors, including, but not limited to, the size of the populations of high-risk patients and the physical plant layout: San Quentin State Prison, Central California Women's Facility, California Health Care Facility, California Institution for Men, California Institution for Women, California Medical Facility, Folsom State Prison, and Richard J. Donovan Correctional Facility. Criteria which excludes inmates from early release under this One-Year plan include serving time for domestic violence or a violent crime, current or prior sentences that require

[6] https://www.cdcr.ca.gov/news/2020/07/10/cdcr-announces-additional-actions-to-reduce-population-and-maximize-space-systemwide-to-address-covid-19/.

registration as a sex offender under California Penal Code 290, and an assessment score that indicates a high risk for violence. Individuals who are thirty years-old and over and who meet the eligibility criteria are immediately eligible for release. Those who are age 29 or under and who meet eligibility criteria will be reviewed on a case-by-case basis for release. CDCR will consider medical risk, case factors, and time served, among other factors, in determining whether to expedite release for those identified in this cohort. Like the 180-Day cohort, the One-Year cohort will be screened on a rolling basis until CDCR determines such releases are no longer necessary.

Third, CDCR will provide positive participation credits "to recognize the impact on access to programs and credit earning during the COVID-19 pandemic." Eligible inmates will be awarded a one-time Positive Programming Credit (PPC) of 12 weeks "to help offset not only credits not earned due to program suspensions, but also to recognize the immense burden incarcerated people have shouldered through these unprecedented times." Inmates must meet the following criteria to be eligible for the credits: (1) currently incarcerated at any of the 35 adult institutions, community correctional facilities, fire camps, Male Community Reentry Program, Community Prisoner Mother Program, Custody to Community Transitional Program, Alternative Custody Program, and those serving a state prison sentence in a state hospital; (2) not condemned to death or serving life without the possibility of parole; and (3) no serious rules violations between March 1 and July 5, 2020. CDCR estimates that nearly 108,000 people will be eligible for PPC. Further, CDCR estimates the population will reduce by approximately 2,100 by the end of August 2020 as a result of the application of this credit.

Finally, CDCR will assess for release individuals deemed "high risk medical," including inmates who are 65 or over who have chronic conditions, or who have respiratory illnesses such as asthma or chronic obstructive pulmonary disease. Criteria for eligibility are (1) being deemed high risk for COVID-19 complications by CCHCS; (2) not serving life without parole or being condemned; (3) having an assessment indicating a low risk for violence; and (4) not being a high-risk sex offender. Because this cohort's eligibility requires an individual review of each incarcerated person's risk factors, an estimate of the number of releases is not yet available.

These plans show Defendants' commitment to ensuring the well-being of all inmates, including that of the *Coleman* class, and to addressing the constantly evolving nature of the COVID-19 pandemic.

C. During the COVID-19 Pandemic, Defendants' Planned Releases Cannot Achieve a Targeted Occupancy Goal to Facilitate Full and Durable Program Guide Compliance.

The State's previous and ongoing population reduction measures have and will directly benefit the *Coleman* class. But those measures are designed to respond to the current public health crisis, and may not improve Program Guide compliance. Of course, Defendants are working tirelessly to mitigate any impacts on Program Guide compliance while simultaneously addressing COVID-19's impact on inmate and staff health and safety. Defendants will track and report on the population reductions, including reductions to the *Coleman* class, in addition to their normal course of tracking and reporting on compliance measures. But further voluntary releases are either sufficient or necessary to achieve full and durable compliance with the Program Guide and other remedial requirements.

First, the Court's July 12, 2018 order required the Special Master during his latest monitoring round to develop and articulate clear benchmarks for compliance. (ECF No. 5852 at 3.) That never happened. Defendants attempted to engage in multiple rounds of settlement discussions in late 2019 into 2020 to identify what they believe to be the targets for compliance under the Program Guide and the innumerable orders concerning mental health programming. Those efforts, too, did not in a clear set of benchmarks to fully and durably comply with the Program Guide and other remedial orders. Defendants' response to the Court's second question must be considered within this limbo, particularly as it appears to require defined benchmarks that, "when met, signal constitutional compliance."[7]

Second, as noted above, a population reduction does not bear on Defendants' ability to safely transfer patients between levels of care during the current pandemic, which is largely dependent on accurate and timely testing for infection among the inmate population as a whole.

[7] Defendants do not concede that future benchmarks and "other remedial requirements" establish constitutional minima.

As a result, Defendants do not have a targeted occupancy goal and certainly not one that is tied to specific compliance with the Program Guide and other remediation measures. There is no specific percentage of design capacity that the State is trying to reach—in the normal course, CDCR's prisons are open to intake from counties and the inmate population is fluid, which further affects its ability to tie occupancy to remedial compliance. Rather, the State is attempting to reduce the population as much as reasonably possible across all institutions to further reduce the risk of infection from COVID-19.

III. QUESTION NO. 3: THE COURT MAY NOT SUA SPONTE REQUEST THE CONVENING OF A NEW THREE-JUDGE PANEL TO RELEASE *COLEMAN* CLASS MEMBERS.

Finally, the Court asked "if Program Guide compliance cannot be achieved without a greater number of population reductions than currently planned, whether this court should sua sponte request the convening of a three-judge court to consider entry of a prisoner release order specifically directed to reduce the number of *Coleman* class members in the California Department of Corrections and Rehabilitation." (ECF No. 6750 at 2:20-25.) The Court may not sua sponte request to convene a new three-judge court where one already exists to consider the same issues presented by the Court's July 2 order. Instead, the appropriate procedural mechanism would be for Plaintiffs to request modification to the existing prisoner release order.

On July 23, 2007, this Court granted Plaintiffs' motion to convene a three-judge court to adjudicate whether the PLRA's standards were met and, specifically, whether Plaintiffs could show that crowding was the primary cause of the ongoing unconstitutional delivery of mental health care. (ECF No. 2320.) The Ninth Circuit empaneled the current *Coleman/Plata* three-judge court on July 26, 2007 to consider these issues. (ECF No. 2328.) On August 4, 2009, the three-judge court ordered the State to cap its system-wide prison population at 137.5% of the institutions' total "design capacity" within two years. *Coleman v. Schwarzenegger/Plata v. Schwarzenegger*, 922 F. Supp. 2d 882, 962, 970 (E.D. Cal., N.D. Cal. Aug. 4, 2009). To meet this order, CDCR needed to reduce its population by 46,000 inmates. *Id*. at 994.

The Supreme Court affirmed the three-judge court's prisoner release order and emphasized that the three-judge court "retains the authority, and the responsibility, to make further

amendments to the existing order." *Brown v. Plata*, 563 U.S. 493, 542 (2011). It explained that "[e]xperience may teach the necessity for modification or amendment" and "the three-judge court must remain open to a showing or demonstration ... that the injunction should be altered to ensure that the rights and interests of the parties are given all due and necessary protection." *Id*. at 542-543 ("the three-judge court must give due deference to informed opinions as to what public safety requires").

Relevant to Defendants' response to the Court's July 2 order, the Supreme Court held that if "a release order limited to . . . mentally ill inmates would be preferable to the order entered by the three-judge court, [then] [a party] can move the three-judge court for modification of the order on that basis." *Brown v. Plata*, 563 U.S. at 532 and 543 ("the three-judge court must remain open to a showing or demonstration by either party that the injunction should be altered to ensure that the rights and interests of the parties are given all due and necessary protection"). Accordingly, referral to a new three-judge court would be procedurally improper based on the Supreme Court's instruction that modification by the existing panel is the appropriate means to change the nature of the release order. To the extent Plaintiffs believe such a modification is warranted, they need to demonstrate that "a significant change in facts or law warrants revision of the [population cap] and that the proposed modification is suitably tailored to the changed circumstance. *Rufo v. Inmates of the Suffolk County Jail*, 502 U.S. 367 (1992); *see also Parton v. White*, 203 F.3d 552 (8th Cir. 2000) (modifying consent decree to increase population cap). Plaintiffs must similarly comply with the PLRA's mandatory requirements in imposing prospective relief, including ensuring that no other relief will remedy the violation at issue, that the relief extends not further than necessary, is narrowly drawn, and is the least intrusive means to correct the violation. 18 U.S.C. §§ 3626(a)(3)(E), (a)(2). The three-judge court would also be required to give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief. *Id*. at § 3626(a)(2).

It bears noting, however, that as of July 8, 2020, the last day that CDCR publicly reported its population on its website, 104,725 inmates were housed in the State's 35 adult institutions,

equating to approximately 123.1% of design capacity.[8] And in less than four months, CDCR has reduced its adult institution population by nearly 10,000 inmates in response to the COVID-19 pandemic.[9] Whereas the *Coleman* class totaled 35,834 inmates as of March 18, 2020, it now totals 33,081 inmates. (Powell Decl., Exhs. A and B.) Further, as detailed above, the prison population is anticipated to decline by at least 8,000 inmates by the end of August. The initial 180-day and One-Year (30 and older) cohorts include approximately 2,000 *Coleman* class members who will be released. In the One-Year (29 and under) and high risk medical cohorts there are approximately 2,200 *Coleman* class members who will be reviewed for possible releases. In addition, Defendants anticipate that a large number of *Coleman* class members will be eligible and receive the positive programming credit, which will expedite their release. The accelerated transition to parole or post-release community supervision of CDCR inmates will continue on a rolling basis. Meanwhile, CDCR remains closed to county intake, and CDCR's adult institution population—including the *Coleman* class—will continue to decline dramatically with these measures in place.

CONCLUSION

The State is making difficult decisions under extraordinary circumstances to protect *Coleman* class members from COVID-19, while still providing mental health services. Further clustering EOP class members at fewer institutions will not avoid patient transfers or bring Defendants closer to meeting the Program Guide's broad and outdated requirements and other remedial orders. And this Court may not sua sponte seek to impanel a new three-judge court to consider the release of *Coleman* class members, nor is modification by the current three-judge court appropriate here where thousands of inmates have been released in response to this pandemic and thousands more will be released imminently.

[8] *See* CDCR Weekly Population Report as of midnight on July 8, 2020, available at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/07/Tpop1d200708.pdf

[9] *Compare* CDCR's adult institution population as of midnight on July 8, 2020 (104,725 inmates) *with* CDCR's adult institution population as of midnight on March 18, 2020 (114,328), available at https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2020/03/Tpop1d200318.pdf

Dated: July 15, 2020

Respectfully Submitted,

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	2:90-cv-00520 KJM-DB (PC) **DECLARATION J. POWELL IN SUPPORT OF DEFENDANTS' RESPONSE TO THE JULY 2, 20202 ORDER**

I, Jay Powell, declare:

1. I am the Correctional Administrator for the Health Care Placement Oversight Program (HCPOP), Corrections Services division of the California Correctional Health Care Services. I make this declaration to support Defendants' response to the Court's July 2, 2020 order. I have personal knowledge of the statements in this declaration and could testify to them if called to do so.

2. I was appointed as HCPOP's Correctional Administrator of the Health Care Placement Oversight Program on May 1, 2018. I am familiar with the numerous and complex policies and procedures that govern the movement of inmates within the mental health care delivery system. I supervise and direct HCPOP's activities. This program area is responsible for managing and tracking the statewide movement of inmates into and out of designated health care beds, including oversight of tracking, endorsing, and managing movement of CDCR patients into and out of Department of State Hospitals (DSH).

3. Attached as Exhibits A and B are true copies of CDCR's Summary of Population by Institution and Level of Care report (also referred to as the H1 report) as of July 15 and March 18, 2020, respectively, which were prepared by my staff at HCPOP. As the footnotes on each report note, the source of the H1 report is Health Care Offender Data Store (HCODS). The report provides information for a specific date and time noted by the report's time stamp. The report shows the operational capacity, design capacity, population number, occupied percentage, and the vacant number of beds at each mental health level of care, including the Correctional Clinical Case Management System (CCCMS), Enhanced Outpatient Program (EOP), Mental Health Crisis Bed (MHCB), Intermediate Care Facility (ICF), and Acute Psychiatric Program (APP). The definitions for operational capacity, population, percent occupied, and vacancy rate are all provided on the report.

4. Attached as Exhibit C is a report prepared by my staff at HCPOP based on data contained in computer data applications called the HCPOP Endorsement and Referrals Tracking (HEART) and the Referrals to Inpatient Program Application (RIPA) as well as HCODS. The report shows the number of mental health patient movements for 2018 and 2019 from each level of care (CCCMS, EOP, MHCB, APP, and ICF) to inpatient beds (APP and ICF) and to crisis beds (MHCB). The applications store numerous data points in the life cycle of each referral type. These data points are validated against secondary sources such as the Strategic Offender Management System, the Electronic Health Record System, and email correspondence.

5. Based on the data in Exhibit C, 5,635 EOP patients transferred to a MHCB in 2018, and 4,768 EOP patients transferred to a MHCB in 2019. Exhibit C also shows 449 EOP patients

transferred to Psychiatric Inpatient Program beds in 2018 and 507 EOP patients transferred to Psychiatric Inpatient Program beds in 2019.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed in Elk Grove, California on July 15, 2020.

Jay Powell
Correctional Administrator
Health Care Placement Oversight Program
(original signature retained by attorney)

Exhibit A

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE (H1)

CONFIDENTIAL

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Mental Health Summary by Level of Care

Institution	Correctional Clinical Case Management System (CCCMS)				Enhanced Outpatient Program (EOP)						Mental Health Crisis Bed (MHCB)				Intermediate Care Facility (ICF)				Acute Psychiatric Program (APP)				Total Mental Health Population
					EOP Operational Capacities																		
	Operational Capacity	Population	% Occupied	Vacant Beds	General Population (GP)	Administrative Segregation Unit (ASU)	Psychiatric Services Unit (PSU)	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP	1,100	956	87 %	144				6		-6		1		-1						1		-1	964
CAL		16		-16				1		-1		2		-2									19
CCC		2		-2																			2
CCI	1,850	1,323	72 %	527				12		-12		3		-3									1,338
CEN		19		-19																			19
CHCF	550	643	117 %	-93	375	50		578	136 %	-153	95	9	9 %	86	356	362	102 %	-6	161	82	51 %	79	1,674
CIM	1,050	896	85 %	154				35		-35	34	4	12 %	30		18		-18		7		-7	960
CMC	750	674	90 %	76	552	100		580	89 %	72	50	15	30 %	35		16		-16		9		-9	1,294
CMF	600	459	77 %	141	391	58		498	111 %	-49	50	11	22 %	39	257	233	91 %	24	207	172	83 %	35	1,373
COR	1,000	1,093	109 %	-93	366	100		257	55 %	209	24	7	29 %	17		8		-8		15		-15	1,380
CRC	1,150	1,048	91 %	102				2		-2													1,050
CTF	1,500	1,274	85 %	226				8		-8		4		-4									1,286
CVSP		2		-2																			2
DVI	500	330	66 %	170																			330
FOL	500	498	100 %	2				7		-7		1		-1									506
HDSP	1,050	1,042	99 %	8				11		-11	10	4	40 %	6		1		-1					1,058
ISP	0	22		-22				1		-1		2		-2									25
KVSP	900	1,007	112 %	-107	96			127	132 %	-31	12	4	33 %	8		6		-6		2		-2	1,146
LAC	1,000	759	76 %	241	600	100		543	78 %	157	12	4	33 %	8		30		-30		11		-11	1,347
MCSP	1,350	1,478	109 %	-128	774	50		668	81 %	156	8	5	63 %	3		8		-8		7		-7	2,166
NKSP	1,000	407	41 %	593				13		-13	10	3	30 %	7		1		-1		2		-2	426
PBSP	300	268	89 %	32				3		-3	10			10									271
PVSP	700	498	71 %	202				7		-7	6			6									505
RJD	1,500	1,319	88 %	181	894	63		833	87 %	124	14	12	86 %	2		11		-11		4		-4	2,179
SAC	500	473	95 %	27	642	64	172	729	83 %	149	44	21	48 %	23		23		-23		29		-29	1,275
SATF	2,000	1,770	89 %	230	660			516	78 %	144	20	5	25 %	15		11		-11		8		-8	2,310
SCC	400	509	127 %	-109				1		-1		1		-1									511
SOL	1,000	641	64 %	359				7		-7	9	1	11 %	8						1		-1	650
SQ	1,250	861	69 %	389	200			257	129 %	-57	0	4		-4	31	28	90 %	3	9	3	33 %	6	1,153
SVSP	850	824	97 %	26	396			369	93 %	27	10	2	20 %	8	246	201	82 %	45					1,396
VSP	1,350	1,043	77 %	307	372			324	87 %	48		3		-3						1		-1	1,371
WSP	1,300	736	57 %	564				24		-24	6	1	17 %	5		2		-2		3		-3	766
DSH-ASH		1		-1				3		-3		1		-1	256	214	84 %	42		3		-3	222
DSH-CSH															50	44	88 %	6		1		-1	45
Male Subtotal	**27,000**	**22,891**	**85%**	**4,109**	**6,318**	**585**	**172**	**6,420**	**91%**	**655**	**424**	**130**	**31%**	**294**	**1,196**	**1,217**	**102%**	**-21**	**377**	**361**	**96%**	**16**	**31,019**
CCWF	1,350	1,132	84 %	218	120	10		102	78 %	28	12	7	58 %	5		1		-1		2		-2	1,244
CIW	750	622	83 %	128	75	10	10	47	49 %	48	29	8	28 %	21	45	29	64 %	16		1		-1	707
FWF	150	97	65 %	53				1		-1													98
DSH-PSH		1		-1				2		-2					30	10	33 %	20					13
Female Subtotal	**2,250**	**1,852**	**82%**	**398**	**195**	**20**	**10**	**152**	**68%**	**73**	**41**	**15**	**37%**	**26**	**75**	**40**	**53%**	**35**	**0**	**3**		**-3**	2,062
Grand Total	**29,250**	**24,743**	**85%**	**4,507**	**6,513**	**605**	**182**	**6,572**	**90%**	**728**	**465**	**145**	**31%**	**320**	**1,271**	**1,257**	**99%**	**14**	**377**	**364**	**97%**	**13**	33,081

NOTES:

1. This report provides operational capacities, population, and vacant beds detail by mental health level of care and institution. Level of care is based on Current Mental Health level of care code in SOMS. For each level of care, a summary of patients by SOMS housing program and institution is provided. Data Source is HCODS, as of the "Data Refreshed" time stamp.
2. Definitions:
   - Operational Capacity = indicates the number of beds available in the program based on factors such as treatment space and staffing, as determined by CCHCS headquarters.
   - Design Capacity = indicates the total number of beds available in the program Determined by Facility Planning, Construction, & Management.
   - Population = total census per SOMS as of the "Data Refreshed" time stamp shown on the report.
   - % Occupied = ([Population] / [Operational Capacity]) x 100.
   - Vacant Beds = the number of beds available after subtracting the Population from the Operational Capacity.
   - The "PIP" column in the "Psychiatry Inpatient Program (PIP) Housing" refers to programs that have the ability to provide multiple levels of care.
3. PIP capacities:
   - SQ PIP is for male condemned patients only, and has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accommodate ICF, APP, and MHCB level of care.
   - CIW PIP has a total capacity of 45 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
   - DSH-PSH has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
4. Housing Groups:

*GP Housing Group census includes patients in the following housing programs: Camp Program Beds, Debrief Processing Unit, Family Visiting, Fire House, General Population, Institution Hearing Program, Minimum Security Facility, Non-Designated Program Facility, Protective Housing Unit, Restricted Custody General Population, Sensitive Needs Yard, SNY Fire House, SNY, MSF, Transitional Housing Unit, Unkown, Varied Use and Work Crew.

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/15/20 6:07 AM

Correctional Clinical Case Management System (CCCMS) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total CCCMS Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		953								3								956
CAL		9									7							16
CCC										2								2
CCI		1,270									53							1,323
CEN		14									5							19
CHCF		211	17	1	1			153		253	7							643
CIM	89	733								14	60							896
CMC		654						3			17							674
CMF		418	1					14	5	12	9							459
COR		875	6					10		6	1		114				81	1,093
CRC		1,046								2								1,048
CTF		1,252								7	15							1,274
CVSP		1									1							2
DVI	103	191								10	26							330
FOL		480									18							498
HDSP		991						7									44	1,042
ISP		22																22
KVSP		909	1					3									94	1,007
LAC		636	17								2						104	759
MCSP		1,431	21								26							1,478
NKSP	217	171						4			15							407
PBSP		220															48	268
PVSP		485															13	498
RJD		1,266	5					2			46							1,319
SAC		335	28					1			1		32		9		67	473
SATF		1,715	1					6									48	1,770
SCC		496								1	12							509
SOL		612						1			28							641
SQ	143	525					1	4			49	139						861
SVSP		737	5					5			6						71	824
VSP		1,018								11	14							1,043
WSP	578	137						3			18							736
DSH-ASH		1																1
DSH-CSH																		
Male Subtotal	**1,130**	**19,814**	**102**	**1**	**1**	**0**	**1**	**216**	**5**	**321**	**436**	**139**	**146**	**0**	**9**	**0**	**570**	**22,891**
CCWF	112	922						18			66	14						1,132
CIW		587						3		7	10					15		622
FWF		97																97
DSH-PSH		1																1
Female Subtotal	**112**	**1,607**	**0**	**0**	**0**	**0**	**0**	**21**	**0**	**7**	**76**	**14**	**0**	**0**	**0**	**15**	**0**	**1,852**
Grand Total	**1,242**	**21,421**	**102**	**1**	**1**	**0**	**1**	**237**	**5**	**328**	**512**	**153**	**146**	**0**	**9**	**15**	**570**	**24,743**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/15/20 6:07 AM

Enhanced Outpatient Program (EOP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total EOP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		5								1								6
CAL		1																1
CCC																		
CCI		11									1							12
CEN																		
CHCF			397	7	1	21		42		88	22							578
CIM	30	1									4							35
CMC		1	521	1				2			55							580
CMF		1	428	7	2	2		12	2	5	39							498
COR		1	186					18		3	49							257
CRC		2																2
CTF		8																8
CVSP																		
DVI																		
FOL		6									1							7
HDSP		4															7	11
ISP		1																1
KVSP		3	96					2									26	127
LAC			474					1			68							543
MCSP			616					1			51							668
NKSP	10										3							13
PBSP		3																3
PVSP		7																7
RJD			769					5			59							833
SAC			541	1							67				120			729
SATF		16	479					7									14	516
SCC		1																1
SOL		1		3							3							7
SQ	15	40	120					1			17	64						257
SVSP		23	304			5		1									36	369
VSP		10	312								2							324
WSP	19							2			3							24
DSH-ASH			1			2												3
DSH-CSH																		
Male Subtotal	**74**	**146**	**5,244**	**19**	**3**	**30**	**0**	**94**	**2**	**97**	**444**	**64**	**0**	**0**	**120**	**0**	**83**	**6,420**
CCWF	2	30	63					1			6							102
CIW			43					1			1				2			47
FWF		1																1
DSH-PSH		2																2
Female Subtotal	**2**	**33**	**106**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**7**	**0**	**0**	**0**	**2**	**0**	**0**	**152**
Grand Total	**76**	**179**	**5,350**	**19**	**3**	**30**	**0**	**96**	**2**	**97**	**451**	**64**	**0**	**0**	**122**	**0**	**83**	**6,572**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/15/20 6:07 AM

Mental Health Crisis Bed (MHCB) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total MHCB Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP										1								1
CAL										2								2
CCC																		
CCI		2									1							3
CEN																		
CHCF				8	1													9
CIM				4														4
CMC				15														15
CMF				11														11
COR			1	6														7
CRC																		
CTF		3								1								4
CVSP																		
DVI																		
FOL											1							1
HDSP				3				1										4
ISP										2								2
KVSP				4														4
LAC		3									1							4
MCSP		3		2														5
NKSP				1							2							3
PBSP																		
PVSP																		
RJD			7	3				1			1							12
SAC				16										5				21
SATF			1	4														5
SCC											1							1
SOL				1														1
SQ					3		1											4
SVSP		2																2
VSP		2									1							3
WSP				1														1
DSH-ASH				1														1
DSH-CSH																		
Male Subtotal	**0**	**15**	**9**	**80**	**4**	**0**	**1**	**2**	**0**	**6**	**8**	**0**	**0**	**5**	**0**	**0**	**0**	**130**
CCWF	2			5														7
CIW				8														8
FWF																		
DSH-PSH																		
Female Subtotal	**2**	**0**	**0**	**13**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**
Grand Total	**2**	**15**	**9**	**93**	**4**	**0**	**1**	**2**	**0**	**6**	**8**	**0**	**0**	**5**	**0**	**0**	**0**	**145**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/15/20 6:07 AM

Intermediate Care Facility (ICF) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total ICF Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF					35	326		1										362
CIM				18														18
CMC			7	4							5							16
CMF			1	8	22	202												233
COR			7								1							8
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP				1														1
ISP																		
KVSP			6															6
LAC			16	1							13							30
MCSP			6								2							8
NKSP	1																	1
PBSP																		
PVSP																		
RJD			4	7														11
SAC			8	4							1			1	9			23
SATF			6	3													2	11
SCC																		
SOL																		
SQ					5		23											28
SVSP		3				198												201
VSP																		
WSP	1										1							2
DSH-ASH		1	48	29	79	54		2		1								214
DSH-CSH		1	14	7	18	4												44
Male Subtotal	**2**	**5**	**123**	**82**	**159**	**784**	**23**	**3**	**0**	**1**	**23**	**0**	**0**	**1**	**9**	**0**	**2**	**1,217**
CCWF											1							1
CIW							28								1			29
FWF																		
DSH-PSH		4	2	1			3											10
Female Subtoal	**0**	**4**	**2**	**1**	**0**	**0**	**31**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**40**
Grand Total	**2**	**9**	**125**	**83**	**159**	**784**	**54**	**3**	**0**	**1**	**24**	**0**	**0**	**1**	**10**	**0**	**2**	**1,257**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 7/15/20 6:07 AM

Acute Psychiatric Program (APP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total APP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP										1								1
CAL																		
CCC																		
CCI																		
CEN																		
CHCF				2	74	3		3										82
CIM				7														7
CMC				9														9
CMF				5	165	1		1										172
COR				15														15
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP				2														2
LAC				11														11
MCSP			1	6														7
NKSP				2														2
PBSP																		
PVSP																		
RJD				4														4
SAC				22				1										29
SATF				8														8
SCC																		
SOL				1														1
SQ					1	1	1											3
SVSP																		
VSP																		1
WSP				3														3
DSH-ASH					2	1												3
DSH-CSH					1													1
Male Subtotal	**0**	**0**	**1**	**97**	**243**	**6**	**1**	**5**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**361**
CCWF				2														2
CIW							1											1
FWF																		
DSH-PSH																		
Female Subtotal	**0**	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3**
Grand Total	**0**	**0**	**1**	**99**	**243**	**6**	**2**	**5**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**364**

Exhibit B

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE (H1)

CONFIDENTIAL

Data Refreshed: 3/18/20 6:10 AM

Mental Health Summary by Level of Care

Institution	Correctional Clinical Case Management System (CCCMS)				Enhanced Outpatient Program (EOP)						Mental Health Crisis Bed (MHCB)				Intermediate Care Facility (ICF)				Acute Psychiatric Program (APP)				Total Mental Health Population
					EOP Operational Capacities																		
	Operational Capacity	Population	% Occupied	Vacant Beds	General Population (GP)	Administrative Segregation Unit (ASU)	Psychiatric Services Unit (PSU)	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	Design Capacity	Population	% Occupied	Vacant Beds	
ASP	1,100	1,074	98 %	26																			1,074
CAL																							
CCC		3		-3																			3
CCI	1,850	1,476	80 %	374				5		-5													1,481
CEN																							
CHCF	550	638	116 %	-88	375	50		574	135 %	-149	78	62	79 %	16	315	342	109 %	-27	219	178	81 %	41	1,794
CIM	1,050	1,131	108 %	-81				35		-35	34	25	74 %	9		4		-4		1		-1	1,196
CMC	750	714	95 %	36	552	100		571	88 %	81	50	28	56 %	22		13		-13		13		-13	1,339
CMF	600	499	83 %	101	391	58		513	114 %	-64	50	27	54 %	23	248	234	94 %	14	218	183	84 %	35	1,456
COR	1,000	931	93 %	69	366	100		273	59 %	193	24	14	58 %	10		4		-4		5		-5	1,227
CRC	1,150	1,519	132 %	-369				2		-2													1,521
CTF	1,500	1,444	96 %	56				2		-2													1,446
CVSP		5		-5																			5
DVI	500	422	84 %	78				5		-5													427
FOL	500	425	85 %	75				1		-1		1		-1									427
HDSP	1,050	1,003	96 %	47				5		-5	10	7	70 %	3									1,015
ISP	0	1		-1																			1
KVSP	900	948	105 %	-48	96			100	104 %	-4	12	7	58 %	5						5		-5	1,060
LAC	1,000	813	81 %	187	600	100		577	82 %	123	12	8	67 %	4		11		-11		6		-6	1,415
MCSP	1,350	1,396	103 %	-46	774	50		720	87 %	104	8	9	113 %	-1		4		-4		1		-1	2,130
NKSP	1,000	895	90 %	105				50		-50	10	6	60 %	4		1		-1		2		-2	954
PBSP	300	282	94 %	18				1		-1	10	1	10 %	9									284
PVSP	700	463	66 %	237				7		-7	6			6									470
RJD	1,500	1,293	86 %	207	894	63		835	87 %	122	14	10	71 %	4		6		-6		1		-1	2,145
SAC	500	526	105 %	-26	642	64	172	769	88 %	109	44	9	20 %	35		10		-10		4		-4	1,318
SATF	2,000	1,911	96 %	89	660			575	87 %	85	20	9	45 %	11		4		-4		6		-6	2,505
SCC	400	522	131 %	-122																			522
SOL	1,000	692	69 %	308				2		-2	9	5	56 %	4									699
SQ	1,250	994	80 %	256	200			291	146 %	-91	0	4		-4	30	27	90 %	3	10	2	20 %	8	1,318
SVSP	850	865	102 %	-15	396			304	77 %	92	10	2	20 %	8	246	243	99 %	3		2		-2	1,416
VSP	1,350	1,078	80 %	272	372			332	89 %	40										1		-1	1,411
WSP	1,300	1,071	82 %	229				60		-60	6	5	83 %	1						1		-1	1,137
DSH-ASH		1		-1				3		-3					256	236	92 %	20		4		-4	244
DSH-CSH															50	47	94 %	3		1		-1	48
Male Subtotal	**27,000**	**25,035**	**93%**	**1,965**	**6,318**	**585**	**172**	**6,612**	**93%**	**463**	**407**	**239**	**59%**	**168**	**1,145**	**1,186**	**104%**	**-41**	**447**	**416**	**93%**	**31**	**33,488**
CCWF	1,350	1,261	93 %	89	120	10		125	96 %	5	12	8	67 %	4						1		-1	1,395
CIW	750	679	91 %	71	75	10	10	64	67 %	31	31	7	23 %	24	43	34	79 %	9		2		-2	786
FWF	150	145	97 %	5				1		-1													146
DSH-PSH		1		-1				2		-2					30	16	53 %	14					19
Female Subtotal	**2,250**	**2,086**	**93%**	**164**	**195**	**20**	**10**	**192**	**85%**	**33**	**43**	**15**	**35%**	**28**	**73**	**50**	**68%**	**23**	**0**	**3**		**-3**	**2,346**
Grand Total	**29,250**	**27,121**	**93%**	**2,129**	**6,513**	**605**	**182**	**6,804**	**93%**	**496**	**450**	**254**	**56%**	**196**	**1,218**	**1,236**	**101%**	**-18**	**447**	**419**	**94%**	**28**	**35,834**

NOTES:

1. This report provides operational capacities, population, and vacant beds detail by mental health level of care and institution. Level of care is based on Current Mental Health level of care code in SOMS. For each level of care, a summary of patients by SOMS housing program and institution is provided. Data Source is HCODS, as of the "Data Refreshed" time stamp.
2. Definitions:
   - Operational Capacity = indicates the number of beds available in the program based on factors such as treatment space and staffing, as determined by CCHCS headquarters.
   - Design Capacity = indicates the total number of beds available in the program Determined by Facility Planning, Construction, & Management.
   - Population = total census per SOMS as of the "Data Refreshed" time stamp shown on the report.
   - % Occupied = ([Population] / [Operational Capacity]) x 100.
   - Vacant Beds = the number of beds available after subtracting the Population from the Operational Capacity.
   - The "PIP" column in the "Psychiatry Inpatient Program (PIP) Housing" refers to programs that have the ability to provide multiple levels of care.
3. PIP capacities:
   - SQ PIP is for male condemned patients only, and has a total capacity of 40 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF, APP, and MHCB level of care.
   - CIW PIP has a total capacity of 45 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
   - DSH-PSH has a total capacity of 30 beds reflected under ICF capacity. It is noted that these are flex beds that can accomodate ICF and APP level of care.
4. Housing Groups:

*GP Housing Group census includes patients in the following housing programs: Camp Program Beds, Debrief Processing Unit, Family Visiting, Fire House, General Population, Institution Hearing Program, Minimum Security Facility, Non-Designated Program Facility, Protective Housing Unit, Restricted Custody General Population, Sensitive Needs Yard, SNY Fire House, SNY MSF, Transitional Housing Unit, Unkown, Varied Use and Work Crew.

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Correctional Clinical Case Management System (CCCMS) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total CCCMS Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP		1,069								5								1,074
CAL																		
CCC		3																3
CCI		1,447									29							1,476
CEN																		
CHCF		222	7					158		249	2							638
CIM	86	1,003		3						11	28							1,131
CMC		700		1				4			9							714
CMF		450						13	6	17	13							499
COR		630	2					14		3			191				91	931
CRC		1,517								2								1,519
CTF		1,425								10	9							1,444
CVSP		2									3							5
DVI	252	127								9	34							422
FOL		422									3							425
HDSP		935						8									60	1,003
ISP		1																1
KVSP		851						4									93	948
LAC		689	23					2			2						97	813
MCSP		1,365	14								17							1,396
NKSP	708	169		1				1			16							895
PBSP		211						2									69	282
PVSP		445															18	463
RJD		1,264	4					4			21							1,293
SAC		354	33					1			1		42		6		89	526
SATF		1,797	12					5									97	1,911
SCC		515								1	6							522
SOL		680						1			11							692
SQ	213	641						2			6	132						994
SVSP		774	7					3									81	865
VSP		1,059								11	8							1,078
WSP	926	131						3			11							1,071
DSH-ASH		1																1
DSH-CSH																		
Male Subtotal	**2,185**	**20,899**	**102**	**5**	**0**	**0**	**0**	**225**	**6**	**318**	**229**	**132**	**233**	**0**	**6**	**0**	**695**	**25,035**
CCWF	259	910						12			64	16						1,261
CIW		645						2		6	2					24		679
FWF		145																145
DSH-PSH		1																1
Female Subtotal	**259**	**1,701**	**0**	**0**	**0**	**0**	**0**	**14**	**0**	**6**	**66**	**16**	**0**	**0**	**0**	**24**	**0**	**2,086**
Grand Total	**2,444**	**22,600**	**102**	**5**	**0**	**0**	**0**	**239**	**6**	**324**	**295**	**148**	**233**	**0**	**6**	**24**	**695**	**27,121**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Enhanced Outpatient Program (EOP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total EOP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI		4									1							5
CEN																		
CHCF			420			2		43		75	34							574
CIM	29	1		1							4							35
CMC		1	519	2				2			47							571
CMF			442	5	4	4		11		10	37							513
COR			213	2				16		5	37							273
CRC		2																2
CTF		2																2
CVSP																		
DVI	3										2							5
FOL		1																1
HDSP		2															3	5
ISP																		
KVSP			87					1									12	100
LAC			502								75							577
MCSP		1	677					1			41							720
NKSP	48										2							50
PBSP																	1	1
PVSP		6															1	7
RJD			796					7			32							835
SAC		1	568					1			64				135			769
SATF		7	554	2				8									4	575
SCC																		
SOL				2														2
SQ	24	19	184					1			3	60						291
SVSP		23	268			1											12	304
VSP		5	323							1	3							332
WSP	58										2							60
DSH-ASH			1			2												3
DSH-CSH																		
Male Subtotal	**162**	**75**	**5,554**	**14**	**4**	**9**	**0**	**91**	**0**	**91**	**384**	**60**	**0**	**0**	**135**	**0**	**33**	**6,612**
CCWF	1	44	65	1				3			11							125
CIW			58				1								5			64
FWF		1																1
DSH-PSH		2																2
Female Subtotal	**1**	**47**	**123**	**1**	**0**	**0**	**1**	**3**	**0**	**0**	**11**	**0**	**0**	**0**	**5**	**0**	**0**	**192**
Grand Total	**163**	**122**	**5,677**	**15**	**4**	**9**	**1**	**94**	**0**	**91**	**395**	**60**	**0**	**0**	**140**	**0**	**33**	**6,804**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Mental Health Crisis Bed (MHCB) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total MHCB Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF			1	60						1								62
CIM		1		24														25
CMC				28														28
CMF			2	24							1							27
COR				13				1										14
CRC																		
CTF																		
CVSP																		
DVI																		
FOL											1							1
HDSP				7														7
ISP																		
KVSP				7														7
LAC			1	5							1						1	8
MCSP			2	7														9
NKSP				6														6
PBSP				1														1
PVSP																		
RJD				9							1							10
SAC				7										2				9
SATF				9														9
SCC																		
SOL				5														5
SQ	1		1		2													4
SVSP		2																2
VSP																		
WSP	1			4														5
DSH-ASH																		
DSH-CSH																		
Male Subtotal	**2**	**3**	**7**	**216**	**2**	**0**	**0**	**1**	**0**	**1**	**4**	**0**	**0**	**2**	**0**	**0**	**1**	**239**
CCWF	1	1		6														8
CIW				6				1										7
FWF																		
DSH-PSH																		
Female Subtotal	**1**	**1**	**0**	**12**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15**
Grand Total	**3**	**4**	**7**	**228**	**2**	**0**	**0**	**2**	**0**	**1**	**4**	**0**	**0**	**2**	**0**	**0**	**1**	**254**

SUMMARY OF MENTAL HEALTH POPULATION BY INSTITUTION AND LEVEL OF CARE

Data Refreshed: 3/18/20 6:10 AM

Acute Psychiatric Program (APP) Level of Care Population by Housing Program

Institution	RC Reception Center	GP* General Population	EOP Enhanced Outpatient Program	MHCB Mental Health Crisis Bed	Psychiatric Inpatient Program (PIP) Housing			Specialized Medical Beds Housing			Segregated Housing							Total APP Population
					Acute	Intermediate	PIP	CTC/SNF Correctional Treatment Center/Skilled Nursing Facility	Hospice	OHU Outpatient Housing Unit	ASU Administrative Segregation Unit	Condemned	LTRH Long Term Restricted Housing Unit	NDS Non-Disciplinary Segregation	PSU Psychiatric Services Unit	SHU Security Housing Unit	STRH Short Term Restricted Housing Unit	
ASP																		
CAL																		
CCC																		
CCI																		
CEN																		
CHCF				8	167	2		1										178
CIM				1														1
CMC				13														13
CMF				9	169	4		1										183
COR				4				1										5
CRC																		
CTF																		
CVSP																		
DVI																		
FOL																		
HDSP																		
ISP																		
KVSP				5														5
LAC				6														6
MCSP								1										1
NKSP				2														2
PBSP																		
PVSP																		
RJD				1														1
SAC				4														4
SATF				6														6
SCC																		
SOL																		
SQ					2													2
SVSP						2												2
VSP			1															1
WSP				1														1
DSH-ASH					2	2												4
DSH-CSH					1													1
Male Subtotal	0	0	1	60	341	10	0	4	0	0	0	0	0	0	0	0	0	416
CCWF				1														1
CIW				1			1											2
FWF																		
DSH-PSH																		
Female Subtotal	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	3
Grand Total	0	0	1	62	341	10	1	4	0	0	0	0	0	0	0	0	0	419

Exhibit C

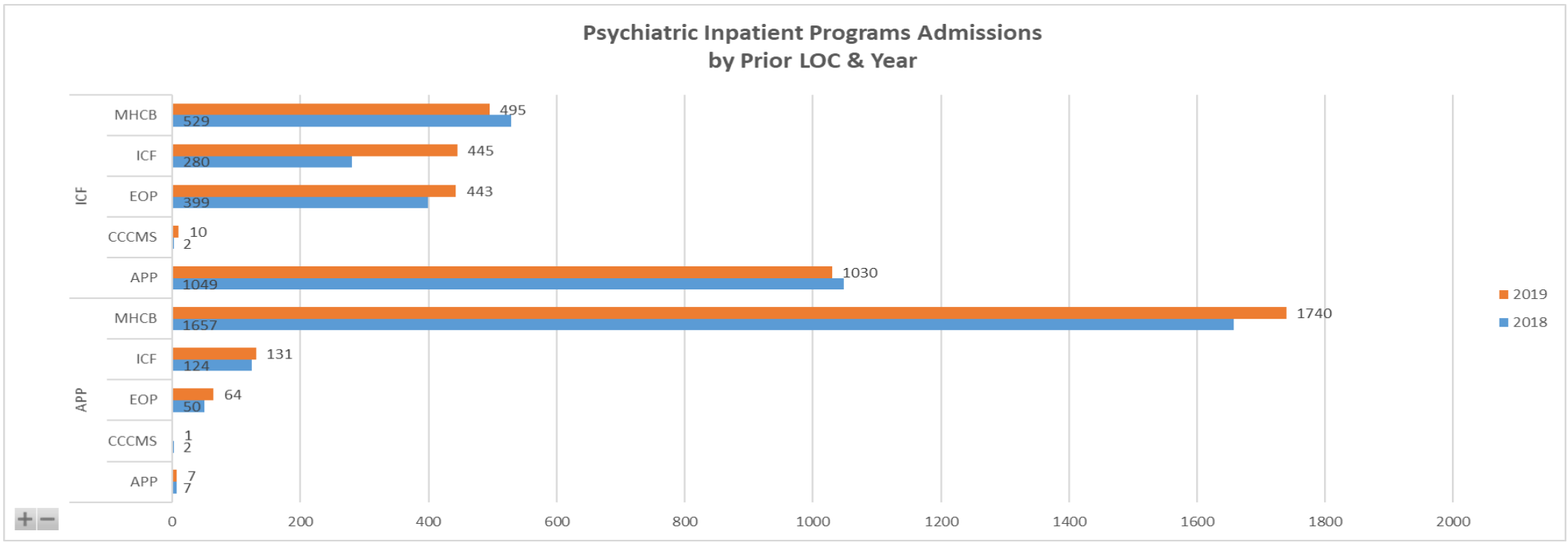
Psychiatric Inpatient Programs Admissions
2018-2019

Referral Type/Prior LOC	2018 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	*2018 Total*	2019 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	*2019 Total*	Grand Total
APP																											
APP			2		2	1		1		1			7					1				3	1		2	7	14
CCCMS											2		2						1							1	3
EOP	4	3	2	3	7	13	4	7	2		3	2	50	5	3	3	5	7	14	6	4	8	4	1	4	64	114
ICF	11	16	12	5	11	11	8	10	3	9	13	15	124	13	15	14	9	9	10	14	8	14	9	9	7	131	255
MHCB	169	145	162	132	120	131	123	161	128	140	142	104	1657	122	112	107	140	184	130	183	169	154	164	128	147	1740	3397
APP Total	**184**	**164**	**178**	**140**	**140**	**156**	**135**	**179**	**133**	**150**	**160**	**121**	**1840**	**140**	**130**	**124**	**154**	**201**	**155**	**203**	**181**	**179**	**178**	**138**	**160**	**1943**	**3783**
ICF																											
APP	97	84	108	81	89	86	67	83	65	106	97	86	1049	57	81	89	83	81	60	101	99	108	93	89	89	1030	2079
CCCMS										2			2	1		1	1	1		2	1	1	2			10	12
EOP	46	48	36	41	29	22	30	29	26	27	31	34	399	31	23	41	31	40	39	47	46	36	39	33	37	443	842
ICF	18	29	34	18	18	15	32	21	28	20	27	20	280	29	17	22	24	33	45	44	81	38	60	28	24	445	725
MHCB	43	60	52	41	34	42	51	42	39	39	39	47	529	34	29	50	46	57	40	51	52	41	43	30	22	495	1024
ICF Total	**204**	**221**	**230**	**181**	**170**	**165**	**180**	**175**	**158**	**194**	**194**	**187**	**2259**	**152**	**150**	**203**	**185**	**212**	**184**	**245**	**279**	**224**	**237**	**180**	**172**	**2423**	**4682**
Grand Total	**388**	**385**	**408**	**321**	**310**	**321**	**315**	**354**	**291**	**344**	**354**	**308**	**4099**	**292**	**280**	**327**	**339**	**413**	**339**	**448**	**460**	**403**	**415**	**318**	**332**	**4366**	**8465**

Yellow highlighted data:

*APP admissions with prior APP LOC were due to medical requirements not available at current APP location or staff separations/enemy concerns at current APP location.

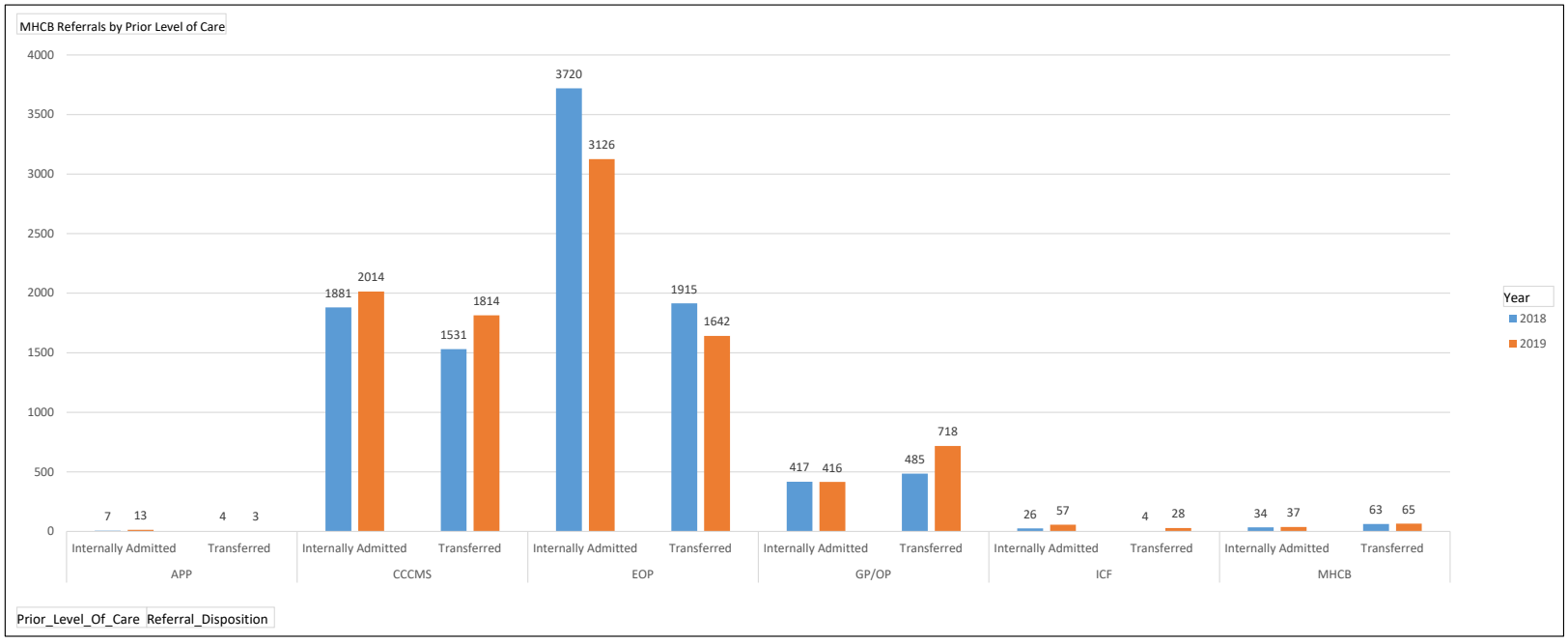
*ICF admissions with prior ICF LOC are transition referrals between ICF-High (Single), ICF-Dorms, and ICF-High (Multi).



Source: RIPA

MHCB Referrals by Prior Level of Care
2018- 2019

MHCB Referrals by Prior Level of Care	2018	2019	Grand Total
APP	**11**	**16**	**27**
Internally Admitted	7	13	20
Transferred	4	3	7
CCCMS	**3412**	**3828**	**7240**
Internally Admitted	1881	2014	3895
Transferred	1531	1814	3345
EOP	**5635**	**4768**	**10403**
Internally Admitted	3720	3126	6846
Transferred	1915	1642	3557
GP/OP	**902**	**1134**	**2036**
Internally Admitted	417	416	833
Transferred	485	718	1203
ICF	**30**	**85**	**115**
Internally Admitted	26	57	83
Transferred	4	28	32
MHCB	**97**	**102**	**199**
Internally Admitted	34	37	71
Transferred	63	65	128
Grand Total	**10087**	**9933**	**20020**



Note: Those referrals originating from MHCB LOC are those patients who are MHCB to MHCB transfers for court appearances, long term hospital stays, and continuity of care purposes.

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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	Case No. 2:90-cv-00520 KJM-DB (PC) **E. THORN DECLARATION SUPPORTING DEFENDANTS' RESPONSE TO JULY 2 ORDER** Judge: The Hon. Kimberly J. Mueller

I, Elise Owens Thorn, declare as follows:

1. I am a Deputy Attorney General with the California Office of the Attorney General, attorney of record for Defendants in this case, and I am admitted to practice before the courts of the State of California and before this Court. I am competent to testify to the matters set forth in this declaration, and if called upon by this Court, would do so. I submit this declaration in support of Defendants' Response to July 2 Order.

2. The Attorney General's Office is counsel of record for Defendants in *Plata v. Newsom*, Case No. 01-cv-01351-JST. In that capacity, my office receives reports prepared by the *Plata* Court Experts.

3. Attached as Exhibit D is a true and correct copy of the Plata Court Experts' Salinas Valley State Prison Report, dated April 13, 2017.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed in Sacramento, California on July 15, 2020.

/s/ Elise Owens Thorn
Elise Owens Thorn

Exhibit D

Plata Court Experts
Salinas Valley State Prison (SVSP) Report
April 13, 2017

Executive Summary

In February 2017, Judge Thelton Henderson asked the court experts to review the severity of problems at SVSP and the extent to which these problems may be related to staffing deficiencies.

Medical care has been inadequate at SVSP for well over four years as evidenced by two court expert reviews and one OIG inspection. High vacancy rates in physician, nursing and ancillary staffing is the major, but not only factor, contributing to problems at SVSP. Other factors include:

- Turnover in health care leadership;
- Breakdown in health care systems;
- High percentage (50%) of mental health patients;
- Total inmate population above design capacity (138%);
- Access to care issues related to custody;
- Inability to terminate poorly performing staff after exhausting the disciplinary process.

CCHCS headquarters has increased access to medical providers through telemedicine and registry staff. This support is insufficient to resolve the systemic problems in the SVSP health care program. Furthermore, CCHCS Regional support to SVSP has been limited.

Although the causes of health care issues at SVSP are multifactorial, adequate care cannot be provided until there are adequate staffing levels and this must be a priority. However, to resolve the persistent issues at SVSP, a comprehensive strategy is required by the Receiver, CDCR and CCHCS, including:

- Retaining qualified health care leadership;
- Increasing staff salaries to market rates;
- Reducing SVSP population to design capacity;
- Reducing the mental health population to lower the mental health/medical acuity of the prison;
- Reassessing the custody Access to Care program;
- Fixing systemic deficiencies by greater sustained on-site presence of CCHCS Headquarters and Regional teams to assist local leadership in instituting improvements;

The Receivership should determine whether any measures needed to resolve systemic issues require waivers of state law and/or regulations. Findings that support our opinions are described below.

Previous Court Expert and OIG Inspection Findings

As background for this report, we note that in June 2013 the court experts conducted a site visit at SVSP and published the results of our review in August 2013. At that time we observed numerous systemic issues related to health care systems and quality of care. In November 2016 the OIG assigned SVSP an

overall rating of inadequate. The OIG report found no area of service proficient and six of twelve primary quality indicators inadequate (50%). SVSP also failed two secondary quality indicators.[1] The list of issues identified by the OIG included the following:

1. A "profound inability to provide patients with adequate access to care".
2. Unstable health care leadership.
3. Significant provider staffing shortages due to inability to hire and retain staff.
4. Severe provider appointment backlogs.
5. Failure to retrieve and/or scan specialty reports and hospital discharge summaries into the eUHR.
6. Failure to scan clinical notes into the eUHR.
7. Failure of providers to follow up after specialty visits and failure to review specialty reports.
8. Failure of providers to review radiology reports.
9. Delayed and missed registered nurse visits.
10. Inconsistent quality of nursing care.
11. Lack of reliable communication of provider orders including medication and nursing orders.
12. Inadequate medication management process.
13. Failure to receive ordered medications.
14. Almost 40% of physician clinical events reviewed were considered deficiencies.
15. Almost 8% of physician clinical events reviewed were of a magnitude that if unaddressed would likely harm the patient.
16. Almost 10% of access to care events were considered significant enough to place the patient at risk of harm. These were related mostly to timely scheduling of physician appointments.
17. 25% of diagnostic tests evaluated had deficiencies with 14% related to medical records and 8% of tests not being done.

Court Expert Review

To perform this review, the court experts conducted interviews with Clark Kelso and CCHCS leadership[2], SVSP health care leadership[3], and reviewed 50 health records. Our review showed several factors contributing to the persistent systemic issues at SVSP and are described below.

Health Care Leadership Turnover

Qualified leadership and supervision are key components to an adequate health program. SVSP has had significant turnover in health care leadership over a period of years. The lack of competent and stable leadership has been a major factor in the ongoing problems at this facility.

Over the past 3 years there have been six different Chief Executive Officers (CEO). The Chief Medical Executive (CME) has been in her position for one year and was in an acting position for one year. Prior to her arrival, there had been multiple CMEs. SVSP has also had 4 Chief Nursing Executives (CNEs) in the past year and 7 (50%) of 14 Supervising Registered Nurse (SRN) positions are vacant.

[1] The two secondary quality indicators are: 1) Internal Monitoring, Quality Improvement, and Administrative Operations and 2) Job Performance, Training, Licensing and Certifications.
[2] Rich Kirkland, Deputy Receiver, Steve Tharratt MD, Statewide Chief Medical Executive.
[3] We spoke with Brittany Brizendine, Dr. Kumar CME, Alex Newton CNE, Patrick McMahon, previous Acting CNE,

With respect to leadership SVSP seems now to have an engaged CEO, CME, and CNE. Following our interviews with health care leadership, we are encouraged that the new leadership team is committed to fixing defective processes. However, retaining SVSP leadership requires support by regional and headquarter leadership staff to ensure the local leadership has the staff and resources necessary to accomplish their mission. Key to their success is the ability to hire and retain qualified staff which continues to be problematic.

As an example, the Chief Medical Executive (CME) indicated that she was unable to find qualified Chief Physician & Surgeon candidates for the position. She ultimately hired an in-house candidate who is not adequately performing the duties of the position, including supervision of other providers. The CME also reported spending an inordinate amount of time (25-30%) performing 100% record review for a physician with long-standing performance issues that resulted in actual harm or risk of harm to patients.[4] A physician whose performance does not improve after prolonged counseling, training and peer review should not be permitted to practice in CDCR. This reflects a failure of the peer review and disciplinary process.

Staffing Recruitment Challenges

SVSP is located in a geographic area that has a high cost of living. This, in combination with leadership turnover and challenging patient population has resulted in difficulty with staff recruitment and retention.

Medical provider vacancy rates have increased from 18% in 2013 to 31% in March 2017. The CME reported that SVSP was allocated 11.5 FTE[5] medical provider positions with 9.3 FTE's filled and 2.2 vacant. This is misleading because only 2.0 FTE's (17%) are filled by on-site state employees. This includes a nurse practitioner and physician who is assigned to the Correctional Treatment Center (CTC). The remaining 7.3 FTE's are backfilled by 3 remote telemedicine providers and 4.3 FTE providers that are part- or full-time registry. Thus, almost 50% of medical providers are registry. According to management, this group frequently changes their hours and commitment. There are insufficient numbers of providers to attend morning huddles in each of the housing unit clinics. Lack of stable medical providers likely contributes to lack of adherence to policy and procedures, poor communication and fragmentation of care.

Health care leadership reported that a 1200 provider appointment backlog has been recently reduced to 600 but this is still a large backlog. The facility has initiated a form of rationing because of the staffing deficiencies. The CME has initiated a "high risk" clinic which is meant to ensure that those with the highest priority problems are seen before other less complicated problems are addressed. This means that those with less serious problems are not seen timely. This is not something that SVSP leadership desires or would continue if staffing were adequate. Over time these types of accommodations are likely to result in harm to patients.

We note that many nursing and ancillary support classifications have high vacancy rates. The table below shows functional vacancy rates for a variety of support and clinical positions.

[4] The physician died in January 2017.

[5] FTE=Full Time Equivalent.

Key Positions as of 3/24/17						
Classification	PY Allocation	Filled	Vacant	Long Term Medical Leave	Functional Vacancy PY	Functional Vacancy %
OT[6]	22	18	1	3	4	18%
OA[7]	9	5	4		4	44%
HRT[8] I	5.5	5	0.5		0.5	9%
LVN[9]	61.9	39	22.9	7	29.7	48%
RN[10]	55.2	43.7	11.5	8	19.5	35%
SRN[11] II	14.3	7	7.3	1	8.3	58%
PROVIDERS[12]	11.5	9.3	2.2		2.2	19%

Health care is a complex process involving coordination of care between different members of a health care team. High vacancies in any category of staff can lead to inefficiency, poorly coordinated care and serious medical errors. Nursing and ancillary staff (OT, HRT) are critical for provider support and efficiency. We were told that provider productivity, despite large backlogs, was recently 6-7 patients per day versus a statewide expectation of 12 patients per day. This low productivity can be associated with insufficient nursing and support staff as well as provider-specific performance issues. The OIG noted that medical providers at times have to search for reports; laboratory tests are not done; medical documents are not filed in the eUHR; and orders for medications and nursing assignments are miscommunicated. This was evident on our record reviews as well. SVSP leadership believes these types of errors affect the morale of the providers and contribute to staffing deficiencies.

Nurse staffing is inadequate. According to nurse leadership, 15 of 55 RN positions are vacant, 26 of 62 LVN positions are vacant, and 12 of 45 psych tech positions are vacant. Nursing leadership backfills the positions with mandatory overtime and registry. The use of mandatory overtime results in low morale. LVNs that provide clinic support to medical providers have a functional vacancy rate of almost 50%.

Lack of support staff to providers lowers productivity and causes delays in access to care that harms patients. In both court expert and OIG reports, many of the deficiencies are the responsibility of support staff that have significant vacancy rates. Medical provider, nursing and support staff vacancies must be remedied to remedy existing systemic deficiencies.

It has not been possible to attain an adequate staffing level at SVSP for years. A rational question is whether this can ever be achieved at reasonable salary levels. If hiring sufficient staff is not possible, the State may need to consider closing this facility or moving the entire mental health population to a facility closer to a geographic location where it is easier to recruit staff. This would make SVSP a true

[6] Office Technician.
[7] Office Assistant.
[8] Health Records Technician.
[9] Licensed Vocational Nurse.
[10] Registered Nurse.
[11] Supervising Registered Nurse.
[12] Physicians and Nurse Practitioners.

basic facility with fewer complex patients thereby making it easier to manage. This would lower the pressure on staffing.

Recognizing that SVSP will probably remain where it is, we recommend an approach that addresses both systemic and staffing deficiencies. Improving staffing levels will undoubtedly raise costs. The market rates to recruit to this facility may be considerable given that the State has placed a difficult to manage mental health facility in a high cost of living area. Correcting staffing deficiencies will require assessing the market and determining what salary it will take to attract sufficient staff for each classification level at this particular facility. This may be difficult with current state bargaining agreements and contracts. Nevertheless, unless this is done, the problems will persist with the accompanying care deficiencies and risk of harm. Accelerating HCFIP and installation of the electronic medical record may improve the ability to recruit. These should be expeditiously finished. The electronic record, in particular, will help in partly eliminating some of the missing medical record documents and will allow existing staff to more effectively scan outside clinical reports to the record.

Quality of Care and Health Care System Issues

With respect to clinical care outcomes, we conducted in depth review of 50 cases. Regarding high acuity cases, eleven of eighteen (61%) hospital cases we reviewed were inadequate. We do not include details of these case reviews in this report, but there were multiple cases of harm to patients including unnecessary and preventable hospitalizations; failure to adequately treat chronic illnesses for extended periods of time; failure to timely diagnose serious illness; and losing patients to specialty follow-up. In addition, there were numerous cases of failure to adequately diagnose illness, failure to timely or adequately follow up on critical lab values, failure to develop an adequate therapeutic plan, and failure to review consultant reports, thereby failing to initiate consultant's recommendations. We also reviewed the medical records of 20 high-risk patients with a variety of chronic illnesses, including diabetes, hypertension, asthma, cardiac disease, hepatitis C, cancer, ulcerative colitis, and rheumatoid arthritis. Most of these patients were being followed in the high-risk clinic described above. While this procedure appears to have successfully addressed the timeliness of provider visits for this population, we identified problems similar to the ones noted above with medical records, diagnostics, and specialty care. Based on our and the OIG findings, it is clear that harm and the risk of harm is significant and ongoing to this population.

The scheduling system for health care appointments in MedSats is a major concern. Health care leadership reported that on two occasions, over 800 chronic disease appointments were lost in MedSats and had to be restored with the assistance of CCHCS. Despite this, leadership reported that scheduling is still "a mess" and is unreliable, increasing risk of harm to patients with serious medical conditions.

This and other systemic deficiencies can be evaluated using root cause analysis and other process improvement and lean techniques and then resolved by applying what is learned to the operations. Central office has indicated to us that CCHCS has developed expertise in these techniques and it makes sense for those in central office with this expertise to join the regional staff in assisting this deficient institution.

SVSP Has a High Percentage of Mentally Ill Inmates

On 3/22/17 the SVSP population was 3,400 with a design capacity of 2,452 or 138.7% of design capacity. SVSP is designated a basic care institution. This designation implies a low level of acuity but is misleading

as 1804 (53%) of 3,400 inmates have serious mental illness. SVSP is also designated an American with Disabilities (ADA) facility which present issues related to management of scarce medical beds.

SVSP Mental Health Caseload	
Mental Health Classification	Number of Inmates
EOP	612
ASU EOP	27
CCCMS	909
CCCMS ASU	64
MHCB	9
DSH	183
Total MH population	**1804**

The Department of State Hospital (DSH) unit on the SVSP grounds is a 250-bed capacity institution with a current census of 183. Later this year DHS plans to transfer management of the hospital to CDCR which will increase both the number and acuity of the mental health population at SVSP. A higher acuity mental health population is more difficult population to manage clinically and is likely to make recruitment of staff even more challenging.

Custody Issues

Record review revealed issues unrelated to health care staffing resulting in inadequate access to care. We noted health care staff documented many refusals of care but there was no associated signed refusal of care in the eUHR. SVSP leadership reported that that this was a serious problem with refusals occurring for all types of clinical encounters including nursing, provider, and specialty appointments. In many instances custody did not escort the patient's to the clinic to sign refusals of care, raising the question of whether the patient actually refused care. SVSP leadership conducted a study by sampling refusals to assess how many have a signed refusal. In a recent study only 30% of refusals included a signed inmate refusal. The numbers of refusals vary by yard can be high. Leadership told us that one yard had 70 refusals in one month. This needs to be assessed more closely to determine if the access to care program is operating effectively at this facility.

Conclusion

In summary, the factors contributing to long-standing problems at SVSP are multifactorial and require a comprehensive plan at the highest levels of CDCR and CCHCS. Without a comprehensive approach and sustained support and monitoring, medical care at SVSP will likely continue to be inadequate.